OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
February 11, 2010 at 1:00PM
Oklahoma Health Care Authority
4545 N. Lincoln Blvd, Suite 124
Oklahoma City, OK

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 January 14, 2010 Board Minutes

Item to be presented by Nico Gomez, Deputy Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) Financial Update – Carrie Evans, Chief Financial Officer

   b) Medicaid Director's Update – Lynn Mitchell, M.D.

   c) Legislative Update – Nico Gomez, Deputy Chief Executive Officer

Item to be presented by Howard Pallotta, General Counsel

4. Announcement of Conflicts of Interest Panel Recommendations for all action items regarding this board meeting

Item to be presented by Nico Gomez, Deputy Chief Executive Officer

5. Action Item – Consideration and Vote to Reduce Program Expenditures and to Revise State Fiscal Year 2010 OHCA Budget Work Program to Achieve a Balanced Budget

   1a) Consideration and Vote to Adopt Agency Recommended Action to Reduce Agency Contracts, and Limit Agency Operations and Personnel.

   2a) Consideration and Vote to Initiate Agency Recommended dental program emergency extraction utilization controls in the adult dental program effective April 1, 2010.

   3a) Consideration and Vote to eliminate payment for newborn circumcision effective April 1, 2010.

   4a&) Consideration and Vote to Note in Budget Work Program
   4b) increased TPL and claim review collections.

   5a) Consideration and Vote to Reduce Payment to Freestanding Medicaid Primary End Stage Renal Disease (ESRD) facilities by decreasing payment for co-insurance by 75% and decreasing payment for deductible by 25%.

   6a) Consideration and Vote to Reduce Payment for Diabetic Supplies by 40% of current Medicaid Rate.

7a&) Consideration and Vote to Decrease remaining Budget Work
7b) Program $5,094,684.00 by again examining provider rates and reducing them in accordance with federal law or achieving other program reduction in accordance with federal law.

Item to be presented by Chairman Roggow

6. Discussion Item – Reports to the Board by Board Committees

a) Audit/Finance Committee – Member Miller

b) Legislative Committee – Member McFall

c) Rules Committee – Member Langekamp

Item to be presented by Beth VanHorn, Director of Legal Operations

7. a) Consideration and Vote to authorize expenditure of funds to amend the My InnerView contract to extend it up to 12 months

b) Consideration and Vote to authorize expenditures of funds to amend the Hewlett Packard (HP)/Electronic Data Systems (EDS) contract to increase the amount for a claims settlement

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

8. Action Item – Consideration and Vote of agency recommended rulemaking pursuant to Article I of the Administrative Procedures Act

a) 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.

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

8.b-1 REVOKING agency rules at OAC 317:30-5-585, 30-5-586 and 30-5-596.2 and AMENDING agency rules at 30-5-595, 30-5-596, 30-5-596.1, 30-5-972 and 30-5-992 to modify targeted case management (TCM) rules to combine adult & children outpatient behavioral health TCM rules into one streamlined set. Revisions also include broadening TCM to all BA/BS level degrees to increase access across the state. Revisions were also made to provide more consistency with DMHSAS policy.
(Reference APA WF # 09-64)

8.b-2 AMENDING agency rules at OAC 317:30-5-95.33 to add licensed alcohol and drug counselors (LADCs) as licensed behavioral health professionals (LBHPs) under children's inpatient psychiatric treatment rules. This addition would expand the type of licensure their staff can hold in order to provide the services required, as well as allow greater access to care for SoonerCare children that receive inpatient psychiatric treatment services.
(Reference APA WF # 09-68)

8.b-3 AMENDING agency rules at OAC 317:30-3-62 and ADDING agency rules at 30-3-63 to establish policy for hospital acquired conditions. Rules will set policy to no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. The selected conditions that OHCA will recognize are those conditions identified as non-payable by Medicare.
(Reference APA WF # 09-77)

c) Consideration and Vote Upon Permanent rules as follows:

Adoption of Permanent Rules as required by the Administrative Procedures Act.

The following rule HAS previously been approved by the Board and has Gubernatorial approval under Emergency rulemaking. This rule has been REVISED for Permanent Rulemaking.

8.c-1 AMENDING agency rules at OAC 317:30-5-42.11 to provide clarification for providers billing for observation/treatment services. The modification provides examples of outpatient observation services that are not covered when they are provided. This change provides clarification and education to providers.
(Reference APA WF # 09-34)

The following rules HAVE previously been approved by the Board and have Gubernatorial approval under Emergency rulemaking.

8.c-2 AMENDING agency rules at OAC 317:30-5-763.1, 30-5-950 and 30-5-952 to remove references to the Long Term Care Authority as the Administrative Agent for the ADvantage Program as the Oklahoma Department of Human Services/Aging Services Division has assumed responsibility of the administration of the ADvantage Program.
(Reference APA WF # 09-02A)

8.c-3 ADDING agency rules at OAC 317:30-3-61 to standardize the operation of all self directed service programs implemented through the SoonerCare program. The rule sets forth minimum requirements that all self directed service programs must adhere to. Self direction is a method of service delivery that allows members to determine what services and supports they need to live successfully in a home and community based setting.
(Reference APA WF # 09-04)

8.c-4 AMENDING agency rules at OAC 317:30-5-761, 30-5-763, 30-5-
service under the ADvantage Waiver program.
(Reference APA WF # 09-06 A & B)

8.c-5 AMENDING agency rules at OAC 317:30-5-1, 30-5-605, 30-5-607, 30-5-611, REVOKING agency rules at 30-5-608, 30-5-609, 30-5-610 and ADDING agency rules at 30-5-612, 30-5-613, 30-5-614 and 30-5-615 to include a new provider type - Anesthesiologist Assistant (AA), as allowed by the Oklahoma Anesthesiologist Assistant Act. AAs will be allowed to perform anesthesiologist services under the direct supervision of a licensed anesthesiologist.
(Reference APA WF # 09-09)

8.c-6 AMENDING agency rules at OAC 317:30-5-72.1 to provide clarification and consistency with practices for coverage for certain nutritional formulas and bars for children diagnosed with certain metabolic disorders.
(Reference APA WF # 09-10)

8.c-7 AMENDING agency rules at OAC 317:35-5-41.9 to disregard as income and resources certain amounts of unemployment compensation for the purpose of determining eligibility for SoonerCare and Insure Oklahoma IP benefits, as authorized and required by the American Recovery and Reinvestment Act.
(Reference APA WF # 09-15A)

8.c-8 AMENDING agency rules at OAC 317:30-3-27 and 30-5-1091 to add Indian Health Service Facilities, Tribally Operated Facilities and Urban Indian Clinics (I/T/Us) as distant site providers for telemedicine, allowing segments of the Native American population in rural areas access to specialty health care services. Revisions also add public health nursing as an allowable service for qualifying Native Americans population on a statewide basis.
(Reference APA WF # 09-16)

8.c-9 AMENDING agency rules at OAC 317:30-3-24 and 35-13-4 to clarify SoonerCare member responsibilities regarding the reporting of third party liability, utilization of private insurance and notification to medical providers of SoonerCare coverage. Additionally, the rule revision provides notification to members of their agreement to allow sharing of medical information, if needed, to State or Federal agencies, medical providers, or an OHCA designee upon their acceptance of medical services provided through the SoonerCare program.
(Reference APA WF # 09-19 A & B)

8.c-10 AMENDING agency rules at OAC 317:40-5-5 to change incorrect references in policy regarding incident reporting and quality assurance for Agency Companion Services under the Developmental Disabilities Services Division (DDSD) Home and Community-Based Services (HCBS) waivers.
(Reference APA WF # 09-21)

8.c-11 REVOKING agency rules at OAC 317:30-3-80 regarding outdated durable medical equipment (DME) policy related to oxygen and oxygen equipment and the requirements for prior authorization.
(Reference APA WF # 09-26)

8.c-12 AMENDING agency rules at OAC 317:45-11-11 to clarify the intent of non-covered benefits related to weight loss intervention and treatment including bariatric surgical procedures, other weight loss surgeries and procedures, drugs primarily used for weight loss, and nutrition services prescribed only for the intent of weight loss. These services have never been covered under the IP program.
(Reference APA WF # 09-27)

8.c-13 AMENDING agency rules at OAC 317:30-5-95 to allow licensing requirements exceptions for hospitals and residential psychiatric treatment centers that are operated by the state mental hospital in accordance with Title 63 O.S. Section 1-702.
(Reference APA WF # 09-29)

8.c-14 ADDING agency rules at OAC 317:30-5-211.18 to establish a policy of ownership for all purchased DME, prosthetics, orthotics, and supplies. This rule allows all DME purchased by SoonerCare to remain the property of OHCA to be used for the benefit of the requesting member until it is no longer medically necessary. This is the first rule in complying with Oklahoma state law (56 O.S. 1011.11) mandating OHCA to promulgate rules and establish procedures necessary to implement a DME retrieval program.
(Reference APA WF # 09-35)

8.c-15 AMENDING agency rules at OAC 317:1-1-8, 317:1-1-9, 1-1-17 and 1-3-3.1, ADDING agency rules at 1-1-9.1 and 1-3-4, and REVOKING agency rules at 1-1-10, 1-3-3.2, 1-5-1, 1-5-2, 1-5,3, 1-5-4, 1-5-5, 1-7-1, 1-7-2, 1-7-3, 1-7-4, 1-7-5, 1-7-6, 1-7-7, 1-7-8, 1-9-1, 1-9-2, 1-9-3, 1-9-4, 1-9-5, 1-9-6, 1-9-9 and 1-9-10 to remove policy regarding certain federal civil rights requirements, to correct references to federal laws and state statutes, amend policy on open records requirements and include the process for ensuring proper review and approval/ disapproval of rate methodologies by the State Plan Amendment Rate Committee (SPARC).
(Reference APA WF # 09-37)

8.c-16 AMENDING agency rules at OAC 317:30-5-22 to allow flexibility in the types of prenatal assessment forms that may be used instead of restricting providers to only use the American College of Obstetricians and Gynecologist (ACOG) assessment form.
(Reference APA WF # 09-38)

8.c-17 AMENDING agency rules at OAC 317:30-5-241.3 to allow family inclusion during Behavioral Health Rehabilitation Services.
(Reference APA WF # 09-39)

8.c-18 AMENDING agency rules at OAC 317:30-5-211.1, 30-5-211.13, 30-5-211.14 and 30-5-216, ADDING agency rules at 30-5-210.1 and 30-5-210.2, and REVOKING agency rules at 30-5-211.8 and 30-5-212 to provide further clarification in regards to the services available to adults and the additional services available to children. These revisions will further align policy with reimbursement practices and help alleviate confusion to the provider community. Revisions include specifying general coverage for adults, providing definition and clarification in regards to adult and children coverage of prosthetics and orthotics, specifying general coverage for children, and general policy cleanup as it relates to these sections.
(Reference APA WF # 09-42)

8.c-19 AMENDING agency rules at OAC 317:35-5-41.2 to comply with Senate Bill 987 of the 1st Session of the 52nd Oklahoma Legislature (2009) by increasing certain burial trust account thresholds from $7,500 to $10,000 effective November 1, 2009.
(Reference APA WF # 09-43)

8.c-20 AMENDING agency rules at OAC 317:35-17-14 regarding case management services furnished under the ADvantage Home and Community Based Services Waiver at the request of the Oklahoma Department of Human Services/Aging Services Division. Revisions would increase the current time frame allowed for case managers to complete and submit an individualized care plan and service plan for the member from ten to fourteen days. Additional revisions outline a schedule for the annual service plan reassessment and procedures for submission of materials to the ADvantage Administration.
(Reference APA WF # 09-45)

8.c-21 ADDING agency rules at OAC 317:40-9-1 to allow SoonerCare members receiving services through the In-Home Supports Waivers the option to self-direct their services. Self-direction provides the opportunity for members to exercise choice and control in accessing and managing specific waiver services and supports in accordance with their needs and personal preferences. The policy covers operation of the program, including agency oversight, budgeting, member eligibility, member responsibility, and the use of a fiscal agent.
(Reference APA WF # 09-48)

8.c-22 AMENDING agency rules at OAC 317:30-5-137, ADDING agency rules at 30-5-137.1 and 30-5-137.2, and REVOKING agency rules at 30-5-138 and 30-5-139 to re-order the bariatric surgery prior authorization process in policy and provide further clarification of the prior authorization process. This revision effectively rearranges policy to present member candidacy guidelines prior to presenting coverage guidelines. This will facilitate the current prior authorization process and encourage providers to request a member candidacy prior authorization before requesting the prior authorization for the surgery. These revisions are not changing the prior authorization process, only reinforcing the current process.
(Reference APA WF # 09-49)

8.c-23 AMENDING agency rules at OAC 317:35-15-8.1 to clarify who could be paid to serve as a Personal Care Assistant (PCA) to SoonerCare members approved for State Plan Personal Care services.
(Reference APA WF # 09-50)

8.c-24 AMENDING agency rules at OAC 317:2-1-1, 2-1-6, 2-1-7, 2-1-8, 2-1-9, 2-1-10, 2-1-11, 2-1-12, and 2-1-13 to include language regarding member and provider appeals processes, specifically concerning the time frames allowed for responses to appeals from the Oklahoma Health Care Authority and the Administrative Law Judge. Additionally, the rule revisions clarify the process for administrative sanction appeals and the process for provider suspension or termination. **(Reference APA WF # 09-24)**

Item to be presented by Chairman Roggow

9. 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.McAlary v. OHCA	CJ-08-021 (Dewey County)
2.Decker (Lightning Creek) v. OHCA	CJ-08-105 (Major County)
3.Price v. Wolford	09-6139 (Tenth Circuit)
4.McAlary v. OHCA	106,308 (Okla. S.Ct.)
5.Decker (Lightning Creek) v. OHCA	107,844 (Okla. S.Ct.)
6.Boone v. OHCA	CV-09-98 (Choctaw County)
7.Boone v. OHCA	CJ-09-10416 (Oklahoma County)

10. New Business

11. Adjournment

NEXT BOARD MEETING
March 11, 2010
Oklahoma City, OK

BOARD AGENDA ATTACHMENT 5

Oklahoma Health Care Authority
SFY10 Budget Reduction Analysis
and Staff Recommendations
February 11, 2010

FY-2010 Proposed Budget Reductions (Effective 04-01-2010)		FY2010 Impact Total	FY2010 Impact State Share	Staff Recommend.
1. Administrative Reductions				
a. Agency Contracts and Operations (Travel, furniture & equipment, frozen positions)		2,800,000	1,400,000	1,400,000
	Total	**2,800,000**	**1,400,000**	**1,400,000**
2. Dental Program Reductions				
a. Adult dental- emergency extraction utilization controls		1,844,467	656,077	656,077
	Total	**1,844,467**	**656,077**	**656,077**
3. Medical Program Reductions				
a. Eliminate payment for newborn circumcision		305,487	108,662	108,662
	Total	**305,487**	**108,662**	**108,662**
4. Increased Third Party Liability and Claim Review Collections				
a. Third Party Liability (one-time revenue savings)		8,000,000	2,845,600	2,845,600
b. Auditing Recoupments (baby weight and baby transfers)		4,609,288	1,639,524	1,639,524
	Total	**12,609,288**	**4,485,124**	**4,485,124**
5. Crossover Co-insurance & Deductible Reductions				
a. Reduce Payment to Freestanding Medicaid Primary End Stage Renal Disease (ESRD) Facilities				
Co-insurance - 75% decrease		980,895	348,904	348,904
Deductible - 25% decrease		1,566	557	557
	Total	982,462	349,462	349,462
6. Durable Medical Equipment Rate Reductions				
a. Diabetic supplies rate reduction by 40% ($11 K)		30,925	11,000	11,000
	Total	30,925	11,000	11,000
7. Provider Payment Reductions				
a. Overall provider rate cuts (3.5%)		14,292,056	5,083,684	5,083,684
b. Capped rental items rate reduction by 10%		30,925	11,000	11,000
	Total	**14,322,981**	**5,094,684**	**5,094,684**
Grand Total of Proposed Budget Reductions (Effective 04-01-2010)		**32,895,610**	**12,105,008**	**12,105,008**

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING OF THE OKLAHOMA HEALTH CARE AUTHORITY BOARD
Held at Oklahoma Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on January 13, 2010.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Roggow called the meeting to order at 1:00PM.

BOARD MEMBERS PRESENT: Vice Chairman Armstrong, Member Miller, Member Bryant, Member McFall, and Chairman Roggow

BOARD MEMBERS ABSENT: Member Langenkamp
Member McVay

OTHERS PRESENT:

Sheree Powell, OKDHS
Samantha Galloway, OKDHS
Barbara Hoberock, Tulsa World
Lonny Wilson, PPOK
Jim Igo, Integris
Nancy Kachel, PPAEO
Sanra Harris, OKDHS
Justin Martino, eCapitol
Cindy Severn, Community Works
Justin Burton, AR
A Cordry, RR
Darrell Smith, Cornerstone Clinical
Morna Rambo, Alternative Opps
Robert Lee, MHSSO
Ray Miller, The OAKS
Don Anderson, Integris
Becky Moore, OAHCP
Krystin Bruehl, COP
David Blatt

OTHERS PRESENT:

Judy Goodwin OCP, Inc.
Karen Nimrock, HP
Lynne White, OHA
Tana Parrott, DHS
Judy Parker, Chickasaw Nation
Megan Haddock, OKDHS
Mari Moore, OKDHS
David Risin, LTC
Scott Pilgrim, OAHCP
Steve Lewis, Day Spring BH
Tammy Franklin, New Frontier
Brandy Tamehill, New Frontier
Tracy Joner, Chickasaw Nation
John Holter, Cedar Ridge
Patrick Brendle, RMG
Mary Brinkley, OKAHSP
Corry Beck, COP
April Wilkerson, Journal Record
Charles Brodt, HP/EDS

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD DECEMBER 10, 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: Member McFall moved for approval of December 10, 2009 minutes as presented. Vice Chairman Armstrong seconded.

