OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
May 10, 2012 at 1:00 P.M.
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A – Ponca Conference Room
Oklahoma City, Oklahoma

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 April 12, 2012 OHCA Board Minutes
3. Discussion Item – Reports to the Board by Board Committees

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

Item to be presented by Mike Fogarty, Chief Executive Officer

4. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Carrie Evans, Chief Financial Officer
    b) Medicaid Director's Update – Becky Pasternik-Ikard, Deputy State Medicaid Director
    c) Legislative Update – Nico Gomez, Deputy Chief Executive Officer

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

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

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

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

    a) Children's Sub-Acute Hospitals

        1. Consideration and Vote to alter the payment methodology for Children's Sub-Acute hospitals from a prospective payment method to a cost settlement method effective July 1, 2012.

    b) Regular Nursing Facilities

1. Consideration and Vote to Raise the Quality Of Care Fee authorized under 56 Oklahoma Statutes 2002 (B) from $6.70 to $9.79 per patient day effective July 1, 2012.
2. Consideration and vote to Raise the Base Rate for Regular Nursing Facilities from $103.20 per patient, per day to $ 106.29 per patient, per day effective July 1, 2012.
3. Consideration and Vote to Raise the pool amount of monies available for portions of the rate payment from $102,318,569 to $147,230,204 effective July 1, 2012.

c) Regular Intermediate Care Facilities for the Mentally Retarded

1. Consideration and Vote to Raise the Quality of Care Fee authorized under 56 Oklahoma Statutes § 2001 from $6.16 to $6.96 per patient day effective July 1, 2012.
2. Consideration and Vote to Raise the Base Rate for Intermediate Care Facilities for the Mentally Retarded from $117.76 per patient, per day to $120.03 per patient, per day effective July 1, 2012.

d) Acute (16 Bed-or-Less) Intermediate Care Facilities for the Mentally Retarded

1. Consideration and Vote to Raise the Quality of Care Fee authorized under 56 Oklahoma Statutes section 2001 from $7.94 to $8.93 per patient day effective July 1, 2012.
2. Consideration and Vote to Raise the Base Rate for the Acute (16 Bed or Less) Intermediate Care Facilities for the Mentally Retarded from $151.65 per patient per day to $154.47 per patient, per day effective July 1, 2012.

e) Rate for Nursing Facility Patients diagnosed with Acquired Immune Deficiency Syndrome

1. Consideration and Vote to Raise the rate for nursing facility patients diagnosed with Acquired Immune Deficiency Syndrome from $182.22 per patient per day to $192.50 per patient per day effective July 1, 2012.

Item to be presented by Dr. Nancy Nesser, Director of Pharmacy Services

7. 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 **Xgeva® (denosumab), 17-Hydroxyprogesterone Caproate,** and **Kalydeco™ (ivacaftor)** to the Utilization and Scope Prior Authorization Program Under OAC 317:30-5-77.2(e).

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

8. a) Action Item - Consideration and Vote for Expenditure of Funds to Contract With PHBV Partners to Audit Disproportionate Share Hospital (DSH) Payments.

b) Action Item - Consideration and Vote Authority for Expenditure of Funds to Amend the External Quality Organization Contract with Telligen.

Item to be presented by Chairman Roggow

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

   a) Status of Pending Suits

10. New Business

11. ADJOURNMENT

NEXT BOARD MEETING
June 14, 2012
Autry Technology Center
1201 West Willow
Oklahoma Room
Enid, OK 73703

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
April 12, 2012
Held at the Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on April 11, 2012, 12:15 p.m. Advance public meeting notice is provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on April 11, 2012, 12:30 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Roggow called the meeting to order at 1:04 p.m.

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

OTHERS PRESENT:	OTHERS PRESENT:
Tom Dunning, OKDHS	Debbie Spaeth, Quest MHSA
Lisa Adams, Varangon Academy	Shirley Russell, OKDHS
Becky Moore, OAHCP	Azure Harmon, CARE PAC
Mary Brinkley, Leading Age OK	Will Widman, HP
Josh Cook, HP	Charles Brodt, HP
Terry Cothran, COP	

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD March 8, 2012.

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

MOTION:	Vice-Chairman Armstrong moved for approval of the March 8, 2012 board minutes as published. Member McVay seconded.
FOR THE MOTION:	Member McVay, Member Bryant, Member Miller Vice-Chairman Armstrong and Chairman Roggow

ITEM 3 / REPORTS TO THE BOARD BY BOARD COMMITTEES

Member McVay reported that the Rules Committee met and briefly discussed current issues with the rule making process.

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Chairman Roggow reported that the Legislative Committee met and Mr. Gomez, Deputy Chief Executive Officer would present the update.

Vice-Chairman Armstrong reported that the Strategic Planning Committee did not meet.

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

Mr. Fogarty introduced Lindsey Bateman as his new Executive Assistant and stated that she will also resume the responsibilities of the Board Secretary.

