IN THE UNITED STATES DISTRICT COURT FOR
THE NORTHERN DISTRICT OF OKLAHOMA

(1) KATHERINE FISHER, (2) EARLEE HEATH, and (3) KAROL LOY, on behalf of themselves and all others similarly situated,	
Plaintiffs,	
v.	**Case No. 02CV 762P (C)**
(1) OKLAHOMA HEALTH CARE AUTHORITY, and (2) MIKE FOGARTY, in his official capacity as CEO of the Oklahoma Health Care Authority	
Defendants.	

DEFENDANTS' MOTION FOR SUMMARY JUDGMENT
AND BRIEF IN SUPPORT

Pursuant to Fed. R. Civ. Pro. 56, Defendants Oklahoma Health Care Authority (OHCA) and Mike Fogarty, in his official capacity as chief executive officer of OHCA (Fogarty), move for summary judgment on all claims made by Plaintiffs Katherine Fisher, Earlee Heath, and Karol Loy (Medicaid Recipients) because the pleadings, affidavits, and other evidentiary materials in this case show there is no genuine issue of material fact and the Defendants are entitled to judgment as a matter of law.

STATEMENT OF UNDISPUTED FACTS

1. Plaintiffs Katherine Fisher, Earlee Heath, and Karol Loy are Medicaid recipients with disabilities who are part of the Home and Community-Based Waiver

Program (sometimes referred to hereafter as Advantage). Complaint ¶¶ 1, 13, 14, and 15.

2. During the current State Fiscal Year and prior to October 1, 2002, the Oklahoma Medicaid program provided Advantage recipients with unlimited prescription drugs. Complaint ¶¶ 1 and 7.

3. On September 18, 2002, the OHCA Board reduced the drug benefit for all Advantage recipients across the State of Oklahoma to five prescriptions per month. OHCA Board Minutes, attached as Exhibit E, page 5, "Board Voted Upon Item 2."

4. The reduction was occasioned by a statewide revenue shortfall. Affidavit of OHCA Chief Executive Officer Mike Fogarty, attached as Exhibit B to Defendants' Memorandum of Law Opposing Plaintiffs' Request for Preliminary Injunction; and Defendants' Motion to Dismiss and Brief in Support (Motion to Dismiss), ¶¶ 4 and 5.

5. On or about September 19, 2002, OHCA informed the Medicaid Recipients that Advantage recipients' drug benefits would be limited to five per month. Complaint ¶ 3.

6. OHCA did not provide the Medicaid Recipients with an opportunity for a hearing about the benefit reduction. Complaint ¶ 4.

7. As part of the creation of the Home and Community-Based Waiver Program, the U.S. Secretary of Health and Human Services waived the requirement that Medicaid services for waiver recipients be comparable to those for other Medicaid recipients. Oklahoma's Advantage Program 1915(c) Waiver Renewal

Document, 2002-2006, attached without appendices as Exhibit D, ¶¶ 10 and 11(s) at pages 4 and 5.

8. With proper scheduling of Earlee Heath's prescription purchases, Earlee Heath's monthly cost for prescription drugs could be reduced to approximately twenty-five dollars rather than the two hundred fifty-five dollars alleged in the Medicaid Recipients complaint. Affidavit of Nancy Nesser, D.Ph., J.D., attached to Motion to Dismiss as Exhibit C, ¶ 6

9. Even that cost could be reduced if Ms. Heath's diabetes prescriptions were managed to avoid drug interactions and conflicting drugs. Exhibit C, ¶ 6.

10. With scheduling, Karol Loy's monthly prescription cost could be reduced to two hundred dollars instead of four hundred seventy-six dollars alleged in the complaint. Exhibit C, ¶ 7

11. Management of Ms. Loy's prescriptions to avoid drugs working at cross purposes could reduce the cost further. Exhibit C, ¶ 7.

12. With scheduling, Katherine Fisher's prescription cost could be reduced to forty-five to sixty dollars per month instead of two hundred seventy-four dollars as alleged in the complaint. Exhibit C, ¶ 5.

13. Management to eliminate duplicate drug therapy and interaction could reduce Ms. Fisher's cost further. Exhibit C, ¶ 5.

STANDARD FOR SUMMARY JUDGMENT

Summary judgment is appropriate "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a

judgment as a matter of law." Fed. R. Civ. Pro 56(c). "[A] motion for summary judgment should be granted only where the moving party has established the absence of any genuine issue as to a material fact." *Mustang Fuel Corp. v. Youngstown Sheet & Tube Co.*, 561 F.2d 202, 204 (10th Cir. 1977).

The movant bears the initial burden of showing a lack of genuinely disputed material fact and thus requiring judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986). A fact is material if it is essential to the proper disposition of the claim. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). If the movant carries this burden, then the non-movant must set forth "specific facts" outside the pleadings and admissible in evidence that would convince a rational trier of fact to find for the non-movant. Fed. R. Civ. Pro. 56(e).

STATEMENT OF THE CASE

After the Court conducted a hearing on the Medicaid Recipients' request for a preliminary injunction (combined with the hearing on the merits), the Plaintiffs amended their complaint so this lawsuit now stands on four legs: The first leg, brought solely against Fogarty in his official capacity, claims violation of the Americans with Disabilities Act, 42 U.S.C. § 12101 *et seq.*, as the State has limited prescription drug coverage for individuals on Advantage to five prescriptions per month while allowing nursing home residents unlimited prescriptions. The second leg, again brought solely against Fogarty in his official capacity, alleges the prescription limitation violates the Medicaid Act, 42 U.S.C. § 1396 *et seq.* The violation alleged appears to be of the Act's "comparability" requirement.

The third leg, brought against Fogarty in his official capacity alone, alleges denial of due process requirements under the Fourteenth Amendment of the U.S. Constitution because OHCA did not provide individual hearings before changing each Advantage recipient's prescription benefit. The final leg is brought against both Fogarty in his official capacity and OHCA and rests on Section 504 of the Rehabilitation Act of 1973, 29 U.S.C. § 794. Exactly what the allegation is, is not clear from the Amended Complaint, but as best the Defendants can tell the claim alleges discrimination against the Medicaid Recipients.

Medicaid is a joint State/federal program designed to provide medical care for various groups in the American population, particularly low-income individuals who are children, pregnant, elderly, or blind or otherwise disabled. 42 U.S.C. § 1396a(a)(10)(A) and (C). Each State has the option to participate with the federal government in Medicaid or to forgo participation. Once a State enters into a partnership with the federal government, Congress requires the State to provide a minimum level of benefits generally known as the mandatory program. 42 U.S.C. § 1396a(a)(10)(A)(i); 42 C.F.R. §§ 440.210 and 440.220. Mandatory services are nursing home care, hospital care, laboratory and X-ray services, physician care, nurse-midwife care, and pediatric nurse practitioner care. *Id.*

States may also expand the program with certain optional coverages. 42 U.S.C. § 1396a(a)(10)(A)(ii). Pharmacy benefits outside hospital and nursing home stays are part of the optional program and are implicated in this suit. *Id.* and 42 U.S.C. § 1396d. The Home and Community-Based Waiver Program, which is also relevant to this action, is part of the optional program. 42 U.S.C. §§ 1396n, 1396t and 1396u.

