OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
December 13, 2012 at 1:00 P.M.
The Oklahoma Health Care Authority
Ponca Conference Room
2401 NW 23rd, Suite 1A
Oklahoma City, Oklahoma

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum
2. Action Item – Approval of November 1, 2012 OHCA Board Minutes
3. Discussion Item – Reports to the Board by Board Committees

    a) Audit/Finance Committee – Member Miller
    b) Rules Committee – Member Robison
    c) Strategic Planning Committee – Vice Chairman 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) All Stars Introduction – Mike Fogarty, CEO
    August – Ayman Boulos, Network Administrator III

Item to be presented by Ed McFall, Chairman and Mike Fogarty, CEO

5. Presentation of the T.J. Brickner Defender of Health Award

Item to be presented by Jennie Melendez, Marketing Coordinator in Public Affairs

6. Discussion Item – Provider Outreach Online Enrollment

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

7. Announcements of Conflicts of Interest Panel Recommendations for all action items regarding this board meeting.

Item to be presented by Cindy Roberts, Deputy CEO – Planning, Policy & Integrity Division

8. 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:

        8. b – 1. AMENDING Agency rules at OAC 317:30-5-291, 30-5-296, and 30-5-676 to comply with federal law, which requires a prescription or referral from a physician or practitioner of the healing arts before therapy services are rendered. Policy is also revised to require a prior authorization for speech therapy services. **(Reference APA WF # 12-07)**

        8. b – 2. AMENDING Agency rules at OAC 317:30-5-2 to match state law and current agency operational requirements that parental or legal guardian consent must be given prior to rendering services to a minor child. **(Reference APA WF # 12-08)**

8. b – 3. AMENDING Agency rules at OAC 317:30-3-25 and 30-5-122 to allow 100% payment of Medicare Crossover deductibles and coinsurance at skilled nursing facilities. **(Reference APA WF # 12-09)**

8. b – 4. AMENDING Agency rules at OAC 317: 30-5-240.1, 30-5-241, and 30-5-241.3 to impose limits on the amount of outpatient Behavioral Health Rehabilitation services available to SoonerCare members in order to ensure appropriateness of the services provided, as well as contain program costs. Psychosocial rehabilitation services will not be allowed for children younger than age 6 unless the services are medically necessary and required pursuant to Federal Early and Periodic Screening, Diagnosis and Treatment (EPSDT) laws. This will ensure that services are of high quality and delivered in the most appropriate manner to the intended populations. **(Reference APA WF # 12-19)**

Item to be presented by Chairman McFall

9. 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) Discussion of Pending Litigation and Claims

10. Action Item – Consideration and Vote upon the Oklahoma Health Care Authority Board Meeting Dates, Times and Locations for Calendar Year 2013

11. New Business

12. ADJOURNMENT

NEXT BOARD MEETING
January 10, 2013
Oklahoma Health Care Authority
Ponca Conference Room

MINUTES OF A REGULARLY SCHEDULED (AMENDED) BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
November 1, 2012
Held at 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 October 31, 2012, 11:00 a.m. Advance public meeting notice is provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on October 30, 2012, 12:30 p.m.

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 1:05 p.m.

BOARD MEMBERS PRESENT: Vice-Chairman Armstrong, Member Miller, Member McFall, Member Bryant, Member Nuttle

BOARD MEMBERS ABSENT: Member McVay, Member Robison

OTHERS PRESENT:

Will Widman, HP
Lisa Gifford, OHCA
Carol Drake, SEU/OHCA
Tom Dunning, OKDHS
Shirley Russell, OKDHS
Terry Cothran, College of Pharmacy
KC Moon, OHCA

OTHERS PRESENT:

Charles Brodt, HP
Becky Moore, OAHCP
David Branson, OHCA
Charlene Kaiser
Orahand Brewer, eCapitol
Juarez McCann, ODMHSAS

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD ON SEPTEMBER 13, 2012.

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 September 13, 2012 board minutes as published. Member Bryant seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member Miller, Member Nuttle

ABSENT: Member McVay, Member Robison

ITEM 3 / REPORTS TO THE BOARD BY BOARD COMMITTEES

Vice-Chairman Armstrong welcomed our newest board member, Marc Nuttle. Mr. Nuttle stated he has heard nothing but positive feedback about the Oklahoma Health Care Authority. Vice-Chairman Armstrong recognized Lyle Roggow for his great leadership to the OHCA board, organization and also the state of Oklahoma.

Audit/Finance Committee

Member Miller stated that the Audit/Finance Committee did meet and noted that it was the August financials because there was no meeting in October. There was discussion on audit activities.

Nominating Committee

Member Bryant stated that the nominating committee met and proposes the following: Ed McFall as Chairman and Tony Armstrong as Vice-Chairman. Please see item 12 for further details.

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

Mike reported that many executive staff attended the National Association of Medicaid Director's meeting in Washington, DC and returned yesterday. He noted that there was expansion discussion.

4a. FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans stated that the state dollar budget variance through August is $4.9 positive. We continue to be under budget in our Medicaid program spending as well as administration. As of August, we were under budget for some of the revenue categories, taxes and fees, drug rebate and overpayments and settlements and Ms. Evans expects those to even out in a month or two. She noted that for September, the program spending has remained under budget and does expect it to grow by $10 million. For more detailed information, see Item 4a in the board packet.

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

Dr. Splinter noted that his presentation included the months of both August and September, 2012. He noted the graph for August shows the total enrollment in the Medicaid program since it was transferred from the Department of Human Services. Dr. Splinter said that there are 805,000 enrollees in SoonerCare with a small increase for September. The enrollment for dual eligibles is 108,400, long term care members at 15,800 with spending an average of $3,350 per member per month. He noted the total enrollment for providers is at 39,300. He stated that he is proud of the number of providers in the medical home program is just under 2,000. OHCA has made payments to 1,528 different entities to incentivize the use of electronic health records for about $86.5 million. Dr. Splinter noted the per member per month graph for traditional and choice programs. Member Miller asked if there was seasonality in a spike of enrollees around the school months. Connie Steffee noted that there is a little seasonality. Vice Chairman Armstrong asked if it was too early to see an impact in the ER utilization rates, inpatient admissions, etc. Dr. Splinter said that they have looked at ER utilization rates and will be looking closer at this information. For more detailed information, see Item 4b in the board packet.

Mike recognized Ernest Chiang, Accountant in the Finance division, as the OHCA July All Star. He presented some background as well as a few highlights of Mr. Chiang's work at OHCA. Mike thanked him for his hard work and dedication.

ITEM 5 / INFORMATION SERVICES UPDATE AND REVIEW OF SECURITY AUDIT RESULTS
Jerry Scherer, Chief Information Officer

Jerry noted that there were two recent audits completed by an external agency. The first one was completed by Clifton Larson Allen to look OHCA's claims processing systems and data center operations in general. We received very good results with no finding. The second one was an examination of OHCA state, standards, HIPAA and HITECH compliance completed by True Digital with generally good findings with room for improvement. Jerry stated that this is an annual audit and has a plan of correction. For more detailed information, see Item 5 in the board packet.

ITEM 6 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Howard Pallotta, General Counsel

Mr. Pallotta stated that there were no conflicts.

ITEM 7 / CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE
Cindy Roberts, Chairperson of State Plan Amendment Rate Committee

a) Medicaid Developmental Disabilities Services Division Waiver

   1. Consideration and Vote of a Rate Increase for the following 55 specific services effective November 1, 2012:
   Homemaker, HTS (Habilitation Training Specialist), Intensive Personal Supports, Daily Living Supports, Community Based Individual Services, Center Based Prevocational Services, Community Based Prevocational Services, Employment Specialist, Enhanced Community Based Prevocational, Enhanced Job Coaching Services, Job Coaching Individual Services, Job Coaching Services, Job Stabilization/Extended Services, Prevocational HTS, Group Home Alternate Living

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Home, Group Home, Group Home Community Living Home, Respite in Group Home, Respite in Community Living Home.

MOTION:	Member Miller moved for approval of Item 7a as presented. Member McFall seconded.
FOR THE MOTION:	Vice-Chairman Armstrong, Member Bryant, Member Nuttle
ABSENT:	Member McVay, Member Robison

b) Medicaid Advantage Home and Community Based Waiver Services

2. Consideration and Vote of a Rate Increase for the following 13 specific services effective November 1, 2012:

Case Management, Transition Case Management, OHCA Personal Care, Supportive/Restorative Assistance, In-Home Respite, Personal Services Assistance (PSA), Advanced PSA, Physical Therapy, Occupational Therapy, Respiratory Therapy, Speech/Language Therapy.

MOTION:	Member Miller moved for approval of Item 7b as presented. Member Bryant seconded.
FOR THE MOTION:	Vice-Chairman Armstrong, Member McFall, Member Nuttle
ABSENT:	Member McVay, Member Robison

c) Oklahoma HealthCare Authority Living Choice and Waivers

3. Consideration and Vote of a Rate Increase for the following 16 specific services effective November 1, 2012:

Case Management (CM), Transition CM, Advantage Personal Care, Supportive/Restorative Assistances, In-Home Respite, Personal Services Assistance (PSA), Advanced PSA, Physical Therapy, Occupational Therapy, Speech/Language Therapy, Assisted Living Low, Assisted Living Medium Assisted Living High, State Plan Personal Care.

