



**STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY**

TRIBAL CONSULTATION MEETING

AGENDA

11 AM, JANUARY 6, 2015

BOARD ROOM

4345 N. LINCOLN BLVD.

OKLAHOMA CITY, OK 73105

1. Welcome—Dana Miller, Director of Tribal Relations
2. Proposed Rule Changes—Sandra Puebla, Senior Policy Specialist
 - 14-05 Member Copayments
 - 14-09 SoonerCare Choice Policy Change
 - 14-17 Moving to an SSI Criteria State for Determining Medicaid Eligibility for Aged, Blind, and Disabled Individuals
 - 14-18 Policy Change for State Plan Personal Care Services
 - 14-20 Hospital Presumptive Eligibility
 - 14-22 Update to DME Policy
 - 14-25 Dental
 - 14-29A&B Lock-in policy clean up
 - 14-33 Tax Equity Fiscal Responsibility Act (TEFRA) Program
 - 14-35 DMEPOS Free Choice
 - 14-36 Long-term Care Eligibility
 - 14-44 Electronic Notices
 - 14-46A&B Developmental Disabilities Services (DDS)
 - 14-49 Insure Oklahoma Eligibility
 - 14-50 Telemedicine
 - 14-52A&B SoonerRide
 - 14-58 High Risk Obstetrical Services
 - 14-60 Federal Qualified Health Centers (FQHC)

3. Behavioral Health Proposed Rule Changes—Traylor Rains, Director, Policy & Planning, ODMHSAS

- 14-13 Psychosocial Rehabilitation (PSR) Service Eligibility Criteria
- 14-38 Individual Plan of Care
- 14-39 Therapeutic Foster Care
- 14-40 Rehab Day Program Progress Note
- 14-42 History and Physical Evaluation
- 14-45 Psychiatric Residential Treatment Programs Staffing Ratios
- 14-47 First Visit by the Physician in Active Treatment
- 14-48 Targeted Case Management
- 14-53 Mental Health Substance Use Screenings
- 14-55 Distinction between LBHPs and Candidates

4. Proposed 1115(a) SoonerCare and Insure Oklahoma Waiver Change—Melinda Thomason

5. Other Business—Dana Miller, Director of Tribal Relations

6. Adjourn—Next Tribal Consultation Scheduled for 11 AM, March 3, 2015

2. PROPOSED RULE CHANGES

14-05 Policy Change for Member Copayments — These rule were reviewed during the emergency rule process with the exception of the following changes: policy is amended to add diabetic supplies and smoking cessation counseling and products to the service copayment exemption list in order to ensure member access to necessary services that improve member health outcomes.

14-09 SoonerCare Choice Policy Change — These rule changes were reviewed during the emergency rule process with the exception of the following change: children in the former foster care eligibility group are excluded from participation in SoonerCare Choice; children who are known to be in OKDHS custody are now eligible to participate in SoonerCare Choice.

14-17 Moving to an SSI Criteria State for Determining Medicaid Eligibility for Aged, Blind, and Disabled (ABD) Individuals — These rule changes were reviewed during the emergency rule process with the exception of the following changes: rules regarding income received from capital resources and rental property are amended to deduct the severance tax from the gross income for ABD applicants. Rules regarding infrequent or irregular income are amended to align with the Social Security Administration rules for determining Supplemental Security Income.

14-18 Policy Change for State Plan Personal Care Services — Rules for the State Plan Personal Care services are amended to align with current procedures that are in place at OKDHS. Changes include: policy clean up to remove unnecessary language regarding personal care service settings, the criteria for persons eligible to serve as Personal Care Assistants, and minor changes to administration of the State Plan Personal Care services.

14-20 Hospital Presumptive Eligibility — Hospital Presumptive Eligibility (HPE) rules are added to comply with Section 1920A of the Act and federal regulations 42 CFR 435.1100-1110. HPE allows participating hospitals to make presumptive eligibility (PE) determinations, on behalf of the agency, for applicants who are deemed eligible for Medicaid services based on preliminary information provided by the applicant. Hospitals may then provide services under HPE and bill OHCA. Hospitals are guaranteed payment for HPE services, regardless of whether or not the applicant is later found eligible for SoonerCare. The rules will delineate the parameters of the HPE program, eligibility guidelines, and hospital participation rules.

14-22 Update to DME Policy — Policy is revised to update Part 17 (Medical Suppliers) in Chapter 30 to clarify rules for durable medical equipment (DME) services. Changes include updating billing and prior authorization requirements for DME items, updating the list of DME items that require a certificate of medical necessity, clarifying that repairs for rental DME items are not covered, and revising the definition of invoice.