ARGUMENT

The Social Security Act, of which Medicaid is part, "is among the most intricate ever drafted by Congress. Its Byzantine construction, as Judge Friendly has observed, makes the Act 'almost unintelligible to the uninitiated.'" *Schweiker v. Gray Panthers,* 453 U.S. 34, 43 (1981), quoting *Friedman v. Berger,* 547 F.2d 724, 727 (2d Cir. 1976).

> There can be no doubt but that the statutes and provisions in question, involving the financing of Medicare and Medicaid, are among the most completely impenetrable texts within human experience. Indeed, one approaches them at the level of specificity herein demanded with dread, for not only are they dense reading of the most tortuous kind, but Congress also revisits the area frequently, generously cutting and pruning in the process and making any solid grasp of the matters addressed merely a passing phase.

Rehabilitation Ass'n of Virginia, Inc., v. Kozlowski, 42 F.3d 1444, 1450 (4th Cir. 1994).

The statutes at issue in this case are abominable, but the Defendants approach them with three goals in mind: to show that (1) an overall change in the State's Medicaid program does not require individual hearings, (2) the Medicaid Recipients have not been discriminated against because of their disabilities, and (3) the waiver of federal law under which the State operates the Home and Community-Based Waiver Program includes waiver of the statutory requirement that the Medicaid Recipients receive the same package of benefits as all other Medicaid clients.

PROPOSITION I: WHEN A STATE EFFECTS A MASS WELFARE BENEFIT REDUCTION, INDIVIDUAL HEARINGS ARE NOT REQUIRED TO SATISFY DUE PROCESS.

A welfare entitlement program, such as Medicaid, creates a property interest in recipients, which typically cannot be affected without adherence to due process. *Atkins v.*

Parker, 472 U.S. 115, 128 (1985). Due process, however, does not always include the right to individual notice and its attendant hearing.

In *Atkins*, the Supreme Court considered another portion of the State/federal social welfare program, namely food stamps. In that case, the Massachusetts Department of Public Welfare was required to make a "mass change" in the food stamp program, which resulted in some individuals losing eligibility for food stamps and other individuals receiving fewer food stamps. Parker and other food stamp recipients argued they should have received individualized notice of the change so each person could determine whether he or she should seek a hearing.

The Court ruled that when alterations in a welfare benefit are not due to individual adverse actions but are instead caused by a "mass change" in program benefits, traditional individual due process is not required. *Atkins*, 472 U.S. at 129-30. "[L]egislative determination provides all the process that is due." *Id.* at 130. The Court explained:

> General statutes within the state power are passed that affect the person or property of individuals, sometimes to the point of ruin, without giving them a chance to be heard. Their rights are protected in the only way that they can be in a complex society, by their power, immediate or remote, over those who make the rule.

Id., quoting *Bi-Metallic Investment Co. v. State Bd. of Equalization*, 239 U.S. 441, 445 (1915).

In the case at bar, the Oklahoma Legislature appropriated a certain sum of money for the mandatory and optional portions of Medicaid program. State revenues fell short of expectations, and all State administrative agencies were forced to cut budgets by the provisions of Oklahoma's Balanced Budget Amendment, Okla. Const. 10 § 23 ¶¶ 1 and

6. Acting in its quasi-legislative capacity, the Oklahoma Health Care Authority Board chose to enact *de facto* rules effecting mass reductions in optional program benefits. As recognized by the Supreme Court in *Atkins*, such mass change does not require individualized notice or hearings.

Oklahoma's implementation of these mass reductions is also consistent with federal Medicaid regulations which provide, "The agency need not grant a hearing [to recipients] if the sole issue is a Federal or State law requiring an automatic change adversely affecting some or all recipients." 42 C.F.R. § 431.220(b). The law requiring automatic change here is Oklahoma's Balanced Budget Amendment.

Since individual due process hearings are not required for mass changes in the Medicaid program, the Medicaid Recipients fail to state a due process claim for which relief can be granted. Judgment for Fogarty as a matter of law is required.

PROPOSITION II: DIFFERENCES IN DRUG BENEFITS FOR NURSING HOME RESIDENTS AND THE PLAINTIFFS ARE NOT BASED ON DISABILITY; THEREFORE, CLAIMS BASED ON THE ADA AND REHABILITATION ACT FAIL AS A MATTER OF LAW.

Two of the ADA's three titles are relevant to the State; the first deals with discrimination in employment against persons with disabilities, and the second, with public access for disabled individuals to facilities and programs. The case at bar implicates Title II, the public access provisions.

Title II provides:

> No qualified individual with a disability shall, ***by reason of such disability***, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.

42 U.S.C. § 12132 (emphasis added).

Likewise, the Rehabilitation Act, recently raised by the Medicaid Recipients, provides:

> No otherwise qualified individual with a disability in the United States, as defined in section 7(20) shall, ***solely by reason of her or his disability,*** be excluded from the participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance. . . .

29 U.S.C. § 794(a) (emphasis added).

At the hearing of this case, the Medicaid Recipients made clear that they believe they are being discriminated against because nursing home residents receive unlimited prescription benefits while the waiver clients have been limited to five prescriptions per month. Each Plaintiff acknowledged that she could receive the unlimited benefit by going to a nursing home but each refused to move. The Medicaid Recipients acknowledge that to participate in the Advantage program they must be qualified for nursing home care. The only physical or mental difference shown between nursing home residents and the Medicaid Recipients is that two of them are younger than the stereotypical nursing home resident. For all intents and purposes, the Advantage recipients and the nursing home recipients are the same medically. The real difference between them is the Advantage recipients' choice to remain in the community. The difference in pharmacy benefit, therefore, is not based on disability.

There is, in fact, a difference in pharmacy benefits for persons with disabilities and persons without disabilities. Recipients without disabilities receive only three prescriptions per month compared with five for Advantage recipients and unlimited prescriptions for nursing home residents. Oklahoma Administrative Code (OAC) 317:30-5-57(19), attached as Exhibit H. If there is discrimination on the basis of disability, it is reverse discrimination against individuals without disabilities.

Because the Medicaid Recipients have not been discriminated against on the basis of their disabilities the actions against Fogarty under the ADA and Rehabilitation Act fail

as a matter of law, as does the Rehabilitation Act claim against OHCA. Judgment must be entered for the Defendants.

PROPOSITION III: OKLAHOMA HAS RECEIVED A WAIVER OF "COMPARABILITY" REQUIREMENTS FOR PRESCRIPTION DRUG BENEFITS; THEREFORE, THE STATE MEDICAID PROGRAM NEED NOT PROVIDE THE SAME BENEFITS TO NURSING HOME RESIDENTS AND WAIVER PROGRAM RECIPIENTS.

Generally, when medical assistance is provided under the Medicaid program, whether through mandatory or option services, benefits must be comparable among recipients. 42 U.S.C. § 1396a(a)(10)(B). The Secretary of Health and Human Services, however, can waive the comparability requirement for programs such as the Home and Community-Based Waiver Program. 42 U.S.C. § 1396n(c)(3).

The Secretary waived that requirement for the State of Oklahoma. Oklahoma's Advantage Program 1915(c) Waiver Renewal Document, 2002-2006, attached without appendices as Exhibit D, ¶¶ 10 and 11(s) at pages 4 and 5. (The waiver is accomplished through a form provided by the Centers for Medicare and Medicaid Services [CMS] within the Department of Health and Human Services. That form is almost as confusing as the Medicaid statutes. In this case, the State indicated the comparability waivers it sought by marking a checklist.)

