OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
November 14, 2013 at 1:00 P.M.
The Oklahoma Health Care Authority
Ponca Conference Room
2401 NW 23rd, Suite 1A
Oklahoma City, Oklahoma

# A G E N D A

***Items to be presented by Ed McFall, Chairman***

1. Call to Order / Determination of Quorum

2. Action Item – Approval of October 10, 2013 OHCA Board Minutes

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

   a) Audit/Finance Committee – Member Miller

   b) Strategic Planning Committee – Member Robison

   c) Legislative Committee – Member Bryant

***Item to be presented by Nico Gomez, Chief Executive Officer***

4. Discussion Item – Chief Executive Officer's Report

   a) All Stars Introduction – Nico Gomez, Chief Executive Officer
      - August – Tiffany Beck, Research Analyst, Electronic Health Operations (Garth Splinter)
      - September – Michelle Ho, DP Analyst/Planning Specialist III, Contractor Systems (Lisa Gifford)
      - October – Rob Guthrie, Finance Analyst, Third Party Liability (Carrie Evans)
      - Supervisor of the Quarter – LaDawn Fulgenzi, Manager II, Provider Services (Becky Pasternik-Ikard)

   b) Financial Update – Carrie Evans, Chief Financial Officer

   c) Medicaid Director's Update – Garth Splinter, State Medicaid Director

      1) Comprehensive Primary Care Presentation – Melody Anthony, Provider Services Director

   d) SFY 15 Budget Request Update – Nico Gomez, Chief Executive Officer

***Item to be presented by Becky Pasternik-Ikard, Deputy State Medicaid Director***

5. Discussion Item -- SoonerCare Choice Program Independent Evaluation by Pacific Health Policy Group

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

6. 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***

7. Action Items – Consideration and Vote Upon the Recommendations of the State Plan Amendment Rate Committee.

   a) Consideration and Vote upon Recommendation to alter rate methodology for Psychiatric Residential Treatment Facility Reimbursement. The methodology change would create an ***add-on payment for PRTF's*** that serve non-verbal children. This method change alters the rate paid only to non-verbal children served in facilities.

b) Consideration and Vote upon Recommendation to alter the rates paid for Anesthesiologist Services as follows:

(1) an ***increase for the conversion factor from $31.48/$31.50 to $39.00 for CPT codes 00100-001966 and 01968 to 01999***,

(2) an ***increase to the flat rate under CPT 01967 from $411.19 to $550.00***.

***Item to be presented by Chairman McFall***

8. 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), (7) and (9)

   a) Discussion of Pending Litigation, Investigations and Claims

9. New Business

10. ADJOURNMENT

NEXT BOARD MEETING
December 12, 2013
Tulsa, OK
Saint Francis Hospital

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
October 10, 2013
Held at 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 October 9, 2013, 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 October 8, 2013, 2:45 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:03 p.m.

| | |
|---|---|
| BOARD MEMBERS PRESENT: | Chairman McFall, Vice-Chairman Armstrong, Member Miller, Member Bryant, Member Nuttle, Member Robison |
| BOARD MEMBERS ABSENT: | Member McVay |
| OTHERS PRESENT: | OTHERS PRESENT: |
| John Giles, OSDH | Becky Moore, OAHCP |
| Catina Baker, OHCA | Brenda Teel, Chickasaw Nation |
| Lisa Spain, HP | Charles Brodt, HP |
| Darlene Surber, OHCA | Lisa Gifford, OHCA |
| Lisa Moses, OHCA | Scott Tohlen, OK House |
| Amy Whiteley, OHCA | |

**DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD SEPTEMBER 12, 2013.**

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 Robison moved for approval of the September 12, 2013 board meeting minutes as published. The motion was seconded by Vice-Chairman Armstrong. |
| FOR THE MOTION: | Chairman McFall, Member Miller, Member Bryant, Member Nuttle |
| ABSENT: | Member McVay |

**ITEM 3 / REPORTS TO THE BOARD BY BOARD COMMITTEES**

Audit/Finance Committee

Member Miller stated that the Audit/Finance committee met and that Mr. Gomez will discuss further during his CEO report.

Strategic Planning Committee

Vice-Chairman Armstrong stated that the Strategic Planning committee did meet and will be discussed further during the CEO report.

**ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT**
Nico Gomez, Chief Executive Officer

**4a. FINANCIAL UPDATE**
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of August with a state dollar variance of $1.9 million and we are under budget in our Medicaid program by $1.1 million and 5 percent under budget. She noted that Administration is .8 million state dollars is 7 percent under budget. Ms. Evans stated that it appears that budget projections for the month of September are accurate. For more detailed information, see Item 4a in the board packet.

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

Dr. Splinter noted that Soonercare enrollment continues to move up and is at 821,785 with a net increase of about 6,400 enrollees. Nursing home continues with about 15, 448 with $3,600 per member per month average cost. The dual eligible enrollment has grown slightly to 109,205. Dr. Splinter stated that total providers enrolled are 37,507 with the in-state providers totaling 28,810. He said that categories in red are noted for a slight drop due to contract renewals. There was an increase in patient centered medical home for 2,199 enrolled. Dr. Splinter reported on the top 5 procedures by utilization and reimbursement. Member Miller asked if any requred lab tests were billed separately for office and outpatient visits? Dr. Splinter noted they were billed separately. For more detailed information, see Item 4b in the board packet.

**4b1. HOME AND COMMUNITY BASED WAIVER PROGRAM UPDATE**
Ivoria Holt, Long Term Care Quality Initiatives Director

Ms. Holt presented the Long Term Care Waiver Operations division which includes, Living Choice (Money Follows the Person), Sooner Seniors, My Life My Choice, Medically Fragile and the PACE Program (all inclusive care for the elderly). For more detailed information, see Item 4b.1 in the board packet.

**4c. ALL STARS INTRODUCTION**
Nico Gomez, Chief Executive Officer

Mr. Gomez introduced OHCA Employee All-Stars for February and May 2013 through his direct reports.

Cindy Roberts presented the February All Star – Darlene Surber, Medical Audit Specialist, Provider Audits.

Carrie Evans presented the May All Star – April Jones, Travel Coordinator, Purchasing.

**4d. PROPOSED 2014 BOARD MEETING DATES AND LOCATIONS**
Nico Gomez, Chief Executive Officer

Mr. Gomez reviewed the proposed calendar for board meeting dates and locations for 2014 and asked the board to review and take into consideration the dates. He stated that we will bring the calendar back at a future board meeting for approval.

Mr. Gomez noted that he had an opportunity to attend a meeting in Washington, D.C. regarding reducing infant mortality and learning what we can do to reduce the number of infants we lose too early. It also gave him the opportunity to hold visits with some of Oklahoma's Congressional delegation.

He stated that our Federal partner (CMS) is half open and half closed.

**ITEM 5 / PRESENTATION OF THE STATE FISCAL YEAR 2015 BUDGET REQUEST**
Vickie Kersey, Purchasing Manager

Mr. Gomez stated that we received notice late last week that our Federal Medical Assistance Percentage (FMAP) will be going down effective October 1, 2014. He noted we did not anticipate this in the budget request but it will be amended and brought back to the board for information. Mr. Gomez said that the reduction is a 2.7 percent reduction in federal funds and is the second largest one year reduction in our history. There will be more discussion on how this impacts OHCA and what can be done.

Ms. Kersey reported the information of the state fiscal year 2015 budget request. For more detailed information, please see Item 5 in the board packet.

**ITEM 6 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS**
Howard Pallotta, General Counsel

There were no recommendations regarding conflicts.

**ITEM 7 / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED EMERGENCY RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT.**
Cindy Roberts, Deputy CEO/Planning, Policy and Integrity Division

7. Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act

   a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of Emergency Rule 7.b-1 in accordance with 75 Okla. Stat. § 253.

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

7. b - 1. AMENDING agency rules at OAC 317:45-11-10 through 45-11-13, 45-11-20 through 45-11-21.1, 45-11-24, and 45-13-1. Insure Oklahoma (IO) rules are revised to align with the Special Terms and Conditions of the Section 1115 Demonstration Waiver. In accordance with waiver special terms and conditions, the federal government has approved a one year (calendar) extension of the Insure Oklahoma program. Rules are revised to remove Individual Plan children (while retaining Employer Sponsored Insurance (ESI) children) and limit adult Individual Plan enrollment to persons with household income at or below 100 percent of Federal Poverty Level. Revisions also include changes to the Individual Plan copayment structure; copayments cannot exceed current federal maximums with the exception of emergency room (ER) visits in which case the existing copay for ER visits will remain at $30.00.

7. b - 2. AMENDING Agency rules at OAC 317:2-1-6.1 to formalize a complaint procedure for employees in civil rights violation events. The procedure allows an employee to submit a complaint when a discriminatory practice is believed to have taken place and dictates steps to be taken by the Agency when such complaint is submitted by the employee.

MOTION: Vice-Chairman Armstrong moved for approval of Item 7a as a declaration of emergency for Item 7b-1. The motion was seconded by Member Bryant.

FOR THE MOTION: Chairman McFall, Member Miller, Member Robison, Member Nuttle

ABSENT: Member McVay

MOTION: Vice-Chairman Armstrong moved for approval of Item 7.b-1 as presented. The motion was seconded by Member Bryant.

FOR THE MOTION: Chairman McFall, Member Miller, Member Robison, Member Nuttle

ABSENT: Member McVay

MOTION: Member Bryant moved for approval of Item 7.b-2 as presented. The motion was seconded by Vice-Chairman Armstrong.

FOR THE MOTION: Chairman McFall, Member Miller, Member Robison, Member Nuttle

ABSENT: Member McVay

**ITEM 8 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES 5030.3.**
Nancy Nesser, Pharmacy Director

8a) Consideration and vote to add **Tysabri (Natalizumab)** and **Diclegis™ (Doxylamine/Pyridoxine)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Vice-Chairman Armstrong moved for the approval of Item 8a as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Member Miller, Member Nuttle, Member Bryant

ABSENT: Member McVay

**ITEM 9 / 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

Chairman McFall entertained a motion to go into Executive Session at this time.

MOTION: Member Robison moved for approval to go into Executive Session. The motion was seconded by Member Nuttle.

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FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Miller, Member Bryant

ABSENT: Member McVay

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), (7) and (9)

a) Discussion of Pending Litigation, Investigations and Claims

b) Discussion of CEO Evaluation Form

**ITEM 10 / APPROVAL OF THE 2014 CEO EVALUATION FORM**

Chairman McFall entertained a motion to approve the 2014 CEO Evaluation Form.

MOTION: Member Nuttle moved for the approval of Item 10 as published. The motion was seconded by Member Miller.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Robison, Member Bryant

ABSENT: Member McVay

**ITEM 11 / NEW BUSINESS**

There was no new business. Mr. Gomez did recognize and article in the paper regarding Member Robison hiring her daughter to her nursing staff.

**ITEM 12 / ADJOURNMENT**

MOTION: Vice-Chairman Armstrong moved for adjournment. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Member Miller, Member Nuttle, Member Bryant

ABSENT: Member McVay

Meeting adjourned at 2:05 p.m., 10/10/2013

NEXT BOARD MEETING
November 14, 2013
The Oklahoma Health Care Authority
Ponca Conference Room
Oklahoma City, Oklahoma

*Lindsey Bateman*
*Board Secretary*

*Minutes Approved:* _______________

*Initials:*_________________

DRAFT

# FINANCIAL REPORT

For the Three Months Ended September 30, 2013
Submitted to the CEO & Board

- Revenues for OHCA through September, accounting for receivables, were **$994,594,968** or **1.3% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$930,542,812 or .7% under** budget.
- The state dollar budget variance through September is **$18,751,656 positive.**
- The budget variance is primarily attributable to the following (in millions):

| | |
|---|---|
| **Expenditures:** | |
| Medicaid Program Variance | 1.4 |
| Administration | 1.1 |
| **Revenues:** | |
| Unanticipated Revenue | 15.7 |
| Drug Rebate | .4 |
| Taxes and Fees | .3 |
| Overpayments/Settlements | (.1) |
| **Total FY 14 Variance** | **$ 18.8** |

**ATTACHMENTS**

Summary of Revenue and Expenditures: OHCA 1
Medicaid Program Expenditures by Source of Funds 2
Other State Agencies Medicaid Payments 3
Fund 205: Supplemental Hospital Offset Payment Program Fund 4
Fund 230: Quality of Care Fund Summary 5
Fund 245: Health Employee and Economy Act Revolving Fund 6
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund 7

## OKLAHOMA HEALTH CARE AUTHORITY
## Summary of Revenues & Expenditures: OHCA
## Fiscal Year 2014, For the Three Months Ended September 30, 2013

| REVENUES | FY14 Budget YTD | FY14 Actual YTD | Variance | % Over/ (Under) |
|---|---|---|---|---|
| State Appropriations | $ 251,179,267 | $ 251,179,267 | $ - | 0.0% |
| Federal Funds | 509,114,908 | 504,579,889 | (4,535,019) | (0.9)% |
| Tobacco Tax Collections | 14,517,035 | 14,805,495 | 288,460 | 2.0% |
| Quality of Care Collections | 20,420,673 | 20,420,673 | - | 0.0% |
| Prior Year Carryover | 35,616,512 | 35,616,512 | - | 0.0% |
| Unanticipated Revenue | - | 15,683,810 | 15,683,810 | 100.0% |
| Federal Deferral - Interest | 60,624 | 60,624 | - | 0.0% |
| Drug Rebates | 40,929,676 | 42,118,675 | 1,188,999 | 2.9% |
| Medical Refunds | 11,277,891 | 11,166,624 | (111,267) | (1.0)% |
| SHOPP | 94,849,174 | 94,849,174 | - | 0.0% |
| Other Revenues | 4,035,218 | 4,114,225 | 79,007 | 2.0% |
| **TOTAL REVENUES** | **$ 982,000,978** | **$ 994,594,968** | **$ 12,593,990** | **1.3%** |

| EXPENDITURES | FY14 Budget YTD | FY14 Actual YTD | Variance | % (Over)/ Under |
|---|---|---|---|---|
| **ADMINISTRATION - OPERATING** | **$ 12,920,567** | **$ 11,310,470** | **$ 1,610,097** | **12.5%** |
| **ADMINISTRATION - CONTRACTS** | **$ 23,379,844** | **$ 22,433,242** | **$ 946,602** | **4.0%** |
| **MEDICAID PROGRAMS** | | | | |
| Managed Care: | | | | |
| SoonerCare Choice | 8,970,068 | 8,690,138 | 279,929 | 3.1% |
| Acute Fee for Service Payments: | | | | |
| Hospital Services | 238,076,747 | 237,525,683 | 551,064 | 0.2% |
| Behavioral Health | 4,948,230 | 5,337,289 | (389,060) | (7.9)% |
| Physicians | 120,766,193 | 120,477,955 | 288,238 | 0.2% |
| Dentists | 37,157,563 | 36,847,737 | 309,827 | 0.8% |
| Other Practitioners | 11,290,737 | 10,889,719 | 401,017 | 3.6% |
| Home Health Care | 5,456,422 | 5,213,130 | 243,292 | 4.5% |
| Lab & Radiology | 16,132,462 | 16,027,309 | 105,153 | 0.7% |
| Medical Supplies | 12,014,501 | 11,775,217 | 239,284 | 2.0% |
| Ambulatory/Clinics | 27,641,972 | 27,103,351 | 538,622 | 1.9% |
| Prescription Drugs | 101,713,638 | 101,504,543 | 209,095 | 0.2% |
| OHCA TFC | 659,731 | 449,764 | 209,967 | 0.0% |
| Other Payments: | | | | |
| Nursing Facilities | 142,941,385 | 142,818,213 | 123,172 | 0.1% |
| ICF-MR Private | 15,144,714 | 15,117,136 | 27,578 | 0.2% |
| Medicare Buy-In | 33,843,096 | 33,801,880 | 41,215 | 0.1% |
| Transportation | 15,540,838 | 15,357,937 | 182,902 | 1.2% |
| MFP-OHCA | 405,787 | 287,856 | 117,932 | 0.0% |
| EHR-Incentive Payments | 2,519,595 | 2,519,595 | - | 0.0% |
| Part D Phase-In Contribution | 19,594,762 | 19,562,404 | 32,358 | 0.2% |
| SHOPP payments | 85,492,242 | 85,492,242 | - | 0.0% |
| **Total OHCA Medical Programs** | **900,310,684** | **896,799,100** | **3,511,585** | **0.4%** |
| OHCA Non-Title XIX Medical Payments | 89,382 | - | 89,382 | 0.0% |
| **TOTAL OHCA** | **$ 936,700,477** | **$ 930,542,812** | **$ 6,157,666** | **0.7%** |
| **REVENUES OVER/(UNDER) EXPENDITURES** | **$ 45,300,500** | **$ 64,052,156** | **$ 18,751,656** | |

