SoonerCare
Oklahoma Health Care Authority

Member Advisory Task Force

MATF Notes
Co-Chairs:
August 3, 2024

Members Present: 10 members presentt

Steering Committee: 4 members present

Guests 12 guests present

OFN Staff: 4 OFN Staff present

X = Virtual √ = In person

Item	Notes	Recommendations / Golden Nuggets
Coffee Time at HCA/ Home		
Welcome & Review Minutes – MATF Cards	Welcome and Introductions The Member Advisory Task Force (MATF) is a collaborative effort, where members and agency representatives alike are equally valued and essential. each person brings to the table their unique perspectives. Understanding different perspectives helps address systemic issues more effectively. MATF consists of a diverse group of individuals, including members who utilize SoonerCare services, representatives from different agencies, and Contracted Entities (CEs). This diversity ensures a comprehensive understanding of the various challenges and successes within the system. As members participate and share their unique perspectives and utilize the available resources to enhance the overall effectiveness of the MATF. Please review the notes from the last meeting. While the notes are in draft form, they are private and available only for those who are part of the group. Before they are sent to the notes are de-identified. If you want to share the notes with someone, contact OFN for a copy when they have been de-identified. The colored note cards available on the table are for you to write down recommendations, golden nuggets, or need to know.	

	Green Cards: Recommendations. Yellow Cards: Golden nuggets of valuable information. Blue Cards: Requests for more in-depth information on certain topics. Please add the month at the top of each card and your name. Those viewing online, please put your thoughts in the chat. If you would like something to be an agenda item, please put a star by it.	
Policy Updates	These are upcoming policy changes that have not been approved by the executive staff yet. When approved they will be posted to the Policy Change Blog probably around August 23. A link will be sent out when published. If you would like another way to get informed is to subscribe to web alerts. **Slide 1 - Psychological Testing Limit Increase** Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has requested a rule change to increase the initial the initial limit on psychological testing hours from eight (8) hours to ten (10) hours. This change will allow for coverage of testing to allow adequate hours for most instruments. Providers may still request an additional six (6) hours for complex testing, bringing the total to sixteen (16) hours. Tentative Effective Date: January 2025 **Slide 2 – Medication Assisted Treatment (MAT) Clarification** ODMHSAS has requested a rule to obtain compliance with new federal requirements that state that a patient's refusal of counseling shall not preclude them from receiving MAT, OHCA policy will be amended to reflect this change – noting that a patient's refusal to participate in the treatment phases shall not preclude the individual form receiving medications from the opioid treatment program (OTP). Tentative Effective Date: November 2024 **Comment -** This may also include when individuals need someone to come daily to provide medication, if they have workers that actually go out and provide treatment in person. **Slide 3 – Applied Behavioral Analysis Changes** The Oklahoma Health Care Authority (OHCA) is seeking approval of a State Plan amendment and emergency rule revisions to update outdated ABSA policies to ensure that services meet a standard level of quality for all applicable members. This includes updates to documentation requirements, updates to medical necessity criteria, and various exclusions to treatment. Tentative Effective Date: November 2024	

	Comment - A very rough draft on this one. It will be an emergency rule presented to the MAC and board in September. **Slide 4 - Hospice Benefit Expansion** The Oklahoma Health Care Authority proposes emergency revisions that are necessary to comply with state law. Currently, only some categorically eligible populations have coverage for hospice care under Medicaid. In accordance with Senate Bill 1703, the proposed revisions will expand Hospice coverage to include all Medicaid members. Existing criteria and payment methodologies will be applied to any new populations. Tentative Effective Date: November 1, 2024 **Comment -** Most hospice members are covered now. This will add the ABD, dual eligible, and parent caretaker group. A State Plan amendment may also be needed. **Slide 5 - High Acuity Tracheostomy Rates for Nursing Facilities** The Oklahoma Health Care Authority is proposing a new policy to establish an add-on rate for nursing facilities that serve high-acuity tracheostomy patients. The rate will help to cover the high cost associated with this type of care. This change will include development of the rate methodology and along with necessary criteria to be met in order to receive the additional rate. Tentative Effective Date: October 1,2024 **Comment -**This will be a State Plan amendment and a rule. OHCA and the Department of Health are currently working in partnership to develop a methodology along with the criteria to figure out this additional payment. **Slide 6 - School-Based Services** The Oklahoma Health Care Authority (OHCA) will seek approval of a State Plan amendment and rule revisions to enhance school-based services and providers across the state of Oklahoma. The change will allow for an expansion of school-based service for all Medicaid eligible students that meet the criteria for medical necessity not just those on an Individualized Education Plan (IEP) or an Individualized Family Service Plan (IFSP). The Oklahoma will partner with the Oklahoma State Department of Education and school districts across the state to develop a strong infrastructure which supports school-based expansion, ensures, proper Medicaid billing, establishes new school-based services around Specialized Transportation and enhances other school-base services, specifically around Nursing Behavioral Health and Nutrition services. Effective Date: January 2025	**NEED TO KNOW:** More on school-based service expansion. If I talk to the superintendent, who do I have him contact for more information

