OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
July 8, 2010 at 1:00 P.M.
Oklahoma State Capitol
2300 N. Lincoln Blvd
Fourth Floor Conference Room 419C
Oklahoma City, Oklahoma

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 June 10, 2010 OHCA Board Minutes

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

3. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Gloria Hudson-Hinkel, Director of General Accounting
    b) Medicaid Director's Update – Garth Splinter, M.D.
    c) Update on Relocation of Staff – Cindy Roberts, Deputy CEO

Item to be presented by Chairman Roggow

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

    a) Audit/Finance Committee – Member Miller
    b) Strategic Planning Committee – Vice Chairman Armstrong
    c) Rules Committee – Member Langenkamp

Item to be presented by Juarez McCann, Chief Budget Officer

5. Action Item – Consideration and Approval of the State Fiscal Year 2011 Budget Work Program

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 Traylor Rains, Policy Development Coordinator

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 317:2-1-2 to give the Administrative Law Judge for the Oklahoma Health Care authority jurisdiction to hear member appeals related to eligibility determinations made by OHCA. These revisions are an integral part of the Online Enrollment process which will transfer determination of SoonerCare eligibility for certain categories of members to the Oklahoma Health Care Authority.
(Reference APA WF # 10-12)

7.b-2 AMENDING Agency rules at OAC 317:30-5-1091 and 30-5-1098 to clarify that smoking and tobacco use cessation counseling is a covered SoonerCare service for the Native American population through the Indian Health Service, Tribally Operated Programs and Urban Indian Clinics (I/T/U's).
(Reference APA WF # 10-20)

7.b-3 AMENDING Agency rules at OAC 317:30-5-555 through 30-5-560.1 to provide clarification for Private Duty Nursing prior authorization requests. Revisions clarify that providers should submit the required OHCA forms and documentation along with the treatment plan when requesting the prior authorization for private duty nursing. Revisions also provide additional flexibility for OHCA to conduct a preliminary telephonic interview with members prior to arranging a personal visit. The additional flexibility in allowing the telephonic interview will provide an opportunity for OHCA to ensure medical necessity prior to arranging the personal home visit. Additional revisions include general policy cleanup as it relates to these sections.
(Reference APA WF # 10-23)

7.b-4 AMENDING Agency rules at OAC 317:30-5-211.5 to provide guidance regarding the delivery of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Rules provide clarification and guidelines for product refills and reorders, including expected utilization patterns, member contact, and timelines. Rules also provide additional guidance with regard to products which are supplied and delivered via mail and the appropriate way for providers to bill for such items. Additional revisions include clarification to the provider cost of delivery and additional language to clarify OHCA's intent on DMEPOS supplier maintenance with regard to equipment-related services.
(Reference APA WF # 10-24)

7.b-5 ADDING Agency rules at OAC 317:25-7-7 to include procedures and guidelines related to primary care provider (PCP) referrals under the Patient Centered Medical Home model. The PCP referral process is clearly defined, including the appropriate use of OHCA administrative referrals. Rules further explain provider expectations and provide guidelines regarding PCP referrals, medical necessity, medical record documentation, and OHCA administrative referrals. These revisions continue to strengthen the OHCA medical home and SoonerCare Choice program.
(Reference APA WF # 10-25)

7.b-6 ADDING Agency rules at OAC 317:30-5-293, 30-5-299 and 30-5-680 to provide guidance with regard to team therapy. Physical, occupational, and speech therapy rules will clarify that when multiple therapists, or therapy assistants, work together as a team to treat one or more SoonerCare members, each therapist or assistant cannot bill separately for the same or different service provided at the same time to the same member. Additionally, rules will provide clarification with regard to billing, multiple therapies, delivery of service, and determining the time counted for service units and codes.
(Reference APA WF # 10-27)

7.b-7 AMENDING Agency rules at OAC 317:30-3-5 to revise OHCA prescription drug cost sharing guidelines in order to correspond with the Centers for Medicare and Medicaid Services (CMS) nominal cost sharing guidelines. Additionally, rules are clarified to state that a member's cost sharing liability is capped at 5% of the member's gross annual income.
(Reference APA WF # 10-42)

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

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

   a) Consideration and vote to add Illaris®(canakinumab) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   b) Consideration and vote to add Requip XL™(ropinirole) and Mirapex ER™(pramipexole) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   c) Consideration and vote to add Lovaza® (Omega-3-Acid Ethyl Esters) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Chairman Roggow

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

Status of pending suits and claims

1.	Webb v. OKDHS	09-CV-438 (USDC, Northern District)
2.	Edwards v. Ardent	106,291 (Okla. Supreme Court)
3.	Woodlawn v. OHCA	107,408 (Okla. Supreme Court)
4.	Henson v. OHCA	CJ-2009-12381 (Oklahoma County)
5.	Castro v. OHCA	CV-2010-690 (Oklahoma County)
6.	OKAAP	Nos. 05-5100 and 05-5107
7.	Water Damage Claim by Agency from Recent Flooding	
8.	Harper v. OKDHS	5:10-CV-00514-R (USDC, Western District)
9.	Price v. Wolford	No. 09-6139 (10th Circuit Ct. of (Appeals)

10. New Business

11. Adjournment

NEXT BOARD MEETING

August 25, 2010 at 4:00 PM
The Reed Center Conference Center
5800 Will Rogers Road
Midwest City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING OF THE OKLAHOMA HEALTH CARE AUTHORITY BOARD
June 10, 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 June 9, 2010.

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

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

OTHERS PRESENT:	OTHERS PRESENT:
Tana Parrott, OKDHS	Steven Goodman, Willow Crest
Scott Anthony, Willow Crest	Anne Anthony, Willow Crest
Mary Brinkley, OKAHSA	Rich Edwards, OSF
Rick Snyder, OHA	Holly Turner, Merck
Sandra Harrison, OKDHS	Tracy Jones, Chickasaw Nation
Kathleen Tipton, OU Physicians	Timothy Cramar, OPM
Justin Martino, eCapitol	Nancy Kachel, PPAEO

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD MAY 10, 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 May 10, 2010 board minutes as presented. Member Miller.
FOR THE MOTION:	Vice Chairman Armstrong, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay
ABSTAIN:	Member Bryant

Mr. Fogarty gave a report on the flood situation within the building. Over the Memorial Day weekend, there was extensive roof damage done to divisions on the second floor and first floor due to flooding and hail damage. Tueday morning, staff arrived and discovered Information Services, Member Services, Medical Authorization Unit, and Care Management were affected. Tbat damage represents about 25% of our employees. Mr. Fogarty then presented pictures of the damage to the

board members. He noted that the landlord had Disaster Recovery come 2 days later. We declared an emergency and began the moving process of those units that were severely damaged. The temporary location is at Shepherd Mall in the AOL space which was the most feasible for a quick move. 110 OHCA employees were moved. Mr. Fogarty thanked all staff involved in making this move possible so swiftly.

ITEM 3.a/FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported the revenues for OHCA through April, accounting for receivables, were **$2,890,676,122** or **.6% over** budget. Expenditures, accounting for encumbrances, were **$2,790,045,527** or **.0% over** budget. The state dollar budget variance through April is **$2,256,758 positive.** The state dollar budget variance due to Medicare Part D Stimulus allocation is **$15,568,845 positive.** Ms. Evans said the budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(14.5)
Medicare Part D		15.6
Administration		3.7
Unbudgeted Carryover		3.4
Revenues:		
Taxes and Fees		3.8
Drug Rebate		1.9
Overpayments/Settlements		3.9
Total FY 10 Variance	**$**	**17.8**

ITEM 3.b/MEDICAID DIRECTOR'S UPDATE
Becky Pasternik-Ikard, State Medicaid Chief Operating Officer

Ms. Ikard stated that since March we have only experienced an increase of slightly over 3000 members in SoonerCare (692,800) and Insure Oklahoma(30,943. We continue to monitor our contracted providers, particularly the SoonerCare Choice PCP network that provides services to the majority of our members and continues to be stable with available capacity to serve additional members. Ms. Ikard stated that last month, Dr. Mitchell reported on the April 1 implementation of the tiered reimbursement methodology for Psychiatric Residential Treatment Facilities. Once again, lengths of stays are decreasing but we continue to see service utilization. Ms. Ikard stated that the agency continues to receive input and feedback from our providers as we monitor this and also on the impact. She then reported that after nearly 2 years of expert and diligent management and guidance since September 2008, the MMIS Reprocurement Request For Proposal (RFP) was released last Friday, June 4, with a closing date of August 4. Ms. Ikard noted that an award will be made in the fall and work will begin around mid November.

ITEM 3.c/LEGISLATIVE UPDATE
Nico Gomez, Deputy Chief Executive Officer

Mr. Gomez the 52nd Oklahoma Legislature came to a close at 5PM on May 28, 2010. The budget was the headliner but there were many pieces of legislation that impacted the Oklahoma Health Care Authority. He reported the agency had to deal with the budget crisis in the current state fiscal year before it could look to state fiscal year 2011 on July 1. The OHCA's general appropriations for state fiscal year 2010 were cut by 7.5 percent, or almost $44 million in state funds. In order to meet the balanced budget requirement, the OHCA board authorized agency staff to reduce the budget. Mr. Gomez noted that one of these steps was an overall provider rate reduction of 6.75 percent scheduled to go into effect April 1, However, on February 17, OHCA was notified that state leadership had reached a budget agreement that provided some relief through the use of federal stimulus funds and state reserves. This allowed the funds to be used to roll back part of the overall provider rate cut. Approved by the board, the rate cut was scaled back by 3.5 percent, leaving a 3.25 percent rate cut effective April. Mr. Gomez discussed all the current House Bills and Senate Bills that affected the Oklahoma Health Care Authority.

Vice Chairman Armstrong expressed the board's appreciation to the Leadership for fully funding OHCA's budget during times of crises. Mr. Fogarty suggested that a letter would be drafted to leadership for signature of the board members showing appreciation and gratitude.

ITEM 3.d/UPDATE ON MEMBER SATISFACTION SURVEYS
Becky Pasternik-Ikard

Ms. Ikard presented the SFY 2010 Adult CAHPS survey for SCC adult enrollees 18 ears of age and older with a paid claim from a SCC provider, and with continuous enrollment in SCC during the period of December 2008 through November 2009. In comparing 2008 and 2010 survey; the fairly high levels of satisfaction held steady across all 8 quality measures, in fact, every measure increased with one statistically significant. Ms. Ikard stated the report states that the "overall picture drawn by the CAHPS data is one of high and rising satisfaction with several adrift aspects of health care received from S providers and also the customer services provided directly by SoonerCare".

Mf. Fogarty reported that we joined a number of other state agencies in offering Voluntary Buyouts for employees ready to retire. We have 14 employees taking advantage of this offer and will retire the end of June. This represents 394 years of service to the state with an average of 30 years.

Mr. Fogarty reported that Dr. Garth Splinter, M.D. will join the Oklahoma Health Care Authority on July 1 as the State Medicaid Director which was vacated by Dr. Mitchell last month. Dr. Splinter left the agency in 1999 after serving as Chief Executive Officer for 5 years.

Dr. Splinter acknowledged the board for extending this offer

ITEM 4/BOARD COMMITTEE REPORTS
Chairman Roggow

4.a)Audit/Finance Committee
Member Miller

Member Miller reported that the Audit/Finance committee met and concluded the fiscal year in the black with the Part D clawback monies. He noted that the last day of the fiscal year is June 30 and the agency will have a $70-80 million run on claims. He said that some of the board members did get to visit with leadership concerning budget. We are extremely fortune to enter the new fiscal year without reduction. All authorized FTE's are fully funded. Member Miller noted that our Budget Work Program Plan will be filed July 1 and will be presented at the July 8th Board Meeting.

4.b)Legislative Committee
Member McFall

Member McFall reported that the Legislative Committee did not meet as Mr. Gomez will present a full report. Member McFall said the board thanked Mr. Gomez for such an excellent job done in such a budget crisis situation. He stated that next month there will be a strategic planning committee meeting to prepare for the upcoming Board Retreat in August.

4.c)Rules Committee
Member Langenkamp

Member Langenkamp stated that the Rules Committee met and reviewed rules and Ms. Roberts will be presenting later.

ITEM 5 - ANNOUNCEMENTS OF CONFLICTS OF INEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING
Howard Pallotta, Director of Legal Services

Mr. Pallotta stated that the Conflicts of Interest Panel had met and there were no conflicts regarding Items 6, 7, 8, and 9.

ITEM 6.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. Member Bryant seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay

ITEM 6.b) CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:

Cindy Roberts, Deputy Chief Executive Officer

6.b-1 through 6.b-8 as published in meeting agenda.

MOTION:	Member Langenkamp moved for approval of rules 6.b-1 through 6.b-8 as published in meeting agenda. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay

ITEM 7 - CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE

Cindy Roberts, Chairperson of State Plan Amendment Rate Committee

7a) Consideration and Vote Upon rate proposal for ADvantage Incontinence Supplies

MOTION:	Member Langenkamp moved for approval of Item 7a as published in meeting agenda. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay

7b) Consideration and Vote Upon rate proposal to implement a weekly rate for Developmental Disabilities Services Division Targeted Case Management(DDSDTCM) services

MOTION:	Member McFall moved for approval of Item 7b published in meeting agenda. Member Langenkamp seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay

7c) Consideration and Vote Upon rate proposal to implement a weekly rate for Child Welfare Targeted Case Management(CWTCM) services

MOTION:	Member Bryant moved for approval of Item 7c as published in meeting agenda. Member McFall seconded.

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

ABSENT: Member McVay

7d) Consideration and Vote Upon rate proposal to implement a weekly rate for Targeted Case Management services for children under age 18 who are involved in or at serious risk of involvement with the juvenile justice system(excludes those who are involuntarily in secure custody of law enforcement of judicial systems)OJATCM

MOTION: Member McFall moved for approval of Item 7d as published in meeting agenda. Member Langenkamp seconded.

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

ABSENT: Member McVay

7e) Consideration and Vote Upon rate proposal to reduce expenditures in the dental program with a change in reimbursement for posterior restorations and an overall decrease in dental rates

MOTION: Vice Chairman Armstrong moved for approval of Item 7e as published in meeting agenda. Member Bryant seconded.

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

ABSENT: Member McVay

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

8. a) Action Item - Consideration and Vote to authorize expenditure of funds for State Fiscal Year 2011 renewal of the Hewlett-Packard contract for the current MMIS

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

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

ABSENT: Member McVay

8. b) Action Item - Consideration and Vote to authorize expenditure of funds for State Fiscal Year 2011 renewal and amendment of the Fox Systems contract

MOTION: Member Bryant moved for approval of 8b as presented. Member McFall seconded.

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

ABSENT: Member McVay

8. c) Action Item – Consideration and Vote to authorize expenditure of funds for Reprocurement of the Third Party Liability (TPL) collection services

MOTION: Member McFall moved for approval of Item 8c as presented. Vice Chairman Armstrong seconded.

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

ABSENT: Member McVay

ITEM 9 – ACTION ITEM – CONSIDERATION AND VOTE REGARDING RECOMMENDATION MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES § 5030.3.

Nancy Nesser, PharmD. JD, Pharmacy Director

a) Consideration and Vote to add Mozobil® (plerixafor), Nplate® (romiplostim), and Arcalyst® (rilonocept) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e)

MOTION: Member McFall moved for approval of Item 9a as presented. Member Bryant.

