MIKE FOGARTY
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

MEDICAL ADVISORY COMMITTEE MEETING
AGENDA
May 19, 2011
1:00 p.m. – Ponca Conference Room
2401 NW 23rd St., Suite 1A
Oklahoma City, OK 73107

I. Welcome, Roll Call, and Public Comment Instructions

II. Approval of minutes of the March 9, 2011 Medical Advisory Committee Meeting

III. MAC Member Comments/Discussion

IV. Legislative Update: Nico Gomez, Deputy Chief Executive Officer

V. Financial Report: Carrie Evans, Chief Financial Officer
   A. March Financial Summary
   B. March Financial Detail Report

VI. SoonerCare Operations Update: Kevin Rupe, Member Services Director
   A. SoonerCare Programs Report
   B. Member Services Highlights & SoonerRide

VII. Team Day: Paul Gibson, Auditor III, Performance and Reporting

VIII. Discussion of MAC Membership, appointments, attendance and guidelines for operation: Terrie Fritz, External Relations Coordinator

IX. Action Items: Joseph Fairbanks, Senior Policy Specialist

OHCA Initiated

11-07 PT/OT/ST Clarification — PT/OT/ST rules restrict individually-contracted provider services to children. Rules are amended to clarify in policy that there is no coverage for adults for services rendered by individually-contracted providers however, therapy services are covered for adults in an outpatient hospital setting.
Budget Impact: Budget Neutral.

Federally Initiated

11-02 Tax Credit Exemption — The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 requires state Medicaid agencies to disregard federal tax refunds or advance payments with respect to refundable tax credits as income and as resources for purposes of determining eligibility. To bring Agency policy in compliance with this law, eligibility rules and income

guidelines are revised to eliminate consideration of the Earned Income Tax Credit, which is th e only refundable tax credit currently counted for eligibility purposes. **Budget Impact:** Budget Neutral

11-05 Insure Oklahoma—Native American Cost-Shari ng — Insure Oklahoma cost-sharing rules are revised to comply with Federal law on Native American cost-sharing exemptions. Native American adults are exempt fro m Insure Oklahoma—Individual Plan co-pays or premiums when they receive services provided by I ndian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/U) providers or through ref erral by con tract health services. Native American children are e xempt from cost-sharing regardless of whether they receive services provided by I/T/U providers or through referral by contract health services. **Budget Impact:** $189,422 total impact; $64,595 state impact

X. New Business

XI. Adjourn

Next Meeting: Thursday, July 21, 2011

MEDICAL ADVISORY COMMITTEE MEETING
Draft Meeting Minutes
March 9, 2011

Members attending: Ms. Bellah, Dr. Bourdeau, Dr. Crawford, Mr. Rick Snyder for Craig Jones, Mr. Goforth, Dr. Grogg (teleconference), Ms. Harrison, Ms. Holliman-James, Dr. Ogle, Dr. Post, Dr. Rhoades, Dr. Rhynes, Mr. Roye, Ms. Slatton-Hodges for Ms. White, Mr. Unruh, Dr. Wells, Dr. Wright

Members absent: Dr. Aulgur, Ms. Bates, Mr. Brose, Ms. Case, Dr. Cavallaro, Ms. Sherry Davis, Dr. Kasulis, Mr. Machtolff, Dr. McNeill, Dr. Simon, Mr. Tallent, Dr. Woodward

I. Welcome, Roll Call, and Public Comment Instructions

Dr. Crawford welcomed the committee members and called the meeting to order. Roll call established the presence of a quorum. There were requests for public comment.

Ms. Verna Foust, Red Rock Behavioral Health Services – Discussed telemedicine revision. She wanted to make sure that in a community mental health setting across the state, they may provide a telemedicine service from a rural county to an urban county. Mr. Rains replied the intent behind the telemedicine was to serve the members located in rural or medically-underserved areas. But almost every provider was serving the underserved, according to the Medicare website. We removed this language to give us more discretion when approving the services. The intent is that access to services will be convenient for the member, and where they are located.

Mr. Brent Willborn, Primary Care Association, for FQHCs – Mr. Willborn said thank you to the agency, and to let the MAC know the agency has been very helpful in making sure to include the health centers in the discussion of how rules are drafted and revised, and has been good in corresponding with CMS regarding policy issues. He thinks there may still be disincentives in some particular cases, but they have to live within guidelines provided.

Ms Kristie Saul, parent, addressed the MAC regarding adult diapers and TEFRA. Her child has spina bifida, hydrocephalus, and neurogenic bladder, which is not appropriately cared for with catheters. She has asked the Health Care Authority to approve diapers as a payable prescription. She is hoping the MAC can help, and she asked how customers know who to contact to get their needs met. It is a medical necessity for her daughter's hygiene that she use diapers. She is not appropriately treated by catheter.

Dr. Crawford assured Ms. Saul that it was appropriate to address such issues at the MAC, which is an advisory committee to the OHCA and the board, but that we do not have authority to make the decisions. Ms. Becky Pasternik-Ikard and Ms. Melinda Jones volunteered to take the information, research Ms. Saul's concerns and provide follow-up.

Ms. Julie Bisbee, Okla. Institute for Child Advocacy (OICA), said she was here to support the application of fluoride varnish by primary care providers. She mentioned that 40.2% of all 3rd graders in Oklahoma have untreated dental caries, and this issue needs attention. Dental disease is the most common chronic disease among children, 5 times more prevalent than asthma.

II. Approval of minutes of the January 20, 2010 Medical Advisory Committee Meeting

Dr. Ogle made the motion to approve the minutes as presented. Dr. Post seconded.

Motion carried.

