Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

AGENDA

July 20th, 2017
1:00 PM – 3:30 PM

Charles Ed McFall Board Room

I. Welcome, Roll Call, and Public Comment Instructions: **Co-Chairman, Steve Goforth**

II. Action Item: Approval of Minutes of the May 18th, 2017: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Gloria Hudson, Director of General Accounting**

A. 2018 Budget Work Program: **Tasha Black, Director of Budget and Fiscal Planning**

VI. Legislative Update: Austin Marshall, Government Relations Director

VII. SoonerCare Operations Update: **Melinda Thomason, Director of Health Care Systems Innovation**

A. Fast Facts Update: **Andy Garnand, Reporting Manager**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Demetria Bennett, Policy Development Coordinator**

A. 17-05 A&B Medical Identification Card Policy Revisions
B. 17-06 Pharmacy Revisions
C. 17-09 Behavioral Health Case Management Limits

IX. Action Item: Vote on Proposed Rule Changes: **Co-Chairman, Steve Goforth**

X. Discussion Item Only

XI. New Business: **Co-Chairman, Steve Goforth**

XII. Future Meeting:
September 21st, 2017

XIII. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the May 18th, 2017 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

I. Welcome, Roll Call, and Public Comment Instructions:

Chairman Steven Crawford called the meeting to order at 1:00 PM.

***Delegates present were*:** Ms. Renee Banks, Ms. Debra Billingsley, Dr. Joe Catalano, Dr. Steve Crawford, Mr. Brett Coble, Dr. Arlen Foulks, Ms. Terri Fritz, Mr. Steve Goforth, Mr. Mark Jones, Dr. Ashley Orynich, Ms. Annette Mays, Mr. Victor Clay, Mr. James Patterson, Dr. J. Daniel Post, Ms. Toni Pratt-Reid, Dr. Jason Rhynes, Mr. Rick Snyder, Dr. John Linck.

Alternates present were: Ms. Sarah Baker, Mr. Traylor Rains-Sims, Dr. Mike Talley and providing a quorum.

***Delegates absent without an alternate were*:** Ms. Mary Brinkley, Dr. David Cavallaro, Ms. Wanda Felty, Dr. Edd Rhoades, and Dr. Kanwal Obhrai.

II. Approval of March 9th, 2017 Minutes

Medical Advisory Committee

Chairman Crawford did a call to vote to approve the meeting minutes for March 9th, 2017.
It was motioned by Dr. Mike Talley and Dr. Joe Catalano seconded the motion. All members voted to approve the minutes.

III. Public Comments (2 minute limit)

Ms. Chris Pollak read a letter from the Ponca City clinic asking OHCA to keep rural areas in mind when considering provider cuts.

IV. MAC Member Comments

Ms. Sara Baker with Oklahoma Speech –Language- Hearing Association presented the MAC members with handouts on voice tips, early intervention, how to talk with someone on the autism spectrum, and hearing loss. Ms. Baker also handed out a chart on "how to calm myself down".
Dr. Crawford identified that some MAC members had a concern about a communication from a prosthetic's firm, and after he spoke with legal on the matter, he announced they would look into the matter. As the agency and MAC members have no oversight, since the issue is at the Attorney General's office.

V. Financial Update:

Gloria Hudson, Director of General Accounting

Ms. Carrie Evans reported on the state's Fiscal Year 2017 financial transactions through the month of January. She reported that the state budget variance is a positive $5.1 million dollars. On the expenditure side, Medicaid Program is positive $4.73 million state dollars and in administration $1.6

million state dollars. On the revenue side, OHCA is positive $0.1 million state dollars in Drug Rebates and Collections. Settlements and Overpayments are positive $.03 million state dollars and in Tobacco Tax Collections is positive $1.3 million state dollars.

A. **2018 Budget update:**

Ms. Evans and Ms. Tywanda Cox presented on SFY 2018 appropriation scenarios including information on cuts to program in last 6 SFYs, Regional physician provider rates, SFY 2018 appropriation scenarios, Access monitoring review plan timeline and service categories, and access to care analysis. For more detailed information please see item 5A in the full agenda packet.

VI. SoonerCare Operations Update:

Kevin Rupe, Member Services Director

Mr. Rupe presented the SoonerCare Operations Update to the committee. He presented information based on data for March of 2017. Patient Centered Medical Home enrollment is at 555,806 which are 2,747 less than December. Sooner Care Traditional has a current enrollment of 232,685 which is 2 less than December. SoonerPlan is down by 438, giving a total of 34,264. Insure Oklahoma has a total enrollment of 19,372 of which 4,909 are in the Individual Plan and 14,463 are in the Employee Sponsored Plan which is a decrease of 1,312 from December. In total, SoonerCare enrollment is at 842,127 for March which is a decrease of 4,499. Total In-State providers are up by 246, giving a total of 34,416.

a. Provider Program Integrity Update:

Josh Richards, Provider Audits Director

Mr. Richards provided a provider program integrity, which included how audits are initiated, referrals, peer to peer comparison, and data- mining. For more detailed information, see item 6A in the Final MAC agenda.

VII. Legislative Update:

Austin Marshall, Director of Governmental Affairs

Mr. Marshall stated that the legislative session was at a critical junction with revenue needing to be completed by Sunday, May 21st, 2017.OHCA still needs about $69 million on top of what was appropriated last year. He stated things at the capitol are changing hour by hour. When asked by Dr. Crawford if House Bill 2382 would affect Insure Oklahoma, Mr. Marshall stated that it would cut in half the existing appropriations of cigarette tax, which funds Insure Oklahoma; he added that about 19,000 members would lose coverage.

VIII. Proposed Rule Changes:

Demetria Bennett, Policy Development Coordinator

A face to face tribal consultation regarding the following proposed changes was held Tuesday, March 7, 2017 in the Board Room of the Oklahoma Health Care Authority (OHCA).

Rule changes within work folders 17-01 and 17-02 were posted on the OHCA public website for a 30-day comment period from March 7, 2017 through April 6, 2017. Rule changes within work folders 17-04 A&B were posted on the OHCA public website for a 30-day comment period from April 17, 2017 through May 18, 2017.

17-01 Policy Revision to Comply with Fairness in Medicaid Supplemental Needs Trusts Act — the proposed revisions are necessary in order to comply with federal regulation. The Fairness in Medicaid Supplemental Needs Trusts adds language into the Social Security Act to give mentally competent disabled individuals the same right to create an exempt trust as a parent, grandparent, guardian, or court. The Fairness Act will apply to trusts established on or after December 13, 2016. Other requirements of these types of trusts, which are exempt from Medicaid resource limits, remain unchanged.
Budget Impact: Budget neutral
Rule change was motioned to approve by Dr. Joe Catalano and seconded by Mr. Steve Goforth

17-02 Self-Employment Language in Insure Oklahoma — the proposed revisions to the Insure Oklahoma Individual Plan policy strengthen program integrity. Revisions make it incumbent upon the self-employed applicant to verify self-employment by completing and submitting certain documentation. Revisions will help ensure that self-employed applicants are engaged in routine, for-profit activity, in accordance with federal Internal Revenue Service guidelines**.**
Budget Impact: Budget neutral
Rule change was motioned to approve by Dr. Arlen Foulks and seconded by Ms. Toni Pratt-Reid

17-04 A&B Money Follows the Person Demonstration for Psychiatric Residential Treatment Facility Wraparound Services — the proposed revisions to the Living Choice rules add a fourth population to be served in the Money Follows the Person (MFP) demonstration. The intent of the change is to develop an implementation plan to transition eligible individuals from Psychiatric Residential Treatment Facilities (PRTF) back into the community. Oklahoma's MFP Demonstration for PRTF transitioning will focus on transitioning youth 16 to 18 who have been in an inpatient psychiatric residential facility for 90 or more days during an episode of care. The individuals must meet criteria for Level 4 on the Individual Client Assessment Record and show critical impairment on a score of 25 and above on the Problems Subscale, or a score of 44 and below on the Functioning Subscales. Additionally, the individuals will be eligible for transitional and community-based services and medications under Oklahoma's Living Choice Program. Services will be provided in accordance

with an individualized plan of care under the direction of appropriate service providers. Finally, revisions replace the term Intermediate Care Facility for Mentally Retarded with Intermediate Care Facility for Individuals with Intellectual Disabilities.

