OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
April 11, 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 March 14, 2013 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
    c) Legislative Committee – Member Bryant

Item to be presented by Nico Gomez, Chief Executive Officer

4. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Carrie Evans, Chief Financial Officer
    b) Medicaid Director's Update – Garth Splinter, State Medicaid Director
    c) Legislative Update – Carter Kimble, Government Affairs Liaison

Item to be presented by Melody Anthony, Provider Services Director

5. Discussion Item - Design and Implementation of the Provider Services Strategic Provider Recruitment Plan and the Current Status of the Patient Centered Medical Home Network

Item to be presented by Howard Pallotta, General Counsel

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

Item to be presented by Nancy Nesser, Pharmacy Director

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

    a) Consideration and vote to add **Chronic Obstructive Pulmonary Disease Medications** to the product-based prior authorization program under OAC 317:30-5-77.3.

    b) Consideration and vote to add **Linzess™ (linaclotide)** and **Select Oral Corticosteroid Medications** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

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) and (7)

    a) Discussion of Pending Litigation and Claims

9. New Business

10. ADJOURNMENT

NEXT BOARD MEETING
May 9, 2013
Oklahoma Health Care Authority
Ponca Conference Room

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
March 14, 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 March 13, 2013, 11:00 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 March 13, 2013, 12:00 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 McVay, Member Nuttle
BOARD MEMBERS ABSENT:	Member Robison

OTHERS PRESENT:	OTHERS PRESENT:
Traylor Rains, ODMHSAS	Will Widman, HP
Lisa Spain, HP	Charles Brodt, HP
Catina Baker, OHCA	Brent Wilburn, OKPCA
David Dude, American Cancer Society	Debbie Spaeth, OPBHAC
Kasie Wren, OHCA	Shirley Russell, OKDHS
Leah Taylor, OHCA	Terry Cothran, PMC

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD ON JANUARY 10, 2013 AND FEBRUARY 14, 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 Miller moved for approval of the January 10, 2013 and February 14, 2013 board minutes as published. Vice-Chairman Armstrong seconded.
FOR THE MOTION:	Chairman McFall, Member McVay, Member Bryant, Member Nuttle
ABSENT:	Member Robison

ITEM 3 / REPORTS TO THE BOARD BY BOARD COMMITTEES

Audit/Finance Committee

Member Miller reported that the financial report continues to look good and noted that we have an additional $5 million in surplus money that wasn't spent. The committee discussed some of the issues of transition with the Department of Mental Health and at this point foresees a successful year without having to ask for additional money. Member Miller stated that the new enrollee count changed from the previous month with about 7,000 fewer members due to reconciliation of some membership and cleaning out some files that were no longer active.

Strategic Planning Committee

Vice Chairman Armstrong stated that the strategic planning committee did meet and discussed a plan for the committee to discuss the Leavitt group and organizational changes within the Oklahoma Health Care Authority.

Legislative Committee

Member Bryant noted that the legislative committee met and Ed Long will give a full report to the board.

Rules Committee

Vice Chairman Armstrong stated that the rules committee did meet and Cindy went over the rules in today's packet.

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 January and we continue to be under budget $21.3 million state dollar variance. We continue to be under budget in our program expenditures and administration and most of our revenues continue to be over budget. She noted that we are in a good position for the seventh month of our fiscal year and it appears we will run slightly under through March. For more detailed information, see Item 4a in the board packet.

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

Dr. Splinter reported that the total enrollment was at 810,000 for the end of January which was a drop of about 7,100 which is within the normal fluctuation amounts. He noted that the lower cost for SoonerCare traditional is up a little. Dual eligibles continue to drift up to 108,000 enrollees with the nursing home population staying flat at about 15,600 with a cost of about $4,100 per month. Dr. Splinter stated that provider contracts are just under 36,000 with 28,300 being in-state. All categories look good and reported that the dentists are at 1,200 in-state for a total of almost 1,400. Patient-centered medical home continues to go up for a total of about 1,900. He reported payments for electronic health records at 1,640 for a total of $103 million. Dr. Splinter reported on two grants that the medical division received recently: Adult Measurement grant and the Strong Start grant. For more detailed information, see Item 4b in the board packet.

Chairman Ed McFall commented on the press that we are getting saying if we did the ACA rollout is that we don't have enough physicians in the state to handle the increase of enrollment and he wanted to point out that we are only 45% and this report is what the physicians report back to us, that they could handle 55% more patients. Dr. Splinter noted that we do have the capacity in the system.

Dr. Sylvia Lopez reported on the two grants that were awarded by CMS: Adult Measurement grant and the Strong Start grant. The Adult Measurement grant is a 2 year grant with an award of $1 million per year with a goal to support states in developing their capacity for standardized collection and reporting of data on the quality of healthcare. The Strong Start grant was awarded last month with a goal to reduce the prematurity rate of participants and to do so in a cost effective manner. Dr. Lopez noted that OHCA was one of fifteen recipients from across the country. The award is for a little over $1 million over 4 years with 3 years of clinical and 1 year being data analysis. We have three clinical partners involved in the grant: the Oklahoma City Indian Clinic, the Choctaw Tribal Clinic and the Oklahoma State University Department of Obstetrics.

4c. LEGISLATIVE UPDATE
Ed Long, Government Affairs Liaison

Mr. Long took a moment to recognize the incredible governmental affairs team of OHCA. He reported that when session started, there were more than 2,500 active bills and as of March 6th, we are at 935 active bills. 78 of those bills are said to have effect on the agency. Mr. Long stated that there are 5 bills in the house that deal with rules that changes language and that will need active approval of each rule. There is a bill that specifically addresses the emergency rules that makes the process more difficult. House Bill 2055 passed out of the house today that will repeal the Administrative Procedures Act. House Bill 1552 is a managed care bill that would move us to a capitated managed care program that has passed out of the house and going to the senate. House Bill 2086 directs us to do a cost benefit analysis to determine if it's beneficial to keep the SoonerCare pharmacy plan in-house or if we should bid that out. Mr. Long stated that House Bill 2151 directs the OHCA to do pilot studies looking at health savings accounts and high deductible policies for women and children. House Bill 1031 extends the SHOPP program which currently expires the end of calendar year 2014 and would extend it to year 2017. Senate Bill 231 has to do with dispersing funds. Senate bill 272 directs the OHCA to conduct a feasibility study that would look at a managed care model for dual eligibles. For more detailed information, see Item 4c in the board packet.

Nico Gomez noted a few organizational changes and stated that we created an Electronic Health Operations unit designed to realign several existing agency functions and putting them together in one unit to focus on e-health and will be user focused. He also stated that the SoonerCare Eligibility Unit will be moving from Insure Oklahoma to Member Services. Mr. Gomez noted that effective tomorrow the Opportunities for Living Life will be realigning some work flow to create efficiencies that will better meet the needs of our members.

ITEM 5 / PRESENTATION OF MANAGEMENT INFORMATION SYSTEM CHANGES
Lynn Puckett, Contract Services Director & Adolph Maren, Electronic Health Operations Director

Ms. Puckett stated that in 2011 we began work on re-procurement enhancements which gave us increased capacity to process things. OHCA also did infrastructure upgrades that will allow us to grow and keep our current speeds up. There were changes to our external correspondence services such as being able to send out emails to providers, track return mail and update addresses which has a big impact and cost savings for OHCA. Ms. Puckett said that we will be replacing and enhancing our provider portal.

Mr. Maren stated that CMS has allowed for a delay in implementing the ICD-10 from October of this year to October of 2014 however we were able to get all of the modifications completed and could have launched October 2013 but will do additional testing to ensure that our system is flawless. In July, we will ask providers to help us test the modifications and will provide education for providers with that extra year. Mr. Maren discussed program integrity and program integrity case tracker that will keep documentation in one place. He discussed the HIE, also known as the Oklahoma Patient Information Exchange, which should become operational in the beginning of 2014 and is used to present SoonerCare specific health information to our providers in a secure private manner through a portal viewer and an interface directly into the providers EHR.

ITEM 6 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Nicole Nantois, Deputy General Counsel

Ms. Nantois stated that there were no conflicts.

ITEM 7 / CONSIDERATION AND VOTE OF AUTHORITY FOR EXPENDITURE OF FUNDS FOR OFFICE FURNITURE FOR THE NEW BUILDING
James Smith, Chief of Staff

Action Item - Consideration and Vote of Authority for Expenditure of Funds for Office Furniture for the New Building

MOTION:	Member Nuttle moved for approval of item 7 as published. Member Bryant seconded.
FOR THE MOTION:	Chairman McFall, Member Miller, Vice-Chairman Armstrong, Member McVay
ABSENT:	Member Robison

ITEM 8 / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED PERMANENT RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT
Cindy Roberts, Deputy CEO Planning, Policy & Integrity Division

The following permanent rules HAVE previously been approved by the Board and the Governor under Emergency rulemaking. These rules have been REVISED for Permanent Rulemaking.

A. AMENDING Agency rules at OAC 317:30-5-240, 30-5-240.1, 30-5-240.2, 30-5-240.3, 30-5-241, 30-5-241.2, 30-5-241.3, 30-5-248, 30-5-276, 30-5-281, 30-5-595 and 30-5-596.1 to disallow coverage of Psychosocial Rehabilitation (PSR) services for children below age 6 unless services are medically necessary and required pursuant to Federal Early and Periodic Screening Diagnostic and Treatment (EPSDT) laws. The Agency is also proposing rule revisions which will control utilization of Rehabilitation services by imposing limits on the number of units that qualified providers will be reimbursed. The utilization limits will be prior authorized by OHCA or its designated agent and will be directly correlated to the individual member's level of need. Utilization parameters will be increased for Medication Training and Support. Revised rules also change the provider qualifications for Behavioral Health Rehabilitation Specialists including specific degree, certification & training requirements. Proposed revisions to Behavioral Health Case Management rules change provider qualifications for Case Managers including specific degree and training requirements as well as remove documentation submission requirements as a condition of payment for the provision of case management services. Revisions are also proposed to clearly state that services must be conducted in a setting that protects and assures

confidentiality, and must be provided as a direct face to face service with the member in order to be compensable. Licensed Behavioral Health Provider rules are revised to correct references to the Agency's behavioral health provider manual. Rules are also revised to make clean-up changes to certain provisions that are outdated or no longer applicable.
(Reference APA WF # 12-19)

MOTION:	Member Miller moved for approval of item 8A as published. Vice-Chairman Armstrong seconded.
FOR THE MOTION:	Chairman McFall, Member Bryant, Member Nuttle, Member McVay
ABSENT:	Member Robison

The following permanent rules HAVE previously been approved by the Board and the Governor under Emergency rulemaking.

B. AMENDING Agency rules at OAC 317:30-5-482 and AMENDING agency rules at OAC 317:40-5-110 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 # 12-01A & B)

C. AMENDING Agency rules at OAC 317:35-5-41.6 for SoonerCare financial eligibility rules for Long Term Care services to increase the income cap for the Medicaid Income Pension Trust (or Miller Trust) to the average monthly cost of nursing home care. This change affects financial eligibility rules for all long term care programs, including the waiver programs for Home and Community Based Services. (Reference APA WF # 12-06)

D. AMENDING Agency rules at 317:30-5-291, 30-5-296, and 30-5-676 to comply with federal law, which requires a prescription or referral from a physician or practitioner of the healing arts before therapy services are rendered. Policy is also revised to require a prior authorization for speech therapy services.
(Reference APA WF # 12-07)

E. AMENDING Agency rules at 317:30-3-25 and 30-5-122 to allow 100% payment of Medicare Crossover deductibles and coinsurance at skilled nursing facilities. Current policy allows payment at the Medicaid rate, which was previously adjusted to 0%. The rationale behind current policy is based on a federal policy that allowed federal reimbursement/write-offs for bad debts. That federal policy is no longer in effect and has prompted the policy amendment request.
(Reference APA WF # 12-09)

MOTION:	Member Bryant moved for approval of items 8B through 8E as published. Member McVay seconded.
FOR THE MOTION:	Chairman McFall, Member Miller, Vice-Chairman Armstrong, Member Nuttle
ABSENT:	Member Robison

The following permanent rules HAVE NOT previously been approved by the Board.

