OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
April 12, 2012 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 March 8, 2012 OHCA Board Minutes
3. Discussion Item – Reports to the Board by Board Committees

   a) Rules Committee – Member McVay
   b) Legislative Committee – Member McFall
   c) Strategic Planning Committee – Member Armstrong

***Item to be presented by Mike Fogarty, Chief Executive Officer***

4. Discussion Item – Chief Executive Officer's Report

   a) Financial Update – Carrie Evans, Chief Financial Officer
   b) Medicaid Director's Update – Garth Splinter, State Medicaid Director
   c) Legislative Update – Nico Gomez, Deputy Chief Executive Officer

***Item to be presented by Alison Martinez, Clinical Data Analyst of Reporting & Statistics***

5. Discussion Item – Presentation: 'The Role of Genetic Technologies in Health Care'

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

6. Discussion Item – Regulatory Mandate for Medicaid Payment Suspensions and Continuing Contract Terminations

   (a) Regulatory Authority and Contract Authority
   (b) Statistical Report Regarding Actions Taken
   (c) Due Process Rights of Providers

***Item to be presented by Chairman Roggow***

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

   a. Status of Pending Suits

8. New Business

9. ADJOURNMENT

NEXT BOARD MEETING
May 10, 2012
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Ponca Conference Room
Oklahoma City, OK 73107

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
March 8, 2012
Held at the Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on March 7, 2012, 12:30 p.m. Advance public meeting notice is provided to the Oklahoma Secretary of State. In addition to the statutory notice, the agency placed its agenda on its website on March 7, 2012, 12:30 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Roggow called the meeting to order at 1:05 PM.

| | |
|---|---|
| BOARD MEMBERS PRESENT: | Member McVay, Member Bryant, Member Miller, Member Robison, Member McFall, and Chairman Roggow, Vice-Chairman Armstrong |

OTHERS PRESENT:

| | |
|---|---|
| Tom Dunning, OKDHS | Debbie Spaeth, Quest MHSA |
| Lisa Adams, Varangon Academy | Shirley Russell, OKDHS |
| Kristi Blackburn, OKDHS | Judy Parker, Chickasaw Nation |
| Shirley Russell, OKDHS | Kenneth Goodwin, OHCA |
| Justin Martino, e-Capitol | Nichole Burland, OHCA |
| Jennifer King, OHCA | |

**DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD JANUARY 12, 2012.**

| | |
|---|---|
| MOTION: | Member McFall moved for approval of the February 9, 2012 board minutes as published. Member McVay seconded. |
| FOR THE MOTION: | Member McVay, Member Bryant, Member Miller, Member Robison, Member McFall, and Chairman Roggow |
| BOARD MEMBER ABSTAINED: | Vice-Chairman Armstrong |

**ITEM 3 / REPORTS TO THE BOARD BY BOARD COMMITTEES**

Member Miller reported that since the January Financial report was good there was no need for a Finance/Audit meeting.

Member McVay reported that the Rules Committee met and reviewed the rules to be presented with Ms. Cindy Roberts, Deputy Chief Executive Officer.

Member McFall reported that the Legislative Committee met and Mr. Gomez, Deputy Chief Executive Officer would present the update.

Vice-Chairman Armstrong reported that the Strategic Planning Committee met and discussed IT Consolidation.

**ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT**
Mike Fogarty, Chief Executive Officer

**4. a. FINANCIAL UPDATE**
Carrie Evans, Chief Financial Officer

Ms. Evans reported that the Agency is under budget with a positive variance of $25.7 million state, $15.5 million under budget in the Medicaid program spending (.8% under budget) as well as 13.4% Administration, and over budget on all revenue items (tobacco tax collections are 7.4% over which is 100% state dollars). The Supplemental Hospital Offset Payment Program (SHOPP) was approved by the Centers for Medicare and Medicaid Services (CMS) on January 17th. Letters of assessment were mailed on January 23rd, and $75.4 million in assessments collected by OHCA. These payments will be mailed out next Wednesday (March 14th). This payment is for two quarters due to the timing of the CMS approval and two quarters will again be paid the next month; however, next year will be a single payment. For a detailed financial report, see Item 4a of the March 8, 2012 board packet.

**4.b. MEDICAID DIRECTOR'S UPDATE**
Garth Splinter, MD, Deputy State Medicaid Director

Dr. Splinter reviewed the Medicaid Director's Report. He noted that enrollment increased by 7,000 individuals and that there was no discernible growth in the Per Member Per Month (PMPM) Trend graph. For more detailed information, see Item 4.b in the board packet

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

Mr. Gomez reported on the following legislation:
House Bill (HB) 2273, OHCA's request bill which authorizes OHCA to pay for professional expenses such as licenses, memberships, continuing education classes, and association dues, will be heard today. It also requests that OHCA's Drug Utilization Review Board be allowed to make changes in how Hepatitis C, and the Human Immunodeficiency Virus (HIV) drugs and other new market entry drugs are handled. There could be an estimated $2.8 million savings in both state and federal funds.

Senate Bill (SB) 1161 another OHCA request bill regarding Program Integrity staffing, passed through one committee but was allowed to fail the second committee. OHCA will pursue this through the appropriation process instead of the statutory process.

The legislature has finished with the Supplemental Budget request and now will turn their attention toward funding SFY'13 which begins July 1. The Board of Equalization certified $6,580,000,000 dollars which is an increase of $47 million since December with $319 million going into the rainy day fund. Going forward the Legislature will focus on tax cuts and balancing that with the priorities of the agencies.

House Bill (HB) 2270 increases the nursing home quality of care fee and it has moved through the process. This raises the cap on nursing home revenue which could in turn increase nursing home rates.

Senate Bill (SB) 1629 is the result of the Federal Health Care Reform Taskforce – Senator Stanislawski and Representative Mulready – creates a 7 member trust where Insure Oklahoma staff and responsibilities would transfer on July 1, 2013. This is not intended to be compliant with the law but would demonstrate to the federal government Oklahoma's solution to health care reform.

More will be known about the budget picture and what other major policy issues are still alive by the April meeting. For more detailed information, see Item 4.c in the board packet.

**ITEM 5 / RADIOLOGY MANAGEMENT PROGRAM PRESENTATION**

Beth VanHorn, Director, Legal Operations & Ken Goodwin, RN, Manager, Medical Authorization Unit

Mr. Goodwin reviewed the PowerPoint presentation on diagnostic imaging along with Ms. VanHorn. Within the first year of the contract there were more than 58,000 prior authorization requests received and reviewed. These reviews took place within 2 business days of receipt with an 80% rate of approval. These reviews covered all CT Scans, MRI scans with and without contrast, and PET scans. For more detailed information please see Item 5 in the board packet.

**ITEM 6 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING**

Mr. Howard Pallotta, General Counsel, stated that the Conflicts of Interest Panel found no conflicts regarding any action items.

**ITEM TO BE PRESENTED BY CINDY ROBERTS, DEPUTY CEO – PLANNING, POLICY & INTEGRITY DIVISION**

### 7.a. Consideration and Vote upon Permanent rules as follows:

Chairman Roggow asked the Board members if they preferred to vote on the rules *en bloc* or if there were specific rules to be taken one at a time. Rules 7.a-1 and 7.a-2 which were previously approved as Emergency and have been revised for Permanent rule making will be voted on together. Rule 7.a-3 had previously been reviewed by the Board and is pending Gubernatorial approval as Emergency will be voted on individually. Rules 7.a-4 through 7.a-26 has not previously been reviewed by the Board and will be voted e*n bloc w*ith the understanding that questions would be entertained at anytime during the review.

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

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

7.a-1 AMENDING Agency rules at OAC 317:30-5-596.1 to remove service prior authorization requirements for Behavioral Health Case Management services. **(Reference APA WF # 11-27)**

7.a-2 AMENDING Agency rules at OAC 317:30-5-763 and 35-17-3 to remove respiratory therapy as an allowable service within the waiver and remove Hospice when the member is in a nursing facility receiving ADvantage Facility Based Extended Respite. Both services are removed due to lack of utilization. Additionally, rules are revised to remove language allowing for reimbursement to providers of case management transition services when the member fails to transition into the ADvantage waiver program. The revisions are necessary to align OHCA policy with revised operational procedures as approved by the Centers for Medicare and Medicaid Services. Rules are also revised to clarify the types of living arrangements allowable for ADvantage members as well as to make clarifications regarding the member's health, safety and welfare. **(Reference APA WF # 11-39A & B)**

MOTION: Member McFall moved for approval of Rule 7.a-1 and 7.a.2 as presented. Member Bryant seconded.

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

**The following rules HAVE previously been reviewed by the Board and are pending gubernatorial approval under Emergency rulemaking.**

7.a-3 AMENDING Agency rules at OAC 317:30-5-95.24 through 30-5-95.31, 30-5-240 through 30-5-240.2, 30-5-241 through 30-5-241.5, 30-5-276, 30-5-281, 30-5-596, 30-5-741 to Agency Behavioral Health rules are revised in order to sufficiently and accurately set forth the substantive requirements for providing covered SoonerCare behavioral health services. Provider credentials and coverage guidelines will be transferred from the current Behavioral Health Provider Manual to the Agency's Behavioral Health rules in order to comply with rule promulgation requirements set forth in Oklahoma Administrative Procedures Act (APA). These revisions will not only ensure that the Agency remains in compliance with the APA, but also provides the Agency the necessary legal basis to successfully maintain program integrity. Additionally, Outpatient Behavioral Health, Psychologist and Licensed Behavioral Health Professional (LBHP) rules are being revised to remove the guidelines for obtaining authorizations to provide services. Authorization requirements will be placed in the Behavioral Health Provider Manual and the rule revisions will reference the Manual. The authorization requirements are procedural in nature

and are more appropriate in the context of a billing manual rather than the Agency's administrative rules.
**(Reference APA WF # 11-27)**

*Ms. Roberts informed the Board that the Governor approved this rule on March 7, 2012.*

MOTION: Member Miller moved for approval of Rule 7.a-3 as presented. Member McFall seconded.

