OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
February 12, 2015 at 1:00 P.M.
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
Oklahoma City, OK

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the January 8, 2015 OHCA Board Meeting Minutes

Item to be presented by Nico Gomez, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

   a) All Star Introduction for December
      - Tina Largent, Sr. Exceptional Needs Coordinator, Population Care Management (Garth Splinter)

   b) Financial Update – Carrie Evans, Chief Financial Officer

      1) Revised Fiscal Year 2016 Budget Request

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

   d) Legislative Update – Carter Kimble, Director of Governmental Relations

   e) Recognition of Matt Lucas

Item to be presented by Nicole Nantois, Chief of Legal Services

4. Announcements of Conflicts of Interest Panel Recommendations for All Action Items Regarding This Board Meeting.

Item to be presented by Vickie Kersey, Director, Fiscal Planning and Procurement

5. a) Action Item – Consideration and Vote on the Request for Proposal (RFP) for the Services of a Vendor to Provide Sickle Cell Disease Services

   b) Action Item – Consideration and Vote of Authority for Expenditure of Funds for the MyHealth Contract Extension

Item to be presented by Tywanda Cox, Chief of Federal and State Policy

6. Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Permanent Rules:

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

A. AMENDING Agency rules at OAC 317:30-3-57, 317:30-3-65.7, and 317:30-5-432.1 to limit the number of payment for glasses to two per year. Any additional glasses beyond this limit must be prior authorized and determined to be medically necessary.
Budget Impact: The rule change has total projected budget savings of $347,055; total state savings are projected as $129,347.

(Reference APA WF # 14-08)

B. AMENDING Agency rules at OAC 317:30-5-126 to eliminate payment for hospital leave to nursing facilities and ICF/IIDs to reserve beds for members who are absent from the facility. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital.
Budget Impact: The rule change has a total projected budget savings of $1,615,367.27; total state savings are projected as $608,993.46.

(Reference APA WF # 14-12)

The following permanent rule HAS previously been approved by the Board and the Governor under Emergency rulemaking. This rule has been REVISED for Permanent Rulemaking.

C. AMENDING Agency SoonerCare Choice enrollment ineligibility rules at OAC 317:25-7-13 and 317:25-7-28 to include making individuals with other forms of creditable health insurance coverage ineligible for SoonerCare Choice; individuals in the former foster care eligibility group are also ineligible for SoonerCare Choice. Additionally, members who are currently enrolled in SoonerCare Choice who have or gain other forms of creditable insurance will be disenrolled from the program. Children who are known to be in OKDHS custody are now eligible to participate in SoonerCare Choice.
Budget Impact: This rule change has total projected budget savings of $3,887,634; total state savings are projected as $1,448,921.

(Reference APA WF # 14-09)

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

D. ADDING Agency rules at OAC 317:30-5-579 to comply with a federal mandate. The purpose of this rule is to outline special provisions for providers participating in the 340B Drug Discount program.
Budget Impact: Budget neutral

(Reference APA WF # 14-24)

E. AMENDING Agency nurse aide training program rules at OAC 317:30-5-134 to specify that payment for training will be directly reimbursed to qualified nurse aides on a quarterly basis for every quarter the individual is employed in a nursing facility. Rules are also revised to

establish a maximum rate for reimbursement for nurse aides who have paid for training and competency examination fees.
Budget Impact: This rule change has total projected budget savings of $1,509,000; total state savings are projected as $529,500.

(Reference APA WF # 14-26)

F. AMENDING Agency Private Duty Nursing (PDN) rules at OAC 317:30-5-559, 317:30-5-560, and 317:30-5-560.1 to reflect an OHCA physician will be responsible for utilizing the acuity grid to help make a determination for medical necessity. The Care Management nurses' responsibility will be to gather, summarize, and present the individual cases to the physician.
Budget Impact: Budget Neutral

(Reference APA WF # 14-27)

G. AMENDING Agency rules at OAC 317:30-3-14 and 317:35-3-1 to lock members in to a single pharmacy and prescriber rather than a single physician and pharmacy. As a result the member is not restricted to one physician; however, the member will be locked in to one pharmacy and must receive prescriptions from an identified and approved lock-in prescriber.
Budget Impact: Budget neutral

(Reference APA WF # 14-29 a & b)

H. AMENDING Agency rules regarding SoonerCare member's freedom of choice to select their provider of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) at OAC 317:30-5-211.7 to state that providers must inform members of this right when filling or ordering DMEPOS.
Budget Impact: Budget neutral

(Reference APA WF # 14-35)

I. AMENDING Agency rules at OAC 317:25-7-7 to convey that electronic referrals will eliminate the need of paper referral documentation within members' medical records.
Budget Impact: Budget neutral

(Reference APA WF # 14-41)

Item to be presented by Nancy Nesser, Pharmacy Director

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

   a) Consideration and vote to add Duavee® (Conjugated Estrogens/ Bazedoxifene), Ofev® (Nintedanib), Esbriet® (Pirfenidone) and Anoro™ Ellipta® (Umeclidinium/Vilanterol), to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Chairman McFall

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

   a) Discussion of Pending Litigation, Investigations and Claims

Choices v. OHCA
Oklahoma Counseling v. OHCA
Pending Long Term Care Eligibility Lawsuits

9. New Business

10. ADJOURNMENT

NEXT BOARD MEETING
March 26, 2015
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 8, 2015
Held at the Oklahoma Health Care Authority
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on January 7, 2015, 10:30 a.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on January 7, 2015, 9:10 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:02 p.m.

BOARD MEMBERS PRESENT: Chairman McFall, Vice-Chairman Armstrong, Member Bryant, Member Robison, Member McVay, Member Case

BOARD MEMBERS ABSENT: Member Nuttle

OTHERS PRESENT:
Becky Moore, OAHCP
Emily Summars, JRLR
Jim Fowler
Ashley Neel, OMES
Crystal Hooper, OHCA
Andy Fosmeer, OHA
Trudy Johnson, OHCA
Tynne White, OHA
Karen, COP
Travis Smith, DHS
Melvin Nwqmadi, Abbott
Kristi Blackburn, DHS
Julie Cox-Kain, OSDH
Bill Baker, OHCA
Corey Burnett, OHCA
Melissa Pratt, OHCA
Magali Salazar, OHCA
Reginald Mason, OHCA
Tony Sellars, OSDH
Joseph Fairbanks, OSDH
Juarez McCann, ODMHSAS

OTHERS PRESENT:
Linda Ehrhardt, OHCA
Tweanna Edwards, OHCA
Warren Viety, Oklahoma Watch
Melanie Lawrence, OHCA
Mike Fogarty
Terry Cothran, COP
Patrick Schlecht, OHCA
MaryAnn Dimrey, OHCA
Roy Simpson, OKAMA
Kevin Rupe, OHCA
Mark Jones, DHS
JoAnne, DHS
Robert Dorrell, BCBSOK
Shana Netherlain, OHCA
Charles Brodt, HP
Brenda Teel, Chickasaw Nation
Sandra Harrison, OHA
Derek Lieser, OHCA
Sherris Harris-Ososanya, OHCA
Jerrod Shouse

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD DECEMBER 11, 2014.

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION: Member Bryant moved for approval of the December 11, 2014 board meeting minutes as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong

ABSTAINED: Member McVay, Member Case

ABSENT: Member Nuttle

ITEM 3 / CHIEF EXECUTIVE OFFICER'S REPORT
Nico Gomez, Chief Executive Officer

DRAFT

3a. OKLAHOMA HEALTH IMPROVEMENT PLAN (OHIP) UPDATE
Julie Cox-Kain, Deputy Secretary of Health & Human Services & Senior Commissioner for the State Department of Health

Ms. Cox-Kain gave an OHIP update that included a description of what the plan was, issues as well as successes and challenges, timeline and milestones, community feedback, key findings, goals and objectives, description of the state innovation model grant (OSIM) and partners. For more detailed information, see Item 3a in the board packet.

3b. ALL STARS INTRODUCTION
Nico Gomez, Chief Executive Officer

The OHCA All-Stars, from September through November 2014 were recognized.

