Oklahoma Health Care Authority

Medical Advisory Committee Meeting

AGENDA

January 21, 2016
1:00 p.m. – 3:30pm

Charles Ed McFall Board Room

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

   A. Introduction of new delegates, Mr. David Rising (Association of Health Care Providers) and Dr. Joe Catalano (Oklahoma Nurses Association)

II. Public Comments (2 minute limit)

III. MAC Member Comments/Discussion

IV. Action Item: Approval of Minutes of the November 19, 2015 Medical Advisory Committee Meeting

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

VI. SoonerCare Operations Update: **Nancy Nesser, Pharmacy Director**

   A. Comprehensive Diabetes Care – Sarah Walker, Clinical Data Analyst
   B. Agency Reorganization – Dr. Sylvia Lopez, Chief Medical Officer
   C. Pain Management Project – Dr. Mike Herndon, Sr. Medical Director

VII. Legislative Update: **Emily Shipley, Director of Governmental Affairs**

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

1. 15-02 – Language Clean-Up – Pgs. 23 - 31
2. 15-13 – Joint Injections - Pgs. 33 - 35
3. 15-15 – Drug Benefit - Pgs. 36 - 38
4. 15-22 – Health Record - Pgs. 39 - 45
5. 15-27A – SoonerCare Primary Care Providers - Pgs. 46 - 48
6. 15-27B – SoonerCare Primary Care Providers - Pg. 49
7. 15-29 – Behavioral Health - Pgs. 50 - 80
8. 15-30 – Biopsychosocial - Pgs. 81 - 88
9. 15-32 - Health Home - Pgs. 89 - 94
10. 15-40 – Hospital Leave - Pgs. 95 – 97

11. 16-01 – Reimbursement for Licensed Behavioral Health Professionals In Independent Practice

IX. Action Item: Vote on Proposed Rule Changes: **Chairman, Steven Crawford, M.D.**

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

XI. Future Meetings

March 10, 2016 at 1:00 PM

May 19, 2016 at 1:00 PM

July 21, 2016 at 1:00 PM

September 15, 2016 at 1:00 PM

November 17, 2016 at 1:00 PM

XII. Adjourn

Next Meeting
Thursday, March 10 , 2016
1:00 p.m. – 3:30pm
Charles Ed McFall Board Room
4345 N Lincoln Blvd
Oklahoma City, OK 73105

Oklahoma Health Care Authority
Medical Advisory Committee Meeting

MINUTES of the November 19, 2015 Meeting

Welcome and Roll Call

Chairman Crawford called the meeting to order at 1:00 PM and asked that the roll call be taken. ***Delegates present were*****:** Dr. Steve Crawford, Ms. Wanda Felty, Mr. Steve Goforth, Dr. Stanley Grogg (via phone), Ms. Tandie Hastings, Mr. Mark Jones, Ms. Annette Mays, Dr. Dan McNeill, Dr. J. Daniel Post, Ms. Toni Pratt-Reid, Dr. Jason Rhynes, Dr. Kanwal Obhrai (via phone), Mr. Rick Snyder, Mr. Jeff Tallent, and Dr. Rick Walton. ***Alternates present were***: Ms. Sarah Baker, Ms. Lois Baer, Ms. Frannie Pryor, Mr. Traylor Rains-Sims, and Dr. Mike Talley, providing a quorum.

Delegates absent without an alternate were**:** Ms. Debbie Booten-Hiser, Dr. David Cavallaro, Ms. Samantha Galloway, Dr. Melissa Gastorf, Dr. Denae Kirkpatrick, Ms. Liz Moran, Mr. James Patterson, and Dr. Edd Rhoades.

Public Comments

There were no public comments

Member Comments Approval of Minutes

Approval of the September 17, 2015 Minutes: Dr. Crawford asked that a motion for approval of the minutes of September 17, 2015 be made. Ms. Frannie Pryor moved to accept the minutes and Mr. Jeff Tallent seconded the motion. The vote to accept was unanimous.

Financial Update

Gloria Hudson, Director of General Accounting, reported on the state's fiscal year 2016 financial transactions through the month of September 2015. From the preliminary data in for the month of October it looks like the agency will continue to remain under budget.

SoonerCare Operations Update

Marlene Asmussen, Population Care Management Director, reported on the September 2015 data on SoonerCare Operations. There was a slight decrease in total SoonerCare enrollment for September across the board. Ms. Asmussen highlighted Healthcare Effectiveness Data and Information Set (HEDIS) Measures. The agency will look at the three measures for combating diabetes this month which are as follows: Hemoglobin A1c status for SoonerCare, Medical Attention for nephropathy, and also retinal eye exams. The members discussed the possible reasons for Oklahoma lagging behind the nation in eye exams for diabetic adults. Dr. Talley also asked that Medical Attention for Nephropathy be more clearly defined and requested this information at the next meeting.

Aged, Blind, and Disabled (ABD) Care Coordination House Bill 1566 Update

Buffy Heater, Director Strategic Planning and Reform, presented additional information since the last MAC meeting specific to the ABD Care Coordination that the agency was directed to undergo as a result of HB 1566, specifically for the A & B, which passed earlier this year during the session. The agency has

undertaken monthly stakeholder meetings. The stakeholder list has grown to over 600 members and that is a very diverse group from the Healthcare industry, from consumer advocates, elected officials, and health plans. This past summer, the agency engaged in this Request for Information (RFI) process and heard roughly from the three types of markets: the fully capitated managed care model and administrative service organization model, and also a regional community based care coordination plan. Ongoing activities can be viewed at public website: www.okhca.org/ABDcareCoordination. The agency has also been engaging other state agencies as well as specific members of the community that have sought input and with other states that have had a recent experience in doing care coordination for the Aged, Blind, and Disabled. As the agency moves forward, it is very close to a November 30th announcement defining which models the Oklahoma Health Care Authority (OHCA) will adopt through the Request for Proposal (RFP) process.

Legislative Update

Dr. Crawford introduced Emily Shipley as the new Director of Governmental Affairs. Ms. Shipley presented updates on the three legislative interim studies: the state budget, enrollment and eligibility criteria, and gubernatorial appointment of the Oklahoma Health Care Authority's (OHCA)Chief Executive Officer.

Health Policy-Proposed Rule Changes

Demetria Bennett, Policy Development Coordinator, presented one rule, 15-14 A&B. This rule change defines federal regulations that impact the Advantage Waiver program. The policy revisions are necessary as the regulation states that providers for the Oklahoma community based services can not have a vetted interest in or be employed by an Oklahoma community based program. The rule is budget neutral. There were some members concerned about the language in a few places and requested that it be revised. The first revision was suggested by Ms. Felty stating that the language in 15-14B (Page 38 of agenda under Section III (vi)) which states "tend to isolate" is pretty vague and not descriptive. Ms. Bennett will take it back to DHS for revision. Ms. Baker stated that the language within the policy on page 28 of the agenda under (12) Speech and Language Therapy services (under (A)) did not have swallowing disorders listed and wanted to know if that could be added. Dr. Crawford stated clarifying it would be good in order to eliminate future corrections. Ms. Baker had another language issue and that being on page 29 of the agenda where it states paraprofessional which needs to be replaced with Speech Language Pathology Assistant. Ms. Bennett is going to refer these suggestions to DHS for revision. Ms. Mays asked for clarification on the breakdown of sections on page 30 under the hospice care to make sure there was no repetition.

New Business / Member Comments

Meetings scheduled for 2016 were voted on and approved with the exception of March 17th due to Spring Break and it was requested that date be rescheduled. Dr. Dan McNeill moved to accept the dates and it was seconded by Dr. Talley. It passed unanimously.

Election of Chairperson and Vice-Chairperson was the last topic on the agenda. Dr. Crawford stated that before the meeting Dr. Dan McNeill indicated that he would decline a nomination. Mr. Goforth was

nominated by Dr. McNeill and Mr. Goforth accepted the nomination for Vice-Chair. Dr. Stanley Grogg moved that Mr. Goforth be made Vice-Chairman of the MAC by acclamation. Dr. Crawford asked for a second to that motion and it was seconded by Dr. Post. It was voted and passed unanimously. It was moved by Dr. Dan Post that Dr. Crawford be nominated to remain as Chairman to the MAC and it was seconded by Dr. Stanley Grogg. Dr. Crawford did accept the nomination and was passed unanimously.

Adjournment

Dr. Walton motioned to adjourn and Dr. Rhynes seconded the motion. It passed unanimously.

AGENDA

FINANCIAL REPORT

For the Five Months Ended November 30, 2015
Submitted to the CEO & Board

- Revenues for OHCA through November, accounting for receivables, were **$1,689,320,647** or **1.8% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,638,168,942 or 2.8% under** budget.
- The state dollar budget variance through November is a **positive $15,890,852.**

The budget variance is primarily attributable to the following (in millions

Expenditures:		
Medicaid Program Variance		11.4
Administration		1.6
Revenues:		
Drug Rebate		1.6
Taxes and Fees		1.9
Overpayments/Settlements		(.6)
Total FY 16 Variance	**$**	**15.9**

ATTACHMENTS

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Fund 205: Supplemental Hospital Offset Payment Program Fund	4
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OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2016, For the Five Month Period Ending November 30, 2015

REVENUES	FY16 Budget YTD	FY16 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 398,018,512	$ 398,018,512	$ -	0.0%
Federal Funds	1,002,931,141	967,357,994	(35,573,147)	(3.5)%
Tobacco Tax Collections	19,275,068	21,183,222	1,908,154	9.9%
Quality of Care Collections	32,213,877	31,724,757	(489,120)	(1.5)%
Prior Year Carryover	67,016,727	67,016,727	-	0.0%
Federal Deferral - Interest	127,676	127,676	-	0.0%
Drug Rebates	77,164,572	81,367,773	4,203,201	5.4%
Medical Refunds	15,880,849	14,452,318	(1,428,531)	(9.0)%
Supplemental Hospital Offset Payment Program	99,892,724	99,892,724	-	0.0%
Other Revenues	7,924,531	8,178,943	254,413	3.2%
TOTAL REVENUES	**$ 1,720,445,677**	**$ 1,689,320,647**	**$ (31,125,030)**	**(1.8)%**

EXPENDITURES	FY16 Budget YTD	FY16 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 22,506,920**	**$ 21,123,032**	**$ 1,383,888**	**6.1%**
ADMINISTRATION - CONTRACTS	**$ 39,679,333**	**$ 37,035,803**	**$ 2,643,530**	**6.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	17,866,029	16,485,687	1,380,342	7.7%
Acute Fee for Service Payments:				
Hospital Services	379,699,685	368,294,205	11,405,480	3.0%
Behavioral Health	8,203,640	8,146,261	57,380	0.7%
Physicians	208,858,999	192,895,134	15,963,865	7.6%
Dentists	53,975,047	56,112,824	(2,137,777)	(4.0)%
Other Practitioners	14,286,879	17,408,436	(3,121,557)	(21.8)%
Home Health Care	8,434,930	8,263,249	171,681	2.0%
Lab & Radiology	31,684,131	25,643,666	6,040,464	19.1%
Medical Supplies	18,779,987	18,715,185	64,802	0.3%
Ambulatory/Clinics	56,419,019	51,917,504	4,501,515	8.0%
Prescription Drugs	214,116,070	211,778,938	2,337,132	1.1%
OHCA Therapeutic Foster Care	669,290	317,031	352,260	52.6%
Other Payments:				
Nursing Facilities	236,143,914	235,482,159	661,755	0.3%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	25,502,276	25,277,996	224,280	0.9%
Medicare Buy-In	55,730,856	56,588,101	(857,245)	(1.5)%
Transportation	30,363,948	27,300,399	3,063,549	10.1%
Money Follows the Person-OHCA	291,246	204,704	86,542	0.0%
Electonic Health Records-Incentive Payments	3,556,987	3,556,987	-	0.0%
Part D Phase-In Contribution	33,324,963	33,318,781	6,182	0.0%
Supplemental Hospital Offset Payment Program	220,924,319	220,924,319	-	0.0%
Telligen	4,157,200	1,378,543	2,778,657	66.8%
Total OHCA Medical Programs	**1,622,989,413**	**1,580,010,107**	**42,979,306**	**2.6%**
OHCA Non-Title XIX Medical Payments	9,158	-	9,158	0.0%
TOTAL OHCA	**$ 1,685,184,824**	**$ 1,638,168,942**	**$ 47,015,882**	**2.8%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 35,260,852**	**$ 51,151,704**	**$ 15,890,852**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2016, For the Five Month Period Ending November 30, 2015

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 16,542,495	$ 16,480,377	$ -	$ 56,808	$ -	$ 5,310	$ -
Inpatient Acute Care	497,174,432	251,034,978	202,786	1,469,707	163,566,452	860,433	80,040,076
Outpatient Acute Care	162,055,068	114,810,882	17,335	1,581,737	44,277,323	1,367,791	
Behavioral Health - Inpatient	21,929,174	4,875,375	-	112,724	12,309,757	-	4,631,318
Behavioral Health - Psychiatrist	4,041,673	3,270,886	-	-	770,787	-	-
Behavioral Health - Outpatient	11,778,250	-	-	-	-	-	11,778,250
Behavioral Health-Health Home	8,209,265	-	-	-	-	-	8,209,265
Behavioral Health Facility- Rehab	94,699,038	-	-	-	-	30,008	94,699,038
Behavioral Health - Case Management	7,481,392	-	-	-	-	-	7,481,392
Behavioral Health - PRTF	34,269,987	-	-	-	-	-	34,269,987
Residential Behavioral Management	8,711,571	-	-	-	-	-	8,711,571
Targeted Case Management	27,107,928	-	-	-	-	-	27,107,928
Therapeutic Foster Care	317,031	317,031	-	-	-	-	-
Physicians	218,111,958	190,580,288	24,209	923,964	-	2,290,637	24,292,859
Dentists	56,118,066	56,108,335	-	5,242	-	4,489	-
Mid Level Practitioners	1,081,391	1,075,384	-	5,873	-	134	-
Other Practitioners	16,366,073	16,144,443	185,985	33,155	-	2,491	-
Home Health Care	8,265,265	8,258,714	-	2,016	-	4,535	-
Lab & Radiology	26,205,649	25,485,710	-	561,983	-	157,956	-
Medical Supplies	18,824,528	17,569,459	1,129,805	109,344	-	15,921	-
Clinic Services	51,817,498	48,888,772	-	264,504	-	65,707	2,598,514
Ambulatory Surgery Centers	3,017,173	2,956,372	-	54,149	-	6,652	-
Personal Care Services	5,423,187	-	-	-	-	-	5,423,187
Nursing Facilities	235,482,159	148,063,338	87,415,708	-	-	3,113	-
Transportation	27,234,535	26,117,521	1,100,370	-	-	16,644	-
GME/IME/DME	59,031,266	-	-	-	-	-	59,031,266
ICF/IID Private	25,277,996	20,649,094	4,628,902	-	-	-	-
ICF/IID Public	17,490,245	-	-	-	-	-	17,490,245
CMS Payments	89,906,882	89,611,795	295,087	-	-	-	
Prescription Drugs	216,190,206	211,068,052	-	4,411,269	-	710,886	-
Miscellaneous Medical Payments	65,864	65,647	-	-	-	217	-
Home and Community Based Waiver	82,295,808	-	-	-	-	-	82,295,808
Homeward Bound Waiver	35,925,335	-	-	-	-	-	35,925,335
Money Follows the Person	2,873,736	204,704	-	-	-	-	2,669,032
In-Home Support Waiver	10,785,362	-	-	-	-	-	10,785,362
ADvantage Waiver	74,642,447	-	-	-	-	-	74,642,447
Family Planning/Family Planning Waiver	2,554,674	-	-	-	-	-	2,554,674
Premium Assistance*	18,714,124	-	-	18,714,124	-	-	-
Telligen	1,378,543	1,378,543	-	-	-	-	-
Electronic Health Records Incentive Payments	3,556,987	3,556,987	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,202,954,260**	**$ 1,258,572,684**	**$ 95,000,187**	**$ 28,306,599**	**$ 220,924,319**	**$ 5,542,925**	**$ 594,637,554**

* Includes $18,589,481 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2016, For the Five Month Period Ending November 30, 2015