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

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

7.a-4 AMENDING agency rules at OAC 317:30-5-12, 30-5-664.5, 30-5-1154 and 35-5-2, 35-5-8, 35-7-37, 35-7-48, 35-7-60, 35-7-60.1 and REVOKING agency rules at OAC 317:30-5-465, 30-5-466, and 30-5-467 to remove references to the Family Planning Waiver. Section 2303 of the Patient Protection and Affordable Care Act allows individuals receiving Family Planning Waiver services to receive those same services plus additional family planning and family planning related services under the Title XIX State Plan rather than a waiver program. In addition to a broader service package, the State Plan option allows a more efficient way of making future changes to the SoonerPlan program. If approved, the rule change will allow over 32,000 SoonerPlan members and future members to receive the enhanced package of State Plan Family Planning services. The rule revision also includes the removal of language relating to family planning centers, clarification of eligibility rules and other minor policy corrections.
**(Reference APA WF # 11-03 A&B)**

7.a-5 AMENDING agency rules at OAC 317:30-3-40, 30-3-42, 30-3-57, 30-5-96.2, 30-5-122, 30-5-390, 30-5-410, 30-5-420, 30-5-423, 30-5-480, 30-5-495, 30-5-515, 30-5-535, 30-5-760, 30-5-1011, 30-5-1076, and 35-9-1, 35-9-5, 35-9-25, 35-9-45, 35-9-48.1, 35-9-49, 35-9-97, 35-10-38, 35-15-1, 35-19-3, 35-19-8, 35-19-9, and 40-1-1, 40-5-152, 40-7-4, and 50-1-2, 50-1-3, 50-3-2, 50-5-2, to change language in policy that references "mental retardation" to "intellectual disabilities". Revisions are necessary to comply with Public Law 111-256 (Rosa's Law) that replaces the term mental retardation with intellectual disability, in federal education, health and labor laws.
**(Reference APA WF # 11-04 A, B, C & D)**

7.a-6 AMENDING agency rules at OAC 317:35-6-15 and 35-7-15 to provide clarification regarding dates of application for SoonerCare services. Current rules are difficult to interpret and, in some instances, obsolete. The revisions will make interpreting rules easier for OHCA staff, contracted agency partners,

and applicants to understand when an application is considered received and completed. Rules are further amended to add the Notification of Date of Service feature for hospitals in official agency policy.
**(Reference APA WF # 11-08)**

7.a-7 AMENDING agency rules at OAC 317:50-3-4 to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
**(Reference APA WF # 11-13)**

7.a-8 AMENDING agency rules at OAC 317:50-5-4 to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
**(Reference APA WF # 11-14)**

7.a-9 AMENDING agency rules at OAC 317:35-5-41.8 to include a brief description of the Long-term Care Partnership program. The Long-term Care Partnership program (LTCP) allows individuals with qualified LTCP insurance policies the opportunity to protect certain assets in determining eligibility for SoonerCare long term care services.
**(Reference APA WF # 11-15)**

7.a-10 AMENDING agency rules at OAC 317:30-5-42.6, 30-5-306 and 30-5-307 to correspond to new Medicare guidelines regarding payment to End Stage Renal Disease (ESRD) facilities. Currently policy and methodology utilizes Medicare's old composite rate for a defined set of ESRD items and services, while paying separately for services not included in the composite rate, such as drugs and laboratory tests. This payment system is replaced with a new bundled prospective payment system (PPS), in which a single bundled payment to the ESRD facility for each treatment will cover all renal dialysis services. If the change is not made, OHCA will be out of line with Medicare reimbursement rates for this provider type.
**(Reference APA WF # 11-19)**

7.a-11 AMENDING agency rules at OAC 317:30-3-2 to ensure clarity. Revisions are made to reflect language in 42 CFR 455.414; that provider agreements must be renewed at least every five years. Additionally, revisions are made to revise the contract information for the OHCA Provider Contracting Unit.
**(Reference APA WF # 11-20)**

7.a-12 AMENDING agency rules at OAC 317: 30-5-1201 and OAC 35-23-2, 35-23-3, 35-23-4 to add Assisted Living services as a compensable service under the

Living Choice demonstration program for the elderly and those with physical disabilities. Assisted Living services are personal care and supportive services that are furnished to Living Choice members who reside in an OHCA certified assisted living center. Additionally, rules are revised to add Private Duty Nursing as an allowable service and revise the re-enrollment policy to allow members who have been in Living Choice for the maximum 365 days, and have been re-institutionalized for a minimum of 90 consecutive days, the opportunity to re-enroll in the Living Choice program for an additional 365 days. Finally, rules are revised to include coverage for people who have transitioned to the community from institutions for mental disease.
**(Reference APA WF # 11-21 A&B)**

7.a-13 AMENDING agency rules at OAC 317:30-5-326.1, 30-5-327, 30-5-327.1, 35-3-2, and REVOKING agency rules at 317:30-5-327.2 and ADDING rules at OAC 317:30-5-328 to clarify OHCA's current policy concerning meals and lodging, travel distance, and eligibility. This rule will assist with future cost savings and prevent abuse of services. This rule will also ensure services for current and future SoonerCare members.
**(Reference APA WF # 11-25 A&B)**

7.a-14 ADDING agency rules at OAC 317:30-3-19.1 to explain situations in which a provider agreement and billing privileges may be revoked for improper actions. These situations include noncompliance with enrollment requirements, provider misconduct, and felony convictions, among others. These rules will assist the agency in provider integrity determinations and will align agency policy with CMS's Medicare regulations on provider agreements.
**(Reference APA WF # 11-26)**

7.a-15 AMENDING agency rules at OAC 317:50-1-4 to clarify waiting list procedures for individuals who apply for services but cannot enter the waiver due to capacity limitations. The rules clarify that individuals applying for the waiver but unable receive services due to capacity limitations are placed on a waiting list and enter the waiver on a first on first off basis.
**(Reference APA WF # 11-29)**

7.a-16 AMENDING agency rules at OAC 317:30-5-1023 and 30-5-1027 to align current policy with systematic and coding procedures.
**(Reference APA WF # 11-30)**

7.a-17 AMENDING agency rules at OAC 317:10-1-1 and 10-1-12 to align policy with Department of Central Services (DCS) rules. Rules refer to sections that are not valid; therefore rules need to be revised to reflect new numbering for DCS policy.
**(Reference APA WF # 11-31)**

7.a-18 AMENDING agency rules at OAC 317:30-5-123, 30-5-482, 30-5-1012,

30-5-1014 and at OAC 317:40-5-3, 40-5-5, 40-5-9, 40-5-13, 40-5-59, 40-5-101, 40-5-113, 40-7-12, 40-7-15, 40-7-21 and REVOKING agency rules at OAC 317:40-5-8 to clarify policy for the termination of Agency Companion providers based on certain background check information and to provide clarification on the limits of background search information for Specialized Foster Care providers regarding involvement in a court action. Additionally policy is revised to require architectural modification contractors to provide evidence of a lead based paint safety certificate; the addition of Adult Day Services for members in the Homeward Bound Waiver; Targeted Case Management to be billed weekly rather than monthly; removal of the Physical Status Review score as one of criteria for determining the enhanced rate for Community Based Group services and Job Coaching Services, and removal of Adult Day Services as an option to the member's required employment hours. Other minor policy revisions are also included.
**(Reference APA WF # 11-32 A&B)**

7.a-19 AMENDING agency rules at OAC 317:45-1-3 and 45-1-4 to clarify in-network is defined as the highest percentage reimbursement network approved by OHCA. The rules are also revised to clarify that OHCA will only reimburse expenses related to the highest percentage network.
**(Reference APA WF # 11-33)**

7.a-20 AMENDING agency rules at OAC 317:35-18-1, 35-18-2, 35-18-3, 35-18-4, 35-18-5, 35-18-6, 35-18-7, 35-18-9, 35-18-10, 35-18-11 to remove pilot specific requirements and replace with language that is applicable to all PACE providers. Additional revisions include revising the Nursing Facility Level of Care criteria to be more specific to PACE eligibility criteria and cleaning up rules for clarity.
**(Reference APA WF # 11-35)**

7.a-21 AMENDING agency rules at OAC 317:30-5-696 and 30-5-698 to allow for permanent restoration of a tooth when done as part of a Cvek Pulpotomy. The Cvek Pulpotomy is a procedure that better maintains the vitality of exposed pulps, especially in young patients. Allowing permanent restoration with the Cvek Pulpotomy will reduce the need for root canals. Finally, rules are revised to allow dentists to choose the proper type of crown that best serves the member's oral environment.
**(Reference APA WF # 11-36)**

7.a-22 AMENDING agency rules at OAC 317:30-5-211.10 to remove the requirement for a certificate of medical necessity for positive airway pressure devices (BiPAP and CPAP) as such CMNs are no longer used for authorization decisions. The agency's Medical Authorization Unit and physicians rely on documentation from sleep studies and other medical records to prior authorize.
**(Reference APA WF # 11-38)**

7.a-23 AMENDING agency rules at OAC 317:35-17-1, 35-17-2, 35-17-3, 35-17-4, 35-17-5, 35-17-11, 35-17-12, 35-17-14, 35-17-15, 35-17-16, 35-17-17, 35-17-18, 35-17-19, 35-17-21.1 and 35-17-24 to include the following: removal of language requiring transportation to be provided by Adult Day Health Care Centers; clarification of family support services versus waiver services; addition of language clarifying "client support moderate risk", "client support high risk" and addition of language describing "client support low risk" and "environmental low risk"; the addition of eligibility language clarifying member reauthorization, recertification and redetermination; clarification regarding the member's level of need in order to be eligible for waiver services; policy is revised to remove language allowing a financial eligibility assessment for individuals who are not applying for waiver services; clarification regarding when a new level of care determination is required; removal of language requiring recertification of the member by a case manager and requiring an OKDHS nurse to provide medical certification, and at a minimum annually; language added regarding plan of care documentation when more than one member of the household receives waiver services; clarification regarding the use of family members as paid providers; clarification of conditions requiring a member's service plan goals to be amended; removal of policy regarding the expedited eligibility determination process (SPEED); other minor clean-up language.
**(Reference APA WF # 11-39 A & B)**

7.a-24 AMENDING agency rules at OAC 317:35-5-4, 35-5-43 and 35-22-1 to revise eligibility policy for clarity and updates. All changes are minor and will not affect programs or budget. The revisions include changing a form number and altering punctuation to ensure the meaning and intention of the policy is clear.
**(Reference APA WF # 11-40)**

7.a-25 AMENDING agency rules at OAC 317:35-13-7 to address sanctioning of members who abuse SoonerCare benefits. For members who OHCA has determined to have abused their benefits, sanctions are put in place such that on the first violation, the member's eligibility will be suspended for up to six months; for the second violation, the member's eligibility will be suspend for up to twelve months; and for the third violation, the member's eligibility will be suspended indefinitely. All sanctions, including the length of the penalty period, are subject to administrative due process.
**(Reference APA WF # 11-42)**

7.a-26 AMENDING agency rules at OAC 317:30-5-7 to allow reimbursement for a pain management procedure when performed during an anesthesia session.
**(Reference APA WF # 11-43)**

<u>MOTION:</u> Member McFall moved for approval of Rules 7.a-4 through 7.a-26 as presented. Member Bryant seconded.