# OKLAHOMA HEALTH CARE AUTHORITY
## Total Medicaid Program Expenditures
## by Source of State Funds
## Fiscal Year 2014, For the Three Months Ended September 30, 2013

| Category of Service | Total | Health Care Authority | Quality of Care Fund | HEEIA | Medicaid Program Fund | BCC Revolving Fund | Other State Agencies |
|---|---|---|---|---|---|---|---|
| SoonerCare Choice | $ 8,803,304 | $ 8,685,619 | $ - | $ 113,166 | $ - | $ 4,519 | $ - |
| Inpatient Acute Care | 173,566,454 | 155,634,485 | 121,672 | 2,760,765 | 12,685,425 | 580,163 | 1,783,944 |
| Outpatient Acute Care | 71,328,515 | 67,356,922 | 10,401 | 2,824,576 | - | 1,136,616 | - |
| Behavioral Health - Inpatient | 5,983,883 | 3,231,825 | - | 168,895 | - | | 2,583,162 |
| Behavioral Health - Psychiatrist | 2,105,464 | 2,105,464 | - | - | - | - | - |
| Behavioral Health - Outpatient | 6,102,256 | - | - | - | - | - | 6,102,256 |
| Behavioral Health Facility- Rehab | 60,957,029 | - | - | - | - | 27,261 | 60,957,029 |
| Behavioral Health - Case Management | 2,317,711 | - | - | - | - | - | 2,317,711 |
| Behavioral Health - PRTF | 23,495,807 | - | - | - | - | - | 23,495,807 |
| Residential Behavioral Management | 5,077,016 | - | - | - | - | - | 5,077,016 |
| Targeted Case Management | 16,252,974 | - | - | - | - | - | 16,252,974 |
| Therapeutic Foster Care | 449,764 | 449,764 | - | - | - | - | - |
| Physicians | 134,492,483 | 102,004,330 | 14,525 | 3,597,000 | 16,975,425 | 1,483,675 | 10,417,527 |
| Dentists | 36,873,784 | 34,869,819 | - | 26,048 | 1,972,859 | 5,059 | - |
| Mid Level Practitioners | 927,638 | 906,565 | - | 20,266 | - | 807 | - |
| Other Practitioners | 10,060,966 | 9,609,527 | 111,591 | 78,619 | 258,952 | 2,278 | - |
| Home Health Care | 5,213,130 | 5,210,224 | - | - | - | 2,906 | - |
| Lab & Radiology | 17,049,438 | 15,841,157 | - | 1,022,129 | - | 186,152 | - |
| Medical Supplies | 11,959,233 | 11,084,405 | 677,884 | 184,016 | - | 12,928 | - |
| Clinic Services | 29,595,213 | 24,799,645 | - | 390,617 | - | 75,764 | 4,329,188 |
| Ambulatory Surgery Centers | 2,342,594 | 2,221,896 | - | 114,652 | - | 6,047 | - |
| Personal Care Services | 3,379,758 | - | - | - | - | - | 3,379,758 |
| Nursing Facilities | 142,818,213 | 80,042,402 | 52,634,659 | - | 10,141,026 | 127 | - |
| Transportation | 15,288,140 | 13,814,289 | 659,057 | - | 800,562 | 14,231 | - |
| GME/IME/DME | 20,959,265 | - | - | - | - | - | 20,959,265 |
| ICF/MR Private | 15,117,136 | 12,103,785 | 2,799,571 | - | 213,780 | - | - |
| ICF/MR Public | 12,052,066 | - | - | - | - | - | 12,052,066 |
| CMS Payments | 53,364,284 | 53,163,535 | 200,749 | - | - | - | |
| Prescription Drugs | 106,578,552 | 89,227,045 | - | 5,074,009 | 11,809,262 | 468,236 | - |
| Miscellaneous Medical Payments | 69,876 | 67,633 | - | 79 | - | 2,165 | - |
| Home and Community Based Waiver | 42,662,804 | - | - | - | - | - | 42,662,804 |
| Homeward Bound Waiver | 22,221,210 | - | - | - | - | - | 22,221,210 |
| Money Follows the Person | 1,387,703 | 287,856 | - | - | - | - | 1,099,847 |
| In-Home Support Waiver | 5,924,855 | - | - | - | - | - | 5,924,855 |
| ADvantage Waiver | 46,106,588 | - | - | - | - | - | 46,106,588 |
| Family Planning/Family Planning Waiver | 2,836,766 | - | - | - | - | - | 2,836,766 |
| Premium Assistance* | 12,352,599 | - | - | 12,352,599 | | - | - |
| EHR Incentive Payments | 2,519,595 | 2,519,595 | - | - | - | - | - |
| SHOPP Payments** | 85,492,242 | 85,492,242 | - | - | - | - | - |
| **Total Medicaid Expenditures** | **$ 1,216,086,309** | **$ 695,237,787** | **$ 57,230,108** | **$ 28,727,435** | **$ 54,857,290** | **$ 4,008,933** | **$ 290,559,774** |

* Includes $12,262,270.15 paid out of Fund 245 and **$85,492,242 paid out of Fund 205

## OKLAHOMA HEALTH CARE AUTHORITY
### Summary of Revenues & Expenditures:
### Other State Agencies
### Fiscal Year 2014, For the Three Months Ended September 30, 2013

| REVENUE | | FY14 Actual YTD |
|---|---|---|
| Revenues from Other State Agencies | $ | 123,565,999 |
| Federal Funds | | 186,918,141 |
| **TOTAL REVENUES** | **$** | **310,484,140** |

| EXPENDITURES | | Actual YTD |
|---|---|---|
| **Department of Human Services** | | |
| Home and Community Based Waiver | $ | 42,662,804 |
| Money Follows the Person | | 1,099,847 |
| Homeward Bound Waiver | | 22,221,210 |
| In-Home Support Waivers | | 5,924,855 |
| ADvantage Waiver | | 46,106,588 |
| ICF/MR Public | | 12,052,066 |
| Personal Care | | 3,379,758 |
| Residential Behavioral Management | | 3,718,908 |
| Targeted Case Management | | 13,065,169 |
| **Total Department of Human Services** | | **150,231,205** |
| | | |
| **State Employees Physician Payment** | | |
| Physician Payments | | 10,417,527 |
| **Total State Employees Physician Payment** | | **10,417,527** |
| | | |
| **Education Payments** | | |
| Graduate Medical Education | | - |
| Graduate Medical Education - PMTC | | 1,354,429 |
| Indirect Medical Education | | 15,544,353 |
| Direct Medical Education | | 4,060,483 |
| **Total Education Payments** | | **20,959,265** |
| | | |
| **Office of Juvenile Affairs** | | |
| Targeted Case Management | | 821,963 |
| Residential Behavioral Management | | 1,358,108 |
| **Total Office of Juvenile Affairs** | | **2,180,071** |
| | | |
| **Department of Mental Health** | | |
| Case Management | | 2,317,711 |
| Inpatient Psych FS | | 2,583,162 |
| Outpatient | | 6,102,256 |
| PRTF | | 23,495,807 |
| Rehab | | 60,957,029 |
| **Total Department of Mental Health** | | **95,455,966** |
| | | |
| **State Department of Health** | | |
| Children's First | | 590,493 |
| Sooner Start | | 583,222 |
| Early Intervention | | 1,138,939 |
| EPSDT Clinic | | 389,381 |
| Family Planning | | (94,092) |
| Family Planning Waiver | | 2,923,921 |
| Maternity Clinic | | 17,114 |
| **Total Department of Health** | | **5,548,977** |
| | | |
| **County Health Departments** | | |
| EPSDT Clinic | | 235,765 |
| Family Planning Waiver | | 6,938 |
| **Total County Health Departments** | | **242,702** |
| | | |
| **State Department of Education** | | **27,460** |
| **Public Schools** | | **608,951** |
| **Medicare DRG Limit** | | **-** |
| **Native American Tribal Agreements** | | **3,103,706** |
| **Department of Corrections** | | **682,688** |
| **JD McCarty** | | **1,101,256** |
| | | |
| **Total OSA Medicaid Programs** | **$** | **290,559,774** |
| | | |
| **OSA Non-Medicaid Programs** | **$** | **19,915,464** |
| | | |
| **Accounts Receivable from OSA** | **$** | **(8,902)** |

# OKLAHOMA HEALTH CARE AUTHORITY
## SUMMARY OF REVENUES & EXPENDITURES:
### Fund 205: Supplemental Hospital Offset Payment Program Fund
### Fiscal Year 2014, For the Three Months Ended September 30, 2013

| REVENUES | | FY 14 Revenue |
|---|---|---|
| SHOPP Assessment Fee | $ | 40,078,869 |
| Federal Draws | | 54,715,035 |
| Interest | | 53,728 |
| Penalties | | 1,542 |
| State Appropriations | | (7,700,000) |
| **TOTAL REVENUES** | $ | 87,149,174 |

| EXPENDITURES | Quarter | | FY 14 Expenditures |
|---|---|---|---|
| **Program Costs:** | 7/1/13 - 9/30/13 | | |
| Hospital - Inpatient Care | 76,710,371 | $ | 76,710,371 |
| Hospital -Outpatient Care | 2,748,407 | $ | 2,748,407 |
| Psychiatric Facilities-Inpatient | 5,785,055 | $ | 5,785,055 |
| Rehabilitation Facilities-Inpatient | 248,410 | $ | 248,410 |
| **Total OHCA Program Costs** | 85,492,242 | $ | 85,492,242 |
| | | | |
| **Total Expenditures** | | $ | 85,492,242 |
| | | | |
| **CASH BALANCE** | | $ | 1,656,932 |

# OKLAHOMA HEALTH CARE AUTHORITY
## SUMMARY OF REVENUES & EXPENDITURES:
## Fund 230: Nursing Facility Quality of Care Fund
## Fiscal Year 2014, For the Three Months Ended September 30, 2013

| REVENUES | Total Revenue | State Share |
|---|---|---|
| Quality of Care Assessment | **$ 19,388,725** | **$ 19,388,725** |
| Interest Earned | **12,502** | **12,502** |
| **TOTAL REVENUES** | **$ 19,401,227** | **$ 19,401,227** |

| EXPENDITURES | FY 14 Total $ YTD | FY 14 State $ YTD | Total State $ Cost |
|---|---|---|---|
| **Program Costs** | | | |
| NF Rate Adjustment | $ 51,708,502 | $ 18,615,061 | |
| Eyeglasses and Dentures | 70,277 | 25,300 | |
| Personal Allowance Increase | 855,880 | 308,117 | |
| Coverage for DME and supplies | 677,884 | 244,038 | |
| Coverage of QMB's | 258,189 | 92,948 | |
| Part D Phase-In | 200,749 | 200,749 | |
| ICF/MR Rate Adjustment | 1,418,517 | 510,666 | |
| Acute/MR Adjustments | 1,381,054 | 497,179 | |
| NET - Soonerride | 659,057 | 237,261 | |
| **Total Program Costs** | **$ 57,230,108** | **$ 20,731,318** | **$ 20,731,318** |
| | | | |
| **Administration** | | | |
| OHCA Administration Costs | $ 113,101 | $ 56,551 | |
| PHBV - QOC Exp | - | - | |
| OSDH-NF Inspectors | - | - | |
| Mike Fine, CPA | - | - | |
| **Total Administration Costs** | **$ 113,101** | **$ 56,551** | **$ 56,551** |
| | | | |
| **Total Quality of Care Fee Costs** | **$ 57,343,210** | **$ 20,787,869** | |
| | | | |
| **TOTAL STATE SHARE OF COSTS** | | | **$ 20,787,869** |

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 2014, For the Three Months Ended September 30, 2013

| REVENUES | FY 13 Carryover | FY 14 Revenue | Total Revenue |
|---|---|---|---|
| Prior Year Balance | $ 10,427,850 | $ - | $ 3,364,554 |
| State Appropriations | - | - | (3,000,000) |
| Tobacco Tax Collections | - | 12,176,965 | 12,176,965 |
| Interest Income | - | 63,497 | 63,497 |
| Federal Draws | 176,996 | 7,048,491 | 7,048,491 |
| All Kids Act | (6,908,780) | 74,724 | 74,724 |
| **TOTAL REVENUES** | **$ 3,696,066** | **$ 19,363,677** | **$ 19,653,508** |

| EXPENDITURES | FY 13 Expenditures | FY 14 Expenditures | Total $ YTD |
|---|---|---|---|
| **Program Costs:** | | | |
| Employer Sponsored Insurance | | $ 12,092,347 | $ 12,092,347 |
| College Students | | 90,329 | 90,329 |
| All Kids Act | | 169,923 | 169,923 |
| **Individual Plan** | | | |
| SoonerCare Choice | | $ 108,561 | $ 39,082 |
| Inpatient Hospital | | 2,750,809 | 990,291 |
| Outpatient Hospital | | 2,775,495 | 999,178 |
| BH - Inpatient Services-DRG | | 162,733 | 58,584 |
| BH -Psychiatrist | | - | - |
| Physicians | | 3,556,467 | 1,280,328 |
| Dentists | | 19,540 | 7,034 |
| Mid Level Practitioner | | 19,920 | 7,171 |
| Other Practitioners | | 75,433 | 27,156 |
| Home Health | | - | - |
| Lab and Radiology | | 1,009,350 | 363,366 |
| Medical Supplies | | 181,572 | 65,366 |
| Clinic Services | | 382,199 | 137,592 |
| Ambulatory Surgery Center | | 114,391 | 41,181 |
| Prescription Drugs | | 5,024,748 | 1,808,909 |
| Miscellaneous Medical | | 79 | 79 |
| Premiums Collected | | - | (575,908) |
| **Total Individual Plan** | | **$ 16,181,296** | **$ 5,249,410** |
| **College Students-Service Costs** | | **$ 156,038** | **$ 56,174** |
| **All Kids Act- Service Costs** | | **$ 37,502** | **$ 13,501** |
| **Total OHCA Program Costs** | | **$ 28,727,435** | **$ 17,671,683** |
| **Administrative Costs** | | | |
| Salaries | $ 7,360 | $ 284,254 | $ 291,614 |
| Operating Costs | 56,861 | 149,232 | 206,093 |
| Health Dept-Postponing | - | - | - |
| Contract - HP | 267,291 | - | 267,291 |
| **Total Administrative Costs** | **$ 331,512** | **$ 433,486** | **$ 764,998** |
| **Total Expenditures** | | | **$ 18,436,680** |
| **NET CASH BALANCE** | **$ 3,364,554** | | **$ 1,216,827** |

# OKLAHOMA HEALTH CARE AUTHORITY

## SUMMARY OF REVENUES & EXPENDITURES:

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

### Fiscal Year 2014, For the Three Months Ended September 30, 2013

| REVENUES | FY 14 Revenue | State Share |
|---|---|---|
| Tobacco Tax Collections | **$ 243,031** | **$ 243,031** |
| **TOTAL REVENUES** | **$ 243,031** | **$ 243,031** |

| EXPENDITURES | FY 14 Total $ YTD | FY 14 State $ YTD | Total State $ Cost |
|---|---|---|---|
| **Program Costs** | | | |
| SoonerCare Choice | $ 4,519 | $ 1,139 | |
| Inpatient Hospital | 580,163 | 146,201 | |
| Outpatient Hospital | 1,136,616 | 286,427 | |
| Inpatient Services-DRG | - | - | |
| Psychiatrist | - | - | |
| TFC-OHCA | - | - | |
| Nursing Facility | 127 | 32 | |
| Physicians | 1,483,675 | 373,886 | |
| Dentists | 5,059 | 1,275 | |
| Mid-level Practitioner | 807 | 203 | |
| Other Practitioners | 2,278 | 574 | |
| Home Health | 2,906 | 732 | |
| Lab & Radiology | 186,152 | 46,910 | |
| Medical Supplies | 12,928 | 3,258 | |
| Clinic Services | 75,764 | 19,092 | |
| Ambulatory Surgery Center | 6,047 | 1,524 | |
| Prescription Drugs | 468,236 | 117,996 | |
| Transportation | 14,231 | 3,586 | |
| Miscellaneous Medical | 2,165 | 545 | |
| **Total OHCA Program Costs** | $ 3,981,672 | $ 1,003,381 | |
| **OSA DMHSAS Rehab** | $ 27,261 | $ 6,870 | |
| **Total Medicaid Program Costs** | $ 4,008,933 | $ 1,010,251 | |
| **TOTAL STATE SHARE OF COSTS** | | | **$ 1,010,251** |

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

## September 2013 Data for November 2013 Board Meeting

### SOONERCARE ENROLLMENT/EXPENDITURES

| Delivery System | | Monthly Enrollment Average SFY2013 | Enrollment September 2013 | Total Expenditures September 2013 | Average Dollars Per Member Per Month September 2013 |
|---|---|---|---|---|---|
| **SoonerCare Choice Patient-Centered Medical Home** | | 513,315 | **548,679** | **$140,842,399** | |
| | *Lower Cost* (Children/Parents; Other) | | 502,357 | $101,075,522 | $201 |
| | *Higher Cost* (Aged, Blind or Disabled; TEFRA; BCC) | | 46,322 | $39,766,877 | $858 |
| **SoonerCare Traditional** | | 217,231 | **198,458** | **$168,781,197** | |
| | *Lower Cost* (Children/Parents; Other) | | 90,406 | $36,036,419 | $399 |
| | *Higher Cost* (Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver) | | 108,052 | $132,744,778 | $1,229 |
| **SoonerPlan** | | 48,346 | **51,691** | **$640,245** | $12 |
| **Insure Oklahoma** | | 30,202 | **28,591** | **$9,121,693** | |
| | *Employer-Sponsored Insurance* | 16,644 | 15,617 | $4,121,458 | $264 |
| | *Individual Plan* | 13,559 | 12,974 | $5,000,235 | $385 |
| **TOTAL** | | **809,094** | **827,419** | **$319,385,534** | |

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 $44,607,862 are excluded.

| Net Enrollee Count Change from Previous Month Total | 5,634 |
|---|---|

| New Enrollees | 19,519 |
|---|---|

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

| Qualifying Group | Age Group | Enrollment |
|---|---|---|
| Aged/Blind/Disabled | *Child* | 19,425 |
| Aged/Blind/Disabled | *Adult* | 134,288 |
| Other | *Child* | 117 |
| Other | *Adult* | 21,160 |
| PACE | *Adult* | 121 |
| TEFRA | *Child* | 491 |
| Living Choice | *Adult* | 136 |
| **OLL Enrollment** | | **175,738** |

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

| Medicare and SoonerCare | Monthly Average SFY2013 | Enrolled September 2013 |
|---|---|---|
| **Dual Enrollees** | **108,514** | **109,248** |

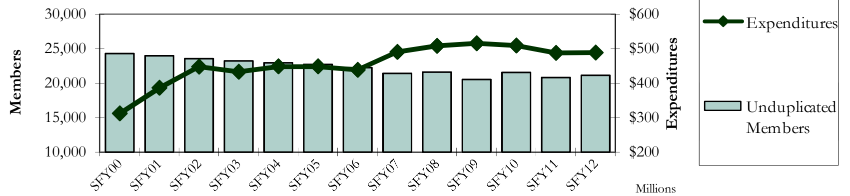
| | | Monthly Average SFY2013 | Enrolled September 2013 | FACILITY PER MEMBER PER MONTH |
|---|---|---|---|---|
| **Long-Term Care Members** | | **15,674** | **15,496** | **$3,633** |
| | *Child* | 64 | 62 | |
| | *Adult* | 15,610 | 15,434 | |

**SFY2012 Long-Term Care**

**Statewide LTC Occupancy Rate - 71.7%**
**SoonerCare funded LTC Bed Days 67.2%**

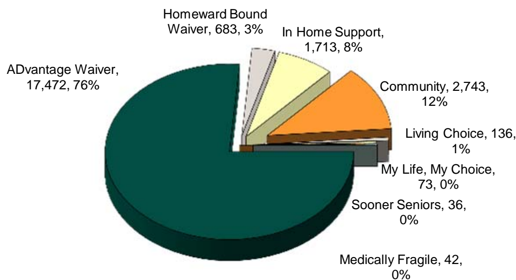
Data as of September 2012

**Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends**




Data as of Nov. 19, 2012. Figures do not include intermediate care facilities for the intellectually disabled (ICF/ID).

