Oklahoma Health Care Authority

MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
June 11, 2014
1:00 p.m. – 3:30pm
Charles Ed McFall Board Room
4345 N Lincoln Blvd
Oklahoma City, OK 73105

I. Welcome, Roll Call, and Dr. Crawford's Comments, Introduction of new delegates (Dr. Denae Kirkpatrick and Dr. Wade Hamil) and alternates (Shelly Collins, MHS, PA-C and Dr. Gail Poyner).

II. Approval of Minutes of the May 15, 2014 Medical Advisory Committee Meeting

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. 54th Legislature Wrap-up: Carter Kimble, OHCA Director of Governmental Relations

VI. Financial Report: Gloria Hudson, OHCA Director of General Accounting
   a. April 30, 2014 Financial Summary
   b. April 30, 2014 Financial Detail Report

VII. SoonerCare Operations Update: Becky Pasternik-Ikard, Deputy State Medicaid Director

VIII. Action Items: Traylor Rains, ODMHSAS Director, Policy and Planning
   a. Discussion on Emergency Proposed Rule Change
   b. Vote on Proposed Rule Changes

IX. Six Informational Items (No Discussion): Joseph Fairbanks

X. New Business

XI. Adjourn

Next Meeting: Wednesday, September 17, 2014, 4345 Lincoln, OKC

MINUTES
MAY 15, 2014

Delegates present: Ms. Bellah, Ms. Case, Dr. Crawford, Ms. Fritz, Dr. Gastorf, Mr. Goforth, Dr. Grogg, Ms. Hastings, Mr. Jones, Ms. Mays, Dr. McNeill, Dr. Post, Dr. Rhynes, Dr. Simon, Mr. Snyder, Mr. Tallent

Alternates present: Ms. Baker for Ms. Bierig, Ms. Bruce for Ms. Felty, Mr. Clay for Ms. Moran, Dr. Hamil for Dr. Bourdeau, Mr. Rains for Ms. Slatton-Hodges, Mr. Raybern for Ms. Galloway, Dr. Talley for Dr. Wright

Delegates absent: Ms. Booten-Hiser, Ms. Brinkley, Dr. Cavallaro, Mr. Patterson, Dr. Rhoades, Dr. Wells and Dr. Woodward

I. Chairman, Dr. Crawford, called the meeting of the Medical Advisory Committee (MAC) to order at 1:03 PM. He welcomed Ms. Joni Bruce as the alternate for Wanda Felty representing Disadvantaged Children; he noted that Rick Snyder is the official delegate and Sandra B. Harrison is the alternate for the Oklahoma Hospital Association; he announced that Antonia Pratt-Reid, APRN would be replacing Patti Wheaton as the official delegate representing the Association of Oklahoma Nurse Practitioners; and he said that Wavel Wells, D.D.S. was stepping down and the Oklahoma Dental Association (ODA) had recommended another delegate yet to be approved.

II. Mr. Tallent requested that the minutes of the March 26, 2014 MAC meeting be changed to reflect the correct spelling of his name. He also moved that the minutes be approved as amended. Dr. Rhynes seconded. The motion passed without objection.

III. Public comments
   a. Denae Kirkpatrick, D.D.S., a pediatric dentist named by ODA to be their new delegate, commented on Proposed Rule Change (PRC) 14-06. She said that Oklahoma Health Care Authority's (OHCA) Chief Dental Officer, Dr. Leon Bragg, had addressed the concerns of pediatric dentists about the proposed elimination of some dental benefits with her and she recommended adoption of PRC 14-06.

IV. There were no general comments or discussion from MAC members.

V. Carter Kimble, OHCA Director of Government Affairs, reviewed the current status of bills before the Oklahoma Legislature due to adjourn by Memorial Day. A budget agreement had not been reached yet and the bills that would have had a major impact on the medical home model currently used by OHCA did not pass. A few bills remained with narrower impact: HB 2902 calling for a study of emergency room utilization; HB 1097 making proposed rule changes to Tax Equity and Fiscal Responsibility Act (TEFRA) rules was being included in a separate bill; and HB2384 requiring a prior authorization for Hepatitis C drugs.

VI. Carrie Evans, Chief Financial Officer, reported on the latest developments of OHCA's proactive effort to target specific programs for cuts in response to the likelihood of SFY15 budget restraints. She said that a potential reduction of Provider Payment Rates could be as much as 14% but added that OHCA was targeting programs in order to keep that figure down.

VII. Gloria Hudson, Director of General Accounting presented the Financial Summary and Detail Report for OHCA for the third quarter, ending March 31, 2014. Dr. Hamil asked if a projected $40M carryover would change the proposed budget cuts. Ms. Hudson said that the carryover had already been calculated into the cuts noted by Ms. Evans.

VIII. Melody Anthony, Provider Services Director, reported on SoonerCare membership and expenditures as of March 31, 2014. She noted that the membership numbers were higher than normal due to a federal mandate to forego recertification of members between January and March. She said that preliminary figures from April 2014 showed a return to the average growth of 2300 members per month. Dips in the number of behavioral health and dental providers were due to the lag of contract renewals. Patient-Centered Medical Homes (PCMH) showed positive growth. Dr. McNeil asked about the Insure Oklahoma program. Cindy Roberts, Deputy Chief Executive Officer, responded by saying that OHCA has already submitted a request to the Centers for Medicare and Medicaid Services (CMS) to extend the program, due to end December 31, 2014, for another year.

IX. Joseph Fairbanks, Policy Development Coordinator, presented eight Proposed Rule Changes (PRCs).

a. PRC 14-02 FQHC and RHC Encounter Limitation – discussion revealed concerns about limiting the encounters with children: whether or not parents would bring back the child for another appointment; and the additional cost to the SoonerRide program. Ms. Fritz asked how the change would affect behavioral health and Kelly Taylor, Director of Financial Management, confirmed that a behavioral health appointment would be counted as an encounter. She also noted that Federally Qualified Health Centers (FQHC) do not allow services by providers who are under-supervision and Dr. Hamil noted that the payment rates did not differentiate between highly qualified providers and Masters-degreed providers. A suggestion to split the PRC into adults and children was not possible, but Ms. Roberts said that the PRC could be amended to exclude limitations on encounters with children. She also noted that reduction in program savings would be reflected in higher provider payment rates.

b. PRC 14-03 Elimination of Hospital & Therapeutic leave – Ms. Moore noted that this change would not cut any provider payment rates or services. A counterpoint was made that leave days are an important economic consideration in rural nursing facilities. Ms. Bellah asked if a member on leave could lose their bed. Ms. Taylor responded affirmatively but noted that the state-wide capacity is at 72% and she did not anticipate such an occurrence.

c. PRC 14-04 Hospital Readmissions - Mr. Fairbanks remarked that OHCA was considering new software that has been effectively utilized in four other states to measure “preventable readmissions.” Mr. Snyder pointed out that OHCA had conducted limited conversations with the Oklahoma Hospital Association and did not think there was enough evidence to determine whether the cost savings of reducing or denying payments would outweigh the outcomes of reducing access. Dr. Gastorf received confirmation that the software would account for admission on unrelated causes.

d. PRC 14-05 Cost Sharing – Mr. Fairbanks noted that a co-pay of $3 would be increased to $4, but would not be raised to the federal allowance of an $8 co-pay. Children, women who are pregnant, and native populations using

Indian Health Services / Tribal facilities / Urban Indian Clinics are exempt. There was no discussion.

e. PRC 14-06 Dental – after the reading of the PRC, Dr. Crawford asked if the elimination of perinatal dental coverage would impact the health of the children born to pregnant members. Dr. Bragg gave a report that since the inception of perinatal dental benefits in 2007, 137,000 members were eligible but only 16% sought treatment and less than 40% of those received services before their delivery. Many dentists did not like to work on patients who were pregnant. The benefit was added to reduce the number of low birth-weight babies but did not find broad utilization. Dr. Talley reported cases where he saw a significant benefit to perinatal dental treatment. Dr. Gastorf pointed out that some mouth bacteria can be transmitted after birth. Ms. Fritz suggested that the benefit be cut off upon delivery, but Dr. Sylvia Lopez, Chief Medical Officer said that the cost of chasing the outliers would counterbalance any savings and CMS may deny that plan. She pointed out that studies showed an association between perinatal dental treatment and better fetal health but not a direct causal relationship. Mr. Raybern questioned the point of under-utilization if the cost savings was projected at $3M.

