OK-SAFE, Inc. - Reporting

Notes on First Joint Committee Meeting on Health Care Reform in Oklahoma

Wednesday, September 14, 2011
9:00 am to 4:00 pm
House Chambers, OK Capitol
Oklahoma City, OK

Link to OK House Video: http://okhouse.granicus.com/MediaPlayer.php?view_id=2&clip_id=387
Video Minute Markers indicated in [brackets]

Key Excerpts:

Question by Rep. Nelson to Julie Cox-Kain (OK Dept. of Health)– "One other question I've got is, what my understanding is that probably the states' health care authority would be where an exchange would be housed, but where are other states putting it, is that the best place for an exchange here? If the federal government produces an exchange, would they house it in Washington, would they house it here, where are these things going to be housed?"

Answer by Julie Cox-Kain - "States have an option for governance of an exchange, governance and operation of an exchange and it can be implemented through a state agency, or you could have a non-profit entity, and you can contract out certain functions of the exchange. And so, in fact, you could even have a quasi-governmental entity. This has been addressed or mentioned some in the dialogue about how we would govern and operate an exchange. Actually even having a trust, and there are some in existence now, that govern that exchange and see to the operation of it. So, there is a little bit of state flexibility in how we choose to go forward and implement and/or operationalize an exchange. Again the question about the federal government exchange, there's very few answers to what the federal government exchange will look like, so it is very hard to make that particular decision without that piece of the equation being known."

Buffy Heater (OHCA) presentation – "Now we're going to talk about the technical aspects of information systems changes. So I think I'll start off by addressing the question that was brought up earlier in the session about the federal data hub or the federal data exchanges that are being established as part of the ACA through both the exchange set-up as well as for the Medicaid income verification pieces. So basically, the federal government is creating a data hub, or a data cloud, as it be, in that there will be sources from federal agencies, the IRS, the Social

Security Administration, and the Department of Homeland Security, where there will be member level or individual level information that is fed up to this data cloud.

Then there will be queries from the states or from a federal exchange that will be able to be sent up to that federal data hub and a match return that basically says for this person's last IRS data here was their modified adjusted gross income, or validating that that individual's social security number is as was reported matches, yes indeed, it matches on that individual's name and date of birth. As well as the Homeland Security is going to verify individual citizenship and identity, if possible.

So the federal data hub is going to require that it is a state level entity that engages in the contractual relationship between the federal government, and so the way the proposed rules that Cindy had mentioned before, right now those proposed rules do limit states in that it is restricted to only state-operated entities that can be able to engage in that federal data hub. I will tell you that they, the feds are specifically soliciting comment on states that might be looking at having a private entity run and operate their exchanges and how the federal rules might be able to accommodate those types of situations. So I put that out there as that question has certainly come up, not only for our state but in other states as well and so now is our opportunity to be able to comment on whatever plans Oklahoma might be able to have going moving forward.

Okay, so information system changes, as we look specifically at the Oklahoma Medicaid program and the systems that support it, the ACA, as Julie had mentioned does indeed require Medicaid to create a 'plug' of sorts to be able to be ready to plug into whatever socket might be behind the exchange, so if it is a state-level exchange, if it is a federal exchange, the requirement on, and the onus is on, the state Medicaid agency to be ready to be able plug into whatever that entity may look like. Now what types of information and what information is going to be sent back and forth between the exchange entity and Medicaid is eligibility information…."

(Slide) New CMS IT Guidance – Service Oriented Architecture, Reusable, Interoperable, Scalable, Ease of Use. Some states are still using legacy mainframe systems. So federal government required (above list).

(Slide) CMS IT Funding – Enhanced funding available – Medicaid Eligibility Systems (thru 12-15-2015) – 90% match – design, development and implementation. 75% match – ongoing operations. In the past was only 50%."

