OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
August 12, 2015 at 1:00 P.M.
Embassy Suites Oklahoma City Downtown/Medical Center
Room – Stanton L. Young ABC
741 North Phillips Avenue
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 June 25, 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

   - May 2015 All-Star – Dorothy Scott, Coding Analyst (Sylvia Lopez)
   - June 2015 All-Star – Shana Netherlain, Community Relations Coordinator (Ed Long)

   b) Financial Update – Carrie Evans, Chief Financial Officer

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

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

   e) Recognition of Dr. Leon Bragg, Chief Dental Officer

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

4. Discussion Item – Public Comment on this meeting's agenda items by attendees who gave 24 hour prior written notice

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

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

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 Emergency Rules:

   Action Item – a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of ***all Emergency Rules*** in item six 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:

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

A. AMENDING Agency rules at OAC 317:30-5-696 to add limited dental services for adult SoonerCare members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. The proposed rule states that services must be prior authorized and are limited to: Comprehensive oral evaluation, two radiographic bitewings, prophylaxis, fluoride application, limited restorative procedures, and periodontal scaling/root planing.
Budget Impact: The proposed rule change has a projected cost to the agency of $60,000 state only dollars.

(Reference APA WF # 15-01)

B. AMENDING Agency long-term care eligibility rules at OAC 317:35-5-41.8 to be consistent with federal regulation. Changes include modifying the home equity maximum amount of $500,000 to include the increased annual percentage increase in the urban component of the consumer price index. Revisions clarify home exemption criteria for persons living in the home. In addition revisions include changes to how annuities are accessed.
Budget Impact: Budget neutral

(Reference APA WF # 15-10)

Item to be presented by Carrie Evans, Chairperson of State Plan Amendment Rate Committee

7. Action Item – Consideration and Vote Upon the Recommendations of the State Plan Amendment Rate Committee.

A. Consideration and Vote to establish a rate for the coverage of Mental Health/Substance Use Disorder (MH/SUD) screens provided in outpatient behavioral health agencies. The rate of $25.32 was established to reimburse for screens provided by qualified providers using approved evidence based tools at a rate of $25.32 per event. This change has an estimated total dollar increase of $193,054, of which $120,272 state dollars.

B. Consideration and Vote to revise the payment methodology for independent Licensed Behavioral Health Practitioners (LBHP) in order to equalize payment for services with the payments made for services provided by the same level of provider in an outpatient behavioral health agency setting. This method change is to establish independent LBHP reimbursement rates for Common Procedure Technology (CPT) codes, which in the aggregate equates to 62.7% of the 2013 non-facility practitioner Medicare Physician Fee Schedule rates. This change has an estimated total dollar savings of $2,072,078, of which $808,110 state.

C. Consideration and Vote to establish a rate for Severe Combined Immunodeficiency Disorder (SCID) Newborn Screen. The rate of $6.00 was established to reimburse for the CPT code applicable to SCID testing is 81479, Unlisted Molecular Pathology Procedure. This change has an estimated total dollar increase of $179,000, of which $68,020 state.

D. Consideration and Vote to establish a rate for a new code (84415) for Exome Sequence Analysis. The new rate was established by cross-walking 1 unit each of 81400, 81401, 81402, 81403, 81404, 81405, 81406, and 81407, so that we are paying the same rate as what was paid in 2014. This would result in a default rate of $3,980.73 ($3,672.22 current with budget reductions). This rate change will result in no budget impact since the proposal is to set the

rate for 81415 at the sum of the rates for the codes that were billed for the service prior to 2015.

E. Consideration and Vote to reduce the reimbursement rate for certain Advantage and State Plan Personal Care Providers by 3.5%. This rate reduction will have a total estimated savings of $5,088,690, of which $1,918,436 state.

F. Consideration and Vote to reduce the reimbursement rate for certain Developmental Disabilities Services Providers by 3.5%. This rate reduction will have a total estimated savings of $10,656,595, of which $3,971,713 state.

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

8. a) Action Item – Consideration and Vote of Authority for Expenditure of Funds for Evaluation Consultant for Care Coordination

   b) Action Item – Consideration and Vote of Authority for Expenditure of Funds for Development Consultant for Care Coordination

Item to be presented by Nancy Nesser, Pharmacy Director

9. 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 **Avycaz™ (Ceftazidime/Avibactam), Zerbaxa™ (Ceftolozane/Tazobactam), Cholbam™ (Cholic Acid), and Natpara® (Parathyroid Hormone Injection)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Ed McFall, Chairman

10. Action Item – Consideration and Vote on letter to be provided to the OHCA provider network

Item to be presented by Ed McFall, Chairman

11. 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).

    Bethesda Family Services
    Stripling vs. OHCA
    Sulphur Manor v. Burwell

12. New Business

RECESS

RECONVENE BOARD MEETING/CONFERENCE AT 2:30PM, WEDNESDAY, AUGUST 12, 2015

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
June 25, 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 June 24, 2015 at 11:00 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 June 24, 2015 at 12:08 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Vice-Chairman Armstrong called the meeting to order at 1:00 p.m.

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

OTHERS PRESENT:	OTHERS PRESENT:
Charles Brodt, HP	Will Widman, HP
Jon Alford, OUMS	Gary Carlile, Warren Clinic SFHS Tulsa
Tyler Talley, eCapitol	Jacey Stanley, LifeCare Solutions
Vikas Jain	David Dude, American Cancer Society
Crystal Palone, Apria	Yasmine Barve, OHCA
Lisa Moses, OHCA	Tanya Mandt, Vitacare
Jimmy Durant, SSM HealthCare	Becky Moore, OAHCP
Dee Delapp, Global Health	Rick Snyder, OHA
Steve Edwards, Edwards Firm	Ms. Moore, OKDHS
Jaclyn Cosgrove, The Oklahoman	Terry Cothran, CoP
Dan Arthrell, CSC/MHSC Tulsa	Ora Lee Wilson, OHCA
John Sullivan, SBL	Kendal Pinkston, OU Med Center / Children's
Susan Rex, Promises Inc.	Kelly Kicklighter, Vitacare
Scott Carter, Oklahoma Watch	Dan Patten, Edwards Firm
Bryce, Legislative Report	Mary Wafford, Chickasaw Nation
Latoya Alexander, MATF	Annette Mays, OK Assoc for Home Care & Hospice
Jim Fowler, AZ	Mike Fogarty
Karen Beam, OHCA	Aaron Morris, OHCA
Melissa Pratt, OHCA	Justin Etchieson, OAG
Robert Dorvell, BCBS OK	Kellie Jones, OUHSC
Vickie Kersey, OHCA	Brent Wilborn, OKPCA
David Ward, OHCA	Kara Kearns, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD MARCH 30, 2015.

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: Vice-Chairman Armstrong moved for approval of the March 30, 2015 board meeting minutes as published. The motion was seconded by Member Bryant.

FOR THE MOTION: Member Nuttle, Member Case

ABSTAINED: Member McVay, Member Robison

PASS: Chairman McFall

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD MAY 14, 2015.

MOTION: Vice-Chairman Armstrong moved for approval of the May 14, 2015 board meeting minutes as published. The motion was seconded by Member Case.

