OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
July 12, 2012 at 1:00 P.M.
Comanche County Memorial Hospital
Oakwood Conference Rooms 1, 2 & 3
3201 West Gore Blvd.
Lawton, 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 June 14, 2012 OHCA Board Minutes
3. Discussion Item – Reports to the Board by Board Committees

   a) Audit/Finance Committee – Member Miller
   b) 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 – Gloria Hinkle, Director of General Accounting
   b) Medicaid Director's Update – Garth Splinter, State Medicaid Director

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 Juarez McCann, Chief Budget Officer

6. Action Item – Consideration and Approval of the State Fiscal Year 2013 Budget Work Program.

Item to be presented by Howard Pallotta- Analysis of Supreme Court Decision in Department of Health and Human Services v. Florida

7. Discussion Item- Discussion of Decision by U.S. Supreme Court, Rationale by Court and Impacts on Medicaid Program.

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

8. Action Item – Consideration and Vote to amend the following actions taken by the Board in May, 2012.

a) 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~~ ~~September 1,~~ November 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~~ September 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~~ September 1, 2012.

b) 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 September~~ November 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~~ September 1, 2012.

c) 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~~ ~~September~~ November 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~~ September 1, 2012.

d) 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~~ September 1, 2012.

e) Rate for End Stage Renal Disease (ESRD) Payment

1. Consideration and Vote to approve a change in methodology for the payment of renal dialysis centers for End Stage Renal Disease (ESRD) from a composite rate method to a prospective payment system.

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

9. Action Item - Consideration and Vote for Authorization to Expend Funds to Procure an Independent Validation and Verification Vendor.

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) Discussion of Pending Litigation and Claims
    b) Evaluation of C.E.O by Board
    c) Discussion of Potential Claims

11. Action Item – Election of Oklahoma Health Care Authority 2013 Board Officers

12. New Business

13. ADJOURNMENT

NEXT BOARD MEETING
OHCA Board Retreat
August 22-24, 2012
Hyatt Regency Tulsa
100 East Second Street
Tulsa, OK 74103

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
June 14, 2012
Held at the Autry Technology Center
Enid, Oklahoma

DRAFT

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 June 13, 2012, 10:30 a.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 June 13, 2012, 12:30 p.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 1:05 p.m.

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

OTHERS PRESENT:

Lisa Simmons, Sooner Success
Theresa Sharp, Oklahoma Family Network
Pan Buckley, Youth & Family Services of NCO
Samantha Galloway, OKDHS
Shirley Russell, OKDHS
Michelle Stathan, ODMHSAS
Don Henderson, Integris Bass Baptist
Dr. Simon, MAC – NW Peds
Mike Ogle, MAC, OSU-CHS
Debbie Spaeth – Quest MHSA & OPBHAC
Mark Ferghtner, DUR Board
Carolyn Pickard, Metro Health Commission

OTHERS PRESENT:

Melinda Snowden, OHCA
Nichole Burland, OHCA
Kimrey McGinnis, OHCA
Jennifer King, OHCA
Erin Gilley, OHCA
Josh Cook, HP
Will Widman, HP
Janet Cordell, Health Planning
Paul Keenan, OHCA
Sean Byrne, United Way of Enid
Jimmy Johnson, Life EMS
Becky Moore, OAHCP

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD MAY 10, 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 May 10, 2012 board minutes as published. Member McFall seconded.

FOR THE MOTION: Chairman Roggow, Member Miller, Member Robison, Member Bryant

ABSTAINED: Member McVay

ITEM 3 / REPORTS TO THE BOARD BY BOARD COMMITTEES

Audit/Finance Committee
Member Miller reported that the Audit/Finance Committee did not meet.

Personnel Committee
Member McVay reported that the Personnel Committee met and were updated by management on performance of employees and stated that they continue to be very dedicated and do a great job.

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

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

Mr. Fogarty mentioned the OHCA All-Star luncheon took place on May 31st where the All-Stars were recognized. He stated that it is an annual event for the agency to get together and celebrate the work that they accomplish. Pictures and a video were shown of the event.

He introduced Dr. Paul Keenan, who is retiring from OHCA. Dr. Keenan gave a farewell speech.