III. MAC Member Comments/Discussion

Update on Medical Necessity Guidelines/Resources – Dr. Keenan discussed how we make medical necessity decisions. Dr. Mike Herndon is a family practitioner. Dr. Sylvia Lopez has a background in neonatology. They are full-time staff, as is Dr. Keenan. Dr. John Bumpus is a family practitioner and was with this agency way back when it was with DHS. His background is Family Practice and Anesthesia. Dr. Janet Rodgers is a Family Practitioner and Emergency Room physician, and used to work with the Okla. Foundation for Medical Quality. On the Dental side, Dr. Leon Bragg was Assistant Dean at OU, as well as being in private practice. Dr. Richard Gilman is an orthodontist. We also have a large group of nurses, in Medical Authorization and in the Quality Assurance divisions. All medical necessity decisions, denials, are under the direction of a physician. The nurses may approve cases, but all denials, if any, are under the direction of a physician. We research these decisions based on the literature, technology assessments, our coverage policies, CMS policy. Several insurance companies , e.g., Blue Cross, Aetna, Cigna,also have some very good technology assessment programs, and solid coverage policies we can reference. Those assessments usually include a long list of pertinent references. Pennsylvania, Wisconsin, Washington State, Minnesota are several Medicaid states in particular that also have very strong coverage policies. Washington state and Minnesota particularly have a strong technology assessment program that we look to. We have a contract with the Oregon Health and Sciences University (OHSU), Center for Evidence-Based Medicine, which is an evidence-based practice center (EPC). In the US, there is a total of 14 EPCs, they are funded by the Agency for Healthcare Quality Research, another agency that does systematic reviews of the literature and critical reviews of medical evidence. The AHRQ supports the EPCs. In particular specific focus of the OHSU Center, over and above the contract we have with them, is the evidence reports for the US Preventive Health Task Force. There are 2 major organizations for us as physicians in the Medicaid program to get research, support and background from. One is sponsored by AHRQ, it is the Medicaid/Medical Directors' Learning Network (MMDLN), a learning network of just the Medicaid/Medical directors, physicians only, from around the country, and about 30-40 states belong to it and come to the meetings on a regular basis. We have those a couple of times a year, as well as phone conferences, and share our knowledge and experience. We get support from AHRQ in terms of the evidence that we use to help make the decisions that we do. In addition to that, our state, in addition to about 12 others, have the subcontract with the OHSU to go even further, to get more detailed and more rapid information and reviews of literature, and documentation for the issues that arise as we are trying to make decisions about coverage. That is something that we as a state pay a little extra for, and the return that we get from working with the Oregon center has been outstanding, very helpful. None of us here can be experts on all these different issues that come up to us, so we reach out to these different groups for support and advice. We have access to Hayes and ECRI, with ECRI being an evidence-based medical center and we have a subcontract to access some of their reports, and can do special projects with them as well in terms of asking them to do special research for us. Hayes is part of our contract with OHSU, and we get better pricing by having multiple states involved in contracting through OHSU.

Also, in Oklahoma we have the DUR board that deals with pharmacy issues, our peer review organization APS, and the Medical Advisory Task Force (MAT). The MAT reached out to the Osteopathic Association, the Medical Association, the geriatricians, the OB/GYNs, the pediatricians, etc., and other specialty organizations. This is a physician-only group as an advisory group for us, and we meet every other month.

Another area is durable medical equipment (DME). Our Division Head, Stan Ruffner, has established an advisory task force and has a long history in the industry.

IMB North Carolina – Dr. Keenan referred to the handout from Pediatrics on the effectiveness of fluoride treatments performed by physicians on Medicaid children. Dr. Keenan mentioned the Medicaid Directors' meeting a few months ago, with dentists from around the country talking about dental issues in Medicaid programs.

Dr. Wells said providing fluoride varnish is like immunizations. Early childhood caries begins at the eruption of primary teeth, which is 6 months. Usually by age 3, there is a full set of 20 primary teeth. From 6-15 months old, dentists don't normally see these patients. Physicians do see the children for well baby check-ups. Application of fluoride varnish by ancillary personnel in a medical practice has been shown to reduce early childhood caries by 40%. The President, Dr. Legako, taught physicians and assistants how to apply fluoride varnish, and has found them very enthusiastic.

Dr. Wells said, initially the cost was estimated to be a lot more than what is on the handout. Dr. Wells urged for us to consider that there will be savings by reducing childhood caries and keeping patients out of the O.R.

Dr. Keenan commented that this project was presented to the Medicaid/Medical Directors a couple of years ago. The project from the N. Carolina Medicaid Program is called, "Into the Mouths of Babes". It involves 3 steps – Screening, risk assessment and referral to the dentist; parental counseling; application of fluoride varnish.

Dr. Crawford asked if there were any other comments.

Dr. Post commented that chiropractors historically have treated primarily neck pain, back pain, headaches, etc. Some of those things are very difficult to treat medically.

Dr. Post said one of the only services that isn't covered in SoonerCare is chiropractic care, even though the research shows that many times chiropractic care actually lowers health care costs. A lot of people think chiropractic care is an added cost, but research shows it actually lowers their overall health care cost. Dr. Post said he has received referrals from physicians for many, many years, yet cannot see a patient from SoonerCare. He asked how to go about having the MAC address this issue. He has talked to various people at various times and hasn't gotten anywhere. He said it is not just for his profession, but there are many people that receive services through the OHCA, that could benefit from the services a chiropractor provides.

Dr. Crawford thanked Dr. Post, and asked if it would be appropriate to address this at the annual budget review and Retreat.

Dr. Splinter said the first step would be to submit to us for consideration, pertinent evidence-based articles. Dr. Splinter suggested peer reviewed, journal articles. There are other considerations such as budget that come into play. First is medical appropriateness. We would be glad to give this issue our full attention.

Dr. Grogg said he is in favor of fluoride varnish prescribed by pediatricians as described in the Pediatrics dental article.

C-Section Update: Dr. Sylvia Lopez
Phase 1 began in January. We gave providers and the hospitals their primary and total c-section rates. Recently they received their second quarter data. Our website lists these rates. Providers and hospitals can submit questions to us and we respond by phone or in writing. Phase 2 is scheduled for September 2011. Before we implement that phase, we will meet with Obstetricians and Family Practitioners to develop guidelines for medical chart review.

Dr. Crawford asked if the presentation to the Legislature went well. Dr. Lopez responded yes, and that the State Medical Assn. also presented their side and their concerns.

IV. Legislative Update: Nico Gomez, Deputy CEO
Please refer to the handout for an update. Dr. Crawford addressed SB676, which is now dormant, but the language can be used in another bill. It was a bill that gave authority to the OHCA to apply administrative sanctions to recipients who were abusing the program, particularly if there was gross overutilization, or they were causing services to be reimbursed that were really not medically necessary.

Ms. Harrison, Legislative Coordinator for DHS, said HB1735 is a bill that OHCA has co-authored with them. It has some of the Medicaid sanction language in it, and it could be a good vehicle.

