Access Monitoring Review Plan 2019

September 24, 2019

Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

Contents

Executive Summary

On Nov. 2, 2015, the Centers for Medicare and Medicaid Services (CMS) issued the final rule with comment period: Methods for Assuring Access to Covered Medicaid Services (CMS-2328-FC). Effective on Jan. 4, 2016, 42 CFR § 447.203(b) required states to develop an Access Monitoring Review Plan (AMRP) once every three years which includes an analysis of access to covered services under fee-for-service (FFS) programs consistent with section 1902(a)(30)(A) of the Social Security Act (SSA). Additional services are reviewed and monitored as states reduce (or restructure) provider payment rates.

The Oklahoma Health Care Authority's (OHCA) initial AMRP in 2016 analyzed and evaluated access to care for services covered through the Medicaid State Plan and reimbursed on a FFS basis. The analysis included data and information from beneficiaries and providers. The report clarified whether and how changes in care and payment data impact delivery and payment systems as access to care is of paramount concern to OHCA. Through this report, OHCA's second AMRP, the State addresses access to care by measuring the following: enrollee needs; the availability of care and providers; and the utilization of services.

Timeline

In accordance with 42 CFR § 447.203(b)

The 2019 AMRP was developed during the months of Feb. through Sept. of 2019. The timeline includes a blog posting of the draft report on OHCA's public website from Friday, June 28, 2019 through Sunday, July 28, 2019 to allow for public review and feedback. A summary of the AMRP was presented to OHCA's Medical Advisory Committee (MAC) on Thursday, July 18, 2019. The final draft of the AMRP was posted for public comment on August 27, 2019 through September 26, 2019, and presented to the OHCA MAC on September 5, 2019. The AMRP was officially submitted to CMS on September 24, 2019.

Public Input

In accordance with 42 CFR § 447.203(b)

No comments were received regarding the AMRP during the public review time period.

Conclusion

Oklahoma demonstrates a robust service capacity for the millions of Oklahomans it serves yearly. Provider contracts, provider networks, and beneficiary access to primary care services remain stable. The provider network increased from 44,300 in the baseline state fiscal year of 2013 to 52,087 in 2018. Providers also received a 3 percent (3%) rate increase in October 2018 after previous decreases in rates in July 2014 and January 2016. The OHCA is committed to continuous quality improvement with respect to services to beneficiaries, while maintaining an extensive provider base. Since the Agency's first AMRP, OHCA continues to focus on access to care for its members by establishing new services and rate increases for providers. In general, unless noted by a policy change, most year-to-year fluctuations in provider counts are from temporary decreases due to contract renewal periods, especially in regards to out-of-state providers, or its due to changes in the methodology of how provider types and specialties are counted. The key measures of the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) for SoonerCare children and adults demonstrate that members continue to be satisfied with services. Further, the AMRP demonstrates the Agency's compliance with 1902(a)(30)(A) of the SSA, which assures state payments are consistent with efficiency, economy, and quality of care and sufficient to enlist enough providers so that services

under the State Plan are available to beneficiaries at least to the extent that those services are available to the general population.

Overview

- Oklahoma has a total population of approximately 3.9 million.
- The Oklahoma Medicaid program, known as SoonerCare, provides healthcare coverage for the following low-income individuals: children, pregnant women, individuals with disabilities, the elderly, parents, and other adults. The OHCA is the single state agency that administers the Medicaid program within the state.
- SoonerCare is the largest payer of health care services in terms of covered lives in the state.
- SoonerCare is the umbrella name for all Oklahoma Medicaid covered lives. SoonerCare Traditional encompasses the FFS program, while SoonerCare Choice is a managed care delivery system. The SoonerCare Choice program is operated as a patient-centered medical home (PCMH) model that is authorized under a federal demonstration waiver. SoonerCare Supplemental is the program for members who have both Medicare and Medicaid.
- Per the OHCA annual report, in 2018, the OHCA provided coverage to approximately 1.02 million unduplicated enrolled beneficiaries, or 26 percent (26%) of the state's citizens.
- Per the OHCA annual report, total expenditures for the SoonerCare program in state fiscal year 2018 were approximately $5.3 billion.
- Oklahoma measures and monitors indicators of healthcare access to ensure that its Medicaid beneficiaries have access to care that is comparable to the general population.
- In accordance with 42 CFR § 447.203, the OHCA developed an AMRP for the defined service categories provided under a FFS arrangement:
    - Primary care services *(in accordance with 42 CFR § 447.203(b)(5)(ii)(A))*
    - Physician specialist services *(in accordance with 42 CFR § 447.203(b)(5)(ii)(B))*
    - Behavioral health services *(in accordance with 42 CFR § 447.203(b)(5)(ii)(C))*
    - Pre- and post-natal obstetric services, including labor and delivery *(in accordance with 42 CFR § 447.203(b)(5)(ii)(D))*
    - Home health services *(in accordance with 42 CFR § 447.203(b)(5)(ii)(E))*
- The AMRP presents data that was used to measure access to care for beneficiaries in FFS. The AMRP considers: the availability of Medicaid providers, utilization of Medicaid services and the extent to which Medicaid beneficiaries' healthcare needs are met.
- The data and information contained in this report verify that Oklahoma's Medicaid beneficiaries have access to healthcare similar to that of the general population in Oklahoma.

Standards and Methodology

In accordance with 42 CFR § 447.203(b)(4)

Data for this report was compiled from various sources including the OHCA state fiscal year annual reports; agency provider fast facts; queries of data available in the Oklahoma Medicaid Management Information System (MMIS); information furnished by the Oklahoma State Department of Health (OSDH); the Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS); and the Oklahoma Department of Human Services (DHS).

42 CFR § 447.203(b)(4) states:

> *Access monitoring review plan standards and methodologies.* The access monitoring review plan and analysis must, at a minimum, include: The specific measures that the state uses to analyze access to care (such as, but not limited to: Time and distance standards, providers participating in the Medicaid program, providers with open panels, providers accepting new Medicaid beneficiaries, service utilization patterns, identified beneficiary needs, data on beneficiary and provider feedback and suggestions for improvement, the availability of telemedicine and telehealth, and other similar measures), how the measures relate to the access monitoring review plan described in paragraph (b)(1) of this section, baseline and updated data associated with the measures, any issues with access that are discovered as a result of the review, and the state agency's recommendations on the sufficiency of access to care based on the review. In addition, the access monitoring review plan must include procedures to periodically monitor access for at least 3 years after the implementation of a provider rate reduction or restructuring, as discussed in paragraph (b)(6)(ii) of this section.

The analysis includes time and distance standards where applicable, providers participating in the Medicaid program, providers with open panels as applicable, service utilization patterns, identified beneficiary needs, data on beneficiary and provider feedback and suggestions for improvement, as well as the availability of telehealth. Measures are presented as baseline data in each section of the AMRP.

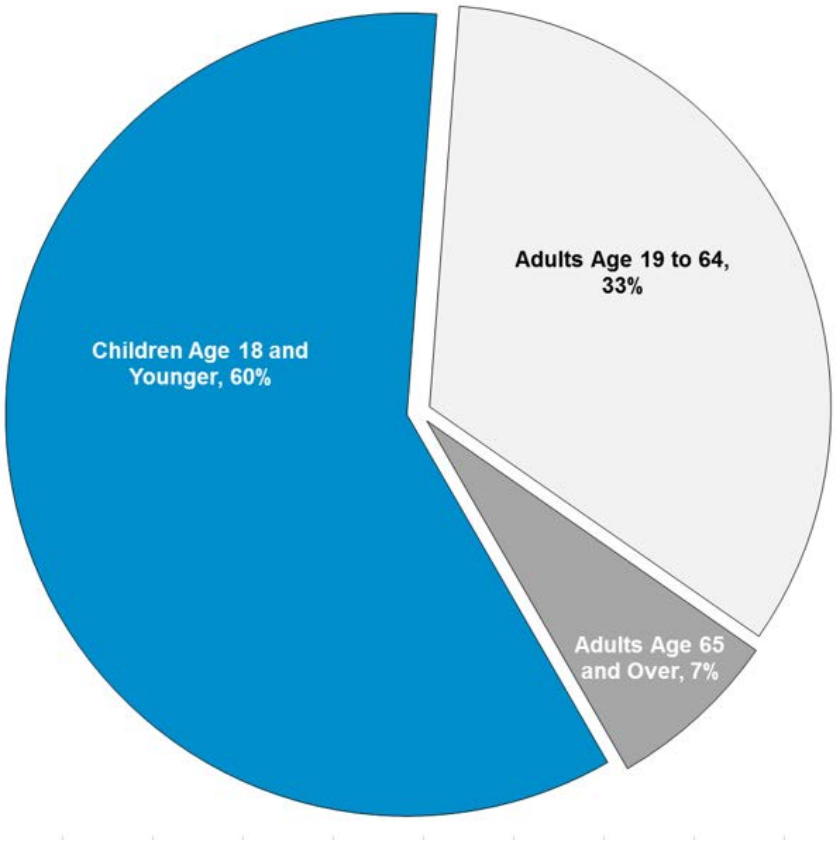
Access to care is a major focus of the Agency's vision, which states, "Our vision is for Oklahomans to be healthy and to have access to quality health care services regardless of their ability to pay." OHCA MAC agendas and Board meeting agendas include the Medicaid Director's Update, which covers the number of contracted providers as does the monthly Provider Fast Facts (See Appendix A). The OHCA Strategic Plan for state fiscal year 2018 through 2022 includes an environmental assessment and relevant action plans which address provider access and telehealth. The latest OHCA Annual Report and archives highlight the Agency's accomplishments, which include assistance with access to care statewide. Claims data which is excerpted from the annual report reflects that the claim was paid in the period covered in the annual report. The actual date of service may vary widely, depending on the timely filing limits applicable at the time.

Beneficiary Population

In accordance with 42 CFR § 447.203(b)(1)(iv)

In 2018 the SoonerCare program provided coverage to approximately 1 million enrolled beneficiaries, including the Insure Oklahoma (IO) population. Low-income individuals receiving care include children, pregnant women, individuals with disabilities, the elderly, parents and other adults. A review of the age categories covered by SoonerCare is contained in Figure 1, demonstrating that the majority of covered lives are children 18 and younger. Thirty-three percent (33%) of eligibles are aged 19-64, with the remaining population, aged 65 and older, comprising seven percent (7%) of eligibles.

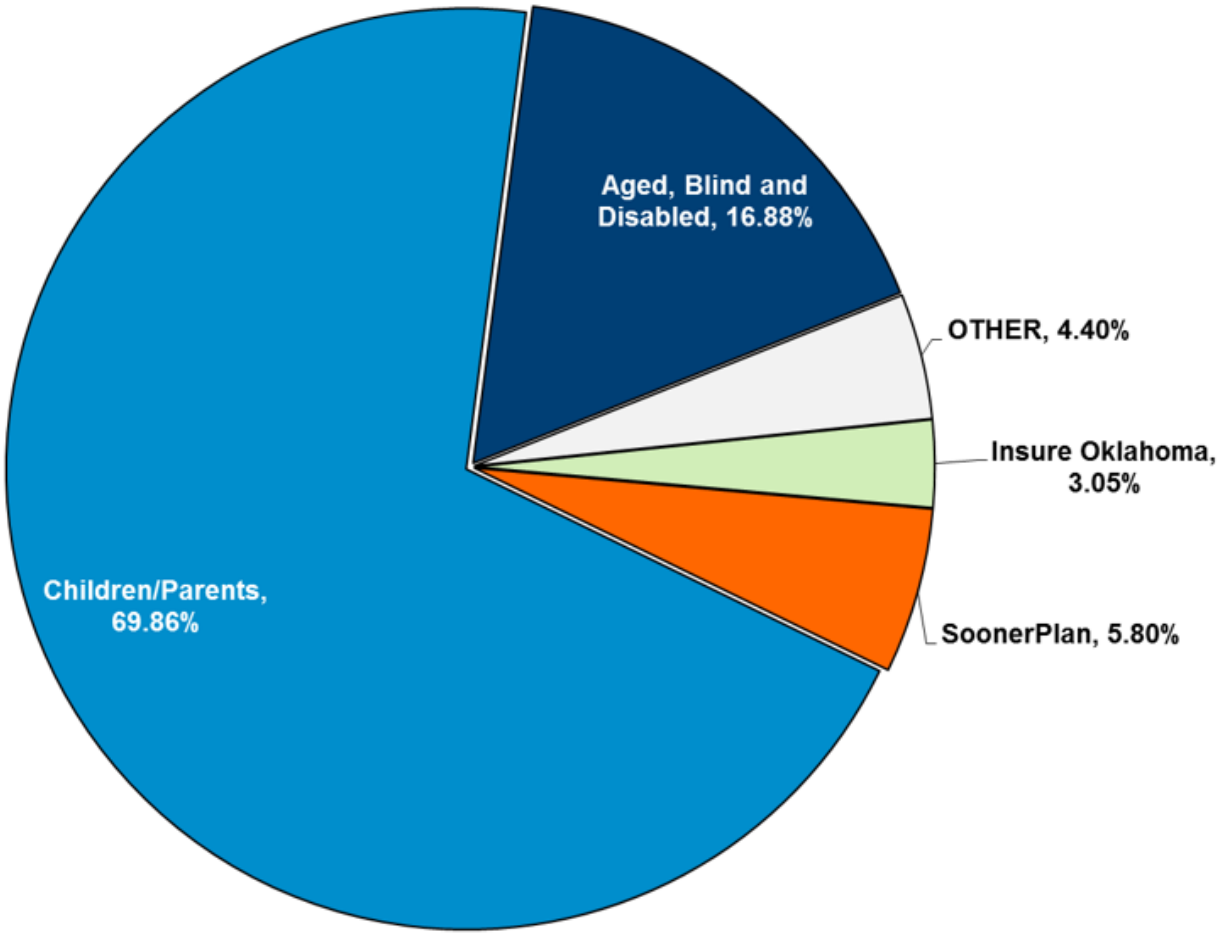
Figure 1. Oklahoma Medicaid Beneficiaries by Age Categories



Data is from OHCA annual reports and MMIS queries.

In order to be covered by SoonerCare an individual must meet eligibility criteria, one of which includes that they be eligible in a qualifying group. Nearly 70 percent (70%) of covered lives are in the children and parents group, as displayed in Figure 2. In addition, qualifying categories include: aged, blind and disabled individuals at 16.88 percent (16.88%); SoonerPlan family planning coverage for men and women who are not otherwise eligible for SoonerCare at 5.80 percent (5.80%); Other (i.e., mostly limited-scope pregnant women and dual (Medicaid/Medicare) enrollees, etc.) at 4.40 percent(4.40%); and Insure Oklahoma premium assistance at 3.05 percent (3.05%).

Figure 2. Oklahoma Medicaid Beneficiaries by Qualifying Group



Data is from OHCA annual reports and MMIS queries.

Access concerns raised by beneficiaries

In accordance with 42 CFR § 447.203(b)(2) and 42 CFR § 447.203(b)(7)

OHCA has developed a comprehensive support system for assisting members and providers with access concerns that may arise. Agency departments which directly specialize in member services, provider services, population care management, and behavioral health services ensure member and provider satisfaction with the program. A number of strategies are employed by these departments, such as helplines, surveys and reviews of grievance and appeals data.

OHCA operates multiple toll-free helplines to assist members and providers, which are answered by trained contractors or Agency staff on every state business day. These helplines form the basis of an early warning system of potential access issues. Some of the highlights of departmental support for access in the SoonerCare program are contained in the summaries which follow.

Further, these departments and helplines rely on additional expertise from throughout the organization to ensure that members have needed access. Medical professional services, pharmacy services, business enterprises, tribal government relations, and third party liability units are just a few of the areas that may be consulted on a daily basis to assist members with access concerns.

During state fiscal years 2016-2018, the Agency received no inquiries related to access to care.

Member Services

The SoonerCare Helpline is the main number available to all members, prominently featured on the back of member ID cards, promotional materials, and in the member handbook. This helpline handled more than 900,000 calls in state fiscal year 2018. Contractor agents respond to Tier One general inquiries (i.e., enrollment, claim status, pharmacy inquiries, etc.), while more complex matters (i.e., complaint on a provider, fraud and abuse, reimbursement, etc.) are referred to Tier Two OHCA staff for assistance. All inquiries are coded and tracked through the interChange Enhancement (iCE) Production, a CMS-certified, web-based system, and issues are resolved within the confines of approved Agency policy. Member services, a staff of approximately 30 individuals, also responds to approximately 450 specialty care referral requests per month. More than 7,000 calls are received every month with a request to enroll with, or to request information about, a particular PCMH.

For assistance with access to care, the OHCA "Find a Provider" web page offers the SoonerCare Provider Directory as well as the following "Find a Provider" Helplines listed in Figure 3.

Figure 3. OHCA SoonerCare Member "Find a Provider" Helplines

SoonerCare Helpline - Changing your PCP/CM, finding a specialist, etc.	800-987-7767 800-522-0114 800-757-5979 TTY
Behavioral Health - Web-based Behavioral Health Provider Directory	800-652-2010 Toll Free
Care Management - Complex and/or unusual health care needs Child health and immunizations	877-252-6002 TTY 405-522-7188
Dental Care - Call the provider first to see if they are accepting new patients. Directory of contracted dentists by county	
Fee-For-Service (FFS) Providers - Please call our Customer Service for the listing of FFS providers in your area	800-522-0310 800-522-0114 405-522-7179 TTY
OB/GYN Providers	
Nursing Facility Quality Improvement **Focus on Excellence** We believe in working together to enrich the lives of our loved ones.	Jennifer Wynn 405-522-7306
Pharmacy & DME (Durable Medical Equipment) Providers Directory	
Pregnancy Specialty Services ‣ Lactation Consultants and Licensed Clinical Social Workers ‣ Maternal/Child Health Licensed Clinical Social Workers	
Vision - Optometrists and Ophthalmologists Directory of contracted optometrists and ophthalmologists by county	800-522-0310 800-522-0114 405-522-7179 TTY
Pharmacy Help Desk	800-522-0310 800-522-0114 405-522-7179 TTY
SoonerRide - non-emergency transportation	877-404-4500

Provider Services

The provider services staff is comprised of roughly 45 individuals who focus on training, recruitment and customer service assistance with program guidance and claims resolution.

Provider services staff answers the toll-free helpline for providers to assist with resolution of claims and policy questions. Calls and resolutions are tracked so that trends can be identified and monitored. Calls tracked in state fiscal year 2017 totaled 35,839 and 30,071 were handled by provider services staff in state fiscal year 2018 (see Appendix G). The provider call tree (see Appendix B) offers the following call types:

- Policy questions
- Internet help desk
- Edi help desk
- Adjustments
- Third party liability
- Pharmacy help desk authorizations
- Behavioral health outpatient authorizations
- Behavioral health inpatient authorizations
- Medical authorizations status
- Prior authorizations
- Dental authorizations

In state fiscal year 2018 (SFY 2018), OHCA provider services also hosted 14 large group workshop provider training sessions attended by more than 1,908 providers. Additionally, some 2,875 on-site provider training sessions were conducted in provider's offices.

While provider inquiries regarding access needs are focused on the provider helplines, another barometer of provider access is provider contracting. Provider enrollment continuously monitors contract termination requests that are initiated by providers and refers such matters to Provider services. Staff in provider services research any reported aspects of provider dissatisfaction to determine if remedies exist that will restore the relationship with the provider. Suggestions to streamline systems and reduce administrative burden are incorporated whenever possible in order to ensure that providers are retained in the network.

In collaboration with the other departments listed above, the total number of calls handled by the provider call tree was 571,864 for SFY 2018 (see Appendix C).

Health Access Networks

OHCA understands the importance of the SoonerCare Choice initiative of adding community-based Health Access Networks (HAN) to work with affiliated PCMH providers to coordinate and improve the quality of care for SoonerCare members; PCMH providers serve as the backbone for health care access to SoonerCare Choice members. HANs are required to offer care management services in targeted populations, such as frequent emergency room (ER) utilization, appointment coordination for members and aligning members with specialty care. In an evaluation completed by Pacific Health Policy Group (PHPG), released in Dec. 2018, emergency room utilization decreased for care-managed HAN members by 31 percent (31%) in the 12 months following the initiation of HAN care coordination services, substantiating HAN efforts. Additionally, HANs pursue quality improvement initiatives focused on the improvement of health outcomes.

Figure 4. Health Access Networks (HANs)

Health Access Networks (HANs)	SFY2013	SFY2016	SFY2017	SFY2018
Number of Contracted HANs	3	3	3	3
Number of Enrollees (at June 30)	90,688	117,750	147,559	168,831
Number of Members Under Care Management	1,418	13,200	11,787	15,728
Number of Unduplicated Providers in HANs	484	767	957	798

Source: Provider services— Numbers reflect point-in-time data

Population Care Management Services

The population care management department serves an average of approximately 2,926 SoonerCare members per month with care coordination services that may include assistance with access to care. This department of nearly 45 individuals, the majority of whom are registered nurses, facilitates the delivery of healthcare through the most appropriate resources, providers, and facilities of the SoonerCare program. With its focus on episodic or event-based care, population care management is charged with coordinating a variety of obstetrical and pediatric services, out-of-state care, long-term care waivers review, and complex case management. Social services coordination is also available through this unit. Population care management is involved in reviewing authorization requests for meals and lodging that may be necessary when members are undergoing certain inpatient or outpatient procedures.

For a more in-depth analysis of the contributions of population care management and the returns on investment of these holistic care coordination efforts, see the June 2018 Independent Evaluation of the SoonerCare Choice Program.

Behavioral Health Department

The behavioral health department provides assistance to SoonerCare members with behavioral health needs as well as their providers. This includes care coordination of both inpatient and outpatient behavioral health services for members who have complex mental health or substance use treatment needs. Referrals are accepted from members, providers and other state agencies as well as OHCA nurse care managers working with members in multiple programs. A toll-free dedicated behavioral health helpline is available for consultation to assist members and providers statewide. For SoonerCare members under the age of 21 who require inpatient behavioral health treatment, a behavioral health care manager follows the member throughout the episode of care to ensure receipt of active treatment in the least restrictive environment, appropriate resources upon discharge, and a smooth transition and engagement with community-based services is established. A psychiatric consultation program is also available to facilitate free, informal, telephonic consultations between psychiatrists and primary care providers regarding psychotropic medication management for children and adolescents. Any provider can contact the behavioral health unit to schedule an appointment. One of three child and adolescent psychiatrists on staff will call the provider back on the appointed day and time to review the case and provide recommendations.

