

**OKLAHOMA STATE BOARD OF HEALTH MEETING  
JANUARY 13, 2014**

<b>1.</b>	<b>DECEMBER 9, 2014 MEETING MINUTES</b>
<b>2.</b>	<b>TRAUMA AND EMERGENCY RESPONSE ADVISORY COUNCIL APPOINTMENT</b>
<b>3.</b>	<b>OKLAHOMA HOSPITAL ASSOCIATION PRESENTATION</b>
<b>4.</b>	<b>STRATEGIC MAP UPDATE PRESENTATION</b>
<b>5.</b>	<b>FINANCE COMMITTEE REPORT</b>
<b>6.</b>	<b>COMMISSIONER'S REPORT</b>

**Agenda for the 11:00 a.m., Tuesday, January 13, 2015  
Regular Meeting of the Oklahoma State Board of Health**

Posted at [www.health.ok.gov](http://www.health.ok.gov)

Oklahoma State Department of Health  
1000 N.E. 10<sup>th</sup> Street – Room 1102  
Oklahoma City, OK 73117-1299

**I. CALL TO ORDER AND OPENING REMARKS**

**II. REVIEW OF MINUTES**

a) Approval of Minutes for December 9, 2014, Regular Meeting

**III. APPOINTMENTS**

b) **Trauma and Emergency Response Advisory Council Appointments (Presented by Henry F. Hartsell, Jr.)**

**Appointment:** One Member

**Authority:** 63 O.S., § 1-103a.1.

**Members:** The Advisory Council shall consist of seven (7) members. Membership is defined in statute. One critical care nurse shall be appointed by the State Board of Health.

**IV. OKLAHOMA HOSPITAL ASSOCIATION PRESENTATION:** Craig W. Jones, FACHE, President, Oklahoma Hospital Association

**V. STRATEGIC MAP UPDATE PRESENTATION:** Mark Newman, Ph.D., Director, Office of State and Federal Policy

**VI. CONSIDERATION OF STANDING COMMITTEES' REPORTS AND ACTION**

Executive Committee – Dr. Woodson, Chair

Discussion and possible action on the following:

c) Update

Finance Committee – Ms. Burger, Chair

Discussion and possible action on the following:

d) Update

Accountability, Ethics, & Audit Committee – Dr. Alexopoulos, Chair

Discussion and possible action on the following:

e) Update

Public Health Policy Committee – Dr. Gerard, Chair

Discussion and possible action on the following:

f) Update

**VII. PRESIDENT'S REPORT**

Related discussion and possible action on the following:

g) Update

**VIII. COMMISSIONER'S REPORT**

Discussion and possible action

**IX. NEW BUSINESS**

Not reasonably anticipated 24 hours in advance of meeting

**X. PROPOSED EXECUTIVE SESSION**

Proposed Executive Session pursuant to 25 O.S. Section 307(B)(4) for confidential communications to discuss pending department litigation, investigation, claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring, appointment, promotion, demotion, disciplining or resignation of any individual salaried public officer or employee and pursuant to 25 O.S. Section 307 (B)(7) for discussing any matter where disclosure of information would violate confidentiality requirements of state or federal law.

- Annual performance evaluation for the Commissioner of Health

Possible action taken as a result of Executive Session.

**XI. ADJOURNMENT**

STATE BOARD OF HEALTH  
OKLAHOMA STATE DEPARTMENT OF HEALTH  
1000 N.E. 10<sup>th</sup>  
Oklahoma City, Oklahoma 73117-1299

Tuesday, December 9, 2014 11:00 a.m.

Ronald Woodson, President of the Oklahoma State Board of Health, called the 394<sup>th</sup> regular meeting of the Oklahoma State Board of Health to order on Tuesday, December 9, 2014 at 11:13 a.m. The final agenda was posted at 11:00 a.m. on the OSDH website on December 8, 2014, and at 11:00 a.m. at the building entrance on December 8, 2014.

**ROLL CALL**

**Members in Attendance:** Ronald Woodson, M.D., President; Martha Burger, M.B.A., Vice-President; Cris Hart-Wolfe, Secretary-Treasurer; Jenny Alexopoulos, D.O.; R. Murali Krishna, M.D.; Terry Gerard, D.O.; Charles W. Grim, D.D.S.; Robert S. Stewart, M.D.

**Absent:** Timothy E. Starkey, M.B.A.

**Central Staff Present:** Terry Cline, Commissioner; Julie Cox-Kain, Chief Operating Officer; Henry F. Hartsell, Deputy Commissioner, Protective Health Services; Steve Ronck, Deputy Commissioner, Community and Family Health Services; Toni Frioux, Deputy Commissioner, Prevention and Preparedness Services; Mark Newman, Director of Office of State and Federal Policy; Don Maisch, Office of General Counsel; Jay Holland, Director of Internal Audit and Office of Accountability Systems; Tony Sellars, Director of Office of Communications; Officer; VaLauna Grissom, Secretary to the State Board of Health; Commissioner’s Office; Felesha Scanlan.

**Visitors in attendance:** (see sign in sheet)

**Call to Order and Opening Remarks**

Dr. Woodson called the meeting to order. He welcomed special guests in attendance.

**REVIEW OF MINUTES**

Dr. Woodson directed attention to review of the minutes of the October 7, 2014, Regular Board meeting.

**Ms. Burger moved Board approval of the minutes of the October 7, 2014, Special Board meeting, as presented. Second Dr. Krishna. Motion carried.**

**AYE: Alexopoulos, Burger, Grim, Krishna, Woodson**

**ABSTAIN: Gerard, Stewart, Wolfe**

**ABSENT: Starkey**

**APPOINTMENTS**

**Hospital Advisory Council Appointments (Presented by Henry F. Hartsell, Jr.)**

**Appointments:** Four Members

**Authority:** 63 O.S., § 1-707

**Members:** The Advisory Council shall consist of seven (9) nine members. Membership is defined in statute. Two members, who are licensed physicians and have privileges to provide services in hospitals; two members, who are hospital administrators of licensed hospitals; and one member, who is a hospital employee, shall be appointed by the State Board of Health.

**Ms. Wolfe moved Board approval for Appointment of Jay Gregory, Tricia Horn, Susan Dragoo, and Stanley Alexander to the Hospital Advisory Council as presented. Second Dr. Krishna. Motion carried.**

There were no comments or questions from the Board.

**AYE: Alexopulos, Burger, Gerard Grim, Krishna, Stewart, Wolfe, Woodson**

**ABSENT: Starkey**

PROPOSED RULEMAKING ACTIONS

**CHAPTER 265. HEARING AID DEALERS AND FITTERS REGULATION**

[PERMANENT] [EMERGENCY] Presented by Donald D. Maisch

**PROPOSED RULES:**

Subchapter 3. Examinations

310:265-3-1 [AMENDED]

310:265-3-2 [AMENDED]

**AUTHORITY:** Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 63 O.S. Section 1-1750.

**SUMMARY:** The purpose of this rule change is to prevent an increase in examination fees charged to applicants for licenses to fit and deal hearing aids pursuant to Title 63 § 1-1750 et seq. The vendor is requiring that its examination fees be raised from the current \$95.00 as provided in rule, to \$225.00. Additionally, the proposed rule will prevent the Oklahoma State Department of Health from being required by the examination vendor to defend the examination questions and answers against requests made under the Oklahoma Open Records Act. Additionally, the proposed rule prevents the Oklahoma State Department of Health from being financially liable for damages to the examination vendor should the Department not succeed in preventing disclosure under the Oklahoma Open Records Act. The proposed changes accomplish these purposes by deleting the business name of a specific examination vendor, and by allowing for testing guidelines to be drawn from a national examination, if available, rather than from a specifically named society. The changes will facilitate the Department’s efforts to compile and offer an examination to license applicant for licensure without fee increases, and without exposing the State of Oklahoma to financial loss related to an Oklahoma Open Records Act disclosure.

**Dr. Alexopulos moved Board approval for Emergency Adoption of Chapter 265. Hearing Aid Dealers and Fitters Regulation as presented. Second Dr. Stewart. Motion carried.**

There was discussion regarding the current vendor providing the test for 39 other states and the issues that may occur with open records. Don Maisch indicated each state’s open records act is different. He also indicated there will be some additional cost to the agency for the development of the new test with CareerTech, however, this vendor has developed other testing of the agency in the past.

**AYE: Alexopulos, Burger, Gerard Grim, Krishna, Stewart, Wolfe, Woodson**

**ABSENT: Starkey**

**Ms. Wolfe moved Board approval for Permanent Adoption of Chapter 265. Hearing Aid Dealers and Fitters Regulation as presented. Second Dr. Gerard. Motion carried.**

**AYE: Alexopulos, Burger, Gerard Grim, Krishna, Stewart, Wolfe, Woodson**

**ABSENT: Starkey**

**CHAPTER 406. LICENSED GENETIC COUNSELORS**

[PERMANENT] Presented by Lynette Jordan

**PROPOSED RULES:**

Subchapter 1. General Provisions

310:406-1-2 [AMENDED]

Subchapter 3. Advisory Committee Operations [REVOKED]

310:406-3-1 [REVOKED]

310:406-3-2 [REVOKED]

310:406-3-3 [REVOKED]

310:406-3-4 [REVOKED]

310:406-3-5 [REVOKED]

Subchapter 23. Enforcement

310:406-23-2 [AMENDED]

1 310:406-23-5 [AMENDED]

2 **AUTHORITY:** Oklahoma State Board of Health, Title 63 O.S. Section 1-104; and Title 63 O.S. Section 1-  
3 561 and Title 63 O.S. Section 1-103.a.1.

4 **SUMMARY:**

5 The current rule applies to licensure of genetic counselors in the State of Oklahoma. The proposed changes  
6 update language to accurately comply with the Oklahoma Public Health Advisory Council Modernization  
7 Act. This change is necessary to bring the regulation in line with the Genetic Counseling Licensure Act and  
8 the Oklahoma Public Health Advisory Council Modernization Act which went into effect November 1, 2014.  
9 The effect of the rule change would be to clarify the advisory council for this particular licensed profession.

10 310:406-1-2 The current rule defines the advisory entity as the Genetic Counseling Advisory Committee.  
11 The proposal establishes to remove the definition. The new advisory council is outlined in the Oklahoma  
12 Public Health Advisory Council Modernization Act. This change is necessary to be in compliance with the  
13 changes established in the Oklahoma Public Health Advisory Council Modernization Act. The effect of the  
14 Rule change would be to clarify the legal advisory entity as the Infant and Children's Health Advisory  
15 Council.

16 310:406 Subchapter 3 [REVOKED] The current rule identifies the title of the advisory entity as a committee.  
17 The proposal revokes the subchapter. This change is needed to be in compliance with the changes established  
18 in the Oklahoma Public Health Advisory Council Modernization Act which created the new Infant and  
19 Children's Health Advisory Council with advisory responsibilities for licensed genetic counseling. The effect  
20 of the Rule change would be to clarify the legal advisory entity as a council.