MOTION:	Member McFall moved for approval of Item 7c as presented. Member Bryant seconded.
FOR THE MOTION:	Vice-Chairman Armstrong, Member Miller, Member Nuttle
ABSENT:	Member McVay, Member Robison

ITEM 8 / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT

Cindy Roberts, Deputy CEO

Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act

AMENDING Agency rules at OAC 35-5-41.6 to increase the income cap for the Medicaid Income Pension Trust (or Miller Trust) to the average monthly cost of nursing home care. This change affects financial eligibility rules for all long term care programs, including the 1915(c) waiver programs for Home and Community Based Services. **(Reference APA WF # 12-06)**

MOTION:	Member McFall moved for approval of Item 8 as a declaration of emergency. Member Nuttle seconded.
FOR THE MOTION:	Vice-Chairman Armstrong, Member Bryant, Member Miller
ABSENT:	Member McVay, Member Robison

MOTION: Member Miller moved for approval of substantive provisions of Item 8 as presented. Member McFall seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member Bryant, Member Nuttle

ABSENT: Member McVay, Member Robison

ITEM 9 / CONSIDERATION AND VOTE FOR AUTHORIZATION FOR EXPENDITURE OF FUNDS FOR RECOVERY AUDIT CONTRACTOR

Beth VanHorn, Legal Operations Director

Action Item - Consideration and Vote for Authorization for Expenditure of Funds for Recovery Audit Contractor.

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

FOR THE MOTION: Vice-Chairman Armstrong, Member Miller, Member Nuttle

ABSENT: Member McVay, Member Robison

ITEM 10 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD

Nancy Nesser, Pharmacy Director

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 Select Gonadotropin-Releasing Hormone Products to the product-based prior authorization program under OAC 317:30-5-77.3.
b) Consideration and vote to add Neupro® (rotigotine) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Member McFall moved for approval of Item 10a and 10b as presented. Member Miller seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member Bryant, Member Nuttle

ABSENT: Member McVay, Member Robison

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)

Howard Pallotta, General Counsel

Director of Legal Services advised that there was a need for Executive Session for this Board meeting.

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) Discussion of Pending Litigation and Claims
b) Discussion of CEO Employment

MOTION: Member McFall moved for approval to go into Executive Session. Member Bryant seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member Miller, Member Nuttle

ABSENT: Member McVay, Member Robison

ITEM 12 / ELECTION OF THE OKLAHOMA HEALTH CARE AUTHORITY 2013 BOARD OFFICERS

As part of the Nomination Committee Member Bryant suggested Ed McFall as Chairman and Anthony Armstrong as Vice-Chairman.

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MOTION: Member Bryant moved for approval of board officers as presented. Member Miller seconded.

FOR THE MOTION: Vice-Chairman Armstrong, Member McFall, Member Nuttle

ABSENT: Member McVay, Member Robison

ITEM 13 / NEW BUSINESS

There was no new business.

ITEM 14 / ADJOURNMENT

MOTION: Chairman McFall moved for adjournment. Member Nuttle seconded.

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

ABSENT: Member McVay, Member Robison

Meeting adjourned at 3:20 p.m., 11/1/2012

NEXT BOARD MEETING
December 13, 2012
Oklahoma Health Care Authority
Ponca Conference Room
2401 NW 23rd, Suite 1A
Oklahoma City, OK 73107

Lindsey Bateman
Board Secretary

Minutes Approved: _______________

*Initials:*___________________

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FINANCIAL REPORT

For the Four Months Ended October 31, 2012
Submitted to the CEO & Board
December 13, 2012

- Revenues for OHCA through October, accounting for receivables, were **$1,341,923,319** or **(.7%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$1,280,986,290** or **1.6% under** budget.
- The state dollar budget variance through October is **$11,500,528 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		6.8
Administration		4.2
Revenues:		
Taxes and Fees		(.3)
Drug Rebate		(.5)
Overpayments/Settlements		1.3
Total FY 13 Variance	**$**	**11.5**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA 1
Medicaid Program Expenditures by Source of Funds 2
Other State Agencies Medicaid Payments 3
Fund 205: Supplemental Hospital Offset Payment Program Fund 4
Fund 230: Quality of Care Fund Summary 5
Fund 245: Health Employee and Economy Act Revolving Fund 6
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund 7

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2013, For the Four Months Ended October 31, 2012

REVENUES	FY13 Budget YTD	FY13 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 332,911,004	$ 332,911,004	$ -	0.0%
Federal Funds	647,186,460	635,631,517	(11,554,943)	(1.8)%
Tobacco Tax Collections	20,284,420	19,936,466	(347,954)	(1.7)%
Quality of Care Collections	18,166,519	18,166,519	-	0.0%
Prior Year Carryover	43,075,735	43,075,735	-	0.0%
Federal Deferral - Interest	45,139	45,139	-	0.0%
Drug Rebates	82,756,493	81,407,462	(1,349,031)	(1.6)%
Medical Refunds	16,143,647	19,703,663	3,560,016	22.1%
SHOPP	186,765,054	186,765,054	-	0.0%
Other Revenues	4,213,384	4,280,761	67,377	1.6%
TOTAL REVENUES	**$ 1,351,547,854**	**$ 1,341,923,319**	**$ (9,624,535)**	**(0.7)%**

EXPENDITURES	FY13 Budget YTD	FY13 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 15,432,118**	**$ 13,555,907**	**$ 1,876,211**	**12.2%**
ADMINISTRATION - CONTRACTS	**$ 34,607,832**	**$ 28,362,477**	**$ 6,245,355**	**18.0%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	11,676,722	10,484,460	1,192,262	10.2%
Acute Fee for Service Payments:				
Hospital Services	317,419,105	312,430,855	4,988,251	1.6%
Behavioral Health	7,011,481	6,463,108	548,373	7.8%
Physicians	160,201,699	159,648,710	552,989	0.3%
Dentists	50,849,310	51,290,338	(441,028)	(0.9)%
Other Practitioners	19,793,243	19,108,236	685,006	3.5%
Home Health Care	7,921,768	7,560,460	361,308	4.6%
Lab & Radiology	20,657,252	20,594,276	62,976	0.3%
Medical Supplies	16,997,498	17,095,717	(98,219)	(0.6)%
Ambulatory/Clinics	37,784,748	39,572,804	(1,788,056)	(4.7)%
Prescription Drugs	133,039,472	127,324,051	5,715,421	4.3%
OHCA TFC	1,083,901	874,603	209,298	0.0%
Other Payments:				
Nursing Facilities	178,388,142	176,200,967	2,187,175	1.2%
ICF-MR Private	19,969,734	19,906,616	63,118	0.3%
Medicare Buy-In	43,158,711	42,743,038	415,673	1.0%
Transportation	20,380,735	21,806,852	(1,426,117)	(7.0)%
MFP-OHCA	-	527,630	(527,630)	0.0%
EHR-Incentive Payments	8,081,924	8,081,924	-	0.0%
Part D Phase-In Contribution	25,998,200	25,784,885	213,316	0.8%
SHOPP payments	171,568,377	171,568,377	-	0.0%
Total OHCA Medical Programs	**1,251,982,021**	**1,239,067,906**	**12,914,115**	**1.0%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 1,302,111,353**	**$ 1,280,986,290**	**$ 21,125,063**	**1.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 49,436,501**	**$ 60,937,029**	**$ 11,500,528**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2013, For the Four Months Ended October 31, 2012

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 10,632,912	$ 10,477,717	$ -	$ 148,452	$ -	$ 6,743	$ -
Inpatient Acute Care	235,930,027	201,512,717	162,229	3,424,532	17,241,488	727,818	12,861,243
Outpatient Acute Care	96,613,620	91,320,158	13,868	3,827,018	-	1,452,577	-
Behavioral Health - Inpatient	7,919,963	4,106,876	-	9,316	-		3,803,771
Behavioral Health - Psychiatrist	2,356,233	2,356,233	-	-	-	-	-
Behavioral Health - Outpatient	6,576,787	-	-	-	-	-	6,576,787
Behavioral Health Facility- Rehab	82,370,339	-	-	206,967	-	38,295	82,125,077
Behavioral Health - Case Management	2,638,758	-	-	-	-	-	2,638,758
Behavioral Health - PRTF	32,591,646	-	-	-	-	-	32,591,646
Residential Behavioral Management	7,120,890	-	-	-	-	-	7,120,890
Targeted Case Management	19,201,677	-	-	-	-	-	19,201,677
Therapeutic Foster Care	874,603	874,603	-	-	-	-	-
Physicians	178,229,918	136,230,604	19,367	4,917,249	21,094,035	2,304,704	13,663,958
Dentists	51,307,560	48,380,706	-	17,223	2,890,256	19,375	-
Mid Level Practitioners	1,375,480	1,338,831	-	35,002	-	1,648	-
Other Practitioners	17,839,825	17,275,926	148,788	72,067	338,831	4,213	-
Home Health Care	7,560,460	7,554,508	-	-	-	5,952	-
Lab & Radiology	21,815,337	20,333,495	-	1,221,061	-	260,781	-
Medical Supplies	17,378,703	16,212,174	860,805	282,987	-	22,738	-
Clinic Services	40,991,252	35,967,537	-	555,564	-	102,439	4,365,712
Ambulatory Surgery Centers	3,685,802	3,495,984	-	182,974	-	6,845	-
Personal Care Services	4,310,860	-	-	-	-	-	4,310,860
Nursing Facilities	176,200,967	115,566,421	46,702,946	-	13,928,532	3,068	-
Transportation	21,695,542	19,767,409	858,866	624	1,047,825	20,818	-
GME/IME/DME	49,781,480	-	-	-	-	-	49,781,480
ICF/MR Private	19,906,616	16,459,796	3,170,082	-	276,738	-	-
ICF/MR Public	18,077,143	-	-	-	-	-	18,077,143
CMS Payments	68,527,923	67,617,383	910,540	-	-	-	-
Prescription Drugs	133,986,509	111,499,321	-	6,662,458	15,242,674	582,056	-
Miscellaneous Medical Payments	111,935	111,714	-	-	-	220	-
Home and Community Based Waiver	56,167,887	-	-	-	-	-	56,167,887
Homeward Bound Waiver	30,345,261	-	-	-	-	-	30,345,261
Money Follows the Person	1,275,333	527,630	-	-	-	-	747,703
In-Home Support Waiver	7,980,330	-	-	-	-	-	7,980,330
ADvantage Waiver	60,725,638	-	-	-	-	-	60,725,638
Family Planning/Family Planning Waiver	3,274,885	-	-	-	-	-	3,274,885
Premium Assistance*	16,722,729	-	-	16,722,729		-	-
EHR Incentive Payments	8,081,924	8,081,924	-	-	-	-	-
SHOPP Payments**	171,568,377	171,568,377	-	-	-	-	-
Total Medicaid Expenditures	**$ 1,693,753,130**	**$ 937,069,667**	**$ 52,847,490**	**$ 38,286,222**	**$ 72,060,378**	**$ 5,560,289**	**$ 416,360,706**