Opening Comments by co-chairs Rep. Glen Mulready and Sen. Gary Stanislawski [00:00:00 to 00:22:00]

I) Julie Cox-Kain, Chief Operating Officer, OK State Dept. of Health
[Minute Marker 00:22:01 to 00:53:26]
Topic - "Present State of Health Outcomes and Health Care in Oklahoma"

Slides: (NOTE: Missing one slide on an OK health stat)

1. OK has excess death and mortality & overall health rankings
2. Chart of Determinants of health and their contribution to premature death. Environmental, social circumstances (stressful), healthcare 10%. Insurance reform addresses access to health care, genetic disposition, behaviors.
3. United Health Foundation rankings for Oklahoma 2010 – showed selected health measures: cardio vascular disease, tobacco use (25%) 48th in nation, access to care measures, leads to other outcomes we'd like to track in our state. (Prevalence of obesity in our state), preventable hospitalizations, i.e. people aren't controlling their conditions very well; infant mortality rate (significantly higher than other

states); immunization coverage, lack of health insurance; primary care physicians availability. Overall health ranking is 46.

4. United Health Foundation Rankings Oklahoma 2010. We track fruits and vegetables consumption. Only 14% of our population gets 5 fruits and vegetables/day. Other stats on people's behaviors. How are you feeling? 19% of our population responded that they don't feel very well.
5. Leading causes of death in Oklahoma.
6. Total Mortality Rate per 100,000 Population - 2005-2007. Source: State of our State Health Report. Some counties earned an "F" due to chronic conditions and behaviors.
7. Leading Causes of Death in Oklahoma – heart disease, cancer, chronic obstruction/pulmonary
8. Heart Disease Rates – Oklahoma is in the bottom for heart disease rates. (Burden of disease.)
9. Leading risk factors for Heart Disease: Physical inactivity, overweight and obesity, high blood pressure, smoking, high cholesterol, diabetes.
10. Cancer Rates per 100,000 Population 2007. OK has one of the worst rates of cancer death
11. Cancer Death Rate per 100,000
12. Leading Cancer Types in Oklahoma – Lung disease, etc.
13. Risk Factors for Lung Cancer
14. Chronic Obstructive Pulmonary Disease in US 1999-2006. Oklahoma has high rate of burden.
15. Chronic Lower Resp. Disease Death Rate per 100,000 Popl 2005-2007
16. Risk Factor for COPD in OK
17. Stroke Rates – U.S. Map
18. Stroke Death Rate per 100,000 Population in OK
19. Risk Factors for Stroke Death – High blood pressure, etc
20. Hospital Cost Associated with Top Four Cause of Death in OK 2009 Heart Disease $2.1 B,
21. Infant Mortality in Oklahoma
22. Infant Mortality Rate per 100,000 Population 2001-2006
23. Infant Mortality Rate per 1,000 Population 2005-?
24. Top 3 Cause of Infant Mortality Death in Oklahoma
25. Risk factors for Infant Mortality – lack of prenatal care, poor nutrition, etc.
26. Health Behaviors and Risk Conditions in OK
27. Adult Obesity – OK at 32%, trending up. Expensive to treat, this is an economic issue.
28. Tobacco Use – slight reductions in use, still over 25% of our population still smokes.
29. Physical Inactivity – our citizenry is not active enough. If more active they are well, and less sick. A lot of these are due to choice and we can contribute to that choice, to encourage them to choose health
30. Fruit and Vegetable Consumption – we trend down. We are teaching our children that we don't eat enough fruits and vegetables (teaching this in our schools.)
31. Summary of Health Status in Oklahoma.

Q & A – [00:53:27 to 1:07:30]

Q. Mulready - cancer state question;
Q. McDaniels - women's health conditions;
Q. Rep. - obesity;
Q. Morgan re Hospital Costs associated with top four causes of death in OK 2009. A: These health outcomes are the result of multiple factors, per capita cost for treatment, will factor in to cost of insuring them. Mulready re United Health Care Rankings about infant mortality and access to prenatal care. "We want mothers to get proper nutrition and supplements and get them early in her pregnancy."

Q. Mulready re $5 billion attributed to obesity, could you name the top three things we could do to impact that, those are public dollars.
A. One thing we can do is create the expectation that we expect wellness, physical activity in school, we need to support communities and empower them to make good choices, increase access to fruits and vegetables. These are available in Certified Health Communities program. Certified Healthy Business program, too. Q. Rep. Grau re ratio of primary care physicians ranking near the bottom, physician assistance, nurse practitioners, telemedicine?
A. Run the state office of primary care.
Q. Grau re pancreatic cancer – outside factors that contribute?
A. Can't answer.
Q. Rep. Nelson re death and mortality rate, is there any correlation between infant mortality and teen pregnancy?
A. High teen pregnancy rate so parents don't have time to educate their offspring on the issue.
End.