- 3rd Quarter Supervisor for 2014 – Susan Lowrey, Behavioral Health Provider Audit Supervisor, Behavioral Health Provider Audits (Kelly Shropshire)
- September – Karen Beam, Medical Administrative Nurse, Medical Professional Services (Yasmine Barve)
- October – Maggie Salazar, Provider Representative II, Provider Services (Kevin Rupe)
- November – Melinda Snowden, Community Relations Coordinator, Communications, Outreach & Reporting (Ed Long)

3c. FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of November and noted that we are under budget with a $14.1 million positive state variance and the agency is under budget in program spending and in administration spending. She stated that the agency is running over budget in several of our revenue categories. Looking ahead for December, Ms. Evans predicts the agency will continue to run slightly under budget. For more detailed information, see Item 3c in the board packet.

3d. MEDICAID DIRECOR'S UPDATE
Kevin Rupe, Chief Operation Officer

Mr. Rupe provided an update for November that included a report on the number of enrollees in the Medicaid program. He also reported on dual enrollees, long term care members and SoonerCare contracted provider information. For more detailed information, see Item 3d in the board packet.

3d.1 HEPATITIS C TREATMENT UPDATE
Nancy Nesser, Pharmacy Director

Ms. Nesser discussed the medications used for hepatitis C therapy and gave the comparison of pre and post prior authorization implantation. She gave member statistics in regards to hepatitis C and discussed care management referrals. For more detailed information, see Item 3d.1 in the board packet.

ITEM 4 / COMMUNITY RELATIONS UPDATE
Hillary Winn, Program Manager of Community Relations

Ms. Winn discussed the Community Relations department that included describing what the unit does such as identifying a wide range of issues, ensuring bi-directional communication and working with local partners to identify local solutions. Ms. Winn recognized the staff and the counties they represent, explained connecting with communities, forums and feedback. She talked about challenges and communication as well as partnering with numerous entities in 2014. For more detailed information, see Item 4 in the board packet.

ITEM 5 / PRESENTATION OF THE 2014 OKLAHOMA HEALTH CARE AUTHORITY ANNUAL REPORT
Connie Steffee, Reporting & Statistics Director

Ms. Steffee provided a brief description of the OHCA 2014 annual report that described the type of information that could be found. She also noted that the report, along with other key documents, could be found on our website at www.okhca.org/reports.

DRAFT

ITEM 6 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTIONITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

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

Action Item a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the Promulgation of the Emergency Rule in action item 7(b) in accordance with 75 Okla. Stat. § 253.

Action Item b) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Emergency Rules:

A. Amending agency rules at OAC 317:40-5-3, 317:40-5-5, 317:40-5-6, 317:40-5-11, 317:40-5-13, 317:40-5-40 and revoking agency rules at OAC 317:40-5-4, 317:40-5-9, 317:40-5-10 to comply with 29 CFR 552.109 regarding domestic service employees employed by third-party employers, or employers other than the individual receiving services, or his or her family, or household. The regulation precludes third party employers from claiming the companion exemption.
Budget Impact: Budget Neutral

(Reference WF # 14-23)

MOTION: Vice-Chairman Armstrong moved for the declaration of emergency for Item 7b as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman McFall, Member Bryant, Member McVay, Member Robison

ABSENT: Member Nuttle

MOTION: Member Case moved for the approval of Item 7b as published. The motion was seconded by Member Bryant.

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

ABSENT: Member Nuttle

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

a) Consideration and vote to add Harvoni® (Ledipasvir/Sofosbuvir), Zubsolv® (Buprenorphine/ Naloxone Tablets) and Bunavail™ (Buprenorphine/Naloxone Buccal Films) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Member Case moved for approval of Item 8a as published. The motion was seconded by Member McVay.

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

ABSENT: Member Nuttle

ITEM 9 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (1), (4), (7) AND (9).
Nicole Nantois, Chief of Legal Services

DRAFT

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

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

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

   a) Discussion of Pending Litigation, Investigations and Claims

   - Stripling v. OHCA
   - Pecha v. OHCA

ITEM 10 / NEW BUSINESS

There was no new business.

ITEM 11 / ADJOURNMENT

MOTION:	Vice-Chairman Armstrong moved for approval for adjournment. The motion was seconded by Member McVay.
FOR THE MOTION:	Chairman McFall, Member Robison, Member Bryant, Member Case
ABSENT:	Member Nuttle

Meeting adjourned at 2:55 p.m., 1/8/2015

NEXT BOARD MEETING
February 12, 2015
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _______________

*Initials:*______________

DRAFT

FINANCIAL REPORT

For the Six Months Ended December 31, 2014
Submitted to the CEO & Board

- Revenues for OHCA through December, accounting for receivables, were **$2,045,361,710** or **1.9% under** budget.

- Expenditures for OHCA, accounting for encumbrances, were **$1,979,877,391 or 2.2% under** budget.

- The state dollar budget variance through December is a **positive $5,629,036.**

- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	14.9
Administration	2.4
Revenues:	
Drug Rebate	(.3)
Taxes and Fees	2.0
Overpayments/Settlements	.6
FY14 Carryover Committed to FY16	(14.0)
Total FY 15 Variance	**$ 5.6**

ATTACHMENTS

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

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
Fiscal Year 2015, For the Six Months Ended December 31, 2014

REVENUES	FY15 Budget YTD	FY15 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 519,687,069	$ 519,687,069	$ -	0.0%
Federal Funds	1,178,878,868	1,150,543,622	(28,335,245)	(2.4)%
Tobacco Tax Collections	22,445,809	24,452,446	2,006,637	8.9%
Quality of Care Collections	38,667,590	38,517,532	(150,058)	(0.4)%
SFY 14 Carryover Committed to SFY16	14,000,000	-	(14,000,000)	100.0%
Prior Year Carryover	61,029,661	61,029,661	-	0.0%
Federal Deferral - Interest	115,419	115,419	-	0.0%
Drug Rebates	120,489,882	119,653,960	(835,922)	(0.7)%
Medical Refunds	22,613,048	24,251,992	1,638,944	7.2%
Supplemental Hospital Offset Payment Program	98,639,148	98,639,148	-	0.0%
Other Revenues	8,406,325	8,470,861	64,536	0.8%
TOTAL REVENUES	**$ 2,084,972,819**	**$ 2,045,361,710**	**$ (39,611,109)**	**(1.9)%**

EXPENDITURES	FY15 Budget YTD	FY15 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 28,603,390**	**$ 25,521,837**	**$ 3,081,553**	**10.8%**
ADMINISTRATION - CONTRACTS	**$ 62,316,239**	**$ 59,074,906**	**$ 3,241,333**	**5.2%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	19,256,962	18,239,296	1,017,666	5.3%
Acute Fee for Service Payments:				
Hospital Services	468,090,520	457,671,746	10,418,774	2.2%
Behavioral Health	10,412,827	10,036,416	376,411	3.6%
Physicians	253,411,368	245,269,160	8,142,209	3.2%
Dentists	70,823,729	67,782,254	3,041,474	4.3%
Other Practitioners	21,405,627	20,583,214	822,414	3.8%
Home Health Care	10,632,948	10,481,077	151,871	1.4%
Lab & Radiology	41,287,715	40,666,969	620,747	1.5%
Medical Supplies	20,520,860	20,235,540	285,320	1.4%
Ambulatory/Clinics	64,471,774	63,474,403	997,372	1.5%
Prescription Drugs	240,500,722	234,489,375	6,011,347	2.5%
OHCA Therapeutic Foster Care	1,045,229	993,121	52,107	5.0%
Other Payments:				
Nursing Facilities	297,304,864	293,907,545	3,397,319	1.1%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	31,349,878	30,318,528	1,031,349	3.3%
Medicare Buy-In	67,948,846	66,371,307	1,577,539	2.3%
Transportation	36,307,237	35,922,635	384,602	1.1%
Money Follows the Person-OHCA	531,015	312,221	218,793	0.0%
Electonic Health Records-Incentive Payments	9,512,095	9,512,095	-	0.0%
Part D Phase-In Contribution	38,078,089	37,797,525	280,563	0.7%
Supplemental Hospital Offset Payment Program	231,216,220	231,216,220	-	0.0%
Total OHCA Medical Programs	**1,934,108,525**	**1,895,280,648**	**38,827,877**	**2.0%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 2,025,117,536**	**$ 1,979,877,391**	**$ 45,240,145**	**2.2%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 59,855,283**	**$ 65,484,319**	**$ 5,629,036**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
Fiscal Year 2015, For the Six Months Ended December 31, 2014