Mr. Fogarty said we met with the appropriation subcommittee chairs, Sen. Jolley and Rep. Doug Cox, Chairman of the House, to focus on the supplemental $15 million request. Those conversations went very well.

Dr. Crawford asked if that would maintain provider rates at the current level.
Mr. Fogarty responded if there is any revenue failure in the current year there will be very little choice other than deeper cuts. They understand we are not starting at zero, we're already below because of the rate cuts made a year and a half ago that were not intended to be permanent. Mr. Fogarty said he is guardedly optimistic on the supplemental, and that we'll be talking about next year's budget soon. Mr. Fogarty thanked the committee for their willingness to come and participate.

V. Financial Report: Gloria Hudson-Hinkle, Director of General Accounting
Ms. Hudson-Hinkle reviewed the financial transactions through the month of January 2011. For more detailed information see MAC information packet. There were no questions from members.

VI. SoonerCare Operations Update: Melody Anthony, Provider Services Director

A. SoonerCare Programs Report
B. Patient Centered Medical Home Overview
C. Electronic Health Records (EHR) Update

Ms. Anthony reviewed the handouts. In the packet is an overview of our programs and our enrollment. We continue to grow our membership, which is one of the missions behind the agency. We added some exclusions, some per member, per month allocations based on the programs, and a component of the program that shows current providers and how they rank by provider types.

Ms. Anthony referred to the EHR Incentive Program. Through January we had made over

$1 million in payments to eligible professionals and hospitals. As of Friday of the prior week, we paid out over $3 million, and $9 million are pending payment. If we add all the money for providers who have registered between January and the end of March, it would be over $27 million. Dr. Crawford reminded us that these are federally-provided funds, not the agency or the state. There were no questions.

Ms. Anthony provided a brief update on our Medical Home model which started in 2009 as recommended by the Medical Advisory Task Force. We started outreach in March 2008. We launched in January 2009 with CMS approval, and implemented our first Health Access Network pilot in July of last year. We have added new PCPs, We also have plenty of capacity as we head toward health care reform and we will be able to add more recipients to the program. Melody reviewed the changes in the Medical Home Tiers. It is our goal to raise all Tier 1's to 2's, and all 2's to 3's, and if we had a Tier 4, we would love our 3's to be able to be a Tier 4, because we think our network is actually a Tier 4 to 5 Medical Home.

The Health Access Network (HAN) is an over-arching program that brings resources from the community to the primary care level, whether behavioral health services, a food bank, synching-up providers; anything that member needs within that community, it's the network's responsibility to help providers develop those relationships, so the members have community resources when they're needed.

We have one pilot, OU School of Medicine, with 145 medical homes, and treating over 28,000 people. They have 528 members in case management. We have transitioned these recipients from our internal case management staff to the network. They include; chronic ER utilization, those in our Breast and Cervical Cancer screening program, the high-risk OB program and pharmacy lock-in. They will also be developing a case management program of their own choosing, and we will be able to track, monitor and report specific outcomes to CMS.

Ms. Anthony referred to the HEDIS report. All categories in green show a significant increase in outcomes for our patient population from the previous calendar year. Our child health study survey, and our adult survey show there was a significant increase in providers delivering care promptly. We are actively recruiting all provider types. A large part of the whole Child Health initiative is to make sure that EPSDT screens are done timely and within the guidelines.

One of the main reasons we changed to the Patient Centered Medical Home model was to be sure that we had adequate access, and that physicians were reimbursed appropriately. One of the biggest challenges we had prior to the change, was members calling us for access to care. One of the major reasons we were asked to make the change has been one of our major successes. We have only had 4 calls in the entire 12-month period for same day or next day access to care. This was a surprise. Medical Home was to be budget neutral, but we have reduced our per capita cost, for preventive and primary care services. We do ER provider profiles. Prior to Medical Home, our observed to expected was one office visit, to every 1.14 ER visits. Last year it was one office visit to every 1.02 ER visits.

The SoonerExcel program is going quite well. Our primary care, medical home providers were paid over $4 million last year.

Dr. Crawford thanked Ms. Anthony, recognized this has been a huge transition for the agency to this, and that a lot of staff have been involved.

There were no questions.

VII. Action Items: Traylor Rains, Policy Development Coordinator

OHCA Initiated

10-04 Federally Qualified Health Center (FQHC) Rules – Rules are revised to clarify reimbursement methods for providers of FQHC's and their relationship to the Prospective Payment System (PPS) rate. Currently rules are not clear as to which providers would be reimbursed the PPS rate for services provided. Additionally, rules are revised to clarify requirements for FQHC contracting and behavioral health services provided in school settings.
Budget Impact – Budget Neutral

10-37 Oklahoma Cares Breast and Cervical Cancer Treatment Program
Rules are revised to add a provision for medical eligibility review by the OHCA. The medical review will ensure that the original screening has properly indentified the woman as eligible for further testing or treatment. The rule revision further clarifies that income is a requirement for eligibility through SoonerCare, clarifies the meaning of "in need of treatment" and adds to policy that medical and financial eligibility appeals for applicants will be handled through the OHCA.
Budget Impact - $543,000 total annual savings; $135,750 state share

10-58 Dental Rules – General Dental and Orthodontic rules are revised to ensure consistency throughout policy by: (1) Clarifying eligibility requirements for SoonerCare orthodontic services; (2) clarifying provider requirements for General or Pediatric dental practitioners who have completed at least 200 certified hours of continuing education in the field of orthodontics practice; (3) requiring certain documentation in order to receive prior authorization for services as well as other minor formatting revisions; and (4) to allow reimbursement to primary care providers for application of fluoride varnish to the gums and teeth of children ages 12 months to 42 months during a well-child visit. Reimbursement is limited to two applications per year.
Budget Impact – Total first Year Impact of $201,115, state share of $70,511; Total Impact for each following year of $39,097, state share of $13,707

Ms. Bella with the Okla. Institute for Child Advocacy said they have a vested interest in seeing this Rule pass, and asked if she needed to abstain from the vote. Dr. Crawford explained that in this setting, it is not necessary. If they were voting at the Board, potentially. Dr. Splinter explained that this group is to advise and give the viewpoint of advocacy groups and other stakeholders, and it is completely appropriate, and this will be noted in the minutes.