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

BOARD MEMBERS ABSENT: Member Langenkamp
Member McVay

ABSTAIN: Member Bryant

ITEM 3.a) FINANCIAL UPDATE
Carrie Evans, CFO

Ms. Evans reported that revenues for OHCA through November, accounting for receivables, were **$1,430,180,714** or **.2% over** budget. The expenditures for OHCA, accounting for encumbrances, were **$1,409,196,582** or **.1% over** budget and the state dollar budget variance through November is **$2,037,989 positive.** The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	(6.4)
Administration	3.9
Revenues:	
Taxes and Fees	2.0
Drug Rebate	1.0
Overpayments/Settlements	1.5
Total FY 10 Variance	**$ 2.0**

Ms. Evans stated OHCA is expecting about an additional $2-$3 million third party medical collections for December and January. She stated that the final December numbers reveal Medicaid is going over budget by $8 million which will put us about $26 million over budget through the month of December. However with revenues being what they are Ms. Evans projected that for December OHCA is still going to be in the black. She also stated that for January we will be coming in on budget for the first time in 4 months. For detailed information see Item 3.a of the board packet.

ITEM 3.b) MEDICAID DIRECTOR'S UPDATE
Lynn Mitchell, MD

Dr. Mitchell reported that the November numbers increased by another 5,000 individuals and December enrollments numbers increased by 2,700. She stated that we hit a historical all time high in November and broke the 700,000 mark for clients being served. She then reported on the Fast Facts for December which shows 14,500 new individuals that have not historically been served by the program. Dr. Mitchell noted that

the Insure Oklahoma numbers for Janu ary stand at 29,62 1. She s tated that economic times are ca using employees to rethink enrolling an d paying the small p remiums. This mon th we hav e a compl etely new fast fact which is the Certified Nurse Ai de Training Program. As of last month, we had 3,123 certified nurse aides that had completed the course with 80% becoming certified. This is a free t raining program started in 2005 and done in collaboration with OSU specifically to address workforce issues. For detailed information, see Item 3.b of the packet.

ITEM 3.c) LEGISLATIVE UPDATE

Nico Gomez, Deputy Chief Executive Officer

Mr. Gomez noted that as of noon, Tuesday, January 12th, the Oklahoma Legislature is tracking a total of 2,812 legislative bills for the upcoming session. Of those 2,812 bills, 1,953 are carry-over bills from last session and 859 a re pre-fi led bills for the new sess ion. OHCA has 148 carry-over bills. Thursday, January 14th is the final date for introduction of bills and joint resolutions. The Governor's State of the State address and the 2010 legislative session begin on Monday , February 1st at no on. Mr. Gomez a lso noted the Sen ate and House deadlines. He pres ented a handout for board members detailing the Public Relations Activities. For details, see Item 3.c of the packet.

Mr. Fogarty discussed the take home packet and also welcomed OHCA's new board member, Ann Bryant.

ITEM 4 – PRESENTATION OF THE TITLE XXI CHIP STATE PLAN AMENDMENT APPROVAL AND THE CMS APPROVAL TO RENEW THE SOONERCARE MEDICAID SECTION 1115 DEMONSTRATION WAIVER

Lynn Mitchell, MD

Dr. Mitchell discussed the recently approved Title X XI State Plan , (stand alone) Children's Health Insurance Program (CHIP). She covered the populations affected, the historical timeline, and the key highlights of the approval package. By and large children's coverage uses the existing Insure Oklahoma framework for benefits, cost sharing, etc. with exception of some additional requirements. She noted that the next steps will consists of revising estimated funding limitations, the pursuit of long-term state revenue sources, the implementation planning, especially nuances of the new Chi ldren's Health Insuranc e Program Reauthorization Act of 2009(CHIPRA) requirements and the most timely, effective and efficient modes of operation and the consideration of pe nding national health care reform efforts and th e potential future environment.

Dr. Mitch ell then discussed the Soon erCare an d Insure Oklahoma 1115 Research and Demonstration Waiver Update. She reported on the waiver renewal, populations affected the his torical timeline. She disc ussed the key highlights of the 1115 renewal which include authorization to implement up to f our Health Access Network (HAN) pilots. HANs wil l offer core components of electronic medical records, improved access to specialty care, telemedicine, expanded quality improvement strategies ; and care management/care coordination to persons with complex health care needs. This renewal process will incorporate the Insure Oklahoma and the SoonerCare Indian Health Services, Tribal and Urban I ndian

Clinic networks in the patient-centered medical home structure already approved for the SoonerCare choice program. Dr. Mitchell said that OHCA is developing a strategic plan to implement these processes.

ITEM 5 – ANNOUNCEMENT OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING

Howard Pallotta, General Counsel

Mr. Pallotta stated that the Conflicts of Interest Panel met with regard to action Items 6, 8, & 9 and found no conflicts. The review was conducted for all Board Members except for Member Bryant who the Conflicts Committee did not have information regarding since she was just appointed to the Board.

ITEM 6 – CONSIDERATION AND VOTE TO REVISE STATE FISCAL YEAR 2010 OHCA BUDGET WORK PROGRAM TO ACHIEVE A BALANCED BUDGET

Mike Fogarty, Chief Executive Officer

Mr. Fogarty said that at the December board meeting, this board took action on a number of programs items, policies, and coverage issues in order to balance the current year budget which amounted to some $27 million state dollars. During the course of that discussion, the reality was discussed that it was not the end of revenue shortfall. Mr. Fogarty stated that OHCA again received instructions from the Office of State Finance (OSF) that to reduce general revenue dollars by and additional 5% for 2 months (December and January) which would be a total for the 2 months of approximately $5 million state dollars. The impact on the total budget is $20 million. The item in front of you would direct this staff to modify the state fiscal year 2010 budget by reducing the state revenue assumption by $5 million. It is staff recommendation that we modify the budget by decreasing rates of payments to providers effective April 1, 2010 in an amount sufficient to balance the state fiscal year 2010 budget and accommodate the reduced general revenue as instructed by OSF. In addition, we are recommending that those cuts be made and applied generally across-the-board. At this point we should be governed by a reduction in rates that apply as much as possible across all provider types but recognize that there is a process required by federal and state law that serves us all well in the establishment of provider rates. The recommendation does not assume a simplistic across-the-board percentage rate reduction, but will require an overall reduction of 3.25%. Several of the rates will be subject to public hearings, publication, and will come back to the board for approval. Mr. Fogarty noted that we are bound by law to file a balanced budget. It is the recommendation of this staff that this board adopt these recommendations.

ITEM 6a – CONSIDERATION AND VOTE TO REDUCE TOTAL EXPENDITURES BY REVIEW AND REVISION OF PROVIDER RATES TO BE EFFECTIVE APRIL 1, 2010. RATE REDUCTIONS ARE TO BE IN AN AMOUNT SUFFICIENT TO BALANCE THE STATE FISCAL YEAR 2010 OHCA BUDGET, ACCOMMODATING REDUCED ALLOCATION OF GENERAL REVENE FOR DECEMBER 2009 AND JANUARY 2010 AS INSTRUCTED BY THE OFFICE OF STATE FINANCE. RATE REDUCTIONS ARE TO BE APPLIED ACROSS-THE-BOARD TO ALL PROVIDER TYPES TO THE EXTEND POSSIBLE AND I ACCORDANCE WITH APPLICALBE MEDICAID REQUIREMENTS

Mike Fogarty, Chief Executive Officer

MOTION: Vice Chairman Armstrong moved for approval of Item 6a as presented. Member McFall seconded.

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

BOARD MEMBERS ABSENT: Member Langenkamp
Member McVay

ABSTAIN: Member Bryant

ITEM 7 – REPORTS TO THE BOARD BY BOARD COMMITTEES
Chairman Roggow

7.a)Audit/Finance Committee
Member Miller

Member Miller stated that the committee did not meet.

7.b)Legislative Committee
Member McFall

Member McFall reported that there is a lot not known regarding bills at this time.

ITEM 8.a)CONSIDERATION AND VOTE UPON A DECLARATION OF A COMPLELLING PUBLIC INTEREST FOR THE PROMULGATION OF ALL EMERGENCY RULES IN ACCORDANCE WITH 75 OKLA. STAT. § 253
Cindy Roberts, Deputy Chief Executive Officer

MOTION: Member Miller moved for declaration of a compelling public interest for promulgation of all emergency rules as presented. Member McFall seconded.

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

BOARD MEMBERS ABSENT: Member Langenkamp
Member McVay

ABSTAIN: Member Bryant

ITEM 8.b)CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:
Cindy Roberts, Deputy Chief Executive Officer

8.b-1 AMENDING agency rules at OAC 317:30-5-1023 and 30-5-1027 to modify EPSDT rules to add a new provider type "Behavior Health School Aide" and service "Therapeutic Behavioral Services". This rule change is needed to help better define and separate behavioral interventions that do not

appropriately fall within the description of personal care services.
(Reference APA WF # 09-47)

8.b-2 AMENDING agency rules at OAC 317:30-5-20 and 30-5-100 to clarify that reimbursement is only made for medically necessary laboratory services. Additional revisions include removing language which calls for OHCA to edit laboratory claims at the specialty/subspecialty level.
(Reference APA WF # 09-52)

8.b-3 AMENDING agency rules at OAC 317:45-11-20 and 45-11-27 to clarify the intent of offering coverage under the Insure Oklahoma Individual Plan (IP) program. Applicants applying for coverage under the IP program should be uninsured individuals without access to Insure Oklahoma Employer Sponsored Insurance (ESI) or other private health insurance. Rules clarify IP eligibility requirements and closure criteria.
(Reference APA WF # 09-53)

8.b-4 AMENDING agency rules at OAC 317:2-1-2, 35-1-2, 35-5-6, 35-5-6.1, 35-6-15, 35-6-38, 35-6-62, 35-6-63, 35-6-64, 35-6-64.1, 35-7-15, 35-7-60.1, 35-7-63, 35-7-64, 35-7-65, 35-10-26, 35-22-9, and 35-22-11 to support the use of the web based online application and eligibility determination system. The process will be phased in over a period of time, beginning with families with children, pregnant women, and individuals requesting only family planning services. Eligibility for these groups will no longer be retroactive to the first day of the month of application but rather, the date of application or later.
(Reference APA WF # 09-56)

8.b-5 AMENDING agency rules at OAC 317:30-5-566 and 30-5-567 to allow reimbursement for services not covered as Medicare Ambulatory Surgical Center (ASC) procedures but otherwise covered under the SoonerCare program. This revision will give OHCA additional flexibility in determining services which are appropriate for the populations we serve.
(Reference APA WF # 09-59)

8.b-6 AMENDING agency rules at OAC 317:30-5-96.3 to clarify reimbursement for acute inpatient psychiatric services provided in free-standing psychiatric hospitals. The modification more clearly defines reimbursement for ancillary and professional services outside of the per diem rate paid to the facilities.
(Reference APA WF # 09-61)

MOTION: Member McFall moved for approval of Rules 8.b-1-6 as presented. Vice Chairman Armstrong seconded.

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

BOARD MEMBERS ABSENT: Member Langenkamp
Member McVay
ABSTAIN: Member Bryant

ITEM 9a - CONSIDERATION AND VOTE TO ADD CERTAIN ANTI-NAUSEA MEDICATION TO THE UTILIZATION AND SCOPE PRIOR AUTHORIZATION PROGRAM UNDER OKLAHOMA ADMINISTRATIVE CODE 317:30-5-77.2(e).

Nancy Nesser, PharmD. Pharmacy Director

Dr. Nesser reported on the following approval criteria for certain anti-nausea medications:

Approval Criteria for granisetron (Kytril® and Sancuso®), dolasetron (Anzemet®), and aprepitant (Emend®):

- FDA Approved Diagnosis
- A recent trial of ondansetron that resulted in inadequate response.
- Existing quantity limits for these medications will apply.

Approval Criteria for cannabinoids (Marinol® and Cesamet®):

- Diagnosis of HIV related loss of appetite - approved
- For chemotherapy induced nausea and vomiting: A recent trial of ondansetron with inadequate response.
- A quantity limit of 60 units per 30 days will apply.

MOTION: Vice Chairman Armstrong moved for approval of Item 9a as presented. Member McFall seconded.

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

BOARD MEMBERS ABSENT: Member Langenkamp
Member McVay

ABSTAIN: Member Bryant

ITEM 10 - 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 McFall moved for executive session. Member Miller seconded.

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

BOARD MEMBERS ABSENT: Member Langenkamp
Member McVay

ABSTAIN: Member Bryant

NEW BUSINESS

None

ADJOURNMENT

MOTION:	Vice Chairman Armstrong moved for adjournment. Member McFall seconded.
FOR THE MOTION:	Vice-Chairman Armstrong, Member Miller, Member Bryant, Member McFall, and Chairman Roggow

BOARD MEMBERS ABSENT: Member Langenkamp
Member McVay

FINANCIAL REPORT

For the Six Months Ended December 31, 2009
Submitted to the CEO & Board
February 11, 2010

- Revenues for OHCA through December, accounting for receivables, were **$1,711,458,497** or **.5% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,723,275,589** or **.5% over** budget.
- The state dollar budget variance through December is **$140,229 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	(10.7)
Administration	3.0
Revenues:	
Taxes and Fees	2.3
Drug Rebate	3.1
Overpayments/Settlements	2.4
Total FY 10 Variance	**$ .1**

ATTACHMENTS

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

REVENUES	FY10 Budget YTD	FY10 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 341,978,393	$ 341,978,393	$ -	0.0%
Federal Funds	1,057,691,964	1,048,499,858	(9,192,106)	(0.9)%
Tobacco Tax Collections	24,778,185	27,763,611	2,985,426	12.0%
Quality of Care Collections	25,981,409	25,327,961	(653,448)	(2.5)%
Prior Year Carryover	23,404,558	23,404,558	-	0.0%
Drug Rebates	71,619,859	80,269,818	8,649,959	12.1%
Medical Refunds	15,516,150	22,300,451	6,784,301	43.7%
Other Revenues	10,513,613	10,363,392	(150,221)	(1.4)%
Stimulus Funds	131,550,453	131,550,453	-	0.0%
TOTAL REVENUES	**$ 1,703,034,584**	**$ 1,711,458,497**	**$ 8,423,912**	**0.5%**

EXPENDITURES	FY10 Budget YTD	FY10 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 19,802,167**	**$ 18,775,825**	**$ 1,026,342**	**5.2%**
ADMINISTRATION - CONTRACTS	**$ 55,015,098**	**$ 39,309,952**	**$ 15,705,146**	**28.5%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	14,488,815	13,914,019	574,796	4.0%
Acute Fee for Service Payments:				
Hospital Services	483,595,184	472,523,717	11,071,468	2.3%
Behavioral Health	131,518,334	142,631,404	(11,113,070)	(8.4)%
Physicians	226,675,863	224,103,770	2,572,093	1.1%
Dentists	77,360,430	85,529,653	(8,169,223)	(10.6)%
Other Practitioners	22,171,345	24,159,273	(1,987,928)	(9.0)%
Home Health Care	9,536,514	10,308,031	(771,516)	(8.1)%
Lab & Radiology	12,364,246	14,711,285	(2,347,039)	(19.0)%
Medical Supplies	29,692,450	28,226,718	1,465,732	4.9%
Ambulatory Clinics	30,990,633	45,487,760	(14,497,126)	(46.8)%
Prescription Drugs	190,616,067	193,017,602	(2,401,535)	(1.3)%
Miscellaneous Medical Payments	15,366,885	14,391,467	975,418	6.3%
Other Payments:				
Nursing Facilities	263,594,302	263,349,667	244,635	0.1%
ICF-MR Private	28,513,439	28,190,687	322,752	1.1%
Medicare Buy-In	57,570,432	57,849,109	(278,676)	(0.5)%
Transportation	12,880,303	12,928,969	(48,666)	(0.4)%
Part D Phase-In Contribution	33,199,269	33,866,682	(667,413)	(2.0)%
Total OHCA Medical Programs	**1,640,134,513**	**1,665,189,812**	**(25,055,299)**	**(1.5)%**
OHCA Non-Title XIX Medical Payments	40,128	-	40,128	0.0%
TOTAL OHCA	**$ 1,714,991,906**	**$ 1,723,275,589**	**$ (8,283,683)**	**(0.5)%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (11,957,321)**	**$ (11,817,092)**	**$ 140,229**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures

by Source of State Funds

Fiscal Year Ended 2010, for the Six Months Ended December 31, 2009

Category of Service	Total	Health Care Authority			Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	14,072,503	13,896,769	13,914,019	17,250	-	158,484	-	17,250	-
Inpatient Acute Care	397,905,717	323,282,330	351,463,924	28,181,594	243,343	5,248,496	24,972,021	2,966,229	41,193,297
Outpatient Acute Care	124,700,333	117,210,052	121,059,793	3,849,741	20,802	3,640,540	-	3,828,939	
Behavioral Health - Inpatient	70,073,823	68,047,259	68,047,259	-	-	2,470	-	-	2,024,094
Behavioral Health - Outpatient	4,325,174	4,307,890	4,307,890	-	-	-	-	-	17,285
Behavioral Health Facility- Rehab	83,416,920	70,017,706	70,086,258	68,552	-	88,870	-	68,552	13,241,791
Behavioral Health - Case Management	189,996	189,650	189,996	346	-	-	-	346	
Residential Behavioral Management	13,479,461	-	-	-	-	-	-	-	13,479,461
Targeted Case Management	37,544,276	-	-	-	-	-	-	-	37,544,276
Therapeutic Foster Care	-	-	-	-	-	-	-	-	-
Physicians	246,926,496	184,975,540	224,103,770	39,128,231	29,050	5,658,503	31,696,276	7,402,904	17,164,223
Dentists	85,533,580	81,602,145	85,529,653	3,927,508	-	3,927	3,814,734	112,774	-
Other Practitioners	24,311,943	23,503,668	24,159,273	655,605	223,182	152,670	402,280	30,142	-
Home Health Care	10,308,091	10,264,494	10,308,031	43,537	-	60	-	43,537	-
Lab & Radiology	15,425,390	14,189,023	14,711,285	522,261	-	714,105	-	522,261	-
Medical Supplies	28,517,603	26,628,544	28,226,718	1,598,174	1,448,740	290,885	-	149,434	-
Ambulatory Clinics	51,155,423	45,067,155	45,487,760	420,605	-	567,255	-	420,605	5,100,408
Personal Care Services	6,431,360	-		-	-	-	-	-	6,431,360
Nursing Facilities	263,349,667	170,375,142	263,349,667	92,974,525	71,792,046	-	21,166,446	16,034	-
Transportation	12,928,969	11,644,366	12,928,969	1,284,603	1,253,250	-	23,884	7,470	-
GME/IME/DME	68,041,279	-		-	-	-	-	-	68,041,279
ICF/MR Private	28,190,687	18,763,606	28,190,687	9,427,082	8,996,931	-	430,150	-	-
ICF/MR Public	40,868,317	-	-	-	-	-	-	-	40,868,317
CMS Payments	91,715,791	88,810,786	91,715,791	2,905,005	2,905,005	-	-	-	-
Prescription Drugs	198,715,474	170,286,952	193,017,602	22,730,650	-	5,697,873	20,800,402	1,930,247	-
Miscellaneous Medical Payments	14,391,467	13,651,013	14,391,467	740,454	-	-	658,156	82,297	-
Home and Community Based Waiver	80,935,484	-	-	-	-	-	-	-	80,935,484
Homeward Bound Waiver	48,902,733	-	-	-	-	-	-	-	48,902,733
Money Follows the Person	759,023	-	-	-					759,023
In-Home Support Waiver	13,239,341	-	-	-	-	-	-	-	13,239,341
ADvantage Waiver	107,117,131	-	-	-	-	-	-	-	107,117,131
Family Planning/Family Planning Waiver	3,235,067	-	-	-	-	-	-	-	3,235,067
Premium Assistance*	23,761,379	-	-	-		23,761,379	-		-
Total Medicaid Expenditures	**2,210,469,900**	**1,456,714,092**	**1,665,189,812**	**208,475,720**	**86,912,350**	**45,985,518**	**103,964,350**	**17,599,021**	**499,294,570**

* Includes $22,761,379 paid out of Fund 245

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

		FY10 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	159,223,500
Federal Funds		325,697,925
TOTAL REVENUES	**$**	**484,921,424**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	80,935,484
Money Follows the Person		759,023
Homeward Bound Waiver		48,902,733
In-Home Support Waivers		13,239,341
ADvantage Waiver		107,117,131
ICF/MR Public		40,868,317
Personal Care		6,431,360
Residential Behavioral Management		10,568,677
Targeted Case Management		28,795,991
Total Department of Human Services		**337,618,058**
State Employees Physician Payment		
Physician Payments		17,164,223
Total State Employees Physician Payment		**17,164,223**
Education Payments		
Graduate Medical Education		20,700,000
Graduate Medical Education - PMTC		6,536,750
Indirect Medical Education		28,137,940
Direct Medical Education		12,666,589
Total Education Payments		**68,041,279**
Office of Juvenile Affairs		
Targeted Case Management		1,509,293
Residential Behavioral Management - Foster Care		72,954
Residential Behavioral Management		2,837,830
Multi-Systemic Therapy		17,285
Total Office of Juvenile Affairs		**4,437,362**
Department of Mental Health		
Targeted Case Management		46,393
Hospital		2,024,094
Mental Health Clinics		13,241,791
Total Department of Mental Health		**15,312,279**
State Department of Health		
Children's First		1,322,411
Sooner Start		1,353,882
Early Intervention		3,578,291
EPSDT Clinic		1,153,650
Family Planning		63,147
Family Planning Waiver		3,144,941
Maternity Clinic		78,368
Total Department of Health		**10,694,691**
County Health Departments		
EPSDT Clinic		448,801
Family Planning Waiver		26,978
Total County Health Departments		**475,780**
State Department of Education		**114,499**
Public Schools		**2,177,398**
Medicare DRG Limit		**39,492,916**
Native American Tribal Agreements		**2,065,705**
Department of Corrections		**32,842**
JD McCarty		**1,667,539**
Total OSA Medicaid Programs	**$**	**499,294,570**
OSA Non-Medicaid Programs	**$**	**4,761,181**
Account Receivable from OSA	**$**	**19,134,327**

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

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 25,303,288	$ 25,303,288
Interest Earned	24,673	24,673
TOTAL REVENUES	**$ 25,327,961**	**$ 25,327,961**

EXPENDITURES	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 69,900,248	$ 24,604,887	
Eyeglasses and Dentures	152,558	53,700	
Personal Allowance Increase	1,739,240	612,212	
Coverage for DME and supplies	1,448,740	509,956	
Coverage of QMB's	516,378	181,765	
Part D Phase-In	2,905,005	2,905,005	
ICF/MR Rate Adjustment	6,900,708	2,429,049	
Acute/MR Adjustments	2,096,224	737,871	
NET - Soonerride	1,253,250	441,144	
Total Program Costs	**$ 86,912,350**	**$ 32,475,590**	**$ 32,475,590**
Administration			
OHCA Administration Costs	$ 260,739	$ 130,369	
DHS - 10 Regional Ombudsman	95,935	95,935	
OSDH-NF Inspectors	65,794	65,794	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 422,467**	**$ 292,098**	**$ 292,098**
Total Quality of Care Fee Costs	**$ 87,334,817**	**$ 32,767,688**	
TOTAL STATE SHARE OF COSTS			**$ 32,767,688**

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 Six Months Ended December 31, 2009

REVENUES	FY 09 Carryover	FY 10 Revenue	Total Revenue
Prior Year Balance	$ 37,974,903		$ 29,412,736
Tobacco Tax Collections	-	22,834,121	22,834,121
Interest Income	-	751,365	751,365
Federal Draws	-	15,585,196	15,585,196
All Kids Act	(8,000,000)		-
TOTAL REVENUES	**$ 29,974,903**	**$ 39,170,682**	**$ 68,583,418**

EXPENDITURES	FY 09 Expenditures	FY 10 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 23,761,379	$ 23,761,379
Individual Plan			
SoonerCare Choice		$ 157,092	$ 55,296
Inpatient Hospital		5,248,496	1,847,470
Outpatient Hospital		3,626,470	1,276,517
Behavioral Health - Inpatient Services		2,470	869
Behavioral Health Facility - Rehabilitation Services		88,399	31,116
Behavioral Health - Case Management		-	-
Physicians		5,645,021	1,987,048
Dentists		3,927	1,382
Other Practitioners		151,530	53,339
Home Health		60	21
Lab and Radiology		710,725	250,175
Medical Supplies		290,624	102,300
Ambulatory Clinics		566,211	199,306
Prescription Drugs		5,677,744	1,998,566
Premiums Collected			(2,337,938)
Total Individual Plan		**$ 22,168,769**	**$ 5,465,469**
College Students-Service Costs		**$ 55,370**	**$ 19,490**
Total Program Costs		**$ 45,985,518**	**$ 29,246,339**
Administrative Costs			
Salaries	$ 18,023	$ 595,305	$ 595,305
Operating Costs	289,025	376,318	376,318
Contract - Electronic Data Systems	255,119	1,168,762	1,168,762
Total Administrative Costs	**$ 562,167**	**$ 2,140,385**	**$ 2,140,385**
Total Expenditures			**$ 31,386,723**
NET CASH BALANCE	**$ 29,412,736**		**$ 37,196,695**

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 Six Months Ended December 31, 2009

REVENUES	FY 10 Revenue	State Share
Tobacco Tax Collections	**455,803**	**455,803**
TOTAL REVENUES		**$ 455,803**

EXPENDITURES	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 17,250	$ 4,250	
Inpatient Hospital	2,966,229	730,879	
Outpatient Hospital	3,828,939	943,451	
Inpatient Free Standing	-	-	
MH Facility Rehab	68,552	16,891	
Case Mangement	346	85	
Nursing Facility	16,034	3,951	
Physicians	7,402,904	1,824,076	
Dentists	112,774	27,787	
Other Practitioners	30,142	7,427	
Home Health	43,537	10,727	
Lab & Radiology	522,261	128,685	
Medical Supplies	149,434	36,820	
Ambulatory Clinics	420,605	103,637	
Prescription Drugs	1,930,247	475,613	
Transportation	7,470	1,841	
Miscellaneous Medical	82,297	20,278	
Total Program Costs	$ 17,599,021	$ 4,336,399	**$ 4,336,399**
TOTAL STATE SHARE OF COSTS			**$ 4,336,399**

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 Six Months Ended December 31, 2009

REVENUES	FY 10 Total Revenue	FY 10 State Share
Tobacco Tax Collections	**27,307,809**	**27,307,809**
TOTAL REVENUES	**$ 27,307,809**	**$ 27,307,809**

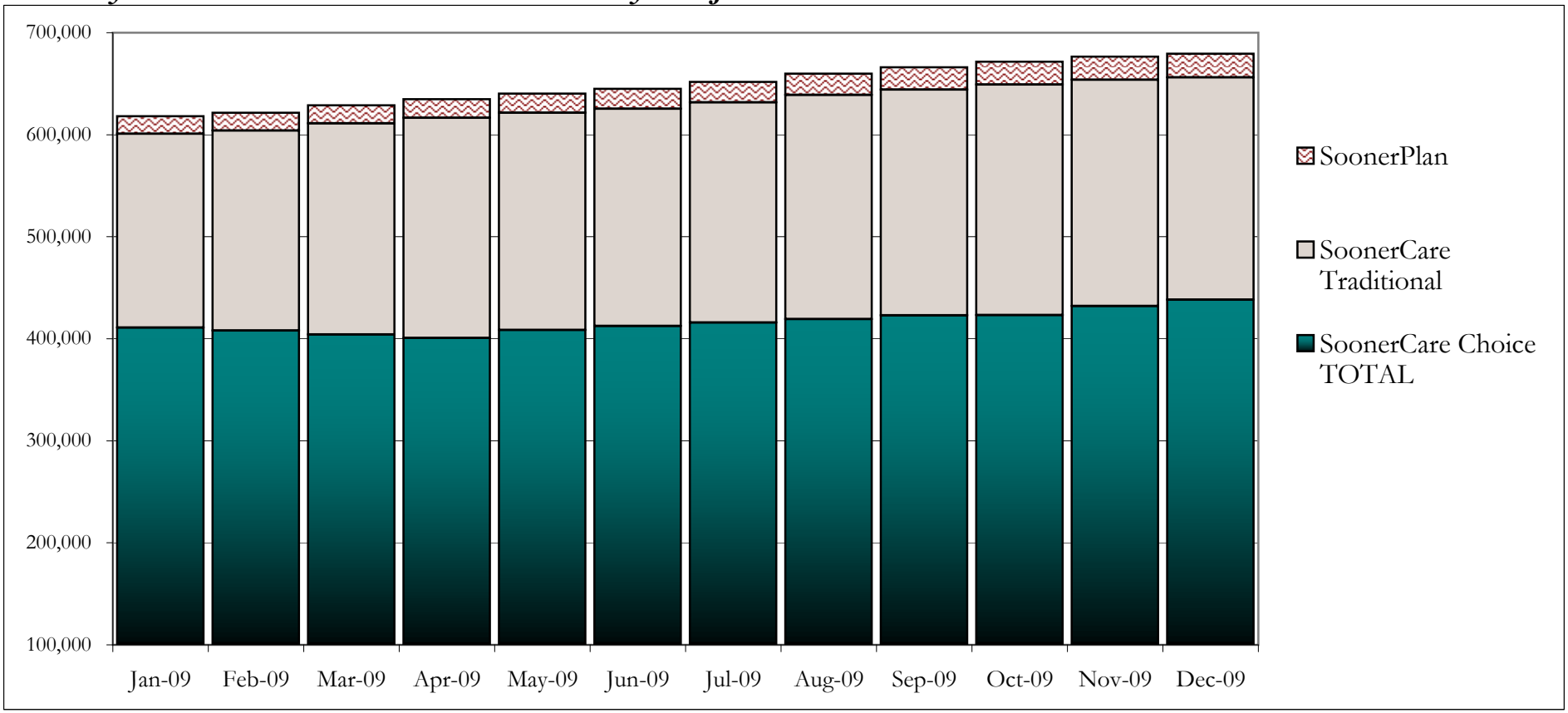
EXPENDITURES Program Costs:	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Adult Dental Services	$ 3,814,734	$ 1,342,786	
Remove Hospital Day Limit	6,047,602	2,128,756	
Hospital Rate Increase - Statewide Median +2%	8,691,478	3,059,400	
Increase Physician Visits from 2 to 4 per Month	264,919	93,252	
Increase Physician Office Visits/OB Visits to 90% of Medicare	15,228,111	5,360,295	
Increase Emergency Room Physician Rates to 90% of Medicare	7,209,725	2,537,823	
Pay 50% of Medicare Crossover - Physician/Ambulance/OP	10,053,957	3,538,993	
Nursing Facility 7% Rate Increase	16,999,602	5,983,860	
Enhanced Drug Benefit for Adults 3 + 3	11,218,188	3,948,802	
Enhanced Drug Benefit for Waiver Adults 3 + 10	9,582,215	3,372,940	
TEFRA Services	5,776,931	2,033,480	
SoonerRide	23,884	8,407	
Replace NSGO Medicare DRG Limit Revenues	9,053,004	3,186,657	
Total Program Costs	**$ 103,964,350**	**$ 36,595,451**	**$ 36,595,451**
TOTAL SHATE SHARE OF COSTS			**$ 36,595,451**

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

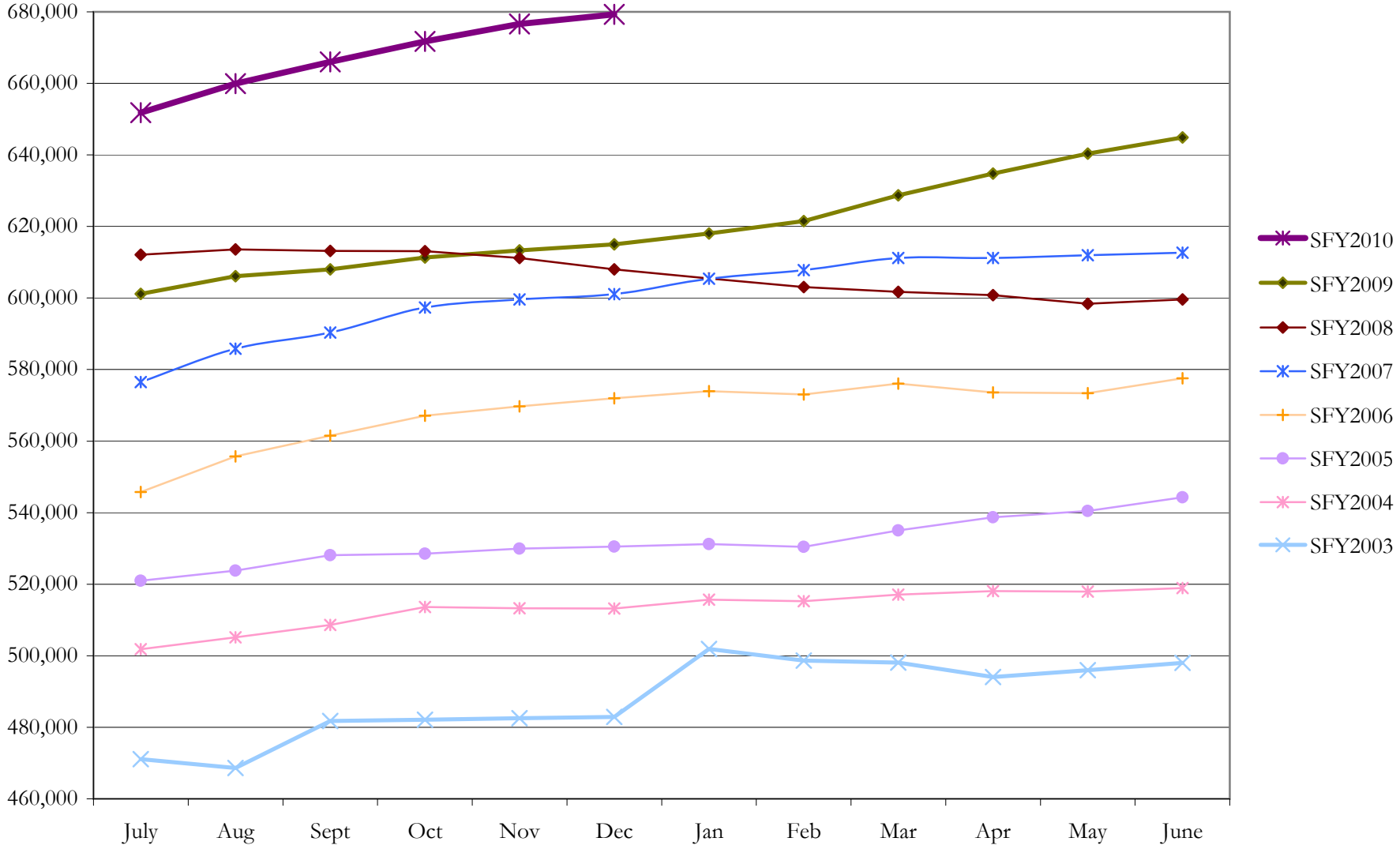
	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Total MMs
ENROLLEES													
SoonerCare Choice													
Choice Total	399,044	396,540	392,568	389,173	396,825	400,642	404,056	407,312	410,597	410,763	419,311	424,913	4,851,744
IHS/Urban/Tribal Total	11,882	11,559	11,672	11,571	11,819	11,831	11,926	12,062	12,329	12,525	12,757	13,363	145,296
SoonerCare Choice TOTAL	410,926	408,099	404,240	400,744	408,644	412,473	415,982	419,374	422,926	423,288	432,068	438,276	4,997,040
SoonerCare Traditional	190,117	196,093	206,886	215,889	212,963	213,073	215,702	219,633	221,392	225,914	221,734	217,945	
SoonerPlan	17,013	17,290	17,600	18,156	18,743	19,359	20,093	20,937	21,724	22,498	22,788	23,073	239,274
TOTAL ENROLLEES	618,056	621,482	628,726	634,789	640,350	644,905	651,777	659,944	666,042	671,700	676,590	679,294	7,793,655
Average Monthly Enrollment													649,471

