OKLAHOMA HEALTH CARE AUTHORITY
REGULAR SCHEDULED BOARD MEETING
September 13, 2018 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
OKC, OK

# A G E N D A

***Items to be presented by Alex Yaffe, Vice-Chairman***

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the August 9, 2018 OHCA Board Meeting Minutes

***Item to be presented by Carrie Evans, Deputy Chief Executive Officer***

3. Discussion Item – Chief Executive Officer's Report

   a) 2017 Fiscal Year Audit Findings – Amber Smith, Audit Manager, State Auditor and Inspection

   b) Medicaid Director's Update – Melody Anthony, Deputy State Medicaid Director

   c) Community Engagement Update – MaryAnn Martin, Senior Director of Communications

***Item to be presented by Nicole Nantois, Chief of Legal Services***

4. Announcements of Conflicts of Interest Panel Recommendations for All Action Items Regarding This Board Meeting.

***Item to be presented by Carrie Evans, Deputy Chief Executive Officer***

5. Action Item – Consideration and Vote Upon the Recommendations of the State Plan Amendment Rate Committee

   a) Consideration and Vote for a rate change to increase the most current provider rate and reimbursement structures in the SoonerCare program by 3.00%, with some exceptions. Upon passage of Senate Bill 1605, OHCA was mandated to increase most provider rates by 2.00%. However, OHCA is proposing to use program and administrative savings and increased drug rebate collections to increase provider rates by an additional one percent, bringing the rate increase to 3.00%. Per Senate Bill 1605, the proposed rate increases excludes: services financed through appropriations to other state agencies; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); non-emergency transportation capitation payments; services provided to Insure Oklahoma (IO) members; payments for drug ingredients/physician supplied drugs; Indian Health Services/Tribal/Urban Clinics (I/T/U); Federally Qualified Health Centers (FQHCs); Rural Health Centers (RHCs); and Long-Term Care Facilities, which will be discussed in the next four agenda items. Program for the All-Inclusive Care for the Elderly (PACE) was excluded from the legislatively mandated rate increases, however OHCA will increase these rates as well. The estimated budget impact for the remainder of SFY2019 will be an increase of $36,338,928 total; of which $13,670,705 is state share. The estimated budget impact for SFY2020 will be an increase of $45,451,904 total; of which $18,689,111 is state share.

   b) Consideration and Vote for a rate change to increase the base rate component to $108.12 for Regular Nursing Facilities and update the pool amount for these facilities in the state plan for the

"Other" and "Direct Care" components to $174,676,429. Upon passage of Senate Bill 1605, OHCA was mandated to increase long-term care facilities rates by 3.00%. However, OHCA is proposing to use program and administrative savings and increased drug rebate collections to increase provider rates by an additional one percent, bringing the rate increase to 4.00%. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.2% for Regular Nursing Facilities. The estimated budget impact for the remainder of SFY2019 will be an increase in the total amount of $15,899,520; with $6,132,445 in state share ($649,119 of the state share is from the increased QOC fee which is paid by the providers). The estimated budget impact for SFY2020 will be an increase in the total amount of $21,199,360; with $8,176,593 in state share ($1,144,723 of the state share is from the increased QOC fee which is paid by the providers).

c) Consideration and Vote for a rate change to increase the base rate component to $207.86 for the Acquired Immune Deficiency Syndrome (AIDS) rate for Nursing Facilities. Upon passage of Senate Bill 1605, OHCA was mandated to increased long-term care facilities rates by 3.00%. However, OHCA is proposing to use program and administrative savings and increased drug rebate collections to increase provider rates by an additional one percent, bringing the rate increase to 4.00%. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.2% for nursing facilities serving residents with AIDS. The estimated budget impact for the remainder of SFY2019 will be an increase in the total amount of $48,377; with $ $18,659 in state share ($1,959 of the state share is from the increased QOC fee which is paid by the providers). The estimated budget impact for SFY2020 will be an increase in the total amount of $64,503; with $ $24,879 in state share ($3,483 of the state share is from the increased QOC fee which is paid by the providers).

d) Consideration and Vote for a rate change to increase the base rate component to $127.49 for the Regular (More than 16 Beds) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Upon passage of Senate Bill 1605, OHCA was mandated to increase long-term care facilities rates by 3.00%. However, OHCA is proposing to use program and administrative savings and increased drug rebate collections to increase provider rates by an additional one percent, bringing the rate increase to 4.00%. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.5% for Regular ICF/IID facilities. The estimated budget impact for the remainder of SFY2019 will be an increase in the total of $657,562; with $253,622 in state share ($30,573 of the state share is from the increased QOC fee which is paid by the providers). The estimated budget impact for SFY2020 will be an increase in the total amount of $876,750; with $338,162 in state share ($54,200 of the state share is from the increased QOC fee which is paid by the providers).

e) Consideration and Vote for a rate change to increase the base rate component to $163.04 for the Acute (16 Beds or Less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). Upon passage of Senate Bill 1605, OHCA was mandated to increase long-term care facilities rates by 3.00%. However, OHCA is proposing to use program and administrative savings and increased drug rebate collections to increase provider rates by an additional one percent, bringing the rate increase to 4.00%. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.5% for Acute ICF/IID facilities. The estimated budget impact for the remainder of SFY2019 will be an increase in the total of $1,167,196; with $450,187 in state share ($53,786 of the state share is from the increased QOC fee which is paid by the providers). The estimated budget impact for SFY2020 will be an increase in the total amount of $1,556,261; with $600,250 in state share ($96,040 of the state share is from the increased QOC fee which is paid by the providers).

f) Consideration and Vote for a rate change to increase the Skill Nursing Services rate for State Plan Personal Care Program to $60.00 per visit. The estimated annual State Plan budget change for State Plan Skilled Nursing is an increase in the amount of $60,000 total dollars or $23,142 state share which is paid by the Department of Human Services.

g) Consideration and Vote for a rate change to increase Behavioral Health Licensure Candidates and Licensed Behavioral Health Professionals in Outpatient Behavioral Health Clinics by 3.00%. With this increase, behavioral health clinics would continue to not exceed the upper limit of 71.75% of the 2007 Medicare Physician Fee Schedule. Estimated cost to ODMHSAS for SFY2019 is $3,826,697 Total; $1,475,957 State Share.

***Item to be presented by Alex Yaffe, Vice-Chairman***

6. Discussion Item – Proposed Executive Session as Recommended by the Chief of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B)(1),(4) and (7).

   Discuss Pending CMS Action

7. New Business

8. ADJOURNMENT

NEXT BOARD MEETING
October 11, 2018
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULAR BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
August 9, 2018
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on August 8, 2018 at 12:45 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on August 3, 2018 at 1:18 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Armstrong called the meeting to order at 1:04 p.m.

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|---|---|
| BOARD MEMBERS PRESENT: | Chairman Armstrong, Vice-Chairman Yaffe, Member Bryant, Member Case, Member Hupfeld, Member Nuttle |
| BOARD MEMBERS ABSENT: | Member McVay |

| OTHERS PRESENT: | OTHERS PRESENT: |
|---|---|
| Carly Putnam, Oklahoma Policy Institute | Tyler Talley, eCap |
| Pam Jackson, OHCA | Alan Danielson, PMC |
| Lindsey Bateman, OHCA | Rhonda Mitchell, OHCA |
| Jennifer Wynn, OHCA | Folonda Cooper, OHCA |
| Will Widman, DXC | MaryAnn Martin, OHCA |
| Sandra Puebla, OHCA | Melinda Thomason, OHCA |
| LeKenya Antwine, OHCA | Kasie Wren, OHCA |
| Garth Splinter | Mike Fogarty |
| Christopher Chesny, Journal Record LR | Mike Herndon, OHCA |
| David Dude, American Cancer Society | Marty Wafford, Chickasaw Nation |
| Katelynn Burns, OHCA | Stephanie Mavredes, OHCA |
| Sasha Teel, OHCA | Kyle Janzen, OHCA |
| Gloria LaFitte, OHCA | Harvey Reynolds, OHCA |
| Kelli Brodersen, OHCA | Della Gregg, OHCA |
| Aaron Morris, OHCA | Dwyna Vick, OHCA |
| David Ward, OHCA | Mary Brinkley, Leading Age OK |
| Daryn Kirkpatrick, OHCA | |

**DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULAR SCHEDULED BOARD MEETING HELD June 28, 2018.**

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

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| MOTION: | Member Case moved for approval of the June 28, 2018 board meeting minutes as published. The motion was seconded by Member Hupfeld. |
| FOR THE MOTION: | Chairman Armstrong, Vice-Chairman Yaffe, Member Bryant |
| ABSTAINED: | Member Nuttle |
| BOARD MEMBERS ABSENT: | Member McVay |

**ITEM 3A / EMPLOYEE RECOGNITION**

The following OHCA employees were recognized

- April All-Star – Pam Jackson, Care Management Supervisor
- June All-Star – Martina Ordonez, Executive Assistant

**ITEM 3B / FINANCIAL UPDATE**
Aaron Morris, Chief Financial Officer

Mr. Morris gave a brief update on OHCA's May and June financials. OHCA has a positive $12.9 million state dollar variance. The agency is over budget in program spending by $3.1 million state dollars and under budget in administrative spending by $4. million state dollars. OHCA continues to run over budget in drug rebates by $8.7 million state dollars and tobacco tax revenues by $4.5 million state dollar. OHCA is running under budget in medical refunds by $1.3 million state dollars. For May, For June, OHCA has a positive $29.8 million state dollar variance. The agency is over budget in program spending by $7.3 million state dollars and under budget in administrative spending by $4.9 million state dollars. OHCA continues to run over budget in drug rebates by $15.3 million state dollars and tobacco tax revenues by $0.7 million state dollar. OHCA is running under budget in medical refunds by $1.4 million state dollars. For more detailed information, see Item 3b in the board packet.

