Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

AGENDA

September 5th, 2019
1:00 PM – 3:30 PM

Charles Ed McFall Board Room

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Steven Crawford, M.D.**

II. Action Item: Approval of Minutes of the July 18th, 2019: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. Financial Report: **Tasha Black, Director of Fiscal Planning**

VI. SoonerCare Operations Update: **Melinda Thomason, Senior Director for Stakeholder Engagement**

VII. Access Monitoring Review Plan: **Sandra Puebla, Director of Federal & State Authorities**

VIII. Proposed Rule Changes: Presentation, Discussion, and Vote: **Sandra Puebla, Director of Federal & State Authorities**

A. **19-06 Diabetes Self-Management Training (DSMT) Services**
B. **19-08 Telehealth Services**
C. **19-13A&B Long-Term Care Facilities Revisions**
D. **19-16 Behavioral Health Targeted Case Management (TCM) Updates**

IX. New Business: **Chairman, Steven Crawford, M.D.**

X. Future Meeting:
November 21st meeting to be rescheduled to either November 7th or 14th

XI. Adjourn

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

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

***Delegates present were*:** Ms. Mary Brinkley, Dr. Erin Balzer, Dr. Joe Catalano, Mr. Victor Clay, Mr. Brett Coble, Dr. Steven Crawford, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Terrie Fritz, Dr. Lori Holmquist-Day, Mr. Mark Jones, Ms. Annette Mays, Dr. J. Daniel Post, Ms. Toni Pratt-Reid, Mr. Traylor Rains, Dr. Edd Rhoades, Dr. Jason Rhynes, Ms. Carrie Slatton-Hodges, Dr. Dwight Sublett, Mr. Jeff Tallent, Mr. William Whited and Dr. Whitney Yeates

Alternates present were: Dr. Mike Talley, providing a quorum.

***Delegates absent without an alternate were*:** Ms. Debra Billingsly, Mr. Don Flinn, Mr. Steve Goforth, Mr. James Patterson, Dr. Raymond Smith, and Mr. Rick Snyder.

Chairman Crawford introduced two new MAC members. Dr. Whitney Yeates as the new delegate for the Oklahoma Dental Association, and Mr. Traylor Rains as the new delegate for the Oklahoma Department of Human Services.

II. Approval of the May 16th, 2019 Minutes

Medical Advisory Committee

The motion to approve the minutes was by Mr. Jeff Tallent and seconded by Dr. Joe Catalano and passed with three abstentions from Mr. William Whited, Ms. Terrie Fritz and Ms. Annette Mays.

III. Public Comments (2 minute limit):

There were no public comments made at this meeting.

IV. MAC Member Comments/Discussion:

There were no MAC Member comments.

V. Financial Report:

Aaron Morris, Chief Financial Officer

Mr. Morris presented the financial report ending in May 2019. Revenues are $18.8 million total under budget, and expenditures are $18.6 million total under budget. The overall state budget variance through May 2019 is a negative $195,693. For more detailed information, see item 5 in the MAC agenda.

VI. SoonerCare Operations Update:

Marlene Asmussen, Director of Population Care Management

Ms. Asmussen presented the SoonerCare Operations Update to the committee. She presented information based on data for April of 2019. Patient Centered Medical Home enrollment is at 524,324 which is 5,946 less than the previous month. Sooner Care Traditional has a current enrollment of 234,444 which is 2,308 less than March. SoonerPlan is down by 824, giving a total number of 27,692. Insure Oklahoma has a total enrollment of 18,819, of which 13,492 are in the Employee Sponsored Plan, and 5,327 are in the individual plan. In total, SoonerCare enrollment is at 805,279 for April, which is a decrease of 4,467.

A. Pharmacy Updates:

Burl Beasley, Senior Director of Pharmacy Services

Mr. Beasley presented an informational update regarding Medication Assisted Treatment, such products as Suboxone, Buprenorphine, and Vivitrol. Currently OHCA requires a prior authorization on all medication assisted treatment, but with a lot of hard work we are removing those prior authorizations. The reason behind this was to make sure they were being used appropriately for Medication Assisted Treatment, and as we move through the opioid crisis spectrum, we decided to release those prior authorizations from those products. Effective July 31st the prior authorization will be removed off certain products.

Mr. Rains asked if the agency has considered reimbursing for methadone.
Mr. Beasley replied that it is something that we will look into as a mandate from CMS in the next coming years.

B. Oklahoma Residency Verification Process:

Melody Anthony, Deputy State Medicaid Director and Chief Operating Officer

Ms. Anthony presented an update on the Oklahoma Residency Verification process, which included the work group members, the current process for returned mail, current and planned new processes, new improvements to processes, broadening the outreach and after the rule is effective. For more detailed information, please see item 6b in the MAC agenda.

VII. Legislative Update:

Audra Cross, Legislative Liaison

Ms. Cross stated that OHCA received appropriations for a 5% provider rate increase, and a 5% rate increase for Long Term Care facilities, going into effect October 1. This session the legislature also created the rate preservation fund for the sole purpose of maintaining those reimbursement rates. When decreases in the state FMAP would otherwise result in a rate decrease funds for state share can come from the $22.8 million appropriated to that fund. We are also working to promulgate rules and implement step therapy reform and telemedicine in schools as required by SB509 and SB575. OHCA has also worked with legislators and stakeholders to draft SB280, which among other reforms changes the quality measures for Long Term Care facilities, modifies staffing ratios, and increases personal needs allowances for residents. OHCA is currently organizing legislators and providers tours, showing SoonerCare in action in legislator's communities.

VIII. Access Monitoring Review Plan (ARMP)

Sandra Puebla, Director of Federal & State Authorities

Federal regulation at 42 CFR 447.203, documentation of access to care and services payments, directs State Medicaid programs to analyze and monitor access to care for Medicaid fee-for-service programs through the Access Monitoring Review Plan (AMRP). Through the AMRP, the State demonstrates access to care by measuring the following: enrollee needs; the availability of care and providers; utilization of services; characteristics of the enrolled members; and estimated levels of provider payment from other payers. The AMRP must be taken through consultation with the Medical Advisory Committee and be published and made available to the public for a period of no less than 30 days prior to being submitted to the Centers for Medicare & Medicaid Services (CMS). The State submitted the initial access monitoring review plan on September 28, 2016, and must submit a revised plan every three years. The AMRP will note any access issues identified during the prior three years and if any issues were identified, the plan will include a corrective action plan. Further, the AMRP includes the State's access to care analyses conducted for State Plan amendments that reduced and/or restructured payment rates that could diminish access to care which were promulgated and approved within the previous three years.

IX. Proposed Rule Changes: Presentation, Discussion, and Vote:

Sandra Puebla, Director of Federal & State Authorities

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, January 8, 2019, Tuesday, March 9, 2019, Tuesday, June 18, 2019, and Tuesday, July 2, 2019 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

APA WF # 19-01 will be posted for public comment through July 31, 2019. APA WF # 19-05 will be posted for public comment through August 3, 2019. APA WF # 19-10 will be posted for public comment through July 23, 2019. APA WF # 19-11 will be posted for public comment through August 1, 2019. APA WF # 19-12 will be posted for public comment through August 12, 2019.

19-01 Retroactive Eligibility — The proposed revisions amend certification policy for pregnant women and children to allow for a retroactive period of eligibility. Revisions provide that, in addition to certifying an applicant for coverage from the date of certification forward, the applicant may also be certified for coverage for a retroactive period of three months directly prior to the date of application. If the applicant received reimbursable SoonerCare services at any time during the prior three months from certification/date of application and if the applicant would have been eligible for SoonerCare at the time he or she received the services, the member may be eligible for retroactive eligibility coverage. Revisions also specify the requirements that must be met to be eligible for retroactive coverage. Oklahoma had been granted a waiver exemption for retroactive eligibility for children and pregnant women through the 1115(a) waiver; however, in the latest renewal of the waiver, this exemption was removed by the Centers for Medicaid and Medicare Services (CMS), thus mandating the Oklahoma Health Care Authority to extend retroactive eligibility for pregnant women and children. The rule revisions apply to children and pregnant women and do not apply to adult parents/caretaker relatives. The timely filing deadline in Oklahoma Administrative Code (OAC) 317:30-3-11 will still apply to the filing of any retroactive claims.
Budget Impact: Although it is expected that implementing retroactive eligibility will have a budget impact to the agency it is not possible at this time, to predict how many applicants will be eligible for and receive a retroactive coverage option.
The rule change motion to approve was by Dr. Catalano and seconded by Dr. Sublett and passed unanimously.