10-60 Electronic Medical Records - Rules are revised to clarify requirements when documenting electronic health records. Electronic health records are required to be completed prior to claim submission or no later than 45 days after the date of service, whichever is later.
Budget Impact – Budget Neutral

10-62 Pharmacy Pricing Benchmark Revisions – Pharmacy rules are revised to allow for a new pricing benchmark, Wholesale Acquisition Cost (WAC), in the event that the Average Wholesale Price (AWP) is no longer published by OHCA's pharmacy pricing vendor. Additional revisions include general policy cleanup as it relates to these sections.
Budget Impact – Budget Neutral

10-67 Clinic Services – Agency rules are revised to add clarification and differentiate between provider group and clinic contracts. Provider groups are business entities in which one or more individual providers practice. Provider clinics are facilities or distinct parts of facilities used for the diagnosis and treatment of outpatients. Provider clinics are limited to organizations serving specialized treatment requirements or distinct groups. Clinics must have a specialized contract with the Oklahoma Health Care Authority (OHCA). These rules allow the OHCA to effectively distinguish between provider business entities and treatment facilities during the contracting process.
Budget Impact – Budget Neutral

10-68 Telemedicine Revisions – Agency telemedicine rules are revised to clarify that telemedicine networks be approved at the OHCA's discretion to ensure medical necessity.
Budget Impact – Budget Neutral

Ms. Slatton-Hodges commented that the Health Care Authority and the Dept. of Mental Health and Substance Abuse Services have, over the last several years, brought telemedicine to the behavioral health community, and that there are many areas where access to psychiatric care is difficult. Time spent for a doctor driving from one clinic to another clinic is time that can be utilized to serve individuals in need. This is a valuable addition to our services; any change to the Rule needs to be looked at closely. Ms. Slatton-Hodges said she feels very comfortable speaking with the leadership at the OHCA, that this Rule change was a positive thing that allowed them discretion to regulate things that were outside what they were comfortable with. If there were any unforeseen impacts, they would come back to the table.

10-70 Medically Fragile Waiver - Rules are revised for the Medically Fragile Waiver program to allow for the inclusion of medically fragile individuals with intellectual disabilities. This population is not currently served in any of the OHCA waivers. The Medically Fragile Waiver has services and supports in place to ensure quality of care for this specific population.
Budget Impact – Budget Neutral

10-71 HCBS Assessment - Rules are revised to include general information about three new Waivers operated by the OHCA, the Medically Fragile Waiver, the My Life My Choice Waiver and the Sooner Seniors Waiver. Additionally language is added requiring the OHCA to assess all contracted home-based providers of waiver services an amount of 5.5% of gross revenues. The assessment is to be placed in a Home-Based Quality Assurance fund and used by the Authority for payment of eligible HCBS services. Initiation of the assessment is contingent upon approval by the Centers for Medicare and Medicaid.
Budget Impact – Total annual cost $54,694,996; state share $2,233,602

This item will not go to Board tomorrow for permanency. Contingent upon approval from CMS.

10-77 Proof of Pregnancy Submission Timeframe – Eligibility rules are revised to clarify that pregnant women have thirty (30) days within application submission to provide medical proof of pregnancy in order to continue receiving SoonerCare benefits. Previous policy allowed a period of ten (10) days for submission of pregnancy verification.
Budget Impact – Budget Neutral

<u>OKDHS Initiated</u>

10-59 DDSD Policy Clean-up - Rule revisions are proposed by the OKDHS Developmental Disability Services Division (OKDHS/DDSD) pertaining to clarification of policy for: Eligibility for

services in an ICF/MR and HCBS waiver for persons with mental retardation and related conditions, screening process for in-home supports providers, back-up plan provisions for specialized foster care members and allowance for natural supports within the specialized foster care member's home. Clarification is also provided on training requirements for providers of job coaching services and the limits on goods and services provided through Self-Direction. Additionally policy is revised to clarify provider qualifications for assistive technology devices, and the procurement review/approval process for assistive technology devices. Further policy revisions include clarification of transportation provider responsibilities, services not covered and limits on the types of adapted transportation allowable. Lastly, policy is revised to include clarification of family training provider qualifications and coverage limitations.
Budget Impact – Budget Neutral

10-69 ADvantage Waitlist and Cost Cap - OHCA rules for the ADvantage Waiver are revised to remove language approving ADvantage services when services exceed the established cost cap and remove exceptions to the cost cap. Additionally, waitlist procedures are revised to prohibit entry into the waiver at 90% of capacity, rather than the current 102% of capacity and all exceptions to the waitlist procedure are eliminated. Lastly, language is revised to state that OKDHS performs all eligibility determinations rather than the ADvantage Administration (AA).
Budget Impact – Total $409,777; OKDHS state share - $143,668

Mr. Duehning said the cost estimate is only due to the hard cap; we now cannot have a one-time exclusion to go over the cost cap. We don't have any expectation that there will be a waiting list in the future. Currently, our individual cap is around $29,000. We are well short of that. CMS is asking that we revise our cost cap numbers closer to our actuals, and we don't foresee any reason that there is going to be any bumping against that cost cap. If necessary we could request CMS to raise our cost cap.

Ms. Harrison made the motion to approve Rules 10-04, 10-37, 10-58, 10-60, 10-62, 10-67, 10-68, 10-70, 10-71, 10-77, 10-59, 10-69 as submitted. Mr. Unruh seconded. Motion Carried.

VIII. New Business – Mr. Fogarty commented that recent experience brings him to the podium to strongly urge the MAC to help us with one thing in particular. The MAC members, each represent some group or entity, or an advocate on behalf of certain populations, certain provider groups, sister State agencies, etc. The MAC's primary contribution is that they bring the skill and knowledge and experience in many areas to advise us and the Board. Mr. Fogarty thanked the MAC members and said that next week he will be in Washington, D.C., to talk to a roomful of representatives from other states about some of the good things that are going on here, e.g., Medical Home, On-line Enrollment, etc. Without exception, when he talks, he stresses that these are products of collaboration with a lot of people, most of whom are not paid State employees, but who are in this, as the MAC is, to try to improve the program to deliver great service. Mr. Fogarty said at least a close second to the first mission is to communicate in the other direction. That is, when the MAC members communicate to the people they represent in this meeting about the deliberation that goes on here, the kind of decisions that are made as a result of that deliberation, it means that we don't end up standing in front of a roomful of people who say, "You made this change, and we never heard about it. Why in the world haven't you talked to us about this?" At that point, it's a little late to say we had X many meetings, and their representatives at these meetings, etc. If we send out a notice to 15,000 providers that something changed, chances are the vast majority of those are going to be surprised, because they weren't in the room with us as we deliberated this process. Mr. Fogarty said he encourages the MAC to help us communicate the other direction, so the people they represent aren't surprised, and that they understand they have their own representative in this room. Please let us help do that. It would serve us all well. Help your group understand and be aware that you

take time out of your schedule and participate in this proce ss to produce a better product. Mr. Fogarty said to let him know if we can help with that communication.

