Oklahoma Health Care Authority

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

OHCA COMMENT DUE DATE: May 13, 2020

Reference: APA WF 20-08A Emergency Rule

SUMMARY:

Medicaid Expansion - The proposed rule changes will expand Medicaid eligibility for individuals, age nineteen (19) or older and under age sixty-five (65), with incomes at or below 133% of the federal poverty level.

LEGAL AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Section 435.119, Title 42 of the Code of Federal Regulations

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 20-08A

A. Brief description of the purpose of the rule:

The proposed rule changes will expand Medicaid eligibility for individuals, age nineteen (19) or older and under age sixty-five (65), with incomes at or below 133% of the federal poverty level (FPL) by creating a "new adult group" as per Section 435.119 of Title 42 of the Code of Federal Regulations.

Additionally, proposed changes will remove any references to the SoonerPlan program as it is being terminated. The adults currently being served by SoonerPlan will transition to the new adult Medicaid expansion population and will be eligible to receive more comprehensive services.

Lastly, revisions will align and better clarify policy with current practice and correct grammatical errors.

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

The proposed rule will likely affect adults with incomes below the 133 % federal poverty level who are deem eligible under the expanded Medicaid eligibility option. The proposed rule will also affect providers who will likely see an increase in patient visits.

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

The proposed rule will benefit those individuals who meet the new eligibility criteria and can receive health care coverage.

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

There is no probable impact of the proposed rule changes upon any classes of persons or political subdivisions.

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

The estimated budget impact for SFY2021 will be an increase in the total amount of $1,134,994,140 with $148,654,454 in state share. The estimated budget impact for SFY2022 will be an increased in the total amount of $1,206,287,815 with $164,790,227 in state share.

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

There is no economic impact on political subdivisions.

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

The proposed rule will not have an adverse effect on small business.

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

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule.

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

The proposed rule should have no adverse effect on the public health, safety, and environment.

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

The agency does not believe there is a detrimental effect on the public health and safety if the rule is not passed. The agency believes that the approval of the rule will have a positive effect on access to care and health outcomes for Oklahomans.

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

Prepared: March 25, 2020
Modified: April 24, 2020

RULE TEXT

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-1. Creation and implementation of rules; applicability

(a) Medical rules of the Oklahoma Health Care Authority (OHCA) are set by the ~~Oklahoma Health Care Authority~~OHCA Board. The rules are based upon the recommendations of the Chief Executive Officer of the Authority, ~~the Deputy Administrator for Health Policy~~the Deputy State Medicaid Director, the ~~Medicaid Operations~~ State Medicaid Director, OHCA tribal partners and the ~~Advisory Committee on Medical Care for Public Assistance Recipients~~OHCA Medical Advisory Committee. The ~~Medicaid Operations~~ State Medicaid Director is responsible for implementing medical policies and programs and directing the Fiscal Agent with regard to proper payment of claims.

(b) Payment to practitioners under Medicaid is made for services clearly identifiable as personally rendered services performed on behalf of a specific ~~patient~~member. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

(c) Payment is made on behalf of Medicaid eligible individuals for services within the scope of the Authority medical programs. Services cannot be paid under Medicaid for ineligible individuals or for services not covered under the scope of medical programs or that do not meet documentation requirements. These claims will be denied, or in some instances upon post-payment review, payment will be recouped.

(d) Payment to practitioners on behalf of Medicaid eligible individuals is made only for services that are medically necessary and essential to the diagnosis and treatment of the patient's presenting problem. ~~Well patient~~Wellness examinations and diagnostic testing are not covered for adults unless specifically set out in coverage guidelines.

(e) The scope of the medical program for eligible children is the same as for adults except as further set out under ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) guidelines.

(f) Services, provided within the scope of the Oklahoma Medicaid ~~Program~~program, shall meet medical necessity criteria. Requests by medical services providers for services in and of itself shall not constitute medical necessity. The ~~Oklahoma Health Care Authority~~OHCA shall serve as the final authority pertaining to all determinations of medical necessity. Service limits listed within OAC 317:30 can be exceeded, upon meeting medical necessity and in alignment with the Oklahoma State Plan, for members in the adult group, age nineteen (19) or older and under age sixty-five (65), and as defined by Section 435.119 of Title 42 of the Code of Federal Regulations. Members must meet medical necessity

criteria, prior authorization, and all other documentation requirements. Medical necessity is established through consideration of the following standards:

(1) Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;

(2) Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records and other supporting records, evidence sufficient to justify the ~~client's~~member's need for the service;

(3) Treatment of the ~~client's~~member's condition, disease or injury must be based on reasonable and predictable health outcomes;

(4) Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the member, family, or medical provider;

(5) Services must be delivered in the most cost-effective manner and most appropriate setting; and

(6) Services must be appropriate for the ~~client's~~member's age and health status and developed for the ~~client~~member to achieve, maintain or promote functional capacity.