* Includes $16,597,709 paid out of Fund 245 and **$171,568,377 paid out of Fund 205

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2013, For the Four Months Ended October 31, 2012

REVENUE	FY13 Actual YTD
Revenues from Other State Agencies	$ 166,297,396
Federal Funds	267,091,372
TOTAL REVENUES	**$ 433,388,768**

EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	$ 56,167,887
Money Follows the Person	747,703
Homeward Bound Waiver	30,345,261
In-Home Support Waivers	7,980,330
ADvantage Waiver	60,725,638
ICF/MR Public	18,077,143
Personal Care	4,310,860
Residential Behavioral Management	5,285,525
Targeted Case Management	14,336,964
Total Department of Human Services	**197,977,311**
State Employees Physician Payment	
Physician Payments	13,663,958
Total State Employees Physician Payment	**13,663,958**
Education Payments	
Graduate Medical Education	14,300,000
Graduate Medical Education - PMTC	986,849
Indirect Medical Education	30,449,271
Direct Medical Education	4,045,360
Total Education Payments	**49,781,480**
Office of Juvenile Affairs	
Targeted Case Management	1,149,550
Residential Behavioral Management - Foster Care	-
Residential Behavioral Management	1,835,364
Total Office of Juvenile Affairs	**2,984,914**
Department of Mental Health	
Case Management	2,638,758
Inpatient Psych FS	3,803,771
Outpatient	6,576,787
PRTF	32,591,646
Rehab	82,125,077
Total Department of Mental Health	**127,736,039**
State Department of Health	
Children's First	751,618
Sooner Start	761,308
Early Intervention	1,698,354
EPSDT Clinic	852,145
Family Planning	21,481
Family Planning Waiver	3,239,052
Maternity Clinic	13,518
Total Department of Health	**7,337,477**
County Health Departments	
EPSDT Clinic	280,549
Family Planning Waiver	14,352
Total County Health Departments	**294,901**
State Department of Education	**16,141**
Public Schools	**1,249,050**
Medicare DRG Limit	**11,250,000**
Native American Tribal Agreements	**2,458,191**
Department of Corrections	**239,793**
JD McCarty	**1,371,450**
Total OSA Medicaid Programs	**$ 416,360,706**
OSA Non-Medicaid Programs	**$ 26,212,731**
Accounts Receivable from OSA	**$ 9,184,669**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
Fiscal Year 2013, For the Four Months Ended October 31, 2012

REVENUES		FY 13 Revenue
SHOPP Assessment Fee	$	77,058,685
Federal Draws		109,700,608
Penalties		5,761
State Appropriations		(15,000,000)
TOTAL REVENUES	$	**171,765,054**

EXPENDITURES	Quarter	Quarter		FY 13 Expenditures
Program Costs:	**7/1/12 - 9/30/12**	**10/1/12 - 12/31/12**		
Hospital - Inpatient Care	76,857,805	76,538,280	$	**153,396,085**
Hospital -Outpatient Care	3,224,900	3,217,022	$	**6,441,922**
Psychiatric Facilities-Inpatient	5,660,381	5,636,765	$	**11,297,146**
Rehabilitation Facilities-Inpatient	217,066	216,157	$	**433,223**
Total OHCA Program Costs	**85,960,153**	**85,608,224**	$	**171,568,377**
Total Expenditures			$	**171,568,377**
CASH BALANCE			$	**196,677**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2013, For the Four Months Ended October 31, 2012

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 17,281,599**	**$ 17,281,599**
Interest Earned	**10,100**	**10,100**
TOTAL REVENUES	**$ 17,291,699**	**$ 17,291,699**

EXPENDITURES	FY 13 Total $ YTD	FY 13 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 45,407,742	$ 16,360,409	
Eyeglasses and Dentures	99,004	35,671	
Personal Allowance Increase	1,196,200	430,991	
Coverage for DME and supplies	860,805	310,148	
Coverage of QMB's	344,252	124,034	
Part D Phase-In	910,540	910,540	
ICF/MR Rate Adjustment	1,571,890	566,352	
Acute/MR Adjustments	1,598,191	575,828	
NET - Soonerride	858,866	309,449	
Total Program Costs	**$ 52,847,490**	**$ 19,623,423**	**$ 19,623,423**
Administration			
OHCA Administration Costs	$ 183,553	$ 91,776	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 183,553**	**$ 91,776**	**$ 91,776**
Total Quality of Care Fee Costs	**$ 53,031,043**	**$ 19,715,199**	
TOTAL STATE SHARE OF COSTS			**$ 19,715,199**

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 2013, For the Four Months Ended October 31, 2012

REVENUES	FY 12 Carryover	FY 13 Revenue	Total Revenue
Prior Year Balance	$ 27,390,790	$ -	$ 19,645,936
State Appropriations			
Tobacco Tax Collections	-	16,397,060	16,397,060
Interest Income	-	259,124	259,124
Federal Draws	674,029	10,820,053	10,820,053
All Kids Act	(7,186,888)	95,633	95,633
TOTAL REVENUES	**$ 20,877,931**	**$ 27,571,870**	**$ 47,122,172**

EXPENDITURES		FY 12 Expenditures	FY 13 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 16,388,806	$ 16,388,806
	College Students		125,020	125,020
	All Kids Act		208,903	208,903
Individual Plan				
	SoonerCare Choice		$ 143,172	$ 51,585
	Inpatient Hospital		3,388,122	1,220,740
	Outpatient Hospital		3,789,597	1,365,392
	BH - Inpatient Services-DRG		206,967	74,570
	BH -Psychiatrist		-	-
	Physicians		4,860,092	1,751,091
	Dentists		10,563	3,806
	Mid Level Practitioner		34,477	12,422
	Other Practitioners		70,842	25,524
	Home Health		-	-
	Lab and Radiology		1,205,354	434,289
	Medical Supplies		271,760	97,915
	Clinic Services		546,118	196,766
	Ambulatory Surgery Center		181,050	65,232
	Prescription Drugs		6,563,422	2,364,801
	Miscellaneous Medical		624	624
	Premiums Collected		-	(793,533)
Total Individual Plan			**$ 21,272,161**	**$ 6,871,226**
	College Students-Service Costs		**$ 234,809**	**$ 84,602**
	All Kids Act- Service Costs		**$ 56,525**	**$ 20,366**
Total OHCA Program Costs			**$ 38,286,223**	**$ 23,698,922**
Administrative Costs				
	Salaries	$ 30,135	$ 506,254	$ 536,390
	Operating Costs	48,643	123,614	172,257
	Health Dept-Postponing	-	-	-
	Contract - HP	1,153,217	982,682	2,135,898
Total Administrative Costs		**$ 1,231,995**	**$ 1,612,550**	**$ 2,844,545**
Total Expenditures				**$ 26,543,467**
NET CASH BALANCE		**$ 19,645,936**		**$ 20,578,705**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2013, For the Four Months Ended October 31, 2012

REVENUES	FY 13 Revenue	State Share
Tobacco Tax Collections	$ 327,245	$ 327,245
TOTAL REVENUES	**$ 327,245**	**$ 327,245**

EXPENDITURES	FY 13 Total $ YTD	FY 13 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 6,743	$ 1,700	
Inpatient Hospital	727,818	183,556	
Outpatient Hospital	1,452,577	366,340	
Inpatient Services-DRG	-	-	
Psychiatrist	0	-	
TFC-OHCA	0	-	
Nursing Facility	3,068	774	
Physicians	2,304,704	581,246	
Dentists	19,375	4,886	
Mid-level Practitioner	1,648	416	
Other Practitioners	4,213	1,062	
Home Health	5,952	1,501	
Lab & Radiology	260,781	65,769	
Medical Supplies	22,738	5,734	
Clinic Services	102,439	25,835	
Amulatory Surgery Center	6,845	1,726	
Prescription Drugs	582,056	146,795	
Transportation	20,818	5,250	
Miscellaneous Medical	220	56	
Total OHCA Program Costs	$ 5,521,994	$ 1,392,647	
OSA DMHSAS Rehab	$ 38,295	$ 9,658	
Total Medicaid Program Costs	$ 5,560,289	$ 1,402,305	
TOTAL STATE SHARE OF COSTS			**$ 1,402,305**

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

October 2012 Data for December 2012 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2012	Enrollment October 2012	Total Expenditures October 2012	Average Dollars Per Member Per Month October 2012
SoonerCare Choice Patient-Centered Medical Home		468,268	**479,057**	**$172,252,888**	
Lower Cost	*(Children/Parents; Other)*		434,373	$126,999,695	$292
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		44,684	$45,253,192	$1,013
SoonerCare Traditional		241,278	**251,738**	**$218,074,205**	
Lower Cost	*(Children/Parents; Other)*		142,900	$60,271,901	$422
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		108,838	$157,802,305	$1,450
SoonerPlan		41,378	**47,081**	**$1,029,283**	$22
Insure Oklahoma		31,502	**30,248**	**$10,246,358**	
Employer-Sponsored Insurance		17,728	16,370	$4,121,363	$252
Individual Plan		13,773	13,878	$6,124,996	$441
TOTAL		**782,425**	**808,124**	**$401,602,734**	

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 $128,819,434 are excluded.