Originally, the State contemplated providing Advantage recipients and nursing home Medicaid recipients with the same benefit; however, the OHCA Board changed that policy at its September 18 meeting. OHCA Board Minutes, attached as Exhibit E, page 5, "Board Voted Upon Item 2." Pursuant to CMS procedure, the change may be made during the current State fiscal year and may have retroactive effect to the beginning of the fiscal year, although this change was prospective. CMS State Medicaid Manual § 4445(A), attached as Exhibit F. ("HCFA" referred to in Section 4445(A) was the Health Care Financing Administration, which has been renamed CMS.) The State Medicaid

Manual is the official CMS interpretation of its rules and Medicaid statutes. State Medicaid Manual Forward, attached as Exhibit G.

The Secretary's statutorily allowed waiver of comparability requirements defeats the Medicaid Recipients' contention that the Medicaid Act has been violated. Judgment for Fogarty as a matter of law is appropriate.

PROPOSITION IV: APPROPRIATE SCHEDULING OF DRUG PURCHASES AND MANAGEMENT OF PRESCRIPTIONS TO AVOID DRUG INTERACTIONS REDUCES MEDICAID RECIPIENTS' OUT-OF-POCKET COSTS TO ZERO OR A MANAGEABLE LEVEL.

The Medicaid Recipients do not show harm. Although the new rules limit them to five prescriptions per month, that does not mean they may receive only five of their drugs through Medicaid. The program allows monthly filling of a prescription with one hundred units (usually pills) or a thirty-four-day supply of the drug, whichever is greater. OAC 317:30-5-77.1, attached as Exhibit I. Obviously, a medication which is taken only once a day, can be stretched into a three-month supply paid for by Medicaid by buying one hundred units in a month. That drug would not need to be purchased the following month and would be replaced by another drug for Medicaid purchase. By carefully scheduling their drug purchases and managing prescriptions to avoid drug interactions, the Medicaid Recipients can obtain full or nearly full payment for their prescriptions.

As shown in the Affidavit of Nancy Nesser, D.Ph., J.D., attached to Motion to Dismiss as Exhibit C, ¶ 6 (and by Nesser's testimony at the injunction hearing), Earlee Heath's monthly cost could be reduced to approximately twenty-five dollars rather than the two hundred fifty-five dollars alleged in the Medicaid Recipients complaint with proper scheduling. Exhibit C, ¶ 6. Even that cost could be reduced if Ms. Heath's diabetes prescriptions were managed. Exhibit C, ¶ 6.

With scheduling, Karol Loy's monthly cost could be reduced to two hundred dollars instead of four hundred seventy-six dollars alleged in the complaint. Exhibit C, ¶ 7. Management of her prescriptions to avoid drugs working at cross purposes—such as toxic levels of acetaminophen—could reduce the cost further. Exhibit C, ¶ 7.

With scheduling, Katherine Fisher's cost could be reduced to forty-five to sixty dollars per month instead of two hundred seventy-four dollars as alleged in the complaint. Exhibit C, ¶ 5. Management to eliminate duplicate drug therapy and interaction could reduce the cost further. Exhibit C, ¶ 5.

Without going to a nursing home and by engaging the OHCA-paid services of the case manager who testified at the hearing, the Medicaid Recipients can obtain the drugs they require—often apparently to the improvement of their health as they avoid improper medicating. The Medicaid Recipients have not shown harm that requires the Court to enter an injunction as requested. Judgment is appropriate for the Defendants.

PROPOSITION V: DIFFERENCES BETWEEN HIGHER AND LOWER INCOME RECIPIENTS CREATES A CONFLICT THAT PRECLUDES CLASS STATUS.

The Medicaid Recipients have asked the Court to declare their suit a class action on behalf of about two hundred Advantage waiver clients in the Tulsa area. The class action status cannot be granted because of a conflict among the class members.

At the hearing on this matter, the Medicaid Recipients, acting through their counsel, suggested cutting off all benefits for Advantage recipients whose income is two hundred or two hundred fifty percent of Supplemental Security Income or higher while retaining the unlimited pharmacy benefit for lower-income recipients. Obviously, this is a conflict with those recipients with greater income .

To obtain class status, the Plaintiffs must to prove that they as the class representatives are capable of representing the rights of all the members of the class. The analysis encompasses two factors. The first is whether the named Plaintiff's counsel is adequate and secondly whether the named Plaintiffs have interests antagonistic to those of the class. *Rosario v. Livaditis,* 963 F.2d 1013, 1018 (7th Cir. 1992). "A class is not fairly and adequately represented if class members have antagonistic or conflicting claims." *Id.* at 1018-19.

By the suggested "fix" for the State funding problem, the Medicaid Recipients have shown there is a fundamental antagonism between the interests of the potential class. These differing interests require a rejection of the Medicaid Recipients' goal of forming a class.

CONCLUSION

(1) Individual due process hearings are not required when a mass change is made in a social welfare program. (2) The Medicaid Recipients have not been discriminated against on the basis of disability. (3) The federal government has exercised its statutory power to waive the comparability requirements of the Medicaid Act for the Plaintiffs.

For these reasons, the requested relief should be denied and judgment entered for Fogarty and OHCA.

Respectfully Submitted,

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CERTIFICATE OF SERVICE

On this 9th day of October, 2002, the undersigned caused the above and foregoing document to be faxed to and placed in the U.S. Mail, postage prepaid, addressed to:

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Andrew Tevington

Oklahoma's

ADvantage Program 1915(c) Waiver

Renewal Document

2002 – 2006

[Original]

SECTION 1915(c) WAIVER FORMAT

1. The State of Oklahoma requests a Medicaid home and community-based services waiver under the authority of section 1915(c) of the Social Security Act. The administrative authority under which this waiver will be operated is contained in Appendix A.

   This is a request for a model waiver.

   a._____ Yes b.__X__ No

   If Yes, the State assures that no more than 200 individuals will be served by this waiver at any one time.

   This waiver is requested for a period of (check one):

   a._____ 3 years (initial waiver)

   b.__X__ 5 years (renewal waiver)

2. This waiver is requested in order to provide home and community-based services to individuals who, but for the provision of such services, would require the following levels (s) of care, the cost of which could be reimbursed under the approved Medicaid State plan:

   a.__X__ Nursing facility (NF)

   b. Intermediate care facility for mentally retarded or persons with related conditions (ICF/MR)

   c._____ Hospital

   d._____ NF (served in hospital)

   e._____ ICF/MR (served in hospital)

3. A waiver of section 1902(a)(10)(B) of the Act is requested to target waiver services to one of the select group(s) of individuals who would be otherwise eligible for waiver services:

   a._____ aged (age 65 and older)

b._____ disabled

c.__X__ aged and disabled

d._____ mentally retarded

e.__X__ developmentally disabled without cognitive impairment related to the developmental disability

f._____ mentally retarded and developmentally disabled

g._____ chronically mentally ill

4. A waiver of section 1902(a)(10)(B) of the Act is also requested to impose the following additional targeting restrictions (specify):

a.__X__ Waiver services are limited to the following age groups (specify): 21 years or older

b._____ Waiver services are limited to individualswith the following disease(s) or condition(s) (specify):

c._____ Waiver services are limited to individuals who are mentally retarded or developmentally disabled, who currently reside in general NFs, but who have been shown, as a result of the Pre-Admission Screening and Annual Resident Review process mandated by P.L. 100-203 to require active treatment at the level of an ICF/MR.

d._____ Other criteria. (Specify):

e._____ Not applicable.

