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: January 17, 2024

The proposed policy is an Emergency Rule. The proposed policy was presented at the January 2, 2024, Tribal Consultation. Additionally, this proposed change will be presented to the Medical Advisory Committee on March 7, 2024, and the OHCA Board of Directors on March 20, 2024.

REFERENCE: APA WF 24-04

SUMMARY:
Hospital-Administered Opioid Antagonist Reimbursement – As directed by Senate Bill 712, Oklahoma Health Care Authority will seek federal and state approval to allow the Agency to separately reimburse for opioid antagonists provided to members in an emergency department with symptoms of an opioid overdose, opioid disorder, or any other adverse opioid event related to opioid use.

LEGAL AUTHORITY:
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; Senate Bill 712

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

SUBJECT: Rule Impact Statement
APA WF # 24-04

A. Brief description of the purpose of the rule:

The proposed rule revisions are to comply with Senate Bill 712. The Oklahoma Health Care Authority will seek federal and state approval to allow the Agency to separately reimburse for opioid antagonists provided to members in an emergency department with symptoms of an opioid overdose, opioid disorder, or any other adverse opioid event related to opioid use.

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:

This rule will affect hospitals as they will be required to distribute to a member that presents to an emergency department the symptoms of an opioid overdose, opioid disorder, or any

other adverse opioid event related to opioid use. who offer services through behavioral health integration and the psychiatric collaborative care model.

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

Complying with this legislation will increase availability and targeted distribution of emergency opioid antagonists as a critical component in reducing/preventing opioid related overdose deaths. Covering this benefit should also promote initiatives that educate our members on the life-saving potential of emergency opioid antagonist.

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 economic impact and there are no fee changes associated with the rule change for the above classes of persons or any political subdivision.

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 SFY 2024 will be an increase in the total amount of $142,203; with $46,173 in state share. The estimated budget impact for SFY 2025 will be an increase in the total amount of $284,406; with $93,314 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 will not have an economic impact on any political subdivisions or require their cooperation in implementing or enforcing the rule.

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 businesses as provided by the Oklahoma Small Business Regulatory Flexibility Act.

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 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 anticipate any detrimental effect on the public health, safety, or environment if the proposed rule changes are not implemented.

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

Prepared: December 21, 2023

RULE TEXT

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.7. Emergency department (ED) care/services

Emergency department care must:

(1) Be provided in a hospital with a designated emergency department; and

(2) Provide direct patient care, including patient assessment, monitoring, and treatment by hospital medical personnel such as physicians, nurses, or lab and x-ray technicians.

(A) Medical records must document the emergency diagnosis and the extent of direct patient care.

(B) Emergency department care does not include unattended waiting time.

(C) Emergency services are covered for a medical emergency. This means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(i) Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or continuation of severe pain;

(ii) serious impairment to bodily functions; serious dysfunction of any bodily organ or part; or death.

(D) Labor and delivery is a medical emergency, if it meets this definition.

(3) Prescheduled services are not considered an emergency.

(4) Services provided as follow-up to initial emergency care are not considered emergency services.
(5) Include provision of emergency opioid antagonist upon discharge as per state law.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services in the following manner:
(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.
(2) The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:
(A) Laboratory services;
(B) Prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;
(C) Technical component on radiology services;
(D) Transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;
(E) Pre-admission diagnostic testing performed within seventy-two (72) hours of admission; and
(F) Organ transplants.
(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.
(4) Covered inpatient services provided to eligible members of the SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.
(5) Cases which indicate transfer from one (1) acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.
(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.
(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.
(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed one-hundred percent (100%) of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.
(9) New providers entering the SoonerCare program will be assigned a peer group and will be

reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.
(10) All inpatient services are reimbursed per the methodology described in this Section and/or as approved under the Oklahoma Medicaid State Plan.
(11) For high-investment drugs, refer to OAC 317:30-5-47.6.
(12) Separate reimbursement may be obtained for provision of two (2) doses of emergency opioid antagonist upon discharge as per state law.