Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0001O | OK-21-0022-A | MIGRATED_HH.OK HH - adults

CMS-10434 OMB 0938-1188

The submission includes the following:

- [ ] Administration
- [ ] Eligibility
- [ ] Benefits and Payments
- [ ] Health Homes Program

Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- ( ) Create new Health Homes program
- ( ) Amend existing Health Homes program
- (•) Terminate existing Health Homes program

MIGRATED_HH.OK HH - adults

Submission - Other Comment

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Package Header

Package ID OK2021MS0001O
SPA ID OK-21-0022-A
Submission Type Official
Initial Submission Date N/A
Approval Date N/A
Effective Date N/A
Superseded SPA ID N/A

SAMHSA Consultation

Name of Health Homes Program

MIGRATED_HH.OK HH - adults

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
4/27/2021

Health Homes Program Termination - Phase-Out Plan

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User-Entered

Provide a description of the phase-out or transition plan for the Health Homes Program that is being terminated

Describe the reason for termination

Oklahoma Medicaid will terminate the Health Home program September 30, 2021. Other care coordination models currently in place will continue to serve the population impacted by the termination of the program.

Describe the overall approach the state will use to terminating the program

The Health Home population will continue to receive integrated behavioral and physical health care coordination from nurses and behavioral health case managers. This will be provided by Community Mental Health Centers (CMHCs) and through Certified Community Behavioral Health service delivery that were previously contracted as Health Homes.

Indicate method of termination

- (●) The state will terminate all participants from the Health Homes Program on the same date
- ( ) The state will phase-out the termination of participation in the Health Homes Program

Termination effective date

9/30/2021

Describe the process the state will use to transition all participants and how referrals will be made to other health care providers

Oklahoma currently has coordinated care delivery for adults with Serious Mental Illness (SMI) through Patient Centered Medical Homes (PCMH), Health Access Networks (HANs), Health Management Program (HMP), and Certified Community Behavioral Health (CCBH) service delivery. Effective October 1, 2021, in partnership with four managed care organizations, Oklahoma will transition to a new health care model called the SoonerSelect Program.

Care coordination will be a seamless transition for members receiving Health Home services through CMHCs and for those receiving CCBH services who are also enrolled with MCOs, effective October 1, 2021. Most CMHCs will become an eligible organization to provide CCBH services. The MCO will coordinate physical and behavioral health integration delivered by the CCBH services provider, with a focus on increased access to care and improved health outcomes.

Current Health Home members who do not choose a CMHC or a CCBH provider to continue services can access physical and behavioral health integration services with a qualified MCO during the open enrollment period, currently set to occur prior to October 1, 2021. Questions regarding this transition can be directed to Malissa McIntire, Director of Integrated Care, ODMHSAS, at (405) 248-9341.

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Submission - Medicaid State Plan

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0002O | OK-21-0022-B | MIGRATED_HH.OK HH - children

CMS-10434 OMB 0938-1188

The submission includes the following:

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Do not use "Create New Health Homes Program" to amend an existing Health Homes program. Instead, use "Amend existing Health Homes program," below.

- ( ) Create new Health Homes program
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MIGRATED_HH.OK HH - children

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0002O | OK-21-0022-B | MIGRATED_HH.OK HH - children

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SAMHSA Consultation

Name of Health Homes Program

MIGRATED_HH.OK HH - children

☐ The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

Date of consultation
4/27/2021

Health Homes Program Termination - Phase-Out Plan

MEDICAID | Medicaid State Plan | Health Homes | OK2021MS0002O | OK-21-0022-B | MIGRATED_HH.OK HH - children

CMS-10434 OMB 0938-1188

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Package ID	OK2021MS0002O	**SPA ID**	OK-21-0022-B
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Approval Date	N/A	**Effective Date**	N/A
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Provide a description of the phase-out or transition plan for the Health Homes Program that is being terminated

Describe the reason for termination

Oklahoma Medicaid will terminate the Health Home program September 30, 2021. Other care coordination models currently in place will continue to serve the population impacted by the termination of the program.

Describe the overall approach the state will use to terminating the program

The Health Home population will continue to receive integrated behavioral and physical health care coordination from nurses and behavioral health case managers. This will be provided by Community Mental Health Centers (CMHCs) and through Certified Community Behavioral Health service delivery that were previously contracted as Health Homes.

