OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
January 14, 2010 at 1:00PM
Oklahoma Health Care Authority
4545 N. Lincoln Blvd, Suite 124
Oklahoma City, OK

A G E N D A

Item to be presented by Lyle Roggow, Chairman

1. Call To Order/Determination of quorum – Lyle Roggow, Chairman
2. Action Item – Approval of December 10, 2009 Board Minutes

Item to be presented by Mike Fogarty, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Carrie Evans, Chief Financial Officer
    b) Medicaid Director's Update – Lynn Mitchell, M.D.
    c) Legislative Update – Nico Gomez, Deputy Chief Executive Officer

Item to be presented by Lynn Mitchell, M.D., State Medicaid Director

4. Discussion Item - Presentation of the Title XXI CHIP State Plan Amendment approval and the CMS approval to renew the "SoonerCare" Medicaid Section 1115 Demonstration Waiver

Item to be presented by Howard Pallotta, General Counsel

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

Item to be presented by Mike Fogarty, Chief Executive Officer

6. Action Item – Consideration and Vote to revise State Fiscal Year 2010 OHCA Budget Work Program to achieve a balanced budget

    a) Consideration and Vote to reduce total expenditures by review and revision of provider rates to be effective April 1, 2010. Rate reductions are to be in an amount sufficient to balance the State Fiscal Year 2010 OHCA budget, accommodating reduced allocation of general revenue for December 2009 and January 2010 as instructed by the Office of State Finance. Rate reductions are to be applied across-the-board to all provider types to the extent possible and in accordance with applicable Medicaid requirements.

Item to be presented by Chairman Roggow

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

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

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

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 317:30-5-1023 and 30-5-1027 to modify EPSDT rules to add a new provider type "Behavior Health School Aide" and service "Therapeutic Behavioral Services". This rule change is needed to help better define and separate behavioral interventions that do not appropriately fall within the description of personal care services.
   (Reference APA WF # 09-47)

   8.b-2 AMENDING agency rules at OAC 317:30-5-20 and 30-5-100 to clarify that reimbursement is only made for medically necessary laboratory services. Additional revisions include removing language which calls for OHCA to edit laboratory claims at the specialty/subspecialty level.
   (Reference APA WF # 09-52)

   8.b-3 AMENDING agency rules at OAC 317:45-11-20 and 45-11-27 to clarify the intent of offering coverage under the Insure Oklahoma Individual Plan (IP) program. Applicants applying for coverage under the IP program should be uninsured individuals without access to Insure Oklahoma Employer Sponsored Insurance (ESI) or other private health insurance. Rules clarify IP eligibility requirements and closure criteria.
   (Reference APA WF # 09-53)

   8.b-4 AMENDING agency rules at OAC 317:2-1-2, 35-1-2, 35-5-6, 35-5-6.1, 35-6-15, 35-6-38, 35-6-62, 35-6-63, 35-6-64, 35-6-64.1, 35-7-15, 35-7-60.1, 35-7-63, 35-7-64, 35-7-65, 35-10-26, 35-22-9, and 35-22-11 to support the use of the web based online application and eligibility determination system. The process will be phased in over a period of time, beginning with families with children, pregnant women, and individuals requesting only family planning services. Eligibility for these groups will no longer be retroactive to the first day of the month of application but rather, the date of application or later.
   (Reference APA WF # 09-56)

8.b-5 AMENDING agency rules at OAC 317:30-5-566 and 30-5-567 to allow reimbursement for services not covered as Medicare Ambulatory Surgical Center (ASC) procedures but otherwise covered under the SoonerCare program. This revision will give OHCA additional flexibility in determining services which are appropriate for the populations we serve.
(Reference APA WF # 09-59)

8.b-6 AMENDING agency rules at OAC 317:30-5-96.3 to clarify reimbursement for acute inpatient psychiatric services provided in free-standing psychiatric hospitals. The modification more clearly defines reimbursement for ancillary and professional services outside of the per diem rate paid to the facilities.
(Reference APA WF # 09-61)

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

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

   a) Consideration and vote to add certain anti-nausea medications to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e)

Item to be presented by Chairman Roggow

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

Status of pending suits and claims

1.McAlary v. OHCA	CJ-08-021 (Dewey County)
2.Decker (Lightning Creek) v. OHCA	CJ-08-105 (Major County)
3.Price v. Wolford	09-6139 (Tenth Circuit)
4.McAlary v. OHCA	106,308 (Okla. S.Ct.)
5.Decker (Lightning Creek) v. OHCA	107,844 (Okla. S.Ct.)
6.Boone v. OHCA	CV-09-98 (Choctaw County)
7.Boone v. OHCA	CJ-09-10416 (Oklahoma County)

11. New Business

12. Adjournment

NEXT BOARD MEETING
February 11, 2010
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING OF THE OKLAHOMA HEALTH CARE AUTHORITY BOARD
Held at College of Osteopathic Medicine
1111 W. 17th Street
Dunlap Auditorium
Tulsa, OK
on December 10, 2009 at 1PM

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority and College of Osteopathic Medicine/Tulsa on December 9th, 2009.

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

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

OTHERS PRESENT:

Steven Feist, LogistiCare
Mary Staples, NACDS
Disha Zarate, OKDHS
Brent Wilborn, OKPCA
Teresa Tisdell, NeuroResources
Sherri Hiseley, Medic-Aire
Angela Henderson, Invacare
Sandra Harrison, OKDHS
Tammy Kirkpatrick, RSW
Dandy Risman, RSI
Richard Desirey, ACT/Mator
Patrice Pratt, LTCA
Will Widman, Hewlett Packard
Pamela Ellis, All Saints Home
Chris Darrow, All Saints Home
Milissa Gofourth, Able Tech
Charlene Kaiser
David Blatt, OK Policy
Conley Tunnell, Daybreak Services
Eric Polak, OSU-CMS

OTHERS PRESENT:

Kim Archer, Tulsa World
Mark DeClerk, Lily
Darnell Powell, Shadow Mountain
Scott Pilgrim, OAHCP
Justin Burthon, AR
Steve Lewis, Dayspring BH
A Cordry, RR
Darrell Smith, Cornerstone
Tammy Franklin, New Frontier Med.
Brandy Tamehill, New Frontier Med.
Patti Davis, OHA
Lynn White, OHA
Morna Rambo, Alternative Opps
Tracey Joner, Chickasaw Nation
Robert Lee, MHSSO
John Holter, Cedar Ridge
Ellen Huffmaster
Wes Bledsoe, Perfect Cause
Lisa Libl, Perfect Cause

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD NOVEMBER 12, 2009

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

MOTION: Vice Chairman Armstrong moved for the approval of the November 12, 2009 board minutes as presented. Member McVay seconded.

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

ABSTAIN: Member McFall

ITEM 3.a)FINANCIAL UPDATE
Carrie Evans, CFO

Ms. Evans stated that revenues for OHCA through October, accounting for receivables, were **$1,198,275,037** or **.2% under** budget. The expenditures for OHCA, accounting for encumbrances, were **$1,135,426,771** or **.5% under** budget. She noted that the state dollar budget variance through October is **$3,471,747 positive.** Ms. Evans said **that** the budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	(3.1)
Administration	2.6
Revenues:	
Taxes and Fees	2.4
Drug Rebate	1.4
Overpayments/Settlements	.2
Total FY 10 Variance	**$ 3.5**

Ms. Evans stated that or the month of November, we are going to go over about $2 million.

ITEM 3.b)MEDICAID DIRECTOR'S UPDATE
Lynn Mitchell, MD

Dr. Mitchell reported that the enrollments continue to rise with 5600 new members from the previous month. There were 16,265 new members that had not received services in the last 6 months. In the SoonerCare Programs you will note that they all have increased since last month. The Providers Fast Facts numbers remain strong. Dr. Mitchell acknowledged the providers for participating in the previous meetings which prepared for today's meeting. Dr. Mitchell stated that Insure Oklahoma numbers are at 28,958 that is about a 1000 member increase from last month. The ESI has 18,133 and IP has 10,825. She said that she would like to discuss the Focus on Excellence Fast Fact in greater detail at a future meeting and tell you about some potential changes as that program continues to develop. She then discussed the PACE Program stating that currently there are 37 members in the program. It is the first Native American PACE in the nation and is a partnership program with the Cherokee Nation. Dr. Mitchell reported on the pharmacy call volume stating that there was an increase due to issues related to the H1N1 virus and the use of Tamiflu. Dr. Mitchell reported on her role in the Medicaid Leadership Institute which is sponsored by the Robert Wood Johnson Foundation and the Center for Health Care Strategies. We

just had the second onsite meeting in Indianapolis which focused on health care data and how to use data to infuse quality into the program.

Mr. Fogarty discussed the take home packet items. 1) SoonerCare Companion published quarterly and provided to all members of the SoonerCare Program. 2) Life Productivity Issue Point of View weighing Mental Health cuts by Jeff Tallent published in this morning's newspaper. Mr. Fogarty thanked Dr. Hess at the College of Osteopathic Medicine for accommodating OHCA for this meeting.

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

4.a)Audit/Finance Committee

Member Miller stated that the committee met last week with key members of the OHCA staff. The financial report before the board today is the 4th month of the fiscal year and we are now in the 6th month of the fiscal year. In addition to operating with less state funding, our enrollments are continuing to rise. We did delay the rebidding of the MMIS system which helped with significant savings in administration. Drug rebates were up in the month of October. Member Miller stated that the day of reckoning has arrived with only 1 day reserve.

4.b)Rules Committee
Member Langenkamp

Member Langekamp stated the rules committee did meet last week and noted that some of the board members have attended the providers meetings.

4.b(i) Committee recommendation regarding study of Oklahoma community practice patterns

Member Langenkamp made a motion that the agency increase the Program Integrity and Quality Assurance activity to include more monitoring, more study, more evaluation of the clinical practice patterns that our providers are doing across the state so that we might make sure that we are being as cost effective in the delivery of our care to all our clients. Member Langekamp stated that we have 825,000 clients which would present quite a picture of the utilization of the services. The Committee hopes that this can be achieved and reported to the board on a monthly basis. This is the motion that the Rules Committee would like to present to this board.

MOTION:	Member Langenkamp moved to adopt the rules committee motion as presented. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

ITEM 5/CONSIDERATION AND VOTE UPON BENEFIT REDUCTION, PROGRAM MODIFICATIONS, AND PAYMENT REDUCTIONS MADE TO ALLOW THE OKLAHOMA HEALTH CARE AUTHORITY TO COMPLY WITH ARTICLE 10, SECTION 23 OF THE OKLAHOMA CONSTITUTION

ITEM 5.a)ANNOUNCEMENT OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS REGADING BENEFIT, PAYMENT AND PROGRAM MODIFICATIONS TO ACHIEVE A BALANCED BUDGET

Nicole Nantois, Deputy General Counsel

Ms. Nantois stated that the Conflicts of Interest Panel met regarding all the action items on the agenda and the panel found no conflicts.

Chairman Roggow thanked staff, board members and providers for all the efforts toward achieving a balanced budget.

ITEM 5.b)AGENCY RECOMMENDATION OF BENEFIT REDUCTIONS, PROGRAM MODIFICATIONS AND PAYMENT REDUCTIONS TO ACHIEVE A BALANCED BUDGET – SEE ATTACHED SFY2010 BUDGET REDUCTION ANALYSIS AND STAFF RECOMMENDATION

Mike Fogarty, Chief Executive Officer

Mr. Fogarty presented recommendations contained in agenda attachment 5.b and further described at agenda tab 5.b.

Member Langenkamp asked if there were 3,000 members affected on level 3&4 behavioral health services. Mr. Fogarty stated that was correct. In the current system, there are about 3,000 individuals who have actually received services that would exceed the new cap.

Mr. Fogarty stated that there will not be any recommendation on this list to reduce financial eligibility or cover fewer people due to the federal stimulus monies coming to Oklahoma. We are not allowed to reduce eligibility under the conditions of the federal stimulus money.

Mr. McFall stated that Dr. Nesser and the College of Pharmacy is working on a list of about 50 drugs that are often generic drugs that we will make no collectible co-pay.

Mr. Fogarty stated that these are staff recommendations. The sum total of the state dollar reduction is $16.8 million. It has been made clear in our legislative budget hearing that this is not the last time we will be talking about reducing our budget. The treasurer expects that we will be dealing with additional cuts even in the remaining months of the year. Mr. Fogarty acknowledged Senator Crain and Dr. Cox of the House whom were extremely helpful and have provided reaction and input on these recommendations. In the course of these discussions it was very clear that if and when this board is back talking about more cuts, provider rates will be on the table. It is the recommendation of this staff that this board adopt the recommendations that have just been presented. Several of these will require further action for the adoption of rulemaking.

Member Langenkamp stated that under cost caps level 3&4, behavioral health is $630,000 state dollars. Any of that money that could then be used to reduce that number would be lovely.

Chairman Roggow stated that we have to overshoot some in order to have some cushion because before the end of this fiscal year we will be back at the table still talking what more can we do. Chairman Roggow commended the staff, providers, the agency, and board members who took time to attend the meetings.

Mr. Fogarty stated that one thing that he did not mention concerning the behavioral health level 3&4 caps that they are not in concrete. There are mechanisms to offer additional services if that service is critically necessary.

MOTION:	Member McFall moved to proceed with the recommendation of benefit reductions, program modifications and payment reductions to achieve a balanced budget under 5.b. Vice Chairman Armstrong seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

ITEM 6.b)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.

Mr. Fogarty stated that these rules will have to be considered as emergency rules. These rules are intended to meet a constitution requirement for a balanced budget.

MOTION:	Member Miller moved for declaration of a compelling public interest for the promulgation of all emergency rules in accordance with 75 OKLA. STAT. § 253. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

ITEM 6.c)CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:

Mr. Fogarty stated that these 4 rules are identified in agenda attachment 5.b.

6.c-1. AMENDING agency rules at OAC 317:30-5-211.10, 30-5-211.12, 30-5-211.15, 30-5-218 and 30-5-547 to reduce and/or eliminate certain durable medical equipment benefits to adults. Revisions include the elimination of osteogenic stimulators, portable oxygen contents, the reduction of blood glucose strips and lancets without a prior authorization, and provides for periodic review and adjustments of the Agency's fee schedule.
(Reference APA WF # 09-76)

6.c2. AMENDING agency rules at OAC 317:30-3-57 and 30-5-72 to reduce the number of allowed brand name prescription drugs from three to two per month for SoonerCare members.
(Reference APA WF # 09-74)
6.c-3. AMENDING agency rules at OAC 317:30-3-5 to increase existing co-payments for certain medical benefits provided through SoonerCare as well as require co-pays for additional benefits.
(Reference APA WF # 09-37)
6.c-4. ADDING a new agency rule at OAC 317:30-3-61 to establish policy for serious reportable events in healthcare, also called never events. Rules will non-cover three surgical errors and set billing policy to implement appropriate claims processing. The three surgical errors are (1) wrong surgical or other invasive procedures performed on a member, (2) surgical or other invasive procedures performed on the wrong body part, and (3) surgical or other invasive procedures performed on the wrong member. Rules will also include a related claims review (if appropriate) and the avoidance of SoonerCare to act as a secondary payer for Medicare non-payment of the three surgical errors.
(Reference APA WF # 09-51)

MOTION:	Vice Chairman Armstrong moved for approval of emergency rules 6c-1 through 6c-4. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

ITEM 7.b)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.

MOTION:	Member Langenkamp moved for declaration of a compelling public interest for the promulgation of all emergency rules in accordance with 75 OKLA. STAT. § 253. Member McFall seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

ITEM 7.c)CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:

Ms. Roberts presented the following rules:

7.c-1 AMENDING agency rules at OAC 317:35-5-25, 35-6-60, and 35-6-61 regarding coverage for deemed newborns to comply with provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3.
(**Reference APA WF # 09-55)**
7.c-2 AMENDING agency rules at OAC 317:30-5-14 to allow for a separate

payment to be made to providers for the administration of pandemic virus vaccine to both adults and children. This change was brought about by the CMS mandate that State Medicaid agencies reimburse providers for the administration of the 2009 H1N1 flu vaccine.
(Reference APA WF # 09-70)

7.c-3 AMENDING agency rules at OAC 317:30-5-25 and 30-5-42.1 to clarify the intent of reimbursement for implantable devices inserted during the course of a surgical procedure. Separate payment will be made for implantable devices, but only when the implantable device is not included in the rate for the procedure to insert the device.
(Reference APA WF # 09-60)

7.c-4 AMENDING agency rules at OAC 317:30-5-1040, 30-5-1041, 30-5-1042, 30-5-1043, 30-5-1044, 30-5-1046, and 30-5-1047.
These rule revisions change the status of the Office of Juvenile Affairs from an Organized Health Care Delivery System to a Foster Care Agency.
(Reference APA WF # 09-69)

7.c-5 AMENDING agency rules at OAC 317:30-5-764, 30-5-950, 35- 15-13.2, and 35-17-22 to add Case Management and Case Management for Transitioning to the list of services that must be documented utilizing the Interactive Voice Response Authentication (IVRA) system in the ADvantage waiver.
(Reference APA WF # 09-65)

MOTION: Vice Chairman Armstrong moved for approval of Item 7.c-1 through 7.c-5. Member McFall seconded.

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

ITEM 8.b)CONSIDERATION AND VOTE UPON PROPOSAL TO ESTABLISH THE THRESHOLD FOR EACH MEASUREMENT IN THE FOCUS ON EXCELLENCE PROGRAM TO SPECIFIC TARGETS FOR NINE OF THE TEN INDICATORS

Ms. Roberts stated that the Rates and Standards Committee did meet to hear staff recommendations on the Focus on Excellence Program and other facility rates and comments. The nursing facility rate is actually made up of 4 different components. We heard staff recommendations on the Focus on Excellence Performance Measurement component. Staff recommended that having had this program in effect for sometime, fixed targets can be set on our Focus on Excellence components. Based on My Innerview and other reports, staff recommends a target equal to the 60th percentile. For detailed targets see Item 8.b of the board packet.

i)Agency request to consider a stay regarding Medicare Utilization factor – Mike Fogarty, Chief Executive Officer

Mr. Fogarty stated that one of the natural evolutions of the Focus on Excellence Program is that we started out with no base data so that all were measured as compared to the other providers that were participating in the program. The point system was designed to recognize facilities that were operating on each of those 10 indicators at the median or above. This raises the bar to a known target so that the facility has something to aim for knowing that when they achieve

this measurement they will be recognized for achievement. This will require all facilities participating to move up on all targets. The tenth item measured is Medicare Participation. It is the one item of the ten that doesn't have a direct relationship to the care being rendered in the facility. It was put on the list because it does incentivize facilities to maximize Medicare and save the Medicaid program money. Mr. Fogarty stated his recommendation exception to the recommendation of the Rates and Standards Committee that for the Medicare participation rate we continue to measure in the same manner that it has been measured for the last 2 years. He noted that we are in the process of creating a formal advisory group to help OHCA continue to improve this program.

MOTION:	Member McFall moved for approval of agency request to consider a stay regarding Medicare Utilization factor as presented. Member McVay seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow
MOTION:	Member McFall moved for approval of Item 8.b as presented. Member McVay seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

ITEM 8.c)CONSIDERATION AND VOTE UPON PROPOSAL TO CHANGE THE METHODOLOGY FOR ADJUSTING RATES TO FACTORS OF $.32 PER DAY, $.22 PER DAY AND $.20 PER DAY FOR EACH PERCENTAGE POINT COLA ADJUSTMENT TO SOCIAL SECURITY FOR NURSING FACILITIES, ICFs/MR AND ACUTE CARE (16 BED OR LESS) ICFS/MR, RESPECTIVELY

MOTION:	Member McFall moved for approval of Item 8.c as presented. Member McVay seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

Mr. Fogarty acknowledged Dr. Stan Grogg, Interim Dean/President of the Oklahoma State University Center for Health Sciences. Dr. Grogg talked about some of the campus construction and welcomed OHCA back anytime.

ITEM 9)CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES § 5030.3.

b) Consideration and vote to add Otic Anti-Infective Products to the product-based prior authorization program under OAC 317: 30-5-77.3.

c) Consideration and vote to add prasugrel (Effient™) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e)

MOTION:	Member McFall moved for approval of Item 9b and Item 9c. Vice Chairman Armstrong seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

ITEM 10)DISCUSSION ITEM – PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLA. STATE. §307(B)(1),(4)&(7)

Nicole Nantois, Deputy General Counsel

Deputy Counsel Nantois recommended Executive Session is waived.

ITEM 11)CONSIDERATION AND VOTE UPON BOARD MEETING DATES, TIMES, AND PLACES FOR THE OKLAHOMA HEALTH CARE AUTHORITY BOARD FOR CALENDAR YEAR 2010

MOTION:	Member McFall moved for approval of Board Calendar as presented. Vice Chairman Armstrong seconded.
FOR THE MOTION:	Vice Chairman Armstrong, Member McVay, Member Miller, Member Langenkamp, Member McFall and Chairman Roggow

NEW BUSINESS

None

ADJOURNMENT

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

FINANCIAL REPORT

For the Five Months Ended November 30, 2009
Submitted to the CEO & Board
January 14, 2010

- Revenues for OHCA through November, accounting for receivables, were **$1,430,180,714** or **.2% over** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$1,409,196,582** or **.1% over** budget.

