OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
April 8, 2010 at 1:00 P.M.
Oklahoma Health Care Authority
4545 N. Lincoln Blvd, Suite 124
Oklahoma City, OK

A G E N D A

Items to be presented by Lyle Roggow, Chairman

1. Call To Order/Determination of Quorum
2. Action Item – Approval of March 11, 2010 OHCA Board Minutes

Item to be presented by Mike Fogarty, Chief Executive Officer

3. Discussion Item – Presentation of All Star Employees for the following months:

   October, 2009 – Brandy Gutierrez, Provider Enrollment, (Supervisor) Peggy Hansen, presented by Nicole Nantois
   November, 2009 – Mari Kaufman, Insure Oklahoma, (Supervisor) Nicole Altobello, presented by Lynn Mitchell, M.D.
   December, 2009 – Loan Tran, Social Services Coordinator, Care Management, (Supervisor) Cheryl Moore, presented by Becky Pasternik-Ikard

Item to be presented by Mike Fogarty, Chief Executive Officer

4. Discussion Item – Chief Executive Officer's Report

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

Item to be presented by Chairman Roggow

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

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

Item to be presented by Nicole Nantois, Deputy General Counsel

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

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

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

a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of ***all Emergency Rules*** in accordance with 75 Okla. Stat. § 253.

b) Consideration and Vote Upon promulgation of ***Emergency Rules*** as follows:

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

7.b-2 AMENDING agency rules at OAC 317:30-5-275, 30-5-276 and 30-5-278, and ADDING agency rules at 30-5-280, 30-5-281, 30-5-282 and 30-5-283 to allow direct reimbursement to licensed masters level behavioral health professionals who, under current rules, are only allowed to provide services in agency settings. Allowing direct contracting with these providers will help increase specialist access, decrease use of Emergency Room (ER) and inpatient psychiatric care, and increase crisis intervention. This revision will also divert psychiatric residential treatment center usage due to Licensed Behavioral Health Practitioners (LBHPs) being more accessible throughout the state. Additionally, psychologist rules are revised to update provider requirements, terminology and to require prior authorization of services for all services provided except the initial assessment and/or crisis intervention.
(Reference APA WF # 10-15)

7.b-3 AMENDING agency rules at OAC 317:35-9-15 and 35-19-4 to remove policy directing Oklahoma Department of Human Services (OKDHS) to conduct the fair hearings in the estate recovery process for individuals in nursing facilities, Intermediate Care Facilities/Mentally Retarded (ICFs/MR) or other medical institutions. Current policy conflicts with the Agency's enabling statutes which provide that the OHCA shall conduct the hearings.
(Reference APA WF # 10-16)

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

8. Action Item - Consideration and Vote to authorize expenditure of funds for Radiology Management Services

Item to be presented by Buffy Heater, Manager of Planning and Development

9. Discussion Item – "Analysis of National Health Reform Legislation"

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.Moss v. Wittmer	CJ-08-506 (Creek County)
2.Wright v. OHCA	CJ-09-3924 (Oklahoma County)
3.Covalt v. OKDHS	CJ-08-85 (Grant County)
4.Daily v. OKDHS	09-1095 (US Supreme Court)
5.McAlary v. OHCA	106,308 (Okla. Supreme Court)
6.Morehead v. OKDHS	CJ-07-1110-L (Cleveland County)
7.PharmaCare v. OHCA	CJ-03-830 (Oklahoma County)

11. New Business

12. Adjournment

NEXT BOARD MEETING
May 13, 2010
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING OF THE OKLAHOMA HEALTH CARE AUTHORITY BOARD
March 11, 2010 at 1:00 P.M.
Held at Oklahoma Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on March 09, 2010.

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

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

OTHERS PRESENT:	OTHERS PRESENT:
John Holter, OPHA	Don Henderson, OPHA
Kevin Borley, Integris	Anne Anthony
Shari Murphree, OPHA	Steven Goodwin, Willowcrest
Becky Moore, OAHCP	Samantha Galloway, OKDHS
Nancy Kachel, PPAEO	Justin Martino eCapitol
Mark DeClerk, Lilly	Sandra Harrison, OKDHS
Nola Hill, SAH	Brent Wilborn, OKPCA
Rick Snyder, OHA	Marie Hailey, OHA
Maria Tucker, Abbott	April Wilkerson, Journal Record
Patti Davis	MHAT
Lanette Long, St Anthony	

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD FEBRUARY 11, 2010

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

MOTION: Member McVay moved for approval of the February 11, 2010 board minutes as presented. Vice Chairman Armstrong seconded.

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

ABSENT: Member McFall

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ITEM 3.a) FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported that revenues for OHCA through January, accounting for receivables, were **$2,114,498,276** or **.5% over** budget. Expenditures for OHCA through January, accounting for encumbrances, were **$1,957,853,892** or **.5% over** budget. Ms. Evans noted the state dollar budget variance through January is **$1,070,748 positive.** For detailed report, see Tab 3a of the board packet.

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

Expenditures:		
Medicaid Program Variance		(10.7)
Administration		2.4
Revenues:		
Taxes and Fees		3.2
Drug Rebate		3.5
Overpayments/Settlements		2.7
Total FY 10 Variance	**$**	**1 .1**

Ms. Evans said that out of the 3-5 runs for the month of March, all things are pointing to going over budget and will continue to monitor but at this time we could go over by $20-30 million for the month of March. Ms. Evans reported that we do have about $13 million in unbudgeted carryover and as of now we expect to be in the black through March.

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

Dr. Mitchell reported that the January enrollment numbers stand at 682,161 which is a 3000 increase of new members over the December numbers. The total of SoonerCare members that have not been enrolled in the past 6 months is 15,240. All SoonerCare Programs increased except the Oklahoma Cares Program which remains stable. Dr. Mitchell noted that Insure Oklahoma is at 30,552 with a decrease in the Employer Sponsored Insurance (ESI). She noted that CMS has been notified regarding the cap of the Insure Oklahoma Program. Dr. Mitchell reported that the College of Pharmacy Prior Authorizations remains consistent at 12-13,000 a month in spite of rising enrollment. She stated that the Drug Utilization Review Board met last night and takes all recommendations very seriously with concerns about the members.

ITEM 3.c) LEGISLATIVE UPDATE
Nico Gomez,

Mr. Gomez reported that after the February committee deadlines, and as of noon, Thursday, March 4th, 2010, the Oklahoma Legislature is

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currently tracking a total of 1,563 active bills. OHCA is currently tracking 100 bills. They are broken down as follows:

- OHCA Request 02
- Direct Impact 29
- Agency Interest 11
- Appropriations 11
- Employee Interest 12
- Carry Over 34
- Governor Signed 01

Mr. Gomez stated the SB 1349 – Obesity Treatment Pilot Program for Medicaid and SB 1836 - Health Information Infrastructure Advisory Board to Assist OHCA in Developing Electronic Health Record Incentive Payments are the OHCA 2 Request Bills. March 11, 2010, is the deadline for Third Reading of bills or joint resolutions in the House of Origin (House/Senate). The next deadlines are Thursday, April 1st for reporting House Bills and Joint Resolutions from Senate Committees and Thursday, April 8th for reporting Senate Bills and Joint Resolutions from House Committees.

Mr. Fogarty discussed the Board take home packet.

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

4.a)Audit/Finance Committee
Member Miller

Member Miller noted that he was privileged to see Mr. Fogarty give an informative presentation 2 weeks ago at the OU School of Social Work on Health Care Not Welfare.

Member Miller stated that he met with Ms. Evans and OHCA is financially in the positive but cash flow is still an issue. It appears that the month of February may be in the negative. The committee also met with Ms. Roberts and discussed the Quarterly Audit Report which will be presented to the board at a later date. There was some discussion regarding the HealthCare Reform Debate.

4.b)Legislative Committee
Member Langenkamp

Member Langenkamp stated the Legislative Committee did meet and Mr. Gomez discussed 29 bills and 3 particular bills of interests.

4.c)Rules Committee
Member Langenkamp

Member Langenkamp stated that the Rules Committee did meet and briefly discussed the upcoming rules to be presented by Ms. Roberts.

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4.d)Personnel Committee
Chairman Roggow

Mr. Roggow stated that the Personnel Committee was given information on the number of individuals who are qualified to retire under the voluntary buy out. He noted that 23 letters of intent have been signed with a possible of 15-18 employees accepting. Mr. Roggow said that OHCA is looking at covering the vacated positions within and no additional FTE's would be hired.

ITEM 5 - ANNOUNCEMENTS OF CONFLICTS OF INEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING
Howard Pallotta, General Counsel

Mr. Pallotta stated that the Conflicts of Interest Panel met with regard to action Items 6, 7, 8, and 9 and found no conflicts.

ITEM 6a - DISCUSSION ITEM/STATUS OF OKLAHOMA HEALTH CARE AUTHORITY BUDGET AFTER ACTION BY OKLAHOMA LEGISLATURE ON STATE FISCAL YEAR 2010 BUDGET
Mike Fogarty, Chief Executive Officer

Mr. Fogarty discussed the Part D claw back at the tier level matching rate of 73.76%. He noted that every $1.00 state funds spent will return $3.00 federal funds under current federal law. The matching rate will remain until December 2010 and under pending law will generate another $150 million if extended through December 2011. Mr. Fogarty discussed the actions that were taken at the February 11, 2010 board meeting and asked the board to rescind those actions. For details of those actions, see the February 11, 2010 board minutes.

6b–1. Rescission of Vote contained under Item 5, subsection 7(a&b) voted upon on February 11, 2010 to reduce Budget Work Program by $5,203,346.00

MOTION: Member Miller moved that the board rescind previous actions taken at the February 11, 2010 board meeting that would have been effective April 1, 2010. Member Langekamp seconded.

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

ABSENT: Member McFall

ITEM 7.a - CONSIDERATION AND VOTE TO REDUCE PROVIDER PAYMENTS FOR THE FOLLOWING CONTRACTED SERVICES
Cindy Roberts, Deputy Chief Executive Officer

Chairman Roggow recognized John Holter. Mr. Holter stated his appreciation for OHCA and asked that we take care of kids that can't take care of themselves. He contended that if the tiered reduction

takes place it will affect care given to state custody kids. Mr. Holter referred to the Mathematica study that he feels was a flawed study of behavior health services in Oklahoma. Mr. Holter noted that the tiered reimbursements is unnecessary and represents excessive reduction of service to a very vulnerable population.

Chairman Roggow recognized Anne Anthony representing Willow Crest Hospital in Miami. She said that her facility only operated with a 1.3% profit margin last year and could not absorb the costs and would have to close the doors of Willow Crest Hospital. Ms. Anthony reported that Willow Crest is dealing with children who are severely traumatized and damaged and "if we don't care about these kids, no one will". She asked that the Board reconsider the tiered system reduction.

Chairman Roggow recognized Kevin Burgess, CEO Shadow Mountain Behavioral Health System noted he had 440 employees and if the tiered reimbursement system is implemented, he could possibly have 50-60 employees lose their jobs. He stated that lack of access would increase the suicide rates in Oklahoma as much as 40-50%.

Chairman Roggow recognized Mike Kistler, CEO Riverside Behavioral Health System. Mr. Kistler asked the board to look again at the Oklahoma Mathematica report. He stated that the tiered system would have negative effect and would be detrimental to kids. He expressed concerns about the way the tiered system would look and what the cost savings per client per day would be.

Ms. Roberts stated that the State Plan Amendment Rate Committee met in a public hearing to hear rate recommendations from staff on Monday, March 8th. She then presented a broad overview of the recommended changes.

MOTION: Member Miller moved for approval of Item 7.a as presented. Vice Chairman Armstrong seconded.

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

ABSENT: Member McFall

ITEM 7.b - CONSIDERATION AND VOTE TO REDUCE THE CAPPED RENTAL OF DUDRABLE MEDICAL EQUIPMENT BY 10% OF THE JANUARY 1, 2010 PUBLISHED RATE
Cindy Roberts, Deputy Chief Executive Officer

Ms. Roberts stated that staff recommends reduction of the capped rental of Durable Medical Equipment by 10% of the January 1, 2010 published.

MOTION: Vice Chairman Armstrong moved for approval of Item 7.b as presented Member McVay seconded.

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

ABSENT: Member McFall

ITEM 7.c – CONSIDERATION AND VOTE TO ALTER METHOD FOR CALCULATION OF THE MAXIMUM ALLOWABLE COST (SMAC) FOR MULTIPLE SOURCE PHARMACY PRODUCTS
Cindy Roberts, Deputy Chief Executive Officer

Ms. Roberts reported that the Oklahoma Health Care Authority implemented a SMAC program in 2000 to determine the reimbursement level for multiple source products. Multiple source products are those which are marketed or sold by two or more manufacturers or which are sold by a single manufacturer under multiple names. Many states have opted to utilize market-based SMAC pricing under a formula developed by a contracted vendor. Ms. Roberts noted that this will protect the agency from inflated published pricing benchmarks and pharmacies are protected because the products must be available within the state to be used in the basis. The methodology is thought to be budget neutral.

MOTION: Member McVay moved for approval of Item 7.c as presented. Member Bryant seconded.

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

ABSENT: Member McFall

ITEM 7.d – CONSIDERATION AND VOTE TO AMEND THE REIMBURSEMENT METHODOLOGY FOR INPATIENT PSYCHIATRIC RESIDENTIAL TREATMENT SERVICE TO IMPLEMENT A TIERED REIMBURSEMENT SYSTEM
Cindy Roberts, Deputy Chief Executive Officer

Ms. Roberts stated that an additional methodology change is being proposed for these services. The OHCA is proposing recalculation of the current per diems along with a tiered reimbursement methodology that declines base on length of stay. These changes are being made in order to encourage discharge to more appropriate community alternatives than residential placement.

MOTION: Member Miller moved for approval of Item 7.d as presented. Vice Chairman Armstrong seconded.

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

ABSENT: Member McFall

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ITEM 8.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
Cindy Roberts, Deputy Chief Executive Officer

MOTION: Member Langenkamp moved for declaration of a compelling public interest for promulgation of all emergency rules as presented. Member McVay seconded.

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

ABSENT: Member McFall

ITEM 8.b) CONSIDERATION AND VOTE UPON PROMULGATION OF EMERGENCY RULES AS FOLLOWS:
Cindy Roberts, Deputy Chief Executive Officer

8.b-1 as published in meeting agenda.

MOTION: Vice Chairman Armstrong moved for approval of emergency rule 8.b-1 as presented. Member McVay seconded.

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

ABSENT: Member McFall

ITEM 8.c-1) CONSIDERATION AND VOTE UPON PERMANENT RULE THAT HAS PREVIOUSLY BEEN APPROVED BY THE BOARD AND HAS GUBERNATORIAL APPOVAL UNDER EMERGENCY RULEMAKING. THIS RULE HAS BE REVISED FOR PERMANENT RULEMAKING
Cindy Roberts, Deputy Chief Executive Officer

8.c-1 as published in meeting agenda.

MOTION: Member Langenkamp moved for approval rule 8.c-1 as presented. Member Bryant seconded.

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

ABSENT: Member McFall

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ITEM 8.c-2 thru 8.c-19) CONSIDERATION AND VOTE UPON PERMANENT RULES AS FOLLOWS:
Cindy Roberts, Deputy Chief Executive Officer

8.c-2 through 8.c-19 as published in meeting agenda.

MOTION:	Member Langenkamp moved for approval of rule 8.c-2 through 8.c-19 as presented. Member Miller seconded.
FOR THE MOTION:	Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, and Chairman Roggow
ABSENT:	Member McFall

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

8.c-20 through 8.c-21 as published in meeting agenda.

MOTION:	Member Miller moved for approval of rules 8.c-20 through 8.c-21 as presented. Vice Chairman Armstrong seconded.
FOR THE MOTION:	Vice-Chairman Armstrong, Member McVay, Member Bryant, Member Miller, Member Langenkamp, and Chairman Roggow
ABSENT:	Member McFall

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)
Howard Pallotta, Director of Legal Services

Chairman Roggow waived the executive session.

ITEM 11/NEW BUSINESS

Chairman Roggow called the meeting back into order. There was no new business up for discussion.

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ITEM 12/ADJOURNMENT

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

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FINANCIAL REPORT

For the Eight Months Ended February 28, 2010
Submitted to the CEO & Board
April 8, 2010

- Revenues for OHCA through February, accounting for receivables, were **$2,351,459,689** or **.3% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,209,269,038** or **.1% over** budget.
- The state dollar budget variance through February is **$1,562,129 positive.**
- The state dollar budget variance due to Medicare Part D Stimulus allocation is **$4,523,896 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(8.7)
Medicare Part D		4.5
Administration		3.2
Revenues:		
Taxes and Fees		3.0
Drug Rebate		1.4
Overpayments/Settlements		2.7
Total FY 10 Variance	**$**	**6.1**

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA	1
Medicaid Program Expenditures by Source of Funds	2
Other State Agencies Medicaid Payments	3
Fund 230: Quality of Care Fund Summary	4
Fund 245: Health Employee and Economy Act Revolving Fund	5
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund	6
Fund 255: OHCA Medicaid Program Fund	7

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2010, for the Eight Months Ended February 28, 2010

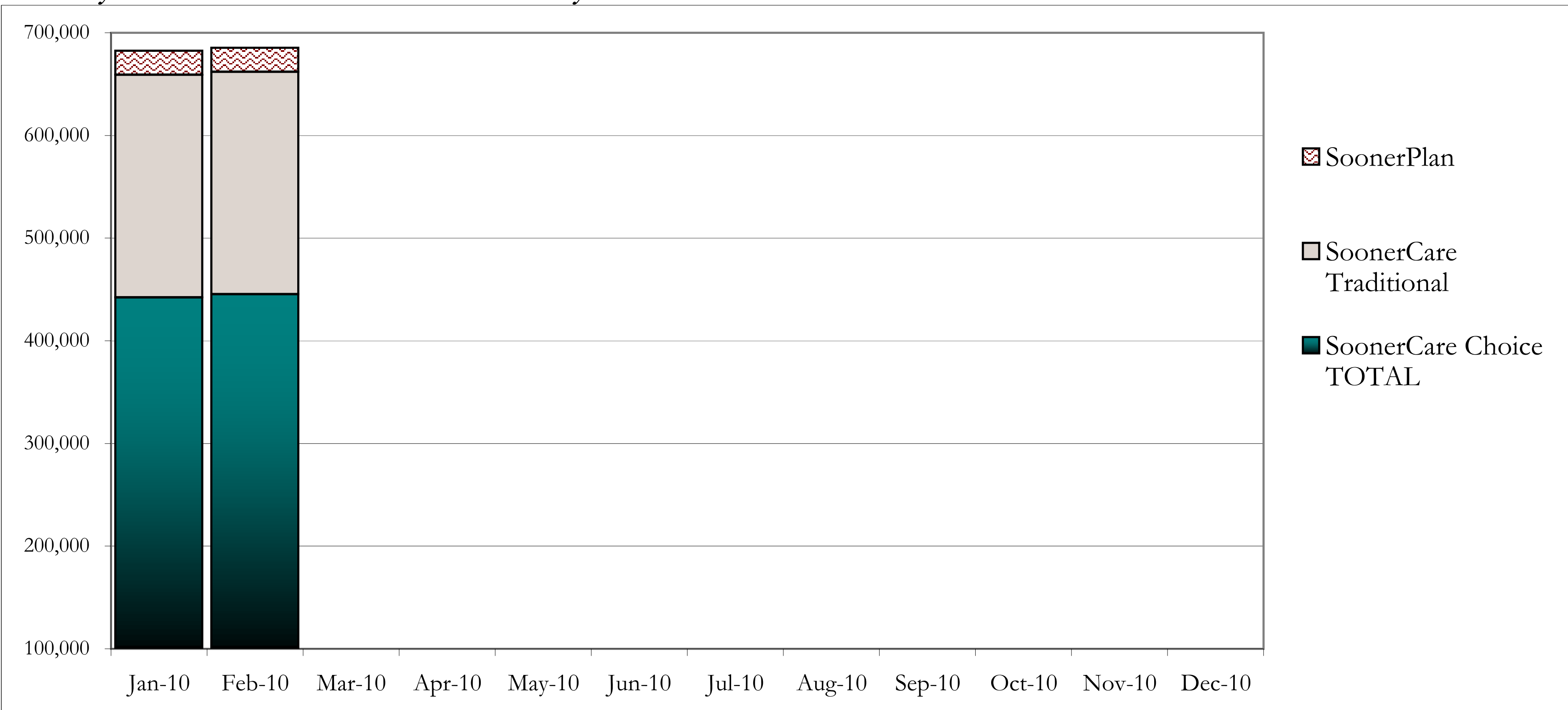
REVENUES	FY 09 Carryover	FY 10 Revenue	Total Revenue
Prior Year Balance	$ 37,974,903		$ 29,412,736
Tobacco Tax Collections	-	30,003,018	30,003,018
Interest Income	-	1,016,396	1,016,396
Federal Draws	-	21,010,255	21,010,255
All Kids Act	(8,000,000)		-
TOTAL REVENUES	**$ 29,974,903**	**$ 52,029,669**	**$ 81,442,406**

