OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
December 10, 2009
College of Osteopathic Medicine
1111 W. 17th Street
Dunlap Auditorium
Tulsa, OK
1:00 PM

A G E N D A

Item to be presented by Lyle Roggow, Chairman

1. Call To Order/Determination of quorum - Lyle Roggow, Chairman
2. Action Item - Approval of November 12, 2009 Board Minutes

Item to be presented by Mike Fogarty, Chief Executive Officer

3. Discussion Item - Chief Executive Officer's Report

    a) Financial Update - Carrie Evans
    b) Medicaid Director's Update - Lynn Mitchell, M.D.

Item to be presented by Chairman Roggow

4. Discussion & Action Item - Reports to the Board by Board Committees

    a) Audit/Finance Committee - Member Miller
    b) Rules Committee - Member Langenkamp
        i) Committee recommendation regarding study of Oklahoma community practice patterns

Items to be presented by Mike Fogarty, Chief Executive Officer

5. Action Items - Consideration and Vote Upon Benefit Reductions, Program Modifications, and Payment Reductions made to allow the Oklahoma Health Care Authority to comply with Article 10, Section 23 of the Oklahoma Constitution

    a) Announcement of Conflicts of Interest Panel Recommendations regarding Benefit, Payment and Program Modifications to Achieve a Balanced Budget
    Nicole Nantois, Deputy General Counsel

    b) Agency Recommendation of Benefit Reductions, Program Modifications and Payment Reductions to achieve a balanced budget - See attached SFY2010 Budget Reduction Analysis and Staff Recommendation

6. Action Item - Consideration and Vote of agency recommended rulemaking pursuant to Article I of the Administrative Procedures Act and To Implement the Action Taken on Item 5.b above

    a) Announcement of Conflicts of Interest Panel Recommendation
    Nicole Nantois, Deputy General Counsel

b) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of *all Emergency Rules* in accordance with 75 Okla. Stat. § 253.

c) Consideration and Vote Upon promulgation of Emergency rules as follows:

6C-1. AMENDING agency rules at OAC 317:30-5-211.10, 30-5-211.12, 30-5-211.15, 30-5-218 and 30-5-547 to reduce and/or eliminate certain durable medical equipment benefits to adults. Revisions include the elimination of osteogenic stimulators, portable oxygen contents, the reduction of blood glucose strips and lancets without a prior authorization, and provides for periodic review and adjustments of the Agency's fee schedule.
(Reference APA WF # 09-76)

6C-2. AMENDING agency rules at OAC 317:30-3-57 and 30-5-72 to reduce the number of allowed brand name prescription drugs from three to two per month for SoonerCare members.
(Reference APA WF # 09-74)

6C-3. AMENDING agency rules at OAC 317:30-3-5 to increase existing co-payments for certain medical benefits provided through SoonerCare as well as require co-pays for additional benefits.
(Reference APA WF # 09-73)

6C-4. ADDING a new agency rule at OAC 317:30-3-61 to establish policy for serious reportable events in healthcare, also called never events. Rules will non-cover three surgical errors and set billing policy to implement appropriate claims processing. The three surgical errors are (1) wrong surgical or other invasive procedures performed on a member, (2) surgical or other invasive procedures performed on the wrong body part, and (3) surgical or other invasive procedures performed on the wrong member. Rules will also include a related claims review (if appropriate) and the avoidance of SoonerCare to act as a secondary payer for Medicare non-payment of the three surgical errors.
(Reference APA WF # 09-51)

Items to be presented by Cindy Roberts, Deputy Chief Executive Officer

7. Action Item – Consideration and Vote on agency recommended rulemaking pursuant to Article 1 of the Administrative Procedures Act

a) Announcement of Conflicts of Interest Panel Recommendation
Nicole Nantois, Deputy General Counsel

b) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of Emergency Rules in accordance with 75 Okla. Stat. § 253

c) Consideration and Vote Upon promulgation of Emergency rules as follows:

7C-1 AMENDING agency rules at OAC 317:35-5-25, 35-6-60, and 35-6-61 regarding coverage for deemed newborns to comply with provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3. **(Reference APA WF # 09-55)**

7C-2 AMENDING agency rules at OAC 317:30-5-14 to allow for a separate payment to be made to providers for the administration of pandemic virus vaccine to both adults and children. This change was brought about by the CMS mandate that State Medicaid agencies reimburse providers for the administration of the 2009 H1N1 flu vaccine. **(Reference APA WF # 09-70)**

7C-3 AMENDING agency rules at OAC 317:30-5-25 and 30-5-42.1 to clarify the intent of reimbursement for implantable devices inserted during the course of a surgical procedure. Separate payment will be made for implantable devices, but only when the implantable device is not included in the rate for the procedure to insert the device. **(Reference APA WF # 09-60)**

7C-4 AMENDING agency rules at OAC 317:30-5-1040, 30-5-1041, 30-5-1042, 30-5-1043, 30-5-1044, 30-5-1046, and 30-5-1047. These rule revisions change the status of the Office of Juvenile Affairs from an Organized Health Care Delivery System to a Foster Care Agency. **(Reference APA WF # 09-69)**

7C-5 AMENDING agency rules at OAC 317:30-5-764, 30-5-950, 35-15-13.2, and 35-17-22 to add Case Management and Case Management for Transitioning to the list of services that must be documented utilizing the Interactive Voice Response Authentication (IVRA) system in the ADvantage waiver. **(Reference APA WF # 09-65)**

Items to be presented by Cindy Roberts, Chairperson of Rates and Standards Committee

8. Action Item - Consideration and Vote Upon the recommendations of the Rates and Standards Committee

a) Announcement of Conflicts of Interest Panel Recommendation Nicole Nantois, Deputy General Counsel

b) Consideration and Vote Upon proposal to establish the threshold for each measurement in the Focus on Excellence program to specific targets for nine of the ten indicators.

i) Agency request to consider a stay regarding Medicare Utilization factor - Mike Fogarty, Chief Executive Officer

c) Consideration and Vote Upon proposal to change the methodology for adjusting rates to factors of $.32 per day, $.22 per day and $.20 per day for each percentage point COLA adjustment to Social Security for Nursing Facilities, ICFs/MR and Acute Care (16 bed or less) ICFs/MR, respectively

Item to be presented by Nancy Nesser, PharmD. JD, Pharmacy Director

9. Action Item - Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under 63 Oklahoma Statutes § 5030.3.

a) Recommendation Regarding Conflicts of Interest Panel Concerning Recommendations of the Drug Utilization Review Board, Nicole Nantois, Deputy General Counsel

b) Consideration and vote to add Otic Anti-Infective Products to the product-based prior authorization program under OAC 317: 30-5-77.3.

c) Consideration and vote to add prasugrel (Effient™) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e)

Item to be presented by Chairman Roggow

10. Discussion Item - Proposed Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meetings Act, 25 Okla. Stat. § 307(B)(1),(4)&(7)

Status of Pending Suits and Claims

1.	Price v. Wolford	09-6139 (Tenth Circuit)
2.	Wright v. OHCA	CJ-09-3924 (Oklahoma County)
3.	Moss v. Wittmer	104,607 (Okla. S.Ct.)
4.	OHCA v. Henry, et al.	107,705 (Okla. S.Ct.)
5.	Cole and Russell v. OHCA	CJ-07-025 (Dewey County)
6.	Schnoebelen v. OHCA	CJ-08-007 (Woodward County
7.	McAlary v. OHCA	CJ-08-021 (Dewey County)
8.	St. John v. OHCA	CJ-08-043 (Major County)
9.	Morris v. OHCA	CJ-08-071 (Dewey County)
10.	Daily v. OHCA	CJ-08-085 (Dewey County)
11.	Moore v. OHCA	CJ-08-088 (Dewey County)
12.	Decker (Lightning Creek) v. OHCA	CJ-08-105 (Major County)
13.	Stevens v. OHCA	CJ-08-151 (Woodward County)
14.	Hedrick v. OHCA	CJ-09-026 (Dewey County)
15.	McClellan v. OHCA	CJ-09-081 (Major County)
16.	Rutledge v. OHCA	CJ-09-155 (Woodward County)

11. Action Item - Consideration and Vote upon board meeting dates, times, and places for the Oklahoma Health Care Authority Board for calendar year 2010.

12. New Business

13. Adjournment

Proposed Next Board Meeting
January 14, 2010
Oklahoma Health Care Authority
Oklahoma City, OK

BOARD AGENDA ATTACHMENT 5.b

Oklahoma Health Care Authority
SFY10 Budget Reduction Analysis and Staff Recommendations

FY-2010 Proposed Budget Reductions	Agenda Rule No.	Annual Impact	FY2010 Impact Total	FY2010 Impact State	* Staff Recommend.
Administration					
* 5% Administration Reduction		6,318,004	5,791,504	2,895,752	2,895,752
Dental					
* Reduce payment for posterior fillings to amalgam rate		10,092,897	5,046,449	1,795,022	1,795,022
Eliminate dental for pregnant women		3,812,596	1,906,298	678,070	
Durable Medical Equipment (DME)	6C - 1				
* Pricing adjustments for oxygen and capped rental (eff. 1/1/10)		1,000,000	500,000	177,850	177,850
* Reduce oxygen payment rates for adults		945,539	472,770	168,164	168,164
* Pricing adjustments for children's nebulizers and eliminate adult nebulizers		1,060,584	530,292	188,625	188,625
* Restrict number of blood glucose test strips w/out a PA to 100 strips		1,528,284	764,142	271,805	271,805
* Eliminate other adult products		717,814	358,907	127,663	127,663
Negative pressure wound therapy pump, blood glucose monitors, osteogenic stimulators, portable oxygen contents, form fitting conductive garments, etc.					934,108
Pharmacy					
* Change script limit to 2 brand + 4 generic for non-waiver adults	6C - 2	3,220,000	1,610,000	572,677	572,677
This also includes the loss of related drug rebate revenue					
* Utilization management of triptans, otics, fibromyalgia, and antipsychotics eff. 4/01/10		7,000,000	1,750,000	622,475	622,475
* Revised reimbursement methodology for certain injectable drugs		2,600,000	1,300,000	462,410	462,410
Provider Payment Changes					
Equalize payment reimbursement for C-sections & vaginal deliveries					
Facility (C-Sec 30% decrease; Vaginal 15% increase)		4,359,738	2,179,869	775,379	
Physician (C-Sec 10% decrease; Vaginal 5% increase)		1,053,499	526,749	187,365	
Crossover Co-insurance & Deductible					
* Hospitals					
Co-insurance - 75% decrease (80% outpatient claims)		31,782,442	11,918,416	4,239,380	4,239,380
Deductible - 25% decrease (95% inpatient claims)		8,339,266	3,127,225	1,112,354	1,112,354
Lab		881,653	440,826	156,802	
Behavioral Health utilization controls					
* Implement cost caps for levels 3 & 4 (25% reduction)		3,542,568	1,771,284	630,046	630,046
* Modify payment methodology to tiered reimbursement (4/01/10) for Psychiatric Residential Treatment Facilities (PRTF's)		5,387,371	1,795,790	638,763	638,763
* Increase member's co-pay not to exceed federal maximum (eff. 4/01/10) Dental, Home Health, Pharmacy, DME, Inpatient, Adult BH	6C - 3	2,453,578	613,395	218,184	218,184
Eliminate reimbursement for newborn circumcision		1,858,621	929,311	330,556	
Modifying hospital payments for patient transfers		1,935,885	967,943	344,297	
ER visits limited to 3 paid visits per year (non-pregnant adults)		8,430,148	4,215,074	1,499,302	
* Eliminate Modifier 57 code (separate payment for E&M and procedure codes)		228,414	114,207	40,623	40,623
* Eliminate separate payment (impacted earwax)		190,108	95,054	33,811	33,811
Eliminate outpatient adult therapies (OT, PT, speech)		1,229,280	614,640	148,558	
* Never events / present on admission	6C - 4		(pending analysis)		
Modify EPSDT periodicity schedule			(pending analysis)		
Provider Rate Reductions (1%)					
Hospital		8,487,842	4,243,921	1,509,563	
Physician		3,438,043	1,719,021	611,456	
Nursing Facilities		5,184,531	2,592,266	922,069	
Other Providers		3,355,675	1,677,837	596,807	
Behavioral Health		2,494,953	1,247,476	443,727	
Subtotal Provider Rate Reductions		22,961,043	11,480,522	4,083,622	
Quality Assurance & Program Integrity					
* Medical necessity inpatient review		395,624	197,812	70,362	70,362
* Eliminate split billing			(pending analysis)		
* Improving inpatient payment accuracy/1 day stay		8,800,000	7,300,000	2,596,610	2,596,610
					16,862,576

Notes

* Indicates staff recommendations

All budget reduction estimates assume a 1/01/10 implementation date unless otherwise noted

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE OKLAHOMA HEALTH CARE AUTHORITY BOARD
Held at Oklahoma Health Care Authority
November 12, 2009
1:00PM

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on November 9th, 2009.

Pursuant to a roll call of the members, a quorum was declared to be present, and Vice-Chairman Roggow called the meeting to order at 1:02pm.

BOARD MEMBERS PRESENT:	Vice Chairman Armstrong, Member Miller, Member McVay, and Chairman Roggow
ABSENT:	Member Langenkamp Member McFall
OTHERS PRESENT:	Rebecca Moore, OAHCP Samantha Gallaway, OKDHS Charles Brodt, EDS/HP Brent Wilborn, OKPCA April Wilkerson, Journal Record Sandra Harrison, OKDHS Ellen Huffmaster

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD OCTOBER 8, 2009

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION:	Vice Chairman Armstrong moved for approval of the October 8, 2009 board minutes as presented. Member Miller seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, and Chairman Roggow
ABSENT:	Member Langenkamp Member McFall

ITEM 4/PRESENTATION OF THE ALL STAR EMPLOYEES FOR THE MONTHS OF AUGUST AND SEPTEMBER 2009

Care Management Supervisor Jennifer Trevino presented Maria Arroyo of Care Management as the August 2009 All Star Employee Recipient, and Rene Davis, Care Management as the September 2009 All Star Employee Recipient.

FINANCIAL UPDATE
Carrie Evans

Ms. Evans stated the revenues for OHCA through September, accounting for receivables, were **$930,412,276** or **.7% under** budget. Expenditures for OHCA, accounting for encumbrances, were **$870,128,950** or **1.2% under** budget. The state dollar budget variance through September is **$4,232,742 positive.** The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	1.0
Administration	1.3
Revenues:	
Taxes and Fees	1.2
Drug Rebate	.3
Overpayments/Settlements	.4
Total FY 09 Variance	$ 4.2

MEDICAID DIRECTOR'S UPDATE
Lynn Mitchell, M.D.

Dr. Mitchell stated that the bar graph and line graph both reflect continued steep enrollment. We continue to see between7, 000-8,000 new members monthly and do not anticipate those numbers leveling off anytime soon. In January we had 618,000 members and currently are at 670,000. Several of OHCA supervisors just returned from the NASMD meeting in Washington, and along with Healthcare Reform one of the topics that gained a lot of momentum was the workforce and the issue of provider capacity in general. She stated that OHCA provider capacity is tracked and currently we are about 40% capacity in the SoonerCare Choice program with room to grow. Dr. Mitchell stated that the Insure Oklahoma numbers are at 28,028. She then presented the rest of the reports. For detailed information see Item 4B of the packet.

Mr. Fogarty discussed the 10th annual report and stated there were copies for everyone. He recognized Ms. Connie Steffee for her efforts in putting together this report.

ITEM 5/STATE FISCAL YEAR 2010-2011 BUDGET PROJECTIONS; IMPACT ON OHCA'S BUDGET
Carrie Evans

Ms. Evans stated that like every other state agency we are preparing for budget reductions by 5% or more for the remainder of this fiscal year. To date we have been able to accommodate those reductions. It is also important to mention that any reduction in state dollars also results in corresponding reduction in federal dollars. Currently, for every dollar spent it results in a $3.00 loss of federal funds for a

total of $4.00 to our program. Ms. Evans stated that the 5% reduction for 11 months for the fiscal year would amount to $26.6 million in state dollars for a total of $110 million for the year. We have already been able to absorb $9.8 million leaving an additional of $16.8 million to still be reduced. We are hearing some reports that it could be 7.5% or 10% reduction in future months. If we have to accommodate those kinds of reductions, that would be a total of $36.2 million in state dollars. The $8.9 million reduction has been achieved without any reductions in services primarily due to $7.3 million in savings available from prior year unbudgeted carryover and lower than estimated growth in the 3 months of this fiscal year. The other $1.8 million was made available due to a settlement on a national class action lawsuit of pharmacy pricing and this resulted in a reduction of payments to pharmacists. Ms. Evans stated there will be another $700,000 made available January 1, 2010 because of a pricing change in codes for certain injectable drugs. In addition to programs cuts, the agency will be making corresponding administrative cuts of 5% as well for the 11 months which is a total state dollar of $2.8 million. We are striving to make this process as transparent and interactive as possible. She said that the agency has been working internally and externally to develop budget savings ideas that minimize the impact on patient care and access to care. We plan to meet and have met externally with several of our contracted provider groups and consumer advocates in an effort to share ideas and get feedback. She stated that OHCA met about a week ago with the agency's 5 largest provider groups. This is the first of which we expect to be several meetings to gain their input. Ms. Evans noted that we will be meeting with the internal groups (DUR, MAC, MAT, Behavioral Health and Perinatal Task Force) and all parties impacted by the cuts. She said that we will be coming up with recommendations to present at the board meeting December 10. As the result of receiving federal stimulus monies we are unable to cut any eligibility standards which leaves only provider rates and reducing services. We are required under Medicaid law to provide mandatory benefits. Several of the optional programs include pharmacy, DME and dental for adults. Ms. Evans noted that this analysis is a working document and then presented the reductions/cost savings in each category from the document. For the reduction analysis document, see Item 4a of the board packet.

Mr. Fogarty stated that this is just a beginning point. It is intended to provide this board with the benefit of conversations that have already taken place internally and externally and is very early in the development. The point is if we could come up with $12 million in reductions in benefit then we would be left with $4-5 million yet to go that we could look to provider rate reductions. This is intended to generate some comments and questions and let the board know the nature of the kinds of things that staff is looking at in terms of options that will possibly have to be presented to the Board in December. Chairman Roggow asked if we are looking at ranking to a degree or impact on number of individuals. Mr. Fogarty replied that it is fairly easy to tell how many people would be affected by a particularly cut in terms of a benefit being used. The staff will provide the board with enough information in order to make appropriate decisions. Mr. Fogarty stated that this is a buffet list which is constantly being updated as information becomes available. Vice Chairman Armstrong asked about what the hospital association's input has been regarding cuts. Mr. Gomez stated the first meeting was last Thursday and the feedback is a

sense of understanding and appreciation of the process we are trying to go through. There were a lot of questions and the meeting was productive. The associations are working on recommendations to present at next week's meeting. Mr. Fogarty stated that the providers were willing to take on some of the tough, but necessary cuts.

Chairman Roggow presented the new assignments for the upcoming year to the Audit/Finance Committee, Rules Committee, Legislative Committee and Strategic Committee. The Chair for the Audit/Finance Committee is George Miller along with Vice Chairman Armstrong and Chairman Roggow. The Chair of the Rules Committee is Sandra Langenkamp along with Mel McVay and the new appointee when made available. Chairman of the Strategic Planning is Vice Chairman Armstrong along with Ed McFall and Chairman Roggow. Chair of the Legislative Committee is Ed McFall along with Sandra Langenkamp and Mel McVay.

ITEM 6/REPORTS TO THE BOARD BY BOARD COMMITTEES
Chairman Roggow

Member Miller of the Finance/Audit Committee reported that the committee did not meet but that he has been attending some of the provider meetings regarding budget cuts as well as Member Langenkamp of the Rules Committee.

Vice-Chairman Armstrong stated that the Rules Committee did not meet.

ITEM 7/CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES § 5030.3.

Mr. Pallotta stated the Conflicts of Interest Panel met with regards to Item 7B, Item 8B and found no conflicts.

ITEM 7B/CONSIDERATION AND VOTE TO ADD FIBROMYALGIA TREATMENT PRODUCTS TO THE PRODUCT-BASE PRIOR AUTHORIZATION PROGRAM UNDER OKLAHOMA ADMINISTRATIVE CODE 317: 30-5-77.3.
Nancy Nesser, PharmD., Pharmacy Director

Dr. Nesser stated that DUR recommends placing Fibromyalgia products into the Product Based Prior Authorization Program.

MOTION: Vice Chairman Armstrong moved for approval of Item 7B as presented. Member McVay seconded.

FOR THE MOTION: Vice Chairman Armstrong, Member McVay, Member Miller, and Chairman Roggow

ABSENT: Member Langenkamp
Member McFall

ITEM 8B/CONSIDERATION AND VOTE UPON DECLARATION OF A COMPELLING PUBLIC INTEREST FOR THE PROMULGATION OF ALL EMERGENCY RULES IN ACCORDANCE WITH 75 OKLA. STAT. 253

Cindy Roberts

CONSIDERATION AND VOTE UPON DECLARATION OF A COMPELLING PUBLIC INTEREST FOR THE PROMULGATION OF ALL EMERGENCY RULES IN ACCORDANCE WITH 75 OKLA. STAT. 253

MOTION: Member Miller moved for declaration. Vice Chairman Armstrong seconded.

FOR THE MOTION: Vice Chairman Armstrong, Member McVay, Member Miller, and Chairman Roggow

ABSENT: Member Langenkamp
Member McFall

Ms. Roberts presented Emergency Rules 8C-1 through 8C-5 as detailed on agenda. All of the rules are budget neutral.

MOTION: Vice Chairman Armstrong moved for declaration of emergency for Rules 8C-1 through 8C-5. Member McVay seconded.

FOR THE MOTION: Vice Chairman Armstrong, Member McVay, Member Miller, and Chairman Roggow

ABSENT: Member Langenkamp
Member McFall

8D1/CONSIDERATION AND VOTE OF NON-ADMINISTRATIVE PROCEDURES ACT RULE CHANGE

Ms. Roberts stated that occasionally we have items that we feel are important to put in our rules. This has to do with rules to strengthen reporting the agency's ethics. There are certain clinical staff that work outside of OHCA at physicians' offices, clinics, etc. and also provide prior authorization and review work for the agency. This is to make sure there is no conflict of interest and that we are appropriately reporting where everyone works and have transparency and accountability in what we do.

MOTION: Member Miller moved for approval of Rule 8D1. Vice Chairman Armstrong seconded.

FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, and Chairman Roggow
ABSENT:	Member Langenkamp Member McFall

ITEM 9/DISCUSSION ITEM - PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLA. STATE. §307(B)(1),(4)&(7)

Howard Pallotta, Director of Legal Services

MOTION:	Member McVay moved for executive session. Vice Chairman Armstrong seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, and Chairman Roggow
ABSENT:	Member Langenkamp Member McFall

NEW BUSINESS

None

ADJOURNMENT

MOTION:	Vice Chairman Armstrong moved for adjournment. Member McVay seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, and Chairman Roggow
ABSENT:	Member Langenkamp Member McFall

oklahoma health care authority

FINANCIAL REPORT

For the Four Months Ended October 31, 2009
Submitted to the CEO & Board
December 10, 2009

- Revenues for OHCA through October, accounting for receivables, were **$1,198,275,037** or **.2% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,135,426,771** or **.5% under** budget.
- The state dollar budget variance through October is **$3,471,747 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	(3.1)
Administration	2.6
Revenues:	
Taxes and Fees	2.4
Drug Rebate	1.4
Overpayments/Settlements	.2
Total FY 10 Variance	**$ 3.5**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2010, for the Four Months Ended October 31, 2009

REVENUES	FY10 Budget YTD	FY10 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 277,401,330	$ 277,401,330	$ -	0.0%
Federal Funds	702,457,445	693,314,363	(9,143,082)	(1.3)%
Tobacco Tax Collections	16,518,790	18,836,241	2,317,451	14.0%
Quality of Care Collections	17,237,016	17,215,750	(21,266)	(0.1)%
Prior Year Carryover	23,404,558	23,404,558	-	0.0%
Drug Rebates	52,226,894	56,346,002	4,119,108	7.9%
Medical Refunds	10,344,098	11,748,988	1,404,890	13.6%
Other Revenues	5,797,883	4,926,869	(871,014)	(15.0)%
Stimulus Funds	95,080,936	95,080,936	-	0.0%
TOTAL REVENUES	**$ 1,200,468,950**	**$ 1,198,275,037**	**$ (2,193,913)**	**(0.2)%**

EXPENDITURES	FY10 Budget YTD	FY10 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 13,389,002**	**$ 12,708,372**	**$ 680,630**	**5.1%**
ADMINISTRATION - CONTRACTS	**$ 38,512,545**	**$ 26,303,721**	**$ 12,208,824**	**31.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	320,109,902	312,266,921	7,842,981	2.5%
Acute Fee for Service Payments:				
Hospital Services				
Behavioral Health	88,053,749	92,003,914	(3,950,165)	(4.5)%
Physicians	151,805,426	152,235,841	(430,415)	(0.3)%
Dentists	51,915,342	56,593,029	(4,677,687)	(9.0)%
Other Practitioners	14,862,180	16,022,490	(1,160,310)	(7.8)%
Home Health Care	6,384,581	6,905,831	(521,250)	(8.2)%
Lab & Radiology	8,291,007	9,589,471	(1,298,463)	(15.7)%
Medical Supplies	19,866,181	18,480,998	1,385,183	7.0%
Ambulatory Clinics	20,688,440	25,967,205	(5,278,764)	(25.5)%
Prescription Drugs	123,367,966	124,923,500	(1,555,535)	(1.3)%
Miscellaneous Medical Payments	10,286,047	9,795,213	490,834	4.8%
Other Payments:				
Nursing Facilities	175,683,578	174,660,062	1,023,516	0.6%
ICF-MR Private	19,008,960	18,717,399	291,561	1.5%
Medicare Buy-In	38,472,947	38,385,700	87,247	0.2%
Transportation	8,562,091	8,595,107	(33,016)	(0.4)%
Part D Phase-In Contribution	22,123,567	22,185,771	(62,204)	(0.3)%
Total OHCA Medical Programs	**1,089,150,757**	**1,096,414,678**	**(7,263,921)**	**(0.7)%**
OHCA Non-Title XIX Medical Payments	40,128	-	40,128	0.0%
TOTAL OHCA	**$ 1,141,092,432**	**$ 1,135,426,771**	**$ 5,665,661**	**0.5%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 59,376,518**	**$ 62,848,266**	**$ 3,471,747**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year Ended 2010, for the Four Months Ended October 31, 2009

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other Stat Agencies
SoonerCare Choice	9,187,946	9,074,631	-	101,718	-	11,597	
Inpatient Acute Care	245,037,346	212,742,636	121,672	3,242,193	16,648,014	2,073,201	10,209,63
Outpatient Acute Care	83,014,125	77,820,447	10,401	2,332,726	-	2,850,551	
Behavioral Health - Inpatient	45,934,264	44,338,990	-	-	-	-	1,595,27
Behavioral Health - Outpatient	2,864,855	2,864,855	-	-	-	-	
Behavioral Health Facility- Rehab	52,204,274	44,576,321	-	45,313	-	43,553	7,539,087
Behavioral Health - Case Management	180,195	179,952	-	-	-	243	
Residential Behavioral Management	8,992,089	-	-	-	-	-	8,992,089
Targeted Case Management	17,814,499	-	-	-	-	-	17,814,499
Therapeutic Foster Care	-	-	-	-	-	-	-
Physicians	166,968,899	125,963,425	14,525	3,488,282	21,130,851	5,127,040	11,244,776
Dentists	56,593,986	53,633,243	-	957	2,878,881	80,905	-
Other Practitioners	16,115,342	15,622,702	111,591	92,852	268,187	20,009	-
Home Health Care	6,905,863	6,876,099	-	32	-	29,732	-
Lab & Radiology	10,035,794	9,247,014	-	446,324	-	342,457	-
Medical Supplies	18,655,402	17,648,594	724,370	174,404	-	108,033	-
Ambulatory Clinics	29,350,684	25,689,552	-	336,171	-	277,653	3,047,308
Personal Care Services	4,208,698	-	-	-	-	-	4,208,698
Nursing Facilities	174,660,062	123,631,710	36,946,276	-	14,078,371	3,705	-
Transportation	8,595,107	7,946,834	627,544	-	15,575	5,154	-
GME/IME/DME	46,126,649	-	-	-	-	-	46,126,649
ICF/MR Private	18,717,399	13,901,117	4,529,515	-	286,767	-	-
ICF/MR Public	19,057,115	-	-	-	-	-	19,057,115
CMS Payments	60,571,471	59,118,968	1,452,503	-	-	-	-
Prescription Drugs	128,465,169	109,813,228	-	3,541,669	13,866,935	1,243,337	-
Miscellaneous Medical Payments	9,795,213	9,299,454	-	-	438,771	56,988	-
Home and Community Based Waiver	54,171,937	-	-	-	-	-	54,171,937
Homeward Bound Waiver	32,288,583	-	-	-	-	-	32,288,583
Money Follows the Person	380,270	-	-	-	-	-	380,270
In-Home Support Waiver	8,873,149	-	-	-	-	-	8,873,149
ADvantage Waiver	71,072,606	-	-	-	-	-	71,072,606
Family Planning/Family Planning Waiver	2,207,477	-	-	-	-	-	2,207,477
Premium Assistance*	15,635,139	-	-	15,635,139	-	-	-
Total Medicaid Expenditures	**1,424,681,608**	**969,989,774**	**44,538,396**	**29,437,780**	**69,612,351**	**12,274,157**	**298,829,150**