F. AMENDING Agency rules at OAC 317:30-5-355.1, 30-5-359.2 and 30-5-361 to allow Rural Health Clinic's to bill lab services separately, as they can under Medicare. RHC policy is also updated to eliminate language that is inapplicable to OHCA's current operational practices.
(Reference APA WF # 12-03)

G. AMENDING Agency rules at OAC 317:30-5-761, 30-5-763, 30-5-763.1, 30-5-764, 35-17-3 and 35-17-14 for the ADvantage Waiver are revised to establish a maximum annual reimbursement cap for Hospice services in order to prevent members from exceeding the individual waiver cost limit. Currently hospice service expenditures are the primary basis for members exceeding the individual ADvantage Waiver cost limit. Rules are also revised to disallow an active Power of Attorney from being a paid caregiver for members self-directing their services, increase the maximum hours of Adult Day Health Services from six hours per day to eight hours per day, and add Skilled Nursing as an allowable service. Finally, rules are revised to clarify criteria for member health and safety, clarify the member/provider dispute resolution process and include other minor policy clarifications.
(Reference APA WF # 12-04A & B)

H. AMENDING Agency rules at OAC 317:30-5-1200, 30-5-1202 and 30-5-1203 for the Living Choice demonstration program to include clarification for the billing of Institutional Case Management Transition services and the inclusion of additional services for persons with physical disabilities and long term illnesses. Additional services added are Assisted Living Services and Private Duty Nursing. Assisted Living Services are services such as personal care and other supportive services furnished to members in an OHCA certified assisted living center. Rules are also revised to add an option for self-direction. Self-direction allows members, as the employer of record, to hire individual providers for Personal Care services, Advanced Supportive/Restorative services and Respite services.
(Reference APA WF # 12-05)

I. AMENDING Agency rules at OAC 317:30-5-4, 30-5-394, 30-5-413, 30-5-424, 30-5-483, 30-5-499, 30-5-519 and 30-5-538 to remove references to the ICD-9 International Classification of Diseases diagnosis coding, which is being replaced by a new system of coding, ICD-10.
(Reference APA WF # 12-13)

J. ADDING Agency rules at OAC 317:30-5-229 and 30-5-890.1 and AMENDING Agency rules at OAC 317:30-5-225, 30-5-226, 30-5-890 and 30-5-891 to align Nurse Midwifes and Birthing Center services with current obstetric policy. Proposed changes include clarification concerning the type of nurse midwife approved to provide SoonerCare coverage, and the coverage the nurse midwife can provide to eligible members. Additionally, proposed revisions include clean-up to remove language that references outdated practices concerning enrollment, and format changes for consistency and clarity purposes.
(Reference APA WF # 12-14)

K. AMENDING Agency rules at OAC 317:30-3-27 to include specific provider responsibilities to assure compliance with HIPAA guidelines. Current policy is silent to appropriate HIPAA compliant applications, guidelines, devices, and/or safeguards concerning telemedicine services. The proposed revisions include additional conditions that apply to services rendered via telemedicine, provider responsibilities, and additional network standards as they relate to assuring HIPAA compliance during telemedicine related transmissions.
(Reference APA WF # 12-20)

L. AMENDING Agency rules at OAC 317:30-5-335.1, 30-5-336.4, 30-5-336.5, 30-5-336.9 and 30-336.13 to update ambulance transportation policy for clarity and consistency. Proposed revisions add definitions for emergency and urgent, and include language that will require a prior authorization for out of state transports. Additional revisions include clean-up to remove outdated policy to align with current practice and to clarify medically necessity requirements for air ambulance services.
(Reference APA WF # 12-22)

M. ADDING Agency rules at OAC 317:30-3-64, AMENDING Agency rules at OAC 317:30-5-327 and 35-3-2 and REVOKING Agency rules at OAC 317:30-5-328 to clarify OHCA's current SoonerCare non-emergency transportation policy concerning meals and lodging, and eligibility. Proposed revisions will move meals and lodging policy to "General Medical Program Information" for clarification purposes. Additional revisions include updating outdated reference to the code of federal regulation concerning non-emergency transportation. Proposed revisions will define lodging for clarification purposes, and include eligibility requirements for escorts if SoonerCare member is removed from his/her home and appointed a temporary guardian.
(Reference APA WF # 12-23A & B)

N. AMENDING Agency rules at OAC 317:45-1-2 and 45-11-10 to align policy with state and federal requirements; additionally rules are revised to align adult outpatient behavioral health services with children outpatient behavioral health services in the Individual Plan.
(Reference APA WF # 12-24)

O. AMENDING Agency rules at OAC 317:30-5-699 and 30-5-700 to align with current practice and language contained in OAC 317:30-5-699. In addition, OAC 317:30-5-700 (C) Orthodontic rules are revised to align OHCA current verification of continuing education policy with the Oklahoma Board of Dentistry prerequisite licensing requirement. The amendment change to OHCA policy will require all General and Pediatric dentists providing orthodontic care to complete 60 hours of continuing education hours and at least 20 hours of continuing education in the field of orthodontics every (3) three year cycle.
(Reference APA WF # 12-25)

P. AMENDING Agency rules at 317:40-5-5 and 40-5-55 and REVOKING Agency rules at OAC 317:40-5-61 to clarify SoonerCare Home and Community Based Waiver Services (HCBS) programs for persons with intellectual disabilities responsibilities for Agency Companion providers and Specialized Foster Care providers regarding reporting requirements when there are allegations of member maltreatment. The rules clarify that the Office of Client Advocacy must be contacted in the event of allegations of maltreatment involving an adult and an abuse hotline must be utilized in the event that the maltreatment involves a child. Rules are also amended to clarify that the Agency Companion must obtain prior approval from the member's representative payee before making purchases over $50 on behalf of the member.
(Reference APA WF # 12-27)

Q. AMENDING Agency rules at OAC 317:35-9-68 and 35-19-21 to clarify that a member receiving Home and Community Based Services (HCBS) (such as ADvantage) is considered a community spouse for the purpose of calculating the community spouse allowance when his/her spouse is in a nursing facility. This amendment brings the rules into compliance with Federal law and regulation and the State Plan. It allows the spouse in the nursing facility to deem income to the spouse who remains at home, regardless of whether that spouse is receiving HCBS, before the vendor payment owed to the nursing facility is calculated.
(Reference APA WF # 12-29)

R. AMENDING Agency rules at OAC 317:50-1-3, 50-1-6 and 50-1-14 to add Institutional Transition Services and Self-Directed Goods and Services to the Medically Fragile Waiver Program. Additional revisions include removing language that does not align with program practices, for consistency and clarity purposes.
(Reference APA WF # 12-30)

S. AMENDING Agency rules at 317:50-3-3, 50-3-6 and 50-3-14 to add Institutional Transition Services, Assisted Living and Self-Directed Goods and Services to the My Life; My Choice Waiver Program. Additional revisions include removing language that does not align with program practices, for consistency and clarity purposes.
(Reference APA WF # 12-31)

T. AMENDING Agency rules at OAC 317:50-5-3, 50-5-6 and 50-5-14 to add Institutional Transition Services, Assisted Living and Self-Directed Goods and Services to the Sooner Seniors Waiver Program. Additional revisions include removing language that does not align with program practices, for consistency and clarity purposes.
(Reference APA WF # 12-32)

U. AMENDING Agency rules at OAC 317:30-5-58 to clarify SHOPP overpayment and recoupment procedures, if it is determined due to appeal, penalty, or other reason that additional allocation/ recoupment fund is necessary.
(Reference APA WF # 12-33)

V. AMENDING Agency rules at OAC 317:35-15-8 and 35-15-13.2 to clarify State Plan Personal Care compliance with the Long Term Care Security Act regarding background checks for providers of long term care services. Personal Care is assistance to a qualifying SoonerCare member in carrying out activities of daily living, such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry or errands directly related to the member's personal care needs. Personal Care is provided to assure personal health and safety of the member or to prevent or minimize physical health regression or deterioration. Background checks are required for all Personal Care providers prior to the provision of services.
(Reference APA WF # 12-34)

W. AMENDING Agency rules at OAC 317:30-5-14 to allow for reimbursement of a separately payable administration fee for vaccines given to adults. Further, the policy clarifies Vaccine for Children Program administration fee rules.
(Reference APA WF # 12-35)

X. AMENDING Agency rules at OAC 317: 30-5-221 and 30-5-223 to expand genetic counseling services to all members that are eligible for medically necessary genetic testing. Currently, OHCA only covers genetic counseling for members with a pregnancy at high risk of genetic abnormalities.
(Reference APA WF # 12-37)

Y. AMENDING Agency rules at OAC 317:30-3-28 to account for changes in federal rules on the Oklahoma Electronic Health Records Incentive Program. Changes include adding additional options for patient volume calculation, expanding the definition of a Children's Hospital, adding an exception to the hospital-based eligible professional criteria, and allowing CMS to take over administrative appeals for cases in which they are they auditor on meaningful use provisions.
(Reference APA WF # 12-38)

AA. AMENDING Agency rules at OAC 317:30-5-2 to define the circumstances under which genetic testing will be covered by OHCA. Both the volume and cost of genetic testing are growing, and the growth rates are expected to rise significantly going forward. Currently, OHCA has no written policy addressing the medical necessity of genetic testing, although claims are being paid through nonspecific laboratory codes. Policy will set medical necessity criteria similar to other states' Medicaid programs and private insurance, which requires the member to undergo a genetic risk assessment or display clinical evidence indicating a chance of a genetic abnormality AND that those results change treatment, change health monitoring, provide prognosis, or provide information needed for genetic counseling for the patient.
(Reference APA WF #12-39)

BB. AMENDING Agency rules at OAC 317:30-5-95.25, 30-5-95.29, 30-5-95.33 through 30-5-95.35, 30-5-95.37, and 317:30-5-95.41 and 30-5-95.42 to clarify the medical necessity criteria required for admission and continued stays in psychiatric residential treatment facility (PRTF) and acute levels of care. Changes are also being proposed to the

rules regarding Individual Plans of Care to ensure early parent/guardian involvement in the treatment of children under the age of 18 receiving inpatient psychiatric services as well as to revise the "active treatment" requirements for individuals 18-21 years of age receiving services in an acute psychiatric hospital by making the requirements less proscriptive for this age group since they typically do not receive services in children's psychiatric units, so these facilities should not be held to the same requirements. Active treatment requirements for children under 18 are further revised to provide more clarity in areas that have been identified as causing provider confusion. Proposed revisions will also revise Inspection of Care (IOC) rules to provide the pro-rating timeline used when reviewing clinical documentation for compliance with active treatment requirements as well as to clarify that certain "critical documents" cannot be substituted with other evaluations/assessments. Rules are also revised to make clean-up changes to certain provisions that are outdated or no longer applicable.
(Reference APA WF # 12-40)

CC. REVOKING Agency rules at OAC 317:30-3-70, 30-3-71, 30-3-75, 30-3-77, 30-3-81, 30-3-85, 30-3-86 and 30-3-87 included in the Provider Manual (Chapter 30). All topics covered in the obsolete sections are already covered in Chapter 35 of agency rules. ADDING Agency rules at OAC 317:35-5-60, 35-5-63, 35-5-64, 35-6-39, 35-6-40, 35-6-41, 35-6-42, 35-6-43, 35-6-44, 35-6-50, 35-6-51, 35-6-52, 35-6-53, 35-6-54, and 35-6-60.1, AMENDING Agency rules at OAC 317:35-1-1, 35-1-2, 35-1-3, 35-5-1, 35-5-2, 35-5-6, 35-5-6.1, 35-5-7, 35-5-8, 35-5-43, 35-5-44, 35-5-45, 35-5-46, 35-6-1, 35-6-15, 35-6-35, 35-6-36, 35-6-37, 35-6-60, 35-6-61, 35-7-48, 35-7-60.1, 35-9-67, 35-9-75, 35-10-10, 35-10-25, 35-10-26, 35-13-1, 35-13-2, 35-15-5, 35-15-6, 35-15-7, 35-19-19, 35-19-20, 35-19-22 and 35-21-13, REVOKING Agency rules at OAC 317:35-6-38, 35-7-15, 35-7-35, 35-7-37, 35-7-63, 35-7-64, 35-7-65, 35-7-66 and RESERVING Agency rules at OAC 35-5-61 and 35-5-62 to provide that eligibility for children, pregnant women, and parents and caretaker relatives is determined using the Modified Adjusted Gross Income (MAGI) methodology, as mandated by federal law. Rules are amended to add two eligibility groups mandated by federal law: former foster care children aged 19-26 and CHIP children who would lose eligibility as a result of the MAGI method. Rules regarding eligibility determination procedures are amended to establish the passive renewal process mandated by federal law, as well as the federal rule that medical verification of pregnancy can only be required when the individual's declaration that she is pregnant is not reasonably compatible with other information available to the agency.