Indicate method of termination

- (●) The state will terminate all participants from the Health Homes Program on the same date
- ( ) The state will phase-out the termination of participation in the Health Homes Program

Termination effective date

9/30/2021

Describe the process the state will use to transition all participants and how referrals will be made to other health care providers

Oklahoma currently has coordinated care delivery for children with Severe Emotional Disturbance (SED) through Patient Centered Medical Homes (PCMH), Health Access Networks (HANs), Health Management Program (HMP), and Certified Community Behavioral Health (CCBH) service delivery. Effective October 1, 2021, in partnership with four managed care organizations, Oklahoma will transition to a new health care model called the SoonerSelect Program.

Care coordination will be a seamless transition for members receiving Health Home services through CMHCs and for those receiving CCBH services who are also enrolled with MCOs, effective October 1, 2021. Most CMHCs will become an eligible organization to provide CCBH services. The MCO will coordinate physical and behavioral health integration delivered by the CCBH services provider, with a focus on increased access to care and improved health outcomes.

Current Health Home members who do not choose a CMHC or a CCBH provider to continue services can access physical and behavioral health integration services with a qualified MCO during the open enrollment period, currently set to occur prior to October 1, 2021. Questions regarding this transition can be directed to Malissa McIntire, Director of Integrated Care, ODMHSAS, at (405) 248-9341.

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AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

13.d Rehabilitative Services

13.d.2 Program of Assertive Community Treatment (continued)

D. Limitation on Services

(a) PACT services must be medically necessary and recommended by a BHP prior to receiving these services. An initial screening/assessment must be completed to receive the service(s). Covered services are available only to Medicaid eligible consumers with a written treatment plan containing the recommended necessary psychiatric, rehabilitation and support services. The treatment plan is completed by an authorized BHP.

(b) Employment services, personal care services, childcare and respite services are not billable activities. Consumers living in an IMD, nursing facility or inmates of public correctional institutions are not eligible for PACT services.

~~**(c) Health Home Services –** PACT teams may also be designated Health Homes. The service components listed in C. i-iv may also be considered Health Home services and duplicate payment cannot be made.~~

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL SERVICES

16. Inpatient Psychiatric Services for individuals under age 21 (42 CFR 440.160) *(continued)*
16.a. Inpatient Psychiatric Services for Individuals under Age 21 *(continued)*
(C) Payment to State–licensed, Private Psychiatric Hospitals and General Hospitals with Psychiatric Units *(continued)*

v. Services Provided under Arrangement

Separate payment may be made directly to individual practitioners or suppliers for services provided under arrangement using existing State plan methodologies and fees. The State assures there is no duplication of payment between the psychiatric hospitals' or general hospitals with psychiatric units' base rate and the items paid for separately. The State also assures that no duplication of payment will be made for transitioning services to both a community Case Manager provider and a Health Home provider for the same person.

(a) **Case Management Transitioning Services** – Transitional case management services are considered to be psychiatric hospital or general hospital with a psychiatric unit services, when services exceed and do not duplicate inpatient discharge planning during the last 30 days of a covered stay. Case management transitioning services to assist children transitioning from a psychiatric hospital or general hospital with a psychiatric unit to a community setting will not duplicate inpatient discharge planning services. Case management transitioning services will be billed by the psychiatric hospital or general hospital with a psychiatric unit as inpatient psychiatric services for individuals under age 21 services and claimed as inpatient psychiatric services for individuals under age 21 services. Payment for Case Management transition services provided under arrangement with the psychiatric hospital or general hospital with a psychiatric unit will be directly reimbursed to a qualified community-based Case Management provider. Payment is made to Outpatient Behavioral Health Agencies with qualified case managers in accordance with the methodology in Attachment 4.19-B, Page 22.

~~**(b) Health Home Transitioning Services** – Health Home services are considered to be inpatient psychiatric services for individuals under age 21, when services exceed and do not duplicate inpatient discharge planning during the last 30 days of a covered stay. Payment for Health Home transitioning services provided under arrangement with the psychiatric hospital or general hospital with a psychiatric unit will be directly reimbursed to the Health Home. Payment is made to certified Health Homes at the Tier 2 Resource Coordination level of care rate, in accordance with the methodology in OK HHA Page 22.~~

Transitional services are exempt from the payment methodology at 16.a.C.ii on Attachment 4.19-A, Page 33.