(g) Emergency medical condition means a medical condition including injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

(h) Verbal or written interpretations of policy and procedure in singular instances is made on a case by case basis and shall not be binding on this Agency or override its policy of general applicability.

(i) The rules and policies in this ~~part~~Part apply to all providers of service who participate in the program.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The ~~Physicians'~~ physicians' Current Procedural Terminology (CPT) and the second level ~~HCPCS~~Healthcare Common Procedure Coding System (HCPCS) provide for ~~2-digit~~two(2) digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four (4) office visits (or home) per month per member, for adults ~~(over age 21)~~[over age twenty-one (21)], regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four per month limitation.

~~(3)~~(2) Payment is allowed for the insertion and/or implantation of contraceptive devices in addition to the office visit.

~~(4)~~(3) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials

(B) Dressing for burns

(C) Contraceptive devices

(D) IV ~~Fluids~~fluids

~~(5)~~(4) Payment is made for routine physical exams only as prior authorized by the ~~OKDHS~~Oklahoma Department of Human Services (OKDHS) and are not counted as an office visit.

~~(6)~~(5) Medically necessary office lab and X-rays are covered.

~~(7)~~(6) Hearing exams by physician for members between the ages of ~~21 and 65~~twenty-one (21) and sixty-five (65) are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

~~(8)~~(7) Hearing aid evaluations are covered for members under ~~21~~twenty-one (21) years of age.

~~(9) IPPB (Intermittent Positive Pressure Breathing)~~(8) Intermittent positive pressure breathing (IPPB) is covered when performed in physician's office.

~~(10)~~(9) Payment is made for an office visit in addition to allergy testing.

~~(11)~~(10) Separate payment is made for antigen.

~~(12)~~(11) Eye exams are covered for members between ages ~~21 and 65~~twenty-one (21) and sixty-five (65) for medical diagnosis only.

~~(13)~~(12) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

~~(14)~~(13) Separate payment is made for the following specimen collections:

(A) Catheterization for collection of specimen; and

(B) Routine ~~Venipuncture~~venipuncture.

~~(15)~~(14) The ~~Professional Component~~professional component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.

~~(16)~~(15) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(c) **Non-covered office services.**

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.

(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.

(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.

(4) Additional payment will not be made for mileage.

(5) Payment is not made for an office visit where the member did not keep appointment.

(6) Refractive services are not covered for persons between the ages of ~~21 and 65~~twenty-one (21) and sixty-five (65).

(7) Removal of stitches is considered part of post-operative care.

(8) Payment is not made for a consultation in the office when the physician also bills for surgery.

(9) Separate payment is not made for oxygen administered during an office visit.

(d) **Covered inpatient medical services.**

(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two (2) physicians when supplemental skills are required and different specialties are involved.

(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one (1) unit per day.

(e) **Non-covered inpatient medical services.**

(1) For inpatient services, all visits to a member on a single day are considered one (1) service except where specified. Payment is made for only one (1) visit per day.

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) **Other medical services.**

(1) Payment will be made to physicians providing ~~Emergency Department~~emergency department services.

(2) Payment is made for two (2) nursing facility visits per month. The appropriate CPT code is used.

(3) When payment is made for "~~Evaluation~~evaluation of arrhythmias" or "~~Evaluation~~evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

317:30-5-12. Family planning

(a) **Adults.** Payment is made for the following family planning services:

(1) physical examination to determine the general health of the member and most suitable method of contraception;

(2) complete general history of the member and pertinent history of immediate family members;

(3) laboratory services for the determination of pregnancy, detection of certain sexually transmitted infections and detection of cancerous or pre-cancerous conditions of the reproductive anatomy;

(4) education and counseling regarding issues related to reproduction and contraception;

(5) annual supply of chosen contraceptive;

(6) insertion and removal of contraceptive devices;

(7) vasectomy and Tubal Ligation procedures; and

(8) additional visits for members experiencing difficulty with a particular contraceptive method or having concerns related to their reproductive health.