4a. FINANCIAL UPDATE
Gloria Hudson, Director of General Accounting

Ms. Hudson reported that the agency is under budget with a positive variance of $28.4 million state, $2.7 million higher than the prior month. She stated that we are $13.6 million under budget in the Medicaid program spending as well as $4.8 million in Administration, and over budget $3.3 million on drug rebate, tobacco tax collections and fees for $3.5 million and settlements and overpayments for $3.2 million. Ms. Hudson foresees that we will continue to remain under budget. For a detailed financial report, see Item 4a of the April 12, 2012 board packet.

Member Miller stated that he did not see a need for the audit/finance committee to meet this month but anticipates that the committee will meet next month because of an important audit.

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

Dr. Splinter reviewed the Medicaid Director's Report. He noted that enrollment increased by 4,000 individuals so that we are now just under 792,000 members with not a lot of change in the cost figures. He noted that in the future, Matt Lucas can provide more detailed information for the Insure Oklahoma program numbers. Dr. Splinter stated that our provider enrollment figure is still a success story with total enrollees being at 39,000 and in-state being at 29,000. For more detailed information, see Item 4b in the board packet.

Member Miller noted our positive budget situation despite the increase in enrollment.

4c. LEGISLATIVE UPDATE
Nico Gomez, Deputy Chief Executive Officer

Mr. Gomez reported on the following legislation:

House Bill (HB) 2273 - Allows OHCA to pay for professional expenses for OHCA CEO and Physicians; Permits Prior Authorizations for Hepatitis C and HIV prescriptions; Committee Substitute passed Senate Appropriations 17-0 on April 4, 2012. There will still be negotiations with language, etc. on this bill.

Mr. Gomez stated that the House Joint Resolution (HJR)1105 disapproves a rule effectively changes the family planning program from a waiver authority program to a state plan which passed out of committee 6-2. It will next go to the house floor and be signed by early May.

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The nursing home quality of care fee cap is HB 2270 and expects to be heard in the Senate next week to continue to move through.
Mr. Gomez noted that as we get closer to the end of May, we still have the negotiation of the budget and expects that the House, Senate and Governor's office will have discussions as they try to identify and work out if and how much an income tax reduction will be and how you balance the other state priorities. He is remaining optimistic that there will be a budget agreement by the end of April.

Member Miller asked about the language in Senate Bill (SB) 1161 and Mr. Gomez stated that they deferred that to the appropriations process and that the vehicle is not alive but the issue still is. He also commented that House Bill 2241, that deals with title 63 rules, will have a particular impact on the agency. There was language added for title 63 permanent rules would have to be affirmatively approved through joint legislation. For more detailed information, see Item 4c in the board packet.

ITEM 5 / GENETIC TECHNOLOGIES IN HEALTH CARE PRESENTATION
Alison Martinez, Clinical Data Analyst of Reporting & Statistics

Dr. Garth Splinter introduced Ms. Martinez. She reviewed the PowerPoint presentation on the role of genetic technologies in health care. She also discussed emerging developments and implications in genetic technologies. Ms. Martinez discussed the types of genetic testing for different issues. She stated that in order for the testing to be covered it needs to impact some type of decision making and that biotech will have a growing budget impact. For more detailed information, please see Item 5 in the board packet.

ITEM 6 / REGULATORY MANDATE FOR MEDICAID PAYMENT SUSPENSIONS AND CONTINUING CONTRACT TERMINATIONS
Howard Pallotta, General Counsel

Mr. Pallotta reviewed the PowerPoint presentation on regulatory mandate for payment suspensions and contract terminations. He stated that OHCA can terminate a contract for: cause with a thirty day notice, without cause with a sixty day notice, immediately (1) to protect the health and safety of members, (2) upon evidence of fraud or (3) if the provider's license / accreditation or certification is modified, suspended, revoked or terminated. Medicaid regulations state "the agency must suspend all Medicaid payments to a provider after the agency determines there is a credible allegation of fraud". Mr. Pallotta discussed the definition of credible allegations of fraud. He stated that there have been 35 contracts terminated and 3 contract providers suspended since July 2011. He reviewed the findings that were the cause for action and then discussed due process for contract terminations.

Member Bryant asked when there was a problem and it is reported it to the Medicaid fraud control unit, can a doctor go to another state and practice and should OHCA keep record of that? Mr. Pallotta answered that there is a list of things the government has to do to investigate a provider and there is a database, that is reviewed, that records a provider's practice history. For more detailed information, please see Item 6 in the board packet.

Mr. Fogarty commented that this program and organization depends on sophisticated information technology systems to get the job done. He stated that OHCA processes 700,000 claims a week, with payments of 100,000 million dollars a week. He noted that every enrolled

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member (or renewal) goes through an electronic enrollment system. He discussed the progress of the statewide IT consolidation.

ITEM 7 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE DIRECTOR OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (1), (4) AND (7)

Howard Pallotta, General Counsel

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

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

8 / NEW BUSINESS

There was no new business

9 / ADJOURNMENT

MOTION: Member Bryant moved for adjournment. Member Miller seconded.