**ITEM 3C / MEDICAID DIRECTOR'S UPDATE**
Melody Anthony, Deputy State Medicaid Director

Ms. Anthony provided an update for June 2018 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program and total in-state providers. Ms. Anthony also presented charts showing monthly enrollment, a monthly trend in enrollment for Choice, Traditional and Insure Oklahoma and enrollment by state fiscal year. For more detailed information, see Item 3c in the board packet.

**ITEM 3D / ABD Wraparound Initiative**
Della Gregg, HMP Manager

Ms. Gregg gave an ABD Wraparound Initiative update, which included information on the background, structure, a status report, the future and the social screening. For more detailed information, see item 3d in the board packet.

**ITEM 3E / Community Engagement Update**
Tywanda Cox, Chief of Federal and State Policy

Ms. Cox gave a Community Engagement update, which included information on the background of the work/community engagement legislation that passed in May 2018, who it will impact, who is exempt, additional proposed exemptions and the timeline. For more detailed information, see item 3e in the board packet.

**ITEM 3F / Regional Strategy Forum Update**
Beth Van Horn, Strategic Planning & Reform Director

Ms. Van Horn gave a Regional Strategy Forum update, which included information on the seven forums scheduled in different regions throughout Oklahoma. For more detailed information, see item 3f in the board packet.

**ITEM 4 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS**
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

**ITEM 5A-D / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUES 5030.3.**
Burl Beasley, Assistant Director of Pharmacy Services

a) **Crysvita® (Burosumab-twza)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) **Imfinzi® (Durvalumab) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).**

c) **Erleada™ (Apalutamide) and Yonsa® (Abiraterone)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

d) **Lyrica® CR (Pregabalin Extended-Release), Restasis MultiDose® (Cyclosporine 0.05% Ophthalmic Emulsion), Sinuva™ (Mometasone Furoate Sinus Implant), and ZTlido™ (Lidocaine 1.8% Topical System) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).**

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| MOTION: | Vice-Chairman Yaffe moved for approval of item 5a-d as published. The motion was seconded by Member Hupfeld |
| FOR THE MOTION: | Chairman Armstrong, Member Bryant, Member Case, Member Nuttle |
| BOARD MEMBERS ABSENT: | Member McVay |

**ITEM 6 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4)**

Nicole Nantois, Chief of Legal Services

Chairman Armstrong entertained a motion to go into Executive Session at this time.

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| MOTION: | Member Case moved for approval to move into Executive Session. The motion was seconded by Member Bryant |
| FOR THE MOTION: | Chairman Armstrong, Vice-Chairman Yaffe Member Hupfeld, Member Nuttle |
| BOARD MEMBERS ABSENT: | Member McVay |

**ITEM 7 / NEW BUSINESS**

There was no new business.

**ITEM 8 / ADJOURNMENT**

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| MOTION: | Member Hupfeld moved for approval for adjournment. The motion was seconded by Vice-Chairman Yaffe |
| FOR THE MOTION: | Chairman Armstrong, Member Case, Member Bryant, Member Nuttle |
| BOARD MEMBERS ABSENT: | Member McVay |

Meeting adjourned at 2:33 p.m., 8/9/2018

NEXT BOARD MEETING
September 13, 2018
Oklahoma Health Care Authority
Oklahoma City, OK

*Martina Ordonez*
*Board Secretary*

*Minutes Approved:* _____

*Initials:*_____

# SINGLE AUDIT FINDING INPUT SHEET
# FISCAL YEAR 2017

| REPORTABLE FINDING: | | X-Ref: |
|---|---|---|
| | Significant Deficiency | Prepared by: GP 3/27/18 |
| | Material Weakness | Reviewed by: AY 3-30-18 |
| x | Compliance | |
| Date Delivered: 4/4/2018 | | Reviewed by: AS 4.4.2018 |
| Likely Questioned Costs: $4,518,446 | | Document No. |
| NON-REPORTABLE: Reason: | | |

**FINDING NO:** 2017-033 (Repeat 2016-006)
**STATE AGENCY:** Oklahoma Health Care Authority
**FEDERAL AGENCY:** United States Department of Health and Human Services
**CFDA NO:** 93.778
**FEDERAL PROGRAM NAME:** Medicaid Cluster
**FEDERAL AWARD NUMBER:** 1605OK5MAP and 1705OK5MAP
**FEDERAL AWARD YEAR:** 2016 and 2017
**CONTROL CATEGORY:** Activities Allowed or Unallowed and Allowable Costs/Cost Principles; Matching
**QUESTIONED COSTS:** $45

***Criteria:*** 45 CFR §75.403 (Subpart E) states in part, "Costs must…
(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles, and (b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items."

***Condition and Context:*** Medical payments are either direct medical payments that are initiated by the provider, or are indirectly related to medical claims and are not initiated by the provider, such as the cost of non-emergency transportation to appointments or capitation payments to primary care providers based on the number of enrolled members. Based on a medical professional's review of 57 direct medical claims initiated by the provider for Medical Assistance Program recipients, two (3.51%) claims had payment errors. One claim was billed using an incorrect rendering provider, while the other claim billed more units than the support documented. For these claims, since the supporting documentation indicated the services provided did not meet Medicaid policy/regulatory requirements and were not adequately supported by medical records or other evidence indicating that the services were actually provided and/or necessary, we will question the costs. The universe included 24,178,498 direct medical payments totaling $4,045,332,849. Payments for direct medical expenditures sampled totaled $40,056. Payments for direct medical expenditures with non-compliance noted in the sample totaled $74, of which $45 ($74 times the applicable Federal Medical Assistance Percentage (FMAP) rate (60.99% for the exception claim in the first quarter/59.94% for the claim in the second quarter) for each exception claim is the federal questioned costs.

***Cause:*** One (1) claim submitted by a provider was not appropriately supported by medical records, and one (1) claim had documentation submitted to the Authority which indicated an incorrect provider number.

***Effect:*** The Authority may be paying for services that are not being performed or are not medically necessary

***Recommendation:*** We recommend the Authority investigate the items identified and, if considered necessary, recoup any funds paid to providers for services that were not supported by medical records.

***Views of Responsible Official(s)***
***Contact Person:*** Josh Richards
***Anticipated Completion Date:*** June 30, 2018
***Corrective Action Planned:*** OHCA will continue its Clinical Audit and Payment Accuracy Measurement processes to ensure oversight of the program. OHCA will also continue with provider training to better educate our providers. Regarding these specific findings, the federal share will be returned to CMS.

# SINGLE AUDIT FINDING INPUT SHEET
# FISCAL YEAR 2017

| REPORTABLE FINDING: | | X-Ref: |
|---|---|---|
| X | Significant Deficiency | Prepared by: GP 4/10/18 |
| | Material Weakness | |
| X | Compliance | Reviewed by: AY 4-10-18 |
| Date Delivered: 4/4/2018 | | Reviewed by: AS 4.10.2018 |
| Likely Questioned Costs: $1,662,666 | | Document No. |
| NON-REPORTABLE: Reason: | | |

**FINDING NO:** 2017-004 (Repeat 2016-008)
**STATE AGENCY:** Oklahoma Health Care Authority
**FEDERAL AGENCY:** United States Department of Health and Human Services
**CFDA NO:** 93.778
**FEDERAL PROGRAM NAME:** Medicaid Cluster
**FEDERAL AWARD NUMBER:** 1605OK5MAP and 1705OK5MAP
**FEDERAL AWARD YEAR:** 2016 and 2017
**CONTROL CATEGORY:** Activities Allowed or Unallowed and Allowable Costs/Cost Principles; Eligibility
**QUESTIONED COSTS:** $1,312

***Criteria:*** 42 CFR §435.916(b) states, "The agency must re-determine the eligibility of Medicaid beneficiaries excepted from modified adjusted gross income under §435.603(j) of this part, for circumstances that may change, at least every 12 months".

42 CFR §431.10(c)(2) states, "The Medicaid agency may delegate authority to make eligibility determinations or to conduct fair hearings under this section only to a government agency which maintains personnel standards on a merit basis."

42 CFR §431.10(c)(3)(ii) states in part, "The Medicaid agency must exercise appropriate oversight over the eligibility determinations and appeals decisions made by such agencies ..."

45 CFR §75.303 states, "The non-Federal entity must:(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)."

Additionally, a component objective of generally accepted accounting principles is to provide accurate and reliable information.