Agency Partners

External to the Agency are eleven agency partners (five of which are Tribal partners) that assist with online eligibility applications and program information. OHCA participates in a number of collaborative endeavors with communities around the state to improve the health of Oklahomans.

Member Advisory Task Force (MATF)

OHCA launched the MATF in October 2010 in an effort to provide a structured process to engage members and connect them with OHCA leadership to identify issues and develop solutions to better inform regarding agency policy and programmatic decision-making. Together with OHCA staff, MATF members have identified areas for policy, program, and process improvement resulting in positive changes.

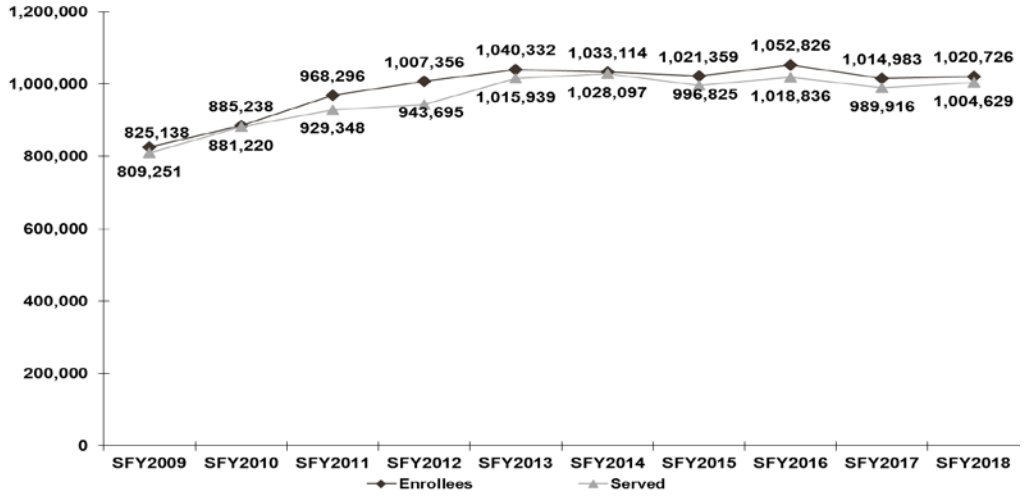
OHCA is committed to addressing the needs and challenges of its members and the MATF has been instrumental in achieving this goal. MATF members have been involved in guiding advancements in SoonerRide policy, improving access to private duty nursing (PDN), TEFRA, oral health care for those with developmental disabilities, and communication strategies. This partnership has also positively impacted the Agency's strategic planning process. Each regional conference in 2019 had SoonerCare members in attendance to ensure input from those served by SoonerCare.

A MATF member from southwest Oklahoma stated, "I have had the opportunity to share my experiences and concerns with the Oklahoma Health Care Authority by being a part of the Member Advisory Task force for the past 3 years. It has been wonderful to have my voice heard by those that can address issues first hand and make changes to improve services to SoonerCare members. Being a mother of three, I have been grateful for access to quality healthcare in rural southwest Oklahoma. Two of my children have been diagnosed with mental health and chronic health conditions, so I have had to learn how to access services via SoonerCare and find services available to them. As I learn information from using SoonerCare and attending MATF meetings, I share my knowledge with SoonerCare families in my home community and through my job. Today my children are healthy because of SoonerCare."

Members with a Paid Claim

During SFY 2018, the Agency served 1,004,629 members as noted below. The chart presents the numbers of members with at least one paid claim in the reported state fiscal year.

Figure 5. SoonerCare Members Enrolled and Served

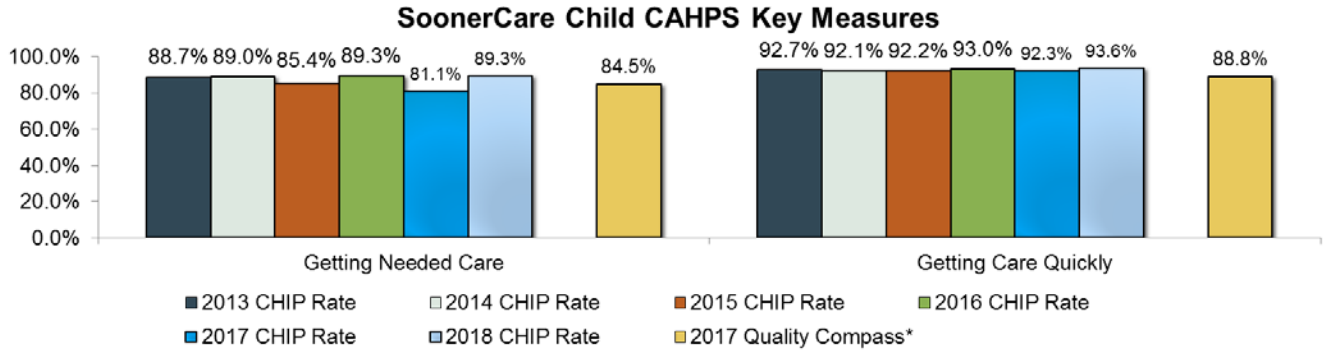


Beneficiary Perceptions of Access to Care

In accordance with 42 CFR § 447.203(b)(2) and 42 CFR § 447.203(b)(7)

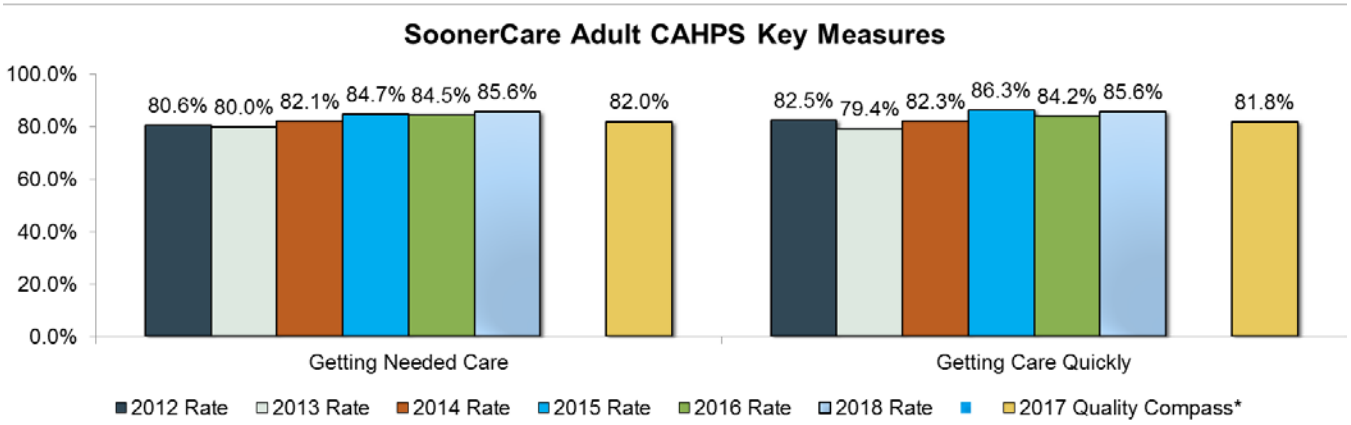
The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) member satisfaction surveys are utilized nationally by both Medicaid and commercial programs as a tool to gauge how well their respective populations feel about the healthcare they are receiving. The results of CAHPS® surveys of both adult and child members for the previous years are included below. The SoonerCare child measures for "Getting Needed Care" and "Getting Care Quickly" were nearly always at or above the national benchmark of the 2017 Quality Compass. The same SoonerCare adult measures show an improving trend such that the last few years exceeded the national benchmark.

Figure 6. SoonerCare Child CAHPS® Key Measures



*The 50th percentile of the 2018 Child Medicaid Quality Compass composite summary rate, which consists of 118 health plans which publicly and non-publicly reported their scores (All Lines of Business excluding PPOs).

Figure 7. SoonerCare Adult CAHPS® Key Measures



*The 50th percentile of the 2018 Adult Medicaid Quality Compass composite summary rate, which consists of 177 health plans which publicly reported their scores (All Lines of Business excluding PPOs).

Comparison Analysis of Medicaid Payment Rates to Medicare and Other Payers

In accordance with 42 CFR § 447.203(b)(3)

Many factors influence provider participation in health care programs. Reimbursement is significant among those factors, but not the only consideration. According to the Kaiser Family Foundation Medicaid-to-Medicare Fee Index for all services (primary care, obstetric care, and other services), only 12 states paid higher rates than Oklahoma in 2016.

Figure 8. 2016 Kaiser Family Foundation Medicaid-to-Medicare Fee Index for Surrounding States

Location	All Services
Arkansas	0.80
Colorado	0.80
Kansas	0.78
Louisiana	0.70
Missouri	0.60
New Mexico	0.89
Oklahoma	0.86
Texas	0.65

Several years ago, the OHCA made a commitment to pay physicians and other practitioners whose reimbursement is tied to the physician fee schedule at 100 percent (100%) of Medicare. However, there has been more than $332 million in state and federal funds reduced from the Oklahoma economy over the last two years and more than $472 million in reductions over the last 10 years. A confluence of budget challenges including successive years of reduced state Federal Medical Assistance Percentages (FMAP) and state budget challenges have caused OHCA to reduce provider reimbursement 3.25 percent (3.5%) in 2010, followed by a further reduction of 7.75 percent (7.75%) in 2014 and an additional 3 percent (3%) in January 2016, making the effective reimbursement rate 86.57 percent (86.57%) of Medicare during SFY 2016. During 2010 through 2016, the total reductions amounted to 13.43 percent (13.43%).

In 2018, the Oklahoma state revenue improved, Oklahoma's FMAP increased, and provider rates increased for the first time in years. .Oklahoma's FMAP increased from 58.6 percent (58.6 %) in federal fiscal year 2018 to 62.4 percent (62.4%) for federal fiscal year 2019. This translates to an FMAP increase of $130 million savings which was used to increase provider rates by 3 percent (3%) effective October 1, 2018. With the 3 percent (3%) provider rate increase, the reimbursement rate increased from 86.57 percent (86.57%) to 89.57 percent (89.57%) of Medicare. Additionally, changes were made to accommodate an increase to SoonerCare-contracted long-term care facilities by 4 percent (4%). Regular nursing facilities received a separate rate increase of 3.2 percent (3.2%) and regular and acute Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) received a rate increase of 3.5 percent (3.5%).

The OHCA evaluated reimbursement rates of the ten most frequently billed CPT codes to analyze how SoonerCare payment rates compare to other public and private payers (see Figure 9). The

payment rates examined consisted of HealthChoice, one of the largest private insurers in Oklahoma; TRICARE; as well as the Medicaid programs of Texas, Kansas, Arkansas, Louisiana, and New Mexico. Although HealthChoice and TRICARE reimburse providers at a higher payment rate than SoonerCare for the ten most frequently billed CPT codes, only one contiguous state (New Mexico) paid slightly higher rates than Oklahoma for half of the ten CPT codes. It should be noted, some states provide different reimbursement for non-physician practitioners, but this is generally not the case for SoonerCare.

Figure 9. 2019 Medicaid and Private Payer Payment Rates

CPT	SoonerCare	SoonerCare Facility	HealthChoice	HealthChoice Facility
99201	$37.82	$23.52	$53.01	$32.96
99202	$64.05	$44.32	$89.79	$62.13
99203	$92.51	$67.34	$129.68	$94.40
99204	$141.95	$113.63	$198.99	$159.29
99205	$179.00	$148.40	$250.93	$208.03
99211	$18.10	$8.09	$25.38	$11.34
99212	$37.23	$22.35	$52.19	$31.34
99213	$62.46	$48.83	$87.55	$63.09
99214	$92.40	$68.95	$129.53	$96.65
99215	$124.96	$97.50	$175.16	$136.68

CPT	Texas MC Child	Texas MC Adult	Arkansas MC	Kansas MC	Louisiana MC Child	Louisiana MC Adult	New Mexico MC
99201	$28.87	$26.04	$29.70	$30.91	$29.52	$26.24 - $29.52	$35.18
99202	$45.56	$41.09	$45.10	$50.66	$51.33	$42.77 - $45.62	$62.74
99203	$61.56	$55.52	$64.90	$75.45	$74.62	$62.10 - $74.62	$93.52
99204	$90.07	$81.24	$88.00	$107.12	$115.88	$96.56 - $115.88	$132.70
99205	$111.98	$101.00	$137.50	$136.62	$146.62	122.19 - $146.62	$169.19
99211	$14.90	$13.49	$14.30	$16.36	$14.82	$12.36 - $14.82	$17.91
99212	$25.04	$22.59	$27.50	$29.76	$29.79	$24.83 - $29.79	$36.89
99213	$37.64	$33.95	$36.30	$40.84	$49.84	$41.53 - $49.84	$53.19
99214	$52.86	$47.68	$70.05	$64.22	$75.18	$62.65 - $75.81	$79.45
99215	$81.38	$73.40	$106.00	$94.00	$101.92	$84.93 - $101.92	$116.27

Louisiana is listed as a range of numbers due to their different fee schedule based on provider type, age, and pregnancy status.

CPT	TriCare physician office	TriCare Physician Facility	TriCare NPP Office	TriCare NPP facility
99201	$26.37	$42.41	$22.42	$36.05
99202	$49.70	$71.83	$42.25	$61.06
99203	$75.52	$103.74	$64.19	$88.18
99204	$127.43	$159.19	$108.32	$135.31
99205	$166.42	$200.74	$141.46	$170.63
99211	$9.07	$20.30	$7.71	$17.25
99212	$25.07	$41.75	$21.31	$35.49
99213	$50.48	$70.04	$42.91	$59.54
99214	$77.32	$103.62	$65.73	$88.08
99215	$109.34	$140.13	$92.94	$119.11

Reimbursement fees as of Feb. 15, 2019

Comparison of Behavioral Health Services Rates

The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) has furnished the following data which represents a comparison of how other states pay for behavioral health services as a percentage of Medicare:

Figure 10. Behavioral Health Services as a Percentage of Medicare for 2015 and 2018

State	Avg % of Medicare	
	2015	2018
OK	71.8%	58.6%
LA	75.0%	68.8%
NM	84.0%	84.1%
AR	64.0%	84.3%
TX	74.0%	97.0%
ID	90.0%	93.8%
NC	76.0%	69.9%
MS	95.0%	89.4%
KY	62.0%	67.8%

Analysis of Primary Care Services

In accordance with 42 CFR § 447.203(b)(5)(ii)(A)

Primary care services can include services for the covered population in general or specific access with the managed care primary care program that is operated as a PCMH and reimbursed on a FFS basis. This section of the analysis will begin with an overview of access to primary care in general across all programs.

The AMRP requirements outline "primary care services" as including those provided by a physician, federally qualified health center, clinic, or dental care. OHCA has compiled the data regarding these four mandated provider types in Figure 11. All primary care services network types increased from

the baseline year. The percentage of SoonerCare beneficiaries accessing services by a physician remains steady as seen in Figure 12.

Provider networks are comprised of providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and/or specialties. The data is from OHCA's Annual Reports and MMIS queries. Figure 11 represents both counts of providers and their distribution in either rural or urban areas of the state.

Figure 11. Primary Care Services Network Types

Provider Network Type	SFY 2013	SFY 2016	SFY 2017	SFY 2018
PCPs*	6,851	7,574	8,688	7,383
Advance Practice Nurse	1,557	2,488	3,128	3,780
Physician Assistant	1,131	1,727	1,574	1,789
FQHC/RHC	129	159	182	210
Dentist	1,448	1,494	1,647	1,740

Provider contract renewal periods can lead to temporary decrease in provider network.

	SFY 2018		
Provider Network Type	Urban	Rural	Out of State
PCPs*	3,193	1,338	2,852
Advance Practice Nurse	1,475	868	1,437
Physician Assistant	1,007	385	397
FQHC/RHC	42	130	38
Dentist	911	522	307

Urban counties include Canadian, Cleveland, Comanche, Creek, Logan, McClain, Oklahoma, Osage, Rogers, Tulsa, and Wagoner.
*Primary Care Providers consist of all providers contracted as a Family Practitioner, General Pediatrician, General Practitioner, Internist and General Internist. They are not necessarily a Choice/Medical Home Provider.

Measures of access to physician and dental services in Figure 12 are based on paid claims adjudicated in the MMIS, and reflect adequate access to care. The adult dental benefit is limited to emergency extractions.

Extensive recruitment and education over the past several years has led to significant gains in children receiving dental care, which is a priority to the Agency.

Figure 12. Beneficiaries Served by Physicians and Dentists

Type of Service - SFY 2018	Members Served	Members Enrolled	Percent Served
Physician*	722,236	1,020,726	71%
Dental	320,933	1,020,726	31%
Dental (Children 20 & Under)	295,023	637,888	46%

Type of Service - SFY 2013	Members Served	Members Enrolled	Percent Served
Physician*	734,533	1,040,332	71%
Dental	323,313	1,040,332	31%
Dental (Children 20 & Under)	286,358	625,680	46%

*Includes both PCP and Physician Specialists

SoonerCare Choice

The OHCA was created to transition Medicaid from FFS to managed care. Today, some 70 percent (70%) of eligibles are enrolled in SoonerCare Choice, or "Choice". The populations that are excluded from SoonerCare Choice include those with dual Medicaid and Medicare coverage, children in state or tribal custody, individuals who are institutionalized, those receiving services in home and community-based services waivers, and those who have other forms of creditable coverage. The delivery system for SoonerCare Choice is primary care case management in a PCMH model. Participating primary care providers receive a monthly care coordination payment and are responsible for referrals and coordinating care with other providers as needed. New members select a medical home once they have been found eligible in the real-time online eligibility and enrollment system. If a member is eligible for Choice but no longer enrolled with a medical home, a toll-free call to the SoonerCare Helpline will let the member select a medical home. A selection takes effect in real time, allowing members to enroll with the provider they really wish to see with ease. In addition, the alignment methodology in the MMIS will lead to enrollment for family members in the same medical home or enroll members with a former medical home if that practice is still appropriate for the member. The time/distance standard for SoonerCare Choice is 45 minutes or miles. Individuals may select a provider farther away, but this may limit their access to non-emergency transportation, except in certain circumstances.

Providers contract with OHCA to be a medical home provider. In the process, the provider identifies readiness to serve a child, adult, or mixed-patient population, while also indicating if services meet the requirements of the standard, advanced, or optimal medical home tier. Further, medical home providers indicate the number of SoonerCare Choice members they can accommodate on their panels. A recent analysis of capacity available in the SoonerCare Choice network showed that there is a substantial number of openings for new members, with approximately 40 percent (40%) of potential capacity used. See Appendix A for additional information about provider availability.

Further, a 2018 analysis of Choice member claims for services with their medical homes found that 87 percent (87%) of Oklahoma's 77 counties sustain an adequate number of medical homes such that SoonerCare beneficiaries traveled no more than 45 miles to see their medical home provider (see Appendix D).

SoonerCare Choice ITU

American Indians/Alaska Natives (AI/AN) make up a large proportion of SoonerCare members, more than 10 percent (10%) of the population, as demonstrated in Figure 13. The Agency has a dedicated tribal government relations unit that fosters relationships with tribal governments and Indian

Health Services, Tribal, and Urban Indian Clinic providers to ensure access to care and work toward the elimination of health disparities. Approximately 18,800 SoonerCare Choice members receive culturally appropriate services through these SoonerCare Choice contracted providers referred to as I/T/Us (see Figure 14 below). Capacity used has remained relatively stable from the baseline year.

Figure 13. SoonerCare Population by Race

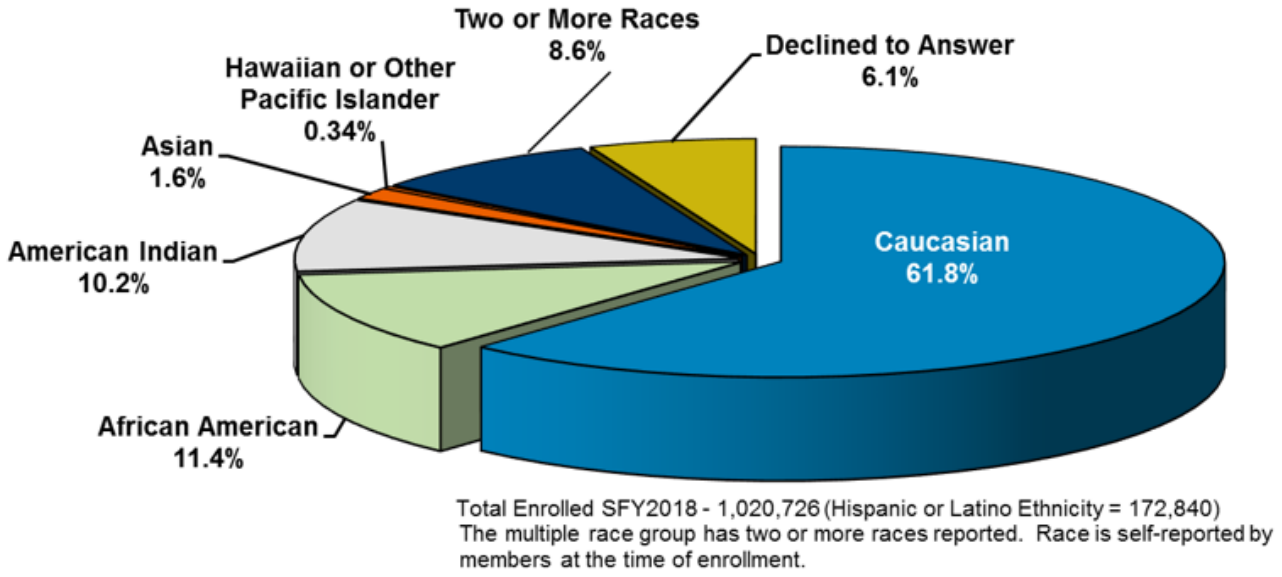


Figure 14. SoonerCare Choice and SoonerCare Choice I/T/U Beneficiaries Served

SoonerCare Program Description - SFY 2018	Max Number of Clients	% of Capacity Used
SoonerCare Choice	1,354,965	40.73%
SoonerCare Choice I/T/U	100,899	18.66%

SoonerCare Program Description - SFY 2013	Max Number of Clients	% of Capacity Used
SoonerCare Choice	1,228,870	46.96%
SoonerCare Choice I/T/U	101,900	16.63%

Total Capacity represents the maximum number of members that PCPs request to have assigned within OHCA's limit. Panels on hold status are excluded from the capacity calculation. The facility's panels such as group practice, FQHC (Federally Qualified Health Clinic), RHC (Rural Health Clinic) and other clinics are included.

