OKLAHOMA HEALTH CARE AUTHORITY
SPECIAL SCHEDULED BOARD MEETING
September 18, 2019 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
OKC, OK

A G E N D A

Items to be presented by Stan Hupfeld, Chairman

1. Call to Order / Determination of Quorum

2. Discussion Item – Creation of OHCA Advisory Committees:

    - Administrative Rules Advisory Committee
    - Legislative Advisory Committee
    - Strategic Planning Advisory Committee
    - Compliance Advisory Committee

3. Action Item – Approval of the August 21, 2019 OHCA Board Meeting Minutes

Item to be presented by Kevin Corbett, Chief Executive Officer

4. Discussion Item – Chief Executive Officer's Report

    a) All-Star Recognition
        - June All-Star – Calvin Cole, Financial Manager III (Aaron)
        - July All-Star – Vanessa Andrade, Senior Policy Specialist (Maria)

Item to be presented by Maria Maule, Interim Chief of Legal Services

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

Item to be presented by Kimberely Helton, Professional Services Contracts Manager

6. Action Item – Consideration and Vote of Authority for Expenditures of Fund for:

    a) First Data – Electronic Visit Verification Services (EVV)

    b) Population Care Management Software System

Item to be presented by Josh Richards, Director of Program Integrity

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

    A. Consideration and Vote for a rate change to increase the Neonatal, Infant, and Young Child services at 100% of the Medicare Physician Fee Schedule. The estimated budget impact for the remainder of SFY2020 will be an increase of $536,318 total; of which $187,121 is state share. The estimated budget impact for SFY2021 will be an increase of $715,090 total; of which $234,264 is state share.

B. Consideration and Vote to establish a new rate. The Oklahoma Health Care Authority is requesting the establishment of rates for Diabetes Self-Management Training (DSMT) services. The estimated budget impact for the remainder of SFY2020 will be an increase of $109,107 total; of which $37,074 is state share. The estimated budget impact for SFY2021 will be an increase of $218,214 total; of which $72,163 is state share.

C. Consideration and Vote for a method change to change some Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) procedure codes to a manual pricing method. The estimated budget impact for SFY2020 and SFY2021 is budget neutral.

D. Consideration and Vote for a rate change to increase the base rate component to $120.57 for Regular Nursing Facilities and update the pool amount for these facilities in the state plan for the "Direct Care" and "Other" components to $220,482,316 due to the passage of Senate Bill 1044 and 280. The estimated budget impact for the remainder of SFY2020 will be an increase of $95,819,280 total; of which $32,559,391 is state share ($4,400,309 of the state share is from the increased QOC fee which is paid by the providers). The estimated budget impact for SFY2021 will be an increase of $127,759,040 total; of which $43,412,522 is state share ($6,286,156 of the state share is from the increased QOC fee which is paid by the providers).

E. Consideration and Vote for a rate change to increase the base rate component to $213.10 for the Acquired Immune Deficiency Syndrome (AIDS) rate for Nursing Facilities. The estimated budget impact for the remainder of SFY2020 will be an increase of $43,781 total; of which $14,877 is state share. The estimated budget impact for SFY2021 will be an increase of $38,653 total; of which $13,134 is state share.

Item to be presented by Jean Hausheer, M.D., Chair of Administrative Rules Advisory Committee

8. Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act

Action Item (a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of ***the Emergency Rules*** in action item eight (b) in accordance with 75 Okla. Stat. § 253.

Action Item (b) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Emergency Rules:

The following emergency rules HAVE NOT previously been approved by the Board.

A. AMENDING agency rules at ***Oklahoma Administrative Code (OAC) 317:30-3-27*** to comply with Oklahoma Senate Bill (SB) No. 575, which amended 25 Oklahoma Statutes (O.S.), Sections 2004 and 2005. Revisions outline and further define requirements for telehealth services including parental consent, confidentiality and security of protected health information, services provided or received outside of Oklahoma that may require prior authorization, and that services provided must be within the scope of the practitioner's license or certification. Revisions also define that program restrictions and coverage for telehealth services mirror those which exist for the same services when not provided through telehealth; however, the rule also outlines that only certain telehealth codes are reimbursable by SoonerCare.
Budget Impact: The estimated budget impact will be $332,330; with $115,950 in state share.

(Reference APA WF # 19-08)

B. ADDING agency rules at ***OAC 317:2-1-17*** to comply with Senate Bill 280. Revisions will implement an administrative appeals process for disputed long-term care facility cost reports and cost report consideration.
Budget Impact: Budget neutral.

(Reference APA WF # 19-13A)

C. AMENDING agency rules at ***OAC 317:30-5-132 and 317:30-5-136.1*** and ADDING agency rules at ***OAC 317:30-5-132.1 and 317:30-5-132.2*** to comply with Senate Bill 280. Revisions provide the OHCA's website location for cost report instructions, establishes procedures for annual cost report submission extension requests for long-term care facilities, outline the processes when, based on onsite audit findings, the cost report may be adjusted, and define allowable and non-allowable costs for long-term care facilities. The proposed policy changes will also establish new quality measures and criteria as well as recalculate the incentive reimbursement rate plan for nursing facilities participating in the pay-for-performance program.
Budget Impact: The estimated budget impact for the remainder of SFY20 will be an increase in the total amount of $95,819,280; with $32,559,391 in state share ($4,400,309 of the state share is from QOC fees paid by providers). The estimated budget impact for SFY21 will be an increase in the total amount of $127,759,040; with $43,412,522 in state share ($6,286,156 of the state share is from QOC fees paid by providers).

(Reference APA WF # 19-13B)

D. AMENDING agency rules ***OAC 317:30-5-241.6*** will increase targeted case management (TCM) limits that are reimbursable by SoonerCare. The TCM limits will be increased from 16 units per member per year to 12 units per member per month. Other revisions will align case management policy with current practice and correct grammatical errors. The proposed policy revisions herein are made at the request of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
Budget Impact: The estimated budget impact for SFY20 will be an increase in the total amount of $6,425,397; with $2,183,350 in state share. The estimated budget impact for SFY21 will be an increase in the total amount of $8,567,136; with $2,833,152 in state share. The state share will be paid by the ODMHSAS.