~~f.~~ PRC 14-07 Oxygen and Oxygen Equipment – Dr. Crawford inquired about the proximity of this change to the federal requirements. Mr. Clay responded by saying that this change contained more stringent verbiage. Medical Director, Dr. Robert Evans, clarified the terms of the PRC noting that requiring a re-authorization annually would keep an eye on improvements in patient outcomes. He also pointed out that multiple types of testing were available for children. ~~but that the arterial blood gas analysis was being required for adults.~~ The non-invasive Oximeter test or the invasive blood gas test are acceptable tests (amended before final vote).

g. PRC 14-08 Limiting Reimbursement for Eyeglasses – Dr. Rhynes expressed his support of the change and thanked OHCA for seeking the input of optometrists in revising the rule.

h. PRC 14-09 SoonerCare Choice Enrollment Ineligibility – garnered no discussion.

X. Proposed Rule Changes Vote

a. Mr. Tallent moved that the rules be approved as presented but the motion died for lack of a second.

b. Dr. Crawford asked if the committee would like to extract any rules for a separate discussion and vote. Mr. Snyder asked to have PRC 14-04 extracted; Ms. Moore asked to extract PRC 14-03; and Ms. Case requested to have 14-02 extracted.

c. Mr. Tallent amended his motion, moving to recommend PRCs 14-05, 14-06, 14-07, 14-08, and 14-09. Ms. Bellah seconded the motion. The vote was yes with the exception of one no.

d. Ms. Case led the discussion concerning PRC 14-02. Brent Wilborn of the Oklahoma Primary Care Association responded to a question from Dr. Rhynes about their perspective on the change by saying that the meeting with OHCA was informative, but the deadline for written comments had not yet passed. Ms. Case moved to amend the PRC to only limit adult

encounters. Ms. Bella seconded the amended rule. The vote to recommend PRC 14-03 as amended was unanimous.

e. Ms. Moore reported that her organization, the Oklahoma Association of Health Care Providers, directed her to vote against any budgetary cuts. She noted that provider fees for the leave days would also be lost. She moved that the committee oppose PRC 14-03. There was no second. Mr. Rains moved to recommend PRC 14-03, Mr. Tallent seconded and the motion passed with two negative votes.
f. Mr. Snyder objected to PRC 14-04 saying that it was too open and broad-sweeping. Dr. McNeill received confirmation that the change would increase the number of days under scrutiny from 15 to 30. Mr. Rains received confirmation that the PRC vote was to recommend changing the number of days from 15 to 30 and not the use of software. Dr. Lopez suggested an amendment that the PRC include the assurance that OHCA would continue to work with the Oklahoma Hospital Association to monitor and change the rule if needed. Dr. Talley moved to amend the PRC to include that assurance. Ms. Fritz seconded the motion and the vote to recommend PRC 14-03 as amended was passed with two noes.

XI. Informational Items

a. Mr. Fairbanks read a statement on Proposed Cuts to Behavioral Health Services issued by the Oklahoma Department of Mental Health and Substance Abuse Services and OHCA. The statement was read without comment or discussion. Dr. Hamil expressed concern that the definition of SMI (serious mental illness) and SED (serious emotional disability was changing; that there were discrepancies between the statement and earlier statements by DMH (Department of Mental Health); and that a Health Home Model was being forced upon members.

XII. New Business

a. The next meeting of the MAC will be changed to Wednesday, June 11, 2014 at 1PM in order to address emergency rule changes before the June board meeting.

XIII. Adjournment

a. Ms. Bellah moved to adjourn, Dr. Post seconded and the meeting was adjourned without dissent at 2:50 PM.

FINANCIAL REPORT
For the Ten Months Ended April 30, 2014
Submitted to the CEO & Board

- Revenues for OHCA through April, accounting for receivables, were **$3,370,255,758** or **(.2%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,329,289,842 or 1.3% under** budget.
- The state dollar budget variance through April is **$35,050,357 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		16.9
Administration		5.1
Revenues:		
Unanticipated Revenue		15.7
Drug Rebate		3.7
Taxes and Fees		(8.3)
Overpayments/Settlements		2.0
Total FY 14 Variance	**$**	**35.1**

ATTACHMENTS

Oklahoma Health Care Authority

Summary of Revenues & Expenditures: OHCA
Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	FY14 Budget YTD	FY14 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 800,001,936	$ 796,113,013	$ (3,888,923)	(0.5)%
Federal Funds	1,754,346,716	1,723,288,928	(31,057,789)	(1.8)%
Tobacco Tax Collections	46,552,907	42,115,558	(4,437,349)	(9.5)%
Quality of Care Collections	67,255,042	67,255,042	-	0.0%
Prior Year Carryover	41,811,007	41,811,007	-	0.0%
Unanticipated Revenue	-	15,683,810	15,683,810	100.0%
Federal Deferral - Interest	193,149	193,149	-	0.0%
Drug Rebates	175,145,681	185,805,803	10,660,122	6.1%
Medical Refunds	40,466,053	46,080,171	5,614,118	13.9%
SHOPP	439,111,504	439,111,504	-	0.0%
Other Revenues	12,618,187	12,797,774	179,586	1.4%
TOTAL REVENUES	**$ 3,377,502,183**	**$ 3,370,255,758**	**$ (7,246,425)**	**(0.2)%**

EXPENDITURES	FY14 Budget YTD	FY14 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 50,447,773**	**$ 42,249,789**	**$ 8,197,984**	**16.3%**
ADMINISTRATION - CONTRACTS	**$ 102,313,334**	**$ 96,492,463**	**$ 5,820,871**	**5.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	31,316,849	30,685,506	631,343	2.0%
Acute Fee for Service Payments:				
Hospital Services	791,590,492	779,233,666	12,356,826	1.6%
Behavioral Health	18,812,880	17,642,953	1,169,928	6.2%
Physicians	432,762,871	426,260,505	6,502,366	1.5%
Dentists	125,867,735	121,396,763	4,470,972	3.6%
Other Practitioners	38,799,724	36,226,700	2,573,024	6.6%
Home Health Care	18,695,775	17,400,412	1,295,363	6.9%
Lab & Radiology	56,868,473	52,963,800	3,904,674	6.9%
Medical Supplies	43,228,773	39,327,280	3,901,492	9.0%
Ambulatory/Clinics	99,261,350	94,773,690	4,487,660	4.5%
Prescription Drugs	358,838,795	378,173,387	(19,334,592)	(5.4)%
OHCA TFC	1,461,472	1,709,688	(248,216)	0.0%
Other Payments:				
Nursing Facilities	489,955,458	482,485,819	7,469,640	1.5%
ICF-MR Private	50,582,109	49,643,360	938,749	1.9%
Medicare Buy-In	113,341,306	113,625,726	(284,420)	(0.3)%
Transportation	52,610,935	54,362,213	(1,751,278)	(3.3)%
MFP-OHCA	1,373,434	828,077	545,357	0.0%
EHR-Incentive Payments	22,894,985	22,894,985	-	0.0%
Part D Phase-In Contribution	63,812,397	64,252,741	(440,343)	(0.7)%
SHOPP payments	406,660,322	406,660,322	-	0.0%
Total OHCA Medical Programs	**3,218,736,136**	**3,190,547,591**	**28,188,545**	**0.9%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 3,371,586,625**	**$ 3,329,289,842**	**$ 42,296,783**	**1.3%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 5,915,558**	**$ 40,965,915**	**$ 35,050,357**	