4a. FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported that the agency is $33 million under budget for April and it is a $ .4 decrease from the previous month. She stated that we ran under budget in Medicaid by $5 million however we did book tobacco settlement funds and did not receive all that were appropriated. We were appropriated $18.1 million and received $4.8 million short of that, so the variance stayed flat even though we did go under budget. She reported that we continue to run under budget in Administration. Ms. Evans foresees that we will stay flat or continue to remain under budget. For a detailed financial report, see Item 4a of the June 14, 2012 board packet.

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

Dr. Splinter reviewed the Medicaid Director's Report and noted a small growth net of 77 for a total of 795,000 members and continue to be about 2/3 medical homes and 1/3 in the traditional program. The Insure Oklahoma program is down slightly but still over 32,000 members. The cost figures are about the same. The OLL dual eligible enrollees are at 108,000 and nursing home members being 15,700 with the average per month cost of $3,200. Dr. Splinter stated that the provider total is almost 40,000 and in-state being 29,000 and almost all categories shows an increase of ten percent over the average from the year before. Electronic Health Records had 59 payments with a total of 1.7 million for May and 1,354 payments with just over $79 million paid since inception. He discussed the next part of that is the Meaningful Use program that pays for software and hardware for practices and they are required to show transmittal of information. He stated that he and Mr. Fogarty did a site visit at the OU Physicians Clinic where our patients are seen and felt confident in sending our members there.

DRAFT

Dr. Splinter noted that Dr. Sylvia Lopez will be taking Dr. Keenan's position at OHCA. For more detailed information, see Item 4b in the board packet.

<u>Melody Anthony, Provider Services Director</u>

Mrs. Anthony discussed the Comprehensive Primary Care Initiative, a four-year multi-payer initiative aiming to strengthen primary care practices' critical role in promoting health, improving care, and reducing overall health care costs. She stated that we applied as a state but they gave us a region of 25 counties in greater Tulsa. Mrs. Anthony said that they had to negotiate an MOU with the Innovation Center that said we would be willing to participate with three payers: Blue Cross and Blue Shield of Oklahoma, Community Care and CMS and beginning tomorrow primary care practices within the designated 25 counties, can start the online application process to be evaluated for selection to participate. She noted that there is strict criteria on how the practice will be selected: they have to have a least 150 Medicare fee for service members in their practice, have a total of 60% of their revenue at the practice from a combination of the four payer, be actively engaged in the electronic health record initiative and have to be able to meet meaningful use. For more detailed information, see Item 4b in the board packet.

<u>4c. LEGISLATIVE UPDATE</u>
Nico Gomez, Deputy Chief Executive Officer

Mr. Gomez stated that the second session of the 53rd Legislature adjourned May 25th.

The appropriation bill passed, House Bill 3149, which Nico stated is very important because it's what keeps our programs running on a daily basis. House Bill 3150 is the behavioral health services transfer of $118 million from OHCA to DMHSAS. We are having weekly meetings with DMH to agree on a MOU. Senate Bill 1975, appropriates to OHCA $833 million from the General Revenue Fund; $3,080,000 to implement provisions of the Oklahoma Hospital Residency Training Program Act; $46,500,000 from Special Cash Fund; $23,500,000 from the Health Employee and Economy Improvement Act (HEEIA); $18,250,000 from the Tobacco Settlement Fund and $8,500,000 from the Special Cash Fund for replacement of FY-12 tobacco settlement funds. OHCA submitted two agency request bills. House Bill 2273 authorized OHCA to pay for professional expenses for OHCA's CEO and Physicians and also permitted prior authorizations for Hepatitis C and HIV prescriptions. In the end, this bill was not heard in committee. Senate Bill 1161 authorized OHCA for every $100 million expended in state and federal funds to employ one program integrity auditor and not be included in our FTE limits. This bill failed deadline early in session. House Bill 3058 created the Oklahoma Hospital Residency Training Program and Senate Bill 1280 redirects $3 million from OHCA to the Oklahoma State University Medical Authority Disbursing Fund to help pay for this program and Nico stated he will be working more on this in the summer. Senate Bill 1386 is a bill that the AG's office was supporting and talks about referring for cases and has been standard operating procedures for the Agency. House Bill 2270 amends the statute requiring the Nursing Home Quality of Care Fee to be increased to the federally allowed level for homes that are not licensed as continuum of care facilities as of January 1, 2012. House Bill 2241 will change the way we promulgate rules and it was vetoed. There are two bills that are and extension of the IT consolidation efforts; House Bill 2939 and House Bill 2197. For more detailed information, see Item 4c in the board packet.