Eligibility rules are also amended to add the mandatory eligibility group of children receiving Kinship Guardianship Assistance. Because the State has established a kinship guardianship assistance program, SoonerCare eligibility is mandated by federal laws and regulations. These amendments will provide eligibility coverage whether the child receives the assistance through the program established by OKDHS or through kinship guardianship programs that may be established by tribes in the future.

In addition, eligibility rules are amended to eliminate presumptive eligibility (PE) for pregnant women. Under the PE program, certain qualified SoonerCare providers used to determine pregnant women presumptively eligible for SoonerCare; the women then had 30 days to apply and be fully determined eligible or ineligible. The purpose of PE was to give pregnant women access to care quickly. PE is no longer used because pregnant women can now have their eligibility fully determined in real-time through Online Enrollment.
Obsolete eligibility rules included in the Provider Manual (Chapter 30) are revoked. All topics covered in the obsolete sections are covered in Chapter 35 of agency rules.
(Reference APA WF # 12-41A & B)

DD. AMENDING Agency rules at OAC 317:30-5-66 and 30-5-67 to update Long Term Care (LTC) Sub-Acute Hospitals reimbursement language from a prospective per diem methodology to a cost based methodology. This revision is proposed to bring policy in alignment with the approved Medicaid State Plan reimbursement methodology and current practice. Additionally, the proposed rule change clarifies cost reporting requirements related to the reimbursement methodology for these facilities. (Reference APA WF # 12-42)

EE. AMENDING Agency rules at OAC 317:30-5-131.1, 30-5-131.2, 30-5-132 and 30-5-133 to add language clarifying that all program requirements set out in State Statute and Oklahoma Health Care Authority policy regarding wage enhancements for certain nursing facility employees have been met. The proposed rule change also clarifies that the Quality of Care fee assessed by the Oklahoma Health Care Authority is authorized through the Medicaid State Plan and clarifies that part of the fee structure is based on a waiver of uniformity as approved by the Centers for Medicare and Medicaid Services (CMS). Finally, proposed revisions include the removal of language incorrectly stating that rates for public ICF's/MR are set through a public rate setting process rather th an the current practice of reimbursement based on cost reports. Other minor policy clarifications are also included as a part of the proposed rule change.
(Reference APA WF # 12-43)

MOTION:	Member McVay moved for approval of items 8F through 8EE as published. Vice-Chairman Armstrong seconded.
FOR THE MOTION:	Chairman McFall, Member Miller, Member Bryant, Member Nuttle
ABSENT:	Member Robison

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)
Nicole Nantois, Deputy General Counsel

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

MOTION:	Vice-Chairman Armstrong moved for approval to go into Executive Session. Member McVay seconded.
FOR THE MOTION:	Chairman McFall, Member Miller, Member Bryant, Member Nuttle
ABSENT:	Member Robison

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

   a) Discussion of Pending Litigation and Claims
   b) 2013 CEO Evaluation

ITEM 10 / NEW BUSINESS

There was no new business.

ITEM 11 / ADJOURNMENT

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

Meeting adjourned at 3:00 p.m., 3/14/2013

NEXT BOARD MEETING
April 11, 2013
Oklahoma Health Care Authority
Ponca Conference Room
2401 NW 23rd, Suite 1A
Oklahoma City, OK 73107

Lindsey Bateman
Board Secretary

Minutes Approved: _____

Initials: _____

FINANCIAL REPORT

For the Eight Months Ended February 28, 2013
Submitted to the CEO & Board
April 11, 2013

- Revenues for OHCA through February, accounting for receivables, were **$2,489,858,967** or **(1.1%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,468,910,844** or **1.7% under** budget.
- The state dollar budget variance through February is **$14,294,094 positive.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		15.1
Administration		7.5
Contingent Liability		(11.0)
Revenues:		
Taxes and Fees		(.9)
Drug Rebate		2.3
Overpayments/Settlements		1.3
Total FY 13 Variance	**$**	**14.3**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2013, For the Eight Months Ended February 28, 2013

REVENUES	FY13 Budget YTD	FY13 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 610,822,008	$ 610,822,008	$ -	0.0%
Federal Funds	1,322,302,969	1,297,079,933	(25,223,036)	(1.9)%
Tobacco Tax Collections	40,110,680	39,109,004	(1,001,676)	(2.5)%
Quality of Care Collections	41,293,657	41,293,657	-	0.0%
Prior Year Carryover	53,075,735	53,075,735	-	0.0%
Federal Deferral - Interest	80,641	80,641	-	0.0%
Contingent Liability	-	(11,000,000)	(11,000,000)	0.0%
Drug Rebates	119,688,312	126,086,029	6,397,717	5.3%
Medical Refunds	31,287,294	34,725,424	3,438,130	11.0%
SHOPP	285,275,923	285,275,923	-	0.0%
Other Revenues	13,195,768	13,310,613	114,845	0.9%
TOTAL REVENUES	**$ 2,517,132,987**	**$ 2,489,858,967**	**$ (27,274,020)**	**(1.1)%**

EXPENDITURES	FY13 Budget YTD	FY13 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 31,595,214**	**$ 27,262,941**	**$ 4,332,273**	**13.7%**
ADMINISTRATION - CONTRACTS	**$ 84,946,102**	**$ 78,771,315**	**$ 6,174,787**	**7.3%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	22,859,772	22,497,205	362,568	1.6%
Acute Fee for Service Payments:				
Hospital Services	591,200,568	573,795,023	17,405,545	2.9%
Behavioral Health	13,231,958	12,672,410	559,548	4.2%
Physicians	317,089,509	316,405,546	683,962	0.2%
Dentists	100,287,682	98,165,176	2,122,505	2.1%
Other Practitioners	48,271,295	47,696,774	574,522	1.2%
Home Health Care	15,250,660	14,447,920	802,740	5.3%
Lab & Radiology	40,395,994	39,470,079	925,914	2.3%
Medical Supplies	34,187,180	34,244,989	(57,810)	(0.2)%
Ambulatory/Clinics	76,081,858	74,646,422	1,435,436	1.9%
Prescription Drugs	264,718,751	263,794,665	924,086	0.3%
OHCA TFC	2,167,456	1,662,302	505,153	0.0%
Other Payments:				
Nursing Facilities	360,802,644	357,097,268	3,705,377	1.0%
ICF-MR Private	39,002,998	39,358,428	(355,430)	(0.9)%
Medicare Buy-In	87,156,421	86,539,559	616,862	0.7%
Transportation	41,364,076	41,062,573	301,502	0.7%
MFP-OHCA	1,057,813	1,032,609	25,204	0.0%
EHR-Incentive Payments	24,631,023	24,631,023	-	0.0%
Part D Phase-In Contribution	52,078,589	51,644,601	433,988	0.8%
SHOPP payments	262,012,013	262,012,013	-	0.0%
Total OHCA Medical Programs	**2,393,848,259**	**2,362,876,588**	**30,971,671**	**1.3%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,510,478,957**	**$ 2,468,910,844**	**$ 41,568,113**	**1.7%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 6,654,029**	**$ 20,948,123**	**$ 14,294,094**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2013, For the Eight Months Ended February 28, 2013

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 22,798,738	$ 22,484,132	$ -	$ 301,533	$ -	$ 13,073	$ -
Inpatient Acute Care	468,876,465	356,973,830	324,458	6,852,728	34,482,976	1,252,063	68,990,410
Outpatient Acute Care	187,902,423	177,716,613	27,736	7,140,727	-	3,017,348	-
Behavioral Health - Inpatient	15,633,658	8,048,233	-	419,424	-		7,166,002
Behavioral Health - Psychiatrist	4,624,177	4,624,177	-	-	-	-	-
Behavioral Health - Outpatient	14,120,015	-	-	-	-	-	14,120,015
Behavioral Health Facility- Rehab	180,575,331	-	-	-	-	69,243	180,575,331
Behavioral Health - Case Management	5,272,295	-	-	-	-	-	5,272,295
Behavioral Health - PRTF	67,684,740	-	-	-	-	-	67,684,740
Residential Behavioral Management	12,790,751	-	-	-	-	-	12,790,751
Targeted Case Management	44,112,391	-	-	-	-	-	44,112,391
Therapeutic Foster Care	1,662,302	1,662,302	-	-	-	-	-
Physicians	352,799,502	269,633,935	38,734	9,437,317	42,188,070	4,544,807	26,956,639
Dentists	98,220,516	92,667,617	-	55,339	5,460,488	37,071	-
Mid Level Practitioners	2,637,327	2,571,983	-	61,626	-	3,719	-
Other Practitioners	45,286,143	44,135,605	297,576	165,071	677,662	10,230	-
Home Health Care	14,447,955	14,436,481	-	35	-	11,439	-
Lab & Radiology	41,771,529	39,001,523	-	2,301,449	-	468,556	-
Medical Supplies	34,769,988	32,481,415	1,721,610	524,998	-	41,964	-
Clinic Services	77,397,021	67,669,541	-	1,053,298	-	184,103	8,490,079
Ambulatory Surgery Centers	7,138,776	6,778,249	-	345,998	-	14,529	-
Personal Care Services	8,297,098	-	-	-	-	-	8,297,098
Nursing Facilities	357,097,268	217,860,217	111,792,092	-	27,435,882	9,077	-
Transportation	40,871,536	37,023,321	1,717,016	-	2,096,170	35,029	-
GME/IME/DME	83,315,193	-	-	-	-	-	83,315,193
ICF/MR Private	39,358,428	32,131,856	6,673,096	-	553,476	-	-
ICF/MR Public	35,988,535	-	-	-	-	-	35,988,535
CMS Payments	138,184,160	136,640,592	1,543,568	-	-	-	-
Prescription Drugs	277,087,636	232,113,854	-	13,292,971	30,485,348	1,195,463	-
Miscellaneous Medical Payments	191,661	189,479	-	624	-	1,558	-
Home and Community Based Waiver	108,370,765	-	-	-	-	-	108,370,765
Homeward Bound Waiver	58,665,166	-	-	-	-	-	58,665,166
Money Follows the Person	2,364,174	1,032,609	-	-	-	-	1,331,565
In-Home Support Waiver	15,272,425	-	-	-	-	-	15,272,425
ADvantage Waiver	118,242,849	-	-	-	-	-	118,242,849
Family Planning/Family Planning Waiver	6,908,492	-	-	-	-	-	6,908,492
Premium Assistance*	33,897,427	-	-	33,897,427		-	-
EHR Incentive Payments	24,631,023	24,631,023	-	-	-	-	-
SHOPP Payments**	262,012,013	262,012,013	-	-	-	-	-
Total Medicaid Expenditures	**$ 3,311,277,894**	**$1,822,508,587**	**$ 124,135,886**	**$ 75,850,565**	**$ 143,380,072**	**$ 10,909,273**	**$ 872,550,741**

