OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
June 9, 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 Lyle Roggow, Chairman

1. Call To Order/Determination of Quorum
2. Action Item – Approval of May 12, 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. "Evaluation of OHCA Paid Claims against Oregon's Prioritized List" - Alison Martinez, Clinical Data Analyst
   c) Legislative Update – Nico Gomez, Deputy Chief Executive Officer

Item to be presented by Mike Fogarty, Chief Executive Officer

4. Discussion Item – FY 2012 Budget Update, Mike Fogarty, CEO

Items to be presented by Lyle Roggow, 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.

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 317:35-5-42 to comply with the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 which requires state Medicaid agencies to disregard federal tax refunds or advance payments with respect to refundable tax credits as income and as resources for purposes of determining eligibility. To bring Agency policy in compliance with this law, eligibility rules and income guidelines are revised to eliminate consideration of the Earned Income Tax Credit, which is the only refundable tax credit currently counted for eligibility purposes.
(Reference APA WF # 11-02)

7.b-2 AMENDING Agency rules at OAC 317:45-9-4, 45-11-10, 45-11-12, 45-11-24, 45-11-25 and 45-13-1 to ensure Insure Oklahoma cost-sharing rules comply with Federal law on Native American cost-sharing exemptions. Native American adults are exempt from Insure Oklahoma—Individual Plan co-pays or premiums when they receive services provided by Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/U) providers or through referral by contract health services. Native American children are exempt from cost-sharing regardless of whether they receive services provided by I/T/U providers or through referral by contract health services.
(Reference APA WF # 11-05)

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 methodology for the Supplemental Hospital Offset Payment Program (SHOPP);
b) Consideration and Vote of 2010 Upper Payment Limit Gap;
c) Consideration and Vote of 2010 Total Medicaid Hospital Payments.

Item to be presented by James Smith, Administrative Chief of Staff

9. Action Item - Consideration and Vote for the Expenditure of Funds for Oklahoma Health Care Authority Lease Option Years 1 and 2

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

10. 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 Pradaxa® (dabigatran etexilate mesylate) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

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

11. a) Consideration and Vote to authorize expenditure of funds for Iowa Foundation for Medical Care (IFMC)

Item to be presented by Chairman Roggow

12. **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)**

A. Oklahoma Health Care Authority Employee Incentives

B. Status of pending suits and claims

1. Choices v. OHCA	CJ-09-229-01	Garfield County, OK
2. Morris v. OHCA	CIV-09-1357C	USDC, Western District of OK
3. Harper v. OHCA	5:10-cv-00514-R	USDC, Western District of OK
4. Wittenberg v. OHCA	10 CV-0238	Oklahoma County, OK
5. Hauenstein v. OHCA	CIV-10-940-M	USDS, Western District of OK
6. Nitschke v. SoonerRide	CJ-10-435-02	Garfield County, OK
7. White Horse Ranch v. OHCA	CV-2011-12	Woodward County,OK
8. Lexis Nexis v. OHCA	CS-2011-4327	Oklahoma County,OK
9. 2010 DMH Administrative	DAB A-10-73	CMS Departmental Appeals Board

Item to be presented by Chairman Roggow

13. Action Item - Consideration and Vote regarding Base Pay and Performance Based Incentives for Chief Executive Officer
    (a)Consideration and Vote regarding Base Pay Increase
    (b)Consideration and Vote regarding Performance Incentives
    (c)Consideration and Vote regarding Future Performance Incentives

14. Action Item – Election of Oklahoma Health Care Authority 2012 Board Officers

15. New Business

16. **ADJOURNMENT**

NEXT BOARD MEETING
July 14, 2011
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
May 12, 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 May 10, 2011.

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

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

BOARD MEMBERS ABSENT: Member McVay
Member Bryant
Chairman Roggow

OTHERS PRESENT:	OTHERS PRESENT:
Will Widman, HPES	Charles Brodt, HPES
Tracy Jones,Chickasaw Nation	Becky Moore
Paul Davis, DMH	Jeannie Fair, DHS
Dean Clancy, OU/Tulsa	Debbie Williams, State Auditors
Rick Snyder, OHA	

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD MAY 12, 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: Member McFall moved for approval of the May 12 2011 board minutes as published. Member Langenkamp seconded.

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

BOARD MEMBER ABSENT: Member McVay
Member Bryant
Chairman Roggow

FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

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**

MEDICAID DIRECTOR'S UPDATE
Garth Splinter, MD

Dr. Splinter reported on program statistics. He noted that for the last 2 months the Medical Home Population has gone up about 10,000, the SoonerCare Traditional is down about 3,000, SoonerPlan has a 2,000 increase, and Insure Oklahoma remains essentially flat with just over 32,000. The total for all programs is about 760,000. Dr. Splinter stated that the total dollars distributed across several categories is up $107 million over January. The total enrollment change is 7,500 with the nursing home numbers still flat with about 15,655, and provider network looking still the same. He stated that in regard to the Electronic Health Records Incentive Program we had 326 health professionals receiving checks and 12 hospitals with a total payout of $17.5 million which brings the total up to $20.5 million. We were the first in the nation on the provider incentive payment and that program continues to move forward. For further details, see Item 3b of the board packet.

PHARMACY DIRECTOR'S UPDATE
Nancy Nesser, PharmD, JD.

Dr. Nesser presented an overview slide presentation of the Pharmacy Program 10 year stats review. The following areas were covered: 1)Federal Medicaid Pharmacy Policy; 2)Federal Drug Rebate Program; 3)Comparison 2001 to 2010; 4)Pharmacy Benefit as of 1-1-10; 5)SoonerCare Pharmacy Policy; 6)Prior Authorization Types; 7)SFY 2010 Drug Benefit Stats; 8)Average Monthly Eligibles; 9)Rx Claims per Year and Annual Rx Spending; 10)Generic Dispensing Rate; 11)Average Pharmacy Spending Per Member Per Month; and 12) the Average Rx Cost Comparison. For a full detailed report, see Item 3b-1 of the board packet.

LEGISLATIVE UPDATE
Mike Fogarty, Chief Executive Office

Mr. Fogarty reported for Mr. Gomez who was at the Capitol. Mr. Fogarty gave accomalades for Mr. Gomez in his incredible job effectiveness at

the Capitol. It appears Sine Die may come a week earlier than projected and will end on a positive note. The March rules (62) have been quite the subject and overwhelming in review with legislators. The debates have been good and the resolution to disapprove the rule was considered yesterday and defeated 7-5. The following report is the bills currently being tracked:

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

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

RELOCATION UPDATE

Joe Hodges, Special Project/Relocation Manager

Mr. Hodges discussed the site selection process and stated that it was narrowed down to about 3 that met the RFP specifications. Out of that 3, there was a round table discussion with 2 being identified and then the winner. He then presented the slide presentation of the new location (NW 16th and Walnut), the layout of the new building, and parking lot plus the underground parking under I-235. He reported that the lease will consist of a 7-10 year period. Mr. Hodges said that we are using Mass Architects which are the capitol complex architects, and Miller Tippins will be the construction company with 12 months of ongoing construction hopefully starting in June 2011. We are within the Capitol Complex with Capitol Security. Mr. Hodges reported that the cost per square foot will be $100.00 in this public/private process. We will have a 7-10 year lease on a build to suit costing $200 less per square foot than it would cost the state to build it, and we will have an option to buy the facility at the end of the 7 year period of time. We will be using about 75% of the present capacity and take 20,000 square feet for our warehouse/storage.

OHCA TEAM DAY REPORT

Paul Gibson, Auditor III/Performance and Reporting

Mr. Gibson stated that May 5th was Quality Oklahoma Team Day at the state capitol. This year a total of 55 teams from 10 state agencies participated in the event. There were 13 teams from OHCA that presented projects and 11 were considered for commendation and 2 presented booth-only displays. He noted that 5 of the 11 OHCA projects were awarded the Governor's Commendation for Excellence. Those

projects are as follows: SooneCare Choice: Oklahoma's Patient Centered Medical Home Program-Provider Services; OHCA Online Enrollment-enrollment Automations and Data Integrity Unit; Practice Facilitation: Strengthening Primary Care For Chronic Illness in Oklahoma through the SoonerCare Health Management Program-Health Management from Care Management; Measuring Success: SoonerCare's Payment Accuracy Project-PERM Unit from Program Integrity and Accountability; and Statewide Care Management Oversight Project-Care Management. Mr. Gibson stated that that other Team Day Projects included projects from the Child Health Unit; Provider Services BH Unit and Financial Services; Health Policy and Waiver & Development Unit; Provider Services BH Unit; Public Information. There were also 2 Booth-Only Exhibits from OLL and Child Health Unit. Mr. Gibson thanked everyone for their participation.

SFY 2010 SINGLE STATE AUDIT FINDINGS OF OHCA

Debbie Williams, Audit Manager, State Auditor and Inspectors Office

Ms. Roberts introduced Ms. Williams from the State Auditor and Inspectors Office. Ms. Williams stated that the Single Audit of the Oklahoma Health Care Authority for the fiscal year ending June 30, 2010 was performed and we performed audit testing of federal compliance at Oklahoma Health Care Authority for the following federal programs:

- Children's Health Insurance Program(CHIP), CFDA #93.767
- State Medicaid Fraud Control Units, DFDA #93.775
- State Survey and Certification of Health Care Providers and Suppliers, CFDA#93.777
- Medical Assistance Program, CFDA #93.778

Material CAFR accounts audited at the Oklahoma Health Care Authority were:

- Federal Grants Receivable
- Accounts Payable/accrued Liabilities
- Federal Grants Revenue
- Health Services Expenditures
- Miscellaneous Claims Expenditures

Ms. Williams stated that the (non-significant) reported findings were being worked on in an effort to bring into federal and state compliance.