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

ABSENT: Member McVay

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

Howard Pallotta, General Counsel

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

ITEM 11 – ACTION ITEM/ELECTION OF OKLAHOMA HEALTH CARE AUTHORITY 2011 BOARD OFFICERS

Chairman Roggow

MOTION:	Member Miller moved that Chairman Roggow and Vice Chairman Armstrong. remain in position. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, Member McFall, and Chairman Roggow
ABSENT:	Member McVay

ITEM 12 - NEW BUSINESS

NONE

ITEM 13 - ADJOURNMENT

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

FINANCIAL REPORT

For the Eleven Months Ended May 31, 2010
Submitted to the CEO & Board
July 8, 2010

- Revenues for OHCA through May, accounting for receivables, were **$3,127,014,621** or **.3% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,044,605,394** or **.5% over** budget.
- The state dollar budget variance through May is **$3,025,528 positive.**
- The state dollar budget variance due to Medicare Part D Stimulus allocation is **$21,082,315 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(13.1)
Medicare Part D		21.1
Administration		4.5
Unbudgeted Carryover		3.4
Revenues:		
Taxes and Fees		4.0
Drug Rebate		.9
Overpayments/Settlements		3.3
Total FY 10 Variance	**$**	**24.1**

ATTACHMENTS

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

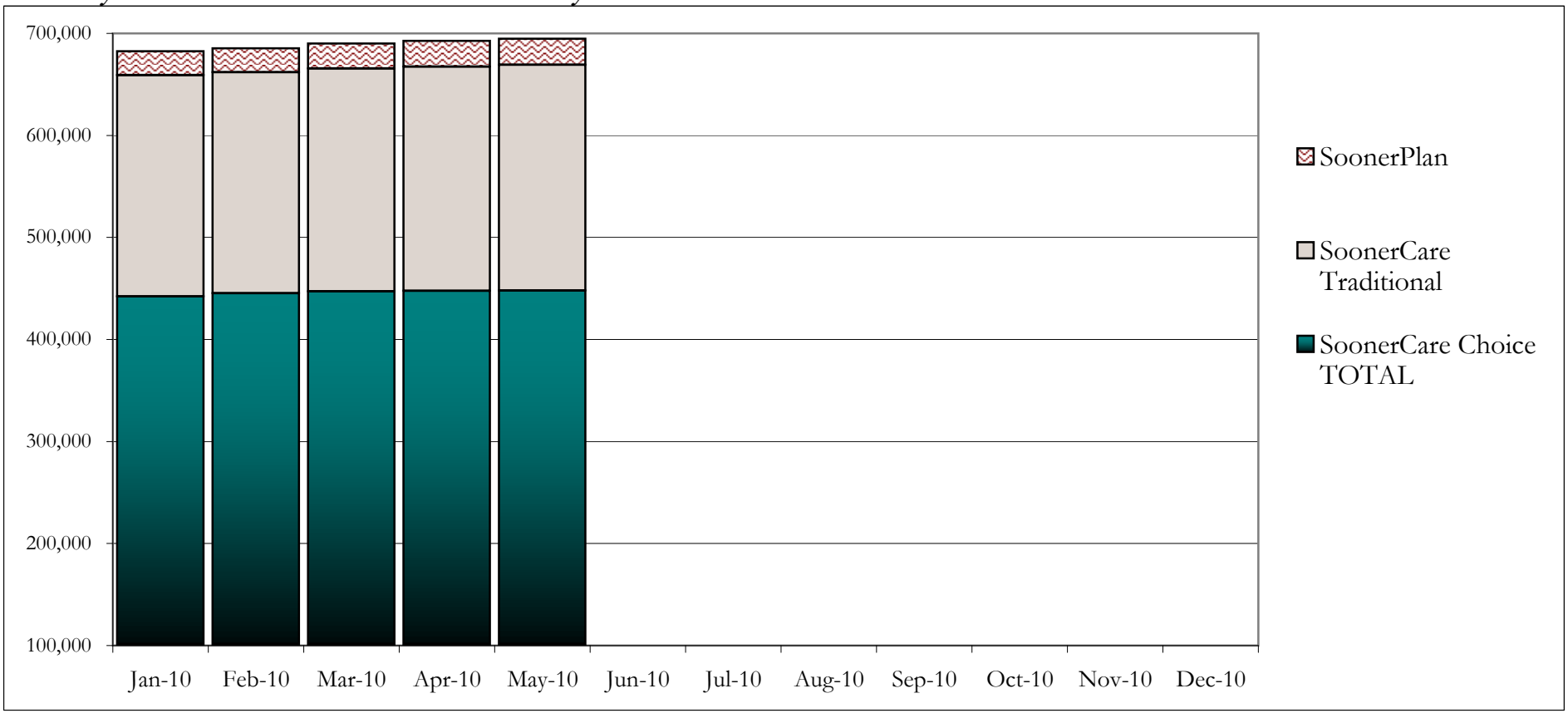
REVENUES	FY10 Budget YTD	FY10 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 531,650,755	$ 531,650,755	$ -	0.0%
Federal Funds	1,867,758,078	1,856,938,211	(10,819,867)	(0.6)%
Tobacco Tax Collections	45,426,672	49,388,167	3,961,495	8.7%
Quality of Care Collections	47,015,848	47,052,298	36,450	0.1%
Prior Year Carryover	24,714,277	28,114,277	3,400,000	13.8%
Drug Rebates	128,491,811	130,916,423	2,424,612	1.9%
Medical Refunds	36,446,270	46,277,010	9,830,740	27.0%
Other Revenues	15,810,913	15,385,238	(425,675)	(2.7)%
Stimulus Funds Appropriated	384,662,709	384,662,709	-	0.0%
Stimulus Funds Drawn	36,629,534	36,629,534	-	0.0%
TOTAL REVENUES	**$ 3,118,606,866**	**$ 3,127,014,621**	**$ 8,407,755**	**0.3%**

EXPENDITURES	FY10 Budget YTD	FY10 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 35,351,920**	**$ 33,210,255**	**$ 2,141,665**	**6.1%**
ADMINISTRATION - CONTRACTS	**$ 98,039,228**	**$ 75,004,445**	**$ 23,034,783**	**23.5%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	26,676,748	25,534,551	1,142,197	4.3%
Acute Fee for Service Payments:				
Hospital Services	866,543,593	833,586,252	32,957,341	3.8%
Behavioral Health	235,610,484	257,466,905	(21,856,421)	(9.3)%
Physicians	409,053,160	378,086,882	30,966,278	7.6%
Dentists	133,438,277	147,246,271	(13,807,994)	(10.3)%
Other Practitioners	39,121,479	45,850,056	(6,728,577)	(17.2)%
Home Health Care	17,137,332	18,532,718	(1,395,386)	(8.1)%
Lab & Radiology	21,829,636	33,850,159	(12,020,523)	(55.1)%
Medical Supplies	50,976,789	49,852,091	1,124,698	2.2%
Ambulatory Clinics	54,946,904	82,394,474	(27,447,570)	(50.0)%
Prescription Drugs	333,694,039	342,395,975	(8,701,936)	(2.6)%
Miscellaneous Medical Payments	27,385,659	25,704,554	1,681,105	6.1%
Other Payments:				
Nursing Facilities	467,195,894	468,064,950	(869,056)	(0.2)%
ICF-MR Private	50,654,996	51,444,741	(789,745)	(1.6)%
Medicare Buy-In	107,944,600	112,722,038	(4,777,438)	(4.4)%
Transportation	23,875,024	23,950,800	(75,776)	(0.3)%
Part D Phase-In Contribution	60,789,593	39,707,278	21,082,315	34.7%
Total OHCA Medical Programs	**2,926,874,206**	**2,936,390,694**	**(9,516,488)**	**(0.3)%**
OHCA Non-Title XIX Medical Payments	40,128	-	40,128	0.0%
TOTAL OHCA	**$ 3,060,305,482**	**$ 3,044,605,394**	**$ 15,700,088**	**0.5%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 58,301,384**	**$ 82,409,227**	**$ 24,107,843**	

SOONERCARE ENROLLMENT CY-2010

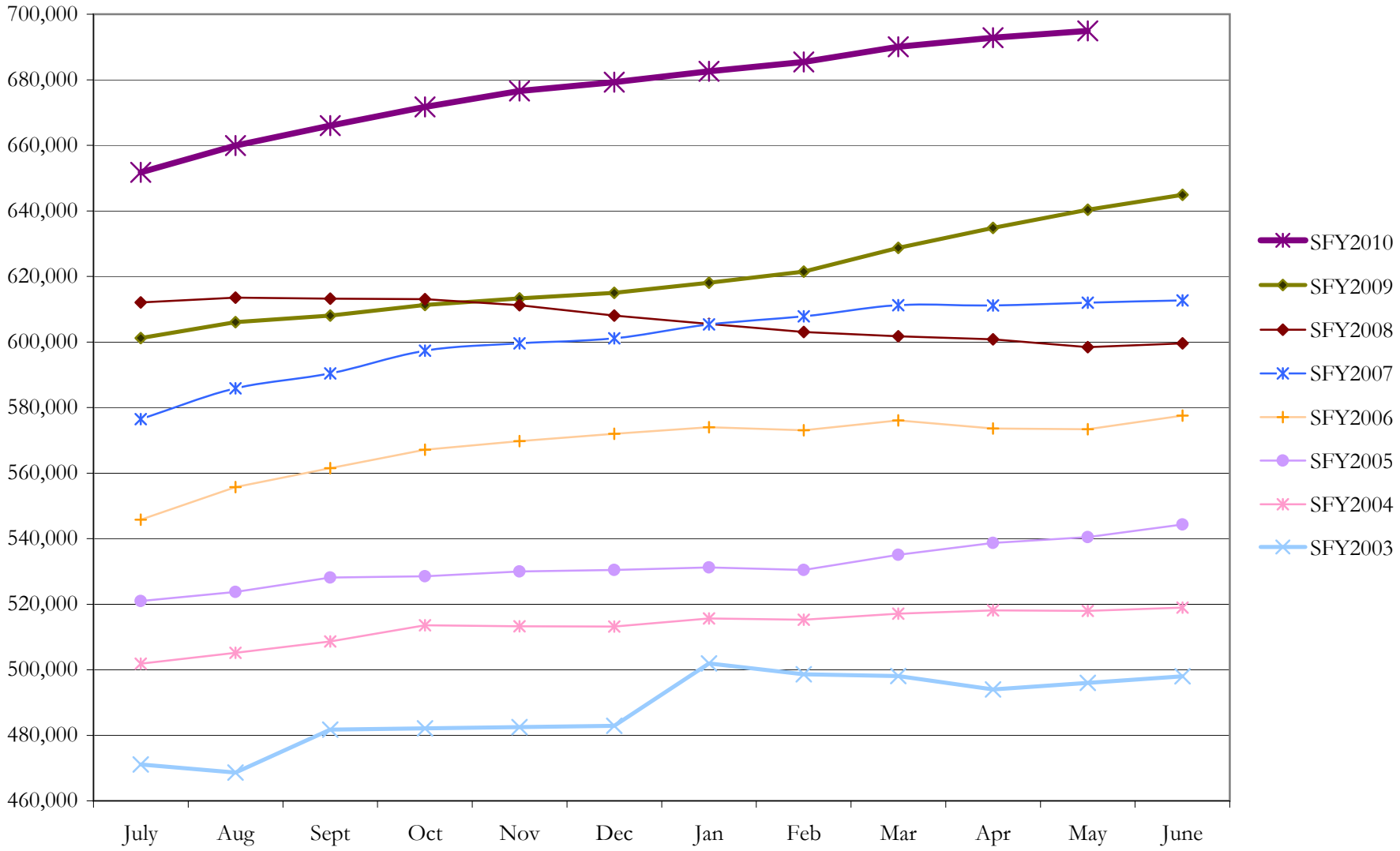
	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Total MMs
ENROLLEES													
SoonerCare Choice													
Choice Total	428,704	431,677	433,447	433,771	433,655								2,161,254
IHS/Urban/Tribal Total	13,503	13,619	13,780	14,000	14,211								69,113
SoonerCare Choice TOTAL	442,207	445,296	447,227	447,771	447,866								2,230,367
SoonerCare Traditional	216,989	216,542	218,449	219,772	221,397								
SoonerPlan	23,420	23,607	24,379	25,257	25,635								122,298
TOTAL ENROLLEES	682,616	685,445	690,055	692,800	694,898								3,445,814
Average Monthly Enrollment													689,163

Monthly Actual SoonerCare Enrollment Trends by Benefit Plan



MMs = Member Months

OHCA SoonerCare Enrollment Figures



SoonerCare Programs

May 2010

Choice PCMH	MAY	
	2009	2010
Total Enrolled	408,644	447,866
American Indian Enrollment	11,819	14,211
Choice Enrollees (PCMH)	396,825	433,655

Traditional	MAY	
	2009	2010
Total Enrolled	212,963	221,397
SoonerCare Programs Total (Unduplicated)	640,350	694,898

Oklahoma Cares	MAY	
	2009	2010
Total Women Enrolled	2,701	2,347
SoonerCare Traditional	2,022	1,646
SoonerCare Choice	679	701
Total Women Ever-enrolled	19,786	23,417

SoonerPlan	MAY	
	2009	2010
Total Enrolled	18,743	25,635
Male Enrollees	515	820
Female Enrollees	18,228	24,815
Total Ever-enrolled	67,751	83,980

TEFRA	MAY	
	2009	2010
Total Children Enrolled	276	337
Male Enrollees	166	195
Female Enrollees	110	142
Total Ever-enrolled	354	453

Insure Oklahoma	MAY	
	2009	2010
IO Total Enrollees	19,986	31,213
IO Enrollees Males	8,797	13,533
IO Enrollees Females	11,189	17,680
ESI Enrollees	13,348	18,799
IP Enrollees	6,638	12,414

Program	DECEMBER 2009	JANUARY 2010	FEBRUARY 2010	MARCH 2010	APRIL 2010	MAY 2010
Choice PCMH	438,276	442,207	445,296	447,227	447,771	447,866
Traditional	217,945	216,989	216,542	218,449	219,772	221,397
Oklahoma Cares	2,373	2,307	2,396	2,368	2,369	2,347
TEFRA	320	325	326	323	329	337
SoonerPlan	23,073	23,420	23,607	24,379	25,257	25,635
Soon-to-be Sooners	2,979	2,955	2,993	3,051	3,034	3,069
SoonerCare Programs Total (Unduplicated)	**679,294**	**682,616**	**685,445**	**690,055**	**692,800**	**694,898**
Insure Oklahoma ESI	18,133	18,521	18,877	18,774	18,946	18,799
Insure Oklahoma IP	10,825	11,100	11,437	11,778	11,997	12,414
Insure Oklahoma Programs Total (Unduplicated)	**28,958**	**29,621**	**30,314**	**30,552**	**30,943**	**31,213**
Programs Total	**708,252**	**712,237**	**715,759**	**720,607**	**723,743**	**726,111**

June 16, 2010

SoonerCare Fast Facts

May 2010

TOTAL ENROLLMENT —
OKLAHOMA SOONERCARE (MEDICAID)

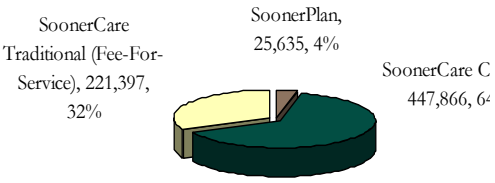
Qualifying Group	Age Group	Enrollment	% of Total
Aged/Blind/Disabled	Child	18,872	2.72%
Aged/Blind/Disabled	Adult	125,821	18.11%
Children/Parents	Child	457,457	65.83%
Children/Parents	Adult	46,393	6.68%
Other	Child	83	0.01%
Other	Adult	17,953	2.58%
Oklahoma Cares (Breast & Cervical Cancer)		2,347	0.34%
SoonerPlan (Family Planning)		25,635	3.69%
TEFRA		337	0.05%

Total Enrollment	**694,898**	Adults	214,661	31%
		Children	480,237	69%

OTHER Group includes—DDSD State-PKU-Q1-Q2-Refugee--SLMB-Soon to be Sooners (STBS) and TB patients. Child custody was moved to Children/Parents effective April 2010.
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) — **870,123**

Other Breakdowns of Total Enrollment

Oklahoma SoonerCare (Medicaid) members residing in a long-term care facility — 15,672

Oklahoma persons enrolled in both Medicare and Medicaid (dual eligibles) — 101,587