* Includes $33,644,983.82 paid out of Fund 245 and **$262,012,012.82 paid out of Fund 205

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2013, For the Eight Months Ended February 28, 2013

REVENUE		FY13 Actual YTD
Revenues from Other State Agencies	$	357,984,609
Federal Funds		560,097,606
TOTAL REVENUES	**$**	**918,082,216**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	108,370,765
Money Follows the Person		1,331,565
Homeward Bound Waiver		58,665,166
In-Home Support Waivers		15,272,425
ADvantage Waiver		118,242,849
ICF/MR Public		35,988,535
Personal Care		8,297,098
Residential Behavioral Management		10,512,778
Targeted Case Management		32,889,080
Total Department of Human Services		**389,570,262**
State Employees Physician Payment		
Physician Payments		26,956,639
Total State Employees Physician Payment		**26,956,639**
Education Payments		
Graduate Medical Education		38,797,122
Graduate Medical Education - PMTC		1,902,474
Indirect Medical Education		30,449,271
Direct Medical Education		12,166,326
Total Education Payments		**83,315,193**
Office of Juvenile Affairs		
Targeted Case Management		2,167,047
Residential Behavioral Management		2,277,973
Total Office of Juvenile Affairs		**4,445,020**
Department of Mental Health		
Case Management		5,272,295
Inpatient Psych FS		7,166,002
Outpatient		14,120,015
PRTF		67,684,740
Rehab		180,575,331
Total Department of Mental Health		**274,818,383**
State Department of Health		
Children's First		1,433,624
Sooner Start		1,438,245
Early Intervention		3,815,040
EPSDT Clinic		1,414,003
Family Planning		40,214
Family Planning Waiver		6,849,749
Maternity Clinic		32,734
Total Department of Health		**15,023,610**
County Health Departments		
EPSDT Clinic		519,992
Family Planning Waiver		18,528
Total County Health Departments		**538,520**
State Department of Education		**65,493**
Public Schools		**3,742,105**
Medicare DRG Limit		**65,425,546**
Native American Tribal Agreements		**5,085,106**
Department of Corrections		**805,424**
JD McCarty		**2,759,440**
Total OSA Medicaid Programs	**$**	**872,550,741**
OSA Non-Medicaid Programs	**$**	**50,448,719**
Accounts Receivable from OSA	**$**	**4,917,244**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
Fiscal Year 2013, For the Eight Months Ended February 28, 2013

REVENUES		FY 13 Revenue
SHOPP Assessment Fee	$	117,581,029
Federal Draws		167,584,535
Interest		21,921
Penalties		88,438
State Appropriations		(15,000,000)
TOTAL REVENUES	$	270,275,923

EXPENDITURES	Quarter	Quarter	Quarter		FY 13 Expenditures
Program Costs:	7/1/12 - 9/30/12	10/1/12 - 12/31/12	1/1/13 - 3/31/13		
Hospital - Inpatient Care	76,857,805	76,538,280	81,236,442	$	234,632,528
Hospital -Outpatient Care	3,224,900	3,217,022	2,815,812	$	9,257,734
Psychiatric Facilities-Inpatient	5,660,381	5,636,765	6,128,236	$	17,425,382
Rehabilitation Facilities-Inpatient	217,066	216,157	263,146	$	696,369
Total OHCA Program Costs	85,960,153	85,608,224	90,443,636	$	262,012,013
Total Expenditures				$	262,012,013

CASH BALANCE		
	$	8,263,910

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2013, For the Eight Months Ended February 28, 2013

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 41,206,446**	**$ 41,206,446**
Interest Earned	**24,427**	**24,427**
TOTAL REVENUES	**$ 41,230,873**	**$ 41,230,873**

EXPENDITURES	FY 13 Total $ YTD	FY 13 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 109,239,106	$ 39,358,850	
Eyeglasses and Dentures	194,226	69,980	
Personal Allowance Increase	2,358,760	849,861	
Coverage for DME and supplies	1,721,610	620,296	
Coverage of QMB's	688,504	248,068	
Part D Phase-In	1,543,568	1,543,568	
ICF/MR Rate Adjustment	3,312,876	1,193,629	
Acute/MR Adjustments	3,360,220	1,210,687	
NET - Soonerride	1,717,016	618,641	
Total Program Costs	**$ 124,135,886**	**$ 45,713,580**	**$ 45,713,580**
Administration			
OHCA Administration Costs	$ 371,179	$ 185,589	
DHS - 10 Regional Ombudsman	-	-	
OSDH-NF Inspectors	-	-	
Mike Fine, CPA	4,500	2,250	
Total Administration Costs	**$ 375,679**	**$ 187,839**	**$ 187,839**
Total Quality of Care Fee Costs	**$ 124,511,564**	**$ 45,901,419**	
TOTAL STATE SHARE OF COSTS			**$ 45,901,419**

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 2013, For the Eight Months Ended February 28, 2013

REVENUES	FY 12 Carryover	FY 13 Revenue	Total Revenue
Prior Year Balance	$ 27,390,790	$ -	$ 19,758,515
State Appropriations			(21,500,000)
Tobacco Tax Collections	-	32,165,702	32,165,702
Interest Income	-	496,379	496,379
Federal Draws	684,936	22,815,530	22,815,530
All Kids Act	(7,085,216)	197,305	197,305
TOTAL REVENUES	$ 20,990,510	$ 55,674,916	$ 53,736,125

EXPENDITURES		FY 12 Expenditures	FY 13 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 33,215,749	$ 33,215,749
	College Students		252,443	252,443
	All Kids Act		429,235	429,235
Individual Plan				
	SoonerCare Choice		$ 290,490	$ 104,664
	Inpatient Hospital		6,792,915	2,447,487
	Outpatient Hospital		7,040,306	2,536,622
	BH - Inpatient Services-DRG		394,018	141,965
	BH -Psychiatrist		-	-
	Physicians		9,345,444	3,367,164
	Dentists		40,462	14,578
	Mid Level Practitioner		60,197	21,689
	Other Practitioners		161,726	58,270
	Home Health		35	13
	Lab and Radiology		2,272,966	818,950
	Medical Supplies		510,287	183,856
	Clinic Services		1,035,996	373,269
	Ambulatory Surgery Center		342,042	123,238
	Prescription Drugs		13,065,260	4,707,413
	Miscellaneous Medical		624	624
	Premiums Collected		-	(1,446,047)
Total Individual Plan			$ 41,352,770	$ 13,453,755
	College Students-Service Costs		$ 481,990	$ 173,661
	All Kids Act- Service Costs		$ 118,379	$ 42,652
Total OHCA Program Costs			$ 75,850,566	$ 47,567,495
Administrative Costs				
	Salaries	$ 30,032	$ 1,064,909	$ 1,094,941
	Operating Costs	48,746	231,344	280,090
	Health Dept-Postponing	-	-	-
	Contract - HP	1,153,217	1,594,715	2,747,932
Total Administrative Costs		$ 1,231,995	$ 2,890,967	$ 4,122,963
Total Expenditures				$ 51,690,458
NET CASH BALANCE		$ 19,758,515		$ 2,045,668

*State Appropriations include $20,000,000 from SFY 2012 and $1,500,000 from SFY 2013

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2013, For the Eight Months Ended February 28, 2013

REVENUES	FY 13 Revenue	State Share
Tobacco Tax Collections	$ 641,970	$ 641,970
TOTAL REVENUES	**$ 641,970**	**$ 641,970**

EXPENDITURES	FY 13 Total $ YTD	FY 13 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 13,073	$ 3,297	
Inpatient Hospital	1,252,063	315,770	
Outpatient Hospital	3,017,348	760,975	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	9,077	2,289	
Physicians	4,544,807	1,146,200	
Dentists	37,071	9,349	
Mid-level Practitioner	3,719	938	
Other Practitioners	10,230	2,580	
Home Health	11,439	2,885	
Lab & Radiology	468,556	118,170	
Medical Supplies	41,964	10,583	
Clinic Services	184,103	46,431	
Amulatory Surgery Center	14,529	3,664	
Prescription Drugs	1,195,463	301,496	
Transportation	35,029	8,834	
Miscellaneous Medical	1,558	393	
Total OHCA Program Costs	$ 10,840,030	$ 2,733,856	
OSA DMHSAS Rehab	$ 69,243	$ 17,463	
Total Medicaid Program Costs	$ 10,909,273	$ 2,751,319	
TOTAL STATE SHARE OF COSTS			**$ 2,751,319**

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

February 2013 Data for April 2013 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2012	Enrollment February 2013	Total Expenditures February 2013	Average Dollars Per Member Per Month February 2013
SoonerCare Choice Patient-Centered Medical Home			468,268	**538,256**	**$147,535,671**	
	Lower Cost	*(Children/Parents; Other)*		491,847	$109,194,714	$222
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		46,409	$38,340,957	$826
SoonerCare Traditional			241,278	**194,504**	**$174,075,996**	
	Lower Cost	*(Children/Parents; Other)*		87,400	$38,399,972	$439
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		107,104	$135,676,024	$1,267
SoonerPlan			41,378	**49,464**	**$798,539**	$16
Insure Oklahoma			31,502	**30,300**	**$9,602,984**	
	Employer-Sponsored Insurance		17,728	16,932	$4,421,927	$261
	Individual Plan		13,773	13,368	$5,181,058	$388
TOTAL			**782,425**	**812,524**	**$332,013,190**	

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 $32,677,337 are excluded.

Net Enrollee Count Change from Previous Month Total	2,463

New Enrollees	17,370

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

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,685
Aged/Blind/Disabled	*Adult*	132,548
Other	*Child*	154
Other	*Adult*	20,914
PACE	*Adult*	119
TEFRA	*Child*	443
Living Choice	*Adult*	97
OLL Enrollment		**173,960**

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

Medicare and SoonerCare	Monthly Average SFY2012	Enrolled February 2013
Dual Enrollees	**107,504**	**108,448**

		Monthly Average SFY2012	Enrolled February 2013
Long-Term Care Members		**15,770**	**15,541**
	Child	87	60
	Adult	15,683	15,481

FACILITY PER MEMBER PER MONTH

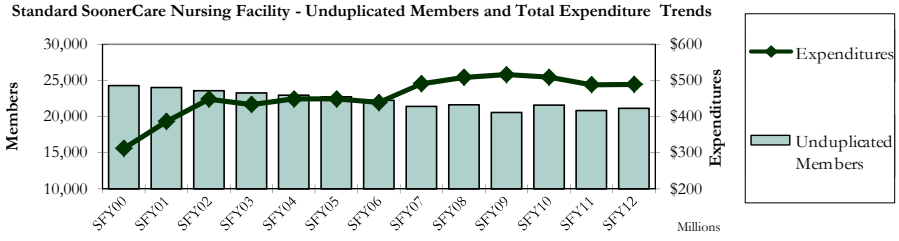
$3,514

SFY2012 Long-Term Care

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

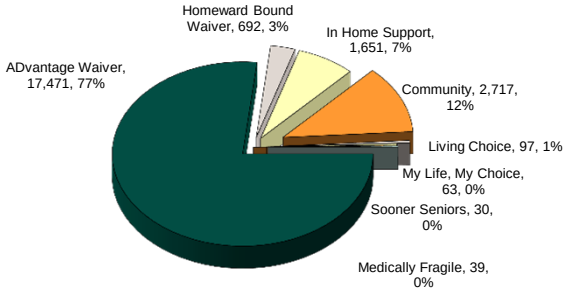
Data as of September 2012

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 SFY2012	Enrolled February 2013*
Total Providers		**29,723**	**36,406**
	In-State	20,881	28,609
	Out-of-State	8,842	7,797