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 18,313,807	$ 18,231,780	$ -	$ 74,511	$ -	$ 7,515	$ -
Inpatient Acute Care	587,013,639	317,592,168	243,343	1,833,690	185,637,139	737,478	80,969,820
Outpatient Acute Care	171,929,161	136,808,853	20,802	2,047,988	30,782,417	2,269,101	
Behavioral Health - Inpatient	26,990,794	6,111,320	-	141,027	14,235,450		6,502,996
Behavioral Health - Psychiatrist	4,486,309	3,925,096	-	-	561,213	-	-
Behavioral Health - Outpatient	14,434,738	-	-	-	-	-	14,434,738
Behavioral Health Facility- Rehab	125,015,059	-	-	-	-	49,038	125,015,059
Behavioral Health - Case Management	10,995,642	-	-	-	-	-	10,995,642
Behavioral Health - PRTF	45,841,603	-	-	-	-	-	45,841,603
Residential Behavioral Management	10,500,825	-	-	-	-	-	10,500,825
Targeted Case Management	34,214,366	-	-	-	-	-	34,214,366
Therapeutic Foster Care	993,121	993,121	-	-	-	-	-
Physicians	276,291,233	242,216,501	29,050	2,914,942	-	3,023,609	28,107,132
Dentists	67,790,538	67,774,918	-	8,283	-	7,337	-
Mid Level Practitioners	1,712,780	1,701,204	-	10,661	-	915	-
Other Practitioners	18,930,171	18,655,442	223,182	49,076	-	2,471	-
Home Health Care	10,485,542	10,471,096	-	4,465	-	9,981	-
Lab & Radiology	41,575,069	40,394,721	-	908,101	-	272,248	-
Medical Supplies	20,380,081	18,830,252	1,355,768	144,541	-	49,521	-
Clinic Services	63,381,179	58,885,557	-	347,964	-	111,711	4,035,948
Ambulatory Surgery Centers	4,590,313	4,464,500	-	113,178	-	12,635	-
Personal Care Services	6,586,978	-	-	-	-	-	6,586,978
Nursing Facilities	293,907,545	185,445,155	108,460,408	-	-	1,982	-
Transportation	35,714,064	34,360,555	1,317,879	-	-	35,630	-
GME/IME/DME	64,140,513	-	-	-	-	-	64,140,513
ICF/IID Private	30,318,528	24,842,063	5,476,466	-	-	-	-
ICF/IID Public	31,393,848	-	-	-	-	-	31,393,848
CMS Payments	104,168,832	103,818,898	349,935	-	-	-	
Prescription Drugs	239,138,662	233,503,878	-	4,649,287	-	985,497	-
Miscellaneous Medical Payments	208,571	196,578	-	-	-	11,993	-
Home and Community Based Waiver	95,386,636	-	-	-	-	-	95,386,636
Homeward Bound Waiver	45,881,886	-	-	-	-	-	45,881,886
Money Follows the Person	7,328,967	312,221	-	-	-	-	7,016,746
In-Home Support Waiver	12,957,932	-	-	-	-	-	12,957,932
ADvantage Waiver	85,634,241	-	-	-	-	-	85,634,241
Family Planning/Family Planning Waiver	4,265,854	-	-	-	-	-	4,265,854
Premium Assistance*	20,189,694	-	-	20,189,694	-	-	-
Electronic Health Records Incentive Payments	9,512,096	9,512,096	-	-	-	-	-
Total Medicaid Expenditures	**$ 2,642,600,817**	**$ 1,539,047,970**	**$ 117,476,833**	**$ 33,437,407**	**$ 231,216,220**	**$ 7,588,663**	**$ 713,882,762**

* Includes $20,035,910.50 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2015, For the Six Months Ended December 31, 2014

REVENUE		FY15 Actual YTD
Revenues from Other State Agencies	$	285,519,914
Federal Funds		452,410,693
TOTAL REVENUES	**$**	**737,930,608**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	95,386,636
Money Follows the Person		7,016,746
Homeward Bound Waiver		45,881,886
In-Home Support Waivers		12,957,932
ADvantage Waiver		85,634,241
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		31,393,848
Personal Care		6,586,978
Residential Behavioral Management		8,972,160
Targeted Case Management		26,450,388
Total Department of Human Services		**320,280,815**
State Employees Physician Payment		
Physician Payments		28,107,132
Total State Employees Physician Payment		**28,107,132**
Education Payments		
Graduate Medical Education		23,985,914
Graduate Medical Education - Physicians Manpower Training Commission		2,172,666
Indirect Medical Education		31,865,924
Direct Medical Education		6,116,009
Total Education Payments		**64,140,513**
Office of Juvenile Affairs		
Targeted Case Management		1,526,246
Residential Behavioral Management		3,039,471
Total Office of Juvenile Affairs		**4,565,717**
Department of Mental Health		
Case Management		10,995,642
Inpatient Psychiatric Free-standing		6,502,996
Outpatient		14,434,738
Psychiatric Residential Treatment Facility		45,841,603
Rehabilitation Centers		125,015,059
Total Department of Mental Health		**202,790,039**
State Department of Health		
Children's First		771,390
Sooner Start		1,497,736
Early Intervention		1,738,836
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,043,353
Family Planning		(36,992)
Family Planning Waiver		4,288,625
Maternity Clinic		16,750
Total Department of Health		**9,319,699**
County Health Departments		
EPSDT Clinic		417,742
Family Planning Waiver		14,220
Total County Health Departments		**431,963**
State Department of Education		**91,521**
Public Schools		**2,125,179**
Medicare DRG Limit		**74,791,622**
Native American Tribal Agreements		**1,060,367**
Department of Corrections		**1,112,602**
JD McCarty		**5,065,596**
Total OSA Medicaid Programs	**$**	**713,882,762**
OSA Non-Medicaid Programs	**$**	**38,849,451**
Accounts Receivable from OSA	**$**	**14,801,605**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
Fiscal Year 2015, For the Six Months Ended December 31, 2014

REVENUES		FY 15 Revenue
SHOPP Assessment Fee	$	98,503,507
Federal Draws		146,027,732
Interest		37,644
Penalties		97,997
State Appropriations		(15,200,000)
TOTAL REVENUES	$	229,466,880

EXPENDITURES	Quarter	Quarter		FY 15 Expenditures
Program Costs:	7/1/14 - 9/30/14	10/1/14 - 12/31/14		
Hospital - Inpatient Care	92,872,986	92,764,153	$	185,637,139
Hospital -Outpatient Care	15,052,817	15,729,600	$	30,782,417
Psychiatric Facilities-Inpatient	6,919,304	7,316,146	$	14,235,450
Rehabilitation Facilities-Inpatient	272,784	288,429	$	561,213
Total OHCA Program Costs	115,117,891	116,098,329	$	231,216,219
Total Expenditures			$	231,216,219
CASH BALANCE			$	(1,749,339)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
Fiscal Year 2015, For the Six Months Ended December 31, 2014

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 38,498,373**	**$ 38,498,373**
Interest Earned	**19,159**	**19,159**
TOTAL REVENUES	**$ 38,517,532**	**$ 38,517,532**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 106,631,100	$ 38,365,870	
Eyeglasses and Dentures	140,448	50,542	
Personal Allowance Increase	1,688,860	607,652	
Coverage for Durable Medical Equipment and Supplies	1,355,768	487,805	
Coverage of Qualified Medicare Beneficiary	516,378	185,793	
Part D Phase-In	349,935	349,935	
ICF/IID Rate Adjustment	2,678,285	963,647	
Acute Services ICF/IID	2,798,181	1,006,786	
Non-emergency Transportation - Soonerride	1,317,879	474,173	
Total Program Costs	**$ 117,476,833**	**$ 42,492,201**	**$ 42,492,201**
Administration			
OHCA Administration Costs	$ 256,312	$ 128,156	
DHS-Ombudsmen	85,376	85,376	
OSDH-Nursing Facility Inspectors	400,000	400,000	
Mike Fine, CPA	-	-	
Total Administration Costs	**$ 741,688**	**$ 613,532**	**$ 613,532**
Total Quality of Care Fee Costs	**$ 118,218,521**	**$ 43,105,733**	
TOTAL STATE SHARE OF COSTS			**$ 43,105,733**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
Fiscal Year 2015, For the Six Months Ended December 31, 2014