(Reference APA WF # 19-16)

Item to be presented by Stan Hupfeld, Chairman

9. ADJOURNMENT

NEXT BOARD MEETING
October 16, 2019
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
August 21, 2019
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

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Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on August 20, 2019 at 12:50 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on August 16, 2019 at 12:14 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Hupfeld called the meeting to order at 1:00 p.m.

BOARD MEMBERS PRESENT: Chairman Hupfeld, Vice Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Shamblin

BOARD MEMBERS ABSENT: Member Nuttle

OTHERS PRESENT:

Kevin Haddock, DHS
Nicole Collins, OHCA
Melanie Lawrence, OHCA
Brent Wilborn, OKPCA
Jimmy Witcosky, OHCA
LeKenya Antwine, OHCA
Bert, OHCA
Ellen Buettner, OHCA
Mike Herndon, OHCA
Clint Migdat, Orexo
Princess Rockmore, OHCA
Rick Snyder, OHA
Suzie Megehee, OHCA
James Meyer, OSMA
Bethany Holderread, OU CoP
Aaron Morris, OHCA
Kaitlyn Wood, OHCA
Mia Smith, OHCA
Nico Gomez, Care Providers Oklahoma
Andy Garnand, OHCA
Daryn Kirkpatrick, OHCA
Josh Richards, OHCA
Fred Oraene, OHCA
Tewanna Edwards, OHCA
Lisa Spain, DXC
Yasmine Barve, OHCA
Sheila Bertleson, OHCA
Denise Roberts
Matt Robison, OSMA
Catina Baker, OHCA
Gloria LaFitte, OHCA

OTHERS PRESENT:

Nick Barton, Southern Plains Tribal Health Board
Jo Stainsby, OHCA
Monika Lutz, OHCA
Laura Wilcox, OHCA
Katelynn Burns, OHCA
Sasha Teel, OHCA
Harvey Reynolds, OHCA
Tasha Black, OHCA
Pauline Whelan, Orexo
Kim Jones, OHCA
Marcus Ayers, OHCA
Dwyna Vick, OHCA
Trudy Johnson, OHCA
Mary Brinkley, Leading Age OK
Melissa Abbott, OU CoP
Constanzia Nizza, DHS
Brenda Teel, Chickasaw Nation
Sandra Puebla, OHCA
Stephanie Mavredes, OHCA
Carolyn Reconnu-Shoffner, OHCA
Kambra Reddick, OHCA
April Jones, OHCA
Lindsey Bateman, OHCA
Melissa Haden, Red Road Counseling
Rose Pina, OHCA
Will Widman, DXC
Jennifer King, DHS
David Ward, OHCA
Vanessa Andrade, OHCA
Carmen Johnson, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE SPECIAL BOARD MEETING HELD JUNE 25, 2019.

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

MOTION: Member Hausheer moved for approval of the June 25, 2019 board meeting minutes as published. The motion was seconded by Member Curry.

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Kennedy, Member Shamblin

ABSTAINED: Vice-Chairman Yaffe, Member Boyd

BOARD MEMBERS ABSENT: Member Nuttle

ITEM 3 / DISCUSSION OF THE CREATION OF A PHARMACY COMMITTEE

ITEM 4 / INTRODUCTION OF OHCA CEO
Chairman Hupfeld

Chairman Hupfeld introduced new OHCA Chief Executive Office, Kevin Corbett.

ITEM 5 / PUBLIC COMMENT ON THIS MEETING'S AGENDA ITEMS BY ATTENDEES WHO GAVE 24 HOUR PRIOR WRITTEN NOTICE
Maria Maule, Interim Chief of Legal Services

Speakers:
- Denise Roberts

ITEM 6 / LEGISLATIVE UPDATE
Audra Cross, Legislative Liaison

Ms. Cross gave a brief legislative update regarding the August 14, 2019 Health Care Working Group Meeting. The working group consists of nine members appointed by Governor Stitt, including Deputy Secretary of Health and Mental Health, Carter Kimble. OHCA presented information on current Medicaid programs, services, enrollment, and federal and state funding. The Health Care Working Group will continue to meet every Wednesday at 9 a.m. and will be live-streamed at www.oksenate.gov under the media tab.

ITEM 7 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Maria Maule, Interim Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 8A-C / CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE
Josh Richards, Director of Program Integrity

a) Consideration and Vote for a rate change to increase the most current provider rate and reimbursement structures in the SoonerCare program by 5.00%, with some exceptions. Upon passage of Senate Bill 1044, OHCA was mandated to increase most provider rates by 5.00%. Per Senate Bill 1044, the proposed rate increases excludes: services financed through appropriations to other state agencies; Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); non-emergency transportation capitation payments; services provided to Insure Oklahoma (IO) members; payments for drug ingredients/physician supplied drugs; Indian Health Services/Tribal/Urban Clinics (I/T/U); Federally Qualified Health Centers (FQHCs); Rural Health Centers (RHCs); and Long-Term Care Facilities, which will be discussed at a later date. Program for the All-Inclusive Care for the Elderly (PACE) was excluded from the legislatively mandated rate increases, however OHCA will increase these rates as well. The estimated budget impact for the remainder of SFY2020 will be an increase of $62,867,943 total; of which $21,362,527 is state share. The estimated budget impact for SFY2021 will be an increase of $85,650,782 total; of which $28,324,714 is state share.

MOTION: Member Hausheer moved for approval of Item 8a as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Shamblin

BOARD MEMBERS ABSENT: Member Nuttle

b) Consideration and Vote for a rate method change to negotiate a higher reimbursement than the current Oklahoma Medicaid rate for an out-of-state service that is prior authorized, provided that the service is not available in Oklahoma and the negotiated reimbursement does not exceed the rate paid by Medicare, unless authorized in the Oklahoma State Plan. This proposal is budget neutral as it sets out to standardize out-of-state coverage and payment methodologies as well as align with practice.