EXPENDITURES	FY 09 Expenditures	FY 10 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 32,443,511	$ 32,443,511
Individual Plan			
SoonerCare Choice		$ 219,918	$ 77,411
Inpatient Hospital		6,983,037	2,458,029
Outpatient Hospital		4,773,865	1,680,401
BH - Inpatient Services		9,263	3,260
BH - Rehabilitation Services		125,179	44,063
Physicians		7,342,586	2,584,590
Dentists		4,651	1,637
Other Practitioners		214,714	75,579
Home Health		60	21
Lab and Radiology		1,032,688	363,506
Medical Supplies		378,173	133,117
Ambulatory Clinics		788,197	277,445
Prescription Drugs		7,687,842	2,706,120
Premiums Collected			(3,208,273)
Total Individual Plan		**$ 29,560,173**	**$ 7,196,908**
College Students-Service Costs		**$ 130,844**	**$ 46,057**
Total Program Costs		**$ 62,134,528**	**$ 39,686,476**
Administrative Costs			
Salaries	$ 18,023	$ 833,836	$ 833,836
Operating Costs	289,025	430,118	430,118
Contract - HP	255,119	1,465,631	1,465,631
Total Administrative Costs	**$ 562,167**	**$ 2,729,585**	**$ 2,729,585**
Total Expenditures			**$ 42,416,061**
NET CASH BALANCE	**$ 29,412,736**		**$ 39,026,344**

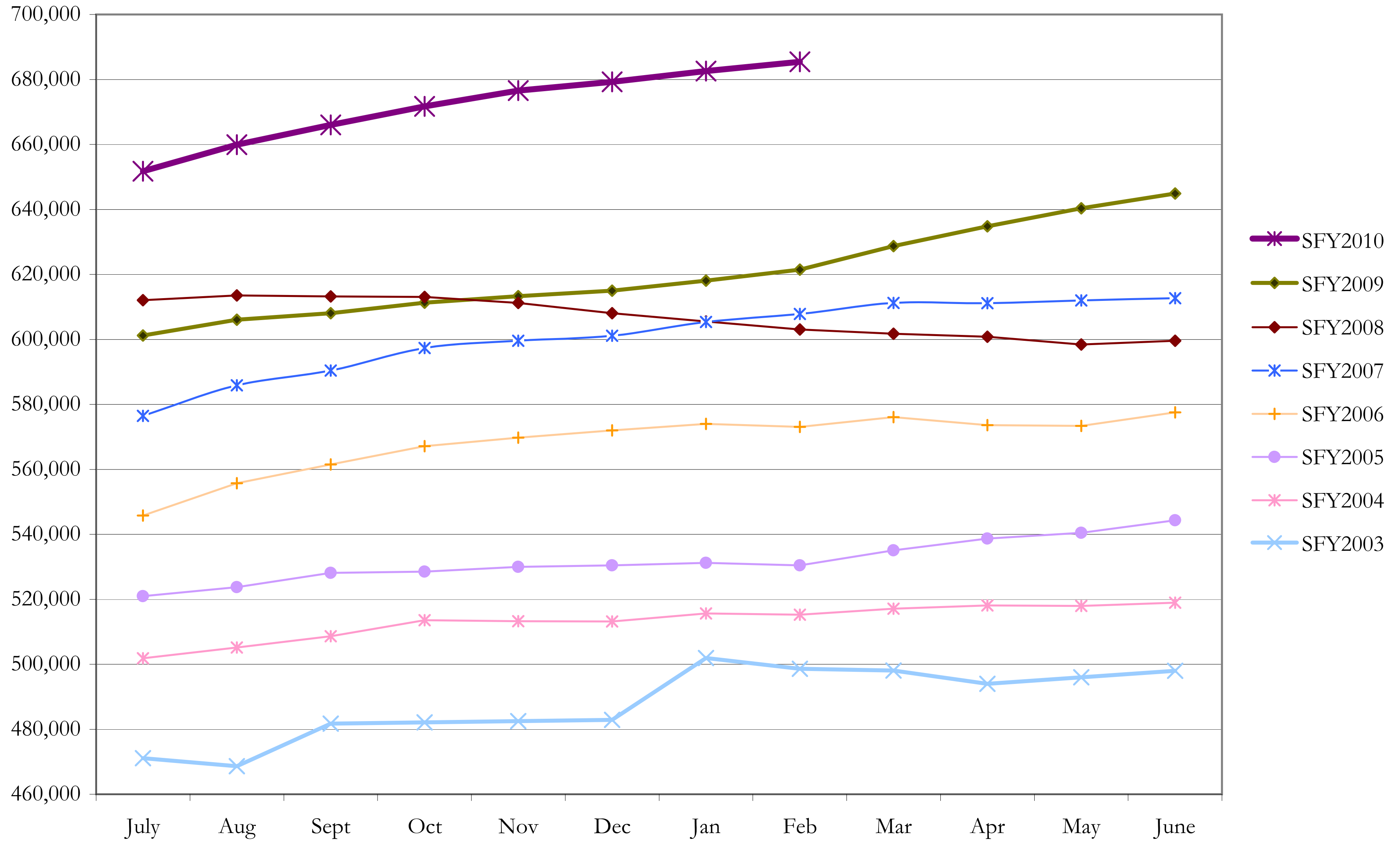
SOONERCARE ENROLLMENT CY-2010

	Jan-10	Feb-10	Mar-10	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Total MMs
ENROLLEES													
SoonerCare Choice													
Choice Total	428,704	431,677											860,381
IHS/Urban/Tribal Total	13,503	13,619											27,122
SoonerCare Choice TOTAL	442,207	445,296											887,503
SoonerCare Traditional	216,989	216,542											
SoonerPlan	23,420	23,607											47,027
TOTAL ENROLLEES	682,616	685,445											1,368,061
Average Monthly Enrollment													684,031

Monthly Actual SoonerCare Enrollment Trends by Benefit Plan



MMs = Member Months


OHCA SoonerCare Enrollment Figures
700,000
680,000
660,000
640,000
620,000
600,000
580,000
560,000
540,000
520,000
500,000
480,000
460,000
July
Aug
Sept
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
June
SFY2010
SFY2009
SFY2008
SFY2007
SFY2006
SFY2005
SFY2004
SFY2003

SoonerCare Programs

February 2010

Choice PCMH	February 2009	February 2010
TOTAL	408,099	445,296
American Indian Enrollees	11,559	13,619
Choice enrollees (enhanced PCMH)	396,540	431,677

Traditional	February 2009	February 2010
Members	196,093	216,542
SoonerCare Programs Total Unduplicated	621,482	685,445

Oklahoma Cares	February 2009	February 2010
Women currently enrolled	2,470	2,396
SoonerCare Traditional	1,835	1,679
SoonerCare Choice	635	717
Women ever-enrolled	18,689	22,572

Insure Oklahoma/ O-EPIC	February 2009	February 2010
IO Total Enrollees	16,818	30,314
IO Total Enrollees **(Male : Female)**	7,396 : 9,422	13,171 : 17,143
ESI Enrollees	11,205	18,877
IP Enrollees	5,613	11,437

TEFRA	February 2009	February 2010
Children enrolled	255	326
Male Enrollees	155	194
Female Enrollees	100	132
Ever-enrolled	332	427

SoonerPlan	February 2009	February 2010
Enrolled	17,290	23,607
Male enrollees	485	728
Female enrollees	16,805	22,879
Ever-enrolled	64,305	79,565

PROGRAM	SEPTEMBER 2009	OCTOBER 2009	NOVEMBER 2009	DECEMBER 2009	JANUARY 2010	FEBRUARY 2010
Choice PCMH	422,926	423,288	432,068	438,276	442,207	445,296
Traditional	221,392	225,914	221,734	217,945	216,989	216,542
Oklahoma Cares	2,651	2,466	2,481	2,373	2,307	2,396
TEFRA	297	307	313	320	325	326
SoonerPlan	21,724	22,498	22,788	23,073	23,420	23,607
Soon to be Sooners	3,132	3,103	3,041	2,979	2,955	2,993
SoonerCare Programs Total Unduplicated	**666,042**	**671,700**	**676,590**	**679,294**	**682,616**	**685,445**
Insure Oklahoma ESI	17,012	17,344	17,882	18,133	18,521	18,877
Insure Oklahoma IP	9,344	9,756	10,146	10,825	11,100	11,437
Insure Oklahoma Programs Total **Unduplicated**	**26,356**	**27,100**	**28,028**	**28,958**	**29,621**	**30,314**
Programs Total	**692,398**	**698,800**	**704,618**	**708,252**	**712,237**	**715,759**

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SoonerCare Fast Facts

February 2010

TOTAL ENROLLMENT —
OKLAHOMA SOONERCARE (MEDICAID)

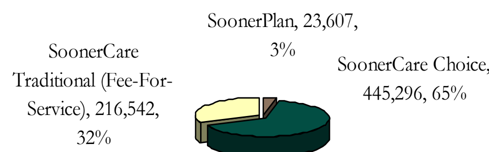
Qualifying Group	Age Group	Enrollment	% of Total
Aged/Blind/Disabled	Child	17,941	2.62%
Aged/Blind/Disabled	Adult	125,015	18.24%
Children/Parents	Child	452,697	66.04%
Children/Parents	Adult	45,284	6.61%
Other	Child	517	0.08%
Other	Adult	17,662	2.58%
Oklahoma Cares (Breast & Cervical Cancer)		2,396	0.35%
SoonerPlan (Family Planning)		23,607	3.44%
TEFRA		326	0.05%

Total Enrollment	685,445	Adults	210,876	31%
		Children	474,569	69%

OTHER Group includes—Child custody-Refugee-Qualified Medicare Beneficiary-SLMB-DDSD Supported Living-Program of All Inclusive 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) — **821,920**

Other Breakdowns of Total Enrollment

Oklahoma SoonerCare (Medicaid) members residing in a long-term care facility — **15,814**

Oklahoma persons enrolled in both Medicare and Medicaid (dual eligibles) — **100,379**

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
5,630	18,877	11,437

New Enrollees

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

Adults	6,130
Children	8,168
Total	**14,298**

Race Breakdown of Total Enrollment

	Children	Adults	Percent	Pregnant Women
American Indian	60,638	19,818	12%	2,781
Asian or Pacific Islander	6,810	2,802	1%	568
Black or African American	69,352	29,240	14%	2,401
Caucasian	324,044	156,720	70%	18,447
Multiple Races	13,725	2,296	2%	631
Hispanic Ethnicity	74,611	10,701	12%	4,694

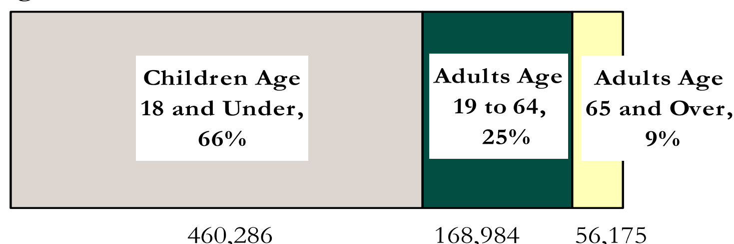
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

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		2,993
INFANT	150% to 185%	1,443
01-05	133% to 185%	11,434
06-12	100% to 185%	32,883
13-18	100% to 185%	20,674
Total		**69,427**

Age Breakdown of Total Enrollment

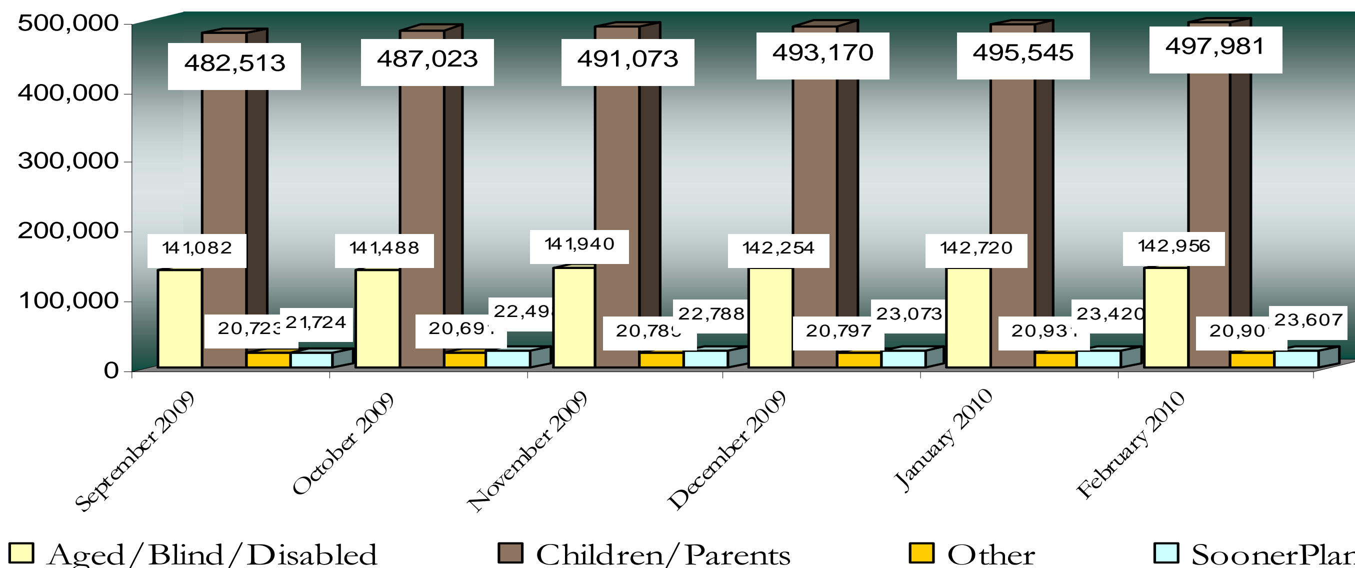


Data was compiled on 3/16/2010. Numbers frequently change due to certifications occurring after the data is extracted and other factors. This report is based on data within the system prior to 3/16/2010. A majority of the data is a "point in time" representation of the specific report month and is not cumulative. Unless stated otherwise, CHILD is defined as an individual under the age of 21.

SoonerCare Fast Facts

February 2010

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.

Have you seen our other Fast Facts?

OHCA generates and distributes all kinds of summary information about our members, providers, dollars and services. The majority of our fast facts are produced after the second Sunday of each month. Some of the additional fast facts we produce are: SoonerCare Children, Provider, Family Planning, Dental, Delivieries, and Insure Oklahoma. To view these and other fast facts, please visit: www.okhca.org/research/data

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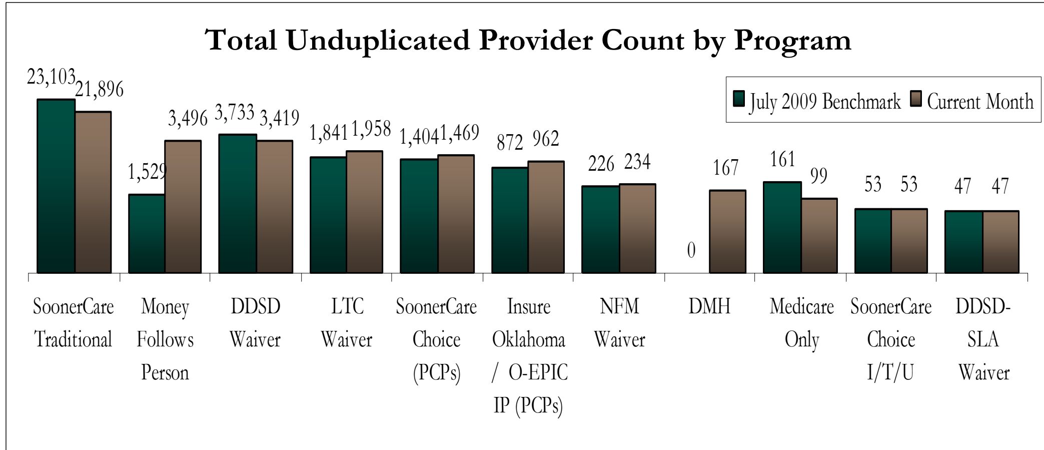
Oklahoma Health Care Authority

Provider Fast Facts

February 2010

Total Unduplicated Provider Count
27,697

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



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
416

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	1,044,677	41.13%
SoonerCare Choice I/T/U	116,150	11.89%
Insure Oklahoma/O-EPIC IP	327,153	3.62%

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

DMH - Department of Mental Health

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

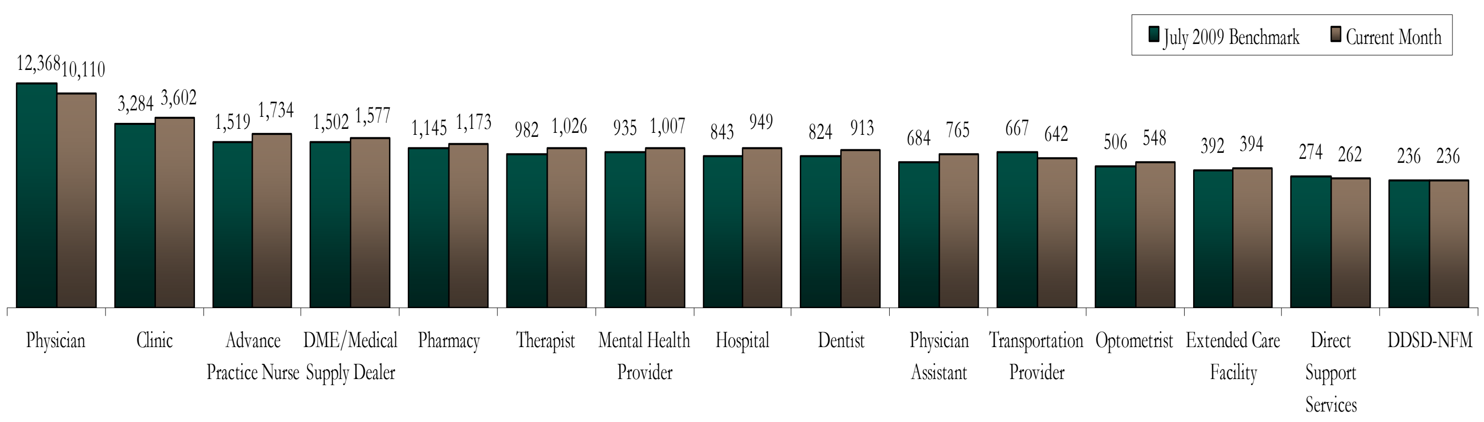
PCMH - Patient-Centered Medical Home

PCP - Primary Care Provider

PCMH Enrollment by Tier

Payment Tier Code	Count
Tier 1	492
Tier 2	231
Tier 3	47

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



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

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Provider Fast Facts

February 2010

Cimarron 1 1
Texas 5 3
Beaver 5 5
Harper 4 3
Woods 4 5
Alfalfa 2 2
Grant 6 6
Kay 17 14
Osage 14 12
Washington 16 11
Nowata 7 8
Craig 12 9
Ottawa 7 6
Ellis 0 1
Woodward 5 3
Major 6 6
Garfield 19 13
Noble 1 0
Pawnee 7 7
Tulsa 337 171
Rogers 3 5
Mayes 13 14
Delaware 22 5
Dewey 0 0
Blaine 15 14
Kingfisher 7 8
Logan 13 11
Payne 30 5
Creek 23 16
Wagoner 18 18
Cherokee 18 17
Adair 7 9
Roger Mills 3 3
Custer 15 13
Canadian 36 23
Oklahoma 297 165
Lincoln 9 9
Okmulgee 15 12
Muskogee 16 8
Sequoyah 6 5
Beckham 16 15
Washita 2 1
Caddo 20 22
Grady 33 26
Cleveland 64 43
McClain 37 10
Pottawatomie 36 29
Okfuskee 3 5
Seminole 13 14
Hughes 2 2
McIntosh 3 3
Haskell 2 3
LeFlore 23 16
Pittsburg 13 8
Latimer 4 3
Greer 6 6
Harmon 3 3
Kiowa 3 3
Jackson 15 6
Comanche 26 21
Tillman 15 16
Cotton 1 1
Stephens 29 27
Garvin 8 8
Pontotoc 17 17
Coal 3 3
Murray 2 1
Carter 14 9
Jefferson 8 7
Love 7 0
Johnston 7 8
Marshall 4 4
Atoka 8 8
Pushmataha 20 20
Bryan 25 17
Choctaw 13 13
McCurtain 10 4

Total Provider Count

- 4,000 to 6,000 (2)
- 300 to 1,000 (8)
- 150 to 300 (16)
- 50 to 150 (28)
- 0 to 50 (23)

Primary Care Providers (PCPs)

- SoonerCare Choice PCPs
- Insure Oklahoma IP PCPs

03/16/2010

Insure Oklahoma

Fast Facts

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

April 2010

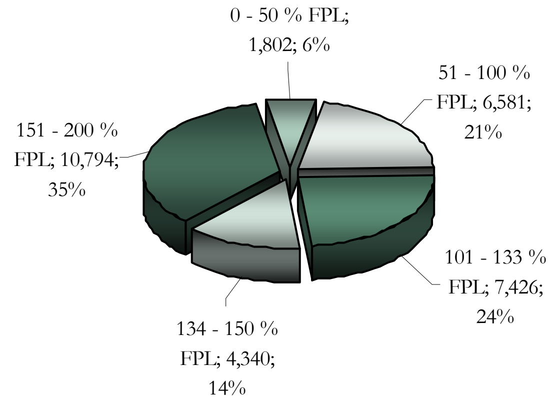
Insure Oklahoma is an innovative program Oklahoma has created to bridge the gap in the health care coverage for low-income working adults. Under the Employer-Sponsored Insurance (ESI) program, premium costs are shared by the state (60 percent), the employer (25 percent) and the employee (15 percent). 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