REPORTS TO THE BOARD BY BOARD COMMITTEES

Chairman Roggow

Audit/Finance Committee

Member Miller stated the committee did meet and discussed the financial report in detail and also the audit report which was previously discussed.

Legislative Committee

Mr. McFall stated that there has been ongoing phone calls and e-mails related to the hospital fee. The 80-15 vote in favor of the fee will

help OHCA in the future. Mr. Gomez will have a completed legislative update at the June board meeting.

Rules Committee

Member Langenkamp stated the Rules Committee did meet regarding the resolutions and the report has been given.

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 Item 7(a)(b).

CONSIDERATION AND BOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATAION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES § 5030.3
Nancy Nesser, PharmD.JD, Pharmacy Director

Dr. Nesser presented the following recommendations for approval:

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

7b) 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.

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

Item to be presented by Chairman Roggow

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 Langenkamp moved for approval of Executive Session. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member Miller, Member Langenkamp, and Member McFall

BOARD MEMBER ABSENT:	Member McVay Member Bryant Chairman Roggow

NEW BUSINESS

None

ADJOURNMENT

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

FINANCIAL REPORT

For the Nine Months Ended April 30, 2011
Submitted to the CEO & Board
June 9, 2011

- Revenues for OHCA through April, accounting for receivables, were **$2,750,593,583** or **(1.1%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,788,283,493** or **1.6% under** budget.
- The state dollar budget variance through April is **$16,015,549 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	9.3
Administration	7.1
Revenues:	
Prior Year-Reduction	(10.0)
Taxes and Fees	2.0
Drug Rebate	6.2
Overpayments/Settlements	1.4
Total FY 11 Variance	**$ 16.0**

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 Ten Months Ended April 30, 2011

REVENUES	FY11 Budget YTD	FY11 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 619,323,208	$ 619,323,208	$ -	0.0%
Federal Funds	1,732,240,907	1,689,228,049	(43,012,858)	(2.5)%
Tobacco Tax Collections	45,097,789	46,083,861	986,072	2.2%
Quality of Care Collections	42,168,482	43,155,330	986,848	2.3%
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	184,352	184,352	-	0.0%
Drug Rebates	120,597,319	138,301,095	17,703,776	14.7%
Medical Refunds	35,526,913	40,047,472	4,520,559	12.7%
Other Revenues	12,948,099	12,478,557	(469,543)	(3.6)%
Stimulus Funds Drawn	96,127,874	96,127,874	-	0.0%
TOTAL REVENUES	**$ 2,779,878,729**	**$ 2,750,593,583**	**$ (29,285,146)**	**(1.1)%**

EXPENDITURES	FY11 Budget YTD	FY11 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 36,194,690**	**$ 31,731,810**	**$ 4,462,880**	**12.3%**
ADMINISTRATION - CONTRACTS	**$ 93,003,771**	**$ 83,860,577**	**$ 9,143,194**	**9.8%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	25,510,182	22,798,025	2,712,157	10.6%
Acute Fee for Service Payments:				
Hospital Services	740,844,836	728,395,695	12,449,141	1.7%
Behavioral Health	234,658,154	238,383,343	(3,725,189)	(1.6)%
Physicians	361,156,199	360,968,131	188,067	0.1%
Dentists	131,002,293	120,841,506	10,160,787	7.8%
Other Practitioners	45,064,260	49,578,304	(4,514,044)	(10.0)%
Home Health Care	17,963,876	17,759,427	204,449	1.1%
Lab & Radiology	40,062,159	40,359,804	(297,645)	(0.7)%
Medical Supplies	43,514,052	39,654,272	3,859,780	8.9%
Ambulatory Clinics	69,538,324	65,727,383	3,810,941	5.5%
Prescription Drugs	300,144,139	288,319,037	11,825,102	3.9%
Miscellaneous Medical Payments	24,816,337	27,227,523	(2,411,185)	(9.7)%
OHCA TFC	-	2,146,678	(2,146,678)	0.0%
Other Payments:				
Nursing Facilities	405,362,679	405,098,905	263,774	0.1%
ICF-MR Private	45,235,173	46,134,464	(899,291)	(2.0)%
Medicare Buy-In	113,182,212	114,394,101	(1,211,888)	(1.1)%
Transportation	22,788,534	22,762,332	26,202	0.1%
HIT-Incentive Payments	25,241,544	25,241,544	-	0.0%
Part D Phase-In Contribution	58,211,392	56,900,633	1,310,759	2.3%
Total OHCA Medical Programs	**2,704,296,345**	**2,672,691,106**	**31,605,239**	**1.2%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,833,584,188**	**$ 2,788,283,493**	**$ 45,300,695**	**1.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (53,705,459)**	**$ (37,689,910)**	**$ 16,015,549**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2011, for the Ten Months Ended April 30, 2011

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 23,146,778	$ 22,779,462	$ -	$ 348,754	$ -	$ 18,563	$ -
Inpatient Acute Care	695,433,952	493,684,269	405,572	9,964,361	40,787,635	3,921,209	146,670,906
Outpatient Acute Care	197,330,348	184,825,886	34,670	7,733,337	-	4,736,455	
Behavioral Health - Inpatient	98,407,043	94,613,415	-	3,585	-	6,033	3,784,011
Behavioral Health - Outpatient	8,208,958	8,149,348	-	-	-	-	59,610
Behavioral Health Facility- Rehab	186,316,354	135,479,713	-	314,676	-	134,617	50,387,347
Behavioral Health - Case Management	218	149	-	-	-	69	
Residential Behavioral Management	18,605,807	-	-	-	-	-	18,605,807
Targeted Case Management	60,265,680	-	-	-	-	-	60,265,680
Therapeutic Foster Care	2,146,678	2,146,678	-	-	-	-	-
Physicians	402,801,362	303,754,686	48,417	11,253,505	48,759,438	8,405,590	30,579,726
Dentists	120,863,661	114,312,595	-	22,154	6,428,489	100,422	-
Other Practitioners	49,991,305	48,397,751	371,970	413,002	767,685	40,898	-
Home Health Care	17,759,508	17,710,587	-	80	-	48,840	-
Lab & Radiology	42,837,045	39,103,238	-	2,477,241	-	1,256,566	-
Medical Supplies	40,131,992	37,307,300	2,264,863	477,721	-	82,109	-
Ambulatory Clinics	76,065,197	65,162,345	-	1,372,084	-	565,037	8,965,730
Personal Care Services	10,287,041	-	-	-	-	-	10,287,041
Nursing Facilities	405,098,905	258,681,860	113,003,805	-	33,378,202	35,039	-
Transportation	22,762,332	20,651,066	2,051,978	-	51,545	7,743	-
GME/IME/DME	87,644,318	-	-	-	-	-	87,644,318
ICF/MR Private	46,134,464	37,842,603	7,592,149	-	699,711	-	-
ICF/MR Public	61,379,767	-	-	-	-	-	61,379,767
CMS Payments	171,294,733	169,128,983	2,165,750	-	-	-	-
Prescription Drugs	301,505,287	250,413,931	-	13,186,249	35,776,692	2,128,414	-
Miscellaneous Medical Payments	27,227,700	25,958,167	-	177	1,155,064	114,292	-
Home and Community Based Waiver	128,660,502	-	-	-	-	-	128,660,502
Homeward Bound Waiver	74,037,194	-	-	-	-	-	74,037,194
Money Follows the Person	3,811,811	-	-	-	-	-	3,811,811
In-Home Support Waiver	19,981,505	-	-	-	-	-	19,981,505
ADvantage Waiver	150,426,714	-	-	-	-	-	150,426,714
Family Planning/Family Planning Waiver	6,197,697	-	-	-	-	-	6,197,697
Premium Assistance*	45,185,648	-	-	45,185,648	-	-	-
HIT Grant Incentive Payments	25,241,544	25,241,544					
Total Medicaid Expenditures	**$ 3,627,189,045**	**$2,355,345,575**	**$ 127,939,175**	**$ 92,752,574**	**$ 167,804,460**	**$ 21,601,896**	**$ 861,745,366**

* Includes $44,657153.59 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2011, for the Ten Months Ended April 30, 2011

REVENUE		FY11 Actual YTD
Revenues from Other State Agencies	$	344,103,963
Federal Funds		560,763,314
TOTAL REVENUES	**$**	**904,867,277**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	128,660,502
Money Follows the Person		3,811,811
Homeward Bound Waiver		74,037,194
In-Home Support Waivers		19,981,505
ADvantage Waiver		150,426,714
ICF/MR Public		61,379,767
Personal Care		10,287,041
Residential Behavioral Management		14,600,875
Targeted Case Management		46,595,485
Total Department of Human Services		**509,780,893**
State Employees Physician Payment		
Physician Payments		30,579,726
Total State Employees Physician Payment		**30,579,726**
Education Payments		
Graduate Medical Education		42,900,000
Graduate Medical Education - PMTC		3,750,184
Indirect Medical Education		28,813,252
Direct Medical Education		12,180,882
Total Education Payments		**87,644,318**
Office of Juvenile Affairs		
Targeted Case Management		2,371,221
Residential Behavioral Management - Foster Care		49,555
Residential Behavioral Management		3,955,377
Multi-Systemic Therapy		59,610
Total Office of Juvenile Affairs		**6,435,762**
Department of Mental Health		
Targeted Case Management		98
Hospital		3,784,011
Mental Health Clinics		50,387,347
Total Department of Mental Health		**54,171,457**
State Department of Health		
Children's First		1,750,417
Sooner Start		1,983,583
Early Intervention		5,159,545
EPSDT Clinic		1,647,559
Family Planning		59,363
Family Planning Waiver		6,096,363
Maternity Clinic		72,660
Total Department of Health		**16,769,490**
County Health Departments		
EPSDT Clinic		648,175
Family Planning Waiver		41,972
Total County Health Departments		**690,146**
State Department of Education		**114,516**
Public Schools		**4,274,398**
Medicare DRG Limit		**143,636,117**
Native American Tribal Agreements		**4,613,752**
Department of Corrections		**102,505**
JD McCarty		**2,932,284**
Total OSA Medicaid Programs	**$**	**861,745,366**
OSA Non-Medicaid Programs	**$**	**60,527,105**
Accounts Receivable from OSA	**$**	**17,405,193**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 230: Nursing Facility Quality of Care Fund

