OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
October 14, 2010 at 1:00 P.M.
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Ponca Conference Room
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 August 25, 2010 OHCA Board Minutes

Item to be presented by Mike Fogarty, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Carrie Evans, Chief Financial Officer
    b) Medicaid Director's Update – Garth Splinter, M.D.
    c) Medicaid On-Line Enrollment System Update – Richard Evans

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

4. Action Item – Consideration and Vote Upon Resolution Supporting Oklahoma Health Improvement Plan

Item to be presented by Chairman Roggow

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

    a) Audit/Finance Committee – Member Miller
    b) Rules Committee – Member Langenkamp
    c) Personnel Committee – Member McVay

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

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

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

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

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

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

7.b-1 AMENDING Agency rules at OAC 317:35-5-25 to comply with new Federal law that eliminates the five-year bar on SoonerCare services for Afghani and Iraqi special immigrants. These special immigrants will now be eligible for SoonerCare services past the previous eight month eligibility period and will no longer be subject to the five-year bar on services that is applied to other immigrants.
(Reference APA WF # 10-01)

7.b-2 ADDING Agency rules at OAC 317:45-3-3 and 45-5-3 to provide clarification regarding carrier and health plan rate structure requirements needed for participation in the Insure Oklahoma Program. Carriers and health plans must meet OHCA's system specifications for all rate structure tiers and requirements. The OHCA must be able to recreate premium invoice amounts for all approved Insure Oklahoma members. If a carrier and/or health plan can not accommodate OHCA's system specifications for all rate structure tiers and requirements, the carrier and/or health plan will not be allowed to participate in the Insure Oklahoma program. Carrier and/or health plan rate structure requirements include all rate tiers and age-up methodologies.
(Reference APA WF # 10-33)

7.b-3 AMENDING Agency rules at OAC 317:35-23-2 to revise eligibility criteria for individuals transitioning from an institution to a home and community based setting through the Living Choice Demonstration. Section 2403 of the Patient Protection and Affordable Care Act reduces the institutional stay requirement from six months to 90 days and the required period of Medicaid eligibility from 30 days to 1 day.
(Reference APA WF # 10-43)

7.b-4 AMENDING Agency rules at OAC 317:2-1-2, 2-1-5, 2-1-6, 2-1-7 and 2-1-13 to comply with Section 1011.9 of Title 56 of Oklahoma Statutes. These revisions allow for the recoupment of overpayments due to identified errors determined not to be fraudulent only after a provider has had the opportunity to exercise the right to an appeal that includes a hearing conducted by an administrative law judge appointed by the Oklahoma Attorney General. Rules also clarify that a provider has the right to participate in the hearing and to be represented by legal counsel. Revisions also grant the Administrative Law Judge (ALJ) jurisdiction over provider appeals related to the Oklahoma Electronic Health Records Incentive Payment Program.
(Reference APA WF # 10-45)

7.b-5 AMENDING Agency rules at OAC 317:30-5-72.1, 30-5-77, 30-5-78 and 30-5-78.1 to reflect the change in pricing methodology for injectable drugs that are submitted through the pharmacy system. Policy revisions are needed to clarify payment methodology and reduce expenditures. As a result, when dispensed through a pharmacy, the provider will be reimbursed at a rate which is equivalent to the Medicare rate plus the standard dispensing fee. Additional revisions include the coverage of non-prescription EPSDT products offered through the pharmacy point of sale system and the exemption of I/T/U facilities from prior authorization requirements for brand name drugs. **(Reference APA WF # 10-48)**

7.b-6 ADDING Agency rules at OAC 317:30-3-28 to establish program criteria and guidelines for the new Oklahoma Electronic Health Records Incentive Payment Program, which will begin January 2011 and is authorized by the American Recovery and Reinvestment Act of 2009. The rules provide a basic governing structure for the program, including the delineation of eligible providers and eligible hospitals, patient volume requirements, and incentive payment processes.
(Reference APA WF # 10-49)

Item to be presented by Cindy Roberts, Chairperson of State Plan Amendment Rate Committee

8. Action Item – Consideration and Vote Upon the recommendations of the State Plan Amendment Rate Committee

   a) Consideration and Vote Upon rate proposal for Nursing Facility Services

   b) Consideration and Vote Upon rate proposal for Nursing Facilities Serving Aids Patients

   c) Consideration and Vote Upon rate proposal for Supplements Payments

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

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

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

   b) Consideration and vote to add **Qutenza® (capsaicin) 8% Patch** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   c) Consideration and vote to add **Victoza® (liraglutide) and Bydureon® (exenatide LAR)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   d) Consideration and vote to add **Special Formulation Antibiotics** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   e) Consideration and vote to add **Anticonvulsants** 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. Morris v. OKDHS	CIV-09-1357C (USDC, Western District)
2. Harper v. OHCA	5:10 cv 00514-R(USDC,Western District)
3. Choices v. OHCA	105,533(Okla S. Ct.)
4. Wright v. OHCA	CJ-09-3924 (Oklahoma County)
5. Henson v. OHCA	CJ-09-12381(Oklahoma County)
6. Castro v. OHCA	CV-10-690(Oklahoma County)
7. Peak Medical v. Sebelius	10 CV-597 TCK PJC(USDC, Northern District)
8. Balenseifen v. OHCA	CJ-10-7962,(Oklahoma County)
9. Wittenberg v. OHCA	10-CV-0238-CVE-TLW (USDC, Northern District)

10. New Business

11. **ADJOURNMENT**

NEXT BOARD MEETING
November 18, 2010
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING/RETREAT OF THE OKLAHOMA HEALTH CARE AUTHORITY BOARD
August 25, 2010 at 4:00 P.M.
Held at Reed Conference Center
Midwest 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 August 24, 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 4:08PM.

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

OTHERS PRESENT:	OTHERS PRESENT:
Melissa Busby, Solutions Pointe HC	Wayne Collard, Solution Pointe HC
David Jolly, Solutions Pointe HC	Latosha Lornes, Voluteers of America
Richard DeSirey, Morton H. Center	Brent Wilborn, OKPCA
David Howlett, Variety Care	Will Widman, HP
Josh Cook, HP	Bill Piatt, SOTS
Anne Anthony, WCH	Shari Murphree, WCH
Lanette Kaiser, St. Anthony BMC	Charles Brodt, HP
Dan Arthrell, MHSC/Tulsa	Sandra Harrison, OKDHS
Laura Dempsey Polan, Life Care	Rebecca Moore
Leon Bragg, OHCA	Becky Pasternik-Ikard, OHCA
Carter Kimble, OHCA	Beth VanHorn, OHCA
Paula Gullion, OHCA	James Smith, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD JULY 8, 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 McFall moved for approval of the July 8, 2010 board minutes as presented. Vice Chairman Armstrong seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member McFall, and Chairman Roggow
ABSENT:	Member Langenkamp

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

Ms. Evans stated that revenues for OHCA through June, accounting for receivables, were **$3,386,232,473** or **.2% over** budget. Expenditures for OHCA, accounting for encumbrances, were **$3,354,175,253** or **.8% over** budget. She noted the state dollar budget variance through June is **$8,760,850 positive.** The state dollar budget variance due to Medicare Part D Stimulus allocation is **$26,399,610 positive.** The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(13.8)
Medicare Part D		26.4
Administration		4.1
Unbudgeted Carryover		3.4
Revenues:		
Unbudgeted State Appropriation		5.7
Taxes and Fees		4.1
Drug Rebate		1.4
Overpayments/Settlements		3.8
Total FY 10 Variance	**$**	**35.1**

ITEM 3.b/MEDICAID DIRECTOR'S UPDATE
Garth Splinter, MD, State Medicaid Director

Dr. Splinter reported on the Fast Facts going over the SoonerCare programs. He stated that the month of July totaled 729,271 members enrolled. The total number of providers for that month was 28,860. He reported that he will be doing a more conclusive report at the next board meeting.

Chairman Roggow and Mike Fogarty, Chief Executive Officer presented Mr. James Smith with his 15 year service pin, and presented Mr. Matt Lucas with his 20 year pin for service.

ITEM 4/REPORTS TO THE BOARD BY BOARD COMMITTEES
Chairman Roggow

Audit/Finance Committee
Member Miller

Member Miller reported that the Audit/Finance Committee did not meet.

Rules Committee
Member McVay

Member McVay stated the Rules Committee did meet and discussed the rules that will be presented by Ms. Roberts.

ITEM 5 - ANNOUNCEMENTS OF CONFLICTS OF INEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING
Howard Pallotta, General Counsel

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

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 McVay, Member Bryant, Member Miller, Member McFall, and Chairman Roggow
ABSENT:	Member Langenkamp

ITEM 6.b) CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:
Cindy Roberts, Deputy Chief Executive Officer

Ms. Roberts presented Rule 6.b-1 as published in meeting agenda.

Chairman Roggow recognized Richard DeSeary, Consultant for Morton Comprehensive Services. Mr. DeSeary stated that 7 years ago there was a reinterpretation of existing rules and it was decided that all FQHC's can do services with licensed clinical workers and psychologists much like we are discussing today. The Federal Qualified Health Centers (FQHC'S) serve the underserved populations, and communities. I have included in the handout a map that shows the disparity in Licensed Clinical Social Workers (LCSW's) and other licensed behavioral health practitioners. He stated that 4 years ago OHCA made a rule change that created Licensed Behavioral Practitioners (LBP's) as core providers. The reason the board is being asked to change these rules today is because of the financial impact. It is a financial matter, not a matter of complying with federal rules. Mr. DeSeary stated that one year ago OHCA officials sent memos to the FQHC's stating they discovered what they thought was an error rate in the rules. This has been going on for 1 year and with no finding of an error. The OHCA called together the FQHC Directors and ask directors to come up with 1 or 2 choices regarding this issue. One choice was to rebase their PPS rate which none were willing to do because of financial risks. The other choice was to go with the fee-for-service arrangement which is what this rule proposes. Mr. DeSeary stated that this will create an access problem if we rely only on Licensed Social Workers. He noted that this is an issue of restricting access to services to save money. He appealed to the OHCA Board as a former Chairman of the Board for Morton Comprehensive Health Services, as a Licensed Professional Counselor, to allow the rules to stand as written, and ask the board to

review this further before you create this impact on the families of SoonerCare members.

Chairman Roggow recognized Mr. Tim Sarkey, CEO for Great Salt Plain in Cherokee, OK. Mr. Sarkey stated Great Salt Plains is a very rural health center located in Alfafa County and has no licensed clinical social workers. We are an important safety net provider and provide a patient center medical home in a more comprehensive way than other providers. SoonerCare provides much of the revenue needed to care for patients. Unlike any other provider type, FQHC's give all the care needed for a one payment amount. Mr. Sarkey noted that the proposed rule before the board today contains a separation of behavioral health providers into 2 categories. These categories are core behavioral health providers and non-core behavioral health providers. He noted that core providers trigger the FQHC encounter rate as discussed, and the non-core providers are paid at a much lower fee-for-service rate. Mr. Sarkey stated his concern is that Licensed Professional Counselors are categorized as non-core providers. Today, I would ask the OHCA board to table this proposed rule until the apparent confusion can be cleared.

Member Miller asked if this issues was taken before the Medical Advisory Committee and the Medical Advisory Task Force. Ms. Roberts replied that they were taken twice to both committees with only 2 speakers requesting to speak. Both committees passed the recommendation to this board to take this policy forward.

MOTION:	Member McFall moved for approval of the Item 6-b.1 as presented and also the Medical Advisory Committee's recommendation. Member Bryant seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member McFall, and Chairman Roggow
ABSENT:	Member Langenkamp

Member McFall asked staff for a 3 month and 6 month report on any access problems related to Rule 6-b.1.

Ms. Roberts presented Rules 6.b-2 through 6.b-4 as published in meeting agenda.

MOTION:	Member McFall moved for approval of the Item 6-b.2 through 6-b.4 as presented. Member Bryant seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member McFall, and Chairman Roggow
ABSENT:	Member Langenkamp

ITEM 7.a) CONSIDERATION AND VOTE FOR AUTHORIZATION TO EXPEND FUNDS FOR THE MEDICAL MANAGEMENT INFORMATION SYSTEM (MMIS) REPROCUREMENT

Beth VanHorn, Director of Legal Operations

Ms. VanHorn stated that Hewlett-Packard Enterprise Services (HP) was awarded the contract as OHCA's fiscal agent in October 2000 to implement and operate a new Medicaid Management Information System (MMIS). This contract expires December 31, 2011. OHCA has released a Request for Proposal (RFP) to obtain a vendor to take over the current fiscal agent responsibilities, enhance, and operate the existing MMIS. The RFP also includes a Program Integrity (PI) system with new technologies for fraud detection and case tracking. This system may be awarded to the MMIS vendor or to a different PI System vendor.

Ms. VanHorn stated that OHCA anticipates making a vendor recommendation about September 21, 2010 and CMS approval about November 21, 2010. The contract has a development period, operational period, and optional one-year extension. OHCA will procure these services by competitive bid. The anticipated cost, including MMIS takeover, enhancements, and operations for an approximately eight-year period (through state fiscal year 2018), is estimated at $300 million or about $38 million each year. The federal matching percentages are 50%, 75% and 90% depending on the nature of the expenditures. Ms. VanHorn asked OHCA Board for approval to expend funds to procure a new MMIS vendor and Program Integrity system. She noted that the board approval is contingent upon approval by CMS.

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

ITEM 8 - 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:	Member Bryant moved for executive session. Vice Chairman Armstrong seconded.

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

ABSENT: Member Langenkamp

RECESS

RECONVENE BOARD MEETING/RETREAT 8:30 a.m. THURSDAY, AUGUST 26, 2010 REED CONFERENCE CENTER

THE FOLLOWING ITEMS WILL FOLLOW RETREAT FORMAT OF PANEL DISCUSSION AND OPEN DISCUSSION: ITEMS (9) THROUGH (19) ARE DISCUSSION ITEMS ONLY

9. **Welcome/Opening Remarks –** Lyle Roggow, OHCA Board Chairman and Mike Fogarty, Chief Executive Officer, OHCA

Chairman Roggow reconvened the meeting at 8:36AM and welcomed each of the attendees to OHCA's 11th Annual Board Retreat. Reflecting back OHCA started the first retreat with about 30 individuals at Western Hills Lodge and today we have 210 registered retreat individuals. Chairman Roggow introduced all of the board members present. He said that strategic planning is one of the most important tools to use to help an organization such as OHCA to effectively vote a plan of action with goals and objections. It shapes our future so we can know where we are going, it provides structure for mutually accepted goals and common agendas. He noted that it also defines the purpose of the group in balancing the goals for realistic resources that are available to us. Chairman Roggow said that everything we talk about has to be looked at from the other side of the issue and that is the financial implications. We will be going through 8 steps in the process. He asked the audience to engage in participation discussion. Chairman Roggow thanked Fox Systems fro providing thumb drives for retreat individuals. The thumb drives are loaded with all the retreat PowerPoint presentations for you perusal.

Chief Executive Officer Mike Fogarty added that on behalf of OHCA staff a heart welcome and thanked all individuals for having investing their time set aside for this board retreat. Mr. Fogarty introduced Secretary of State Susan Savage. He stated that this is not a series of lectures but your participation. He said that tomorrow there will be an open forum for each of you to have discussion and participation.