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

**ITEM TO BE PRESENTED BY NANCY NESSER, DIRECTOR, PHARMACY SERVICES**

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

   a. Consideration and vote to add **prenatal vitamins, Soliris® (eculizumab),** and **Onfi® (clobazam)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

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

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

**ITEM 11 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (1), (4) AND (7)**

Mr. Howard Pallotta advised that an Executive Session was not needed for this board meeting.

**12 / NEW BUSINESS**

There was no new business

**13 / ADJOURNMENT**

MOTION: Member McFall moved for adjournment. Member Bryant seconded.

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

Meeting adjourned at 2:10 p.m., 3/8/2012

NEXT BOARD MEETING
April 12, 2012

Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A, Ponca Conference Room
Oklahoma City, OK 73107

*Kay Davis*
*Acting Board Secretary*

*Minutes Approved:* _______________

*Initials:* _______________

# FINANCIAL REPORT

For the Eight Months Ended February 29, 2012
Submitted to the CEO & Board
April 12, 2012

- Revenues for OHCA through February, accounting for receivables, were **$2,386,006,316** or **(.2%) under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$2,338,392,883** or **1.4% under** budget.

- The state dollar budget variance through February is **$28,413,814 positive.**

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

| | | |
|---|---|---|
| **Expenditures:** | | |
| Medicaid Program Variance | | 13.6 |
| Administration | | 4.8 |
| **Revenues:** | | |
| Taxes and Fees | | 3.5 |
| Drug Rebate | | 3.3 |
| Overpayments/Settlements | | 3.2 |
| **Total FY 12 Variance** | **$** | **28.4** |

**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 2012, For the Eight Months Ended February 29, 2012

| REVENUES | FY12 Budget YTD | FY12 Actual YTD | Variance | % Over/ (Under) |
|---|---|---|---|---|
| State Appropriations | $ 635,141,710 | $ 635,141,710 | $ - | 0.0% |
| Federal Funds | 1,438,692,885 | 1,411,659,854 | (27,033,031) | (1.9)% |
| Tobacco Tax Collections | 36,880,358 | 40,110,680 | 3,230,322 | 8.8% |
| Quality of Care Collections | 34,029,156 | 34,310,889 | 281,733 | 0.8% |
| Prior Year Carryover | 55,003,490 | 55,003,490 | - | 0.0% |
| Federal Deferral - Interest | 242,644 | 242,644 | - | 0.0% |
| Drug Rebates | 114,100,498 | 123,254,729 | 9,154,231 | 8.0% |
| Medical Refunds | 27,400,582 | 35,704,282 | 8,303,700 | 30.3% |
| SHOPP | 37,317,269 | 37,317,269 | - | 0.0% |
| Other Revenues | 12,817,382 | 13,260,768 | 443,387 | 3.5% |
| **TOTAL REVENUES** | **$ 2,391,625,974** | **$ 2,386,006,316** | **$ (5,619,658)** | **(0.2)%** |

| EXPENDITURES | FY12 Budget YTD | FY12 Actual YTD | Variance | % (Over)/ Under |
|---|---|---|---|---|
| **ADMINISTRATION - OPERATING** | **$ 29,143,306** | **$ 25,538,203** | **$ 3,605,103** | **12.4%** |
| **ADMINISTRATION - CONTRACTS** | **$ 80,819,917** | **$ 70,335,071** | **$ 10,484,846** | **13.0%** |
| **MEDICAID PROGRAMS** | | | | |
| Managed Care: | | | | |
| SoonerCare Choice | 21,779,913 | 20,480,815 | 1,299,098 | 6.0% |
| Acute Fee for Service Payments: | | | | |
| Hospital Services | 599,372,512 | 582,328,750 | 17,043,762 | 2.8% |
| Behavioral Health | 215,870,403 | 241,906,985 | (26,036,582) | (12.1)% |
| Physicians | 283,947,987 | 271,861,565 | 12,086,423 | 4.3% |
| Dentists | 98,088,537 | 96,549,613 | 1,538,923 | 1.6% |
| Other Practitioners | 49,975,900 | 47,818,101 | 2,157,799 | 4.3% |
| Home Health Care | 15,076,075 | 14,197,369 | 878,706 | 5.8% |
| Lab & Radiology | 36,664,203 | 34,729,386 | 1,934,817 | 5.3% |
| Medical Supplies | 32,756,565 | 32,441,713 | 314,852 | 1.0% |
| Ambulatory Clinics | 59,193,019 | 54,758,976 | 4,434,043 | 7.5% |
| Prescription Drugs | 253,591,126 | 255,402,950 | (1,811,823) | (0.7)% |
| Miscellaneous Medical Payments | 21,915,306 | 22,388,056 | (472,750) | (2.2)% |
| OHCA TFC | - | - | - | 0.0% |
| Other Payments: | | | | |
| Nursing Facilities | 330,001,508 | 329,843,567 | 157,941 | 0.0% |
| ICF-MR Private | 39,611,699 | 38,172,956 | 1,438,742 | 3.6% |
| Medicare Buy-In | 97,852,767 | 93,563,173 | 4,289,594 | 4.4% |
| Transportation | 18,740,543 | 18,424,602 | 315,941 | 1.7% |
| EHR-Incentive Payments | 38,230,295 | 38,230,295 | - | 0.0% |
| Part D Phase-In Contribution | 49,705,392 | 49,420,737 | 284,655 | 0.6% |
| **Total OHCA Medical Programs** | **2,262,373,750** | **2,242,519,609** | **19,854,141** | **0.9%** |
| OHCA Non-Title XIX Medical Payments | 89,382 | - | 89,382 | 0.0% |
| **TOTAL OHCA** | **$ 2,372,426,355** | **$ 2,338,392,883** | **$ 34,033,472** | **1.4%** |
| **REVENUES OVER/(UNDER) EXPENDITURES** | **$ 19,199,619** | **$ 47,613,433** | **$ 28,413,814** | |

# SoonerCare Programs

## February 2012 Data for April 2012 Board Meeting

### SOONERCARE ENROLLMENT/EXPENDITURES

| Delivery System | | Monthly Enrollment Average SFY2011 | Enrollment February 2012 | Total Expenditures February 2012 | Average Dollars Per Member Per Month February 2012 |
|---|---|---|---|---|---|
| **SoonerCare Choice Patient-Centered Medical Home** | | 449,392 | **478,156** | **$169,582,464** | |
| *Lower Cost* | *(Children/Parents; Other)* | | 433,292 | $124,205,216 | $287 |
| *Higher Cost* | *(Aged, Blind or Disabled; TEFRA; BCC)* | | 44,864 | $45,377,248 | $1,011 |
| **SoonerCare Traditional** | | 239,274 | **240,205** | **$209,021,753** | |
| *Lower Cost* | *(Children/Parents; Other)* | | 132,589 | $52,732,831 | $398 |
| *Higher Cost* | *(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)* | | 107,616 | $156,288,923 | $1,452 |
| **SoonerPlan** | | 31,082 | **42,111** | **$1,052,284** | $25 |
| **Insure Oklahoma** | | 32,181 | **31,479** | **$11,495,723** | |
| *Employer-Sponsored Insurance* | | 19,095 | 17,774 | $5,158,474 | $290 |
| *Individual Plan* | | 13,085 | 13,705 | $6,337,249 | $462 |
| **TOTAL** | | **751,928** | **791,951** | **$391,152,225** | |

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 $35,775,546 are excluded.

| Net Enrollee Count Change from Previous Month Total | 4,092 |
|---|---|

| New Enrollees | 19,696 |
|---|---|

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

| Qualifying Group | Age Group | Enrollment |
|---|---|---|
| Aged/Blind/Disabled | *Child* | 19,397 |
| Aged/Blind/Disabled | *Adult* | 131,409 |
| Other | *Child* | 176 |
| Other | *Adult* | 20,633 |
| PACE | *Adult* | 93 |
| TEFRA | *Child* | 430 |
| Living Choice | *Adult* | 99 |
| **OLL Enrollment** | | **172,237** |

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

| | | Monthly Average SFY2011 | Enrolled February 2012 | PER MEMBER PER MONTH |
|---|---|---|---|---|
| **Long-Term Care Members** | | **15,733** | **15,751** | **$3,840** |
| | *Child* | 92 | 82 | |
| | *Adult* | 15,641 | 15,669 | |

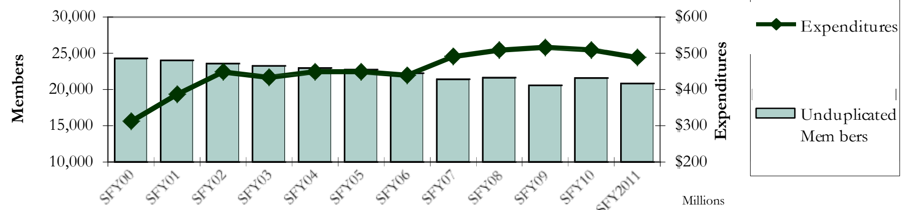
**SFY2011 Long-Term Care**

**Statewide LTC Occupancy Rate - 71.0%**
**SoonerCare funded LTC Bed Days 68.2%**

Data as of October 2011

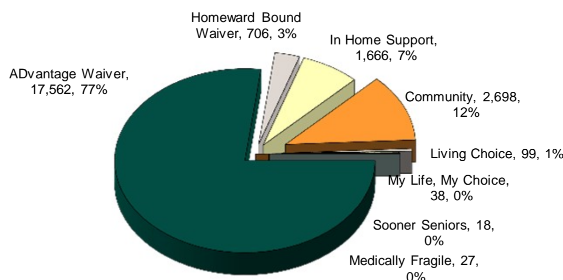
| Medicare and SoonerCare | Monthly Average SFY2011 | Enrolled February 2012 |
|---|---|---|
| **Dual Enrollees** | **103,906** | **108,059** |

**Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends**




Data as of Aug. 8, 2011. 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.
**Sooner Seniors** - This program is for adults 65 and older with long term illnesses who transitioned to community-based services in the Living Choice program.