Oklahoma Health Care Authority

Total Medicaid Program Expenditures

by Source of State Funds

Fiscal Year 2014, For the Ten Months Ended April 30, 2014

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 30,955,878	$ 30,671,387	$ -	$ 270,372	$ -	$ 14,119	$ -
Inpatient Acute Care	637,733,031	499,497,782	405,572	7,399,484	42,284,749	1,674,086	86,471,358
Outpatient Acute Care	243,325,999	231,689,505	34,670	7,954,522	-	3,647,302	-
Behavioral Health - Inpatient	21,602,135	10,450,186	-	439,307	-		10,712,642
Behavioral Health - Psychiatrist	7,192,766	7,192,766	-	-	-	-	-
Behavioral Health - Outpatient	21,761,700	-	-	-	-	-	21,761,700
Behavioral Health Facility- Rehab	243,010,864	-	-	-	-	71,465	242,939,399
Behavioral Health - Case Management	8,553,895	-	-	-	-	-	8,553,895
Behavioral Health - PRTF	79,013,183	-	-	-	-	-	79,013,183
Residential Behavioral Management	17,317,614	-	-	-	-	-	17,317,614
Targeted Case Management	55,055,523	-	-	-	-	-	55,055,523
Therapeutic Foster Care	1,709,688	1,709,688	-	-	-	-	-
Physicians	474,430,560	364,322,163	48,417	10,200,263	56,584,749	5,305,176	37,969,792
Dentists	121,457,480	115,562,976	-	60,716	5,810,214	23,574	-
Mid Level Practitioners	3,042,134	2,985,045	-	53,664	-	3,425	-
Other Practitioners	33,443,511	31,994,579	371,970	205,282	863,172	8,509	-
Home Health Care	17,400,601	17,376,912	-	189	-	23,500	-
Lab & Radiology	55,593,550	52,407,753	-	2,629,750	-	556,047	-
Medical Supplies	39,802,135	37,029,976	2,259,614	474,855	-	37,690	-
Clinic Services	97,736,793	86,391,208	-	978,623	-	202,974	10,163,989
Ambulatory Surgery Centers	8,525,919	8,164,604	-	346,411	-	14,904	-
Personal Care Services	11,236,310	-	-	-	-	-	11,236,310
Nursing Facilities	482,485,819	271,010,881	177,431,689	-	34,034,926	8,323	-
Transportation	54,161,802	49,248,113	2,195,694	-	2,670,733	47,261	-
GME/IME/DME	91,050,944	-	-	-	-	-	91,050,944
ICF/MR Private	49,643,360	39,784,927	9,145,832	-	712,601	-	-
ICF/MR Public	32,530,538	-	-	-	-	-	32,530,538
CMS Payments	177,878,466	177,277,670	600,797	-	-	-	
Prescription Drugs	392,225,332	337,419,530	-	14,051,945	39,364,206	1,389,651	-
Miscellaneous Medical Payments	200,490	192,905	-	79	-	7,506	-
Home and Community Based Waiver	144,925,264	-	-	-	-	-	144,925,264
Homeward Bound Waiver	75,955,577	-	-	-	-	-	75,955,577
Money Follows the Person	8,579,360	828,077	-	-	-	-	7,751,284
In-Home Support Waiver	20,134,595	-	-	-	-	-	20,134,595
ADvantage Waiver	154,883,044	-	-	-	-	-	154,883,044
Family Planning/Family Planning Waiver	9,816,685	-	-	-	-	-	9,816,685
Premium Assistance*	37,808,149	-	-	37,808,149		-	-
EHR Incentive Payments	22,894,985	22,894,985	-	-	-	-	-
SHOPP Payments**	406,660,323	406,660,323	-	-	-	-	-
Total Medicaid Expenditures	**$ 4,391,736,001**	**$2,802,763,938**	**$ 192,494,256**	**$ 82,873,610**	**$ 182,325,349**	**$ 13,035,513**	**$1,118,243,336**

* Includes $37,517,602.19 paid out of Fund 245 and **$182,116,227.02 paid out of Fund 205

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	FY 13 Carryover	FY 14 Revenue	Total Revenue
Prior Year Balance	$ 10,427,850	$ -	$ 3,665,468
State Appropriations	-	-	(3,000,000)
Tobacco Tax Collections	-	34,639,050	34,639,050
Interest Income	-	180,936	180,936
Federal Draws	375,153	25,548,224	25,548,224
All Kids Act	(6,777,250)	206,106.38	206,106
TOTAL REVENUES	$ 4,025,753	$ 60,574,317	$ 61,033,678

EXPENDITURES		FY 13 Expenditures	FY 14 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 37,025,853	$ 37,025,853
	College Students		290,547	290,547
	All Kids Act		491,750	491,750
Individual Plan				
	SoonerCare Choice		$ 259,785	$ 93,523
	Inpatient Hospital		7,385,424	2,658,753
	Outpatient Hospital		7,838,529	2,821,871
	BH - Inpatient Services-DRG		423,698	152,531
	BH -Psychiatrist		-	-
	Physicians		10,119,706	3,643,094
	Dentists		42,920	15,451
	Mid Level Practitioner		52,904	19,045
	Other Practitioners		198,625	71,505
	Home Health		189	68
	Lab and Radiology		2,602,403	936,865
	Medical Supplies		470,676	169,444
	Clinic Services		960,387	345,739
	Ambulatory Surgery Center		345,553	124,399
	Prescription Drugs		13,890,051	5,000,418
	Miscellaneous Medical		79	79
	Premiums Collected		-	(1,078,386)
Total Individual Plan			$ 44,590,930	$ 14,974,399
	College Students-Service Costs		$ 393,764	$ 141,755
	All Kids Act- Service Costs		$ 80,768	$ 29,076
Total OHCA Program Costs			$ 82,873,611	$ 52,953,380
Administrative Costs				
	Salaries	$ 7,360	$ 899,468	$ 906,828
	Operating Costs	85,634	618,116	703,751
	Health Dept-Postponing	-	-	-
	Contract - HP	267,291	906,478	1,173,769
Total Administrative Costs		$ 360,286	$ 2,424,062	$ 2,784,347
Total Expenditures				$ 55,737,727
NET CASH BALANCE		$ 3,665,468		$ 5,295,951

Oklahoma Health Care Authority

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2014, For the Ten Months Ended April 30, 2014