*Effective July 2012, the methodology for counting providers has changed to count provider network. Previous counts include group practice and its members; the current count will include members only. Provider Network is 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,

Program	% of Capacity Used
SoonerCare Choice	44%
SoonerCare Choice I/T/U	17%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2012	*Enrolled February 2013**	Monthly Average SFY2012	Enrolled February 2013
Physician***	*7,497*	*7,606*	*13,790*	11,410
Pharmacy	*874*	*906*	*1,153*	1,213
Mental Health Provider**	*3,395*	*5,976*	*3,449*	6,046
Dentist	*986*	*1,209*	*1,124*	1,385
Hospital	*194*	*197*	*934*	1,109
Optometrist	*550*	*606*	*587*	642
Extended Care Facility	*375*	*359*	375	359

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

Total Primary Care Providers***	*4,915*	*4,913*	6,955	6,283
Patient-Centered Medical Home	*1,711*	*1,931*	1,739	1,973

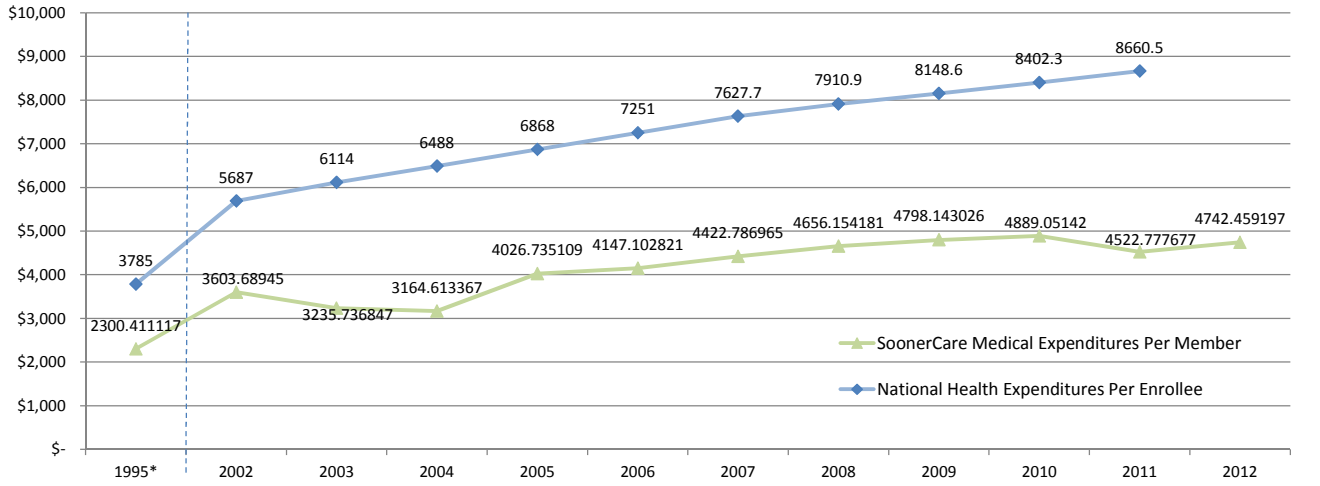
Including Physicians, Physician Assistants and Advance Nurse Practitioners.

*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.

***Decrease in current month's count is due to contract renewal period which is typical during all renewal periods.

SOONERCARE AND NATIONAL MEDICAL EXPENDITURES



*The methodology used to determine 1995 national data is different than the methodology used to determine the subsequent years, however it is approximately correct. Members/Enrollees and medical expenditures include supplemental hospital payments and are based on state fiscal year (July through June) from the OHCA Annual Reports. National Health Expenditures Per Capita from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2005; file nhegdp05.zip

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 4/1/2013	March 2013		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	77	$1,269,334	1,588	$34,963,334
Eligible Hospitals	5*	$4,584,103	89	$73,958,610
Totals	82	$5,853,437	1,677	$108,921,944

*Current Eligible Hospitals Paid
CIMARRON MEMORIAL HOSPITAL
MED CTR OF SE OKLA
MERCY HOSPITAL LOGAN COUNTY
MIDWEST CITY REGIONAL HOSP
ST ANTHONY HSP

OHCA BOARD MEETING

APRIL 11TH, 2013 OHCA BOARD MEETING

OHCA REQUEST BILL:

- SB 254 – Senator Kimberly David – Allows OHCA to utilize Internal Revenue Service records to verify an individual's income for Medicaid eligibility – **Current Status: Title Restored, on (H) General Order.**

After the March14th & March 28th deadlines and as of April 3, 2013, the Oklahoma Legislature is currently tracking a total of 867 legislative bills. OHCA is now tracking 58 bills. They are broken down as follows.

- OHCA Request 01
- Direct Impact 40
- Agency Interest 11
- Employee Interest 06
-

The following are the remaining Senate and House deadlines for 2013:

SENATE AND HOUSE DEADLINES
Remaining Deadlines

April 4, 2013	Deadline for Reporting Single Assigned House Bills from Senate Committees
April 11, 2013	Deadline for Reporting Double-Assigned House Bills from 2nd Senate Committee
April 25, 2013	Deadline for Third Reading of Bills from Opposite Chamber
May 31, 2013	Sine Die Adjournment, No later than 5:00 p.m.

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

March 2013 PCMH Provider Tiers and Panel Capacity Report

Data Run Date	PCMH Tier	Provider Type	# of PCMH Locations	Provider Count	Maximum Capacity	Current Panel Size	Avg. member per provider
March 03, 2013							
	PWP						
		Physician - DO	2	2	1,100	171	86
		Physician - MD	3	3	600	108	36
		Tier Totals	5		1,700	279	
	Tier 1						
		Advance Practice Nurse	58	58	34,800	13,967	241
		Group - FQHC	27	143	80,495	31,352	219
		Group - Other	133	466	175,132	74,391	160
		Group - RHC	33	118	69,820	14,855	126
		Mid-Level Practitioner	21	21	12,750	6,679	318
		Physician - DO	55	55	36,840	14,725	268
		Physician - MD	166	166	90,562	46,539	280
		Tier Totals	493		500,399	202,508	
	Tier 2						
		Advance Practice Nurse	25	25	17,660	9,464	379
		Group - FQHC	11	77	45,025	12,106	157
		Group - Other	73	594	163,082	72,986	123
		Group - RHC	2	12	4,300	1,205	100
		Mid-Level Practitioner	7	7	4,100	1,741	249
		Physician - DO	42	42	30,425	18,253	435
		Physician - MD	68	68	53,376	30,178	444
		Tier Totals	228		317,968	145,933	
	Tier 3						
		Advance Practice Nurse	11	11	6,600	3,418	311
		Group - FQHC	4	25	14,950	2,074	83
		Group - Other	56	550	299,365	112,548	205
		Group - RHC	1	4	1,250	509	127
		Mid-Level Practitioner	1	1	850	593	593
		Physician - DO	15	15	6,175	3,837	256
		Physician - MD	24	24	5,925	6,121	255
		Tier Totals	112		335,115	129,100	
		Overall Totals	**838**		**1,155,182**	**477,820**	

1,949 Total Unduplicated SoonerCare Choice PCPs in March 2013

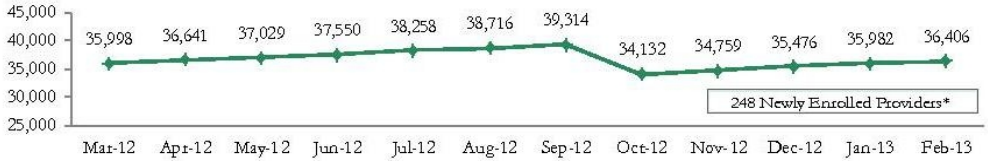
567 New PCP's added between January 1, 2009 and March 31, 2013

Provider Fast Facts

February 2013

Effective July 2012, the methodology for counting providers has changed to count provider network. Previous counts include group practice and its members; the current count will include members only. **Provider Network** is 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/or specialties. The term "contracted" is defined as a provider that was enrolled with Oklahoma SoonerCare within the reporting period, it does not necessarily indicate participation.

Provider Network Count



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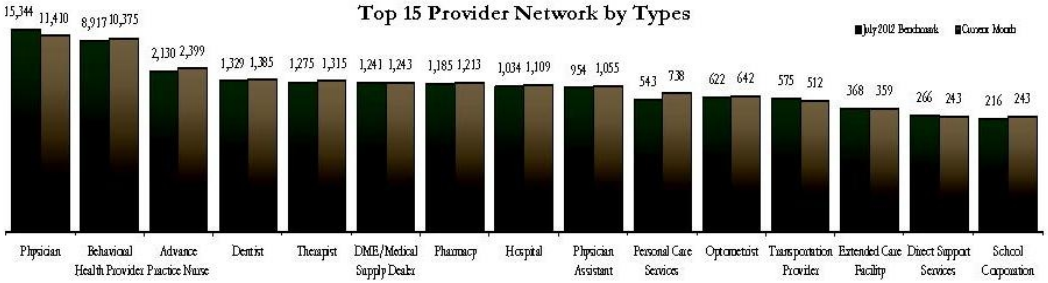
Top 15 Provider Network by Types



Primary Care Provider (PCP) Capacities

SoonerCare Program	Total Capacity	% of Capacity Used
SoonerCare Choice	1,125,722	44.17%
SoonerCare Choice I/T/U	101,900	17.26%
Insure Oklahoma IP	427,197	3.15%

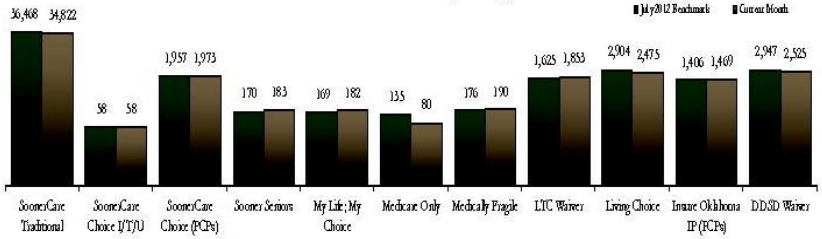
Total Capacity represents the maximum number of members that PCPs request to have assigned within OHCA's limit. Panels on hold status are excluded from the capacity calculation.

Patient-Centered Medical Home (PCMH) Enrollment by Tier

Payment Tier Code	Count
Tier 1	494
Tier 2	223
Tier 3	108

These counts were computed using a different method than indicated elsewhere on the report and are not comparable to any other figures. Non-participating PCMH are excluded.