<u>ITEM 5 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS</u>

DRAFT

Howard Pallotta, General Counsel

Mr. Pallotta stated that there were no conflicts.

ITEM 6 / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT
Cindy Roberts, Deputy Chief Executive Officer

AMENDING Agency rules at OAC 317:30-5-482 and 40-5-110 to provide an exception for members of the Homeward Bound Waiver receiving Habilitation Training Specialist (HTS) services. The rule revision will allow the HTS to provide more than 40 hours of service per week, when the HTS resides in the same home as the member. The rule revision is promulgated as the result of a lawsuit filed on behalf of class members of the Homeward Bound waiver. **(Reference APA WF # 12-01 A & B)**

MOTION:	Member Miller moved for approval of Item 6 as presented. Member McFall seconded.
FOR THE MOTION:	Member Bryant, Member Armstrong, Member Robison, Chairman Roggow, Member McVay

ITEM 7 / OHCA TEAM DAY PRESENTATION
Paul Gibson, Performance and Reporting Supervisor

Mr. Gibson stated that Team Day is an annual event hosted by OPM in conjunction with Public Service Recognition Week and is an opportunity to share the outcome of projects and to be seen by the public, state agency officials and members of the legislature in the Capitol rotunda. He noted that the projects are evaluated based on uniqueness or originality, use of quality processes, methods or tools and measurable results. He stated that OHCA staff presented 10 projects; 6 projects were considered for Governor's Commendation for Excellence and 4 projects presented booth-only. For more detailed information, see item 7 in the board packet.

ITEM 8 / 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

Director of Legal Services advised that there was a need for Executive Session for this Board meeting.

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 Litigation
b) Potential Federal and State Law Claims

9 / NEW BUSINESS

Chairman Roggow reported that there was no new business.

DRAFT

10 / ADJOURNMENT

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

Meeting adjourned at 3:08 p.m., 6/14/2012

NEXT BOARD MEETING
July 12, 2012
Comanche County Memorial Hospital
3201 West Gore Blvd
Lawton, OK 73505

Lindsey Bateman
Board Secretary

Minutes Approved: _______________

*Initials:*____________

DRAFT

FINANCIAL REPORT

For the Eleven Months Ended May 31, 2012
Submitted to the CEO & Board
July 12, 2012

- Revenues for OHCA through May, accounting for receivables, were **$3,552,856,455** or **(.3%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,243,578,316** or **1.4% under** budget.
- The state dollar budget variance through May is **$37,617,570 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	10.9
Administration	7.8
Revenues:	
Tobacco Settlement Funds	4.8
Taxes and Fees	4.6
Drug Rebate	5.2
Overpayments/Settlements	4.3
Total FY 12 Variance	**$ 37.6**

ATTACHMENTS

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

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

REVENUES	FY12 Budget YTD	FY12 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 840,522,477	$ 835,711,056	$ (4,811,421)	(0.6)%
Federal Funds	1,990,646,354	1,954,897,259	(35,749,095)	(1.8)%
Tobacco Tax Collections	50,262,839	54,836,268	4,573,429	9.1%
Quality of Care Collections	46,464,586	46,464,586	-	0.0%
Prior Year Carryover	55,003,490	55,003,490	-	0.0%
Federal Deferral - Interest	370,920	370,920	-	0.0%
Drug Rebates	155,885,784	170,369,598	14,483,814	9.3%
Medical Refunds	36,988,301	48,433,450	11,445,149	30.9%
SHOPP	372,565,711	372,565,711	-	0.0%
Other Revenues	13,730,482	14,204,117	473,635	3.4%
TOTAL REVENUES	**$ 3,562,440,944**	**$ 3,552,856,455**	**$ (9,584,489)**	**(0.3)%**