	FY14 Actual YTD
REVENUE	
Revenues from Other State Agencies	$ 467,424,216
Federal Funds	719,881,733
TOTAL REVENUES	**$ 1,187,305,949**
EXPENDITURES	**Actual YTD**
Department of Human Services	
Home and Community Based Waiver	$ 144,925,264
Money Follows the Person	7,751,284
Homeward Bound Waiver	75,955,577
In-Home Support Waivers	20,134,595
ADvantage Waiver	154,883,044
ICF/MR Public	32,530,538
Personal Care	11,236,310
Residential Behavioral Management	12,691,272
Targeted Case Management	40,438,583
Total Department of Human Services	**500,546,467**
State Employees Physician Payment	
Physician Payments	37,969,792
Total State Employees Physician Payment	**37,969,792**
Education Payments	
Graduate Medical Education	44,367,799
Graduate Medical Education - PMTC	3,412,990
Indirect Medical Education	31,088,706
Direct Medical Education	12,181,449
Total Education Payments	**91,050,944**
Office of Juvenile Affairs	
Targeted Case Management	2,500,376
Residential Behavioral Management	4,626,342
Total Office of Juvenile Affairs	**7,126,718**
Department of Mental Health	
Case Management	8,553,895
Inpatient Psych FS	10,712,642
Outpatient	21,761,700
PRTF	79,013,183
Rehab	242,939,399
Total Department of Mental Health	**362,980,819**
State Department of Health	
Children's First	1,826,318
Sooner Start	1,956,772
Early Intervention	5,167,802
EPSDT Clinic	1,798,935
Family Planning	(150,382)
Family Planning Waiver	9,934,789
Maternity Clinic	54,591
Total Department of Health	**20,588,826**
County Health Departments	
EPSDT Clinic	673,545
Family Planning Waiver	32,277
Total County Health Departments	**705,822**
State Department of Education	**99,970**
Public Schools	**5,022,475**
Medicare DRG Limit	**77,702,312**
Native American Tribal Agreements	**5,680,146**
Department of Corrections	**2,028,503**
JD McCarty	**6,740,543**
Total OSA Medicaid Programs	**$ 1,118,243,336**
OSA Non-Medicaid Programs	**$ 64,660,766**
Accounts Receivable from OSA	**$ (4,401,847)**

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	FY 14 Revenue
SHOPP Assessment Fee	$ 178,616,889
Federal Draws	260,325,604
Interest	148,131
Penalties	20,881
State Appropriations	(22,700,000)
TOTAL REVENUES	$ 416,411,504

EXPENDITURES	Quarter	Quarter	Thru Fund 340 Quarter	Quarter	FY 14 Expenditures
Program Costs:	7/1/13 - 9/30/13	10/1/13 - 12/31/13	1/1/14 - 3/31/14	4/1/14 - 6/30/14	
Hospital - Inpatient Care	76,710,371	86,962,208	87,919,865	93,110,378	$ 344,702,822
Hospital -Outpatient Care	2,748,407	2,899,948	14,433,147	15,081,373	$ 35,162,875
Psychiatric Facilities-Inpatient	5,785,055	6,483,431	6,540,191	6,928,169	$ 25,736,846
Rehabilitation Facilities-Inpatient	248,410	278,398	257,838	273,133	$ 1,057,779
Total OHCA Program Costs	85,492,242	96,623,985	109,151,041	115,393,054	$ 406,660,322
Total Expenditures					$ 406,660,322

CASH BALANCE	$ 9,751,182

Oklahoma Health Care Authority

SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 64,573,758	$ 64,573,758
Interest Earned	33,842	33,842
TOTAL REVENUES	**$ 64,607,600**	**$ 64,607,600**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 174,379,581	$ 62,776,649	
Eyeglasses and Dentures	236,329	85,078	
Personal Allowance Increase	2,815,780	1,013,681	
Coverage for DME and supplies	2,259,613	813,461	
Coverage of QMB's	860,630	309,827	
Part D Phase-In	600,797	600,797	
ICF/MR Rate Adjustment	4,587,947	1,651,661	
Acute/MR Adjustments	4,557,885	1,640,839	
NET - Soonerride	2,195,694	790,450	
Total Program Costs	**$ 192,494,255**	**$ 69,682,442**	**$ 69,682,442**
Administration			
OHCA Administration Costs	$ 392,910	$ 196,455	
PHBV - QOC Exp	-	-	
OSDH-NF Inspectors	800,000	800,000	
Mike Fine, CPA	9,500	4,750	
Total Administration Costs	**$ 1,202,410**	**$ 1,001,205**	**$ 1,001,205**
Total Quality of Care Fee Costs	**$ 193,696,665**	**$ 70,683,647**	
TOTAL STATE SHARE OF COSTS			**$ 70,683,647**

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

Oklahoma Health Care Authority

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	FY 13 Carryover	FY 14 Revenue	Total Revenue
Prior Year Balance	$ 10,427,850	$ -	$ 3,665,468
State Appropriations	-	-	(3,000,000)
Tobacco Tax Collections	-	34,639,050	34,639,050
Interest Income	-	180,936	180,936
Federal Draws	375,153	25,548,224	25,548,224
All Kids Act	(6,777,250)	206,106.38	206,106
TOTAL REVENUES	$ 4,025,753	$ 60,574,317	$ 61,033,678

EXPENDITURES		FY 13 Expenditures	FY 14 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 37,025,853	$ 37,025,853
	College Students		290,547	290,547
	All Kids Act		491,750	491,750
Individual Plan				
	SoonerCare Choice		$ 259,785	$ 93,523
	Inpatient Hospital		7,385,424	2,658,753
	Outpatient Hospital		7,838,529	2,821,871
	BH - Inpatient Services-DRG		423,698	152,531
	BH -Psychiatrist		-	-
	Physicians		10,119,706	3,643,094
	Dentists		42,920	15,451
	Mid Level Practitioner		52,904	19,045
	Other Practitioners		198,625	71,505
	Home Health		189	68
	Lab and Radiology		2,602,403	936,865
	Medical Supplies		470,676	169,444
	Clinic Services		960,387	345,739
	Ambulatory Surgery Center		345,553	124,399
	Prescription Drugs		13,890,051	5,000,418
	Miscellaneous Medical		79	79
	Premiums Collected		-	(1,078,386)
Total Individual Plan			$ 44,590,930	$ 14,974,399
	College Students-Service Costs		$ 393,764	$ 141,755
	All Kids Act- Service Costs		$ 80,768	$ 29,076
Total OHCA Program Costs			$ 82,873,611	$ 52,953,380
Administrative Costs				
	Salaries	$ 7,360	$ 899,468	$ 906,828
	Operating Costs	85,634	618,116	703,751
	Health Dept-Postponing	-	-	-
	Contract - HP	267,291	906,478	1,173,769
Total Administrative Costs		$ 360,286	$ 2,424,062	$ 2,784,347
Total Expenditures				$ 55,737,727
NET CASH BALANCE		$ 3,665,468		$ 5,295,951

Oklahoma Health Care Authority

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2014, For the Ten Months Ended April 30, 2014

REVENUES	FY 14 Revenue	State Share
Tobacco Tax Collections	$ 691,231	$ 691,231
TOTAL REVENUES	**$ 691,231**	**$ 691,231**

