OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
May 12, 2011 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 Tony Armstrong, Vice Chairman

1. Call To Order/Determination of Quorum
2. Action Item – Approval of March 10, 2011 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.
        1. Pharmacy Update – Nancy Nesser, PharmD. JD, Pharmacy Director
    c) Legislative Update – Nico Gomez, Deputy Chief Executive Officer
    d) Relocation Update – Joe Hodges, Special Project/Relocation Manager
    e) OHCA Team Day Report – Paul Gibson, Auditor III/Performance and Reporting

Item to be presented by Kelly Shropshire, Audit Director

4. Discussion Item – SFY 2010 Single State Audit Findings of the Oklahoma Health Care Authority by the State Auditor and Inspectors presented by Debbie Williams, Audit Manager.

Item to be presented by Tony Armstrong, Vice Chairman

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

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

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

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

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

7. 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 Zyflo (zileuton) CR® to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) Consideration and vote to add medications used to treat **Benign Prostatic Hyperplasia (BPH)** to the product-based prior authorization program under OAC 317:30-5-77.3.

Item to be presented by Vice Chairman Armstrong

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

Status of pending suits and claims

1. Choices v. OHCA	CJ-09-229-01	Garfield County, OK
2. Harper v. OHCA	5:10-cv-00514-R	USDC, Western District of OK
3. Wittenberg v. OHCA	10 CV-0238	Oklahoma County, OK
4. Hauenstein v. OHCA	CIV-10-940-M	USDS, Western District of OK
5. Peak v. OHCA	10-5145	10th Circuit Court of Appeals
6. Gohl v. OHCA	108,993	Supreme Court OK
7. Ishcomer v. OHCA	CIV-11-148-F	USDC, Western District of OK
8. Nitschke v. SoonerRide	CJ-10-435-02	Garfield County, OK
9. 2010 DMH Administrative Claiming	DAB A-10-73	CMS Departmental Appeals Board

9. New Business

10. **ADJOURNMENT**

NEXT BOARD MEETING
June 9, 2011
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
March 10, 2011
Held at Oklahoma Health Care Authority
Oklahoma City, OK

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on March 9, 2011.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Roggow called the meeting to order at 1:03PM.

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

OTHERS PRESENT:	OTHERS PRESENT:
Dan Alcorn, DMHSAS Will Widman, HPES Charles Brodt, HPES Smanatha Galloway, DHS/DDSD Kelli Bowie, MedSolutions	Dan Arthrell, Community Service Council/Tulsa Tracy Jones, Chickasaw Nation Kristi Blackburn, DHS/DDSD

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD JANUARY 13, 2011

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

MOTION:	Vice Chairman Armstrong moved for approval of the January 13, 2011 board minutes as published. Member Langenkamp seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Bryant, Member Miller, Member Langenkamp, and Chairman Roggow
BOARD MEMBER ABSENT:	Member McVay Member McFall

Mr. Fogarty presented Terrie Fritz, External Relations Coordinator, with her 25 year pin for state service.

FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Revenues for OHCA through January, accounting for receivables, were **$2,002,846,976** or **(1.9%) under** budget. Expenditures for OHCA, accounting for encumbrances, were **$1,903,220,234** or **3% under** budget.

The state dollar budget variance through January is **$20,411,868 positive.** The prior year carryover was reduced by **$10,000,000** due to the Office of State Finance redistribution of State Fiscal Stabilization Funds. The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		16.9
Administration		5.3
Revenues:		
Prior Year-Reduction		(10.0)
Taxes and Fees		1.7
Drug Rebate		5.0
Overpayments/Settlements		1.5
Total FY 11 Variance	**$**	**20.4**

Ms. Evans stated that for February it appears we will be under budget but for March there is some increase in the runs. She stated that the second week of March appears to be the highest run we have had since November 2009.

MEDICAID DIRECTOR'S UPDATE
Garth Splinter, MD

Dr. Splinter reported on program statistics. He noted the SoonerCare Choice program is up to 446,700, with the Traditional Program at 241,000. The SoonerPlan is now 31,200 with Insure Oklahoma slightly over 32,000 for a total of almost 751,000. He reported the net enrollment change is just over 700 with 19,500 new enrollees. OLL is staying flat with the nursing enrollment at 15,700 with expenditures staying the same. Dr. Splinter discussed the waiver programs noting they are essentially unchanged. Living Choice, My Life My Choice, and Medically Fragile continue to have slow increases as expected. He noted that the hospital count went up substantially and currently are working on the cause of that increase. The total primary providers continue to show growth with over 4,000 primary providers, and pushing close to 1500 patient centered medical homes. He then stated that the mid-year report on the licensed behavioral practitioners number of 486 is up and at this years retreat there will be another chart showing the county distribution and the difference by county from the baseline. Dr. Splinter reported that he gave a speech on the Affordable Care Act and has slides upon request for the Board. We are continuing with the C-Section project with the second round of information going out to the OB providers. The implementation for the C-Section project is September 1. For further details, see Item 3b of the board packet.

LEGISLATIVE UPDATE
Nico Gomez, Deputy Chief Executive Office

Mr. Gomez discussed the OHCA Request Bills as follows:

SB 0412 – Sen. Bill Brown – Prohibits Commercial Insurance Companies from Charging Fees to Process SoonerCare Secondary Claims

SB 0676 – Sen. Clark Jolley – Allows Administrative Sanctions to Medicaid Recipients Who Abuse the State Medicaid Program

He noted that after the February deadlines and as of noon Wednesday, March 02, 2011, the Oklahoma Legislature is currently tracking a total of 1,777 bills. OHCA is currently tracking 132 bills. They are broken down as follows:

- OHCA Request 02
- Direct Impact & Agency Interest 78
- Appropriations 06
- Employee Interest 46

Mr. Gomez stated that the Senate and House Remaining Deadlines are as follows:

March 3, 2011	Deadline for Reporting Double-Assigned Senate Bills from 2nd Committee and Deadline for Reporting House Bills and Joint Resolutions from House Committees
March 17, 2011	Deadline for Third Reading of a Bill in the House of Origin (House/Senate)
March 31, 2011	Deadline for Reporting Double-Assigned House Bills from lst Committee
April 7, 2011	Deadline for Reporting Single Assigned House Bills in Senate Committees
April 14, 2011	Deadline for Reporting Double-Assigned House Bills from 2nd Committee and Deadline for Reporting Senate Bills and Joint Resolutions from House Committees
April 28, 2011	Deadline for Third Reading of Bills in Opposite Chamber
May 27, 2011	Sine Die of the first session of the 53rd Legislature

For a full detailed report, see Item 3c of the board packet.

SOONERCARE PRENATAL UPDATE – TOBACCO SETTLEMENT ENDOWMENT TRUST (TSET)
Shelly Patterson, Director of Child Health Unit

Ms. Patterson presented slides related to the following: SoonerQuit Prenatal Goals; the SoonerQuit Need; Adverse Health Outcomes; SoonerCare & Pregnancy; Partners; Funding; Objectives; Methods; Practice Facilitation; Targeting the Need; and Good Things. Ms. Patterson introduced Ms. Tracy Strader with the Tobacco Settlement Endowment Trust(TSET). Ms. Strader then presented Mr. Fogarty with a $235,000 check to help further resources for tobacco cessation.

Mr. Fogarty noted that one of the highlights for this year was to be able to attend the February 25th ribbon cutting and opening of the George Miller Building in Ada, OK.

Mr. Fogarty recognized Ms. Paula Gullion for her years of service to the state and stated she is leaving OHCA to pursue her new career in nursing.

Mr. Fogarty reported that OHCA continues to receive speaking invitations from in state and out of state regarding programs within this agency such as Medical Home; Online Enrollment; and the Early Innovator Grant. Oklahoma was one of seven states to receive the Early Innovator Grant in the amount of $54 million. See board packet for press release.

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

Audit/Finance Committee

Member Miller stated the committee did not meet.

Legislative Committee

Mr. Gomez met with the committee and reviewed current legislation.

Rules Committee

Member Langenkamp stated the Rules Committee did meet and reviewed 62 rules

ITEM 5/ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING

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

ITEM 6.a)CONSIDERATION AND VOTE UPON PROMULGATION OF PERMANENT RULES AS PRESENTED

Ms. Roberts stated that the following rules have been thru the Medical Advisory Committee, and all have had public hearings. The public hearings are designed specifically to get comments from the public on any individual rule. Ms. Roberts stated the rules will be divided into 4 categories for voting purposes.

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

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

The following rules HAVE previously been approved by the Board and have Gubernatorial approval under Emergency rulemaking. These rules have been REVISED for Permanent Rulemaking.

6.a-1 AMENDING Agency rules at OAC 317:30-5-660.1, 30-5-660.4, 30-5-661.1, 30-5-661.5, 30-5-664.5, 30-5-664.7, and 30-5-664.10 to revise contracting requirements for Federally Qualified Health Centers (FQHC); clarify Health Center enrollment requirements

for services rendered in a school setting; revise the definition of core services to include services rendered by Licensed Behavioral Health Professionals as authorized under the FQHC State Plan pages; and clarify general reimbursement requirements for FQHC's. **(Reference APA WF # 10-04)**

6.a-2 AMENDING agency rules at OAC 317:45-1-3, 45-3-2, 45-5-1, 45-5-2, 45-7-2, 45-7-3, 45-7-6, 45-7-8, 45-9-1, 45-9-2, 45-9-7, 45-11-1, 45-11-2, 45-11-10 through 45-11-13, 45-11-20, 45-11-21, 45-11-23, 45-11-27, 45-11-28 to clarify and expand on definitions of College Student, Employee and Employer within the Insure Oklahoma program; clarify procedures for credits and adjustments for employers participating in the program; require college students to submit current course schedules to prove full-time status; add Ultraviolet Treatment-Actinotherapy and Private Duty Nursing as non-covered services; clarify that no standard deduction for work related expenses may be made for self-employed individuals; require that approved individuals notify OHCA of any changes in household status and income, that might impact eligibility, within 30 calendar days of the change; and to clean up references to the Oklahoma Administrative Code to comply with APA formatting requirements. **(Reference APA WF # 10-08)**

6.a-3 AMENDING Agency rules at OAC 317:50-1-3 to revise eligibility requirements for the Medically Fragile Waiver to allow individuals with intellectual disabilities. **(Reference APA WF # 10-13)**

6.a-4 AMENDING agency rules at OAC 317:30-5-276 and 30-5-281 to revise psychologist rules to update provider requirements, terminology and to require prior authorization of services for all services provided except the initial assessment and/or crisis intervention. **(Reference APA WF # 10-15)**

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

6.a-6 AMENDING Agency rules at OAC 317:30-5-556 and 30-5-560 to clarify that Private Duty Nursing (PDN) is available to eligible individuals in their primary residence and to remove the requirement that treatment plans for (PDN) be updated and signed by the member's physician annually. **(Reference APA WF # 10-23)**

6.a-7 AMENDING Agency rules at OAC 317:30-5-241 to refer to the Behavioral health provider reference tool as the Behavioral

Health Manual rather than the Behavioral Health Billing Manual. **(Reference APA WF # 10-29)**

6.a-8 AMENDING Agency rules at OAC 317:30-5-241.2 to revise the definition of Partial Hospitalization Services to require that the services are reasonable and necessary for the diagnosis and active treatment of the member's condition, are reasonably expected to improve or maintain the member's condition and are provided in accordance with the Code of Federal Regulations. **(Reference APA WF # 10-53)**

6.a-9 AMENDING Agency rules at OAC 317:30-3-5 to exempt from SoonerCare cost sharing requirements, Native Americans who have provided documentation of ethnicity and receive items and services furnished by the Indian Health Service, Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U's) or through referral under contract health services. **(Reference APA WF # 10-56)**

6.a-10 AMENDING Agency rules at OAC 317:30-5-700 and 30-5-700.1 to clarify eligibility requirements for SoonerCare Orthodontic services; clarify provider requirements for General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice; and remove references to Relative Value Units (RVU's) as well as other minor formatting revisions. **(Reference APA WF # 10-58)**

6.a-11 AMENDING Agency rules at OAC 317:30-5-78 to allow for a new pricing benchmark, Wholesale Acquisition Cost (WAC), in the event that the Average Wholesale Price (AWP) is no longer published by OHCA's pharmacy pricing vendor. Rules are also revised to reflect the change in pricing methodology for injectable drugs that are submitted through the pharmacy system. **(Reference APA WF # 10-62)**

6.a-12 AMENDING Agency rules at OAC 317:35-5-25 to revise SoonerCare eligibility rules so that only new certified birth certificates will be accepted as verification of citizenship for Puerto Ricans who are using their birth certificate as proof of citizenship and whose eligibility for benefits will be determined for the first time on or after October 1, 2010. This rule change does not prohibit Puerto Ricans from using other forms of citizenship verification; it only applies to the use of birth certificates. When the applicant has not yet received his or her new certified birth certificate, reasonable opportunity to obtain citizenship verification will be afforded to the applicant. These changes are made pursuant to CMS guidance. **(Reference APA WF # 10-63)**

MOTION: Member Langenkamp moved for approval of rules 6.a-1 thru 6.a-12 as presented. Member Bryant seconded.