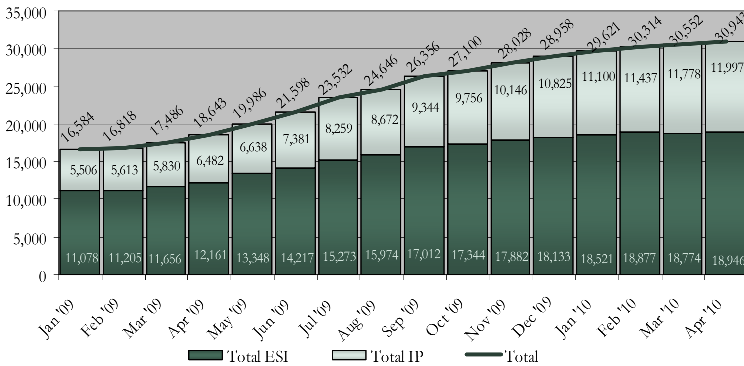
Qualifying Enrollment		Enrollment	% of Total
Employer Sponsored Insurance (ESI)	Employee	15,821	51.13%
Employer Sponsored Insurance (ESI)	Spouse	3,068	9.92%
Individual Plan (IP)	Employee	9,053	29.26%
Individual Plan (IP)	Spouse	2,765	8.94%
Student (ESI)	---	57	0.18%
Student (IP)	---	179	0.58%
Businesses	---	5,596	---
Carriers / HealthPlans	---	20 / 474	---
Primary Care Physician	---	983	---

Total Enrollment	30,943	ESI	18,946	61%
		IP	11,997	39%

Federal Poverty Level Breakdown of Total Enrollment



Total Insure Oklahoma Member Monthly Enrollment



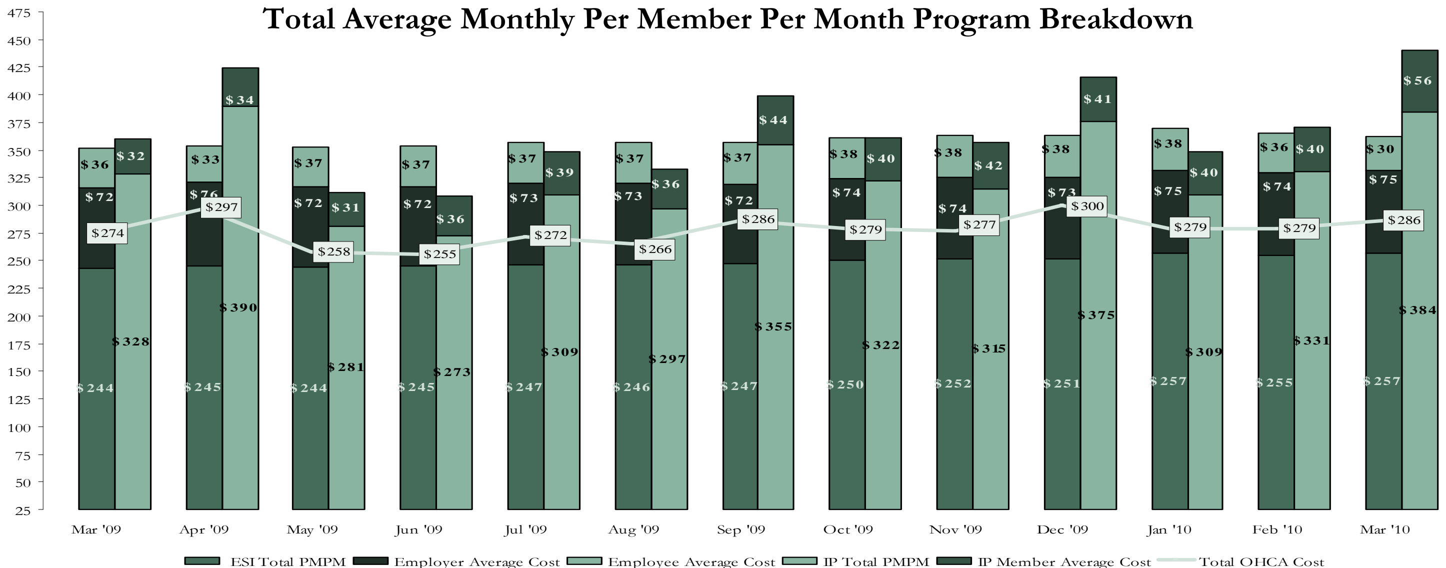
Currently Enrolled		Up from Previous Year
Businesses	5,596	36%
ESI Enrollees	18,946	63%
IP Enrollees	11,997	106%

ESI & IP Enrollee totals include Students.

Latest Monthly Marketing Statistics	
Web Hits on InsureOklahoma.org	44,328
Call Center - Calls Answered	15,729

Call Center count now includes OHCA calls.
March 2010 Fast Facts was missing Employer Calls should have been 15,225.

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.)

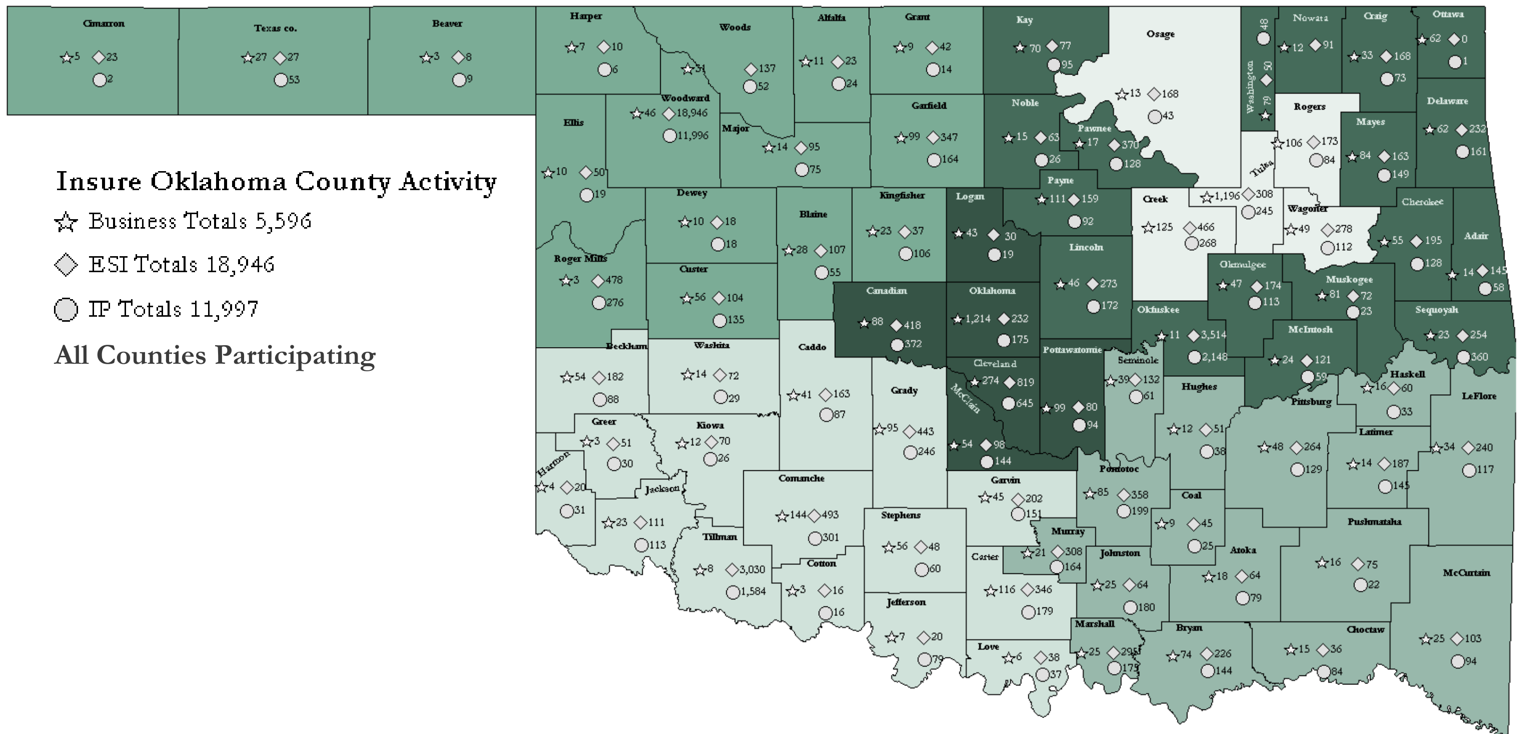
Insure Oklahoma

Fast Facts

April 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

April 2010

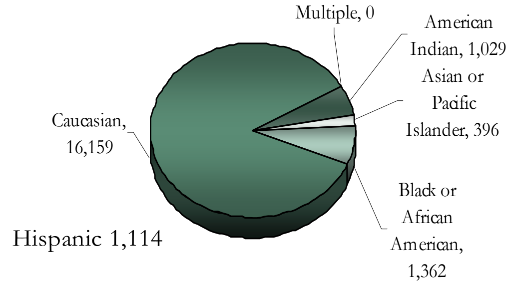
Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

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			Breakdown of Current Enrollment: Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	7,670	8,151	**15,821**	466	440	**906**	892	762	**1,654**
Spouse	808	2,260	**3,068**	52	119	**171**	95	247	**342**
Student	29	28	**57**	3	1	**4**	2	1	**3**
Total	8,507	10,439	**18,946**	521	560	**1,081**	989	1,010	**1,999**

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

Race Breakdown of ESI Members



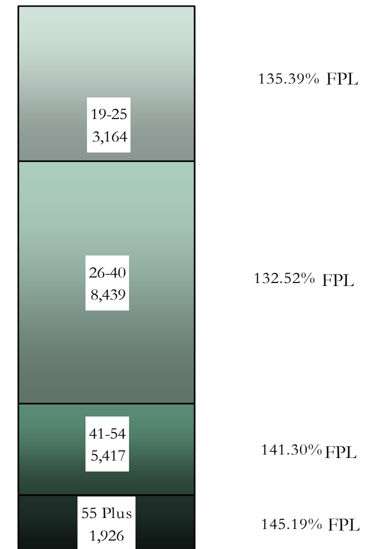
Hispanic 1,114

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.

Business Activity with Employee Participation Counts				
	0 to 25	**26 to 50**	**51 to 100**	**Total**
Current	4,516	593	371	**5,480**
New	94	17	5	**116**
Total	**4,610**	**610**	**376**	**5,596**

Some approved businesses may not have approved employees.

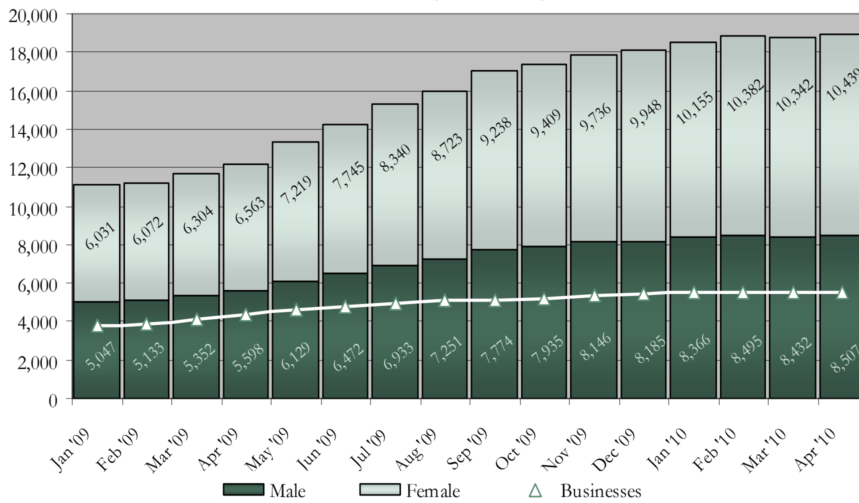
Age Breakdown with Average Federal Poverty Level of ESI Members



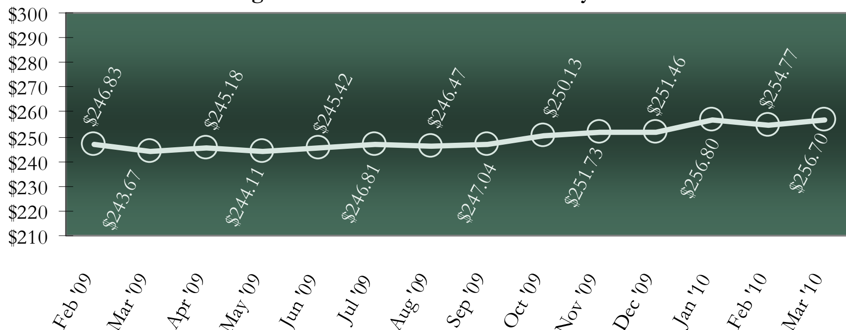
135.39% FPL
132.52% FPL
141.30% FPL
145.19% FPL

Federal Poverty Level is used to determine income qualification.

Member and Employer Monthly Enrollment



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	631	2,445	16 of 16
Region 2	382	1,114	16 of 16
Region 3	1,772	5,545	6 of 6
Region 4	1,489	4,456	5 of 5
Region 5	846	3,593	18 of 18
Region 6	476	1,793	16 of 16
Total	**5,596**	**18,946**	**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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4/7/2010

Individual Plan (IP)

Fast Facts

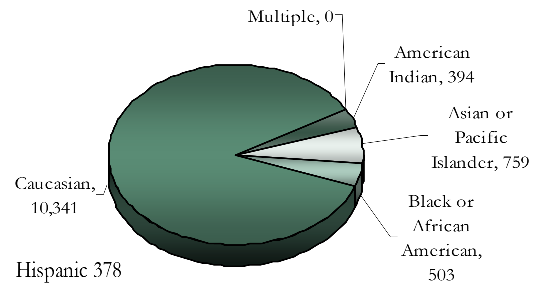
Business, insurance, state government and you Working Together to ***Insure Oklahoma!***

April 2010

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			Breakdown of Current Enrollment: Expanded 185 to 200% FPL*		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Employee	4,212	4,841	**9,053**	151	198	**349**	334	312	**646**
Spouse	616	2,149	**2,765**	35	59	**94**	56	170	**226**
Student	72	107	**179**	2	1	**3**	7	5	**12**
Total	4,900	7,097	**11,997**	186	257	**446**	390	482	**884**

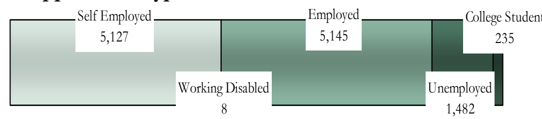
Race Breakdown of IP Members



Hispanic 378

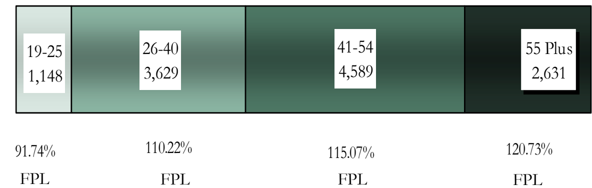
Race is self-reported by members at the time of enrollment. The multiple race members have selected two or more races. Hispanic is an ethnicity not a race. Hispanics can be of any race and are accounted for in a race category above.

IP Application Type Breakdown



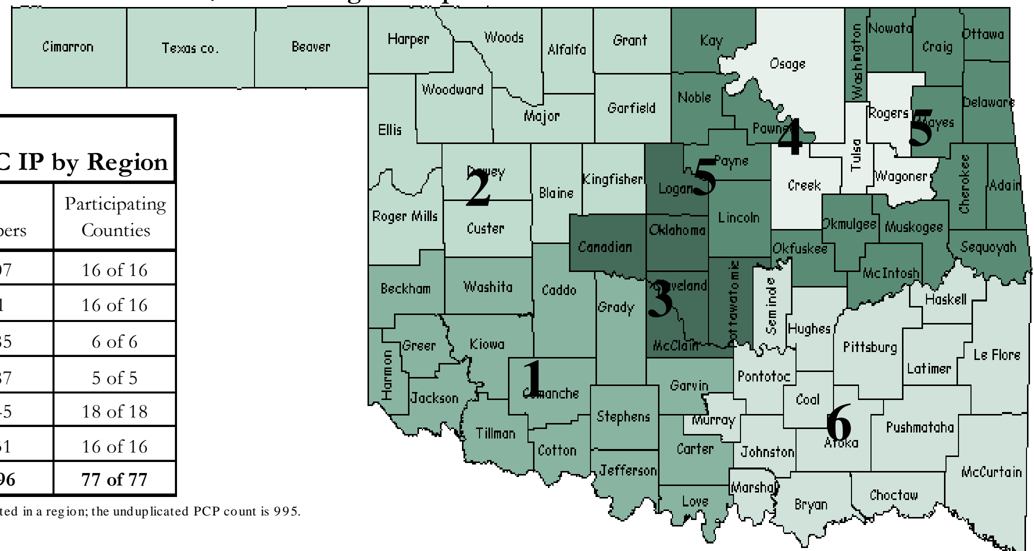
Unduplicated Counts	
IP Members SFY2010 (July 2009 - Current)	15,923
IP Members Since Program Inception March 2007	18,733
Miscellaneous	
Average IP Member Premium	$55.20
Average Federal Poverty Level of IP Members	112.60%
Federal Poverty Level is used to determine income qualification.	

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



91.74% FPL | 110.22% FPL | 115.07% FPL | 120.73% FPL

Insure Oklahoma/OEPIC Region Map



Insure Oklahoma/OEPIC IP by Region

	PCP	Participating Counties	Members	Participating Counties
Region 1	141	15 of 16	1,907	16 of 16
Region 2	82	15 of 16	741	16 of 16
Region 3	254	6 of 6	3,685	6 of 6
Region 4	227	5 of 5	2,487	5 of 5
Region 5	147	17 of 18	1,745	18 of 18
Region 6	132	16 of 16	1,431	16 of 16
Total	**983**	**74 of 77**	**11,996**	**77 of 77**

PCPs maybe counted in multiple regions or out of state and not counted in a region; the unduplicated PCP count is 995.

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4/7/2010

Program of All-Inclusive Care for the Elderly (PACE)
Fast Facts
February 2010

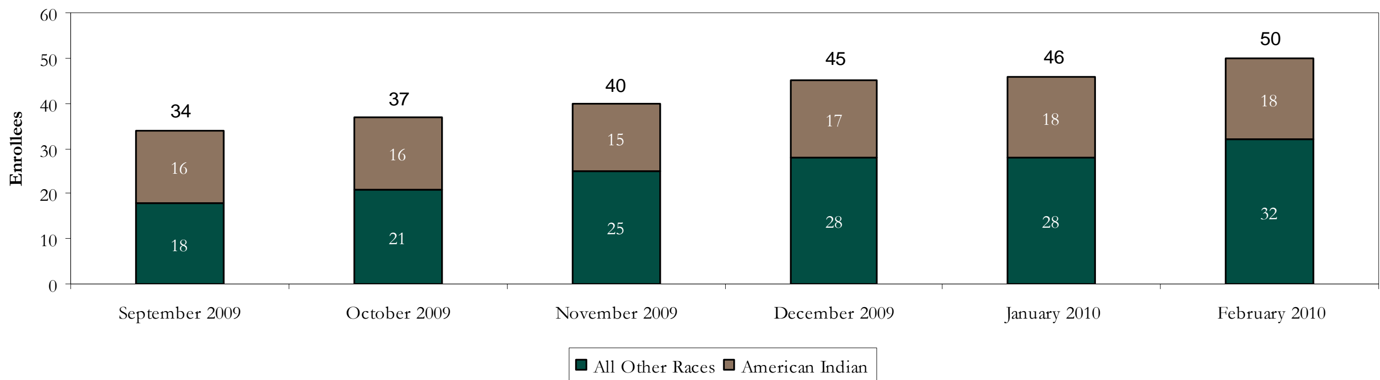
Program of All-Inclusive Care for the Elderly (PACE) is a unique, capitated, one-stop, home and community-based program. PACE provides an array of necessary medical and social services for the frail and elderly within the home or at the Cherokee Elder Care Center in Tahlequah. It is the first Native American sponsored program in the United States and is available to those living within specific Zip Codes of Cherokee, Mayes, Delaware, Muskogee, and Adair counties. Moreover, one must be 55 years of age or older, qualify for state nursing home level of care, be safely cared for in a community setting and meet the financial qualifications for SoonerCare .

PACE programs assume full financial risk for each member's care without limits on dollars or duration and are responsible for a full range of needed services. PACE is a permanent provider under the Medicare program and a state option under the SoonerCare program.