REVENUES	FY 14 Carryover	FY 15 Revenue	Total Revenue
Prior Year Balance	$ 13,950,701	$ -	$ 7,168,968
State Appropriations	-	-	-
Tobacco Tax Collections	-	20,111,954	20,111,954
Interest Income	-	159,117	159,117
Federal Draws	160,262	13,385,763	13,385,763
All Kids Act	(6,689,370)	55,715	55,715
TOTAL REVENUES	**$ 7,421,593**	**$ 33,712,549**	**$ 40,825,802**

EXPENDITURES	FY 14 Expenditures	FY 15 Expenditures	Total $ YTD
Program Costs:			
Employer Sponsored Insurance		$ 19,881,247	$ 19,881,247
College Students		153,783	55,331
All Kids Act		154,663	154,663
Individual Plan			
SoonerCare Choice		$ 71,856	$ 25,854
Inpatient Hospital		1,811,083	651,628
Outpatient Hospital		2,022,379	727,652
BH - Inpatient Services-DRG		138,261	49,746
BH -Psychiatrist		-	-
Physicians		2,905,987	1,045,574
Dentists		7,663	2,757
Mid Level Practitioner		10,120	3,641
Other Practitioners		48,165	17,330
Home Health		4,465	1,606
Lab and Radiology		898,857	323,409
Medical Supplies		135,551	48,771
Clinic Services		344,781	124,052
Ambulatory Surgery Center		107,448	38,660
Prescription Drugs		4,584,134	1,649,371
Miscellaneous Medical		-	-
Premiums Collected		-	(282,588)
Total Individual Plan		**$ 13,090,748**	**$ 4,427,463**
College Students-Service Costs		**$ 156,780**	**$ 56,409**
All Kids Act- Service Costs		**$ 186**	**$ 67**
Total OHCA Program Costs		**$ 33,437,407**	**$ 24,575,181**
Administrative Costs			
Salaries	$ 30,565	$ 632,566	$ 663,131
Operating Costs	125,839	303,241	429,080
Health Dept-Postponing	-	-	-
Contract - HP	96,221	420,704	516,925
Total Administrative Costs	**$ 252,625**	**$ 1,356,511**	**$ 1,609,136**
Total Expenditures			**$ 26,184,317**
NET CASH BALANCE	**$ 7,168,968**		**$ 14,641,486**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
Fiscal Year 2015, For the Six Months Ended December 31, 2014

REVENUES	FY 15 Revenue	State Share
Tobacco Tax Collections	$ 401,268	$ 401,268
TOTAL REVENUES	**$ 401,268**	**$ 401,268**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 7,515	$ 1,893	
Inpatient Hospital	737,478	185,771	
Outpatient Hospital	2,269,101	571,587	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	1,982	499	
Physicians	3,023,609	761,647	
Dentists	7,337	1,848	
Mid-level Practitioner	915	230	
Other Practitioners	2,471	622	
Home Health	9,981	2,514	
Lab & Radiology	272,248	68,579	
Medical Supplies	49,521	12,474	
Clinic Services	111,711	28,140	
Ambulatory Surgery Center	12,635	3,183	
Prescription Drugs	985,497	248,247	
Transportation	35,630	8,975	
Miscellaneous Medical	11,993	3,022	
Total OHCA Program Costs	$ 7,539,625	$ 1,899,233	
OSA DMHSAS Rehab	$ 49,038	$ 12,353	
Total Medicaid Program Costs	$ 7,588,663	$ 1,911,585	
TOTAL STATE SHARE OF COSTS			**$ 1,911,585**

Note: Expenditure amounts are for informational purposes only. Actual payments are made from Fund 340. Revenues deposited into the fund are tranferred to Fund 340 to support the costs, not to exceed the calculated state share amount.

OKLAHOMA HEALTH CARE AUTHORITY
SFY 2016
Budget Request Detail

Description of Priority	# FTE	State	Total
1 **Annualizations**			
FFP Match Rate from 62.30% to 60.99%		45,495,897	-
Medicare A & B Premiums - 01/01/15		(721,616)	(1,865,485)
Additonal State Dollars to cover CHIP population under Title 19		14,441,839	-
	-	**59,216,120**	**(1,865,485)**
2 **Maintenance**			
FY'16 Growth/Utilization increases		26,006,252	75,218,023
Medicare A & B premiums - 01/01/2016		(455,670)	(1,168,084)
Medicare Part D (clawback) - 100% State		2,539,377	2,539,377
Rebase physician fee schedule to align with current RVUs		2,135,637	5,520,938
	-	**30,225,596**	**82,110,254**
3 **One-Time Funding**			
FY-14 Onetime Carryover & Replace		31,029,661	-
	-	**31,029,661**	**-**
4 **Mandates**			
Administrative Law Judge & Paralegal	2.0	30,064	60,128
	2.0	**30,064**	**60,128**
5 **Provider Rate Maintenance**			
Inpatient Hosp DRG / Per diem		21,815,081	56,395,219
Outpatient Hosp		9,942,100	25,701,804
SoonerCare Choice Care Management		343,944	889,146
Behavioral Health (OHCA)		950,442	2,457,034
Nursing Facilities (100% of Allowable Costs)		23,903,575	61,794,287
ICF/MR's (100% of Allowable Costs)		752,894	1,946,344
Physicians (Increase to 100% of Medicare)		18,926,812	48,928,617
Dental		5,921,718	15,308,519
Mid-Level Practioners		148,305	383,392
Other Practitioner		1,598,566	4,132,529
Home Health		243,493	629,466
Lab & Radiology		2,695,401	6,968,011
Clinic Services		635,325	1,642,408
Ambulatory Surgery Center (ASC)		372,586	963,190
Durable Medical Equipment (DME)		1,488,605	3,848,264
Pharmacy Dispensing Fees		1,243,399	3,214,371
Crossovers		11,501,002	29,731,797
	-	**102,483,248**	**264,934,397**
FY-2016 Budget Request Priorities	**2.0**	**$ 222,984,689**	**$ 345,239,295**

Note: SFY 2016 budget request calculated with SFY 2015 base of $953,050,514

Note: If CHIP is reauthorized thru FFY 2019 , Priority #1 will decrease by $42 million
FFY 2016 Enhanced CHIP rate is 72.69%, will increase to 95.69% if reauthorized

Note: Priority #3 was originally $61,029,661 but has been reduced by $14 million in
SFY 2015 positive variance and $16 million in unanticipated SFY 2014 revenue

SoonerCare Programs

December 2015 Data for February 2016 Board Meeting

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System		Monthly Enrollment Average SFY2014	Enrollment December 2015	Total Expenditures December 2015	Average Dollars Per Member Per Month December 2015
SoonerCare Choice Patient-Centered Medical Home		559,363	**539,647**	**$169,951,269**	
Lower Cost	*(Children/Parents; Other)*		492,444	$122,862,490	$249
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*		47,203	$47,088,779	$998
SoonerCare Traditional		196,936	**233,324**	**$198,974,890**	
Lower Cost	*(Children/Parents; Other)*		122,803	$44,994,234	$366
Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*		110,521	$153,980,656	$1,393
SoonerPlan*		48,266	**41,065**	**$462,363**	$11
Insure Oklahoma		23,567	**17,416**	**$5,171,387**	
Employer-Sponsored Insurance		14,795	12,885	$2,888,195	$224
*Individual Plan**		8,772	4,531	$2,283,192	$504
TOTAL		**828,131**	**831,452**	**$374,559,909**	

The enrollment totals above include all members enrolled during the report month; therefore, some members may not have expenditure data.
Custody expenditures are excluded. Non-member specific expenditures of $133,681,498 are excluded.

Effective July 2014, members with other forms of credible health insurance coverage were no longer eligible for Choice PCMH.

*In January 2014, SoonerPlan's qualifying income guidelines decreased from 185% to 133% of FPL and Insure Oklahoma IP's qualifying income guidelines decreased from 200% to 100% of FPL.

Net Enrollee Count Change from Previous Month Total	(6,203)

New Enrollees	15,202

Members that have not been enrolled in the past 6 months.

Dual Enrollees & Long-Term Care Members (subset of data above)

Medicare and SoonerCare		Monthly Average SFY2014	Enrolled December 2015
Dual Enrollees		**109,653**	**110,917**
	Child	192	190
	Adult	109,461	110,727

		Monthly Average SFY2014	Enrolled December 2015	FACILITY PER MEMBER PER MONTH
Long-Term Care Members		**15,358**	**15,030**	**$4,034**
	Child	63	55	
	Adult	15,295	14,975	

Child is defined as an individual under the age of 21.