# SoonerCare Programs

## SOONERCARE CONTRACTED PROVIDER INFORMATION

| Provider Counts | Monthly Average SFY2011 | Enrolled February 2012 |
|---|---|---|
| **Total Providers** | **29,026** | **38,981** |
| *In-State* | 20,585 | 28,691 |
| *Out-of-State* | 8,442 | 10,290 |

| Program | % of Capacity Used |
|---|---|
| SoonerCare Choice | 39% |
| SoonerCare Choice I/T/U | 14% |
| Insure Oklahoma IP | 3% |

| Select Provider Type Counts | In-State Monthly Average SFY2011* | In-State Enrolled February 2012** | Total Monthly Average SFY2011 | Total Enrolled February 2012 |
|---|---|---|---|---|
| Physician | *6,489* | *7,699* | *11,777* | 13,883 |
| Pharmacy | *901* | *876* | *1,230* | 1,160 |
| Mental Health Provider*** | *935* | *4,168* | *982* | 4,227 |
| Dentist | *798* | *1,005* | *901* | 1,148 |
| Hospital | *187* | *195* | *739* | 961 |
| Licensed Behavioral Health Practitioner*** | *503* | *3,516* | *524* | 3,550 |
| Extended Care Facility | *392* | *363* | 392 | 363 |

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

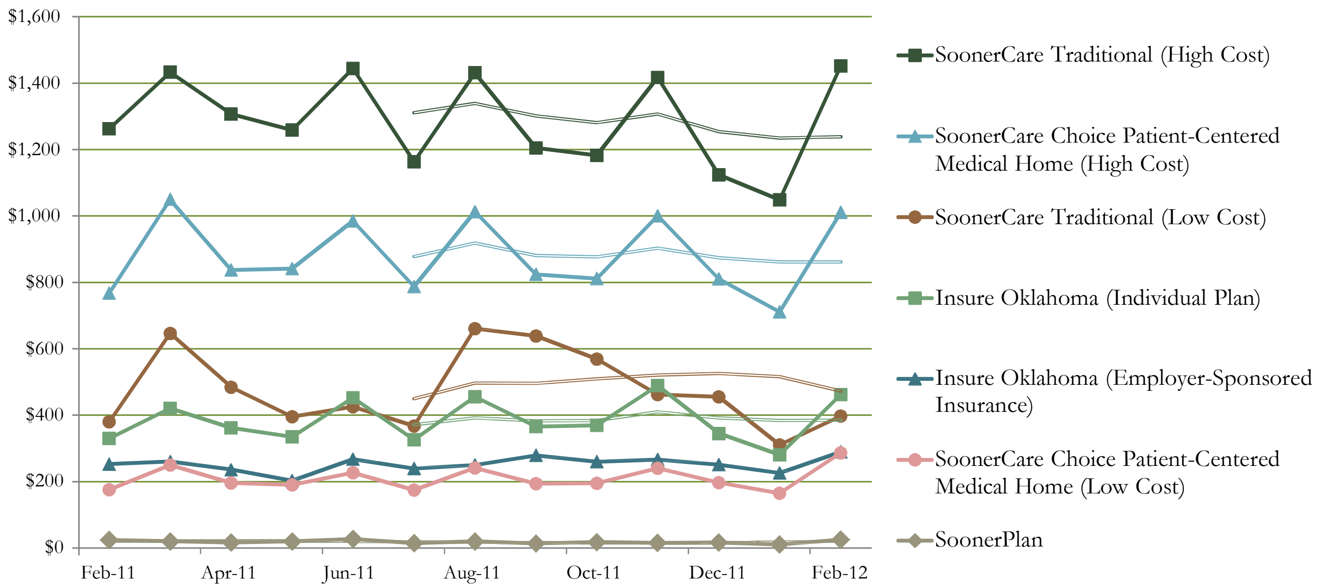
| | | | | |
|---|---|---|---|---|
| Total Primary Care Providers | *4,461* | *4,690* | 6,467 | 6,511 |
| Patient-Centered Medical Home | *1,476* | *1,748* | 1,502 | 1,776 |

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.

***Due to federal regulations, OHCA must have an approved agreement on file for all providers providing care to our members. To meet this requirement OHCA is directly contracting with providers that had previously billed through a group or agency. This contributed to the increase in the provider counts for Licensed Behavioral Health Practitioners and Mental Health Providers.

## SOONERCARE PER MEMBER PER MONTH (PMPM) TRENDS




*In January 2012 there was a change in billing which led to a marked decrease in physician and hospital claims for January and an increase in February claims.

## 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.

| As Of 4/2/2012 | March 2012 | | Since Inception | |
|---|---|---|---|---|
| | Number of Payments | Payment Amount | Total Number of Payments | Total Payment Amount |
| Eligible Professionals | 75 | $1,593,750 | 1,170 | $25,025,417 |
| Eligible Hospitals | 1* | $225,000 | 73 | $50,762,837 |
| Totals | 76 | $1,818,750 | 1,243 | $75,788,254 |

*Current Eligible Hospitals Paid
PUSHMATAHA HSP

# OHCA BOARD MEETING

**APRIL 12, 2012 OHCA BOARD MEETING**

OHCA REQUEST BILLS:

- HB 2273 – Rep. Doug Cox – Allows OHCA to pay for professional expenses for OHCA CEO and Physicians; Permits Prior Authorizations for Hepatitis C and HIV prescriptions; **Committee Substitute passed Senate Appropriations 17-0 on 4-4-2012.**
- SB 1161 – Sen. Gary Stanislawski – Authorizes OHCA to employ one Program Integrity auditor for every $100,000,000 expended in state and federal funds if the return on investment, including cost avoidance, is greater than the total direct and indirect costs of the employee. Program integrity auditors shall not count toward any full-time equivalent limitations on the agency. **Failed Deadline 2-20-2012**.

After the March 15th and 29th Senate bill deadlines and as of noon, Thursday, April 5th, 2012, the Oklahoma Legislature is currently tracking a total of 966 bills. OHCA is currently tracking 95 bills. They are broken down as follows:

| | |
|---|---|
| • OHCA Request | 02 |
| • Direct Impact | 29 |
| • Agency Interest | 08 |
| • Employee Interest | 17 |
| • 2011 Carryover | 39 |

**SENATE AND HOUSE DEADLINES**
**Remaining Deadlines**

| | |
|---|---|
| April 05, 2012 | Deadline for Reporting Single Assigned House Bills in Senate Committees |
| April 12, 2012 | Deadline for Reporting Double-Assigned House Bills from 2nd Committee and Deadline for Reporting Senate Bills and Joint Resolutions from House Committees |
| April 26, 2012 | Deadline for Third Reading of Bills in Opposite Chamber |
| May 25, 2012 | Sine Die Adjournment of the Second Session of the 53rd Legislature |

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

# The Role of Genetic Technologies in Health Care

Alison A. Martinez
Reporting & Statistics
April 12, 2012

# Agenda

- Genetics in Health Care
- Emerging Developments
- Implications

# Genetic Advancement has Enabled Development of the Biotech Market

## Biotechnology/Biopharmaceuticals/Biologics

- Products derived from cells or cellular products
- Products that are modified genetically in any way
- Generally large, complex molecules
- Can not be administered orally (with current technology)



Source: Regulatory Rapporteur, Biopharmaceuticals in the U.S. and European Markets

# Significant Proportion of the Pipeline is Now Biotech

**Pharmaceutical Pipeline by Therapeutic Group (2010)**

Number of Active Pharmaceuticals

3,000
2,500
2,000
1,500
1,000
500
0

Alimentary / Metabolic
Anti-Infective
Anticancer
Neurological
Biotech

24% of Active Pharmaceuticals

Source: PharmaProjects (Therapeutic groups are not mutually exclusive, and not all therapeutic groups are displayed)

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# Biologics are a Key Driver of Growth in Pharmaceutical Costs

**Global Market for Biologic Drugs (2009-2015F)**

Billions

$300
$250
$200
$150
$100
$50
$0

2009
2010
2015

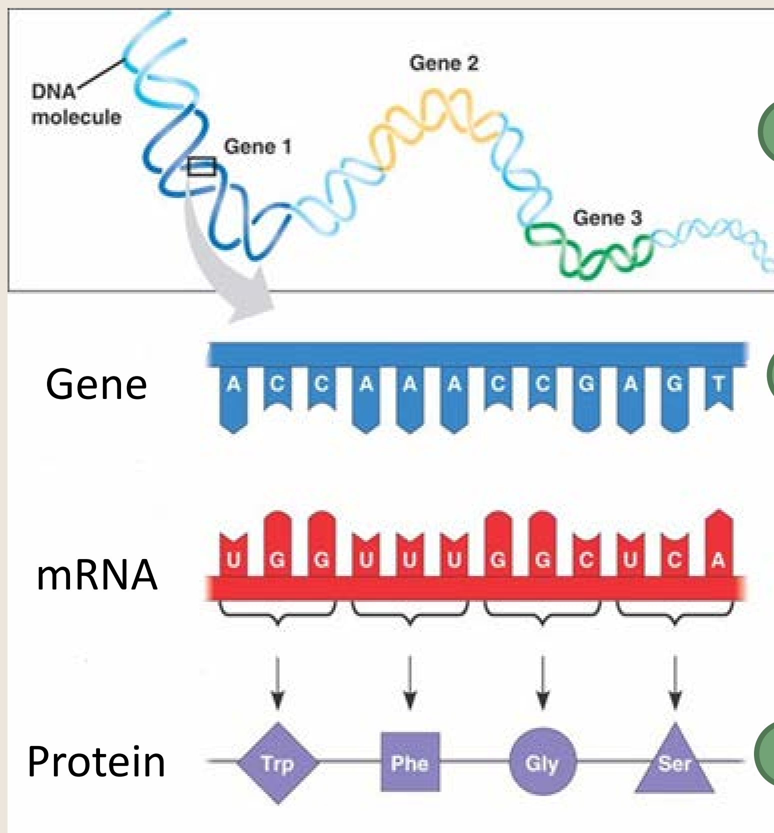
Therapeutic Proteins | MAbs | Vaccines

Key challenge will be ensuring that biologic therapies are used appropriately via genetic testing and/or prior authorization requirements



