OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
May 13, 2010 at 1:00 P.M.
Oklahoma Health Care Authority
4545 N. Lincoln Blvd, Suite 124
Oklahoma City, OK

A G E N D A

Items to be presented by Lyle Roggow, Chairman

1. Call To Order/Determination of Quorum
2. Action Item – Approval of April 8, 2010 OHCA Board Minutes

Item to be presented by Mike Fogarty, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) Financial Update – Carrie Evans, Chief Financial Officer
   b) Medicaid Director's Update – Lynn Mitchell, M.D.
   c) Legislative Update – Nico Gomez, Deputy Chief Executive Officer
   d) OHCA Team Day Report – Cindy Roberts, Deputy Chief Executive Officer

Item to be presented by Kelly Shropshire, Audit Director

4. Discussion Item – 2009 Audit Findings of the Oklahoma Health Care Authority by the State Auditor and Inspectors presented by Debbie Williams, Audit Manager

Item to be presented by Chairman Roggow

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

   a) Audit/Finance Committee – Member Miller
   b) Legislative Committee – Member McFall
   c) Rules Committee – Member Langenkamp

Item to be presented by Howard Pallotta, Director of Legal Services

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

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

7. 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:

7.b-1 AMENDING Agency rules at OAC 317:45-1-1 through 45-1-4, 45-3-1, 45-3-2, 45-5-1, 45-5-2, 45-7-1 through 45-7-8, 45-9-1 through 45-9-4, 45-9-6 through 45-9-8, 45-11-1, 45-11-2, 45-11-10, 45-11-11, 45-11-20 through 45-11-28, and ADDING agency rules at OAC 317:45-11-12 and 45-11-13 to expand the Insure Oklahoma ESI and IP programs. Expansions include incorporating Oklahoma children through 18 years of age whose household income is from 185 up to and including 300 percent of the Federal Poverty Level. The inclusion of children into the program will be phased in over a period of time as determined by the OHCA. In addition, revisions will expand the current Insure Oklahoma ESI and IP program guidelines to include employees and working adults whose family income does not exceed 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the OHCA. These revisions comply with Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes. This expansion to the Insure Oklahoma program will help increase access to health care for Oklahomans thereby reducing the amount of uncompensated care provided by health care providers.
(Reference APA WF # 10-08)

7.b-2 ADDING Agency rules to OAC 317:25-9-1 through 25-9-3 to implement a pilot program to pay Health Access Networks to coordinate and improve the quality of care for SoonerCare members. Rules are needed to establish provider requirements and billing guidelines for HAN's which are not-for-profit, administrative entities that work with SoonerCare providers to coordinate and improve the quality of care for our members. Contracted HAN's will be paid a $5.00 per member per month fee in order to enhance the development of comprehensive medical homes for SoonerCare Choice members.
(Reference APA WF # 10-14)

7.b-3 AMENDING Agency rules at OAC 317:30-5-241.1 to reflect that behavioral health assessments may only be provided by licensed behavioral health professionals. Currently, bachelor level Certified Alcohol and Drug Counselors (CADC's) may perform substance abuse assessments in accordance with their Licensure Act. Due to accreditation standard requirements for Assessments, all outpatient agencies are required to conduct full bio-psycho-social assessments by a licensed Masters level professional. As a result, ODMHSAS and OHCA collaboratively agreed to restrict the realm of behavioral health assessments to licensed behavioral health professionals and disallow the use of CADC's for substance abuse assessments.
(Reference APA WF # 10-18)

7.b-4 AMENDING Agency rules at OAC 317:30-5-1023 and 30-5-1027 to add a new provider type "Behavior Health School Aide" and service description "Therapeutic Behavioral Services". Currently schools are being allowed to include behavior interventions as a personal care service. 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 # 10-22)

Item to be presented by Chairman Roggow

8. 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. PharmCare v. OHCA   CJ-03-830(Oklahoma County)
   2. Morehead v. OKDHS   CJ-07-1110-L(Cleveland County)
   3. Webb v. OKDHS   09-CV-438(USDC, Northern District)
   4. Morris v. OKDHS   CIV-09-1357-C(USDC, Western District)
   5. Woodlawn v. OHCA   107,408(Okla. Supreme Court)
   6. Daily v. OKDHS   09-1095(US Supreme Court)
   7. Edwards v. Ardent   106,291(Okla. Supreme Court)

9. New Business

10. Adjournment

NEXT BOARD MEETING
June 10, 2010
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING OF THE OKLAHOMA HEALTH CARE AUTHORITY BOARD
April 8, 2010 at 1:00 P.M.
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 April 6th, 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 1:03PM.

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

ABSENT: Member Bryant

OTHERS PRESENT:	OTHERS PRESENT:
James Baughman, MH Assn./Tulsa	Laura Boyd,OTFCIA
Don Sanderson, OPHA	Anne Anthony, Willow Crest Hospital
Sahri Murphree, Willow Crest H.	Scott Anthony,Willow Crest Hospital
Patricia Christensen, OPCA	Maria Tucker, Western OK Diabetes
Suzanne Seward, Abbot Diabetes	Rich Edwards, OSF
Karen Nimocks, HP	Ray Miller, KIBOIS/ The Oaks
Monte Akridge, Integris H.	Rick Snyder, OHA
Portia Nickelberg, APS	Tracey Jones, Chickasaw Nation
Becky Moore, OAHCP	Tom Dunning, OKDHS
Heather Gauthney, OU Phys.	Edna Case, OU Phys.
Lanette Long, St. Anthony	Sandra Harrison, OKDHS
Mike Kistler, Shadow Mtn.	Sonya Colberg, OPUBCO

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD MARCH 11, 2010

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 Langenkamp moved for approval of the March 11, 2010 board minutes as amended. Member McVay seconded.

BOARD MEMBERS PRESENT: Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, and Chairman Roggow

ABSTAIN: Member McFall

ABSENT: Member Bryant

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ITEM 3/PRESENTATION OF ALL STAR EMPL0YEES
Mike Fogarty, Chief Executive Officer

Each of the following All Star Employees were presented to the board by the Director of each of their units:

October, 2009 – Brandy Gutierrez, Provider Enrollment, (Supervisor) Peggy Hansen, presented by Nicole Nantois
November, 2009 – Mari Kaufman, Insure Oklahoma, (Supervisor) Nicole Altobello, presented by Lynn Mitchell, M.D.
December, 2009 – Loan Tran, Social Services Coordinator, Care Management, (Supervisor) Cheryl Moore, presented by Becky Pasternik-Ikard

Mr. Fogarty reorganized Item 4 and asked Dr. Mitchell to present first.

ITEM 4.b/MEDICAID DIRECTOR'S UPDATE
Lynn Mitchell, M.D.

Dr. Mitchell reported that the February numbers have not grown to the number we saw in the fall of last year. The February enrollment numbers are up 2,829 members. Looking back from December to January our numbers grew by 3,322. Dr. Mitchell stated that we are 3 months into roughly 3,000 member increase per month, and are entering a flattening of the trend of growth that was seen during the fall. The SoonerCare Programs including the Insure Oklahoma Programs total have gone over the 700,000 with a current total of 715,759 members. Insure Oklahoma added 392 new members which is consistent with the last 2 months. Dr. Mitchell reported on the PACE Program which is an all inclusive care for the elderly. This is a partnership with the Cherokee Nation, CMS, and OHCA. The program has been in existence about 20 months and currently has 50 members. This is the first American Native PACE program in the United States with the current site being in Tahlequah, OK. Dr. Mitchell then presented the pharmacy data including discussion regarding the implementation of the new drug class into OHCA's tiered reimbursement system (atypical psychotics). Those programs begin the first of the month with no aberrant events from adopting this tiered reimbursement system and prior authorization. She stated that she spent March 29 in Washington, DC with Cindy Mann, Director of Medicaid. The Centers for Medicare and Medicaid (CMS) is focusing on Health Care Reform and looking diligently at the issue of payment reform, and the issue of global payments. There was discussion on CHIPPA, CMS realignment, and how SPA's are reviewed. Ms. Mann talked about system changes that will take place with Health Care Reform and also spoke about a collaborative role with Medicare to take care of dual eligible's. Dr. Mitchell noted that EPSDT in Oklahoma has surpassed the national benchmark for child health screenings. Approximately 540,000 children age 21 and under enrolled in SoonerCare in 2009 83% received regular health screenings up from 73% in 2008. The national standard set by CMS is 80%.

ITEM 4.d/PROGRAM INTEGRITY REPORT
Cindy Roberts, Deputy Chief Executive Officer

Ms. Roberts stated that with some of the recent talk of Medicare and Medicaid Program Integrity efforts in the news, some of the board members wanted a presentation for everyone to hear. A lot of people

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probably have not heard much and with good reason. One reason is that our state has an impressive system of pre-payment edits in place compared to other state Medicaid programs. This allows us to deny a claim that appears inappropriate rather than pay it and then "chase" it down later. Ms. Roberts noted that the second reason is that with the technology that we have in place, we don't just randomly review providers. Our tools, such as data-mining and peer-to-peer comparisons help us assess risk and hone in where OHCA believes there may be possible errors, and as a result we don't need to review too many providers. Ms. Roberts then provided some recovery statistics for the first 3 quarters of SFY 2010. She stated that we closed 88 audits which included looking at 1,155 providers. Total recoveries were $14.6 million total dollars. The agency is required to return the federal share to CMS.

Ms. Roberts concluded by saying that while $14.6 million may sound like quiet a bit, it is only equal to less than ½ of a percentage of the nearly $3.8 billion in program expenditures for the first 3 quarters of the SFY 2010.

ITEM 4.c/LEGISLATIVE UPDATE
Nico Gomez, Deputy Chief Executive Officer

OHCA REQUEST BILLS:
SB 1349 – Obesity Treatment Pilot Program for Medicaid; SB 1836 - Health Information Infrastructure Advisory Board to Assist OHCA In Developing Electronic Health Record Incentive Payments

Mr. Gomez reported that after the March 11th committee deadline, and as of noon, Wednesday, March 31st, 2010, the Oklahoma Legislature is currently tracking a total of 1,438 active bills. OHCA is currently tracking 100 bills.

They are broken down as follows:
OHCA Request 02
- Direct Impact 32
- Agency Interest 12
- Appropriations 10
- Employee Interest 13
- Carry Over 29
- Governor Signed 02

Mr. Gomez noted that the next deadlines are Wednesday, March 31, 2010 for reporting House Bills and Joint Resolutions from Senate Committees and Thursday, April 8th for reporting Senate Bills and Joint Resolutions from House Committees. The deadline for Third Reading of Bills and Joint Resolutions in the opposite chamber is April 22nd and Sine Die is set for May 28th.

ITEM 4.a/FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported the revenues for OHCA through February, accounting for receivables, were **$2,351,459,689** or **.3% over** budget. Expenditures for OHCA, accounting for encumbrances, were **$2,209,269,038** or **.1% over** budget. Ms. Evans noted that the state dollar budget variance through

February is **$1,562,129 positive.** The state dollar budget variance due to Medicare Part D Stimulus allocation is **$4,523,896 positive.**

The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(8.7)
Medicare Part D		4.5
Administration		3.2
Revenues:		
Taxes and Fees		3.0
Drug Rebate		1.4
Overpayments/Settlements		2.7
Total FY 10 Variance	**$**	**6.1**

Ms. Evans stated that for the month of March we have all 5 cycle runs and they are still all preliminary but it appears as if we will go $20 million over budget in Medicaid for the month of March. She noted that all administrative cuts have been budgeted so we will probably see the administrative variance dropping some.

Mr. Fogarty stated that on March 17th, we set an all time record by processing over a million claims which produced payments totaling over $100 million. The totals for March established new all time records. He said there were over 4.5 million claims paid monthly producing payments in excess of $460 million. He stated that we are seeing a slowing of the growth but utilization is still high.

Mr. Fogarty presented the Budget Request Detail outlook for 2011. The base for this current year was almost exactly $980 million and when we ended this year we were at that same number. We had to reduce base expenditures by $35 million in order to end this year at this same amount. The adjusted base is nearly $937 million which is the current less 7.5%. Mr. Fogarty stated that he spoke yesterday with the Speaker of the House, Senate Pro Tempe and the State Treasurer. OHCA also received a notice yesterday that legislative budget hearings will begin next week. The assumptions of those hearings and the request that has been made of OHCA is that we along with other state agencies will appear at the state capitol to describe the impact on our program if we start with this year's base less the 7.5% and reduce that by another 10% (one scenario) and then reduce that by 15% respectively. This first page of the budget request includes a grand total of $1 billion $97 million that would be required in state monies to support the program next year at the same level we have operated this year. So if you deduct the new revised base of $937 million that is where you get the total at the bottom of the page of $160 million. Reducing that by an additional 10% would require an additional $93.7 million in cuts to balance the budget, and obviously that number goes up again if you take it to 15%. Mr. Fogarty stated that for today's discussion he would focus only on the 10% cut. He said that there are a few benefits in the program that are optional and not required by the federal

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government and we are down to 4 of those programs. These benefits affect adults only and include the pharmacy benefit, dental benefit, certain durable medical equipment, and behavioral services. Mr. Fogarty said that if a decision was made to eliminate all 4 of those benefits it would reduce our budget requirements by about $86 million. What we know is that eliminating pharmacy benefits are not going to reduce the budget of this agency. It would reduce the amount of money we pay for medicine. It would increase substantially the amount of money we pay for treating the consequences of not buying medicine. The same can be true of each and every one of those 4 benefits. The failure to provide appropriate behavioral health services will result not only in increases that directly affect our budget but other state costs. The same can be said for Durable Medical Equipment (DME) and also for other optional services. Mr. Fogarty stated that we have maintenance of effort requirement tied to hundreds of millions of dollars of federal funds that says we cannot at this time reduce the number of people that are qualified for this program (eligibility). So we are down to provider rates. If we were to propose a balanced budget relying only on reduction in provider rates to establish a balanced budget, it would be an across the board reduction of 29% provider rate cut. He said that in the real world we cannot buy services at rates of 29% less than we are currently paying. For purpose of filing a constitutionally balanced budget, that is the number it will take. If we arbitrally decided that we would reduce those 4 optional services or a part of those optional services by as much as half on some theory that we might be able to cut those services as much as half saving about $43 million to achieve a balanced budget, we would have to reduce provider rates by 19% across the board which is the total including the 3.25% cut. The operating assumption in our request for next year is that the reduction in rates of 3.25% was an emergency matter that was designed to respond to a revenue failure. As an agency we are out of options and if forced we will file a budget showing this is what we are going to do but this program will not survive these cuts. Mr. Fogarty said every dollar is a state dollar and every one of those dollars will result in the loss of two additional federal dollars in our normal match. There is an additional dollar in the match as a result of the economic stimulus money which is still in effect through next December. A cut of $200 million state dollars is going to pull about $600 million out of the state's economy. Mr. Fogarty stated that every one at the capitol knows and understands the agency's financial crisis. For every one percent we reduce provider rates, OHCA saves $8.7 million state dollars. So, divide the shortfall by $8.7 million and that will tell you how much to a percentage the rates have to be reduced to get to the number.

Member McFall stated that that he sent an e-mail to Mr. Fogarty last week and every board member has a copy in the packet. Member McFall stated the document is the mission statement for OHCA written in 1994. The mission is to purchase state and federally funded healthcare in the most efficient and comprehensive manner possible and to study and to recommend strategies for optimizing accessibility and quality of healthcare. Member McFall noted that this is a great way to express to leadership at the capitol what OHCA is charged with and the things we need the funding to accomplish.

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ITEM 5 – REPORTS TO THE BOARD BY BOARD COMMITTEES
Chairman Roggow

5.a)Audit/Finance Committee
Member Miller

Member Miller stated that the Committee met and discussed the records set for most claims paid I one week and most claims paid for an entire month. Ms. Roberts reported on the single state audit for the fiscal year ended June 30, 2009 and this audit will be discussed at next month's board meeting.

5.b)Legislative Committee
Member McFall

Member McFall stated the Legislative Committee did meet and discussed the tracking lists of bills.

5.c)Legislative Committee
Member Langenkamp

Member Langenkamp stated that the Rules Committee met and reviewed rules.

ITEM 6 - ANNOUNCEMENTS OF CONFLICTS OF INEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING
Nicole Nantois, Deputy Counsel

Ms. Nantois stated that the Conflicts of Interest Panel had met and there were no conflicts regarding Item 7 and 8.

ITEM 7.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
Cindy Roberts, Deputy Chief Executive Officer

MOTION: Member McFall moved for declaration of emergency as presented. Vice Chairman Armstrong seconded.

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

ABSENT: Member Bryant

ITEM 7.b)CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:
Cindy Roberts, Deputy Chief Executive Officer

7.b-1 through 7.b-3 as published in meeting agenda.

MOTION: Member Langenkamp moved for approval of rules 7.b-1 through 7.b-3 as published in meeting agenda. Member McFall seconded.

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OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
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4545 N. Lincoln Blvd, Suite 124
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Item to be presented by Kelly Shropshire, Audit Director

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Item to be presented by Chairman Roggow

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(Reference APA WF # 10-08)

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7.b-4 AMENDING Agency rules at OAC 317:30-5-1023 and 30-5-1027 to add a new provider type "Behavior Health School Aide" and service description "Therapeutic Behavioral Services". Currently schools are being allowed to include behavior interventions as a personal care service. 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.
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   Status of pending suits and claims

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   3. Webb v. OKDHS   09-CV-438(USDC, Northern District)
   4. Morris v. OKDHS   CIV-09-1357-C(USDC, Western District)
   5. Woodlawn v. OHCA   107,408(Okla. Supreme Court)
   6. Daily v. OKDHS   09-1095(US Supreme Court)
   7. Edwards v. Ardent   106,291(Okla. Supreme Court)

9. New Business

10. Adjournment

NEXT BOARD MEETING

June 10, 2010

Oklahoma Health Care Authority

Oklahoma City, OK

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Chairman Roggow

5.a)Audit/Finance Committee
Member Miller

Member Miller stated that the Committee met and discussed the records set for most claims paid I one week and most claims paid for an entire month. Ms. Roberts reported on the single state audit for the fiscal year ended June 30, 2009 and this audit will be discussed at next month's board meeting.

5.b)Legislative Committee
Member McFall

Member McFall stated the Legislative Committee did meet and discussed the tracking lists of bills.

5.c)Legislative Committee
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Member Langenkamp stated that the Rules Committee met and reviewed rules.

ITEM 6 - ANNOUNCEMENTS OF CONFLICTS OF INEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING
Nicole Nantois, Deputy Counsel

Ms. Nantois stated that the Conflicts of Interest Panel had met and there were no conflicts regarding Item 7 and 8.

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Cindy Roberts, Deputy Chief Executive Officer

MOTION: Member McFall moved for declaration of emergency as presented. Vice Chairman Armstrong seconded.

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

ABSENT: Member Bryant

ITEM 7.b)CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:
Cindy Roberts, Deputy Chief Executive Officer

7.b-1 through 7.b-3 as published in meeting agenda.

MOTION: Member Langenkamp moved for approval of rules 7.b-1 through 7.b-3 as published in meeting agenda. Member McFall seconded.

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

ABSENT: Member Bryant

ITEM 8/CONSIDERATION AND VOTE TO AUTHORIZE EXPENDITURE OF FUNDS FOR RADIOLOGY MANAGEMENT SERVICES

Beth VanHorn, Director of Legal Operations

Ms. VanHorn presented the background, the scope of work, the contract period, the contract amount and procurement method. Staff's recommendation to the board is to approve this contract to procure the services discussed.

MOTION: Member McFall moved for approval of Item 8 as presented. Member McVay seconded.

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

ABSENT: Member Bryant

ITEM 9/DISCUSSION ITEM – "ANALYSIS OF NATIONAL HEALTH REFORM LEGISLATION"

Buffy Heater, Manager of Planning and Development

Ms. Heater presented the high points of National Health Reform focusing on SoonerCare-specific points. The following were presented and discussed: Oklahoma FMAP Outlook: Newly Qualified(time period); Oklahoma CHIP FMAP Outlook(time period); Enrollment Today; Enrollment Post-Reform; Potential Oklahoma Impact; Additional Options; Basic State Health Plan Example; and other Reform Notables. For a copy of the Powerpoint Presentation see the OHCA Website.

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)

Nicole Nantois, Deputy General Counsel

MOTION: Vice Chairman Armstrong moved for an executive session. Member McFall seconded.

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

ABSENT: Member Bryant

ITEM 11/NEW BUSINESS

NONE

ITEM 12/ADJOURNMENT

MOTION:	Member McFall moved for adjournment. Member McVay seconded.
BOARD MEMBERS PRESENT:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow
ABSENT:	Member Bryant

FINANCIAL REPORT

For the Nine Months Ended March 31, 2010
Submitted to the CEO & Board
May 13, 2010

- Revenues for OHCA through March, accounting for receivables, were **$2,682,969,277** or **.8% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,546,182,306** or **.5% over** budget.
- The state dollar budget variance through March is **$183,325 positive.**
- The state dollar budget variance due to Medicare Part D Stimulus allocation is **$10,021,700 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	(14.5)
Medicare Part D	10.0
Administration	3.4
Unbudgeted Carryover	3.4
Revenues:	
Taxes and Fees	2.6
Drug Rebate	1.5
Overpayments/Settlements	3.8
Total FY 10 Variance	**$ 10.2**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA 1
Medicaid Program Expenditures by Source of Funds 2
Other State Agencies Medicaid Payments 3
Fund 230: Quality of Care Fund Summary 4
Fund 245: Health Employee and Economy Act Revolving Fund 5
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund 6
Fund 255: OHCA Medicaid Program Fund 7

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

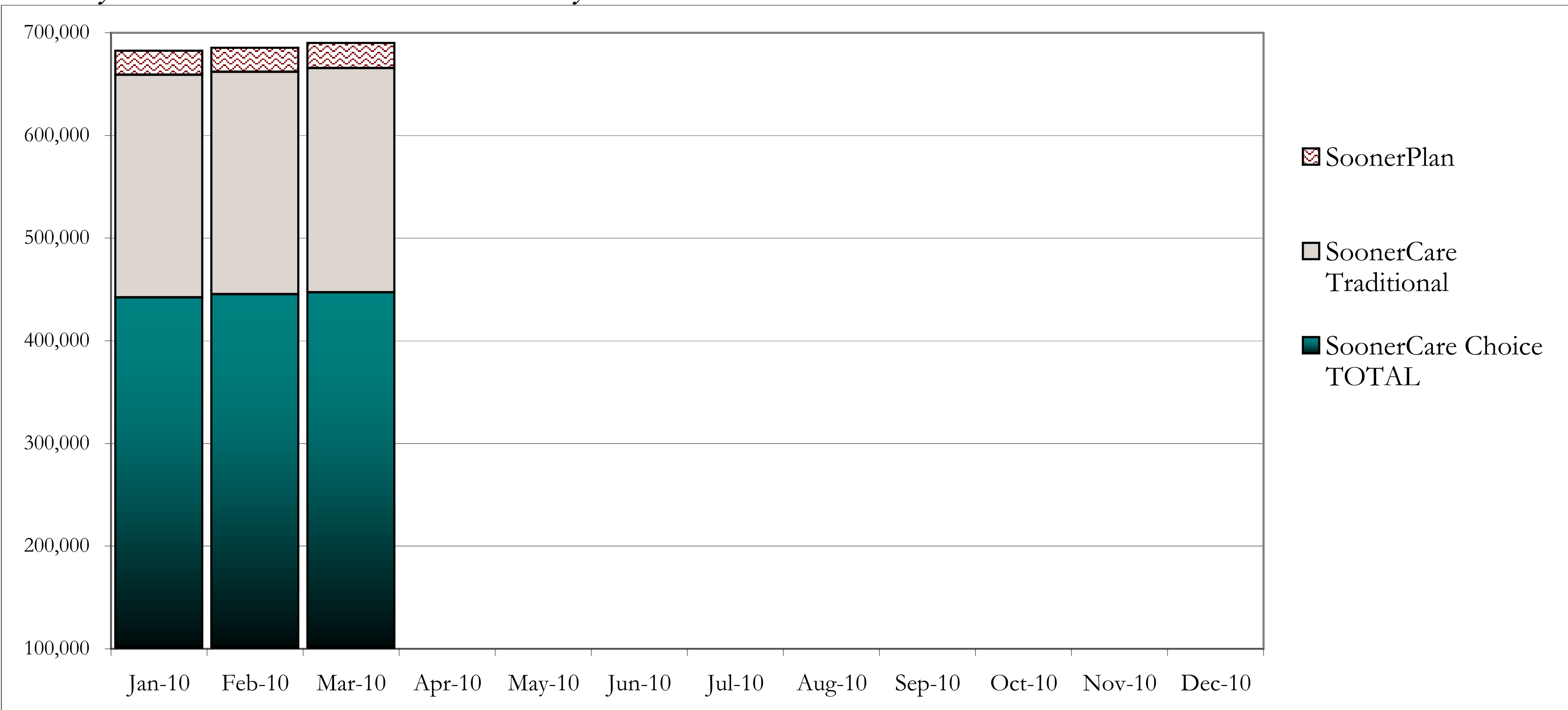
REVENUES	FY10 Budget YTD	FY10 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 477,591,048	$ 477,591,048	$ -	0.0%
Federal Funds	1,557,821,843	1,559,720,685	1,898,842	0.1%
Tobacco Tax Collections	37,167,277	40,205,369	3,038,092	8.2%
Quality of Care Collections	38,855,558	38,374,490	(481,068)	(1.2)%
Prior Year Carryover	24,714,277	28,114,277	-	0.0%
Drug Rebates	97,643,367	101,816,614	4,173,247	4.3%
Medical Refunds	31,274,221	41,914,171	10,639,950	34.0%
Other Revenues	15,203,179	14,826,015	(377,164)	(2.5)%
Stimulus Funds Appropriated	291,662,709	291,662,709	-	0.0%
Stimulus Funds Drawn	88,743,900	88,743,900	-	0.0%
TOTAL REVENUES	**$ 2,660,677,379**	**$ 2,682,969,277**	**$ 18,891,899**	**0.7%**

EXPENDITURES	FY10 Budget YTD	FY10 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 29,211,356**	**$ 27,613,758**	**$ 1,597,598**	**5.5%**
ADMINISTRATION - CONTRACTS	**$ 79,238,267**	**$ 61,486,497**	**$ 17,751,770**	**22.4%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	21,806,495	20,895,334	911,162	4.2%
Acute Fee for Service Payments:				
Hospital Services	718,263,215	696,258,965	22,004,250	3.1%
Behavioral Health	196,361,975	212,868,643	(16,506,668)	(8.4)%
Physicians	330,881,366	327,832,828	3,048,538	0.9%
Dentists	113,067,939	123,113,661	(10,045,721)	(8.9)%
Other Practitioners	33,089,775	37,952,661	(4,862,886)	(14.7)%
Home Health Care	14,256,839	15,112,356	(855,517)	(6.0)%
Lab & Radiology	18,255,183	26,138,109	(7,882,926)	(43.2)%
Medical Supplies	43,025,062	41,848,483	1,176,579	2.7%
Ambulatory Clinics	45,990,587	63,235,678	(17,245,091)	(37.5)%
Prescription Drugs	277,959,579	288,092,854	(10,133,275)	(3.6)%
Miscellaneous Medical Payments	22,782,900	21,362,460	1,420,440	6.2%
Other Payments:				
Nursing Facilities	390,563,176	390,114,537	448,640	0.1%
ICF-MR Private	42,321,627	42,231,221	90,406	0.2%
Medicare Buy-In	87,792,386	90,792,655	(3,000,269)	(3.4)%
Transportation	19,458,600	19,524,331	(65,731)	(0.3)%
Part D Phase-In Contribution	49,728,978	39,707,278	10,021,700	20.2%
Total OHCA Medical Programs	**2,425,605,682**	**2,457,082,051**	**(31,476,369)**	**(1.3)%**
OHCA Non-Title XIX Medical Payments	40,128	-	40,128	0.0%
TOTAL OHCA	**$ 2,534,095,433**	**$ 2,546,182,306**	**$ (12,086,873)**	**(0.5)%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 126,581,946**	**$ 136,786,971**	**$ 10,205,025**	

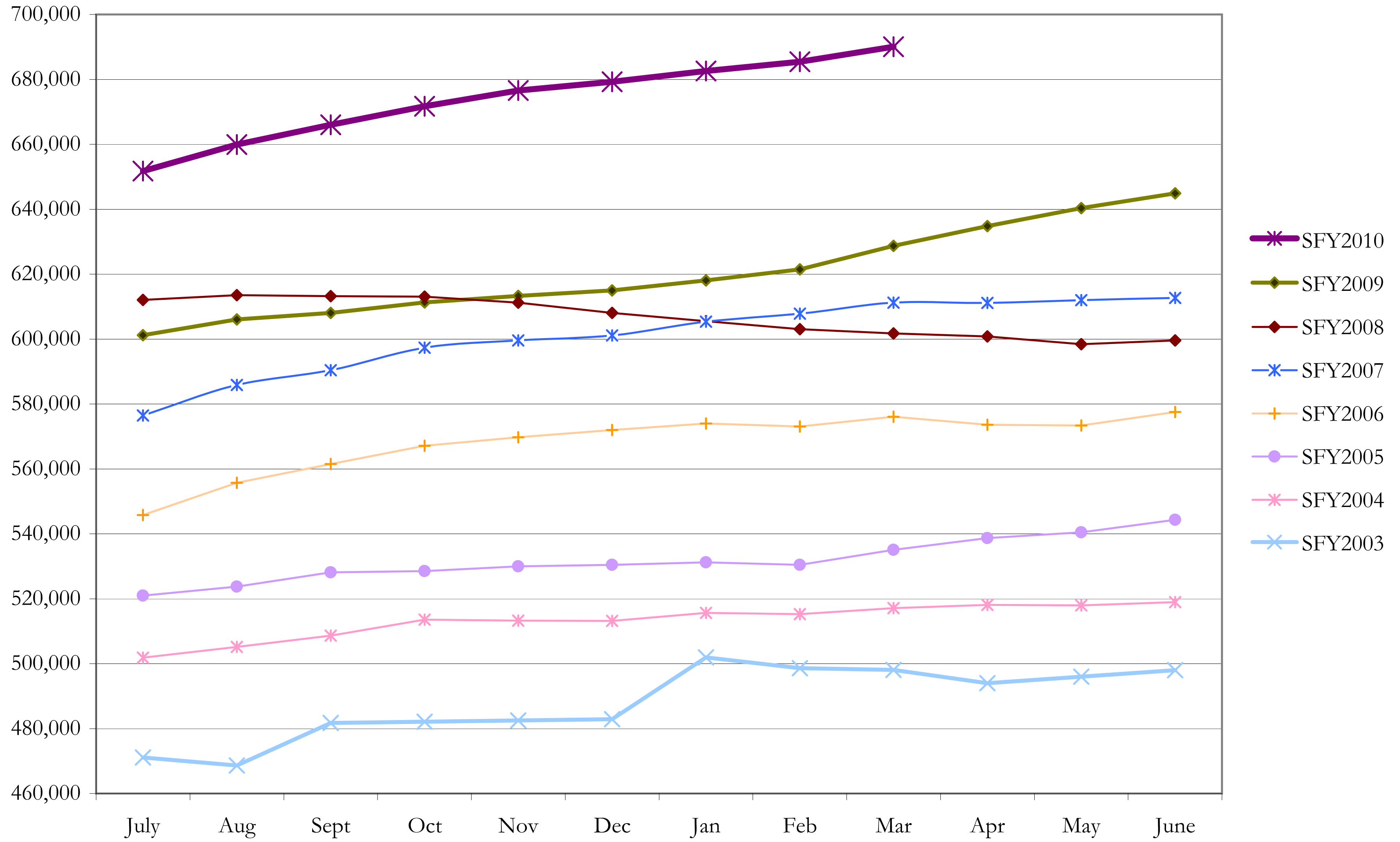
SOONERCARE ENROLLMENT CY-2010

	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Total MMs
ENROLLEES													
SoonerCare Choice													
Choice Total	428,704	431,677	433,447										1,293,828
IHS/Urban/Tribal Total	13,503	13,619	13,780										40,902
SoonerCare Choice TOTAL	442,207	445,296	447,227										1,334,730
SoonerCare Traditional	216,989	216,542	218,449										
SoonerPlan	23,420	23,607	24,379										71,406
TOTAL ENROLLEES	682,616	685,445	690,055										2,058,116
Average Monthly Enrollment													686,039

Monthly Actual SoonerCare Enrollment Trends by Benefit Plan



MMs = Member Months



OHCA SoonerCare Enrollment Figures
700,000
680,000
660,000
640,000
620,000
600,000
580,000
560,000
540,000
520,000
500,000
480,000
460,000
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
June
SFY2010
SFY2009
SFY2008
SFY2007
SFY2006
SFY2005
SFY2004
SFY2003

SoonerCare Programs

March 2010

Choice PCMH	MARCH	
	2009	2010
Total Enrolled	404,240	447,227
American Indian Enrollment	11,672	13,780
Choice Enrollees (PCMH)	392,568	433,447

Traditional	MARCH	
	2009	2010
Total Enrolled	206,886	218,449
SoonerCare Programs Total (Unduplicated)	628,726	690,055

Oklahoma Cares	MARCH	
	2009	2010
Total Women Enrolled	2,632	2,368
SoonerCare Traditional	2,026	1,652
SoonerCare Choice	606	716
Total Women Ever-enrolled	19,112	22,828

SoonerPlan	MARCH	
	2009	2010
Total Enrolled	17,600	24,379
Male Enrollees	470	734
Female Enrollees	17,130	23,645
Total Ever-enrolled	65,386	80,919

TEFRA	MARCH	
	2009	2010
Total Children Enrolled	263	323
Male Enrollees	158	192
Female Enrollees	105	131
Total Ever-enrolled	341	432

Insure Oklaoma	MARCH	
	2009	2010
IO Total Enrollees	17,486	30,552
IO Enrollees Males	7,693	13,223
IO Enrollees Females	9,793	17,329
ESI Enrollees	11,656	18,774
IP Enrollees	5,830	11,778

