MEDICAL ADVISORY COMMITTEE MEETING
Draft Meeting Minutes
July 15, 2010

Members attending: Ms. Bellah, Dr. Cavallaro, Dr. Crawford, Ms. Patti Davis, Ms. Sherry Davis, Mr. Goforth, Ms. Dena Thayer for Ms. Harrison, Ms. Holliman, Mr. Gerald Duehning for Mr. Machtolff, Dr. McNeill, Dr. Edd Rhoades for Dr. Kline, Dr. Rhynes, Mr. Roye, Dr. Simon, Mr. Steve Buck for Commissioner White, Dr. Strom-Aulgur, Ms. Rebecca Moore for Mr. Unruh, Dr. Wells, Dr. Woodward, Dr. Wright

Members absent: Ms. Bates, Dr. Bourdeau, Ms. Case, Ms. Dyson, Dr. Grogg, Dr. Kasulis, Dr. Ogle, Dr. Post, Mr. Tallent

I. Welcome, Roll Call, and Public Comment Instructions

Dr. Crawford welcomed the committee members and called the meeting to order. Roll call established the presence of a quorum. There were 2 individuals signed in for public comment. Dr. Crawford asked the clinicians to stay for the sub-committee. Dr. Crawford introduced Dr. Splinter who is taking on the role of State Medicaid Director replacing Lynn Mitchell. Also Dr. Keenan will be the Agency consultant to the committee.

Public Comments:

Mr. Brent Wellborn, Director of Public Policy at the Oklahoma Primary Care Association spoke regarding rule 10-04 – Federally Qualified Health Center Rules informed the committee that there are 17 FQHCs with 37 satellites. The community mental health centers want to use licensed behavioral health professionals which would greatly enhance services. He thanked OHCA for the open communication with association members, CMHCs and staff regarding the rules. The concern from their perspective is the changing payment for LPCs, LADCs, LMFTs, and LBHPs. In 2006-2007 OHCA amended the rules to add these as providers to render services in CMHCs and to that extent CMHCs have built business plans to allow for these providers to provide services. In so doing some health centers are very concerned what this rule will do having a plan based on the current status. The rules were established at a meeting in April and then correspondence from PCA in May with 2 options presented that would allow them to be paid PPS with change of scope or Fee-For-Service. Both of these presented the health centers with very painful results for those who provide these services. He pointed out the words "budget savings estimated" that would come from the CMHCs lack of revenue due to this change. He doesn't believe there is federal regulation at this time that prohibits the current payment method for CMHCs using these provider types. It is very difficult to recruit LCSWs due to places served which are both medically and mental health underserved areas. He referred to an American Psychological study/article of 2007which basically stated that by providing proper behavioral health services for those with chronic conditions decreases overall medical costs. The point is that by using these services greatly enhances providing behavioral health services and potentially reduces utilization of medical services, especially for those with chronic condition. The Association believes that this rule change in fact this payment change will disincentivize the use of these provider types. It is reluctantly acknowledged that of the 2 options presented this is the least painful based upon the provider response.

Mr. Richard DeSirey handed out 2 maps: 1 map was of the combined licensed LADCs, LMFTs, LPCs; and the 2nd map was of the LCSWs He stated that the rule was to be sent to the Behavioral Health Advisory Task Force for review but the meeting was canceled;

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however, a memo was sent to the task force members stating the history of the rule including the LADCs, LMFTs, LPCs, etc. to be included in the core providers. Then notice was received from OHCA stating that payment of these providers through the PPS rate was incorrect and to continue to pay them as core providers would result in a re-basing of the PPS rate. Re-basing the payment is not what the FQHC's want to do and this creates a two tier payment system.. He stated that there are not enough providers to address the critical need in Oklahoma of behavioral health services for children. Mr. DeSirey stated that passing this rule will have a profound effect on peoples' lives and well-being and asked once again for OHCA to look at other options.

Ms. Patti Davis asked that a staff member explain the rate differences. Chairman Crawford asked that this be held until the actual rule is discussed.

II. Approval of minutes of the January 21, 2010 Medical Advisory Committee Meeting
Dr. McNeil made the motion to approve the minutes as presented. Dr. Cavallaro seconded. Motion passed.

