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 16, 2022

The proposed policy is an Emergency Rule. The proposed policy was presented at the November 1, 2022 Tribal Consultation. Additionally, this proposal is scheduled to be presented to the Medical Advisory Committee on January 5, 2023 and the OHCA Board of Directors on January 18, 2023.

Reference: APA WF # 22-21A

SUMMARY: Increase Income Standard for Pregnant Women and Extend Postpartum Coverage — The proposed revisions will increase the income standard for pregnancy benefits as well as extend the postpartum coverage period.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; 42 CFR § 435.116; and Public Law 117-2 (the American Rescue Plan Act of 2021)

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 22-21A

A. Brief description of the purpose of the rule:

The proposed revisions will expand Medicaid eligibility for full-scope pregnancy benefits by increasing the income standard from 133% of the Federal Poverty Level (FPL) to 185% FPL, or 210% once converted to MAGI and applying the applicable MAGI disregards. Additionally, the proposed revisions will extend Medicaid postpartum coverage from 60 days to 12 months. This new postpartum coverage option is afforded through March 31, 2027 by the American Rescue Plan Act of 2021.

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:

Pregnant women whose income falls between 133% FPL and 210% FPL who will now qualify for SoonerCare, provided all other eligibility factors are met, as well as women who will

experience better health outcomes in childbirth and the postpartum period, are most likely to be affected by the proposed rule. This rule change should not place any cost burden on private or public entities. No information on any cost impacts were received from any entity.

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

Pregnant women whose income falls between 133% FPL and 210% FPL who will now qualify for SoonerCare, provided all other eligibility factors are met, as well as women who will experience better health outcomes in childbirth and the postpartum period, will benefit from the proposed rule.

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

There is no probable economic impact and there are no fee changes associated with the rule change for the above classes of persons or any 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 affect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The estimated total cost for SFY 2023 is $6,150,000 ($4,640,790 in federal share and $1,509,210 in state share). The estimated total cost for SFY 2024 is $12,300,000 total ($8,245,674 in federal share and $4,054,326 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:

The proposed rule changes will not have an economic impact on any political subdivision or require their cooperation in implementing or enforcing the rule changes.

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 agency does not anticipate that the proposed rule changes will have an adverse effect on small businesses.

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 are no other legal methods to achieve the purpose of the proposed rule. Measures included a formal public comment period and tribal consultation.

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:

It is anticipated that the proposed rule will positively effect on the public health, safety or environment by improving health outcomes during childbirth and the postpartum period by increasing access to prenatal, delivery and postpartum care.

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

The agency does not anticipate any detrimental effect on the public health and safety if the proposed rule is not passed.

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

Prepared date: September 8, 2022

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

(1) Inpatient hospital services.

(A) Adult coverage for inpatient hospital stays as described at Oklahoma Administrative Code (OAC) 317:30-5-41.

(B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or freestanding dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).

(6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified hospital-based facilities that are also qualified

mental health clinics.
(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.
(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
(9) Maternity clinic services.
(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the Agency's Medical Authorization Unit.
(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
(12) Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).
(13) Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA child-health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.12.

(A) EPSDT screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.
(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.
(C) Immunizations.
(D) Outpatient care.
(E) Dental services as outlined in OAC 317:30-3-65.8.
(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(G) Hearing services as outlined in OAC 317:30-3-65.9.
(H) Prescribed drugs.
(I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.
(J) Inpatient psychiatric services as outlined in OAC 317:30-5-94 through 317:30-5-97.
(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
(L) Inpatient hospital services.
(M) Medical supplies, equipment, appliances, orthotics and prosthetics.
(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device,

and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a long-term care facility, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

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

(A) Podiatrists' services;

(B) Optometrists' services;

(C) Psychologists' services;

(D) Certified registered nurse anesthetists;

(E) Certified nurse midwives;

(F) Advanced practice registered nurses; and

(G) Anesthesiologist assistants.

(17) Freestanding ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

(A) Unlimited medically necessary monthly prescriptions for:

(i) Members under the age of twenty-one (21) years; and

(ii) Residents of long-term care facilities or ICF/IID.

(B) Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of medical supplies, equipment, and appliances.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.

(21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).

(22) For non-expansion adults, prosthetic devices are limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage for orthotic devices for adults.

(23) Orthotics and prosthetics are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.