21 310:406-3-1 [REVOKED] The current rule creates the Genetic Counseling Advisory Committee. The  
22 proposal removes this language. This change is needed to be in compliance with the changes established in  
23 the Oklahoma Public Health Advisory Council Modernization Act. The effect of the Rule change would be  
24 to clarify the purpose of the newly established council.

25 310:406-3-2 [REVOKED] The current rule defines the membership of the Genetic Counseling Advisory  
26 Committee. The proposal revokes this subchapter. This change is needed because the Oklahoma Public  
27 Health Advisory Council Modernization Act establishes the membership of the newly established Infant and  
28 Children's Health Advisory Council. The effect of the Rule change would be to revoke the membership of  
29 the Genetic Counseling Advisory Committee which is no longer supported in the Act.

30 310:406-3-3 [REVOKED] The current rule defines the officers of the Genetic Counseling Advisory  
31 Committee. The proposal revokes this subchapter. This change is needed because the Oklahoma Public  
32 Health Advisory Council Modernization Act already establishes the officers of the newly established Infant  
33 and Children's Health Advisory Council. The effect of the Rule change would be to revoke the officer  
34 designation of the Genetic Counseling Advisory Committee which is no longer supported in the Act.

35 310:406-3-4 [REVOKED] The current rule states the "committee" will utilize Robert's Rules of Order  
36 Newly Revised, 10th ed. The proposal revokes this subchapter. This change is needed because the Oklahoma  
37 Public Health Advisory Council Modernization Act establishes the new Infant and Children's Health  
38 Advisory Council.

39  
40 **Dr. Stewart moved Board approval for Permanent Adoption of Chapter 406. Licensed Genetic  
41 Counselors as presented. Second Dr. Krishna. Motion carried.**

42  
43 **AYE: Alexopulos, Burger, Gerard Grim, Krishna, Stewart, Wolfe, Woodson**

44 **ABSENT: Starkey**

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46 **CHAPTER 667. HOSPITAL STANDARDS**

47 **[PERMANENT]** Presented by Timothy Cathey

48 **PROPOSED RULES:** Subchapter 59. Classification of Hospital Emergency Services

49 310:667-59-20 [AMENDED]

50 **AUTHORITY:** Oklahoma State Board of Health, Title 63 O.S. Section 1-104; Title 63 O.S. Section 1-270;  
51 and Title 63 O.S. Section 1-705.

52 **SUMMARY:**

53 The amendments to OAC 310:667 revise sections of rule within Subchapter 59, Classification of Hospital  
54 Emergency Services, to update classification standards for stroke centers. These standards are intended to  
55 stratify hospitals into those hospitals capable of providing comprehensive care for all stroke patients from  
56 those with limited or no capability to care for the acutely ill, time sensitive stroke patient.

1 The proposed rules would allow the Oklahoma State Department of Health (OSDH) to recognize four levels  
 2 of hospital based stroke care. Level I would be a comprehensive center capable of care for all stroke patients.  
 3 The Level II would represent the most current standard required to be a primary stroke center. OSDH will  
 4 recognize certification from a Center for Medicare and Medicaid Services deemed accrediting agency or an  
 5 OSDH approved organization using nationally recognized guidelines for Level I and II facilities.  
 6 The Level III stroke facility will be mainly focused on the acute care of a patient presenting to the emergency  
 7 room who is likely to benefit from stabilization and expeditious thrombolytic therapy prior to transfer to a  
 8 higher level of care. The Level IV hospital reflects a facility without the resources to provide acute care for  
 9 the time sensitive needs of the stroke patient. They would be organized to quickly evaluate, stabilize and  
 10 arrange transfer of the acute stroke patient. OSDH would recognize a Level III facility by way of a current  
 11 certification as an Acute Stroke Ready Hospital from a deemed accrediting agency, a department approved  
 12 nationally recognized guidelines based organization or through OSDH. The Level IV facility would be  
 13 certified only by OSDH.

14  
 15 **Dr. Krishna moved Board approval for Permanent Adoption of Chapter 406. Licensed Genetic**  
 16 **Counselors as presented. Second Ms. Wolfe. Motion carried.**

17  
 18 There was discussion from the Board to clarify language within the rule labeling certain facilities as “stroke  
 19 referral” facilities. Dr. Cathey clarified these facilities are not receiving stroke patients, rather referring them  
 20 to facilities with resources to serve needs of stroke patients.

21  
 22 **AYE: Alexopulos, Burger, Gerard Grim, Krishna, Stewart, Wolfe, Woodson**  
 23 **ABSENT: Starkey**

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 25 **CHAPTER 526. DENTAL SERVICES**

26 **[PERMANENT]** Presented by Jana Winfree

27 **PROPOSED RULES:**

28 Subchapter 3. Oklahoma Dental Loan Repayment Program

29 310:526-3-2 [AMENDED]

30 310:526-3-3 [AMENDED]

31 310:526-3-4 [AMENDED]

32 **AUTHORITY:** Oklahoma State Board of Health, Title 63 O.S. Sections 1-104 and 1-2710 et seq. as  
 33 amended by Senate Bill 1664, effective November 1, 2014.

34 **SUMMARY:**

35 310:526-3-2 The current Rule sets forth the description and general operation of the Oklahoma  
 36 Dental Loan Repayment Program (Program). The proposed action expands the locations of practice sites and  
 37 increases the maximum amount allowed of individual awards from \$25,000 to \$50,000.

38 The circumstance for the rule change is compelled by legislation in SB 1664, effective November 1,  
 39 2014. The intended effect is to increase Program participation, allow a more competitive compensation, and  
 40 better utilize available funding.

41 310:526-3-3 The current Rule establishes eligibility requirements to participate in the Program.

42 The proposed action allows an exemption from the requirement to practice in a designated dental  
 43 health professional shortage area for Pediatric Dentistry Specialists or any dentist practicing in a Federally  
 44 Qualified Health Center (FQHC), FQHC look-alike, county health department, or city-county health  
 45 department. The intended effect is to include participation by specialists trained to treat the younger  
 46 Medicaid population and those practicing in specific public health facilities regardless of the practice site  
 47 location.

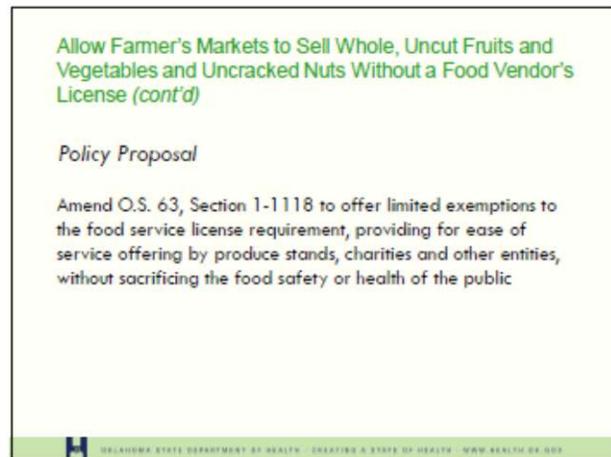
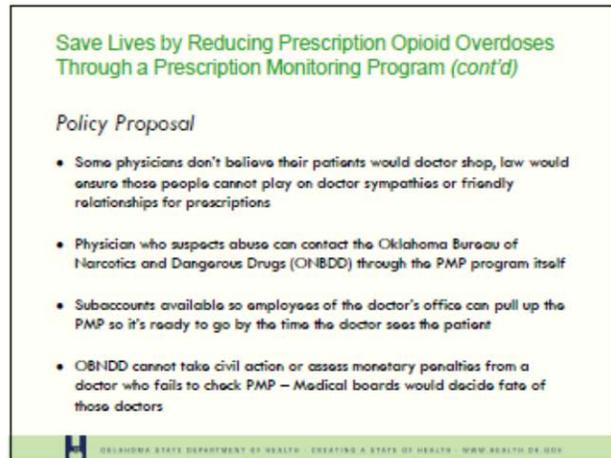
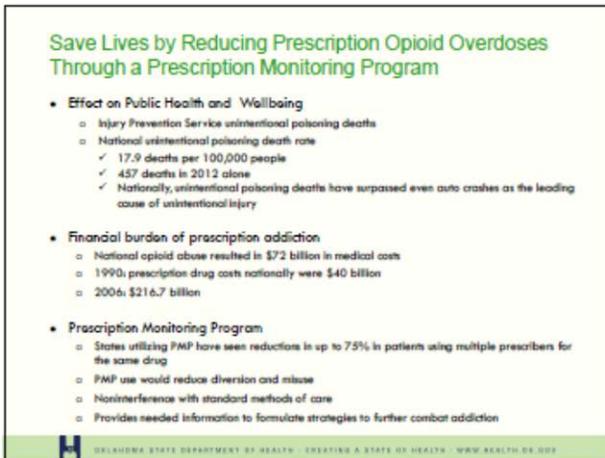
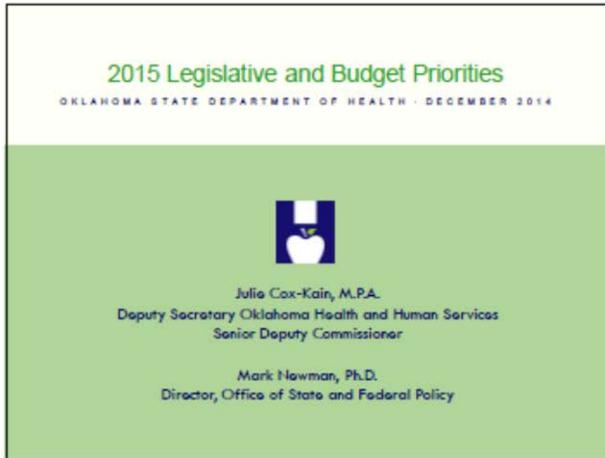
48 310:526-3-4 The current Rule describes the procedures for administering the Program. The proposed action  
 49 describes what is monitored to determine the dental health professional shortage areas for purposes of the  
 50 Oklahoma Dental Loan Repayment Program instead of how the determination is calculated. This change is  
 51 needed to resolve complicated, technical, and outdated language. The purpose is to improve the  
 52 understanding of shortage area determinations while upholding the intent of the law. The description of  
 53 annual shortage area calculations will be maintained in agency files to ensure consistency with the use of  
 54 current available data, current advisory entities, and topical circumstances associated with Medicaid dental  
 55 providers and enrollees.

Dr. Grim moved Board approval for Permanent Adoption of Chapter 526. Dental Services as presented. Second Ms. Burger. Motion carried.