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

ABSTAINED: Member Bryant

ITEM 3a / ALL STARS INTRODUCTION
Nico Gomez, Chief Executive Officer

The following OHCA All-Star was recognized:

- March 2015 All-Star – Theo Hensley, Accountant, Finance (Carrie Evans presented)

ITEM 3b / FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of April and noted that we are under budget in program spending by $18.8 million and by $3.4 million state dollars in administration for a total variance of $20.1 million. Ms. Evans predicted that OHCA will be slightly under budget for May. For more detailed information, see Item 3b in the board packet.

ITEM 3c / MEDICAID DIRECTOR'S UPDATE
Garth Splinter, State Medicaid Director

Dr. Splinter provided an update for April data that included a report on the number of enrollees in the Medicaid program. He stated that things have relatively stayed the same. For more detailed information, see Item 3c in the board packet.

Mr. Gomez recognized Dr. Courtney Barrett who has been accepted into the ADA Institute Diversity for Leadership and commended her for her accomplishments.

He also recognized Dr. Leon Bragg who has been recently named the Medicaid CHIP State Dental Association President, at their last conference, representing dentists nationwide. Mr. Gomez thanked him for his leadership and expertise.

Mr. Gomez recognized that Dr. Allison Martinez was in Washington, DC representing the agency and participating in a panel discussion titled 'Covering and Paying for Genetic Services'.

Mr. Gomez mentioned that Becky Pasternik-Ikard was recently published in The Oklahoman for her point of view 'Working to Improve Oklahomans' Health'. He also stated that some staff were able to join Governor Fallin's Walk for Wellness at the capitol a few weeks ago.

He thanked the board, OHCA staff, providers and patients for their support and patience as we go through a difficult process with the budget.

ITEM 4 / PUBLIC COMMENT ON THIS MEETING'S AGENDA ITEMS BY ATTENDEES WHO GAVE 24 HOUR PRIOR WRITTEN NOTICE
Nicole Nantois, Chief of Legal Services

Speakers: Kellie Jones/OUHSC and Vikas Jain/MD FAASM CCSH

ITEM 5 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 6a / CONSIDERATION AND VOTE UPON DECLARATION OF A COMPELLING PUBLIC INTEREST FOR THE PROMULGATION OF ALL EMERGENCY RULES IN ACTION ITEM SIX OF THIS AGENDA IN ACCORDANCE WITH 75 OKLA. STAT. § 253.

Tywanda Cox, Chief of Federal and State Policy

MOTION: Member Case moved for approval of all emergency rules in action item six as published. The motion was seconded by Member Robison.

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

ITEM 6b / 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:

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

A. AMENDING Agency rules at OAC 317:30-5-41 and 317:30-5-47 to clarify the reimbursement methodology for DRG hospitals. Proposed policy revisions clarify that compensable inpatient services provided to SoonerCare eligible members admitted to acute care and critical access hospitals will be reimbursed the lesser of the billed charges **OR** the DRG amount. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature.
Budget Impact: The agency will observe a total savings of $11,181,897; state savings of $3,964,760.

(Reference APA WF # 15-03)

MOTION: Member McVay moved for approval of item 6b.A as published. The motion was seconded by Member Nuttle.

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

B. 1) AMENDING Agency rules at OAC 317:30-3-59, 317:30-5-2, and 317:30-5-42.17 to eliminate coverage for the removal of benign skin lesions for adults. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature. **Budget Impact: The agency estimates that the savings from eliminating coverage for the removal of benign skin lesions for adults will be $106,832 total dollars; state savings of $37,879.**

(Reference APA WF # 15-04)

MOTION: Member Case moved for approval of item 6b.B.1 as published. The motion was seconded by Member McVay.

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

2) AMENDING Agency rules at OAC 317:30-3-59, 317:30-5-2, and 317:30-5-42.17 to eliminate coverage for adult sleep studies. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature.
Budget Impact: The agency estimates that the savings from eliminating adult sleep studies will be $1,459,302 total dollars; state savings of $517,420.

(Reference APA WF # 15-04)

MOTION: Vice-Chairman Armstrong moved for approval of item 6b.B.2 as published. The motion was seconded by Member McVay.

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

AGAINST THE MOTION: Member Case

C. AMENDING Agency High Risk Obstetrical (HROB) program rules at OAC 317:30-5-22 and 317:30-5-22.1 to update provider qualifications to allow certain Board Eligible or Board Certified obstetrical providers to refer and render services for members eligible for the HROB program; revisions also include amendments to the number of units allowed for ultrasounds. The change will decrease the allowed units for ultrasounds from six to three. Additionally, ultrasounds to assist in the diagnosis of a high risk condition are revised to one from six. Further, revisions include decreasing the number of units from 12 for a singleton fetus for biophysical profiles/non-stress tests or any combination thereof to a total of five, with one test per week beginning at 34 weeks gestation and continuing to 38 weeks. These changes align with the current standards of care and reflect the current number of ultrasounds and biophysical profiles that are being utilized by SoonerCare pregnant women. The effective date of this emergency rule will be July 1, 2015 or immediately upon Governor's signature. The emergency rule will be superseded by the 2014 permanent rule (APA WF# 14-28) August 27, 2015.
Budget Impact: The proposed rule change is projected to save $292,433 total dollars; state savings of $103,687.

(Reference APA WF # 15-05)

MOTION: Member Case moved for approval of item 6b.C as published. The motion was seconded by Member Bryant.

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

D. AMENDING Agency rules regarding coverage for durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) at OAC 317:30-5-210.2 to restrict coverage for continuous positive airway pressure devices (CPAP) to children only. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature.
Budget Impact: The proposed rule change is projected to save $506,630 total dollars; state savings of $179,634.

(Reference APA WF # 15-06)

MOTION: Vice-Chairman Armstrong moved for approval of item 6b.D as published. The motion was seconded by Member Robison.

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

AGAINST THE MOTION: Member Case

E. AMENDING Agency rules at OAC 317:30-5-20 and ADDING Agency rules at OAC 317:30-5-20.1 to establish policy for the appropriate administration of urine drug screening and testing to align with recommended allowances based on clinical evidence and standards of care. Criteria include: purpose for urine testing, coverage requirements, non-covered testing, provider qualifications, and medical record documentation requirements necessary to support medical necessity. Additionally, revisions include clean-up to reimbursement language from general laboratory services policy. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature.
Budget Impact: The proposed rule change is projected to save $11,703,400 total dollars; state savings of $4,149,635.

(Reference APA WF # 15-08)

MOTION: Member Nuttle moved for approval of item 6b.E as published. The motion was seconded by Member Bryant.

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

F. ADDING Agency rules at OAC 317:30-3-11, 317:30-3-11.1, 317:30-5-44, 317:30-5-744, 317:30-5-893, 317:30-5-973, 317:30-5-993, and 317:30-5-1045 to restrict the timely filing of claims for reimbursement from 12 months to six months. In addition, policy regarding resubmission is revised to update the deadline from 24 months to 12 months.

Changes to the timely filing restrictions are in accordance with federal authority. Timely filing for crossover claims will remain one year. In addition, language corrections are included at 317:30-5-44 to reflect current practice. The effective date of this emergency rule will be July 1, 2015 or immediately upon governor's signature.
Budget Impact: The proposed rule change is projected to save $3,330,000 total dollars; state savings of $1,288,044.