II) Mike Fogarty, Chief Executive Officer, Oklahoma Health Care Authority
[Minute Marker 01:12:11 to 02:00:00]
Presentation: Oklahoma Sooner Care: Access to health care

Slides:

1. First slide –title. Critically important that we put things in the context of where we are today. In a close partnership with OK State Dept. of Health "and" not a "versus". Improving health will take motivation. Driven by crises. Not the first time OK has faced this crisis. Number of uninsured in OK.
2. 'Why OHCA was created: Cost Crisis - Manage and Control'. 1998-1996 history slide. 1995 First Generation Reform. 1996 HMO yield saving first three years.
3. Graph of rising costs slide, years 1995 to 2005
4. Medicaid payments graph slide – same years
5. Legislative Mission. Crisis of the Uninsured. 1997 – Second Generation Reform. Coverage expansion – Higher Income Qualifications. Incl. kids, preg. Women. 3 years later added aged, blind, and disabled.
6. Graph slide of OK Sooner Care Expansion. 2 ways to increase participation – increase the FPL rate; and expand categories of who is eligibility. Federal government provided incentives to make this possible. Sooner Plan.
7. Evolution of Medicaid Managed Care – first crisis was out of control cost; second crisis was uninsured and extended coverage to more people. Soon we saw the rise in cost of care again. The modification that finally came was really a hybrid of the two (fully-capitated HMO in the state and ?) Legislature looked at costs of plans. Leg. Gave the OHCA more funding. In January 2004 the fully-capitated HMO plan was terminated.
8. Post HMO Managed Care. We've been in the process of moving toward another plan. Started in 2004. 2004-2010: Third Generation Reform: - Focus on Service Delivery system improvements, -Patient-centered Medical Home, - Care Management, -ER Utilization Program, --Streamlined Newborn enrollment, -Online Enrollment. Goal: avoidance. (Newborn enrollment – the moment a child is born, they will leave the hospital already covered and assigned to a primary care physician.) (Online enrollment has been effective.) Goal is to get as many qualified people enrolled as possible.
9. Third Generation Reform – Streamlined Newborn Enrollment got national attention.
10. Third Generation Reform – Online Enrollment got national attention.

11. 'Legislative Mission: Fill Uninsured Gap.' 2004-2010 – Fourth Generation Reform (arrow heading right). Public Private Partnership – Insure Oklahoma – Employer Sponsored; Insure Oklahoma – Individual Plan; College Students; All Kids Act.
12. 'Fourth Generation Reform' – Insure Oklahoma gained local media attention.
13. 'Demonstration Waiver Accumulated Savings' - plotted graph on savings chart.
14. 'Fourth Generation Reform' – 2-column excel list: Programs, and Enrollment July 2011
15. 'Date Comparison' – 5-column list of Measure, OK, U.S., High State, Low State numbers
16. 'Challenges for Generation Five' –
    - **Flexibility -** Cost Sharing, Benefit Package;
    - **Provider Access Issues**, Rural Oklahoma, Specialty Care, Primary Care, Graduate Medical Education Support; (GME money from federal government to universities.)
    - **Paying Responsible Rates**;
    - **Program Integrity**, Protecting against waste, fraud, and abuse.
    - Fogarty commented that OHCA wants to grow the infrastructure to support their plans.

Q & A – [02:00:00 to 02:40:00]

Q. Sen. Bill Brown - told of some medical providers not going to take Sooner Care patients any longer. Reimbursement rate was about 60% compared to other plans.

A. Fogarty – if we find there have been errors made we have to practice our fiduciary responsibility.

Q. Rep. Grau – your slide number 6 that shows a dramatic increase in individuals that are covered by insurance in this state. Is our goal to have more people to have more people covered by Medicaid in our state, or fewer people covered by Medicaid in this state?

A. Fogarty – don't want to say what the goal is. It was the state legislature that allowed for the increase in enrollment.

Q. Grau – which leads to another question – those policy changes how many of those were precipitated by the federal government.

A. Fogarty – everyone of those program were federal funding to incentivize the program

Q. Grau – so the federal incentives led to the state's decision to

A. Fogarty – the incentives drove the decisions

Q. Sen. Crain – I think you said all of the changes that were done were based on legislative action? Weren't some of those ballot initiatives?