EXPENDITURES	FY 14 Total $ YTD	FY 14 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 14,119	$ 3,558	
Inpatient Hospital	1,674,086	421,870	
Outpatient Hospital	3,647,302	919,120	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	8,323	2,097	
Physicians	5,305,176	1,336,904	
Dentists	23,574	5,941	
Mid-level Practitioner	3,425	863	
Other Practitioners	8,509	2,144	
Home Health	23,500	5,922	
Lab & Radiology	556,047	140,124	
Medical Supplies	37,690	9,498	
Clinic Services	202,974	51,149	
Ambulatory Surgery Center	14,904	3,756	
Prescription Drugs	1,389,651	350,192	
Transportation	47,261	11,910	
Miscellaneous Medical	7,506	1,892	
Total OHCA Program Costs	$ 12,964,048	$ 3,266,940	
OSA DMHSAS Rehab	$ 71,465	$ 18,009	
Total Medicaid Program Costs	$ 13,035,513	$ 3,284,949	
TOTAL STATE SHARE OF COSTS			**$ 3,284,949**

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

SoonerCare Programs

April 2014 Data for June 2014 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2013	Enrollment April 2014	Total Expenditures April 2014	Average Dollars Per Member Per Month April 2014
SoonerCare Choice Patient-Centered Medical Home		513,315	565,329	$185,870,951	
	Lower Cost (Children/Parents; Other)		518,292	$144,031,382	$278
	Higher Cost (Aged, Blind or Disabled; TEFRA; BCC)		47,037	$41,839,569	$890
SoonerCare Traditional		217,231	197,795	$222,749,740	
	Lower Cost (Children/Parents; Other)		88,978	$47,613,261	$535
	Higher Cost (Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)		108,174	$175,136,480	$1,619
SoonerPlan*		48,346	45,282	$766,425	$17
Insure Oklahoma		30,202	19,106	$7,121,533	
	Employer-Sponsored Insurance	16,644	14,154	$4,148,436	$293
	Individual Plan"	13,559	4,952	$2,973,097	$600
TOTAL		809,094	827,512	$416,508,650	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data. Custody expenditures are excluded. Non-member specific expenditures of $161,249,978 are excluded.

*In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of FPL and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL.

Net Enrollee Count Change from Previous Month Total**	(22,908)

**The decrease in Net Enrollees was mostly due to the requirement to maintain coverage through March 2014.

New Enrollees	18,047

Members that have not been enrolled in the past 6 months.

Dual Enrollees & Long-Term Care Members (subset of data above)

Medicare and SoonerCare		Monthly Average SFY2013	Enrolled April 2014
Dual Enrollees		108,514	109,819
	Child	201	179
	Adult	108,313	109,640

		Monthly Average SFY2013	Enrolled April 2014	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		15,674	15,276	$4,210
	Child	64	61	
	Adult	15,610	15,215	

Child is defined as an individual under the age of 21.

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2013	Enrolled April 2014
Total Providers		36,948	38,790
	In-State	28,587	29,532
	Out-of-State	8,362	9,258

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

Program	% of Capacity Used
SoonerCare Choice	45%
SoonerCare Choice I/T/U	19%
Insure Oklahoma IP	1%

Select Provider Type Counts	In-State		Totals	
	Monthly Average SFY2013	Enrolled April 2014*	Monthly Average SFY2013	Enrolled April 2014
Physician	7,859	8,570	12,432	14,037
Pharmacy	901	952	1,208	1,289
Mental Health Provider**	5,811	5,217	5,880	5,257
Dentist**	1,205	1,017	1,380	1,148
Hospital**	194	184	923	775
Optometrist	578	576	612	607
Extended Care Facility	362	355	362	355

Above counts are for specific provider types and are not all-inclusive.

Total Primary Care Providers***	4,997	5,519	6,541	7,120
Patient-Centered Medical Home	1,935	2,134	1,985	2,225

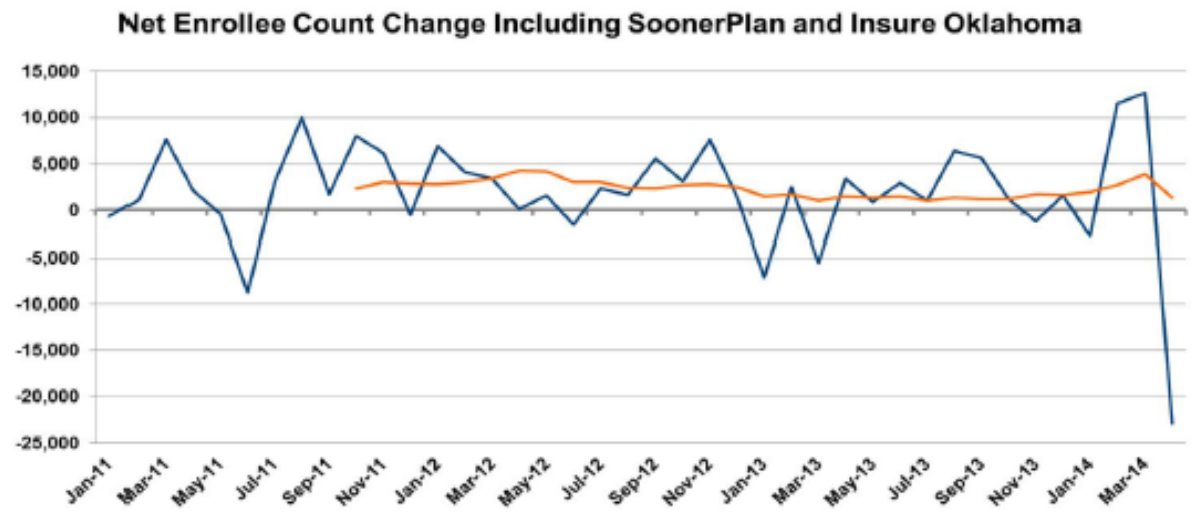
Including Physicians, Physician Assistants and Advance Nurse Practitioners.

*Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

**Decrease in current month's count is due to contract renewal period which is typical during all renewal periods. Hospitals renewal started in March 2013, renewals for Mental Health Providers started in June 2013 and Dentist renewals started in October 2013.

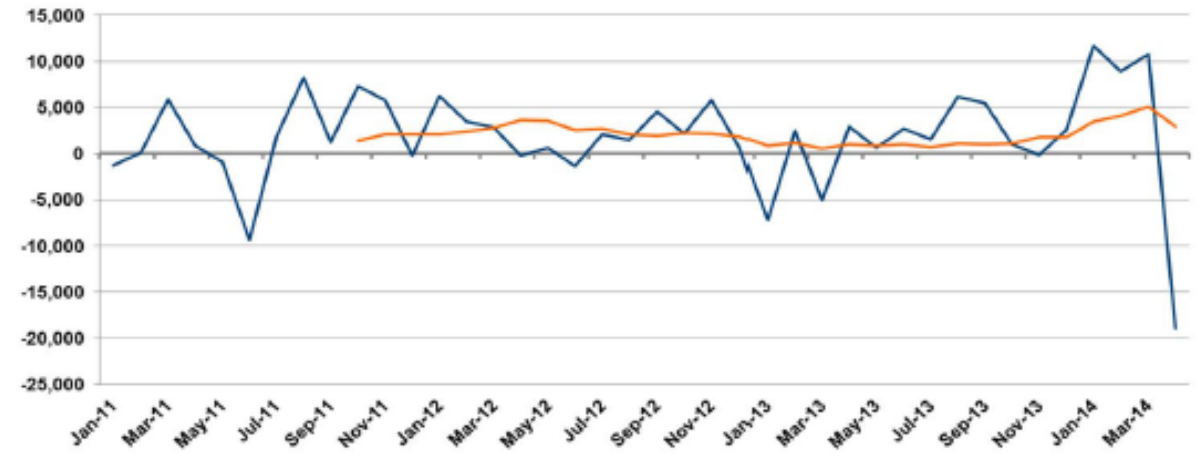
SoonerCare Programs

SOONERCARE NET ENROLLEE COUNT CHANGE FROM MONTH TO MONTH (Including SoonerPlan & Insure Oklahoma)



Net Enrollee Count Change includes SoonerPlan and Insure Oklahoma. Trendline is 10 month rolling average. In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of federal poverty level (FPL) and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL. The large decrease in April 2014 was due to some members with eligibility redeterminations between January and March 2014 having their enrollment extended until the end of March.