Provider Network by Program



Acronyms

DDSD - Developmental Disabilities Services Division

DME - Durable Medical Equipment

IP - Individual Plan

I/T/U - Indian Health Service/ Tribal/Urban Indian

LTC - Long-Term Care

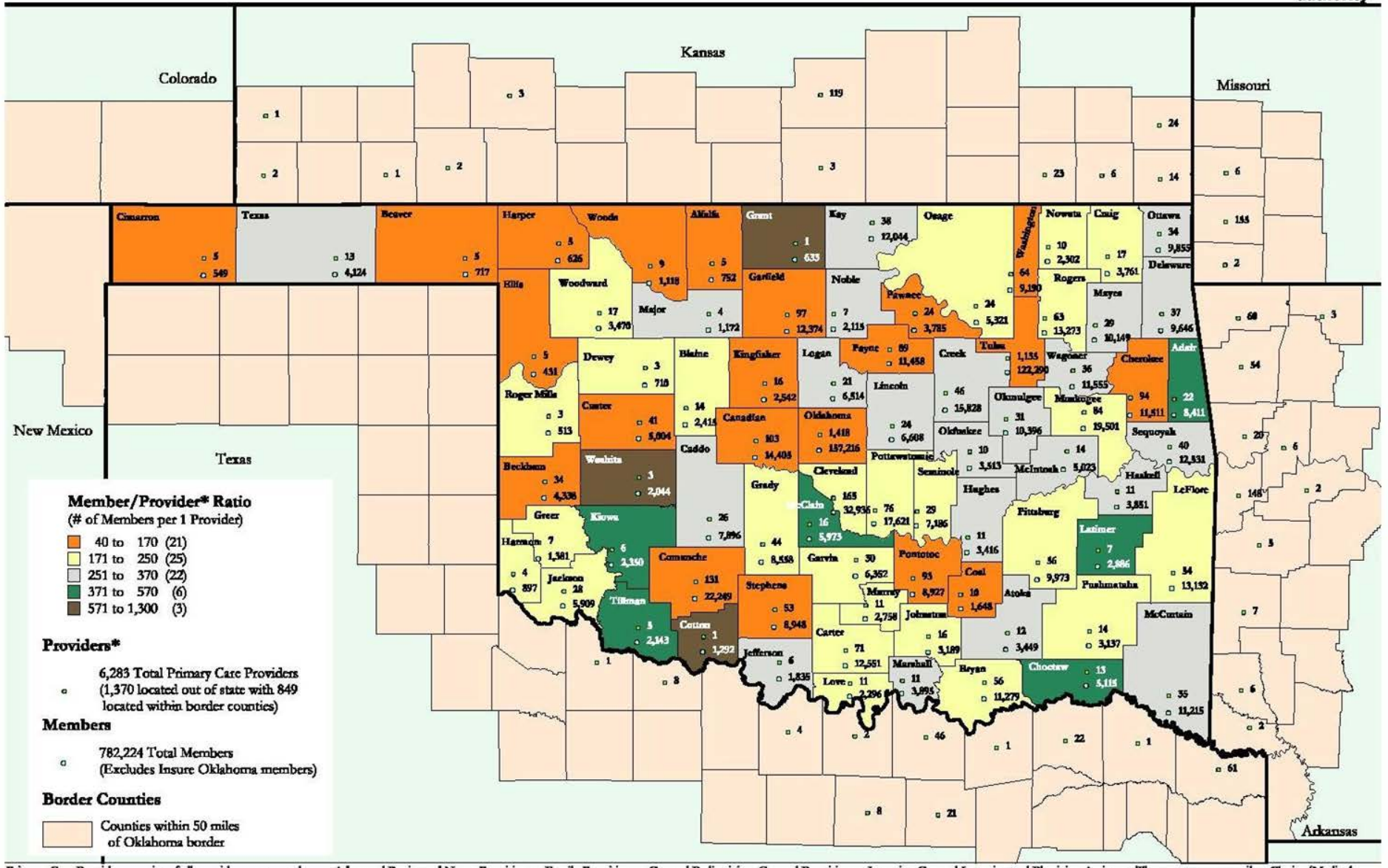
PCMH - Patient-Centered Medical Home

PCP - Primary Care Provider

3/12/2013

SoonerCare Member to Provider* Ratio
February 2013

oklahoma health care authority



Primary Care Providers consist of all providers contracted as an Advanced Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant. They are not necessarily a Choice/Medical Home Provider. Data is valid as of the report date and is subject to change.

* Provider Network is define on previous page.

03/12/2013

SoonerCare Choice PCMH: PCP Tier Summary

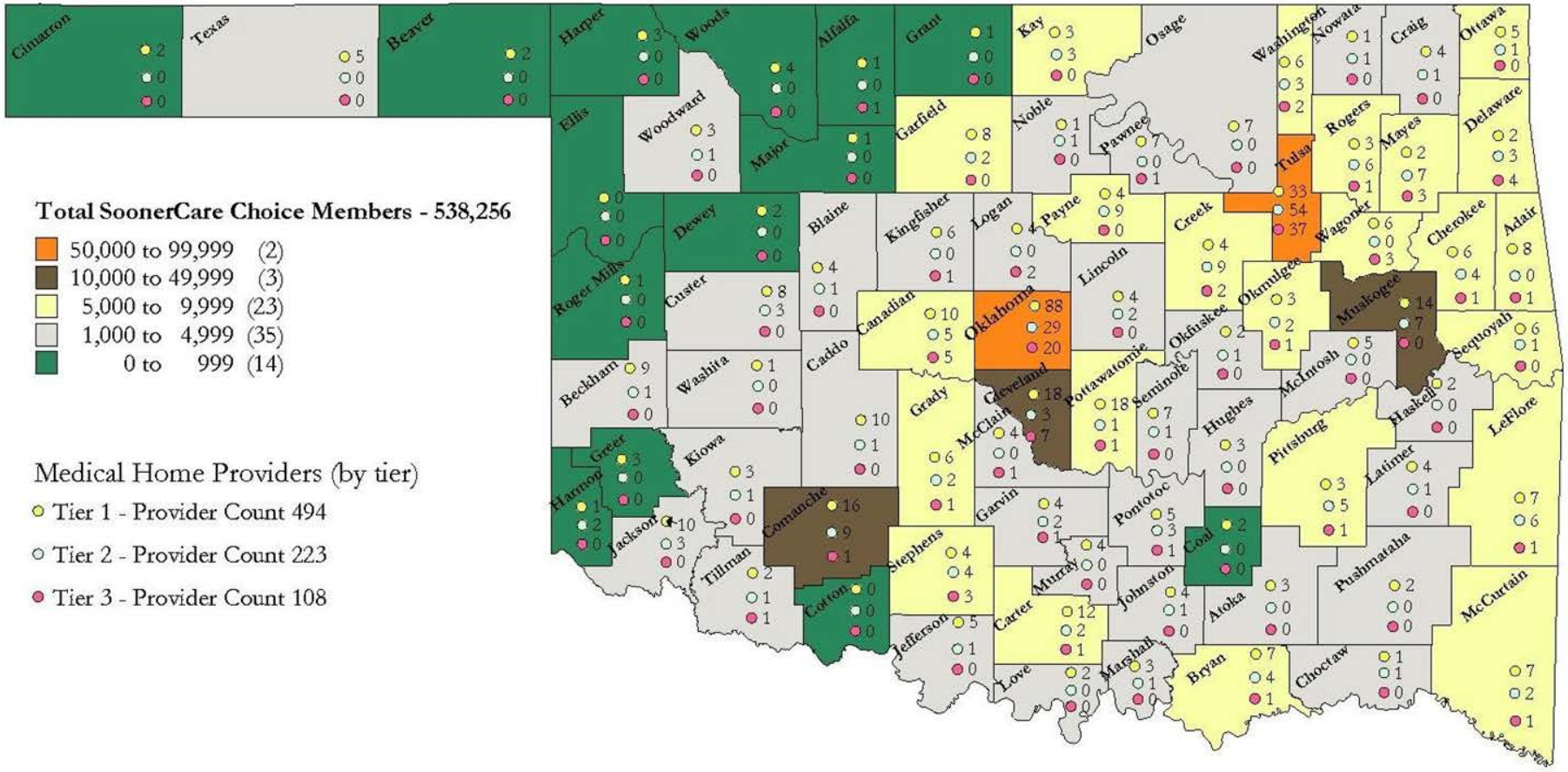
	January 2009	February 2013
Tier 1	445	494
Tier 2	223	223
Tier 3	31	108
TOTAL	699	825

Tier count is determined by provider location

SoonerCare Choice Members & Medical Home Tiers

February 2013

oklahoma health care authority



Total SoonerCare Choice Members - 538,256

50,000 to 99,999		(2)
10,000 to 49,999		(3)
5,000 to	9,999	(23)
1,000 to	4,999	(35)
0 to	999	(14)

Medical Home Providers (by tier)

- Tier 1 - Provider Count 494
- Tier 2 - Provider Count 223
- Tier 3 - Provider Count 108

Some providers are not represented in the map due to his/her locations being outside the state of Oklahoma.

Complied by OHCA Reporting and Statistics Unit. Data is valid as of the report date and is subject to change.

03/12/2013

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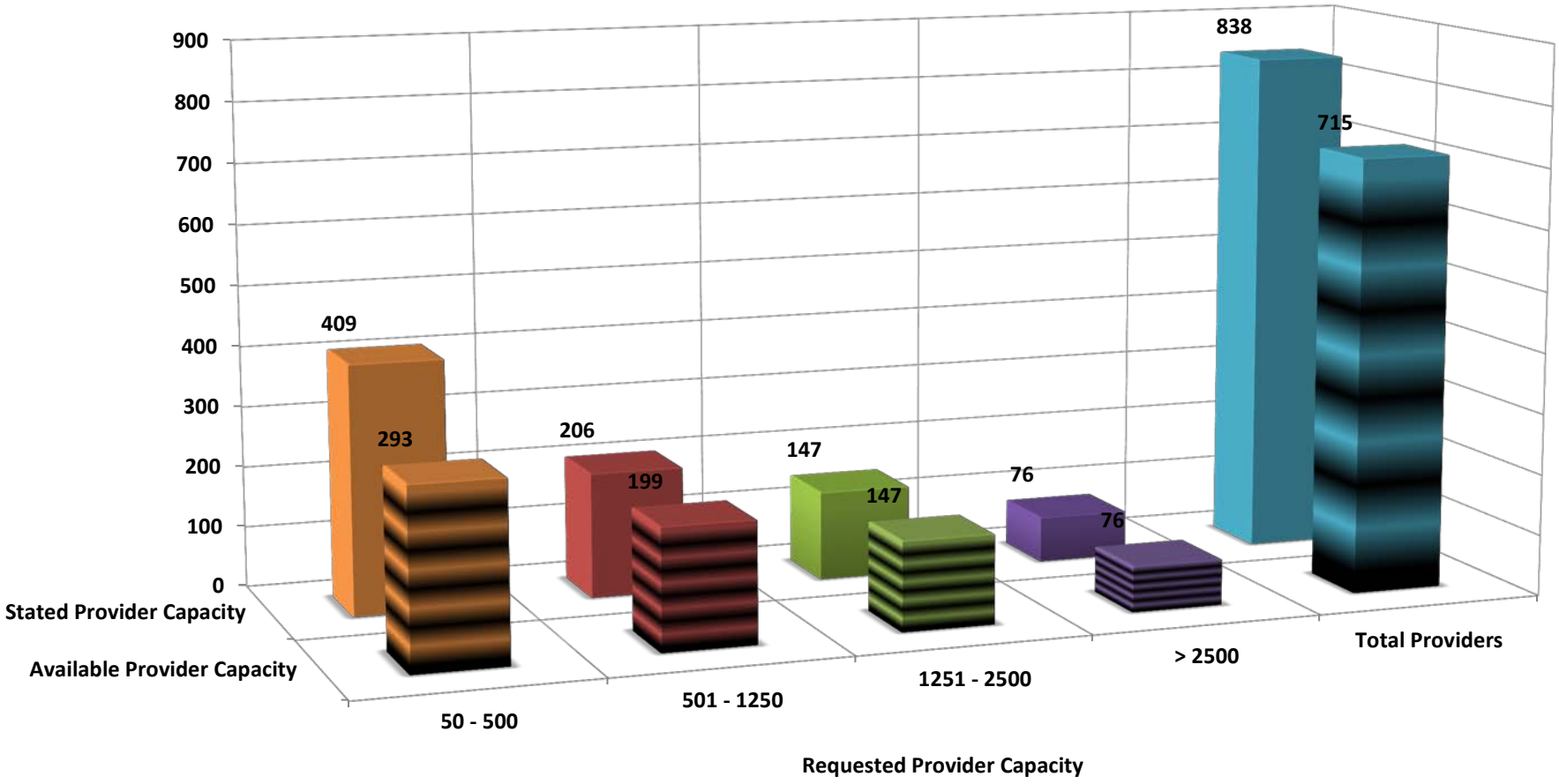
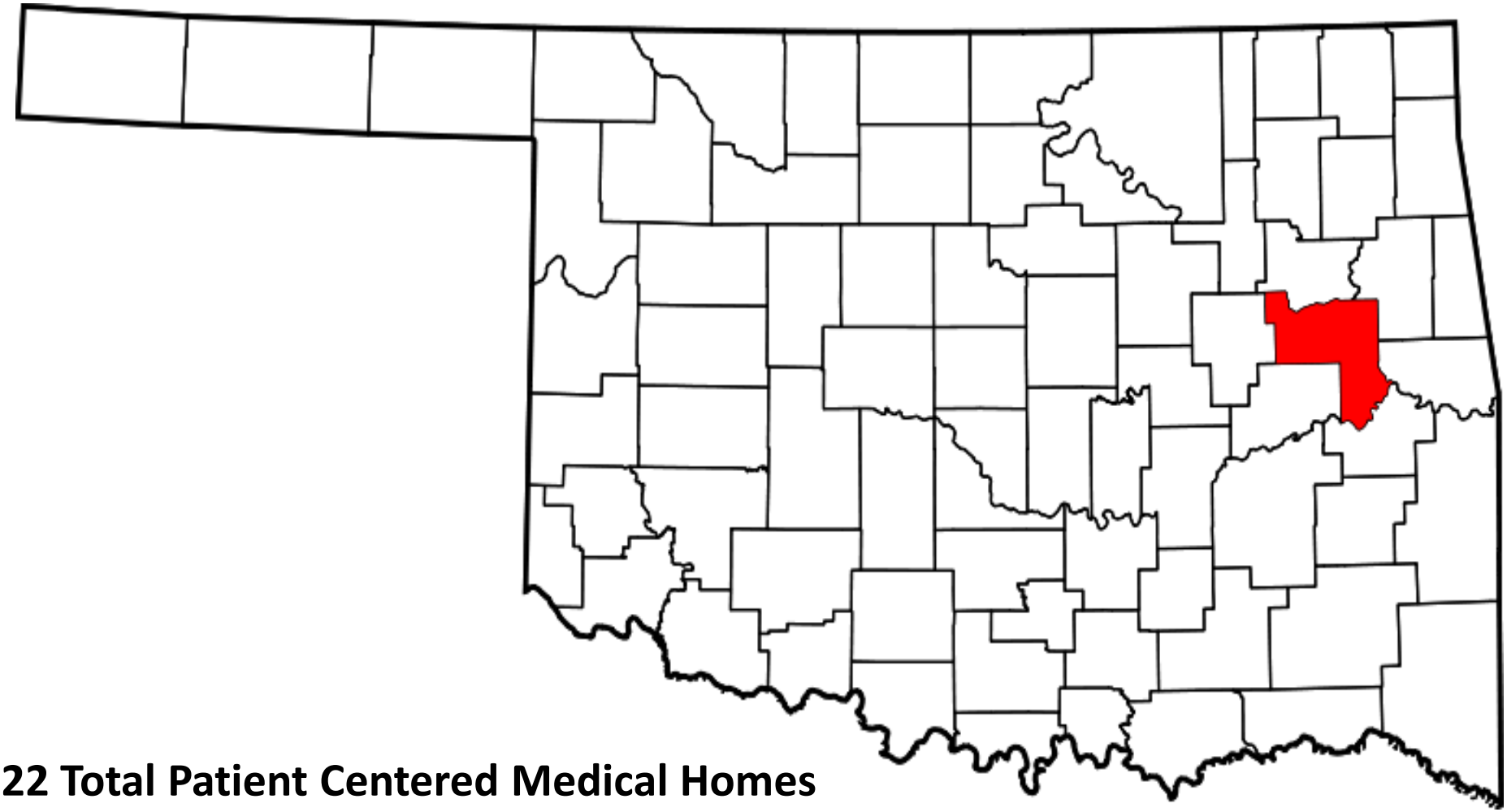
Oklahoma PCMH Provider Panel Capacities March 2013: Stated Capacity vs. Available Capacity