19-05 Therapeutic Foster Care (TFC) Revisions — The proposed revisions will align therapeutic foster care policy with current business practice. Revisions will also add new language establishing a more intensive treatment program for children in DHS and OJA custody known as Intensive Treatment Family Care (ITFC). ITFC is a therapeutic foster care model that addresses children's' complex/severe behavioral and emotional health disorders. ITFC utilizes a team approach of professionals including therapists, care coordinators, and foster parents to provide the intensive treatment services in a family care setting. The proposed revisions will define ITFC, member criteria for the provision of ITFC services, provider participation and credentialing requirements, program coverage, and program limitations. Lastly, the proposed revisions will establish reimbursement methodology and applicable rates for ITFC services.
Budget Impact: The proposed changes would potentially result in an estimated annual total cost for SFY20 of $1,731,183 with a state match of $594,557 and an SFY21 total cost of $2,324,813 with a state match of $768,816. The state share will be paid by the Oklahoma Department of Human Services with the current TFC budget.
The rule change motion to approve was by Dr. Talley and seconded by Mr. Rains and passed unanimously.

19-10 American Indian/Alaska Native Cost Sharing Exemption — The proposed revisions will make Oklahoma's Administrative Code language consistent with the Oklahoma State Plan language and federal regulation at 42 Code of Federal Regulation (CFR) 447.56 (a)(x) regarding cost sharing exemptions.
Budget Impact: Budget neutral.
The rule change motion to approve was by Dr. Catalano and seconded by Ms. Fritz and passed unanimously.

19-11 Board Organization and Policy Revisions — The proposed revisions will comply with Oklahoma Senate Bill (SB) 456, which was signed into law on March 13th, 2019 and directed the reorganization of the Oklahoma Health Care Authority (OHCA) Board. The seven-member Board was replaced with a nine-member Board. Further revisions establish that the chair and vice-chair elections are held at the last regular meeting before January 1st of each year. Other revisions are needed to correct outdated language.
Budget Impact: Budget neutral.
The rule change motion to approve was by Dr. Talley and seconded by Dr. Post and passed unanimously.

19-12 High Risk Obstetrical Services (HROB) — The proposed revisions will add "family practice physician - obstetrics (FP/OB)" as a new provider type under the enhanced services for medically high risk pregnancies policy. This policy change will address and improve access to care for obstetrical related services in rural Oklahoma. Further revisions will update policy to reflect current business practices.
Budget Impact: The proposed changes can potentially result in a combined federal and state spending of $154,549.10 total with $52,515.78 in state share for SFY2020.
The rule change motion to approve was by Ms. Felty and seconded by Dr. Balzer and passed unanimously.

X. New Business: Chairman, Steven Crawford, M.D.

Dr. Jason Rhynes discussed the possibility of changing the comprehensive eye exam at 365 plus 1 day to changing it to calendar year.

XI. Future Meeting

September 19th, 2019
November 21st, 2019

XII. Adjournment

There was no dissent and the meeting was adjourned at 2:32p.m.

FINANCIAL REPORT

For the Fiscal Year Ended June 30, 2019
Submitted to the CEO & Board

- Revenues for OHCA through June, accounting for receivables, were **$4,297,835,852** or **.3% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$4,316,356,071** or **.7% under** budget.
- The state dollar budget variance through June is a positive **$17,150,085.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		13.2
Administration		6.4
Revenues:		
Drug Rebate		.8
Medical Refunds		1.7
Taxes and Fees		(5.0)
Total FY 19 Variance	**$**	**17.1**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2019, For the Fiscal Year Ended June 30, 2019

REVENUES	FY19 Budget YTD	FY19 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 1,016,421,626	$ 1,016,421,626	$ -	0.0%
State Appropriations - GME Appropriated Funds	$ 110,044,320	$ 110,044,320	$ -	0.0%
Federal Funds	2,404,879,397	2,390,098,770	(14,780,627)	(0.6)%
Tobacco Tax Collections	49,070,050	44,880,544	(4,189,506)	(8.5)%
Quality of Care Collections	79,429,596	78,190,927	(1,238,669)	(1.6)%
Prior Year Carryover	20,414,314	20,414,314	-	0.0%
Federal Deferral - Transfer	4,676,719	4,676,719	-	0.0%
Federal Deferral - Interest	352,590	352,590	-	0.0%
Drug Rebates	361,783,138	364,019,737	2,236,599	0.6%
Medical Refunds	37,014,933	41,641,433	4,626,500	12.5%
Supplemental Hospital Offset Payment Program	210,565,236	210,565,236	-	0.0%
Other Revenues	16,113,669	16,529,635	415,967	2.6%
TOTAL REVENUES	**$ 4,310,765,587**	**$ 4,297,835,852**	**$ (12,929,735)**	**(0.3)%**

EXPENDITURES	FY19 Budget YTD	FY19 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 59,799,758**	**$ 49,135,725**	**$ 10,664,033**	**17.8%**
ADMINISTRATION - CONTRACTS	**$ 118,350,752**	**$ 107,903,164**	**$ 10,447,588**	**8.8%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	39,537,173	39,361,970	175,203	0.4%
Acute Fee for Service Payments:				
Hospital Services	949,623,941	961,864,544	(12,240,604)	(1.3)%
Behavioral Health	19,618,923	17,510,840	2,108,083	10.7%
Physicians	413,091,913	391,097,583	21,994,330	5.3%
Dentists	128,845,088	129,623,840	(778,752)	(0.6)%
Other Practitioners	54,201,712	51,655,904	2,545,808	4.7%
Home Health Care	21,524,325	24,468,597	(2,944,272)	(13.7)%
Lab & Radiology	27,265,862	25,697,645	1,568,217	5.8%
Medical Supplies	53,080,241	54,154,496	(1,074,255)	(2.0)%
Ambulatory/Clinics	232,135,589	248,573,459	(16,437,871)	(7.1)%
Prescription Drugs	650,871,301	633,346,630	17,524,671	2.7%
OHCA Therapeutic Foster Care	166,427	18,696	147,731	88.8%
Other Payments:				
Nursing Facilities	557,060,824	566,671,273	(9,610,449)	(1.7)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	62,609,273	64,073,757	(1,464,485)	(2.3)%
Medicare Buy-In	178,548,314	175,527,521	3,020,794	1.7%
Transportation	71,490,162	69,044,201	2,445,961	3.4%
Money Follows the Person-OHCA	346,999	323,919	23,080	6.7%
Electonic Health Records-Incentive Payments	5,508,088	5,508,088	-	0.0%
Part D Phase-In Contribution	108,587,739	107,713,341	874,397	0.8%
Supplemental Hospital Offset Payment Program	473,090,847	473,090,847	-	0.0%
Telligen	10,946,940	9,910,738	1,036,202	9.5%
Total OHCA Medical Programs	**4,058,151,679**	**4,049,237,888**	**8,913,791**	**0.2%**
OHCA Non-Title XIX Medical Payments	89,382	34,974	54,408	0.0%
OHCA Non-Title XIX - GME	110,044,319	110,044,319	-	0.0%
TOTAL OHCA	**$ 4,346,435,891**	**$ 4,316,356,071**	**$ 30,079,820**	**0.7%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (35,670,304)**	**$ (18,520,219)**	**$ 17,150,085**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2019, For the Fiscal Year Ended June 30, 2019