Net Enrollee Count Change from Previous Month Total	3,121

New Enrollees	21,612

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

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,601
Aged/Blind/Disabled	*Adult*	132,547
Other	*Child*	176
Other	*Adult*	20,781
PACE	*Adult*	115
TEFRA	*Child*	440
Living Choice	*Adult*	98
OLL Enrollment		**173,758**

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

Medicare and SoonerCare	Monthly Average SFY2012	Enrolled October 2012
Dual Enrollees	**107,504**	**108,575**

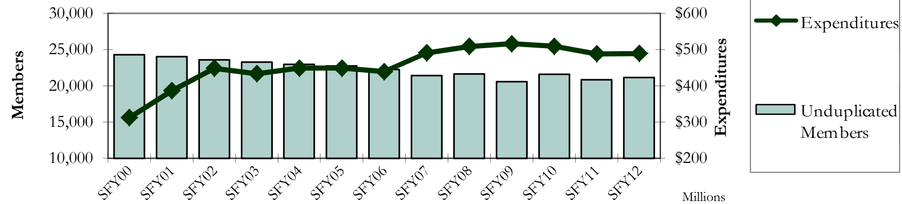
		Monthly Average SFY2012	Enrolled October 2012	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		**15,770**	**15,800**	**$4,065**
	Child	87	68	
	Adult	15,683	15,732	

SFY2012 Long-Term Care

Statewide LTC Occupancy Rate - 71.7%
SoonerCare funded LTC Bed Days 67.2%

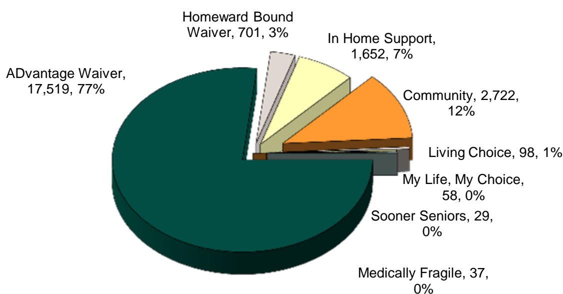
Data as of September 2012

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Nov. 19, 2012. Figures do not include intermediate care facilities for the intellectually disabled (ICF/ID).

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 intellectually disabled (ICF/ID).
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/ID.
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/ID.
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 SFY2012	Enrolled October 2012*
Total Providers	**29,723**	**34,132**
In-State	20,881	27,129
Out-of-State	8,842	7,003

*Effective July 2012, the methodology for counting providers has changed to count provider network. Previous counts include group practice and its members; the current count will include members only. Provider Network is providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types,

Program	% of Capacity Used
SoonerCare Choice	43%
SoonerCare Choice I/T/U	14%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2012	*Enrolled October 2012**	Monthly Average SFY2012	Enrolled October 2012
Physician***	7,497	6,801	13,790	10,008
Pharmacy	874	894	1,153	1,197
Mental Health Provider**	3,395	5,496	3,449	5,564
Dentist	986	1,192	1,124	1,363
Hospital	194	200	934	1,069
Optometrist	550	600	587	638
Extended Care Facility	375	364	375	364

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

Total Primary Care Providers***	4,915	4,499	6,955	5,738
Patient-Centered Medical Home	1,711	1,819	1,739	1,857

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 Mental Health Providers.

***Decrease in current month's count is due to contract renewal period which is typical during all renewal periods.

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 12/4/2012	November 2012		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	30	$497,250	1,474	$32,216,417
Eligible Hospitals	2*	$985,336	82	$55,491,872
Totals	32	$1,482,586	1,556	$87,708,289

*Current Eligible Hospitals Paid

DUNCAN REGIONAL HOSP

EASTERN OKLAHOMA MEDICAL CENTER

PROVIDER OUTREACH: ONLINE ENROLLMENT

OHCA BOARD UPDATE

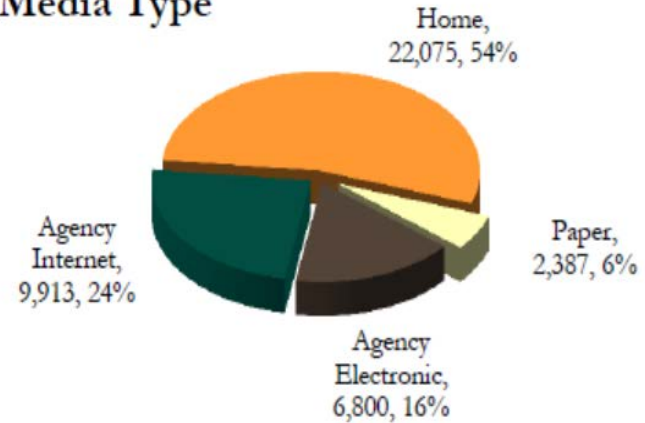
December 13, 2012

BACKGROUND

oklahoma health care authority

Online Enrollment is a Success!

- More than 420,000 real-time applications were submitted in SFY 2012
- How do we get to 100% online enrollment?
- How can our providers help us reach this goal?



oklahoma health care authority

SURVEY RESULTS

Are you familiar with mysoonercare.org, the online enrollment portal for SoonerCare benefits?

Yes- 66.88%

No- 33.12%

SURVEY RESULTS

oklahoma health care authority

Have you ever told someone about mysoonercare.org?

Yes- 56.27%

No- 23.15%

SURVEY RESULTS

oklahoma health care authority

Do you have a computer with an Internet connection available at your place of business for clients/patients to apply for SoonerCare benefits?

Yes- 45.98% **No- 54.02%**

oklahoma health care authority

SURVEY RESULTS

Would you be willing to provide such a set-up?

Yes- 49.84%   No- 50.16%

SURVEY RESULTS

oklahoma health care authority

What barriers prevent people in your community from accessing mysoonercare.org?

- No Internet access
- No computer access
- Technical issues w/online enrollment form

SURVEY RESULTS

oklahoma health care authority

Why Not?

- Time
- Don’t have the resources (human and technical/computers)
- Don’t have the Space
- Technical issues w/online enrollment form
- HIPAA (Privacy)

INTO ACTION

- **COMMUNITY RESOURCES**
- **PROVIDER BLITZ**

COMMUNITY RESOURCES

- **Partnership with Community Action Agencies began July 2012.**
- **List of state-wide locations for Online Enrollment help available to public is now listed on mysoonercare.org.**
- **Community Action Agencies have benefit access kiosks throughout state.**

COMMUNITY RESOURCES

- Big Five Community Services
- Central Oklahoma Community Action Agency
- CAA of Oklahoma City & Oklahoma/Canadian Counties
- Community Action Development Corporation
- Community Action Project of Tulsa County
- Community Action Resource & Development
- Community Development Support Association
- Delta Community Action Foundation
- Deep Fork Community Action Foundation
- Great Plains Improvement Foundation
- INCA Community Services
- KI BOIS Community Action Foundation
- Little Dixie Community Action Agency
- Muskogee County Community Action Foundation
- Northeast Oklahoma Community Action Agency
- Opportunities, Inc.
- Southwest Oklahoma Community Action Group
- United Community Action Program
- Washita Valley Community Action Council

Helping People. Changing Lives.
community Action PARTNERSHIP
AMERICA'S POVERTY FIGHTING NETWORK

PROVIDER BLITZ

- **Provider Services staff have begun specific online enrollment outreach to our existing providers. This team makes on-site visits and provides training and support.**

- **Including distribution of marketing materials. (Includes a brochure, leave-behind card, one-sheet with online enrollment tips.)**

PROVIDER BLITZ

- Marketing Campaign
- Collateral Pieces
- Call-to-Action

PROVIDER BLITZ

Provider Services staff will assess each providers specific situation and connect them with an appropriate resource:

- **Phone number for local Community Action Agency**
- **An appointment for a PS staff on-site visit for online enrollment training and/or assessment of their office for assistance with setting-up a kiosk**
- **OHCA technical team on-site visit**

QUESTIONS?

Health Care Is Just A Click Away!

Online Enrollment

www.mysoonercare.org

- One application covers your whole family.
- Apply in private anytime, 24/7.
- It's quick, easy, secure.
- Find out immediately if you qualify.
- No more waiting for appointments or filling out paper applications!

Apply Today

www.mysoonercare.org

1-800-987-7767

Have Insurance Today!