	Comment – OHCA is partnering with the Department of Education and school districts to develop an infrastructure for billing. **Question -** I am not quite sure I understand, can you explain? If your student is at school and they are on an IEP or IFSP they are already able to get those services, and the school can be paid (reimbursed) from Medicaid for it. **Question –** What are the medical services? From my understanding the schools don't even have nurses every day. At my child's school may have a nurse that they share on Tuesday and Wednesdays, and the nurse goes to another school on Thursday. Is this going to increase? Yes, the goal is to increase providers in schools. If schools can submit more claims to Medicaid and be reimbursed for those services. Then schools should have more funding to provide more services. Schools are required by IDEA to provide for those with an IEP and IFSP. This will open it so that any child on Medicaid can get services in schools. This should bring more revenue to the schools, and schools should be able to have more coverage, and more staff. **Comment –** What has happened historically regarding Sooner Care benefits is the school has to have a contract that meets the standards of OHCA . Early on there were contracts with the schools, however, many schools didn't renew them. It's still up to the school to have that contract with OHCA and one of these Contracted Entities (CEs). I don't want you to think just because this policy changed - we get nursing at school. There's still a lot of criteria - does it meet medical necessity? Is it educational based or is it medical needs? There are other things that go into this. The school may not even have a contract. **Question –** Is it the school that needs the contract or the district? The school district holds the contract. **Comment -** I come from a small school, and they were not billing any school-based services. However, I connected with OHCA staff with school based services and connected her with my local school. She did all the training over Zoom and my school was ready to go in one day. It's not a difficult process. **Comment -** Some schools don't want that paperwork. This is a great opportunity. It's a benefit but it doesn't mean it's automatic. It's a great tool. This means that they don't have to have a disability that meets the IEP criteria for services. It's an entitlement if you're on SoonerCare and it is medically necessary, it should be a benefit whether they're at school or not.	

	Question - Two of my kids that are on IEP, and we were trying to get them transferred from the north side schools. Three of my kids were accepted. For the two on IEPs, we were told that they don't have the staffing or whatever, and that we had to unenroll to get the paperwork to try to enroll. But they were denied. Will this help with that? **Comment:** From a parent's perspective who tried to get a transfer to a school closer to my home. Because my child was on an IEP that is all educational based. The rule I was told is that for a student on an IEP, the receiving school has to agree to all educational expenses. This has nothing to do with state plan Medicaid benefits. It is all educational shuffling of money. There are some state provisions on open transfer, but it doesn't have anything to do with this Medicaid benefit. I think you are right in continuing to pursue this as an option. It is my understanding it is not within this policy or even the OHCA policy. **Question –** Why wouldn't a school do this other than paperwork? It's going to be that administrative. They have to have a person assigned to oversee all the paperwork requirements. It is like other providers of health care services. The school has to document the services provided in order to justify billing Medicaid for that service. Families can educate the schools and help them reconnect with the OHCA. Let them know OHCA is offering more support now. It's an option. But remember your child, regardless of what their medical condition is, is entitled to education. And if the only way they can be educated is with this level of medical support, whether the school bills for it or not, it's an educational entitlement. OHCA has stepped up and said we will provide the support in the school setting because it is a Medicaid benefit, but here's what you have to go through. **Comment –** After meeting with OHCA staff the school superintendent said it is going to benefit our school so much. Because there are many students receiving services. The process has been streamlined and is a lot different from years ago. It is still a lot but not as much as it was. **Comment -** How do we make sure that the schools know? A few years ago, my son needed to be transferred from a 504 to IEP. I was told if you do that, he is not going to be able to be fireman or policeman or be in the military and he's not going to be able to do this. They need to know about the extra stuff, **Comment -** After this policy goes into effect, come to the MATF and tell us about it. So, we can then support the school and bring awareness. Maybe a meeting with the school and the OHCA and look at it as an option. If it's needed for educational purposes, the school's required to provide it.	**RECOMMENDATION:** Educational piece for enhanced school-based services.