SOONERCARE CONTRACTED PROVIDER INFORMATION

Provider Counts		Monthly Average SFY2014	Enrolled December 2015
Total Providers		**38,330**	**40,191**
	In-State	29,277	30,636
	Out-of-State	9,053	9,555

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

Program	% of Capacity Used
SoonerCare Choice	44%
SoonerCare Choice I/T/U	20%
Insure Oklahoma IP	1%

Select Provider Type Counts	*In-State*		*Totals*	
	Monthly Average SFY2014	*Enrolled December 2015**	Monthly Average SFY2014	Enrolled December 2015
Physician	*8,452*	*9,083*	*13,597*	15,405
Pharmacy	*936*	*901*	*1,266*	1,186
Mental Health Provider	*4,864*	*4,564*	*4,902*	4,619
Dentist	*1,069*	*1,102*	*1,206*	1,264
Hospital	*183*	*191*	*685*	926
Optometrist	*565*	*611*	*594*	646
Extended Care Facility	*356*	*347*	356	347

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

Total Primary Care Providers**	*5,410*	*5,937*	7,011	7,917
Patient-Centered Medical Home	*2,099*	*2,345*	2,188	2,454

**Including Physicians, Physician Assistants and Advance Nurse Practitioners.

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

FEBRUARY 12TH, 2015 OHCA BOARD MEETING

The Governor's State of the State address and the 2015 legislative session began Monday, February 2nd at noon. After the November elections there are a total of 29 freshman legislators which include 7 new Senate members and 22 new House members. This session there are 72 Republicans and 29 Democrats in the House and 40 Republicans and 8 Democrats in the Senate. Senator Brian Bingman was re-elected as President Pro Tempore of the Senate and Representative Jeff Hickman was re-elected as Speaker of the House. Representative Lee Denney was elected Speaker Pro Tempore of the House.

As of February 3, 2015, the Oklahoma Legislature filed a total of 2,129 legislative bills. OHCA is currently tracking 130 bills, of which two are OHCA request bills, 47 are direct impact bills, and the remaining bills are agency interest and employee interest, which we are still reviewing.

OHCA REQUEST BILLS:

- HB2164 – Rep. Mark McCullough – The bill repeals Sec. 994.2 of Title 12 which was put in place as part of the Tort Reform package in the late 2000s. If a SoonerCare member is the beneficiary of a settlement, OHCA may place a lien on the settlement for medical expenditures. This section of law deals with Medicaid liens being reduced regardless of a settlement amount by a calculated ratio.
- SB704 – Sen. AJ Griffin - Allows OHCA to recover funds put in a trust for, but not spent on, burial/funeral expenses. Recovery amount not to exceed cost of services provided.

The following are the remaining Senate and House deadlines for 2015:

SENATE AND HOUSE DEADLINES

February 27, 2015	Deadline for Reporting House bills and joint resolutions from House committees
March 12, 2015	Deadline for Third Reading of Bills and Joint Resolutions in the Chamber of Origin
April 10, 2015	Deadline for Reporting Senate bills and Joint Resolutions from House committees
April 23, 2015	Deadline for Third Reading of Bills and Joint Resolutions from Opposite Chamber
May 29, 2015	Sine Die Adjournment, No later than 5:00 p.m.

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

Submitted to the C.E.O. and Board on February 12, 2015

AUTHORITY FOR EXPENDITURE OF FUNDS
SICKLE CELL DISEASE SERVICES RFP

BACKGROUND
OHCA is issuing this Request for Proposal (RFP) for the services of a Vendor to provide Sickle Cell Disease Services.

SCOPE OF WORK
- Review current case management efforts and SoonerCare services to identify a baseline of outreach activities related to sickle cell disease.
- Provide education, outreach, and a statewide marketing plan to educate SoonerCare members with sickle cell disease.
- Complete reports to assist OHCA in creating a plan for ongoing and future statewide outreach development and operations.

CONTRACT PERIOD
Date of Award through June 30, 2015 with annual options to renew through June 30, 2016

CONTRACT AMOUNT AND PROCUREMENT METHOD
- Will be awarded through competitive bidding conducted by OHCA
- Federal matching is estimated at 50%
- Estimated at $100,000 per year

RECOMMENDATION
- Board approval to procure the services discussed above

Submitted to the C.E.O. and Board on February 12, 2015
AUTHORITY FOR EXPENDITURE OF FUNDS
MyHealth

BACKGROUND

OHCA contracted with MyHealth to obtain reports on the Comprehensive Primary Care Initiatives grant and the OHCA medical homes. For the grant, OHCA and private payers provide claims data to MyHealth to perform analytics on Medical Homes primary care model impacts; this allows OHCA to obtain reports on the OHCA data submitted to MyHealth.

This contract was originally established for a 12 month period, for a total amount of $100,000.00. This contract has now been extended for another six month period, and the contract increased by $50,000.00; for a total of $150,000.

AMENDMENT SCOPE OF WORK

The contract is extended for six months only, and the scope of work remains the same.

AMENDMENT AMOUNT AND PROCUREMENT METHOD

Additional expenditures are estimated as follows: $50,000.00 in SFY15

Federal matching funds percentage 50%

The original acquisition was made by sole source contract.

OMES Information Services Division has approved the amendment.

RECOMMENDATION

Board approval to expend funds as explained above.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

(1) Inpatient hospital services other than those provided in an institution for mental diseases.

(A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.

(B) Coverage for members under 21 years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or free standing dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with OHCA.

(6) Outpatient Mental Health Services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity Clinic Services.

(10)Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.

(11)Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12)Nursing facility services (other than services in an institution for tuberculosis or mental diseases).

(13)Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under 21 years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified

during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

(A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one visual screening and glasses each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient Psychological services as outlined in OAC 317:30-5-275 through OAC 317:30-5-278.

(J) Inpatient Psychotherapy services and psychological testing as outlined in OAC 317:30-5-95 through OAC 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient hospital services.

(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members 21 years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least 30 days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of

sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ~~ICF/MR~~ICF/IID, or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services
(B) Optometrists' services
(C) Psychologists' services
(D) Certified Registered Nurse Anesthetists
(E) Certified Nurse Midwives
(F) Advanced Practice Nurses
(G) Anesthesiologist Assistants

(17) Free-standing ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six prescriptions with a limit of two brand name prescriptions per month. Exceptions to the six prescription limit are:

(A) unlimited medically necessary monthly prescriptions for:

(i) members under the age of 21 years; and
(ii)residents of Nursing Facilities or Intermediate Care Facilities for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities.

(B) seven medically necessary generic prescriptions per month in addition to the six covered under the State Plan are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the two brand name or thirteen total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of durable medical equipment.

(20) Adaptive equipment, when prior authorized, for members residing in private ~~ICF/MR's~~ICF/IID's.

(21) Dental services for members residing in private ~~ICF/MR's~~ICF/IID's in accordance with the scope of dental services for members under age 21.

(22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment

and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.
(23) Standard medical supplies.
(24) Eyeglasses under EPSDT for members under age 21. Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(25) Blood and blood fractions for members when administered on an outpatient basis.
(26) Inpatient services for members age 65 or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.
(28) Inpatient psychiatric facility admissions for members under 21 are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.
(29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for 60 days after the pregnancy ends, beginning on the last date of pregnancy.
(31) Nursing facility services for members under 21 years of age.
(32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N.
(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.
(34) Home and Community Based Waiver Services for the intellectually disabled.
(35) Home health services limited to 36 visits per year and standard supplies for 1 month in a 12-month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed 36 per year.
(36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.
(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.
(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.
(D) Finally, procedures considered experimental or investigational are not covered.

(37) Home and community-based waiver services for intellectually disabled members who were determined to be inappropriately placed in a NF (Alternative Disposition Plan - ADP).
(38) Case Management services for the chronically and/or severely mentally ill.
(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.
(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.
(41) Early Intervention services for children ages 0-3.
(42) Residential Behavior Management in therapeutic foster care setting.
(43) Birthing center services.
(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.
(45) Home and Community-Based Waiver services for aged or physically disabled members.
(46) Outpatient ambulatory services for members infected with tuberculosis.
(47) Smoking and Tobacco Use Cessation Counseling for children and adults.
(48) Services delivered to American Indians/Alaskan Natives in I/T/Us. Payment is made on an encounter basis.
(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) PROGRAM/CHILD HEALTH SERVICES

317:30-3-65.7. Vision services

(a) At a minimum, vision services include diagnosis and treatment for defects in vision, including eyeglasses once each 12 months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal (refer to OAC 317:30-5-2(b)(5) for amount, duration, and scope). Payment

is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary. The following schedule outlines the services required for vision services adopted by the OHCA.