		FY16
REVENUE		**Actual YTD**
Revenues from Other State Agencies	$	248,108,227
Federal Funds		367,808,239
TOTAL REVENUES	**$**	**615,916,466**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	82,295,808
Money Follows the Person		2,669,032
Homeward Bound Waiver		35,925,335
In-Home Support Waivers		10,785,362
ADvantage Waiver		74,642,447
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		17,490,245
Personal Care		5,423,187
Residential Behavioral Management		6,654,932
Targeted Case Management		22,340,228
Total Department of Human Services		**258,226,575**
State Employees Physician Payment		
Physician Payments		24,292,859
Total State Employees Physician Payment		**24,292,859**
Education Payments		
Graduate Medical Education		24,915,759
Graduate Medical Education - Physicians Manpower Training Commission		1,867,191
Indirect Medical Education		32,248,316
Direct Medical Education		-
Total Education Payments		**59,031,266**
Office of Juvenile Affairs		
Targeted Case Management		1,283,400
Residential Behavioral Management		2,056,639
Total Office of Juvenile Affairs		**3,340,039**
Department of Mental Health		
Case Management		7,481,392
Inpatient Psychiatric Free-standing		4,631,318
Outpatient		11,778,250
Health Homes		8,209,265
Psychiatric Residential Treatment Facility		34,269,987
Rehabilitation Centers		94,699,038
Total Department of Mental Health		**161,069,250**
State Department of Health		
Children's First		853,070
Sooner Start		848,963
Early Intervention		2,148,822
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,001,965
Family Planning		33,283
Family Planning Waiver		2,518,407
Maternity Clinic		6,628
Total Department of Health		**7,411,138**
County Health Departments		
EPSDT Clinic		278,309
Family Planning Waiver		2,984
Total County Health Departments		**281,293**
State Department of Education		**85,250**
Public Schools		**397,159**
Medicare DRG Limit		**74,500,000**
Native American Tribal Agreements		**462,649**
Department of Corrections		**423,826**
JD McCarty		**5,116,250**
Total OSA Medicaid Programs	**$**	**594,637,554**
OSA Non-Medicaid Programs	**$**	**28,976,871**
Accounts Receivable from OSA	**$**	**7,697,958**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2016, For the Five Month Period Ending November 30, 2015

REVENUES	FY 16 Revenue
SHOPP Assessment Fee	$ 99,679,223
Federal Draws	136,213,508
Interest	63,710
Penalties	149,791
State Appropriations	(15,100,000)
TOTAL REVENUES	$ 221,006,231

EXPENDITURES	Quarter	Quarter	FY 16 Expenditures
Program Costs:	7/1/15 - 9/30/15	10/1/15 - 12/31/15	
Hospital - Inpatient Care	83,225,354	80,341,099	$ 163,566,452
Hospital -Outpatient Care	22,465,442	21,811,881	44,277,323
Psychiatric Facilities-Inpatient	6,265,547	6,044,210	12,309,757
Rehabilitation Facilities-Inpatient	392,213	378,574	770,787
Total OHCA Program Costs	112,348,555	108,575,764	$ 220,924,319
Total Expenditures			$ 220,924,319

CASH BALANCE	$ 81,912

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund

SFY 2016, For the Five Month Period Ending November 30, 2015

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 31,706,745	$ 31,706,745
Interest Earned	18,012	18,012
TOTAL REVENUES	**$ 31,724,757**	**$ 31,724,757**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 85,903,933	$ 32,832,483	
Eyeglasses and Dentures	113,455	43,363	
Personal Allowance Increase	1,398,320	534,438	
Coverage for Durable Medical Equipment and Supplies	1,129,805	431,811	
Coverage of Qualified Medicare Beneficiary	430,315	164,466	
Part D Phase-In	295,087	112,782	
ICF/IID Rate Adjustment	2,184,946	835,086	
Acute Services ICF/IID	2,443,956	934,080	
Non-emergency Transportation - Soonerride	1,100,370	420,562	
Total Program Costs	**$ 95,000,187**	**$ 36,309,071**	**$ 36,309,071**
Administration			
OHCA Administration Costs	$ 216,434	$ 108,217	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 216,434**	**$ 108,217**	**$ 108,217**
Total Quality of Care Fee Costs	**$ 95,216,621**	**$ 36,417,288**	
TOTAL STATE SHARE OF COSTS			**$ 36,417,288**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

SFY 2016, For the Five Month Period Ending November 30, 2015

REVENUES	FY 15 Carryover	FY 16 Revenue	Total Revenue
Prior Year Balance	$ 27,746,235	$ -	$ 1,498,834
State Appropriations	(25,000,000)	-	-
Tobacco Tax Collections	-	17,423,108	17,423,108
Interest Income	-	96,616	96,616
Federal Draws	235,637	12,278,471	12,278,471
TOTAL REVENUES	$ 2,981,872	$ 29,798,196	$ 31,297,030

EXPENDITURES		FY 15 Expenditures	FY 16 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 18,589,481	$ 18,589,481
	College Students		124,643	47,639
Individual Plan				
	SoonerCare Choice		$ 54,378	$ 20,783
	Inpatient Hospital		1,469,707	561,722
	Outpatient Hospital		1,560,213	596,313
	BH - Inpatient Services-DRG		110,153	42,101
	BH -Psychiatrist		-	-
	Physicians		908,875	347,372
	Dentists		4,485	1,714
	Mid Level Practitioner		5,839	2,232
	Other Practitioners		32,684	12,492
	Home Health		2,016	771
	Lab and Radiology		552,978	211,348
	Medical Supplies		104,294	39,861
	Clinic Services		260,583	99,595
	Ambulatory Surgery Center		54,149	20,696
	Prescription Drugs		4,346,983	1,661,417
	Miscellaneous Medical		-	-
	Premiums Collected		-	(183,227)
Total Individual Plan			$ 9,467,336	$ 3,435,189
	College Students-Service Costs		$ 125,137	$ 45,024
Total OHCA Program Costs			$ 28,306,598	$ 22,117,333
Administrative Costs				
	Salaries	$ 73,467	$ 893,844	$ 967,311
	Operating Costs	60,069	376,269	436,338
	Health Dept-Postponing	-	-	-
	Contract - HP	1,349,503	1,937,047	3,286,550
Total Administrative Costs		$ 1,483,038	$ 3,207,160	$ 4,690,199
Total Expenditures				$ 26,807,532
NET CASH BALANCE		$ 1,498,834		$ 4,489,498

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2016, For the Five Month Period Ending November 30, 2015

REVENUES	FY 16 Revenue	State Share
Tobacco Tax Collections	$ 347,609	$ 347,609
TOTAL REVENUES	**$ 347,609**	**$ 347,609**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 5,310	$ 932	
Inpatient Hospital	860,433	151,092	
Outpatient Hospital	1,367,791	240,184	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	3,113	547	
Physicians	2,290,637	402,236	
Dentists	4,489	788	
Mid-level Practitioner	134	24	
Other Practitioners	2,491	437	
Home Health	4,535	796	
Lab & Radiology	157,956	27,737	
Medical Supplies	15,921	2,796	
Clinic Services	65,707	11,538	
Ambulatory Surgery Center	6,652	1,168	
Prescription Drugs	710,886	124,832	
Transportation	16,644	2,923	
Miscellaneous Medical	217	38	
Total OHCA Program Costs	$ 5,512,917	$ 968,068	
OSA DMHSAS Rehab	$ 30,008	$ 7,919	
Total Medicaid Program Costs	$ 5,542,925	$ 975,987	
TOTAL STATE SHARE OF COSTS			**$ 975,987**

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

SoonerCare Operations Report

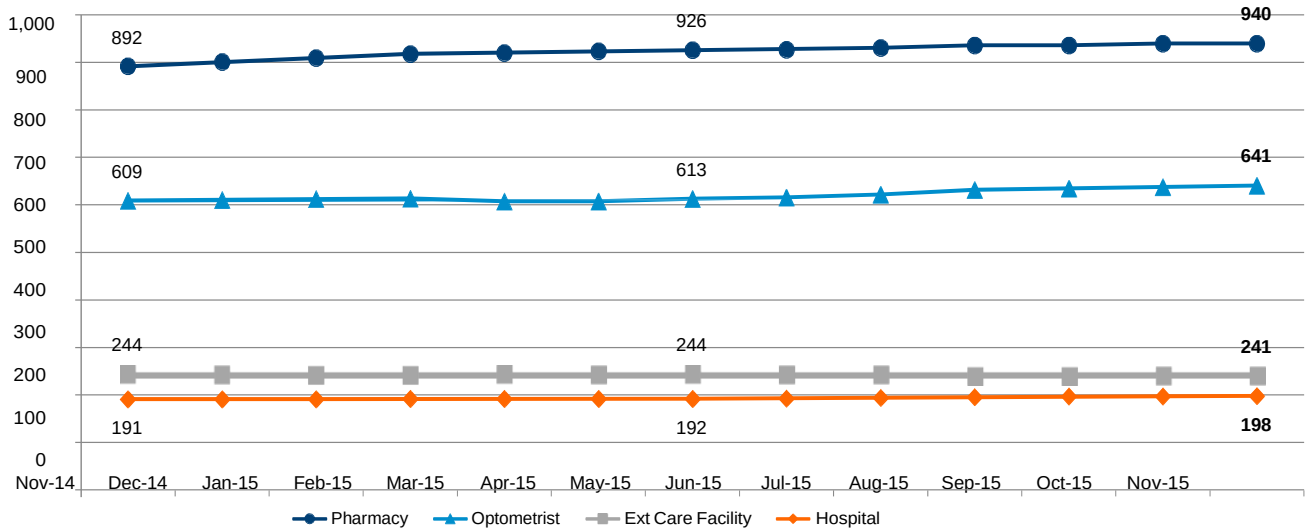
SOONERCARE ENROLLMENT/EXPENDITURES

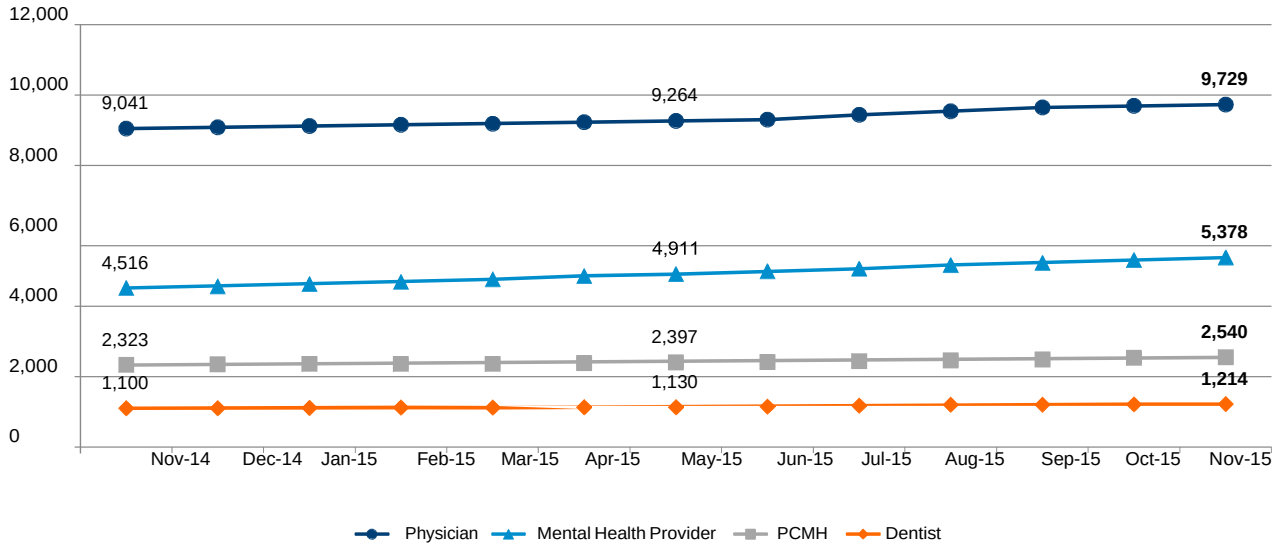
Delivery System			Enrollment November 2016	Children November 2016	Adults November 2016	Enrollment Change	Total Expenditures November	PMPM November 2016	Forecasted Nov 2016 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**531,672**	**437,309**	**94,363**	**-3,108**	**$136,857,284**		
	Lower Cost	*(Children/Parents; Other)*	487,809	423,439	64,370	-2,941	$95,118,382	$195	$213
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,863	13,870	29,993	-167	$41,738,902	$952	$962
SoonerCare Traditional			**237,909**	**91,249**	**146,660**	**1,832**	**$186,207,935**		
	Lower Cost	*(Children/Parents; Other)*	126,510	86,139	40,371	1,633	$46,200,068	$365	$377
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	111,399	5,110	106,289	199	$140,007,867	$1,257	$1,268
SoonerPlan			**38,327**	**2,943**	**35,384**	**-146**	**$307,937**	$8	$8
Insure Oklahoma			**18,152**	**510**	**17,642**	**714**	**$5,572,126**		
	Employer-Sponsored Insurance		14,274	334	13,940	756	$3,809,836	$267	$279
	Individual Plan		3,878	176	3,702	-42	$1,762,291	$454	$451
TOTAL			**826,060**	**532,011**	**294,049**	**-708**	**$328,945,283**		

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

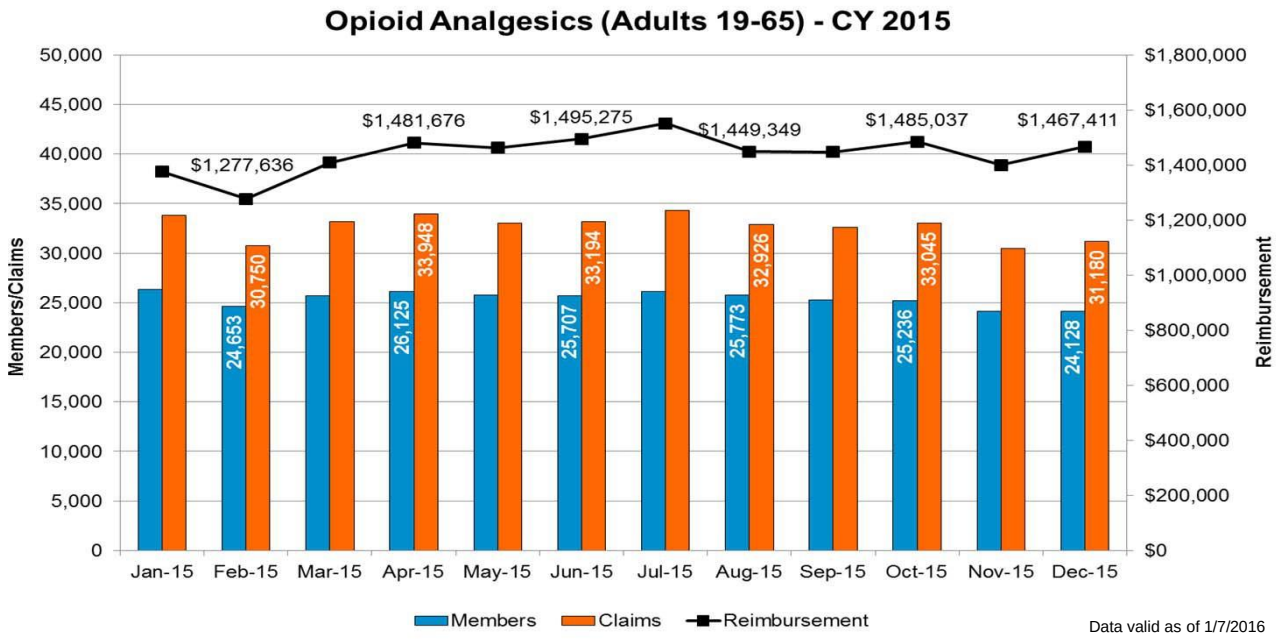
IN-STATE CONTRACTED PROVIDERS

Total In-State Providers: 34,008 (+239) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**





SOONERCARE PAIN MANAGEMENT



Data valid as of 1/7/2016

Monthly Average	Members	Claims	Reimbursement
	25,413	32,716	$ 1,441,984

AGENDA

SoonerCare Pain Management Program:

SOONERCARE PAIN MANAGEMENT PROGRAM

1. Provider toolkit
2. Practice facilitation
3. Substance use resource specialists

TOOLKIT CONTENTS

- Treatment protocols
- Oklahoma Opioid Prescribing Guidelines
- Office visit forms
- Patient handouts
- Monitoring recommendations
- Additional resources

CONTINUING WORK/ADDITIONS TO GUIDELINES

1. CME
2. Involvement of other agencies
   a. Oklahoma State Plan guideline recommendations
   b. Possible endorsement of toolkit and guidelines
3. Electronic health records

CONTACT INFORMATION

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AGENDA

Presentation, Discussion and Vote on Proposed Rule Changes

January MAC
Proposed Rule Amendment Summaries

Face to face tribal consultations regarding the following proposed changes were held Tuesday, September 1, 2015 and Tuesday, November 3, 2015 in the Board Room of the OHCA.

