

Oklahoma Health Care Authority

It is very important that you provide your comments regarding the proposed rule change by the comment due date. Comments are directed to Oklahoma Health Care Authority (OHCA) Health Policy Unit <http://www.okhca.org/proposed-rule-changes.aspx>

OHCA COMMENT DUE DATE: April 24, 2016

The proposed policy is an Emergency Rule. This proposal is scheduled to be presented to the Medical Advisory Committee (MAC) on April 25, 2016 and the (OHCA) Board of Directors on April 28, 2016.

Reference: APA WF 16-06

SUMMARY:

Treatment Plan Update Limits - Proposed outpatient behavioral health agency policy changes will reduce the number of SoonerCare compensable service plan updates to one every six months. Outpatient behavioral health agencies will now be reimbursed for one initial comprehensive treatment plan and one update thereto bi-annually.

LEGAL AUTHORITY

The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Article 10, Section 23 of the Oklahoma Constitution

RULE IMPACT STATEMENT:

TO: Tywanda Cox
Health Policy

FROM: Traylor Rains-Sims
Oklahoma Department of Mental Health & Substance Abuse
Services

SUBJECT: Rule Impact Statement
APA WF # 16-06

A. Brief description of the purpose of the rule:

Outpatient behavioral health agency rules are amended in order to reduce the number of SoonerCare compensable service

plan updates to one every six months. Outpatient behavioral health agencies will now be reimbursed for one initial comprehensive treatment plan and one update thereto bi-annually. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget for the remainder of SFY 2016 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. We are recommending an effective date of May 1, 2016, or upon governor's approval.

- 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:

SoonerCare providers who currently update treatment plans in excess of what would be authorized by the proposed rule will be affected. There have been no cost impacts received by the agency from any private or public entities.

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

SoonerCare members currently receiving or in need of behavioral health treatment services will benefit from the proposed rule in that access to a full array of behavioral health services will be preserved by making targeted cuts to the SoonerCare behavioral health program rather than reducing all behavioral health provider reimbursement rates to an extent that would in all probability reduce the behavioral health provider network.

- 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 potential for an economic impact on individuals & outpatient behavioral health clinics currently providing services to SoonerCare members. There are no fee changes associated with the proposed rule revisions.

- 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 Agency has determined there are no probable net costs to OHCA or other agencies expected as a result of the proposed rules. The Agency anticipates that the proposed changes would result in approximately \$12,817 Total; \$5,000 State share savings for SFY2016 to the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) which would enable ODMHSAS to file a balanced budget.

- 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:

There is no anticipated 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 Agency has determined that there would be no potential adverse effects on small business in Oklahoma.

- 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:

Throughout the year Agency staff gather relevant information through stakeholder involvement and public forums in order to communicate the planned actions of the Agency concerning rulemaking, as well as other issues. While it is difficult to balance the needs of SoonerCare members with those of the

various providers, the Agency proposes rules with each of these issues and interests considered.

- 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 Agency anticipates that the proposed revisions, in combination with other budget reduction measures, would allow the Agency to continue the SoonerCare behavioral health program without drastically reducing the provider reimbursement rates for all behavioral health services which would have a detrimental impact on access to behavioral health services. SoonerCare members who would experience reduced amount of services because of this proposed rule change would still have other appropriate therapeutic interventions available to them so that they are not left without access to appropriate services.

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

If the rule is not implemented, the Oklahoma Department of Mental Health and Substance Abuse Services would have to rely on significant provider reimburse rate reductions for all behavioral health services in order to meet its constitutional requirement of filing a balanced budget. Reducing rates to the extent necessary to fulfill this obligation would have a detrimental effect on access to behavioral health services for all SoonerCare members, as the Agency would anticipate a reduction in its contracted behavioral health provider network.

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

The rule impact statement was prepared March 25, 2016.

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

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

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

(1) Screening.

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

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

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

(2) Assessment.

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

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

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

(D) **Target population and limitations.** The Behavioral Health Assessment by a Non-Physician, moderate complexity, is compensable on behalf of a member who is seeking services for the first time from the contracted agency.

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

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

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

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

(xv) Mental status and Level of Functioning information, including questions regarding:

- (I) Physical presentation, such as general appearance, motor activity, attention and alertness, etc.;
- (II) Affective process, such as mood, affect, manner and attitude, etc.;
- (III) Cognitive process, such as intellectual ability, social-adaptive behavior, thought processes, thought content, and memory, etc.; and
- (IV) Full DSM diagnosis.

(xvi) Pharmaceutical information to include the following for both current and past medications;

- (I) Name of medication;
- (II) Strength and dosage of medication;
- (III) Length of time on the medication; and
- (IV) Benefit(s) and side effects of medication.

(xvii) Practitioner's interpretation of findings and diagnosis;

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

(xix) Client Data Core Elements reported into designated OHCA representative.

(3) Behavioral Health Services Plan Development.

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized plan is developed that addresses the member's strengths,

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

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

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

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

- (i) member strengths, needs, abilities, and preferences(SNAP);
- (ii) identified presenting challenges, problems, needs and diagnosis;
- (iii) specific goals for the member;
- (iv) objectives that are specific, attainable, realistic, and time-limited;
- (v) each type of service and estimated frequency to be received;
- (vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
- (vii) any needed referrals for service;
- (viii) specific discharge criteria;

(ix) description of the member's involvement in, and responses to, the service plan, and his/her signature and date;

(x) service plans are not valid until all signatures are present (signatures are required from the member, if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate; and

(xi) all changes in service plan must be documented in a service plan update (low complexity) or within the service plan until time for the update (low complexity). Any changes to the existing service plan must be signed and dated by the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the lead LBHP or Licensure Candidate.

(xii) Updates to goals, objectives, service provider, services, and service frequency, must be documented within the service plan until the six month review/update is due.

(xiii) Service plan updates must address the following:

(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;

(II) progress, or lack of, on previous service plan goals and/or objectives;

(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;

(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(V) change in frequency and/or type of services provided;

(VI) change in practitioner(s) who will be responsible for providing services on the plan;

(VII) change in discharge criteria;

(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and

(IX) service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate.

(E) Service limitations:

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

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

(4) Assessment/Evaluation testing.

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

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

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

- (i) date;
 - (ii) start and stop time for each session/unit billed and physical location where service was provided;
 - (iii) signature of the provider;
 - (iv) credentials of provider;
 - (v) specific problem(s), goals and/or objectives addressed;
 - (vi) methods used to address problem(s), goals and objectives;
 - (vii) progress made toward goals and objectives;
 - (viii) patient response to the session or intervention;
- and

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

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