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

BOARD MEMBER ABSENT: Member McVay
Member McFall

The following rules HAVE previously been reviewed by the Board DO NOT have Gubernatorial approval under Emergency rulemaking. These rules have been REVISED for Permanent Rulemaking.

6.a-13 AMENDING Agency rules at OAC 317:30-5-660.5, 30-5-661.4 and 30-5-664.3 to clarify reimbursement for certain Licensed Behavioral Health Professionals in Federally Qualified Health Centers (FQHC). Additionally, revisions are made to reflect contracting and reimbursement requirements for covered services in FQHC and school settings. Policy revisions are needed to make certain LBHP's who provide behavioral health services in FQHC's are reimbursed appropriately. Revisions are also needed to identify behavioral health services that are permissible in FQHC's and school settings. These revisions ensure that the reimbursement rates for services rendered in FQHC's comply with cost based reimbursement accounting principles thereby eliminating payment errors and guarding the Agency's Federal Financial Participation (FFP) from being at risk. **(Reference APA WF # 10-04)**

MOTION: Member Langenkamp moved for approval of rule 6.a-13 as presented. Member Bryant seconded.

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

BOARD MEMBER ABSENT: Member McVay
Member McFall

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

6.a-14 AMENDING agency rules at OAC 317:30-5-740, 30-5-740.1, 30-5-741, 30-5-742, 30-5-742.1, 30-5-742.2, 30-5-743.1, 30-5-744 and 30-5-745, and REVOKING agency rules at 30-5-743 to change outpatient behavioral health reimbursement methodology for services provided in therapeutic foster care settings from an all inclusive per diem payment to fee-for-service. The requirement of "unbundling" per diem rates has been an ongoing trend for CMS and this change more closely aligns our reimbursements with CMS preferences and requirements. **(Reference APA WF # 10-02)**

6.a-15 AMENDING Agency rules at OAC 317:30-5-660.3, 30-5-661.7 and REVOKING 30-5-664.11 to clarify the allowable places of services where Federally Qualified Health Center providers are eligible to be reimbursed the Prospective Payment System (PPS) rate for services rendered. Revisions also revoke references to outdated policies and practices. **(Reference APA WF # 10-04)**

6.a-16 AMENDING Agency rules at OAC 317:45-1-1, 45-1-2, 45-1-4, 45-3-1, 45-7-1, 45-7-4, 45-7-5, 45-7-7, 45-9-3, 45-9-4, 45-9-6, 45-9-8, 45-11-22, 45-11-24 through 45-11-26 to expand the Insure Oklahoma ESI and IP programs. Expansions include incorporating Oklahoma children through 18 years of age whose household income is from 185 up to and including 300 percent of the Federal Poverty Level. The inclusion of children into the program will be phased in over a period of time as determined by the OHCA. In addition, revisions will expand the current Insure Oklahoma ESI and IP program guidelines to include employees and working adults whose family income does not exceed 250 percent of the Federal Poverty Level. The increase from 200 to 250 percent of the FPL will be phased in over a period of time as determined by the OHCA. These revisions comply with Sections 1009.2 and 1010.1 of Title 56 of Oklahoma Statutes. This expansion to the Insure Oklahoma program will help increase access to healthcare for Oklahomans thereby reducing the amount of uncompensated care provided by healthcare providers.
(Reference APA WF # 10-08)

6.a-17 AMENDING agency rules at OAC 317:10-1-1, 10-1-2, 10-1-3, 10-1-4, 10-1-12 and 10-1-16, and REVOKING agency rules at 10-1-5, 10-1-6, 10-1-7, 10-1-8, 10-1-9, 10-1-10, 10-1-11, 10-1-15, 10-1-17, 10-1-18, 10-1-18.1, 10-1-18.2, 10-1-19 and 10-1-20 to better coordinate and comply with new purchasing rules and regulations from the Oklahoma Department of Central Services (DCS). Proposed revisions will: (1) incorporate updated procedures corresponding to higher purchasing thresholds; (2) allow OHCA subject matter experts to make purchases in house without DCS approval, pursuant to 74 Okla. Stat. § 85.5(T); (3) provide for the appeals process on these purchases to be handled by OHCA; (4) remove unnecessary language; and (5) update policy to reflect changes in the internal purchasing manual. **(Reference APA WF # 10-09)**

6.a-18 ADDING Agency rules at OAC 317:50-1-1, 50-1-2, and 50-1-4 through 50-1-16 to include provisions for a new Home and Community based Waiver Program providing non-institutional long–term care for individuals requiring skilled nursing or hospital level of care. These individuals' needs exceed the service capacity of the current ADvantage waiver and therefore require additional funding and waiver authority to be adequately served. Creation of the Medically Fragile Waiver will result in a more appropriate service delivery mechanism for this fragile population thereby increasing quality and continuity of care. **(Reference APA WF # 10-13)**

6.a-19 ADDING agency rules to OAC 317:25-9-1 through 25-9-3 to implement a pilot program to pay Health Access Networks to coordinate and improve the quality of care for SoonerCare members. Rules are needed to establish provider requirements and billing guidelines for HAN's which are not-for-profit, administrative entities that work with SoonerCare providers to coordinate and improve the quality of care for our members. Contracted HAN's will be paid a $5.00 per member per month fee in order to enhance the development of comprehensive medical homes for SoonerCare Choice members. **(Reference APA WF # 10-14)**

6.a-20 AMENDING agency rules at OAC 317:30-5-275, 30-5-278, and ADDING agency rules at 30-5-280, 30-5-282 and 30-5-283 to allow direct reimbursement to licensed masters level behavioral health professionals who, under current rules, are only allowed to provide services in agency settings. Allowing direct contracting with these providers will help increase specialist access, decrease use of ER and inpatient psych, and increase crisis intervention. This revision will also divert psychiatric residential treatment center usage due to LBHPs being more accessible throughout the state. **(Reference APA WF # 10-15)**

6.a-21 AMENDING agency rules at OAC 317:35-9-15 and 35-19-4 to remove policy directing OKDHS to conduct the fair hearings in the estate recovery process for individuals in nursing facilities, ICFs/MR or other medical institutions. Current policy conflicts with the Agency's enabling statutes which provide that the OHCA shall conduct the hearings. **(Reference APA WF # 10-16)**

6.a-22 REVOKING Agency rules at OAC 317:30-5-586.1 and 30-5-589, and AMENDING Agency rules at OAC 317:30-5-595 through 30-5-596 to remove language that allows reimbursement for behavioral health case managers' travel time to and from meetings for the purpose of development or implementation of the individual plan of care. Current policy conflicts with the Agency's State Plan reimbursement methodology which includes travel time as a component of the case management rate. Additionally, rules are revised to revoke sections that were previously combined with other areas of policy. **(Reference APA WF # 10-19)**

6.a-23 AMENDING Agency rules at OAC 317:30-5-1091 and 30-5-1098 to clarify that smoking and tobacco use cessation counseling is a covered SoonerCare service for the Native American population through the Indian Health Service, Tribally Operated Programs and Urban Indian Clinics (I/T/U's). **(Reference APA WF # 10-20)**

6.a-24 AMENDING Agency rules at OAC 317:30-5-1023 and 30-5-1027 to add a new provider type "Behavior Health School Aide" and service description "Therapeutic Behavioral Services". Currently schools are being allowed to include behavior interventions as a personal care service. This rule change is needed to help better define and separate behavioral interventions that do not appropriately fall within the description of personal care services. **(Reference APA WF # 10-22)**

6.a-25 AMENDING agency rules at OAC 317:30-5-555, 30-5-557 through 30-5-559 and 30-5-560.1 to provide clarification for Private Duty Nursing prior authorization requests. Revisions clarify that providers should submit the required OHCA forms and documentation along with the treatment plan when requesting the prior authorization for private duty nursing. Revisions also provide additional flexibility for OHCA to conduct a preliminary telephonic interview with members prior to arranging a personal visit. The additional flexibility in allowing the telephonic interview will provide an opportunity for OHCA to ensure medical necessity prior to arranging the personal home visit.

Additional revisions include general policy cleanup as it relates to these sections. **(Reference APA WF # 10-23)**

6.a-26 AMENDING Agency rules at OAC 317:30-5-211.5 to provide guidance regarding the delivery of Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS). Rules provide clarification and guidelines for product refills and reorders, including expected utilization patterns, member contact, and timelines. Rules also provide additional guidance with regard to products which are supplied and delivered via mail and the appropriate way for providers to bill for such items. Additional revisions include clarification to the provider cost of delivery and additional language to clarify OHCA's intent on DMEPOS supplier maintenance with regard to equipment-related services. **(Reference APA WF # 10-24)**

6.a-27 ADDING Agency rules at OAC 317:25-7-7 to include procedures and guidelines related to primary care provider (PCP) referrals under the Patient Centered Medical Home model. The PCP referral process is clearly defined, including the appropriate use of OHCA administrative referrals. Rules further explain provider expectations and provide guidelines regarding PCP referrals, medical necessity, medical record documentation, and OHCA administrative referrals. These revisions continue to strengthen the OHCA medical home and SoonerCare Choice program. **(Reference APA WF # 10-25)**

6.a-28 AMENDING Agency rules at OAC 317:30-3-2.1 to allow providers the option of requesting OHCA to perform a full-scope audit or utilize an extrapolation method to determine overpayments, if during a review a sample indicates an error rate greater than 10 percent of paid claims. If the full-scope audit produces an error rate less than the initial error rate, OHCA will bear the cost of the full-scope audit. However, if it produces an error rate equal to or greater than that of the initial audit, the provider will be responsible for the cost of the full-scope audit and repayment of the identified overpayment resulting from the review method chosen. **(Reference APA WF # 10-26)**

6.a-29 ADDING Agency rules at OAC 317:30-5-293, 30-5-299 and 30-5-680 to provide guidance with regard to team therapy. Physical, occupational, and speech therapy rules will clarify that when multiple therapists, or therapy assistants, work together as a team to treat one or more SoonerCare members, each therapist or assistant cannot bill separately for the same or different service provided at the same time to the same member. Additionally, rules will provide clarification with regard to billing, multiple therapies, delivery of service, and determining the time counted for service units and codes. **(Reference APA WF # 10-27)**

6.a-30 AMENDING agency rules at OAC 317:30-3-24 and 35-5-43 to reflect changes in third party liability recovery procedures necessitated by the Agency's implementation of Online Enrollment. In 2007, the OHCA received a Transformation Grant through the Centers for Medicare and Medicaid Services (CMS) to develop a web based online application and eligibility

determination system in order to improve the ease and efficiency of enrollment. The Online Enrollment process allows potential members to apply for SoonerCare electronically. Because OHCA will assume responsibility for determining eligibility for certain groups of individuals under SoonerCare through this process, rules regarding Third Party Liability are in need of revision to update procedures to be followed by both OKDHS and OHCA employees. **(Reference APA WF # 10-28 A & B)**