* Includes $15,635,139 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2010, for the Four Months Ended October 31, 2009

REVENUE	FY10 Actual YTD
Revenues from Other State Agencies	$ 62,575,542
Federal Funds	225,760,045
TOTAL REVENUES	**$ 288,335,587**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	$ 54,171,937
Money Follows the Person	380,270
Homeward Bound Waiver	32,288,583
In-Home Support Waivers	8,873,149
ADvantage Waiver	71,072,606
ICF/MR Public	19,057,115
Personal Care	4,208,698
Residential Behavioral Management	7,014,681
Targeted Case Management	12,805,287
Total Department of Human Services	**209,872,327**
State Employees Physician Payment	
Capitation Payments	-
Physician Payments	11,244,776
Total State Employees Physician Payment	**11,244,776**
Education Payments	
Graduate Medical Education	13,008,934
Graduate Medical Education - PMTC	928,226
Indirect Medical Education	28,137,940
Direct Medical Education	4,051,549
Total Education Payments	**46,126,649**
Office of Juvenile Affairs	
Targeted Case Management	921,731
Residential Behavioral Management - Foster Care	39,656
Residential Behavioral Management	1,937,753
Multi-Systemic Therapy	1,753
Total Office of Juvenile Affairs	**2,900,893**
Department of Mental Health	
Targeted Case Management	40,346
Hospital	1,595,274
Mental Health Clinics	7,539,087
Total Department of Mental Health	**9,174,707**
State Department of Health	
Children's First	892,317
Sooner Start	814,209
Early Intervention	2,159,400
EPSDT Clinic	899,911
Family Planning	43,506
Family Planning Waiver	2,142,086
Maternity Clinic	52,516
Total Department of Health	**7,003,945**
County Health Departments	
EPSDT Clinic	315,095
Family Planning Waiver	21,886
Total County Health Departments	**336,980**
State Department of Education	72,313
Public Schools	921,352
Medicare DRG Limit	9,106,106
Native American Tribal Agreements	965,577
Department of Corrections	224
JD McCarty	1,103,301
Total OSA Medicaid Programs	**$ 298,829,150**
OSA Non-Medicaid Programs	$ 3,244,514
Account Receivable from OSA	**$ 13,738,077**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2010, For the Four Months Ended October 31, 2009

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 12,773,429	$ 12,773,429
Interest Earned	14,729	14,729
TOTAL REVENUES	**$ 12,788,158**	**$ 12,788,158**

EXPENDITURES	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 46,480,142	$ 15,849,729	
Eyeglasses and Dentures	101,431	34,588	
Personal Allowance Increase	1,159,860	395,512	
Coverage for DME and supplies	965,827	329,347	
Coverage of QMB's	344,252	117,390	
Part D Phase-In	1,936,670	1,936,670	
ICF/MR Rate Adjustment	4,597,247	1,567,661	
Acute/MR Adjustments	1,391,526	474,510	
NET - Soonerride	835,969	285,065	
Total Program Costs	**$ 57,812,924**	**$ 20,990,473**	**$ 20,990,473**
Administration			
OHCA Administration Costs	$ 178,945	$ 89,472	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 178,945**	**$ 89,472**	**$ 89,472**
Total Quality of Care Fee Costs	**$ 57,991,868**	**$ 21,079,945**	
TOTAL STATE SHARE OF COSTS			**$ 21,079,945**

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 2010, for the Four Months Ended October 31, 2009

REVENUES	FY 09 Carryover	FY 10 Revenue	Total Revenue
Prior Year Balance	$ 37,974,903		$ 29,412,736
Tobacco Tax Collections	-	15,491,813	15,491,813
Interest Income	-	496,578	496,578
Federal Draws	-	9,923,408	9,923,408
All Kids Act	(8,000,000)		-
TOTAL REVENUES	**$ 29,974,903**	**$ 25,911,799**	**$ 55,324,535**

EXPENDITURES	FY 09 Expenditures	FY 10 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 15,635,139	$ 15,635,139
Individual Plan			
SoonerCare Choice		$ 101,718	$ 34,686
Inpatient Hospital		3,242,193	1,105,588
Outpatient Hospital		2,332,726	795,460
Behavioral Health - Inpatient Services		-	-
Behavioral Health Facility - Rehabilitation Services		45,313	15,452
Behavioral Health - Case Management		-	-
Physicians		3,488,282	1,189,504
Dentists		957	326
Other Practitioners		92,852	31,663
Home Health		32	11
Lab and Radiology		446,324	152,196
Medical Supplies		174,404	59,472
Ambulatory Clinics		336,171	114,634
Prescription Drugs		3,541,669	1,207,709
Premiums Collected			(1,469,268)
Total Individual Plan		**$ 13,802,641**	**$ 3,237,433**
Total Program Costs		**$ 29,437,780**	**$ 18,872,572**
Administrative Costs			
Salaries	$ 18,023	$ 319,553	$ 319,553
Operating Costs	289,025	252,396	252,396
Contract - Electronic Data Systems	255,119	484,280	484,280
Total Administrative Costs	**$ 562,167**	**$ 1,056,230**	**$ 1,056,230**
Total Expenditures			**$ 19,928,802**
NET CASH BALANCE	**$ 29,412,736**		**$ 35,395,733**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2010, for the Four Months Ended October 31, 2009

REVENUES	FY 10 Revenue	State Share
Tobacco Tax Collections	309,242	309,242
TOTAL REVENUES		**$ 309,242**

EXPENDITURES	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 11,597	$ 2,768	
Inpatient Hospital	2,073,201	494,873	
Outpatient Hospital	2,850,551	680,427	
Inpatient Free Standing	-	-	
MH Facility Rehab	43,553	10,396	
Case Mangement	243	58	
Nursing Facility	3,705	884	
Physicians	5,127,040	1,223,824	
Dentists	80,905	19,312	
Other Practitioners	20,009	4,776	
Home Health	29,732	7,097	
Lab & Radiology	342,457	81,744	
Medical Supplies	108,033	25,788	
Ambulatory Clinics	277,653	66,276	
Prescription Drugs	1,243,337	296,785	
Transportation	5,154	1,230	
Miscellaneous Medical	56,988	13,603	
Total Program Costs	$ 12,274,156	$ 2,929,841	**$ 2,929,841**
TOTAL STATE SHARE OF COSTS			**$ 2,929,841**

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 255: OHCA Medicaid Program Fund
Fiscal Year 2010, For the Four Months Ended October 31, 2009

REVENUES	FY 10 Total Revenue	FY 10 State Share
Tobacco Tax Collections	18,526,999	18,526,999
TOTAL REVENUES	**$ 18,526,999**	**$ 18,526,999**

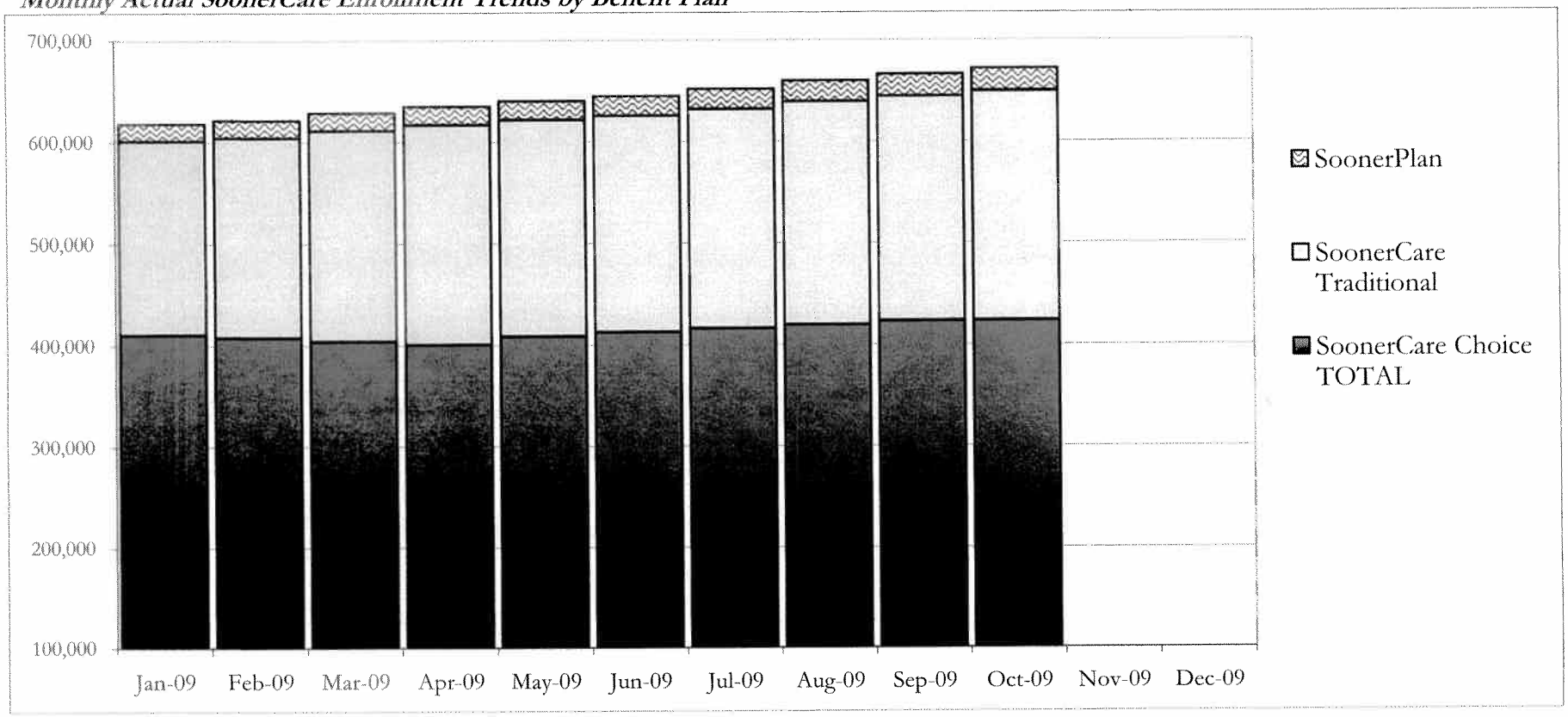
EXPENDITURES Program Costs:	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Adult Dental Services	$ 2,878,881	$ 981,698	
Remove Hospital Day Limit	4,031,735	1,374,822	
Hospital Rate Increase - Statewide Median +2%	5,794,319	1,975,863	
Increase Physician Visits from 2 to 4 per Month	176,613	60,225	
Increase Physician Office Visits/OB Visits to 90% of Medicare	10,152,074	3,461,857	
Increase Emergency Room Physician Rates to 90% of Medicare	4,806,483	1,639,011	
Pay 50% of Medicare Crossover - Physician/Ambulance/OP	6,702,638	2,285,600	
Nursing Facility 7% Rate Increase	11,300,475	3,853,462	
Enhanced Drug Benefit for Adults 3 + 3	7,478,792	2,550,268	
Enhanced Drug Benefit for Waiver Adults 3 + 10	6,388,143	2,178,357	
TEFRA Services	3,851,288	1,313,289	
SoonerRide	15,575	5,311	
Replace NSGO Medicare DRG Limit Revenues	6,035,336	2,058,050	
Total Program Costs	**$ 69,612,351**	**$ 23,737,812**	**$ 23,737,812**
TOTAL SHATE SHARE OF COSTS			**$ 23,737,812**

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 ENROLLMENT CY-2009

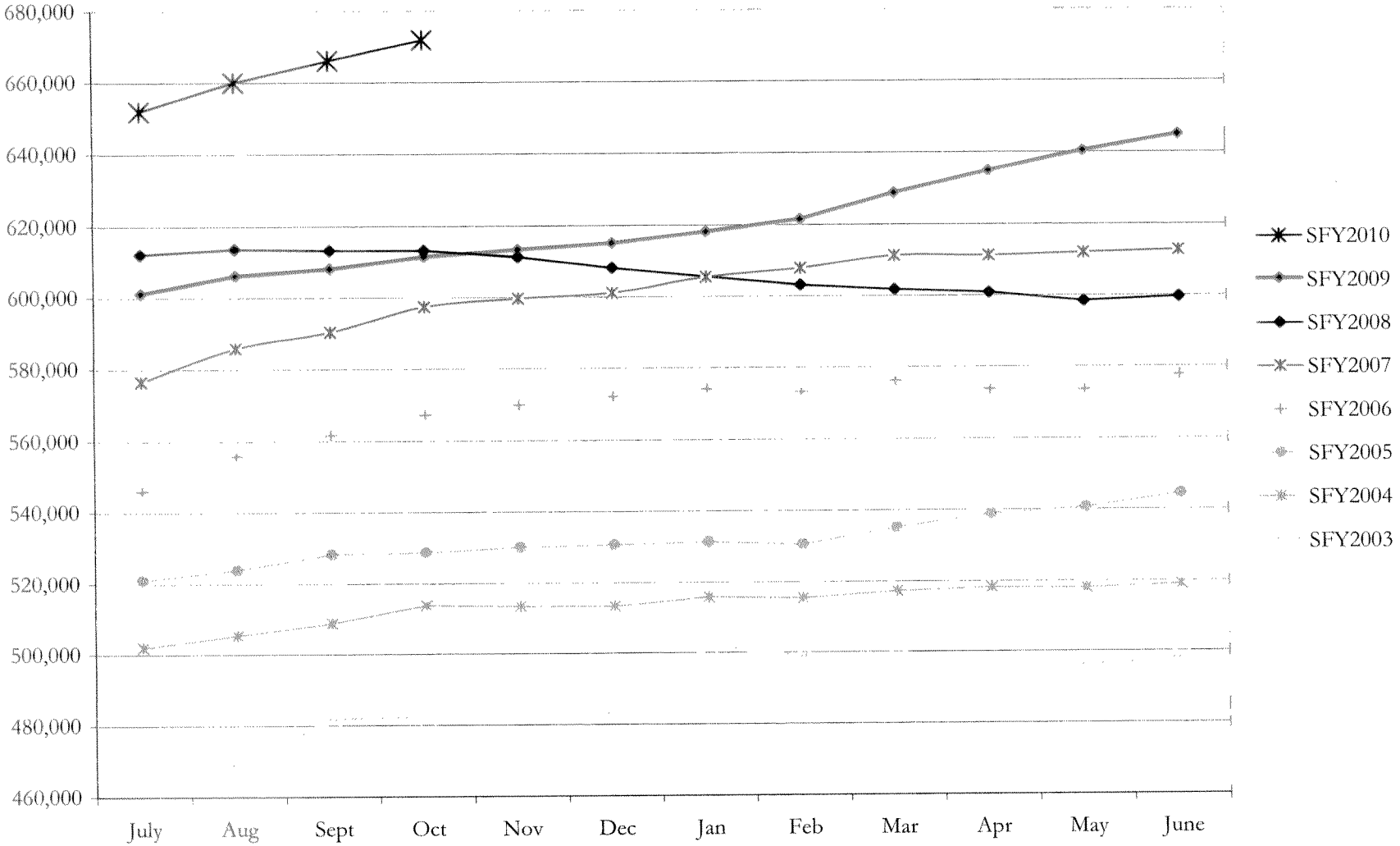
	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Total MMs
ENROLLEES													
SoonerCare Choice													
Choice Total	399,044	396,540	392,568	389,173	396,825	400,642	404,056	407,312	410,597	410,763			4,007,520
IHS/Urban/Tribal Total	11,882	11,559	11,672	11,571	11,819	11,831	11,926	12,062	12,329	12,525			119,176
SoonerCare Choice TOTAL	410,926	408,099	404,240	400,744	408,644	412,473	415,982	419,374	422,926	423,288			4,126,696
SoonerCare Traditional	190,117	196,093	206,886	215,889	212,963	213,073	215,702	219,633	221,392	225,914			
SoonerPlan	17,013	17,290	17,600	18,156	18,743	19,359	20,093	20,937	21,724	22,498			193,413
TOTAL ENROLLEES	618,056	621,482	628,726	634,789	640,350	644,905	651,777	659,944	666,042	671,700			6,437,771
Average Monthly Enrollment													643,777

Monthly Actual SoonerCare Enrollment Trends by Benefit Plan



MMs = Member Months

OHCA SoonerCare Enrollment Figures



SoonerCare Fast Facts

October 2009

oklahoma health care authority

TOTAL ENROLLMENT — OKLAHOMA SOONERCARE (MEDICAID)

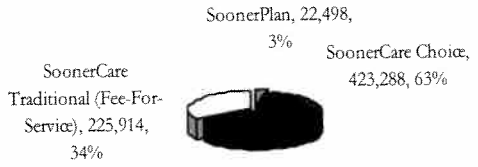
Qualifying Group	Age Group	Enrollment	% of Total
Aged/Blind/Disabled	Child	17,725	2.64%
Aged/Blind/Disabled	Adult	123,763	18.43%
Children/Parents	Child	442,203	65.83%
Children/Parents	Adult	44,820	6.67%
Other	Child	642	0.10%
Other	Adult	17,276	2.57%
Oklahoma Cares (Breast & Cervical Cancer)		2,466	0.37%
SoonerPlan (Family Planning)		22,498	3.35%
TEFRA		307	0.05%

Total Enrollment	**671,700**	Adults	207,752	31%
		Children	463,948	69%

OTHER Group includes—Child custody-Refugee-Qualified Medicare Beneficiary-SLMB-DDSD Supported Living-Program of All Inclusice Care for the Elderly (PACE)-Soon to be Sooners (STBS) and TB patients.
For more information go to www.okhca.org under Individuals then to Programs. Insure Oklahoma members are NOT included in the figures above.

Note that all subsequent figures are groups within the above total enrollment numbers (except Insure Oklahoma). SoonerPlan (Family Planning) members are not entitled to the full scope of benefits only family planning services are covered.

Delivery System Breakdown of Total Enrollment



Other Enrollment Facts

Unduplicated enrollees State Fiscal Year-to-Date (July through report month including Insure Oklahoma) — **750,999**

Other Breakdowns of Total Enrollment

Oklahoma SoonerCare (Medicaid) members residing in a long-term care facility — **15,896**

Oklahoma persons enrolled in both Medicare and Medicaid (dual eligibles) — **99,606**

The Insure Oklahoma (Oklahoma Employer/Employee Partnership for Insurance Coverage—O-EPIC) is a program to assist qualifying small business owners, employees & their spouses (Employer Sponsored Insurance—**ESI**) and some individual Oklahomans (Individual Plan—**IP**) with health insurance premiums. www.insureoklahoma.org

Small Businesses Enrolled in ESI	Employees w/ ESI	Individual Plan (IP) Members
5,388	17,344	9,756

New Enrollees

Oklahoma SoonerCare members that have not been enrolled in the past 6 months.

Adults	6,408
Children	9,857
Total	**16,265**

Race Breakdown of Total Enrollment

	Children	Adults	Percent	Pregnant Women
American Indian	59,946	19,412	12%	2,862
Asian or Pacific Islander	6,497	2,812	1%	498
Black or African American	68,983	28,877	15%	2,452
Caucasian	316,307	154,737	70%	18,495
Multiple Races	12,215	1,914	2%	581
Hispanic Ethnicity	71,917	10,475	12%	4,423

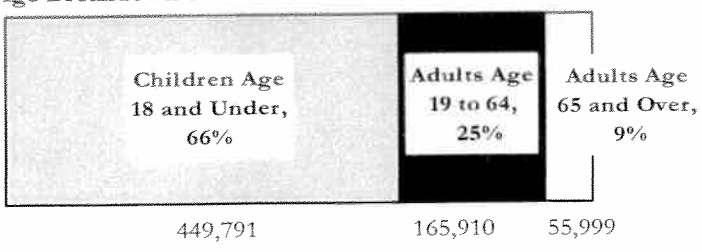
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

SCHIP Breakdown of Total Enrollment

Members qualifying for SoonerCare (Medicaid) eligibility under the SCHIP program are under age 19 and have income between the maximum for standard eligibility and the expanded 185% of Federal Poverty Level (FPL) income guidelines.

Age Breakdown	% of FPL	SCHIP Enrollees
PRENATAL		3,103
INFANT	150% to 185%	1,353
01-05	133% to 185%	11,565
06-12	100% to 185%	33,340
13-18	100% to 185%	20,868
Total		**70,229**

Age Breakdown of Total Enrollment



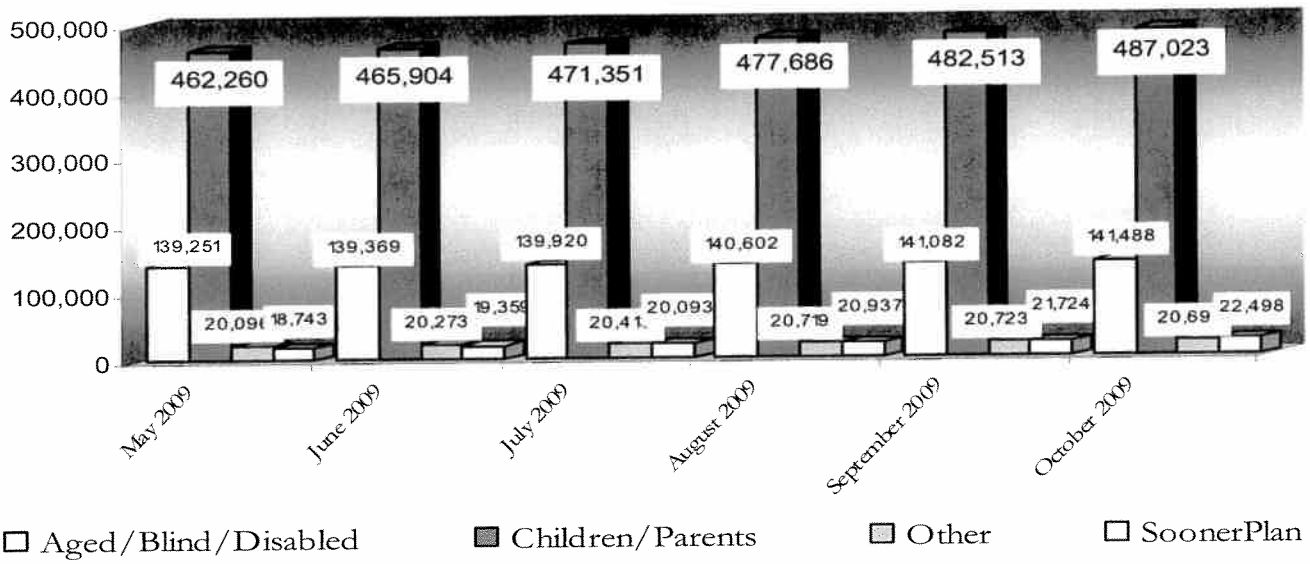
Data was compiled on 11/9/2009. Numbers frequently change due to certifications occurring after the data is extracted and other factors. This report is based on data within the system prior to 11/9/2009. A majority of the data is a "point in time" representation of the specific report month and is not cumulative. Unless stated otherwise, CHILD is defined as an individual under the age of 21.

SoonerCare Fast Facts

October 2009

oklahoma health care authority

Enrollment by Aid Category



State Fiscal Year is defined as the period between July 1 and June 30 of each fiscal year. Oklahoma Cares (Breast and Cervical Cancer coverage) and TEFRA are included in the OTHER category. SoonerPlan are members receiving family planning services only.

Have you seen our other Fast Facts?

OHCA generates and distributes all kinds of summary information about our members, providers, dollars and services. The majority of our fast facts are produced after the second Sunday of each month. Some of the additional fast facts we produce are: SoonerCare Children, Provider, Family Planning, Dental, Delivieries, and Insure Oklahoma. To view these and other fast facts, please visit: www.okhca.org/research/data

SoonerCare Programs
October 2009

Choice PCMH	October 2008	October 2009
TOTAL	396,709	423,288
American Indian Enrollees	11,071	12,525
Choice enrollees (enhanced PCMH)	385,638	410,763

Traditional	October 2008	October 2009
Members	197,763	225,914
SoonerCare Programs Total Unduplicated	611,298	671,700

Oklahoma Cares	October 2008	October 2009
Women currently enrolled	2,535	2,466
SoonerCare Traditional	1,914	1,735
SoonerCare Choice	621	731
Women ever-enrolled	17,453	21,423

Insure Oklahoma/ O-EPIC	October 2008	October 2009
IO Total Enrollees	14,868	27,100
IO Total Enrollees **(Male : Female)**	6,519 : 8,349	11,905 : 15,195
ESI Enrollees	10,401	17,344
IP Enrollees	4,467	9,756

TEFRA	October 2008	October 2009
Children enrolled	230	307
Male Enrollees	140	183
Female Enrollees	90	124
Ever-enrolled	296	395

SoonerPlan	October 2008	October 2009
Enrolled	16,826	22,498
Male enrollees	522	647
Female enrollees	16,304	21,851
Ever-enrolled	60,602	74,820

PROGRAM	MAY 2009	JUNE 2009	JULY 2009	AUGUST 2009	SEPTEMBER 2009	OCTOBER 2009
Choice PCMH	408,644	412,473	415,982	419,374	422,926	423,288
Traditional	212,963	213,073	215,702	219,633	221,392	225,914
Oklahoma Cares	2,701	2,713	2,701	2,748	2,651	2,466
TEFRA	276	283	285	292	297	307
SoonerPlan	18,743	19,359	20,093	20,937	21,724	22,498
Soon to be Sooners	3,138	3,107	3,153	3,099	3,132	3,103
SoonerCare Programs Total Unduplicated	640,350	644,905	651,777	659,944	666,042	671,700
Insure Oklahoma ESI	13,348	14,217	15,273	15,974	17,012	17,344
Insure Oklahoma IP	6,638	7,381	8,259	8,672	9,344	9,756
Insure Oklahoma Programs Total Unduplicated	**19,986**	**21,598**	**23,532**	**24,646**	**26,356**	**27,100**

Oklahoma Health Care Authority

Provider Fast Facts

October 2009

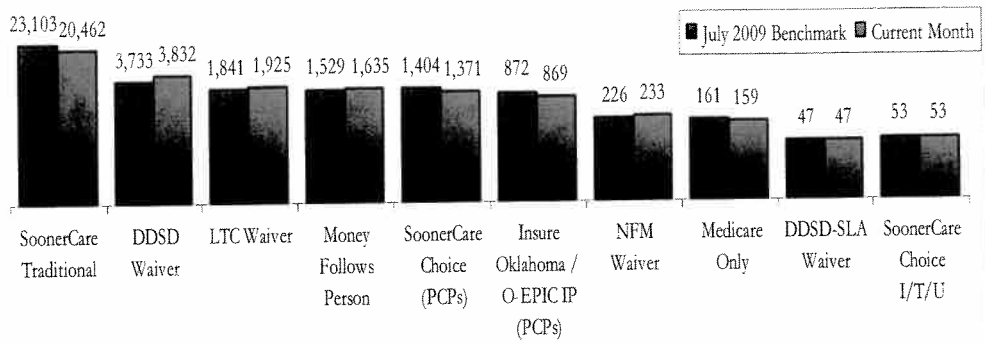
OHCA is currently in a provider contract renewal period. Some of the totals below may indicate a decrease in the provider counts due to this process. This occurrence is typical during all renewal periods.

Total Unduplicated Provider Count

26,457

All subsequent provider counts were derived from the total unduplicated provider count. Some providers may be counted in multiple programs.

Total Unduplicated Provider Count by Program



A group provider is a corporation that houses multiple individual providers. In order to provide a more accurate count, the group's individual providers were counted instead of the group provider.

Total Unduplicated Newly Enrolled Provider Count

361

Total unduplicated newly enrolled provider count was determined by the number of newly unduplicated provider IDs added during the month of this report.

Primary Care Provider (PCP) Capacities

SoonerCare Program Description	Capacity Available	% of Capacity Used
SoonerCare Choice	1,017,458	40.45%
SoonerCare Choice I/T/U	331,824	3.10%
Insure Oklahoma/O-EPIC IP	116,150	10.89%

Capacity available represents the maximum number of members that PCPs request to have assigned within OHCA's limit.