A. Fogarty – The tobacco tax revenue (lawsuit?) was on the ballot. The legislature decided to devote funds to…?

Q. Crain – Go back to Fourth Generation Reform slide for enrollment in our state. How many are making a conscious choice to not enroll, etc.

A. Fogarty – OK have responded to the knowledge that the coverage was available. The children's enrollment really drove enrollment. Insure Oklahoma was the subject of much media attention. Estimate that there about 350,000 Oklahomans working for small businesses that would be eligible for enrollment. By policy we have extended coverage to about 350,000 additional people.

Q. Crain – If you go to the Challenges for Generation Five slide. What can we do to beef up our residency numbers in our state? Crain cited OU and OSU residency rates.

A. Fogarty – I will be meeting with the deans of both of those schools to discuss this issue. Schools get an enhanced payment. $63 million.

Q. Rep. Mulready – Gap on slide.

A. Fogarty – Benefit package for adults has various coverages, i.e. adult dental coverage covers extraction. There are much richer benefit packages out there.
Q. Mulready – Guidance, nudges. Do we go there, can we go there?
A. Fogarty – We're about to find out. I have about 8 people…we're at our wits' end. "You're out of program for 6 months based on unwillingness to…?"
Q. Rep. McDaniel – Fourth Generation Reform and DVIS waiting list. Who pays the cost for the duals?
A Fogarty – The Duals means they qualify for both Medicaid and Sooner Care. There are about 105,000 of those in Oklahoma. Might come to the stage where you pay a third party.
Q. McDaniel – What do you see for the future of having the two working together.
A. Fogarty –
Q. Crain – How far does the OHCA go to be at its' wits' end?
A. Fogarty – If we suspect fraud or inappropriate use of ER we could take it to the A.G.
In this particular example…we thought about sanctioning someone who goes to the ER too often. Now we have a system that monitors this circumstance – have a specific ER utilization report a management program. And Pay for performance.
Q. Mulready – do you see the feds allowing more flexibility?
A. Fogarty – Costs around $5 billion dollars. Add per enrollee costs. There was a 2005 Task Force on Medicaid reform in this very chamber. One of the goals of that task force was to reduce the cost of Medicaid (and error rate reduction from 9% to 4%). How much automation do we need in the system. On the result of that analysis, the legislature appropriated additional money that helped get us on the path to that reduction
Q. Mulready – are we going to get flexibility from the feds?
A. Fogarty – I think not. They're going to use Medicaid as the program. The logic of that policy decision drives me to conclude that we are going to hear more about the mandate of that program. We're looking 55 different Medicaid programs (all the states, plus 5 territories). When you hear their going to shave off all the differences in the programs, that doesn't sound like flexibility to me. Went to a meeting (out of state).
Q. (By?) Question on insurance fraud – do you see much of that in OK?
A. Fogarty – Not really.

Lunch Break – meeting resumed at roughly 1 pm.

III) Julie Cox-Kain, Chief Operating Officer, OK State Dept. of Health
[Minute Marker 04:10:39 to 05:27:24. Exchange discussion begins at 04:24:50]
Topic: PPACA Summary
Cox-Kain admitted she is not an expert on the PPACA and there may be some SMEs in the audience who can fill in the gaps. Source: "I used information from the **Kaiser Family Foundation's summary** of PPACA for the titles of my slides …"

(Refer to ppt slides distributed at meeting by OHCA)

Q & A – [05:08:03 to 05:27:24)
Q. Sen. Crain – What is the difference between the HUB concept that we passed and the PPACA Exchange?
A. Cox-Kain - Can't remember the provision of that – can't answer that.

Q. Sen. Crain – Mechanical question: Let's just assume, for a moment, that the state legislature says "health information exchange is just the greatest thing in the world" and on day one we tell…whomever, the state agencies, go ahead and implement, prepare and implement, a health information exchange, from day one, how long would it take to design and do all the details to say that we have done a health information exchange?

A. Cox-Kain – Are you saying a Health Information Exchange or Health Insurance Exchange?

Q. Crain – Whatever you want to answer.

A. Cox-Kain – "The NGA actually just did an estimate for us and they said we would need to ready to begin building a Health Insurance Exchange in April of 2012 to have it fully operational."