The following rules were posted for comment on December 16, 2015 through January 15, 2016.

15-02 Language Clean-Up Due to OHCA Determining Eligibility Instead of DHS and Update Transitional Medical Assistance (TMA) Policy to Match Federal Regulations — OHCA proposes to revise rules to clean up language where policy references Appendix C-1 (Maximum Income, Resource, and Payment Standards) which is a Department of Human Services (DHS) document. The language Appendix C-1 will be replaced with SoonerCare Income Guidelines when referencing eligibility groups for which the Oklahoma Health Care Authority (OHCA) determines eligibility. The previous language was appropriate when DHS was determining eligibility for those groups. Also, the language referencing Categorically Needy Standards will be deleted.
OHCA also proposes to revise rules to update TMA policy to match Federal regulations on MAGI eligibility determinations. Policy states that health benefits are continued when SoonerCare case closure is due to the receipt of new or increased child support. These health benefits are called TMA. However, under MAGI rules a case would never be closed due to Child Support income because Child Support income is not counted under MAGI rules for determining income eligibility.
Budget Impact: Budget neutral

15-13 Joint Injections — Proposed physician policy changes will allow payment for a joint injection and office visit if the claim is billed appropriately and medical documentation supports separate payments. Further, current policy states that payment is made for joint injections without a global coverage designation; however, all joint injection codes have a global coverage designation. Therefore, proposed policy changes are also needed to decrease provider confusion.
Budget Impact: Budget neutral

15-15 Drug Benefit — Proposed pharmacy policy changes will reflect guidance in federal law regarding included and excluded prescription drug coverage and to update the list of covered over-the-counter drugs. This proposal will also update items within the State Plan to reflect most recent federal guidance.
Budget Impact: Budget neutral

15-22 Health Record Signature Requirements — The proposed rules are revised to specify electronic and paper based medical records must be authenticated on the same day the record

is completed or, if completed by someone else, the record must be signed within three business days. Current rules only address signature requirements for edits of a medical record.
Budget Impact: Budget neutral

15-27A SoonerCare Primary Care Providers — OHCA proposes policy changes that would clarify inconsistent and conflicting language authorizing medical residents as Primary Care Physicians (PCP) under SoonerCare. Language cleanup will reflect current OHCA practices.
Budget Impact: Budget neutral

15-27B SoonerCare Primary Care Providers — OHCA proposes policy changes that would clarify inconsistent and conflicting references to language authorizing medical residents as Primary Care Physicians (PCP) under SoonerCare. Language cleanup will reflect current OHCA practices.
Budget Impact: Budget neutral

15-29 Behavioral Health Case Management — Proposed Behavioral Health Case Management policy changes will transfer coverage guidelines and provider requirements for case management services to another Part of rules addressing guidelines for services provided by Outpatient Behavioral Health Agencies. This change is being made to reduce provider confusion and to organize outpatient behavioral health agency service rules in a way that is more comprehensive and easily understood by SoonerCare providers and members.
Budget Impact: Budget neutral

15-30 Biopsychosocial Requirements — Proposed outpatient Behavioral Health Agency policy changes will allow providers more flexibility in conducting biopsychosocial assessments by removing specific required elements. This change in policy will align the assessment requirements in OHCA rules with those in the ODMHSAS contract. Furthermore, outpatient behavioral health agency rules are revised to remove specific minimum time requirements for behavioral health assessment services. Current rules require at least 1.5 hours in order to bill a low complexity assessment and over 2 hours to bill a moderate complexity assessment. By removing the time requirements from rules, there will be more flexibility in allowing providers to bill in alternative ways that may be different based upon the type of assessment conducted.
Budget Impact: Budget neutral

15-32 Health Home Rules — SoonerCare Health Homes for adults with Serious Mental Illness (SMI) and Children with Serious Emotional Disturbances (SED) were implemented in February 2015. Since implementation, some inconsistencies between OHCA rules and Health Home Certification rules administered by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) have been identified that need to be cleaned up. Some examples are specifics regarding provider requirements and which providers are allowed to provide specific Health Home services.
Budget Impact: Budget neutral

15-40 Hospital Leave Payments — Proposed policy would clean up language in Chapter 35 to match 2014 changes to Chapter 30 that eliminated hospital leave payments to long term care facilities. Proposed changes to Chapter 35 would remove existing references to reimbursement for hospital leave and reflect current OHCA practices. Payments will continue for therapeutic leave.
Budget Impact: Budget neutral

16-01 Reimbursement for Licensed Behavioral Health Professionals in Independent Practice – The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) is proposing revisions to SoonerCare rules regarding coverage and reimbursement for services provided by Licensed Behavioral Health Professionals in independent practice. The proposed revisions revoke all coverage and reimbursement guidelines for this specific provider type, as ODMHSAS is requesting that independently contracted providers in private practice no longer be reimbursed for SoonerCare services. LBHP services will remain available to all SoonerCare members through SoonerCare contracted outpatient behavioral health agencies. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.
Budget Impact: $9,707,264 total/$3,786,413 State Annual; $1,262,137 for remaining SFY2016. Savings are attributable to ODMHSAS.

AGENDA

15-02 Language Clean-Up Due to OHCA Determining Eligibility Instead of DHS and Update Transitional Medical Assistance (TMA) Policy to Match Federal Regulations

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE HEALTH BENEFITS FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-37. Financial eligibility of categorically needy individuals related to AFDC or pregnancy-related services

Individuals whose income is less than the ~~standards on DHS Appendix C-1~~SoonerCare Income Guidelines for the applicable eligibility group are financially eligible for SoonerCare.

(1) **~~Categorically needy standards/categorically~~Categorically related to pregnancy-related services.** For an individual related to pregnancy-related services to be financially eligible, the countable income must be less than the appropriate standard according to the family size on ~~DHS Appendix C-1~~the SoonerCare Income Guidelines. In determining the household size, the pregnant woman and her unborn child(ren) are included.

(2) **~~Categorically needy standards/categorically~~Categorically related to children's and parent/caretakers' groups.**

(A) **~~Categorical relationship.~~Parent/caretakers' group.** For the individual ~~related to AFDC~~in the parent/caretakers' group to be considered categorically needy, the ~~standards on DHS Appendix C-1 schedules~~SoonerCare Income Guidelines must be used.

(i) **~~DHS Appendix C-1, Schedule X.~~SoonerCare Income Guidelines.** Individuals age 19 years or older, other than pregnant women, are determined categorically needy if countable income is less than the Categorically Needy Standard, according to the family size.

(ii) **~~DHS Appendix C-1, Schedule I.A.~~SoonerCare Income Guidelines.** All individuals under 19 years of age are determined categorically needy if countable income is equal to or less than the Categorically Needy Standard, according to the size of the family.

(B) **Families with children.** Individuals who meet financial eligibility criteria for the children's and

parent/caretakers' groups are:

(i) All persons included in an active TANF case.

(ii) Individuals related to the children's or parent/caretakers' groups whose countable income is within the current appropriate income standard, but who do not receive TANF assistance.

(iii) All persons in a TANF case in Work Supplementation status who meet TANF eligibility conditions other than earned income.

(iv) Those individuals who continue to be eligible for Medicaid in a TANF case after they become ineligible for a TANF payment. These individuals will continue to be considered categorically needy if the TANF case was closed due to child or spousal support, the loss or reduction of earned income exemption by any member of the assistance unit, or the new or increased earnings of the caretaker relative.

317:35-6-39. General calculation of countable income for MAGI eligibility groups

(a) The income that is counted in determining eligibility for an individual is that individual's household income.

(b) In order to calculate the countable household income for an individual:

(1) Determine who is in the individual's household (see OAC 317:35-6-40 to 317:35-6-43);

(2) Identify all sources of income for all household members;

(3) Determine whether each source of income is considered for SoonerCare eligibility or is excluded (see Part 6, Countable Income, of this Subchapter);

(4) Determine the gross monthly amount of each source of countable income (see Part 6, Countable Income, of this subchapter);

(5) Determine whether each household member's income counts toward the household (see 317:35-6-44);

(6) Sum the gross monthly amounts of all countable sources of income of all household members whose income is counted;

(7) Subtract allowable adjustments to income (see OAC 317:35-6-52); and

(8) Compare the result to the income limit for the individual's eligibility group ~~(see the appropriate Schedule of OKDHS Appendix C-1)~~ (see SoonerCare Income Guidelines). If the result is equal to or less than the dollar amount of the income limit, the individual is financially eligible.

(9) When calculating the percentage of the Federal Poverty Level (FPL) that corresponds to the individual's monthly countable income, subtract 5% from the FPL percentage reached

to determine the countable FPL level for the individual. This countable percentage of FPL is compared to the FPL limit for the individual's eligibility group in order to determine whether the individual is financially eligible. This 5% deduction from FPL has already been accounted for in the dollar amounts of the income limits given in ~~OKDHS Appendix C-1~~the SoonerCare Income Guidelines.

(c) If an individual's household income using this methodology is over the income limit for SoonerCare eligibility and that individual's household income using the MAGI household and income-counting methodology used by the Federally Facilitated Exchange (FFE) is less than 100% of FPL, the FFE's MAGI rules, as promulgated by the Internal Revenue Service, are used to determine SoonerCare eligibility in place of the rules in this Chapter. The FFE rules including, but not limited to, those in the following areas may need to be followed in place of the SoonerCare rules in this Chapter:

(1) Rules on household composition;

(2) Rules on countable sources of income; and

(3) Rules on the budget period used to calculate income, i.e. annual income (FFE) versus current monthly income (SoonerCare).

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-64.1. Transitional Medical Assistance (TMA)

(a) **Conditions for TMA.**

(1) **Transitional Medical Assistance.** Health benefits are continued when the benefit group loses eligibility due to new or increased earnings of the parent(s)/caretaker relative or the receipt of ~~child or~~ spousal support. The health benefit coverage is of the same amount, duration, and scope as if the benefit group continued receiving SoonerCare. Eligibility for TMA begins with the effective date of case closure or the effective date of closure had the income been reported timely. An individual is included for TMA only if that individual was eligible for SoonerCare and included in the benefit group at the time of the closure. To be eligible for TMA the benefit group must meet all of the requirements listed in (A) - (C) of this paragraph.

(A) At least one member of the benefit group was included in at least three of the six months immediately preceding the month of ineligibility.

(B) The health benefit cannot have been received fraudulently in any of the six months immediately preceding the month of ineligibility.

(C) The benefit group must have included a dependent child who met the age and relationship requirements for SoonerCare and whose needs were included in the benefit group at the time of closure, unless the only eligible child is a Supplemental Security Income (SSI) recipient.

(2) **Closure due to ~~child support or~~ spousal support.** Health benefits are continued if the case closure is due to the receipt of new or increased ~~child support or~~ payments for spousal support in the form of alimony. The needs of the parent(s)or caretaker relative must be included in the benefit group at the time of closure. The health benefits are continued for four months.

(3) **Closure due to new or increased earnings of parent(s) or caretaker relative.** Health benefits are continued if the closure is due to the new or increased earnings of the parent(s) or caretaker relative. The needs of the parent(s)or caretaker relative must be included in the benefit group at the time of closure. The parent(s) or caretaker relative is required to cooperate with OKDHS Oklahoma Child Support Services during the period of time the family is receiving TMA.

(4) **Eligibility period.** Health benefits may be continued for a period up to 12 months if the reason for closure is new or increased earnings of the parent(s) or caretaker relative. This period is divided into two six-month periods with eligibility requirements and procedures for each period.

(A) **Initial six-month period.**

(i) The benefit group is eligible for an initial six-month period of TMA without regard to income or resources if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same; and

(III) the benefit group remains in the state.

(ii) An individual benefit group family member remains eligible for the initial six-month period of TMA unless the individual:

(I) moves out of the state,

(II) dies,

(III) becomes an inmate of a public institution,

(IV) leaves the household,

(V) does not cooperate, without good cause, with the OKDHS Oklahoma Child Support Services or third party liability requirements.

(B) **Additional Six-month period.**

(i) Health benefits are continued for the additional six-month period if:

(I) an eligible child remains in the home;
(II) the parent(s) or caretaker relative remains the same;
(III) the benefit group remains in the state;
(IV) the benefit group was eligible for and received TMA for each month of the initial six-month period;
(V) the benefit group has complied with reporting requirements in subsection (g) of this Section;
(VI) the benefit group has average monthly earned income (less child care costs that are necessary for the employment of the parent or caretaker relative) that does not exceed the 185% of the Federal Poverty Level ~~(see OKDHS Appendix C-1, Schedule I.A;)~~(see SoonerCare Income Guidelines); and
(VII) the parent(s) or caretaker relative had earnings in each month of the required three-month reporting period described in (g)(2) of this Section, unless the lack of earnings was due to an involuntary loss of employment, illness, or other good cause.

(ii) An individual benefit group family member remains eligible for the additional six-month period unless the individual meets any of the items listed in (4)(A)(ii) of this paragraph.

(b) **Income and resource eligibility.**

(1) The unearned income and resources of the benefit group are disregarded in determining eligibility for TMA. There is no earned income test for the initial six-month period.

(2) Health benefits are continued for the additional six-month period if the benefit group's countable earnings less child care costs that are necessary for the employment of the parent(s) or caretaker relative are below 185% of the Federal Poverty Level (see the standards on the OHCA website or the OKDHS Form 08AX001E, Schedule I.A) and the benefit group meets the requirements listed in (a)(4)(B).

(A) The earnings of all benefit group members are used in determining the earned income test. The only exception is that earnings of full time students included in the benefit group are disregarded.

(B) Income is determined by averaging the benefit group's gross monthly earnings (except full time student earnings) for the required three-month reporting period.

(C) A deduction from the benefit group's earned income is allowed for the cost of approved child care necessary for the employment of the parent(S) or caretaker relative. The child care deduction is averaged for the same three-month reporting period. There is no maximum amount for

this deduction.

(D) All individuals whose earnings are considered are included in the benefit group. The family size remains the same during both reporting periods.

(c) **Eligible child.** When the SoonerCare benefit is closed and TMA begins, the benefit group must include an eligible child whose needs were included in the SoonerCare benefit at the time of closure, unless the only eligible child is a SSI recipient. After the TMA begins, the benefit group must continue to include an eligible child. Age is the only requirement an eligible child must meet.

(d) **Additional members.** After the TMA begins, family members who move into the home cannot be added to the TMA coverage. This includes siblings and a natural or adoptive parent(s) or caretaker relative. If the additional member is in need of health benefits, an application for services under the SoonerCare program is completed. If a benefit group member included in TMA leaves the home and then returns, that member may be added back to TMA coverage if all conditions of eligibility are met.

(e) **Third party liability.** The benefit group's eligibility for TMA is not affected by a third party liability. However, the benefit group is responsible for reporting all insurance coverage and any changes in the coverage. The worker must explain the necessity for applying benefits from private insurance to the cost of medical care.

(f) **Notification.**

(1) **Notices.** Notices are sent to the benefit group, both at the onset of and throughout the TMA period. These notices, which are sent at specific times, inform the benefit group of its rights and responsibilities. When SoonerCare is closed and the benefit group is eligible for TMA, the computer generated closure notice includes notification of the continuation of health benefits. Another computer generated notice is sent at the same time to advise the benefit group of the reporting requirements and under what circumstances the health benefits may be discontinued. Each notice listed in (A)-(C) of this paragraph includes specific information about what the benefit group must report. The notices serve as the required advance notification in the event benefits are discontinued as a result of the information furnished in response to these notices.

