OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
December 8, 2011 at 1:00 P.M.
OSU College of Osteopathic Medicine
CAME/Merkel Auditorium
1111 W. 17th, Tulsa, 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 November 10, 2011 OHCA Board Minutes
3 Discussion Item – Reports to the Board by Board Committees

    a) Audit/Finance Committee – Member Miller
    b) Rules Committee – Member McVay
    c) Strategic Planning Committee – Vice Chairman Armstrong

Items to be presented by Mike Fogarty, Chief Executive Officer

4. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Carrie Evans, Chief Financial Officer
    b) Medicaid Director's Update – Garth Splinter, State Medicaid Director

Items to be presented by Kimrey McGinnis, Waiver Development Coordinator

5. Discussion Item – Waiver Development and Reporting

    a) 1115 SoonerCare Choice waiver renewal
    b) Proposal for limited benefit package for aspect of Breast and Cervical Cancer program

Items to be presented by Garth Splinter, State Medicaid Director, Nancy Nesser, Pharmacy Director, Melody Anthony, Provider Services Director, and Alison Martinez, Clinical Data Analyst

6. Discussion Item – Utilization Controls Tools for Pharmacy and Emergency Room (ER) Services and Analysis of Utilization Control Initiatives

    a) Utilization Controls for Narcotic Analgesics & Analysis of Brand Drug Utilization – Nancy Nesser, JD, PharmD, Director – Pharmacy Services
    b) Frequent ER Utilization Program – Identifying Persistent Members and Steps for Intervention – Melody Anthony, MS, Director – Provider Services
    c) Legal Intervention and the ER Utilization Program – Garth Splinter, MD, State Medicaid Director
    d) ER Utilization Analysis – Efforts by State of Washington and How Those Would Translate for State of Oklahoma – Alison Martinez, PhD, Clinical Data Analyst

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

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

Items to be presented by Cindy Roberts, Chairperson of State Plan Amendment Rate Committee

8. Action Item – Consideration and Vote Upon the recommendations of the State Plan Amendment Rate Committee

   a) Consideration and vote to increase the regular nursing home facility rate serving adults by increasing the pool of funds available for the direct care and other components from $97,607,577 to $102,318,569.

Item to be presented by Dr. Nancy Nesser – Pharmacy Services

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

   a) Consideration and vote to add Selected Biologic Products used to treat the product-based prior authorization program under Oklahoma Administrative Code (OAC) 317:30-5-77.3.

   b) Consideration and vote to add Firazyr® (icatibant) to the utilization and scope prior authorization program under Oklahoma Administrative Code (OAC) 317:30-5-77.2(e).

Item to be presented by Chairman Roggow

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

    A. Status of Pending Suits

    Status of Pending suits and claims

    2010 DMH Administrative Claiming DAB A-10-73 CMS Departmental Appeals Board

11. New Business

12. ADJOURNMENT

NEXT BOARD MEETING
January 12, 2012
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A
Ponca Conference Room
Oklahoma City, OK 73107

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
November 10, 2011
Held at the Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A public notice was placed on the front door of the Oklahoma Health Care Authority on November 8, 2011.

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

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

OTHERS PRESENT:

Charles Brodt, HP
Will Widman, HP
Lisa Adams, Varangon Academy
Billie Thompson, Varangon Academy

OTHERS PRESENT:

Josh Cook, HP
Lisa Spain, HP
Tim Dumas, Varangon Academy
Becky Moore, OAHCP

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD OCTOBER 13, 2011.

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 October 13, 2011 board minutes as published. Member McFall seconded.

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

ITEM 3/REPORTS TO THE BOARD BY BOARD COMMITTEES

Vice-Chairman Armstrong reported that the Strategic Planning Committee had met, discussing in particular the Health Information Exchange. The OHCA is doing everything that we need and can be doing at this time.

Before moving to the Chief Executive Officer's Report, Chairman Roggow recognized that CEO, Mike Fogarty is being honored with OBU's Alumni Achievement Award.

FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported that the Revenues for OHCA through September, accounting for receivables, were **$974,501,520** or **(.0%) under** budget. Expenditures for OHCA, accounting for encumbrances, were **$861,326,492** or 1.4% **under** budget. The state dollar budget variance through September is **$11,956,196 positive.**

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

Expenditures:		
Medicaid Program Variance		6.3
Administration		1.7
Revenues:		
Taxes and Fees		1.0
Drug Rebate		1.7
Overpayments/Settlements		1.3
Total FY 12 Variance	**$**	**12.0**

For a detailed report, see Item 4a of the November 10, 2011 board packet.

Ms. Evans also discussed receivables due from other state agencies. Because the FMAP dropped October 1, we did go ahead and pay some expenditures for other state agencies without getting their state share up front. This was to allow them to benefit from the higher FMAP. The OHCA has been paid back by all of these agencies.

MEDICAID DIRECTOR'S UPDATE
Becky Pasternik-Ikard, JD, RN – Deputy State Medicaid Director

Ms. Pasternik-Ikard went over the data sheet highlighting the fact that the overall SoonerCare Enrollment for September 2011 is 767,270. This is an increase of less than 2,000 members. Again, enrollment remains level with a very small increase in dual eligible enrollment. Total primary care providers, as well as patient center medical home providers, continue to increase. Electronic health record payment incentives continue to increase with a total of 920 payments for almost $56 million since January 2011.

She also addressed Member McFall's question from the October Board meeting about how Oklahoma compares with other states with regard to the electronic health record payments. A chart, with data from CMS, was provided which depicts the 22 states making incentive payments since January of 2011. Overall, Oklahoma is second in the amount of incentive payments made to providers, fourth in incentive payments to hospitals and fourth overall.

For a detailed report, see Item 4b of the November 10, 2011 board packet.

EXCELLENCE IN CHILDREN'S HEALTH OUTREACH AND ENROLLMENT (ECHOE) AWARD
Mike Fogarty, Chief Executive Officer

Mr. Fogarty informed the Board that the OHCA received the ECHOE Award at a gathering, sponsored by CMS, of the National Children's Health Insurance Summit. It was intended to specifically bring attention to states that had successfully made strides in getting children covered. In this instance, it demonstrated how bringing our various resources together produces the type of results that are desired. He introduced Ed Long, Child Health and Tracy Turner, Information Services who were instrumental in these efforts and who attended the meeting. Ed and Tracy gave the group an overview of the meeting and the OHCA projects that were highlighted.

ITEM 5/EVOLUTION, INITIATIVES AND OUTCOMES OF THE SOONERCARE CARE MANAGEMENT PROGRAM

Marlene Asmussen, RN, CCM, Director – Care Management

Ms. Asmussen presented an overview of the Care Management Department, including its mission, how it has evolved over time, the services that it provides and how it is organized to provide maximum coverage for all areas of the state. She discussed targeted outreach programs of the department and outcomes.

ITEM 6/ONLINE DEMONSTRATION OF THE ELECTRONIC PROVIDER ENROLLMENT SYSTEM

Beth VanHorn, Director – Legal Operations

Ms. VanHorn presented an overview of the original manual provider enrollment process and the development of an electronic provider enrollment system, highlighting the benefits of the new electronic systems. These benefits include increased efficiency, reduced time and expenses associated with mailing, manual data entry, a consistent process for each provider and convenience of access to information for providers. The group was shown a live demonstration of how a provider would access and complete their information online.

As the group moved through the live demonstration, Board members asked questions about the information providers were asked to provide and how some of that information was used. Ms. VanHorn addressed each of these, including how credentials were verified through the various licensing boards.

ITEM 7/UPDATE ON TELEWORK PILOT PROGRAM

Lisa Gifford, JD, Director – Financial Resources

Ms. Gifford gave an overview of the Telework Pilot Program authorized by House Bill 1086. Her division, which consists of 3 units and 33 employees, was designated to perform the pilot project. As of November 1, 2011, the telework project is in place. Many factors were considered when deciding which employees would be able to participate. Some of these were internet broadband connections, actual job functions and ability of the functions to be paperless. Participating employees cannot print information at home because of protected health information. The OHCA will be publishing all the steps and paperwork that have been established, including employee agreements and checklists. The original hope was that there would be some cost savings, but we do not expect to see those at this time with the small group. We are looking at other measures to determine the success of the project. For instance, this could be our long term contingency plan in the event of hazardous weather or disaster. It is also expected that employee productivity will increase, and there are systems in place to measure this.

Ms. Gifford addressed questions and discussion regarding employee schedules and initiatives by other states. For employees with customer service functions, they work the same hours as those employees physically in the office. For those who do not have customer service functions, there are core hours within which they must work and all other work may be completed during the hours of the employee's choice. A lot of the information that was reviewed when developing this pilot was based on best practices from the State of Minnesota.

ITEM 8/ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS REGARDING THIS BOARD MEETING

Mr. Pallotta stated that the Conflicts of Interest Panel met and found no conflicts regarding action items.

ITEM 11/NEW BUSINESS

Chairman Roggow moved Item 11 up on the agenda at the request of CEO, Mike Fogarty.

Mr. Fogarty and Becky Pasternik-Ikard updated the Board on the implementation of a recent contract that has been difficult. The contract deals with prior authorizations and our behavioral health providers. On November 9, 2011, there was a meeting with the Behavioral Health Advisory group. Representatives from the contractor, Optum Health, were at this meeting to answer questions, identify problems and have an exchange. We hope that this discussion was beneficial and will help us to make progress, and continue to meet daily with Optum to resolve issues.

In response to questions from the Board members, Ms. Pasternik-Ikard informed the group that this change to Optum was part of the regular bid process and that the timeline for full functionality is November 18, 2011. Mr. Fogarty stated that it is very important that our providers get paid and as a result, the agency did a very quick analysis of historic numbers, and has started generating payments to providers based on that data. Our number one focus at this time is to get this system fully functional and operational.

ITEM 9/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) and (7)

Howard Pallotta, General Counsel

MOTION: Vice-Chairman Armstrong moved for Executive Session. Member McFall seconded.

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

ITEM 10/CONSIDERATION AND VOTE UPON BOARD MEETING DATES, TIMES AND PLACES FOR CALENDAR YEAR 2012

The Board discussed the dates and places, in particular the Board Retreat in 2012.

MOTION: Member McFall moved for adoption of the calendar for 2012. Vice-Chairman Armstrong seconded.

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

ITEM 12/ADJOURNMENT

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

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

FINANCIAL REPORT

For the Four Months Ended October 31, 2011
Submitted to the CEO & Board
December 8, 2011

- Revenues for OHCA through October, accounting for receivables, were **$1,253,416,902** or **(.2%) under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$1,150,461,084** or **1.4% under** budget.

- The state dollar budget variance through October is **$12,958,682 positive.**

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

Expenditures:		
Medicaid Program Variance		5.2
Administration		2.2
Revenues:		
Taxes and Fees		1.6
Drug Rebate		2.4
Overpayments/Settlements		1.6
Total FY 12 Variance	**$**	**13.0**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2012, For the Four Months Ended October 31, 2011

REVENUES	FY12 Budget YTD	FY12 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 374,167,354	$ 374,167,354	$ -	0.0%
Federal Funds	701,641,943	685,966,530	(15,675,413)	(2.2)%
Tobacco Tax Collections	19,351,409	21,134,420	1,783,011	9.2%
Quality of Care Collections	17,338,906	17,201,869	(137,037)	(0.8)%
Prior Year Carryover	55,003,490	55,003,490	-	0.0%
Federal Deferral - Interest	109,355	109,355	-	0.0%
Drug Rebates	70,783,021	77,506,835	6,723,814	9.5%
Medical Refunds	13,450,291	17,587,870	4,137,579	30.8%
Other Revenues	4,375,415	4,739,179	363,763	8.3%
TOTAL REVENUES	**$ 1,256,221,184**	**$ 1,253,416,902**	**$ (2,804,283)**	**(0.2)%**

EXPENDITURES	FY12 Budget YTD	FY12 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 14,608,036**	**$ 12,994,995**	**$ 1,613,041**	**11.0%**
ADMINISTRATION - CONTRACTS	**$ 37,768,832**	**$ 33,925,868**	**$ 3,842,964**	**10.2%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	11,437,238	9,346,797	2,090,440	18.3%
Acute Fee for Service Payments:				
Hospital Services	301,072,412	290,854,715	10,217,697	3.4%
Behavioral Health	100,836,419	106,135,021	(5,298,602)	(5.3)%
Physicians	142,238,767	141,699,194	539,573	0.4%
Dentists	50,266,356	48,493,466	1,772,890	3.5%
Other Practitioners	21,158,729	24,498,279	(3,339,550)	(15.8)%
Home Health Care	7,415,298	6,999,036	416,262	5.6%
Lab & Radiology	17,327,248	17,125,621	201,627	1.2%
Medical Supplies	15,580,902	15,144,927	435,975	2.8%
Ambulatory Clinics	30,625,724	27,475,831	3,149,893	10.3%
Prescription Drugs	116,536,149	118,067,022	(1,530,873)	(1.3)%
Miscellaneous Medical Payments	10,310,239	10,811,112	(500,873)	(4.9)%
OHCA TFC	-	-	-	0.0%
Other Payments:				
Nursing Facilities	161,284,387	160,275,725	1,008,662	0.6%
ICF-MR Private	18,915,976	18,726,146	189,830	1.0%
Medicare Buy-In	48,125,231	47,742,380	382,851	0.8%
Transportation	9,333,093	9,154,899	178,194	1.9%
EHR-Incentive Payments	26,852,111	26,852,111	-	0.0%
Part D Phase-In Contribution	24,441,517	24,137,937	303,581	1.2%
Total OHCA Medical Programs	**1,113,757,799**	**1,103,540,221**	**10,217,578**	**0.9%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 1,166,224,049**	**$ 1,150,461,084**	**$ 15,762,965**	**1.4%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 89,997,135**	**$ 102,955,818**	**$ 12,958,682**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2012, For the Four Months Ended October 31, 2011