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
5,539	18,799	12,414

New Enrollees

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

Adults	6,210
Children	7,951
Total	**14,161**

Race Breakdown of Total Enrollment

	Children	Adults	Percent	Pregnant Women
American Indian	60,768	20,212	12%	2,846
Asian or Pacific Islander	7,005	2,870	1%	651
Black or African American	69,740	29,946	14%	2,434
Caucasian	327,780	159,089	70%	19,491
Multiple Races	14,944	2,544	3%	718
Hispanic Ethnicity	76,045	11,015	13%	5,594

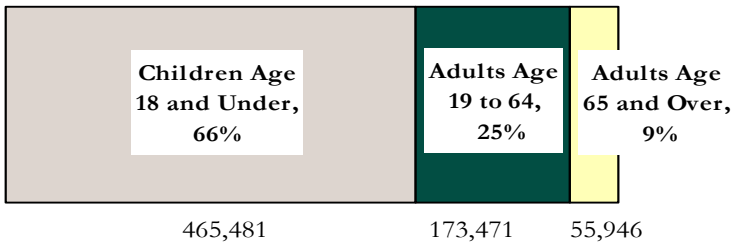
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

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		3,069
INFANT	150% to 185%	1,453
01-05	133% to 185%	11,600
06-12	100% to 185%	32,945
13-18	100% to 185%	20,654
Total		**69,721**

Age Breakdown of Total Enrollment

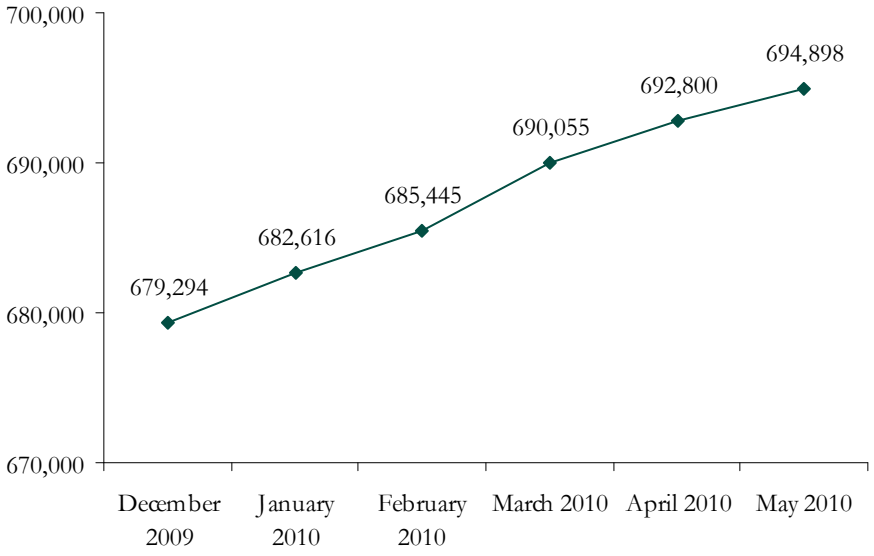


Data was compiled on 5/15/2010. Numbers frequently change due to certifications occurring after the data is extracted and other factors. This report is based on data within the system prior to 5/15/2010. A majority of the data is a "point in time" representation of the specific report month and is not cumulative. Unless stated otherwise, CHILD is defined as an individual under the age of 21.

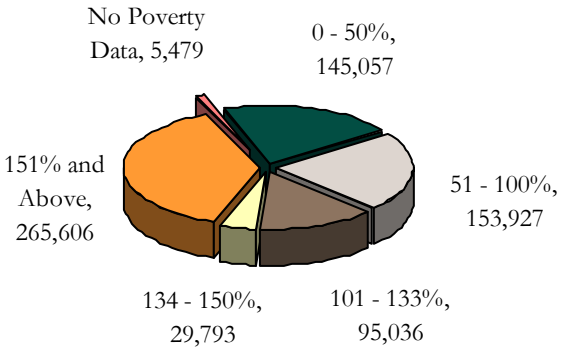
SoonerCare Fast Facts

May 2010

Total Enrollment Trend



Percent of Federal Poverty Level Totals



The "No Poverty Data" group consists of members with no poverty data and members enrolled with an aid category of U- DDSD State, R2 - OJA not Incarcerated, or R4 - OJA Incarcerated. These aid categories do not require poverty data or do not use the poverty data.

Have you seen our other Fast Facts?

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

Oklahoma Health Care Authority

Provider Fast Facts

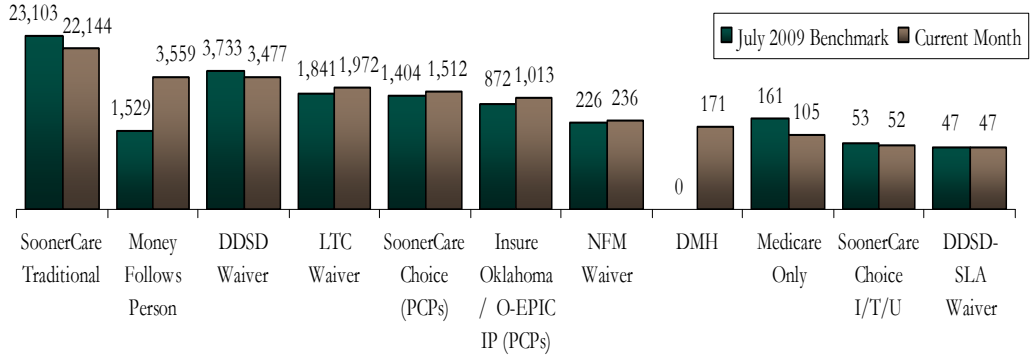
May 2010

Total Unduplicated Provider Count

28,213

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

Total Unduplicated Provider Count by Program



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

Total Unduplicated Newly Enrolled Provider Count

318

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	1,023,944	41.35%
SoonerCare Choice I/T/U	115,650	12.32%
Insure Oklahoma/O-EPIC IP	329,620	4.03%

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

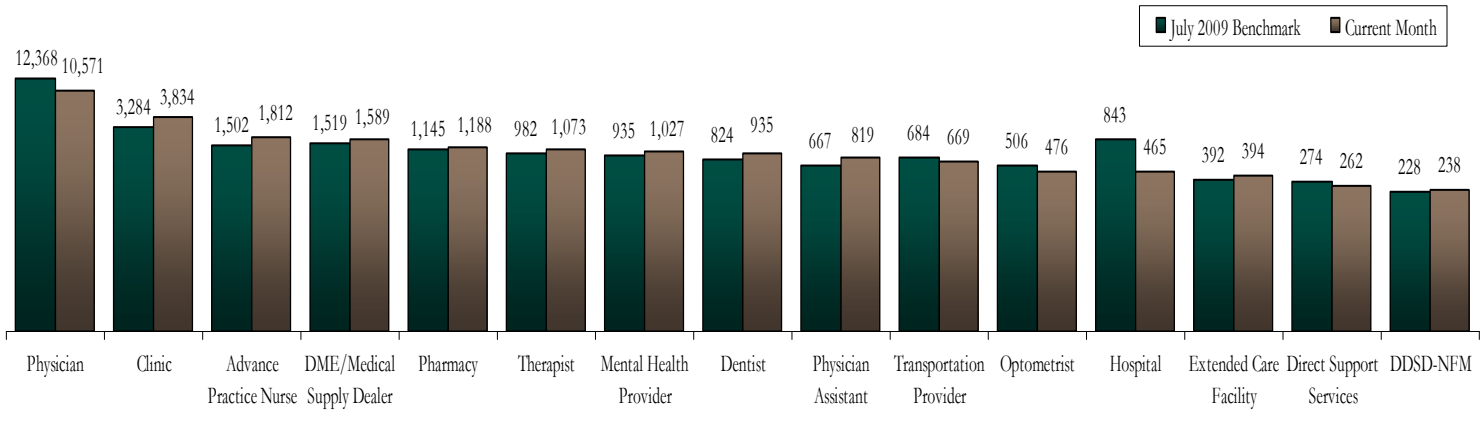
PCP - Primary Care Provider

PCMH Enrollment by Tier

Payment Tier Code	Count
Tier 1	489
Tier 2	232
Tier 3	46

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

Top 15 Provider Types

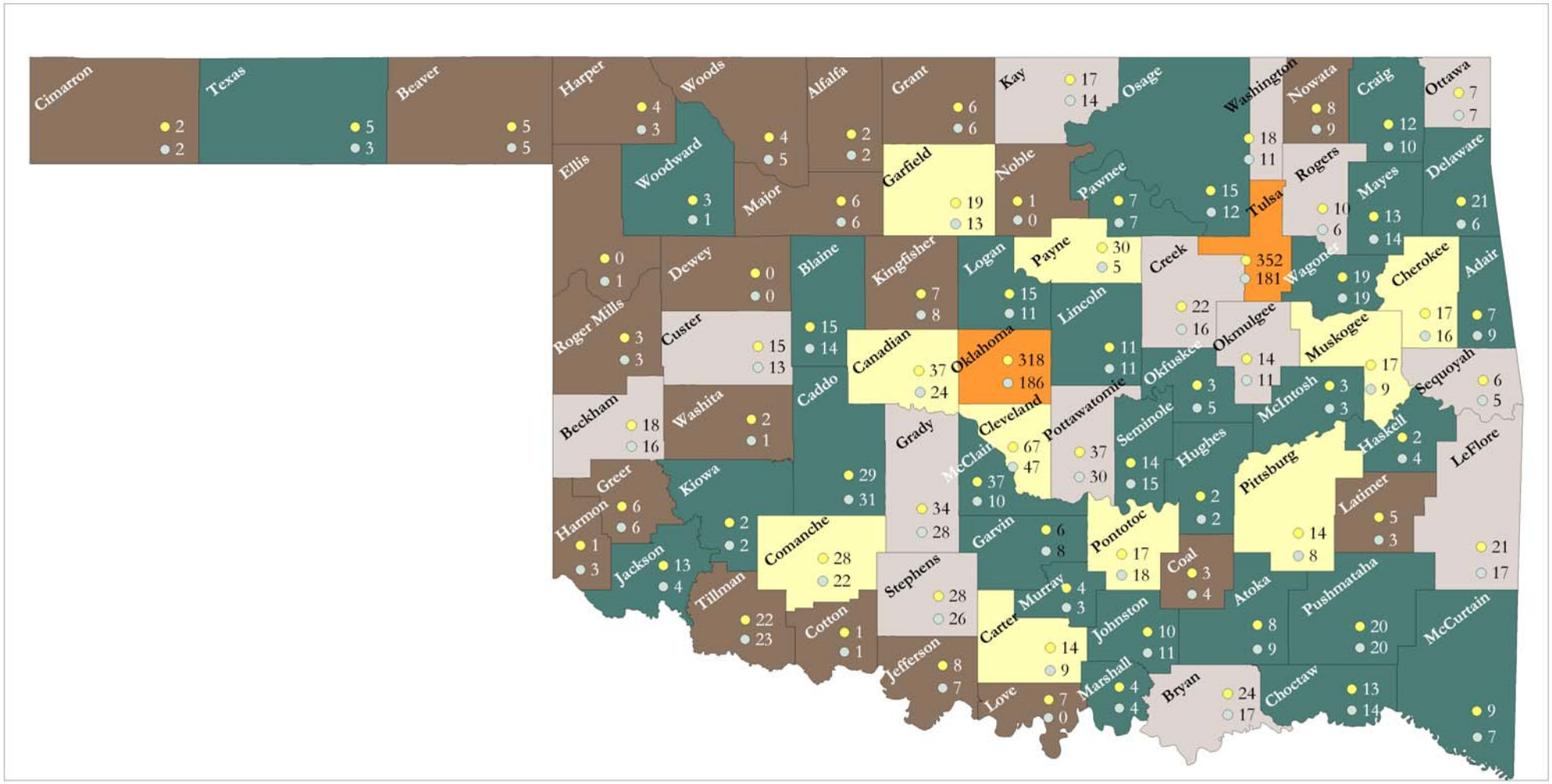


The top 15 provider types consists of the 15 provider types with the highest number of contracted providers.

Provider Fast Facts

May 2010

oklahoma health care authority



Total Provider Count

- 4,000 to 5,380 (2)
- 300 to 1,000 (10)
- 150 to 300 (14)
- 50 to 150 (29)
- 0 to 50 (22)

Primary Care Providers (PCPs)

- SoonerCare Choice PCPs
- Insure Oklahoma IP PCPs

06/15/2010

Insure Oklahoma
Fast Facts
July 2010

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

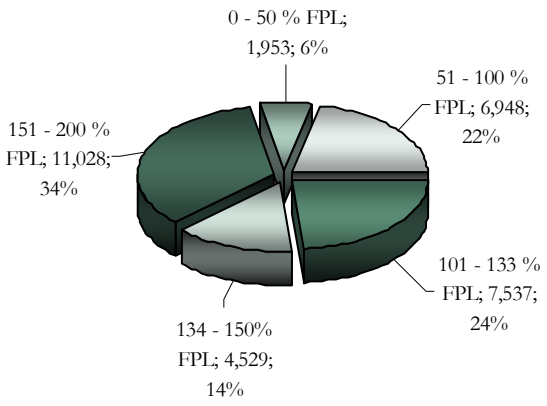
Insure Oklahoma is an innovative program Oklahoma has created to bridge the gap in the health care coverage for low-income working adults. Under the Employer-Sponsored Insurance (ESI) program, premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent).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

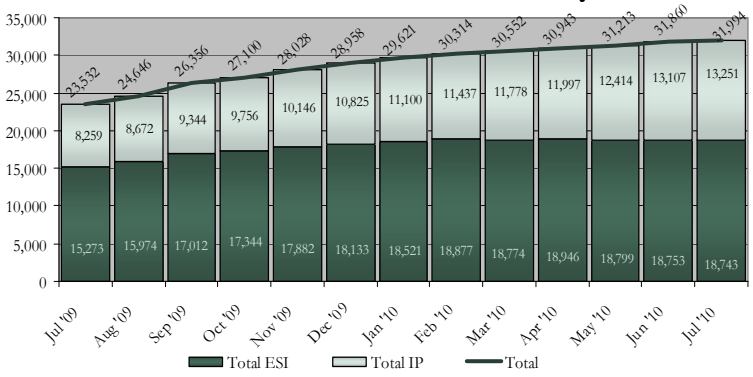
Qualifying Enrollment		Enrollment	% of Total
Employer Sponsored Insurance (ESI)	Employee	15,594	48.74%
Employer Sponsored Insurance (ESI)	Spouse	3,091	9.66%
Individual Plan (IP)	Employee	10,011	31.29%
Individual Plan (IP)	Spouse	3,031	9.47%
Student (ESI)	---	58	0.18%
Student (IP)	---	209	0.65%
Businesses	---	5,460	---
Carriers / HealthPlans	---	20 / 478	---
Primary Care Physician	---	1,061	---

Total Enrollment	**31,994**	ESI	18,743	59%
		IP	13,251	41%

Federal Poverty Level Breakdown of Total Enrollment



Total Insure Oklahoma Member Monthly Enrollment



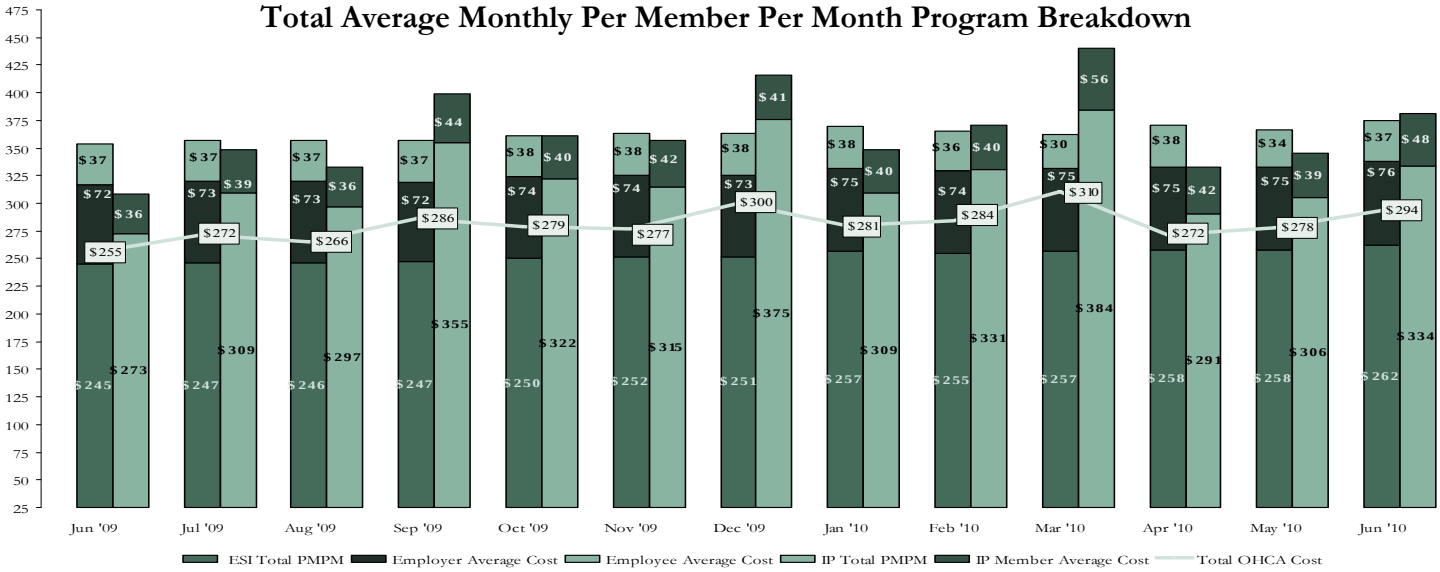
Currently Enrolled		Up from Previous Year
Businesses	5,460	11%
ESI Enrollees	18,743	23%
IP Enrollees	13,251	60%

ESI & IP Enrollee totals include Students.