(Reference APA WF # 15-09)

MOTION: Member Case moved for approval of item 6b.F as published. The motion was seconded by Member McVay.

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

The following emergency rules HAVE previously been approved by the Board. These rules have been REVISED for emergency rulemaking.

G. AMENDING Agency High Risk Obstetrical (HROB) program rules at OAC 317:30-5-22 and 317:30-5-22.1 to update provider qualifications to allow certain Board Eligible or Board Certified obstetrical providers to refer and render services for members eligible for the HROB program; revisions also include amendments to the number of units allowed for ultrasounds. The change will decrease the allowed units for ultrasounds from six to three. Additionally, ultrasounds to assist in the diagnosis of a high risk condition are revised to one from six. Further, revisions include decreasing the number of units from 12 for a singleton fetus for biophysical profiles/non-stress tests or any combination thereof to a total of five, with one test per week beginning at 34 weeks gestation and continuing to 38 weeks. These changes align with the current standards of care and reflect the current number of ultrasounds and biophysical profiles that are being utilized by SoonerCare pregnant women. The effective date of this emergency rule will be August 27, 2015 or immediately upon governor's signature, whichever is later.
Budget Impact: This rule will not result in any additional costs or savings to the agency.

(Reference APA WF # 15-07)

MOTION: Member Bryant moved for approval of item 6b.G as published. The motion was seconded by Member Robison.

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

ITEM 7 / CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE

Carrie Evans, Chairperson of State Plan Amendment Rate Committee

A. Consideration and Vote to reduce Diagnosis-Related Group Outlier payments by increasing the DRG threshold to $50,000. This change has an estimated total dollar savings of $18,881,600, of which $6,694,786 is state savings.

MOTION: Vice-Chairman Armstrong moved for approval of item 7A as published. The motion was seconded by Member Bryant.

FOR THE MOTION: Chairman McFall, Member Case, Member McVay, Member Nuttle, Member Robison

B. Consideration and Vote to pay the lesser of billed charges or the Diagnosis-Related Group amount. This change has an estimated total dollar savings of $11,914,717, of which $4,224,561 is state savings.

MOTION: Member Nuttle moved for approval of item 7B as published. The motion was seconded by Member McVay.

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

C. Consideration and Vote to pay the lesser of the transfer fee or the Diagnosis-Related Group. This change has an estimated total dollar savings of $2,774,924, of which $983,896 is state savings.

MOTION: Member Bryant moved for approval of item 7C as published. The motion was seconded by Member Nuttle.

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

D. Consideration and Vote to revise the methodology and reimbursement structure for physician/practitioner Resource Based Relative Value Scale reimbursement by assigning Relative Value Units based on Facility or Non-Facility Place of Service. This change has an estimated total dollar savings of $7,376,605, of which $2,615,498 is state savings.

MOTION: Member Robison moved for approval of item 7D as published. The motion was seconded by Member Bryant.

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

E. Consideration and Vote to reduce the reimbursement for deductibles and co-insurance for nursing facility Medicare Crossover claims to 75 percent. This change has an estimated total dollar savings of $6,179,930, of which $2,191,197 is state savings.

MOTION: Member Case moved for approval of item 7E as published. The motion was seconded by Member McVay.

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

F. Consideration and Vote to reduce the reimbursement rate for polycarbonate lens to $10.00 per unit, or $20 per pair of glasses. This change has an estimated total dollar savings of $4,150,150, of which $1,471,505 is state savings.

MOTION: Vice-Chairman Armstrong moved for approval of item 7F as published. The motion was seconded by Member Nuttle.

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

G. Consideration and Vote to increase the base rate to $156.19 for Acute (16 Beds or Less) Intermediate Care Facilities for Individuals with Intellectual Disabilities. This change will increase the annual budget by an estimated $61,297, comprised of $37,587 in federal matching funds and $28,710 in state matching funds coming from the increased Quality of Care Fee, which is paid by the facilities.

MOTION: Member Robison moved for approval of item 7G as published. The motion was seconded by Vice-Chairman Armstrong.

FOR THE MOTION: Chairman McFall, Member Nuttle, Member Case, Member McVay, Member Bryant

H. Consideration and Vote to increase the base rate component to $198.22 for the Acquired Immune Deficiency Syndrome rate for Nursing Facilities. This change will increase the annual budget by an estimated $1,769, comprised of $1,085 in federal matching funds and $684 in state matching funds coming from the increased Quality of Care Fee, which is paid by the facilities.

MOTION: Member Case moved for approval of item 7H as published. The motion was seconded by Vice-Chairman Armstrong.

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

I. Consideration and Vote to increase the base rate component to $107.29 for Regular Nursing Facilities and decrease the pool amount for these facilities in the state plan for the "Other" and "Direct Care" components to $155,145,293. This change will increase the annual budget by an estimated $833,616, comprised of $511,173 in federal matching funds and $322,443 in state matching funds coming from the increased Quality of Care Fee, which is paid by the facilities.

MOTION: Member McVay moved for approval of item 7I as published. The motion was seconded by Member Nuttle.

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

J. Consideration and Vote to increase the base rate to $121.96 for Regular Intermediate Care Facilities for Individuals with Intellectual Disabilities. This change will increase the annual budget by an estimated $28,291, comprised of $17,348 in federal matching funds and $10,943 in state matching funds coming from the increased Quality of Care Fee, which is paid by the facilities.

MOTION: Member Case moved for approval of item 7J as published. The motion was seconded by Member Robison.

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

K. Consideration and Vote to approve the method change and rate of $65.25 per day for Agency Companion (Contractor) Intermittent and Respite Service. The estimated total annualized savings is $4,654, of which $1,754 is state savings.

MOTION: Member Nuttle moved for approval of item 7K as published. The motion was seconded by Vice-Chairman Armstrong.

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

ITEM 8a / CONSIDERATION AND VOTE OF THE STATE FISCAL YEAR 2016 BUDGET WORK PROGRAM

Vickie Kersey, Director of Fiscal Planning and Procurement

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

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

ITEM 9a / CONSIDERATION AND VOTE OF AUTHORITY FOR EXPENDITURE OF FUNDS FOR INCONTINENCE SUPPLIES

Vickie Kersey, Director of Fiscal Planning and Procurement

MOTION: Member Case moved for Item 9a as published. The motion was seconded by Member Robison.

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

ITEM 9b / CONSIDERATION AND VOTE OF AUTHORITY FOR EXPENDITURE OF FUNDS FOR VOXIVA HEALTH SERVICES

Vickie Kersey, Director of Fiscal Planning and Procurement

MOTION: Member Nuttle moved for Item 9b as published. The motion was seconded by Member Bryant.

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

ITEM 10a / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLA. STAT. §5030.3.

Nancy Nesser, Pharmacy Director

a) Consideration and vote to add **Ruconest® (C1 Esterase Inhibitor), Hemangeol™ (Propranolol Oral Solution), and Sotylize™ (Sotalol Oral Solution)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Member Case moved for approval of Item 10a as published. The motion was seconded by Member McVay.

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

ITEM 11 / NEW BUSINESS

Chairman McFall read a statement regarding the budget. There was no other new business.