	My child must have personal care. Whether the school's paraprofessional provides it or whether it's billable from the OHCA. It must be provided for their education. This is an opportunity to start that conversation, just like the member commented about what happened in that school district. Let's learn from their process and reach out. After this policy passes, let's have a future agenda item so we can be educated and then think about how we can help other parents open this conversation up to their school that may have washed their hands or a school district that had no idea it was an option. **Comment –** Maybe create an educational piece for the school districts. **Comment –** That is a good idea. **Question –** What do the nutrition services look like? We are still working through the codes. The process right now is we can expand the code set that they can provide through this change being made. Some of the decisions are still being made on what those additional services are going to be. The normal things you see are personal care, speech, some therapy, pt, some screening, and things like that. One was an expansion of the amount of nutrition services and kind of counseling and what that they can have. **Comment –** This doesn't go into effect until January. OHCA will be happy to come to a future meeting. By that time, we will have a draft, and we will have feedback. We have more time to meet and discuss and go over the details of it. We will be happy to come to both. In October will be like the proposed and then December will be more refined, like final draft. **Slide 7 – Third Party Liability for School Based Services** Proposed rule change to add an exception to the Third-Party Liability requirement for services rendered in a school setting for certain populations. For students with an Individualized Education Program (IEP) or an Individual Family Service Plan (IFSP). Medicaid shall be the payor of first resort. Tentative Effective Date: January 2025 **Question –** Could you give an example of what that would be? It's any service. You have private insurance, traditionally Medicaid is the payer of last resort. This change flips it and says for these types of services, which is school based - Medicaid is the first payer. The change now is OHCA will take the primary lead and then they will turn around and bill the primary insurance. **Update on Federal Rules/Changes**	

	In late April, CMS released final rule changes to the state requirement for various Medicaid Advisory groups. This brief will outline these requirements and the necessary changes that OHCA needs to make. <u>Required Changes</u> **1. Rename the MCAC to the Medicaid Advisory Committee (MAC) and expand the scope of purpose of the committee.** a. Must be in place by July 9, 2025 **2. Establish the Beneficiary Advisory Council (BAC).** a. States must form and support a BAC to advise the state regarding their experience with the Medicaid program. The BAC which can be an existing beneficiary group composed of: i. Individuals who are currently or have Medicaid beneficiaries ii. Individuals with direct experience supporting Medicaid beneficiaries b. Must in place by July 9, 2025 **(Note:** This requirement is already met through the MATF.) **3. Establish minimum requirements for Medicaid member representation on the MAC**. a. A percentage of MAC members must come from the BAC. i. Applicability 1. 7/9/25 -7/9/26: 10% 2. 7/10/26 – 7/10/27: 20% 3. 7/11/27 – Indefinitely: 25% b. By July 2025, remaining committee members must include representation of at least one from each of the following categories: i. State or local consumer advocacy groups or other community-based organizations that represent the interest of, or provide direct service, to Medicaid beneficiaries. ii. Clinical providers or administrators who are familiar with the health and social needs of Medicaid beneficiaries. iii. As applicable, participating Medicaid MCOs, PAHPS, PCCM entities or PCCMs or a health plan representing more than one such plans. iv. Other state agencies that serve Medicaid beneficiaries as ex-officio, non-voting members. c. Applicability: July 9, 2025 **Question** - What's the difference between MAC, BAC, and MATF?	

Oklahoma already has the MATF which meets the requirement for BAC (MATF is BAC)
It requires changes to the Medical Advisory Committee (MAC) membership which is kind of like our board. Eventually more of the members on the MATF will be on the MAC.

OHCA was already moving in this direction and restructuring. A MATF member and Oklahoma Family Network (OFN) have already been added to the MAC.

Question – Do we currently have MCOs on the MAC?
We do not.
The composition of the MAC is regulated by Legislation. We do have to go through some changes within the rules. The statute requires 14 unique roles. We will need to request to expand the MAC or allow for duplicate roles or make some changes to accommodate this.

Question – Regarding the trach care update. It said facilities, but would that include agencies or is it just facilities? Just facilities – Nursing Homes.

4. **Promote transparency and accountability of the MAC and BAC through the public reporting of membership, meeting materials, bylaws and attendance.**

5. **Develop public-facing annual reports on MAC and BAC activities.**
    a. The MAC, with support from the state, must submit an annual report of its activities, topics discussed, and recommendations. The state must review the reports and include responses to the recommended actions. The state must then report and include responses to the recommended actions. The state must then:
        i. Provide MAC members with the final review of the report
        ii. Ensure that the annual report of the MAC includes a section describing the activities, topics discussed, and recommendations of the BAC, as well as the state's responses to the recommendation.
        iii. Post the report to the state's website.
    b. Applicability:
        i. July 9, 2026, to finalize the first annual report
        ii. Once the report has been finalized, states have 30 days to post.
        iii. Annually thereafter