10. **Session I - OHCA Overarching Goals & Agenda Highlights**

Presenter: Cindy Roberts, Deputy Chief Executive Officer, OHCA

Ms. Roberts reviewed the agency's six overarching goals, highlighted upcoming sessions during the retreat and described the relationship between the agency's goals and session topics for this year's strategic planning activities.

11. **Session I (Oklahoma's Health – It's Everyone's Business)**

Panelists: Mike Fogarty, CEO, OHCA; Terri White, Oklahoma Secretary of Health, Commissioner of Mental Health and Substance Abuse Services; Terry Cline, Commissioner, Oklahoma State Department of Health

This session gathered Oklahoma health leaders to discuss how we might come together collectively to achieve change. Each panelist discussed their current capacities and collaborative initiatives, where their agencies are now, and where they may need to be. Additionally, each leader offered their perspective as to the role each respective agency may play within the roll-out of health care reform.

12. **Session III (National Health Care Reform – Changes are in store for Oklahoma....are we ready?**

Introduction by Becky Pasternik-Ikard, Chief Operating Officer, Medicaid Operations, OHCA

Presenters:
Chad Shearer, Senior Program Officer, Center for Health Care Strategies
Andrew Cohen, Director, Pacific Health Policy Group

Ms. Ikard stated that the passage of national health care reform provides Oklahoma both opportunities and challenges in the years ahead. Ms. Ikard introduced Chad Shearer, Senior Program Officer, Center for Health Care Strategies, and Andrew Cohen, Director, Pacific Health Policy Group. During this session Mr. Shearer and Mr. Cohen explained facts of what the new federal law contains, brainstormed effective ways to ensure Oklahoma citizens know the facts, and discussed the early steps being taken to analyze potential benefits to Oklahoma state agencies.

13. **Session IV (Online Enrollment-Easy as 1-2-3 for SoonerCare members and partners)**

Presenters: Derek Lieser, Project/Planning Manager, OHCA
Richard Evans, Eligibility Automation and Data Integrity Manager, OHCA
Yvonne Myers, Chief, Federal Funds, Okla. State Dept. of Health
Jim Struby, Programs Administrator with Family Support Services/ Okla. State Dept. of Health
Tracy Jones, Chickasaw Nation Health System

The OHCA has launched *www.mysoonercare.org* which provides 24-hour-a-day, seven-day-a-week access to SoonerCare enrollment via an online enrollment process. Members may access SoonerCare application through avenues most convenient to them such as home computers, community partners including the Oklahoma State Health Department, Oklahoma Department of Mental Health and Substance Abuse Services, Tribal Nations, Indian Health Service, public libraries, as well as other sites with an internet connection. During this session, OHCA staff demonstrated the online application process in a step-by-step walk through of the application. The session concluded with agency partners sharing their perspectives as to how online enrollment has changed

their business processes and presented opportunity to move SoonerCare enrollment into a new age of technology.

14. **Session V (Health Insurance Exchanges in Oklahoma – The devil is in the details**

Panelists: Deborah Chollet, Senior Fellow, Mathematica Policy Research Inc.
Mike Fogarty, CEO, OHCA
Kim Holland, Commissioner, Oklahoma Insurance Department

A central feature of national health care reform is the creation of a new exchange marketplace where members will be able to compare and purchase affordable coverage. This session featured a national expert, Deborah Chollet, Mathematica Policy Research, who explained the requirements for health insurance exchanges as included in the federal law. Mike Fogarty, CEO, OHCA, and Kim Holland, Commissioner, Oklahoma Insurance Department presented the perspectives of two state agencies regarding development of a strategic plan to implement an Oklahoma exchange.

15. **Session VI (Health Information Technology (HIT)/Oklahoma's roadmap to the health information highway)**

Presenters: John Calabro, Chief Information Officer, OHCA
Adolph Maren, Planning Coordinator, OHCA
Melody Anthony, Provider Services Director, OHCA
Carol McFarland, Performance & Reporting Manager, OHCA

As a result of the American Recovery and Reinvestment Act of 2009 and supported by the Patient Protection and Affordable Care Act of 2010. Oklahoma has been provided significant opportunity to explore and expand its technological infrastructure. This session began with an explanation of SoonerCare's role and responsibility in the statewide Health Information Exchange (HIE) efforts. The panelists provided a "Medicaid Electronic Health Record (EHR) Incentive Payments 101" that explained the mechanics behind the additional payments available for providers who choose to purchase and use HER technology in their day-to-day operations. The session concluded with a discussion surrounding the question, "What are the roles of all state agencies in Oklahoma's HIE efforts?"

16. **Session VII (Last Call/Questions & Answers)**

Facilitator: Nico Gomez, Deputy Chief Executive Officer, OHCA

The entire audio recordings of this question and answer session are available on the OHCA website.

RECESS

RECONVENE BOARD MEETING/RETREAT 8:30 a.m. FRIDAY, AUGUST 27, 2010
REED CONFERENCE CENTER

17. **Session VIII (Oklahoma's Budget Outlook/Managing resources to maintain member services)**

Presenters: Carrie Evans, Chief Financial Officer, OHCA
Juarez McCann, Chief Budget Officer, OHCA
Stephen Weiss, Senior Financial Analyst, OHCA

In this session each of the panelists provided insight into the federal environment's impact on OHCA especially the longevity of stimulus funds, maintenance of effort eligibility requirements, and estimated costs of health care reform; as well as the state environment's impact on OHCA including the enrollment trends for SoonerCare and Insure Oklahoma programs and available funding moving forward. The panelists also provided an update regarding the newly resurrected federal emphasis on oversight, coupled with existing state oversight.

18. **Session IX (The Patient Centered Medical Home - The business of serving our members**

Panelists: Dr. Daniel Duffy, MD, Dean, College of Medicine University Of Oklahoma – Tulsa, School of Community Medicine
Becky Pasternik-Ikard, Chief Operating Officer, Medicaid Operations, OHCA
Melody Anthony, Provider Services Director, OHCA
Patricia Johnson, Quality Assurance Director, OHCA
Marlene Asmussen, Care Management and Medical Authorization Director, OHCA
Kevin Rupe, Member Services Director, OHCA

In January, 2009, the OHCA embraced the joint principles of the Patient-Centered Medical Home (PCMH) collaborative and implemented the medical home model into the SoonerCare Choice program. During this session panelists discussed the 18 month post-implementation status report on outcomes of the PCMH program as well as learning what infrastructure the SoonerCare program supplies to the benefit of all members such as the Health Management Program, Patient Advice Line, and other outreach initiatives to name a few. During this session Dr. Daniel Duffy, Dean, College of Medicine, University of Oklahoma/Tulsa, School of Community Medicine one of the Health Access Networks (HAN) delivered a presentation which provided a perspective from the provider community as to changes made at the practice-level to better serve members, and the additional supports made possible by the HAN efforts.

19. **Session X (Last Call/Open Forum/Action Review**

Facilitator:
Nico Gomez, Deputy Chief Executive Officer, OHCA

There were various questions raised from attendees of the board retreat which were answered by panelists, board members, and distinguished guests. The entire audio recordings of the board meeting and retreat are available on the OHCA

website.

20. **Wrap-up/Closing Remarks)**

Vice Chairman Armstrong expressed his appreciation for the hard work staff has done and expressed thanks to all the OHCA Board Retreat attendees and Board Members for their involvement.

21. New Business

22. **ADJOURNMENT**

ITEM 21/NEW BUSINESS

NONE

ITEM 22/ADJOURNMENT

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

FINANCIAL REPORT

For the Two Months Ended August 31, 2010
Submitted to the CEO & Board
October 14, 2010

- Revenues for OHCA through August, accounting for receivables, were **$845,658,350** or **(1.1%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$498,745,105** or **2.3% under** budget.
- The state dollar budget variance through August is **$2,004,820 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		.6
Administration		1.2
Revenues:		
Taxes and Fees		.3
Drug Rebate		(.1)
Overpayments/Settlements		0
Total FY 10 Variance	**$**	**2.0**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2011, for the Two Months Ended August 31, 2010

REVENUES	FY11 Budget YTD	FY11 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 297,112,960	$ 297,112,960	$ -	0.0%
Federal Funds	295,443,481	285,982,955	(9,460,526)	(3.2)%
Tobacco Tax Collections	9,926,378	9,624,409	(301,969)	(3.0)%
Quality of Care Collections	8,410,583	8,967,496	556,913	6.6%
Prior Year Carryover	33,448,876	33,448,876	-	0.0%
Federal Deferral	16,022	16,022	-	0.0%
Drug Rebates	33,821,390	33,549,048	(272,342)	(0.8)%
Medical Refunds	9,505,388	9,510,416	5,028	0.1%
Other Revenues	4,913,067	4,893,336	(19,731)	(0.4)%
Stimulus Funds Appropriated	116,028,396	116,028,396	-	0.0%
Stimulus Funds Drawn	46,524,435	46,524,435	-	0.0%
TOTAL REVENUES	**$ 855,150,976**	**$ 845,658,350**	**$ (9,492,627)**	**(1.1)%**

EXPENDITURES	FY11 Budget YTD	FY11 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 7,132,984**	**$ 5,797,808**	**$ 1,335,176**	**18.7%**
ADMINISTRATION - CONTRACTS	**$ 19,245,706**	**$ 18,300,903**	**$ 944,803**	**4.9%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	5,409,267	3,884,896	1,524,371	28.2%
Acute Fee for Service Payments:				
Hospital Services	130,206,623	128,839,611	1,367,012	1.0%
Behavioral Health	42,583,219	40,941,794	1,641,424	3.9%
Physicians	62,102,604	60,836,116	1,266,488	2.0%
Dentists	24,886,950	23,935,946	951,004	3.8%
Other Practitioners	8,663,157	8,822,019	(158,862)	(1.8)%
Home Health Care	3,283,904	3,588,679	(304,775)	(9.3)%
Lab & Radiology	7,399,044	7,482,359	(83,315)	(1.1)%
Medical Supplies	7,974,398	7,208,008	766,391	9.6%
Ambulatory Clinics	15,456,861	13,075,140	2,381,721	15.4%
Prescription Drugs	52,645,841	49,724,291	2,921,550	5.5%
Miscellaneous Medical Payments	4,640,423	5,163,699	(523,276)	(11.3)%
Other Payments:				
Nursing Facilities	75,200,117	76,892,718	(1,692,600)	(2.3)%
ICF-MR Private	8,747,992	8,966,079	(218,086)	(2.5)%
Medicare Buy-In	21,959,867	22,195,275	(235,408)	(1.1)%
Transportation	4,530,459	4,496,675	33,784	0.7%
Part D Phase-In Contribution	8,083,753	8,593,090	(509,337)	(6.3)%
Total OHCA Medical Programs	**483,774,480**	**474,646,394**	**9,128,086**	**1.9%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 510,242,552**	**$ 498,745,105**	**$ 11,497,447**	**2.3%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 344,908,424**	**$ 346,913,245**	**$ 2,004,820**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2011, for the Two Months Ended August 31, 2010

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 3,956,692	$ 3,880,632	$ -	$ 71,797	$ -	$ 4,264	$ -
Inpatient Acute Care	98,372,806	86,667,618	81,114	1,997,331	8,157,527	754,762	714,453
Outpatient Acute Care	34,712,239	32,258,793	6,934	1,533,649	-	912,862	
Behavioral Health - Inpatient	17,551,521	17,423,810	-	1,792	-	4,958	120,961
Behavioral Health - Outpatient	1,185,802	1,178,178	-	-	-	-	7,624
Behavioral Health Facility- Rehab	37,360,423	21,987,606	-	49,144	-	14,642	15,309,031
Behavioral Health - Case Management	152	152	-	-	-	-	
Residential Behavioral Management	3,956,902	-	-	-	-	-	3,956,902
Targeted Case Management	12,092,040	-	-	-	-	-	12,092,040
Therapeutic Foster Care	332,449	332,449	-	-	-	-	-
Physicians	66,134,645	47,299,068	9,683	2,094,525	9,751,888	1,775,477	5,204,004
Dentists	23,936,516	22,827,888	-	570	1,083,326	24,733	-
Other Practitioners	8,898,186	8,581,838	74,394	76,167	153,537	12,250	-
Home Health Care	3,588,679	3,578,412	-	-	-	10,266	-
Lab & Radiology	7,984,624	7,251,273	-	502,265	-	231,086	-
Medical Supplies	7,300,485	6,738,168	452,972	92,477	-	16,867	-
Ambulatory Clinics	14,050,444	12,960,001	-	300,269	-	115,139	675,035
Personal Care Services	2,066,325	-	-	-	-	-	2,066,325
Nursing Facilities	76,892,718	48,830,983	21,621,750	-	6,439,985	-	-
Transportation	4,496,675	4,075,193	410,086	-	9,612	1,784	-
GME/IME/DME	-	-	-	-	-	-	-
ICF/MR Private	8,966,079	7,339,626	1,486,510	-	139,942	-	-
ICF/MR Public	11,092,764	-	-	-	-	-	11,092,764
CMS Payments	26,603,094	26,164,875	438,220	-	-	-	-
Prescription Drugs	52,025,703	42,125,143	-	2,301,413	7,155,338	443,810	-
Miscellaneous Medical Payments	5,163,709	4,906,581	-	10	231,013	26,105	-
Home and Community Based Waiver	24,230,058	-	-	-	-	-	24,230,058
Homeward Bound Waiver	13,696,059	-	-	-	-	-	13,696,059
Money Follows the Person	717,626	-	-	-	-	-	717,626
In-Home Support Waiver	3,766,520	-	-	-	-	-	3,766,520
ADvantage Waiver	29,531,233	-	-	-	-	-	29,531,233
Family Planning/Family Planning Waiver	948,337	-	-	-	-	-	948,337
Premium Assistance*	8,436,256	-	-	8,436,256	-	-	-
Total Medicaid Expenditures	**$ 610,047,758**	**$ 406,408,286**	**$ 24,581,663**	**$ 17,457,664**	**$ 33,122,168**	**$ 4,349,006**	**$ 124,128,970**

* Includes $8,401,492.13 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2011, for the Two Months Ended August 31, 2010

		FY11
REVENUE		**Actual YTD**
Revenues from Other State Agencies	$	51,363,587
Federal Funds		80,382,287
TOTAL REVENUES	**$**	**131,745,873**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	24,230,058
Money Follows the Person		717,626
Homeward Bound Waiver		13,696,059
In-Home Support Waivers		3,766,520
ADvantage Waiver		29,531,233
ICF/MR Public		11,092,764
Personal Care		2,066,325
Residential Behavioral Management		3,068,947
Targeted Case Management		10,626,964
Total Department of Human Services		**98,796,495**
State Employees Physician Payment		
Physician Payments		5,204,004
Total State Employees Physician Payment		**5,204,004**
Education Payments		
Graduate Medical Education		-
Graduate Medical Education - PMTC		-
Indirect Medical Education		-
Direct Medical Education		-
Total Education Payments		**-**
Office of Juvenile Affairs		
Targeted Case Management		309,826
Residential Behavioral Management - Foster Care		3,323
Residential Behavioral Management		884,632
Multi-Systemic Therapy		7,624
Total Office of Juvenile Affairs		**1,205,404**
Department of Mental Health		
Targeted Case Management		22
Hospital		120,961
Mental Health Clinics		15,309,031
Total Department of Mental Health		**15,430,013**
State Department of Health		
Children's First		333,036
Sooner Start		211,202
Early Intervention		554,007
EPSDT Clinic		303,139
Family Planning		7,194
Family Planning Waiver		936,597
Maternity Clinic		14,686
Total Department of Health		**2,359,861**
County Health Departments		
EPSDT Clinic		146,007
Family Planning Waiver		4,546
Total County Health Departments		**150,554**
State Department of Education		**26,912**
Public Schools		**241,274**
Medicare DRG Limit		**-**
Native American Tribal Agreements		**-**
Department of Corrections		**-**
JD McCarty		**714,453**
Total OSA Medicaid Programs	**$**	**124,128,970**
OSA Non-Medicaid Programs	**$**	**7,852,845**
Account Receivable from OSA	**$**	**235,942**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2011, for the Two Months Ended August 31, 2010