SOONERCARE NET ENROLLEE COUNT CHANGE FROM MONTH TO MONTH (Excluding SoonerPlan & Insure Oklahoma)



Net Enrollee Count Change excludes SoonerPlan and Insure Oklahoma. Trendline is 10 month rolling average. The large decrease in April 2014 was due to some members with eligibility redeterminations between January and March 2014 having their enrollment extended until the end of March.

These rules were posted for comment on June 3, 2014 through June 25, 2014.

Face to face tribal consultations regarding the proposed changes were held Tuesday, May 6, 2014 in the Board room of the OHCA.

14-10 Psychosocial rehabilitation (PSR) Service Eligibility Criteria — Rules are amended to add eligibility criteria required in order to receive psychosocial rehabilitation (PSR) services. Adult PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; or who are residing in residential care facilities. Children's PSR services will be limited to members with a history of psychiatric hospitalization or admissions to crisis centers; have been determined disabled by the Social Security Administration for mental health reasons; or have a current Individual Education Plan (IEP) for emotional disturbance. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Department is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program.
Budget Impact: $54,322,344 **Total Savings** $20,479,524 **State Share** $33,842,820 **Federal Share**

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241.2. Psychotherapy

(a) **Psychotherapy.**

(1) **Definition.** Psychotherapy is a face-to-face treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. The therapy must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(2) **Interactive Complexity.** Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

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

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

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

participants.

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

(3) **Qualified professionals.** Psychotherapy must be provided by a Licensed Behavioral Health Professional (LBHP) in a setting that protects and assures confidentiality.

(4) **Limitations.** A maximum of 6 units per day per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the Licensed Behavioral Health Professional (LBHP) should be present during the session. Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual.

(b) **Group Psychotherapy.**

(1) **Definition.** Group psychotherapy is a method of treating behavioral disorders using the interaction between the LBHP and two or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under Behavioral Health Rehabilitation Services.

(2) **Group sizes.** Group Psychotherapy is limited to a total of eight adult (18 and over) individuals except when the individuals are residents of an ICF/IID where the maximum group size is six. For all children under the age of 18, the total group size is limited to six.

(3) **Multi-family and conjoint family therapy.** Sessions are limited to a maximum of eight families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified professionals.** Group psychotherapy will be provided by a LBHP. Group Psychotherapy must take place in a confidential setting limited to the LBHP, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Limitations.** A maximum of 12 units per day per member is compensable. Group Psychotherapy for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Prior Authorization Manual.

(c) **Family Psychotherapy.**

(1) **Definition.** Family Psychotherapy is a face-to-face psychotherapeutic interaction between a LBHP and the member's family, guardian, and/or support system. It is typically inclusive of the identified member, but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the Evidence Based Practice titled Family Psychoeducation.

(2) **Qualified professionals.** Family Psychotherapy must be provided by a LBHP.

(3) **Limitations.** A maximum of 12 units per day per member/family unit is compensable. The provider may not bill any time associated with note taking and/or medical record upkeep. The provider may only bill the time spent in direct face-to-face contact. Provider must comply with documentation requirements listed in OAC 317:30-5-248.

(d) **Multi-Systemic Therapy (MST).**

(1) **Definition.** MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Case loads are kept low due to the intensity of the services provided.

(2) **Qualified professionals.** Masters level professionals who work with a team that may include bachelor level staff.

(3) **Documentation requirements.** Providers must comply with documentation requirements in 317:30-5-248.

(4) **Service limitations.** Partial billing is not allowed, when only one service is provided in a day, providers should not bill for services performed for less than 8 minutes.

(e) **Children/Adolescent Partial Hospitalization Program (PHP).**

(1) **Definition.** Partial hospitalization services are services that (1) Are reasonable and necessary for the diagnosis or active treatment of the member's condition; (2) Are reasonably expected to improve the member's condition and functional level and to prevent relapse or hospitalization and (3) Include the following:

(A) Assessment, diagnostic and service plan services for mental illness and/or substance use disorders provided by LBHPs.

(B) Individual/Group/Family (primary purpose is treatment

of the member's condition) psychotherapies provided by LBHPs.

(C) Substance use disorder specific services are provided by LBHPs qualified to provide these services.

(D) Drugs and biologicals furnished for therapeutic purposes.

(E) Family counseling, the primary purpose of which is treatment of the member's condition.

(F) Behavioral health rehabilitation services ~~for children who meet the criteria established in 317:30-5-241.3~~ (this language was not included in the text presented to the MAC)to the extent the activities are closely and clearly related to the member's care and treatment, provided by a Certified Behavioral Health Case Manager II, Certified Alcohol and Drug Counselor (CADC)or LBHP who meets the professional requirements listed in 317:30-5-240.3.

(G) Care Coordination of behavioral health services provided by certified behavioral health case managers.

(2) **Qualified professionals.**

(A) All services in the PHP are provided by a clinical team, consisting of the following required professionals:

(i) A licensed physician;

(ii) Registered nurse; and

(iii) One or more of the licensed behavioral health professionals (LBHP) listed in 30-5-240.3(a).

(B) The clinical team may also include a Certified Behavioral Health Case Manager.

(C) The service plan is directed under the supervision of a physician and the number of professionals and paraprofessionals required on the clinical team is dependent on the size of the program.

(3) **Qualified providers.** Provider agencies for PHP must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA) for partial hospitalization and enrolled in SoonerCare. Staff providing these services are employees or contractors of the enrolled agency.

(4) **Limitations.** Services are limited to children 0-20 only. Children under age 6 are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity. Services must be offered at a minimum of 3 hours per day, 5 days per week. Therapeutic services are limited to 4 billable hours per day. PHP services are all inclusive with the exception of physician services and drugs that cannot be

self-administered, those services are separately billable. Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Occupational, Physical and Speech therapy will be provided by the Independent School District (ISD). Academic instruction, meals, and transportation are not covered.

(5) **Service requirements.**

(A) Therapeutic Services are to include the following:

(i) Psychiatrist/physician face-to-face visit 2 times per month;

(ii) Crisis management services available 24 hours a day, 7 days a week;

(B) Psychotherapies to be provided a minimum of four (4) hours per week and include the following:

(i) Individual therapy - a minimum of 1 session per week;

(ii) Family therapy - a minimum of 1 session per week; and

(iii) Group therapy - a minimum of 2 sessions per week;

(C) Interchangeable services which include the following:

(i) Behavioral Health Case Management (face-to-face);

(ii) Behavioral health rehabilitation services/alcohol and other drug abuse education (except for children under age 6, unless a prior authorization has been granted for children ages 4 and 5);

(iii) Medication Training and Support; and

(iv) Expressive therapy.