Latest Monthly Marketing Statistics	
Web Hits on InsureOklahoma.org	37,163
Call Center - Calls Answered	12,296

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.)

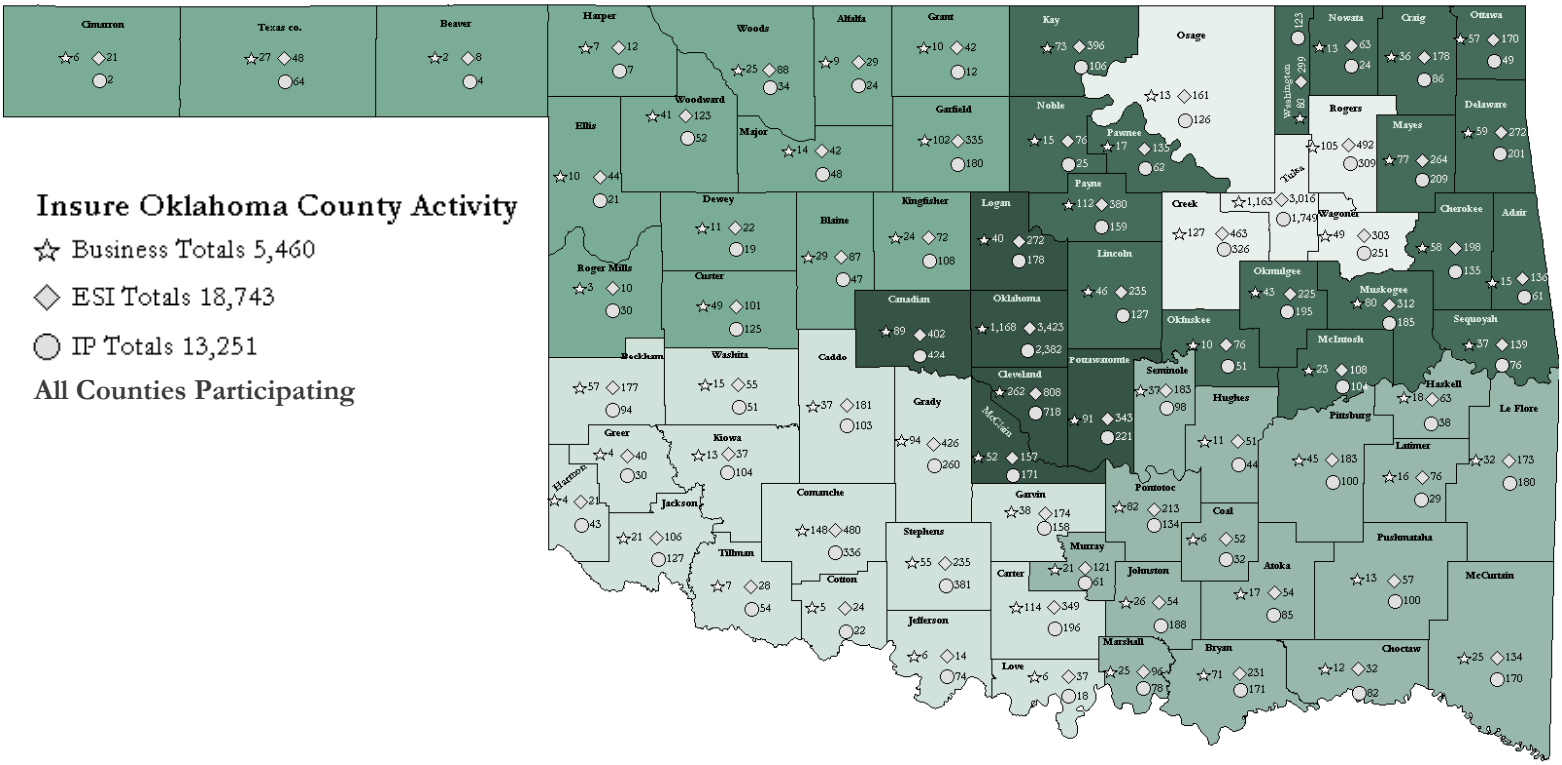
Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

7/6/2010

Insure Oklahoma
Fast Facts
July 2010

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

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



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7/6/2010

Employer Sponsored Insurance (ESI)

Fast Facts

July 2010

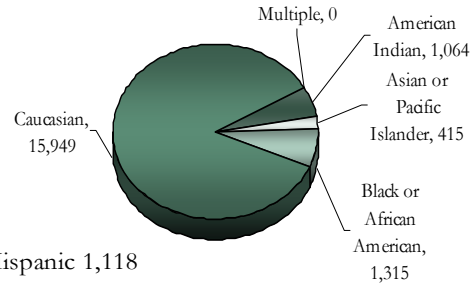
Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

The Insure Oklahoma 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	7,674	7,920	**15,594**	322	314	**636**	908	770	**1,678**
Spouse	779	2,312	**3,091**	30	80	**110**	82	240	**322**
Student	30	28	**58**	2	0	**2**	3	1	**4**
Total	8,483	10,260	**18,743**	354	394	**748**	993	1,011	**2,004**

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

Race Breakdown of ESI Members

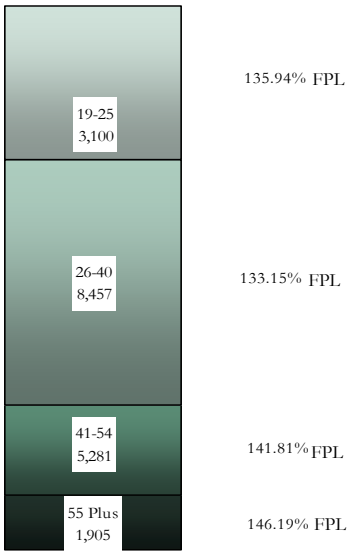


Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Business Activity with Employee Participation Counts				
	0 to 25	26 to 50	51 to 100	Total
Current	4,581	506	266	**5,353**
New	82	15	10	**107**
Total	**4,663**	**521**	**276**	**5,460**

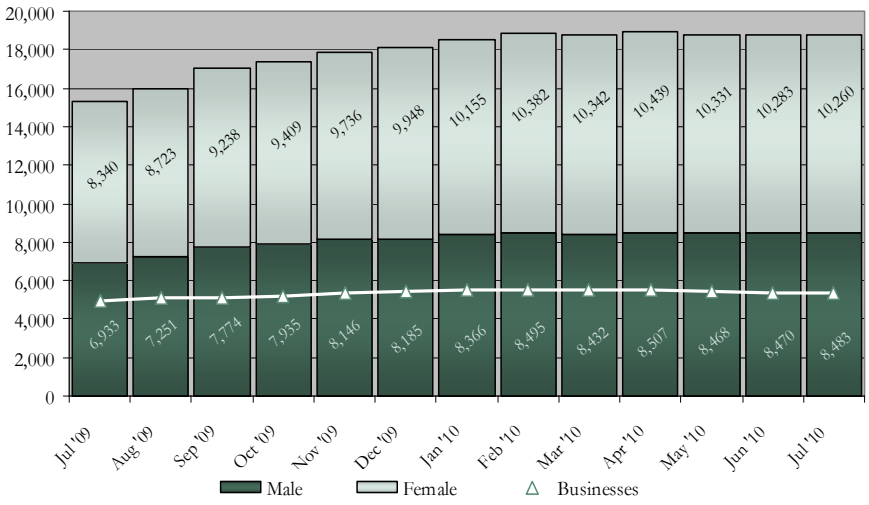
Some approved businesses may not have approved employees.

Age Breakdown with Average Federal Poverty Level of ESI Members

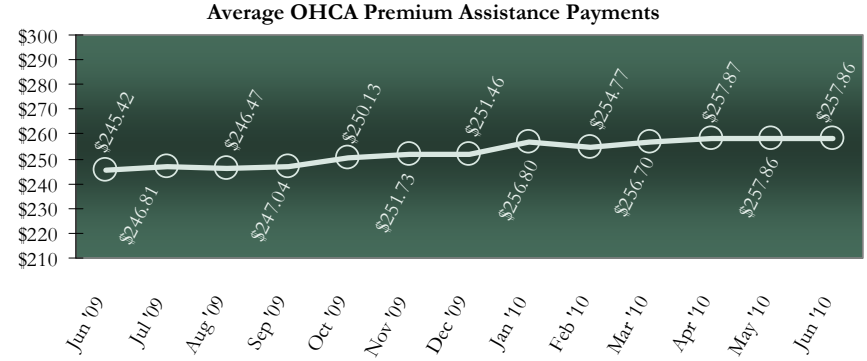


Federal Poverty Level is used to determine income qualification.

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	624	2,384	16 of 16
Region 2	369	1,084	16 of 16
Region 3	1,702	5,405	6 of 6
Region 4	1,457	4,435	5 of 5
Region 5	851	3,662	18 of 18
Region 6	457	1,773	16 of 16
Total	**5,460**	**18,743**	**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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7/6/2010

Individual Plan (IP)
Fast Facts

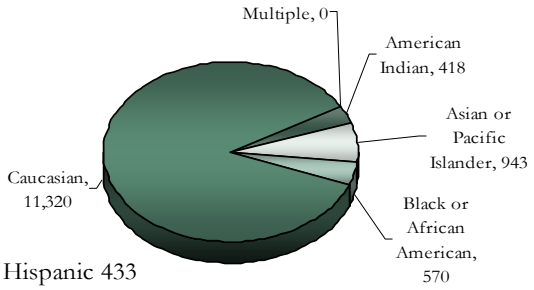
July 2010

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

The Insure Oklahoma 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 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**.

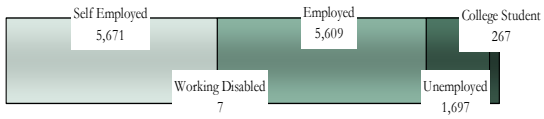
	Total Current Enrollment			Breakdown of Current Enrollment					
				New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	4,571	5,440	**10,011**	222	308	**530**	342	347	**689**
Spouse	690	2,341	**3,031**	50	113	**163**	63	179	**242**
Student	88	121	**209**	5	6	**11**	9	6	**15**
Total	5,349	7,902	**13,251**	272	421	**704**	405	526	**946**

Race Breakdown of IP Members



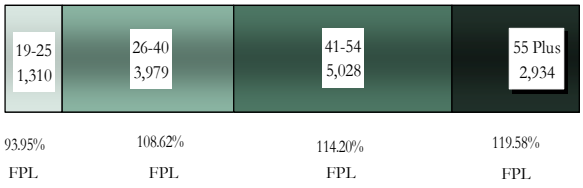
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

IP Application Type Breakdown

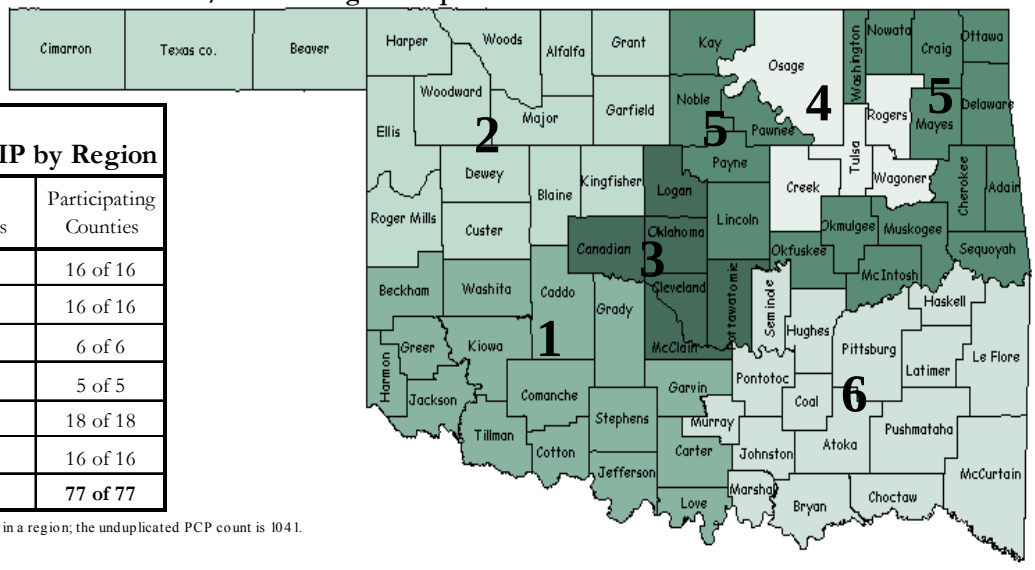


Unduplicated Counts	
IP Members SFY2010 (July 2009 - Current)	0
IP Members Since Program Inception March 2007	21,239
Miscellaneous	
Average IP Member Premium	$56.57
Average Federal Poverty Level of IP Members	111.71%
Federal Poverty Level is used to determine income qualification.	

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	148	15 of 16	2,051	16 of 16
Region 2	83	15 of 16	777	16 of 16
Region 3	286	6 of 6	4,094	6 of 6
Region 4	239	5 of 5	2,761	5 of 5
Region 5	160	17 of 18	1,978	18 of 18
Region 6	145	16 of 16	1,590	16 of 16
Total	**1,061**	**74 of 77**	**13,251**	**77 of 77**

PCPs maybe counted in multiple regions or out of state and not counted in a region; the unduplicated PCP count is 1041.

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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7/6/2010

Opportunities for Living Life Fast Facts

May 2010

Under Opportunities for Living Life (OLL) the OHCA develops, operates and administers new program initiatives for SoonerCare members. Additionally, OLL develops collaboration among state and private agencies, community organizations, and stakeholders in creating a system of health care, long-term care support and home and community-based services support that meets the needs of Oklahoma citizens. Opportunities for Living Life offers long-term care services and support benefits to certain members who are enrolled in SoonerCare Traditional or SoonerCare Supplemental plans. More information is available at www.okhca.org.

