

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: November 9, 2020

The proposed policy is an Emergency Rule. The proposed policy was presented at the July 7 Tribal Consultation. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on November 12, 2020 and the OHCA Board of Directors on November 12, 2020.

Reference: APA WF # 20-16

SUMMARY:

Opioid Treatment Program (OTP) and Medication-Assisted Treatment (MAT) Services – The proposed revisions will comply with the SUPPORT Act, HR 6, and establish coverage and reimbursement of medically necessary medication-assisted treatment (MAT) services and/or medications for SoonerCare members with opioid use disorder (OUD) in opioid treatment programs (OTPs) and within office-based opioid treatment (OBOT) settings.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Act, Section 5007 of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; the 2018 Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act, HR 6, Section 1006.

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 20-16

A. Brief description of the purpose of the rule:

The proposed revisions will comply with the SUPPORT Act, HR 6, Section 1006, and establish coverage and reimbursement of medically necessary medication-assisted treatment (MAT) services and/or medications for SoonerCare members with opioid use disorder (OUD) in opioid treatment programs (OTPs) and within office-based opioid treatment (OBOT) settings.

- 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:

SoonerCare members with opioid use disorders who need access to MAT services and/or medications will most likely be positively affected by the proposed rule changes.

OTP and OBOT providers will most likely be positively affected by the proposed rule changes.

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

The proposed rule changes to establish coverage and reimbursement of medically necessary MAT services and/or medications will benefit SoonerCare members with OUD, by establishing member access to treatment that will help them manage their dependency and move toward recovery.

The proposed rule changes to establish coverage and reimbursement of medically necessary MAT services and/or medications will benefit OTPs and OBOTs by providing reimbursement for the delivery of services and/or medications.

- 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 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 proposed changes to implement substance use disorder coverage in opioid treatment programs may potentially result in an estimated annual total cost of \$1,492,594.06 with a state share of \$446,416.73 for SFY21 and a total cost of \$1,992,835.46 with a state share of \$637,906.63 for SFY22. The state share will be paid by the Oklahoma Department of Mental Health and Substance Abuse Services.

The proposed changes to implement coverage of MAT medications may potentially result in an estimated annual total cost of \$1,311,223 with a state share of \$392,171 for SFY21 and a total cost of \$1,750,679 with a state share of \$562,318 for SFY22. The state share will be paid by the Oklahoma Health Care Authority.

- 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 a positive effect on the public health, safety, and environment due to expanding access to these services.

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

OHCA does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

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

Prepared: September 1, 2020
Modified: October 12, 2020

RULE TEXT:

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

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 ~~HCPCH~~Healthcare Common Procedure Coding System (HCPCS) provide for 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 (4) per month limitation.

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

(4) 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; and
- (D) IV ~~Fluids~~fluids.

~~(5) Payment is made for routine physical exams only as prior authorized by the 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)~~(8) IPPB (Intermittent Positive Pressure Breathing) 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~~twenty one (21) and ~~65~~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 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.

(16) Payment may be made for medication-assisted treatment (MAT) medications prescribed and/or administered by a physician.

(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 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 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 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 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 of arrhythmias" or "Evaluation of sinus node"~~ evaluation of arrhythmias or 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.

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.7. Medication-assisted treatment (MAT) services for eligible individuals with opioid use disorder (OUD)

(a) **Definitions.** The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Medication-assisted treatment (MAT)"** means an evidence-based practice approved by the Food and Drug Administration (FDA) to treat opioid use disorder, including methadone and all biological products licensed under federal law for such purpose. MAT also includes the provision of counseling and behavioral therapy.

(2) **"Office-based opioid treatment (OBOT)"** means a fully contracted SoonerCare provider that renders MAT services in OBOT settings. OBOT providers must have capacity to provide all drugs approved by the FDA for the treatment of opioid use disorder, directly or by referral, including for maintenance, detoxification, overdose reversal, and relapse prevention, and appropriate counseling and other appropriate ancillary services.