**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 intellectually disabled (ICF/ID).
**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/ID.
**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/ID.
**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 SFY2013 | Enrolled September 2013 |
|---|---|---|
| **Total Providers** | **36,948** | **38,223** |
| *In-State* | 28,587 | 29,236 |
| *Out-of-State* | 8,362 | 8,987 |

Provider Network includes providers who are contracted to provide health care services by locations, programs, types, and specialties. Providers are being counted multiple times if they have multiple locations, programs, types, and specialties.

| Select Provider Type Counts | *In-State* | | *Totals* | |
|---|---|---|---|---|
| | *Monthly Average SFY2013* | *Enrolled September 2013** | Monthly Average SFY2013 | Enrolled September 2013 |
| Physician | *7,859* | *8,402* | *12,432* | 13,230 |
| Pharmacy | *901* | *922* | *1,208* | 1,248 |
| Mental Health Provider** | *5,811* | *4,551* | *5,880* | 4,586 |
| Dentist | *1,205* | *1,310* | *1,380* | 1,511 |
| Hospital** | *194* | *183* | *923* | 604 |
| Optometrist | *578* | *559* | *612* | 586 |
| Extended Care Facility | *362* | *358* | 362 | 358 |

Above counts are for specific provider types and are not all-inclusive.

| | | | | |
|---|---|---|---|---|
| Total Primary Care Providers*** | *4,997* | *5,401* | 6,541 | 7,047 |
| Patient-Centered Medical Home | *1,935* | *2,135* | 1,985 | 2,223 |

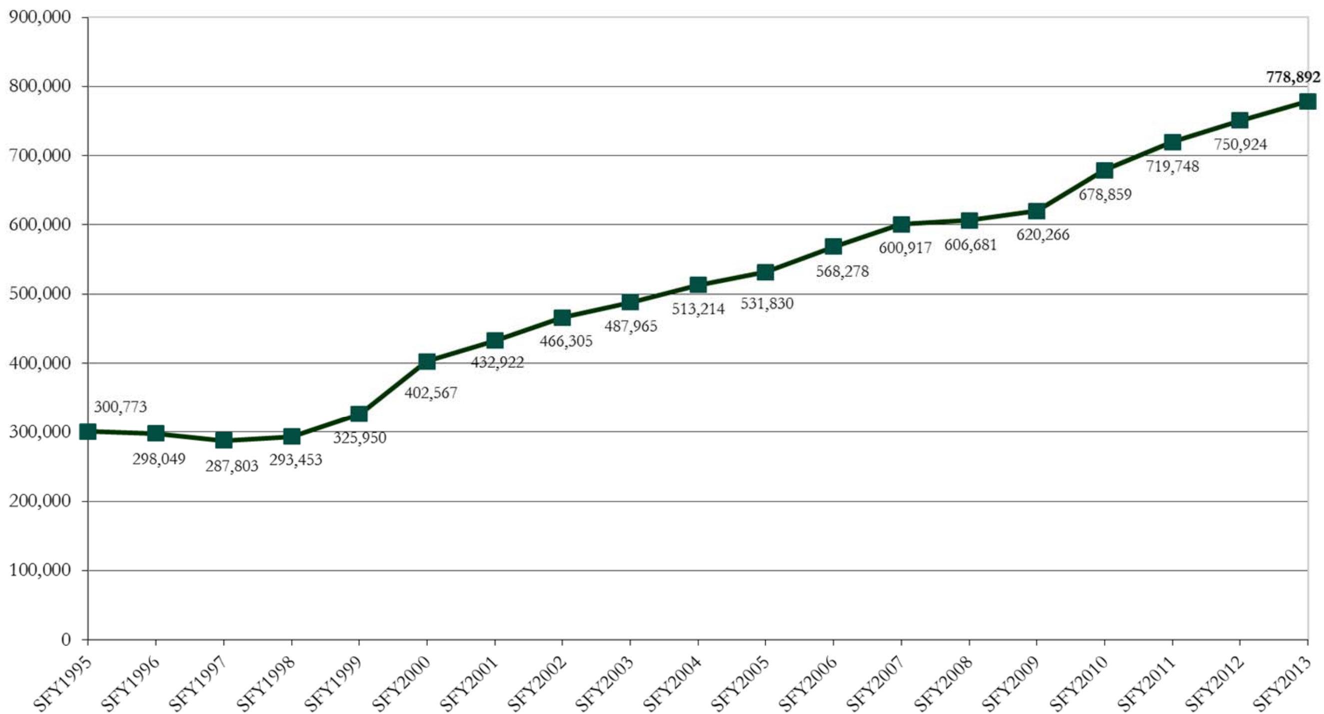
Including Physicians, Physician Assistants and Advance Nurse Practitioners.

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

**Decrease in current month's count is due to contract renewal period which is typical during all renewal periods. Hospitals renewal started in March 2013 while renewal for Mental Health Providers started in June 2013.

| Program | % of Capacity Used |
|---|---|
| SoonerCare Choice | 45% |
| SoonerCare Choice I/T/U | 18% |
| Insure Oklahoma IP | 3% |

## HISTORIC AVERAGE MONTHLY SOONERCARE ENROLLMENT PER STATE FISCAL YEAR




State Fiscal Year (SFY) is July - June. Data prior to SFY2000 is from the OKDHS County Summary Report. During SFY1998 Title 19 expansion and CHIP were implemented. SoonerPlan and Oklahoma Cares enrollment began in the last half of SFY2005. In SFY2006 OHCA implemented 12 month certifications and TEFRA.

Figures do not include Insure Oklahoma enrollees.

## 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 11/4/2013 | October 2013 | | Since Inception | |
|---|---|---|---|---|
| | Number of Payments | Payment Amount | Total Number of Payments | Total Payment Amount |
| Eligible Professionals | 90 | $1,351,500 | 1,850 | $43,164,418 |
| Eligible Hospitals | 2* | $410,000 | 91 | $78,943,319 |
| Totals | 92 | $1,761,500 | 1,941 | $122,107,737 |

*Current Eligible Hospitals Paid
HASKELL COUNTY HOSPITAL
LATIMER CO GEN HSP

# Comprehensive Primary Care (CPCi) Greater Tulsa Region

Melody Anthony, MS
Director Provider/Medical Home Services

November 14, 2013

# CPCi's Mission

- Through the collaboration of public and private payers working together, we will establish a model for the purchase and delivery of comprehensive primary care that will reduce cost across the country.
  - Our regions multi-payers are:
    - CMS 47,173 covered lives
    - SoonerCare 29,364 covered lives
    - Community Care 46,611 covered lives
    - Blue Cross and Blue Shield of Oklahoma 22,750 covered lives

TOTAL 145,898 covered lives.

# CPCI Counties

68 Practice Locations

317 Individual Providers

Cimarron
Texas
Beaver
Harper
Woods
Alfalfa
Grant
Kay
Osage
Washington
Nowata
Craig
Ottawa
Ellis
Woodward
Major
Garfield
Noble
Pawnee
Rogers
Mayes
Delaware
Dewey
Blaine
Kingfisher
Logan
Payne
Creek
Tulsa
Wagoner
Cherokee
Adair
Roger Mills
Custer
Canadian
Oklahoma
Lincoln
Okmulgee
Muskogee
Caddo
Okfuskee
Sequoyah
Beckham
Washita
Pottawatomie
Cleveland
Seminole
McIntosh
Grady
Hughes
Haskell
LeFlore
McClain
Greer
Kiowa
Pittsburg
Harmon
Latimer
Comanche
Garvin
Pontotoc
Coal
Jackson
Stephens
Murray
Atoka
Pushmataha
Tillman
Johnston
McCurtain
Cotton
Carter
Jefferson
Marshall
Bryan
Choctaw
Love

# CPCi Choice Service Locations: September 2013

CPCi Choice Service Locations: 38 total locations

118 Individual Providers

Cimarron
Texas
Beaver
Harper
Woods
Alfalfa
Grant
Kay
Osage
Washington 2
Nowata
Craig
Ottawa
Ellis
Woodward
Major
Garfield
Noble
Pawnee
Rogers
Mayes 5
Delaware 2
Tulsa 18
Dewey
Blaine
Kingfisher
Logan
Payne 2
Creek 2
Wagoner 3
Cherokee 1
Adair 1
Roger Mills
Custer
Canadian
Oklahoma
Lincoln
Okmulgee 2
Muskogee
Sequoyah
Okfuskee
Mcintosh
Beckham
Washita
Caddo
Cleveland
Pottawatomie
Seminole
Haskell
Grady
Hughes
Greer
Kiowa
McClain
Pittsburg
Latimer
Le Flore
Harmon
Jackson
Comanche
Garvin
Pontotoc
Coal
Stephens
Murry
Tillman
Cotton
Johnston
Atoka
Pushmataha
Carter
McCurtain
Jefferson
Marshall
Choctaw
Love
Bryan

# CPCi Timeline

- **September-December 2011**: Applications submitted to Center for Medicare and Medicaid Innovation (CMMI)
- **April 10, 2012**: Selected participants notified
- **April 18, 2012**: Kick-off meeting
- **May 1-2, 2012**: Face to face meeting in Washington
- **June 4, 2012**: MOU signed between OHCA and CMMI
- **June 6 -July 20, 2012**: Practice application period

  108 applications received from our region.

  68 practices were chosen.

  A four year commitment. Providers can withdraw

# CPCi Timeline (con't)

- **August 21, 2012**:  CMS national market kickoff – CMS provided a comprehensive public notification of all participating practices for all 7 markets
- **First week of Sept 2012:**  CMS hosted a national kickoff webinar for all payers/practices with overarching framework of initiative; this was followed by a series of web-based meetings
- **October 2012**:  after October 1 implementation date, CMS attended an in-person Tulsa market learning session with the selected practices.

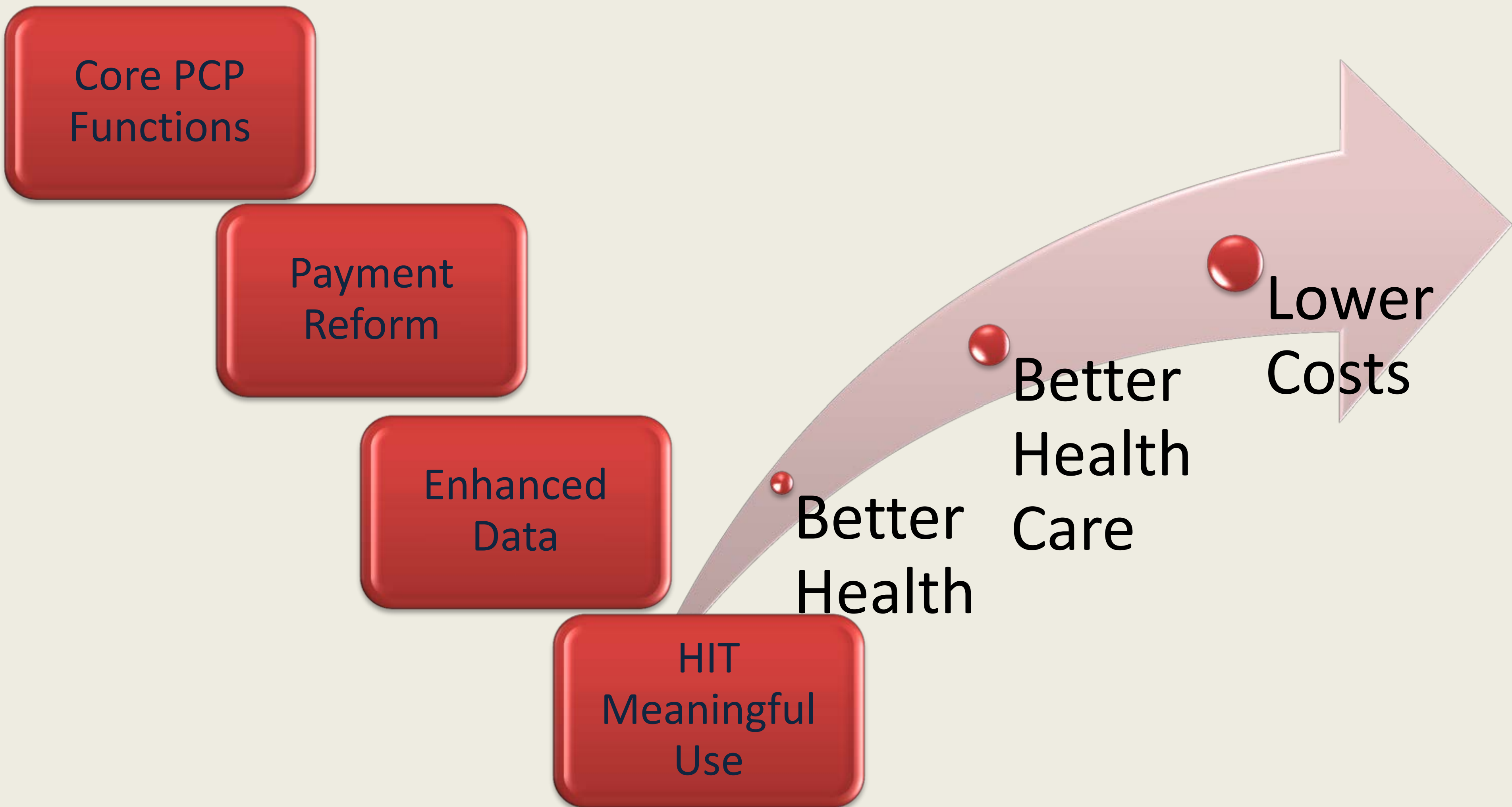
# CPCi Timeline (con't)

- **February 2013**: Second face to face learning session meeting in Tulsa. Introduced the case management concept.
- **March- May 2013:** Field service team developed. Staff from BCBS, CC and OHCA meets with each practice to assist them in meeting the CPC milestones.
- **July 2013**: all day training for the practices case managers discussion was focused on care management integration at the practice site.
- **October 2013:** Web based meeting with CMS and all the CPC regions.
- **October 2013:** CPC sessions held at the Transformation of HealthCare Summit in Tulsa.
- **November 2013:** Third Learning session. Virtual meeting via web X.
- **January 2014:** First cost and utilization reports from the participating practices due to CMS.

# Year One Milestones and How They Match Our PCMH

- Complete an annual budget or forecast.
  - Not a requirement of SCC PCMH.
- Provide care management for high risk patients.
  - We require Care Coordination, if our providers are part of a HAN or HMP then care management is incorporated into the practice.
- Provide 24/7 patient access guided by medical record.
  - We require 24/7 Voice to Voice.
- Assess and improve patients experience of care.
  - CHAPS and ECHO's survey shows our results.
- Use data to guide improvement in care at the provider/care team level.
  - Recommended in Tier 3.
- Demonstrate active engagement and care coordination across the medical neighborhood.
  - We notify PCMH providers of IP admissions and discharges. Still working on more timely notification of ER visits.
- Improve patient shared decision making.
  - Requirement of Tier 3.
- Participate in market based learning collaborative
  - Through our HMP program.
- Meet the requirements for Stage 1 meaningful use.
  - Part of our PCMH model as our providers have applied for incentive payments.

# CPCi Objectives



# OKLAHOMA HEALTH CARE AUTHORITY
## SFY 2015
## Budget Request Detail

| Description of Priority | # FTE | State | Total |
|---|---|---|---|
| 1 **Annualizations** | | | |
| FFP Match Rate 64.02% to 62.30% | | 44,882,193 | - |
| Medicare A & B Premiums rate increase - 01/01/14 | | 699,478 | 1,876,785 |
| Anesthesiologist ($39 CF/25% rate inc) - 6 Months impact | | 1,583,664 | 4,249,166 |
| Cost to cover woodwork population (34k) - 6 Months impact | | 11,597,920 | 31,118,648 |
| | - | **58,763,255** | **37,244,599** |
| 2 **Maintenance** | | | |
| FY15 growth/utilization increases (4.1%) | | 44,350,120 | 125,920,326 |
| Medicare A & B premiums rate increase - 01/01/2015 | | 726,527 | 1,927,127 |
| Medicare Part D (clawback) - 100% State | | (271,391) | (271,391) |
| Physician fee schedule (Medicare RVU rebasing upto 96.75%) | | 2,057,653 | 5,520,938 |
| FTE maintenance for growth in Medicaid Program | 14.0 | 589,579 | 1,179,159 |
| | 14.0 | **47,452,488** | **134,276,158** |
| 3 **One-Time Funding** | | | |
| FY-13 Onetime Carryover & Replace | | 42,616,512 | - |
| | - | **42,616,512** | - |
| 4 **Provider Rate Maintenance** (6 months impact) | | | |
| Inpatient Hosp DRG / Per diem | | 3,598,949 | 9,656,422 |
| DSH (Incr Pymt to spend Est. Federal Share FFY15 Allotment) | | 6,182,456 | 16,588,290 |
| SoonerCare Choice Care Management | | 310,108 | 832,058 |
| Nursing Facilities (100% of Allowable Costs **-12 months impact**) | | 32,172,658 | 86,323,203 |
| ICF/MR's (100% of Allowable Costs - **12 months impact** ) | | 1,876,471 | 5,034,803 |
| Program of All Inclusive Care for the Edlerly (PACE rate increase) | | 710,493 | 1,906,340 |
| Private Duty Nurses (20.6% inc) | | 1,310,602 | 3,516,508 |
| Physician fee schedule (increase to 100% of Medicare) | | 3,923,163 | 10,526,330 |
| Other Practitioner | | 234,914 | 630,303 |
| Home Health | | 132,026 | 354,242 |
| Clinic Services (new FQHCs, RHCs, Family Planning and ESRD) | | 346,928 | 930,851 |
| Ambulatory Surgery Center (ASC) | | 65,053 | 174,545 |
| Lab & Radiology | | 334,616 | 897,816 |
| Dental | | 882,963 | 2,369,100 |
| Ambulance (Emergency Transportation) increase to 100% of Medicare | | 1,368,901 | 3,672,930 |
| Durable Medical Equipment | | 386,775 | 1,037,765 |
| Pharmacy Dispensing Fees | | 343,498 | 921,648 |
| | - | **55,755,578** | **149,599,083** |
| 5 **Remove insulin/immunosupp from mo rx limit** | | **500,909** | **1,344,000** |
| 6 **Diabetic Supplies thro RxPOS system** | | **700,035** | **1,878,279** |
| 7 **Restore 1 brand drug to 6 drug limit** | | **2,280,924** | **6,120,000** |
| 8 **New Care and Case Management System** | | **300,000** | **3,000,000** |
| 9 **HMP value-add** | | **34,000** | **340,000** |
| 10 **HIE SFY2015 - Medical Home and OHCA/Care Management** | | **698,000** | **6,980,000** |
| 11 **HIE SFY2015 - SoonerCare Providers and HIE Usage Incentive** | | **1,798,000** | **17,980,000** |
| 12 **Professional fee for compounded prescriptions** | | **473,160** | **1,150,000** |
| 13 **IS Staffing Request- Interoperability Manager** | 1.0 | **50,555** | **101,109** |
| 14 **Care initiative Coordination Team** | 2.0 | **79,667** | **159,334** |
| 15 **Dental Officer** | 1.0 | **104,643** | **209,287** |
| 16 **Senior Medical Review Nurse - MAU** | 1.0 | **43,621** | **87,242** |
| 17 **Research Analyst - MAU** | 1.0 | **36,046** | **72,092** |
| 18 **Quality Improvement Coordinator** | 1.0 | **38,800** | **77,599** |
| **FY-2015 Budget Request Priorities** | **21.0** | **$ 211,726,192** | **$ 360,618,782** |