MOTION: Member Case moved for approval of Item 8b as published. The motion was seconded by Member Hausheer.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Kennedy, Member Shamblin

BOARD MEMBERS ABSENT: Member Nuttle

c) Consideration and Vote for a rate method change to add a third outlier intensity adjustment requested on a case by case basis for those children who have costs beyond the payments made for the base rate and add-ons. The third add-on is a $210.00 per diem. The estimated total budget impact for the remainder of SFY2020 is $4,310,344; $1,500,000 state share and an annual total cost of $5,747,126; $2,000,000 state share for SFY2021. The state share will be paid by the Oklahoma Department of Mental Health and Substance Abuse Service (ODMHSAS).

MOTION: Member Hausheer moved for approval of Item 8c as published. The motion was seconded by Member Shamblin.

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Curry, Member Kennedy

ABSTAINED: Vice-Chairman Yaffe, Member Boyd

BOARD MEMBERS ABSENT: Member Nuttle

ITEM 9A-C / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT. THE AGENCY REQUESTS THE ADOPTION OF THE FOLLOWING EMERGENCY RULES

Maria Maule, Interim Chief of Legal Services

Action Item – a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of *all Emergency Rules* in item nine in accordance with 75 Okla. Stat. § 253.

Action Item – b) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Emergency Rules:

The following emergency rules HAVE NOT previously been approved by the Board.

A. A. AMENDING agency rules at ***Oklahoma Administrative Code (OAC) 317:30-5-740, 317:30-5-740.1, 317:30-5-740.2, 317:30-5-741, 317:30-5-742, 317:30-5-742.1, 317:30-5-742.2, 317:30-5-743.1, 317:30-5-744, 317:30-5-745, 317:30-5-746*** and ADDING agency rules at ***OAC 317:30-5-750 through 317:30-5-757*** will align therapeutic foster care (TFC) policy with current business practice. Revisions will also add new language establishing a more intensive treatment program for children in Oklahoma Department of Human Services (DHS) and Office of Juvenile Affairs (OJA) custody known as Intensive Treatment Family Care (ITFC). ITFC is a TFC model that addresses children's complex/severe behavioral and emotional health needs and/or disorders. ITFC utilizes a team approach of professionals including therapists, care coordinators, and foster parents to provide the intensive treatment services in a family care setting. The proposed revisions will define ITFC, member criteria for the provision of ITFC services, provider participation and credentialing requirements, program coverage, and

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program limitations. Lastly, the proposed revisions will establish reimbursement methodology and applicable rates for ITFC services.
Budget Impact: The proposed changes will potentially result in an estimated annual total cost for SFY20 of $1,731,183 with a state share of $594,557 and an SFY21 total cost of $2,324,813 with a state share of $768,816. The state share will be paid by the Oklahoma Department of Human Services with the current TFC budget.

(Reference APA WF # 19-05)

MOTION:	Member Hausheer moved for approval of Item 9a.A as published. The motion was seconded by Vice-Chairman Yaffe
FOR THE MOTION:	Chairman Hupfeld, Member Boyd, Member Case, Member Curry, Member Kennedy, Member Shamblin
BOARD MEMBERS ABSENT:	Member Nuttle
MOTION:	Member Hausheer moved for approval of Item 9b.A as published. The motion was seconded by Vice-Chairman Yaffe
FOR THE MOTION:	Chairman Hupfeld, Member Boyd, Member Case, Member Curry, Member Kennedy, Member Shamblin
BOARD MEMBERS ABSENT:	Member Nuttle

B. AMENDING agency rules at ***OAC 317:1-1-4, 317:1-1-6, and 317:1-1-7*** to comply with Oklahoma Senate Bill (SB) 456, which was signed into law on March 13, 2019 and directed the reorganization of the OHCA Board. The seven-member Board was replaced with a nine-member Board. Further revisions will establish that the chair and vice-chair elections are held at the last regular meeting before January 1 of each year. Other revisions are needed to correct outdated language.
Budget Impact: Budget neutral.

(Reference APA WF # 19-11)

MOTION:	Member Hausheer moved for approval of Item 9a.B as published. The motion was seconded by Member Kennedy
FOR THE MOTION:	Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Shamblin
BOARD MEMBERS ABSENT:	Member Nuttle
MOTION:	Vice Chairman Yaffe moved for approval of Item 9b.B as published. The motion was seconded by Member Hausheer
FOR THE MOTION:	Chairman Hupfeld, Member Boyd, Member Case, Member Curry, Member Kennedy, Member Shamblin
BOARD MEMBERS ABSENT:	Member Nuttle

C. AMENDING agency rules at OAC 317:30-5-22.1 and 317:30-5-42.11 will add "family practice physician - obstetrics (FP/OB)" as a new provider type under the enhanced services for medically high risk pregnancy policy. This policy change will address and improve access to care for obstetrical-related services in rural Oklahoma. Further revisions will update policy to reflect current business practices.
Budget Impact: The proposed changes will potentially result in a combined total federal and state budget impact of $154,549.10; with $52,515.78 in state share for SFY2020.