Budget Impact: The budget impact is approximately $695,739 total federal dollars, $174,261 state dollars. State share will be paid by the ODMHSAS.

Rule change was motioned to approve by Ms. Tony Pratt-Reid and seconded by Ms. Terri Fritz

IX. 1115 Renewal Update:

Tywanda Cox, Chief of Federal and State Policy

Ms. Cox provides an update regarding the 1115 waiver. OHCA is requesting an additional year extension of the waiver for the period of January 1, 2018 to December 31st, 2018. The comment period will remain open until June 24th, 2017. For more detailed information see item 10 in the full agenda packet.

X. New Business:

There was no new business to discuss

XI. Future Meeting

July 20, 2017

XII. Adjournment

Dr. Crawford asked for a motion to adjourn. Motion was provided by Ms. Toni Pratt- Reid and seconded by Mr. Victor Clay. There was no dissent and the meeting was adjourned.

FINANCIAL REPORT

For the Ten Months Ended April 30, 2017
Submitted to the CEO & Board

- Revenues for OHCA through April, accounting for receivables, were **$3,447,138,223** or **.5% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,402,578,152 or .8% under** budget.
- The state dollar budget variance through April is a **positive $10,578,326.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		6.0
Administration		4.0
Revenues:		
Drug Rebate		1.8
Taxes and Fees		(1.1)
Overpayments/Settlements		(.1)
Total FY 17 Variance	**$**	**10.6**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2017, For the Ten Month Period Ending April 30, 2017

REVENUES	FY17 Budget YTD	FY17 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 884,419,129	$ 884,419,129	$ -	0.0%
Federal Funds	1,947,674,294	1,928,187,597	(19,486,697)	(1.0)%
Tobacco Tax Collections	40,901,633	40,292,682	(608,951)	(1.5)%
Quality of Care Collections	64,959,849	64,461,968	(497,881)	(0.8)%
Prior Year Carryover	27,584,042	27,584,042	-	0.0%
Federal Deferral - Interest	124,505	124,505	-	0.0%
Drug Rebates	228,144,086	232,685,629	4,541,543	2.0%
Medical Refunds	32,543,821	32,287,877	(255,944)	(0.8)%
Supplemental Hospital Offset Payment Program	220,178,424	220,178,424	-	0.0%
Other Revenues	16,926,508	16,916,370	(10,138)	(0.1)%
TOTAL REVENUES	**$ 3,463,456,290**	**$ 3,447,138,223**	**$ (16,318,068)**	**(0.5)%**

EXPENDITURES	FY17 Budget YTD	FY17 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 47,644,702**	**$ 42,000,235**	**$ 5,644,467**	**11.8%**
ADMINISTRATION - CONTRACTS	**$ 78,651,826**	**$ 72,268,340**	**$ 6,383,486**	**8.1%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	34,622,428	34,539,952	82,476	0.2%
Acute Fee for Service Payments:				
Hospital Services	759,425,509	752,181,328	7,244,181	1.0%
Behavioral Health	16,495,844	16,753,095	(257,252)	(1.6)%
Physicians	349,021,832	343,978,383	5,043,449	1.4%
Dentists	106,411,269	105,417,328	993,941	0.9%
Other Practitioners	44,831,763	45,526,964	(695,201)	(1.6)%
Home Health Care	15,109,223	14,188,326	920,897	6.1%
Lab & Radiology	29,004,142	26,551,121	2,453,021	8.5%
Medical Supplies	39,248,322	40,030,389	(782,066)	(2.0)%
Ambulatory/Clinics	153,566,681	156,608,375	(3,041,694)	(2.0)%
Prescription Drugs	460,314,330	462,169,361	(1,855,031)	(0.4)%
OHCA Therapeutic Foster Care	19,272	(81,907)	101,179	0.0%
Other Payments:				
Nursing Facilities	464,016,926	459,813,474	4,203,452	0.9%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	51,415,277	50,642,037	773,240	1.5%
Medicare Buy-In	139,720,311	139,668,732	51,579	0.0%
Transportation	54,183,525	54,666,095	(482,569)	(0.9)%
Money Follows the Person-OHCA	292,209	180,684	111,525	0.0%
Electonic Health Records-Incentive Payments	15,258,342	15,258,342	-	0.0%
Part D Phase-In Contribution	81,413,775	81,499,843	(86,068)	(0.1)%
Supplemental Hospital Offset Payment Program	478,779,674	478,779,674	-	0.0%
Telligen	9,937,980	9,937,980	-	0.0%
Total OHCA Medical Programs	**3,303,088,636**	**3,288,309,577**	**14,779,059**	**0.4%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 3,429,474,546**	**$ 3,402,578,152**	**$ 26,896,393**	**0.8%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 33,981,745**	**$ 44,560,071**	**$ 10,578,326**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2017, For the Ten Month Period Ending April 30, 2017