ITEM 12 / ADJOURNMENT

MOTION: Member Nuttle moved for approval for adjournment. The motion was seconded by Member McVay.

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

Meeting adjourned at 2:07 p.m., 6/25/2015

NEXT BOARD MEETING
August 12, 2015
STRATEGIC PLANNING CONFERENCE
August 12, 13 & 14, 2015
Location - TBD

Lindsey Bateman
Board Secretary

Minutes Approved: _____

Initials: _____

FINANCIAL REPORT

For the Eleven Months Ended May 31, 2015
Submitted to the CEO & Board

- Revenues for OHCA through May, accounting for receivables, were **$3,636,774,156** or 1**% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,635,687,490 or 1.4% under** budget.
- The state dollar budget variance through May is a **positive $21,429,885.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		18.5
Administration		4.0
Revenues:		
Drug Rebate		2.0
Taxes and Fees		2.9
Overpayments/Settlements		8.0
FY15 Carryover Committed to FY16		(14.0)
Total FY 15 Variance	**$**	**21.4**

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 Eleven Months Ended May 31, 2015

REVENUES	FY15 Budget YTD	FY15 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 883,198,269	$ 883,198,269	$ -	0.0%
Federal Funds	2,165,694,872	2,124,877,620	(40,817,252)	(1.9)%
Tobacco Tax Collections	41,150,651	44,596,791	3,446,140	8.4%
Quality of Care Collections	70,571,333	69,864,834	(706,499)	(1.0)%
SFY 15 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	244,483	244,483	-	0.0%
Drug Rebates	185,828,146	191,147,102	5,318,956	2.9%
Medical Refunds	41,457,255	51,011,937	9,554,682	23.0%
Supplemental Hospital Offset Payment Program	197,496,333	197,496,333	-	0.0%
Other Revenues	13,180,745	13,307,128	126,383	1.0%
TOTAL REVENUES	**$ 3,673,851,748**	**$ 3,636,774,156**	**$ (37,077,591)**	**(1.0)%**

EXPENDITURES	FY15 Budget YTD	FY15 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 52,931,248**	**$ 46,984,927**	**$ 5,946,321**	**11.2%**
ADMINISTRATION - CONTRACTS	**$ 116,572,148**	**$ 112,569,600**	**$ 4,002,548**	**3.4%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	37,085,082	33,903,058	3,182,024	8.6%
Acute Fee for Service Payments:				
Hospital Services	833,902,381	832,515,909	1,386,472	0.2%
Behavioral Health	18,376,351	17,847,397	528,953	2.9%
Physicians	454,765,775	446,105,190	8,660,585	1.9%
Dentists	125,826,396	118,105,998	7,720,398	6.1%
Other Practitioners	38,802,480	32,917,007	5,885,473	15.2%
Home Health Care	19,360,499	18,174,925	1,185,574	6.1%
Lab & Radiology	69,389,813	68,925,445	464,367	0.7%
Medical Supplies	36,658,869	37,046,442	(387,573)	(1.1)%
Ambulatory/Clinics	115,061,149	114,403,948	657,201	0.6%
Prescription Drugs	441,305,357	444,234,799	(2,929,442)	(0.7)%
OHCA Therapeutic Foster Care	1,855,800	1,486,067	369,733	19.9%
Other Payments:				
Nursing Facilities	534,510,111	518,905,519	15,604,592	2.9%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	55,947,774	54,419,494	1,528,280	2.7%
Medicare Buy-In	125,139,923	122,786,271	2,353,652	1.9%
Transportation	64,600,617	63,387,373	1,213,244	1.9%
Money Follows the Person-OHCA	944,026	585,751	358,275	0.0%
Electonic Health Records-Incentive Payments	29,850,515	29,850,515	-	0.0%
Part D Phase-In Contribution	71,364,398	70,676,981	687,418	1.0%
Supplemental Hospital Offset Payment Program	449,854,873	449,854,873	-	0.0%
Total OHCA Medical Programs	**3,524,602,189**	**3,476,132,963**	**48,469,226**	**1.4%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 3,694,194,967**	**$ 3,635,687,490**	**$ 58,507,477**	**1.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (20,343,219)**	**$ 1,086,666**	**$ 21,429,885**	

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

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 34,038,121	$ 33,889,265	$ -	$ 135,063	$ -	$ 13,793	$ -
Inpatient Acute Care	1,006,537,029	568,873,890	446,130	3,204,934	347,449,538	1,347,422	85,215,115
Outpatient Acute Care	340,085,018	257,983,959	38,137	3,570,564	74,665,987	3,826,371	
Behavioral Health - Inpatient	49,024,898	10,769,505	-	246,858	26,415,674	-	11,592,861
Behavioral Health - Psychiatrist	8,401,567	7,077,893	-	-	1,323,674	-	-
Behavioral Health - Outpatient	25,912,348	-	-	-	-	-	25,912,348
Behaviorial Health-Health Home	2,595,304	-	-	-	-	-	2,595,304
Behavioral Health Facility- Rehab	231,258,543	-	-	-	-	81,962	231,258,543
Behavioral Health - Case Management	19,060,760	-	-	-	-	-	19,060,760
Behavioral Health - PRTF	82,742,043	-	-	-	-	-	82,742,043
Residential Behavioral Management	21,337,688	-	-	-	-	-	21,337,688
Targeted Case Management	62,897,794	-	-	-	-	-	62,897,794
Therapeutic Foster Care	1,486,067	1,486,067	-	-	-	-	-
Physicians	503,071,528	440,583,595	53,259	5,032,597	-	5,468,336	51,933,741
Dentists	118,134,148	118,091,802	-	28,150	-	14,196	-
Mid Level Practitioners	2,720,976	2,703,007	-	16,210	-	1,759	-
Other Practitioners	30,292,423	29,796,177	409,167	80,182	-	6,897	-
Home Health Care	18,181,040	18,155,422	-	6,116	-	19,503	-
Lab & Radiology	70,425,687	68,470,961	-	1,500,241	-	454,484	-
Medical Supplies	37,298,843	34,488,378	2,485,574	252,402	-	72,490	-
Clinic Services	114,131,729	106,756,669	-	634,889	-	189,512	6,550,659
Ambulatory Surgery Centers	7,637,298	7,435,328	-	179,531	-	22,439	-
Personal Care Services	12,043,110	-	-	-	-	-	12,043,110
Nursing Facilities	518,905,519	326,835,766	192,067,771	-	-	1,982	-
Transportation	63,077,574	60,612,657	2,395,330	-	-	69,587	-
GME/IME/DME	113,759,749	-	-	-	-	-	113,759,749
ICF/IID Private	54,419,494	44,596,044	9,823,450	-	-	-	-
ICF/IID Public	40,284,650	-	-	-	-	-	40,284,650
CMS Payments	193,463,252	192,801,564	661,688	-	-	-	
Prescription Drugs	453,013,956	442,506,020	-	8,779,157	-	1,728,779	-
Miscellaneous Medical Payments	309,799	290,889	-	-	-	18,910	-
Home and Community Based Waiver	171,878,827	-	-	-	-	-	171,878,827
Homeward Bound Waiver	81,576,117	-	-	-	-	-	81,576,117
Money Follows the Person	11,628,875	585,751	-	-	-	-	11,043,123
In-Home Support Waiver	23,060,596	-	-	-	-	-	23,060,596
ADvantage Waiver	158,671,019	-	-	-	-	-	158,671,019
Family Planning/Family Planning Waiver	6,940,669	-	-	-	-	-	6,940,669
Premium Assistance*	38,671,866	-	-	38,671,866	-	-	-
Electronic Health Records Incentive Payments	29,850,515	29,850,515	-	-	-	-	-
Total Medicaid Expenditures	**$ 4,758,826,437**	**$ 2,804,641,124**	**$ 208,380,505**	**$ 62,338,760**	**$ 449,854,873**	**$ 13,338,424**	**$ 1,220,354,714**