6.a-31 AMENDING Agency rules at OAC 317:30-5-240,30-5-240.1 through 30-5-240.3, 30-5-241.2, 30-5-241.3, 30-5-241.5, and 30-5-248 to clarify the definition and credential requirements of a Behavioral Health Rehabilitation Specialists (BHRS).Current policy conflicts with Oklahoma Department of Mental Health Substance Abuse Services (ODMHSAS) definition and credential requirements. Additionally, rules are revised to clean up discrepancies between OHCA and ODMHSAS policy for consistency. **(Reference APA WF # 10-29)**

6.a-32 AMENDING Agency rules at OAC 317:30-5-95, 30-5-95.4 through 30-5-95.6, 30-5-95.8 through 30-5-95.10, 30-5-95.13 through 30-5-95.16, 30-5-95.18 through 30-5-95.20, 30-5-95.22 through 30-5-95.40, 30-5-95.42, 30-5-96.2 through 30-5-96.4, and 30-5-96.7 to modify Residential Treatment Center (RTC) requirements for Community Based transitional level of care. Modifications allow the requirements to be less restrictive as a step-down from standard RTC. By reducing the treatment requirements for the Community Based Transitional level of care, this allows facilities to step down that member to a lower level of RTC care and focus on transitioning the member back to the community, which supports RTC diversion. Additionally, rules are revised to add the Child and Adolescent Level of Care Utilization System (CALOCUS) to be used when determining level of care. Other revisions include removing medical necessity from policy and directing providers to reference the OHCA Behavioral Health Provider Manual. **(Reference APA WF # 10-30)**

6.a-33 ADDING Agency rules at OAC 317:2-1-14 to provide for an appeals process for purchasing decisions made internally at OHCA, pursuant to 74 Okla. Stat., §85.5(T). These revisions are needed to provide immediate consistency and clarity within agency purchasing rules. **(Reference APA WF # 10-31)**

6.a-34 ADDING Agency rules at OAC 317:45-13-1 to add dental services requirements and benefits for children in the Insure Oklahoma Program. The Oklahoma Health Care Authority (OHCA), as a requirement of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), will provide dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Rules will include requirements and benefits for direct dental coverage. The benefits extended to children will include class A, B, C, orthodontic care, and emergency dental services. All dental services for children will follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. **(Reference APA WF # 10-32)**

6.a-35 ADDING Agency rules at OAC 317:50-5-1 through 50-5-16 to include language allowing for a new Home and Community Based Services Waiver program known as Sooner Seniors. The Sooner Seniors Waiver is targeted to members who are age 65 or older, have a clinically documented degenerative disease process and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new home and community based waiver program allows SoonerCare members improved quality of life by providing medically necessary institutional services in a home setting. The program is more cost effective than institutionalized care; therefore a substantial savings will be realized over time through operation of this Waiver. **(Reference APA WF # 10-40)**

6.a-36 ADDING Agency rules at OAC 317:50-3-1 through 50-3-16 to include language allowing for a new Home and Community Based Services Waiver program known as My Life, My Choice. The My Life, My Choice Waiver is targeted to members who are 20 to 64 years of age, are physically disabled and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new home and community based waiver program allows SoonerCare members improved quality of life by providing medically necessary institutional services in a home setting. The program is more cost effective than institutionalized care; therefore a substantial savings will be realized over time through operation of this Waiver. **(Reference APA WF # 10-41)**

6.a-37 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. A recent change in federal law reduce 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)**

6.a-38 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. Appeals' rules are also revised to add the responsibility of hearing members' grievances relating to Online Enrollment eligibility determinations. **(Reference APA WF # 10-45)**

6.a-39 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)**

6.a-40 AMENDING agency rules at OAC 317:30-5-42.16 and 30-5-532 to allow hospice services to be available to children eligible for SoonerCare without forgoing any other service for treatment of the underlying terminal conditions. Families are no longer required to elect hospice services in lieu of standard SoonerCare services that have the objective to treat or cure the terminal illness. Additional revisions include allowing nurse practitioners to recertify the continuation of hospice services. The revisions ensure Agency compliance with Public Laws 111-148 and 111-152. **(Reference APA WF # 10-54)**

6.a-41 AMENDING Agency rules at OAC 317:30-5-72.1, 30-5-77, and 30-5-78.1 to include the 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. **(Reference APA WF # 10-62)**

MOTION: Vice Chairman Armstrong moved for approval of rules 6.a-14 thru 6.a-41 as presented. Member Langenkamp seconded.

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

BOARD MEMBER ABSENT: Member McVay
Member McFall

The following rules HAVE NOT previously been reviewed by the Board.

6.a-42 AMENDING agency rules at OAC 317:30-3-59, 30-3-60, 30-5-2 and 30-5-9 to insure OHCA rules are consistent with reimbursement practices and make coverage rules more consistent throughout policy. Specifically, rules are revised to be consistent with the Centers for Medicare and Medicaid Services (CMS) regarding the elimination of office and inpatient consultation codes. Additional revisions include general policy cleanup as it relates to these sections. **(Reference APA WF # 10-11)**

6.a-43 ADDING agency rules at OAC 317:30-5-211.19 to set guidelines for quality assurances and safeguards. Rules set guidelines related to DMEPOS quality standards, manufacturer standards, member education, maintenance and repair of products, safety and infection control, and provider contact and follow-up services. **(Reference APA WF # 10-34)**

6.a-44 ADDING agency rules at OAC 317:30-3-29 to clarify the criteria used to review and revise provider fee schedules. Rules clarify that provider fee schedules may be revised based on efficiency, budget considerations, economy, and quality of care. Rules provide guidelines related to fee schedule updates and provider

notifications of such updates. Rules also provide guidance related to public notice of significant proposed changes in methods and standards for setting provider payment rates for services. **(Reference APA WF # 10-36)**

6.a-45 AMENDING agency rules at OAC 317:35-21-1 through 35-21-6, 35-21-8 through 35-21-9, 35-21-11 through 35-21-13, 2-1-1, and ADDING Agency rules at OAC 317:35-21-14 to add a provision for medical eligibility review by the OHCA. The medical review will ensure that the original screening has properly indentified the woman as eligible for further testing or treatment. The rule revision further clarifies that income is a requirement for eligibility through SoonerCare, clarifies the meaning of "in need of treatment" and adds to policy that medical and financial eligibility appeals for applicants will be handled through the OHCA. **(Reference APA WF # 10-37 A & B)**

6.a-46 ADDING agency rules at OAC 317:30-3-30 to establish provider signature requirements. For medical review purposes, the OHCA will require that all services provided and/or ordered be authenticated by the author. The method used shall be a hand written signature, electronic signature, or signature attestation statement. Stamp signatures are not acceptable. Rules are revised to be consistent with the Centers for Medicare and Medicaid Services (CMS) regarding such provider signature requirements. **(Reference APA WF # 10-39)**

6.a-47 REVOKING agency rules at OAC 317:30-3-20.1 to update pharmacy provider appeals rules in order to bring them in line with current practice. Current pharmacy provider appeals rules refer to processes that no longer take place. **(Reference APA WF # 10-44)**

6.a-48 AMENDING agency rules at OAC 317:30-5-24 to update coverage guidelines to include positron emission tomography (PET) and computed tomography (CT/CTA). **(Reference APA WF # 10-50)**

6.a-49 AMENDING agency rules at OAC 317:30-5-336.10 to clarify fixed wing air ambulance services. The action is to remove the prior authorization requirement in order to concur with OHCA current claims process that requires an authorization of medical necessity. **(Reference APA WF # 10-52)**

6.a-50 AMENDING Agency rules at OAC 317:30-5-763 to include a re-evaluation and approval of additional hospice services within the ADvantage waiver. The ADvantage waiver is a Home and Community Based Services program that allows individuals qualifying for SoonerCare long term care institutional services to live in a home or community based setting. Hospice is a service provided to SoonerCare members within the waiver, and currently has no authorization limits. Rules are revised to include a re-authorization process after the initial 6 months of hospice care. A re-evaluation of the member will be performed and additional hospice care authorized for a period not to exceed 60 days. A re-evaluation will be performed every 60 days until the member no longer requires hospice. **(Reference APA WF # 10-55 A)**

6.a-51 AMENDING Agency rules at OAC 317:30-5-65.8, 30-5-695, 30-5-696, 30-5-698 through 30-5-699, to ensure consistency throughout policy. Additionally, rules are revised to allow reimbursement to primary care providers for application of fluoride varnish to the gums and teeth of children ages 12 months to 42 months during a well-child visit. Reimbursement is limited to two applications per year. **(Reference APA WF # 10-58)**

6.a-52 AMENDING agency rules at OAC 317:30-3-43, 30-5-122, 30-5-412, 35-9-4, 35-9-5, 35-9-45, 40-1-1, 40-5-8, 40-5-40, 40-5-55, 40-5-59, 40-5-100, 40-5-103, 40-5-113, 40-7-5, 40-7-7, 40-7-15, 40-7-21, 40-9-1 and REVOKING Agency rules at OAC 317:35-9-5.1 to clarify policy for: eligibility for services in an ICF/MR and HCBS waiver for persons with mental retardation and related conditions, screening process for in-home supports providers, back-up plan provisions for specialized foster care members and allowance for natural supports within the specialized foster care member's home. Clarification is also provided on training requirements for providers of job coaching services and the limits on goods and services provided through Self-Direction. Additionally policy is revised to clarify provider qualifications for assistive technology devices, and the procurement review/approval process for assistive technology devices. Further policy revisions include clarification of transportation provider responsibilities, services not covered and limits on the types of adapted transportation allowable. Lastly, policy is revised to include clarification of family training provider qualifications and coverage limitations. **(Reference APA WF # 10-59 A, B, & C)**

6.a-53 AMENDING agency rules at OAC 317:30-3-4.1 to clarify requirements when documenting electronic health records. **(Reference APA WF # 10-60)**

6.a-54 AMENDING agency rules at OAC 317:30-5-210 to clarify OHCA's DMEPOS provider criteria. DMEPOS providers must meet Medicare accreditation standards unless the OHCA grants an exemption based on CMS exemptions, the provider is a government-owned entity, or at a provider's request. Revisions clarify that DMEPOS providers be located within the State of Oklahoma, unless the OHCA provides an exception to this requirement. Additionally, DMEPOS providers must comply with Medicare DMEPOS Supplier Standards as specified in 42 C.F.R. 424.57(c). **(Reference APA WF # 10-61)**

6.a-55 AMENDING Agency rules at OAC 317:30-5-72, 30-5-77.3 to allow for a prior authorization for a third brand name prescription if determined to be medically necessary by OHCA and if the member has not already utilized their six covered prescriptions for the month. Additional revisions include general policy cleanup as it relates to these sections. **(Reference APA WF # 10-62)**

6.a-56 AMENDING agency rules at OAC 317:35-5-41.6, 35-5-41.9, 35-5-42 and 35-10-26 to clarify OHCA's treatment of Individual Indian Money (IIM) Accounts as a converted resource. Funds and property held in IIM Accounts will no longer be used in an

eligibility test. References to per capita payments are removed and the period in which money disbursed from IIM accounts can be counted as a resource is revised. **(Reference APA WF # 10-65)**

6.a-57 AMENDING agency rules at OAC 317:30-5-1076 to clarify and to bring the language in line with current reimbursement practices and rules. **(Reference APA WF # 10-66)**

6.a-58 AMENDING agency rules at OAC 317:30-3-3 and ADDING Agency rules at OAC 317:30-5-575, 30-5-576, 30-5-577, and 30-5-578 to add clarification and differentiate between provider group and clinic contracts. Provider groups are business entities in which one or more individual providers practice. Provider clinics are facilities or distinct parts of facilities used for the diagnosis and treatment of outpatients. Provider clinics are limited to organizations serving specialized treatment requirements or distinct groups. Clinics must have a specialized contract with the Oklahoma Health Care Authority (OHCA). These rules allow the OHCA to effectively distinguish between provider business entities and treatment facilities during the contracting process. **(Reference APA WF # 10-67)**

6.a-59 AMENDING agency rules at OAC 317:30-3-27 to clarify that all services and/or networks be allowed and approved at the OHCA's discretion to ensure medical necessity. **(Reference APA WF # 10-68)**

6.a-60 AMENDING agency rules at OAC 317:35-17-3, 35-17-4, and 35-17-16 to remove language approving ADvantage services when services exceed the established cost cap. Additionally, waitlist procedures are revised to prohibit entry into the waiver at 90% of capacity, rather than the current 102% of capacity and all exceptions to the waitlist procedure are eliminated. Lastly, language is revised to state that OKDHS performs all eligibility determinations rather than the ADvantage Administration (AA). **(Reference APA WF # 10-69)**

6.a-61 ADDING agency rules at OAC 317:30-3-39 and AMENDING agency rules at OAC 317:30-3-40 through 30-3-41 to include general information about three new Waivers operated by the OHCA, the Medically Fragile Waiver, the My Life My Choice Waiver and the Sooner Seniors Waiver. **(Reference APA WF # 10-71)**

6.a-62 AMENDING Agency rules at OAC 317:35-5-6 and 35-5-6.1 to clarify that pregnant women have thirty (30) days within application submission to provide medical proof of pregnancy in order to continue receiving SoonerCare benefits. Previous policy allowed a period of ten (10) days for submission of pregnancy verification. **(Reference APA WF # 10-77)**

MOTION: Member Langenkamp moved for approval of rule 6.a-42 thru 6.a-62 as presented. Member Bryant seconded.