Program	OCTOBER 2009	NOVEMBER 2009	DECEMBER 2009	JANUARY 2010	FEBRUARY 2010	MARCH 2010
Choice PCMH	423,288	432,068	438,276	442,207	445,296	447,227
Traditional	225,914	221,734	217,945	216,989	216,542	218,449
Oklahoma Cares	2,466	2,481	2,373	2,307	2,396	2,368
TEFRA	307	313	320	325	326	323
SoonerPlan	22,498	22,788	23,073	23,420	23,607	24,379
Soon-to-be Sooners	3,103	3,041	2,979	2,955	2,993	3,051
SoonerCare Programs Total (Unduplicated)	**671,700**	**676,590**	**679,294**	**682,616**	**685,445**	**690,055**
Insure Oklahoma ESI	17,344	17,882	18,133	18,521	18,877	18,774
Insure Oklahoma IP	9,756	10,146	10,825	11,100	11,437	11,778
Insure Oklahoma Programs Total (Unduplicated)	**27,100**	**28,028**	**28,958**	**29,621**	**30,314**	**30,552**
Programs Total	**698,800**	**704,618**	**708,252**	**712,237**	**715,759**	**720,607**

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April 16, 2010

SoonerCare Fast Facts

March 2010

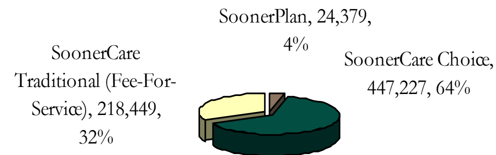
TOTAL ENROLLMENT —
OKLAHOMA SOONERCARE (MEDICAID)

Qualifying Group	Age Group	Enrollment	% of Total
Aged/Blind/Disabled	Child	18,317	2.65%
Aged/Blind/Disabled	Adult	125,506	18.19%
Children/Parents	Child	454,900	65.92%
Children/Parents	Adult	45,992	6.66%
Other	Child	490	0.07%
Other	Adult	17,780	2.58%
Oklahoma Cares (Breast & Cervical Cancer)		2,368	0.34%
SoonerPlan (Family Planning)		24,379	3.53%
TEFRA		323	0.05%
Total Enrollment	**690,055**	Adults	212,778 31%
		Children	477,277 69%

OTHER Group includes—Child custody-Refugee-Qualified Medicare Beneficiary-SLMB-DDSD Supported Living-Program of All Inclusive 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) — **838,019**

Other Breakdowns of Total Enrollment

Oklahoma SoonerCare (Medicaid) members residing in a long-term care facility — **15,868**

Oklahoma persons enrolled in both Medicare and Medicaid (dual eligibles) — **100,853**

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
5,606	18,774	11,778

New Enrollees

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

Adults	6,836
Children	9,017
Total	**15,853**

Race Breakdown of Total Enrollment

	Children	Adults	Percent	Pregnant Women
American Indian	60,778	19,989	12%	2,818
Asian or Pacific Islander	6,888	2,821	1%	598
Black or African American	69,583	29,511	14%	2,436
Caucasian	325,839	158,039	70%	18,866
Multiple Races	14,189	2,418	2%	665
Hispanic Ethnicity	75,194	10,871	12%	5,053

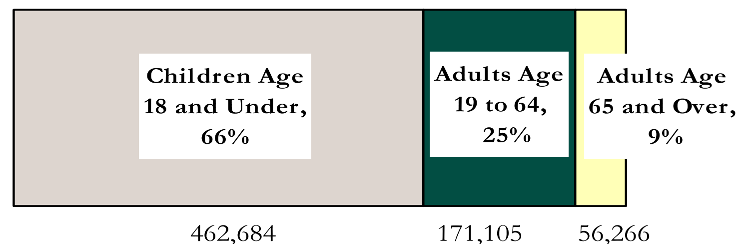
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

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		3,051
INFANT	150% to 185%	1,478
01-05	133% to 185%	11,486
06-12	100% to 185%	32,954
13-18	100% to 185%	20,711
Total		**69,680**

Age Breakdown of Total Enrollment



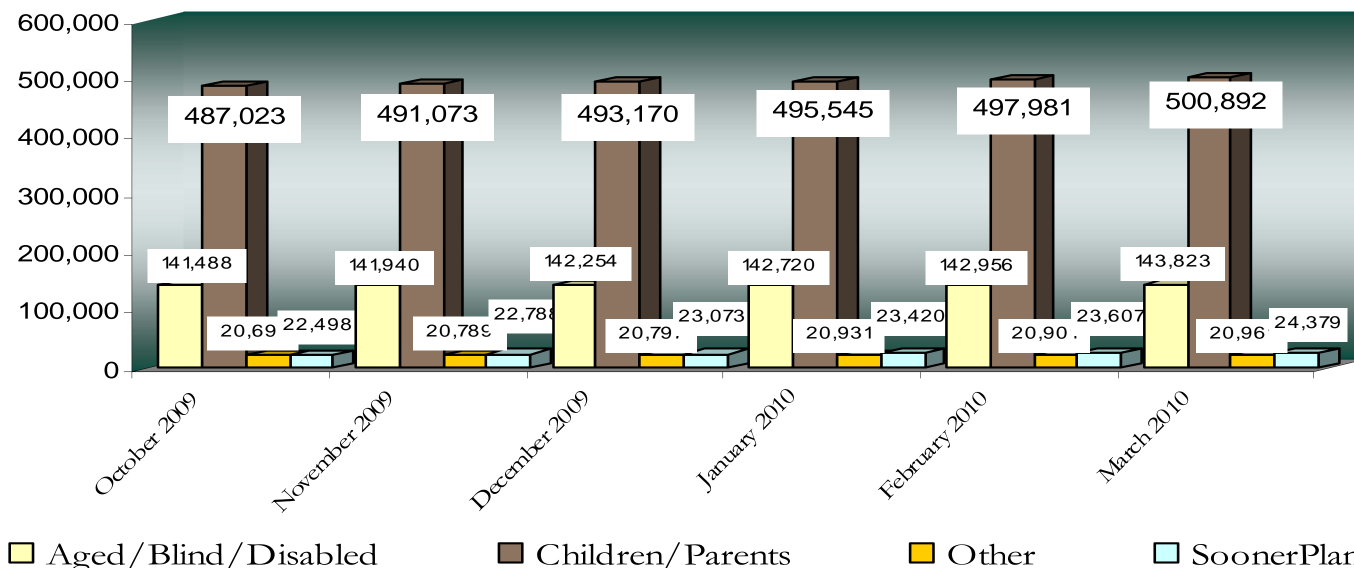
Data was compiled on 4/12/2010. Numbers frequently change due to certifications occurring after the data is extracted and other factors. This report is based on data within the system prior to 4/12/2010. A majority of the data is a "point in time" representation of the specific report month and is not cumulative. Unless stated otherwise, CHILD is defined as an individual under the age of 21.

SoonerCare Fast Facts

March 2010

oklahoma health care authority

Enrollment by Aid Category



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

April 8, 2010

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

OHCA Program Integrity Division Ensures Quality Program

OKLAHOMA CITY – Provider audits are one of the tools the Oklahoma Health Care Authority uses in it’s program integrity efforts to make sure state and federal tax dollars are being used correctly in the state’s SoonerCare (Oklahoma Medicaid) program.

Deputy Chief Executive Officer Cindy Roberts who leads the agency’s Policy, Planning and Integrity Division presented the OHCA Board with an update of their efforts during the board’s meeting April 8. According to Roberts, in 2009 approximately 5 percent of the estimated 28,000 SoonerCare providers had some level of audit or review performed.

The reviews, she said, are initiated because of some type of risk analysis such as peer-to-peer comparisons, referrals or data mining. Federal regulations require each Medicaid state agency to have an automated claims processing and retrieval system that can be used to detect post-payment errors. These systems, known as Medicaid Management Information Systems contain subsystems which compare and contrast SoonerCare claims activity by provider in comparison to their peers. The system also allows the program integrity division to perform comprehensive data mining of claims history.

“The extent of these audits or reviews may vary, from the validation of a single claim line to a representative sample of a provider’s SoonerCare services over a certain time period to a 100 percent review of a specific service billed by a provider,” Roberts noted.

For the first three quarters of state fiscal year 2010, OHCA closed 88 audits involving 1,155 providers. The majority of those audits, 73 percent, were the result of data-mining and peer-to-peer comparisons. The audits resulted in the recovery of $14.7 million in state and federal funds. The recovery represents .4 percent of the agency’s total program expenditures of $3.4 billion for the first three quarters of 2010.The federal share of any overpayment must be returned to the agency’s federal partner, the Centers for Medicare & Medicaid Services.

“It is interesting to note that these recoveries represent only .4 percent of the total program spending for the same time period,” Roberts said. “We have found that errors are far more common than activities that are specifically fraudulent or abusive.”
If fraud is suspected, the case is turned over to the Oklahoma Attorney General’s Medicaid Fraud Control Unit for further investigation. The OHCA also regularly reviews its policy and educates providers to try to avoid overpayments.

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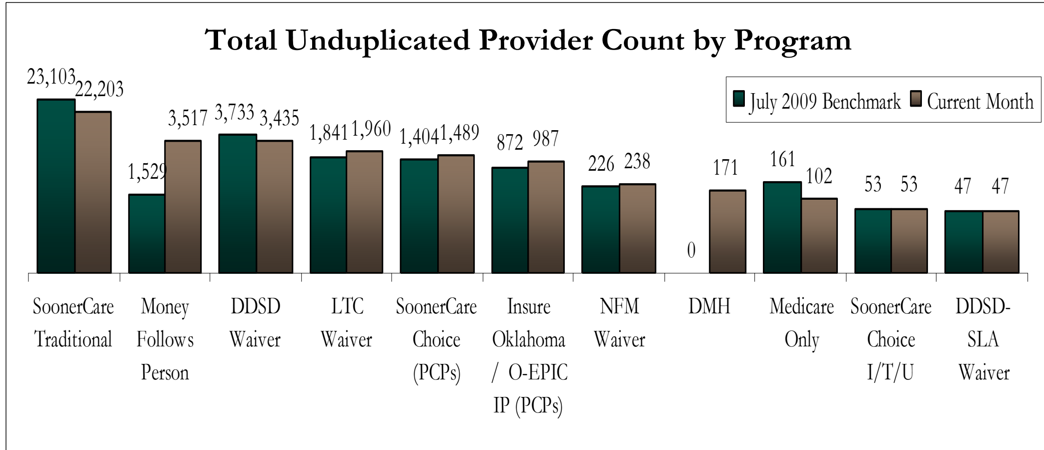
Oklahoma Health Care Authority

Provider Fast Facts

March 2010

Total Unduplicated Provider Count
28,135

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



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
369

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	1,049,749	40.19%
SoonerCare Choice I/T/U	116,150	11.98%
Insure Oklahoma/O-EPIC IP	327,983	3.71%

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

DMH - Department of Mental Health

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

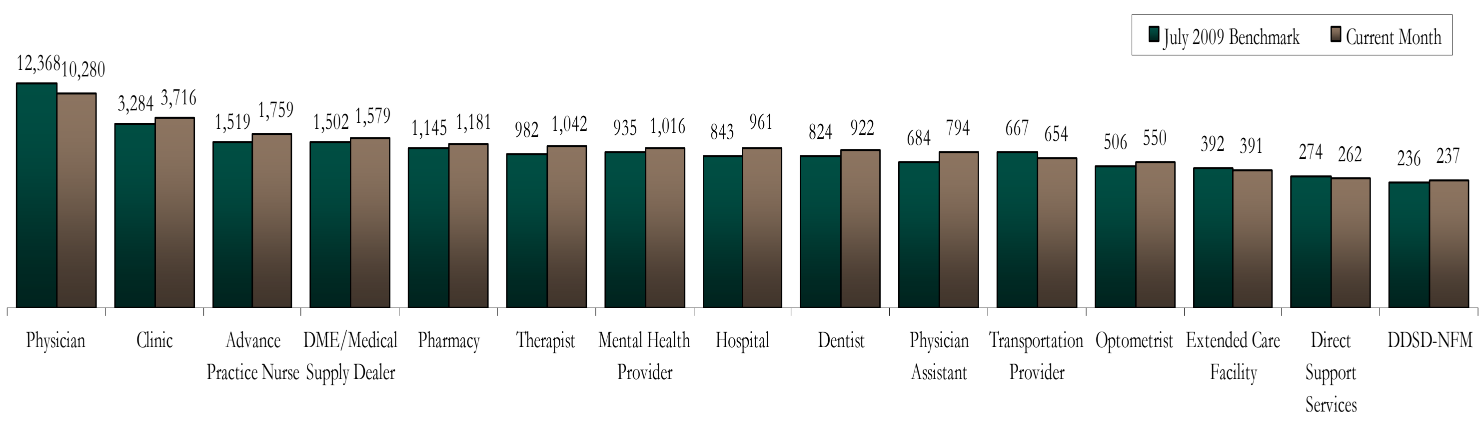
PCMH - Patient-Centered Medical Home

PCP - Primary Care Provider

PCMH Enrollment by Tier

Payment Tier Code	Count
Tier 1	487
Tier 2	235
Tier 3	47

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



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

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Provider Fast Facts

March 2010

oklahoma health care authority

County	SoonerCare Choice PCPs	Insure Oklahoma IP PCPs
Cimarron	1	1
Texas	5	3
Beaver	5	5
Harper	4	3
Woods	4	5
Alfalfa	2	2
Grant	6	6
Kay	17	14
Osage	14	12
Washington	16	11
Nowata	8	9
Craig	12	9
Ottawa	7	6
Ellis	0	1
Woodward	5	3
Major	6	6
Garfield	19	13
Noble	1	0
Pawnee	7	7
Rogers	7	6
Mayes	13	14
Delaware	22	5
Dewey	0	0
Blaine	15	14
Kingfisher	7	8
Logan	14	11
Payne	30	5
Creek	23	16
Tulsa	342	175
Wagoner	19	19
Cherokee	17	17
Adair	7	9
Roger Mills	3	3
Custer	15	13
Canadian	36	23
Oklahoma	305	172
Lincoln	9	9
Okmulgee	15	12
Muskogee	17	9
Okfuskee	3	5
McIntosh	3	3
Sequoyah	6	5
Beckham	16	15
Washita	2	1
Caddo	22	24
Grady	34	27
McClain	37	10
Cleveland	66	46
Pottawatomie	37	30
Seminole	13	14
Hughes	2	2
Pittsburg	13	8
Haskell	2	4
LeFlore	23	18
Latimer	4	3
Greer	6	6
Harmon	3	3
Kiowa	3	3
Jackson	15	6
Comanche	25	20
Tillman	17	18
Cotton	1	1
Stephens	29	27
Garvin	8	8
Pontotoc	16	16
Coal	3	4
Murray	3	2
Atoka	8	9
Pushmataha	20	20
McCurtain	10	7
Carter	14	9
Jefferson	8	7
Johnston	7	8
Love	7	0
Marshall	4	4
Bryan	25	17
Choctaw	13	14

Total Provider Count

- 4,000 to 6,000 (2)
- 300 to 1,000 (8)
- 150 to 300 (16)
- 50 to 150 (28)
- 0 to 50 (23)

Primary Care Providers (PCPs)

- SoonerCare Choice PCPs
- Insure Oklahoma IP PCPs

04/12/2010

Insure Oklahoma

Fast Facts

May 2010

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

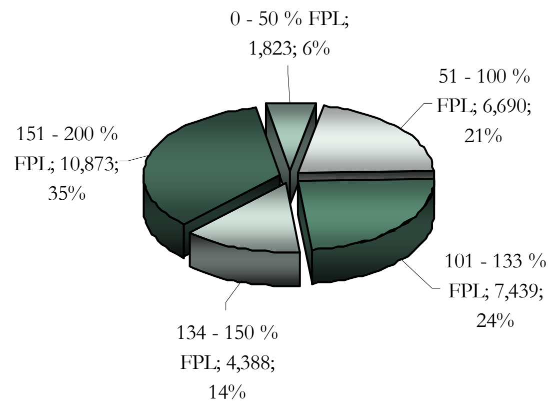
Insure Oklahoma is an innovative program Oklahoma has created to bridge the gap in the health care coverage for low-income working adults. Under the Employer-Sponsored Insurance (ESI) program, premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent).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

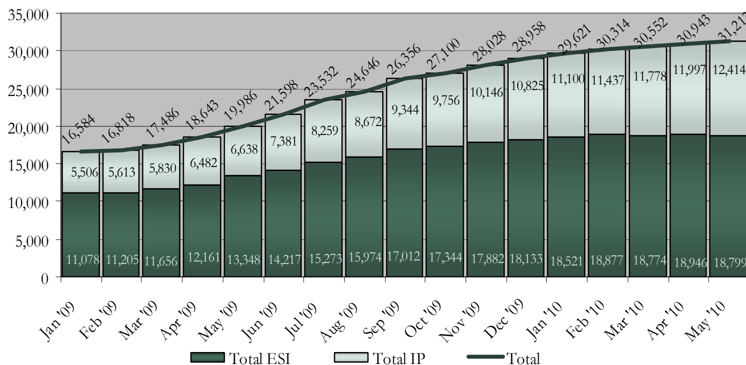
Qualifying Enrollment		Enrollment	% of Total
Employer Sponsored Insurance (ESI)	Employee	15,705	50.32%
Employer Sponsored Insurance (ESI)	Spouse	3,041	9.74%
Individual Plan (IP)	Employee	9,407	30.14%
Individual Plan (IP)	Spouse	2,828	9.06%
Student (ESI)	---	53	0.17%
Student (IP)	---	179	0.57%
Businesses	---	5,539	---
Carriers / HealthPlans	---	20 / 476	---
Primary Care Physician	---	1,005	---

Total Enrollment	**31,213**	ESI	18,799	60%
		IP	12,414	40%

Federal Poverty Level Breakdown of Total Enrollment



Total Insure Oklahoma Member Monthly Enrollment

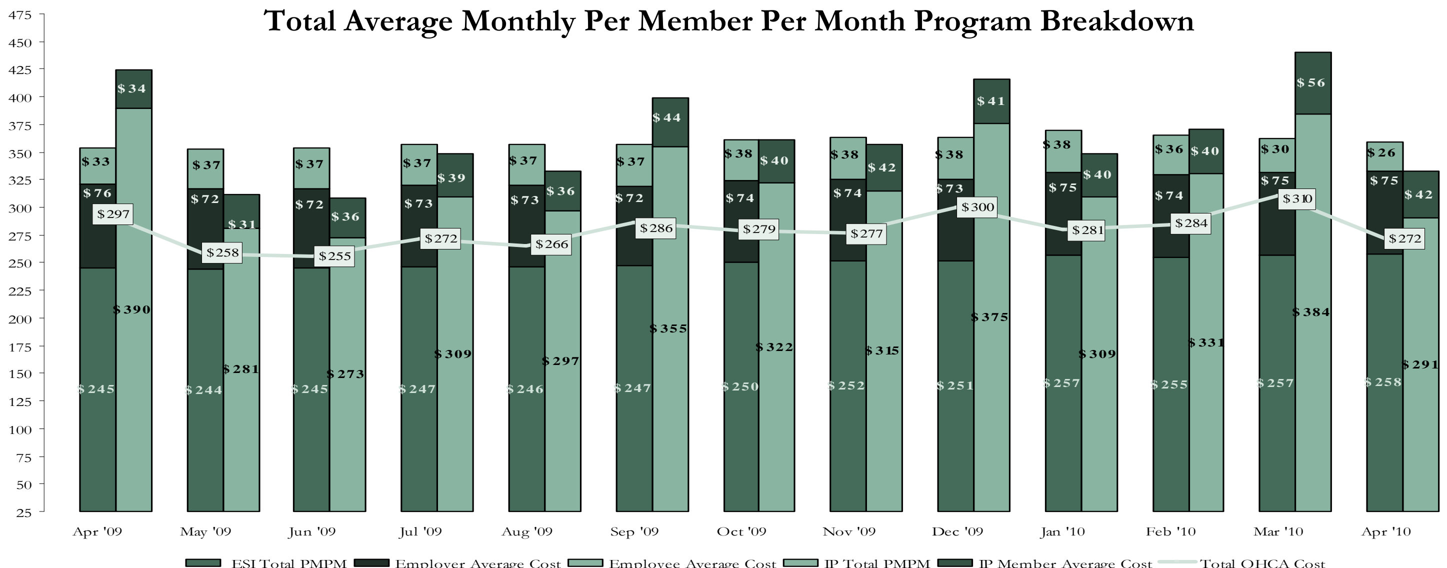


Currently Enrolled		Up from Previous Year
Businesses	5,539	35%
ESI Enrollees	18,799	61%
IP Enrollees	12,414	113%

ESI & IP Enrollee totals include Students.

Latest Monthly Marketing Statistics	
Web Hits on InsureOklahoma.org	39,089
Call Center - Calls Answered	14,290

Call Center count now includes OHCA calls.
Unable to produce Call Center Counts for April.



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.)

Insure Oklahoma

Fast Facts

May 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.

Insure Oklahoma County Activity

☆ Business Totals 5,539

◇ ESI Totals 18,799

○ IP Totals 12,414

All Counties Participating

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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5/6/2010

Employer Sponsored Insurance (ESI)

Fast Facts

May 2010

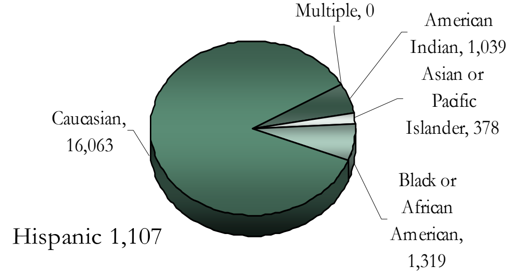
Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

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	7,638	8,067	**15,705**	326	366	**692**	894	773	**1,667**
Spouse	803	2,238	**3,041**	41	100	**141**	91	241	**332**
Student	27	26	**53**	1	0	**1**	2	1	**3**
Total	8,468	10,331	**18,799**	368	466	**834**	987	1,015	**2,002**

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

Race Breakdown of ESI Members



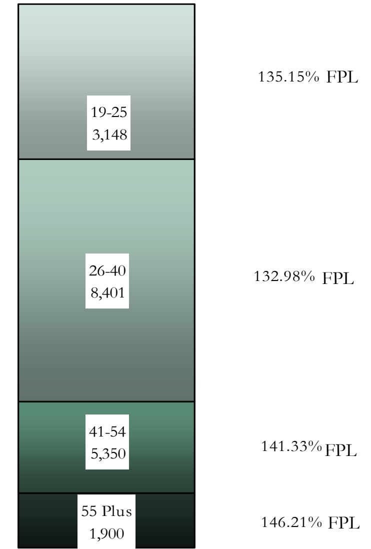
Hispanic 1,107

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	4,560	565	320	**5,445**
New	76	11	7	**94**
Total	**4,636**	**576**	**327**	**5,539**

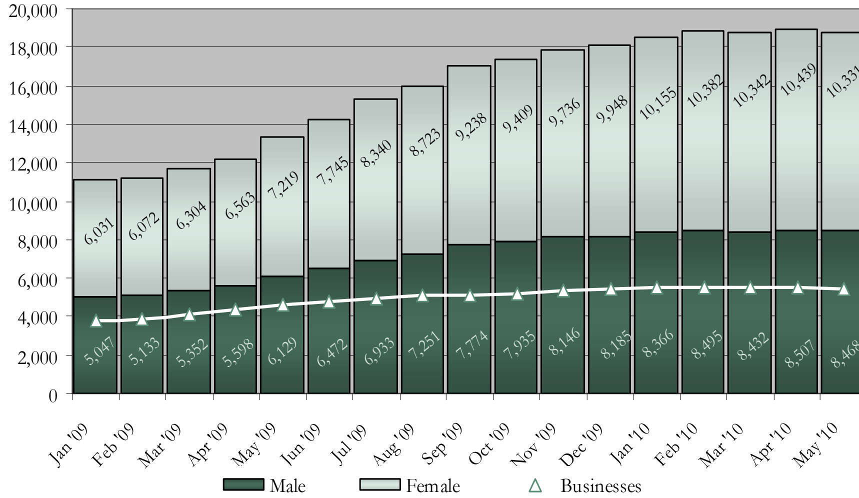
Some approved businesses may not have approved employees.

Age Breakdown with Average Federal Poverty Level of ESI Members

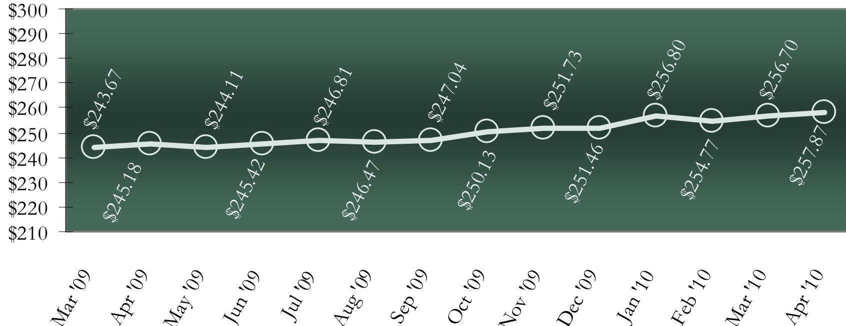


Federal Poverty Level is used to determine income qualification.

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	627	2,421	16 of 16
Region 2	373	1,063	16 of 16
Region 3	1,739	5,449	6 of 6
Region 4	1,482	4,426	5 of 5
Region 5	850	3,655	18 of 18
Region 6	468	1,785	16 of 16
Total	**5,539**	**18,799**	**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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Individual Plan (IP)

Fast Facts

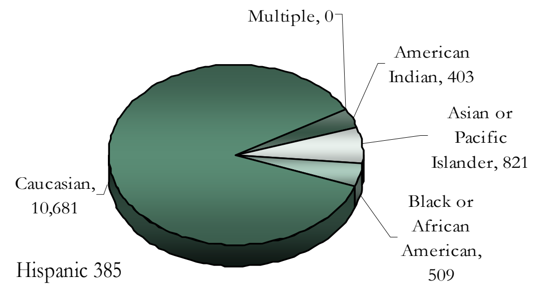
Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

May 2010

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**.

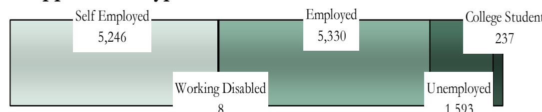
	Total Current Enrollment			Breakdown of Current Enrollment: New Enrollment this Month			Breakdown of Current Enrollment: Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	4,349	5,058	9,407	190	264	454	341	322	663
Spouse	642	2,186	2,828	31	63	94	55	172	227
Student	74	105	179	4	6	10	6	5	11
Total	5,065	7,349	12,414	221	327	558	396	494	901

Race Breakdown of IP Members



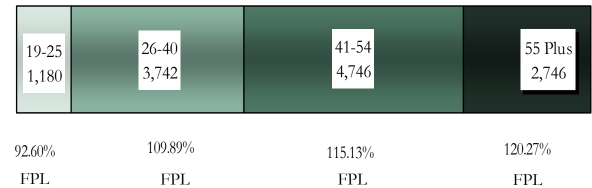
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

IP Application Type Breakdown

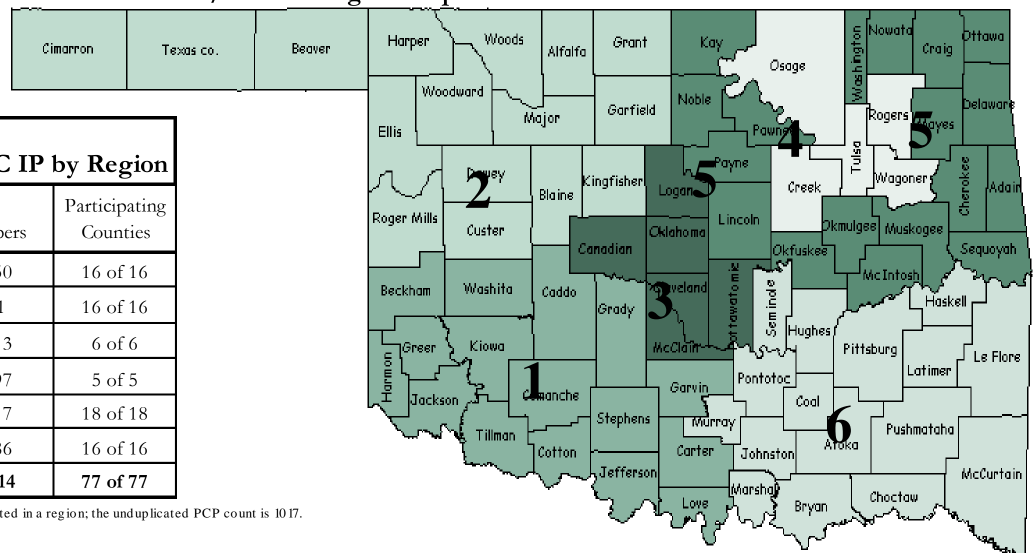


Unduplicated Counts	
IP Members SFY2010 (July 2009 - Current)	16,708
IP Members Since Program Inception March 2007	19,497
Miscellaneous	
Average IP Member Premium	$56.28
Average Federal Poverty Level of IP Members	112.54%
Federal Poverty Level is used to determine income qualification.	

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	144	15 of 16	1,950	16 of 16
Region 2	83	15 of 16	751	16 of 16
Region 3	266	6 of 6	3,813	6 of 6
Region 4	230	5 of 5	2,597	5 of 5
Region 5	149	17 of 18	1,817	18 of 18
Region 6	133	16 of 16	1,486	16 of 16
Total	**1,005**	**74 of 77**	**12,414**	**77 of 77**

PCPs maybe counted in multiple regions or out of state and not counted in a region; the unduplicated PCP count is 1017.