EXPENDITURES	FY12 Budget YTD	FY12 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 39,939,559**	**$ 35,843,953**	**$ 4,095,606**	**10.3%**
ADMINISTRATION - CONTRACTS	**$ 105,652,264**	**$ 94,208,542**	**$ 11,443,722**	**10.8%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	29,838,849	28,781,859	1,056,990	3.5%
Acute Fee for Service Payments:				
Hospital Services	845,752,340	805,228,795	40,523,545	4.8%
Behavioral Health	290,980,205	316,192,397	(25,212,191)	(8.7)%
Physicians	414,418,130	415,582,064	(1,163,934)	(0.3)%
Dentists	135,026,850	133,728,633	1,298,217	1.0%
Other Practitioners	67,189,493	67,805,568	(616,076)	(0.9)%
Home Health Care	20,519,156	19,274,691	1,244,466	6.1%
Lab & Radiology	50,638,821	50,096,286	542,535	1.1%
Medical Supplies	45,151,746	45,202,871	(51,125)	(0.1)%
Ambulatory Clinics	83,359,884	78,261,179	5,098,705	6.1%
Prescription Drugs	351,786,650	355,499,738	(3,713,088)	(1.1)%
Miscellaneous Medical Payments	30,866,849	31,201,770	(334,921)	(1.1)%
OHCA TFC	-	-	-	0.0%
Other Payments:				
Nursing Facilities	450,569,861	451,042,015	(472,154)	(0.1)%
ICF-MR Private	54,693,172	52,582,785	2,110,387	3.9%
Medicare Buy-In	136,279,521	125,583,516	10,696,005	7.8%
Transportation	25,841,851	25,376,950	464,901	1.8%
EHR-Incentive Payments	43,354,295	43,354,295	-	0.0%
Part D Phase-In Contribution	68,831,497	68,730,409	101,088	0.1%
Total OHCA Medical Programs	**3,145,099,170**	**3,113,525,821**	**31,573,348**	**1.0%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 3,290,780,375**	**$ 3,243,578,316**	**$ 47,202,058**	**1.4%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 271,660,569**	**$ 309,278,139**	**$ 37,617,570**	

SoonerCare Programs

May 2012 Data for July 2012 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2011	Enrollment May 2012	Total Expenditures May 2012	Average Dollars Per Member Per Month May 2012
SoonerCare Choice Patient-Centered Medical Home		449,392	**476,800**	**$159,449,776**	
Lower Cost	*(Children/Parents; Other)*		432,394	$114,529,387	$265
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		44,406	$44,920,389	$1,012
SoonerCare Traditional		239,274	**244,932**	**$202,838,254**	
Lower Cost	*(Children/Parents; Other)*		137,252	$52,413,281	$382
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		107,680	$150,424,973	$1,397
SoonerPlan		31,082	**44,699**	**$966,790**	$22
Insure Oklahoma		32,181	**30,615**	**$10,792,975**	
Employer-Sponsored Insurance		19,095	17,030	$4,599,738	$270
Individual Plan		13,085	13,585	$6,193,236	$456
TOTAL		**751,928**	**797,046**	**$374,047,794**	

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 $40,517,899 are excluded.

Net Enrollee Count Change from Previous Month Total	1,600

New Enrollees	19,967

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

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,111
Aged/Blind/Disabled	*Adult*	131,753
Other	*Child*	173
Other	*Adult*	20,713
PACE	*Adult*	101
TEFRA	*Child*	429
Living Choice	*Adult*	93
OLL Enrollment		**172,373**

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 May 2012
Dual Enrollees	**103,906**	**108,199**

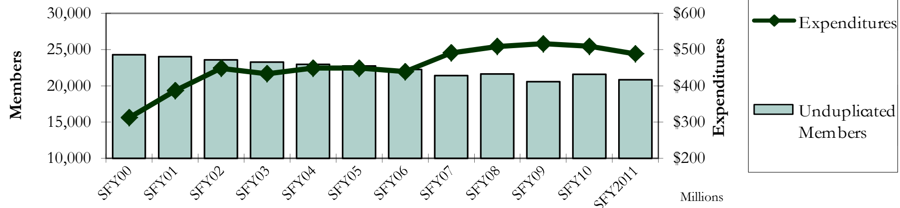
		Monthly Average SFY2011	Enrolled May 2012	PER MEMBER PER MONTH
Long-Term Care Members		**15,733**	**15,717**	**$3,693**
	Child	92	78	
	Adult	15,641	15,639	

SFY2011 Long-Term Care

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

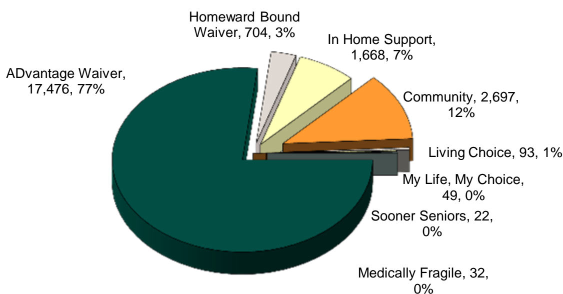
Data as of October 2011

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 May 2012
Total Providers	**29,026**	**40,289**
In-State	20,585	29,597
Out-of-State	8,442	10,692