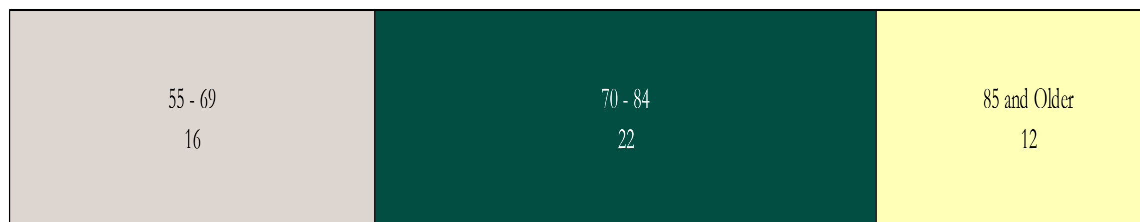
PACE Enrollment	
Gender	Total Currently Enrolled
Male	17
Female	33
Total	**50**

Breakdown of Current Enrollment		
Gender	Continued Enrollment from Previous Month	New Enrollment This Month
Male	16	1
Female	30	3
Total	**46**	**4**

Total PACE Enrollment and Race Groupings



Age Breakdown of Total PACE Enrollment



Unduplicated Count of Members SFY2010 (July 2009 - Current)	**55**
Unduplicated Count of Members Since Program Inception August 2008	**59**

Capitation Payment Information	
Capitation Rate per SoonerCare Member	**$3,444.39**
Capitation Rate per Dual Member	**$2,736.63**
Total Payments Since Program Inception August 2008	**$1,273,005.00**

(A Dual member is a member enrolled in both Medicare and SoonerCare)

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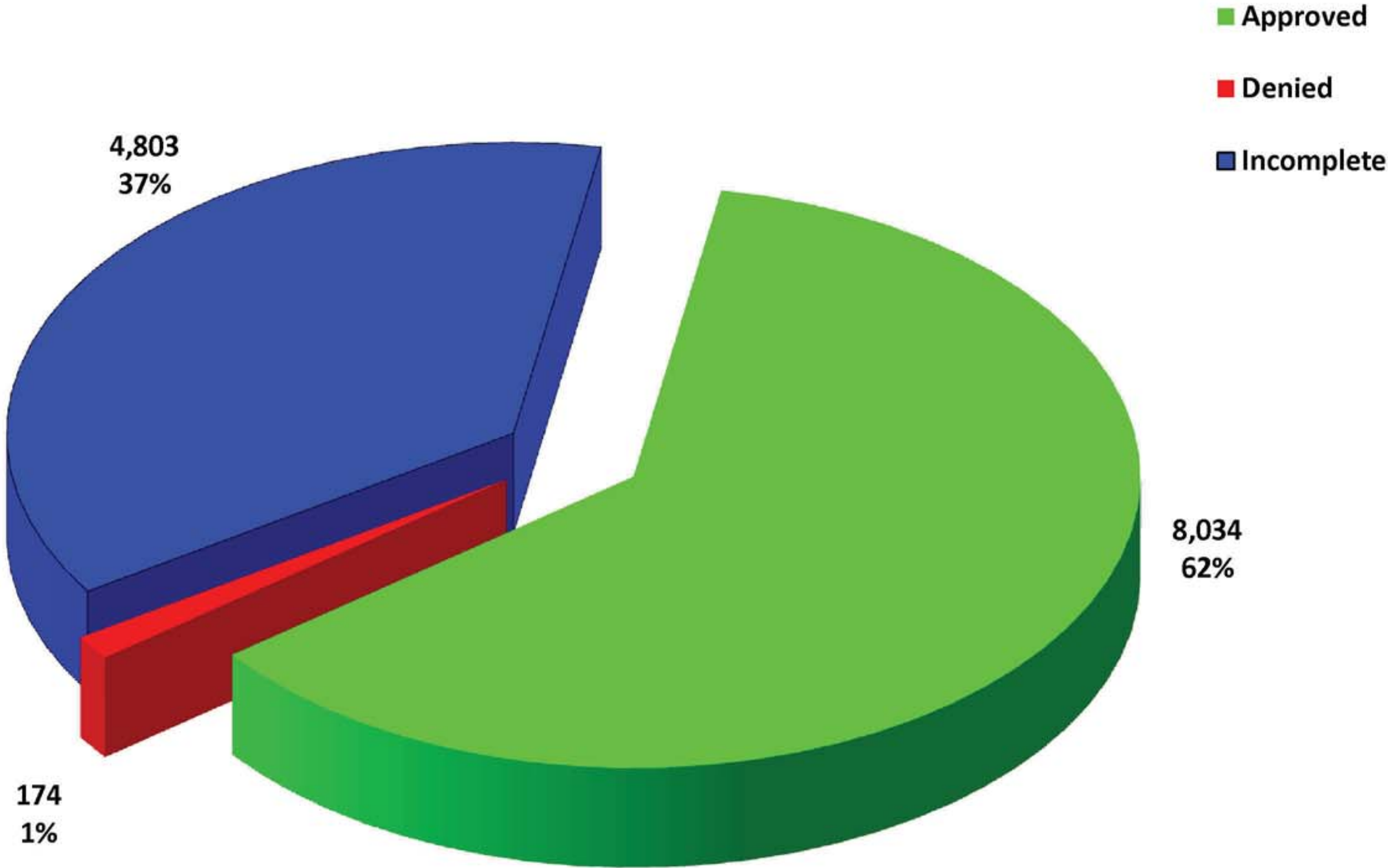
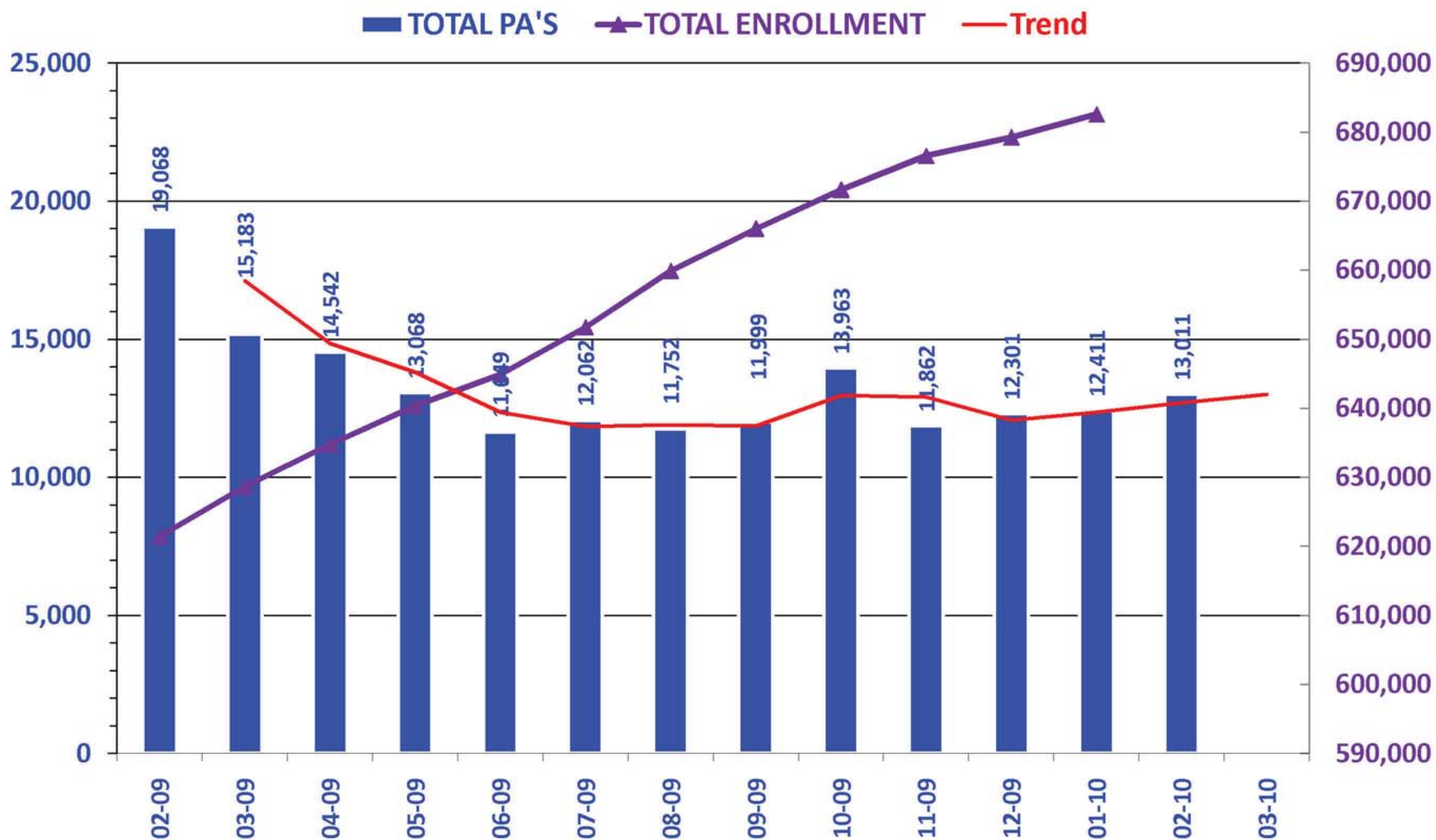
3/16/2010

PRIOR AUTHORIZATION ACTIVITY REPORT: February 2010



PA totals include overrides

PRIOR AUTHORIZATION REPORT: February 2009 – February 2010



PA totals include overrides

Prior Authorization Activity

February 2010

	Total	Approved	Denied	Incomplete	Average Length of Approvals in Days
Advair/Symbicort	517	270	2	245	357
Amitiza	25	9	0	16	269
Antidepressant	417	125	1	291	340
Antihistamine	323	172	0	151	286
Antihypertensives	139	53	0	86	338
Antimigraine	132	24	0	108	199
Benzodiazepines	4,577	3,985	11	581	89
Bladder Control	90	17	4	69	339
Byetta	13	2	0	11	364
Elidel/Protopic	40	23	1	16	88
ESA	156	120	2	34	56
Fibric Acid Derivatives	7	0	0	7	0
Fibromyalgia	170	60	3	107	334
Forteo	5	2	0	3	353
Glaucoma	29	6	0	23	362
Growth Hormones	44	36	3	5	155
HFA Rescue Inhalers	92	43	0	49	276
Insomnia	120	30	2	88	126
Misc Analgesics	56	10	19	27	144
Muscle Relaxant	187	72	54	61	46
Nasal Allergy	449	50	2	397	170
NSAIDS	167	39	6	122	218
Nucynta	3	2	0	1	47
Ocular Allergy	16	1	0	15	364
Ocular Antibiotics	24	7	0	17	13
Opioid Analgesic	184	85	4	95	171
Other	564	240	17	307	139
Otic Antibiotic	165	64	0	101	24
Pediculicides	77	29	2	46	17
Plavix	123	99	0	24	360
Proton Pump Inhibitors	641	98	4	539	98
Qualaquin (Quinine)	2	0	1	1	0
Singulair	690	355	1	334	276
Smoking Cessation	84	25	2	57	56
Statins	112	21	1	90	349
Stimulant	945	613	5	327	234
Symlin	2	1	0	1	364
Synagis	153	119	9	25	45
Topical Antibiotics	25	6	0	19	28
Topical Antifungals	30	7	0	23	24
Ultram ER and ODT	9	1	0	8	364
Xolair	2	1	0	1	358
Xopenex Nebs	48	25	0	23	231
Zetia (Ezetimibe)	30	23	0	7	360
Emergency PAs	0	0	0	0	
Total	**11,684**	**6,970**	**156**	**4,558**	

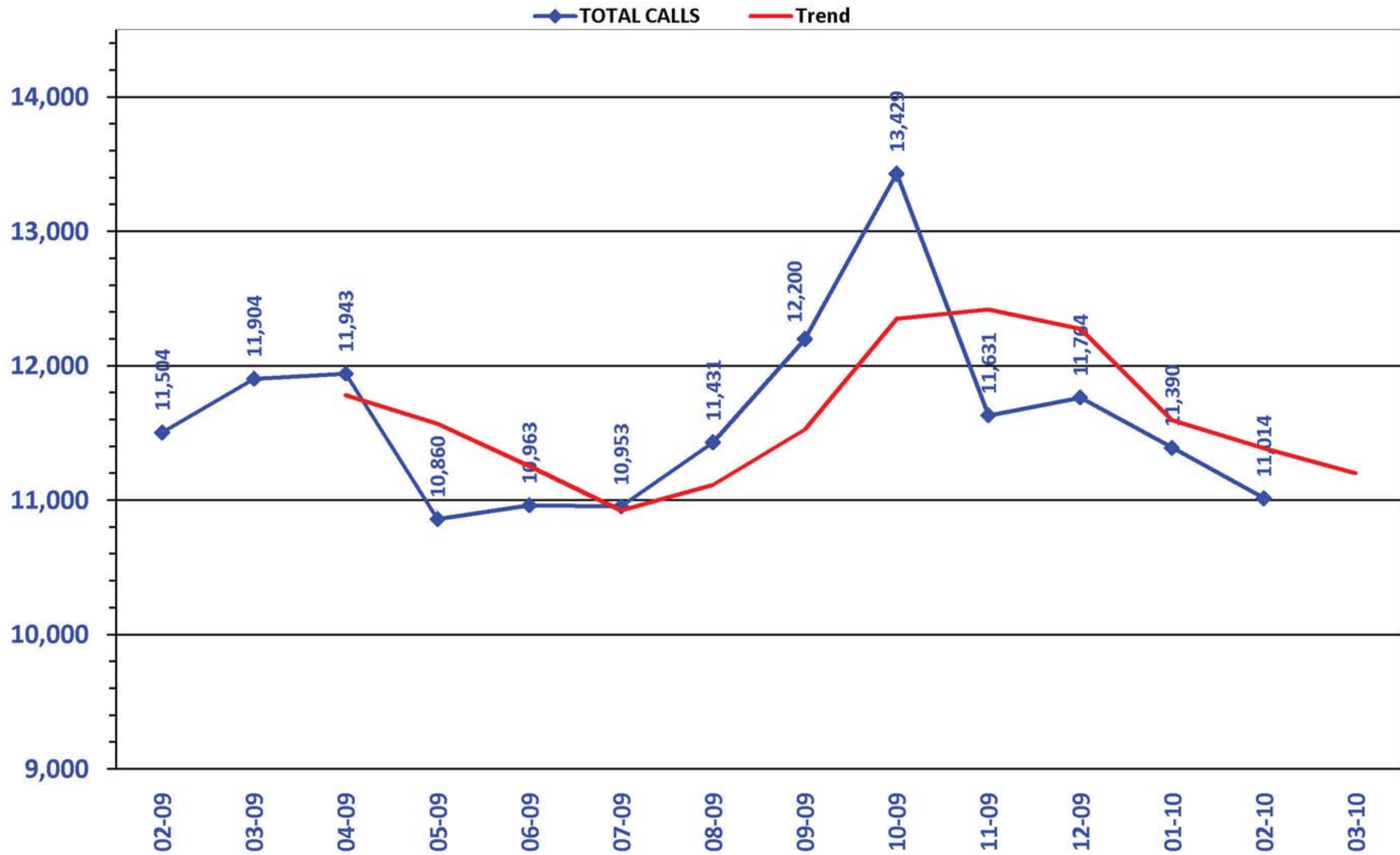
Overrides					
Brand	113	94	1	18	182
Dosage Change	454	422	5	27	17
High Dose	2	0	0	2	0
IHS - Brand	80	67	0	13	102
Ingredient Duplication	7	6	0	1	22
Lost/Broken Rx	72	67	1	4	17
Nursing Home Issue	71	62	1	8	15
Other	20	19	0	1	32
Quantity vs. Days Supply	505	325	9	171	238
Stolen	1	0	1	0	0
Wrong D.S. on Previous Rx	2	2	0	0	360
Overrides Total	**1,327**	**1,064**	**18**	**245**	
Total Regular PAs + Overrides	**13,011**	**8,034**	**174**	**4,803**	

Denial Reasons	
Lack required information to process request.	2,326
Unable to verify required trials.	1,881
Does not meet established criteria.	202
Not an FDA approved indication/diagnosis.	166
Member has active PA for requested medication.	160
Considered duplicate therapy. Member has a prior authorization for similar medication.	114
Requested dose exceeds maximum recommended FDA dose.	68
Medication not covered as pharmacy benefit.	21
Drug Not Deemed Medically Necessary	4

Duplicate Requests: 849

Changes to existing PAs: 817

CALL VOLUME MONTHLY REPORT:
February 2009 – February 2010



OHCA BOARD MEETING

APRIL 08, 2010 OHCA BOARD MEETING

OHCA REQUEST BILLS:

- SB 1349 – Obesity Treatment Pilot Program for Medicaid
- SB 1836 - Health Information Infrastructure Advisory Board to Assist OHCA In Developing Electronic Health Record Incentive Payments

After the March 11th committee deadline, and as of noon, Wednesday, March 31st, 2010, the Oklahoma Legislature is currently tracking a total of 1,438 active bills. OHCA is currently tracking 100 bills. They are broken down as follows:

- OHCA Request 02
- Direct Impact 32
- Agency Interest 12
- Appropriations 10
- Employee Interest 13
- Carry Over 29
- Governor Signed 02

The next deadlines are Wednesday, March 31, 2010 for reporting House Bills and Joint Resolutions from Senate Committees and Thursday, April 8th for reporting Senate Bills and Joint Resolutions from House Committees. The deadline for Third Reading of Bills and Joint Resolutions in the opposite chamber is April 22nd and Sine Die is set for May 28th.

7.b-1 CHAPTER 10. PURCHASING

OAC 317:10-1-1 through 317:10-1-4. [AMENDED]
OAC 317:10-1-5 through 317:10-1-11.[REVOKED]
OAC 317:10-1-12. [AMENDED]
OAC 317:10-1-15. [REVOKED]
OAC 317:10-1-16. [AMENDED]
OAC 317:10-1-17 through 317:10-1-20. [REVOKED]
(Reference APA WF # 10-09)

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 contract and purchasing guidelines. These emergency rule revisions will ensure rules are consistent and in compliance with current Oklahoma law. They will also clarify OHCA's ability to handle contracts and purchases internally, thereby allowing OHCA to make purchases necessary to agency operations without unnecessary delay.

ANALYSIS: OHCA contract and purchasing rules are revised to better coordinate and comply with new purchasing rules and regulations from the Oklahoma Department Central Services (DCS). Proposed revisions will: (1) incorporate updated procedures corresponding to higher purchasing thresholds; (2) allow OHCA subject matter experts to make purchases in house without DCS approval, pursuant to 74 Okla. Stat. §85.5 (T); (3) provide for the appeals process on these purchases to be handled by OHCA; (4) remove unnecessary language; and (5) update policy to reflect changes in the internal purchasing manual. These revisions are needed to provide immediate consistency and clarity within agency rules.

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 March 25, 2010, 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; Oklahoma Central Purchasing Act, and 74 Okla. Stat. §§ 85.1 et seq.

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising purchasing rules to: (1) incorporate updated procedures corresponding to higher purchasing thresholds; (2) allow OHCA subject matter experts to make purchases in house without DCS approval, pursuant to 74 Okla. Stat. §85.5 (T); (3) provide for the appeals process on these purchases to be handled by OHCA; (4) remove unnecessary language; and (5) update policy to reflect changes in the internal purchasing manual.

CHAPTER 10. PURCHASING

317:10-1-1. Purpose

(a) The purpose of this Chapter is to describe the rules governing the contracting and purchasing requirements of the Oklahoma Health Care Authority (OHCA). The Contracts and Purchasing Divisions are internal divisions of the OHCA. These divisions provide the mechanism for the acquisition of goods, equipment, non-professional and professional services for the operation of the OHCA. These rules are superseded by the Oklahoma Department of Central Services (DCS) Purchasing rules (OAC 580:15) whenever DCS has final authority on an acquisition.

(b) Different rules apply depending on which of the above three entities is making the acquisition and whether the purchase is for professional services or non-professional services and products. When an acquisition is made by DCS, the DCS Purchasing rules at OAC 580:15 apply. When an acquisition is made by OHCA, these rules must be read in conjunction with the DCS rules.

317:10-1-2. Definitions

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

~~**"Acquisition"** means all types of purchases and rentals necessary to perform the duties assigned to the OHCA, whether bought or leased by contract or otherwise, and includes every means by which the OHCA obtains any materials, supplies, service or equipment.~~

~~**"Associate director(s)"** means the most senior agency administrative personnel directly below the Chief Executive Officer in the agency line of authority.~~

"Authority" means the Oklahoma Health Care Authority.

"Authority Board" means the board designated by the Oklahoma Legislature to establish policies and adopt and promulgate rules for the OHCA.

~~**"Award"** means when the Chief Executive Officer or designee and Certified Procurement Officer agree on a suitable vendor for a competitive solicitation and the Chief Executive Officer, Certified Procurement Officer or designee notifies the successful vendor.~~

~~**"Best Value"** means a method for bid award that uses criteria established by the Oklahoma Central Purchasing Act and outlined under 74 O.S., 1998, Section 85.2(2).~~

~~**"Bid"** is an offer a vendor submits in response to a solicitation.~~

~~**"Certified Procurement Officer"** or **"CPO"** means a state agency official authorized by the Director of the Central Purchasing Division, Oklahoma Department of Central Services to make acquisitions for a state agency.~~

"Chief Executive Officer" or **"CEO"** means the highest ranking administrator at the OHCA.

~~**"Commodity code"** means a group of like products or services.~~

~~**"Contracts"** means the Contracts Division of the OHCA~~.