Q. Crain – So that's the middle of next session? Okay.

Q. Crain – Third question, you had an earlier frame up there. Will PPACA improve access or not? Really a clarification – we can insure everyone in the state, but if you don't have any more physicians or health care providers, all you're doing is providing access for some; you could go to some sort of rationing?

A. May not adequately address the lack of primary care.

Q. Sen. Bill Brown – You said we need to start by April when?

A. Fully operation by Jan.1, 2014, but accepting enrollees by Oct. 1, 2013, so there's an enrollment period there. NGA estimate. Lot of policy considerations that have to take place, but have to begin by April 2012.

Q. Rep. Nelson – Let's say the state doesn't do this the federal government will do this?

A. They'll manage it.

Q. Requirements?

A. Federal requires interface – they're going to have to understand the insurance plan in OK.

Q. So those with concerns about the federal government creating an exchange vs. the state's building it?

A. That is the number one question the states are asking. (Just got back from a NGA meeting in D.C. devoted to that issue.)

Comment: Stanislawski – the 3rd meeting will be bringing in experts from other states to address that issue.

Q. Nelson - What personal information will the exchange need?

A. Age, tobacco use, IRS check, salary entities, to see if person qualifies for tax credit.

Q. Rep. Grau - Real time access to tax records, is that correct?

A. Yes, I will have to get someone…,

Q. (Front row). Some of these policies have already been put into effect. Cost estimates to our local governments, mandates for coverage of children up to 26 years of age.

Q. Mulready – How much is driven by the feds and how much by the states?

A. Good question – Described funding. Categorical funding streams that have to be put together. Our challenge at the OK Health Dept. is to put all those streams together. What we'd like to see is funding. For example, epidemiological funding and other funding important to them.

Q. Mulready – The slide about the increase of reimbursement for Medicaid up to 130% of FPL to be funded by federal dollars we're already at that level. Are they going to fund that?

A. That pertains to Medicaid…I have that same question…I'll be interested to hear the answer.

Q. **[Minute Marker 05:21:07 to 05:23:00] Rep. Nelson – One other question I've got is, what my understanding is that probably the states' health care authority would be where an exchange would be housed, but where are other states putting it, is that the best place for an exchange here? If the federal government produces an exchange, would they house it in Washington, would they house it here, where are these things going to be housed?**

A. **States have an option for governance of an exchange, governance and operation of an exchange and it can be implemented through a state agency, or you could have a non-profit entity, and you can contract out certain functions of the exchange. And so, in fact, you could even have a quasi-governmental entity. This has been addressed or mentioned some in the dialogue about how we would govern and operate an exchange. Actually even having a trust, and there are some in existence now, that govern that exchange and see to the operation of it. So, there is a little bit of state flexibility in how we choose to go forward and implement and/or operationalize an exchange. Again the question about the federal government exchange, there's very few answers to what the federal government exchange will look like, so it is very hard to make that particular decision without that piece of the equation being known.**

Q. Rep. Grau – Reduction in certain Medicare reimbursements. Will there also be reductions in Medicaid matching?

A. Differ to the Medicaid person.

Q. Rep. McDaniel – same day airline tickets cost more than those purchased ahead of time. Any cost analysis if we wait?

A. Doing an analysis now. Gaps and impacts on health outcomes.

Q. Stanislawski – You sayid "ACA has potentially detrimental effect to public health." Is that correct?

A. What I meant Mr. Chairman, to say is the cost in developing public health infrastructure.

Q. Stanislawski – You mentioned the ability to respond to a public health outbreak, ie. What happened in Oologah, is this what could potentially be affected?

A. Yes.

End.

IV) Buffy Heater, Director of Planning and Development, OHCA and Cindy Roberts, Deputy Chief Executive Officer, OHCA.