5. Except as specified in item 6 below, an individual must meet the Medicaid eligibility criteria set forth in Appendix C-1 in addition to meeting the targeting criteria in items 2 through 4 of this request.

6. This waiver program includes individuals who are eligible under medically needy groups.

a._____ Yes b.___X___ No

7. A waiver of '1902(a)(10)(C)(i)(III) of the Social Security Act has been requested in order to use institutional income and resource rules for the medically needy.

a._____ Yes b.___X___ No c._____ N/A

8. The State will refuse to offer home and community-based services to any person for whom it can reasonably be expected that the cost of home or community-based services furnished to that individual would exceed the cost of a level of care referred to in item 2 of this request.

a.___X___ Yes b._____ No

EXCEPTION See Page 3-a

9. A waiver of the "statewideness" requirements set forth in section 1902(a)(1) of the Act is requested.

a._____ Yes b.___X___ No

If yes, waiver services will be furnished only to individuals in the following geographic areas or political subdivisions of the State (Specify):

EXCEPTIONS TO INDIVIDUAL COST-CAP

The cost of home or community-based services furnished to a person may exceed the reasonably expected cost of serving a person in a nursing facility when all of the increased expenditures above the reasonably expected cost are due solely to (1) a one time purchase of home modifications and/or specialized medical equipment and/or (2) a documented need for a temporary (not to exceed a 60 day limit) increase in frequency of service or number of services to prevent institutionalization, and/or (3) expenditures are for ADvantage Hospice Care and/or (4) expenditures are for prescribed drugs, which would be paid by Medicaid if the individual were receiving services in a nursing facility, and the annualized expenditures for waiver home or community-based services to a person under these circumstances can reasonably be expected to be no more than 200% of an expected annualized cost of nursing facility care.

10. A waiver of the amount, duration and scope of services requirements contained in section 1902(a)(10)(B) of the Act is requested, in order that services not otherwise available under the approved Medicaid State plan may be provided to individuals served on the waiver.

11. The State requests that the following home and community-based services, as described and defined in Appendix B.1 of this request, be included under this waiver:

a. X Case management

b. _____ Homemaker

c. _____ Home health aide services

d. _____ Personal care services

e. X Respite care

f. X Adult day health (Including Enhancements: Personal Care, Physical, Occupational, Speech/Language and Respiratory Therapies)

g. _____ Habilitation

_____ Residential habilitation

_____ Day habilitation

_____ Prevocational services

_____ Supported employment services

_____ Educational services

h. X Environmental accessibility adaptations

i. X Skilled nursing

j. _____ Transportation

k. X Specialized medical equipment and supplies

l. _____ Chore services

m. _____ Personal Emergency Response Systems

n._____ Companion services

o._____ Private duty nursing

p._____ Family training

q._____ Attendant care

r._____ Adult Residential Care

_____ Adult foster care

_____ Assisted living

s. X Extended State plan services (Check all that apply):

_____ Physician services

_____ Home health care services

_____ Physical therapy services

_____ Occupational therapy services

_____ Speech, hearing and language services

X Prescribed drugs

_____ Other (specify):

t. X Other services (specify): Advanced Supportive/Restorative Assistance; Home-Delivered Meals; Physical Therapy; Occupational Therapy; Speech and Language Therapy; Respiratory Therapy; Comprehensive Home Care; Hospice.

u._____ The following services will be provided to individuals with chronic mental illness:

_____ Day treatment/Partial hospitalization

_____ Psychosocial rehabilitation

_____ Clinic services (whether or not furnished in a facility)

12. The state assures that adequate standards exist for each provider of services under the waiver. The State further assures that all provider standards will be met.

13. An individual written plan of care will be developed by qualified individuals for each individual under this waiver. This plan of care will describe the medical and other services (regardless of funding source) to be furnished, their frequency, and the type of provider who will furnish each. All services will be furnished pursuant to a written plan of care. The plan of care will be subject to the approval of the Medicaid agency's designated Administrative Agent for the waiver. FFP will not be claimed for waiver services furnished prior to the development of the plan of care. FFP will not be claimed for waiver services which are not included in the individual written plan of care.

14. Waiver services will not be furnished to individuals who are inpatients of a hospital, NF, or ICF/MR.

15. FFP will not be claimed in expenditures for the cost of room and board, with the following exception(s) (Check all that apply):

a. X When provided as part of respite care in a facility approved by the State that is not a private residence (hospital, NF, foster home, or community residential facility).

b. X Meals furnished as part of a program of adult day health services.

c. _____ When a live-in personal caregiver (who is unrelated to the individual receiving care) provides approved waiver services, a portion of the rent and food that may be reasonably attributed to the caregiver who resides in the same household with the waiver recipient. FFP for rent and food for a live-in caregiver

is not available if the recipient lives in the caregiver's home, or in a residence that is owned or leased by the provider of Medicaid services. An explanation of the method by which room and board costs are computed is included in Appendix G-3.

For purposes of this provision, "board" means 3 meals a day, or any other full nutritional regimen.

16. The Medicaid agency provides the following assurances to HCFA:

a. Necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. Those safeguards include:

1. Adequate standards for all types of providers that furnish services under the waiver (see Appendix B);

2. Assurance that the standards of any State licensure or certification requirements are met for services or for individuals furnishing services that are provided under the waiver (see Appendix B). The State assures that these requirements will be met on the date that the services are furnished; and

3. Assurance that all facilities covered by section 1616(e) of the Social Security Act, in which home and community-based services will be provided, are in compliance with applicable State standards that meet the requirements of 45 CFR Part 1397 for board and care facilities.

b. The agency will provide for an evaluation (and periodic reevaluations, at least every 36 months ~~annually~~) of the need for a level of care indicated in item 2 of this request, when there is a reasonable indication that individuals might need such services in the near future (one month or less), but for the availability of home and community-based services. The requirements for such evaluations and reevaluations are detailed in Appendix D.

c. When an individual is determined to be likely to require a level of care indicated in item 2 of this request, and is included in the targeting criteria

included in items 3 and 4 of this request, the individual or his or her legal representative will be:

1. Informed of any feasible alternatives under the waiver; and

2. Given the choice of either institutional or home and community-based services.

d. The agency will provide an opportunity for a fair hearing, under 42 CFR Part 431, subpart E, to persons who are not given the choice of home or community-based services as an alternative to institutional care indicated in item 2 of this request, or who are denied the service(s) of their choice, or the provider(s) of their choice.

e. The average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures for the level(s) of care indicated in item 2 of this request under the State plan that would have been made in that fiscal year had the waiver not been granted.

f. The agency's actual total expenditure for home and community-based and other Medicaid services under the waiver and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred by the State's Medicaid program for these individuals in the institutional setting(s) indicated in item 2 of this request in the absence of the waiver.

g. Absent the waiver, persons served in the waiver would receive the appropriate type of Medicaid-funded institutional care that they require, as indicated in item 2 of this request.

h. The agency will provide HCFA annually with information on the impact of the waiver on the type, amount and cost of services provided under the State plan and on the health and welfare of the persons served on the waiver. The information will be consistent with a data collection plan designed by HCFA.

i. The agency will assure financial accountability for funds expended for home and community-based services, provide for an independent audit of its waiver program (except as HCFA may otherwise specify for particular

waivers), and it will maintain and make available to HHS, the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver, including reports of any independent audits conducted.