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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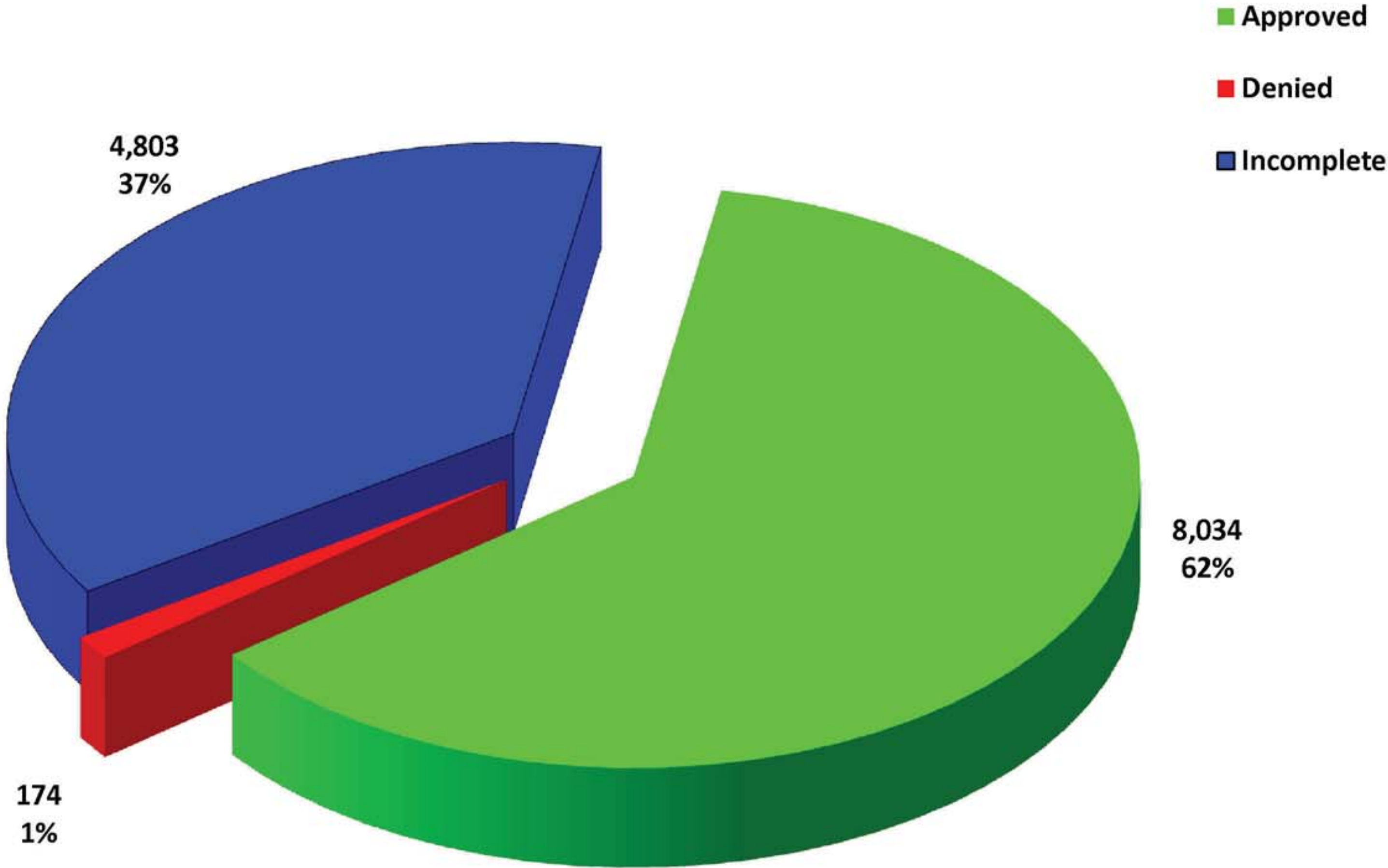
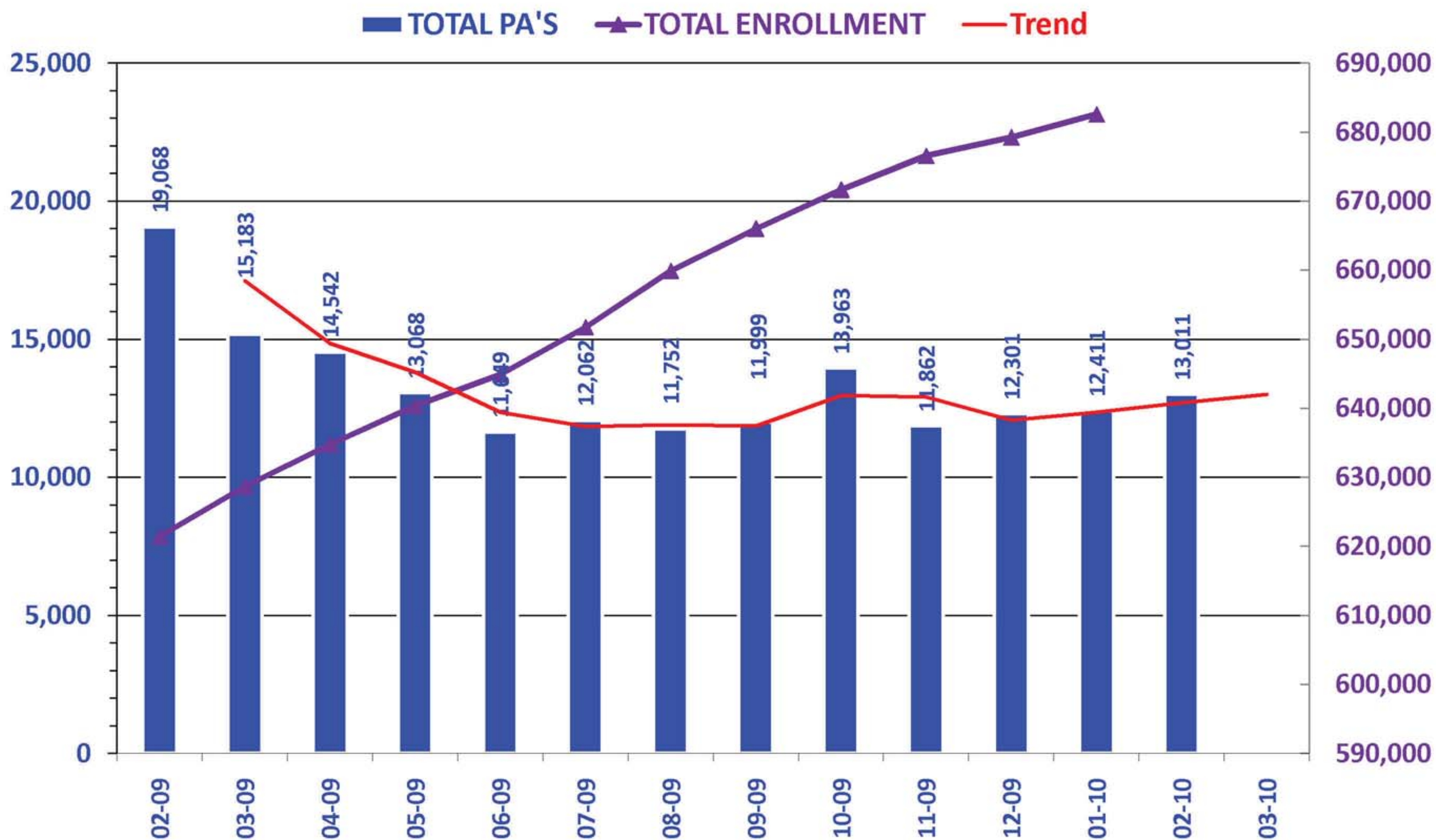
5/5/2010

PRIOR AUTHORIZATION ACTIVITY REPORT: February 2010



PA totals include overrides

PRIOR AUTHORIZATION REPORT: February 2009 – February 2010



PA totals include overrides

Prior Authorization Activity

February 2010

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort	517	270	2	245	357
Amitiza	25	9	0	16	269
Antidepressant	417	125	1	291	340
Antihistamine	323	172	0	151	286
Antihypertensives	139	53	0	86	338
Antimigraine	132	24	0	108	199
Benzodiazepines	4,577	3,985	11	581	89
Bladder Control	90	17	4	69	339
Byetta	13	2	0	11	364
Elidel/Protopic	40	23	1	16	88
ESA	156	120	2	34	56
Fibric Acid Derivatives	7	0	0	7	0
Fibromyalgia	170	60	3	107	334
Forteo	5	2	0	3	353
Glaucoma	29	6	0	23	362
Growth Hormones	44	36	3	5	155
HFA Rescue Inhalers	92	43	0	49	276
Insomnia	120	30	2	88	126
Misc Analgesics	56	10	19	27	144
Muscle Relaxant	187	72	54	61	46
Nasal Allergy	449	50	2	397	170
NSAIDS	167	39	6	122	218
Nucynta	3	2	0	1	47
Ocular Allergy	16	1	0	15	364
Ocular Antibiotics	24	7	0	17	13
Opioid Analgesic	184	85	4	95	171
Other	564	240	17	307	139
Otic Antibiotic	165	64	0	101	24
Pediculicides	77	29	2	46	17
Plavix	123	99	0	24	360
Proton Pump Inhibitors	641	98	4	539	98
Qualaquin (Quinine)	2	0	1	1	0
Singulair	690	355	1	334	276
Smoking Cessation	84	25	2	57	56
Statins	112	21	1	90	349
Stimulant	945	613	5	327	234
Symlin	2	1	0	1	364
Synagis	153	119	9	25	45
Topical Antibiotics	25	6	0	19	28
Topical Antifungals	30	7	0	23	24
Ultram ER and ODT	9	1	0	8	364
Xolair	2	1	0	1	358
Xopenex Nebs	48	25	0	23	231
Zetia (Ezetimibe)	30	23	0	7	360
Emergency PAs	0	0	0	0	
Total	**11,684**	**6,970**	**156**	**4,558**	

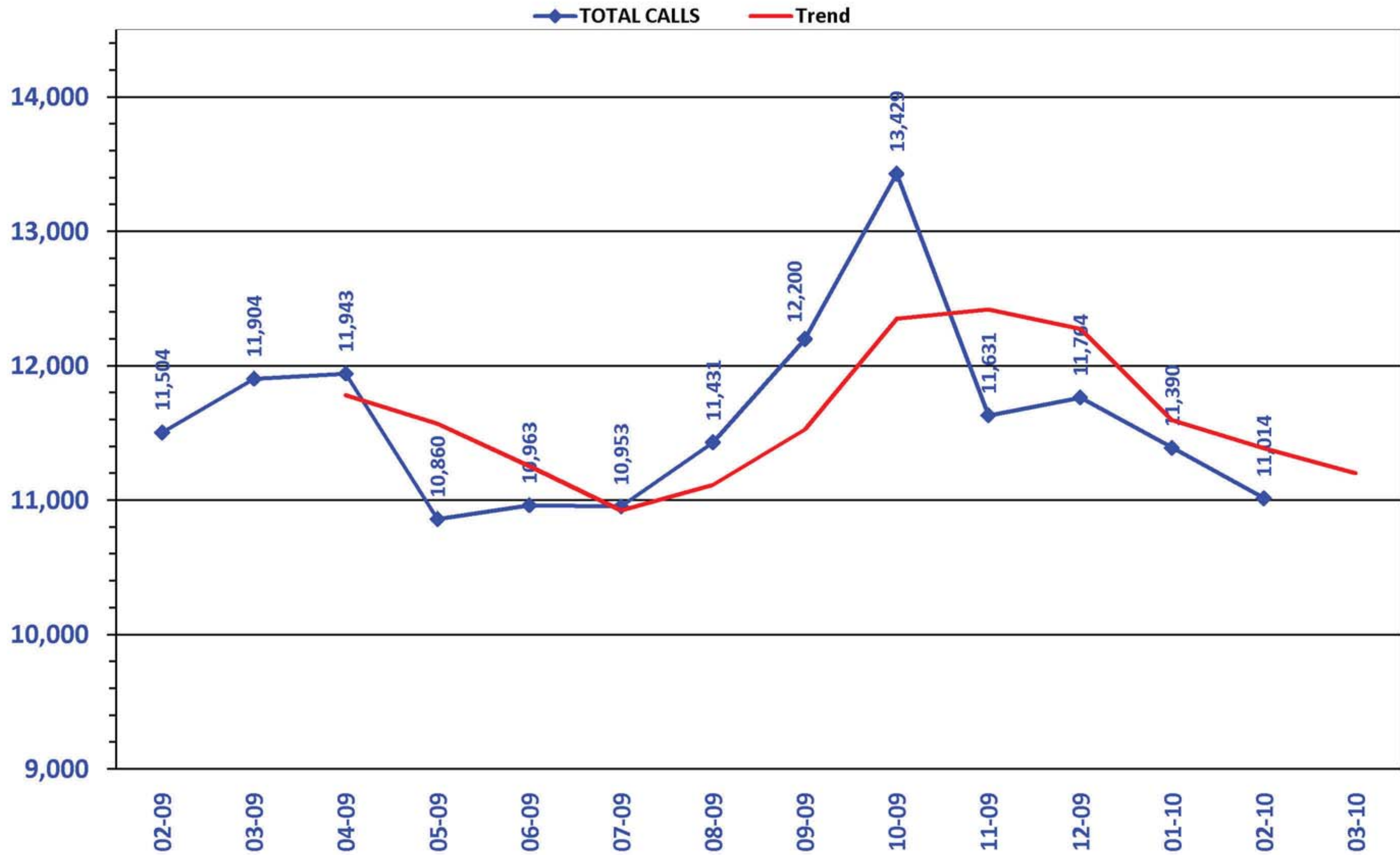
Overrides					
Brand	113	94	1	18	182
Dosage Change	454	422	5	27	17
High Dose	2	0	0	2	0
IHS - Brand	80	67	0	13	102
Ingredient Duplication	7	6	0	1	22
Lost/Broken Rx	72	67	1	4	17
Nursing Home Issue	71	62	1	8	15
Other	20	19	0	1	32
Quantity vs. Days Supply	505	325	9	171	238
Stolen	1	0	1	0	0
Wrong D.S. on Previous Rx	2	2	0	0	360
Overrides Total	**1,327**	**1,064**	**18**	**245**	
Total Regular PAs + Overrides	**13,011**	**8,034**	**174**	**4,803**	

Denial Reasons	
Lack required information to process request.	2,326
Unable to verify required trials.	1,881
Does not meet established criteria.	202
Not an FDA approved indication/diagnosis.	166
Member has active PA for requested medication.	160
Considered duplicate therapy. Member has a prior authorization for similar medication.	114
Requested dose exceeds maximum recommended FDA dose.	68
Medication not covered as pharmacy benefit.	21
Drug Not Deemed Medically Necessary	4

Duplicate Requests: 849

Changes to existing PAs: 817

CALL VOLUME MONTHLY REPORT:
February 2009 – February 2010



OHCA BOARD MEETING

APRIL 08, 2010 OHCA BOARD MEETING

OHCA REQUEST BILLS:

- SB 1349 – Obesity Treatment Pilot Program for Medicaid (Failed 4/8/10 deadline)
- SB 1836 - Health Information Infrastructure Advisory Board to Assist OHCA In Developing Electronic Health Record Incentive Payments

After the April 22nd committee deadline, and as of noon, Wednesday, May 5, 2010, the Oklahoma Legislature is currently tracking a total of 1,106 active bills. OHCA is currently tracking 63 bills. They are broken down as follows:

- OHCA Request 01
- Direct Impact 21
- Agency Interest 07
- Appropriations 10
- Employee Interest 09
- Carry Over 04
- Governor Signed 11

April 29, 2010 was the internal House deadline for rejecting Senate Amendments to House measures and requesting conference. Tuesday, May 4th was the internal House deadline for members to request House conferees for House bills. Monday, May 10th will be the deadline for filing first Conference Committee Reports other than CCRS referred to the General Conference Committee on Appropriations (GCCA).

Sine Die adjournment is set for May 28th.

7.b-1 CHAPTER 45. INSURE OKLAHOMA~~/OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE~~

Subchapter 1. General Provisions
OAC 317:45-1-1 through 317:45-1-4. [AMENDED]
Subchapter 3. Insure Oklahoma~~/O-Epic~~ Carriers
OAC 317:45-3-1. [AMENDED]
OAC 317:45-3-2. [AMENDED]
Subchapter 5. Insure Oklahoma~~/O-Epic~~ Qualified Health Plans
OAC 317:45-5-1. [AMENDED]
OAC 317:45-5-2. [AMENDED]
Subchapter 7. Insure Oklahoma~~/O-Epic~~ ESI Employer Eligibility
OAC 317:45-7-1 through 317:45-7-8. [AMENDED]
Subchapter 9. Insure Oklahoma~~/O-Epic~~ ESI Employee Eligibility
OAC 317:45-9-1 through 317:45-9-4. [AMENDED]
OAC 317:45-9-6 through 317:45-9-8. [AMENDED]
Subchapter 11. Insure Oklahoma~~/O-Epic~~ IP
Part 1. Individual Plan Providers
OAC 317:45-11-1. [AMENDED]
OAC 317:45-11-2. [AMENDED]
Part 3. Insure Oklahoma~~/O-Epic~~ IP Member Health Care Benefits
OAC 317:45-11-10. [AMENDED]
OAC 317:45-11-11. [AMENDED]
OAC 317:45-11-12. [NEW]
OAC 317:45-11-13. [NEW]
Part 5. Insure Oklahoma~~/O-Epic~~ IP Member Eligibility
OAC 317:45-11-20 through 317:45-11-28. [AMENDED]
(Reference APA WF # 10-08)

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 Insure Oklahoma program to comply with Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes. Rules are revised to expand the Insure Oklahoma ESI and IP programs. Expansions include incorporating Oklahoma children through 18 years of age whose household income is from 185 up to and including 300 percent of the Federal Poverty Level. In addition, revisions will expand the current Insure Oklahoma ESI and IP program guidelines to include employees and working adults whose family income does not exceed 250 percent of the Federal Poverty Level. This expansion to the Insure Oklahoma program will help increase access to health care for Oklahomans, thereby reducing the amount of uncompensated care provided by health care providers.

ANALYSIS: Rules are revised to expand the Insure Oklahoma ESI and IP programs. Expansions include incorporating Oklahoma children through 18 years of age whose household income is from 185 up to and including 300 percent of the Federal Poverty Level. The inclusion of children into the program will be phased in over a period of time as determined by the OHCA. In addition, revisions will expand the current Insure Oklahoma ESI and IP program guidelines to include employees and working adults whose family income does not exceed 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the OHCA. These revisions comply with Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes. This expansion to the

Insure Oklahoma program will help increase access to health care for Oklahomans thereby reducing the amount of uncompensated care provided by health care providers.

BUDGET IMPACT: State dollars used to fund the expansion of the Insure Oklahoma Program will be provided from the unused funds from the HEEIA Revolving Fund, in an amount not to exceed $8,000,000.00.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 25, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: July 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; Sections 1009.2 and 1010.1 of Title 56 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:
Revise Insure Oklahoma rules to expand the Program to include Oklahoma children through 18 years of age whose household income is from 185 up to and including 300 percent of the Federal Poverty Level; and expand the current Insure Oklahoma ESI and IP program guidelines to include employees and working adults whose family income does not exceed 250 percent of the Federal Poverty Level.

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-1. Purpose and general program provisions

The purpose of this Chapter is to provide rules, in compliance with all applicable federal and state regulations, for the Insure Oklahoma~~/Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC)~~ program that establishes access to affordable health coverage for low-income working adults, ~~their spouses~~ their dependents, and qualified college students. ~~The Oklahoma Health Care Authority (OHCA) contracts with a Third Party Administrator (TPA) for administration of the program.~~

317:45-1-2. Program limitations

(a) The Insure Oklahoma~~/O-EPIC~~ program is contingent upon sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(1) All monies accruing to the credit of the fund are budgeted and expended by the OHCA to implement the program.

(2) The program is funded through a portion of monthly proceeds from the Tobacco Tax, ~~O.S.S.~~ Okla. Stat. '68-302-5 et seq., collected and dispersed through the HEEIA revolving fund, pursuant to Title 68,

Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes.

(3) The program is limited in scope such that available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the available funding may be exceeded, OHCA must take action to ensure the Insure Oklahoma~~/O-EPIC~~ program continues to operate within its fiscal capacity.

(A) Insure Oklahoma~~/O-EPIC~~ may limit eligibility based on:

(i) the federally-approved ~~capacity of the Insure Oklahoma/O-EPIC services for the~~ Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver; ~~and~~

(ii) Tobacco Tax collections~~.~~; and

(iii) the State Child Health Plan for the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

(B) The Insure Oklahoma~~/O-EPIC~~ program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list.

(i) Applicants, not previously enrolled and participating in the program, submitting new applications for the Insure Oklahoma~~/O-EPIC~~ program are placed on a waiting list. ~~These applications are date and time stamped when received by the TPA.~~ Applications, with the exception of college students, are identified by region and Insure Oklahoma~~/O-EPIC~~ program. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. Insure Oklahoma~~/O-EPIC~~ program size is determined by OHCA and may be periodically adjusted.

(ii) The waiting list utilizes a "first in - first out" method of selecting eligible applicants by region and program.

(iii) When an applicant is determined eligible and moves from the waiting list to active participation, the applicant must submit a new application.

(iv) Enrolled applicants who are currently participating in the program are not subject to the waiting list.

(v) For approved employers, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate during the employer's current eligibility period.

(vi) For approved employers, if the employer has an employee who has a ~~Qualifying Event~~ qualifying event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the ~~Qualifying Event~~ qualifying event.

(b) College ~~students-~~ student eligibility and participation in the Insure Oklahoma~~/O-EPIC~~ program is contingent upon sufficient funding from the Oklahoma legislature. This funding is separate from the funding described in subsection (a) of this Section.

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

(A) an insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs);
(B) a Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;
(C) a domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36; or
(D) any entity organized pursuant to the Interlocal Cooperation Act, Section 1001 et seq. of Title 74 of the Oklahoma Statutes as authorized by Title 36 Section 607.1 of the Oklahoma Statutes and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"Child Care Center" means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in OAC 340:110-3-1 through OAC 340:110-3-33.3.

"College Student" means an Oklahoma resident between the age of 19 through 22 that is a full-time student at an Oklahoma accredited University or College.

"Dependent" means the spouse of the approved applicant and/or child under 19 years of age or his or her child 19 years through 22 years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"Eligibility period" means the period of eligibility extending from an approval date to an end date.

"Employee" means a person who works for an employer in exchange for earned income. This includes the owners of a business.

"Employer" means the business entity that pays earned income to employees.

"Employer Sponsored Insurance" means the program that provides premium assistance to qualified businesses for approved applicants.

"EOB" means an Explanation of Benefits.

"Explanation of Benefit" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma~~/O-EPIC~~ member.

"Full-time Employment" means a normal work week of 24 or more hours.

"Full-time Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

"Gross Household Income" or "Annual Gross Household Income" means the countable income (earned or unearned) that is computed pursuant to OHCA's waiver and/or state plan using rules found in OAC 317:35.

"Individual Plan" means the safety net program for those qualified individuals who do not have access to Insure Oklahoma~~/O-EPIC~~ ESI.

"Insure Oklahoma~~/O-EPIC~~" means a health plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of health plan coverage for eligible populations.

"Insure Oklahoma~~/O-EPIC~~ IP" means the Individual Plan program.

"Insure Oklahoma~~/O-EPIC~~ ESI" means the Employer Sponsored Insurance program.

"Member" means an individual enrolled in the Insure Oklahoma~~/O-EPIC~~ ESI or IP program.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCP" means Primary Care Provider.

"PEO" or "Professional Employer Organization" means any person engaged in the business of providing professional employer services. A person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et.seq.

"Primary Care Provider" means a provider under contract ~~to~~ with the Oklahoma Health Care Authority to provide primary care services, including all ~~medically-necessary~~ medically necessary referrals.

"Premium" means a monthly payment to a carrier for health plan coverage.

~~**"QHP"** means Qualified Health Plan.~~

"Qualified Health Plan" means a health plan that has been approved by the OHCA for participation in the Insure Oklahoma~~/O-EPIC~~ program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority ~~or its designee~~.

~~**"TPA"** means the Third Party Administrator.~~

~~**"Third Party Administrator"** means the entity contracted by the State to provide the administration of the Insure Oklahoma/Oklahoma Employer and Employee Partnership for Insurance Coverage program.~~

317:45-1-4. Reimbursement for out-of-pocket medical expenses

(a) ~~Members are responsible for all out-of-pocket expenses. Out-of-pocket expenses for services covered by the health plan, as defined by the health plan's benefit summary and policies, that exceed five percent of the employee's gross annual household income during the current eligibility period may be reimbursable.~~ Out-of-pocket medical expenses for all approved and eligible members (and/or their approved and eligible dependents) will be limited to 5 percent of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket medical expenses in excess of the 5 percent annual gross household income. A medical expense must be for an allowed and covered service by a qualified health plan to be eligible for reimbursement. For the purpose of this Section, an allowed and covered service is defined as an in-network service covered in accordance with a qualified health plan's benefit summary and policies.

(b) ~~The member must submit a reimbursement claim form with appropriate documentation to the TPA. Information may be submitted at any time but no later than 90 days after the close of their eligibility period to be considered for reimbursement. Appropriate supporting documentation includes an original EOB or paid receipt if no EOB is issued. Both EOB and paid receipts must include required information listed in OAC 317:45-5-1(c)(1)-(6). Reimbursement for out-of-pocket medical expenses is made for the amount indicated as the member's responsibility on the EOB or receipt reflecting the amount paid for medical expenses. Appropriate supporting documentation for prescribed prescriptions must be an original receipt and include information about the pharmacy at which the drug was purchased, the name of the drug dispensed, the quantity dispensed, the prescription number, the name of the person the drug is for, the date the drug was dispensed and the total amount paid.~~ For all eligible medical expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket medical expense. The required documentation must be submitted no later than 90 days after the close of the member's eligibility period. The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket medical expenses.

~~(c) Reimbursement for qualified medical expenses is subject to a fixed cap amount. The fixed cap for reimbursement is established annually and is calculated using local and national data concerning individual out-of-pocket health care expenses. The objective of the fixed cap is to set the amount high enough such that, in the great majority of households, all of the costs above the five percent threshold would be absorbed.~~

SUBCHAPTER 3. INSURE OKLAHOMA~~/O-EPIC~~ CARRIERS

317:45-3-1. Carrier eligibility

Carriers must be able to submit all required and requested information and documentation to OHCA for each health plan to be considered for qualification. Carriers must be able to supply specific claim payment scenarios as requested by OHCA. Carriers must also provide the name, address, telephone number, and, if available, email address of a contact individual who is able to verify employer enrollment status in a ~~QHP~~ qualified health plan.

317:45-3-2. Audits

Carriers are subject to audits related to health plan qualifications. These audits may be conducted periodically to determine if ~~QHPs continue~~ each qualified health plan continues to meet all requirements as defined in OAC 317:45-5-1.

SUBCHAPTER 5. INSURE OKLAHOMA~~/O-EPIC~~ QUALIFIED HEALTH PLANS

317:45-5-1. Qualified Health Plan requirements

(a) Participating ~~QHPs~~ qualified health plans must offer, at a minimum, benefits that include:

(1) hospital services;
(2) physician services;
(3) clinical laboratory and radiology;

(4) pharmacy; ~~and~~
(5) office visits~~.~~;
(6) well baby/well child exams;
(7) age appropriate immunizations as required by law; and
(8) emergency services as required by law.

(b) The health plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. All health plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the health plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

(1) An annual in-network out-of-pocket maximum cannot exceed ~~an amount that is established by OHCA. This amount includes any non-pharmacy, annual deductible amount for in-network services~~ $3,000 per individual, excluding pharmacy deductibles.
(2) Office visits cannot require a co-payment exceeding $50 per visit.
(3) Annual in-network pharmacy deductibles cannot exceed $500 per individual.

(c) ~~QHPs may~~ Qualified health plans will provide an EOB, an expense summary, or required documentation for paid ~~or~~ and/or denied claims subject to member co-insurance or member deductible calculations. ~~If an EOB is provided it~~ The required documentation must contain, at a minimum, the:

(1) provider's name;
(2) patient's name;
(3) date(s) of service;
(4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
(5) reason code(s) and description(s) for any denied service(s); and
(6) amount due and/or paid from the patient or responsible party.

317:45-5-2. Closure criteria for health plans

Eligibility for the carrier's health plans ends when:

(1) changes are made to the design or benefits of the ~~QHP~~ health plan such that it no longer meets the requirements ~~for QHPs~~ to be considered a qualified health plan. Carriers are required to report to OHCA any changes in health plans potentially affecting ~~its~~ their qualification for participation in the program not less than 90 days prior to the effective date of such change(s).
(2) the carrier no longer meets the definition set forth in OAC 317:45-1-3.
(3) the health plan is no longer an available product in the Oklahoma market.
(4) the health plan fails to meet or comply with all requirements for a ~~QHP~~ qualified health plan as defined in OAC 317:45-5-1.

SUBCHAPTER 7. INSURE OKLAHOMA~~/O-EPIC~~ ESI EMPLOYER ELIGIBILITY

317:45-7-1. Employer application and eligibility requirements for Insure Oklahoma~~/O-EPIC~~ ESI

(a) In order for an employer to be eligible to participate in the Insure Oklahoma~~/O-EPIC~~ program the employer must:

(1) have no more than a total of 250 employees on its payroll. The increase in the number of employees from 50 to 250 will be phased in over a period of time as determined by the Oklahoma Health Care

Authority. The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC) ~~and that is in compliance with all requirements of the OESC~~. Employers may provide additional documentation confirming terminated employees that will be excluded from the OESC employee count. If the employer is exempt from filing an OES-3 form or is contracted with a PEO or is a Child Care Center, in accordance with OHCA rules, this determination is based on appropriate supporting documentation, such as the W-2 Summary Wage and Tax form to verify employee count. Employers must be in compliance with all OESC requirements to be eligible for the program. As requested by the OHCA, employers that do not file with the OESC must submit documentation that proves compliance with state law;

(2) have a business that is physically located in Oklahoma;

(3) be currently offering, or at the contracting stage to offer a ~~QHP~~ qualified health plan. The ~~QHP~~ qualified health plan coverage must begin on the first day of the month and continue through the last day of the month;

(4) offer ~~QHP~~ qualified health plan coverage to employees; and

(5) contribute a minimum 25 percent of the eligible employee monthly health plan premium or an equivalent 40 percent of premiums for covered dependent children~~;~~.

(b) An employer who meets all of the requirements listed ~~in subsection (a) of this Section must complete and submit an employer enrollment packet to the TPA~~ in OAC 317:45-7-1(a) must complete and submit the OHCA required forms and application to be considered for participation in the program.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) ~~The employer must notify the TPA, within 5 working days from occurrence, of any Insure Oklahoma/O-EPIC employee's termination or resignation.~~ It is the employer's responsibility to notify the OHCA of any changes that might impact eligibility in the program. Employers must notify the OHCA of any participating employee terminations, resignations, or new hires within five working days of the occurrence.

317:45-7-2. Employer eligibility determination

Eligibility for employers is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-7-1. An employer determined eligible for Insure Oklahoma~~/O-EPIC~~ is approved for up to a 12 month period. The eligibility period begins on the first day of the month following the date of approval. The eligibility period ends the last day of the 12th month. The eligibility period will renew automatically unless the employer's eligibility has been closed (refer to OAC 317:45-7-8). ~~The TPA notifies the employer of the eligibility decision for employer and employees.~~ Employers will be notified of their eligibility decision.

317:45-7-3. Employer cost sharing

Employers are responsible for a portion of the eligible employee's monthly health plan premium as defined in OAC 317:45-7-1. ~~Employers are not required to contribute to an eligible dependent's coverage.~~

317:45-7-4. Qualifying Event

Employers must allow an employee to enroll or change coverage following a ~~Qualifying Event~~ qualifying event. The employer ~~files form~~

~~4, Small Business Employer Change Form, with the TPA for that~~ must submit the required form for each employee experiencing the ~~Qualifying Event~~ qualifying event.

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit all pages of the current health plan invoice ~~or other approved documentation to the TPA~~.

317:45-7-6. Credits and adjustments

When an overpayment ~~has occurred~~ occurs, the employer must immediately ~~refund~~ report the ~~TPA, by check, to the attention of the Finance Division~~ erroneous payment. ~~The TPA system has the capability of automatic credits and debits. When an erroneous payment occurs, that results in an overpayment, an automatic recoupment is made to the employer's account against monies owed to the employer on behalf of their employee(s).~~ When such an overpayment(s) occurs, an automatic recoupment is made to the employer's account against future reimbursements.

317:45-7-7. Audits

Employers are subject to audits related to program eligibility ~~status~~ requirements found at OAC 317:45-7-1 and subsidy payments. Eligibility may be revoked at any time if inconsistencies are found. Any monies paid in error are subject to recoupment.

317:45-7-8. Closure

Eligibility provided under the Insure Oklahoma~~/O-EPIC~~ ESI program may end during the eligibility period when:

(1) the employer no longer meets the eligibility requirements in OAC 317:45-7-1;

(2) the employer fails to pay premiums to the carrier;

(3) the employer fails to provide an invoice verifying the monthly health plan premium has been paid; or

(4) an audit indicates a discrepancy that makes the employer ineligible.

SUBCHAPTER 9. INSURE OKLAHOMA~~/O-EPIC~~ ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) ~~Employee applications are submitted to the TPA~~ Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.

(b) The eligibility determination ~~is~~ will be processed within 30 days from the date the application is received ~~by the TPA~~. The employee ~~is~~ will be notified in writing of the eligibility decision.

(c) All eligible employees described in this ~~Section are enrolled in their Employer's QHP~~ section must be enrolled in their employer's qualified health plan. Eligible employees must:

(1) have ~~a countable~~ an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level (FPL). The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member;

(2) be a US citizen or alien as described in OAC 317:35-5-25;

(3) be Oklahoma residents;
(4) provide social security number for all household members;
(5) not be receiving benefits from ~~SoonerCare/Medicare~~ SoonerCare or Medicare;
(6) be employed with a qualified employer at a business location in Oklahoma;
(7) be age 19 through age 64 or an emancipated minor;
(8) be eligible for enrollment in the employer's ~~QHP~~ qualified health plan;
(9) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
(10) select one of the ~~QHPs~~ qualified health plans the employer is offering.

(d) An employee's dependents are eligible when:
(1) the employer's health plan includes coverage for dependents;
(2) the employee is eligible;
(3) if employed, the spouse may not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
(4) the dependents are enrolled in the same health plan as the employee.

(e) If an employee or their dependents are eligible for multiple ~~QHPs~~ qualified health plans, each may receive a subsidy under only one health plan.

(f) Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA).

(g) Dependent children in families whose annual gross household income is from 185 up to and including 300 percent of the Federal Poverty Level may be eligible. The inclusion of children into the Insure Oklahoma program will be phased in over a period of time as determined by the OHCA. No other deductions or disregards apply.
(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.
(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Oklahoma State Employee Health Insurance Plan.
(3) Children who already have coverage through another source must undergo, or be excepted from, a six month uninsured waiting period prior to becoming eligible for Insure Oklahoma. Exceptions to the waiting period may include:
(A) the cost of covering the family under the ESI plan meets or exceeds ten percent of the annual gross household income. The cost of coverage includes premiums, deductibles, co-insurance, and co-payments;
(B) loss of employment by a parent which made coverage available;
(C) affordable ESI is not available; “affordable” coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); or
(D) loss of medical benefits under SoonerCare.

317:45-9-2. Employee eligibility period

(a) Employee eligibility is contingent upon the employer's program eligibility.

(b) The employee's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-9-1.

(c) If the employee is determined eligible, he/she is approved for a period not greater than 12 months. ~~The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period.~~

(d) The employee's eligibility period begins on the first day of the month following the date of approval.

317:45-9-3. Qualifying Event

~~(a) Employees are allowed to apply following a Qualifying Event.~~

~~(b) An employee's dependents may become eligible for coverage and are allowed to apply following a Qualifying Event.~~

Employees and/or an employee's dependents may apply for the ESI program following a qualifying event.

317:45-9-4. Employee cost sharing

Employees are responsible for up to ~~15%~~ 15 percent of their health plan premium. The employees are also responsible for up to ~~15%~~ 15 percent of their dependent's health plan premium if the dependent is included in the program. The combined portion of the employee's cost sharing for health plan premiums cannot exceed three percent of his/her annual gross ~~annual~~ household income computed monthly.

317:45-9-6. Audits

Individuals participating in the Insure Oklahoma~~/O EPIC~~ program are subject to audits related to their eligibility, subsidy payments, and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-9-7. Closure

(a) Employer and employee eligibility are tied together. If the employer is no longer eligible, then the associated employees enrolled under that employer are also ineligible. Employees are mailed a notice 10 days prior to closure of eligibility.

(b) The employee's certification period may be terminated when:

(1) termination of employment, either voluntary or involuntary, occurs;

(2) the employee moves out-of-state;

(3) the covered employee dies;

(4) the employer ends its contract with the ~~QHP~~ qualified health plan;

(5) the employer's eligibility ends;

(6) an audit indicates a discrepancy that makes the employee or employer ineligible;

(7) the employer is terminated from the program;

(8) the employer fails to pay the premium;

(9) the ~~QHP~~ qualified health plan or carrier ~~is no longer qualified~~ no longer meets the requirements set forth in this Chapter;

(10) the employee becomes eligible for ~~Medicaid/Medicare~~ SoonerCare or Medicare;

(11) the employee or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility;
(12) the employee is no longer listed as a covered person on the employer's health plan invoice; or
(13) the employee requests closure.

317:45-9-8. Appeals
(a) Employee appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.
(b) ~~Employee appeals regarding out-of-pocket expenses are made to the TPA. If the employee disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final~~ Employee appeals regarding out-of-pocket medical expense reimbursements may be made to the OHCA. The OHCA may request documentation to support the out-of-pocket appeal. The decision of the OHCA is final.

SUBCHAPTER 11. INSURE OKLAHOMA~~/O-EPIC~~ IP
PART 1. INDIVIDUAL PLAN PROVIDERS

317:45-11-1. Insure Oklahoma~~/O-EPIC~~ Individual Plan providers
Insure Oklahoma~~/O-EPIC~~ Individual Plan (IP) providers must comply with existing SoonerCare rules found at OAC 317:25 and OAC 317:30. In order to receive reimbursement, the IP provider:
(1) must enter into a SoonerCare contract; and
(2) must complete Insure Oklahoma~~/O-EPIC~~ IP addendum if provider wants to provide primary care services as a PCP.

317:45-11-2. Insure Oklahoma~~/O-EPIC~~ IP provider payments
Payment for covered benefits rendered to Insure Oklahoma~~/O-EPIC~~ IP members~~, as shown in OAC 317:45-11-10 and not listed as a non-covered service in OAC 317:45-11-11,~~ is made to contracted Insure Oklahoma~~/O-EPIC~~ IP healthcare providers for medical and surgical services within the scope of OHCA's medical programs, provided the services are medically necessary as defined in OAC 317:30-3-1(f).
(1) Coverage of certain services requires prior authorization ~~as shown in OAC 317:45-11-10~~ and may be based on a determination made by a medical consultant in individual circumstances;
(2) The decision to charge a ~~copayment~~ co-payment for a missed visit is at the provider's discretion;
(3) The provider may collect the member's ~~co-pay~~ co-payment in addition to the SoonerCare reimbursement for services provided; and
(4) The provider may refuse to see members based on their inability to pay their ~~co-pay~~ co-payment.