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 9,496,320	$ 9,339,983	$ -	$ 149,523	$ -	$ 6,814	$ -
Inpatient Acute Care	217,653,038	194,234,654	162,229	4,012,165	16,771,875	1,041,508	1,430,607
Outpatient Acute Care	82,061,484	76,915,110	13,868	3,417,035	-	1,715,471	
Behavioral Health - Inpatient	41,056,705	39,520,064	-	-	-	2,658	1,533,984
Behavioral Health - Outpatient	6,311,710	6,302,188	-	-	-	-	9,522
Behavioral Health Facility- Rehab	75,858,057	59,182,499	-	165,775	-	43,711	16,466,072
Behavioral Health - Case Management	-	-	-	-	-	-	
Residential Behavioral Management	4,784,407	-	-	-	-	-	4,784,407
Targeted Case Management	19,411,020	-	-	-	-	-	19,411,020
Therapeutic Foster Care	1,083,901	1,083,901	-	-	-	-	-
Physicians	158,978,263	118,099,481	19,367	5,338,344	20,439,956	3,140,389	11,940,724
Dentists	48,518,079	45,815,380	-	24,613	2,652,262	25,824	-
Other Practitioners	24,688,543	24,010,768	148,788	190,264	326,113	12,610	-
Home Health Care	6,999,043	6,985,544	-	6	-	13,493	-
Lab & Radiology	18,178,000	16,649,973	-	1,052,379	-	475,649	-
Medical Supplies	15,392,312	14,297,376	825,316	247,385	-	22,235	-
Ambulatory Clinics	31,499,366	27,349,040	-	612,653	-	126,791	3,410,883
Personal Care Services	4,022,928	-	-	-	-	-	4,022,928
Nursing Facilities	160,275,725	102,346,924	44,766,120	-	13,154,037	8,644	-
Transportation	9,154,899	8,269,700	860,705	-	22,305	2,189	-
GME/IME/DME	53,244,105	-	-	-	-	-	53,244,105
ICF/MR Private	18,726,146	15,392,548	3,050,635	-	282,963	-	-
ICF/MR Public	19,454,852	-	-	-	-	-	19,454,852
CMS Payments	71,880,317	71,041,050	839,267	-	-	-	-
Prescription Drugs	124,013,547	103,101,520	-	5,946,524	14,339,298	626,204	-
Miscellaneous Medical Payments	10,811,164	10,305,206	-	51	474,500	31,406	-
Home and Community Based Waiver	51,880,737	-	-	-	-	-	51,880,737
Homeward Bound Waiver	28,833,364	-	-	-	-	-	28,833,364
Money Follows the Person	922,361	-	-	-	-	-	922,361
In-Home Support Waiver	7,905,471	-	-	-	-	-	7,905,471
ADvantage Waiver	56,672,959	-	-	-	-	-	56,672,959
Family Planning/Family Planning Waiver	1,808,228	-	-	-	-	-	1,808,228
Premium Assistance*	20,123,321	-	-	20,123,321	-	-	-
EHR Incentive Payments	26,852,111	26,852,111					
Total Medicaid Expenditures	**$ 1,428,552,483**	**$ 977,095,021**	**$ 50,686,295**	**$ 41,280,039**	**$ 68,463,310**	**$ 7,295,594**	**$ 283,732,223**

* Includes $20,013,769.98 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2012, For the Four Months Ended October 31, 2011

		FY12
REVENUE		**Actual YTD**
Revenues from Other State Agencies	$	95,909,081
Federal Funds		184,326,462
TOTAL REVENUES	**$**	**280,235,542**

EXPENDITURES	**Actual YTD**
Department of Human Services	
Home and Community Based Waiver	$ 51,880,737
Money Follows the Person	922,361
Homeward Bound Waiver	28,833,364
In-Home Support Waivers	7,905,471
ADvantage Waiver	56,672,959
ICF/MR Public	19,454,852
Personal Care	4,022,928
Residential Behavioral Management	3,874,323
Targeted Case Management	14,720,606
Total Department of Human Services	**188,287,599**
State Employees Physician Payment	
Physician Payments	11,940,724
Total State Employees Physician Payment	**11,940,724**
Education Payments	
Graduate Medical Education	18,150,000
Graduate Medical Education - PMTC	1,355,971
Indirect Medical Education	29,677,651
Direct Medical Education	4,060,483
Total Education Payments	**53,244,105**
Office of Juvenile Affairs	
Targeted Case Management	809,386
Residential Behavioral Management - Foster Care	17,693
Residential Behavioral Management	892,391
Multi-Systemic Therapy	9,522
Total Office of Juvenile Affairs	**1,728,992**
Department of Mental Health	
Targeted Case Management	-
Hospital	1,533,984
Mental Health Clinics	16,466,072
Total Department of Mental Health	**18,000,056**
State Department of Health	
Children's First	687,144
Sooner Start	739,296
Early Intervention	2,177,507
EPSDT Clinic	799,370
Family Planning	19,226
Family Planning Waiver	1,773,202
Maternity Clinic	45,507
Total Department of Health	**6,241,252**
County Health Departments	
EPSDT Clinic	295,436
Family Planning Waiver	15,799
Total County Health Departments	**311,236**
State Department of Education	**46,581**
Public Schools	**969,796**
Medicare DRG Limit	**-**
Native American Tribal Agreements	**1,531,273**
Department of Corrections	**128,825**
JD McCarty	**1,301,783**
Total OSA Medicaid Programs	**$ 283,732,223**
OSA Non-Medicaid Programs	**$ 27,271,988**
Accounts Receivable from OSA	**$ 30,768,668**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2012, For the Four Months Ended October 31, 2011

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 12,802,499	$ 12,802,499
Interest Earned	12,774	12,774
TOTAL REVENUES	**$ 12,815,273**	**$ 12,815,273**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 43,508,012	$ 15,597,622	
Eyeglasses and Dentures	94,928	34,032	
Personal Allowance Increase	1,163,180	417,000	
Coverage for DME and supplies	825,316	295,876	
Coverage of QMB's	344,252	123,414	
Part D Phase-In	839,267	839,267	
ICF/MR Rate Adjustment	1,606,915	576,079	
Acute/MR Adjustments	1,443,720	517,573	
NET - Soonerride	860,705	308,563	
Total Program Costs	**$ 50,686,295**	**$ 18,709,426**	**$ 18,709,426**
Administration			
OHCA Administration Costs	$ 136,287	$ 68,143	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 136,287**	**$ 68,143**	**$ 68,143**
Total Quality of Care Fee Costs	**$ 50,822,582**	**$ 18,777,570**	
TOTAL STATE SHARE OF COSTS			**$ 18,777,570**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

Fiscal Year 2012, For the Four Months Ended October 31, 2011

REVENUES	FY 11 Carryover	FY 12 Revenue	Total Revenue
Prior Year Balance	$ 21,470,039	$ -	$ 18,163,006
State Appropriations			
Tobacco Tax Collections	-	17,382,436	17,382,436
Interest Income	-	164,445	164,445
Federal Draws	4,432,268	13,298,657	13,298,657
All Kids Act	(7,440,241)	102,390	102,390
TOTAL REVENUES	$ 18,462,066	$ 30,947,927	$ 49,008,544

EXPENDITURES		FY 11 Expenditures	FY 12 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 19,770,341	$ 19,770,341
	College Students		109,551	109,551
	All Kids Act		243,429	243,429
Individual Plan				
	SoonerCare Choice		$ 145,497	$ 52,161
	Inpatient Hospital		3,998,933	1,433,617
	Outpatient Hospital		3,372,221	1,208,941
	BH - Inpatient Services		-	-
	BH Facility - Rehabilitation Services		164,795	59,079
	Physicians		5,299,578	1,899,899
	Dentists		19,754	7,082
	Other Practitioners		184,262	66,058
	Home Health		6	2
	Lab and Radiology		1,037,215	371,842
	Medical Supplies		240,540	86,234
	Ambulatory Clinics		606,499	217,430
	Prescription Drugs		5,868,615	2,103,898
	Miscellaneous Medical		-	-
	Premiums Collected		-	(778,484)
Total Individual Plan			$ 20,937,914	$ 6,727,758
	College Students-Service Costs		$ 176,626	$ 63,321
	All Kids Act- Service Costs		$ 42,178	$ 15,121
Total Program Costs			$ 41,280,039	$ 26,929,521
Administrative Costs				
	Salaries	$ 13,534	$ 533,212	$ 546,746
	Operating Costs	29,081	43,488	72,569
	Health Dept-Postponing	-	-	-
	Contract - HP	256,445	740,506	996,950
Total Administrative Costs		$ 299,059	$ 1,317,205	$ 1,616,265
Total Expenditures				$ 28,545,785
NET CASH BALANCE		$ 18,163,006		$ 20,462,758

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2012, For the Four Months Ended October 31, 2011

REVENUES	FY 12 Revenue	State Share
Tobacco Tax Collections	$ 346,893	$ 346,893
TOTAL REVENUES	**$ 346,893**	**$ 346,893**

EXPENDITURES	FY 12 Total $ YTD	FY 12 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 6,814	$ 1,710	
Inpatient Hospital	1,041,508	261,418	
Outpatient Hospital	1,715,471	430,583	
Inpatient Free Standing	2,658	667	
MH Facility Rehab	43,711	10,972	
Case Mangement	0	-	
Nursing Facility	8,644	2,170	
Physicians	3,140,389	788,238	
Dentists	25,824	6,482	
Other Practitioners	12,610	3,165	
Home Health	13,493	3,387	
Lab & Radiology	475,649	119,388	
Medical Supplies	22,235	5,581	
Ambulatory Clinics	126,791	31,825	
Prescription Drugs	626,204	157,177	
Transportation	2,189	549	
Miscellaneous Medical	31,406	7,883	
Total Program Costs	$ 7,295,594	$ 1,831,194	**$ 1,831,194**
TOTAL STATE SHARE OF COSTS			**$ 1,831,194**

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

SoonerCare Programs

October 2011 Data for December 2011 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2011	Enrollment October 2011	Total Expenditures October 2011	Average Dollars Per Member Per Month October 2011
SoonerCare Choice Patient-Centered Medical Home			449,392	**455,919**	**$116,907,647**	
	Lower Cost	*(Children/Parents; Other)*		410,703	$80,237,186	$195
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		45,216	$36,670,462	$811
SoonerCare Traditional			239,274	**247,079**	**$206,291,600**	
	Lower Cost	*(Children/Parents; Other)*		140,026	$79,680,218	$569
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		107,053	$126,611,382	$1,183
SoonerPlan			31,082	**40,356**	**$741,642**	$18
Insure Oklahoma			32,181	**31,895**	**$9,828,880**	
	Employer-Sponsored Insurance		19,095	17,969	$4,670,853	$260
	Individual Plan		13,085	13,926	$5,158,027	$370
TOTAL			**751,928**	**775,249**	**$333,769,769**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $22,320,416 are excluded.

Net Enrollee Count Change from Previous Month Total	7,979

New Enrollees	21,444

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

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,651
Aged/Blind/Disabled	*Adult*	130,671
Other	*Child*	166
Other	*Adult*	20,321
PACE	*Adult*	84
TEFRA	*Child*	404
Living Choice	*Adult*	97
OLL Enrollment		**171,394**

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

Medicare and SoonerCare	Monthly Average SFY2011	Enrolled October 2011
Dual Enrollees	**103,906**	**107,161**

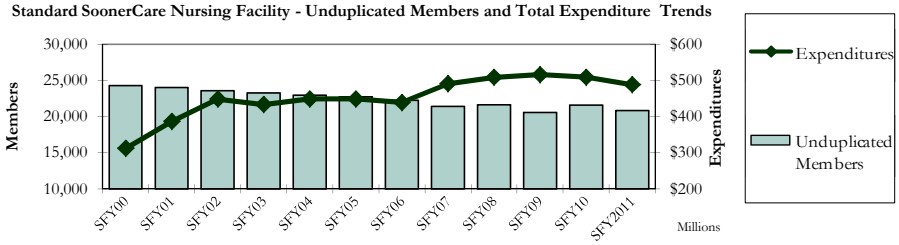
		Monthly Average SFY2011	Enrolled October 2011	PER MEMBER PER MONTH
Long-Term Care Members		**15,733**	**15,895**	**$3,162**
	Child	92	93	
	Adult	15,641	15,802	

SFY2011 Long-Term Care

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

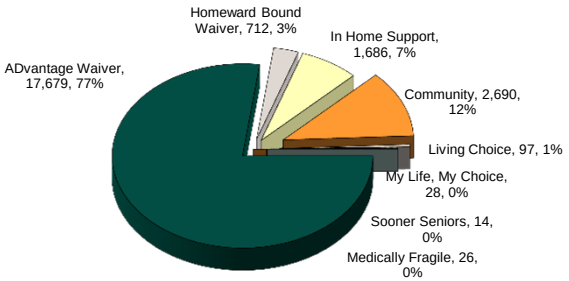
Data as of October 2011

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Aug. 8, 2011. Figures do not include intermediate care facilities for the mentally retarded (ICF/MR).

Waiver Enrollment Breakdown Percent



ADvantage Waiver - Serves frail elderly individuals age 65 or older and adults age 21 and older with physical disabilities who would otherwise require placement in a nursing facility.
Community - serves individuals 3 years of age and older who have intellectual disabilities and certain persons with related conditions who would otherwise require placement in an intermediate care facility for the mentally retarded/intellectually disabled (ICF/MR).
Homeward Bound Waiver - Designed to serve the needs of individuals with intellectual disabilities or "related conditions" who are also members of the Plaintiff Class in Homeward Bound et al. v. The Hissom Memorial Center, et al, who would otherwise qualify for placement in an ICF/MR.
In Home Support - Serves the needs of individuals 3 years of age and older with intellectual disabilities who would otherwise require placement in an ICF/MR.
Living Choice - Promotes community living for people of all ages who have disabilities or long-term illnesses.
Medically Fragile - This program serves qualifying individuals who meet hospital or skilled nursing facility level of care.
My Life, My Choice - This program is for adults with physical disabilities who transitioned to the community under the Living Choice program.
Sooner Seniors - This program is for adults 65 and older with long term illnesses who transitioned to community-based services in the Living Choice program.