# SOONERCARE CHOICE PROGRAM INDEPENDENT EVALUATION

THE PACIFIC HEALTH POLICY GROUP

NOVEMBER 2013

# INTRODUCTION

- Andrew Cohen is a founding director of the Pacific Health Policy Group
- PHPG specializes in design, implementation and evaluation of health reform initiatives for publicly-funded populations (Medicaid, Medicare, TRICARE)
- PHPG has assisted over 30 state Medicaid programs since 1994
- In addition to Oklahoma, in the past three years PHPG has worked on Medicaid managed care engagements for public or managed care organization clients in the following fourteen states:

| | | | |
|---|---|---|---|
| *Arizona* | *California* | *Florida* | *Hawaii* |
| *Kansas* | *Kentucky* | *Missouri* | *New Jersey* |
| *New Mexico* | *New York* | *Ohio* | *Tennessee* |
| *Texas* | *Vermont* | | |

# INTRODUCTION *cont'd*

PHPG was retained to evaluate SoonerCare Choice and address the following:

- ***Trends*** - How has SoonerCare Choice performed since 2008 (most recent prior evaluation) on the critical measures of Access to Care, Quality and Cost Effectiveness?
- ***New Initiatives*** – What has been the impact to-date of the recent initiatives?
- ***National Perspective*** - How does SoonerCare Choice compare to programs elsewhere in the country, particularly "traditional MCO" managed care?

# INTRODUCTION *cont'd*

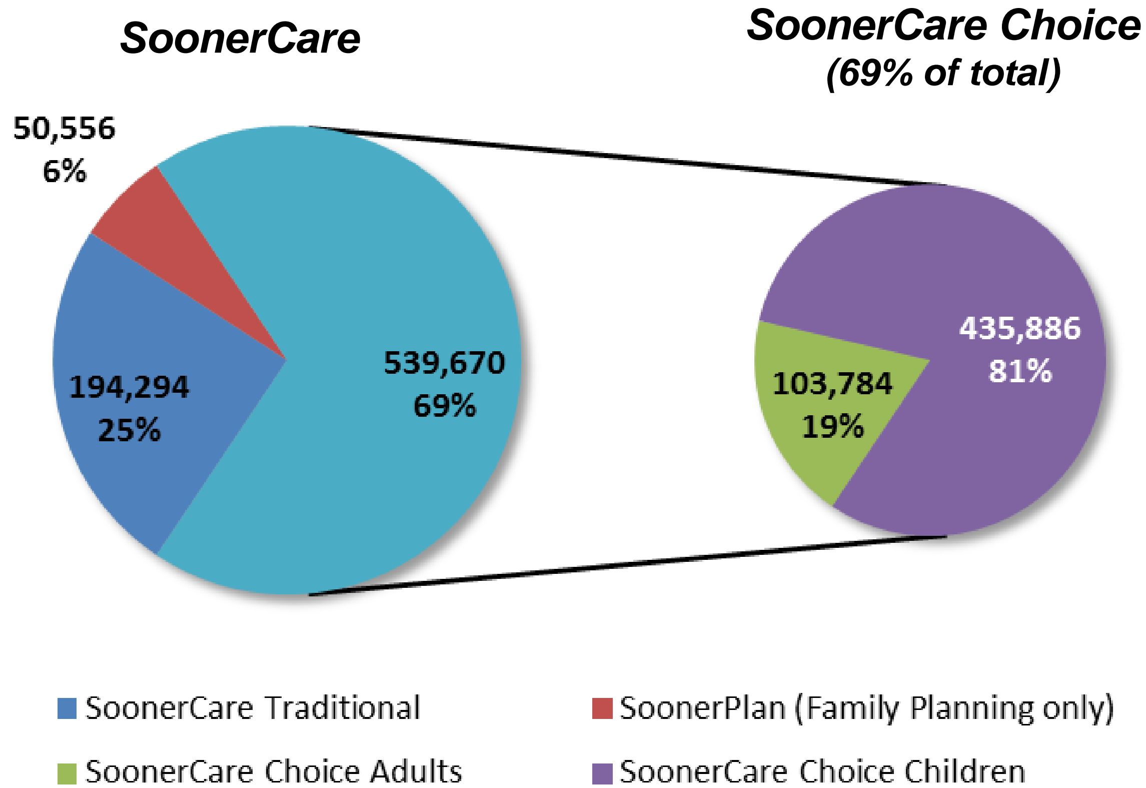
In the past five years, the OHCA has sought to transform SoonerCare Choice through introduction of:

- ***Patient Centered Medical Homes (PCMH)*** – every member is aligned with a primary care provider responsible for meeting access and quality standards
- ***Health Access Networks (HAN)*** – Community-based integrated networks intended to improve care coordination through support of affiliated PCMH providers
- ***SoonerCare Health Management Program (HMP)* –** holistic, person-centered care management for members with complex/chronic conditions and practice management support for their providers

# INTRODUCTION *cont'd*

## ***SoonerCare – June 2013***

***Total Enrollment – 784,520***



# INTRODUCTION *cont'd*

## *PCMH Tiers*

- PCMH includes three tiers with escalating responsibilities and associated per member per month care coordination fees
- Providers also can earn "SoonerExcel" quality incentives for meeting performance targets, such as for preventive care, member use of the ER and prescribing of generic drugs

### *Tier 1*

**Entry Level**

- **12 requirements**
- Includes 24/7 telephone coverage by medical professional
- \$3.46 - \$4.85 per month
- Practice with average caseload receives up to \$16,005 per year in care coordination fees

### *Tier 2*

**Advanced**

- **19 requirements**, including all Tier 1 requirements
- Includes offering at least 30 hours of office time to see patients
- \$4.50 - \$6.32 per month
- Practice with average caseload receives up to \$20,856 per year in care coordination fees

### *Tier 3*

**Optimal**

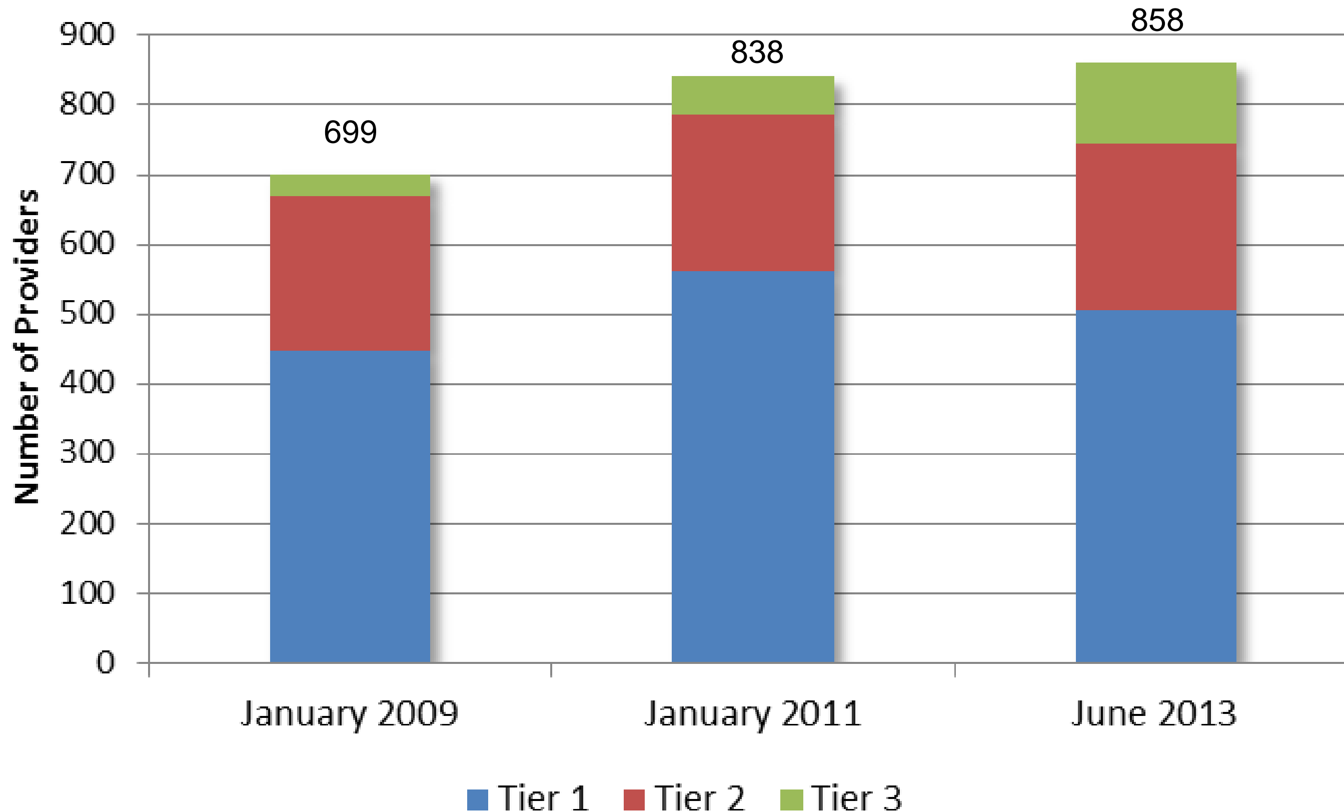
- **23 requirements**, including all Tier 1 and Tier 2 requirements
- Includes using health assessment tools to characterize patient needs/risks
- \$5.99 - \$8.41 per month
- Practice with average caseload receives up to \$27,753 per year in care coordination fees

# INTRODUCTION *cont'd*

## ***PCMH Practice Participation***

- The total number of participating practices increased significantly from 2009 to 2013
- Since 2009, Tier 3 practices, as a percent of total, have increased from six percent to nearly 14 percent
- About 60 percent of SoonerCare Choice members are now enrolled with a Tier 2 or Tier 3 practice

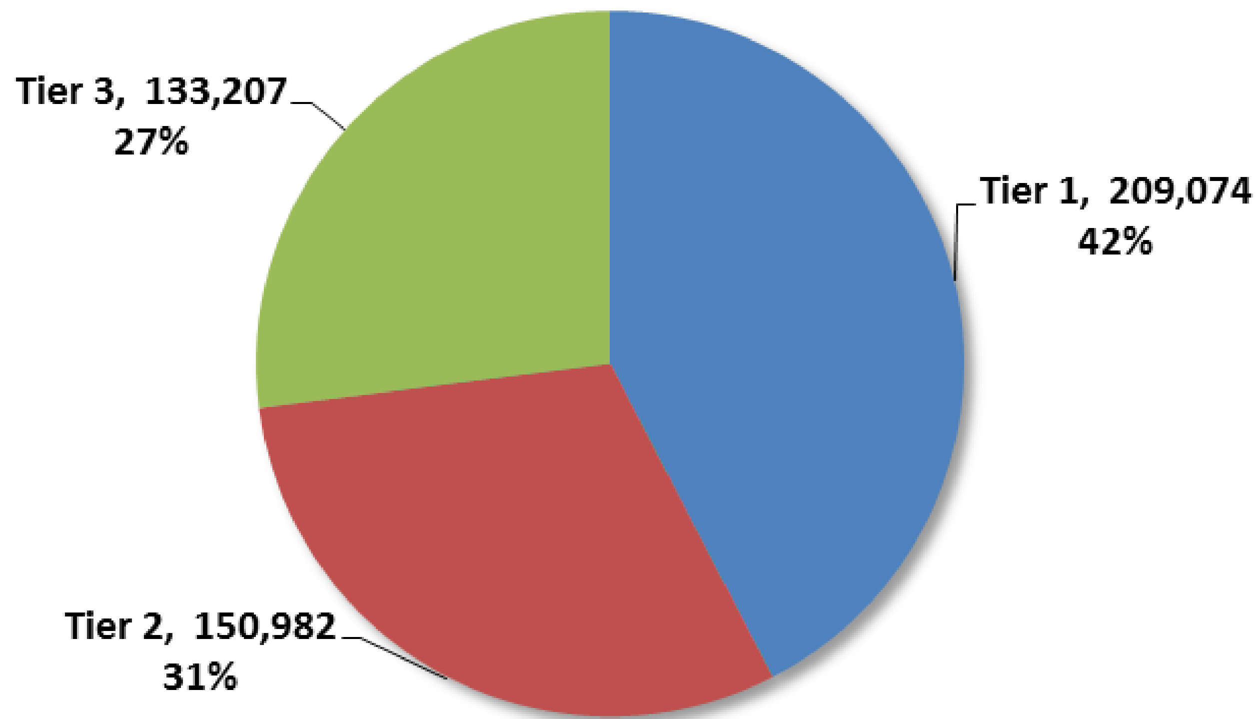
# INTRODUCTION *cont'd*




*Notes – Approximately 20 percent of practices surveyed in 2012 reported that their tier level had changed at some point; practices can include multiple providers
Sources: OHCA PCMH roster data; Patient-Centered Medical Home – Survey of SoonerCare-Contracted PCPs

# INTRODUCTION *cont'd*

## *Enrollment by Tier Level – June 2013*




Source: June 2013 Fast Facts

# INTRODUCTION *cont'd*

## Health Access Networks (HANs)

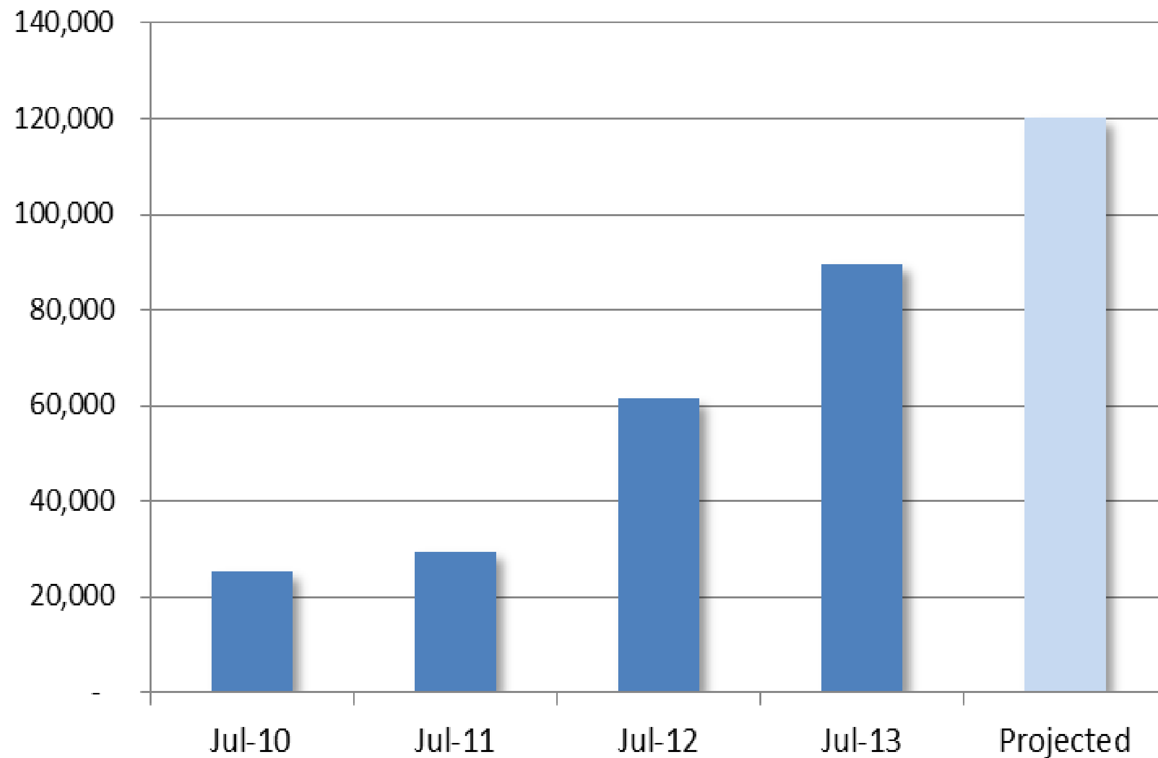
- Launched in July 2010
- Expands on the PCMH by creating community-based, integrated networks
- Intended to increase access to health care services, enhance quality and coordination of care and reduce costs.