PART 3. INSURE OKLAHOMA~~/O-EPIC~~ IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma~~/O-EPIC~~ IP adult benefits
(a) All IP adult benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section. The scope of IP adult benefits described in this Section ~~are~~ is subject to specific non-covered services listed in OAC 317:45-11-11.
(b) A PCP referral is required to see any other provider with the exception of the following services:
(1) behavioral health services;
(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;

(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;
(4) women's routine and preventive health care services;
(5) emergency medical condition as defined in OAC 317:30-3-1; and
(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) IP covered adult benefits for in-network services, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000. Dependent children coverage is found at OAC 317:45-11-12. Children are not held to the maximum lifetime benefit. Coverage includes:

(1) Anesthesia / Anesthesiologist Standby. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).
(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
(3) Chelation Therapy. Covered for heavy metal poisoning only.
(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): $0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); $25 co-pay per scan.
(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.
(6) Inpatient Hospital Benefits. Covered in accordance with OAC 317:30-5-41, 317:30-5-47 and 317:30-5-95; $50 co-pay per admission.
(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a $10 co-pay. This visit counts as an office visit.
(8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits; $10 co-pay per visit.
(9) Outpatient Hospital/Facility Services.
(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; $25 co-pay per visit.
(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; $10 co-pay per visit.
(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year; $10 co-pay per visit.
(10) Maternity (Obstetric). Covered in accordance with OAC 317:30-5-22. Nursery care paid separately under eligible child; $50 inpatient hospital co-pay.

(11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20; $0 co-pay.
(12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901; $0 co-pay.
(13) Immunizations. Covered in accordance with OAC 317:30-5-2.
(14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.
(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; $0 co-pay.
(16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital $50 or Outpatient Hospital/Facility; $25 co-pay applies.
(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1; $50 co-pay per admission.
(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient).

(A) Agency services. Covered in accordance with OAC 317:30-5-241 and OAC 317:30-5-596; $10 co-pay per visit.

(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient ~~Mental~~ Behavioral Health Services and Outpatient Substance Abuse Treatment:

(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(ii) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (I) through (VI) below. The exemptions from licensure under ~~59 §1353(4) and (5)~~ 59 Okla. Stat. §1353(4) and (5), 59 §1903(C) and (D), 59 §1925.3(B) and (C), and 59 §1932(C) and (D) do not apply to Outpatient Behavioral Health Services.

(I) Psychology,
(II) Social Work (clinical specialty only),
(III) Professional Counselor,
(IV) Marriage and Family Therapist,
(V) Behavioral Practitioner, or
(VI) Alcohol and Drug Counselor.

(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.

(iv) A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.

(vi) LBHP services require prior authorization and are limited to 8 therapy services per month per member and 8 testing units per year per member; $10 co-pay per visit.

(19) Durable Medical Equipment and Supplies. Covered in accordance with OAC 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a $15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; $5 co-pay for durable/non-durable supplies and $25 co-pay for durable medical equipment.
(20) Diabetic Supplies. Covered in accordance with OAC 317:30-5-211.15; not subject to $15,000 annual DME limit; $5 co-pay per prescription.
(21) Oxygen. Covered in accordance with OAC 317:30-5-211.11 through 317:30-5-211.12; not subject to $15,000 annual DME limit; $5 co-pay per month.
(22) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; $5/$10 co-pay per prescription.
(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with OAC 317:30-5-72.1; $5/$10 co-pay per product.
(24) Nutrition Services. Covered in accordance with OAC 317:30-5-1076; $10 co-pay per visit.
(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with OAC 317:30-5-211.13; $25 co-pay per prosthesis.
(26) Surgery. Covered in accordance with OAC 317:30-5-8; $50 co-pay per inpatient admission and $25 co-pay per outpatient visit.
(27) Home Dialysis. Covered in accordance with OAC 317:30-5-211.13; not subject to $15,000 annual DME limit; $0 co-pay.
(28) Parenteral Therapy. Covered in accordance with OAC 317:30-5-211.14; not subject to $15,000 annual DME limit; $25 co-pay per month.
(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57; $0 co-pay.
(30) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with OAC 317:30-5-211.15 and 317:30-5-42.16(b)(3).
(31) Ultraviolet Treatment-Actinotherapy.
(32) Fundus photography.
(33) Perinatal dental care for pregnant women. Covered in accordance with OAC 317:30-5-696; $0 co-pay.

317:45-11-11. Insure Oklahoma~~/O-EPIC~~ IP adult non-covered services

Certain health care services are not covered in the Insure Oklahoma~~/O-EPIC~~ IP adult benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:

(1) services ~~that the member's PCP or Insure Oklahoma/O-EPIC does not consider~~ not considered medically necessary;
(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
(3) organ and tissue transplant services;
(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
(5) procedures, services and supplies related to sex transformation;

(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in OAC 317:30-5-696;
(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
(12) physical medicine including chiropractic~~, acupuncture and osteopathic manipulation~~ and acupuncture therapy;
(13) hearing services;
(14) transportation [~~emergent~~ emergency or ~~non-emergent~~ non-emergency (air or ground)];
(15) rehabilitation (inpatient);
(16) cardiac rehabilitation;
(17) allergy testing and treatment;
(18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
(19) hospice regardless of location;
(20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(21) genetic counseling;
(22) fertility evaluation/treatment/and services;
(23) sterilization reversal;
(24) Christian Science Nurse;
(25) Christian Science Practitioner;
(26) skilled nursing facility;
(27) long-term care;
(28) stand by services;
(29) thermograms;
(30) abortions (for exceptions, refer to OAC 317:30-5-6);
(31) services of a Lactation Consultant;
(32) services of a Maternal and Infant Health Licensed Clinical Social Worker; and
(33) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1.

317:45-11-12. Insure Oklahoma IP children benefits

(a) IP covered child benefits for in-network services, limits, and applicable co-payments are listed in this Subsection. All IP benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section. All services provided must be medically necessary as defined in OAC 317:30-3-1(f). The scope of IP child benefits described in this Section is subject to specific non-covered services listed in OAC 317:45-11-13. Dependent children are not held to the maximum lifetime benefit of $1,000,000. Coverage includes:
(1) Ambulance services. Covered as medically necessary; $50 co-pay per occurrence; waived if admitted.
(2) Blood and blood products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
(3) Chelation therapy. Covered for heavy metal poisoning only.
(4) Chemotherapy and radiation therapy. Covered as medically necessary; $10 co-pay per visit.

(5) Clinic services including renal dialysis services. Covered as medically necessary; $0 co-pay for dialysis services; $10 co-pay per office visit.
(6) Diabetic supplies. One glucometer, one spring-loaded lancet device, three replacement batteries per year - 100 glucose strips and lancets per month; not included in DME $15,000 max/year; $5 co-pay per billable service. Additional supplies require prior authorization.
(7) Diagnostic X-ray services. Covered as medically necessary; $25 co-pay per scan for MRI, MRA, PET, CAT scans only.
(8) Dialysis. Covered as medically necessary.
(9) Durable medical equipment and supplies. Covered as medically necessary with $15,000 annual maximum; $5 co-pay per item for durable/non-durable supplies; $25 co-pay per item for DME.
(10) Emergency department services. Covered as medically necessary; $30 co-pay per occurrence; waived if admitted.
(11) Family planning services and supplies. Birth control information and supplies; pap smears; pregnancy tests.
(12) Home health services. Home health visits limited to 36 visits per year, prior authorization required, includes medications IV therapy and supplies; $10 co-pay per visit, appropriate pharmacy and DME co-pays will apply.
(13) Hospice services. Covered as medically necessary, prior authorization required; $10 co-pay per visit.
(14) Immunizations. Covered as recommended by ACIP; $0 co-pay.
(15) Inpatient hospital services (acute care only). Covered as medically necessary; $50 co-pay per admission.
(16) Laboratory services. Covered as medically necessary.
(17) Psychological testing. Psychological, neurological and development testing; outpatient benefits per calendar year, prior authorization required issued in four unit increments - not to exceed eight units/hours per testing set; $0 co-pay.
(18) Mental health/substance abuse treatment-outpatient. All outpatient benefits require prior authorization. Outpatient benefits limited to 48 visits per calendar year. Additional units as medically necessary; $10 co-pay per outpatient visit.
(19) Mental health/substance abuse treatment-inpatient. Acute, detox, partial, and residential treatment center (RTC) with 30 day max per year, 2 days of partial or RTC treatment equals 1 day accruing to maximum. Additional units as medically necessary; $50 co-pay per admission. Requires prior authorization.
(20) Nurse midwife services. Covered as medically necessary for pregnancy-related services only; $0 co-pay.
(21) Nutrition services. Covered as medically necessary; $10 co-pay.
(22) Nutritional support. Covered as medically necessary; not included in DME $15,000 max/year. Parenteral nutrition covered only when medically necessary; $25 co-pay.
(23) Other medically necessary services. Covered as medically necessary.
(24) Oral surgery. Covered as medically necessary and includes the removal of tumors and cysts; $25 co-pay for outpatient; $50 co-pay for inpatient hospital.
(25) Outpatient hospital services. Covered as medically necessary and includes ambulatory surgical centers and therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for children with proven malignancies

visit for therapeutic radiology or chemotherapy.

(26) Oxygen. Covered as medically necessary; not included in DME $15,000 max/year; $5 co-pay per month.

(27) PCP visits. Blood lead screen covered as medically necessary. Hearing services limited to one outpatient newborn screening. Well baby/well child exams follow recommended schedule to age 19; $0 co-pay for preventive visits and well baby/well child exams; $10 co-pay for all other visits.

(28) Physical, occupational, and speech therapy. Covered as medically necessary; prior authorization required; $10 co-pay per visit.

(29) Physician services, including preventive services. Covered as medically necessary; $0 co-pay for preventive visits; $10 co-pay for all other visits.

(30) Prenatal, delivery and postpartum services. Covered as medically necessary; $0 co-pay for office visits; $50 co-pay for delivery.

(31) Prescription drugs and insulin. Limited to six per month; generic preferred. Prenatal vitamins and smoking cessation products do not count toward the six prescription limit; $5-$10 co-pay.

(32) Smoking cessation products. Limited coverage; 90-day supply; products do not count against prescription drug limit; $5-$10 co-pay.

(33) Specialty clinic services. Covered as medically necessary; $10 co-pay.

(34) Surgery. Covered as medically necessary; $25 co-pay for outpatient facility; $50 co-pay for inpatient hospital.

(35) Tuberculosis services. Covered as medically necessary; $10 co-pay per visit.

(36) Ultraviolet treatment-actinotherapy. Covered as medically necessary; prior authorization required after one visit per 365 sequential days; $5 co-pay.

(b) A PCP referral is required to see any other provider with the exception of the following services:

(1) behavioral health services;

(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;

(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;

(4) women's routine and preventive health care services;

(5) emergency medical condition as defined in OAC 317:30-3-1; and

(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

317:45-11-13. Insure Oklahoma IP children non-covered services

Certain health care services are not covered in the Insure Oklahoma IP benefit package for children listed in OAC 317:45-11-12. These services include, but are not limited to:

(1) services not considered medically necessary;

(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;

(3) organ and tissue transplant services;

(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of

nutritional services prescribed only for the treatment of weight loss;
(5) procedures, services and supplies related to sex transformation;
(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) transportation [non-emergency (air or ground)];
(11) rehabilitation (inpatient);
(12) cardiac rehabilitation;
(13) allergy testing and treatment;
(14) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(15) genetic counseling;
(16) fertility evaluation/treatment/and services;
(17) sterilization reversal;
(18) Christian Science Nurse;
(19) Christian Science Practitioner;
(20) skilled nursing facility;
(21) long-term care;
(22) stand by services;
(23) thermograms;
(24) abortions (for exceptions, refer to OAC 317:30-5-6);
(25) donor transplant expenses; and
(26) tubal ligations and vasectomies.

PART 5. INSURE OKLAHOMA/~~O-EPIC~~ IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma/~~O-EPIC~~ IP eligibility requirements

(a) ~~Employees~~ Working adults not eligible to participate in an employer's ~~QHP~~ qualified health plan, employees of non-participating employers, self-employed, unemployed seeking work, ~~and~~ workers with a disability, and qualified college students may apply for the Individual Plan. Applicants cannot obtain IP coverage if they are eligible for ESI. Applicants, unless a qualified college student, must be engaged in employment as defined under state law, or must be considered unemployed as defined under state law.
(b) The eligibility determination ~~is~~ will be processed within 30 days from the date the complete application is received ~~by the TPA~~. The applicant ~~is~~ will be notified in writing of the eligibility decision.
(c) In order to be eligible for the IP, the applicant must:
(1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time they make application;
(2) be a US citizen or alien as described in OAC 317:35-5-25;
(3) be an Oklahoma resident;
(4) provide social security numbers for all household members;
(5) be not currently enrolled in, or have an open application for~~,~~ ~~SoonerCare/Medicare~~ SoonerCare or Medicare;
(6) be age 19 through 64 or an emancipated minor;
(7) make premium payments by the due date on the invoice; ~~and~~
(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and

(9) be not currently covered by a private health insurance policy or plan.

(d) If employed and working for an approved Insure Oklahoma~~/O-EPIC~~ employer who offers a ~~QHP~~ qualified health plan, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.

(2) be ineligible for participation in their employer's ~~QHP~~ qualified health plan due to number of hours worked.

(3) have received notification from Insure Oklahoma~~/O-EPIC~~ indicating their employer has applied for Insure Oklahoma~~/O-EPIC~~ and has been approved.

(e) If employed and working for an employer who ~~doesn't~~ does not offer a ~~QHP~~ qualified health plan, the applicant must meet the requirements in subsection (c) of this Section and have ~~a countable~~ an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) must have an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority;

(2) verify self-employment by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms;

(3) verify current income by providing appropriate supporting documentation; and

(4) ~~must not be employed by any full-time employer who meets the eligibility requirements in OAC 317:45-7-1(a)(1)-(2)~~ must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2).

(g) If unemployed seeking work, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicant must have an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. In determining income, payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010 and any amount of emergency unemployment compensation paid through May 31, 2010, will not be counted, as authorized under the American Recovery and Reinvestment Tax Act of 2009.

(2) Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) OESC eligibility letter,

(B) OESC weekly unemployment payment statement, or

(C) bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and:

(1) Applicant must have an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level based on a family size of one~~; and~~. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.
(2) Applicant must verify eligibility by providing a copy of their:
(A) ticket to work, or
(B) ticket to work offer letter.

317:45-11-21. Dependent eligibility

(a) If the spouse of an Insure Oklahoma~~/O-EPIC~~ IP approved individual is eligible for Insure Oklahoma~~/O-EPIC~~ ESI, they must apply for Insure Oklahoma~~/O-EPIC~~ ESI. Spouses cannot obtain Insure Oklahoma~~/O-EPIC~~ IP coverage if they are eligible for Insure Oklahoma~~/O-EPIC~~ ESI.
(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in OAC 317:45-11-20(a) through (g) to be eligible for Insure Oklahoma~~/O-EPIC~~ IP.
(c) The dependent of an applicant approved according to the guidelines listed in OAC 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma~~/O-EPIC~~ IP.
(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma~~/O-EPIC~~ IP, then the associated dependent enrolled under that applicant is also ineligible.
(e) Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA).
(f) Dependent children in families whose annual gross household income is from 185 up to and including 300 percent of the Federal Poverty Level may be eligible. The inclusion of children into the Insure Oklahoma program will be phased in over a period of time as determined by the OHCA. No other deductions or disregards apply.
(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.
(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Oklahoma State Employee Health Insurance Plan.
(3) Children who already have coverage through another source must undergo, or be excepted from, a six month uninsured waiting period prior to becoming eligible for Insure Oklahoma. Exceptions to the waiting period may include:
(A) the cost of covering the family under the ESI plan meets or exceeds 10 percent of the annual gross household income. The cost of coverage includes premiums, deductibles, co-insurance, and co-payments;
(B) loss of employment by a parent which made coverage available;
(C) affordable ESI is not available; "affordable" coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); or
(D) loss of medical benefits under SoonerCare.

317:45-11-21.1. Certification of newborn child deemed eligible

(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma~~/O-EPIC~~ IP and the ~~household countable~~ annual gross household income does not exceed SoonerCare requirements. ~~(For purposes of this subparagraph, a newborn child is defined as any child under the age of one year).~~ The newborn child is deemed eligible through the last day of the month the child attains the age of one year.
(b) The newborn child's eligibility is not dependent on the mother's continued eligibility ~~for~~ in Insure Oklahoma~~/O-EPIC~~ IP. The child's eligibility is based on the original eligibility determination of the mother for Insure Oklahoma~~/O-EPIC~~ IP and consideration is not given to any income or resource changes that occur during the deemed eligibility period.
(c) The newborn child's certification period is shortened only in the event the child:

~~(1) leaves the mother's home;~~
~~(2)~~ (1) loses Oklahoma residence; or
~~(3) has medical needs included in another assistance case; or~~
~~(4)~~ (2) expires.

(d) No other conditions of eligibility are applicable, including social security number enumeration~~; however, it~~ and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the child's birth.

317:45-11-22. PCP choices

(a) The applicant (and dependents if also applying for Insure Oklahoma~~/O-EPIC~~ IP) is required to select a valid PCP ~~choices as required on the application~~.
(b) If a valid PCP is selected by the applicant or dependents and they are not enrolled with the first PCP choice, they are enrolled with the next available PCP choice. The applicant is notified in writing why their initial choice was not selected.
(c) After initial enrollment in Insure Oklahoma~~/O-EPIC~~ IP, the applicant or dependents can change their PCP selection by calling the Insure Oklahoma~~/O-EPIC~~ helpline. ~~Changes take effect the first day of the next month or the first day of the 2nd consecutive month. Applicant and dependents are only allowed to change their PCP a maximum of four times per calendar year.~~

317:45-11-23. Employee eligibility period

(a) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a) through (e).

(1) The employee's coverage period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is received and approved on January 14th and the premium is received before February 15th, eligibility begins March 1st; or an application is received and approved January 15th and the premium is received on March 15th, eligibility begins April 1st.)
(B) If premiums are paid early, eligibility still begins as scheduled.

(2) Employee eligibility is contingent upon the employer meeting the program guidelines.

(3) The employee's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-9-1 or OAC 317:45-11-20(a) through (e).

(4) If the employee is determined eligible for Insure Oklahoma~~/O-EPIC~~ IP, he/she is approved for a period not greater than 12 months. ~~The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period as defined in OAC 317:45-7-1, 317:45-7-2 and 317:45-7-8.~~

(b) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).

(1) The applicant's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).

(2) If the applicant is determined eligible for Insure Oklahoma~~/O-EPIC~~ IP, he/she is approved for a period not greater than 12 months.

(3) The applicant's eligibility period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is approved on January 14th and the premium is received before February 15th, eligibility begins March 1st; or an application is approved January 15th and the premium is received on March 15th, eligibility begins April 1st.)

(B) If premiums are paid early, eligibility still begins as scheduled.

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for health plan premiums. The premiums are due, and must be paid in full, no later than the 15th day of the month prior to the month of IP coverage.

(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent of their ~~gross~~ monthly gross household income.

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed ~~4%~~ four percent of their ~~gross~~ monthly gross household income, based on a family size of one and capped at ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.

(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of Insufficient/Non-sufficient funds.

317: 45-11-25. Premium payment

IP health plan premiums are established by the OHCA. Employees and college students are responsible for up to 20 percent of their IP health plan premium. The employees are also responsible for up to 20 percent of their ~~spouse=s~~ dependent's IP health plan premium if the dependent is included in the program. The combined portion of the employee's or college student=s cost sharing for IP health plan

premiums cannot exceed four percent of his/her ~~gross~~ annual gross household income computed monthly.

317:45-11-26. Audits

Members participating in the Insure Oklahoma~~/O-EPIC~~ program are subject to audits related to their eligibility, subsidy payments, premium payments and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-11-27. Closure

(a) Members are mailed a notice 10 days prior to closure of eligibility.
(b) The employer and employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma~~/O-EPIC~~ then eligibility for the associated employees enrolled under that employer are also ineligible.
(c) The employee's certification period may be terminated when:
  (1) the member requests closure;
  (2) the member moves out-of-state;
  (3) the covered member dies;
  (4) the employer's eligibility ends;
  (5) an audit indicates a discrepancy that makes the member or employer ineligible;
  (6) the employer is terminated from Insure Oklahoma~~/O EPIC~~;
  (7) the member fails to pay the amount due within 60 days of the date on the bill;
  (8) the ~~QHP~~ qualified health plan or carrier ~~is no longer qualified~~ no longer meets the requirements set forth in this chapter;
  (9) the member begins receiving ~~SoonerCare/Medicare~~ SoonerCare or Medicare benefits;
  (10) the member begins receiving coverage by a private health insurance policy or plan; or
  (11) the member or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility.
(d) This subsection applies to applicants eligible according to OAC 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h). The member's certification period may be terminated when:
  (1) the member requests closure;
  (2) the member moves out-of-state;
  (3) the covered member dies;
  (4) the employer's eligibility ends;
  (5) an audit indicates a discrepancy that makes the member or employer ineligible;
  (6) the member fails to pay the amount due within 60 days of the date on the bill;
  (7) the member becomes eligible for ~~SoonerCare/Medicare~~ SoonerCare or Medicare;
  (8) the member begins receiving coverage by a private health insurance policy or plan; or
  (9) the member or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility.

317:45-11-28. Appeals

(a) Member appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.

(b) ~~Member appeals related to premium payments and/or out of pocket expenses are made to the TPA. If the member disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final.~~
~~(c) Employee appeals regarding out-of-pocket expenses are made to the TPA. If the employee disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final~~ Employee appeals regarding out-of-pocket medical expense reimbursements may be made to the OHCA. The OHCA may request documentation to support the out-of-pocket appeal. The decision of the OHCA is final.

7.b-2 CHAPTER 25. SOONERCARE CHOICE
Subchapter 9. Health Access Networks
OAC 317:25-9-1. through 317:25-9-3. [NEW]
(Reference APA WF # 10-14)

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 establish provider requirements and billing guidelines for Health Access Networks (HAN's). HAN's are non-profit, administrative entities that work with providers to coordinate and improve the quality of care for SoonerCare members. Effective July 1, 2010, OHCA will initiate a pilot program to pay HAN's a per member per month fee in order to enhance the development of comprehensive medical homes for SoonerCare Choice members. Emergency rules are needed in order to have rules in place by July 1, 2010, the start date for the HAN's pilot project.

ANALYSIS: Beginning July 1, 2010, the Oklahoma Health Care Authority will implement a pilot program to pay Health Access Networks to coordinate and improve the quality of care for SoonerCare members. Rules are needed to establish provider requirements and billing guidelines for HAN's which are not-for-profit, administrative entities that work with SoonerCare providers to coordinate and improve the quality of care for our members. Contracted HAN's will be paid a $5.00 per member per month fee in order to enhance the development of comprehensive medical homes for SoonerCare Choice members.

BUDGET IMPACT: Agency staff has determined that implementation of the Health Access Networks will cost approximately $3.3 million total annual dollars with a state share of $825,000.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 25, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: July 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 SoonerCare Choice rules to initiate a pilot program to reimburse Health Access Networks to coordinate and improve the quality of care for SoonerCare members.

SUBCHAPTER 9. HEALTH ACCESS NETWORKS

317:25-9-1. Purpose

The purpose of this Subchapter is to describe the rules governing the Health Access Networks (HAN's) participating in the statewide

Networks will work with providers to coordinate and improve the quality of care for SoonerCare members. The use of Health Access Networks is a limited pilot program with the purpose of enhancing the development of comprehensive medical homes for Oklahoma SoonerCare Choice members.

317:25-9-2. Requirements

(a) HAN's are non-profit, administrative entities that work with providers to coordinate and improve the quality of care for SoonerCare members. The HAN must:

(1) be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members;

(2) offer patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or the State;

(3) submit an application to the OHCA as specified in (c) of this Section;

(4) offer core components of electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies;

(5) have an organized and systematic quality improvement process, including the identification of measurable performance targets; and

(6) offer care management/care coordination to persons with complex health care needs including:

(A) the co-management of individuals enrolled in OHCA's Health Management Program;

(B) individuals with frequent emergency room utilization;

(C) women enrolled in the Oklahoma Cares Program diagnosed with breast or cervical cancer;

(D) pregnant women enrolled in the High Risk OB Program; and

(E) individuals enrolled in the Pharmacy Lock-In Program; and

(b) Networks must meet at least two of the following:

(1) have a formal affiliation agreement/partnership at the community-level with traditional and non-traditional providers;

(2) have a formal program to promote public health principles, community development, and local educational programs to address the challenges of rural and underserved populations; and

(3) have 501(c)3 or not-for-profit status.

(c) In order to qualify to participate as a SoonerCare contracted HAN's, the network must submit an application to the OHCA that details how the network plans to:

(1) reduce costs associated with the provision of health care services to SoonerCare, uninsured and underinsured individuals;

(2) improve access to, and the availability of, health care services provided to individuals served by the health access network;

(3) enhance the quality and coordination of health care services provided to such individuals through mutually defined quality improvement initiatives;

(4) improve the health status of communities served by the health access network;

(5) reduce health disparities in such communities;

(6) identify all PCPs, specialty providers, and other provider types affiliated with the health access network.

(d) The application to participate as a SoonerCare contracted HAN's will be accepted and approved at the sole discretion of OHCA with

staff and approval by OHCA's Medical Advisory Taskforce (MAT).

317:25-9-3. Reimbursement

(a) In order to be eligible for payment, HAN's must have on file with OHCA, an approved Provider Agreement. Through this agreement, the HAN assures that OHCA's requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed annually with each provider.

(b) The HAN will be reimbursed a per member per month (PMPM) rate based on the number of member months paid to the PCPs affiliated with the HAN. OHCA reserves the right to limit reimbursement based on availability of funds.

7.b-3 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
OAC 317:30-5-241.1. [AMENDED]
(Reference APA WF # 10-18)

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 reflect behavioral health assessments and service plan development may only be provided by licensed behavioral health professionals effective July 1, 2010. Policy revisions are needed to clarify services that are permissible under licensed behavioral health providers and certified behavioral health providers. This change ensures compliance with accreditation and certification standards for behavioral health services pursuant to Oklahoma law.

ANALYSIS: Rules are being revised to reflect behavioral health assessments and service plan development may only be provided by licensed behavioral health professionals. Currently, bachelor level Certified Alcohol and Drug Counselors (CADC's) may perform substance abuse assessments in accordance with their Licensure Act. Due to accreditation standard requirements for assessments, all outpatient agencies are required to conduct full bio-psycho-social assessments by a licensed Masters level professional. As a result, ODMHSAS and OHCA collaboratively agreed to restrict the realm of behavioral health assessments to licensed behavioral health professionals and disallow the use of CADC's for substance abuse assessments.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 25, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: July 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 reflect that behavioral health assessments may only be provided by licensed behavioral health professionals beginning July 1, 2010.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

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

All providers must comply with the requirements as set forth in the OHCA BH Provider Billing Manual.

(1) **Screening.**

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

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

(C) **Target population.** This service is compensable only on behalf of a member who is under a PACT program.

(2) **Assessment.**

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

(B) **Qualified professional.** This service is performed by an LBHP ~~or AODTP for AOD~~. CADCs are permitted to provide Drug and Alcohol assessments through June 30, 2010. Effective July 1, 2010, all assessments must be provided by LBHPs.

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

(D) **Target population and limitations.** This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months and it has been more than one year since the previous assessment.

(3) **Behavioral Health Services Plan Development.**

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the member=s strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. BH Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of ~~16~~ 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training.

(B) **Qualified professional.** This service is performed by an LBHP~~ or AODTP for AOD~~.

(C) **Time requirements.** Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member.

(4) **Assessment/Evaluation testing.**

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

(B) **Qualified professionals.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment.

7.b-4 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 103. Qualified Schools As Providers of Health Related Services
OAC 317:30-5-1023. [AMENDED]
OAC 317:30-5-1027. [AMENDED]
(Reference APA WF # 10-22)

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 add a new provider type, Behavior Health School Aide, and service description, Therapeutic Behavioral Services. Currently schools are being allowed to include behavior interventions as a personal care service. 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.

ANALYSIS: Rules are being revised to add a new provider type and services description for services provided in schools. Therapeutic Behavioral Services will be furnished by a Behavior Health Schools Aide in order to improve a student's ability to function in the community and includes behavioral management, redirection and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive skills.

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

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

PROPOSED EFFECTIVE DATE: July 15, 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:
EPSDT rules are revised to add a new provider type, Behavior Health School Aide, and service description, Therapeutic Behavioral Services.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1023. Coverage by category
(a) **Adults.** There is no coverage for services rendered to adults.
(b) **Children.** Payment is made for compensable services rendered by local, regional, and state educational services agencies as defined by IDEA:

(1) **Child health screening examination.** An initial screening may be requested by an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Coordination referral is made to the ~~***SoonerCare***~~ SoonerCare provider to assure at a minimum, that periodic screens are scheduled and provided in accordance with the periodicity schedule following the initial screening.
(2) **Child health encounter.** The child health encounter may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A Child Health Encounter may include a child health history, physical examination, developmental assessment, nutrition assessment and counseling, social assessment and counseling, genetic evaluation and counseling, indicated laboratory and screening tests, screening for appropriate immunizations, health counseling and treatment of childhood illness and conditions.
(3) **Hearing and Hearing Aid evaluation.** Hearing evaluation includes pure tone air, bone and speech audiometry provided by a state licensed audiologist who:
(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or
(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or
(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.
(4) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state licensed audiologist who:
(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or
(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or
(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.
(5) **Ear impression (for earmold).** Ear impression (for earmold) includes taking impression of a ~~client's~~ member's ear and providing a finished earmold which is used with the ~~client's~~ member's hearing aid provided by a state licensed audiologist who:
(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or
(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or
(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.
(6) **Vision Screening**. Vision screening examination must be provided by a state licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). At a minimum, vision services include diagnosis and treatment for defects in vision.
(7) **Speech Language evaluation.** Speech Language evaluation must be provided by state licensed speech language pathologist who:
(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or
(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or
(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(8) **Physical Therapy evaluation**. Physical Therapy evaluation must be provided by a state licensed physical therapist.

(9) **Occupational Therapy evaluation**. Occupational Therapy evaluation must be provided by a state licensed occupational therapist.

(10) **Psychological Evaluation and Testing.** Psychological Evaluation and Testing must be provided by state licensed, Board Certified, Psychologist or School Psychologist certified by State Department of Education (SDE).

(11) **Dental Screening Examination.** Screening for dental disease by a state licensed dentist. The child may be referred directly to a dentist for further screening and/or treatment.

(12) **Child guidance treatment encounter.** A child guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children who are identified as having specific disorders or delays in development, emotional, or behavioral problems, or disorders of speech, language or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an IEP or IFSP and may include the following:

(A) **Hearing and Vision Services.** Hearing and vision services may include provision of habilitation activities, such as auditory training, aural and visual habilitation training, including Braille, and communication management, orientation and mobility, counseling for vision and hearing losses and disorders. Services must be provided by:

(i) state licensed, Master's Degree Audiologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed, Master's Degree Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(iii) state certified Speech Therapist working under the direction of a state licensed Speech Language Pathologist;

(iv) state certified deaf education teacher;

(v) certified orientation and mobility specialists; and

(vi) state certified vision impairment teachers.

(B) **Speech Language Therapy Services.** Speech Language Therapy Services must be provided by a state licensed Speech Language Pathologist who:

(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or

(iv) a Speech Therapy Assistant who has been authorized by the Board of Examiners, working under the direction of a state licensed speech language pathologist. The licensed Speech Language Pathologist may not supervise more that two Speech Therapy assistants, and must be on site.

(C) **Physical Therapy Services.** Physical Therapy Services must be provided by state licensed physical therapist or a Physical Therapy Assistant who has been authorized by the Board of Examiners working under the supervision of a licensed Physical Therapist. The licensed Physical Therapist may not supervise more than three Physical Therapy Assistants.

(D) **Occupational Therapy Services**. Occupational therapy may include provision of services to improve, develop or who restore impaired ability to function independently and must be provided by a state licensed Occupational Therapist or an Occupational Therapy Assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed Occupational Therapist.

(E) **Nursing Services.** Nursing Services may include provision of services to protect the health status of children, correct health problems and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, administration and monitoring of medication.

(F) **Psychological Services.** Psychological services are planning and managing a program of psychological services, including the provision of counseling for children and parents, consulting on management of severe behavioral and emotional concerns in school and home. All services must be for the direct benefit of the child. Psychological services must be provided by a state licensed Psychologist, or School Psychologist certified by SDE.

(G) **Psychotherapy Counseling Services.** Psychotherapy counseling services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy counseling services must be provided by a state licensed Social Worker, a state Licensed Professional Counselor, a State licensed Psychologist or School Psychologist certified by the SDE, a State licensed Marriage and Family Therapist or a State licensed Behavioral Practitioner, or under Board supervision to be licensed in one of the above stated areas.

(H) **Assistive Technology.** Assistive technology are the provision of services that help to select a device and assist a student with disability(ies) to use an Assistive technology device including coordination with other therapies and training of child and caregiver. Services must be provided by a:

(i) state licensed, Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed Physical Therapist; or

(iii) state licensed Occupational Therapist.

(13) **Personal Care.** Provision of personal care services allow students with disabilities to safely attend school; includes, but is not limited to assistance with toileting, feeding, positioning, hygiene, and riding school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals/assistants who have completed training approved or provided by SDE, or Personal Care Assistants, including Licensed Practical Nurses, who have completed on-the-job training specific to their duties.

(14) **Therapeutic Behavioral Services**. Therapeutic behavioral services is an intervention to modify the non-adaptive behavior necessary to improve the student's ability to function in the community as identified on the plan of care. Medical necessity must be identified and documented through assessment and evaluation. Services encompass behavioral management, redirection, and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive skills. This service must be provided by a Behavioral Health School Aide (BHSA) who has a high school diploma or equivalent and has successfully completed the paraprofessional training approved by The State Department of Education and a training curriculum in behavioral interventions for Pervasive Developmental Disorders as recognized by OHCA. BHSA must be supervised by a bachelor's level individual with a special education certification. BHSA must have CPR and First Aid certification. Six additional hours of related continuing education is required per year.