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 39,451,703	$ 39,351,995	$ -	$ 89,733	$ -	$ 9,976	$ -
Inpatient Acute Care	1,134,228,611	619,635,991	486,687	3,334,980	354,121,348	985,691	155,663,914
Outpatient Acute Care	446,024,607	335,040,932	41,604	4,293,006	100,975,425	5,673,639	-
Behavioral Health - Inpatient	53,019,239	9,004,508	-	441,846	16,336,426	-	27,236,459
Behavioral Health - Psychiatrist	10,163,981	8,506,332	-	-	1,657,648	-	-
Behavioral Health - Outpatient	16,627,732	-	-	-	-	-	16,627,732
Behavioral Health-Health Home	40,142,319	-	-	-	-	-	40,142,319
Behavioral Health Facility- Rehab	229,288,507	-	-	-	-	102,867	229,288,507
Behavioral Health - Case Management	2,685,664	-	-	-	-	-	2,685,664
Behavioral Health - PRTF	44,914,688	-	-	-	-	-	44,914,688
Behavioral Health - CCBHC	64,343,368	-					64,343,368
Residential Behavioral Management	11,850,790	-	-	-	-	-	11,850,790
Targeted Case Management	72,903,433	-	-	-	-	-	72,903,433
Therapeutic Foster Care	18,696	18,696	-	-	-	-	-
Physicians	459,313,889	387,116,100	58,101	5,048,555	-	3,923,382	63,167,750
Dentists	129,670,417	129,611,023	-	46,578	-	12,817	-
Mid Level Practitioners	2,164,334	2,154,195	-	9,660	-	479	-
Other Practitioners	50,012,750	48,942,004	446,364	511,520	-	112,862	-
Home Health Care	24,480,789	24,459,366	-	12,193	-	9,231	-
Lab & Radiology	26,443,773	25,473,362	-	746,128	-	224,283	-
Medical Supplies	54,385,608	51,408,998	2,711,532	231,112	-	33,966	-
Clinic Services	250,953,167	242,213,308	-	1,770,507	-	269,213	6,700,138
Ambulatory Surgery Centers	6,256,675	6,081,257	-	165,737	-	9,681	-
Personal Care Services	10,572,463	-	-	-	-	-	10,572,463
Nursing Facilities	566,671,273	346,546,844	220,123,338	-	-	1,091	-
Transportation	69,007,589	66,211,067	2,541,124	114,867	-	140,531	-
IME/DME/GME	114,539,305	-	-	-	-	-	114,539,305
ICF/IID Private	64,073,757	52,425,655	11,648,102	-	-	-	-
ICF/IID Public	13,899,670	-	-	-	-	-	13,899,670
CMS Payments	283,240,862	282,794,114	446,748	-	-	-	-
Prescription Drugs	648,177,634	630,575,472	-	14,831,005	-	2,771,158	-
Miscellaneous Medical Payments	151,478	141,638	-	-	-	9,841	-
Home and Community Based Waiver	210,043,188	-	-	-	-	-	210,043,188
Homeward Bound Waiver	78,548,143	-	-	-	-	-	78,548,143
Money Follows the Person	323,919	323,919	-	-	-	-	-
In-Home Support Waiver	24,467,157	-	-	-	-	-	24,467,157
ADvantage Waiver	145,195,678	-	-	-	-	-	145,195,678
Family Planning/Family Planning Waiver	4,180,052	-	-	-	-	-	4,180,052
Premium Assistance*	57,924,895	-	-	57,924,894.81	-	-	-
Telligen	9,910,738	9,910,738	-	-	-	-	-
Electronic Health Records Incentive Payments	5,508,088	5,508,088	-	-	-	-	-
Total Medicaid Expenditures	**$ 5,475,780,627**	**$ -**	**$ 3,323,455,602**	**$ 238,503,599**	**$ 89,572,322**	**$ 473,090,847**	**$ 14,290,707**	**$ 1,336,970,416**

* Includes $57,469,103.39 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2019, For the Fiscal Year Ended June 30, 2019

	FY19
REVENUE	**Actual YTD**
Revenues from Other State Agencies	$ 562,866,606
Federal Funds	848,430,682
TOTAL REVENUES	**$ 1,411,297,288**

EXPENDITURES	**Actual YTD**
Department of Human Services	
Home and Community Based Waiver	210,043,188
Money Follows the Person	-
Homeward Bound Waiver	78,548,143
In-Home Support Waivers	24,467,157
ADvantage Waiver	145,195,678
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	13,899,670
Personal Care	10,572,463
Residential Behavioral Management	6,827,072
Targeted Case Management	64,149,468
Total Department of Human Services	**553,702,839**
State Employees Physician Payment	
Physician Payments	63,167,750
Total State Employees Physician Payment	**63,167,750**
Education Payments	
Graduate Medical Education	76,064,780
Indirect Medical Education	34,965,572
Direct Medical Education	3,508,953
Total Education Payments	**114,539,305**
Office of Juvenile Affairs	
Targeted Case Management	2,397,616
Residential Behavioral Management	5,023,718
Total Office of Juvenile Affairs	**7,421,334**
Department of Mental Health	
Case Management	2,685,664
Inpatient Psychiatric Free-standing	27,236,459
Outpatient	16,627,732
Health Homes	40,142,319
Psychiatric Residential Treatment Facility	44,914,688
Certified Community Behavioral Health Clinics	64,343,368
Rehabilitation Centers	229,288,507
Total Department of Mental Health	**425,238,736**
State Department of Health	
Children's First	704,396
Sooner Start	2,055,196
Early Intervention	3,829,546
Early and Periodic Screening, Diagnosis, and Treatment Clinic	1,612,792
Family Planning	369,138
Family Planning Waiver	3,801,660
Maternity Clinic	964
Total Department of Health	**12,373,693**
County Health Departments	
EPSDT Clinic	625,227
Family Planning Waiver	9,254
Total County Health Departments	**634,481**
State Department of Education	**162,094**
Public Schools	**1,660,313**
Medicare DRG Limit	**144,535,167**
Native American Tribal Agreements	**2,405,958**
Department of Corrections	**2,101,563**
JD McCarty	**9,027,184**
Total OSA Medicaid Programs	**$ 1,336,970,416**
OSA Non-Medicaid Programs	**$ 81,451,321**
Accounts Receivable from OSA	**$ 7,124,449**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2019, For the Fiscal Year Ended June 30, 2019

REVENUES		FY 19 Revenue
SHOPP Assessment Fee		210,366,014
Federal Draws	$	290,755,133
Interest		196,939
Penalties		2,283
State Appropriations		(30,200,000)
TOTAL REVENUES	$	471,120,369

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 19 Expenditures
Program Costs:	7/1/18 - 9/30/18	10/1/18 - 12/31/18	1/1/19 - 3/31/19	4/1/19 - 6/30/19		
Hospital - Inpatient Care	84,988,728	99,052,816	83,045,794	87,034,010	$	354,121,348
Hospital -Outpatient Care	25,649,937	29,135,930	22,823,205	23,366,353		100,975,425
Psychiatric Facilities-Inpatient	3,352,856	3,909,783	4,421,971	4,651,816		16,336,426
Rehabilitation Facilities-Inpatient	416,290	485,439	368,383	387,537		1,657,648
Total OHCA Program Costs	114,407,810	132,583,968	110,659,352	115,439,716	$	473,090,847
Total Expenditures					$	473,090,847

CASH BALANCE		
	$	(1,970,478)

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2019, For the Fiscal Year Ended June 30, 2019

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 78,140,155**	**$ 78,140,155**
Interest Earned	**50,772**	**50,772**
TOTAL REVENUES	**$ 78,190,927**	**$ 78,190,927**