- There are three HAN contractors:

  Central Communities (Canadian County)
  Oklahoma State University (OSU) Center for Health Sciences
  Oklahoma University (OU) Sooner

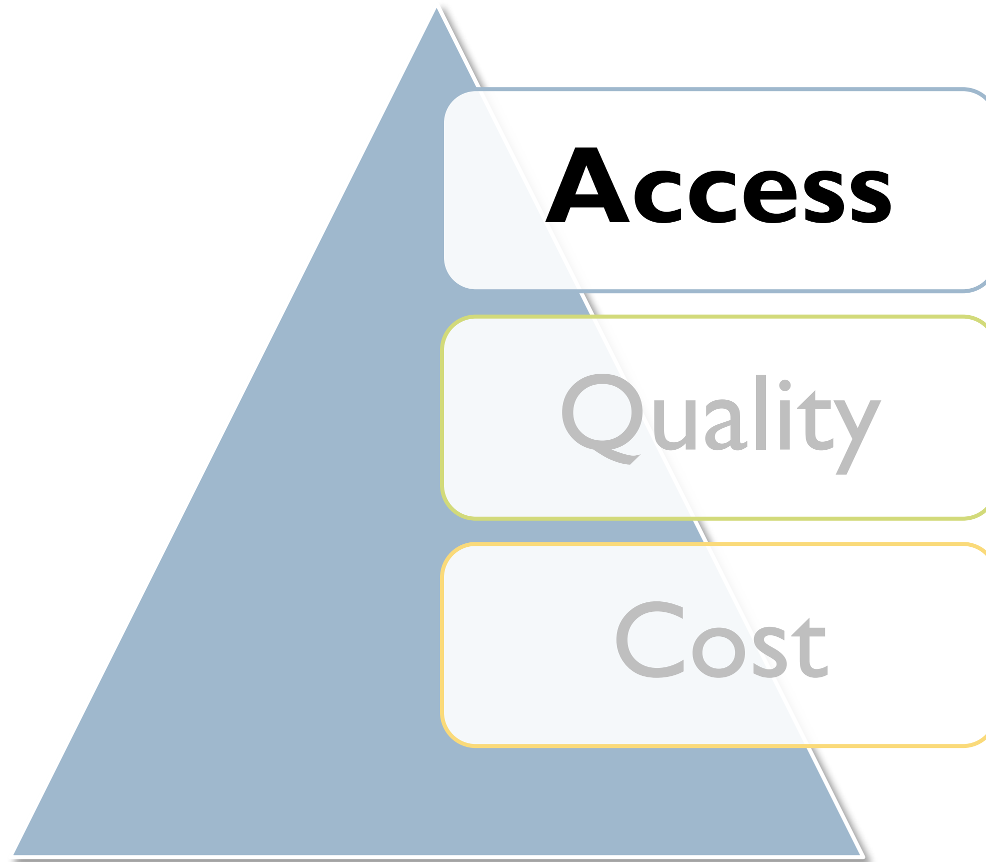
- The HANs receive $5.00 PMPM in return for certain enhancements, which include offering telemedicine, specialty care assistance and care management to PCMH providers and their members.

# INTRODUCTION *cont'd*




Sources: OHCA enrollment and payment data for historical; OHCA for projection.

# SoonerCare Choice Evaluation - TRENDS



## Evaluation Questions

- Is it easy or difficult to enroll in SoonerCare Choice?
- Once enrolled:
  - Is there an adequate selection of primary care providers?
  - Are services (primary care and specialty) accessible?
- Are members with complex or chronic conditions able to navigate the system?

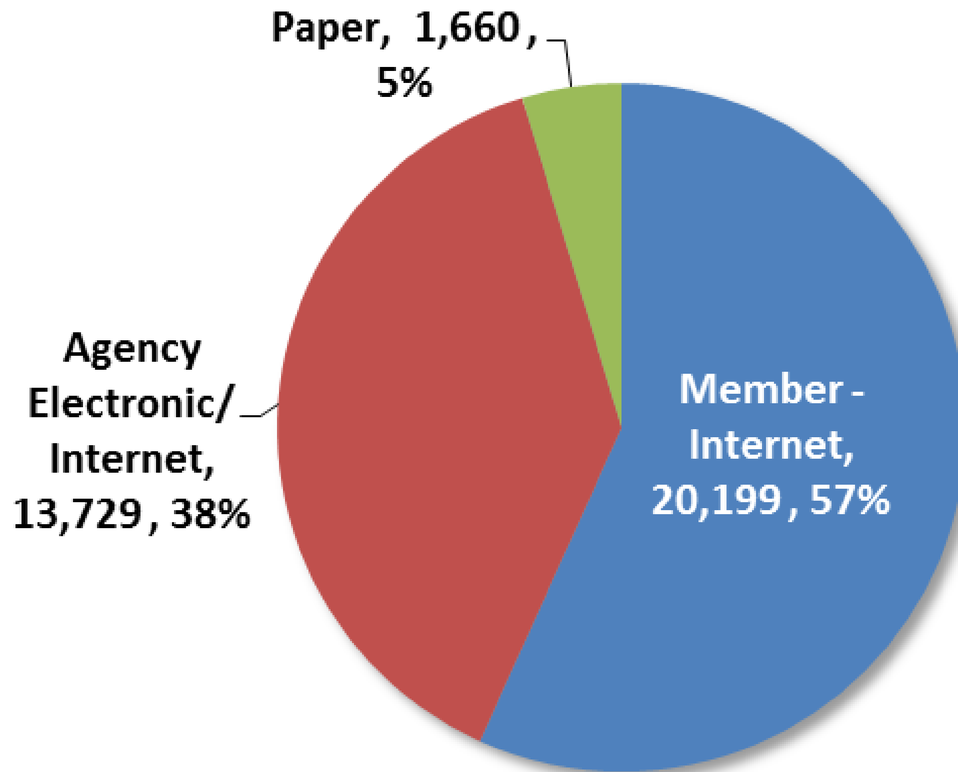
# TRENDS – ACCESS TO CARE *cont'd*

## Online Enrollment

- Over 30,000 applications for SoonerCare processed each month
- Online enrollment objectives:
  - Provide 24/7 access to enrollment and "real time" determination of eligibility
  - Facilitate selection of a medical home
  - Reduce staff hours required for processing applications
- Online enrollment was launched in September 2010
- Impact was immediate – paper applications have nearly ended

# TRENDS – ACCESS TO CARE *cont'd*

***Enrollment Method – February 2013 Snapshot***




Source: OHCA Online Enrollment Fast Facts

# TRENDS – ACCESS TO CARE *cont'd*

## Online Enrollment Savings

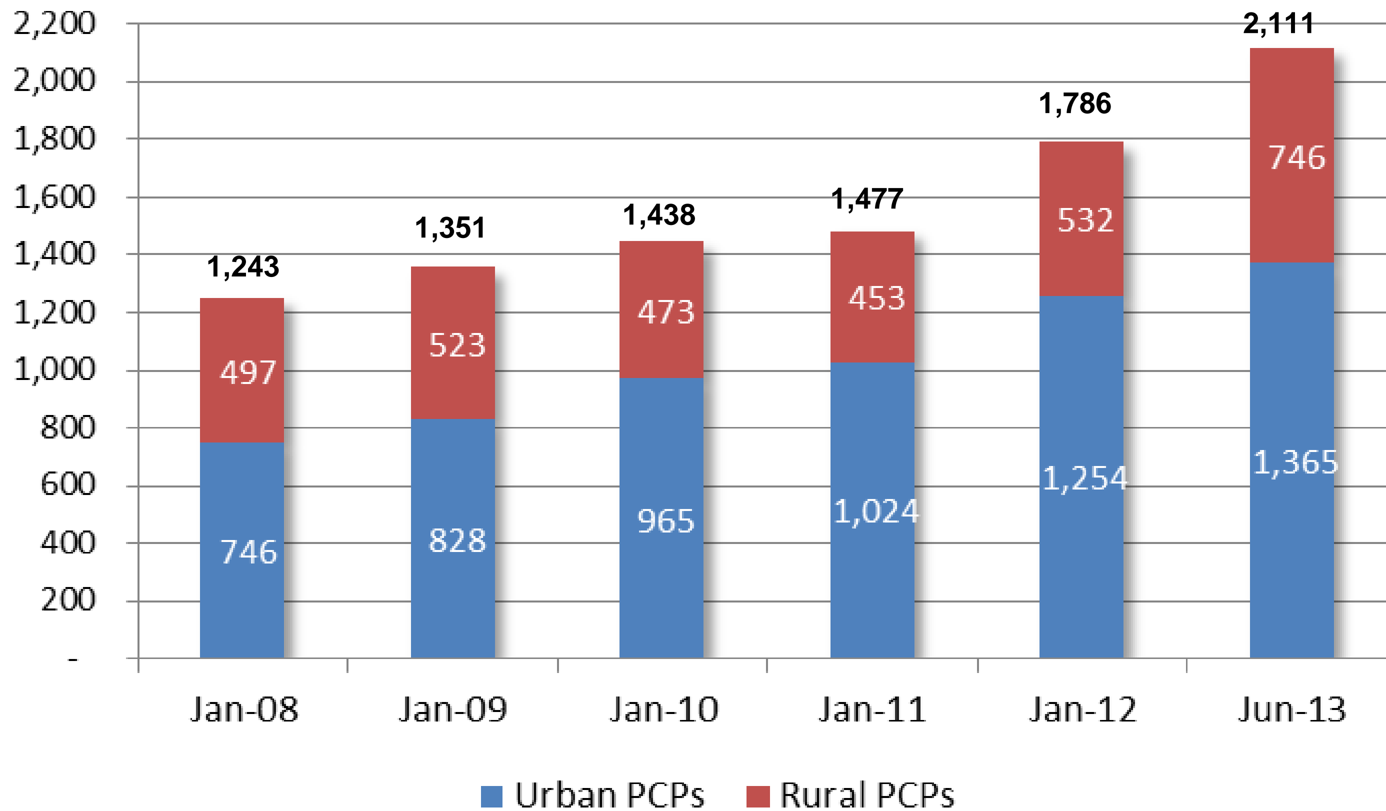
- PHPG evaluated the "return on investment" for online enrollment by comparing state share of operational costs over the first five years to potential for reallocating caseworker resources
- A separate study was conducted by Mathematica Policy Research of "Express Lane Eligibility" in multiple states, with Oklahoma included as a comparison state
- Both firms estimated annual savings in the initial post go-live period of about **$1.5 million**; PHPG projected the savings would continue to grow in out years, as online enrollment volume increases
- The "savings" represent case worker resources freed-up for other activities, such as assisting individuals applying to DHS for cash assistance or Supplemental Security Income benefits

# TRENDS – ACCESS TO CARE

## Evaluation Questions

- Is there an adequate selection of primary care providers?
- Are services accessible?
- Is emergency room use rising or declining?
- Is help available to members with complex/chronic conditions?

# TRENDS – ACCESS TO CARE *cont'd*

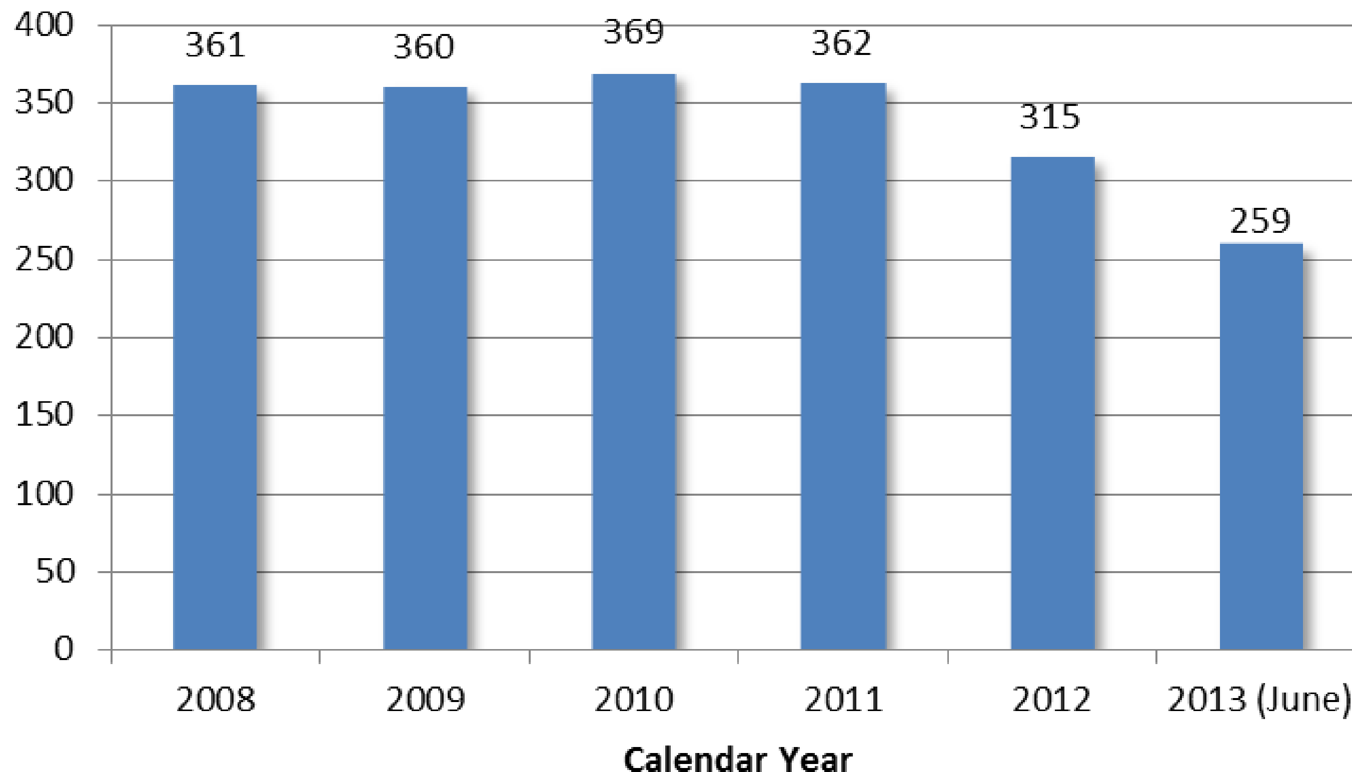



* Urban includes former SC Plus counties. A portion of the increase may be attributable to more precise taxonomy in 2012 - 2013; Cotton County had no PCPs in May 2013

Sources: OHCA Provider Fast Facts Report; KFF.org (total active PCP count)

# TRENDS – ACCESS TO CARE *cont'd*

## *Average SoonerCare Members per PCP (PCMH)**

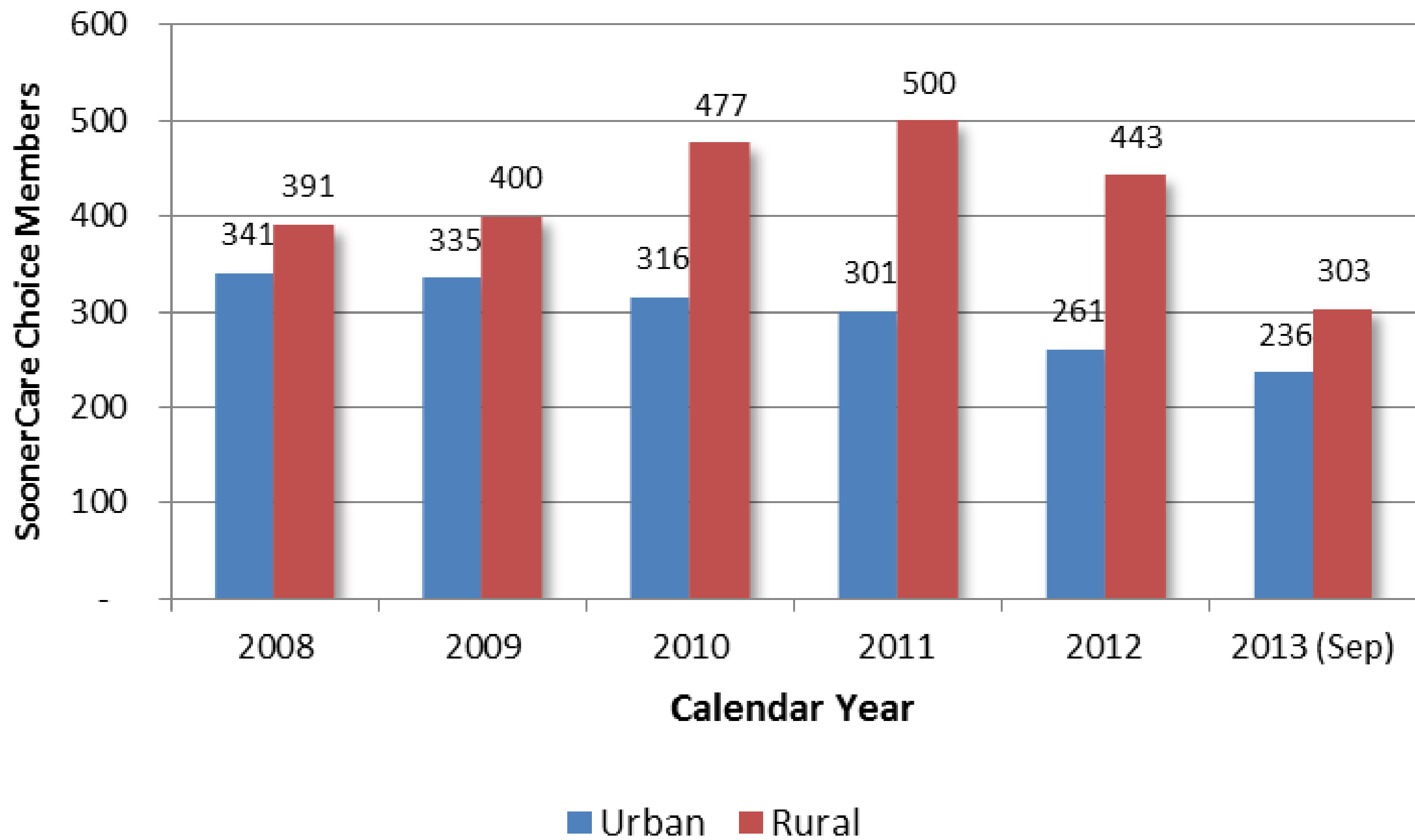



* Annualized member count divided by PCP count (2013 enrollment as of May)

Sources: OHCA Provider Fast Facts Report; Waiver Enrollment Reports; Enrollment Fast Facts (May 2013 data)

# TRENDS – ACCESS TO CARE *cont'd*

## *Average SoonerCare Members per PCP – Urban/Rural*



# TRENDS – ACCESS TO CARE *cont'd*

## Appointment Availability

- PCP (and specialist) capacity must translate into appointment availability or members will bypass in favor of the emergency room
- SoonerCare Choice members are routinely surveyed on their ability to see their personal doctor and specialists
- PHPG evaluated appointment availability through
  - Review and trending of published survey data
  - Analysis and trending of total SoonerCare Choice emergency room utilization