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

Meeting adjourned at 2:30 p.m., 4/12/2012

NEXT BOARD MEETING
May 10, 2012
Oklahoma Health Care Authority
2401 NW 23rd, Suite 1-A, Ponca Conference Room
Oklahoma City, OK 73107

Lindsey Bateman
Board Secretary

*Minutes Approved:*_____

*Initials:*_____

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FINANCIAL REPORT

For the Nine Months Ended March 31, 2012
Submitted to the CEO & Board
April 12, 2012

- Revenues for OHCA through March, accounting for receivables, were **$2,812,476,497** or **(.2%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,639,258,072** or **1.5% under** budget.
- The state dollar budget variance through March is **$33,428,729 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		15.2
Administration		5.3
Revenues:		
Taxes and Fees		4.1
Drug Rebate		4.8
Overpayments/Settlements		4.0
Total FY 12 Variance	**$**	**33.4**

ATTACHMENTS

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

REVENUES	FY12 Budget YTD	FY12 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 700,385,299	$ 700,385,299	$ -	0.0%
Federal Funds	1,635,852,060	1,600,983,756	(34,868,304)	(2.1)%
Tobacco Tax Collections	41,029,075	44,747,494	3,718,419	9.1%
Quality of Care Collections	38,232,627	38,660,068	427,441	1.1%
Prior Year Carryover	55,003,490	55,003,490	-	0.0%
Federal Deferral - Interest	284,824	284,824	-	0.0%
Drug Rebates	117,433,807	130,731,113	13,297,306	11.3%
Medical Refunds	30,263,155	40,979,395	10,716,240	35.4%
SHOPP	187,240,570	187,240,570	-	0.0%
Other Revenues	13,013,524	13,460,488	446,964	3.4%
TOTAL REVENUES	**$ 2,818,738,431**	**$ 2,812,476,497**	**$ (6,261,934)**	**(0.2)%**

EXPENDITURES	FY12 Budget YTD	FY12 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 32,756,920**	**$ 28,952,983**	**$ 3,803,937**	**11.6%**
ADMINISTRATION - CONTRACTS	**$ 87,944,179**	**$ 78,561,681**	**$ 9,382,498**	**10.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	24,145,134	22,984,651	1,160,483	4.8%
Acute Fee for Service Payments:				
Hospital Services	687,943,963	662,688,726	25,255,237	3.7%
Behavioral Health	236,451,881	252,828,609	(16,376,729)	(6.9)%
Physicians	336,107,634	332,905,730	3,201,904	1.0%
Dentists	109,029,799	108,796,280	233,519	0.2%
Other Practitioners	55,331,217	53,659,926	1,671,290	3.0%
Home Health Care	16,764,428	15,754,739	1,009,689	6.0%
Lab & Radiology	41,025,186	39,416,576	1,608,610	3.9%
Medical Supplies	36,649,965	36,603,812	46,154	0.1%
Ambulatory Clinics	66,865,978	61,525,387	5,340,591	8.0%
Prescription Drugs	284,060,356	289,096,528	(5,036,171)	(1.8)%
Miscellaneous Medical Payments	24,695,149	25,127,318	(432,169)	(1.8)%
OHCA TFC	-	-	-	0.0%
Other Payments:				
Nursing Facilities	367,310,358	367,244,720	65,638	0.0%
ICF-MR Private	44,280,660	42,594,837	1,685,823	3.8%
Medicare Buy-In	110,597,918	104,202,246	6,395,672	5.8%
Transportation	21,106,443	20,748,252	358,191	1.7%
EHR-Incentive Payments	39,717,795	39,717,795	-	0.0%
Part D Phase-In Contribution	56,074,389	55,847,276	227,113	0.4%
Total OHCA Medical Programs	**2,558,158,253**	**2,531,743,408**	**26,414,845**	**1.0%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,678,948,734**	**$ 2,639,258,072**	**$ 39,690,662**	**1.5%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 139,789,696**	**$ 173,218,425**	**$ 33,428,729**	

SoonerCare Programs

March 2012 Data for May 2012 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2011	Enrollment March 2012	Total Expenditures March 2012	Average Dollars Per Member Per Month March 2012
SoonerCare Choice Patient-Centered Medical Home			449,392	**483,976**	**$143,706,612**	
	Lower Cost	*(Children/Parents; Other)*		439,276	$104,792,465	$239
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		44,700	$38,914,148	$871
SoonerCare Traditional			239,274	**237,282**	**$173,149,717**	
	Lower Cost	*(Children/Parents; Other)*		129,481	$46,063,850	$356
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		107,801	$127,085,867	$1,179
SoonerPlan			31,082	**42,973**	**$782,476**	$18
Insure Oklahoma			32,181	**31,138**	**$10,040,223**	
	Employer-Sponsored Insurance		19,095	17,564	$4,650,988	$265
	Individual Plan		13,085	13,574	$5,389,235	$397
TOTAL			**751,928**	**795,369**	**$327,679,028**	

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 $218,565,586 are excluded.