AYE: Alexopulos, Burger, Gerard Grim, Krishna, Stewart, Wolfe, Woodson  
ABSENT: Starkey

2014 LEGISLATION

Mark Newman, Ph.D., Director, Office of State and Federal Policy



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Modify Advance Directive Law to Allow for Contracting With Private Enterprise

Public/Private Partnership

- Existing enterprise with infrastructure in place
- Service is provided conveniently, quickly and at a lower cost
- OSDH does not spend taxpayer money creating fees and databases which already exist in a private enterprise

Modify Advance Directive Law to Allow for Contracting With Private Enterprise (cont'd)

Policy Proposal

- Amend O.S. 63, Section 3102.1 allowing contracts with private vendors to fulfill the provisions of the Advance Directive Act and removing the provisions directing the OSDH establish a database for advance directives
- The costs and fees for the vendor would be established by contract
- Amend O.S. 63, Section 3102.2 to remove the language relating to the Board of Health establishing a fee for submission of each Alternative Advance Directive Forms

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For More Information

Mark Newman, Ph.D., Director, Office of State and Federal Policy  
(405) 271-4200

[MarkSN1@health.ok.gov](mailto:MarkSN1@health.ok.gov)

BUDGET PRIORITIES

STATE FISCAL YEAR 2016 OPERATIONAL DECISION PACKAGE	REQUESTED
Public Health Laboratory (Priority #1)	\$5,835,996
Vaccine Purchase (Priority (Priority #1)	\$2,687,645
Adolescent & Children's Health (Priority #2)	\$1,000,000
Reduce Hospitalizations / Emergency Department Visits (Priority #2)	\$9,000,000
<b>Total</b>	<b>\$18,523,641</b>

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Operational Decision Package  
Priority #1



**Public Health Laboratory Bond Repayment \$5,835,996**

- Critical public health & healthcare infrastructure
- Current facilities are antiquated (built in 1970's) and capacity is limited
- Physical & mechanical systems failing
- 10 year bond repayment of \$49 million



**Vaccine Purchase, Distribution & Administration \$2,687,645**

- Vaccine investment to ensure all Oklahoma residents have access to immunization
- Vaccine for Children (VFC) program changes have limited accessibility to vaccine
- Rural healthcare access & cost of vaccines contribute to accessibility challenges
- Initial investment of vaccine to enable 3<sup>rd</sup> party insurance billing by OSDH
- Every dollar spent on childhood vaccine returns \$16.50

Operational Decision Package  
Priority #2



**Public/Private Partnership for Improvement of Adolescent & Children Health \$1 Million**

- Public private investment in evidence based programs
- Pay for performance/risk based contracting dependent upon outcome improvement
- Partnership with City-County Health Departments and Private Funders
- Outcomes include teen pregnancy prevention (TPP), increased graduation rates, decreased social support spending
- Every dollar spent on evidence based TPP returns \$3.78 in the first year



**Reduce Preventable Hospitalizations & ED Visits for the Uninsured \$9 Million**

- Voluntary, outcome based incentive payment pool
- Requires community collaborative relationships with PCMH, FQHC, CMC, local CHDs
- Focuses on care coordination for high risk patients
- Aligns community benefit plans/expenditures with CHIP/CHP

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QUESTIONS

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CONSIDERATION OF STANDING COMMITTEES' REPORTS AND ACTION**Executive Committee**

Dr. Woodson provided an update on the subcommittee assignments based on survey feedback. Beginning in January of 2015, a rotating schedule will allow board members expressing an interest in the finance committee to attend 2 finance committee meetings then rotate back to their assigned committee. Dr. Grim, Dr. Stewart, Dr. Gerard, Tim Starkey. Other assignments are as follows:

- **Executive and Finance** (*Officers*)
- **Policy** (*Gerard, Starkey, Grim*)
- **Accountability, Ethics, Audit** (*Alexopulos, Stewart, Krishna*)

**Finance Committee**

Ms. Burger directed attention to the Financial Brief provided to each Board member and presented the following SFY 2015 Finance Report and Board Brief as of November 19, 2014:

- Approximately \$424 million budgeted for state fiscal year 2015
- Forecasted expenditure rate of 97.78% through June 30, 2015
- "Green Light" overall for Department, with one division in "Yellow Light" status: Health Improvement Services. Yellow status is due to program growth and vacancies.

The *Financial Brief* this month focuses on the Department's FY 2016 Budget Request Hearing and Legislative Needs. *See Attachment A*

**Accountability, Ethics, & Audit Committee**

The Accountability, Ethics, & Audit Committee met with Jay Holland. Dr. Alexopulos indicated that there were no known significant audit issues to report at this time.

**Public Health Policy Committee**

Dr. Gerard referred to Legislative Presentation. These items discussed in Policy Committee. If members of the Board have any questions regarding any policy issues or proposed legislation, please do not hesitate to contact Mark Newman for additional information or to provide input.

The next meeting of the Policy Committee will be prior to the January Board Meeting.

**PRESIDENT'S REPORT**

Dr. Woodson directed Board attention to the 2015 Board Work calendar, 2015 meeting dates and locations for review and approval.

**Ms. Wolfe moved Board approval of the 2015 Board Work calendar and 2015 meeting dates and locations as presented. Second Dr. Grim. Motion carried.**

**AYE: Alexopulos, Burger, Gerard Grim, Krishna, Stewart, Wolfe, Woodson**

**ABSENT: Starkey**

**COMMISSIONER'S REPORT**

Dr. Cline thanked staff and Board members who attend the launch of the Governor's Get Fit Challenge. He briefly discussed the launch with Governor Fallin and Kevin Durant which took place at the State Capitol on September 26<sup>th</sup>. The Get Fit Challenge is part of many exciting public private partnerships seeking to address OHIP recommendations, such as the Parks Passport Initiative, and Fitnessgram. The Oklahoma Health Improvement Plan (OHIP) seeks to address factors contributing to negative health outcomes. The plan also addresses individual conditions, health behaviors and key populations through a focus on flagship issues targeting tobacco, obesity, children's health and behavioral health. The plan is currently in the process of being updated is scheduled to be published in January of 2015. Dr. Cline encouraged all to review the updates proposed to the plan, available on the Oklahoma State Department of Health website, and provide comments. The comment period closes December 11, 2014. Lastly, Dr. Cline encouraged members of the Board to attend the Governor's Healthy Aging Summit on the December 15<sup>th</sup>, 2014

1 from 10:00 AM to 4:30 PM.

2  
3 The report concluded.

4  
5 **NEW BUSINESS**

6 No new business.

7  
8 **PROPOSED EXECUTIVE SESSION**

9 **Ms. Burger moved Board approval to go in to Executive Session at 12:57 PM** pursuant to 25 O.S.  
10 Section 307(B)(4) for confidential communications to discuss pending department litigation, investigation,  
11 claim, or action; pursuant to 25 O.S. Section 307(B)(1) to discuss the employment, hiring, appointment,  
12 promotion, demotion, disciplining or resignation of any individual salaried public officer or employee and  
13 pursuant to 25 O.S. Section 307 (B)(7) for discussing any matter where disclosure of information would  
14 violate confidentiality requirements of state or federal law.

- 15 • Annual performance evaluation for the Office of Accountability Systems Director & Internal
- 16 Audit Unit Director, and Board of Health Secretary
- 17 • OAS Investigation, Number 2014-021
- 18 • State’s public health investigation, Ebola

19 **Second Ms. Wolfe. Motion carried.**

20  
21 **AYE: Alexopulos, Burger, Gerard Grim, Krishna, Stewart, Wolfe, Woodson**

22 **ABSENT: Starkey**

23  
24 **Ms. Wolfe moved Board approval to move out of Executive Session. Second Ms. Burger. Motion carried.**

25  
26 **AYE: Alexopulos, Burger, Gerard Grim, Krishna, Stewart, Wolfe, Woodson**

27 **ABSENT: Starkey**

28  
29 **ADJOURNMENT**

30 **Mr. Grim moved Board approval to Adjourn. Second Dr. Alexopulos. Motion carried.**

31  
32 **AYE: Alexopulos, Burger, Gerard Grim, Krishna, Stewart, Wolfe, Woodson**

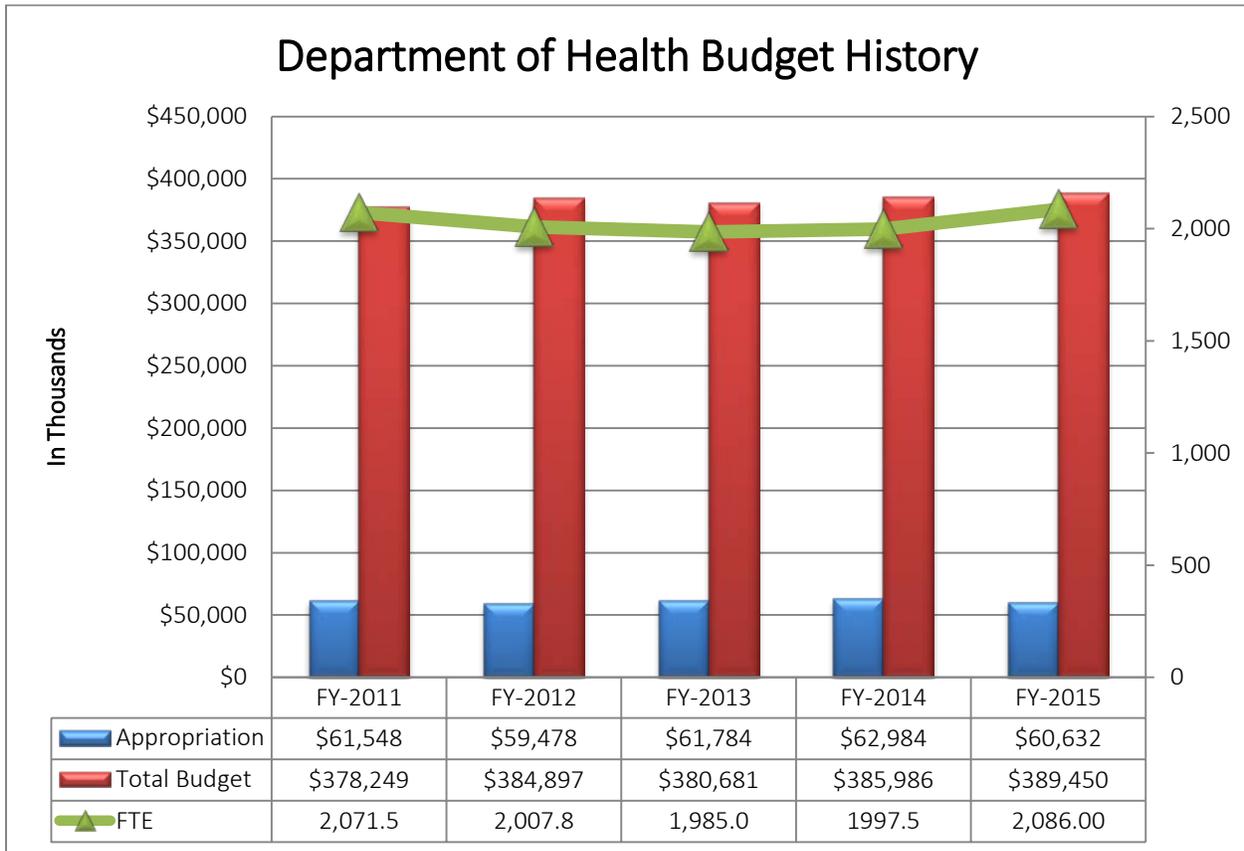
33 **ABSENT: Starkey**

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35 The meeting adjourned at 2:40 p.m.