IX. Adjourn – 2:20 p.m.

OHCA MAC MEETING

MAY 19, 2011 OHCA MEDICAL ADVISORY COMMITTEE MEETING

OHCA REQUEST BILLS:

- SB 0412 – Sen. Bill Brown – Prohibits Commercial Insurance Companies From Charging Fees to Process SoonerCare Secondary Claims – Signed & Sent to Governor 5-4-2011.
- SB 0679 – Sen. Clark Jolley – Allows Administrative Sanctions to Medicaid Recipients Who Abuse the State Medicaid Program – Passed & Enrolled from Senate 5-10-2011.

After the April 28th deadline for Third Reading of Bills in the Opposite Chamber and as of noon on Tuesday, May 10th, 2011, the Oklahoma Legislature is tracking a total of 686 active bills. OHCA is currently tracking 66 bills. They are broken down as follows:

- OHCA Request 02
- Direct Impact & Agency Interest 36
- Appropriations 06
- Employee Interest 09
- Governor Signed 13

SENATE AND HOUSE REMAINING DEADLINE

May 27, 2011 Sine Die of the first session of the 53rd Legislature

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

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2011, for the Nine Months Ended March 31, 2011

REVENUES	FY11 Budget YTD	FY11 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 579,046,927	$ 579,046,927	$ -	0.0%
Federal Funds	1,571,656,078	1,529,456,367	(42,199,711)	(2.7)%
Tobacco Tax Collections	40,205,369	41,029,075	823,706	2.0%
Quality of Care Collections	37,808,870	39,378,095	1,569,225	4.2%
Prior Year Carryover	45,663,786	35,663,786	(10,000,000)	(21.9)%
HEEIA Fund Transfer	30,000,000	30,000,000	-	0.0%
Federal Deferral - Interest	158,707	158,707	-	0.0%
Drug Rebates	94,148,922	105,228,639	11,079,717	11.8%
Medical Refunds	32,274,221	38,756,498	6,482,277	20.1%
Other Revenues	12,697,079	12,274,771	(422,309)	(3.3)%
Stimulus Funds Drawn	93,302,619	93,302,619	-	0.0%
TOTAL REVENUES	**$ 2,536,962,578**	**$ 2,504,295,484**	**$ (32,667,094)**	**(1.3)%**

EXPENDITURES	FY11 Budget YTD	FY11 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 32,683,890**	**$ 28,323,355**	**$ 4,360,535**	**13.3%**
ADMINISTRATION - CONTRACTS	**$ 81,596,428**	**$ 75,793,099**	**$ 5,803,329**	**7.1%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	23,188,360	20,647,137	2,541,223	11.0%
Acute Fee for Service Payments:				
Hospital Services	682,778,107	660,735,101	22,043,006	3.2%
Behavioral Health	212,359,705	214,553,489	(2,193,785)	(1.0)%
Physicians	312,835,362	325,238,287	(12,402,925)	(4.0)%
Dentists	117,798,769	108,528,763	9,270,006	7.9%
Other Practitioners	40,949,563	44,526,404	(3,576,841)	(8.7)%
Home Health Care	16,186,738	16,062,693	124,045	0.8%
Lab & Radiology	36,396,715	36,645,687	(248,972)	(0.7)%
Medical Supplies	39,495,523	35,849,852	3,645,672	9.2%
Ambulatory Clinics	69,278,619	58,994,452	10,284,168	14.8%
Prescription Drugs	272,396,577	260,308,149	12,088,428	4.4%
Miscellaneous Medical Payments	22,510,070	24,262,438	(1,752,368)	(7.8)%
OHCA TFC	-	1,834,456	(1,834,456)	0.0%
Other Payments:				
Nursing Facilities	366,372,788	367,310,358	(937,570)	(0.3)%
ICF-MR Private	40,617,809	41,722,147	(1,104,339)	(2.7)%
Medicare Buy-In	101,478,680	102,599,105	(1,120,425)	(1.1)%
Transportation	20,460,997	20,250,930	210,068	1.0%
HIT-Incentive Payments	14,858,736	14,858,736	-	0.0%
Part D Phase-In Contribution	51,947,450	50,603,660	1,343,790	2.6%
Total OHCA Medical Programs	**2,441,910,568**	**2,405,531,843**	**36,378,725**	**1.5%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,556,280,268**	**$ 2,509,648,297**	**$ 46,631,971**	**1.8%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (19,317,690)**	**$ (5,352,813)**	**$ 13,964,877**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2011, for the Nine Months Ended March 31, 2011