[Minute Marker 05:27:25 to 60:07:39. Information Technology Systems discussion begins at 05:48:54]

Topic: Oklahoma SoonerCare (Medicaid) and Affordable Care Act (ACA) and Accountable Care Organizations (ACOs)

Slides:

1. Oklahoma SoonerCare (Medicaid) and the Affordable Care Act (ACA) – title slide
2. SoonerCare Today
3. Color box graph – categorical groups: children, pregnant women, OCARES, Soonerplan (family planning services), aged/blind/disabled.
4. Color slide Federal Poverty Level (FPL) Guidelines 2009-2010 Chart
5. SoonerCare Landscape – Today
6. Challenge: Oklahoma's Uninsured diagram
7. Generation "Five" Medicaid and the ACA (Cindy Roberts)
8. Health Care Coverage – 2014 – color box chart depicting coverage. Some categories will be expected to get their coverage through the exchange. (133% of FPL group)
9. Participation Scenarios – 2014. If everyone came in on Jan. 1, 2014 (these are just estimates). "Woodwork" term defined.
10. Oklahoma FMAP Outlook: Newly Qualified, bar graph 2014- thru 2016, through 2020

11. State Dollars Offsets – pregnant women; Insurance Oklahoma (Insure Oklahoma would go away and those would get their coverage through SoonerCare of through the Exchange.); SoonerPlan (Family Planning Services); Other state agencies
12. Impact Analysis for Planning – www.implan.com (Robert's husband works for Commerce) (Question no one asked re: Jobs creation – by what method was the 22,000 'jobs created' figure estimated? Are these government jobs?)
13. Eligibility Rules Change. MAGI (Modified Adjusted Gross Income); Intended to simplify; Consistency between states.
14. **(Buffy Heater) Information System Changes. [Minute Marker 05:48:54 to 05:56:53]**
    Now we're going to talk about the technical aspects of information systems changes. So I think I'll start off by addressing the question that was brought up earlier in the session about the federal data hub or the federal data exchanges that are being established as part of the ACA through both the exchange set-up as well as for the Medicaid income verification pieces. So basically, the federal government is creating a data hub, or a data cloud, as it be, in that there will be sources from federal agencies, the IRS, the Social Security Administration, and the Department of Homeland Security, where there will be member level or individual level information that is fed up to this data cloud.

    Then there will be queries from the states or from a federal exchange that will be able to be sent up to that federal data hub and a match return, that basically says for this person's last IRS data here was their modified adjusted gross income. Or validating that that individual's social security number is as was reported matches, yes indeed, it matches on that individual's name and date of birth. As well as the Homeland Security is going to verify individual citizenship and identity, if possible.

    So the federal data hub is going to require that it is a state level entity that engages in the contractual relationship between the federal government, and so the way the proposed rules that Cindy had mentioned before, right now those proposed rules do limit states in that it is restricted to only state operated entities that can be able to engage in that federal data hub. I will tell you that the feds are specifically soliciting comment on states that might be looking at having a private entity run and operate their exchanges and how the rules might accommodate that…. the ACA requires a 'plug' of sorts to be ready to plug Medicaid into the exchanges….
15. **New CMS IT Guidance – Service Oriented Architecture, Reusable, Interoperable, Scalable, Ease of Use. Some states are still using legacy mainframe systems. So federal government required (above list).**
16. **CMS IT Funding – Enhanced funding available – Medicaid Eligibility Systems (thru 12-15-2015) – 90% match – design, development and implementation. 75% match – ongoing operations. In the past was only 50%.**
17. **(Cindy Roberts)** Federal/State Decisions and Concluding Steps. Rules we're looking at is flexibility, i.e. cost sharing, and benefit design. Eligibility rules do not have any options for an individual to opt out and go into the private market. We're working on some of those eligibility rules.
18. ACA Requirements – Decisions still needed…Benefit Packages, Other Issues.
19. Other Authority and Approvals – State Plan Amendments, Waivers, Promulgated Policy, Tribal Consultation, Medical Advisory Committee, OHCA Board, Legislature, Oklahoma Governor. Will start moving on some of the requirements real soon.
20. **(Buffy Heater)** Accountable Care Organizations **[Minute Marker 06:01:17 to 06:07:39]** Separate and distinct from ACA. ACOs are an opportunity that is available to medical providers.

21. Accountable Care Organizations (ACO) – Shared savings model (a network of providers to realize savings). Savings in caring for those patient populations would be shared amongst members.
22. ACO Basic Features – bulleted list. Providers must agree to a 3-yr contract; Must serve an assigned Medicare patient population of at least 5,000 individuals. Performance measures, to show they've passed the test to qualify for savings.
23. ACO Challenges – Volume-based incentives for providers, slow growth uptake, significant upfront investment, no early incentives & financial rewards, long-range savings dependent upon culture change. ACOs are a work in progress.