(6) **Documentation requirements.** Documentation needs to specify active involvement of the member's family, caretakers, or significant others involved in the individual's treatment. A nursing health assessment must be completed within 24 hours of admission. A physical examination and medical history must be coordinated with the Primary Care Physician. Service plan updates are required every three (3) months or more frequently based on clinical need. Records must be documented according to Section OAC 317:30-5-248.

(7) **Staffing requirements.** Staffing requirements must consist of the following:

(A) RN trained and competent in the delivery of behavioral health services as evidenced by education and/or experience that is available onsite during program hours to provide necessary nursing care and/or psychiatric nursing care (1 RN at a minimum can be backed up by an LPN but an RN must always be onsite). Nursing staff

administers medications, follows up with families on medication compliance, and restraint assessments.

(B) Medical director must be a licensed psychiatrist.

(C) A psychiatrist/physician must be available 24 hours a day, 7 days a week.

(f) **Children/Adolescent Day Treatment Program.**

(1) **Definition.** Day Treatment Programs are for the stabilization of children and adolescents with severe emotional and/or behavioral disturbances. Treatment is designed for children who have difficulty functioning in mainstream community settings such as classrooms, and who need a higher intensity of services than outpatient counseling provides. Treatment is time limited and includes therapeutically intensive clinical services geared towards reintegration to the home, school, and community.

(2) **Qualified professionals.** All services in Day Treatment are provided by a team, which must be composed of one or more of the following participants: physician, registered nurse, licensed behavioral health professional (LBHP), a case manager, or other certified Behavioral Health/Substance Abuse paraprofessional staff. Services are directed by an LBHP.

(3) **Qualified providers.** Provider agencies for Day Treatment must be accredited by one of the national accrediting bodies; The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF) or The Council on Accreditation (COA).

(4) **Limitations.** Services must be offered at a minimum of 4 days per week at least 3 hours per day. Behavioral Health Rehabilitation Group size is limited to a maximum of 8 individuals as clinically appropriate given diagnostic and developmental functioning. Children under age 6 are not eligible for behavioral health rehabilitation services, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on a finding of medical necessity.

(5) **Service requirements.** On-call crisis intervention services must be available 24 hours a day, 7 days a week (When members served have psychiatric needs, psychiatric services are available which include the availability of a psychiatrist 24 hours a day, 7 days a week. A psychiatrist can be available either on site or on call but must be available at all times). Day treatment program will provide assessment and diagnostic services and/or medication monitoring, when necessary.

(A) Treatment activities are to include the following every week:

(i) Family therapy at least one hour per week (additional hours of FT may be substituted for other day treatment services);
(ii) Group therapy at least two hours per week; and
(iii) Individual therapy at least one hour per week.

(B) Additional services are to include at least one of the following services per day:
(i) Medication training and support (nursing) once monthly if on medications;
(ii) Behavioral health rehabilitation services to include alcohol and other drug education if the child meets the criteria established in 317:30-5-241.3 and is clinically necessary and appropriate (except for children under age 6, unless a prior authorization has been granted for children ages 4 and 5);
(iii) Behavioral health case management as needed and part of weekly hours for member;
(iv) Occupational therapy as needed and part of weekly hours for member; and
(v) Expressive therapy as needed and part of weekly hours for the member.

(6) **Documentation requirements.** Service plans are required every three (3) months.

317:30-5-241.3. Behavioral Health Rehabilitation (BHR) services

(a) **Definition.** Behavioral Health Rehabilitation (BHR) services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning. BHR services must be coordinated in a manner that is in the best interest of the member and may be provided in a variety of community and/or professional settings that protect and assure confidentiality. For purposes of this Section, BHR includes Psychosocial Rehabilitation, Outpatient Substance Abuse Rehabilitation, and Medication Training and Support.

(b) **Psychosocial Rehabilitation (PSR).**

(1) **Definition.** PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum based education and skills training.

(2) **Clinical restrictions.** This service is generally

performed with only the members and the qualified provider, but may include a member and the member's family/support system when providing educational services from a curriculum that focuses on the member's diagnosis, symptom management, and recovery. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

(3) **Qualified providers.** A Certified Behavioral Health Case Manager II (CM II), CADC, and LBHP may perform PSR, following development of a service plan and treatment curriculum approved by a LBHP. The CM II and CADC must have immediate access to a fully licensed LBHP who can provide clinical oversight and collaborate with the qualified PSR provider in the provision of services. A minimum of one monthly face-to-face consultation with a fully licensed LBHP is required for PSR providers ~~regularly rendering services in an agency setting~~. A minimum of one face-to-face consultation per week with ~~a fully licensed~~a LBHP is required for PSR providers regularly rendering services away from the outpatient behavioral health agency site.

(4) **Group sizes.** The maximum staffing ratio is fourteen members for each qualified provider for adults and eight to one for children under the age of eighteen.

(5) **Limitations.**

(A) **Transportation.** Travel time to and from PSR treatment is not compensable. Group PSR services do not qualify for the OHCA transportation program, but OHCA will arrange for transportation for those who require specialized transportation equipment.

(B) **Time.** Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time.

(C) **Location.** In order to develop and improve the member's community and interpersonal functioning and self care abilities, PSR services may take place in settings away from the outpatient behavioral health agency site as long as the setting protects and assures confidentiality. When this occurs, the qualified provider must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(D) **Eligibility for PSR services.** ~~PSR services are intended for adults with Serious Mental Illness (SMI), children with Serious Emotional Disturbance (SED), and~~

~~children with other emotional or behavioral disorders. The following members are not eligible for PSR services:~~All PSR services require prior authorization and must meet established medical necessity criteria.

(i)Adults. PSR services for adults are limited to members who have a history of psychiatric hospitalization or admissions to crisis centers, have been determined disabled by the SSA for mental health reasons, ~~or who~~ are residing in residential care facilities, or are receiving services through a specialty court program. (changes made to language before the MAC vote)

(ii) Children. PSR services for children are limited to members who have a history of psychiatric hospitalization or admissions to crisis centers, have been determined disabled by the SSA for mental health reasons, or who have a current Individual Education Plan (IEP) or 504 Plan (changes before MAC vote) for emotional disturbance.

(iii) The following members are not eligible for PSR services:

~~(i)~~(I) Residents of ICF/IID facilities, unless authorized by OHCA or its designated agent;

~~(ii)~~(II) children under age 6, unless a prior authorization for children ages 4 and 5 has been granted by OHCA or its designated agent based on the criteria in (5)(D)(ii) above as well as a finding of medical necessity;

~~(iii)~~(III) children receiving RBMS in a group home or therapeutic foster home, unless authorized by OHCA or its designated agent;

~~(iv)~~(IV) inmates of public institutions;

~~(v)~~(V) members residing in inpatient hospitals or IMDs; and

~~(vi)~~(VI) members residing in nursing facilities.

(E) **Billing limits.** PSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to compliment more intensive behavioral health therapies. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. PSR services authorized under this Section are separate and distinct

from, but should not duplicate the structured services required for children residing in group home or therapeutic foster care settings, or receiving services in Day Treatment or Partial Hospitalization Programs. Children under an ODMHSAS Systems of Care program and adults residing in residential care facilities may be prior authorized additional units as part of an intensive transition period. PSR is billed in unit increments of 15 minutes with the following limits:

(i) **Group PSR.** The maximum is 24 units per day for adults and 16 units per day for children.