~~(14)~~ (15) **Immunization.** Immunizations must be coordinated with the Primary Care Physician for those Medicaid eligible children enrolled in ~~***SoonerCare***~~ SoonerCare. An administration fee, only, can be paid for immunizations provided by the schools.

(c) **Individuals eligible for Part B of Medicare.** EPSDT school health related services provided to Medicare eligible recipients are billed directly to the fiscal agent.

317:30-5-1027. Billing

The following units are billed on the appropriate claim form:

(1) Service: Child Health Screening; Unit: Completed comprehensive screening.

(2) Service: Interperiodic Child Health Screening; Unit: Completed interperiodic screening.

(3) Service: Child Health Encounter; Unit: 5-10 minutes equals 1 unit; 11-20 minutes equals 2 units; over 21 minutes equals 3 units; limited to 30 units per year, additional units must be prior authorized.

(4) Service: Individual Treatment Encounter for IEP School Based and School Based; Unit: 15 minutes, unless otherwise specified.

(A) Hearing and Vision Services, IEP School Based.

(B) Hearing and Vision Services, School Based.

(C) Speech Language Therapy, IEP School Based.

<u>BOARD MEMBERS PRESENT:</u> Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

<u>ABSENT:</u> Member Bryant

ITEM 8/CONSIDERATION AND VOTE TO AUTHORIZE EXPENDITURE OF FUNDS FOR RADIOLOGY MANAGEMENT SERVICES

Beth VanHorn, Director of Legal Operations

Ms. VanHorn presented the background, the scope of work, the contract period, the contract amount and procurement method. Staff's recommendation to the board is to approve this contract to procure the services discussed.

<u>MOTION:</u> Member McFall moved for approval of Item 8 as presented. Member McVay seconded.

<u>BOARD MEMBERS PRESENT:</u> Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

<u>ABSENT:</u> Member Bryant

ITEM 9/DISCUSSION ITEM – "ANALYSIS OF NATIONAL HEALTH REFORM LEGISLATION"

Buffy Heater, Manager of Planning and Development

Ms. Heater presented the high points of National Health Reform focusing on SoonerCare-specific points. The following were presented and discussed: Oklahoma FMAP Outlook: Newly Qualified(time period); Oklahoma CHIP FMAP Outlook(time period); Enrollment Today; Enrollment Post-Reform; Potential Oklahoma Impact; Additional Options; Basic State Health Plan Example; and other Reform Notables. For a copy of the Powerpoint Presentation see the OHCA Website.

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)

Nicole Nantois, Deputy General Counsel

<u>MOTION:</u> Vice Chairman Armstrong moved for an executive session. Member McFall seconded.

<u>BOARD MEMBERS PRESENT:</u> Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

<u>ABSENT:</u> Member Bryant

ITEM 11/NEW BUSINESS

NONE

ITEM 12/ADJOURNMENT

MOTION:	Member McFall moved for adjournment. Member McVay seconded.
BOARD MEMBERS PRESENT:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow
ABSENT:	Member Bryant

FINANCIAL REPORT

For the Nine Months Ended March 31, 2010
Submitted to the CEO & Board
May 13, 2010

- Revenues for OHCA through March, accounting for receivables, were **$2,682,969,277** or **.8% over** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$2,546,182,306** or **.5% over** budget.

- The state dollar budget variance through March is **$183,325 positive.**

- The state dollar budget variance due to Medicare Part D Stimulus allocation is **$10,021,700 positive.**

- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	(14.5)
Medicare Part D	10.0
Administration	3.4
Unbudgeted Carryover	3.4
Revenues:	
Taxes and Fees	2.6
Drug Rebate	1.5
Overpayments/Settlements	3.8
Total FY 10 Variance	**$ 10.2**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA 1
Medicaid Program Expenditures by Source of Funds 2
Other State Agencies Medicaid Payments 3
Fund 230: Quality of Care Fund Summary 4
Fund 245: Health Employee and Economy Act Revolving Fund 5
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund 6
Fund 255: OHCA Medicaid Program Fund 7

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

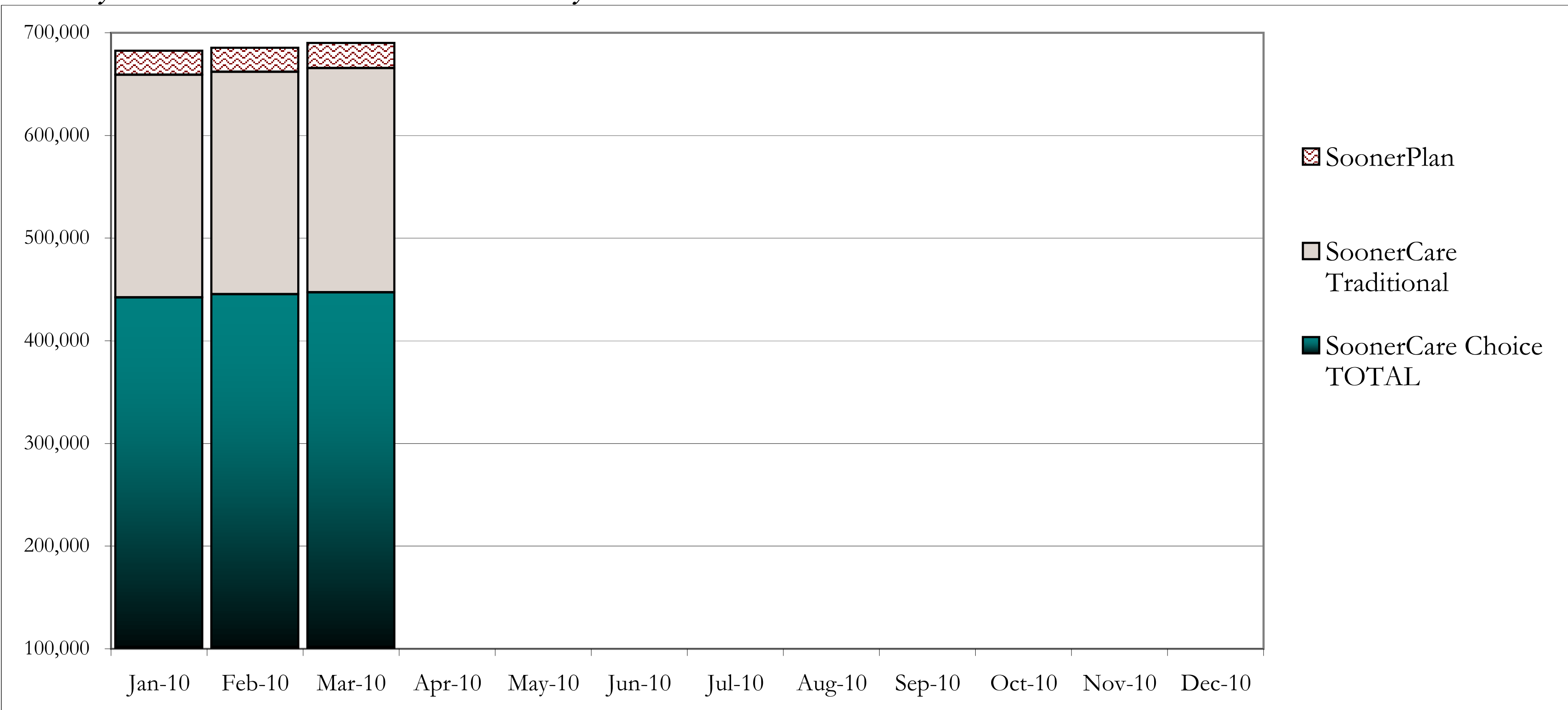
REVENUES		FY10 Budget YTD		FY10 Actual YTD		Variance	% Over/ (Under)
State Appropriations	$	477,591,048	$	477,591,048	$	-	0.0%
Federal Funds		1,557,821,843		1,559,720,685		1,898,842	0.1%
Tobacco Tax Collections		37,167,277		40,205,369		3,038,092	8.2%
Quality of Care Collections		38,855,558		38,374,490		(481,068)	(1.2)%
Prior Year Carryover		24,714,277		28,114,277		-	0.0%
Drug Rebates		97,643,367		101,816,614		4,173,247	4.3%
Medical Refunds		31,274,221		41,914,171		10,639,950	34.0%
Other Revenues		15,203,179		14,826,015		(377,164)	(2.5)%
Stimulus Funds Appropriated		291,662,709		291,662,709		-	0.0%
Stimulus Funds Drawn		88,743,900		88,743,900		-	0.0%
TOTAL REVENUES	**$**	**2,660,677,379**	**$**	**2,682,969,277**	**$**	**18,891,899**	**0.7%**

EXPENDITURES		FY10 Budget YTD		FY10 Actual YTD		Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$**	**29,211,356**	**$**	**27,613,758**	**$**	**1,597,598**	**5.5%**
ADMINISTRATION - CONTRACTS	**$**	**79,238,267**	**$**	**61,486,497**	**$**	**17,751,770**	**22.4%**
MEDICAID PROGRAMS							
Managed Care:							
SoonerCare Choice		21,806,495		20,895,334		911,162	4.2%
Acute Fee for Service Payments:							
Hospital Services		718,263,215		696,258,965		22,004,250	3.1%
Behavioral Health		196,361,975		212,868,643		(16,506,668)	(8.4)%
Physicians		330,881,366		327,832,828		3,048,538	0.9%
Dentists		113,067,939		123,113,661		(10,045,721)	(8.9)%
Other Practitioners		33,089,775		37,952,661		(4,862,886)	(14.7)%
Home Health Care		14,256,839		15,112,356		(855,517)	(6.0)%
Lab & Radiology		18,255,183		26,138,109		(7,882,926)	(43.2)%
Medical Supplies		43,025,062		41,848,483		1,176,579	2.7%
Ambulatory Clinics		45,990,587		63,235,678		(17,245,091)	(37.5)%
Prescription Drugs		277,959,579		288,092,854		(10,133,275)	(3.6)%
Miscellaneous Medical Payments		22,782,900		21,362,460		1,420,440	6.2%
Other Payments:							
Nursing Facilities		390,563,176		390,114,537		448,640	0.1%
ICF-MR Private		42,321,627		42,231,221		90,406	0.2%
Medicare Buy-In		87,792,386		90,792,655		(3,000,269)	(3.4)%
Transportation		19,458,600		19,524,331		(65,731)	(0.3)%
Part D Phase-In Contribution		49,728,978		39,707,278		10,021,700	20.2%
Total OHCA Medical Programs		**2,425,605,682**		**2,457,082,051**		**(31,476,369)**	**(1.3)%**
OHCA Non-Title XIX Medical Payments		40,128		-		40,128	0.0%
TOTAL OHCA	**$**	**2,534,095,433**	**$**	**2,546,182,306**	**$**	**(12,086,873)**	**(0.5)%**
REVENUES OVER/(UNDER) EXPENDITURES	**$**	**126,581,946**	**$**	**136,786,971**	**$**	**10,205,025**	

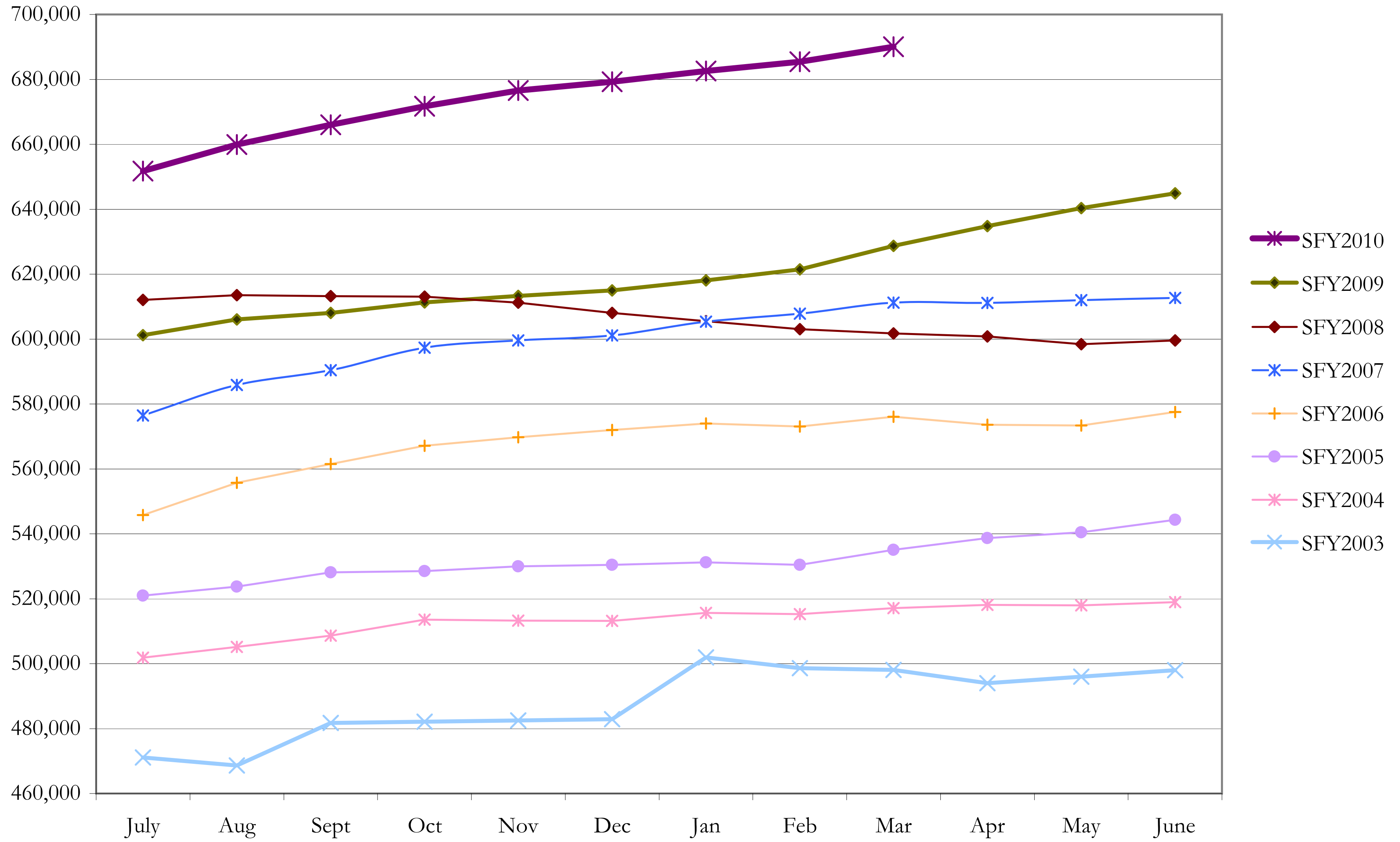
SOONERCARE ENROLLMENT CY-2010

	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Total MMs
ENROLLEES													
SoonerCare Choice													
Choice Total	428,704	431,677	433,447										1,293,828
IHS/Urban/Tribal Total	13,503	13,619	13,780										40,902
SoonerCare Choice TOTAL	442,207	445,296	447,227										1,334,730
SoonerCare Traditional	216,989	216,542	218,449										
SoonerPlan	23,420	23,607	24,379										71,406
TOTAL ENROLLEES	682,616	685,445	690,055										2,058,116
Average Monthly Enrollment													686,039

Monthly Actual SoonerCare Enrollment Trends by Benefit Plan



MMs = Member Months



OHCA SoonerCare Enrollment Figures
700,000
680,000
660,000
640,000
620,000
600,000
580,000
560,000
540,000
520,000
500,000
480,000
460,000
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
June
SFY2010
SFY2009
SFY2008
SFY2007
SFY2006
SFY2005
SFY2004
SFY2003

SoonerCare Programs

March 2010

Choice PCMH	MARCH	
	2009	2010
Total Enrolled	404,240	447,227
American Indian Enrollment	11,672	13,780
Choice Enrollees (PCMH)	392,568	433,447

Traditional	MARCH	
	2009	2010
Total Enrolled	206,886	218,449
SoonerCare Programs Total (Unduplicated)	628,726	690,055

Oklahoma Cares	MARCH	
	2009	2010
Total Women Enrolled	2,632	2,368
SoonerCare Traditional	2,026	1,652
SoonerCare Choice	606	716
Total Women Ever-enrolled	19,112	22,828

SoonerPlan	MARCH	
	2009	2010
Total Enrolled	17,600	24,379
Male Enrollees	470	734
Female Enrollees	17,130	23,645
Total Ever-enrolled	65,386	80,919

TEFRA	MARCH	
	2009	2010
Total Children Enrolled	263	323
Male Enrollees	158	192
Female Enrollees	105	131
Total Ever-enrolled	341	432

Insure Oklaoma	MARCH	
	2009	2010
IO Total Enrollees	17,486	30,552
IO Enrollees Males	7,693	13,223
IO Enrollees Females	9,793	17,329
ESI Enrollees	11,656	18,774
IP Enrollees	5,830	11,778

Program	OCTOBER 2009	NOVEMBER 2009	DECEMBER 2009	JANUARY 2010	FEBRUARY 2010	MARCH 2010
Choice PCMH	423,288	432,068	438,276	442,207	445,296	447,227
Traditional	225,914	221,734	217,945	216,989	216,542	218,449
Oklahoma Cares	2,466	2,481	2,373	2,307	2,396	2,368
TEFRA	307	313	320	325	326	323
SoonerPlan	22,498	22,788	23,073	23,420	23,607	24,379
Soon-to-be Sooners	3,103	3,041	2,979	2,955	2,993	3,051
SoonerCare Programs Total (Unduplicated)	**671,700**	**676,590**	**679,294**	**682,616**	**685,445**	**690,055**
Insure Oklahoma ESI	17,344	17,882	18,133	18,521	18,877	18,774
Insure Oklahoma IP	9,756	10,146	10,825	11,100	11,437	11,778
Insure Oklahoma Programs Total (Unduplicated)	**27,100**	**28,028**	**28,958**	**29,621**	**30,314**	**30,552**
Programs Total	**698,800**	**704,618**	**708,252**	**712,237**	**715,759**	**720,607**

This publication is authorized by the Oklahoma Health Care Authority in accordance with state and federal regulations. OHCA is in compliance with Title VI and Title VII of the 1964 Civil Rights Act and the Rehabilitation Act of 1973. For additional copies, you can go online to OHCA's web site www.okhca.org/research/data. The Oklahoma Health Care Authority does not discriminate on the basis of race, color, national origin, gender, religion, age or disability in employment or the provision of services. The data is valid as of the report date and is subject to change.

April 16, 2010

SoonerCare Fast Facts

March 2010

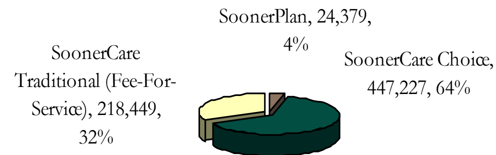
TOTAL ENROLLMENT —
OKLAHOMA SOONERCARE (MEDICAID)

Qualifying Group	Age Group	Enrollment	% of Total
Aged/Blind/Disabled	Child	18,317	2.65%
Aged/Blind/Disabled	Adult	125,506	18.19%
Children/Parents	Child	454,900	65.92%
Children/Parents	Adult	45,992	6.66%
Other	Child	490	0.07%
Other	Adult	17,780	2.58%
Oklahoma Cares (Breast & Cervical Cancer)		2,368	0.34%
SoonerPlan (Family Planning)		24,379	3.53%
TEFRA		323	0.05%
Total Enrollment	**690,055**	Adults	212,778 31%
		Children	477,277 69%

OTHER Group includes—Child custody-Refugee-Qualified Medicare Beneficiary-SLMB-DDSD Supported Living-Program of All Inclusive 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) — **838,019**

Other Breakdowns of Total Enrollment

Oklahoma SoonerCare (Medicaid) members residing in a long-term care facility — **15,868**

Oklahoma persons enrolled in both Medicare and Medicaid (dual eligibles) — **100,853**

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
5,606	18,774	11,778

New Enrollees

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

Adults	6,836
Children	9,017
Total	**15,853**

Race Breakdown of Total Enrollment

	Children	Adults	Percent	Pregnant Women
American Indian	60,778	19,989	12%	2,818
Asian or Pacific Islander	6,888	2,821	1%	598
Black or African American	69,583	29,511	14%	2,436
Caucasian	325,839	158,039	70%	18,866
Multiple Races	14,189	2,418	2%	665
Hispanic Ethnicity	75,194	10,871	12%	5,053

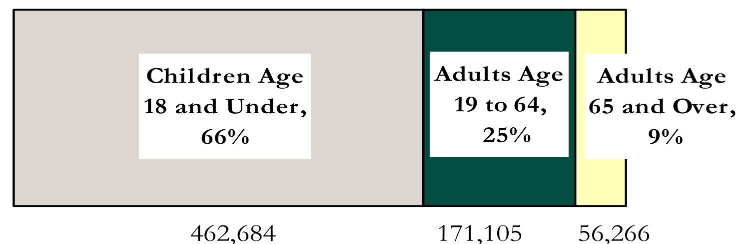
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

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		3,051
INFANT	150% to 185%	1,478
01-05	133% to 185%	11,486
06-12	100% to 185%	32,954
13-18	100% to 185%	20,711
Total		**69,680**

Age Breakdown of Total Enrollment



462,684 171,105 56,266

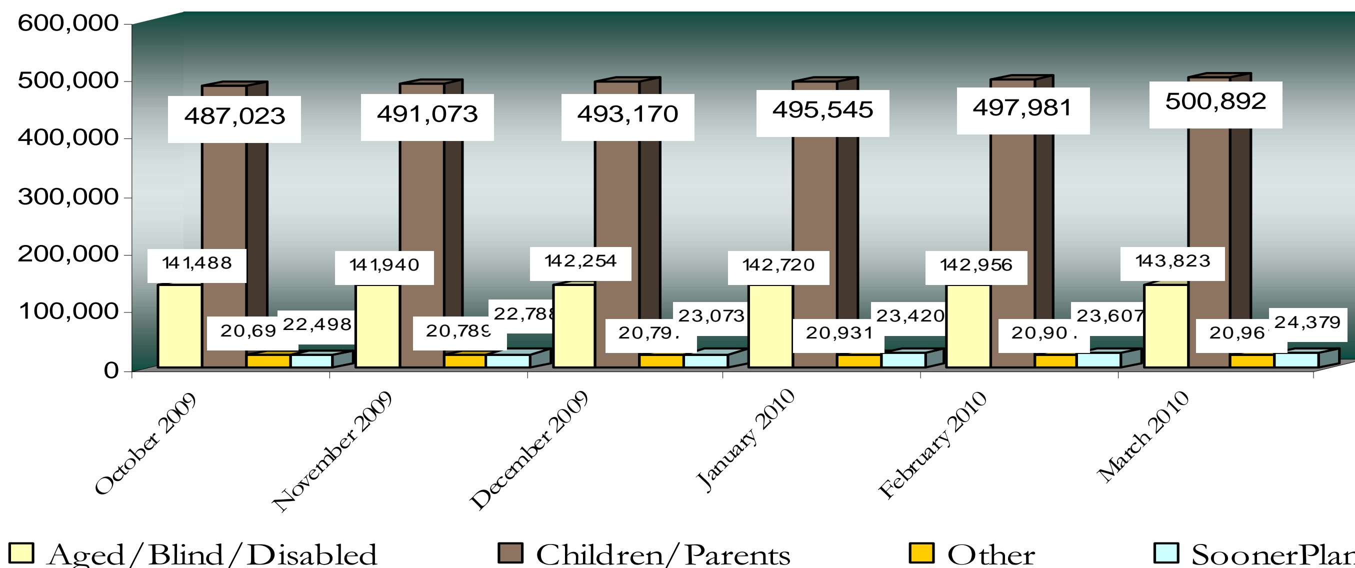
Data was compiled on 4/12/2010. Numbers frequently change due to certifications occurring after the data is extracted and other factors. This report is based on data within the system prior to 4/12/2010. A majority of the data is a "point in time" representation of the specific report month and is not cumulative. Unless stated otherwise, CHILD is defined as an individual under the age of 21.

SoonerCare Fast Facts

March 2010

oklahoma health care authority

Enrollment by Aid Category



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

April 8, 2010

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

OHCA Program Integrity Division Ensures Quality Program

OKLAHOMA CITY – Provider audits are one of the tools the Oklahoma Health Care Authority uses in it's program integrity efforts to make sure state and federal tax dollars are being used correctly in the state's SoonerCare (Oklahoma Medicaid) program.

Deputy Chief Executive Officer Cindy Roberts who leads the agency's Policy, Planning and Integrity Division presented the OHCA Board with an update of their efforts during the board's meeting April 8. According to Roberts, in 2009 approximately 5 percent of the estimated 28,000 SoonerCare providers had some level of audit or review performed.

The reviews, she said, are initiated because of some type of risk analysis such as peer-to-peer comparisons, referrals or data mining. Federal regulations require each Medicaid state agency to have an automated claims processing and retrieval system that can be used to detect post-payment errors. These systems, known as Medicaid Management Information Systems contain subsystems which compare and contrast SoonerCare claims activity by provider in comparison to their peers. The system also allows the program integrity division to perform comprehensive data mining of claims history.

"The extent of these audits or reviews may vary, from the validation of a single claim line to a representative sample of a provider's SoonerCare services over a certain time period to a 100 percent review of a specific service billed by a provider," Roberts noted.

For the first three quarters of state fiscal year 2010, OHCA closed 88 audits involving 1,155 providers. The majority of those audits, 73 percent, were the result of data-mining and peer-to-peer comparisons. The audits resulted in the recovery of $14.7 million in state and federal funds. The recovery represents .4 percent of the agency's total program expenditures of $3.4 billion for the first three quarters of 2010.The federal share of any overpayment must be returned to the agency's federal partner, the Centers for Medicare & Medicaid Services.

"It is interesting to note that these recoveries represent only .4 percent of the total program spending for the same time period," Roberts said. "We have found that errors are far more common than activities that are specifically fraudulent or abusive."
If fraud is suspected, the case is turned over to the Oklahoma Attorney General's Medicaid Fraud Control Unit for further investigation. The OHCA also regularly reviews its policy and educates providers to try to avoid overpayments.

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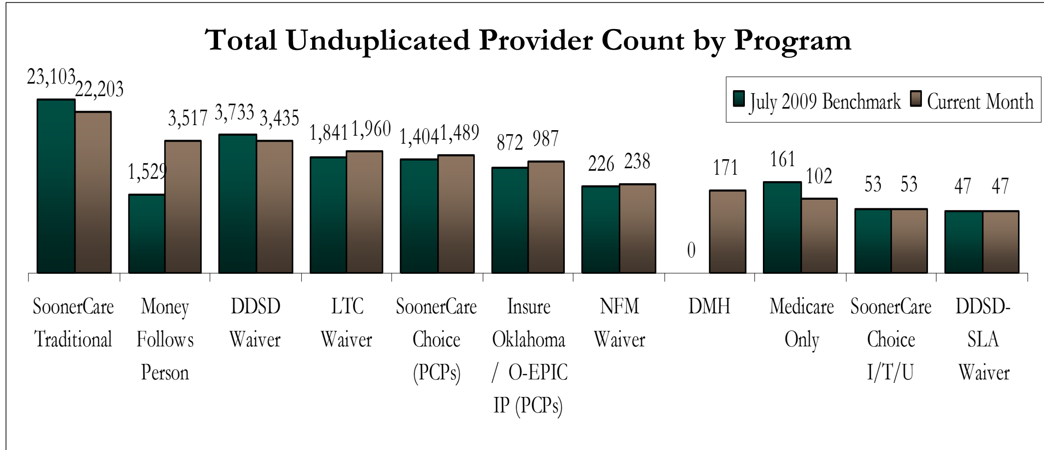
Oklahoma Health Care Authority

Provider Fast Facts

March 2010

Total Unduplicated Provider Count
28,135

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



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
369

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	1,049,749	40.19%
SoonerCare Choice I/T/U	116,150	11.98%
Insure Oklahoma/O-EPIC IP	327,983	3.71%

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

DMH - Department of Mental Health

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

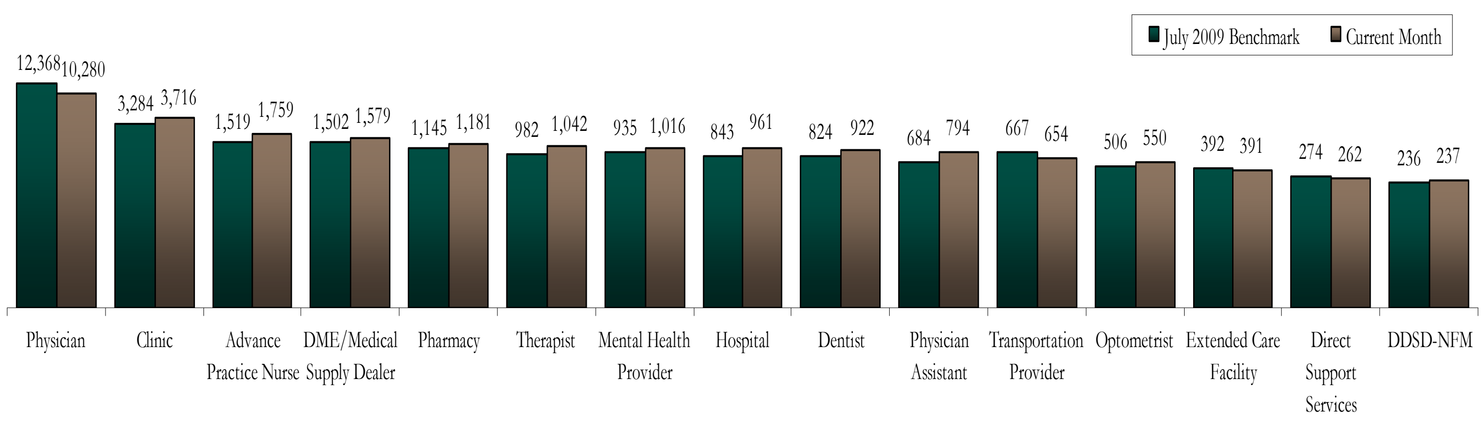
PCMH - Patient-Centered Medical Home

PCP - Primary Care Provider

PCMH Enrollment by Tier

Payment Tier Code	Count
Tier 1	487
Tier 2	235
Tier 3	47

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



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

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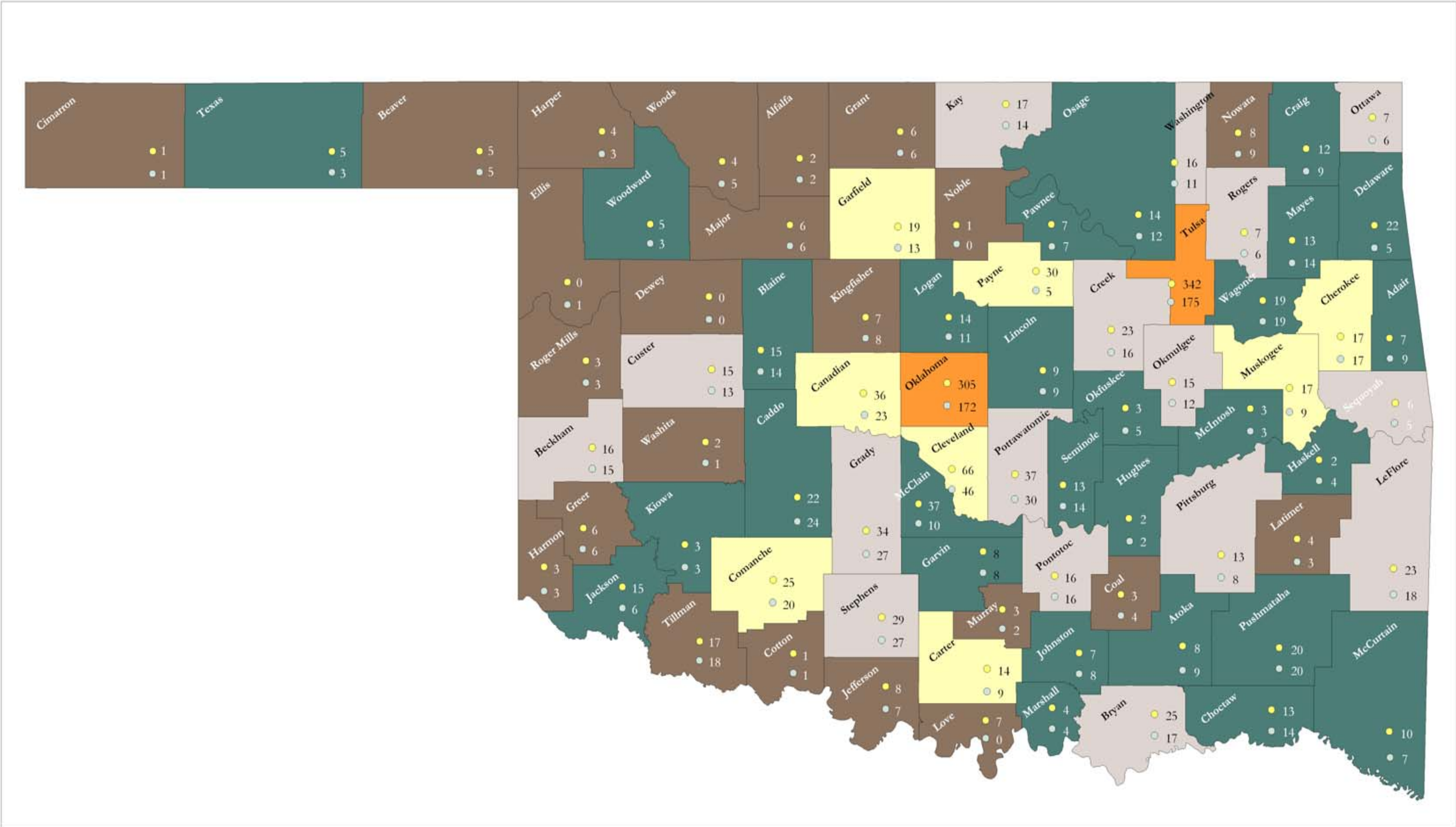
Provider Fast Facts

March 2010

oklahoma health care authority



Total Provider Count

- 4,000 to 6,000 (2)
- 300 to 1,000 (8)
- 150 to 300 (16)
- 50 to 150 (28)
- 0 to 50 (23)

Primary Care Providers (PCPs)