Monthly Actual SoonerCare Enrollment Trends by Benefit Plan



MMs = Member Months

OHCA SoonerCare Enrollment Figures



SoonerCare Programs

December 2009

Choice PCCM	December 2008	December 2009
TOTAL	407,408	438,276
American Indian Enrollees	11,339	13,363
Choice enrollees (enhanced PCMH)	396,069	424,913

Traditional	December 2008	December 2009
Members	190,626	217,945
SoonerCare Programs Total Unduplicated	615,013	679,294

Oklahoma Cares	December 2008	December 2009
Women currently enrolled	2,552	2,373
SoonerCare Traditional	1,926	1,671
SoonerCare Choice	626	702
Women ever-enrolled	18,121	21,980

Insure Oklahoma/ O-EPIC	December 2008	December 2009
IO Total Enrollees	15,907	28,958
IO Total Enrollees **(Male : Female)**	7,020 : 8,887	12,578 : 16,380
ESI Enrollees	10,696	18,133
IP Enrollees	5,211	10,825

TEFRA	December 2008	December 2009
Children enrolled	241	320
Male Enrollees	149	192
Female Enrollees	92	128
Ever-enrolled	317	414

SoonerPlan	December 2008	December 2009
Enrolled	16,979	23,073
Male enrollees	502	648
Female enrollees	16,477	22,425
Ever-enrolled	62,456	77,149

PROGRAM	JULY 2009	AUGUST 2009	SEPTEMBER 2009	OCTOBER 2009	NOVEMBER 2009	DECEMBER 2009
Choice PCMH	415,982	419,374	422,926	423,288	432,068	438,276
Traditional	215,702	219,633	221,392	225,914	221,734	217,945
Oklahoma Cares	2,701	2,748	2,651	2,466	2,481	2,373
TEFRA	285	292	297	307	313	320
SoonerPlan	20,093	20,937	21,724	22,498	22,788	23,073
Soon to be Sooners	3,153	3,099	3,132	3,103	3,041	2,979
SoonerCare Programs Total Unduplicated	**651,777**	**659,944**	**666,042**	**671,700**	**676,590**	**679,294**
Insure Oklahoma ESI	15,273	15,974	17,012	17,344	17,882	18,133
Insure Oklahoma IP	8,259	8,672	9,344	9,756	10,146	10,825
Insure Oklahoma Programs Total **Unduplicated**	**23,532**	**24,646**	**26,356**	**27,100**	**28,028**	**28,958**
Programs Total	**675,309**	**684,590**	**692,398**	**698,800**	**704,618**	**708,252**

SoonerCare Fast Facts

December 2009

oklahoma health care authority

TOTAL ENROLLMENT —
OKLAHOMA SOONERCARE (MEDICAID)

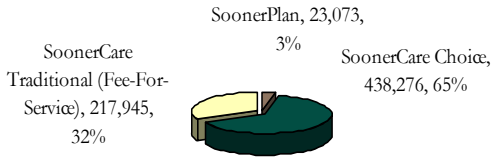
Qualifying Group	Age Group	Enrollment	% of Total
Aged/Blind/Disabled	Child	17,880	2.63%
Aged/Blind/Disabled	Adult	124,374	18.31%
Children/Parents	Child	448,426	66.01%
Children/Parents	Adult	44,744	6.59%
Other	Child	651	0.10%
Other	Adult	17,453	2.57%
Oklahoma Cares (Breast & Cervical Cancer)		2,373	0.35%
SoonerPlan (Family Planning)		23,073	3.40%
TEFRA		320	0.05%

Total Enrollment	**679,294**	Adults	208,933	31%
		Children	470,361	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) — **788,420**

Other Breakdowns of Total Enrollment

Oklahoma SoonerCare (Medicaid) members residing in a long-term care facility — 15,864

Oklahoma persons enrolled in both Medicare and Medicaid (dual eligibles) — 100,340

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
5,552	18,133	10,825

New Enrollees

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

Adults	6,098
Children	8,381
Total	**14,479**

Race Breakdown of Total Enrollment

	Children	Adults	Percent	Pregnant Women
American Indian	60,590	19,577	12%	2,782
Asian or Pacific Islander	6,670	2,796	1%	557
Black or African American	69,297	29,012	14%	2,388
Caucasian	320,856	155,478	70%	18,374
Multiple Races	12,948	2,070	2%	579
Hispanic Ethnicity	73,506	10,533	12%	4,697

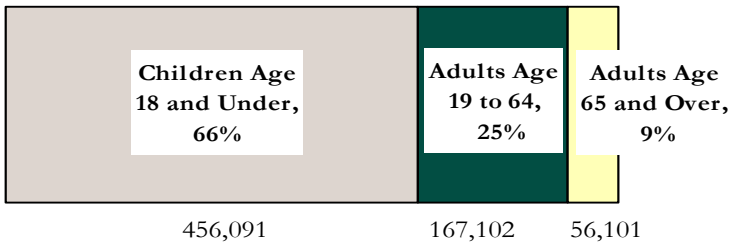
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

CHIP Breakdown of Total Enrollment

Members qualifying for SoonerCare (Medicaid) eligibility under the CHIP 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	CHIP Enrollees
PRENATAL		2,979
INFANT	150% to 185%	1,418
01-05	133% to 185%	11,760
06-12	100% to 185%	33,831
13-18	100% to 185%	21,175
Total		**71,163**

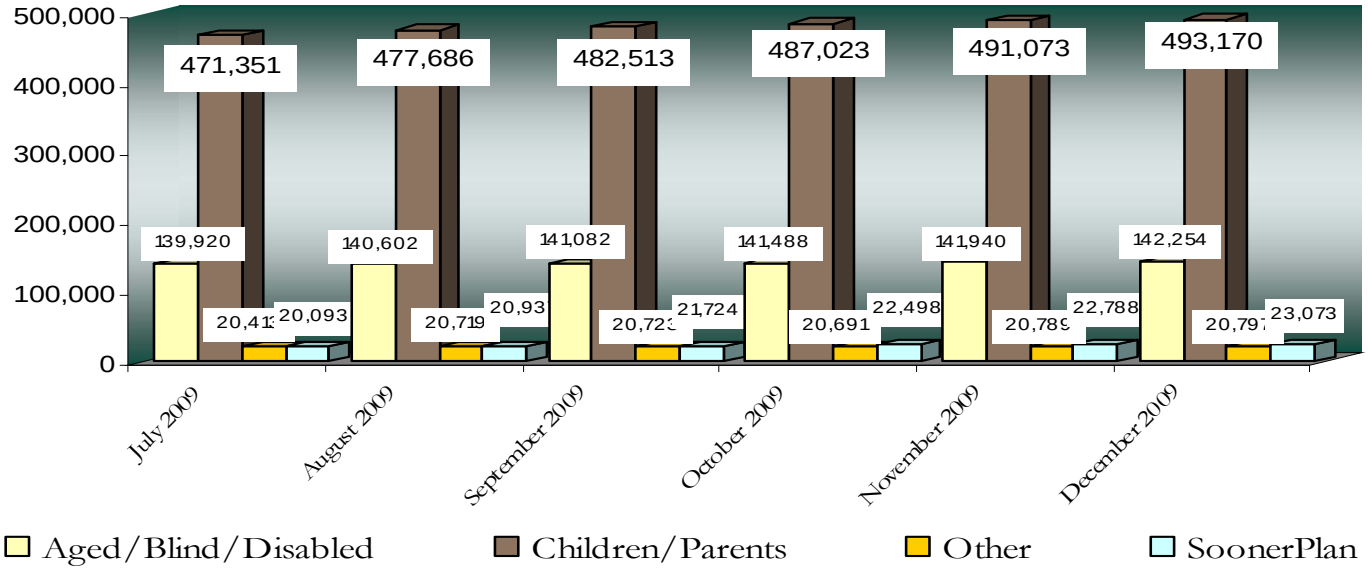
Age Breakdown of Total Enrollment



Data was compiled on 1/11/2010. 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 1/11/2010. 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
December 2009

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.

December 16, 2009

OHCA Contact: Jo Kilgore, Public Information Manager, (405) 522-7474.

In Re: Additional state revenue reductions

OKLAHOMA CITY – The Oklahoma Health Care Authority is evaluating the impact of the additional state revenue reductions. Once the extent of the revenue reduction is known, an action plan will be developed and recommended to the OHCA Board at its next meeting. Cuts will likely include reductions in provider payment rates and additional benefit reductions.

Hopefully, uncommitted federal Medicaid stimulus funds will be made available to replace lost state revenue. It is also important to note that any reduction in state dollars in the SoonerCare (Medicaid) program results in a reduction in federal dollars to fund the program; currently, $1 cut in state funds means a loss of $3 in federal funds for a total program reduction of $4 dollars. – OHCA spokesperson Jo Kilgore

Oklahoma Health Care Authority

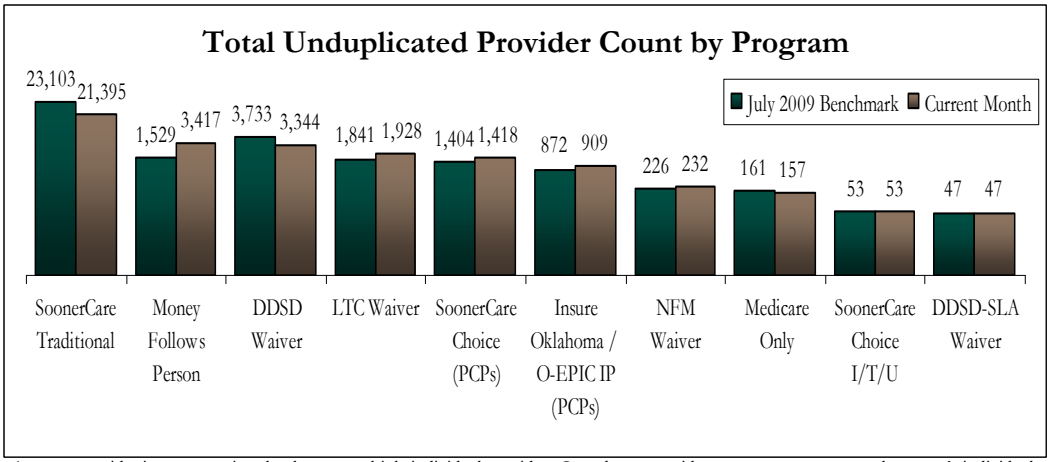
Provider Fast Facts

December 2009

Total Unduplicated Provider Count
27,062

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
385

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	Total Capacity	% of Capacity Used
SoonerCare Choice	1,037,470	40.73%
SoonerCare Choice I/T/U	116,150	11.55%
Insure Oklahoma/O-EPIC IP	328,278	3.41%

Total Capacity 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

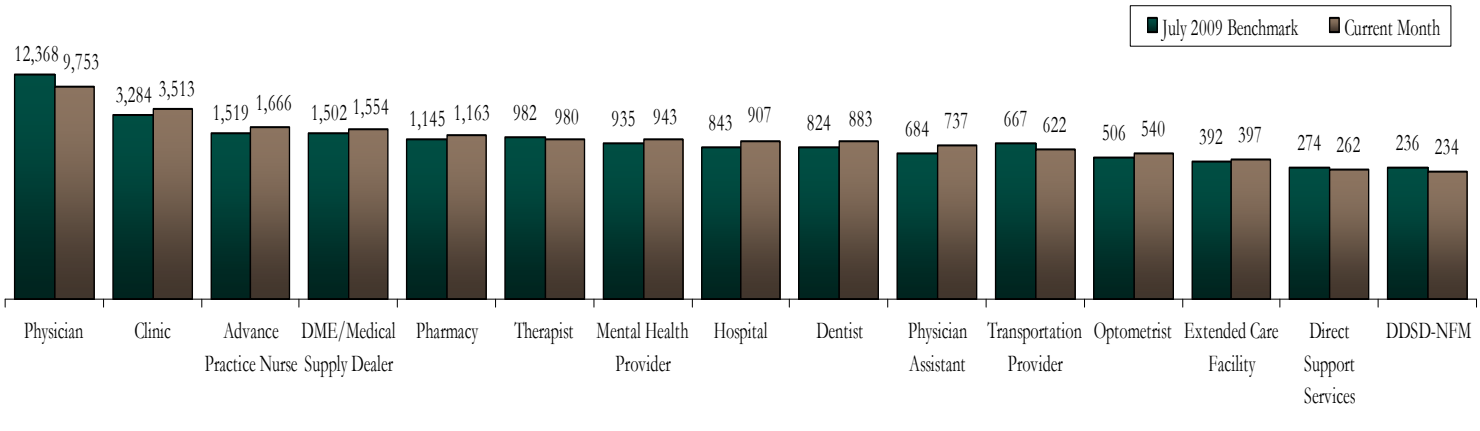
PCP - Primary Care Provider

PCMH Enrollment by Tier

Payment Tier Code	Count
Tier 1	491
Tier 2	224
Tier 3	35

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

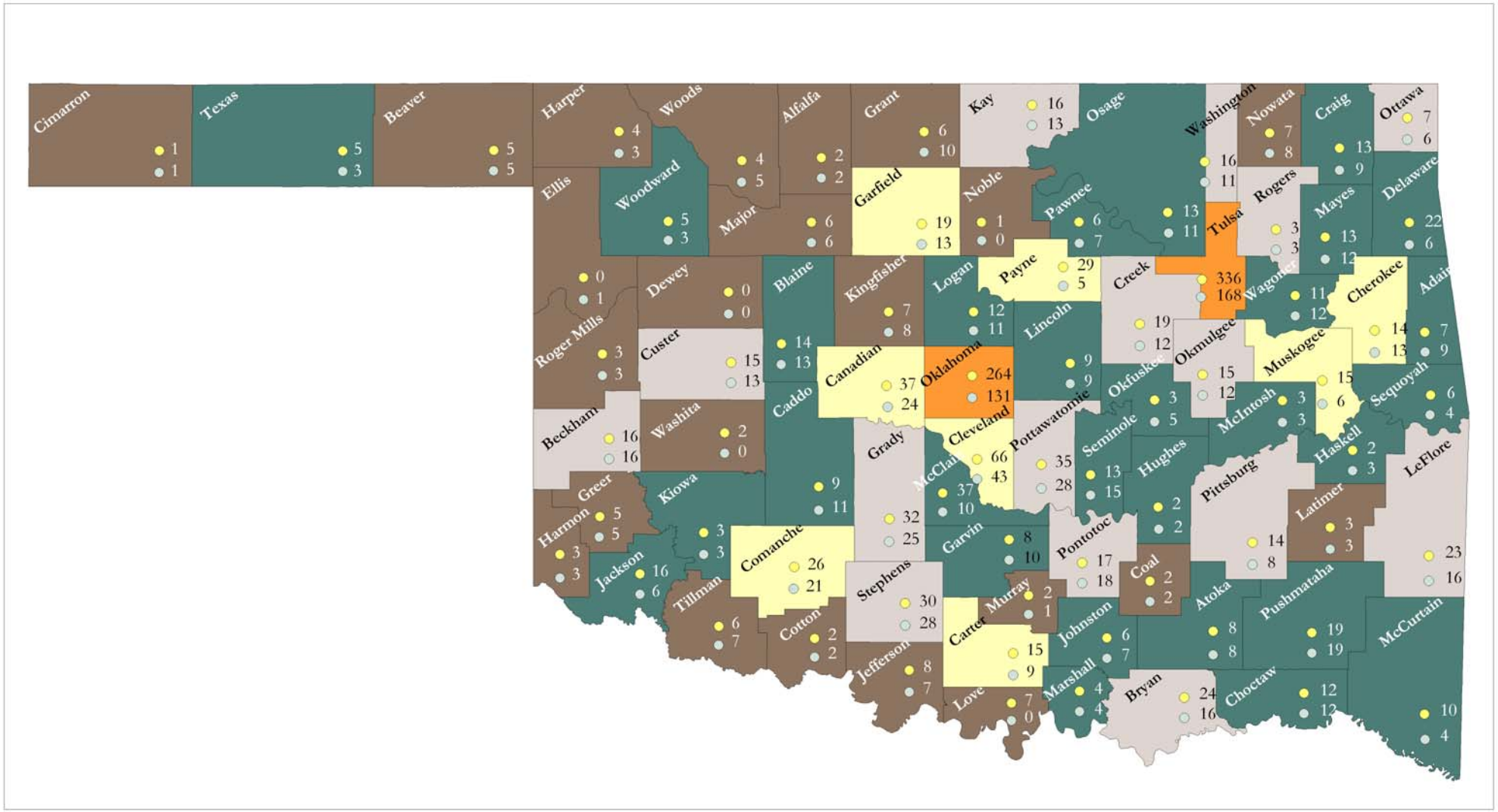
Top 15 Provider Types



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

Provider Fast Facts
December 2009

oklahoma health care authority



Total Provider Count

4,000 to 6,000		(2)
300 to 1,000		(8)
150 to	300	(15)
50 to	150	(29)
0 to	50	(23)