(A) **Notice #1.** Notice #1 is issued in the third month of the initial TMA period. This notice advises the benefit group of the additional six-month period of TMA, the eligibility conditions, reporting requirements, and appeal rights.

(B) **Notice #2.** Notice #2 is issued in the sixth month of the TMA period, but only if the benefit group is eligible for the additional six-month period. This notice advises the benefit group of the eligibility conditions, reporting requirements, and appeal rights.

(C) **Notice #3.** Notice #3 is issued in the ninth month of the TMA period, or the third month of the additional six-month period. This notice advises the benefit group of the eligibility conditions, the reporting requirements, appeal rights, and the expiration of TMA coverage.

(2) **Notices not received.** In some instances the benefit group does not receive all of the notices listed in (1) of this subsection. The notices and report forms are not issued retroactively.

(g) **Reporting.** The benefit group is required to periodically report specific information. The information may be reported by telephone or by letter.

(1) The benefit group must report:

(A) gross earned income of the entire benefit group for the appropriate three-month period;

(B) child care expenses, for the appropriate three-month period, necessary for the continued employment of the parent(s) or caretaker relative;

(C) changes in members of the benefit group;

(D) residency; and

(E) third party liability.

(2) The reporting requirement time frames are explained in this subparagraph.

(A) The information requested in the third month must be received by the 21st day of the fourth month and is used to determine the benefit group's eligibility for the additional six-month period. While this report is due in the fourth month, negative action cannot be taken during the initial period for failure to report. If the benefit group fails to submit the requested information, benefits are automatically suspended effective the seventh month. If action to reinstate is not taken by deadline of the suspension month, the computer automatically closes the case effective the next month.

(B) The information requested in the sixth month must be furnished by the 21st day of the seventh month. The decision to continue benefits into the eighth month is determined by the information reported.

(C) The information requested in the ninth month must be furnished by the 21st day of the tenth month. The decision to continue health benefits into the 11th month is determined by the information reported. When the

information is not reported timely, the TMA is automatically suspended by the computer for the appropriate effective date. If the benefit group subsequently reports the necessary information, the worker determines eligibility. If all eligibility factors are met during and after the suspension period, the health benefits are reinstated. The effective date of the reinstatement is the same as the effective date of the suspension so the benefit group has continuous medical coverage.

(h) **Termination of TMA.** The TMA coverage is discontinued any time the benefit group fails to meet the eligibility requirements as shown in this Section. If it becomes necessary to discontinue the TMA coverage for the benefit group or any member of the benefit group, the individual(s) must be advised that he or she may be eligible for health benefits under the SoonerCare program and how to obtain these benefits.

(i) **Receipt of health benefits after TMA ends.** To ensure continued medical coverage a computer generated recertification form is mailed to the benefit group during the third month of TMA for benefits closed due to the receipt of child or spousal support or the 11th month of TMA for benefits closed due to increased earnings. The benefit group must return the form prior to the termination of the TMA benefits. When determined eligible, health benefits continue as SoonerCare, not TMA. If the benefit group fails to return the recertification form, TMA benefits are terminated.

SUBCHAPTER 7. MEDICAL SERVICES

PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-48. Eligibility for the SoonerPlan Family Planning Program

(a) Non-pregnant women and men ages 19 and above are eligible to receive family planning services if they meet all of the conditions of eligibility in paragraphs (1), (2), (3), and (4) of this Subsection. This is regardless of pregnancy or paternity history and includes women who gain eligibility for SoonerCare family planning services due to a pregnancy, but whose eligibility ends 60 days postpartum.

(1) The countable income is at or below the applicable standard on the ~~OKDHS Appendix C-1~~SoonerCare Income Guidelines. Prior to October 1, 2013, the standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240

per each full-time or part-time employed member of the benefit group. Deductions for work related expenses for self-employed individuals are found at OAC 317:35-10-26(b)(1). Effective October 1, 2013, MAGI financial eligibility rules are used to determine eligibility for SoonerPlan.

(2) Prior to October 1, 2013, in determining financial eligibility for the SoonerPlan Family Planning program the income of the individual and spouse (if any) is considered. The individual has the option to include or exclude minor dependent children and their income in the eligibility process. October 1, 2013, MAGI household composition rules are used to determine eligibility for SoonerPlan.

(3) SoonerPlan members with minor dependent children and a parent absent from the home are required to cooperate with the Oklahoma Department of Human Services, Child Support Services Division (OCSS) in the collection of child support payments. Federal regulations provide a waiver of this requirement when cooperation is not in the best interest of the child.

(4) Individuals eligible for SoonerCare can choose to enroll only in the SoonerPlan Family Planning Program with the option of applying for SoonerCare at any time.

(5) Persons who have Medicare or creditable health insurance coverage are not precluded from applying for the SoonerPlan Family Planning program.

(b) All health insurance is listed on ~~the OKDHS computer system~~applicable systems in order for OHCA Third Party Liability Unit to verify insurance coverage. The OHCA is the payer of last resort.

(c) Income for the SoonerPlan Family Planning Program does not require verification, unless questionable. If the income is questionable the worker must verify the income.

(d) There is not an asset test for the SoonerPlan Family Planning Program.

15-13 Joint Injections

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 1. PHYSICIANS

317:30-5-9. Medical services

(a) **Use of medical modifiers.** The Physicians' Current Procedural Terminology (CPT) and the second level HCPCS provide for 2-digit medical modifiers to further describe medical services. Modifiers are used when appropriate.

(b) **Covered office services.**

(1) Payment is made for four office visits (or home) per month per member, for adults (over age 21), regardless of the number of physicians involved. Additional visits per month are allowed for services related to emergency medical conditions.

(2) Visits for the purpose of family planning are excluded from the four per month limitation.

(3) Payment is allowed for the insertion and/or implantation of contraceptive devices in addition to the office visit.

(4) Separate payment will be made for the following supplies when furnished during a physician's office visit.

(A) Casting materials
(B) Dressing for burns
(C) Contraceptive devices
(D) IV Fluids

(5) Payment is made for routine physical exams only as prior authorized by the OKDHS and are not counted as an office visit.

(6) Medically necessary office lab and X-rays are covered.

(7) Hearing exams by physician for members between the ages of 21 and 65 are covered only as a diagnostic exam to determine type, nature and extent of hearing loss.

(8) Hearing aid evaluations are covered for members under 21 years of age.

(9) IPPB (Intermittent Positive Pressure Breathing) is covered when performed in physician's office.

~~(10) Payment is made for both an office visit and an injection of joints performed during the visit if the joint injection code does not have a global coverage designation.~~

~~(11)~~(10) Payment is made for an office visit in addition to allergy testing.

~~(12)~~(11) Separate payment is made for antigen.

~~(13)~~(12) Eye exams are covered for members between ages 21 and 65 for medical diagnosis only.

~~(14)~~(13) If a physician personally sees a member on the same day as a dialysis treatment, payment can be made for a separately identifiable service unrelated to the dialysis.

~~(15)~~(14) Separate payment is made for the following specimen collections:

(A) Catheterization for collection of specimen; and

(B) Routine Venipuncture.

~~(16)~~(15) The Professional Component for electrocardiograms, electroencephalograms, electromyograms, and similar procedures are covered on an inpatient basis as long as the interpretation is not performed by the attending physician.

~~(17)~~(16) Cast removal is covered only when the cast is removed by a physician other than the one who applied the cast.

(c) **Non-covered office services.**

(1) Payment is not made separately for an office visit and rectal exam, pelvic exam or breast exam. Office visits including one of these types of exams should be coded with the appropriate office visit code.

(2) Payment cannot be made for prescriptions or medication dispensed by a physician in his office.

(3) Payment will not be made for completion of forms, abstracts, narrative reports or other reports, separate charge for use of office or telephone calls.

(4) Additional payment will not be made for mileage.

(5) Payment is not made for an office visit where the member did not keep appointment.

(6) Refractive services are not covered for persons between the ages of 21 and 65.

(7) Removal of stitches is considered part of post-operative care.

(8) Payment is not made for a consultation in the office when the physician also bills for surgery.

(9) Separate payment is not made for oxygen administered during an office visit.

(d) **Covered inpatient medical services.**

(1) Payment is allowed for inpatient hospital visits for all SoonerCare covered admissions. Psychiatric admissions must be prior authorized.

(2) Payment is allowed for the services of two physicians when supplemental skills are required and different specialties are involved.

(3) Certain medical procedures are allowed in addition to office visits.

(4) Payment for critical care is all-inclusive and includes payment for all services that day. Payment for critical care, first hour is limited to one unit per day.

(e) **Non-covered inpatient medical services.**

(1) For inpatient services, all visits to a member on a single day are considered one service except where specified. Payment is made for only one visit per day.

(2) A hospital admittance or visit and surgery on the same day would not be covered if post-operative days are included in the surgical procedure. If there are no post-operative days, a physician can be paid for visits.

(3) Drugs administered to inpatients are included in the hospital payment.

(4) Payment will not be made to a physician for an admission or new patient work-up when the member receives surgery in out-patient surgery or ambulatory surgery center.

(5) Payment is not made to the attending physician for interpretation of tests on his own patient.

(f) **Other medical services.**

(1) Payment will be made to physicians providing Emergency Department services.

(2) Payment is made for two nursing facility visits per month. The appropriate CPT code is used.

(3) When payment is made for "Evaluation of arrhythmias" or "Evaluation of sinus node", the stress study of the arrhythmia includes inducing the arrhythmia and evaluating the effects of drugs, exercise, etc. upon the arrhythmia.

(4) When the physician bills twice for the same procedure on the same day, it must be supported by a written report.

15-15 Drug Benefit

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72.1. Drug benefit

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

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

(A) Agents used to promote fertility.

(B) Agents primarily used to promote hair growth.

(C) Agents used for cosmetic purposes.

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

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

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

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

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

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

medically necessary and prior authorized.

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

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

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

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

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

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

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

(C) Agents used for smoking cessation. A limited smoking cessation benefit is available.

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

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

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

(ii) certain smoking cessation products;

(iii) family planning products;

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

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

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

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

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

(A) the prescribed use is not for a medically accepted

indication as provided under 42 U.S.C. § 1396r-8; or (B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

15-22 Health Record Signature Requirements

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-4.1. Uniform Electronic Transaction Act

The Oklahoma Health Care Authority enacts the provisions of the Uniform Electronic Transaction Act as provided in this Section with the exception to the act as provided in this Section.

(1) **Scope of Act.** The Electronic Transaction Act applies to an electronic record and an electronic signature created with a record that is generated, sent, communicated, received or stored by the Oklahoma Health Care Authority.

(2) **Use of electronic records and electronic signatures.** The rules regarding electronic records and electronic signatures apply when both parties agree to conduct business electronically. Nothing in these regulations requires parties to conduct business electronically. However, should a party have the capability and desire to conduct business electronically with the Oklahoma Health Care Authority, then the following guidelines must be adhered to:

(A) Only employees designated by the provider's agency may make entries in the member's medical record. All entries in the member's medical record must be dated and authenticated with a method established to identify the author. The identification method may include computer keys, Private/Public Key Infrastructure (PKIs), voice authentication systems that utilize a personal identification number (PIN) and voice authentication, or other codes. Providers must have a process in place to deactivate an employee's access to records upon termination of employment of the designated employee.

(B) When PKIs, computer key/code(s), voice authentication systems or other codes are used, a signed statement must be completed by the agency's employee documenting that the chosen method is under the sole control of the person using it and further demonstrate that:

(i) A list of PKIs, computer key/code(s), voice authentication systems or other codes can be verified;

(ii) All adequate safeguards are maintained to protect against improper or unauthorized use of PKIs, computer keys, or other codes for electronic signatures; and

(iii) Sanctions are in place for improper or unauthorized use of computer key/code(s), PKIs, voice authentication systems or other code types of electronic signatures.

(C) There must be a specific action by the author to indicate that the entry is verified and accurate. Systems requiring an authentication process include but are not limited to:

(i) Computerized systems that require the provider's employee to review the document on-line and indicate that it has been approved by entering a unique computer key/code capable of verification;

(ii) A system in which the provider's employee signs off against a list of entries that must be verified in the member's records;

(iii) A mail system that sends transcripts to the provider's employee for review;

(iv) A postcard identifying and verifying the accuracy of the record(s) signed and returned by the provider's employee; or

(v) A voice authentication system that clearly identifies author by a designated personal identification number or security code.

(D) Auto-authentication systems that authenticate a report prior to the transcription process do not meet the stated requirements and will not be an acceptable method for the authentication process.

(E) The authentication of an electronic medical record (signature and date entry) is expected on the day the record is completed. If the electronic medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three business days from the day the record is completed.

~~(E)~~ (F) Records may be edited by designated administrators within the provider's facility ~~but must be authenticated by the original author~~. Edits must be in the form of a correcting entry which preserves entries from the original record. Edits must be completed prior to claims submission or no later than 45 days after the date of service, whichever is later.

~~(F)~~ (G) Use of the electronic signature, for clinical documentation, shall be deemed to constitute a signature and will have the same effect as a written signature on the clinical documentation. The section of the electronic record documenting the service provided must be authenticated by the employee or individual who provided

the described service.

~~(G)~~(H) Any authentication method for electronic signatures must:

(i) be unique to the person using it;

(ii) identify the individual signing the document by name and title;

(iii) be capable of verification, assuring that the documentation cannot be altered after the signature has been affixed;

(iv) be under the sole control of the person using it;

(v) be linked to the data in such a manner that if the data is changed, the signature is invalidated; and

(vi) provide strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

~~(H)~~(I) Failure to properly maintain or authenticate medical records (i.e., signature and date entry) may result in the denial or recoupment of SoonerCare payments.

(3) **Record retention for provider medical records.** Providers must retain electronic medical records and have access to the records in accordance with guidelines found at OAC 317:30-3-15.

(4) **Record retention for documents submitted to OHCA electronically.**

(A) The Oklahoma Health Care Authority's system provides that receivers of electronic information may both print and store the electronic information they receive. The Oklahoma Health Care Authority is the custodian of the original electronic record and will retain that record in accordance with a disposition schedule as referenced by the Records Destruction Act. The Oklahoma Health Care Authority will retain an authoritative copy of the transferable record as described in the Electronic Transaction Act that is unique, identifiable and unalterable.

(i) **Manner and format of electronic signature.** The manner and format required by the Oklahoma Health Care Authority will vary ~~dependant~~dependent upon whether the sender of the document is a member or a provider. In the limited case where a provider is a client, the manner and format is dependent upon the function served by the receipt of the record. In the case the function served is a request for services, then the format required is that required by a recipient. In the case the function served is related to payment for services, then the format required is that required by a provider.

(ii) **Recipient format requirements.** The Oklahoma Health Care Authority will allow members to request SoonerCare services electronically. An electronic signature will be authenticated after a validation of the data on the form by another database or databases.

(iii) **Provider format requirements.** The Oklahoma Health Care Authority will permit providers to contract with the Oklahoma Health Care Authority, check and amend claims filed with the Oklahoma Health Care Authority, and file prior authorization requests with the Oklahoma Health Care Authority. Providers with a social security number or federal employer's identification number will be given a personal identification number (PIN). After using the PIN to access the database, a PIN will be required to transact business electronically.

(B) Providers with the assistance of the Oklahoma Health Care Authority will be required to produce and enforce a security policy that outlines who has access to their data and what transaction employees are permitted to complete as outlined in the policy rules for electronic records and electronic signatures contained in paragraph (2) of this section.

(C) Third Party billers for providers will be permitted to perform electronic transaction as stated in paragraph (2) only after the provider authorizes access to the provider's PIN and a power of attorney by the provider is executed.

(5) **Time and place of sending and receipt.** The provisions of the Electronic Transaction Act apply to the time and place of receipt with the exception of a power failure, Internet interruption or Internet virus. Should any of the exceptions in this paragraph occur, confirmation is required by the receiving party.

(6) **Illegal representations of electronic transaction.** Any person who fraudulently represents facts in an electronic transaction, acts without authority, or exceeds their authority to perform an electronic transaction may be prosecuted under all applicable criminal and civil laws.