(Reference APA WF # 19-12)

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MOTION: Member Hausheer moved for approval of Item 9a.C as published. The motion was seconded by Member Kennedy

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Shamblin

BOARD MEMBERS ABSENT: Member Nuttle

MOTION: Member Case moved for approval of Item 9b.C as published. The motion was seconded by Member Hausheer

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Kennedy, Member Shamblin

BOARD MEMBERS ABSENT: Member Nuttle

ITEM 10A-E / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUES 5030.3.
Member Randy Curry, Pharmacy Committee Chairman

a) Jornay PM™ [Methylphenidate Extended-Release (ER) Capsule], Evekeo ODT™ [Amphetamine Orally Disintegrating Tablet (ODT)], Adhansia XR™ (Methylphenidate ER Capsule), and Sunosi™ (Solriamfetol Tablet) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) Balversa™ (Erdafitinib) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

c) Various Special Formulations: Annovera™ (Segesterone Acetate/Ethinyl Estradiol Vaginal System), Bijuva™ (Estradiol/Progesterone Capsule), Cequa™ (Cyclosporine 0.09% Ophthalmic Solution), Corlanor® (Ivabradine Oral Solution), Crotan™ (Crotamiton 10% Lotion), Gloperba® (Colchicine Oral Solution), Glycate® (Glycopyrrolate Tablet), Khapzory™ (Levoleucovorin Injection), Qmiiz™ ODT [Meloxicam Orally Disintegrating Tablet (ODT)], Seconal Sodium™ (Secobarbital Sodium Capsule), TaperDex™ (Dexamethasone Tablet), Tiglutik™ (Riluzole Oral Suspension), TobraDex® ST (Tobramycin/Dexamethasone 0.3%/0.05% Ophthalmic Suspension), Tolsura™ (Itraconazole Capsule), and Yutiq™ (Fluocinolone Acetonide Intravitreal Implant) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

d) Abilify MyCite® (Aripiprazole Tablets with Sensor), Aristada Initio® [Aripiprazole Lauroxil Extended-Release (ER) Injectable Suspension], and Perseris™ [Risperidone ER Subcutaneous (Sub-Q) Injectable Suspension]to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

e) Cassipa® (Buprenorphine/ Naloxone) and Levorphanol to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

The Drug Utilization Review Board, recommends that select medication assisted treatment (MAT) products no longer require prior authorization.

MOTION: Member Curry moved for approval of Item 10a-e as published. The motion was seconded by Member Hausheer.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Kennedy, Member Shamblin

BOARD MEMBERS ABSENT: Member Nuttle

ITEM 11 / ADJOURNMENT

MOTION: Member Hausheer moved for approval for adjournment. The motion was seconded by Member Boyd.

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FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Kennedy, Member Shamblin

BOARD MEMBERS ABSENT: Member Nuttle

Meeting adjourned at 1:28 p.m., 8/21/2019

NEXT BOARD MEETING
September 18, 2019
Oklahoma Health Care Authority
Oklahoma City, OK

Martina Ordonez
Board Secretary

Minutes Approved: _______________

*Initials:*______________

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SUBMITTED TO THE C.E.O. AND BOARD ON SEPTEMBER 18, 2019
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	Electronic Visit Verification Services (EVV)
Contractor Name	First Data
Purpose and Scope	First Data's AuthentiCare Solution is an automated scheduling, time/attendance tracking, and billing system for home and community-based services. First Data shall provide the following services through the AuthentiCare system: • Act as the system aggregator by accepting claims data from OHCA Service Providers who perform home health visits. • Service Providers to check-in and check-out when providing care in SoonerCare members' homes either using a mobile app or phones. The check-in and check-out information is recorded in the AuthentiCare system and is used to validate claims submitted by the Service Provider. • Allow Service Providers to submit and modify, as needed, claims data to ensure an accurate and billable claim.
Mandate	The 21st Century Cures Act.
Procurement Method	Participation Agreement to allow OHCA to obtain services through an existing contract with the Oklahoma Department of Human Services (DHS). DHS released a competitive bid to originally obtain the services.
External Approvals	CMS and OMES
Incumbent Contractor Name & Contract Term	There is not an incumbent contractor.
New Contract Term	Date of signature through June 30, 2020 with 2 options to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$330,950.00

Federal Match Percentage(s) within the Total Contract Not-to-Exceed

75% Operations Federal Match Costs	$180,000.00
90% Implementation Federal Match Costs	$150,950.00

RECOMMENDATION

Board approval is requested to contract with First Data for 3 years, not-to-exceed $330,950.00 total dollars.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

SUBMITTED TO THE C.E.O. AND BOARD ON SEPTEMBER 18, 2019
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	Population Care Management Software System
Purpose and Scope	Oklahoma Department of Mental Health and Substance Abuse Services is seeking for the services of a vendor to administer a Behavioral Health Home Management Software System. The Behavioral Health Home Management System shall enable electronic communication between the Oklahoma Health Homes, the Oklahoma Health Care Authority, the Oklahoma Department of Mental Health and Substance Abuse Services and the Centers for Medicare and Medicaid Services. The system will contain: 1. Enrollment and discharge tracking; 2. Compliance; 3. Quality Assurance; and, 4. Outcome monitoring for the Serious Emotional Disturbance and Serious Mental Illness populations.
Mandate	N/A
Procurement Method	Competitive Bid
Award	Single Contractor
External Approvals	OMES
Incumbent Contractor Name & Contract Term	Care Management Technologies, Inc. 07/01/2015 through 6/30/2020
New Contract Term	Date of award through June 30, 2021 with four (4) options to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	**$3,340,000.00**
50% Federal Match	
State Share will be paid by ODMHSAS	

RECOMMENDATION

Board approval is requested to procure the Disease Registry Management System services described above for 5 years, for a total not-to-exceed $3,340,000.00.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

NEONATAL, INFANT, & YOUNG CHILD SERVICE RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority is requesting to increase rates for Neonatal services.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Currently, Neonatal, Infant, and Young Child services are paid at 89.17% of the Medicare Physician Fee Schedule.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed rate methodology is to pay certain Neonatal, Infant, and Young Child services at 100% of the Medicare Physician Fee Schedule. Neonatal, Infant, and Young Child services will be using an existing rate methodology that is used for physician services. The payment amount for each service paid under the fee schedule is the product of a uniform relative value unit (RVU) for each service and the Medicare conversion factor (CF). The Medicare CF converts the relative values into payment amount. CMS updates the RVU and CF annually. The current proposed rates are as follows:

CODE	DESCRIPTION	CURRENT RATE	OCTOBER 1, 2019 RATE
99238	HOSPITAL DISCHARGE DAY MANAGEMENT, 30 MINUTES OR LESS	$63.65	$71.38
99239	HOSPITAL DISCHARGE DAY MANAGEMENT, MORE THAN 30 MINUTES	$93.37	$104.71
99460	INITIAL HOSPITAL OR BIRTHING CENTER CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN INFANT	$84.57	$94.84
99462	SUBSEQUENT HOSPITAL CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN	$37.14	$41.65

99463	INITIAL HOSPITAL OR BIRTHING CENTER CARE, PER DAY, FOR EVALUATION AND MANAGEMENT OF NORMAL NEWBORN INFANT ADMITTED AND DISCHARGED ON THE SAME DATE	$97.37	$109.19
99464	ATTENDANCE AT DELIVERY (WHEN REQUESTED BY THE DELIVERING PHYSICIAN OR OTHER QUALIFIED HEALTH CARE PROFESSIONAL) AND INITIAL STABILIZATION OF NEWBORN	$66.16	$74.19
99465	DELIVERY/BIRTHING ROOM RESUSCIATION, PROVISIONS OF POSITIVE PRESSURE VENTILATION AND/OR CHEST COMPRESSION IN THE PRESENCE OF ACUTE INADEQUATE VENTILATION AND/OR CARDIAC OUTPUT	$128.90	$144.56
99468	INITIAL INPATIENT HOSPITAL CRITICAL CARE OF NEWBORN, 28 DAYS OF AGE OR YOUNGER, PER DAY	$811.53	$910.08
99469	SUBSEQUENT INPATIENT HOSPITAL CRITICAL CARE OF NEWBORN, 28 DAYS OF AGE OR YOUNGER, PER DAY	$350.84	$393.45
99471	INITIAL INPATIENT HOSPITAL CRITICAL CARE OF INFANT OR YOUNG CHILD, 29 DAYS THROUGH 24 MONTHS OF AGE, PER DAY	$702.58	$787.90
99472	SUBSEQUENT INPATIENT HOSPITAL CRITICAL CARE OF INFANT OR YOUNG CHILD, 29 DAYS THROUGH 24 MONTHS OF AGE, PER DAY	$359.37	$403.01
99475	INITIAL INPATIENT HOSPITAL CRITICAL CARE OF INFANT OR YOUNG CHILD, 2 THROUGH 5 YEARS OF AGE, PER DAY	$494.40	$554.44
99476	SUBSEQUENT INPATIENT HOSPITAL CRITICAL CARE OF INFANT OR YOUNG CHILD, 2 THROUGH 5 YEARS OF AGE, PER DAY	$307.11	$344.40
99477	INITIAL INTENSIVE CARE OF NEWBORN, 28 DAYS OF AGE OR YOUNGER, PER DAY	$307.45	$344.79
99478	SUBSEQUENT INTENSIVE CARE OF RECOVERING LOW BIRTH WEIGHT INFANT, PER DAY	$120.81	$135.48

99479	SUBSEQUENT INTENSIVE CARE OF RECOVERING LOW BIRTH WEIGHT INFANT, PER DAY	$109.87	$123.21
99480	SUBSEQUENT INTENSIVE CARE OF RECOVERING LOW BIRTH WEIGHT INFANT, PER DAY	$105.21	$117.98

6. **BUDGET ESTIMATE.**
The estimated budget impact for the remainder of SFY2020 will be an increase in the total amount of $536,318; with $187,121 in state share. The estimated budget impact for SFY2021 will be an increase in the total amount of $715,090; with $234,264 in state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the above rates for Neonatal, Infant, and Young Child services.

9. **EFFECTIVE DATE OF CHANGE.**
October 1, 2019, contingent upon CMS approval.

DIABETES SELF-MANAGEMNT TRAINING (DSMT) RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority is requesting the establishment of rates for Diabetes Self-Management Training (DSMT) services.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Currently, Diabetes Self-Management Training (DSMT) services are not covered.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   Diabetes Self-Management Training (DSMT) will be using an existing rate methodology that is used for physician services. The payment amount for each service paid under the fee schedule is the product of a uniform relative value unit (RVU) for each service and the Medicare conversion factor (CF). The Medicare CF converts the relative values into payment amount. CMS updates the RVU and CF annually. The current proposed rates are as follows:

Code	Description	January 1, 2020 Rate
G0108	DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES, INDIVIDUAL, PER 30 MINUTES	$50.30
G0109	DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES, GROUP SESSION (2 OR MORE), PER 30 MINUTES	$13.87

6. **BUDGET ESTIMATE.**
   The estimated budget impact for the remainder of SFY2020 will be an increase in the total amount of $109,107; with $37,074 in state share. The estimated budget impact for SFY2021 will be an increase in the total amount of $218,214; with $72,163 in state share.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.
The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following rates for Diabetes Self-Management Training (DSMT) services:

- Procedure Code G0108: $50.30/30 minutes
- Procedure Code G0109: $13.87/30 minutes

9. EFFECTIVE DATE OF CHANGE.
January 1, 2020, contingent upon CMS approval.

DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS) FAIR MARKET VALUE RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   Changes to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) are being made to change some procedure codes to a manual pricing method.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current methodology for DMEPOS Procedure Codes B4087, B4088, E0240, E0625, E1399, E2599, and K0108 is paid a percentage of the Medicare fee schedule or a Fair Market Value fee determined by the OHCA.

   Manual pricing is reasonable when one HCPCS code covers a broad range of items with a broad range of costs, since a single fee may not be a reasonable fee for all items covered under the HCPCS code, resulting in access-to-care issues. Examples include: 1) HCPCS codes with a description of not otherwise covered, unclassified, or other miscellaneous items; and 2) HCPCS codes covering customized items. Effective October 1, 2014, if manual pricing is used, the provider is reimbursed the documented Manufacturer's Suggested Retail Price (MSRP) less 30% or the provider's documented invoice cost plus 30%, whichever is less.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
The proposed methodology for the below DMEPOS Procedure Codes is to use a manual pricing method. The provider is reimbursed the documented Manufacturer's Suggested Retail Price (MSRP) less 30% or the provider's documented invoice cost plus 30%, whichever is less.