Comprehensive Primary Care Plus (CPC+)

CMS has replaced the original Comprehensive Primary Care Initiative (CPCI) with Comprehensive Primary Care Plus (CPC+). CPC+ is a five-year multi-payer initiative that began January 1, 2017. This endeavor includes public and private payers and supports the provision of five "comprehensive" primary care functions, including access and continuity.

CPC+ includes three payment elements which are a care management fee, performance-based incentive payment, and payment under the Medicare physician fee schedule.

In CPCI, Oklahoma's northeast region had 66 practices participating in the program. CMS expanded the program for CPC+ in Oklahoma to include statewide participation to interested practices. As of May 2019, there are 694 providers in Oklahoma currently participating in CPC+.

Analysis of Physician Specialists

In accordance with 42 CFR § 447.203(b)(5)(ii)(B)

Developing a suitable network of specialty care providers has been a priority at OHCA for a number of years. Thanks to adequate reimbursement, reasonable administrative policies, and outstanding provider support, the network of specialists has grown to encompass a wide variety of practitioners. Roughly 12,000 physician specialists are contracted and available to serve SoonerCare members as identified in Figure 15. While there was an increase in pediatric specialists and other specialists, there was a slight decrease in cardiologists and radiologists during their contract renewal period in SFY 2017; this fluctuation is common during renewal periods.

In January 2014, SoonerCare launched a new, secure provider portal. One of the portal features is the ability for providers to search for other providers. Providers may search by either address or distance and then select the provider type and specialty. A listing of providers who match the search criteria will be returned. The information returned will include the address and phone number of the provider. The provider's name is a hyperlink that will open a new window with other useful information about the provider selected. A link to Mapquest is also available so that patients may be given a map and directions to the provider's location. This functionality is especially helpful in identifying specialty care providers for referral purposes and to enhance care coordination. Around 28,846 page views were counted in the first three months of calendar year 2019.

OHCA staff that assist members rely on the provider subsystem of the MMIS. The provider subsystem is customized so that the primary and secondary specialties can be designated in the data for each contracted SoonerCare provider. Refer to Appendix E for more extensive information about contracted provider specialties and to Appendix F for the provider type options.

Figure 15. Physician Specialists Provider Network Types

Provider Network Type	SFY 2013	SFY 2016	SFY 2017	SFY 2018
Cardiologist	684	671	759	656
Pediatric Specialist	1,518	1,957	2,321	2,016
Radiologist	1,726	1,644	1,915	1,605
Physician - Other Specialist	6,081	6,958	8,314	7,443

Provider contract renewal periods can lead to temporary decrease in provider network.

	SFY 2018		
Provider Network Type	Urban	Rural	Out of State
Cardiologist	298	76	282
Pediatric Specialist	355	18	1,643
Radiologist	452	96	1,057
Physician - Other Specialist	3,074	747	3,622

Urban counties include Canadian, Cleveland, Comanche, Creek, Logan, McClain, Oklahoma, Osage, Rogers, Tulsa and Wagoner.

Data is from OHCA's annual reports and MMIS queries.

As noted in Strategy 3, Rural Services, of the Strategic Plan, OHCA is committed to use technology to improve access to services and information including behavioral health services delivered via

telehealth; address technology needs related to originating sites for telehealth and consider pharmacies, public libraries, schools and other community locations. For additional information about telehealth, see the section of this report named Availability of Telemedicine and Telehealth.

Analysis of Behavioral Health Specialties

In accordance with 42 CFR § 447.203(b)(5)(ii)(C)

SoonerCare covers a full array of behavioral health treatment services (mental health and substance use disorder treatment) for members across the spectrum of treatment needs. Outpatient services include, but are not limited to, crisis intervention and stabilization, targeted case management, peer support services, psychosocial rehabilitation, psychotherapy, diagnostic evaluation and assessment, and evidence based models of treatment such as Program of Assertive Community Treatment (PACT) for adults and a statewide System of Care for children which incorporates a high fidelity Wraparound® approach to treatment.

In order to ensure adequate access to behavioral health treatment services throughout the state, most behavioral health treatment services are available via telehealth. Telehealth technology is available statewide through Oklahoma's Community Mental Health Center (CMHC) network of providers.

The OHCA has an extensive network of behavioral health providers including CMHCs, outpatient behavioral health agencies, licensed behavioral health professionals, psychologists, and psychiatrists. In order to augment the work done by the licensed professionals, The OHCA also contracts with various levels of paraprofessionals such as case managers and peer support specialists.

Data on the extensive availability of behavioral health contracted providers, specialists, services, and the number of members served is found in Figures 16 through 18. The behavioral health provider network is comparable to the baseline year with recent fluctuations due to contract renewal period. In addition, there has been an overall increase in the number of members served.

Figure 16. Behavioral Health Provider Network Types

Provider Network Type	SFY 2013	SFY 2016	SFY 2017	SFY 2018
Behavioral Health Providers**	10,425	11,974	11,310	10,474
Community Mental Health Center (CMHC)	112	99	105	95
Outpatient Behavioral Health Agency*	524	589	632	532
Psychologist	374	408	443	357
Hospital - Psychiatric	19	25	28	40
Hospital - Resident Treatment Center	49	43	44	47
Psychiatric Residential Treatment Facility	-	-	-	21

Provider contract renewal periods can lead to temporary decrease in provider network.

	SFY 2018		
Provider Network Type	Urban	Rural	Out of State
Behavioral Health Providers**	6,428	4,008	38
Community Mental Health Center (CMHC)	35	60	-
Outpatient Behavioral Health Agency	284	248	-
Psychologist	242	58	57
Hospital - Psychiatric	19	8	13
Hospital - Resident Treatment Center	27	8	12
Psychiatric Residential Treatment Facility	13	4	4

Urban counties include Canadian, Cleveland, Comanche, Creek, Logan, McClain, Oklahoma, Osage, Rogers, Tulsa, and Wagoner.
**Breakout by Type of the Behavioral Health Providers count
Data is from Annual Reports and MMIS queries.

Figure 17. Behavioral Health Provider Specialists

Behavioral Health Provider Type	Behavioral Health Specialty Code	Provider Network
DDSD (Developmental Disability Service Division) - Waiver Behavioral Health Provider	Certified Social Worker	29
DDSD (Developmental Disability Service Division) - Waiver Behavioral Health Provider	Family Training	11
DDSD (Developmental Disability Service Division) - Waiver Behavioral Health Provider	Licensed Alcohol and Drug Counselor	549
Health Home	Health Home	135
Licensed Behavioral Health Professional	Alcohol and Other Drug Treatment Professional	1
Licensed Behavioral Health Professional	LADC/MH	93
Licensed Behavioral Health Professional	Licensed Behavioral Practitioner	164
Licensed Behavioral Health Professional	Licensed Clinical Social Worker	830
Licensed Behavioral Health Professional	Licensed Marital and Family Therapist	326
Licensed Behavioral Health Professional	Licensed Professional Counselor	3069
Licensure Candidates	Under Supervision	2061
Para Professional	Para Professional	3,350
Partial Hospitalization	Partial Hospitalization	8

Provider networks are comprised of providers who are contracted to provide health care services by locations, programs, types and specialties. Providers are being counted multiple times if they have multiple locations, programs, types and/or specialties.
The data is from OHCA's Annual Reports and MMIS queries.

Figure 18. State Fiscal Year Behavioral Health Services and Number of Members Served

Behavioral Health Services - SFY 2018 Type of Service	Members Served (Children Younger than Age 21)	Members Served (Adults Ages 21 and Older)	Members Served (All Ages)
Inpatient (Acute - General)	1,011	2,564	3,575
Inpatient (Acute - Freestanding)	2,525	25	2,550
Psychiatric Residential Treatment Facility (PRTF)	3,469	-	3,469
Outpatient	78,130	43,573	121,703
Psychologist	15,898	1,981	17,879
Psychiatrist	10,717	13,254	23,971
Residential Behavior Mgmt Services (Group)	964	-	964
Residential Behavior Mgmt Services (TFC)	591	-	591
SMI/SED Case Management	20,165	12,772	32,937
Other OP Behavioral Hlth Services	168	1,399	1,567
Psychotropic Drugs	60,644	59,117	119,761
Total	100,915	55,187	156,102

Behavioral Health Services - SFY 2013 Type of Service	Members Served (Children Younger than Age 21)	Members Served (Adults Ages 21 and Older)	Members Served (All Ages)
Inpatient (Acute - General)	1,474	2,822	4,292
Inpatient (Acute - Freestanding)	2,348	42	2,390
Psychiatric Residential Treatment Facility (PRTF)	4,656	-	4,656
Outpatient	78,684	37,690	116,050
Psychologist	12,727	1,797	14,503
Psychiatrist	9,075	11,306	20,298
Residential Behavior Mgmt Services (Group)	990	-	990
Residential Behavior Mgmt Services (TFC)	1,177	-	1,177
SMI/SED Case Management	15,839	16,634	32,405
Other OP Behavioral Hlth Services	287	1,082	1,346
Psychotropic Drugs	57,619	83,576	141,195
Total	90,336	47,899	137,789

Data is from Annual Reports and MMIS queries.

Health Homes

In February 2015, a new form of integrated care called health homes began serving Oklahomans with serious mental illness or severe emotional disturbances. Health homes are person-centered systems of care that achieve improved outcomes and better services and value for members with complex needs. Health homes provide coordinated primary and behavioral health integration. The six core services are:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Transitions of care;
- Individual and family support; and
- Referral to community and social support services.

In 2018, there were 13,857 adults and 14,386 children enrolled in health homes. Some 31 health home providers are contracted, with 135 locations available to serve members. Enrollment figures for each population are shown in Figure 19.

Figure 19. Health Home Enrollment

Age Group	SFY 2015	SFY 2016	SFY 2017	SFY 2018
Adult (21+)	8,424	8,760	11,495	13,857
Child (0-20)	4,171	7,908	10,464	14,386
Total	12,595	16,668	21,959	28,243

Analysis of Pre- and Post-Natal Obstetric Services

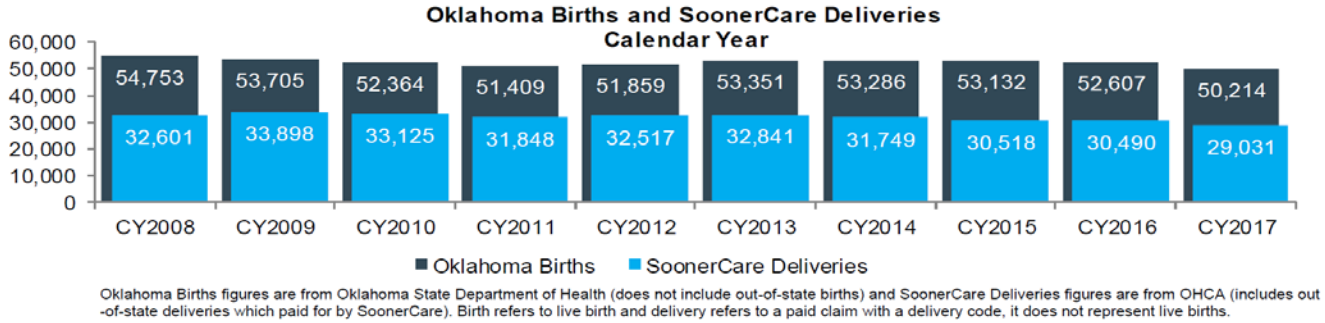
In accordance with 42 CFR § 447.203(b)(5)(ii)(D)

Utilization of health care for pregnant women is a primary focus of the Agency. Pregnancy services are offered to increase the likelihood of healthy pregnancies and births, along with healthy children. SoonerCare is both a primary and secondary payer of pregnancy-related services for members.

Provider access is considered adequate, based on a complementary array of public and private providers; SoonerCare makes access available to obstetric services comparable to other payers. For 2018, there were 898 obstetrician-gynecologists (OB/GYNs) compared to 771 in the baseline year of 2013.

Pregnancy-related services are stable for SoonerCare members, covering approximately 30,000 deliveries annually or nearly 60 percent (60%) of Oklahoma births, as noted in Figure 20.

Figure 20. Oklahoma Births and SoonerCare Deliveries



Oklahoma Births figures are from Oklahoma State Department of Health (does not include out-of-state births) and SoonerCare Deliveries figures are from OHCA (includes out -of-state deliveries which paid for by SoonerCare). Birth refers to live birth and delivery refers to a paid claim with a delivery code, it does not represent live births.

The most recent OHCA "Quality of Care in the SoonerCare Program" features outcomes for reporting year 2017, based on 2016 data. The CMS core set of quality measures includes measures that focus on prenatal and postpartum care as shown in Figure 21.

Prenatal care measures calculate the percentage of live births in which the mother received the expected number of prenatal care visits. Rates are presented to encompass provider billing for services that was based on global obstetrical code billing and billing outside of the global code for both prenatal and post-partum visits. Postpartum visit code rates are for days between 21 and 56 days after delivery. SoonerCare uses global codes where a member's prenatal, delivery, and postpartum services are bundled into a single claim, which often differs from the quality measures specifications. Measures may also have minor or major specification or methodology changes from year to year.

The prenatal care measures increased slightly over the past two report years, while post-partum care measures declined slightly. Measures related to low birthweight show that less than 9 percent (9%) of deliveries are considered in this category. As low birthweight can cause health problems for

newborns, the OHCA is committed to ensuring that as many babies as possible arrive at their optimal weight. This measure is tracked to determine if the State is succeeding with this goal.

Figure 21. Prenatal and Postpartum Care Quality Measures

Quality Measure	Report Year 2013	Report Year 2015	Report Year 2016	Report Year 2017
Prenatal & Postpartum Care: Timeliness of Prenatal Care				
Measure Specifications Rate	18.91%	22.40%	22.60%	23.00%
Global Rate:	69.12%	70.30%	70.30%	70.80%
Percent of Live Births Weighing <2,500 grams	8.96%	8.81%	9.02%	8.91%
Postpartum Care Rate				
Measure Specifications Rate	24.68%	20.89%	21.10%	21.80%
Global Rate	68.64%	67.70%	68.00%	68.50%

Quality Measure data is the previous calendar year (Report 2017 is CY 2016 data, etc.)
Data is from OHCA's 'Quality of Care in the SoonerCare Program' reports.

Analysis of Home Health Services

In accordance with 42 CFR §447.203(b)(5)(ii)(E)

Home health is a mandatory service in the Medicaid program. Home health agencies are distributed fairly evenly across the state, with more agencies concentrated in rural locations.

These agencies provide home health services for members that may include skilled nursing and private duty nursing for qualifying children and adult members. Some services are reimbursed through the FFS system, while a number of members qualify for care in long-term care programs called Home and Community-Based Services (HCBS) Waivers. There was a decrease in both the home health services provider network and number of members served when comparing 2018 to the baseline of 2013. The decrease in 2016 occurred during the contract renewal period, which is typical during this timeframe.

Private duty nursing can be an area that is difficult to staff depending on an agency's ability to recruit experienced nurses for these long-term assignments to care for children in their homes.

Figure 22. Home Health Services

Provider Network Type	SFY 2013	SFY 2016	SFY 2017	SFY 2018
Home Health Agency	216	249	171	175

Provider contract renewal periods can lead to temporary decrease in provider network.

	SFY 2018		
Provider Network Type	Urban	Rural	Out of State
Home Health Agency	81	94	-

Urban counties include Canadian, Cleveland, Comanche, Creek, Logan, McClain, Oklahoma, Osage, Rogers, Tulsa and Wagoner.
Data is from Annual Reports and MMIS queries.

Provider networks are comprised of provider agencies that are contracted to provide health care services by locations, programs, types and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and/or specialties.

Figure 23. Members Receiving Home Health Services

SFY 2018 Type of Service	Members Served (Children Younger than Age 21)	Members Served (Adults Ages 21 and Older)	Members Served (All Ages)
Home Health	1,448	3,291	4,739

SFY 2013 Type of Service	Members Served (Children Younger than Age 21)	Members Served (Adults Ages 21 and Older)	Members Served (All Ages)
Home Health	2,460	4,336	6,796

Data is from OHCA's annual reports and MMIS queries.

Home and Community-Based Waiver Services

Enrollees who meet institutional levels of care and qualify for long-term care services may receive services through one of six Home and Community-Based Services (HCBS) waivers. Figure 24 represents the waivers that are currently available. AD*vantage*, Community, Homeward Bound, In-home Supports for Children and In-home Supports for Adults are programs operated by the Oklahoma Department of Human Services (DHS). AD*vantage* serves frail elders 65 and older along with adults over 21 with physical disabilities. Community, Homeward Bound, In-home Supports for Children, and In-home Supports for Adults are offered to individuals with intellectual disabilities. The OHCA operates the Living Choice demonstration program, which transitions qualifying individuals from nursing facilities to the home and community-based settings of their choice. While the Medically Fragile waiver program serves individuals who meet hospital or skilled nursing facility level of care, eligibility for this program begins at age 19; it is also operated by the OHCA. For 2018, total unduplicated members served by the waivers were 26,831 compared to 27,398 in the baseline year of 2013. Part of the decrease is due to the termination of the My Life My Choice and Sooner Seniors waiver programs. Members of these waivers were transitioned to the AD*vantage* waiver program.

Figure 24. Home & Community-Based Services Waiver

HCBS Waivers	Total	ADvantage	Community	Homeward Bound
Members Served SFY 2018	26,831	21,366	3,011	604
Members Served SFY 2013	27,398	21,681	2,849	709

HCBS Waivers	In-Home Support	Living Choice	Medically Fragile	My Life My Choice	Sooner Seniors
Members Served SFY 2018	1,702	55	98	-	-
Members Served SFY 2013	1,742	240	50	86	41

Data is from Annual Reports and MMIS queries.

These home and community-based services programs require special conditions of provider participation and certification in order for providers to be contracted to furnish waiver services.

Home and community-based waiver service programs operational personnel report that services are adequate, although certain areas of the state may have localized pockets or services that are difficult to staff.

Program of All-inclusive Care for the Elderly (PACE)

The Program of All-Inclusive Care for the Elderly, PACE, is a unique program designed to help individuals receive services as needed in their own homes. Calendar year 2015 brought the expansion of this community-based services program to three providers across the State. Oklahoma is fortunate to have in its ranks the first tribally-sponsored PACE program, with Cherokee Elder Care as the sponsor. Additional fully-capitated PACE locations have been opened in Oklahoma City and Tulsa. There were 563 members enrolled in PACE for 2018 compared to 138 members in 2013.

Implemented in Oklahoma in August 2008, PACE is a managed care model of acute and long-term care that serves individuals who are 55 and older and meet nursing facility level of care. PACE allows individuals to remain in their homes as long as they are safely able to do so. PACE offers a multidisciplinary, patient-centered approach to servicing its participant's social and health care needs. The goal is to maximize the participant's independence and ability to live in the community for as long as possible while receiving quality care tailored to their specific needs.

There are currently three PACE programs in the state of Oklahoma: Cherokee Elder Care, LIFE PACE, and Valir PACE Foundation. Cherokee Elder Care (CEC), located in Tahlequah, Oklahoma, opened August 1, 2008 with two enrolled participants. CEC was created to work in conjunction with the community as well as state and federal governments to provide specialized care to the eldering population in northeastern Oklahoma. CEC is the first PACE program in the state of Oklahoma and the first PACE program to be sponsored by a Native American Tribe in the United States. LIFE PACE, located in Tulsa, Oklahoma, is an affiliate of LIFE Senior Services. LIFE Senior Services has provided home and community-based services to individuals aged 55 and older for more than 35 years. The LIFE PACE team provides the helping hands so important to the health and well-being of aging adults. The care team's focus is on preventive care in order to lessen the need for hospitalization and emergency room visits, improve quality of life and create better health outcomes. Valir PACE is located in Oklahoma City and operates with a philosophy that combines holistic and wellness approaches to healthy living. Prevention comes in the form of nutritious meals, medication management, regular checkups, and preventive therapies.

Access to Care Initiatives

In accordance with 42 CFR § 447.203(b)(8)(i) and 42 CFR § 447.203(b)(8)(ii)

Availability of Telehealth

Telehealth is the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment that occurs in real time and when the member is actively participating during the transmission. OHCA approved policy to implement telehealth as a form of service delivery in 2009. Since then, this modality has increased in popularity as a means of affording access for multiple reasons.

More than 36,000 telehealth claims were paid for more than 18,000 members in calendar year 2017. A telehealth service is differentiated from others by the presence of a specific modifier on the claim. As appropriate, telehealth claims may be of a general nature as an office visit or a consultation and assessment. In addition, several behavioral health services have seen increased usage of telehealth

for psychiatric diagnostic testing, psychotherapy, pharmacological management, and behavioral health service plan development or modification.

Prior to September 1, 2015, OHCA's policy included reimbursement for an originating site provider in the telehealth transaction. For services provided on or after this date, payment is made only to the telehealth provider. Through calendar year 2017, $13 million in telehealth services have been reimbursed to assist members with access to care over the following years.

The OHCA's telehealth claims and reimbursement trends for the reporting periods through calendar year 2017 can be seen in the data in Figures 25 through 32 below. The number of telehealth providers has increased from 363 in 2013 to 778 in 2018 (over 100 percent) while members utilizing telehealth increased from 13,502 to 18,812 (39 percent).