Acronyms

DDSD - Developmental Disabilities Services Division

DDSD-SLA - Developmental Disabilities Services Division-Supported Living Arrangement

DME - Durable Medical Equipment

I/T/U - Indian Health Service/Tribal/Urban Indian

LTC - Long-Term Care

NET - Non-Emergency Transportation

NFM - Non-Federal Medical

NPI - National Provider Identifier

O-EPIC IP - Oklahoma Employer/Employee Partnership for Insurance Coverage Individual Plan

PCMH - Patient-Centered Medical Home

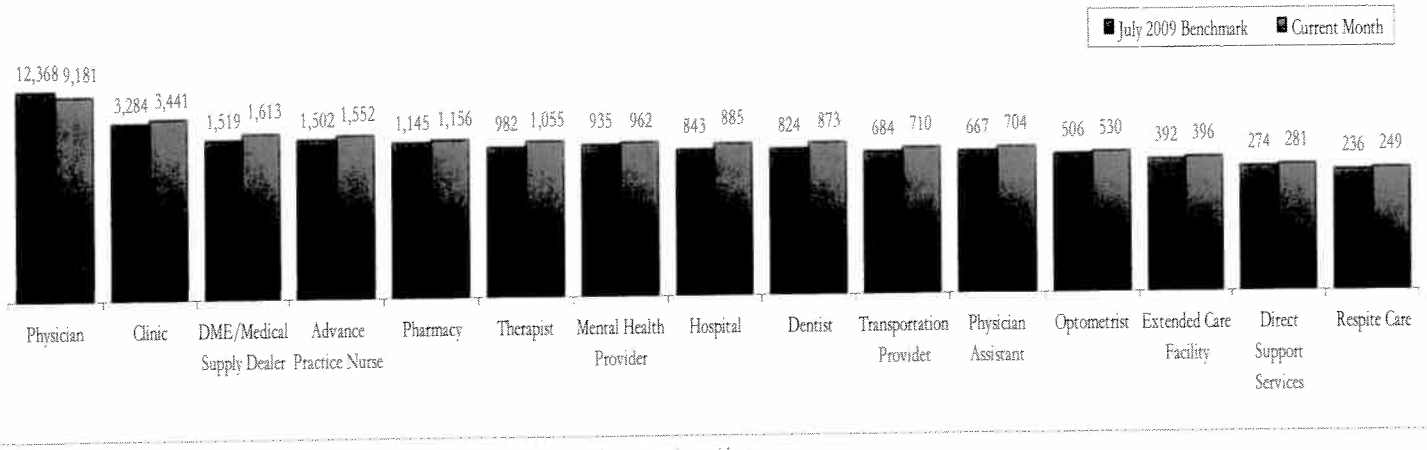
PCP - Primary Care Provider

PCMH Enrollment by Tier

Payment Tier Code	Count
Tier 1	481
Tier 2	221
Tier 3	34

These counts were computed using a different method than indicated elsewhere on the report and are not comparable to any other figures.

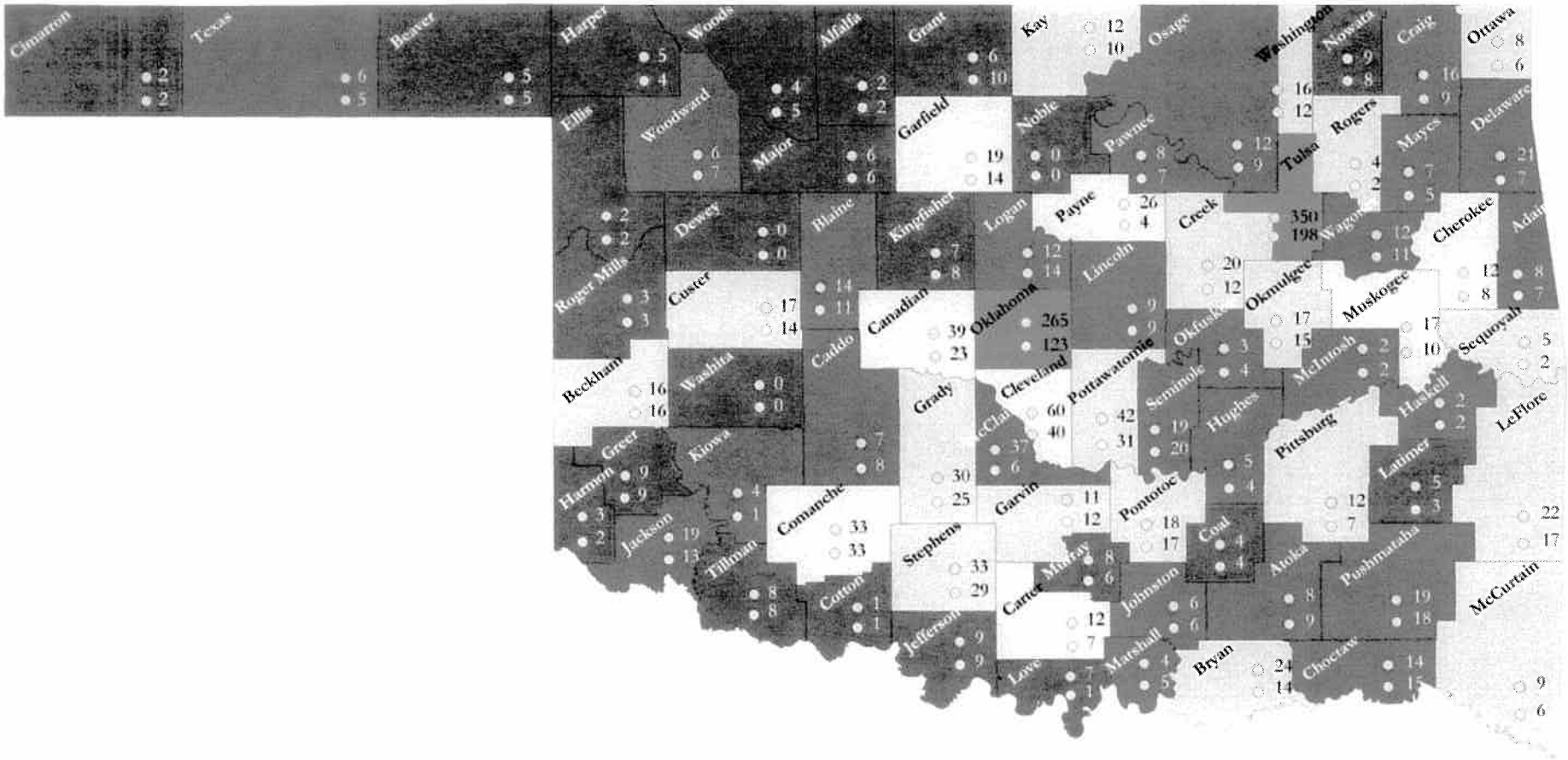
Top 15 Provider Types



The top 15 provider types consists of the 15 provider types with the highest number of contracted providers.

Provider Fast Facts
October 2009

oklahoma health care authority



Total Provider Count

- 4,000 to 6,000 (2)
- 300 to 1,000 (8)
- 150 to 300 (18)
- 50 to 150 (26)
- 0 to 50 (23)

Primary Care Providers (PCPs)

- SoonerCare Choice PCPs
- Insure Oklahoma IP PCPs

11/9/2009

Insure Oklahoma

Fast Facts

November 2009

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

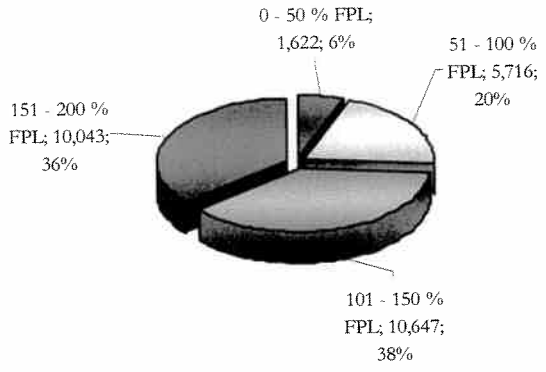
Insure Oklahoma is an innovative program Oklahoma has created to bridge the gap in the health care coverage for low-income working adults. Under the Employer-Sponsored Insurance (ESI) program, premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent). The Individual Plan (IP) allows people who can't access the benefits through their employer, including those who are self-employed or may be temporarily unemployed, to buy health insurance directly through the state. Find out more information by visiting www.insureoklahoma.org or by calling 1-888-365-3742.

Insure Oklahoma Total Enrollment

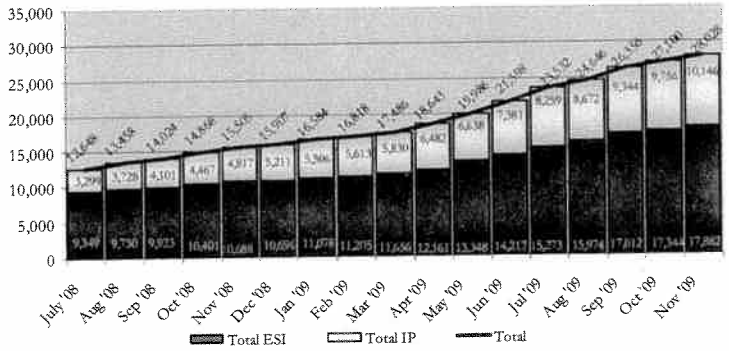
Qualifying Enrollment		Enrollment	% of Total
Employer Sponsored Insurance (ESI)	Employee	14,913	53.21%
Employer Sponsored Insurance (ESI)	Spouse	2,933	10.46%
Individual Plan (IP)	Employee	7,701	27.48%
Individual Plan (IP)	Spouse	2,343	8.36%
Student (ESI)	---	36	0.13%
Student (IP)	---	102	0.36%
Businesses (ESI)	---	5,464	---
Businesses (IP)	---	5	---
Carriers / HealthPlans	---	21 / 467	---
Primary Care Physician	---	882	---

Total Enrollment	**28,028**	ESI	17,882	64%
		IP	10,146	36%

Federal Poverty Level Breakdown of Total Enrollment



Total Insure Oklahoma Member Monthly Enrollment



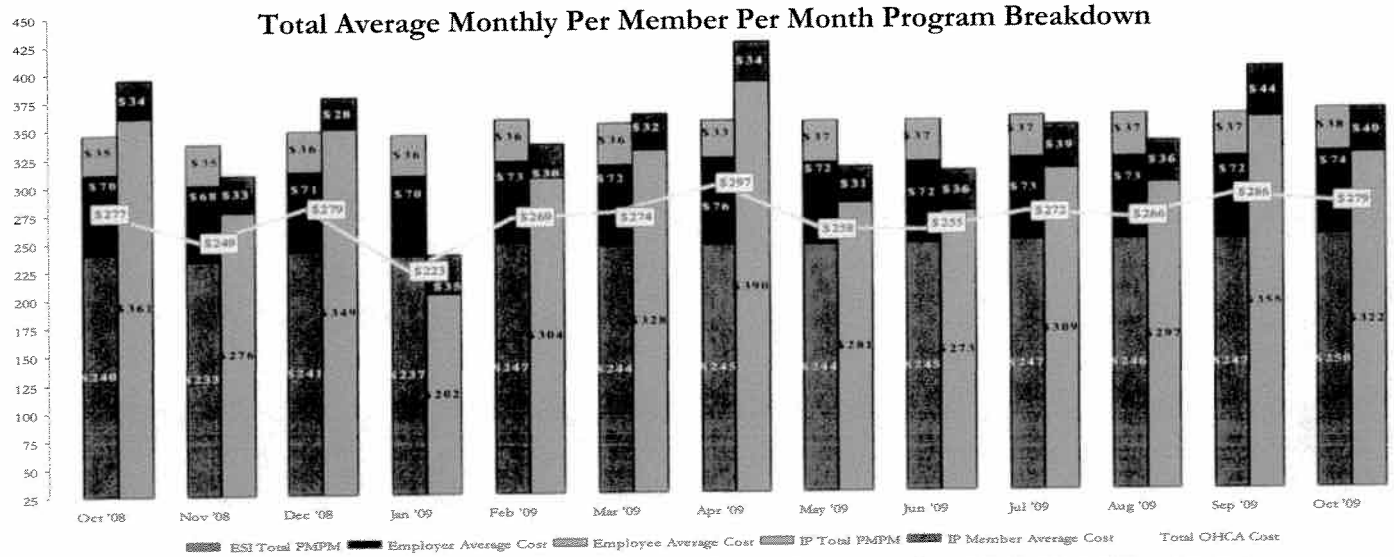
Currently Enrolled		Up from Previous Year
Businesses	5,469	54%
ESI Enrollees	17,882	67%
IP Enrollees	10,146	111%

ESI & IP Enrollee totals include Students.

Latest Monthly Marketing Statistics	
Web Hits on InsureOklahoma.org	34,379
Call Center - Calls Answered	13,896

Call Center count now includes OHCA calls.(October 2009 was missing Employer calls.)

Total Average Monthly Per Member Per Month Program Breakdown



All the state share of the Insure Oklahoma program costs are budgeted from the state's tobacco tax revenues. (All financial information is previous month activity.)

Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

11/4/2009

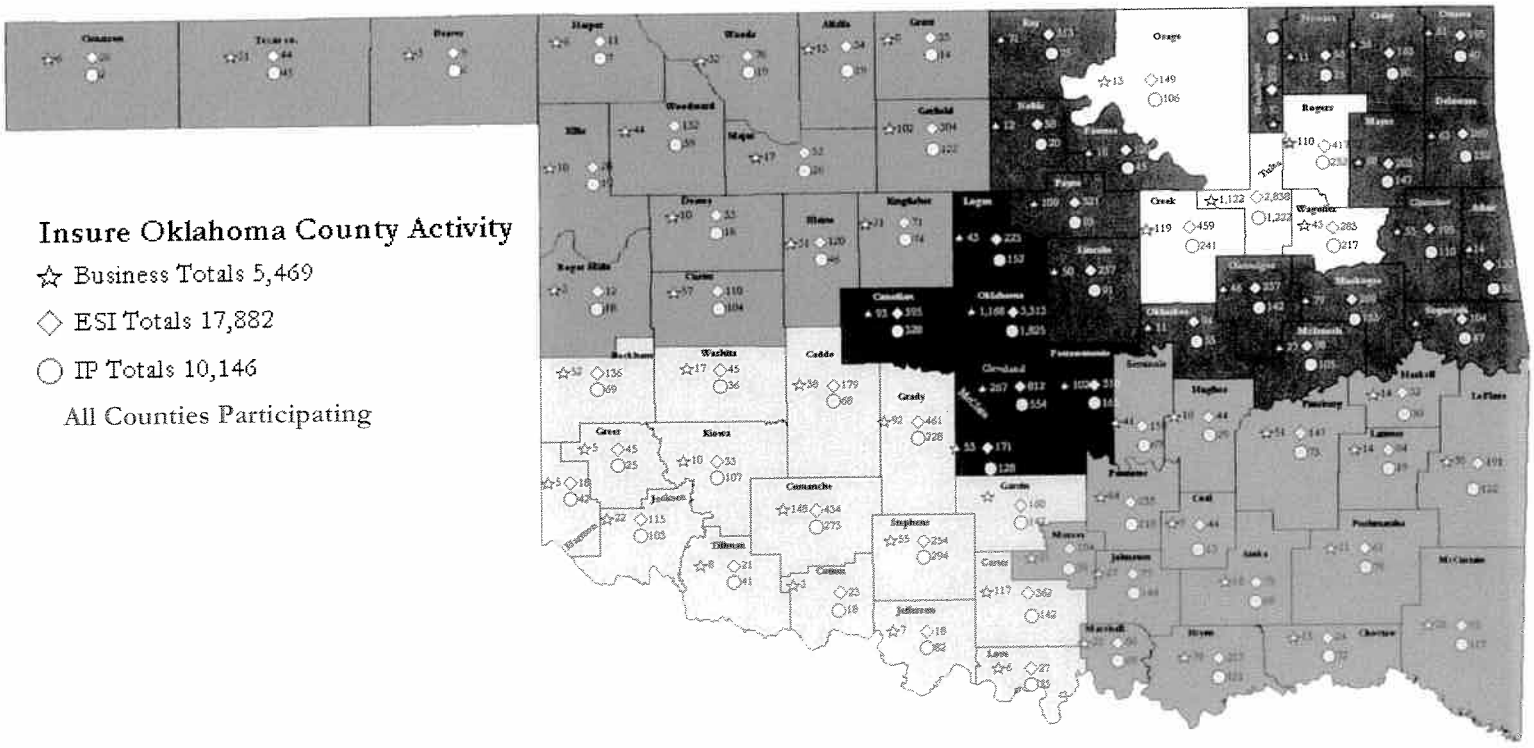
Insure Oklahoma

Fast Facts

November 2009

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

November 2005	Oklahoma implemented Insure Oklahoma Employer Sponsored Insurance (ESI), the premium assistance for health insurance coverage targeting some 50,000 low-wage working adults in Oklahoma.
January 2007	Insure Oklahoma implements the Individual Plan (IP) to assist sole proprieetors (self employed), certain unemployed individuals, and working individuals who do not have access to small group health coverage.
November 2007	Increased Insure Oklahoma ESI qualifying income guidelines from 185 to 200 percent of the federal poverty level.
	ESI available to businesses with 25 to 50 employees.
March 2009	Expanded IP to offer coverage for full-time Oklahoma college students within qualifying income guidelines age 19 through 22.
	ESI available to businesses with 50 to 99 employees.



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11/4/2009

Employer Sponsored Insurance (ESI)

Fast Facts

November 2009

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

The Insure Oklahoma - Oklahoma Employer/Employee Partnership for Insurance Coverage-OEPIC Employer Sponsored Insurance program is designed to assist small business owners, employees and their spouses with health insurance premiums. Find out more information by visiting www.insureoklahoma.org.

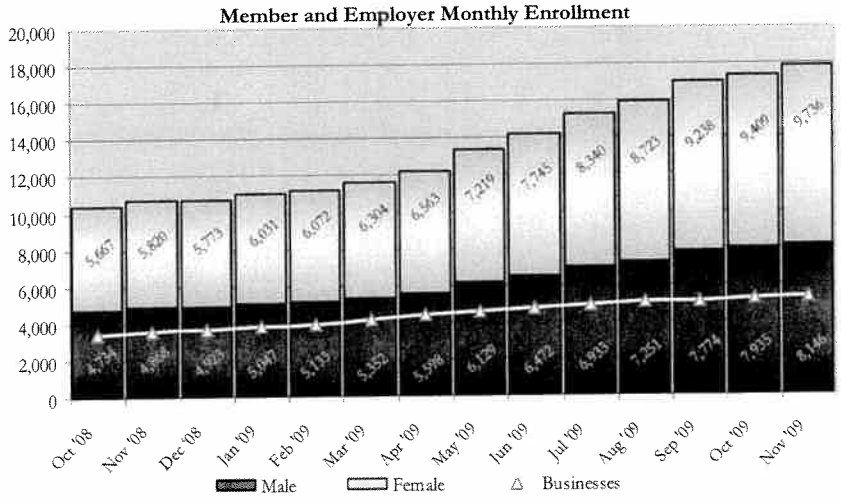
	Total Current Enrollment			Breakdown of Current Enrollment					
				New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	7,401	7,512	14,913	439	495	934	888	749	1,637
Spouse	731	2,202	2,933	53	126	179	103	260	363
Student	14	22	36	1	3	4	1	1	2
Total	8,146	9,736	17,882	493	624	1,117	992	1,010	2,002

*Expanded income qualifications from 185 to 200% effective November 2007.

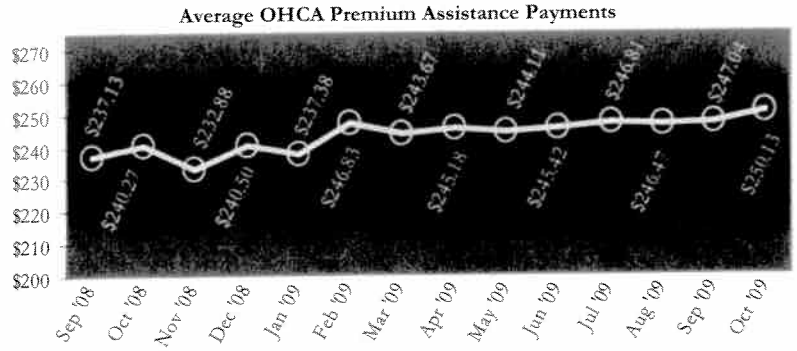
Business Activity with Employee Participation Counts				
	0 to 25	26 to 50	51 to 100	Total
Current	4,331	658	343	**5,332**
New	113	10	9	**132**
Total	**4,444**	**668**	**352**	**5,464**

Some approved businesses may not have approved employees.

Member and Employer Monthly Enrollment

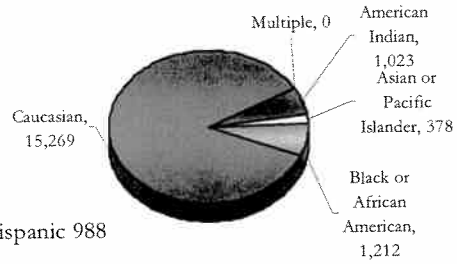


Average OHCA Premium Assistance Payments



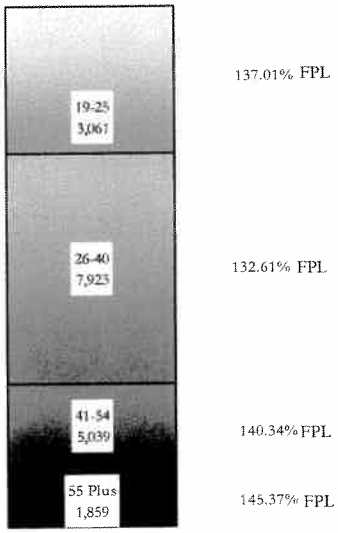
Effective February 2007 OHCA Per Member Per Month reporting will be of the previous month due to semi-monthly payments verses monthly payments.

Race Breakdown of ESI Members



Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Age Breakdown with Average Federal Poverty Level of ESI Members



Federal Poverty Level is used to determine income qualification.

Insure Oklahoma/OEPIC ESI by Region				
	Employers	Employee/ Spouse	Capacity	Participating Counties
Region 1	630	2,331	2,240	16 of 16
Region 2	396	1,092	1,078	16 of 16
Region 3	1,724	5,231	5,808	6 of 6
Region 4	1,406	4,146	4,306	5 of 5
Region 5	825	3,388	3,230	18 of 18
Region 6	483	1,694	1,838	16 of 16
Total	**5,464**	**17,882**	**18,500**	**77 of 77**

Regions identified on Insure Oklahoma/OEPIC Region map on next page.

Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

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11/4/2009

Individual Plan (IP)

Fast Facts

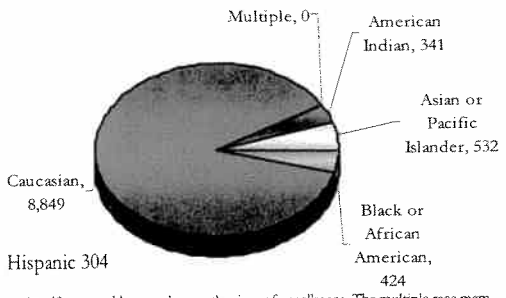
Business, insurance, state government and you Working Together to *Insure Oklahoma!*

November 2009

The Insure Oklahoma Oklahoma Employer Employee Partnership for Insurance Coverage (OEPIC) Individual Plan program is designed to provide Oklahoma individuals with health insurance for themselves and their spouse if needed. It is available to Oklahomans who are not qualified for an OEPIC employer-sponsored health plan and work for an Oklahoma small business with 99 or fewer full time employees; temporarily unemployed adults who are eligible to receive unemployment benefits through the Oklahoman Employment Security Commission; or working adults with a disability who work for any size employer and have a "ticket to work". Find out more information by visiting www.insureoklahoma.org.

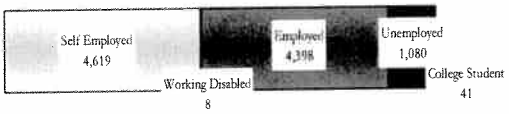
	Total Current Enrollment			Breakdown of Current Enrollment					
				New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	3,565	4,136	**7,701**	163	242	**405**	284	293	**577**
Spouse	510	1,833	**2,343**	28	76	**104**	49	153	**202**
Student	28	74	**102**	1	10	**11**	1	2	**3**
Total	4,103	6,043	**10,146**	191	318	**520**	333	446	**782**

Race Breakdown of IP Members



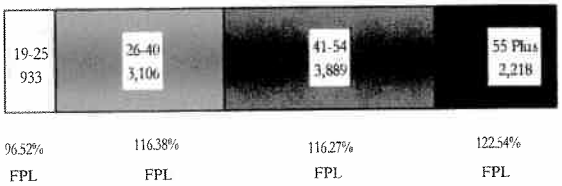
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

IP Application Type Breakdown

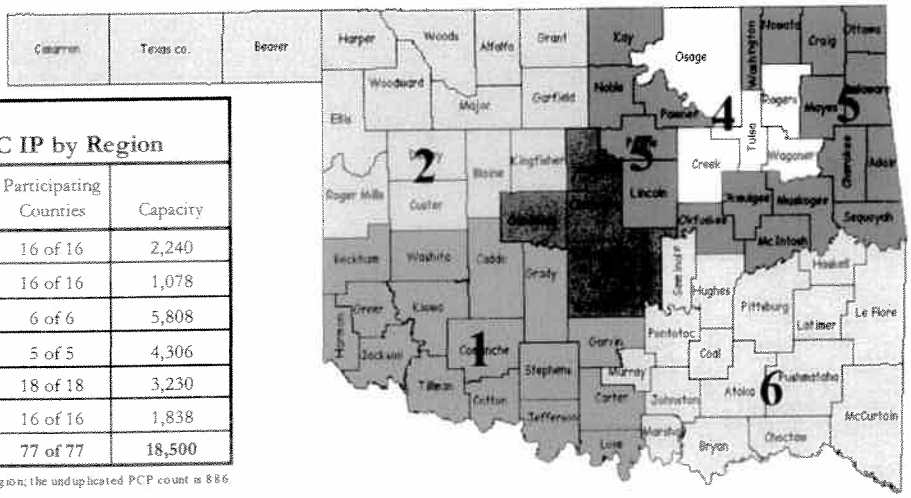


Unduplicated Counts	
IP Members SFY2010 (July 2009 - Current)	11,989
IP Members Since Program Inception March 2007	14,997
Miscellaneous	
Average IP Member Premium	$49.51
Average Federal Poverty Level of IP Members	116.11%
Federal Poverty Level is used to determine income qualification.	

IP Age Breakdown with Average Federal Poverty Level for each group.



Insure Oklahoma/OEPIC Region Map



Insure Oklahoma/OEPIC IP by Region

	PCP	Participating Counties	Members	Participating Counties	Capacity
Region 1	141	14 of 16	1,693	16 of 16	2,240
Region 2	85	15 of 16	580	16 of 16	1,078
Region 3	215	6 of 6	3,152	6 of 6	5,808
Region 4	199	5 of 5	2,018	5 of 5	4,306
Region 5	130	17 of 18	1,490	18 of 18	3,230
Region 6	112	16 of 16	1,213	16 of 16	1,838
Total	**882**	**73 of 77**	**10,146**	**77 of 77**	**18,500**

PCPs maybe counted in multiple regions or out of state and not counted in a region; the unduplicated PCP count is 886

Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

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11/4/2009

Program of All-Inclusive Care for the Elderly (PACE)

Fast Facts

October 2009

oklahoma health care authority

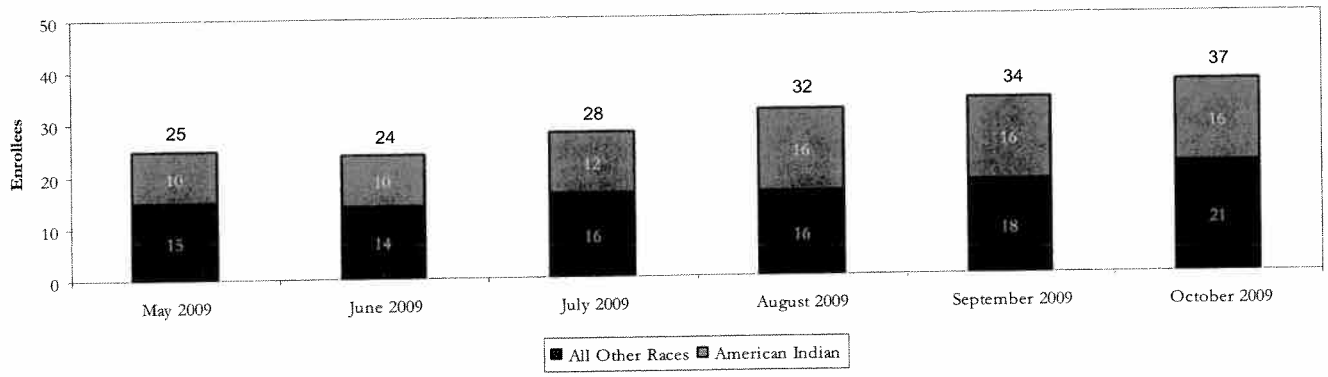
Programs of All-Inclusive Care for the Elderly (PACE) is a unique, capitated, one-stop, home and community-based program. PACE provides an array of necessary medical and social services for the frail and elderly within the home or at the Cherokee Elder Care Center in Tahlequah. It is the first Native American sponsored program in the United States and is available to those living within specific Zip Codes of Cherokee, Mayes, Delaware, Muskogee, and Adair counties. Moreover, one must be 55 years of age or older, qualify for state nursing home level of care, be safely cared for in a community setting, and meet the financial qualifications for SoonerCare .

PACE programs assume full financial risk for each member's care without limits on dollars or duration and are responsible for a full range of needed services. PACE is a permanent provider under the Medicare program and a state option under state SoonerCare programs.