***Condition and Context:*** The Authority delegates the Oklahoma Department of Human Services (DHS) to determine eligibility for non-MAGI (modified adjusted gross income) recipients. For one of the 80 (1.25%) non-MAGI recipients of Medical Assistance Program payments tested, a redetermination of Medicaid eligibility had not been performed within 12 months of the last eligibility determination or redetermination and benefits were not discontinued after the period of eligibility expired. The recipient was ineligible for a portion of state fiscal year 2017. For five of the 80 (6.25%) non-MAGI recipients of Medical Assistance Program payments tested, the recipient passed away during our audit period; however, the recipient had claims paid with date of service after their date of death. The universe included 241,645 non-MAGI recipients with medical expenditures totaling $2,601,060,240. Payments for medical expenditures for recipients sampled totaled $2,058,696. Questioned costs include all payments to those six recipients within the time period for which they were ineligible during SFY 2017. Payments for medical expenditures to recipients with non-compliance noted in the sample totaled $2,186, of which $1,312 ($2,186 times the applicable Federal Medical Assistance Percentage (FMAP) rate (60.99% for the exception claims in the first quarter/59.94% for the claims in the second, third, and fourth quarters) for each exception claim is the federal questioned costs.

***Cause:*** The Authority did not exercise appropriate oversight over the eligibility determinations made by DHS to ensure adequate controls are in place to properly close ineligible cases.

***Effect:*** The Authority may be paying for services for which the recipient is not entitled.

***Recommendation:*** We recommend the Authority investigate the recipients identified and, if considered necessary, recoup any funds paid to providers for services that the recipients were not entitled to. We also recommend the Authority take steps to ensure proper oversight over DHS eligibility determinations in order to identify and timely close any ineligible cases.

***Views of Responsible Official(s)***
***Contact Person:*** Josh Richards
***Anticipated Completion Date:*** June 1, 2018
***Corrective Action Planned:*** OHCA will continue to monitor member eligibility and implement appropriate system changes and internal controls to ensure appropriate eligibility determinations and closures occur to avoid inappropriate payments. DHS will provide training and oversight to ensure 12-month redeterminations are completed in a timely manner. For the one instance of untimely redetermination the review has been completed. The five cases related to death match issues are closed and no further payments will occur. OHCA will continue to audit death matches. OHCA will recoup where appropriate, and will reimburse the Federal share for claims paid during periods of ineligibility.

# SINGLE AUDIT FINDING INPUT SHEET
# FISCAL YEAR 2017

| REPORTABLE FINDING: | | X-Ref: |
|---|---|---|
| | | Prepared by: AS 3.16.2018 |
| x | Significant Deficiency | |
| | Material Weakness | Reviewed by: AY 4-4-18 |
| | Compliance | |
| Date Delivered: 4/4/2018 | | Reviewed by: |
| Likely Questioned Costs: $0 | | Document No. |
| NON-REPORTABLE: Reason: | | |

**FINDING NO:** 2017-002 (Repeat 2016-004)
**STATE AGENCY:** Oklahoma Health Care Authority
**FEDERAL AGENCY:** United States Department of Health and Human Services
**CFDA NO:** 93.767; 93.778
**FEDERAL PROGRAM NAME:** Children's Health Insurance Program (CHIP); Medicaid Cluster (MAP)
**FEDERAL AWARD NUMBER:** 1605OK5021 and 1705OK0301; 1605OK5MAP and 1705OK5MAP
**FEDERAL AWARD YEAR:** 2016 and 2017
**CONTROL CATEGORY:** Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Eligibility (*MAP only*)

***Criteria:*** 45 CFR §75.303 states, "The non-Federal entity must:(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)."

The Government Accountability Office (GAO) Standards for Internal Control in the Federal Government 10.03 states, in part, "Transactions are promptly recorded to maintain their relevance and value to management in controlling operations and making decisions. This applies to the entire process or life cycle of a transaction or event from its initiation and authorization through its final classification in summary records. In addition, management designs control activities so that all transactions are completely and accurately recorded."

The GAO Standards for Internal Control in the Federal Government 10.13 states, in part, "Segregation of duties helps prevent fraud, waste, and abuse in the internal control system. Management considers the need to separate control activities related to authority, custody, and accounting of operations to achieve adequate segregation of duties."

Adequate internal controls over access and accountability for resources include (1) limiting access to resources and records to authorized individuals and (2) assigning and maintaining accountability for the custody and use of resources.

Adequate internal controls over separation of duties and supervision include separating key duties and responsibilities in authorizing, processing, recording, and reviewing official agency transactions.

***Condition and Context:*** The Independent Service Auditor's Report on the Service Organization's System (SOC-1) for the period of September 1, 2015 to August 31, 2016 indicated (1) a segregation of duties control issue related to the organization and administration control objective and related controls for transaction processing; and (2) control issues related to the application, operating system and database development and maintenance and access to data and programs control objectives and related controls for the general computer controls.

The SOC-1 for the period of September 1, 2016 to August 31, 2017 indicated control issues related to the job scheduling and access to data and programs control objectives and related controls for the general computer controls.

***Cause:*** There was a lack of segregation of duties over the production changes within the application. However, change requests, implemented by developers who promoted their own changes during the period of examination were approved prior to implementation of each change.

The Service Organization did not ensure users were restricted only to either development or production access in the job scheduling.

The Service Organization did not ensure active users had appropriate access or terminated users were eliminated from the access to data and programs. Inappropriate user access increases the risk of waste, loss, unauthorized use or misappropriation of State and/or Federal funds.

***Effect:*** Lack of segregation of duties over the production changes within the application, access to both development and production, and inappropriate use access increase the risk of waste, loss, unauthorized use or misappropriation of State and/or Federal funds.

***Recommendation:*** We recommend the agency continue to follow-up with the service organization and ensure noted deficiencies are addressed and corrective actions noted in the SOC-1 report are implemented in a timely manner.

***Views of Responsible Official(s)***
***Contact Person:*** Josh Richards
***Anticipated Completion Date:*** March 31, 2018
***Corrective Action Planned:*** The Oklahoma Health Care Authority had direct communications with our service provider about these deficiencies and their corrective actions during regularly scheduled status meetings on December 21, 2017 and January 18, 2018. All of these deficiencies have already been corrected with the last issue (5.2) corrected March 31, 2018. Deficiency 6.3 was corrected in July 2017 and processes were implemented in October 2017 to prevent future issues. Deficiencies 8.7 and 8.9 were corrected in October of 2017 and processes were started in July to prevent further issues. Deficiencies 8.13 and 8.15 were corrected in July of 2017 and processes were started in July to prevent further issues. These findings and corrective

actions are monitored monthly by the agency Security Governance Committee to ensure actions are taken timely and are appropriate.

***Auditor Response:*** The Authority indicated in its corrective action plan that the deficiencies noted in the SOC-1 report were followed-up on with their service provider and corrective actions were implemented. These corrective actions occurred outside the audit period. Therefore, no determinations on the corrections were made.

# SINGLE AUDIT FINDING INPUT SHEET
# FISCAL YEAR 2017

| REPORTABLE FINDING: | | X-Ref: |
|---|---|---|
| | | Prepared by: GP 4/5/18 |
| X | Significant Deficiency | |
| | Material Weakness | Reviewed by: AY 4-5-18 |
| | Compliance | |
| Date Delivered: | | Reviewed by: AS 4.5.2018 |
| Likely Questioned Costs: | | Document No. |
| NON-REPORTABLE: Reason: | | |

**FINDING NO:** 2017-005
**STATE AGENCY:** Oklahoma Health Care Authority (OHCA)
**FEDERAL AGENCY:** United States Department of Health and Human Services
**CFDA NO:** 93.767; 93.778
**FEDERAL PROGRAM NAME:** Children's Health Insurance Program (CHIP); Medicaid Cluster (MAP)
**FEDERAL AWARD NUMBER:** 1605OK5021 and 1705OK0301; 1605OK5MAP and 1705OK5MAP
**FEDERAL AWARD YEAR:** 2016 and 2017
**CONTROL CATEGORY:** Activities Allowed or Unallowed and Allowable Costs/Cost Principles; Matching; Reporting

***Criteria:*** 45 CFR §75.303(a) states in part, "The non-Federal entity must: Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)."

The Government Accountability Office (GAO) Standards for Internal Control in the Federal Government section OV4.01 states, "Management may engage external parties to perform certain operational processes for the entity, such as accounting and payroll processing, security services, or health care claims processing. For the purpose of the Green Book, these external parties are referred to as service organizations. Management, however, retains responsibility for the performance of processes assigned to service organizations."

The GAO Standards for Internal Control in the Federal Government section 11.05 states, "Management also evaluates information processing objectives to meet the defined information requirements. Information processing objectives may include …completeness, accuracy, and validity."

The GAO Standards for Internal Control in the Federal Government section 15.04 states, "Management receives information through reporting lines from external parties. Information communicated to management includes significant matters relating to risks, changes, or issues that impact the entity's internal control system. This communication is necessary for the effective operation of internal control. Management evaluates external information received against the characteristics of quality information and information processing objectives and takes any necessary actions so that the information is quality information."

OHCA's RMTS Operations Guide states in part, "Surveys not responded to within 48 hours are counted as "nonresponses" and do not contribute to the time study." In addition, "OHCA calculates the quarterly results based on the total number of moments received, minus the non-responses. Non-responses are excluded for the denominator and are not coded to any activity."