Fiscal Year 2011, for the Ten Months Ended April 30, 2011

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 43,117,194**	**$ 43,117,194**
Interest Earned	**38,136**	**38,136**
TOTAL REVENUES	**$ 43,155,330**	**$ 43,155,330**

EXPENDITURES	FY 11 Total $ YTD	FY 11 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 109,875,266	$ 38,665,106	
Eyeglasses and Dentures	239,779	84,378	
Personal Allowance Increase	2,888,760	1,016,555	
Coverage for DME and supplies	2,264,863	797,005	
Coverage of QMB's	860,630	302,856	
Part D Phase-In	2,165,750	2,165,750	
ICF/MR Rate Adjustment	4,048,435	1,424,644	
Acute/MR Adjustments	3,543,715	1,247,033	
NET - Soonerride	2,051,978	722,091	
Total Program Costs	**$ 127,939,175**	**$ 46,425,418**	**$ 46,425,418**
Administration			
OHCA Administration Costs	$ 439,146	$ 219,573	
DHS - 10 Regional Ombudsman	159,103	159,103	
OSDH-NF Inspectors	243,085	243,085	
Mike Fine, CPA	16,500	8,250	
Total Administration Costs	**$ 857,834**	**$ 630,011**	**$ 630,011**
Total Quality of Care Fee Costs	**$ 128,797,009**	**$ 47,055,430**	
TOTAL STATE SHARE OF COSTS			**$ 47,055,430**

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 Ten Months Ended April 30, 2011

REVENUES	FY 10 Carryover	FY 11 Revenue	Total Revenue
Prior Year Balance	$ 45,276,770	$ -	$ 7,548,983
State Appropriations	(30,000,000)		
Tobacco Tax Collections	-	37,580,878	37,580,878
Interest Income	-	893,908	893,908
Federal Draws	383,873	29,428,033	29,428,033
All Kids Act	(7,678,434)	321,566	321,566
TOTAL REVENUES	**$ 7,982,209**	**$ 68,224,386**	**$ 75,451,802**

EXPENDITURES	FY 10 Expenditures	FY 11 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 44,657,154	$ 44,657,154
College Students		220,900	220,900
All Kids Act		307,951	307,951
Individual Plan			
SoonerCare Choice		$ 340,765	$ 119,915
Inpatient Hospital		9,909,645	3,487,204
Outpatient Hospital		7,650,372	2,692,166
BH - Inpatient Services		3,585	1,261
BH Facility - Rehabilitation Services		312,823	110,083
Physicians		11,151,518	3,924,219
Dentists		15,443	5,435
Other Practitioners		403,953	142,151
Home Health		80	28
Lab and Radiology		2,447,748	861,362
Medical Supplies		475,978	167,497
Ambulatory Clinics		1,359,436	478,386
Prescription Drugs		13,071,632	4,599,907
Miscellaneous Medical		177	62
Premiums Collected		-	(1,683,635)
Total Individual Plan		**$ 47,143,156**	**$ 14,906,042**
College Students-Service Costs		**$ 385,080**	**$ 135,510**
All Kids Act- Service Costs		**$ 38,690**	**$ 13,615**
Total Program Costs		**$ 92,752,931**	**$ 60,241,171**
Administrative Costs			
Salaries	$ 22,395	$ 1,164,447	$ 1,186,842
Operating Costs	117,115	109,015	226,131
Health Dept-Postponing	29,637	-	29,637
Contract - HP	264,080	2,230,909	2,494,988
Total Administrative Costs	**$ 433,227**	**$ 3,504,371**	**$ 3,937,598**
Total Expenditures			**$ 64,178,770**
NET CASH BALANCE	**$ 7,548,983**		**$ 11,273,032**

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 Ten Months Ended April 30, 2011

REVENUES	FY 11 Revenue	State Share
Tobacco Tax Collections	$ 756,432	$ 756,432
TOTAL REVENUES	**$ 756,432**	**$ 756,432**

EXPENDITURES	FY 11 Total $ YTD	FY 11 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 18,563	$ 4,572	
Inpatient Hospital	3,921,209	965,794	
Outpatient Hospital	4,736,455	1,166,589	
Inpatient Free Standing	6,033	1,486	
MH Facility Rehab	134,617	33,156	
Case Mangement	69	17	
Nursing Facility	35,039	8,630	
Physicians	8,405,590	2,070,297	
Dentists	100,422	24,734	
Other Practitioners	40,898	10,073	
Home Health	48,840	12,029	
Lab & Radiology	1,256,566	309,492	
Medical Supplies	82,109	20,223	
Ambulatory Clinics	565,037	139,169	
Prescription Drugs	2,128,414	524,228	
Transportation	7,743	1,907	
Miscellaneous Medical	114,292	28,150	
Total Program Costs	$ 21,601,896	$ 5,320,547	**$ 5,320,547**
TOTAL STATE SHARE OF COSTS			**$ 5,320,547**

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

April 2011 Data for June 2011 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2010	Enrollment April 2011	Total Expenditures April 2011	Average Dollars Per Member Per Month April 2011
SoonerCare Choice Patient-Centered Medical Home		435,958	**448,103**	**$117,087,692**	
Lower Cost	*(Children/Parents; Other)*		402,476	$78,891,179	$196
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		45,627	$38,196,513	$837
SoonerCare Traditional		219,646	**246,457**	**$206,024,132**	
Lower Cost	*(Children/Parents; Other)*		141,130	$68,334,842	$484
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		105,327	$137,689,290	$1,307
SoonerPlan		23,255	**34,708**	**$579,192**	$17
Insure Oklahoma		28,594	**32,523**	**$9,349,441**	
Employer-Sponsored Insurance		17,857	19,196	$4,530,812	$236
Individual Plan		10,736	13,327	$4,818,629	$362
TOTAL		**707,453**	**761,791**	**$333,040,457**	

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 $23,494,150 are excluded.

Net Enrollee Count Change from Previous Month Total	2,073

New Enrollees	20,517

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

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,908
Aged/Blind/Disabled	*Adult*	128,918
Other	*Child*	136
Other	*Adult*	19,611
PACE	*Adult*	78
TEFRA	*Child*	383
Living Choice	*Adult*	119
OLL Enrollment		**169,153**

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 April 2011
Dual Enrollees	**100,143**	**104,812**

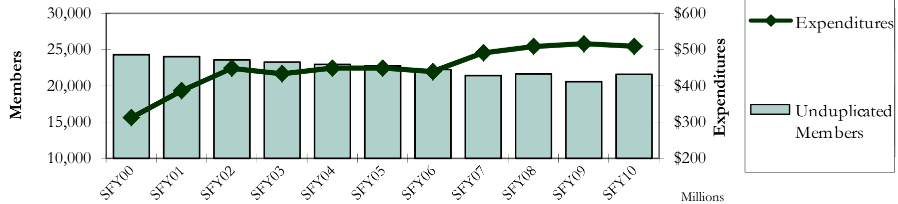
		Monthly Average SFY2010	Enrolled April 2011	PER MEMBER PER MONTH
Long-Term Care Members		**15,820**	**15,657**	**$3,246**
	Child	37	93	
	Adult	15,783	15,564	

SFY2010 Long-Term Care

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

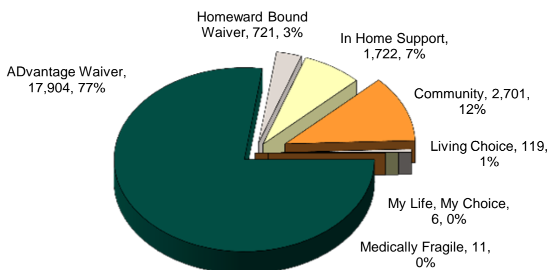
Data as of September 2010

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.

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2010	Enrolled April 2011
Total Providers		**28,000**	**28,795**
	In-State	19,563	20,331
	Out-of-State	8,437	8,464

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 SFY2010**	*In-State Enrolled April 2011***	Total Monthly Average SFY2010	Total Enrolled April 2011
Physician	*6,074*	*6,539*	10,664	11,974
Pharmacy	*879*	*903*	1,168	1,233
Mental Health Provider	*908*	*956*	983	1,001
Dentist	*790*	*822*	893	934
Hospital	*179*	*187*	790	778
Licensed Behavioral Health Practitioner	*N/A*	*538*	N/A	565
Extended Care Facility	*392*	*394*	395	394

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

Total Primary Care Providers	*4,072*	*4,496*	6,063	6,543
Patient-Centered Medical Home	*1,339*	*1,488*	1,360	1,516

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.