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40 Approved

41 \_\_\_\_\_  
42 Ronald W. Woodson, M.D.  
43 President, Oklahoma State Board of Health  
44 January 13, 2015

Department of Health - 340

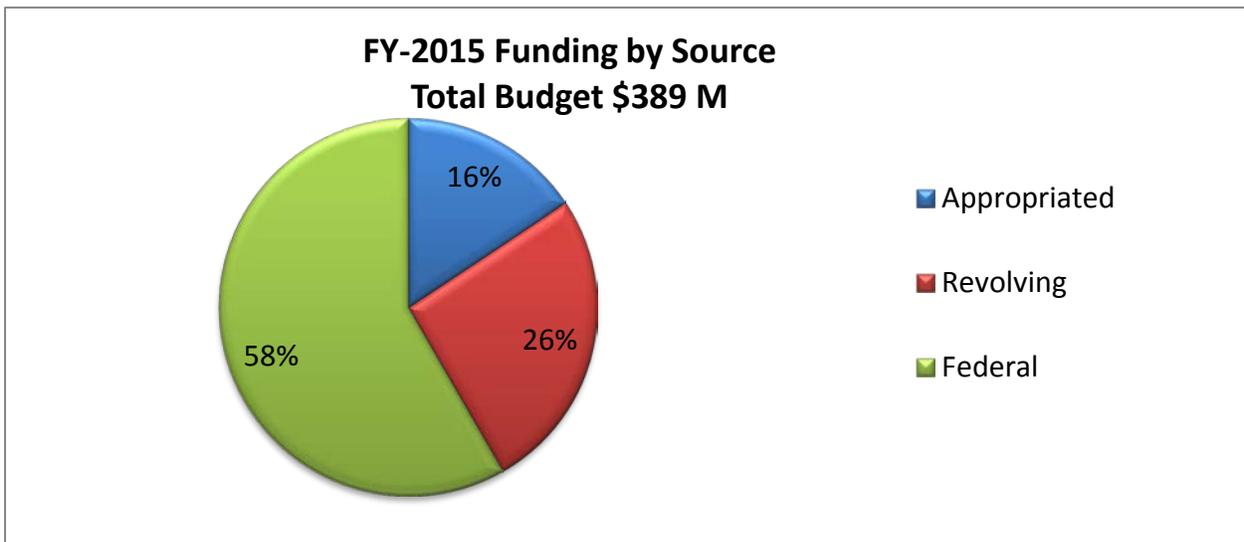
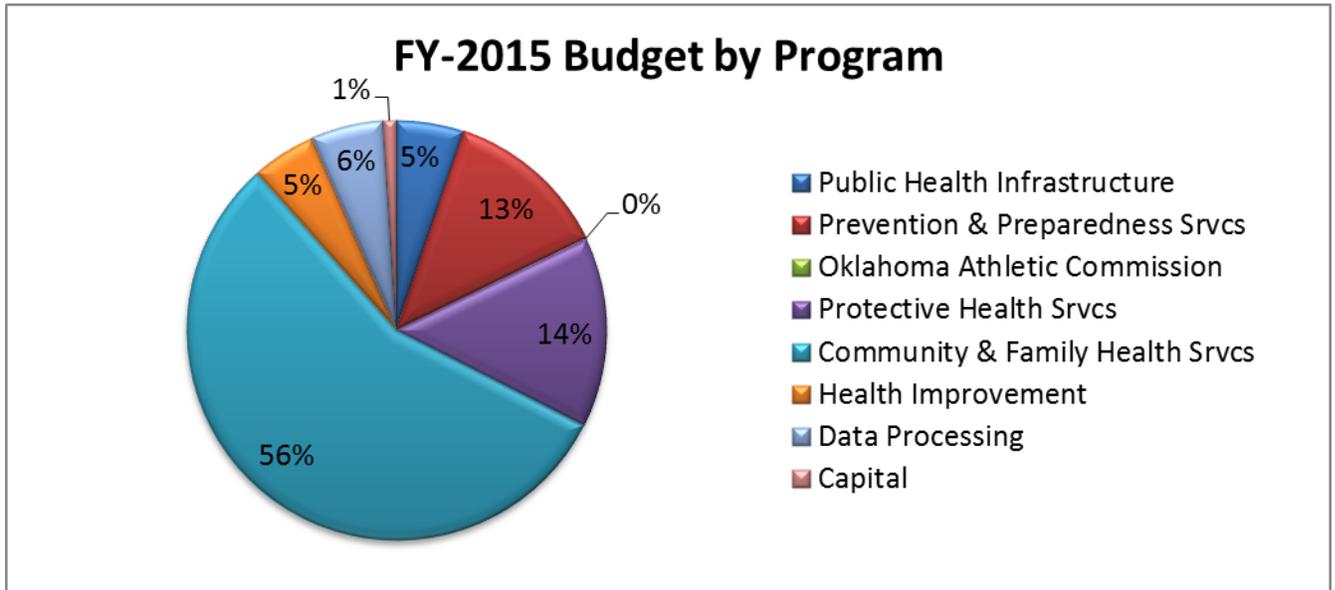


State Funds as a percentage of total state appropriations – 0.9%

Filled positions increased as a result of improved turnover rates and position refill processes;

- Refill processing time improved by 66% resulting in fewer vacant positions at any given time
- An estimated 23% of the increase is a result of decreased turnover rates
- Seventy-seven percent of the increase in filled positions benefited Community and Family Health Services, 11% in Protective Health Services

**I. Funding**



Federal funding includes WIC payments from the disbursing fund, which is 17% of the federal funding.

**II. FY-2015 Supplemental Request Summary**

No supplemental requested.

**III. FY-2016 Budget Request Summary**

- Bond Request \$49,178,000
- Appropriations Request \$18,523,641

1. **Public Health Laboratory – \$49,178,000 Bond,  
\$5,835,996 Estimated Annual Bond Repayment (10 years)**

- Aging lab built over 40 years ago to 1970's specifications and lacks the best practice designs adopted in recent decades
- Modernized testing and screening procedures necessary for rapid identification of disease threats requires more lab space
- Enhanced laboratory testing equipment has reduced necessary workspace of laboratory scientists resulting in as many as three staff sharing a workspace originally meant for one
- 54,000 newborn screening tests for over 50 metabolic disorders performed per year, sole laboratory in the state performing this testing
- Performs high-risk and critical microbial and toxin testing, "white powder" and Ebola testing
- Sole Biological Safety Level 3 laboratory in the state performing tests on specific biologic agents
- Specialized testing for high-risk diseases such as tuberculosis, rabies and smallpox
- New facilities necessary to ensure continued College of American Pathologists laboratory accreditation and/or licensure; loss of accreditation and/or licensure would halt necessary testing in the Public Health Lab until minimum standards are met

2. **Vaccine Purchase, Distribution and Administration – \$2,687,645**

- Few private providers purchase and stock needed vaccines due to cost and speed at which vaccines pass their shelf life
- In rural areas this problem is exacerbated due to extreme healthcare provider shortages and few corner drugstores that provide vaccinations making access to basic preventive health services for insured Oklahomans unnecessarily difficult
- Already poor access to vaccines is worsened as Federal Vaccines for Children (VFC) guidelines prohibit persons with the ability to pay (insurance or other form of payment) from receiving VFC vaccines available at County Health Departments (CHDs)
- Using existing State Department of Health infrastructure, this initiative will fund the purchase and administration of vaccines allowing Oklahomans to purchase vaccines from County Health Departments (CHDs)
- Appropriation request will provide seed money and will diminish as insurance is billed or citizens pay for vaccines
- This initiative will improve statewide vaccination rates (*47<sup>th</sup> in the nation for two-year-old immunization rates in 2013*) by allowing Oklahomans the ability to purchase vaccines from County Health Departments (CHDs)
- Studies show that increased immunization rates contribute to the reduction of the spread of preventable diseases; one dollar spent on childhood vaccines saves an estimated \$16.50 in future health costs
- This means significant amounts of taxpayer and insurance dollars are not spent on curing diseases that could have otherwise been prevented with an improved immunization rate

**3. Public/Private Partnership for Improvement of Adolescent and Children’s Health – \$1,000,000**

- This initiative will utilize private investments to assume the majority of financial risk to achieve health outcomes
- Outcomes must have a demonstrable savings (or return on investment) to the State of Oklahoma and be documented through standardized data collection
- Under the program, Oklahoma and Tulsa City- County Health Departments will partner with private entities to engage in efforts to reduce teen pregnancy. Upon successfully delivering results, the State of Oklahoma will pay for the outcomes achieved and the private investment will be reinvested in the program for another year
- According to the CDC, teens who get pregnant have far poorer outcomes, both for themselves and their children, leading to an increase in costs to the social welfare system, and a reduction for the mother and child in everything from lifetime earning expectancy to academic performance
- Oklahoma has the second highest teen birth rate in the United States at 47.3 per 1,000 live births to teens aged 15-19, the national average is 29.4
- According to the OSDH’s Center for Health Statistics, 15 girls between the ages of 15-19 give birth in Oklahoma *per day*
- 30% of teen girls in the United States who drop out of high school cite pregnancy or parenthood as the reason
- In 2011, more than 75% of teen deliveries in Oklahoma were unintended pregnancies
- Lack of educational achievement and ability to develop work skills negatively impacts wealth generation in our state
- This issue affects many areas of state expenditure, including common and higher education, corrections, social services and the healthcare system
- It is estimated that in 2010, teen childbearing in Oklahoma cost taxpayers \$169 million. This figure includes public health care expenses, potential for incarceration and other negative outcomes that require intervention or assistance from the system. However, one dollar spent on reduction efforts leads to \$3.78 in savings for taxpayers in the first year alone, as these negative outcomes are countered

**4. Reduce Preventable Hospitalization and Emergency Room Visits for the Uninsured – \$9,000,000**

- Preventable in-patient hospital stays and emergency department visits are contributing factors to increasing healthcare costs
- Studies show that up to 76% of ER visits are non-emergency and avoidable and that each unnecessary ER visit costs the system more than \$580
- A 30% reduction in chronic disease preventable hospitalizations would save the system and taxpayers more than \$54 million in a single year
- Further, Oklahoma’s uninsured rate is 17% leading to uncompensated care costs of \$2.4 billion in 2013. The majority of these costs are attributed to hospital care
- Payment models that encourage more efficient healthcare delivery and reward improved health outcomes are necessary to change the healthcare business model