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

Select Provider Type Counts	*In-State*		*Totals*	
	*Monthly Average SFY2011**	*Enrolled May 2012***	Monthly Average SFY2011	Enrolled May 2012
Physician	*6,489*	*7,795*	*11,777*	14,323
Pharmacy	*901*	*883*	*1,230*	1,173
Mental Health Provider***	*935*	*4,662*	*982*	4,723
Dentist	*798*	*1,033*	*901*	1,188
Hospital	*187*	*197*	*739*	1,005
Optometrist	N/A	*556*	*534*	592
Extended Care Facility	*392*	*370*	392	370

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

Total Primary Care Providers	*4,461*	*4,863*	6,467	6,814
Patient-Centered Medical Home	*1,476*	*1,827*	1,502	1,857

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 Mental Health Providers.

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 6/28/2012	June 2012		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	20	$374,000	1,295	$27,902,667
Eligible Hospitals	0*	$0	74	$51,537,837
Totals	20	$374,000	1,369	$79,440,504

*Current Eligible Hospitals Paid

OKLAHOMA HEALTH CARE AUTHORITY
FY13 BUDGET WORK PROGRAM
Summary by Program Expenditure

Description	FY-12	FY-13	Inc / (Dec)	% Change
Medical Program				
Managed Care - Choice	28,887,142	30,841,517	1,954,375	6.8%
Hospitals	925,850,124	951,854,746	26,004,622	2.8%
Behavioral Health	316,056,196	22,860,551	(293,195,645)	-92.8%
Nursing Homes	487,574,085	556,937,597	69,363,512	14.2%
Physicians	449,351,376	463,552,649	14,201,273	3.2%
Dentists	146,649,630	146,649,630	(0)	0.0%
Other Practitioners	72,546,169	75,375,944	2,829,775	3.9%
Home Health	22,206,309	22,432,397	226,088	1.0%
Lab & Radiology	54,970,846	59,992,100	5,021,254	9.1%
Medical Supplies	48,942,350	51,047,838	2,105,488	4.3%
Clinics	90,819,604	93,743,297	2,923,693	3.2%
Prescription Drugs	382,109,025	406,116,914	24,007,889	6.3%
Miscellaneous	33,626,631	1,726,558	(31,900,073)	-94.9%
ICF-MR Private	59,358,483	58,219,396	(1,139,087)	-1.9%
Transportation	28,211,700	60,849,446	32,637,746	115.7%
Medicare Buy-in	149,030,462	131,728,088	(17,302,374)	-11.6%
MMA clawback payment	75,219,620	78,256,064	3,036,444	4.0%
SHOPP - Supplemental Hosp Offset Pymt.	343,000,000	343,840,610	840,610	0.2%
HIT Grant Incentive Payments	73,854,823	72,702,373	(1,152,450)	-1.6%
HAN - Health Access Network	3,300,000	3,300,000	-	0.0%
Non-Title XIX Medical	89,382	89,382	-	0.0%
TOTAL OHCA MEDICAL PROGRAM	3,791,653,957	3,632,117,095	(159,536,862)	-4.2%
OEPIC - Premium Assistance (HIFA)				
Employer Sponsored Insurance - ESI	58,797,620	55,576,498	(3,221,122)	-5.5%
Individual Plan - IP	52,850,549	65,651,723	12,801,174	24.2%
TOTAL O-EPIC PROGRAM	111,648,169	121,228,220	9,580,051	8.6%
OHCA Administration				
Operations	44,177,974	42,428,024	(1,749,950)	-4.0%
Contracts	103,913,731	57,573,091	(46,340,640)	-44.6%
HIFA admin	8,288,503	3,711,407	(4,577,096)	-55.2%
Information Services	-	90,579,586	90,579,586	0.0%
Grant Mgmt	10,432,956	2,405,973	(8,026,983)	-76.9%
TOTAL OHCA ADMIN	166,813,164	196,698,082	29,884,918	17.9%
TOTAL OHCA PROGRAMS	**4,070,115,290**	**3,950,043,397**	**(120,071,893)**	**-3.0%**
Other State Agency (OSA) Programs				
DHS	616,826,445	592,924,830	(23,901,615)	-3.9%
ODSH	20,595,099	21,699,075	1,103,976	5.4%
OJA	8,204,395	8,043,174	(161,221)	-2.0%
University Hospitals	324,618,843	291,873,560	(32,745,283)	-10.1%
PMTC	5,529,093	5,529,093	-	0.0%
DMHSAS / Behavioral Health	70,803,189	354,746,873	283,943,684	401.0%
DOE	5,560,780	7,101,970	1,541,190	27.7%
OSU Supplemental / DRG	-	9,000,000	9,000,000	0.0%
OSU Residency Program	-	8,548,432	8,548,432	0.0%
Non-Indian Payments	6,151,670	6,398,469	246,799	4.0%
DOC	136,673	723,501	586,828	429.4%