* Includes $38,386,819.49 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
Fiscal Year 2015, For the Eleven Months Ended May 31, 2015

REVENUE		FY15 Actual YTD
Revenues from Other State Agencies	$	504,611,247
Federal Funds		769,383,675
TOTAL REVENUES	**$**	**1,273,994,922**

EXPENDITURES		Actual YTD
Department of Human Services		
Home and Community Based Waiver	$	171,878,827
Money Follows the Person		11,043,123
Homeward Bound Waiver		81,576,117
In-Home Support Waivers		23,060,596
ADvantage Waiver		158,671,019
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		40,284,650
Personal Care		12,043,110
Residential Behavioral Management		16,211,066
Targeted Case Management		49,206,780
Total Department of Human Services		**563,975,288**
State Employees Physician Payment		
Physician Payments		51,933,741
Total State Employees Physician Payment		**51,933,741**
Education Payments		
Graduate Medical Education		70,019,832
Graduate Medical Education - Physicians Manpower Training Commission		5,757,984
Indirect Medical Education		31,865,924
Direct Medical Education		6,116,009
Total Education Payments		**113,759,749**
Office of Juvenile Affairs		
Targeted Case Management		2,858,454
Residential Behavioral Management		5,126,622
Total Office of Juvenile Affairs		**7,985,076**
Department of Mental Health		
Case Management		19,060,760
Inpatient Psychiatric Free-standing		11,592,861
Outpatient		25,912,347
Health Homes		2,595,304
Psychiatric Residential Treatment Facility		82,742,043
Rehabilitation Centers		231,258,543
Total Department of Mental Health		**373,161,857**
State Department of Health		
Children's First		1,421,116
Sooner Start		2,466,207
Early Intervention		3,614,858
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,902,019
Family Planning		(58,258)
Family Planning Waiver		6,977,108
Maternity Clinic		27,485
Total Department of Health		**16,350,536**
County Health Departments		
EPSDT Clinic		691,124
Family Planning Waiver		21,819
Total County Health Departments		**712,942**
State Department of Education		**107,708**
Public Schools		**5,688,877**
Medicare DRG Limit		**77,041,622**
Native American Tribal Agreements		**1,463,825**
Department of Corrections		**1,451,481**
JD McCarty		**6,722,012**
Total OSA Medicaid Programs	**$**	**1,220,354,714**
OSA Non-Medicaid Programs	**$**	**69,391,465**
Accounts Receivable from OSA	**$**	**15,751,257**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

Fiscal Year 2015, For the Eleven Months Ended May 31, 2015

REVENUES	FY 15 Revenue
SHOPP Assessment Fee	$ 197,157,031
Federal Draws	282,239,613
Interest	166,784
Penalties	172,517
State Appropriations	(30,200,000)
TOTAL REVENUES	$ 449,535,946

EXPENDITURES	Quarter	Quarter	Quarter	Quarter	FY 15 Expenditures
Program Costs:	7/1/14 - 9/30/14	10/1/14 - 12/31/14	1/1/15 - 3/31/15	4/1/15 - 6/30/15	
Hospital - Inpatient Care	92,872,986	92,764,153	78,587,045	83,225,354	$ 347,449,538
Hospital -Outpatient Care	15,052,817	15,729,600	21,418,128	22,465,442	$ 74,665,987
Psychiatric Facilities-Inpatient	6,919,304	7,316,146	5,914,677	6,265,547	$ 26,415,674
Rehabilitation Facilities-Inpatient	272,784	288,429	370,249	392,213	$ 1,323,674
Total OHCA Program Costs	115,117,891	116,098,329	106,290,098	112,348,555	$ 449,854,873
Total Expenditures					$ 449,854,873

CASH BALANCE	$ (318,926)

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

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 69,825,561**	**$ 69,825,561**
Interest Earned	**39,272**	**39,272**
TOTAL REVENUES	**$ 69,864,834**	**$ 69,864,834**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 188,741,289	$ 71,155,466	
Eyeglasses and Dentures	249,162	93,934	
Personal Allowance Increase	3,077,320	1,160,150	
Coverage for Durable Medical Equipment and Supplies	2,485,574	937,061	
Coverage of Qualified Medicare Beneficiary	946,693	356,903	
Part D Phase-In	661,688	661,688	
ICF/IID Rate Adjustment	4,734,776	1,785,010	
Acute Services ICF/IID	5,088,674	1,918,430	
Non-emergency Transportation - Soonerride	2,395,330	903,039	
Total Program Costs	**$ 208,380,505**	**$ 78,971,682**	**$ 78,971,682**
Administration			
OHCA Administration Costs	$ 455,695	$ 227,848	
DHS-Ombudsmen	263,027	263,027	
OSDH-Nursing Facility Inspectors	400,000	400,000	
Mike Fine, CPA	11,000	5,500	
Total Administration Costs	**$ 1,129,722**	**$ 896,375**	**$ 896,375**
Total Quality of Care Fee Costs	**$ 209,510,227**	**$ 79,868,057**	
TOTAL STATE SHARE OF COSTS			**$ 79,868,057**

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 Eleven Months Ended May 31, 2015

REVENUES	FY 14 Carryover	FY 15 Revenue	Total Revenue
Prior Year Balance	$ 13,950,701	$ -	$ 7,231,137
State Appropriations	-	-	-
Tobacco Tax Collections	-	36,680,638	36,680,638
Interest Income	-	327,568	327,568
Federal Draws	160,262	25,499,488	25,499,488
All Kids Act	(6,627,201)	117,797	117,797
TOTAL REVENUES	**$ 7,483,762**	**$ 62,625,491**	**$ 69,738,830**