- The state dollar budget variance through November is **$2,037,989 positive.**

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

Expenditures:		
Medicaid Program Variance		(6.4)
Administration		3.9
Revenues:		
Taxes and Fees		2.0
Drug Rebate		1.0
Overpayments/Settlements		1.5
Total FY 10 Variance	**$**	**2.0**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2010, for the Five Months Ended November 30, 2009

REVENUES	FY10 Budget YTD	FY10 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 298,400,362	$ 298,400,362	$ -	0.0%
Federal Funds	864,153,447	860,423,523	(3,729,924)	(0.4)%
Tobacco Tax Collections	20,648,487	23,075,360	2,426,873	11.8%
Quality of Care Collections	21,425,835	20,986,387	(439,448)	(2.1)%
Prior Year Carryover	23,404,558	23,404,558	-	0.0%
Drug Rebates	59,505,698	60,526,269	1,020,571	1.7%
Medical Refunds	12,930,123	18,012,142	5,082,019	39.3%
Other Revenues	10,477,746	9,549,489	(928,257)	(8.9)%
Stimulus Funds	115,802,623	115,802,623	-	0.0%
TOTAL REVENUES	**$ 1,426,748,879**	**$ 1,430,180,714**	**$ 3,431,834**	**0.2%**

EXPENDITURES	FY10 Budget YTD	FY10 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 16,838,708**	**$ 15,711,230**	**$ 1,127,478**	**6.7%**
ADMINISTRATION - CONTRACTS	**$ 49,049,849**	**$ 32,546,680**	**$ 16,503,169**	**33.6%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	12,073,003	11,865,803	207,201	1.7%
Acute Fee for Service Payments:				
Hospital Services	395,044,715	386,866,409	8,178,306	2.1%
Behavioral Health	107,472,416	114,431,168	(6,958,752)	(6.5)%
Physicians	185,616,781	186,894,297	(1,277,517)	(0.7)%
Dentists	63,323,568	70,109,620	(6,786,052)	(10.7)%
Other Practitioners	18,122,419	19,691,747	(1,569,328)	(8.7)%
Home Health Care	7,792,535	8,442,253	(649,718)	(8.3)%
Lab & Radiology	10,109,009	12,085,727	(1,976,718)	(19.6)%
Medical Supplies	24,273,026	22,820,278	1,452,748	6.0%
Ambulatory Clinics	25,277,387	35,501,749	(10,224,362)	(40.4)%
Prescription Drugs	155,855,457	154,557,406	1,298,051	0.8%
Miscellaneous Medical Payments	12,546,404	11,602,407	943,998	7.5%
Other Payments:				
Nursing Facilities	214,731,165	215,557,822	(826,657)	(0.4)%
ICF-MR Private	23,237,902	23,547,335	(309,433)	(1.3)%
Medicare Buy-In	48,022,970	48,157,243	(134,272)	(0.3)%
Transportation	10,718,042	10,765,724	(47,682)	(0.4)%
Part D Phase-In Contribution	27,657,251	28,041,685	(384,434)	(1.4)%
Total OHCA Medical Programs	**1,341,874,051**	**1,360,938,672**	**(19,064,621)**	**(1.4)%**
OHCA Non-Title XIX Medical Payments	40,128	-	40,128	0.0%
TOTAL OHCA	**$ 1,407,802,736**	**$ 1,409,196,582**	**$ (1,393,846)**	**(0.1)%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 18,946,143**	**$ 20,984,132**	**$ 2,037,989**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year Ended 2010, for the Five Months Ended November 30, 2009

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	11,994,476	11,851,320	-	128,673	-	14,482	-
Inpatient Acute Care	301,899,798	263,710,782	202,786	4,167,743	20,810,018	2,493,815	10,514,654
Outpatient Acute Care	102,527,860	96,328,174	17,335	2,878,852	-	3,303,499	
Behavioral Health - Inpatient	56,209,153	54,530,171	-	1,853	-	-	1,677,129
Behavioral Health - Outpatient	3,502,342	3,491,914	-	-	-	-	10,428
Behavioral Health Facility- Rehab	66,814,261	56,169,307	-	65,766	-	53,799	10,525,388
Behavioral Health - Case Management	185,977	185,631	-	-	-	346	
Residential Behavioral Management	10,683,548	-	-	-	-	-	10,683,548
Targeted Case Management	29,798,614	-	-	-	-	-	29,798,614
Therapeutic Foster Care	-	-	-	-	-	-	-
Physicians	205,318,085	154,441,558	24,209	4,455,573	26,413,563	6,014,967	13,968,215
Dentists	70,112,468	66,684,286	-	2,848	3,331,584	93,751	-
Other Practitioners	19,810,630	19,144,567	185,985	118,883	335,234	25,961	-
Home Health Care	8,442,285	8,406,102	-	32	-	36,151	-
Lab & Radiology	12,653,503	11,661,065	-	567,777	-	424,662	-
Medical Supplies	23,060,265	21,491,323	1,207,283	239,987	-	121,672	-
Ambulatory Clinics	39,104,578	35,164,576	-	437,660	-	337,173	3,165,170
Personal Care Services	5,169,696	-	-	-	-	-	5,169,696
Nursing Facilities	215,557,822	139,072,642	59,035,365	-	17,446,111	3,705	-
Transportation	10,765,724	9,695,117	1,044,575	-	19,688	6,344	-
GME/IME/DME	47,249,518	-	-	-	-	-	47,249,518
ICF/MR Private	23,547,335	15,682,736	7,506,140	-	358,459	-	-
ICF/MR Public	23,715,185	-	-	-	-	-	23,715,185
CMS Payments	76,198,927	73,778,090	2,420,838	-	-	-	-
Prescription Drugs	159,064,182	135,684,494	-	4,506,776	17,333,669	1,539,243	-
Miscellaneous Medical Payments	11,602,407	10,988,471	-	-	548,463	65,472	-
Home and Community Based Waiver	66,529,122	-	-	-	-	-	66,529,122
Homeward Bound Waiver	39,834,358	-	-	-	-	-	39,834,358
Money Follows the Person	498,247	-					498,247
In-Home Support Waiver	10,883,706	-	-	-	-	-	10,883,706
ADvantage Waiver	87,407,274	-	-	-	-	-	87,407,274
Family Planning/Family Planning Waiver	2,470,791	-	-	-	-	-	2,470,791
Premium Assistance*	19,506,604	-		19,506,604	-		-
Total Medicaid Expenditures	**1,762,118,739**	**1,188,162,326**	**71,644,516**	**37,079,026**	**86,596,788**	**14,535,042**	**364,101,042**

* Includes $18,506,603.82 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2010, for the Five Months Ended November 30, 2009

		FY10
REVENUE		**Actual YTD**
Revenues from Other State Agencies	$	79,045,132
Federal Funds		275,305,514
TOTAL REVENUES	**$**	**354,350,646**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	66,529,122
Money Follows the Person		498,247
Homeward Bound Waiver		39,834,358
In-Home Support Waivers		10,883,706
ADvantage Waiver		87,407,274
ICF/MR Public		23,715,185
Personal Care		5,169,696
Residential Behavioral Management		8,663,239
Targeted Case Management		23,373,748
Total Department of Human Services		**266,074,574**
State Employees Physician Payment		
Physician Payments		13,968,215
Total State Employees Physician Payment		**13,968,215**
Education Payments		
Graduate Medical Education		13,000,000
Graduate Medical Education - PMTC		2,051,095
Indirect Medical Education		28,137,940
Direct Medical Education		4,060,483
Total Education Payments		**47,249,518**
Office of Juvenile Affairs		
Targeted Case Management		1,258,943
Residential Behavioral Management - Foster Care		52,695
Residential Behavioral Management		1,967,615
Multi-Systemic Therapy		10,428
Total Office of Juvenile Affairs		**3,289,680**
Department of Mental Health		
Targeted Case Management		44,870
Hospital		1,677,129
Mental Health Clinics		10,525,388
Total Department of Mental Health		**12,247,388**
State Department of Health		
Children's First		1,075,040
Sooner Start		821,119
Early Intervention		2,550,175
EPSDT Clinic		934,874
Family Planning		52,334
Family Planning Waiver		2,395,188
Maternity Clinic		63,428
Total Department of Health		**7,892,158**
County Health Departments		
EPSDT Clinic		380,172
Family Planning Waiver		23,269
Total County Health Departments		**403,441**
State Department of Education		**93,074**
Public Schools		**1,402,764**
Medicare DRG Limit		**9,106,106**
Native American Tribal Agreements		**965,577**
Department of Corrections		**224**
JD McCarty		**1,408,323**
Total OSA Medicaid Programs	**$**	**364,101,042**
OSA Non-Medicaid Programs	**$**	**4,021,796**
Account Receivable from OSA	**$**	**13,772,192**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2010, For the Five Months Ended November 30, 2009

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 20,967,418	$ 20,967,418
Interest Earned	18,969	18,969
TOTAL REVENUES	**$ 20,986,387**	**$ 20,986,387**

EXPENDITURES	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 57,462,535	$ 20,226,812	
Eyeglasses and Dentures	125,410	44,144	
Personal Allowance Increase	1,447,420	509,492	
Coverage for DME and supplies	1,207,283	424,964	
Coverage of QMB's	430,315	151,471	
Part D Phase-In	2,420,838	2,420,838	
ICF/MR Rate Adjustment	5,760,345	2,027,641	
Acute/MR Adjustments	1,745,795	614,520	
NET - Soonerride	1,044,575	367,691	
Total Program Costs	**$ 71,644,516**	**$ 26,787,572**	**$ 26,787,572**
Administration			
OHCA Administration Costs	$ 222,429	$ 111,215	
DHS - 10 Regional Ombudsman	95,935	95,935	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 318,364**	**$ 207,150**	**$ 207,150**
Total Quality of Care Fee Costs	**$ 71,962,880**	**$ 26,994,722**	
TOTAL STATE SHARE OF COSTS			**$ 26,994,722**

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 2010, for the Five Months Ended November 30, 2009

REVENUES	FY 09 Carryover	FY 10 Revenue	Total Revenue
Prior Year Balance	$ 37,974,903		$ 29,412,736
Tobacco Tax Collections	-	18,978,258	18,978,258
Interest Income	-	628,668	628,668
Federal Draws	-	12,294,031	12,294,031
All Kids Act	(8,000,000)		-
TOTAL REVENUES	**$ 29,974,903**	**$ 31,900,957**	**$ 61,313,693**

EXPENDITURES	FY 09 Expenditures	FY 10 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 19,506,604	$ 19,506,604
Individual Plan			
SoonerCare Choice		$ 127,692	$ 44,948
Inpatient Hospital		4,167,743	1,467,046
Outpatient Hospital		2,867,164	1,009,242
Behavioral Health - Inpatient Services		1,853	652
Behavioral Health Facility - Rehabilitation Services		65,437	23,034
Behavioral Health - Case Management		-	-
Physicians		4,447,021	1,565,351
Dentists		2,848	1,002
Other Practitioners		118,101	41,572
Home Health		32	11
Lab and Radiology		564,982	198,874
Medical Supplies		239,860	84,431
Ambulatory Clinics		436,860	153,775
Prescription Drugs		4,491,912	1,581,153
Premiums Collected			(1,801,521)
Total Individual Plan		**$ 17,531,504**	**$ 4,369,569**
College Students-Service Costs		**$ 40,918**	**$ 14,403**
Total Program Costs		**$ 37,079,026**	**$ 23,890,576**
Administrative Costs			
Salaries	$ 18,023	$ 463,355	$ 463,355
Operating Costs	289,025	342,853	342,853
Contract - Electronic Data Systems	255,119	948,509	948,509
Total Administrative Costs	**$ 562,167**	**$ 1,754,717**	**$ 1,754,717**
Total Expenditures			**$ 25,645,292**
NET CASH BALANCE	**$ 29,412,736**		**$ 35,668,401**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2010, for the Five Months Ended November 30, 2009

REVENUES	FY 10 Revenue	State Share
Tobacco Tax Collections	**378,838**	**378,838**
TOTAL REVENUES		**$ 378,838**

EXPENDITURES	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 14,482	$ 3,568	
Inpatient Hospital	2,493,815	614,476	
Outpatient Hospital	3,303,499	813,982	
Inpatient Free Standing	-	-	
MH Facility Rehab	53,799	13,256	
Case Mangement	346	85	
Nursing Facility	3,705	913	
Physicians	6,014,967	1,482,088	
Dentists	93,751	23,100	
Other Practitioners	25,961	6,397	
Home Health	36,151	8,908	
Lab & Radiology	424,662	104,637	
Medical Supplies	121,672	29,980	
Ambulatory Clinics	337,173	83,079	
Prescription Drugs	1,539,243	379,270	
Transportation	6,344	1,563	
Miscellaneous Medical	65,472	16,132	
Total Program Costs	$ 14,535,042	$ 3,581,434	**$ 3,581,434**
TOTAL STATE SHARE OF COSTS			**$ 3,581,434**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 255: OHCA Medicaid Program Fund
Fiscal Year 2010, For the Five Months Ended November 30, 2009

REVENUES	FY 10 Total Revenue	FY 10 State Share
Tobacco Tax Collections	22,696,522	22,696,522
TOTAL REVENUES	**$ 22,696,522**	**$ 22,696,522**

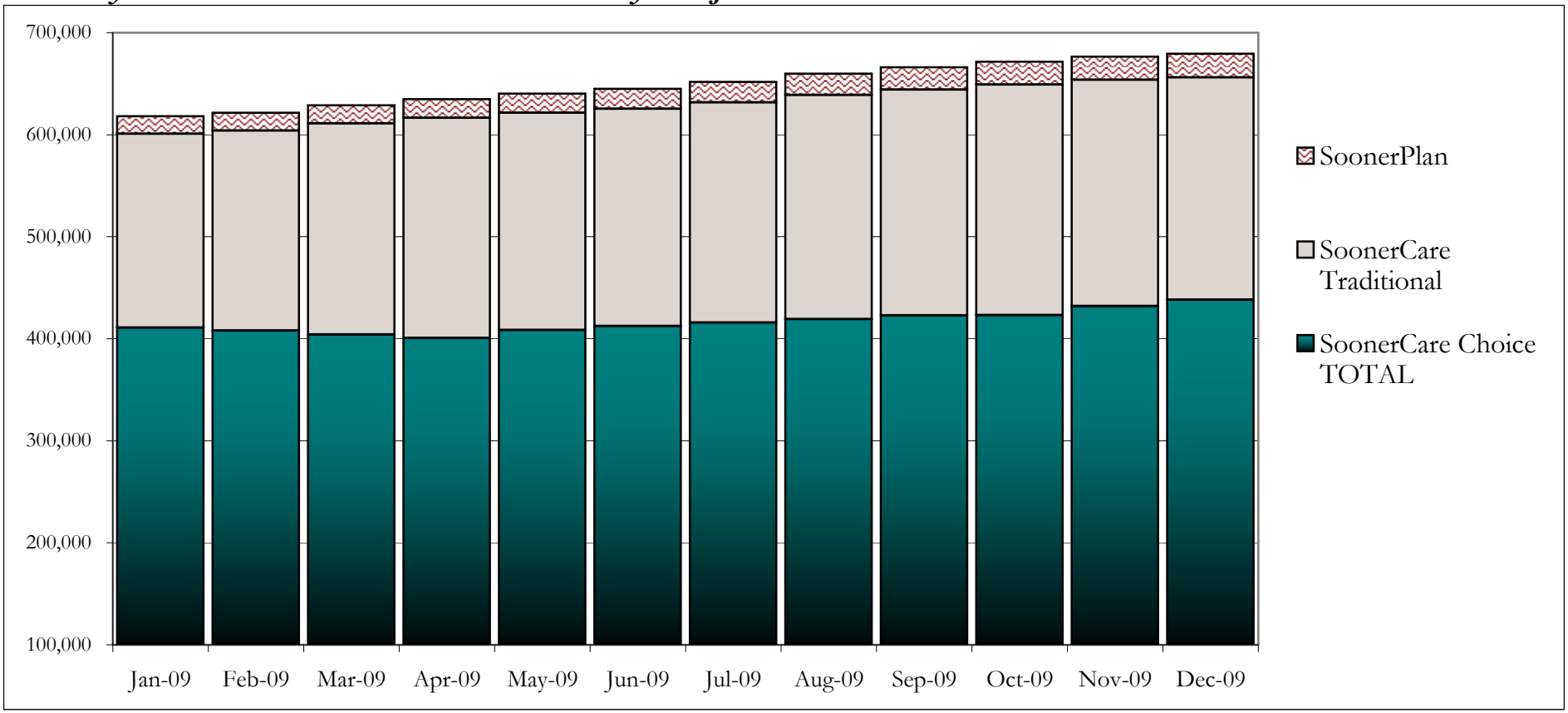
EXPENDITURES Program Costs:	FY 10 Total $ YTD	FY 10 State $ YTD	Total State $ Cost
Adult Dental Services	$ 3,331,584	$ 1,172,718	
Remove Hospital Day Limit	5,039,669	1,773,963	
Hospital Rate Increase - Statewide Median +2%	7,242,898	2,549,500	
Increase Physician Visits from 2 to 4 per Month	220,766	77,710	
Increase Physician Office Visits/OB Visits to 90% of Medicare	12,690,092	4,466,912	
Increase Emergency Room Physician Rates to 90% of Medicare	6,008,104	2,114,853	
Pay 50% of Medicare Crossover - Physician/Ambulance/OP	8,378,298	2,949,161	
Nursing Facility 7% Rate Increase	13,973,741	4,918,757	
Enhanced Drug Benefit for Adults 3 + 3	9,348,490	3,290,668	
Enhanced Drug Benefit for Waiver Adults 3 + 10	7,985,179	2,810,783	
TEFRA Services	4,814,110	1,694,567	
SoonerRide	19,688	6,930	
Replace NSGO Medicare DRG Limit Revenues	7,544,170	2,655,548	
Total Program Costs	**$ 86,596,788**	**$ 30,482,069**	**$ 30,482,069**
TOTAL SHATE SHARE OF COSTS			**$ 30,482,069**

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 ENROLLMENT CY-2009

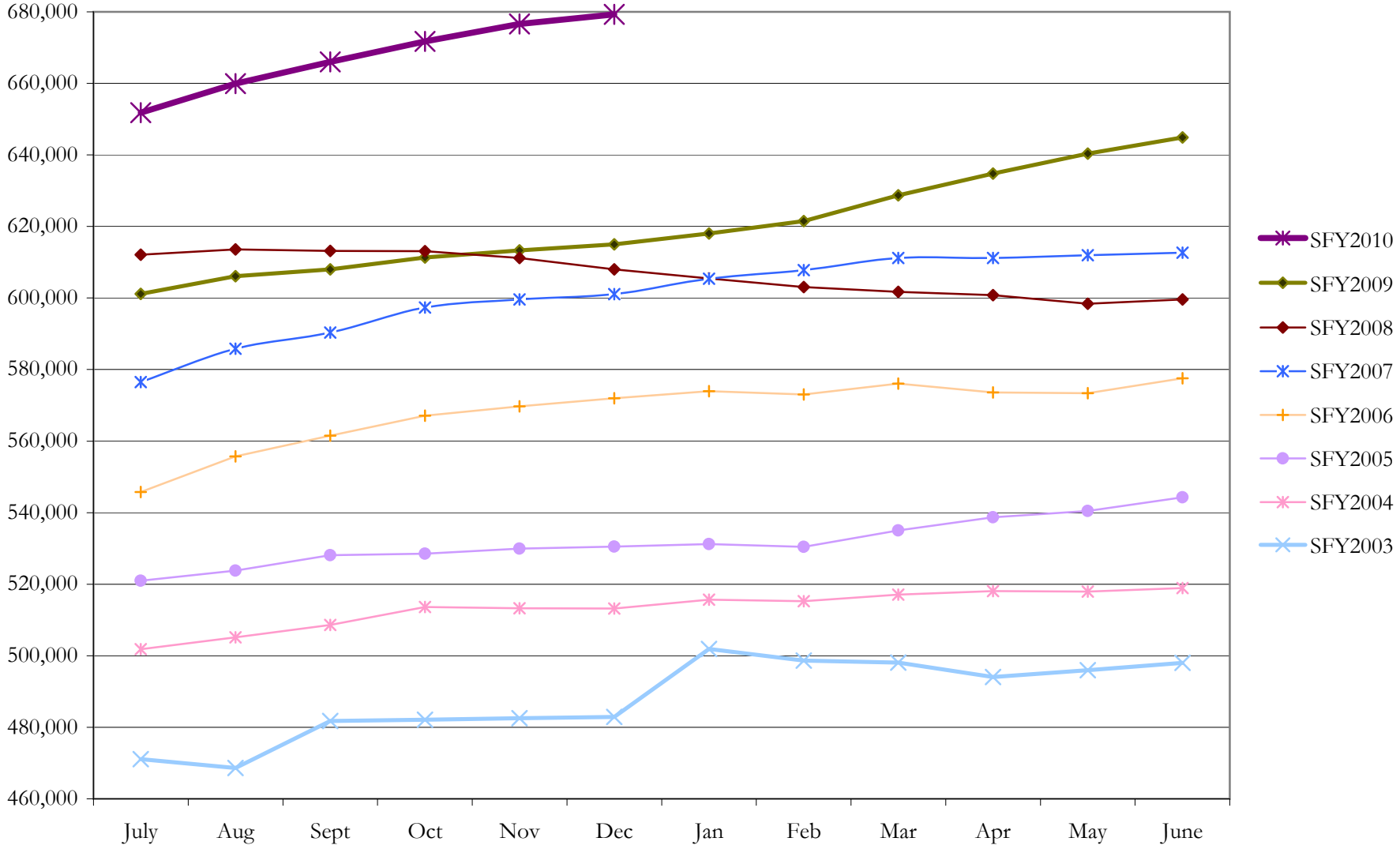
	Jan-09	Feb-09	Mar-09	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Total MMs
ENROLLEES													
SoonerCare Choice													
Choice Total	399,044	396,540	392,568	389,173	396,825	400,642	404,056	407,312	410,597	410,763	419,311	424,913	4,851,744
IHS/Urban/Tribal Total	11,882	11,559	11,672	11,571	11,819	11,831	11,926	12,062	12,329	12,525	12,757	13,363	145,296
SoonerCare Choice TOTAL	410,926	408,099	404,240	400,744	408,644	412,473	415,982	419,374	422,926	423,288	432,068	438,276	4,997,040
SoonerCare Traditional	190,117	196,093	206,886	215,889	212,963	213,073	215,702	219,633	221,392	225,914	221,734	217,945	
SoonerPlan	17,013	17,290	17,600	18,156	18,743	19,359	20,093	20,937	21,724	22,498	22,788	23,073	239,274
TOTAL ENROLLEES	618,056	621,482	628,726	634,789	640,350	644,905	651,777	659,944	666,042	671,700	676,590	679,294	7,793,655
Average Monthly Enrollment													649,471

Monthly Actual SoonerCare Enrollment Trends by Benefit Plan



MMs = Member Months

OHCA SoonerCare Enrollment Figures



SoonerCare Programs

December 2009

Choice PCCM	December 2008	December 2009
TOTAL	407,408	438,276
American Indian Enrollees	11,339	13,363
Choice enrollees (enhanced PCMH)	396,069	424,913

Traditional	December 2008	December 2009
Members	190,626	217,945
SoonerCare Programs Total Unduplicated	615,013	679,294

Oklahoma Cares	December 2008	December 2009
Women currently enrolled	2,552	2,373
SoonerCare Traditional	1,926	1,671
SoonerCare Choice	626	702
Women ever-enrolled	18,121	21,980

Insure Oklahoma/ O-EPIC	December 2008	December 2009
IO Total Enrollees	15,907	28,958
IO Total Enrollees **(Male : Female)**	7,020 **:** 8,887	12,578 **:** 16,380
ESI Enrollees	10,696	18,133
IP Enrollees	5,211	10,825

TEFRA	December 2008	December 2009
Children enrolled	241	320
Male Enrollees	149	192
Female Enrollees	92	128
Ever-enrolled	317	414

SoonerPlan	December 2008	December 2009
Enrolled	16,979	23,073
Male enrollees	502	648
Female enrollees	16,477	22,425
Ever-enrolled	62,456	77,149

PROGRAM	JULY 2009	AUGUST 2009	SEPTEMBER 2009	OCTOBER 2009	NOVEMBER 2009	DECEMBER 2009
Choice PCMH	415,982	419,374	422,926	423,288	432,068	438,276
Traditional	215,702	219,633	221,392	225,914	221,734	217,945
Oklahoma Cares	2,701	2,748	2,651	2,466	2,481	2,373
TEFRA	285	292	297	307	313	320
SoonerPlan	20,093	20,937	21,724	22,498	22,788	23,073
Soon to be Sooners	3,153	3,099	3,132	3,103	3,041	2,979
SoonerCare Programs Total Unduplicated	**651,777**	**659,944**	**666,042**	**671,700**	**676,590**	**679,294**
Insure Oklahoma ESI	15,273	15,974	17,012	17,344	17,882	18,133
Insure Oklahoma IP	8,259	8,672	9,344	9,756	10,146	10,825
Insure Oklahoma Programs Total Unduplicated	**23,532**	**24,646**	**26,356**	**27,100**	**28,028**	**28,958**

SoonerCare Fast Facts

December 2009

oklahoma health care authority

TOTAL ENROLLMENT —
OKLAHOMA SOONERCARE (MEDICAID)

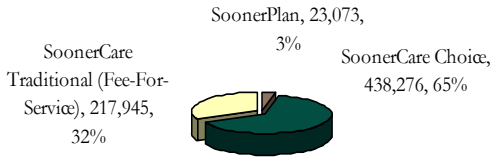
Qualifying Group	Age Group	Enrollment	% of Total
Aged/Blind/Disabled	Child	17,880	2.63%
Aged/Blind/Disabled	Adult	124,374	18.31%
Children/Parents	Child	448,426	66.01%
Children/Parents	Adult	44,744	6.59%
Other	Child	651	0.10%
Other	Adult	17,453	2.57%
Oklahoma Cares (Breast & Cervical Cancer)		2,373	0.35%
SoonerPlan (Family Planning)		23,073	3.40%
TEFRA		320	0.05%

Total Enrollment	**679,294**	Adults	208,933	31%
		Children	470,361	69%

OTHER Group includes—Child custody-Refugee-Qualified Medicare Beneficiary-SLMB-DDSD Supported Living-Program of All Inclusice Care for the Elderly (PACE)-Soon to be Sooners (STBS) and TB patients.
For more information go to www.okhca.org under Individuals then to Programs. Insure Oklahoma members are NOT included in the figures above.

Note that all subsequent figures are groups within the above total enrollment numbers (except Insure Oklahoma). SoonerPlan (Family Planning) members are not entitled to the full scope of benefits only family planning services are covered.