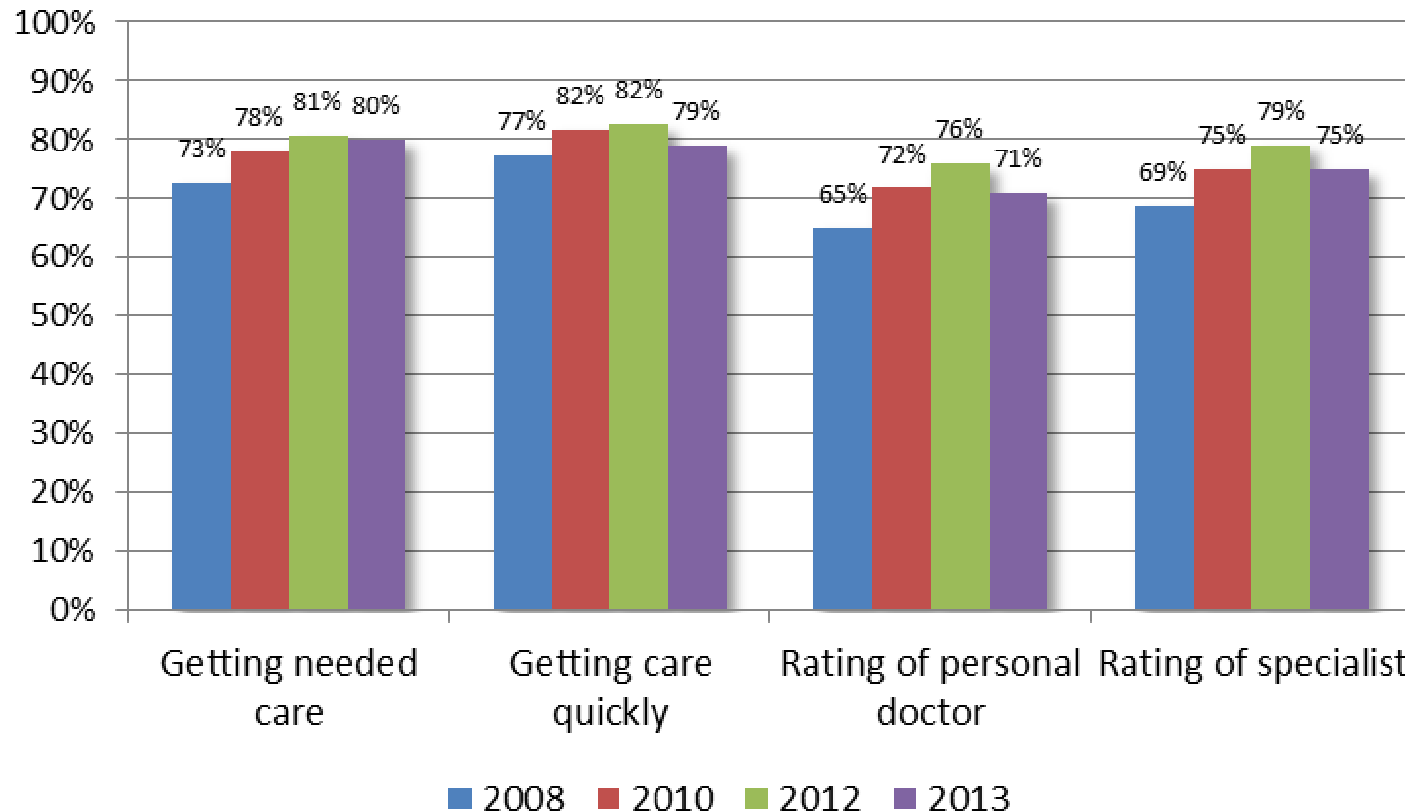
# TRENDS – ACCESS TO CARE *cont'd*

## Member Satisfaction

- Consumer Assessment of Healthcare Providers and Systems survey (CAHPS)
- Satisfaction with adult services increased from 2008, though it dipped slightly in the most recent survey
- Satisfaction with services for children has shown an uninterrupted rise

# TRENDS – ACCESS TO CARE *cont'd*

## *High Satisfaction with Care for Adults**

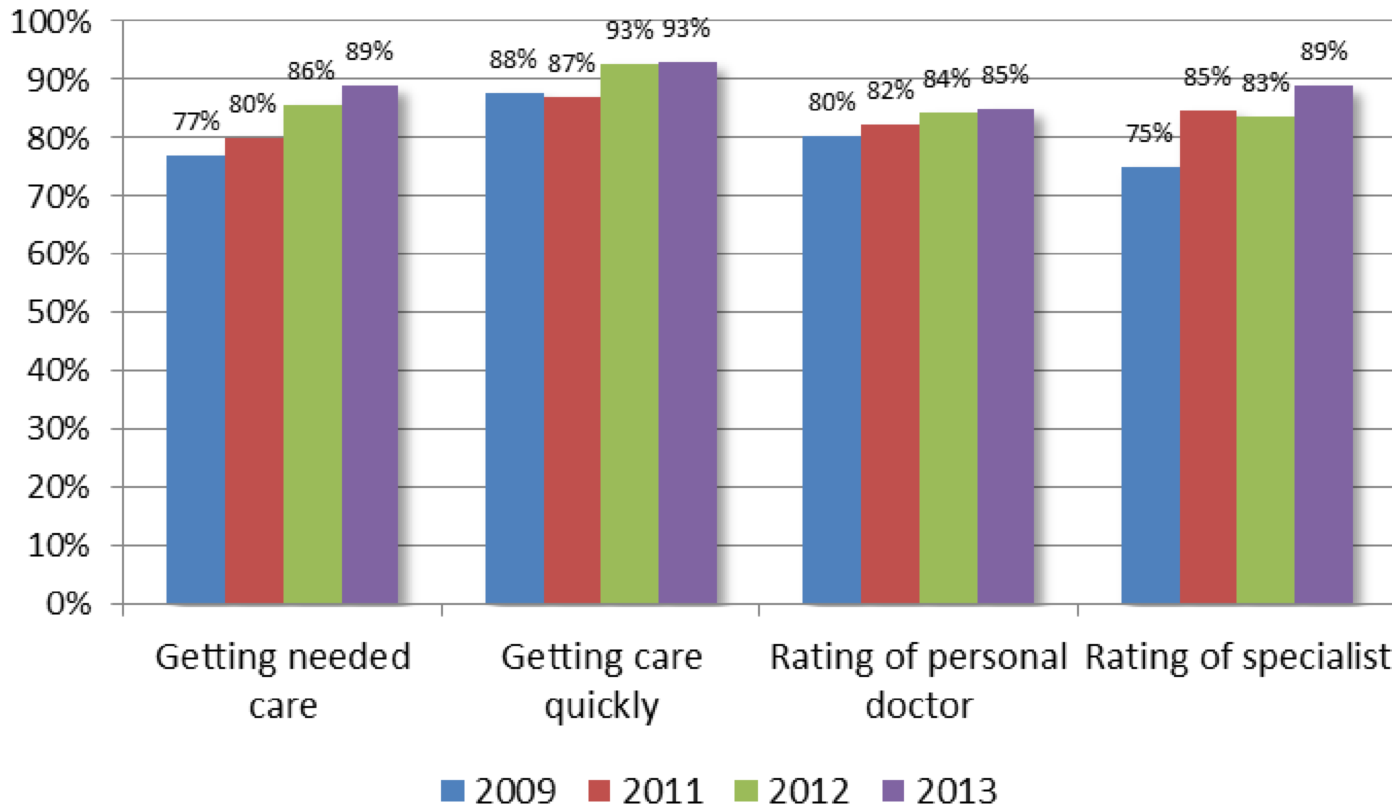



* Percent rating 8, 9 or 10 on a 10-point satisfaction scale; "Getting care quickly" is a composite measure based on questions regarding satisfaction with obtaining needed care, both urgent and non-urgent

Sources: CAHPS Health Plan Survey Adult Version – Telligen through 2012; Morpace for 2013 (surveys are conducted from July to December of year preceding reporting year)

# TRENDS – ACCESS TO CARE *cont'd*

## *High Satisfaction with Care for Children**

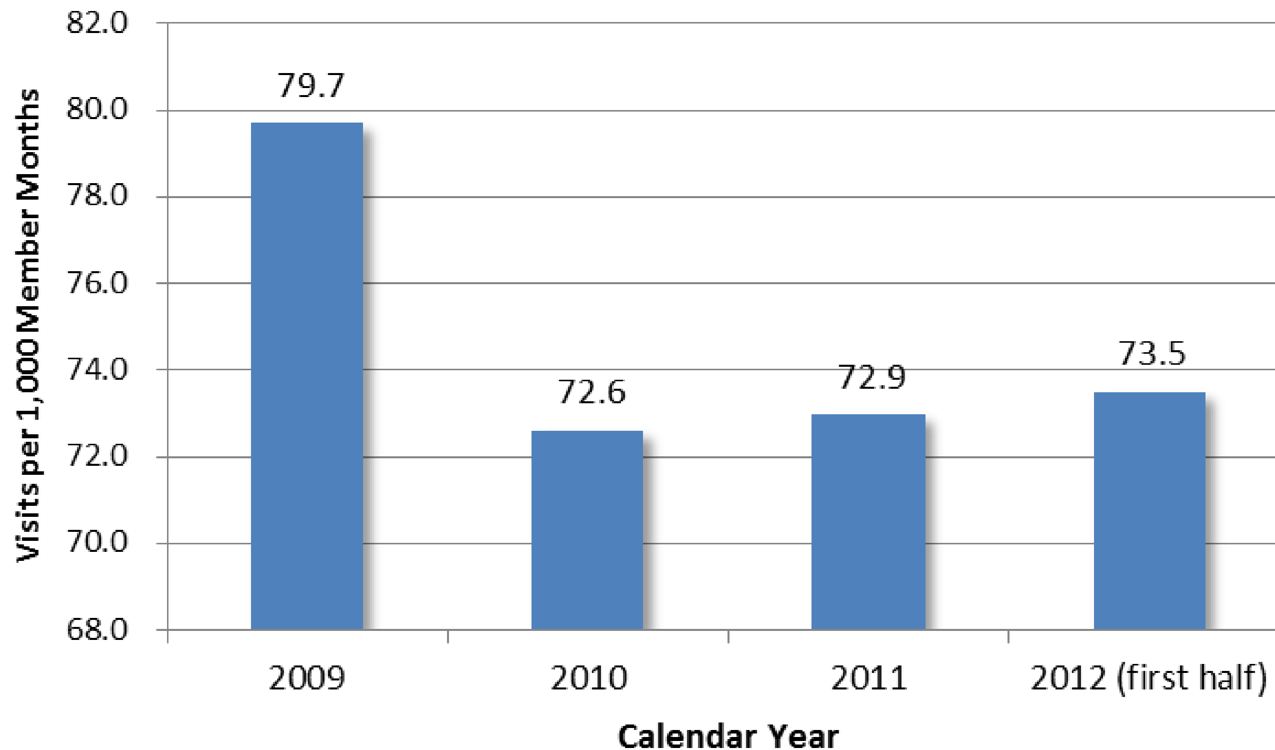



* Percent rating 8, 9 or 10 on a 10-point satisfaction scale

Sources: CAHPS Health Plan Survey Child Version – Telligen through 2012; Morpace for 2013 (surveys are conducted from July to December of year preceding reporting year)

# TRENDS – ACCESS TO CARE *cont'd*

## ***Emergency Room Utilization per 1,000 Member Months****



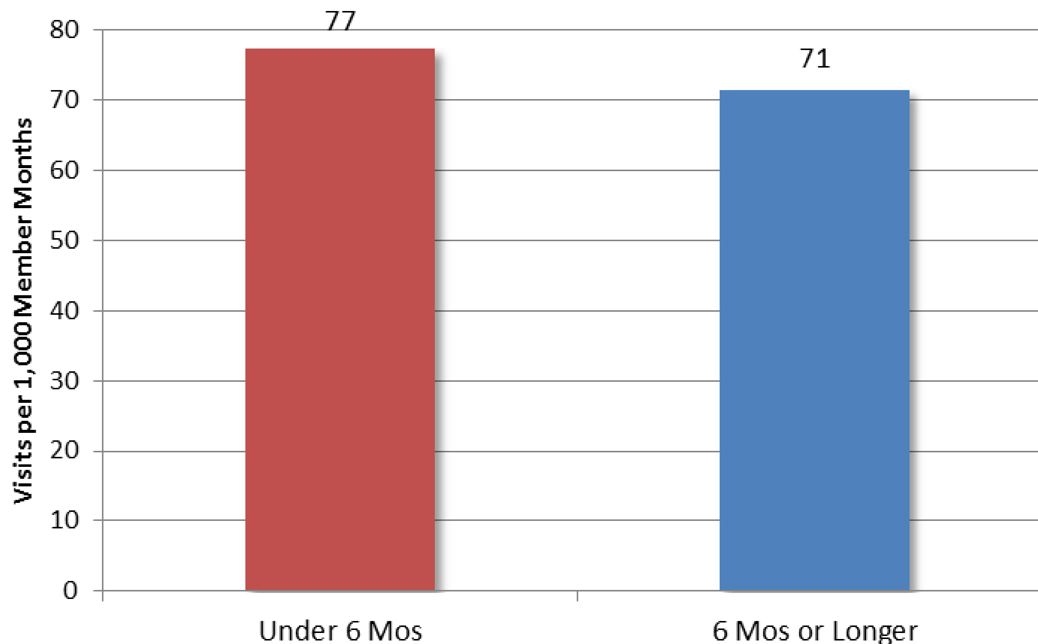

*SoonerCare Choice members enrolled in a Patient Centered Medical Home; 2012 rate includes seasonality adjustment; data excludes dual eligibles whose ER claims are paid by Medicare

Sources: Oklahoma rate derived from analysis of paid claims data; national Medicaid rate reported in Health Affairs

# TRENDS – ACCESS T0 CARE *cont'd*

## Emergency Room Utilization (Per 1,000 Member Months)

- ***Comparison by Tenure***: Members enrolled at least 6 months have lower ER utilization*, suggesting that the impact of PCMH care management increases over time



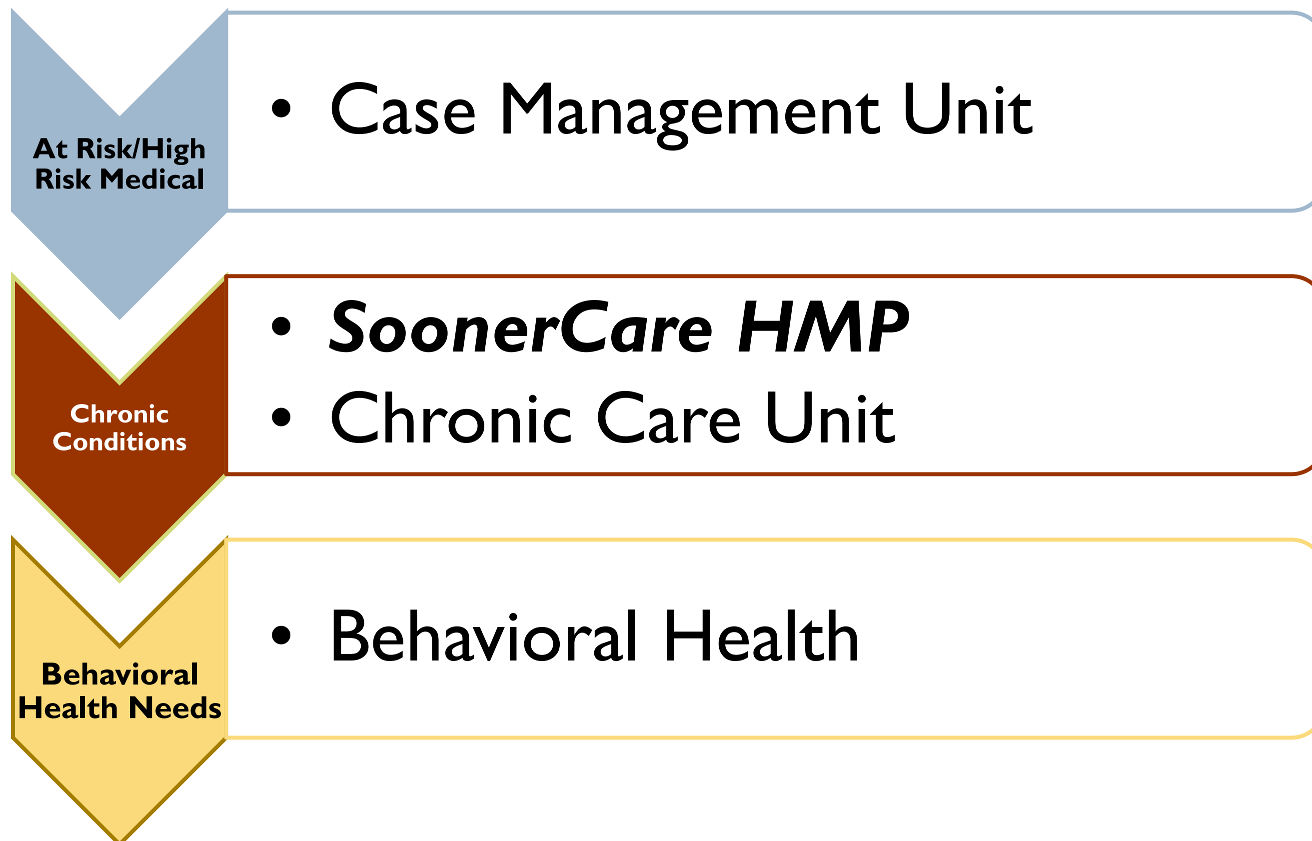

*Note: Average for 2009 – 2012

Source: OHCA paid claims data

# TRENDS – ACCESS TO CARE *cont'd*

## Assistance to Members with Complex/Chronic Needs

- The OHCA Population Care Management and BH Departments oversee a needs-based, multi-tiered care management structure