	April 2011		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	77	$1,636,250	430	$9,137,500
Eligible Hospitals	6*	$3,056,737	22	$16,104,044
Totals	77	$4,692,987	452	$25,241,544

*Current Eligible Hospitals Paid

INTEGRIS BAPTIST REGIONAL HEALTH CENTER
JANE PHILLIPS EP HOSPITAL
INTEGRIS CLINTON REGIONAL HOSPITAL
BLACKWELL REGIONAL HOSPITAL
CHOCTAW MEMORIAL HOSPITAL
INTEGRIS SEMINOLE MEDICAL CENTER

Evaluation of OHCA Paid Claims Against Oregon's Prioritized List

Oklahoma Health Care Authority
Board Meeting

06/09/2011

Project Objectives

- Compare OHCA's paid claims to the Oregon Health System's Prioritized List
- Determine whether there is any high spending on conditions and/or treatments not covered under the Oregon system

If OHCA's claims match up well with Oregon's prioritized list, it provides additional external validation of our benefit structure

Oregon’s Health Care Plan

- In 1994, Oregon received a waiver to determine health care benefits according to a Prioritized List of paired conditions and treatments that explicitly incorporates medical logic
  - For example, coverage of a given diagnosis does not imply coverage of all treatments for that diagnosis
- Groups of condition-treatment pairs have been ranked based on:
  - Rank order among 9 broad health care categories
  - Population and individual impact measures
  - Effectiveness
  - Percentage requiring medical services
  - Net cost used to break any ties
- The end result is a prioritized list of ~700 lines, each representing a related group of diagnoses and treatments

Example Lines

- Line 1: Maternity Care for Pregnancy
- Line 2: Newborn Care for Birth of Infant

↓

- Line 26: Medical Therapy for Cystic Fibrosis
- Line 27: Medical/Psychotherapy for Schizophrenic Disorders

↓

- Line 220: Suture/Repair for Rupture of Liver
- Line 221: Medical and Surgical Treatment (Including Chemotherapy and Radiation Therapy) for Cancer of Thyroid

↓

- Line 553: Medical Therapy for Tension Headaches
- Line 554: Medical Therapy for Mild Psoriasis

↓

- Line 679: Evaluation of Gastrointestinal Conditions with No or Minimally Effective Treatments

Claim Payment Methodology

- The Oregon legislature sets a funding level for the Prioritized List of Health Services, which determines the cutoff for the benefits package
  - Actuaries determine the cost to provide each service on this list
  - Services are covered from Line 1 through as many additional lines as funding allows
- Currently, Oregon covers through line 502 of the Prioritized List
- Any condition/treatment pairs falling below this cutoff are not part of Oregon's benefits package
  - Upon diagnosis, providers use the List to determine whether the condition and treatment fall within the currently funded region
  - Providers can offer services beyond the currently funded line if the client agrees to be billed for these services

Matching OHCA Claims

- Most of OHCA's calendar year 2010 physician claims could be matched to an Oregon line

- Overall, our paid claims match very well with the condition/treatment pairs in Oregon's benefits package
  - 98% of claims by volume and by dollars would fall within Oregon's funded range

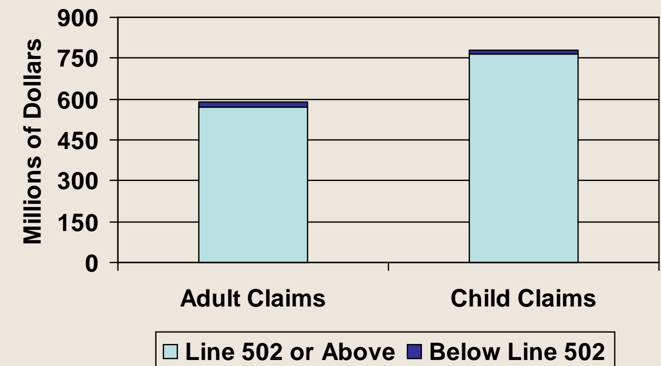
2010 Paid Professional Claims		
Match to Oregon Line	Claims	Amount Paid
Yes	13.4M (96%)	$1.37B (96%)
No	0.5M (4%)	$0.06B (4%)
Total	14.0M	$1.43B

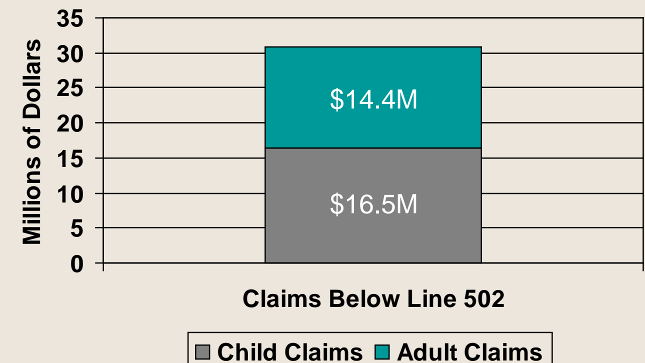
Overall Claims Matching Oregon Lines		
Position on Oregon List	Claims	Amount Paid
Line 502 or Above	13.2M (98%)	$1.34B (98%)
Below Line 502	0.3M (2%)	$0.03B (2%)
Total	13.4M	$1.37B

Compiled by OHCA Reporting and Statistics Unit. Data is valid as of March 17, 2011 and is subject to change.

OHCA Claims Below Line 502

- OHCA paid $31M for condition-treatment groups below the cutoff line in 2010
- Of the adult claims below line 502, only one line had payments of more than $1M
  - Line 551 (40K Claims, $4.5M): *Medical and Surgical Treatment for Acute and Chronic Disorders of the Spine Without Neurologic Impairment*
- An additional three lines had payments of over $1M for children's claims
  - Line 564 (7K Claims, $2.0M): *Tonsillectomy and Adenoidectomy*
  - Line 573: (42K Claims, $2.3M): *Medical Therapy for Allergic Rhinitis and Conjunctivitis*
  - Line 642: (10K Claims, $1.7M): *Elective Circumcision*

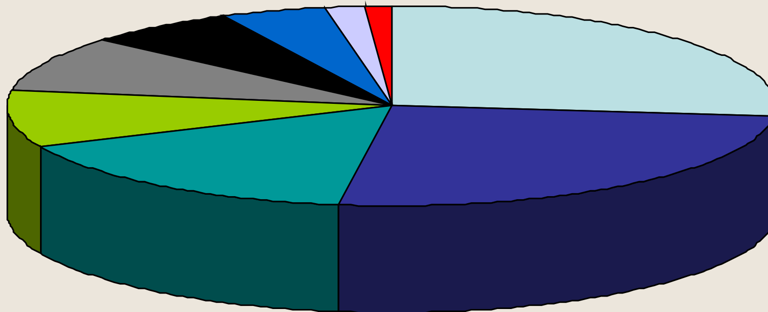




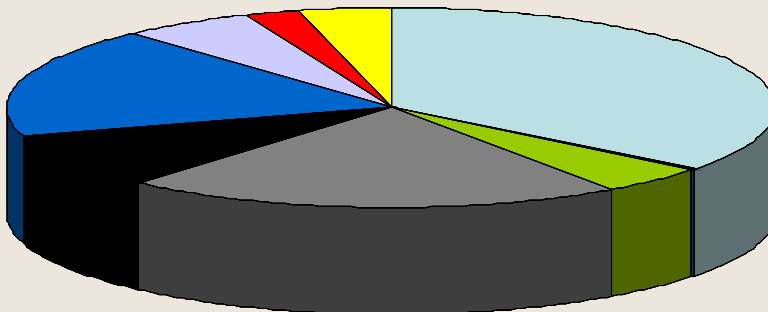
Compiled by OHCA Reporting and Statistics Unit. Data is valid as of March 17, 2011 and is subject to change.

Services Below Line 502

Adult Claims by Procedure Type ($14.4M)



Child Claims by Procedure Type ($16.5M)



- Children's claims falling below Line 502 include treatment-related procedures and products while adult claims are more heavily weighted toward services not directly related to the diagnosis (i.e., personal care and case management)

Compiled by OHCA Reporting and Statistics Unit. Data is valid as of March 17, 2011 and is subject to change.

Conclusions

- Despite using a very different process for determining covered benefits, the distribution of claims paid by Oklahoma largely overlaps with Oregon's benefit set
- Although we do not have Oregon's data to compare our distribution of dollars paid by line, the fact that such a large proportion of our claims falls above the cutoff line is a positive indicator
- If we assume that Oregon "got it right" with its in-depth prioritization process, then this comparison provides good external validation of Oklahoma's set of covered benefits

7.b-1 CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 5. Eligibility and Countable Income
Part 5. Countable Income and Resources
OAC 317:35-5-42. [AMENDED]
(Reference APA WF # 11-02)

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. Changes in Federal law require OHCA to amend eligibility policy. These emergency rule revisions will ensure OHCA policy is in compliance with Federal mandates and provide access to services in accordance with Federal regulations.

ANALYSIS: The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 requires state Medicaid agencies to disregard federal tax refunds or advance payments with respect to a refundable tax credits as income and as resources for purposes of determining eligibility. To bring Agency policy in compliance with this law, eligibility rules and income guidelines are revised to eliminate consideration of the Earned Income Tax Credit, which is the only refundable tax credits currently counted for eligibility purposes.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 19, 2011 and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Public Law 111-312, the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revise Agency eligibility rules to ensure compliance with the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 which requires the Agency to disregard federal tax refunds or advance payments with respect to a refundable tax credits as income and as resources for purposes of determining eligibility.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-42. Determination of countable income for individuals categorically related to aged, blind and disabled

DRAFT

(a) **General.** The term income is defined as that gross gain or gross recurrent benefit which is derived from labor, business, property, retirement and other benefits, and many other forms which can be counted on as currently available for use on a regular basis. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income.

(1) If it appears the applicant or SoonerCare member is eligible for any type of income (excluding SSI) or resources, he/she must be notified in writing by the Agency of his/her potential eligibility. The notice must contain the information that failure to file for and take all appropriate steps to obtain such benefit within 30 days from the date of the notice will result in a determination of ineligibility.

(2) If a husband and wife are living in their own home, the couple's total income and/or resource is divided equally between the two cases. If they both enter a nursing facility, their income and resources are considered separately.

(3) If only one spouse in a couple is eligible and the couple ceases to live together, only the income and resources of the ineligible spouse that are actually contributed to the eligible spouse beginning with the month after the month which they ceased to live together are considered.