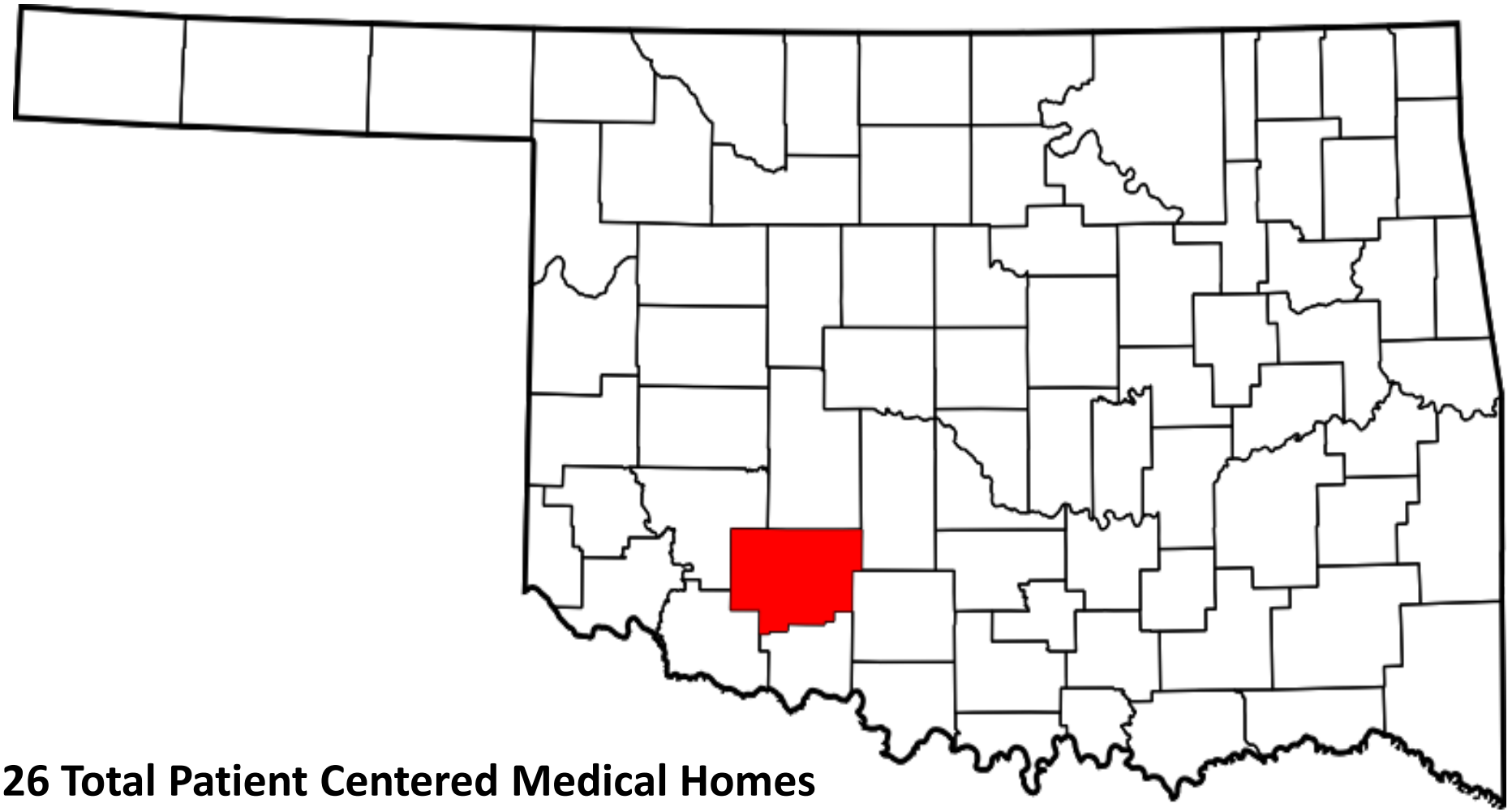
Muskogee County PCMHs - March 2013



22 Total Patient Centered Medical Homes

- **Stated Capacity – 36,795**
- **Available Capacity – 12,619**

Comanche County PCMHs - March 2013



26 Total Patient Centered Medical Homes

- **Stated Capacity – 18,750**
- **Available Capacity – 13,299**

Recruitment Strategies

- Previously Contracted Providers
- Internet/Social Media
- Medical Licensure Boards
- **OU OSU** Residency Programs
- State Medical Association Meeting
- ARNP, PA State Association Meetings
- Current PCMH Providers
- Community and Advocacy Outreach

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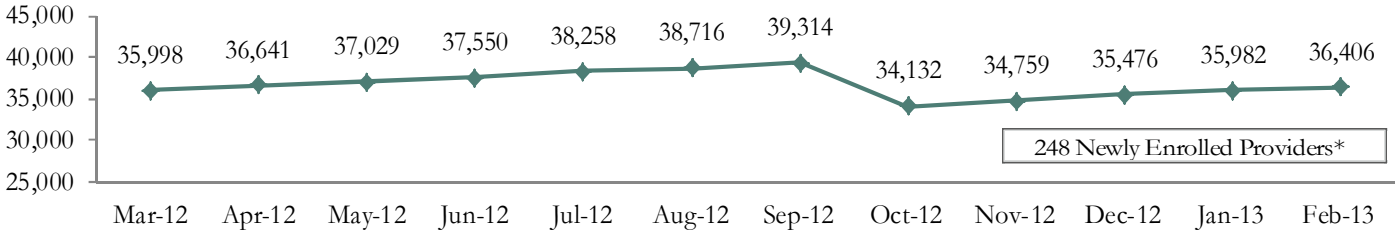

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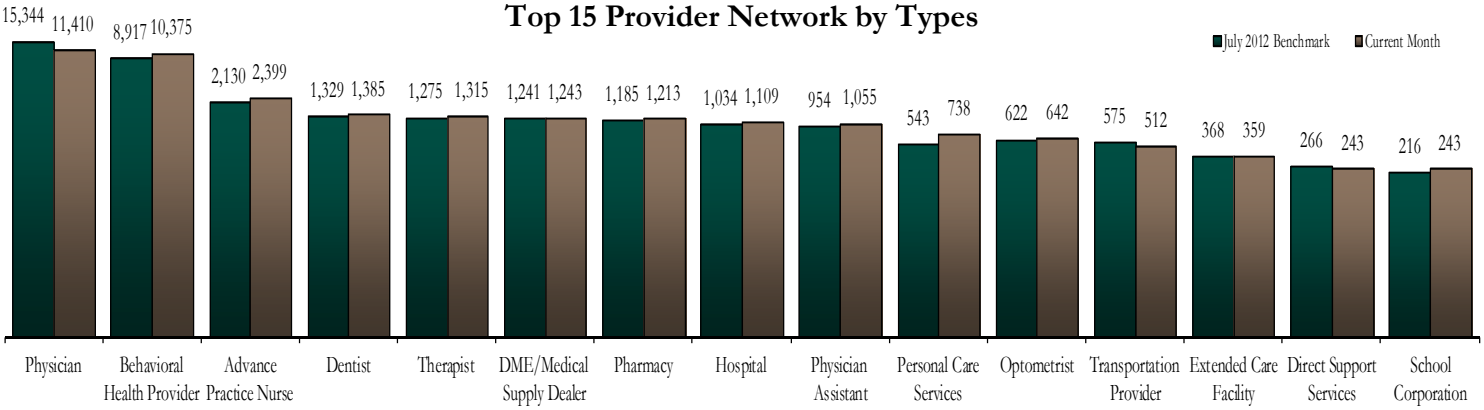