Figure 25. Telehealth Claims Paid by Category

Reporting Period	Consultations-Assessments	Office-Outpatient	Psychiatric Diagnostic/Testing	Psychotherapy	Pharmacologic Management	Behavioral Health Svc Plan	Telehealth Modifier Total
2008	$0	$2,880	$0	$0	$2,106	$0	$4,986
2009	$114	$6,225	$0	$124	$71,090	$0	$77,553
2010	$1,232	$4,953	$0	$246	$617,848	$575	$624,853
2011	$2,802	$5,730	$0	$22,714	$1,217,143	$889	$1,249,278
2012	$13,657	$5,529	$0	$18,090	$1,029,789	$5,150	$1,072,216
2013	$22,389	$1,346,105	$18,169	$31,265	$225,432	$0	$1,643,360
2014	$36,298	$1,918,041	$6,770	$29,360	$3,317	$415	$1,994,201
2015	$31,579	$1,871,714	$12,760	$115,891	$0	$1,563	$2,033,507
2016	$36,042	$1,699,552	$21,440	$216,727	$0	$60,974	$2,034,734
2017	$23,893	$1,949,781	$38,170	$219,800	$0	$36,285	$2,267,929
Totals:	$168,005	$8,810,511	$97,310	$654,219	$3,166,724	$105,850	**$13,002,618**

Figure 26. Telehealth Provider and Originating Site Total Dollars Spent

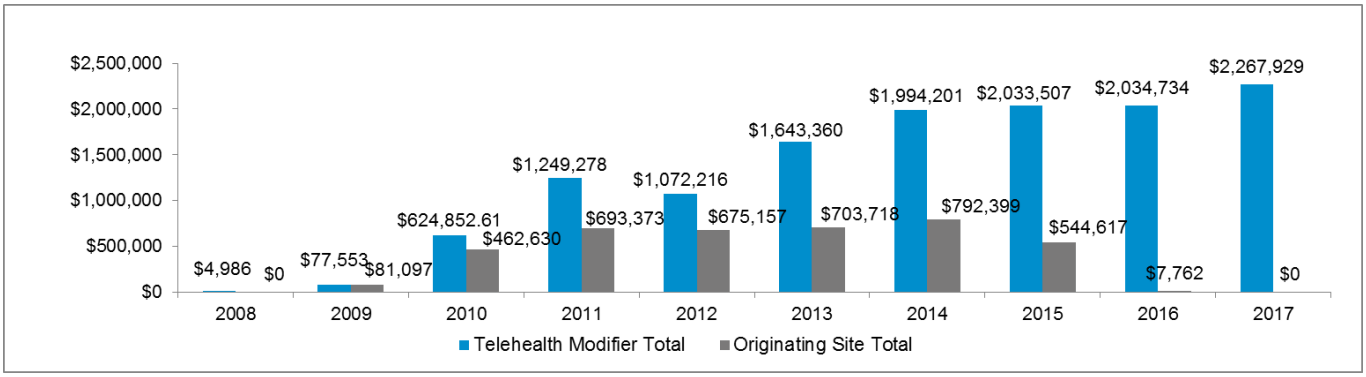
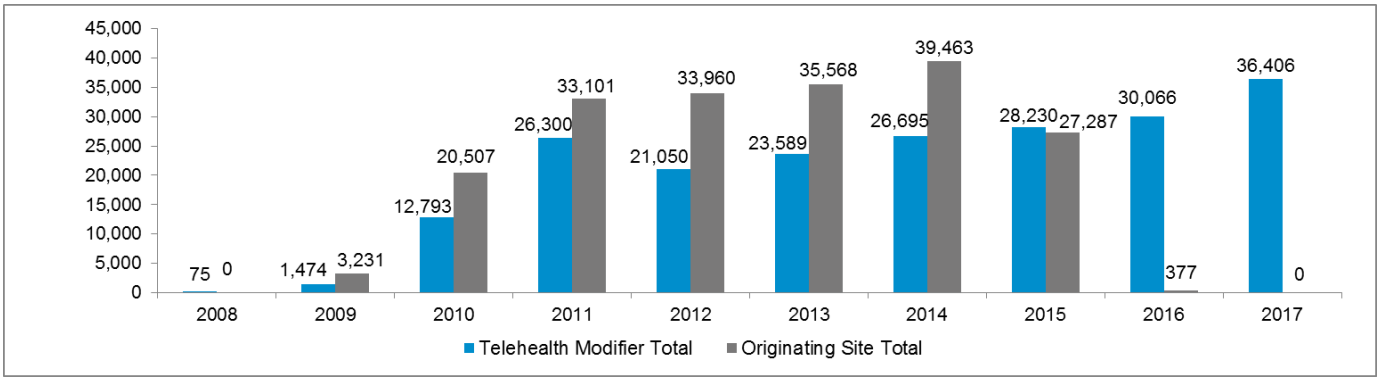


Figure 27. Number of Telehealth Claims Paid by Category

Reporting Period	Consultations-Assessments	Office-Outpatient	Psychiatric Diagnostic/Testing	Psychotherapy	Pharmacologic Management	Behavioral Health Svc Plan	Telehealth Modifier Total
2008	0	33	0	0	42	0	75
2009	1	63	0	2	1,408	0	1,474
2010	26	51	0	5	12,700	11	12,793
2011	190	51	0	606	25,435	18	26,300
2012	359	59	0	442	19,922	268	21,050
2013	301	19,162	141	407	3,414	164	23,589
2014	387	25,478	47	415	66	302	26,695
2015	336	25,448	118	1,741	0	587	28,230
2016	424	23,794	790	3,402	0	1,656	30,066
2017	256	29,830	365	4,513	0	1,442	36,406
Totals:	2,280	123,969	1,461	11,533	62,987	4,448	**206,678**

*Due to CPT code changes from CMS for 2013, Pharmacologic Management claims paid in 2013 will be included with and listed under the Office-Outpatient category

Figure 28. Telehealth Provider and Originating Site Total Claims Paid



The OHCA's providers' and members' telehealth trends for the reporting periods through 2017 can be seen in the data below.

Figure 29. Number of Telehealth Providers Serving SoonerCare Members

Reporting Period	Consultations-Assessments	Office-Outpatient	Psychiatric Diagnostic/Testing	Psychotherapy	Pharmacologic Management	Behavioral Health Svc Plan	Telehealth Modifier Total
2008	0	5	0	0	5	0	10
2009	1	11	0	1	16	0	29
2010	8	8	0	3	58	5	82
2011	11	18	0	13	80	4	126
2012	47	17	0	30	63	15	172
2013	89	192	16	37	23	6	363
2014	110	289	10	73	6	12	500
2015	93	321	11	110	0	22	557
2016	104	288	14	150	0	53	609
2017	88	369	16	188	0	117	778
Totals:	551	1,518	67	605	251	234	**3,226**

Figure 30. Number of Telehealth Providers and Originating Sites Serving SoonerCare Members

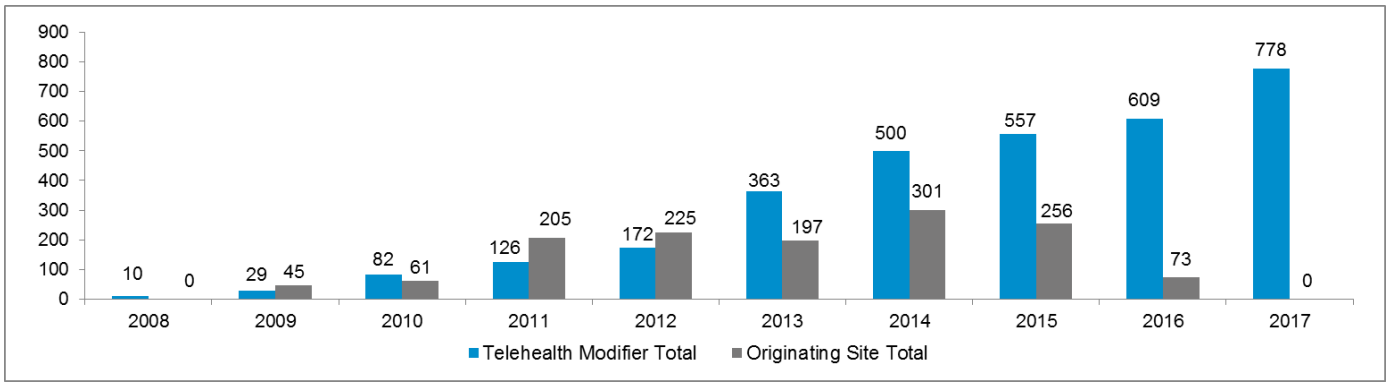
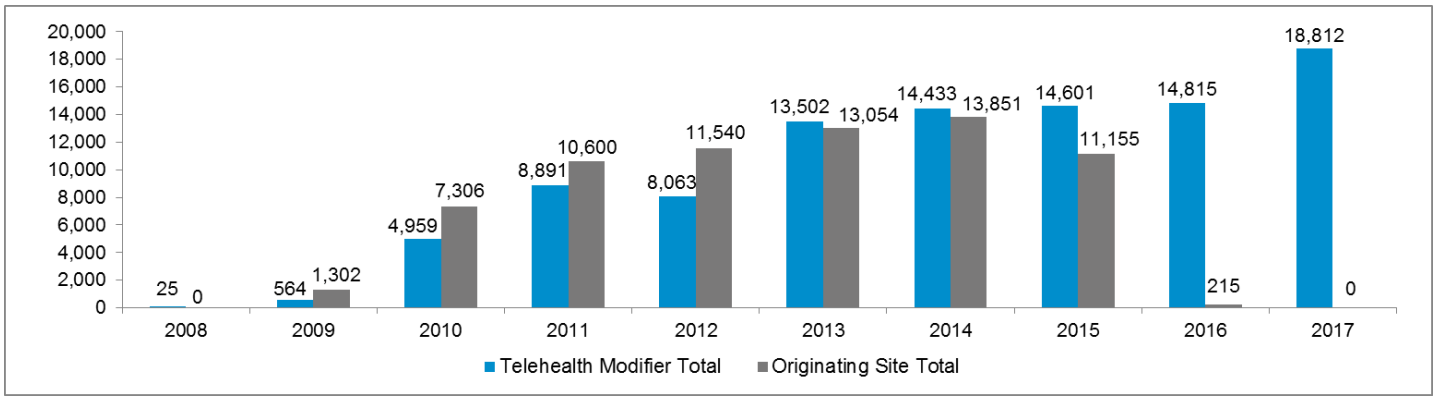


Figure 31. Number of SoonerCare Members with a Telehealth Claim

Reporting Period	Consultations-Assessments	Office-Outpatient	Psychiatric Diagnostic/Testing	Psychotherapy	Pharmacologic Management	Behavioral Health Svc Plan	Telehealth Modifier Total
2008	0	15	0	0	10	0	25
2009	1	29	0	2	532	0	564
2010	26	28	0	5	4,889	11	4,959
2011	182	37	0	600	8,058	14	8,891
2012	348	37	0	417	7,018	243	8,063
2013	294	10,264	140	115	2,532	157	13,502
2014	386	13,458	45	191	64	289	14,433
2015	336	13,005	118	626	0	516	14,601
2016	413	12,597	354	891	0	560	14,815
2017	255	16,323	357	1,219	0	658	18,812
Totals:	2,241	65,793	1,014	4,066	23,103	2,448	**98,665**

*Due to CPT code changes from CMS for 2013, Pharmacologic Management claims paid in 2013 will be included with and listed under the Office-Outpatient category

Figure 32. Number of SoonerCare Members Served by a Telehealth Provider and/or Originating Site



Access to Care Issues Identified in the Analysis

In accordance with 42 CFR § 447.203(b)(8)

SoonerCare members generally express satisfaction with their care, as noted in the CAHPS® results featured in this report. OHCA makes available a number of helplines to assist members and providers with access to care. OHCA's premier delivery system, the SoonerCare Choice PCMH is designed to foster the alignment and coordination of care through the primary care provider. Approximately 70 percent (70%) of beneficiaries are enrolled in this program which addresses

primary and preventive care, along with referrals to specialty care where appropriate. Behavioral health and pregnancy-related services are self-referred. Members may access these services from any contracted network provider. Even though Oklahoma is a state with several designated health professional shortages, OHCA strives to ensure that members have access to quality health care services. Ongoing monitoring is required so that any new needs with regard to access can be identified and strategies can be implemented to address particular needs.

Recommendations on the Sufficiency of Access to Care

In accordance with 42 CFR § 447.203(b)(7) and 42 CFR § 447.203(b)(8)

OHCA continues efforts to develop and maintain an adequate provider network to provide statewide access for SoonerCare members. Provider recruitment operations continue to be performed on a regular basis by the provider services unit; provider services representatives target providers that are not currently contracted with OHCA to help reduce the shortage of available providers. In addition to provider rate increases, the Agency has established and/or is currently establishing new services for members which include: applied behavioral analysis (ABA) services for individuals under the age of 19 and maternal depression screenings for new moms of children with SoonerCare benefits. These and the ongoing modernization of the SoonerCare online enrollment system are resulting in better maintenance of coverage, consistent treatment, and an increase in access to care for beneficiaries. Further, OHCA offers various helplines to assist members with access to care concerns specific to their situations.

OHCA has no additional recommendations on the sufficiency of access to care at this time. Rather, the Agency reaffirms its commitment to the OHCA vision – which speaks both to healthy Oklahomans and access to care.

Plan Update Provisions

In accordance with 42 CFR § 447.203(b)(4) and 42 CFR § 447.203(b)(6)

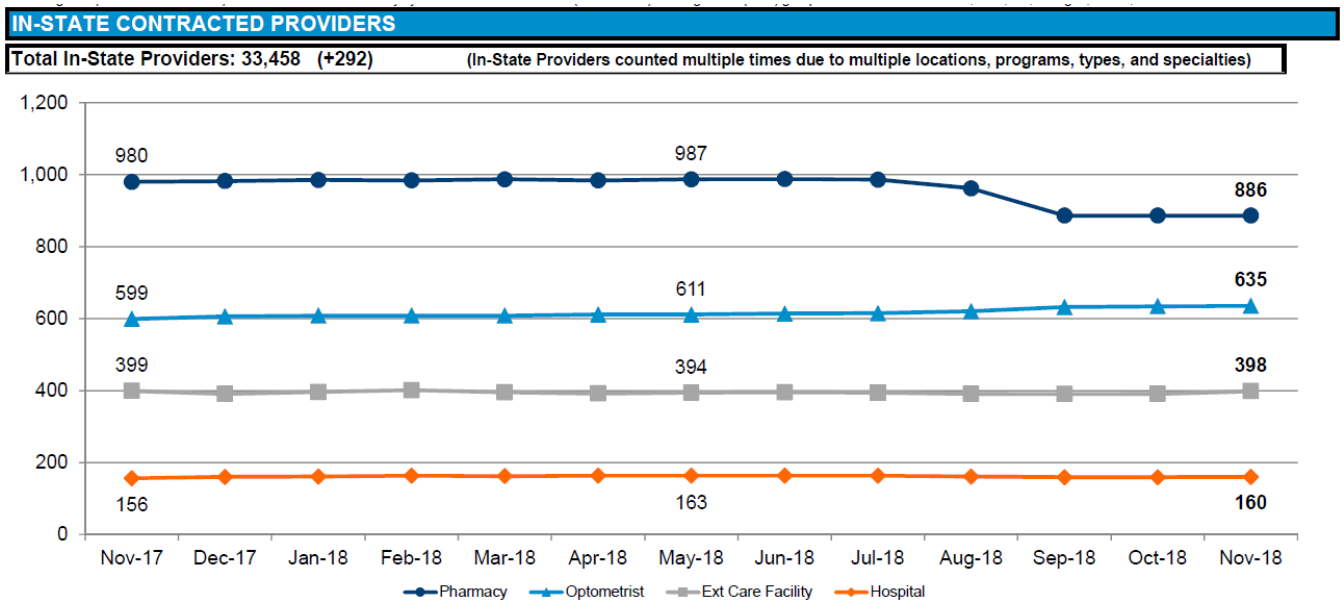
The OHCA will update this plan every three years, based on feedback from members and providers alike. The MAC, in consultation with Agency staff, will coordinate and develop the report.

As the State seeks to revise any payments to providers that propose to reduce provider payment rates or restructure provider payments in circumstances when the changes could result in diminished access, an access to care analysis will be prepared to demonstrate that access to care is sufficient as of the effective date of the state plan amendment. The analysis will accompany any aforementioned state plan amendment filed with the CMS and is updated annually for a period of at least three years after the effective date of the state plan amendment. Analyses conducted within SFY2016 – SFY2018 are included in Appendix H of this report.

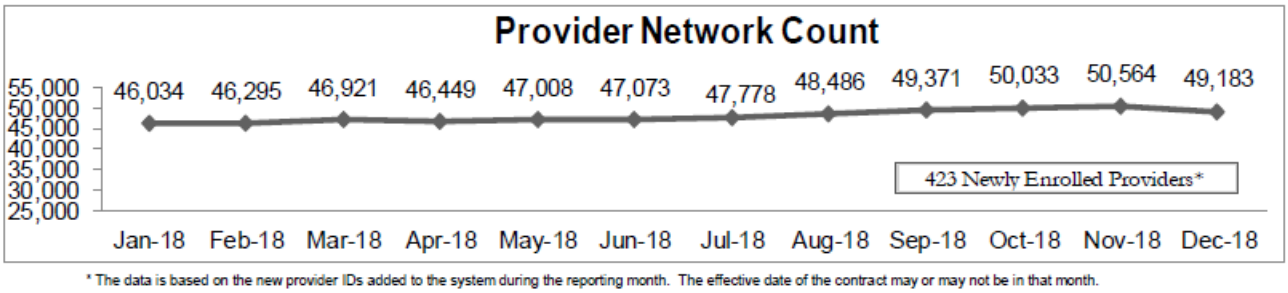
OHCA offers various opportunities for stakeholder engagement when provider rate changes are initiated. This includes the forums of tribal consultation, meetings with provider groups and advocates, the State Plan Amendment Rate Committee (SPARC) and, ultimately, the Board meeting. Public comment is welcome in writing or in oral presentations at the SPARC and Board. Payment policies may also be discussed at the MAC or Behavioral Health Advisory Committee (BHAC). Input may be used to change proposals to make them more generally acceptable to stakeholders when possible. Additionally, the OHCA posts all proposed rule changes, state plan amendments, and waiver requests on its public website; any stakeholder may provide feedback on the proposed changes to the Medicaid program.

Appendix A

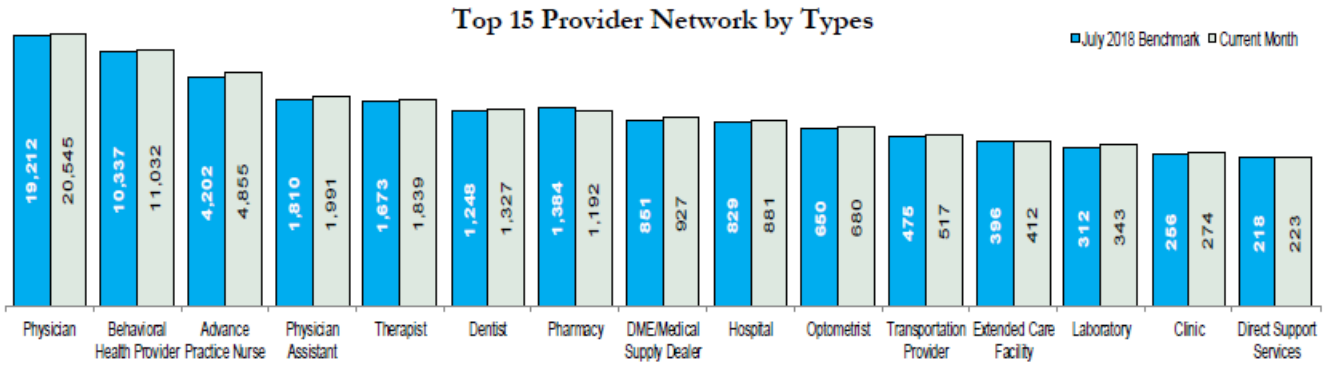
Example of the in-state provider data included in OHCA's Board Meeting that is part of the Medicaid Director's Update.



Example of the total (in-state & out-of-state) provider data, including capacity and member to provider ratio, included in the monthly Provider Fast Facts:



* The data is based on the new provider IDs added to the system during the reporting month. The effective date of the contract may or may not be in that month.



Provider contract renewal periods can lead to temporary decrease in provider network.

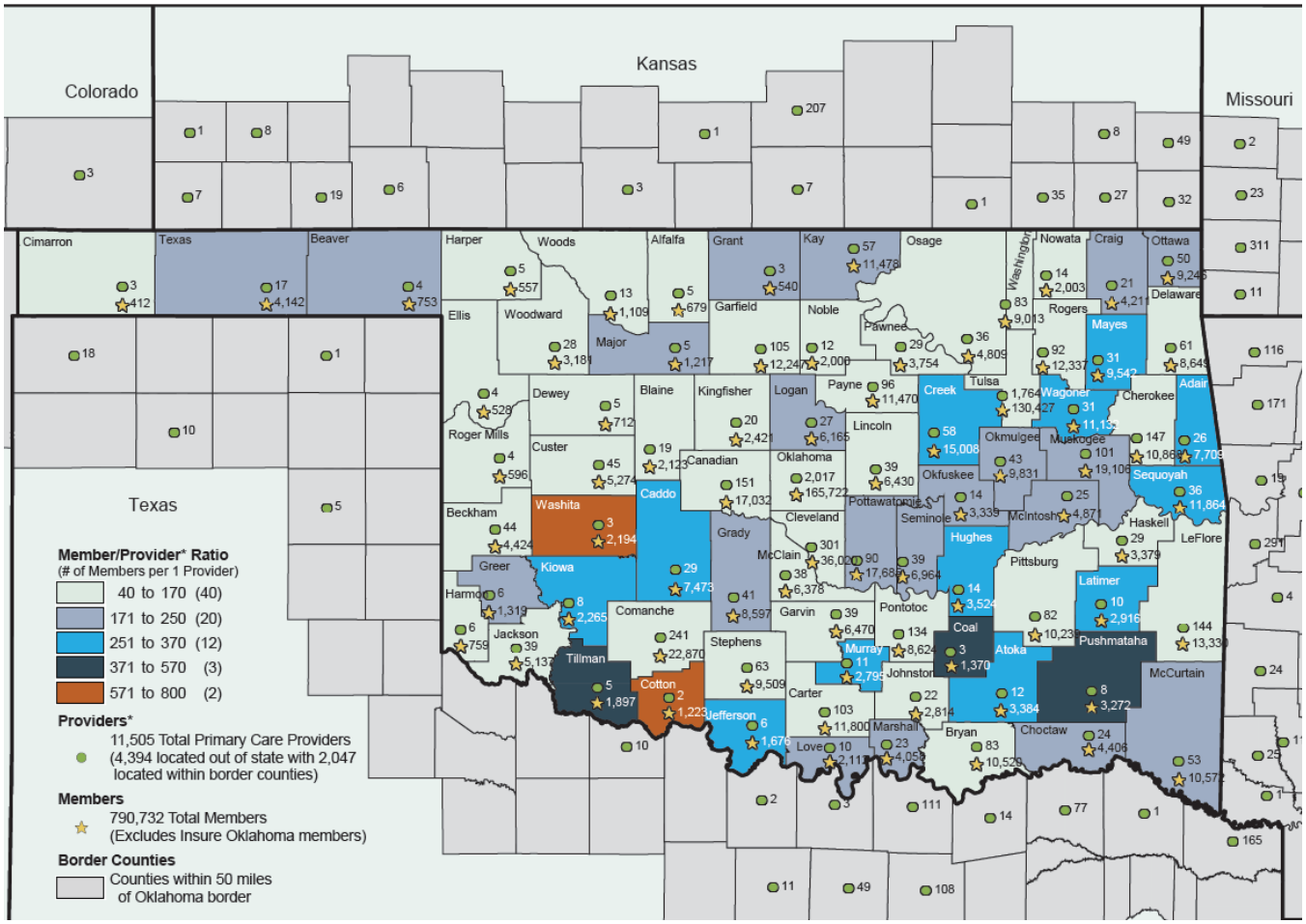
Appendix A (continued)

Primary Care Provider (PCP) Capacities

SoonerCare Program	Total Capacity	% of Capacity Used
SoonerCare Choice	1,290,858	37.47%
SoonerCare Choice I/T/U	103,899	22.90%
Insure Oklahoma IP	470,692	1.08%

Total Capacity represents the maximum number of members that PCPs request to have assigned within OHCA's limit. Panels on hold status are excluded from the capacity calculation. The facility's panels such as group practice, FQHC (Federally Qualified Health Clinic), RHC (Rural Health Clinic), and other clinics are included.