(4) In calculating monthly income, cents are included in the computation until the monthly amount of each individual's source of income has been established. When the monthly amount of each income source has been established, cents are rounded to the nearest dollar (1 - 49 cents is rounded down, and 50 - 99 cents is rounded up). For example, an individual's weekly earnings of $99.90 are multiplied by 4.3 and the cents rounded to the nearest dollar ($99.90 x 4.3 = $429.57 rounds to $430). See rounding procedures in OAC 340:65-3-4 when using BENDEX to verify OASDI benefits.

(b) **Income disregards.** In determining need, the following are not considered as income:

(1) The coupon allotment under the Food Stamp Act of 1977;

(2) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

(3) Educational grants (excluding work study), scholarships, etc., that are contingent upon the student regularly attending school. The student's classification (graduate or undergraduate) is not a factor;

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes:

(A) An acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan agreement is not written, an OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified.

(B) If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or

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without interest) and the lender's verification of the loan are required to indicate that the loan is bona fide.

(C) Proceeds of a loan secured by an exempt asset are not an asset;

(5) One-third of child support payments received on behalf of the disabled minor child;

(6) Indian payments (including judgment funds or funds held in trust) distributed by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgment funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc. However, any interest or income derived from the principal or produced by purchases made with funds after distribution is considered as any other income;

(7) Special allowance for school expenses made available upon petition (in writing) for funds held in trust for the student;

(8) Title III benefits from State and Community Programs on Aging;

(9) Payment for supportive services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);

(10) Payments to volunteers under the Domestic Volunteer Services Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;

(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the national School Lunch Act;

(12) Any portion of payments made under the Alaska Native Claims Settlement Act to an Alaska Native which are exempt from taxation under the Settlement Act;

(13) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training and uniform allowance if the uniform is uniquely identified with company names or logo;

(14) Assistance or services from the Vocational Rehabilitation program such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and any other such complementary payments;

(15) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

(16) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;

(17) Governmental rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;

(18) LIHEAP payments for energy assistance and payments for emergency situations under Emergency Assistance to Needy Families with Children;

DRAFT

(19) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);

(20) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;

(21) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by States, local governments and disaster assistance organizations;

(22) Income of a sponsor to the sponsored eligible alien;

(23) Income that is set aside under an approved Plan for Achieving Self-Support for Blind or Disabled People (PASS). The Social Security Administration approves the plan, the amount of income excluded and the period of time approved. A plan can be approved for an initial period of 18 months. The plan may be extended for an additional 18 months if needed, and an additional 12 months (total 48 months) when the objective involves a lengthy educational or training program;

(24) Payments made to individuals because of their status as victims of Nazi persecution (PL 103-286);

(25) Payments received under the Civil Liberties Act of 1988. These payments are to be made to individuals of Japanese ancestry who were detained in internment camps during World War II;

(26) Payments received as a result of participation in a class action lawsuit entitled "Factor VIII or IX Concentrate Blood Products Litigation". These payments are made to hemophilia patients who are infected with HIV. However, if the payments are placed in an interest-bearing account, or some other investment medium that produces income, the income generated by the account may be countable as income to the individual;

(27) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-204);

(28) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);

(29) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);

(30) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010, and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and

(31) Wages paid by the Census Bureau for temporary employment related to Census activities.

(c) **Determination of income.** The member is responsible for reporting information regarding all sources of available income. This information is verified and used by the worker in determining eligibility.

(1) Gross income is listed for purposes of determining eligibility. It may be derived from many sources, and some items may be automatically disregarded by the computer when so provided by state or federal law.

(2) If a member is determined to be categorically needy and is also an SSI recipient, any change in countable income (see OAC 317:35-5-42(d)(3) to determine countable income) will not affect receipt of SoonerCare and amount of State Supplemental Payment (SSP) as long as the amount does not cause SSI ineligibility. Income which will be considered by SSI in the retrospective cycle is documented in the

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case with computer update at the time that SSI makes the change (in order not to penalize the member twice). If the SSI change is not timely, the worker updates the computer using the appropriate date as if it had been timely. If the receipt of the income causes SSI ineligibility, the income is considered immediately with proper action taken to reduce or close the SoonerCare benefit and SSP case. Any SSI overpayment caused by SSA not making timely changes will result in recovery by SSI in the future. When the worker becomes aware of income changes which will affect SSI eligibility or payment amount, the information is to be shared with the SSA office.

(3) Some of the more common income sources to be considered in determining eligibility are as follows:

(A) **Retirement and disability benefits.** These include but are not limited to OASDI, VA, Railroad Retirement, SSI, and unemployment benefits. Federal and State benefits are considered for the month they are intended when determining eligibility.

(i) Verifying and documenting the receipt of the benefit and the current benefit amount are achieved by:

(I) seeing the member's award letter or warrant;

(II) obtaining a signed statement from the individual who cashed the warrant; or

(III) by using BENDEX and SDX.

(ii) Determination of OASDI benefits to be considered (disregarding COLA's) for former State Supplemental recipients who are reapplying for medical benefits under the Pickle Amendment must be computed according to OKDHS Form 08AX011E.

(iii) The Veterans Administration allows their recipients the opportunity to request a reimbursement for medical expenses not covered by SoonerCare. If a recipient is eligible for the readjustment payment, it is paid in a lump sum for the entire past year. This reimbursement is disregarded as income and a resource in the month it is received; however, any amount retained in the month following receipt is considered a resource.

(iv) Government financial assistance in the form of VA Aid and Attendance or Champus payments is considered as follows:

(I) **Nursing facility care.** VA Aid and Attendance or Champus payment whether paid directly to the member or to the facility, are considered as third party resources and do not affect the income eligibility or the vendor payment of the member.

(II) **Own home care.** The actual amount of VA Aid and Attendance payment paid for an attendant in the home is disregarded as income. In all instances, the amount of VA Aid and Attendance is shown on the computer form.

(v) Veterans or their surviving spouse who receive a VA pension may have their pension reduced to $90 by the VA if the veteran does not have dependents, is SoonerCare eligible, and is residing in a nursing facility that is approved under SoonerCare. Section 8003 of Public Law 101-508 allows these veterans' pensions to be reduced to $90 per month. None of the $90 may be used in computing any vendor payment or spenddown. In these instances, the nursing home resident is entitled to the $90 reduced VA pension as well as the regular nursing facility maintenance standard. Any vendor payment or

spenddown will be computed by using other income minus the monthly nursing facility maintenance standard minus any applicable medical deduction(s). Veterans or their surviving spouse who meet these conditions will have their VA benefits reduced the month following the month of admission to a SoonerCare approved nursing facility.

(B) **SSI benefits.** SSI benefits may be continued up to three months for a recipient who enters a public medical or psychiatric institution, a SoonerCare approved hospital, extended care facility, intermediate care facility for the mentally retarded or nursing facility. To be eligible for the continuation of benefits, the SSI recipient must have a physician's certification that the institutionalization is not expected to exceed three months and there must be a need to maintain and provide expenses for the home. These continued payments are intended for the use of the recipient and do not affect the vendor payment.

(C) **Lump sum payments.**

(i) Any income received in a lump sum (with the exception of SSI lump sum) covering a period of more than one month, whether received on a recurring or nonrecurring basis, is considered as income in the month it is received. Any amount from any lump sum source, including SSI (with the exception of dedicated bank accounts for disabled/blind children under age 18), retained on the first day of the next month is considered as a resource. Such lump sum payments may include, but are not limited to, accumulation of wages, retroactive OASDI, VA benefits, Workers' Compensation, bonus lease payments and annual rentals from land and/or minerals.

(ii) Lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded. The dedicated bank account consisting of the retroactive SSI lump sum payment and accumulated interest is excluded as a resource in both the month received and any subsequent months.

(iii) A life insurance death benefit received by an individual while living is considered as income in the month received and as a resource in the following months to the extent it is available.

(iv) Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment.

(D) **Income from capital resources and rental property.** Income from capital resources can be derived from rental of a house, rental from land (cash or crop rent), leasing of minerals, life estate, homestead rights or interest.

(i) If royalty income is received monthly but in irregular amounts, an average based on the previous six months' royalty income is computed and used to determine income eligibility. Exception: At any time that the county becomes aware of and can establish a trend showing a dramatic increase or decrease in royalty income, the previous two month's royalty income is averaged to compute countable monthly income.

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(ii) Rental income may be treated as earned income when the individual participates in the management of a trade or business or invests his/her own labor in producing the income. The individual's federal income tax return will verify whether or not the income is from self-employment. Otherwise, income received from rent property is treated as unearned income.

(iii) When property rental is handled by a leasing agent who collects the rent and deducts a management fee, only the rent actually received by the member is considered as income.

(E) **Earned income/self-employment.** The term "earned income" includes income in cash earned by an individual through the receipt of wages, salary, commission or profit from activities in which he/she is engaged as a self-employed individual or as an employee. See subparagraph (G) of this paragraph for earnings received in fluctuating amounts. "Earned Income" is also defined to include in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. The cash value of the in-kind benefits must be verified by the employer. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in his/her business enterprise. An exchange of labor or services; e.g., barter, is considered as an in-kind benefit. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind but is recorded on the case computer input document for coordination with SoonerCare benefits.

~~(i) Advance payments of EITC or refunds of EITC received as a result of filing a federal income tax return are considered as earned income in the month after they are received.~~

~~(ii)~~ (i) Work study received by an individual who is attending school is considered as earned income with appropriate earned income disregards applied.

~~(iii)~~ (ii) Money from the sale of whole blood or blood plasma is considered as self-employment income subject to necessary business expense and appropriate earned income disregards.