~~**"Division"** means a division within the OHCA.~~

~~**"EEOC"** means Equal Employment Opportunity Commission.~~

~~**"Equipment"** means all personal property acquired for use by the OHCA which is in the nature of a tool, device, or machine and shall be deemed to include all personal property used or consumed by the OHCA which is not included within the category of materials and supplies.~~

~~**"Goods"** means products, material, supplies and includes all property except real property acquired by the OHCA.~~

~~**"Invitation" to Bid"** or **"ITB"** means a type of solicitation a state agency or the State Purchasing Director sends to suppliers for submission of bids for acquisitions.~~

~~**"Non-Professional"** means services which are predominately physical or manual in character and may involve the supplying of products.~~

~~**"Professional services"** means services which are predominantly advisory or intellectual in character, or involve support rather than supplying equipment, supplies or other merchandise. Professional services include services to support or improve agency policy development, decision making, management, administration, or the operation of management systems.~~

~~**"Public agency"** means~~

~~(A) any political subdivision of the state;~~

~~(B) any agency of the state government or of the United States;~~

~~(C) each and every public trust of this state, whether such trust is a municipality, a county, or the State of Oklahoma except the Oklahoma Ordinance Works Authority;~~

~~(D) any corporation organized not for profit pursuant to the provisions of the Oklahoma General Corporation Act, Section 1001 et seq. Of Title 18 of the Oklahoma Statutes; and~~

~~(E) any political subdivision of another state.~~

~~**"Purchasing"** means the Purchasing Division of the OHCA.~~

~~**"Request for Proposal"** or **"RFP"** means a type of solicitation a state agency or the State Purchasing Director provides to suppliers requesting submission of proposals for acquisitions.~~

~~**"Request for Quotation"** or **"RFQ"** means a simplified written or oral solicitation a state agency or the State Purchasing Director sends to suppliers requesting submission of a quote.~~

~~**"Services"** means labor rendered by a person to another as distinguished from providing tangible goods. It shall include any type of personal or professional service, employment or undertaking except the employment of regular officers and employees by a state agency or such extra seasonal help as is authorized by law and is regularly used.~~

~~**"Solicitation"** is a request from a state agency or the State Purchasing Director for a proposal and/or pricing for an acquisition. Solicitation shall be by invitation to bid, request for proposal or request for quotation.~~

~~**"State Agency or agency"** means any office, officer, bureau, board, counsel, court, commission, institution, unit, division, body or house of the executive or judicial branches of the state government, whether elected or appointed, excluding only municipalities, counties, and other governmental subdivisions of the state.~~

~~**"Supplier"** or **"Vendor"** means an individual or business entity that sells or desires to sell acquisitions to state agencies.~~

317:10-1-3. General contracting and purchasing provisions

~~(a) The Authority has the statutory authority to directly purchase or acquire goods, services or equipment in compliance with the provisions of the Oklahoma Central Purchasing Act, the State Use Committee, other statutory provisions and rules of the Central Purchasing Division,~~

~~Oklahoma Department of Central Services, for state agency acquisitions.~~

~~(b) Goods, services and equipment for the Oklahoma Health Care Authority shall be acquired by one of the following methods and in accordance with the statutes of the State of Oklahoma:~~

~~(1) Acquisition of products and/or services through mandatory statewide contracts, State Use Committee procurement schedule, scheduled acquisition or non-encumbered contracts.~~

~~(2) Purchases from other governmental agencies.~~

~~(3) Acquisition of products and/or services through non-mandatory statewide contracts if the price does not exceed the purchase price the agency could pay in an open market acquisition.~~

~~(4) Direct order for products and/or services by purchase order or purchase card to the vendor within the authorized dollar amounts and other limitations contained in this Chapter.~~

~~(5) Competitive solicitation of products and services by the Authority.~~

~~(6) Competitive solicitation of products or services by the Oklahoma Department of Central Services, Central Purchasing Division.~~

~~(7) Sole source acquisitions according to the procedure in OAC 317:10-1-15.~~

~~(8) Donations to the Authority.~~

~~(c) The goods, services and equipment shall meet the specifications required, be acquired in compliance with the Central Purchasing Act and be cost effective.~~

~~(d) Except for acquisitions requiring the approval of the Authority Board, the CEO or a designated associate director, a CPO, in consultation with the requesting division, shall evaluate bids based upon criteria outlined in the solicitation, and shall document that evaluation.~~

~~(e) All amendments to any acquisition shall be initiated by the requesting division, but must be approved by the CEO, a designated associate director or a CPO.~~

(a) All acquisitions made by the Oklahoma Health Care Authority shall be in accordance with the Oklahoma Central Purchasing Act, 74 Okla. Stat. §§ 85.1 et seq., other applicable statutory provisions, Oklahoma Department of Central Services Central Purchasing Rules and the Authority's approved internal purchasing procedures.

(b) When these rules are silent on a relevant issue related to an acquisition made by the Authority, the appropriate DCS rule applies, except that where "State Purchasing Director" is specified, this means "the Authority CPO making the acquisition and/or the CEO". Where "Purchasing Division" is specified, this means "the Authority".

317:10-1-4. Vendor registration

Any vendor wishing to do business with the Authority should ~~be~~ register on the vendor bidder list maintained by the Central Purchasing Division of the Oklahoma Department of Central Services. ~~Any vendor who wants to be on the bidder list must register with the Central Purchasing Division at the Oklahoma Department of Central Services to receive copies of solicitations for the commodities or services which the vendor wishes to sell. All vendors are eligible for consideration.~~ The Authority may also send solicitations by request to vendors that are not on the vendor bidder list.

317:10-1-5. Reports of vendor non-compliance to the Central Purchasing Division, Oklahoma Department of Central Services [REVOKED]

~~(a) To ensure that vendors will perform in the best interest of the Authority, it is necessary to address problems in a swift and equitable manner for all concerned. In addition, varying degrees of vendor misconduct can cause irreparable harm to the Authority and its divisions. It is therefore recognized that penalties for poor vendor performance and/or violation of state statutes must be addressed. Reports of vendor non-compliance may be reported by the Authority to the Central Purchasing Division, Oklahoma Department of Central Services.~~

~~(b) Reports of vendor non-compliance may be considered, but is not limited to, the following infractions:~~

~~(1) Failure to perform pursuant to specifications on a solicitation.~~

~~(2) Failure on the part of the vendor to meet promised and/or required delivery dates and prices.~~

~~(3) Delivery by the vendor of substitutes in lieu of the items(s) specified on the approved bid and/or purchase order.~~

~~(4) Failure on the part of the vendor to meet EEOC and other requirements mandated by public legislation or the Authority Board.~~

~~(5) Problems created by the vendor regarding incorrect or inappropriate billing adjustment for goods and/or services furnished.~~

~~(6) Failure to support purchased products by not supplying necessary information, required maintenance and/or parts.~~

317:10-1-6. Vendor samples [REVOKED]

~~(a) Samples provided by vendors for evaluation will be accepted if they meet the following conditions:~~

~~(1) The product is one which is of a type presently in use or is of potential use to the Authority. Samples of goods or equipment not likely to be purchased will not be accepted.~~

~~(2) The quantity or size of the sample is relatively small and of low value. The object of a sample is the examination of its fitness for agency use.~~

~~(3) If a vendor sample is an item of equipment, the item must be inspected and approved by the CEO, associate director or designee for the area in which the equipment is to be sampled prior to the delivery to the division requesting the sample.~~

~~(4) Any manufacturer warranty and liability will be in effect for any product samples being evaluated by the agency.~~

~~(b) If vendor-supplied samples are accepted, they shall be promptly conveyed to the requesting division for evaluation.~~

~~(c) The vendor may follow up with the appropriate CPO on any sample left for evaluation.~~

~~(d) Samples not destroyed by examination and testing or retained for comparison will be returned at cost to the vendor upon written request.~~

317:10-1-7. Submission of bids [REVOKED]

~~(a) If a vendor wishes to bid on the item(s) listed in a solicitation, the vendor shall complete the bid via the instructions provided with the solicitation. It is the vendor's responsibility to read and understand the instructions and terms and conditions provided with the solicitation. Failure to comply with the instructions and terms and~~

~~conditions in the solicitation may disqualify the bid as per OAC 317:10-1-11. Any questions should be directed to the Authority's appropriate CPO.~~
~~(b) If the vendor does not wish to bid on the items, the vendor should fill in the vendor name, address, and write "No Bid" in the unit price column and return the solicitation to Contracts or Purchasing, whichever is appropriate.~~
~~(c) It is the responsibility of the vendor to ensure delivery of a bid to the Authority at or prior to the designated time on the solicitation. The agency will not be responsible for late bids.~~

317:10-1-8. Bid openings [REVOKED]
~~(a) All sealed bids will be stamped with the date and time upon receipt in the Contracts or Purchasing Division. The bids will be placed in a secured bid file until time for the scheduled bid opening. Access to the file is limited to the CPO or designee until the bid opening.~~
~~(b) Bids will be opened at the designated date and time of closing by the appropriate CPO. A bid opening record will be completed and maintained in the bid file.~~
~~(c) Award recommendations are made in writing upon conclusion of the bid evaluation.~~
~~(d) All bids and bid records are open to the public during normal working hours, after the bid opening, and in accordance with 51 O.S. 1991, Sections 24A.1 et seq., as amended. Copies may be requested in writing from the CPO.~~

317:10-1-9. Bid evaluations [REVOKED]
~~(a) After the bid opening, the appropriate Certified Procurement Officer will utilize a spread sheet referred to as the "bid evaluation sheet". A bid evaluation sheet will be completed for each solicitation. The vendor's bid will be reviewed for compliance with the instructions, compliance with the terms and conditions, and for compliance with the bid as per OAC 317:10-1-10 and 317:10-1-11.~~
~~(b) The bid evaluation sheet will be provided to the agency's division requesting the solicitation for their evaluation.~~

317:10-1-10. Award of bid [REVOKED]
~~(a) The solicitation, the bid evaluation sheet, and the literature and/or samples provided by the vendor will be forwarded to the requisitioning division. The division will review the information to determine compliance with the solicitation specifications. The division will make a recommendation of award based on the information provided. The recommendation will be reviewed by Contracts or Purchasing to ensure compliance with all Authority rules, policies and procedures.~~
~~(b) Contracts or Purchasing has the right to waive minor deficiencies or informalities in a bid provided that, in the CPO's judgment, the best interest of the state would be served without prejudice to the rights of the other bidder(s).~~
~~(c) Tie bids may develop between bidders. If these bidders are equal in price and all specifications, the award will be determined by a coin toss or by a series of coin tosses.~~
~~(d) If the solicitation specifies that the bid evaluation criteria is lowest and best, the bid will be evaluated by applying the following criteria:~~

(1) Lowest total purchase price. The bid price shall be a firm fixed price for each acquisition the solicitation specifies for the duration of the contract period.
(2) Quality and reliability of the acquisition. Additional factors regarding the responsiveness of the bid and the responsibility of the bidder shall be considered.
(3) Consistency of the proposed solution with state agency objectives. The Authority shall determine if the bid meets the specifications of the solicitation and determine the consistency with state agency planning documents and announced strategic direction.

(e) The Authority reserves the right to implement criteria of "Best Value" in the bid award process as outlined in 74 O.S., 1998, Section 85.7, and pursuant to the provisions of the Oklahoma Department of Central Services, Rules of the Central Purchasing Division, OAC 580:15-4-11(h).
(f) The Authority reserves the right to accept by item, group of items, or by the total bid, as specified in the solicitation.
(g) The Authority reserves the right to reject in part or whole any bid.
(h) No award will be made if the Authority determines the lowest bid totals more than the money available for purchase or if the lowest bid exceeds the reasonable market price.
(i) The Authority will send a purchase order or a notice of award as acceptable notification of a valid and binding contract with a vendor.
(j) All awards will be made under the terms and conditions as outlined in OAC 317:10-1-11 and any additional terms and conditions as described in the solicitation.
(k) The solicitation together with the successful vendor's responsive bid shall constitute a binding contract and will be interpreted under Oklahoma Law.
(l) All ethics rules and laws related to conflicts of interest and doing business with public officials apply to any acquisition by the Authority.

317:10-1-11. Terms and conditions for acceptable bids [REVOKED]

(a) All bids submitted are subject to the Authority's policies and procedures and/or any special conditions and specifications listed in this Subchapter, and made part of the solicitation.
(b) Sealed bids will be opened by the appropriate Certified Procurement Officer at the time and date shown on the solicitation.
(c) Bids received after the closing time will not be considered. Envelopes must contain only one bid, be sealed and the name and address of the bidder inserted in the upper left hand corner. The requisition number and closing date must appear on the face of the envelope.
(d) The bid shall be in strict conformity with the instructions to the bidder and shall be submitted on the approved form. The bid must be signed by an authorized representative of the bidder. The bids must be typewritten or written in ink, and corrections must be initialed by a representative of the vendor prior to the submission of the bid. Corrections made by correction fluid or by correctable typewriter ribbons will not be accepted unless initialed. Penciled bids will not be accepted.
(e) The non collusion affidavit form must be completed and returned.

~~(f) The bid may be awarded on an all or none basis, by item or groups of items, as specified in the solicitation.~~

~~(g) All bidders must guarantee that the quoted unit price in a bid is correct.~~

~~(h) Acquisitions by the Authority are not subject to any sales tax or federal excise tax.~~

~~(i) Prices shall be bid F.O.B. and include packaging, handling, shipping, and delivery charges prepaid by the bidder, unless otherwise specified in the solicitation.~~

~~(j) The bidder shall deliver the merchandise or services as bid. Any deviation must be approved in writing with the Authority CEO, designated associate director or the appropriate CPO.~~

~~(k) Any questions pertaining to the clarification of the solicitation shall be directed to the appropriate CPO.~~

~~(l) Any manufacturer, trade names, brand names, information and/or catalog numbers listed in the specification are for information and are not intended to limit competition. The bidder may offer any brand which meets or exceeds the specification for any item(s). If the bid is based on equivalent products, the bidder shall indicate on the bid form the manufacturer's name and number. The alternate bid shall be accompanied with sketches, descriptive literature, and/or completed specifications. Samples of the alternate item(s) may be required in the solicitation. Reference to literature submitted with a previous bid will not satisfy this provision. If necessary, the bidder shall also explain in detail the reason(s) why the proposed requirements may be satisfied with a substitute product. Bids lacking any written indication of intent to quote an alternate brand will be received and considered in complete compliance with the specifications as listed on the solicitation.~~

~~(m) A bid constitutes a legal offer which becomes a contract upon acceptance by the Authority pursuant to OAC 317:10-1-10(k).~~

~~(n) The bid must be made out in the name of the bidder and must be fully and properly executed by an authorized person and signed in ink with full knowledge and acceptance of all its provisions.~~

~~(o) In accepting a contract with the Authority, the bidder must agree to an audit clause which provides that books, records, documents, accounting procedures, practices or any other items of the bidder relevant to the contract are subject to examination by the Authority, and the State Auditor and Inspector.~~

~~(p) Failure to comply with the terms and conditions will subject the bid to disqualification.~~

317:10-1-12. Protest of award

~~(a) Any bidder may protest the award of a bid. A protest may be based, but is not limited to, the following:~~

- ~~(1) Error in the calculation of price;~~
- ~~(2) The bid of the successful vendor did not meet the solicitation specifications;~~
- ~~(3) The solicitation procedure was done in violation of the Authority's rules; or~~
- ~~(4) Authority personnel handling the solicitation procedure acted in a willful or capricious manner.~~

~~(b) After the award is made, the protesting bidder shall submit written notice to the State Purchasing Director, Oklahoma Department of Central Services within ten (10) days of reasonable notice of~~

~~contract award. The protest notice shall state supplier facts and reasons for protest.~~

~~(c) The State Purchasing Director shall review the protest and contract award documentation, responding to the protesting bidder as outlined in the Oklahoma Department of Central Services, Rules of the Central Purchasing Division, OAC 580:15-4-13.~~

(a) Protests of awards made by the Authority under 74 Okla. Stat. § 85.5T are addressed at OAC 317:2-1-1 et seq.

(b) Bidders who wish to protest any other award shall follow the process outlined in the Oklahoma Department of Central Services rules at OAC 580:15-4-13.

317:10-1-15. Sole source or sole brand acquisitions [REVOKED]

~~(a) The Authority need not seek competitive solicitations for goods or services, if the person with authority to make the acquisition affirms that:~~

~~(1) The goods, equipment or services may only be obtained from a single or sole source; must be a sole brand; or,~~

~~(2) A public exigency or emergency exists in which the urgency for the requirement will not permit a delay incident to competitive solicitation; or,~~

~~(3) After solicitation of a number of sources, competition is deemed inadequate.~~

~~(b) The person wishing to make an acquisition through a sole source shall forward an affidavit to Contracts or Purchasing which gives all the reasons why the specifications to fill the need restricts the item or service to one person or business, or brand. The appropriate CPO shall confirm the information on the affidavit by consulting with the Central Purchasing Division, Office of State Finance, contacts in the business community, Internet searches and any other resources identified.~~

~~(1) If the total acquisition price exceeds $2,500 but does not exceed $25,000:~~

~~(A) If the CPO determines the acquisition is a sole source or sole brand, the affidavit shall be submitted to the CEO for signature of approval. In the prolonged absence of the CEO, the designee of the CEO may approve a sole source acquisition.~~

~~(B) Upon approval by the CEO or in the CEO's absence, the designee, the CPO completes the acquisition pursuant to the provisions of the Oklahoma Central Purchasing Act.~~

~~(C) The affidavit shall be maintained in a file within the Authority.~~

~~(2) If the total acquisition price exceeds $25,000:~~

~~(A) The appropriate CPO shall submit the affidavit to the CEO or in the CEO's absence, to the designee for approval/signature.~~

~~(B) The affidavit and acquisition information shall be submitted to the State Purchasing Director, Oklahoma Department of Central Services for completion of the acquisition.~~

~~(C) Copies of the affidavit are maintained in a file within the Authority.~~

~~(c) Criteria which may be sufficient to justify a sole source or sole brand contract include, but are not limited to:~~

~~(1) Replacement or repair parts require the same brand.~~

~~(2) Compatibility of equipment or the continuity of services rendered from the same vendor is an essential factor for effective utilization of the product or service.~~

~~(3) The goods, service or equipment is the only one of its kind that will fulfill the need of the agency.~~
~~(4) The product or service furnished by the vendor is very specialized or the vendor providing the service possesses great acquired expertise, and the vendor is the only one singularly and peculiarly qualified to provide such product or service.~~

317:10-1-16. Delegation of authority

The authority to procure needed products and services for the Authority has been delegated to the Authority from the Oklahoma Department of Central Services, Central Purchasing Division. The Authority Board delegates ~~procurement~~ authority for expenditure of funds to the CEO and other Authority officers and personnel according to the dollar limits and types of products stated in (1), (2) and (3) of this Section. Within this authority, the CEO may delegate in writing to other specific individuals the responsibility for the performance of the procurement duties.

(1) **Supply and non-professional services acquisitions.** Each division director or supervisor may initiate any supply or non-professional services acquisition which is within his or her authorized division budget and approved by the CEO, associate director or designee. Any single acquisition of this kind over $5,000 up to $500,000 must be approved by the CEO or a designated associate director. Any single acquisition of this kind over $500,000 must be approved by the Authority Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds $500,000 for a supply or non-professional services contract must be prior approved by the ~~OHCA~~ Authority Board. Any amendment to a contract that would result in a 10 percent or greater increase in the total acquisition cost originally approved by the OHCA Board must be submitted to the ~~OHCA~~ Authority Board for prior approval.

(2) **Professional service contracts.** Acquisitions of professional services must be approved by the CEO or designee. All professional service contracts over $125,000 must be approved by the Authority Board. A contract amendment that would increase the total original contract acquisition cost to an amount that equals or exceeds $125,000 for a professional service contract must be prior approved by the OHCA Board. Any amendment to a contract that would result in a 25 percent or greater increase or a $250,000 or greater increase in the total acquisition cost originally approved by the OHCA Board must be submitted to the OHCA Board for prior approval. Board approval is not required if the increase in total contract acquisition cost results from the exercise of a price increase methodology, option for additional work, or option to renew that was contained in the previously approved contract.

(3) **Interagency/intergovernmental agreements.** All agreements with another state agency or public agency must be approved by the CEO or designee, but are exempt from the Authority Board approval.