Delivery System Breakdown of Total Enrollment



Other Enrollment Facts

Unduplicated enrollees State Fiscal Year-to-Date (July through report month including Insure Oklahoma) — **788,420**

Other Breakdowns of Total Enrollment

Oklahoma SoonerCare (Medicaid) members residing in a long-term care facility — 15,864

Oklahoma persons enrolled in both Medicare and Medicaid (dual eligibles) — 100,340

The Insure Oklahoma (Oklahoma Employer/Employee Partnership for Insurance Coverage—O-EPIC) is a program to assist qualifying small business owners, employees & their spouses (Employer Sponsored Insurance—**ESI**) and some individual Oklahomans (Individual Plan—**IP**) with health insurance premiums. www.insureoklahoma.org

Small Businesses Enrolled in ESI	Employees w/ ESI	Individual Plan (IP) Members
5,552	18,133	10,825

New Enrollees

Oklahoma SoonerCare members that have not been enrolled in the past 6 months.

Adults	6,098
Children	8,381
Total	**14,479**

Race Breakdown of Total Enrollment

	Children	Adults	Percent	Pregnant Women
American Indian	60,590	19,577	12%	2,782
Asian or Pacific Islander	6,670	2,796	1%	557
Black or African American	69,297	29,012	14%	2,388
Caucasian	320,856	155,478	70%	18,374
Multiple Races	12,948	2,070	2%	579
Hispanic Ethnicity	73,506	10,533	12%	4,697

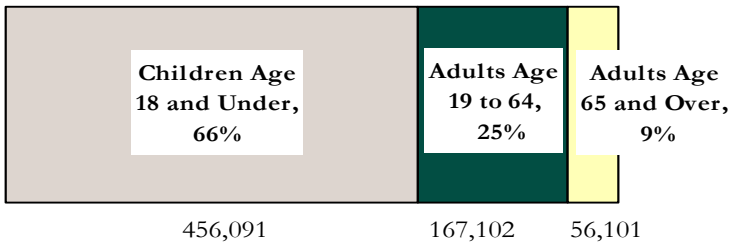
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

CHIP Breakdown of Total Enrollment

Members qualifying for SoonerCare (Medicaid) eligibility under the CHIP program are under age 19 and have income between the maximum for standard eligibility and the expanded 185% of Federal Poverty Level (FPL) income guidelines.

Age Breakdown	% of FPL	CHIP Enrollees
PRENATAL		2,979
INFANT	150% to 185%	1,418
01-05	133% to 185%	11,760
06-12	100% to 185%	33,831
13-18	100% to 185%	21,175
Total		**71,163**

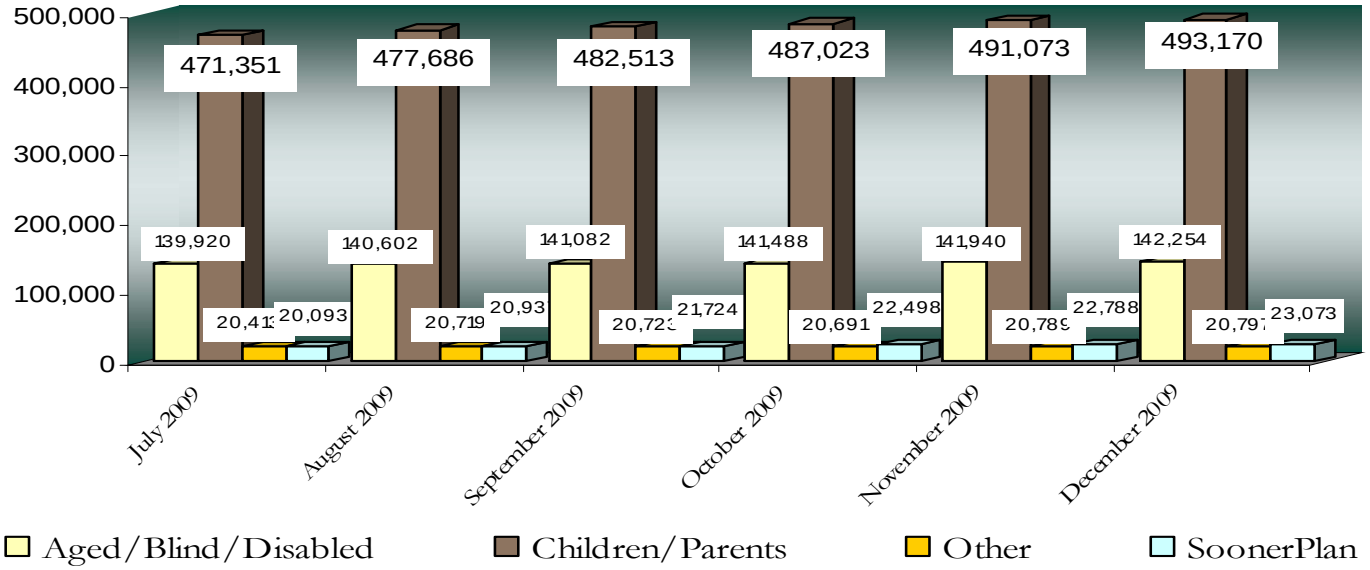
Age Breakdown of Total Enrollment



Data was compiled on 1/11/2010. Numbers frequently change due to certifications occurring after the data is extracted and other factors. This report is based on data within the system prior to 1/11/2010. A majority of the data is a "point in time" representation of the specific report month and is not cumulative. Unless stated otherwise, CHILD is defined as an individual under the age of 21.

SoonerCare Fast Facts
December 2009

Enrollment by Aid Category



State Fiscal Year is defined as the period between July 1 and June 30 of each fiscal year. Oklahoma Cares (Breast and Cervical Cancer coverage) and TEFRA are included in the OTHER category. SoonerPlan are members receiving family planning services only.

December 16, 2009

OHCA Contact: Jo Kilgore, Public Information Manager, (405) 522-7474.

In Re: Additional state revenue reductions

OKLAHOMA CITY – The Oklahoma Health Care Authority is evaluating the impact of the additional state revenue reductions. Once the extent of the revenue reduction is known, an action plan will be developed and recommended to the OHCA Board at its next meeting. Cuts will likely include reductions in provider payment rates and additional benefit reductions.

Hopefully, uncommitted federal Medicaid stimulus funds will be made available to replace lost state revenue. It is also important to note that any reduction in state dollars in the SoonerCare (Medicaid) program results in a reduction in federal dollars to fund the program; currently, $1 cut in state funds means a loss of $3 in federal funds for a total program reduction of $4 dollars. – OHCA spokesperson Jo Kilgore

Oklahoma Health Care Authority

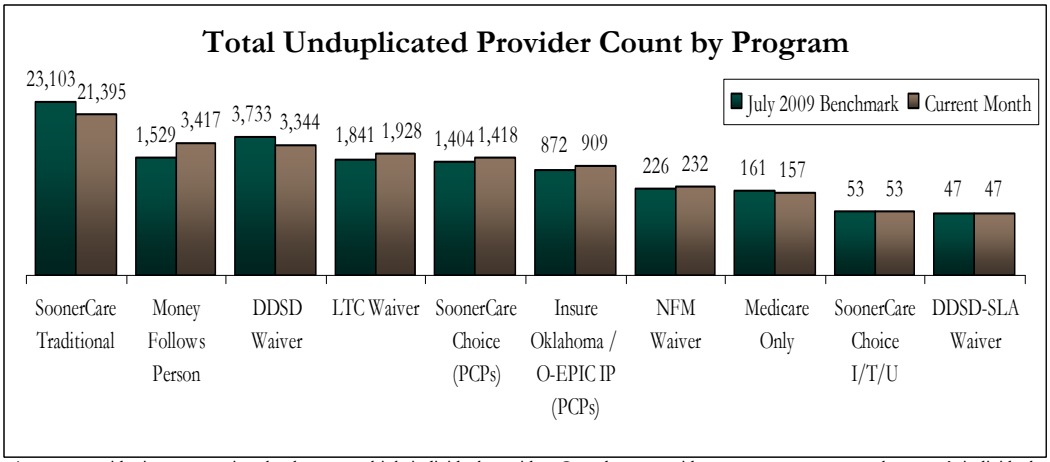
Provider Fast Facts

December 2009

Total Unduplicated Provider Count
27,062

All subsequent provider counts were derived from the total unduplicated provider count. Some providers may be counted in multiple programs.

Total Unduplicated Provider Count by Program



A group provider is a corporation that houses multiple individual providers. In order to provide a more accurate count, the group's individual providers were counted instead of the group provider.

Total Unduplicated Newly Enrolled Provider Count
385

Total unduplicated newly enrolled provider count was determined by the number of newly unduplicated provider IDs added during the month of this report.

Primary Care Provider (PCP) Capacities

SoonerCare Program Description	Total Capacity	% of Capacity Used
SoonerCare Choice	1,037,470	40.73%
SoonerCare Choice I/T/U	116,150	11.55%
Insure Oklahoma/O-EPIC IP	328,278	3.41%

Total Capacity represents the maximum number of members that PCPs request to have assigned within OHCA's limit.

Acronyms

DDSD - Developmental Disabilities Services Division

DDSD-SLA - Developmental Disabilities Services Division-Supported Living Arrangement

DME - Durable Medical Equipment

I/T/U - Indian Health Service/Tribal/Urban Indian

LTC - Long-Term Care

NET - Non-Emergency Transportation

NFM - Non-Federal Medical

NPI - National Provider Identifier

O-EPIC IP - Oklahoma Employer/Employee Partnership for Insurance Coverage Individual Plan

PCMH - Patient-Centered Medical Home

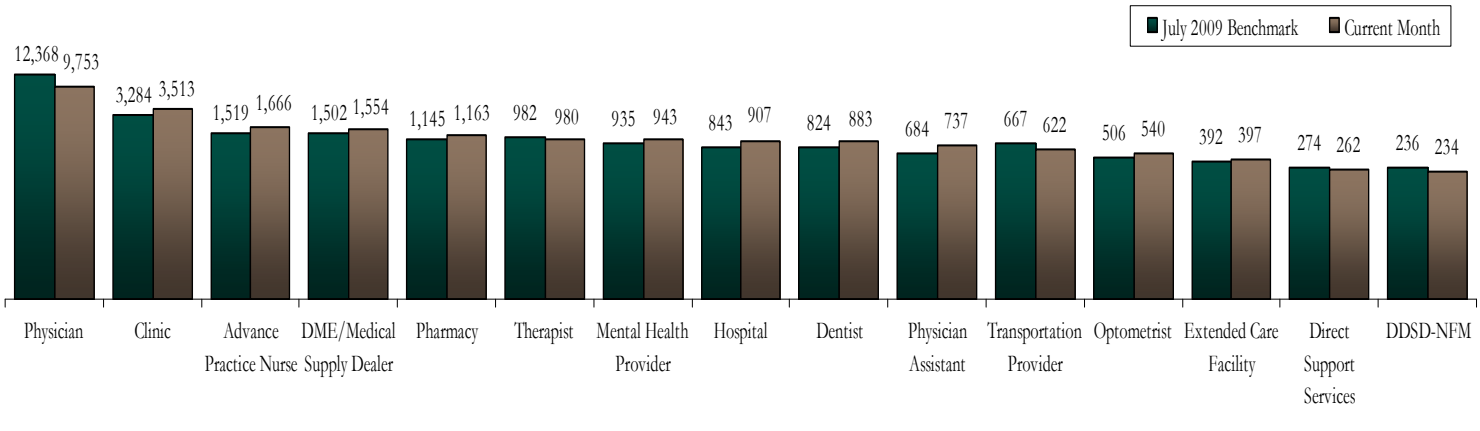
PCP - Primary Care Provider

PCMH Enrollment by Tier

Payment Tier Code	Count
Tier 1	491
Tier 2	224
Tier 3	35

These counts were computed using a different method than indicated elsewhere on the report and are not comparable to any other figures.

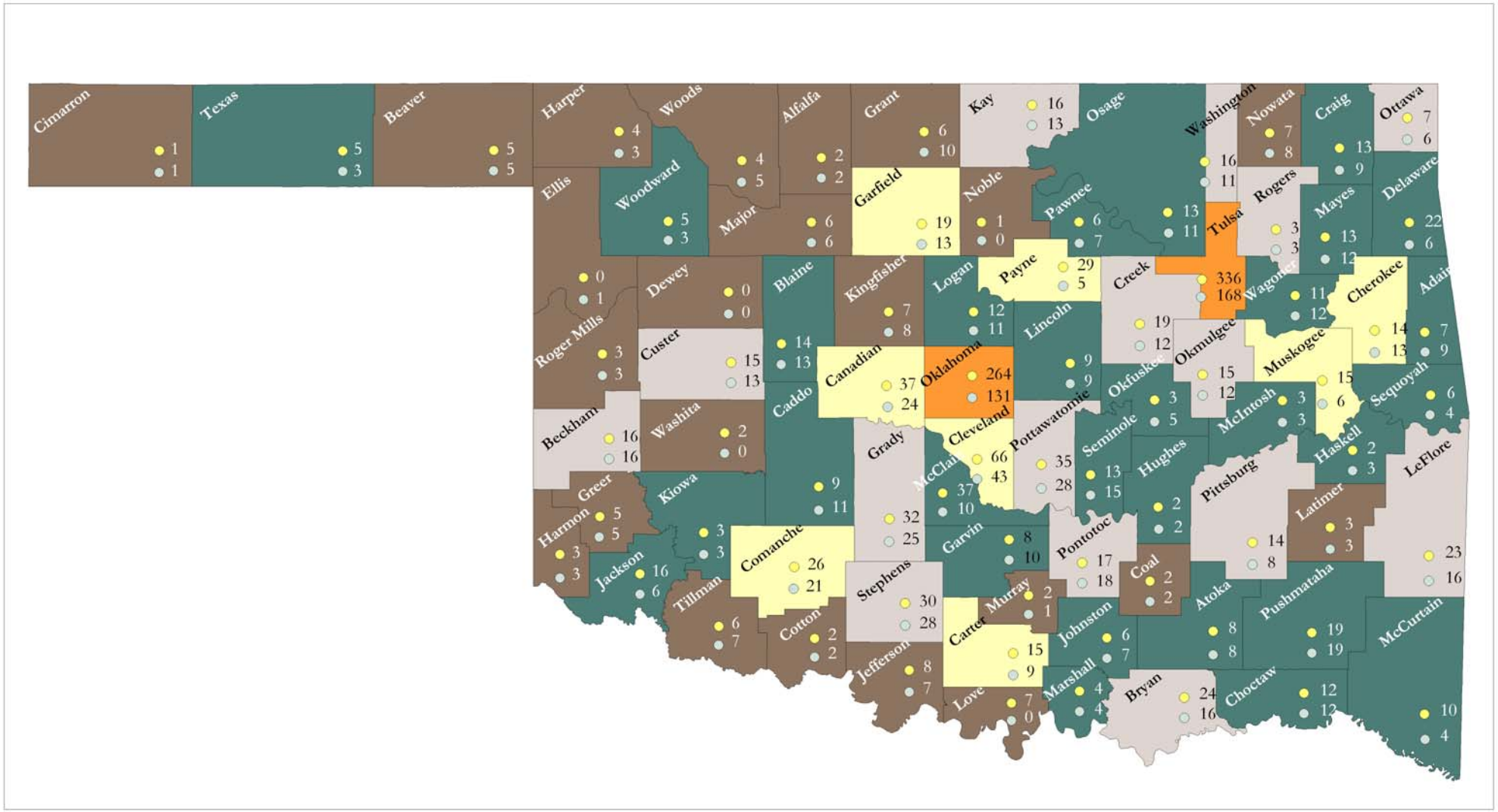
Top 15 Provider Types



The top 15 provider types consists of the 15 provider types with the highest number of contracted providers.

Provider Fast Facts
December 2009

oklahoma health care authority



Total Provider Count

4,000 to 6,000		(2)
300 to 1,000		(8)
150 to	300	(15)
50 to	150	(29)
0 to	50	(23)

Primary Care Providers (PCPs)

- SoonerCare Choice PCPs
- Insure Oklahoma IP PCPs

01/11/2010

Insure Oklahoma

Fast Facts

January 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

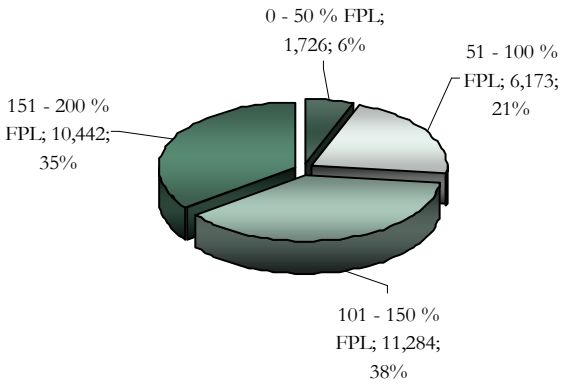
Insure Oklahoma is an innovative program Oklahoma has created to bridge the gap in the health care coverage for low-income working adults. Under the Employer-Sponsored Insurance (ESI) program, premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent). The Individual Plan (IP) allows people who can't access the benefits through their employer, including those who are self-employed or may be temporarily unemployed, to buy health insurance directly through the state. Find out more information by visiting **www.insureoklahoma.org** or by calling 1-888-365-3742.

Insure Oklahoma Total Enrollment

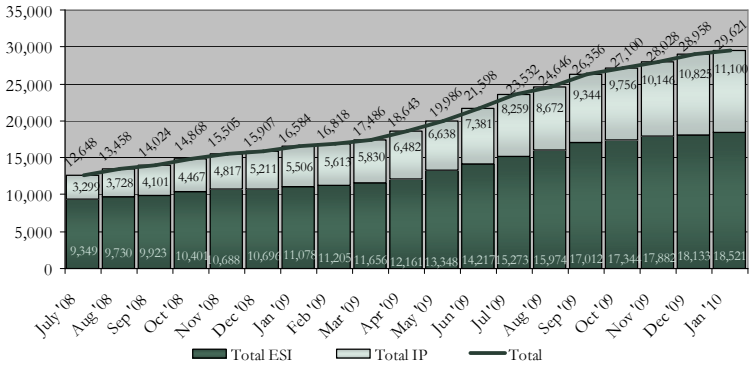
Qualifying Enrollment		Enrollment	% of Total
Employer Sponsored Insurance (ESI)	Employee	15,482	52.27%
Employer Sponsored Insurance (ESI)	Spouse	2,995	10.11%
Individual Plan (IP)	Employee	8,392	28.33%
Individual Plan (IP)	Spouse	2,561	8.65%
Student (ESI)	---	44	0.15%
Student (IP)	---	147	0.50%
Businesses (ESI)	---	5,632	---
Businesses (IP)	---	4	---
Carriers / HealthPlans	---	20 / 473	---
Primary Care Physician	---	914	---

Total Enrollment	**29,621**	ESI	18,521	63%
		IP	11,100	37%

Federal Poverty Level Breakdown of Total Enrollment



Total Insure Oklahoma Member Monthly Enrollment



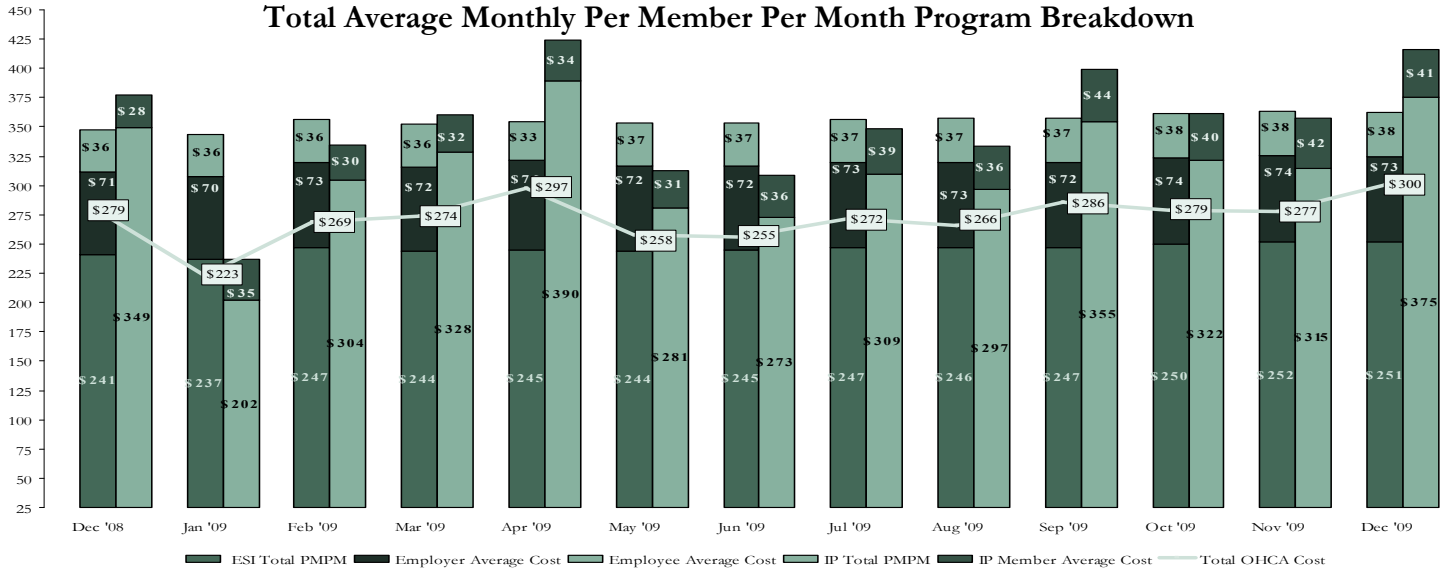
Currently Enrolled		Up from Previous Year
Businesses	5,636	59%
ESI Enrollees	18,521	73%
IP Enrollees	11,100	130%

ESI & IP Enrollee totals include Students.

Latest Monthly Marketing Statistics	
Web Hits on InsureOklahoma.org	34,379
Call Center - Calls Answered	13,896

Call Center count now includes OHCA calls.(October 2009 was missing Employer calls.)

Total Average Monthly Per Member Per Month Program Breakdown



All the state share of the Insure Oklahoma program costs are budgeted from the state's tobacco tax revenues. (All financial information is previous month activity.)

Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

1/6/2010

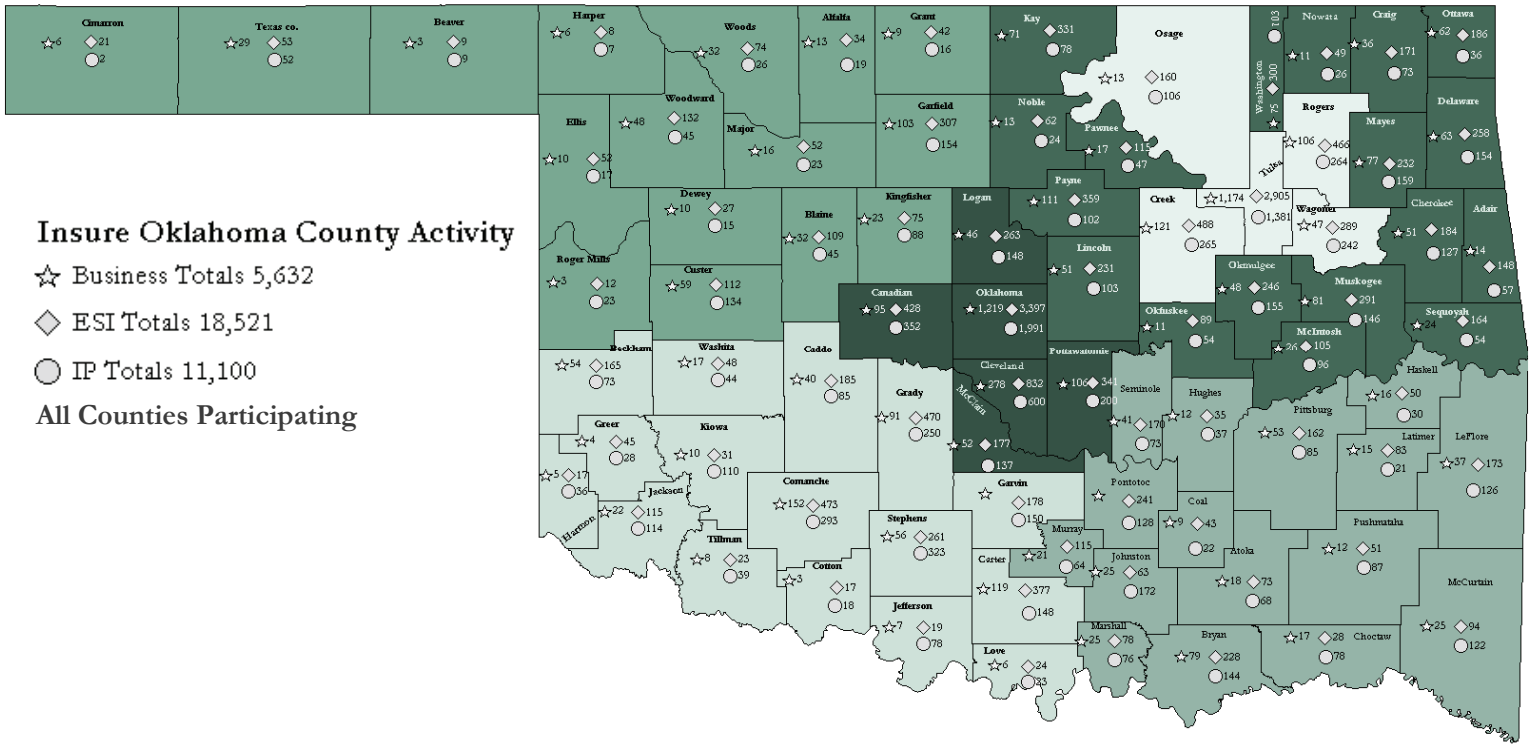
Insure Oklahoma

Fast Facts

January 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

November 2005	Oklahoma implemented Insure Oklahoma Employer Sponsored Insurance (ESI), the premium assistance for health insurance coverage targeting some 50,000 low-wage working adults in Oklahoma.
January 2007	Insure Oklahoma implements the Individual Plan (IP) to assist sole proprieetors (self employed), certain unemployed individuals, and working individuals who do not have access to small group health coverage.
November 2007	Increased Insure Oklahoma ESI qualifying income guidelines from 185 to 200 percent of the federal poverty level.
	ESI available to businesses with 25 to 50 employees.
March 2009	Expanded IP to offer coverage for full-time Oklahoma college students within qualifying income guidelines age 19 through 22.
	ESI available to businesses with 50 to 99 employees.