8.b-1 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 27. Independent Licensed Physical Therapists
OAC 317:30-5-291. [AMENDED]
Part 28. Occupational Therapy Services
OAC 317:30-5-296. [AMENDED]
Part 77. Speech and Hearing Services
OAC 317:30-5-676. [AMENDED]
(Reference APA WF # 12-07)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's individual providers and specialties guidelines. Federal law requires a prescription or referral be in place prior to rendering therapy services in accordance with 42 CFR 440.110. These emergency rule revisions will ensure OHCA policy is in compliance with Federal law and ensure services are rendered to only those who are in need of the services.

ANALYSIS: Policy will be amended to comply with federal law, which requires a prescription or referral from a physician or practitioner of the healing arts before therapy services are rendered. Policy is also revised to require a prior authorization for speech therapy services.

BUDGET IMPACT: The Agency has estimated that this proposed rule will result in total budget savings of $25,000, with state savings of $8,750.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 14, 2012, 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; 42 CFR 440.230.

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Adopt revisions to agency rules on therapy services to require a prescription or referral from a physician or practitioner of the healing arts before therapy services are rendered to comply with federal law. In addition, revise rules to require a prior authorization for speech therapy services.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 27. INDEPENDENT LICENSED PHYSICAL THERAPISTS

317:30-5-291. Coverage by category

Payment is made to registered physical therapists as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

PART 28. OCCUPATIONAL THERAPY SERVICES

317:30-5-296. Coverage by category

Payment is made for occupational therapy services as set forth in this Section.

(1) **Children.** Initial therapy evaluations do not require prior authorization. All therapy services following the initial evaluation must be prior authorized for continuation of service. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

PART 77. SPEECH AND HEARING SERVICES

317:30-5-676. Coverage by category

Payment is made for speech and hearing services as set forth in this Section.

(1) **Children.** Coverage for children is as follows:

(A) **Preauthorization required.** ~~Initial therapy evaluations and the first three therapy visits do not require prior authorization. All therapy services following the initial evaluation and first three visits must be preauthorized prior to continuation of service.~~ All therapy services, including the initial evaluation, must be prior authorized. Prior to the initial evaluation, the therapist must have on file a signed and dated prescription or referral for the therapy services from the member's physician or other licensed practitioner of the healing arts. The prescribing or referring provider must be able

to provide, if requested, clinical documentation from the member's medical record that supports the medical necessity for the evaluation and referral.

(B) **Speech/Language Services.** Speech/language therapy services may include speech/language evaluations, individual and group therapy services provided by a state licensed speech/language pathologist.

(C) **Hearing aids.** Hearing and hearing aid evaluations include pure tone air, bone and speech audiometry by a state licensed audiologist. Payment is made for a hearing aid following a recommendation by a Medical or Osteopathic physician and a hearing aid evaluation by a state licensed audiologist.

(2) **Adults.** There is no coverage for adults for services rendered by individually contracted providers. Coverage for adults is permitted in an outpatient hospital setting as described in 30-5-42.1.

(3) **Individuals eligible for Part B of Medicare.** Services provided to Medicare eligible recipients are filed directly with the fiscal agent.

8.b-2 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-2. [AMENDED]
(Reference APA WF # 12-08)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's parental consent policy. OHCA has identified numerous instances of non-compliance with this regulation. These emergency rule revisions will ensure OHCA providers follow OHCA operational policy and state law that requires parental or legal guardian consent prior to rendering services on a minor child.

ANALYSIS: Policy will be amended to match state law and current agency operational requirements that parental or legal guardian consent must be given prior to rendering services to a minor child, unless an explicit state or federal exception to this requirement exists.

BUDGET IMPACT: The Agency has determined that this proposed rule is budget neutral.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 14, 2012, 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; 42 CFR 440.230.

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Adopt parental consent rules to ensure compliance with state law and agency operational requirements.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-2. General coverage by category
(a) **Adults.** Payment for adults is made to physicians for medical and surgical services within the scope of the Oklahoma Health Care Authority's (OHCA's) SoonerCare program, provided the services are reasonable and necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Coverage of certain services must be based on a determination made by the OHCA's medical consultant in individual circumstances.
(1) Coverage includes the following medically necessary services:

(A) Inpatient hospital visits for all SoonerCare covered stays. All inpatient services are subject to post-payment review by the OHCA, or its designated agent.
(B) Inpatient psychotherapy by a physician.
(C) Inpatient psychological testing by a physician.
(D) One inpatient visit per day, per physician.
(E) Certain surgical procedures performed in a Medicare certified free-standing ambulatory surgery center (ASC) or a Medicare certified hospital that offers outpatient surgical services.
(F) Therapeutic radiology or chemotherapy on an outpatient basis without limitation to the number of treatments per month for members with proven malignancies or opportunistic infections.
(G) Direct physician services on an outpatient basis. A maximum of four visits are allowed per month per member in office or home regardless of the number of physicians providing treatment. Additional visits per month are allowed for those services related to emergency medical conditions and for services in connection with Family Planning.
(H) Direct physician services in a nursing facility for those members residing in a long-term care facility. A maximum of two nursing facility visits per month are allowed. To receive payment for a second nursing facility visit in a month denied by Medicare for a Medicare/SoonerCare member, attach the EOMB from Medicare showing denial and mark "carrier denied coverage".
(I) Diagnostic x-ray and laboratory services.
(J) Mammography screening and additional follow-up mammograms.
(K) Obstetrical care.
(L) Pacemakers and prostheses inserted during the course of a surgical procedure.
(M) Prior authorized examinations for the purpose of determining medical eligibility for programs administered by OHCA. A copy of the authorization, OKDHS form 08MA016E, Authorization for Examination and Billing, must accompany the claim.
(N) If a physician renders direct care to a member on the same day as a dialysis treatment, payment is allowed for a separately identifiable service unrelated to the dialysis.
(O) Family planning includes sterilization procedures for legally competent members 21 years of age and over who voluntarily request such a procedure and execute the federally mandated consent form with his/her physician. A copy of the consent form must be attached to the claim form. Separate payment is allowed for the insertion and/or implantation of contraceptive devices during an office visit. Certain family planning products may be obtained through the Vendor Drug Program. Reversal of sterilization procedures for the purposes of conception is not allowed. Reversal of sterilization procedures are allowed when medically indicated and substantiating documentation is attached to the claim.
(P) Genetic counseling.
(Q) Laboratory testing (such as complete blood count (CBC), platelet count, or urinalysis) for monitoring members receiving chemotherapy, radiation therapy, or medications that require monitoring during treatment.
(R) Payment for ultrasounds for pregnant women as specified in OAC 317:30-5-22.

(S) Payment to the attending physician in a teaching medical facility for compensable services when the physician signs as claimant and renders personal and identifiable services to the member in conformity with federal regulations.
(T) Payment to clinical fellow or chief resident in an outpatient academic setting when the following conditions are met:
(i) Recognition as clinical faculty with participation in such activities as faculty call, faculty meetings, and having hospital privileges;
(ii) Board certification or completion of an accredited residency program in the fellowship specialty area;
(iii) Hold unrestricted license to practice medicine in Oklahoma;
(iv) If Clinical Fellow, practicing during second or subsequent year of fellowship;
(v) Seeing members without supervision;
(vi) Services provided not for primary purpose of medical education for the clinical fellow or chief resident;
(vii) Submit billing in own name with appropriate Oklahoma SoonerCare provider number.
(viii) Additionally if a clinical fellow practicing during the first year of fellowship, the clinical fellow must be practicing within their area of primary training. The services must be performed within the context of their primary specialty and only to the extent as allowed by their accrediting body.
(U) Payment to the attending physician for the services of a currently Oklahoma licensed physician in training when the following conditions are met.
(i) Attending physician performs chart review and signs off on the billed encounter;
(ii) Attending physician is present in the clinic/or hospital setting and available for consultation;
(iii) Documentation of written policy and applicable training of physicians in the training program regarding when to seek the consultation of the attending physician.
(V) Payment to the attending physician for the outpatient services of an unlicensed physician in a training program when the following conditions are met:
(i) The member must be at least minimally examined by the attending physician or a licensed physician under the supervision of the attending physician;
(ii) The contact must be documented in the medical record.
(W) The payment to a physician for medically directing the services of a CRNA or for the direct supervision of the services of an Anesthesiologist Assistant (AA) is limited. The maximum allowable fee for the services of both providers combined is limited to the maximum allowable had the service been performed solely by the anesthesiologist.
(X) One pap smear per year for women of child bearing age. Two follow-up pap smears are covered when medically indicated.
(Y) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (i)-(iv) of this subparagraph:
(i) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(ii) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
(iii) To be compensable under the SoonerCare program, all organ transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.
(iv) Procedures considered experimental or investigational are not covered.

(Z) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.
(i) Donor expenses incurred for complications are covered only if they are directly and immediately attributable to the donation procedure.
(ii) Donor expenses that occur after the 90 day global reimbursement period must be submitted to the OHCA for review.

(AA) Total parenteral nutritional therapy (TPN) for identified diagnoses and when prior authorized.

(BB) Ventilator equipment.

(CC) Home dialysis equipment and supplies.

(DD) Ambulatory services for treatment of members with tuberculosis (TB). This includes, but is not limited to, physician visits, outpatient hospital services, rural health clinic visits and prescriptions. Drugs prescribed for the treatment of TB beyond the prescriptions covered under SoonerCare require prior authorization by the University of Oklahoma College of Pharmacy Help Desk using form "Petition for TB Related Therapy". Ambulatory services to members infected with TB are not limited to the scope of the SoonerCare program, but require prior authorization when the scope is exceeded.