EXPENDITURES		FY 14 Expenditures	FY 15 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 38,059,618	$ 38,059,618
	College Students		285,047	102,560
	All Kids Act		327,201	327,201
Individual Plan				
	SoonerCare Choice		$ 129,897	$ 46,737
	Inpatient Hospital		3,178,095	1,143,479
	Outpatient Hospital		3,515,133	1,264,745
	BH - Inpatient Services-DRG		243,851	87,738
	BH -Psychiatrist		-	-
	Physicians		5,021,524	1,806,744
	Dentists		27,431	9,870
	Mid Level Practitioner		15,473	5,567
	Other Practitioners		78,805	28,354
	Home Health		6,116	2,200
	Lab and Radiology		1,482,562	533,426
	Medical Supplies		240,410	86,500
	Clinic Services		627,687	225,842
	Ambulatory Surgery Center		172,497	62,064
	Prescription Drugs		8,646,262	3,110,925
	Miscellaneous Medical		-	-
	Premiums Collected		-	(456,609)
Total Individual Plan			**$ 23,385,743**	**$ 7,957,581**
	College Students-Service Costs		**$ 280,955**	**$ 101,088**
	All Kids Act- Service Costs		**$ 195**	**$ 70**
Total OHCA Program Costs			**$ 62,338,760**	**$ 46,548,118**
Administrative Costs				
	Salaries	$ 30,565	$ 1,235,886	$ 1,266,451
	Operating Costs	125,839	531,050	656,889
	Health Dept-Postponing	-	-	-
	Contract - HP	96,221	836,771	932,992
Total Administrative Costs		**$ 252,625**	**$ 2,603,707**	**$ 2,856,332**
Total Expenditures				**$ 49,404,451**
NET CASH BALANCE		**$ 7,231,137**		**$ 20,334,379**

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 Eleven Months Ended May 31, 2015

REVENUES	FY 15 Revenue	State Share
Tobacco Tax Collections	$ 731,822	$ 731,822
TOTAL REVENUES	**$ 731,822**	**$ 731,822**

EXPENDITURES	FY 15 Total $ YTD	FY 15 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 13,793	$ 3,640	
Inpatient Hospital	1,347,422	355,585	
Outpatient Hospital	3,826,371	1,009,779	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	1,982	523	
Physicians	5,468,336	1,443,094	
Dentists	14,196	3,746	
Mid-level Practitioner	1,759	464	
Other Practitioners	6,897	1,820	
Home Health	19,503	5,147	
Lab & Radiology	454,484	119,938	
Medical Supplies	72,490	19,130	
Clinic Services	189,512	50,012	
Ambulatory Surgery Center	22,439	5,922	
Prescription Drugs	1,728,779	456,225	
Transportation	69,587	18,364	
Miscellaneous Medical	18,910	4,990	
Total OHCA Program Costs	$ 13,256,461	$ 3,498,380	
OSA DMHSAS Rehab	$ 81,962	$ 21,630	
Total Medicaid Program Costs	$ 13,338,424	$ 3,520,010	
TOTAL STATE SHARE OF COSTS			**$ 3,520,010**

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.

June 2015 Data for August 2015 Board Meeting

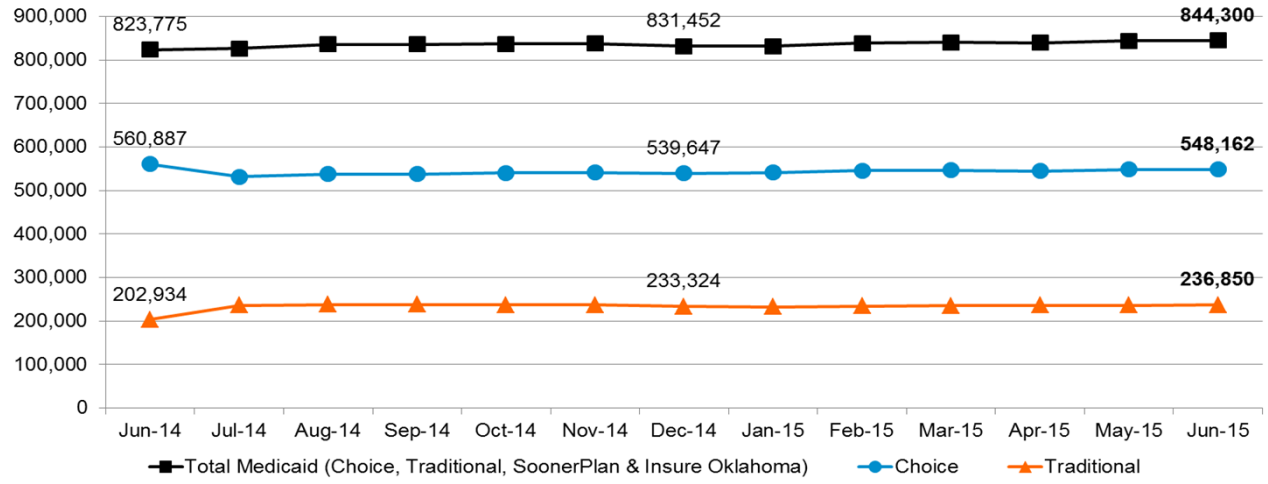
SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment June 2015	Children June 2015	Adults June 2015	Enrollment Change	Total Expenditures June 2015	Average Dollars Per Member Per Month June 2015
SoonerCare Choice Patient-Centered Medical Home			548,162	450,399	97,763	-28	**$134,038,480**	
	Lower Cost	*(Children/Parents; Other)*	503,158	435,582	67,576	250	$99,364,320	$197
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	45,004	14,817	30,187	-278	$34,674,160	$770
SoonerCare Traditional			236,850	91,231	145,619	614	**$183,289,677**	
	Lower Cost	*(Children/Parents; Other)*	126,323	86,135	40,188	704	$44,633,732	$353
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	110,527	5,096	105,431	-90	$138,655,945	$1,254
SoonerPlan			41,677	3,243	38,434	381	**$370,966**	$9
Insure Oklahoma			17,611	508	17,103	-312	**$5,730,787**	
	Employer-Sponsored Insurance		13,295	341	12,954	-232	$3,642,918	$274
	Individual Plan		4,316	167	4,149	-80	$2,087,869	$484
TOTAL			**844,300**	**545,381**	**298,919**	**655**	**$323,429,909**	

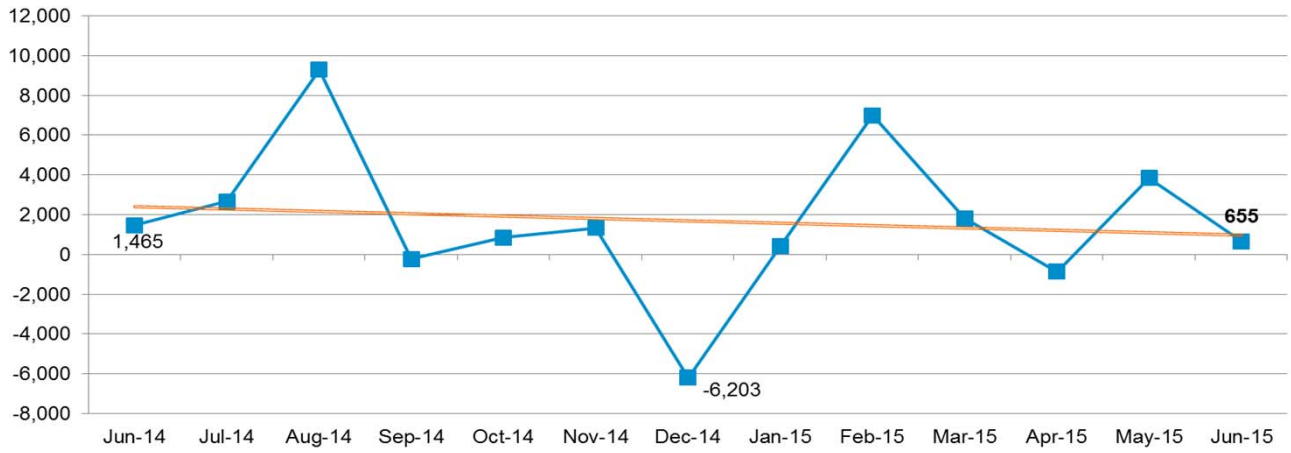
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