317:10-1-17. Acquisitions of $2,500 or less [REVOKED]

~~(a) Any acquisition for an amount of $2,500 or less shall be exempt from the competitive solicitation procedures. The items may be acquired by a purchase order or purchase card order issued directly to the vendor and pursuant to the provisions of the Oklahoma Department~~

~~of Central Services, Rules of the Central Purchasing Division, OAC 580:15-6-6.~~
~~(b) Contracts or Purchasing will monitor these orders to see if the combined usage from the various divisions for the same items exceeds the $2,500 amount allowed. Should this occur, the division will be notified that competitive solicitation specifications must be prepared and that the acquisition will be processed in accordance with agency policy based upon the overall dollar amount of the acquisition.~~
~~(c) The Authority may not make split purchases for the purpose of evading the dollar threshold for competitive solicitations.~~

317:10-1-18. Acquisitions in excess of $2,500 and not exceeding $10,000 [REVOKED]
~~(a) If the acquisition is for an amount exceeding $2,500, but is not more than $10,000, the appropriate CPO shall determine if the goods or services are available from a mandatory statewide contract, State Use Committee procurement schedule, scheduled acquisition, non-encumbered contract, another governmental agency or from non-mandatory statewide contracts. If the goods or services are available through one of these methods, the agency will acquire the goods or services in this manner.~~
~~(b) If the acquisition is not available utilizing one of the methods stated in (a) of this Section, the agency shall acquire the goods or services by an open market acquisition.~~
~~(1) The CPO may select suppliers from the registered supplier list maintained by the Central Purchasing Division, Oklahoma Department of Central Services, suppliers that can meet the agency's delivery date or suppliers in the vicinity. Suppliers will not be chosen that have been suspended or debarred from the registered supplier list.~~
~~(2) The CPO shall secure price quotations and delivery dates from suppliers. Price quotations may be in writing or documented by the CPO.~~
~~(3) If the Authority and the supplier execute a contract for the acquisition, the supplier shall submit a notarized, sworn statement of non collusion pursuant to 74 O.S., Section 85.23.~~
~~(4) The Authority shall pay the supplier following receipt, inspection and acceptance of the acquisition.~~
~~(5) The Authority shall retain documents and records of each acquisition for three years following acquisition date.~~
~~(6) All records and documentation shall be made available to the State Auditor and Inspector or the State Purchasing Director, Oklahoma Department of Central Services, upon request. Further, all contracting and purchasing records required to be open under the Open Records Act shall be available.~~
~~(c) The Authority may not make split purchases for the purpose of evading the dollar threshold for competitive solicitations.~~
~~(d) The Authority may issue change orders to increase a purchase order for an acquisition not to exceed ten percent of the original purchase order total price.~~

317:10-1-18.1. Acquisitions in excess of $10,000 and not exceeding $25,000 [REVOKED]
~~(a) The CPO shall determine if the acquisition is available from a mandatory statewide contract, State Use Committee procurement schedule, scheduled acquisition, non-encumbered contract, another~~

~~governmental agency or from a non-mandatory statewide contract. If the acquisition is available through one of these methods, the agency will acquire the goods or services in this manner.~~

~~(b) If the acquisition is not available utilizing one of the above methods, the agency shall acquire the goods or services by an open market acquisition.~~

~~(1) The CPO shall select a minimum of three suppliers for solicitation. The CPO may select suppliers from the registered supplier list maintained by the Central Purchasing Division, Oklahoma Department of Central Services, suppliers that can meet the agency's delivery date or suppliers in the vicinity. Suppliers will not be chosen that have been suspended or debarred from the registered supplier list.~~

~~(2) The CPO shall secure price quotations and delivery dates from suppliers. Price quotations may be in writing or documented by the Certified Procurement Officer.~~

~~(3) If a vendor submits a bid, the vendor shall submit an original notarized non collusion affidavit pursuant to 74 O.S., Section 85.22.~~

~~(4) If the Authority and the supplier execute a contract for the acquisition, the supplier shall submit a notarized, sworn statement of non collusion pursuant to 74 O.S., Section 85.23.~~

~~(5) The Authority shall pay the supplier following receipt, inspection and acceptance of the acquisition.~~

~~(6) The Authority shall retain documents and records of each acquisition for three years following acquisition date.~~

~~(7) All records and documentation shall be made available to the State Auditor and Inspector or the State Purchasing Director, Oklahoma Department of Central Services, upon request. Further, all purchasing records required to be open under the Open Records Act shall be available.~~

~~(c) The Authority may not make split purchases for the purpose of evading the dollar threshold for competitive solicitations.~~

~~(d) The Authority may issue change orders to increase a purchase order for an acquisition not to exceed ten percent of the original purchase order total price. The Authority shall notify the Department of Central Services, State Purchasing Director, if a change order increases an acquisition purchase price above $25,000.~~

317:10-1-18.2. Acquisitions in excess of $25,000 [REVOKED]

~~(a) The CPO shall determine if the acquisition is available from a mandatory statewide contract, State Use Committee procurement schedule, scheduled acquisition, non-encumbered contract, another governmental agency or from a non-mandatory statewide contract. If the acquisition is available through one of these methods, the agency will acquire the goods or services in this manner subject to the provisions of OAC 317:10-1-16.~~

~~(b) If the acquisition is not available utilizing one of the above methods, the agency shall submit a request for the acquisition to the State Purchasing Director, Oklahoma State Department of Central Services.~~

317:10-1-19. Professional service contracts [REVOKED]

~~(a) The Contracts Unit (Contracts) is the official repository for all original professional service agreements/contracts except as otherwise authorized by the CEO. Divisions must forward to Contracts all~~

~~original agreements/contracts in their files. A standard format for all agreements will be on file and any changes will be coordinated with Contracts. Any correspondence affecting the contract must also be forwarded to Contracts. Contracts staff will assist agency personnel in obtaining copies of documents requested from the files. Contracts' central file will contain:~~

~~(1) Official copy of the agreement/contract,~~

~~(2) Amendments,~~

~~(3) Compliance audits or reviews,~~

~~(4) Historical vendor performance,~~

~~(5) The requisition, and~~

~~(6) Other related documents including purchase orders.~~

~~(b) The Authority may not enter into a professional service contract with any person who has been employed by the Authority within one year after the termination date of the individual's employment, unless specifically permitted by statute. This shall not apply to contracts with qualified interpreters for the deaf.~~

~~(c) All professional services contracts shall contain an audit clause which provides that books, records, documents, accounting procedures, practices and any other item of the services provider relevant to the contract are subject to examination by OHCA or the State Auditor and Inspector.~~

~~(d) The Authority shall monitor and review compliance all professional services contracts periodically, but not less than twice during the contract period.~~

~~(e) A performance evaluation is required of the service provided under a professional service contract. Such evaluations shall assess the performance of the vendor during the contractual period. Evaluations shall be completed by the division responsible for initiating the contract no less than 90 days after the end of the contract. A copy of each evaluation is forwarded to Contracts for filing in the contract file.~~

~~(f) If the final product of a contract is a report, written proposal or study, the vendor shall comply with the following:~~

~~(1) the vendor shall provide a sworn statement certifying that said vendor has not previously entered into a contract with the Authority or any other state agency which would result in a substantial duplication of the previous end report. A sworn statement shall not be required of a vendor who is renewing a contract; and~~

~~(2) the vendor must deliver two copies of the report to Contracts. Contracts will file one copy with the State Librarian and Archivist.~~

~~(g) Contract terms and price must be definite and fixed. Contracts for professional services shall provide for payments to vendors at a uniform rate for the duration of the contract if the services being provided are similar and consistent. If the professional services are not similar and consistent for the duration of the contract, the Authority shall comply with the provisions of 74 O.S., 1998, Section 85.41(G).~~

~~(h) The following professional services are exempt from competitive bidding pursuant to 74 O.S., Section 85.7(2), and 18 O.S., Section 803:~~

~~(1) Physician, Surgeon or doctor of medicine;~~

~~(2) Osteopathic Physician or Surgeon;~~

~~(3) Chiropractor;~~

~~(4) Chiropodist-podiatrist;~~
~~(5) Optometrist;~~
~~(6) Veterinarian;~~
~~(7) Architect;~~
~~(8) Attorney;~~
~~(9) Dentist;~~
~~(10) Public Accountant;~~
~~(11) Psychologist;~~
~~(12) Physical Therapist;~~
~~(13) Registered Nurse;~~
~~(14) Professional Engineer;~~
~~(15) Land Surveyor;~~
~~(16) Pharmacist;~~
~~(17) Occupational Therapist;~~
~~(18) Speech Pathologist;~~
~~(19) Audiologist; and~~
~~(20) Licensed Perfusionist.~~

~~(i) The Authority shall require proof of professional certification or license of all vendors providing professional services described in (h) of this Section.~~

~~(j) All professional service contracts other than those specified in (h) of this Section must be competitively bid pursuant to this Chapter unless criteria exist sufficient to justify a sole source contract, or unless the contract does not exceed the $25,000 threshold required for competitive bidding, or as otherwise provided by state law.~~

~~(k) The requirement for competitive bidding may not be avoided by entering into a contract with an individual licensed in one of the professional categories identified in (h) of this Section, to perform non-germane services. For example, a lawyer may not be given a contract to serve as an investment counselor without competitive bidding.~~

~~(l) Bids for professional services contracts shall be evaluated by the appropriate division and/or evaluation team, and reviewed by the Contracts Administrator or designee prior to submittal to the State Purchasing Director. Both cost and technical expertise shall be considered in determining the lowest and best or best value bid.~~

~~(m) The travel expenses to be incurred by the vendor pursuant to the contract for services shall be included in the total amount of the contract award, unless the Authority decides to reimburse the vendor under state statues for such expenses, and informs vendors of such reimbursement in the ITB or request for proposal. The vendor shall be responsible for all travel arrangements and provide supporting documentation when submitting claims for reimbursement.~~

317:10-1-20. Interagency/Intergovernmental agreements [REVOKED]

~~(a) OHCA may contract with another state agency pursuant to 74 O.S., Section 581.~~

~~(b) OHCA may contract with a political subdivision or agency of the United States pursuant to 74 O.S., Sections 1001 through 1008.~~

~~(c) OHCA shall not attempt to make or make an acquisition through another state agency or public agency for the purpose of evading competitive solicitation provisions of the Oklahoma Central Purchasing Act or rules of the Central Purchasing Division.~~

7.b-2 CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
Subchapter 9. ICF/MR, HCBW/MR, And Individuals Age 65 Or Older In Mental Health Hospitals
Part 2. Medicaid Recovery Program
OAC 317:35-9-15. [AMENDED]
Subchapter 19. Nursing Facility Services
OAC 317:35-19-4. [AMENDED]
(Reference APA WF # 10-16)

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 remove policy allowing the Oklahoma Department of Human Services (OKDHS) to conduct hearings in the Medicaid estate recovery process for individuals in nursing facilities, ICFs/MR or other medical institutions. Current policy conflicts with State Statue providing that the Oklahoma Health Care Authority (OHCA) shall conduct the hearings.

ANALYSIS: Rules are revised to remove policy allowing OKDHS to conduct fair hearings in the estate recovery process for individuals in nursing facilities, ICFs/MR or other medical institutions, having a lien placed on their property. Current policy conflicts with State Statue at O.S. Title 63, Section 5051.3(B)(3) providing that the OHCA shall conduct the hearings. Elimination of the OKDHS hearing will prevent potential confusion in the estate recovery process as the State Medicaid Agency, the Oklahoma Health Care Authority will be conducting the hearings for its members.

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 March 25, 2010, 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, and 63 Okla. Stat. § 5051.3

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:
Revising estate recovery rules to provide that OHCA will conduct the fair hearings in the estate recovery process for individuals in nursing facilities, ICFs/MR or other medical institutions, having a lien placed on their property rather than OKDHS.

SUBCHAPTER 9. ICF/MR, HCBW/MR, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS
PART 2. MEDICAID RECOVERY PROGRAM

317:35-9-15. Medicaid recovery

(a) **General overview.** The Omnibus Budget Reconciliation Act of 1993 mandates the State to seek recovery against the estate of certain Title XIX members who received medical care on or after July 1, 1994, and who were 55 years of age or older when the care was received. The payment of Title XIX by the Oklahoma Health Care Authority (OHCA) on behalf of a member who is an inpatient of a nursing facility, intermediate care facility for the mentally retarded or other medical institution creates a debt to the OHCA subject to recovery by legal action either in the form of a lien filed against the real property of the member and/or a claim made against the estate of the member. Only Title XIX received on or after July 1, 1994, will be subject to provisions of this Part. Recovery for payments made under Title XIX for nursing care is limited by several factors, including the family composition at the time the lien is imposed and/or at the time of the member's death and by the creation of undue hardship at the time the lien is imposed or the claim is made against the estate. [See OAC 317:35-5-41.8(a)(3)(H) for consideration of home property as a countable resource.] State Supplemental Payments are not considered when determining the countable income. The types of medical care for which recovery can be sought include:

(1) nursing facility services;
(2) home and community based services;
(3) related hospital services;
(4) prescription drug services;
(5) physician services; and
(6) transportation services.

(b) **Recovery through lien.** The Oklahoma Health Care Authority (OHCA) may file and enforce a lien, after notice and opportunity for a hearing ~~(OKDHS will conduct hearings)~~, against the real property of a member who is an inpatient in a nursing facility, ICF/MR or other medical institution in certain instances.

(1) **Exceptions to filing a lien**.

(A) A lien may not be filed on the home property if the member's family includes:

(i) a surviving spouse residing in the home;
(ii) a child or children age 20 or less lawfully residing in the home ;
(iii) a disabled child or children of any age lawfully residing in the home; or
(iv) a brother or sister of the member who has an equity interest in the home and has been residing in the home for at least one year immediately prior to the member's admission to the nursing facility and who has continued to live there on a continuous basis since that time.

(B) If an individual covered under an Oklahoma Long-term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual for the amount of assets or resources disregarded.

(2) **Reasonable expectation to return home.** A lien may be filed only after it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return to the home. To return home means the member leaves the nursing facility and resides in the home on which the lien has been placed for a period of at least 90 days without being re-admitted as an inpatient to a facility providing nursing care. Hospitalizations of short duration that do not include convalescent care are not counted in the 90 day period. Upon certification for Title XIX for nursing care, OKDHS provides written notice to the member that a one-year period of inpatient care constitutes a determination by the OKDHS that there is no reasonable expectation that the member will be discharged and return home for a period of at least 90 days. The member or the member's representative is asked to declare intent to return home by signing the OKDHS Form 08MA024E, Acknowledgment of Intent to Return Home/Medicaid Recovery Program. Intent is defined here as a clear statement of plans in addition to other evidence and/or corroborative statements of others. Should the intent be to return home, the member must be informed that a one-year period of care at a nursing facility or facilities constitutes a determination that the member cannot reasonably be expected to be discharged and return home. When this determination has been made, the member receives a notice and opportunity for hearing. This notification occurs prior to filing of a lien. At the end of the 12-month period, a lien may be filed against the member's real property unless medical evidence is provided to support the feasibility of his/her returning to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for the return to the home.
(3) **Undue hardship waiver.** When enforcing a lien or a recovery from an estate [see (c) of this Section] would create an undue hardship, a waiver may be granted. Undue hardship exists when enforcing the lien would deprive the individual of medical care such that the individual's health or life would be endangered. Undue hardship exists when application of the rule would deprive the individual or family members who are financially dependent on him/her for food, clothing, shelter, or other necessities of life. Undue hardship does not exist, however, when the individual or his/her family is merely inconvenienced or when their lifestyle is restricted because of the lien or estate recovery being enforced. Decisions on undue hardship waivers are made at OKDHS State Office, Family Support Services Division, Health Related and Medical Services Section. Upon applying for an undue hardship waiver, an individual will receive written notice, in a timely process, whether an undue hardship waiver will be granted. If an undue hardship waiver is not granted, the individual will receive written notice of the process under which an adverse determination can be appealed. The OHCA Legal Division staff will receive notification on all undue hardship waiver decisions.
(4) **Filing the lien.** After it has been determined that the member cannot reasonably be expected to be discharged from the nursing facility and return home and the member has been given notice of an intent to file a lien against the real property and an opportunity for a hearing on the matter, a lien is filed by the Oklahoma Health Care Authority, Third Party Liability Unit, for record against the

legal description of the real property in the office of the county clerk of the county in which the property is located. A copy of the lien is sent by OHCA to the member or his/her representative. The lien must contain the following information:

(A) the name and mailing address of the member, spouse, legal guardian, authorized representative, or individual acting on behalf of the member;

(B) the amount of Title XIX paid at the time of the filing of the lien and a statement that the lien amount will continue to increase by any amounts paid thereafter for Title XIX on the member's behalf;

(C) the date the member began receiving compensated inpatient care at a nursing facility or nursing facilities, intermediate care facility for the mentally retarded or other medical institution;

(D) the legal description of the real property against which the lien will be recorded; and

(E) the address of the Oklahoma Health Care Authority.

(5) **Enforcing the lien**. The lien filed by OHCA for Title XIX correctly received may be enforced before or after the death of the member. But it may be enforced only:

(A) after the death of the surviving spouse of the member or until such time as the surviving spouse abandons the homestead to reside elsewhere;

(B) when there is no child of the member, natural or adopted, who is 20 years of age or less residing in the home;

(C) when there is no adult child of the member, natural or adopted, who is blind or disabled, as defined in OAC 317:35-1-2, residing in the home;

(D) when no brother or sister of the member is lawfully residing in the home, who has resided there for at least one year immediately before the date of the member's admission to the nursing facility, and has resided there on a continuous basis since that time; and

(E) when no son or daughter of the member is lawfully residing in the home who has resided there for at least two years immediately before the date of the member's admission to the nursing facility, and establishes to the satisfaction of the OKDHS that he or she provided care to the member which permitted the member to reside at home rather than in an institution and has resided there on continuous basis since that time.

(6) **Dissolving the lien**. The lien remains on the property even after transfer of title by conveyance, sale, succession, inheritance or will unless one of the following events occur:

(A) The lien is satisfied. The member or member's representative may discharge the lien at any time by paying the amount of lien to the OHCA. Should the payment of the debt secured by the lien be made to the county office, the payment is forwarded to OHCA/Third Party Liability, so that the lien can be released within 50 days. After that time, the member or the member's representative may request in writing that it be done. This request must describe the lien and the property with reasonable certainty. By statute, a fine may be levied against the lien holder if it is not released in a timely manner.

(B) The member leaves the nursing facility and resides in a property to which the lien is attached, for a period of more

than 90 days without being re-admitted to a facility providing nursing care, even though there may have been no reasonable expectation that this would occur. If the member is re-admitted to a nursing facility during this period, and does return to his/her home after being released, another 90 days must be completed before the lien can be dissolved.

(7) **Capital resources**. Rules on the determination of capital resources for individuals related to the aged, blind, or disabled (See OAC 317:35-5-41 through 317:35-5-41.7) apply to the proceeds received for the property in excess of the amount of the lien after the lien is satisfied.

(c) **Recovery from estates.**

(1) If the member was age 55 or older when the nursing care was received, adjustment or recovery may be made only after the death of the individual's spouse, if any, and at a time when there are no surviving children age 20 or less and no surviving disabled children of any age living in the home. Oklahoma Statutes contain stringent time frames concerning when and how claims against an estate in probate are filed and paid. Therefore, timely updating of computer input forms indicating the death of the member is crucial to insure the OHCA's ability to file timely against the estate.

(2) The estate consists of all real and personal property and other assets included in member's estate as defined by Title 58 of the Oklahoma Statutes. Although county staff ordinarily will not be responsible for inventorying or assessing the estate, assets and property that are not considered in determining eligibility should be documented in the case record.

(3) After updating of computer input form indicating member's death, a computer generated report is sent to OHCA/Third Party Liability (TPL). This report will serve as notification to OHCA/TPL to initiate estate recovery.

(4) Undue hardship waivers may be granted for estate recovery as provided in (b)(3) of the Section.

(5) If an individual covered under an Oklahoma Long-Term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual's estate for the amount of assets or resources disregarded.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-4. Medicaid recovery

(a) **General overview.** The Omnibus Budget Reconciliation Act of 1993 mandates the state to seek recovery against the estate of certain Title XIX members who received medical care on or after July 1, 1994, and who were 55 years of age or older when the care was received. The payment of Title XIX by the Oklahoma Health Care Authority (OHCA) on behalf of a member who is an inpatient of a nursing facility, intermediate care facility for the mentally retarded or other medical institution creates a debt to the OHCA subject to recovery by legal action either in the form of a lien filed against the real property of the member and/or a claim made against the estate of the member. Only Title XIX received on or after July 1, 1994, will be subject to provisions of this part. Recovery for payments made under Title XIX

for nursing care is limited by several factors, including the family composition at the time the lien is imposed and/or at the time of the member's death and by the creation of undue hardship at the time the lien is imposed or the claim is made against the estate. [See OAC 317:35-5-41.8(a)(3)(H) for consideration of home property as a countable resource.] State Supplemental Payments are not considered when determining the countable income. The types of medical care for which recovery can be sought include:

(1) nursing facility services,
(2) home and community based services,
(3) related hospital services,
(4) prescription drug services,
(5) physician services, and
(6) transportation services.

(b) **Recovery through lien.** The Oklahoma Health Care Authority (OHCA) may file and enforce a lien, after notice and opportunity for a hearing, ~~(OKDHS will conduct hearings)~~ against the real property of a member who is an inpatient in a nursing facility, ICF/MR or other medical institution in certain instances.

(1) **Exceptions to filing a lien.**

(A) A lien may not be filed on the home property if the member's family includes:

(i) a surviving spouse residing in the home;
(ii) a child or children age 20 or less lawfully residing in the home;
(iii) a disabled child or children of any age lawfully residing in the home; or
(iv) a brother or sister of the member who has an equity interest in the home and has been residing in the home for at least one year immediately prior to the member's admission to the nursing facility and who has continued to live there on a continuous basis since that time.

(B) If an individual covered under an Oklahoma Long-Term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual for the amount of assets or resources disregarded.

(2) **Reasonable expectation to return home.** A lien may be filed only after it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return to the home. To return home means the member leaves the nursing facility and resides in the home on which the lien has been placed for a period of at least 90 days without being re-admitted as an inpatient to a facility providing nursing care. Hospitalizations of short duration that do not include convalescent care are not counted in the 90 day period. Upon certification for Title XIX for nursing care, OKDHS provides written notice to the member that a one-year period of inpatient care constitutes a determination by the OKDHS that there is no reasonable expectation that the member will be discharged and return home for a period of at least three months. The member or the member's representative is asked to declare intent to return home by signing the OKDHS Form 08MA024E, Acknowledgment of Intent to Return Home/Medicaid Recovery Program. Intent is defined here as a clear statement of plans in addition to other evidence and/or corroborative statements of

others. Should the intent be to return home, the member must be informed that a one-year period of care at a nursing facility or facilities constitutes a determination that the member cannot reasonably be expected to be discharged and return home. When this determination has been made, the member receives a notice and opportunity for hearing. This notification occurs prior to filing of a lien. At the end of the 12-month period, a lien may be filed against the member's real property unless medical evidence is provided to support the feasibility of his/her returning to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for the return to the home.