SoonerCare Member to Provider* Ratio
December 2018



Appendix B

OHCA Provider Helpline

Toll-Free: 800-522-0114 Oklahoma City Area: 405-522-6205

Option	Unit	Hours
1	OHCA Call Center	8 a.m. - 5 p.m. Mon-Fri
2, 1	Internet Help Desk (SoonerCare Provider Portal)	8 a.m. - noon & 1-5 p.m. Mon-Fri
2, 2	EDI Help Desk (batch transactions)	8 a.m. - noon & 1-5 p.m. Mon-Fri
3, 1	Adjustments (claims)	7:30 a.m. - 4 p.m. M, W, Th, F Noon - 4 p.m. Tues
3, 2	Third Party Liability	8 a.m. - 5 p.m. Mon-Fri
4	Pharmacy Help Desk (issues)	8 a.m. - 7 p.m. Mon-Fri 9 a.m. - 5 p.m. Sat 11 a.m.-5 p.m. Sun
5	Provider Contracts	8 a.m. - 5 p.m. M, Tu, Th, F 1 p.m. - 5 p.m. Wed
6, 1	Pharmacy Help Desk (authorizations)	8:00 a.m. - 7 p.m. Mon-Fri 9 a.m. - 5 p.m. Sat 11 a.m. - 5 p.m. Sun
6, 2, 1	Behavioral Health Authorizations (OP)	8 a.m. - 5 p.m. Mon-Fri
6, 2, 2	Behavioral Health Authorizations (IP)	8 a.m. - 5 p.m. Mon-Fri
6, 3	Medical Authorizations (status only)	8 a.m. - 5 p.m. Mon-Fri
6, 4	Prior Authorizations (PAs)	8 a.m. - 5 p.m. Mon-Fri
6, 5	Dental Authorizations	8 a.m. - 5 p.m. Mon-Fri

OHCA Quick Reference Guide

Appendix C

The below charts represents the total number of calls handled by the OHCA's Call Trees for State Fiscal Year 2015 and 2018.

SFY 2015	Provider		Member	
	Answer	Abandon	Answer	Abandon
7/1/2014	49,444	4,082	84,118	25,877
8/1/2014	44,076	4,582	87,841	22,645
9/1/2014	46,624	4,315	93,009	23,687
10/1/2014	49,482	2,874	98,486	8,093
11/1/2014	37,865	3,387	78,065	7,949
12/1/2014	45,197	1,926	94,401	16,939
1/1/2015	47,295	2,177	99,721	12,945
2/1/2015	41,640	1,096	90,946	5,307
3/1/2015	46,975	800	102,887	5,409
4/1/2015	46,128	747	92,541	3,002
5/1/2015	40,088	713	79,750	2,557
6/1/2015	48,580	1,128	99,105	5,215
Total	**543,394**	**27,827**	**1,100,870**	**139,625**
%	**95.13%**	**4.87%**	**88.74%**	**11.26%**

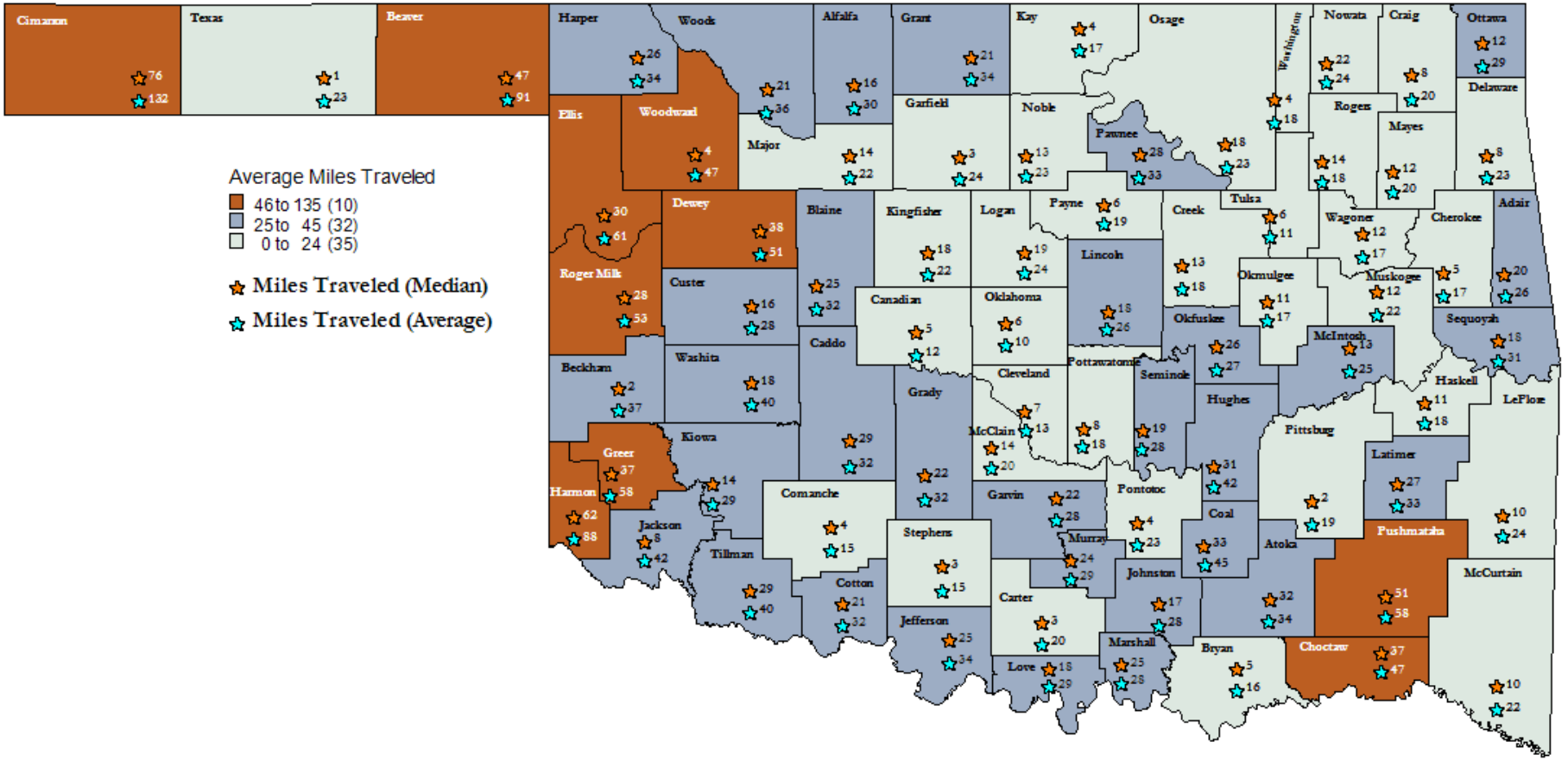
SFY 2018	Provider		Member	
	Answer	Abandon	Answer	Abandon
7/1/2017	46,451	4,108	83,658	4,639
8/1/2017	54,435	2,228	106,839	1,983
9/1/2017	48,651	2,885	82,177	1,445
10/1/2017	53,530	1,704	80,350	1,614
11/1/2017	49,157	1,620	78,300	1,834
12/1/2017	44,318	1,692	74,025	2,102
1/1/2018	51,660	2,143	92,890	2,714
2/1/2018	40,963	1,444	66,578	4,472
3/1/2018	50,226	2,229	74,967	1,828
4/1/2018	42,715	1,408	65,500	1,340
5/1/2018	45,907	1,240	66,142	1,528
6/1/2018	43,851	1,089	66,202	1,645
Total	**571,864**	**23,790**	**937,628**	**27,144**
%	**95.84%**	**4.16%**	**97.11%**	**2.89%**

Abandon is a call in which the caller hangs up before able to answer

SoonerCare Members Miles Traveled to PCP

SFY2018

Oklahoma HealthCare Authority



The data above represents the median or average miles traveled by a SoonerCare member to a SoonerCare Primary Care Provider (PCP) located in the state of Oklahoma. PCPs consist of all providers contracted as an Advanced Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant. The miles were identified from HCFA 1500 claims paid during SFY2018. Claims from referrals are excluded. Calculations are based on number of unique PCPs, not number of visits, and uses members and providers locations at time of service. Both the median and average miles traveled were included for comparisons.

Appendix E

The table below shows Contracted Providers by Specialty.

Provider Network is providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and/or specialties.

Provider Network Type	Specialty Type	Provider Network
Adult Day Care	Adult Day Care	45
Advance Practice Nurse	Certified Nurse Midwife	87
Advance Practice Nurse	Certified Nurse Practitioner	3,534
Advance Practice Nurse	Clinical Nurse Specialist	179
Advance Practice Nurse	CNP Allergist	1
Advance Practice Nurse	Pediatric Nurse Practitioner	1
Advantage Home Delivery Meal	Advantage Home Delivered Meal	18
Ambulatory Surgical Center (ASC)	Ambulatory Surgical Center (ASC)	58
Anesthesiology Assistant	Anesthesiology Assistant	23
Audiologist	Audiologist	136
Capitation Provider - IHS (Indian Health Services) Case Manager	IHS Case Manager	85
Capitation Provider - PACE (Program of All-Inclusive Care for the Elderly)	PACE	2
Case Manager	Case Management Agency	79
Case Manager	Child Welfare Targeted Case Management	1
Case Manager	DDSD/ICFMR Waiver	1
Case Manager	E.I. Case Mgmt	1
Case Manager	High Risk Pregnant Women	1
Case Manager	OJA Targeted Case Management	1
Certified Community Behavioral Health Centers (CCBHC)	Certified Behavioral Health Clinic	35
Certified Registered Nurse Anesthetist (CRNA)	Certified Registered Nurse Anesthetist (CRNA)	1,594
Chiropractor	Chiropractor	26
Clinic - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	EPSDT Clinic	2
Clinic - Family Planning Clinic	Family Planning Clinic	2
Clinic - Federally Qualified Health Clinic (FQHC)	Federally Qualified Health Clinic (FQHC)	110
Clinic - Native American	Hospital-Based Outpatient ITU Clinic	20
Clinic - Native American	IHS/Tribal Clinic	63
Clinic - Native American	Outpatient ITU Clinic/FQHC	11
Clinic - Rural Health	Free Standing Rural Health Clinic	11
Clinic - Rural Health	Hospital Based Rural Health Clinic	73
Clinic - Rural Health	Rural Health Clinic (RHC)	18
Clinic - Tuberculosis	Tuberculosis Clinic	2
Community Mental Health Center (CMHC)	Community Mental Health Center (CMHC)	95
County/City Health Department	Children First	1
County/City Health Department	City/County Health Department	1
County/City Health Department	County Health Department	5
DDSD (Developmental Disability Service Division) - Architectural Modification	Architectural Modification	22
DDSD (Developmental Disability Service Division) - Community Transition Services	Community Transition Services	38
DDSD (Developmental Disability Service Division) - Employee Training Specialist	Employee Training Specialist	81
DDSD (Developmental Disability Service Division) - Group Home	Waiver Group Home	41
DDSD (Developmental Disability Service Division) - Homemaker Services	Homemaker Services	64
DDSD (Developmental Disability Service Division) - Volunteer Transportation Provider	Volunteer	222
DDSD (Developmental Disability Service Division) - Waiver Behavioral Health Provider	Certified Social Worker	29
DDSD (Developmental Disability Service Division) - Waiver Behavioral Health Provider	Family Training	11
DDSD (Developmental Disability Service Division) - Waiver Behavioral Health Provider	Licensed Alcohol and Drug Counselor	549
Dentist	Endodontist	17
Dentist	General Dental Anesthesia	11
Dentist	General Dentistry Practitioner	1477
Dentist	General Dentist with Orthodontic Priviledges	10
Dentist	Oral Pathologist	6
Dentist	Oral Surgeon	110
Dentist	Orthodontist	94
Dentist	Pediatric Dentist	98
Dentist	Periodontist	13
Dentist	Prosthodontist	8

Provider Network Type (Cont.)	Specialty Type	Provider Network
Direct Support Services	Agency Companion	41
Direct Support Services	Daily Living Supports	73
Direct Support Services	Habilitation Training Specialist	104
DME (Durable Medical Equipment)/Medical Supply Dealer	Assistive Technology	2
DME (Durable Medical Equipment)/Medical Supply Dealer	Complex Rehab Technology Supplier	28
DME (Durable Medical Equipment)/Medical Supply Dealer	DME/Medical Supply Dealer	1238
DME (Durable Medical Equipment)/Medical Supply Dealer	Hearing Aid Dealer	2
End-Stage Renal Disease Clinic	Free-standing Renal Dialysis Clinic	110
Extended Care and Skilled Nursing Facilities	Nursing Facility	216
Extended Care and Skilled Nursing Facilities	Skilled Nursing Facility	240
Extended Care Facility - Facility Based Respite Care	Respite Care - Facility Based	91
Extended Care Facility - ICF/MR	ICF/IID < 6 Beds	11
Extended Care Facility - ICF/MR	ICF/IID > 6 Beds	81
Genetic Counselor	Genetic Counselor	16
Health Home	Health Home	135
Home Health Agency	Home Health Agency	168
Home Health Agency	Specialized Home Nursing Services	29
Hospice	Hospice	73
Hospital - Acute Care	Acute Care	693
Hospital - Acute Care	Rehabilitation	11
Hospital - Critical Access	Critical Access	99
Hospital - Native American	IHS Hospital	13
Hospital - Psychiatric	Psychiatric	22
Hospital - Resident Treatment Center	Children's Specialty	19
Hospital - Resident Treatment Center	Residential Treatment Center	30
Laboratory	County Health Department Lab	2
Laboratory	Independent Lab	477
Lactation Consultant	Lactation Consultant	78
Licensed Behavioral Health Professional	Alcohol and Other Drug Treatment Professional	1
Licensed Behavioral Health Professional	LADC/MH	93
Licensed Behavioral Health Professional	Licensed Behavioral Practitioner	164
Licensed Behavioral Health Professional	Licensed Clinical Social Worker	830
Licensed Behavioral Health Professional	Licensed Marital and Family Therapist	326
Licensed Behavioral Health Professional	Licensed Professional Counselor	3069
Licensure Candidates	Under Supervision	2061
Maternal/Child Health LCSW	Maternal/Child Health LCSW	12
Nursing Agency - Non-Skilled	Registered Nurse (RN)	30
Nursing Agency - Skilled	Skilled Nursing Agency	101
Nutritionist	Nutritionist	296
Optician	Optician	58
Optometrist	Optometrist	650
Outpatient Behavioral Health Agency	Outpatient Mental Health Clinic	427
Outpatient Behavioral Health Agency - DMHSAS Contracted	DMHSAS Contracted	105
Para Professional	Para Professional	3,350
Partial Hospitalization	Partial Hospitalization	8
Personal Care Services	Assisted Living	12
Personal Care Services	Consumer Directed Personal Care	1,754
Personal Care Services	Personal Care - Agency	59
Personal Care Services	Personal Care - Individual	35
Pharmacy	Pharmacy	1396
Physician - Allergist	Allergist	88
Physician - Anesthesiologist	Anesthesiologist	1,262
Physician Assistant	PA Allergist	2
Physician Assistant	Physician Assistant	1789
Physician - Cardiologist	Cardiologist	656

Provider Network Type (Cont.)	Specialty Type	Provider Network
Physician - General/Family Medicine	Family Practitioner	2763
Physician - General/Family Medicine	General Practitioner	431
Physician - General Pediatrician	General Pediatrician	1860
Physician - General Surgeon	General Surgeon	828
Physician - Internist	General Internist	4
Physician - Internist	Internist	2,399
Physician - Obstetrician/Gynecologist	Maternal Fetal Medicine	55
Physician - Obstetrician/Gynecologist	Obstetrician/Gynecologist	885
Physician - Other Specialist	Abdominal Surgery	1
Physician - Other Specialist	Adolescent Medicine	18
Physician - Other Specialist	Cardiovascular Surgeon	88
Physician - Other Specialist	Critical Care	206
Physician - Other Specialist	Dermatologist	105
Physician - Other Specialist	Diabetes	8
Physician - Other Specialist	Dispensing Physician	1
Physician - Other Specialist	Emergency Medicine Practitioner	2112
Physician - Other Specialist	Endocrinology	101
Physician - Other Specialist	Gastroenterologist	236
Physician - Other Specialist	Geriatric Practitioner	74
Physician - Other Specialist	Geriatric Psychiatry	5
Physician - Other Specialist	Gynecological Oncology	34
Physician - Other Specialist	Hand Surgeon	46
Physician - Other Specialist	Hematology	22
Physician - Other Specialist	Hematology Oncology	135
Physician - Other Specialist	Immunology	11
Physician - Other Specialist	Infectious Diseases	92
Physician - Other Specialist	Laryngology	8
Physician - Other Specialist	Maxillofacial Surgery	3
Physician - Other Specialist	Musculoskeletalonocology	1
Physician - Other Specialist	Nephrologist	223
Physician - Other Specialist	Neurological Surgeon	185
Physician - Other Specialist	Neurologist	369
Physician - Other Specialist	Nuclear Medicine Practitioner	24
Physician - Other Specialist	Occupational Medicine	10
Physician - Other Specialist	Oncologist	202
Physician - Other Specialist	Ophthalmologist	336
Physician - Other Specialist	Orthopedic Surgeon	615
Physician - Other Specialist	Otologist, Laryngologist, Rhinologist	247
Physician - Other Specialist	Pain Medicine	101
Physician - Other Specialist	Pathologist	277
Physician - Other Specialist	Physical Medicine and Rehabilitation Practitioner	106
Physician - Other Specialist	Plastic Surgeon	98
Physician - Other Specialist	Podiatrist	140
Physician - Other Specialist	Proctologist	1
Physician - Other Specialist	Psychiatrist	594
Physician - Other Specialist	Pulmonary Diseases	6
Physician - Other Specialist	Pulmonary Disease Specialist	271
Physician - Other Specialist	Radiation Therapist	32
Physician - Other Specialist	Rheumatology	68
Physician - Other Specialist	Rhinology	2
Physician - Other Specialist	Sleep Medicine	20
Physician - Other Specialist	Sports Medicine	55
Physician - Other Specialist	Surgery Colon and Rectal	39
Physician - Other Specialist	Surgery Head and Neck	8
Physician - Other Specialist	Surgery Traumatic	35

Provider Network Type (Cont.)	Specialty Type	Provider Network
Physician - Other Specialist	Thoracic Surgeon	124
Physician - Other Specialist	Transplant Surgery	26
Physician - Other Specialist	Urologist	237
Physician - Pediatric Specialist	Internal Medicine Pediatrics	1
Physician - Pediatric Specialist	Neonatal Perinatal Medicine	176
Physician - Pediatric Specialist	Neonatologist	205
Physician - Pediatric Specialist	Neurology Child	73
Physician - Pediatric Specialist	Pediatric Critical Care Medicine	210
Physician - Pediatric Specialist	Pediatric Emergency Med (Pediatrics)	335
Physician - Pediatric Specialist	Pediatric Endocrinology	71
Physician - Pediatric Specialist	Pediatric Gastroenterology	129
Physician - Pediatric Specialist	Pediatric Hematology Oncology	167
Physician - Pediatric Specialist	Pediatric Infectious Disease	42
Physician - Pediatric Specialist	Pediatric Nephrology	40
Physician - Pediatric Specialist	Pediatric Ophthalmology	11
Physician - Pediatric Specialist	Pediatric Orthopedics	26
Physician - Pediatric Specialist	Pediatric Otolaryngology	24
Physician - Pediatric Specialist	Pediatric Pathology	11
Physician - Pediatric Specialist	Pediatric Pulmonology	78
Physician - Pediatric Specialist	Pediatric Rheumatology	18
Physician - Pediatric Specialist	Pediatrics Allergy	19
Physician - Pediatric Specialist	Pediatrics Cardiology	205
Physician - Pediatric Specialist	Pediatric Surgeon	142
Physician - Pediatric Specialist	Pediatric Surgery (Neurology)	43
Physician - Pediatric Specialist	Pediatric Urology	19
Physician - Pediatric Specialist	Psychiatry Child	45
Physician - Pediatric Specialist	Surgery Pediatric	1
Physician - Radiologist	Radiologist	1605
Physician - Resident in Training	Medical Resident In Training	250
Preadmission Screening and Resident Review (PASRR)	PASRR CMHC	9
Program for Assertive Community Treatment (PACT)	PACT	12
Psychiatric Residential Treatment Facility (PRTF)	Children's Psychiatric Specialty	7
Psychiatric Residential Treatment Facility (PRTF)	Community Based Extended PRTF	1
Psychiatric Residential Treatment Facility (PRTF)	Community Based Transitional PRTF	2
Psychiatric Residential Treatment Facility (PRTF)	Psychiatric Hospital	18
Psychiatric Residential Treatment Facility (PRTF)	Psychiatric Residential Treatment Facility	11
Psychologist	Psychologist	357
Registered Nurse	Registered Nurse	12
Residential Behavior Management Services (RBMS)	RBMS Room and Board	4
Residential Behavior Management Services (RBMS)	RBMS Therapeutic Foster Care	27
Respite Care	Respite Care - Community Based	72
Room and Board	Room and Board	14
School Based Para Professional	School Based Para Professional	100
School Corporation	School Corporation	74
Specialized Foster Care/MR	Specialized Foster Care/MR	121
Therapist - Occupational	Occupational Therapist	434
Therapist - Physical	Physical Therapist	1006
Therapist - Speech/Hearing	Speech/Hearing Therapist	1080
Transportation Provider	Air Ambulance	166
Transportation Provider	Ambulance	234
Transportation Provider	Common Carrier (Non-ambulatory)	1
X-Ray Clinic	Independent Diagnostics Testing Facility	47
X-Ray Clinic	Mammography	1
X-Ray Clinic	Mobile X-Ray	26

Data is from Annual Reports and MMIS queries.