OPPORTUNITY FOR LIVING LIFE (OLL)

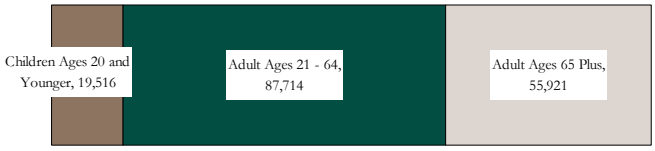
TOTAL ENROLLMENT —

Qualifying Group	Age Group	Enrollment	% of Total
Aged/Blind/Disabled	Child	16,839	10.32%
Aged/Blind/Disabled	Adult	128,069	78.50%
Other	Child	8	10.90%
Other	Adult	17,788	0.04%
PACE	Adult	58	0.04%
TEFRA	Child	337	0.21%
Living Choice	Adult	52	0.03%
Total OLL Enrollment	**163,151**	Child	17,242 11%
		Adult	145,909 89%

"Other" Qualifying Group includes; ALIEN, SLMB, DDSD Supported Living and Non Federal Medical.

These Qualifying Groups are based on secondary and/or primary Aid Categories. Refer to the "Total Enrollment Monthly Fast Fact" to view the main qualifying group totals of enrolled members.

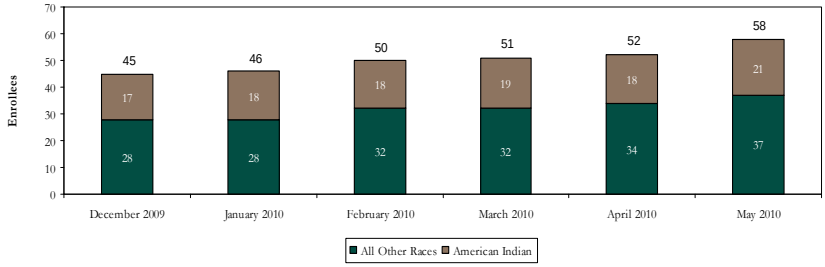
Age Breakdown of OLL Members



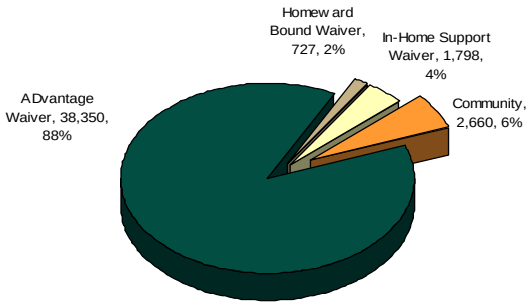
Oklahoma SoonerCare members residing in a long-term care facility:	**15,672**

Program of All-Inclusive Care for the Elderly (**PACE**) is a unique, capitated, one-stop, home and community-based program. PACE programs assume full financial risk for each member's care without limits on dollars or duration and are responsible for a full range of needed services. PACE is a permanent provider under the Medicare program and a state option under the SoonerCare program.

Total PACE Enrollment and Race Groupings



Waiver Enrollment Breakdown Percent



SoonerCare Home and Community-Based Services (HCBS) Waivers allow the flexibility to develop and implement creative alternatives to safely serve SoonerCare-qualified individuals in a community-based setting other than a long-term care facility or an intermediate care facility for the mentally retarded (ICF/MR). There are five HCBS waivers available in Oklahoma that are administered by the Oklahoma Department of Human Services; the ADvantage Waiver is operated by the Aging Services Division (ASD); the Community, Homeward Bound, In-Home Supports for Children and In-Home Supports for Adults Waivers are operated by the Developmental Disabilities Services Division (DDSD).

Race Breakdown of OLL Members

	Total Members	Percent
American Indian	13,504	8%
Asian or Pacific Islander	1,934	1%
Black or African American	24,653	15%
Caucasian	121,692	75%
Multiple Races	1,357	1%
Enroll Totals	163,140	
Hispanic Ethnicity	5,295	

This is a summary of long-term care members, plus a few programs and/or services managed by the Opportunity for Living Life (**OLL**) Division. There are other fast facts available reporting detailed statistical measures on individual programs available for qualifying OHCA members located on our website at www.okhca.org/research/data.

4/13/2010

Opportunities for Living Life Fast Facts

May 2010

Opportunities for Living Life (OLL) offers additional benefits to certain members enrolled in one of the SoonerCare plans. Those benefits include: 1) Nursing Facility Services (NF) - an inpatient benefit providing 24 hour nursing care. 2) Intermediate Care Facility Services for the Mentally Retarded (ICF-MR) - an inpatient benefit providing 24 hour care and active treatment. 3) Personal Care Services - an in home benefit providing assistance with mobility, meals, hygiene, grooming and other non-skilled personal services. 4) Home and Community-Based Services - a community-based benefit that provides comprehensive medical and other supportive services as an alternative to NF and ICF-MR inpatient care.

OPPORTUNITY FOR LIVING LIFE (OLL)

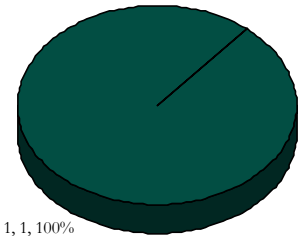
PROVIDERS BY PROGRAM—

Program Groups	Total	% of Total
Money Follows Person	3,559	37.88%
DDSD Waiver	3,477	37.01%
LTC Waiver	1,972	20.99%
NFM Waiver	236	2.51%
Medicare Only	105	1.12%
DDSD-SLA Waiver	47	0.50%
Total Providers	**9,396**	

These counts include clinics, hospitals, and other specialty physicians that serve the SoonerCare and Medicare members as well as those who qualify for OLL benefits.

Acronyms:
DDSD: Developmental Disabilities Services Division
SLA: Supported Living Arrangements
LTC: Long-Term Care
NFM: Non Federal Medical
ICF/MR: Intermediate Care Facility for Mentally Retarded
SNF: Skilled Nursing Facility
NF: Nursing Facility

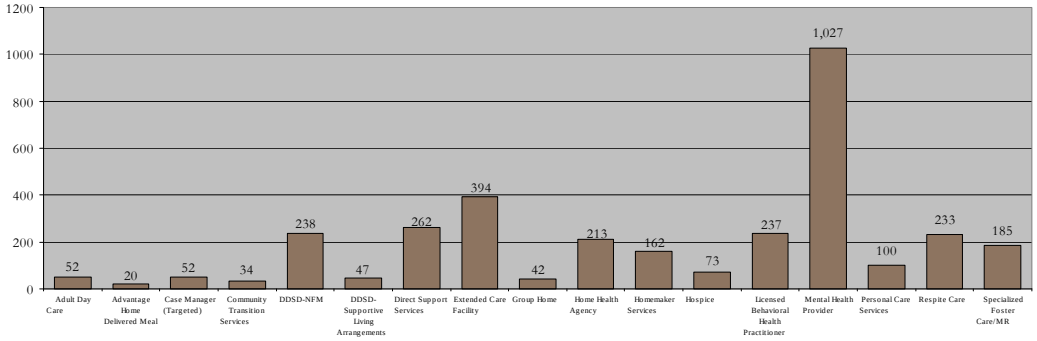
Providers By OLL Benefit Group Breakdown



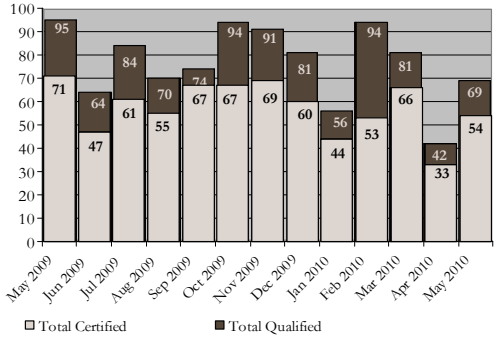
Some Providers may qualify to provide services for more than one Benefit group.

Our C.N.A. program is a dually beneficial program that assists in more skilled care for Oklahomans, as well as offering free training for Oklahomans to pursue a C.N.A. career.

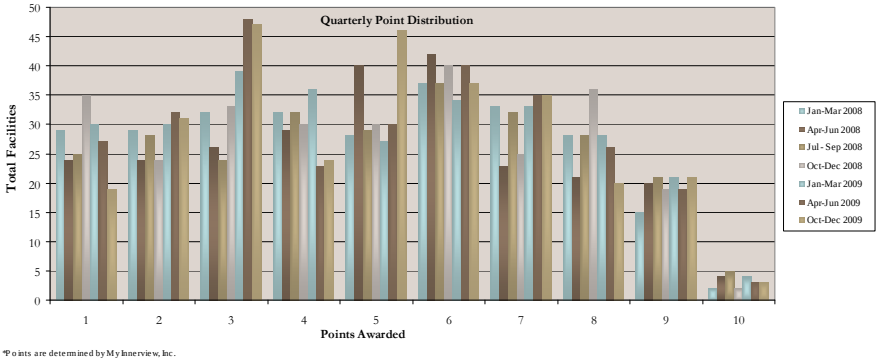
Unduplicated Provider Types Serving OLL Members



Certified Nursing Aides Qualified and Certified through OHCA Free Training Program



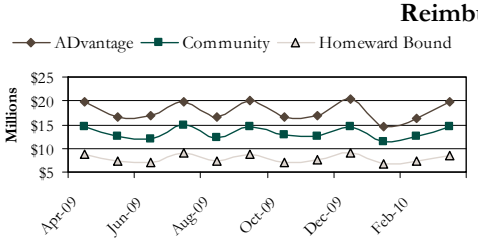
Focus on Excellence Nursing Home Participation and Point Tracking

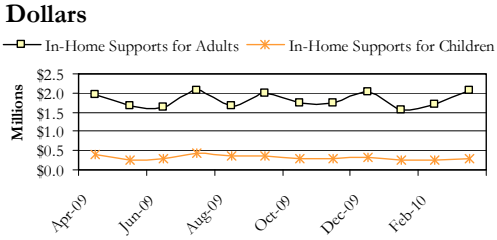


*Points are determined by My Innerview, Inc.

SoonerCare Home and Community-Based Services (HCBS) Waivers allow the flexibility to develop and implement creative alternatives to safely serve SoonerCare-qualified individuals in a community-based setting other than a long term care facility or an intermediate care facility for the mentally retarded (ICF/MR).

Reimbursed Dollars

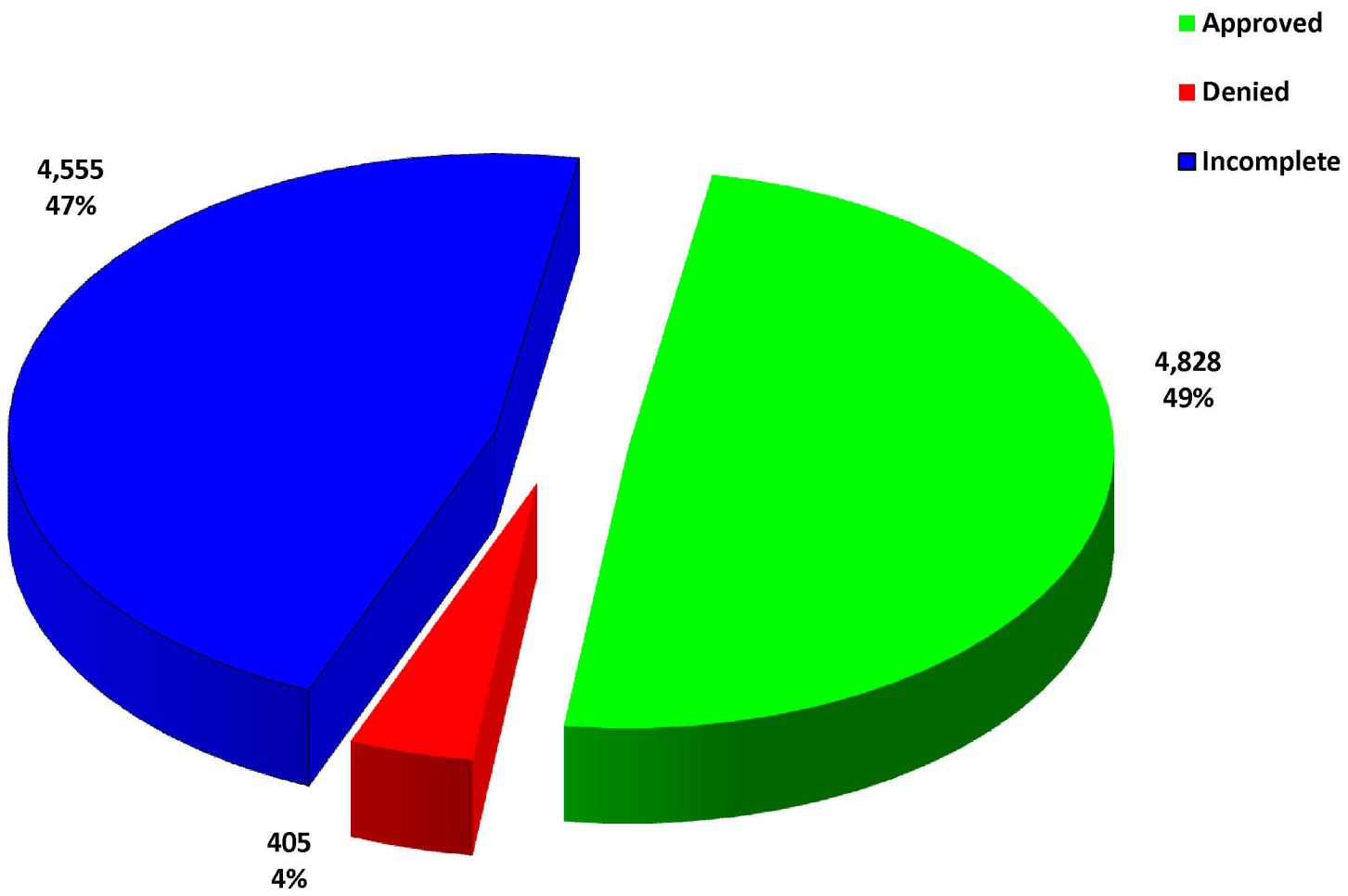




This is a summary on some of the programs and services managed by the OLL Division. More detailed information is available on individual fast facts located on our website at www.okhca.org/research/data.