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2011	Enrolled October 2011
Total Providers		**29,026**	**34,045**
	In-State	20,585	27,178
	Out-of-State	8,442	6,867

Program	% of Capacity Used
SoonerCare Choice	38%
SoonerCare Choice I/T/U	13%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2011**	*In-State Enrolled October 2011***	Total Monthly Average SFY2011	Total Enrolled October 2011
Physician	*6,489*	*7,196*	*11,777*	13,106
Pharmacy	*901*	*870*	*1,230*	1,142
Mental Health Provider****	*935*	*3,664*	*982*	3,714
Dentist	*798*	*953*	*901*	1,079
Hospital	*187*	*192*	*739*	884
Licensed Behavioral Health Practitioner****	*503*	*3,185*	*524*	3,216
Extended Care Facility	*392*	*379*	392	379

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

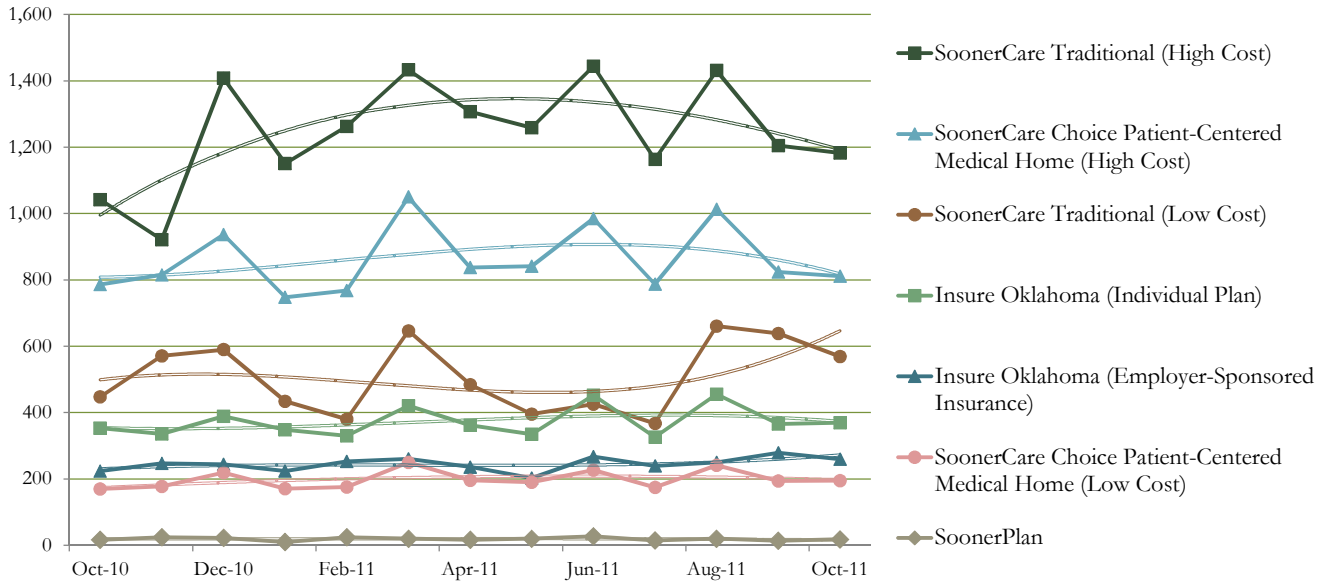
Total Primary Care Providers	*4,461*	*5,127*	6,467	7,384
Patient-Centered Medical Home	*1,476*	*1,709*	1,502	1,736

Including Physicians, Physician Assistants and Advance Nurse Practitioners.

**Items shaded above represent a 10% or more increase (green) or decrease (red) from the previous fiscal year's average.

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

SOONERCARE PER MEMBER PER MONTH (PMPM) TRENDS



ELECTRONIC HEALTH RECORDS (EHR) INCENTIVE STATISTICS

The Electronic Health Records Incentive Program is a federal program that offers major financial support to assist certain providers to adopt (acquire and install), implement (train staff, deploy tools, exchange data), upgrade (expand functionality or interoperability) or meaningfully use certified EHR technology.

As of 12/5/2011	November 2011		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	48	$1,020,000	989	$21,030,417
Eligible Hospitals	6*	$3,015,753	61	$45,511,657
Totals	54	$4,035,753	1,050	$66,542,074

*Current Eligible Hospitals Paid
ARBUCKLE MEM HSP
CAH ACQUISITION COMPANY 12 LLC
MCALESTER REGIONAL
MED CTR OF SE OKLA
MIDWEST CITY REGIONAL HOSP
STILLWATER MEDICAL CENTER

SoonerCare Choice Renewal

OHCA intends to submit a request for renewal of the SoonerCare Choice/Insure Oklahoma Section 1115(a) Research and Demonstration Waiver to the Centers for Medicare and Medicaid Services (CMS), extending the waiver from January 1, 2013 through December 31, 2015.

The SoonerCare 1115(a) Waiver is currently approved through December 31, 2012. The application to extend the demonstration project is due to CMS December 31, 2011.

OHCA plans to request a renewal of the program in its present form, although amendments will need to be made later for 2014. Only one amendment is requested with the renewal.

Renewal and Amendment Language in the Application:

> Oklahoma is aware that the SoonerCare / Insure Oklahoma waiver will need to be amended in order to bring the program into compliance with provisions of the Patient Protection and Affordable Care Act (PPACA) that take effect January 1, 2014. At this time, the State is requesting renewal of this waiver in its present form, pending instructions from leadership on the direction the State intends to take with regard to health reform. OHCA plans to request appropriate amendments to the waiver after receiving proper guidance. OHCA is also requesting approval to maintain the Health Access Network (HAN) program as a pilot from 2013 to 2015. The State is not at present requesting authorization to implement the HAN program statewide.
>
> The State requests that one amendment be made to the waiver for the extension period; it is specific to the Insure Oklahoma (IO) Individual Plan (IP) program. The State requests that the adult outpatient behavioral health benefit for IO IP be limited to 48 visits per year. This change will match the adult benefit with the children's benefit, which is already limited to 48 outpatient behavioral health visits per year.

Oklahoma Cares Program Change

The objective of the Oklahoma Cares program, which was implemented in January 2005, is to provide eligible women with treatment for breast or cervical cancer and pre-cancerous conditions. Women receiving treatment for these conditions have access to full-scope medical benefits under SoonerCare Choice. Currently, full-scope benefits are also available to women who are completing diagnostic testing following an abnormal finding through fee-for-service. In order to determine if a woman has a qualifying diagnosis to receive full coverage, Oklahoma is seeking to implement a limited diagnostic testing benefit package as an entry-level phase of the Oklahoma Cares program.

Those who qualify for the limited benefit package include women, ages 19 to 65 who receive an abnormal finding result from a CDC screener on their clinical breast exam, mammogram screening or pap smear, and have an income at-or-below 185% FPL or 250% FPL for American Indians.

An abnormal finding is interpreted as:

- A discrete, palpable breast mass (clinical documentation must include a detailed description of when the mass was identified, location, size, shape, tenderness, skin color change);
- Screening mammogram results of BIRAD 0 (only after comparison with prior films and a suspicious clinical exam);
- Screening mammogram results of BIRAD's 3, 4, or 5;
- ASC-H, LISL, HSIL, AGC;
- Cervical Dysplasia (CIN I, II, III).

Women who qualify for the diagnostic testing benefit package have access to the following services:

- Diagnostic Mammogram (not as a primary evaluation)
- Diagnostic Ultrasound (not as a primary evaluation)
- Breast biopsy
- Colposcopy with or without cervical biopsy
- LEEP, Conization
- Pathology
- Breast MRI
- Office Visits

By implementing the diagnostic testing package, women will still be able to receive a definitive diagnosis of their condition; however, full-scope medical coverage will only be available to those women receiving treatment for a cancerous or pre-cancerous condition.

Pharmacy Overview and Discussion – Utilization Controls

Oklahoma Health Care Authority

Board of Directors meeting

December 8, 2011

Comparison 2010 to 2011

FY 2010	FY 2011
$375 million	$359 million
5.6 million Rx	5.9 million Rx
680,000 elig/mo	720,000 elig/mo
197,000 user/mo	203,000 user/mo
$66/rx	$60/rx
2.6 rx/user/mo	2.4 rx/user/mo
$44 PMPM	$39 PMPM
77% generic	84% generic

Pharmacy Benefit for Adults

- 6 prescriptions per month
- Includes up to 2 branded prescriptions
  - Prior to Jan 2010 was 3 branded
  - Have approval for 2 brands only through Dec 31
  - Have submitted request for continuing with 2
- Applies to approximately 121,000 adults
  - 28,500 used 6 Rx/month
  - 8,300 used 2 brands/month

Most Commonly Used Brand Drugs

- Diabetic medications (including insulin)
- Respiratory medications
- Plavix (cardiovascular)
- Mental health medications
- OxyContin (chronic pain)

Generics Coming Soon

- Zyprexa – out now (as of Oct 2011)
- Lexapro – March 2012
- Seroquel – March 2012
- Plavix – May 2012
- Singulair – August 2012

- Projected savings = at least $12 million per year for FY 2013

Budget Impact Scenarios

- Drop one brand prescription (allow 1/month)
  - First brand rx = $300, second = $170
  - “Savings” = $8.5 million for FY 2013
  - Cost of disease complications would cost far more
- Drop one Rx (allow 5/month with 2 brands)
  - Generic Rx = $20
  - “Savings” = $570,000
  - Cost of disease complications would cost far more

Recommendation for Rx Benefit

- No changes at this time
- Continue to monitor brand utilization
- Encourage generic prescribing and dispensing
- Review biologic classes with DUR Board and implement utilization control programs

Narcotic Utilization

Fiscal Year	Cost per Claim	Per-Diem Cost	Cost/member
2007	$27.75	$2.13	$98.43
2008	$33.11	$2.41	$119.87
2009	$34.44	$2.47	$120.20
2010	$32.87	$2.25	$114.57
2011	$31.17	$2.05	$111.17

Utilization Control Tools

- Quantity limits
  - For example, 60 tabs/month
- Early refill limit
  - 75% of the medication must be used before refill
- High dose limit
  - Used for products that contain acetaminophen
    - Lortab, Vicodin, Percocet, etc.

Utilization Control Tools

- Ingredient duplication limit
  - Hydrocodone – different strengths
- Maximum Rx/Year - hydrocodone
  - More than 13 requires prior authorization
- Step therapy
  - Use short acting meds until the patient can tolerate longer acting, higher doses
- Oncology-only medications

Pharmacy Lock-In Program

- Locks a member into one pharmacy
  - Rx claims will not pay at other pharmacies
  - Members selected based on
    - Number of pharmacies
    - Number of physicians
  - Drawbacks
    - Member can pay cash at any pharmacy
    - Does not address potential substance abuse
    - Probably does not change behavior long-term

OBNDD Prescription Monitoring Program

- OBNDD = Okla Bureau of Narcotics and Dangerous Drugs
- Prescription Monitoring Program – online database of prescriptions filled for controlled dangerous substances, such as narcotics. Can be viewed by pharmacies and prescribers. Cannot be viewed by medical personnel at OHCA at this time.

Recommendations for Narcotic Utilization Monitoring

- Collaborate with Okla Bureau of Narcotics and Dangerous Drugs to allow OHCA medical staff to view the Prescription Monitoring Program information. This will provide a more complete record for review.
- Analyze the high ER Utilizer group for possible inclusion in the Lock-In program

Utilization Controls for Narcotic Analgesics in the SoonerCare Program

The SoonerCare pharmacy benefit design includes several controls for the appropriate use of narcotic analgesics, including quantity limits, early refill edit, high dose edit, ingredient duplication edit, maximum number of prescriptions per year, and step therapy. Each of these is discussed below.

- **Quantity limits** – Narcotic analgesics are limited to the usual monthly supply. For example, OxyContin should be dosed one tablet every 12 hours, and therefore is limited to 60 tablets per month. In special circumstances, the quantity limit can be waived when medically necessary.
- **Early refill edit** – All prescriptions are subject to a 75% usage prior to refill of the same medication.
- **High dose edit** – Since there is no upper limit on most narcotic analgesics, those containing acetaminophen are limited according to the acetaminophen content of the product.
- **Ingredient duplication edit** – This edit stops a prescription claim if the member has received a prior prescription claim for a different strength of hydrocodone and the new claim is within the previous claim's active period. For example, if a member got a 10 day prescription for hydrocodone 7.5 mg on September 25 and tried to get a prescription for hydrocodone 5 mg on September 30, the claim would deny.
- **Maximum number of prescriptions per year** – This edit applies to hydrocodone and the member is limited to 13 prescriptions within a 12 month period. The goals of this edit is to (1) limit payment for repeat fills of small quantities most often seen with doctor shopping, and (2) encourage patients with chronic pain to seek treatment with a qualified pain management physician so as not to consume large quantities of hydrocodone and acetaminophen.
- **Step therapy** – All narcotic analgesics are placed into a step therapy category. The information about this process is shown on the back of this page. The premise of the step therapy process is that members should not be started on long acting pain control until they have some experience with immediate release narcotics. Within the long acting narcotics, they are segregated into preferred (Tier 2) and non-preferred (Tier 3) product groups. Additionally, all branded short acting products require a prior authorization, as do the short acting fentanyl products such as Actiq. Most of the fentanyl immediate release products are approved only for oncology related diagnoses.

Narcotic Analgesics

PA Criteria:
Tier 1 medications are available without prior authorization.
Tier 2 authorization requires:

- documented 30 day trial/titration period with at least two Tier 1 medications within the last 90 days, or
- clinically appropriate pain therapy requiring time-released medication

Tier 3 authorization requires:

- documented 30 day trial with at least two long-acting Tier 2 medications within the last 90 days, or
- documented allergy or contraindication to all Tier 2 medications

Other criteria for this category:

- Members with an oncology-related diagnosis are exempt from the step therapy process, although quantity and dosage limits still apply. Immediate release fentanyl products are approved only for oncology-related diagnoses
- Only one long-acting and one short-acting agent can be used concurrently

Tier 1	Tier 2	Tier 3	Oncology
	Long Acting		
• All immediate Release Narcotics Not Listed in Higher Tier*	• morphine ER • Duragesic patches	• Avinza • Butrans • Embeda • Exalgo • Kadian • Opana ER • Oxycontin • Ryzolt • Ultram ER	
	Short Acting		
	• Nucynta • Opana IR	• Branded versions of tier one drugs	• Fentanyl short acting products

Analysis of Brand Drug Utilization by SoonerCare Adults

State Fiscal Year 2011

Within the SoonerCare program, there are approximately 121,000 adult members who are subject to the prescription limit of six per month, with a maximum of two brands. The two brand limit was implemented in January 2010. Prior to that time, the limit was six per month with a maximum of three brands. Generic drugs accounted for over 80% of all paid pharmacy claims in FY 2011. The total pharmacy spend for adults and children FY 2011 was approximately $360 million. This is down slightly from the $375 million spent in FY 2010.

Of the 121,000 adults who are subject to the prescription limits, 28,500 members filled six prescriptions at least one month of the last six months of FY 2011. Of those 28,500 members, 8300 filled both branded prescriptions at least one month of the last six months of FY 2011.

The most common categories of drugs filled as brand name products are:

- Diabetic medications (Lantus, other insulin, Actos)
- Respiratory Medications (Advair, Spireva, Singulair)
- Plavix
- Mental health (Seroquel, Abilify, Zyprexa, Cymbalta, Lexapro)
- OxyContin

Of these medications, Singulair, Seroquel, Zyprexa and Lexapro will all be available as generic formulations within the next twelve months. We expect significant savings as those drugs lose their patent protection. Our calculations indicate we will save much more from the patent expirations than we could by reducing the prescription limit further. The cost of complications from diabetes, COPD, asthma, heart disease and mental illness could easily exceed any savings we might generate by reducing the brand limit to one per month.

We also analyzed the cost of the first and second branded medications filled for this group. While the first branded prescription averages $304, the second drops to $170. Based on this, the calculated savings is $8.5 million (federal + state, or less than $3 million state) in FY 2013. The savings from the brand patent expirations mentioned above is a minimum of $12 million for that same year.