~~(iv)~~ (iii) Self-employment income is determined as follows:

(I) Generally, the federal or state income tax form for the most recent year is used for calculating the self-employment income to project income on a monthly basis for the certification period. The gross income amount as well as the allowable deductions are the same as can be claimed under the Internal Revenue code for tax purposes.

(II) Self-employment income which represents a household's annual support is prorated over a 12-month period, even if the income is received in a short period of time. For example, self-employment income received by crop farmers is averaged over a 12-month period if the income represents the farmer's annual support.

(III) If the household's self-employment enterprise has been in existence for less than a year, the income from that self-employment enterprise is averaged over the period of time the business has been in operation to establish the monthly income amount.

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(IV) If a tax return is not available because one has not been filed due to recent establishment of the self-employment enterprise, a profit and loss statement must be seen to establish the monthly income amount.

(V) The purchase price and/or payment(s) on the principal of loans for capital assets, equipment, machinery, and other durable goods is not considered as a cost of producing self-employed income. Also not considered are net losses from previous periods, depreciation of capital assets, equipment, machinery, and other durable goods; and federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation (these expenses are accounted for by the work related expense deduction given in OAC 340:10-3-33(1)).

~~(v)~~ (iv) Countable self-employment income is determined by deducting allowable business expenses to determine the adjusted gross income. The earned income deductions are then applied to establish countable earned income.

(F) **Inconsequential or irregular income.** Inconsequential or irregular receipt of income in the amount of $10 or less per month or $30 or less per quarter is disregarded. The disregard is applied per individual for each type of inconsequential or irregular income. To determine whether the income is inconsequential or irregular, the gross amount of earned income and the gross minus business expense of self-employed income are considered.

(G) **Monthly income received in fluctuating amounts.** Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

(i) **Daily**. Income received on a daily basis is converted to a weekly amount then multiplied by 4.3.

(ii) **Weekly**. Income received weekly is multiplied by 4.3.

(iii) **Twice a month**. Income received twice a month is multiplied by 2.

(iv) **Biweekly**. Income received every two weeks is multiplied by 2.15.

(H) **Non-negotiable notes and mortgages.** Installment payments received on a note, mortgage, etc., are considered as monthly income.

(I) **Income from the Job Training and Partnership Act (JTPA).** Unearned income received by an adult, such as a needs based payment, cash assistance, compensation in lieu of wages, allowances, etc., from a program funded by JTPA is considered as any other unearned income. JTPA earned income received as wages is considered as any other earned income.

(J) **Other income.** Any other monies or payments which are available for current living expenses must be considered.

(d) **Computation of income.**

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(1) **Earned income.** The general income exclusion of $20 per month is allowed on the combined earned income of the eligible individual and eligible or ineligible spouse. See paragraph (6) of this subsection if there are ineligible minor children. After the $20 exclusion, deduct $65 and one-half of the remaining combined earned income.
(2) **Unearned income.** The total gross amount of unearned income of the eligible individual and eligible or ineligible spouse is considered. See paragraph (6) of this subsection if there are ineligible minor children.
(3) **Countable income.** The countable income is the sum of the earned income after exclusions and the total gross unearned income.
(4) **Deeming computation for disabled or blind minor child(ren).** An automated calculation is available for computing the income amount to be deemed from parent(s) and the spouse of the parent to eligible disabled or blind minor child(ren) by use of transaction CID. The ineligible minor child in the computation regarding allocation for ineligible child(ren) is defined as: a dependent child under age 18.

(A) A mentally retarded child living in the home who is ineligible for SSP due to the deeming process may be approved for SoonerCare under the Home and Community Based Services Waiver (HCBS) Program as outlined in OAC 317:35-9-5.
(B) For TEFRA, the income of child's parent(s) is not deemed to him/her.

(5) **Premature infants.** Premature infants (i.e., 37 weeks or less) whose birth weight is less than 1200 grams (approximately 2 pounds 10 ounces) will be considered disabled by SSA even if no other medical impairment(s) exist. In this event, the parents' income is not deemed to the child until the month following the month in which the child leaves the hospital and begins living with his/her parents.
(6) **Procedures for deducting ineligible minor child allocation.** When an eligible individual has an ineligible spouse and ineligible minor children (not receiving TANF), the computation is as follows:

(A) Each ineligible child's allocation (OKDHS Form 08AX001E, Schedule VII. C.) minus each child's gross countable income is deducted from the ineligible spouse's income. Deeming of income is not done from child to parent.
(B) The deduction in subparagraph (A) of this paragraph is prior to deduction of the general income exclusion and work expense.
(C) After computations in subparagraphs (A) and (B) of this paragraph, the remaining amount is the ineligible spouse's countable income considered available to the eligible spouse.

(7) **Special exclusions for blind individuals.** Any blind individual who is employed may deduct the general income exclusion and the work exclusion from the gross amount of earned income. After the application of these exclusions, one-half of the remaining income is excluded. The actual work expense is then deducted from the remaining half to arrive at the amount of countable income. If this blind individual has a spouse who is also eligible due to blindness and both are working, the amount of ordinary and necessary expenses attributable to the earning of income for each of the blind individuals may be deducted. Expenses are deductible as paid but may not exceed the amount of earned income. To be deductible, an expense need not relate directly to the blindness of the individual, it need only be an ordinary and necessary work expense of the blind individual. Such expenses fall into three broad categories:

(A) transportation to and from work;

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(B) job performance; and
(C) job improvement.

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7.b-2 CHAPTER 45. INSURE OKLAHOMA
Subchapter 9. Insure Oklahoma ESI Employee Eligibility
OAC 317:45-9-4. [AMENDED]
Subchapter 11. Insure Oklahoma IP
Part 3. Insure Oklahoma IP Member Health Care Benefits
OAC 317:45-11-10. [AMENDED]
OAC 317:45-11-12. [AMENDED]
Part 5. Insure Oklahoma IP Member Eligibility
OAC 317:45-11-24. [AMENDED]
OAC 317:45-11-25. [AMENDED]
Subchapter 13. Insure Oklahoma Dental Services
OAC 317:45-13-1. [AMENDED]
(Reference APA WF # 11-05)

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 rules. Federal law requires OHCA to amend Insure Oklahoma eligibility and cost-sharing policy in accordance with Section 5006(a) of the American Recovery and Reinvestment and 42 CFR 457.535. These emergency rule revisions will ensure OHCA policy is in compliance with Federal mandates and provide access to services in accordance with Federal regulations.

ANALYSIS: Insure Oklahoma cost-sharing rules are revised to comply with Federal law on Native American cost-sharing exemptions. Native Americans are exempt from Insure Oklahoma co-pays or premiums when they receive services provided by I/T/U providers or through referral by contract health services. Native American children are exempt from all cost-sharing requirements regardless of where the services were rendered.

BUDGET IMPACT:

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on May 19, 2011 and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; Section 5006(a) of the American Recovery and Reinvestment Act; 42 CFR 457.535

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revise Insure Oklahoma rules to ensure compliance with Federal law by exempting Native American adults from IO co-pays and/or premiums when they receive services provided by I/T/U providers or through referral by contract health services & exempting Native American children from cost sharing requirements regardless of where services were rendered.

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SUBCHAPTER 9. INSURE OKLAHOMA ESI EMPLOYEE ELIGIBILITY

317:45-9-4. Employee cost sharing

Employees are responsible for up to 15 percent of their health plan premium. The employees are also responsible for up to 15 percent of their dependent's health plan premium if the dependent is included in the program. The combined portion of the employee's cost sharing for health plan premiums cannot exceed three percent of his/her annual gross household income computed monthly. Native American children providing documentation of ethnicity are exempt from cost-sharing requirements, including premium payments and out-of-pocket expenses.

SUBCHAPTER 11. INSURE OKLAHOMA IP
PART 3. Insure Oklahoma IP MEMBER HEALTH CARE BENEFITS

317:45-11-10. Insure Oklahoma IP adult benefits

(a) All IP adult benefits are subject to rules delineated in 317:30 except as specifically set out in this Section. The scope of IP adult benefits described in this Section is subject to specific non-covered services listed in 317:45-11-11.

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

(1) behavioral health services;

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

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

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

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

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

(c) IP covered adult benefits for in-network services, limits, and applicable co-payments are listed in this subsection. In addition to the benefit-specific limits, there is a maximum lifetime benefit of $1,000,000. Dependent children coverage is found at 317:45-11-12. Children are not held to the maximum lifetime benefit. Native American adults providing documentation of ethnicity who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services are exempt from co-payments. Coverage includes:

(1) Anesthesia / Anesthesiologist Standby. Covered in accordance with 317:30-5-7. Eligible services are covered for covered illness or surgery including services provided by a Certified Registered Nurse Anesthetist (CRNA) or Anesthesiologist Assistant (AA).

(2) Blood and Blood Products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.

(3) Chelation Therapy. Covered for heavy metal poisoning only.

(4) Diagnostic X-ray, including Ultrasound. Covered in accordance with 317:30-5-22(b)(2). PCP referral is required. Standard radiology (X-ray or Ultrasound): $0 co-pay. Specialized scanning and imaging (MRI, MRA, PET, or CAT Scan); $25 co-pay per scan.