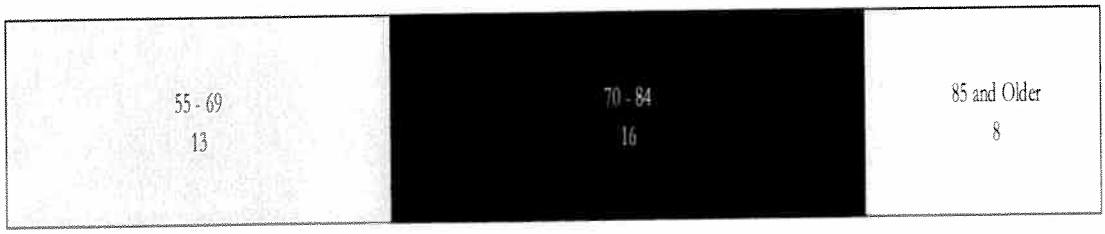
PACE Enrollment	
Gender	Total Currently Enrolled
Male	10
Female	27
Total	37

Breakdown of Current Enrollment		
Gender	Continued Enrollment from Previous Month	New Enrollment This Month
Male	7	3
Female	26	1
Total	33	4

Total PACE Enrollment and Race Groupings



Age Breakdown of Total PACE Enrollment



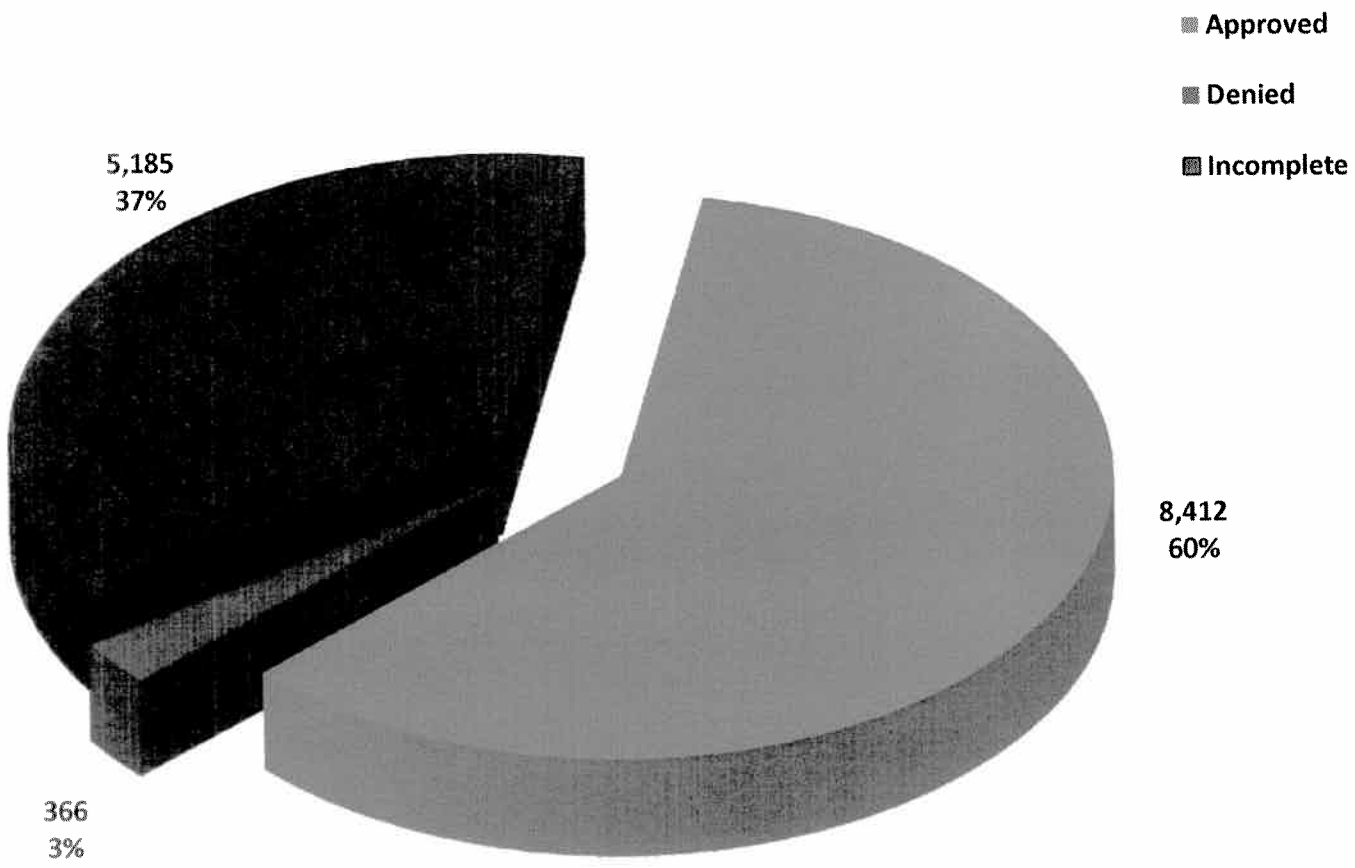
Unduplicated Count of Members SFY2010 (July 2009 - Current)	40
Unduplicated Count of Members Since Program Inception August 2008	44

Claims for the Report Month	
Members who received services	0
Count of Paid Claims	0
Payments to Providers on Behalf of Members	$0

(Above figures are for claims paid within the report month only.) No claims were paid on behalf of the PACE members during the report month.

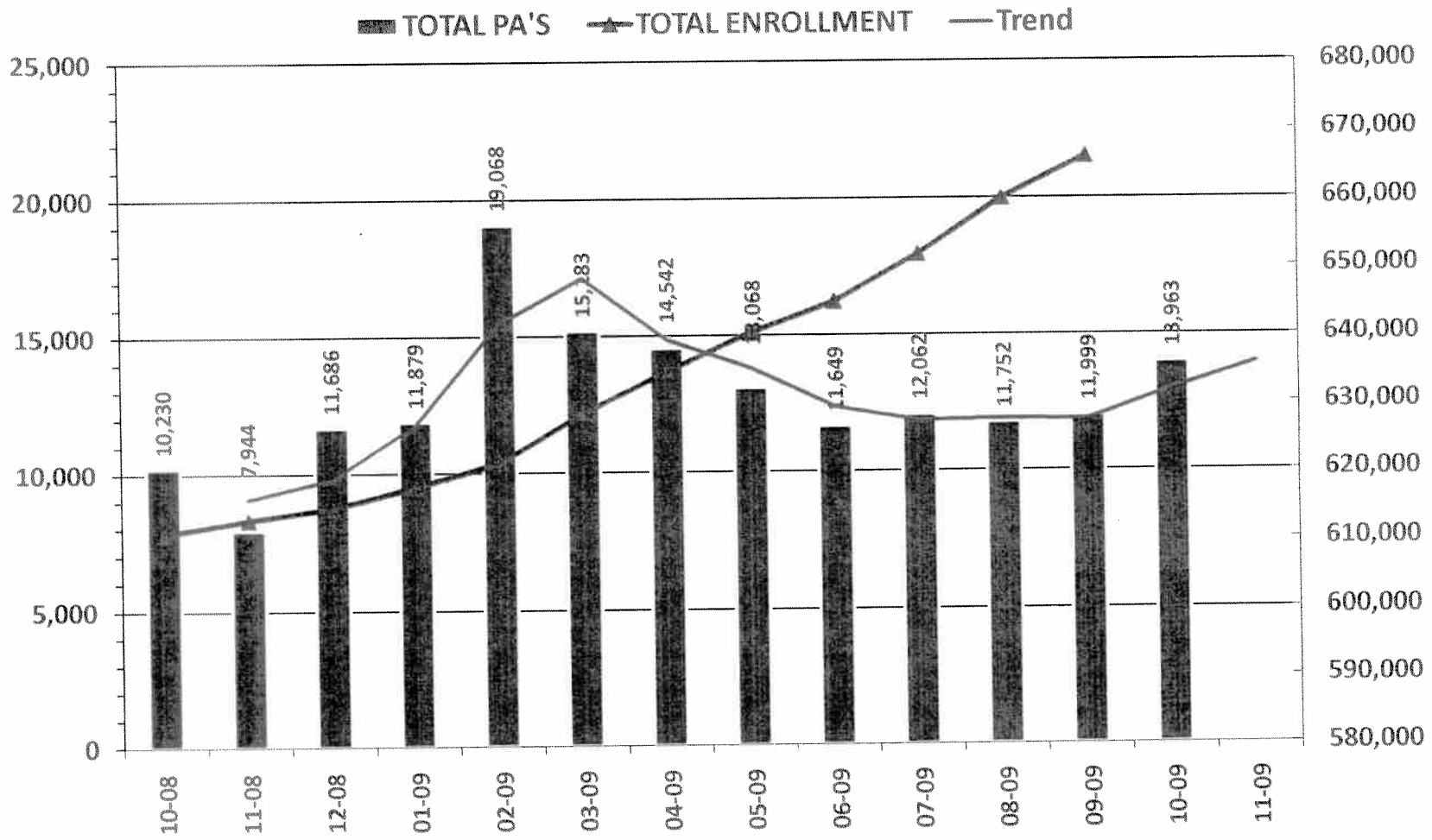
11/10/2009

PRIOR AUTHORIZATION ACTIVITY REPORT: October 2009



PA totals include overrides

PRIOR AUTHORIZATION REPORT: October 2008 – October 2009



PA totals include overrides

Prior Authorization Activity

10/1/2009 Through 10/31/2009

	Average Length of	Approved	Denied	Incomplete	Total
Advair/Symbicort	355	345	3	485	833
Amitiza	193	8	0	9	17
Antidepressant	337	194	1	416	611
Antihistamine	315	178	1	231	410
Antihypertensives	353	67	2	113	182
Benzodiazepines	102	3,788	20	778	4,586
Bladder Control	336	10	0	11	21
Brovana (Arformoterol)	365	1	0	0	1
Byetta	363	7	0	10	17
Elidel/Protopic	91	19	0	36	55
ESA	62	124	1	45	170
Fibric Acid Derivatives	271	3	0	7	10
Fortamet/Glumetza	360	1	0	0	1
Forteo	359	1	0	2	3
Glaucoma	363	8	0	6	14
Growth Hormones	175	36	3	7	46
HFA Rescue Inhalers	258	68	1	97	166
Insomnia	135	50	4	129	183
Misc Analgesics	128	14	18	17	49
Muscle Relaxant	41	71	52	62	185
Nasal Allergy	215	9	45	128	182
SAIDS	325	49	2	99	150
Nucynta	0	0	1	5	6
Ocular Allergy	170	5	0	36	41
Ocular Antibiotics	16	5	1	17	23
Opioid Analgesic	153	70	7	119	196
Other	140	179	16	310	505
Pediculicides	18	35	0	56	91
Plavix	352	110	0	65	175
Proton Pump Inhibitors	115	124	5	311	440
Qualaquin (Quinine)	0	0	1	0	1
Singulair	272	476	3	543	1,022
Smoking Cessation	52	20	4	57	81
Statins	346	18	2	35	55
Stimulant	227	719	4	365	1,088
Symlin	92	1	0	5	6
Synagis	163	379	143	227	749
Topical Antibiotics	28	9	0	39	48
Topical Antifungals	16	5	0	24	29
Ultram ER and ODT	0	0	0	1	1
Xolair	361	1	0	2	3
Xopenex Nebs	254	39	0	36	75
Zetia (Ezetimibe)	347	20	0	7	27
Emergency PAs		0	0	0	0
Total		**7,266**	**340**	**4,948**	**12,554**

** Changes to existing PAs: Backdates, changing units, end dates, etc.*

Overrides					
Brand	173	53	2	16	71
Dosage Change	20	494	7	35	536
High Dose	128	3	1	1	5
IHS - Brand	60	53	0	7	60
Ingredient Duplication	29	13	0	6	19
Lost/Broken Rx	18	94	1	1	96
Nursing Home Issue	14	74	0	5	79
Other	20	31	1	8	40
Quantity vs. Days Supply	198	328	14	158	500
Stolen	31	3	0	0	3
Overrides Total		**1,146**	**26**	**237**	**1,409**
Regular PAs + Overrides Total		**8,412**	**366**	**5,185**	**13,963**

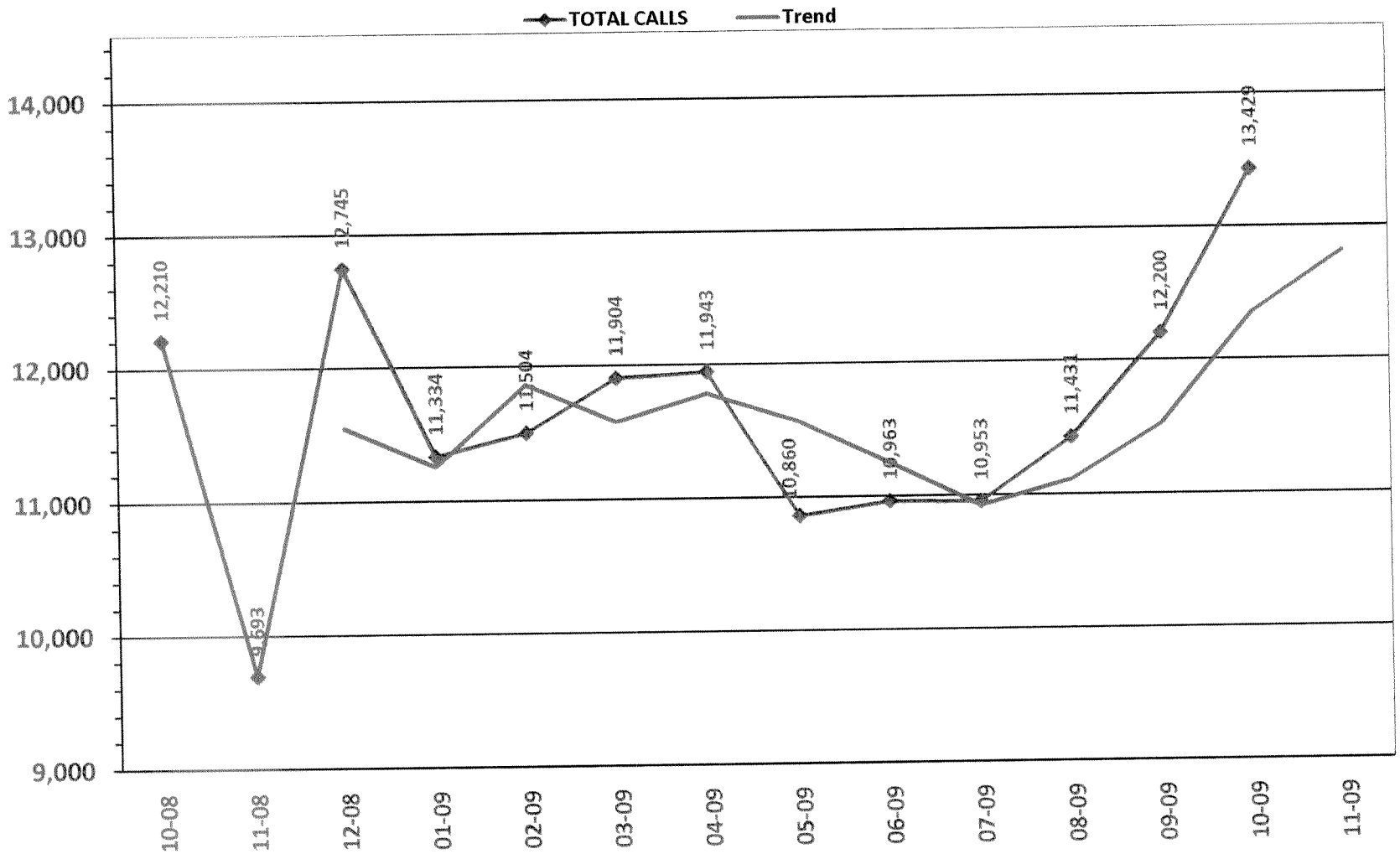
Denial Reasons	
Lack required information to process request.	3,000
Unable to verify required trials.	1,927
Does not meet established criteria.	208
Member has active PA for requested medication.	110
Considered duplicate therapy. Member has a prior authorization for similar medication.	105
Not an FDA approved indication/diagnosis.	74
Requested dose exceeds maximum recommended FDA dose.	64
Medication not covered as pharmacy benefit.	20
Drug Not Deemed Medically Necessary	2

Duplicate Requests: 1,103

Changes to existing PAs: 885

** Changes to existing PAs: Backdates, changing units, end dates, etc.*

CALL VOLUME MONTHLY REPORT:
October 2008 – October 2009



Oklahoma Health Care Authority
SFY2010 Budget Fast Facts Summary

What is the current budget situation?

Like every other state agency we are preparing for budget reductions of five percent or more for the remainder of this fiscal year. To date, we have been able to accommodate reductions. However, because the agency can no longer absorb such reductions, we expect to take recommended reductions to the board at its December 10th meeting in Tulsa. It is also important to note that any reduction in state dollars in Medicaid results in a reduction in federal dollars to operate the program; currently, $1 cut in state funds means a loss of $3 in federal funds for a total program reduction of $4 dollars.

A five percent reduction in general revenue for 11 months of state fiscal year 2010 equals $26.6 million ($110.2 million total). As noted below, the agency has reduced the current year budget $9.8 million ($40.5 million total). Therefore, the agency needs to be able to accommodate an additional $16.8 million ($69.6 million) cut in state funds for a five percent reduction.

If the reduction increases to 7.5 or 10 percent for the remainder of the fiscal year then the net cut is increased to $26.5 million ($109.7 million total) or $36.2 million ($150 million total), respectively.

What has the agency done so far?

The Oklahoma Health Care Authority reduced the budget $9.8 million state dollars ($40.5 million total) to accommodate the five percent cut for the months of August through November. The agency was able to implement this cut without any reduction in services primarily thanks to $7.3 million in savings available through unbudgeted carryover from the previous year and lower than estimated growth in the first quarter. Another $1.8 million was made available due to a settlement of a national class action lawsuit of pharmacy pricing in September. This resulted in a reduction in payments to pharmacists. More than $700,000 will be available beginning January 1 because of a pricing change in codes for certain injectable drugs.

The agency will also reduce its administrative budget at least five percent for the 11-month timeframe and it will produce a savings of $2.8 million in state dollars ($5.8 million total).

What are the agency's next steps?

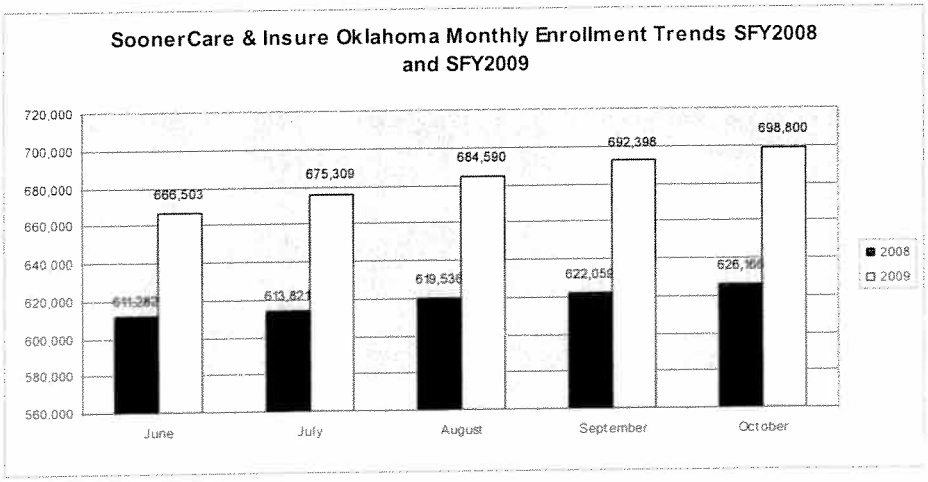
We have found there is really no great way to go about this exercise. However, we are striving to make our process as transparent and interactive as possible.

The agency is working both internally and externally to develop budget savings ideas that minimize the impact on patient care and access to care. Externally, we met at least a dozen times with our contracted provider groups and consumer advocates in an effort to share ideas and get feedback on potential surgical cuts. These meetings included a group of provider associations representing our five largest provider groups including the hospital association, both long-term care provider associations, both of the physician associations, the pharmacists association and the dental association (Nov. 5 and Nov. 19). This was the first of several meetings to identify budget savings in the most cooperative and enlightened manner possible. The agency also met with the OHCA board (Nov. 12) and the Drug Utilization Review board (Nov. 12), the Perinatal Advisory Task Force (Nov. 17), the Medical Advisory Committee which includes consumer advocates (Nov. 19), the Medical Advisory Task Force which is comprised of physicians (Nov. 19), the Behavioral Health Advisory Council (Nov. 23), the Child Health Advisory Council (Nov. 24) and the House and Senate Appropriation Subcommittees (Dec. 2 and 3, respectively). We believe information was shared with more than 200 people representing many more providers and members.

OHCA staff also met daily to research and refine all potential reductions including those suggested by the external stakeholders. The end result will be the recommendation submitted to the OHCA board at its Dec. 10 meeting in Tulsa.

Are there other factors potentially affecting the agency's budget?

In addition to the state revenue shortfall, the program is experiencing continued growth in its population and utilization of services. During the second quarter, this growth is creeping above budgeted amounts and looks to continue on that trend. This is compounded because the Medicaid program is designed to be countercyclical, in that, as the economy suffers more people become qualified for help and because medical issues such as H1N1 cause greater utilization of the program.



How does the budget impact providers and members?

Because the current budget is funded with federal stimulus dollars, and in order to access and use those dollars, the state is restricted from eliminating any groups of people from the program. Therefore, the agency must look to optional benefits primarily for adults and what we pay providers for services for potential cuts.

The federal government requires state Medicaid programs to provide some mandatory benefits including inpatient hospital and physician services. However, the state has benefits it is not required to provide including pharmacy, durable medical equipment and dental.

Paying providers a responsible amount has been a priority of the Oklahoma Health Care Authority. It would be an area of last resort for potential cuts. However, if the size of the revenue deficit increases beyond the current five percent level, it will likely be unavoidable.

Current budget realities are not a complete surprise, what have you done to make the program more efficient?

Ever mindful that the money funding our budget comes from taxpayers, the Oklahoma Health Care Authority has been working to contain costs in the inflationary field of health care while also carrying out our mandate to efficiently provide the best possible care for our state's children, pregnant women, aged, blind and disabled. From 2005 to 2008, the growth in SoonerCare's per capita costs has been only 8.1 percent, compared to more than 20 percent nationally.

Here is a quick outline of some measures that have proved to be especially effective:

Cost-containment through targeted programs

Pharmacy lock-in: SoonerCare's pharmacy lock-in program encourages appropriate use of health care resources among members whose past claims data might indicate misuse of resources or potentially fraudulent behavior. The program provides a mechanism to detect potential misuse of narcotics and other medications and a procedure to "lock in" the member to one pharmacy, thus limiting the opportunity for inappropriate behavior within the SoonerCare system. Results so far indicate positive change in members' behavior, including reduced narcotic use. Cumulative estimated narcotic cost savings for the first 12 months post lock-in for the 52 members studied was more than $31,500 – an average of about $600 per member.

Emergency room use: Inappropriate use of emergency department services is a long-term, frustrating problem. Hospital emergency departments are inundated with patients who need care but are consuming time and resources better spent on actual emergencies. The inappropriate visits also represent a missed opportunity for primary care physicians to offer patients continuity of care from a provider familiar with their medical needs and

history. A recent special initiative by the Oklahoma Health Care Authority allowed staff to intervene with SoonerCare members who have a history of frequent, inappropriate emergency department visits. During five quarters of calendar years 2006 and 2007, OHCA identified 13,447 SoonerCare members for intervention. These members received letters and sometimes phone calls reminding them who their primary care provider was. Based on information from the members, some were referred for further intervention from nurse care managers and behavioral health specialists. OHCA also contacted those members' primary care providers to exchange information such as ER dates of service, facilities visited and diagnoses. Post-intervention analysis revealed an 80 percent reduction in the number of members that met the criteria for intervention. We estimate that the intervention efforts with these members resulted in 19,260 fewer emergency department visits and about $5.8 million in avoided ER costs for state fiscal year 2007. Although recent cost savings data is unavailable, this effort continues.

Living Choice: The Oklahoma Long-Term Living Choice Project helps people of all ages with disabilities or long-term illnesses to live as independently as possible. The Living Choice Project promotes community living, such as returning to their own home or residing in a group home, rather than ongoing institutional care, if that is the member's desire. A $41 million dollar grant in 2007 from the Centers for Medicare & Medicaid Services under the Money Follows the Person solicitation allows OHCA to facilitate the transition of people from institutional settings to their own homes in the community by offering such supports as home health care, environmental modifications and medical equipment. Right now our target is a population of about 2,000 people.

Cost savings through better patient care

Medical Home: SoonerCare Choice members are assigned a primary care provider, or PCP, who sees to their medical needs and refers them for specialized care as needed. Having a "medical home" allows members to develop a relationship with a provider who knows their medical issues and history.

Care Management: The Oklahoma Health Care Authority's care management program assists SoonerCare members who have complex or exceptionally costly health care needs (such as cancer, organ transplants or multiple long-term conditions like diabetes and heart disease). Nurses and social workers help members and their health care providers use the appropriate providers, resources and facilities within the scope of the state's Medicaid program.

Prenatal Care: Since SoonerCare pays for about 60 percent of the deliveries that take place in Oklahoma each year, we have a strong interest in bringing about more positive birth outcomes by making sure members receive proper prenatal care early in their pregnancy and that high-risk members are identified and receive appropriate care. "Special Delivery," a program for pregnant women, encourages early prenatal care, helps members to understand available benefits and identifies high-risk OB cases for early care management intervention.

Pay for Performance: In January, SoonerCare Choice began transitioning to a "patient-centered medical home" model that pays providers for care coordination and medical visits. It also includes payments for excellence through the SoonerExcel program. When the first quarterly SoonerExcel payments were made in May, 87 percent of our Choice providers received a payment. The average payment per provider was $935. "Focus on Excellence" provides similar payments for nursing homes and other long-term care facilities.

Improved technology and efficiencies

Avoiding payment errors: Oklahoma's error rate for medical claims is much lower than the national average. The federal government's Payment Error Rate Measurement (PERM) program checks the accuracy with which states pay Medicaid and State Children's Health Insurance Program (SCHIP) claims for members' medical services. In the state's last federal review in 2006, Oklahoma's error rate was 2.51 percent, while the national rate was 4.7 percent. The PERM considers paid claims, capitation payments, reimbursement and premium policies, coding and more. Unlike other states that tend to pay claims and then try to recoup funds for payments made in error, the Oklahoma Health Care Authority has technology in place to catch many such errors before they can occur. Our claims processing system scans claims to look for common errors based on such factors as age, gender and duplicate payments. For instance, circumcision is only a covered benefit for male members; birth claims must be for a female age 10 or older; if a SoonerCare member is also eligible for Medicare, we hold the claim until Medicare has paid its part of the bill. OHCA's Provider Audit/Review unit has identified more than $19 million in recoveries during the last three years, according the OHCA annual reports.

Tracking down other payment sources: OHCA is taking full benefit of legislative changes passed in 2003 and 2006 to enhance collections and obtain data from private insurance companies. Electronic data matching with various health insurers not only increases collections but has a big impact on cost avoidance and assists other state agencies with their goals, such as child support enforcement.

Web-based operations: The Oklahoma Health Care Authority (OHCA) uses a variety of computerized and Web-based operations to improve quality while simultaneously minimizing the costs of its services. Here are some examples of the operational efficiencies currently in place:

- Specific computer systems allow OHCA staff to improve turnaround times for prior authorizations.

- A secure Web site for providers allows them to submit forms, claims and contract renewals online rather than relying upon time-consuming, paper transactions. More than 95 percent of the nearly 38 million claims submitted during the past calendar year were submitted electronically, allowing OHCA to process them more quickly.

- Participating hospitals can submit newborn registration forms electronically using a customized, secure Web site. Doing this creates a SoonerCare ID for the newborn and instant linking of the newborn to the mother's records within hours of delivery.

- Currently developing a Web site which will allow Oklahomans to apply for SoonerCare benefits online from any computer with Internet access.

- SoonerScribe, an electronic prescribing system, allows providers to automate the prescription process, enhancing not only the speed of transactions but the safety and efficiency of care. The system, available at no cost to SoonerCare providers, manages patient prescription costs by displaying formulary information and a list of alternatives and by checking for interactions between medicines.