Net Enrollee Count Change from Previous Month Total	3,418

New Enrollees	19,503

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

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,394
Aged/Blind/Disabled	*Adult*	131,504
Other	*Child*	191
Other	*Adult*	20,647
PACE	*Adult*	98
TEFRA	*Child*	432
Living Choice	*Adult*	98
OLL Enrollment		**172,364**

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 March 2012
Dual Enrollees	**103,906**	**108,312**

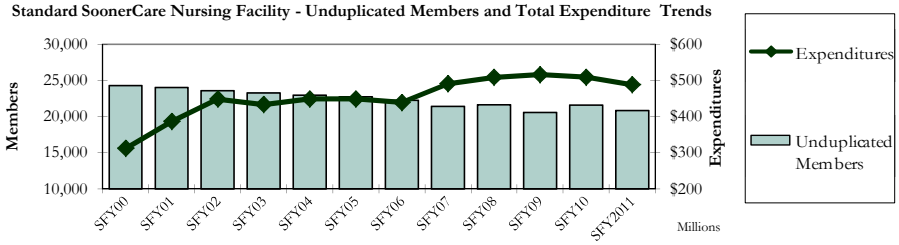
		Monthly Average SFY2011	Enrolled March 2012	PER MEMBER PER MONTH
Long-Term Care Members		**15,733**	**15,731**	**$3,110**
	Child	92	80	
	Adult	15,641	15,651	

SFY2011 Long-Term Care

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

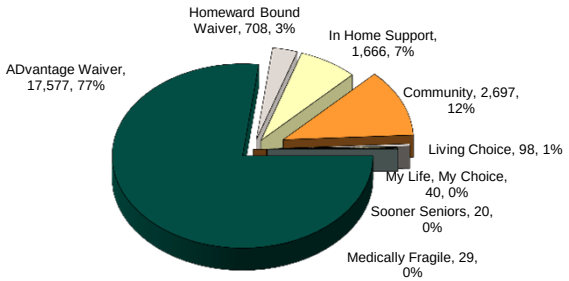
Data as of October 2011

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 March 2012
Total Providers		**29,026**	**39,191**
	In-State	20,585	28,918
	Out-of-State	8,442	10,273

Program	% of Capacity Used
SoonerCare Choice	38%
SoonerCare Choice I/T/U	14%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2011**	*In-State Enrolled March 2012***	Total Monthly Average SFY2011	Total Enrolled March 2012
Physician	*6,489*	*7,755*	*11,777*	14,099
Pharmacy	*901*	*878*	*1,230*	1,162
Mental Health Provider***	*935*	*4,387*	*982*	4,448
Dentist	*798*	*1,013*	*901*	1,168
Hospital	*187*	*195*	*739*	980
Licensed Behavioral Health Practitioner***	*503*	*3,287*	*524*	3,311
Extended Care Facility	*392*	*367*	392	367

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

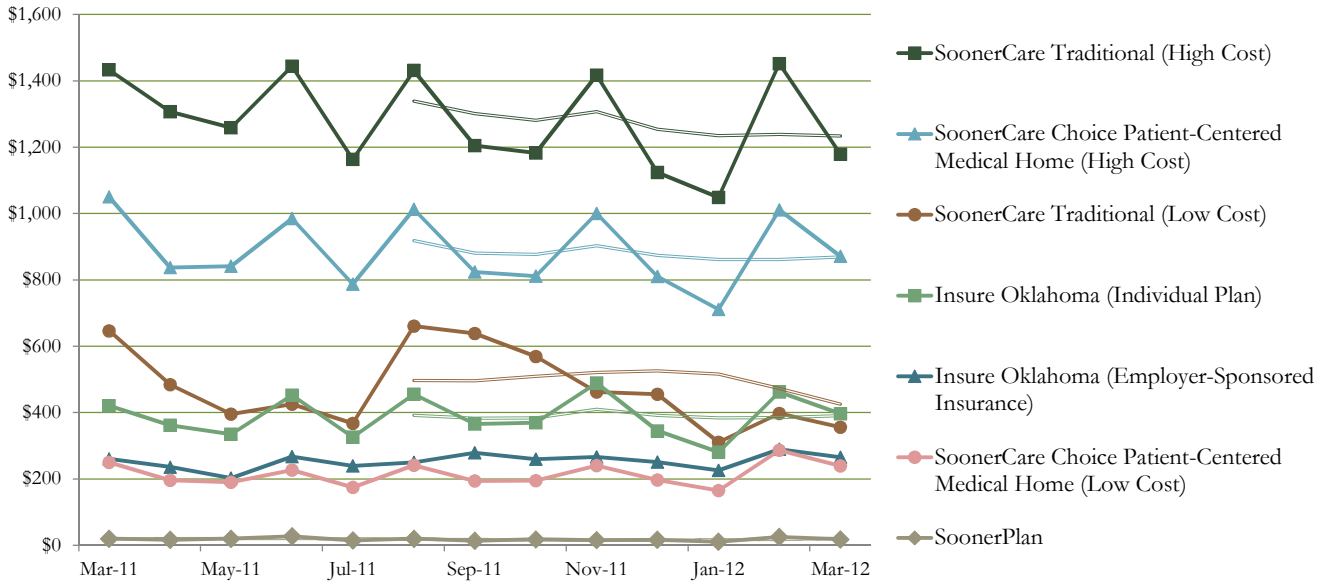
Total Primary Care Providers	*4,461*	*4,780*	6,467	6,685
Patient-Centered Medical Home	*1,476*	*1,768*	1,502	1,798