Primary Care Providers (PCPs)

- SoonerCare Choice PCPs
- Insure Oklahoma IP PCPs

01/11/2010

Insure Oklahoma

Fast Facts

February 2010

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

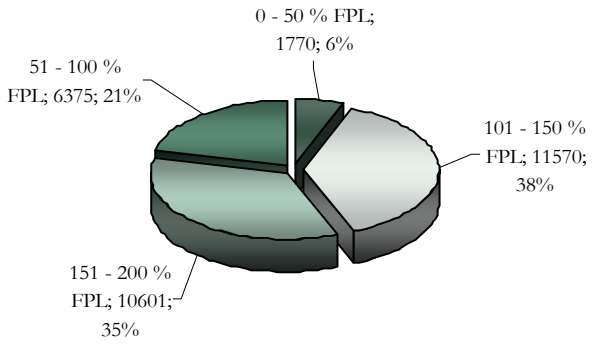
Insure Oklahoma is an innovative program Oklahoma has created to bridge the gap in the health care coverage for low-income working adults. Under the Employer-Sponsored Insurance (ESI) program, premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent). 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

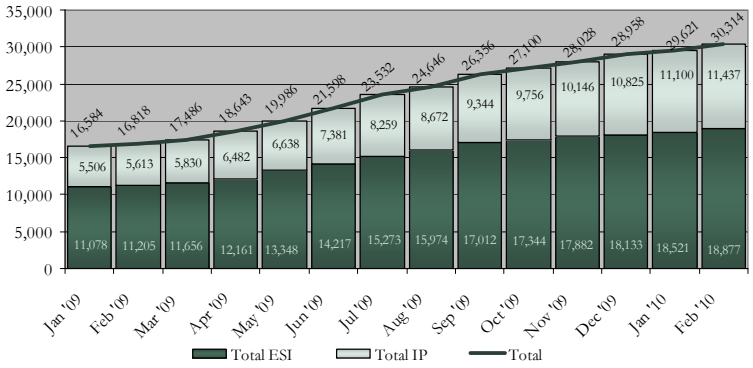
Qualifying Enrollment		Enrollment	% of Total
Employer Sponsored Insurance (ESI)	Employee	15,776	52.04%
Employer Sponsored Insurance (ESI)	Spouse	3,051	10.06%
Individual Plan (IP)	Employee	8,637	28.49%
Individual Plan (IP)	Spouse	2,645	8.73%
Student (ESI)	---	50	0.16%
Student (IP)	---	155	0.51%
Businesses (ESI)	---	5,630	---
Businesses (IP)	---	4	---
Carriers / HealthPlans	---	20 / 477	---
Primary Care Physician	---	943	---

Total Enrollment	**30,314**	ESI	18,877	62%
		IP	11,437	38%

Federal Poverty Level Breakdown of Total Enrollment



Total Insure Oklahoma Member Monthly Enrollment



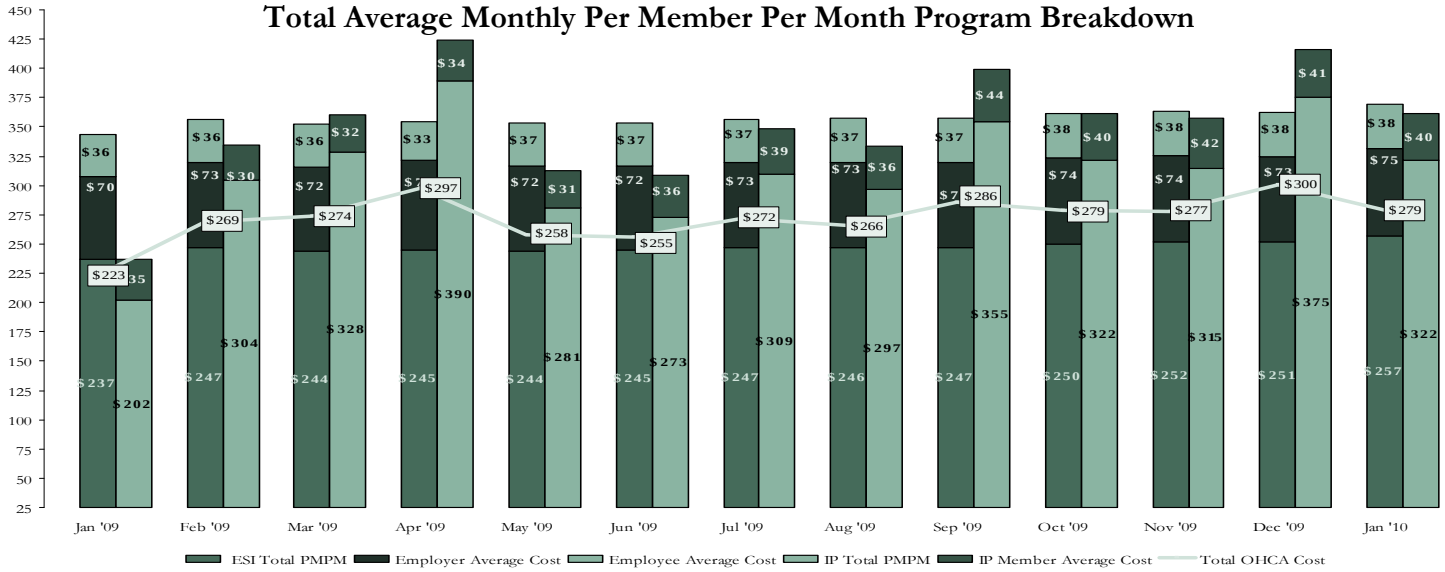
Currently Enrolled		Up from Previous Year
Businesses	5,634	59%
ESI Enrollees	18,877	77%
IP Enrollees	11,437	137%

ESI & IP Enrollee totals include Students.

Latest Monthly Marketing Statistics	
Web Hits on InsureOklahoma.org	34,077
Call Center - Calls Answered	13,513

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

2/8/2010

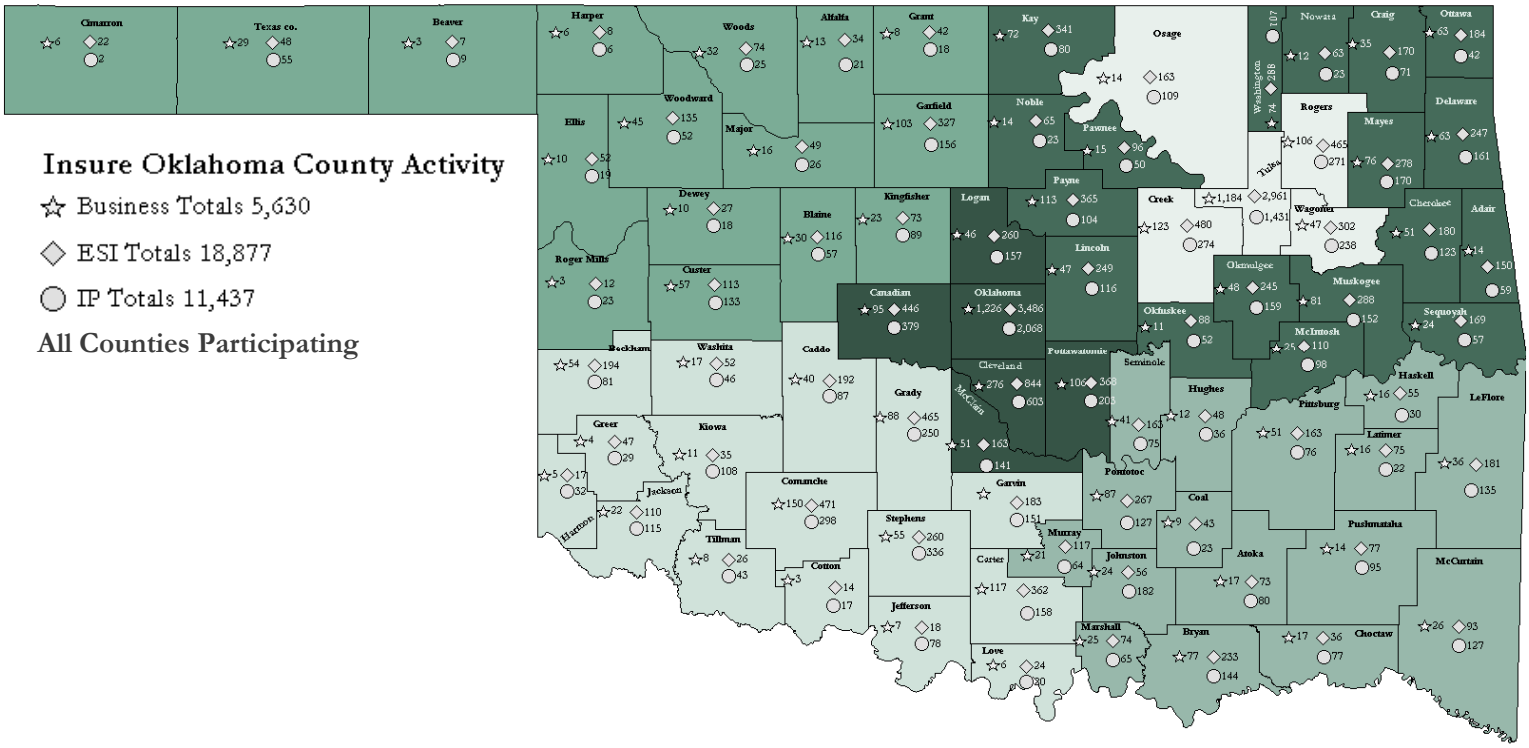
Insure Oklahoma

Fast Facts

February 2010

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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2/8/2010

Employer Sponsored Insurance (ESI)

Fast Facts

February 2010

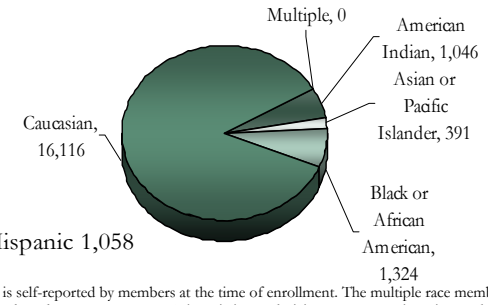
Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

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	7,677	8,099	**15,776**	296	493	**789**	896	759	**1,655**
Spouse	794	2,257	**3,051**	49	90	**139**	95	251	**346**
Dependent	24	26	**50**	1	2	**3**	1	1	**2**
Total	8,495	10,382	**18,877**	346	585	**931**	992	1,011	**2,003**

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

Race Breakdown of ESI Members

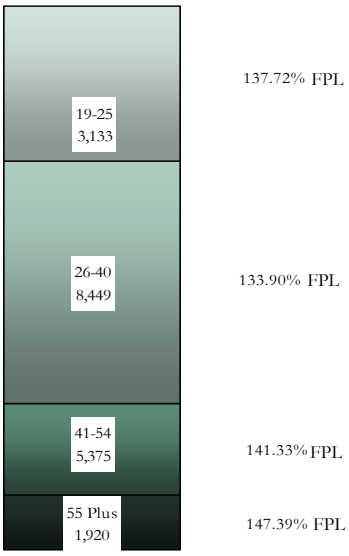


Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

	Business Activity with Employee Participation Counts			
	0 to 25	26 to 50	51 to 100	Total
Current	4,469	667	399	**5,535**
New	77	10	8	**95**
Total	**4,546**	**677**	**407**	**5,630**

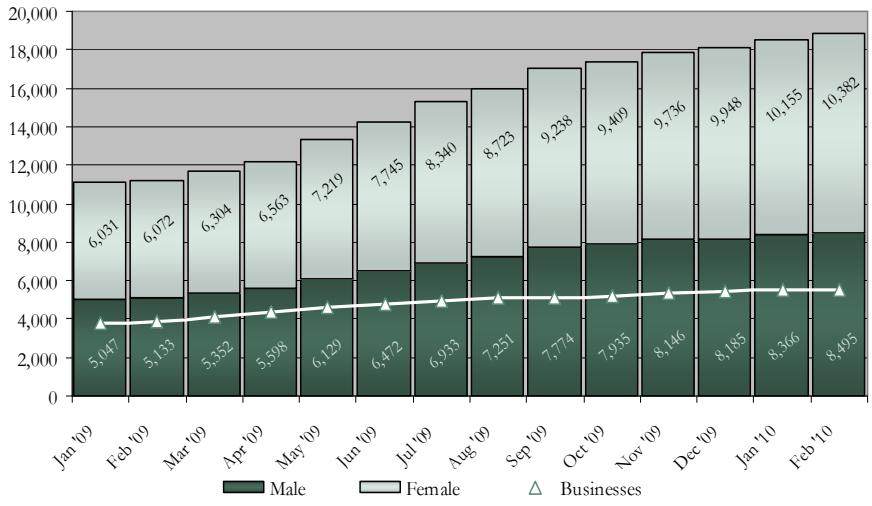
Some approved businesses may not have approved employees.

Age Breakdown with Average Federal Poverty Level of ESI Members

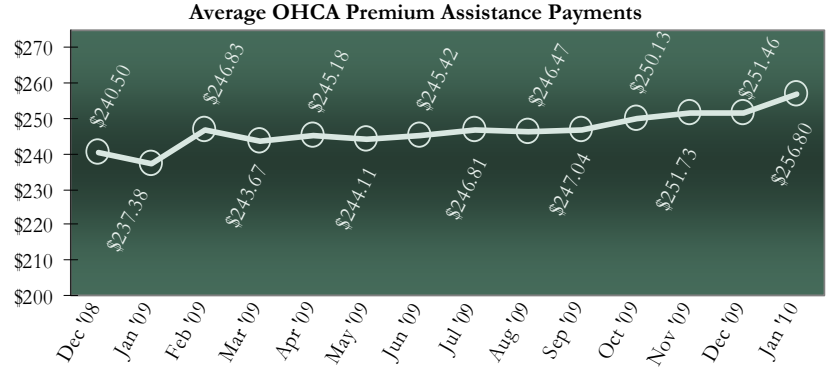


Federal Poverty Level is used to determine income qualification.

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.

	Insure Oklahoma/OEPIC ESI by Region		
	Employers	Employee/ Spouse	Participating Counties
Region 1	635	2,470	16 of 16
Region 2	394	1,139	16 of 16
Region 3	1,800	5,567	6 of 6
Region 4	1,474	4,371	5 of 5
Region 5	838	3,576	18 of 18
Region 6	489	1,754	16 of 16
Total	**5,630**	**18,877**	**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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2/9/2010

Individual Plan (IP)
Fast Facts

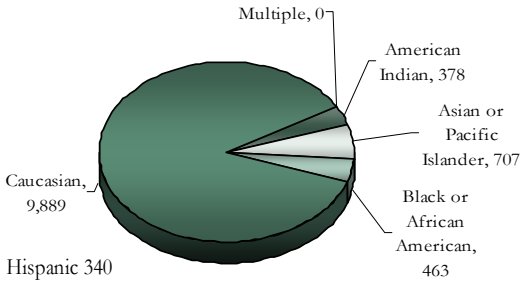
February 2010

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

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 O-EPIC 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	4,029	4,608	**8,637**	162	229	**391**	306	315	**621**
Spouse	589	2,056	**2,645**	28	74	**102**	57	158	**215**
Dependent	58	97	**155**	4	6	**10**	4	4	**8**
Total	4,676	6,761	**11,437**	190	303	**503**	363	473	**844**

Race Breakdown of IP Members



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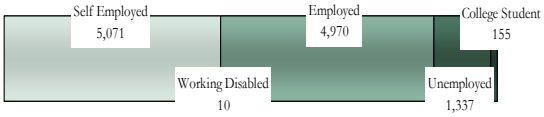
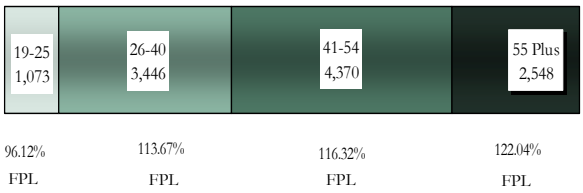
IP Application Type Breakdown

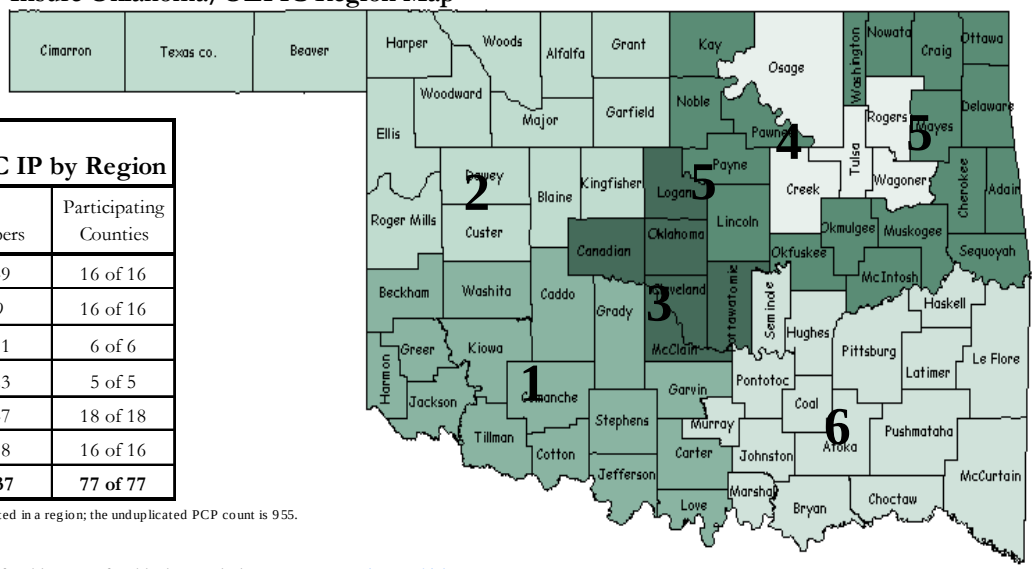


Unduplicated Counts	
IP Members SFY2010 (July 2009 - Current)	14,586
IP Members Since Program Inception March 2007	17,452
Miscellaneous	
Average IP Member Premium	$53.41
Average Federal Poverty Level of IP Members	115.41%
Federal Poverty Level is used to determine income qualification.	