Total In-State Providers		**32,246**	**(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**					
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,298	927	1,147	193	4,986	616	345	6,291	2,410

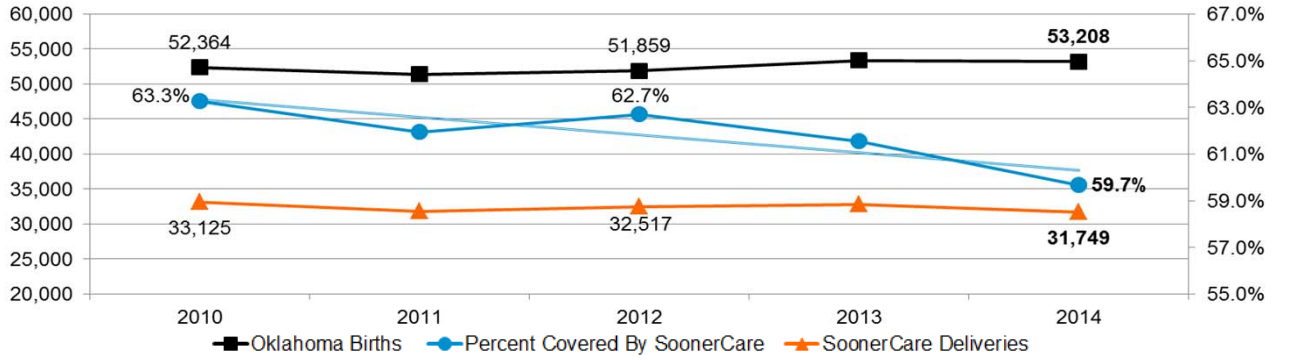
ENROLLMENT BY MONTH



MONTHLY CHANGE IN ENROLLMENT

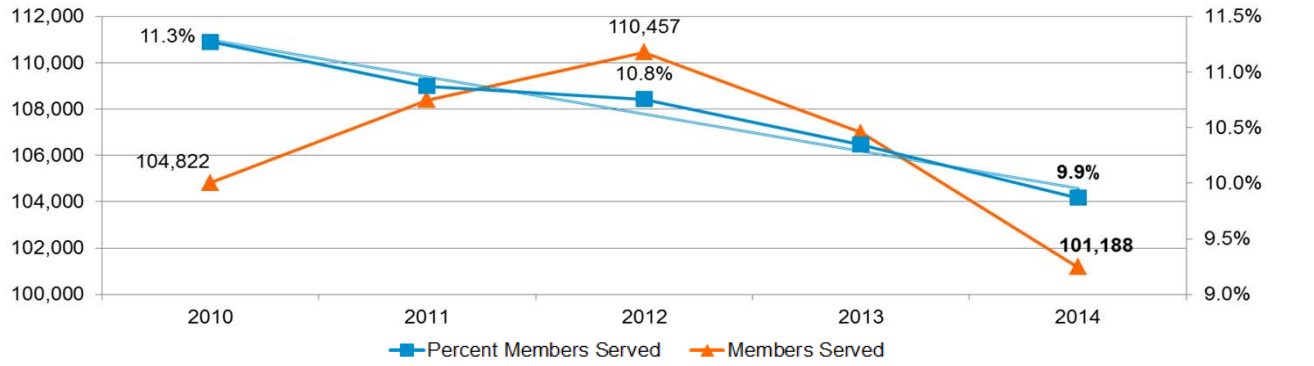


SOONERCARE DELIVERIES



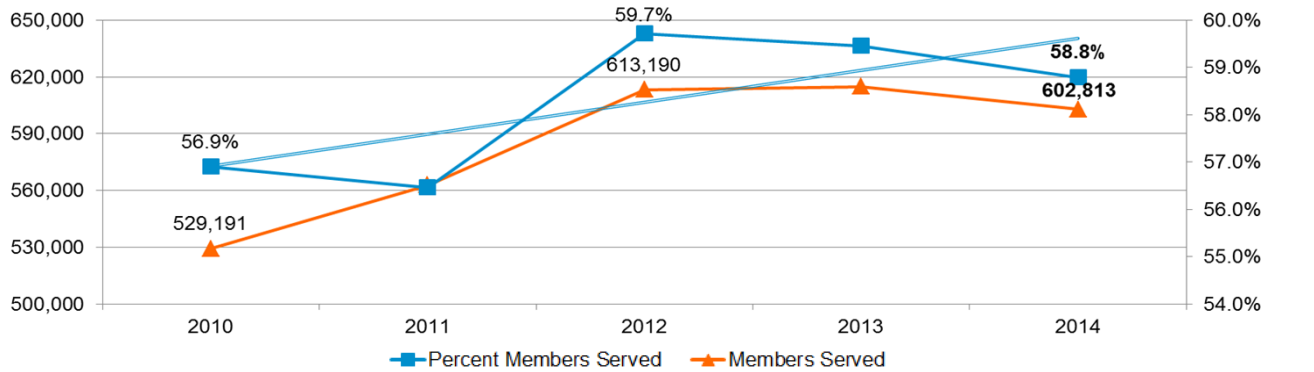
SoonerCare deliveries are based on paid claims with delivery codes. Oklahoma births refer to live births and data is from Oklahoma State Department of Health. Data is Calendar Year. 2014 Oklahoma birth data is preliminary and subject to change.

HOSPITALIZATION



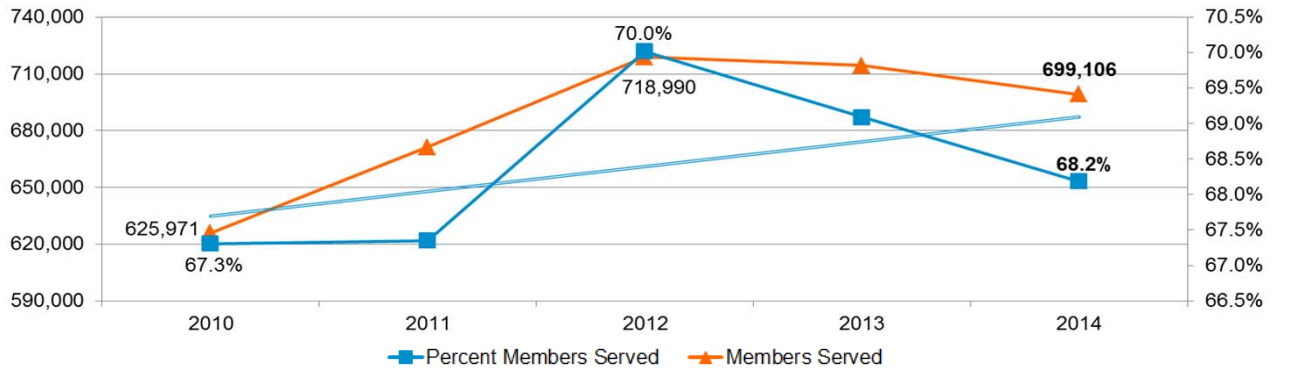
Based on paid and denied inpatient hospital claims incurred during the calendar year. Excludes psychiatric, rehabilitation and residential treatment center.