317:30-3-15. Record retention

Federal regulations and rules promulgated by the Oklahoma Health Care Authority Board require that the provider retain, for a period of six years, any records necessary to disclose the extent of services the provider, wholly owned supplier, or subcontractor, furnishes to recipients and, upon request, furnish such records to the Secretary of the Department of Health and Human Services. Records in a provider's office must

contain adequate documentation of services rendered. ~~Documentation must include the provider's signature and credentials.~~ Documentation must include the dated provider's signature and credentials. The provider's signature must be handwritten or electronically submitted if the provider and the Oklahoma Health Care Authority have agreed to conduct transactions by electronic means pursuant to the Uniform Electronic Act. Electronic records and electronic signatures must be in accordance with guidelines found at OAC 317:30-3-4.1. Where reimbursement is based on units of time, it will be necessary that documentation be placed in the member's record as to the beginning and ending times for the service claimed. All records must be legible. Failure to maintain legible records may result in denial of payment or recoupment of payment for services provided when attempts to obtain transcription of illegible records is unsuccessful or the transcription of illegible records appears to misrepresent the services documented. The provider may, after one year from the date of service(s), microfilm or microfiche the records for the remaining five years, as long as the microfilm or microfiche is of a quality that assures that the records remain legible. Electronic records are acceptable as long as they have a secured signature. Provider (other than individual practitioner) agrees to disclose, upon request, information relating to ownership or control, business transactions and criminal offenses involving any program under Title V of the Child Health Act or Titles, XVIII, XIX, XX, or XXI of the Federal Social Security Act.

317:30-3-30. Signature requirements

(a) For medical review purposes, the Oklahoma Health Care Authority (OHCA) requires that all services provided and/or ordered be authenticated by the author. The method used shall be a hand written signature, electronic signature, or signature attestation statement. Stamped signatures are not acceptable. Pursuant to federal and/or state law, there are some circumstances for which an order does not need to be signed.

(1) Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

(2) Orders for clinical diagnostic tests are not required to be signed. If the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a hand written or electronic signature.

(3) Orders for outpatient prescription drugs are not required

to be signed. If the order for a prescription drug is unsigned, there must be medical documentation by the treating physician that he/she intended that the prescription drug be ordered. This documentation showing the intent that the prescription drug be ordered must be authenticated by the author via a hand written or electronic signature.

(b) A hand written signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance, or obligation. The authentication of a medical record (signature and date entry) is expected on the day the record is completed. If the medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three business days from the day the record is completed.

(1) If a signature is illegible, the OHCA will consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

(2) If the signature is missing from an order, the OHCA will disregard the order during the review of the claim.

(3) If the signature is missing from any other medical documentation, the OHCA will accept a signature attestation from the author of the medical record entry.

(c) Providers may include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature.

(1) The signature log may be included on the actual page where the initials or illegible signature are used or may be a separate document.

(2) The OHCA will not deny a claim for a signature log that is missing credentials.

(3) The OHCA will consider all submitted signature logs regardless of the date they were created.

(d) Providers may include in the documentation they submit a signature attestation statement. In order to be considered valid for medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the member.

(1) The OHCA will not consider signature attestation statements where there is no associated medical record entry.

(2) The OHCA will not consider signature attestation statements from someone other than the author of the medical record entry in question.

(3) The OHCA will consider all signature attestation statements that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or rules indicate that a signature must be in

place prior to a given event or a given date.

(e) Providers may use electronic signatures as an alternate signature method.

(1) Providers must use a system and software products which are protected against modification and must apply administrative procedures which are adequate and correspond to recognized standards and laws.

(2) Providers utilizing electronic signatures bear the responsibility for the authenticity of the information being attested to.

(3) Providers utilizing electronic signatures must comply with OAC 317:30-3-4.1.

(f) Nothing in this section is intended to absolve the provider of their obligations in accordance with the conditions set forth in their SoonerCare contract and the rules delineated in OAC 317:30.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-3. Documentation of services

(a) Records in a physician's office or a medical institution (hospital, nursing home or other medical facility), must contain adequate documentation of services rendered. Such documentation must include the physician's signature or identifiable initials in relation to every patient visit, every prescription, or treatment. In verifying the accuracy of claims for procedures which are reimbursed on a time frame basis, it will be necessary that documentation be placed in the patient's chart as to the beginning and ending times for the service claimed.

(b) Providers must adhere to signature requirements found at OAC 317:30-3-30.

15-27A SoonerCare Primary Care Providers

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE

SUBCHAPTER 7. SOONERCARE

PART 1. GENERAL PROVISIONS

317:25-7-5. Primary care providers

For provision of health care services, the OHCA contracts with qualified Primary Care Providers. All providers serving as PCPs must have a valid SoonerCare Fee-for-Service contract as well as an exercised SoonerCare Choice addendum. Additionally, all PCPs, excluding Provider or Physician Groups, must agree to accept a minimum capacity of patients, however this does not guarantee PCPs a minimum patient volume. Primary Care Providers are limited to:

(1) **Physicians.** Any physician licensed to practice medicine in the state in which he or she practices who is engaged in a general practice or in family medicine, general internal medicine or general pediatrics may serve as a PCP. The Chief Executive Officer (CEO) of the OHCA may designate physicians to serve as PCPs who are licensed to practice medicine in the state in which they practice who are specialized in areas other than those described above. In making this determination, the CEO may consider such factors as the percentage of primary care services delivered in the physician's practice, the availability of primary care providers in the geographic area of the state in which the physician's practice is located, the extent to which the physician has historically provided services to SoonerCare members, and the physician's medical education and training.

(A) For physicians serving as SoonerCare Choice PCPs, the State caps the number of members per physician at 2,500. However, the CEO in his/her discretion may increase this number in under served areas based on a determination that this higher cap is in conformance with usual and customary standards for the community. If a physician practices at multiple sites, the capacity at each site is determined based on the number of hours per week the physician holds office hours, not to exceed one FTE. Thus, the physician cannot exceed a maximum total capacity of 2500 members.

(B) In areas of the State where cross-state utilization patterns have developed because of limited provider capacity in the State, the CEO may authorize contracts with out-of-state providers for PCP services. Out-of-

State PCPs are required to comply with all access standards imposed on Oklahoma physicians.

(2) **Advanced Practice Nurses.** Advanced Practice Nurses who have prescriptive authority may serve as PCPs for the Primary Care Case Management delivery system if licensed to practice in the state in which he or she practices. Advanced Practice Nurses who have prescriptive authority may serve as PCPs for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

(3) **Physician Assistants.** Physician Assistants may serve as PCPs if licensed to practice in the state in which he or she practices. Physician Assistants may serve as PCPs for a maximum number of 1,250 members. However, the CEO in his/her discretion may increase this number.

~~(4) **Medical Residents.**~~

~~(A) Medical residents may serve as PCPs when the following conditions are met:~~

~~(i) The resident is licensed to practice in the state in which he or she practices.~~

~~(ii) The resident is at least at the Post-Graduate 2 (PG-2) level.~~

~~(iii) The resident serves as a PCP only within his or her continuity clinic setting (for example, Family Practice residents may only serve as the PCP within the Family Practice Residency clinic setting).~~

~~(iv) The resident works under the supervision of a licensed attending physician.~~

~~(v) The resident specifies the residency program or clinic to which payment will be made.~~

~~(B) Medical residents practicing as a PCP may not exceed a capacity of more than 875 members. However, the CEO in his/her discretion may increase this number.~~

~~(5)~~(4) **Indian Health Service (IHS) Facilities and Federally Qualified Health Center (FQHC) provider groups.**

(A) Indian Health Service facilities whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements at OAC 317:30-5-1088 may serve as PCPs.

(B) Federally Qualified Health Centers whose professional staff meet the general requirements in paragraphs (1) through (3) of this Section and the provider participation requirements in OAC 317:30-5-660.2 may serve as PCPs.

~~(6)~~(5) **Provider or physician group capacity and enrollment.**

(A) Provider or physician groups must agree to accept a minimum enrollment capacity and may not exceed 2,500 members per physician participating in the provider group.

(B) If licensed physician assistants or advanced practice

nurses are members of a group, the capacity may be increased by 1,250 members if the provider is available full-time.

(C) Provider or physician groups must designate a medical director to serve as the primary contact with OHCA.

15-27B SoonerCare Primary Care Providers

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660.5. Health Center service definitions

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

"Core Services" means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence.

"Encounter or Visit" means a face-to-face contact between an approved health care professional as authorized in the FQHC state plan pages and an eligible SoonerCare member for the provision of defined services through a Health Center within a 24-hour period ending at midnight, as documented in the patient's medical record.

"Licensed Behavioral Health Professional (LBHP)" means licensed psychologists, licensed clinical social workers (LCSWs), licensed marital and family therapists (LMFTs), licensed professional counselors (LPCs), licensed behavioral practitioners (LBPs), and licensed alcohol and drug counselors (LADCs).

"Other ambulatory services" means other health services covered under the State plan other than core services.

"Physician" means:

(A) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) within limitations as to the specific services furnished, a doctor of dentistry or dental or oral surgery, a doctor of optometry, or a doctor of podiatry;

~~(C) a resident as defined in OAC 317:25-7-5(4) who meet the requirements for payment under SoonerCare;~~

"Physicians' services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the State plan.

15-29 Behavioral Health Case Management

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-240.3 Staff Credentials

(a) **Licensed Behavioral Health Professional (LBHPs).** LBHPs are defined as follows:

(1) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(2) Practitioners with a license to practice in the state in which services are provided, issued by one of the licensing boards listed in (A) through (F). The exemptions from licensure under 59 § 1353(4) (Supp. 2000) and (5), 59 § 1903(C) and (D) (Supp. 2000), 59 § 1925.3(B) (Supp. 2000) and (C), and 59 § 1932(C) (Supp. 2000) and (D) do not apply to Outpatient Behavioral Health Services.

(A) Psychology,
(B) Social Work (clinical specialty only),
(C) Professional Counselor,
(D) Marriage and Family Therapist,
(E) Behavioral Practitioner, or
(F) Alcohol and Drug Counselor.

(3) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.

(4) A Physician Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(b) **Licensure Candidates.** Licensure candidates are practitioners actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (2)(A) through (F) above. The supervising LBHP responsible for the member's care must:

(1) staff the member's case with the candidate,

(2) be personally available, or ensure the availability of an LBHP to the candidate for consultation while they are providing services,

(3) agree with the current plan for the member, and

(4) confirm that the service provided by the candidate was appropriate; and

(5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

(c) **Certified Alcohol and Drug Counselors (CADCs).** CADCs are defined as having a current certification as a CADC in the state in which services are provided.

(d) **Multi-Systemic Therapy (MST) Provider.** Masters level therapist who works on a team established by OJA which may include Bachelor level staff.

(e) **Peer Recovery Support Specialist (PRSS).** The Peer Recovery Support Specialist must be certified by ODMHSAS pursuant to requirements found in OAC 450:53.

(f) **Family Support and Training Provider (FSP).** FSPs are defined as follows:

(1) Have a high school diploma or equivalent;

(2) be 21 years of age and have successful experience as a family member of a child or youth with serious emotional disturbance, or a minimum of 2 years' experience working with children with serious emotional disturbance or be equivalently qualified by education in the human services field or a combination of work experience and education with one year of education substituting for one year of experience (preference is given to parents or care givers of child with SED);

(3) successful completion of ODMHSAS Family Support Training;

(4) pass background checks; and

(5) service plans must be overseen and approved by an LBHP or Licensure Candidate; and

(6) must function under the general direction of an LBHP, or Licensure Candidate or systems of care team, with an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.

(g) **Behavioral Health Aide (BHA).** BHAs are defined as follows:

(1) Behavioral Health Aides must have completed 60 hours or equivalent of college credit; or

(2) may substitute one year of relevant employment and/or responsibility in the care of children with complex emotional needs for up to two years of college experience; and

(3) must have successfully completed the specialized training and education curriculum provided by the ODMHSAS; and

(4) must be supervised by a bachelor's level individual with a minimum of two years case management or care coordination experience; and

(5) service plans must be overseen and approved by an LBHP or Licensure Candidate; and

(6) must function under the general direction of an LBHP, or Licensure Candidate and/or systems of care team, with an LBHP or Licensure Candidate available at all times to provide back up, support, and/or consultation.

(h) **Behavioral Health Case Manager.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the services must be an LBHP, Licensure Candidate, CADC or have and maintain a current certification as a Case Manager II (CM II) or Case Manager I (CM I) from ODMHSAS. The requirements for obtaining these certifications are as follows:

(1) Certified Behavioral Health Case Manager II (CM II) must meet the requirements in (A), (B), (C) or (D) below:

(A) Possess a Bachelor's or Master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or a Bachelor's or Master's degree in education; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(B) Possess a current license as a registered nurse in the State of Oklahoma with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.

(C) Possess a Bachelor's or Master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA);

complete the behavioral health case management web-based training as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the US Psychiatric Association (USPRA) must also complete the behavioral health rehabilitation web-based training as specified by ODMHSAS.

(D) Possess a Bachelor's or Master's degree in any field and proof of active progression toward obtaining a clinical licensure Master's or Doctoral degree at a regionally accredited college or university recognized by the USDE and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(2) Certified Behavioral Health Case Manager I meets the requirements in either (A) or (B) and (C):

(A) completed 60 college credit hours; or

(B) has a high school diploma with 36 total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and

(C)completes two days of ODMHSAS specified behavioral health case management training and passes a web-based competency exam for behavioral health case management.

(3) **Wraparound Facilitator Case Manager.** LBHP, Licensure Candidate, CADC, or meets the qualifications for CM II and has the following:

(A) successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and

(B) participate in ongoing coaching provided by ODMHSAS and employing agency; and

(C) successfully complete wraparound credentialing process within nine months of beginning process; and

(D) direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS.

(4) **Intensive Case Manager.** LBHP, Licensure Candidate, CADC or meets the provider qualifications of a Case Manager II and has the following:

(A) A minimum of two years Behavioral Health Case Management experience, crisis diversion experience, and
(B) must have attended the ODMHSAS six hours Intensive case management training.

317:30-5-241.6 Behavioral Health Case Management [NEW]

Payment is made for behavioral health case management services as set forth in this Section.

(1) Payment is made for services rendered to SoonerCare members as follows:

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

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

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

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

(iii) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral

health case management activities will be provided in accordance with an individualized plan of care.

(iv) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b).

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

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

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

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

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

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

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

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

(VIII) Transitioning from institutions to the community. Behavioral Health Case Management is available to individuals transitioning from institutions to the community (except individuals

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

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

(i) Basic Case Management/Resource Coordination. Resource coordination services are targeted to adults with serious mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard managers have caseloads of 30 - 35 members. Basic case management/resource coordination is limited to 25 units per member per month.

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

ICM/WFCM is limited to 54 units per member per month.

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

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

(ii) managing finances; or

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

(iv) Delivering bus tickets, food stamps, money, etc.; or

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

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

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

(viii) mentoring or tutoring;

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

(x) non-face-to-face time spent preparing the assessment document and the service plan paperwork;

(xi) monitoring financial goals;

(xii) services to nursing home residents;

(xiii) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or

(xix) services to members residing in ICF/IID facilities.

(D) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:

(i) children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;

(ii) members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;

(iii) residents of ICF/IID and nursing facilities unless transitioning into the community;

(iv) members receiving services under a Home and Community Based services (HCBS) waiver program.

(E) Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(F) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must

relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(i) date;
(ii) person(s) to whom services are rendered;
(iii) start and stop times for each service;
(iv) original signature or the service provider (original signatures for faxed items must be added to the clinical file within 30 days);
(v) credentials of the service provider;
(vi) specific service plan needs, goals and/or objectives addressed;
(vii) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;
(viii) progress and barriers made towards goals, and/or objectives;
(ix) member (family when applicable) response to the service;
(x) any new service plan needs, goals, and/or objectives identified during the service; and
(xi) member satisfaction with staff intervention.

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

317:30-5-249. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage. Work and education services:

(1) Talking about the past and current and future employment

goals, going to various work sites to explore the world of work, and assisting client in identifying the pros and cons of working.