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 34,642,609	$ 34,530,232	$ -	$ 102,657	$ -	$ 9,720	$ -
Inpatient Acute Care	984,139,125	497,453,922	405,572	3,150,852	343,210,127	1,160,327	138,758,324
Outpatient Acute Care	360,873,403	249,868,089	34,670	3,698,625	104,013,272	3,258,748	
Behavioral Health - Inpatient	51,406,477	9,489,148	-	234,767	30,408,458	-	11,274,105
Behavioral Health - Psychiatrist	8,411,765	7,263,948	-	-	1,147,817	-	-
Behavioral Health - Outpatient	14,006,636	-	-	-	-	-	14,006,636
Behaviorial Health-Health Home	31,894,032	-	-	-	-	-	31,894,032
Behavioral Health Facility- Rehab	199,887,916	-	-	-	-	47,682	199,887,916
Behavioral Health - Case Management	15,196,739	-	-	-	-	-	15,196,739
Behavioral Health - PRTF	56,457,196	-	-	-	-	-	56,457,196
Residential Behavioral Management	14,678,639	-	-	-	-	-	14,678,639
Targeted Case Management	59,045,216	-	-	-	-	-	59,045,216
Therapeutic Foster Care	(81,907)	(81,907)	-	-	-	-	-
Physicians	395,845,521	340,068,194	48,417	(272,730)	-	3,861,771	52,139,868
Dentists	105,440,843	105,407,308	-	23,515	-	10,020	-
Mid Level Practitioners	2,314,419	2,292,791	-	20,125	-	1,502	-
Other Practitioners	43,583,943	42,781,675	371,970	351,273	-	79,026	-
Home Health Care	14,199,536	14,180,442	-	11,210	-	7,884	-
Lab & Radiology	27,178,553	26,360,513	-	627,432	-	190,608	-
Medical Supplies	40,262,400	37,746,378	2,259,610	232,012	-	24,401	-
Clinic Services	154,944,814	150,463,338	-	831,039	-	128,041	3,522,397
Ambulatory Surgery Centers	6,117,276	6,006,876	-	100,280	-	10,120	-
Personal Care Services	9,944,302	-	-	-	-	-	9,944,302
Nursing Facilities	459,813,474	281,913,914	177,899,560	-	-	-	-
Transportation	54,560,762	52,424,380	2,061,062	34,853	-	40,468	-
GME/IME/DME	140,667,565	-	-	-	-	-	140,667,565
ICF/IID Private	50,642,037	41,388,117	9,253,921	-	-	-	-
ICF/IID Public	11,339,964	-	-	-	-	-	11,339,964
CMS Payments	221,168,575	220,509,615	658,960	-	-	-	-
Prescription Drugs	473,235,407	460,280,227	-	11,066,046	-	1,889,135	-
Miscellaneous Medical Payments	140,185	140,185	-	-	-	-	-
Home and Community Based Waiver	167,597,538	-	-	-	-	-	167,597,538
Homeward Bound Waiver	68,132,070	-	-	-	-	-	68,132,070
Money Follows the Person	222,785	180,684	-	-	-	-	42,101
In-Home Support Waiver	20,860,713	-	-	-	-	-	20,860,713
ADvantage Waiver	154,521,714	-	-	-	-	-	154,521,714
Family Planning/Family Planning Waiver	3,771,866	-	-	-	-	-	3,771,866
Premium Assistance*	50,139,363	-	-	50,139,363	-	-	-
Telligen	9,937,980	9,937,980	-	-	-	-	-
Electronic Health Records Incentive Payments	15,258,342	15,258,342	-	-	-	-	-
Total Medicaid Expenditures	**$ 4,532,399,796**	**$ 2,605,864,390**	**$ 192,993,742**	**$ 70,351,317**	**$ 478,779,674**	**$ 10,719,453**	**$1,173,738,901**

* Includes $49,789,913.87 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2017, For the Ten Month Period Ending April 30, 2017

REVENUE		FY17 Actual YTD
Revenues from Other State Agencies	$	496,334,445
Federal Funds		725,736,904
TOTAL REVENUES	**$**	**1,222,071,348**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	167,597,538
Money Follows the Person		42,101
Homeward Bound Waiver		68,132,070
In-Home Support Waivers		20,860,713
ADvantage Waiver		154,521,714
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		11,339,964
Personal Care		9,944,302
Residential Behavioral Management		10,749,004
Targeted Case Management		51,559,202
Total Department of Human Services		**494,746,609**
State Employees Physician Payment		
Physician Payments		52,139,868
Total State Employees Physician Payment		**52,139,868**
Education Payments		
Graduate Medical Education		100,650,804
Graduate Medical Education - Physicians Manpower Training Commission		5,077,410
Indirect Medical Education		33,086,772
Direct Medical Education		1,852,579
Total Education Payments		**140,667,565**
Office of Juvenile Affairs		
Targeted Case Management		2,106,261
Residential Behavioral Management		3,929,635
Total Office of Juvenile Affairs		**6,035,895**
Department of Mental Health		
Case Management		15,196,739
Inpatient Psychiatric Free-standing		11,274,105
Outpatient		14,006,636
Health Homes		31,894,032
Psychiatric Residential Treatment Facility		56,457,196
Rehabilitation Centers		199,887,916
Total Department of Mental Health		**328,716,624**
State Department of Health		
Children's First		1,351,900
Sooner Start		642,582
Early Intervention		3,560,519
Early and Periodic Screening, Diagnosis, and Treatment Clinic		692,512
Family Planning		153,834
Family Planning Waiver		3,603,773
Maternity Clinic		7,412
Total Department of Health		**10,012,533**
County Health Departments		
EPSDT Clinic		581,950
Family Planning Waiver		14,259
Total County Health Departments		**596,208**
State Department of Education		**109,981**
Public Schools		**357,353**
Medicare DRG Limit		**130,345,215**
Native American Tribal Agreements		**1,597,940**
Department of Corrections		**974,762**
JD McCarty		**7,438,348**
Total OSA Medicaid Programs	**$**	**1,173,738,901**
OSA Non-Medicaid Programs	**$**	**57,549,952**
Accounts Receivable from OSA	**$**	**9,217,505**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2017, For the Ten Month Period Ending April 30, 2017

REVENUES	FY 17 Revenue
SHOPP Assessment Fee	$ 219,921,664
Federal Draws	288,139,562
Interest	178,641
Penalties	78,119
State Appropriations	(30,200,000)
TOTAL REVENUES	$ 478,117,986

EXPENDITURES	Quarter	Quarter	Quarter	Quarter	FY 17 Expenditures
Program Costs:	7/1/16 - 9/30/16	10/1/16 - 12/31/16	1/1/17 - 3/31/17	4/1/17 - 6/30/17	
Hospital - Inpatient Care	76,250,540	79,946,392	93,024,133	95,602,569	$ 344,823,635
Hospital -Outpatient Care	27,213,505	28,255,818	24,271,974	24,836,782	104,578,079
Psychiatric Facilities-Inpatient	6,661,677	6,824,842	7,150,512	7,574,695	28,211,725
Rehabilitation Facilities-Inpatient	257,683	269,198	310,468	328,886	1,166,235
Total OHCA Program Costs	110,383,405	115,296,250	124,757,088	128,342,931	$ 478,779,674
Total Expenditures					$ 478,779,674

CASH BALANCE	
	$ (661,688)

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund

SFY 2017, For the Ten Month Period Ending April 30, 2017

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 64,433,050	$ 64,433,050
Interest Earned	28,919	28,919
TOTAL REVENUES	**$ 64,461,968**	**$ 64,461,968**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 174,861,424	$ 69,507,416	
Eyeglasses and Dentures	227,316	90,358	
Personal Allowance Increase	2,810,820	1,117,301	
Coverage for Durable Medical Equipment and Supplies	2,259,610	898,195	
Coverage of Qualified Medicare Beneficiary	860,630	342,100	
Part D Phase-In	658,960	261,936	
ICF/IID Rate Adjustment	4,327,265	1,720,088	
Acute Services ICF/IID	4,926,656	1,958,346	
Non-emergency Transportation - Soonerride	2,061,062	819,272	
Total Program Costs	**$ 192,993,742**	**$ 76,715,012**	**$ 76,715,012**
Administration			
OHCA Administration Costs	$ 452,649	$ 226,325	
DHS-Ombudsmen	149,654	149,654	
OSDH-Nursing Facility Inspectors	404,441	404,441	
Mike Fine, CPA	12,000	6,000	
Total Administration Costs	**$ 1,018,744**	**$ 786,420**	**$ 786,420**
Total Quality of Care Fee Costs	**$ 194,012,486**	**$ 77,501,432**	
TOTAL STATE SHARE OF COSTS			**$ 77,501,432**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