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
Region 1	145	15 of 16	1,849	16 of 16
Region 2	83	15 of 16	709	16 of 16
Region 3	240	6 of 6	3,551	6 of 6
Region 4	213	5 of 5	2,323	5 of 5
Region 5	143	17 of 18	1,647	18 of 18
Region 6	119	16 of 16	1,358	16 of 16
Total	**943**	**74 of 77**	**11,437**	**77 of 77**

PCPs maybe counted in multiple regions or out of state and not counted in a region; the unduplicated PCP count is 955.

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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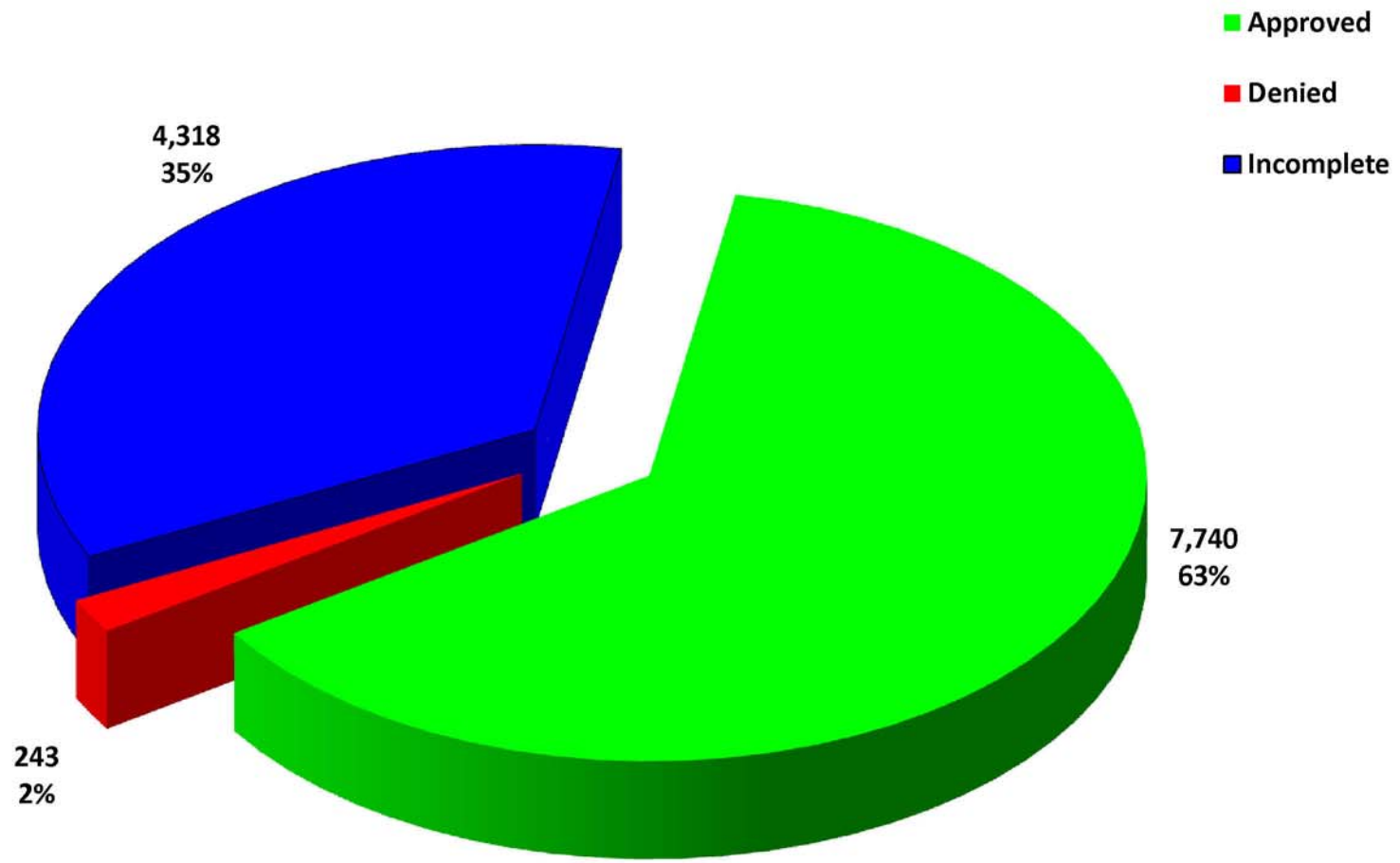
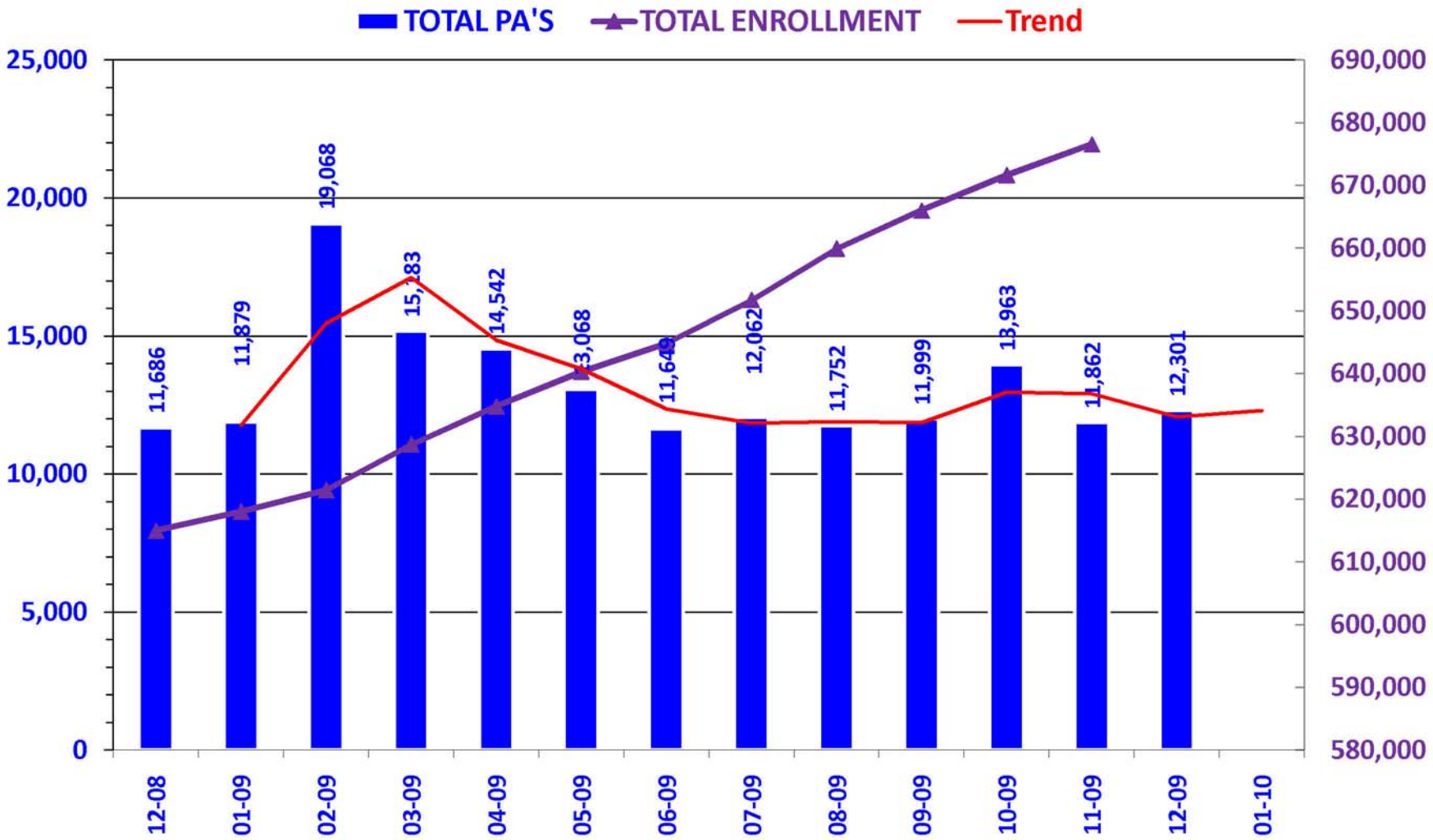
2/9/2010

PRIOR AUTHORIZATION ACTIVITY REPORT: December 2009



PA totals include overrides

PRIOR AUTHORIZATION REPORT: December 2008 – December 2009



PA totals include overrides

Prior Authorization Activity

December 2009

	Average Length of Approvals in Days	Approved	Denied	Incomplete	Total
Advair/Symbicort	357	276	2	390	668
Amitiza	141	5	1	21	27
Antidepressant	335	157	7	424	588
Antihistamine	288	178	3	165	346
Antihypertensives	344	62	0	92	154
Antimigraine	59	2	0	1	3
Benzodiazepines	92	3,720	9	740	4,469
Bladder Control	268	5	0	20	25
Brovana (Arformoterol)	0	0	0	2	2
Byetta	268	2	0	5	7
Elidel/Protopic	102	18	1	37	56
ESA	59	141	0	35	176
Fibric Acid Derivatives	90	1	0	1	2
Fibromyalgia	342	30	0	29	59
Forteo	360	1	0	3	4
Glaucoma	272	8	0	12	20
Growth Hormones	172	31	0	2	33
HFA Rescue Inhalers	214	64	0	42	106
Insomnia	122	39	3	109	151
Misc Analgesics	176	6	30	30	66
Muscle Relaxant	41	64	76	72	212
Nasal Allergy	225	2	30	97	129
NSAIDS	325	37	3	76	116
Nucynta	48	3	0	2	5
Ocular Allergy	207	3	0	7	10
Ocular Antibiotics	17	4	0	9	13
Opioid Analgesic	164	75	4	115	194
Other	146	167	11	302	480
Otic Antibiotic	22	2	1	1	4
Pediculicides	16	16	4	32	52
Plavix	327	10	1	14	25
Proton Pump Inhibitors	111	83	2	283	368
Qualaquin (Quinine)	0	0	3	1	4
Singulair	256	474	4	412	890
Smoking Cessation	60	18	1	54	73
Statins	347	14	1	42	57
Stimulant	231	645	3	315	963
Symlin	222	2	0	1	3
Synagis	100	139	27	35	201
Topical Antibiotics	49	2	0	25	27
Topical Antifungals	72	7	0	37	44
Ultram ER and ODT	145	4	0	6	10
Xolair	195	2	1	5	8
Xopenex Nebs	232	33	0	22	55
Zetia (Ezetimibe)	361	10	0	10	20
Emergency PAs		3	0	0	3
Total		**6,565**	**228**	**4,135**	**10,928**

Overrides					
Brand	106	77	2	16	95
Dosage Change	21	452	4	25	481
High Dose	266	18	0	5	23
IHS - Brand	95	40	0	4	44
Ingredient Duplication	52	9	1	2	12
Lost/Broken Rx	28	89	2	4	95
Nursing Home Issue	9	98	1	11	110
Other	56	27	0	6	33
Quantity vs. Days Supply	240	380	7	151	538
Stolen	12	8	0	0	8
Overrides Total		**1,198**	**17**	**224**	**1,439**
Total Regular PAs + Overrides		**7,763**	**245**	**4,359**	**12,367**

Denial Reasons

Lack required information to process request.	2,149
Unable to verify required trials.	1,695
Does not meet established criteria.	196
Not an FDA approved indication/diagnosis.	181
Considered duplicate therapy. Member has a prior authorization for similar medication.	121
Member has active PA for requested medication.	101
Requested dose exceeds maximum recommended FDA dose.	95
Medication not covered as pharmacy benefit.	25
Drug Not Deemed Medically Necessary	4

Duplicate Requests: 870

Changes to existing PAs: 827

CALL VOLUME MONTHLY REPORT:
December 2008 – December 2009

OHCA BOARD MEETING

FEBRUARY 11TH, 2010 OHCA BOARD MEETING

As of noon, Wednesday, February 3, 2010, the Oklahoma Legislature is tracking a total of 4,127 legislative bills for this session OHCA has 148 carry-over bills. The next deadline is Thursday, February 18th for reporting Senate Bills and Joint Resolutions from Senate committees.

The following are the Senate and House deadlines for 2010.

SENATE AND HOUSE DEADLINES

January 14, 2010	Deadline for Introduction of Bills and Joint Resolutions (House/Senate)
February 1, 2010	Second Session of the 52nd Legislature Convenes at Noon
February 18, 2010	Deadline for Reporting Senate Bills and Joint Resolutions from Senate Committees (Senate)
February 25, 2010	Deadline for Reporting House Bills and Joint Resolutions from House Committees
March 11, 2010	Deadline for Third Reading of a Bill or Joint Resolution in the House of Origin (House/Senate)
April 1, 2010	Deadline for Reporting House Bills and Joint Resolutions from Senate Committees (Senate)
April 8, 2010	Deadline for Reporting Senate Bills and Joint Resolutions from House Committees (House)
April 22, 2010	Deadline for Third Reading of Bills and Joint Resolutions in opposite chamber
May 28, 2010	Sine Die of the second session of the 52nd Legislature

Submitted to the C.E.O. and Board on February 11, 2010
AUTHORITY FOR EXPENDITURE OF FUNDS
FOCUS ON EXCELLENCE PROGRAM

AMENDMENT TO CONTRACT WITH MY INNERVIEW

BACKGROUND

Focus on Excellence (FOE) is the Oklahoma Health Care Authority's program to assess and reward the quality-improvement efforts of long term care facilities. The program measures the relative quality of nursing facilities in Oklahoma and provides a payment for nursing homes that report and improve quality measures. OHCA has contracted with My InnerView since July 1, 2007 to develop and operate the program. The contract was set to terminate on June 30, 2010.

AMENDMENT SCOPE OF WORK

Because of an independent evaluation of this program and new recommendations from the contractor, OHCA needs additional time to consider and implement program changes before rebidding the contract. The amendment allows for the extension of the contract for up to 12 months, no later than June 30, 2011.

AMENDMENT AMOUNT AND PROCUREMENT METHOD

The cost of a one-year extension for FY11 would be with no increase over the FY10 amount.

FY10	not to exceed $646,664.00
FY11	not to exceed $646,664.00

The original acquisition was made by competitive bid. The Department of Central Services has verbally agreed to this extension.

RECOMMENDATION

Board approval to expend funds to extend the contract with My InnerView; Board approval is contingent on approval by the Department of Central Services

Submitted to the C.E.O. and Board on February 11, 2010
AUTHORITY FOR EXPENDITURE OF FUNDS
FISCAL AGENT

AMENDMENT TO CONTRACT WITH HP (EDS)

BACKGROUND

Hewlett Packard ("HP") formerly Electronic Data Systems, LLC ("EDS") is contracted to develop, operate and maintain OHCA's MMIS (Medicaid Management Information System).

AMENDMENT SCOPE OF WORK

- ✓ Claim Volume Settlement in the amount of $337,808.00, and implementing an updated Claims/Encounters Volume Range since claims have exceeded a specified level
- ✓ Redefine the scope of the MedAI Clinical Guidelines project and reduce the total cost from $660,000 to $280,140, spending $60,900 in FY10 and $146,160 in FY11.
- ✓ Addition of the option to direct HP to hire an additional up to 25 new employees to assist with online enrollment at a cost not-to-exceed $1,875,000.

AMENDMENT AMOUNT AND PROCUREMENT METHOD

The cost impact of these new items are:

		SFY10	SFY11	SFY12	Total
Claims Settlement	$	337,808			337,808
MedAI Clinical Guidelines	$	(269,100)	(183,840)	73,080	(379,860)
Online enrollment	$	187,500	1,125,000	562,500	1,875,000
Total	$	256,208	941,160	635,580	1,832,948

The original acquisition was made by competitive bid. The Department of Central Services has approved this amendment to the bid pricing and tasks.

RECOMMENDATION

Board approval to expend funds for the HP contract amendment; Board approval is contingent on approval by the Department of Central Services and the Centers for Medicare and Medicaid Services

8.b-1 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 65. Case Management Services for Over 21
OAC 317:30-5-585. [REVOKED]
OAC 317:30-5-586. [REVOKED]
Part 67. ~~Behavior~~ Behavioral Health Case Management Services ~~For Individuals Under 21 Years of Age~~
OAC 317:30-5-595. [AMENDED]
OAC 317:30-5-596. [AMENDED]
OAC 317:30-5-596.1. [AMENDED]
OAC 317:30-5-596.2 [REVOKED]
Part 97. Case Management Services for Under Age 18 At Risk of or in the Temporary Custody or Supervision of Office of Juvenile Affairs
OAC 317:30-5-972. [AMENDED]
Part 99. Case Management Services for Under Age 18 In Emergency, Temporary or Permanent Custody or Supervision of the Department of Human Services
OAC 317:30-5-992. [AMENDED]
(Reference APA WF # 09-64)

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 amend policy to broadening Targeted Case Management (TCM) to all BA/BS level degrees. This rule change is needed in order to increase access across the state.