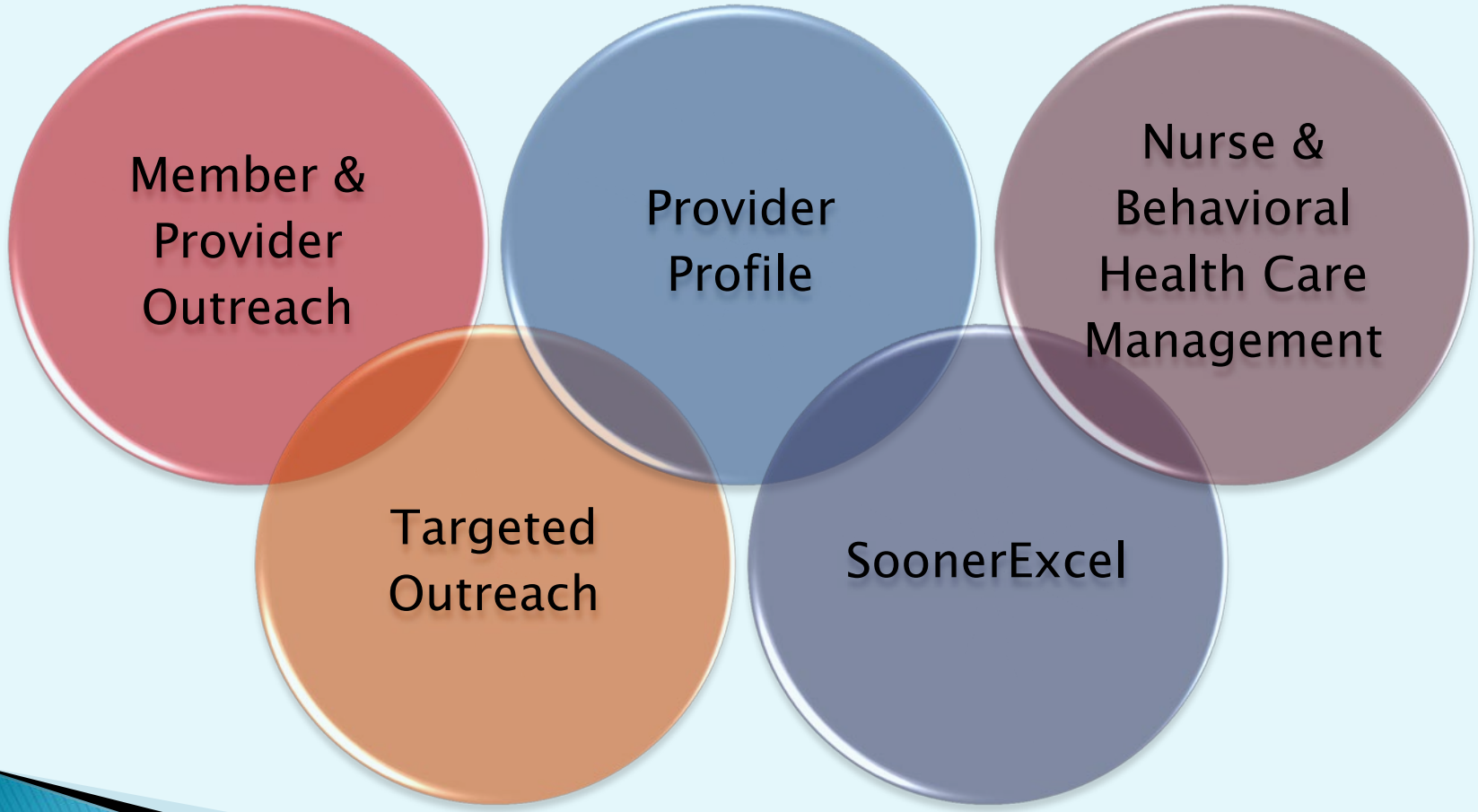
SoonerCare Choice ER Utilization Program

Melody Anthony, MS
Director of Provider Services
SoonerCare Operations

Purpose of Program

Educate on the appropriate use of primary care services in lieu of emergency room utilization