EXPENDITURES	FY 19 Total $ YTD	FY 19 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 216,448,114	$ 83,470,295	
Eyeglasses and Dentures	275,804	106,339	
Personal Allowance Increase	3,399,420	1,311,008	
Coverage for Durable Medical Equipment and Supplies	2,711,532	1,045,906	
Coverage of Qualified Medicare Beneficiary	1,032,756	398,360	
Part D Phase-In	446,748	446,748	
ICF/IID Rate Adjustment	5,365,614	2,069,191	
Acute Services ICF/IID	6,282,488	2,421,643	
Non-emergency Transportation - Soonerride	2,541,124	979,911	
Total Program Costs	**$ 238,503,599**	**$ 92,249,400**	**$ 92,249,400**
Administration			
OHCA Administration Costs	$ 540,053	$ 270,027	
DHS-Ombudsmen	184,199	184,199	
OSDH-Nursing Facility Inspectors	376,209	376,209	
Mike Fine, CPA	18,600	9,300	
Total Administration Costs	**$ 1,119,061**	**$ 839,735**	**$ 839,735**
Total Quality of Care Fee Costs	**$ 239,622,661**	**$ 93,089,135**	
TOTAL STATE SHARE OF COSTS			**$ 93,089,135**

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 2019, For the Fiscal Year Ended June 30, 2019

REVENUES	FY 18 Carryover	FY 19 Revenue	Total Revenue
Prior Year Balance	$ 12,902,064	$ -	$ 6,997,587
State Appropriations	(6,000,000)	-	-
Tobacco Tax Collections	-	36,912,553	36,912,553
Interest Income	-	227,283	227,283
Federal Draws	208,931	36,963,759	36,963,759
TOTAL REVENUES	$ 7,110,995	$ 74,103,595	$ 81,101,181

EXPENDITURES		FY 18 Expenditures	FY 19 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 57,469,103	$ 57,469,103
	College Students/ESI Dental		455,791	175,869
Individual Plan				
	SoonerCare Choice		$ 87,333	$ 33,696
	Inpatient Hospital		3,317,991	1,280,620
	Outpatient Hospital		4,185,952	1,624,860
	BH - Inpatient Services-DRG		425,782	163,639
	BH -Psychiatrist		-	-
	Physicians		4,975,452	1,923,839
	Dentists		45,444	17,396
	Mid Level Practitioner		8,435	3,252
	Other Practitioners		507,176	195,734
	Home Health		12,193	4,779
	Lab and Radiology		734,531	283,293
	Medical Supplies		229,629	88,742
	Clinic Services		1,719,981	662,228
	Ambulatory Surgery Center		165,166	64,028
	Prescription Drugs		14,614,356	5,614,100
	Transportation		112,788	43,336
	Premiums Collected		-	(494,418)
Total Individual Plan			$ 31,142,208	$ 11,509,123
	College Students-Service Costs		$ 505,220	$ 195,380
Total OHCA Program Costs			$ 89,572,322	$ 69,349,475
Administrative Costs				
	Salaries	$ 24,543	$ 2,320,668	$ 2,345,211
	Operating Costs	9,662	133,396	143,058
	Health Dept-Postponing	-	-	-
	Contract - HP	79,204	931,171	1,010,374
Total Administrative Costs		$ 113,409	$ 3,385,235	$ 3,498,644
Total Expenditures				$ 72,848,119
NET CASH BALANCE		$ 6,997,587		$ 8,253,062

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2019, For the Fiscal Year Ended June 30, 2019

REVENUES	FY 19 Revenue	State Share
Tobacco Tax Collections	$ 736,713	$ 736,713
TOTAL REVENUES	**$ 736,713**	**$ 736,713**

EXPENDITURES	FY 19 Total $ YTD	FY 19 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 9,976	$ 2,691	
Inpatient Hospital	985,691	263,042	
Outpatient Hospital	5,673,639	1,528,073	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	1,091	287	
Physicians	3,923,382	1,068,155	
Dentists	12,817	3,432	
Mid-level Practitioner	479	129	
Other Practitioners	112,862	30,332	
Home Health	9,231	2,468	
Lab & Radiology	224,283	60,286	
Medical Supplies	33,966	9,102	
Clinic Services	269,213	72,666	
Ambulatory Surgery Center	9,681	2,583	
Prescription Drugs	2,771,158	746,460	
Transportation	140,531	37,968	
Miscellaneous Medical	9,841	2,603	
Total OHCA Program Costs	**$ 14,187,841**	**$ 3,830,276**	
OSA DMHSAS Rehab	$ 102,867	27,723	
Total Medicaid Program Costs	**$ 14,290,707**	**$ 3,857,999**	
TOTAL STATE SHARE OF COSTS			**$ 3,857,999**

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.

Access Monitoring Review Plan (AMRP) – UPDATE

As presented at the July 18, 2019 Medical Advisory Committee (MAC) meeting, federal regulation at 42 CFR 447.203 directs State Medicaid programs to analyze and monitor access to care for Medicaid fee-for-service programs through an Access Monitoring Review Plan (AMRP). An AMRP demonstrates access to care by measuring the following: enrollee needs; the availability of care and providers; utilization of services; characteristics of the enrolled members; and estimated levels of provider payment from other payers. Further, the AMRP includes the State's access to care analyses conducted for State Plan amendments that reduced and/or restructured payment rates that could diminish access to care which were promulgated and approved within the previous three years.

The AMRP must be taken through consultation with the Medical Advisory Committee and be published and made available to the public for a period of no less than 30 days prior to being submitted to the Centers for Medicare & Medicaid Services (CMS). The State's second AMRP was posted to the Agency's website for a public review period on August 27, 2019 through September 26, 2019. The plan will ultimately be submitted to CMS on or before Monday, September 30, 2019.

As with the 2016 AMRP, the updated plan identified no access issues during the prior three years.

September MAC
Proposed Rule Amendment Summaries

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, January 8, 2019, Tuesday, June 18, 2019, Tuesday, July 2, 2019, and Tuesday, September 3, 2019 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

APA WF # 19-06 will be posted for public comment through October 4, 2019. APA WF # 19-08 was posted for public comment from August 5, 2019 through September 4, 2019. APA WF # 19-13 A&B will be posted for public comment through September 17, 2019. APA WF # 19-16 will be posted for public comment through September 16, 2019.

19-06 Diabetes Self-Management Training (DSMT) Services — The proposed revisions will establish DSMT as a new benefit in the SoonerCare program. DSMT is an educational disease management benefit designed to teach members how to successfully manage and control his/her diabetes. The proposed revisions will outline member eligibility, program coverage and limitations, provider requirements, and reimbursement.

Budget Impact: The proposed changes will potentially result in an estimated annual total cost of $144,057 with a state share of $50,262 for State Fiscal Year (SFY) 2020.

19-08 Telehealth Services — The proposed revisions to telehealth policies are to comply with Oklahoma Senate Bill (SB) 575, which amended 25 Oklahoma Statutes (O.S.), Section 2004 and 2005. Revisions outline and further define the following requirements for telehealth services: parental consent; confidentiality and security of protected health information; services provided or received outside of Oklahoma that may require prior authorization; and that services provided must be within the scope of the practitioner's license or certification. Revisions also define that program restrictions and coverage for telehealth services mirror those which exist for the same services when not provided through telehealth; however, the rule also outlines that only certain telehealth codes are reimbursable by SoonerCare.

Budget Impact: The proposed changes will result in a budget impact of $332,330 of which $115,950 is the state share.

19-13A&B Long-Term Care Facilities Revisions — The proposed revisions will bring OHCA into compliance with Senate Bill (SB) 280. Revisions will increase rates and recalculate the Quality of Care fee for regular nursing facilities and nursing facilities serving residents with Acquired Immune Deficiency Syndrome (AIDS). Revisions will establish new quality measures and criteria, as well as, recalculate the incentive reimbursement rate plan for nursing facilities participating in the paid-for-performance program. In addition, revisions will direct certain redistribution of funds; update staffing ratios; establish an advisory group; implement an administrative appeals process for disputed nursing facility cost reporting adjustments; streamline the audit process; and increase the personal needs allowance for residents of nursing homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs).