SFY 2017, For the Ten Month Period Ending April 30, 2017

REVENUES	FY 16 Carryover	FY 17 Revenue	Total Revenue
Prior Year Balance	$ 5,199,281	$ -	$ 3,102,480
State Appropriations	(2,000,000)	-	-
Tobacco Tax Collections	-	33,140,261	33,140,261
Interest Income	-	101,394	101,394
Federal Draws	246,145	31,307,976	31,307,976
TOTAL REVENUES	**$ 3,445,426**	**$ 64,549,631**	**$ 67,652,111**

EXPENDITURES		FY 16 Expenditures	FY 17 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 49,789,914	$ 49,789,914
	College Students/ESI Dental		349,449	138,906
Individual Plan				
	SoonerCare Choice		$ 98,847	$ 39,292
	Inpatient Hospital		3,132,492	1,245,166
	Outpatient Hospital		3,650,457	1,451,057
	BH - Inpatient Services-DRG		223,933	89,013
	BH -Psychiatrist		-	-
	Physicians		(247,384)	(98,335)
	Dentists		23,337	9,276
	Mid Level Practitioner		20,047	7,969
	Other Practitioners		345,870	137,483
	Home Health		9,369	3,724
	Lab and Radiology		612,536	243,483
	Medical Supplies		222,243	88,341
	Clinic Services		812,232	322,862
	Ambulatory Surgery Center		94,193	37,442
	Prescription Drugs		10,899,650	4,332,611
	Transportation		34,523	13,723
	Premiums Collected		-	(470,044)
Total Individual Plan			**$ 19,932,344**	**$ 7,453,063**
	College Students-Service Costs		**$ 279,610**	**$ 111,145**
Total OHCA Program Costs			**$ 70,351,317**	**$ 57,493,028**
Administrative Costs				
	Salaries	$ 32,930	$ 1,723,681	$ 1,756,611
	Operating Costs	15,971	182,135	198,106
	Health Dept-Postponing	-	-	-
	Contract - HP	294,045	1,789,581	2,083,626
Total Administrative Costs		**$ 342,946**	**$ 3,695,397**	**$ 4,038,343**
Total Expenditures				**$ 61,531,371**
NET CASH BALANCE		**$ 3,102,480**		**$ 6,120,740**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund

SFY 2017, For the Ten Month Period Ending April 30, 2017

REVENUES	FY 17 Revenue	State Share
Tobacco Tax Collections	$ 661,235	$ 661,235
TOTAL REVENUES	**$ 661,235**	**$ 661,235**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 9,720	$ 469	
Inpatient Hospital	1,160,327	55,928	
Outpatient Hospital	3,258,748	157,072	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	3,861,771	186,137	
Dentists	10,020	483	
Mid-level Practitioner	1,502	72	
Other Practitioners	79,026	3,809	
Home Health	7,884	380	
Lab & Radiology	190,608	9,187	
Medical Supplies	24,401	1,176	
Clinic Services	128,041	6,172	
Ambulatory Surgery Center	10,120	488	
Prescription Drugs	1,889,135	91,056	
Transportation	37,714	1,818	
Miscellaneous Medical	2,753	133	
Total OHCA Program Costs	**$ 10,671,771**	**$ 514,379**	
OSA DMHSAS Rehab	$ 47,682	$ 2,298	
Total Medicaid Program Costs	**$ 10,719,453**	**$ 516,678**	
TOTAL STATE SHARE OF COSTS			**$ 516,678**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

OKLAHOMA HEALTH CARE AUTHORITY

SFY-2018 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	SFY-2017	SFY-2018	Inc / (Dec)	% Change
Medical Program				
Managed Care - Choice / HAN / PACE	41,144,343	45,574,844	4,430,501	10.8%
Hospitals	921,501,958	861,050,566	(60,451,392)	-6.6%
Behavioral Health	19,944,652	18,895,988	(1,048,664)	-5.3%
Nursing Homes	560,565,843	516,456,945	(44,108,898)	-7.9%
Physicians	427,103,707	391,331,396	(35,772,311)	-8.4%
Dentists	128,588,912	118,837,744	(9,751,167)	-7.6%
Mid-Level Practitioner	2,648,893	2,611,527	(37,366)	-1.4%
Other Practitioners	51,086,437	49,166,897	(1,919,540)	-3.8%
Home Health	18,472,976	15,827,383	(2,645,593)	-14.3%
Lab & Radiology	35,866,801	29,886,163	(5,980,638)	-16.7%
Medical Supplies	47,146,589	46,584,312	(562,277)	-1.2%
Clinic Services	177,885,602	182,714,691	4,829,089	2.7%
Ambulatory Surgery Center	7,285,659	6,730,723	(554,936)	-7.6%
Prescription Drugs	559,917,410	563,025,770	3,108,359	0.6%
Miscellaneous	191,590	150,403	(41,187)	-21.5%
ICF/IID	62,034,311	58,171,526	(3,862,785)	-6.2%
Transportation	65,156,691	62,913,080	(2,243,612)	-3.4%
Medicare Buy-in (Part A & B)	168,686,738	177,764,062	9,077,324	5.4%
Medicare clawback payment (Part D)	99,112,467	110,847,119	11,734,651	11.8%
SHOPP - Supplemental Hosp Offset Pymt.	482,774,622	516,242,406	33,467,784	6.9%
Nursing Home UPL Payments	-	104,283,834	104,283,834	0.0%
Money Follows the Person - Enhanced	353,369	236,807	(116,562)	-33.0%
Health Management Program (HMP)	10,277,520	10,579,560	302,040	2.9%
Electronic Health Records Incentive Pymts	39,788,361	39,788,361	-	0.0%
Non-Title XIX Medical	89,382	89,382	-	0.0%
TOTAL OHCA MEDICAL PROGRAM	3,927,624,835	3,929,761,490	2,136,655	0.1%
Insure Oklahoma - Premium Assistance				
Employer Sponsored Insurance - ESI	55,812,912	62,022,233	6,209,321	11.1%
Individual Plan - IP	29,804,409	27,630,850	(2,173,559)	-7.3%
TOTAL INSURE OKLAHOMA PROGRAM	85,617,321	89,653,083	4,035,762	4.7%
OHCA Administration				
Operations	52,550,020	53,285,176	735,156	1.4%
Contracts	39,827,303	30,870,425	(8,956,878)	-22.5%
Insure Oklahoma Admin	4,031,359	4,072,082	40,723	1.0%
Information Services	64,907,175	73,679,434	8,772,259	13.5%
Grant Mgmt	6,096,142	5,852,082	(244,060)	-4.0%
TOTAL OHCA ADMIN	167,411,999	167,759,199	347,200	0.2%
TOTAL OHCA PROGRAMS	**4,180,654,156**	**4,187,173,773**	**6,519,617**	**0.2%**
Other State Agency (OSA) Programs				
Department of Human Services (OKDHS)	609,163,813	603,243,836	(5,919,978)	-1.0%
Oklahoma State Dept of Health (OSDH)	16,972,849	13,623,998	(3,348,851)	-19.7%
The Office of Juvenile Affairs (OJA)	8,346,893	7,032,296	(1,314,597)	-15.7%
University Hospitals (Medical Education Pymnts)	345,665,493	344,700,756	(964,737)	-0.3%
Physician Manpower Training Commission	6,319,093	6,864,093	545,000	8.6%
Department of Mental Health (DMHSAS)	416,367,703	404,905,141	(11,462,562)	-2.8%
Department of Education (DOE)	3,184,069	1,436,234	(1,747,835)	-54.9%
Non-Indian Payments	1,841,891	2,132,165	290,273	15.8%
Department of Corrections (DOC)	1,631,713	1,348,819	(282,893)	-17.3%
JD McCarty	7,922,686	8,208,720	286,033	0.0%
OSA Non-Title XIX	83,650,000	83,650,000	-	0.0%
TOTAL OSA PROGRAMS	**1,501,066,205**	**1,477,146,058**	**(23,920,147)**	**-1.6%**
TOTAL MEDICAID PROGRAM	**5,681,720,360**	**5,664,319,830**	**(17,400,530)**	**-0.3%**