Q & A – [Begins at 06:07:40]

Q. Rep. Grau – The question that I have is that if everything is implemented will the number of enrolled in SoonerCare would go up?
A. It would go up.
Q. Where are all these newly qualified individuals coming from?
A. We're keeping children at 185% so the children aren't changing. Will lose about 6,000 of our pregnant women to the exchange. SoonerPlan is a limited benefit package – so don't count them. What we're picking up are those newly qualified adults, generally childless adults.
Q. Rep. Morgan – Impact Analysis plan – why the increase? Help me with those numbers, jobs figure.
A. Explained charts
Q. Mulready –Participation Scenarios slide
A. If you go back to the woodwork individuals.
Q. Mulready – Block grants?
A. C.R. – Don't know if we fully explored what the Block grants look like.

End.

V) Jason Sutton, J.D., from OCPA (Oklahoma Council of Public Affairs**) [06:27:30 to 06:51:39]**
Topic: Projecting Oklahoma's Medicaid Expenditure Growth under the Patient Protection and Affordable Care Act (PPACA)

1. Title Slide
2. Where We Are: 2010 (numbers came from the OKHCA)
3. By the Numbers (#s from OHCA) percentages of Oklahomans paid for by Medicaid
4. Two pie charts: enrollment and expenditures
5. Oklahoma's Medicaid costs vs. the five most populous states. OK = $4500/year, outstrips every other state but New York. Probably because we have a sicker population
6. OK Map of SoonerCare enrollees. (Medicaid) Suspect whole state will look like this under PPACA.
7. Table on all categories of enrollment populations
8. Where We Have Been: 2000-2010 – 169% Growth in State Medicaid Expenditures; 47% enrollment
9. 169% Growth 2000-2010 – Expenditures chart
10. Oklahoma's Medicaid Expenditure Growth is Outstripping Almost Every Other State
11. Where We Are Going: 2014 & Beyond – 16 million to 20 million more Americans enrolled? A lot of surveys show employers will drop coverage.
12. Where We Are Going: 2014 & Beyond – OCPA did a report in conjunction with ind. from Cato Institute.
13. We considered ALL the relevant factors that contribute to rapidly rising Medicaid costs…and projected those historical growth into the future.

14. Medicaid enrollment will surge to 36% of the population by 2023.
15. PPACA will increase state Medicaid expenditures by $11.4 billion between 2014-2023. Kaiser has made some major assumptions that we disagree with. Other group found individual mandate will hurt.
16. So What Can Be Done? Unfortunately, not much. PPACA "Maintenance of Effort" Clause. HHS Guidance – states can cut optional benefits, not optional populations. Waivers? Arizona had a population of childless adults.
17. Three Ingredients for Smarter Medicaid Reform –
    - Simplify eligibility based on one's conditions, and for those who can afford it, reasonable premiums and co-pays.
    - Block grant – Medicaid to give states flexibility and opportunity to innovate.
    - Better leverage marketplace through premium assistance to allow Medicaid recipients to have access to the same kind of health coverage as employees of companies and government.
    - Government financed health care doesn't have to be government run.
18. Contact slide.

Q & A – [06:51:40 to 07:03:20]

Q. Mulready – You're projections are about double what we saw earlier. Do you have details of how those numbers were reached?
A. J.S. – Don't think the OHCA is accounting for certain categories. We were told the cost of a relatively healthy child. Poverty and health correlate, right? We think the numbers can't use the cost of a healthy child to project the cost of the entire population.
Q. McDaniel – Statistical review – either way we have people without care. Do you believe this a right or a privilege?
Are you asking me if I think healthcare coverage is a right? No, I don't.
Q. McDaniel – Why do you think costs (expenditures) raised 169% vs enrollment's 47% rise during the same time frame?
A. Because we have a sicker population.

Comments by Mike Fogarty.

Conclusion.

Next Joint Committee meeting is scheduled for Wednesday, October 5, 2011 at the Tulsa Technology Riverside Campus, Tulsa, OK. 9:00 am to 4:00 pm.

Notes taken by:
Amanda Teegarden
OK-SAFE, Inc.
09/14/11