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 5/1/2012	April 2012		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	76	$1,615,000	1,246	$26,491,667
Eligible Hospitals	0*	$0	73	$50,762,837
Totals	76	$1,615,000	1,319	$77,254,504

*Current Eligible Hospitals Paid

OHCA BOARD MEETING

MAY 10, 2012 OHCA BOARD MEETING

OHCA REQUEST BILLS:

- HB 2273 – Rep. Doug Cox – Allows OHCA to pay for professional expenses for OHCA CEO and Physicians; Permits Prior Authorizations for Hepatitis C and HIV prescriptions; **Conference Granted to Senate 5-1-2012.**
- SB 1161 – Sen. Gary Stanislawski – Authorizes OHCA to employ one Program Integrity auditor for every $100,000,000 expended in state and federal funds if the return on investment, including cost avoidance, is greater than the total direct and indirect costs of the employee. Program integrity auditors shall not count toward any full-time equivalent limitations on the agency. **Failed Deadline 2-20-2012**.

After the April 26th Deadline for Third Reading of Bills in the Opposite Chamber and as of noon, Tuesday, May 1st, 2012, the Oklahoma Legislature is currently tracking a total of 768 bills. OHCA is currently tracking 69 bills. They are broken down as follows:

- OHCA Request 01
- Direct Impact 19
- Agency Interest 08
- Employee Interest 14
- 2011 Carryover 30
- Governor Signed/Vetoed 07

May 25, 2012 Sine Die Adjournment of the Second Session of the 53rd Legislature

A Legislative Bill Tracking Report will be included in your handout at the Board Meeting.

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

Agenda
Rates & Standards Hearing
April 27, 2012
10:00 am
Ponca Conference Room

Rate issues to be addressed:

- Children's Sub-Acute Long Term Care Hospitals
- Regular Nursing Facilities
- Regular Intermediate Care Facilities for the Mentally Retarded
- Acute (16 Bed-or-Less) Intermediate Care Facilities for the Mentally Retarded
- Aids Rate for Nursing Facilities

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SPARC
April 27, 2012

1. **Is this a rate change or a method change?**
   This is a method change for a single entity in the state that is categorized as a Children's Sub-Acute Long Term Care Hospital. Payments will go from prospective to settlement of costs. This will be accomplished by paying an interim rate and settling to total allowable costs as reported on the facility's annual cost report.

2. **Is this change an increase, decrease or no impact?**
   The change will impact annual expenditures by an estimated $270,725 based on the average increase in allowable cost per day for the last four fiscal periods; which includes inflation and new products that are needed for this population. It will increase the facility's reimbursement approximately $12.23 per day.

3. **Presentation of Issue**
   The change is made to enhance the methodology and allow the providers to keep up with any changes in needs while providing services for this medically fragile population. Currently, because the provider's classification does not fit neatly into nursing home methodology or the hospital methodology and because of annual changes to the method of Medicaid payment, this alteration in the payment methodology should allow fair reimbursement to the facility while creating an accountable method for the Medicaid Program.

4. **Current Methodology/Rate Structure:**
   The current rate methodology calls for the establishment of a prospective rate based on the estimated cost of providing services. The current rate is $522.54 per day.

5. **Budget Estimate:**
   The annual state share and federal share of the budget will increase by an estimated $270,725 ($97,785 in state funds).

6. **Estimated impact on access to care:**
   This change will allow this population to be served in-state and guarantee access.

7. **Requested change:**
   The agency requests approval of a change in the state plan methodology for Children's Sub-Acute Long Term Care Hospitals to go from paying a prospective rate to setting an interim rate and settling to total allowable costs through an annual cost report and audit process.

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

DRAFT

SPARC
April 27, 2012

Regular Nursing Facilities

1. **Is this a rate change or a method change?**
   This is a rate change.

2. **Is this change an increase, decrease or no impact?**
   The change will increase the annual expenditures by an estimated $60.7 million.

3. **Presentation of Issue**
   The change is made to implement the previously approved Tax Waiver and Plan Changes and implement HB 2270 which unfreezes the Quality of Care (QOC) fee. The net effect will be to raise the QOC Fee from $6.70 per day to $9.79 per day and match the additional fee collections through rate increases to providers. This provider group has not had a significant increase since SFY 2008 (in fact a decrease was made in SFY 2010 to balance the budget and meet our constitutional requirements) and this increase will help fill the gap between allowable costs and rates and allow the OHCA to assure the provision of services for this medically fragile and elderly population.