OHCA's Cost Allocation Plan states, "The OHCA Federal Reporting Unit will be responsible for coordinating the preparation and revision of the Cost Allocation Plan, the accumulation of all administrative costs, overseeing the collection of data necessary for allocations, and distribution using generally accepted accounting procedures of those costs as described in the plan."

***Condition and Context:*** For the four quarters during state fiscal year (SFY) 2017, 15 surveys were submitted over 48 hours after being received and appeared to be included in the detailed data provided by the service organization (Interactive Voice Applications (IVA)) that supports the RMTS. This would result in an incorrect amount of surveys being used to calculate the RMTS allocation percentages. In addition, we tested the RMTS allocation results for all four quarters of SFY 2017 and noted that administrative costs were allocated incorrectly by IVA. OHCA did not evaluate IVA's allocation to ensure complete, accurate and valid information was available before using the information to prepare the CMS-64 Report. The RMTS survey total used for the 529 statistic allocations based on those RMTS percentages were incorrect.

We also noted that a line item was included in the June 2017 quarterly CapPlus report, but was not included in the corresponding RMTS survey summary report. Without that line item being included in the survey summary report, we could not determine if the survey was answered on time.

***Cause:*** The quarterly RMTS results from IVA were not reviewed by OHCA before inclusion on the CMS-64 Report.

***Effect:*** Total administrative expenditures in the subsequent cost allocation calculations were misstated causing an immaterial misstatement on the CMS 64 Reports.

***Recommendation:*** We recommend the Authority utilize check figures relating to the RMTS cost allocation spreadsheets to prevent or detect errors. We also recommend the Authority review the current procedures in place to determine where any additional breakdowns in the internal control processes occurred and implement the necessary procedures to ensure compliance with Federal reporting requirements for accurate reporting of administrative costs on the CMS-64 Report in the future.

***Views of Responsible Official(s)***
***Contact Person:*** Susan Crooke
***Anticipated Completion Date:*** Completed December 2017 quarter (FFY18)
***Corrective Action Planned:*** OHCA concurs with the finding. The errors noted were a result of a glitch in the contractor's system. IVA corrected the method that gathers the responses to not include 'nonresponses' and to clear prior quarter results beginning with the December 2017 quarter (FFY18). The response count going forward will be accurate and reported correctly.

Oklahoma is not the first or only state to use IVA's RMTS software. The statements made in the RMTS Operations Guide provided to OHCA by IVA comply with federal requirements and when tested during implementation the allocations were correct. The collection of surveys is an automated system process therefore; OHCA management had no reason not to rely on the results provided. OHCA staff will now compare the RMTS summary report to the response detail to ensure data used to calculate the RMTS allocation percentages is correct.

# SINGLE AUDIT FINDING INPUT SHEET
# FISCAL YEAR 2017

| REPORTABLE FINDING: | | X-Ref: |
|---|---|---|
| | | Prepared by: ZM 3/19/2018 |
| | Significant Deficiency | |
| | Material Weakness | Reviewed by: AY 3-23-18 |
| | Compliance | |
| Date Delivered: 4/4/2018 | | Reviewed by: AS 3.28.2018 |
| Likely Questioned Costs: $0 | | Document No. |
| NON-REPORTABLE: Reason: Does not meet the definition of a significant deficiency. | | |

**FINDING NO:** 2017-003 Verbal Finding
**STATE AGENCY:** Oklahoma Health Care Authority
**FEDERAL AGENCY:** United States Department of Health and Human Services
**CFDA NO:** 93.778
**FEDERAL PROGRAM NAME:** Medicaid Cluster
**FEDERAL AWARD NUMBER:** 1605OK5MAP and 1705OK5MAP
**FEDERAL AWARD YEAR:** 2016 and 2017
**CONTROL CATEGORY:** Allowable Costs/Cost Principles

***Criteria:*** A component objective of an effective internal control system is to ensure accurate and reliable information is available for reporting. Further, an effective internal control system provides for proper record retention to ensure that all information and transactions are accurately recorded and retained.

45 CFR §75.303 states, "The non-Federal entity must:(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)."

42 CFR §431.17(c) states "The plan must provide that the records required under paragraph (b) of this section will be retained for the periods required by the Secretary."

4.7 of the State Plan states "The Medicaid agency maintains or supervises the maintenance of records necessary for the proper and efficient operation of the plan, including records regarding …fiscal and other records necessary for reporting and accountability, and retains these records in accordance with Federal requirements. All requirements of 42 CFR 431.17 are met"

***Condition and Context:*** While determining completeness of drug rebates we were informed by Oklahoma Health Care Authority (OHCA) staff that an error had occurred when running the drug rebate invoices and the invoices were regenerated. The original report summarizing the data was maintained by OHCA; however, the updated report for the regenerated invoices was not maintained.

***Cause:*** The Authority has not implemented adequate procedures to ensure appropriate supporting documentation is maintained according to the State plan.

***Effect:*** Failure to maintain appropriate supporting documentation could result in inaccurate and unreliable information being reported.

***Recommendation:*** We recommend management review current policies and procedures and update them where necessary to ensure appropriate supporting documentation is maintained.

***Views of Responsible Official(s)***
***Contact Person:*** Stacey Hale
***Anticipated Completion Date:*** April 12, 2018
***Corrective Action Planned:*** Stacey Hale, Drug Rebate Manager, will notify DXC, fiscal agent, of this error. Ms. Hale will reiterate that no reports should be deleted or removed from the COLD report's warehouse, without written consent from Drug Rebate Manager. Ms. Hale will also ask for DXC to notify Drug Rebate Manager when all reports have been loaded to COLD along with a date and time stamp for all reports each invoice cycle.

# SINGLE AUDIT FINDING INPUT SHEET
# FISCAL YEAR 2017

| REPORTABLE FINDING: | | X-Ref: |
|---|---|---|
| | Significant Deficiency | Prepared by: GP 3/27/18 |
| | Material Weakness | Reviewed by: AY 3-30-18 |
| x | Compliance | |
| Date Delivered: 4/4/2018 | | Reviewed by: AS 4.4.2018 |
| Likely Questioned Costs: $1,676,832 | | Document No. |
| NON-REPORTABLE: Reason: | | |

**FINDING NO:** 2017-034 (Repeat 2016-007)
**STATE AGENCY:** Oklahoma Health Care Authority
**FEDERAL AGENCY:** United States Department of Health and Human Services
**CFDA NO:** 93.767
**FEDERAL PROGRAM NAME:** Children's Health Insurance Program
**FEDERAL AWARD NUMBER:** 1605OK5021 and 1705OK0301
**FEDERAL AWARD YEAR:** 2016 and 2017
**CONTROL CATEGORY:** Activities Allowed or Unallowed and Allowable Costs/Cost Principles; Matching
**QUESTIONED COSTS:** $122

***Criteria:*** 45 CFR §75.403 (Subpart E) states in part, "Costs must…
(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles, and (b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items."

***Condition and Context:*** Medical payments are either direct medical payments that are initiated by the provider, or are indirectly related to medical claims and are not initiated by the provider, such as the cost of non-emergency transportation to appointments or capitation payments to primary care providers based on the number of enrolled members. Based on a medical professional's review of 70 direct medical claims initiated by the provider for Children's Health Insurance Program recipients, three (4.29%) claims had payment errors. For these claims, since the supporting documentation indicated the services provided did not meet Medicaid policy/regulatory requirements and were not adequately supported by medical records or other evidence indicating that the services were actually provided and/or necessary, we will question the costs. The universe included 2,248,310 direct medical payments totaling $288,903,321. Payments for direct medical expenditures sampled totaled $21,042. Payments for direct medical expenditures with non-compliance noted in the sample totaled $128, of which $122 ($128 x the applicable Federal Medical Assistance Percentage (FMAP) rate (94.96%) for each exception claim) is the federal questioned costs.

In addition, three (3) claims had documentation errors. For these claims, since the supporting documentation indicated the services provided did meet Medicaid policy/regulatory requirements and were adequately supported by medical records or other evidence indicating that the services were actually provided and/or necessary, we will not question the costs.

***Cause:*** Three (3) claims submitted by a provider were not appropriately supported by medical records, and three (3) claims had documentation submitted to the Authority which were missing an electronic signature.

***Effect:*** The Authority may be paying for services that are not being performed or are not medically necessary

***Recommendation:*** We recommend the Authority investigate the items identified and, if considered necessary, recoup any funds paid to providers for services that were not supported by medical records.

***Views of Responsible Official(s)***
***Contact Person:*** Josh Richards
***Anticipated Completion Date:*** June 30, 2018
***Corrective Action Planned:*** OHCA will continue its Clinical Audit and Payment Accuracy Measurement processes to ensure oversight of the program. OHCA will also continue with provider training to better educate our providers. Regarding these specific findings, the federal share will be returned to CMS.