(2) Development of an ongoing educational and employment rehabilitation plan to help each individual establish job specific skills and credentials necessary to achieve ongoing employment. Psycho-social skills training however would be covered.

(3) Work/school specific supportive services, such as assistance with securing of appropriate clothing, wake-up calls, addressing transportation issues, etc. These would be billed as Case Management following ~~317:30-5-595 through 317:30-5-599~~317:30-5-241.6.

(4) Job specific supports such as teaching/coaching a job task.

PART 67. BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES

317:30-5-595. Eligible providers [REVOKED]

~~Services are provided by outpatient behavioral health agencies established for the purpose of providing behavioral health outpatient and case management services.~~

~~(1) **Provider agency requirements.** Services are provided by outpatient behavioral health agencies contracted with OHCA that meet the requirements under OAC 317:30-5-240. The agency must demonstrate its capacity to deliver behavioral health case management services in terms of the following items:~~

~~(A) OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.~~

~~(B) Agencies that are eligible to contract with OHCA to provide behavioral health case management services to eligible individuals must be community based.~~

~~(C) The agency must be able to demonstrate the ability to develop and maintain appropriate patient records including but not limited to assessments, service plans, and progress notes.~~

~~(D) An agency must agree to follow the Oklahoma Department of Mental Health and Substance Abuse Services established behavioral health case management rules found in OAC 450:50.~~

~~(E) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.~~

~~(F) Each site operated by a behavioral health outpatient and case management facility must have a separate provider number, per OAC 317:30-5-240.2.~~

~~(2) **Provider Qualifications**. For behavioral health case management services to be compensable by SoonerCare, the provider performing the service must be an LBHP, Licensure Candidate, CADC, or have and maintain a current certification as a Case Manager II (CM II) or Case Manager I (CM I) from the ODMHSAS. The requirements for obtaining these certifications are as follows:~~

~~(A) Certified Behavioral Health Case Manager II (CM II) must meet the requirements in (i), (ii), (iii) or (iv) below:~~

~~(i) Possess a Bachelor's or Master's degree in a behavioral health related field earned from a regionally accredited college or university recognized by the United States Department of Education (USDE) or a Bachelor's or Master's degree in education; and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; and complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.~~

~~(ii) Possess a current license as a registered nurse in the State of Oklahoma with experience in behavioral health care; complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams for behavioral health case management and behavioral health rehabilitation.~~

~~(iii) Possess a Bachelor's or Master's degree in any field earned from a regionally accredited college or university recognized by the USDE and a current certification or Children's Certificate in Psychiatric Rehabilitation from the US Psychiatric Rehabilitation Association (USPRA); complete the behavioral health case management web-based training as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training; and pass web-based competency exams for behavioral health case management. Applicants who have not received a certificate in children's psychiatric rehabilitation from the US Psychiatric Association (USPRA) must also complete the~~

behavioral health rehabilitation web-based training as specified by ODMHSAS.

(iv) Possess a Bachelor's or Master's degree in any field and proof of active progression toward obtaining a clinical licensure Master's or Doctoral degree at a regionally accredited college or university recognized by the USDE and complete web-based training for behavioral health case management and behavioral health rehabilitation as specified by ODMHSAS; complete one day of face-to-face behavioral health case management training and two days of face-to-face behavioral health rehabilitation training as specified by ODMHSAS; and pass web-based competency exams in behavioral health case management and behavioral health rehabilitation.

(B) Certified Behavioral Health Case Manager I meets the requirements in either (i) or (ii), and (iii):

(i) completed 60 college credit hours; or

(ii) has a high school diploma with 36 total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and

(iii)Completes two days of ODMHSAS specified behavioral health case management training and passes a web-based competency exam for behavioral health case management.

(C) **Wraparound Facilitator Case Manager.** LBHP, Licensure Candidate, CADC, or meets the qualifications for CM II and has the following:

(i) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and

(ii) Participate in ongoing coaching provided by ODMHSAS and employing agency; and

(iii) Successfully complete wraparound credentialing process within nine months of beginning process; and

(iv) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS.

(D) **Intensive Case Manager.** LBHP, Licensure Candidate, CADC or meets the provider qualifications of a Case Manager II and has the following:

(i) A minimum of two years Behavioral Health Case Management experience, crisis diversion experience, and

(ii) must have attended the ODMHSAS six hours Intensive case management training.

(E) All certified case managers must fulfill the continuing education requirements as outlined under OAC

~~450:50-5-4.~~

317:30-5-596. Coverage by category [REVOKED]

~~Payment is made for behavioral health case management services as set forth in this Section.~~

~~(1) Payment is made for services rendered to SoonerCare members as follows:~~

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

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

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

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

~~(iii) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral~~

~~health case management activities will be provided in accordance with an individualized plan of care.~~

~~(iv) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b).~~

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

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

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

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

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

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

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

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

~~(VIII) Transitioning from institutions to the community. Behavioral Health Case Management is available to individuals transitioning from~~

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

~~(B)~~ **~~Levels of Case Management.~~**

~~(i) Basic Case Management/Resource Coordination. Resource coordination services are targeted to adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard managers have caseloads of 30 – 35 members. Basic case management/resource coordination is limited to 25 units per member per month.~~

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

~~experience, must have attended the ODMHSAS 6 hours ICM training, and 24 hour availability is required. ICM/WFCM is limited to 54 units per member per month.~~

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

~~(i) Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment; or~~

~~(ii) Managing finances; or~~

~~(iii) Providing specific services such as shopping or paying bills; or~~

~~(iv) Delivering bus tickets, food stamps, money, etc.; or~~

~~(v) Counseling, rehabilitative services, psychiatric assessment, or discharge planning; or~~

~~(vi) Filling out forms, applications, etc., on behalf of the member when the member is not present; or~~

~~(vii) Filling out SoonerCare forms, applications, etc.;~~

~~(viii) Mentoring or tutoring;~~

~~(ix) Provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;~~

~~(x) Non face-to-face time spent preparing the assessment document and the service plan paperwork;~~

~~(xi) monitoring financial goals;~~

~~(xii) services to nursing home residents;~~

~~(xiii) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or~~

~~(xix) services to members residing in ICF/IID facilities.~~

~~(D) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:~~

~~(i) Children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;~~

~~(ii) Members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;~~

~~(iii) Residents of ICF/IID and nursing facilities unless transitioning into the community;~~

~~(iv) Members receiving services under a Home and Community Based services (HCBS) waiver program.~~

~~(E) Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.~~

~~(F) **Documentation requirements**. The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the participation by, as well as, reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:~~

~~(i) date;~~
~~(ii) person(s) to whom services are rendered;~~
~~(iii) start and stop times for each service;~~
~~(iv) original signature or the service provider (original signatures for faxed items must be added to the clinical file within 30 days);~~
~~(v) credentials of the service provider;~~
~~(vi) specific service plan needs, goals and/or objectives addressed;~~
~~(vii) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;~~
~~(viii) progress and barriers made towards goals, and/or objectives;~~
~~(ix) member (family when applicable) response to the service;~~
~~(x) any new service plan needs, goals, and/or objectives identified during the service; and~~
~~(xi) member satisfaction with staff intervention.~~

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

317:30-5-599. Documentation of records [REVOKED]

~~All behavioral health case management services rendered must~~

~~be reflected by documentation in the records. In addition to a complete behavioral health case management individual plan of service, documentation of each session must include but is not limited to:~~

~~(1) date;~~
~~(2) person(s) to whom services were rendered;~~
~~(3) start and stop time for each service;~~
~~(4) original signature of the service provider (in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature, this is acceptable; however, the provider needs to obtain the original signature for the clinical file within 30 days. No stamped or Xeroxed signatures are allowed);~~
~~(5) credentials of service provider;~~
~~(6) specific service plan need(s), goals and/or objectives addressed;~~
~~(7) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address problem(s), goals and/or objectives;~~
~~(8) progress or barriers made towards goals and/or objectives;~~
~~(9) client (and family, when applicable) response to the services;~~
~~(10) any new individual plan of service need(s), goals and/or objectives identified during the service; and~~
~~(11) member satisfaction with staff intervention(s).~~

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-660.3. Health Center enrollment requirements for specialty behavioral health services

~~(a) For the provision of behavioral health related case management services, Health Centers must meet the requirements found at OAC 317:30-5-595 through 317:30-5-599.~~

~~(b)~~(a) For the provision of behavioral health related case management services and psychosocial rehabilitation services, Health Centers must contract as an outpatient behavioral health agency and meet the requirements found at OAC 317:30-5-240 through ~~30-5-249~~317:30-5-249.

~~(c)~~(b) Health Centers which provide substance abuse treatment services must also be certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

317:30-5-661.4. Behavioral health professional services provided at Health Centers and other settings

(a) Medically necessary behavioral health services that are

primary, preventive, and therapeutic and that would be covered if provided in another setting may be provided by Health Centers. Services provided by a Health Center (refer to OAC 317:30-5-240.3 for a description of services) must meet the same requirements as services provided by other behavioral health providers. Rendering providers must be eligible to individually enroll or meet the requirements as an agency/organization provider specified in OAC 317:30-5-240.2~~,~~and 317:30-5-280~~ and 317:30-5-595~~.

(1) Behavioral Health services include:

(A) Assessment/Evaluation;

(B) Crisis Intervention Services;

(C) Individual/Interactive Psychotherapy;

(D) Group Psychotherapy;

(E) Family Psychotherapy;

(F) Psychological Testing; and

(G) Case Management (as an integral component of services 1-6 above).

(b) Medically necessary behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified behavioral health disorder(s). A minimum of a 45 to 50 minute one-on-one standard clinical session must be completed by an health care professional authorized in the approved FQHC State Plan pages in order to bill the PPS encounter rate for the session. Services rendered by providers not authorized under the approved FQHC state plan pages to bill the PPS encounter rate will be reimbursed pursuant to the SoonerCare fee-for-service fee schedule and must comply with rules found at OAC 317:30-5-280 through 317:30-5-283.

(c) Centers are reimbursed the PPS rate for services when rendered by approved health care professionals, as authorized under FQHC state plan pages, if the Health Center receives funding pursuant to Section 330 or is otherwise funded under Public Law to provide primary health care services at locations off-site (not including satellite or mobile locations) to Health Center patients on a temporary or intermittent basis, unless otherwise limited by Federal law.

(d) Health Centers that operate day treatment programs in school settings must meet the requirements found at OAC ~~317:30-5-240.2(7)~~317:30-5-240.2(b)(7).

(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.

317:30-5-664.1. Provision of other health services outside of the Health Center core services

(a) If the Center chooses to provide other SoonerCare State Plan covered health services which are not included in the Health Center core service definition in OAC 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment and billing procedures described by the OHCA, and these services (e.g., home health services) are not included in the PPS settlement methodology in OAC 317:30-5-664.12.

(b) Other health services include, but are not limited to:

(1) dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;

(2) eyeglasses (refer to OAC 317:30-5-450);

(3) clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);

(4) technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);

(5) durable medical equipment (refer to OAC 317:30-5-210);

(6) emergency ambulance transportation (refer to OAC 317:30-5-335);

(7) prescribed drugs (refer to OAC 317:30-5-70);

(8) prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(9) specialized laboratory services furnished away from the clinic;

(10) Psychosocial Rehabilitation Services [refer to OAC 317:30-5-241(a)(7)]; and

(11) Behavioral health related case management services (refer to OAC ~~317:30-5-585 through 317:30-5-589 and OAC 317:30-5-595 through 317:30-5-599~~317:30-5-240 through 317:30-5-249).

317:30-5-664.5. Health Center encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to OAC 317:30. Excluded from the definition of reimbursable encounter core services are:

(1) Services provided by an independently CLIA certified and enrolled laboratory.

(2) Radiology services including nuclear medicine and diagnostic ultrasound services.

(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate CPT code. A visit for "lab test only" is not considered a Center encounter.

(4) Durable medical equipment or medical supplies not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare.

(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service.

(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy.

(7) Administrative medical examinations and report services;

(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;

(9) SoonerPlan family planning services;

(10) Optometry and podiatric services other than for dual eligible for Part B of Medicare;

(11) Other services that are not defined in this rule or the State Plan.

(b) In addition, the following limitations and requirements apply to services provided by Health Centers:

(1) Physician services are not covered in a hospital.

(2) Behavioral health case management and psychosocial rehabilitation services are limited to Health Centers enrolled under the provider requirements in OAC 317:30-5-240~~,~~ ~~and 317:30-5-595~~ and contracted with OHCA as an outpatient behavioral health agency.

Part 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN GROUP SETTINGS AND NON-SECURE DIAGNOSTIC AND EVALUATION CENTERS

317:30-5-1043. Coverage by category

(a) **Adults.** Residential Behavioral Management Services in Group Settings and Non-Secure Diagnostic and Evaluation Center

Services are not covered for adults.

(b) **Children.** Residential Behavioral Management Services (RBMS) in Group Settings and Non-Secure Diagnostic and Evaluation Centers are covered for children as set forth in this subsection.

(1) **Description.** Residential Behavior Management Services are provided by Organized Health Care Delivery Systems (OHCDS) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more intensive care than can be provided in a family or foster home setting. The behavior management services are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. Residential Behavior Management Services are reimbursed in accordance with the intensity of supervision and treatment required for the group setting in which the child is placed. Members residing in a Level E and Intensive Treatment Services (ITS) Group Homes receive maximum supervision and treatment. In addition, ITS group homes provide crisis and stabilization intervention and treatment. Members residing in a Level D+ Group Home receive highly intensive supervision and treatment. Members residing in a Level D Group home or in a wilderness camp receive close supervision and moderate treatment. Members residing in a Level C Group Home receive minimum supervision and treatment. Members residing in Residential Diagnostic and Evaluation Centers receive intensive supervision and a 20 day comprehensive assessment. Members residing in a Sanctions Home receive highly intensive supervision and treatment. Members residing in an Independent Living Group Home receive intensive supervision and treatment. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one day. In the case of a child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the OHCDS collaborates with the provider of such services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody are funded in the normal manner. The OHCDS must provide concurrent documentation that these services are not duplicative. The OHCDS determines the need for RBMS.

(2) **Medical necessity criteria.** The following medical necessity criteria must be met for residential behavior Management Services.

(A) Any DSM~~-IV AXIS I~~ primary diagnosis, with the exception of V codes, with a detailed description of the symptoms supporting the diagnosis. A detailed description of the child's emotional, behavioral and psychological condition must be on file. A diagnosis is not required for behavior management services provided in Diagnostic and Evaluation centers.

(B) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(C) It has been determined by the OHCDS that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(D) Documentation that the child's presenting emotional and/or behavioral problems prevent the child from living in a traditional family home. The child requires the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff.

(E) The Agency which has permanent or temporary custody of the child agrees to active participation in the child's treatment needs and planning.

(F) All of the medical necessity criteria must also be met for continued stay in residential group settings.

(3) **Treatment components.**

(A) **Individual plan of care development.** A comprehensive individualized plan of care for each resident shall be formulated by the provider agency staff within 30 days of admission, for ITS level within 72 hours, with documented input from the agency which has permanent or temporary custody of the child and when possible, the parent. This plan must be revised and updated at least every three months, every seven days for ITS, with documented involvement of the agency which has permanent or temporary custody of the child. Documented involvement can be written approval of the individual plan of care by the agency which has permanent or temporary custody of the child and indicated by the signature of the agency case worker or liaison on the individual plan of care. It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature; however, the provider obtains the original signature for the clinical file within 30 days. No stamped or Xeroxed signatures are allowed. An

individual plan of care is considered inherent in the provision of therapy and is not covered as a separate item of behavior management services. The individual plan of care is individualized taking into account the child's age, history, diagnosis, functional levels, and culture. It includes appropriate goals and time limited and measurable objectives. Each member's individual plan of care must also address the provider agency's plans with regard to the provision of services in each of the following areas:

(i) group therapy;
(ii) individual therapy;
(iii) family therapy;
(iv) alcohol and other drug counseling;
(v) basic living skills redevelopment;
(vi) social skills redevelopment;
(vii) behavior redirection; and
(viii) the provider agency's plan to access appropriate educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

(B) **Individual therapy.** The provider agency must provide individual therapy on a weekly basis with a minimum of one or more sessions totaling one hour or more of treatment per week to children and youth receiving RBMS in Wilderness Camps, Level D, Level D+ homes, Level E Homes, Independent Living Homes, and Sanctions Homes. ITS Level residents will receive a minimum of five or more sessions totaling a minimum of five or more hours of individual therapy per week. Members residing in Diagnostic and Evaluation Centers and Level C Group Homes receive Individual Therapy on an as needed basis. Individual therapy must be age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. Individual counseling is a face to face, one to one service, and must be provided in a confidential setting.