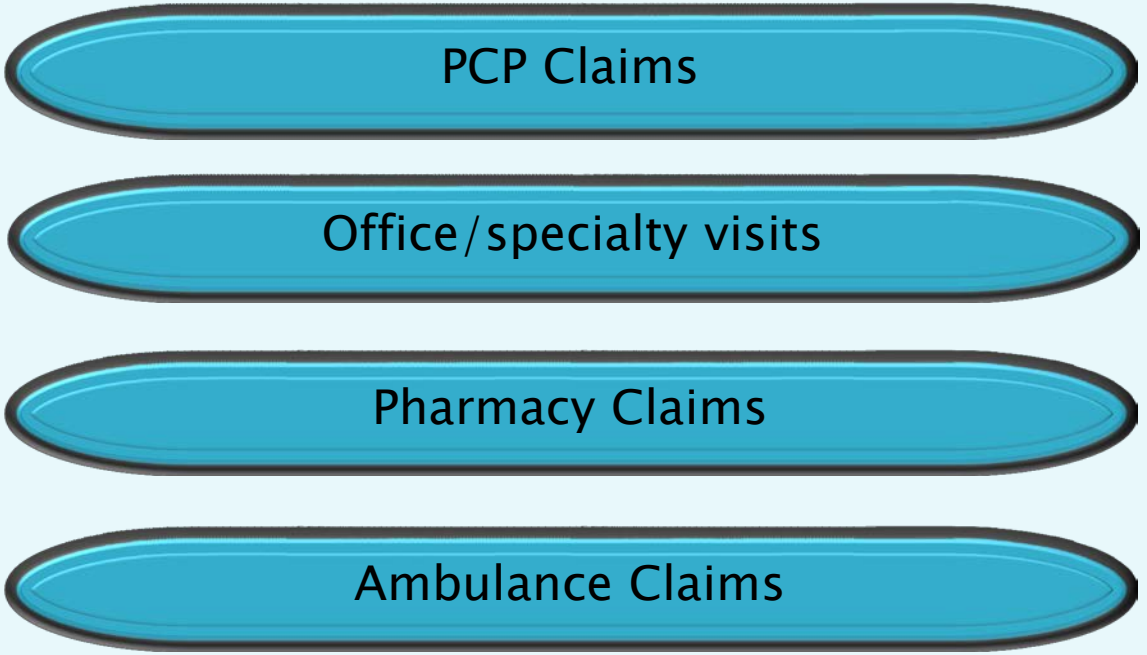
ER Utilization Program Elements



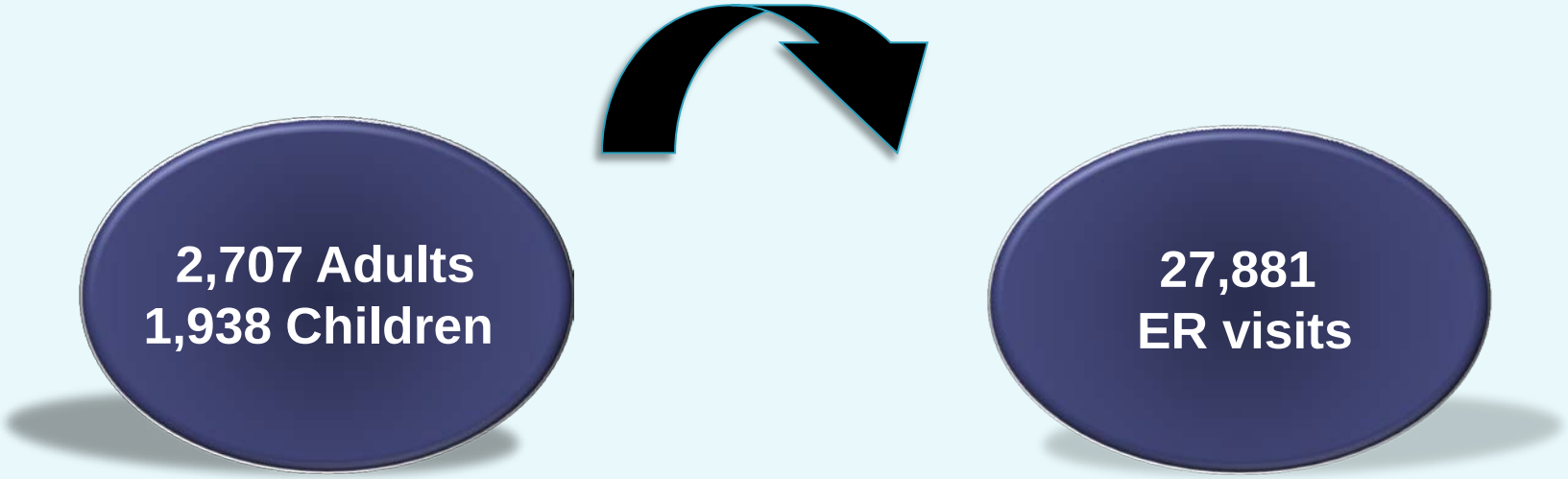
Member Identification

- SoonerCare Choice members with 3 or more ER visits per quarter

- High Utilization members are those with 15 or more ER visits per quarter

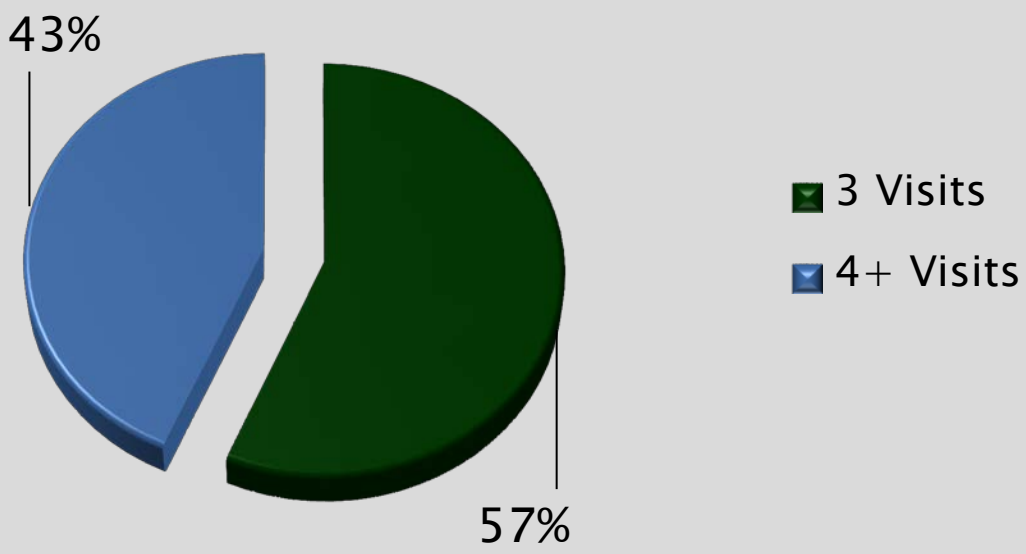


Utilization July 2011 – September 2011
3 or more ER visits per quarter



4,645 members is 1% of the SoonerCare Choice population

ER Visit Breakdown

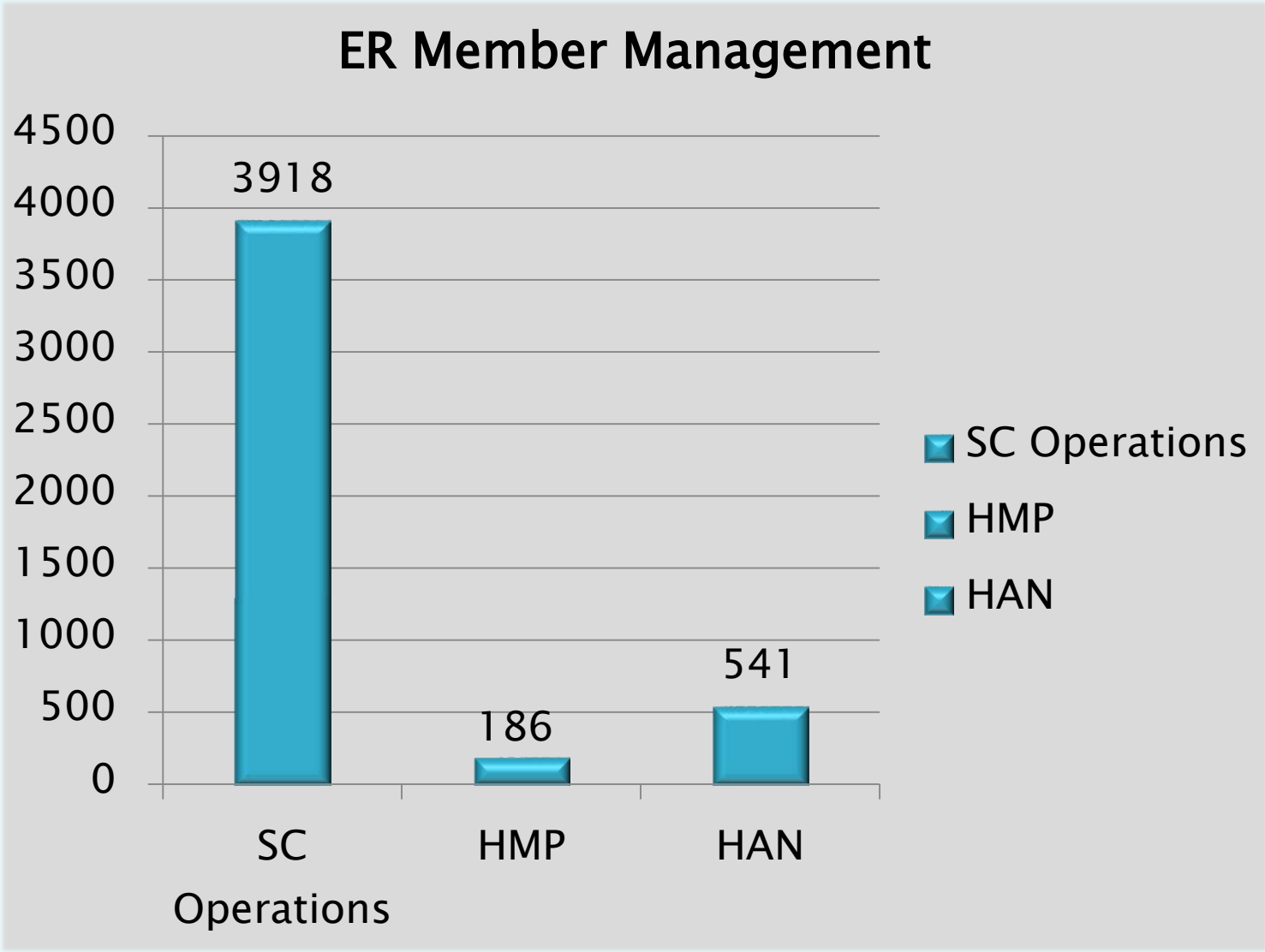


3 visits

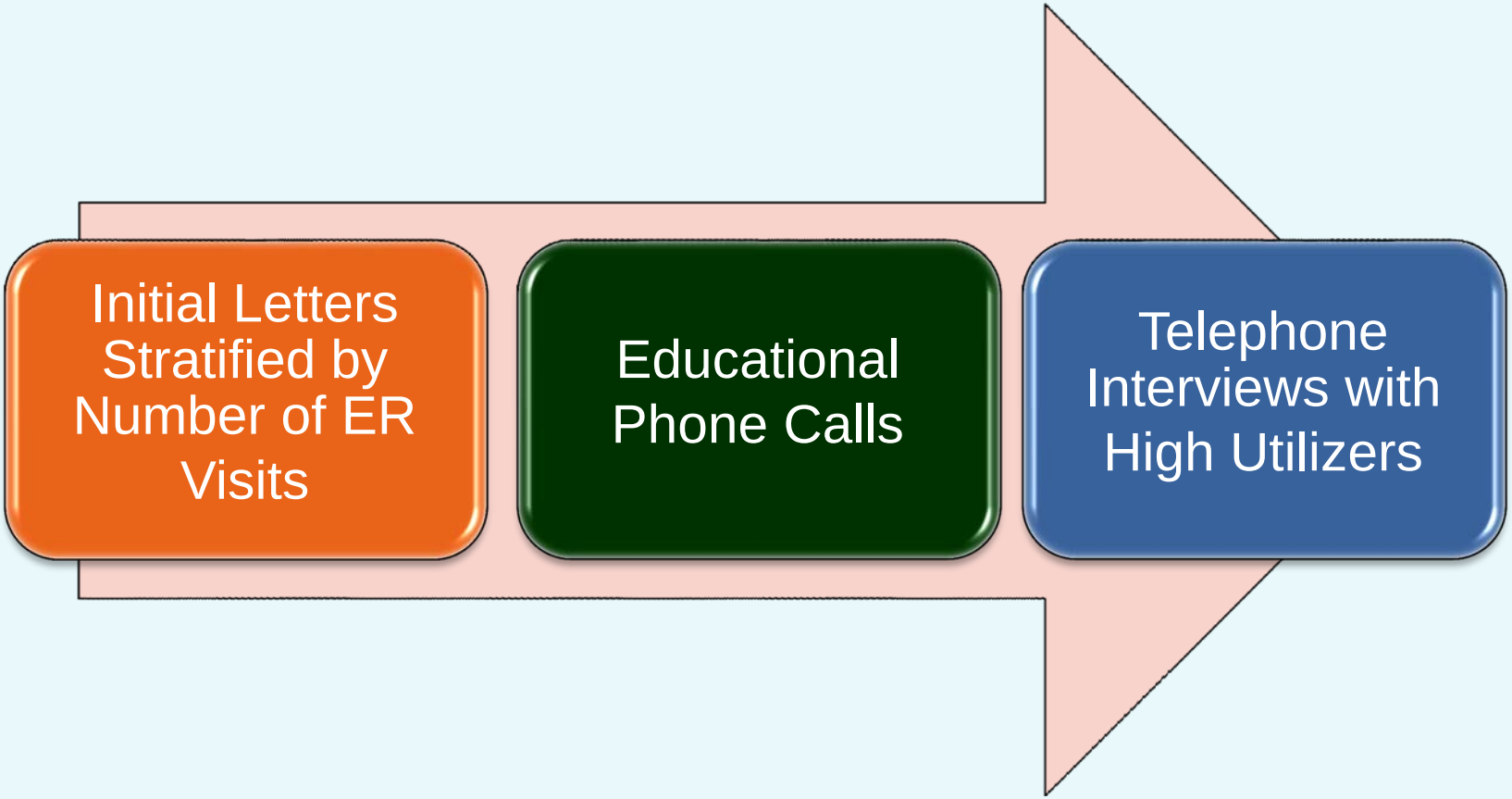
1,258 adults
1,368 children

4+ visits

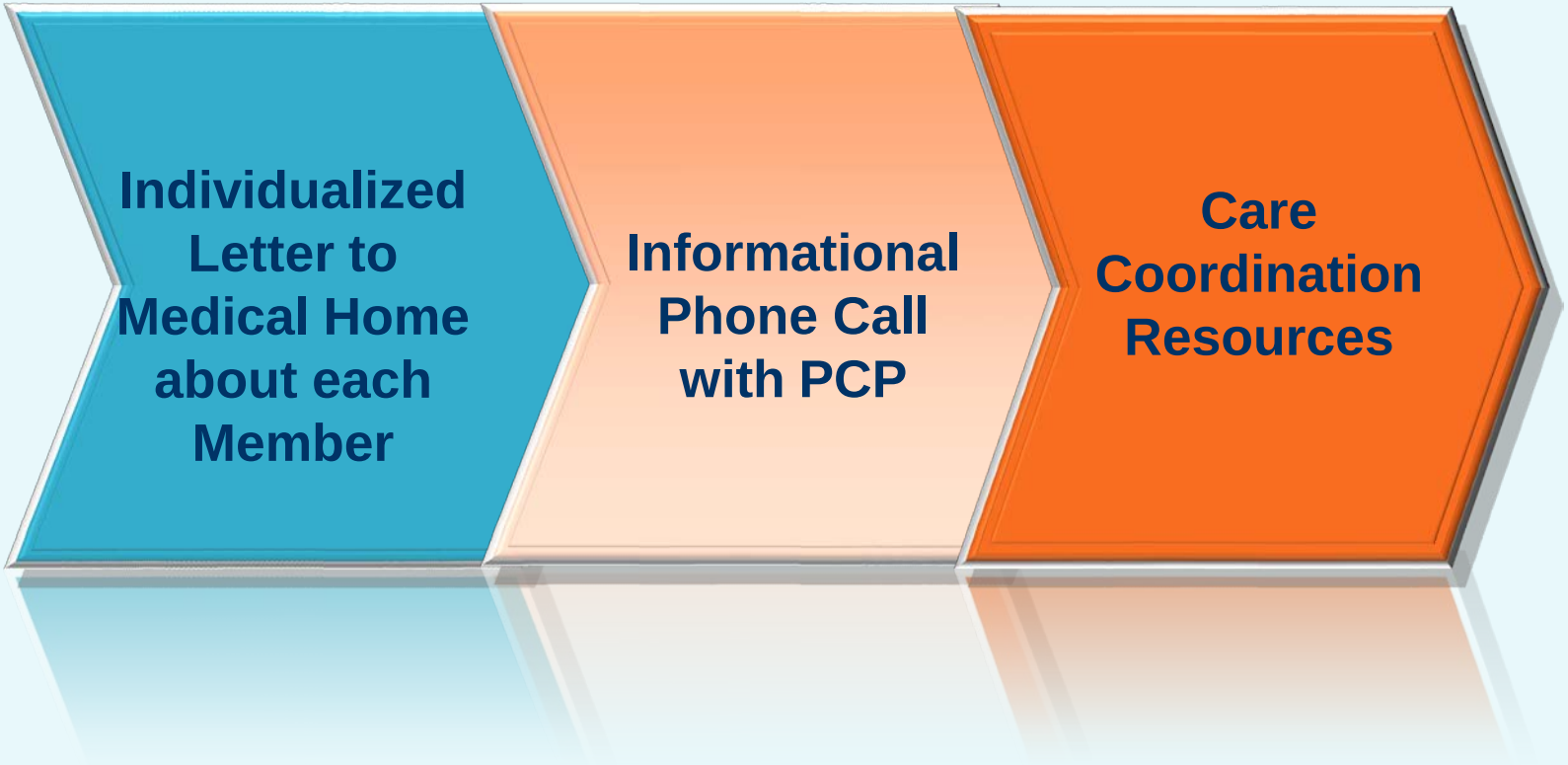
1,449 adults
570 children


ER Member Management
4500
4000
3500
3000
2500
2000
1500
1000
500
0
3918
186
541
SC Operations
HMP
HAN
SC Operations
HMP
HAN

Member Interventions



Medical Home Interventions



Historical Data from SFY 2010

1. Majority saw PCP at least once
2. 94% successfully contacted
3. 90% contacted by phone identified PCP
4. SFY 2010 average cost per visit was $241.58
5. SFY 2010 ER costs avoided = $3.3 million

Contact Information

Melody Anthony, MS, Provider Services Director
Melody.Anthony@okhca.org

Kevin Rupe, Member Services Director
Kevin.Rupe@okhca.org

Frequent ER Utilization Program

Revise September 2011

Identification criteria: SoonerCare Choice and ITU with 3 or more paid ER visits per calendar year quarter are identified 45 days after the end of the quarter by Member Services, and member information is maintained in an Access Database.

Insure Oklahoma IP members receive benefit information via telephone intervention specific to the Insure Oklahoma program based on 4 or more ER visits. Letters are only sent to the member as warranted. These members are identified by Care Management.

Example identification: ER use in January – March is selected using Business Objects in mid-May. The information is then uploaded into the Access database, and letters are distributed. It takes approximately two days to prepare the letters for distribution. In collaboration with Legal certain members with persistent ER usage do not receive ER Program letters.

Provider Intervention: A letter is generated to the PCPs of all identified SC Choice & ITU members. The letter includes the ER date of service, facility, and first three diagnoses billed on the claim. The letter is generated through a mail merge report built into the Access database. The letters are electronically sent to HP via disc and HP prints and mails letters.

Provider Intervention: Dedicated Provider Services Education Specialist responds to & documents all resulting PCP inquiries in Access. Appropriate members are referred to Care Management/Behavioral Health. In addition, hospital outreach is done as needed.

Member Intervention: A letter which varies according to ER visit range (3 only & 4-14) is sent to each SC Choice & ITU member identified .The letter is stratified based on Adult - 21 and older and Child – 20 and younger. Letter (Ethel Rayburn) for the 4-14 group requests that member contact Member Services for education according to ER guidelines. The 3 only letter is an informational letter requiring no response. Appropriate members are referred to Care Management/Behavioral Health.

The letters are generated through mail merge report built into the Access database. The letters are electronically sent to HP via disc, HP prints and mails letters.

For members identified as persistent with15 or more ER visits in a quarter (Persistent Members), Provider Services Specialist contacts PCP regarding member, then emails the provider access information to Member Services Specialist who at that point mails a Persistent letter to member to initiate contact. Member Service Specialist then logs information into database.

Member Intervention: A 2nd letter is generated to members with 4-14 ER visits after 2 weeks.

Member Intervention:

SoonerCare Choice & ITU: Incoming calls from Ethel Rayburn letter are handled by Member Services & documented in Access database.

Insure Oklahoma Individual Plan: Insure Oklahoma Medical Review Nurse initiates outreach based on data provided by Care Management.

Persistent: Outreach of members with greater than or equal to 15 ER visits in a quarter is done by ER Intervention team (which consists of a Member Services and Provider Services rep).

*Targeted intervention with members with high-cost, high utilization, and pre-persistent discontinued approximately September 2010 by Member Services & May 2011 by Care Management.

Persistent Members

Identification criteria: SoonerCare Choice and ITU with 15 or more paid ER visits per quarter are identified 45 days after the end of the quarter by Member Services, and member information is maintained in separate Access Database.

Once members are identified they are exclusively assigned to the ER Intervention Team for care evaluation. The ER Intervention Team has 3 months from the date of identification to verify eligibility and intervene through phone contact.

If team is unable to contact member after 2 quarters, the member is referred to the OHCA Legal Division for investigation.

Data/Claims Analysis: Using member's RID claims information is gathered via Business Objects and uploaded in a Persistent Outreach Access database. Information includes ER claims, PCP claims, office visit / specialty visit claims, pharmacy claims and ambulance claims. The intervention team uses the information to begin research members who have not had a previous intervention.

Provider Intervention: Dedicated Provider Services Education Specialist immediately conducts outreach calls to all persistent members' PCPs. Staff discusses the following with PCPs:

- The ER reduction initiative by all departments involved: Care Management, Provider Services, Member Services, Health Management, and Behavioral Health.
- The PCP's perspective of the member's ER usage and the utilization of the PCP's office.
- The member's utilization of office hours, office visits and appointment history.
- The availability of urgent care office visits and protocol to obtain, i.e. triage nurse
- Review member's chronic illnesses, pharmacy history, and specialty history
- Educate PCP on resources, i.e. SoonerCare Choice training, Care Management referral form, Pharmacy Lock-in, Patient Advice Line and Provider Services phone number and availability.
- Explain specialty referral protocol and assistance with available specialists
- Review ER provider profile letter from Quality Assurance: stats, billing, and questions
- Explain member outreach for education opportunity, refer to provider ER letter
- Closing comments and suggestions from provider.

Member Intervention: Dedicated Member Services Coordinator attempts contact via phone 3 times on 3 different days at 3 different times. Coordinator researches the following information for intervention:

- Continued eligibility
- Demographic information, i.e. current address
- Current PCP information: recent PCP changes, and recent PCP dismissals
- ER Claims:
  - Facility location and dates of service: time of visit and if there are multiple visits in the same day
- Office Claims:
  - Location, dates of service & diagnosis
- Pharmacy:
  - Prescription filled list; double medication in one day & Lock-in status
- Review Patient Advice Line records & CTI calls from member or providers

Letter from Member Service Coordinator: Provider Service Education Specialist completes research and forwards to the Member Service Coordinator, who then mails the Persistent ER Letter to the member, which indicates total ER visits for the quarter and directs member to contact Coordinator. If no response is received within 7 business days, the coordinator will make 3 attempts to notify and educate the member.

Member Dismissal Action- Legal

ER Overutilization members were identified by category

Action taken prior to legal referral:

- Letter mailed to member to educate them on ER usage
- 2 weeks later a second letter mailed
- Additional letter mailed to member asking member to call for ER education by telephone
- Members told by care management staff to see their primary care physicians for routine care
- Care management staff conducted face to face intervention
- Medical records reviewed

Referred to Legal:

- 11 members referred to Legal
- 8 members subsequently pursued by Legal (3 cases had been closed by DHS)

Totals for these 8 members:

- Total billed $3,353,280 (only for days of ER visits, no hospitalizations)
- Total reimbursed $472,228 (only for days of ER visits, no hospitalizations)
- Total ER visits of 2,279 in a 2 – 6 year period (5.1 visits/mo. avg.)

Top complaints for ER usage were:

- Headache
- abdominal pain
- dizziness
- unspecified chest pains
- pain in soft tissues or limb
- shortness of breath

Actions:

APS reviewed members' medical records (all 2,279 ER visits).