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	Medicaid Program Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 20,960,520	$ 20,630,446	$ -	$ 313,384	$ -	$ 16,690	$ -
Inpatient Acute Care	636,551,123	449,153,496	365,015	8,946,913	36,708,871	3,582,907	137,793,921
Outpatient Acute Care	177,929,512	166,588,642	31,203	7,004,700	-	4,304,967	
Behavioral Health - Inpatient	89,982,449	86,188,820	-	3,585	-	6,033	3,784,011
Behavioral Health - Outpatient	7,339,550	7,284,646	-	-	-	-	54,904
Behavioral Health Facility- Rehab	161,205,948	120,947,557	-	279,651	-	126,216	39,852,525
Behavioral Health - Case Management	218	149	-	-	-	69	
Residential Behavioral Management	17,235,535	-	-	-	-	-	17,235,535
Targeted Case Management	52,069,720	-	-	-	-	-	52,069,720
Therapeutic Foster Care	1,834,456	1,834,456	-	-	-	-	-
Physicians	362,828,840	273,762,576	43,576	10,012,814	43,883,494	7,548,641	27,577,739
Dentists	108,548,454	102,679,473	-	19,691	5,758,786	90,505	-
Other Practitioners	44,899,419	43,463,777	334,773	373,015	690,916	36,938	-
Home Health Care	16,062,693	16,018,762	-	-	-	43,931	-
Lab & Radiology	38,909,898	35,499,364	-	2,264,210	-	1,146,323	-
Medical Supplies	36,287,240	33,734,990	2,038,376	437,389	-	76,486	-
Ambulatory Clinics	68,822,145	58,485,781	-	1,240,588	-	508,671	8,587,106
Personal Care Services	9,307,733	-	-	-	-	-	9,307,733
Nursing Facilities	367,310,358	234,399,514	102,614,298	-	30,261,506	35,039	-
Transportation	20,250,930	18,356,721	1,840,937	-	46,199	7,073	-
GME/IME/DME	87,216,110	-	-	-	-	-	87,216,110
ICF/MR Private	41,722,147	34,212,827	6,879,580	-	629,740	-	-
ICF/MR Public	56,448,744	-	-	-	-	-	56,448,744
CMS Payments	153,202,765	151,237,615	1,965,150	-	-	-	-
Prescription Drugs	272,146,072	226,157,611	-	11,837,923	32,199,023	1,951,515	-
Miscellaneous Medical Payments	24,262,615	23,118,522	-	177	1,039,558	104,358	-
Home and Community Based Waiver	116,175,629	-	-	-	-	-	116,175,629
Homeward Bound Waiver	66,875,285	-	-	-	-	-	66,875,285
Money Follows the Person	3,524,819	-	-	-	-	-	3,524,819
In-Home Support Waiver	18,132,469	-	-	-	-	-	18,132,469
ADvantage Waiver	136,585,267	-	-	-	-	-	136,585,267
Family Planning/Family Planning Waiver	5,613,881	-	-	-	-	-	5,613,881
Premium Assistance*	40,582,504	-	-	40,582,504	-	-	-
HIT Grant Incentive Payments	14,858,736	14,858,736					
Total Medicaid Expenditures	**$ 3,275,683,785**	**$2,118,614,480**	**$ 116,112,908**	**$ 83,316,543**	**$ 151,218,093**	**$ 19,586,361**	**$ 786,835,399**

* Includes $40,387,674.35 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2011, for the Nine Months Ended March 31, 2011

		FY11 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	316,360,821
Federal Funds		511,906,486
TOTAL REVENUES	**$**	**828,267,306**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	116,175,629
Money Follows the Person		3,524,819
Homeward Bound Waiver		66,875,285
In-Home Support Waivers		18,132,469
ADvantage Waiver		136,585,267
ICF/MR Public		56,448,744
Personal Care		9,307,733
Residential Behavioral Management		13,237,110
Targeted Case Management		39,894,449
Total Department of Human Services		**460,181,505**
State Employees Physician Payment		
Physician Payments		27,577,739
Total State Employees Physician Payment		**27,577,739**
Education Payments		
Graduate Medical Education		42,900,000
Graduate Medical Education - PMTC		3,321,976
Indirect Medical Education		28,813,252
Direct Medical Education		12,180,882
Total Education Payments		**87,216,110**
Office of Juvenile Affairs		
Targeted Case Management		2,149,957
Residential Behavioral Management - Foster Care		43,049
Residential Behavioral Management		3,955,377
Multi-Systemic Therapy		54,904
Total Office of Juvenile Affairs		**6,203,287**
Department of Mental Health		
Targeted Case Management		98
Hospital		3,784,011
Mental Health Clinics		39,852,525
Total Department of Mental Health		**43,636,635**
State Department of Health		
Children's First		1,575,787
Sooner Start		1,793,899
Early Intervention		4,755,858
EPSDT Clinic		1,510,908
Family Planning		56,699
Family Planning Waiver		5,520,067
Maternity Clinic		67,589
Total Department of Health		**15,280,808**
County Health Departments		
EPSDT Clinic		600,957
Family Planning Waiver		37,115
Total County Health Departments		**638,072**
State Department of Education		**105,515**
Public Schools		**3,588,055**
Medicare DRG Limit		**135,030,011**
Native American Tribal Agreements		**4,613,752**
Department of Corrections		**102,505**
JD McCarty		**2,661,405**
Total OSA Medicaid Programs	**$**	**786,835,399**
OSA Non-Medicaid Programs	**$**	**53,710,991**
Accounts Receivable from OSA	**$**	**12,279,084**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2011, for the Nine Months Ended March 31, 2011

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 39,346,084	$ 39,346,084
Interest Earned	32,011	32,011
TOTAL REVENUES	**$ 39,378,095**	**$ 39,378,095**

EXPENDITURES	FY 11 Total $ YTD	FY 11 State $ YTD	Total State $ Cost
Program Costs			
NF Rate Adjustment	$ 99,796,483	$ 35,118,383	
Eyeglasses and Dentures	217,775	76,635	
Personal Allowance Increase	2,600,040	914,954	
Coverage for DME and supplies	2,038,376	717,305	
Coverage of QMB's	774,567	272,570	
Part D Phase-In	1,965,150	1,965,150	
ICF/MR Rate Adjustment	3,676,485	1,293,755	
Acute/MR Adjustments	3,203,095	1,127,169	
NET - Soonerride	1,840,937	647,826	
Total Program Costs	**$ 116,112,908**	**$ 42,133,746**	**$ 42,133,746**
Administration			
OHCA Administration Costs	$ 399,313	$ 199,656	
DHS - 10 Regional Ombudsman	159,103	159,103	
OSDH-NF Inspectors	243,085	243,085	
Mike Fine, CPA	13,500	6,750	
Total Administration Costs	**$ 815,001**	**$ 608,594**	**$ 608,594**
Total Quality of Care Fee Costs	**$ 116,927,909**	**$ 42,742,340**	
TOTAL STATE SHARE OF COSTS			**$ 42,742,340**

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 2011, for the Nine Months Ended March 31, 2011

REVENUES	FY 10 Carryover	FY 11 Revenue	Total Revenue
Prior Year Balance	$ 45,276,770	$ -	$ 7,497,524
State Appropriations	(30,000,000)		
Tobacco Tax Collections	-	33,745,035	33,745,035
Interest Income	-	853,980	853,980
Federal Draws	383,873	25,182,089	25,182,089
All Kids Act	(7,729,892)	270,108	270,108
TOTAL REVENUES	$ 7,930,751	$ 60,051,212	$ 67,278,628