Procedure Code	Description
B4087	GASTROSTOMY/JEJUNOSTOMY TUBE, STANDARD, ANY MATERIAL, ANY TYPE, EACH
B4088	GASTROSTOMY/JEJUNOSTOMY TUBE, LOW-PROFILE, ANY MATERIAL, ANY TYPE, EACH
E0240	BATH/SHOWER CHAIR, WITH OR WITHOUT WHEELS, ANY SIZE
E0625	PATIENT LIFT, BATHROOM OR TOILET, NOT OTHERWISE CLASSIFIED
E1399	DURABLE MEDICAL EQUIPMENT, MISCELLANEOUS
E2599	ACCESSORY FOR SPEECH GENERATING DEVICE, NOT OTHERWISE CLASSIFIED
K0108	WHEELCHAIR COMPONENT OR ACCESSORY, NOT OTHERWISE SPECIFIED

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY2020 and SFY2021 is budget neutral.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the proposed methodology to reimburse providers the documented Manufacturer's Suggested Retail Price (MSRP) less 30% or the provider's documented invoice cost plus 30%, whichever is less for DMEPOS Procedure Codes B4087, B4088, E0240, E0625, E1399, E2599, and K0108.

9. **EFFECTIVE DATE OF CHANGE.**
October 1, 2019

REGULAR NURSING FACILITIES RATE

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to implement Senate Bills 1044 and 280. Senate Bill 1044 mandates OHCA to increase Regular Nursing Facility rates by 5%, and Senate Bill 280 mandates OHCA to increase the average rate for nursing facilities to equal to the statewide average cost as derived from audited cost reports for SFY 2018, ending June 30 2018, after adjustment for inflation. Also, Senate Bill 280 directed OHCA to change the current Focus on Excellence (FOE) to a new quality assurance component; Pay For Performance (PFP) program. Under the new quality assurance program, payments can be earned quarterly based on facility specific performance achievement of four equally-weighted, Long-Stay Quality Measures as defined by the Centers for Medicare and Medicaid Services. Additionally, this change will increase the Quality of Care (QOC) fee, and the pool amount for “Direct Care” and “Other” Components of the rate.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing Facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:
   A. Base Rate Component is $108.31 per patient day.
   B. A Focus on Excellence (FOE) Component defined by the points earned under this performance program ranging from $1.00 to $5.00 per patient day.
   C. An “Other Cost” Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and FOE Components by the total estimated Medicaid days for the rate period. This component once calculated is the same for each facility.
   D. A “Direct Care “Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and FOE Components to the facilities. This component is determined separately and is

different for each facility. The method (as approved in the State Plan) allocates the 70% pool of funds to each facility (on a per day basis) based on their relative expenditures for direct care costs. The current combined pool amount for "Direct Care" and "Other Cost" components is $186,146,037. The Quality of Care (QOC) fee is $11.81 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is a change in methodology; for the rate period beginning October 1, 2019, fifty percent (50%) of the resulting rate increase will be allocated toward an increase of the existing base reimbursement rate and distributed accordingly. $5 per patient will be reserved for the PFP component of the rate. The remaining fifty percent (50%) will be allocated in accordance with the currently approved 70/30 reimbursement rate methodology as outlined in the existing State Plan. Also, under the PFP program, payments will be earned quarterly based on facility specific performance achievement of four equally-weighted, Long-Stay Quality Measures as defined by the Centers for Medicare and Medicaid Services. Points earned under this performance program can be average of $5.00 per patient day. The new Base Rate Component will be $120.57 per patient day. The new combined pool amount for "Direct Care" and "Other Cost" components will be $220,482,316. The recalculated Quality of Care (QOC) fee will be $12.92 per patient day.

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

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular Nursing Facilities:

- An increase to the base rate component from $108.31 per patient day to $120.57 per patient day.
- A change to the combined pool amount for “Direct Care” and “Other Cost” Components from $186,146,037 to $220,482,316 for reallocation of the Direct Care Cost Component.
- For the data collection period beginning 10-01-2019, with a payment effective date of first quarter of 2020, change the assurance program measures and payment (Please see Attachment 1) to the following:
    - Payment points of $1.25 per patient day can be earned by achieving either five percent (5%) relative improvement each quarter from the baseline or by achieving or exceeding the National Average Benchmark for each of the following CMS measures:
    - percentage of long-stay, high-risk residents with pressure ulcers,
    - percentage of long-stay residents who lose too much weight,
    - percentage of long-stay residents with a urinary tract infection, and
    - percentage of long-stay residents who got an antipsychotic medication.

9. EFFECTIVE DATE OF CHANGE.

October 1, 2019, contingent upon CMS approval.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITES RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) Fee for nursing facilities serving residents with AIDS per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to the facilities.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current rate for this provider type is $209.50 per patient day. The Quality of Care (QOC) fee is $11.81 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however there is a rate change for nursing facilities serving residents with AIDS as a result of recalculation of the Quality of Care (QOC) fee. The rate for this provider type will be $213.10 per patient day. The recalculated Quality of Care (QOC) fee will be $12.92 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for the remainder of SFY2020 will be an increase in the total amount of $43,781; with $14,877 in state share. The estimated budget impact for SFY2021 will be an increase in the total amount of $38,653; with $ $13,134 in state share

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority anticipates a positive impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive

or negative impact to access or quality of care, in accordance with requirements at 42 CFR 447.203(b)(6)..

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:

- An increase to the AIDS rate from $209.50 per patient day to $213.10 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
October 1, 2019, contingent upon CMS approval.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-27. Telehealth

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

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

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

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

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

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

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

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

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

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

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

there is often no stored data in such encounters.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Chart notes;
(B) Start and stop times;
(C) Service provider's credentials; and
(D) Provider's signature.