OKLAHOMA HEALTH CARE AUTHORITY
SFY10 Budget Reduction Analysis

FY-2010 Budget Analysis with 5% Base Reduction for 11 Months	Appropriation	Federal	Stimulus	Total
FY-2010 Annual General Revenue Allocation	$ 581,040,412	$ 1,548,880,172	$ 274,052,987	$ 2,403,973,571
FY-2010 5% Appropriation Reduction (11 mths)	**$ (26,631,019)**	**$ (70,990,341)**	**$ (12,560,762)**	**$ (110,182,122)**
Details of YTD Budget Cuts Implemented:				
FY09 Reappropriated budget reduction	$ 834,642			
Budget reduction due to lower than est. growth in first qtr.	4,007,362			
Unbudgeted prior year carryover	2,421,002			
AWP calculation change/9 months - eff 10/01/2009	1,812,750			
J Code pricing change/6 months - eff 01/01/2009	725,100			
YTD FY10 Budget Reductions	**$ 9,800,856**			
FY10 Remaining Reduction Balance	**$ (16,830,163)**	**$ (44,864,187)**	**$ (7,938,099)**	**$ (69,632,449)**

BUDGET REDUCTION MEETINGS TIMELINE

Date	Meeting	Number in Attendance
Thursday, November 5, 2009	Budget Meeting with Large Provider Representatives	20
Thursday, November 12, 2009	OHCA Board Meeting	30
Thursday, November 12, 2009	Drug Utilization Review Board Meeting	40
Tuesday, November 17, 2009	Perinatal Task Force Meeting	37
Wednesday, November 18, 2009	Durable Medical Equipment (DME) Provider Meeting	60
Thursday, November 19, 2009	Medical Advisory Committee Meeting	37
Thursday, November 19, 2009	Budget Meeting with Large Provider Representatives	19
Thursday, November 19, 2009	Medical Advisory Task Force Meeting	15
Monday, November 23, 2009	Behavioral Health Advisory Meeting	34
Tuesday, November 24, 2009	Child Health Advisory Council Meeting	22
Wednesday, December 2, 2009	House SFY11 Request and SFY10 Reduction Meeting	20
Thursday, December 3, 2009	Senate SFY11 Request and SFY 10 Reduction Meeting	10

OKLAHOMA HEALTH CARE AUTHORITY
SFY10 Budget Reduction Analysis
And Staff Recommendations
Detailed Descriptions

Administration
OHCA will absorb a 5% cut in administration. These cuts will come from restricted purchases of furniture & equipment, non-essential travel, discretionary supplies, and administrative service contracts. In addition, vacant positions will be reviewed and evaluated for cost savings.
Proposed state reduction - $2.8 million

Dental
Reduce payment for posterior fillings to amalgam rate.
The payment for posterior fillings will be reimbursed at the rate paid for amalgam fillings. Reimbursement rate for resin fillings will be reduced by 45%.
Proposed state reduction - $1.8 million

Durable Medical Equipment (DME)

- Pricing adjustments for oxygen and capped rental
  All pricing for the rental of stationary and portable oxygen will be reduced by 11% and 8% respectively to match Medicare 2009 fee schedule for oxygen. Capped rental of oxygen items were adjusted to match the total outlay for Medicare Capped Rental items (Medicare discounts 25% for rental months 4 – 13). OHCA brought its capped rental in alignment with Medicare's capped rental policies. However, oxygen remains a continuous rental item per OHCA's policies.
  Proposed state reduction - $178k

- Reduce oxygen payment rate for adults
  Stationary and portable oxygen pricing rates for adult members not residing in a nursing facility will be reduced by 10%. Stationary and portable oxygen pricing rates for adult members residing in nursing facilities will be reduced by 24%.
  Proposed state reduction - $168k

- Pricing adjustments for children's nebulizers and eliminate adult nebulizers
  Pricing for compressor driven nebulizers will be reduced by 36%. Adult coverage of compressor driven nebulizers will be eliminated.
  Proposed state reduction - $189k
  Adults affected – 1,500

- Restrict number of blood glucose test strips without a prior authorization from 300 to 100 strips
  Restricting test strips to 100 w/out a Prior authorization will reduce utilization by 40%. In addition, applied discounted rate for mail order supplies dispensed by using CMS modifier will allow for an additional 15% reduction.
  Proposed state reduction - $272k

- Eliminate other adult DME products
  Adult coverage of the following items will be eliminated:
  Negative pressure wound therapy
  Osteogenic stimulators
  Form fitting conductive garments
  Blood glucose monitors
  Portable oxygen contents
  Water circulating heat pad w/pump
  Proposed state reduction - $127k
  Adults affected – 2,843

DME TOTALS
Proposed state reduction - $934k

Pharmacy

- Change script limit to 2 brand + 4 generic
  Currently members receive 6 prescriptions per month with a maximum of 3 brands within the 6 script limit. This change will decrease the number of brands to 2 brands within the 6 script limit. The impact also includes the loss of related drug rebate revenue.
  Proposed state reduction - $572k

- Utilization management of triptans, otics, fibromyalgia, and antipsychotics (eff. 4/01/10)
  These categories will be added to the product based prior authorization program.
  Proposed state reduction - $622k

- Revise reimbursement methodology for certain injectable drugs including but not limited to growth hormone and blood factor.
  Proposed state reduction - $462k

PHARMACY TOTALS
Proposed state reduction - $ 1.7 million

Provider Payment Changes

- Hospital crossover co-insurance and deductible change
  OHCA will reduce the Medicaid allowable for Medicare Part A & Part B crossover claims from 100% of the Medicaid allowable for co-insurance (part B) and deductibles (part A) to 25% of the Medicaid allowable for co-insurance and 75% of the Medicaid allowable for deductibles. However, providers can list this unpaid amount as "bad debt" on hospital Medicare cost reporting to CMS. Under the Medicare statutes, a provider is entitled to claim as reimbursable cost bad debts attributable to amounts unpaid for Medicare co-insurance and deductible amounts. According to the Oklahoma Hospital Association 70% of the unpaid amount is reimbursable by Medicare.
  Proposed state reduction - $5.3 million

- Implement cost caps for behavioral health utilization for outpatient levels of care.
  Behavioral health categorizes outpatient services of care into 4 levels with level 4 being the most intensive method of service delivery. All services are authorized with a maximum of units available within each level of care from levels 1 - 4. OHCA will reduce the utilization cap on levels of care 3 & 4 by 25%.
  Proposed state reduction - $630k
  Members affected – 3,000

- Modify payment methodology to a tiered reimbursement schedule for Psychiatric (eff. 4/01/10)
  Residential Treatment Facilities (PRTF). Reimbursement for residential treatment in PRTF's will be reduced after 30 days by 15%. An additional 15% will be reduced from the rate after 60 days of residential treatment. Accordingly the PRTF's rates will remain at 70% of the initial rate throughout the completion of the residential treatment. In addition, program savings have been offset with additional costs due to enhanced continuum of care services in outpatient.
  Proposed state reduction - $639k

- Increase member's co-pay not to exceed federal maximum (eff. 4/01/10)
  Member's co-pay will be increased for the following provider groups:
  Inpatient Hospital will increase from $3.00 to $10.00 per day with a cap of $90.00
  Adult behavioral health will increase from -0- to $3.00 per visit
  Home Health will increase from $1.00 to $3.00 per visit
  DME will increase from -0- to $3.00 per visit

Pharmacy will increase from $1.00 to $2.00 for prescriptions having a Medicaid allowable of $29.99 or less and will increase from $2.00 to $3.00 for prescriptions having a Medicaid allowable of $30.00 or more. In addition, preferred generic prescriptions will decrease to a zero co-pay.
Proposed state reduction – 218k
Adults affected – 280,000

- Eliminate Modifier 57 code
  This change will eliminate payment for the evaluation & management (E&M) service which resulted in the decision to perform a major surgery, which is reported by appending Modifier 57 to the E&M service code when the E&M service is performed on the day before or the day of said major surgery. (A major surgery is defined as a surgery having a 90-day global period).
  Proposed state reduction - $41k

- Eliminate separate payment for impacted earwax
  OHCA will no longer provide a separate payment for impacted earwax removal.
  Proposed state reduction - $34k

- Never Events / Present on Admission
  CMS has established National Coverage Determinations that nationally "non-cover" three surgical errors. These errors are: 1) wrong surgical or other invasive procedures performed; 2) surgical or other invasive procedures performed on the wrong body part; and, 3) surgical or invasive procedures performed on the wrong patient. OHCA is adopting the same policy position effective February 1, 2010. Additionally, hospitals will not receive reimbursement for conditions that are acquired during a hospital stay (termed POA, or present on admission). Payment will be made as though this secondary diagnosis was not present.

- Medical necessity inpatient review
  The pool of inpatient claims will be expanded to review more claims for medical necessity.
  Proposed state reduction - $70k

- Inpatient Hospital Stay Reviews
  Instances have been noted during a current review in which hospitals were billed and reimbursed inappropriately for one-day stays. Claims should have been made for an emergency room visit, observation visit, or outpatient surgery, but were instead billed as an inpatient hospital admission. Overpayments will be recouped and appropriate edits will be added to the claims payment system to assist in cost avoided overpayments in the future.
  Proposed state reduction - $2.5 million

PROVIDER PAYMENT TOTALS
Proposed state reductions - $9.6 million

6C-1. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 17. Medical Suppliers
OAC 317:30-5-211.10. [AMENDED]
OAC 317:30-5-211.12. [AMENDED]
OAC 317:30-5-211.15. [AMENDED]
OAC 317:30-5-218. [AMENDED]
Part 61. Home Health Agencies
OAC 317:30-5-547. [AMENDED]
(Reference APA WF # 09-76)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of revisions to the Agency's durable medical equipment rules. Revisions are necessary to reduce the Agency's operations budget in order to comply with the budget reductions mandated by the Oklahoma Legislature through the end of State Fiscal Year 2010. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

SUMMARY: Durable medical equipment (DME) rules are revised to reduce and/or eliminate certain durable medical equipment benefits to adults in order to comply with the budget reductions mandated by the Oklahoma Legislature through the end of State Fiscal Year 2010. Revisions include the elimination of osteogenic stimulators, portable oxygen contents, the reduction of blood glucose strips and lancets without a prior authorization, and provides for periodic review and adjustments of the Agency's fee schedule.

BUDGET IMPACT: Agency staff has estimated that the revisions would provide a total budget savings of $2,626,111 for the remainder of State Fiscal Year 2010, with a state share savings of $934,108.

MEDICAL ADVISORY COMMITTEE: The committee was presented with a summary of potential budget reduction items at their November 19, 2009 meeting, which included the items outlined within the text of this rule. The committee was given opportunity to participate in policy development and program administration regarding the potential budget reduction items.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising DME rules to reduce and/or eliminate certain durable medical equipment benefits for adults.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.10. Durable medical equipment (DME)

(a) **DME.** DME includes, but is not limited to: medical supplies, orthotics and prosthetics, custom braces, therapeutic lenses, respiratory equipment and other qualifying items when acquired from a contracted DME provider.

(b) **Certificate of medical necessity.** Certain items of DME require a CMN/OHCA CMN which should be submitted with the request for prior authorization. These items include but are not limited to:

(1) hospital beds;

(2) support surfaces;

~~(3) wheelchairs;~~

~~(4)~~ (3) continuous positive airway pressure devices (~~BiCAP~~ BiPAP and CPAP);

~~(5)~~ (4) patient lift devices;

~~(6)~~ (5) external infusions pumps;

~~(7)~~ (6) enteral and parenteral nutrition; and

~~(8) osteogenesis stimulators; and~~

~~(9)~~ (7) pneumatic compression devices.

(c) **Prior authorization.**

(1) **Rental.** Rental of hospital beds, support surfaces, ~~wheelchairs,~~ continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts require prior authorization and a completed CMN/OHCA CMN; medical necessity must be documented in the member's medical record and be signed by the physician.

(2) **Purchase.** Equipment will be purchased when a member requires the equipment for an extended period of time. During the prior authorization review the PA consultant may change the authorization from a rental to a purchase or a purchase to a rental based on the documentation submitted. The provider must indicate whether the DME item provided is new or used.

(d) **Backup equipment.** Backup equipment is considered part of the rental cost and not a covered service without prior authorization.

(e) **Home modification.** Equipment used for home modification is not a covered service.

317:30-5-211.12. Oxygen rental

A monthly rental payment is made for rental of liquid oxygen systems, gaseous oxygen systems and oxygen concentrators. The rental payment for a stationary system includes all contents and supplies, such as, regulators, tubing, masks, etc that are medically necessary. An additional monthly payment may be made for a portable liquid or gaseous oxygen system based on medical necessity.

(1) Oxygen concentrators are covered items for members residing in their home or in a nursing facility.

(2) For members who meet medical necessity criteria, SoonerCare covers portable liquid or gaseous oxygen systems ~~and portable oxygen content~~. Portable oxygen contents are not covered. The need for a portable oxygen system must be stated on the CMN. A portable system that is used as a ~~standby~~ backup system only is not a covered item.

(3) When six or more liters of oxygen are medically necessary, an additional payment will be paid up to 150% of the allowable for a stationary system when billed with the appropriate modifier.

317:30-5-211.15. Supplies

(a) The OHCA provides coverage for supplies that are prescribed by the appropriate medical provider, medically necessary and meet the special requirements below.

(b) Special requirements:

(1) **Intravenous therapy.** Supplies for intravenous therapy are covered items. Drugs for IV therapy are covered items only as specified by the Vendor Drug program.

(2) **Diabetic supplies.** ~~The purchase of one glucometer, one spring loaded lancet device, and replacement batteries as defined by the life of the battery are covered items. In addition, a~~ A maximum of ~~200~~ 100 glucose test strips and ~~200~~ 100 lancets per month when medically necessary and prescribed by a physician are covered items. Diabetic supplies in excess of these parameters must be prior authorized.

(3) **Catheters.** Permanent indwelling catheters, male external catheters, drain bags and irrigation trays are covered items. Single use self catheters when the member has a history of urinary tract infections is a covered item. The prescription from the attending physician must indicate such documentation is available in the member's medical record.

(4) **Colostomy and urostomy supplies.** Colostomy and urostomy bags and accessories are covered items.

317:30-5-218. Reimbursement

(a) **Medical equipment and supplies.** Reimbursement for durable medical equipment and supplies will be made using an amount derived from the lesser of the OHCA maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established ~~based on efficiency, economy, and quality of care as determined by the OHCA~~. The fee schedule will be reviewed annually and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

(b) **Oxygen equipment and supplies.**

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. ~~Content for portable systems should be billed monthly with one unit equal to one month's supply.~~ Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.

(3) ~~Effective July 1, 2007, payment~~ Payment for oxygen and ~~for~~ oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code ~~be based on the Medicaid allowable in effect for the Oklahoma region on June 30, 2007~~. Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually~~,~~ and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

PART 61. HOME HEALTH AGENCIES

317:30-5-547. Reimbursement

(a) Nursing services and home health aide services are covered services on a per visit basis. Reimbursement for any combination of nursing or home aid service shall not exceed 36 visits per calendar year per member. Additional visits for children must be prior authorized when medically necessary.

(b) Reimbursement for durable medical equipment and supplies will be made using the amount derived from the lesser of the OHCA fee schedule or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that OHCA will pay a provider for an allowable procedure code. When a procedure code is not assigned a maximum allowable fee for a unit of service, a fee will be established ~~based on efficiency, economy, and quality of care as determined by the OHCA~~. Once the service has been provided, the supplier is required to include a copy of the invoice documenting the supplier's cost of the item with the claim.

(c) Reimbursement for oxygen and oxygen supplies is as follows:

(1) Payment for oxygen systems (stationary, liquid and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment is made as long as it is medically necessary. The rental payment includes all contents and supplies, i.e., regulators, tubing, masks, etc. Portable oxygen systems are also considered continuous rental. ~~Content for portable systems should be billed monthly with one unit equal to one month's supply.~~ Ownership of the equipment remains with the supplier.

(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pickup the equipment when it is no longer medically necessary.

(3) ~~Effective July 1, 2007, payment~~ Payment for oxygen and ~~for~~ oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code ~~be based on the Medicaid allowable in effect for the Oklahoma region on June 30, 2007~~. Reimbursement for members who reside in a nursing facility may be at a reduced rate. The fee schedule will be reviewed annually~~,~~ and adjustments to the fee schedule may be made at any time based on efficiency, budget considerations, and quality of care as determined by the OHCA.

6C-2. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
OAC 317:30-3-57. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part. 5 Pharmacies
OAC 317:30-5-72. [AMENDED]
(Reference APA WF # 09-74)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to reduce the number of allowed brand name prescription drugs from three to two per month for SoonerCare members. SoonerCare members will still receive a total of six prescriptions per month, however only a maximum of two brand name drugs. Revisions are necessary to reduce the Agency's operations budget in order to comply with the budget reductions mandated by the Oklahoma Legislature through the end of State Fiscal Year 2010. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

SUMMARY: Agency rules are revised to reduce the number of allowed brand name prescription drugs from three to two per month for SoonerCare members. The revisions are needed in order to reduce the Agency's budget to comply with the legislative mandated budget reductions.

BUDGET IMPACT: Agency staff has estimated that the revisions would provide a total budget savings of $1,610,000 for the remainder of State Fiscal Year 2010, with a state share savings of $572,677.

MEDICAL ADVISORY COMMITTEE: The committee was presented with a summary of potential budget reduction items at their November 19, 2009 meeting, which included the items outlined within the text of this rule. The committee was given opportunity to participate in policy development and program administration regarding the potential budget reduction items.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising rules to reduce the number of allowed brand name prescription drugs from three to two per month for SoonerCare members.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare ~~coverages~~ coverage guidelines for the categorically needy:

(1) Inpatient hospital services other than those provided in an institution for mental diseases.

(A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.

(B) Coverage for members under 21 years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or free standing dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with OHCA.

(6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity Clinic Services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 21 years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

(A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one visual screening and glasses each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected.
(G) Hearing services as outlined in OAC 317:30-3-65.9.
(H) Prescribed drugs.
(I) Outpatient Psychological services as outlined in OAC 317:30-5-275 through OAC 317:30-5-278.
(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC ~~317:30-5-95~~ 317:30-5-95 through OAC 317:30-5-97.
(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
(L) Inpatient hospital services.
(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.
(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 30 days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ICF/MR, or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services
(B) Optometrists' services
(C) Psychologists' services
(D) Certified Registered Nurse Anesthetists
(E) Certified Nurse Midwives
(F) Advanced Practice Nurses
(G) Anesthesiologist Assistants

(17) Free-standing ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six prescriptions with a limit of ~~three~~ two brand name prescriptions per month. Exceptions to the six prescription limit are:

(A) unlimited medically necessary monthly prescriptions for:
(i) members under the age of 21 years; and
(ii) residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded.

(B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the ~~1~~1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the ~~three~~ two brand name or thirteen total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of durable medical equipment.
(20) Adaptive equipment, when prior authorized, for members residing in private ICF/MR's.
(21) Dental services for members residing in private ICF/MR's in accordance with the scope of dental services for members under age 21.
(22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.
(23) Standard medical supplies.
(24) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal.
(25) Blood and blood fractions for members when administered on an outpatient basis.
(26) Inpatient services for members age 65 or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.
(28) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.
(29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.
(31) Nursing facility services for members under 21 years of age.
(32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N.
(33) Part A deductible and Part B ~~medicare~~ Medicare Coinsurance and/or deductible.
(34) Home and Community Based Waiver Services for the mentally retarded.
(35) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.
(36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(D) Finally, procedures considered experimental or investigational are not covered.

(37) Home and community-based waiver services for mentally retarded members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).

(38) Case Management services for the chronically and/or severely mentally ill.

(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.

(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.

(41) Early Intervention services for children ages 0-3.

(42) Residential Behavior Management in therapeutic foster care setting.

(43) Birthing center services.

(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.

(45) Home and Community-Based Waiver services for aged or physically disabled members.

(46) Outpatient ambulatory services for members infected with tuberculosis.

(47) Smoking and Tobacco Use Cessation Counseling for children and adults.

(48) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.

(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 5. PHARMACIES

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six covered prescriptions per month with a limit of ~~three~~ two brand name prescriptions.

(2) Subject to the limitations set forth in OAC 317:30-5-72.1, OAC 317:30-5-77.2, and OAC 317:30-5-77.3, exceptions to the six medically necessary prescriptions per month limit are:

(A) unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of Nursing Facilities or Intermediate Care Facilities for the Mentally Retarded; and

(B) seven additional medically necessary prescriptions which are generic products per month to the six covered under the State Plan are allowed for adults receiving services under the 915(c) Home and Community Based Services Waivers. Medically necessary prescriptions beyond the ~~three~~ two brand name or thirteen total prescriptions will be covered with prior authorization.

(3) Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, low-phenylalanine formula and amino acid bars for persons with a diagnosis

of PKU, certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month.

(b) **Coverage for children.** Prescription drugs for SoonerCare eligible individuals under 21 years of age are not limited.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. The exclusion will become effective January 1, 2006, or the date Medicare Part D is implemented for dual eligible individuals, whichever is later. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

6C-3. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
OAC 317:30-3-5. [AMENDED]
(Reference APA WF # 09-73)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to increase existing co-payments for certain medical benefits provided through SoonerCare as well as require co-pays for additional medical benefits. Revisions are necessary to reduce the Agency's operations budget in order to comply with the budget reductions mandated by the Oklahoma Legislature through the end of State Fiscal Year 2010. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

SUMMARY: Agency rules are revised to increase existing co-payments for certain medical benefits provided through SoonerCare as well as require co-pays for additional medical benefits. Under Section 1902(a)(14) of the Social Security Act, States are permitted to require certain members to share some of the cost of their health care by imposing upon them such payments as enrollment fees, premiums, deductibles, co-insurance, co-payments, or similar cost sharing charges. The Centers for Medicare and Medicaid Services excludes the States from requiring cost sharing for children, pregnant women and institutionalized individuals as well as for emergency and family planning services. According to Article 10, Section 23 of the Oklahoma Constitution, all state agencies must maintain a balanced budget. In order for the Agency to accomplish the necessary financial reductions, rules are in need of revision to increase the existing co-payments for some services for certain SoonerCare members.

BUDGET IMPACT: Agency staff has estimated that the revisions would provide a total budget savings of $613,395 for the remainder of State Fiscal Year 2010, with a state share savings of $218,184.

MEDICAL ADVISORY COMMITTEE: The committee was presented with a summary of potential budget reduction items at their November 19, 2009 meeting, which included the items outlined within the text of this rule. The committee was given opportunity to participate in policy development and program administration regarding the potential budget reduction items.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Article X Section 23 of the Oklahoma Constitution; 42 CFR 447.50 through 447.55

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:

Revising rules to increase existing co-payments for certain medical benefits provided through SoonerCare as well as require co-pays for additional medical benefits.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and Cost Sharing

(a) **Definitions.** The following words and terms, when used in subsection (c) of this Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.

(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the ~~Primary Care Case Manager~~ SoonerCare Choice contracts in the SoonerCare Program.

(3) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the ~~Primary Care Case Manager~~ SoonerCare Choice contracts in the SoonerCare Program.

(b) **Assignment in fee-for-service.** The ~~Authority's~~ OHCA's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or ~~copayment~~ co-payment required by the State Plan to be paid by the ~~recipient~~ member and make no additional charges to the ~~patient~~ member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the ~~patient~~ member must not be billed and the ~~patient~~ member is not responsible for any balance except the amount indicated by OHCA. The only amount a ~~patient~~ member may be responsible for is ~~the personal participation as agreed to at the time of determination of eligibility~~ a co-payment, or the ~~patient~~ member may be responsible for services not covered under the medical programs. ~~The amount of personal participation will be shown on the OHCA notification of eligibility.~~ In any event, the ~~patient~~ member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, ~~Customer~~ Provider Services.

(3) When potential assignment violations are detected, the ~~Authority~~ OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the ~~Authority~~ OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a fee for service contract and also executes a contract with a provider in the ~~Primary Care Case Management~~ SoonerCare Choice program ~~shall~~ must adhere to the rules of this subsection regarding assignment.

~~(1) If the service provided to the recipient is within the scope of the services outlined in the SoonerCare Contract, the recipient shall not be billed for the service. In this case, the provider shall pursue~~

~~collection from the Primary Care Physician in the case of the SoonerCare Program.~~

~~(2)~~ (1) If the service provided to the ~~recipient~~ member is outside of the scope of the services outlined in the SoonerCare Contract, then the provider may bill or seek collection from the ~~recipient~~ member.

~~(3)~~ (2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) ~~and (2)~~ of this subsection, the Oklahoma Health Care Authority shall be the final authority for this decision. The provider seeking payment under the SoonerCare Program may appeal to OHCA under the provisions of OAC 317:2-1-2.1.

~~(4)~~ (3) Violation of this provision shall be grounds for a contract termination in the fee-for-service and SoonerCare programs.

(d) **Cost Sharing-Copayment.** Section 1902(a)(14) of the Social Security Act permits states to require certain ~~recipients~~ members to share some of the costs of ~~Medicaid~~ SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, ~~copayments~~ co-payments, or similar cost sharing charges. OHCA requires a ~~copayment~~ co-payment of some ~~Medicaid recipients~~ SoonerCare members for certain medical services provided through the fee for service program. A ~~copayment~~ co-payment is a charge which must be paid by the ~~recipient~~ member to the service provider when the service is covered by ~~Medicaid~~ SoonerCare. Section 1916(e) of the Act requires that a provider participating in the ~~Medicaid~~ SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the ~~copayment~~ co-payment. A person's assertion of their inability to pay the copayment co-payment establishes this inability. This rule does not change the fact that a ~~recipient~~ member is liable for these charges and it does not preclude the provider from attempting to collect the ~~copayment~~ co-payment.

(1) ~~Copayment~~ Co-payment is not required of the following ~~recipients~~ members:

(A) Individuals under age 21. Each ~~recipient's~~ member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) ~~Recipients~~ Members in nursing facilities and intermediate care facilities for the mentally retarded.

(C) Pregnant women.

(D) Home and Community Based ~~Waiver service recipients~~ Service waiver members except for prescription drugs.

(2) ~~Copayment~~ Co-payment is not required for the following services:

(A) Family planning services. Includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(3) ~~Copayments required include~~ Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) ~~$3.00 per day for inpatient~~ Inpatient hospital ~~services~~ stays. ~~Copayments for inpatient care paid under the Diagnosis Related Groups (DRG) methodology are calculated on the actual length of stay and are capped at $90. Copayments for claims paid under Level of Care methodology are calculated at $3.00 per day.~~

(B) ~~$3.00 per day for outpatient~~ Outpatient hospital ~~services~~ visits.

(C) ~~$3.00 per day for ambulatory~~ Ambulatory surgery ~~services~~ visits including free-standing ambulatory surgery centers.

(D) ~~$1.00 for each service rendered by~~ Encounters with the following rendering providers:

(i) Physicians,
(ii) Advanced Practice Nurses,
(iii) Physician Assistants,
~~(ii)~~ (iv) Optometrists,
~~(iii)~~ (v) Home Health Agencies,
~~(iv) Rural Health Clinics,~~
~~(v)~~ (vi) Certified Registered Nurse Anesthetists, ~~and~~
~~(vi)~~ (vii) ~~Federally Qualified Health Centers.~~
Anesthesiologist Assistants,
(viii) Durable Medical Equipment providers, and
(ix) Outpatient behavioral health providers.

(E) Prescription drugs.
(i) Zero for preferred generics.
~~(i)~~ (ii) ~~$1.00~~ $2.00 for prescriptions having a ~~Medicaid~~ SoonerCare allowable of $29.99 or less.
~~(ii)~~ (iii) ~~$2.00~~ $3.00 for prescriptions having a ~~Medicaid~~ SoonerCare allowable of $30.00 or more.

(F) Crossover claims. Dually eligible ~~Medicare/Medicaid recipients~~ Medicare/SoonerCare members must make a ~~copayment~~ co-payment ~~of $.50~~ in an amount that does not exceed the federal allowable per ~~service~~ visit/encounter for all Part B covered services. This does not include dually eligible ~~HCBW service recipients~~ HCBS waiver members.

6C-4. **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
OAC 317:30-3-61. [NEW]
(Reference APA WF # 09-51)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's general provider policies. Rules are written to establish a policy for serious reportable events in healthcare. These emergency rule revisions will implement the non-coverage of three surgical errors and address the applicable billing procedures for such serious events. This quality initiative ensures that state and federal funds are not being used to promote serious medical errors and that all Oklahomans will continue to have access to quality healthcare. Revisions are necessary to reduce the Agency's operations budget in order to comply with the budget reductions mandated by the Oklahoma Legislature through the end of State Fiscal Year 2010. Without the recommended revisions, the Agency is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Program.

ANALYSIS: Agency rules are written to establish policy for serious reportable events in healthcare, also called never events. Rules will non-cover three surgical errors and set billing policy to implement appropriate claims processing. The three surgical errors are (1) wrong surgical or other invasive procedures performed on a member, (2) surgical or other invasive procedures performed on the wrong body part, and (3) surgical or other invasive procedures performed on the wrong member. Rules will also include a related claims review (if appropriate) and the avoidance of SoonerCare to act as a secondary payer for Medicare non-payment of the three surgical errors.

BUDGET IMPACT: Agency staff expects these revisions to result in budget savings should the three surgical errors occur. Additionally, these revisions are the pre-requisite to the Agency pursuing future revisions which would non-cover Hospital Acquired Conditions which is expected to result in further budget savings.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, and recommended Board approval.

PROPOSED EFFECTIVE DATE: February 1, 2010

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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising agency rules to establish policy for serious reportable events in healthcare, also called never events. Rules will non-cover three surgical errors and set billing policy to implement appropriate

claims processing. The three surgical errors are (1) wrong surgical or other invasive procedures performed on a member, (2) surgical or other invasive procedures performed on the wrong body part, and (3) surgical or other invasive procedures performed on the wrong member.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-61. Serious reportable events - never events

(a) **Definitions.** The following words and terms, when used in this Section, have the following meaning, unless the context clearly indicates otherwise.

(1) **"Surgical and other invasive procedures"** are defined as operative procedures in which skin or mucous membranes and connective tissues are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.

(2) A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that member.

(3) A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that member including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).

(4) A surgical or other invasive procedure is considered to have been performed on the wrong member if that procedure is not consistent with the correctly documented informed consent for that member.

(b) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs (1) a different procedure altogether; (2) the correct procedure but on the wrong body part; or (3) the correct procedure but on the wrong member. SoonerCare will not cover hospitalizations or any services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are also not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. A provider cannot shift financial liability or responsibility for the non-covered services to the member if the OHCA has determined that the service is related to one of the above erroneous surgical procedures.

(c) **Billing.** For inpatient claims, hospitals are required to bill two claims when the erroneous surgery is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS

modifiers to all lines related to the erroneous surgery. Claim lines submitted with one of the applicable HCPCS modifiers will be line-item denied.

(d) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an 18-month period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.

(e) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned erroneous surgery(s).