The State conducts a single audit in conformance with the Single Audit Act of 1984, P.L. 98-502.

a. X Yes b. _____ No

17. The State will provide for an independent assessment of its waiver that evaluates the quality of care provided, access to care, and cost-neutrality The results of the assessment will be submitted to HCFA at least 90 days prior to the expiration of the approved waiver period and cover the first 24 months (new waivers) or 48 months (renewal waivers) of the waiver.

a. _____ Yes b. X No

18. The State assures that it will have in place a formal system by which it ensures the health and welfare of the individuals served on the waiver, through monitoring of the quality control procedures described in this waiver document (including Appendices). Monitoring will ensure that all provider standards and health and welfare assurances are continuously met, and that plans of care are periodically reviewed to ensure that the services furnished are consistent with the identified needs of the individuals. Through these procedures, the State will ensure the quality of services furnished under the waiver and the State plan to waiver persons served on the waiver. The State further assures that all problems identified by this monitoring will be addressed in an appropriate and timely manner, consistent with the severity and nature of the deficiencies.

18. An effective date of July 1, 2002 is requested.

19. The State contact person for this request is Phil Forslund / Michael Fogarty, who can be reached by telephone at (405) 522-7476.

20. This document, together with Appendices A through G, and all attachments, constitutes the State's request for a hoe and community-based services waiver under section 1915(c) of the

Social Security Act. The State affirms that it will abide by all terms and conditions set forth in the waiver (including Appendices and attachments), and certifies that any modifications to the waiver request will be submitted in writing by the State Medicaid agency. Upon approval by HCFA, this waiver request will serve as the State's authority to provide home and community services to the target group under its Medicaid plan. Any proposed changes to the approved waiver will be formally requested by the State in the form of waiver amendments.

The State assures that all material referenced in this waiver application (including standards, licensure and certification requirements) will be kept on file at the Medicaid agency.

Signature: _____

Print Name: Michael Fogarty

Title: Chief Executive Officer

Oklahoma Health Care Authority

Date: _____

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0449. The time required to complete this information collection is estimated to average 160 hours for each new and renewed waiver request and an average of 30 hours for each amendment, including the time to review instructions, searching existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to: HCFA, P.O. Box 26684, Baltimore, Maryland 21207 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C. 20503.

MINUTES OF A SPECIAL BOARD MEETING
OF THE OKLAHOMA HEALTH CARE AUTHORITY
Held at Oklahoma Health Care Authority
4545 N. Lincoln Blvd.
September 18, 2002
2:00 p.m.

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on September 16, 2002.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Brickner called the meeting to order at 2:00 p.m.

BOARD MEMBERS PRESENT:	Chairman Brickner, Member Rounds, Member McFall, Member Roggow, Member Humble
ABSENT:	Member Hoffman, Member Miller
OTHERS PRESENT:	Sally Venator, HHPO Jodi Price, Unicare Kelli McNeal, OICA Belinda Rogers, OICA Christine Eagleson, United Care Dewayne Anderson, OU College of Medicine Tamara Pratt, KWTV David Ward, KWTV Laura Brookins, OAHP Karen Utterback, Stepping Stones Tom Dunning, DHS Sara Barry, IBH Ron Graham, COP Tanya Case, Prime Advantage Mary Brinkley, OKAHSA Barabara Hoberock, Tulsa World Jim Killackey, Daily Oklahoman Gerry Clancy, M.D., OU Tulsa Leeland Alexander, OU Tulsa Belinda Summers, Evergreen Community Services William Guinn, Office of Handicapped Concerns Jim Nicholson, DHS DDSD Daniel Sorrells, Unicare

David Hobert, IBH
Bill Bateman, KTOK
Steve Anderson, OSF
Bob Parks, DRS
Dena Thayer, DHS
Rick Lewis, Progressive Independence
Jeff Hughes, Progressive Independence
Jeff Wagner, OPCA
Chris Campbell, REM
Lisa Smith, OCCY
Jimmy Durant, SSM Health Care
Ric Munoz, CAPTC
Marc F., KOCO
Damone Butler, OETA
Jean Kelsey, Variety
Shawn Black, House Staff
Beverlee Brown, DHS
Windy Rinehart, Evergreen

Chairman Brickner asked the Board members to review the letters submitted by Mr. Craig Jones, Mr. Milton Evans, and Representative Mitchell and Senator Monson, while waiting for Member Roggow to arrive.

General Discussion regarding Item 2.
Consideration and Vote Upon Emergency Eligibility & Service Reductions, and Service Eliminations Made to Allow the Oklahoma Health Care Authority to comply with Article 10, Section 23 of the Oklahoma Constitution

Chairman Brickner asked Mr. Fogarty to update the financial situation and the CEO asked Ms. Garcia to give an update. Ms. Garcia stated that during the first two months of the new fiscal year general revenue collections were below 13.5% of the estimate in July. The Director of State Finance declared a state revenue shortfall and ordered all agencies to have a general revenue appropriations cut of 4.75% for the fiscal year. The cut was effective immediately and was 17.6 million dollars in general revenue. Ms. Garcia stated that the agency has been directed to make these decisions timely and to file a revised budget work program by the end of this month.

Chairman Brickner asked the record to reflect that Member Roggow had arrived and five board members were now present for more than a quorum.

CEO Fogarty stated that the situation had not changed since the regular Board meeting of September 12, 2002. Dr. Mitchell related comments of the staff regarding the cuts to be made. The staff realizes that the Board is having to

make difficult decisions and wanted to state their support of the Board for their continuing efforts.

Chairman Brickner summarized his thoughts about getting more money for the agency and the difficulty in getting federal dollars. He stated that because the agency could not generate additional monies, the Board needed to address cutting costs. CEO Fogarty stated that if we laid the entire staff off for 700 days we might solve our financial problem but that is not possible. CEO Fogarty stated that the agency is cutting costs by not filling positions, travel budget limitations, being extremely cautious about expenditures, and enhancing revenue. Furloughs would not be effective for the agency.

Presentations regarding Item 2.
Consideration and Vote Upon Emergency Eligibility & Service Reductions, and Service Eliminations Made to Allow the Oklahoma Health Care Authority to comply with Article 10, Section 23 of the Oklahoma Constitution

The first speaker was Mr. Steven Dow, the Executive Director of the Community Action Project of Tulsa, which is a private anti-poverty agency. He urged that the Board not roll back eligibility for children below 185% of the poverty level. He stated that the option to provide coverage under federal law does not exist under state law in Oklahoma.

Mr. Charles Campbell, Oklahoma Silver Haired Legislators Alumni Association, asked that the Board not abuse seniors by cutting prescriptions, eyeglasses, hearing aids, nursing homes.

Dr. Joseph Ferritti, Provost of the OU Health Sciences Center, introduced Dr. Dwayne Andrews, Executive Dean of the OU College of Medicine. He stated that the College of Medicine will work with the OHCA and urged as we do this that the Board keep the managed care system in place.