(b) **Children.** Payment is made for children as set forth in this Section for adults. However payment cannot be made for the sterilization of persons under the age of 21.

~~(c) **SoonerPlan Members.** Non-pregnant women and men ages 19 and older not enrolled in SoonerCare may apply for the SoonerPlan program. Eligible members receive family planning services set forth in this Section as well as family planning related services (vaccinations for the prevention of certain sexually transmitted infections and male exams). SoonerPlan eligibility requirements are found at OAC 317:35-7-48.~~

~~(d)~~(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Claims for services which are not covered by Medicare should be filed directly with the Fiscal Agent for payment within the scope of the program.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 35. RURAL HEALTH CLINICS

317:30-5-356. Coverage for adults

Payment is made to rural health clinics (RHC) for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for ~~one~~(1) encounter per member per day. Payment is also limited to four (4) visits per member per month. Refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-1, General Provisions, and OAC 317:30-3-65.2 for exceptions to the four (4) visit limit for children under the Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment Program (EPSDT). Additional preventive service exceptions include: obstetrical care and family planning.

(A) ~~**Obstetrical care.** A Rural Health Clinic~~An RHC should have a written contract with its physician, certified nurse midwife, advanced practice registered nurse, or physician assistant that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for rural health and non-rural health clinic (other ambulatory) services. Obstetrical care is exempted from the four (4) visit limitation.

(i) If the clinic compensates the physician, certified nurse midwife or advanced practice registered nurse to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.

(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, certified nurse midwives, physician assistants, and advanced practice registered nurses (refer to OAC 317:30-5-22).

(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated

to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits~~ do not count as one of the four RHC visits per month.~~are exempted from the four (4) visit limitation.

~~(2)~~(3) **Other ambulatory services.** Services defined as "other ambulatory" services are not considered a part of ~~a~~an RHC visit and are therefore billable to the SoonerCare program by the RHC or provider of service on the appropriate claim forms. Other ambulatory services are subject to the same scope of coverage as other SoonerCare services billed to the program, i.e., limited adult services and some services for ~~under 21~~individuals under twenty-one (21) are subject to the same prior authorization process. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows: Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors. There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

PART 61. HOME HEALTH AGENCIES

317:30-5-546. Coverage by category

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

(1) **Adults.** Payment is made for home health services provided in the member's residence to all categorically needy adults and adults, age nineteen (19) or older and under age sixty-five (65), as defined per 42 C.F.R. § 435.119. Coverage for adults is as follows.

(A) **Covered items.**

(i) Part-time or intermittent nursing services;

(ii) Home health aide services;

(iii) Standard medical supplies;

(iv) ~~Durable medical equipment (DME) and appliances DMEPOS~~Medical supplies, equipment, and appliances; and

(v) Items classified as prosthetic devices.

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

(i) Sales tax;

(ii) Enteral therapy and nutritional supplies;

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

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

(2) **Children.** ~~Home Health Services~~Home health services are covered for persons under age ~~21~~twenty-one (21).

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

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.5. Health Center encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30. Excluded from the definition of reimbursable encounter core services are:

(1) Services provided by an independently ~~CLIA~~Clinical Laboratory Improvement Amendments (CLIA) certified and enrolled laboratory.

(2) Radiology services including nuclear medicine and diagnostic ultrasound services.

(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.

(4) ~~Durable medical equipment or medical supplies~~Medical supplies, equipment and appliances are not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare.

(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service.

(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.

(7) Administrative medical examinations and report services;

(8) Emergency services including delivery for pregnant members that are eligible under the ~~Non-Qualified~~non-qualified (ineligible) provisions of OAC 317:35-5-25;

~~(9) SoonerPlan family planning services;~~Family planning services;

~~(10)~~(9) Optometry and podiatric services other than for dual eligible for Part B of Medicare; and

~~(11)~~(10) Other services that are not defined in this rule or the State Plan.

(b) In addition, the following limitations and requirements apply to services provided by Health Centers:

(1) Physician services are not covered in a hospital.

(2) Behavioral health case management and psychosocial rehabilitation services are limited to Health Centers enrolled under the provider requirements in OAC 317:30-5-240 and contracted with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) as an outpatient behavioral health agency.