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Employer Sponsored Insurance (ESI)

Fast Facts

January 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

The Insure Oklahoma (Oklahoma Employer/Employee Partnership for Insurance Coverage-OEPIC) Employer Sponsored Insurance program is designed to assist small business owners, employees and their spouses with health insurance premiums. Find out more information by visiting **www.insureoklahoma.org**.

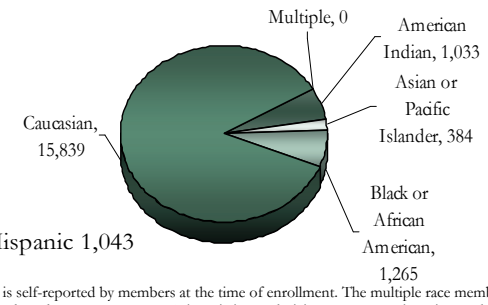
	Total Current Enrollment			Breakdown of Current Enrollment					
				New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	7,576	7,906	**15,482**	450	513	**963**	872	760	**1,632**
Spouse	771	2,224	**2,995**	60	111	**171**	95	246	**341**
Student	19	25	**44**	0	1	**1**	1	1	**2**
Total	8,366	10,155	**18,521**	510	625	**1,135**	968	1,007	**1,975**

*Expanded income qualifications from 185 to 200% effective November 2007.

	Business Activity with Employee Participation Counts			
	0 to 25	26 to 50	51 to 100	Total
Current	4,439	682	380	**5,501**
New	100	17	14	**131**
Total	**4,539**	**699**	**394**	**5,632**

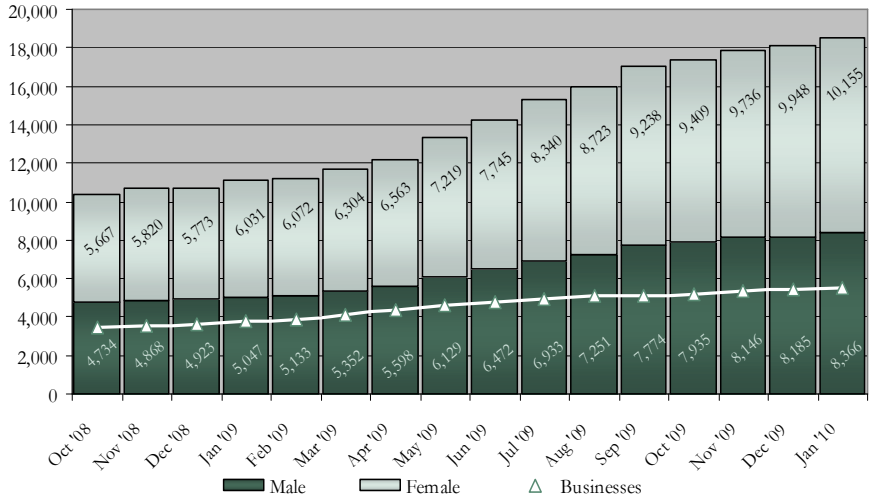
Some approved businesses may not have approved employees.

Race Breakdown of ESI Members

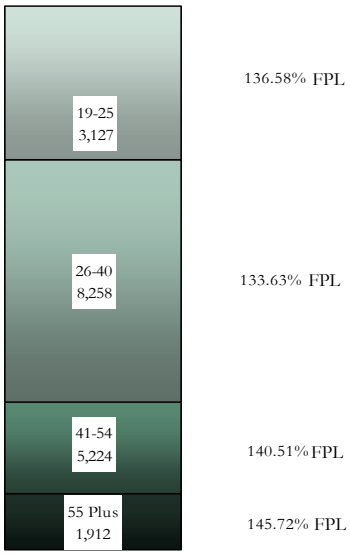


Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Member and Employer Monthly Enrollment

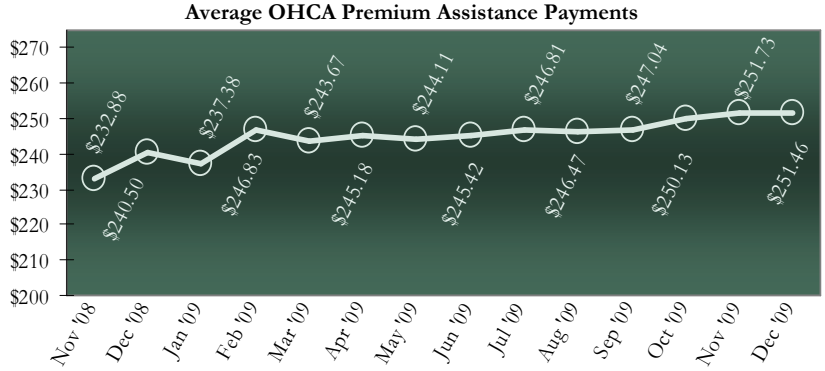


Age Breakdown with Average Federal Poverty Level of ESI Members



Federal Poverty Level is used to determine income qualification.

Average OHCA Premium Assistance Payments



Effective February 2007 OHCA Per Member Per Month reporting will be of the previous month due to semi-monthly payments verses monthly payments.

	Insure Oklahoma/OEPIC ESI by Region		
	Employers	Employee/ Spouse	Participating Counties
Region 1	642	2,448	16 of 16
Region 2	402	1,119	16 of 16
Region 3	1,794	5,438	6 of 6
Region 4	1,460	4,308	5 of 5
Region 5	842	3,521	18 of 18
Region 6	492	1,687	16 of 16
Total	**5,632**	**18,521**	**77 of 77**

Regions identified on Insure Oklahoma/OEPIC Region map on next page.

Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

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1/5/2010

Individual Plan (IP)

Fast Facts

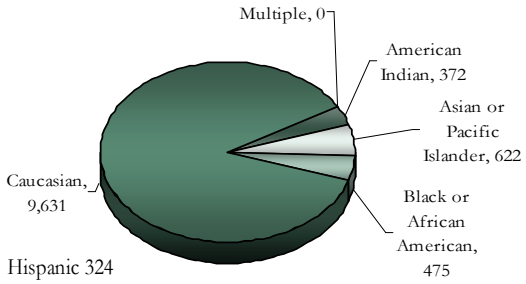
January 2010

Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

The Insure Oklahoma (Oklahoma Employer/Employee Partnership for Insurance Coverage-OEPIC) Individual Plan program is designed to provide Oklahoma individuals with health insurance for themselves and their spouse if needed. It is available to Oklahomans who are not qualified for an O-EPIC employer-sponsored health plan and work for an Oklahoma small business with 99 or fewer full time employees; temporarily unemployed adults who are eligible to receive unemployment benefits through the Oklahoman Employment Security Commission; or working adults with a disability who work for any size employer and have a "ticket to work". Find out more information by visiting **www.insureoklahoma.org**.

	Total Current Enrollment			Breakdown of Current Enrollment					
				New Enrollment this Month			Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	3,909	4,483	**8,392**	197	249	**446**	307	309	**616**
Spouse	568	1,993	**2,561**	36	77	**113**	58	157	**215**
Student	54	93	**147**	2	9	**11**	4	4	**8**
Total	4,531	6,569	**11,100**	233	326	**570**	365	466	**839**

Race Breakdown of IP Members

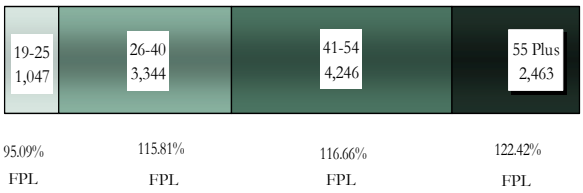


Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

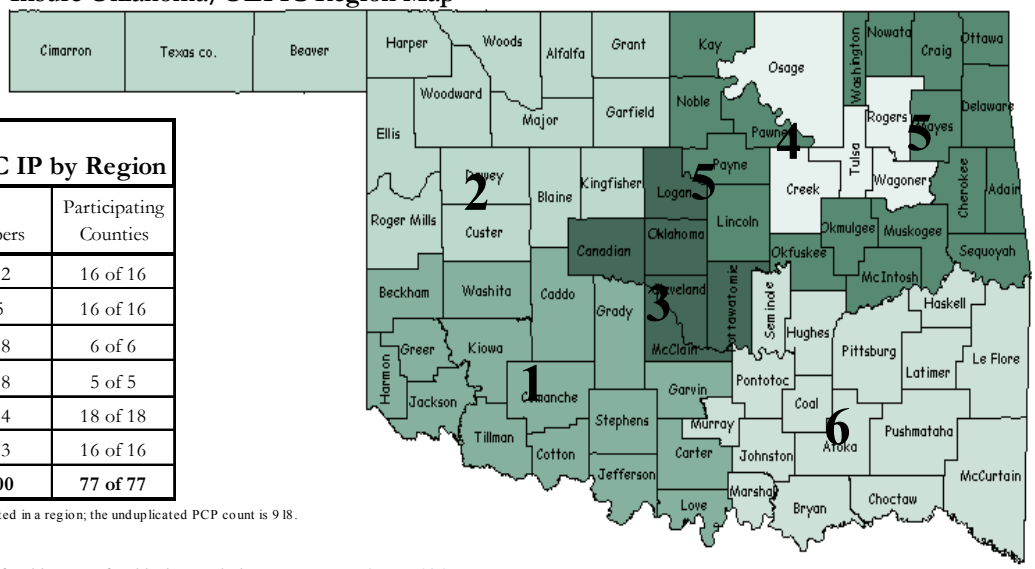
IP Application Type Breakdown

Unduplicated Counts	
IP Members SFY2010 (July 2009 - Current)	13,848
IP Members Since Program Inception March 2007	16,742
Miscellaneous	
Average IP Member Premium	$52.53
Average Federal Poverty Level of IP Members	116.08%
Federal Poverty Level is used to determine income qualification.	

IP Age Breakdown with Average Federal Poverty Level for each group.



Insure Oklahoma/OEPIC Region Map



Insure Oklahoma/OEPIC IP by Region

	PCP	Participating Counties	Members	Participating Counties
Region 1	142	14 of 16	1,812	16 of 16
Region 2	84	15 of 16	675	16 of 16
Region 3	224	6 of 6	3,428	6 of 6
Region 4	208	5 of 5	2,258	5 of 5
Region 5	137	17 of 18	1,594	18 of 18
Region 6	119	16 of 16	1,333	16 of 16
Total	**914**	**73 of 77**	**11,100**	**77 of 77**

PCPs maybe counted in multiple regions or out of state and not counted in a region; the unduplicated PCP count is 918.

Data is valid as of the date of the report; any subsequent figures for this group for this time period may vary. www.insureoklahoma.org

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1/5/2010

Certified Nursing Aide Training Program

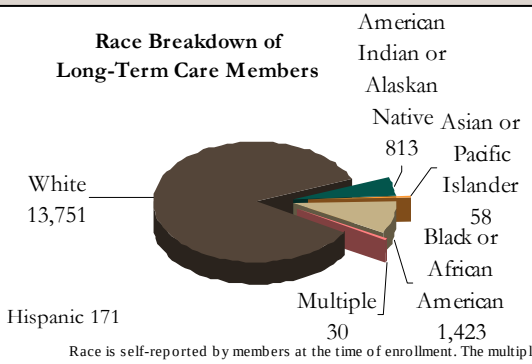
Fast Facts

November 2009

A Certified Nurse Aide (C.N.A.) is an individual who provides nursing or nursing related service to residents in a long-term care facility. Oklahoma Health Care Authority (OHCA) recognizes the significant role of a C.N.A. in the planning and providing of care for long-term care (LTC) residents. The C.N.A. training program has offered free nurse aide training to qualified applicants since 2005. Two of the continued goals of this program are to improve the quality of life for residents in LTC facilities and to decrease staff turn-over rate. Prospective students must sign an agreement with OHCA that states they will work in a SoonerCare LTC facility for 12 out of 24 months after they receive their certification. Find out more information by visiting www.osuokc.edu/cna

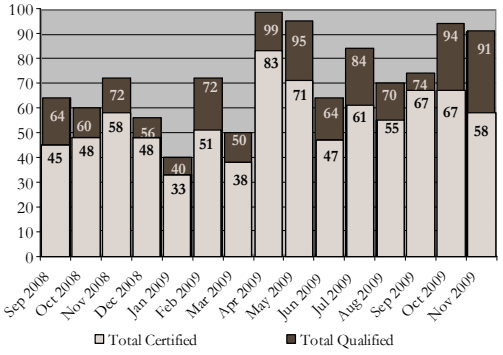
SoonerCare Members Residing in Long-Term Care Facilities		
	November 2009	Since Inception May 2005
Female	10,890	29,673
Male	5,185	14,304
Total	**16,075**	**43,977**

Race Breakdown of Long-Term Care Members



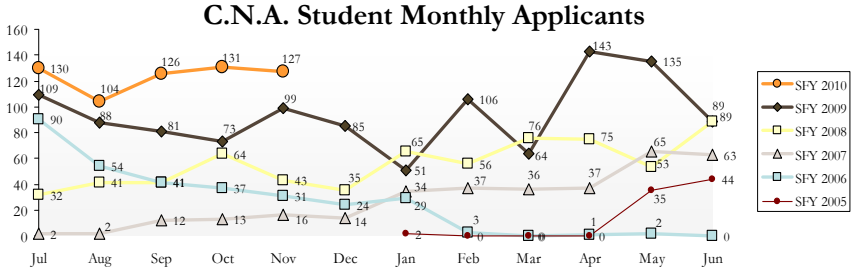
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

Total Students Certified



Upon completion of training, students must sign a 12 month contract working in a Oklahoma SoonerCare contracted Long-Term Care Facility (nursing home) during their 24 month certification period.

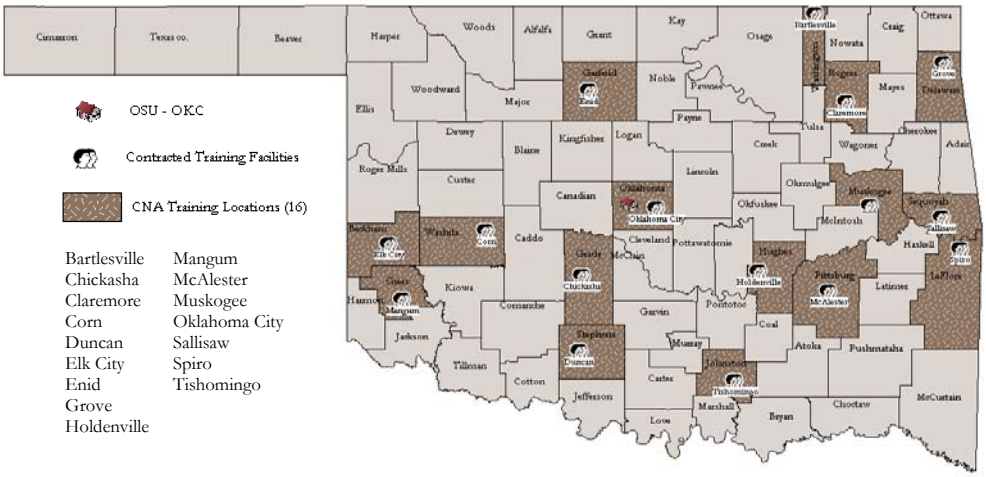
C.N.A. Student Monthly Applicants



LTC Facility Participation		
SoonerCare Facilities	Total Beds	Training Facilities
391	**39,112**	**16**

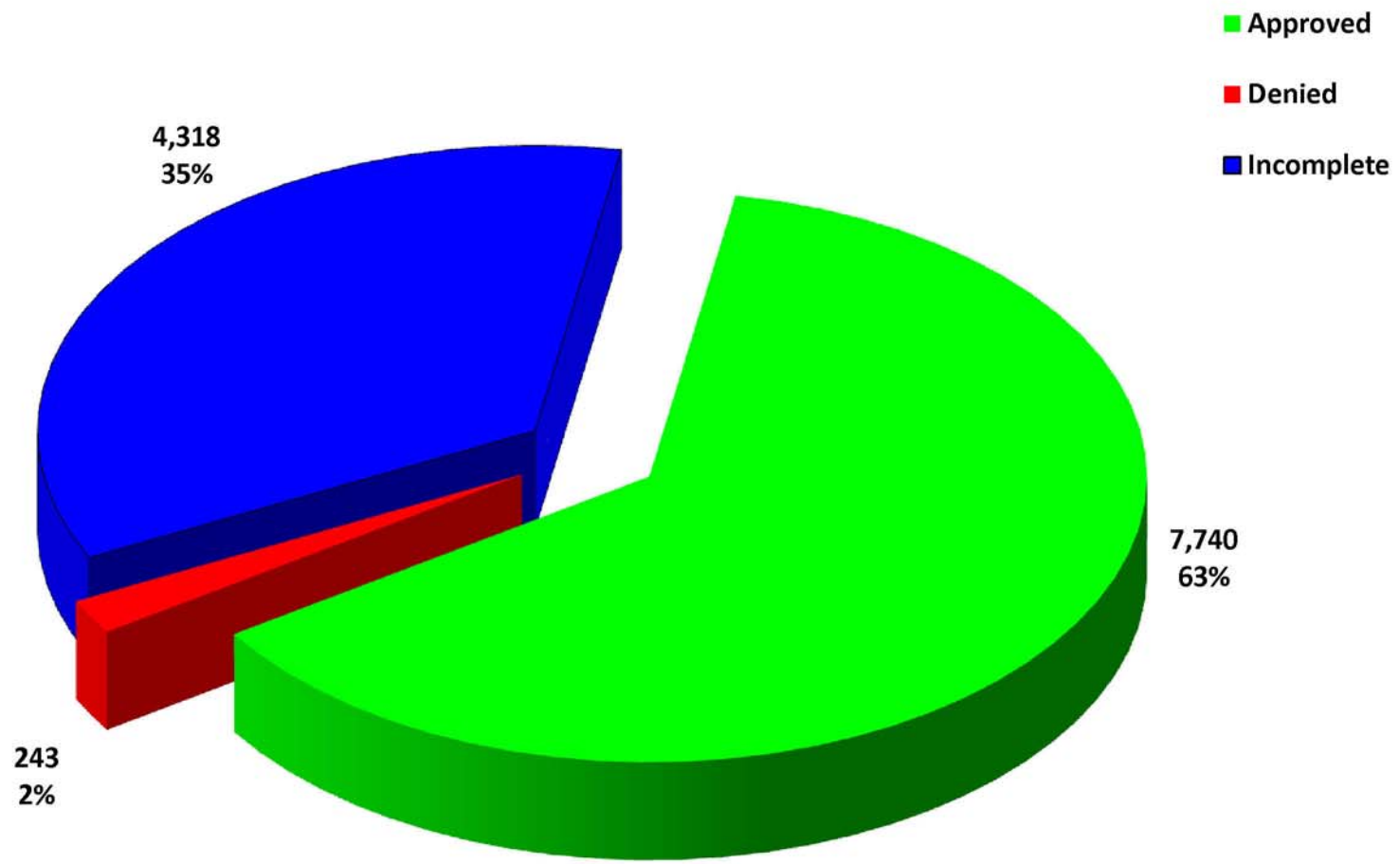
Currently a few of the contracted intermediate care facilities (ICF or standard nursing facilities) offer training and employment for C.N.A. students.