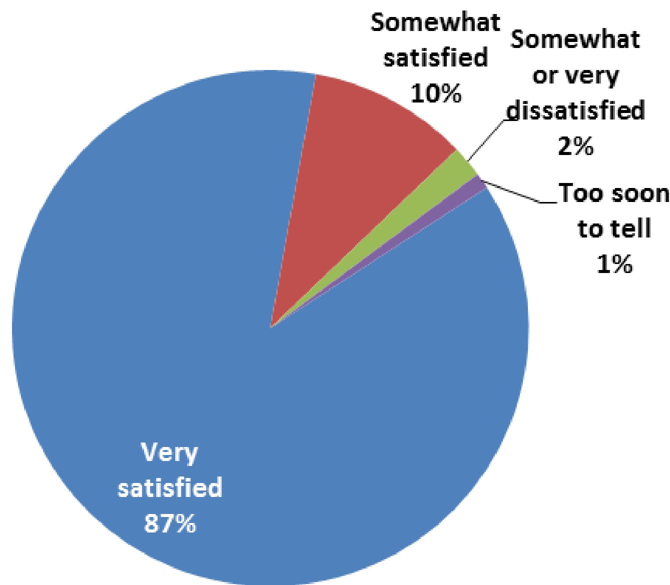
# IN-DEPTH EVALUATION - HMP

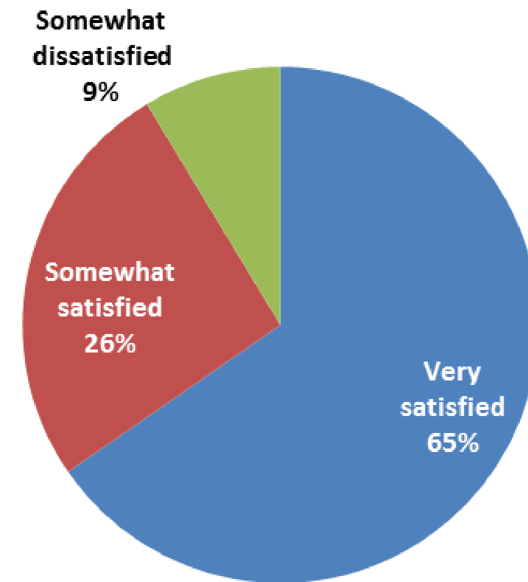
## SoonerCare HMP

- The SoonerCare Health Management Program (HMP) was mandated by the Oklahoma Medicaid Reform Act of 2006 and implemented in 2008 to:
  - Better manage the needs of members with complex/chronic conditions (e.g., Asthma and Diabetes) through a holistic model of care (focus on the person, not the disease)
  - Prepare members to self-manage their conditions
  - Enhance the ability of primary care providers to manage the needs of patients with complex/chronic conditions
- The program has two components:
  - Nurse Care Management/Health Coaching – up to 7,500 members at any given time, selected based on projected risk of adverse health outcomes and high healthcare expenditures using predictive modeler
  - Practice Facilitation (88 practices since 2008)

# Satisfaction

- Both members and providers have expressed high levels of satisfaction with the program




Source: 2013 SoonerCare HMP Satisfaction & Self-Management Impact Report

## SoonerCare HMP Participant Interviews

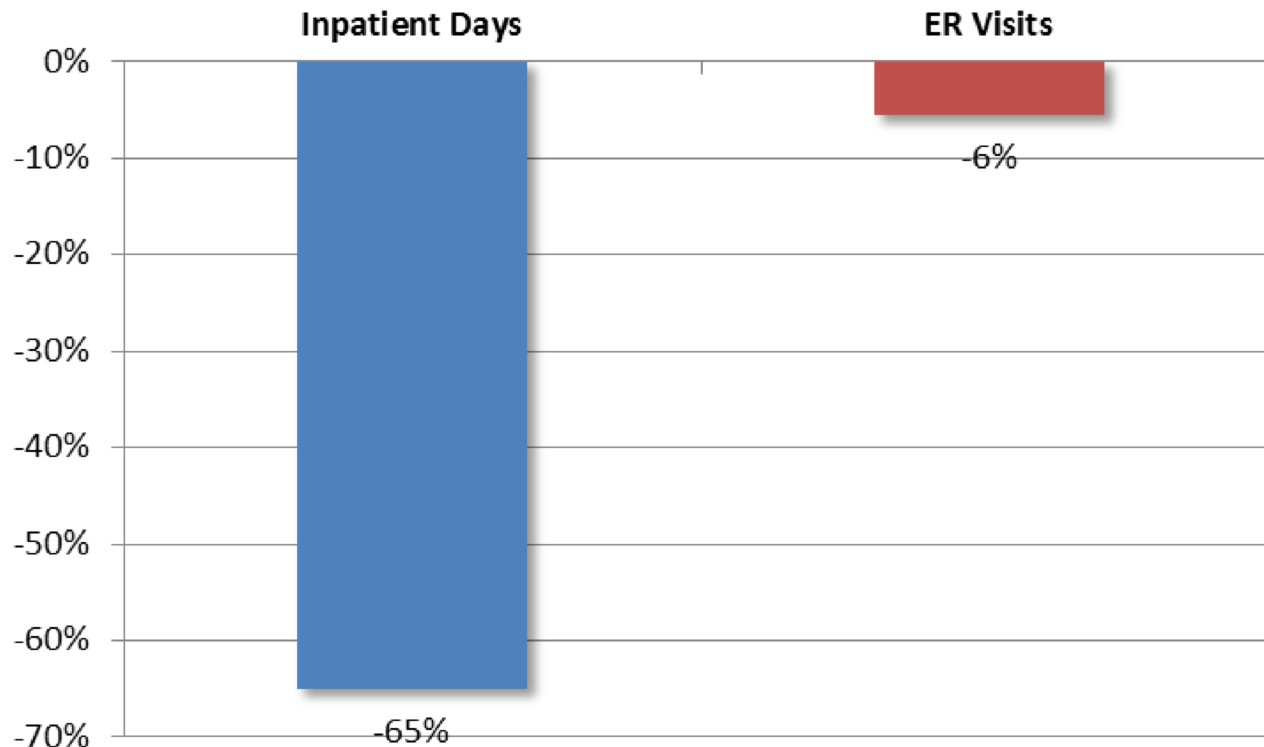
- *"Well, I mean, health-wise, I feel like I'm better. I lost, like, 92 pounds. I'm exercising three times a week...and when it's warm I try to walk as much as I can outside. When it's cold I walk inside my apartment building in the hall. There's other things going on too, but my nurse also helped me to come up with a plan to lose weight."*
- *"She keeps my health and my mind together. Exercising and eating right and taking my medication, my blood sugar and my blood pressure."*
- *"I love it that someone's checking up on me and making sure that I'm OK every month. I can't say that anybody I've given birth to would do that!"*

Source: 2013 SoonerCare HMP Satisfaction & Self-Management Impact Report

# IN-DEPTH EVALUATION – HMP *cont'd*

## HMP Impact on Inpatient and ER Utilization

- Inpatient days and ER visits were below forecast for all participants (results shown for highest risk cohort)




Source: SFY 2012 SoonerCare HMP Annual Evaluation Report

# IN-DEPTH EVALUATION – HMP *cont'd*

## HMP Impact on Cost

- The program's net cost effectiveness (accounting for administrative expenses) has increased each year, with total savings through SFY 2012 exceeding $139 million

***SoonerCare HMP – Net Savings (Deficit) by State Fiscal Year (in millions)****

| Program Component | 2009 | 2010 | 2011 | 2012 | Total |
|---|---|---|---|---|---|
| Care Management | ($2.5) | $1.2 | $45.8 | $48.7 | $93.1 |
| Practice Facilitation | ($0.6) | $7.1 | $27.1 | $12.5 | $46.1 |
| Total Program | ($3.1) | $8.3 | $72.9 | $61.2 | **$139.2** |

*Savings are net of HMP administrative expenses (OHCA staff and vendor payments). Administrative expenses have totaled $26.6 million through SFY 2012, yielding a program return-on-investment of 524 percent

Source: SFY 2012 SoonerCare HMP Annual Evaluation Report

# SoonerCare Choice Evaluation - TRENDS

# TRENDS – QUALITY OF CARE

## Evaluation Questions

- Does the program have mechanisms to measure and reward quality?
- Are members receiving appropriate preventive and diagnostic services?
- Are health outcomes improving?

# Preventive and Diagnostic Services

- The OHCA tracks preventive and diagnostic service delivery for SoonerCare Choice through "Healthcare Effectiveness Data and Information Set" (HEDIS®) measures
- PHPG evaluated HEDIS results over time and in comparison to national HEDIS Medicaid MCO rates (where available)
- Measures included:
  - HEDIS Trends: Child/adolescent access to PCPs
  - HEDIS Trends: Adult access to preventive services
  - HEDIS Trends: Annual dental visit rates for members under 21
  - HEDIS Trends: Breast and cervical cancer screening rates

# TRENDS – QUALITY OF CARE *cont'd*

## HEDIS Trends

- SoonerCare Choice has achieved improvement in child/adolescent access to PCPs since 2008
- The SoonerCare Choice access rate is higher than the national rate for all groups

| HEDIS Measure | 2008 | 2009 | 2010 | 2011 | 2012 | Change 2008 -12 | National Rate |
|---|---|---|---|---|---|---|---|
| Child access to PCP, 12-24 months | 94.1% | 96.2.% | 97.8% | 97.2% | 96.6% | **↑2.5%** | 96.1% |
| Child access to PCP, 3-6 years | 83.1% | 86.9% | 89.1% | 88.4% | 90.1% | **↑7.0%** | 88.2% |
| Child access to PCP, 7-11 years | 82.7% | 87.6% | 89.9% | 90.9% | 91.7% | **↑9.0%** | 89.5% |
| Adolescent access to PCP, 12-18 years | 81.4% | 85.8% | 88.8% | 89.9% | 91.6% | **↑10.2%** | 87.9% |

Source: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) for national Medicaid HMO rates. Reporting years represent results for activity in the prior year

# TRENDS – QUALITY OF CARE *cont'd*

## HEDIS Trends

- Annual dental visit rates for members under 21 have improved modestly and reached 64 percent in 2012
- Adult access to preventive/ambulatory services also has improved and is over 80 percent for members 20 – 44 and over 90 percent for members 45 - 64

| HEDIS Measure | 2008 | 2009 | 2010 | 2011 | 2012 | Change 2008 -12 | National Rate |
|---|---|---|---|---|---|---|---|
| Annual dental visit under 21 years | 59.7% | 62.1% | 60.2% | 62.0% | 64.0% | ↑4.3% | -- |
| | | | | | | | |
| Adult access to preventive/ ambulatory services, 20 – 44 years | 78.4% | 83.3% | 83.6% | 84.2% | 83.1% | ↑4.7% | -- |
| Adult access to preventive/ ambulatory services, 45 – 64 years | 86.8% | 89.7% | 90.9% | 91.1% | 91.0% | ↑4.2% | -- |

Source: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) for national Medicaid HMO rates. Reporting years represent results for activity in the prior year

# TRENDS – QUALITY OF CARE *cont'd*

**HEDIS Trends**

- The exceptions to the broader positive trends are breast and cervical cancer screening rates
- Both rates are down slightly from 2008 and below the national rate
- Recommended screening age raised for mammograms and recommended cervical screening intervals lengthened in 2012 (both nationally) after several years of review; may have contributed to flat/declining trend

| HEDIS Measure | 2008 | 2009 | 2010 | 2011 | 2012 | Change 2008 -12 | National Rate |
|---|---|---|---|---|---|---|---|
| Breast cancer screening rate | 38.3% | 43.0% | 41.1% | 41.3% | 36.9% | ↓1.4% | 50.4% |
| Cervical cancer screening rate | 44.4% | 46.6% | 44.2% | 47.2% | 42.5% | ↓1.9% | 66.7% |

Source: Oklahoma Health Care Authority (OHCA) for Oklahoma HEDIS® results and National Committee for Quality Assurance (NQCA) for national Medicaid HMO rates. Reporting years represent results for activity in the prior year

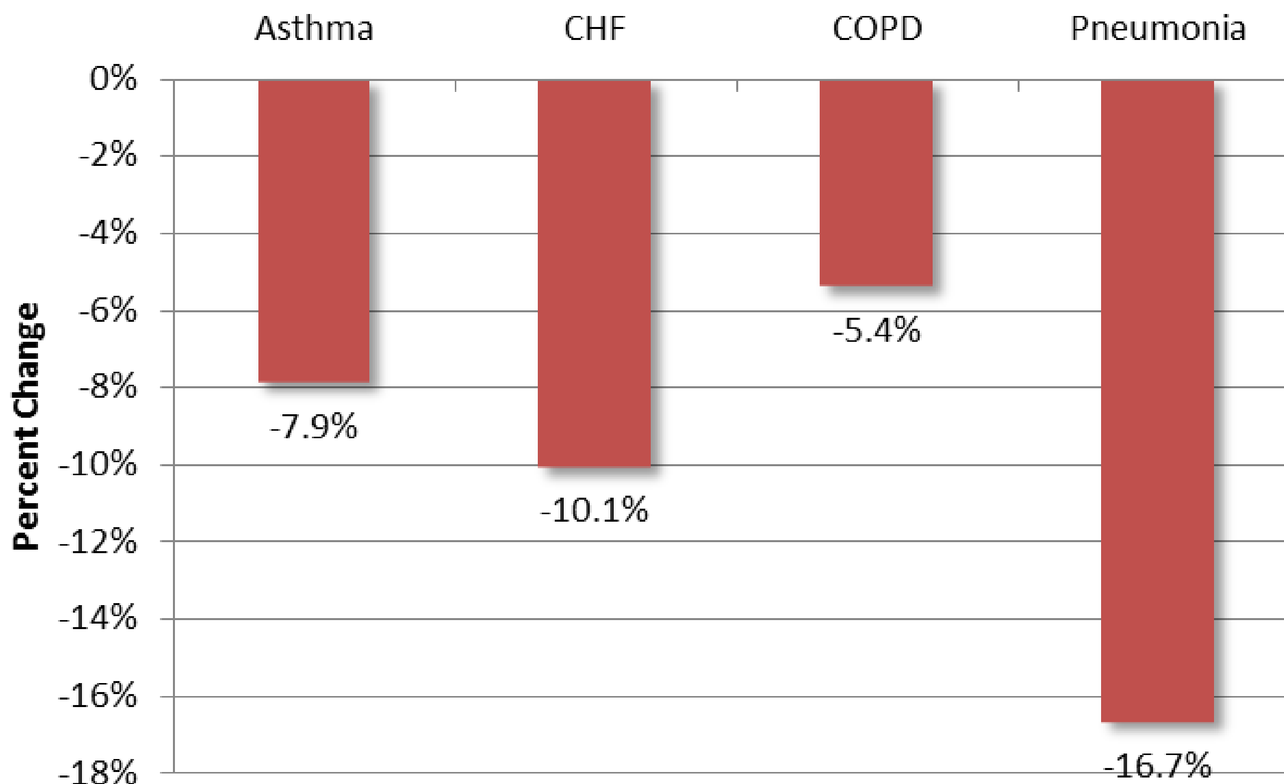
# TRENDS – QUALITY OF CARE *cont'd*

## Avoidable Hospitalizations

- Avoidable hospitalization rate is an effective indicator of the quality of ambulatory health care for persons with complex and chronic conditions
- PCMH and SoonerCare Choice care management activities are both directed in part to ensuring access to the right care in the right setting
- PHPG used paid claims data to evaluate the avoidable hospitalization rate among SoonerCare Choice members with Asthma, CHF, COPD and Pneumonia (based on admitting diagnosis)
- The rate fell for all four conditions from 2009 to 2012