Appendix F

The tables below shows overall Contracted Providers and Contracted Providers by Type.

Provider Network is providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and/or specialties.

	SFY 2013	SFY 2016	SFY 2017	SFY 2018
Provider Network (Unduplicated)	44,300	49,426	54,835	52,087

Provider Network Type	Provider Network
Adult Day Care	45
Advance Practice Nurse	3,780
Advantage Home Delivery Meal	18
Ambulatory Surgical Center (ASC)	58
Anesthesiology Assistant	23
Audiologist	136
Capitation Provider - IHS (Indian Health Services) Case Manager	85
Capitation Provider - PACE (Program of All-Inclusive Care for the Elderly)	2
Case Manager	84
Certified Community Behavioral Health Centers (CCBHC)	35
Certified Registered Nurse Anesthetist (CRNA)	1,594
Chiropractor	26
Clinic - Early and Periodic Screening, Diagnosis, and Treatment (EPSDT)	2
Clinic - Family Planning Clinic	2
Clinic - Federally Qualified Health Clinic (FQHC)	110
Clinic - Native American	63
Clinic - Rural Health	100
Clinic - Tuberculosis	2
Community Mental Health Center (CMHC)	95
County/City Health Department	6
DDSD (Developmental Disability Service Division) - Architectural Modification	22
DDSD (Developmental Disability Service Division) - Community Transition Services	38
DDSD (Developmental Disability Service Division) - Employee Training Specialist	81
DDSD (Developmental Disability Service Division) - Group Home	41
DDSD (Developmental Disability Service Division) - Homemaker Services	64
DDSD (Developmental Disability Service Division) - Volunteer Transportation Provider	222
DDSD (Developmental Disability Service Division) - Waiver Behavioral Health Provider	588
Dentist	1,740
Direct Support Services	218
DME (Durable Medical Equipment)/Medical Supply Dealer	1,238
End-Stage Renal Disease Clinic	110
Extended Care and Skilled Nursing Facilities	356
Extended Care Facility - Facility Based Respite Care	91
Extended Care Facility - ICF/MR	90

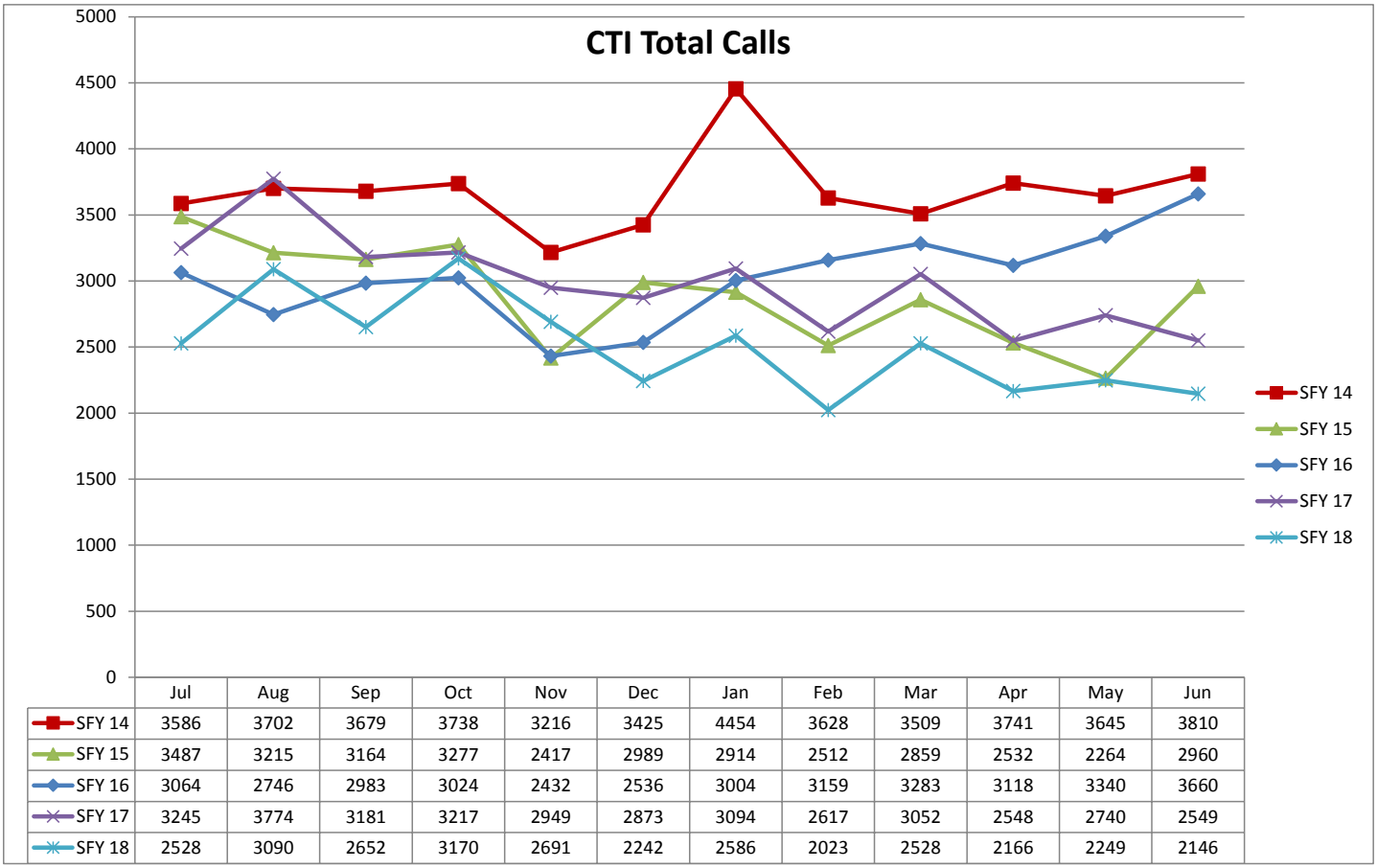
Provider Network Type (Cont.)	Provider Network
Genetic Counselor	16
Health Home	135
Home Health Agency	175
Hospice	73
Hospital - Acute Care	701
Hospital - Critical Access	99
Hospital - Native American	13
Hospital - Psychiatric	22
Hospital - Resident Treatment Center	47
Laboratory	479
Lactation Consultant	78
Licensed Behavioral Health Professional	4,332
Licensure Candidates	2,061
Maternal/Child Health LCSW	12
Nursing Agency - Non-Skilled	30
Nursing Agency - Skilled	101
Nutritionist	296
Optician	58
Optometrist	650
Outpatient Behavioral Health Agency	427
Outpatient Behavioral Health Agency - DMHSAS Contracted	105
Para Professional	3,350
Partial Hospitalization	8
Personal Care Services	1,840
Pharmacy	1,396
Physician - Allergist	88
Physician - Anesthesiologist	1,262
Physician Assistant	1,789
Physician - Cardiologist	656
Physician - General/Family Medicine	3,121
Physician - General Pediatrician	1,860
Physician - General Surgeon	828
Physician - Internist	2,402
Physician - Obstetrician/Gynecologist	898
Physician - Other Specialist	7,443
Physician - Pediatric Specialist	2,016
Physician - Radiologist	1,605
Physician - Resident in Training	250
Preadmission Screening and Resident Review (PASRR)	9
Program for Assertive Community Treatment (PACT)	12
Psychiatric Residential Treatment Facility (PRTF)	39
Psychologist	357
Registered Nurse	12
Residential Behavior Management Services (RBMS)	28
Respite Care	72
Room and Board	14

Provider Network Type (Cont.)	Provider Network
School Based Para Professional	100
School Corporation	74
Specialized Foster Care/MR	121
Therapist - Occupational	434
Therapist - Physical	1,006
Therapist - Speech/Hearing	1,080
Transportation Provider	390
X-Ray Clinic	72

Data is from Annual Reports and MMIS queries.

Appendix G

The following chart represents total calls handled by provider services' staff for state fiscal year 2014 through 2018.



	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
SFY 14	3586	3702	3679	3738	3216	3425	4454	3628	3509	3741	3645	3810
SFY 15	3487	3215	3164	3277	2417	2989	2914	2512	2859	2532	2264	2960
SFY 16	3064	2746	2983	3024	2432	2536	3004	3159	3283	3118	3340	3660
SFY 17	3245	3774	3181	3217	2949	2873	3094	2617	3052	2548	2740	2549
SFY 18	2528	3090	2652	3170	2691	2242	2586	2023	2528	2166	2249	2146

Appendix H

Access to Care Analyses

OK SPA 16-19 Freestanding Psychiatric Hospitals Rate Decrease Access to Care Analysis

1. Introduction

As part of the documentation of access to care and service payment rates federal requirements found at 42 CFR § 447.203, the State must submit an access to care analysis for any service within a state plan amendment that proposes to reduce or restructure provider payment rates in circumstances when the changes could result in diminished access. The access review conducted must demonstrate that access to care is sufficient as of the effective date of the state plan amendment. Further, a state must establish procedures in its Access Monitoring Review Plan (AMRP) to monitor continued access to care after implementation of state plan service rate reduction or payment restructuring. Within 90 days of identifying access deficiencies, the state must submit a corrective action plan with specific steps and timelines to address those issues. While the corrective action plan may include longer-term objectives, remediation of the access deficiency should take place within 12 months.

The State must conduct a yearly update to previously submitted access to care analyses on state plan amendments (SPA) that proposes to reduce or restructure provider payment rates for a period of three years as specified in 42 CFR § 447.203(b)(6)(ii). Oklahoma's (OK) SPA 16-19, freestanding psychiatric hospitals budget reduction, revised the payment methodology for freestanding psychiatric hospitals reimbursed using a fixed capital per diem methodology and reduced rates by 3 percent. OK SPA 16-19 was submitted June 22, 2016, with an effective date of May 1, 2016, and approved on Feb. 10, 2017. This is the second annual update to the access to care analysis for the restructured payment methodology within OK SPA 16-19.

From the data gathered for this report, access to care is adequate despite the reduction in rates; please refer to the "Effect on Access to Care" section below for a more detailed analysis.

2. State Plan Amendment (SPA)

OK SPA 16-19, Freestanding Psychiatric Hospitals Budget Reduction

3. Analysis of the Effect of the Change in Payment Rates on Access

▪ Requested Methodology or Rate Structure

The revision to the payment methodology for freestanding psychiatric hospitals required an amendment to the Title XIX state plan. The rates for freestanding psychiatric hospitals are set at a fixed capital per diem methodology and were reduced by 3 percent than the State Fiscal Year 2015 rates.

- ## Rationale of SPA

This State Plan Amendment was necessary to reduce provider reimbursement rates thereby reducing the Oklahoma Department of Mental Health and Substance Abuse Services' (ODMHSAS) operations budget in order to meet the balanced budget requirements as mandated by State law. Without the revisions, the Department was at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program. Following an extensive analysis of the potential effect on access to care as noted below, the Department initiated the processes necessary to implement this State Plan Amendment.

- ## Effect on Access to Care

In order to monitor beneficiary utilization of the impacted services, the State relied on the analysis of MMIS data against established baseline data and thresholds. The study included assessments of the available provider network, number of members with a paid claim in the first year of the restructured methodology, and utilization of services over time to determine that access was currently sufficient and access would not be negatively impacted by the proposed rate reduction.

2016 Access to Care Analysis

Based on the data from Calendar Year (CY) 2016 and out of 814,470 members eligible for Medicaid as of Dec. 31, 2016, freestanding psychiatric hospitals served a total of 2,506 members (0.3 percent of the total Medicaid eligible beneficiaries), of which 2,470 members (0.3 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 36 members (0.004 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

Compared to CY2015, the data represents a slight increase in the number of distinct beneficiaries that accessed freestanding psychiatric hospitals in CY2016. From Jan. 1, 2016 through Dec. 31, 2016, the total number of distinct beneficiaries served increased by 8 percent or by approximately 191 members. The data represents an approximate 8 percent increase of children younger than age 21 served and an approximate 38 percent increase of adults ages 21 and older served. The increase in distinct beneficiaries accessing freestanding psychiatric hospitals over the last year could be attributed to the addition of a new provider (Bethany Behavioral Hospital) since the last reporting period.

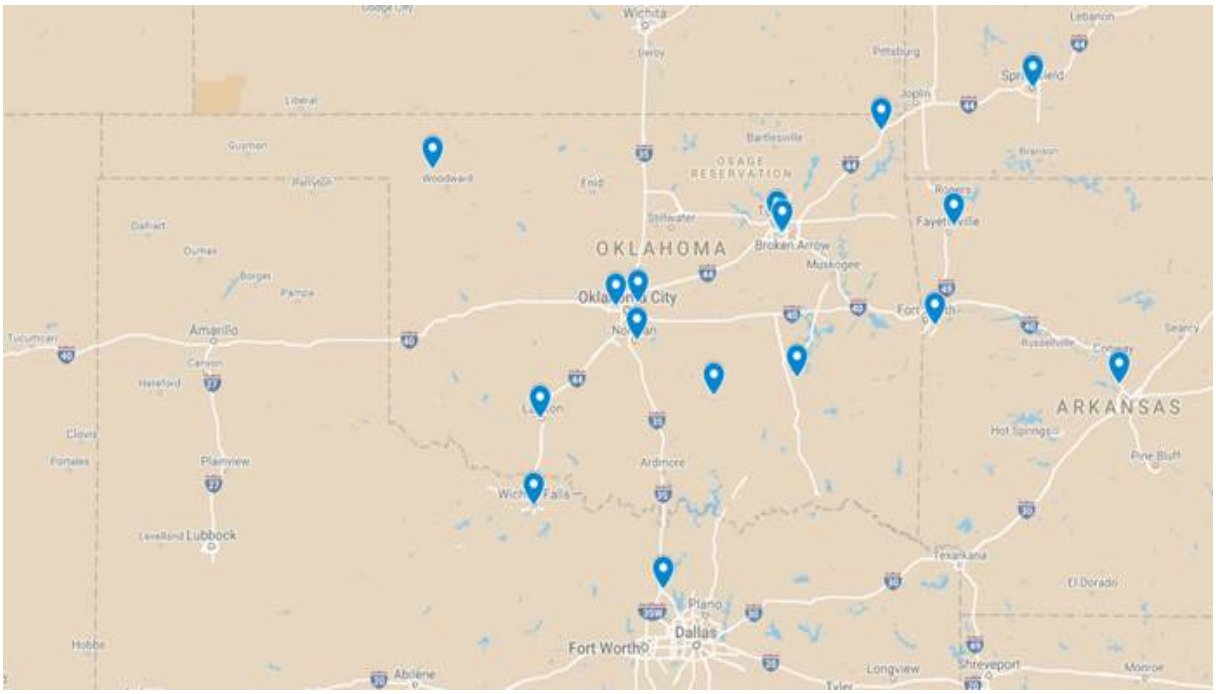
Additionally, the State surveyed 18 contracted freestanding psychiatric hospitals regarding capacity and available bed days. Seventeen out of eighteen contracted freestanding psychiatric hospitals responded. Based on utilization data and survey results, Medicaid reimbursed 17,758 bed days in CY2016. This is in comparison to the 19,160 patient bed days in CY2015 (a 7.3 percent decrease in paid bed days). So although the state has reported an increase in distinct beneficiaries accessing this service, there has been a decrease in overall utilization. The remaining available bed capacity within the State's freestanding psychiatric hospital system for the 17 responding providers was 194,180 patient bed days. The State has never had a facility turn away a SoonerCare member due to insufficient reimbursement rates. In fact, the State has added an additional provider (Bethany Behavioral Hospital) since

the CY2015 reporting period. Since 2015, the State has implemented several community based initiatives aimed at reducing inpatient admissions and readmissions such as Health Homes for Children with Serious Emotional Disturbance and Adults with Serious Mental Illness[1], reimbursement for transitional case management and mobile response and stabilization. The State believes that at least a portion of the decreases in the utilization of freestanding psychiatric hospital services can be attributed to these initiatives. Given this data, the State continues to feel that its freestanding psychiatric hospital network is sufficient to ensure access to care and services for the SoonerCare population even though less bed days were reimbursed as compared to CY2015.

Total number of providers and available beds

Provider	Total Beds	Location
Glen Oaks Hospital	>16	Greenville, TX
Griffin Memorial Hospital	120	Norman, OK
Lakeland Behavioral Health System	>16	Springfield, MO
Laureate Psychiatric Clinic and Hospital	30	Tulsa, OK
Carl Albert	15	McAlester, OK
Jim Taliaferro	14	Lawton, OK
Rolling Hills Hospital	38	Ada, OK
Willow Crest Hospital	10	Miami, OK
Northwest Center for Behavioral Health	24	Woodward, OK
Parkside Hospital	30	Tulsa, OK
Shadow Mountain Behavioral Health	60	Tulsa, OK
Vista Health of Ft Smith	34	Ft. Smith, AR
Vista Health of Fayetteville	38	Fayetteville, AR
Red River Hospital	40	Wichita Falls, TX
University Behavioral Health of Denton	>16	Denton, TX
Cedar Ridge Acute Hospital	60	Oklahoma City, OK
United Methodist Behavioral Health	>16	Maumelle, AR
Bethany Behavioral Hospital	19	Oklahoma City, OK

[1] May 2017 Outcomes measures for Health Homes indicate that follow up rates after hospitalization for Mental Illness within 7 days after discharge have gone from 33.8% in June 2016 to 84.2% in March 2017.



Source: https://www.google.com/maps/d/viewer?mid=1wg6JWulUSwC6K5dPBde1JeUcu2c&ll=34.78459799999999%2C-96.62738439999998&z=8

2017 Access to Care Analysis

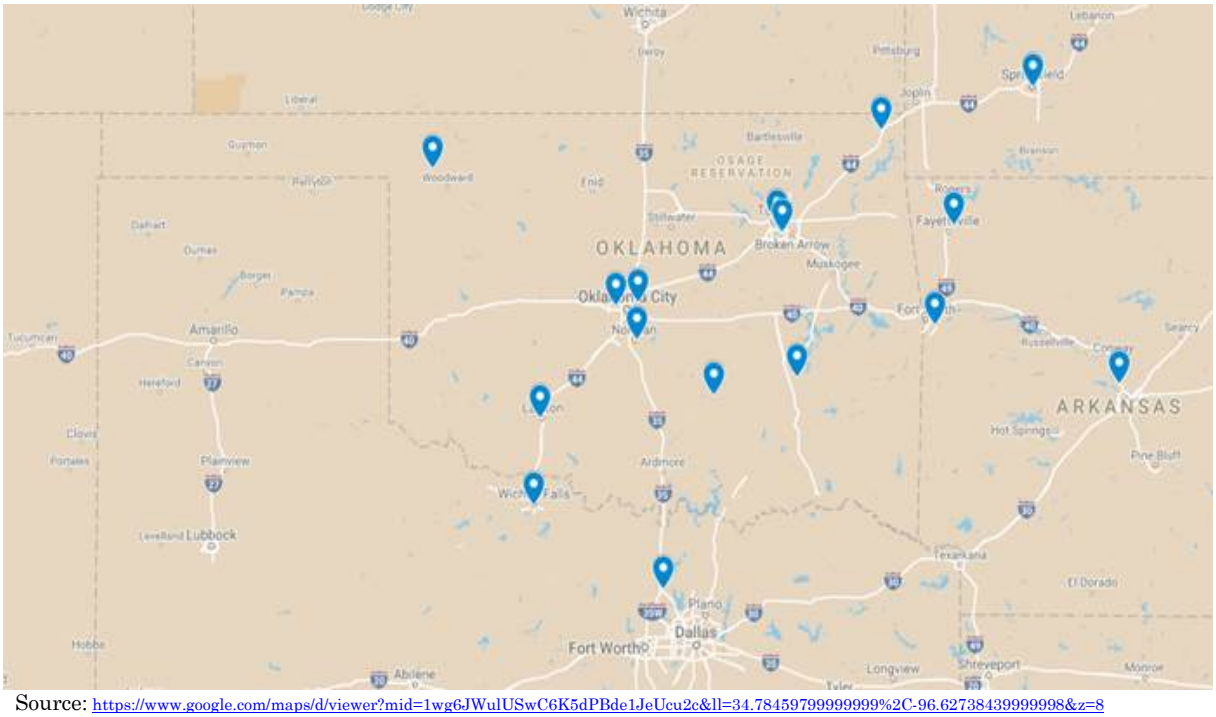
Based on the data from Calendar Year (CY) 2017 and out of 797,759 members eligible for Medicaid as of Dec. 31, 2017, freestanding psychiatric hospitals served a total of 2,278 members (0.3 percent of the total Medicaid eligible beneficiaries), of which 2,252 members (0.3 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 26 members (0.003 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

Compared to CY2015, the data represents a slight decrease in the number of distinct beneficiaries that accessed freestanding psychiatric hospitals in CY2017. From Jan. 1, 2017 through Dec. 31, 2017, the total number of distinct beneficiaries served increased by .93 percent or by approximately 16 children younger than age 21 served 5 slight decrease in distinct beneficiaries accessing freestanding psychiatric hospitals over the last year could be attributed to a new mobile response prior authorization process implemented in 33 counties throughout the state that require a more in depth assessment of a child under the age of 21 by an outpatient provider to ensure that the child cannot be better served in a community based setting prior to admission to an inpatient/residential setting.