(3) **Undue hardship waiver**. When enforcing a lien or a recovery from an estate [see (C) of this Section] would create an undue hardship, a waiver may be granted. Undue hardship exists when enforcing the lien would deprive the individual of medical care such that the individual's health or life would be endangered. Undue hardship exists when application of the rule would deprive the individual or family members who are financially dependent on him/her for food, clothing, shelter, or other necessities of life. Undue hardship does not exist, however, where the individual or his/her family is merely inconvenienced or where their lifestyle is restricted because of the lien or estate recovery being enforced. Decisions on undue hardship waivers are made at OKDHS State Office, Family Support Services Division, Health Related and Medical Services Section. Upon applying for an undue hardship waiver, an individual will receive written notice, in a timely process, whether an undue hardship waiver will be granted. If an undue hardship waiver is not granted, the individual will receive written notice of the process under which an adverse determination can be appealed. The OHCA Legal Division staff will receive notification on all undue hardship waiver decisions.

(4) **Filing the lien**. After it has been determined that the member cannot reasonably be expected to be discharged from the nursing facility and return home and the member has been given notice of the intent to file a lien against the real property and an opportunity for a hearing on the matter, a lien is filed by the Oklahoma Health Care Authority, Third Party Liability Unit, for record against the legal description of the real property in the office of the county clerk of the county in which the property is located. A copy of the lien is sent by OHCA to the member or his/her representative. The lien must contain the following information:

(A) the name and mailing address of the member, member's spouse, legal guardian, authorized representative, or individual acting on behalf of the member,

(B) the amount of Title XIX paid at the time of the filing of the lien and a statement that the lien amount will continue to increase by any amounts paid thereafter for XIX on the member's behalf,

(C) the date the member began receiving compensated inpatient care at a nursing facility or nursing facilities, intermediate care facility for the mentally retarded or other medical institution,

(D) the legal description of the real property against which the lien will be recorded, and

(E) the address of the Oklahoma Health Care Authority.

(5) **Enforcing the lien**. The lien filed by the OHCA for Title XIX correctly received may be enforced before or after the death of the member. But it may be enforced only:

(A) after the death of the surviving spouse of the member or until such time as the surviving spouse abandons the homestead to reside elsewhere;

(B) when there is no child of the member, natural or adopted, who is 20 years of age or less residing in the home;

(C) when there is no adult child of the member, natural or adopted, who is blind or disabled as defined in, OAC 317:35-1-2 residing in the home;

(D) when no brother or sister of the member is lawfully residing in the home, who has resided there for at least one year immediately before the date of the member's admission to the nursing facility, and has resided there on a continuous basis since that time; and

(E) when no son or daughter of the member is lawfully residing in the home who has resided there for at least two years immediately before the date of the member's admission to the nursing facility, and establishes to the satisfaction of the OKDHS that he or she provided care to the member which permitted the member to reside at home rather than in an institution and has resided there on continuous basis since that time.

(6) **Dissolving the lien**. The lien remains on the property even after transfer of title by conveyance, sale, succession, inheritance or will unless one of the following events occur:

(A) The lien is satisfied. The member or member's representative may discharge the lien at any time by paying the amount of lien to the OHCA. Should the payment of the debt secured by the lien be made to the county office, the payment is forwarded to OHCA/Third Party Liability, so that the lien can be released within 50 days. After that time, the member or the member's representative may request in writing that it be done. This request must describe the lien and the property with reasonable certainty. By statute, a fine may be levied against the lien holder if it is not released in a timely manner.

(B) The member leaves the nursing facility and resides in a property to which the lien is attached, for a period of more than 90 days without being re-admitted to a facility providing nursing care, even though there may have been no reasonable expectation that this would occur. If the member is re-admitted to a nursing facility during this period, and does return to his/her home after being released, another 90 days must be completed before the lien can be dissolved.

(7) **Capital resources**. Rules on the determination of capital resources for individuals related to the aged, blind, or disabled (See OAC 317:35-5-41 through 317:35-5-41.7) apply to the proceeds received for the property in excess of the amount of the lien after the lien is satisfied.

(c) **Recovery from estates.**

(1) If the member was age 55 or older when the nursing care was received, adjustment or recovery may be made only after the death of the individual's spouse, if any, and at a time when there are no surviving children age 20 or less and no surviving disabled children of any age living in the home. Oklahoma Statutes contain

stringent time frames concerning when and how claims against an estate in probate are filed and paid. Therefore, timely updating of computer input forms indicating the death of the member is crucial to insure the OHCA's ability to file timely against the estate.
(2) The estate consists of all real and personal property and other assets included in member's estate as defined by Title 58 of the Oklahoma Statutes. Although county staff ordinarily will not be responsible for inventorying or assessing the estate, assets and property that are not considered in determining eligibility should be documented in the case record.
(3) After updating of computer input form indicating member's death, a computer generated report is sent to OHCA/Third Party Liability (TPL). This report will serve as notification to OHCA/TPL to initiate estate recovery.
(4) Undue hardship waivers may be granted for estate recovery as provided in (b)(3) of the Section.
(5) If an individual covered under an Oklahoma Long-Term Care Partnership Program approved policy received benefits for which assets or resources were disregarded as provided for in OAC 317:35-5-41.9, the Oklahoma Health Care Authority will not seek recovery from the individual's estate for the amount of assets or resources disregarded.

7.b-3 **CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE**
Subchapter 5. Individual Providers and Specialties
Part 25. Psychologists
OAC 317:30-5-275. [AMENDED]
OAC 317:30-5-276. [AMENDED]
OAC 317:30-5-278. [AMENDED]
Part 26. Licensed Behavioral Health Providers
OAC 317:30-5-280. [NEW]
OAC 317:30-5-281. [NEW]
OAC 317:30-5-282. [NEW]
OAC 317:30-5-283. [NEW]
(Reference APA WF #10-15)

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 & issue policy to allow for direct contracting by licensed master's level Licensed Behavioral Health Professionals (LBHP). By allowing direct contracting with these providers it will increase specialist access, increase access to care in rural communities, decrease emergency room utilization, and increase crisis intervention. This rule revision will also divert psychiatric residential treatment center (RTC) usage due to LBHPs being more accessible throughout the state. The RTC diversion will decrease costs and allow members to be seen in their own communities.

ANALYSIS: Rules are revised to allow direct reimbursement to licensed masters level behavioral health professionals who, under current rules, are only allowed to provide services in agency settings. Additionally, psychologist rules are revised to update provider requirements, terminology and to require authorization of services for all services provided except the initial assessment, health and behavior codes and/or crisis intervention. Revisions require LBHPs and Psychologist to complete a customer data core (CDC) assessment sheet to receive reimbursement for services. The CDC data enables OHCA to review quality of service and measure outcomes.

BUDGET IMPACT: Agency staff has determined that the revisions will cost approximately $156,144 in FY 2011 but will result in a budget savings in 2012 of approximately $5,111,520 due to RTC diversion.

MEDICAL ADVISORY COMMITTEE: The Medical Advisory Committee considered the proposed rule revisions on March 25, 2010, and recommended Board approval.

PROPOSED EFFECTIVE DATE: July 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

RESOLUTION:
Resolved, that the Oklahoma Health Care Authority Board does hereby approve the Administrative Rules, subject to the Administrative Procedure Act, as indicated:

Revising behavioral health rules to provide direct reimbursement to licensed masters level behavioral health professionals and to update provider requirements and terminology as well as to require authorization of services for all services provided by Psychologists and LBHPs except the initial assessment, health and behavior codes (for Psychologists only) and/or crisis intervention.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 25. PSYCHOLOGISTS

317:30-5-275. Eligible providers

(a) Licensed Psychologist must be licensed to practice in the state in which services are provided. Payment is made for compensable services to psychologists licensed in the state in which face to face services are delivered. ~~Payment is also made to practitioners who have completed education requirements to begin an internship or a post-doctoral fellowship in an accredited clinical psychology academic training program and are under current board approved supervision toward licensure. Each psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA). Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider.~~

~~(b) In order for services provided by clinical psychology interns completing required internships and post-doctoral fellows completing required supervision for licensure to be reimbursed, the following conditions must be met:~~

~~(1) The practitioner billing SoonerCare must have a letter on file covering the dates of services of the internship or post doctoral fellowship;~~

~~(2) The psychology intern or post-doctoral fellow must be under the direct supervision of the licensed psychologist responsible for the member's care;~~

~~(3) The licensed psychologist responsible for the member's care must:~~

~~(A) staff the member's case with the intern or fellow,~~

~~(B) actively direct the services,~~

~~(C) be available to the intern or fellow for in-person consultation while they are providing services,~~

~~(D) agree with the current plan for the member, and~~

~~(E) confirm that the service provided by the intern or fellow was appropriate; and~~

~~(4) The member's medical record must show that the requirements for reimbursement were met and the licensed psychologist responsible for the member's care has reviewed, countersigned, and dated the notes in the medical record at least every week so that it is documented that the licensed psychologist is responsible for the member's care.~~

(b) Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider.

(c) Services provided by practitioners who have completed education requirements to begin an internship or a post-doctoral fellowship in an accredited clinical psychology academic training program and are under current board approved supervision toward licensure are eligible

for reimbursement. Each supervising psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA).
(d) For those licensure candidates who are actively and regularly receiving board approved supervision, or extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, each supervising psychologist must have a current contract with the Oklahoma Health Care Authority (OHCA).
(e) In order for services provided by clinical psychology interns completing required internships, post-doctoral fellows completing required supervision for licensure to be reimbursed, the following conditions must be met:

(1) The licensed practitioner billing SoonerCare must have a letter on file covering the dates of services of the internship or post doctoral fellowship;
(2) The psychology intern or post-doctoral fellow must be under the direct supervision of the licensed psychologist responsible for the member's care;
(3) The licensed psychologist responsible for the member's care must:
    (A) staff the member's case with the intern or fellow,
    (B) actively direct the services,
    (C) be available to the intern or fellow for in-person consultation while they are providing services,
    (D) agree with the current plan for the member, and
    (E) confirm that the service provided by the intern or fellow was appropriate; and
(4) The member's medical record must show that the requirements for reimbursement were met and the licensed psychologist responsible for the member's care has reviewed, countersigned, and dated the notes in the medical record at least every week so that it is documented that the licensed psychologist is responsible for the member's care.

317:30-5-276. Coverage by category
(a) **Adults.** There is no coverage for adults for services by a psychologist.
(b) **Children.** Coverage for children includes the following services (all services, except Initial or Level of Care Assessment, health and behavior codes and/or Crisis Intervention services, require authorization by OHCA, or its designated agent):

(1) ~~Psychiatric Diagnostic Interview Examination (PDIE). The interview and assessment is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one PDIE is allowable per provider. If there has been a break in service over a six month period, then an additional unit can be prior authorized by OHCA, or their designated agent.~~ Bio-Psycho-Social Assessment (Psychiatric Diagnostic Interview Examination [PDIE] initial assessment or Level of Care Assessment) is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation

of laboratory or other medical diagnostic studies. Only one PDIE is allowable per provider per member. If there has been a break in service over a six month period, then an additional unit of PDIE can be prior authorized by OHCA, or their designated agent.

(2) Individual and/or Interactive psychotherapy in an outpatient setting including an office, ~~or~~ clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or ~~member's residence~~ other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of a SoonerCare eligible child as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is ~~eight~~ six patients for children four years of age up to the age of 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of a SoonerCare eligible child four years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Psychological, Developmental, Neuropsychological, Neurobehavioral Testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Four hours/units of testing per patient (over the age of two), per provider is allowed without prior authorization every 12 months. In circumstances where it is determined that further testing is medically necessary, additional hours/units may be prior authorized by the OHCA or designated agent based upon medical necessity and consultation review. In circumstances where there is a clinical need for specialty testing, then more hours/units of testing can be authorized. Any testing performed for a child under three must be prior authorized. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) ~~Payment for therapy services provided by a psychologist to any one member is limited to five sessions/units per month without prior authorization. In circumstances where it is determined that further sessions/units are medically necessary, then more sessions/units can be prior authorized by the Oklahoma Health Care Authority or their designated agent. A maximum of 12 sessions/units of therapy and testing services per day per provider~~

~~are allowed.~~ Health and Behavior codes – behavioral health services are available only to chronically and severely medically ill children.

(7) ~~A child who is being treated in an acute inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only.~~ Crisis intervention services for the purpose of stabilization and hospital diversion as clinically appropriate.

(8) ~~A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or psychological testing without prior authorization by the OHCA or its designated agent.~~ Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. All units/sessions, except the Initial or Level of Care Assessments or Crisis Intervention must be authorized by the OHCA or its designated agent. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.

(9) A child who is being treated in an acute psychiatric inpatient setting can receive separate Psychological services as the inpatient per diem is for "non-physician" services only.

(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or psychological testing without prior authorization by the OHCA or its designated agent.

(c) **Home and Community Based Waiver Services for the Mentally Retarded.** All providers participating in the Home and Community Based Waiver Services for the mentally retarded program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

(d) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

317:30-5-278. Non-covered procedures

The following procedures by psychologists are not covered:

(1) sensitivity training
(2) encounter
(3) workshops
(4) sexual competency training
(5) marathons or retreats for mental disorders
(6) strictly education training
(7) psychotherapy to persons under three years of age unless specifically approved by OHCA, or its designated agent.

PART 26. LICENSED BEHAVIORAL HEALTH PROVIDERS

317:30-5-280. Eligible Providers

(a) Licensed Behavioral Health Professionals (LBHP) are defined as follows:

(1) Allopathic or Osteopathic Physicians with a current license and board certification in psychiatry or board eligible in the state in

which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(2) Practitioners with a license to practice in the state in which services are provided.

(A) Psychologist,

(B) Social Worker (clinical specialty only),

(C) Professional Counselor,

(D) Marriage and Family Therapist,

(E) Behavioral Practitioner, or

(F) Alcohol and Drug Counselor.

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

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

(b) Practitioners who have completed education requirements to begin an internship or a post-doctoral fellowship in an accredited clinical academic training program and are under current board approved supervision toward licensure. Each supervising LBHP must have a current contract with the Oklahoma Health Care Authority (OHCA).

(c) For those LBHP candidates who are actively and regularly receiving a LBHP board approved supervision, or extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one of the licensing boards listed in 2 (A) through (F) above.

(d) In order for services provided by clinical academic interns completing required internships and LBHP candidates completing required supervision for licensure to be reimbursed, the following conditions must be met:

(1) The licensed LBHP practitioner billing SoonerCare must have a letter on file covering the dates of services of the internship or LBHP board approved supervision;

(2) The academic intern or LBHP candidate must be under the direct supervision of the licensed professional responsible for the member's care;

(3) The supervising licensed professional responsible for the member's care must:

(A) staff the member's case with the academic intern or LBHP candidate,

(B) actively direct the services,

(C) be available to the intern or LBHP candidate for in-person consultation while they are providing services,

(D) agree with the current plan for the member, and

(E) confirm that the service provided by the intern or LBHP candidate was appropriate; and

(4) The member's medical record must show that the requirements for reimbursement were met and the licensed professional responsible for the member's care has reviewed, countersigned, and dated the notes in the medical record at least every week so that it is documented that the licensed professional is responsible for the member's care.

317:30-5-281. Coverage by Category

(a) **Adults**. There is no coverage for adults for services by a LBHP.

(b) **Children**. Coverage for children includes the following services (all services, except for the Initial or Level of Care Assessments or Crisis Intervention, require authorization by OHCA or its designated agent, providers listed in 317:30-5-280(a)(1),(a)(3)and (a)(4) are exempt from authorization):

(1) Bio-Psycho-Social and Level of Care Assessments.

(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.

(B) Assessments for Children's Level of Care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

(2) Individual and/or Interactive psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis.

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six for ages four up to 18. Groups 18-20 year olds can include eight individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Evaluation and Testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight hours/units of testing per patient (over the age of two), per provider is allowed every 12 months. In circumstances where it is determined that further testing is medically necessary, additional hours/units may be prior authorized by the OHCA or designated agent based upon medical necessity and consultation review. In circumstances where there is clinical need for specialty

testing, then more hours/units of testing may be authorized. Testing units must be billed on the date the testing interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to eight sessions/units per month. All units/sessions, except Assessment and Crisis Intervention must be authorized by the OHCA or their designated agent. A maximum of 12 sessions/units of therapy and testing services per day per provider are allowed. Case Management services are considered an integral component of the behavioral health services listed above.

(8) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or testing without authorization by the OHCA or their designated agent.

(c) **Home and Community Based Waiver Services for the Mentally Retarded.** All providers participating in the Home and Community Based Waiver Services for the mentally retarded program must have a separate contract with the OHCA to provide services under this program. All services are specified in the individual's plan of care.

(d) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

317:30-5-282. Non-covered procedures

The following procedures by LBHPs are not covered:

(1) sensitivity training

(2) encounter

(3) workshops

(4) sexual competency training

(5)_marathons or retreats for mental disorders

(6) strictly education training

(7) psychotherapy to persons under three years of age unless specifically approved by OHCA, or its designated agent.

317:30-5-283. Documentation of records

All behavioral health services will be reflected by documentation in the patient records.

(1) All assessment, testing, and treatment services/units billed must include the following:

(A) date;

(B) start and stop time for each session/unit billed;

(C) signature of the provider;

(D) credentials of provider;

(E) specific problem(s), goals, and/or objectives addressed;

(F) methods used to address problem(s), goals and objectives;

(G) progress made toward goals and objectives;

(H) patient response to the session or intervention; and

(I) any new problem(s), goals and/or objectives identified during the session.

(2) For each group psychotherapy session, a separate list of participants must be maintained.

(3) Testing will be documented for each date of service performed which should include at a minimum, the objectives for testing, the

test administered, the results/conclusions and interpretation of the tests, and recommendations for treatment and/or care based on testing and analysis.

Submitted to the C.E.O. and Board on April 8, 2010

AUTHORITY FOR EXPENDITURE OF FUNDS
Radiology Management Services

BACKGROUND
OHCA intends to procure the services of a vendor to manage the utilization of radiology services. For calendar year 2009, OHCA paid almost 180,000 claims for services that will be covered by this program, for a total expenditure of $26 million or about $520 per covered member. Currently, some claims are processed through the MMIS and other claims are prior authorized. The claims that are prior authorized require much agency staff time. A conservative estimate is that we receive some 100 requests per day for Positron Emission Tomography (PET) and Magnetic Resonance Imaging (MRI) which are clinically reviewed.

Estimated savings from utilization management range from 5% to 20% which translates into a potential savings of $1.3 to $5.2 million for OHCA. A similar Alabama Medicaid program recently generated a 32% reduction in utilization over the first few months.