(EE) Smoking and Tobacco Use Cessation Counseling for treatment of individuals using tobacco.
(i) Smoking and Tobacco Use Cessation Counseling consists of the 5As:
(I) Asking the member to describe their smoking use;
(II) Advising the member to quit;
(III) Assessing the willingness of the member to quit;
(IV) Assisting the member with referrals and plans to quit; and
(V) Arranging for follow-up.
(ii) Up to eight sessions are covered per year per individual.
(iii) Smoking and Tobacco Use Cessation Counseling is a covered service when performed by physicians, physician assistants, advanced registered nurse practitioners, certified nurse midwives, dentists, and Oklahoma State Health Department and FQHC nursing staff. It is reimbursed in addition to any other appropriate global payments for obstetrical care, PCP care coordination payments, evaluation and management codes, or other appropriate services rendered. It must be a significant, separately identifiable service, unique from any other service provided on the same day.
(iv) Chart documentation must include a separate note and signature along with the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(FF) Immunizations as specified by the Advisory Committee on Immunization Practices (ACIP) guidelines.

(2) General coverage exclusions include the following:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Refractions and visual aids.

(E) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(F) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(G) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(H) Non-therapeutic hysterectomies.

(I) Medical services considered experimental or investigational.

(J) Payment for more than four outpatient visits per month (home or office) per member, except those visits in connection with family planning or related to emergency medical conditions.

(K) Payment for more than two nursing facility visits per month.

(L) More than one inpatient visit per day per physician.

(M) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(P) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(Q) Speech and Hearing services.

(R) Mileage.

(S) A routine hospital visit on the date of discharge unless the member expired.

(T) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(U) Inpatient chemical dependency treatment.

(V) Fertility treatment.

(W) Payment for removal of benign skin lesions unless medically necessary.

(b) **Children.** Payment is made to physicians for medical and surgical services for members under the age of 21 within the scope of the Authority's

SoonerCare program, provided the services are medically necessary for the diagnosis and treatment of illness or injury, or to improve the functioning of a malformed body member. Medical and surgical services for children are comparable to those listed for adults. For services rendered to a minor child, the child's parent or court-appointed legal guardian must provide written authorization prior to the service being rendered, unless there is an explicit state or federal exception to this requirement. In addition to those services listed for adults, the following services are covered for children.

(1) **Pre-authorization of inpatient psychiatric services.** All inpatient psychiatric services for members under 21 years of age must be prior authorized by an agency designated by the Oklahoma Health Care Authority. All psychiatric services are prior authorized for an approved length of stay. Non-authorized inpatient psychiatric services are not SoonerCare compensable.

(A) All residential and acute psychiatric services are authorized based on the medical necessity criteria as described in OAC 317:30-5-95.25,317:30-5-95.27 and 317:30-5-95.29.

(B) Out of state placements are not authorized unless it is determined that the needed medical services are more readily available in another state or it is a general practice for members in a particular border locality to use resources in another state. If a medical emergency occurs while a member is out of the State, treatment for medical services is covered as if provided within the State. A prime consideration for placements is proximity to the family or guardian in order to involve the family or guardian in discharge and reintegration planning.

(2) **General acute care inpatient service limitations.** All general acute care inpatient hospital services for members under the age of 21 are not limited. All inpatient care must be medically necessary.

(3) **Procedures for requesting extensions for inpatient services.** The physician and/or facility must provide necessary justification to enable OHCA, or its designated agent, to make a determination of medical necessity and appropriateness of treatment options. Extension requests for psychiatric admissions must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment in accordance with the medical necessity criteria described in OAC 317:30-5-95.26, 317:30-5-95.28 and 317:30-5-95.30. Requests must be made prior to the expiration of the approved inpatient stay. All decisions of OHCA or its designated agent are final.

(4) **Utilization control requirements for psychiatric beds.** Utilization control requirements for inpatient psychiatric services for members under 21 years of age apply to all hospitals and residential psychiatric treatment facilities.

(5) **Early and periodic screening diagnosis and treatment program.** Payment is made to eligible providers for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) of members under age 21. These services include medical, dental, vision, hearing and other necessary health care. Refer to OAC 317:30-3-65.2 through 317:30-3-65.11 for specific guidelines.

(6) **Child abuse/neglect findings.** Instances of child abuse and/or neglect discovered through screenings and regular exams are to be reported in accordance with State Law. Section 7103 of Title 10 of the Oklahoma Statutes mandates reporting suspected abuse or neglect to the Oklahoma Department of Human Services. Section 7104 of Title 10 of the Oklahoma Statutes further requires reporting of criminally injurious conduct to the nearest law enforcement agency.

(7) **General exclusions.** The following are excluded from coverage for members under the age of 21:

(A) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(B) Services or any expense incurred for cosmetic surgery unless the physician certifies the procedure emotionally necessary.

(C) Services of two physicians for the same type of service to the same member on the same day, except when supplemental skills are required and different specialties are involved.

(D) Pre-operative care within 24 hours of the day of admission for surgery and routine post-operative care as defined under the global surgery guidelines promulgated by Current Procedural Terminology (CPT) and the Centers for Medicare and Medicaid Services (CMS).

(E) Payment to the same physician for both an outpatient visit and admission to hospital on the same date.

(F) Sterilization of members who are under 21 years of age, mentally incompetent, or institutionalized or reversal of sterilization procedures for the purposes of conception.

(G) Non-therapeutic hysterectomies.

(H) Medical Services considered experimental or investigational.

(I) More than one inpatient visit per day per physician.

(J) Induced abortions, except when certified in writing by a physician that the abortion was necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, or that the pregnancy is the result of an act of rape or incest. (Refer to OAC 317:30-5-6 or 317:30-5-50.)

(K) Physician services which are administrative in nature and not a direct service to the member including such items as quality assurance, utilization review, treatment staffing, tumor board review or multidisciplinary opinion, dictation, and similar functions.

(L) Payment for the services of social workers, licensed family counselors, registered nurses or other ancillary staff, except as specifically set out in OHCA rules.

(M) Direct payment to perfusionist as this is considered part of the hospital reimbursement.

(N) Charges for completion of insurance forms, abstracts, narrative reports or telephone calls.

(O) Mileage.

(P) A routine hospital visit on date of discharge unless the member expired.

(c) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services. Claims filed with Medicare Part B should automatically cross over to OHCA. The explanation of Medicare Benefits (EOMB) reflects a message that the claim was referred to SoonerCare. If such a message is not present, a claim for coinsurance and deductible must be filed with the OHCA within 90 days of the date of Medicare payment or within one year of the date of service in order to be considered timely filed.

(1) In certain circumstances, some claims do not automatically "cross over". Providers must file a claim for coinsurance and/or deductible to SoonerCare within 90 days of the Medicare payment or within one year from the date of service.

(2) If payment was denied by Medicare Part B and the service is a SoonerCare covered service, mark the claim "denied by Medicare" and attach the Medicare EOMB showing the reason for the denial.

8.b-3 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 3. General Provider Policies
Part 1. General Scope and Administration
OAC 317:30-3-25. [AMENDED]
Subchapter 5. Individual Providers and Specialties
Part 9. Long Term Care Facilities
OAC 317:30-5-122. [AMENDED]
(Reference APA WF # 12-09)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists and finds that an imminent peril exists to the preservation of the public health, safety, or welfare which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's Medicare Crossover payment policy. These emergency rule revisions will ensure OHCA policy allows proper funding for skilled nursing facilities and ensure services will be maintained for SoonerCare members residing in the facilities.

ANALYSIS: Policy will be amended to allow 100% payment of Medicare Crossover deductibles and coinsurance at skilled nursing facilities. Current policy allows payment at the Medicaid rate, which was previously adjusted to 0%. The rationale behind current policy is based on a federal policy that allowed federal reimbursement/write-offs for bad debts. That federal policy is no longer in effect and has prompted the policy amendment request.

BUDGET IMPACT: The Agency has estimated a budget impact of $24 million, with $8.6 million state share.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 14, 2012, 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; 42 CFR 440.230.

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Adopt Medicare Crossover payment rules to ensure appropriate reimbursement of the services provided in skilled nursing facilities.

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

317:30-3-25. Crossovers (coinsurance and deductible)
(a) **Medicare Part B**. Payment is made for Medicare deductible and coinsurance on behalf of eligible individuals.

(b) **Medicare Part A**. Payment is made for Medicare deductible and coinsurance on behalf of eligible individuals. ~~limited to the Medicaid allowable reimbursement for services in a skilled nursing facility.~~
(c) **Medicare Advantage Plans.** Payment is made for Medicare HMO co-payments. For services offered by Medicare Advantage Plans that revert to traditional Medicare type benefits, payment is made for coinsurance and deductibles according to subsection (a) and (b) in this section.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 9. LONG TERM CARE FACILITIES

317:30-5-122. Levels of care
(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for People with Mental Retardation (ICF/MR). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.
(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental and social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** ~~When total payments from all other payers are less than the Medicaid rate, payment~~ Payment is made for the Part A coinsurance and deductible for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.
(2) **Nursing Facility.** Care provided by a nursing facility to patients who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.
(3) **Intermediate Care Facility for the Mentally Retarded.** Care for persons with intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/MR level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) Self-care. The individual requires assistance, training or supervision to eat, dress, groom, bathe, or use the toilet.
(B) Understanding and use of language. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of request or is unable to follow two-step instructions.
(C) Learning. The individual has a valid diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders.
(D) Mobility. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.
(E) Self-direction. The individual is 7 years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical

care, personal safety or for legal, financial, habilitative or residential issues and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) Capacity for independent living. The individual who is 7 years old or older and is unable to locate and use a telephone, cross the street safely or understand that it is unsafe to accept rides, food or money from strangers or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping or paying bills.