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 8,956,615	$ 8,956,615
Interest Earned	10,881	10,881
TOTAL REVENUES	**$ 8,967,496**	**$ 8,967,496**

EXPENDITURES	FY 11 Total $ YTD	FY 11 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 20,997,817	$ 7,468,923	
Eyeglasses and Dentures	45,833	16,303	
Personal Allowance Increase	578,100	205,630	
Coverage for DME and supplies	452,972	161,122	
Coverage of QMB's	172,126	61,225	
Part D Phase-In	438,220	438,220	
ICF/MR Rate Adjustment	827,415	294,311	
Acute/MR Adjustments	659,095	234,440	
NET - Soonerride	410,086	145,867	
Total Program Costs	**$ 24,581,663**	**$ 9,026,043**	**$ 9,026,043**
Administration			
OHCA Administration Costs	$ 86,626	$ 43,313	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 86,626**	**$ 43,313**	**$ 43,313**
Total Quality of Care Fee Costs	**$ 24,668,289**	**$ 9,069,356**	
TOTAL STATE SHARE OF COSTS			**$ 9,069,356**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2011, for the Two Months Ended August 31, 2010

REVENUES	FY 10 Carryover	FY 11 Revenue	Total Revenue
Prior Year Balance	$ 45,276,770	$ -	$ 37,310,798
Tobacco Tax Collections	-	7,915,749	7,915,749
Interest Income	-	260,723	260,723
Federal Draws	379,631	5,179,830	5,179,830
All Kids Act	(8,000,000)	-	-
TOTAL REVENUES	**$ 37,656,401**	**$ 13,356,302**	**$ 50,667,100**

EXPENDITURES	FY 10 Expenditures	FY 11 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 8,401,492	$ 8,401,492
ESI-College Students		34,764	34,764
Individual Plan			
SoonerCare Choice		$ 70,147	$ 24,951
Inpatient Hospital		1,974,200	702,223
Outpatient Hospital		1,520,028	540,674
BH - Inpatient Services		1,792	638
BH Facility - Rehabilitation Services		49,073	17,455
Physicians		2,080,473	740,024
Dentists		570	203
Other Practitioners		74,783	26,600
Home Health		-	-
Lab and Radiology		496,873	176,738
Medical Supplies		92,355	32,851
Ambulatory Clinics		299,568	106,556
Prescription Drugs		2,284,974	812,765
Miscellaneous Medical		10	3
Premiums Collected		-	(193,834)
Total Individual Plan		**$ 8,944,847**	**$ 2,987,848**
College Students-Service Costs		**$ 76,562**	**$ 27,233**
Total Program Costs		**$ 17,457,664**	**$ 11,451,337**
Administrative Costs			
Salaries	$ 22,395	$ 239,143	$ 261,537
Operating Costs	39,799	9,152	48,952
Health Dept-Postponing	19,330	-	19,330
Contract - HP	264,080	254,854	518,933
Total Administrative Costs	**$ 345,603**	**$ 503,149**	**$ 848,752**
Total Expenditures			**$ 12,300,089**
NET CASH BALANCE	**$ 37,310,798**		**$ 38,367,011**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2011, for the Two Months Ended August 31, 2010

REVENUES	FY 11 Revenue	State Share
Tobacco Tax Collections	$ 157,979	$ 157,979
TOTAL REVENUES	**$ 157,979**	**$ 157,979**

EXPENDITURES	FY 11 Total $ YTD	FY 11 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 4,264	$ 1,062	
Inpatient Hospital	754,762	187,936	
Outpatient Hospital	912,862	227,303	
Inpatient Free Standing	4,958	1,235	
MH Facility Rehab	14,642	3,646	
Case Mangement	0	-	
Nursing Facility	-	-	
Physicians	1,775,477	442,094	
Dentists	24,733	6,158	
Other Practitioners	12,250	3,050	
Home Health	10,266	2,556	
Lab & Radiology	231,086	57,540	
Medical Supplies	16,867	4,200	
Ambulatory Clinics	115,139	28,670	
Prescription Drugs	443,810	110,509	
Transportation	1,784	444	
Miscellaneous Medical	26,105	6,500	
Total Program Costs	$ 4,349,006	$ 1,082,903	**$ 1,082,903**
TOTAL STATE SHARE OF COSTS			**$ 1,082,903**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 255: OHCA Medicaid Program Fund
Fiscal Year 2011, for the Two Months Ended August 31, 2010

REVENUES	FY 11 Total Revenue	FY 11 State Share
Tobacco Tax Collections	$ 9,466,430	$ 9,466,430
TOTAL REVENUES	**$ 9,466,430**	**$ 9,466,430**

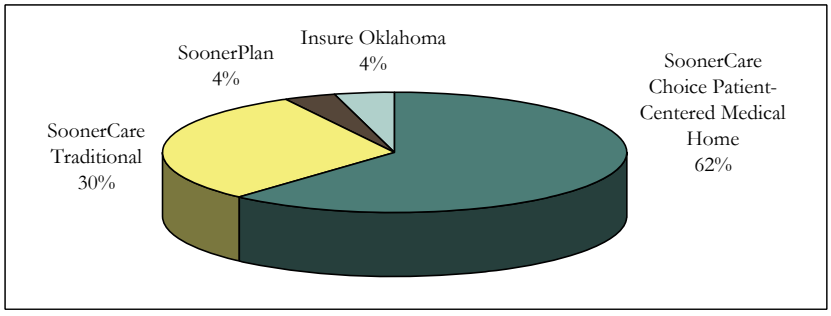
EXPENDITURES Program Costs:	FY 11 Total $ YTD	FY 11 State $ YTD	Total State $ Cost
Adult Dental Services	$ 1,083,326	$ 385,339	
Remove Hospital Day Limit	1,975,550	702,703	
Hospital Rate Increase - Statewide Median +2%	2,839,216	1,009,909	
Increase Physician Visits from 2 to 4 per Month	81,507	28,992	
Increase Physician Office Visits/OB Visits to 90% of Medicare	4,685,182	1,666,519	
Increase Emergency Room Physician Rates to 90% of Medicare	2,218,192	789,011	
Pay 50% of Medicare Crossover - Physician/Ambulance/OP	3,151,556	1,121,009	
Nursing Facility 7% Rate Increase	5,109,373	1,817,404	
Enhanced Drug Benefit for Adults 3 + 3	3,859,057	1,372,666	
Enhanced Drug Benefit for Waiver Adults 3 + 10	3,296,285	1,172,489	
TEFRA Services	1,856,001	660,179	
SoonerRide	9,612	3,419	
Replace NSGO Medicare DRG Limit Revenues	2,957,315	1,051,917	
Total Program Costs	**$ 33,122,171**	**$ 11,781,556**	**$ 11,781,556**
TOTAL SHATE SHARE OF COSTS			**$ 11,781,556**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

SoonerCare Programs

August 2010 Data for October 2010 Board Meeting

Delivery System	Monthly Enrollment Average SFY2009	Enrollment August 2010	Total Expenditures August 2010	Average Dollars Per Member Per Month August 2010
SoonerCare Choice Patient-Centered Medical Home	435,958	**457,273**		
Lower Cost				
Higher Cost (Aged, Blind or Disabled)				
SoonerCare Traditional	219,646	**224,994**		
Lower Cost (Supplemental, HMO, etc.)				
Higher Cost (Institutionalized Aged, Blind or Disabled)				
SoonerPlan	23,255	**26,386**		
Insure Oklahoma	28,594	**31,805**		
Employer-Sponsored Insurance	17,857	18,825		
Individual Plan	10,736	12,980		
TOTAL	**707,453**	**740,458**		



Net Enrollee Count Change from Previous Month Total	**11,187**
New Enrollees	**17,275**

Opportunities for Living Life (OLL)

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	17,084
Aged/Blind/Disabled	*Adult*	129,092
Other	*Child*	12
Other	*Adult*	18,369
PACE	*Adult*	59
TEFRA	*Child*	357
Living Choice	*Adult*	82
OLL Enrollment		**165,055**

Medicare and SoonerCare	Monthly Average SFY2009	Enrolled August 2010
Dual Enrollees	**100,143**	**102,233**

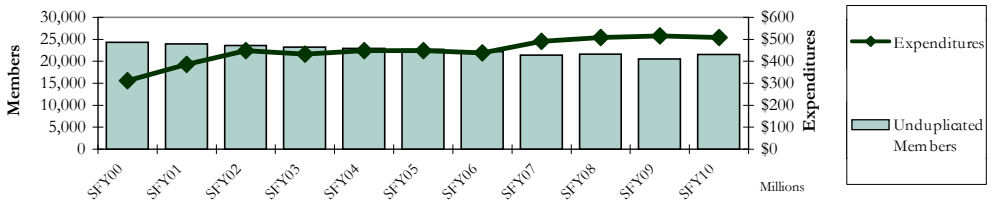
	Monthly Average SFY2009	Enrolled August 2010
Long-Term Care Members	**15,820**	**15,620**
Child	37	88
Adult	15,783	15,532

SFY2010 Long-Term Care

Statewide LTC Occupancy Rate - 69.8%; SoonerCare funded LTC Bed Days 68.6%

Data as of September 2010

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Sept. 9, 2010. Figures do not include intermediate care facilities for the mentally retarded (ICF/MR).

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts	Monthly Average SFY2009	Enrolled August 2010
Total Providers	**28,000**	**29,452**
In-State	19,563	21,074
Out-of-State	8,437	8,378

Program	% of Capacity Used
SoonerCare Choice	40%
SoonerCare Choice I/T/U	12%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2009*	*In-State Enrolled August 2010*	Total Monthly Average SFY2009	Total Enrolled August 2010
Physician	*5,884*	*6,274*	10,664	11,089
Pharmacy	*874*	*896*	1,168	1,211
Dentist	*793*	*868*	893	982
Mental Health Provider	*915*	*882*	983	916
Hospital	*159*	*186*	790	587
Extended Care Facility	*394*	*393*	395	393
Licensed Behavioral Health Practitioner	*N/A*	*378*	N/A	392

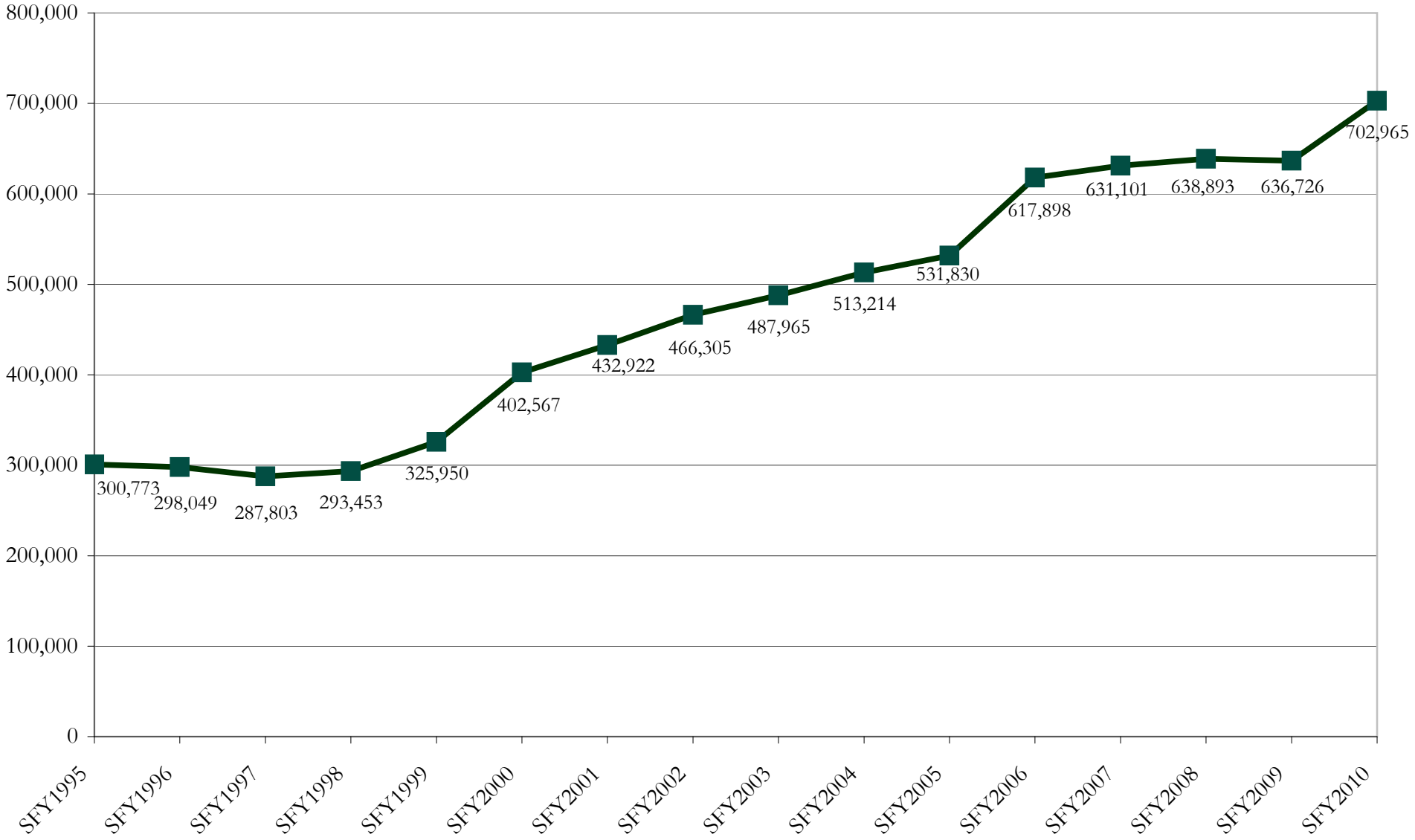
Above counts are for specific provider types and are not all-inclusive.