Dr. Gerry Clancey, Dean of the College of Medicine of the University of Oklahoma in Tulsa. He addressed eligibility, his support of managed care and the relationship of the OHCA and OU College of Medicine.

Chairman Brickner addressed the letter from Co-Chairmen Mitchell and Monson. The OHCA is voting on a rule to suspend state-legislated eligibility temporarily. The Board can do this under the Attorney General's opinion in a state of emergency due to a budgetary imbalance.

Howard Pallotta reported that the Conflict of Interest Panel recommends that Member McFall abstain from Items Nos. 2(i) and 2(n) because he is a pharmacist provider and asked that he abstain from discussion, deliberation or vote on those items. There was still a quorum.

Member McFall accepted the recommendation of the Conflicts Panel and will abstain on Item Nos. 2(i) and No. 2(n).

CEO Fogarty stated that rates of payments to providers will not be affected. All recommendations will be reversible. Seven recommendations were made.

Agency Recommendations Regarding Item 2. Consideration and Vote Upon Emergency Eligibility & Service Reductions, and Service Eliminations Made to Allow the Oklahoma Health Care Authority to comply with Article 10, Section 23 of the Oklahoma Constitution

Recipient Eligibility Changes

Mr. Fogarty reported to the Board what staff recommendations were made regarding each item. The recommendations were as follows:

Concerning Item No. 2(a), staff would recommend the elimination of the medically needy program by accepting no new certifications on or after October 1, 2002, effective October 1, 2002.

Staff recommended that no action be taken on Item No. 2(b). Dr. Mitchell agreed that no change be made to this item.

Staff would recommend to the Board that Item No. 2(c), eligibility standards for children ages one through five, be reduced to 133% of the federal poverty level, effective November 1, 2002.

Staff would recommend the approval of Item No. 2(d), decreasing the eligibility standard for children ages six through 18 from 185% of the federal poverty level to 115% of the federal poverty level, with November 1, 2002 as the effective date.

On Item No. 2(e) staff would recommend the approval of decreasing the eligibility standard for aged, blind and disabled recipients who are not institutionalized from the current standard of 100% of the federal poverty level to the previous standard for state supplemental cash assistance program, or about 80% of the federal poverty level, effective November 1, 2002.

Staff would recommend no action be taken on Item No. 2(f).

Service Reductions or Eliminations

Staff would recommend eliminating Item No. 2(h), the optional adult dental services, with an effective date of October 1, 2002.

Staff would recommend eliminating Item No. 2(i), reduction of prescription drug coverage for all recipients in a Home and Community Based Waiver from an unlimited number of prescriptions, to a maximum of five per month. The effective date would be October 1, 2002.

Staff would recommend no action on Item Nos. 2(j), (k), (l), (m), and (n).

Staff would recommend on Item No. 2(o) the reduction of paid annual hospital day Medicaid coverage from 24 days per year to 15 days per year, with an effective date of October 1, 2002.

Board Vote Upon Item 2.
Consideration and Vote Upon Emergency Eligibility & Service Reductions, and Service Eliminations Made to Allow the Oklahoma Health Care Authority to comply with Article 10, Section 23 of the Oklahoma Constitution

Based upon staff recommendations, the Board took the following actions:

Motion:	Member Humble moved that the Board accept the recommendation of the staff to reduce the number of prescription drugs for all recipients in a Home and Community Based Waiver from an unlimited number of drugs to five prescriptions, effective October 1, 2002. Member Rounds seconded.
For the Motion:	Chairman Brickner, Member Humble, Member Rounds, Member Roggow.
Abstained:	Member McFall.
Absent:	Member Hoffman, Member Miller
Motion:	Member McFall moved that we accept the recommendation of the staff to eliminate the optional adult dental services in the Fee for Service program, effective October 1, 2002. Member Humble seconded.
For the Motion:	Chairman Brickner, Member McFall, Member Humble, Member Rounds, Member Roggow.
Absent:	Member Hoffman, Member Miller.

Motion:	Member McFall moved for the reduction of paid annual hospital day Medicaid coverage from 24 days to 15 days in the Fee for Service and Choice program for adults, effective October 1, 2002. Member Roggow seconded.
For the Motion:	Chairman Brickner, Member McFall, Member Humble, Member Rounds, Member Roggow.
Absent:	Member Hoffman, Member Miller.
Motion:	Member McFall moved for the temporary suspension of the Medically Needy Program, effective October 1, 2002. Member Roggow seconded the motion.
For the Motion:	Chairman Brickner, Member McFall, Member Humble, Member Rounds, Member Roggow.
Absent:	Member Hoffman, Member Miller.
Motion:	Member McFall moved for decreasing the eligibility standards for children from one through five from 185% of the poverty level to 133% of the poverty level effective November 1, 2002, and decrease the eligibility standard for children ages 6 through 18 from 185% of the federal poverty level to 115% of the federal poverty level, effective November 1, 2002. Member Humble seconded the motion.
For the Motion:	Chairman Brickner, Member McFall, Member Humble, Member Rounds, Member Roggow.
Absent:	Member Hoffman, Member Miller.
Motion:	Member McFall moved to decrease the eligibility standard for those aged, blind or disabled recipients who are not living in an institution from 100% of the current poverty level and reduced to the state supplemental income eligibility effective November 1, 2002. Member Humble seconded.

For the Motion:	Chairman Brickner, Member McFall, Member Humble, Member Rounds, Member Roggow.
Absent:	Member Hoffman, Member Miller.

ADJOURNMENT

Motion:	Member McFall moved for adjournment of the meeting. Member Roggow seconded.
For the Motion:	Chairman Brickner, Member McFall, Member Humble, Member Rounds, Member Roggow.
Absent:	Member Hoffman, Member Miller.

4445. HOME AND COMMUNITY-BASED SERVICES - AMENDMENTS

A. When an Amendment Is Required.--An amendment is required when a change in a waiver results in the waiver document no longer accurately reflecting the policies and procedures in the approved waiver document. *The amendment usually must be approved by HCFA prior to the implementation of the proposed change. However, there are instances where amendments may be approved with a retroactive effective date as far back as the beginning of the waiver year in which it is submitted. Some examples of such situations would be revisions to the cost estimates, deletion of a waiver service, or compliance with revised State rules or regulations.*

B. Submission.--An amendment request is processed like a waiver request. (See §4441 for process related instructions.) Amendment requests consist of two types: substantive requests and technical requests.

It is to your benefit to submit technical amendments under separate cover from substantive amendments. This maximizes the likelihood of approval without the delay caused by a request for additional information, which is often necessary on substantive amendments.

1. Technical Amendment.--A technical amendment is any amendment in which the change has no impact on cost or utilization of services (directly or indirectly). Such amendments must be accompanied by specific assurances that there will be no change to the costs, utilization of services, or number of persons served by the waiver, and an explanation of why this is so.

2. Substantive Amendment.--A substantive amendment is any amendment which directly or indirectly affects any of the values under which the waiver was shown to be cost effective or cost neutral at its approval. Therefore, in most cases, a change in any of the following would constitute a substantive amendment:

a. Any change in the number of waiver recipients served, the cost of waiver services, or the mix of beneficiary groups or services provided.