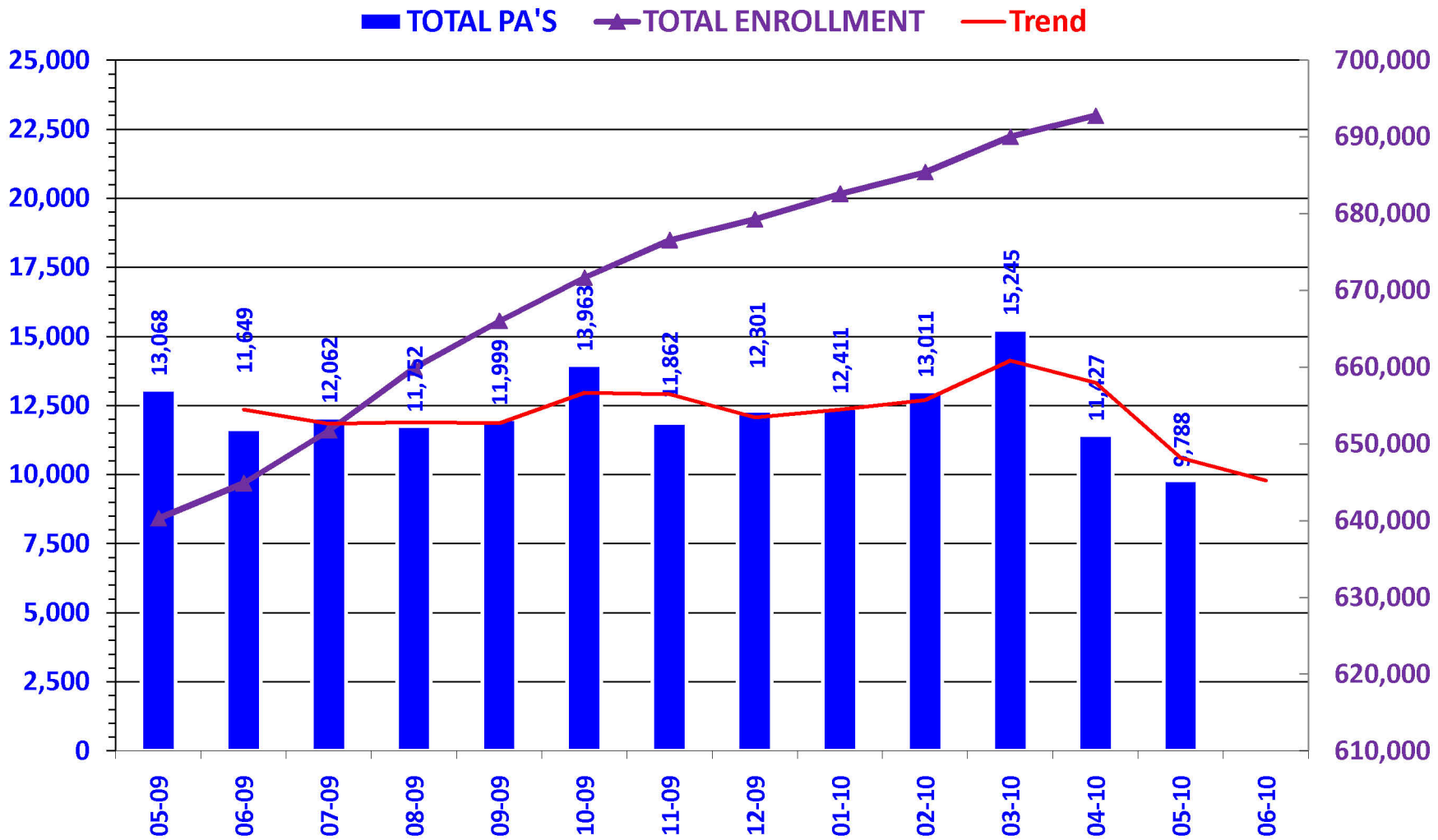
4/13/2010

PRIOR AUTHORIZATION ACTIVITY REPORT: May 2010



PA totals include overrides

PRIOR AUTHORIZATION REPORT: May 2009 – May 2010



PA totals include overrides

Prior Authorization Activity

May 2010

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort	495	232	5	258	358
Amitiza	27	8	4	15	218
Antidepressant	394	113	20	261	342
Antihistamine	479	263	16	200	323
Antihypertensives	110	46	8	56	333
Antimigraine	110	23	4	83	254
Atypical Antipsychotics	694	339	14	341	347
Benzodiazepines	171	49	0	122	202
Bladder Control	68	10	5	53	333
Brovana (Arformoterol)	2	0	1	1	0
Byetta	10	5	0	5	361
Elidel/Protopic	42	23	0	19	91
ESA	289	168	53	68	61
Fibric Acid Derivatives	9	2	1	6	228
Fibromyalgia	139	46	7	86	326
Fortamet/Glumetza	3	0	0	3	0
Forteo	5	4	0	1	361
Glaucoma	17	10	0	7	269
Growth Hormones	46	37	3	6	182
HFA Rescue Inhalers	93	38	2	53	275
Insomnia	82	17	5	60	180
Misc Analgesics	37	7	14	16	179
Muscle Relaxant	180	49	58	73	72
Nasal Allergy	449	104	26	319	150
NSAIDS	136	27	8	101	334
Ocular Allergy	42	8	1	33	155
Ocular Antibiotics	138	50	2	86	11
Opioid Analgesic	150	64	4	82	179
Other	457	125	34	298	143
Otic Antibiotic	140	73	2	65	11
Pediculicides	89	39	0	50	19
Plavix	305	194	3	108	294
Proton Pump Inhibitors	511	112	15	384	100
Qualaquin (Quinine)	4	0	4	0	0
Singulair	1,059	672	19	368	254
Smoking Cessation	51	15	2	34	50
Statins	121	34	4	83	346
Stimulant	954	579	19	356	237
Symlin	2	0	0	2	0
Topical Antibiotics	23	3	0	20	33
Topical Antifungals	21	6	0	15	33
Ultram ER and ODT	8	3	0	5	238
Xolair	6	1	3	2	361
Xopenex Nebs	53	24	1	28	243
Zetia (Ezetimibe)	22	13	0	9	360
Emergency PAs	12	12	0	0	
Total	**8,255**	**3,647**	**367**	**4,241**	

Overrides					
Brand	31	18	1	12	214
Dosage Change	497	477	2	18	13
High Dose	11	7	0	4	157
IHS - Brand	37	33	2	2	138
IHS – Brand	2	0	0	2	0
Ingredient Duplication	4	4	0	0	11
Lost/Broken Rx	104	97	6	1	9
NDC vs Age	42	41	0	1	258
Nursing Home Issue	102	97	0	5	16
Other	18	12	0	6	56
Quantity vs. Days Supply	720	428	26	266	250
Stolen	9	8	1	0	3
Overrides Total	**1,533**	**1,181**	**38**	**314**	
Total Regular PAs + Overrides	**9,788**	**4,828**	**405**	**4,555**	

Denial Reasons

Unable to verify required trials.	2,354
Lack required information to process request.	2,112
Does not meet established criteria.	236
Not an FDA approved indication/diagnosis.	131
Member has active PA for requested medication.	50
Medication not covered as pharmacy benefit.	44
Considered duplicate therapy. Member has a prior authorization for similar medication.	20
Requested dose exceeds maximum recommended FDA dose.	20
Drug Not Deemed Medically Necessary	1

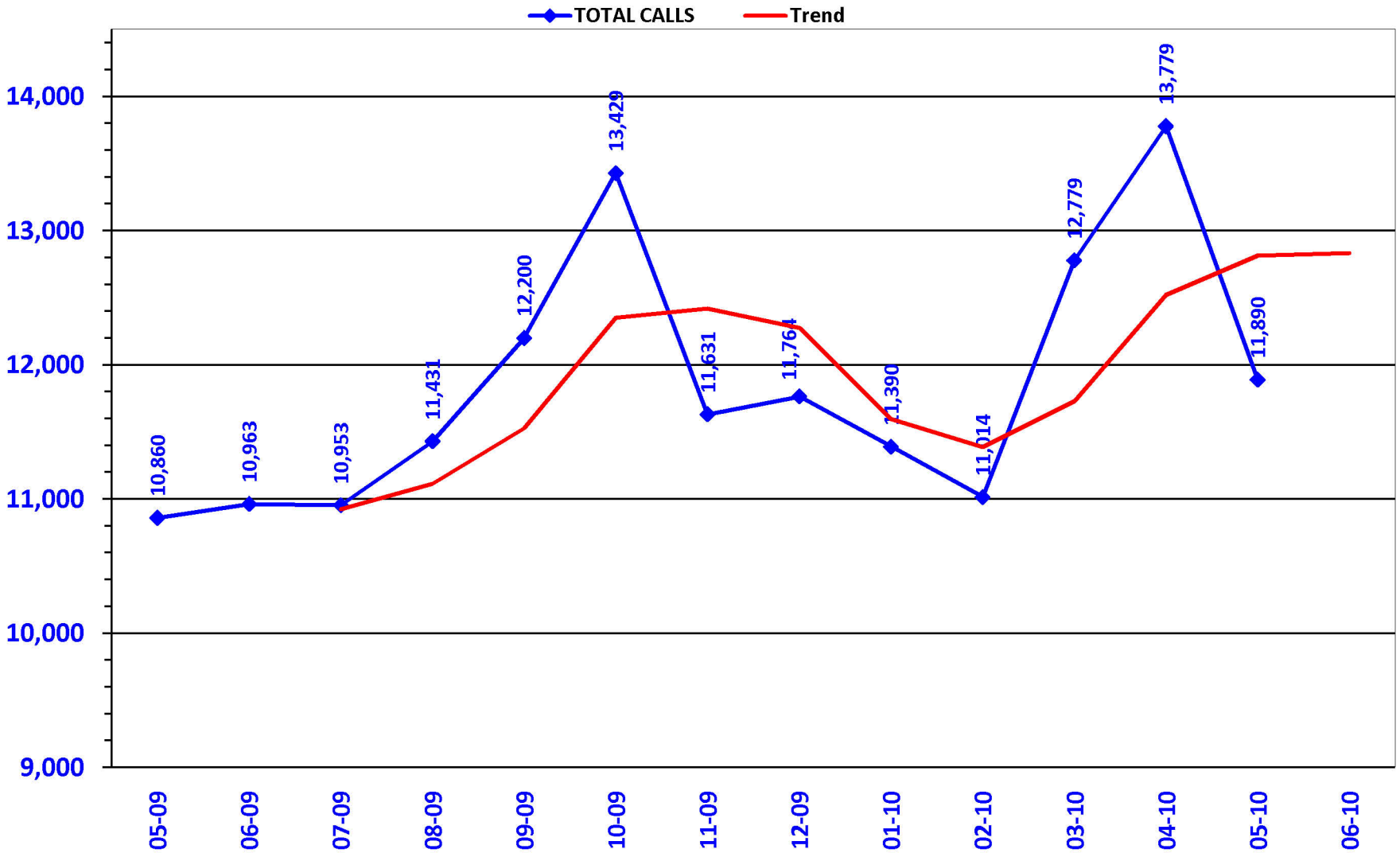
Duplicate Requests: 650

Letters: 1,393

No Process: 407

Changes to existing PAs: 439

CALL VOLUME MONTHLY REPORT:
May 2009 – May 2010



OKLAHOMA HEALTH CARE AUTHORITY

FY11 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	FY-10	FY-11	Inc / (Dec)	% Change
Medical Program				
Managed Care - Choice	28,950,269	31,086,445	2,136,176	7.4%
Hospitals	965,136,844	945,599,886	(19,536,957)	-2.0%
Behavioral Health	259,968,167	291,173,372	31,205,206	12.0%
Nursing Homes	514,933,783	493,089,933	(21,843,849)	-4.2%
Physicians	455,888,069	420,786,689	(35,101,381)	-7.7%
Dentists	146,245,706	163,941,061	17,695,355	12.1%
Other Practitioners	42,896,333	49,132,203	6,235,870	14.5%
Home Health	18,909,315	22,002,021	3,092,706	16.4%
Lab & Radiology	24,028,039	42,362,748	18,334,709	76.3%
Medical Supplies	55,979,172	52,501,386	(3,477,785)	-6.2%
Clinics	60,516,037	117,703,157	57,187,120	94.5%
Prescription Drugs	367,264,212	379,170,698	11,906,486	3.2%
Miscellaneous	30,229,336	30,009,791	(219,545)	-0.7%
ICF-MR Private	55,809,847	54,482,140	(1,327,707)	-2.4%
Transportation	26,092,736	27,470,618	1,377,882	5.3%
Medicare Buy-in	117,994,998	136,566,184	18,571,186	15.7%
MMA clawback payment	66,106,888	77,726,392	11,619,504	17.6%
Non-Title XIX Medical	89,382	89,382	-	0.0%
TOTAL OHCA MEDICAL PROGRAM	3,237,039,133	3,334,894,108	97,854,975	3.0%
OEPIC - Premium Assistance (HIFA)				
Employer Sponsored Insurance - ESI	51,055,347	57,318,322	6,262,975	12.3%
Individual Plan - IP	57,122,957	64,648,296	7,525,339	13.2%
TOTAL O-EPIC PROGRAM	108,178,303	121,966,618	13,788,315	12.7%
OHCA Administration				
Operations	38,538,957	42,396,158	3,857,201	10.0%
Contracts	94,305,384	106,633,884	12,328,500	13.1%
HIFA admin	9,018,750	8,413,868	(604,882)	-6.7%
Grant Mgmt	10,611,931	5,593,814	(5,018,117)	-47.3%
TOTAL OHCA ADMIN	152,475,022	163,037,723	10,562,701	6.9%
TOTAL OHCA PROGRAMS	**3,497,692,458**	**3,619,898,449**	**122,205,991**	**3.5%**
Other State Agency (OSA) Programs				
DHS	634,355,251	650,073,310	15,718,059	2.5%
ODSH	24,919,121	23,059,295	(1,859,826)	-7.5%
OJA	8,937,259	8,580,495	(356,764)	-4.0%
University Hospitals	212,382,995	141,330,088	(71,052,907)	-33.5%
PMTC	5,246,424	5,246,424	-	0.0%
DMHSAS	31,056,685	47,769,491	16,712,806	53.8%
DOE	6,090,798	6,773,443	682,645	11.2%
OSA DSH Supplemental	34,424,424	34,424,424	-	0.0%
Non-Indian Payments	1,200,000	3,299,210	2,099,210	174.9%
DOC	330,853	118,564	(212,289)	-64.2%
JD McCarty	4,745,295	3,430,466	(1,314,830)	0.0%
OSA Non-Title XIX	21,659,710	21,659,710	-	0.0%
TOTAL OSA PROGRAMS	**985,348,815**	**945,764,921**	**(39,583,894)**	**-4.0%**
TOTAL MEDICAID PROGRAM	**4,483,041,273**	**4,565,663,370**	**82,622,098**	**1.8%**
REVENUES				
Federal - program	2,685,636,851	2,780,408,240	94,771,389	3.5%
Federal Stimulus funds (ARRA)	431,111,338	187,812,209	(243,299,129)	-56.4%

OKLAHOMA HEALTH CARE AUTHORITY

FY11 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	FY-10	FY-11	Inc / (Dec)	% Change
Federal - admin	91,336,054	97,766,323	6,430,269	7.0%
Drug Rebates	130,544,319	115,562,630	(14,981,689)	-11.5%
Medical Refunds	39,032,295	39,032,295	0	0.0%
NF Quality of Care Fee	51,563,226	51,459,689	(103,536)	-0.2%
OSA Refunds & Reimbursements	381,857,164	368,602,182	(13,254,982)	-3.5%
Tobacco Tax	91,320,173	97,231,854	5,911,681	6.5%
Health Carrier Access Fee	-	52,000,000	52,000,000	100.0%
Insurance Premiums	-	7,757,796	7,757,796	100.0%
Misc Revenue	1,209,000	84,000	(1,125,000)	-93.1%
Prior Year Carryover	25,863,191	33,448,876	7,585,685	29.3%
Other Grants	9,977,144	4,621,507	(5,355,638)	-53.7%
OEPIC Transfer	-	30,000,000	30,000,000	100.0%
State Appropriated	543,590,519	699,875,770	156,285,252	28.8%
TOTAL REVENUES	**4,483,041,273**	**4,565,663,371**	**82,622,098**	**1.8%**
Diff	0	1	1	

EXPENDITURES		
SoonerCAre (Medicaid)		
Medical Services	3,334,894,108	75%
Adminstration	154,623,856	3%
Other State Agencies	945,764,921	21%
TOTAL	4,435,282,884	100%
Insure Oklahoma		
Medical Services	121,966,618	94%
Adminstration	8,413,868	6%
TOTAL	130,380,486	100%
OHCA TOTAL BUDGET	4,565,663,370	
REVENUE		
Federal	2,878,174,563	64%
Stimulus	187,812,209	4%
Appropriated	699,875,770	16%
Tobacco Tax	97,231,854	2%
Quality Care Fee	51,459,689	1%
Other State Agencies	368,602,182	8%
Other State Revenue	222,749,308	5%
TOTAL REVENUE	4,505,905,576	100%

7.b-1 CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
OAC 317:2-1-2. [AMENDED]
(Reference APA WF # 10-12)

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 give the Administrative Law Judge for the Oklahoma Health Care Authority jurisdiction to hear member appeals related to eligibility determinations made by OHCA. Revisions to the agency's grievance rules are needed to coincide with the Online Enrollment process which will transfer determination of SoonerCare eligibility for some individuals to the Oklahoma Health Care Authority.