- SoonerCare Choice PCPs
- Insure Oklahoma IP PCPs

04/12/2010

Insure Oklahoma

Fast Facts

May 2010

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

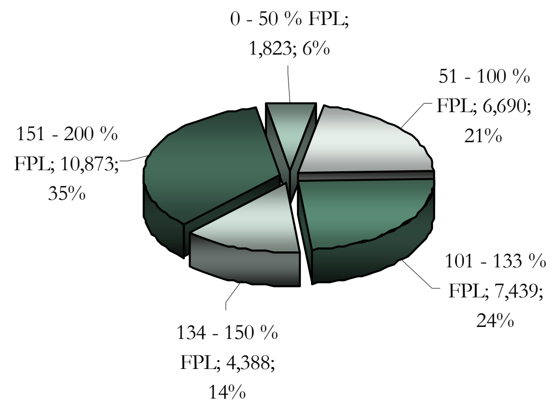
Insure Oklahoma is an innovative program Oklahoma has created to bridge the gap in the health care coverage for low-income working adults. Under the Employer-Sponsored Insurance (ESI) program, premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent).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

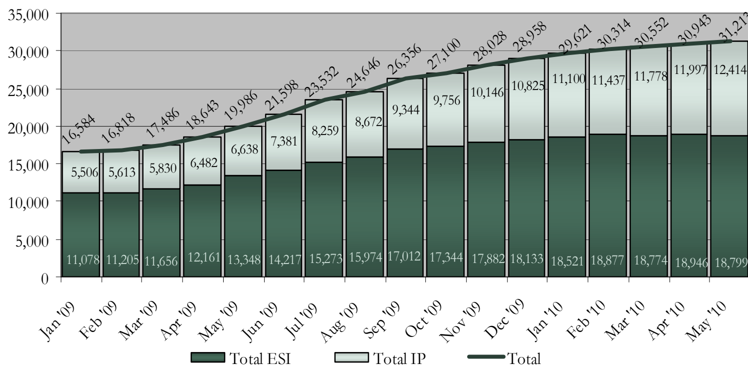
Qualifying Enrollment		Enrollment	% of Total
Employer Sponsored Insurance (ESI)	Employee	15,705	50.32%
Employer Sponsored Insurance (ESI)	Spouse	3,041	9.74%
Individual Plan (IP)	Employee	9,407	30.14%
Individual Plan (IP)	Spouse	2,828	9.06%
Student (ESI)	---	53	0.17%
Student (IP)	---	179	0.57%
Businesses	---	5,539	---
Carriers / HealthPlans	---	20 / 476	---
Primary Care Physician	---	1,005	---

Total Enrollment	31,213			
		ESI	18,799	60%
		IP	12,414	40%

Federal Poverty Level Breakdown of Total Enrollment



Total Insure Oklahoma Member Monthly Enrollment



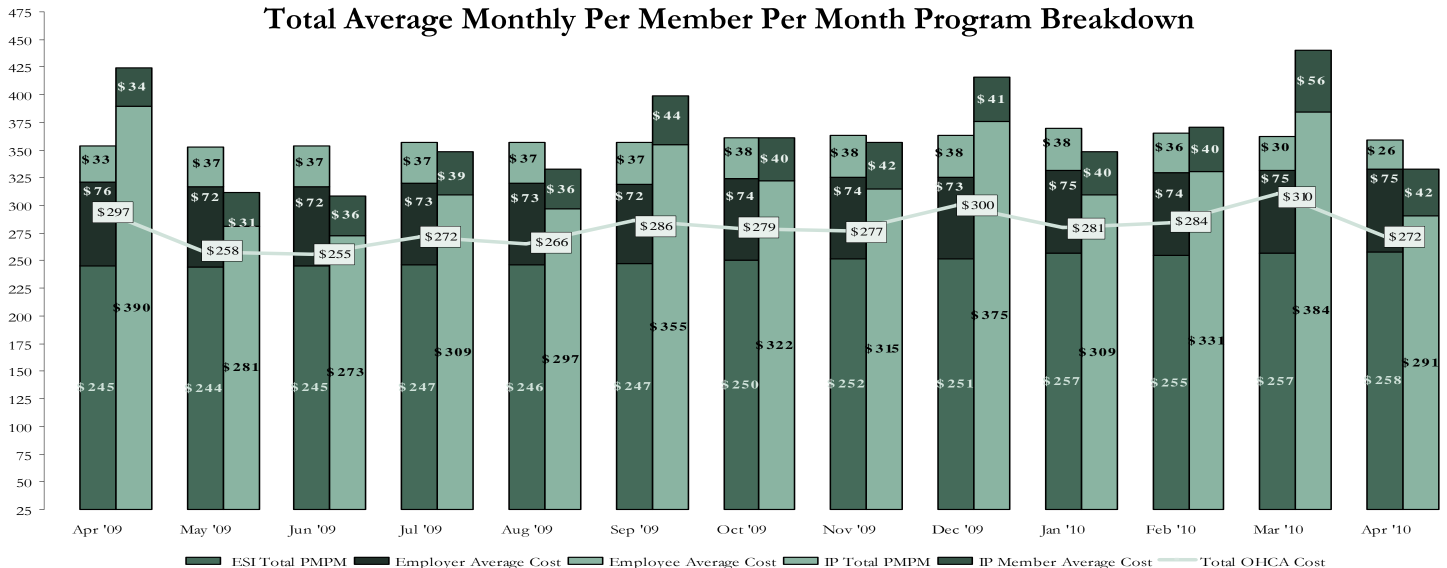
Currently Enrolled		Up from Previous Year
Businesses	5,539	35%
ESI Enrollees	18,799	61%
IP Enrollees	12,414	113%

ESI & IP Enrollee totals include Students.

Latest Monthly Marketing Statistics	
Web Hits on InsureOklahoma.org	39,089
Call Center - Calls Answered	14,290

Call Center count now includes OHCA calls.
Unable to produce Call Center Counts for April.

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.)

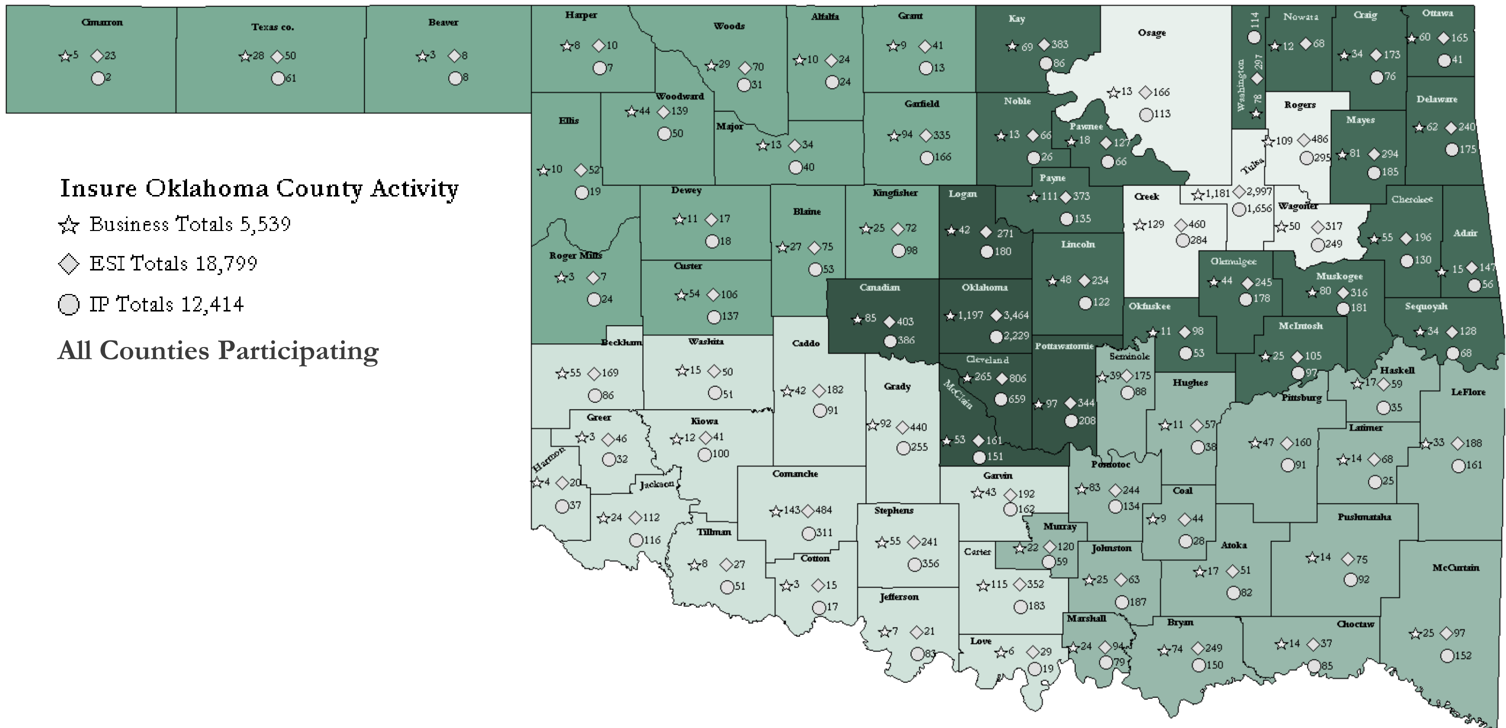
Insure Oklahoma

Fast Facts

May 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.



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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Employer Sponsored Insurance (ESI)

Fast Facts

May 2010

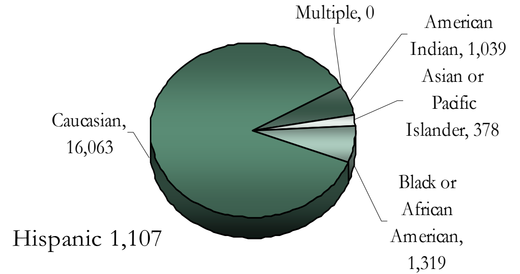
Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

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	7,638	8,067	**15,705**	326	366	**692**	894	773	**1,667**
Spouse	803	2,238	**3,041**	41	100	**141**	91	241	**332**
Student	27	26	**53**	1	0	**1**	2	1	**3**
Total	8,468	10,331	**18,799**	368	466	**834**	987	1,015	**2,002**

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

Race Breakdown of ESI Members



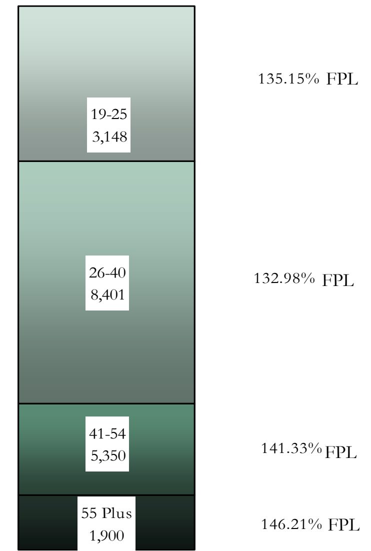
Hispanic 1,107

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	4,560	565	320	**5,445**
New	76	11	7	**94**
Total	**4,636**	**576**	**327**	**5,539**

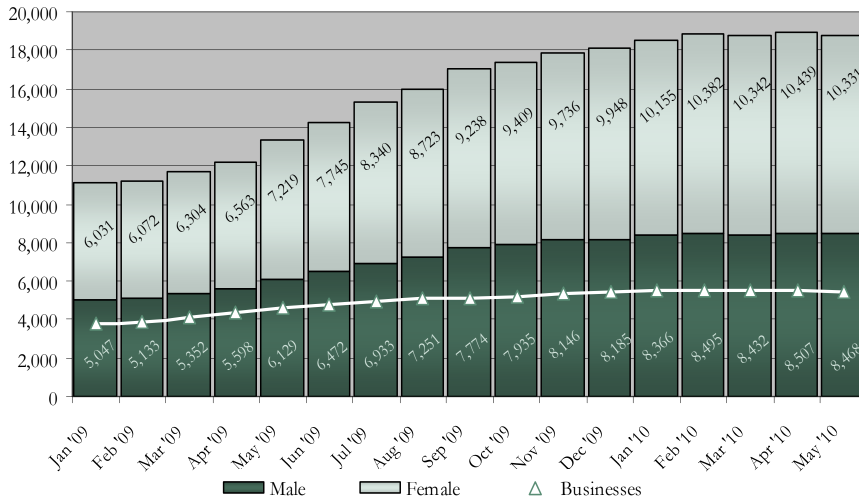
Some approved businesses may not have approved employees.

Age Breakdown with Average Federal Poverty Level of ESI Members

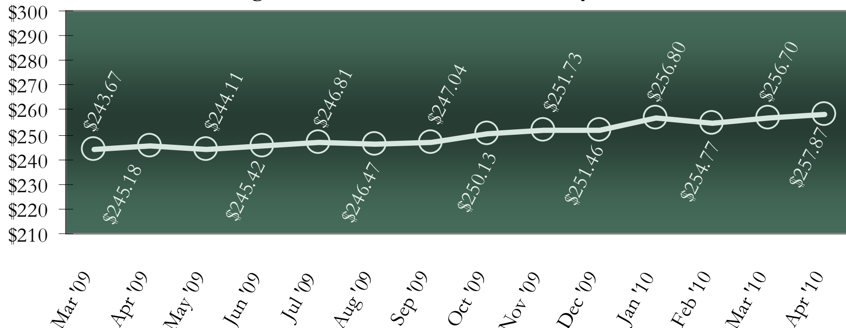


Federal Poverty Level is used to determine income qualification.

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	627	2,421	16 of 16
Region 2	373	1,063	16 of 16
Region 3	1,739	5,449	6 of 6
Region 4	1,482	4,426	5 of 5
Region 5	850	3,655	18 of 18
Region 6	468	1,785	16 of 16
Total	**5,539**	**18,799**	**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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Individual Plan (IP)

Fast Facts

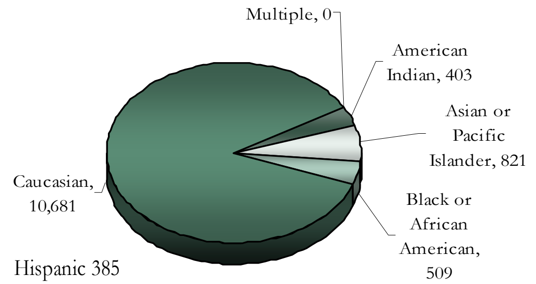
Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

May 2010

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**.

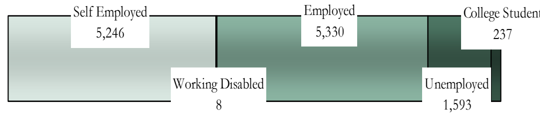
	Total Current Enrollment			Breakdown of Current Enrollment: New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	4,349	5,058	9,407	190	264	454	341	322	663
Spouse	642	2,186	2,828	31	63	94	55	172	227
Student	74	105	179	4	6	10	6	5	11
Total	5,065	7,349	12,414	221	327	558	396	494	901

Race Breakdown of IP Members



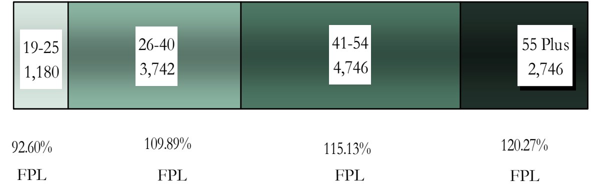
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

IP Application Type Breakdown

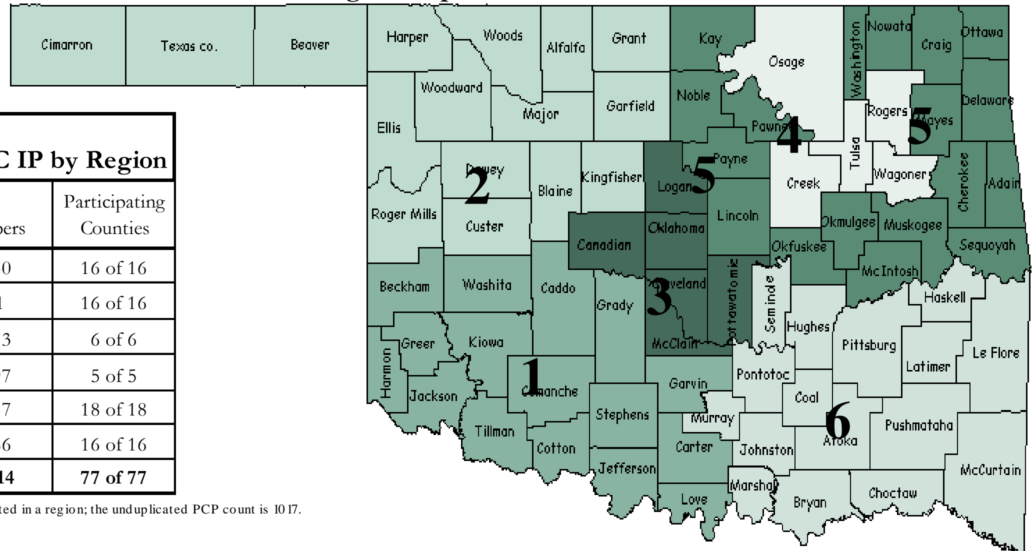


Unduplicated Counts	
IP Members SFY2010 (July 2009 - Current)	16,708
IP Members Since Program Inception March 2007	19,497
Miscellaneous	
Average IP Member Premium	$56.28
Average Federal Poverty Level of IP Members	112.54%
Federal Poverty Level is used to determine income qualification.	

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	144	15 of 16	1,950	16 of 16
Region 2	83	15 of 16	751	16 of 16
Region 3	266	6 of 6	3,813	6 of 6
Region 4	230	5 of 5	2,597	5 of 5
Region 5	149	17 of 18	1,817	18 of 18
Region 6	133	16 of 16	1,486	16 of 16
Total	**1,005**	**74 of 77**	**12,414**	**77 of 77**

PCPs maybe counted in multiple regions or out of state and not counted in a region; the unduplicated PCP count is 1017.

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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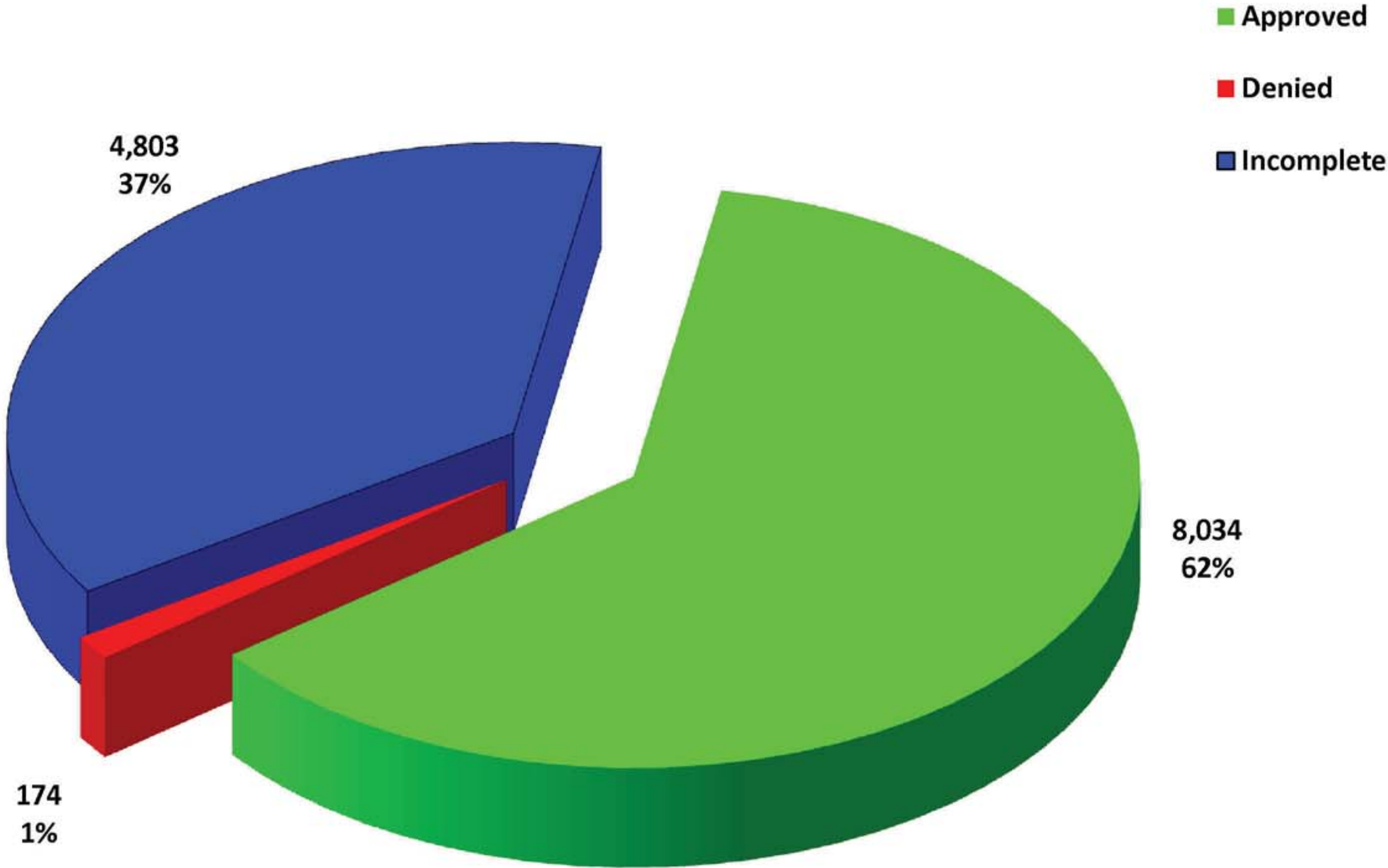
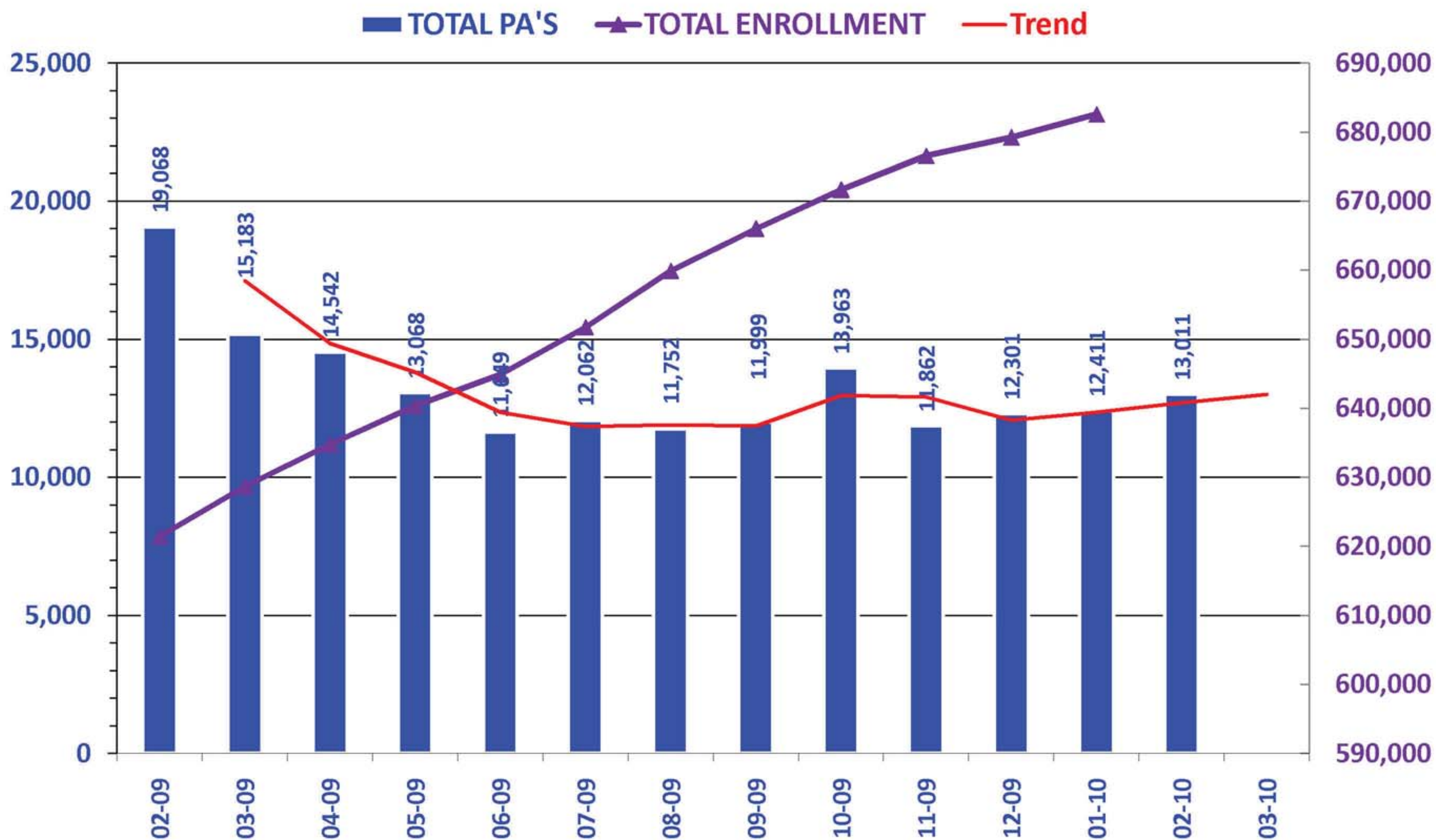
5/5/2010

PRIOR AUTHORIZATION ACTIVITY REPORT: February 2010



PA totals include overrides

PRIOR AUTHORIZATION REPORT: February 2009 – February 2010



PA totals include overrides

Prior Authorization Activity

February 2010

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort	517	270	2	245	357
Amitiza	25	9	0	16	269
Antidepressant	417	125	1	291	340
Antihistamine	323	172	0	151	286
Antihypertensives	139	53	0	86	338
Antimigraine	132	24	0	108	199
Benzodiazepines	4,577	3,985	11	581	89
Bladder Control	90	17	4	69	339
Byetta	13	2	0	11	364
Elidel/Protopic	40	23	1	16	88
ESA	156	120	2	34	56
Fibric Acid Derivatives	7	0	0	7	0
Fibromyalgia	170	60	3	107	334
Forteo	5	2	0	3	353
Glaucoma	29	6	0	23	362
Growth Hormones	44	36	3	5	155
HFA Rescue Inhalers	92	43	0	49	276
Insomnia	120	30	2	88	126
Misc Analgesics	56	10	19	27	144
Muscle Relaxant	187	72	54	61	46
Nasal Allergy	449	50	2	397	170
NSAIDS	167	39	6	122	218
Nucynta	3	2	0	1	47
Ocular Allergy	16	1	0	15	364
Ocular Antibiotics	24	7	0	17	13
Opioid Analgesic	184	85	4	95	171
Other	564	240	17	307	139
Otic Antibiotic	165	64	0	101	24
Pediculicides	77	29	2	46	17
Plavix	123	99	0	24	360
Proton Pump Inhibitors	641	98	4	539	98
Qualaquin (Quinine)	2	0	1	1	0
Singulair	690	355	1	334	276
Smoking Cessation	84	25	2	57	56
Statins	112	21	1	90	349
Stimulant	945	613	5	327	234
Symlin	2	1	0	1	364
Synagis	153	119	9	25	45
Topical Antibiotics	25	6	0	19	28
Topical Antifungals	30	7	0	23	24
Ultram ER and ODT	9	1	0	8	364
Xolair	2	1	0	1	358
Xopenex Nebs	48	25	0	23	231
Zetia (Ezetimibe)	30	23	0	7	360
Emergency PAs	0	0	0	0	
Total	**11,684**	**6,970**	**156**	**4,558**	

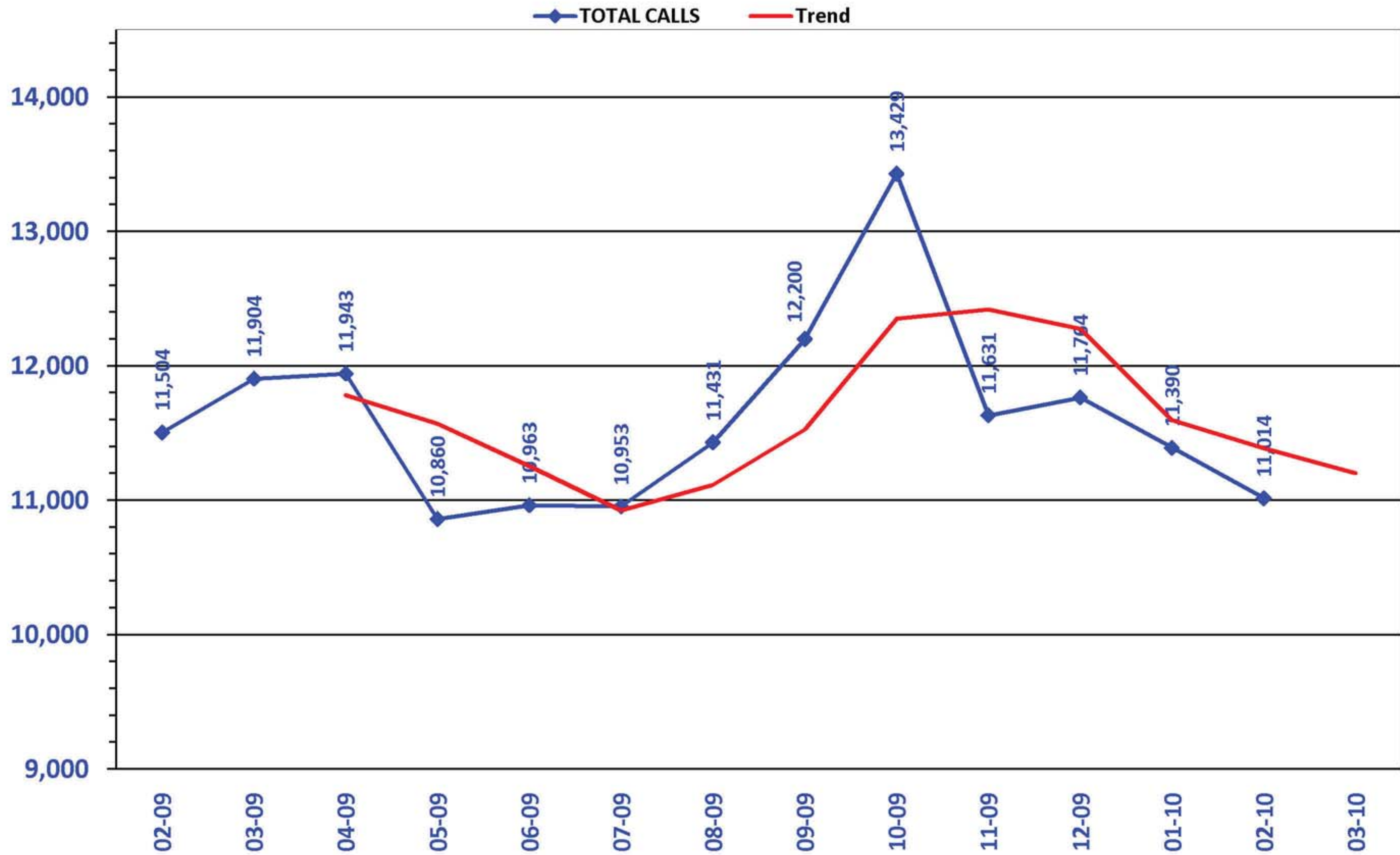
Overrides					
Brand	113	94	1	18	182
Dosage Change	454	422	5	27	17
High Dose	2	0	0	2	0
IHS - Brand	80	67	0	13	102
Ingredient Duplication	7	6	0	1	22
Lost/Broken Rx	72	67	1	4	17
Nursing Home Issue	71	62	1	8	15
Other	20	19	0	1	32
Quantity vs. Days Supply	505	325	9	171	238
Stolen	1	0	1	0	0
Wrong D.S. on Previous Rx	2	2	0	0	360
Overrides Total	**1,327**	**1,064**	**18**	**245**	
Total Regular PAs + Overrides	**13,011**	**8,034**	**174**	**4,803**	

Denial Reasons	
Lack required information to process request.	2,326
Unable to verify required trials.	1,881
Does not meet established criteria.	202
Not an FDA approved indication/diagnosis.	166
Member has active PA for requested medication.	160
Considered duplicate therapy. Member has a prior authorization for similar medication.	114
Requested dose exceeds maximum recommended FDA dose.	68
Medication not covered as pharmacy benefit.	21
Drug Not Deemed Medically Necessary	4

Duplicate Requests: 849

Changes to existing PAs: 817

CALL VOLUME MONTHLY REPORT:
February 2009 – February 2010



OHCA BOARD MEETING

APRIL 08, 2010 OHCA BOARD MEETING

OHCA REQUEST BILLS:

- SB 1349 – Obesity Treatment Pilot Program for Medicaid (Failed 4/8/10 deadline)
- SB 1836 - Health Information Infrastructure Advisory Board to Assist OHCA In Developing Electronic Health Record Incentive Payments

After the April 22nd committee deadline, and as of noon, Wednesday, May 5, 2010, the Oklahoma Legislature is currently tracking a total of 1,106 active bills. OHCA is currently tracking 63 bills. They are broken down as follows:

- OHCA Request 01
- Direct Impact 21
- Agency Interest 07
- Appropriations 10
- Employee Interest 09
- Carry Over 04
- Governor Signed 11

April 29, 2010 was the internal House deadline for rejecting Senate Amendments to House measures and requesting conference. Tuesday, May 4th was the internal House deadline for members to request House conferees for House bills. Monday, May 10th will be the deadline for filing first Conference Committee Reports other than CCRS referred to the General Conference Committee on Appropriations (GCCA).

Sine Die adjournment is set for May 28th.