NOTE: Although the C x D FFP limitation has been eliminated effective for waiver applications (or renewals) filed before, on, or after April 7, 1986 and for services furnished on or after August 13, 1981, if you anticipate substantial changes in your cost estimates, submit these changes in the form of an amendment to your waiver. This amendment should provide a complete explanation of the reasons for the change and recomputed cost effectiveness or cost neutrality formulas documenting the continued cost effective or cost neutrality of the waiver program.

b. Changes to the definition of services.

c. Changes to who is eligible to participate.

d. Changes to who may provide services.

e. Changes in health and safety standards for providers which would increase the cost of services (e.g., change in the number of individuals who can be cared for in a foster home).

f. Changes necessary to implement specific statutory provisions, e.g., the 1985 COBRA provisions pertaining to habilitation services or maintenance of income standards *and the*

1997 BBA provisions which deleted the requirement that individuals be discharged from an NF or ICF/MR to be eligible for expanded habilitation.

Requests for substantive amendments must be accompanied by a revised formula which demonstrates that the waiver will remain cost effective or cost neutral with the amendment. The formula format to be used must comply with the formula given in 42 CFR 441.303(f) for amendments approved on or after August 24, 1994.

State Medicaid Manual

Part 2 - General

FOREWORD

A. Function of the State Medicaid Manual (SMM).--This manual makes available to all State Medicaid agencies, in a form suitable for ready reference, informational and procedural material needed by the States to administer the Medicaid program. It is an official medium by which the Health Care Financing Administration (HCFA) issues mandatory, advisory, and optional Medicaid policies and procedures to the Medicaid State agencies.

B. Contents and Organization.--

1. Contents.--The manual provides instructions, regulatory citations, and information for implementing provisions of Title XIX of the Social Security Act (the Act). Instructions are official interpretations of the law and regulations, and, as such, are binding on Medicaid State agencies. This authority is recognized in the introductory paragraph of State plans. Interpretations and instructions relating to common policy under Titles I, IV-A, X, XIV, XVI, and XIX of the Act are also included.

2.Organization.--The material is organized into major Parts, which are divided into chapters and sections. The manual is structured as close as possible to the codification of Medicaid regulations. A crosswalk of manual sections and regulations is also included.

The instructions interpret or clarify issues in the regulations and set forth procedures you are required to follow in implementing the regulations.

C. The SMM and Other Reference Material.--Title XIX is the statutory basis for the Medicaid program and the foundation for the regulations and all manual material. Medicaid regulations are contained in Parts 42 and 45 of the Code of Federal Regulations. Regulation citations are included in the manual text.

D. Manual Revisions.--The manual is designed to accommodate new pages as text is added or revised. Substitute pages containing revised sections or chapters are, therefore, issued as needed. The transmittal pages summarize the changes and include the effective dates of the revisions. When a major change in regulations, policies, or procedures is involved, the background is provided. New or changed materials are indicated in the left margin of a page in the following manner:

Line on which change begins.

Line on which change ends.

Note that Internet manuals to not have the red vertical bar in the margin, which is present in paper manuals; but do have red font to show change.

The revision transmittal sheet identifies new page numbers and the pages replaced. If at a later date, you need to refer to the background explanation given on a transmittal sheet, you can identify the transmittal by its number which appears on each manual page.

E. Use of the Revision Transmittal Check List.--Each manual Part has its own check sheet for recording receipt of revisions since different parts of the manual have different distributions. Each Part will have its own numerical sequence of transmittals. File revised manual transmittals in transmittal number order as a safeguard against discarding a more recent page in favor of an older one.

Transmittals are not always distributed in strict numerical sequence. Therefore, if it appears that you have not received a particular transmittal, allow 15 working days after receipt of a higher numbered transmittal before requesting a transmittal that you have not received.

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Return to Program Manuals

Last Modified on Wednesday, August 28, 2002

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Centers for Medicare & Medicaid Services
7500 Security Boulevard, Baltimore MD 21244-1850
CMS Telephone Numbers

317:30-3-57. General Medicaid coverages - categorically needy

The following are general Medicaid coverages for the categorically needy:

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

(A) Adult coverage limited to 24 compensable inpatient hospital days per State fiscal year (July 1 through June 30).

(B) Coverage for persons under 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 the Authority.

(6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities who are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

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

(9) Maternity Clinic Services through the Oklahoma State Health Department.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided adults, not specifically

addressed, are covered only when prior authorized by the Medical Professional Services Units of the Oklahoma Health Care Authority.

(11) One screening mammogram (76092) and one follow-up mammogram (76090 and 76091) every year for women beginning at age 30. Additional follow-up mammograms are covered when medically necessary. Additional follow-up mammograms require a prior authorization from the Medical Professional Services Division of the Oklahoma Health Care Authority.

(12)Nursing facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for each eligible individual under 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 will require prior authorization. EPSDT services include payment for:

(A) Child health screening examinations for eligible children by a medical or osteopathic physician.

(i) Scheduled screenings include:

(I) Six screenings during the first year of life;

(II) two screenings in the second year;

(III) one screening yearly for ages 2 thru 5 years; and

(IV) one screening every other year for ages 6 thru 20 years.

(ii) Interperiodic screenings outside the periodicity schedule for screening examinations are allowed at necessary intervals when a medical condition is suspected.

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

(C) Immunizations.

(D) Outpatient care.

(E) Dental services, including inpatient services in an eligible participating hospital, outpatient dental screening every 12 months, two bite wing x-rays, and/or oral prophylaxis one each 12 months; emergency services for relief of pain and/or acute infection; limited restoration, repair and/or replacement of dental defects after the treatment plan submitted by dentist has been authorized.

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

(G) Hearing services include hearing evaluation at least once every 12 months, hearing aid evaluation if indicated and purchase of a hearing aid when prescribed by a state licensed audiologist who holds a certificate of clinical competence from the American Speech and Hearing Association and preauthorized. Interperiodic hearing examinations are allowed at intervals outside the periodicity schedule when a hearing condition is suspected.

(H) Prescribed drugs.

(I) Outpatient Psychological services for eligible individuals under 21 years of age must be prior authorized. Payment is made to eligible psychologists who are duly licensed to practice. Outpatient testing and diagnosis is limited to one hour per patient each 12 months. Additional hours may be prior authorized.

(J) Inpatient Psychotherapy Services. Payment is made to eligible psychologists and psychiatrists. Inpatient psychotherapy by a psychologist must be prior authorized.

(K) Inpatient psychological testing for eligible individuals under 21 years of age. Limited to one hour per recipient each 12 months. If medically necessary, additional hours must be prior authorized. Payment is made to eligible psychologists who are duly licensed to practice.

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

(M) Inpatient hospital services.

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

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

(14) Family planning services and supplies for individuals of child-bearing age, including counseling, insertion of intrauterine device and sterilization for persons 21 years of age and over who are legally competent, not institutionalized and have signed the "Consent Form" at least 30 days prior to procedure. Reversal of sterilization procedures for the purposes of conception are not covered. Reversal of sterilization procedures may be covered when medically indicated and substantiating documentation is attached to the claim. The Norplant System for birth control is covered; however, removal of the Norplant System prior to five years is covered only when documented as medically necessary. Reinsertion of Norplant contraceptive will be considered on a case by case basis.

(15) Family planning centers.