Total Primary Care Providers	*4,072*	*4,370*	6,063	6,342
Patient-Centered Medical Home	*1,339*	*1,405*	1,360	1,431

Including Physicians, Physician Assistants and Advance Nurse Practitioners

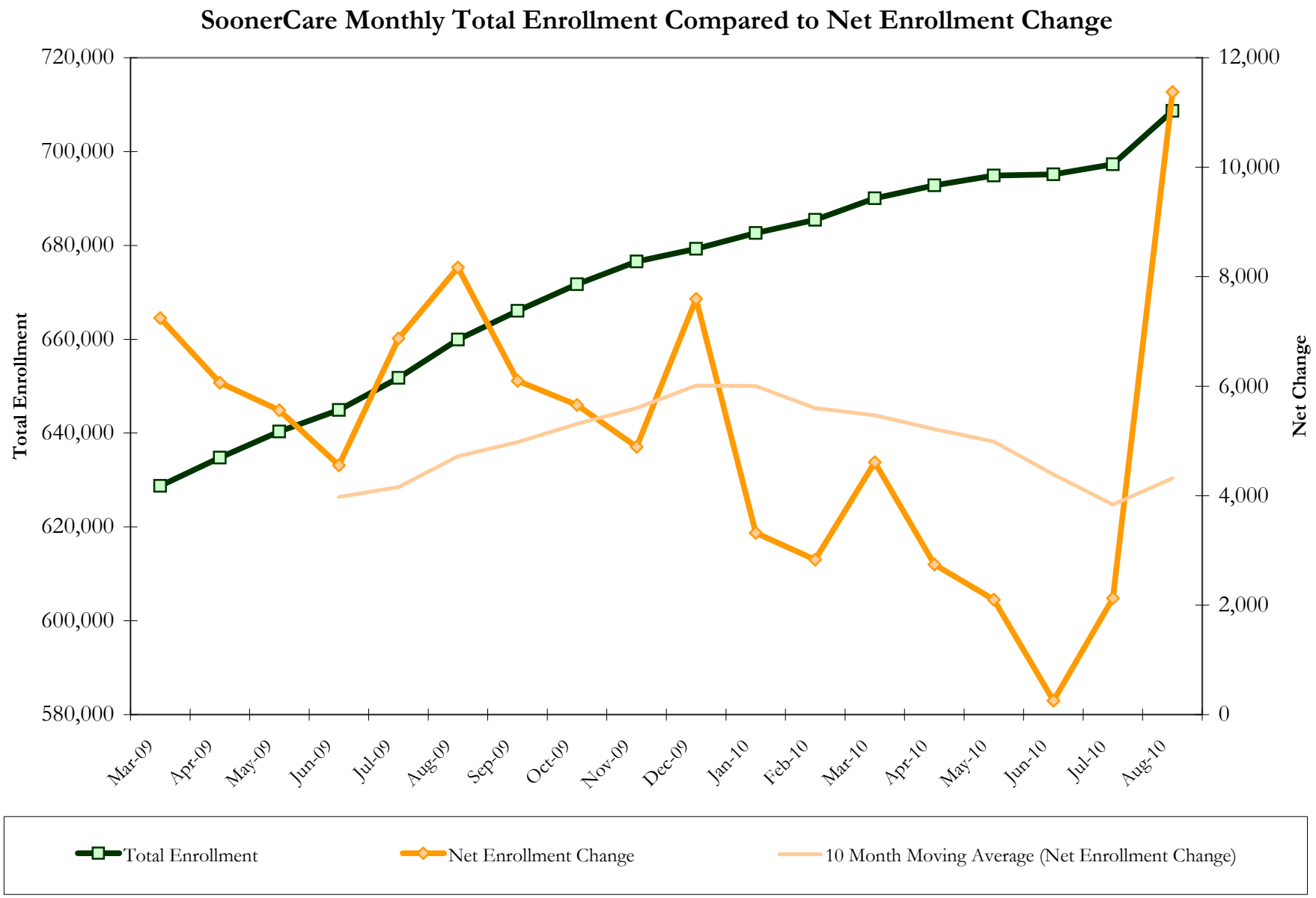
10/8/2010

Historic Average SoonerCare Enrollment Per Month



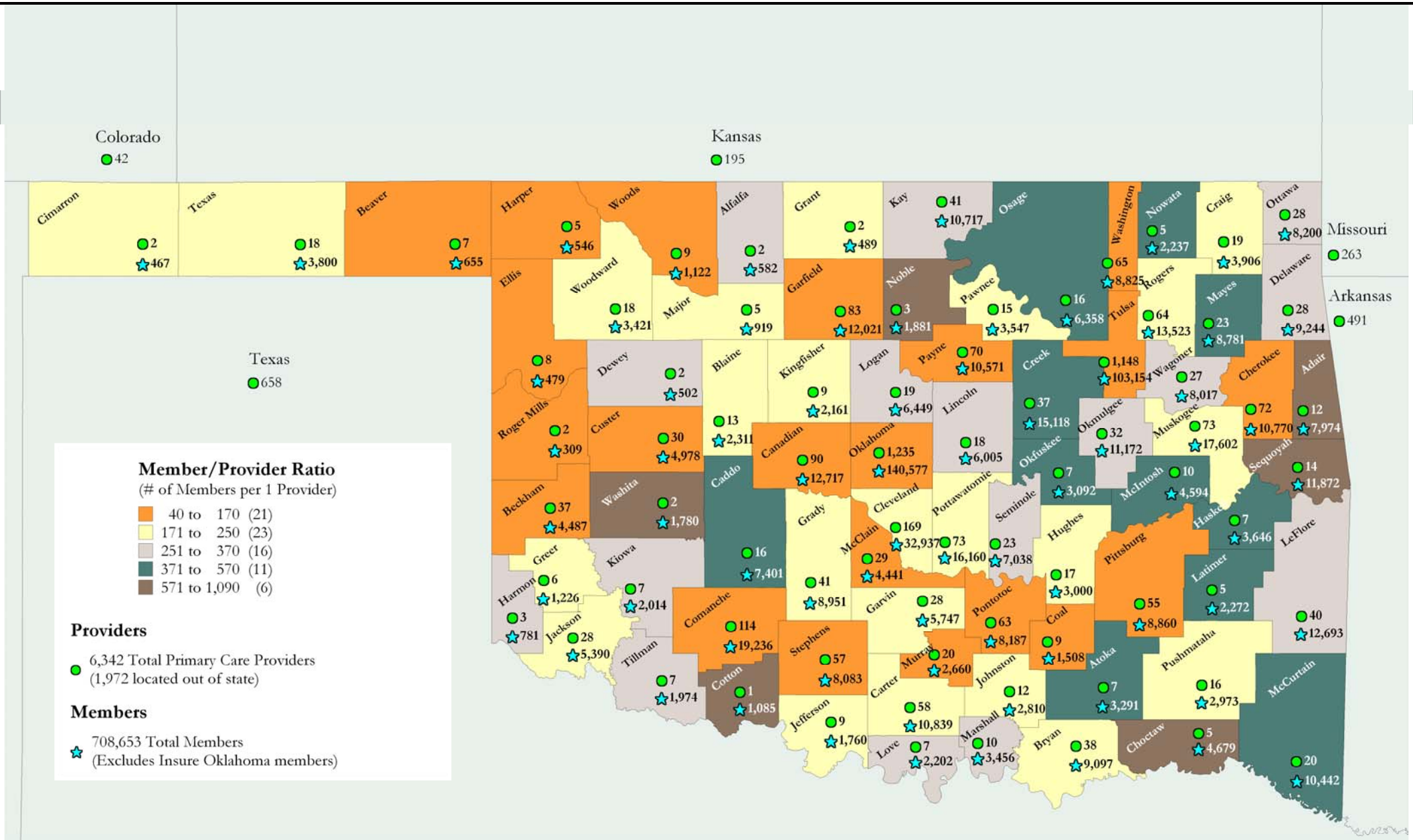
Data prior to SFY2000 is from the OKDHS County Summary Report. During SFY1998 Title 19 expansion and CHIP were implemented. SoonerPlan and Oklahoma Cares enrollment began in the last half of SFY2005. In SFY2006 OHCA implemented 12 month certifications and TEFRA.

Figures do not include Insure Oklahoma enrollees.


SoonerCare Monthly Total Enrollment Compared to Net Enrollment Change
Total Enrollment
Net Change
720,000
700,000
680,000
660,000
640,000
620,000
600,000
580,000
12,000
10,000
8,000
6,000
4,000
2,000
0
Mar-09
Apr-09
May-09
Jun-09
Jul-09
Aug-09
Sep-09
Oct-09
Nov-09
Dec-09
Jan-10
Feb-10
Mar-10
Apr-10
May-10
Jun-10
Jul-10
Aug-10
Total Enrollment
Net Enrollment Change
10 Month Moving Average (Net Enrollment Change)

Member to Provider Ratio
August 2010

oklahoma health care authority



Member/Provider Ratio
(# of Members per 1 Provider)

40 to	170	(21)
171 to	250	(23)
251 to	370	(16)
371 to	570	(11)
571 to	1,090	(6)

Providers

6,342 Total Primary Care Providers
(1,972 located out of state)

Members

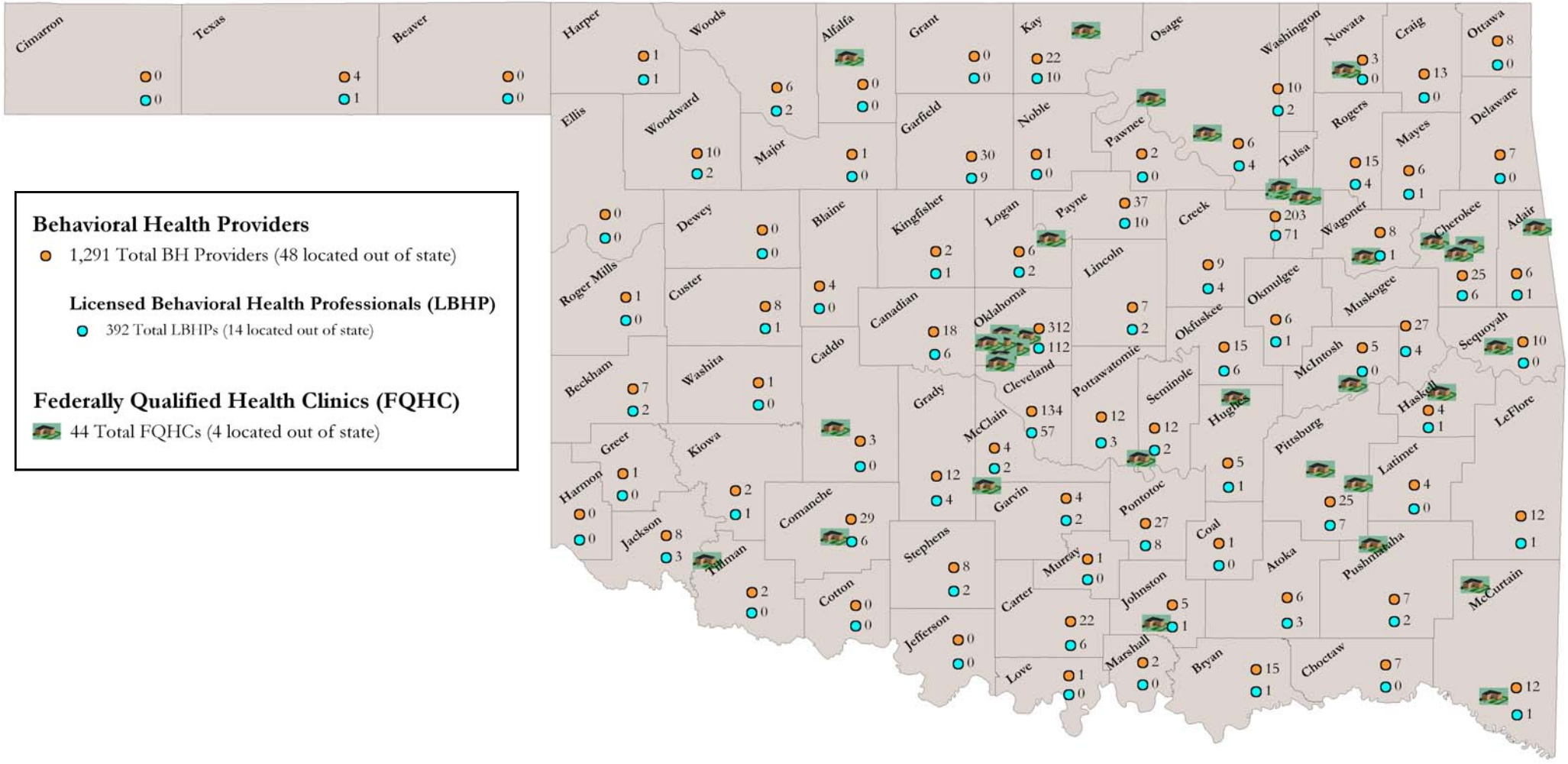
708,653 Total Members
(Excludes Insure Oklahoma members)

Primary Care Providers consist of all providers contracted as an Advanced Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, and Physician Assistant.
The data above is valid as of the report date and is subject to change.

9/30/2010

Federally Qualified Health Clinics and Behavioral Health Providers
August 2010

oklahoma health care authority



Behavioral Health Providers

- 1,291 Total BH Providers (48 located out of state)

Licensed Behavioral Health Professionals (LBHP)

- 392 Total LBHPs (14 located out of state)

Federally Qualified Health Clinics (FQHC)

- 44 Total FQHCs (4 located out of state)

Behavioral Health Providers consist of Mental Health Providers and Licensed Behavioral Health Professionals. Some providers may not be represented in the map due to his/her location being outside the state of Oklahoma. Please note that a provider may be contracted as more than one provider type. The data above is valid as of the report date and is subject to change.

9/30/2010

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

BRAD HENRY
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

Resolution Supporting Oklahoma Health Improvement Plan

Whereas, Oklahoma ranks poorly in important health status indicators that include deaths due to heart disease, adult obesity, smoking, and an infant mortality rate consistently higher than the national average; and

Whereas, these outcomes are often tied to personal health behaviors such as tobacco use, poor nutrition habits, lack of exercise, use of alcohol, and high rates of mental illness; and

Whereas, the Oklahoma Health Care Authority provides health care services to one in every five Oklahomans and thus is in a position to reach a large percentage of the state's population; and

Whereas, if Oklahoma was simply able to match the national average in health status indicators, 5,320 Oklahoma lives might be saved each year and Oklahomans would enjoy healthier lives; and

Whereas, in 2008, the Oklahoma State Legislature issued Senate Joint Resolution No. 41, which required the Oklahoma State Board of Health to prepare and present to the Legislature a health improvement plan for Oklahoma; and

Whereas, the Board of Health conducted community listening sessions and convened a broad-based group which included the Oklahoma Health Care Authority as well as representatives from the business and labor sectors, the legislature, health care providers, tribes, academia, non-profit health organizations, government agencies, professional affiliations, and parents. This group developed a health improvement plan guided by strategic planning principles and the *Oklahoma Health Improvement Plan* is a culmination of this group's work; and

Whereas, the final *Oklahoma Health Improvement Plan* recommendations – presented to the Oklahoma State Legislature on December 10, 2009 – focus on several key priorities and outcomes including developing and initiating appropriate policies and legislation to maximize opportunities for all Oklahomans to lead healthy lives; then

Therefore be it resolved that the Oklahoma Health Care Authority Board heartily extends its support of the programmatic and policy recommendations outlined within the *Oklahoma Health Improvement Plan* that will transform Oklahoma from a state that consistently reports a poor health status to a state that assures all Oklahomans will lead healthier lives…**indeed, perhaps saving 5,320 lives each year.**

Adopted: _____

7.b-1 CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 5. Eligibility and Countable Income
Part 3. Non-Medical Eligibility Requirements
317:35-5-25. [AMENDED]
(Reference APA WF # 10-01)

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 eligibility guidelines. These emergency rule revisions will ensure OHCA policy is in compliance with current Federal law and provide continuous access to services for refugee members who depend on SoonerCare.