# FINANCIAL AUDIT FINDING INPUT SHEET
# FISCAL YEAR 2017

| REPORTABLE FINDING: | | X-Ref: 201.7010 |
|---|---|---|
| | Significant Deficiency | Prepared by: ZM 11/2/17 |
| | Material Weakness | Reviewed by: AY 11-15-17 |
| | Compliance | |
| Date Delivered: 12-7-17 | | Reviewed by: AS 11.15.2017 |
| Projected Costs: | | Document No. |
| NON-REPORTABLE: Reason: | | |

**Reference Number:** 17-807-002
**State Agency:** Oklahoma Health Care Authority
**Fund Type:** General Fund
**Other Information:** Federal Grant Receivable

**Criteria/Condition:** The Government Accountability Office (GAO) Standards for Internal Control in the Federal Government 10.03 states, in part, "Management designs appropriate types of control activities for the entity's internal control system. Control activities help management fulfill responsibilities and address identified risk responses in the internal control system… Transactions are promptly recorded to maintain their relevance and value to management in controlling operations and making decisions. This applies to the entire process or life cycle of a transaction or event from its initiation and authorization through its final classification in summary records. In addition, management designs control activities so that all transactions are completely and accurately recorded."

Adequate internal controls over separation of duties and supervision include separating key duties and responsibilities in authorizing, processing, recording, and reviewing official agency transactions.

In preparing Generally Accepted Accounting Principles Package D – Grants/Entitlements Receivable and Deferred Revenue (GAAP Package D) an excel spreadsheet was used to formulate the Survey and Certification CFDA #93.796 Grant/Entitlement Receivable. The sum formula was used to total the 'Total Expenditures' and the 'Total Draws'; however, state fiscal year 2017 expenditures after October 2016 and draws after June 2016 were not included in the sum, thus overstating the Federal Grants Revenue and the Federal Grants Receivable in the amount of $2,335,470.25.

**Cause/Effect:** The review of the GAAP Package D did not detect an erroneous formula in the supporting documentation resulting in an overstatement in the Federal Grants Revenue and the Federal Grants Receivable totals reported on GAAP Package D in the amount of $2,335,470.25.

**Recommendation:** We recommend the agency improve its procedures to ensure GAAP Packages and supporting documentation are properly reviewed and approved for accuracy prior to submission. We also recommend OMES make the following entry to their Federal Grant Revenue and Federal Grants Receivable overstatement reported on GAAP Package D.

| | Debit | Credit |
|---|---|---|
| Federal Revenue (455101) | $2,335,470.25 | |
| Federal Receivable (116000) | | $2,335,470.25 |

**Agency Management Response:** The expenditures reported in GAAP Package D were reviewed by OHCA staff for accuracy prior to being reported on the SEFA. Management examined why the review did not detect the error and determined the error was not detected because the excel spreadsheet was reviewed in paper format rather than electronically and therefore did not detect the cell error.

The OHCA grant spreadsheet used has been corrected and procedures for reporting expenditures on the SEFA have been revised. A review of all Excel spreadsheets used as supporting documentation will now include a review of the electronic version.

# FINANCIAL AUDIT FINDING INPUT SHEET
# FISCAL YEAR 2017

| REPORTABLE FINDING: | | X-Ref: 014.0015 |
|---|---|---|
| X | Significant Deficiency | Prepared by: AS 12.11.2017 |
| | Material Weakness | Reviewed by: SF 12/11/17 |
| | Compliance | |
| Date Delivered: 12-12-17 | | Reviewed by: |
| Projected Costs: | | Document No. |
| NON-REPORTABLE: Reason: | | |

**Reference Number:** 17-807-004
**State Agency:** Oklahoma Health Care Authority
**Fund Type:** General Fund
**Other Information:** Accounts Payable/Expenditures

**Criteria/Condition:** The Government Accountability Office (GAO) Standards for Internal Control in the Federal Government 10.03 states, in part, "Transactions are promptly recorded to maintain their relevance and value to management in controlling operations and making decisions. This applies to the entire process or life cycle of a transaction or event from its initiation and authorization through its final classification in summary records. In addition, management designs control activities so that all transactions are completely and accurately recorded."

The GAO Standards for Internal Control in the Federal Government 10.13 states, in part, "Segregation of duties helps prevent fraud, waste, and abuse in the internal control system. Management considers the need to separate control activities related to authority, custody, and accounting of operations to achieve adequate segregation of duties."

Adequate internal controls over access and accountability for resources include (1) limiting access to resources and records to authorized individuals and (2) assigning and maintaining accountability for the custody and use of resources.

Adequate internal controls over separation of duties and supervision include separating key duties and responsibilities in authorizing, processing, recording, and reviewing official agency transactions.

The Independent Service Auditor's Report on the Service Organization's System (SOC-1) for the period of September 1, 2015 to August 31, 2016 indicated (1) a segregation of duties control issue related to the organization and administration control objective and related controls for transaction processing; and (2) control issues related to the application, operating system and database development and maintenance and access to data and programs control objectives and related controls for the general computer controls.

The SOC-1 for the period of September 1, 2016 to August 31, 2017 indicated control issues related to the job scheduling and access to data and programs control objectives and related controls for the general computer controls.

**Cause/Effect:** There was a lack of segregation of duties over the production changes within the application. However, change requests, implemented by developers who promoted their own changes during the period of examination were approved prior to implementation of each change. Lack of segregation of duties over the production changes within the application increases the risk of waste, loss, unauthorized use or misappropriation of State funds.

The Service Organization did not ensure users were restricted only to either development or production access in the job scheduling. Access to both development and production increases the risk of waste, loss, unauthorized use or misappropriation of State funds.

The Service Organization did not ensure active users had appropriate access or terminated users were eliminated from the access to data and programs. Inappropriate user access increases the risk of waste, loss, unauthorized use or misappropriation of State funds.

**Recommendation:** We recommend the agency continue to follow-up with the service organization and ensure noted deficiencies are addressed and corrective actions noted in the SOC-1 report are implemented in a timely manner.

**Agency Management Response:** The Oklahoma Health Care Authority will continue our standard process of reviewing the SOC-1 report and following up with the service organization to ensure that effective corrective actions are designed and implemented to address noted deficiencies.