SCOPE OF WORK
- Prior authorization of radiology services based on criteria developed jointly with OHCA
- Services include Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Computerized Tomography (CT), Computerized Tomography Angiography (CTA), and Positron Emission Tomography (PET) provided through freestanding diagnostic facilities and outpatient hospital clinics
- Expedited process for providers who consistently meet criteria
- Retrospective review of radiology services to verify consistency of information
- Provider education on appropriate utilization of radiology services through a call center, provider training, and other activities

CONTRACT PERIOD
July 1, 2010 through June 30, 2011 with annual options to renew through June 30, 2015
Program to begin operations about September 15, 2010

CONTRACT AMOUNT AND PROCUREMENT METHOD
- Contract will be awarded through a competitive bid process
- Estimated contract amount: Not to exceed $1.7 million per fiscal year to be offset by savings
- Provision to reduce or eliminate payments if savings aren't realized

RECOMMENDATION
- Board approval to procure the services discussed above

Presented to OHCA Board

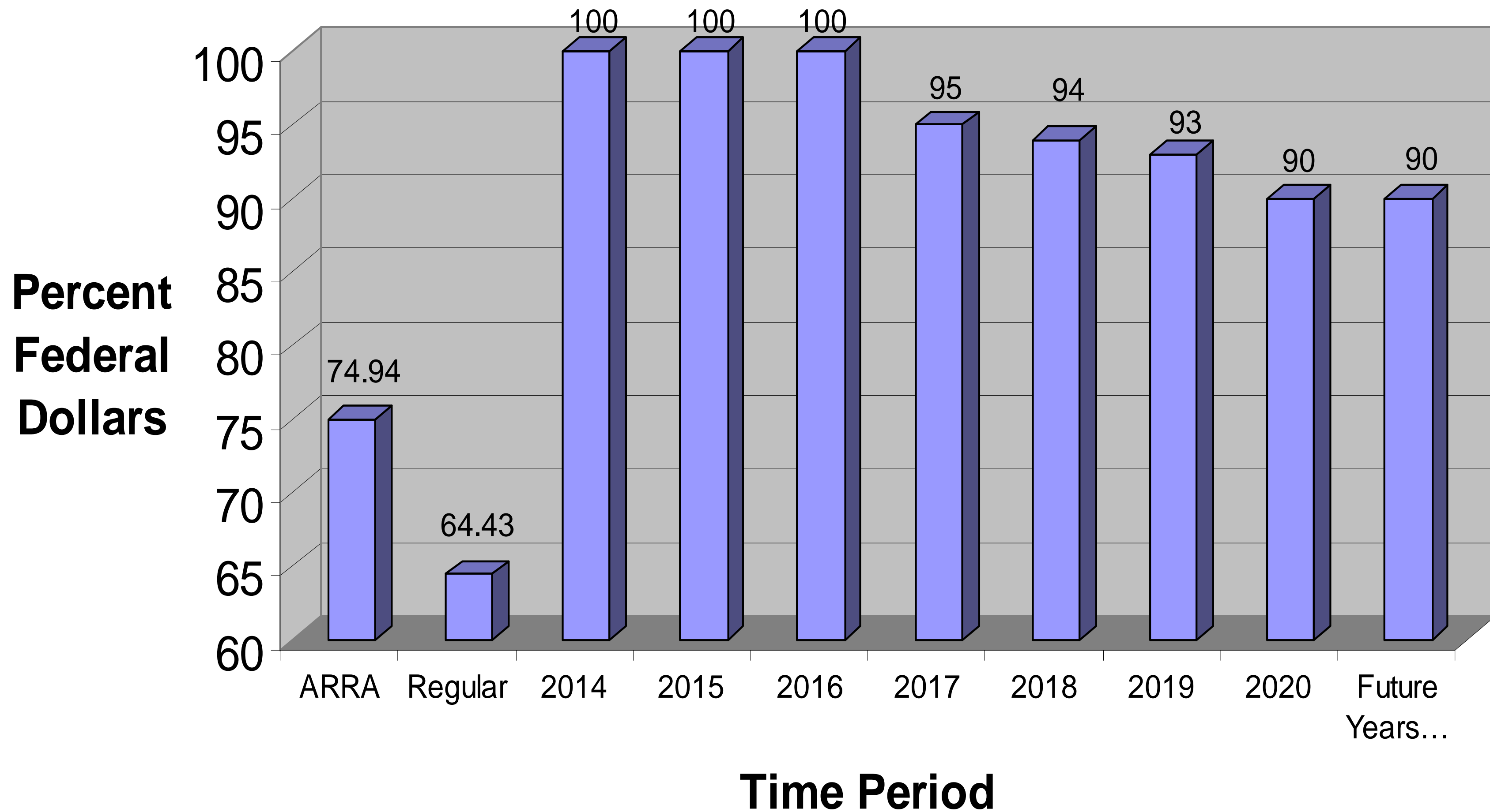
April 8, 2010

Hitting the High Points

Today’s Focus: SoonerCare-specific points

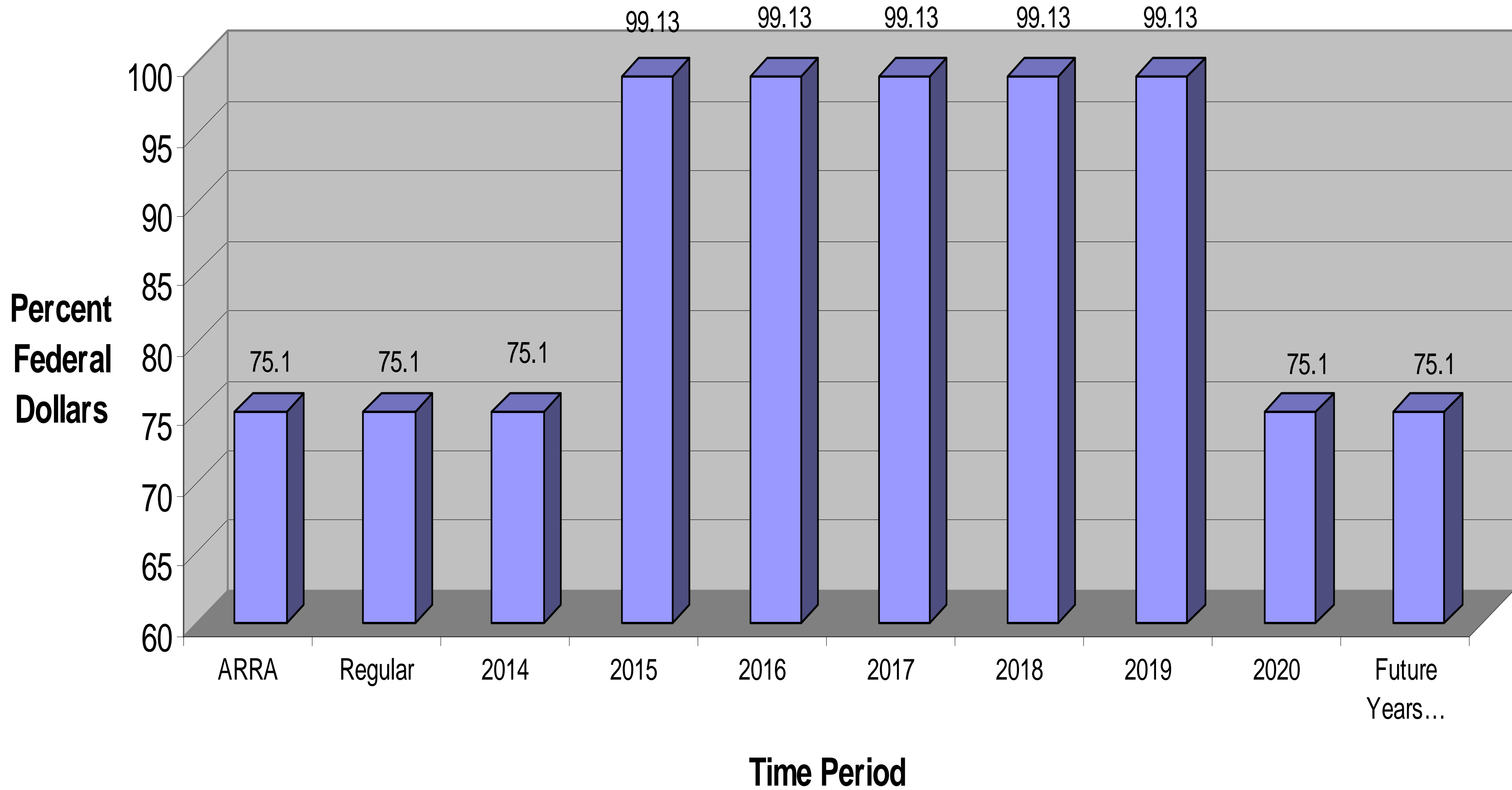
- Challenge: Oklahoma’s Uninsured
- Opportunity: Health Care Reform
  - Financing
  - Enrollment Today vs Enrollment Post-Reform
  - Potential Impact
- Additional Opportunities
  - Potential Impact

Oklahoma FMAP Outlook: Newly Qualified



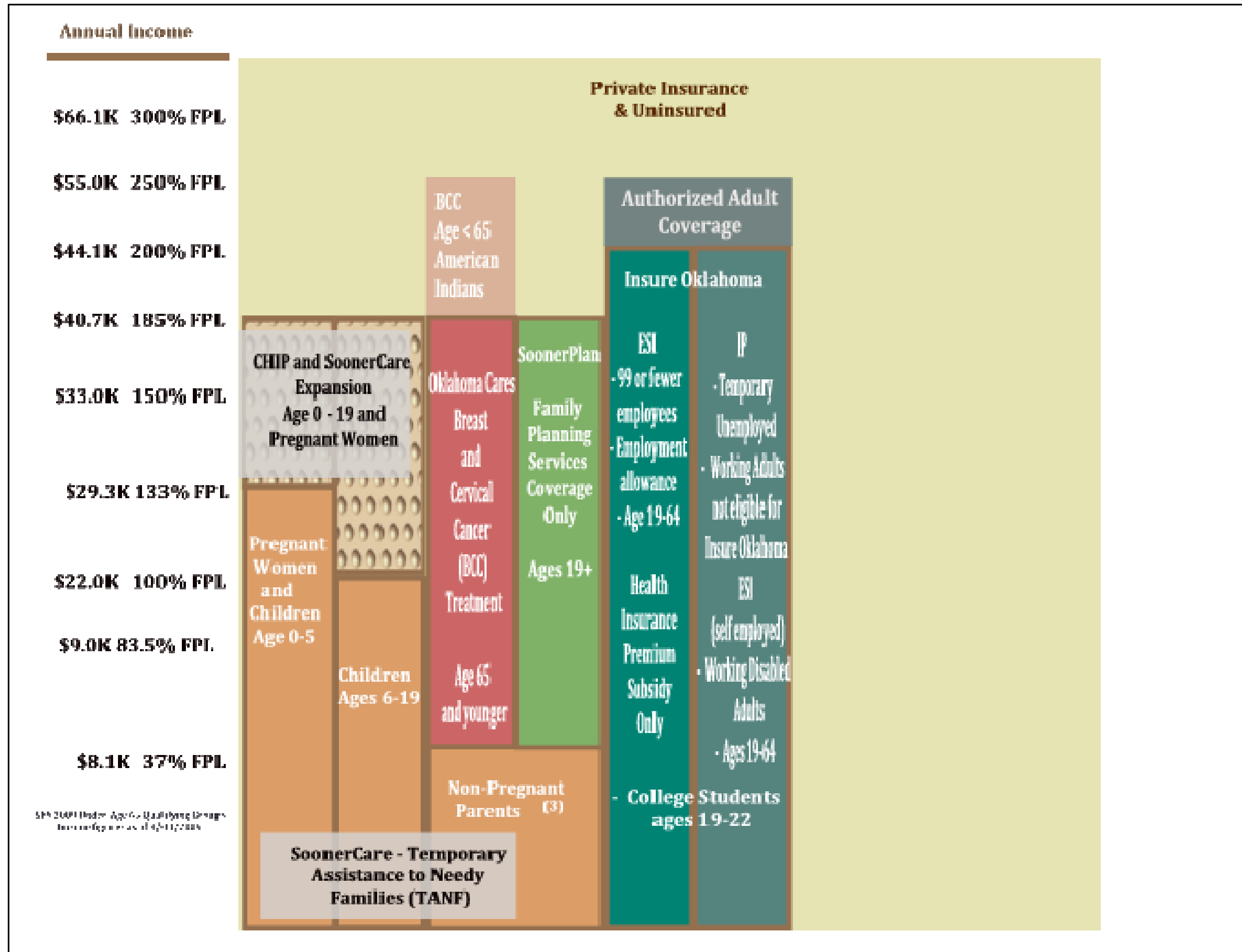
Source: CMS, Regular reflects FY 2010 FMAP Estimates

Oklahoma CHIP FMAP Outlook



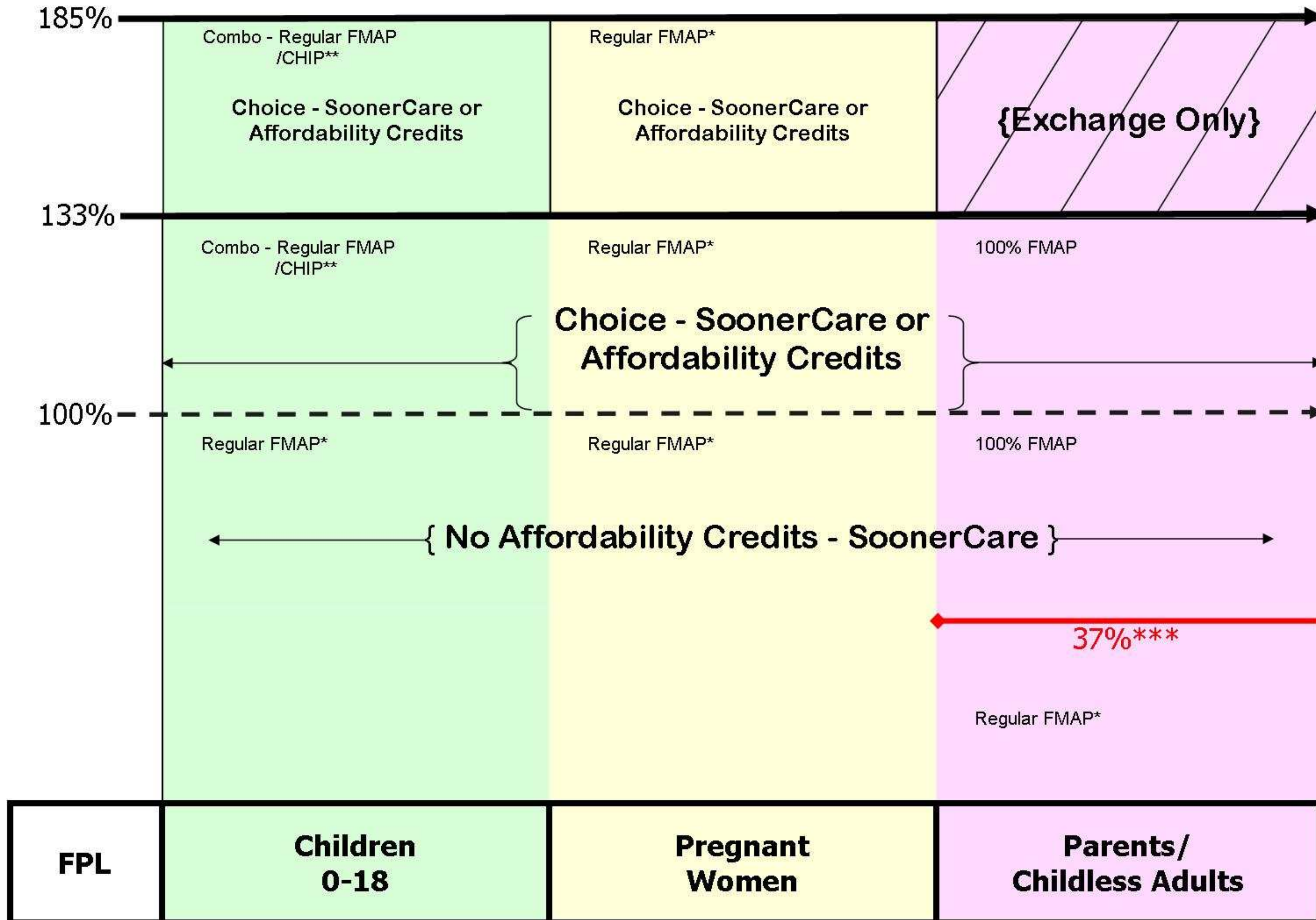
Source: CMS, Regular reflects FY 2010 CHIP FMAP Estimates

Enrollment Today



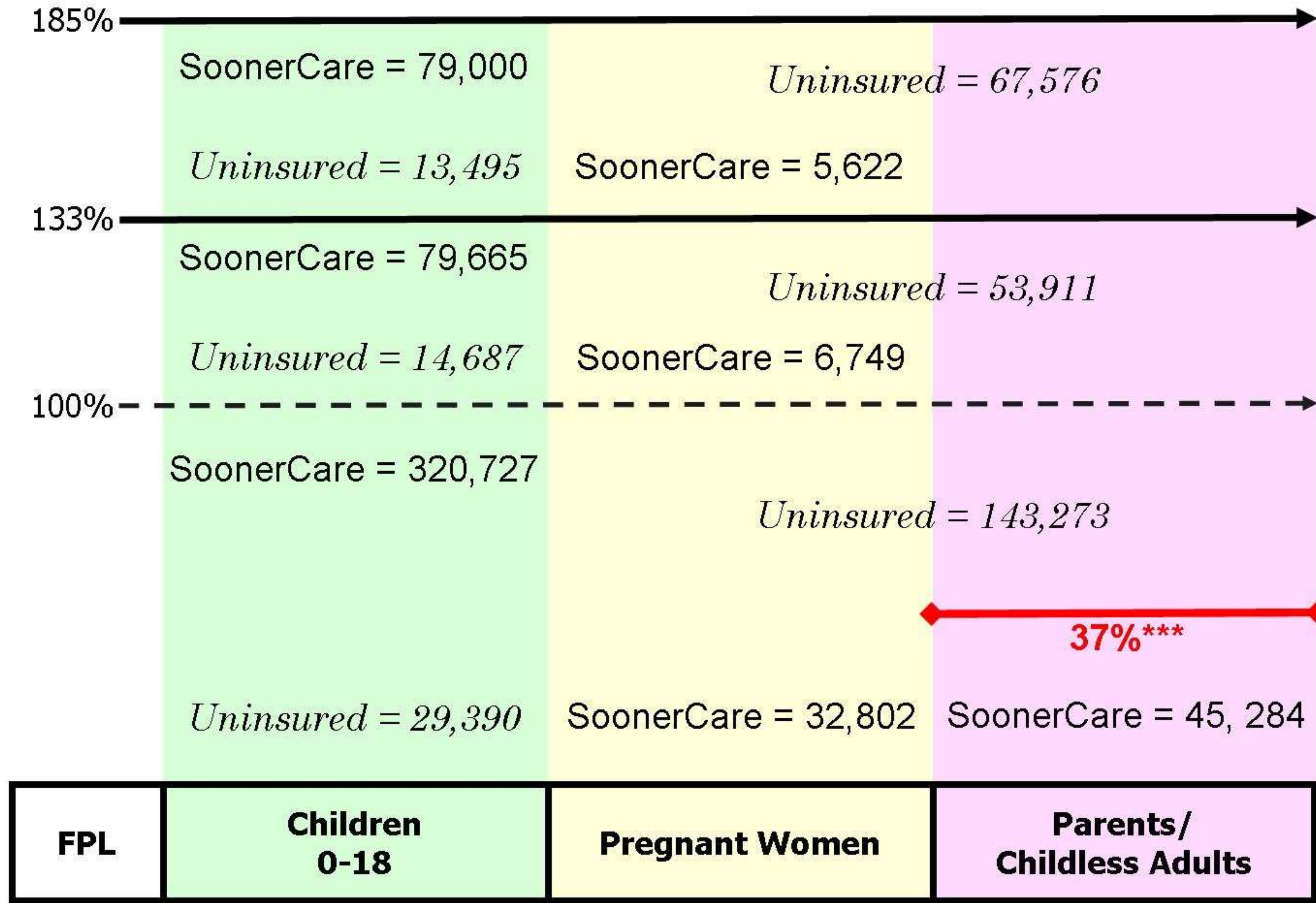
Source: OHCA Annual Report SFY 2009, page 21, figure revised from original publication

Enrollment Post-Reform



Source: OHCA, per analysis of HCR bill as signed by the President on 3/23/10

Enrollment Post-Reform



Source: SoonerCare figures from OHCA, business objects report retrieved 4/7/10; Uninsured figures from US Census Bureau, 2008 data collected in 2009, http://www.census.gov/hhes/www/cpstc/cps_table_creator.html

Potential Oklahoma Impact

Estimated Annual State Costs - Newly Qualified / Woodwork								
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**Future Years**
FMAP	100%	100%	100%	95%	94%	93%	90%	90%
Newly Qualified	200,000	200,000	200,000	200,000	200,000	200,000	200,000	200,000
Woodwork	50,000	50,000	50,000	50,000	50,000	50,000	50,000	50,000
Total State Cost (in millions)	$41.5	$42	$43	$67	$73	$79	$95	$95
State PMPM	$14	$14	$14	$23	$25	$27	$32	$32

Current Annual Uncompensated Care:

Hospitals = $365 M

Cost-Shifting to Insured = $1,000 per family or $1 B total

Source: OHCA, per analysis of HCR bill as signed by the President on 3/23/10. Population figures estimated with US Census Bureau uninsured data. Cost figures estimated with average SoonerCare expenses and include 3% administration. Uncompensated care figures estimated with cost-reports from 103 Oklahoma hospitals, and national study conducted in 2005 by Dr. Kenneth Thorpe, PhD.

- States may choose to expand coverage to childless adults under 133% FPL effective 4/1/10.
  - Regular FMAP applies.
- States may choose to establish a basic state health plan for families earning 133-200% FPL effective 1/1/14.
  - In lieu of FMAP states receive 85% of the tax credits and cost-sharing reductions that would have applied through Exchange plans.

Basic State Health Plan Example

	Household Income at 200% FPL		
	Single Person	Household of 2	Household of 3
Annual Earnings	$21,660	$29,140	$36,620
Out of Pocket Maximum (6.3% of Earnings)	$1,365	$1,836	$2,307
Premium Estimate for 2nd lowest cost Silver Plan (Annual)	$3,600	$7,200	$10,800
Affordability Credit	**$2,235**	**$5,364**	**$8,493**
85% of Credit (Annual)	$1,900	$4,560	$7,219
85% of Credit (Monthly)	**$158**	**$380**	**$602**
Adult Comparison (Reg FMAP)	$230	2 Adults = $460	3 Adults = $690
Child Comparison (Reg FMAP)	$152	1 Adult 1 Child = $382	2 Adults 1 Child = $612
Child Comparison (CHIP FMAP)	$110	1 Adult 1 Child = $340	1 Adult 2 Children = $450

- State receives 85% of the consumer's affordability credits
- Compare state receipts to typical cost of coverage under SoonerCare

Other Reform Notables…

- Income definition for Medicaid & CHIP set as IRS, AGI, and a 5% income disregard.
- Medicaid enrollment must be coordinated with Exchange enrollment to provide seamless enrollment for all programs.
- States required to create and run a website which:
  - Allows application and enrollment in Medicaid, CHIP or Exchange plans.
  - Contains benefit/cost/quality information on plans.
- Medicaid provider rates must equal Medicare provider rates for preventive services.
  - Full 100% FMAP applies to the difference.

Sources: Reform Summaries

- NASMD Health Reform Side by Side

http://www.nasmd.org/home/doc/draftHRsidebyside.pdf

- Kaiser Side by Side of Major Health Reform Proposals

http://www.kff.org/healthreform/sidebyside.cfm

- Library of Congress
  - HR 3590

http://thomas.loc.gov/cgi-bin/bdquery/z?d111:HR03590:

  - HR 4872

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