14-25 Dental — These rule changes were reviewed during the emergency rule process with the exception of the following changes: proposed dental policy is revised to align practice with the Code on Dental Procedures and Nomenclature (CDT) and to ensure the delivery of dental services meets the standard of care. Proposed revisions include guidelines for x-rays, comprehensive and periodic oral evaluations, and dental sealants. Rules are revised to add coverage for the replacement of sealants;

current policy restricts coverage for replacement sealants when medically necessary. Revisions also include clean-up to remove language regarding composite and amalgam restorations as it is referenced in a different section. Proposed revisions outline guidelines for stainless steel crowns to clarify that placement is allowed once for a minimum period of 24 months as well as other clean-up for clarity.

14-29A&B Lock-in Policy Clean Up — Policy is revised to clean up language regarding the pharmacy lock-in program. Current policy locks members in to one primary physician and/or one pharmacy. Policy is revised to allow members to be locked in to an approved prescriber rather than a primary care physician and pharmacy.

14-33 Policy Change for the Tax Equity Fiscal Responsibility Act (TEFRA) Program — Policy is amended to change the TEFRA program eligibility rules to align with federal guidelines for level of care (LOC). Changes include replacing all TEFRA language regarding mental retardation or ICF/MR to individuals with intellectual disabilities or ICF/IID. Rules regarding ICF/IID LOC eligibility will change to match current DSM-5 and Social Security Act (SSA) guidelines regarding intellectual disabilities. Specific LOC criteria for determining both hospital and nursing facility will be added to coincide with the ICF/IID criteria. TEFRA rules will also allow one additional psychological evaluation after the age of six, as medically needed. Finally, the "Definitions" section is updated to include the term "Ineligible Spouse".

14-35 DMEPOS Free Choice — Rules for SoonerCare members' freedom of choice to select their provider of durable medical equipment, prosthetics, and orthotics supplies (DMEPOS) are amended to state that providers must inform members of this right when filling or ordering DMEPOS.

14-36 Long-term Care Eligibility — Rules are amended to align with 42 U.S. Code §1396p. Changes include increasing home equity maximum amount to \$500,000 plus the increase by the annual percentage increase in the urban component of the consumer price index and allowing the individual to decrease this equity interest through the use of a reverse mortgage or home equity loan. The term "relative" is removed from the home exemption rules for members who fail to return back home from a long-term care institution. The term "annuity" is changed to also include annuities purchased by, or on behalf of, an annuitant seeking long-term care services.

14-44 Electronic Notices — Rules are revised to allow electronic notices to be sent to SoonerCare members' designated email addresses. Members may actively select that they wish to receive electronic communications from the agency through the SoonerCare application. The agency will confirm that the member is informed of their right to change this election at any time, ensure that members receive mailed notice of this election, and that all notices are posted on the SoonerCare application for member viewing within one business day. In instances of failed electronic communications, the agency will notify the member, through the mail, of this failed correspondence and that action is necessary.

14-46A&B Developmental Disabilities Services (DDS) — Rules are revised to implement policy changes recommended during the Oklahoma Department of Human Services (DHS) Developmental Disabilities Services (DDS) annual policy review process. The recommendations will also assist DDS with being in full compliance with the new federal regulation for Home and Community-Based Services with regard

to members and their settings. Additionally, the proposed policy revisions will position DDS to utilize best practice in the administration of the statewide Request for Waiver Services list.

14-49 Insure Oklahoma Eligibility — In order to enhance the enrollment and eligibility process for Insure Oklahoma (IO), the methodology for determining IO eligibility, for both IP and ESI, is changing to the Modified Adjusted Gross Income (MAGI) methodology. This change will align the eligibility methodology for the IO program with that of SoonerCare and allow the Agency to move the IO program to the Online Enrollment platform to enroll members. The reasonable opportunity for SoonerCare members to obtain citizenship or alienage documentation will also be amended. In order to have an effective date of January 1, 2016, the MAGI transition will also require an amendment to the 1115 Demonstration Waiver.

14-50 Telemedicine — OHCA rules for telemedicine are revised to clarify the definition for telemedicine, and to remove the Definitions sections for consistency. Proposed changes also remove coverage guidelines to expand the scope of the telemedicine delivery method. Revisions remove requirements for a presenter at the distant site to align with the Oklahoma Medical Licensure rules, and guidelines regarding the required use of OHCA-approved telemedicine networks. Proposed revisions also eliminate the originating site fee payment. Additional clean-up ensures that there are no restrictions for services rendered using the telemedicine delivery model.