# OHCA Board Meeting
# September 13, 2018
# (July 2018 Data)

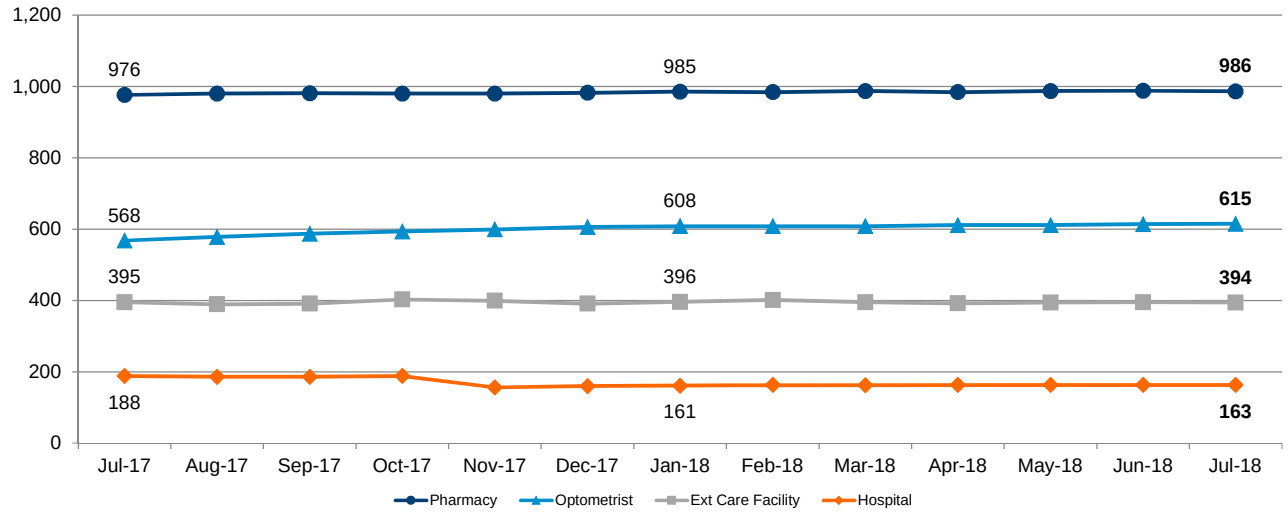
## SOONERCARE ENROLLMENT/EXPENDITURES

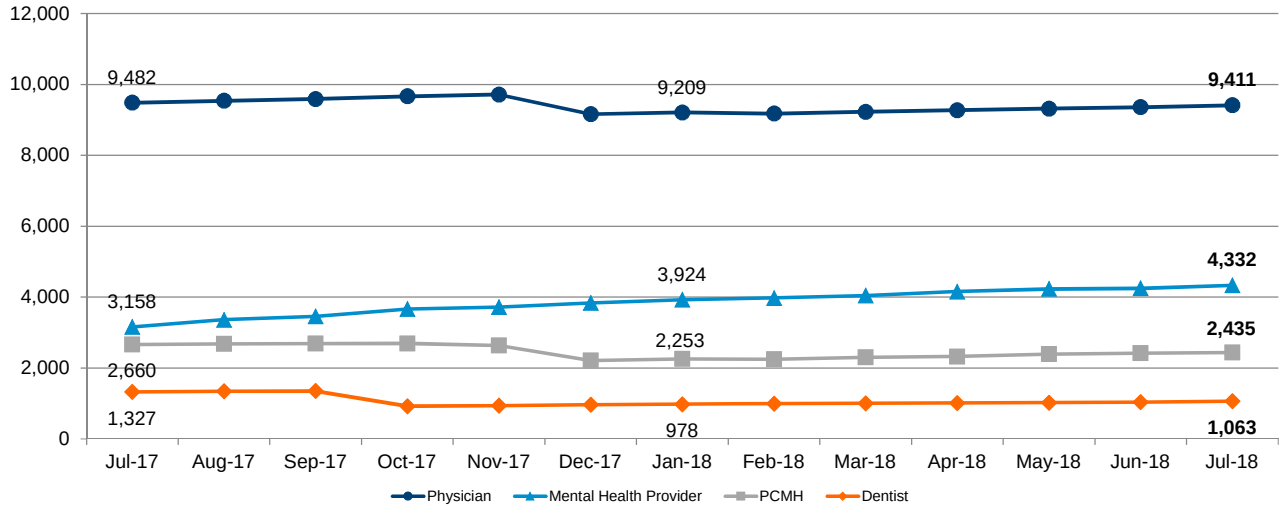
| Delivery System | | | Enrollment July 2018 | Children July 2018 | Adults July 2018 | Enrollment Change | Total Expenditures July 2018 | PMPM July 2018 |
|---|---|---|---|---|---|---|---|---|
| **SoonerCare Choice Patient-Centered Medical Home** | | | **533,758** | **441,907** | **91,851** | **-347** | **$140,118,384** | |
| | *Lower Cost* | *(Children/Parents; Other)* | 489,883 | 428,069 | 61,814 | -259 | $99,260,835 | $203 |
| | *Higher Cost* | *(Aged, Blind or Disabled; TEFRA; BCC)* | 43,875 | 13,838 | 30,037 | -88 | $40,857,550 | $931 |
| **SoonerCare Traditional** | | | **231,931** | **85,115** | **146,816** | **1,489** | **$162,260,014** | |
| | *Lower Cost* | *(Children/Parents; Other; Q1; SLMB)* | 117,077 | 80,348 | 36,729 | 1,432 | $37,744,000 | $322 |
| | *Higher Cost* | *(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)* | 114,854 | 4,767 | 110,087 | 57 | $124,516,014 | $1,084 |
| **Insure Oklahoma** | | | **19,509** | **528** | **18,981** | **24** | **$7,217,481** | |
| | *Employer-Sponsored Insurance* | | 14,180 | 325 | 13,855 | 80 | $4,914,310 | $347 |
| | *Individual Plan* | | 5,329 | 203 | 5,126 | -56 | $2,303,170 | $432 |
| **SoonerPlan** | | | **29,888** | **2,542** | **27,346** | **249** | **$262,875** | $9 |
| **TOTAL** | | | **815,086** | **530,092** | **284,994** | **1,415** | **$309,858,754** | |

Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents. Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

## IN-STATE CONTRACTED PROVIDERS

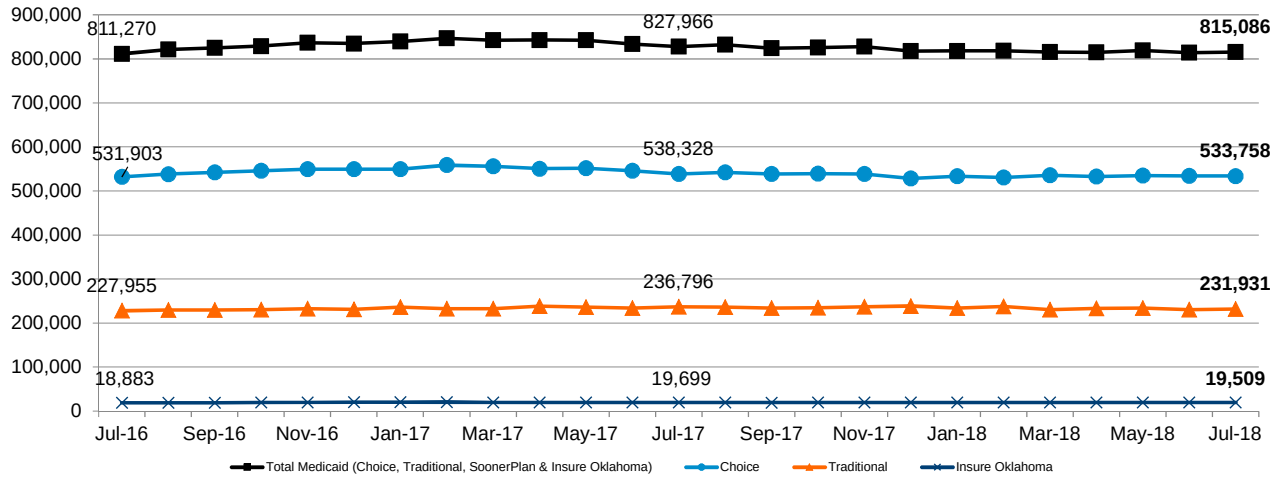
**Total In-State Providers: 31,932 (+266)** **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

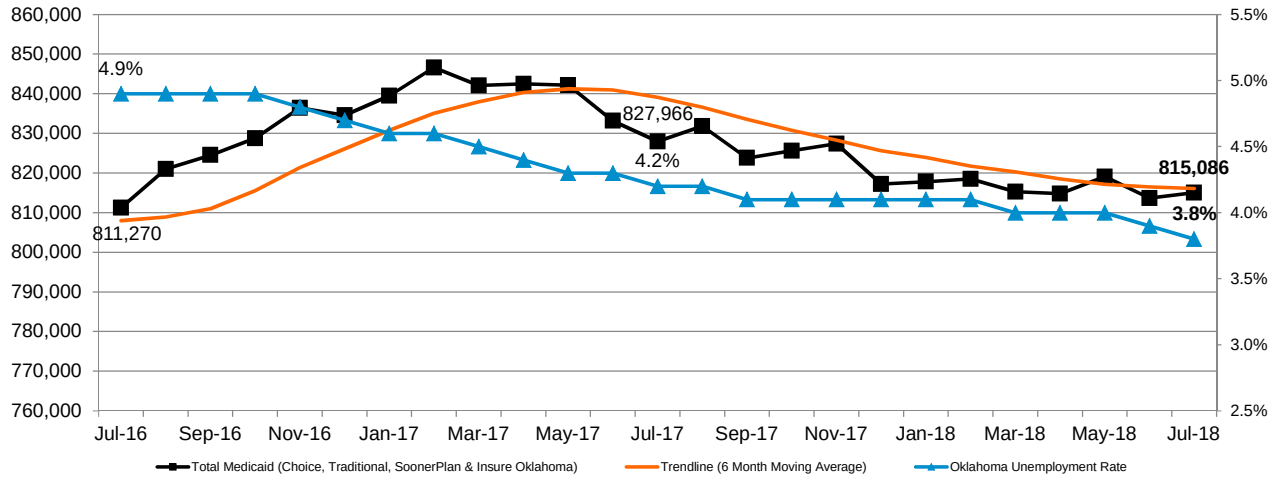



*In general, decreases are due to contract renewal. Decrease during contract renewal period is typical during all renewal periods. Hospital decrease in November 2017 was due to psychiatric hospitals and residential treatment centers changing from provider type hospital to provider type inpatient psychiatric facility.

## ENROLLMENT BY MONTH




Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted. Data was extracted on August 22, 2018.
In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds.

# IT TAKES A COMMUNITY

*An Update on the Proposed Work/Community Engagement Requirements for SoonerCare Members*

**To best serve our members, the Oklahoma Health Care Authority needs community input and feedback on this proposed waiver**

## Background

In March 2017, the federal government granted states flexibility in their work requirements for Medicaid members. In October 2017, Gov. Mary Fallin formed a workgroup on work requirements. She then signed an executive order in March 2018 directing the Oklahoma Health Care Authority (OHCA) to apply for a waiver that would allow the state to carry out work requirements. She also signed HB 2932, directing the agency to apply for the waiver so that gaining SoonerCare coverage is dependent upon documentation of certain education, skills training, work or job activities.

## What counts as work or community engagement?

OHCA is still working to define what will count as work or community engagement so members easily understand how to maintain eligibility and to streamline reporting requirements for member and employers.