Source: BCC Research

# 'Genetic Testing' Includes a Range of Test Types

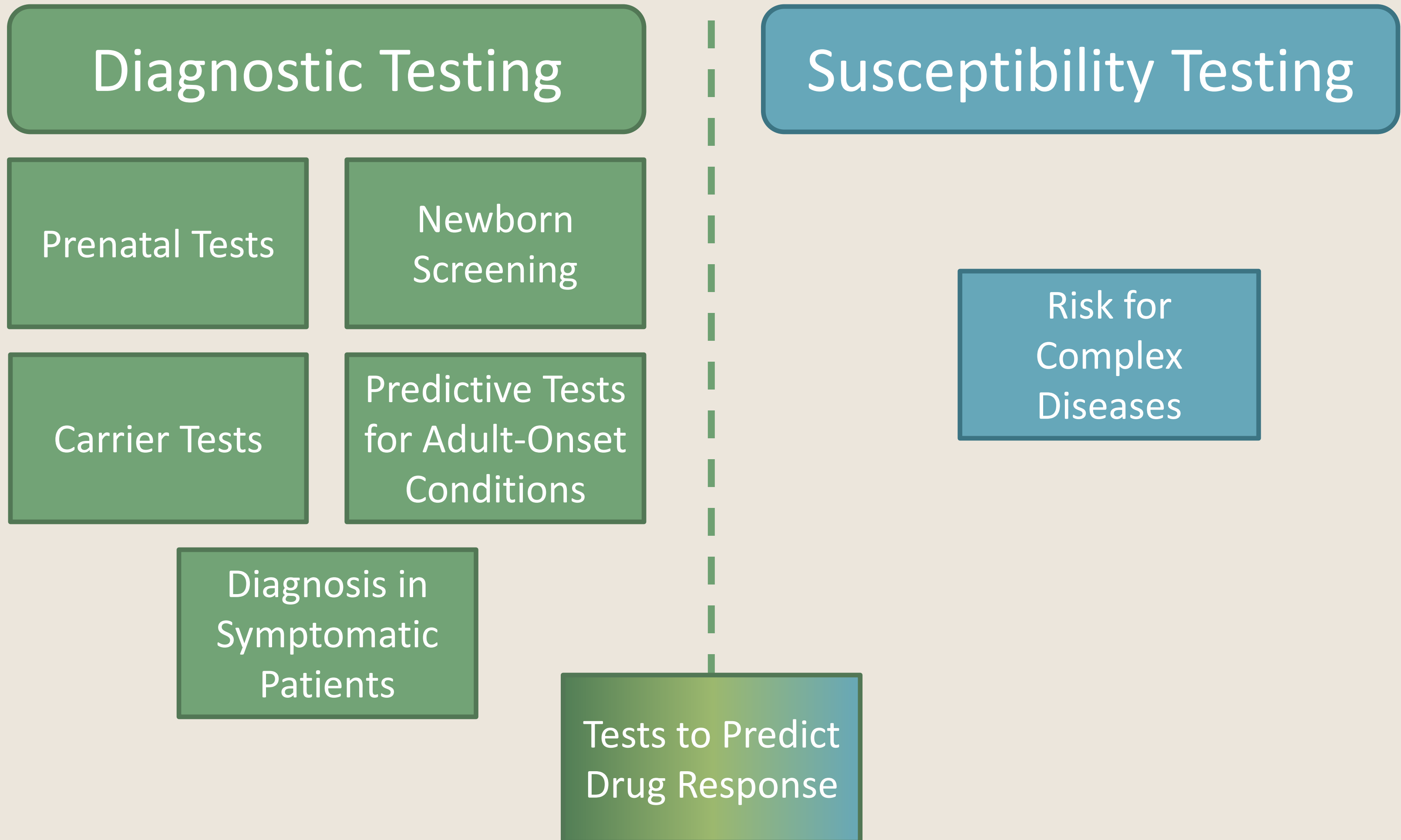



1 → Chromosomal Tests

2 → Gene Tests

3 → Biochemical Tests

# Genetic Testing Already Plays an Important Role in Health Care




Source: Nature

# Payers are Setting Criteria for Coverage of Genetic Tests

| | |
|---|---|
| Cigna | • The results will directly impact clinical decision-making and/or clinical outcome for the individual |
| Aetna | • The result of the test will directly impact the treatment being delivered |
| Oregon Medicaid | • Results would change treatment, change health monitoring, or provide prognosis |



Source: Cigna, Aetna, Oregon Health and Science University

# Genetic Testing is Critical when Drug Requires a Specific Genotype

| Drug | Label |
|---|---|
| Herceptin<br>(Breast Cancer)<br>~$70K / Course | "… HER2 protein overexpression is necessary for selection of patients appropriate for Herceptin therapy …" |
| Erbitux<br>(Colorectal Cancer)<br>~$80K / Course | "… Use of Erbitux is not recommended for the treatment of colorectal cancer with these mutations …" |
| Ziagen<br>(HIV)<br>~$20 / day | "… screening for the HLA-B*5701 allele is recommended…" |
| Plavix<br>(Blood Clot Prevention)<br>~$7 / day | "… Consider alternative treatment strategies in patients identified as CYP2C19 poor metabolizers …" |

In some cases, genetic testing should be required.
In others, genetic testing should be limited.



Source: MedCo, Medscape, Product Labels, Medical Device Daily, ASCO, Bloomberg

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# Patients Can Now Initiate Their Own Genetic Testing

- Several companies (e.g., www.23andme.com, www.decodeme.com) now offer direct-to-consumer (DTC) genetic information
- After sending a DNA sample to one of these firms, the customer receives an estimated level of risk for specific conditions based on their genotype
- The clinical utility of DTC genetic tests is currently questionable at best
  - Few specific, actionable interventions are available to patients at risk for common, complex diseases

Providers must become more adept at patient education and interpretation of genetic data