OKLAHOMA HEALTH CARE AUTHORITY
FY13 BUDGET WORK PROGRAM
Summary by Program Expenditure

Description	FY-12	FY-13	Inc / (Dec)	% Change
JD McCarty	3,530,139	6,496,210	2,966,071	0.0%
OSA Non-Title XIX	101,659,710	101,659,710	-	0.0%
TOTAL OSA PROGRAMS	**1,163,616,036**	**1,414,744,898**	**251,128,862**	**21.6%**
TOTAL MEDICAID PROGRAM	**5,233,731,326**	**5,364,788,295**	**131,056,969**	**2.5%**

OKLAHOMA HEALTH CARE AUTHORITY
FY13 BUDGET WORK PROGRAM
Summary by Program Expenditure

Description	FY-12	FY-13	Inc / (Dec)	% Change
REVENUES				
Federal - program	3,080,689,112	3,100,423,234	19,734,122	0.6%
Federal Stimulus funds (ARRA)	70,866,174	-	(70,866,174)	-100.0%
Federal - admin	100,841,531	131,935,012	31,093,481	30.8%
Drug Rebates	158,801,516	174,376,376	15,574,860	9.8%
Medical Refunds	40,350,874	47,598,826	7,247,952	18.0%
NF Quality of Care Fee	51,175,731	73,566,746	22,391,015	43.8%
OSA Refunds & Reimbursements	500,151,762	592,493,265	92,341,503	18.5%
Tobacco Tax	95,576,605	103,462,058	7,885,453	8.3%
Insurance Premiums	6,342,066	7,178,501	836,435	100.0%
Misc Revenue	3,284,000	84,000	(3,200,000)	-97.4%
Prior Year Carryover	52,767,553	46,347,943	(6,419,610)	-12.2%
Other Grants	6,573,412	2,753,558	(3,819,854)	-58.1%
Hospital Provider Fee (SHOPP bill)	154,091,600	154,085,772	(5,828)	0.0%
OEPIC Transfer	-	23,500,000	23,500,000	0.0%
State Appropriated	912,219,389	906,983,007	(5,236,382)	-0.6%
TOTAL REVENUES	**5,233,731,325**	**5,364,788,296**	**131,056,971**	**2.5%**

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 beginning November 1, 2012 and appropriations for the period of September to October 2012 with 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:** September 1, 2012

SPARC
April 27, 2012
Regular ICF M/R Facilities

1. **<u>Is this a rate change or a method change?</u>**
   This is a rate change.

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

3. **<u>Presentation of Issue</u>**
   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. **<u>Current Methodology/Rate Structure:</u>**
   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. **<u>Budget Estimate</u>:**
   The annual budget will increase by an estimated $506,549 funded by $183,383 state funds coming from the increased QOC Fee collections beginning November 1, 2012 and appropriations for the period of September to October 2012 with matching Federal funds of $323,166.

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

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

6. **<u>Effective Date of Change:</u>** September 1, 2012

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 beginning November 1, 2012 and appropriations for the period of September to October 2012 with and matching Federal funds of $450,770.

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:** September 1, 2012

SPARC
April 27, 2012

Aids Rate for Nursing Facilities

1. **<u>Is this a rate change or a method change?</u>**
   This is a rate change.

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

3. **<u>Presentation of Issue</u>**
   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. **<u>Current Methodology/Rate Structure:</u>**
   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. **<u>Budget Estimate</u>:**
   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. **<u>Estimated impact on access to care:</u>**
   This change will insure access for this fragile population by paying a more appropriate amount for these services.