(b)~~(c)~~ Evaluation and psychological testing by a licensed Psychologist - Payment is made in accordance with the methodology in Attachment 4.19-B, Page 8.

(D) Payment for Out–of–State Services

Reimbursement for out-of-state placements for individuals under the age of 21 shall be made in the same manner as in-state providers. In the event that comparable services cannot be purchased from an out-of-state provider using Medicaid established rates, a rate may be negotiated that is acceptable to both parties. The rate will generally be the lesser of usual and customary charges or the Medicaid rate in the state in which services are provided. Reimbursement shall not be made for inpatient psychiatric services for individuals under age 21 provided out of state unless the services are medically necessary and are not available within the State and prior authorization has been granted.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of inpatient psychiatric services for individuals under 21. The agency's fee schedule rate was set as of May 1, 2016 and is effective for services provided on or after that date. All rates are published on the Agency's website www.okhca.org/feeschedules.

Revised ~~01-01-15~~ 09-30-21

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

16. Inpatient Psychiatric Services for individuals under age 21 (42 CFR 440.160) *(continued)*

16.b. Residential Level of Care in a PRTF *(continued)*

(D) PRTF Add-on Payments

(a) Intensive Treatment Services (ITS) Add-on Per Diem

An ITS per diem of **$110.99** will be allowed for children requiring intensive staffing supports in a PRTF setting when it is determined that there is medical necessity for non-acute care, the services are documented in the facilities' records, and are prior authorized.

(b) Prospective Complexity Add-on Per diem for Non-verbal Children

A per diem of **$77.51** will be allowed to recognize the increased cost of serving children with a mental health diagnosis complicated with non-verbal communication in a PRTF setting. These services must be medically necessary, documented in the facilities' record, and prior authorized.

(c) Specialty Add-on Per Diem

A per diem of **$210.00** will be allowed to recognize the increased cost of serving children with specialized needs in a PRTF setting. These services must be medically necessary, documented in the facility's record, and prior authorized.

(E) Outlier Intensity Adjustment

(A) An outlier payment adjustment may be made on a case by case basis for complex cases. The intent of the outlier payment is to promote access to inpatient psychiatric services for individuals under 21 for those patients who require services beyond the cost of services provided by ITS, Prospective Complexity, and Specialty add-on payments.

(B) The outlier adjustment may be a short stay outlier adjustment or a high cost outlier adjustment.

(C) In order to be eligible for the short stay outlier adjustment:

1. The facility must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The total length of stay must be less than 6 days.
3. The outlier adjustment will be the lessor of the following:
   a. 100% of the facility's cost; or
   b. 120% of the peer group per diem multiplied by the LOS.

(D) In order to be eligible for the high cost outlier adjustment:

1. The facility must submit an annual cost report in a format prescribed by the agency and request the outlier adjustment only upon the member's discharge; and
2. The outlier payment will be made if the facility's total cost of care exceeds 115% of the Medicaid payment.
3. The appropriate outlier amount will be determined by comparing the total cost and 115% of the Medicaid payment for the entire stay, and multiplying the difference by a loss sharing ratio of .20 to the facility and .80 to the state, if the stay is less than or equal to 90 days, and .40 to the facility and .60 to the state for a stay > 90 days.

(F) PRTF Services Provided under Arrangement

Separate payment may be made directly to individual practitioners or suppliers for services provided under arrangement using existing State plan methodologies and fees. The State assures there is no duplication of payment between the psychiatric hospitals' or general hospitals with psychiatric units' base rate and the items paid for separately. ~~The State also assures that no duplication of payment will be made for transitioning services to both a community Case Manager provider and a Health Home provider for the same person.~~