ANALYSIS: OHCA eligibility rules are revised to comply with new Federal law that eliminates the five-year bar on SoonerCare services for Afghan and Iraqi special immigrants. Previously, Afghan and Iraqi special immigrants were eligible for SoonerCare services for their eight months and then were required to wait five years before they became eligible again. New policy eliminates the five-year bar so Afghan and Iraqi special immigrants may continue to receive SoonerCare services after eight months.

BUDGET IMPACT: Agency staff has determined that the impact of the rule revisions to the Agency is minimal. Total reimbursement for this population in FY 2010 was $2,397.00 total dollars.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 16, 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; Public Law 111-118, Section 8120 of the Department of Defense Appropriations Act, 2010

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising Agency eligibility rules to comply with new Federal law that eliminates the five-year bar on SoonerCare services for Afghan and Iraqi special immigrants.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-25. Citizenship/alien status and identity verification requirements
(a) **Citizenship/alien status and identity verification requirements.** Verification of citizenship/alien status and identity are required for all adults and children approved for SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare

eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

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

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

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

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

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

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

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

(A) Most reliable forms of citizenship verification are:

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

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

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

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

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

(vi) A Final Adoption Decree showing the child's name and U. S. place of birth;

(vii) Evidence of U.S. Civil Service employment before 6/1/1976;

(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);

(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;

(x) Oklahoma Voter Registration Card; or

(xi) Other acceptable documentation as approved by OHCA.

(B) Other less reliable forms of citizenship verification are:

(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and that indicates a U.S. place of birth. For children under 16 the evidence must have been created near the time of birth or five years before the date of application;

(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five years before the initial application date and that indicates a U.S. place of birth;

(iii) Federal or State census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or

(iv) One of the following items that show a U.S. place of birth and was created at least five years before the application for SoonerCare. This evidence must be one of the following and show a U.S. place of birth:

(I) Seneca Indian tribal census record;

(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;

(III) U.S. State Vital Statistics official notification of birth registration;

(IV) An amended U.S. public birth record that is amended more than five years after the person's birth; or

(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

(B) A school identification card with a photograph of the individual;

(C) An identification card issued by Federal, state, or local government with the same information included on driver's licenses;

(D) A U.S. military card or draft record;

(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;

(H) A state court order placing a child in custody as reported by the OKDHS;

(I) For children under 16, school records may include nursery or daycare records;

(J) If none of the verification items on the list are available, an affidavit may be used for children under 16. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and ~~**cannot be used if an affidavit for citizenship was provided.**~~cannot be used if an affidavit for citizenship was provided.

(b) **Reasonable opportunity to obtain citizenship verification.**

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

(2) The following methods of verification are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the

record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

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

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

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

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

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

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

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

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

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

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

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

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

(ii) paroled into the United States under Section 212(d)(5) of such Act for a period of at least one year;

(iii) granted conditional entry pursuant to Section 203(a)(7) of such Act as in effect prior to April 1, 1980; or

(iv) a battered spouse, battered child, or parent or child of a battered person with a petition under 204(a)(1)(A) or (B) or 244(a)(3) of the Immigration and Naturalization Act.

(B) an alien who was admitted to the United States and who was:

(i) granted asylum under Section 208 of such Act regardless of the date asylum is granted;

(ii) a refugee admitted to the United States under Section 207 of such Act regardless of the date admitted;

(iii) an alien with deportation withheld under Section 243(h) of such Act regardless of the date deportation was withheld;

(iv) a Cuban or Haitian entrant as defined in Section 501(e) of the Refugee Education Assistance Act of 1980, regardless of the date of entry;

(v) an alien who is a veteran as defined in 38 U.S.C. § 101, with a discharge characterized as an honorable discharge and not on the grounds of alienage;

(vi) an alien who is on active duty, other than active duty for training, in the Armed Forces of the United States;

(vii) the spouse or unmarried dependent child of an individual described in (C) of this paragraph~~.~~;

(viii) a victim of a severe form of trafficking pursuant to Section 107(b) of the Trafficking Victims Protection Act of 2000; or

(ix) admitted as an Amerasian immigrant.

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

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

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

(4) **Iraqi Special Immigrants.** Iraqi special immigrants, as defined in Public Law 110-181, who have special immigration status after January 28, 2008, are exempt from the five year period of ineligibility for SoonerCare services. ~~for a time-limited period. The time-limited exemption period for Iraqi special immigrants is eight months from the date of entry into the United States as a special immigrant or the date of conversion to special immigrant status.~~ All other eligibility requirements must be met to qualify for SoonerCare services. If these individuals do not meet one of the categorical relationships, they may apply and be determined eligible for Refugee Medical Assistance. ~~Once the eight month exemption period ends, Iraqi special immigrants are no longer exempt from the five year bar for SoonerCare services and are only eligible for services~~

~~described in (2) of this subsection until the five year period ends.~~ Iraqi special immigrants are considered lawful permanent residents.

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

(6) **Ineligible aliens.**

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

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

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

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

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

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

(3) **Refugees and Western Hemisphere aliens.** Under Section 203(a)(7) of the Immigration and Nationality Act, Refugees and Western Hemisphere aliens may be lawfully admitted to the United States if, because of persecution or fear of prosecution due to race, religion, or political opinion, they have fled from a Communist or Communist-dominated country or from the area of the Middle East; or if they are refugees from natural catastrophes. These entries meet the citizenship and alienage requirement. Western Hemisphere aliens will meet the citizenship requirement for

SoonerCare if they can provide either of the documents in subparagraphs (A) and (B) of this paragraph as proof of their alien status.

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

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

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

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

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

7.b-2 CHAPTER 45. INSURE OKLAHOMA~~/OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE~~
Subchapter 3. Insure Oklahoma~~/O Epic~~ Carriers
317:45-3-3. [NEW]
Subchapter 5. Insure Oklahoma~~/O Epic~~ Qualified Health Plans
317:45-5-3. [NEW]
(Reference APA WF # 10-33)

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 Insure Oklahoma program. Insure Oklahoma rules are revised to provide clarification to carrier and health plan rate structure requirements. Carriers and health plans must meet OHCA's system specifications for all rate structure tiers and requirements. The OHCA must be able to recreate premium invoice amounts for all approved Insure Oklahoma members. If a carrier and/or health plan can not accommodate OHCA's system specifications for all rate structure tiers and requirements, the carrier and/or health plan will not be allowed to participate in the Insure Oklahoma program. Carrier and/or health plan rate structure requirements include all rate tiers and age-up methodologies. These emergency rule revisions will ensure that the Oklahoma Health Care Authority can continue to meet the needs of uninsured Oklahomans, while remaining in compliance with all federal and state rules and guidelines.

ANALYSIS: Insure Oklahoma rules are revised to provide clarification to carrier and health plan rate structure requirements. Carriers and health plans must meet OHCA's system specifications for all rate structure tiers and requirements. The OHCA must be able to recreate premium invoice amounts for all approved Insure Oklahoma members. If a carrier and/or health plan can not accommodate OHCA's system specifications for all rate structure tiers and requirements, the carrier and/or health plan will not be allowed to participate in the Insure Oklahoma program. Carrier and/or health plan rate structure requirements include all rate tiers and age-up methodologies.

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 July 15, 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 Insure Oklahoma rules in order to require insurance carriers and health plans to meet OHCA's system specifications for all rate structure tiers and requirements.

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

317:45-3-3. Carrier rate structure requirements

Carriers must meet OHCA's system specifications for all rate structure tiers and requirements. The OHCA must be able to recreate premium invoice amounts for all approved Insure Oklahoma members. If a carrier can not accommodate OHCA's system specifications for all rate structure tiers and requirements, the carrier will not be allowed to participate in the Insure Oklahoma program and all health plans submitted by the carrier for participation in the Insure Oklahoma program as a qualified health plan will not be considered. Carrier rate structure requirements include all rate tiers and age-up methodologies.

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

317:45-5-3. Health plan rate structure requirements

Health plans must meet OHCA's system specifications for all rate structure tiers and requirements. The OHCA must be able to recreate premium invoice amounts for all approved Insure Oklahoma members. If a health plan can not accommodate OHCA's system specifications for all rate structure tiers and requirements, the health plan will not be allowed to participate in the Insure Oklahoma program. Health plan rate structure requirements include all rate tiers and age-up methodologies.

7.b-3 CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 23. Living Choice Program
317:35-23-2. [AMENDED]
(Reference APA WF # 10-43)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to change eligibility requirements for individuals transitioning from an institutional setting to home and community based setting through the Living Choice Program. The less stringent federal regulation will allow individuals to qualify for transition in a shorter period of time, therefore, decreasing the amount of time individuals spend in costly institutional care. In a time of shrinking state revenues, the revisions will hasten the reduction in number of persons receiving costly institutional care and create a substantial savings over time by utilizing the less expensive home and community based method of care.

ANALYSIS: Rules are revised to include new eligibility criteria for individuals transitioning from an institution to a home and community based setting through the Living Choice Demonstration program. Current rules require individuals to be institutionalized for a minimum of 6 months and be SoonerCare eligible for at least 30 days. Section 2403 of the Patient Protection and Affordable Care Act reduces the institutional stay requirement to a minimum of 90 consecutive days. Additionally, CMS has provided new guidance regarding the length of time required for Medicaid eligibility and has revised the eligibility time frame from 30 days to 1 day.

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 September 16, 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; Section 2403 of the Patient Protection and Affordable Care Act

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 change eligibility criteria for individuals transitioning from an institution to a home and community based setting through the Living Choice Demonstration pursuant to Section 2403 of the Patient Protection and Affordable Care Act which reduces the institutional stay requirement from six months to 90 days and the required period of Medicaid eligibility from 30 days to 1 day

SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

~~(a)~~ Adults with disabilities or long-term illnesses, members with mental retardation and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through ~~(6)~~ (7) of this subsection.

(1) He/she must be at least 19 years of age.

(2) He/she must reside in an institution (nursing facility or public ICF/MR) for at least ~~six months~~ 90 consecutive days prior to the proposed transition date. If any portion of the 90 days includes time in a skilled nursing facility, those days cannot be counted toward the 90 day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one ~~month~~ day of ~~SoonerCare~~ Medicaid paid long-term care services prior to transition.

(4)If transitioning from an out of state institution, he/she must be SoonerCare eligible.

~~(4)~~ (5) He/she requires at least the same level of care that necessitated admission to the institution.

~~(5)~~ (6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

~~(6)~~ (7) His/her needs can be met by the Living Choice program while living in the community.

7.b-4 CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
317:2-1-2. [AMENDED]
317:2-1-5. [AMENDED]
317:2-1-6. [AMENDED]
317:2-1-7. [AMENDED]
317:2-1-13. [AMENDED]
(Reference APA WF # 10-45)

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 appeals rules. Agency rules are revised regarding provider program integrity audits/reviews appeals to comply with Section 1011.9 of Title 56 of Oklahoma Statutes. These revisions allow for the recoupment of overpayments due to identified errors determined not to be fraudulent only after a provider has had the opportunity to exercise the right to an appeal that includes a hearing conducted by an administrative law judge appointed by the Oklahoma Attorney General. Rules also clarify that a provider has the right to participate in the hearing and to be represented by legal counsel. Revisions also grant the Administrative Law Judge jurisdiction over provider appeals related to the Oklahoma Electronic Health Records Incentive Payment Program. These emergency rule revisions will ensure compliance with Oklahoma state law.

ANALYSIS: Agency rules are revised in order to comply with Section 1011.9 of Title 56 of Oklahoma Statutes. These revisions allow for the recoupment of overpayments due to identified errors determined not to be fraudulent only after a provider has had the opportunity to exercise the right to an appeal that includes a hearing conducted by an administrative law judge appointed by the Oklahoma Attorney General. Rules also clarify that a provider has the right to participate in the hearing and to be represented by legal counsel.

BUDGET IMPACT: Agency staff has determined that the estimated budget impact to the Agency for FY 2011 is $33,000 total dollars; State share of $16,500.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on July 15, 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, Section 1011.9 of Title 56 of Oklahoma Statutes

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

Revising provider program integrity audit/review appeals rules in order to comply with Section 1011.9 of Title 56 of Oklahoma Statutes as well as to grant the Administrative Law Judge jurisdiction over provider appeals related to the Oklahoma Electronic Health Records Incentive Program.

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 ~~Section OAC~~ 317:2-1-5. The ALJ's decision may be appealed to the ~~CEO~~ 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 ~~to be~~ 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 ~~U.S.C.~~ C.F.R. Section 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision ~~will be~~ 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~~ Unless an exception is provided in 317:2-1-13, 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 ~~Medicaid~~ 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); ~~and~~

(F) Proposed administrative sanction appeals pursuant to 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;

(G) Appeals which relate to eligibility determinations made by OHCA;

(H) Appeals of insureds participating in Insure Oklahoma which are authorized by 317:45-9-8(a); 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 O-EPIC which are authorized by OAC 317:45-9-8(a);~~

~~(F)~~ (E) Appeals to the decision made by the ~~Business~~ Contracts manager related to ~~Purchasing as found at OAC 317:10-1-5~~ reports of supplier non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services and other appeal rights granted by contract;

~~(G)~~ (F) Drug rebate appeals;

~~(H)~~ (G) Nursing home contracts which are terminated, denied, or non-renewed; ~~and~~

~~(I)~~ (H) Proposed administrative sanction appeals pursuant to ~~OAC 317:35-13-7~~ 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~~.~~;

(I) Contract award appeals;

(J) Provider appeals of OHCA audit findings pursuant to 317:2-1-7. This is the final and only appeals process for appeals of OHCA audits; and

(K) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, and upgrading, and meaningful use eligibility for incentives.

317:2-1-5. Hearing procedures

~~Administrative Law Judge.~~

~~(1)~~ (a) Hearings will be conducted in an informal manner without formal rules of evidence or procedure~~.~~, except for hearings under 317:2-1-7.

~~(2)~~ (b) No party is required to be represented by an attorney. Members may represent themselves or authorize another party to represent them. A person or entity desiring to represent a member must provide documentation of the consent of the member to be represented by that person or entity. An appeal will be rejected without documentation of representation. Individuals appearing for corporate entities will be deemed to be authorized to represent the corporation in a hearing.

~~(3)~~ (c) The docket clerk will send the Appellant and any other necessary party notice which states the hearing location, date, and time.

~~(4)~~ (d) The OHCA Administrative Law Judge or designee may:

~~(A)~~ (1) Rule on any requests for extension of time;

~~(B)~~ (2) Hold pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end in the expeditious disposition of the proceeding;

~~(C)~~ (3) Require the parties to state their positions concerning the various issues in the proceeding;

~~(D)~~ (4) Require the parties to produce for examination those relevant witnesses and documents under their control;

~~(E)~~ (5) Rule on motions and other procedural items;

~~(F)~~ (6) Regulate the course of the hearing and conduct of the participants;

~~(G)~~ (7) Establish time limits for the submission of motions or memoranda;

~~(H)~~ (8) Impose appropriate sanctions against any person failing to obey an order of the ALJ or authorized under the rules in this Chapter which may include:

~~(i)~~ (A) Refusing to allow the person to assert or oppose designated claims or defenses, or prohibiting that person from introducing designated matters in evidence;

~~(ii)~~ (B) Excluding all testimony of an unresponsive or evasive witness; or

~~(iii)~~ (C) Expelling the person from further participation in the hearing;

~~(I)~~ (9) Take official notice of any material fact not appearing as evidence in the record, if the fact is among traditional matters of judicial notice;

~~(J)~~ (10) Administer oaths or affirmations;

~~(K)~~ (11) Determine the location of the hearing;

~~(L)~~ (12) Allow either party to request that the hearing be recorded by a court reporter with costs to be borne by the requesting party. The original of such transcription, if ordered, will be given to the ALJ with a copy to be given to the requesting party;

~~(M)~~ (13) Recess and reconvene the hearing;

~~(N)~~ (14) Set and/or limit the time frame of the hearing;

~~(O)~~ (15) Reconsider or rehear a matter for good cause shown; and

~~(P)~~ (16) Send a copy of the decision by the ALJ to both parties outlining their rights to appeal the decision. The decision letter need not contain findings of fact or conclusions of law.