C.N.A. Training Locations



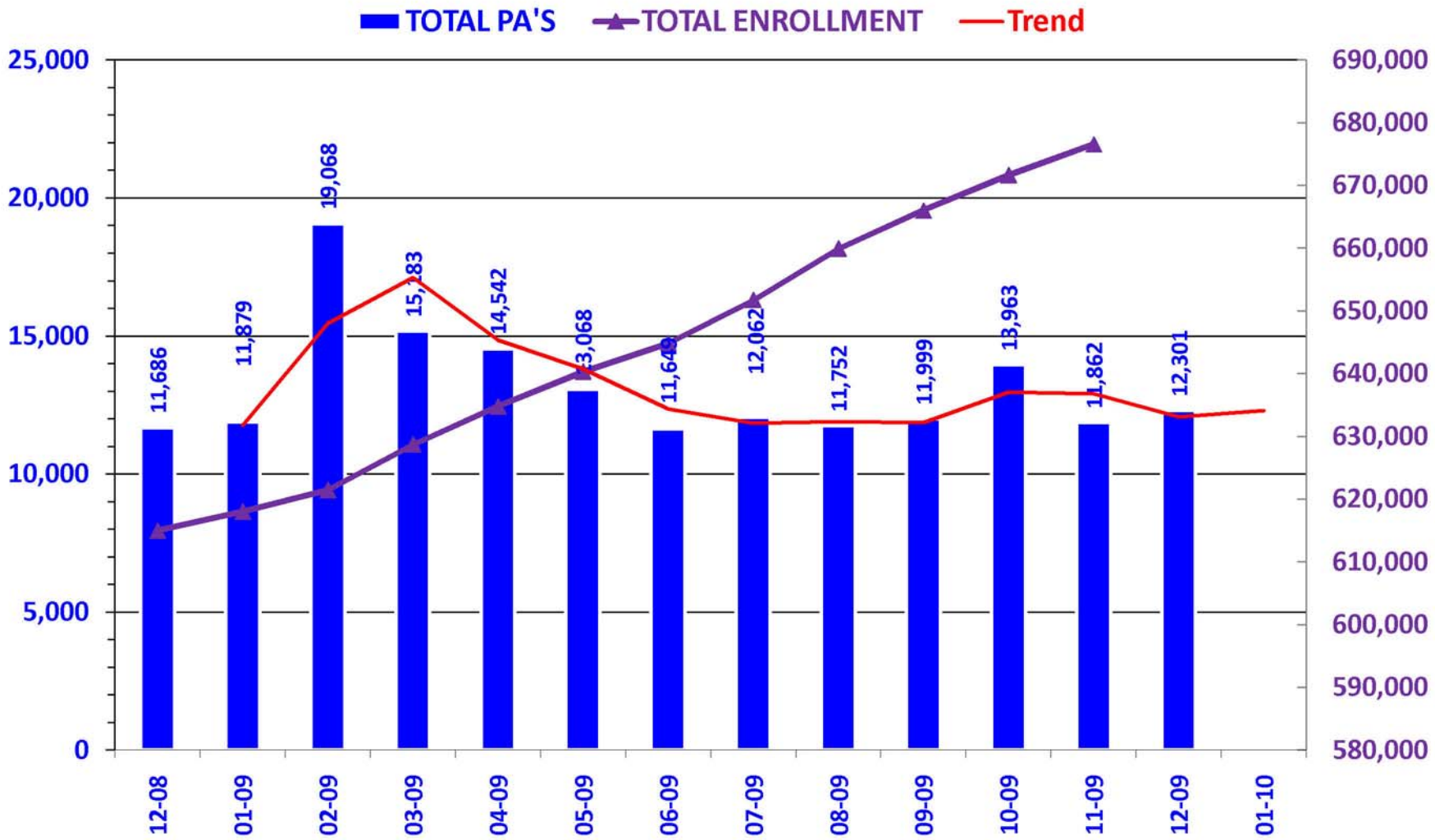
12/28/2009

PRIOR AUTHORIZATION ACTIVITY REPORT: December 2009



PA totals include overrides

PRIOR AUTHORIZATION REPORT: December 2008 – December 2009



PA totals include overrides

Prior Authorization Activity

December 2009

	Average Length of Approvals in Days	Approved	Denied	Incomplete	Total
Advair/Symbicort	357	276	2	390	668
Amitiza	141	5	1	21	27
Antidepressant	335	157	7	424	588
Antihistamine	288	178	3	165	346
Antihypertensives	344	62	0	92	154
Antimigraine	59	2	0	1	3
Benzodiazepines	92	3,720	9	740	4,469
Bladder Control	268	5	0	20	25
Brovana (Arformoterol)	0	0	0	2	2
Byetta	268	2	0	5	7
Elidel/Protopic	102	18	1	37	56
ESA	59	141	0	35	176
Fibric Acid Derivatives	90	1	0	1	2
Fibromyalgia	342	30	0	29	59
Forteo	360	1	0	3	4
Glaucoma	272	8	0	12	20
Growth Hormones	172	31	0	2	33
HFA Rescue Inhalers	214	64	0	42	106
Insomnia	122	39	3	109	151
Misc Analgesics	176	6	30	30	66
Muscle Relaxant	41	64	76	72	212
Nasal Allergy	225	2	30	97	129
NSAIDS	325	37	3	76	116
Nucynta	48	3	0	2	5
Ocular Allergy	207	3	0	7	10
Ocular Antibiotics	17	4	0	9	13
Opioid Analgesic	164	75	4	115	194
Other	146	167	11	302	480
Otic Antibiotic	22	2	1	1	4
Pediculicides	16	16	4	32	52
Plavix	327	10	1	14	25
Proton Pump Inhibitors	111	83	2	283	368
Qualaquin (Quinine)	0	0	3	1	4
Singulair	256	474	4	412	890
Smoking Cessation	60	18	1	54	73
Statins	347	14	1	42	57
Stimulant	231	645	3	315	963
Symlin	222	2	0	1	3
Synagis	100	139	27	35	201
Topical Antibiotics	49	2	0	25	27
Topical Antifungals	72	7	0	37	44
Ultram ER and ODT	145	4	0	6	10
Xolair	195	2	1	5	8
Xopenex Nebs	232	33	0	22	55
Zetia (Ezetimibe)	361	10	0	10	20
Emergency PAs		3	0	0	3
Total		**6,565**	**228**	**4,135**	**10,928**

Overrides					
Brand	106	77	2	16	95
Dosage Change	21	452	4	25	481
High Dose	266	18	0	5	23
IHS - Brand	95	40	0	4	44
Ingredient Duplication	52	9	1	2	12
Lost/Broken Rx	28	89	2	4	95
Nursing Home Issue	9	98	1	11	110
Other	56	27	0	6	33
Quantity vs. Days Supply	240	380	7	151	538
Stolen	12	8	0	0	8
Overrides Total		**1,198**	**17**	**224**	**1,439**
Total Regular PAs + Overrides		**7,763**	**245**	**4,359**	**12,367**

Denial Reasons

Lack required information to process request.	2,149
Unable to verify required trials.	1,695
Does not meet established criteria.	196
Not an FDA approved indication/diagnosis.	181
Considered duplicate therapy. Member has a prior authorization for similar medication.	121
Member has active PA for requested medication.	101
Requested dose exceeds maximum recommended FDA dose.	95
Medication not covered as pharmacy benefit.	25
Drug Not Deemed Medically Necessary	4

Duplicate Requests: 870

Changes to existing PAs: 827

CALL VOLUME MONTHLY REPORT:
December 2008 – December 2009

OHCA BOARD MEETING

JANUARY 14TH, 2010 OHCA BOARD MEETING

As of noon, Tuesday, January 12, 2010, the Oklahoma Legislature is tracking a total of 2,812 legislative bills for the upcoming session. Of those 2,812 bills, 1,953 are carry-over bills from last session and 859 are pre-filed bills for the new session. OHCA has 148 carry-over bills. Thursday, January 14th is the final date for introduction of bills and joint resolutions. The Governor's State of the State address and the 2010 legislative session begin on Monday, February 1st at noon.

The following are the Senate and House deadlines for 2010.

SENATE AND HOUSE DEADLINES

January 14, 2010	Deadline for Introduction of Bills and Joint Resolutions (House/Senate)
February 1, 2010	Second Session of the 52nd Legislature Convenes at Noon
February 18, 2010	Deadline for Reporting Senate Bills and Joint Resolutions from Senate Committees (Senate)
February 25, 2010	Deadline for Reporting House Bills and Joint Resolutions from House Committees
March 11, 2010	Deadline for Third Reading of a Bill or Joint Resolution in the House of Origin (House/Senate)
April 1, 2010	Deadline for Reporting House Bills and Joint Resolutions from Senate Committees (Senate)
April 8, 2010	Deadline for Reporting Senate Bills and Joint Resolutions from House Committees (House)
April 22, 2010	Deadline for Third Reading of Bills and Joint Resolutions in opposite chamber
May 28, 2010	Sine Die of the second session of the 52nd Legislature

Recently Received CMS Approvals
OHCA Board Meeting January 14, 2010

Name of Federal Authority Vehicle:
Title XXI State Plan, (stand alone) Children's Health Insurance Program (CHIP)

Populations Affected:
Children under 19 years of age, in families with workers from any size business, and whose household earns from 185 percent of the Federal Poverty Level (FPL) up to and including 300 percent FPL. Children will be served by the Insure Oklahoma Employer Sponsored Insurance (ESI) or Individual Plan (IP) program. Children in ESI will receive coverage through their family's private insurance plan. ESI will subsidize a portion of the family's premium costs. Children in IP will receive coverage through the state-operated Individual Plan network and benefit plan. The family's financial responsibility for coverage will not exceed 5 percent of their household income.

Historical Timeline:
May 2007 – Oklahoma State Legislature passes the "All Kids Act" (56 O.S. 1009.2) and establishes a one-time $8M set-aside within tobacco tax collections. An estimated 20,000 children could be served with the $8M set-aside.
August 10, 2007 – OHCA submits an 1115 HIFA Waiver Amendment to the Centers for Medicare and Medicaid Services (CMS) requesting authority to implement the law.
August 17, 2007 – CMS issues a State Health Official (SHO) letter presenting significant barriers to states pursuing coverage for populations earning more than 250 percent FPL. Oklahoma pursues creative solutions to comply with 95 percent participation rate requirements. Negotiations with CMS continue.
May 20, 2008 – CMS letter indicates waiver request "not under active consideration".
June 2008 – Response with solution to SHO requirements submitted to CMS and negotiations with CMS continue.
October 8, 2008 – CMS indicates the OHCA solution to SHO requirements is not approvable.
October through November 2008 – CMS provides options for pursuing federal authority other than the 1115 HIFA waiver, negotiations continue.
February 4, 2009 – Presidential Memorandum rescinds the August 17, 2007 SHO letter, CMS directs OHCA to utilize a stand alone CHIP SPA as the federal authority vehicle.
CHIPRA passes in the US Congress, establishes new requirements and options for states to pursue under Title XXI authority.
February through July 2009– OHCA submits CHIP SPA to CMS, pursuant to CHIPRA regulations and CMS reviews.
August 24, 2009 – CMS provides formal response to CHIP SPA indicating several areas must be revised in order for review to continue. (1) Gross income; (2) Additional children's benefits; (3) Option for coverage in either ESI or IP; (4) Waiting period / crowd out period; (5) 40% Employer Contribution.
September – November 2009 – OHCA submits revised CHIP SPA pursuant to CMS direction. CMS issues guidance for new CHIPRA regulations.
December 18, 2009 – CMS issues approval letter.

Recently Received CMS Approvals
OHCA Board Meeting January 14, 2010

Key Highlights of Approval Package:
By and large children's coverage uses the existing IO framework for benefits, cost sharing, etc. with exception of the additional requirements listed below.

- ✓ Allows CHIP enhanced federal matching rate.
- ✓ 40% Employer Contribution for children's premium costs
- ✓ Additional benefits for children must include well baby/child, immunization, emergency transportation, any service determined 'emergent', elimination of lifetime maximum policies or limits on number of physician visits.
- ✓ Medical Home and Health Access Network models apply to IO children.
- ✓ Children in IO now receive dental coverage, including orthodontia.
- ✓ Affordability tests allow for exceptions to the 6 month waiting period/crowd out.
- ✓ Enrollment cap's allowed based on available funding.
- ✓ Third Party Liability matches necessary to ensure exclusion of children of state workers covered under state subsidized benefits.
- ✓ Eliminated cost sharing for Native American children.
- ✓ Qualified health plans in ESI must meet or exceed the scope of benefits offered in IP for children.
- ✓ New performance goals and objectives identified for all CHIP-eligible children.

Next Steps:

- Revising estimated funding limitations.
- Pursuit of long-term state revenue sources.
- Implementation planning, especially nuances of new CHIPRA requirements and the most timely, effective and efficient modes of operation.
- Consideration of pending national health care reform efforts and the potential future environment.

SoonerCare and Insure Oklahoma
1115 Research and Demonstration Waiver Update

Waiver Renewal

On December 30, 2009, OHCA received approval of the SoonerCare and Insure Oklahoma waiver. The waiver is approved to continue January 1, 2010, through December 31, 2012. The renewal request was filed with CMS on June 30, 2009.

Populations Affected

The current SoonerCare Choice member population continues unchanged. Insure Oklahoma is authorized to expand coverage to uninsured adults up to and including 250 percent of the federal poverty level. Two new eligibility groups will be added to Insure Oklahoma, providing coverage for foster parents regardless of employer size and employees of not-for-profit businesses with up to 500 employees. These new adult eligibility groups include the uninsured with incomes up to and including 250 percent of the federal poverty level.

Historical Timeline

Providing coverage for the uninsured at increased income levels was first requested of CMS in August 2007 as an amendment to the 1115 demonstration waiver. Changes in federal law and CMS guidance resulted in modification of the proposal four times. The most recent submission was June 22, 2009. The actual waiver renewal request was submitted June 30, 2009.

Key Highlights

The renewal approval also included authorization to:

1. Implement up to four Health Access Network pilots, first requested October 28, 2008. HANs will offer core components of electronic medical records, improved access to specialty care, telemedicine, expanded quality improvement strategies; and care management/care coordination to persons with complex health care needs

2. Incorporate the Insure Oklahoma and the SoonerCare IHS, Tribal and Urban Indian Clinic networks in the Patient-Centered Medical Home structure already approved for the SoonerCare Choice program. The renewal request of June 30, 2009, contained this modification.

Next Steps

OHCA is developing a strategic plan to implement the above.

8.b-1. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 103. Qualified Schools As Providers of Health Related Services
OAC 317:30-5-1023. [AMENDED]
OAC 317:30-5-1027. [AMENDED]
(Reference APA WF # 09-47)

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 amend policy to add a new provider type "Behavior Health School Aide" and service description "Therapeutic Behavioral Services". This rule change is needed to insure services are defined and reimbursed appropriately.

ANALYSIS: Rules are revised to add a new provider type "Behavior Health School Aide" and service description "Therapeutic Behavioral Services". Currently schools provide both personal care and behavior interventions but have only one mechanism to bill which is under personal care. Since the two services are separate and distinct, the change is needed to better define the services and provide a billing mechanism for behavioral interventions.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, 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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
EPSDT rules are revised to add a new provider type “Behavior Health School Aide” and service “Therapeutic Behavioral Services".

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 103. QUALIFIED SCHOOLS AS PROVIDERS OF HEALTH RELATED SERVICES

317:30-5-1023. Coverage by category
(a) **Adults.** There is no coverage for services rendered to adults.
(b) **Children.** Payment is made for compensable services rendered by local, regional, and state educational services agencies as defined by IDEA:
(1) **Child health screening examination.** An initial screening may be requested by an eligible individual at any time and must be provided without regard to whether the individual's age coincides with the established periodicity schedule. Coordination referral is made to the ~~***SoonerCare***~~ SoonerCare provider to assure at a minimum, that periodic

screens are scheduled and provided in accordance with the periodicity schedule following the initial screening.

(2) **Child health encounter.** The child health encounter may include a diagnosis and treatment encounter, a follow-up health encounter, or a home visit. A Child Health Encounter may include a child health history, physical examination, developmental assessment, nutrition assessment and counseling, social assessment and counseling, genetic evaluation and counseling, indicated laboratory and screening tests, screening for appropriate immunizations, health counseling and treatment of childhood illness and conditions.

(3) **Hearing and Hearing Aid evaluation.** Hearing evaluation includes pure tone air, bone and speech audiometry provided by a state licensed audiologist who:

(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(4) **Audiometry test.** Audiometric test (Immittance [Impedance] audiometry or tympanometry) includes bilateral assessment of middle ear status and reflex studies (when appropriate) provided by a state licensed audiologist who:

(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(5) **Ear impression (for earmold).** Ear impression (for earmold) includes taking impression of a ~~client's~~ member's ear and providing a finished earmold which is used with the ~~client's~~ member's hearing aid provided by a state licensed audiologist who:

(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(6) **Vision Screening**. Vision screening examination must be provided by a state licensed Doctor of Optometry (O.D.) or licensed physician specializing in ophthalmology (M.D. or D.O.). At a minimum, vision services include diagnosis and treatment for defects in vision.

(7) **Speech Language evaluation.** Speech Language evaluation must be provided by state licensed speech language pathologist who:

(A) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(B) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(C) has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

(8) **Physical Therapy evaluation**. Physical Therapy evaluation must be provided by a state licensed physical therapist.

(9) **Occupational Therapy evaluation**. Occupational Therapy evaluation must be provided by a state licensed occupational therapist.

(10) **Psychological Evaluation and Testing.** Psychological Evaluation and Testing must be provided by state licensed, Board Certified, Psychologist or School Psychologist certified by State Department of Education (SDE).
(11) **Dental Screening Examination.** Screening for dental disease by a state licensed dentist. The child may be referred directly to a dentist for further screening and/or treatment.
(12) **Child guidance treatment encounter.** A child guidance treatment encounter may occur through the provision of individual, family, or group treatment services to children who are identified as having specific disorders or delays in development, emotional, or behavioral problems, or disorders of speech, language or hearing. These types of encounters are initiated following the completion of a diagnostic encounter and subsequent development of a treatment plan, or as a result of an IEP or IFSP and may include the following:

(A) **Hearing and Vision Services.** Hearing and vision services may include provision of habilitation activities, such as auditory training, aural and visual habilitation training, including Braille, and communication management, orientation and mobility, counseling for vision and hearing losses and disorders. Services must be provided by:

(i) state licensed, Master's Degree Audiologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed, Master's Degree Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(iii) state certified Speech Therapist working under the direction of a state licensed Speech Language Pathologist;

(iv) state certified deaf education teacher;

(v) certified orientation and mobility specialists; and

(vi) state certified vision impairment teachers.

(B) **Speech Language Therapy Services.** Speech Language Therapy Services must be provided by a state licensed Speech Language Pathologist who:

(i) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(ii) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(iii) has completed the academic program and is acquiring supervised work experience to qualify for the certificate; or

(iv) a Speech Therapy Assistant who has been authorized by the Board of Examiners, working under the direction of a state licensed speech language pathologist. The licensed Speech Language Pathologist may not supervise more that two Speech Therapy assistants, and must be on site.

(C) **Physical Therapy Services.** Physical Therapy Services must be provided by state licensed physical therapist or a Physical Therapy Assistant who has been authorized by the Board of Examiners working

under the supervision of a licensed Physical Therapist. The licensed Physical Therapist may not supervise more than three Physical Therapy Assistants.

(D) **Occupational Therapy Services**. Occupational therapy may include provision of services to improve, develop or who restore impaired ability to function independently and must be provided by a state licensed Occupational Therapist or an Occupational Therapy Assistant who has been authorized by the Board of Examiners, working under the supervision of a licensed Occupational Therapist.

(E) **Nursing Services.** Nursing Services may include provision of services to protect the health status of children, correct health problems and assist in removing or modifying health related barriers and must be provided by a registered nurse or licensed practical nurse under supervision of a registered nurse. Services include medically necessary procedures rendered at the school site, such as catheterization, suctioning, administration and monitoring of medication.

(F) **Psychological Services.** Psychological services are planning and managing a program of psychological services, including the provision of counseling for children and parents, consulting on management of severe behavioral and emotional concerns in school and home. All services must be for the direct benefit of the child. Psychological services must be provided by a state licensed Psychologist, or School Psychologist certified by SDE.

(G) **Psychotherapy Counseling Services.** Psychotherapy counseling services are the provision of counseling for children and parents. All services must be for the direct benefit of the child. Psychotherapy counseling services must be provided by a state licensed Social Worker, a state Licensed Professional Counselor, a State licensed Psychologist or School Psychologist certified by the SDE, a State licensed Marriage and Family Therapist or a State licensed Behavioral Practitioner, or under Board supervision to be licensed in one of the above stated areas.

(H) **Assistive Technology.** Assistive technology are the provision of services that help to select a device and assist a student with disability(ies) to use an Assistive technology device including coordination with other therapies and training of child and caregiver. Services must be provided by a:

(i) state licensed, Speech Language Pathologist who:

(I) holds a certificate of clinical competence from the American Speech and Hearing Association; or

(II) has completed the equivalent educational requirements and work experience necessary for the certificate; or

(III) has completed the academic program and is acquiring supervised work experience to qualify for the certificate;

(ii) state licensed Physical Therapist; or

(iii) state licensed Occupational Therapist.

(13) **Personal Care.** Provision of personal care services allow students with disabilities to safely attend school; includes, but is not limited to assistance with toileting, feeding, positioning, hygiene, and riding school bus to handle medical or physical emergencies. Services must be provided by registered paraprofessionals/assistants who have completed training approved or provided by SDE, or Personal Care Assistants, including Licensed Practical Nurses, who have completed on-the-job training specific to their duties.

(14) **Therapeutic Behavioral Services**. Therapeutic behavioral services are interventions to modify the non-adaptive behavior necessary to improve the student's ability to function in the community as identified on the plan of care. Medical necessity must be identified and documented through assessment and evaluation. Services encompass behavioral management, redirection, and assistance in acquiring, retaining, improving, and generalizing socialization, communication and adaptive skills. This service must be provided by a Behavioral Health School Aide (BHSA) who has a high school diploma or equivalent and has successfully completed the paraprofessional training approved by The State Department of Education and a training curriculum in behavioral interventions for Pervasive Developmental Disorders as recognized by OHCA. BHSA must be supervised by a bachelor's level individual with a special education certification. BHSA must have CPR and First Aid certification. Six additional hours of related continuing education is required per year.

~~(14)~~ (15) **Immunization.** Immunizations must be coordinated with the Primary Care Physician for those Medicaid eligible children enrolled in ~~***SoonerCare***~~ SoonerCare. An administration fee, only, can be paid for immunizations provided by the schools.

(c) **Individuals eligible for Part B of Medicare.** EPSDT school health related services provided to Medicare eligible recipients are billed directly to the fiscal agent.

317:30-5-1027. Billing

The following units are billed on the appropriate claim form:

(1) Service: Child Health Screening; Unit: Completed comprehensive screening.

(2) Service: Interperiodic Child Health Screening; Unit: Completed interperiodic screening.

(3) Service: Child Health Encounter; Unit: 5-10 minutes equals 1 unit; 11-20 minutes equals 2 units; over 21 minutes equals 3 units; limited to 30 units per year, additional units must be prior authorized.

(4) Service: Individual Treatment Encounter for IEP School Based and School Based; Unit: 15 minutes, unless otherwise specified.

(A) Hearing and Vision Services, IEP School Based.
(B) Hearing and Vision Services, School Based.
(C) Speech Language Therapy, IEP School Based.
(D) Speech Language Therapy, School Based.
(E) Physical Therapy, IEP School Based.
(F) Physical Therapy, School Based.
(G) Occupational Therapy, IEP School Based.
(H) Occupational Therapy, School Based.
(I) Nursing Services, IEP School Based; Unit: 5 minutes equals 1 unit; limited to 24 per day.
(J) Nursing Services, School Based; Unit: 5 minutes equals 1 unit; limited to 24 per day.
(K) Psychological Services, IEP School Based.
(L) Psychological Services, School Based.
(M) Psychotherapy Counseling Services, IEP School Based.
(N) Psychotherapy Counseling Services, School Based.
(O) Assistive Technology, IEP School Based.
(P) Assistive Technology, School Based.
(Q) Dental Screening, IEP School Based.
(R) Dental Screening, School Based.
(S) Therapeutic Behavioral Services, IEP School Based; limited to 12 units per day.

(5) Service: Group Treatment Encounter for IEP School Based and School Based; No more than 5 recipients per group, Unit: 15 minutes, unless otherwise specified.

(A) Hearing and Vision Services, IEP School Based.

(B) Hearing and Vision Services, School Based.

(C) Speech Language Therapy, IEP School Based.

(D) Speech Language Therapy, School Based.

(E) Physical Therapy, IEP School Based.

(F) Physical Therapy, School Based.

(G) Occupational Therapy, IEP School Based.

(H) Occupational Therapy, School Based.

(I) Psychological Services, IEP School Based.

(J) Psychological Services, School Based.

(K) Psychotherapy Counseling Services, IEP School Based.

(L) Psychotherapy Counseling Services, School Based.

(6) Service: Administration only, Immunization; Unit: one administration.

(7) Service: Hearing Evaluation; Unit: Completed Evaluation.

(8) Service: Hearing Aid Evaluation; Unit: Completed Evaluation.

(9) Service: Audiometric Test (Impedance); Unit: Completed Test (Both Ears).

(10) Service: Tympanometry and acoustic reflexes.

(11) Service: Ear Impression Mold; Unit: 2 molds (one per ear).

(12) Service: Vision Screening; Unit: one examination, by state licensed O.D., M.D., or D.O.

(13) Service: Speech Language Evaluation; Unit: one evaluation.

(14) Service: Physical Therapy Evaluation; Unit: one evaluation.

(15) Service: Occupational Therapy Evaluation; Unit: one evaluation.

(16) Service: Psychological Evaluation and Testing; Unit: one hour (with written report).

(17) Service: Personal Care Services; Unit: 10 minutes.

8.b-2. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 1. Physicians
OAC 317:30-5-20. [AMENDED]
Part 7. Certified Laboratories
OAC 317:30-5-100. [AMENDED]
(Reference APA WF # 09-52)

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 laboratory services guidelines. Rules are revised to clarify the intent of coverage for medically necessary laboratory services and to provide consistency throughout policy. These emergency rule revisions will make rules consistent with reimbursement practices and clarify coverage and access to healthcare for Oklahomans, thereby reducing confusion among SoonerCare providers regarding laboratory services coverage and requirements and ultimately reducing the amount of uncompensated care provided by healthcare providers.

ANALYSIS: Agency rules are revised to clarify that reimbursement is only made for medically necessary laboratory services. Additional revisions include removing language which calls for OHCA to edit laboratory claims at the specialty/subspecialty level. CMS only allows edits for SoonerCare claims at the CLIA certificate level. Other revisions include general policy cleanup as it relates to these sections.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, 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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
SoonerCare rules are revised to clarify that reimbursement is only made for medically necessary laboratory services.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 1. PHYSICIANS

317:30-5-20. Laboratory services

This Section covers the guidelines for payment of laboratory services by a provider in his/her office, a certified laboratory and for a pathologist's interpretation of laboratory procedures.