Revised ~~01-01-15~~ 09-30-21

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

16. Inpatient Psychiatric Services for individuals under age 21 (42 CFR 440.160) *(continued)*

16.b. Residential Level of Care in a PRTF *(continued)*

(F) PRTF Services Provided under Arrangement *(continued)*

(a) Case Management Transitioning Services – Transitional case management services are considered to be psychiatric hospital or general hospital with a psychiatric unit services, when services exceed and do not duplicate inpatient discharge planning during the last 30 days of a covered stay. Case management transitioning services to assist children transitioning from a psychiatric hospital or general hospital with a psychiatric unit to a community setting will not duplicate inpatient discharge planning services. Case management transitioning services will be billed by the psychiatric hospital or general hospital with a psychiatric unit as inpatient psychiatric services for individuals under age 21 services and claimed as inpatient psychiatric services for individuals under age 21 services. Payment for Case Management transition services provided under arrangement with the psychiatric hospital or general hospital with a psychiatric unit will be directly reimbursed to a qualified community-based Case Management provider. Payment is made to Outpatient Behavioral Health Agencies with qualified case managers in accordance with the methodology in Attachment 4.19-B, Page 22.

~~**(b) Health Home Transitioning Services** – Health Home services are considered to be inpatient psychiatric services for individuals under age 21, when services exceed and do not duplicate inpatient discharge planning during the last 30 days of a covered stay. Payment for Health Home transitioning services provided under arrangement with the psychiatric hospital or general hospital with a psychiatric unit will be directly reimbursed to the Health Home. Payment is made to certified Health Homes at the Tier 2 Resource Coordination level of care rate, in accordance with the methodology in OK HHA Page 22.~~

Transitional services are exempt from the payment methodology at 16.b.B.ii on Attachment 4.19-A, Page 35 and 16.b.C.ii on Attachment 4.19-A, Page 36.

(b)~~(c)~~ Evaluation and psychological testing by a licensed Psychologist - Payment is made in accordance with the methodology in Attachment 4.19-B, Page 8.

(G) PRTF Payment for Out–of–State Services

Reimbursement for out-of-state placements for individuals under the age of 21 shall be made in the same manner as instate providers. In the event that comparable services cannot be purchased from an out-of-state provider using Medicaid established rates, a rate may be negotiated that is acceptable to both parties. The rate will generally be the lesser of usual and customary charges or the Medicaid rate in the state in which services are provided. Reimbursement shall not be made for private PRTF services provided in out of state unless the services are medically necessary and are not available within the State and prior authorization has been granted.

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED CATEGORICALLY NEEDY

13.d Rehabilitative Services *(continued)*

13.d.2 Reimbursement for PACT Services

Reimbursement for PACT service components listed in Att. 3.1A page 6a-1.5 through 6a-1.6a provided by multi-disciplinary team members will be made under a fee schedule.

(a) Service Contacts - The fee schedule rate for eligible service contacts by qualified team members is all-inclusive of the service components and will be reimbursed per 15-minute unit, using a Procedure code for PACT. The unit costs were derived from the 2006 average salaries and wages for physicians as reported in the Bureau of Labor Statistics website for occupations for Oklahoma, and actual provider reported costs for the other staffing composition required for a caseload of 100. The rate also accounts for employee benefits, indirect costs, clinical oversight and supervision. Total costs were divided by the annual available productive time. In order to account for the fact that Medicaid enrollment for adults enrolled in PACT may not be continuous, the average caseload of 100 for a team of 10 assumed in the methodology was adjusted by a standardized enrollment continuity ratio for Oklahoma (75.6%) to account for lapses in coverage. The source document for the continuity ratio is from Table 1, "Improving Medicaid's Continuity and Quality of Care", by L. Ku. Targeted Case Management (TCM) service contacts are separately billable.

~~**(b) Health Home services**. PACT service components share much in common with Health Home requirements. In order to avoid duplication, a portion of the rate for equivalent service contacts was allocated to Health Home services. This portion was based on PACT team place of treatment, using the 2003 *National Program Standards for Assertive Community Treatment Teams*, which has a goal of 75% of services to be provided *in vivo*, (non office-based, non-facility) or in the community. Therefore the PACT rate described in (a) above will be reduced by 25% for any consumer that does not opt-out of Health Homes.~~

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of PACT services. The agency's fee schedule rate was set as of January 1, 2015 and is effective for services provided on or after that date. All rates are published on the Agency's website www.okhca.org.