ANALYSIS: Rules are revised to broaden TCM to all BA/BS level degrees. Currently a Case Manager II and III bachelor's degree had to be in a behavioral health field, with the revisions any bachelor's degree earned from a regionally accredited college or university recognized by the United States Department of Education will be accepted. Additionally rules were revised to combine adult and children outpatient Behavioral Health TCM rules into one streamlined set. Revisions were also made to provide more consistency with Oklahoma Department of Mental Health Substance Abuse Services (ODMHSAS) policy.

BUDGET IMPACT: Agency staff has determined that the revisions will result in an estimated cost savings of $65,280.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on January 21, 2010, 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:
Revising targeted case management (TCM) rules to combine adult & children outpatient behavioral health TCM rules into one streamlined set.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 65. CASE MANAGEMENT SERVICES FOR OVER 21

317:30-5-585. Eligible providers [REVOKED]

~~Services are provided by case management agencies established for the purpose of providing case management services.~~

~~(1) **Provider agency requirements.** The agency must demonstrate its capacity to deliver case management services in terms of the following:~~

~~(A) On or after July 1, 2007, the OHCA will require agencies to have accreditation appropriate to case management from JCAHO, CARE, COA, or AOA, and meet the standards of the accreditation agency at all times.~~

~~(B) The OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.~~

~~(C) Agencies that are eligible to contract with the OHCA to provide case management services for seriously mentally ill adults must be community based.~~

~~(D) Agencies must be able to demonstrate the ability to develop and maintain appropriate patient records including, but not limited to, assessments, service plans, and progress notes.~~

~~(E) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.~~

~~(F) Each site operated by a case management facility must have a separate provider number. A site is defined as an office, clinic, or other business setting where case management services are routinely performed. When services are rendered at the patient's residence, a school, or an appropriate community based setting, a site is determined according to where the professional staff conduct administrative duties and where the patient's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.~~

~~(2) **Provider types.**~~

~~(A) **ODMHSAS public and private facilities.** Public ODMHSAS facilities are regionally based Community Mental Health Centers. Private ODMHSAS facilities are providers that have contracted with the ODMHSAS to provide mental health, substance abuse, and case management treatment services. Both of these provider types must also contract with the OHCA directly to receive SoonerCare reimbursement.~~

~~(B) **Private facilities.** Private facilities are those facilities that contract directly with the Oklahoma Health Care Authority to provide case management services.~~

~~(3) **Service provider education and experience requirements before July 1, 2001.** For case management services to be compensable by SoonerCare, the case manager performing the service must maintain current case management certification from the Department of Mental Health and Substance Abuse Services. For those case managers who are certified on or before July 1, 2001, the following education and experience requirements apply:~~

~~(A) Associate's degree in a related human service field, OR;~~

~~(B) Two years of college education plus two years or more human service experience, OR;~~

~~(C) Bachelor's degree in a related human service field plus one year or more human service experience, OR;~~

~~(D) Master's degree in a related human service field.~~

(4) **Service provider education and experience requirements after July 1, 2001.** The following education and experience requirements apply after July 1, 2001.

(A) Bachelor's or Master's degree in a mental health related field including, but not limited to psychology, social work, occupational therapy, family studies, sociology, criminal justice, school guidance and counseling, OR

(B) A current license as a registered nurse in Oklahoma; OR

(C) Certification as an alcohol and drug counselor allowed to provide substance abuse case management to those with alcohol and/or other drug-dependencies or addictions as a primary or secondary DSMIV Axis I diagnosis, AND

(D) Current case management certification from the Department of Mental Health and Substance Abuse Services.

(5) **Service provider education and experience requirements after July 1, 2007.** For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current behavioral health case manager certification from the ODMHSAS and meet either (A), (B), or (C) below, and (D):

(A) Certified Behavioral Health Case Manager III B meets the Licensed Behavioral Health Professional status as defined at OAC 317:30-5-240, and passes the ODMHSAS web-based Case Management Competency Exam.

(B) Certified Behavioral Health Case Manager II B a bachelor's or master's degree in a behavioral health field, earned from a regionally accredited college or university recognized by the United States Department of Education, which includes but is not limited to psychology, social work/sociology, occupational therapy, family studies, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency studies, school guidance/counseling/education, rehabilitative services, and/or criminal justice; a current license as a registered nurse in Oklahoma with experience in behavioral health care; or a current certification as an alcohol and drug counselor in Oklahoma, and pass the ODMHSAS web-based Case Management Competency Exam, and complete seven hours of ODMHSAS specified CM training.

(C) Certified Behavioral Health Case Manager I B meets the following requirements:

(i) completed 60 college credit hours; or

(ii) high school diploma with 36 total months of experience working with persons who have a mental illness. Documentation of experience must be on file with ODMHSAS; and

(iii) passes the ODMHSAS web-based Case Management Competency Exam, and completes 14 hours of ODMHSAS specified CM training.

(D) All certified case managers must fulfill the continuing education requirements as laid out in OAC 450:50-5-4.

317:30-5-586. Coverage by category [REVOKED]

Payment is made for case management services as set forth in this Section.

(1) **Adults.** Payment is made for services to adults as follows:

(A) **Description of case management services.** Services under case management are not comparable in amount, duration and scope. The target group for case management services is the chronically and/or severely mentally ill. Chronically and/or severely

~~mentally ill individuals refer to institutionalized adults or adults at risk of institutionalization. All case management services will be subject to medical necessity criteria. The criteria will be applied to each individual case by an agent designated by the OHCA or its designated agent.~~

~~(i) Behavioral health case management services are provided to assist consumers in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides referral, linkage and advocacy on behalf of consumers, to help consumers access appropriate community resources. Case management is designed to assist individuals in accessing services for themselves. The consumer has the right to refuse case management and cannot be restricted from other services because of a refusal of case management services. However, in referring a consumer for medical services, the case manager should be aware that the SoonerCare program is limited in scope. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by the ODMHSAS. In order to be compensable, the service must be performed utilizing the ODMHSAS Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Helping activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the member by phone or face-to-face, to identify immediate needs for return to home/community. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month.**

~~(ii) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.~~

~~(iii) In order to ensure that case management services are not duplicated by other staff, case management activities will be provided in accordance with a comprehensive individualized treatment/service plan.~~

~~(iv) The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the participation by, as well as, reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health case manager, and a licensed behavioral health professional as defined at OAC 317:30-5-240.~~

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

~~(I) Gathering necessary psychological, educational, medical, and social information for the purpose of service plan development.~~

~~(II) Face-to-face meetings with the child and/or the parent/guardian/family member for the implementation of activities delineated in the service plan.~~

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

~~(IV) Supportive activities such as non face-to-face communication with the child and/or parent/guardian/family member or the behavioral health case manager's travel time to and from meetings for the purpose of development or implementation of the service plan.~~

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

~~(vi) Reimbursable case management does not include:~~

~~(I) physically escorting or transporting a member to scheduled appointments or staying with the member during an appointment; or~~

~~(II) monitoring financial goals; or~~

~~(III) providing specific services such as shopping or paying bills; or~~

~~(IV) delivering bus tickets, food stamps, money, etc.; or~~

~~(V) services to nursing home residents; or~~

~~(VI) counseling or rehabilitative services, psychiatric assessment, or discharge; or~~

~~(VII) filling out forms, applications, etc., on behalf of the member when the member is not present; or~~

~~(VIII) filling out SoonerCare forms, applications, etc., or;~~

~~(IX) services to members residing in ICF/MR facilities.~~

~~(B)~~ **~~Providers.~~** ~~Case management services must be provided by a Community Mental Health Center or other qualifying provider agency of case management. Two different provider agencies may~~

~~not bill case management service(s) for the same member on the same day.~~

~~(2) **Children.** Coverage for children is found in OAC 317:30-5-596.~~

~~(3) **Individuals eligible for Part B of Medicare.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.~~

PART 67. ~~**BEHAVIOR**~~ BEHAVIORAL HEALTH CASE MANAGEMENT SERVICES ~~**FOR INDIVIDUALS UNDER 21 YEARS OF AGE**~~

317:30-5-595. Eligible providers

Services are provided by ~~case management~~ outpatient behavioral health agencies established for the purpose of providing behavioral health outpatient and case management services.

(1) **Provider agency requirements.** Services are provided by outpatient behavioral health agencies contracted with OHCA that meet the requirements under OAC 317:30-5-240. The agency must demonstrate its capacity to deliver behavioral health case management services in terms of the following items:

(A) ~~On or after July 1, 2004, OHCA will require agencies to have~~ Agencies must hold current accreditation appropriate to outpatient behavioral health ~~case management~~ from JCAHO, CARF, COA, or AOA, and maintain the standards of the accreditation at all times.

(B) OHCA reserves the right to obtain a copy of any accreditation audit and/or site visit reports from the provider and/or the accreditation agency.

(C) Agencies that are eligible to contract with OHCA to provide behavioral health case management services to eligible individuals ~~under the age of 21~~ must be community based ~~with a history of serving seriously emotionally disturbed (SED) children and their families~~.

(D) The agency must be able to demonstrate the ability to develop and maintain appropriate patient records including but not limited to assessments, service plans, and progress notes.

(E) An agency must agree to follow the Oklahoma Department of Mental Health and Substance Abuse Services established behavioral health case management rules found in OAC 450:50.

(F) An agency's behavioral health case management staff must serve the target group on a 24 hour on call basis.

(G) Each site operated by a behavioral health outpatient and case management facility must have a separate provider number, per OAC 317:30-5-240.2. ~~A site is defined as an office, clinic, or other business setting where case management services are routinely performed. When services are rendered at the patient's residence, a school, or an appropriate community based setting, a site is determined according to where the professional staff conduct administrative duties and where the patient's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.~~

(2) **Provider** ~~types~~ **Qualifications.**

~~(A) **ODMHSAS public and private facilities.** Public ODMHSAS facilities are regionally based Community Mental Health Centers. Private ODMHSAS facilities are providers that have a contract with the ODMHSAS to provide Mental Health, Substance Abuse, and Case Management Treatment Services. Both of these provider types must also contract with the OHCA directly to receive SoonerCare reimbursement.~~

~~(B) **Private facilities.** Private facilities are those facilities that contract directly with the Oklahoma Health Care Authority to provide case management (CM) services.~~

~~(3)~~(A) **Service provider education and experience requirements if certified before July 1, 2001.** For case management services to be compensable by SoonerCare, the case manager performing the service must maintain current case management certification from the ~~Oklahoma Department of Mental Health and Substance Abuse Services~~ ODMHSAS. For those case managers who are certified on or before July 1, 2001, the following education and experience requirements apply:

~~(A)~~ (i) ~~Associate's~~ Associate degree in a related human service field, OR;

~~(B)~~ (ii) Two years of college education plus two years or more human service experience, OR;

~~(C)~~ (iii) ~~Bachelor's~~ Bachelors degree in a related human service field plus one year or more human service experience, OR;

~~(D)~~ (iv) ~~Master's~~ Masters degree in a related human service field.

~~(4)~~(B) **Service provider education and experience requirements if certified after July 1, 2001 and before July 1, 2007.** For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current ~~children's~~ behavioral health case manager certification from the ODMHSAS and have a:

~~(A)~~ (i) ~~Bachelor's~~ Bachelors or ~~Master's~~ masters degree in a mental health related field including, but not limited to psychology, social work, occupational therapy, family studies, sociology, criminal justice, school guidance and counseling; OR

~~(B)~~ (ii) A current license as a registered nurse in Oklahoma with experience in behavioral health care; OR

~~(C)~~ (iii) Certification as an alcohol and drug counselor allowed to provide substance abuse case management to those with alcohol and/or other drug dependencies or addictions as a primary or secondary ~~DSMIV~~ DSM-IV Axis I diagnosis; and

~~(D)~~ (iv) Current case management certification from the ODMHSAS.

~~(5)~~(C) **Service provider education and experience requirements if certified after July 1, 2007.** For behavioral health case management services to be compensable by SoonerCare, the case manager performing the service must have and maintain a current ~~children's~~ behavioral health case manager certification from the ODMHSAS and meet either ~~(A)~~ (i), ~~(B)~~ (ii), or ~~(C)~~ (iii) below, and ~~(D)~~ (iv):

~~(A)~~ (i) Certified Behavioral Health Case Manager III ~~-~~meets the Licensed Behavioral Health Professional status as defined at OAC 317:30-5-240, and passes the ODMHSAS web-based Case Management Competency Exam.

~~(B)~~ (ii) Certified Behavioral Health Case Manager II~~-~~ a ~~bachelor's~~ bachelors or ~~master's~~ masters degree in a behavioral health field, earned from a regionally accredited college or university recognized by the United States Department of Education, which includes ~~but is not limited to~~ psychology, social work/sociology, occupational therapy, family studies, human resources/services counseling, human developmental psychology, gerontology, early childhood development, chemical dependency studies, school guidance/counseling/education, rehabilitative services, education and/or criminal justice; a current license as a registered nurse in Oklahoma with experience in behavioral health care; or a current certification as an alcohol and drug counselor in Oklahoma, and pass the ODMHSAS web-

based Case Management Competency Exam, and complete seven hours of ODMHSAS specified CM training.
(After July 1, 2010: Any bachelors or masters degree earned from a regionally accredited college or university recognized by the USDE).
~~(C)~~ (iii) Certified Behavioral Health Case Manager I~~-~~ meets the requirements in either ~~(i)~~ (I) or ~~(ii)~~ (II), and ~~(iii)~~ (III):
~~(i)~~ (I) completed 60 college credit hours; or
~~(ii)~~ (II) has a high school diploma with 36 total months of experience working with persons who have a mental illness and/or substance abuse. Documentation of experience on file with ODMHSAS; and
~~(iii)~~ (III) passes the ODMHSAS web-based Case Management Competency Exam, and completes 14 hours of ODMHSAS specified CM training.

(D) **Wraparound Facilitator Case Manager** - meets the qualifications for CM II or CM III and has the following:
(i) Successful completion of the ODMHSAS training for wraparound facilitation within six months of employment; and
(ii) Participate in ongoing coaching provided by ODMHSAS and employing agency; and
(iii) Successfully complete wraparound credentialing process within nine months of beginning process; and
(iv) Direct supervision or immediate access and a minimum of one hour weekly clinical consultation with a Qualified Mental Health Professional, as required by ODMHSAS;

(E) **Intensive Case Manager** - meets the provider qualifications of a Case Manager II or III and has the following:
(i) A minimum of 2 years Behavioral Health Case Management experience, crisis intervention experience, and
(ii) must have attended the ODMHSAS 6 hours Intensive case management training.

~~(D)~~ (F) All certified case managers must fulfill the continuing education requirements as outlined under OAC 450:50-5-4.

317:30-5-596. Coverage by category

Payment is made for behavioral health case management services as set forth in this Section.

~~(1) **Adults.** Coverage for adults is found in OAC 317:30-5-586.~~

~~(2)~~ (1) ~~**Children.**~~ Payment is made for services ~~to persons under age 21~~ rendered to SoonerCare member's as follows:

(A) **Description of behavioral health case management services.** Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age 21 who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be subject to medical necessity criteria.

(i) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral,

linkage, monitoring and advocacy on behalf of the ~~child~~ member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ~~the Oklahoma Department of Mental Health and Substance Abuse Services~~ ODMHSAS. In order to be compensable, the service must be performed utilizing the ~~ODMHSAS~~ Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The community based behavioral health case management agency will coordinate with the ~~child~~ member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than 72 hours after notification that the member/family requests case management services. For ~~children~~ member's discharging from an ~~out of home placement~~ higher level of care than outpatient, ~~the out of home agency/placement~~ the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and ~~services~~ post discharge services. The case manager will make contact with the ~~child~~ member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within 72 hours of discharge, and then conduct a ~~face-to-face~~ follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, counseling services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual=s ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within ~~2~~ two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the

right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.
(ii) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.
(iii) In order to ensure that behavioral health case management services appropriately meet the needs of the ~~child~~ member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.
(iv) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the ~~child~~ member (and family's, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. ~~Behavioral health case management individual plan of care development is compensable if the time is spent communicating with the child, parent/guardian/family member or provider of other services.~~ The individual plan of care must be developed with participation by, as well as, reviewed and signed by the ~~child~~ member (~~only if over 16 years of age)~~, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional as defined in OAC 317:30-5-240(d).
(v) SoonerCare reimbursable behavioral health case management services include the following:

(I) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.
(II) Face-to-face meetings with the ~~child~~ member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.
(III) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.
(IV) Supportive activities such as non face-to-face communication with the ~~child~~ member and/or parent/guardian/family member or the behavioral health case manager's travel time to and from meetings for the purpose of development or implementation of the individual plan of care.
(V) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.
(VI) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.
(VII) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual=s ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(VIII) Transitioning from institutions to the community. Individuals (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions) may be considered to be transitioning to the community during the last 60 consecutive days of a covered, long-term, institutional stay that is 180 consecutive days or longer in duration. For a covered, short term, institutional stay of less than 180 consecutive days, individuals may be considered to be transitioning to the community during the last 14 days before discharge. These time requirements are to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community.

(B) Levels of Case Management

(i) Basic Case Management/Resource Coordination. Resource coordination services are targeted to adults with serious and persistent mental illness and children and adolescents with mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individuals strengths and meet needs in order to achieve stability in the community.

(ii) Intensive Case Management (ICM)/Wraparound Facilitation Case Management (WFCM).