Total number of providers and available beds

Provider	Total Beds	Location
Glen Oaks Hospital	>16	Greenville, TX
Griffin Memorial Hospital	120	Norman, OK

Lakeland Behavioral Health System	100	Springfield, MO
Laureate Psychiatric Clinic and Hospital	45	Tulsa, OK
Carl Albert	15	McAlester, OK
Jim Taliaferro	14	Lawton, OK
Rolling Hills Hospital	38	Ada, OK
Willow Crest Hospital	25	Miami, OK
Northwest Center for Behavioral Health	28	Woodward, OK
Parkside Hospital	31	Tulsa, OK
Shadow Mountain Behavioral Health	51	Tulsa, OK
Vista Health of Ft Smith -Valley	52	Ft. Smith, AR
Vista Health of Fayetteville – Vantage	34	Fayetteville, AR
Red River Hospital	48	Wichita Falls, TX
University Behavioral Health of Denton	Contract ended 07-02-2016	Denton, TX
Cedar Ridge Acute Hospital	60	Oklahoma City, OK
United Methodist Behavioral Health	>16	Maumelle, AR
Bethany Behavioral Hospital	19	Oklahoma City, OK



Source: https://www.google.com/maps/d/viewer?mid=1wg6JWulUSwC6K5dPBde1JeUcu2c&ll=34.784597999999999%2C-96.627384399999998&z=8

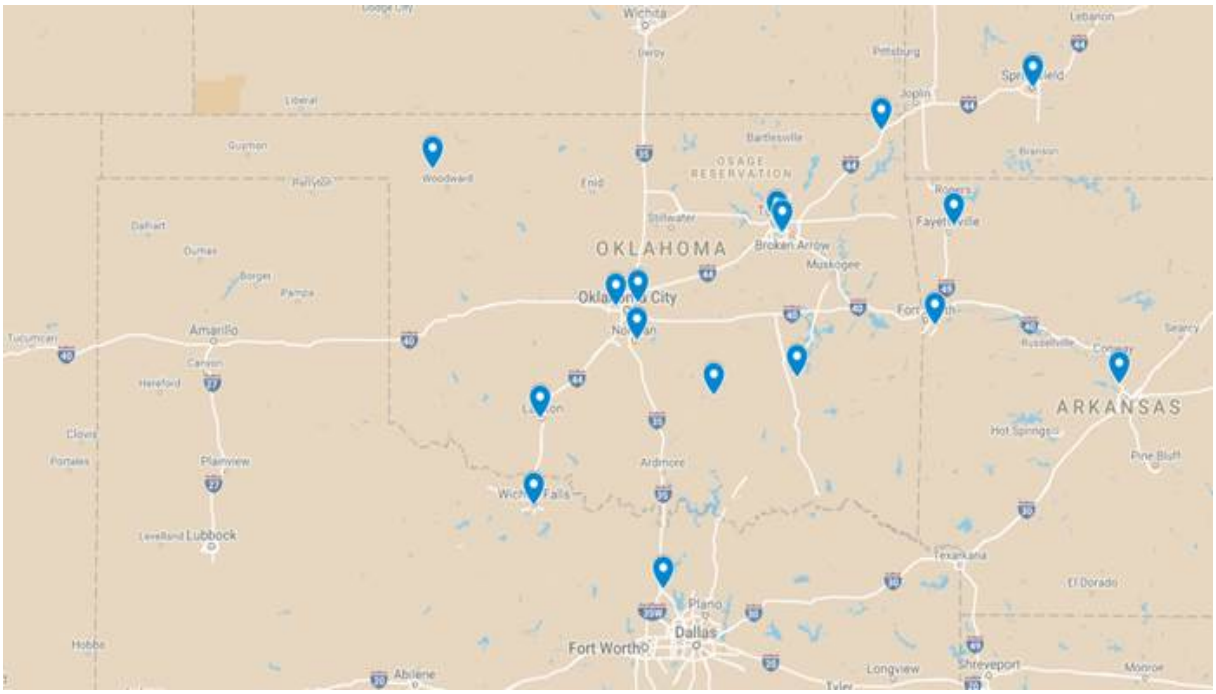
2018 Access to Care Analysis

Based on the data from Calendar Year (CY) 2018 and out of 790,732 members eligible for Medicaid as of Dec. 31, 2018, freestanding psychiatric hospitals served a total of 2,063 members (0.3 percent of the total Medicaid eligible beneficiaries).

Compared to CY2015, the data represents a moderate increase in the number of distinct beneficiaries that accessed freestanding psychiatric hospitals in CY2018. From Jan. 1, 2018 through Dec. 31, 2018, the total number of distinct beneficiaries served decreased by 24 percent or by approximately 194 individuals. The decrease in utilization of freestanding psychiatric hospitals could be attributed to community based programs aimed at providing clients the most appropriate, least restrictive level of care such as community based authorizations, mobile response and care coordination through Behavioral Health Homes.

Total number of providers and available beds

Provider	Total Beds	Location
Bethany Behavioral Hospital	19	Oklahoma City, OK
Brookhaven Hospital Inc.	40	Tulsa, OK
Carl Albert	15	McAlester, OK
Cedar Ridge Acute Hospital	60	Oklahoma City, OK
Griffin Memorial Hospital	60	Norman, OK
Jim Taliaferro	14	Lawton, OK
Lakeland Behavioral Health System	100	Springfield, MO
Laureate Psychiatric Clinic and Hospital	45	Tulsa, OK
Northwest Center for Behavioral Health	28	Woodward, OK
Parkside Hospital	31	Tulsa, OK
Red River Hospital	48	Wichita Falls, TX
Rolling Hills Hospital	38	Ada, OK
Shadow Mountain Behavioral Health	51	Tulsa, OK
Tulsa Center for Behavioral Health	56	Tulsa, OK
United Methodist Behavioral Health	>16	Maumelle, AR
Vista Health of Fayetteville – Vantage	34	Fayetteville, AR
Vista Health of Ft Smith – Valley	52	Ft. Smith, AR
Willow Crest Hospital	25	Miami, OK



Source: https://www.google.com/maps/d/viewer?mid=1wg6JWulUSwC6K5dPBde1JeUcu2c&ll=34.78459799999999%2C-96.62738439999998&z=8

4. Analysis of the Information and Concerns Expressed in Input from Affected Stakeholders

▪ Call Monitoring

The OHCA monitors member and provider calls regarding access to care. To date there have been no calls directly pertaining to this budget reduction request.

5. Conclusion

The Agency continues to assert that reducing provider rates as outlined in this analysis allowed the State to continue the SoonerCare behavioral health program without drastically reducing the provider reimbursement rates for all behavioral health services or eliminating services completely which would have a detrimental impact on access to behavioral health services. Without these rate reductions, the State would have been forced to eliminate certain classes of services in order to meet its State constitutional requirement of filing a balanced budget.

After careful analysis and stakeholder outreach, the State has determined that reducing provider rates as mentioned above was in the best interest of Oklahoma's Medicaid Behavioral Health Program and the beneficiaries it serves and did not have a significant impact on access to care for SoonerCare members.

Of note, effective July 1, 2018, the state implemented a 3 percent (3%) rate increase for psychiatric hospitals in the State; the Agency has determined that the change will have a positive impact on access to care.

OK SPA 16-20 Independent Practice LBHP & Psychologist Rate Reduction Access to Care Analysis

Introduction

As part of the documentation of access to care and service payment rates federal requirements found at 42 CFR § 447.203, the State must submit an access to care analysis for any service within a state plan amendment that proposes to reduce or restructure provider payment rates in circumstances when the changes could result in diminished access. The access review conducted must demonstrate that access to care is sufficient as of the effective date of the state plan amendment. Further, a state must establish procedures in its Access Monitoring Review Plan (AMRP) to monitor continued access to care after implementation of state plan service rate reduction or payment restructuring. Within 90 days of identifying access deficiencies, the state must submit a corrective action plan with specific steps and timelines to address those issues. While the corrective action plan may include longer-term objectives, remediation of the access deficiency should take place within 12 months.

The State must conduct a yearly update to previously submitted access to care analyses on state plan amendments (SPA) that proposes to reduce or restructure provider payment rates for a period of three years as specified in 42 CFR § 447.203(b)(6)(ii). Oklahoma's (OK) SPA 16-20, independent practice licensed behavioral health professional (LBHP) & psychologist rate reduction, revised the methodology and reimbursement structure for payments to independently contracted LBHPs who choose to practice on their own by reducing rates by 30 percent and by reducing rates for psychologists by 10 percent. OK SPA 16-20 was submitted June 24, 2016, with an effective date of May 1, 2016, and approved on April 5, 2017. This is the second annual update to the access to care analysis for the restructured payment methodology within OK SPA 16-20.

From the data gathered for this report, access to care is adequate despite the reduction in rates; please refer to the "Effect on Access to Care" section below for a more detailed analysis.

1. State Plan Amendment (SPA)

OK SPA 16-20, Independent Practice Licensed Behavioral Health Professional (LBHP) & Psychologist Rate Reduction

2. Analysis of the Effect of the Change in Payment Rates on Access

▪ Requested Methodology or Rate Structure

The revision to the payment rates for LBHPs and psychologists required an amendment to the Title XIX state plan. The rates for the aforementioned settings were 30 percent less than the State Fiscal Year 2015 rates for LBHPs and 10% less than rates for psychologists.

▪ Rationale of SPA

This state plan amendment was necessary to reduce provider reimbursement rates thereby reducing the Oklahoma Department of Mental Health and Substance Abuse Services'

(ODMHSAS) operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Department was at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program. Following an extensive analysis of the potential effect on access to care as noted below, the Department initiated the processes necessary to request this State Plan Amendment.

Effect on Access to Care

In order to monitor beneficiary utilization of the impacted services, the State relied on the analysis of MMIS data against established baseline data and thresholds. The study included assessments of the available provider network, number of members with a paid claim within the first and second calendar year of the restructured methodology, and utilization of services over time to determine that access was currently sufficient and access would not be negatively impacted by the proposed rate reduction. It should be noted that since the initial access to care analyses was submitted with the SPA and to better capture access to care, the State has transitioned from analyzing provider counts based on contracted providers only to contracted providers actively providing services within the calendar year.

2016 Access to care Analysis

Based on the data from Calendar Year (CY) 2016, the number of independent LBHPs actively providing services included 608 providers. Further, based on the same 12-month data and out of 814,470 members eligible for Medicaid as of Dec. 31, 2016, independent LBHPs served a total of 12,189 members (1.5 percent of the total Medicaid eligible beneficiaries), of which 10,919 members (1.3 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 1,270 members (0.16 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

In Quarter (Q) 1 of CY2016, there were 639 contracted independent LBHPs, compared to 540 contracted independent LBHPs in Quarter 4 of CY2016. Between Q2 and Q4 of CY2016, 67 independent LBHPs were gained and 173 lost. However, enrollment data shows that 91 independent LBHPs moved to an outpatient behavioral health agency setting to provide services which is only a net loss of 15 independent LBHPs to the behavioral health service delivery network. When compared to CY2015 data, the total number of LBHPs in an agency setting increased by approximately 5 percent or by 195 providers. From Jan. 1, 2016 to Dec. 31, 2016, the total number of beneficiaries served by LBHPs decreased by approximately 3 percent or by 403 members. The data represents an approximate 6 percent decrease of children younger than age 21 served and an approximate 28 percent increase of adults ages 21 and older served.

Based on data from CY2016, the number of contracted psychologists actively providing services, included a total of 411 providers. Based on the same 12-month data and out of 814,470 members eligible for Medicaid as of Dec. 31, 2016, psychologists served a total of 20,099 members (2.5 percent of the total Medicaid eligible beneficiaries), of which 18,017 members (2.2 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 2,082 members (0.26 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

The number of independently contracted Level 1 LBHPs (i.e., Psychologists), based on CY2016 data, represents a slight increase over the previous year. Further, compared to CY2015, the data represents a slight increase of members that accessed psychologists in CY2016. From Jan. 1, 2016 through Dec. 31, 2016, the total number of beneficiaries served increased by nearly 3 percent or by approximately 512 members. The data represents an approximate 3 percent increase of children younger than age 21 served and an approximate 0.05 percent increase of adults ages 21 and older served.

Although there was a slight reduction in independently contracted Level 2 LBHPs, the State has observed that access to care has continued to be sufficient since the State chose not to reduce rates for Level 1 and 2 LBHPs practicing in an outpatient behavioral health clinic setting. To demonstrate this, the State analyzed access to psychotherapy services across the outpatient behavioral service delivery system since psychotherapy is the only service that independently contracted Level 2 LBHPs can provide per the State Plan. The state compared data from CY2015 to CY2016 data post rate reduction. In Q3 of CY2015, 54,480 clients received a therapy service in an outpatient behavioral health clinic setting. In Q3 of CY2016, 56,986 clients received a therapy service in an outpatient behavioral health clinic setting (+2,506 distinct clients). This represents a 0.8 percent increase in clients receiving psychotherapy as a percentage of total Medicaid eligible clients ages 3-20. Although the cost per client has gone down nearly $95 per client per month, utilization and access to psychotherapy has increased.

2017 Access to care Analysis

Based on the data from Calendar Year (CY) 2017, the number of independent LBHPs actively providing services included 511 providers. Further, based on the same 12-month data and out of 797,759 members eligible for Medicaid as of Dec. 31, 2017, independent LBHPs served a total of 8,841 members (1.5 percent of the total Medicaid eligible beneficiaries), of which 8,075 members (1 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 766 members (0.1 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

In Quarter (Q) 1 of CY2017, there were 511 contracted independent LBHPs, compared to 455 contracted independent LBHPs in Quarter 4 of CY2017. Between Q2 and Q4 of CY2017, 72 independent LBHPs were gained and 129 lost. However, enrollment data shows that 65 independent LBHPs moved to an outpatient behavioral health agency setting to provide services which is only a net loss of 8 independent LBHPs to the behavioral health service delivery network.

Based on data from CY2017, the number of contracted psychologists actively providing services, included a total of 180 providers. Based on the same 12-month data and out of 797,759 members eligible for Medicaid as of Dec. 31, 2017, psychologists served a total of 19,237 members (2.41 percent of the total Medicaid eligible beneficiaries), of which 17,088 members (2.14 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 2,149 members (0.27 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

Based on CY2017 data, the number of independently contracted Level 1 LBHPs (i.e., Psychologists) actively providing services, represents a slight decrease of 35 providers (an approximate 16.28 percent decrease) over the baseline data in CY15. Further, compared to CY2015, the data represents a slight decrease of members that accessed psychologists in CY2017. From Jan. 1, 2017 through Dec. 31, 2017, the total number of beneficiaries served decreased by 1.79 percent or by 350 members. The data represents an approximate 2.39 percent decrease of children younger than age 21 served and an approximate 3.27 percent increase of adults ages 21 and older served.

Although there was a slight reduction in independently contracted Level 2 LBHPs, the State has observed that access to care has continued to be sufficient since the State chose not to reduce rates for Level 1 and 2 LBHPs practicing in an outpatient behavioral health clinic setting. To demonstrate this, the State analyzed access to psychotherapy services across the outpatient behavioral service delivery system since psychotherapy is the only service that independently contracted Level 2 LBHPs can provide per the State Plan.

2018 Access to care Analysis

Based on the data from Calendar Year (CY) 2018, the number of independent LBHPs actively providing services included 509 providers. Further, based on the same 12-month data and out of 790,732 members eligible for Medicaid as of Dec. 31, 2018, independent LBHPs served a total of 7,333 members (0.9 percent of the total Medicaid eligible beneficiaries), of which 6,611 members (0.8 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 722 members (0.09 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

When compared to CY2015 data, the total number of independent LBHPs increased by approximately 7.84 percent or by 37 providers. From Jan. 1, 2018 to Dec. 31, 2018, the total number of beneficiaries served by LBHPs decreased by approximately 42 percent or by 5,259 members. The data represents an approximate 42 percent decrease of children younger than age 21 served and an approximate 27 percent decrease of adults ages 21 and older served.

Based on data from CY2018, the number of contracted psychologists actively providing services, included a total of 291 providers. Based on the same 12-month data and out of 790,732 members eligible for Medicaid as of Dec. 31, 2018, psychologists served a total of 17,446 members (2.2 percent of the total Medicaid eligible beneficiaries), of which 15,612 members (2 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 1,834 members (0.23 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

Based on CY2018 data, the number of independently contracted Level 1 LBHPs (i.e., Psychologists) actively providing services, represents a slight increase of 76 providers (an approximate 35.35 percent increase) over the baseline data in CY2015. Further, compared to CY2015, the data represents a slight decrease of members that accessed psychologists in CY2018. From Jan. 1, 2018 through Dec. 31, 2018, the total number of beneficiaries served decreased by 10.93 percent or by 2,141 members. The data represents an approximate 10.82 percent decrease of children younger than age 21 served and an approximate 11.87 percent increase of adults ages 21 and older served.

The State has observed that access to care has continued to be sufficient since the State chose not to reduce rates for Level 1 and 2 LBHPs practicing in an outpatient behavioral health clinic setting.

3. Analysis of the Information and Concerns Expressed in Input from Affected Stakeholders

- ### Call Monitoring

The OHCA monitors member and provider calls regarding access to care. To date there have been no calls directly pertaining to this budget reduction request.

4. Summary/Conclusion

Based on data collected since implementing the rate reduction, the Agency continues to believe that reducing the provider rates as outlined in this analysis has allowed the State to continue the SoonerCare behavioral health program without drastically reducing the provider reimbursement rates for all behavioral health services or eliminating services completely which would have a detrimental impact on access to behavioral health services.

After careful analysis and stakeholder outreach, the State has determined that reducing provider rates as mentioned above continues to be in the best interest of Oklahoma's Medicaid Behavioral Health Program and the beneficiaries it serves and has not had a significant impact on access to care for SoonerCare members.

OK SPA 16-21 Psychiatric Residential Treatment Facility (PRTF) Rate Reduction 2019 Annual Access to Care Analysis

1. Introduction

As part of the documentation of access to care and service payment rates federal requirements found at 42 CFR § 447.203, the State must submit an access to care analysis for any service within a state plan amendment that proposes to reduce or restructure provider payment rates in circumstances when the changes could result in diminished access. The access review conducted must demonstrate that access to care is sufficient as of the effective date of the state plan amendment. Further, a state must establish procedures in its Access Monitoring Review Plan (AMRP) to monitor continued access to care after implementation of state plan service rate reduction or payment restructuring. Within 90 days of identifying access deficiencies, the state must submit a corrective action plan with specific steps and timelines to address those issues. While the corrective action plan may include longer-term objectives, remediation of the access deficiency should take place within 12 months.

The State must conduct a yearly update to previously submitted access to care analyses on state plan amendments (SPA) that proposes to reduce or restructure provider payment rates for a period of three years as specified in 42 CFR § 447.203(b)(6)(ii). Oklahoma's (OK) SPA 16-20, independent practice licensed behavioral health professional (LBHP) & psychologist rate reduction, revised the methodology and reimbursement structure for payments to independently contracted LBHPs who choose to practice on their own by reducing rates by 30 percent and by reducing rates for psychologists by 10 percent. OK SPA 16-20 was submitted June 24, 2016, with an effective date of May 1, 2016, and approved on April 5, 2017. This is the second annual update to the access to care analysis for the restructured payment methodology within OK SPA 16-20.

From the data gathered for this report, access to care is adequate despite the reduction in rates; please refer to the "Effect on Access to Care" section below for a more detailed analysis.

2. State Plan Amendment (SPA)

OK SPA 16-20, Independent Practice Licensed Behavioral Health Professional (LBHP) & Psychologist Rate Reduction

3. Analysis of the Effect of the Change in Payment Rates on Access

▪ Requested Methodology or Rate Structure

The revision to the payment rates for LBHPs and psychologists required an amendment to the Title XIX state plan. The rates for the aforementioned settings were 30 percent less than the State Fiscal Year 2015 rates for LBHPs and 10% less than rates for psychologists.

▪ Rationale of SPA

This state plan amendment was necessary to reduce provider reimbursement rates thereby reducing the Oklahoma Department of Mental Health and Substance Abuse Services'

(ODMHSAS) operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Department was at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program. Following an extensive analysis of the potential effect on access to care as noted below, the Department initiated the processes necessary to request this State Plan Amendment.

Effect on Access to Care

In order to monitor beneficiary utilization of the impacted services, the State relied on the analysis of MMIS data against established baseline data and thresholds. The study included assessments of the available provider network, number of members with a paid claim within the first and second calendar year of the restructured methodology, and utilization of services over time to determine that access was currently sufficient and access would not be negatively impacted by the proposed rate reduction. It should be noted that since the initial access to care analyses was submitted with the SPA and to better capture access to care, the State has transitioned from analyzing provider counts based on contracted providers only to contracted providers actively providing services within the calendar year.

2016 Access to care Analysis

Based on the data from Calendar Year (CY) 2016, the number of independent LBHPs actively providing services included 608 providers. Further, based on the same 12-month data and out of 814,470 members eligible for Medicaid as of Dec. 31, 2016, independent LBHPs served a total of 12,189 members (1.5 percent of the total Medicaid eligible beneficiaries), of which 10,919 members (1.3 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 1,270 members (0.16 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

In Quarter (Q) 1 of CY2016, there were 639 contracted independent LBHPs, compared to 540 contracted independent LBHPs in Quarter 4 of CY2016. Between Q2 and Q4 of CY2016, 67 independent LBHPs were gained and 173 lost. However, enrollment data shows that 91 independent LBHPs moved to an outpatient behavioral health agency setting to provide services which is only a net loss of 15 independent LBHPs to the behavioral health service delivery network. When compared to CY2015 data, the total number of LBHPs in an agency setting increased by approximately 5 percent or by 195 providers. From Jan. 1, 2016 to Dec. 31, 2016, the total number of beneficiaries served by LBHPs decreased by approximately 3 percent or by 403 members. The data represents an approximate 6 percent decrease of children younger than age 21 served and an approximate 28 percent increase of adults ages 21 and older served.

Based on data from CY2016, the number of contracted psychologists actively providing services, included a total of 411 providers. Based on the same 12-month data and out of 814,470 members eligible for Medicaid as of Dec. 31, 2016, psychologists served a total of 20,099 members (2.5 percent of the total Medicaid eligible beneficiaries), of which 18,017 members (2.2 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 2,082 members (0.26 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

The number of independently contracted Level 1 LBHPs (i.e., Psychologists), based on CY2016 data, represents a slight increase over the previous year. Further, compared to CY2015, the data represents a slight increase of members that accessed psychologists in CY2016. From Jan. 1, 2016 through Dec. 31, 2016, the total number of beneficiaries served increased by nearly 3 percent or by approximately 512 members. The data represents an approximate 3 percent increase of children younger than age 21 served and an approximate 0.05 percent increase of adults ages 21 and older served.