Budget Impact: The estimated budget impact for the remainder of SFY2020 will be an increase in the total amount of $95,819,280; with $32,559,391 in state share ($4,400,309 of the state share is from QOC fees paid by providers). The estimated budget impact for SFY2021 will be an increase in the total amount of $127,759,040; with $43,412,522 in state share ($6,286,156 of the state share is from QOC fees paid by providers).

19-16 Behavioral Health Targeted Case Management (TCM) Updates — The proposed revisions, requested by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), increases the TCM limits that are reimbursable by SoonerCare. The TCM limits will be increased from sixteen (16) units per member per year to twelve (12) units per member per month. Other revisions will align case management policy with current practice and correct grammatical errors.

Budget Impact: The proposed changes will potentially result in an estimated annual total cost for SFY20 of $6,425,397 with a state share of $2,183,350 and an SFY21 total cost of $8,567,136 with a state share of $2,833,152. The state share will be paid by ODMHSAS.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.1. Outpatient hospital services

(a) Hospitals providing outpatient hospital services are required to meet the same requirements that apply to ~~OHCA~~the Oklahoma Health Care Authority (OHCA) contracted, non-hospital providers performing the same services. Outpatient services performed outside the hospital facility are not reimbursed as hospital outpatient services.

(b) Covered outpatient hospital services must meet all of the criteria listed in (1) through (4) of this subsection.

(1) The care is directed by a physician or dentist.

(2) The care is medically necessary.

(3) The member is not an inpatient ~~(see OAC 317:30-5-41)~~[refer to Oklahoma Administrative Code (OAC) 317:30-5-41].

(4) The service is provided in an approved hospital facility.

(c) Covered outpatient hospital services are those services provided for a member who is not a hospital inpatient. A member in a hospital may be either an inpatient or an outpatient, but not both (see OAC 317:30-5-41).

(d) In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

(e) Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

(f) Physical, occupational, and speech therapy services are covered when performed in an outpatient hospital based setting. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and ~~15~~fifteen (15) visits (units) per discipline per date of service per calendar year. Claims for these services must include the appropriate revenue code(s).

(g) Diabetes self-management training (DSMT) is provided to members diagnosed with diabetes. DSMT services are comprised of one (1) hour of individual instruction (face-to-face encounters between the certified diabetes educator and the member) and nine (9) hours of group instruction on diabetes self-management. Members shall receive up to ten (10) hours of services during the first twelve (12) month period beginning with the initial training date. After the first twelve (12) month period has ended, members shall only be eligible for two (2) hours of individual instruction

on DSMT per calendar year. Refer to OAC 317:30-5-1080 through 1084 for specific provider and program requirements, and reimbursement methodology.

PART 109. DIABETES SELF-MANAGEMENT TRAINING

317:30-5-1080. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"ADA" means American Diabetes Association.

"AADE" means American Association of Diabetes Educators.

"CDE" means certified diabetes educator.

"DSMT" means diabetes self-management training.

"OAC" means Oklahoma Administrative Code.

"OHCA" means Oklahoma Health Care Authority.

"Qualified non-physician provider" means a physician assistant or advanced practice registered nurse.

317:30-5-1081. Eligible providers and requirements

(a) Eligible DSMT providers include any of the following professionals:

(1) A registered dietician (RD) who is licensed and in good standing in the state in which s/he practices, and who is:

(A) Certified as a CDE; and

(B) Fully contracted with SoonerCare as a CDE provider.

(2) A registered nurse (RN) who is licensed and in good standing in the state in which s/he practices, and who is:

(A) Certified as a CDE; and

(B) Fully contracted with SoonerCare as a CDE provider.

(3) A pharmacist who is licensed and in good standing in the state in which s/he practices, and who is:

(A) Certified as a CDE; and

(B) Fully contracted with SoonerCare as a CDE provider.

(b) In order to receive Medicaid reimbursement for DSMT services, professional service providers, outpatient hospitals, Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/Us), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) must have a DSMT program that meets the quality standards of one (1) of the following accreditation organizations:

(1) The ADA; or

(2) The AADE.

(c) All DSMT programs must adhere to the national standards for diabetes self-management education.

(1) Each member of the instructional team must:

(A) Be a CDE; or

(B) Have documentation of at least fifteen (15) hours of

recent diabetes education or diabetes management experience.

(2) At a minimum, every instructional team must consist of at least one (1) of the CDE professionals listed in subsection a, above.

(d) All members of the instructional team must obtain the nationally recommended annual continuing education hours for diabetes management.

317:30-5-1082. Scope of services

(a) **General provisions.** The OHCA covers medically necessary DSMT services when all the following criteria are met:

(1) The member has been diagnosed with diabetes by a physician or qualified non-physician provider working within the scope of his/her licensure;

(2) The services have been ordered by a physician or qualified non-physician provider who is actively managing the member's diabetes;

(3) The services are provided by a qualified DSMT provider [Refer to OAC 317:30-5-1081(b)(2)]; and

(4) The program meets the current ADA or ADE training standards.

(b) **Training.** DSMT services shall provide one (1) initial assessment per lifetime. Initial DSMT shall be comprised of up to ten (10) hours [can be performed in any combination of thirty (30) minute increments] of diabetes training within a consecutive twelve (12) month period beginning with the initial training date, including:

(1) One (1) hour of individual instruction, consisting of face-to-face encounters between the CDE and the member; and

(2) Nine (9) hours of group instruction.

(c) **Follow-up DSMT.** After the first twelve (12) month period has concluded, members shall only be eligible for two (2) hours of individual or group DSMT instruction per calendar year.

(d) **Referral.** The physician or qualified non-physician provider managing the member's diabetes must submit a DSMT order that includes:

(1) Diabetes diagnosis;

(2) Plan of care;

(3) Number of initial or follow-up hours needed;

(3) Expected health outcomes; and

(4) Any identified barriers that would require individualized member education.

317:30-5-1083. Coverage by category

The purpose of DSMT services must be to provide the member with the knowledge, skill, and ability necessary for diabetes self-care.

(1) **Adults.** Payment is made for medically necessary DSMT provided by a registered nurse (RN), registered dietitian (RD),

or pharmacist certified as a diabetes educator, as described in OAC 317:30-5-1081.

(2) **Children/adolescents.** Payment is made for medically necessary DSMT for members under twenty-one (21) years of age provided by a RN, RD, or pharmacist certified as a diabetes educator, as described in OAC 317:30-5-1081.

317:30-5-1084 . Reimbursement Methodology

SoonerCare shall provide reimbursement for DSMT services as follow:

(1) Payment shall be made to fully-contracted providers. If the rendering provider operates through an enrolled SoonerCare provider, or is contracted to provide services by an enrolled SoonerCare provider, payment may be made to that enrolled SoonerCare provider.

(2) Reimbursement for DSMT services is only made on a fee-for-service basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary change to the general public for the service, or the maximum allowable per unit of service.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-27. Telehealth

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

(1)**"Remote patient monitoring"** means the use of digital technologies to collect medical and other forms of health data (e.g. vital signs, weight, blood pressure, blood sugar) from individuals in one location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

(2)**"School-based services"** means medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of twenty-one (21), pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act. See Oklahoma Administrative Code (OAC) 317:30-5-1020.

~~(2)~~(3)**"Store and forward"** means the ~~acquisition (storing) of clinical information (e.g. data, document, image, sound, video) that is then electronically transmitted (forwarded to or retrieved by) to another site for clinical evaluation~~transmission of a patient's medical information from an originating site to the health care provider at the distant site; provided, photographs visualized by a telecommunications system shall be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis or treatment plan. Store and forward technologies shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

~~(3)~~(4)**"Telehealth"** means the ~~mode of delivering healthcare services via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of patients, at a distance from health care providers~~practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to

exclude store and forward technologies, between a patient and a health care provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. Telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

(5) **"Telehealth medical service"** means, for the purpose of the notification requirements of OAC 317:30-3-27(d)(2), telehealth services that expressly do not include physical therapy, occupational therapy, and/or speech and hearing services.