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

BOARD MEMBER ABSENT: Member McVay
Member McFall

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

Mr. Pallotta presented all of the following contracts in detail. See board packet.

7. a) Consideration and Vote for Authorization to Expend Funds to increase the Hewlett Packard(HP) Contract for the Development and Implementation of the Medicaid Management Information System

MOTION: Member Langenkamp moved for approval of contract as presented. Chairman Armstrong seconded.

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

BOARD MEMBER ABSENT: Member McVay
Member McFall

b) Action Item - Consideration and Vote for Authorization to Expend Funds to increase the Fox Systems Contract for Consultant Services for Medicaid Management Information System

MOTION: Chairman Armstrong moved for approval of contract as presented. Member Langenkamp seconded.

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

BOARD MEMBER ABSENT: Member McVay
Member McFall

Member McFall arrived at 2:10pm.

c) Action Item – Consideration and Vote for Authorization for Expenditure of Funds for Legal Representation Covington & Burling, LLP

MOTION: Member Miller moved for approval of contract as presented. Member McFall seconded.

FOR THE MOTION: Vice Chairman Armstrong, Member Bryant, Member Miller, Member

Langenkamp, Member McFall and Chairman Roggow

BOARD MEMBER ABSENT: Member McVay

d) Action Item – Consideration and Vote for Authority for Expenditure of Funds Behavioral Health Utilization Management Services

MOTION: Member Miller moved for approval of contract as presented. Member McFall seconded.

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

BOARD MEMBER ABSENT: Member McVay

Item to be presented by Chairman Roggow

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

MOTION: Member McFall moved for approval of Executive Session. Member Bryant seconded.

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

BOARD MEMBER ABSENT: Member McVay

9. New Business

There was no new business discussed.

10. **ADJOURNMENT**

MOTION: Member McFall moved for adjournment. Vice Chairman Armstrong seconded.

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

BOARD MEMBER ABSENT: Member McVay

FINANCIAL REPORT

For the Nine Months Ended March 31, 2011
Submitted to the CEO & Board
May 12, 2011

- Revenues for OHCA through March, accounting for receivables, were **$2,504,295,484** or **(1.3%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,509,648,297** or **1.8% under** budget.
- The state dollar budget variance through March is **$13,964,877 positive.**
- The prior year carryover was reduced by **$10,000,000** due to the Office of State Finance redistribution of State Fiscal Stabilization Funds.
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		10.4
Administration		5.2
Revenues:		
Prior Year-Reduction		(10.0)
Taxes and Fees		2.4
Drug Rebate		3.9
Overpayments/Settlements		2.1
Total FY 11 Variance	**$**	**14.0**

ATTACHMENTS

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

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

REVENUES	FY11 Budget YTD	FY11 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 579,046,927	$ 579,046,927	$ -	0.0%
Federal Funds	1,571,656,078	1,529,456,367	(42,199,711)	(2.7)%
Tobacco Tax Collections	40,205,369	41,029,075	823,706	2.0%
Quality of Care Collections	37,808,870	39,378,095	1,569,225	4.2%
Prior Year Carryover	45,663,786	35,663,786	(10,000,000)	(21.9)%
HEEIA Fund Transfer	30,000,000	30,000,000	-	0.0%
Federal Deferral - Interest	158,707	158,707	-	0.0%
Drug Rebates	94,148,922	105,228,639	11,079,717	11.8%
Medical Refunds	32,274,221	38,756,498	6,482,277	20.1%
Other Revenues	12,697,079	12,274,771	(422,309)	(3.3)%
Stimulus Funds Drawn	93,302,619	93,302,619	-	0.0%
TOTAL REVENUES	**$ 2,536,962,578**	**$ 2,504,295,484**	**$ (32,667,094)**	**(1.3)%**

EXPENDITURES	FY11 Budget YTD	FY11 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 32,683,890**	**$ 28,323,355**	**$ 4,360,535**	**13.3%**
ADMINISTRATION - CONTRACTS	**$ 81,596,428**	**$ 75,793,099**	**$ 5,803,329**	**7.1%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	23,188,360	20,647,137	2,541,223	11.0%
Acute Fee for Service Payments:				
Hospital Services	682,778,107	660,735,101	22,043,006	3.2%
Behavioral Health	212,359,705	214,553,489	(2,193,785)	(1.0)%
Physicians	312,835,362	325,238,287	(12,402,925)	(4.0)%
Dentists	117,798,769	108,528,763	9,270,006	7.9%
Other Practitioners	40,949,563	44,526,404	(3,576,841)	(8.7)%
Home Health Care	16,186,738	16,062,693	124,045	0.8%
Lab & Radiology	36,396,715	36,645,687	(248,972)	(0.7)%
Medical Supplies	39,495,523	35,849,852	3,645,672	9.2%
Ambulatory Clinics	69,278,619	58,994,452	10,284,168	14.8%
Prescription Drugs	272,396,577	260,308,149	12,088,428	4.4%
Miscellaneous Medical Payments	22,510,070	24,262,438	(1,752,368)	(7.8)%
OHCA TFC	-	1,834,456	(1,834,456)	0.0%
Other Payments:				
Nursing Facilities	366,372,788	367,310,358	(937,570)	(0.3)%
ICF-MR Private	40,617,809	41,722,147	(1,104,339)	(2.7)%
Medicare Buy-In	101,478,680	102,599,105	(1,120,425)	(1.1)%
Transportation	20,460,997	20,250,930	210,068	1.0%
HIT-Incentive Payments	14,858,736	14,858,736	-	0.0%
Part D Phase-In Contribution	51,947,450	50,603,660	1,343,790	2.6%
Total OHCA Medical Programs	**2,441,910,568**	**2,405,531,843**	**36,378,725**	**1.5%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,556,280,268**	**$ 2,509,648,297**	**$ 46,631,971**	**1.8%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (19,317,690)**	**$ (5,352,813)**	**$ 13,964,877**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2011, for the Nine Months Ended March 31, 2011

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 20,960,520	$ 20,630,446	$ -	$ 313,384	$ -	$ 16,690	$ -
Inpatient Acute Care	636,551,123	449,153,496	365,015	8,946,913	36,708,871	3,582,907	137,793,921
Outpatient Acute Care	177,929,512	166,588,642	31,203	7,004,700	-	4,304,967	
Behavioral Health - Inpatient	89,982,449	86,188,820	-	3,585	-	6,033	3,784,011
Behavioral Health - Outpatient	7,339,550	7,284,646	-	-	-	-	54,904
Behavioral Health Facility- Rehab	161,205,948	120,947,557	-	279,651	-	126,216	39,852,525
Behavioral Health - Case Management	218	149	-	-	-	69	
Residential Behavioral Management	17,235,535	-	-	-	-	-	17,235,535
Targeted Case Management	52,069,720	-	-	-	-	-	52,069,720
Therapeutic Foster Care	1,834,456	1,834,456	-	-	-	-	-
Physicians	362,828,840	273,762,576	43,576	10,012,814	43,883,494	7,548,641	27,577,739
Dentists	108,548,454	102,679,473	-	19,691	5,758,786	90,505	-
Other Practitioners	44,899,419	43,463,777	334,773	373,015	690,916	36,938	-
Home Health Care	16,062,693	16,018,762	-	-	-	43,931	-
Lab & Radiology	38,909,898	35,499,364	-	2,264,210	-	1,146,323	-
Medical Supplies	36,287,240	33,734,990	2,038,376	437,389	-	76,486	-
Ambulatory Clinics	68,822,145	58,485,781	-	1,240,588	-	508,671	8,587,106
Personal Care Services	9,307,733	-	-	-	-	-	9,307,733
Nursing Facilities	367,310,358	234,399,514	102,614,298	-	30,261,506	35,039	-
Transportation	20,250,930	18,356,721	1,840,937	-	46,199	7,073	-
GME/IME/DME	87,216,110	-	-	-	-	-	87,216,110
ICF/MR Private	41,722,147	34,212,827	6,879,580	-	629,740	-	-
ICF/MR Public	56,448,744	-	-	-	-	-	56,448,744
CMS Payments	153,202,765	151,237,615	1,965,150	-	-	-	-
Prescription Drugs	272,146,072	226,157,611	-	11,837,923	32,199,023	1,951,515	-
Miscellaneous Medical Payments	24,262,615	23,118,522	-	177	1,039,558	104,358	-
Home and Community Based Waiver	116,175,629	-	-	-	-	-	116,175,629
Homeward Bound Waiver	66,875,285	-	-	-	-	-	66,875,285
Money Follows the Person	3,524,819	-	-	-	-	-	3,524,819
In-Home Support Waiver	18,132,469	-	-	-	-	-	18,132,469
ADvantage Waiver	136,585,267	-	-	-	-	-	136,585,267
Family Planning/Family Planning Waiver	5,613,881	-	-	-	-	-	5,613,881
Premium Assistance*	40,582,504	-	-	40,582,504	-	-	-
HIT Grant Incentive Payments	14,858,736	14,858,736					
Total Medicaid Expenditures	**$ 3,275,683,785**	**$2,118,614,480**	**$ 116,112,908**	**$ 83,316,543**	**$ 151,218,093**	**$ 19,586,361**	**$ 786,835,399**

* Includes $40,387,674.35 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2011, for the Nine Months Ended March 31, 2011

		FY11 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	316,360,821
Federal Funds		511,906,486
TOTAL REVENUES	**$**	**828,267,306**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	116,175,629
Money Follows the Person		3,524,819
Homeward Bound Waiver		66,875,285
In-Home Support Waivers		18,132,469
ADvantage Waiver		136,585,267
ICF/MR Public		56,448,744
Personal Care		9,307,733
Residential Behavioral Management		13,237,110
Targeted Case Management		39,894,449
Total Department of Human Services		**460,181,505**
State Employees Physician Payment		
Physician Payments		27,577,739
Total State Employees Physician Payment		**27,577,739**
Education Payments		
Graduate Medical Education		42,900,000
Graduate Medical Education - PMTC		3,321,976
Indirect Medical Education		28,813,252
Direct Medical Education		12,180,882
Total Education Payments		**87,216,110**
Office of Juvenile Affairs		
Targeted Case Management		2,149,957
Residential Behavioral Management - Foster Care		43,049
Residential Behavioral Management		3,955,377
Multi-Systemic Therapy		54,904
Total Office of Juvenile Affairs		**6,203,287**
Department of Mental Health		
Targeted Case Management		98
Hospital		3,784,011
Mental Health Clinics		39,852,525
Total Department of Mental Health		**43,636,635**
State Department of Health		
Children's First		1,575,787
Sooner Start		1,793,899
Early Intervention		4,755,858
EPSDT Clinic		1,510,908
Family Planning		56,699
Family Planning Waiver		5,520,067
Maternity Clinic		67,589
Total Department of Health		**15,280,808**
County Health Departments		
EPSDT Clinic		600,957
Family Planning Waiver		37,115
Total County Health Departments		**638,072**
State Department of Education		**105,515**
Public Schools		**3,588,055**
Medicare DRG Limit		**135,030,011**
Native American Tribal Agreements		**4,613,752**
Department of Corrections		**102,505**
JD McCarty		**2,661,405**
Total OSA Medicaid Programs	**$**	**786,835,399**
OSA Non-Medicaid Programs	**$**	**53,710,991**
Accounts Receivable from OSA	**$**	**12,279,084**