<u>Composition of the MAC</u>
Currently, Oklahoma Statutes allow for no more than 15 members to be on the MAC. Additionally, the MAC must be comprised of the following individuals.
1. One physician from the six classes of physicians (DPM, DC, DDS/DMD, MD, OD, DO)

	2. Members of consumer groups for: Medicaid recipients, nursing homes, developmental disabilities, behavioral health professions 3. Director of DHS or designee 4. Commissioner of DMH or designee 5. Pediatrician 6. Member of a tribe In total, Oklahoma Statutes require 14 unique "roles" to serve on the AMC. The CMS Access rule will add in one other unique role not previously required by OK Statute (representative form the MCE) to bring the number of unique roles to 15. By July 2025, we will need two individuals from the BAC to be on MAC. By July 2026, three individuals from BAC will need to be on MAC. By July 2027, 4 individuals from BAC will need to be on MAC. Therefore, in order to meet the 25% threshold, it seems that we will either need to: amend the Oklahoma Statutes to expand MAC/decrease the number of required roles or replace current members with BAC members.	
Redetermination/ renewal Process	• The coverage for services is one year and each year thereafter redetermination of each member must be completed to renew services. • OHCA continues to work on the renewal process which involves automatically rechecking the member's information against data exchanges to verify eligibility without requiring the member to reapply if the specific criteria in the system is met. This process has two names either a passive renewal or an ex parte renewal. • Each member who meets the specific criteria in the system can be automatically renewed for another year without further action. • If the automatic renewal is unsuccessful OHCA sends a notification to the member. This notice informs them that their eligibility period and services will end on this date unless they complete the renewal process. There may be additional documents or updates or to just review the application and make sure all the information is correct, the right boxes are checked, and update any changes for the year that were not updated. **Question –** Wasn't there a family who received a letter of a decline of service or renewal, and it was very confusing to them? It was a renewal. The family received a letter stating they needed to upload their income, but it didn't say whose income. The family didn't realize it was their 16-year-old's $200 a month. It was canceled. Staff assisted, it was corrected, and service was backdated. It's okay now. **Question –** On the renewal, if a member in your household becomes employed should their income be included too?	**GOLDEN NUGGET:** Passive renewal process **RECOMMENDATION:** Family friendly letters

	Yes, income verification request is for all household members, including children. Income changes should be reported on the app within 10 days of a change. When OHCA is asking for the household income it is income for the adults and others who are working. **Comment –** My family except for my 18-year-old is on the expansion. My older child has gone to work, and I didn't think to report that income. We received notice that we needed to add our income, and it said services ended, and also the website said ended. It was confusing because it said ended but goes to August 25th. We didn't think about it, but my older child had turned 21 and needed to be their own household. Some letters are hard to understand. OHCA is working on revising and improving the clarity and understanding of the letters. Also looking at: What can we do to make enrolling and applying easier? How can we make it make sense? How can we keep it simple and easy? How do we help our members navigate this? Staff are looking at how do we make this better than it has been and less burdensome. **Comment –** The MATF could assist in reviewing some of the letters and make them family friendly. My adult child recently updated her income and uploaded one payroll sheet, but now has three more that has not been uploaded. The letter was brought to me and the question asked was 'show me where on this letter that it says how many I have to upload'. There were no specifics in the letter. OHCA actually will use in point in time to calculate income. **Comment -** My boyfriend is on the expansion and has a heart condition. Something went wrong with his pacemaker. We went to the hospital, and while there, were told he didn't have coverage. I pulled up his information on my phone. It said he had coverage, but it also said his coverage had ended. The hospital was saying he only had mental health coverage. It was a very confusing process and super stressful being in the ER and having to navigate all of that too. If you will let OHCA know about issues like this and can share some information about it. The team can look at the case, see where it went through the system to make sure it followed all the right rules and figure out exactly what happened. (Note: member did that) As MATF members you have a deeper understanding of how this works. As you share your experiences, it is helpful for OHCA.	**RECOMMENDATION:** Create a "in case of coverage emergency' link on the website or MySoonerCare.org site