(b) **Applicability and scope.** The purpose of this Section is to implement telehealth policy that improves access to health care services, while complying with all applicable ~~Federal and State~~State and Federal laws and regulations. Telehealth services are not an expansion of ~~SoonerCare-covered~~SoonerCare-covered services, but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective, thorough medical assessment, or problems in the member's understanding of telehealth, hands-on-assessment and/or ~~in person~~in-person care must be provided for the member. Any service delivered using telehealth technology must be appropriate for telehealth delivery and be of the same quality and otherwise on par with the same service delivered in person. A telehealth encounter must ~~comply with the Health Information Portability and Accountability Act (HIPAA)~~maintain the confidentiality and security of protected health information in accordance with applicable State and Federal law, including, but not limited to, 42 Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164, and 43A Oklahoma Statutes (O.S.) § 1-109. For purposes of SoonerCare reimbursement, telehealth is the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment that ~~occur~~occurs in real-time and when the member is actively participating during the transmission. ~~Telehealth does not include the use of audio only telephone, electronic mail or facsimile transmission.~~

(c) **~~Conditions~~Requirements.** The following ~~conditions~~requirements apply to all services rendered via telehealth.

(1) Interactive audio and video telecommunications must be used, permitting encrypted, real-time communication between the physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted. As a condition of payment the member must actively participate in the telehealth visit.

(2) The telehealth equipment and transmission speed and image must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telehealth visit need to be trained in the use of the telehealth equipment and competent in its operation.
(3) The medical or behavioral health related service must be provided at an appropriate site for the delivery of telehealth services. An appropriate telehealth site is one that has the proper security measures in place; the appropriate administrative, physical, and technical safeguards should be in place that ensures the confidentiality, integrity, and security of electronic protected health information. The location of the room for the encounter at both ends should ensure comfort, privacy, and confidentiality. Both visual and audio privacy are important, and the placement and selection of the rooms should consider this. Appropriate telehealth equipment and networks must be used considering factors such as appropriate screen size, resolution, and security. Providers and/or members may provide or receive telehealth services outside of Oklahoma when medically necessary; however, prior authorization may be required, per OAC 317:30-3-89 through 317:30-3-91.
(4) The provider must be contracted with SoonerCare and appropriately licensed ~~for the service to be provided~~or certified, in good standing. Services that are provided must be within the scope of the practitioner's license or certification. If the provider is outside of Oklahoma, the provider must comply with all laws and regulations of the provider's location, including health care and telehealth requirements.
(5) If the member is a minor~~ child~~, a ~~parent/guardian~~parent or legal guardian must present the minor ~~child~~ for telehealth services unless otherwise exempted by State or Federal law. The ~~parent/guardian~~parent or legal guardian need not attend the telehealth session unless attendance is therapeutically appropriate. The requirements of subsection OAC 317:30-3-27(c)(5), however, do not apply to telehealth services provided in a primary or secondary school setting.
(6) The member retains the right to withdraw at any time.
(7) All telehealth activities must comply with ~~the HIPAA Security Standards, OHCA~~Oklahoma Health Care Authority (OHCA) policy, and all other applicable State and Federal laws and regulations, including, but not limited to, 59 O.S. § 478.1.
(8) The member has access to all transmitted medical information, with the exception of live interactive video as

there is often no stored data in such encounters.

(9) There will be no dissemination of any member images or information to other entities without written consent from the member or member's parent or legal guardian, if the member is a minor.

(10) A telehealth service is subject to the same SoonerCare program restrictions, limitations, and coverage which exist for the service when not provided through telehealth; provided, however, that only certain telehealth codes are reimbursable by SoonerCare. For a list of the SoonerCare-reimbursable telehealth codes, refer to the OHCA's Behavioral Health Telehealth Services and Medical Telehealth Services, available on OHCA's website, www.okhca.org.

(d) **Additional requirements specific to telehealth services in a school setting.** In order for OHCA to reimburse medically necessary telehealth services provided to SoonerCare members in a primary or secondary school setting, all of the requirements in (c) above must be met, with the exception of (c)(5), as well as all of the requirements shown below, as applicable.

(1) **Consent requirements.** Advance parent or legal guardian consent for telehealth services must be obtained for minors, in accordance with 25 O.S. §§ 2004 through 2005. Additional consent requirements shall apply to school-based services provided pursuant to an IEP, per OAC 317:30-5-1020.

(2) **Notification requirements.** For telehealth medical services provided in a primary or secondary school setting, the telehealth practitioner must provide a summary of the service, including, but not limited to, information regarding the exam findings, prescribed or administered medications, and patient instructions, to:

(A) The SoonerCare member, if he or she is an adult, or the member's parent or legal guardian, if the member is a minor; or

(B) The SoonerCare member's primary care provider, if requested by the member or the member's parent or legal guardian.

(3) **Requirements specific to physical therapy, occupational therapy, and/or speech and hearing services.** Even though physical therapy, occupational therapy, and/or speech and hearing services are not subject to the notification requirements of OAC 317:30-3-27(d)(2), said services must still comply with all other State and Federal Medicaid requirements, in order to be reimbursable by Medicaid. Accordingly, for those physical therapy, occupational therapy, and/or speech and hearing services that are provided in a primary or secondary school setting, but that are not school-based services (i.e.,

not provided pursuant to an IEP), providers must adhere to all State and Federal requirements relating to prior authorization and prescription or referral, including, but not limited to, 42 C.F.R. § 440.110, OAC 317:30-5-291, OAC 317:30-5-296, and OAC 317:30-5-676.

~~(d)~~ (e) **Reimbursement.**

(1) Health care services delivered by telehealth such as Remote Patient Monitoring, Store and Forward, or any other telehealth technology, must be compensable by OHCA in order to be reimbursed.

(2) Services provided by telehealth must be billed with the appropriate modifier.

(3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed during a telehealth transmission, the technical component can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.

(4) The cost of telehealth equipment and transmission is not reimbursable by SoonerCare.

~~(e)~~ (f) **Documentation.**

(1) Documentation must be maintained by the rendering provider to substantiate the services rendered.

(2) Documentation must indicate the services were rendered via telehealth, and the location of the services.

(3) All other SoonerCare documentation guidelines apply to the services rendered via telehealth. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

~~(f)~~ (g) **Final authority.** The OHCA has discretion and the final authority to approve or deny any telehealth services based on agency and/or SoonerCare members' needs.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-17. Nursing Facility Cost Report Appeals

Any long-term care facility has the right to administratively appeal any cost adjustment(s) made by the Oklahoma Health Care Authority (OHCA) to the facility's annual cost report, in accordance with Oklahoma Administrative Code (OAC) 317:30-5-132, or any cost report reconsideration decision, in accordance with OAC 317:30-5-132.1.

(1) The following are appealable issues of the program:

(A) Any disputed adjustment(s) that are made by the OHCA to the facility's annual cost report, in accordance with OAC 317:30-5-132(5); or

(B) Any disputed cost report adjustment reconsideration decision, made by OHCA's Chief Financial Officer or his/her designee in accordance with OAC 317:30-5-132.1.

(2) Appeals are heard by the OHCA Administrative Law Judge (ALJ).

(3) To file an appeal, the provider shall file an LD-2 form within thirty (30) days of the date of the written notice of the OHCA's report adjustment(s) that resulted from an on-site audit, or a cost report reconsideration decision, as applicable.

(4) The LD-2 shall only be filed by the provider or the provider's attorney in accordance with five (5) below.

(5) Consistent with Oklahoma rules of practice, the provider shall be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma shall comply with Article II, Section (§) 5 of Title 5 of the Oklahoma Statutes (O.S.), and rules of the Oklahoma Bar Association.

(6) Parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(7) The long-term care facility has the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.

(8) The docket clerk will send the long-term care facility and any other necessary party a notice which states the hearing location, date, and time.