~~(5)~~ (e) The burden of proof during the hearing will be upon the appellant and the ALJ will decide the case based upon a preponderance of evidence standard as defined by the Oklahoma Supreme Court. Parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

~~(6)~~ (f) Parties may file preliminary motions in the case. Any such motions must be filed within 15 calendar days prior to the hearing date. Response to preliminary motions must be made within 7 calendar days of the date the motion is filed with OHCA. Preliminary motions will be ruled upon 3 days prior to the hearing date.

~~(7)~~ (g) In any case in which a member requests a continuance, OHCA will not be prejudiced to complete the case within 90 days.

(h) An appeal, or an issue addressed by an appeal, may be dismissed if:

(1) it is moot or there is insufficient evidence to support the allegations;

(2) the appellant fails or refuses to appear for a scheduled meeting;

(3) the appellant refuses to accept a settlement offer which affords the relief he or she could reasonably expect if he or she prevailed in the appeal; or

(4) it is not timely filed or is not within the OHCA's jurisdiction or authority.

317:2-1-6. Other grievance procedures and processes

Other grievance procedures and processes include those set out in ~~OAC~~ 317:2-1-7 (~~Program Integrity Audits/Reviews Appeals~~ Provider Appeals of OHCA Audit Findings); ~~OAC~~ 317:2-1-8 (Nursing Home Provider Contract Appeals); ~~OAC~~ 317:2-1-9 (OHCA's Designated Agent's Appeal Process for QIO Services); ~~OAC~~ 317:2-1-10 (Drug Rebate Appeal Process); ~~OAC~~ 317:2-1-11 [Medicaid Drug Utilization Review Board (DUR) Appeal Process]; ~~and OAC~~ 317:2-1-12 (For Cause Provider Contract Suspension/Termination Appeals Process); and 317:2-1-14 (Contract Award Protest Process).

317:2-1-7. ~~Program Integrity~~ Oklahoma Health Care Authority Audit

All ~~Program Integrity Audits/Reviews appeals~~ appeals related to audits and/or reviews resulting in overpayments are ~~made to the State Medicaid Director~~ heard by an OHCA Administrative Law Judge.

(1) If a provider disagrees with a decision of ~~Program Integrity including statewide surveillance and utilization control program appeals~~ an OHCA audit, which has determined that the provider has received an overpayment, the provider may appeal, within 20 days of the date of that decision ~~to the State Medicaid Director~~ by submitting an LD-2 form to OHCA's docket clerk.

(2) The appeal ~~from the Program Integrity decision~~ will be commenced by the receipt of ~~a letter~~ an LD-2 form from the appellant provider. The ~~letter~~ form must set out with specificity, the overpayment decision to which the provider objects along with the grounds for appeal. The ~~letter~~ provider should explain in detail, the factual and/or legal basis for disagreement with the allegedly erroneous decision. ~~The letter should also include all~~ All relevant exhibits the provider believes necessary to decide the appeal should be attached to the LD-2 form, including the following~~.~~:

(A) Citations for any statute or rule that the provider feels has been violated;

(B) The provider's name, address and telephone number;

(C) The name, address, and phone number of the provider's representative, if any; and

(D) The LD-2 must be signed by the provider or provider's representative.

(3) Upon receipt of the appeal by the docket clerk, the matter will be docketed for ~~the next meeting of the Medical Advisory Committee (MAC). Any appeal received less than four weeks before a scheduled MAC meeting will be set for the following MAC meeting~~ a hearing before an OHCA Administrative Law Judge.

~~(4) The appeal will be forwarded to the OHCA Legal Services Division by the docket clerk for distribution to the members of the subcommittee and for preparation of the OHCA's case. A subcommittee of the MAC will be formed and render a recommendation to the State Medicaid Director.~~

~~(5) At the discretion of the MAC, witnesses may be called and information may be solicited from any party by letter, telephonic communication, fax, or other means. The subcommittee may request that members of the OHCA be present during their consideration of the appeal. Members of the OHCA=s Legal Division may be asked to answer legal questions regarding the appeal.~~

~~(6) The subcommittee will issue a recommendation regarding the appeal, in writing, within 30 days of the hearing. An exception to the 30 day rule will apply in cases where the subcommittee sets the case over until its next scheduled meeting in order to gather additional evidence. The written recommendation will list the members of the subcommittee who participated in the decision. In cases where an appeal must be continued, the subcommittee will issue a letter within 30 days of the initial hearing to inform the appellant of the continuance.~~

~~(7) The recommendation, after being formalized, will be sent to the docket clerk for review by the State Medicaid Director. The State Medicaid Director will ordinarily issue a decision regarding the appeal within 60 days of the docket clerk's receipt of the recommendation from the MAC. The decision will be issued to the appellant or his/her authorized agent.~~

~~(8) If the provider is dissatisfied with the Medicaid Director's decision, it may be appealed to the CEO under OAC 317:2-1-13.~~

(4) Any change in contact information during the course of the appeal should be immediately reported to the OHCA docket clerk.

(5) The OHCA, on its own initiative or upon written request of a party, may consolidate or join appeals if to do so will expedite the processing of the appeals and not adversely affect the interest of the parties.

(6) Within 45 days of the LD-2 being received and filed by the OHCA, any settlement discussions being held by the parties must be finalized. Settlement or mediation of audit disputes is encouraged and can begin at any time of the audit process between the provider and OHCA's Legal Division. If settlement is reached, the terms shall be set out in writing and signed by both parties and/or their representatives. Upon the finalization and signature of the settlement agreement, the appeal(s) shall be dismissed.

(7) Audit appeals which are not settled will commence with a prehearing conference before the assigned administrative law judge as follows:

(A) At the conference the parties shall clarify and isolate the legal and factual issues involved in the audit appeal.

(B) Each party shall be present, on time and prepared. Failure to do so may result in dismissal of the appeal or other sanctions unless good cause is shown.

(C) Prior to the prehearing conference each party shall file with the OHCA and provide a copy to the other party:

(i) A brief statement of his or her case, to include a list of stipulations and legal and factual issues to be heard;

(ii) A list of any witnesses who have direct knowledge of the facts surrounding the issues of the appeal and who are expected to be called at the hearing. The list shall include a brief statement of the testimony each witness will offer;

(iii) A list of any documents and exhibits and the original or a copy of each document or exhibit to be offered into evidence or presented at the hearing; and

(iv) Any requirements or requests for discovery.

(D) Administrative Law Judge shall:

(i) hear and rule on pending requests or motions;

(ii) rule on whether or not witnesses have knowledge of the facts at issue;

(iii) rule on whether or not documents and exhibits are relevant;

(iv) rule on whether or not discovery requests and other motions and requests are relevant;

(v) strike or deny witnesses, documents, exhibits, discovery requests and other requests or motions which are cumulative, not relevant or not material, used as a means of harassment, unduly burdensome or not timely filed; and

(vi) identify and rule on errors being appealed and issues to be heard at the administrative hearing.

(E) The prehearing conference shall be informal, structured by the administrative law judge and not open to the public. The administrative law judge shall record the prehearing conference by digital recording.

(i) Each party shall be notified of the date of the prehearing conference at least 10 calendar days prior to the scheduled prehearing conference.

(ii) Witnesses shall not appear or present testimony at the prehearing conference.

(F) A request for continuance of a prehearing conference can be made up to three days prior to the scheduled prehearing conference date. A lesser period of time may be permitted for good cause shown. The administrative judge shall rule on the request and in no case shall a combination of continuances exceed a total of 30 calendar days except for good cause shown.

(G) The administrative judge shall issue a prehearing conference statement setting out the witnesses, exhibits, documents and issues to be presented at the hearing; the hearing date; the decisions reviewed and made during the prehearing conference and any stipulations agreed to by the parties.

(8) The hearing shall be digitally recorded and closed to the public.

(9) The administrative law judge should attempt to make the final hearing decision within 180 days from the date of the prehearing conference. The final order shall be the entire record of the appeal. Pursuant to Administrative Procedures Act, the Order does not need to contain findings

of fact or conclusions of law. The final order is the final decision and is not appealable to the CEO.

317:2-1-13. Appeal to the Chief Executive Officer

~~An appeal to the Chief Executive Officer (CEO) of the Oklahoma Health Care Authority includes:~~

~~(1) Within 20 days of decisions made pursuant to provider or Program Integrity Audits/Reviews appeals found at this Chapter, either party may appeal a decision to the CEO of the OHCA. Such appeal will be commenced by a letter or fax received by the CEO within 20 days of the receipt of the prior decision made by the ALJ or Medicaid Director. The appeal will concisely and fully explain the reasons for the request. No new evidence may be presented to the CEO. Evidence presented must be confined to the records below.~~

~~(2) Appeals to the CEO under member proceedings will be commenced by a letter received no later than 10 days of the receipt of the decision by the ALJ. Should the appellant request a transcription to prosecute its appeal to the CEO, the appellant will be required to execute a waiver relieving the OHCA from completing its fair process hearing within 90 days.~~

~~(3) For provider and Program Integrity Audits/Reviews proceedings, the CEO will ordinarily have 90 days from receipt of the appeal to render a written decision.~~

~~(4) For member proceedings, the CEO will ordinarily have 30 days from receipt of the appeal to render a written decision.~~

~~(5) The only appeal for proposed provider or member administrative sanctions is before the ALJ and the ALJ decision is not appealable to the CEO.~~

(a) The Oklahoma Health Care Authority offers approximately 40 different types of administrative appeals. Some of the appeals are appealable to the Chief Executive Officer, and some are not. The following appeals may be heard by the Chief Executive Officer:

(1) Appeals under 317:2-1-2(c)(1)(A) to (c)(1)(H), with the exception of Subsection (F);

(2) Appeals under 317:2-1-2(c)(2)(A) to (c)(2)(K), with the exceptions of Subsections (H) and (J); and

(3) Appeals under 317:2-1-8 and 317:2-1-10.

(b) Appeals to the Chief Executive Officer must be filed with the OHCA within twenty (20) days of the date of the Order, or decision by OHCA.

(c) No new evidence may be presented to the Chief Executive Officer.

(d) Appeals to the Chief Executive Officer under (a) of this Section may be filed by the provider, member, or agency. The Chief Executive Officer will ordinarily render decisions within sixty (60) days of the receipt of the appeal.

7.b-5 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 5. Pharmacies
317:30-5-72.1. [AMENDED]
317:30-5-77. [AMENDED]
317:30-5-78. [AMENDED]
317:30-5-78.1. [AMENDED]
(Reference APA WF # 10-48)

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 pharmacy program. Pharmacy rules are revised to reflect the change in pricing methodology for injectable drugs that are submitted through the pharmacy system. This change ensures compliance with the Oklahoma Constitution, Article X, Section 23 which prohibits a state agency from spending more money than is allocated. The resulting rate is equivalent to the Medicare rate plus the standard dispensing fee. Additional revisions include the coverage of non-prescription EPSDT products offered through the pharmacy point of sale system and the exemption of I/T/U facilities from prior authorization requirements for brand name drugs. These emergency rule revisions will ensure compliance with Oklahoma state law and increase access to healthcare services for Oklahoma children, thereby reducing the amount of uncompensated care provided by health care providers.

ANALYSIS: Pharmacy rules are revised to reflect the change in pricing methodology for injectable drugs that are submitted through the pharmacy system. Policy revisions are needed to clarify payment methodology and reduce expenditures. The resulting rate is equivalent to the Medicare rate plus the standard dispensing fee. Additional revisions include the coverage of non-prescription EPSDT products offered through the pharmacy point of sale system and the exemption of I/T/U facilities from prior authorization requirements for brand name drugs.

BUDGET IMPACT: Agency staff has determined that the estimated budget impact to the Agency is an annual savings of $2,600,000 total dollars; State share savings $924,820.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 16, 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; Article X Section 23 of the Oklahoma Constitution

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising Pharmacy rules to reflect the change in pricing methodology for injectable drugs submitted through the pharmacy system, include

coverage of non-prescription EPSDT products offered through the pharmacy point of sale system and exempt I/T/U facilities from prior authorization requirements for brand name drugs.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 5. PHARMACIES

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

(A) Agents used to promote fertility.

(B) Agents primarily used to promote hair growth.

(C) Agents used for cosmetic purposes.

(D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.

(E) Agents that are experimental or whose side effects make usage controversial.

(F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.

(2) The drug categories listed in (A) through (E) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Agents used for the systematic relief of cough and colds. Antihistamines for allergies or antihistamine use associated with asthmatic conditions may be covered when medically necessary and prior authorized.

(B) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

(i) prenatal vitamins are covered for pregnant women up to age 50;

(ii) fluoride preparations are covered for persons under 16 years of age or pregnant; ~~and~~

(iii) vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered~~.~~<u>;</u>

<u>(iv) iron supplements may be covered for pregnant women if determined to be medically necessary; and</u>

<u>(v) vitamin preparations may be covered for children less than 21 years of age when medically necessary and furnished pursuant to EPSDT protocol.</u>

(C) Agents used for smoking cessation. A limited smoking cessation benefit is available.

(D) Coverage of non-prescription or over the counter drugs is limited to:

(i) Insulin, PKU formula and amino acid bars,
other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions~~,~~<u>;</u>

(ii) certain smoking cessation products~~,~~;
(iii) family planning products~~, and~~;
(iv) OTC products may be covered if the particular product is both cost-effective and clinically appropriate~~.~~; and
(v) prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

(E) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317-30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

(A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. ' 1396r-8; or

(B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

317:30-5-77. Brand necessary certification

(a) When a product is available in both a brand and generic form, a prior authorization is required before the branded product may be dispensed. The prescribing provider must certify the brand name drug product is medically necessary for the well being of the patient, otherwise a generic must be substituted for the name brand product.

(1) The certification must be written in the physician's or other prescribing provider's handwriting.

(2) Certification must be written directly on the prescription blank or on a separate sheet which is attached to the original prescription.

(3) A standard phrase indicating the need for a specific brand is required. The OHCA recommends use of the phrase "Brand Necessary".

(4) It is unacceptable to use a printed box on the prescription blank that could be checked by the physician to indicate brand necessary, or to use a hand-written statement that is transferred to a rubber stamp and then stamped onto the prescription blank.

(5) If a physician phones a prescription to the pharmacy and indicates the need for a specific brand, the physician should be informed of the need for a handwritten certification. The pharmacy can either request that the certification document be given to the patient who then delivers it to the pharmacy upon receipt of the prescription, or request the physician send the certification through the mail.