ANALYSIS: In 2007, the OHCA received a Transformation Grant through the Centers for Medicare and Medicaid Services (CMS) to develop a web based online application and eligibility determination system in order to improve the ease and efficiency of enrollment. The Online Enrollment process allows potential members to apply for SoonerCare electronically. Soon, the OHCA will assume responsibility for determining SoonerCare eligibility for certain groups of individuals using this process. As OHCA will now be making eligibility determinations, our appeals' rules are in need of revision to add the responsibility of hearing members' grievances relating to these eligibility determinations.

BUDGET IMPACT: Agency staff has determined that the rule 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: Upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes, 42 CFR 431.205

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 give the Administrative Law Judge for the Oklahoma Health Care Authority jurisdiction to hear member appeals related to eligibility determinations made by OHCA.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2. Appeals
(a) **Member Process Overview.**
(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal.
(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. § 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.
(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.
(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.
(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (Section OAC 317:2-1-13).
(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 CFR Section 431.244(f)]
(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) **Provider Process Overview.**
(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).
(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(c)(2).
(A) The Appellant (Appellant is the provider who files a grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)
(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.
(C) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.
(D) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.
(E) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.

(c) **ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:
(1) Member Appeals:
(A) Discrimination complaints regarding the SoonerCare program;
(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;
(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;
(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
(F) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions; ~~and~~
(G) Appeals which relate to eligibility determinations made by OHCA; and

(2) Provider Appeals:
(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;
(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;
(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);
(D) Petitions for Rulemaking;
(E) Appeals of insureds participating in Insure Oklahoma/ O-EPIC which are authorized by OAC 317:45-9-8(a);
(F) Appeals to the decision made by the Contracts manager related to reports of supplier non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services and other appeal rights granted by contract;
(G) Drug rebate appeals;
(H) Nursing home contracts which are terminated, denied, or non-renewed;
(I) Proposed administrative sanction appeals pursuant to OAC 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions; and
(J) Contract award appeals.

7.b-2 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 110. Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us)
OAC 317:30-5-1091 [AMENDED]
OAC 317:30-5-1098 [AMENDED]
(Reference APA WF # 10-20)

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 clarify that smoking and tobacco use cessation counseling is a covered SoonerCare service for the Native American population through the Indian Health Service, Tribally Operated Programs and Urban Indian Clinics (I/T/U's). The Native American population has a high risk of suffering from tobacco related death and disease as this population has the highest prevalence of smoking and other tobacco use compared to any other population group in the United States. The cost for treatment of smoking related disease is high for this population and will likely continue to climb unless the rate of smoking and tobacco use is dramatically reduced.

ANALYSIS: Rules are revised to clarify that smoking and tobacco use cessation counseling is a covered SoonerCare service for the Native American population through the Indian Health Service, Tribally Operated Programs and Urban Indian Clinics. The revision will eliminate any confusion regarding availability of services among I/T/U's providing SoonerCare services.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 and Section 5051.3 of Title 63 of Oklahoma Statutes, and 42 CFR § 431.110

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 clarify that smoking and tobacco use cessation counseling is a covered SoonerCare service for the Native American population through the Indian Health Service, Tribally Operated Programs and Urban Indian Clinics.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1091. Definition of I/T/U services

(a) As described in Title 42 of the Code of Federal Regulations (CFR) 136.11(a), the I/T/U services may include hospital and medical care, dental care, public health nursing and preventive care (including immunizations), and health examination of special groups such as school children.

(b) Further, Title 42 CFR 136.11(c) allows that the scope and availability of I/T/U services will depend upon the resources of the facility.

(c) I/T/U services may be covered when furnished to a patient at the clinic or other location, including a mobile clinic, or the patient's place of residence.

(d) I/T/U outpatient encounters include but are not limited to:

(1) Physicians' services and supplies incidental to a physician's services;

(2) Within limitations as to the specific services furnished, a doctor of dentistry or oral surgery, a doctor of optometry, or a doctor of podiatry [Refer to Section 1861(r) of the Act for specific limitations];

(3) The services of a resident as defined in OAC 317:25-7-5(4) who meets the requirements for payment under SoonerCare and the supplies incidental to a resident's services;

(4) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;

(5) Services and supplies incidental to the services of APNs and PAs (including services furnished by certified nurse midwives);

(6) Public health nursing services include but are not limited to services in the following areas:

(A) Phlebotomy;

(B) Wound care;

(C) Public health education;

(D) Administration of immunizations;

(E) Administration of medication;

(F) Child health screenings meeting EPSDT criteria;

(G) Smoking and Tobacco Use Cessation Counseling;

~~(G)~~ (H) Prenatal, newborn and postpartum assessments, including case management services for first time mothers; and

~~(H)~~ (I) General health assessments and management of conditions such as tuberculosis, diabetes and hypertension.

(7) Visiting nurse services to the homebound;

(8) Behavioral health professional services and services and supplies incidental to the services of LBHPs; and

(9) Dental services.

317:30-5-1098. I/T/U outpatient encounters

(a) I/T/U outpatient encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by the OHCA. These services include health services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

(b) The following words and terms have the following meaning unless the context clearly indicates otherwise:

(1) An I/T/U outpatient encounter is a face-to-face contact between a health care professional and a CDIB card eligible SoonerCare member for the provision of Title XIX and Title XXI covered outpatient services in an I/T/U facility within a 24-hour period ending at midnight, as documented in the patient's medical record.

(2) An I/T/U encounter means outpatient services that may be covered when furnished to a patient by employees of the I/T/U facility at the I/T/U facility or other location, including the patient's place of residence.

(c) The following services may be considered reimbursable encounters subject to the limitations of the Oklahoma State Plan and include any related medical supplies provided during the course of the encounter:

(1) Medical;
(2) Diagnostic;
(3) Behavioral Health services [refer to OAC 317:30-5-1094];
(4) Dental, Medical and Mental Health Screenings;
(5) Vision;
(6) Physical Therapy;
(7) Occupational Therapy;
(8) Podiatry;
(9) Speech;
(10) Hearing;
(11) Visiting Nurse Services;
(12) Smoking and Tobacco Use Cessation Counseling
~~(12)~~ (13) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;
~~(13)~~ (14) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug sample. Drug samples are included in the encounter rate. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;
~~(14)~~ (15) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members; and
~~(15)~~ (16) I/T/U Multiple Outpatient Encounters.

(A) OHCA will cover one medically necessary outpatient medical encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit with a different diagnosis. Then, a second encounter is allowed.

(B) OHCA will cover one dental encounter per member per day regardless of how many procedures are done or how many providers are seen unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(C) OHCA will cover one behavioral health professional outpatient encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(D) Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U outpatient encounters. For example, a medical visit and a dental visit on the same day are considered different services with distinctly different diagnoses.

(E) Similar services, even when provided by two different I/T/U health care practitioners, are not considered multiple encounters. Situations that would not be considered multiple encounters provided on the same date of service include, but are not limited to:

(i) A well child check and an immunization;
(ii) A preventive dental screen and fluoride varnish application in a single setting;

(iii) A medical encounter with a mental health or addiction diagnosis on the same day as a mental health or addiction encounter;

(iv) A mental health and addiction encounter with similar diagnosis;

(v) Any time a member receives only a partial service with one provider and partial service from another provider. This would be considered a single encounter.

(d) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a member who comes to the I/T/U facility for a prenatal visit in the morning and delivers in the afternoon would not be considered a distinctly different diagnosis and can only be billed as a single encounter.

(e) The following services may be considered as separate or multiple encounters when two or more services are provided on the same date of service with distinctly different diagnoses:

(1) Medical Services;

(2) Dental Services;

(3) Mental Health and addiction services with similar diagnoses can only be billed as one encounter. In addition, if the member is also seen for a medical office visit with a mental health or addiction diagnosis, then it is considered a single encounter;

(4) Physical or occupational therapy (PT/OT). If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter;

(5) Administration of immunizations. If no other medical office visit occurs on the same date of services; and

(6) Tobacco cessation limited to state plan services. If no other medical or addiction encounter occurs on the same date of service.

(f) I/T/U outpatient encounters for CDIB eligible SoonerCare members whether medical, dental, or behavioral health, are not subject to prior authorization. Other State Plan covered services that the I/T/U facility chooses to provide but which are not part of the I/T/U encounter are subject to all applicable SoonerCare regulations which govern the provision and coverage for that service.

7.b-3 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 62. Private Duty Nursing
317:30-5-555. through 317:30-5-560.1. [AMENDED]
(Reference APA WF # 10-23)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the Agency's private duty nursing rules. Rules are revised to provide additional flexibility for OHCA to conduct a preliminary telephonic interview with members prior to arranging a personal visit. The additional flexibility in allowing the telephonic interview will provide an opportunity for OHCA to ensure medical necessity prior to arranging the personal home visit. These emergency rule revisions will make rules consistent with other OHCA medical necessity practices and clarify access to healthcare for Oklahomans, thereby reducing the overall administrative burden(s) on both the agency and the Oklahomans who depend on these services.

ANALYSIS: Private duty nursing rules are revised to provide additional clarification with regard to prior authorization requests for such services. Revisions clarify that providers should submit the required OHCA forms and documentation along with the treatment plan when requesting the prior authorization for private duty nursing. Revisions also provide additional flexibility for OHCA to conduct a preliminary telephonic interview with members prior to arranging a personal visit. The additional flexibility in allowing the telephonic interview will provide an opportunity for OHCA to ensure medical necessity prior to arranging the personal home visit. Additional revisions include general policy cleanup as it relates to these sections.

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 May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Upon Governor's approval

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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising rules to provide clarification and guidance to providers requesting prior authorization for private duty nursing services. Revisions also provide additional flexibility for OHCA to conduct a preliminary telephonic interview with members prior to arranging a personal visit.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 62. PRIVATE DUTY NURSING

317:30-5-555. Eligible providers

(a) An organization who desires to be paid by ~~Oklahoma Medicaid~~ SoonerCare for private duty nursing must meet the following requirements prior to providing services to eligible ~~Medicaid beneficiaries~~ SoonerCare members:

(1) an executed contract with OHCA, and

(2) the organization must meet the requirements of OAC 317:30-5-545 or it must be licensed by the State Health Department as a Home Care Agency.

(b) The provider of services within the organization must be a licensed practical nurse or a registered nurse.

317:30-5-556. Definitions

~~The definition of private~~ Private duty nursing is medically necessary care provided on a regular basis by a Licensed Practical Nurse or Registered Nurse in the member's residence or to assist outside the home during transport to medical appointments and emergency room visits in lieu of transport by ambulance.

317:30-5-557. Coverage by category

(a) **Adults.** ~~Oklahoma Medicaid~~ SoonerCare does not cover adults (~~persons age~~ Age 21 or over) for private duty nursing with the exception of subsection (c).

(b) **Children.** ~~Oklahoma Medicaid~~ SoonerCare does cover children (~~Persons under~~ Under the age of 21) if:

(1) the child is eligible for ~~Medicaid~~ SoonerCare; and

(2) the Oklahoma Health Care Authority, in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with OAC 317:30-5-560.1.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the ~~Medicaid~~ SoonerCare allowable for comparable services.

317:30-5-558. Private duty nursing coverage limitations

The following regulations apply to all private duty nursing services and provide coverage limitations:

(1) All services must be prior authorized to receive payment from the Oklahoma Health Care Authority (OHCA). Prior authorization means authorization in advance of services provided in accordance with OAC 317:30-5-560.1;

(2) A treatment plan must be completed by the Nursing agency before requesting prior authorization and must be updated at least annually and signed by the physician;

(3) A telephonic interview and/or personal visit by an OHCA Care Management Nurse is required prior to the authorization for services;

(4) Care in excess of the designated hours per day granted in the prior authorization is not ~~Medicaid compensable~~ SoonerCare compensable. Prior-authorized but unused service hours cannot be "banked," "saved," or otherwise "accumulated" for use at a future date or time. If such hours or ~~service~~ services are provided, they are not ~~Medicaid compensable~~ SoonerCare compensable.

(5) Any care provided outside of the home is limited to assisting during transport to medical appointments and emergency room visits in lieu of transport by ambulance and is limited to the number of hours requested on the treatment plan and approved by OHCA.

(6) Private duty nursing services do not include office time or administrative time in providing the service. The time billed is for direct nursing services only.
(7) Staff must be engaged in purposeful activity that directly benefits the member receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will OHCA compensate an organization for nursing staff time when sleeping.
(8) OHCA will not approve Private Duty Nursing service if all health and safety issues cannot be met in the home setting.
(9) A provider must not misrepresent or omit facts in a treatment plan.
(10) It is outside the scope of coverage to deliver care in a manner outside the treatment plan or to deliver units over the authorized units of care.
(11) Private duty nursing is not authorized in excess of 16 hours per day except immediately following a hospital stay or the temporary incapacitation of the primary caregiver. Under these two exceptions, care in excess of 16 hours is authorized for a period up to 30 days. As expressed in this subsection, incapacity means an involuntary ability to provide care.
(12) Family and/or caregivers and/or guardians are required to provide some of the nursing care to the member without compensation.

317:30-5-559. How services are authorized

An eligible provider may have private duty nursing services authorized by following all the following steps:

(1) create a treatment plan for the patient as expressed in OAC 317:30-5-560;

(2) ~~request a home visit by an OHCA Care Management Nurse~~ submit the prior authorization request with the appropriate OHCA required forms, the treatment plan, and request the telephonic interview and/or personal visit by an OHCA Care Management Nurse; and

(3) have an OHCA Care Management Nurse determine medical necessity of the service by scoring the ~~client's~~ member's needs on the Private Duty Nursing Acuity Grid ~~(Form OHCA 26)~~.

317:30-5-560. Treatment Plan

(a) An eligible organization must create a treatment plan for the member as part of the authorization process for private duty nursing services. The initial treatment plan must be signed by the member's attending physician. It must be updated and signed annually.

(b) The treatment plan must include all of the following medical and social data so that ~~OHCA Care Managers~~ an OHCA Care Management Nurse can appropriately determine medical necessity by the use of the Private Duty Nursing Acuity Grid:

(1) diagnosis;
(2) prognosis;
(3) anticipated length of treatment;
(4) number of hours of private duty nursing requested per day;
(5) assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory);
(6) medication method of administration and frequency;
(7) age-appropriate feeding requirements (diet, method and frequency);
(8) respiratory needs;
(9) mobility requirements including need for turning and positioning, and the potential for skin breakdown;
(10) developmental deficits;

(11) casting, orthotics, therapies;
(12) age-appropriate elimination needs;
(13) seizure activity and precautions;
(14) age-appropriate sleep patterns;
(15) disorientation and/or combative issues;
(16) age-appropriate wound care and/or personal care;
(17) communication issues;
(18) social support needs;
(19) name, skill level, and availability of all caregivers; and
20) other pertinent nursing needs such as dialysis, isolation.

317:30-5-560.1. Prior authorization requirements

(a) Authorizations are provided for a maximum period of six months.
(b) Authorizations require:
(1) a treatment plan for the member; and
(2) a telephonic interview and/or personal visit by an OHCA Care Management Nurse to determine medical necessity using the Private Duty Nursing Acuity Grid.
(c) The number of hours authorized may differ from the hours requested on the treatment plan based on the assessment of the Care Management Nurse.
(d) If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.
(e) Changes in the treatment plan may necessitate another telephonic interview and/or personal visit by the OHCA Care Management staff.

7.b-4 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 17. Medical Suppliers
317:30-5-211.5. [AMENDED]
(Reference APA WF # 10-24)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the Agency's durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) rules. Rules are revised to provide clarification and guidelines for product refills and reorders, including expected utilization patterns, member contact, and timelines. Rules also provide additional guidance in regard to products which are supplied and delivered via mail and the appropriate way for providers to bill for such items. These emergency rule revisions will make rules consistent with other OHCA and Medicare medical necessity practices and clarify access to healthcare for Oklahomans, thereby reducing the overall administrative burden(s) on both the agency and the Oklahomans who depend on these services.