- APS was concerned that five members were getting overexposure to radiation
- Medical records showed doctors had noted in charts that member was instructed to conduct a follow up appointment with their primary care physician
- Very few of the visits were considered appropriate (5?)

09/13/11 - 5 Pre-Termination Letters sent

10/28/11 - 4 Termination Letters sent (effective 12/1/11 for 6 months; 1 case was closed by DHS)

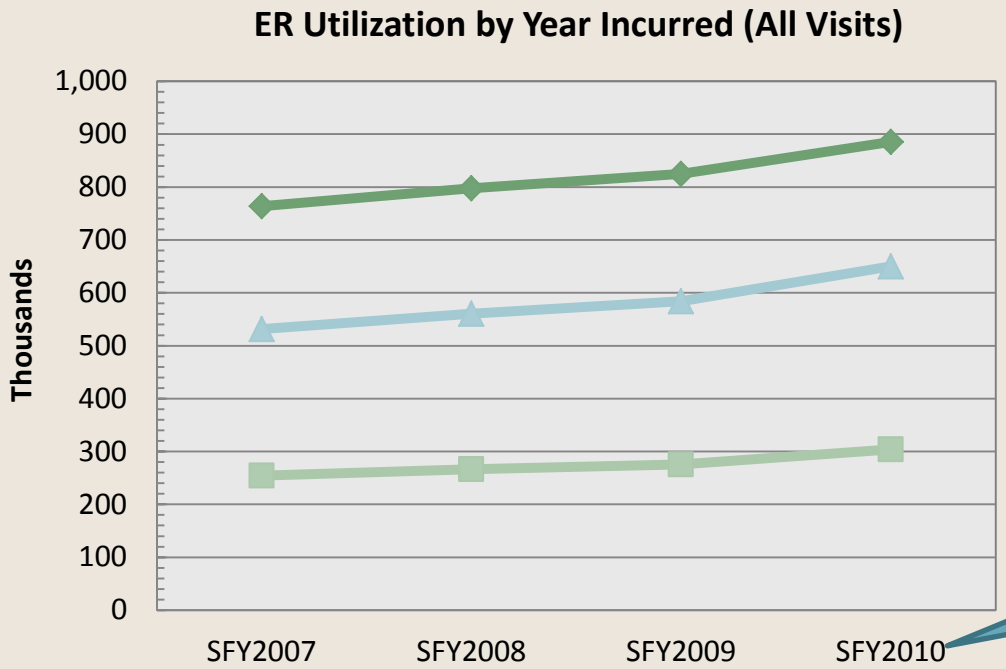
- These 4 had 449 Total ER visits (6.0 visits/mo. avg.)

As of 12-06-11 no appeals have been filed; no provider complaints

ER Utilization Analysis

Alison A. Martinez
Reporting & Statistics
December 8, 2011

ER Utilization Has Grown Faster than Overall Membership



	CAGR (2007-2010)
Total Members	5.1%
ER Visits	6.9%
Members Using ER	6.1%

$322M in ER-related spending in SFY 2010

An increasing proportion of members are using the ER, and those that are using the ER are using it more often

Compiled by OHCA Reporting and Statistics Unit. Data is valid as of October 21, 2011 and is subject to change.

Only a Subset of Visits Would be Amenable to ER Intervention

Procedure for Identifying Potentially Addressable ER Visits (SFY2010)

Total ER Utilization

- 649,843 visits ***incurred*** in SFY 2010

Exclude Children's Visits

- Imposing a limit on children's visits would be challenging
- 378,671 children's visits are excluded

Exclude Cross-Over Visits

- Cross-over claims are excluded from this analysis since OHCA has less ability to influence behavior when Medicare is the primary payer
- 102,733 additional visits excluded due to Medicare as primary payer

Exclude Visits with Admissions

- ER visits that result in inpatient admissions are likely to be emergent and should not be considered for intervention
- 13,029 additional visits excluded due to same-day admission

Potentially Addressable ER Visits

- 155,410 visits ***incurred*** in SFY 2010
- **All subsequent analyses are based on this population of addressable visits**

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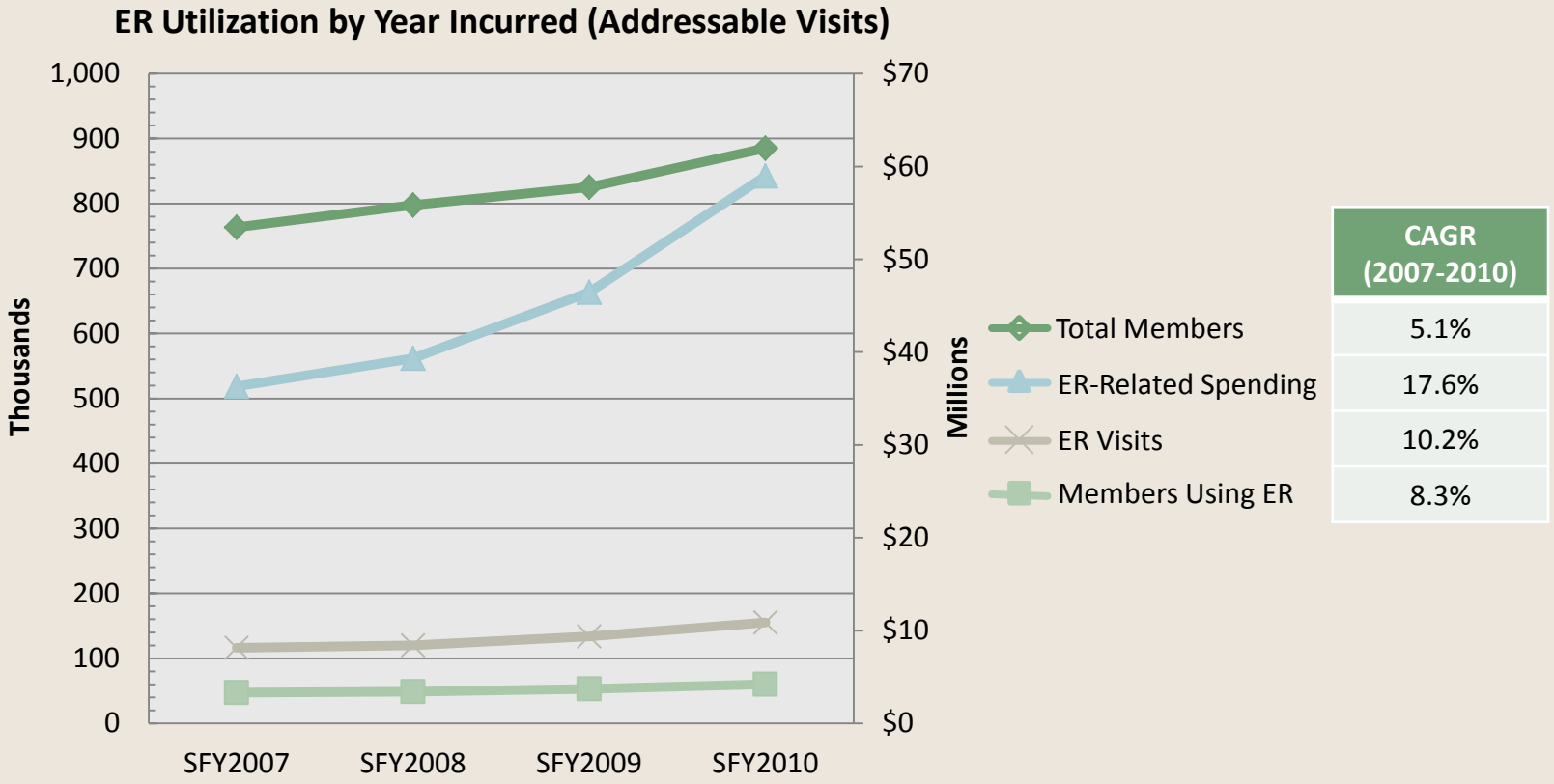
ER Growth Trends are More Severe in the Addressable Population



	CAGR (2007-2010)
Total Members	5.1%
ER-Related Spending	17.6%
ER Visits	10.2%
Members Using ER	8.3%

Note: This and all subsequent slides exclude visits that result in an inpatient admission and cross-over visits. ER-Related spending includes the reimbursement for the ER visit as well as reimbursement for other same-day physician, outpatient, and drug services.

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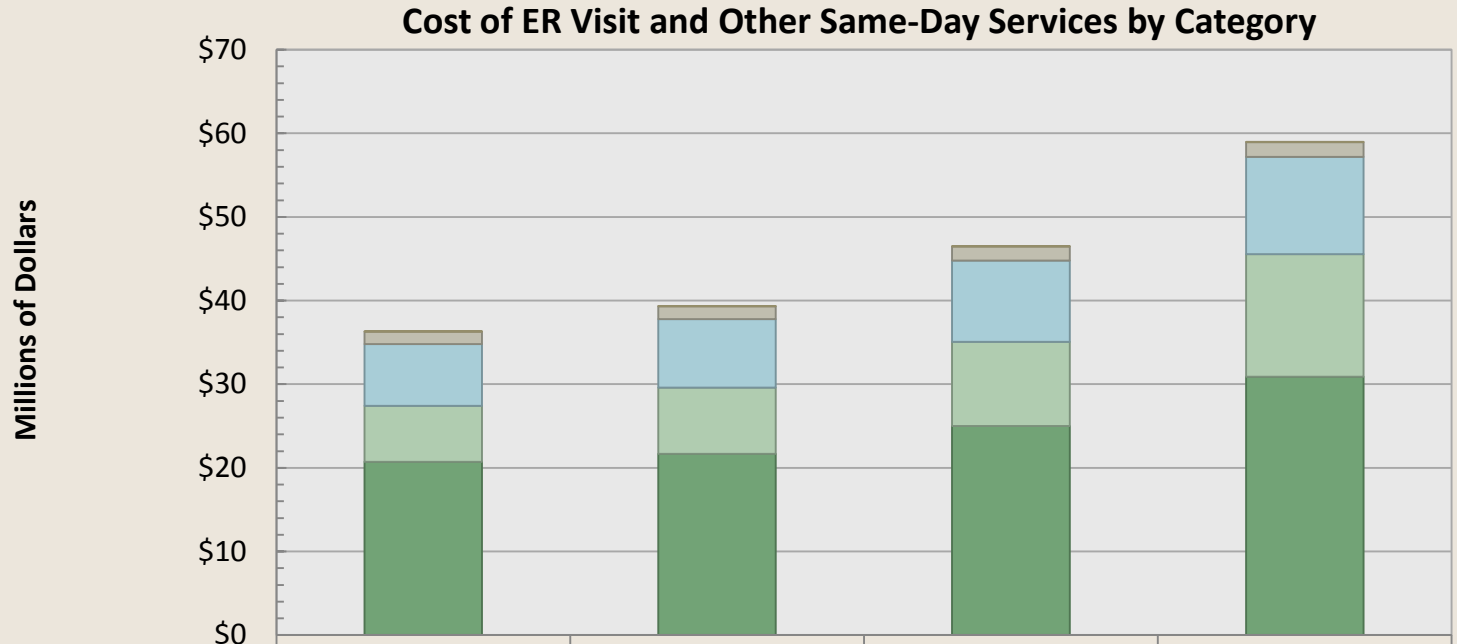
Cost of ER Visits: Includes Services Beyond the Visit Itself



	SFY2007	SFY2008	SFY2009	SFY2010
Compounded Drugs	$2,899	$3,171	$3,983	$5,863
Pharmacy	$1,491,179	$1,540,515	$1,652,733	$1,776,221
Physician	$7,369,433	$8,189,702	$9,749,963	$11,613,327
Outpatient	$6,693,093	$7,910,942	$10,059,759	$14,667,825
ER Visit	$20,729,433	$21,688,933	$24,994,187	$30,904,798

Note: ER Visit includes the physician and facility cost for the visit only (CPT code 99281-99288). Outpatient includes the facility costs for services besides the visit itself (e.g., imaging). Physician includes professional fees for services besides the visit itself.

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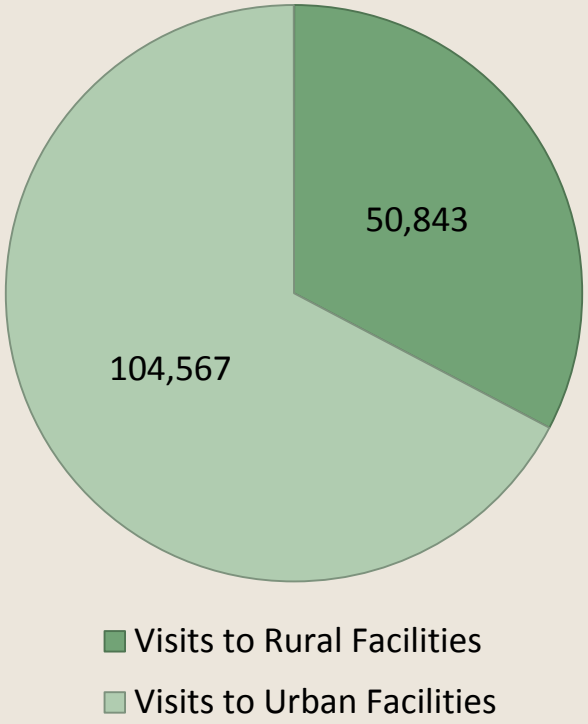
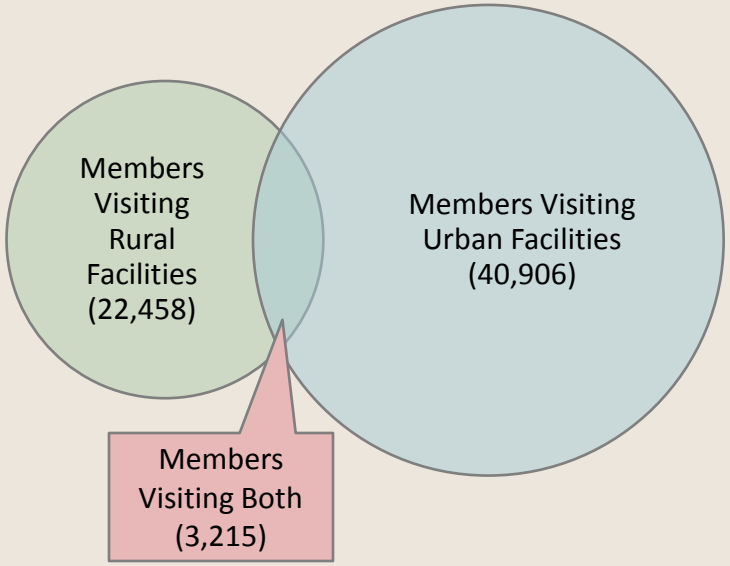
Two-Thirds of ER Visits Occur in Urban Facilities

ER Visits by Facility Location



ER Utilizing Members by Facility Location



Note: Facility location based on county of billing provider. Urban/rural designation by county is defined by Metropolitan Statistical Area (MSA) data and definitions adopted by the U.S. Health and Human Services Office of Rural Health Policy (ORHP/HHS)

Compiled by OHCA Reporting and Statistics Unit. Data is valid as of October 21, 2011 and is subject to change.