8.b-4 CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 21. Outpatient Behavioral Health Services
OAC 317:30-5-240.1. [AMENDED]
OAC 317:30-5-241. [AMENDED]
OAC 317:30-5-241.3. [AMENDED]
(Reference APA WF # 12-19)

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 outpatient behavioral health rules in order to avoid imminent reduction to the budget of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), the state agency responsible for administering the State's Medicaid outpatient behavioral health program. Utilization of Behavioral Health Rehabilitation (BHR) services has increased over the last several years at an alarming rate, increasing from 14% of the outpatient behavioral health budget in SFY 2008, to 24% of the budget in SFY 2012. Proposed rule revisions would impose limits on the amount of BHR services available to SoonerCare members in order to ensure appropriateness of the services provided as well as contain program costs. The Agency also finds that promulgation of emergency rules is necessary to protect the public health, safety or welfare by ensuring that services are of high quality and delivered in the most appropriate manner to the intended populations.

ANALYSIS: Over the past two years, the Agency has observed a dramatic increase in the amount of Behavioral Health Rehabilitation Services delivered to SoonerCare members, prompting the Agency to examine the appropriateness and quality of the services being delivered. It was discovered that an overwhelming amount of Psychosocial Rehabilitation Services (PSR), a type of BHR, were being delivered to children under the age of 6 while research shows that PSR is not an effective treatment modality for children in this age range experiencing emotional or behavioral disorders. The Agency is proposing rule revisions to deny reimbursement for PSR services for children below age 6 unless services are medically necessary and required pursuant to Federal Early and Periodic Screening Diagnostic and Treatment (EPSDT) laws. The Agency is also proposing rule revisions which will control utilization of Rehabilitation services by imposing limits on the number of units that qualified providers will be reimbursed. The utilization limits will be prior authorized by OHCA or its designated agent and will be directly correlated to the individual member's level of need.

BUDGET IMPACT: The Agency has determined that the proposed rule revisions will result in an estimated budget savings of $7,823,775 Total Savings ($2,814,994 State Savings) in SFY 2013 and $18,777,062 Total Savings ($6,755,986 State Savings) in SFY 2014. ODMHSAS is responsible for the state share funding for SoonerCare outpatient behavioral health services.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 14, 2012, and recommended Board approval.

PROPOSED EFFECTIVE DATE: Immediately upon Governor's approval or January 15, 2013, whichever is later.

AUTHORITY: The Oklahoma Health Care Authority Board; The Oklahoma Health Care Authority Act, Section 5003 through 5016 of Title 63 of Oklahoma Statutes; 42 CFR 440.230.

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Adopt Outpatient Behavioral Health Rehabilitation service utilization limits to ensure appropriateness of the services provided as well as contain program costs.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-240.1. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"Accrediting body" means one of the following:
- (A) Accreditation Association for Ambulatory Health Care (AAAHC);
- (B) American Osteopathic Association (AOA);
- (C) Commission on Accreditation of Rehabilitation Facilities (CARF);
- (D) Council on Accreditation of Services for Families and Children, Inc. (COA);
- (E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations; or
- (F) other OHCA approved accreditation.

"Adult" means an individual 21 and over, unless otherwise specified.

"AOD" means Alcohol and Other Drug.

"AODTP" means Alcohol and Other Drug Treatment Professional.

"ASAM" means the American Society of Addiction Medicine.

"ASAM Patient Placement Criteria (ASAM PPC)" means the most current edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

~~**"BH"** means behavioral health, which relates to mental, substance abuse, addictions, gambling, and other diagnosis and treatment.~~**"Behavioral Health (BH) Services"** means a wide range of diagnostic, therapeutic, and rehabilitative services used in the treatment of mental illness, substance abuse, and co-occurring disorders.

"BHAs" means Behavioral Health Aides.

"BHRS" means Behavioral Health Rehabilitation Specialist.

"Certifying Agency" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

"Child" means an individual younger than 21, unless otherwise specified.

"Client Assessment Record (CAR)" means the standardized tool recognized by OHCA and ODMHSAS to evaluate the functioning of the member.

"CM" means case management.

~~**"CMHC's"**~~**"CMHCs"** means Community Mental Health Centers who are state operated or privately contracted providers of behavioral health services for adults with ~~severe~~serious mental illnesses, and youth with serious emotional disturbances.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, age group, religious, sexual orientation, and/or social group.

"DSM" means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"EBP" means an Evidence Based Practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).

"EPSDT" means the Medicaid Early and Periodic Screening, Diagnostic and Treatment benefit for children. In addition to screening services, EPSDT also covers the diagnostic and treatment services necessary to ameliorate acute and chronic physical and mental health conditions.

"FBCS" means Facility Based Crisis Stabilization.

"FSPs" means Family Support Providers.

"ICF/MR" means Intermediate Care Facility for the Mentally Retarded.

"Institution" means an inpatient hospital facility or Institution for Mental Disease (IMD).

"IMD" means Institution for Mental Disease as per 42 CFR 435.1009 as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age 21 receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under 65 years of age [section 1905(a)(24)(B)].

"**Level of Functioning Rating"** means a standardized mechanism to determine the intensity or level of services needed based upon the severity of the member's condition. The CAR level of function rating scale is the tool that links the clinical assessment to the appropriate level of treatment. The CAR level of functioning rating scale is to be utilized in conjunction with the clinical judgment of the Licensed Behavioral Health Professional.

"LBHP" means a Licensed Behavioral Health Professional.

"MST" means the EBP Multi-Systemic Therapy.

"OAC" means Oklahoma Administrative Code, the publication authorized by 75 O.S. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time-limited.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"ODMHSAS contracted facilities" means those providers that have a contract with the ODMHSAS to provide mental health or substance abuse

treatment services, and also contract directly with the Oklahoma Health Care Authority to provide Outpatient Behavioral Health Services.

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

"Provider Manual" means the OHCA BH Provider Billing Manual.

"RBMS" means Residential Behavioral Management Services within a group home or therapeutic foster home.

"Recovery" means an ongoing process of discovery and/or rediscovery that must be self defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.

"RSS" means Recovery Support Specialist.

"SAMHSA" means the Substance Abuse and Mental Health Services Administration.

~~**"SED"** means Severe Emotional Disturbance.~~**"Serious Emotional Disturbance (SED)"** means a condition experienced by persons from birth to 18 that show evidence of points of (1), (2) and (3) below:

(1) The disability must have persisted for six months and be expected to persist for a year or longer.

(2) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

(3) The child must exhibit either (A) or (B) below:

(A) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(B) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(i) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(ii) Impairment in community function manifested by a consistent lack of age appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.

(iii) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

(iv) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

(v) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

~~**"SMI"** means Severely Mentally Ill.~~**"Serious Mental Illness (SMI)"** means a condition experienced by persons age 18 and over that show evidence of points of (1), (2) and (3) below:

(1) The disability must have persisted for six months and be expected to persist for a year or longer.

(2) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.

(3) The adult must exhibit either (A) or (B) below:

(A) Psychotic symptoms of a serious mental illness (e.g. Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(B) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two of the following capacities (compared with expected developmental level):

(i) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(ii) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.

(iii) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.

(iv) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations.

(v) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

"Trauma informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-241. Covered Services

(a) Outpatient behavioral health services are covered for adults and children as set forth in this Section unless specified otherwise, and when provided in accordance with a documented individualized service plan, developed to treat the identified behavioral health and/or substance abuse disorder(s).

(b) All services are to be for the goal of improvement of functioning, independence, or well-being of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(c) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Behavioral Health Provider Manual.
(d) All outpatient BH services must be provided following established medical necessity criteria. Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Behavioral Health Provider Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

317:30-5-241.3. Behavioral Health Rehabilitation (BHR) services
(a) **Definition.** ~~BHR are behavioral health rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. This service may include the Evidence Based Practice of Illness, Management, and Recovery.~~Behavioral Health Rehabilitation (BHR) services are goal oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning. BHR services must be coordinated in a manner that is in the best interest of the member and may be provided in a variety of community and/or professional settings. For purposes of this Section, BHR includes Psychosocial Rehabilitation, Outpatient Substance Abuse Rehabilitation, and Medication Training and Support.
(b) **Psychosocial Rehabilitation (PSR).**

(1) **Definition.** PSR services are face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live interdependently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. For adults, this service may include the Evidence Based Practice of Illness Management and Recovery. For children, PSR services include two levels of intervention: Children's Psychosocial Rehabilitation - Intensive (CPSR-I) and Children's Psychosocial Rehabilitation – Skills Training (CPSR-ST).

(A) **CPSR-I.** CPSR-I is a level of support designed to help children with Serious Emotional Disturbance (SED) who are experiencing an acute psychiatric condition, alleviating or eliminating the need to admit them into a psychiatric inpatient or residential setting. It is a comprehensive, time-limited, community-based service delivered to children with SED who are exhibiting symptoms that interfere with their individual lives in a highly disabling or incapacitating manner.

(B) **CPSR-ST.** CPSR-ST is a level of support designed to help children/adolescents who have been diagnosed with serious social, behavioral and/or emotional issues that substantially

interfere with functioning in the home, school or community. The service plan is focused toward age-appropriate rehabilitation. Primary emphasis is to develop stabilization in the community and home. CPSR-ST services teach members a variety of life skills.