4. **Current Methodology/Rate Structure:**
   The current rate methodology calls for the establishment of a prospective rate which consists of the following four components:
   (A) A Base Rate Component defined as the rate in effect at 06-30-05, or $103.20 per day.
   (B) A Focus on Excellence (FOE) Component defined by the points earned under this performance program as defined in the state plan. The bonus component paid may be from $1.00 to $5.00 per day based on points earned.
   (C) An Other Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and FOE Components by the total estimated Medicaid days for the rate period.
   (D) A Direct Care Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and FOE Components to the facilities. This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the 70% pool funds to each facility (on a per day basis) based on their relative expenditures for direct care.

5. **Budget Estimate:**
   The annual budget will increase by an estimated $60,610,570 funded by $21,942,542 state funds coming from the increased QOC Fee collections and matching Federal funds of $38,668,028.

6. **Estimated impact on access to care:**
   This change will insure access for this elderly population by paying an appropriate amount for these services.

7. **Requested change:**
   The agency requests approval of a change in the state plan to implement the following:
   - *Base Rate*-to increase the base rate component to include the increase in the QOC fee from $103.20 per day to $106.29 per day.
   - *Pool Amount* – to increase the pool amount in the state plan for the "Other" and "Direct Care" Components from $ 102,318,569 to $147,230,204 to account for the increase in available funds from the increased QOC Fee collections.

6. **Effective Date of Change:** July 1, 2012

DRAFT

SPARC
April 27, 2012
Regular ICF M/R Facilities

1. **Is this a rate change or a method change?**
   This is a rate change.

2. **Is this change an increase, decrease or no impact?**
   The change will increase the annual expenditures by $506,549.

3. **Presentation of Issue**
   The change is made to implement the previously approved Tax Waiver and Plan Changes and implement HB 2270 which unfreezes the Quality of Care (QOC) fee. The net effect will be to raise the QOC Fee from $6.16 per day to $6.96 per day and match the additional fee collections through rate increases to providers. This provider group has not had a significant increase since SFY 2008 (in fact a decrease was made in SFY 2010 to balance the budget and meet our constitutional requirements) and this increase will help fill the gap between allowable costs and rates and allow the OHCA to assure the provision of services for this medically fragile population.

4. **Current Methodology/Rate Structure:**
   The current rate methodology calls for the establishment of a state-wide prospective rate which is based on the reported allowable cost per day.

5. **Budget Estimate:**
   The annual budget will increase by an estimated $506,549 funded by $183,383 state funds coming from the increased QOC Fee collections and matching Federal funds of $323,166.

6. **Estimated impact on access to care:**
   This change will help insure access for this fragile population by paying an appropriate amount for these services.

7. **Requested change:**
   The agency requests approval of a change in the state plan to implement the following:
   - *Base Rate*-to increase the base rate by 1.0193% from $117.76 per day to $120.03 per day.

6. **Effective Date of Change:** July 1, 2012

DRAFT

SPARC
April 27, 2012

Acute (16 Bed-or-Less) ICF M/R Facilities

1. **Is this a rate change or a method change?**
   This is a rate change.

2. **Is this change an increase, decrease or no impact?**
   The change will increase the annual expenditures by an estimated $706,564.

3. **Presentation of Issue**
   The change is made to implement the previously approved Tax Waiver and Plan Changes and implement HB 2270 which unfreezes the Quality of Care (QOC) fee. The net effect will be to raise the QOC fee from $7.94 per day to $8.93 per day and match the additional fee collections through rate increases to providers. This provider group has not had a significant increase since SFY 2008 (in fact a decrease was made in SFY 2010 to balance the budget and meet our constitutional requirements) and this increase will help fill the gap between allowable costs and rates and allow the OHCA to assure the provision of services for this medically fragile population.

4. **Current Methodology/Rate Structure:**
   The current rate methodology calls for the establishment of a state-wide prospective rate which is based on the reported allowable cost per day.

5. **Budget Estimate:**
   The annual budget will increase by an estimated $706,564 funded by $255,794 state funds coming from the increased QOC Fee collections and matching Federal funds of $450,770. No new appropriations are included in these totals. The increase in available funds will allow for an increase in the rates.

6. **Estimated impact on access to care:**
   This change will help insure access for this fragile population by paying a more appropriate amount for these services.

7. **Requested change:**
   The agency requests approval of a change in the state plan to implement the following:
   - *Base Rate*-to increase the base rate by 1.0186% from $151.65 per day to $154.47 per day.

6. **Effective Date of Change:** July 1, 2012

DRAFT

SPARC
April 27, 2012

Aids Rate for Nursing Facilities

1. **Is this a rate change or a method change?**
   This is a rate change.