	As we get into those projects and start looking at some letters different things we will be calling on the MATF to help guide those steps. OHCA appreciates it very much. **Question –** With the passive renewal and the attempt to increase that as you're doing, will that decrease the number of dis-enrollment that we see on a monthly basis? It could. I think what it will help with is mostly procedural terminations. For those people who didn't realize they were up for renewal, or who maybe didn't get their stuff turned in, it'll help with some of those. For some people who forget to turn something in, then turn it in and then are eligible. It'll help keep those numbers a little steadier. **Question –** Is there any letters or anything that we can show to a teenager that questions why do I have to give you my check stubs? Sometimes teenagers think we're just trying to be nosy. There isn't anything for that situation now, but it's something we could add. **Comment -** Maybe your communication department could use social media. **Comment –** Maybe a young adult page on our website. Have targeted information especially for those who are transitioning into their own household and must obtain their own case through Medicaid but are still living at home and have targeted information. **Comment -** We helped a number of young adults try to untangle from their parents' account. It is not easy. Especially if the young adult has a disability, but they don't have a guardian, that can really be difficult. They can't even sign up for a PCP. It really gets tough when a young adult tries to separate and to become independent from their parents because there may be some relational issues. It is an issue because young adults do want to be independent. They don't want to have to go to their mommy and say, I want to change my doctor. **Comment -** We've had the expansion for a few years, but it was launched during the covid public health emergency. Transitions and renewals for the new adult population were not happening then because nobody was losing coverage. Now that we are back to like steady state operations and processing our Medicaid as normal, we have this whole population who doesn't know about Medicaid, they don't understand the renewal process, they don't understand the documentation process because they haven't been exposed to it before. We also have this group of 18-year-olds turning 19 or the ones who are, who are moving from their family case into having that expansion coverage. I'm seeing ways where we can kind of work with that group and get information out to help with some of those things with that group specifically. **Question -** I recently went through cancer treatments. I have SoonerCare and tribal. Going through everything was like a nightmare and pretty crazy with everything we had to keep up with. Approvals had to be from both OHCA and tribal. Tests and other things are set months	**RECOMMENDATION:** Renewal and adult children - How can we help families know who all should be considered? **RECOMMENDATION:** Information for young adults transitioning to their own household - Social media Young adult page on the website.

	out. There was a scan that we had waited for six months. The week before the scan I got a letter from the OHCA that said, you are being canceled because you need to upload these documents. So, this renewal process, would it have already checked for me? I'm trying to understand this. That could have happened for different reasons. It could have been that we checked you against the data exchanges and the information wasn't matching or that we got conflicting information from somewhere. So that's why you got that verification. What you put in your last application doesn't match the more current information that we have. Do you have something more current to give us? Data exchanges happen at different points in times in people's situation and can fluctuate at any given second. It could have been what we had didn't match with what we saw, or it could have been it was your renewal time. Wage checks are verified quarterly. So sometimes those can show and then that'll kick out a letter. There could be any reason. **Comment -** I could see this happening for those seasonal workers that have during summertime high 60 hours a week. But in wintertime they have two and then I could see that happening. But over the year their average is what qualifies them. Several years ago, the legislature required OHCA to do quarterly renewal checks. OHCA allows them to send in their last year's a tax return and what they've made to show that balance of that income.	
Medical-PA Services	Recently a compliance review for the Mental Health Parity and Addition Equity Act (MHPAEA) was completed and it was discovered that certain prior authorizations (PA) were required for behavioral health providers for any psychological or neuropsychological testing they might want to order but it was not required for medical providers. To have some continuity certain codes for psychological testing will require prior authorizations for the medical providers effective September 13th. Guidelines for medical providers are pretty much in line with what's required for behavioral health. This will align the medical providers with the behavioral health providers. **Slide 1 – MATF PRESENTATION – OHCA staff-** Director, Medical Administrative Support Services SoonerCare Operations **Slide 2 - Prior Authorization (PA) for Psychological Testing.**	

	Slide 3 - During an OHCA compliance review for the **Mental Health Parity and Addiction Equity Act (MHPAEA)** it was noted: • A Prior Authorization (PA) for psychological/neuropsychological test was required for Behavioral Health providers, **however** • No PA was required for Medical providers **Slide 4 –** As a result of these findings, OHCA will be adding a PA requirement for psychological testing codes 96130-96139 for Medical providers effective 9/13/24. Guidelines for Medical will closely follow those of Behavioral Health. **Slide 5 –** General Requirements Must meet **ALL** of the following conditions: • Member is experiencing difficulty in functioning with origins not clearly determined; **AND** • An evaluation has been recommended and/or requested by a physician, psychiatrist, psychologist, or a licensed mental health professional; **AND** • Results of evaluation will directly impact current treatment strategies. • If client has been tested recently a different testing battery will be performed. **Slide 6 –** Documentation Requirements Documentation requirements must include **ALL** of the following information: • What tests will be used? • How many hours will the testing require? • Who will be performing the tests, and what are their credentials? • What is the reason for the testing? • How will the evaluation results specifically affect goals and objectives for the client? **Slide 7 –** Psychological/neuropsychological testing codes: • **96130 –** EVALUATION OF PSYCHOLOGICAL TEST BY QHP, FIRST HOUR • **96131 –** EVALUATION OF PSYCHOLOGICAL TEST BY QHP, EACH ADDITIONAL HOUR • **96132 –** EVALUATION OF NEUROPSYCHOLOGICAL TEST BY QHP, FIRST HOUR • **96133 –** EVALUATION OF NEUROPSYCHOLOGICAL TEST BY QHP, EACH ADDITIONAL HOUR	