(1) Each newborn should have an assessment of the anatomy of the lids, alignment of the eyes and clarity of the ocular media with particular attention to documenting the presence of a normal red reflex. The history should document either a normal birth or other condition such as prematurity.

(2) Red reflex and external appearance should be repeated and recorded on infants between one and four months of age.

(3) At six months of age, repeat red reflex and external exam and add an evaluation of ocular alignment with a corneal light reflex test.

(4) One screen should occur between nine and 12 months to mirror the six month screening.

(5) One screening from age three to five including alignment and an acuity test e.g., Allen Cards, Snellen chart or HOTV Test in each eye.

(6) Objective visual acuity testing should be provided at ages five through ten, and once during ages 11 through 18. All other years are subjective by history.

(b) Interperiodic vision examinations are allowed at intervals outside the periodicity schedule when a vision condition is suspected.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 45. OPTOMETRISTS

317:30-5-432.1. Corrective lenses and optical supplies

(a) Payment will be made for children for lenses, frames, low vision aids and certain tints when medically necessary including to protect children with monocular vision. Coverage includes one set of lenses and frames per year. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(b) Corrective lenses must be based on medical need. Medical need includes a change in prescription or replacement due to normal lens wear.

(c) SoonerCare provides frames when medically necessary. Frames are expected to last at least one year and must be reusable. If a lens prescription changes, the same frame must be used if possible. Payment for frames includes the dispensing fee.

(d) SoonerCare reimbursement for frames or lenses represents payment in full. No difference can be collected from the patient, family or guardians.

(e) Replacement of or additional lenses and frames are allowed when medically necessary. Prior authorization is not required;

unless the number of glasses exceeds two per year. ~~however, the~~The provider must always document in the patient record the reason for the replacement or additional eyeglasses. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to ensure guidelines are followed. Payment adjustments will be made on claims not meeting these requirements.

(f) Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses and tints for children require prior authorization and medical necessity. Polycarbonate lenses are covered for children when medically necessary. Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(g) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are not compensable and may be billed to the patient.

(h) Replacement of lenses and frames due to abuse and neglect by the member is not covered.

(i) Bandage contact lenses are a covered benefit for adults and children. Contact lenses for medically necessary treatment of conditions such as aphakia, keratoconus, following keratoplasty, aniseikonia/anisometropia or albinism are a covered benefit for adults and children. Other contact lenses for children require prior authorization and medical necessity.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 9. LONG TERM CARE FACILITIES

317:30-5-126. Therapeutic leave and Hospital leave

Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made.

(1) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven (7) days of therapeutic leave per calendar year for each recipient to reserve the bed.

(2) ~~Effective January 1, 1996, the nursing facility may receive payment for a maximum of five days of hospital leave per calendar year for each recipient to reserve the bed when the patient is admitted to a licensed hospital.~~ No payment shall be made to a nursing facility for hospital leave.

(3) The Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each recipient to reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. Recipients approved for ICF/IID on or after July 1 of the year will only be eligible for 30 days of therapeutic leave during the remainder of that year. No payment shall be made for hospital leave.

(4) Midnight is the time used to determine whether a patient is present or absent from the facility. The day of discharge for therapeutic leave is counted as the first day of leave, but the day of return from such leave is not counted. ~~For hospital leave, the day of hospital admission is the first day of leave. The day the patient is discharged from the hospital is not counted as a leave day.~~

(5) Therapeutic ~~and hospital~~ leave balances are recorded on the Medicaid Management Information System (MMIS). When a patient moves to another facility, it is the responsibility of the transferring facility to forward the patient's leave records to the receiving facility.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE
SUBCHAPTER 7. SOONERCARE
PART 3. ENROLLMENT CRITERIA

317:25-7-13. Enrollment ineligibility

Members in certain categories are excluded from participation in the SoonerCare Choice program. All other members are enrolled in the SoonerCare Choice program and subject to the provisions of this Subchapter. Members excluded from participation in SoonerCare Choice include:

(1) Individuals receiving services in a nursing facility, in an ~~intermediate care facility for the mentally retarded (ICF-MR)~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver.

(2) Individuals privately enrolled in an HMO.

(3) Individuals who would be traveling more than 45 miles or an average of 45 minutes to obtain primary care services.

(4) ~~Children who are known to the OHCA to be in custody, as reported by the Oklahoma Department of Human Services.~~ Individuals in the former foster care children's group (see OAC 317:35-5-2).

(5) Individuals who are eligible for SoonerCare solely due to presumptive eligibility.

(6) Non-qualified or ineligible aliens.

(7) Children in subsidized adoptions.

(8) Individuals who are dually-eligible for SoonerCare and Medicare.

(9) Individuals who are in an Institution for Mental Disease (IMD).

(10) Individuals who have other primary medical insurance.

PART 5. ENROLLMENT PROCESS

317:25-7-28. Disenrolling a member from SoonerCare

(a) The OHCA may disenroll a member from SoonerCare if:

(1) the member is no longer eligible for SoonerCare services;

(2) the member has been incarcerated;

(3) the member dies;

(4) disenrollment is determined to be necessary by the OHCA;

(5) the status of the member changes, rendering him/her ineligible for SoonerCare;

~~(6) the member is already enrolled in the SoonerCare Program, when they are taken or found to be in custody as reported by the Oklahoma Department of Human Services;~~

~~(7)~~(6) the member is authorized to receive services in a nursing facility, in an ~~intermediate care facility for the~~

~~mentally retarded (ICF-MR)~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) or through a Home and Community Based Waiver; ~~or~~

~~(8)~~(7) the member becomes dually-eligible for SoonerCare and Medicare~~.~~; or

(8) the member becomes covered under other primary medical insurance.

(b) The OHCA may disenroll the member at any time if the member is disenrolled for good cause, as it is defined in OAC 317:25-7-27. The OHCA will inform the PCP of any disenrollments from his or her member roster.

(c) OHCA may disenroll a member upon the PCP's request as described in (1) through (5) of this subsection.

(1) The PCP may file a written request asking OHCA to take action including, but not limited to, disenrolling a member when the member:

(A) is physically or verbally abusive to office staff, providers and/or other patients;

(B) is habitually non-compliant with the documented medical directions of the PCP; or

(C) regularly fails to arrive for scheduled appointments without cancelling and the PCP has made all reasonable efforts to accommodate the member.

(2) The request from the PCP for disenrollment of a member must include one of more of the following:

(A) documentation of the difficulty encountered with the member including the nature, extent, and frequency of abusive or harmful behavior, violence, and/or inability to treat or engage the member;

(B) identification and documentation of unique religious or cultural issues that may be effecting the PCP's ability to provide treatment effectively to the member; or

(C) documentation of special assistance or intervention offered.

(3) The PCP may not request disenrollment because of a change in the member's health status, the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the member's special needs except when the member's enrollment with the PCP seriously impairs his/her ability to furnish services to this member or other members.

(4) The PCP must document efforts taken to inform the member orally or in writing of any actions that have interfered with the effective provision of covered services, as well as efforts to explain what actions or language of the member are acceptable and unacceptable and the consequences of unacceptable behavior, including disenrollment from the PCP.

(5) The OHCA will give written notice of the disenrollment request to the member.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 64. CLINIC SERVICES

317:30-5-579. Prescription drugs purchased under the 340B Drug Discount Program provided by Clinics

For 340B Drug Discount Program guidelines refer to section 317:30-5-87.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 9. LONG TERM CARE FACILITIES

317:30-5-134. Nurse Aide Training Reimbursement

(a) Nurse Aide training programs and competency evaluation programs occur in two settings, a nursing facility setting and private training courses. Private training includes, but is not limited to, certified training offered at vocational technical institutions. This rule outlines payment to qualified nurse aides trained ~~for training~~ in either setting.

(b) In the case a nursing facility provides training and competency evaluation in a program that is not properly certified under federal law, the Oklahoma Health Care Authority may offset the nursing facility's payment for monies paid to the facility for these programs. Such action shall occur after notification to the facility of the period of non-certification and the amount of the payment by the Oklahoma Health Care Authority.