(ii) **Individual PSR.** The maximum is six units per day.

(iii) **Per-Member service levels and limits.** Unless otherwise specified, group and/or individual PSR services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on PSR services are established based on the level for which the member has been approved.

(iv) **EPSDT.** Pursuant to OAC 317:30-3-65 et seq., billing limits may be exceeded or may not apply if documentation demonstrates that the requested services are medically necessary and are needed to correct or ameliorate defects, physical or behavioral illnesses or conditions discovered through a screening tool approved by OHCA or its designated agent. The OHCA has produced forms for documenting an EPSDT child health checkup screening which the provider can access on the OHCA website.

(F) **Progress Notes.** In accordance with OAC 317:30-5-241.1, the behavioral health service plan developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level. Progress notes for PSR day programs may be in the form of daily summary or weekly summary notes. Progress notes for all Behavioral Health Rehabilitation services must include the following:

(i) Curriculum sessions attended each day and/or dates

attending during the week;
(ii) Start and stop times for each day attended and the physical location in which the service was rendered;
(iii) Specific goal(s) and objectives addressed during the week;
(iv) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;
(v) Member satisfaction with staff intervention(s);
(vi) Progress, or barrier to, made towards goals, objectives;
(vii) New goal(s) or objective(s) identified;
(viii) Signature of the lead qualified provider; and
(ix) Credentials of the lead qualified provider;

(G) **Additional documentation requirements.**
(i) a list/log/sign in sheet of participants for each Group rehabilitative session and facilitating qualified provider must be maintained; and
(ii) Documentation of ongoing consultation and/or collaboration with a LBHP related to the provision of PSR services.

(H) **Non-Covered Services.** The following services are not considered BHR and are not reimbursable:
(i) Room and board;
(ii) educational costs;
(iii) supported employment; and
(iv) respite.

(c) **Outpatient Substance Abuse Rehabilitation Services.**

(1) **Definition.** Covered outpatient substance abuse rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance abuse rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum based education and skills training.

(2) **Limitations.** Group sessions may not be provided in the home.

(3) **Eligibility.** Members eligible for substance abuse rehabilitation services must meet the criteria for ASAM PCC Treatment Level 1, Outpatient Treatment.

(4) **Qualified providers.** CM II, CADC or LBHP.

(5) **Billing limits.** Group rehabilitation is limited to two (2) hours per session. Group and/or individual outpatient substance abuse rehabilitation services provided in combination may not exceed the monthly limits established in the individual's prior authorization. Limits on services are established based on the level for which the member has been approved. There are no limits on substance abuse rehabilitation services for individuals determined to be Level 4.

(6) **Documentation requirements.** Documentation requirements are the same as for PSR services as set forth in 30-5-241.3(b)(5)(F).

(d) **Medication training and support.**

(1) **Definition.** Medication Training and Support is a documented review and educational session by a registered nurse, advanced practice nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the medical or clinical record. A physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations.**

(A) Medication Training and Support may not be billed for SoonerCare members who reside in ICF/IID facilities.

(B) Two units are allowed per month per patient.

(C) Medication Training & Support is not allowed to be billed on the same day as an evaluation and management (E/M) service provided by a psychiatrist.

(3) **Qualified professionals.** Must be provided by a licensed registered nurse, an advanced practice nurse, or a physician assistant as a direct service under the supervision of a physician.

(4) **Documentation requirements. –** Medication Training and Support documented review must focus on:

(A) a member's response to medication;

(B) compliance with the medication regimen;

(C) medication benefits and side effects;

(D) vital signs, which include pulse, blood pressure and respiration; and

(E) documented within the progress notes/medication record.

June 2014 MAC
Proposed Waiver and State Plan Amendment Summaries

Information Only

The following are summaries of proposed waiver and state plan amendments. These proposals are still in the research stage and are not final. As such, some of the proposals you see here may not advance beyond the research stage. OHCA prepared this document to give members of the MAC a preview of rules, waivers, and state plan revisions. This document is for informational purposes only.

Dental – Effective August 1, 2014 the OHCA will discontinue all reimbursements for the following codes:

- D6985 - Pediatric partial denture, fixed. This decision was based on the finding that early loss of maxillary incisors will not have any significant, long-lasting effect on the growth and development of the child, especially when the eruption of the primary canines has occurred.

- D9420 – hospital or ambulatory surgical center call. This code does not reflect a direct delivery of care and is an optional service that is being eliminated to reduce the total impact of provider rate cuts as a result of decrease appropriations of State dollars for medical services.

Moving to an SSI Criteria State for Determining Medicaid Eligibility for Aged, Blind, and Disabled Individuals:

In order to come into compliance with federal regulations regarding eligibility determinations for Aged, Blind, and Disabled (ABD) individuals applying for Medicaid services, OHCA is transitioning from a 209(b) State to the Supplemental Security Income (SSI) Criteria administrative option. This change includes amending current policy and the State Plan pertaining to financial criteria for determining countable income and resources for ABD populations and matching that to current Social Security Administration regulations for persons receiving SSI.

Hospital Presumptive Eligibility:

Beginning in 2014, the Affordable Care Act gives qualified hospitals that participate in their state's Medicaid program the opportunity to determine presumptive eligibility (PE) for certain Medicaid-eligible populations. This will enable these qualified hospitals the opportunity to temporarily enroll individuals in Medicaid, ensuring compensation for hospital-based services, while providing patients access to medical care and a pathway to longer-term Medicaid coverage.

Home and Community-Based Waiver Services:

The Final Rule at 42 CFR 441.301, et seq. provides specific instruction regarding what constitutes a home and community-based setting as well as what is required in the process of creating a person centered service plan. OHCA proposes to amend the 1915 (c) waivers to provide assurances to CMS that any areas of non-compliance will be addressed.

Department of Mental Health and Substance Abuse Services:

Limit on outpatient behavioral health provider billable hours — ODMHSAS in collaboration with OHCA is exploring revisions to SoonerCare Outpatient Behavioral Health rules that would limit the number of weekly billable hours for all outpatient behavioral health providers to 40 hours. Without the recommended revisions, ODMHSAS is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program

Prior Authorizations for Partial Hospitalization — ODMHSAS in collaboration with OHCA is exploring reducing the authorization period for members in Partial Hospitalization from 90 days to 60, 45 or 30 days. Without the recommended change to utilization management procedures for this level of care, ODMHSAS is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program.

Coordinated Care Health Homes:

The State is currently collaborating with the Oklahoma Department of Mental Health Substance Abuse Services (ODMHSAS) to provide coordinated care through a health home for individuals with chronic conditions. This option is afforded under Section 2703 of the Affordable Care Act in accordance with statutory provisions at Section 1945(c)(1) of the Social Security Act. Health Homes service delivery model will enhance integration and coordination of primary, acute, behavioral health (mental health and substance use), and long-term services and supports for persons across the lifespan with chronic illness. A Health Homes State Plan Amendment (SPA) will be required to secure authority for the proposed services for children with serious emotional disturbances and adults with serious mental illness. To ensure public participation, OHCA and DMH representatives will take the SPA proposal to the Behavioral Health Advisory Council and Tribal Consultation. A draft of the SPA will be posted for comment on the OHCA website July 2. Rulemaking will commence with Tribal Consultation on September 2. January 1, 2015, is the planned implementation date.