	NOTE: a Qualified Health Professional (QHP) is a psychologist, certified psychometrist who is certified to administer the test, a psychological technician working with a psychologist, or a licensed behavioral health professional. **Slide 8 –** Psychological/neuropsychological testing codes (cont'd): • **96136 –** ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY QHP, FIRST 30 MINUTES • **96137 –** ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY QHP, EACH ADDITIONAL 30 MINUTES • **96138 –** ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY TECHNICIAN, FIRST 30 MINUTES • **96139 –** ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY TECHNICIAN, EACH ADDITIONAL 30 MINUTES • **96146 –** ADMINISTRATION OF PSYCHOLOGICAL OR NEUROPSYCHOLOGICAL TEST BY SINGLE STANDARDIZED INSTRUMENT VIA ELECTRONIC PLATFORM WITH AUTOMATED RESULT **Slide 9 – Oklahoma Health Care Authority** **GET IN TOUCH** **4345 N. Lincoln Blvd** **oklahoma.gov/ohca** **Agency 405-522-7300** **Oklahoma City, OK 73105** **myscoonercare.org** **Helpline: 800987-7767** **Question -** How often is it - a once-a-year thing or is there a time period that needs to happen before follow-up testing can be done? I am not sure. I will research that and get an answer back to you. **Question –** How much do you think that this will impact primary care providers? I don't think that it will be too much stress and strain since behavioral health providers have been doing this. As far as I know, the process has been okay for them. There shouldn't be too many issues but I'm not a hundred percent sure. **Question -** When I was working at Green Country, there were certain things that they needed psychological testing for and sometimes there would be like a year away to see a psychologist. Will this add more time to that having to get the prior authorization? I wouldn't think so, but I'm not sure. A certified psychometrist, and a licensed behavioral health professional can run these tests.	

	As far as ordering goes, I hope it will be a little easier now since we have the medical providers. The PA might slow it down a bit, but it should be moving smoothly since it's not too much of a new process. **Other response -** I'd say on the medical side, any authorizations coming through the medical authorization unit since the switch to Sooner Select and a lot of those members are now being managed by the CEs. The CEs have strong requirements for turnaround times. And our internal unit here who does our fee for service population is caught up. So typically, we're not seeing, unless the required documentation doesn't come in with it then, then you might be talking about a delay. Once we have everything it turns pretty quick. **Question –** This policy will then turn around and be part of the CEs process as well for the same codes, right? Yes.	
Lunch -		
DME – Overview of What is covered for Adults vs Children	**Slide 1 - DURABLE MEDICAL EQUIPMENT (DME)** **Slide 2 – AGENDA** • Introduction • Policy • Adult vs Children Coverage • Top 5 Requested Items • DME Reuse Program • Resources • **Slide 3 – INTRODUCTION** **Slide 4 – Policy** o The Policy for Durable Medical Equipment can be found on the OHCA Public Website. o Policy specific to DME is located in sections 317:30-5-210 thru 317:30-5-218 **Slide 5 - ADULT VS CHILDREN COVERAGE** Coverage for TXIX Adults 21 years of age and older is the same as the coverage for children with the exception of following: o Orthotics – non-covered ages 21 and above o Prosthetics – non-covered ages 21 and above ▪ Exceptions – Items covered for adults	**GOLDEN NUGGET:** ABLE TECH is a good place to go for durable medical equipment **GOLDEN NUGGET:** DME Reuse program

	○ Home dialysis equipment ○ Nerve Stimulators ○ External breast prosthesis ○ Implantable devices inserted during surgery ○ Eyeglasses – Non-Covered ages 21 and above ○ Hearing Aids – Non-Covered ages 21 and above **(Note:** if a member is on the expansion program, they are covered for orthotics and all prosthetics.**)** **Slide 6 – TOP 5 REQUESTED ITEMS** ○ Incontinence Supplies ○ Wheelchairs ○ Bath Equipment ○ Oxygen ○ C-paps **Slide 7 – DME REUTILATION PROGRAM** OHCA partners with Able Tech who runs our DME Reutilization Program. ABLE Tech staff retrieves donated equipment; sanitizes and refurbishes devices; works with vendors to repair the equipment if needed; and reassigns DME devices to the best-matched Oklahoman. Any Oklahoman who is in need of medical equipment or devices, regardless of income, is eligible for the program. Priority will be given to SoonerCare members. This program is 100% donation-based — which means without community contribution, we don't have a robust inventory! Device Reutilization Program - Oklahoma ABLE Tech (okabletech.org) **(Note:** all donated equipment is held for 30 days for SoonerCare members first. If a SoonerCare member is not matched with a piece of equipment, it is rolled into the inventory for the general public to use. The reutilization program has different places where donations can be dropped off and there are schedule assignments for pick up those donations. For anyone wanting to donate something that needs to be picked up at their home contact any of the places or Able Tech directly and a time will be scheduled.**)** **Slide 8 - DME REUTILIZATION PROGRAM (CONT.)**	