14-52A&B SoonerRide — Rules remove reference to inpatient under the exclusion group as this is not considered an eligibility criterion. Rules also remove coverage for transport to state Veterans Affairs hospitals as these facilities are not contracted with the Oklahoma Health Care Authority. Rules also clarify coverage guidelines for escorts.

14-58 High Risk Obstetrical Services — Rules are revised to allow general OB/GYN providers the ability to evaluate pregnant women for a defined list of high risk obstetrical services without a referral from a Maternal Fetal Medicine doctor.

14-60 Federal Qualified Health Centers (FQHC) — Rules are proposed to allow FQHCs to be reimbursed at the PPS rate immediately upon receiving their Health Resources and Services Administration (HRSA) grant award letter. Currently, OHCA requires the facility to submit the award letter and their Medicare certification number. In the interim, facilities contract as a clinic and are paid the fee for service (FFS) rate.

3. BEHAVIORAL HEALTH PROPOSED RULE CHANGES

14-13 Psychosocial Rehabilitation (PSR) Service Eligibility Criteria — These rules were reviewed but the following changes have been made: revisions to outpatient behavioral health rules to clarify that daily or weekly summary notes and related requirements are for rehab day programs only, to create distinction between licensed behavioral health professionals and licensure candidates, to clarify that group psychotherapy is not reimbursable, and other grammatical changes.

14-38 Individual Plan of Care — Inpatient psychiatric hospital policy is revised to clarify that the member's signature on the Individual Plan of Care is required at the time of completion. However, if

the member was too physically ill or their acuity level precluded them from signing the plan of care and/or the plan of care review at the time of completion, the member must sign the plan when their condition improves but before discharge. Rules are also revised to indicate that the Individual Plan of Care must adhere to the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

14-39 Therapeutic Foster Care — Policy is revised to indicate a 1.5 hours daily limit on services billed by the Treatment Parent Specialist (TPS) within the Therapeutic Foster Care (TFC) setting. This change in policy aligns with limitations delineated within the State Plan for this particular provider and setting.

14-40 Rehab Day Program Progress Note — Policy is revised to clarify that the daily or weekly summary notes and related requirements are for rehab day programs only. All other rehab should follow general progress note requirements and a note should be written per session.

14-42 History and Physical Evaluation — Policy is revised to reflect that the History and Physical (H&P) should be completed within 24 hours after admission into an inpatient psychiatric hospital. Rules are also amended to clarify that the psychiatric evaluation is performed by a psychiatrist. Further, rules are amended to clarify that the psychiatric evaluation is completed within 60 hours of admission. Rules are amended to clarify recoupment methodology when documentation is not in the member's file. Additionally, rules are amended to reflect a distinction of LBHPs and Licensure Candidates.

14-45 Psychiatric Residential Treatment Programs Staffing Ratios — Inpatient psychiatric hospital policy is revised to indicate that non-specialty Psychiatric Residential Treatment Facilities (PRTF) should have a staff to member ratio of 1:6 during wake hours and 1:8 during sleeping hours. Additionally, changes are made to clarify that staffing ratios should always be present for each individual unit not by facility or program. Other minor grammatical changes were made to the rule.

14-47 First Visit by the Physician in Active Treatment — Policy is revised to indicate that when the H&P or a combined H&P and psychiatric evaluation are completed by an allopathic or osteopathic physician with a current license and a board certification/eligible in psychiatry, the assessment(s) may count as the first visit by the physician in active treatment. Additionally, rules are revised to include a distinction between LBHPs and Licensure Candidates.

14-48 Targeted Case Management (TCM) — Policy is revised to add the State Plan authorized billing limits of 25 units per month for regular TCM and 54 units for intensive TCM. Rules are also amended to create a distinction between LBHPs and licensure candidates. Additionally, rules are revised to correct scrivener's errors made during the 2014 permanent rulemaking session.

14-53 Mental Health Substance Use Screenings — Policy is revised to reflect that screens are available for children and adults. Additionally, limitations will be added to rules to indicate that screens are only reimbursable once per member per year unless the client has experienced a break in service for over six months.

14-55 Distinction between LBHPs and Candidates — Outpatient behavioral health rules are revised to create distinction between licensed behavioral health professionals and licensure candidates.

4. PROPOSED 1115(A) SOONERCARE AND INSURE OKLAHOMA WAIVER CHANGE

OHCA will seek to amend the 1115 demonstration waiver to update the SoonerExcel payments list to include the current incentives.