(1) **Covered lab services.** Providers may be paid for covered clinical diagnostic laboratory services only when they personally perform or supervise the performance of the test. If a provider refers specimen to a certified laboratory or a hospital laboratory serving outpatients, the certified laboratory or the hospital must bill for performing the test.

(A) ~~Effective September 1, 1992, reimbursement~~ Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Eligible providers must be certified under the CLIA program and have obtained a CLIA ID number from ~~HCFA~~ CMS and have a current contract on file with the OHCA. ~~Payment is made only for those services which fall within the approved specialties/subspecialties.~~

(B) ~~Effective May 1, 1993, reimbursement~~ Reimbursement rate for laboratory procedures is the lesser of the ~~HCFA~~ CMS National 60% fee or the local carrier's allowable (whichever is lower).

(C) ~~All claims for laboratory services are considered medically necessary unless specifically disallowed in this Chapter~~ Medically necessary laboratory services are covered.

(2) **Compensable outpatient laboratory services.** Medically necessary laboratory services are covered. ~~Genetic counseling requires special medical review prior to approval.~~

(3) ~~**Noncompensable**~~ **Non-compensable laboratory services.**

(A) Separate payment is not made for blood specimens obtained by venipuncture or urine specimens collected by a laboratory. These services are considered part of the laboratory analysis.

(B) Claims for inpatient full service laboratory procedures are not covered since this is considered a part of the hospital rate.

(C) Laboratory services not considered medically necessary are not covered.

(4) **Covered services by a pathologist.**

(A) A pathologist may be paid for interpretation of inpatient surgical pathology specimen. The appropriate CPT procedure code and modifier is used.

(B) Full service or interpretation of surgical pathology for outpatient surgery performed in an outpatient hospital or Ambulatory Surgery Center setting.

(5) **Non-compensable services by a pathologist.** The following are non-compensable pathologist services:

(A) Tissue examinations for identification of teeth and foreign objects.

(B) Experimental or investigational procedures.

(C) Interpretation of clinical laboratory procedures.

PART 7. CERTIFIED LABORATORIES

317:30-5-100. Eligible providers

~~Effective September 1, 1992, reimbursement~~ Reimbursement for lab services is made in accordance with the Clinical Laboratory Improvement Amendment of 1988 (CLIA). These regulations provide that payment may be made only for services furnished by a laboratory that meets CLIA conditions, including those furnished in physicians' offices. Regulations specify that any and every facility which

tests human specimens for the purpose of providing information for the diagnosis, prevention, or treatment of any disease, or impairment of, or the assessment of the health of human beings is subject to CLIA. All facilities which perform these tasks must make application for certification by ~~HCFA~~ CMS. Eligible ~~Medicaid~~ SoonerCare providers must be certified under the CLIA program and have obtained a ~~CLIAID~~ CLIA ID number from ~~HCFA~~ CMS and have a current contract on file with ~~this Authority~~ the OHCA. ~~Payment is made only for those services which fall within the approved specialties/subspecialties.~~

8.b-3. CHAPTER 45. INSURE OKLAHOMA/OKLAHOMA EMPLOYER AND EMPLOYEE PARTNERSHIP FOR INSURANCE COVERAGE
Subchapter 11. Insure Oklahoma/O-EPIC IP
Part 5. Insure Oklahoma/O-EPIC IP Member Eligibility
OAC 317:45-11-20. [AMENDED]
OAC 317:45-11-27. [AMENDED]
(Reference APA WF # 09-53)

FINDING OF EMERGENCY: The Agency finds that a compelling public interest exists which necessitates promulgation of emergency rules and requests emergency approval of rule revisions to the agency's Insure Oklahoma program. Rules are revised to clarify the intent of offering coverage under the Individual Plan and to provide consistency throughout policy. These emergency rule revisions will make rules consistent with federal approval and waiver guidelines and clarify coverage and access to the Insure Oklahoma Individual Plan program.

ANALYSIS: Insure Oklahoma/O-EPIC rules are revised to clarify the intent of offering coverage under the Individual Plan (IP) program. Applicants applying for coverage under the IP program should be uninsured individuals without access to Employer Sponsored Insurance (ESI) or other private health insurance. It has never been the intent of Insure Oklahoma IP to be a secondary payer for services rendered under ESI or any other private health insurance policy or plan. Rules clarify IP eligibility requirements and closure criteria.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, 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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Rules are revised to clarify the intent of offering coverage under the Insure Oklahoma Individual Plan (IP) program. Applicants applying for coverage under the IP program should be uninsured individuals without access to Employer Sponsored Insurance (ESI) or other private health insurance.

PART 5. INSURE OKLAHOMA/O-EPIC IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma/O-EPIC IP eligibility requirements

(a) Employees not eligible to participate in an employer's QHP, employees of non-participating employers, self-employed, unemployed seeking work, and workers with a disability may apply for the Individual Plan. Applicants cannot obtain IP coverage if they are eligible for ESI.

(b) The eligibility determination is processed within 30 days from the date the complete application is received by the TPA. The applicant is notified in writing of the eligibility decision.

(c) In order to be eligible for the IP, the applicant must:

(1) choose a valid PCP according to the guidelines listed in OAC 317:45-11-22, at the time they make application;

(2) be a US citizen or alien as described in OAC 317:35-5-25;

(3) be an Oklahoma resident;

(4) provide social security numbers for all household members;

(5) be not currently enrolled in, or have an open application for, SoonerCare/Medicare;

(6) be age 19 through 64 or an emancipated minor;

(7) make premium payments by the due date on the invoice; ~~and~~

(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in OAC 317:45-7-1(a)(1)-(2)~~.~~; and

(9) be not currently covered by a private health insurance policy or plan.

(d) If employed and working for an approved Insure Oklahoma/O-EPIC employer who offers a QHP, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have household income at or below 200% of the Federal Poverty Level.

(2) be ineligible for participation in their employer's QHP due to number of hours worked.

(3) have received notification from Insure Oklahoma/O-EPIC indicating their employer has applied for Insure Oklahoma/O-EPIC and has been approved.

(e) If employed and working for an employer who doesn't offer a QHP, the applicant must meet the requirements in subsection (c) of this Section and have a countable household income at or below 200% of the Federal Poverty Level. The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) must have household income at or below 200% of the Federal Poverty Level;

(2) verify self-employment by providing the most recent federal tax return with all supporting schedules and copies of all 1099 forms;

(3) verify current income by providing appropriate supporting documentation; and

(4) must not be employed by any full-time employer who meets the eligibility requirements in OAC 317:45-7-1(a)(1)-(2).

(g) If unemployed seeking work, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicant must have household income at or below 200% of the Federal Poverty Level~~; and~~. In determining income, payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010 and any amount of emergency unemployment compensation paid through May 31, 2010, will not be counted, as authorized under the American Recovery and Reinvestment Tax Act of 2009.

(2) Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:
(A) OESC eligibility letter,
(B) OESC weekly unemployment payment statement, or
(C) bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and:
(1) must have household income at or below 200% of the Federal Poverty Level based on a family size of one; and
(2) verify eligibility by providing a copy of their:
(A) ticket to work, or
(B) ticket to work offer letter.

317:45-11-27. Closure

(a) Members are mailed a notice 10 days prior to closure of eligibility.
(b) The employer and employees' eligibility are tied together. If the employer no longer meets the requirements for Insure Oklahoma/O-EPIC then eligibility for the associated employees enrolled under that employer are also ineligible.
(c) The employee's certification period may be terminated when:
(1) the member requests closure;
(2) the member moves out-of-state;
(3) the covered member dies;
(4) the employer's eligibility ends;
(5) an audit indicates a discrepancy that makes the member or employer ineligible;
(6) the employer is terminated from Insure Oklahoma/O-EPIC;
(7) the member fails to pay the amount due within 60 days of the date on the bill;
(8) the QHP or carrier is no longer qualified;
(9) the member begins receiving SoonerCare/Medicare benefits; ~~or~~
(10) the member begins receiving coverage by a private health insurance policy or plan; or
~~(10)~~ (11) the member or employer reports to the OHCA or the TPA any change affecting eligibility.

(d) This subsection applies to applicants eligible according to OAC 317:45-11-20(a) through (c) and 317:45-11-20(f) through (h). The member's certification period may be terminated when:
(1) the member requests closure;
(2) the member moves out-of-state;
(3) the covered member dies;
(4) the employer's eligibility ends;
(5) an audit indicates a discrepancy that makes the member or employer ineligible;
(6) the member fails to pay the amount due within 60 days of the date on the bill;
(7) the member becomes eligible for SoonerCare/Medicare; ~~or~~
(8) the member begins receiving coverage by a private health insurance policy or plan; or
~~(8)~~ (9) the member or employer reports to the OHCA or the TPA any change affecting eligibility.

8.b-4. CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS
OAC 317:2-1-2. [AMENDED]
Chapter 35. Medical Assistance for Adults and Children-Eligibility
Subchapter 1. General Provisions
317:35-1-2. [AMENDED]
Subchapter 5. Eligibility and Countable Income
Part 1. Determination of Qualifying Categorical Relationships
317:35-5-6. [AMENDED]
317:35-5-6.1. [AMENDED]
Subchapter 6. SoonerCare ~~Health Benefits~~ for ~~Categorically Needy~~ Pregnant Women and Families with Children
Part 3. Application Procedures
317:35-6-15. [AMENDED]
Part 5. Determination of Eligibility for Sooner ~~Health Benefits~~ for Pregnant Women and Families with Children
317:35-6-38. [AMENDED]
Part 7. Certification, Redetermination and Notification
317:35-6-60. [AMENDED]
317:35-6-62. [AMENDED]
317:35-6-63. [AMENDED]
317:35-6-64. [AMENDED]
317:35-6-64.1. [AMENDED]
Subchapter 7. Medical Services
Part 3. Application Procedures
317:35-7-15. [AMENDED]
Part 7. Certification, Redetermination and Notification
317:35-7-60.1. [AMENDED]
317:35-7-63. [AMENDED]
317:35-7-64. [AMENDED]
317:35-7-65. [AMENDED]
Subchapter 10. ~~Medical Aid to Families with Dependent Children~~ Other Eligibility Factors for Families with Children and Pregnant Women
Part 5. Income
317:35-10-26. [AMENDED]
Subchapter 22. Pregnancy Related Benefits Covered Under Title XXI
317:35-22-9. [AMENDED]
317:35-22-11. [AMENDED]
(Reference APA WF # 09-56 A & B)

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 eliminate the barriers of providing effective and efficient services to potential SoonerCare members. The online enrollment process creates a single point-of-entry eligibility intake system that results in the applicant's SoonerCare eligibility determination. Initial applications and redeterminations of eligibility for SoonerCare will be processed in less time than the current process, allowing individuals to more rapidly access needed health care.

SUMMARY: In 2007, the OHCA received a Transformation Grant through the Centers for Medicare and Medicaid Services (CMS) to develop a web based online application and eligibility determination system in order

to improve the ease and efficiency of enrollment. Originally known as No Wrong Door, the process allows potential members to apply for SoonerCare electronically. Effective in March 2010, the OHCA will assume responsibility for determining eligibility for certain groups of individuals under SoonerCare. The process will be phased in over a period of time, starting with the easiest groups who have no asset test and use income declaration: families with children, pregnant women, and individuals requesting only family planning services. As OHCA will now be determining eligibility for some of our population, parts of our eligibility rules and grievance rules are revised to incorporate these new responsibilities. In addition, eligibility for these three groups will no longer be retroactive to the first day of the month of application but will be effective the date of application or later.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, and recommended Board approval.

PROPOSED EFFECTIVE DATE: March 1, 2010

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 435.902; 42 CFR 435.930

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
SoonerCare rules are revised to support the use of the web based online application and eligibility determination system.

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2. Appeals

(a) **Member Process Overview.**

(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received within 30 days of written notice sent by OHCA according to Title 68 O.S. ' 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out and necessary documentation not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.
(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (Section OAC 317:2-1-13).
(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 C.F.R. Section 431.244(f)]
(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) **Provider Process Overview.**

(1) The proceedings as described in this Section contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).
(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under OAC 317:2-1-2(c)(2).
(A) The Appellant (Appellant is the provider who files a grievance) files an LD form requesting a grievance hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider grievances and LD-3 forms are for nursing home wage enhancement grievances.)
(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.
(C) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.
(D) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.
(E) The Administrative Law Judge's decision is appealable to OHCA's CEO under OAC 317:2-1-13.

(c)**ALJ jurisdiction.** The administrative law judge has jurisdiction of the following matters:

(1) Member Appeals:
(A) Discrimination complaints regarding the SoonerCare program;
(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;
(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;
(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;
(E) Complaints regarding the possible violation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA);
(F) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within

20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

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

(2) Provider Appeals:

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5), (e)(8), and (e)(12);

(D) Petitions for Rulemaking;

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

(F) Appeals to the decision made by the Business Contracts manager related to Purchasing as found at OAC 317:10-1-5 and other appeal rights granted by contract;

(G) Drug rebate appeals;

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

(I) Proposed administrative sanction appeals pursuant to OAC 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 1. GENERAL PROVISIONS

317:35-1-2. Definitions

The following words and terms, when used in this Chapter, have the following meaning, unless the context clearly indicates otherwise:

"Acute Care Hospital" means an institution that meets the requirements of 42 CFR, Section 440.10 and:

(A) is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) meets the requirements for participation in Medicare as a hospital.

"ADvantage Administration (AA)" means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

"AFDC" means Aid to Families with Dependent Children.

"Aged" means an individual whose age is established as 65 years or older.

"Agency partner" means an agency or organization contracted with the OHCA that will assist those applying for services.

"Aid to Families with Dependent Children" means the group of low income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for Aid to

Families with Dependent Children in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC.

"Area nurse" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

"Authority" means the Oklahoma Health Care Authority (OHCA).

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the Oklahoma Health Care Authority Board.

"Buy-in" means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

"Categorically needy" means that income and when applicable, resources are within the standards for the category to which the individual is related.

"Categorically related" or "related" means the individual is:

(A) aged, blind, or disabled;

(B) pregnant;

(C) an adult individual who has a minor child under the age of 18 and who is deprived of parental support due to absence, death, incapacity, unemployment; or

(D) a child under 19 years of age.

"Certification period" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"County" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

~~**"CSED"** means the Oklahoma Department of Human Services' Child Support Enforcement Division.~~

"Custody" means the custodial status, as reported by the Oklahoma Department of Human Services.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for in-patient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays 80% of the allowable charge. The remaining 20% is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than 12 months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

"Gatekeeping" means the performance of a comprehensive assessment by the OKDHS nurse utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the determination of Medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Local office" means the Oklahoma Department of Human Services' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving OASDI or Railroad Retirement income who are age 65 or older and for those under age 65 who have been receiving disability benefits under these programs for at least 24 months.

(i) Persons with end stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age 65 or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for ~~Medicaid~~ SoonerCare benefits as categorically needy. They must however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a Qualified Disabled and Working Individual (QDWI) under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are

required to do so under ~~Authority~~ OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of 18.

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for the mentally retarded or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the Oklahoma Department of Human Services' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the Oklahoma Health Care Authority that assists with the eligibility determination process.

"OKDHS" means the Oklahoma Department of Human Services.

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the Uniform Comprehensive Assessment Tool (UCAT) for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings, but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Recipient lock-in" means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a 12-month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The Oklahoma Health Care Authority Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, ICF/MRs, or inpatient acute care hospital stays are expected to last not less than 60 days.

"Worker" means the OHCA or OKDHS worker responsible for ~~SoonerCare~~ assisting in eligibility ~~determinations~~ determinations.

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME
PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIPS

317:35-5-6. Determining categorical relationship to pregnancy-related services

Categorical relationship to pregnancy-related services can be established by determining through medical evidence that the individual is currently or has been pregnant. Pregnancy must be verified by providing medical proof of pregnancy within 10 days of application submission. ~~Form MS-MA-5~~ OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. ~~Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is or has been pregnant.~~ If proof of pregnancy is not provided within 10 days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the ten day period. The expected date of delivery must be established either by information from the applicant's physician or certified nurse midwife or the ~~client's~~ member's statement.

317:35-5-6.1. Determining categorical relationship for pregnancy related services covered under Title XXI

Categorical relationship for pregnancy related benefits covered under Title XXI are determined in accordance with OAC 317:35-22-1 and through medical evidence that the individual is currently or has recently been pregnant and may qualify for pregnancy related services. Pregnancy must be verified by providing medical proof of pregnancy within 10 days of application submission. ~~Form MS-MA-5~~ OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. ~~Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is or has been pregnant.~~ If proof of pregnancy is not provided within 10 days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the ten day period. The applicant must be residing in the State of Oklahoma with the intent to remain at the time the medical service is received. The expected date of delivery must be established either by information from the applicant's physician or other qualified practitioner.

SUBCHAPTER 6. SOONERCARE ~~HEALTH BENEFITS~~ FOR ~~CATEGORICALLY NEEDY~~ PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 3. APPLICATION PROCEDURES

317:35-6-15. Application for SoonerCare ~~Health Benefits~~ for Pregnant Women and Families with Children; forms

(a) **Application**. An application for categorically needy pregnant women and families with children consists of the ~~Health Benefits Application~~ SoonerCare application. The application form is signed by the individual, parent, spouse, guardian, or someone else acting on the individual's behalf. A categorically needy individual does not have to have received a medical service nor expect to receive one to be certified for ~~Health Benefits for Pregnant Women and Families with Children~~ SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility, Health Department, ~~or~~ in the county OKDHS office, or online. A face to face interview is not required. Applications ~~may be~~ are mailed ~~or faxed~~ to the ~~local county OKDHS office~~ OHCA Eligibility Unit. ~~If faxed, it is not necessary to send the original application.~~ When an individual indicates a need for ~~health benefits~~ SoonerCare, the physician or facility may forward an application to the ~~OKDHS county office of the patient's residence~~ OHCA Eligibility Unit for processing. If the applicant is

unable to sign the application, someone acting on his/her behalf may sign the application.

(2) ~~Form~~ OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the ~~Health Benefits~~ SoonerCare Application form or ~~Form~~ OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If ~~Form~~ OKDHS form 08MA005E is received and ~~an~~ a SoonerCare application cannot be completed, receipt of ~~Form~~ OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The ~~member~~ applicant and provider are notified by computer-generated notice.

(b) **Date of application**. When an application is made online, the date of application is the date the application is submitted online. When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or ~~Form~~ OKDHS form 08MA005E is stamped with the date the application was received into the ~~county office~~ OHCA Eligibility Unit. ~~When an application is faxed, the application date is the date the fax is received.~~ When a request for ~~Health Benefits~~ SoonerCare is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application ~~to be shown on the computer form~~ to be used. When ~~Form~~ OKDHS form 08MA005E is received in the ~~county office~~ OHCA Eligibility Unit prior to the completion of the application form, the date that ~~Form~~ OKDHS form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the ~~OKDHS county office~~ OHCA Eligibility Unit for ~~Health Benefits~~ SoonerCare eligibility determination. Under this circumstance, the application date is the date the ~~member~~ applicant signed the application form for the provider.

PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE ~~HEALTH BENEFITS~~ FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-38. Presumptive eligibility for pregnant women

(a) Presumptive Eligibility (PE) is a limited period of ~~Medicaid~~ SoonerCare eligibility for categorically needy pregnant women that is determined by a qualified provider. Its purpose is to encourage pregnant women to receive adequate prenatal care in the earlier months of their pregnancy, and to ensure qualified providers of payment for the prenatal care. The PE period precedes the ~~Health Benefits~~ SoonerCare eligibility determination ~~made by the county office,~~ and begins on the date a qualified provider makes a determination of presumptive eligibility. The basis for the determination is preliminary information that the net family income of the pregnant woman does not exceed the standards on the OHCA website or the ~~DHS Appendix C-1~~ OKDHS form 08AX001E, Schedule I, which are 185% of the Federal Poverty Level.

(b) Pregnant women are excluded from a resource test. When a qualified provider has made this determination, the provider is required to notify the county office in the ~~pregnant woman's residence county~~ OHCA Eligibility Unit within five working days after the date of PE determination. The ~~county office~~ OHCA Eligibility Unit does not make PE determinations. When a PE

determination is received, the worker determines ~~Health Benefits~~ SoonerCare eligibility using normal procedures.

(1) **Qualified providers**. The determination that a provider is qualified to make a PE determination is made by the OHCA. A listing of approved qualified providers is found ~~in DHS Appendix M-10, Certified Medicaid Presumptive Eligibility Providers which is available only on-line on the computer terminal~~ on the OHCA website. The ~~county office~~ OHCA Eligibility Unit must be sure a PE determination is made only by a qualified provider ~~who is included in this Appendix~~.

(2) **Application and eligibility determination process for presumptive eligibility**. The ~~county offices supply~~ OHCA Eligibility Unit supplies the qualified providers with the necessary forms and instructions to complete and correctly determine PE for pregnant women.

(A) The forms include the following:

(i) The ~~Health Benefits~~ SoonerCare Application. This form must be completed at the PE determination and serves to gather information to complete PE determination and also to use for ~~Health Benefits~~ SoonerCare eligibility determination~~ by the worker~~;

(ii) OHCA Form MA-PE-1, Presumptive Eligibility Budget Sheet, which is completed by the qualified provider to verify pregnancy and provide income screening necessary to determine PE. Instructions for completing the form and eligibility rules are included on the back of the form; and

(iii) OHCA Form MA-PE-2, Notice to Pregnant Women Regarding Presumptive Eligibility for ~~Medicaid~~ SoonerCare, which is completed and given to the pregnant woman by the qualified provider. It informs her whether she has been determined to be presumptively eligible or ineligible by the qualified provider. It also contains information regarding the application process as well as a detailed list of what ~~the DHS county office needs~~ is needed to complete the ~~Health Benefits~~ SoonerCare application.

(B) After determining the pregnancy of the individual, the qualified provider determines financial eligibility. OHCA Form MA-PE-1 is completed to document the pregnancy and the financial eligibility. If the qualified provider determines the individual meets PE requirements, OHCA Form MA-PE-2 is completed and given to the individual. The originals of the ~~Health Benefits~~ SoonerCare Application form and OHCA Form MA-PE-1 are sent to the ~~DHS county office of the woman's residence~~ OHCA Eligibility Unit. They must be received within five working days after the date of the PE determination.

(C) If the individual is determined by the qualified provider to not meet PE requirements, the qualified provider completes OHCA Form MA-PE-2 and gives it to the individual. The qualified provider also advises the individual she may be eligible for ~~Medicaid~~ SoonerCare and refers her to the on line application or the OKDHS county office for ~~Medicaid~~ SoonerCare eligibility determination.

(D) A PE determination may be made at any time during a pregnancy, even if there is an application pending ~~at the county office~~. Only one PE period will be granted during a pregnancy.

(E) Only a pregnant woman may be determined as PE. No other household member may be certified as presumptively eligible.

(3) **Household definition**. For purposes of this Section, the household is defined as the pregnant woman, her spouse or male acting in the role of the spouse, and her minor dependent children. The unborn child(ren) is also included as a member(s) of the household. If the pregnant woman is under age 18 and lives with her parent(s), the parent(s) is considered a

household member(s). Other minor siblings may be included as household members.

(4) **Income computation**. The PE determination of the pregnant woman requires the provider to compute the total monthly income of the household as shown on the ~~Health Benefits~~ SoonerCare Application. The total monthly income includes the earned and unearned income of all household members. If the pregnant woman is a minor (under age 18) and lives with her parents, her parents' income must be included, regardless of the minor pregnant woman's marital status. The income included in the PE determination is the total income received in the month that PE is determined by the qualified provider. The household's total net income must be equal to or less than the ~~applicable maintenance standard~~ standards on the OHCA website or the ~~DHS Appendix C-1~~ OKDHS Form 08AX001E, Schedule I, which are 185% of the Federal Poverty Level.

(A) Countable earned income is the gross earnings of each household member minus the AFDC work related expenses and paid dependent care expenses not to exceed the AFDC dependent care limits (see OAC 317:35-10). Countable unearned income is the total unearned income of all household members. The AFDC rule on unearned income exclusions is followed.

(B) The total countable net earned income plus the total countable unearned income is the total countable net income. This total and the household size is compared to the standards on OHCA Form MA-PE-1 to determine financial eligibility.