7C-1. **CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**
Subchapter 5. Eligibility and Countable Income
Part 3. Non-Medical Eligibility Requirements
OAC 317:35-5-25. [AMENDED]
Subchapter 6. ~~Soonercare Health Benefits~~ SoonerCare for Categorically Needy Pregnant Women and Families with Children
Part 7. Certification, Redetermination and Notification
OAC 317:35-6-60. [AMENDED]
OAC 317:35-6-61. [AMENDED]
(Reference APA WF # 09-55)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to comply with provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3. The legislation amended the citizenship and identity documentation requirements added by the Deficit Reduction Act of 2005 to provide that children who were initially eligible for Medicaid as deemed newborns are now considered to have provided satisfactory documentation of citizenship and identity when their eligibility is renewed on their first birthday. In addition, Public Law 111-3 eliminated the requirement for Medicaid that newborns coming home from the hospital must live with and remain a member of the mother's household, and the mother must remain eligible for Medicaid (or would remain eligible if still pregnant). Emergency rulemaking is required in order to comply with the federal mandate.

SUMMARY: SoonerCare eligibility rules regarding coverage for deemed newborns are revised to comply with provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3. The Deficit Reduction Act of 2005 added specific citizenship and identity documentation requirements in order for individuals to qualify for Medicaid. Public Law 111-3 provides that children who were initially eligible for Medicaid as deemed newborns shall be considered to have provided satisfactory documentation of citizenship and identity when their eligibility is renewed on their first birthday. The legislation further eliminates the requirement that, in order to receive coverage, newborns coming home from the hospital must live with the mother, remain a member of the mother's household, and that the mother remain eligible for Medicaid (or would remain eligible if still pregnant). Rules are revised to state that a deemed newborn will be regarded as meeting the citizenship and identity requirements for all future SoonerCare eligibility determinations. Further, the certification period for the deemed newborn will be shortened only in the event the child loses Oklahoma residence or expires. Other revisions clarify that deemed newborns are to be certified for SoonerCare through the end of the month that the child reaches age one.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 435.117; Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
SoonerCare eligibility rules regarding coverage for deemed newborns are revised to comply with provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-25. Citizenship/alien status and identity verification requirements
(a) **Citizenship/alien status and identity verification requirements.** Verification of citizenship/alien status and identity are required for all adults and children approved for ~~Medicaid~~ SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) Passport;

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS) (Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);

(D) Copy of the Medicare card or printout of a BENDEX or SDX screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one of the 50 states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986;

(ii) A Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen ID Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873) (Issued by the INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);

(vi) A Final Adoption Decree showing the child's name and U. S. place of birth;
(vii) Evidence of U.S. Civil Service employment before 6/1/1976;
(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);
(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;
(x) Oklahoma Voter Registration Card; or
(xi) Other acceptable documentation as approved by OHCA.

(B) Other less reliable forms of citizenship verification are:
(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and that indicates a U.S. place of birth. For children under 16 the evidence must have been created near the time of birth or five years before the date of application;
(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five years before the initial application date and that indicates a U.S. place of birth;
(iii) Federal or State census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or
(iv) One of the following items that show a U.S. place of birth and was created at least five years before the application for ~~Medicaid~~ SoonerCare. This evidence must be one of the following and show a U.S. place of birth:
(I) Seneca Indian tribal census record;
(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;
(III) U.S. State Vital Statistics official notification of birth registration;
(IV) An amended U.S. public birth record that is amended more than five years after the person's birth; or
(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:
(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;
(B) A school identification card with a photograph of the individual;
(C) An identification card issued by Federal, state, or local government with the same information included on driver's licenses;
(D) A U.S. military card or draft record;
(E) A U.S. military dependent's identification card;
(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;
(G) A U.S. Coast Guard Merchant Mariner card;
(H) A state court order placing a child in custody as reported by the OKDHS;
(I) For children under 16, school records may include nursery or daycare records;
(J) If none of the verification items on the list are available, an affidavit may be used for children under 16. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or

guardian stating the date and place of the birth of the child and **cannot be used if an affidavit for citizenship was provided.**

(b) ~~**Centralized Verification Unit**~~ **Reasonable opportunity to obtain citizenship verification.**

(1) When the applicant/member is unable to obtain citizenship verification, a reasonable opportunity is afforded the applicant/member to obtain the evidence as well as assistance in doing so. A reasonable opportunity is afforded the applicant/member before taking action affecting the individual's eligibility for ~~Medicaid~~ SoonerCare. The reasonable opportunity time frame usually consists of 60 days. In rare instances, the ~~CVU may extend the~~ time frame may be extended to a period not to exceed an additional 60 days.

(2) ~~Additional~~ The following methods of verification are ~~available to the CVU. These methods are~~ the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five years before the initial application date that indicates a U.S. place of birth. For children under 16, the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;

(ii) At least one of the individuals making the affidavit cannot be related to the applicant/member;

(iii) In order for the affidavit to be acceptable the persons making them must be able to provide proof of their own citizenship and identity;

(iv) If the individual(s) making the affidavit has information which explains why evidence establishing the applicant's/member's claim or citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Alienage verification requirements.** ~~Medicaid~~ SoonerCare services are provided as listed to the defined groups as indicated in this subsection if they meet all other factors of eligibility.

(1) **Eligible aliens (qualified aliens).** The groups listed in the following subparagraphs are eligible for the full range of ~~Medicaid~~ SoonerCare services. A qualified alien is:

(A) an alien who was admitted to the United States and has resided in the United States for a period greater than five years from the date of entry and who was:

(i) lawfully admitted for permanent residence under the Immigration and Nationality Act;

(ii) paroled into the United States under Section 212(d)(5) of such Act for a period of at least one year;
(iii) granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or
(iv) a battered spouse, battered child, or parent or child of a battered person with a petition under 204(a)(1)(A) or (B) or 244(a)(3) of the Immigration and Naturalization Act.

(B) an alien who was admitted to the United States and who was:
(i) granted asylum under Section 208 of such Act regardless of the date asylum is granted;
(ii) a refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;
(iii) an alien with deportation withheld under Section 243(h) of such Act regardless of the date deportation was withheld;
(iv) a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, regardless of the date of entry;
(v) an alien who is a veteran as defined in 38 U.S.C. ' 101, with a discharge characterized as an honorable discharge and not on the grounds of alienage;
(vi) an alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;
(vii) the spouse or unmarried dependent child of an individual described in (C) of this paragraph.
(viii) a victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or
(ix) admitted as an Amerasian immigrant.

(C) permanent residents who first entered the country under (B) of this paragraph and who later converted to lawful permanent residence status.

(2) **Other aliens lawfully admitted for permanent residence (non-qualified aliens).** Non-qualified aliens are those individuals who were admitted to the United States and who do not meet any of the definitions in paragraph (1) of this subsection. Non-qualified aliens are ineligible for ~~Medicaid~~ SoonerCare for five years from the date of entry except that non-qualified aliens are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(3) **Afghan Special Immigrants.** Afghan special immigrants, as defined in Public Law 110-161, who have special immigration status after December 26, 2007, are exempt from the five year period of ineligibility for SoonerCare services for a time-limited period. The time-limited exemption period for Afghan special immigrants is ~~six~~ eight months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Once the eight month exemption period ends, Afghan special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services described in (2) of this subsection until the five year period ends. Afghan special immigrants are considered lawful permanent residents.

(4) **Iraqi Special Immigrants.** Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are

exempt from the five year period of ineligibility for SoonerCare services for a time-limited period. The time-limited exemption period for Iraqi special immigrants is eight months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status. All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. Once the eight month exemption period ends, Iraqi special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services described in (2) of this subsection until the five year period ends. Iraqi special immigrants are considered lawful permanent residents.

(5) **Undocumented aliens.** Undocumented aliens who do not meet any of the definitions in (1)-(2) of this subsection are eligible for emergency services only when the individual has a medical condition (including emergency labor and delivery) with acute symptoms which may result in placing his/her health in serious jeopardy, serious impairment to bodily functions or serious dysfunction of body organ or part without immediate medical attention. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(6) **Ineligible aliens.**

(A) Ineligible aliens who do not fall into the categories in (1) and (2) of this subsection, yet have been lawfully admitted for temporary or specified periods of time include, but are not limited to: foreign students, visitors, foreign government representatives, crewmen, members of foreign media and temporary workers including agricultural contract workers. This group is ineligible for ~~Medicaid~~ SoonerCare, including emergency services, because of the temporary nature of their admission status. The only exception is when a pregnant woman qualifies under the pregnancy related benefits covered under the Title XXI program because the newborn child will meet the citizenship requirement at birth.

(B) These individuals are generally issued Form I-94, Arrival Departure Record, on which an expiration date is entered. This form is not the same Form I-94 that is issued to persons who have been paroled into the United States. Parolees carry a Form I-94 that is titled "Arrival-Departure Record - Parole Edition". Two other forms that do not give the individual "Immigrant" status are Form I-186, Nonresident Alien Mexican Border Crossing Card, and Form SW-434, Mexican Border Visitors Permit.

(7) **Preauthorization.** Preauthorization is required for payment of emergency medical services rendered to non-qualified and undocumented aliens. Persons determined as having lawful alien status must have the status verified through Systematic Alien Verification for Entitlements (SAVE).

(d) **Alienage.** A decision regarding eligibility cannot be made until the eligibility condition of citizenship and alienage is determined.

(1) **Immigrants.** Aliens lawfully admitted for permanent residence in the United States are classified as immigrants by the BCIS. These are individuals who entered this country with the express intention of residing here permanently.

(2) **Parolees.** Under Section 212(d)(5) of the Immigration and Nationality Act, individuals can be paroled into the United States for an indefinite or temporary period at the discretion of the United States Attorney General. Individuals admitted as Parolees are considered to meet the "citizenship and alienage" requirement.

(3) **Refugees and Western Hemisphere aliens.** Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to race, religion, or political opinion, they have fled

from a Communist or Communist-dominated country or from the area of the Middle East; or if they are refugees from natural catastrophes. These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for ~~Medicaid~~ SoonerCare if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status.

(A) Form I-94 endorsed "Voluntary Departure Granted-Employment Authorized", or

(B) The following court-ordered notice sent by BCIS to each of those individuals permitted to remain in the United States: "Due to a Court Order in Silva vs. Levi, 76 C4268 entered by District Judge John F. Grady in the District Court for the Northern District of Illinois, we are taking no action on your case. This means that you are permitted to remain in the United States without threat of deportation or expulsion until further notice. Your employment in the United States is authorized".

(4) **Special provisions relating to Kickapoo Indians.** Kickapoo Indians migrating between Mexico and the United States carry Form I-94, Arrival-Departure Record (Parole Edition). If Form I-94 carries the statement that the Kickapoo is "paroled pursuant to Section 212(d)(5) of the Immigration and Nationality Act" or that the "Kickapoo status is pending clarification of status by Congress" regardless of whether such statements are preprinted or handwritten and regardless of a specific mention of the "treaty", they meet the "citizenship and alienage" requirement. All Kickapoo Indians paroled in the United States must renew their paroled status each year at any local Immigration Office. There are other Kickapoos who have entered the United States from Mexico who carry Form I-151 or Form I-551, Alien Registration Receipt Cards. These individuals have the same status as other individuals who have been issued Form I-151 or Form I-551 and therefore, meet the citizenship and alienage requirements. Still other Kickapoos are classified as Mexican Nationals by the BCIS. They carry Form I-94, Arrival-Departure Record, which has been issued as a visiting visa and does not make mention of the treaty. Such form does not meet the "citizenship and alienage" requirements but provides only the ineligible alien status described in (c)(4)(b) of this Section.

(5) **American Indians born in Canada.** An American Indian born in Canada, who has maintained residence in the United States since entry, is considered to be lawfully admitted for permanent residence if he/she is of at least one-half American Indian blood. This does not include the non-citizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50 percent or more Indian blood. The methods of documentation are birth or baptismal certificate issued on a reservation, tribal records, letter from the Canadian Department of Indian Affairs, or school records.

(6) **Permanent non-immigrants.** Marshall Islanders and individuals from the Republic of Palau and the Federated States of Micronesia are classified as permanent non-immigrants by BCIS. They are eligible for emergency services only.

SUBCHAPTER 6. SOONERCARE ~~HEALTH BENEFITS~~ FOR CATEGORICALLY NEEDY PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60. Certification for SoonerCare ~~Health Benefits~~ for pregnant women and families with children

An individual determined eligible for SoonerCare ~~Health Benefits~~ may be certified for a medical service provided on or after the first day of the month of application. The period of certification may not be for retroactive months.

~~The certification period in family cases is assigned for the shortest period of eligibility determined for any individual in the case. However, the~~ The individual who is categorically needy and ~~categorically~~ related to pregnancy-related services retains eligibility for the period covering prenatal, delivery and postpartum periods without regard to eligibility for other ~~certification periods~~ household members in the case.

(1) **Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

(2) **Certification of non-cash assistance individuals categorically needy and ~~categorically~~ related to AFDC.** The certification period for the individual ~~categorically~~ related to AFDC is 12 months. The certification period can be less than 12 months if the individual:

(A) is certified as eligible in a money payment case during the 12-month period;

(B) is certified for long-term care during the 12-month period;

(C) becomes ineligible for ~~medical assistance~~ SoonerCare after the initial month; or

(D) becomes ineligible as categorically needy.

(i) If an income change after certification causes the case to exceed the categorically needy maximums, the case is closed.

(ii) Individuals, however, who are determined pregnant and eligible as categorically needy continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy related services through the postpartum period.

(3) **Certification of individuals categorically needy and ~~categorically~~ related to pregnancy-related services.** The certification period for the individual ~~categorically~~ related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two months following the month the pregnancy ends. Eligibility as categorically needy is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

(4) **Certification of newborn child deemed eligible.**

(A) ~~A~~ Every newborn child is deemed eligible on the date of birth for ~~Medicaid benefits~~ SoonerCare when the child is born to a woman who is eligible for pregnancy-related services as categorically needy. ~~(For purposes of this subparagraph, a newborn child is defined as any child under the age of one year.)~~ The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one. The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

(B) The newborn child is deemed eligible for ~~Medicaid only~~ SoonerCare as long as he/she continues to live in Oklahoma ~~with the mother~~. No other conditions of eligibility are applicable, including social security number enumeration, ~~and~~ child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to ~~DHS Child Support Enforcement Division (CSED)~~ the Oklahoma Child Support Services (OCSS)

division at OKDHS. The referral enables ~~Child Support Services~~ child support services to be initiated.

~~(C) During the original eligibility determination process for pregnancy-related services, the worker informs the mother that the newborn child will be deemed eligible on the date of birth. The mother is also advised of the importance of her reporting the newborn child's birth immediately so deeming can be done timely.~~

~~(D)~~ (C) When a categorically needy newborn child is deemed eligible for ~~Medicaid~~ SoonerCare, he/she ~~is added for a certification period of 13 months. The certification period expires at~~ remains eligible through the end of the month that the newborn child reaches age one. If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

~~(i) leaves the mother's home;~~

~~(ii)~~ (i) loses Oklahoma residence;

~~(iii) has medical needs included in another assistance case;~~ or

~~(iv)~~ (ii) expires.

~~(E)~~ (D) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

317:35-6-61. Redetermination of eligibility for persons receiving SoonerCare ~~Health Benefits.~~

A periodic redetermination of eligibility for SoonerCare ~~Health Benefits~~ is required on all categorically needy cases ~~categorically~~ related to AFDC. The redetermination is made prior to the end of the initial certification period and each 12 months thereafter. A deemed newborn is eligible through the last day of the month the newborn child attains the age of one year, without regard to eligibility of other household members in the case.

7C-2. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-14. [AMENDED]
(Reference APA WF # 09-70)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to comply with the Centers for Medicare & Medicaid Services (CMS) State Health Official Letter (SHO) 09-011. SHO #09-011 requires all State Medicaid agencies to reimburse a vaccine administration fee to all Medicaid contracted providers administering the 2009 H1N1 vaccine to eligible populations.

SUMMARY: Agency rules are revised to comply with CMS SHO #09-111 requiring all State Medicaid agencies to reimburse a vaccine administration fee to all Medicaid contracted providers administering the 2009 H1N1 vaccine to eligible populations. Currently, rules only allow for reimbursement for vaccine administration in limited circumstances. Revisions allow for reimbursement of an administration fee for pandemic virus vaccines administered to eligible SoonerCare members following a declaration by the Centers for Disease Control of a pandemic virus. Revisions also allow for an administration fee to be paid to providers administering the Human Papillomavirus (HPV) vaccine to eligible SoonerCare members.

BUDGET IMPACT: Agency staff has estimated that the rule revision will cost $212,000 for State Fiscal Year 2010, with a state share of approximately $53,000.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; The Centers for Medicare & Medicaid Services State Health Official Letter #09-011

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Physician rules are revised to allow for a separate payment to be made to providers for the administration of pandemic virus vaccine to both adults and children. This change was brought about by the CMS mandate that State Medicaid agencies reimburse providers for the administration of the 2009 H1N1 flu vaccine. revised to allow for a separate payment for the administration of the Human Papillomavirus (HPV) vaccine to the population of members who have been approved for its use by the ACIP.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-14. Injections

(a) Coverage for injections is limited to those categories of drugs included in the vendor drug program for SoonerCare. SoonerCare payment is not available for injectable drugs whose manufacturers have not entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS). OHCA administers and maintains an open formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) subject to the exclusions and limitations provided in OAC 317:30-5-72.1.

(1) **Immunizations for children.** An administration fee will be paid for vaccines administered by providers participating in the Vaccines for Children Program. When the vaccine is not included in the program, the administration fee is included in the vaccine payment. Payment will not be made for vaccines covered by the Vaccines for Children Program.

(2) **Immunizations for adults.** Coverage for adults is provided as per the Advisory Committee on Immunization Practices (ACIP) guidelines. A separate payment will not be made for the administration of a vaccine. The administration fee is included in the vaccine payment.

(b) Providers must use ~~Use~~ the appropriate HCPCS code and National Drug Code (NDC). In addition to the NDC and HCPCS code, claims must contain the drug name, strength, and dosage amount.

(c) Payment is made for allergy injections for adults and children. When the contracted provider actually administers or supervises the administration of the injection, the administration fee is compensable. No payment is made for administration when the allergy antigen is self-administered by the member. When the allergy antigen is purchased by the physician, payment is made by invoice attached to the claim.

(d) Rabies vaccine, Imovax, Human Diploid and Hyperab, Rabies Immune Globulin are covered under the vendor drug program and may be covered as one of the covered prescriptions per month. Payment can be made separately to the physician for administration. If the vaccine is purchased by the physician, payment is made by invoice attached to the claim.

(e) Human Papillomavirus (HPV) vaccine is covered as approved and recommended by the ACIP for children and adults. Payment can be made separately to the physician for administration and the vaccine product.

(f) Trigger point injections (TPI's) are covered using appropriate CPT codes. Modifiers are not allowed for this code. Payment is made for up to three injections (3 units) per day at the full allowable. Payment is limited to 12 units per month. The medical records must clearly state the reasons why any TPI services were medically necessary. All trigger point records must contain proper documents and be available for review. Any services beyond 12 units per month or 36 units per 12 months will require mandatory review for medical necessity. Medical records must be automatically submitted with any claims for services beyond 36 units.

~~(f)~~ (g) If a physician bills separately for surgical injections and identifies the drugs used in a joint injection, payment will be made for the cost of the drug in addition to the surgical injection. The same guidelines apply to aspirations.

~~(g)~~ (h) When IV administration in a Nursing Facility is filed by a physician, payment may be made for medication. Administration should be done by nursing home personnel.

~~(h)~~ (i) Intravenous fluids used in the administration of IV drugs are covered. Payment for the set is included in the office visit reimbursement.

(j) In the event a pandemic virus is declared by the Centers for Disease Control (CDC) and/or the Department of Health & Human Services, an administration fee will be paid to providers for administering the pandemic virus vaccine to adults and children as authorized by the Centers for Medicare and Medicaid Services (CMS).

7C-3. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-24. [AMENDED]
Part 3. Hospitals
OAC 317:30-5-42.1. [AMENDED]
(Reference APA WF # 09-60)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's outpatient hospital policies. Rules are revised to clarify the intent of coverage for implantable devices inserted during the course of a surgical procedure and to provide consistency throughout policy. These emergency rule revisions will make rules consistent with reimbursement practices and clarify coverage and access to healthcare for Oklahomans, thereby reducing confusion among SoonerCare providers and ultimately reducing the amount of uncompensated care provided by healthcare providers.

SUMMARY: Outpatient hospital rules are revised to clarify the intent of reimbursement for implantable devices inserted during the course of a surgical procedure. Separate payment will be made for implantable devices, but only when the implantable device is not included in the rate for the procedure to insert the device. Additional revisions include removing all-inclusive reimbursement language for outpatient radiological services and additional clarification in regards to adult therapies performed in an outpatient hospital based setting.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Rules are revised to clarify the intent of reimbursement for implantable devices inserted during the course of a surgical procedure. Separate payment will be made for implantable devices, but only when the implantable device is not included in the rate for the procedure to insert the device. Additional revisions include removing all-inclusive reimbursement language for outpatient radiological services and additional clarification in regards to adult therapies performed in an outpatient hospital based setting.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

317:30-5-24. Radiology

(a) **Outpatient and emergency department.**

(1) The technical component of outpatient radiological services performed during an emergency department visit is ~~included in the emergency department all inclusive payment rate on a per visit basis which is paid to the hospital~~ covered.

(2) The professional component of x-rays performed during an emergency department visit is covered.

(3) Ultrasounds for obstetrical care are paid in accordance with provisions found at OAC 317:30-5-22(b)(2)(A-C).

(4) Payment is made for charges incurred for the administration of chemotherapy for the treatment of medically necessary and medically approved procedures. Payment for radiation therapy is limited to the treatment of proven malignancies and benign conditions appropriate for ~~sterotactic~~ stereotactic radiosurgery (e.g.,gamma knife).

(5) Medically necessary screening mammography is a covered benefit. Additional follow-up mammograms are covered when medically necessary.

(b) **Inpatient procedures.** Inpatient radiological procedures are compensable if done on a referral basis. Claims for inpatient interpretations by the attending physician are not compensable unless the attending physician reads interpretations for the hospital on all patients.

(c) **Inpatient radiology performed outside of hospital.** When a member is an inpatient but has to be taken elsewhere for an x-ray, such as to an office or another hospital because the admitting hospital did not have proper equipment, the place of service must still be inpatient hospital, since the member is considered to be in the hospital at the time of service.

(d) **Radiology therapy management.** Weekly clinical management is based on five fractions delivered comprising one week regardless of the time interval separating the delivery of treatments. Weekly clinical management must be billed as one unit of service rather than five.

(e) **Miscellaneous.**

(1) **Arteriograms, angiograms and aortograms.** When arteriograms, angiograms or aortograms are performed by a radiologist, they are considered radiology, not surgery.

(2) **Injection procedure for arteriograms, angiograms and aortograms.** The "interpretation only" code and the "complete procedure" code are not both allowed for one of these procedures.

(3) **Evac-U-Kit or Evac-O-Kit.** Evac-U-Kit and Evac-O-Kit are included in the charge for the Barium Enema.

(4) **Examination.** Examination at bedside or in operating room allows an additional charge to be made. Examination outside regular hours is not a covered charge.

(5) **Supplies.** Separate payment is not made for supplies such as "administration set" used in provision of office chemotherapy.

(6) **Fluoroscopy or Esophagus study.** Separate charge for fluoroscopy or esophagus study in addition to a routine gastrointestinal tract examination is not covered unless a report is submitted indicating an esophagram was done as a separate procedure.

(f) **Magnetic Resonance Imaging.** MRI/MRA scans are covered when medically necessary. Documentation in the progress notes must reflect the medical necessity. The diagnosis code must be shown on the claim.

(g) **Placement of radium or other radioactive material.**

(1) For Radium Application use the appropriate HCPCS code.

(2) When a physician supplies the therapeutic radionuclides (implant grains or Gold Seeds) and provides a copy of the invoice, payment is made at 100% of the invoice charges. Fee must include cost of radium, container, and

shipping and handling.

PART 3. HOSPITALS

317:30-5-42.1. Outpatient hospital services

(a) Hospitals providing outpatient hospital services are required to meet the same requirements that apply to OHCA contracted, non-hospital providers performing the same services. Outpatient services performed outside the hospital facility are not reimbursed as hospital outpatient services.

(b) Covered outpatient hospital services must meet all of the criteria listed in (1) through (4) of this subsection.

(1) The care is directed by a physician or dentist.

(2) The care is medically necessary.

(3) The member is not an inpatient.

(4) The service is provided in an approved hospital facility.

(c) Covered outpatient hospital services are those services provided for a member who is not a hospital inpatient. A member in a hospital may be either an inpatient or an outpatient, but not both (see OAC 317:30-5-41).

(d) Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

(e) Physical, occupational, and speech therapy services are covered when performed in an outpatient hospital based setting. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year. Claims for these services must include the appropriate revenue code(s).

7C-4. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 105. Residential Behavioral Management Services in Group Settings and Non-Secure Diagnostic and Evaluation Centers
OAC 317:30-5-1040 through 317:30-5-1044. [AMENDED]
OAC 317:30-5-1046. [AMENDED]
OAC 317:30-5-1047. [AMENDED]
(Reference APA WF # 09-69)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to change the status of the Office of Juvenile Affairs (OJA) from an Organized Health Care Delivery System to a Foster Care Agency for reimbursement purposes. Rule revisions are necessary to comply with federal regulations regarding Targeted Case Management. Rules are also being revised to limit the number of beds that may be served in a Residential Behavioral Management Services home to 16 beds or less.

SUMMARY: Agency rules are revised to change the status of the Office of Juvenile Affairs from an Organized Health Care Delivery System to a Foster Care Agency. The revisions are needed in order to maintain current levels of reimbursement after OJA's Targeted Case Management (TCM) Services were affected by the CMS final rule regarding TCM Services, CMS-2237-IFC. Rules are also revised to reduce the number of beds in Residential Behavioral Management Services (RBMS) homes to 16 or less in order for the homes to not be considered "public institutions" and risk loss of federal financial participation for the services currently provided in the homes to SoonerCare members.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; CMS-2237-IFC
RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
For RBMS reimbursement purposes rules are being revised to change the status of the Office of Juvenile Affairs from an Organized Health Care Delivery System to a Foster Care Agency. This change was initiated in order to comply with federal regulations regarding Targeted Case Management. Rules are also revised to limit the number of beds that may be served in an RBMS home to 16 or less in order to comply with the State Plan and avoid classification as an "institution".

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 105. RESIDENTIAL BEHAVIORAL MANAGEMENT SERVICES IN GROUP SETTINGS AND NON-SECURE DIAGNOSTIC AND EVALUATION CENTERS

317:30-5-1040. ~~Organized health care delivery system~~ Foster Care Agency

~~The OHCA recognizes an Organized Health Care Delivery System (OHCDS) as an entity with an identifiable component within its mission which is organized for the purpose of delivering health care. The entity must furnish at least one service covered by the Oklahoma Medicaid State Plan itself (i.e. through its own employees). Those employees who furnish each service must meet the State=s minimum qualifications for its provision. So long as the entity continues to furnish at least one service itself, it may contract with other qualified providers to furnish Medicaid covered services.~~

A Foster Care Agency is an agency that provides foster care as defined in the Code of Federal Regulations (CFR) as A24-hour substitute care for children outside their own homes.@ Foster care settings include, but are not limited to, non-relative foster family homes, relative foster homes (whether payments are being made or not), group homes, emergency shelters, residential facilities, and pre-adoptive homes.

317:30-5-1041. Eligible providers

Payment is made for Residential Behavior Management Services (RBMS) provided in private group settings and non-secure Diagnostic and Evaluation (D&E) Centers with 16 beds or less. ~~to any OHCDS who is a child placing agency who has a statutory authority for the care of children in the custody of the State of Oklahoma and which enters into a contract with the State Medicaid program. The OHCDS must certify to the OHCA that all direct providers of services (whether furnished through its own employees or under contract) meet the minimum program qualifications. Residential Behavior Management Services and Diagnostic and Evaluation services are covered only for those beds contracted by the OHCDS.~~ All providers eligible for reimbursement under this section must be a legally recognized Foster Care Agency (FCA) in the State of Oklahoma and have a contract on file with the Oklahoma Health Care Authority. Employees and contractors of the FCA who furnish each covered service must meet the State=s minimum qualifications for its provision. All services must be prior authorized by the Oklahoma Department of Human Services (OKDHS) or the Office of Juvenile Affairs (OJA).

317:30-5-1042. Memorandum of agreement

A Memorandum of Agreement between the Oklahoma Health Care Authority and the ~~Organized Heath Care Delivery System~~ Foster Care Agency (FCA) must be in effect before reimbursement can be made for compensable services. The agreement outlines the contractual and ~~subcontractual~~ sub-contractual requirements for reimbursement. ~~This agreement provides that the OHCDS is responsible for the Medicaid State share required for federal financial participation for all RBMS provided to custody children in residential group home and diagnostic and evaluation settings.~~

317:30-5-1043. Coverage by category

(a) **Adults.** Residential Behavioral Management Services (RBMS) in Group Settings and Non-Secure Diagnostic and Evaluation Center Services are not covered for adults.

(b) **Children.** Residential Behavioral Management Services ~~(RBMS)~~ in Group Settings and Non-Secure Diagnostic and Evaluation Centers are covered for children as set forth in this subsection.