III. MAC Member Comments/Discussion Dr. Rhynes noted a 7% decrease in the optometry providers. He stated that this is due more to a material increase issue because of a lab being destroyed by fire in Jakarta than the 3.25% provider rate decrease.

IV. Legislative Update, Nico Gomez, Deputy Chief Executive Officer
Mr. Gomez reviewed the Legislative Summary for 2010 included in the MAC information packet.

V. Financial Report: Carrie Evans, Chief Financial Officer
Ms. Evans reviewed the Financial Report for the five months ended May 31, 2010. For more detailed information see MAC information packet. There were no questions from members.

A. FY'11 Budget Work Program: Juarez McCann, Chief Budget Officer
Ms. Tasha Black filled in for Mr. McCann by reviewing the information provided. For more detail, refer to the MAC information packet. There were no questions from committee members.

VI. Program Operations & Benefits Update: Becky Pasternik-Ikard, Chief Operating Officer
Ms. Pasternik-Ikard reviewed the SoonerCare FastFacts for May 2010, the Insure Oklahoma FastFacts for July 2010, and the SoonerCare Program Operations For more detailed information see report included in MAC information packet.

VIII. Provider Services Support Update: Paul Keenan, MD, Chief Medical Officer
Dr. Keenan reviewed the Provider Fast Fact for May 2010 and responded to a question regarding why the number of contracted hospitals had dropped so significantly from last year. Hospital contracting is on a three-year cycle. During that period, a series of hospitals will contract with us so that we can pay them for care they have provided to a limited number of patients who are being treated out of state. Our contracting period finished in April this year, so many of those hospitals had no reason to renew. We expect the number of hospitals to climb again as the three-year period progresses.

VIII.A. Bariatric Report; Mike Herndon, D.O.
Dr. Herndon gave a brief summary of the bariatric requests: to date 88 surgery requests from approximately 75 members. Approved 14 of these members for Phase 1 which

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means they are determined to be appropriate candidates for this surgery and they enter the 6 month pre-surgical phase. 69 requests were denied with 5 pending the most common reason for denial is the failure to participate in a medically supervised weight-loss program where they failed to lose weight or effectively kept weight off. In the process the member must participate in the program in which they keep a diary instructed by physician, weight loss provider or a nutritionist along with exercise therapy. Coverage for 6 hours of nutritional therapy and prior to the inception of this program only covered 2 hours of nutritional counseling for adults or children. Patients do not have documentation of an attempt prior to the request for surgery and the 2nd reason is the member does not have a co-morbid condition. OHCA does not cover the treatment of obesity alone with bariatric surgery, must have a co-morbid condition (i.e. diabetes, or degenerative joint disease). Dr. Herndon passed out a document with a detailed description of the process along with a check list for providers who have begun submitting the check list with their PA requests. Ms. Patti Davis asked if there is any follow-up after. Dr. Herndon stated that once a member has been approved they are assigned a care manager who follows them throughout the process and follow up after the surgery. Dr. Simon asked what the outcomes have shown. Dr. Herndon stated that since only 5 cases have been approved only a couple have gone through the complete program and had the surgery so there is not a lot of information at this time. Dr. Simon then asked if the age had been changed to 18 year olds. Dr. Herndon explained that at the time the program was implemented there was no evidence showing that those under the age of 18 would be appropriate candidates. But that in recent months the American Academy of Pediatrics had published information stating that females down to age 13 and males to age 15 might benefit, but they must have a BMI over 40 and have failed a comprehensive weight loss program. It is possible that OHCA may need to review the age. Dr. Simon stated that their office has run into the issue that the member gets discouraged because the surgery is not authorized, they don't follow up with the dietician, and then their weight begins to rise. Dr. Herndon explained that the individual who can't meet the criteria upfront may not be a good candidate for the surgery since the post-surgical dietary conditions are very rigid. The whole process is very intense. Dr. Crawford asked if the agency keeps a list of those comprehensive weight management programs around the state that the member can be referred to. Dr. Herndon stated this is an option. There are 2 prior authorization processes: 1) determined as a candidate; 2) after determination members enter into a phase II comprehensive weight loss program.