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-17. Long-term care facility cost report appeals

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

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

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

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

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

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

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

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

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

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

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

(9) The ALJ may:

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-132. Cost reports

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

(1) The report must be prepared on the basis of generally accepted accounting principles and the accrual basis of accounting, except as otherwise specified in the cost report instructions. The OHCA's cost report instructions are publicly available on the OHCA's website, in the Nursing Home Cost Report Instruction Manual: A Guide for Entering Annual Nursing Home Cost Report Data via the OHCA Secure Site (hereinafter referred to as "Cost Report Instruction Manual").

(2) The cost report must be filed using the Secure Website~~.~~, ~~The instructions and data entry screen simulations will be made available on the OHCA public website.~~as set forth in the Cost Report Instruction Manual.

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

(4) ~~Normally, all ordinary and necessary expenses net of any offsets of credits incurred in the conduct of an economical and efficiently operated business are recognized as allowable. Allowable costs include all items of Medicaid-covered expense which nursing facilities incur in the provision of routine services. "Routine services" include, but are not limited to, regular room, dietary and nursing services, minor medical and surgical supplies, over-the-counter medications, transportation, dental examinations, dentures and related~~

~~services, eye glasses, routine eye examinations, and the use and maintenance of equipment and facilities essential to the provision of routine care. Allowable costs must be considered reasonable, necessary and proper, and shall include only those costs that are considered allowable for Medicare purposes and that are consistent with federal Medicaid requirements. (The guidelines for allowable costs in the Medicare program are set forth in the Medicare Provider Reimbursement Manual ("PRM"), HCFA-Pub. 15.). Ancillary items reimbursed outside the nursing facility rate are not included in the cost report and are not allowable costs.~~A long-term care facility may request an extension of time to submit an annual cost report, not to exceed fifteen (15) calendar days. Extensions of time shall be requested by a letter addressed to the Finance Division or by email, as is set forth in the Cost Report Instruction Manual. Any such request must be received by October 1, and must explain the good faith reason for the extension. OHCA shall provide a written notice of any denial of a request for an extension, which shall become effective on the date it is sent to the long-term care facility. Decisions to deny requests for extensions are solely within the discretion of the OHCA and are not administratively appealable.

(5) All reports ~~are~~may be subject to on-site audits~~ and are deemed public records~~. An on-site audit may result in cost adjustment(s), by which the OHCA, or its designee, identifies and corrects for costs that were included in the cost report. The OHCA or its designee shall provide written notice of any cost adjustment(s) it makes to a cost report, to the long-term care facility affected by the cost adjustment(s). Such notice shall contain, but is not limited to, a written list of the audit findings with a summary explanation of why any cost is deemed non-allowable.

(6) In accordance with 63 Oklahoma Statute § 1-1925.2, a long-term care facility may contest any cost adjustment(s) it disagrees with by requesting reconsideration of the cost adjustment(s), and/or by requesting an administrative appeal of the cost adjustment(s), pursuant to Oklahoma Administrative Code (OAC) 317:30-5-132.1 and OAC 317:2-1-17, respectively.

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

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

(b) Simultaneous with the request for reconsideration, the long-term care facility shall submit a statement as to why the request for reconsideration is being made and may submit any new or additional information that he or she wishes the CFO or his/her designee to consider. Any request for an informal meeting according to subsection (c), below, must be made at the same time as the request for reconsideration.
(c) At the request of the long-term care facility, the reconsideration may be conducted by the CFO or his/her designee as:
(1) An informal meeting between the long-term care facility and the CFO or his/her designee; or
(2) A review by the CFO or his/her designee of the information described below:
(A) A review of all information submitted by the long-term care facility; and,
(B) A review of the cost report adjustments made by the OHCA, in order to determine the accuracy of the adjustments.
(d) The CFO or his/her designee shall send a written decision of the reconsideration to the long-term care facility within thirty (30) calendar days of the date of OHCA's receipt of the reconsideration request, or the date of any informal meeting, whichever occurs later.
(e) If the provider disagrees with the decision rendered by the CFO or his or her designee, the provider may utilize the administrative appeals process in accordance with Oklahoma Administrative Code 317:2-1-17.

317:30-5-132.2. Allowable Costs

The Oklahoma Health Care Authority (OHCA) shall reimburse long-term care facilities in accordance with its federally-approved Oklahoma Medicaid Plan. According to the Oklahoma Medicaid Plan, per-diem rates for long-term care facilities are established on, among other things, analyses of annual uniform cost reports. These reports may only include allowable costs, as follows:
(1) To be allowable, the costs shall be reasonable and necessary for services related to resident care, and pertinent to the operation of the long-term care facility. More specifically:
(A) To be reasonable, costs shall be such as would ordinarily be incurred for comparable services provided by comparable facilities, for example, facilities of similar size and level of care; and
(B) To be necessary, costs related to patient care must be common and accepted occurrences; and,
(C) Allowable costs for services and items directly related to resident care include routine services, as established by Oklahoma Administrative Code (OAC) 317:30-5-133.1, and

quality of care assessment fees, as established by OAC 317:30-5-131.2. Ancillary services, as established by OAC 317:30-5-133.2, are not allowable costs, but may be reimbursed outside the long-term care facility rate, unless reimbursement is available from Medicare or other insurance or benefit programs.

(2) The following costs shall not be allowable:

(A) Costs resulting from inefficient operations;

(B) Costs resulting from unnecessary or luxurious care;

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

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

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

(F) Cost of services, facilities, and supplies furnished by organizations related to the provider, by common ownership or control, that exceed the price of comparable services, facilities, or supplies purchased by independent providers in Oklahoma, in accordance with 42 Code of Federal Regulations § 413.17; and,

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

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

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

(a) **Purpose.** The ~~Focus on Excellence (FOE)~~Pay-for-Performance (PFP) program was established through Oklahoma State Statute, Title 56, Section 56-1011.5~~.~~as amended. ~~FOE's~~PFP's mission is to enhance the quality of life for target citizens by delivering effective programs and facilitating partnerships with providers and the community they serve. The program has a full commitment to the very best in quality, service and value which will lead to measurably improved quality outcomes, healthier lifestyles; greater satisfaction and confidence for our members.