(5) **Presumptive eligibility period**. Presumptive eligibility begins on the date a qualified provider determines the total countable monthly net income of a pregnant woman's household does not exceed the eligibility standard on the OHCA website ~~DHS Appendix C-1~~ or OKDHS Form 08AX001E, Schedule I. Presumptive eligibility ends with (and includes) the earlier of:

(A) The day an eligibility or ineligibility determination is made ~~by the worker~~; or

(B) The 45th day after the date on which the qualified provider made the PE determination (the 45 day count begins on the day following the eligibility determination date).

(6) **Approval of presumptive eligibility**. When the ~~county~~ OHCA Eligibility Unit receives timely a completed PE certification, a case number, if needed, is assigned. The PE certification is processed within five working days. The ~~client~~ applicant ~~and the qualified provider are~~ is notified of the PE determination by computer generated notice. The notice also advises that the PE period expires 45 days from the date of the qualified provider's approval. The case is automatically closed at the end of the 45 day period if a ~~Health Benefits~~ decision has not been made ~~by the worker~~ on the SoonerCare application. ~~Although not reflected on the computer, the Health Benefits case remains pending until appropriate action is taken by the worker.~~

(7) **Incomplete/incorrect presumptive eligibility forms**. Upon receipt of the ~~Health Benefits~~ SoonerCare Application and OHCA Form ~~MA-PE-1~~ MA-PE-1 from the qualified provider, the ~~county office~~ OHCA Eligibility Unit immediately screens them for completeness and correct determination.

(A) The ~~Health Benefits~~ SoonerCare Application for PE is considered incomplete if it is not filled out in its entirety, properly signed and dated. OHCA Form MA-PE-1 is considered incomplete if any response is omitted or if the form is not properly signed and dated.

(B) The presumptive eligibility determination is considered to be incorrect if the provider submitting the certification ~~is not shown on~~

~~Appendix M-10, Certified Medicaid Presumptive Eligibility Providers, as~~ has not been determined to be a qualified provider by the OHCA. The presumptive eligibility decision is also incorrect if the income computed by the qualified provider exceeds the allowable standard.

(C) When it is determined the PE certification is incomplete or incorrect, the original OHCA Form MA-PE-1 and a copy of the ~~Health Benefits~~ SoonerCare application, are returned to the qualified provider. The worker proceeds with the ~~Health Benefits~~ SoonerCare eligibility determination. To maintain the original PE certification period, the qualified provider must correct and/or complete the forms and return them to the ~~county office~~ OHCA Eligibility Unit within the original five working days. If this requirement is not met, an amended PE determination and PE determination date must be completed by the provider.

(8) **Presumptive eligibility forms not received within five working days**. A qualified provider is required to provide the PE determination to the ~~DHS county office of the pregnant woman's residence~~ OHCA Eligibility Unit within five working days after the date of the PE determination. The forms must be complete and correct as explained in paragraph (7) of this subsection. Forms received on the sixth day (or later) after the PE determination date are returned to the qualified provider with a request for an amended PE determination and PE determination date.

(9) **Erroneous payments and appeal rights**. When an individual is certified as presumptively eligible and a determination is made later that the individual is not eligible for ~~Health Benefits~~ SoonerCare, the PE period ends with the effective date of the ~~Health Benefit~~ SoonerCare application denial. In this instance, the effective date of denial is the day following the date the ineligibility decision is made.

(A) If the ineligibility is not due to a misrepresentation by the ~~client~~ applicant, any payments made are not considered to be erroneous. If the ineligibility is due to the ~~client~~ applicant withholding or misrepresenting information, any payments made are considered to be erroneous and a recipient overpayment is submitted to ~~DHS~~ OKDHS State Office, FSS Overpayment Section.

(B) The ~~client~~ applicant cannot appeal a PE determination made by a qualified provider or the expiration of the PE period (45 days).

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60. Certification for SoonerCare for pregnant women and families with children

An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the ~~first day of the month of application~~ date of certification. The period of certification may not be for a retroactive ~~months~~ period. The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery and postpartum periods without regard to eligibility for other household members in the case.

(1) **Certification as a TANF (cash assistance) recipient**. A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF eligibility.

(2) **Certification of non-cash assistance individuals categorically needy and related to AFDC**. The certification period for the individual related to AFDC is 12 months. The certification period can be less than 12 months if the individual:

(A) is certified as eligible in a money payment case during the 12-month period;
(B) is certified for long-term care during the 12-month period;
(C) becomes ineligible for SoonerCare after the initial month; or
(D) becomes ineligible as categorically needy.
(i) If an income change after certification causes the case to exceed the categorically needy maximums, the case is closed.
(ii) Individuals, however, who are determined pregnant and eligible as categorically needy continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy related services through the postpartum period.

(3) **Certification of individuals categorically needy and related to pregnancy-related services**. The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two months following the month the pregnancy ends. Eligibility as categorically needy is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

(4) **Certification of newborn child deemed eligible**.
(A) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one. The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.
(B) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. No other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at OKDHS. The referral enables child support services to be initiated.
(C) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one. If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:
(i) loses Oklahoma residence; or
(ii) expires.
(D) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

317:35-6-62. Notification of eligibility

When eligibility for SoonerCare ~~Health Benefits~~ is established, the ~~county office updates the computer form and the~~ appropriate notice is computer generated to the ~~client and provider~~ applicant. When the computer file is updated for changes, notices are generated only if there is a change in the ~~client's financial responsibility~~ eligibility of any household member.

317:35-6-63. Denials

If the denial of ~~Health Benefits~~ SoonerCare is for ~~an~~ the entire ~~family case~~ household, ~~the computer input form is updated and~~ the appropriate notice is computer generated to the ~~client and provider~~ applicant. If an individual(s) is being denied but other family members are eligible, the ~~county provides the~~ denied individual(s) is provided with a notice ~~using the Notification of Eligibility Status for Medical Assistance form~~.

317:35-6-64. Closures

~~Health benefit~~ SoonerCare cases are closed ~~by the county~~ at any time during the certification period that the case becomes ineligible. A computer-generated notice is sent to the ~~client~~ head of the household ~~and the provider~~.

317:35-6-64.1. Transitional Medical Assistance (TMA)

(a) **Conditions for TMA.**

(1) **Transitional Medical Assistance.** Health benefits are continued when the benefit group loses eligibility due to new or increased earnings of the parent(s)/caretaker relative or the receipt of child or spousal support. The health benefit coverage is of the same amount, duration, and scope as if the benefit group continued receiving ~~health benefits~~ SoonerCare. Eligibility for TMA begins with the effective date of case closure or the effective date of closure had the income been reported timely. An individual is included for TMA only if that individual was eligible for ~~Medicaid~~ SoonerCare and included in the benefit group at the time of the closure. To be eligible for TMA the benefit group must meet all of the requirements listed in (A) - (C) of this paragraph.

(A) At least one member of the benefit group was included in at least three of the six months immediately preceding the month of ineligibility.

(B) The health benefit cannot have been received fraudulently in any of the six months immediately preceding the month of ineligibility.

(C) The benefit group must have included a dependent child who met the age and relationship requirements for ~~Medicaid~~ SoonerCare and whose needs were included in the benefit group at the time of closure, unless the only eligible child is a Supplemental Security Income (SSI) recipient.

(2) **Closure due to child support or spousal support**. Health benefits are continued if the case closure is due to the receipt of new or increased child support or payments for spousal support in the form of alimony. The needs of the parent(s)or caretaker relative must be included in the benefit group at the time of closure. The health benefits are continued for four months.

(3) **Closure due to new or increased earnings of parent(s) or caretaker relative.** Health benefits are continued if the closure is due to the new or increased earnings of the parent(s) or caretaker relative. The needs of the parent(s)or caretaker relative must be included in the benefit group at the time of closure. The parent(s) or caretaker relative is required to cooperate with ~~Child Support Enforcement Division~~ OKDHS

Oklahoma Child Support Services during the period of time the family is receiving TMA.

(4) **Eligibility period.** Health benefits may be continued for a period up to 12 months if the reason for closure is new or increased earnings of the parent(s) or caretaker relative. This period is divided into two six-month periods with eligibility requirements and procedures for each period.

(A) **Initial six-month period**.

(i) The benefit group is eligible for an initial six-month period of TMA without regard to income or resources if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same; and

(III) the benefit group remains in the state.

(ii) An individual benefit group family member remains eligible for the initial six-month period of TMA unless the individual:

(I) moves out of the state,

(II) dies,

(III) becomes an inmate of a public institution,

(IV) leaves the household,

(V) does not cooperate, without good cause, with the ~~Child Support Enforcement Division~~ OKDHS Oklahoma Child Support Services or third party liability requirements.

(B) **Additional Six-month period.**

(i) Health benefits are continued for the additional six-month period if:

(I) an eligible child remains in the home;

(II) the parent(s) or caretaker relative remains the same;

(III) the benefit group remains in the state;

(IV) the benefit group was eligible for and received TMA for each month of the initial six-month period;

(V) the benefit group has complied with reporting requirements in subsection (g) of this Section;

(VI) the benefit group has average monthly earned income (less child care costs that are necessary for the employment of the parent or caretaker relative) that does not exceed the 185% of the Federal Poverty Level (see OKDHS Appendix C-1, Schedule I.A); and

(VII) the parent(s) or caretaker relative had earnings in each month of the required three-month reporting period described in (g)(2) of this Section, unless the lack of earnings was due to an involuntary loss of employment, illness, or other good cause.

(ii) An individual benefit group family member remains eligible for the additional six-month period unless the individual meets any of the items listed in (4)(A)(ii) of this paragraph.

(b) **Income and resource eligibility**.

(1) The unearned income and resources of the benefit group are disregarded in determining eligibility for TMA. There is no earned income test for the initial six-month period.

(2) Health benefits are continued for the additional six-month period if the benefit group's countable earnings less child care costs that are necessary for the employment of the parent(s) or caretaker relative are below 185% of the Federal Poverty Level (see the standards on the OHCA website or the OKDHS ~~Appendix C-1~~ Form 08AX001E, Schedule I.A) and the benefit group meets the requirements listed in (a)(4)(B).

(A) The earnings of all benefit group members are used in determining the earned income test. The only exception is that earnings of full time students included in the benefit group are disregarded.

(B) Income is determined by averaging the benefit group's gross monthly earnings (except full time student earnings) for the required three-month reporting period.

(C) A deduction from the benefit group's earned income is allowed for the cost of approved child care necessary for the employment of the parent(S) or caretaker relative. The child care deduction is averaged for the same three-month reporting period. There is no maximum amount for this deduction.

(D) All individuals whose earnings are considered are included in the benefit group. The family size remains the same during both reporting periods.

(c) **Eligible child**. When the ~~regular health~~ SoonerCare benefit is closed and TMA begins, the benefit group must include an eligible child whose needs were included in the ~~health~~ SoonerCare benefit at the time of closure, unless the only eligible child is a SSI recipient. After the TMA begins, the benefit group must continue to include an eligible child. Age is the only requirement an eligible child must meet.

(d) **Additional members**. After the TMA begins, family members who move into the home cannot be added to the TMA coverage. This includes siblings and a natural or adoptive parent(s) or caretaker relative. If the additional member is in need of health benefits, an application for services under the ~~regular Medicaid~~ SoonerCare program is completed. If a benefit group member included in TMA leaves the home and then returns, that member may be added back to TMA coverage if all conditions of eligibility are met.

(e) **Third party liability**. The benefit group's eligibility for TMA is not affected by a third party liability. However, the benefit group is responsible for reporting all insurance coverage and any changes in the coverage. The ~~social services specialist~~ worker must explain the necessity for applying benefits from private insurance to the cost of medical care.

(f) **Notification**.

(1) **Notices.** Notices are sent to the benefit group, both at the onset of and throughout the TMA period. These notices, which are sent at specific times, inform the benefit group of its rights and responsibilities. When ~~a health benefit~~ SoonerCare is closed and the benefit group is eligible for TMA, the computer generated closure notice includes notification of the continuation of health benefits. Another computer generated notice is sent at the same time to advise the benefit group of the reporting requirements and under what circumstances the health benefits may be discontinued. Each notice listed in (A)-(C) of this paragraph includes specific information about what the benefit group must report. The notices serve as the required advance notification in the event benefits are discontinued as a result of the information furnished in response to these notices.

(A) **Notice #1**. Notice #1 is issued in the third month of the initial TMA period. This notice advises the benefit group of the additional six-month period of TMA, the eligibility conditions, reporting requirements, and appeal rights.

(B) **Notice #2**. Notice #2 is issued in the sixth month of the TMA period, but only if the benefit group is eligible for the additional six-month period. This notice advises the benefit group of the eligibility conditions, reporting requirements, and appeal rights.

(C) **Notice #3**. Notice #3 is issued in the ninth month of the TMA period, or the third month of the additional six-month period. This notice advises the benefit group of the eligibility conditions, the reporting requirements, appeal rights, and the expiration of TMA coverage.

(2) **Notices not received**. In some instances the benefit group does not receive all of the notices listed in (1) of this subsection. The notices and report forms are not issued retroactively.

(g) **Reporting**. The benefit group is required to periodically report specific information. The information may be reported by telephone~~, in an office interview,~~ or by letter.

(1) The benefit group must report:

(A) gross earned income of the entire benefit group for the appropriate three-month period;

(B) child care expenses, for the appropriate three-month period, necessary for the continued employment of the parent(s) or caretaker relative;

(C) changes in members of the benefit group;

(D) residency; and

(E) third party liability.

(2) The reporting requirement time frames are explained in this subparagraph.

(A) The information requested in the third month must be received by the 21st day of the fourth month and is used to determine the benefit group's eligibility for the additional six-month period. While this report is due in the fourth month, negative action cannot be taken during the initial period for failure to report. If the benefit group fails to submit the requested information, benefits are automatically suspended effective the seventh month. If action to reinstate is not taken by deadline of the suspension month, the computer automatically closes the case effective the next month.

(B) The information requested in the sixth month must be furnished by the 21st day of the seventh month. The decision to continue benefits into the eighth month is determined by the information reported.

(C) The information requested in the ninth month must be furnished by the 21st day of the tenth month. The decision to continue health benefits into the 11th month is determined by the information reported. When the information is not reported timely, the TMA is automatically suspended by the computer for the appropriate effective date. If the benefit group subsequently reports the necessary information, the ~~social services specialist~~ worker determines eligibility. If all eligibility factors are met during and after the suspension period, the health benefits are reinstated. The effective date of the reinstatement is the same as the effective date of the suspension so the benefit group has continuous medical coverage.

(h) **Termination of TMA**. The TMA coverage is discontinued any time the benefit group fails to meet the eligibility requirements as shown in this Section. If it becomes necessary to discontinue the TMA coverage for the benefit group or any member of the benefit group, the individual(s) must be advised that he or she may be eligible for health benefits under the ~~regular Medicaid~~ SoonerCare program and how to obtain these benefits.

(i) **Receipt of health benefits after TMA ends**. To ensure continued medical coverage a computer generated recertification form is mailed to the benefit group during the third month of TMA for benefits closed due to the receipt of child or spousal support or the 11th month of TMA for benefits closed due to increased earnings. The benefit group must return the form prior to the termination of the TMA benefits. When determined eligible, health benefits continue as ~~health benefits~~ SoonerCare, not TMA. If the benefit group fails to return the recertification form, TMA benefits are terminated.

PART 3. APPLICATION PROCEDURES

317:35-7-15. Application for Medical Services; forms

(a) **Application**. An application for Medical Services consists of the Medical Assistance Application. The application form is signed by the individual, parent, spouse, guardian or someone else acting on the individual's behalf. A ~~categorically needy~~ individual does not have to have received a medical service nor expect to receive one to be certified for SoonerCare.

(1) An application may be made in a variety of locations, for example, a physician's office, a hospital or other medical facility or in the county OKDHS office. An application may be made online by individuals who are pregnant, have children or are applying for family planning services only. A face to face interview is not required. SoonerCare applications for women who are pregnant, families with children and for family planning services only are mailed to the OHCA Eligibility Unit. Applications for other medical services may be mailed or faxed to the local county OKDHS office. If faxed, it is not necessary to send the original application. When an individual indicates a need for health benefits, the physician or facility may forward an application or 08MA005E to the OKDHS county office of the patient's residence for processing. The physician or facility may forward an application or 08MA005E for individuals who are pregnant, have children or are applying for family planning services only to the OHCA Eligibility Unit for processing. If the applicant is unable to sign the application, someone acting on his/her behalf may sign the application.

(2) ~~Form~~ OKDHS form 08MA005E, Notification of Needed Medical Services, is required only for preauthorization of medical services. Although not required, the form may be submitted by the physician or facility as notification for a need for medical service. The form also may be accepted as medical verification of pregnancy.

(3) Receipt of the ~~Medical Assistance~~ SoonerCare Application form or ~~Form~~ OKDHS form 08MA005E constitutes an application for SoonerCare.

(4) If ~~Form~~ OKDHS form 08MA005E is received and an application cannot be completed, receipt of ~~Form~~ OKDHS form 08MA005E constitutes an application which must be registered and subsequently denied. The ~~member~~ applicant and provider are notified by computer-generated notice.

(5) If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the Medical Assistance Application form.

(b) **Date of application**. When an application is made online, the date of application is the date the application is submitted online. When application is made in the county office, the date of application is the date the applicant or someone acting on his/her behalf signs the application form. When the application is initiated outside the county office, the date of application is the date the application or ~~Form~~ OKDHS form 08MA005E is stamped into the ~~county office~~ OHCA Eligibility Unit. When an application is faxed, the application date is the date the fax is received. When a request for SoonerCare is first made by an oral request to the county office, and the application form is signed later, the date of the oral request is entered in "red" on the application form above the date the form is signed. The date of the oral request is the date of application to be ~~shown on the computer form~~ used. When ~~Form~~ OKDHS form 08MA005E is received in the county office or the OHCA Eligibility Unit prior to the completion of the application form, the date that ~~Form~~ OKDHS form 08MA005E is received is considered as the date of application and must be registered as an application. Certain providers may take applications and then forward them to the OKDHS county office or the OHCA Eligibility Unit for SoonerCare eligibility determination. Under this

circumstance, the application date is the date the member signed the application form for the provider.

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-60.1. Certification for the Family Planning Waiver Program.

The effective date of certification for the Family Planning Waiver Program is the ~~first day of the month~~ date of application or later. The period of certification may not be for a retroactive period. An individual determined eligible for the Family Planning Waiver Program is assigned a certification period of 12 months. At any time during the certification period the individual becomes ineligible, the case is closed using standard negative action procedures. At the end of the certification period, a redetermination of eligibility is required.

317:35-7-63. Notification of eligibility

When eligibility for ~~short-term medical care~~ SoonerCare is established, the ~~county office updates the computer form and~~ the appropriate notice is computer generated to the ~~client and provider~~ applicant. When the computer file is updated for changes, notices are generated only if there is a change in the~~ client's financial responsibility~~ SoonerCare eligibility of a household member.

317:35-7-64. Denials

If denial of ~~medical care~~ SoonerCare is for ~~an entire family case~~ the entire household, the ~~computer input form~~ application is ~~updated~~ denied and the appropriate notice is computer generated to the ~~client and provider~~ applicant. If an individual(s) is being denied but other family members are eligible, the ~~county provides the~~ denied individual(s) is provided with a notice ~~using the Notification of Eligibility Status for Medical Assistance form~~.

317:35-7-65. Closures

~~Short-term medical care~~ SoonerCare cases are closed ~~by the county~~ at any time during the certification period that the case becomes ineligible. A computer-generated notice is sent to the ~~client and the provider~~ head of the household. Otherwise, a case automatically closes at the end of the certification period if eligibility is not redetermined ~~with the exception of~~ except for children in the custody of ~~DHS~~ OKDHS who are placed outside their own home.

SUBCHAPTER 10. ~~MEDICAL AID TO FAMILIES WITH DEPENDENT CHILDREN~~ OTHER ELIGIBILITY FACTORS FOR FAMILIES WITH CHILDREN AND PREGNANT WOMEN

PART 5. INCOME

317:35-10-26. Income

(a) **General provisions regarding income.**

(1) The income of categorically needy individuals who are related to AFDC or Pregnancy does not require verification, unless questionable. If the income information is questionable, ~~the worker must verify the income~~ it must be verified. ~~The worker views all data exchange screens on all individuals included in the household size.~~ If ~~the data exchange screen reveals conflicting information, the worker must resolve the conflicting information and if necessary, request verification~~ there appears to be a

conflict in the information provided, the worker must investigate the situation to determine if income verification is necessary.

(2) All available income, except that required to be disregarded by law or OHCA's policy, is taken into consideration in determining need. Income is considered available both when actually available and when the applicant or member has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. When an individual's income is reduced due to recoupment of an overpayment or garnishment, the gross amount before the recoupment or garnishment is counted as income. The member is responsible for reporting all income, the source, amount and how often received.

(A) Income received on behalf of a member of the benefit group by another individual such as, but not limited to, a guardian or conservator, is considered available to the benefit group.

(B) Money received and used for the care and maintenance of a third party who is not included in the benefit group is not counted as income if it can be identified and verified as intended for third party use.

(C) If it appears any member of the benefit group or an individual whose income is considered when determining eligibility is eligible for any type of income or benefits, the benefit group must be notified in writing by the Oklahoma Department of Human Services (OKDHS). The notice must contain the information that failure to apply for and take all appropriate steps to obtain such benefits within 30 days from the date of the notice will result in a determination of ineligibility. An application for Supplemental Security Income (SSI) is not required.

(D) If the member and spouse are living together or they are living apart but there has not been a clear break in the family relationship, income received by either spouse and income received jointly is considered as family income. Income cannot be diverted to a household member who is not included in the household size for health benefits. Consideration is not given to a SSI recipient's income in computing eligibility for the AFDC or Pregnancy related unit.

(E) Income which can reasonably be anticipated to be received is considered to be available for the month its receipt is anticipated.

(F) Income produced from resources must be considered as unearned income.

(3) Income that must be verified is verified by the best available information such as pay stubs presented by the member or an interview with the employer. Pay stubs may only be used for verification if they have the member's name and/or social security number indicating that the pay stubs are in fact the member's wages. The stubs should also include the date(s) of the pay period and the amount of income before deductions. If this information is not included, employer verification is required. The worker verifies medical insurance which may be available at the same time that income is verified. When a member of the benefit group accepts employment and has not received any wages, verification (if necessary) of the amount of income to be considered and the anticipated date of receipt must be obtained from the employer. Income which is expected to be received during a month is considered available to the benefit group and is counted in determining eligibility for the month of receipt.

(4) Monies received in a lump sum from any source are considered income in the month received. Changing a resource from one form to another, such as converting personal property to cash, is not considered a lump sum payment. Exception: lump sum payments used to establish dedicated bank accounts by representative payees in order to receive and maintain retroactive SSI

benefits for disabled/blind children under age 18 are excluded as income. The interest income generated from dedicated bank accounts is also excluded.

(A) A nonrecurring lump sum payment considered as income includes payments based on accumulation of income and payments which may be considered windfall in nature and may include but are not limited to TANF grant diversion, VA or Social Security lump sum payments, inheritance, gifts, worker's compensation payments, cash winnings, personal injury awards, etc. Retirement benefits received in a lump-sum are considered as unearned income. A non-recurring lump sum SSI retroactive payment, made to an AFDC or pregnancy related recipient who is not currently eligible for SSI, is not counted as income.

(B) Lump sum payments (minus allowable deductions related to establishing the lump sum payment) which are received by AFDC/Pregnancy related individuals or applicants are considered as income. Allowable deductions are expenses earmarked in the settlement or award to be used for a specific purpose which may include, but are not limited to, attorney's fees and court costs that are identified in the lump sum settlement, medical or funeral expenses for the immediate family, etc. "Earmarked" means that such expense is specifically set forth in the settlement or award.

(C) When a lump sum is received by a stepparent not included in the household size, only the stepparent's contribution is considered in accordance with the stepparent's liability policy.

(D) When a third party reveals that a lump sum payment has been received or is expected to be received by the applicant or member, adverse action notification is given or mailed to the applicant/member and appropriate action taken.