- This initiative would develop and pay for voluntary, community-based emergency room diversion techniques and systems of care that prevent the need for acute care delivery in a hospital
- Payments will be based on outcomes including reduced preventable hospitalizations and emergency room visits

## IV. Legislative Needs

### 1. Save lives by reducing prescription opioid overdoses through a Prescription Monitoring Program (PMP)

- According to the OSDH Injury Prevention Service, there were 3,900 unintentional poisoning deaths in Oklahoma from 2007-2012, and 87% of those involved at least one opioid prescription drug
- In 2010, Oklahoma had the dubious distinction of having the fourth highest unintentional poisoning death rate in the nation at 17.9 deaths per 100,000 population
- Prescription painkillers were involved in 9 out of 10 prescription drug-related deaths in Oklahoma, with 457 opioid-involved deaths in 2012
- In 2009, unintentional poisoning became the leading cause of unintentional injury in the state, surpassing even car crashes
- Nationwide, it is estimated that the abuse of opioid analgesics results in over \$72 billion in medical costs alone
- States such as Florida, New York and Tennessee have seen reductions of up to 75% in patients using multiple prescribers to receive the same drug
- Physicians checking the PMP prior to prescribing will reduce diversions and misuse of prescription opioids
- Allows physicians to ensure patient receives medically necessary medication while safeguarding against using multiple prescribers to receive the same prescription drug
- Will not interfere with standard methods of care
- Allows for data sets to be studied, leading to better practices in combating prescription drug abuse and for bad actors to be exposed, removing sources of obtaining illegally prescribed opioids

#### *Policy Proposal*

- Some physicians don't believe their patients would doctor shop; law would ensure those people cannot play on doctor sympathies or friendly relationships for prescriptions
- Physicians who suspects abuse can contact the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD) through the PMP program itself
- Subaccounts available so employees of the doctor's office can pull up the PMP so it's ready to go by the time the doctor sees the patient
- OBNDD cannot take civil action or assess monetary penalties from a doctor who fails to check PMP; medical licensure boards would decide fate of those doctors
- PMP required checks for new patients and any prescription for the top five medications found in autopsies to have contributed to overdose deaths

**2. Allow farmer's markets to sell whole, uncut fruits and vegetables and uncracked nuts without a food vendor's license**

- Reduces expense and regulations on a small, temporary vendor selling healthy foods with minimal risks of food-borne illness
- Increases access to fresh fruits and vegetables for Oklahomans by incentivizing farmer's markets and potentially reducing food deserts
- Increases healthy food options for SNAP enrollees who can use EBT cards at farmer's markets to purchase fruits and vegetables
- Organizes exemptions which already exist in statute and administrative rules for private kitchens, day care centers, nursing homes and other assisted living facilities

*Policy Proposal*

- Amend O.S. 63, Section 1-1118 to offer limited exemptions to the food service license requirement, providing for ease of service offering by produce stands, charities and other entities, without sacrificing the food safety or health of the public

**3. Modify advance directive law to allow for contracting with private enterprise**

- Allows a private enterprise with preexisting infrastructure to maintain the Advance Directive Registry
- Service is provided more conveniently and at a lower cost for Oklahomans who wish to file an advance directive
- Contracting with a private enterprise saves taxpayer resources that would otherwise be expended in setting up a fee structure and an advance directive registry
- Allows the OSDH to ensure the provisions of the Act are fulfilled through an oversight role while saving state dollars by negating the need for infrastructure and maintenance

*Policy Proposal*

- Amend O.S. 63, Section 3102.1 allowing contracts with private vendors to fulfill the provisions of the Advance Directive Act and removing the provisions directing the OSDH establish a database for advance directives
- The costs and fees for the vendor would be established by contract
- Amend O.S. 63, Section 3102.2 to remove the language relating to the Board of Health establishing a fee for submission of each Alternative Advance Directive Form

**STATE OF OKLAHOMA  
OKLAHOMA STATE DEPARTMENT OF HEALTH**

**Memorandum**

**DATE:** December 16, 2014

**TO:** Terry Cline, Ph.D.  
Commissioner *T.C. 12-17-2014*  
Secretary of Health and Human Services

**FROM:** Henry Hartsell, Ph.D.  
Deputy Commissioner *HH*  
Protective Health

**SUBJECT:** Trauma and Emergency Response Advisory Council

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The purpose of this memorandum is to request your appointment of a critical care nurse to serve on the subject advisory council.

**Appointing Authority**

The State Board of Health shall appoint one critical care nurse to the Trauma and Emergency Response Advisory Council as directed in Title 63 O.S Section 1-103a.1.

**Critical Care Nurse Candidates**

The Oklahoma State Department of Health identified four qualified candidates for appointment to the Trauma and Emergency Response Advisory Council, as follows:

- Susan M. Watkins, R.N., J.D., C.N.M.L.  
Trauma Program Manager  
Saint Francis Health System, Tulsa, OK
- Kaye McMullin, R.N., B.S.N., C.C.R.N.  
Critical and Progressive Care Educator  
Saint Mary's Regional Medical Center, Enid, OK
- Cynthia M. Moore, R.N., B.S.N.  
Clinical Manager Trauma I.C.U. and Trauma Emergency Department  
OU Medical Center, Oklahoma City, OK
- William (Bill) Thomas Holland, III, M.S.N., APRN-CNP  
Emergency Department and Family Practice  
Prague Community Hospital, Prague, OK

We recommend appointment of Susan M. Watkins based on her extensive experience within the Oklahoma Trauma System as the Trauma Program Manager for one of the Level II trauma centers in this state. Ms. Watkins also chairs the Tulsa Regional Trauma Advisory Board.

Oklahoma State Department of Health staff members conducted a check of all of the candidates using public information, including the Oklahoma Department of Corrections Offender Lookup, the Oklahoma

State Court Networks Court Dockets, and Oklahoma State Department of Health licensure records. The staff identified no offenses or adverse actions that would impair the ability of either individual to perform the responsibilities of the advisory council. Ms. Watkins has been contacted and has confirmed willingness to serve and attend public meetings of the advisory council.

#### **Statutory Citation**

The Trauma and Emergency Response Advisory Council is authorized in Title 63 O.S. Section 1-103a.1.

#### **Membership**

The Trauma and Emergency Response Advisory Council has seven members. The membership includes:

##### **Governor Appointments**

- One member who is an administrative director of a licensed ambulance service;
- One member who is a Board Certified Emergency Physician;

##### **President Pro Tempore of the Senate Appointments**

- One member who is a representative from a hospital with trauma and emergency services;
- One member who is a Board Certified Emergency Physician;

##### **Speaker of the House of Representatives Appointments**

- One member representing the trauma registrar of a licensed hospital that is classified as providing trauma and emergency operative services;
- One member who is an Emergency Medical technician; and

##### **State Board of Health Appointment**

- The State Board of Health shall appoint one member who is a critical care nurse.

The one new member will join the six current Advisory Council Members, who are as follows:

- Mr. Greg Reid, Current Term Expires November 2017
- Dr. Angela Selmon, Current Term Expires November 2017
- Mr. Eddie Sims, Current Term Expires November 2017
- Mr. Bob Swietek, Current Term Expires November 2017
- Dr. David Teague, Current Term Expires November 2017
- Dr. Michael Thomas, Current Term Expires November 2017

#### **Advisory Council Duties/Responsibilities**

All members of the Advisory Council shall be knowledgeable of issues that arise in a hospital setting and issues that arise concerning emergency response. The jurisdictional areas shall include:

- Emergency response systems development;
- Injury prevention;
- Catastrophic health emergency;
- Trauma systems improvement and development; and
- Other such areas designated by the State Board of Health.

#### **Advisory Board Meeting Frequency**

Each Advisory Council shall meet at least twice a year, but no more than four times a year.

### **Appointment Process**

The steps in the appointment process are as follows:

- Oklahoma State Department of Health identifies critical care nurses with experience in the field of trauma, reviews the qualifications of the candidates, and contacts candidates to confirm willingness to serve;
- The Commissioner of Health submits the candidates to the State Board of Health; and
- The State Board of Health appoints one member.

### **Attachments**

- Resume for Susan M. Watkins, R.N., J.D., C.N.M.L.
- Resume for Kaye McMullin, R.N., B.S.N., C.C.R.N.
- Resume for Cynthia Moore, R.N., B.S.N.
- Resume for William (Bill) Thomas Holland, III, M.S.N., APRN-CNP

*Transforming Health Care:*  
**A Proposal for Oklahoma's Future**

Presentation to the Oklahoma  
State Board of Health

January 13, 2015

Craig W. Jones, FACHE



**This presentation was developed in conjunction with Manatt Health and informed by discussions with multiple public and private stakeholders.**



- **The Case for Change**
- **Payment and Delivery System Reforms**
- **Broadening Coverage in Oklahoma**

# The Case for Change

# The “*New Reality*”

- Transitioning from “Curve 1 to 2”

## FIRST

- Volume vs.
- Fee/Service vs.
- Acute care vs.
- Stand-alone vs.

## SECOND

- Value
- Quality/Efficiency
- Chronic care
- Highly integrated

# Forces Driving Reform of Health Care in Oklahoma

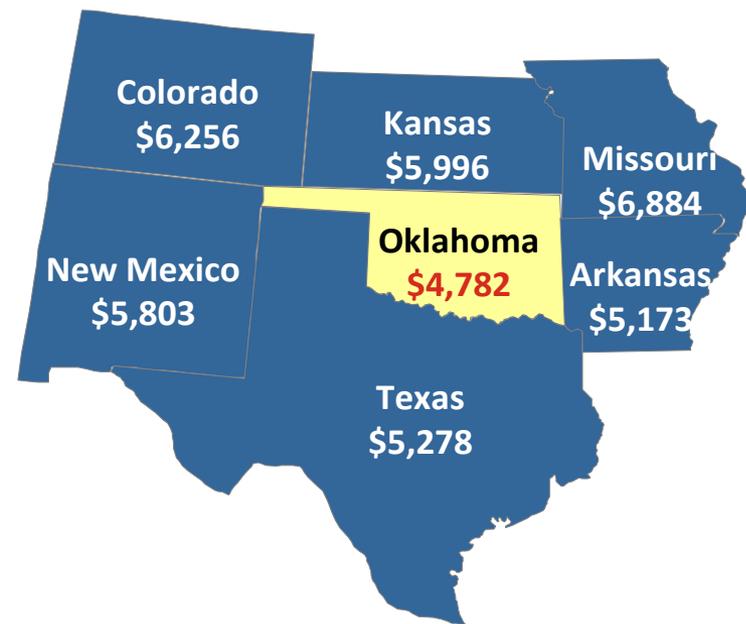
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- To achieve a balanced budget, Oklahoma must **control state spending**.
- Oklahoma spends approximately **\$5 B annually** (36% of which is state funds) on the Medicaid program.
- Despite the state's investment in health care, more than 630,000 remain **uninsured (17% of the population)** in Oklahoma; **cost of that care is shifted to the private sector**.
- Oklahoma has **poor health outcomes**, as evidenced by high rates of smoking, obesity, and diabetes.
- The high rates of uninsurance and poor health status contribute to the **high cost of health care in Oklahoma**.