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

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

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

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

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

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

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

~~(6)~~ **Certified Nurse Assistant (CNA) Retention.** ~~Facility must maintain a one-year tenure rate of 50 percent (50%) or higher of its CNA staff to receive the points for this metric. This metric must be completed monthly by the 15th of the month.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.6. Behavioral ~~Health Case Management~~health case management

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

(1) **Description of behavioral health case management services and targeted case management services**. Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. Services under behavioral health targeted case management are not comparable in amount, duration and scope. The target ~~group~~groups for behavioral health case management services are persons under age twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons, and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be authorized ~~for the target group~~ based on established medical necessity criteria.

(A) ~~Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs.~~ The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case

management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate.

(B) The provider will coordinate transition services with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care other than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven (7) days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan.

(C) Case ~~Managers~~managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two (2) business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

~~(B)~~(D) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.
~~(C)~~(E) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.
~~(D)~~(F) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian [if the member is under eighteen (18)], the behavioral health case manager, and a licensed behavioral health professional (LBHP) or licensure candidate as defined in OAC 317:30-5-240.3(a) and (b).
~~(E)~~(G) SoonerCare reimbursable behavioral health case management services include the following:

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

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

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

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

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

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

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

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

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

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

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

~~six (6) hours ICM training, and twenty-four (24) hour availability is required. ICM/WFCM is limited to fifty-four (54) units per member per month.~~

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

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

~~(B) managing finances;~~

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

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

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

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

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

~~(H) mentoring or tutoring;~~

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

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

~~(K) monitoring financial goals;~~

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

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

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

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

~~(4) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:~~

~~(A) children/families for whom behavioral health case management services are available through Oklahoma Department of Human Services (OKDHS) and Oklahoma Office of Juvenile Affairs (OJA) staff without special arrangements with OKDHS, OJA, and the Oklahoma Health Care Authority (OHCA);~~

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

~~(C) residents of Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) and nursing facilities unless transitioning into the community;~~

~~(D) members receiving services under a Home and Community Based services (HCBS) waiver program; or~~

~~(E) members receiving services in the Health Home program.~~

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

~~(6) **Documentation requirements**. The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:~~

~~(A) date;~~

~~(B) person(s) to whom services are rendered;~~

~~(C) start and stop times for each service;~~

~~(D) original signature or the service provider [original signatures for faxed items must be added to the clinical file within thirty (30) days];~~

~~(E) credentials of the service provider;~~

~~(F) specific service plan needs, goals and/or objectives addressed;~~

~~(G) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals and/or objectives;~~

~~(H) progress and barriers made towards goals, and/or objectives;~~

~~(I) member (family when applicable) response to the service;~~

~~(J) any new service plan needs, goals, and/or objectives identified during the service; and~~

~~(K) member satisfaction with staff intervention.~~

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

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

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

children/adolescents with serious emotional disturbance, or who have or are at-risk for mental disorders, including substance use disorders (SUD), and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard case managers have caseloads of thirty (30) to thirty-five (35) members. Standard case management/resource coordination is limited to twelve (12) units per member per month. Additional units may be authorized up to twenty-five (25) units per member per month if medical necessity criteria for transitional case management are met.

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

(C) Wraparound facilitation case management (WFCM) is targeted to children/adolescents with significant mental health conditions being treated in a System of Care (SOC) Network who are deemed at imminent risk of out-of-home placement due to psychiatric or SUD reasons and in need of more intensive case management services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. Staff providing WFCM must meet the requirements for the SOC/WF. WFCM is limited to fifty-four (54) units per member per month.

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

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

(B) Managing finances;

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

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

(E) Counseling, rehabilitative services, psychiatric assessment, or discharge planning;
(F) Filling out forms, applications, etc., on behalf of the member when the member is not present;
(G) Filling out SoonerCare forms, applications, etc.;
(H) Mentoring or tutoring;
(I) Provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;
(J) Non-face-to-face time spent preparing the assessment document and the service plan paperwork;
(K) Monitoring financial goals;
(L) Leaving voice or text messages for clients and other failed communication attempts.

(4) **Excluded individuals.** The following SoonerCare members who are receiving similar services through another method are not eligible for behavioral health case management services without special arrangements with the Oklahoma Department of Human Services (OKDHS), the Office of Juvenile Affairs (OJA), OHCA or ODMHSAS as applicable, in order to avoid duplication in payment. Services/programs include, but may not be limited to:
(A) Children/families for whom at-risk case management services are available through OKDHS and OJA staff
(B) Children/youth in out-of-home placement and receiving targeted case management services through staff in a foster care or group home setting, unless transitioning into the community;
(C) Residents of intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) and nursing facilities unless transitioning into the community;
(D) Members receiving targeted case management services under a Home and Community Based Services (HCBS) waiver program; or
(E) Members receiving services in the health home program; or
(F) Members receiving case management through the ADvantage waiver program; or
(G) Members receiving targeted case management available through a Certified Community Behavioral Health Center (CCBHC); or
(H) Members receiving case management services through Programs of All-Inclusive Care for the Elderly (PACE); or
(I) Children receiving Early Intervention case management (EICM); or
(J) Children/youth receiving case management services through certified school providers (SBCM); or

(K) Children/youth receiving partial hospitalization services; or
(L) Children/youth receiving Multi-systemic Therapy (MST).

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

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

(A) Date;
(B) Person(s) to whom services are rendered;
(C) Start and stop times for each service;
(D) Original signature or the service provider [original signatures for faxed items must be added to the clinical file within thirty (30) days];
(E) Credentials of the service provider;
(F) Specific service plan needs, goals, and/or objectives addressed;
(G) Specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals, and/or objectives;
(H) Progress and barriers made towards goals, and/or objectives;
(I) Member (family when applicable) response to the service;
(J) Any new service plan needs, goals, and/or objectives identified during the service; and
(K) Member satisfaction with staff intervention.

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