	Able Tech has partnered with the below locations for donation drop-offs ○ **Bethany** ○ The Children's Center Rehabilitation Hospital, 405-789-6711 ○ **Enid** ○ Larry's Home Oxygen, 580-233-5556 ○ **Oklahoma City** ○ Able Tech Reutilization Office, 405-967-6010 OR 833-431-9706 ○ **Lawton** ○ Lawton Public Library, 580-581-3450 *for larger items like hospital beds please contact the library ahead of time to make arrangements for the drop off ○ **Owasso** ○ Entrusted Hearts Medical, 877-277-6263 ○ **Shawnee** ○ Central Oklahoma Economic Developmet District Area Agency on Aging 405-273-6410 OR 800-375-8255 ○ **Stillwater** ○ Lawton Public Library, 580-581-3450 *for larger items like hospital beds please contact the library ahead of time to make arrangements for the drop off ○ **Owasso** ○ Oklahoma ABLE Tech, 405-744-9748 OR 800-257-1705 ○ **Shawnee** ○ Central Oklahoma Economic Developmet6 District Area Agency on Aging 405-273-6410 OR 800-375-8255 ○ **Stillwater** ○ Oklahoma ABLE Tech, 405-744-9748 O 800-257-1705 ○ **Tulsa** ○ Christ for Humanity, 918-605-3703 (Steve Worden) ○ Special Education Resolution Center, 918-270-1849 OR 888-267-0028 ○ **Wilburton** Kiamichi Economic Development District of Oklahoma Program, 918-465-2367 **Slide 9- DME REUTILIZATION PROGRAM (CONT.)** Bathroom Devices ○ Bath Benches ○ Commodes ○ Grab Bars ○ Raised Toilet Seats ○ Shower Chairs Blood Glucose Monitors* Blood Pressure Monitors	

	Braces o Back Brace o Cervical Collar/Traction o Lower Extremity Brace o Upper Extremity Brace Compression and Cold Therapy o Motorized Cryotherapy o Lower Extremity Compression Sleeves o Upper Extremity Compression Sleeves Note - * Requires a physician's prescription ** Requires a physician's prescription and an evaluation from an ATP/OT/PT *** Requires a physician's prescription and a sleep study (within last 5 years) **(Note:** Several years ago, there was a recall on a donated CPAP, and they worked with a company and were able to get it replaced.**)** **Slide 10 – DME REUTILIZATION PROGRAM (CONT.)** CPAPS*** BIPAPS*** Hospital Beds – Electric and Semi-Electric* Mobility Support o Canes o Crutches o Gait Trainers** o Knee Walkers o Quad Canes o Standers** o Walker – Two-Wheeled* o Walker – Four-Wheeled/Rollator* o Walking Boot o Nebulizer* o Patient Lifts** Note - * Requires a physician's prescription ** Requires a physician's prescription and an evaluation from an ATP/OT/PT *** Requires a physician's prescription and a sleep study (within last 5 years) **Slide 11 – DME REUTILIZATION PROGRAM (CONT.)**	

	Pediatric Devices ○ Wheelchair – Manual* ○ Wheelchair – Electric** ○ Wheelchair – Specialized** ○ Standers** ○ Helmets ○ Walkers* ○ Positioning Support ○ Wedges ○ Multi-Podus Boots ○ Heel Suspension Boots ○ Wheelchair Cushions ○ Pulleys Note - * Requires a physician's prescription ** Requires a physician's prescription and an evaluation from an ATP/OT/PT *** Requires a physician's prescription and a sleep study (within last 5 years) **Slide 12 - RESOURCES** ○ Medical Authorization Unit (MAU) (oklahoma.gov) ○ DMEAdmin@okhca.org ○ TherapyAdmin@okhca.org ○ MAUAdmin@okhca.org Questions about: DME specifically can send to DMEAdmin@okhca.org Therapy or speech therapy to TherapyAdmin@okhca.org Medical/surgical related to MAUAdmin@ohca.org **Comment –** This is a really good resource. If you know someone who needs these types of items tell them about this resource. **Question –** Is an insulin pump DME? Yes. Natasha stated she accepts donations at the Health Care Authority. The items are kept in her office until Able Tech can pick them up. MATF member requested a copy of the PowerPoint.	**GOLDEN NUGGET:** DME has insulin pumps.