XI. Action Items: John Giles, Sr. Policy Specialist

OHCA Initiated

10-04 Federally Qualified Health Center Rules - Rules are revised to clarify reimbursement methods for providers of FQHCs and their relationship to the Prospective Payment System (PPS) rate. Currently rules are not clear as to which providers would be reimbursed the PPS rate for services provided. Additionally, rules are revised to clarify requirements for FQHC contracting and behavioral health services provided in school settings.
Budget Impact – Budget savings estimated

The Behavioral Health Advisory Task Force did not meet and sent no feed back in response to correspondence from the agency. Ms. Patti Davis asked for an explanation of the PPS rate vs. the fee-for-service rate.

For core providers the PPS rate is $150 and Fee-for-service rate would be $74.28 for a 60 minute session. Ms. Kelly Botten explained that in 2009 a memo was sent to the FQHCs stating

that there was an issue with the reimbursement for the LPCs, LMFTs, and LADCs. If these individuals were to be considered core providers that the cost need to be included and the PPS rate re-based or they needed to be paid at the fee-for-service rate in compliance with federal regs. Ms. Botten explained that the agency does not know what this will do budget wise. Dr. Crawford stated that there were 2 ways of paying them. Ms. Botten stated that the FQHCs were given 2 options: 1) re-base the PPS rate or 2) pay fee for service. The FQHCs chose the fee for service way. Ms. Ragina Holiman asked if there was a rush or if it could wait until the Behavioral Health Task Force could meet. Mr. Giles stated that the agency wants to move forward on this rule as we have been working with the Primary Care Association for over a year. This is the second time to review by the MAC. The Behavioral Health Advisory Task Force didn't meet due to the flooding at the Lincoln Plaza location, but the agency is ready to move forward. After continued lengthy discussion it was decided to take a roll call vote.

Motion to approve made by Dr. Woodward, Second made by Ms. Sherry Davis

Members voting yes: Dr. Cavallaro, Dr. Crawford, Ms. Patti Davis, Mr. Goforth, Ms. Thayer for Ms. Harrison, Mr. Duehning for Mr. Machtolff, Dr. McNeill, Dr. Rhoades, Dr. Rhynes, Mr. Roye, Dr. Simon, Mr. Buck for Ms. White, Dr. Strom-Aulgur, Mr. Unruh, Dr. Wells, Dr. Woodward, Dr. Wright

Members voting to no: Ms. Bellah, Ms. Sherry Davis, Ms. Holliman

Motion approved 19 yes votes vs. 3 no votes

10-11 General Coverage - General coverage rules are revised to make OHCA rules consistent with reimbursement practices and make coverage rules more consistent throughout policy. Specifically, rules are revised to be consistent with the Centers for Medicare and Medicaid Services (CMS) regarding the elimination of office and inpatient consultation codes. Additional revisions include general policy cleanup as it relates to these sections.
Budget Impact – Budget Neutral

10-32 Insure Oklahoma Dental - Insure Oklahoma rules are revised to add dental services requirements and benefits for children. The Oklahoma Health Care Authority (OHCA), as a requirement of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), will provide dental services to children who qualify for the Insure Oklahoma Individual Plan (IP). Rules will include requirements and benefits for direct dental coverage. The benefits extended to children will include class A, B, C, orthodontic care, and emergency dental services. All dental services for children will follow the American Academy of Pediatric Dentistry (AAPD) periodicity schedule. **Budget Impact –** Approximately $1,312,200 total dollars; State share approximately $460,057.32 for SFY 2011. The state share will be provided from the unused funds from the HEEIA Revolving Fund.

Dr. Wright asked if the $25 copay required is that for every visit. Mr. Giles explained that the program runs parallel to the SoonerCare program. The criteria for SoonerCare will be the same for the Insure Oklahoma Program. Dr. Wells explained also that the orthodontic program is a more stringent program than it was.