(3) **"Opioid treatment program (OTP)"** means a program or provider:

(A) Registered under federal law;

(B) Certified by the Substance Abuse and Mental Health Services Administration (SAMHSA);

(C) Certified by ODMHSAS, unless deemed an exempted entity as

defined by federal law;

(D) Registered by the Drug Enforcement Agency (DEA);

(E) Registered by the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD); and

(F) Engaged in opioid treatment of individuals by use of an opioid agonist treatment medication, including methadone.

(4) "**Opioid use disorder (OUD)**" means a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opioids despite significant opioid-induced problems.

(5) "**Phase I**" means a minimum ninety (90) day period in which the member attends the opioid treatment program for observation of medication assisted treatment daily or at least six (6) days a week.

(6) "**Phase II**" means the phase of treatment for members who have been admitted for more than ninety (90) days and who have successfully completed Phase I.

(7) "**Phase III**" means the phase of treatment for members who have been admitted for more than six (6) months and who have successfully completed Phase II.

(8) "**Phase IV**" means the phase of treatment for members who have been admitted for more than nine (9) months and who have successfully completed Phase III.

(9) "**Phase V**" means the phase of treatment for members who have been admitted for more than one (1) year.

(10) "**Phase VI**" means the phase of treatment for members who voluntarily seek medically supervised withdrawal and abstinence from all drugs, including methadone as prescribed. A member may enter this phase at any time in the treatment and rehabilitation process.

(b) **Coverage.** The SoonerCare program provides coverage of medically necessary MAT services in OTPs, including but not limited to, methadone treatment, to eligible individuals with OUD. An OTP must have the capacity to provide the full range of services included in the definition of MAT and must document both medication dosing and supporting behavioral health services, including but not limited to, individual, family and group therapy and rehabilitation services. MAT services and/or medications may also be provided in OBOT settings per OAC 317:30-5-9(b) (17).

(c) **OTP requirements.** Every OTP provider shall:

(1) Have a current contract with the OHCA as an OTP provider;

(2) Hold a certification as an OTP from ODMHSAS, unless deemed an exempted entity as defined by federal law;

(3) Hold a certification from the Substance Abuse and Mental Health Services Administration (SAMHSA);

(4) Be appropriately accredited by a SAMHSA-approved accreditation organization;

(5) Be registered with the DEA and the OBNDD; and

(6) Meet all state and federal opioid treatment standards,

including all requirements within OAC 450:70.

(d) **Individual OTP providers.** OTP providers include:

(1) **MAT provider** is a physician, physician's assistant (PA), or advanced practice registered nurse (APRN) who may prescribe, dispense, and administer medications in accordance with state and federal law and the Oklahoma Medicaid State Plan.

(2) **OTP behavioral health services practitioner** is a practitioner that meets the qualifications in OAC 317:30-5-240.3, except for family support and training providers, qualified behavioral therapy aide providers, multi-systemic therapy providers, and case manager I providers, for the provision of outpatient behavioral health services.

(e) **Intake and assessment.** OTPs shall conduct intake and assessment procedures in accordance with OAC 450:70-3-5 through OAC 450:70-3-7.

(f) **Service phases.** In accordance with OAC 450:70-6-17.2 through OAC 450:70-6-17.8, the OTP shall have structured phases of treatment and rehabilitation to support member progress and to establish requirements regarding member attendance and service participation. Treatment requirements for each phase shall include, but not limited to, the following:

(1) During phase I, the member shall participate in a minimum of four (4) sessions of therapy or rehabilitation services per month with at least one (1) session being individual therapy, rehabilitation, or case management.

(2) During phase II the member shall participate in at least two (2) therapy or rehabilitation service sessions per month during the first ninety (90) days, with at least one (1) of the sessions being individual therapy, rehabilitation, or case management. After the initial ninety (90) days in Phase II, the member shall participate in at least one (1) session of individual therapy or rehabilitation service per month.

(3) During phase III, phase IV and phase V, the member shall participate in at least one (1) session of individual therapy, rehabilitation, or case management per month.