# Oklahoma Must Become a Value-Based Purchaser

- Medicaid spending per beneficiary in Oklahoma is less than the national average and less than spending in neighboring states.



National Average = \$5,563

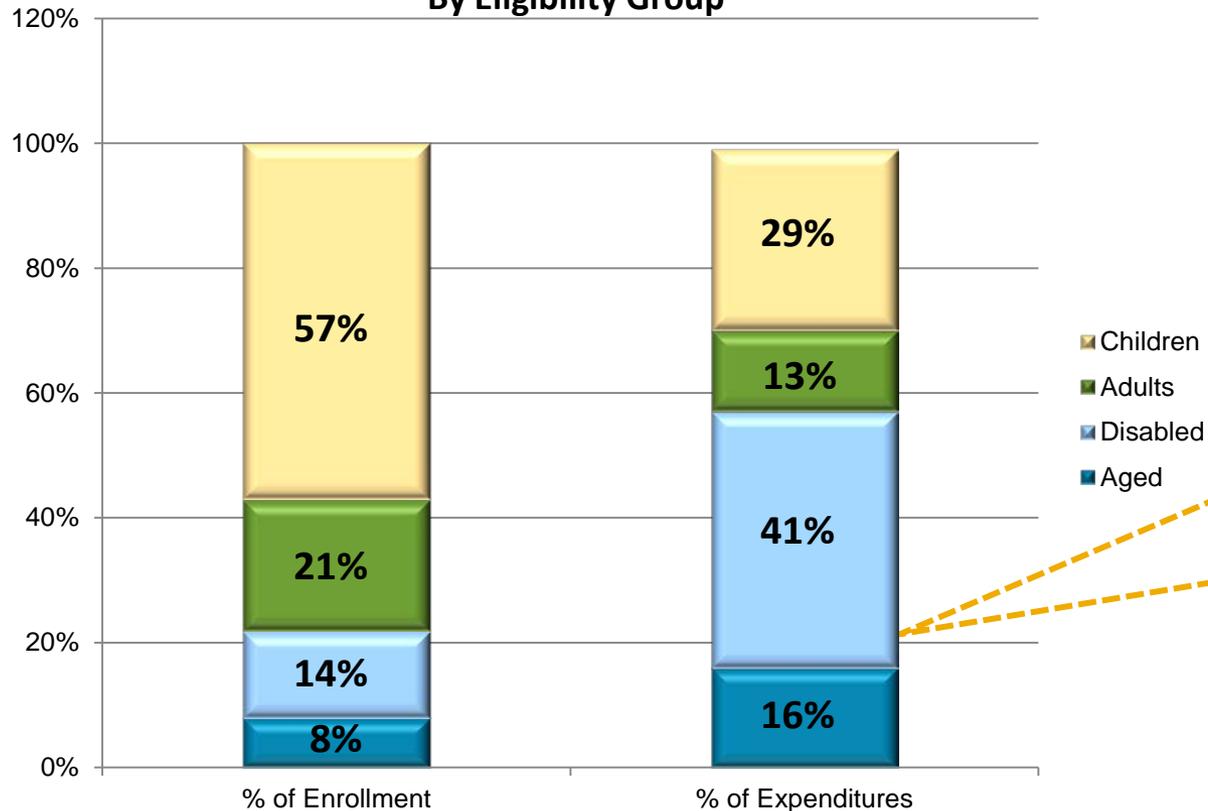
Even so....

- Oklahoma can become a more **prudent purchaser of care**, ensuring access and improving transparency, accountability and value.

# A Small Percentage of Beneficiaries Drive Costs

22% of beneficiaries account for 57% of program costs

2010 OK SoonerCare Enrollment and Expenditures  
By Eligibility Group



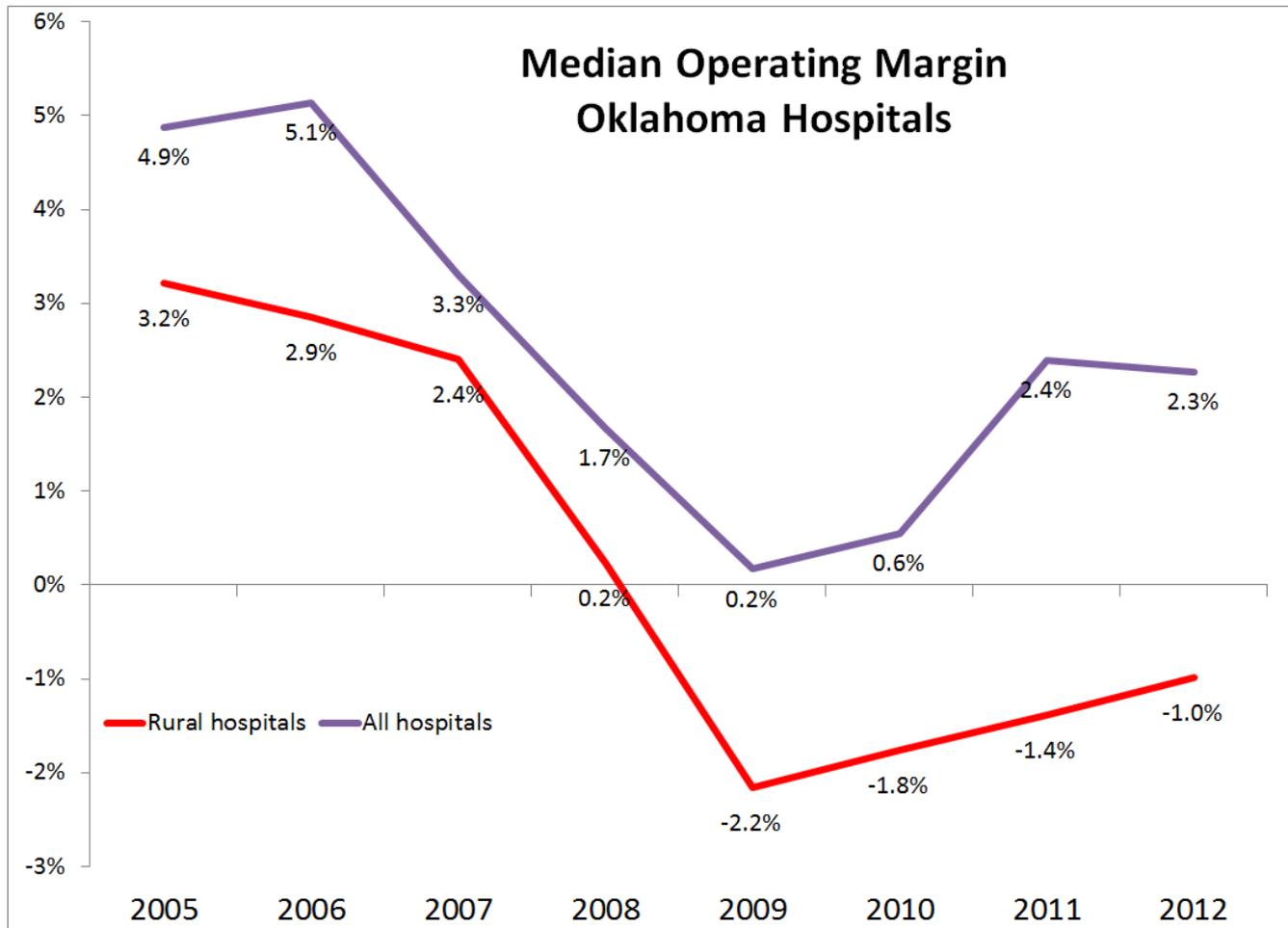
*Medicaid Payments per Aged and Disabled Enrollees are \$10,085 and \$13,820, respectively, compared to \$2,462 for children and \$2,973 for adults.*



## Broadening Coverage Reduces Uncompensated Care Costs <sup>9</sup>

- In 2012, Oklahoma hospitals absorbed **\$547 million in uncompensated care costs**, which represented 6.1% of Oklahoma hospitals' total expenses.
- The cost of treating **the uninsured disproportionately affects rural hospitals.**
  - Uncompensated care accounted for 10-17% of the expenses for 20 rural Oklahoma hospitals (compared to the 6.1% state average).
- **Rural hospitals are less able to shift costs** to insured patients given their payer mix. (7 bankruptcies in recent years)

# Investment in Coverage Preserves Access in Rural Communities 10



## Top 10 Diagnoses for Readmissions 2011

<u>Medicaid</u>
Mood disorders
Schizophrenia, other psychosis
Diabetes mellitus
Other complications of pregnancy
Alcohol-related disorders
Early or threatened labor
Congestive Heart Failure*
Septicemia (except labor)*
COPD and bronchiectasis*
Substance-related disorders

**Four of the top 10 diagnoses related to readmissions are for behavioral health conditions.**

# Coverage Increases Resources for Behavioral Health

12

- Federal dollars are available to pay for mental health and substance abuse services currently funded with state dollars.
  - Increasing coverage would result in the federal government covering **\$34 M** of Department of Mental Health and Substance Abuse expenditures annually.
  - The Department would then be able to use the freed up state dollars on other services that are not reimbursable by the federal government, e.g. social supports.
- The Department of Corrections would save **\$11 M** in spending on prisoner hospitalizations.
  - Individuals discharged from prisons become eligible for Medicaid.
  - Access to physical and behavioral health services during transition could help prevent recidivism.

In addition to these savings, the state would save **\$2.4 M** in Department of Health expenditures for a **total of \$48.2 M** in annual state savings.

# Investing in Coverage Provides a High Rate of Return

- **An additional \$8.6 B in available federal funds** flows to the state over 10 years.
- **13,211\* new jobs** in Oklahoma are created over 10 years.
- **\$50 M** in state expenditures for health services are replaced by federal dollars annually, including a significant amount for behavioral health services.
- **Uncompensated care costs** for hospitals, physicians, and other providers **go down**, particularly benefiting rural communities.
- **Cost shifting** between payers and between the uninsured and the insured **is reduced**.

\*Based on median coverage take-up rate.



**With such factors as these, driving and/or influencing  
the status of Oklahoma's health care....**

# Goals for the State's Investment in Health Care

15

1. **Improve quality, outcomes and value** by holding providers accountable through value based purchasing models emphasizing care coordination and transparency.

2. **Improve access** by broadening coverage, identifying gaps in provider capacity and targeting resources more effectively.