2. **Is this change an increase, decrease or no impact?**
   The change will increase the annual expenditures by an estimated $115,661.

3. **Presentation of Issue**
   The change is made to implement the previously approved Tax Waiver and Plan Changes and implement HB 2270 which unfreezes the Quality of Care (QOC) fee. The net effect will be to raise the QOC Fee from $6.70 per day to $9.79 per day and match the additional fee collections through rate increases to providers. This provider group has not had a significant increase since SFY 2008 (in fact a decrease was made in SFY 2010 to balance the budget and meet our constitutional requirements) and this increase will help fill the gap between allowable costs and rates and allow the OHCA to assure the provision of services for this medically fragile population.

4. **Current Methodology/Rate Structure:**
   The current rate methodology calls for the establishment of a state-wide prospective rate based on reported allowable costs. This facility type also participates in the Focus on /excellence and may earn an additional $1.00 to $5.00 depending on performance.

5. **Budget Estimate:**
   The annual budget will increase by an estimated $115,661 funded by $41,872 state funds coming from the increased QOC Fee collections and matching Federal funds of $73,789.

6. **Estimated impact on access to care:**
   This change will insure access for this fragile population by paying a more appropriate amount for these services.

7. **Requested change:**
   The agency requests approval of a change in the state plan to implement the following:
   - *Base Rate*-to increase the base rate component by 5.64% from $182.22 per day to $192.50 per day.

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

DRAFT

OKLAHOMA HEALTH CARE AUTHORITY
2013 BUDGET WORK PROGRAM
RATES AT 0701/12

4/16/2012

	NF'S	AID'S	VENT'S Add-On	REG MR'S	ACUTE MR'S	GRAND TOTAL
Current Base Rate	$ 103.20	$ 179.79	$ 135.43	$ 117.76	$ 151.65	
Current Average FOE Earned	$ 2.43					
Current Average Other Component	$ 6.38					
Current Average Direct Care Copmponent	$ 14.89					
Total Current Rate	**$ 126.90**	**$ 179.79**	**$ 135.43**	**$ 117.76**	**$ 151.65**	
QOC Fund Increase**	$ 12.71	$ 12.71		$ 2.27	$ 2.82	
Net Rate	**$ 139.61**	**$ 192.50**	**$ 135.43**	**$ 120.03**	**$ 154.47**	
Base Rate at 06-30-12	$ 103.20					
Increase in QOC Fee	***$ 3.09***					
Base Rate For 07-01-2012	***$ 106.29***					
FOE Est per day average (current rate component)	$ 2.43	$ 2.43				
Net Amount for Pool	$ 30.89					
Other Care Component Amount (30%)	$ 9.27					
Direct Care Component Amount (70%)	$ 21.62					
Total NF Days	4,766,274	9,100	19,858	224,205	251,331	5,250,910
Total Tiered Estimate	11,582,046	$ 22,113				
Total Pool Estimate	***147,230,204***					
Base Rate Estimate	506,607,263					
Other Rate Add-ons for Vent and Aids	$ 4,463,232	$ 1,773,863	$ 2,689,369			
Total Budget	$ 669,882,745			$ 26,911,326	$ 38,823,100	$ 735,617,171
Estimated Spenddown	$ 130,560,147			$ 3,624,956	$ 3,890,075	$ 138,075,177
Net State and Federal Budget	$ 539,322,598			$ 23,286,371	$ 34,933,025	$ 597,541,994
Federal Share	$ 344,074,334			$ 14,856,122	$ 22,286,397	$ 381,216,853
Quality of Care Fee Collections	$ 69,645,383			$ 1,604,224	$ 2,317,139	$ 73,566,746
Appropriated State Monies	$ 125,602,881			$ 6,826,024	$ 10,329,490	$ 142,758,394

*SSI 3.1% at $.32 per each 1 percent implies that Spend-down will increase by $.99 per day for NF's-Adjusted to $.65 for 18 months.
*SSI 3.1% at $.22 per each 1 percent implies that Spend-down will increase by $.68 per day for MR's-Adjusted to $.45 for 18 months.
*SSI 3.1% at $.20 per each 1 percent implies that Spend-down will increase by $.62 per day for AMR's-Adjusted to $.41 for 18 months.
**Increase in rate per day from available funds due to lifting the QOC Fee Cap.

** ***CY 2011 Quality of Care Report Data***	***NF***	***MR***	AMR
Net Receipts	$ 1,162,558,020	$ 26,325,388	$ 37,659,292
Total patient Days	7,123,317	$ 227,086	253,149
Net Per Patient Day	$ 163.20	$ 115.93	$ 148.76
6% For Fee	$ 9.79	$ 6.96	$ 8.93
Current Fee	$ 6.70	$ 6.16	$ 7.94
Increase in Fee	$ 3.09	$ 0.80	$ 0.99
Estimated Total Days	7,109,462	230,492	259,478
Total Additional Collections	$ 21,984,414	$ 183,383	$ 255,794
Federal Matching Funds	$ 38,741,817	$ 323,166	$ 450,770
Total New Available Funds	$ 60,726,231	$ 506,549	$ 706,563
Estimated Medicaid Days	4,773,184	224,205	251,331
Per Day Available	$ 12.71	$ 2.27	$ 2.82

Rate Range Prior to 07-01-2012	$118.40 to $130.63
Rate Range form this Change	$130.73 to $142.55

Recommendation 1: Prior Authorize Xgeva® (denosumab)

The Drug Utilization Review Board recommends medical prior authorization of Xgeva® (denosumab) with the following criteria:

FDA approved indication of prevention of skeletal-related events in patients with bone metastases from solid tumors.