(C) **Group therapy.** The provider agency must provide group therapy to children and youth receiving residential behavioral management services. Group therapy must be a face to face interaction, age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. The minimum expected occurrence would be one hour per week in Level D, Level C, Wilderness Camps and Independent Living. Two hours per week are required in Levels D+ and E. Ten hours per week are required in Sanctions Homes, Intensive

Treatment Service Level. Group therapy is not required for Diagnostic and Evaluation Centers. Group size should not exceed six members and group therapy sessions must be provided in a confidential setting. One half hour of individual therapy may be substituted for one hour of group therapy.

(D) **Family therapy.** Family therapy is a face to face interaction between the therapist/counselor and family, to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. The provider agency must provide family therapy as indicated by the resident's individual plan of care. The agency must work with the caretaker to whom the resident will be discharged, as identified by the OHCDS custody worker. The agency must seek to support and enhance the child's relationships with family members (nuclear and appropriate extended), if the custody plan for the child indicates family reunification. The RBMS provider must also seek to involve the child's parents in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program. Any service provided to the family must have the child as the focus.

(E) **Alcohol and other drug abuse treatment education, prevention, therapy.** The provider agency must provide alcohol and other drug abuse treatment for residents who have emotional or behavioral problems related to substance abuse/chemical dependency, to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. This service is considered ancillary to any other formal treatment program in which the child participates for treatment and rehabilitation. For residents who have no identifiable alcohol or other drug use, abuse, or dependency, age appropriate education and prevention activities are appropriate. These may include ~~self esteem~~self-esteem enhancement, violence alternatives, communication skills or other skill development curriculums.

(F) **Basic living skills redevelopment.** The provider agency must provide goal directed activities designed for each resident to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopment is age appropriate and relevant to the goals and objectives of the individual plan of care. This many include, but is not limited to food planning and preparation, maintenance of personal hygiene and living environment, household

management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, job application and retention skills.

(G) **Social skills redevelopment.** The provider agency must provide goal directed activities designed for each resident to restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. For ITS level of care, the minimum skill redevelopment per day is three hours. Any combination of basic living skills and social skills redevelopment that is appropriate to the need and developmental abilities of the child is acceptable.

(H) **Behavior redirection.** The provider agency must be able to provide behavior redirection management by agency staff as needed 24 hours a day, 7 days per week. The agency must ensure staff availability to respond in a crisis to stabilize residents' behavior and prevent placement disruption. In addition, ITS group homes will be required to provide crisis stabilization interaction and treatment for new residents 24 hours a day, seven days a week.

(4) **Providers.** For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services of their providers, the providers of individual, group and family therapies must:

(A) be a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, or under Board Supervision to be licensed in one of the above stated areas; or

(B) have one year of experience in a behavioral health treatment program and a master's degree in a mental health treatment field licensable in Oklahoma by one of the following licensing boards:

(i) Psychology,

(ii) Social work (clinical specialty only),

(iii) Licensed professional counselor,

(iv) Licensed marriage and family therapist, or

(v) Licensed behavioral practitioner; or

(C) have a baccalaureate degree in a mental health field in one of the stated areas listed in (B) of this paragraph AND three or more years post-baccalaureate experience in providing direct patient care in a behavioral health treatment setting and be provided a minimum of weekly

supervision by a staff member licensed as listed in (A) of this paragraph; or

(D) be a registered psychiatric nurse; AND

(E) demonstrate a general professional or educational background in the following areas:

(i) case management, assessment and treatment planning;

(ii) treatment of victims of physical, emotional, and sexual abuse;

(iii) treatment of children with attachment disorders;

(iv) treatment of children with hyperactivity or attention deficit disorders;

(v) treatment methodologies for emotional disturbed children and youth;

(vi) normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) treatment of children and families with substance abuse and chemical dependency disorders;

(viii) anger management; and

(ix) crisis intervention.

(5) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services provided by their staff for behavior management therapies (Individual, Group, Family) as of July 1, 2007, providers must have the following qualifications:

(A) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor or under Board approved Supervision to be licensed in one of the above stated areas; or

(B) be licensed as an Advanced Practice Nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided, AND

(C) demonstrate a general professional or educational background in the following areas:

(i) case management, assessment and treatment planning;

(ii) treatment of victims of physical, emotional, and sexual abuse;

(iii) treatment of children with attachment disorders;

(iv) treatment of children with hyperactivity or attention deficit disorders;

(v) treatment methodologies for emotionally disturbed children and youth;

(vi) normal childhood development and the effect of

abuse and/or neglect on childhood development;
(vii) treatment of children and families with substance abuse and chemical dependency disorders;
(viii) anger management; and
(ix) crisis intervention.

(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, must meet one of the following areas:
(i) Bachelor's or Master's degree in a behavioral health related field including but not limited to, psychology, sociology, criminal justice, school guidance and counseling, social work, occupational therapy, family studies, alcohol and drug; or
(ii) a current license as a registered nurse in Oklahoma; or
(iii) certification as an Alcohol and Drug Counselor to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary DSM~~IV Axis I~~ diagnosis; or
(iv) current certification as a Behavioral Health Case Manager from DMHSAS and meets OHCA requirements to perform case management services, as described in OAC ~~317:30-5-595~~317:30-5-240 through 317:30-5-249.

(E) Staff providing behavior redirection services must have current certification and required updates in nationally recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one of the following areas:
(i) trauma informed methodology,
(ii) anger management,
(iii) crisis intervention,
(iv) normal child and adolescent development and the effect of abuse,
(v) neglect and/or violence on such development,
(vi) grief and loss issues for children in out of home placement,
(vii) interventions with victims of physical, emotional and sexual abuse,
(viii) care and treatment of children with attachment disorders,
(ix) care and treatment of children with hyperactive, or attention deficit, or conduct disorders,
(x) care and treatment of children, youth and families

with substance abuse and chemical dependency disorders,
(xi) passive physical restraint procedures,
(xii) procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of Minors Act.

(F) In addition, Behavioral Management staff must have access to consultation with an appropriately licensed mental health professional.

15-30 Biopsychosocial Requirements

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.1. Screening, assessment and service plan

All providers must comply with the requirements as set forth in this Section.

(1) **Screening.**

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further BH assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population and limitations.** Screening is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months. To qualify for reimbursement, the screening tools used must be evidence based or otherwise approved by OHCA and ODMHSAS and appropriate for the age and/or developmental stage of the member.

(2) **Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other informants, or group of persons resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified practitioners.** This service is performed by an LBHP or Licensure Candidate.

~~(C) **Time requirements.** The minimum face-to-face time spent in assessment session(s) with the member and others as identified previously in paragraph (1) of this subsection for a low complexity Behavioral Health Assessment by a Non-Physician is one and one half hours. For a moderate complexity, it is two hours or more.~~

~~(D)~~ (C) **Target population and limitations.** The Behavioral Health Assessment by a Non-Physician, moderate complexity,

is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months and it has been more than one year since the previous assessment.

~~(E)~~ (D) **Documentation requirements**. The assessment must include all elements and tools required by the OHCA. In the case of children under the age of 18, it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition. The information in the assessment must contain but is not limited to the following:

~~(i) Date, to include month, day and year of the assessment session(s);~~
~~(ii) Source of information;~~
~~(iii) Member's first name, middle initial and last name;~~
~~(iv) Gender;~~
~~(v) Birth Date;~~
~~(vi) Home address;~~
~~(vii) Telephone number;~~
~~(viii) Referral source;~~
~~(ix) Reason for referral;~~
~~(x) Person to be notified in case of emergency;~~
~~(xi) Presenting reason for seeking services;~~
~~(xii) Start and stop time for each unit billed;~~
~~(xiii) Signature of parent or guardian participating in face-to-face assessment. Signature required for members over the age of 14;~~
~~(xiv) Bio-Psychosocial information which must include:~~
~~(I) Identification of the member's strengths, needs, abilities and preferences;~~
~~(II) History of the presenting problem;~~
~~(III) Previous psychiatric treatment history, include treatment for psychiatric; substance abuse; drug and alcohol addiction; and other addictions;~~
~~(IV) Health history and current biomedical conditions and complications;~~
~~(V) Alcohol, Drug, and/or other addictions history;~~
~~(VI) Trauma, abuse, neglect, violence, and/or sexual assault history of self and/or others, include Department of Human Services involvement;~~

~~(VII) Family and social history, include MH, SA, Addictions, Trauma/Abuse/Neglect;~~
~~(VIII) Educational attainment, difficulties and history;~~
~~(IX) Cultural and religious orientation;~~
~~(X) Vocational, occupational and military history;~~
~~(XI) Sexual history, including HIV, AIDS, and STD at-risk behaviors;~~
~~(XII) Marital or significant other relationship history;~~
~~(XIII) Recreation and leisure history;~~
~~(XIV) Legal or criminal record, including the identification of key contacts, (e.g., attorneys, probation officers, etc.);~~
~~(XV) Present living arrangements;~~
~~(XVI) Economic resources;~~
~~(XVII) Current support system including peer and other recovery supports.~~

~~(xv) Mental status and Level of Functioning information, including questions regarding:~~
~~(I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;~~
~~(II) Affective process, such as mood, affect, manner and attitude, etc.;~~
~~(III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc.; and~~
~~(IV) Full DSM diagnosis.~~

~~(xvi) Pharmaceutical information to include the following for both current and past medications;~~
~~(I) Name of medication;~~
~~(II) Strength and dosage of medication;~~
~~(III) Length of time on the medication; and~~
~~(IV) Benefit(s) and side effects of medication.~~

~~(xvii) Practitioner's interpretation of findings and diagnosis;~~
~~(xviii) Signature and credentials of the practitioner who performed the face-to-face behavioral assessment;~~
~~(xix) Client Data Core Elements reported into designated OHCA representative.~~

(i) Behavioral, including substance use, abuse, and dependence;
(ii) Emotional, including issues related to past or current trauma;
(iii) Physical;
(iv)Social and recreational;

(v) Vocational;

(vi) Date of the assessment sessions as well as start and stop times;

(vii) Signature of parent or guardian participating in face-to-face assessment. Signature required for members over the age of 14; and

(viii) Signature and credentials of the practitioner who performed the face-to-face behavioral assessment

(3) **Behavioral Health Services Plan Development.**

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. Behavioral Health Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. A Service Plan Development, Low Complexity is required every 6 months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

(B) **Qualified practitioners.** This service is performed by an LBHP or Licensure Candidate.

(C) **Time requirements.** Service Plan updates must be conducted face-to-face and are required every six months during active treatment. Updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member.

(D) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences(SNAP);

(ii) identified presenting challenges, problems, needs and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, attainable, realistic, and time-limited;

(v) each type of service and estimated frequency to be received;

(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;

(vii) any needed referrals for service;
(viii) specific discharge criteria;
(ix) description of the member's involvement in, and responses to, the service plan, and his/her signature and date;
(x) service plans are not valid until all signatures are present (signatures are required from the member, if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate; and
(xi) all changes in service plan must be documented in a service plan update (low complexity) or within the service plan until time for the update (low complexity). Any changes to the existing service plan must be signed and dated by the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the lead LBHP or Licensure Candidate.
(xii) Updates to goals, objectives, service provider, services, and service frequency, must be documented within the service plan until the six month review/update is due.
(xiii) Service plan updates must address the following:
(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;
(II) progress, or lack of, on previous service plan goals and/or objectives;
(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;
(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;
(V) change in frequency and/or type of services provided;
(VI) change in practitioner(s) who will be responsible for providing services on the plan;
(VII) change in discharge criteria;
(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and
(IX) service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate.

(E) **Service limitations:**

(i) Behavioral Health Service Plan Development, Moderate complexity (i.e., pre-admission procedure code group) are limited to 1 per member, per provider, unless more than a year has passed between services, then another one can be requested and may be authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member. The date of service is when the service plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

(4) **Assessment/Evaluation testing.**

(A) **Definition.** Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Service Plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) **Qualified practitioners.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist, an LBHP or Licensure Candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the Oklahoma Health Care Authority.

(C) **Documentation requirements.** All psychological services must be reflected by documentation in the member's record. All assessment, testing, and treatment services/units billed must include the following:

(i) date;

(ii) start and stop time for each session/unit billed and physical location where service was provided;

(iii) signature of the provider;

(iv) credentials of provider;

(v) specific problem(s), goals and/or objectives addressed;

(vi) methods used to address problem(s), goals and objectives;

vii) progress made toward goals and objectives;

(viii) patient response to the session or intervention; and

(ix) any new problem(s), goals and/or objectives identified during the session.

(D) **Service Limitations.** Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Behavioral Health Provider Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight hours/units of testing per patient over the age of three, per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Behavioral Health Provider Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of 12 hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving Residential level treatment in either a therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Individuals who qualify for Part B of Medicare: Payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

15-32 Health Home

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 22. HEALTH HOMES

317:30-5-251. Eligible providers

(a) **Agency requirements.** Providers of Health Home (HH) services are responsible for providing HH services to qualifying individuals within the provider's specified service area. Qualifying providers must be:

(1) Certified by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) as a Community Mental Health Center under OAC 450:17; or

(2) Accredited as a provider of outpatient behavioral health services from one of the national accrediting bodies; or

(3) Certified by ODMHSAS as a Mental Illness Service Program pursuant to OAC 450:27; or

(4) Certified by ODMHSAS as a Program of Assertive Community Treatment (PACT) pursuant to OAC 450:55.

(5) In addition to the accreditation/certification requirements in (1) – (4), providers must also have provider specific credentials from ODMHSAS for Health Home Services (OAC 450:17; OAC 450:27; OAC 450:55).

(b) **Health Home team.** Health Homes will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual's strengths and needs, create a unified plan to empower persons toward self-management and coordinate the individual's varied healthcare needs. HH teams will vary in size depending on the size of the member panel and acuity of members. HH team composition will vary slightly between providers working with adults and children.

(1) Health Homes working with adults with Serious Mental Illness (SMI) will utilize a multidisciplinary team consisting of the following:

(A) Health Home Director;

(B) Nurse Care Manager (RN or LPN);

(C) Consulting Primary Care Practitioner (PCP);

(D) Psychiatric Consultant (317:30-5-11);

(E) Certified Behavioral Health Case Manager(CM)(OAC 450:50; 317:30-5-595);

(F) Wellness Coach~~/Peer Support Specialist (OAC 450:53; 317:30-5-240.3)~~ credentialed through ODMHSAS; and

(G) Administrative support.

(2) In addition to the individuals listed in (1) (A) through (G) above, teams working with adults with SMI (PACT teams only) will also have at least one of the following team members:

(A) Licensed Behavioral Health Professional or Licensure Candidate (317:30-5-240.3);

(B) Substance abuse treatment specialist (Licensed Alcohol and Drug Counselor (LADC) or Certified Alcohol and Drug Counselor (CADC); or

(C) Employment specialist.

(3) Health Homes working with children with Serious Emotional Disturbance (SED) will utilize a multidisciplinary team consisting of the following:

(A) ~~Project~~ Health Home Director;

(B) Nurse Care Manager (RN or LPN);

(C) Consulting Primary Care Practitioner (PCP);

(D) Psychiatric Consultant (317:30-5-11);

(E) Care Coordinator (CM II Wraparound Facilitator as defined in 317:30-5-595(2) (C);

(F) Family Support Provider (317:30-5-240.3);

(G) Youth/Peer Support Specialist (OAC 450:53; 317:30-5-240.3);

(H) Children's Health Home Specialist (Behavioral Health Aide or higher, with additional training in WellPower or credentialed as a Wellness Coach through ODMHSAS); and

(I) Administrative Support.