(9) The ALJ may:

(A) Identify and rule on issues being appealed which will be determined at the administrative hearing;

(B) Require the parties to state their positions concerning appeal issue(s);

(C) Require the parties to produce for examination those relevant witnesses and documents under their control;
(D) Rule on whether witnesses have knowledge of the facts at issue;
(E) Establish time limits for the submission of motions or memoranda;
(F) Rule on relevant motions, requests, and other procedural items, limiting all decisions to procedural matters and issues directly related to the contested determination resulting from OAC 317:30-5-132 and /or 317:30-5-132.1;
(G) Rule on whether discovery requests are relevant;
(H) Strike or deny witnesses, documents, exhibits, discovery requests, and other requests or motions which are cumulative, not relevant, not material, or used as a means of harassment, unduly burdensome, or not timely filed;
(I) Schedule pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end the appeal;
(J) Impose appropriate sanctions against any party failing to obey an order of the ALJ;
(K) Rule on any requests for extension of time;
(L) Dismiss an issue or appeal if:
(i) It is not timely filed or is not within the OHCA's jurisdiction or authority; and/or
(ii) It is moot or there is insufficient evidence to support the allegations; and/or
(iii) The appellant fails or refuses to appear for a scheduled meeting, conference, or hearing; and/or
(iv) The appellant refuses to accept a settlement offer which affords the relief the party could reasonably expect if the party prevailed in the appeal; and/or
(M) Set and/or limit the time frame for the hearing.
(10) After the hearing:
(A) The ALJ should attempt to make the final hearing decision within ninety (90) days from the date of the hearing and send a copy of the ALJ's decision to both parties outlining their rights to appeal the decision. Any appeal of the final order pursuant to 12 O.S. § 951 shall be filed with the District Court of Oklahoma County within thirty (30) days.
(B) It shall be the duty of the appellant in any district court appeal to order a written transcript of proceedings to be used on appeal as required by 12 O.S. § 951.
(11) All orders and settlements are non-precedential decisions.
(12) The hearing shall be digitally recorded.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-132. Cost reports

Each Medicaid-participating ~~long term~~long-term care facility is required to submit an annual uniform cost report, designed by ~~OHCA,~~the Oklahoma Health Care Authority (OHCA), for the state fiscal year just completed. The state fiscal year is July 1 through June 30. The reports must be submitted to the OHCA on or before ~~the last day of~~ October ~~of the subsequent year.~~31.

(1) The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions.

(2) The cost report must be filed using the Secure Website. The instructions and data entry screen simulations will be made available on the OHCA public website.

(3) When there is a change of operation or ownership, the selling or closing ownership is required to file a cost report for that portion of the fiscal year it was in operation. The successor ownership is correspondingly required to file a cost report for that portion of the fiscal year it was in operation. These "Partial Year Reports" must be filed on paper or electronically by e-mail (not on the secure website system) to the Finance Division of the OHCA on the forms and by the instructions found on the OHCA public website (see directions as noted above).

(4) Normally, all ordinary and necessary expenses net of any offsets of credits incurred in the conduct of an economical and efficiently operated business are recognized as allowable. Allowable costs include all items of Medicaid-covered expense which ~~nursing~~long-term care facilities incur in the provision of routine services. "Routine services" include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, dental examinations, dentures and related services, eye glasses, routine eye examinations, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. Reasonable costs shall be such as would ordinarily be incurred

for comparable services by comparable facilities. Necessary and proper costs related to patient care are usually costs which are common and accepted occurrences in the field of the provider's activity. [(The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.)] Ancillary items reimbursed outside the ~~nursing~~long-term care facility rate are not included in the cost report and are not allowable costs.

(5) All reports are subject to on-site audits and are deemed public records.

317:30-5-132.1. Reconsideration of cost report adjustments

(a) A long-term care facility may request reconsideration of cost report adjustment(s)/finding(s) within thirty (30) calendar days of the date of notification of the cost adjustment(s) by submitting a request for reconsideration to the Oklahoma Health Care Authority (OHCA), Chief Financial Officer (CFO), Finance /NF Cost Reporting, 4345 North Lincoln Boulevard, Oklahoma City, Oklahoma 73105.

(b) Simultaneous with the request for reconsideration, the long-term care facility shall submit a statement as to why the request for reconsideration is being made and may submit any new or additional information that he or she wishes the CFO or his/her designee to consider. Any request for an informal meeting according to subsection (c), below, must be made at the same time as the request for reconsideration.

(c) At the request of the long-term care facility, the reconsideration may be conducted by the CFO or his/her designee as:

(1) An informal meeting between the long-term care facility and the CFO or his/her designee; or

(2) A review by the CFO or his/her designee of the information described below:

(A) A review of all information submitted by the long-term care facility; and,

(B) A review of the cost report adjustments made by the OHCA, in order to determine the accuracy of the adjustments.

(d) The CFO or his/her designee shall send a written decision of the reconsideration to the long-term care facility within thirty (30) calendar days of the date of OHCA's receipt of the reconsideration request, or the date of any informal meeting, whichever occurs later.

317:30-5-132.2. Allowable Costs

The Oklahoma Health Care Authority (OHCA) shall reimburse long-term care facilities in accordance with its Oklahoma Medicaid State Plan. According to the Oklahoma Medicaid State Plan, per-diem rates for long-term care facilities are established on, among other

things, analyses of annual uniform cost reports. These reports may only include allowable costs, as follows:

(1) To be allowable, the costs shall be reasonable and necessary for services related to resident care, and pertinent to the operation of the long-term care facility. More specifically:

(A) To be reasonable, costs shall be such as would ordinarily be incurred for comparable services provided by comparable facilities (facilities of similar size and level of care);

(B) To be necessary, costs related to patient care must be common and accepted occurrences; and,

(C) Allowable costs for services and items directly related to resident care include routine services, as established by Oklahoma Administrative Code (OAC) 317:30-5-133.1, and Quality of Care assessment fees, as established by OAC 317:30-5-131.2. Ancillary services, as established by OAC 317:30-5-133.2, are not allowable costs, but may be reimbursed outside the long-term care facility rate, unless reimbursement is available from Medicaid or other insurance or benefit programs.

(2) The following costs shall not be allowable:

(A) Costs that are a result of inefficient operations;

(B) Costs resulting from unnecessary or luxurious care;

(C) Costs related to activities not common and accepted in a long-term care facility, as determined by OHCA or its designee;

(D) Costs that are not actually paid by the provider, including, but not limited to, costs that are discharges in bankruptcy, forgiven, or converted to a promissory note;

(E) Costs that are paid to a related party that has not been identified on the reports;

(F) Cost of services, facilities, and supplies furnished by organizations related to the provider, by common ownership or control, that exceed the price of comparable services, facilities, or supplies purchased by independent providers in Oklahoma, in accordance with 42 Code of Federal Regulations § 431.17; and,

(G) Costs or financial transactions used to circumvent OHCA's applicable reimbursement rules.

(3) Allowable costs shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual, HCFA-Pub. 15.

317:30-5-136.1. ~~Focus on Excellence~~Paid-for-Performance program

(a) **Purpose.** The ~~Focus on Excellence (FOE)~~Paid-for-Performance (PFP) program was established through Oklahoma State Statute,

Title 56, Section 56-1011.5. ~~FOE's~~PFP's mission is to enhance the quality of life for target citizens by delivering effective programs and facilitating partnerships with providers and the community they serve. The program has a full commitment to the very best in quality, service and value which will lead to measurably improved quality outcomes, healthier lifestyles; greater satisfaction and confidence for our members.

(b) **Eligible Providers.** Any Oklahoma long-term care nursing facilities that are licensed and certified by the Oklahoma State Department of Health and accommodate SoonerCare members at their facility as defined in Oklahoma Administrative Code (OAC) 317:30-5-120.

(c) **Quality measure care criteria.** To maintain status in the ~~FOE~~PFP program, each ~~nursing~~long-term care facility ~~must enter quality data either monthly, quarterly, annually for the following care criteria metrics. All metrics in detail can be found on the Oklahoma Health Care Authority's (OHCA) FOE website or on FOE/QOC (Quality of Care) Data Collection Portal.~~shall submit documentation as it relates to program metrics (below) upon the request of the Oklahoma Health Care Authority (OHCA). The program metrics can be found on the OHCA's PFP website or on PFP/Quality of Care (QOC) data collection portal.