(c) In the case of nurse aide training provided in private training courses, reimbursement is made to nurse aides who have paid a reasonable fee for training in a certified training program at the time training was received. The federal regulations prescribe applicable rules regarding certification of the program and certification occurs as a result of certification by the State Survey Agency. For nurse aides to receive reimbursement for private training courses, all of the following requirements must be met:

(1) the training and competency evaluation program must be certified at the time the training occurred;
(2) the nurse aide has paid for training;
(3) a reasonable fee was paid for training (however, reimbursement will not exceed the maximum amount set by the Oklahoma Health Care Authority of 800 dollars);
(4) the Oklahoma Health Care Authority is billed by the nurse aide receiving the training within 12 months of the completion of the training~~;~~. Reimbursement requests outside the first 12 months are not compensable;
(5) the nurse aide has passed her or his competency evaluation; and
(6) the nurse aide is employed at a SoonerCare contracted nursing facility as a nurse aide during all or part of the year after completion of the training and competency evaluation.

~~(1) For every month employed (d) If all the conditions in subsection (c) are met, then the Authority will compensate the nurse aide based upon the following pro-rata formula:~~

~~in a nursing facility, OHCA will pay 1/12 of the sum of eligible expenses incurred by the nurse aide. The term "every month" is defined as a period of 16 days or more within one month.~~

~~(2) The maximum amount paid by the Oklahoma Health Care Authority may be set by the Rates and Standards Committee. The rate paid by the nurse aide, up to the maximum set by the Oklahoma Health Care Authority, will be paid in the event a nurse aide was employed all 12 months after completion of the training program.~~

~~(e) The claimant must submit a completed Nurse Aide Training Reimbursement Program Form and ADM-12 claim voucher. Documentation of eligible expenses must also be provided. Eligible expenses include course training fees, textbooks and exam fees.~~

~~(f) No nurse aide trained in a nursing facility program that has an offer of employment or is employed by the nursing facility in any capacity at the inception of the training program may be charged for the costs associated with the nurse aide training or competency evaluation program.~~

~~(g) The SoonerCare share of Nurse Aide training and testing costs incurred by a nursing facility will be reimbursed in the following manner:~~

~~(1) Quarterly, the facilities incurring expense and requesting reimbursement for the Medicaid share of Nurse Aide Training costs will complete and file a "Nurse Aide Training and Testing Costs" report as prescribed by the OHCA. These reports will be due by the end of the subsequent month.~~

~~(2) From the "Nurse Aide Training and Testing Costs" reports the OHCA will determine a cost per day for each facility for the period.~~

~~(3) The OHCA will pay each facility based on the reported cost per day applied to the actual SoonerCare paid days that matches the period reported by the facility.~~

~~(4) Nurse Aide Training Costs are not allowable for cost reporting purposes.~~

(d) If all the conditions in subsection (c) are met, then the Authority will compensate the nurse aide on a quarterly basis. For every qualifying month employed in a nursing facility during a quarter, OHCA will pay the previous quarter's sum of eligible expenses incurred by the nurse aide. The term "qualifying month" is defined as a period of 16 days or more within one calendar month. The terms "quarter" and "quarterly basis" are defined as three qualifying months.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 62. PRIVATE DUTY NURSING

317:30-5-559. How services are authorized

An eligible provider may have private duty nursing services authorized by following all the following steps:

(1) create a treatment plan for the patient as expressed in OAC 317:30-5-560;
(2) submit the prior authorization request with the appropriate OHCA required forms, the treatment plan, and request the telephonic interview and/or personal visit by an OHCA Care Management Nurse; and
(3) have an OHCA ~~Care Management Nurse~~ physician determine medical necessity of the service ~~by~~ including scoring the member's needs on the Private Duty Nursing Acuity Grid.

317:30-5-560. Treatment Plan

(a) An eligible organization must create a treatment plan for the member as part of the authorization process for private duty nursing services. The initial treatment plan must be signed by the member's attending physician.
(b) The treatment plan must include all of the following medical and social data so that an OHCA ~~Care Management Nurse~~ physician can appropriately determine medical necessity ~~by the~~ including use of the Private Duty Nursing Acuity Grid:

(1) diagnosis;
(2) prognosis;
(3) anticipated length of treatment;
(4) number of hours of private duty nursing requested per day;
(5) assessment needs and frequency (e.g., vital signs, glucose checks, neuro checks, respiratory);
(6) medication method of administration and frequency;
(7) age-appropriate feeding requirements (diet, method and frequency);
(8) respiratory needs;
(9) mobility requirements including need for turning and positioning, and the potential for skin breakdown;
(10) developmental deficits;
(11) casting, orthotics, therapies;
(12) age-appropriate elimination needs;
(13) seizure activity and precautions;
(14) age-appropriate sleep patterns;
(15) disorientation and/or combative issues;
(16) age-appropriate wound care and/or personal care;

(17) communication issues;
(18) social support needs;
(19) name, skill level, and availability of all caregivers; and
(20) other pertinent nursing needs such as dialysis, isolation.

317:30-5-560.1. Prior authorization requirements

(a) Authorizations are provided for a maximum period of six months.

(b) Authorizations require:

(1) a treatment plan for the member; ~~and~~

(2) a telephonic interview and/or personal visit by an OHCA Care Management Nurse ~~to determine medical necessity using the Private Duty Nursing Acuity Grid.~~ ; and

(3) an OHCA physician to determine medical necessity including use of the Private Duty Nursing Acuity Grid.

(c) The number of hours authorized may differ from the hours requested on the treatment plan based on the ~~assessment of the Care Management Nurse~~ review by an OHCA physician.

(d) If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.

(e) Changes in the treatment plan may necessitate another telephonic interview and/or personal visit by the OHCA Care Management staff.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES
PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-14. Freedom of choice

(a) **Any Qualified provider.** The ~~Medicaid Agency~~Oklahoma Health Care Authority (OHCA) assures that any individual eligible for ~~Medicaid~~SoonerCare, may obtain services from any institution, agency, pharmacy, person, or organization that is contracted with OHCA and qualified to perform the services.

(b) **~~Recipient~~Member lock-in.** ~~Medicaid recipients~~SoonerCare members who have demonstrated ~~Medicaid usage~~utilization above the statistical norm, during a ~~12-month~~6-month period, may be "locked-in" to ~~one primary physician~~a prescriber and/or one pharmacy for medications classified as controlled dangerous substances in accordance with Federal Regulation 42 CFR 431.54.

(1) Over-utilization patterns by ~~Medicaid recipients~~SoonerCare members may be identified either by referral or by OHCA automated computer systems. ~~Medicaid~~SoonerCare records, for a ~~12-month~~6-month period, of those identified ~~recipients~~members are then reviewed. ~~Medical histories are ordered and~~Medical and pharmacy claim histories are reviewed by OHCA ~~medical~~pharmacy consultants to determine if high usage is medically justified.

(2) If it is determined that ~~Medicaid~~SoonerCare has been over-utilized, the ~~recipient~~member may be notified, by letter, of the need to select a ~~primary physician~~prescriber and/or pharmacy and of their opportunity for a fair hearing. If they do not select a ~~physician~~prescriber or pharmacy one is selected for them. ~~The primary-care provider must be a general practice, family practice, OB_GYN, pediatrician or internal-medicine physician and currently be enrolled as a Medicaid provider.~~ In some cases ~~recipients~~members may be sanctioned under OAC 317:35-13-7.

(3) The ~~provider~~prescriber and/or pharmacy of choice, unless ~~that provider has~~the aforementioned providers have been identified as having problems with ~~Medicaid~~ over-utilization, ~~is~~are notified by letter and ~~is~~ given an opportunity to accept or decline to be the ~~recipient's primary physician~~member's prescriber and/or pharmacy.

(4) When the provider accepts, a confirmation letter is sent to both ~~recipient~~member and provider showing the effective date of the arrangement. ~~The recipient will be issued a monthly Medicaid identification card which will designate them as a participant in the lock-in program.~~

(5) After the lock-in arrangement is made, the provider may file claims for services provided in accordance with OHCA ~~procedure~~guidelines.