317:30-5-252. Covered Services

Health Home services are covered for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED) as set forth in this Section unless specified otherwise, and when provided in accordance with a documented care plan. The care plan must be client directed, integrated, and reflect the input of the team (including the involvement of the consulting primary care physician or APRN in managing the medical component of the plan), as well as others the client chooses to involve. Coverage includes the following services:

(1) **Comprehensive Care Management.**

(A) **Definition.** Comprehensive care management services consist of developing a Comprehensive Care Plan to address needs of the whole person and involves the active participation of the Nurse Care Manager, certified Behavioral Health Case Manager, Primary Care Practitioner, the Health Home clinical support staff with participation of other team members, family and caregivers.

(B) **Service requirements.** Comprehensive care management services include the following, but are not limited to:

(i) Identifying high-risk members and utilizing member information to determine level of participation in care management services;
(ii) Assessing preliminary service needs; participating in comprehensive person-centered service plan development; responsible for member physical health goals, preferences and optimal clinical outcomes;
(iii) Developing treatment guidelines that establish clinical pathways for health teams to follow across risk levels or health conditions;
(iv) Monitoring individual and population health status and service use to determine adherence to or variance from best practice guidelines; and
(v) Developing and disseminating reports that indicate progress toward meeting outcomes for member satisfaction, health status, service delivery and cost.

(C) **Qualified professionals.** Comprehensive care management services are provided by a health care team with participation from the client, family and caregivers~~, consisting of the following required professionals and paraprofessionals~~. The following team members are eligible to provide comprehensive care management:
(i) Nurse Care Manager (RN or LPN within scope of practice);
(ii) Certified Behavioral Health Case Manager;~~ and~~
(iii) Primary Care Practitioner~~.~~;
(iv) Psychiatric consultant; and
(v) Licensed Behavioral Health Professional (LBHP).

(2) **Care coordination.**

(A) **Definition.** Care coordination is the implementation of the Comprehensive Care Plan with active member involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports.

(B) **Service requirements.** Care coordination services include the following, but are not limited to:
(i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals and Psychiatric Residential Treatment Facilities (PRTFs);
(ii) Ensuring integration and compatibility of mental health and physical health activities;
(iii) Providing on-going service coordination and link members to resources;
(iv) Tracking completion of mental and physical health goals in member's Comprehensive Care Plan;

(v) Coordinating with all team members to ensure all objectives of the Comprehensive Care Plan are progressing;
(vi) Appointment scheduling;
(vii) Conducting referrals and follow-up monitoring;
(viii) Participating in hospital discharge processes; and
(ix) Communicating with other providers and members/family.

(C) **Qualified professionals.** Team members are responsible to ensure implementation of the Comprehensive Care Plan, which includes mental health goals, physical health goals, and other life domain goals for achievement of clinical outcomes. Care coordination services are provided by a primary care practitioner-led team which includes the following professionals and paraprofessionals:
(i) Nurse Care Manager (RN or LPN); ~~and~~
(ii) Certified Behavioral Health Case Managers~~.~~;
(iv) Health Home Director;
(v) Family Support Provider;
(vi) Youth/Peer Support Specialist; and
(vi) Health Home Specialist/Hospital Liaison.

(3) **Health promotion.**

(A) **Definition.** Health promotion consists of providing health education specific to the member's chronic condition.

(B) **Service requirements.** Health promotion will minimally consist of the following, but is not limited to:
(i) Providing health education specific to member's condition;
(ii) Developing self-management plans with the member;
(iii) Providing support for improving social networks and providing health promoting lifestyle interventions including:
(I) Substance use prevention;
(II) Smoking prevention and cessation;
(III) Obesity reduction and prevention;
(IV) Nutritional counseling; and
(V) Increasing physical activity.

(C) **Qualified professionals.** Health promotion services must be provided by the Primary Care Practitioner, Registered Nurse Care Manager (or LPN within full scope of practice) and the Wellness Coach or Health Home Specialist at the direction of the Health Home Director.

(4) **Comprehensive transitional care.**

(A) **Definition.** Care coordination services for comprehensive transitional care are designed to streamline

plans of care, reduce hospital admissions and interrupt patterns of frequent hospital emergency department use.

(B) **Service requirements.** ~~In conducting comprehensive transitional care, the Nurse Care Manager and the case manager will work as co-leads.~~ The duties of the ~~Nurse Care Manager or the case manager~~ qualified team members providing transitional care services include, but are not limited to the following:

(i) Developing contracts or Memorandums of Understanding (MOUs) with regional hospitals or system(s) to ensure a formalized structure for transitional care planning, to include communication of inpatient admissions and discharges of Health Home members;

(ii) Maintaining a mutual awareness and collaboration to identify individuals seeking emergency department services that may benefit from connection with a Health Home site; and

(iii) Motivate hospital staff to notify the Health Home staff of such opportunities.

(C) **Qualified individuals.** Comprehensive transitional care services can be provided by the following team members:

(i) Nurse Care Manager;

(ii) Certified behavioral health case manager; and

(iii) Family Support provider.

(5) **Individual and family support services.**

(A) **Definition.** Individual and family support services assist individuals in accessing services that will reduce barriers and improve health outcomes, with a primary focus on increasing health literacy, the ability of the member to self- manage their care, and facilitate participation in the ongoing revision of their Comprehensive Care Plan.

(B) **Service requirements.** Individual and family support services include, but are not limited to:

(i) Teaching individuals and families self-advocacy skills;

(ii) Providing peer support groups;

(iii) Modeling and teaching how to access community resources;

(iv) Assisting with obtaining and adhering to medications and other prescribed treatments; and

(v) Identifying resources to support the member in attaining their highest level of health and functioning in their families and in the community, including transportation to medically necessary services.

(C) **Qualified individuals.** Individual and family support service activities must be provided by one of the following:

(i) Wellness Coaches, Recovery support specialist, Children's Health Home specialist; or

(ii) Care coordinators; or

(iii) Family Support Providers.; or

(iv) Nurse Care Manager.

(6) **Referral to community and social support services.**

(A) **Definition.** Provide members with referrals to community and social support services in the community.

(B) **Service requirements.** Providing assistance for members to obtain and maintain eligibility for the following services as applicable, including but not limited to:

(i) Healthcare;

(ii) Disability benefits;

(iii) Housing;

(iv) Transportation;

(v) Personal needs; and

(vi) Legal services.

(C) **Limitations.** For members with Developmental Disabilities, the Health Home will refer to and coordinate with the approved Developmental Disabilities case management entity for these services.

(D) **Qualified individuals.** Referral to community and social support services may be provided by a certified behavioral health case manager, Family Support Provider or a nurse care manager.

15-40 Hospital Leave Payments

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

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

PART 11. PAYMENT, BILLING, AND OTHER ADMINISTRATIVE PROCEDURES

317:35-9-95. Payment to ICF/~~MR~~IID (public and private)

The Oklahoma Health Care Authority may execute agreements to provide care only with facilities which are properly licensed by the state licensing agency. The agreement is initiated by application from the facility and expires on a specified date, or with termination of the facility license, or shall be automatically terminated on notice to OHCA that the facility is not in compliance with Medicaid (or other federal long-term care) requirements.

(1) In the event that a facility changes ownership, the agreement with the previous owner may be extended to the new owner, pending certification of the new owner to provide care to individuals during the change of ownership. In the event that the new owner is not showing good faith in pursuit of certification, the OHCA will begin planning for alternate placement of Medicaid patients. The county office is immediately notified of any relevant change in facility status.

(2) Payment for long-term care is made only for those individuals who have been approved by the DHS for such care. The amount of payment is based on the actual time the individual received care (including therapeutic/hospital leave) from a nursing facility during any given month. Payment for nursing care cannot be made for any period during which the care has been temporarily interrupted for reasons other than therapeutic leave. Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made by the OHCA. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital.

(3) A nursing facility may receive payment for up to 7 days per calendar year for each eligible individual in order to reserve a bed when the patient is on therapeutic leave.

(4)The ICF/~~MR~~IID may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each recipient to

reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. Recipients approved for ICF/~~MR~~IID on or after July 1 of the year will only be eligible for 30 days of therapeutic leave during the remainder of that year.

(5) The Statement of Compensable Therapeutic Leave Only form is used by the facility to record use of therapeutic leave. This form is to be made available by the local office to the nursing facility upon request.

(6) ~~Effective August 1, 1995, a nursing facility may receive payment for a maximum of three (3) days of hospital leave per calendar year for each recipient to reserve a bed when the patient is admitted to a licensed hospital, if the facility has an occupancy rate of at least 90 percent at the time of hospital admission. Claims for hospital leave are submitted on Form Adm-41 (Long Term Care Claim Form).~~No payment shall be made for hospital leave.

~~(7) Effective January 1, 1996, the nursing facility may receive payment for a maximum of five (5) days of hospital leave per calendar year for each recipient to reserve the bed when the patient is admitted to a licensed hospital.~~

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-26. Payment to NF

The OHCA may execute agreements to provide care only with facilities which are properly licensed by the state licensing agency. The agreement is initiated by application from the facility and expires on a specified date, or with termination of the facility license, or shall be automatically terminated on notice to this Authority that the facility is not in compliance with Medicaid (or other federal long-term care) requirements.

(1) In the event that a facility changes ownership, the agreement with the previous owner may be extended to the new owner, pending certification of the new owner to provide care to individuals during the change of ownership. In the event that the new owner is not showing good faith in pursuit of certification, the OHCA will begin planning for alternate placement of Medicaid patients. The county office is immediately notified of any relevant change in facility status.

(2) Payment for long-term care is made only for those individuals who have been approved by the Department of Human Services for such care. The amount of payment is based on the actual time the individual received care (including therapeutic leave) from a nursing facility during any given month. Payment for nursing care cannot be made for any period

during which the care has been temporarily interrupted for reasons other than therapeutic leave. Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made by the OHCA.

(3) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven days of therapeutic leave per calendar year for each eligible individual to reserve the bed.

(4) The Statement of Compensable Therapeutic Leave Only form is used by the facility to record use of therapeutic leave. This form is to be made available by the local office to the nursing facility upon request.

(5) ~~Effective August 1, 1995, a nursing facility may receive payment for a maximum of three (3) days of hospital leave per calendar year for each recipient to reserve a bed when the patient is admitted to a licensed hospital, if the facility has an occupancy rate of at least 90 percent at the time of hospital admission. Claims for hospital leave are submitted on Form Adm-41 (Long Term Care Claim Form).~~No payment shall be made for hospital leave.

~~(6) Effective January 1, 1996, the nursing facility may receive payment for a maximum of five (5) days of hospital leave per calendar year for each recipient to reserve the bed when the patient is admitted to a licensed hospital.~~

16-01 Reimbursement for Licensed Behavioral Health Professionals in Independent Practice

TITLE 317. OKLAHOMA HEALHT CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

317:30-5-280 Eligible Providers [REVOKED]

~~Licensed Behavioral Health Professionals (LBHP) are defined as follows:~~

~~(1) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.~~

~~(2) Practitioners with a license to practice in the state in which services are provided.~~

~~(A) Social Worker (clinical specialty only),~~
~~(B) Professional Counselor,~~
~~(C) Marriage and Family Therapist,~~
~~(D) Behavioral Practitioner, or~~
~~(E) Alcohol and Drug Counselor.~~

~~(3) Advanced Practice Nurse (certified in psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.~~

~~(4) A Physician Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.~~

317:30-5-281. Coverage by Category [REVOKED]

~~(a) **Outpatient Behavioral Health Services**. Outpatient behavioral health services are covered as set forth in this Section, and when provided in accordance with a documented individualized service plan and/or medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.~~

~~(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.~~

~~(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.~~

~~(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.~~

~~(b) **Adults.** Coverage for adults by a LBHP is limited to Bio-Psycho-Social Assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.~~

~~(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.(2) For bariatric preoperative assessments, issues to address include, but are not limited to: depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.~~

~~(c) **Children.** Coverage for children includes the following services:~~

~~(1) Bio-Psycho-Social and Level of Care Assessments.~~

~~(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other~~

~~sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.~~

~~(B) Assessments for Children's Level of Care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.~~

~~(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:~~

~~(A) The need to manage maladaptive communication (i.e. related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.~~

~~(B) Caregiver emotions/behavior that interfere with implementation of the treatment plan.~~

~~(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e. abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.~~

~~(D) Use of play equipment, physical devices, interpreter or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.~~

~~(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.~~

~~(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six for ages four up to 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.~~

~~(5) Assessment/Evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Eight hours/units of testing per patient (over the age of three), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.~~

~~(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.~~

~~(7) Payment for therapy services provided by a LBHP to any one member is limited to eight sessions/units per month. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. A maximum of 35 hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four week average. Case Management services are considered an integral component of the behavioral health services listed above.~~

~~(8) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or testing unless allowed by the OHCA or their designated agent.~~

~~(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.~~

~~(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.~~

~~(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.~~

317:30-5-282. Non-covered procedures [REVOKED]

~~The following procedures by LBHPs are not covered:~~

~~(1) sensitivity training~~
~~(2) encounter~~
~~(3) workshops~~
~~(4) sexual competency training~~
~~(5) marathons or retreats for mental disorders~~
~~(6) strictly education training~~
~~(7) psychotherapy to persons under three years of age unless specifically approved by OHCA, or its designated agent.~~

317:30-5-283. Documentation of records [REVOKED]

~~All behavioral health services will be reflected by documentation in the patient records.~~

~~(1) All assessment, testing, and treatment services/units billed must include the following:~~

~~(A) date;~~
~~(B) start and stop time for each session/unit billed;~~
~~(C) signature of the provider;~~

~~(D) credentials of provider;~~
~~(E) specific problem(s), goals, and/or objectives addressed;~~
~~(F) methods used to address problem(s), goals and objectives;~~
~~(G) progress made toward goals and objectives;~~
~~(H) patient response to the session or intervention; and~~
~~(I) any new problem(s), goals and/or objectives identified during the session.~~

~~(2) For each Group psychotherapy session, a separate list of participants must be maintained.~~

~~(3) Testing will be documented for each date of service performed which should include at a minimum, the objectives for testing, the test administered, the results/conclusions and interpretation of the tests, and recommendations for treatment and/or care based on testing and analysis.~~

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-661.4. Behavioral health professional services provided at Health Centers and other settings

(a) Medically necessary behavioral health services that are primary, preventive, and therapeutic and that would be covered if provided in another setting may be provided by Health Centers. Services provided by a Health Center (refer to OAC 317:30-5-240.3 for a description of services) must meet the same requirements as services provided by other behavioral health providers. Rendering providers must be eligible to individually enroll or meet the requirements as an agency/organization provider specified in OAC 317:30-5-240.2, 317:30-5-280 and 317:30-5-595.

(1) Behavioral Health services include:
- (A) Assessment/Evaluation;
- (B) Crisis Intervention Services;
- (C) Individual/Interactive Psychotherapy;
- (D) Group Psychotherapy;
- (E) Family Psychotherapy;
- (F) Psychological Testing; and
- (G) Case Management (as an integral component of services 1-6 above).

(b) Medically necessary behavioral health professional therapy services are covered when provided in accordance with a documented individualized treatment plan, developed to treat the identified behavioral health disorder(s). A minimum of a 45 to 50 minute one-on-one standard clinical session must be completed by an health care professional authorized in the approved FQHC State Plan pages in order to bill the PPS encounter rate for the

session. Services rendered by providers not authorized under the approved FQHC state plan pages to bill the PPS encounter rate will be reimbursed pursuant to the SoonerCare fee-for-service fee schedule and must comply with rules found at OAC ~~317:30-5-280~~317:30-5-240 through ~~317:30-5-283~~317:30-5-249.

(c) Centers are reimbursed the PPS rate for services when rendered by approved health care professionals, as authorized under FQHC state plan pages, if the Health Center receives funding pursuant to Section 330 or is otherwise funded under Public Law to provide primary health care services at locations off-site (not including satellite or mobile locations) to Health Center patients on a temporary or intermittent basis, unless otherwise limited by Federal law.

(d) Health Centers that operate day treatment programs in school settings must meet the requirements found at OAC 317:30-5-240.2(7).

(e) In order to support the member's access to behavioral health services, these services may take place in settings away from the Health Center. Off-site behavioral health services must take place in a confidential setting.

AGENDA

New Business