	MATF members were encouraged to send out the information regarding the reuse program not only for donations but for those who may need something that is available there. **Question –** Do you have a list of what you do take? We'll take anything DE wise. If they can't use it within the DE program, they have what they call an exchange program or they can map people with equipment to members that need something. There's a couple of different avenues within Able Tech that they can utilize anything that comes in, and even things that's not on that list. I have taken in breast pumps and things like that, and Able Tech was able to give it to a mother in need.	
Additional Questions	**Question –** What happens when the provider won't make a referral because they think that it's not a covered service, but it is? Call the CE's member services department and give them the doctor's name and information. The information will be given to the PR team, which will reach out to that provider and let them know it is a covered service. **Comment –** In the member toolkit on the member page of OHCA's website, there is the side-by-side benefit chart. It shows traditional or fee for service, SoonerSelect, and adults versus kids. It does kind of crosswalk across all the different benefit types. **Comment –** On the CE websites members can find a member handbook that list the covered benefits. They should align with what OHCA covers. **Comment -** If there is a rare occasion of a misunderstanding between OHCA and a CE as far as something that's covered or not covered. Go through the helpline, express what that is and then the helpline gets that information over to the SoonerSelect team who works it out. **Comment -** Families or individuals who need to know information about their plan can look online if they can't navigate that, they can call the SoonerSelect helpline. They can start with the insurance agency and begin building a relationship with them. **Question –** You are trying to fill a prescription, and they say it has to be generic. It is being denied because it's the name brand. You talk to the insurance, and they say no it has to be name brand, and it is filled. Then you're trying to get a refill, and it will not take either one. Do we contact SoonerCare or contact our CE to see why we are now not being covered? Contact your CEs customer service. That is where most of the problem solving gets done. Each medicine formulation has an NDC number, a national drug code number and the systems all set off those drug codes. The doctor may say, well this is the exact same	**GOLDEN NUGGET:** SoonerSelect can assist with contacting doctors who won't refer because they do not know something is covered.

	medicine I've been given. But if he writes the prescription a little bit differently or a different volume, that puts it over what that NDC allows, sometimes it will kick it out and say not covered. When you're on a plan and having issues with scripts or appointments or whatever you contact for that. The plan is responsible for all of the benefits, all of the coverage, and making sure that you're getting everything you need. OHCA handles your eligibility, making sure you are eligible and that you remain eligible for your coverage. If you call OHCA, we will get you to the right place. But if you are having an issue like a surprise bill, something you didn't expect, getting a script, an appointment, or something approved, the fastest result is to contact your plan. The plans have their own dedicated provider help plans too. If it is a Humana issue, the pharmacist has the ability to contact the provider side to get guidance on what to do. My child takes a drug that is not typically a covered prescription because it's for what they consider a cosmetic, and only children take. It is typically denied. It requires prior authorization which is written for a year's worth. It took a while, but the system now understands that it is a medical necessity and not for a cosmetic reason. I put on my calendar for December a reminder to send the insurance a note - hey, this is coming up for renewal. Any other questions? Fill out your cards, you can leave them on the table. Those online, either private chat or in the chat box. Any comments, recommendations, thoughts, follow ups, golden nuggets for the members. Be sure and fill out your stipend form here. Note – The next meeting will be October 12th, note it is not the first Saturday.	
Stipend forms, Future Agenda Items	Please complete and turn your Stipend forms.	**GOLDEN NUGGET:** OHCA staff is amazing
Future MATF Meetings: October 12, 2024 Future agenda items–-School-Based Services,– Cover school expansion David: Medical: Accessing Adult Preventive Care re: mammograms, paps, colonoscopies. What adult BH Services are available, Adult Physical Therapy-What is the limit per year per incident, What extra benefits are there for high-risk pregnancies? (no information listed in handbook) Limits on RX-what are options for more than 6 medications, what to do in the case of medication denial and multiple resubmissions, DMA covered for adults, School Based service updates, (2025 summer) Board of Directors Meetings: Link for Board Meeting information here: http://www.okhca.org/about.aspx?id=2671Traylor to speak about SoonerSelect, Health Information Exchange, MATF Recommendation Log, Provider Rate Changes,		

Board of Directors Meetings: Link for Board Meeting information here: *http://www.okhca.org/about.aspx?id=2671*

Comments and questions may be submitted online through the Policy Change Blog and the Native American Consultation Page by contacting the HCA Federal & State Reporting Division by telephone at 405-522-7914 or via email at HCAcommunityengagement@okhca.org