~~(1)~~(2) **Clinical restrictions**. This service is generally performed with only the members and the ~~BHRS~~qualified provider, but may include a member and the member's family/support system group that focuses on the member's diagnosis, management, and recovery based curriculum. A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery, but does not constitute family therapy, which requires a licensed provider.

~~(2)~~(3) **Qualified providers**. A BHRS, CADC, or LBHP may perform ~~BHR~~PSR and CPSR, following development of a service plan and treatment curriculum approved by a LBHP. ~~Staff~~ CPSR staff must be appropriately trained in a recognized behavioral/management intervention program such as MANDT or CAPE or trauma informed methodology.

~~(3)~~(4) **Group sizes**. The ~~minimum~~maximum staffing ratio is fourteen members for each BHRS, CADC, or LBHP for adults and eight to one for children under the age of eighteen.

~~(4)~~(5) **Limitations.**

(A) **Transportation**. Travel time to and from ~~BHR~~PSR treatment is not compensable. Group ~~psychosocial rehabilitation~~PSR services do not qualify for the OHCA transportation program, but ~~they~~OHCA will arrange for transportation for those who require specialized transportation equipment. ~~A member who at the time of service is not able to cognitively benefit from the treatment due to active hallucinations, substance use, or other impairments is not suitable for this service.~~

(B) **Time**. Breaks, lunchtime and times when the member is unable or unwilling to participate are not compensable and must be deducted from the overall billed time.

(C) **Location**. In order to develop and improve the member's community and interpersonal functioning and self care abilities, ~~rehabilitation~~PSR services may take place in settings away from the outpatient behavioral health agency site. When this occurs, the BHRS, CADC, or LBHP must be present and interacting, teaching, or supporting the defined learning objectives of the member for the entire claimed time.

(D) **Eligibility for PSR services.** PSR services are intended for adults with Serious Mental Illness (SMI) and children with emotional or behavioral disorders. The following members are not eligible for PSR services:

(i) Residents of ICF/MR facilities, unless authorized by OHCA or its designated agent;

(ii) children under age 6, unless a prior authorization has been granted by OHCA or its designated agent based on a finding of medical necessity;

(iii) children receiving RBMS in a group home or therapeutic foster home, unless authorized by OHCA or its designated agent;

(iv) inmates of public institutions;

(v) members residing in inpatient hospitals or IMDs; and

(vi) members residing in nursing facilities.

~~(D)~~(E) **Billing limits**. ~~Residents of ICF/MR facilities and children receiving RBMS in a group home or therapeutic foster home are not eligible for this service, unless allowed by OHCA or its designated agent.~~PSR/CPSR services are time-limited services designed to be provided over the briefest and most effective period possible and as adjunct (enhancing) interventions to compliment more intensive behavioral health therapies. Service limits are based on the member's needs according to the CAR or other approved tool, the requested placement based on the level of functioning rating, medical necessity, and best practice. Service limitations are designed to help prevent rehabilitation diminishing return by remaining within reasonable age and developmentally appropriate daily limits. PSR/CPSR services authorized under this Section should not duplicate the structured services required for children residing in group home or therapeutic foster care settings, or receiving services in Day Treatment or Partial Hospitalization Programs. PSR/CPSR is billed in unit increments of 15 minutes with the following limits:

(i) **Group PSR/CPSR**. The maximum is 24 units per day for ~~adults~~PSR and CPSR-I and 16 units per day for ~~children~~CPSR-ST.

(ii) **Individual PSR/CPSR**. The maximum is six units per day. Children under an ODMHSAS Systems of Care program may be prior authorized additional units as part of an intensive transition period.

(iii) **Per-Member service levels and limits.** CPSR-I is only authorized as a Level 4 service. Group and/or individual CPSR-ST and adult PSR services provided in combination may not exceed the following monthly limits depending upon which level for which the member has been approved:

(I) Level 1: 32 units.

(II) Level 2: 48 units.

(III) Level 3: 64 units.

(iv) **EPSDT.** Pursuant to OAC 317:30-3-65 et seq., billing limits may be exceeded or may not apply if documentation demonstrates that the requested services are medically necessary and are needed to correct or ameliorate defects, physical or behavioral illnesses or conditions discovered through a screening tool approved by OHCA or its designated agent. The OHCA has produced forms for documenting an EPSDT child health checkup screening which the provider can access on the OHCA website.

~~(E)~~(F) **Documentation requirements.** In accordance with OAC 317:30-5-241.1, the behavioral health service plan developed by the LBHP must include the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time-limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. When PSR/CPSR services are prescribed, the plan must address objectives that are specific, attainable, realistic, and time-limited. The plan must include the appropriate treatment coordination to achieve the maximum reduction of the mental and/or behavioral health disability and to restore the member to their best possible functional level. Progress notes for intensive and skills training ~~outpatient~~

~~mental~~behavioral health, substance abuse or integrated programs may be in the form of daily summary or weekly summary notes and must include the following:

(i) Curriculum sessions attended each day and/or dates attending during the week;
(ii) Start and stop times for each day attended and the physical location in which the service was rendered;
(iii) Specific goal(s) and objectives addressed during the week;
(iv) Type of Skills Training provided each day and/or during the week including the specific curriculum used with member;
(v) Member satisfaction with staff intervention(s);
(vi) Progress, or barrier to, made towards goals, objectives;
(vii) New goal(s) or objective(s) identified;
(viii) Signature of the lead ~~BHRS~~qualified professional; and
(ix) Credentials of the lead ~~BHRS~~qualified professional.

(G) **Non-Covered Services.** The following services are not considered BHR and are not reimbursable:

(i) Room and board;
(ii) educational costs;
(iii) supported employment; and
(iv) respite.

(c) **Outpatient Substance Abuse Rehabilitation Services.**

(1) **Definition.** Covered outpatient substance abuse rehabilitation services are provided in non-residential settings in regularly scheduled sessions intended for individuals not requiring a more intensive level of care or those who require continuing services following more intensive treatment regimes. The purpose of substance abuse rehabilitation services is to begin, maintain, and/or enhance recovery from alcoholism, problem drinking, drug abuse, drug dependency addiction or nicotine use and addiction. Rehabilitation services may be provided individually or in group sessions.

(2) **Limitations**. Group sessions may not be provided in the home.

(3) **Eligibility.** Members eligible for substance abuse rehabilitation services must meet the criteria for ASAM PCC Treatment Level 1, Outpatient Treatment.

(4) **Qualified providers.** Services may be provided by a LBHP, BHRS or CADC within the scope of their practice under state law for adults and children.

(5) **Billing limits.** Group rehabilitation is limited to two (2) hours per session. Group and/or individual outpatient substance abuse rehabilitation services provided in combination may not exceed the following monthly limits depending upon which level for which the member has been approved:

(A) Level 1: 32 units.
(B) Level 2: 48 units.
(C) Level 3: 64 units.

(6) **Documentation requirements**. Documentation requirements are the same as for PSR services as set forth in 30-5-241.3(b)(5)(F).

~~(b)~~(d) **Medication training and support.**

(1) **Definition**. Medication Training and Support is a documented review and educational session by a registered nurse, or physician assistant focusing on a member's response to medication and compliance with the medication regimen. The review must include an assessment of medication compliance and medication side effects. Vital signs must be taken including pulse, blood pressure and respiration and documented within the medical or clinical record. A

physician is not required to be present, but must be available for consult. Medication Training and Support is designed to maintain the member on the appropriate level of the least intrusive medications, encourage normalization and prevent hospitalization.

(2) **Limitations.**

(A) Medication Training and Support may not be billed for SoonerCare members who reside in ICF/MR facilities.

(B) One unit is allowed per month per patient.

(C) Medication Training & Support is not allowed to be billed on the same day as pharmacological management.

(3) **Qualified professionals.** Must be provided by a licensed registered nurse, or a physician assistant as a direct service under the supervision of a physician.

(4) **Documentation requirements** - Medication Training and Support documented review must focus on:

(A) a member's response to medication;

(B) compliance with the medication regimen;

(C) medication benefits and side effects;

(D) vital signs, which include pulse, blood pressure and respiration; and

(E) documented within the progress notes/medication record.

PROPOSED OHCA BOARD MEETINGS/LOCATIONS - 2013

JANUARY

S	M	T	W	T	F	S
		1	2	3	4	5
6	7	8	9	**10**	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

FEBRUARY

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MARCH

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APRIL

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MAY

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JUNE

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*Dates in **Red** are Proposed Board Dates

January 10, 2013 • 1:00 pm
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Oklahoma City, Oklahoma

February 14, 2013 • 1:00 pm
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Oklahoma City, Oklahoma

March 14, 2013 • 1:00 pm
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Oklahoma City, Oklahoma

April 11, 2013 • 1:00 pm
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Oklahoma City, Oklahoma

May 9, 2013 • 1:00 pm
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Oklahoma City, Oklahoma

June 13, 2013 • 1:00 pm
Enid

July 11, 2013 • 1:00 pm
Lawton

August 21, 2013 • Board Meeting • 4:00 pm
August Retreat 22 & 23, 2013 • 8:30 am
Tulsa, Oklahoma

September 12, 2013 • 1:00 pm
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Oklahoma City, Oklahoma

October 10, 2013 • 1:00 pm
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Oklahoma City, Oklahoma

November 14, 2013 • 1:00 pm
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Oklahoma City, Oklahoma

December 12, 2013 • 1:00 pm
Tulsa

JULY

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AUGUST

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SEPTEMBER

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OCTOBER

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NOVEMBER

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DECEMBER

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*Physical Location Yet To Be Determined for Dates with City, but No Address