Intensive Case Management is targeted to adults with serious and persistent mental illness (including member's in PACT programs) and Wraparound Facilitation Case Management is targeted to children with serious mental illness and emotional disorders (including member's in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To ensure that these intense needs are met, case manager caseloads are limited to 25. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of 2 years Behavioral Health Case Management experience, crisis intervention experience, must have attended the ODMHSAS 6 hours ICM training, and 24 hour availability is required.

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

~~(I)~~(i) Physically escorting or transporting a ~~child~~ member or family to scheduled appointments or staying with the ~~child~~ member during an appointment; or

~~(II)~~(ii) Managing finances; or

~~(III)~~(iii) Providing specific services such as shopping or paying bills; or

~~(IV)~~(iv) Delivering bus tickets, food stamps, money, etc.; or

~~(V)~~(v) Counseling, rehabilitative services, psychiatric assessment, or discharge planning; or
~~(VI)~~(vi) Filling out forms, applications, etc., on behalf of the ~~child~~ member when the ~~child~~ member is not present; or
~~(VII)~~(vii) Filling out SoonerCare forms, applications, etc., ~~or~~;
~~(VIII)~~(viii) Mentoring or tutoring; or
~~(IX)~~ (ix) Provision of behavioral health case management services to the same family by two separate behavioral health case management agencies.

~~(B)~~(D) **Excluded Individuals.** The following SoonerCare members are not eligible for behavioral health case management services:
(i) Children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;
(ii) ~~Children~~ Members receiving ~~services in~~ Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;
(iii) Residents of ICF/MR and nursing facilities unless transitioning into the community; ~~and~~
(iv) ~~Children~~ Members receiving services under a Home and Community Based ~~Waiver~~ services (HCBS) waiver program.

~~(C) **Restriction.** Two different provider agencies may not bill case management services for the member on the same day.~~

~~(3)~~(E) ~~**Individuals eligible for Part B of Medicare.**~~ Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

317:30-5-596.1. Prior authorization

(a) Prior authorization of behavioral health case management services is mandatory. The provider must request prior authorization from the OHCA, or its designated agent.

(b) SoonerCare members who are eligible for services will be considered for prior authorization after receipt of complete and appropriate information submitted by the provider in accordance with the guidelines for behavioral health case management services developed by OHCA or its designated agent. Based on diagnosis, functional assessment, history and other SoonerCare services being received, the SoonerCare member may be approved to receive case management services. SoonerCare members who reside in nursing facilities, residential behavior management services, group or foster homes, or ICF/MR's may not receive SoonerCare compensable case management services unless transitioning from a higher level of care than outpatient. A SoonerCare member may be approved for a time frame of one to ~~six~~ twelve months. The OHCA, or its designated agent will review the initial request in accordance with the guidelines for prior authorization in the Outpatient Behavioral Health Service Provider Manual. An initial request for case management services requires the provider to submit specific documentation to OHCA, or its designated agent. A fully developed individual plan of service is not required at the time of initial request. The provider will be given a time frame to develop the individual plan of service while working with the child and his/her family and corresponding units of service will be approved prior to the completion of the service plan. ~~The provider will be required to engage with the child/family within 72 hours of discharge from an inpatient psychiatric hospital and/or within 72 hours of receiving the request for services from the family or other community resource. The expectation is for the behavioral health case manager to immediately engage with the child/family to prevent hospital readmission or other out-of-home~~

~~placement, and refer to needed community resources.~~ Prior authorization requests will be reviewed by licensed behavioral health professionals as defined at OAC 317:30-5-240.
~~(c) In the event that a member disagrees with the decision by OHCA's contractor, it receives an evidentiary hearing under OAC 317:2-1-2(a). The member's request for such an appeal must commence within 20 calendar days of the initial decision.~~
~~(d) Providers seeking prior authorization will follow OHCA's or its designated agent's prior authorization process guidelines for submitting behavioral health case management requests on behalf of the SoonerCare member.~~

317:30-5-596.2. Direct and Indirect Case Management services [REVOKED]

~~Case management services are provided using one of two categories of service.~~

~~(1) **Direct case management services.** For Direct case management services the behavioral health case manager performs face to face interactions with the child and/or the child's parent/guardian/family member or service providers necessary for the implementation of activities delineated in the service plan. Service plan development, when performed face to face, is considered direct behavioral health case management.~~

~~(2) **Indirect behavioral health case management.** For Indirect case management services the behavioral health case manager performs non face to face services related to the child's case, excluding those activities cited as non Medicaid compensable in OAC 317:30-5-596(2)(vi). Examples of indirect behavioral health case management are phone calls, monitoring of client progress and the case manager's travel time to or from activities necessary for the implementation of the service plan. Other indirect services may be communication through letters, memorandums or e-mail to treatment or other service providers necessary for the implementation of activities delineated in the service plan. Electronic communication documentation must be encrypted and meet HIPAA guidelines.~~

PART 97. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 AT RISK OF OR IN THE TEMPORARY CUSTODY OR SUPERVISION OF OFFICE OF JUVENILE AFFAIRS

317:30-5-972. Reimbursement

~~(a) Reimbursement for OJATCM services is a unit rate based on the monthly cost per case for documented OJATCM services. A unit of service is defined as one calendar month of case management, provided that a minimum of one contact which meets the description of a case management activity with or on behalf of the recipient has been documented during the month claimed. Payment is made on the basis of claims submitted for payment. The provider bills at the monthly unit rate for documented Medicaid OJATCM services provided to each Medicaid eligible recipient during the calendar month.~~
~~(b) Only one unit of OJATCM services may be billed for each Medicaid eligible recipient per month. OJATCM services may not be billed for any recipient already receiving case management services as part of a Home and Community Based waiver.~~

Office of Juvenile Affairs Targeted Case Management (OJATCM) services will be reimbursed pursuant to the methodology described in the Oklahoma Title XIX State Plan.

PART 99. CASE MANAGEMENT SERVICES FOR UNDER AGE 18 IN EMERGENCY, TEMPORARY OR PERMANENT CUSTODY OR SUPERVISION OF THE DEPARTMENT OF HUMAN SERVICES

317:30-5-992. Reimbursement

~~(a) Reimbursement for CWTCM services is a unit rate based on the monthly cost per case for documented CWTCM services. A unit of service is defined as one calendar month of case management, provided that a minimum of one contact which meets the description of a case management activity with or on behalf of the recipient has been documented during the month claimed. Payment is made on the basis of claims submitted for payment. The provider bills at the monthly unit rate for documented unit of Medicaid CWTCM services provided to each Medicaid eligible recipient during the calendar month.~~

~~(b) Only one unit of CWTCM services may be billed for each Medicaid eligible recipient per month. CWTCM services may not be billed for any recipient already receiving case management services as part of a Home and Community Based waiver.~~

Child Welfare Targeted Case Management (CWTCM) services will be reimbursed pursuant to the methodology described in the Oklahoma Title XIX State Plan.

8.b-2 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
OAC 317:30-5-95.33 [AMENDED]
OAC 317:30-5-95.35 [AMENDED]
(Reference APA WF # 09-68)

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 add Licensed Alcohol and Drug Counselors (LADCs) as Licensed Behavioral Health Professionals (LBHP). This rule change is needed to allow greater access to care for SoonerCare children that receive inpatient psychiatric treatment. By allowing reimbursement for this provider type in the inpatient setting, SoonerCare children with alcohol/drug/chemical dependency diagnoses will have access to more appropriate treatments and behavioral interventions which would affect the child's inpatient length of stay thereby reducing overall SoonerCare inpatient psychiatric facility reimbursement costs.

ANALYSIS: Children's inpatient psychiatric treatment rules are revised to add LADCs as a qualified LBHP's in inpatient settings for children. Currently LADCs are not one of the licensed behavioral health professionals that provide services in an inpatient setting for children, which limits access for specialized treatment in alcohol and drug addiction. The revisions will increase the specialty access to care for people with drug or alcohol addiction as well as expand the type of licensure children's inpatient psychiatric treatment centers staff can hold in order to provide services.

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 January 21, 2010, 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:
Revising rules to add licensed alcohol and drug counselors (LADCs) as licensed behavioral health professionals (LBHPs) under children's inpatient psychiatric treatment rules.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 6.INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-95.33. Individual plan of care for children

(a) The following words and terms, when used in this section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) **"Licensed Behavioral Health Professional ~~(LBPH)~~ (LBHP)"** means licensed psychologists, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral practitioners (LBP), licensed alcohol and drug counselors (LADC), and advanced practice nurses (APN).

(2) **"Individual plan of Care (IPC)"** means a written plan developed for each member within four calendar days of any admission to a PRTF and is the document that directs the care and treatment of that member. The individual plan of care must be recovery focused, trauma informed, and specific to culture, age and gender and includes:

(A) the complete record of the DSM-IV-TR five-axis diagnosis, including the corresponding symptoms, complaints, and complications indicating the need for admission;

(B) the current functional level of the individual;

(C) treatment goals and measurable time limited objectives;

(D) any orders for psychotropic medications, treatments, restorative and rehabilitative services, activities, therapies, social services, diet and special procedures recommended for the health and safety of the patient;

(E) plans for continuing care, including review and modification to the plan of care; and

(F) plan for discharge, all of which is developed to improve the child's condition to the extent that the inpatient care is no longer necessary.

(b) The individual plan of care:

(1) must be based on a diagnostic evaluation that includes examination of the medical, psychological, social, behavioral and developmental aspects of the individual member and reflects the need for inpatient psychiatric care;

(2) must be developed by a team of professionals as specified in OAC 317:30-5-95.35 in collaboration with the member, and his/her parents for members under the age of 18, legal guardians, or others in whose care he/she will be released after discharge;

(3) must establish treatment goals that are general outcome statements and reflective of informed choices of the member served. Additionally, the treatment goal must be appropriate to the patient's age, culture, strengths, needs, abilities, preferences and limitations;

(4) must establish measurable and time limited treatment objectives that reflect the expectations of the member served and parent/legal guardian (when applicable) as well as being age, developmentally and culturally appropriate. When modifications are being made to accommodate age, developmental level or a cultural issue, the documentation must be reflected on the individual plan of care. The treatment objectives must be achievable and understandable to the member and the parent/guardian (when applicable). The treatment objectives also must be appropriate to the treatment setting and list the frequency of the service;

(5) must prescribe an integrated program of therapies, activities and experiences designed to meet the objectives;

(6) must include specific discharge and after care plans that are appropriate to the member's needs and effective on the day of discharge. At the time of discharge, after care plans will include referral to medication management, out-patient behavioral health counseling and case management to include the specific appointment date(s), names and addresses of service provider(s) and related community services to ensure

continuity of care and reintegration for the member into their family school, and community;
(7) must be reviewed every five to nine calendar days when in acute care and a regular PRTF and every 11 to 16 calendar days in the OHCA approved longer term treatment programs or specialty PRTF treatment programs by the team specified to determine that services are being appropriately provided and to recommend changes in the individual plan of care as indicated by the member's overall adjustment, progress, symptoms, behavior, and response to treatment;
(8) development and review must satisfy the utilization control requirements for physician re-certification and establishment of periodic reviews of the individual plan of care; and,
(9) each individual plan of care review must be clearly identified as such and be signed and dated individually by the physician, LBHP, member, parent/guardian (for patients under the age of 18), registered nurse, and other required team members. Individual plans of care and individual plan of care reviews are not valid until completed and appropriately signed and dated. All requirements for the individual plan of care or individual plan of care reviews must be met or a partial per diem recoupment will be merited. In those instances where it is necessary to fax an Individual Plan of Care or Individual Plan of Care review to a parent or OKDHS/OJA worker for review, the parent and/or OKDHS/OJA worker may fax back their signature. The Provider must obtain the original signature for the clinical file within 30 days. Stamped or Xeroxed signatures are not allowed for any parent or member of the treatment team.

317:30-5-95.35. Credentialing requirements for treatment team members for children

(a) The team developing the individual plan of care for the child must include, at a minimum, the following:
(1) Allopathic or Osteopathic Physician with a current license and a board certification/eligible in psychiatry, or a current resident in psychiatry practicing as described in OAC 317:30-5-2(a)(1)(U), and
(2) a mental health professional licensed to practice by one of the following boards: Psychology (health service specialty only); Social Work (clinical specialty only); Licensed Professional Counselor, Licensed Behavioral Practitioner~~,~~ ; Licensed Alcohol and Drug Counselor (LADC),(or) Licensed Marital and Family Therapist or 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 the services are provided), and
(3) a registered nurse with a minimum of two years of experience in a mental health treatment setting.

(b) Candidates for licensure for Licensed Professional Counselor, Social Work (clinical specialty only), Licensed Marital and Family Therapist, Licensed Behavioral Practitioner and Psychology (health services specialty only) can provide individual therapy, family therapy and process group therapy as long as they are involved in the supervision that complies with their respective approved licensing regulations and the Department of Health and their work must be co-signed by a licensed LBHP who is additionally a member on the treatment team. Individuals who have met their supervision requirements and are waiting to be licensed by one of the licensing boards in OAC 317:30-5-95.35(a)(1) must have their work co-signed by a licensed MHP who is additionally a member on the treatment team.

(c) Services provided by treatment team members not meeting the above credentialing requirements are not Medicaid compensable and can not be billed to the Medicaid recipient.

8.b-3 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 3. General Provider Policies
Part 3. General Medical Program Information
OAC 317:30-3-62. [NEW]
OAC 317:30-3-63. [NEW]
(Reference APA WF # 09-77)

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 hospital acquired conditions. These emergency rule revisions will set policy to no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. This quality initiative ensures that state and federal funds are not being used to promote serious medical errors and conditions and that all Oklahomans will continue to have access to quality healthcare.

ANALYSIS: Agency rules are written to establish policy for hospital acquired conditions. Rules will set policy to no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. For discharges, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. Payment will be made as though the secondary diagnosis was not present. The selected conditions that OHCA will recognize are those conditions identified as non-payable by Medicare. Rules will also include the avoidance of SoonerCare to act as a secondary payer for Medicare non-payment of the recognized hospital acquired conditions.

BUDGET IMPACT: Agency staff has determined that the revisions will result in an estimated budget savings but the savings is not quantifiable by OHCA at this time.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on January 21, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: April 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

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 no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital.

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

317:30-3-62. 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).
(f) **Hospital acquired conditions.** SoonerCare will not reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. See OAC 317:30-3-63 for specific information regarding hospital acquired conditions.

317:30-3-63. Hospital acquired conditions
(a) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. For discharges, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. The claim will be grouped to a DRG as if the diagnosis was not present on the claim. The selected conditions that OHCA recognizes are those conditions identified as non-payable by Medicare. OHCA may revise through addition or deletion the selected conditions at any time during the fiscal year. The following is a complete list of the hospital acquired conditions (HACs) currently recognized by OHCA:

- (1) Foreign Object Retained After Surgery
- (2) Air Embolism
- (3) Blood Incompatibility
- (4) Pressure Ulcer Stages III & IV
- (5) Falls and Trauma
  - (A) Fracture
  - (B) Dislocation
  - (C) Intracranial Injury
  - (D) Crushing Injury
  - (E) Burn
  - (F) Electric Shock
- (6) Catheter-Associated Urinary Tract Infection
- (7) Vascular Catheter-Associated Infection
- (8) Manifestations of Poor Glycemic Control
  - (A) Diabetic Ketoacidosis
  - (B) Nonketotic Hyperosmolar Coma
  - (C) Hypoglycemic Coma
  - (D) Secondary Diabetes with Ketoacidosis
  - (E) Secondary Diabetes with Hyperosmolarity
- (9) Surgical Site Infection Following:
  - (A) Coronary Artery Bypass Graft- Mediastinitis
  - (B) Bariatric Surgery
    - (i) Laparoscopic Gastric Bypass
    - (ii) Gastroenterostomy
    - (iii) Laparoscopic Gastric Restrictive Surgery
  - (C) Orthopedic Procedures
    - (i) Spine
    - (ii) Neck
    - (iii) Shoulder
    - (iv) Elbow
- (10) Deep Vein Thrombosis and Pulmonary Embolism
  - (A) Total Knee Replacement
  - (B) Hip Replacement

(b) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a present on admission (POA) indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims

involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator.

(c) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned hospital acquired conditions.

8.c-1 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 3. Hospitals
OAC 317:30-5-42.11. [AMENDED]
(Reference APA WF # 09-34)

ANALYSIS: Agency rules are modified to provide clarification for providers billing for observation/treatment services. The modification provides examples of outpatient observation services that are not covered when they are provided. This change provides clarification and education to providers.

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 July 16, 2009, and recommended Board approval.

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

PUBLIC HEARING: A public hearing was held January 19, 2010. No comments were received before, during, or after the hearing.

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

317:30-5-42.11. Observation/treatment
(a) Payment is made for the use of a treatment room associated with outpatient observation services. Observation services must be ordered by a physician or other individual authorized by state law. Observation services are furnished by the hospital on the hospital's premises and include use of the bed and periodic monitoring by hospital staff. Observation services must include a minimum of 8 hours of continuous care. The maximum length of stay for an observation service is 48 hours. Outpatient observation services are not covered when they are provided:

(1) On the same day as an emergency department visit.
(2) Prior to an inpatient admission, as those observation services are considered part of the inpatient DRG.
(3) For the convenience of the member, member’s family or provider.
(4) When specific diagnoses are not present on the claim.
(5) As part of another service, i.e. for post operative monitoring; recovery after diagnostic testing or concurrently with therapeutic services such as chemotherapy.

(b) Payment is made for observation services in a labor or delivery room. Specific pregnancy-related diagnoses are required. During active labor, a fetal non-stress test is covered in addition to the labor and delivery room charge.