Although there was a slight reduction in independently contracted Level 2 LBHPs, the State has observed that access to care has continued to be sufficient since the State chose not to reduce rates for Level 1 and 2 LBHPs practicing in an outpatient behavioral health clinic setting. To demonstrate this, the State analyzed access to psychotherapy services across the outpatient behavioral service delivery system since psychotherapy is the only service that independently contracted Level 2 LBHPs can provide per the State Plan. The state compared data from CY2015 to CY2016 data post rate reduction. In Q3 of CY2015, 54,480 clients received a therapy service in an outpatient behavioral health clinic setting. In Q3 of CY2016, 56,986 clients received a therapy service in an outpatient behavioral health clinic setting (+2,506 distinct clients). This represents a 0.8 percent increase in clients receiving psychotherapy as a percentage of total Medicaid eligible clients ages 3-20. Although the cost per client has gone down nearly $95 per client per month, utilization and access to psychotherapy has increased.

2017 Access to care Analysis

Based on the data from Calendar Year (CY) 2017, the number of independent LBHPs actively providing services included 511 providers. Further, based on the same 12-month data and out of 797,759 members eligible for Medicaid as of Dec. 31, 2017, independent LBHPs served a total of 8,841 members (1.5 percent of the total Medicaid eligible beneficiaries), of which 8,075 members (1 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 766 members (0.1 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

In Quarter (Q) 1 of CY2017, there were 511 contracted independent LBHPs, compared to 455 contracted independent LBHPs in Quarter 4 of CY2017. Between Q2 and Q4 of CY2017, 72 independent LBHPs were gained and 129 lost. However, enrollment data shows that 65 independent LBHPs moved to an outpatient behavioral health agency setting to provide services which is only a net loss of 8 independent LBHPs to the behavioral health service delivery network.

Based on data from CY2017, the number of contracted psychologists actively providing services, included a total of 180 providers. Based on the same 12-month data and out of 797,759 members eligible for Medicaid as of Dec. 31, 2017, psychologists served a total of 19,237 members (2.41 percent of the total Medicaid eligible beneficiaries), of which 17,088 members (2.14 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 2,149 members (0.27 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

Based on CY2017 data, the number of independently contracted Level 1 LBHPs (i.e., Psychologists) actively providing services, represents a slight decrease of 35 providers (an approximate 16.28 percent decrease) over the baseline data in CY15. Further, compared to CY2015, the data represents a slight decrease of members that accessed psychologists in CY2017. From Jan. 1, 2017 through Dec. 31, 2017, the total number of beneficiaries served decreased by 1.79 percent or by 350 members. The data represents an approximate 2.39 percent decrease of children younger than age 21 served and an approximate 3.27 percent increase of adults ages 21 and older served.

Although there was a slight reduction in independently contracted Level 2 LBHPs, the State has observed that access to care has continued to be sufficient since the State chose not to reduce rates for Level 1 and 2 LBHPs practicing in an outpatient behavioral health clinic setting. To demonstrate this, the State analyzed access to psychotherapy services across the outpatient behavioral service delivery system since psychotherapy is the only service that independently contracted Level 2 LBHPs can provide per the State Plan.

2018 Access to care Analysis

Based on the data from Calendar Year (CY) 2018, the number of independent LBHPs actively providing services included 509 providers. Further, based on the same 12-month data and out of 790,732 members eligible for Medicaid as of Dec. 31, 2018, independent LBHPs served a total of 7,333 members (0.9 percent of the total Medicaid eligible beneficiaries), of which 6,611 members (0.8 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 722 members (0.09 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

When compared to CY2015 data, the total number of independent LBHPs increased by approximately 7.84 percent or by 37 providers. From Jan. 1, 2018 to Dec. 31, 2018, the total number of beneficiaries served by LBHPs decreased by approximately 42 percent or by 5,259 members. The data represents an approximate 42 percent decrease of children younger than age 21 served and an approximate 27 percent decrease of adults ages 21 and older served.

Based on data from CY2018, the number of contracted psychologists actively providing services, included a total of 291 providers. Based on the same 12-month data and out of 790,732 members eligible for Medicaid as of Dec. 31, 2018, psychologists served a total of 17,446 members (2.2 percent of the total Medicaid eligible beneficiaries), of which 15,612 members (2 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 1,834 members (0.23 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

Based on CY2018 data, the number of independently contracted Level 1 LBHPs (i.e., Psychologists) actively providing services, represents a slight increase of 76 providers (an approximate 35.35 percent increase) over the baseline data in CY2015. Further, compared to CY2015, the data represents a slight decrease of members that accessed psychologists in CY2018. From Jan. 1, 2018 through Dec. 31, 2018, the total number of beneficiaries served decreased by 10.93 percent or by 2,141 members. The data represents an approximate 10.82 percent decrease of children younger than age 21 served and an approximate 11.87 percent increase of adults ages 21 and older served.

The State has observed that access to care has continued to be sufficient since the State chose not to reduce rates for Level 1 and 2 LBHPs practicing in an outpatient behavioral health clinic setting.

4. Analysis of the Information and Concerns Expressed in Input from Affected Stakeholders

- ### Call Monitoring

The OHCA monitors member and provider calls regarding access to care. To date there have been no calls directly pertaining to this budget reduction request.

5. Summary/Conclusion

Based on data collected since implementing the rate reduction, the Agency continues to believe that reducing the provider rates as outlined in this analysis has allowed the State to continue the SoonerCare behavioral health program without drastically reducing the provider reimbursement rates for all behavioral health services or eliminating services completely which would have a detrimental impact on access to behavioral health services.

After careful analysis and stakeholder outreach, the State has determined that reducing provider rates as mentioned above continues to be in the best interest of Oklahoma's Medicaid Behavioral Health Program and the beneficiaries it serves and has not had a significant impact on access to care for SoonerCare members.

OK SPA 16-26 Licensure Candidate Rate Reduction 2019 Annual Access to Care Analysis

1. Introduction

As part of the documentation of access to care and service payment rates federal requirements found at 42 CFR § 447.203, the State must submit an access to care analysis for any service within a state plan amendment that proposes to reduce or restructure provider payment rates in circumstances when the changes could result in diminished access. The access review conducted must demonstrate that access to care is sufficient as of the effective date of the state plan amendment. Further, a state must establish procedures in its Access Monitoring Review Plan (AMRP) to monitor continued access to care after implementation of state plan service rate reduction or payment restructuring. Within 90 days of identifying access deficiencies, the state must submit a corrective action plan with specific steps and timelines to address those issues. While the corrective action plan may include longer-term objectives, remediation of the access deficiency should take place within 12 months.

The State must conduct a yearly update to previously submitted access to care analyses on state plan amendments (SPA) that proposes to reduce or restructure provider payment rates for a period of three years as specified in 42 CFR 447.203(b)(6)(ii). Oklahoma's (OK) SPA 16-26, licensure candidate rate reduction, revised the payment methodology and reimbursement structure for payments to behavioral health practitioners actively and regularly receiving board approved supervision to become licensed by an Oklahoma behavioral health licensing board (Licensure Candidate). The fees paid to Licensure Candidates for services rendered were reduced by 10%. OK SPA 16-26 was submitted June 24, 2016, with an effective date of May 1, 2016, and approved on Feb. 13, 2017. This is the second annual update to the access to care analysis for the restructured payment methodology within OK SPA 16-26.

From the data gathered for this report, access to care is adequate despite the reduction in rates; please refer to the "Effect on Access to Care" section below for a more detailed analysis.

2. State Plan Amendment (SPA)

OK SPA 16-26 Licensure Candidate Rate Reduction

3. Analysis of the Effect of the Change in Payment Rates on Access

- ### Requested Methodology or Rate Structure

  The revision to the payment rates for licensure candidates required an amendment to the Title XIX state plan. The rates for the aforementioned settings were 10 percent less than the State Fiscal Year 2015 rates.

- ### Rationale of SPA

  This state plan amendment was necessary to reduce provider reimbursement rates thereby reducing the Oklahoma Department of Mental Health and Substance Abuse Services'

(ODMHSAS) operations budget in order to meet the balanced budget requirements as mandated by State law. Without the revisions, the Department was at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program. Following an extensive analysis of the potential effect on access to care as noted below, the Department initiated the processes necessary to request this State Plan Amendment.

- ## Effect on Access to Care

In order to monitor beneficiary utilization of the impacted services, the State relied on the analysis of MMIS data against established baseline data and thresholds. The study included assessments of the available provider network, number of members with a paid claim in the first year of the restructured methodology, and utilization of services over time to determine that access was currently sufficient and access would not be negatively impacted by the proposed rate reduction. It should be noted that since the initial access to care analyses was submitted with the SPA and to better capture access to care, the State has transitioned from analyzing provider counts based on contracted providers only to contracted providers actively providing services within the calendar year.

2016 Access to Care Analysis

Based on Calendar Year (CY) 2016 data, the number of licensure candidates, under supervision, included 1,493 active providers. Further, based on the same 12-month data and out of 814,470 members eligible for Medicaid as of Dec. 31, 2016, licensure candidates, under supervision, served a total of 41,671 members (5 percent of the total Medicaid eligible beneficiaries), of which 28,328 members (3 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 13,343 members (2 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

Compared to CY2015, the data represents a slight increase in licensure candidates, under supervision and a moderate increase of members that accessed licensure candidates, under supervision, in CY2016. From Jan. 1, 2016 through Dec. 31, 2016, the total number of licensure candidates, under supervision, increased by approximately 0.07 percent or by 1 provider. The total number of beneficiaries served increased by 25 percent or by approximately 8,362 members. The data represents an approximate 24 percent increase of children younger than age 21 served and approximate 27 percent increase of adults ages 21 and older served.

On average, 15 percent of individuals identified through prevalence data as potentially having a mental health need in the State (including those not on Medicaid) have received a service through a Medicaid contracted provider. 12 percent of the total eligible Medicaid population in the State has received a behavioral health service through a Medicaid contracted behavioral health provider. This is up from 11.7% in CY2015.

Based on national research, "excellent behavioral health networks have penetration rates of 8% to 10% or greater, whereas average ones will have a rate between 5% and 6%. The latter figure is based not only on the experience of managed health plans but also epidemiologic

and health services research on the rates of specialty mental health services in the United States, which runs 5.6% to 5.9% per year."[2]

Based on Oklahoma's current mental health penetration rates among Medicaid beneficiaries, the State determined that even with a potential loss in the amount of services provided by Licensure Candidates due to the rate reductions, there will continue to be sufficient access to behavioral healthcare for Medicaid beneficiaries through the rest of the Medicaid behavioral health provider network.

2017 Access to Care Analysis

Based on Calendar Year (CY) 2017 data, the number of licensure candidates, under supervision, included 1,602 active providers. Further, based on the same 12-month data and out of 797,759 members eligible for Medicaid as of Dec. 31, 2017, licensure candidates, under supervision, served a total of 41,159 members (5 percent of the total Medicaid eligible beneficiaries), of which 28,067 members (4 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 13,092 members (2 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

Compared to CY2015, the data represents a slight increase in licensure candidates, under supervision and a moderate increase of members that accessed licensure candidates, under supervision, in CY2017. From Jan. 1, 2017 through Dec. 31, 2017, the total number of licensure candidates, under supervision, increased by approximately 5 percent or by 108 provider. The total number of beneficiaries served increased by 24 percent or by approximately 7,850 members. The data represents an approximate 23 percent increase of children younger than age 21 served and approximate 25 percent increase of adults ages 21 and older served.

On average, 16 percent of individuals identified through prevalence data as potentially having a mental health need in the State (including those not on Medicaid) have received a service through a Medicaid contracted provider. Of the total eligible Medicaid population in the State, 12.4 percent of individuals have received a behavioral health service through a Medicaid contracted behavioral health provider. This is up from 12% in CY2016.

Based on national research, "excellent behavioral health networks have penetration rates of 8% to 10% or greater, whereas average ones will have a rate between 5% and 6%. The latter figure is based not only on the experience of managed health plans but also epidemiologic and health services research on the rates of specialty mental health services in the United States, which runs 5.6% to 5.9% per year."[3]

Based on Oklahoma's current mental health penetration rates among Medicaid beneficiaries, coupled with the increase in contracted licensure candidates and beneficiaries being served by licensure candidates, the State has determined not only that access is sufficient but that access to services has increased since implementing the rate reductions in 2016.

[2] http://www.medscape.com/viewarticle/442673
[3] http://www.medscape.com/viewarticle/442673

2018 Access to Care Analysis

Based on Calendar Year (CY) 2018 data, the number of licensure candidates, under supervision, included 1,671 active providers. Further, based on the same 12-month data and out of 790,732 members eligible for Medicaid as of Dec. 31, 2018, licensure candidates, under supervision, served a total of 39,772 members (5 percent of the total Medicaid eligible beneficiaries), of which 27,608 members (3 percent of the total Medicaid eligible beneficiaries) were children younger than age 21 and 12,114 members (2 percent of the total Medicaid eligible beneficiaries) were adults ages 21 and older.

Compared to CY2015, the data represents a slight increase in licensure candidates, under supervision and a moderate increase of members that accessed licensure candidates, under supervision, in CY2018. From Jan. 1, 2018 through Dec. 31, 2018, the total number of licensure candidates, under supervision, increased by approximately 12 percent or by 179 provider. The total number of beneficiaries served increased by 19 percent or by approximately 6,463 members. The data represents an approximate 21 percent increase of children younger than age 21 served and approximate 16 percent increase of adults ages 21 and older served.

On average, 16 percent of individuals identified through prevalence data as potentially having a mental health need in the State (including those not on Medicaid) have received a service through a Medicaid contracted provider. Of the total eligible Medicaid population in the State, 12.4 percent of individuals have received a behavioral health service through a Medicaid contracted behavioral health provider. This is up from 12% in CY2016.

Based on national research, "excellent behavioral health networks have penetration rates of 8% to 10% or greater, whereas average ones will have a rate between 5% and 6%. The latter figure is based not only on the experience of managed health plans but also epidemiologic and health services research on the rates of specialty mental health services in the United States, which runs 5.6% to 5.9% per year."[4]

Based on Oklahoma's current mental health penetration rates among Medicaid beneficiaries, coupled with the increase in contracted licensure candidates and beneficiaries being served by licensure candidates, the State has determined not only that access is sufficient but that access to services has increased since implementing the rate reductions in 2016.

4. Analysis of the Information and Concerns Expressed in Input from Affected Stakeholders

- Call Monitoring

The OHCA monitors member and provider calls regarding access to care. To date there have been no number of calls directly pertaining to this budget reduction request.

5. Summary/Conclusion

[4] http://www.medscape.com/viewarticle/442673

The Agency continues to assert that reducing provider rates as outlined in this analysis allows the State to continue the SoonerCare behavioral health program without drastically reducing the provider reimbursement rates for all behavioral health services or eliminating services completely which would have a detrimental impact on access to behavioral health services. Without these rate reductions, the State would be forced to eliminate certain classes of services in order to meet its State constitutional requirement of filing a balanced budget.

After careful analysis and stakeholder outreach, the State has determined that reducing provider rates as mentioned above continues to be in the best interest of Oklahoma's Medicaid Behavioral Health Program and the beneficiaries it serves and continues to not have a significant impact on access to care for SoonerCare members.

OK SPA 16-23 Eyeglassess Flat Rate Access to Care Analysis

1. Introduction

As part of the documentation of access to care and service payment rates federal requirements found at 42 CFR 447.203, the State must submit an access to care analysis for any service within a state plan amendment that proposes to reduce or restructure provider payment rates in circumstances when the changes could result in diminished access. The access review conducted must demonstrate that access to care is sufficient as of the effective date of the state plan amendment. Further, a state must establish procedures in its Access Monitoring Review Plan (AMRP) to monitor continued access to care after implementation of state plan service rate reduction or payment restructuring. Within 90 days of identifying access deficiencies, the state must submit a corrective action plan with specific steps and timelines to address those issues. While the corrective action plan may include longer-term objectives, remediation of the access deficiency should take place within 12 months.

The State must conduct a yearly update to previously submitted access to care analyses on state plan amendments (SPA) that proposes to reduce or restructure provider payment rates for a period of three years as specified in 42 CFR 447.203(b)(6)(ii). OK SPA 16-23, eyeglasses flat rate, restructured the payment methodology from a maximum fee rate to a flat rate for the frame and the lens. OK SPA 16-23 was submitted September 28, 2016, with an effective date of September 1, 2016, and approved on April 5, 2017.

From the data gathered for this report, access to care is adequate despite the reduction in rates; please refer to the annual "Effect on Access to Care" sections below for a more detailed analysis.

2. State Plan Amendment (SPA)

OK SPA 16-23 Eyeglasses Flat Rate

3. Analysis of the Effect of the Change in Payment Rates on Access

- ### Requested Methodology or Rate Structure

  The revision to the payment methodology for eyeglasses required an amendment to the Title XIX state plan. The rates for eyeglass materials was set at a flat rate for the frame and single vision and bifocal vision lenses. All lenses will be made of polycarbonate material except in those circumstances were polycarbonate is not appropriate due to refraction requirements. Refraction and fitting fee are reimbursed separately.

- ### Rationale of SPA

  It was determined that Oklahoma could achieve a cost savings by combining professional services and the cost of eyeglass materials. This would ensure a quality service was provided to our members, access was maintained, and it would keep the services within the State.

  The proposed rates were established by doing a comparative analysis of other state's

reimbursement methodologies as well as reviewing competitive bid contracts and wholesale invoices for these products in Oklahoma and the geographical region, including AL, AR, ID, ME, MI, NH, OH, VT, WI, KY, MN, GA, ND, TX, WA. After review, the rate is based on reimbursement combinations of several different services, including the additional reimbursements that will be allowed for refraction and fitting fee services. The rates are recommended as follows:

Total reimbursement for a set of eyeglasses, including refraction and fitting = $83.01
V2020 = Eyeglass frame = $10.00 per frame
V2100-V2114 and V2200-V2214 lens = $13.95 per lens (x 2 per one set of eyeglasses)
V2784 = Polycarbonate lens = $0.00
92015, refraction = will reimburse at $16.63
92340, monofocal fitting fee = will reimburse at $28.48
(CPT 92015 and 92340-92342 are based on the RBRVS pricing and will be subject to any rate changes made to these tables annually.)

With each set of eyeglasses, the provider will be reimbursed for the refraction performed, the fitting fee, and the materials will be priced separately. Currently, 95% of the eyeglasses being made include polycarbonate materials, as this is standard of care for children's eye glasses; this will now be required for all eyeglass lens (with the exception of some lens where polycarbonate is not appropriate) and will not be separately reimbursed.

2016 Effect of Access to Care

Based on State Fiscal Year 2015 data, there were a total of 429 contracted providers in the SoonerCare network that provide eyeglasses and vision services and 117,960 members that accessed those services. No comments were received about access to eyeglasses and/or vision services during the public comment period for the Access Monitoring Review Plan. No impact on access is expected after discussions and agreements with representatives of the stakeholders.

2017 Effect on Access to Care

In order to monitor beneficiary utilization of the impacted services, the State relied on the analysis of MMIS data against established baseline data and thresholds. The study included assessments of the available provider network, number of members with a paid claim in the first year of the restructured methodology, and utilization of services over time to determine that access was currently sufficient and access would not be negatively impacted by the proposed rate reduction.

Based on the data from September 1, 2016 through August 31, 2017, there were a total of 456 contracted providers in the SoonerCare network that provide eyeglass services. Further, based on the same 12-month data and out of 537,747 children (younger than age 21) eligible for Medicaid as of August 31, 2017, a total of 150,108 members (27.91 percent of the total Medicaid eligible child beneficiaries) accessed eyeglass services.

The number of eyeglass providers, actively providing eyeglass services during the first year of implementation, represents a slight increase over the previous year. From September 1,

2016 through August 31, 2017, the total number of eyeglass services providers increased by 6.30 percent or by 27 providers. Further, compared to the baseline data from September 1, 2015 through August 31, 2016, the State observed a moderate increase of members that accessed eyeglass services during the first year of the restructured methodology. From September 1, 2016 through August 31, 2017, the total number of children beneficiaries served increased by nearly 27.25 percent or by approximately 32,148 members.

2018 Effect on Access to Care

Based on the data from September 1, 2017 through August 31, 2018, there were a total of 454 contracted providers in the SoonerCare network that provide eyeglass services. Further, based on the same 12-month data and out of 534,028 children (younger than age 21) eligible for Medicaid as of August 31, 2018, a total of 152,842 members (28.62 percent of the total Medicaid eligible child beneficiaries) accessed eyeglass services.

The number of eyeglass providers, actively providing eyeglass services during the second year of implementation, represents a slight increase when compared to the baseline year. From September 1, 2017 through August 31, 2018, the total number of eyeglass services providers increased by 5.83 percent or by 25 providers. Further, compared to the baseline data from September 1, 2015 through August 31, 2016, the State observed a moderate increase of members that accessed eyeglass services during the first year of the restructured methodology. From September 1, 2017 through August 31, 2018, the total number of children beneficiaries served increased by nearly 28.57 percent or by approximately 34,882 members from the baseline year.

2019 Effect on Access to Care

Based on the data from September 1, 2018 through August 31, 2019, there were a total of 443 contracted providers in the SoonerCare network that provide eyeglass services. Further, based on the same 12-month data and out of 529,925 children (younger than age 21) eligible for Medicaid as of August 31, 2019, a total of 149,164 members (28.15 percent of the total Medicaid eligible child beneficiaries) accessed eyeglass services.

The number of eyeglass providers, actively providing eyeglass services during the second year of implementation, represents a slight increase when compared to the baseline year. From September 1, 2018 through August 31, 2019, the total number of eyeglass services providers increased by 3.26 percent or by 14 providers. Further, compared to the baseline data from September 1, 2015 through August 31, 2016, the State observed a moderate increase of members that accessed eyeglass services during the first year of the restructured methodology. From September 1, 2018 through August 31, 2019, the total number of children beneficiaries served increased by nearly 26.45 percent or by approximately 31,204 members from the baseline year.

4. Analysis of the Information and Concerns Expressed in Input from Affected Stakeholders

- Call Monitoring

The OHCA monitors member and provider calls regarding access to care. To date there have been no calls directly pertaining to this budget reduction measure.

5. Summary/Conclusion

Based on data collected since implementing the restructured methodology, the Agency continues to believe that SoonerCare providers who currently furnish and are reimbursed for eyeglass frames and lenses are not affected by this state plan amendment because the state observed an overall increase in access to these services.

After careful analysis and stakeholder outreach, the State has determined that restructuring the methodology for the provider rates as mentioned above continues to be in the best interest of Oklahoma's Medicaid Program and the beneficiaries it serves and has not had a significant impact on access to care for SoonerCare members.