

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 the [Oklahoma Health Care Authority \(OHCA\) Proposed Changes Blog](#).

OHCA COMMENT DUE DATE: August 11, 2017

The proposed policy is an Emergency Rule. The proposed policy is scheduled to be presented at the July 11, 2017 Tribal Consultation, the Medical Advisory Committee on July 20, 2017 and the OHCA Board of Directors on August 24, 2017.

Reference: APA WF #17-09

SUMMARY:

Behavioral Health Case Management Limits – Proposed policy revisions for Behavioral Health Targeted Case Management (TCM) are amended to reduce the yearly limit on the amount of basic case management/resource coordination from 25 units per member per month to 16 units per member per year.

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:

STATE OF OKLAHOMA OKLAHOMA HEALTH CARE AUTHORITY

TO: Tywanda Cox
Federal and State Policy

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

SUBJECT: Rule Impact Statement
APA WF #17-09

A. Brief description of the purpose of the rule:

Behavioral Health Targeted Case Management (TCM) rules are amended in order to establish yearly limits on the amount of basic case management/ resource coordination that is reimbursable by SoonerCare on a fee-for-service basis. The current limit of 25 units per member per month for basic case management/resource coordination will be reduced to 16 units per member per year. A process for authorizing up to 25 units per member per month will be used for individuals who meet established medical necessity criteria demonstrating the need for additional units. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget for SFY 2018 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.

- 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 members who currently receive case management services 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 and outpatient behavioral health clinics currently providing case management 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 anticipates that the proposed changes would result in approximately \$8,447,984 Total; \$3,500,000 State share savings for SFY2018 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 may be potential adverse effects on small business in Oklahoma. Limiting the amount of behavioral health case management reimbursable by SoonerCare will have a direct effect on a provider agency's total reimbursement which would result in a loss of revenue.

- 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 limiting the amount of billable behavioral health case management 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 provider reimburse rate reductions for all behavioral health services in order to meet its constitutional requirement of filing a balanced budget. These reductions would be in addition to the significant provider rate cuts implemented in SFY 2016. Reducing rates again 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 June 23, 2017.

**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

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

(1) **Description of behavioral health case management services.** Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age 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 subject to 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 ODMHSAS. In

order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The provider will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than 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 than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse

behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

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

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

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

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

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

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

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

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

- (vii) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they

become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(viii) Behavioral Health Case Management is available to individuals transitioning from institutions to the community (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions). Individuals are considered to be transitioning to the community during the last 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 30 - 35 members. Basic case management/resource coordination is limited to ~~twenty-five (25)~~ sixteen (16) units per member per month/year. Additional units may be authorized up to 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 (including members in PACT programs) and Wraparound Facilitation Case Management (WFCM) is targeted to children with serious mental illness and emotional disorders (including members in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a

facilitator can facilitate between eight (8) and ten (10) families. To ensure that these intense needs are met, case manager caseloads are limited between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of two (2) years Behavioral Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS six (6) hours ICM training, and twenty-four (24) hour availability is required. ICM/WFCM is limited to fifty-four (54) units per member per month.

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

- (A) physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;
- (B) managing finances;
- (C) providing specific services such as shopping or paying bills;
- (D) delivering bus tickets, food stamps, money, etc.;
- (E) counseling, rehabilitative services, psychiatric assessment, or discharge planning;
- (F) filling out forms, applications, etc., on behalf of the member when the member is not present;
- (G) filling out SoonerCare forms, applications, etc.;
- (H) mentoring or tutoring;
- (I) provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;
- (J) non-face-to-face time spent preparing the assessment document and the service plan paperwork;
- (K) monitoring financial goals;
- (L) services to nursing home residents;
- (M) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or
- (N) services to members residing in ICF/IID facilities.

(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 OKDHS/OJA staff without special arrangements with OKDHS, OJA, and 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 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 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.

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