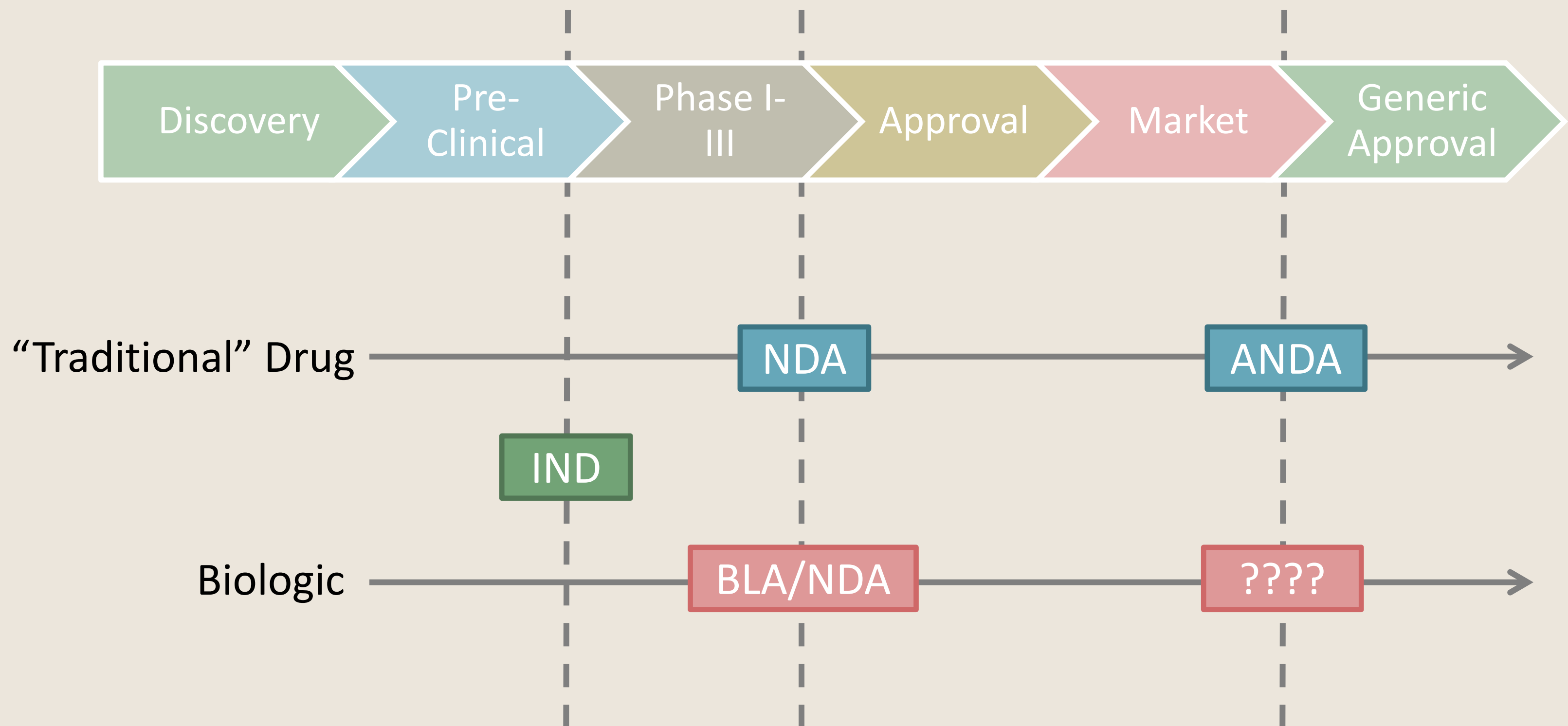


Source: New England Journal of Medicine

# Agenda

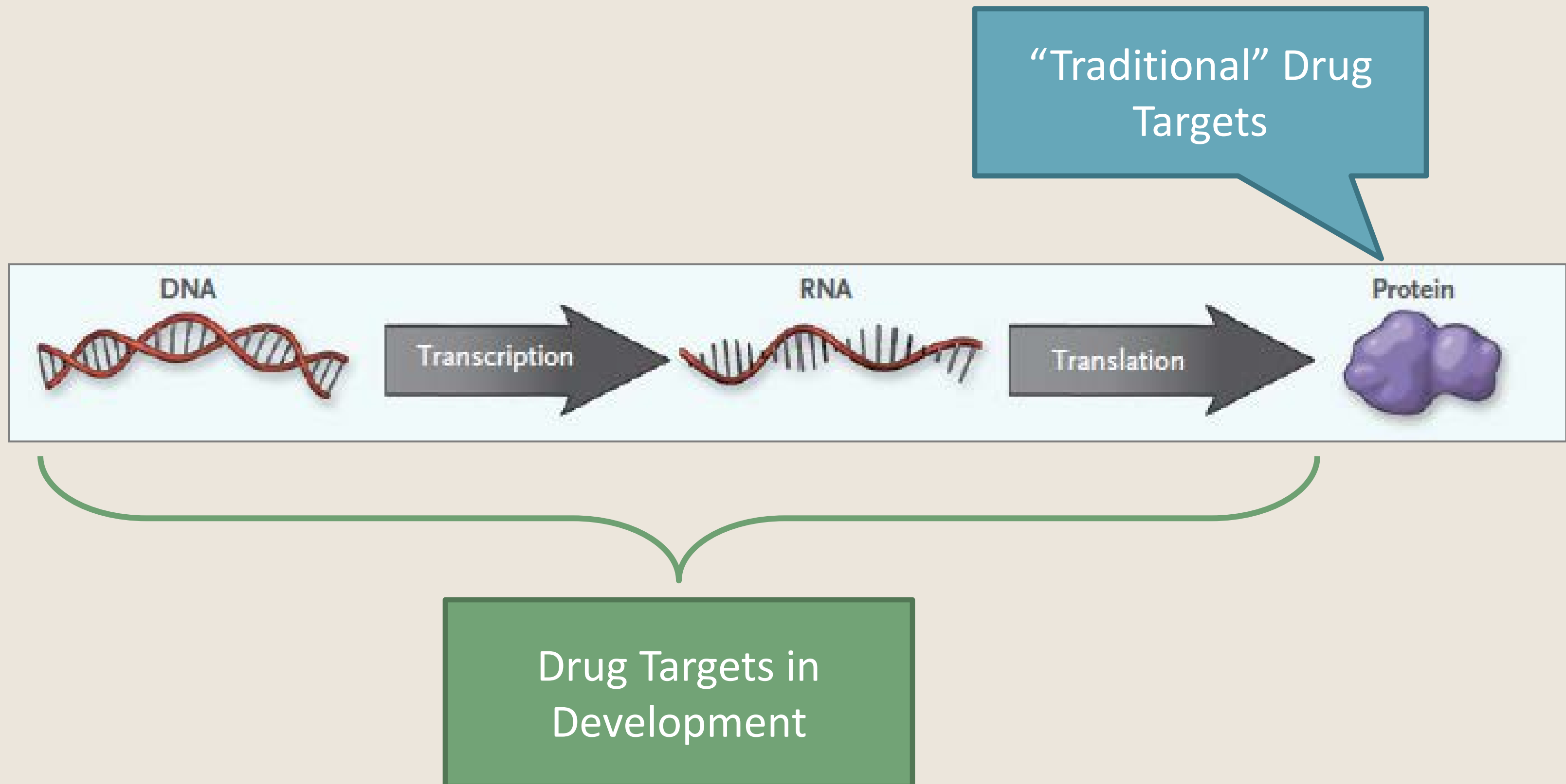
- Genetics in Health Care
- Emerging Developments
- Implications

# Path to FDA Approval for Generic Biologics is Still Being Defined




Source: ThomsonReuters

# New Therapies Offer Alternatives to "Traditional" Drug Targets




Source: New England Journal of Medicine

# Agenda

- Genetics in Health Care
- Recent and Emerging Developments
- Implications

# Biotech Will Have a Growing Budget Impact

- "Blockbuster" biologic drugs will continue to emerge
- Many pipeline biologics—cancer therapeutics, in particular—are currently in development as adjuvant therapies
  - Their cost will be in addition to—and likely significantly greater than—the current standard of care
- Introduction of novel biologic drugs will increase costs without necessarily reducing utilization of other services
- The introduction of generic biologics could partially mitigate the impact of biotech growth

# Ongoing Evaluation of New Tests and Drugs will be Required

- More approved products will vary in effectiveness or safety profile across genotypes
- Significant effort will be needed to determine whether genetic testing should be covered
  - When a specific genotype is required for effectiveness, testing should be mandatory
  - When effectiveness or risk varies across genotypes, criteria should be set for individual products
  - In the absence of clinical utility, testing should not be covered

# Regulatory Mandate for Payment Suspensions and Continuing Contract Terminations

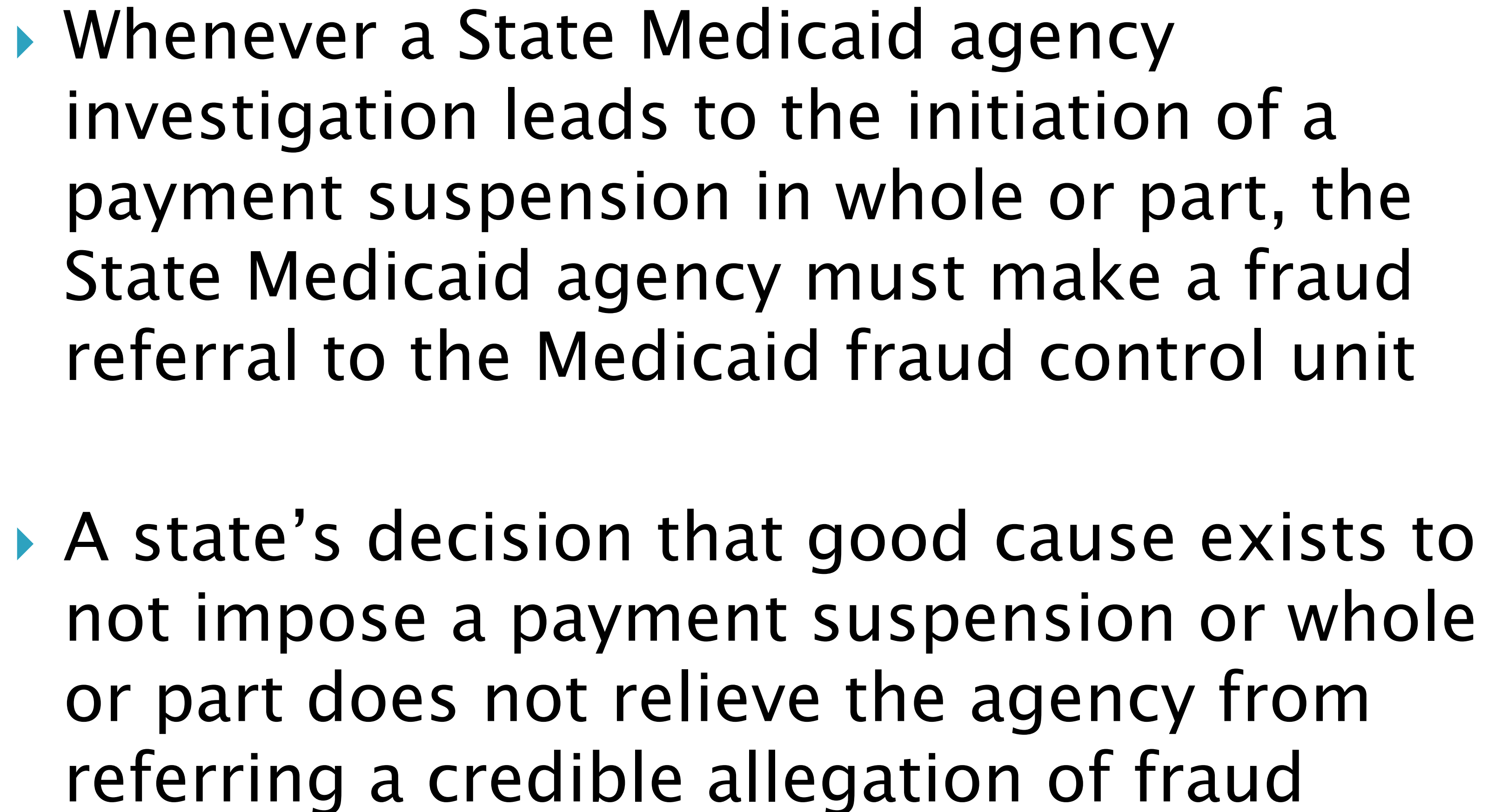
# Soonercare Contract Provisions

- OHCA may terminate a contract for :
  - Cause with a thirty (30) day notice,
  - Without cause with a sixty (60) day notice,
  - Immediately; (1) to protect the health and safety of Members, (2) upon evidence of fraud or (3) if the provider’s license/ accreditation or certification is modified, suspended, revoked or terminated.