3. **Contain costs** by targeting medically complex, high-cost populations (e.g. individuals with co-morbid physical and behavioral health conditions) and reducing unnecessary emergency department visits and potentially preventable admissions and readmissions.

4. **Improve sustainability and budget certainty** of the Medicaid program.

# Building Blocks for an Oklahoma Plan



## Payment & Delivery System Reform



Improve quality & contain costs by moving from volume-based to value-based purchasing.

Reduce unnecessary utilization, including ER visits and hospitalizations, through enhanced care coordination and access to primary care.

Integrate services for high cost, high need beneficiaries with physical and behavioral health comorbidities.



## Coverage Reform

Build on Insure Oklahoma

Engage the private sector

Require personal responsibility

Incent work and education

Ensure sustainability

**Enables budget predictability for the state**

# Payment & Delivery System Reforms

## Goals

## Strategies

Improve Quality, Outcomes, and Value

- Support care coordination
- **Build accountability into payment models through shared savings** tied to both quality and cost metrics
- Improve transparency

Improve Access

- **Broaden coverage using Insure Oklahoma** as a framework
- **Target resources to providers and services where additional capacity required** (e.g. primary care and behavioral health)
- Provide technical assistance to providers with less familiarity with insurance models (e.g. behavioral health providers)

Contain Costs

- **Target medically complex, high cost populations**, providing coordinated care and integrating social supports
- Support beneficiaries in accessing preventive care and receiving **care in the most appropriate setting**

Improve Sustainability & Budget Certainty

- Transition to **payment models that include both upside and downside risk sharing**
- Evaluate **transition to community-led capitated models**

**Metrics for Success Developed Collaboratively**

# Proposed Building Blocks of Reform in Oklahoma

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## Medical Homes

- Expand patient-centered medical homes (PCMHs) to all Medicaid beneficiaries
- Establish linkages between and among PCMHs, hospitals and FQHCs
- Build on Health Access Networks to support medical home development
- PCMHs, partner hospitals and FQHCs eligible for shared savings

## Health Homes

- Expand health homes for individuals with behavioral health conditions
- Establish health homes for individuals with chronic conditions
- Establish linkages with hospitals and FQHCs
- Health homes, partner hospitals and FQHCs eligible for shared savings

## Community-Led Accountable Care Models

- Enroll beneficiaries in community-led accountable care models
- PCMHs and health homes provide care coordination and support services; foundation of accountable care
- Payment model developed over three years beginning with shared savings and transitioning to full capitation

**Transition to Provider Risk-Bearing Models Over Time**

# Broaden Coverage in Oklahoma

# Increased Coverage Facilitates Medicaid Reform

- **Reduces churn** between types of coverage and uninsurance
- **Enables the management of care** for individuals – directing them to preventive services and the most appropriate setting of care
- **Reduces cost shifting** across payers and employers
- **Improves access to care** and retains providers in the Medicaid delivery system
- **Facilitates financial sustainability** for providers who are particularly vulnerable to high rates of uninsured patients (e.g. rural providers)
- **Returns Oklahoma tax dollars** via additional federal dollars **to support transformation efforts “the Oklahoma way.”**



## NEWLY ELIGIBLE ADULTS



- Childless adults with income below 138% FPL (\$16,105)
- Parents with incomes between 42% - 138% FPL  
*(Example: family of two with parent and child, income between \$6,606-\$21,707)*
- Estimated 233,334 individuals would enroll in coverage over 10 years based on medium take-up rate

# Insure Oklahoma: Proposed Coverage Solution

1

**Insure Oklahoma: Employer Sponsored Insurance (ESI)**  
Newly eligible adults with access to ESI.

2

**Insure Oklahoma: Individual Plan**  
Medically frail newly eligible adults.

2

**Insure Oklahoma: Individual Plan**  
Newly eligible adults who do not have access to cost-effective ESI.

3

**Insure Oklahoma: Individual Market**  
Newly eligible individuals who do not have access to cost-effective ESI.

FPL

0%

100%

138%

## Insure Oklahoma

- 1 Insure Oklahoma: ESI** builds on the existing premium assistance program. Employer funding stays in the system.
- 2 Insure Oklahoma: Individual Plan** builds on existing program and incorporates personal responsibility features for newly eligible adults, including cost sharing and non-coverage of non-emergent use of the ER, and payment and delivery system reforms holding providers accountable for improved quality and outcomes with a particular focus on high need beneficiaries.
- 3 Insure Oklahoma: Individual Market** provides premium assistance to individuals enrolled in commercial health plans coupled with personal responsibility features including premiums and cost-sharing.

# Examples of the Newly Insured Adults



**Rachel**  
Single Working Mother  
Annual Income: \$12,584

Rachel is a single mom who works part-time for a large company. While pregnant, she was covered through SoonerCare Choice. However, 60 days post-partum her income exceeded the limit for SoonerCare Choice. Her employer is too large to participate in Insure Oklahoma and she cannot afford her employer's premiums. Her daughter, Anne, is enrolled in SoonerCare. (IO: ESI)



**Rob, Janet, & Peter**  
Family with Working Parent  
Annual Income: \$17,811

Rob works full time making \$9/hour for an employer in Texas that does not offer insurance. Janet stays at home with their 1-year-old son, Peter. Peter is enrolled in SoonerCare Choice. Rob and Janet are uninsured. Their income is too high to qualify for SoonerCare, and because Rob's employer is based out-of-state, he and Janet are not eligible for Insure Oklahoma. (IO:IP)



**Jim**  
Working Adult  
Annual Income: \$11,086

Jim works for a small construction company. His employer used to offer health insurance for which employees paid 50% of the cost of the premiums. The company can no longer afford to offer insurance. If Jim's employer were enrolled in Insure Oklahoma, both Jim and his employer would receive assistance toward the cost of the premiums, with the state covering at least 60%. (IO: ESI)



**Donna**  
Unemployed Adult  
Annual Income: \$0

Donna recently lost her job as a result of missed days due to treatments for liver cancer. Because of the illness, she is not currently looking for work. She is not eligible for SoonerCare due to her type of cancer (i.e., not breast or cervical cancer). Meanwhile, she is not eligible for Insure Oklahoma because she is not working or looking for work. (IO: IP)

# Features of this New Coverage Approach for Okla.

-  **Benefits.** Alignment of the alternative benefit plan for newly eligible adults with the benefits offered by QHPs to the maximum extent possible.
-  **Premiums and Cost-Sharing.** Targeted use of premiums and cost sharing for individuals with incomes above 100% FPL.
-  **Healthy Behavior Incentives.** Incentives for meeting health or wellness standards, including elimination or reduction of co-pays or premiums.
-  **Work and Education Referrals.** Referrals to job training and placement programs (e.g., [www.OKJobMatch.com](http://www.OKJobMatch.com)) for unemployed individuals with incentives for participation.
-  **State Protections.** Use of a trust fund and a provider fee backstop to cover the non-federal share of the newly eligible; adoption of a provision to sunset coverage should the federal match rate go down. Sunset provision.

# Time Frame for Implementation of Proposals

Current	Phase 1 (2015-2016)	Phase 2 (2017-2020)
<ul style="list-style-type: none"><li>Multi-stakeholder process to develop specific coverage and reform features and develop metrics for success.</li></ul>	<ul style="list-style-type: none"><li>Expand Insure Oklahoma: ESI</li><li>Expand Insure Oklahoma: Individual Plan</li><li>Launch Insure Oklahoma: Individual Market</li><li>Expand PCMHs and develop shared savings program</li><li>Expand health homes and develop shared savings program</li><li>Develop community-led accountable care model(s) and launch initially with FFS and shared savings</li></ul>	<ul style="list-style-type: none"><li>Transition community-led model(s) to capitated payments, potentially requiring a health plan or other state license.</li></ul>

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# Thank You...

## Comments or Questions?

[jones@okoha.com](mailto:jones@okoha.com)

405-427-9537



# Appendix

# States Cover ABP Benefits for New Adults at Enhanced Match

## ALTERNATIVE BENEFIT PLAN (ABP)

- 10 Essential Health Benefits
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Mental health and substance use disorder services, including behavioral health treatment
  - Prescription drugs
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care
- Early Periodic Screening, Diagnosis, and Treatment (EPSDT) for 19 and 20 year olds
- Non-emergency medical transportation

YEAR	ENHANCED FEDERAL MATCHING RATE NEWLY ELIGIBLE ADULTS UP TO 138% FPL	
	<i>State Share</i>	<i>Federal Share</i>
<b>2014</b>	0%	100%
<b>2015</b>	0%	100%
<b>2016</b>	0%	100%
<b>2017</b>	5%	95%
<b>2018</b>	6%	94%
<b>2019</b>	7%	93%
<b>2020+</b>	10%	90%

## Premiums

- Individuals with incomes 100% to 138% FPL subject to a premium up to 2% of household income
- Failure to pay premium for 90 days results in disenrollment
  - Re-enrollment not tied to repayment of back premiums
  - Unpaid premiums are a collectible debt
  - Consistent with PA's approach
- Individuals with incomes <100% FPL have no premium obligation

## Cost Sharing

- Cost sharing consistent with federal rules for newly eligible adults 100-138% FPL (*see appendix*)
- Medicaid cost sharing for individuals >100% FPL generally aligns with QHP cost sharing for individuals <150% FPL

# Medicaid Premium & Cost-Sharing Rules

	< 100% FPL	100% - 149% FPL	≥ 150% FPL
<i>Maximum Allowable Medicaid Premiums and Cost-Sharing</i>			
<b>Aggregate Cost-Sharing Cap</b>	5% household income	5% household income	5% household income
<b>Premiums</b>	Not allowed	Not allowed	Permitted, subject to aggregate cap
<i>Maximum Service-Related Co-pays/Co-Insurance</i>			
<b>Outpatient services</b>	\$4	10% of cost the agency pays	20% of cost the agency pays
<b>Non-emergency ER</b>	\$8	\$8	No limit
<b>Rx Drugs</b>	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: \$8	Preferred: \$4 Non-Preferred: 20% of cost the agency pays
<b>Institutional</b>	\$75 per stay	10% of total cost the agency pays for the entire stay	20% of total cost the agency pays for the entire stay

- Specific services are exempt from cost-sharing, including emergency services, family planning and pregnancy-related services
- Specific populations are exempt from cost-sharing requirements (e.g., pregnant women, spend-down beneficiaries, and individuals receiving hospice). However, exempt individuals may be charged cost-sharing for non-preferred drugs and non-emergency use of the emergency room
- Services may not be denied for individuals who fail to make co-payments if their income <100% FPL; services may be denied for those with incomes >100% FPL
- If non-preferred drugs are medically necessary, preferred drug cost sharing applies



## Healthy Behavior Standards

- Reduction in cost sharing obligation or premiums for meeting healthy behavior standards, such as attending smoking cessation counseling or receiving all recommended preventive screenings

## Work & Education Referrals

- Unemployed individuals referred to job training or work placement programs, e.g., [www.OKJobMatch.com](http://www.OKJobMatch.com)
- May include vouchers to reduce premiums or cost sharing for participation

## Trust Fund

- Savings generated from increased coverage set aside to offset the State's share beginning in 2017.
- Sources of savings: cost of services for new adults currently funded with state dollars (e.g., mental health and substance abuse programs) and enhanced match for coverage of some existing eligibility groups e.g., Insure Oklahoma.