7.b-1 CHAPTER 45. INSURE OKLAHOMA~~/OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE~~

Subchapter 1. General Provisions
OAC 317:45-1-1 through 317:45-1-4. [AMENDED]
Subchapter 3. Insure Oklahoma~~/O-Epic~~ Carriers
OAC 317:45-3-1. [AMENDED]
OAC 317:45-3-2. [AMENDED]
Subchapter 5. Insure Oklahoma~~/O-Epic~~ Qualified Health Plans
OAC 317:45-5-1. [AMENDED]
OAC 317:45-5-2. [AMENDED]
Subchapter 7. Insure Oklahoma~~/O-Epic~~ ESI Employer Eligibility
OAC 317:45-7-1 through 317:45-7-8. [AMENDED]
Subchapter 9. Insure Oklahoma~~/O-Epic~~ ESI Employee Eligibility
OAC 317:45-9-1 through 317:45-9-4. [AMENDED]
OAC 317:45-9-6 through 317:45-9-8. [AMENDED]
Subchapter 11. Insure Oklahoma~~/O-Epic~~ IP
Part 1. Individual Plan Providers
OAC 317:45-11-1. [AMENDED]
OAC 317:45-11-2. [AMENDED]
Part 3. Insure Oklahoma~~/O-Epic~~ IP Member Health Care Benefits
OAC 317:45-11-10. [AMENDED]
OAC 317:45-11-11. [AMENDED]
OAC 317:45-11-12. [NEW]
OAC 317:45-11-13. [NEW]
Part 5. Insure Oklahoma~~/O-Epic~~ IP Member Eligibility
OAC 317:45-11-20 through 317:45-11-28. [AMENDED]
(Reference APA WF # 10-08)

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 Insure Oklahoma program to comply with Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes. Rules are revised to expand the Insure Oklahoma ESI and IP programs. Expansions include incorporating Oklahoma children through 18 years of age whose household income is from 185 up to and including 300 percent of the Federal Poverty Level. In addition, revisions will expand the current Insure Oklahoma ESI and IP program guidelines to include employees and working adults whose family income does not exceed 250 percent of the Federal Poverty Level. This expansion to the Insure Oklahoma program will help increase access to health care for Oklahomans, thereby reducing the amount of uncompensated care provided by health care providers.

ANALYSIS: Rules are revised to expand the Insure Oklahoma ESI and IP programs. Expansions include incorporating Oklahoma children through 18 years of age whose household income is from 185 up to and including 300 percent of the Federal Poverty Level. The inclusion of children into the program will be phased in over a period of time as determined by the OHCA. In addition, revisions will expand the current Insure Oklahoma ESI and IP program guidelines to include employees and working adults whose family income does not exceed 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the OHCA. These revisions comply with Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes. This expansion to the

Insure Oklahoma program will help increase access to health care for Oklahomans thereby reducing the amount of uncompensated care provided by health care providers.

BUDGET IMPACT: State dollars used to fund the expansion of the Insure Oklahoma Program will be provided from the unused funds from the HEEIA Revolving Fund, in an amount not to exceed $8,000,000.00.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 25, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: July 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; Sections 1009.2 and 1010.1 of Title 56 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:
Revise Insure Oklahoma rules to expand the Program to include Oklahoma children through 18 years of age whose household income is from 185 up to and including 300 percent of the Federal Poverty Level; and expand the current Insure Oklahoma ESI and IP program guidelines to include employees and working adults whose family income does not exceed 250 percent of the Federal Poverty Level.

SUBCHAPTER 1. GENERAL PROVISIONS

317:45-1-1. Purpose and general program provisions

The purpose of this Chapter is to provide rules, in compliance with all applicable federal and state regulations, for the Insure Oklahoma~~/Oklahoma Employer and Employee Partnership for Insurance Coverage (O-EPIC)~~ program that establishes access to affordable health coverage for low-income working adults, ~~their spouses~~ their dependents, and qualified college students. ~~The Oklahoma Health Care Authority (OHCA) contracts with a Third Party Administrator (TPA) for administration of the program.~~

317:45-1-2. Program limitations

(a) The Insure Oklahoma~~/O-EPIC~~ program is contingent upon sufficient funding that is collected and dispersed through a revolving fund within the State Treasury designated as the "Health Employee and Economy Improvement Act (HEEIA) Revolving Fund". This fund is a continuing fund, not subject to fiscal year limitations.

(1) All monies accruing to the credit of the fund are budgeted and expended by the OHCA to implement the program.

(2) The program is funded through a portion of monthly proceeds from the Tobacco Tax, ~~O.S.S.~~ Okla. Stat. '68-302-5 et seq., collected and dispersed through the HEEIA revolving fund, pursuant to Title 68,

Section 302-5 (B.1. and D.1.) and Section 402-3 (B.1 and C.1.) of the Oklahoma Statutes.

(3) The program is limited in scope such that available funding is not exceeded. Available funding includes the estimated annual deposits from tax collections, accrued interest, federal matching funds and any other revenue source deposited in the HEEIA Revolving Fund for the purpose of this program. If at any time it becomes apparent there is risk the available funding may be exceeded, OHCA must take action to ensure the Insure Oklahoma~~/O-EPIC~~ program continues to operate within its fiscal capacity.

(A) Insure Oklahoma~~/O-EPIC~~ may limit eligibility based on:

(i) the federally-approved ~~capacity of the Insure Oklahoma/O-EPIC services for the~~ Health Insurance Flexibility and Accountability (HIFA) Waiver/1115 Waiver; ~~and~~

(ii) Tobacco Tax collections~~.~~; and

(iii) the State Child Health Plan for the State Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act.

(B) The Insure Oklahoma~~/O-EPIC~~ program may limit eligibility when the utilization of services is projected to exceed the spending authority, or, may suspend new eligibility determinations instead, establishing a waiting list.

(i) Applicants, not previously enrolled and participating in the program, submitting new applications for the Insure Oklahoma~~/O-EPIC~~ program are placed on a waiting list. ~~These applications are date and time stamped when received by the TPA.~~ Applications, with the exception of college students, are identified by region and Insure Oklahoma~~/O-EPIC~~ program. Regions are established based on population density statistics as determined through local and national data and may be periodically adjusted to assure statewide availability. Insure Oklahoma~~/O-EPIC~~ program size is determined by OHCA and may be periodically adjusted.

(ii) The waiting list utilizes a "first in - first out" method of selecting eligible applicants by region and program.

(iii) When an applicant is determined eligible and moves from the waiting list to active participation, the applicant must submit a new application.

(iv) Enrolled applicants who are currently participating in the program are not subject to the waiting list.

(v) For approved employers, if the employer hires a new employee after the employer's program eligibility begins, the new employee is allowed to participate during the employer's current eligibility period.

(vi) For approved employers, if the employer has an employee who has a ~~Qualifying Event~~ qualifying event after the employer's program eligibility begins, the employee is allowed to make changes pertaining to the ~~Qualifying Event~~ qualifying event.

(b) College ~~students-~~ student eligibility and participation in the Insure Oklahoma~~/O-EPIC~~ program is contingent upon sufficient funding from the Oklahoma legislature. This funding is separate from the funding described in subsection (a) of this Section.

317:45-1-3. Definitions

The following words or terms, when used in this Chapter, will have the following meanings unless the context clearly indicates otherwise:

"Carrier" means:

(A) an insurance company, insurance service, insurance organization, or group health service, which is licensed to engage in the business of insurance in the State of Oklahoma and is subject to State law which regulates insurance, or Health Maintenance Organization (HMO) which provides or arranges for the delivery of basic health care services to enrollees on a prepaid basis, except for copayments or deductibles for which the enrollee is responsible, or both and is subject to State law which regulates Health Maintenance Organizations (HMOs);

(B) a Multiple Employer Welfare Arrangement (MEWA) licensed by the Oklahoma Insurance Department;

(C) a domestic MEWA exempt from licensing pursuant to Title 36 O.S., Section 634(B) that otherwise meets or exceeds all of the licensing and financial requirements of MEWAs as set out in Article 6A of Title 36; or

(D) any entity organized pursuant to the Interlocal Cooperation Act, Section 1001 et seq. of Title 74 of the Oklahoma Statutes as authorized by Title 36 Section 607.1 of the Oklahoma Statutes and which is eligible to qualify for and hold a certificate of authority to transact insurance in this State and annually submits on or before March 1st a financial statement to the Oklahoma Insurance Department in a form acceptable to the Insurance Commissioner covering the period ending December 31st of the immediately preceding fiscal year.

"Child Care Center" means a facility licensed by OKDHS which provides care and supervision of children and meets all the requirements in OAC 340:110-3-1 through OAC 340:110-3-33.3.

"College Student" means an Oklahoma resident between the age of 19 through 22 that is a full-time student at an Oklahoma accredited University or College.

"Dependent" means the spouse of the approved applicant and/or child under 19 years of age or his or her child 19 years through 22 years of age who is attending an Oklahoma qualified institution of higher education and relying upon the insured employee or member for financial support.

"Eligibility period" means the period of eligibility extending from an approval date to an end date.

"Employee" means a person who works for an employer in exchange for earned income. This includes the owners of a business.

"Employer" means the business entity that pays earned income to employees.

"Employer Sponsored Insurance" means the program that provides premium assistance to qualified businesses for approved applicants.

"EOB" means an Explanation of Benefits.

"Explanation of Benefit" means a statement issued by a carrier that indicates services rendered and financial responsibilities for the carrier and Insure Oklahoma~~/O-EPIC~~ member.

"Full-time Employment" means a normal work week of 24 or more hours.

"Full-time Employer" means the employer who employs an employee for 24 hours or more per week to perform work in exchange for wages or salary.

"Gross Household Income" or "Annual Gross Household Income" means the countable income (earned or unearned) that is computed pursuant to OHCA's waiver and/or state plan using rules found in OAC 317:35.

"Individual Plan" means the safety net program for those qualified individuals who do not have access to Insure Oklahoma~~/O-EPIC~~ ESI.

"Insure Oklahoma~~/O-EPIC~~" means a health plan purchasing strategy in which the State uses public funds to pay for a portion of the costs of health plan coverage for eligible populations.

"Insure Oklahoma~~/O-EPIC~~ IP" means the Individual Plan program.

"Insure Oklahoma~~/O-EPIC~~ ESI" means the Employer Sponsored Insurance program.

"Member" means an individual enrolled in the Insure Oklahoma~~/O-EPIC~~ ESI or IP program.

"OESC" means the Oklahoma Employment Security Commission.

"OHCA" means the Oklahoma Health Care Authority.

"OKDHS" means the Oklahoma Department of Human Services.

"PCP" means Primary Care Provider.

"PEO" or "Professional Employer Organization" means any person engaged in the business of providing professional employer services. A person engaged in the business of providing professional employer services shall be subject to registration under the Oklahoma Professional Employer Organization Recognition and Registration Act as provided in Title 40, Chapter 16 of Oklahoma Statutes, Section 600.1 et.seq.

"Primary Care Provider" means a provider under contract ~~to~~ with the Oklahoma Health Care Authority to provide primary care services, including all ~~medically-necessary~~ medically necessary referrals.

"Premium" means a monthly payment to a carrier for health plan coverage.

~~**"QHP"** means Qualified Health Plan.~~

"Qualified Health Plan" means a health plan that has been approved by the OHCA for participation in the Insure Oklahoma~~/O-EPIC~~ program.

"Qualifying Event" means the occurrence of an event that permits individuals to join a group health plan outside of the "open enrollment period" and/or that allows individuals to modify the coverage they have had in effect. Qualifying events are defined by the employer's health plan and meet federal requirements under Public Law 104-191 (HIPAA), and 42 U.S.C. 300bb-3.

"State" means the State of Oklahoma, acting by and through the Oklahoma Health Care Authority ~~or its designee~~.

~~**"TPA"** means the Third Party Administrator.~~

~~**"Third Party Administrator"** means the entity contracted by the State to provide the administration of the Insure Oklahoma/Oklahoma Employer and Employee Partnership for Insurance Coverage program.~~

317:45-1-4. Reimbursement for out-of-pocket medical expenses

(a) ~~Members are responsible for all out-of-pocket expenses. Out-of-pocket expenses for services covered by the health plan, as defined by the health plan's benefit summary and policies, that exceed five percent of the employee's gross annual household income during the current eligibility period may be reimbursable.~~ Out-of-pocket medical expenses for all approved and eligible members (and/or their approved and eligible dependents) will be limited to 5 percent of their annual gross household income. The OHCA will provide reimbursement for out-of-pocket medical expenses in excess of the 5 percent annual gross household income. A medical expense must be for an allowed and covered service by a qualified health plan to be eligible for reimbursement. For the purpose of this Section, an allowed and covered service is defined as an in-network service covered in accordance with a qualified health plan's benefit summary and policies.

(b) ~~The member must submit a reimbursement claim form with appropriate documentation to the TPA. Information may be submitted at any time but no later than 90 days after the close of their eligibility period to be considered for reimbursement. Appropriate supporting documentation includes an original EOB or paid receipt if no EOB is issued. Both EOB and paid receipts must include required information listed in OAC 317:45-5-1(c)(1)-(6). Reimbursement for out-of-pocket medical expenses is made for the amount indicated as the member's responsibility on the EOB or receipt reflecting the amount paid for medical expenses. Appropriate supporting documentation for prescribed prescriptions must be an original receipt and include information about the pharmacy at which the drug was purchased, the name of the drug dispensed, the quantity dispensed, the prescription number, the name of the person the drug is for, the date the drug was dispensed and the total amount paid.~~ For all eligible medical expenses as defined above in OAC 317:45-1-4(a), the member must submit the OHCA required form and all OHCA required documentation to support that the member incurred and paid the out-of-pocket medical expense. The required documentation must be submitted no later than 90 days after the close of the member's eligibility period. The OHCA required documentation must substantiate that the member actually incurred and paid the eligible out-of-pocket expense. The OHCA may request additional documentation at any time to support a member's request for reimbursement of eligible out-of-pocket medical expenses.

~~(c) Reimbursement for qualified medical expenses is subject to a fixed cap amount. The fixed cap for reimbursement is established annually and is calculated using local and national data concerning individual out-of-pocket health care expenses. The objective of the fixed cap is to set the amount high enough such that, in the great majority of households, all of the costs above the five percent threshold would be absorbed.~~

SUBCHAPTER 3. INSURE OKLAHOMA~~/O-EPIC~~ CARRIERS

317:45-3-1. Carrier eligibility

Carriers must be able to submit all required and requested information and documentation to OHCA for each health plan to be considered for qualification. Carriers must be able to supply specific claim payment scenarios as requested by OHCA. Carriers must also provide the name, address, telephone number, and, if available, email address of a contact individual who is able to verify employer enrollment status in a ~~QHP~~ qualified health plan.

317:45-3-2. Audits

Carriers are subject to audits related to health plan qualifications. These audits may be conducted periodically to determine if ~~QHPs continue~~ each qualified health plan continues to meet all requirements as defined in OAC 317:45-5-1.

SUBCHAPTER 5. INSURE OKLAHOMA~~/O-EPIC~~ QUALIFIED HEALTH PLANS

317:45-5-1. Qualified Health Plan requirements

(a) Participating ~~QHPs~~ qualified health plans must offer, at a minimum, benefits that include:

(1) hospital services;
(2) physician services;
(3) clinical laboratory and radiology;

(4) pharmacy; ~~and~~
(5) office visits~~.~~;
(6) well baby/well child exams;
(7) age appropriate immunizations as required by law; and
(8) emergency services as required by law.

(b) The health plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. All health plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the health plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

(1) An annual in-network out-of-pocket maximum cannot exceed ~~an amount that is established by OHCA. This amount includes any non-pharmacy, annual deductible amount for in-network services~~ $3,000 per individual, excluding pharmacy deductibles.
(2) Office visits cannot require a co-payment exceeding $50 per visit.
(3) Annual in-network pharmacy deductibles cannot exceed $500 per individual.

(c) ~~QHPs may~~ Qualified health plans will provide an EOB, an expense summary, or required documentation for paid ~~or~~ and/or denied claims subject to member co-insurance or member deductible calculations. ~~If an EOB is provided it~~ The required documentation must contain, at a minimum, the:

(1) provider's name;
(2) patient's name;
(3) date(s) of service;
(4) code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);
(5) reason code(s) and description(s) for any denied service(s); and
(6) amount due and/or paid from the patient or responsible party.

317:45-5-2. Closure criteria for health plans

Eligibility for the carrier's health plans ends when:

(1) changes are made to the design or benefits of the ~~QHP~~ health plan such that it no longer meets the requirements ~~for QHPs~~ to be considered a qualified health plan. Carriers are required to report to OHCA any changes in health plans potentially affecting ~~its~~ their qualification for participation in the program not less than 90 days prior to the effective date of such change(s).
(2) the carrier no longer meets the definition set forth in OAC 317:45-1-3.
(3) the health plan is no longer an available product in the Oklahoma market.
(4) the health plan fails to meet or comply with all requirements for a ~~QHP~~ qualified health plan as defined in OAC 317:45-5-1.

SUBCHAPTER 7. INSURE OKLAHOMA~~/O-EPIC~~ ESI EMPLOYER ELIGIBILITY

317:45-7-1. Employer application and eligibility requirements for Insure Oklahoma~~/O-EPIC~~ ESI

(a) In order for an employer to be eligible to participate in the Insure Oklahoma~~/O-EPIC~~ program the employer must:

(1) have no more than a total of 250 employees on its payroll. The increase in the number of employees from 50 to 250 will be phased in over a period of time as determined by the Oklahoma Health Care

Authority. The number of employees is determined based on the third month employee count of the most recently filed OES-3 form with the Oklahoma Employment Security Commission (OESC) ~~and that is in compliance with all requirements of the OESC~~. Employers may provide additional documentation confirming terminated employees that will be excluded from the OESC employee count. If the employer is exempt from filing an OES-3 form or is contracted with a PEO or is a Child Care Center, in accordance with OHCA rules, this determination is based on appropriate supporting documentation, such as the W-2 Summary Wage and Tax form to verify employee count. Employers must be in compliance with all OESC requirements to be eligible for the program. As requested by the OHCA, employers that do not file with the OESC must submit documentation that proves compliance with state law;

(2) have a business that is physically located in Oklahoma;

(3) be currently offering, or at the contracting stage to offer a ~~QHP~~ qualified health plan. The ~~QHP~~ qualified health plan coverage must begin on the first day of the month and continue through the last day of the month;

(4) offer ~~QHP~~ qualified health plan coverage to employees; and

(5) contribute a minimum 25 percent of the eligible employee monthly health plan premium or an equivalent 40 percent of premiums for covered dependent children~~;~~.

(b) An employer who meets all of the requirements listed ~~in subsection (a) of this Section must complete and submit an employer enrollment packet to the TPA~~ in OAC 317:45-7-1(a) must complete and submit the OHCA required forms and application to be considered for participation in the program.

(c) The employer must provide its Federal Employee Identification Number (FEIN).

(d) ~~The employer must notify the TPA, within 5 working days from occurrence, of any Insure Oklahoma/O-EPIC employee's termination or resignation.~~ It is the employer's responsibility to notify the OHCA of any changes that might impact eligibility in the program. Employers must notify the OHCA of any participating employee terminations, resignations, or new hires within five working days of the occurrence.

317:45-7-2. Employer eligibility determination

Eligibility for employers is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-7-1. An employer determined eligible for Insure Oklahoma~~/O-EPIC~~ is approved for up to a 12 month period. The eligibility period begins on the first day of the month following the date of approval. The eligibility period ends the last day of the 12th month. The eligibility period will renew automatically unless the employer's eligibility has been closed (refer to OAC 317:45-7-8). ~~The TPA notifies the employer of the eligibility decision for employer and employees.~~ Employers will be notified of their eligibility decision.

317:45-7-3. Employer cost sharing

Employers are responsible for a portion of the eligible employee's monthly health plan premium as defined in OAC 317:45-7-1. ~~Employers are not required to contribute to an eligible dependent's coverage.~~

317:45-7-4. Qualifying Event

Employers must allow an employee to enroll or change coverage following a ~~Qualifying Event~~ qualifying event. The employer ~~files form~~

~~4, Small Business Employer Change Form, with the TPA for that~~ must submit the required form for each employee experiencing the ~~Qualifying Event~~ qualifying event.

317:45-7-5. Reimbursement

In order to receive a premium subsidy, the employer must submit all pages of the current health plan invoice ~~or other approved documentation to the TPA~~.

317:45-7-6. Credits and adjustments

When an overpayment ~~has occurred~~ occurs, the employer must immediately ~~refund~~ report the ~~TPA, by check, to the attention of the Finance Division~~ erroneous payment. ~~The TPA system has the capability of automatic credits and debits. When an erroneous payment occurs, that results in an overpayment, an automatic recoupment is made to the employer's account against monies owed to the employer on behalf of their employee(s).~~ When such an overpayment(s) occurs, an automatic recoupment is made to the employer's account against future reimbursements.

317:45-7-7. Audits

Employers are subject to audits related to program eligibility ~~status~~ requirements found at OAC 317:45-7-1 and subsidy payments. Eligibility may be revoked at any time if inconsistencies are found. Any monies paid in error are subject to recoupment.

317:45-7-8. Closure

Eligibility provided under the Insure Oklahoma~~/O-EPIC~~ ESI program may end during the eligibility period when:

(1) the employer no longer meets the eligibility requirements in OAC 317:45-7-1;

(2) the employer fails to pay premiums to the carrier;

(3) the employer fails to provide an invoice verifying the monthly health plan premium has been paid; or

(4) an audit indicates a discrepancy that makes the employer ineligible.

SUBCHAPTER 9. INSURE OKLAHOMA~~/O-EPIC~~ ESI EMPLOYEE ELIGIBILITY

317:45-9-1. Employee eligibility requirements

(a) ~~Employee applications are submitted to the TPA~~ Employees must complete and submit the OHCA required forms and application to be considered for participation in the program.

(b) The eligibility determination ~~is~~ will be processed within 30 days from the date the application is received ~~by the TPA~~. The employee ~~is~~ will be notified in writing of the eligibility decision.

(c) All eligible employees described in this ~~Section are enrolled in their Employer's QHP~~ section must be enrolled in their employer's qualified health plan. Eligible employees must:

(1) have ~~a countable~~ an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level (FPL). The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member;

(2) be a US citizen or alien as described in OAC 317:35-5-25;

(3) be Oklahoma residents;
(4) provide social security number for all household members;
(5) not be receiving benefits from ~~SoonerCare/Medicare~~ SoonerCare or Medicare;
(6) be employed with a qualified employer at a business location in Oklahoma;
(7) be age 19 through age 64 or an emancipated minor;
(8) be eligible for enrollment in the employer's ~~QHP~~ qualified health plan;
(9) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
(10) select one of the ~~QHPs~~ qualified health plans the employer is offering.

(d) An employee's dependents are eligible when:
(1) the employer's health plan includes coverage for dependents;
(2) the employee is eligible;
(3) if employed, the spouse may not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and
(4) the dependents are enrolled in the same health plan as the employee.

(e) If an employee or their dependents are eligible for multiple ~~QHPs~~ qualified health plans, each may receive a subsidy under only one health plan.

(f) Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA).

(g) Dependent children in families whose annual gross household income is from 185 up to and including 300 percent of the Federal Poverty Level may be eligible. The inclusion of children into the Insure Oklahoma program will be phased in over a period of time as determined by the OHCA. No other deductions or disregards apply.
(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.
(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Oklahoma State Employee Health Insurance Plan.
(3) Children who already have coverage through another source must undergo, or be excepted from, a six month uninsured waiting period prior to becoming eligible for Insure Oklahoma. Exceptions to the waiting period may include:
(A) the cost of covering the family under the ESI plan meets or exceeds ten percent of the annual gross household income. The cost of coverage includes premiums, deductibles, co-insurance, and co-payments;
(B) loss of employment by a parent which made coverage available;
(C) affordable ESI is not available; “affordable” coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); or
(D) loss of medical benefits under SoonerCare.

317:45-9-2. Employee eligibility period

(a) Employee eligibility is contingent upon the employer's program eligibility.

(b) The employee's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-9-1.

(c) If the employee is determined eligible, he/she is approved for a period not greater than 12 months. ~~The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period.~~

(d) The employee's eligibility period begins on the first day of the month following the date of approval.

317:45-9-3. Qualifying Event

~~(a) Employees are allowed to apply following a Qualifying Event.~~

~~(b) An employee's dependents may become eligible for coverage and are allowed to apply following a Qualifying Event.~~

Employees and/or an employee's dependents may apply for the ESI program following a qualifying event.

317:45-9-4. Employee cost sharing

Employees are responsible for up to ~~15%~~ 15 percent of their health plan premium. The employees are also responsible for up to ~~15%~~ 15 percent of their dependent's health plan premium if the dependent is included in the program. The combined portion of the employee's cost sharing for health plan premiums cannot exceed three percent of his/her annual gross ~~annual~~ household income computed monthly.

317:45-9-6. Audits

Individuals participating in the Insure Oklahoma~~/O-EPIC~~ program are subject to audits related to their eligibility, subsidy payments, and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-9-7. Closure

(a) Employer and employee eligibility are tied together. If the employer is no longer eligible, then the associated employees enrolled under that employer are also ineligible. Employees are mailed a notice 10 days prior to closure of eligibility.

(b) The employee's certification period may be terminated when:

(1) termination of employment, either voluntary or involuntary, occurs;

(2) the employee moves out-of-state;

(3) the covered employee dies;

(4) the employer ends its contract with the ~~QHP~~ qualified health plan;

(5) the employer's eligibility ends;

(6) an audit indicates a discrepancy that makes the employee or employer ineligible;

(7) the employer is terminated from the program;

(8) the employer fails to pay the premium;

(9) the ~~QHP~~ qualified health plan or carrier ~~is no longer qualified~~ no longer meets the requirements set forth in this Chapter;

(10) the employee becomes eligible for ~~Medicaid/Medicare~~ SoonerCare or Medicare;

(11) the employee or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility;
(12) the employee is no longer listed as a covered person on the employer's health plan invoice; or
(13) the employee requests closure.

317:45-9-8. Appeals
(a) Employee appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.
(b) ~~Employee appeals regarding out-of-pocket expenses are made to the TPA. If the employee disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final~~ Employee appeals regarding out-of-pocket medical expense reimbursements may be made to the OHCA. The OHCA may request documentation to support the out-of-pocket appeal. The decision of the OHCA is final.

SUBCHAPTER 11. INSURE OKLAHOMA~~/O-EPIC~~ IP
PART 1. INDIVIDUAL PLAN PROVIDERS

317:45-11-1. Insure Oklahoma~~/O-EPIC~~ Individual Plan providers
Insure Oklahoma~~/O-EPIC~~ Individual Plan (IP) providers must comply with existing SoonerCare rules found at OAC 317:25 and OAC 317:30. In order to receive reimbursement, the IP provider:
(1) must enter into a SoonerCare contract; and
(2) must complete Insure Oklahoma~~/O-EPIC~~ IP addendum if provider wants to provide primary care services as a PCP.

317:45-11-2. Insure Oklahoma~~/O-EPIC~~ IP provider payments
Payment for covered benefits rendered to Insure Oklahoma~~/O-EPIC~~ IP members~~, as shown in OAC 317:45-11-10 and not listed as a non-covered service in OAC 317:45-11-11,~~ is made to contracted Insure Oklahoma~~/O-EPIC~~ IP healthcare providers for medical and surgical services within the scope of OHCA's medical programs, provided the services are medically necessary as defined in OAC 317:30-3-1(f).
(1) Coverage of certain services requires prior authorization ~~as shown in OAC 317:45-11-10~~ and may be based on a determination made by a medical consultant in individual circumstances;
(2) The decision to charge a ~~copayment~~ co-payment for a missed visit is at the provider's discretion;
(3) The provider may collect the member's ~~co-pay~~ co-payment in addition to the SoonerCare reimbursement for services provided; and
(4) The provider may refuse to see members based on their inability to pay their ~~co-pay~~ co-payment.

PART 3. INSURE OKLAHOMA~~/O-EPIC~~ IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma~~/O-EPIC~~ IP adult benefits
(a) All IP adult benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section. The scope of IP adult benefits described in this Section ~~are~~ is subject to specific non-covered services listed in OAC 317:45-11-11.
(b) A PCP referral is required to see any other provider with the exception of the following services:
(1) behavioral health services;
(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;

(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;
(4) women's routine and preventive health care services;
(5) emergency medical condition as defined in OAC 317:30-3-1; and
(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

(c) IP covered adult benefits for in-network services, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000. Dependent children coverage is found at OAC 317:45-11-12. Children are not held to the maximum lifetime benefit. Coverage includes:

(1) Anesthesia / Anesthesiologist Standby. Covered in accordance with OAC 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).
(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
(3) Chelation Therapy. Covered for heavy metal poisoning only.
(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with OAC 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): $0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); $25 co-pay per scan.
(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.
(6) Inpatient Hospital Benefits. Covered in accordance with OAC 317:30-5-41, 317:30-5-47 and 317:30-5-95; $50 co-pay per admission.
(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a $10 co-pay. This visit counts as an office visit.
(8) Office Visits/Specialist Visits. Covered in accordance with OAC 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits; $10 co-pay per visit.
(9) Outpatient Hospital/Facility Services.
(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; $25 co-pay per visit.
(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; $10 co-pay per visit.
(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year; $10 co-pay per visit.
(10) Maternity (Obstetric). Covered in accordance with OAC 317:30-5-22. Nursery care paid separately under eligible child; $50 inpatient hospital co-pay.

(11) Laboratory/Pathology. Covered in accordance with OAC 317:30-5-20; $0 co-pay.
(12) Mammogram (Radiological or Digital). Covered in accordance with OAC 317:30-5-901; $0 co-pay.
(13) Immunizations. Covered in accordance with OAC 317:30-5-2.
(14) Assistant Surgeon. Covered in accordance with OAC 317:30-5-8.
(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; $0 co-pay.
(16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital $50 or Outpatient Hospital/Facility; $25 co-pay applies.
(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with OAC 317:30-5-95.1; $50 co-pay per admission.
(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient).

(A) Agency services. Covered in accordance with OAC 317:30-5-241 and OAC 317:30-5-596; $10 co-pay per visit.

(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient ~~Mental~~ Behavioral Health Services and Outpatient Substance Abuse Treatment:

(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(ii) Practitioners with a license to practice in the state in which services are provided or those actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in (I) through (VI) below. The exemptions from licensure under ~~59 §1353(4) and (5)~~ 59 Okla. Stat. §1353(4) and (5), 59 §1903(C) and (D), 59 §1925.3(B) and (C), and 59 §1932(C) and (D) do not apply to Outpatient Behavioral Health Services.

(I) Psychology,
(II) Social Work (clinical specialty only),
(III) Professional Counselor,
(IV) Marriage and Family Therapist,
(V) Behavioral Practitioner, or
(VI) Alcohol and Drug Counselor.

(iii) Advanced Practice Nurse (certified in a psychiatric mental health specialty), licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided.

(iv) A Physician's Assistant who is licensed in good standing in this state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(v) LBHPs must have a valid Insure Oklahoma contract in order to bill for services rendered.

(vi) LBHP services require prior authorization and are limited to 8 therapy services per month per member and 8 testing units per year per member; $10 co-pay per visit.

(19) Durable Medical Equipment and Supplies. Covered in accordance with OAC 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a $15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; $5 co-pay for durable/non-durable supplies and $25 co-pay for durable medical equipment.
(20) Diabetic Supplies. Covered in accordance with OAC 317:30-5-211.15; not subject to $15,000 annual DME limit; $5 co-pay per prescription.
(21) Oxygen. Covered in accordance with OAC 317:30-5-211.11 through 317:30-5-211.12; not subject to $15,000 annual DME limit; $5 co-pay per month.
(22) Pharmacy. Covered in accordance with OAC 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; $5/$10 co-pay per prescription.
(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with OAC 317:30-5-72.1; $5/$10 co-pay per product.
(24) Nutrition Services. Covered in accordance with OAC 317:30-5-1076; $10 co-pay per visit.
(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with OAC 317:30-5-211.13; $25 co-pay per prosthesis.
(26) Surgery. Covered in accordance with OAC 317:30-5-8; $50 co-pay per inpatient admission and $25 co-pay per outpatient visit.
(27) Home Dialysis. Covered in accordance with OAC 317:30-5-211.13; not subject to $15,000 annual DME limit; $0 co-pay.
(28) Parenteral Therapy. Covered in accordance with OAC 317:30-5-211.14; not subject to $15,000 annual DME limit; $25 co-pay per month.
(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with OAC 317:30-3-57; $0 co-pay.
(30) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with OAC 317:30-5-211.15 and 317:30-5-42.16(b)(3).
(31) Ultraviolet Treatment-Actinotherapy.
(32) Fundus photography.
(33) Perinatal dental care for pregnant women. Covered in accordance with OAC 317:30-5-696; $0 co-pay.

317:45-11-11. Insure Oklahoma~~/O-EPIC~~ IP adult non-covered services

Certain health care services are not covered in the Insure Oklahoma~~/O-EPIC~~ IP adult benefit package listed in OAC 317:45-11-10. These services include, but are not limited to:

(1) services ~~that the member's PCP or Insure Oklahoma/O-EPIC does not consider~~ not considered medically necessary;
(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;
(3) organ and tissue transplant services;
(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of weight loss including appetite suppressants and supplements, and/or nutritional services prescribed only for the treatment of weight loss;
(5) procedures, services and supplies related to sex transformation;

(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) dental services (preventive, basic, major, orthodontia, extractions or services related to dental accident) except for pregnant women and as covered in OAC 317:30-5-696;
(11) vision care and services (including glasses), except services treating diseases or injuries to the eye;
(12) physical medicine including chiropractic~~, acupuncture and osteopathic manipulation~~ and acupuncture therapy;
(13) hearing services;
(14) transportation [~~emergent~~ emergency or ~~non-emergent~~ non-emergency (air or ground)];
(15) rehabilitation (inpatient);
(16) cardiac rehabilitation;
(17) allergy testing and treatment;
(18) home health care with the exception of medications, intravenous (IV) therapy, supplies;
(19) hospice regardless of location;
(20) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(21) genetic counseling;
(22) fertility evaluation/treatment/and services;
(23) sterilization reversal;
(24) Christian Science Nurse;
(25) Christian Science Practitioner;
(26) skilled nursing facility;
(27) long-term care;
(28) stand by services;
(29) thermograms;
(30) abortions (for exceptions, refer to OAC 317:30-5-6);
(31) services of a Lactation Consultant;
(32) services of a Maternal and Infant Health Licensed Clinical Social Worker; and
(33) enhanced services for medically high risk pregnancies as found in OAC 317:30-5-22.1.

317:45-11-12. Insure Oklahoma IP children benefits

(a) IP covered child benefits for in-network services, limits, and applicable co-payments are listed in this Subsection. All IP benefits are subject to rules delineated in OAC 317:30 except as specifically set out in this Section. All services provided must be medically necessary as defined in OAC 317:30-3-1(f). The scope of IP child benefits described in this Section is subject to specific non-covered services listed in OAC 317:45-11-13. Dependent children are not held to the maximum lifetime benefit of $1,000,000. Coverage includes:
(1) Ambulance services. Covered as medically necessary; $50 co-pay per occurrence; waived if admitted.
(2) Blood and blood products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
(3) Chelation therapy. Covered for heavy metal poisoning only.
(4) Chemotherapy and radiation therapy. Covered as medically necessary; $10 co-pay per visit.