EXPENDITURES	FY 10 Expenditures	FY 11 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 40,129,550	$ 40,129,550
College Students		194,830	194,830
All Kids Act		258,124	258,124
Individual Plan			
SoonerCare Choice		$ 306,289	$ 107,783
Inpatient Hospital		8,892,212	3,129,169
Outpatient Hospital		6,932,781	2,439,646
BH - Inpatient Services		3,585	1,261
BH Facility - Rehabilitation Services		278,096	97,862
Physicians		9,922,536	3,491,741
Dentists		14,036	4,939
Other Practitioners		365,099	128,478
Home Health		-	-
Lab and Radiology		2,237,090	787,232
Medical Supplies		435,790	153,355
Ambulatory Clinics		1,229,191	432,552
Prescription Drugs		11,732,298	4,128,596
Miscellaneous Medical		177	62
Premiums Collected		-	(1,683,635)
Total Individual Plan		$ 42,349,180	$ 13,219,041
College Students-Service Costs		$ 350,806	$ 123,449
All Kids Act- Service Costs		$ 34,054	$ 11,984
Total Program Costs		$ 83,316,543	$ 53,936,978
Administrative Costs			
Salaries	$ 22,395	$ 1,044,055	$ 1,066,450
Operating Costs	117,115	105,082	222,197
Health Dept-Postponing	29,637	-	29,637
Contract - HP	264,080	2,230,909	2,494,988
Total Administrative Costs	$ 433,227	$ 3,380,046	$ 3,813,272
Total Expenditures			$ 57,750,250
NET CASH BALANCE	$ 7,497,524		$ 9,528,377

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

Fiscal Year 2011, for the Nine Months Ended March 31, 2011

REVENUES	FY 11 Revenue	State Share
Tobacco Tax Collections	$ 673,464	$ 673,464
TOTAL REVENUES	**$ 673,464**	**$ 673,464**

EXPENDITURES	FY 11 Total $ YTD	FY 11 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 16,690	$ 4,111	
Inpatient Hospital	3,582,907	882,470	
Outpatient Hospital	4,304,967	1,060,313	
Inpatient Free Standing	6,033	1,486	
MH Facility Rehab	126,216	31,087	
Case Mangement	69	17	
Nursing Facility	35,039	8,630	
Physicians	7,548,641	1,859,230	
Dentists	90,505	22,291	
Other Practitioners	36,938	9,098	
Home Health	43,931	10,820	
Lab & Radiology	1,146,323	282,339	
Medical Supplies	76,486	18,838	
Ambulatory Clinics	508,671	125,286	
Prescription Drugs	1,951,515	480,658	
Transportation	7,073	1,742	
Miscellaneous Medical	104,358	25,703	
Total Program Costs	$ 19,586,361	$ 4,824,121	**$ 4,824,121**
TOTAL STATE SHARE OF COSTS			**$ 4,824,121**

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.

FINANCIAL REPORT

For the Nine Months Ended March 31, 2011
Submitted to the CEO & Board
May 12, 2011

- Revenues for OHCA through March, accounting for receivables, were **$2,504,295,484** or **(1.3%) under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,509,648,297** or **1.8% under** budget.
- The state dollar budget variance through March is **$13,964,877 positive.**
- The prior year carryover was reduced by **$10,000,000** due to the Office of State Finance redistribution of State Fiscal Stabilization Funds.
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		10.4
Administration		5.2
Revenues:		
Prior Year-Reduction		(10.0)
Taxes and Fees		2.4
Drug Rebate		3.9
Overpayments/Settlements		2.1
Total FY 11 Variance	**$**	**14.0**

ATTACHMENTS

SoonerCare Programs

March 2011 Data for May 2011 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Monthly Enrollment Average SFY2010	Enrollment March 2011	Total Expenditures March 2011	Average Dollars Per Member Per Month March 2011
SoonerCare Choice Patient-Centered Medical Home			435,958	**456,045**	**$150,803,926**	
	Lower Cost	*(Children/Parents; Other)*		410,236	$102,709,565	$250
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		45,809	$48,094,361	$1,050
SoonerCare Traditional			219,646	**237,670**	**$236,299,832**	
	Lower Cost	*(Children/Parents; Other)*		132,546	$85,668,533	$646
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		105,124	$150,631,299	$1,433
SoonerPlan			23,255	**33,654**	**$682,272**	$20
Insure Oklahoma			28,594	**32,349**	**$10,532,464**	
	Employer-Sponsored Insurance		17,857	19,246	$5,013,852	$261
	Individual Plan		10,736	13,103	$5,518,613	$421
TOTAL			**707,453**	**759,718**	**$398,318,495**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $22,790,489 are excluded.

Net Enrollee Count Change from Previous Month Total	7,625

New Enrollees	20,625

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

Qualifying Group	Age Group	Enrollment
Aged/Blind/Disabled	*Child*	19,893
Aged/Blind/Disabled	*Adult*	128,778
Other	*Child*	146
Other	*Adult*	19,540
PACE	*Adult*	79
TEFRA	*Child*	385
Living Choice	*Adult*	130
OLL Enrollment		**168,951**

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

Medicare and SoonerCare	Monthly Average SFY2010	Enrolled March 2011
Dual Enrollees	**100,143**	**104,538**

		Monthly Average SFY2010	Enrolled March 2011
Long-Term Care Members		**15,820**	**15,655**
	Child	37	87
	Adult	15,783	15,568

PER MEMBER PER MONTH

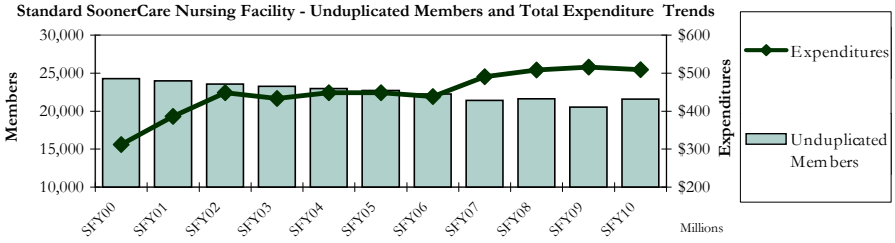
$3,637

SFY2010 Long-Term Care

Statewide LTC Occupancy Rate - 69.8%
SoonerCare funded LTC Bed Days 68.6%

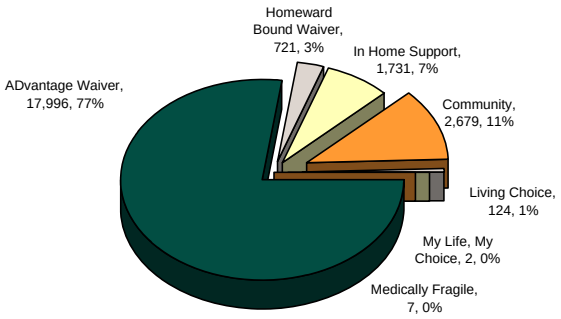
Data as of September 2010

Standard SoonerCare Nursing Facility - Unduplicated Members and Total Expenditure Trends



Data as of Oct. 15, 2010. Figures do not include intermediate care facilities for the mentally retarded (ICF/MR).