(5) Emergency Room Treatment, services and supplies for treatment in an emergency. Contracted provider services are subject to a $30 co-

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pay per occurrence. The emergency room co-pay will be waived if the member is admitted to the hospital or death occurs before admission.
(6) Inpatient Hospital Benefits. Covered in accordance with 317:30-5-41, 317:30-5-47 and 317:30-5-95; $50 co-pay per admission.
(7) Preventive Office Visit. For services of evaluation and medical management (wellness exam); one visit per year with a $10 co-pay. This visit counts as an office visit.
(8) Office Visits/Specialist Visits. Covered in accordance with 317:30-5-9, 317:30-5-10, and 317:30-5-11. For services of evaluation and medical management; up to four visits are covered per month; PCP referral required for specialist visits; $10 co-pay per visit.
(9) Outpatient Hospital/Facility Services.
(A) Includes hospital surgery services in an approved outpatient facility including outpatient services and diagnostic services. Prior authorization required for certain procedures; $25 co-pay per visit.
(B) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for persons with proven malignancies or opportunistic infections; $10 co-pay per visit.
(C) Physical, Occupational and Speech Therapy services. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and 15 visits (units) per discipline per date of service per calendar year; $10 co-pay per visit.
(10) Maternity (Obstetric). Covered in accordance with 317:30-5-22. Nursery care paid separately under eligible child; $50 inpatient hospital co-pay.
(11) Laboratory/Pathology. Covered in accordance with 317:30-5-20; $0 co-pay.
(12) Mammogram (Radiological or Digital). Covered in accordance with 317:30-5-901; $0 co-pay.
(13) Immunizations. Covered in accordance with 317:30-5-2.
(14) Assistant Surgeon. Covered in accordance with 317:30-5-8.
(15) Dialysis, Kidney dialysis, and services and supplies, either at home or in a facility; $0 co-pay.
(16) Oral Surgery. Services are limited to the removal of tumors or cysts; Inpatient Hospital $50 or Outpatient Hospital/Facility; $25 co-pay applies.
(17) Behavioral Health (Mental Health and Substance Abuse) Treatment (Inpatient). Covered in accordance with 317:30-5-95.1; $50 co-pay per admission.
(18) Behavioral Health (Mental Health and Substance Abuse) Treatment (Outpatient).
(A) Agency services. Covered in accordance with 317:30-5-241 and 317:30-5-596; $10 co-pay per visit.
(B) Individual provider services. Licensed Behavioral Health Professionals (LBHPs) are defined as follows for the purpose of Outpatient Behavioral Health Services and Outpatient Substance Abuse Treatment:
(i) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in 317:30-5-2.

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

(I) Psychology,

(II) Social Work (clinical specialty only),

(III) Professional Counselor,

(IV) Marriage and Family Therapist,

(V) Behavioral Practitioner, or

(VI) Alcohol and Drug Counselor.

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

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

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

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

(19) Durable Medical Equipment and Supplies. Covered in accordance with 317:30-5-210 through 317:30-5-218. A PCP referral and prior authorization is required for certain items. DME/Supplies are covered up to a $15,000 annual maximum; exceptions from the annual DME limit are diabetic supplies, oxygen, home dialysis, and parenteral therapy; $5 co-pay for durable/non-durable supplies and $25 co-pay for durable medical equipment.

(20) Diabetic Supplies. Covered in accordance with 317:30-5-211.15; not subject to $15,000 annual DME limit; $5 co-pay per prescription.

(21) Oxygen. Covered in accordance with 317:30-5-211.11 through 317:30-5-211.12; not subject to $15,000 annual DME limit; $5 co-pay per month.

(22) Pharmacy. Covered in accordance with 317:30-5-72.1 and 317:30-5-72. Prenatal vitamins and smoking cessation products do not count against monthly prescription limits; $5/$10 co-pay per prescription.

(23) Smoking Cessation Products. Products do not count against monthly prescription limits. Covered in accordance with 317:30-5-72.1; $5/$10 co-pay per product.

(24) Nutrition Services. Covered in accordance with 317:30-5-1076; $10 co-pay per visit.

(25) External Breast Prosthesis, Bras and Prosthetic Garments. Covered in accordance with 317:30-5-211.13; $25 co-pay per prosthesis.

(26) Surgery. Covered in accordance with 317:30-5-8; $50 co-pay per inpatient admission and $25 co-pay per outpatient visit.

(27) Home Dialysis. Covered in accordance with 317:30-5-211.13; not subject to $15,000 annual DME limit; $0 co-pay.

(28) Parenteral Therapy. Covered in accordance with 317:30-5-211.14; not subject to $15,000 annual DME limit; $25 co-pay per month.

(29) Family Planning Services and Supplies, including Sterilizations. Covered in accordance with 317:30-3-57; $0 co-pay.
(30) Home Health Medications, Intravenous (IV) Therapy and Supplies. Covered in accordance with 317:30-5-211.15 and 317:30-5-42.16(b)(3).
(31) Fundus photography.
(32) Perinatal dental care for pregnant women. Covered in accordance with 317:30-5-696; $0 co-pay.

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

(a) IP covered child benefits for in-network services, limits, and applicable co-payments are listed in this Subsection. All IP benefits are subject to rules delineated in 317:30 except as specifically set out in this Section. All services provided must be medically necessary as defined in 317:30-3-1(f). The scope of IP child benefits described in this Section is subject to specific non-covered services listed in 317:45-11-13. Dependent children are not held to the maximum lifetime benefit of $1,000,000. Native American children providing documentation of ethnicity are exempt from co-payments. Coverage includes:

(1) Ambulance services. Covered as medically necessary; $50 co-pay per occurrence; waived if admitted.
(2) Blood and blood products. Processing, storage, and administration of blood and blood products in inpatient and outpatient settings.
(3) Chelation therapy. Covered for heavy metal poisoning only.
(4) Chemotherapy and radiation therapy. Covered as medically necessary; $10 co-pay per visit.
(5) Clinic services including renal dialysis services. Covered as medically necessary; $0 co-pay for dialysis services; $10 co-pay per office visit.
(6) Diabetic supplies. One glucometer, one spring-loaded lancet device, two replacement batteries per year - 100 glucose strips and lancets per month; not included in DME $15,000 max/year; $5 co-pay per billable service. Additional supplies require prior authorization.
(7) Diagnostic X-ray services. Covered as medically necessary; $25 co-pay per scan for MRI, MRA, PET, CAT scans only.
(8) Dialysis. Covered as medically necessary.
(9) Durable medical equipment and supplies. Covered as medically necessary with $15,000 annual maximum; $5 co-pay per item for durable/non-durable supplies; $25 co-pay per item for DME.
(10) Emergency department services. Covered as medically necessary; $30 co-pay per occurrence; waived if admitted.
(11) Family planning services and supplies. Birth control information and supplies; pap smears; pregnancy tests.
(12) Home health services. Home health visits limited to 36 visits per year, prior authorization required, includes medications IV therapy and supplies; $10 co-pay per visit, appropriate pharmacy and DME co-pays will apply.
(13) Hospice services. Covered as medically necessary, prior authorization required; $10 co-pay per visit.
(14) Immunizations. Covered as recommended by ACIP; $0 co-pay.
(15) Inpatient hospital services (acute care only). Covered as medically necessary; $50 co-pay per admission.
(16) Laboratory services. Covered as medically necessary.
(17) Psychological testing. Psychological, neurological and development testing; outpatient benefits per calendar year, prior

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authorization required issued in four unit increments - not to exceed eight units/hours per testing set; $0 co-pay.
(18) Mental health/substance abuse treatment-outpatient. All outpatient benefits require prior authorization. Outpatient benefits limited to 48 visits per calendar year. Additional units as medically necessary; $10 co-pay per outpatient visit.
(19) Mental health/substance abuse treatment-inpatient. Acute, detox, partial, and residential treatment center (RTC) with 30 day max per year, 2 days of partial or RTC treatment equals 1 day accruing to maximum. Additional units as medically necessary; $50 co-pay per admission. Requires prior authorization.
(20) Nurse midwife services. Covered as medically necessary for pregnancy-related services only; $0 co-pay.
(21) Nutrition services. Covered as medically necessary; $10 co-pay.
(22) Nutritional support. Covered as medically necessary; not included in DME $15,000 max/year. Parenteral nutrition covered only when medically necessary; $25 co-pay.
(23) Other medically necessary services. Covered as medically necessary.
(24) Oral surgery. Covered as medically necessary and includes the removal of tumors and cysts; $25 co-pay for outpatient; $50 co-pay for inpatient hospital.
(25) Outpatient hospital services. Covered as medically necessary and includes ambulatory surgical centers and therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for children with proven malignancies or opportunistic infections; $25 co-pay per visit; $10 co-pay per visit for therapeutic radiology or chemotherapy.
(26) Oxygen. Covered as medically necessary; not included in DME $15,000 max/year; $5 co-pay per month.
(27) PCP visits. Blood lead screen covered as medically necessary. Hearing services limited to one outpatient newborn screening. Well baby/well child exams follow recommended schedule to age 19; $0 co-pay for preventive visits and well baby/well child exams; $10 co-pay for all other visits.
(28) Physical, occupational, and speech therapy. Covered as medically necessary; prior authorization required; $10 co-pay per visit.
(29) Physician services, including preventive services. Covered as medically necessary; $0 co-pay for preventive visits; $10 co-pay for all other visits.
(30) Prenatal, delivery and postpartum services. Covered as medically necessary; $0 co-pay for office visits; $50 co-pay for delivery.
(31) Prescription drugs and insulin. Limited to six per month; generic preferred. Prenatal vitamins and smoking cessation products do not count toward the six prescription limit; $5-$10 co-pay.
(32) Smoking cessation products. Limited coverage; 90-day supply; products do not count against prescription drug limit; $5-$10 co-pay.
(33) Specialty clinic services. Covered as medically necessary; $10 co-pay.
(34) Surgery. Covered as medically necessary; $25 co-pay for outpatient facility; $50 co-pay for inpatient hospital.
(35) Tuberculosis services. Covered as medically necessary; $10 co-pay per visit.

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

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

(1) behavioral health services;

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

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

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

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

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

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

317:45-11-24. Member cost sharing

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

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

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

(3) Native Americans providing documentation of ethnicity are exempt from premium payments.