(5) Clinic services including renal dialysis services. Covered as medically necessary; $0 co-pay for dialysis services; $10 co-pay per office visit.
(6) Diabetic supplies. One glucometer, one spring-loaded lancet device, three replacement batteries per year - 100 glucose strips and lancets per month; not included in DME $15,000 max/year; $5 co-pay per billable service. Additional supplies require prior authorization.
(7) Diagnostic X-ray services. Covered as medically necessary; $25 co-pay per scan for MRI, MRA, PET, CAT scans only.
(8) Dialysis. Covered as medically necessary.
(9) Durable medical equipment and supplies. Covered as medically necessary with $15,000 annual maximum; $5 co-pay per item for durable/non-durable supplies; $25 co-pay per item for DME.
(10) Emergency department services. Covered as medically necessary; $30 co-pay per occurrence; waived if admitted.
(11) Family planning services and supplies. Birth control information and supplies; pap smears; pregnancy tests.
(12) Home health services. Home health visits limited to 36 visits per year, prior authorization required, includes medications IV therapy and supplies; $10 co-pay per visit, appropriate pharmacy and DME co-pays will apply.
(13) Hospice services. Covered as medically necessary, prior authorization required; $10 co-pay per visit.
(14) Immunizations. Covered as recommended by ACIP; $0 co-pay.
(15) Inpatient hospital services (acute care only). Covered as medically necessary; $50 co-pay per admission.
(16) Laboratory services. Covered as medically necessary.
(17) Psychological testing. Psychological, neurological and development testing; outpatient benefits per calendar year, prior authorization required issued in four unit increments - not to exceed eight units/hours per testing set; $0 co-pay.
(18) Mental health/substance abuse treatment-outpatient. All outpatient benefits require prior authorization. Outpatient benefits limited to 48 visits per calendar year. Additional units as medically necessary; $10 co-pay per outpatient visit.
(19) Mental health/substance abuse treatment-inpatient. Acute, detox, partial, and residential treatment center (RTC) with 30 day max per year, 2 days of partial or RTC treatment equals 1 day accruing to maximum. Additional units as medically necessary; $50 co-pay per admission. Requires prior authorization.
(20) Nurse midwife services. Covered as medically necessary for pregnancy-related services only; $0 co-pay.
(21) Nutrition services. Covered as medically necessary; $10 co-pay.
(22) Nutritional support. Covered as medically necessary; not included in DME $15,000 max/year. Parenteral nutrition covered only when medically necessary; $25 co-pay.
(23) Other medically necessary services. Covered as medically necessary.
(24) Oral surgery. Covered as medically necessary and includes the removal of tumors and cysts; $25 co-pay for outpatient; $50 co-pay for inpatient hospital.
(25) Outpatient hospital services. Covered as medically necessary and includes ambulatory surgical centers and therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for children with proven malignancies

visit for therapeutic radiology or chemotherapy.

(26) Oxygen. Covered as medically necessary; not included in DME $15,000 max/year; $5 co-pay per month.

(27) PCP visits. Blood lead screen covered as medically necessary. Hearing services limited to one outpatient newborn screening. Well baby/well child exams follow recommended schedule to age 19; $0 co-pay for preventive visits and well baby/well child exams; $10 co-pay for all other visits.

(28) Physical, occupational, and speech therapy. Covered as medically necessary; prior authorization required; $10 co-pay per visit.

(29) Physician services, including preventive services. Covered as medically necessary; $0 co-pay for preventive visits; $10 co-pay for all other visits.

(30) Prenatal, delivery and postpartum services. Covered as medically necessary; $0 co-pay for office visits; $50 co-pay for delivery.

(31) Prescription drugs and insulin. Limited to six per month; generic preferred. Prenatal vitamins and smoking cessation products do not count toward the six prescription limit; $5-$10 co-pay.

(32) Smoking cessation products. Limited coverage; 90-day supply; products do not count against prescription drug limit; $5-$10 co-pay.

(33) Specialty clinic services. Covered as medically necessary; $10 co-pay.

(34) Surgery. Covered as medically necessary; $25 co-pay for outpatient facility; $50 co-pay for inpatient hospital.

(35) Tuberculosis services. Covered as medically necessary; $10 co-pay per visit.

(36) Ultraviolet treatment-actinotherapy. Covered as medically necessary; prior authorization required after one visit per 365 sequential days; $5 co-pay.

(b) A PCP referral is required to see any other provider with the exception of the following services:

(1) behavioral health services;

(2) prenatal and obstetrical supplies and services, meaning prenatal care, delivery and 60 days of postpartum care;

(3) family planning supplies and services, meaning an office visit for a comprehensive family planning evaluation, including obtaining a Pap smear;

(4) women's routine and preventive health care services;

(5) emergency medical condition as defined in OAC 317:30-3-1; and

(6) services delivered to American Indians at Indian Health Service, tribal, or urban Indian clinics.

317:45-11-13. Insure Oklahoma IP children non-covered services

Certain health care services are not covered in the Insure Oklahoma IP benefit package for children listed in OAC 317:45-11-12. These services include, but are not limited to:

(1) services not considered medically necessary;

(2) any medical service when the member refuses to authorize release of information needed to make a medical decision;

(3) organ and tissue transplant services;

(4) weight loss intervention and treatment including, but not limited to, bariatric surgical procedures or any other weight loss surgery or procedure, drugs used primarily for the treatment of

nutritional services prescribed only for the treatment of weight loss;
(5) procedures, services and supplies related to sex transformation;
(6) supportive devices for the feet (orthotics) except for the diagnosis of diabetes;
(7) cosmetic surgery, except as medically necessary and as covered in OAC 317:30-3-59(19);
(8) over-the-counter drugs, medicines and supplies except contraceptive devices and products, and diabetic supplies;
(9) experimental procedures, drugs or treatments;
(10) transportation [non-emergency (air or ground)];
(11) rehabilitation (inpatient);
(12) cardiac rehabilitation;
(13) allergy testing and treatment;
(14) Temporomandibular Joint Dysfunction (TMD) (TMJ);
(15) genetic counseling;
(16) fertility evaluation/treatment/and services;
(17) sterilization reversal;
(18) Christian Science Nurse;
(19) Christian Science Practitioner;
(20) skilled nursing facility;
(21) long-term care;
(22) stand by services;
(23) thermograms;
(24) abortions (for exceptions, refer to OAC 317:30-5-6);
(25) donor transplant expenses; and
(26) tubal ligations and vasectomies.

PART 5. INSURE OKLAHOMA~~/O-EPIC~~ IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma~~/O-EPIC~~ IP eligibility requirements

(a) ~~Employees~~ Working adults not eligible to participate in an employer's ~~QHP~~ qualified health plan, employees of non-participating employers, self-employed, unemployed seeking work, ~~and~~ workers with a disability, and qualified college students may apply for the Individual Plan. Applicants cannot obtain IP coverage if they are eligible for ESI. Applicants, unless a qualified college student, must be engaged in employment as defined under state law, or must be considered unemployed as defined under state law.
(b) The eligibility determination ~~is~~ will be processed within 30 days from the date the complete application is received ~~by the TPA~~. The applicant ~~is~~ will be notified in writing of the eligibility decision.
(c) In order to be eligible for the IP, the applicant must:
(1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time they make application;
(2) be a US citizen or alien as described in OAC 317:35-5-25;
(3) be an Oklahoma resident;
(4) provide social security numbers for all household members;
(5) be not currently enrolled in, or have an open application for~~,~~ ~~SoonerCare/Medicare~~ SoonerCare or Medicare;
(6) be age 19 through 64 or an emancipated minor;
(7) make premium payments by the due date on the invoice; ~~and~~
(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2); and

(9) be not currently covered by a private health insurance policy or plan.

(d) If employed and working for an approved Insure Oklahoma~~/O-EPIC~~ employer who offers a ~~QHP~~ qualified health plan, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.

(2) be ineligible for participation in their employer's ~~QHP~~ qualified health plan due to number of hours worked.

(3) have received notification from Insure Oklahoma~~/O-EPIC~~ indicating their employer has applied for Insure Oklahoma~~/O-EPIC~~ and has been approved.

(e) If employed and working for an employer who ~~doesn't~~ does not offer a ~~QHP~~ qualified health plan, the applicant must meet the requirements in subsection (c) of this Section and have ~~a countable~~ an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) must have an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority;

(2) verify self-employment by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms;

(3) verify current income by providing appropriate supporting documentation; and

(4) ~~must not be employed by any full-time employer who meets the eligibility requirements in OAC 317:45-7-1(a)(1)-(2)~~ must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2).

(g) If unemployed seeking work, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicant must have an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority. In determining income, payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010 and any amount of emergency unemployment compensation paid through May 31, 2010, will not be counted, as authorized under the American Recovery and Reinvestment Tax Act of 2009.

(2) Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) OESC eligibility letter,

(B) OESC weekly unemployment payment statement, or

(C) bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and:

(1) Applicant must have an annual gross household income at or below ~~200%~~ 250 percent of the Federal Poverty Level based on a family size of one~~; and~~. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.

(2) Applicant must verify eligibility by providing a copy of their:

(A) ticket to work, or

(B) ticket to work offer letter.

317:45-11-21. Dependent eligibility

(a) If the spouse of an Insure Oklahoma~~/O-EPIC~~ IP approved individual is eligible for Insure Oklahoma~~/O-EPIC~~ ESI, they must apply for Insure Oklahoma~~/O-EPIC~~ ESI. Spouses cannot obtain Insure Oklahoma~~/O-EPIC~~ IP coverage if they are eligible for Insure Oklahoma~~/O-EPIC~~ ESI.

(b) The employed or self-employed spouse of an approved applicant must meet the guidelines listed in OAC 317:45-11-20(a) through (g) to be eligible for Insure Oklahoma~~/O-EPIC~~ IP.

(c) The dependent of an applicant approved according to the guidelines listed in OAC 317:45-11-20(h) does not become automatically eligible for Insure Oklahoma~~/O-EPIC~~ IP.

(d) The applicant and the dependents' eligibility are tied together. If the applicant no longer meets the requirements for Insure Oklahoma~~/O-EPIC~~ IP, then the associated dependent enrolled under that applicant is also ineligible.

(e) Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA).

(f) Dependent children in families whose annual gross household income is from 185 up to and including 300 percent of the Federal Poverty Level may be eligible. The inclusion of children into the Insure Oklahoma program will be phased in over a period of time as determined by the OHCA. No other deductions or disregards apply.

(1) Children found to be eligible for SoonerCare may not receive coverage through Insure Oklahoma.

(2) Children are not eligible for Insure Oklahoma if they are a member of a family eligible for employer-sponsored dependent health insurance coverage under any Oklahoma State Employee Health Insurance Plan.

(3) Children who already have coverage through another source must undergo, or be excepted from, a six month uninsured waiting period prior to becoming eligible for Insure Oklahoma. Exceptions to the waiting period may include:

(A) the cost of covering the family under the ESI plan meets or exceeds 10 percent of the annual gross household income. The cost of coverage includes premiums, deductibles, co-insurance, and co-payments;

(B) loss of employment by a parent which made coverage available;

(C) affordable ESI is not available; "affordable" coverage is defined by the OHCA annually using actuarially sound rates established by the Oklahoma State and Education Employee Group Insurance Board (OSEEGIB); or

(D) loss of medical benefits under SoonerCare.

317:45-11-21.1. Certification of newborn child deemed eligible

(a) A newborn child is deemed eligible on the date of birth for SoonerCare benefits when the child is born to a member of Insure Oklahoma~~/O-EPIC~~ IP and the ~~household countable~~ annual gross household income does not exceed SoonerCare requirements. ~~(For purposes of this subparagraph, a newborn child is defined as any child under the age of one year).~~ The newborn child is deemed eligible through the last day of the month the child attains the age of one year.
(b) The newborn child's eligibility is not dependent on the mother's continued eligibility ~~for~~ in Insure Oklahoma~~/O-EPIC~~ IP. The child's eligibility is based on the original eligibility determination of the mother for Insure Oklahoma~~/O-EPIC~~ IP and consideration is not given to any income or resource changes that occur during the deemed eligibility period.
(c) The newborn child's certification period is shortened only in the event the child:

~~(1) leaves the mother's home;~~
~~(2)~~ (1) loses Oklahoma residence; or
~~(3) has medical needs included in another assistance case; or~~
~~(4)~~ (2) expires.

(d) No other conditions of eligibility are applicable, including social security number enumeration~~; however, it~~ and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the child's birth.

317:45-11-22. PCP choices
(a) The applicant (and dependents if also applying for Insure Oklahoma~~/O-EPIC~~ IP) is required to select a valid PCP ~~choices as required on the application~~.
(b) If a valid PCP is selected by the applicant or dependents and they are not enrolled with the first PCP choice, they are enrolled with the next available PCP choice. The applicant is notified in writing why their initial choice was not selected.
(c) After initial enrollment in Insure Oklahoma~~/O-EPIC~~ IP, the applicant or dependents can change their PCP selection by calling the Insure Oklahoma~~/O-EPIC~~ helpline. ~~Changes take effect the first day of the next month or the first day of the 2nd consecutive month. Applicant and dependents are only allowed to change their PCP a maximum of four times per calendar year.~~

317:45-11-23. Employee eligibility period
(a) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a) through (e).

(1) The employee's coverage period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is received and approved on January 14th and the premium is received before February 15th, eligibility begins March 1st; or an application is received and approved January 15th and the premium is received on March 15th, eligibility begins April 1st.)
(B) If premiums are paid early, eligibility still begins as scheduled.

(2) Employee eligibility is contingent upon the employer meeting the program guidelines.

(3) The employee's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-9-1 or OAC 317:45-11-20(a) through (e).

(4) If the employee is determined eligible for Insure Oklahoma~~/O-EPIC~~ IP, he/she is approved for a period not greater than 12 months. ~~The length of the eligibility period is based on the remaining number of months the employer has left in its eligibility period as defined in OAC 317:45-7-1, 317:45-7-2 and 317:45-7-8.~~

(b) The rules in this subsection apply to applicants eligible according to OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).

(1) The applicant's eligibility is determined ~~by the TPA~~ using the eligibility requirements listed in OAC 317:45-11-20(a) through (c) and OAC 317:45-11-20(f) through (h).

(2) If the applicant is determined eligible for Insure Oklahoma~~/O-EPIC~~ IP, he/she is approved for a period not greater than 12 months.

(3) The applicant's eligibility period begins only after receipt of the premium payment.

(A) If the application is received and approved before the 15th of the month, eligibility begins the first day of the second consecutive month. If the application is not received or approved before the 15th of the month, eligibility begins the first day of the 3rd consecutive month. (Examples: An application is approved on January 14th and the premium is received before February 15th, eligibility begins March 1st; or an application is approved January 15th and the premium is received on March 15th, eligibility begins April 1st.)

(B) If premiums are paid early, eligibility still begins as scheduled.

317:45-11-24. Member cost sharing

(a) Members are given monthly invoices for health plan premiums. The premiums are due, and must be paid in full, no later than the 15th day of the month prior to the month of IP coverage.

(1) Members are responsible for their monthly premiums, in an amount not to exceed four percent of their ~~gross~~ monthly gross household income.

(2) Working disabled individuals are responsible for their monthly premiums in an amount not to exceed ~~4%~~ four percent of their ~~gross~~ monthly gross household income, based on a family size of one and capped at ~~200%~~ 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the Oklahoma Health Care Authority.

(b) IP coverage is not provided until the premium and any other amounts due are paid in full. Other amounts due may include but are not limited to any fees, charges, or other costs incurred as a result of Insufficient/Non-sufficient funds.

317: 45-11-25. Premium payment

IP health plan premiums are established by the OHCA. Employees and college students are responsible for up to 20 percent of their IP health plan premium. The employees are also responsible for up to 20 percent of their ~~spouse=s~~ dependent's IP health plan premium if the dependent is included in the program. The combined portion of the employee's or college student=s cost sharing for IP health plan

premiums cannot exceed four percent of his/her ~~gross~~ annual gross household income computed monthly.

317:45-11-26. Audits

Members participating in the Insure Oklahoma~~/O-EPIC~~ program are subject to audits related to their eligibility, subsidy payments, premium payments and out-of-pocket reimbursements. Eligibility may be reversed at any time if inconsistencies are found. Any monies paid in error will be subject to recoupment.

317:45-11-27. Closure

(a) Members are mailed a notice 10 days prior to closure of eligibility.
(b) The employer and employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma~~/O-EPIC~~ then eligibility for the associated employees enrolled under that employer are also ineligible.
(c) The employee's certification period may be terminated when:
    (1) the member requests closure;
    (2) the member moves out-of-state;
    (3) the covered member dies;
    (4) the employer's eligibility ends;
    (5) an audit indicates a discrepancy that makes the member or employer ineligible;
    (6) the employer is terminated from Insure Oklahoma~~/O EPIC~~;
    (7) the member fails to pay the amount due within 60 days of the date on the bill;
    (8) the ~~QHP~~ qualified health plan or carrier ~~is no longer qualified~~ no longer meets the requirements set forth in this chapter;
    (9) the member begins receiving ~~SoonerCare/Medicare~~ SoonerCare or Medicare benefits;
    (10) the member begins receiving coverage by a private health insurance policy or plan; or
    (11) the member or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility.
(d) This subsection applies to applicants eligible according to OAC 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h). The member's certification period may be terminated when:
    (1) the member requests closure;
    (2) the member moves out-of-state;
    (3) the covered member dies;
    (4) the employer's eligibility ends;
    (5) an audit indicates a discrepancy that makes the member or employer ineligible;
    (6) the member fails to pay the amount due within 60 days of the date on the bill;
    (7) the member becomes eligible for ~~SoonerCare/Medicare~~ SoonerCare or Medicare;
    (8) the member begins receiving coverage by a private health insurance policy or plan; or
    (9) the member or employer reports ~~to the OHCA or the TPA~~ any change affecting eligibility.

317:45-11-28. Appeals

(a) Member appeal procedures based on denial of eligibility due to income are described at OAC 317:2-1-2.

(b) ~~Member appeals related to premium payments and/or out of pocket expenses are made to the TPA. If the member disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final.~~
~~(c) Employee appeals regarding out-of-pocket expenses are made to the TPA. If the employee disagrees with the TPA's findings, reconsideration of the finding may be made to the OHCA. The decision of the OHCA is final~~ Employee appeals regarding out-of-pocket medical expense reimbursements may be made to the OHCA. The OHCA may request documentation to support the out-of-pocket appeal. The decision of the OHCA is final.

7.b-2 CHAPTER 25. SOONERCARE CHOICE
Subchapter 9. Health Access Networks
OAC 317:25-9-1. through 317:25-9-3. [NEW]
(Reference APA WF # 10-14)

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 establish provider requirements and billing guidelines for Health Access Networks (HAN's). HAN's are non-profit, administrative entities that work with providers to coordinate and improve the quality of care for SoonerCare members. Effective July 1, 2010, OHCA will initiate a pilot program to pay HAN's a per member per month fee in order to enhance the development of comprehensive medical homes for SoonerCare Choice members. Emergency rules are needed in order to have rules in place by July 1, 2010, the start date for the HAN's pilot project.

ANALYSIS: Beginning July 1, 2010, the Oklahoma Health Care Authority will implement a pilot program to pay Health Access Networks to coordinate and improve the quality of care for SoonerCare members. Rules are needed to establish provider requirements and billing guidelines for HAN's which are not-for-profit, administrative entities that work with SoonerCare providers to coordinate and improve the quality of care for our members. Contracted HAN's will be paid a $5.00 per member per month fee in order to enhance the development of comprehensive medical homes for SoonerCare Choice members.

BUDGET IMPACT: Agency staff has determined that implementation of the Health Access Networks will cost approximately $3.3 million total annual dollars with a state share of $825,000.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 25, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: July 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 SoonerCare Choice rules to initiate a pilot program to reimburse Health Access Networks to coordinate and improve the quality of care for SoonerCare members.

SUBCHAPTER 9. HEALTH ACCESS NETWORKS

317:25-9-1. Purpose

The purpose of this Subchapter is to describe the rules governing the Health Access Networks (HAN's) participating in the statewide

Networks will work with providers to coordinate and improve the quality of care for SoonerCare members. The use of Health Access Networks is a limited pilot program with the purpose of enhancing the development of comprehensive medical homes for Oklahoma SoonerCare Choice members.

317:25-9-2. Requirements

(a) HAN's are non-profit, administrative entities that work with providers to coordinate and improve the quality of care for SoonerCare members. The HAN must:

(1) be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare members;

(2) offer patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or the State;

(3) submit an application to the OHCA as specified in (c) of this Section;

(4) offer core components of electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies;

(5) have an organized and systematic quality improvement process, including the identification of measurable performance targets; and

(6) offer care management/care coordination to persons with complex health care needs including:

(A) the co-management of individuals enrolled in OHCA's Health Management Program;

(B) individuals with frequent emergency room utilization;

(C) women enrolled in the Oklahoma Cares Program diagnosed with breast or cervical cancer;

(D) pregnant women enrolled in the High Risk OB Program; and

(E) individuals enrolled in the Pharmacy Lock-In Program; and

(b) Networks must meet at least two of the following:

(1) have a formal affiliation agreement/partnership at the community-level with traditional and non-traditional providers;

(2) have a formal program to promote public health principles, community development, and local educational programs to address the challenges of rural and underserved populations; and

(3) have 501(c)3 or not-for-profit status.

(c) In order to qualify to participate as a SoonerCare contracted HAN's, the network must submit an application to the OHCA that details how the network plans to:

(1) reduce costs associated with the provision of health care services to SoonerCare, uninsured and underinsured individuals;

(2) improve access to, and the availability of, health care services provided to individuals served by the health access network;

(3) enhance the quality and coordination of health care services provided to such individuals through mutually defined quality improvement initiatives;

(4) improve the health status of communities served by the health access network;

(5) reduce health disparities in such communities;

(6) identify all PCPs, specialty providers, and other provider types affiliated with the health access network.

(d) The application to participate as a SoonerCare contracted HAN's will be accepted and approved at the sole discretion of OHCA with

staff and approval by OHCA's Medical Advisory Taskforce (MAT).

317:25-9-3. Reimbursement

(a) In order to be eligible for payment, HAN's must have on file with OHCA, an approved Provider Agreement. Through this agreement, the HAN assures that OHCA's requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed annually with each provider.

(b) The HAN will be reimbursed a per member per month (PMPM) rate based on the number of member months paid to the PCPs affiliated with the HAN. OHCA reserves the right to limit reimbursement based on availability of funds.

7.b-3 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
OAC 317:30-5-241.1. [AMENDED]
(Reference APA WF # 10-18)

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 reflect behavioral health assessments and service plan development may only be provided by licensed behavioral health professionals effective July 1, 2010. Policy revisions are needed to clarify services that are permissible under licensed behavioral health providers and certified behavioral health providers. This change ensures compliance with accreditation and certification standards for behavioral health services pursuant to Oklahoma law.

ANALYSIS: Rules are being revised to reflect behavioral health assessments and service plan development may only be provided by licensed behavioral health professionals. Currently, bachelor level Certified Alcohol and Drug Counselors (CADC's) may perform substance abuse assessments in accordance with their Licensure Act. Due to accreditation standard requirements for assessments, all outpatient agencies are required to conduct full bio-psycho-social assessments by a licensed Masters level professional. As a result, ODMHSAS and OHCA collaboratively agreed to restrict the realm of behavioral health assessments to licensed behavioral health professionals and disallow the use of CADC's for substance abuse assessments.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 25, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: July 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 reflect that behavioral health assessments may only be provided by licensed behavioral health professionals beginning July 1, 2010.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

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

All providers must comply with the requirements as set forth in the OHCA BH Provider Billing Manual.

(1) **Screening.**

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

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

(C) **Target population.** This service is compensable only on behalf of a member who is under a PACT program.

(2) **Assessment.**

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

(B) **Qualified professional.** This service is performed by an LBHP ~~or AODTP for AOD~~. CADCs are permitted to provide Drug and Alcohol assessments through June 30, 2010. Effective July 1, 2010, all assessments must be provided by LBHPs.

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

(D) **Target population and limitations.** This service is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months and it has been more than one year since the previous assessment.

(3) **Behavioral Health Services Plan Development.**

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized rehabilitation plan is developed that addresses the member=s strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. BH Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of ~~16~~ 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training.

(B) **Qualified professional.** This service is performed by an LBHP~~ or AODTP for AOD~~.

(C) **Time requirements.** Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member.

(4) **Assessment/Evaluation testing.**

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

(B) **Qualified professionals.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment.

7.b-4 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 103. Qualified Schools As Providers of Health Related Services
OAC 317:30-5-1023. [AMENDED]
OAC 317:30-5-1027. [AMENDED]
(Reference APA WF # 10-22)

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 add a new provider type, Behavior Health School Aide, and service description, Therapeutic Behavioral Services. Currently schools are being allowed to include behavior interventions as a personal care service. 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.

ANALYSIS: Rules are being revised to add a new provider type and services description for services provided in schools. Therapeutic Behavioral Services will be furnished by a Behavior Health Schools Aide in order to improve a student's ability to function in the community and includes behavioral management, redirection and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive skills.

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

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

PROPOSED EFFECTIVE DATE: July 15, 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:
EPSDT rules are revised to add a new provider type, Behavior Health School Aide, and service description, Therapeutic Behavioral Services.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1023. Coverage by category
(a) **Adults.** There is no coverage for services rendered to adults.
(b) **Children.** Payment is made for compensable services rendered by local, regional, and state educational services agencies as defined by IDEA:

(1) **Child health screening examination.** An initial screening may be requested by an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Coordination referral is made to the ~~***SoonerCare***~~ SoonerCare provider to assure at a minimum, that periodic screens are scheduled and provided in accordance with the periodicity schedule following the initial screening.

(2) **Child health encounter.** The child health encounter may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A Child Health Encounter may include a child health history, physical examination, developmental assessment, nutrition assessment and counseling, social assessment and counseling, genetic evaluation and counseling, indicated laboratory and screening tests, screening for appropriate immunizations, health counseling and treatment of childhood illness and conditions.

(3) **Hearing and Hearing Aid evaluation.** Hearing evaluation includes pure tone air, bone and speech audiometry provided by a state licensed audiologist who:

(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(4) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state licensed audiologist who:

(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(5) **Ear impression (for earmold).** Ear impression (for earmold) includes taking impression of a ~~client's~~ member's ear and providing a finished earmold which is used with the ~~client's~~ member's hearing aid provided by a state licensed audiologist who:

(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(6) **Vision Screening**. Vision screening examination must be provided by a state licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). At a minimum, vision services include diagnosis and treatment for defects in vision.

(7) **Speech Language evaluation.** Speech Language evaluation must be provided by state licensed speech language pathologist who:

(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(8) **Physical Therapy evaluation**. Physical Therapy evaluation must be provided by a state licensed physical therapist.

(9) **Occupational Therapy evaluation**. Occupational Therapy evaluation must be provided by a state licensed occupational therapist.

(10) **Psychological Evaluation and Testing.** Psychological Evaluation and Testing must be provided by state licensed, Board Certified, Psychologist or School Psychologist certified by State Department of Education (SDE).

(11) **Dental Screening Examination.** Screening for dental disease by a state licensed dentist. The child may be referred directly to a dentist for further screening and/or treatment.

(12) **Child guidance treatment encounter.** A child guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children who are identified as having specific disorders or delays in development, emotional, or behavioral problems, or disorders of speech, language or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an IEP or IFSP and may include the following:

(A) **Hearing and Vision Services.** Hearing and vision services may include provision of habilitation activities, such as auditory training, aural and visual habilitation training, including Braille, and communication management, orientation and mobility, counseling for vision and hearing losses and disorders. Services must be provided by:

(i) state licensed, Master's Degree Audiologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed, Master's Degree Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(iii) state certified Speech Therapist working under the direction of a state licensed Speech Language Pathologist;

(iv) state certified deaf education teacher;

(v) certified orientation and mobility specialists; and

(vi) state certified vision impairment teachers.

(B) **Speech Language Therapy Services.** Speech Language Therapy Services must be provided by a state licensed Speech Language Pathologist who:

(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or

(iv) a Speech Therapy Assistant who has been authorized by the Board of Examiners, working under the direction of a state licensed speech language pathologist. The licensed Speech Language Pathologist may not supervise more that two Speech Therapy assistants, and must be on site.

(C) **Physical Therapy Services.** Physical Therapy Services must be provided by state licensed physical therapist or a Physical Therapy Assistant who has been authorized by the Board of Examiners working under the supervision of a licensed Physical Therapist. The licensed Physical Therapist may not supervise more than three Physical Therapy Assistants.

(D) **Occupational Therapy Services**. Occupational therapy may include provision of services to improve, develop or who restore impaired ability to function independently and must be provided by a state licensed Occupational Therapist or an Occupational Therapy Assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed Occupational Therapist.

(E) **Nursing Services.** Nursing Services may include provision of services to protect the health status of children, correct health problems and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, administration and monitoring of medication.

(F) **Psychological Services.** Psychological services are planning and managing a program of psychological services, including the provision of counseling for children and parents, consulting on management of severe behavioral and emotional concerns in school and home. All services must be for the direct benefit of the child. Psychological services must be provided by a state licensed Psychologist, or School Psychologist certified by SDE.

(G) **Psychotherapy Counseling Services.** Psychotherapy counseling services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy counseling services must be provided by a state licensed Social Worker, a state Licensed Professional Counselor, a State licensed Psychologist or School Psychologist certified by the SDE, a State licensed Marriage and Family Therapist or a State licensed Behavioral Practitioner, or under Board supervision to be licensed in one of the above stated areas.

(H) **Assistive Technology.** Assistive technology are the provision of services that help to select a device and assist a student with disability(ies) to use an Assistive technology device including coordination with other therapies and training of child and caregiver. Services must be provided by a:

(i) state licensed, Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or
(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;
(ii) state licensed Physical Therapist; or
(iii) state licensed Occupational Therapist.

(13) **Personal Care.** Provision of personal care services allow students with disabilities to safely attend school; includes, but is not limited to assistance with toileting, feeding, positioning, hygiene, and riding school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals/assistants who have completed training approved or provided by SDE, or Personal Care Assistants, including Licensed Practical Nurses, who have completed on-the-job training specific to their duties.

(14) **Therapeutic Behavioral Services**. Therapeutic behavioral services is an intervention to modify the non-adaptive behavior necessary to improve the student's ability to function in the community as identified on the plan of care. Medical necessity must be identified and documented through assessment and evaluation. Services encompass behavioral management, redirection, and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive skills. This service must be provided by a Behavioral Health School Aide (BHSA) who has a high school diploma or equivalent and has successfully completed the paraprofessional training approved by The State Department of Education and a training curriculum in behavioral interventions for Pervasive Developmental Disorders as recognized by OHCA. BHSA must be supervised by a bachelor's level individual with a special education certification. BHSA must have CPR and First Aid certification. Six additional hours of related continuing education is required per year.

~~(14)~~ (15) **Immunization.** Immunizations must be coordinated with the Primary Care Physician for those Medicaid eligible children enrolled in ~~***SoonerCare***~~ SoonerCare. An administration fee, only, can be paid for immunizations provided by the schools.

(c) **Individuals eligible for Part B of Medicare.** EPSDT school health related services provided to Medicare eligible recipients are billed directly to the fiscal agent.

317:30-5-1027. Billing

The following units are billed on the appropriate claim form:

(1) Service: Child Health Screening; Unit: Completed comprehensive screening.
(2) Service: Interperiodic Child Health Screening; Unit: Completed interperiodic screening.
(3) Service: Child Health Encounter; Unit: 5-10 minutes equals 1 unit; 11-20 minutes equals 2 units; over 21 minutes equals 3 units; limited to 30 units per year, additional units must be prior authorized.
(4) Service: Individual Treatment Encounter for IEP School Based and School Based; Unit: 15 minutes, unless otherwise specified.
(A) Hearing and Vision Services, IEP School Based.
(B) Hearing and Vision Services, School Based.
(C) Speech Language Therapy, IEP School Based.

(D) Speech Language Therapy, School Based.
(E) Physical Therapy, IEP School Based.
(F) Physical Therapy, School Based.
(G) Occupational Therapy, IEP School Based.
(H) Occupational Therapy, School Based.
(I) Nursing Services, IEP School Based; Unit: 5 minutes equals 1 unit; limited to 24 per day.
(J) Nursing Services, School Based; Unit: 5 minutes equals 1 unit; limited to 24 per day.
(K) Psychological Services, IEP School Based.
(L) Psychological Services, School Based.
(M) Psychotherapy Counseling Services, IEP School Based.
(N) Psychotherapy Counseling Services, School Based.
(O) Assistive Technology, IEP School Based.
(P) Assistive Technology, School Based.
(Q) Dental Screening, IEP School Based.
(R) Dental Screening, School Based.
(S) Therapeutic Behavioral Services, IEP School Based; limited to 12 units per day.

(5) Service: Group Treatment Encounter for IEP School Based and School Based; No more than 5 recipients per group, Unit: 15 minutes, unless otherwise specified.
(A) Hearing and Vision Services, IEP School Based.
(B) Hearing and Vision Services, School Based.
(C) Speech Language Therapy, IEP School Based.
(D) Speech Language Therapy, School Based.
(E) Physical Therapy, IEP School Based.
(F) Physical Therapy, School Based.
(G) Occupational Therapy, IEP School Based.
(H) Occupational Therapy, School Based.
(I) Psychological Services, IEP School Based.
(J) Psychological Services, School Based.
(K) Psychotherapy Counseling Services, IEP School Based.
(L) Psychotherapy Counseling Services, School Based.

(6) Service: Administration only, Immunization; Unit: one administration.
(7) Service: Hearing Evaluation; Unit: Completed Evaluation.
(8) Service: Hearing Aid Evaluation; Unit: Completed Evaluation.
(9) Service: Audiometric Test (Impedance); Unit: Completed Test (Both Ears).
(10) Service: Tympanometry and acoustic reflexes.
(11) Service: Ear Impression Mold; Unit: 2 molds (one per ear).
(12) Service: Vision Screening; Unit: one examination, by state licensed O.D., M.D., or D.O.
(13) Service: Speech Language Evaluation; Unit: one evaluation.
(14) Service: Physical Therapy Evaluation; Unit: one evaluation.
(15) Service: Occupational Therapy Evaluation; Unit: one evaluation.
(16) Service: Psychological Evaluation and Testing; Unit: one hour (with written report).
(17) Service: Personal Care Services; Unit: 10 minutes.