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

8. **<u>Effective Date of Change:</u>** September 1, 2012

MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

Agenda
Rates & Standards Hearing
June 28, 2012
1:00 pm
Ponca Conference Room

Rate issues to be addressed:

- End Stage Renal Disease (ESRD) Payment Methodology Change

1. Is this a “Rate Change” or a “Method Change”?
   Method change

1b. Is this change an increase, decrease, or no impact?
   Increase.

2. Presentation of issue – Why is change being made?
   The Oklahoma Medicaid State Plan states that dialysis visits will be reimbursed at the provider’s Medicare composite rate for dialysis services determined by Medicare. Effective January 2011, Medicare changed its reimbursement methodology from the composite rate to an ESRD prospective payment system (ESRD PPS). The Oklahoma Medicaid State Plan states that dialysis visits will be reimbursed at the provider’s Medicare composite rate as determined by Medicare. However it is the agency’s intent to alter its payment method to match the January 2011 change in Medicare method.

3. Current methodology and/or rate structure.
   Currently, the agency pays for dialysis services at the Medicare composite rate which is a payment for complete dialysis treatment, except for a physician’s professional services, separately billable lab services, and separately billable drugs.

4. New methodology or rate.
   The new prospective payment system uses essentially the previous composite rate for services and then bundles lab and drugs into a single site specific payment. The ESRD PPS is a single payment to ESRD facilities that will cover all the resources used in furnishing an outpatient dialysis treatment; the supplies and equipment that administer dialysis, drugs, biological, lab tests, and training and support services. There will be very few separately billable services (only vaccines and blood and blood products are allowed by OHCA policy). Medicare is phasing in the change over four years but also allowing providers to immediately opt in fully if they chose to; OHCA is fully implementing July 1, 2012. Medicare is also making some adjustments to their rate that OHCA is not planning on implementing.

5. Budget estimate.
   The budget impact for state fiscal year 2013 is estimated to be approximately $1,164,200 total dollars; $419,462 state dollars. This represents increased payments to providers of approximately $949,805 total dollars; $342,214 state dollars as well as a loss of drug rebate revenue of approximately $214,395 total dollars; $77,247 state dollars.

6. Agency estimated impact on access to care.
   There is no expected impact to care. The majority of Oklahoma Medicaid ESRD claims are crossovers and the payment method for crossovers is unchanged. The new ESRD PPS payment method may result in a small increase in payments to service providers, thus no impact on access to care is expected.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve a method change from the composite rate system to an ESRD PPS for all dialysis providers.

8. Effective date of change.
   July 1, 2012

Submitted to the C.E.O. and Board on July 12, 2012

AUTHORITY FOR EXPENDITURE OF FUNDS
Independent Validation and Verification Services
Request for Proposal

BACKGROUND

OHCA currently has a contract with Cognosante for independent validation and verification (IV&V) services related to enhancements to the Medicaid Management Information System (MMIS). Procurement of an IV&V vendor approved by the Center for Medicaid and Medicare Services (CMS) is one requirement to allow OHCA to qualify for 90% enhanced federal matching funds. The IV&V vendor must be independent, that is, not under the control of or associated with the MMIS contractor (currently HPES). The contract with Cognosante expires on September 30, 2012.

OHCA plans to release a new Request for Proposals (RFP) to obtain a contractor that is technically, managerially, and financially independent of HPES. The contractor will ensure that the software, hardware, system documentation, and technical support provided by HPES meets the OHCA's requirements (validation) and check that the system is well engineered (verification) according to CMS standards and industry best practices.

SCOPE OF WORK

- Analyze and advise OHCA whether systems enhancements work according to specifications, are efficient, and satisfy system and interface requirements.
- Assess and advise OHCA whether all appropriate business issues have been satisfactorily addressed, meet OHCA's current and planned needs, and whether necessary training, policy, process, and procedural changes have been defined and implemented.
- Support the CMS Certification process for the system and enhancements by gathering and consolidating critical pieces of information and documentation for CMS reviews or certification visits.

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Will be awarded through competitive bidding conducted by OHCA
- Contract term is Date of Award through June 30, 2016
- Estimated contract amounts:
    - FY12 $1,000,000
    - FY13 $1,235,000
    - FY14 $1,235,000
    - FY15 $1,235,000
    - FY16 $1,235,000

RECOMMENDATION

- Board approval to procure the services discussed above
- Board approval is subject to CMS approval