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

317: 45-11-25. Premium payment

IP health plan premiums are established by the OHCA. Employees and college students are responsible for up to 20 percent of their IP health plan premium. The employees are also responsible for up to 20 percent of their dependent's IP health plan premium if the dependent is included in the program. The combined portion of the employee's or college students cost sharing for IP health plan premiums cannot exceed four percent of his/her annual gross household income computed monthly. Native Americans providing documentation of ethnicity are exempt from premium payments.

SUBCHAPTER 13. INSURE OKLAHOMA DENTAL SERVICES

317:45-13-1. Dental services requirements and benefits

The Oklahoma Health Care Authority (OHCA) provides dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Dental coverage is obtained through direct purchase from the OHCA. The existing cost sharing requirements for IP qualified children apply. Native Americans children providing documentation of their ethnicity are exempt from dental co-pay requirements. Children obtaining medical

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coverage through IP receive Dental IP coverage. The OHCA contracts with Dental IP providers utilizing the SoonerCare network. The Dental IP providers are reimbursed pursuant to the SoonerCare fee schedule for rendered services.

(1) The Dental IP program is covered as medically necessary and includes coverage for Class A, B, C, and orthodontia services. All coverage is provided as necessary to prevent disease, promote and restore oral health, and treat emergency conditions. Dental services follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. Prior authorization is required for certain services.

(2) Class A services are covered as medically necessary and include preventive, diagnostic care such as cleanings, check-ups, X-rays, and fluoride treatments, no co-pay is required.

(3) Class B services are covered as medically necessary and include basic, restorative, endodontic, periodontic, oral and maxillofacial surgery care such as fillings, extractions, periodontal care, and some root canal, $10 co-pay is required.

(4) Class C services are covered as medically necessary and include major, prosthodontic care such as crowns, bridges and dentures, $25 co-pay is required.

(5) Class D services are covered as medically necessary and include orthodontic care. Orthodontic care is not covered for cosmetic purposes or any purposes which are not medical in nature, $25 co-pay is required.

(6) Emergency dental services are covered as medically necessary, no co-pay is required.

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MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

Agenda
Rates & Standards Hearing
June 08, 2011
10:00 A.M.
PONCA CONFERENCE ROOM

Provider assessment to be addressed:

- Supplemental Hospital Offset Payment Program (SHOPP)

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Oklahoma Health Care Authority
Finance Division
Presentation to the State Plan Reimbursement Committee
Supplemental Hospital Offset Payment Program Funded by Provider Assessments
Hearing Date-June 8, 2011

Background

A provider assessment is a method of collecting revenue from specified categories of providers. Provider assessments are used as a mechanism to generate new state funds and are used to match federal funds. The additional revenues allow states to increase provider reimbursements. Oklahoma currently imposes provider assessments on Nursing Facilities and Intermediate Care Facilities for the Mentally Retarded based on a percentage of patient revenue.

House Bill 1381, signed by the Governor on May 13, 2011, creates a Supplemental Hospital Offset Payment Program (SHOPP). The bill will create new law at Title 63 Okla. Stat. §§ 3241.1- 3241.6 (2011). Upon Federal approval by the Centers for Medicare and Medicaid Services (CMS) of the resulting State Plan Amendments, the Oklahoma Health Care Authority (OHCA) will be authorized to assess and collect a hospital provider fee.

Before the state law can be effective, OHCA must seek an approval of the assessment from the federal government based on the provisions of 42 U.S.C. § 1396(b)(w)(1).

Rate Methodology for the Supplemental Hospital Offset Payment Program

The rate methodology for the Supplemental Hospital Offset Payment Program (SHOPP) is driven largely by the new law created at 63 Okla. Stat. § 3241.1-3241.6 (2011). The methodology involves excluding certain hospitals exempt under state law. Based upon 2009 cost reports, which is the base year for the determining which Oklahoma licensed hospitals are included and excluded, 75 hospitals will be included in the fee assessment and approximately 74 hospitals will be excluded from the fee assessment.

All hospitals included in the fee assessment will pay a 2.5% fee based on 2009 net patient revenue as defined by state law.

As an important first step in creating the methodology OHCA must determine its total payments in 2010 to all hospitals as well as the 2010 Medicare Upper Payment Limit Gap (UPL); that is the gap between the payments made and the federal upper limit of payment. This item will be noted in this paper below.

Participating hospitals that pay into the SHOPP fund (at 2.5% of net patient revenue) will be eligible for supplemental Medicaid payments for inpatient and outpatient services. SHOPP assessments will be matched with federal dollars after approval by the CMS. In addition, the state law requires supplemental payments to be made to Critical Access hospitals that are paid less than 101 percent of Medicare cost for Medicaid services. At this time OHCA has determined 34 Oklahoma licensed hospitals are critical access hospitals. Payments will be made on a quarterly basis. Each participating hospital will receive a pro rata share of the assessment fund based on the hospital's Medicaid payments for services divided by the total Medicaid payments to all participating hospitals; however the UPL cannot be exceeded.

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The funds collected will be deposited into a revolving fund in the State Treasury designated as the SHOPP Fund, and will be used to support hospital reimbursement.

2010 Total Medicaid Payments

After a review of Medicaid outlays to hospitals in state fiscal year 2010, OHCA has determined that hospitals were paid $710,300,00.00 (710.3 million dollars).

2010 Upper Payment Limit Gap

Under CMS regulations, States are allowed to pay hospitals up to the amount Medicare would pay under comparable circumstances. Based on federal fiscal year 2010 data, Oklahoma hospitals could be paid up to approximately $1.1 billion under this methodology. This is the 2010 Medicare UPL. The OHCA has determined that subtracting the UPL from the total Medicaid payments leaves a “gap” of $336,453,000.00 (336.4 million dollars). This dollar value sets the amount OHCA can pay hospitals eligible for SHOPP.

Budget Impact

The assessments are expected to generate approximately $152 million for the state share to garner a federal match of about $267 million for a total of $419,509,000.00 (419.5 million dollars) for state fiscal year 2012. Of this $419.5 million, $336,453,000.00 (336.4 million dollars) would be paid to hospitals as supplemental payments.

Importantly $83,056,000.00 (83.0 million dollars) of the assessments will be used to maintain current SoonerCare payments for all providers.

Effective Date
Dependent upon CMS approval.

June, 2011 Oklahoma Health Care Authority Board Meeting

ITEM 9/CONSIDERATION AND VOTE FOR THE EXPENDITURE OF FUNDS FOR OPTION YEARS 1 AND 2 OF LEASEHOLD

Under OAC 317:30-1-16 the agency must seek board approval of all non-professional acquisitions of over $500,000.00**.**

As you know last summer on an emergency basis we completed a lease hold through the Department of Central Services because of flooding at Lincoln Plaza Office Park.

Since then we have occupied Shepard Mall Suite 1A. Recently we have acquired space in Suite 2B for Member Services Division, Insure Oklahoma, the Information Technology Division, and the Legal Division.

In June we must exercise Option year 1 of the lease and next year we will need to exercise Option year 2 of the lease. While we may not need to exercise a full year 2 option, I am requesting the Board approve the encumbrance for Option years 1 and 2 at this time.

The total cost of the lease is $3,401,176.00. As you know the state cost for 2 years of the lease is 50% of this amount or roughly $1,700,560.00.

As you may also know DCS must approve the lease as well.

At this time I am requesting the Board approve the expenditure of funds for the lease of two years.

Information for the agenda:

Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under 63 Oklahoma Statutes 5030.3.

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

Recommendation 1: Prior Authorize Pradaxa® (dabigatran etexilate mesylate)

The Drug Utilization Review Board recommends prior authorization of Pradaxa® (dabigatran etexilate mesylate) requiring an FDA approved indication (special consideration will be given for a diagnosis of DVT when warfarin is not a viable option).

QUALITY IMPROVEMENT ORGANIZATION
Bid# 8070000450

BACKGROUND

The Oklahoma Health Care Authority issued a Request for Proposal (RFP) for a quality improvement organization to perform utilization and peer review functions, and quality improvement activities. The Medicaid program by law must provide methods and procedures to safeguard against unnecessary utilization of care and services and to assure "efficiency, economy and quality of care" as required by law pursuant to section 1902 (a)(30)(A) thru (C) of the Social Security Act (Act) and 42 U.S.C. § 1320c et. seq.

This contract would replace the existing contract with the Innovative Resource Group, d/b/a APS Healthcare Midwest (APS) beginning July 1, 2011 with options to renew through June 30, 2016.

SCOPE OF WORK

Major components of the program are as follows:

- Provide inpatient hospital and outpatient retrospective reviews for the fee-for-service program.
- Provide quality interventions and education for providers.
- Provide quality of care reviews and client satisfaction surveys for the SoonerCare Choice managed care program.
- Complete quality assessment and performance improvement projects.

SOLICITATION & EVALUATION RESULTS

OHCA received four (4) bids in response to this RFP. The responsive bidders are **Iowa Foundation for Medical Care (IFMC), Kansas Foundation for Medical Care (KFMC), and Qualis Health.** We received one bid after the closing time which was judged nonresponsive**.** Bids were scored based on a written evaluation plan and awarded on "best value" criteria which allow consideration of both cost (300 points) and technical merit (700 points.)

The scores are as follows:

IFMC:	Technical score: 514	Cost score: 300	Total Score: 814
KFMC:	Technical score: 498	Cost score: 114	Total Score: 612
Qualis Health:	Technical score: 585	Cost score: 81	Total Score: 666

CONTRACT AMOUNT

The five-year total bid price (through 6/30/16) is $5,117,306.00. This pricing is similar to current contract pricing. Based on estimated volume for SFY 2012, the contract not-to-exceed amount is $1.1 million.

RECOMMENDATION

Board approval to award the contract to Iowa Foundation for Medical Care (IFMC).