## Who will be impacted?

- Non-exempted individuals between ages 19 and 50
- Parents/Caretakers of children ages 6 or older

## Who is exempt from the proposed changes?

Members who are:

- Enrolled in Insure Oklahoma
- Under age 19 and over 50
- A pregnant or postpartum woman
- Certified mentally or physically unable to work
- A parent or caretaker of a child less than age 6
- A parent or caretaker for an incapacitated person
- A person with a disability under the Americans with Disabilities Act (ADA)

Or members who are:

- In compliance with Temporary Assistance for Needy Families (TANF) work registration requirements
- In substance abuse treatment
- A student enrolled at least part time
- Employed and working at least 30 hours per week
- Self-employed and working at least 30 hours per week

*Please note, these work requirements are for TANF eligibility, not SoonerCare*

## OHCA is also proposing these additional exemptions:

- American Indians and Alaska Natives
- Oklahoma foster care parents
- Members that were formerly in foster care
- Members enrolled in Oklahoma Cares, the OHCA Breast and Cervical Cancer Program
- Those enrolled in SoonerPlan, the OHCA family planning program
- Those released from incarceration in the last six months

## What is the timeline?

>The public comment period closes September 3, 2018

>OHCA submits the plan to the federal government in October

>November and December are a negotiating period between the federal government and OHCA

>The application moves to Centers for Medicare & Medicaid Services (CMS) for consideration

>Implementation efforts can begin upon CMS approval

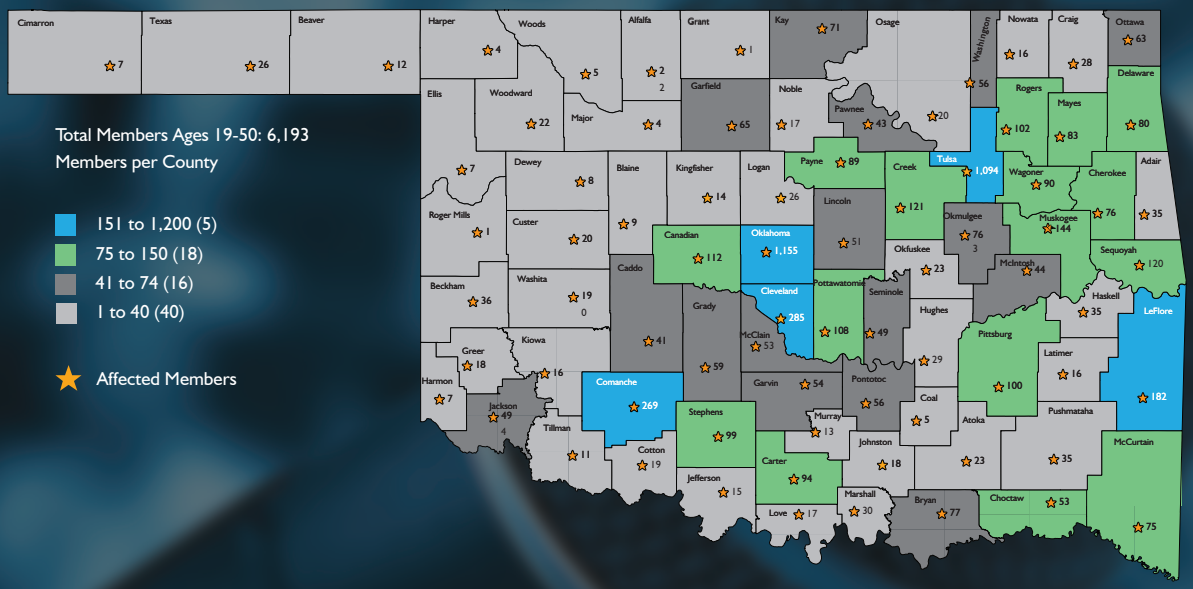
**Questions and comments can be emailed to:**
OHCACommunityEngagement@OKHCA.org

**Find more information at www.okhca.org**

Oklahoma Health Care Authority

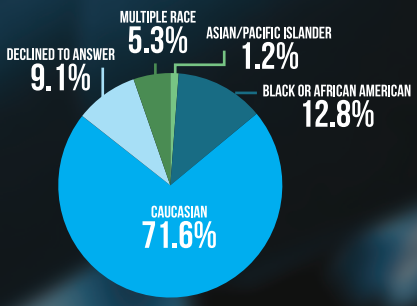
# Who are they?

Learn about the SoonerCare members potentially impacted by the proposed community engagement requirements.



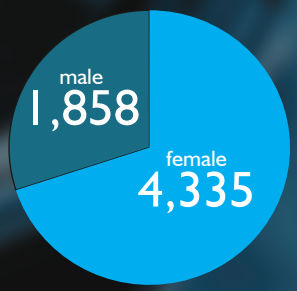

# By the numbers

## Race




Members self-reported race identification

## Gender




Approximately 70% of members potentially affected are female and 30% are male

## Number of Parent/Caretakers Per Household*

Total Single Parent/Caretakers: **4,003/ 79.7%**

Total Multiple Parent/Caretakers: **1,017/ 20.3%**

*Excludes 19 year-olds (1,173 out of 6,193)

# Affected members' income levels

The average household has three members and an annual income of

**$9,348**

A family of **three** at 45% of the federal poverty level (FPL) earns no more than

**$779/month or $9,348 annually**

A family of **four** at 45% of FPL earns no more than

**$941/month or $11,292 annually**

A family of **three** at **20% of FPL** earns $340/mo., or $4,085 annually.
A family of **four** at **20% of FPL** earns $410/mo., or $4,920 annually.

*Number of enrolled adults in household based on case number. Case number is used to group members of same family living in same household. Members are non-pregnant. Excludes Insure Oklahoma, SoonerPlan, Oklahoma Cares, Native Americans and foster care (former and current).*

# 3.00% ACROSS-THE-BOARD PROVIDER RATE INCREASE

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 3.00% increase, to the current rate and reimbursement structures in the SoonerCare program. Upon passage of Senate Bill 1605, OHCA was mandated to increase most provider rates by 2.00%. However, OHCA is proposing to use program and administrative savings and increased drug rebate collections to increase provider rates by an additional one percent, bringing the rate increase to 3.00%.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   OHCA currently reimburses providers under a variety of different rate structures; diagnostic-related group (DRG), per diem, max fee, percent of Medicare, and a percent of costs are some examples. Our current rates for most providers reflect a 3.25% reduction, a 7.75% reduction, and a 3.00% reduction from the applicable rate structures, implemented in April of 2010, July 2014, and January 2016. Some provider rates were not reduced by all three rate reductions.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   OHCA seeks to increase provider rates by 3.00% of the applicable rate structures. Per Senate Bill 1605, the proposed rate increases excludes: services financed through appropriations to other state agencies; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); non-emergency transportation capitation payments; services provided to Insure Oklahoma (IO)

members; payments for drug ingredients/physician supplied drugs; Indian Health Services/Tribal/Urban Clinics (I/T/U); Federally Qualified Health Centers (FQHCs); Rural Health Centers (RHCs); and Long-Term Care Facilities, which will be discussed in the next four agenda items. Program for the All-Inclusive Care for the Elderly (PACE) was excluded from the legislatively mandated rate increases, however OHCA will increase these rates by 3.00% as well.

**6. BUDGET ESTIMATE.**

The estimated budget impact for the remainder of SFY2019 will be an increase of $36,338,928 total; of which $13,670,705 is state share. The estimated budget impact for SFY2020 will be an increase of $45,451,904 total; of which $18,689,111 is state share.

**7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**

The Oklahoma Health Care Authority anticipates a positive impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care, in accordance with requirements at 42 CFR 447.203(b)(6).

**8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the 3.00% across-the-board provider rate increase of the applicable rate structures for all providers excluding those providers/services mentioned.

**9. EFFECTIVE DATE OF CHANGE.**

October 1, 2018

# REGULAR NURSING FACILITIES RATE INCREASE

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 4.00% increase, to the rate for Regular Nursing Facilities. Upon passage of Senate Bill 1605, OHCA was mandated to increase long-term care facilities rates by 3.00%. However, OHCA is proposing to use program and administrative savings and increased drug rebate collections to increase provider rates by an additional one percent, bringing the rate increase to 4.00%. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.2% for Regular Nursing Facilities. Also, this change will increase the Quality of Care (QOC) fee, and the pool amount for "Direct Care" and "Other" Components of the rate.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing Facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:
   A. Base Rate Component is $107.98 per patient day.
   B. A Focus on Excellence (FOE) Component defined by the points earned under this performance program ranging from $1.00 to $5.00 per patient day.
   C. An "Other" Component is $10.54 per patient day, which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and FOE Components by the total estimated Medicaid days for the rate period. This component once calculated is the same for each facility.
   D. A "Direct Care "Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and FOE Components to the facilities. This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the 70% pool of funds to each facility (on a per day basis) based on their relative expenditures for direct care costs.
   The current combined pool amount for "Direct Care" and "Other" components is $158,938,847. The current Quality of Care (QOC) fee is $11.48 per patient day.

**5. NEW METHODOLOGY OR RATE STRUCTURE.**

There is no change in methodology; however, there is a rate change for Regular Nursing Facilities because of the 4.00% rate increase. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.2% for Regular Nursing Facilities. Also, this action calls for recalculation of the Quality of Care (QOC) fee, and reallocation of the pool for "Direct Care" and "Other" components of the rate as per The State Plan. The Base Rate Component will be $108.12 per patient day. The "Other" component will be $11.90 per patient day. The new combined pool amount for "Direct Care" and "Other" components will be $174,676,429. The new Quality of Care (QOC) fee will be $11.62 per patient day.

**6. BUDGET ESTIMATE.**

The estimated budget impact for the remainder of SFY2019 will be an increase in the total amount of $15,899,520; with $6,132,445 in state share ($649,119 of the state share is from the increased QOC fee which is paid by the providers). The estimated budget impact for SFY2020 will be an increase in the total amount of $21,199,360; with $8,176,593 in state share ($1,144,723 of the state share is from the increased QOC fee which is paid by the providers).