OKLAHOMA HEALTH CARE AUTHORITY

SFY-2018 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	SFY-2017	SFY-2018	Inc / (Dec)	% Change
REVENUES				
Federal - program	3,167,775,551	3,032,831,094	(134,944,458)	-4.3%
Federal - admin	105,694,316	109,017,990	3,323,674	3.1%
Drug Rebates	289,921,060	316,812,473	26,891,412	9.3%
Medical Refunds	40,502,796	37,811,635	(2,691,161)	-6.6%
NF Quality of Care Fee	78,739,526	78,841,226	101,699	0.1%
OSA Refunds & Reimbursements	649,596,138	665,110,623	15,514,485	2.4%
Tobacco Tax	84,997,069	86,777,306	1,780,238	2.1%
Insurance Premiums	1,568,432	1,910,000	341,568	21.8%
Misc Revenue	265,888	255,904	(9,984)	-3.8%
Prior Year Carryover	26,397,254	20,000,260	(6,396,995)	-24.2%
Other Grants	3,898,137	3,405,353	(492,784)	-12.6%
Nursing Home UPL Fund	-	43,763,800	43,763,800	0.0%
Hospital Provider Fee (SHOPP bill)	222,440,488	242,266,132	19,825,644	8.9%
OHCA Revolving Fund 200 - Transfer	-	6,000,000	6,000,000	
Insure Oklahoma Fund 245 - Transfer	2,000,000	3,000,000	1,000,000	50.0%
State Appropriated	1,007,923,704	1,016,516,034	8,592,330	0.9%
TOTAL REVENUES	**5,681,720,360**	**5,664,319,830**	**(17,400,530)**	**-0.3%**

Oklahoma HealthCare Authority

June 2017 Legislative and Budget Update

Government Relations Division

FY 2018 Appropriations

General Revenue	$	854,718,820.00
Special Cash	$	50,000,000.00
Tobacco Settlement	$	11,797,214.00
Cigarette fee*	$	70,000,000.00
HEIIA Fund	$	3,000,000.00
Revolving Fund	$	4,000,000.00
Rainy Day Fund	$	32,000,000.00
Total Appropriations	$	1,025,516,034.00

SB 845: Health Care Enhancement Fund

This measure levies a new $1.50/pack cigarette fee and appropriates the funding to three agencies for FY 2018:

Agency	Appropriation
OHCA	$70,000,000
ODMHSAS	$75,000,000
OKDHS	$69,000,000

SB 845: Health Care Enhancement Fund, *cont.*

Tobacco companies and vendors challenged the measure in the Oklahoma Supreme Court on June 7. The plaintiffs argue the bill violates several provisions of the Oklahoma Constitution.

The court will hear oral arguments on August 8.

FY 2018 Shortfall

The agency was appropriated $34M less than requested to maintain existing services in FY 2018. OHCA is evaluating all options to minimize the impact to providers and members.

Federal Landscape

- The Senate continues to deliberate the Better Care Reconciliation Act. The act would repeal many provisions of the Affordable Care Act and may impact the Medicaid Program. The measure has been laid over until after the summer recess.

- The Children's Health Insurance Program (CHIP) has not been reauthorized by Congress for the upcoming fiscal year, although legislative committees are holding preliminary discussions beginning later this month.

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MAC Meeting July 20th, 2017 (May 2017 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

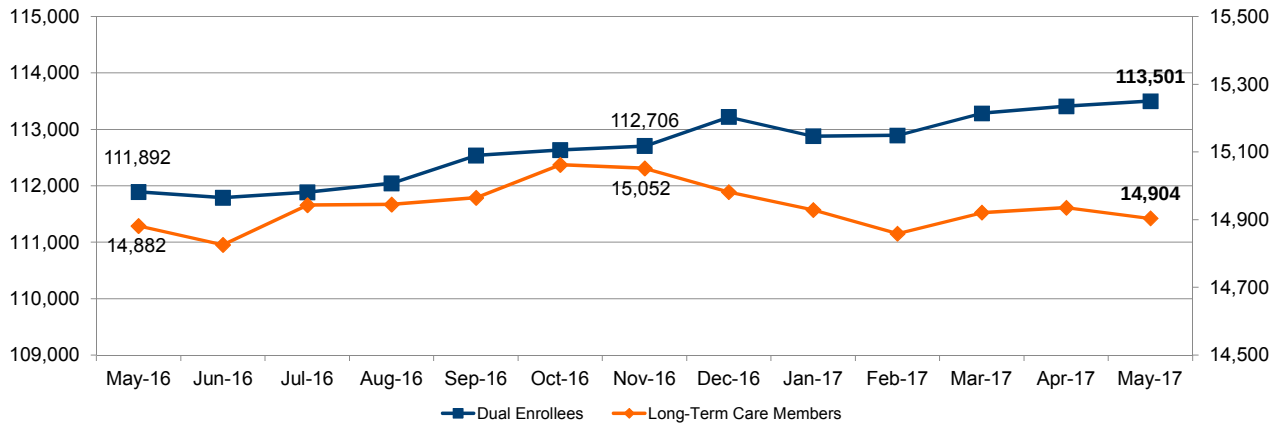
Delivery System			Enrollment May 2017	Children May 2017	Adults May 2017	Enrollment Change	Total Expenditures May 2017	PMPM May 2017	Forecasted May 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**551,829**	**455,112**	**96,717**	**1,345**	**$180,026,502**		
	Lower Cost	*(Children/Parents; Other)*	507,847	441,128	66,719	1,029	$130,528,981	$257	$212
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,982	13,984	29,998	316	$49,497,520	$1,125	$944
SoonerCare Traditional			**236,214**	**89,216**	**146,998**	**-1,994**	**$202,531,314**		
	Lower Cost	*(Children/Parents; Other)*	122,575	84,296	38,279	-1,929	$46,331,650	$378	$468
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	113,639	4,920	108,719	-65	$156,199,664	$1,375	$1,288
SoonerPlan			**34,520**	**2,835**	**31,685**	**251**	**$383,296**	$11	$9
Insure Oklahoma			**19,612**	**541**	**19,071**	**54**	**$7,098,045**		
	Employer-Sponsored Insurance		14,698	377	14,321	106	$4,784,641	$326	$301
	Individual Plan		4,914	164	4,750	-52	$2,313,405	$471	$434
TOTAL			**842,175**	**547,704**	**294,471**	**-344**	**$390,039,157**		

Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

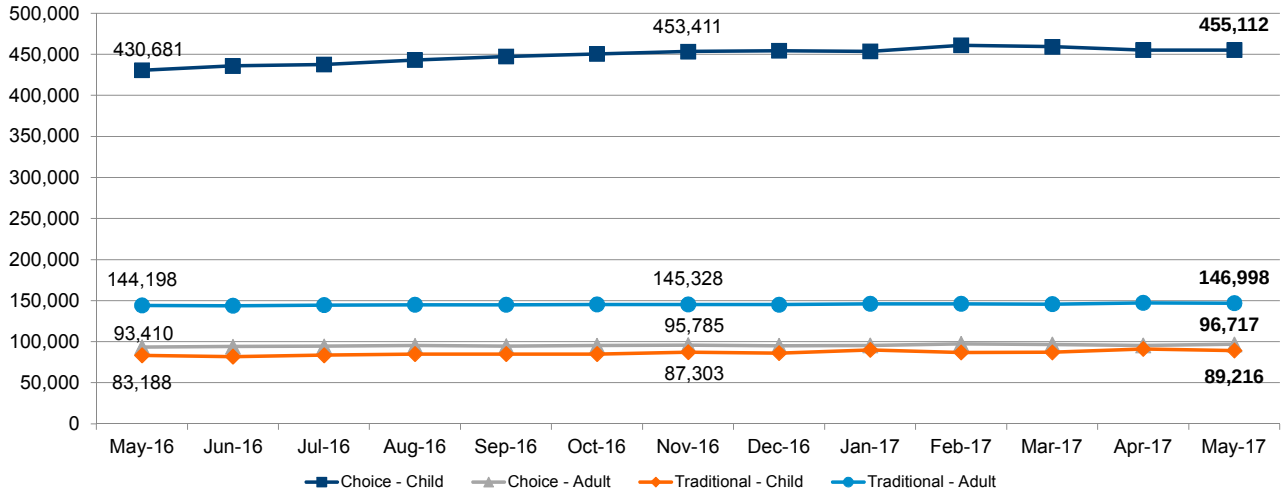
Total In-State Providers: 34,736 (+192) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,350	972	1,290	183	6,471	554	388	6,677	2,638

DUAL ENROLLEES & LONG-TERM CARE MEMBERS



CHILDREN & ADULTS ENROLLMENT



July MAC
Proposed Rule Amendment Summaries

Face to face tribal consultations regarding the following proposed changes were held Tuesday, May 23, 2017 and Tuesday, July 11, 2017 in the Board Room of the Oklahoma Health Care Authority (OHCA).

Rule changes within work folders 17-05 A&B and 17-06 were posted on the OHCA public website for a comment period from June 15, 2017 through July 14, 2017. Rule changes within work folder 17-09 will be posted on the OHCA public website for comments through July 28, 2017.

17-05 A&B Medical Identification Card Policy Revisions — The proposed revisions remove references that refer to the issuing/mailing of member medical identification cards. This policy change is the result of the Oklahoma Health Care Authority no longer printing and/or issuing plastic cards. Members now have access to print their medical identification card from their online member account, or non-online enrollment members can visit their local county Oklahoma Department of Human Services (OKDHS) office to obtain a printed card. Providers can verify the member's eligibility online via the Eligibility Verification System. Additionally, revisions update language to reflect how the OKDHS notifies members of eligibility and ineligibility determinations for medical services by mailing out computer-generated notification forms. Finally, the policy revisions update the language for the medical and financial certification processes for the OKDHS ADvantage program.
Budget Impact: Revisions to medical identification cards will result in a total budget savings of $96,000 (CY).

17-06 Pharmacy Revisions — The proposed pharmacy revisions remove coverage of optional non-prescription drugs for adults. (Insulin, nicotine replacement products for smoking cessation, and family planning products are not optional.) Additionally, compounded prescriptions for topical use will require a prior authorization for allowable cost exceeding a pre-determined limit. Finally, revisions cleanup language by correcting the number of prescriptions allowed for adults receiving services under the 1915(c) Home and Community-Based Services Waivers from two (2) to three (3), which will align with current practices.
Budget Impact: Revisions that remove coverage of optional non-prescription drugs for adults will result in a total budget savings of $825,000 for SFY 2018; state share $338,992.50; federal share $486,007.50.

17-09 Behavioral Health Case Management Limits — The proposed Behavioral Health Targeted Case Management (TCM) revisions establish yearly limits on the amount of basic case management/resource coordination that is reimbursable by SoonerCare on a fee-for-service basis. The current limit of twenty-five (25) units per member per month basic case management/resource coordination will be reduced to sixteen (16) units per member per year. A process for authorizing up to twenty-five (25) units per member per month will be used for individuals who demonstrate the medical need for additional units. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget for the remainder of SFY 2018 in order to meet the balanced budget requirements as mandated by state law. Without the recommended revisions, the Department is at risk of exhausting its state appropriated dollars required to maintain the State's Medicaid Behavioral Health Program.
Budget Impact: Estimated savings to ODMHSAS for SFY 2018 is $8,447,984 Total; $3,500,000 state share.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 5. ELIGIBILITY

317:30-3-88. Medical identification card [REVOKED]
~~(a) Providers should carefully check the permanent plastic identification card utilizing the REVS system or a commercial swipe card system to verify that the patient is eligible.~~

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 7. MEDICAL SERVICES

PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-40. Eligibility as Qualified Medicare Beneficiary Plus

~~(a)~~ An individual determined to be categorically related to aged, blind or disabled is eligible for Medical Services as a Qualified Medicare Beneficiary Plus (QMBP) if he/she meets the conditions of eligibility shown in paragraphs (1)-(3) of this subsection. For persons age 65 and older in mental health hospitals, refer to OAC 317:35-9-7.

(1) The individual's/couple's income and resources do not exceed the standards as shown on DHS Appendix C-1, Schedule VI, of which the income standard is based on ~~100%~~100 percent of the Federal Poverty Level.

(2) Countable income and resources are determined using the same rules followed in determining eligibility for individuals categorically related to ~~Aid to the~~ Aged, Blind or Disabled, except that a $20 general income disregard is applied to either earned or unearned income, but not both. For couples, only one $20 general income disregard is given.

(3) The individual meets all other eligibility conditions for ~~Medicaid~~SoonerCare.

~~(b) Medical identification cards are issued to all individuals determined eligible for QMBP coverage.~~

SUBCHAPTER 9. ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 9. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-9-75. Certification for long-term medical care through ~~ICF/MR~~ICF/IID, ~~HCBW/MR~~HCBW/IID services and to persons age 65 and older in a mental health hospital

(a) **Application date**. If the applicant is found eligible for ~~Medicaid~~SoonerCare, certification may be made retroactive for any service provided on or after the first day of the third month prior to the month of application and for future months. The first month of the certification period must be the first month that medical service was provided and the recipient was determined eligible. ~~An applicant approved for long-term medical care under Medicaid as categorically needy is mailed a permanent Medical Identification Card.~~

(b) **Certification period for long-term medical care**. A certification period of 12 months is assigned for an individual who is approved for long-term care.

317:35-15-7. Certification for Personal Care

(a) **Personal Care certification period.** The first month of the Personal Care certification period must be the first month the member was determined eligible for Personal Care, both financially and medically. When eligibility or ineligibility for Personal Care is established, the local office updates the computer-generated form and the appropriate notice is mailed to the member.