(1) **Description.** Residential Behavior Management Services are provided by ~~Organized Health Care Delivery Systems (OHCDS)~~ Foster Care Agencies (FCA) for children in the care and custody of the State who have special psychological, behavioral, emotional and social needs that require more

intensive care than can be provided in a family or foster home setting. The behavior management services are provided in the least restrictive environment and within a therapeutic milieu. The group setting is restorative in nature, allowing children with emotional and psychological problems to develop the necessary control to function in a less restrictive setting. Residential Behavior Management Services are reimbursed in accordance with the intensity of supervision and treatment required for the group setting in which the child is placed. Members residing in a Level E and Intensive Treatment Services (ITS) Group Homes receive maximum supervision and treatment. In addition, ITS group homes provide crisis and stabilization intervention and treatment. Members residing in a Level D+ Group Home receive highly intensive supervision and treatment. Members residing in a Level D Group ~~home~~ Home ~~or in a wilderness camp~~ receive close supervision and moderate treatment. Members residing in a Level C Group Home receive minimum supervision and treatment. Members residing in Residential Diagnostic and Evaluation Centers receive intensive supervision and a 20 day comprehensive assessment. Members residing in a Sanctions Home receive highly intensive supervision and treatment. Members residing in an Independent Living Group Home receive intensive supervision and treatment. It is expected that RBMS in group settings are an all-inclusive array of treatment services provided in one day. In the case of a child who needs additional specialized services, under the Rehabilitation Option or by a psychologist, prior authorization by the OHCA or designated agent is required. Only specialized rehabilitation or psychological treatment services to address unique, unusual or severe symptoms or disorders will be authorized. If additional services are approved, the ~~OHCDS~~ FCA collaborates with the provider of such services as directed by the OHCA or its agent. Any additional specialized behavioral health services provided to children in state custody are funded in the normal manner. The ~~OHCDS~~ FCA must provide concurrent documentation that these services are not duplicative. The OHCDS determines the need for RBMS.

(2) **Medical necessity criteria.** The following medical necessity criteria must be met for residential behavior Management Services.

(A) Any DSM-IV AXIS I primary diagnosis, with the exception of V codes, with a detailed description of the symptoms supporting the diagnosis. A detailed description of the child's emotional, behavioral and psychological condition must be on file. A diagnosis is not required for behavior management services provided in Diagnostic and Evaluation centers.

(B) The child is medically stable and not actively suicidal or homicidal and not in need of substance abuse detoxification services.

(C) It has been determined by the ~~OHCDS~~ FCA that the current disabling symptoms could not have been or have not been manageable in a less intensive treatment program.

(D) Documentation that the child's presenting emotional and/or behavioral problems prevent the child from living in a traditional family home. The child requires the availability of 24 hour crisis response/behavior management and intensive clinical interventions from professional staff.

(E) The ~~Agency~~ agency which has permanent or temporary custody of the child agrees to active participation in the child's treatment needs and planning.

(F) All of the medical necessity criteria must also be met for continued stay in residential group settings.

(3) **Treatment components.**

(A) **Individual plan of care development.** A comprehensive

individualized plan of care for each resident shall be formulated by the provider agency staff within 30 days of admission, for ITS level within 72 hours, with documented input from the agency which has permanent or temporary custody of the child and when possible, the parent. This plan must be revised and updated at least every three months, every seven days for ITS, with documented involvement of the agency which has permanent or temporary custody of the child. Documented involvement can be written approval of the individual plan of care by the agency which has permanent or temporary custody of the child and indicated by the signature of the agency case worker or liaison on the individual plan of care. It is acceptable in circumstances where it is necessary to fax a service plan to someone for review and then have them fax back their signature; however, the provider obtains the original signature for the clinical file within 30 days. No stamped or ~~Xeroxed~~ photo copied signatures are allowed. An individual plan of care is considered inherent in the provision of therapy and is not covered as a separate item of behavior management services. The individual plan of care is individualized taking into account the child's age, history, diagnosis, functional levels, and culture. It includes appropriate goals and time limited and measurable objectives. Each member=s individual plan of care must also address the provider agency's plans with regard to the provision of services in each of the following areas:

(i) group therapy;
(ii) individual therapy;
(iii) family therapy;
(iv) alcohol and other drug counseling;
(v) basic living skills redevelopment;
(vi) social skills redevelopment;
(vii) behavior redirection; and
(viii) the provider agency's plan to access appropriate educational placement services. (Any educational costs are excluded from calculation of the daily rate for behavior management services.)

(B) **Individual therapy.** The provider agency must provide individual therapy on a weekly basis with a minimum of one or more sessions totaling one hour or more of treatment per week to children and youth receiving RBMS in ~~Wilderness Camps,~~ Level D, Level D+ homes, Level E Homes, Independent Living Homes, and Sanctions Homes. ITS Level residents will receive a minimum of five or more sessions totaling a minimum of five or more hours of individual therapy per week. Members residing in Diagnostic and Evaluation Centers and Level C Group Homes receive Individual Therapy on an as needed basis. Individual therapy must be age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. Individual counseling is a face to face, one to one service, and must be provided in a confidential setting.

(C) **Group therapy.** The provider agency must provide group therapy to children and youth receiving residential behavioral management services. Group therapy must be a face to face interaction, age appropriate and the techniques and modalities employed relevant to the goals and objectives of the individual's plan of care. The minimum expected occurrence would be one hour per week in Level D, Level C, ~~Wilderness Camps~~ and Independent Living. Two hours per week are required in Levels D+ and E. Ten hours per week are required in Sanctions Homes, Intensive Treatment Service Level.

Group therapy is not required for Diagnostic and Evaluation Centers. Group size should not exceed six members and group therapy sessions must be provided in a confidential setting. One half hour of individual therapy may be substituted for one hour of group therapy.

(D) **Family therapy.** Family therapy is a face to face interaction between the therapist/counselor and family, to facilitate emotional, psychological or behavioral changes and promote successful communication and understanding. The provider agency must provide family therapy as indicated by the resident's individual plan of care. The agency must work with the caretaker to whom the resident will be discharged, as identified by the ~~OHCDS~~ FCA custody worker. The agency must seek to support and enhance the child's relationships with family members (nuclear and appropriate extended), if the custody plan for the child indicates family reunification. The RBMS provider must also seek to involve the child's parents in treatment team meetings, plans and decisions and to keep them informed of the child's progress in the program. Any service provided to the family must have the child as the focus.

(E) **Alcohol and other drug abuse treatment education, prevention, therapy.** The provider agency must provide alcohol and other drug abuse treatment for residents who have emotional or behavioral problems related to substance abuse/chemical dependency, to begin, maintain and enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. This service is considered ancillary to any other formal treatment program in which the child participates for treatment and rehabilitation. For residents who have no identifiable alcohol or other drug use, abuse, or dependency, age appropriate education and prevention activities are appropriate. These may include self esteem enhancement, violence alternatives, communication skills or other skill development curriculums.

(F) **Basic living skills redevelopment.** The provider agency must provide goal directed activities designed for each resident to restore, retain, and improve those basic skills necessary to independently function in a family or community. Basic living skills redevelopment is age appropriate and relevant to the goals and objectives of the individual plan of care. This ~~many~~ may include~~, but is not limited to~~ food planning and preparation, maintenance of personal hygiene and living environment, household management, personal and household shopping, community awareness and familiarization with community resources, mobility skills, job application and retention skills.

(G) **Social skills redevelopment.** The provider agency must provide goal directed activities designed for each resident to restore, retain and improve the self help, communication, socialization, and adaptive skills necessary to reside successfully in home and community based settings. These are age appropriate, culturally sensitive and relevant to the goals of the individual plan of care. For ITS level of care, the minimum skill redevelopment per day is three hours. Any combination of basic living skills and social skills redevelopment that is appropriate to the need and developmental abilities of the child is acceptable.

(H) **Behavior redirection.** The provider agency must be able to provide behavior redirection management by agency staff as needed 24 hours a day, 7 days per week. The agency must ensure staff availability to respond in a crisis to stabilize residents' behavior and prevent placement disruption. In addition, ITS group homes will be required to provide crisis stabilization interaction and

treatment for new residents 24 hours a day, seven days a week.

(4) **Providers.** For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services of their providers, the ~~providers~~ provider of individual, group and family therapies must:

(A) be a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, or under ~~Board Supervision~~ board supervision to be licensed in one of the above stated areas; or

(B) have one year of experience in a behavioral health treatment program and a master's degree in a mental health treatment field licensable in Oklahoma by one of the following licensing boards:

(i) Psychology,

(ii) Social work (clinical specialty only),

(iii) Licensed professional counselor,

(iv) Licensed marriage and family therapist, or

(v) Licensed behavioral practitioner; or

(C) have a baccalaureate degree in a mental health field in one of the stated areas listed in (B) of this paragraph AND three or more years post-baccalaureate experience in providing direct patient care in a behavioral health treatment setting and be provided a minimum of weekly supervision by a staff member licensed as listed in (A) of this paragraph; or

(D) be a registered psychiatric nurse; AND

(E) demonstrate a general professional or educational background in the following areas:

(i) case management, assessment and treatment planning;

(ii) treatment of victims of physical, emotional, and sexual abuse;

(iii) treatment of children with attachment disorders;

(iv) treatment of children with hyperactivity or attention deficit disorders;

(v) treatment methodologies for emotional disturbed children and youth;

(vi) normal childhood development and the effect of abuse and/or neglect on childhood development;

(vii) treatment of children and families with substance abuse and chemical dependency disorders;

(viii) anger management; and

(ix) crisis intervention.

(5) For eligible RBMS agencies to bill the Oklahoma Health Care Authority for services provided by their staff for behavior management therapies (Individual, Group, Family) as of July 1, 2007, providers must have the following qualifications:

(A) be licensed in the state in which the services are delivered as a licensed psychologist, social worker (clinical specialty only), professional counselor, marriage and family therapist, or behavioral practitioner, alcohol and drug counselor or under Board approved Supervision to be licensed in one of the above stated areas; or

(B) be licensed as an Advanced Practice Nurse certified in a psychiatric mental health specialty, licensed as a registered nurse with a current certification of recognition from the Board of Nursing in the state in which services are provided, AND

(C) demonstrate a general professional or educational background in the following areas:

(i) case management, assessment and treatment planning;

(ii) treatment of victims of physical, emotional, and sexual abuse;

(iii) treatment of children with attachment disorders;

(iv) treatment of children with hyperactivity or attention deficit disorders;
(v) treatment methodologies for emotionally disturbed children and youth;
(vi) normal childhood development and the effect of abuse and/or neglect on childhood development;
(vii) treatment of children and families with substance abuse and chemical dependency disorders;
(viii) anger management; and
(ix) crisis intervention.

(D) Staff providing basic living skills redevelopment, social skills redevelopment, and alcohol and other substance abuse treatment, must meet one of the following areas:
(i) Bachelor's or Master's degree in a behavioral health related field including but not limited to, psychology, sociology, criminal justice, school guidance and counseling, social work, occupational therapy, family studies, alcohol and drug; or
(ii) a current license as a registered nurse in Oklahoma; or
(iii) certification as an Alcohol and Drug Counselor to provide substance abuse rehabilitative treatment to those with alcohol and/or other drug dependencies or addictions as a primary or secondary ~~DSMIV~~ DMS-IV Axis I diagnosis; or
(iv) current certification as a Behavioral Health Case Manager from DMHSAS and meets OHCA requirements to perform case management services, as described in OAC 317:30-5-595.

(E) Staff providing behavior redirection services must have current certification and required updates in nationally recognized behavior management techniques, such as Controlling Aggressive Patient Environment (CAPE) or MANDT. Additionally, staff providing these services must receive initial and ongoing training in at least one of the following areas:
(i) trauma informed methodology,
(ii) anger management,
(iii) crisis intervention,
(iv) normal child and adolescent development and the effect of abuse,
(v) neglect and/or violence on such development,
(vi) grief and loss issues for children in out of home placement,
(vii) interventions with victims of physical, emotional and sexual abuse,
(viii) care and treatment of children with attachment disorders,
(ix) care and treatment of children with hyperactive, or attention deficit, or conduct disorders,
(x) care and treatment of children, youth and families with substance abuse and chemical dependency disorders,
(xi) passive physical restraint procedures,
(xii) procedures for working with delinquents or the Inpatient Mental Health and Substance Abuse Treatment of Minors Act.

(F) In addition, Behavioral Management staff must have access to consultation with an appropriately licensed mental health professional.

317:30-5-1044. Payment rates

~~A per diem rate is established for each residential level of care in which~~

~~behavior management services are provided. The payment rate is based upon a sample analysis of the average annual allowable cost of providing the program components of behavior management services using facility time study and cost reports of the OHCDS and the facilities under contract to them. The payment is an all inclusive daily rate for all behavior management services provided under the auspices of the OHCDS. Room and Board costs, educational costs and related administrative costs are not reimbursable and are excluded from the calculation of the daily rate. RBMS services are limited to a maximum of one service per day per eligible recipient.~~ Payment is made at the lower of the provider=s usual and customary charge or the OHCA fee schedule for SoonerCare compensable services.

317:30-5-1046. Documentation of records and records review

(a) The ~~OHCDS~~ FCA and the facilities with whom it contracts must maintain appropriate records system. Current individual plans of care, case files, and progress notes are maintained in the facilities' files during the time the child or youth is receiving services. All services rendered must be reflected by documentation in the case records.

(b) OHCA and the Centers for Medicare and Medicaid Services (CMS) may evaluate through inspection or other means, the quality, appropriateness and timeliness of services provided by the ~~OHCDS~~ FCA or facilities with whom it contracts.

(c) All residential behavioral management services in group settings and non-secure diagnostic and evaluation centers must be reflected by documentation in the patients' records. Individual, group, family, and alcohol and other drug counseling and social and basic living skills development services must include all of the following:

(1) date;
(2) start and stop time for each session;
(3) signature of the therapist/staff providing service;
(4) credentials of therapist/staff providing service;
(5) specific problem(s) addressed (problem must be identified on individualized plan of care);
(6) methods used to address problem(s);
(7) progress made toward goals;
(8) patient response to the session or intervention; and
(9) any new problem(s) identified during the session.

317-30-5-1047. Confidentiality of information

In accordance with the provisions of 42 CFR 431, Subpart F, the ~~OHCDS~~ FCA and the facilities with whom it contracts must safeguard information about the ~~client~~ member.

7C-5. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 85. ADvantage Program Waiver Services
OAC 317:30-5-764. [AMENDED]
Part 95. Agency Personal Care Services
OAC 317:30-5-950. [AMENDED]
Chapter 35. Medical Assistance for Adults
and Children-Eligibility
Subchapter 15. Personal Care Services
OAC 317:35-15-13.2. [AMENDED]
Subchapter 17. ADvantage Waiver Services
OAC 317:35-17-22. [AMENDED]
(Reference APA WF # 09-65)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to require that the provision of Case Management and certain other in-home ADvantage services to SoonerCare members be documented using the Interactive Voice Response Authentication (IVRA) time and attendance system. The new electronic IVRA system will replace the current system of manual time documentation and therefore increase the efficiency of processing claims while reducing the error rate caused by duplication of records, resulting in a substantial savings of SoonerCare dollars over time.

ANALYSIS: Rules are revised to require the use of the new Interactive Voice Response Authentication (IVRA) system to document time and attendance for certain in-home ADvantage services provided to SoonerCare members. In-home services are necessarily provided in the individual homes of persons with physical and cognitive disabilities. The verification of service delivery is typically a paper time sheet signed by the member receiving services with a high potential for errors. Additionally, a paper based time and attendance system which requires transcription of time units from paper to computer is both inefficient and affords many opportunities for inadvertent errors.

BUDGET IMPACT: Agency staff has determined that the revisions are budget neutral to the agency. OKDHS is providing the state share of funding for implementation and use of the new system.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, and recommended Board approval.

PROPOSED EFFECTIVE DATE: February 1, 2010

AUTHORITY:
The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.180

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Rules are revised to add Case Management and Case Management for Transitioning to the list of services that must be documented utilizing

the Interactive Voice Response Authentication (IVRA) system in the ADvantage waiver. The IVRA system provides an accurate electronic accounting of time and attendance for Personal Care, Case Management and other Waiver services delivery as well as elimination of inefficiencies from the former paper based system.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-764. Reimbursement

(a) Rates for waiver services are set in accordance with the rate setting process by the ~~Committee for Rates and Standards~~ State Plan Amendment Rate Committee (SPARC) and approved by the Oklahoma Health Care Authority Board.

(1) The rate for NF Respite is set equivalent to the rate for routine level of care nursing facility services that require providers having equivalent qualifications;

(2) The rate for daily units for Adult Day Health Care are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Adult Day Service Program that require providers having equivalent qualifications;

(3) The rate for units of Home-Delivered Meals are set equivalent to the rate established by the Oklahoma Department of Human Services for the equivalent services provided for the OKDHS Home-Delivered Meals Program that require providers having equivalent qualifications;

(4) The rates for units of ADvantage Personal Care and In-Home Respite are set equivalent to State Plan Agency Personal Care unit rate which require providers having equivalent qualifications;

(5) The rates for Advanced Supportive/Restorative Assistance is set equivalent to 1.077 of the State Plan Agency Personal Care unit rate;

(6) CD-PASS rates are determined using the Individual Budget Allocation (IBA) Expenditure Accounts Determination process for each member. The IBA Expenditure Accounts Determination process includes consideration and decisions about the following:

(A) The ~~individual~~ Individual Budget Allocation (IBA) ~~expenditure~~ Expenditure Accounts Determination constrains total Medicaid reimbursement for CD-PASS services to be less than expenditures for equivalent services using agency providers.

(B) The PSA and APSA service unit rates are calculated by the ~~AA~~ OKDHS/ASD during the CD-PASS service eligibility determination process. The ~~AA~~ OKDHS/ASD sets the PSA and APSA unit rates at a level that is not less than 80 percent and not more than 95 percent of the comparable Agency Personal Care (for PSA) or Advanced Supportive/Restorative (for APSA) service rate. The allocation of portions of the PSA and/or APSA rate to cover salary, mandatory taxes, and optional benefits (including Worker's Compensation insurance, if available) is determined individually for each member using the CD-PASS Individualized Budget Allocation Expenditure Accounts Determination Process.

(C) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for CD-PASS services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources to meet needs, the Case Manager, based upon an updated assessment, amends the service plan to increase CD-PASS service units appropriate to meet additional member need. The ~~AA~~ OKDHS/ASD, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PSA or APSA rate. The member, with

assistance from the FMS, reviews and revises the IBA Expenditure Accounts calculation annually or more often to the extent appropriate and necessary.

(7) Three per diem reimbursement rate levels for the ADvantage assisted living services are set. Different rate per diem levels are established to adequately reimburse the provider for the provision of different levels of service to accommodate different level of member need for services-type, intensity and frequency to address member ADL/IADL and health care needs. Rounded to the nearest cent, the lowest level Assisted Living Services per diem rate is set equivalent to 11.636 of the State Plan Agency Personal Care unit rate; the mid-level per diem rate is set equivalent to 15.702 of the State Plan Agency Personal Care unit rate; and the highest level Assisted Living Services per diem rate is set equivalent to 21.964 of the State Plan Agency Personal Care unit rate. The specific rate level appropriate to a particular member's service is determined by UCAT assessment by the member's ADvantage Case Manager employed by a Case Management agency that is independent of the Assisted Living Services provider. ADvantage payment is not made for 24-hour skilled care in an Assisted Living Center. Federal financial participation is not available for room and board, items of comfort or convenience, or the costs of facility maintenance, upkeep and improvement. Separate payment is not made for ADvantage services of personal care, advanced supportive/restorative assistance, skilled nursing, Personal Emergency Response System, home-delivered meals, adult day care or environmental modifications to a member while receiving Assisted Living Services since these services are integral to and inherent in the provision of Assisted Living Service. However, separate payment may be made for Medicaid State Plan and/or Medicare Home Health benefits to members receiving ADvantage Assisted Living. Separate payment is not made for ADvantage respite to a member while receiving Assisted Living Services since by definition Assisted Living Services assume the responsibility for 24-hour oversight/monitoring of the member, eliminating the need for informal support respite. The member is responsible for room and board costs; however, for an ADvantage member, the ADvantage Assisted Living Services provider is allowed to charge a maximum for room and board that is no more than 90% of the SSI Federal Benefit Rate. If in accordance with OAC 317:35-17-1(b) and 317:35-17-11, the member has a vendor payment obligation, the provider is responsible for collecting the vendor payment from the member.

(b) The ~~AA~~ OKDHS/ASD approved ADvantage service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;
(2) service provider;
(3) units authorized; and
(4) begin and end dates of service authorization.

(c) ~~As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provisions will be turned over to SURS for follow-up investigation.~~ Service time for Personal Care, Case Management, Case Management services for Transitioning, Nursing, Advanced Supportive/Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance, and Advanced Personal Services Assistance is documented solely through the use of the Interactive Voice Response Authentication (IVRA) system when services are provided in the home. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

(d) As part of ADvantage quality assurance, provider audits evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provisions will be turned over to SURS for follow-up investigation.

PART 95. AGENCY PERSONAL CARE SERVICES

317:30-5-950. Eligible providers

Payment is made only to agencies that have been certified as personal care providers by the Oklahoma State Department of Health and are certified by the ~~ADvantage Program Administrative Agent (AA)~~ as meeting applicable federal, state and local laws, rules and regulations. In order to be eligible for payment, the personal care agency must have an approved provider agreement on file with the ~~Medicaid agency~~ OHCA, in accordance with OAC 317:30-3-2. Service time of Personal Care is documented solely through the Interactive Voice Response Authentication (IVRA) system when services are provided in the home. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency's backup procedures are only permitted when the IVRA system is unavailable.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-13.2. Individual Personal Care contractor; billing, training, and problem resolution

While OHCA is the contractor authorized under federal law, the Oklahoma Department of Human Services (OKDHS) initiates initial contracts with qualified individuals for provision of Personal Care services as defined in OAC 317:35-15-2. The contract renewal for the PCA is the responsibility of the Oklahoma Health Care Authority (OHCA).

(1) **Payment for Personal Care.** Payment for Personal Care is generally made for care in the ~~client's~~ member's own home. A rented apartment, room or shelter shared with others is considered "own home". A facility that meets the definition of a nursing facility, room and board, licensed residential care facility, licensed assisted living facility, group home, rest home or a specialized home as set forth in O.S. Title 63, Section 1-819 et seq., Section 1-890.1 et seq., and Section 1-1902 et seq., does not constitute a suitable substitute home. Personal Care may not be approved if the ~~client~~ member lives in the PCA's home except with the interdisciplinary team's written approval. The potential individual PCA must meet the minimum requirements under (2) of this subsection. With ~~DHS~~ OKDHS area nurse approval, or for ADvantage waiver ~~clients~~ members, with service plan authorization and ADvantage Program Manager approval, Personal Care services may be provided in an educational or employment setting to assist the ~~client~~ member in achieving vocational goals identified on the service plan.

(A) **Reimbursement.** Personal Care payment for a ~~client~~ member is made according to the number of units of service identified in the service plan.

(i) The unit amounts paid to individual contractors is according to the established rates. A service plan will be developed for each eligible individual in the home and units of service assigned to meet the needs of each ~~client~~ member. The service plans will combine units in the most efficient manner to meet the needs of all eligible

persons in the household.

(ii) From the total amounts billed by the individual PCA in (i) of this subparagraph, the OHCA (acting as agent for the ~~client-employer~~ member-employer) withholds the appropriate percentage of FICA tax and sends it to the Internal Revenue Service as the individual contractor's contribution toward Social Security coverage. To assure that the individual contractor's social security account may be properly credited, it is vital that the individual contractor's social security number be entered correctly on each claim. In order for the OHCA to withhold FICA tax, the LTC nurse must obtain a signed OHCA Form HCA-66, Authorization for Withholding of FICA Tax in Personal Care, from the ~~client~~ member as soon as the area nurse, or designee, has approved Personal Care. A copy of the signed HCA-66 must be in the case record. A signed OHCA-0026, Personal Care Program Individual Contract, must be on file with the OHCA before the individual contractor's first claim can be submitted.

(iii) The contractor payment fee covers all Personal Care services included on the service and care plans developed by the LTC nurse or ADvantage case manager. Payment is made for direct services and care of the eligible ~~client(s)~~ member(s) only. The area nurse, or designee, authorizes the number of units of service the ~~client~~ member receives each month.

(iv) A ~~client~~ member may select more than one individual contractor. This may be necessary as indicated by the service and care plans.

(v) The individual contractor may provide ~~Medicaid~~ SoonerCare Personal Care services for several households during one week, as long as the daily number of paid service units do not exceed eight per day. The total number of hours per week cannot exceed 40.

(B) **Release of wage and/or employment information for individual contractors**. Any inquiry received by the local office requesting wage and/or employment information for an individual Personal Care contractor will be forwarded to the OHCA, Claims Resolution.

(2) **~~Client~~ Member selection of individual PCA**. ~~Clients~~ Members and/or family members recruit, interview, conduct reference checks, and select the individual to be considered as an individual contractor. An individual contractor applicant must have a background check performed by the Oklahoma State Bureau of Investigation (OSBI). The results of the background check determine whether a person will be permitted to work as an individual Personal Care contractor. According to Section 1025.2 of Title 56 of the Oklahoma Statutes, before the ~~client~~ member employer makes an offer to employ or contract with a ~~Medicaid~~ SoonerCare Personal Care Assistant applicant to provide Personal Care Services to a person who receives ~~state Medicaid~~ SoonerCare Personal Care Services, the ~~DHS~~ OKDHS LTC nurse, acting for the ~~client~~ member, must check the ~~DHS~~ OKDHS Community Services Worker Registry to determine if the name of the applicant seeking employment or contract has been entered. The ~~DHS~~ OKDHS LTC nurse must also check the Certified Nurse Aid Registry. The ~~DHS~~ OKDHS LTC nurse must affirm that the applicant's name is not contained on either registry. The LTC nurse will notify the OHCA if the applicant is on the registry.

(A) **Persons eligible to serve as individual Personal Care Assistants.** Payment is made for Personal Care Services to an individual who:

(i) is at least 18 years of age,

(ii) has no pending notation related to abuse, neglect or exploitation as reported by the Oklahoma State Department of Health Nurse Aide Registry,

(iii) is not included on the ~~DHS~~ OKDHS Community Services Worker Registry in accordance with Section 1025.2 of Title 56, of Oklahoma Statutes,

(iv) has not been convicted of a crime as outlined in Title 63 of Oklahoma Statutes, Sections 1-1950 as determined by an OSBI background check,
(v) demonstrates the ability to understand and carry out assigned tasks,
(vi) is not a legally responsible family member (spouse, legal guardian, or parent of a minor child) of the ~~client~~ member being served,
(vii) has a verifiable work history and/or personal references, verifiable identification, and
(viii) meets any additional requirements as outlined in the contract and certification requirements with the Oklahoma Health Care Authority.

(B) **Persons ineligible to serve as Personal Care Assistants.** Payment from ~~Medicaid~~ SoonerCare funds for Personal Care services may not be made to an individual who is a legally responsible family member (spouse, legal guardian, or parent of a minor child) of the ~~client~~ member to whom he/she is providing personal care services.

~~(i) The DHS Director may give approval for payment from DHS state funds for Personal Care to a legally responsible family member of the client being served when no other PCA is available, available PCAs are unable to provide care to the client, or the needs of the client are so extensive that the legally responsible family member who provides the care is prohibited from working outside the home due to the client's need for care.~~

~~(ii)~~ (i) Payment cannot be made to a ~~DHS~~ OKDHS or OHCA employee. Payment cannot be made to an immediate family member of ~~a DHS~~ an OKDHS employee who works in the same county without OKDHS/Aging Services Division approval. When a family member relationship exists between ~~a DHS~~ an OKDHS LTC nurse and a PCA in the same county, the LTC nurse cannot manage services for a ~~client~~ member whose individual provider is a family member of the LTC nurse.

(iii) If it is determined that an employee is interfering in the process of providing Personal Care Services for personal or family benefit, he/she will be subject to disciplinary action.

(3) **Orientation of the Personal Care Assistant.** When a ~~client~~ member selects an individual PCA, the LTC nurse contacts the individual to report to the county office to complete the ODH form 805, Uniform Employment Application for Nurse Aide Staff, and the ~~DHS~~ OKDHS form ~~DDS-39~~ 06PE039E, Employment Application Supplement, and for a determination of qualifications and orientation. This process is the responsibility of the LTC nurse. The PCA can begin work when:

(A) he/she has been interviewed by the ~~client~~ member,
(B) he/she has been oriented by the LTC nurse,
(C) he/she has executed a contract (OHCA-0026) with the OHCA,
(D) the effective service date has been established,
(E) the Community Service Worker Registry has been checked and the PCA's name is not on the Registry,
(F) the Oklahoma State Department of Health Nurse Aide Registry has been checked and no notations found, and
(G) the OSBI background check has been completed.

(4) **Training of Personal Care Assistants.** It is the responsibility of the LTC nurse to make sure for each client, that the PCA has the training needed to carry out the plan of care prior to service initiation.

(5) **Problem resolution related to the performance of the Personal Care Assistant.** When it comes to the attention of the LTC nurse or ~~social~~ worker that there is a problem related to the performance of the PCA, a counseling conference is held between the ~~client~~ member, LTC nurse and ~~social~~ worker.

The LTC nurse will counsel the PCA regarding problems with his/her performance. Counseling is considered when the staff believe that counseling will result in improved performance.

(6) **Termination of the PCA Provider Agreement.**

(A) A recommendation for the termination of a PCA's contract is submitted to the OHCA and the services of the PCA are suspended immediately when:

(i) a PCA's performance is such that his/her continued participation in the program could pose a threat to the health and safety of the ~~client~~ member or others; or

(ii) the PCA failed to comply with the expectations outlined in the PCA Provider Agreement and counseling is not appropriate or has not been effective; or

(iii) a PCA's name appears on the ~~DHS~~ OKDHS Community Services Worker Registry, even though his/her name may not have appeared on the Registry at the time of application or hiring.