(b) The Brand Necessary Certification applies to CMS Federal Upper Limit and State Maximum Allowable Cost (SMAC) products.

(c) For certain narrow therapeutic index drugs, a prior authorization will not be required. The DUR Board will select and maintain the list of narrow therapeutic index drugs.

(d) Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/U) facilities are exempt from prior authorization requirements for brand name drugs.

317:30-5-78. Reimbursement

(a) **Reimbursement**. Reimbursement for pharmacy claims is based on the sum of an estimate of the ingredient cost, plus a dispensing fee.

(b) **Ingredient Cost.** Ingredient cost is estimated by one of the following methods:

(1) **Maximum Allowable Cost.**

(A) The State Maximum Allowable Cost ~~(MAC)~~ (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The ~~State MAC~~ SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific ~~product's MAC~~ product's SMAC price by providing invoices that reflect a net cost higher than the calculated ~~State MAC~~ SMAC price and by certifying that there is not another product available to them which is generically equivalent to the higher priced product.

(B) The Federal Upper Limit (FUL) is established by CMS in accordance with applicable federal laws and regulations.

(C) Injectable drugs which are dispensed by a retail pharmacy through the Vendor Drug Program shall be priced based on a formula equivalent to the Medicare allowed charge whether they are furnished through the pharmacy program or through the medical program.

(2) **The Estimated Acquisition Cost.** The Estimated Acquisition Cost (EAC) means the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler. EAC is typically based on a benchmark published price plus or minus a percentage. The current benchmark price is the Average Wholesale Price (AWP) as provided by the OHCA's pricing resource. EAC is calculated as AWP minus 12%.

(c) **Maximum allowable dispensing fee.** The maximum allowable dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the ~~Rates and Standards Committee~~ State Plan Amendment Rate Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products. Failure to participate may result in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.

(d) ~~**Payment**~~ **Reimbursement for prescription claims.** ~~Payment for prescription claims will be:~~ Prescription claims will be reimbursed using the lower of the following calculation methods:

(1) the lower of estimated acquisition cost, Federal Upper Limit (FUL), or State Maximum Allowable Cost (SMAC) plus a dispensing fee, or

(2) usual and customary charge to the general public~~, whichever is lower~~. The pharmacy is responsible to determine its usual and customary charge to the general public. The OHCA may conduct periodic reviews within its audit guidelines to verify the pharmacy's usual and customary charge to the general public and the pharmacy agrees to make available to the OHCA's reviewers prescription and pricing records deemed necessary by the reviewers. The OHCA defines general public as the patient group accounting for the largest number of non-SoonerCare prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers. If a pharmacy offers discount prices to a portion of its customers (i.e. -10% discount to senior citizens), these lower prices would be excluded from the usual and customary calculations unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. The usual and customary charge will be a single price which includes both the product price and the dispensing fee. For routine usual and customary reviews, the pharmacy may provide prescription records for non-SoonerCare

customers in a manner which does not identify the customer by name so long as the customer's identity may be determined later if a subsequent audit is initiated. The OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

(e) **Payment of Claims.** In order for an eligible provider to be paid for filling a prescription drug, the pharmacy must complete all of the following:

(1) have an existing provider agreement with OHCA,

(2) submit the claim in a format acceptable to OHCA,

(3) have a prior authorization before filling the prescription, if a prior authorization is necessary,

(4) have a proper brand name certification for the drug, if necessary, and

(5) include the usual and customary charges to the general public as well as the estimated acquisition cost and dispensing fee.

(f) **Claims.** Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be accessed by swiping a SoonerCare identification card through a commercial card swipe machine which is connected to the eligibility database or via the Point of Sale (POS) system when a prescription claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.

317:30-5-78.1. Special billing procedures

(a) **Antihemophiliac Factor (AHF) Products.** AHF products are sold by the amount of drug (International Units of AHF) in the container. For their products, regardless of the container size, the package size is always "1". Therefore, pricing assumes that the "package size" actually dispensed is the actual number of units dispensed. Examples: If 250 AHF units are dispensed and multiplied by a unit cost of $.25, the allowable cost would be $62.50. Metric Quantity is shown as 250; if 500 AHF units are dispensed and multiplied by a unit cost of $.25, the allowable would be $125.00. Metric Quantity is shown as 500.

(b) **Compound and intravenous drugs.** Prescriptions claims for compound and Intravenous (IV) drugs are billed and reimbursed using the NDC number and quantity for each compensable ingredient in the compound or IV, up to 25 ingredients. Ingredients without an NDC number are not compensable. A dispensing fee as described in OAC 317:30-5-78(c) is added to the total ingredient cost.

(c) **Co-Payment.** Pharmacies must pursue all third party resources before filing a claim with OHCA as set out in 42 CFR 433.139.

(d) **Over-the-counter drugs.** Payment for covered over-the-counter medication is made according to the reimbursement methodology in OAC 317:30-5-78(d).

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the SoonerCare allowable for comparable services. The appropriate Durable Medical Equipment Regional Carrier (DMERC) must be billed prior to billing OHCA for all Medicare compensable drugs. Part B crossover claims cannot be submitted through the pharmacy point of sale system and must be submitted using the CMS 1500 form or electronic equivalent.

(f) **Claims for prescriptions which are not picked up.** A prescription for a member which has been submitted to and approved for payment by OHCA which has not been received by the member within 15 days of the date of service must be reversed. An electronic reversal will cause a refund to be generated to the agency. Claims may also be reversed using a manual process if electronic reversal is not possible. For the purpose of this Section, the date of service means the date the prescription was filled.

(g) **Non-prescription products.** The coverage of non-prescription products that are determined to be medically necessary must be billed through the pharmacy point of sale system.

7.b-6 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
317:30-3-28. [NEW]
(Reference APA WF # 10-49)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the Agency's general provider policies. These emergency rule revisions will bring the Agency into compliance with Federal regulations with respect to the Electronic Health Records Incentive Program, as required under the American Recovery and Reinvestment Act. The rules will enable a program to reduce administrative burdens on health care providers and SoonerCare members, thereby enhancing access to quality health care.

ANALYSIS: OHCA policy is revised to create rules for the new Oklahoma Electronic Health Records Incentive Payment Program, which will begin January 2011 and is authorized by the American Recovery and Reinvestment Act of 2009. The rules provide a basic governing structure for the program, including the delineation of eligible providers and eligible hospitals, patient volume requirements, and incentive payment processes.

BUDGET IMPACT: Agency staff has determined that the estimated budget impact to the Agency is $170,000 State share.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on September 16, 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; American Recovery and Reinvestment Act of 2009; CMS-0033-F; 45 CFR 170; Sections 4101(a) and 4102(a)(1) of HITECH Act

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 create program guidelines for the Oklahoma Electronic Health Records Incentive Payment Program as authorized by the American Recovery and Reinvestment Act of 2009.

SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-28. Electronic Health Records Incentive Program

(a) **Program.** The Oklahoma Electronic Health Records Incentive Program is authorized by the American Recovery and Reinvestment Act of 2009. Under this program, SoonerCare providers may qualify for incentive payments if they meet the eligibility guidelines in this section and demonstrate they are engaged in efforts to adopt, implement, upgrade, or meaningfully use certified

electronic health records (EHR) technology. The EHR incentive program is governed by the policy in this section and the Electronic Health Records Program Final Rule issued by CMS in CMS-0033-F and 45 CFR 170. Providers should also use the EHR program manual as a reference for additional program details.

(b) **Eligible providers.** To qualify for incentive payments, a provider must be an "eligible professional" or an "eligible hospital." Providers who receive incentive payments must have an existing Provider Agreement with OHCA and at least one of their facilities must be located within the State of Oklahoma.

(1) **Eligible professionals.** An eligible professional is defined as a physician, a physician assistant practicing in a Federally Qualified Health Center (FQHC) or Rural Health Center (RHC) led by a physician assistant, a board certified pediatrician, a nurse practitioner, a certified nurse midwife, or a dentist. OHCA will determine eligibility based on the provider type, specialty associated with the provider in the MMIS system, and documentation.

(A) Eligible professionals may not be hospital-based, unless they practice predominantly at an FQHC or RHC as defined by the CMS Final Rule. A "hospital-based" professional furnishes ninety percent (90%) or more of their SoonerCare-covered professional services during the relevant EHR reporting period in a hospital setting, whether inpatient or Emergency Room, through the use of the facilities and equipment of the hospital.

(B) Eligible professionals may not participate in both the Medicaid and Medicare EHR incentive payment program during the same payment year.

(2) **Eligible hospitals.** Eligible hospitals are Children's Hospitals or Acute Care Hospitals, including Critical Access Hospitals and cancer hospitals. An Acute Care Hospital is defined as a health care facility where the average length of patient stay is twenty-five (25) days or fewer and that has a CMS certification number that has the last four digits in the series 0001-0879 and 1300-1399. A Children's Hospital is defined as a separately certified children's hospital, either freestanding or hospital-within-hospital, that predominantly treats individuals under 21 years of age and has a CMS certification number with the last 4 digits in the series 3300-3399. Hospitals that do not meet either of the preceding definitions are not eligible for incentive payments.

(c) **Patient volume.** Eligible professionals and eligible hospitals must meet SoonerCare patient volume criteria to qualify for incentive payments. Patient volume criteria compliance will be verified by the OHCA through claims data and provider audits. When calculating SoonerCare patient volume, all SoonerCare populations may be counted. To calculate patient volume, the provider's total SoonerCare patient encounters in the specified reporting period must be divided by the provider's total patient encounters in the same reporting period.

(1) **Eligible professionals**. Eligible professionals must meet a 30% SoonerCare patient volume threshold over a continuous 90-day period in the preceding calendar year. The only exception is for pediatricians, as discussed in OAC 317:30-3-28(c)(5).

(2) **Eligible hospitals.** With the exception of children's hospitals, which have no patient volume requirement, eligible hospitals must meet a 10% SoonerCare patient volume threshold over a continuous 90-day period in the preceding calendar year.

(3) **FQHC or RHC patient volume.** Eligible professionals practicing predominantly in an FQHC or RHC may be evaluated according to their "needy

individual" patient volume. To qualify as a "needy individual," patients must meet one of the following criteria:

(A) Received medical assistance from SoonerCare;

(B) Were furnished uncompensated care by the provider; or (C) Were furnished services at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

(4) **Clinics and group practices.** Clinics or group practices may calculate patient volume using the clinic's or group's SoonerCare patient volume under the following conditions:

(A) The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the eligible professional;

(B) There is an auditable data source to support the patient volume determination;

(C) All eligible professionals in the clinic or group practice use the same methodology for the payment year;

(D) The clinic or group practice uses the entire practice's patient volume and does not limit patient volume in any way; and

(E) If an eligible professional works inside and outside of the clinic or practice, the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the eligible professional's outside encounters.

(5) **Pediatricians.** Pediatricians may qualify for 2/3 incentive payments if their SoonerCare patient volume is 20-29%. A pediatrician is defined as a medical doctor who diagnoses, treats, examines, and prevents diseases and injuries in children and possesses a valid, unrestricted medical license and board certification in Pediatrics through either the American Board of Pediatrics (ABP) or the American Osteopathic Board of Pediatrics (AOBP). To qualify as a pediatrician for the purpose of receiving a 2/3 payment under the incentive program, the provider must provide OHCA with a copy of their pediatric licenses and board certification.

(6) **Out of state patients.** For eligible professionals and eligible hospitals using out of state Medicaid recipients for patient volume requirement purposes, the provider must retain proof of the encounter for the out of state patient.

(d) **Attestation.** Eligible professionals and eligible hospitals must execute an amendment to their SoonerCare Provider Agreement to attest to meeting program criteria through the Electronic Provider Enrollment (EPE) system in order to qualify for incentive payments. Registration in the CMS EHR Incentive Payment Registration and Attestation system is a pre-requisite to EPE attestation.

(e) **Adoption/ Implementation/ Upgrade (A/I/U).** Eligible professionals or eligible hospitals in their first participation year under the Oklahoma EHR Incentive Payment Program may choose to attest to adopting, implementing, or upgrading certified EHR technology. Proof of A/I/U must be submitted to OHCA in order to receive payment.

(f) **Meaningful use.** Eligible professionals in their second through sixth participation year and eligible hospitals in their second through third participation year must attest to meaningful use of certified EHR technology. Eligible hospitals must attest to meaningful use if they are participating in both the Medicare and Oklahoma EHR Incentive Programs in their first participation year. The definition of "meaningful use" is outlined in, and determined by, the Electronic Health Records Program Final Rule CMS-0033-F.

(g) **Payment.** Eligible professionals may receive a maximum of $63,750 in incentive payments over six years. Providers must begin their participation by 2016 to be eligible for payments. Payments will be made one time per year

per provider and will be available through 2021. Eligible hospitals cannot initiate payments after 2016 and payment years must be consecutive after 2016.

(1) Eligible professionals and eligible hospitals must use a Taxpayer Identification Number (TIN) to assign a valid entity as the incentive payments recipient. Valid entities may be the individual provider or a group with which the provider is associated. The assigned payee must have a current Provider Agreement with OHCA.

(2) The provider is responsible for repayment of any identified overpayment. In the event OHCA determines monies have been paid inappropriately, OHCA will recoup the funds by reducing any future payments owed to the provider.

(h) **Administrative appeals.** Administrative appeals of decisions related to the Oklahoma Electronic Health Records Incentive Program will be handled under the procedures described in OAC 317:2-1-2(b).