Most ER Visitors Utilize Primary Care, but Few See Their PCPs Post-ER Visit

Pre- and Post-ER Office Visits	
Total Number of ER Visits (SFY2010)	155,410
ER Visits with at Least One Office Visit* within Six Months **Prior to** the ER Visit	113,859 (73%)
ER Visits with at Least One Office Visit* within Two Weeks **Following** the ER Visit	51,455 (33%)

Pre- and Post-ER Medical Home Visits	
Total Number of ER Visits by Members with an Assigned PCP at Time of Visit (SFY2010)	92,961
ER Visits with at Least One Medical Home Claim** within Six Months **Prior to** the ER Visit	72,619 (78%)
ER Visits with at Least One Medical Home Claim** within Two Weeks **Following** the ER Visit	32,624 (35%)

Note: *Office visit identified as a claim with Evaluation and Management CPT codes 99201-99215 (Office or Other Outpatient Services), 99241-99245 (Consultations), 99363-99364 (Case management), or 99374-99380 (Care Plan Oversight); **Medical Home claims include services provided in the Medical Home or referred by the Medical Home

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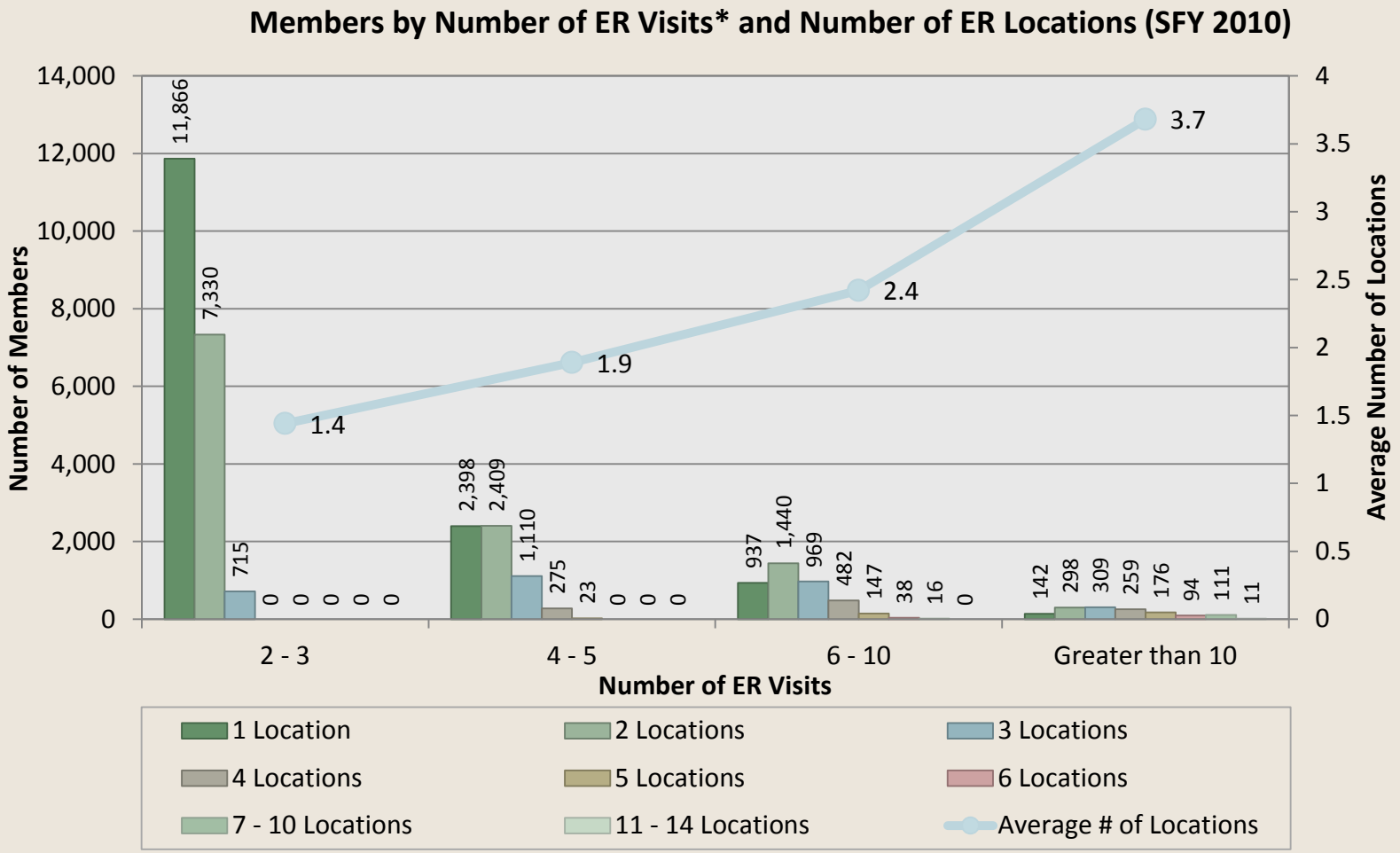
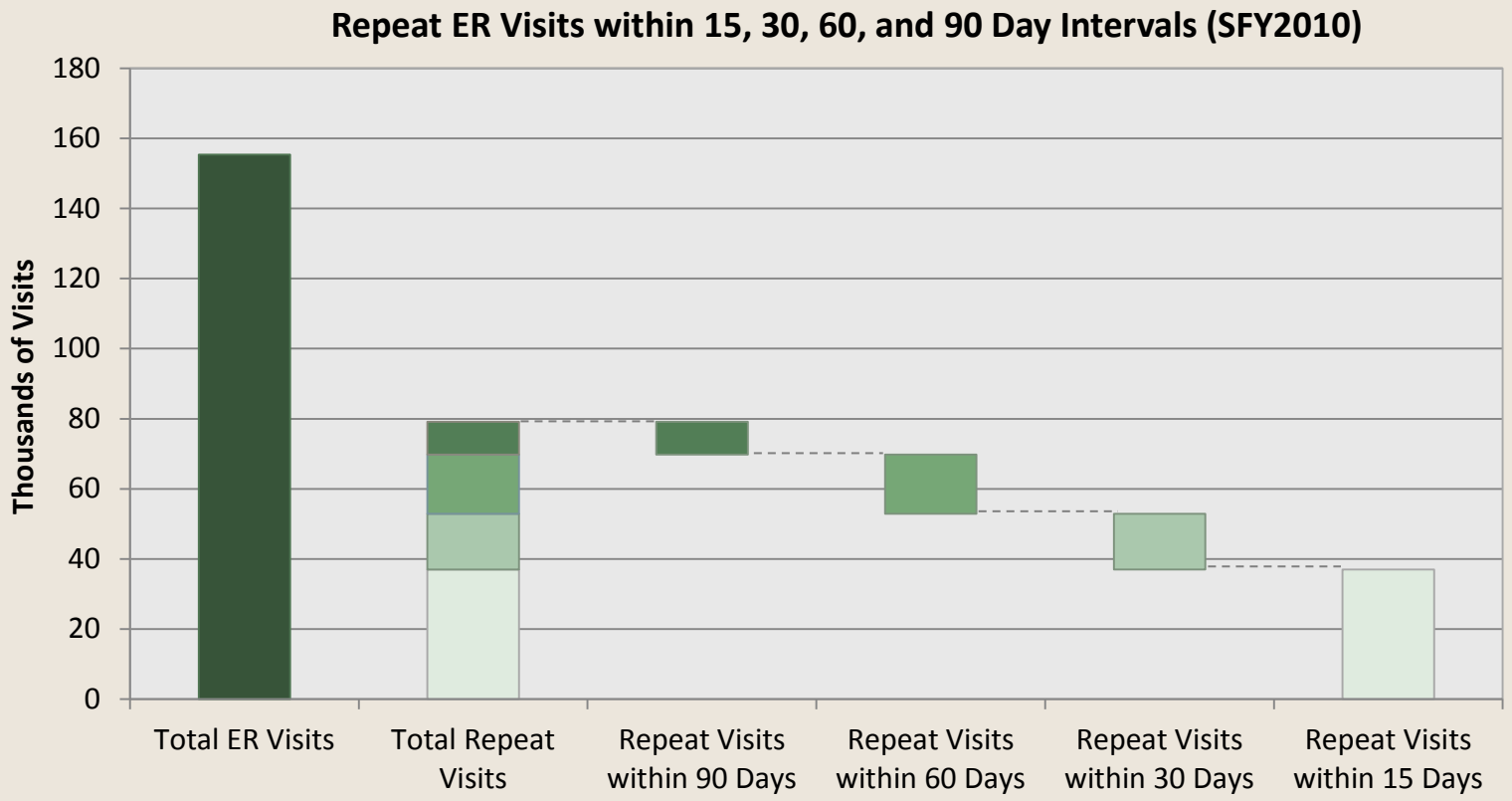
High ER Utilizers are More Likely to Use Multiple ER Locations



Note: *Includes only those members with more than one visit

Compiled by OHCA Reporting and Statistics Unit. Data is valid as of October 21, 2011 and is subject to change.

Nearly Half of Repeat Visits Occur within 15 Days



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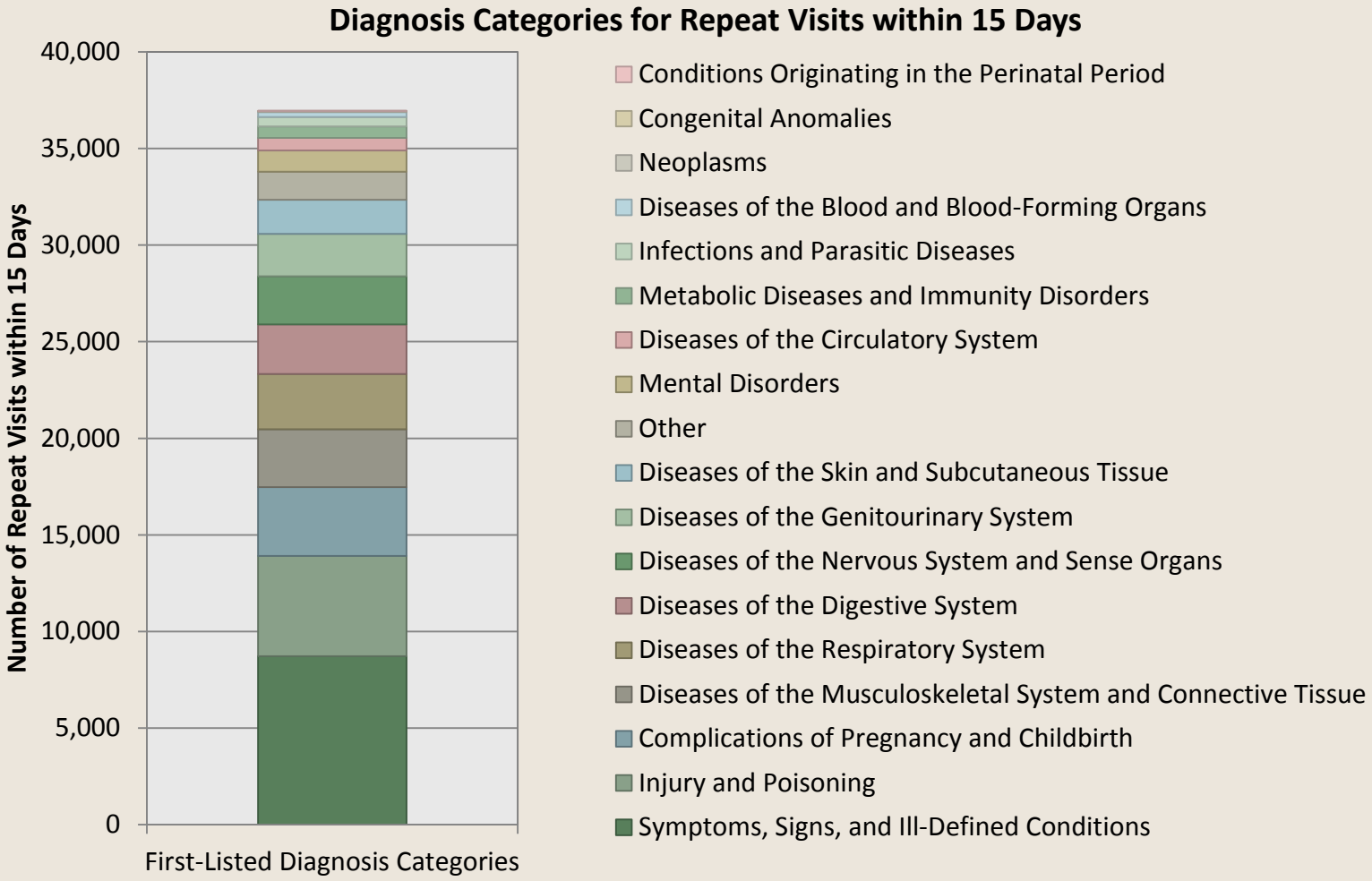
Poorly Defined Conditions Account for Many Repeat Visits…



Compiled by OHCA Reporting and Statistics Unit. Data is valid as of October 21, 2011 and is subject to change.

…As Evidenced by the Top Diagnoses for these Repeat Visits

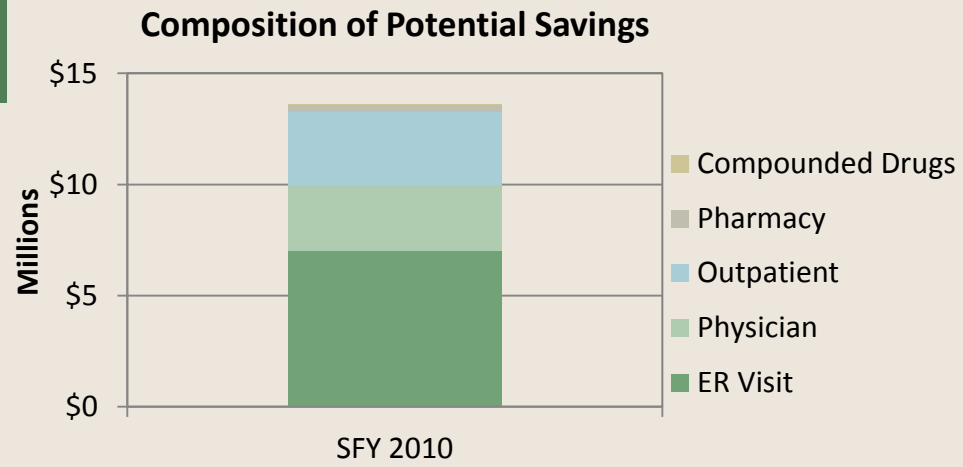
Top 10 First-Listed Diagnoses for 15-Day Repeat Visits

First-Listed Diagnosis	Number of Repeat Visits
Headache	1,133
Abdominal Pain, Unspecified Site	856
Unspecified Chest Pain	855
Other Chest Pain	654
Unspecified Migraine	651
Unspecified Urinary Tract Infection	645
Lumbago	605
Other Antepartum Condition Classifiable Elsewhere	585
Other Specified Complications of Pregnancy	482
Abdominal Pain, Other Specified Site	478

Compiled by OHCA Reporting and Statistics Unit. Data is valid as of October 21, 2011 and is subject to change.