ANALYSIS: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) rules are revised to provide guidance regarding the delivery of DMEPOS products. Rules provide clarification and guidelines for product refills and reorders, including expected utilization patterns, member contact, and timelines. Rules also provide additional guidance with regard to products which are supplied and delivered via mail and the appropriate way for providers to bill for such items. Additional revisions include clarification with regard to the provider cost of delivery and additional language to clarify OHCA's intent on DMEPOS supplier maintenance with regard to equipment-related services.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Upon Governor's approval

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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising rules to provide guidance regarding the delivery of durable medical equipment, prosthetics, orthotics and supplies. Rules provide clarification and guidelines for product refills and reorders, including expected utilization patterns, member contact, and timelines. Rules also provide additional guidance with regard to products which are supplied and delivered via mail and the appropriate way for providers to bill for such items. Additional revisions include

clarification with regard to the provider cost of delivery and additional language to clarify OHCA's intent on DMEPOS supplier maintenance with regard to equipment-related services.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.5. Repairs, maintenance, replacement and delivery

(a) **Repairs.** Repairs to equipment that a member owns are covered when they are necessary to make the equipment usable. The repair charge includes the use of "loaner" equipment as required. If the expense for repairs exceeds the estimated expense of purchasing or renting another item of equipment for the remaining period of medical need, payment can not be made for the amount in excess.

(b) **Maintenance.** Routine periodic servicing, such as testing, cleaning, regulating, and checking the member's equipment is considered maintenance and not a separate covered service. DMEPOS suppliers must provide equipment-related services consistent with the manufacturer's specifications and in accordance with all federal, state and local laws and regulations. Equipment-related services may include, but are not limited to, checking oxygen system purity levels and flow rates, changing and cleaning filters, and assuring the integrity of equipment alarms and back-up systems. However, more extensive maintenance as recommended by the manufacturer and performed by authorized technicians ~~are~~ is considered repairs. This may include breaking down sealed components and performing tests that require specialized testing equipment not available to the member. The supplier of a capped rental item that supplied the item the 13th month must provide maintenance and service for the item. In very rare circumstances of malicious damage, culpable neglect, or wrongful disposition, the supplier may document the circumstances and be relieved of the obligation to provide maintenance and service.

(c) **Replacement.**

(1) If a capped rental item of equipment has been in continuous use by the member for the equipment's useful life or if the item is irreparably damaged, lost, or stolen, a prior authorization must be submitted to obtain new equipment. The reasonable useful life for capped rental equipment cannot be less than five years. Useful life is determined by the delivery of the equipment to the member, not the age of the equipment.

(2) Replacement parts must be billed with the appropriate HCPCS code that represents the item or part being replaced, along with a pricing modifier and replacement modifier. If a part that has not been assigned a HCPCS code is being replaced, the provider should use a miscellaneous HCPCS code to bill each part. Each claim that contains miscellaneous codes for replacement parts must include a narrative description of the item, the brand name, model name/number of the item and an invoice.

(d) **Delivery.** ~~Delivery costs are included in setting the price for covered items. Delivery costs are not allowed except in rare and unusual circumstances when the delivery is outside the supplier's normal range of operation and cannot be provided by a more local supplier.~~ DMEPOS products are set with usual maximum quantities and frequency limits. Suppliers are not expected to provide these amounts routinely, nor are members required to accept DMEPOS products at frequencies or in quantities that exceed the amount the member would typically use. Suppliers must not dispense a quantity of any DMEPOS product exceeding a member's expected utilization. The reordering

or refilling of DMEPOS products should always be based on actual member usage. Suppliers should stay attuned to atypical utilization patterns on behalf of their members and verify with the ordering physician that the atypical utilization is warranted. Suppliers must exercise the following guidelines in regard to the delivery of DMEPOS products:

(1) For DMEPOS products that are supplied as refills to the original order, suppliers must contact the member prior to dispensing the refill. This shall be done to ensure that the refilled item is necessary and to confirm any changes/modifications to the order. Contact with the member regarding refills should take place no sooner than 7 days prior to the delivery/shipping date. For subsequent deliveries of refills, the supplier must deliver the DMEPOS product no sooner than 5 days prior to the end of the usage for the current product. This is regardless of which delivery method is utilized. A member must specifically request the refill before a supplier dispenses the product. Suppliers must not automatically dispense a quantity of supplies on a predetermined basis, even if the member has authorized this in advance. The supplier must have member contact documentation on file to substantiate that the DMEPOS product was refilled in accordance with this section.

(2) For DMEPOS products that are supplied via mail order, suppliers must bill using the appropriate modifier which indicates that the DMEPOS product was delivered via the mail. Reimbursement for DMEPOS products supplied and delivered via mail may be at a reduced rate.

(3) For DMEPOS products that are covered in the scope of the SoonerCare program, the cost of delivery is always included in the rate for the covered item(s).

7.b-5 CHAPTER 25. SOONERCARE CHOICE
Subchapter 7. ~~Soonercare~~ SoonerCare
Part 1. General Provisions
317:25-7-7. [NEW]
(Reference APA WF # 10-25)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of revisions to the Agency's SoonerCare Choice rules. Rules are revised to include procedures and guidelines related to primary care provider (PCP) referrals under the current medical home model. These emergency rule revisions will make rules consistent with other OHCA and private insurance medical necessity practices and clarify access to healthcare for Oklahomans, thereby reducing the overall administrative burden(s) on both the agency and the Oklahomans who depend on these services.

ANALYSIS: SoonerCare Choice rules are revised to include procedures and guidelines related to primary care provider (PCP) referrals under the current medical home model. The PCP referral process is clearly defined, including the appropriate use of OHCA administrative referrals. Rules further explain provider expectations and provide guidelines regarding PCP referrals, medical necessity, medical record documentation, and OHCA administrative referrals. These revisions continue to strengthen the OHCA medical home model and SoonerCare Choice program.

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 May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Upon Governor's approval

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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Promulgating rules to create procedures and guidelines related to primary care provider (PCP) referrals under the current Patient Centered Medical Home model. The PCP referral process is clearly defined, including the appropriate use of OHCA administrative referrals. Rules further explain provider expectations and provide guidelines regarding PCP referrals, medical necessity, medical record documentation, and OHCA administrative referrals.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE
SUBCHAPTER 7. SOONERCARE
PART 1. GENERAL PROVISIONS

317:25-7-7. Referrals for specialty services

(a) PCPs are required to assure the delivery of medically necessary preventive and primary care medical services, including securing referrals for specialty services. Some services, as defined in OAC 317:25-7-2(c) and OAC 317:25-7-10(b), do not require a referral from the PCP. A PCP referral does not guarantee payment, as all services authorized by the PCP must be in the scope of coverage of the SoonerCare Choice program to be considered compensable.

(b) Pursuant to OAC 317:30-3-1(f), SoonerCare Choice referrals must always be made on the basis of medical necessity. Referrals from the PCP are required prior to receiving the referred service, except for retrospective referrals as deemed appropriate by the PCP.

(c) Documentation in the medical record must include a copy of each referral to another health care provider. The PCP and specialty provider are responsible for maintaining appropriate documentation of each referral to support the claims for medically necessary services.

(d) As approved and deemed appropriate, the OHCA may provide administrative referrals for specialty services. Administrative referrals are only provided by the OHCA under special and extenuating circumstances. Administrative referrals should not be requested as a standard business practice. The OHCA will not process retrospective administrative referrals, unless one of the following exceptions applies:

(1) the specialty services are referred from an IHS, tribal, or urban Indian clinic;

(2) the specialty services are referred as the result of an emergency room visit or emergency room follow-up visit;

(3) the specialty services are referred for pre-operative facility services prior to a dental procedure; or

(4) the retrospective administrative referral request for specialty services is requested from the OHCA within 30 calendar days of the specialty care date of service. If the retrospective administrative referral is requested within the 30 calendar days, the request must include appropriate documentation for the OHCA to approve the request. Appropriate documentation must include:

(A) proof that the specialist has attempted to collect a PCP referral from the member's assigned PCP; and

(B) medical documentation to substantiate that the specialty services are medically necessary pursuant to OAC 317:30-3-1(f).

(e) Nothing in this section is intended to absolve the PCP of their obligations in accordance with the conditions set forth in their PCP SoonerCare Choice contract and the rules delineated in OAC 317:30.

7.b-6 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 27. Independent Licensed Physical Therapists
317:30-5-293. [NEW]
Part 28. Occupational Therapy Services
317:30-5-299. [NEW]
Part 77. Speech and Hearing Services
317:30-5-680. [NEW]
(Reference APA WF # 10-27)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the Agency's physical, occupational, and speech therapy rules. Rules are revised to clarify that when multiple therapists, or therapy assistants, work together as a team to treat one or more SoonerCare members, each therapist or assistant cannot bill separately for the same or different service provided at the same time to the same member. These emergency rule revisions will make rules consistent with other OHCA and private insurance medical necessity practices and clarify access to healthcare for Oklahomans, thereby reducing the amount of uncompensated care provided by Oklahoma healthcare providers.

ANALYSIS: Agency rules are revised to provide guidance in regards to team therapy. Physical, occupational, and speech therapy rules will clarify that when multiple therapists, or therapy assistants, work together as a team to treat one or more SoonerCare members, each therapist or assistant cannot bill separately for the same or different service provided at the same time to the same member. Additionally, rules will provide clarification in regards to billing, multiple therapies, delivery of service, and determining the time counted for service units and codes.

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 May 20, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Upon Governor's approval

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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising rules to provide guidance with regard to team therapy. Physical, occupational, and speech therapy rules will clarify that when multiple therapists, or therapy assistants, work together as a team to treat one or more SoonerCare members, each therapist or assistant cannot bill separately for the same or different service provided at the same time to the same member.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 27. INDEPENDENT LICENSED PHYSICAL THERAPISTS

317:30-5-293. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one or more members cannot each bill separately for the same or different service provided at the same time to the same member.

(1) CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one member at the same time, only one therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two therapists, each service unit of time the member is being treated can count as only one unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

PART 28. OCCUPATIONAL THERAPY SERVICES

317:30-5-299. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one or more members cannot each bill separately for the same or different service provided at the same time to the same member.

(1) CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one member at the same time, only one therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two therapists, each service unit of time the member is being treated can count as only one unit of each code. The service units billed must equal the total time

the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

PART 77. SPEECH AND HEARING SERVICES

317:30-5-680. Team therapy (Co-treatment)

Therapists, or therapy assistants, working together as a team to treat one or more members cannot each bill separately for the same or different service provided at the same time to the same member.

(1) CPT codes are used for billing the services of one therapist or therapy assistant. The therapist cannot bill for his/her services and those of another therapist or a therapy assistant, when both provide the same or different services, at the same time, to the same member.

(2) If multiple therapies (physical therapy, occupational therapy, and/or speech therapy) are provided to one member at the same time, only one therapist can bill for the entire service, or each therapist can divide the service units.

(3) Providers must report the CPT code for the time actually spent in the delivery of the modality requiring constant attendance and therapy services. Pre- and post-delivery services are not to be counted in determining the treatment service time. The time counted must begin when the therapist is directly working with the member to deliver treatment services.

(4) The time counted is the time the member is being treated. If the member requires both a therapist and an assistant, or even two therapists, each service unit of time the member is being treated can count as only one unit of each code. The service units billed must equal the total time the member was receiving actual therapy services. It is not allowable for each therapist or therapy assistant to bill for the entire therapy session. The time the member spends not being treated, for any reason, must not be billed.

7.b-7 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 3. General Provider Policies
OAC 317:30-3-5. [AMENDED]
(Reference APA WF # 10-42)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the Agency's cost-sharing guidelines. These emergency rule revisions will ensure rules are consistent and in compliance with current Federal law and Centers for Medicare and Medicaid Services (CMS) regulations.

ANALYSIS: OHCA cost-sharing rules are revised to correspond with CMS nominal cost share guidelines pertaining to prescription co-pays. Additionally, rules are clarified to state that a member's cost sharing liability is capped at 5% of the member's gross annual income.

BUDGET IMPACT: Agency staff has determined that implementation of the CMS four tier cost sharing system will cost approximately $589,000 total annual dollars with a state share of approximately $147,250.

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

PROPOSED EFFECTIVE DATE: Upon Governor's approval

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 447.54

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

TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES

317:30-3-5. Assignment and Cost Sharing
(a) **Definitions.** The following words and terms, when used in subsection (c) of this Section, shall have the following meaning, unless the context clearly indicates otherwise:
(1) **"Fee-for-service contract"** means the provider agreement specified in OAC 317:30-3-2. This contract is the contract between the Oklahoma Health Care Authority and medical providers which provides for a fee with a specified service involved.
(2) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare Program.

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

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

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

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

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

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

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

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

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

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

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

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

(B) Members in nursing facilities and intermediate care facilities for the mentally retarded.
(C) Pregnant women.
(D) Home and Community Based Service waiver members except for prescription drugs.

(2) Co-payment is not required for the following services:
(A) Family planning services. Includes all contraceptives and services rendered.
(B) Emergency services provided in a hospital, clinic, office, or other facility.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:
(A) Inpatient hospital stays.
(B) Outpatient hospital visits.
(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.
(D) Encounters with the following rendering providers:
(i) Physicians,
(ii) Advanced Practice Nurses,
(iii) Physician Assistants,
(iv) Optometrists,
(v) Home Health Agencies,
(vi) Certified Registered Nurse Anesthetists, and
(vii) Anesthesiologist Assistants,
(viii) Durable Medical Equipment providers, and
(ix) Outpatient behavioral health providers.
(E) Prescription drugs.
(i) Zero for preferred generics.
~~(ii) $2.00 for prescriptions having a SoonerCare allowable of $29.99 or less.~~
~~(iii) $3.00 for prescriptions having a SoonerCare allowable of $30.00 or more.~~
(ii) $0.65 for prescriptions having a SoonerCare allowable payment of $0.00-$10.00.
(iii) $1.20 for prescriptions having a SoonerCare allowable payment of $10.01-$25.00.
(iv) $2.40 for prescriptions having a SoonerCare allowable payment of $25.01-$50.00.
(v) $3.50 for prescriptions having a SoonerCare allowable payment of $50.01 or more.
(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Aggregate cost-sharing liabilities in a given calendar year may not exceed 5% of the member's gross annual income.

(ITEM 8)

a) Prior Authorize Ilaris® (canakinumab)

The Drug Utilization Review Board recommends pharmacy prior authorization of ILARIS® (canakinumab) with the following criteria.

1. FDA approved indication of Cryopyrin-Associated Periodic Syndromes (CAPS) verified by genetic testing. This includes Familial Cold Auto-inflammatory Syndrome (FCAS) and Muckle-Wells Syndrome (MWS) in adults and children 4 and older.
2. The member should not be using a tumor necrosis factor blocking agent (e.g. adalimumab, etanercept, and infliximab) or anakinra
3. Should not be initiated in patients with active or chronic infection including hepatitis B, hepatitis C, human immunodeficiency virus, or tuberculosis.
4. Dosing should not be more often than once every 8 weeks.
5. **Approved dosing schedule based on weight:**
   a. Body weight >40 kg: 150mg
   b. Body weight 15 kg – 40 kg: 2mg/kg. If inadequate response, may be increased to 3mg/kg
6. Approval period is for one year.

b) Prior Authorize Requip XL™ (ropinirole) and Mirapex® ER™ (pramipexole)

The Drug Utilization Review Board recommends prior authorization for Requip XL™ (ropinirole) tablets and Mirapex ER™ (pramipexole) tablets to ensure appropriate utilization for the FDA approved indication for the treatment of signs and symptoms of Parkinson's Disease and a justifiable reason why the immediate release products cannot be utilized.

c) Prior Authorize Lovaza® (Omega-3-Acid Ethyl Esters)

The Drug Utilization Review Board recommends prior authorization of Lovaza® with the following criteria:

1. Laboratory documentation of severe hypertriglyceridemia (fasting triglycerides ≥500 mg/dL).
2. Previous failure with both nicotinic acid and fibric acid medications.