~~(1) **Person-Centered Care.** Facility must meet six (6) out of ten (10) of the established measurement criteria for this metric to receive the points. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.~~

~~(2) **Direct-Care Staffing.** Facility must maintain a direct care staffing ratio of three and a half (3.5) hours per patient day to receive the points for this metric. This metric must be completed monthly by the 15th of each month.~~

~~(3) **Resident/Family Satisfaction.** Facility must maintain a score of 76 of a possible 100 points on overall satisfaction to receive the points for this metric. This metric is collected in a survey format and must be completed once a year in the fall. Surveys are to be completed by the resident, power of attorney and/or with staff assistance.~~

~~(4) **Employee Satisfaction.** Facility must maintain a score of 70 points or higher in order to receive the points for this metric. Surveys are completed by FOE facility employees and must be completed once a year in the fall.~~

~~(5) **Licensed-Nurse Retention.** Facility must maintain a one-year tenure rate of 60 percent (60%) or higher of its licensed nursing staff to receive the points for this metric. This metric must be completed monthly by the 15th of the month.~~

~~(6) **Certified Nurse Assistant (CNA) Retention.** Facility must maintain a one-year tenure rate of 50 percent (50%) or higher~~

~~of its CNA staff to receive the points for this metric. This metric must be completed monthly by the 15th of the month.~~

~~(7) **Distance Learning Program Participation.** Facility must contract and use an approved distance learning vendor for its frontline staff in order to receive points for this metric. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.~~

~~(8) **Peer Mentoring.** Facility must establish a peer-mentoring program in accordance with OHCA guidelines. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.~~

~~(9) **Leadership Commitment.** Facility must meet six (6) out of ten (10) of the established measurement criteria for this metric to receive the points. This metric is measured quarterly and must be completed by the 15th of the month following the close of the quarter.~~

(d) For the period beginning October 1, 2019 and until changed by amendment, qualifying facilities participating in the PFP program have the potential to earn an average of the five dollars ($5.00) quality incentive per Medicaid patient per day. Facility(s) baseline is calculated annually and will remain the same for the twelve (12) month period. Facility(s) will meet or exceed five-percent (5%) relative improvement or the CMS national average each quarter for the following metrics:

(1) Decrease of high risk pressure ulcer for long stay residents.

(2) Decrease percent of unnecessary weight loss for long stay residents.

(3) Decrease percent of use of anti-psychotic medications for long stay residents.

(4) Decrease percent of urinary tract infection for long stay residents.

~~(d)~~(e) **Payment.** ~~The amount of eligible dollars is reimbursable based on the SoonerCare FOE nursing facility meeting the quality metric thresholds listed in (b). Facilities must meet a minimal of 100 points to even be eligible for reimbursement.~~Payment to nursing facilities for meeting the metrics will be awarded quarterly. A facility may earn a minimum of $1.25 per Medicaid patient per day for each qualifying metric. A facility receiving a deficiency of "I" or greater related to a targeted quality measure in the program is disqualified from receiving an award related to that measure for that quarter.

(1) **Distribution of Payment.** OHCA will notify the ~~FOE~~PFP facility of the quality reimbursement amount on a quarterly basis.

(2) **Penalties.** Facilities ~~that do not submit on the appropriate due dates will not receive reimbursable dollars. Facilities~~

~~that do not submit quality measures will not receive reimbursable dollars for those specific measures. Due dates can be found on the OHCA FOE webpage.~~shall have performance review(s) and provide documentation upon request from OHCA to maintain program compliance. Program payments will be withheld from facilities that fail to submit the requested documentation fifteen (15) days after the submission due date.

~~(e)~~(f) **Appeals.** Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC 317:2-1-2(c) and 317:2-1-16.

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~~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 and targeted case management services**. 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. Services under behavioral health targeted case management are not comparable in amount, duration and scope. The target ~~group~~groups 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 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 Oklahoma Department of Mental Health and Substance Abuse Services (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.

(B) The provider will coordinate transition services 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 other than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven (7) 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.

(C) Case ~~Managers~~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 (2) 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)~~ (D) 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)~~ (E) 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)~~ (F) 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 eighteen (18)], the behavioral health case manager, and a licensed behavioral health professional (LBHP) or licensure candidate as defined in OAC 317:30-5-240.3(a) and (b).

~~(E)~~ (G) 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~~health targeted case management is available to individuals transitioning from institutions to the community [except individuals ages twenty-two (22) to sixty-four (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 thirty (30) to thirty-five (35) members. Basic case management/resource coordination is limited to sixteen (16) units per member per year. Additional units may be authorized up to twenty-five (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 in PACT programs and Wraparound Facilitation Case Management (WFCM) is targeted to children with serious mental illness and emotional disorders being treated 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 ten (10) to fifteen (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.

(O) leaving voice or text messages for clients and other failed communication attempts.

(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 Oklahoma Department of Human Services (OKDHS) and Oklahoma Office of Juvenile Affairs (OJA) staff without special arrangements with OKDHS, OJA, and the Oklahoma Health Care Authority (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 Intermediate Care Facility for Individuals with Intellectual Disabilities (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 thirty (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.~~

(2) **Levels of case management.**

(A) Standard case management/resource coordination services are targeted to adults with serious mental illness or

children/adolescents with serious emotional disturbance, or who have or are at-risk for mental disorders, including substance use disorders (SUD), 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 case managers have caseloads of thirty (30) to thirty-five (35) members. Standard case management/resource coordination is limited to twelve (12) units per member per month. Additional units may be authorized up to twenty-five (25) units per member per month if medical necessity criteria for transitional case management are met.

(B) Intensive case management (ICM) is targeted to adults with serious and persistent mental illness in PACT programs. To ensure that these intense needs are met, caseloads are limited to between ten (10) to fifteen (15) members. The ICM shall: be a certified behavioral health case manager II; have a minimum of two (2) years' behavioral health case management experience; have crisis diversion experience; have attended the ODMHSAS six (6) hour ICM training and be available twenty-four (24) hours a day. ICM is limited to fifty-four (54) units per member per month.

(C) Wraparound facilitation case management (WFCM) is targeted to children/adolescents with significant mental health conditions being treated in a System of Care (SOC) Network who are deemed at imminent risk of out-of-home placement due to psychiatric or SUD reasons and in need of more intensive case management 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. Staff providing WFCM must meet the requirements for the SOC/WF. 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) Leaving voice or text messages for clients and other failed communication attempts.

(4) **Excluded individuals.** The following SoonerCare members who are receiving similar services through another method are not eligible for behavioral health case management services without special arrangements with the Oklahoma Department of Human Services (OKDHS), the Office of Juvenile Affairs (OJA), OHCA or ODMHSAS as applicable, in order to avoid duplication in payment. Services/programs include, but may not be limited to:

(A) Children/families for whom at-risk case management services are available through OKDHS and OJA staff
(B) Children/youth in out-of-home placement and receiving targeted case management services through staff in a foster care or group home setting, unless transitioning into the community;
(C) Residents of intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and nursing facilities unless transitioning into the community;
(D) Members receiving targeted case management services under a Home and Community Based Services (HCBS) waiver program; or
(E) Members receiving services in the health home program; or
(F) Members receiving case management through the ADvantage waiver program; or
(G) Members receiving targeted case management available through a Certified Community Behavioral Health Center (CCBHC); or
(H) Members receiving case management services through Programs of All-Inclusive Care for the Elderly (PACE); or
(I) Children receiving Early Intervention case management (EICM); or
(J) Children/youth receiving case management services through certified school providers (SBCM); or

(K) Children/youth receiving partial hospitalization services; or

(L) Children/youth receiving Multi-systemic Therapy (MST).

(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 thirty (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.