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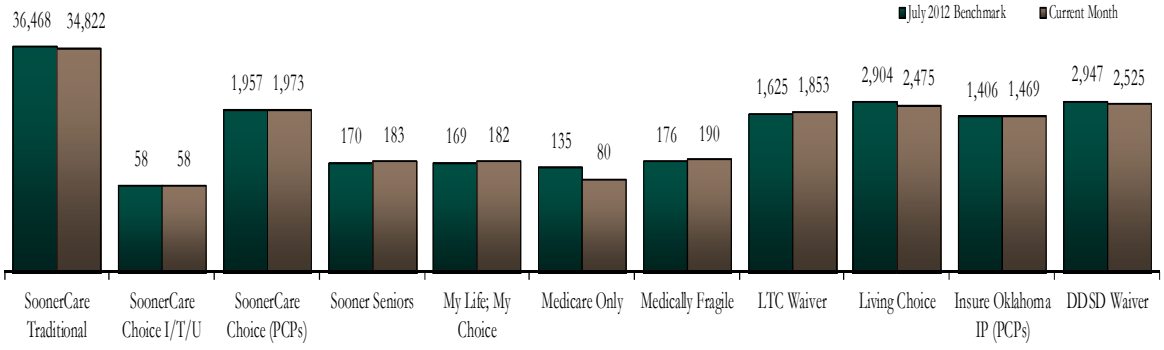

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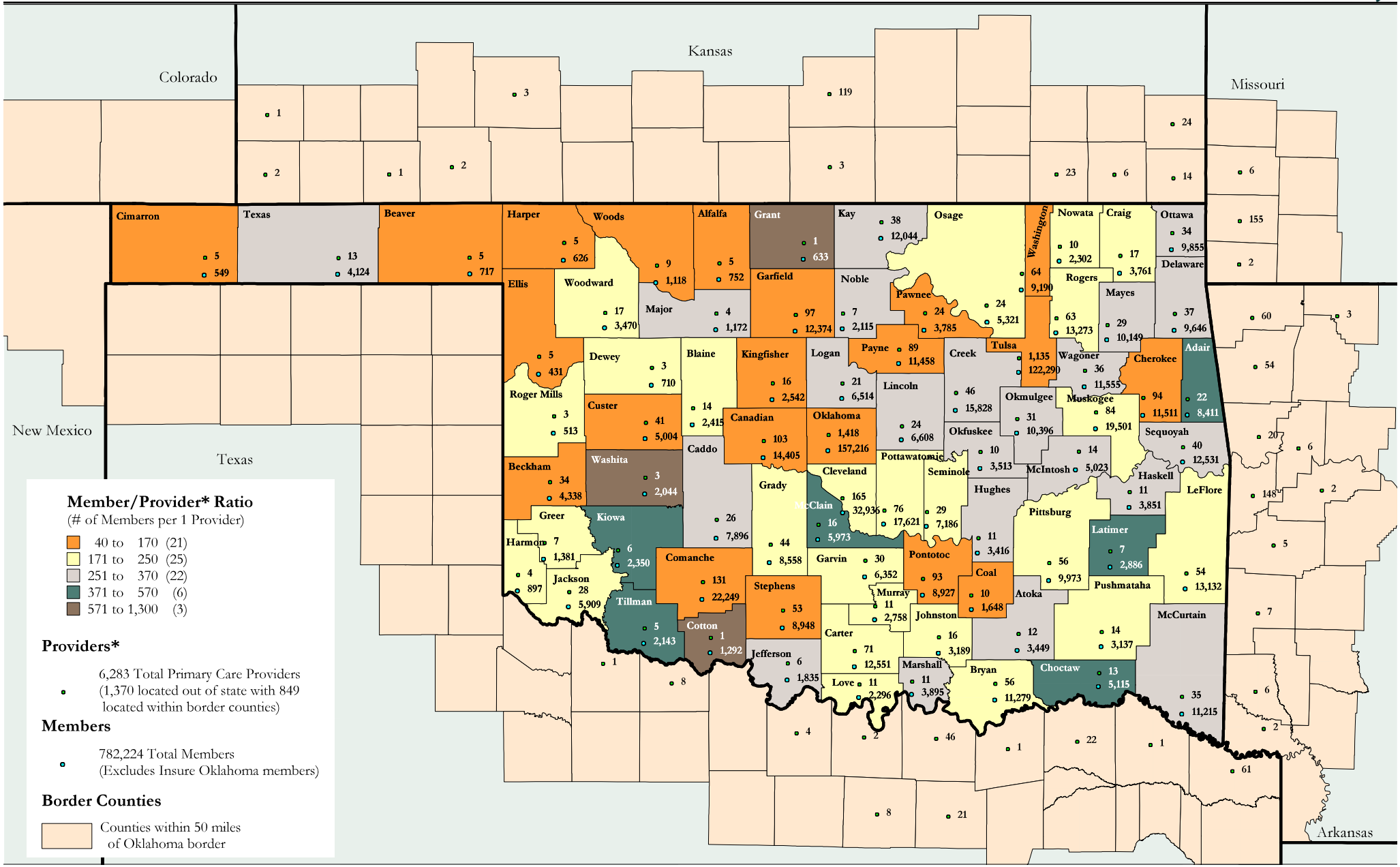
3/12/2013

SoonerCare Member to Provider* Ratio

February 2013

oklahoma health care authority



Member/Provider* Ratio

(# of Members per 1 Provider)

- 40 to 170 (21)
- 171 to 250 (25)
- 251 to 370 (22)
- 371 to 570 (6)
- 571 to 1,300 (3)

Providers*

6,283 Total Primary Care Providers
(1,370 located out of state with 849 located within border counties)

Members

782,224 Total Members
(Excludes Insure Oklahoma members)

Border Counties

Counties within 50 miles of Oklahoma border

Primary Care Providers consist of all providers contracted as an Advanced Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant. They are not necessarily a Choice/Medical Home Provider. Data is valid as of the report date and is subject to change.

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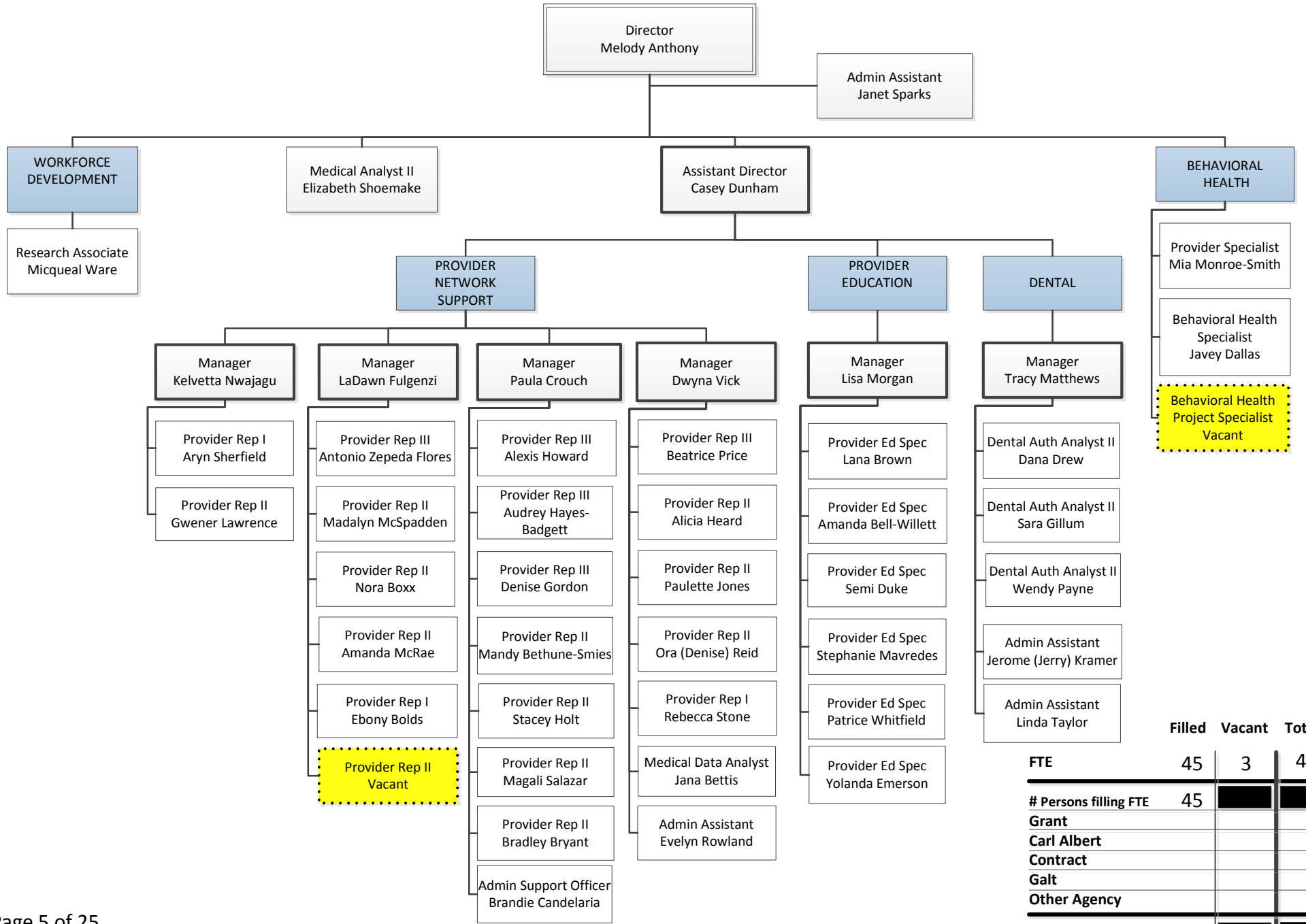
03/12/2013

Oklahoma Health Care Authority

Provider/Medical Home Services



	Filled	Vacant	Total
FTE	45	3	48
# Persons filling FTE	45		
Grant			
Carl Albert			
Contract			
Galt			
Other Agency			
# ALL PERSONS	45		

Recommendation 1: Prior Authorize Chronic Obstructive Pulmonary Medications

The Drug Utilization Review Board recommends establishing a Product Based Prior Authorization category for long acting bronchodilator medications to ensure appropriate and cost-effective utilization in accordance with current treatment guidelines. The following Tier 1 drug list has been determined to be acceptable for use as initial therapy for the majority of members.

Tier 1	Tier 2
Long Acting $Beta_2$ Agonists*	
Serevent® (Salmeterol inhalation powder) Foradil® (formoterol aerosolized powder)	Perforomist® (formoterol nebulizer solution) Brovana® (arformoterol nebulizer solution) Arcapta® (indacaterol inhalation powder)
Long Acting Anticholinergics	
Spiriva® (tiotropium inhalation powder)	Tudorza® (aclidinium inhalation powder)

*Combination agents qualify as Tier 1 agents

Tier 2 Approval Criteria:

1. The member must be age 18 or older, and
2. Have a diagnosis of COPD, chronic bronchitis, or emphysema, and
3. A 4 week trial of at least one LABA and a four week trial of one LAMA within the past 90 days, or
4. A documented adverse effect, drug interaction, or contraindication to all available Tier 1 products.
5. A clinical exception will be made for members who are unable to effectively use hand-actuated devices, such as Spiriva Handihaler® or those who are stable on nebulized therapy.

Recommendation 2: Prior Authorize Select Oral Corticosteroid Medications

The Drug Utilization Review Board recommends prior authorization of the following products:

- Orapred ODT® (prednisolone sodium phosphate, orally disintegrating tabs)
- Prednisolone sodium phosphate oral solution: 5 mg/5 ml, 20 mg/5 ml (Veripred™), and 25 mg/5ml

Approval Criteria:

1. Approval requires a patient specific, clinically significant reason why the member cannot use a tablet or an alternative strength liquid formulation.
2. Orapred ODT® will have a quantity limit of 10 tabs per month available without prior authorization for members 10 years or younger.

Recommendation 3: Prior Authorize Linzess™

The Drug Utilization Review Board recommends the prior authorization of Linzess™ (linaclotide) with the following changes to the current criteria for Amitiza® (lubiprostone):

Amitiza® and Linzess™ Prior Authorization Criteria:

1. Members 18 years of age or older with an FDA approved diagnosis, and
    a. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients).
    b. Documented and updated Colon Screening for members >50 years of age.
2. Documented trials of at least three different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be OTC or prescription.
3. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment.
4. Quantity limits apply based on maximum recommended daily dose.