Recommendation 2: Prior Authorize 17-Hydroxyprogesterone Caproate

The Drug Utilization Review Board recommends medical prior authorization of this medication.

Criteria for Approval for 17-Hydroxyprogesterone Caproate

1) Documented history of previous singleton spontaneous preterm delivery (SPTD) prior to 37 weeks gestation; and
2) Current singleton pregnancy; and
3) Gestational age between 16 weeks, 0 days and 20 weeks, 6 days of gestation.
4) Authorizations will be for once a week administration in an office setting through 36 weeks, 6 days of gestation.

Recommendation 3: Prior Authorize Kalydeco™ (ivacaftor)

The Drug Utilization Review Board recommends prior authorization of Kalydeco™ (ivacaftor) with the following criteria:

1) FDA approved indication of Cystic Fibrosis with a G551D mutation in the CFTR gene detected by genetic testing.
2) Age of 6 years or older.
3) Quantity limit of two tablets per day, #60 per 30 days will apply.
4) Initial approval will be for 6 months, after which time, compliance and information regarding efficacy, such as improvement in $FEV_{1,}$ will be required for continued approval.

Submitted to the C.E.O. and Board on May 10, 2012

AUTHORITY FOR EXPENDITURE OF FUNDS
Audit and Reporting of Disproportionate Share Hospital (DSH) Payments
PHBV Partners, LLP

BACKGROUND

Federal law specifies audit and reporting requirements for states that make disproportionate share hospital (DSH) payments and for each hospital that receives DSH payments. These requirements include annual reports and an independent certified audit.

SCOPE OF WORK

- Perform a DSH Agreed-Upon Procedures Engagement (AUPE) and annual reports in conformance with federal requirements
- Work with OHCA to assess and assign risk levels to DSH hospitals
- Represent OHCA in the event of a CMS audit or questions
- Assist OHCA in achieving compliance in the event of any audit findings
- Provide training to Oklahoma DSH hospitals on the DSH audit process

CONTRACT PERIOD

July 1, 2013 – June 30, 2023

CONTRACT AMOUNT AND PROCUREMENT METHOD

- The award to PHBV Partners, LLP was made through the professional services exemption to competitive bidding (Certified Public Accountants).
- The estimated contract amount for state fiscal year 2013 is not to exceed $600,000. Subsequent fiscal years will not exceed $700,000.
- Federal matching funds for this contract are at 50%

RECOMMENDATION

- Board approval to expend funds for the services discussed above

Submitted to the C.E.O. and Board on May 10, 2012

AUTHORITY FOR EXPENDITURE OF FUNDS
To Amend the contract for External Quality Review
Telligen Healthcare Intelligence

BACKGROUND

The Board previously approved authority to expend funds for a contract with Telligen for federally-required peer review and quality improvement activities at an estimated amount of $1.1 million per year.

AMENDMENT

Tasks within the original scope of work have been revised as follows:

- Implement new CMS requirements for member satisfaction surveys;
- Clarify contract specifications for volume and complexity of review and corrective action tasks including new intermediate pricing levels;
- Additional requirements for performance improvement projects;
- Provide for research staff at both Telligen and OHCA for additional data extraction and analysis to support quality improvement;
- Remove specific tasks no longer needed, such as HEDIS and C-Section case review.

AMENDMENT AMOUNT AND PROCUREMENT METHOD

The cost of the additional activities for each state fiscal year (SFY) are as follows:

Annual Pricing	**SFY2012 3/1/2012 - 6/30/2012**	**SFY2013 7/1/2012- 6/30/2013**	**SFY2014 7/1/2013- 6/30/2014**	**SFY2015 7/1/2014- 6/30/2015**	**SFY2016 7/1/2015- 6/30/2016**	
Bid Pricing	$999,160	$999,160	$1,019,143	$1,039,526	$1,060,317	
Amendment Pricing	$1,236,030	$1,840,502	$1,871,210	$1,902,878	$1,935,064	**Total Increase:**
Increase:	$236,870	$841,342	$852,067	$863,352	$874,747	**$3,668,378**

- The original acquisition was made by competitive bid issued by OHCA.
- The amendment was negotiated with participation from the Central Purchasing Division.
- Federal matching funds for this contract are at 75% .

RECOMMENDATION

Board approval to expend funds for activities described above