## Provider Fee Backstop

- Revenue generated from provider fee may be used to cover a portion of the State's share for increased coverage if cost for new adults exceeds an established target.

## Sunset Provision

- Termination of coverage for new adults if Congress reduces the federal share authorized by the Affordable Care Act (federal share is 100% through 2016 and decreases overtime until it reaches 90% in 2020).

# Current Coverage Programs: SoonerCare

**SoonerCare Choice** is a primary care case management program where individuals are assigned to a medical home through which they receive primary care and care coordination services. High need beneficiaries receive additional care coordination and management support through Health Assistance Networks and the Health Management Program. Most children, parents, and many non-Medicare aged, blind and disabled (ABD) beneficiaries are enrolled in this program.

**SoonerCare Traditional** is a fee-for-service program that provides the standard Medicaid benefit package through a statewide network of providers. Individuals in long term care (LTC) facilities, dual eligibles, and LTC waiver populations are enrolled in this program. The primary difference between SoonerCare Choice and SoonerCare Traditional is that individuals in the Traditional plan are not enrolled in medical homes and physician visits are capped (children excluded).

**Oklahoma Cares** provides full SoonerCare benefits for women receiving treatment for breast and cervical cancer. Women who earn <185% Federal Poverty Level (FPL) and are less than 65 are eligible.

**SoonerPlan** covers only family planning services for men and women up to 133% FPL.

# Current Coverage Programs: Insure Oklahoma

Insure Oklahoma offers **premium assistance for employer-sponsored insurance (ESI)** to individuals who make <200% FPL and work at eligible employers. Under this plan, employees, the state, and the employer all share in the cost of private health plan coverage for the employee.

Eligible individuals who make <100% FPL may purchase subsidized health insurance coverage through the Insure Oklahoma **Individual Plan (IP)**. Enrollees in the plan pay up to 20% of the premium on a sliding scale, which is subject to a cap of 4% of gross income. The Individual Plan is administered by the Oklahoma Health Care Authority.

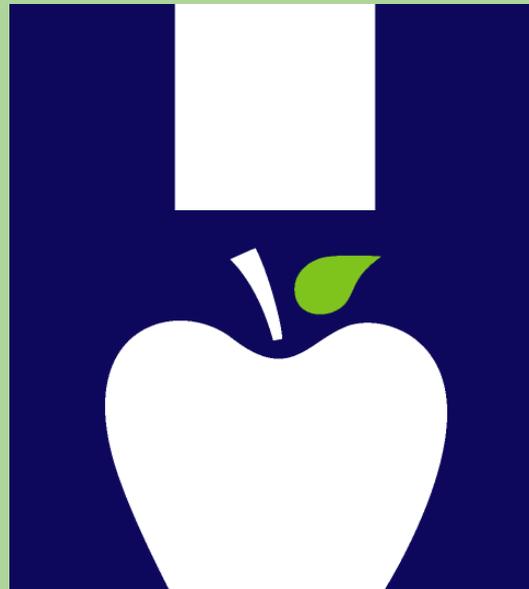
The state's portion of Insure Oklahoma is financed by a sales tax on tobacco products; federal Medicaid matching funds cover the balance.

The program is authorized under an 1115 waiver. Without a waiver extension, it will end December 31, 2015.



# Public Policy & Advocacy Development

OKLAHOMA STATE DEPARTMENT OF HEALTH · MARCH 2013



**Mark S. Newman, Ph.D.**

**Director, Office of State and Federal Policy**

# Oklahoma State Department of Health Strategic Map: SFY 2011-2015

**Achieve Targeted Improvements in the Health Status of Oklahomans**

**Improve Targeted Health Outcomes**

**Achieve Improvements In Oklahoma Health Improvement Plan (OHIP) Flagship Issues**

**Focus on Core Public Health Priorities**

**Reduce Health Inequities**

**Lead Public Health Policy & Advocacy Development**

**Target Campaigns on Community Needs, Return on Investment, & Scientific Evidence**

**Identify & Establish Public Health Champions**

**Serve as Educational Resource on the Value of All Public Health Issues**

**Strengthen Public Health Systems**

**Evaluate Infrastructure to Support Public Health Systems**

**Employ Strategies for Public Health Workforce Recruitment**

**Achieve Accreditation & Create a Quality Improvement Culture**

**Achieve Compatible Health Information Exchange Across Public/Private Sectors**

**Foster Collaborative Relationships With Public & Private Partnerships**

**Leverage Resources for Health Outcome Improvement**

**Facilitate Access to Primary Care**

**Focus on Prevention**

**Use Comparative Effectiveness Research & Evaluate Science**

**Monitor Funding Opportunities**

**Educate & Strategically Plan for Health Systems Change**

**Engage Communities to Leverage Effectiveness  
Utilize Social Determinants of Health & Whole Person Wellness Approaches  
Responsibly Align Resources to Maximize Health Outcomes**



# **Lead Public Health Policy & Advocacy Development**

## **Goals**



# Target Campaigns on Community Needs, Return on Investment, & Scientific Evidence

- Work with community and national organizations to identify core public health issues for legislative emphasis on both an annual and long-term basis
- Building a network of partners to support policy issues and creating a grassroots advocacy component is essential to any successful policy campaign
- The ability to build on previous policy gains and create an atmosphere which fosters future cooperation and both human and financial investment will pay the biggest dividends



# Identify & Establish Public Health Champions

- Identify Champions
  - ✓ Champions may be ordinary people with an extraordinary desire or passion to accomplish a goal
  - ✓ Champions must believe in the issue and be willing to face criticism for taking a stand
  - ✓ Finding and developing public health champions in the business community will be vital to future successes in public health



# Identify & Establish Public Health Champions

- Establishing and Arming Champions
  - ✓ Provide the resources and knowledge to allow an individual to be considered a respected authority on a given issue
  - ✓ Provide educational materials about public health issues or legislation to answer both the hard questions as well as the easy ones
  - ✓ Meet with local boards of health and community leaders to help them understand how they may advocate for public health issues at the local level
  - ✓ Demonstrate how investments in prevention produce both short- and long-term savings in health care costs and are a driver for economic development



# Serve as Educational Resource on the Value of All Public Health Issues

- OSDH must be the best and most reliable source for all information related to public health
- Lead the way in providing excellent customer service, finding new and innovative ways to utilize technology, and demonstrating responsible use of taxpayer funds in each and every program
- Serve in leadership roles in both state and national organizations which represent or impact public health



# Public Policy & Advocacy Development

## Questions?



**OKLAHOMA STATE DEPARTMENT OF HEALTH  
SFY 2015 BUDGET AND EXPENDITURE FORECAST: AS OF 12/29/14**

**SUMMARY**

<u>Division</u>	<u>Current Budget</u>	<u>Expenditures</u>	<u>Encumbrances</u>	<u>Forecasted Expenditures</u>	<u>Surplus/(Deficit)</u>	<u>Performance Rate</u>
Public Health Infrastructure	\$25,389,248	\$6,560,544	\$5,875,094	\$11,420,327	\$1,533,284	93.96%
Protective Health Services	\$59,533,074	\$16,893,038	\$6,936,968	\$36,002,307	(\$299,239)	100.50%
Prevention & Preparedness Services	\$56,608,479	\$16,261,188	\$23,531,534	\$16,512,754	\$303,003	99.46%
Information Technology	\$7,313,390	\$1,180,623	\$5,733,263	\$0	\$399,504	94.54%
Health Improvement Services	\$20,745,552	\$5,669,860	\$3,918,064	\$9,714,058	\$1,443,571	93.04%
Community & Family Health Services	\$257,904,318	\$74,744,312	\$32,489,043	\$141,543,730	\$9,127,233	96.46%
<b>Totals:</b>	<b>\$427,494,061</b>	<b>\$121,309,565</b>	<b>\$78,483,966</b>	<b>\$215,193,176</b>	<b>\$12,507,355</b>	<b>97.07%</b>



**Expenditure Forecast Assumptions**

- Payroll forecasted through June 30, 2015
- Encumbrances shown are actual as of the report date
- Expenditures forecasts limited to realistic amounts expected to spend out during the current budget period
- Surplus/(Deficit) is projected as of June 30, 2015

**Explanation of Dashboard Warning(s)**

- Public Health Infrastructure is in “Yellow Light” status due to recent vacancies/retirements.
- Information Technology is in “Yellow Light” status due to final IT contract amount being less than anticipated. IT services are billed to all programs in the OSDH, thus this amount represents savings to agency programs and the budget will be modified accordingly.
- Health Improvement Services is in “Yellow Light” status due to program growth and vacancies including recent notification of \$2 million State Innovation Model (SIM) grant award.
- Green Light status is anticipated as vacancies are filled, contracts are in place and budget adjustments are complete.

**OKLAHOMA STATE BOARD OF HEALTH**  
**COMMISSIONER'S REPORT**  
Terry Cline, Ph.D., Commissioner  
January 13, 2015

**PUBLIC RELATIONS/COMMUNICATIONS**

Oklahoma General Officers' Annual Open House  
Oklahoma Healthy Aging Summit – speaker  
Dr. Jinfeng Liu, Dr. Gary Raskob, COPH, Dr. Bob Roswell, Dr. Bob Lynch, and Dr. Julie Stoner, OUHSC

**STATE/FEDERAL AGENCIES/OFFICIAL**

Governor Mary Fallin  
Governor Cabinet Meeting  
Steve Mullins, Governor's General Counsel & Terri White, Commissioner, ODMHSAS  
OMES OSDH Budget Discussion  
OSDH Tribal Advisory Committee  
Randy Dowell & Anthony Sammons, Senate Staff  
Cindy Roberts, OHCA

**SITE VISITS**

Pittsburg County Health Department  
Pushmataha County Health Department  
Atoka County Health Department  
Coal County Health Department  
Pontotoc County Health Department  
Pottawatomie County Health Department

**OTHERS:**

Bryan Fried & Tom Cobble, Nursing Home Association  
ASTHO Board Meeting & Annual Winter Conference  
OHIP Executive Committee  
OHIP Full Team Meeting  
ASTHO Million Hearts Meeting  
PHAB Board Meeting  
Dan Boren, Tammy Lindsey, Chad Sandvig & Fay Wells, Chickasaw Nation  
Dr. Risa Lavizzo-Mourey, President & CEO, Dr. Jim Marks, Sr. Vice President & Tara Oakman,  
Program Officer, RWJF  
Monica Basu, George Kaiser Family Foundation