(B) The LTC nurse makes the recommendation for the termination of the PCA to the ~~OHCA Legal Division with a copy to the DHS~~ OKDHS State Office Aging Services Division who then notifies the OHCA Legal Division of the recommendation. When the problem is related to allegations of abuse, neglect, or exploitation, OKDHS Adult Protective Services, State Attorney General's Medicaid Unit, the OHCA, and the Oklahoma State Department of Health are notified by the LTC nurse.

(C) When the problem is related to allegations of abuse, neglect or exploitation, the LTC nurse follows the process as outlined in OAC 340:100-3-39.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-22. Billing procedures for ADvantage services

(a) Billing procedures for long-term care medical services are contained in the OKMMIS Billing and Procedure Manual. Questions regarding billing procedures which cannot be resolved through a study of the manual should be referred to the OHCA.

(b) The OKDHS/ASD approved ADvantage service plan is the basis for the MMIS service prior authorization, specifying:

(1) service;

(2) service provider;

(3) units authorized; and

(4) begin and end dates of service authorization.

(c) As part of ADvantage quality assurance, provider audits are used to evaluate whether paid claims are consistent with service plan authorizations and documentation of service provision. Evidence of paid claims that are not supported by service plan authorization and/or documentation of service provision will be turned over to ~~SURS~~ the OHCA Provider Audit Unit for follow-up investigation.

(d) Service time of Personal Care, Case Management, Case Management for transitioning, Nursing, Advanced Supportive/ Restorative Assistance, In-Home Respite, CD-PASS Personal Services Assistance and Advanced Personal Services Assistance is ~~reimbursed~~ documented solely through the Interactive Voice Response Authentication (IVRA) system when provided in the home. Providers are required to use the IVRA system after access to the system is made available by OKDHS. The IVRA system provides alternate backup solutions should the automated system be unavailable. In the event of IVRA backup system failure, the provider will document time in accordance with their agency backup plan. The agency=s backup procedures are only permitted when the IVRA system is unavailable.

Presentation to the Committee on Rates and Standards
Proposed Reimbursement for Nursing Facilities and ICFs/MR
November 30th, 2009

Background

Under the State Plan as amended to meet the requirements of Title 56, §1011.5 and Title 63 §1928 of the Oklahoma Statutes, nursing facilities are paid in the following manner. A facility specific rate is established for each home that is the combination of four componen The four rate components are:

- "Base Rate Component" as defined in statute as the rate that will remunerate the "existing funds paid to the nursing homes at 06 05". *Under the approved state plan this is defined as the rate in effect at 06-30-05 or $103.20 per patient day.*
- Focus on Excellence "Performance Measure Component" Each facility participating in the program may earn an additional rate component based on their score on ten quality measures. $1.10 per patient day is the value of a percentage earned and a facility earn up to an additional 5 percentage points. Zero to ten points may be earned by meeting the established threshold for the quali measures under the Focus on Excellence program. The current threshold is the median score for each measure. For earning 1 to points the facility earns a 1 percentage rate component add-on, for earning 3 to 4 points the facility earns a 2 percentage rate component add-on component, for earning 5 to 6 points the facility earns a 3 percentage component add-on, for earning 7 to 8 po the facility earns a 4 percentage component add-on and for earning 9 to 10 points the facility earns a 5 percentage component add on.
- The remaining funds after fully funding the Base Rate and Performance measure Components are split into two pools: 30% for th "Other Costs Component" and 70% for the "Direct Care Cost Component". The 30% "Other Cost Component" pool is divided u on an equal per day amount for each facility and the current rate for this component is $7.07 per day. The "Direct Care Compone is facility specific and is determined by allocating the remaining available pool, the 70% "Direct Care Component" pool to each facility based on their total direct care costs relative to the other facilities' direct care cost totals. Direct care is defined as the salaries and wages and benefits for the RN, LPN, Nurse Aide and Certified Medication Aide classifications. The current range for this component is from $10.28 to $20.56 per day and the current total rate range is from $120.55 to $136.33 per day.
- Also under the current state plan the rates for nursing facilities and ICFs/MR are adjusted each January 1 to recognize the estimate effect to the program funds from the effect of the Social Security Cost of Living adjustment to the patient spend-down. In the current state plan this is calculated by using the most recent MMIS data and estimating a per day adjustment.

Proposed Changes for Review

The OHCA staff recommends the following changes to the current methodology.

- The first change proposed is to *establish the threshold for each measurement in the Focus on Excellence Program to specific targe for nine of the ten indicators*. The threshold is currently the median score. Attachment I details the scores since inception and the recommended targets. These targets are taken from the recommendations that MyInnerview (the contractor in charge of collecting and analyzing the data for the program) has proposed. Discussions with the industry, MyInnerview, executive staff and others suggested that a better way to measure improvement and scoring would be to set targets rather than have the median as the target. The median would always be the middle value whether there were any improvements or not. This new method of established target would guarantee improvements before any increases are granted.
- The second proposal is to change the method of calculating the estimate for the Social Security Cost of Living (COLA) adjustment by establishing a per diem dollar amount based on actual experience. The CY 2004 to CY 2009 actual experience was analyzed and per day factors for Nursing facilities, Regular ICF/MR facilities and Acute Care (16 bed-or-less) ICF/MR facilities for each percentage point COLA adjustment were determined. See the attached schedule for calculation of these factors.

Recommendations for the Rate for the period beginning 01-01-2010

1. The OHCA recommends for the period beginning 01-01-2010 setting the targets for the Focus on Excellence at the following amounts (also see Attachment I):

1.	Resident/Family Satisfaction:	Recommended Target of 72.0
2.	Quality of Life:	Recommended Target of 75.0
3.	Employee Satisfaction:	Recommended Target of 65.0
4.	Culture Change:	Recommended Target of 72.0
5.	Clinical Outcomes:	Recommended Target of 58.0
6.	Direct Care Hours:	Recommended Target of 3.50
7.	CNA/NA Stability:	Recommended Target of 58.0
8.	RN/LPN Stability:	Recommended Target of 60.0
9.	Medicare Utilization	Recommended Target of 10.5
10.	State Survey Compliance:	NO Change

2. Also staff recommends changing the methodology for adjusting rates for the facilities to application of the factors of $.32 per day, $.2 day and $.20 per day for each percentage point COLA adjustment to Social Security for Nursing facilities, ICFs/MR and Acute Care (16 or less) ICFs/MR, respectively. The regular NF factor would be applied when the pool allocations are made.

Budget Impact

The above change in targets would constitute no increase in total funds expended for nursing facility services. The changes would result the re-allocation of funds between the rate component pools for the facilities. The resulting change to the rate components would be as follows:

- Base Rate Component: Would remain at $ 103.20 per patient day.
- Other Costs Component: Would change from $ 7.07 to $ 7.05 per patient day.
- The Performance Measure Component percentage which is defined as 1% of the sum of the Base Rate Component and the Other Component amount would not change and remain at $1.10 per day for each point earned. The average incentive earned estimate the new targets is $2.48 per day versus $2.56 per day under the old method.
- The range for the Direct Care Component would change from a range of $10.28 thru $20.56 per day to $10.00 thru $20.65 per da The resulting total rates would change from a range of $120.55 per day thru $136.33 to $120.22 thru $136.37 per day. The chang are due to the estimates of points earned being adjusted and the adjustment for fewer days in the next year and the mix of days between facilities.
- The net effect of the Social Security COLA method change is zero because the current COLA is zero for next year and because th method mirrors the estimates under the old method but simplifies the calculation.

ATTACHMENT I-FOCUS ON EXCELLENCE PROGRAM
HISTORY AND PROPOSALS FOR SCORING

Resident/Family Satisfaction	**25th percentile**	Median	**55th percentile**	**60th percentile**	**75th percentile**
Qtr 3 2007	64.3	69.3	70.4	71.5	74.9
Qtr 4 2007	64.3	69.3	70.4	71.5	76.6
Qtr 1 2008	64.3	69.2	70.1	71.5	75.0
Qtr 2 2008	65.0	69.9	71.2	72.2	76.2
Qtr 3 2008	64.3	69.6	70.7	71.8	76.1
Qtr 4 2008	62.9	70.6	71.5	72.7	76.4
Average	64.2	69.7	70.7	71.9	75.9
Recommended Target					***72.0***

Quality of Life	**25th percentile**	Median	**55th percentile**	**60th percentile**	**75th percentile**
Qtr 3 2007	66.6	72.2	72.8	73.9	76.6
Qtr 4 2007	66.6	72.2	72.8	73.9	76.6
Qtr 1 2008	66.6	72.2	72.7	73.8	76.6
Qtr 2 2008	67.2	72.6	74.2	74.9	77.7
Qtr 3 2008	66.1	72.2	73.6	74.6	77.6
Qtr 4 2008	65.3	72.2	73.4	74.3	77.9
Average	66.4	72.3	73.3	74.2	77.2
Recommended Target					***75.0***

Employee Satisifaction	**25th percentile**	Median	**55th percentile**	**60th percentile**	**75th percentile**
Qtr 3 2007	54.0	60.7	62.3	63.8	67.8
Qtr 4 2007	54.0	60.7	62.3	63.8	67.8
Qtr 1 2008	54.0	61.1	62.8	63.8	67.9
Qtr 2 2008	53.3	61.5	63.9	64.9	69.3
Qtr 3 2008	51.6	61.2	63.5	64.4	68.9
Qtr 4 2008	54.6	61.9	64.0	65.6	69.2
Average	53.6	61.2	63.1	64.4	68.5

Recommended Target

65.0

ATTACHMENT I-FOCUS ON EXCELLENCE PROGRAM
HISTORY AND PROPOSALS FOR SCORING

Culture Change	**25th percentile**	Median	**55th percentile**	**60th percentile**	**75th percentile**
Qtr 3 2007	59.6	65.9	67.2	69.9	74.0
Qtr 4 2007	59.6	65.9	67.2	69.9	74.0
Qtr 1 2008	59.7	66.0	67.3	69.9	74.3
Qtr 2 2008	57.4	67.2	69.0	70.8	75.9
Qtr 3 2008	56.8	67.1	68.5	70.7	75.9
Qtr 4 2008	58.7	69.8	71.0	71.9	76.8
Average	58.6	67.0	68.4	70.5	75.2

Recommended Target

72.0

Clinical Outcomes	**25th percentile**	Median	**55th percentile**	**60th percentile**	**75th percentile**
Qtr 3 2007	39.6	52.6	54.8	56.2	63.0
Qtr 4 2007	38.2	52.9	54.4	56.6	63.2
Qtr 1 2008	39.0	51.5	54.0	57.0	65.0
Qtr 2 2008	40.0	54.0	56.0	58.0	66.0
Qtr 3 2008	39.0	52.0	54.0	57.5	65.0
Qtr 4 2008	40.0	53.0	56.0	58.0	65.0
Average	39.3	52.7	54.9	57.2	64.5

Recommended Target

58.0

Direct Care Hours	**25th percentile**	Median	**55th percentile**	**60th percentile**	**75th percentile**
Qtr 3 2007	3.06	3.31	3.39	3.44	3.64
Qtr 4 2007	3.05	3.35	3.42	3.46	3.67
Qtr 1 2008	3.03	3.33	3.37	3.45	3.67
Qtr 2 2008	3.06	3.37	3.46	3.54	3.72
Qtr 3 2008	3.08	3.41	3.45	3.50	3.69
Qtr 4 2008	3.11	3.44	3.51	3.54	3.75
Average	3.07	3.37	3.43	3.49	3.69

Recommended Target

3.50

ATTACHMENT I-FOCUS ON EXCELLENCE PROGRAM
HISTORY AND PROPOSALS FOR SCORING

CAN/NA Stability	**25th percentile**	Median	**55th percentile**	**60th percentile**	**75th percentile**
Qtr 3 2007	29.5	51.5	53.5	59.0	69.0
Qtr 4 2007	32.3	48.5	53.5	57.0	68.0
Qtr 1 2008	33.0	49.5	52.0	55.0	68.0
Qtr 2 2008	32.0	50.0	54.0	57.0	70.0

Qtr 3 2008	32.0	52.0	55.0	58.0	69.0
Qtr 4 2008	30.0	53.0	58.0	62.0	70.0
Average	31.5	50.8	54.3	58.0	69.0
Recommended Target					***58.0***

RN/LPN Stability	**25th percentile**	Median	**55th percentile**	**60th percentile**	**75th percentile**
Qtr 3 2007	33.0	50.0	54.0	58.0	69.5
Qtr 4 2007	31.5	52.3	56.5	60.5	71.0
Qtr 1 2008	32.0	52.0	55.0	60.0	71.0
Qtr 2 2008	32.0	52.0	56.0	59.0	69.0
Qtr 3 2008	31.0	51.0	55.0	57.5	71.0
Qtr 4 2008	31.0	54.0	59.0	63.0	72.0
Average	31.8	51.9	55.9	59.7	70.6
Recommended Target					***60.0***

Medicare Utilization	**25th percentile**	Median	**55th percentile**	**60th percentile**	**75th percentile**
Qtr 3 2007	0.0104	0.0838	0.0925	0.1072	0.1642
Qtr 4 2007	0.0000	0.0731	0.0859	0.1010	0.1484
Qtr 1 2008	0.0171	0.0913	0.1061	0.1280	0.1770
Qtr 2 2008	0.0150	0.0870	0.1030	0.1210	0.1850
Qtr 3 2008	0.0190	0.0835	0.0950	0.1090	0.1610
Qtr 4 2008	0.0260	0.0855	0.0920	0.1040	0.1615
Average	0.0146	0.0840	0.0958	0.1117	0.1662
Recommended Target					10.50

State Survey Compliance

A reimbursement point is awarded if:

1. no citations were made as a result of their most recent annual survey,
2. any subsequent care-related citations cannot have scope/severity greater than "D", and
3. any subsequent non-care related citations cannot have a scope/severity greater than "E".

Oklahoma: Focus on Excellence
Description of Measure Calculations

This guide provides you with a description of how the ten measures for the Focus on Excellence program are calculated and how the facility's performance is presented on the facility level report as well as the Oklahoma consumer website. The scores and information on these reports will be updated quarterly.

The maximum a facility may receive is 10 points. One point is awarded for facility performance in each of the areas listed below except *Occupancy*. *Occupancy* will only be used for the consumer website and is not part of the reimbursement system.

For the Oklahoma consumer website, each participating nursing home can receive from one to five stars on each measure, with one star indicating the lowest possible rating and five stars indicating the highest possible rating. Stars will be assigned based on quintile rankings, meaning the highest 20% of facility scores will receive five stars for that measure; the next highest 20% will receive four stars, etc., with the lowest 20% of facility scores receiving one star.

Quality of Life:

- This score is based on the most recent My InnerView family and resident satisfaction surveys. Ten survey items related to resident quality of life are averaged and ranked for each facility.
- If 4 or more of these 10 survey items are not answered by a given respondent, that respondent's answers will not be counted in this measure.
- Overall combined facility response rate for the most recent family and resident surveys must be at least 30%, or else the facility will be disqualified for this measure.

- If more than 35% of all surveys sent are returned because of a bad address, that facility's score will be disqualified for this meas

Resident/Family Satisfaction:

- This score is based on the most recent My InnerView family and resident satisfaction surveys. The fourteen survey items not comprising resident quality of life are averaged and ranked for each facility.
- If 5 or more of these 14 survey items are not answered by a given respondent, that respondent's answers will not be counted in th measure.
- Overall combined facility response rate for the most recent family and resident surveys must be at least 30%, or else the facility v be disqualified for this measure.
- If more than 35% of all surveys sent are returned because of a bad address, that facility's score will be disqualified for this measu

Employee Satisfaction:

- This score is based on the most recent the My InnerView employee satisfaction surveys. The twenty-one survey items on these surveys are averaged and ranked for each facility.
- If 7 or more of these 21 survey items are not answered by a given respondent, that respondent's answers will not be counted in thi measure.
- Overall facility response rate for the most recent employee survey must be at least 30%, or else the facility will be disqualified for this measure.

System Wide Culture Change:

- This score is based on the seventeen culture change items from the most recent My InnerView employee satisfaction surveys. The seventeen items are averaged and ranked for each facility.
- If 5 or more of these 17 survey items are not answered by a given respondent, that respondent's answers will not be counted in this measure.
- Overall facility response rate for the most recent employee survey must be at least 30%, or else the facility will be disqualified for this measure.

CNA/NA without turnover and CNA stability:

- This score is based on data entered in My InnerView's Quality Profile. Facility scores for 'CNAs without turnover' and 'CNA stability' are ranked separately, and then these ranked scores are averaged together. Finally, this average rank score is then ranked across facilities.
- If the facility's average score exceeds the 50th percentile threshold, one point is awarded.

Nurse without turnover and Nurse stability:

- This score is based on data entered in My InnerView's Quality Profile. Facility scores for 'Nurses without turnover' and 'Nurse stability' are ranked separately, and then these ranks are averaged together. Finally, this average is then ranked across facilities.
- If any of the three months of data are missing for a given facility, that facility will be disqualified for this measure.

Clinical Measures:

- The Clinical Measures score is based on the following data entered in My InnerView's Quality Profile:
  - Residents without falls
  - Residents without acquired catheters
  - Residents without acquired physical restraints
  - Residents without unplanned weight loss/gain
  - Residents without acquired pressure ulcers
- Facility scores for each of these 5 measures are ranked separately, and then these ranks are averaged together. Finally, this average is then ranked across facilities.
- If any of the three months of data are missing for a given facility, that facility will be disqualified for this measure.

State Survey Compliance:

- The provider will need to record the results of their most recent standard survey (regardless of outcome) in the My InnerView Quality Profile. Additionally, any subsequent survey activity that results in F-tag citations will also need to be entered. This cycle repeats with the next standard survey.
- Stars are awarded in the following way: facilities with no care-related citations on and since their most recent standard survey receive five stars. For the remaining facilities, a score is calculated using an algorithm that assigns weights based on the scope and severity of the care-related citations – the worse the scope and severity, the lower this score. These scores are then ranked, and stars assigned based on quartiles, meaning the highest 25% of facility scores will receive four stars, the next highest 25% will receive three stars, etc., with the lowest 25% of facility scores receiving one star.
- A reimbursement point is awarded if one of the following two conditions are met: [i] no citations on or since their most recent standard survey; or [ii] any care-related citations cannot have scope/severity greater than 'D' and any non-care related citations cannot have scope/severity greater than 'E.'

Occupancy:

- This score is based on data entered in My InnerView's Quality Profile. If any of the three months of data are missing for a given facility, that facility will be disqualified for this measure.

Medicare Utilization/SoonerCare:

- This metric is derived from Quality of Care report data received from the Oklahoma Health Care Authority on a quarterly basis. any of the three months of data are missing for a given facility, that facility will be disqualified for this measure.
- This metric is a ratio of the total Medicare Part A days divided by the total Medicaid days for the quarter.
- The nursing home must have Medicaid occupancy greater than 50% for the given quarter to qualify for this measure.

Direct Care Hours per Patient Day:

- This metric is derived from Quality of Care report data received from the Oklahoma Health Care Authority on a quarterly basis. I any of the three months of data are missing for a given facility, that facility will be disqualified for this measure.

OKLAHOMA FOCUS ON EXCELLENCE 2009: Quarter 2
EXAMPLE SCORE SHEET

	Facility Score	50th Percentile Threshold	Reimbursement Points
Resident/Family satisfaction	87.42	72.42	1
Quality of Life	88.12	73.67	1
Employee Satisfaction	79.35	65.72	1
System Wide Culture Change	81.73	71.76	1
CNA/NA without turnover and Stability*			1
CNA/NA without turnover	96.33	87	
CNA/NA stability	68.00	92	
Nurse without turnover and stability			1
Nurse without turnover	96.67	58	
Nurse stability	80.00	84	
Clinical Measures			1
Residents without falls	94.67	96	
Residents without acquired catheters	98.67	39	
Residents without acquired physical restraints	100.00	99	
Residents without unplanned weight loss/gain	96.67	56	
Residents without acquired pressure ulcer	94.67	17	
State Survey Compliance**			0
Medicare Utilization/SoonerCare	10.8	10.3	1
Direct Care hours per day (PPD)	3.62	3.54	1
TOTAL POINTS EARNED			9

Notes: 10 points maximum can be earned. Reimbursement will be effective the 2nd quarter following the end of the reporting perioc

OKLAHOMA NURSING FACILITIES
PAYMENT SUMMARIES CY2004 TO CY2009
ANALYSES OF EFFECT TO PAYMENT FOR SSI INCREASES
Attachment II
REGULAR NURSING FACILITIES

	CY 2004	CY 2005	CY 2006	CY 2007	CY 2008
Allowed	$ 574,695,723	$ 559,572,615	$ 566,482,360	$ 604,475,936	$ 633,306,2
Patient Spend-down	$ 104,443,359	$ 105,488,109	$ 107,479,500	$ 110,024,959	$ 113,292,1
OKHCA Paid	$ 470,252,364	$ 454,084,506	$ 459,002,860	$ 494,450,977	$ 520,014,1
SSI Increase	2.10%	2.70%	4.10%	3.30%	2.3
Days	5,733,478	5,485,618	5,225,148	5,097,121	5,098,1
Allowed Per Day	$ 100.24	$ 102.01	$ 108.41	$ 118.59	$ 124.2
Patient Spend-down Per Day	$ 18.22	$ 19.23	$ 20.57	$ 21.59	$ 22.2
OKHCA Paid Per Day	$ 82.02	$ 82.78	$ 87.84	$ 97.01	$ 102.(
Percent of Spend-down Per Day	22.21%	23.23%	23.42%	22.25%	21.7
	Per day increase in Spend-down for 1% increase in SSI				

REGULAR ICFs/MR

Allowed	$ 32,414,571	$ 29,098,182	$ 29,860,920	$ 28,672,326	$ 29,097,96
Patient Spend-down	$ 3,824,984	$ 3,694,155	$ 3,915,137	$ 3,695,411	$ 3,862,68
OKHCA Paid	$ 28,589,587	$ 25,404,027	$ 25,945,783	$ 24,976,915	$ 25,235,27
SSI Increase	2.10%	2.70%	4.10%	3.30%	2.30
Days	321,073	291,556	289,758	253,817	246,01
Allowed Per Day	$ 100.96	$ 99.80	$ 103.05	$ 112.96	$ 118.2
Patient Spend-down Per Day	$ 11.91	$ 12.67	$ 13.51	$ 14.56	$ 15.7
OKHCA Paid Per Day	$ 89.04	$ 87.13	$ 89.54	$ 98.41	$ 102.5
Percent of Spend-down Per Day	13.38%	14.54%	15.09%	14.80%	15.31
	Per day increase in Spend-down for 1% increase in SSI				

ACUTE (16 BED OR LESS) ICFs/MR

Allowed	$ 24,809,732	$ 26,201,700	$ 28,191,349	$ 33,236,506	$ 36,616,51
Patient Spend-down	$ 2,142,047	$ 2,490,048	$ 2,704,927	$ 3,097,290	$ 3,463,23
OKHCA Paid	$ 22,667,684	$ 23,711,651	$ 25,486,422	$ 30,139,216	$ 33,153,281
SSI Increase	2.10%	2.70%	4.10%	3.30%	2.30
Days	190,056	196,699	202,673	226,421	242,13
Allowed Per Day	$ 130.54	$ 133.21	$ 139.10	$ 146.79	$ 151.22
Patient Spend-down Per Day	$ 11.27	$ 12.66	$ 13.35	$ 13.68	$ 14.30
OKHCA Paid Per Day	$ 119.27	$ 120.55	$ 125.75	$ 133.11	$ 136.92
Percent of Spend-down Per Day	9.45%	10.50%	10.61%	10.28%	10.45
	Per day increase in Spend-down for 1% increase in SSI				

b) Consideration and vote to add Otic Anti-Infective Products to the product-based prior authorization program under OAC 317: 30-5-77.3.

c) Consideration and vote to add prasugrel (Effient™) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e)

Recommendation 1: Prior Authorize Otic Anti-Infectives

The Drug Utilization Review Board recommends establishing a PBPA category for otic antibiotics to ensure appropriate use in accordance with current treatment guidelines. The following Tier 1 drug list has been approved and determined to be acceptable for use as initial therapy for the majority of members.

Otic Antibiotics		
Tier 1	**Tier 2**	**Special PA***
Ofloxacin **(Floxin Otic)**	Ofloxacin (**Floxin Otic**) **Droperette**	Acetic Acid, Antipyrine, Benzocaine, Glycerin **(Auralgan)**
Acetic acid **(Vosol, Acetasol)**	Ciprofloxacin, Dex or HC **(Ciprodex, Cipro HC, Cetraxal Drop.)**	Acetic Acid, HC **(Acetasol HC, Vosol HC)**
Neomycin, Polymixin B, HC **(Cortisporin, Cortomycin, Pediotic)**	Neomycin,Polymixin B, HC, thonzonium **(Cortisporin TC)**	
Chloroxylenol/Pramoxine **(Pramotic)**	Neomycin,Colistin, HC **(Coly-Mycin, and Coly Mycin-ES)**	
	Chloroxylenol/Pramoxine/Zinc **(Zinotic, Zinotic ES, Chlorpram Z)**	
	Chloroxylenol, benzocaine, and HC **(Trioxin)**	

***Special Prior Authorization criteria previously approved by the OHCA Board.**

Prior Authorization Criteria

1. Member must have adequate 14-day trial of at least two Tier 1 medications, or
2. Approval may be granted if there is a unique FDA approved indication not covered by Tier 1 products or infection by organism not known to be covered by any of the Tier 1 agents.
3. A ciprofloxacin combination product may be approved when a steroid containing product is required for severe otitis externa and the tympanic membrane is not intact.

A specialized form will be included with the faxed back response for petitions submitted for this category.

Recommendation 2: Prior Authorize Effient™(prasugrel)

The DUR Board recommends placing a prior authorization on Effient™ after 90 days of therapy.

The approval criteria for Effient™ would be as follows:

1. Effient™ therapy will be approved for members who meet approved diagnostic criteria:
    a. The approved diagnoses are UA/NSTEMI and STEMI patients who are to be managed with percutaneous coronary intervention (PCI), primary or delayed.
2. Length of approval: 1 year.
3. Effient™ will not be approved for members with the following situations:
    a. CABG surgery
    b. Members with a history of TIA or stroke
4. Members greater than 75 years of age will generally not be approved without supporting information.

After the end of 15 months, prescribers should provide supporting information for the continuation of these products.

2010

Oklahoma Health Care Authority

Regulary Scheduled Board Meetings

January 14, 2010 • 1:00 p.m.
Oklahoma Health Care Authority
4545 N. Lincoln, Suite 124
Oklahoma City, Oklahoma

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February 11, 2010 • 1:00 p.m.
Oklahoma Health Care Authority
4545 N. Lincoln, Suite 124
Oklahoma City, Oklahoma

◆

March 11, 2010 • 1:00 p.m.
Oklahoma Health Care Authority
4545 N. Lincoln, Suite 124
Oklahoma City, Oklahoma

◆

April 8, 2010 • 1:00 p.m.
Oklahoma Health Care Authority
4545 N. Lincoln, Suite 124
Oklahoma City, Oklahoma

◆

May 13, 2010 • 1:00 p.m.
Oklahoma Health Care Authority
4545 N. Lincoln, Suite 124
Oklahoma City, Oklahoma

◆

June 10, 2010 • 1:00 p.m.
Oklahoma Health Care Authority
4545 N. Lincoln, Suite 124
Oklahoma City, Oklahoma

◆

July 8, 2010 • 1:00 p.m.
Duncan Area Economic Development
2124 N. Hwy. 81 Duncan, Oklahoma

◆

August 25, 2010 • Board Meeting • 4:00 p.m.
August Retreat 25, 26, 27, 2010 • 8:30 a.m.
Oklahoma Health Care Authority
4545 N. Lincoln, Suite 124
Oklahoma City, Oklahoma

◆

September 9, 2010 • 1:00 p.m.
Commanche County Memorial Hospital
3402 W. Gore Blvd. Lawton, Oklahoma

◆

October 14, 2010 • 1:00 p.m.
Oklahoma Health Care Authority
4545 N. Lincoln, Suite 124
Oklahoma City, Oklahoma

◆

November 18, 2010 • 1:00 p.m.
Oklahoma Health Care Authority
4545 N. Lincoln, Suite 124
Oklahoma City, Oklahoma

◆

December 9, 2010 • 1:00 p.m.
Oklahoma Health Care Authority
4545 N. Lincoln, Suite 124
Oklahoma City, Oklahoma

January 2010

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	(14)	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

February 2010

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	(11)	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

March 2010

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	(11)	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

April 2010

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	(8)	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

May 2010

S	M	T	W	T	F	S
						1
2	3	4	5	6	7	8
9	10	11	12	(13)	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

June 2010

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	(10)	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

July 2010

S	M	T	W	T	F	S
				1	2	3
4	5	6	7	(8)	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

August 2010

S	M	T	W	T	F	S
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	(25)	(26)	(27)	28
29	30	31				

September 2010

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	(9)	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

October 2010

S	M	T	W	T	F	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	(14)	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

November 2010

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	(18)	19	20
21	22	23	24	25	26	27
28	29	30				

December 2010

S	M	T	W	T	F	S
			1	2	3	4
5	6	7	8	(9)	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	