Waiver Enrollment Breakdown Percent



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

SoonerCare Programs

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2010	Enrolled March 2011
Total Providers		**28,000**	**28,871**
	In-State	19,563	20,509
	Out-of-State	8,437	8,362

Program	% of Capacity Used
SoonerCare Choice	41%
SoonerCare Choice I/T/U	12%
Insure Oklahoma IP	3%

Select Provider Type Counts	*In-State Monthly Average SFY2010**	*In-State Enrolled March 2011***	Total Monthly Average SFY2010	Total Enrolled March 2011
Physician	*6,074*	*6,480*	10,664	11,808
Pharmacy	*879*	*903*	1,168	1,231
Mental Health Provider	*908*	*949*	983	991
Dentist	*790*	*802*	893	910
Hospital	*179*	*186*	790	754
Licensed Behavioral Health Practitioner	*N/A*	*523*	N/A	543
Extended Care Facility	*392*	*393*	395	393

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

Total Primary Care Providers	*4,072*	*4,429*	6,063	6,418
Patient-Centered Medical Home	*1,339*	*1,484*	1,360	1,510

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.

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.

	March 2011		Since Inception	
	Number of Payments	Payment Amount	Total Number of Payments	Total Payment Amount
Eligible Professionals	326	$6,927,500	353	$7,501,250
Eligible Hospitals	12*	$10,576,612	16	$13,047,307
Totals	326	$17,504,112	369	$20,548,557

*Current Eligible Hospitals Paid

GREAT PLAINS REGIONAL MEDICAL CENTER
INTEGRIS BASS MEMORIAL BAPTIST HOSPITAL
INTEGRIS GROVE HOSPITAL
HOLDENVILLE GENERAL HOSPITAL
MAYES COUNTY MEDICAL CENTER
DUNCAN REGIONAL HOSPITAL
INTEGRIS SOUTHWEST MEDICAL
OKMULGEE MEMORIAL HOSPITAL
INTEGRIS MARSHALL MEM HOSPITAL
INTEGRIS CANADIAN VALLEY HOSPITAL
GRADY MEMORIAL HOSPITAL
INTEGRIS BAPTIST MEDICAL CENTER

SoonerCare Program Operations & Benefits
May 2011 MAC Meeting

SoonerRide: Non-Emergency Transportation

- **SoonerRide** is curb-to-curb service designed to assist individuals without adequate transportation to and from medically necessary appointments. A trip to the pharmacy may also be included.
- **SoonerRide** members may call 1-877-404-4500 to schedule their trip. The reservation clerks are required to screen the member's needs for the most appropriate transportation. Appropriate forms of transportation might be determined to include mileage reimbursement or public transportation/bus passes.
- **SoonerRide** requires that a trip reservation be made at least 3 business days prior for routine trips. Examples might include regular physician or dental visits and standing appointments such as physical therapy. Whenever possible, SoonerRide will give consideration to members who request transportation even if under the 3-day guideline. The request may be accommodated depending on available space and resources.

    - An **urgent care** trip request can be evaluated for SoonerRide services; however, a doctor's office must verify that an urgent care appointment is necessary. After an urgent care appointment is scheduled, SoonerRide will contact the doctor's office to verify the appointment.
    - **Mileage reimbursement** is available for members who find their own transportation to appointments such as for urgent care. A trip authorization number must be obtained by calling the SoonerRide reservation line at 1-877-404-4500 in advance of the appointment.
    - A **transportation request** for a same-day hospital or emergency room discharge should be initiated by the hospital making the request.
    - When **transport from a nursing facility** is requested, an attendant from the facility at the level of a nurse's aide or an adult family member must accompany the member to provide any and all assistance needed.
    - Members having a **medically necessary overnight procedure** scheduled at a medical facility 50 or more miles away from their home may receive assistance with the necessary expenses for lodging and meals. Members can pay for lodging and meals and submit reimbursement form with receipts, if a contracted motel is not available. Reimbursement cannot exceed state per diem amounts.

        - Contracts are held with various hospitals, Ronald McDonald houses and motels to provide lodging and food for members receiving services. A voucher is submitted by OHCA to the lodging facility prior to the scheduled medical procedure. The member would not have to pay for lodging and food at these approved locations; however, a request must be made by the member and approved through SoonerRide prior to travel.
        - Food and lodging may be provided for one authorized escort, when a member's health does not permit traveling alone and/or if the member is a minor child. The necessity of the escort is determined by OHCA.

OHCA Initiated

11-07 PT/OT/ST Clarification — PT/OT/ST rules restrict individually-contracted provider services to children. Rules are amended to clarify in policy that there is no coverage for adults for services rendered by individually-contracted providers however, therapy services are covered for adults in an outpatient hospital setting. **Budget Impact:** Budget Neutral.

Federally Initiated

11-02 Tax Credit Exemption — The Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 requires state Medicaid agencies to disregard federal tax refunds or advance payments with respect to refundable tax credits as income and as resources for purposes of determining eligibility. To bring Agency policy in compliance with this law, eligibility rules and income guidelines are revised to eliminate consideration of the Earned Income Tax Credit, which is the only refundable tax credit currently counted for eligibility purposes. **Budget Impact:** Budget Neutral

11-05 Insure Oklahoma—Native American Cost-Sharing — Insure Oklahoma cost-sharing rules are revised to comply with Federal law on Native American cost-sharing exemptions. Native American adults are exempt from Insure Oklahoma—Individual Plan co-pays or premiums when they receive services provided by Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/U) providers or through referral by contract health services. Native American children are exempt from cost-sharing regardless of whether they receive services provided by I/T/U providers or through referral by contract health services. **Budget Impact:** $189,422 total impact; $64,595 state impact