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

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 39,346,084	$ 39,346,084
Interest Earned	32,011	32,011
TOTAL REVENUES	**$ 39,378,095**	**$ 39,378,095**

EXPENDITURES	FY 11 Total $ YTD	FY 11 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 99,796,483	$ 35,118,383	
Eyeglasses and Dentures	217,775	76,635	
Personal Allowance Increase	2,600,040	914,954	
Coverage for DME and supplies	2,038,376	717,305	
Coverage of QMB's	774,567	272,570	
Part D Phase-In	1,965,150	1,965,150	
ICF/MR Rate Adjustment	3,676,485	1,293,755	
Acute/MR Adjustments	3,203,095	1,127,169	
NET - Soonerride	1,840,937	647,826	
Total Program Costs	**$ 116,112,908**	**$ 42,133,746**	**$ 42,133,746**
Administration			
OHCA Administration Costs	$ 399,313	$ 199,656	
DHS - 10 Regional Ombudsman	159,103	159,103	
OSDH-NF Inspectors	243,085	243,085	
Mike Fine, CPA	13,500	6,750	
Total Administration Costs	**$ 815,001**	**$ 608,594**	**$ 608,594**
Total Quality of Care Fee Costs	**$ 116,927,909**	**$ 42,742,340**	
TOTAL STATE SHARE OF COSTS			**$ 42,742,340**

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 Nine Months Ended March 31, 2011

REVENUES	FY 10 Carryover	FY 11 Revenue	Total Revenue
Prior Year Balance	$ 45,276,770	$ -	$ 7,497,524
State Appropriations	(30,000,000)		
Tobacco Tax Collections	-	33,745,035	33,745,035
Interest Income	-	853,980	853,980
Federal Draws	383,873	25,182,089	25,182,089
All Kids Act	(7,729,892)	270,108	270,108
TOTAL REVENUES	$ 7,930,751	$ 60,051,212	$ 67,278,628

EXPENDITURES	FY 10 Expenditures	FY 11 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 40,129,550	$ 40,129,550
College Students		194,830	194,830
All Kids Act		258,124	258,124
Individual Plan			
SoonerCare Choice		$ 306,289	$ 107,783
Inpatient Hospital		8,892,212	3,129,169
Outpatient Hospital		6,932,781	2,439,646
BH - Inpatient Services		3,585	1,261
BH Facility - Rehabilitation Services		278,096	97,862
Physicians		9,922,536	3,491,741
Dentists		14,036	4,939
Other Practitioners		365,099	128,478
Home Health		-	-
Lab and Radiology		2,237,090	787,232
Medical Supplies		435,790	153,355
Ambulatory Clinics		1,229,191	432,552
Prescription Drugs		11,732,298	4,128,596
Miscellaneous Medical		177	62
Premiums Collected		-	(1,683,635)
Total Individual Plan		$ 42,349,180	$ 13,219,041
College Students-Service Costs		$ 350,806	$ 123,449
All Kids Act- Service Costs		$ 34,054	$ 11,984
Total Program Costs		$ 83,316,543	$ 53,936,978
Administrative Costs			
Salaries	$ 22,395	$ 1,044,055	$ 1,066,450
Operating Costs	117,115	105,082	222,197
Health Dept-Postponing	29,637	-	29,637
Contract - HP	264,080	2,230,909	2,494,988
Total Administrative Costs	$ 433,227	$ 3,380,046	$ 3,813,272
Total Expenditures			$ 57,750,250
NET CASH BALANCE	$ 7,497,524		$ 9,528,377

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 Nine Months Ended March 31, 2011

REVENUES	FY 11 Revenue	State Share
Tobacco Tax Collections	$ 673,464	$ 673,464
TOTAL REVENUES	**$ 673,464**	**$ 673,464**

EXPENDITURES	FY 11 Total $ YTD	FY 11 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 16,690	$ 4,111	
Inpatient Hospital	3,582,907	882,470	
Outpatient Hospital	4,304,967	1,060,313	
Inpatient Free Standing	6,033	1,486	
MH Facility Rehab	126,216	31,087	
Case Mangement	69	17	
Nursing Facility	35,039	8,630	
Physicians	7,548,641	1,859,230	
Dentists	90,505	22,291	
Other Practitioners	36,938	9,098	
Home Health	43,931	10,820	
Lab & Radiology	1,146,323	282,339	
Medical Supplies	76,486	18,838	
Ambulatory Clinics	508,671	125,286	
Prescription Drugs	1,951,515	480,658	
Transportation	7,073	1,742	
Miscellaneous Medical	104,358	25,703	
Total Program Costs	$ 19,586,361	$ 4,824,121	**$ 4,824,121**
TOTAL STATE SHARE OF COSTS			**$ 4,824,121**

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

March 2011 Data for May 2011 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2010	Enrollment March 2011	Total Expenditures March 2011	Average Dollars Per Member Per Month March 2011
SoonerCare Choice Patient-Centered Medical Home			435,958	**456,045**	**$150,803,926**	
	Lower Cost	*(Children/Parents; Other)*		410,236	$102,709,565	$250
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		45,809	$48,094,361	$1,050
SoonerCare Traditional			219,646	**237,670**	**$236,299,832**	
	Lower Cost	*(Children/Parents; Other)*		132,546	$85,668,533	$646
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		105,124	$150,631,299	$1,433
SoonerPlan			23,255	**33,654**	**$682,272**	$20
Insure Oklahoma			28,594	**32,349**	**$10,532,464**	
	Employer-Sponsored Insurance		17,857	19,246	$5,013,852	$261
	Individual Plan		10,736	13,103	$5,518,613	$421
TOTAL			**707,453**	**759,718**	**$398,318,495**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $22,790,489 are excluded.

Net Enrollee Count Change from Previous Month Total	7,625

New Enrollees	20,625

Opportunities for Living Life (OLL) (subset of data above)

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,893
Aged/Blind/Disabled	*Adult*	128,778
Other	*Child*	146
Other	*Adult*	19,540
PACE	*Adult*	79
TEFRA	*Child*	385
Living Choice	*Adult*	130
OLL Enrollment		**168,951**

The "Other" category includes DDSD State, PKU, Q1, Q2, Refugee, SLMB, Soon-to-be-Sooners (STBS) and TB members.

Medicare and SoonerCare	Monthly Average SFY2010	Enrolled March 2011
Dual Enrollees	**100,143**	**104,538**

		Monthly Average SFY2010	Enrolled March 2011
Long-Term Care Members		**15,820**	**15,655**
	Child	37	87
	Adult	15,783	15,568

PER MEMBER PER MONTH

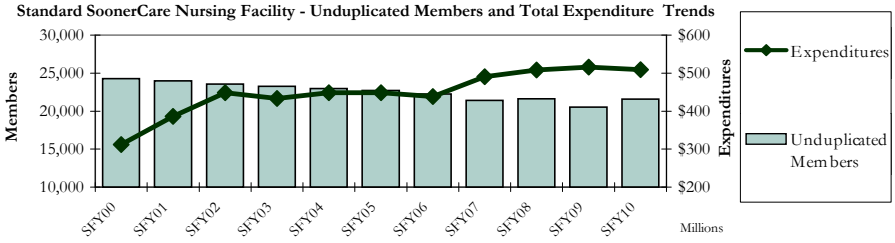
$3,637

SFY2010 Long-Term Care

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

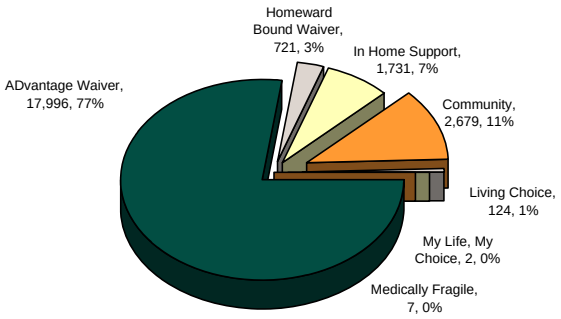
Data as of September 2010

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Oct. 15, 2010. Figures do not include intermediate care facilities for the mentally retarded (ICF/MR).

Waiver Enrollment Breakdown Percent



ADvantage Waiver - Serves frail elderly individuals age 65 or older and adults age 21 and older with physical disabilities who would otherwise require placement in a nursing facility.
Community - serves individuals 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the mentally retarded/intellectually disabled (ICF/MR).
Homeward Bound Waiver - Designed to serve the needs of individuals with intellectual disabilities or "related conditions" who are also members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center, et al, who would otherwise qualify for placement in an ICF/MR.
In Home Support - Serves the needs of individuals 3 years of age and older with intellectual disabilities who would otherwise require placement in an ICF/MR.
Living Choice - Promotes community living for people of all ages who have disabilities or long-term illnesses.
Medically Fragile - This program serves qualifying individuals who meet hospital or skilled nursing facility level of care.
My Life, My Choice - This program is for adults with physical disabilities who transitioned to the community under the Living Choice program.

Pharmacy Program Overview and 10 Year Stats Review

Nancy Nesser, PharmD, JD
Pharmacy Director
May 12, 2011

Federal Medicaid Pharmacy Policy

- Covered Drugs
  - Federal Drug Rebate Agreement
- Optional/Excludable Coverage
  - *Cough and cold**
  - Fertility
  - Cosmetic
  - Weight loss/gain
  - Nutritional Supplements
  - *Smoking cessation**
  - *Non-prescription**
    - **some coverage for these items under the State Plan*

Federal Drug Rebate Program

- If a drug has a rebate, Medicaid must cover it *unless* it is in an optional or excluded category.
  - Prior authorization is the primary tool given to states for managing pharmacy program
- Generally, a manufacturer contracts for all of their product line.
- Fed rebates FY 10 = $131 million
- State Supplemental Rebates = $7 million
- 30% of spend

Comparison 2001 to 2010

FY 2001	FY 2010
HMO's	No HMO's (2004)
Dual Eligibles	No Dual Eligibles (06)
3 Rx limit	6 Rx limit (04)
280,000 mem/mo	680,000 mem/mo
PMPM $39 ($48)	PMPM $44

Pharmacy Benefit as of 1-1-10

- **6 Rx per month with 2 brand limit**
  - **Some drugs don't count**
    - **HIV antiretrovirals, Chemo, BC**
  - **Long Term Care – no limit**
  - **Children under 21 - no limit**
  - **ADvantage and other waiver programs – 7 extra generics + Therapy Management**

SoonerCare Pharmacy Policy

- Dispensing limitation
  - 34 days supply
  - Maintenance list up to 100 units
  - Over 150 drugs with specific quantity limits based on FDA maximum dose
- Aggressive use of Prior Authorization
  - Over 300 drug products require PA or Step Therapy
- Copayments – sliding scale
  - 0, 0.65, 1.20, 2.40, 3.50

Prior Authorization Types

- **Utilization**
  - Quantity, duration
- **Scope**
  - Specific diagnosis
- **Step Therapy or "Product Based" (PBPA)**
  - Use most cost-efficient products first