~~(1) As soon as eligibility or ineligibility for Personal Care is established, the local office updates the computer form and the appropriate notice is computer generated. Notice information is retained on the notice file for county use.~~

~~(2) An applicant approved for Personal Care under SoonerCare as categorically needy is mailed a Medical Identification Card.~~

(b) **Financial certification period~~ for Personal Care Services~~.** The financial certification period for Personal Care services is 12 months. Redetermination of eligibility is completed according to the categorical relationship.

(c) **Medical certification period~~ for Personal Care services~~**. A medical certification period of not more than 36 months is assigned for an individual who is approved for Personal Care. The certification period for Personal Care is based on the ~~UCAT~~Uniform Comprehensive Tool (UCAT) evaluation and clinical judgment of the ~~OKDHS~~Oklahoma Department of Human Services (DHS) area nurse or designee.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-12. Certification for ADvantage program services

(a) **Application date**. ~~If~~When the applicant is ~~found~~determined eligible for ~~SoonerCare~~ADvantage, his/her certification ~~may be~~is effective the date ~~of application~~that medical and financial eligibility was determined. ~~The first month of the certification period must be the first month the member was determined eligible for ADvantage, both financially and medically.~~When eligibility or ineligibility for ADvantage program services is established, the worker updates the authorization and the computer-generated notice is mailed to the member and ADvantage Administration (AA).

~~(1) As soon as eligibility or ineligibility for ADvantage program services is established, the worker updates the computer form and the appropriate notice is computer generated to the member and the ADvantage Administration~~

~~(AA). Notice information is retained on the notice file for county use.~~

~~(2) An applicant approved for ADvantage program services is mailed a Medical Identification Card.~~

(b) **Financial certification period~~ for ADvantage program services~~**. The financial certification period ~~for the ADvantage program services~~ is 12 months. ~~Although "medical eligibility number of months" on the computer input record will show 99 months, redetermination of eligibility is completed according to the categorical relationship.~~

~~(c) **Medical Certification period for ADvantage program services**. The medical certification period for ADvantage program services is up to 12 months. Redetermination of medical eligibility is completed by OKDHS in coordination with the annual reauthorization of the member's service plan. An independent redetermination of medical eligibility is completed by the OKDHS Nurse when, depending upon the needs of the member, the medical certification is determined to be less than 12 months, or, at any time documentation supports a reasonable expectation that the member may not continue to meet medical eligibility criteria.~~

(c) **Medical Certification period**. The medical certification period is 12 months. Redetermination of medical eligibility by an Oklahoma Department of Human Services (DHS) nurse is:

(1) completed annually in coordination with the annual reauthorization of the member's patient-centered service plan.

(2) completed when documentation is received that supports a reasonable expectation the member may not continue to meet medical eligibility criteria.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-22. Certification for ~~NF~~Nursing Facility (NF)

(a) **Application date**. The date of the application for NF care is most important in determining the date of eligibility. If the applicant is found eligible for ~~Medicaid~~SoonerCare, certification may be made retroactive for any service provided on or after the first day of the third month prior to the month of application and for future months. ~~An applicant approved for long-term medical care under Medicaid as categorically needy is mailed a Medical Identification Card.~~

(b) **Time limited approvals for nursing care**. A medical certification period of a specific length may be assigned for an individual who is categorically related to ~~ABD~~Aged, Blind and Disabled or ~~AFDC~~Aid to Families with Dependent Children. This time limit is noted on the system. It is the responsibility of the nursing facility to notify the area nurse 30 days prior to

the end of the certification period if an extension of approval is required by the client. Based on the information from the NF the area nurse, or nurse designee, determines whether or not an update of the ~~UCAT~~Uniform Comprehensive Tool (UCAT) is necessary for the extension. The area nurse, or nurse designee, coordinates with appropriate staff for any request for further UCAT assessments.

(c) **Certification period for long-term medical care**. A financial certification period of 12 months is assigned for an individual who is approved for long-term care.

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 other than those provided in an institution for mental diseases.

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

(B) Coverage for members under 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 free standing 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 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) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 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 317:30-3-65.4.

(A) Child health 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 visual screening and glasses each 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 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 OAC 317:30-5-278.

(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC 317:30-5-95 through OAC 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 and prosthetic devices beyond the normal scope of SoonerCare.

(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 21 years of age and

older who are legally competent, not institutionalized and have signed the "Consent Form" at least 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 nursing facility, 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 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 Nurses
(G) Anesthesiologist Assistants
(17) Free-standing ambulatory surgery centers.
(18) Prescribed drugs not to exceed a total of six prescriptions with a limit of two brand name prescriptions per month. Exceptions to the six prescription limit are:
(A) unlimited medically necessary monthly prescriptions for:
(i) members under the age of 21 years; and
(ii) residents of Nursing Facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities.
(B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan (including three brand name prescriptions) are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the ~~two~~three brand name or thirteen total prescriptions are covered with prior authorization.
(19) Rental and/or purchase of durable medical equipment.
(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 21.
(22) Prosthetic devices 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.
(23) Standard medical supplies.
(24) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(25) Blood and blood fractions for members when administered on an outpatient basis.
(26) Inpatient services for members age 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.
(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.
(28) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.
(29) 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.
(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.
(31) Nursing facility services for members under 21 years of age.
(32) 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 R.N.
(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.
(34) Home and Community Based Waiver Services for the intellectually disabled.

(35) Home health services limited to 36 visits per year and standard supplies for ~~1~~one (1) month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.
(36) 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) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.
(D) Finally, procedures considered experimental or investigational are not covered.
(37) Home and community-based waiver services for intellectually disabled members who were determined to be inappropriately placed in a ~~NF~~Nursing Facility (Alternative Disposition Plan - ADP).
(38) Case Management services for the chronically and/or severely mentally ill.
(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.
(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.
(41) Early Intervention services for children ages 0-3.
(42) Residential Behavior Management in therapeutic foster care setting.
(43) Birthing center services.
(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.
(45) Home and Community-Based Waiver services 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 in 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.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALITIES

PART 5. PHARMACIES

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six covered prescriptions per month with a limit of two brand name prescriptions. A prior authorization may be granted for a third brand name if determined to be medically necessary by OHCA and if the member has not already utilized their six covered prescriptions for the month.

(2) Subject to the limitations set forth in OAC 317:30-5-72.1, OAC 317:30-5-77.2, and OAC 317:30-5-77.3, exceptions to the six medically necessary prescriptions per month limit are:

(A) unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of Nursing Facilities or Intermediate Care Facilities for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities; and

(B) seven additional medically necessary prescriptions which are generic products per month to the six covered under the State Plan (including three brand name prescriptions) are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. Medically necessary prescriptions beyond the ~~two~~three brand name or thirteen total prescriptions will be covered with prior authorization.

(3) Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, low-phenylalanine formula and amino acid bars for persons with a diagnosis of PKU, certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month.

(4) When a brand drug is preferred over its generic equivalent due to lower net cost, that drug shall not count toward the brand limit; however, it will count toward the monthly prescription limit.

(b) **Coverage for children**. Prescription drugs for SoonerCare eligible individuals under 21 years of age are not limited in number per month, but may be subject to prior authorization, quantity limits or other restrictions.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

(A) Agents used to promote fertility.