**7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**

The Oklahoma Health Care Authority anticipates positive impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care, in accordance with requirements at 42 CFR 447.203(b)(6).

**8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular Nursing Facilities:

- An increase in the base rate component from $107.98 per patient day to $108.12 per patient day.
- An increase in the combined pool amount for the "Direct Care" and "Other" Components from $158,938,847 to $174,676,429 to account for the rate increase and reallocation of the Direct Care Cost Component as per the State Plan.

**9. EFFECTIVE DATE OF CHANGE.**

October 1, 2018

# ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITES RATE INCREASE

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 4.00% increase, to the rate for nursing facilities serving residents with AIDS. Upon passage of Senate Bill 1605, OHCA was mandated to increased long-term care facilities rates by 3.00%. However, OHCA is proposing to use program and administrative savings and increased drug rebate collections to increase provider rates by an additional one percent, bringing the rate increase to 4.00%. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.2% for nursing facilities serving residents with AIDS. Also, this change will increase the Quality of Care (QOC) fee.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current rate for this provider type is $201.32 per patient day. The Quality of Care (QOC) fee is $11.48 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for nursing facilities serving residents with AIDS because of the 4.00% rate increase, and recalculation of the Quality of Care (QOC) fee. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.20% for nursing facilities serving residents with AIDS. The rate for this provider type will be $207.86 per patient day. The recalculated Quality of Care (QOC) fee will be $11.62 per patient day.

**6. BUDGET ESTIMATE.**

The estimated budget impact for the remainder of SFY2019 will be an increase in the total amount of $48,377; with $ $18,659 in state share ($1,959 of the state share is from the increased QOC fee which is paid by the providers). The estimated budget impact for SFY2020 will be an increase in the total amount of $64,503; with $ $24,879 in state share ($3,483 of the state share is from the increased QOC fee which is paid by the providers).

**7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**

The Oklahoma Health Care Authority anticipates positive impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care, in accordance with requirements at 42 CFR 447.203(b)(6).

**8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:

- An increase in the AIDS rate from $201.32 per patient day to $207.86 per patient day.

**9. EFFECTIVE DATE OF CHANGE.**

October 1, 2018

# REGULAR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE INCREASE

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 4.00% increase, to the rate for Regular ICF/IID. Upon passage of Senate Bill 1605, OHCA was mandated to increase long-term care facilities rates by 3.00%. However, OHCA is proposing to use program and administrative savings and increased drug rebate collections to increase provider rates by an additional one percent, bringing the rate increase to 4.00%. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.5% for Regular ICF/IID facilities. Also, this change will increase the Quality of Care (QOC) fee.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current rate for this provider type is $123.21 per patient day. The Quality of Care (QOC) fee is $7.39.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for Regular ICF/IID facilities because of the 4.00% rate increase, and the recalculation of the QOC fee. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.5% for Regular ICF/IID facilities. The rate for this provider type will be $127.49 per patient day. The new Quality of Care (QOC) fee will be $7.58 per patient.

**6. BUDGET ESTIMATE.**

The estimated budget impact for the remainder of SFY2019 will be an increase in the total of $657,562; with $253,622 in state share ($30,573 of the state share is from the increased QOC fee which is paid by the providers). The estimated budget impact for SFY2020 will be an increase in the total amount of $876,750; with $338,162 in state share ($54,200 of the state share is from the increased QOC fee which is paid by the providers).

**7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**

The Oklahoma Health Care Authority anticipates positive impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care, in accordance with requirements at 42 CFR 447.203(b)(6).

**8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular ICF/IID facilities:

- An increase in Regular ICF/IID rate from $123.21 per patient day to 127.49 per patient day.

**9. EFFECTIVE DATE OF CHANGE.**

October 1, 2018

# ACUTE (16 BED-OR-LESS) INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE INCRESE

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Increase

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 4.00% increase, to the rate for Acute ICF/IID facilities. Upon passage of Senate Bill 1605, OHCA was mandated to increase long-term care facilities rates by 3.00%. However, OHCA is proposing to use program and administrative savings and increased drug rebate collections to increase provider rates by an additional one percent, bringing the rate increase to 4.00%. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.5% for Acute ICF/IID facilities. Also, this change will increase the Quality of Care (QOC) fee.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Acute ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current rate for this provider type is $157.43 per patient day. The Quality of Care (QOC) fee is $9.41 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for Acute ICF/IID facilities because of the 4.00% rate increase, and the recalculation of the QOC fee. The 4.00% increase for long-term care facilities is calculated only on the portion of the rate funded by state appropriations, resulting in an increase on the total rate of 3.5% for Acute ICF/IID facilities. The rate for this provider type will be $163.04 per patient day. The new Quality of Care (QOC) fee will be $9.66 per patient day.

**6. BUDGET ESTIMATE.**

The estimated budget impact for the remainder of SFY2019 will be an increase in the total of $1,167,196; with $450,187 in state share ($53,786 of the state share is from the increased QOC fee which is paid by the providers). The estimated budget impact for SFY2020 will be an increase in the total amount of $1,556,261; with $600,250 in state share ($96,040 of the state share is from the increased QOC fee which is paid by the providers).

**AGENCY ESTIMATED IMPACT ON ACCESS TO CARE**

**7.** The Oklahoma Health Care Authority anticipates positive impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care, in accordance with requirements at 42 CFR 447.203(b)(6).

**8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:

- An increase in Acute ICF/IID rate from $157.43 per patient day to $163.04 per patient day.

**9. EFFECTIVE DATE OF CHANGE.**

October 1, 2018

# STATE PLAN SKILLED NURSING SERVICES RATE

**1. IS THIS A RATE CHANGE OR A METHOD CHANGE?**

Rate Change

**2. IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**

Increase

**3. PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**

This is a proposal to increase the rate paid for State Plan skilled nursing services for recipients on the State Plan Personal Care Program.

**4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**

The current rate structure for the service for which the rate increase is being requested is a fixed and uniform rate configuration established through the State Plan Amendment Rate Committee process. The service, current service code and rate are as follows:

| Service | Service Code | Current Rate |
|---|---|---|
| State Plan Skilled Nursing | T1001 | $54.00 |

**5. NEW METHODOLOGY OR RATE STRUCTURE.**

The table below indicates the service, current service code and rate, as well as the proposed rate and the amount of the increase. The rate is a per visit rate.

| Service | Service Code | Current Rate | New Rate | % Increase |
|---|---|---|---|---|
| State Plan Skilled Nursing | T1001 | $54.00 | $60.00 | 11.1% |

**6. BUDGET ESTIMATE.**

The estimated annual State Plan budget change for State Plan Skilled Nursing is an increase in the amount of $60,000 total dollars or $23,142 state share which is paid by the Department of Human Services.

**7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**

A rate increase will stabilize existing programs enabling providing agencies to provide salaries comparable to similar type service salaries.

**8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**

The Department of Human Services requests the State Plan Amendment Rate Committee approve the proposed 11.1% rate increase from $54 per nursing visit to $60 per nursing visit.

**9. EFFECTIVE DATE OF CHANGE.**

The new rate will be effective and eligible for Federal match upon approval of the proposed measure by the Oklahoma Health Care Authority Board. Contingent upon approval by the Board, the Department of Human Services will implement a retroactive effective date of July 1, 2018, and will cover the Federal match portion of costs from July 1 to the date of Board approval (scheduled September 13, 2018).

# PSYCHOTHERAPY PROVIDED IN OUTPATIENT BEHAVIORAL HEALTH CLINICS RATE INCREASE

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   This change represents an Increase in the reimbursement rates for psychotherapy services (individual, group and family) provided by Behavioral Health Licensure Candidates and Licensed Behavioral Health Professionals in Outpatient Behavioral Health Clinics.

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) received $2,000,000 in funding from the Legislature through HB3707 to assist with restoring provider reimbursement rates that were reduced in 2016. ODMHSAS is proposing that a portion of these funds be used to increase reimbursement rates for psychotherapy services (individual, group and family) provided by Behavioral Health Licensure Candidates and Licensed Behavioral Health Professionals in Outpatient Behavioral Health Clinics by 3%.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Outpatient Behavioral Health Clinics are reimbursed at payment rates which in the aggregate equal 71.75% of the 2007 Medicare Physician Fee Schedule.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   ODMHAS proposes to increase the reimbursement rates for psychotherapy services provided by Behavioral Health Licensure Candidates and Licensed Behavioral Health Professionals in Outpatient Behavioral Health Clinics by 3%. With this increase, behavioral health clinics would continue to not exceed the upper limit of 71.75% of the 2007 Medicare Physician Fee Schedule.

6. **BUDGET ESTIMATE.**
   Estimated cost to ODMHSAS for SFY2019 is $3,826,697 Total; $1,475,957 State Share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Agency has determined that this change will have a positive impact on access to care.

**8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**

The Agency requests the SPARC to approve the proposed 3% increase to rates for psychotherapy services provided by Licensure Candidates and Licensed Behavioral Health Professionals in Outpatient Behavioral Health Clinics.

**9. EFFECTIVE DATE OF CHANGE.**

July 1, 2018