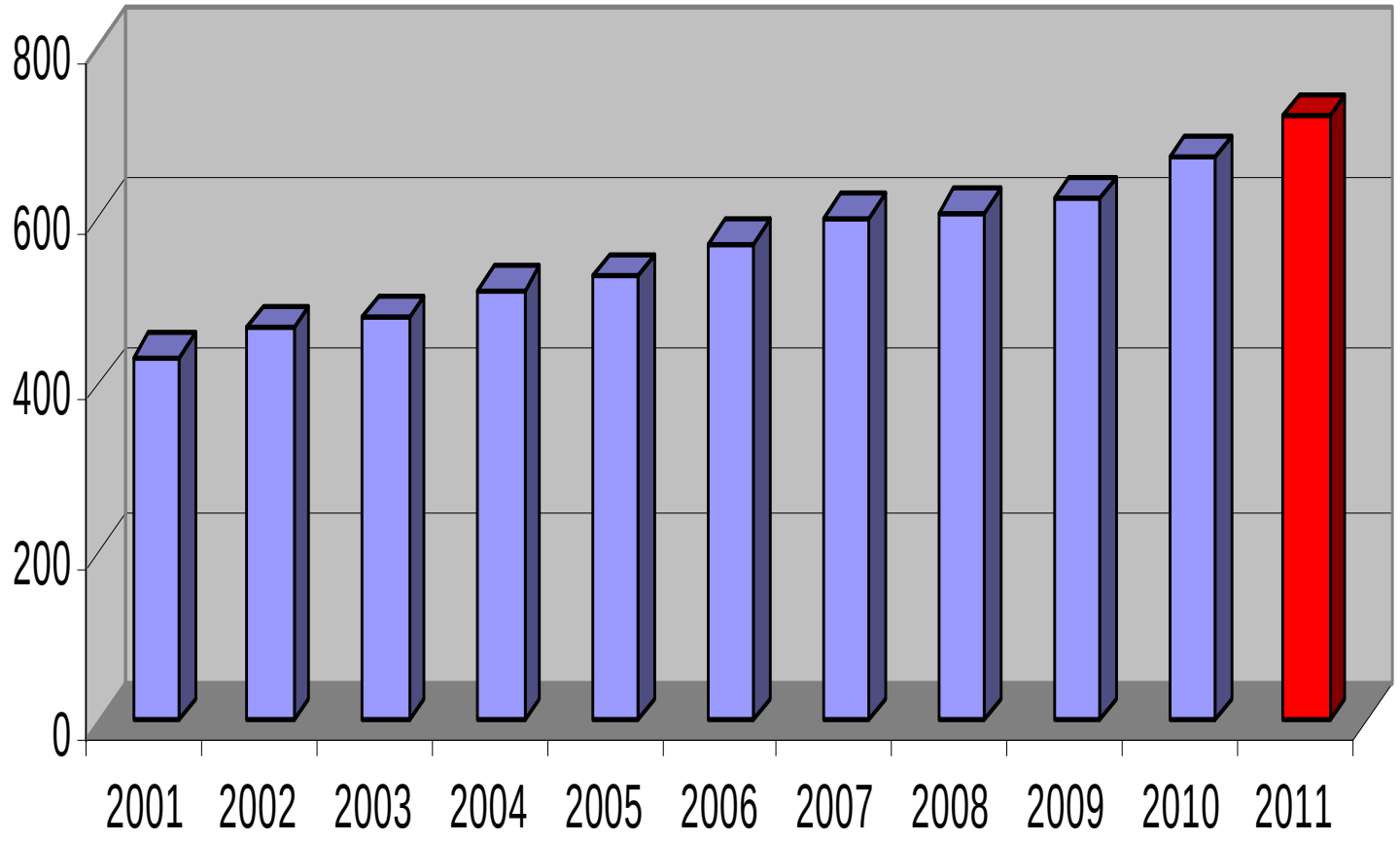
Comparison 2001 to 2010

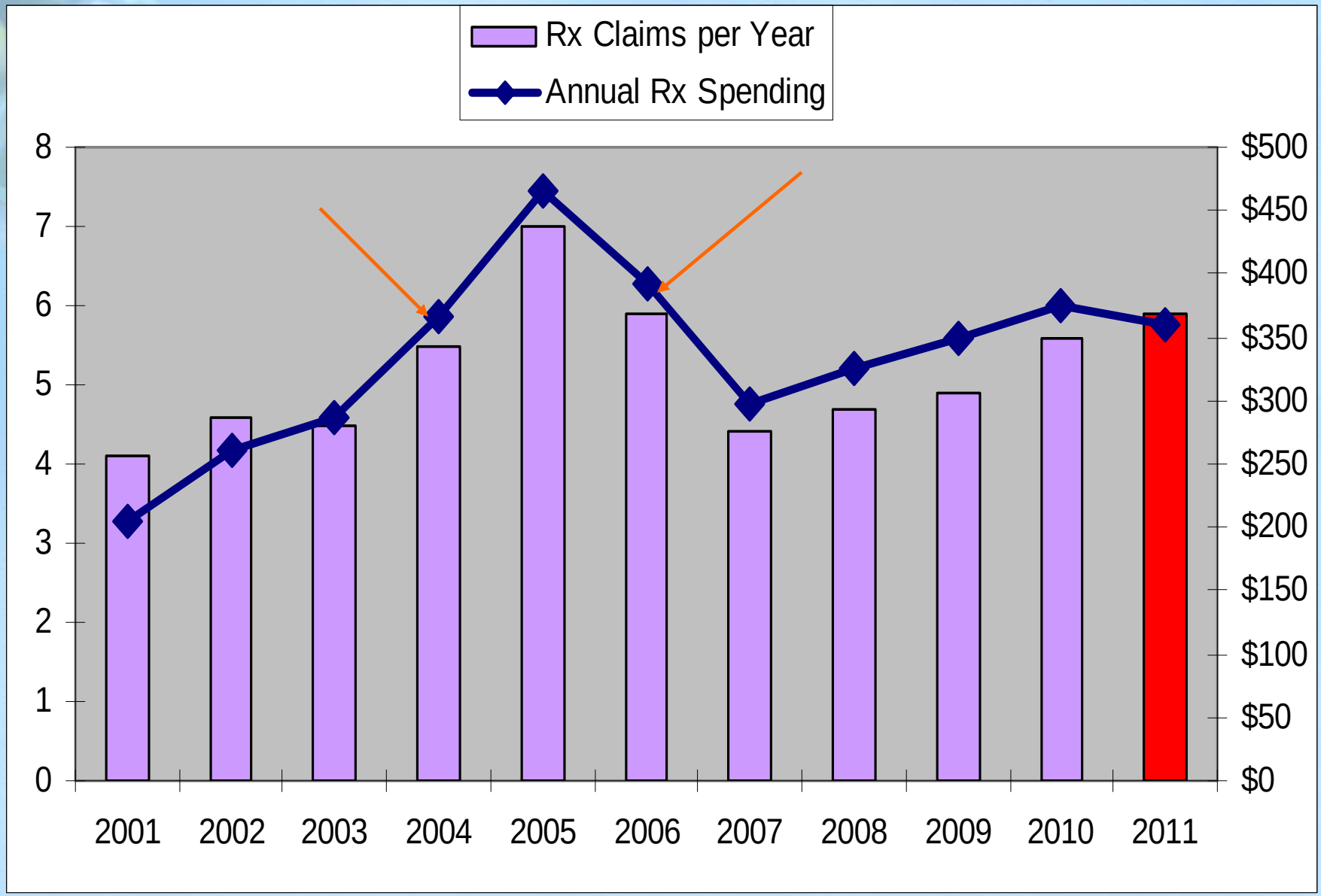
FY 2001	FY 2010
$204 million	$375 million
4.1 million Rx	5.6 million Rx
280,000 elig/mo	680,000 elig/mo
102,000 use/mo	197,000 use/mo
$50/rx	$66/rx
3.4 rx/user/mo	2.6 rx/user/mo
$39 PMPM	$44 PMPM
48% generic	77% generic

SFY 2010 Drug Benefit Stats

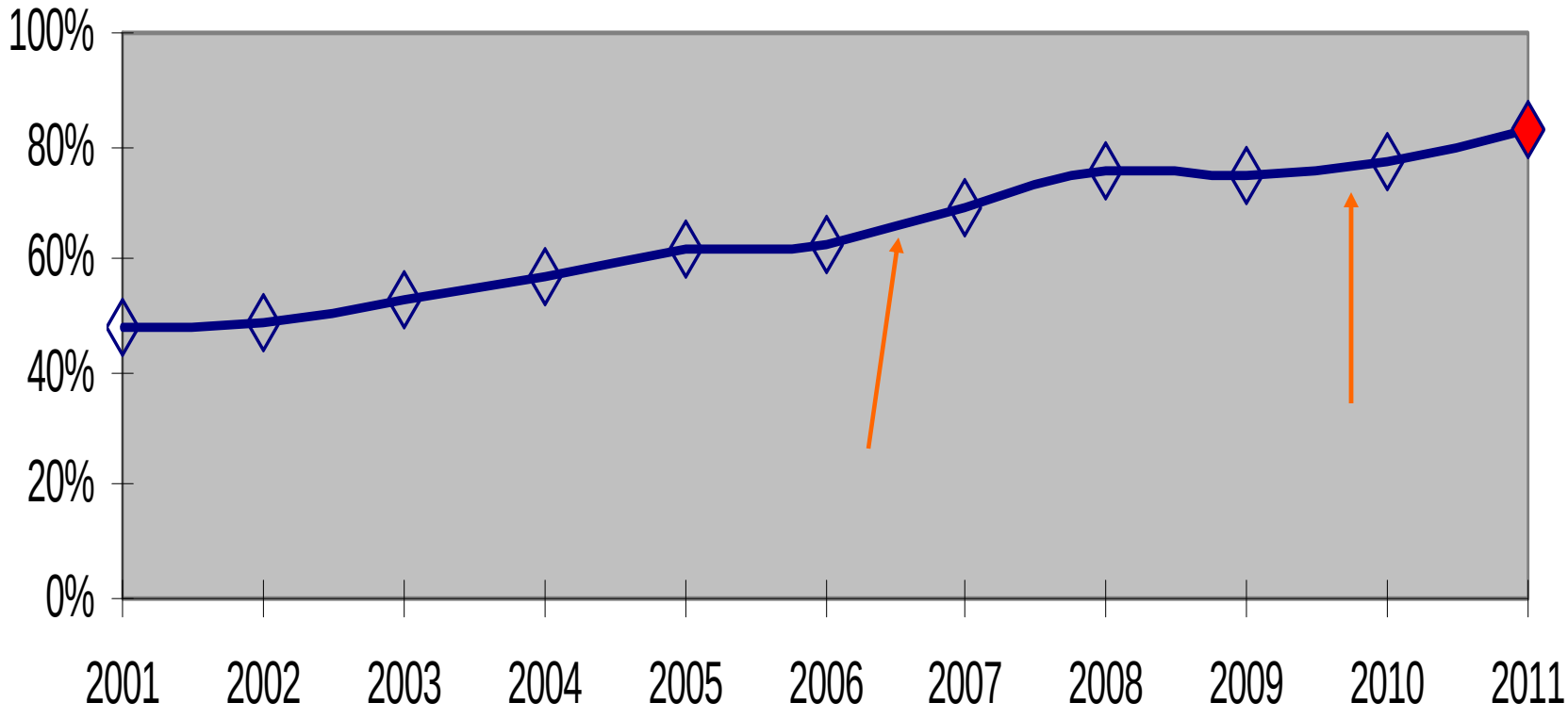
- **$375 million** Rx expenditures
- Monthly cost per Rx user- $169.00
- **5.6 million** paid Rx claims
- Average monthly Rx Clients – 197,000
- Average Rx cost - $66.57
- Average Claims/client/month – 2.6
- **77% generic utilization**