Savings Could Result from Limiting ER Visits to 4 per Year

	SFY 2007	SFY 2008	SFY 2009	SFY 2010	CAGR
Members with > 4 ER Visits per Year	5,447	5,697	6,620	7,781	12.6%
Percent of Members with > 4 ER Visits per Year	11.5%	11.7%	12.5%	12.9%	4.0%
Visits Among Members with > 4 ER Visits per Year	44,640	46,957	54,497	64,793	13.2%
Average Number of Visits Among Members with > 4 ER Visits per Year	8.2	8.2	8.2	8.3	0.5%
Excess Visits Beyond 4 Visit Limit	22,852	24,169	28,017	33,669	13.8%
Potential Savings with 4 Visit Limit	**$7.6M**	**$8.5M**	**$10.3M**	**$13.6M**	**21.2%**



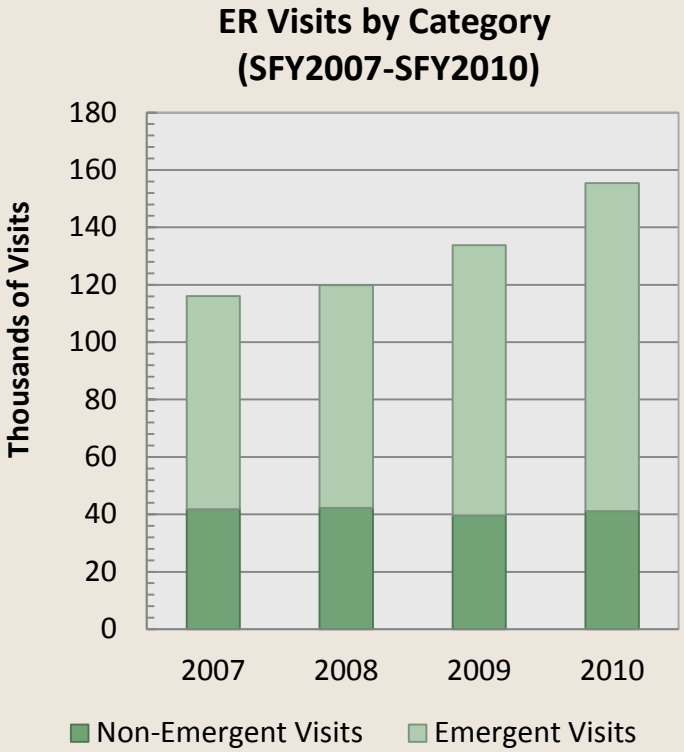
The potential savings indicated here ***does not account for*** the expected increase in PCP-based treatment costs as members shift from the ER

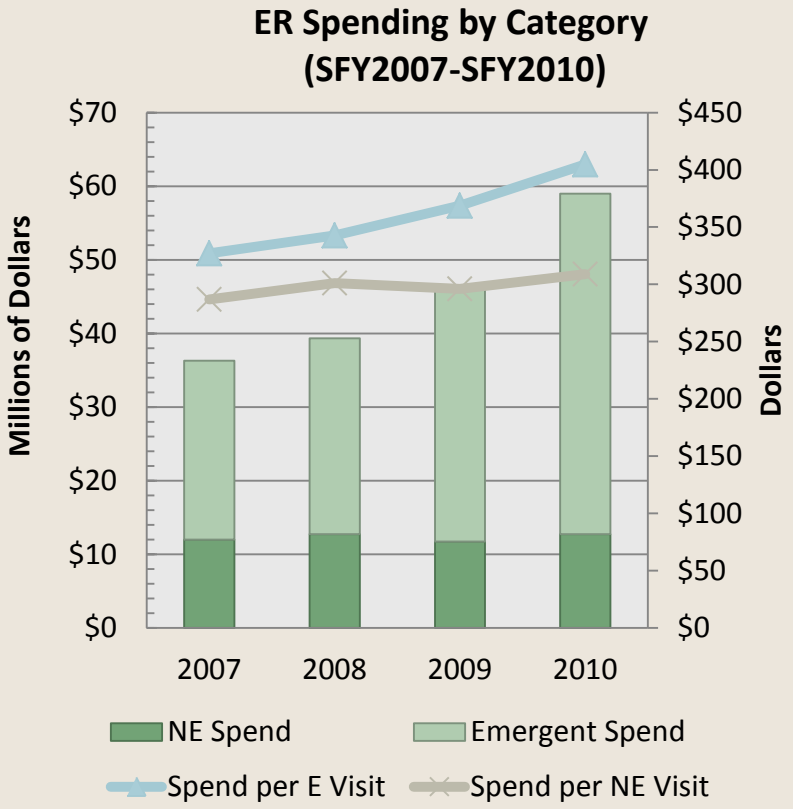
Compiled by OHCA Reporting and Statistics Unit. Data is valid as of October 21, 2011 and is subject to change.

Washington's Strategy: Emergent vs. Non-Emergent Approach

- Washington has taken a unique approach to addressing ER utilization: ***defining each possible diagnosis as Emergent or Non-Emergent***
- Non-Emergent conditions are better treated and managed in a PCP setting as opposed to the ER
- Under Washington's plan, members are allowed 3 non-emergent ER visits per year before ER payments for non-emergent conditions are discontinued
  - Washington will pay for unlimited ER visits for emergent conditions

Many ER Visits are Non-Emergent





- Non-emergent conditions accounted for ~26% of visits and ~22% of spending for ER visits incurred in SFY2010
  - Both of these proportions have been declining since 2009
- In general, average spending per non-emergent visit is less than that of an emergent visit

Compiled by OHCA Reporting and Statistics Unit. Data is valid as of October 21, 2011 and is subject to change.

Most Top ER Diagnoses Would be Categorized as NE by Washington

Diagnosis	Number of Visits	Dollars Reimbursed in SFY2010
Unspecified Chest Pain	3,585	$2.5M
Other Chest Pain	2,437	$1.6M
Headache	3,947	$1.4M
Abdominal Pain in Unspecified Site	2,974	$1.3M
Urinary Tract Infection in Unspecified Site	3,491	$1.3M
Abdominal Pain in Other Specified Site	1,715	$0.9M
Other Convulsions	1,301	$0.9M
Other Antepartum Condition Classifiable Elsewhere	2,967	$0.9M
Other Specified Complications of Pregnancy	2,308	$0.8M
Threatened Abortion, Antepartum Condition	1,853	$0.7M
Painful Respiration	1,447	$0.7M
Acute Bronchitis	2,321	$0.7M
Noninfectious Gastroenteritis Not Elsewhere Classified	1,576	$0.7M
Unspecified Migraine, Not Intractable or Status Migrainosus	2,157	$0.6M
Bronchitis, Not Specified as Acute or Chronic	2,136	$0.6M
Neck Sprain or Strain	1,605	$0.6M
Obstructive Chronic Bronchitis, with Acute Exacerbation	1,121	$0.6M
Lumbago	2,289	$0.6M
Epigastric Abdominal Pain	1,034	$0.6M
Abdominal Pain, Right Lower Quadrant	799	$0.6M
Infection of Genitourinary Tract in Pregnancy	1,581	$0.5M
Syncope and Collapse	822	$0.5M
Lumbar Sprain or Strain	2,026	$0.5M
Unspecified Epilepsy	751	$0.5M
Unspecified Backache	1,612	$0.5M

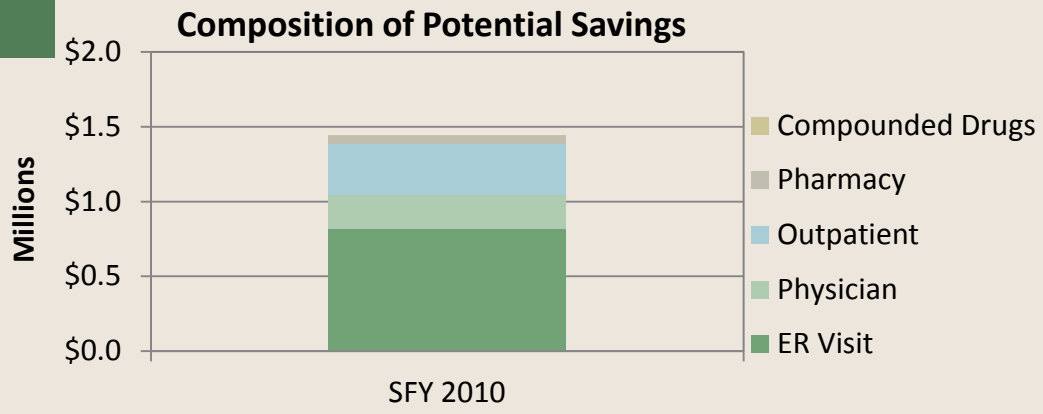
Emergent
Non-Emergent

Note: Includes all outpatient, physician, and drug costs incurred on the same day as the ER visit; costs are attributed to the first-listed diagnosis

Compiled by OHCA Reporting and Statistics Unit. Data is valid as of October 21, 2011 and is subject to change.

Modest Savings Could Result from Non-Emergent ER Limits

	SFY 2007	SFY 2008	SFY 2009	SFY 2010	CAGR
Members with > 3 NE ER Visits per Year	1,824	1,889	1,628	1,640	(3.5%)
Percent of Members with > 3 NE ER Visits per Year	3.9%	3.9%	3.1%	2.7%	(10.9%)
NE Visits Among Members with > 3 NE ER Visits per Year	10,822	10,999	9,263	9,217	(5.2%)
Average Number of NE Visits Among Members with > 3 NE ER Visits per Year	5.9	5.8	5.7	5.6	(1.8%)
Excess Visits Beyond 3 NE ER Visit Limit	5,350	5,332	4,379	4,297	(7.0%)
Potential Savings with 3 NE ER Visit Limit	**$1.6M**	**$1.7M**	**$1.4M**	**$1.4M**	**(4.3%)**



The potential savings indicated here ***does not account for*** the expected increase in PCP-based treatment costs as members shift from the ER

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Rates & Standards
December 1, 2011

1. **Is this a rate change or a method change?**
   Rate-The rates will change as a result of the change in available funds due to the SSI COLA Increase.

2. **Is this change an increase, decrease or no impact?**
   The change has no impact on the use of state or federal funds. The increase in patient spend-down resulting from the SSI COLA will increase the total available funding in turn increasing the pools used for the rate component calculations. The average rate will go up by $1.15 per day to match.

3. **Presentation of Issue**
   The change is made as a part of following the methodology as established in the state plan and required by Title 63 § 5023 (1991).

4. **Current Methodology/Rate Structure:**
   The current rate methodology calls for the establishment of four components for each facility. The current rate components and rate ranges are:
   - The current rate components are:
     Base Rate Component: $103.20 per day, defined as the rate in effect at 06-30-05.
     Other Cost Component: $5.95 per day, defined as a per diem amount reflecting 30% of the available funding after meeting the funding for the base rate and the Focus on Excellence (FOE) points earned.
     Focus on Excellence Component: $1.00 to $5.00 per day earned for performance in the FOE program, the current average is $2.73 per day.
     Direct Care Component: $ $7.44 per day to $17.30 per day, with an average of $13.87 per day, dependent on the facility's relative direct care expenditures.
   - The current average rate is $125.75 and the current rate range is from $116.59 to $131.90

5. **Budget Estimate:**
   The state share and federal share of the budget will not change-the only rate changes are due to the added patient spend-down amounts.

6. **Estimated impact on access to care:**
   No impact is expected. The rates are going up on the average by $1.15 per day and the annual change in number of days has remained constant for some time, 1 to 2 % reduction each year no matter what the changes in rates were.

7. **Requested change:**
   The agency requests approval of a change in the state plan to increase the pool of funds available for the direct care and other components from $97,607,577 to $102,318,569. The increase is due to the funds available from the SSI COLA of 3.6%, effective January 1, 2012. The effect of this change would result in the following rate components: Base Rate $103.20, Other Component $6.38, Focus on Excellence average Component $2.43 and Direct Care average component of $14.89 for an overall average rate of $126.90 and a rate range from $118.33 to $133.09. See Attachment for more detail.

8. **Effective Date of Change:** January 1, 2012

Recommendation 1: Prior Authorize Select Biologic Products

The Drug Utilization Review Board recommends pharmacy and medical prior authorization of this class of medications with the following criteria and tier structure:

Tier 2 authorization criteria:

1. FDA approved diagnosis (Rheumatoid Arthritis, Crohn's Disease, Plaque Psoriasis, and Ankylosing Spondylitis)
2. A trial of at least one Tier 1 product in the last 90 days that did not yield adequate relief of symptoms or resulted in intolerable adverse effects.
3. Prior stabilization on the Tier 2 medication documented within the last 100 days.

Tier 3 authorization criteria:

1. FDA approved diagnosis
2. Recent trials of one Tier 1 product and all available Tier 2 medications that did not yield adequate relief of symptoms or resulted in intolerable adverse effects.
3. Prior stabilization on the Tier 3 medication documented within the last 100 days.
4. A unique FDA-approved indication not covered by Tier 2 products.

Tier 1	Tier 2	Tier 3
DMARDs appropriate to disease State :	**Supplemental rebated medications**	Abatacept (Orencia®)
Methotrexate		Adalimumab (Humira®)
Hydroxychloroquine		Alefacept (Amevive®)
Sulfasalazine		Anakinra (Kineret®)
Minocycline		Certolizumab pegol (Cimzia®)
Oral Corticosteroids		Etanercept (Enbrel®)
Leflunomide		Golimumab (Simponi®)
Mesalamine		Infliximab (Remicade®)
6-Mercaptopurine		Rituximab (Rituxan®)
Azathioprine		Tocilizumab (Actemra®)
NSAIDs		Ustekinumab (Stelara®)

Recommendation 2: Prior Authorize Firazyr® (icatibant)

The Drug Utilization Review Board recommends placing a prior authorization on Firazyr® (icatibant) with the following criteria:

1. Documented diagnosis of Hereditary Angioedema (HAE)
2. For acute attacks of Hereditary Angioedema (HAE)