(B) Agents primarily used to promote hair growth.

(C) Agents used for cosmetic purposes.

(D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.

(E) Agents that are investigational, experimental or whose side effects make usage controversial.

(F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(G) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

(2) The drug categories listed in (A) through (D) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Agents used for the ~~systematic~~symptomatic relief of cough and colds. ~~Antihistamines for allergies or antihistamine use associated with asthmatic conditions may be covered when medically necessary and prior authorized.~~

(B) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

(i) prenatal vitamins are covered for pregnant women up to age 50;

(ii) fluoride preparations are covered for persons under 16 years of age or pregnant;

(iii) vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered;

(iv) iron supplements may be covered for pregnant women if determined to be medically necessary;

(v) vitamin preparations may be covered for children less than 21 years of age when medically necessary and furnished pursuant to EPSDT protocol; and

(vi) some vitamins are covered for a specific diagnosis when the FDA has approved the use of that vitamin for a specific indication.

(C) Coverage of non-prescription or over the counter drugs is limited to:

(i) Insulin~~, PKU formula and amino acid bars, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions~~;

(ii) certain smoking cessation products;

(iii) family planning products;

(iv) OTC products may be covered for children if the particular product is both cost-effective and clinically appropriate; and

(v) prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

(D) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317:30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. § 1396r-8; or

(B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

317:30-5-77.2. Prior authorization

(a) **Definition**. The term prior authorization in pharmacy means an approval for payment by OHCA to the pharmacy before a prescription is dispensed by the pharmacy. An updated list of all products requiring prior authorization is available at the agency's website.

(b) **Process**. Because of the required interaction between a prescribing provider (such as a physician) and a pharmacist to receive a prior authorization, OHCA allows a pharmacist up to 30 calendar days from the point of sale notification to provide the data necessary for OHCA to make a decision regarding prior authorization. Should a pharmacist fill a prescription prior to the actual authorization he/she takes a business risk that payment for filling the prescription will be denied. In the case that information regarding the prior authorization is not provided within the 30 days, claims will be denied.

(c) **Documentation.** Prior Authorization petitions with clinical exceptions must be mailed or faxed to the Medication Authorization Unit of OHCA's contracted prior authorization processor. Other authorization petitions, claims processing questions and questions pertaining to DUR alerts must be addressed by contacting the Pharmacy help desk. Authorization petitions with complete information are reviewed and a response returned to the dispensing pharmacy within 24 hours. Petitions and other claim forms are available on the OHCA public website.

(d) **Emergencies.** In an emergency situation the Health Care Authority will authorize a 72 hour supply of medications to a member. The authorization for a 72 hour emergency supply of medications does not count against the SoonerCare limit described in OAC 317:30-5-72(a)(1).

(e) **Utilization and scope.** There are three reasons for the use of prior authorization: utilization controls, scope controls and product based controls. Product based prior authorization is covered in OAC 317:30-5-77.3. The Drug Utilization Review Board recommends the approved clinical criteria and any restrictions or limitations.

(1) **Utilization controls.** Prior authorizations that fall under this category generally apply to the quantity of medication or duration of therapy approved.

(2) **Scope controls**. Scope controls are used to ensure a drug is used for an approved indication and is clinically appropriate, medically necessary and cost effective.

(A) Medications which have been approved by the FDA for multiple indications may be subject to a scope-based prior authorization when at least one of the approved indications places that drug into a therapeutic category or treatment class for which a prior authorization is required. Prior authorizations for these drugs may be structured as step therapy or a tiered approach as recommended by the Drug Utilization Review Board and approved by the OHCA Board of Directors.

(B) Prior authorization may be required to assure compliance with FDA approved and/or medically accepted indications, dosage, duration of therapy, quantity, or other appropriate use criteria including pharmacoeconomic consideration.

(C) Prior authorization may be required for certain non-standard dosage forms of medications when the drug is available in standard dosage forms.

(D) Prior authorization may be required for certain compounded prescriptions if the allowable cost exceeds a predetermined limit as published on the agency's website.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.6. Behavioral Health Case Management

Payment is made for behavioral health case management services as set forth in this Section. The limitations set forth in this Section do not apply to case management provided in programs and service delivery models which are not reimbursed for case management on a fee-for-service basis.

(1) **Description of behavioral health case management services**. Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be ~~subject to~~ authorized for the target group based on established medical necessity criteria.

(A) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality,

collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The provider will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(B) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(C) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(D) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of

care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b).

(E) SoonerCare reimbursable behavioral health case management services include the following:

(i) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(ii) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(iii) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

(iv) Supportive activities such as non-face-to-face communication with the member and/or parent/guardian/family member.

(v) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(vi) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(vii) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(viii) Behavioral Health Case Management is available to individuals transitioning from institutions to the community (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions). Individuals are considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(2) **Levels of Case Management.**

(A) Resource coordination services are targeted to adults with serious mental illness and children and adolescents with

mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard managers have caseloads of 30 - 35 members. Basic case management/resource coordination is limited to ~~twenty-five (25)~~sixteen (16) units per member per ~~month~~year. Additional units may be authorized up to 25 units per member per month if medical necessity criteria are met.

(B) Intensive Case Management (ICM) is targeted to adults with serious and persistent mental illness (including members in PACT programs) and Wraparound Facilitation Case Management (WFCM) is targeted to children with serious mental illness and emotional disorders (including member in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. To ensure that these intense needs are met, case manager caseloads are limited between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of two (2) years Behavioral Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS six (6) hours ICM training, and twenty-four (24) hour availability is required. ICM/WFCM is limited to fifty-four (54) units per member per month.

(3) **Excluded Services**. SoonerCare reimbursable behavioral health case management does not include the following activities:

(A) physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;

(B) managing finances;

(C) providing specific services such as shopping or paying bills;

(D) delivering bus tickets, food stamps, money, etc.;

(E) counseling, rehabilitative services, psychiatric assessment, or discharge planning;

(F) filling out forms, applications, etc., on behalf of the member when the member is not present;

(G) filling out SoonerCare forms, applications, etc.;

(H) mentoring or tutoring;

(I) provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;

(J) non-face-to-face time spent preparing the assessment document and the service plan paperwork;
(K) monitoring financial goals;
(L) services to nursing home residents;
(M) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or
(N) services to members residing in ICF/IID facilities.

(4) **Excluded Individuals**. The following SoonerCare members are not eligible for behavioral health case management services:
(A) children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;
(B) members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;
(C) residents of ICF/IID and nursing facilities unless transitioning into the community;
(D) members receiving services under a Home and Community Based services (HCBS) waiver program; or
(E) members receiving services in the Health Home program.

(5) **Filing Requirements.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(6) **Documentation requirements**. The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:
(A) date;
(B) person(s) to whom services are rendered;
(C) start and stop times for each service;
(D) original signature or the service provider (original signatures for faxed items must be added to the clinical file within 30 days);
(E) credentials of the service provider;
(F) specific service plan needs, goals and/or objectives addressed;
(G) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals

and/or objectives;
(H) progress and barriers made towards goals, and/or objectives;
(I) member (family when applicable) response to the service;
(J) any new service plan needs, goals, and/or objectives identified during the service; and
(K) member satisfaction with staff intervention.

(7) **Case Management Travel Time**. The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.