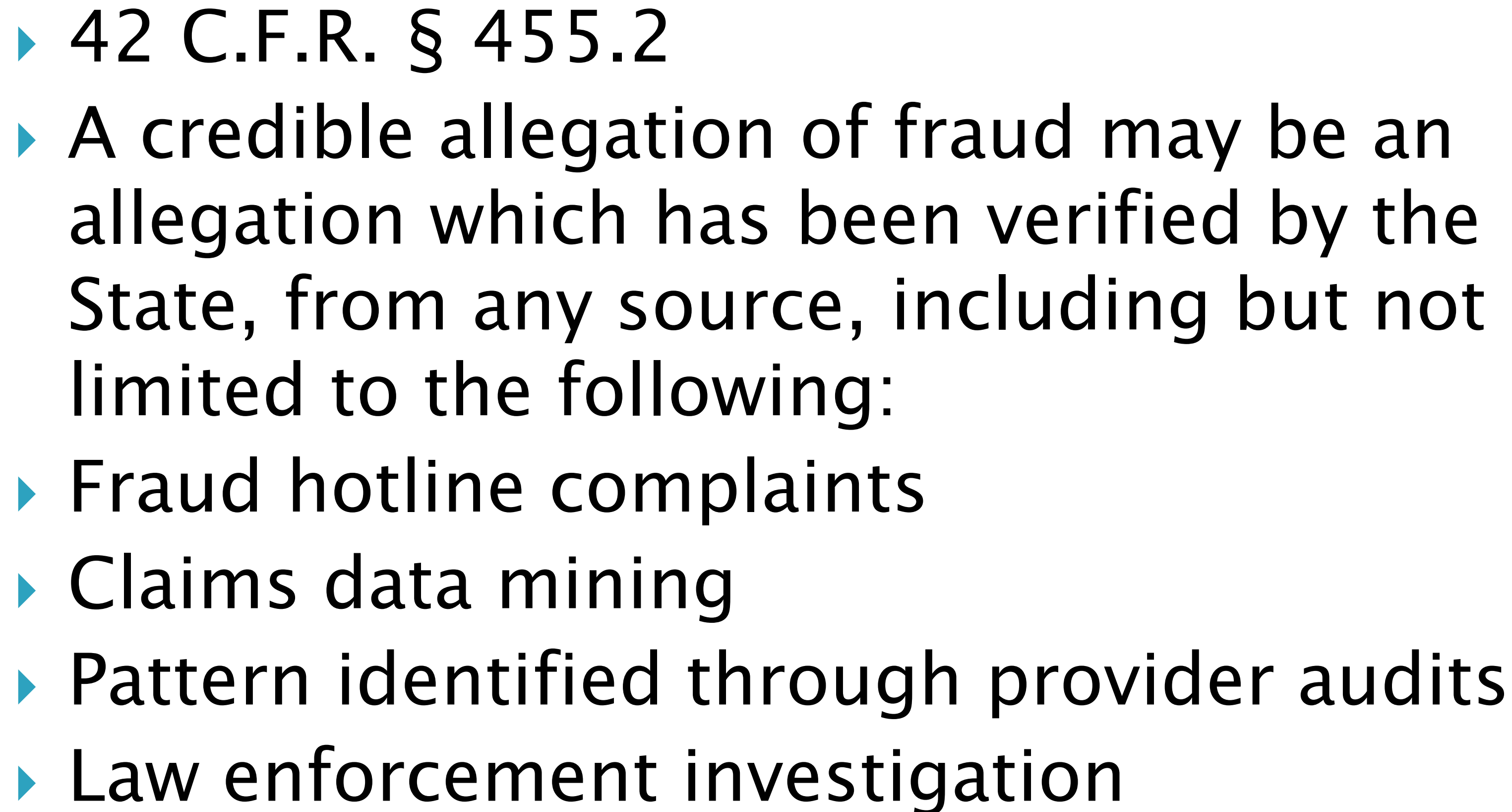
# Medicaid Regulations

- 42 C.F.R. § 455.23
  - "The State Medicaid Agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud"
  - The State Medicaid Agency may suspend payments in part or not suspend, if during an investigation it determines it has good cause to do so.

# 42 C.F.R. § 455.23 (d)

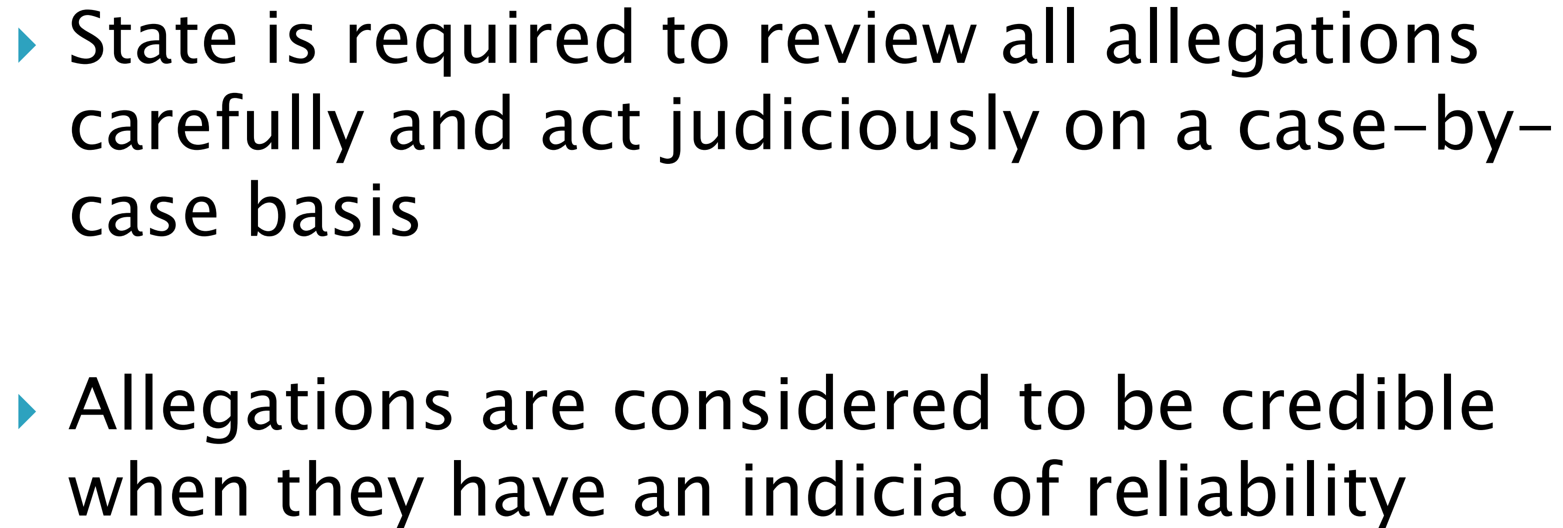


# Credible Allegation of Fraud



- 42 C.F.R. § 455.2
- A credible allegation of fraud may be an allegation which has been verified by the State, from any source, including but not limited to the following:
- Fraud hotline complaints
- Claims data mining
- Pattern identified through provider audits
- Law enforcement investigation

# Credible Allegation of Fraud



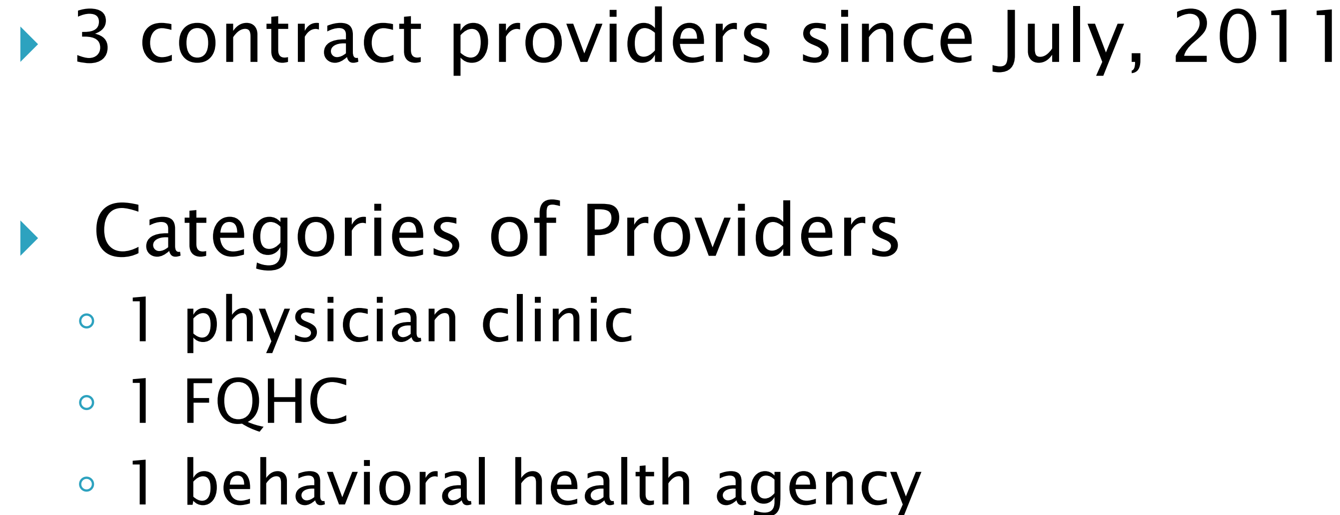
- State is required to review all allegations carefully and act judiciously on a case-by-case basis
- Allegations are considered to be credible when they have an indicia of reliability

# Contract Terminations Since July 2011

- 35 contract terminated– these include all terminations; cause and or fraud, immediate and 30, or 60 day terminations

- Categories of Providers
  - 20 Physicians
  - 5 Physician Assistants
  - 1 Dentist
  - 2 Licensed Behavioral Health Agencies
  - 3 Licensed Counselors
  - 3 Licensed Behavioral Health Professionals
  - 1 Telemedicine Provider

# Provider Suspension of Payments



# Why activity increase?

- Three causes
  - Quality Control Activity has increased
  - New federal regulatory guidance
  - Increase in the agency’s ability to data mine

# New Activity in Context

- Number of Soonercare Physician contracts
  - July 2011 Benchmark 12,490 ;  26 actions

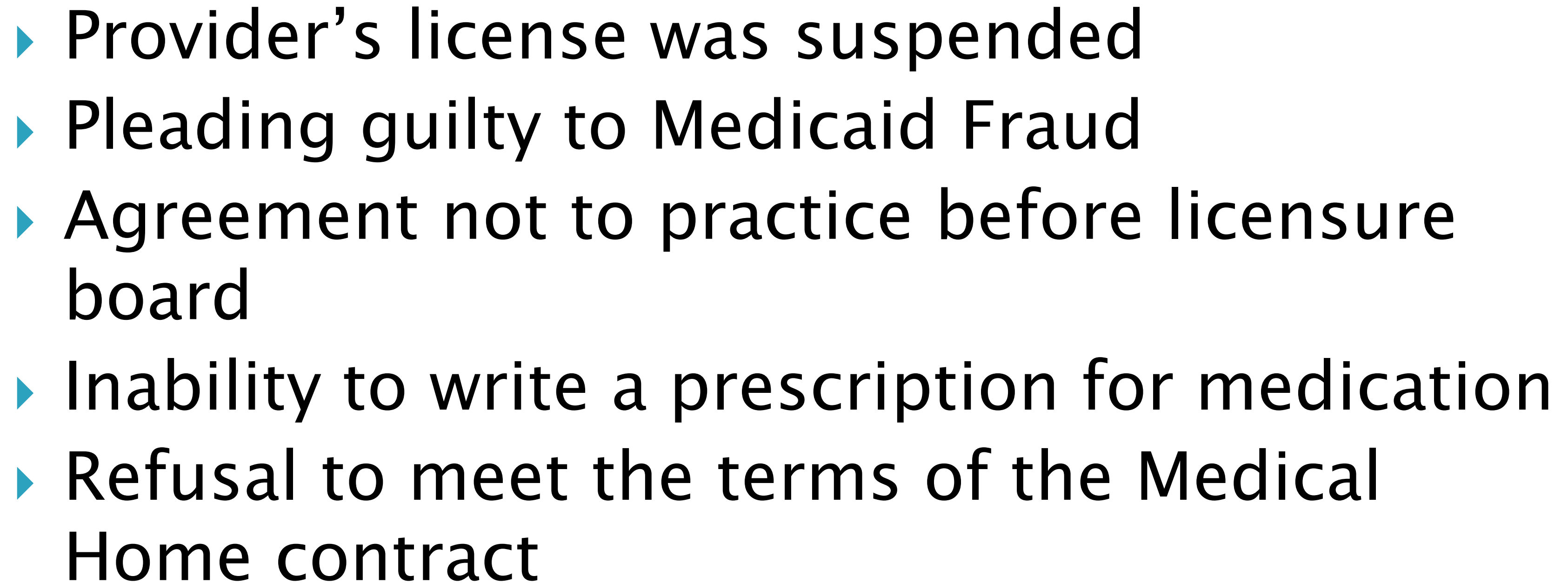
- Number of Behavioral Health Agencies
  - July 2011 Benchmark 904 ; 3 actions