(4) During phase VI, the LBHP, licensure candidate or certified alcohol and drug counselor (CADC) determines the frequency of therapy or rehabilitation service sessions with input from the member.

(5) If an OTP is providing MAT medications to members receiving residential substance use disorder services, the required minimum services for the OTP may be delivered by the residential substance use disorder provider. The OTP provider shall document the provision of these services and the provider delivering such services in the member's service plan.

(g) **Service plans.** In accordance with OAC 450:70-3-8, a service plan shall be completed for each member upon completion of the admission evaluation. The service plan shall be based on the patient's presenting problems or diagnosis, intake assessment,

biopsychosocial assessment, and expectations of their recovery.

(1) **Service plan development.** Service plans shall be completed by an LBHP or licensure candidate. Service plans completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP.

(2) **Service plan content.** Service plans shall address, but not limited to, the following:

(A) Presenting problems or diagnosis;

(B) Strengths, needs, abilities, and preferences of the member;

(C) Goals for treatment with specific, measurable, attainable, realistic and time-limited;

(D) Type and frequency of services to be provided;

(E) Dated signature of primary service provider;

(F) Description of member's involvement in, and responses to, the service plan and his or her signature and date;

(G) Individualized discharge criteria or maintenance;

(H) Projected length of treatment;

(I) Measurable long and short term treatment goals;

(J) Primary and supportive services to be utilized with the patient;

(K) Type and frequency of therapeutic activities in which patient will participate;

(L) Documentation of the member's participation in the development of the plan; and

(M) Staff who will be responsible for the member's treatment.

(3) **Service plan updates.** Service plan updates shall be completed by an LBHP or licensure candidate. Service updates completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP. Service plan review and updates shall occur no less than every six (6) months and shall occur more frequently if required based upon the service phase or certain circumstances:

(A) During phase I, the service plan shall be reviewed and updated a minimum of once monthly.

(B) During phase II, the service plan shall be reviewed and updated a minimum of once every three (3) months.

(C) A service plan review shall be completed for the following situations:

(i) Change in goals and objectives based upon member's documented progress, or identification of any new problem(s);

(ii) Change in primary therapist or rehabilitation service provider assignment;

(iii) Change in frequency and types of services provided;

(iv) Critical incident reports;

(v) Sentinel events; or

(vi) Phase change.

(4) **Service plan timeframes.** Service plans shall be completed by

the fourth therapy or rehabilitation service visit after admission.

(h) **Progress notes.** Progress notes shall be completed in accordance with OAC 317:30-5-248(3).

(i) **Discharge planning.** All members shall be assessed for biopsychosocial appropriateness of discharge from each level of care using ASAM criteria that includes a list of symptoms for all six (6) dimensions and each of the levels of care, to determine a clinically appropriate placement in the least restrictive level of care. This organized process involves a professional determination by an LBHP or licensure candidate for appropriate placement to a specific level of care based on the following symptoms and situations:

(1) Acute intoxication and/or withdrawal potential;

(2) Biomedical conditions and complications;

(3) Emotional, behavioral or cognitive conditions and complications;

(4) Readiness to change;

(5) Relapse, continued use or continued problem potential; and

(6) Recovery/living environment.

(j) **Service exclusions.** The following services are excluded from coverage:

(1) Components that are not provided to or exclusively for the treatment of the eligible individual;

(2) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services;

(3) Telephone calls or other electronic contacts (not inclusive of telehealth);

(4) Field trips, social, or physical exercise activity groups; and

(k) **Reimbursement.** In order to be eligible for payment, OTPs shall:

(1) Have an approved provider agreement on file with the OHCA. Through this agreement, the OTP assures that they are in compliance with all applicable federal and State Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma Medicaid State Plan.

(2) Obtain prior authorization for applicable drugs and services by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization for applicable drugs and services, payment is not authorized.

(3) Record the National Drug Code (NDC) number for each drug used in every encounter at the time of billing.

(3) Be reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.