(24) Standard medical supplies.
(25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(26) Blood and blood fractions for members when administered on an outpatient basis.
(27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
(28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.
(29) Inpatient psychiatric facility admissions for members are limited to an approved length of stay with provision for requests for extensions.
(30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
(31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for ~~sixty (60) days~~twelve (12) months after the pregnancy ends regardless of the reason, beginning on the last date of pregnancy.
(32) Long-term care facility services for members under twenty-one (21) years of age.
(33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a registered nurse (RN).
(34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.
(35) HCBS for the intellectually disabled.
(36) Home health services can be provided without a PA for the first thirty-six (36) visits. A PA will be required beyond the 36th visit. The visits are limited to any combination of RN and nurse aide visits.
(37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) All transplantation services, except kidney and cornea, must be prior authorized;

(B) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;

(C) All organ transplants must be performed at a Medicare approved transplantation center;

(D) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and

(E) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.

(38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a long-term care facility (Alternative Disposition Plan - ADP).
(39) Case management services for the chronically and/or seriously mentally ill.
(40) Emergency medical services, including emergency labor and delivery for undocumented or ineligible aliens.
(41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on

an encounter basis.
(42) Early intervention services for children ages zero (0) to three (3).
(43) Residential behavior management in therapeutic foster care setting.
(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
(45) HCBS for aged or physically disabled members.
(46) Outpatient ambulatory services for members infected with tuberculosis.
(47) Smoking and tobacco use cessation counseling for children and adults.
(48) Services delivered to American Indians/Alaskan Natives (AI/AN) in Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.
(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.
(50) Residential substance use disorder (SUD) services.
(51) Medication-assisted treatment (MAT) services.
(52) Diabetes self-management education and support (DSMES).

PART 16. MATERNAL AND INFANT HEALTH LICENSED CLINICAL SOCIAL WORKERS

317:30-5-208. Reimbursement

(a) Maternal and infant health social work services must be billed using appropriate CPT codes and guidelines.
(b) SoonerCare does not allow more than ~~32~~thirty-two (32) units ~~(15 minutes = 1 unit)~~[fifteen (15) minutes = one (1) unit] during the pregnancy which includes ~~60 days~~twelve (12) months postpartum.
(c) LCSWs that are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.
(d) Only the LCSW directly performing the care or a county health department may bill the SoonerCare Program.
(e) The time indicated on the claim form must be the time actually spent with the member.

PART 18. GENETIC COUNSELORS

317:30-5-221. Coverage

(a) Genetic counseling services are covered for SoonerCare members who meet the criteria for receiving medically necessary genetic testing as set forth in 317:30-5-2 (a)(1)(FF) and for pregnant/postpartum SoonerCare members as set forth in this section. Services for pregnant/postpartum SoonerCare members must be referred by a provider involved in the provision of obstetric or pediatric care. Members are eligible for genetic counseling during pregnancy which includes ~~sixty (60) days~~twelve (12) months postpartum. Reasons for genetic counseling include but are not limited to the following:
(1) Advanced maternal age;
(2) Abnormal maternal serum first or second screening;
(3) Previous child or current fetus/infant with an abnormality;

(4) Consanguinity/incest;
(5) Parent is a known carrier or has a family history of a genetic condition;
(6) Parent was exposed to a known or suspected reproductive hazard;
(7) Previous fetal demise, stillbirth, or neonatal death involving known/suspected abnormalities;
(8) History of recurrent pregnancy loss; or
(9) Parent(s) are in an ethnic or racial group associated with an increased risk for specific genetic conditions.

(b) These services may be provided in an office or outpatient setting.

317:30-5-222. Reimbursement

(a) Counseling services must be billed using appropriate CPT codes and guidelines and must be medically necessary. SoonerCare does not allow more than six units ~~(30 minutes = 1 unit)~~[thirty (30) minutes = one (1) unit] per pregnancy including ~~60 days~~twelve (12) months postpartum care.
(b) Genetic Counselors who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

PART 20. LACTATION CONSULTANTS

317:30-5-232. Coverage

Lactation Consultant services are covered for pregnant women and women up to ~~60 days~~twelve (12) months postpartum. SoonerCare members may self-refer or be referred by any provider. Reasons for lactation services include but are not limited to the following:

(1) ~~prenatal~~Prenatal education/training for ~~first time~~first-time mothers;
(2) ~~women~~Women who have not previously breastfed, have a history of breastfeeding difficulty, have identified risk factors for breastfeeding difficulty or lactation insufficiency (e.g., history of breast surgery, infertility, hormonal imbalance, diabetes, obesity);
(3) ~~women~~Women expecting an infant with risk factors for ineffective breastfeeding (e.g., preterm, multiples, congenital birth defects);
(4) ~~latch on~~Latch-on difficulties;
(5) ~~low~~Low milk supply;
(6) ~~breastfeeding~~Breastfeeding a premature baby (~~36~~thirty-six (36) weeks or less gestation);
(7) ~~breastfeeding~~Breastfeeding multiples; and
(8) ~~a~~A baby with special needs (e.g., Down Syndrome, cleft lip/or palate).