OKLAHOMA HEALTH CARE AUTHORITY
CURRENT RATES FOR 04-01-10
RATE COMPONENT DETERMINATIONS
REGULAR NURSING FACILITIES

9/1/2010

FOCUS ON EXCELLENCE	Earned	Percent of	Weighted
95.0% Participating Facilities	Percentage	Facilities	Points
0 Points Earned	0%	0.0414	0
1 to 2 Points Earned	1%	0.2103	0.0021
3 to 4 Points Earned	2%	0.2759	0.0055
5 to 6 Points Earned	3%	0.3069	0.0092
7 to 8 Points earned	4%	0.1379	0.0055
9 to 10 Points earned	5%	0.0276	0.0014
		1.0000	0.0237
At 95 %			2.25%

UPL Available	$	125.75
Base Rate	$	103.20
Balance for Pool and Tiered	$	22.55

X = Pool Amount

$22.55 =X + ($103.20+ 3X) Times.0225
or $22.55 = X + $2.32716 + .00675X
or $20.24934 = 1.00675X
or X = 20.24934/1.00675
or X = 20.11

Tiered Amount(=$22.55 less$20.11)	$	2.44
Other Component Amount (Thirty Percent of $20.11)	$	6.03
Direct Care Component (Seventy Percent of $20.11)	$	14.08
Total	$	22.55
Incentive Point Amount (one percent of $6.03 + $103.20)	$	1.09

Estimated Days for Regular NF		4,935,283
Base Rate Component Amount	$	509,321,206
Other Rate Component Amount	$	29,759,756
Incentive Payment Component Amount	$	12,042,091
Direct Care Rate Component Amount	$	69,488,785
Total Rate Amount	$	620,611,837
Per Day	$	125.75
Total Pool Amount (Other plus Direct Care)	$	99,248,541
Estimated Patient Spend-down (19.65%)	$	121,950,226
Net OHCA Portion	$	498,661,611

OKLAHOMA HEALTH CARE AUTHORITY
PROPOSED RATES FOR 11-01-10
RATE COMPONENT DETERMINATIONS
REGULAR NURSING FACILITIES

9/1/2010

FOCUS ON EXCELLENCE	Earned	Percent of	Weighted
97.01% Participating Facilities	Percentage	Facilities	Points
0 Points Earned	0%	0.0137	0
1 to 2 Points Earned	1%	0.2055	0.0021
3 to 4 Points Earned	2%	0.2774	0.0055
5 to 6 Points Earned	3%	0.2534	0.0076
7 to 8 Points earned	4%	0.1986	0.0079
9 to 10 Points earned	5%	0.0514	0.0026
		1.0000	0.0257
At 97.01%			2.50%

UPL Available	$	125.75
Base Rate	$	103.20
Balance for Pool and Tiered	$	22.55

X = Pool Amount

$22.55 =X + ($103.20+ 3X) Times.0250
or $22.55 = X + $2.58 + .0075X
or $19.97 = 1.0075X
or X = 19.97/1.0075
or X = 19.82

Tiered Amount(=$22.55 less$19.82)	$	2.73
Other Component Amount (Thirty Percent of $19.82)	$	5.95
Direct Care Component (Seventy Percent of $19.82)	$	13.87
Total	$	22.55
Incentive Point Amount (one percent of $5.95 + $103.20)	$	1.09

Estimated Days for Regular NF		4,823,793
Base Rate Component Amount	$	497,815,438
Other Rate Component Amount	$	28,701,568
Incentive Payment Component Amount	$	13,168,955
Direct Care Rate Component Amount	$	66,906,009
Total Rate Amount	$	606,591,970
Per Day	$	125.75
Total Pool Amount (Other plus Direct Care)	$	95,607,577
Pool Amount in Current State Plan (04-01-10 Rates)	$	99,248,541
Difference	$	(3,640,964)
Estimated Patient Spend-down (19.65%)	$	119,195,322
Net OHCA Portion	$	487,396,648
04-01-10 Component	$	498,661,611
Difference (111,490 days at current rate less spend-down)	$	(11,264,963)

OKLAHOMA HEALTH CARE AUTHORITY
RATE COMPARISONS 04-01-10 VERSUS 11-01-10
REGULAR NURSING FACILITIES

9/1/2010	Current Rates	04-01-10		Proposed Rates	11-01-10	
Rate Components	**4/1/2010**	**Minimum**	**Maximum**	**11/1/2010**	**Minimum**	**Maximum**
Base Rate Component	$ 103.20	$ 103.20	$ 103.20	$ 103.20	$ 103.20	$ 103.20
Other Cost Component	$ 6.03	$ 6.03	$ 6.03	$ 5.95	$ 5.95	$ 5.95
Direct Care Cost Component	$ 14.08	$ 8.61	$ 17.70	$ 13.87	$ 7.44	$ 17.30
Incentive Rate Component	$ 2.44	$ -	$ 5.45	$ 2.73	$ -	$ 5.45
Total Rate	$ 125.75	$ 117.84	$ 132.38	$ 125.75	$ 116.59	$ 131.90

Oklahoma Health Care Authority
Financial Services Division
Presentation to State Plan Amendment Reimbursement Committee
Proposed Reimbursement for Regular Nursing Facilities
October 11, 2010

Background

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

- Base Rate Component
- Focus on Excellence Performance Measure Component
- Direct Care Component
- Other Costs Component

Under the current methodology the rate components are established in the following manner:

1. The base rate component is $103.20, the rate in effect at 06-30-05. The base rate was established by legislation in SFY 2004.
2. The Focus on Excellence Component is an amount awarded for a point earned under the Focus on Excellence program and is established as 1% of the total of the Base Rate and Other Cost Components. The rate component is currently $1.09 per point. A facility may earn from 0 to 5 points. The current average component is $2.44 per day.
3. The Other Cost Component is a statewide rate (the same for all facilities) and is determined by dividing 30 % of the total funds available after meeting the requirements for the Base Rate and Focus on Excellence Components by the total estimated Medicaid Days. The current Component amount is $6.03 per patient day.
4. The Direct Care Component is facility-specific and is determined by allocating 70% of the funds available after meeting the requirements for the Base Rate and Focus on Excellence components to each facility based on their relative expenditures for direct care. The current average component is $14.08 per patient day.
5. The total average rate for the above components is $ 125.75.

Proposed Changes for Review

The following changes, effective November 1, 2010, are being proposed in the methodology to establish the rate components.

1. When enacted by the legislature and approved by CMS, OHCA staff is requesting approval to add any resulting increase in the Quality of Care Fee to the Base Rate. The increase will be determined in advance of the rate period and will be set at the maximum allowed by both state and federal legislation.
2. OHCA staff is requesting approval to amend the state plan to increase the Quality of Care fee to the maximum allowed by both federal and state legislation. At the current time the rates are frozen so no actual component change would occur (i.e. the component will remain at $6.70 per patient day).
3. OHCA staff is requesting approval to amend the State Plan to incorporate a waiver of uniformity for the Quality of Care Fee. The waiver language has been reviewed by CMS and verbal approval has been given. The waiver will leave the fee frozen at the current amount of $6.70 PPD for the following facilities:

a. Facilities that are licensed or have made application by November 1, 2010 and subsequently receive licensure as "Continuum of Care" facilities. A Continuum of Care (COC) Facility is one that offers day care, assisted living and regular nursing home care.
b. Facilities that have 50,000 or more Medicaid patient days in the most recent State Fiscal Year (as reported and paid in the MMIS system).

All other facilities will pay the maximum amount allowed by state and federal legislation. We currently have 12 licensed COC Facilities and 1 facility with 50,000 or more Medicaid patient days, which make up approximately 4% of the facilities.

4. OHCA staff is requesting approval to amend the state plan for the rate period beginning November 1, 2010 to change the pool amount to reflect the current available funds. This entails changing the pool amount from $99,248,541 to $95,607,577.

The proposals would result in the following rate component changes for the period beginning 11-01-10.

- The Base Rate Component would remain the same at $103.20.
- The component amount awarded for a point earned under the Focus on Excellence program will remain at $1.09 per patient day (PPD). The average estimated payment will change from $2.44 to $2.73 PPD.
- The Other Costs Component will change from $6.03 PPD to $5.95 PPD.
- The average Direct Care Component will change from $14.08 PPD to $13.87 PPD.
- The total minimum and maximum rates from this re-allocation will change from a range of $117.84 to $132.38 to a rate range of $116.59 to $131.90 and the estimated average rate will remain the same at $125.75 PPD.
- No changes will occur in the Base Rate for the Quality of Care Fee until such time as the Oklahoma Legislature passes legislation allowing change to the fee which is now frozen at the $6.70 PPD amount.

Access to services should not be disrupted because at the current time the overall occupancy rate for this facility type is 68%.

Budget Impact

The net effect of the re-allocation of funds and estimate of days of service will be to decrease Medicaid expenditures by $ 11,264,963 ($ 3,949,496 in appropriated state funds). The reduction is due to the reduction in expected service days as has been the case with this population for the last ten years.

Oklahoma Health Care Authority
Financial Services Division
Presentation to State Plan Amendment Reimbursement Committee
Proposed Reimbursement Method for Nursing Facilities Serving Aids Patients
October 11, 2010

Background

Under HB 2842 the Legislature directed the Authority to develop a graduated or tiered reimbursement methodology for calculating state Medicaid program reimbursement. The Authority through it's approved methodology also must meet the requirements in Titles 56 and 63 of the Oklahoma Statutes as amended through HB2019 (the Quality of Care Fee legislation) and SB 1622 (the facility specific Direct Care Staffing legislation).

Under the current methodology the rate components for Aids patients in nursing facilities are as follows:

- The Base, the rate which was established under the Quality of Care Fee Legislation and enhanced through previous plan changes for inflation. The current rate is $177.93 established as of April 1, 2010. Included in the base rate is the quality of care fee for nursing facilities, currently set at $6.70 per day and frozen at that amount by legislation.
- The Focus on Excellence Performance Measure Component. The Aids only facilities are considered the same as regular facilities for this program. This component is the same as that used for all facilities participating the program meaning each facility may earn from one to five percentage points (based on relative scores) at $1.09 per point.

Proposed Reimbursement Methodology changes for the period beginning November 1, 2010

For the period beginning 11-01-2010 the Authority will pay rates that are a combination of the two components currently in use, the base rate and the focus on excellence incentive components.

(a) *Base Component Value*: The base component will be the difference in the reported costs from the SFY 2009 cost report data for the one aids-only facility and the reported cost for all regular nursing facilities plus the current average rate for regular facilities (not including incentive amounts). This amount would be $178.64 ($193.79 less $138.17 plus $123.02). We request the base component value be approved at $178.64 for the period beginning 11-01-10, as defined above.

(b) *Base Component Value:* When the legislature passes amendments to the statutes to unfreeze the Quality of Care Fee OHCA staff is requesting approval to add the increased fee amounts to the base rate. Under federal law this is an allowable cost.

Budget Impact

The cost for the above change in the base rate is $6,401 ($2,244 in state funds) for the 9,016 days at $.71 PPD difference. When and if the quality of care fee is unfrozen the base rate will be increased to cover that amount and staff will initiate a new Rates and Standards Hearing to approve any increases in rates made available from additional collections.

Oklahoma Health Care Authority
Financial Services Division
Presentation to State Plan Amendment Reimbursement Committee
Elimination of Supplemental Payment in Outpatient Hospitals
October 11, 2010

Background

In SFY06, the ratio of Medicaid outpatient payments to costs was approximately 80 percent. The intent of the supplemental payments was to address the overall payment disparity and the following additional agency objectives:

- To create incentives for appropriate use of the outpatient setting as providers shift from inpatient to outpatient care;
- To provide partial compensation for services that are extremely costly and ensure access to appropriate clinical treatments for Medicaid beneficiaries; and
- To ensure sufficient reimbursement to small rural hospitals and critical access hospitals.

To achieve the above objectives, in January 1, 2007, all in-state hospitals could qualify for a supplemental payment adjustment for outpatient services.

Proposed Elimination of Supplemental Payment Effective October 1, 2010

The outpatient hospital supplemental payments were temporary. The agency's goal was to increase payment rates through the system. Over a period of time, the agency has been able to allow coverage of new codes under observation and APC procedures.

Budget Impact

There is no budget impact to the agency as this payment is being eliminated.

Recommendation 1: Prior Authorize Ampyra™ (dalfampridine)

The Drug Utilization Review Board recommends prior authorizing Ampyra™ (dalfampridine) with the following criteria:

- Member must have a diagnosis of Multiple Sclerosis
- Kurtzke Expanded Disability Status Scale (EDSS) score between 4 and 7.5
- A 90 day trial will be approved. If member has responded well to treatment and physician states that the member has shown improvement or the drug was effective, member may receive authorization for one year
- Quantity limit of 60 for 30 days

Recommendation 2: Prior Authorize Qutenza® (capsaicin) 8% Patch

The DUR Board recommends pharmacy and medical prior authorization of Qutenza® (capsaicin) 8% patch with the following criteria:

1. FDA approved diagnosis (Postherpetic Neuralgia).
2. Provide documented treatment attempts at recommended dosing or contraindication to at least one agent from each of the following drug classes:
    a. Tricyclic antidepressants
    b. Anticonvulsants
    c. Topical lidocaine
3. Quantity limit of no more than 4 patches per treatment every 90 days.
4. Product must be administered by a healthcare provider.

Recommendation 3: Prior Authorize Victoza® (liraglutide) and Bydureon® (exenatide LAR)

The DUR Board recommends placing a prior authorization on Victoza® (liraglutide) and Bydureon® (exenatide long-acting), when it becomes available. Approval is based on prior authorization criteria similar to that required for Byetta® (exenatide):

1. Diagnosis of Type 2 Diabetes.
2. Therapy with metformin, sulfonylurea, thiazolidinediones, or a combination, for at least 90 days within the last 180 days, that has not yielded adequate glycemic control.

Recommendation 4: Prior Authorize Special Formulation Antibiotics

The DUR Board recommends pharmacy prior authorization of these special formulation antibiotics with the criteria as follows:

Moxatag® (extended-release amoxicillin) criteria:

1. FDA-approved diagnosis of tonsillitis and/or pharyngitis secondary to *Streptococcus pyogenes,* confirmed by clinical testing, in members 12 and older.

2. Must provide a clinical reason why the member cannot take immediate-release forms of penicillin, amoxicillin, or amoxicillin/clavulanate.

Augmentin XR® (amoxicillin/clavulanate potassium) criteria:

1. FDA-approved diagnosis of community-acquired pneumonia or acute bacterial sinusitis due to confirmed or suspected β-lactamase-producing pathogens (i.e. *H. influenza, M. catarrhalis, H. parainfluenzae, K. pneumoniae*, or methicillin-susceptible *S. aureus*) and *S. pneumoniae* with reduced susceptibility to penicillin (i.e. penicillin MICs = 2 mcg/mL, but not indicated if MICs ≥ 4 mcg/mL).
2. Must provide a clinical reason why the member cannot take immediate-release forms of penicillin, amoxicillin, or other forms of amoxicillin/clavulanate.

Oracea® (extended-release doxycycline) criteria:

1. FDA-approved diagnosis of rosacea with inflammatory lesions in adults 18 and older.
2. Must provide a clinical reason why the member cannot take immediate-release forms of doxycycline.

Doryx® (extended-release doxycycline) criteria:

1. FDA-approved diagnosis.
2. Must provide a clinical reason why the member cannot take immediate-release forms of doxycycline.

Oravig® (miconazole buccal tablets) criteria:

1. FDA-approved diagnosis of oropharyngeal candidiasis in adults age 18 and older.
2. Recent trials (within the last month) of the following medications at recommended dosing and duration of therapy:
    a. Clotrimazole troches, AND
    b. Nystatin suspension, AND
    c. Fluconazole tablets
3. Contraindication(s) to all available alternative medications.

The DUR Board also recommends the prior authorization of drugs on the market that are reformulations of existing anti-infectives. Member must have a clinically significant reason why the existing formulation and/or other cost effective therapeutic equivalent medication(s) cannot be used.

Recommendation 5: Prior Authorize Anticonvulsants

The College of Pharmacy recommends prior authorization of the anticonvulsant category under the scope/utilization PA program.

1. Anticonvulsants will be included in the current mandatory generic plan.
    a. All brand-name anticonvulsants (with a generic equivalent) will require prior authorization.

        i. Brand-name medications (with a generic equivalent) will be approved for all members who are currently stable on these medications and have a seizure diagnosis.

2. Prior authorization will be required for certain non-standard dosage forms of medications when the drug is available in standard dosage forms.
    a. Members 12 and older must have a documented medical reason demonstrating need for non-standard dosage forms.
    b. Criteria for approval of extended-release formulations:
        i. Previously stabilized on the short-acting formulation.
        ii. Dosing is not more than once daily.
        iii. Member must provide a reason why the short-acting formulation is not adequate.
    c. Dosepacks will not be approved if standard dosage forms are available.
3. Quantity limit restrictions will be placed on lower strength tablets and capsules. The highest strengths will continue to have no quantity restrictions unless a maximum dose is specified for a particular medication.
4. Felbamate will require prior authorization with the following criteria:
    a. Initial prescription written by a neurologist.
    b. Member has failed therapy with at least three other medications commonly used for seizures.