Oklahoma Health Care Authority

The Oklahoma Health Care Authority (OHCA) values your feedback and input. It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments can be submitted on the OHCA's Proposed Changes Blog.

OHCA COMMENT DUE DATE: February 18, 2020

The proposed policy changes are currently in effect as Emergency Rules and must be promulgated as Permanent Rules. The proposed policy was presented at the September 3, 2019 Tribal Consultation and to the Medical Advisory Committee on September 5, 2019. Additionally, this proposal will be presented at a Public Hearing on February 19, 2020 and to the OHCA Board of Directors on March 18 2020.

Reference: APA WF # 19-16

SUMMARY:
Behavioral health targeted case management (TCM) updates - The proposed rule change, requested by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), increases the TCM monthly limits that are reimbursable by SoonerCare.

LEGAL AUTHORITY
The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board

RULE IMPACT STATEMENT:

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

TO: Maria Maule
Legal Services

FROM: Vanessa Andrade
Federal and State Authorities

SUBJECT: Rule Impact Statement
APA WF # 19-16

A. Brief description of the purpose of the rule:

The proposed rule change, requested by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS),

increases the targeted case management (TCM) monthly limits that are reimbursable by SoonerCare. The TCM limits will be increased from sixteen (16) units per member per year to twelve (12) units per member per month. Other revisions will align case management policy with current practice and correct grammatical errors.

B. A description of the classes of persons who most likely will be affected by the proposed rule, including classes that will bear the cost of the proposed rule, and any information on cost impacts received by the agency from any private or public entities:

Members receiving TCM and providers providing TCM will be affected by the proposed rule change.

C. A description of the classes of persons who will benefit from the proposed rule:

The proposed rule changes will benefit the SoonerCare member diagnosed with a serious mental illness and/or serious emotional disturbance who is in need of assistance with improving his/her quality of life and further enhancing his/her integration in the community.

D. A description of the probable economic impact of the proposed rule upon the affected classes of persons or political subdivisions, including a listing of all fee changes and, whenever possible, a separate justification for each fee change:

There is no probable impact of the proposed rule change upon any classes of persons or political subdivisions.

E. The probable costs and benefits to the agency and to any other agency of the implementation and enforcement of the proposed rule, the source of revenue to be used for implementation and enforcement of the proposed rule, and any anticipated effect on state revenues, including a projected net loss or gain in such revenues if it can be projected by the agency:

The proposed rule changes will not result in any additional costs and/or savings to the agency. Budget allocation for implementation and enforcement of the proposed rules, was approved during promulgation of the emergency rule on September 18, 2019. The state share is the responsibility of the ODMHSAS.

F. A determination of whether implementation of the proposed rule will have an economic impact on any political subdivisions or

require their cooperation in implementing or enforcing the rule:

The proposed rule changes will not have an economic impact on political subdivisions, and cooperation by political subdivisions in implementing or enforcing the rule is not required.

G. A determination of whether implementation of the proposed rule will have an adverse effect on small business as provided by the Oklahoma Small Business Regulatory Flexibility Act:

The proposed rule changes will not have an adverse effect on small business.

H. An explanation of the measures the agency has taken to minimize compliance costs and a determination of whether there are less costly or non-regulatory methods or less intrusive methods for achieving the purpose of the proposed rule:

The agency has taken measures to determine that there is no less costly or non-regulatory method or less intrusive method for achieving the purpose of the proposed rule change.

I. A determination of the effect of the proposed rule on the public health, safety, and environment and, if the proposed rule is designed to reduce significant risks to the public health, safety, and environment, an explanation of the nature of the risk and to what extent the proposed rule will reduce the risk:

The proposed rule changes should have no adverse effect on the public health, safety, and environment.

J. A determination of any detrimental effect on the public health, safety, and environment if the proposed rule is not implemented:

The agency does not believe there is a detrimental effect on the public health and safety if the rule is not passed.

K. The date the rule impact statement was prepared and if modified, the date modified:

Prepared: August 14, 2019
Modified: January 14, 2020

RULE TEXT:

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 targeted case management

Payment is made for behavioral health targeted 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.** 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)~~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 (1) 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)~~an 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)~~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;

(C) 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 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 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/WFCM. 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 (2) 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), OJA, OHCA or ODMHSAS as applicable, in order to avoid duplication in payment. Services/programs include, but may not be limited to:

(A) Members/families (when applicable) for whom at-risk case management services are available through OKDHS and OJA staff;

(B) Members 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 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) Members receiving Early Intervention case management (EICM); or

(J) Members receiving case management services through certified school-based targeted case management (SBTCM) providers; or

(K) Members receiving partial hospitalization services; or

(L) Members receiving 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 an LBHP 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 member 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.