Average Monthly Eligibles

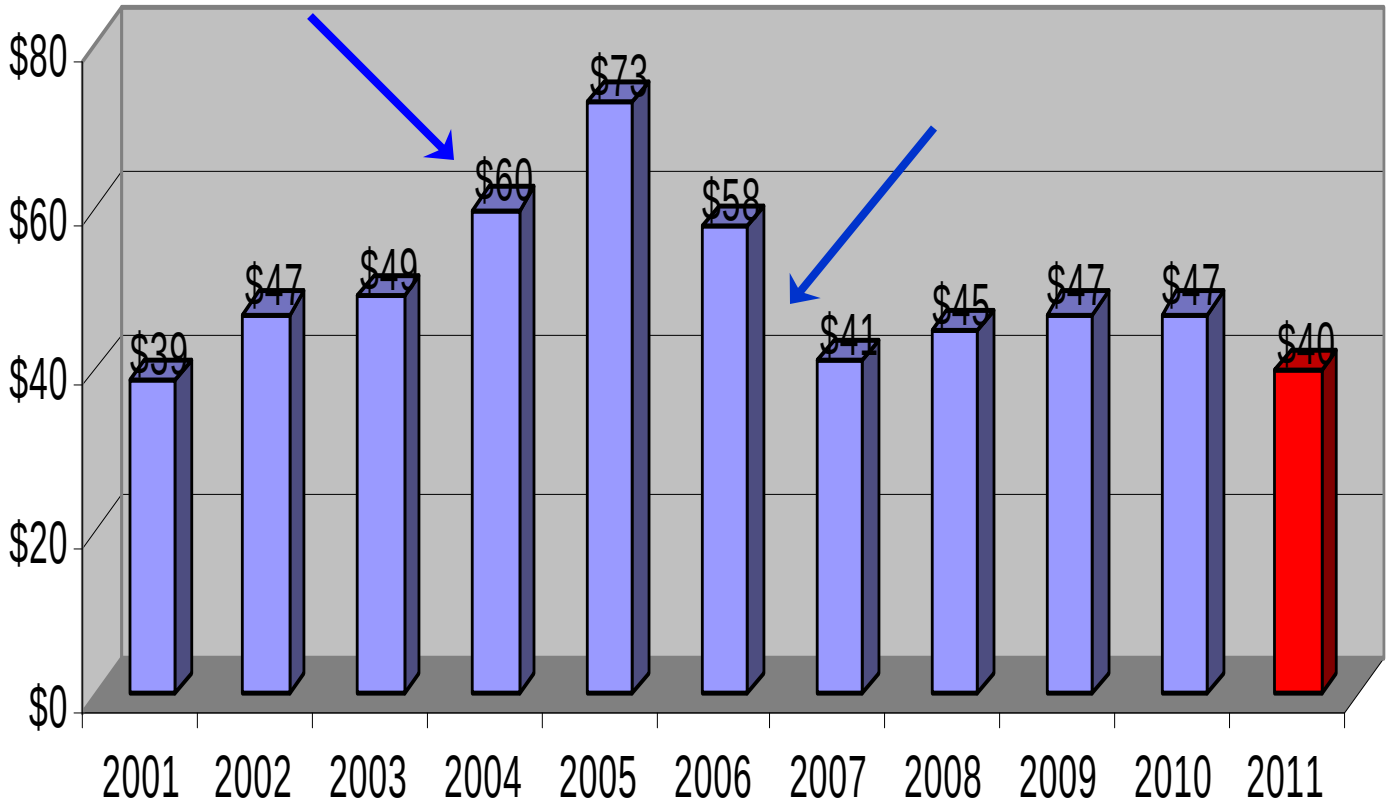


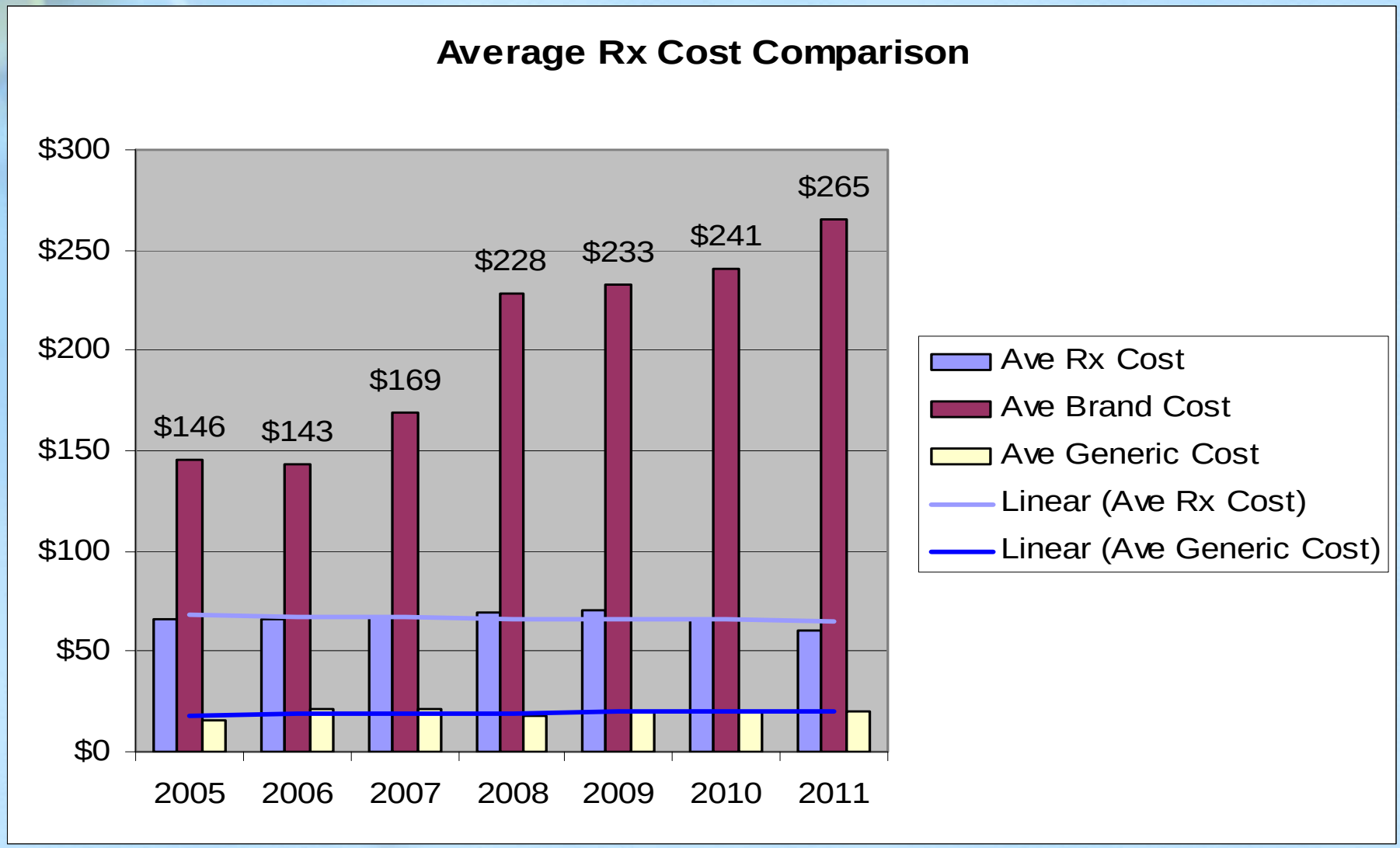

Rx Claims per Year
Annual Rx Spending
8
7
6
5
4
3
2
1
0
$500
$450
$400
$350
$300
$250
$200
$150
$100
$50
$0
2001
2002
2003
2004
2005
2006
2007
2008
2009
2010
2011

Generic Dispensing Rate



Average Pharmacy Spending Per Member Per Month




Average Rx Cost Comparison
$300
$250
$200
$150
$100
$50
$0
$146
$143
$169
$228
$233
$241
$265
2005
2006
2007
2008
2009
2010
2011
Ave Rx Cost
Ave Brand Cost
Ave Generic Cost
Linear (Ave Rx Cost)
Linear (Ave Generic Cost)

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2010	Enrolled March 2011
Total Providers		**28,000**	**28,871**
	In-State	19,563	20,509
	Out-of-State	8,437	8,362

Program	% of Capacity Used
SoonerCare Choice	41%
SoonerCare Choice I/T/U	12%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2010**	*In-State Enrolled March 2011***	Total Monthly Average SFY2010	Total Enrolled March 2011
Physician	*6,074*	*6,480*	10,664	11,808
Pharmacy	*879*	*903*	1,168	1,231
Mental Health Provider	*908*	*949*	983	991
Dentist	*790*	*802*	893	910
Hospital	*179*	*186*	790	754
Licensed Behavioral Health Practitioner	*N/A*	*523*	N/A	543
Extended Care Facility	*392*	*393*	395	393

*The In-State Monthly Averages above were recalculated due to a change in the original methodology.

Total Primary Care Providers	*4,072*	*4,429*	6,063	6,418
Patient-Centered Medical Home	*1,339*	*1,484*	1,360	1,510

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

**Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

	March 2011		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	326	$6,927,500	353	$7,501,250
Eligible Hospitals	12*	$10,576,612	16	$13,047,307
Totals	326	$17,504,112	369	$20,548,557

*Current Eligible Hospitals Paid

GREAT PLAINS REGIONAL MEDICAL CENTER
INTEGRIS BASS MEMORIAL BAPTIST HOSPITAL
INTEGRIS GROVE HOSPITAL
HOLDENVILLE GENERAL HOSPITAL
MAYES COUNTY MEDICAL CENTER
DUNCAN REGIONAL HOSPITAL
INTEGRIS SOUTHWEST MEDICAL
OKMULGEE MEMORIAL HOSPITAL
INTEGRIS MARSHALL MEM HOSPITAL
INTEGRIS CANADIAN VALLEY HOSPITAL
GRADY MEMORIAL HOSPITAL
INTEGRIS BAPTIST MEDICAL CENTER

OHCA BOARD MEETING

MAY 12, 2011 OHCA BOARD MEETING

OHCA REQUEST BILLS:

- SB 0412 – Sen. Bill Brown – Prohibits Commercial Insurance Companies From Charging Fees to Process SoonerCare Secondary Claims
- SB 0679 – Sen. Clark Jolley – Allows Administrative Sanctions to Medicaid Recipients Who Abuse the State Medicaid Program

After the April 28th deadline and as of noon Wednesday, May 4th, the Oklahoma Legislature is currently tracking a total of 682 bills. OHCA is currently tracking 64 bills. They are broken down as follows:

- OHCA Request 02
- Direct Impact & Agency Interest 34
- Appropriations 06
- Employee Interest 10
- Governor Signed 12

May 27, 2011 is Sine Die of the first session of the 53rd Legislature

A Legislative Bill Tracking Report will be included in your handout at the board Meeting.