(16) Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility, ICF/MR, or elsewhere. For adults, payment will be made for up to 24 hospital days paid on hospital claims during a state fiscal

year for each individual recipient. These days will be maintained on the recipient record. Physician claims for hospital visits will be paid until the last compensable hospital day is captured. After 24 hospital days have been captured, inpatient physician services will not be paid beyond the last compensable hospital day. Office visits for adults are limited to two per month except when in connection with emergency medical conditions.

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

(A) Podiatrists' services

(B) Optometrists' services

(C) Psychologists' services

(D) Certified Registered Nurse Anesthetists

(E) Certified Nurse Midwives

(F) Advanced Practice Nurses

(18) Free-standing ambulatory surgery centers.

(19) Prescribed drugs not to exceed three prescriptions per month. Medically necessary prescribed drugs for persons in nursing facilities, ICF/MR's, Home and Community Based Waivers, and the Advantage Program Waiver. Prescriptions are not limited for persons under 21 years of age.

(20) Rental and/or purchase of durable medical equipment.

(21) Adaptive equipment, when prior authorized, for persons residing in private ICF/MR's.

(22) Dental services for persons residing in private ICF/MR's in accordance with the scope of dental services for persons under age 21.

(23) 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, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.

(24) Standard medical supplies.

(25) Eyeglasses under EPSDT for individuals under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal.

(26) Payment to blood banks for blood when not included in the hospital per diem cost.

(27) Blood and blood fractions for eligible persons suffering from a congenital or acquired disease of the blood.

(28) Inpatient services for individuals age 65 or older in institutions for mental diseases, limited to those persons whose Medicare, Part A benefits are exhausted for this particular service and/or those persons who are not eligible for Medicare services.

(29) Nursing facility services, limited to individuals preauthorized and approved by OHCA for such care.

(30) Inpatient psychiatric facility admissions for individuals under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.

(31) Transportation and subsistence (room and board) to and from providers of medical services to meet patient's needs (ambulance or bus, etc.), to obtain medical treatment.

(32)Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.

(33) Nursing facility services for patients under 21 years of age.

(34) Personal care in recipient's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of an R.N.

(35) Part A deductible and Part B medicare Coinsurance and/or deductible.

(36) Home and Community Based Waiver Services for the mentally retarded.

(37) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits may be any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.

(38) Organ and tissue transplantation services for children and adults, limited to bone marrow, stem cells, cornea, heart, kidney, liver, lung, SPK (simultaneous pancreas kidney), PAK (pancreas after kidney), and heart-lung, are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) All transplantation services, 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 Medicaid program all organ transplants must be performed at a Medicare approved transplantation center.

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

(39) Home and community-based waiver services for mentally retarded individuals who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).

(40) Case Management services for the chronically and/or severely mentally ill.

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

(42) Services delivered in Federally Qualified Health Centers. Payment will be made on an encounter basis. An encounter is all medical or dental services provided by the center in one day.

(43) Early Intervention services for children ages 0-3.

(44) Residential Behavior Management in therapeutic foster care setting.

(45) Birthing center services.

(46) Case management services through the Department of Mental Health and Substance Abuse.

(47) Home and Community-Based Waiver services in limited geographic areas for aged or disabled individuals.

(48) Outpatient ambulatory services for persons infected with tuberculosis.

317:30-5-76. Generic drugs

All eligible providers are required to substitute generic medications for prescription name brand medications with the exception of prescriptions in which a brand necessary certification as provided in OAC 317:30-5-77 is made by a prescribing provider.

317:30-5-77. Brand necessary certification

(a) Unless the prescribing provider certifies a brand name drug product is medically necessary for the well being of the patient a generic must be substituted for the name brand product. The requirements for a brand name certification are as follows:

(1) The certification must be written in the physician's or other prescribing provider's handwriting.

(2) Certification must be written directly on the prescription blank or on a separate sheet which is attached to the original prescription.

(3) A standard phrase indicating the need for a specific brand is required. The Authority recommends use of the phrase "Brand Necessary".

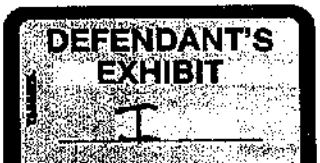
(4) It is unacceptable to use a printed box on the prescription blank that could be checked by the physician to indicate brand necessary, or to use a hand-written statement that is transferred to a rubber stamp and then stamped onto the prescription blank.

(5) If a physician phones a prescription to the pharmacy and indicates the need for a specific brand, the physician should be informed of the need for a handwritten certification. The pharmacy can either request that the certification document be given to the patient who then delivers it to the pharmacy upon receipt of the prescription, or request the physician send the certification through the mail.

(b) The Brand Necessary Certification applies to HCFA Upper Limit and State Maximum Allowable Cost (SMAC) products.

317:30-5-77.1. Dispensing limitation

Prescription quantities are to be limited to 34 day supply or 100 dosage units, whichever is greater, except in instances where the manufacturer recommends a lessor amount. Refills are to be provided only if authorized by the prescriber and should be in accordance with the best medical and pharmacological practices. All maintenance medications must be filled at the maximum quantity allowed, except when determined medically imprudent. For products covered by the Oklahoma Vendor Drug Program the metric quantity shown on the claim form must be in agreement with the descriptive unit of measure applicable to the specific NDC. Only numeric characters should be entered. Designations, such as the form of drug, i.e., Tabs, Caps, Suppositories, etc., must not



be used. Products should be billed in a manner consistent with quantity measurements.

317:30-5-77.2. Prior authorization
[Revised 4-24-02]
(a) **Definition.** The term prior authorization means an authorization by OHCA to the pharmacist to fill the prescription before it is filled by the pharmacist.
(b) **Process.** Because of the required interaction between a prescribing provider (such as a physician) and a pharmacist to receive a prior authorization, OHCA allows a pharmacist up to a 30 calendar day period from the point of sale notification to provide the data necessary for OHCA to make a decision regarding prior authorization. Should a pharmacist fill a prescription prior to the actual authorization he/she takes a business risk that the claim for filling the prescription will be denied. In the case that information regarding the prior authorization is not provided within the 30 day calendar period, claims will be denied.
(c) **Documentation.** OHCA administers a prior authorization program through a contract with an agent. Prior Authorization requests with clinical exceptions must be mailed or faxed to the Medication Authorization unit of the agent. Other authorization requests, claims processing questions and questions pertaining to DUR alerts must be addressed by contacting the Pharmacy help desk. Authorization requests with complete information are reviewed and a response returned to the dispensing pharmacy within 24 hours.
(d) **Emergencies.** In an emergency situation the Health Care Authority will authorize a 72 hour supply of medications to a client. The authorization for a 72 hour emergency supply of medications does not count against the Medicaid limit described in OAC 317:30-5-72(a)(1).
(e) **Utilization and scope.** There are three reasons for the use of prior authorization: utilization controls, product based controls, and scope controls. Scope controls refer to constraints used to insure a drug is used for approved indications and is therapeutically appropriate.
(1) **Utilization.**
(A) **Quantity.** Toradol is covered for eligible individuals for a quantity up to 22 tablets or a 5 day supply which ever is less, each month. Prior authorization is required when additional coverage is medically necessary beyond this limit.
(B) **Duration.**
(i) **H2 antagonists/proton pump inhibitors/carafate.** H2 receptor antagonists and Carafate are covered for eligible individuals for 90 days of therapy in the previous 360 days. H2 antagonists and Carafate do not