(6) Locked-in ~~recipients~~members may obtain emergency services from an emergency room facility for an emergency medical condition or as part of an inpatient admission.
~~(7) Medicaid-compensable visits to a specialist are covered when referred by the primary-care physician. The primary-care physician must be shown as the referring physician on Item 17 of HCFA-1500 submitted by the specialist.~~
~~(8)~~(7) If a claim for a controlled dangerous substance is filed by another ~~provider~~pharmacy, ~~it is reviewed to see if a referral was given or services were for an acute physical injury. Claims not meeting this criteria are denied and the recipient is responsible for charges~~the claim will be denied.
~~(9)~~(8) When a ~~recipient~~member is enrolled into the lock-in program, usage is monitored ~~when necessary~~periodically and reviewed every 24 months. A provider may send a written request for ~~recipient~~member review. If review indicates utilization patterns meet lock-in removal criteria, the ~~recipient~~member may be removed from lock-in at the discretion of OHCA staff.
~~(10)~~(9) During a review, OHCA may elect to continue lock-in, remove the ~~recipient~~member from lock-in because of medical necessity, remove them because of decreased utilization, or impose sanctions under OAC 317:35-13-7.
~~(11)~~(10) The ~~recipient~~member in the lock-in program may make a ~~written~~ request to change providers after the initial three months; when the ~~recipient~~member moves to a different city or if the ~~recipient~~member feels irreconcilable differences will prevent necessary medical care. Change of providers based on irreconcilable differences must be approved by OHCA staff or contractor.
~~(12)~~(11) OHCA may make a provider change when the provider makes a ~~written~~ request for change or may initiate a change anytime it is determined necessary to meet program goals.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY
SUBCHAPTER 3. COVERAGE AND EXCLUSIONS

317:35-3-1. ~~Payment for Medicaid~~Reimbursement

(a) **Payment eligibility.** In order for the Authority to make payment for ~~Medicaid~~SoonerCare services, the individual must be determined eligible to have such payment made by:

(1) having eligibility previously determined, or

(2) making application for ~~Medicaid~~SoonerCare at the time the medical services is requested, and having eligibility determined at that time.

(b) **~~Recipient~~Member lock-in.** ~~Medicaid recipients~~SoonerCare members who have demonstrated ~~Medicaid usage~~utilization above the statistical norm, during a ~~12-month~~6-month period, may be "locked-in" to ~~one primary physician~~a prescriber and/or one pharmacy for medications classified as controlled dangerous substances. If OHCA has determined that ~~Medicaid~~SoonerCare has been over-utilized, the ~~recipient~~member is notified, by letter, of the need to select a ~~primary physician~~prescriber and/or pharmacy and of their opportunity for a fair hearing. ~~A copy of the letter is sent to the DHS county office.~~ If the ~~recipient~~member does not select a ~~physician and/or pharmacy~~prescriber or pharmacy, one is selected for her/him. "Locked-in" ~~recipients~~members may obtain emergency services from a physician and/or an emergency room facility in the event of a medical emergency.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 17. MEDICAL SUPPLIERS

317:30-5-211.7. Free choice

A member has the choice of which provider will fill the prescription or order for a DMEPOS. ~~The prescribing physician should give the written prescription or order to the member in order to allow the member freedom of choice~~. All providers must inform the member they have a choice of provider when filling or ordering DMEPOS.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 25. SOONERCARE CHOICE
SUBCHAPTER 7. SOONERCARE
PART 1. GENERAL PROVISIONS

317:25-7-7. Referrals for specialty services

(a) PCPs are required to assure the delivery of medically necessary preventive and primary care medical services, including securing referrals for specialty services. Some services, as defined in OAC 317:25-7-2(c) and OAC 317:25-7-10(b), do not require a referral from the PCP. A PCP referral does not guarantee payment, as all services authorized by the PCP must be in the scope of coverage of the SoonerCare Choice program to be considered compensable.

(b) Pursuant to OAC 317:30-3-1(f), SoonerCare Choice referrals must always be made on the basis of medical necessity. Referrals from the PCP are required prior to receiving the referred service, except for retrospective referrals as deemed appropriate by the PCP.

(c) ~~Documentation in the medical record must include a copy of each referral to another health care provider.~~ The PCP and specialty provider are responsible for maintaining appropriate documentation of each referral to support the claims for medically necessary services.

(d) As approved and deemed appropriate, the OHCA may provide administrative referrals for specialty services. Administrative referrals are only provided by the OHCA under special and extenuating circumstances. Administrative referrals should not be requested as a standard business practice. The OHCA will not process retrospective administrative referrals, unless one of the following exceptions applies:

(1) the specialty services are referred from an IHS, tribal, or urban Indian clinic;

(2) the specialty services are referred as the result of an emergency room visit or emergency room follow-up visit;

(3) the specialty services are referred for pre-operative facility services prior to a dental procedure; or

(4) the retrospective administrative referral request for specialty services is requested from the OHCA within 30 calendar days of the specialty care date of service. If the retrospective administrative referral is requested within the 30 calendar days, the request must include appropriate documentation for the OHCA to approve the request. Appropriate documentation must include:

(A) proof that the specialist has attempted to collect a PCP referral from the member's assigned PCP; and

(B) medical documentation to substantiate that the specialty services are medically necessary pursuant to OAC 317:30-3-1(f).

(e) Nothing in this section is intended to absolve the PCP of their obligations in accordance with the conditions set forth in their

PCP SoonerCare Choice contract and the rules delineated in OAC 317:30.

Recommendation 1: Prior Authorize Duavee® (Conjugated Estrogens/ Bazedoxifene)

The Drug Utilization Review Board recommends the prior authorization of Duavee® (conjugated estrogens/bazedoxifene) with the following criteria:

Duavee® (Conjugated Estrogens/Bazedoxifene) Approval Criteria:

1. An FDA approved diagnosis of moderate to severe vasomotor symptoms associated with menopause or for prevention of postmenopausal osteoporosis; and
2. Member must be a female with an intact uterus; and
3. For a diagnosis of moderate to severe vasomotor symptoms associated with menopause:
    a. Member must have at least 7 moderate to severe hot flushes per day or at least 50 per week prior to treatment; and
4. For a diagnosis of prevention of postmenopausal osteoporosis:
    a. A trial of Fosamax® (alendronate), Actonel® (risedronate), Boniva® (ibandronate) or Reclast® (zoledronic acid) compliantly used for at least 6 months concomitantly with calcium + vitamin D, that failed to prevent fracture or improve BMD scores; or
    b. Contraindication to, hypersensitivity to, or intolerable adverse effects with all bisphosphonates indicated for prevention of postmenopausal osteoporosis; and
5. Member must not have any of the contraindications for use of Duavee®; and
6. Members greater than 65 years of age will generally not be approved without supporting information.
7. Approvals will be for the duration of 6 months to ensure the need for continued therapy is reassessed periodically and the medication is being used for the shortest duration possible.
8. A quantity limit of 30 tablets per 30 days will apply.

Recommendation 2: Prior Authorize Ofev® (Nintedanib) and Esbriet® (Pirfenidone)

The Drug Utilization Review Board recommends prior authorization of Ofev® (nintedanib) and Esbriet® (pirfenidone) with the following criteria:

Ofev® (Nintedanib) Approval Criteria:

1. An FDA approved diagnosis of idiopathic pulmonary fibrosis (IPF); and
2. Member must be 18 years of age or older; and
3. Medication must be prescribed by a pulmonologist or pulmonary specialist; and
4. A quantity limit of 60 capsules per 30 days will apply.

Esbriet® (Pirfenidone) Approval Criteria:

1. An FDA approved diagnosis of idiopathic pulmonary fibrosis (IPF); and
2. Member must be 18 years of age or older; and
3. Medication must be prescribed by a pulmonologist or pulmonary specialist; and
4. A quantity limit of 270 capsules per 30 days will apply.

Recommendation 3: Prior Authorize Anoro™ Ellipta® (Umeclidinium/Vilanterol)

The Drug Utilization Review Board recommends the prior authorization of Anoro™ Ellipta® (umeclidinium/vilanterol inhalation powder) with the following criteria:

Anoro™ Ellipta® (Umeclidinium/Vilanterol Inhalation Powder) Approval Criteria:

1. Member must be 18 years of age or older; and
2. An FDA approved diagnosis of chronic obstructive pulmonary disease (COPD); and
3. A patient-specific, clinically significant reason why the member cannot use Tier-1 long-acting $beta_2$ agonist (LABA) and long-acting muscarinic antagonist (LAMA) individual components.