# TRENDS – QUALITY OF CARE *cont'd*

## *Avoidable Hospitalization Rate (2009 – 2012)*




*SoonerCare Choice members enrolled in a Patient Centered Medical Home

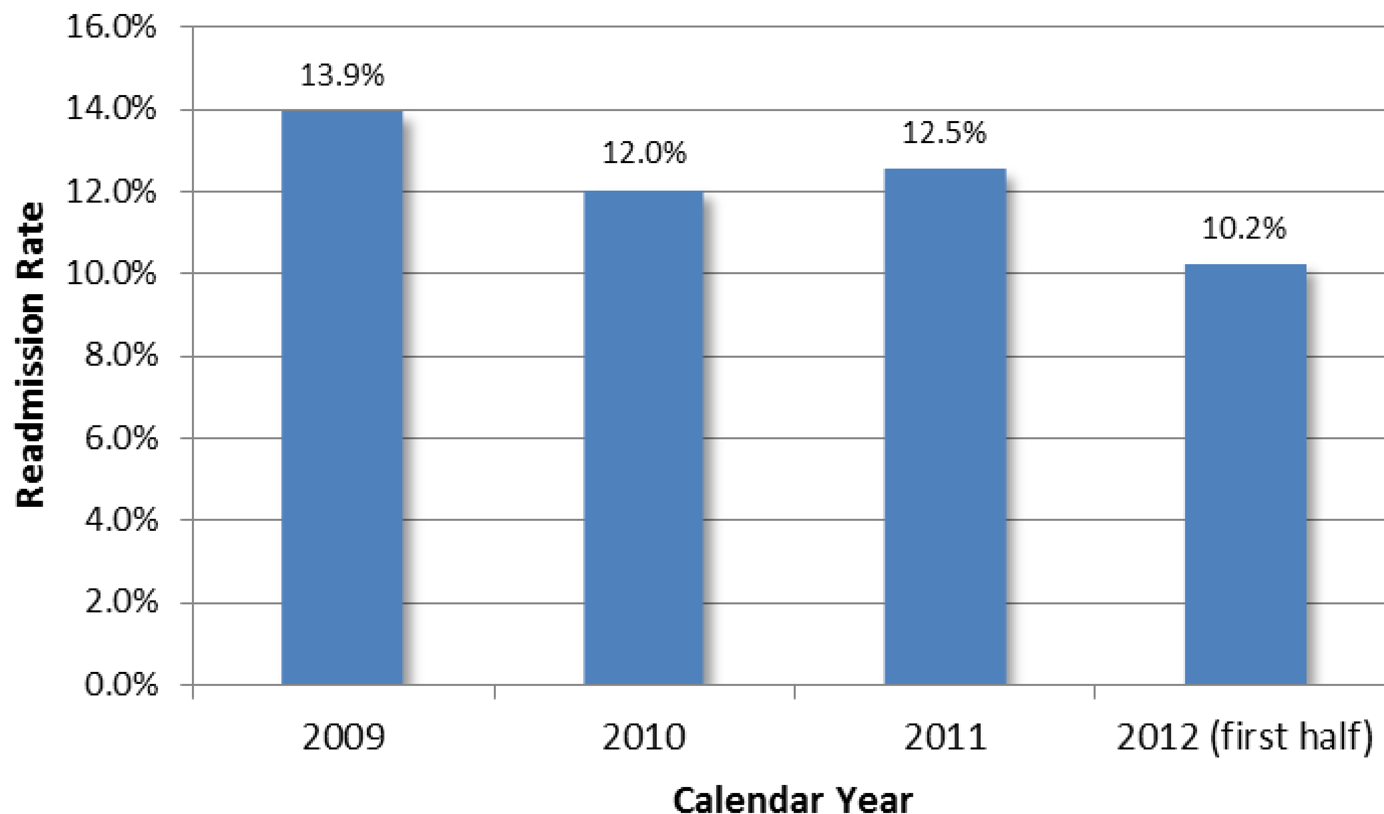
Source: OHCA paid claims

# TRENDS – QUALITY OF CARE *cont'd*

## Hospital Readmissions

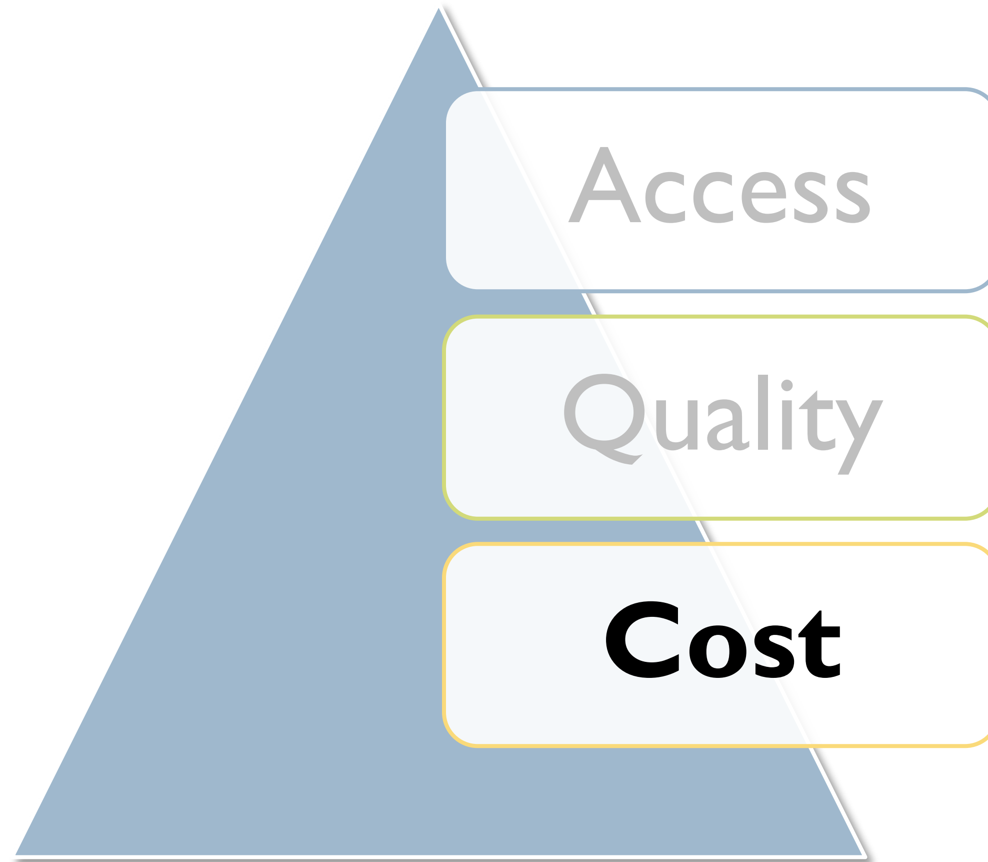
- The hospital 30-day readmission rate is an effective indicator of discharge planning activities, PCP post-discharge care and SoonerCare Choice case management
- PHPG used paid claims data to evaluate the 30-day readmission rate for 2009 – 2012 (first six months)
- The rate declined by 26 percent from 2009 - 2012

# TRENDS – QUALITY OF CARE *cont'd*




*SoonerCare Choice members enrolled in a Patient Centered Medical Home
Source: OHCA paid claims

# SoonerCare Choice Evaluation - TRENDS



# TRENDS – COST EFFECTIVENESS

## Evaluation Questions

- Is the SoonerCare program cost effective in terms of health care expenditures?
- Is the SoonerCare program cost effective in terms of administrative expenses?

# Health Expenditures

- Improved program performance must be cost effective to be sustainable
- PHPG used paid claims data to calculate per member per month expenditures for SoonerCare Choice members for the period Jan 2009 to June 2012
- PHPG also evaluated SoonerCare Choice expenditures against the national health care inflation rate

# TRENDS – COST EFFECTIVENESS *cont'd*

## Health Expenditures

- PMPM health expenditures for SoonerCare Choice members* rose modestly from 2009 – 2012, increasing an average of 1.4 percent per year
- During the same period, per capita national health expenditures increased by an average of 3.2 percent per year

***SoonerCare Choice Member PMPM Expenditures***

| Admitting Diagnosis | 2009 | 2010 | 2011 | 2012 (First 6 Mos.) | Avg. Annual Change |
|---|---|---|---|---|---|
| ABD (non-duals) | $863 | $851 | $848 | $862 | ↓0.0% |
| TANF/Other | $205 | $199 | $206 | $225 | ↑3.2% |
| TOTAL | $274 | $264 | $277 | $286 | ↑1.4% |

*Note – Data is for members assigned to a PCMH
Source: OHCA paid claims data

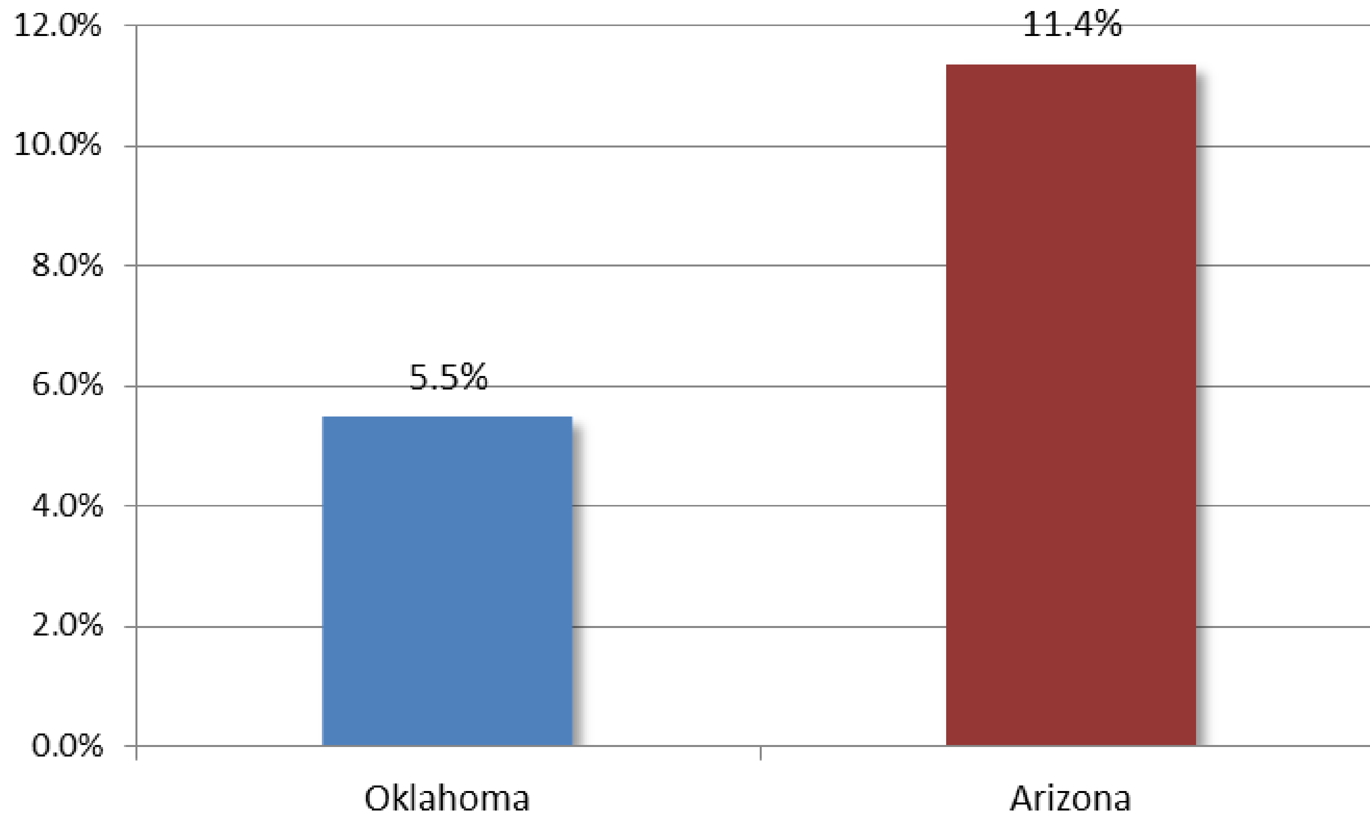
# TRENDS – COST EFFECTIVENESS *cont'd*

## Administrative Expenditures

- The OHCA contracts for some care management activities (e.g., SoonerCare HMP) but otherwise operates as a state managed care plan
- This structure enables the agency to devote a larger share of expenditures to the delivery of care
- States with MCO contracts can have slightly lower agency costs but the difference is typically offset by administrative costs incurred by the managed care organizations
- A national survey of 94 Medicaid MCOs found that 11.6 percent of capitation on average went to administration and an additional 1.3 percent was retained as profit
- PHPG compared Oklahoma to Arizona, which enrolls all Medicaid beneficiaries into MCOs

# TRENDS – COST EFFECTIVENESS *cont'd*

## *Administrative Cost Comparison*




Sources: OHCA 2012 Annual Report; Arizona AHCCCS FY 2013 budget

# FINAL OBSERVATIONS

## Managed Care Organization (MCO) Model

- The majority of states introducing or expanding managed care have done so through MCO contracts
- Among Oklahoma's neighbors, Missouri, Kansas, New Mexico and Texas contract with MCOs, including for ABD members and long term care (Missouri is TANF only)
- The industry is undergoing consolidation and a small number of national MCOs increasingly dominate (although qualified single state and regional plans also participate)
- Seven large plans (Aetna, Anthem Blue Cross, Centene, Health Net, Molina, United, WellCare) have combined enrollment of 6.2 million lives
- These MCOs can bring expertise from existing markets into states implementing or expanding managed care (e.g., Kansas)

# MCO Model *cont'd*

- However, market consolidation and competition among national MCOs also has meant:
  - Lengthier procurements, to allow for resolution of protests by losing organizations (e.g., Ohio program)
  - Willingness on the part of national contractors to depart states if early profit expectations are not met (e.g., Florida and Kentucky programs)
  - MCO model works best when there is a strong partnership with the Medicaid agency, since reforms (e.g., PCMH) must be implemented through the MCOs

## Community-Based Systems of Care

- A smaller number of states, like Oklahoma, have developed managed care programs that:
  - Combine community-based systems of care with support at the state level in the form of chronic care/health management and quality initiatives (either directly administered or purchased)
  - Use market-based incentives to drive and reward holistic, cost-effective care
- Examples of programs similar in concept to SoonerCare Choice include:
  - California – CalOptima Program (Orange County)
  - North Carolina – Community Care of NC/ACCESS
  - Oregon – Coordinated Care Organization (new)
  - Vermont – Global Commitment to Health

# FINAL OBSERVATIONS – MANAGED CARE MODELS

***Managed Care Models – Comparison of Features***

| Component | SoonerCare Choice | MCO Model |
|---|---|---|
| Contracted Network | *Yes* | *Yes* |
| Patient Centered Medical Homes | *Yes* | *Yes* |
| Provider Pay-for-Performance | *Yes* | *Yes* |
| Member Education | *Yes* | *Yes* |
| Medical/Case Management | *Yes* | *Yes* |
| Chronic Care/Health Management | *Yes* | *Yes* |
| Quality Improvement Initiatives | *Yes* | *Yes* |
| Program Oversight/Administration | *State* | *Shared* |
| Stability | *High* | *Variable* |
| Administrative Expense | *5.46%* | *10%+* |

State Plan Amendment Rate Change (SPARC)
October 30, 2013
Inpatient Psychiatric Services - Method Change for Specialty Services

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 Department of Mental Health and Substance Abuse (ODMHSAS) proposes a prospective complexity add-on payment to the specialty per diem base rate for psychiatric residential treatment facilities (PRTF) services, to recognize the increased costs of serving children who have a mental health diagnosis complicated with non-verbal communication. The OHCA has identified three Specialty PRTFs that serve children with mental health diagnoses such as Autism, Reactive Attachment Disorder or Asperger syndrome. The current statewide rate for one of these facilities is not sufficient to cover the direct costs of providing services to this population, and without a rate increase, access to in-state care could be compromised, forcing the Agency to seek placement out-of-state. The proposed add-on is $77.51 per diem.

   Current methodology and/or rate structure.
   The current specialty base rate for in-state PRTFs is $400.05 per day. The rate is prospective, based on 2005 pro forma financial/survey data provided by in-state facilities. Out-of-state specialty rates are usually negotiated. For example, the rate paid to an out-of-state specialty PRTF for deaf children, is $470.33 per day. In addition to the base rate, a facility may receive an intensive treatment services (ITS) per diem for children requiring intensive supports such as 1:1 staffing. The need for this adjustment must be documented in the patient's medical record. A cost-based outlier payment adjustment may also be made on a case-by-case basis for unusually expensive cases.

3. New methodology or rate.
   ODMHSAS proposes a prospective complexity add-on for a patient level characteristic of the specialty PRTF population. The proposed complexity add-on rate for non-verbal children is $77.51 per day. Since there are no psychometric tools or diagnostic criteria specifically for this co-occurring condition, we do not have any data or analysis to determine a specific add-on that is directly related to the challenges of serving this population in a PRTF. Providers attest that there are increased costs for serving children that are non-verbal. These costs will vary based on the age and individual needs of the child, and will impact the direct costs (or labor portion) of the per diem. We averaged the 2012 reported costs of the three current in-state specialty facilities that serve the specific population and the "total" rate was adequate to cover costs. We then compared the costs, patient days, and staffing hours for each facility individually, which varied significantly. We further reviewed the 2009 reported costs of Camelot specialty facility[1] and decided to use this data to calculate the add-on, as we felt this would better reflect the overall costs of an adequately staffed, efficient and economically operated facility. Assuming that 50% of the facility's per diem cost and the current payment rate are for direct costs, we computed the difference. The result was shortfall of $38.11 per day. Since this adjustment is only for a small percentage of the patient population (approximately 15 children), we updated this shortfall by one year CPI (1.68%) and multiplied the result by a factor of 2 to arrive at the add-on. A facility may receive both the complexity add-on per diem in addition to the ITS add-on for a patient, if applicable. Payment will require prior authorization

[1] Camelot was the previous name of Rose Rock prior to change in ownership, which began operations in the state circa 2006.

and the need for this add-on will rely on the competence and administrative documentation of the clinician, (e.g., child does not respond to commands, verbal skills are not reaching age appropriate milestones, points to communicate).

4. Budget estimate.
In 2012, there were 35,628 in-state specialty patient days. We estimate that 15%[2] of the population, or 5,324 days were for children that were non-verbal. The estimated annual budget impact is $412,663, total dollars. We anticipate a December 1, 2014 implementation date, so there will only be a 7-month impact for SFY14; therefore the budget impact would be $240,720 total dollars; $86,611 state dollars. The ODMHSAS has adequate funds to cover the state share of the projected cost of services. The budget impact is budget neutral for the Oklahoma Health Care Authority. All of the increase is represented by increased payments to providers.

5. Agency estimated impact on access to care. It is believed that this rate increase will encourage in-state providers to continue to provide services to complex patients and thus have a positive impact on access to care to individuals who have a specialty mental health diagnosis with non-verbal communication.

6. Rate or Method change in the form of a motion.
The agency requests the State Plan Amendment Rate Committee to approve a new rate methodology for a per diem add-on payment for specialty PRTFs serving children with comorbid specialty mental health and non-verbal conditions.

7. Effective date of change.
December 1, 2013

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[2] It is estimated that 6.3% of children in the general population are likely to be identified with a communication disorder. Source: Communication Disorders: Prevalence and Comorbid Intellectual Disability, Autism, and Emotional/Behavioral Disorders, American Journal of Speech-Language Pathology • Vol. 16 • 359–367 • November 2007.

State Plan Amendment Rate Change (SPARC)
October 30, 2013
Anesthesia Payment Rate Change

1. Is this a "Rate Change" or a "Method Change"?
   Rate change

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

2. Presentation of issue – Why is change being made?
   This change is being requested to increase the anesthesia conversion factor from the budget reduction conversion factor of $30.48 ($31.50 default) to $39.00 for CPT codes 00100 – 01966 and 01968 – 01999. CPT code 01967 (analgesia / anesthesia for vaginal delivery) will continue to pay at a flat fee; the flat fee will increase from the budget reduction max fee of $411.19 ($425.00 default) to $550.00

   In 2006 during a work group meeting involving the Oklahoma Health Care Authority (OHCA) and other state agency (OSA) representatives a proposal was introduced to use two State of Oklahoma agencies' conversion factors as a benchmark for the OHCA program.

   At that time, the Oklahoma state employee insurance company, HealthChoice, reimbursed anesthesiologists using a conversion factor of $45 and the Oklahoma Workers Compensation Court Schedule of Medical and Hospital Fees allowed for a conversion factor of $39.00. OHCA set a conversion factor of $39.00 as the goal.

   Currently (1/1/2013) HealthChoice is using a conversion factor of $55.00 and the Oklahoma Workers Compensation Court Schedule of Medical and Hospital Fees is using $46.58.

3. Current methodology and/or rate structure.
   OHCA currently uses an industry standard anesthesia reimbursement methodology based on a formula involving base units and time units multiplied by a conversion factor.

4. New methodology or rate.
   The change is to increase the conversion factor from $30.48/$31.50 to $39.00.

5. Budget estimate.
   The annual total dollar impact is $8,498,332; state share $3,057,700. OHCA is planning a Jan 1 implementation date so there would only be a 6 month impact in SFY2014. The 6 month impact is 4,249,166 total dollars; 1,528,850 state share.

6. Agency estimated impact on access to care.
   This rate increase will encourage providers to participate in the Medicaid program and thus have a positive impact on access to care.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve a rate change for all anesthesia providers.

8. Effective date of change.
   January 1, 2014