(E) Recurring lump sum income received from any source for a period covering more than one month, that is received in a lump sum recurrently (such as annual rentals from surface or minerals, Windfall Profits tax refund, etc.) is prorated over a period of time it is intended to cover, beginning with the month of receipt of a lump sum payment.

(F) Net income from oil and gas production (gross minus production taxes withheld), received in varying amounts on a regular or irregular basis for the past six months, will be averaged and considered as income for the next six months. In instances where an applicant or a member receives new income from oil and gas production and verification for the past six months is not available, the worker accepts the available verification and averages over the period of time intended to cover. Net income may be verified by seeing the individual's production check stub, or by contacting the oil and gas company.

(5) Income that is based on the number of hours worked, as opposed to income based on regular monthly wages, must be computed as irregular income. The income received irregularly or in varying amounts will be averaged using the past two months to establish the amount to be anticipated and considered for prospective budgeting.

(6) A caretaker relative can only be included in the benefit group when the biological or adoptive parent is not in the home. A stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home.

(A) Consideration is not given to the income of the caretaker relative or the income of his or her spouse in determining the eligibility of the children regardless of whether the caretaker relative's needs are

or are not included. However, if that person is the stepparent, the policy on stepparent liability is applicable.

(B) If a caretaker relative is married and living with the spouse who is an SSI or SSP recipient, the spouse or spouse's income is not considered in determining the eligibility of the caretaker relative. The income of the caretaker relative and the spouse who is not an SSI or SSP recipient must be considered. Only one caretaker relative is eligible to be included in any one month.

(7) A stepparent can be included when the biological or adoptive parent is either incapacitated or not in the home. The income of the stepparent is counted if the stepparent's needs are being included.

(8) When there is a stepparent or person living in the home with the biological or adoptive parent who is not a spouse by legal marriage to or common-law relationship with the own parent, the worker determines the amount of income that will be made available to meet the needs of the child(ren) and the parent. Only contributions made in cash directly to the benefit group can be counted as income. In-kind contributions are disregarded as income. When the individual and the member state the individual does not make a cash contribution, further exploration is necessary. This statement can only be accepted after clarifying that the individual's contributions are only in-kind.

(b) **Earned income.** The term "earned income" refers to monies earned by an individual through the receipt of wages, salary, commission or profit from activities in which the individual is engaged as self-employed or as an employee. Payments made for accumulated annual leave/vacation leave, sick leave or as severance pay are considered as earned income whether paid during employment or at termination of employment. Temporary disability insurance payment(s) and temporary worker's compensation payments are considered as earned income if payments are employer funded and the individual remains employed. Income received as a one-time nonrecurring payment is considered as a lump sum payment. Earned income includes in-kind benefits received by an employee from an employer in lieu of wages or in conjunction with wages. An exchange of labor or services, e.g., barter, is considered as an in-kind benefit. Such benefits received in-kind are considered as earned income only when the employee/employer relationship has been established. Income from self-employment also includes in-kind benefits for a work activity or service for which the self-employed person ordinarily receives payment in the business enterprise. Medical insurance secured through the employer, whether purchased or as a benefit, is not considered in-kind income. Gross earned income is used to determine eligibility. Gross earned income is defined as the wage prior to payroll deductions and/or withholdings.

(1) **Earned income from self-employment.** If the income results from the individuals's activities primarily as a result of the individuals's own labor from the operation of a business enterprise, the "earned income" is the total profit after deducting the business expenses (cost of the production). Money from the sale of whole blood or blood plasma is also considered as self-employment income subject to necessary business expense and appropriate earned income exemptions.

(A) Allowable costs of producing self-employment income include, but are not limited to, the identifiable cost of labor, stock, raw material, seed and fertilizer, interest payments to purchase income-producing property, insurance premiums, and taxes paid on income-producing property.

(i) The federal or state income tax form for the most recent year is used for calculating the income only if it is representative of the individual's current situation. The individual's business

records beginning the month income became representative of the individual's current situation is used if the income tax information does not represent the individual's current situation.

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

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

(B) **Items not considered**. The following items are not considered as a cost of producing self-employed income:

(i) The purchase price and/or payments on the principal of loans for capital assets, equipment, machinery, and other durable goods;

(ii) Net losses from previous periods;

(iii) Depreciation of capital assets, equipment, machinery, and other durable goods; and

(iv) Federal, state and local income taxes, FICA, money set aside for retirement purposes, and other work related personal expenses, such as meals and necessary transportation. These expenses are accounted for by the work related expense deduction.

(C) **Room and/or board.** Earned income from a room rented in the home is determined by considering 25% of the gross amount received as a business expense. If the earned income includes payment for room and board, 50% of the gross amount received is considered as a business expense.

(D) **Rental property.** Income from rental property is to be considered income from self employment if none of the activities associated with renting the property is conducted by an outside-person or agency.

(2) **Earned income from wages, salary or commission.** If the income is from wages, salary or commission, the "earned income" is the gross income prior to payroll deductions and/or withholdings. Income from the Older American Community Service Employment Act (Title V), including AARP and Green Thumb organizations as well as employment positions allocated at the discretion of the Governor of Oklahoma, is counted as any other earned income.

(3) **Earned income from work and training programs.** Earned income from work and training programs such as the Job Training Partnership Act (JTPA) received by an adult as wages is considered as any other earned income. Also, JTPA earned income of a dependent child is considered when received in excess of six months in any calendar year.

(4) **Individual earned income exemptions.** Exemptions from each individual's earned income include a monthly standard work related expense and child care expenses the individual is responsible for paying. Expenses cannot be exempt if paid through state or federal funds or the care is not in a licensed facility or home. Exempt income is that income which by law may not be considered in determining need.

(A) **Work related expenses.** The standard deduction for work related expenses such as income tax payments, Social Security taxes, and transportation to and from work, is $240 per each full-time or part-time employed member of the benefit group.

(B) **Child care expenses.** Disregard of child care expense is applied after all other income disregards.

(i) Child care expense may be deducted when:

(I) suitable care for a child included in the benefit group is not available from responsible persons living in the home or through other alternate sources; and

(II) the employed member whose income is considered must purchase care.

(ii) ~~Child care expenses must be verified and the~~ The actual amount paid for child care per month, ~~as paid,~~ up to a maximum of $200 for a child under the age of two or $175 for a child age two or older may be deducted.

(iii) Oklahoma law requires all child care centers and homes be properly approved or licensed; therefore, child care expenses can only be deducted if the child is in a properly licensed facility or receiving care from an approved in-home provider.

(iv) Child care provided by another person in the household who is not a member of the benefit group may be considered as child care expenses as long as the home meets applicable standards of State, local or Tribal law.

(v) Documentation is made of the child care arrangement indicating the name of the child care facility or the name of the in-home provider, and the documentation used to verify the actual payment of child care per month.

(5) **Formula for determining the individual's net earned income.** Formulas used to determine net earned income to be considered are:

(A) **Net earned income from employment other than self-employment.** Gross Income minus work related expense minus child care expense equals net income.

(B) **Net earned income from self-employment.** Gross income minus allowable business expenses minus work related expense and child care expense equals net income.

(c) **Unearned income.**

(1) **Capital investments.** Proceeds, i.e., interest or dividends from capital investments, such as savings accounts, bonds (other than U.S. Savings Bonds, Series A through EE), notes, mortgages, etc., received constitute income.

(2) **Life estate and homestead rights.** Income from life estate or homestead rights, constitute income after deducting actual business expenses.

(3) **Minerals.** If the member owns mineral rights, only actual income from minerals, delayed rentals, or production is considered. Evidence is obtained from documents which the member has in hand. When the member has no documentary evidence of the amount of income, the evidence, if necessary, is secured from the firm or person who is making the payment.

(4) **Contributions.** Monetary contributions are considered as income except in instances where the contribution is not made directly to the member.

(5) **Retirement and disability benefits.** Income received monthly from retirement and disability benefits are considered as unearned income. Information as to receipt and amount of OASDI benefits is obtained, if necessary, from BENDEX, the member's award letter, or verification from SSA. Retirement benefits received as a lump sum payment at termination of employment are considered as income. Supplemental Security Income (SSI) does not fall under these types of benefits.

(6) **Unemployment benefits.** Unemployment benefits are considered as unearned income.

(7) **Military benefits.** Life insurance, pensions, compensation, servicemen dependents' allowances and the like, are all sources of income which the member and/or dependents may be eligible to receive. In each case under

consideration, information is obtained as to whether the member's son, daughter, husband or parent, has been in any military service. Clearance is made with the proper veterans' agency, both state and federal, to determine whether the benefits are available.

(8) **Casual and inconsequential gifts.** Monetary gifts which do not realistically represent income to meet living expenses, e.g., Christmas, graduation and birthday gifts, not to exceed $30 per calendar quarter for each individual, are disregarded as income. The amount of the gifts are disregarded as received during the quarter until the aggregate amount has reached $30. At that time the portion exceeding $30 is counted as lump sum income. If the amount of a single gift exceeds $30, it is not inconsequential and the total amount is therefore counted. If the member claims that the gift is intended for more than one person in the family unit, it is allowed to be divided. Gifts between members of the family unit are not counted.

(9) **Grants.** Grants which are not based on financial need are considered income.

(10) **Funds held in trust by Bureau of Indian Affairs (BIA).** The BIA frequently puts an individual's trust funds in an Individual Indian Money (IIM) account. To determine the availability of funds held in trust in an IIM account, the social worker must contact the BIA in writing and ascertain if the funds, in total or any portion, are available to the individual. If any portion of the funds is disbursed to the individual member, guardian or conservator, such funds are considered as available income. If the BIA determines the funds are not available, they are not considered. Funds held in trust by the BIA and not disbursed are considered unavailable.

(A) In some instances, BIA may determine the account is unavailable; however, they release a certain amount of funds each month to the individual. In this instance the monthly disbursement is considered as income.

(B) When the BIA has stated the account is unavailable and the account does not have a monthly disbursement plan, but a review reveals a recent history of disbursements to the individual member, guardian or conservator, these disbursements must be resolved with the BIA. These disbursements indicate all or a portion of the account may be available to the individual member, guardian or conservator.

(C) When disbursements have been made, the worker verifies whether such disbursements were made to the member or to a third party vendor in payment for goods or services. Payments made directly from the BIA to vendors are not considered as income to the member. Workers obtain documentation to verify services rendered and payment made by BIA.

(D) Amounts disbursed directly to the members are counted as non-recurring lump sum payments in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is counted in the month received.

(d) **Income disregards.** Income that is disregarded in determining eligibility includes:

(1) Food Stamp benefits;

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

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

(4) Loans (regardless of use) if a bona fide debt or obligation to pay can be established. Criteria to establish a loan as bona fide includes an acknowledgment of obligation to repay or evidence that the loan was from an individual or financial institution in the loan business. If the loan was from a person(s) not in the loan business, the borrower's acknowledgment of obligation to repay (with or without interest) is required to indicate that the loan is bona fide. If the loan agreement is not written, OKDHS Form 08AD103E, Loan Verification, should be completed by the borrower attesting that the loan is bona fide and signed by the lender verifying the date and amount of loan. When copies of written agreements or OKDHS Form 08AD103E are not available, detailed case documentation must include information that the loan is bona fide and how the debt amount and date of receipt was verified;
(5) Indian payments (including judgement funds or funds held in trust) which are distributed per capita by the Secretary of the Interior (BIA) or distributed by the tribe subject to approval by the Secretary of the Interior. Also, any interest or investment income accrued on such funds while held in trust or any purchases made with judgement funds, trust funds, interest or investment income accrued on such funds. Any income from mineral leases, from tribal business investments, etc., as long as the payments are paid per capita. For purposes of this paragraph, per capita is defined as each tribal member receiving an equal amount. However, any interest or income derived from the principal or produced by purchases made with the funds after distribution is considered as any other income;
(6) Special allowance for school expenses made available upon petition in writing from trust funds of the student;
(7) Benefits from State and Community Programs on Aging under Title III of the Older Americans Act of 1965 amended by PL 100-175 to become the Older Americans Act amendments of 1987;
(8) Unearned income received by a child, such as a needs based payment, cash assistance, compensation in lieu of wages, allowance, etc., from a program funded by the Job Training and Partnership Act (JTPA) including Job Corps income. Also, JTPA earned income received as wages, not to exceed six months in any calendar year;
(9) Payments for supportive services or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE);
(10) Payments to volunteers under the Domestic Volunteer Service Act of 1973 (VISTA), unless the gross amount of VISTA payments equals or exceeds the state or federal minimum wage, whichever is greater;
(11) The value of supplemental food assistance received under the Child Nutrition Act or the special food service program for children under the National School Lunch Act;
(12) Any portion of payments, made under the Alaska Native Claims Settlement Act to an Alaska Native, which are exempt from taxation under the Settlement Act;
(13) If an adult or child from the family group is living in the home and is receiving SSI, his/her individual income is considered by the Social Security Administration in determining eligibility for SSI. Therefore, that income cannot be considered as available to the benefit group;
(14) Experimental Housing Allowance Program (EHAP) payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;

(15) Earnings of a child who is a full-time student are disregarded;
(16) The first $50 of the current monthly child support paid by an absent parent. Only one disregard is allowed regardless of the number of parents paying or amounts paid. An additional disregard is allowed if payments for previous months were paid when due but not received until the current month;
(17) Government rental or housing subsidies by governmental agencies, e.g., HUD (received in-kind or in cash) for rent, mortgage payments or utilities;
(18) Reimbursements from an employer for out-of-pocket expenditures and allowances for travel or training to the extent the funds are used for expenses directly related to such travel or training, and uniform allowances if the uniform is uniquely identified with company name or logo;
(19) Low Income Home and Energy Assistance Program (LIHEAP) and Energy Crisis Assistance Program (ECAP) payments;
(20) Advance payments of Earned Income Tax Credit (EITC) or refunds of EITC as a result of filing a federal income tax return;
(21) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.);
(22) Payments made from the Radiation Exposure Compensation Trust Fund as compensation for injuries or deaths resulting from the exposure to radiation from nuclear testing and uranium mining;
(23) Federal major disaster and emergency assistance provided under the Disaster Relief Act of 1974, and comparable disaster assistance provided by states, local governments and disaster assistance organizations;
(24) Interests of individual Indians in trust or restricted lands;
(25) Income up to $2,000 per year received by individual Indians, which is derived from leases or other uses of individually-owned trust or restricted lands;
(26) Any home produce from garden, livestock and poultry utilized by the member and his/her household for their consumption (as distinguished from such produce sold or exchanged);
(27) Any payments made directly to a third party for the benefit of a member of the benefit group;
(28) Financial aid provided to individuals by agencies or organizations which base their payment on financial need;
(29) Assistance or services received from the Vocational Rehabilitation Program, such as transportation expenses to a rehabilitation center, extra clothing, lunches, grooming needed for a training program and an other such complimentary payments;
(30) Payments made by a public or private non-profit child care agency for a child placed in foster care or subsidized adoption;
(31) Payments made to certain Vietnam veterans' children with spina bifida (PL 104-214);
(32) Payments made to certain Korea service veterans' children with spina bifida (PL 108-183);
(33) Payments made to the children of women Vietnam veterans who suffer from certain birth defects (PL 106-419);
(34) Additional payments of regular unemployment compensation in the amount of $25 per week ending June 30, 2010 and any amount of emergency unemployment compensation paid through May 31, 2010, as authorized under the American Recovery and Reinvestment Tax Act of 2009; and
(35) Wages paid by the Census Bureau for temporary employment related to Census activities.

(e) In computing monthly income, cents will be carried at all steps until the monthly amount is determined and then will be rounded to the nearest dollar. These rounding procedures apply to each individual and each type of income. Income which is received monthly but in irregular amounts is averaged using two month's income, if possible, to determine income eligibility. Less than two month's income may be used when circumstances (e.g., new employment, unpaid sick leave, etc.) would indicate that previous income amounts would not be appropriate to use in determining future income amounts. Income received more often than monthly is converted to monthly amounts as follows:

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

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

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

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

SUBCHAPTER 22. PREGNANCY RELATED BENEFITS COVERED UNDER TITLE XXI

317:35-22-9. Notification of eligibility

When eligibility for the pregnancy benefits covered under Title XXI is established, the ~~OKDHS county office updates the computer form and the~~ appropriate notice is computer generated to the member.

317:35-22-11. Closures

~~Health benefit~~ SoonerCare cases are closed ~~by the OKDHS county office~~ at any time during the certification period that the ~~case~~ member becomes ineligible. A computer-generated notice is sent to the member.

8.b-5. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 63. Ambulatory Surgical Centers (ASC)
OAC 317:30-5-566. [AMENDED]
OAC 317:30-5-567. [AMENDED]
(Reference APA WF # 09-59)

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 Ambulatory Surgical Center (ASC) guidelines. Rules are revised to add flexibility in offering services already covered by SoonerCare in an ASC setting. These emergency rule revisions will make rules consistent with current insurance market practices and clarify access to healthcare for Oklahomans, thereby reducing confusion among SoonerCare providers and ultimately reducing the amount of uncompensated care provided by Oklahoma healthcare providers.

ANALYSIS: Ambulatory Surgery Center (ASC) rules are revised to allow reimbursement for services not covered as Medicare ASC procedures but otherwise covered under the SoonerCare program. Currently, policy restricts OHCA reimbursement to only those services on the Medicare approved list of covered services. This revision will give OHCA additional flexibility in determining services which are appropriate for the populations we serve.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, 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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Rules are revised to allow reimbursement for services not covered as Medicare Ambulatory Surgical Center (ASC) procedures but otherwise covered under the SoonerCare program.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 63. AMBULATORY SURGICAL CENTERS (ASC)

317:30-5-566. Ambulatory Surgery Center services

(a) **Reimbursement**. Reimbursement is made for selected services based on the Medicare approved list of covered services that can be performed at an ASC. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA. Ambulatory surgery center services are paid on a rate-per-service basis that varies according to the Health Care Procedure Coding System (HCPCS) codes. Separate payments may be made to the ASC for covered ancillary services. To be considered a covered ancillary service for which separate payment is made, the items and services must be provided integral to covered surgical procedures, that is, immediately before, during, or immediately after the covered surgical procedure.

(b) **Multiple surgeries**. Multiple procedures furnished during the same visit are discounted. The full amount is paid for the procedure with the highest payment rate. Fifty percent is paid for any other procedure(s) performed at the same time if the procedure is subject to discounting based on the discount indicator established by Medicare.

(c) **Payment indicators**. Payment indicators identify whether the service described by a HCPCS code is paid under the ASC methodology and if so, whether payment is made separately or packaged. SoonerCare follows Medicare's guidelines for packaged/bundled service costs.

(d) **Minor procedures.** Minor procedures that are normally performed in a physician's office are not covered in an ambulatory surgery center unless medically necessary and they are on the Medicare list for procedures approved to be performed in an ASC. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA.

(e) **Dental Procedures**. For OHCA payment purposes, the ASC list has been expanded to cover dental services for adults in an ICF/MR and all children.

(1) Non-emergency routine dental that is provided in an ambulatory surgery center is covered for children under the following circumstances:

(A) The child has a medical history of uncontrolled bleeding or other medical condition renders in-office treatment impossible.

(B) The child has uncontrollable behavior in the dental office even with premedication.

(C) The child needs extensive dental procedures or oral surgery procedures.

(2) Non-emergency routine dental that is provided in an ambulatory surgical center is covered for children and/or adults who are residents in ICFs/MR only under the following circumstances:

(A) A concurrent hazardous medical condition exists;

(B) The nature of the procedure requires hospitalization; or~~;~~

(C) Other factors (e.g. behavioral problems due to mental impairment) necessitate hospitalization.

317:30-5-567. Coverage by category

Payment is made for ambulatory surgical center services as set forth in this Section.

(1) **Children.** Payment is made for children for medically necessary surgical procedures which are included on ~~the~~ Medicare's list of covered ASC surgical procedures and dental procedures in certain circumstances. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA.

(A) Services, deemed medically necessary and allowable under federal regulations, may be covered by the EPSDT/OHCA Child Health program even though those services may not be part of the OHCA SoonerCare program. Such services must be prior authorized.

(B) Federal regulations also require the State to make the determination as to whether the service is medically necessary and do not require the provision of any items or services that the State determines are not safe and effective or which are considered experimental.

(2) **Adults.** Payment is made for adults for medically necessary surgical procedures which are included on Medicare's list of covered ASC surgical procedures. Services not covered as Medicare ASC procedures and otherwise covered under SoonerCare may be reimbursed as determined by the OHCA.

(3) **Individuals eligible For Part B of Medicare.** Payment is made utilizing the OHCA allowable for comparable services.

8.b-6. CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
Subchapter 5. Individual Providers and Specialties
Part 6. Inpatient Psychiatric Hospitals
OAC 317:30-5-96.3. [AMENDED]
(Reference APA WF # 09-61)

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 modify Inpatient Behavioral Rules to clarify reimbursement for acute inpatient psychiatric services provided in free-standing psychiatric hospitals. The modification more clearly defines reimbursement for ancillary and professional services outside of the per diem rate paid to the facilities.

ANALYSIS: Inpatient behavioral health rules are revised to more clearly define reimbursement methods for ancillary and professional services provided in inpatient psychiatric hospitals.

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

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on November 19, 2009, 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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
SoonerCare rules are revised to clarify reimbursement for acute inpatient psychiatric services provided in free-standing psychiatric hospitals. The modification more clearly defines reimbursement for ancillary and professional services outside of the per diem rate paid to the facilities.

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALITIES
PART 6. INPATIENT PSYCHIATRIC HOSPITALS

317:30-5-96.3. Methods of payment
(a) **Reimbursement.** Covered inpatient psychiatric and/or substance abuse services ~~rendered on or after October 1, 2005,~~ will be reimbursed using one of the following methodologies:
(1) Diagnosis Related Group (DRG);
(2) cost based; or
(3) a predetermined per diem payment.

(b) **Acute Level of Care.**

(1) Psychiatric units within general medical surgical hospitals and Critical Access hospitals. Payment will be made utilizing a DRG methodology. ~~[See OAC 317:30-5-41(1)(B)]~~ [See OAC 317:30-5-41(b)]. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the DRG paid to the hospital;

(2) Freestanding Psychiatric Hospitals ~~and Psychiatric Units within Rehabilitation Hospitals~~. A predetermined statewide per diem payment will be made for all facility services provided during the inpatient stay. Psychiatric professional (physicians and psychologists) services provided in conjunction with the inpatient stay are separately payable from the per diem paid to the hospital. Rates vary for public and private providers.

(c) **Psychiatric Residential Treatment Facility (PRTF).**

(1) **Instate Levels of Service.**

(A) Community-Based, extended. A pre-determined all-inclusive per diem payment will be made for routine, ancillary and professional services.

(B) Community-Based, transitional. A pre-determined per diem payment will be made for routine services. All other services are separately billable.

(C) Freestanding, Private. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services.

(D) Freestanding, Public. Facilities will be reimbursed using either the statewide or facility specific interim rates and settled to total allowable costs as determined by analyses of the cost reports (Form CMS 2552) filed with the OHCA.

(E) Provider based. A predetermined all-inclusive per diem payment will be made for routine, ancillary and professional services.

(2) **Out-of-state services.**

(A) Border and "border status" placements. Facilities are reimbursed in the same manner as in-state PRTFs.

(B) Out-of-state placements. In the event comparable services cannot be purchased from an Oklahoma facility and the current payment levels are insufficient to obtain access for the member, the OHCA may negotiate a predetermined, all-inclusive per diem rate for specialty programs/units and/or subacute services. An incremental payment adjustment may be made for 1:1 staffing (if clinically appropriate and prior authorized). Payment may be up to, but no greater, than usual and customary charges.

Agenda Item 9.a:
Prior Authorize Anti-Nausea Medications

Approval Criteria for granisetron (Kytril® and Sancuso®), dolasetron (Anzemet®), and aprepitant (Emend®):

- FDA Approved Diagnosis
- A recent trial of ondansetron that resulted in inadequate response.
- Existing quantity limits for these medications will apply.

Approval Criteria for cannabinoids (Marinol® and Cesamet®):

- Diagnosis of HIV related loss of appetite - approved
- For chemotherapy induced nausea and vomiting: A recent trial of ondansetron with inadequate response.
- A quantity limit of 60 units per 30 days will apply.