  - Number of Individual Behavioral Health Providers 3550; 6 providers

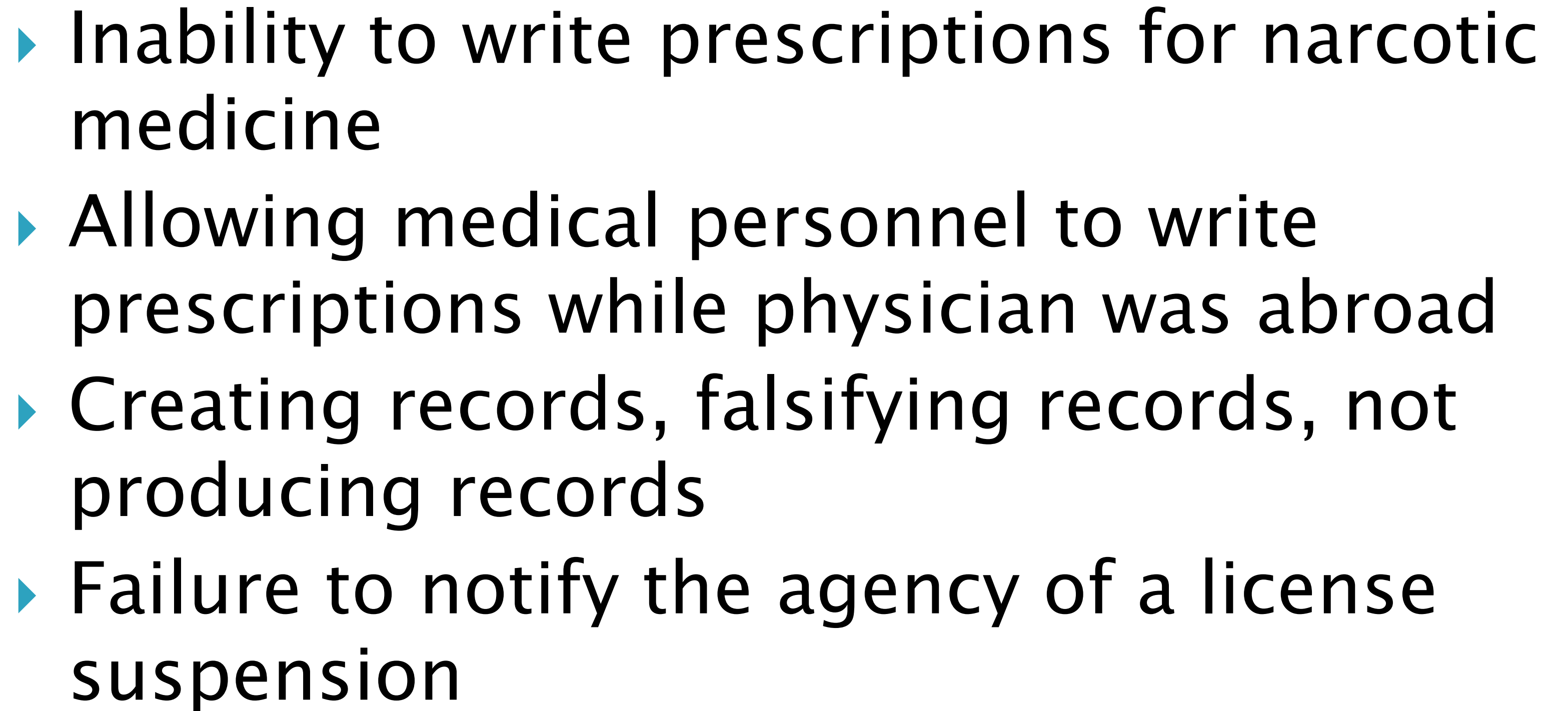
# Some findings we have made causing action

- In a four month period, billing > 24 hours/day occurred 47 times
- In a four month period, billing >16 hours/day occurred 85 times
- In a year period, billing > 24 hours/day occurred 32 times
- In a seven month period, billing > 16 hours/day occurred17 times, 5 of which were > 24 hours/day
- During a nine month period, billing > 12 hours/day occurred165 times, 81 times > 24 hours/day

# More Findings

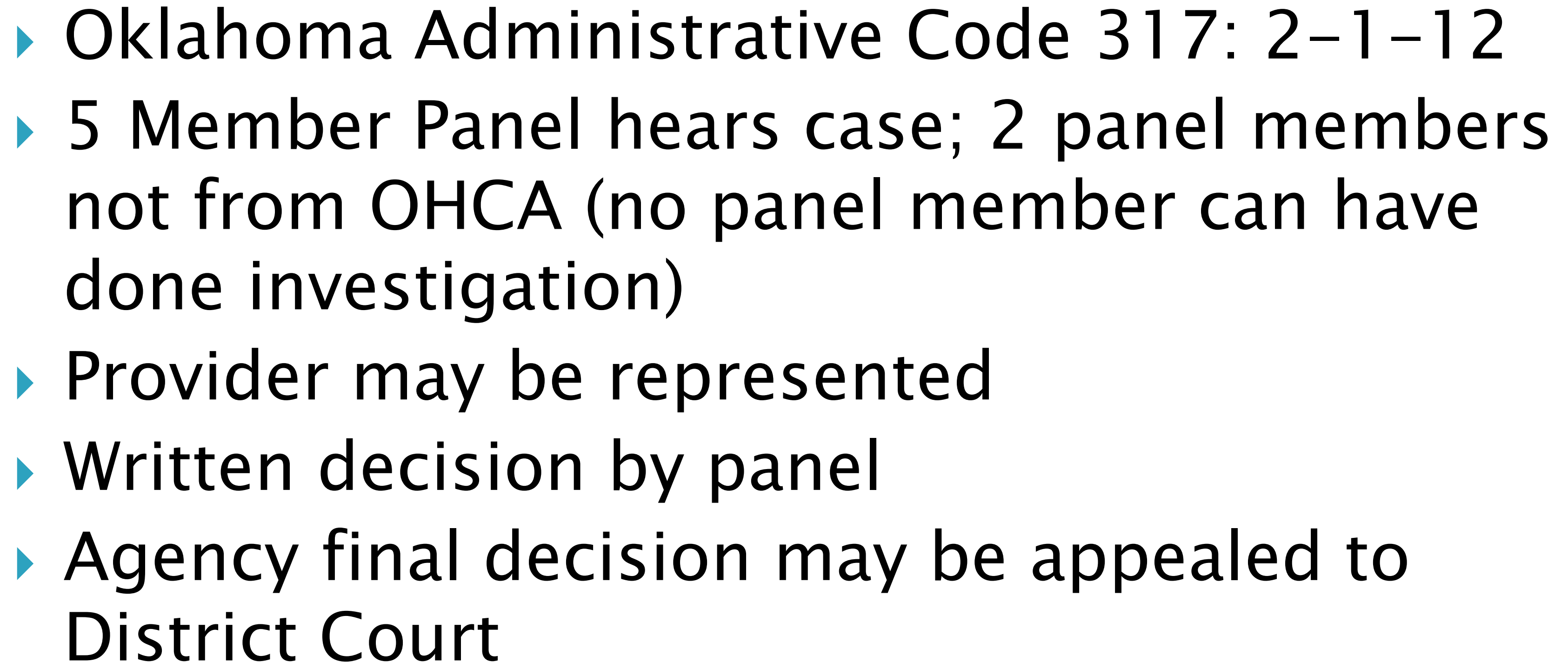


# More Findings



- Inability to write prescriptions for narcotic medicine
- Allowing medical personnel to write prescriptions while physician was abroad
- Creating records, falsifying records, not producing records
- Failure to notify the agency of a license suspension

# Due Process for Contract Terminations



# PROVIDER LETTER

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

OHCA 2012-13

March 26, 2012

**Re: Provider Suspension of Payments & Provider Enrollment Verification**

Dear Provider:

In March, 2011 new, more stringent Medicaid regulations were implemented at the federal level, which directly affect the way the Oklahoma Health Care Authority (OHCA) enforces accountability in the SoonerCare program.

The new regulations primarily command OHCA to perform three tasks:

1. Upon "receipt of a credible allegation of fraud, "OHCA must suspend provider payments. 42 C.F.R. § 455.23(a)(1). While the term allegation of fraud does not require proof of fraud, OHCA conducts investigation of fact, reviews every case independently, and subjects each case to legal review.
2. Upon receipt of a credible allegation of fraud, OHCA must refer the case to law enforcement authorities 42 C.F.R. § 455.23(d).
3. The agency may use its discretion to take other actions instead of a suspension of payments including contract termination or suspend payment in part 42 C.F.R. § 455.23.

Whereas OHCA once had the option to exercise discretion in reporting serious allegations of fraud to law enforcement officials, these new Federal requirements *mandate* referral of allegations to law enforcement and OHCA risks penalization through the loss of Federal Financial Participation (i.e. federal funding) if the Agency fails to comply.

In addition to the new mandatory payment suspension requirements, federal law also now requires enhanced provider screening procedures *prior* to enrolling SoonerCare providers. Under 42 C.F.R. § 455.410 all Medicaid providers must be screened by either Medicare or Medicaid programs. These new screening requirements mandate:

1. verification of licenses;
2. re-verification of licenses;
3. criminal background checks (in some cases);
4. routine checks of four federal databases;
5. site visits for both high and moderate categorical risk providers; and
6. collection of an application fee from certain providers. (*See* *42 C.F.R. §§ 455.412*, *414*, *432*, *434*, *436* & *460*).

When a SoonerCare provider's contract is terminated "for cause" as a result of either of these sets of regulations, a provider may appeal the Agency's decision and a hearing would be held at

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OHCA. The provider is afforded the opportunity to present their position at the hearing regarding the allegations. Each case is heard separately and determinations are made separately after careful consideration.

OHCA remains committed to maintaining its relationships with our providers and helping you stay in compliance with State and Federal law. It is important to hire qualified billers, to be aware and attentive to the information you submit to the Agency for payment, to be vigilant of the billings for your services even if it is done by another and to be responsible business partners.

Thank you for your continued support and for the services you provide to SoonerCare and Insure Oklahoma members.

Respectfully,

Howard J. Pallotta
General Counsel