10-33 Insure Oklahoma Rate Structure Requirements - Insure Oklahoma rules are revised to provide clarification with regard to carrier and health plan rate structure requirements. Carriers and health plans must meet OHCA's system specifications for all rate structure tiers and requirements. The OHCA must be able to recreate premium invoice amounts for all approved Insure Oklahoma members. If a carrier and/or health plan can not accommodate OHCA's

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system specifications for all rate structure tiers and requirements, the carrier and/or health plan will not be allowed to participate in the Insure Oklahoma program. Carrier and/or health plan rate structure requirements include all rate tiers and age-up methodologies.
Budget Impact – Budget Neutral

10-34 DMEPOS Quality Assurances - Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) rules are revised to set guidelines for quality assurances and safeguards. Rules set guidelines related to DMEPOS quality standards, manufacturer standards, member education, maintenance and repair of products, safety and infection control, and provider contact and follow-up services.
Budget Impact – Budget Neutral

10-36 Fee Schedule Revisions - Agency rules are revised to clarify the criteria used to review and revise provider fee schedules. Rules clarify that provider fee schedules may be revised based on efficiency, budget considerations, economy, and quality of care. Rules provide guidelines related to fee schedule updates and provider notifications of such updates. Rules also provide guidance related to public notice of significant proposed changes in methods and standards for setting provider payment rates for services.
Budget Impact – Budget Neutral

Ms. Patti Davis asked how providers will be notified of these changes prior to the changes made. Dr. Crawford asked if she meant in writing through the mail or by e-mail? Ms. Roberts asked about notifying the associations. Ms. Davis stated that not everyone/hospital is a member of the associations. Ms. Botten asked how much notice Ms. Davis felt was acceptable? Ms. Roberts suggested bringing a proposal for addressing this to a future meeting.

10-39 Signature Requirements - Agency rules are revised to establish provider signature requirements. For medical review purposes, the OHCA will require that all services provided and/or ordered be authenticated by the author. The method used shall be a hand written signature, electronic signature, or signature attestation statement. Stamp signatures are not acceptable. Rules are revised to be consistent with the Centers for Medicare and Medicaid Services (CMS) regarding such provider signature requirements.
Budget Impact – Budget Neutral

10-40 Sooner Seniors Waiver - Rules are revised to include language creating a new Home and Community Based Services Waiver program known as Sooner Seniors. The Sooner Seniors Waiver is targeted to members who are age 65 or older, have a clinically documented degenerative disease process and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new waiver allows members to continue receiving the same home and community based services offered through Living Choice.
Budget Impact – Approximately $159,072 Total dollars, SFY 2011; State share approximately $39,529

10-41 My Life, My Choice Waiver - Rules are revised to include language creating a new Home and Community Based Services Waiver program known as My Life, My Choice. The My Life, My Choice Waiver is targeted to members who are 20 to 64 years of age, physically disabled and have been transitioned from a nursing facility to a home and community based setting through the Living Choice demonstration program. The new waiver allows members to continue receiving the same home and community based services offered through Living Choice.

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Budget Impact – Approximately $798,840 Total, SFY 2011; State Share approximately $198,511

Mr. Unruh asked if the 2 waivers needed to be implemented now with the budget issues and how many people will this affect. Ms. Melinda Jones spoke to his questions about the waivers the commitment is an on-going commitment that the individuals involved only have one year in the demonstration grant and now we are establishing the continuity of care. It is less costly to provide these services at home instead of the institutional settings.

10-45 Provider Audit Appeal Rules - Agency rules are revised regarding provider program integrity audits/reviews appeals to comply with Section 1011.9 of Title 56 of Oklahoma Statutes. These revisions allow for the recoupment of overpayments due to identified errors determined not to be fraudulent only after a provider has had the opportunity to exercise the right to an appeal that includes a hearing conducted by an administrative law judge appointed by the Oklahoma Attorney General. Rules also clarify that a provider has the right to participate in the hearing and to be represented by legal counsel.
Budget Impact – Approximately $33,000 Total SFY 2011; State share approximately $16,500 SFY‘11.

Rules 10-11, 10-32, 10-33, 10-34, 10-36, 10-39 10-40, 10-41, 10-45 to be taken En Bloc.
Motion to approve rules made by Ms. Bellah and Seconded by Dr. Cavallaro
Motion passed

X. New Business - None

XI. Adjourn – 2:50 p.m.

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