Oklahoma Healthcare Authority
office relocation proposal

NE 18th St. and N Walnut Ave.
Oklahoma City, OK

18 WEST PARK PLACE, OKC, OK 73103 V.405.231.1990 - F.405.231.1930 - WWW.MASSARCH.COM

EXTERIOR RENDERINGS

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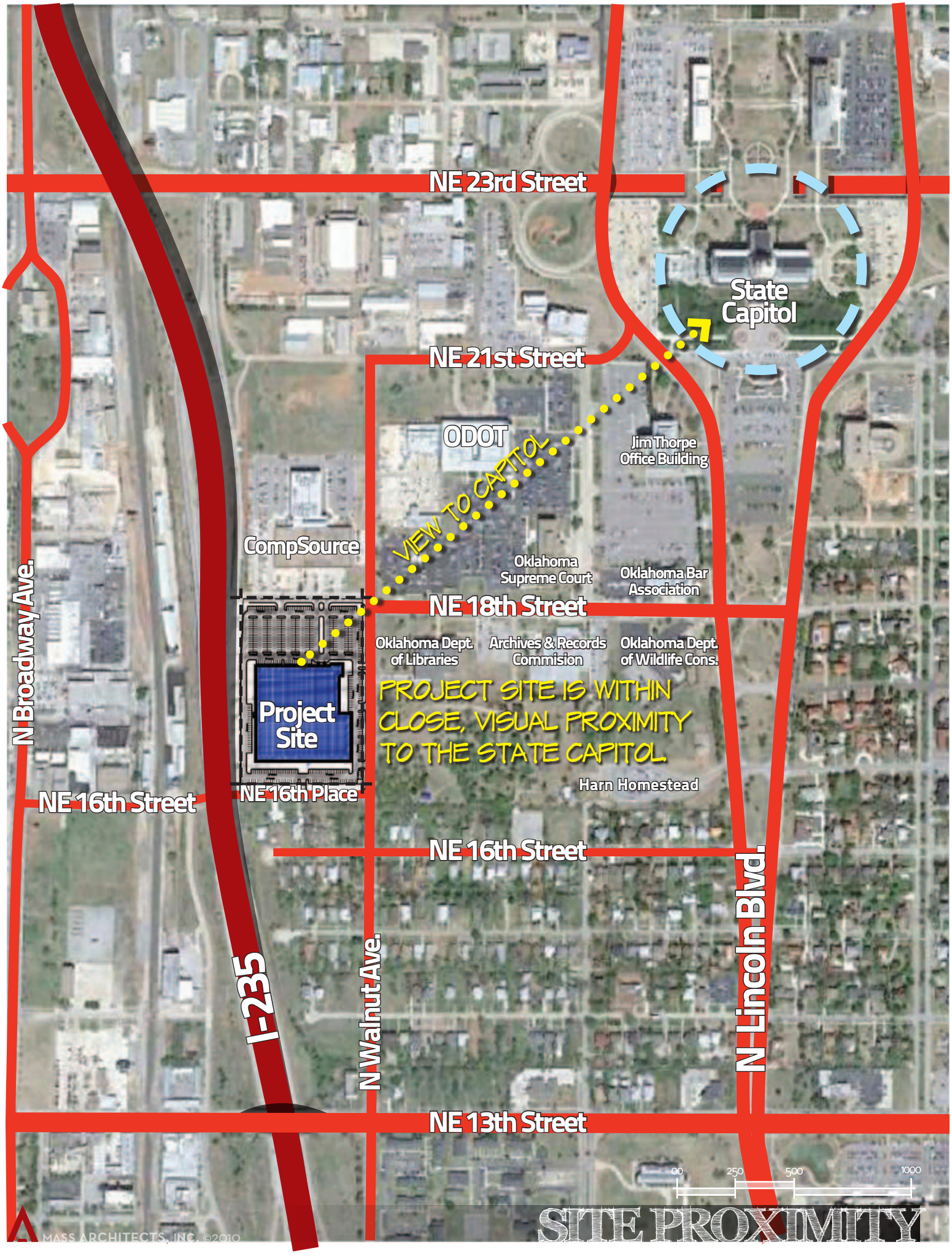
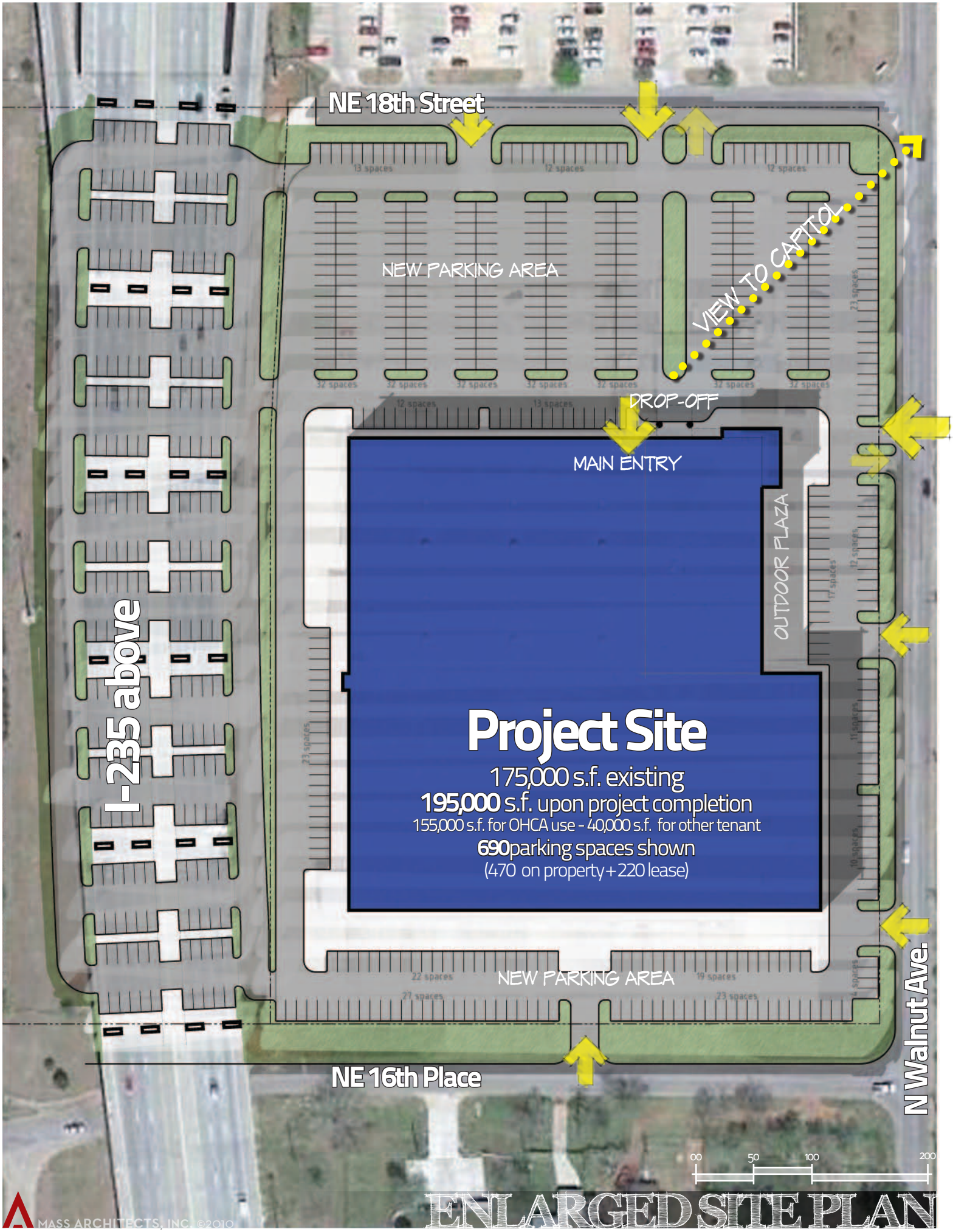
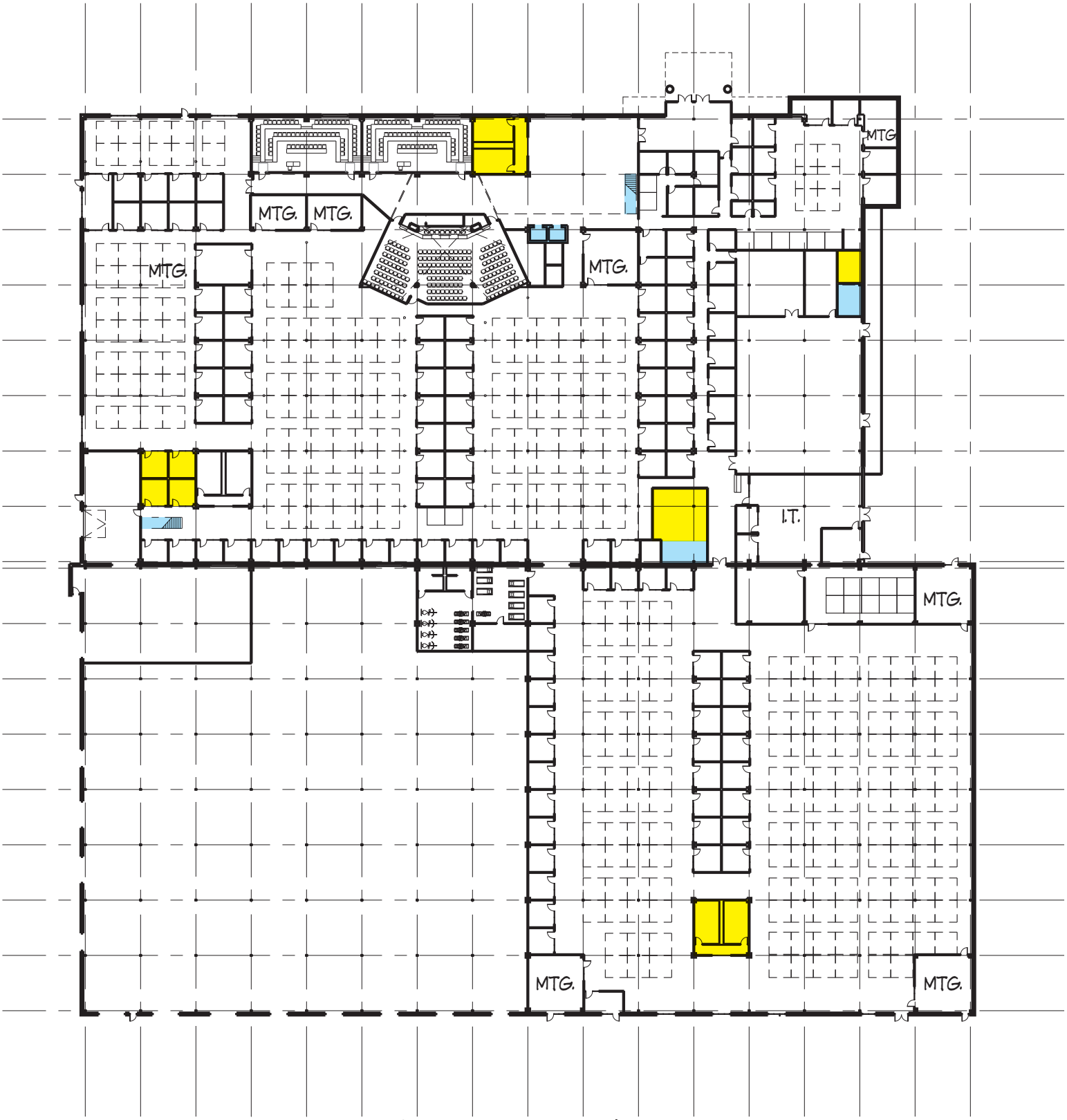
AERIAL RENDERING




PRIMARY ACCESS WILL BE FROM I-235 EXITING ONTO 23rd ST. LINCOLN OR BROADWAY WILL PROVIDE DIRECT ACCESS TO THE SITE.
LINCOLN BLVD. ALSO PROVIDES ACCESS FROM I-44.
NE 23rd Street
State Capitol
NE 21st Street
N Broadway Ave.
NE 18th Street
Project Site
NE 16th Place
NE 16th Street
NE 16th ST. PROVIDES ACCESS FROM BROADWAY.
NE 16th Street
N Walnut Ave.
I-235
N Lincoln Blvd.
NE 13th Street
NE 13th ST. PROVIDES ACCESS TO/FROM THE DOWNTOWN AREA.
00
250
500
1000
VEHICULAR APPROACH
MASS ARCHITECTS, INC. ©2010



ENLARGED SITE PLAN



	GL	2L	total
OFFICES	107	94	201
SEMIPRIVATE	330	45	375
WORKSTATIONS ONLY	8	10	18
Totals	445	149	594
MEETING ROOMS (of various sizes)	8	6	14

00 30 60 120

FLOOR PLAN

00 30 60 120

FLOOR PLAN

INTERIOR RENDERINGS

Oklahoma Healthcare Authority
office relocation proposal

NE 18th St. and N Walnut Ave.
Oklahoma City, OK

18 WEST PARK PLACE, OKC, OK 73103 V.405.231.1990 - F.405.231.1930 - WWW.MASSARCH.COM

Information for the packet:
Recommendation 1: Prior Authorize Zyflo (zileuton) CR®

The Drug Utilization Review Board recommends prior authorization of Zyflo (zileuton) CR® with the following criteria:

Children age 12 and older and adults:

- Diagnosis of mild or moderate persistent asthma, AND
- Trial of inhaled corticosteroid AND corticosteroid/LAB_2A therapy within the previous 6 months and reason for trial failure, AND
- Recent trial with at least one other available leukotriene modifier that did not yield adequate response.

Recommendation 2: Prior Authorize Benign Prostatic Hyperplasia (BPH) Medications

The Drug Utilization Review Board recommends the addition of the BPH class of medications to the Product Based Prior Authorization program.

Tier 1	Tier 2
Hytrin® (Terazosin)	Uroxatrol® (Alfuzosin)
Cardura® (Doxazosin)	Rapaflo® (Silodosin)
Flomax® (Tamsulosin)	Cardura XL® (Doxazosin)
Proscar® (Finasteride)	Avodart® (Dutasteride)
	Jalyn® (Dutasteride/Tamsulosin)

Prior Authorization Criteria:

1. FDA approved diagnosis.
2. Recent 4-week trial of at least two Tier 1 medications from different pharmacological classes within the last 90 days.
3. Documented adverse effect, drug interaction, or contraindication to all available Tier 1 products.