PCP VISITS



Based on paid and denied claims incurred during the calendar year. PCPs were the rendering provider and include Certified Registered Nurse Practitioners, Family Practitioners, General Pediatricians, General Practitioners, Internists, General Internists and Physician Assistants.

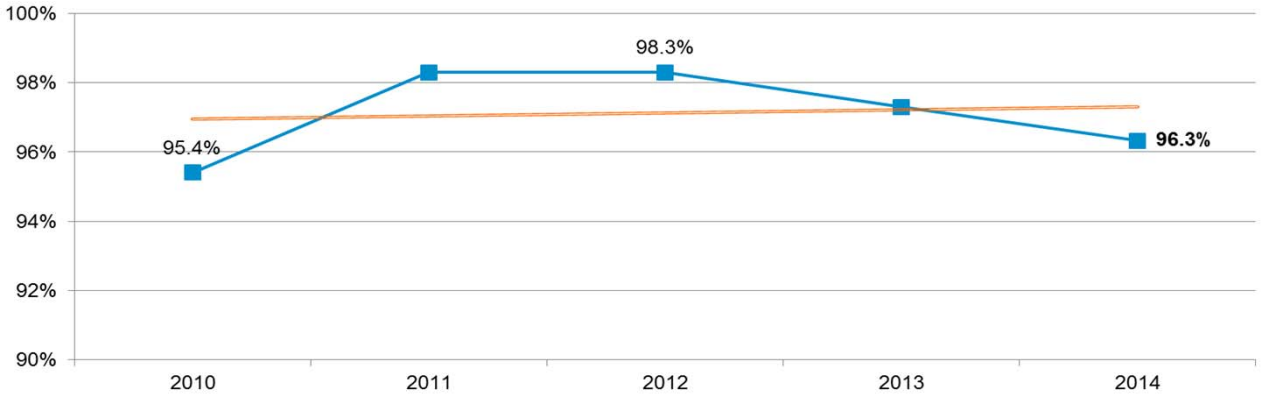
PHARMACY



Based on paid and denied pharmacy claims incurred during the calendar year.

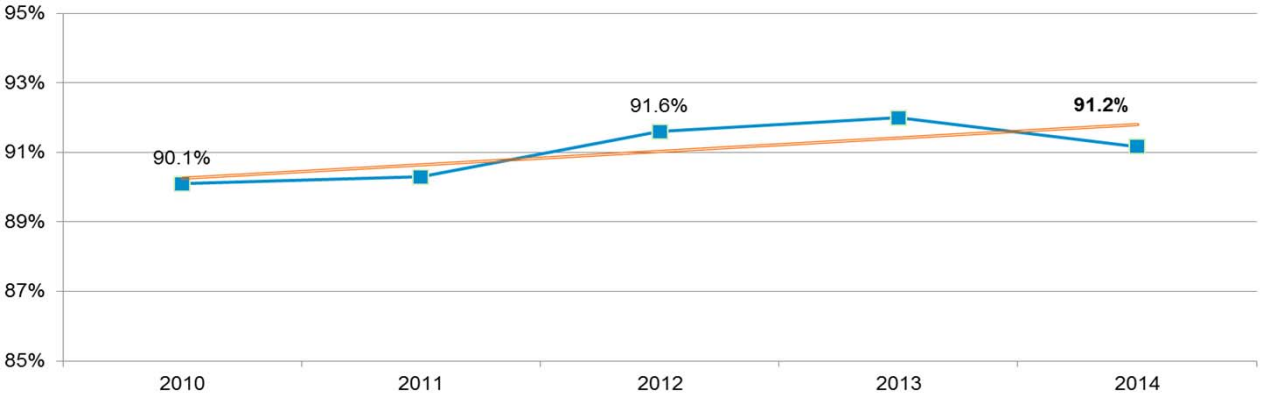
HEDIS QUALITY MEASURE - WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE

The percentage of members who turned 15 months old during the measurement year and who had at least one well-child visit with a PCP between their date of birth and turning 15 months old based on specific procedure codes indicating well-child visits.



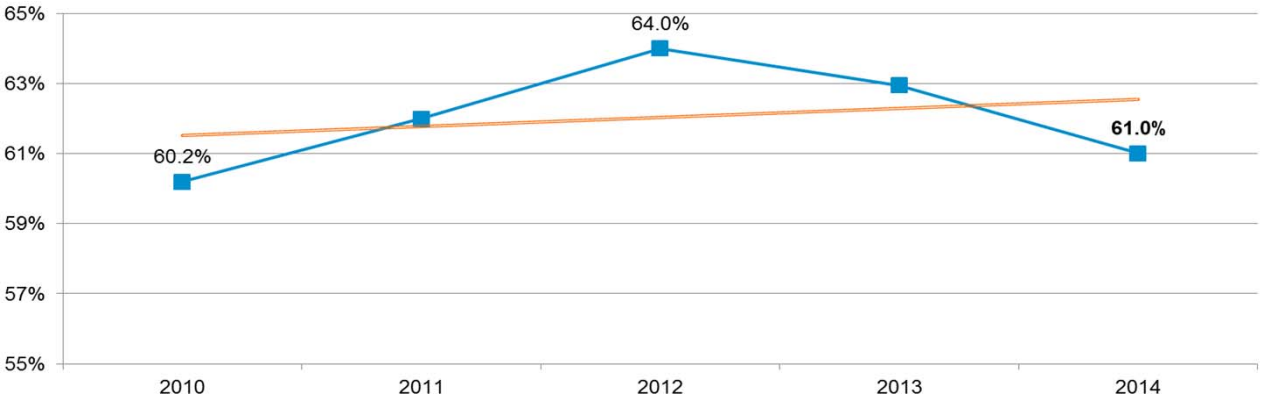
HEDIS QUALITY MEASURE - CHILD & ADOLESCENT ACCESS TO PCPs

The percentage of members 12 months to 19 years of age who had a visit with a PCP based on specific procedure codes indicating well-child visits. Children 12 months to 6 years had a PCP visit during the measurement year. Children and adolescents 7 to 19 years had a PCP visit during the current or previous measurement year.



HEDIS QUALITY MEASURE - ANNUAL DENTAL VISIT

The percentage of members 2 to 21 years of age who had at least one dental visit during the measurement year based on specific procedure codes indicating dental visits.



NOTE: For all HEDIS quality measures, members were continuously enrolled during the measurement period with a gap in enrollment of up to 45 days allowed.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
PART 79. DENTIST

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) medically necessary extractions and approved boney adjustments. Tooth extraction must have medical need documented;

(ii) Smoking and Tobacco Use Cessation Counseling; and

(iii) medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age 21.

(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must have prior authorization for all services before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved ADA form and must include diagnostic X-rays, six-point periodontal charting, narratives and comprehensive treatment plans. The OHCA will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:

(i)Comprehensive oral evaluation,
(ii)two radiographic bitewings,
(iii)prophylaxis,
(iv)fluoride application,
(v)limited restorative procedures, and
(vi)periodontal scaling/root planing.

(2) **Home and community based waiver services (HCBWS) for the intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each

waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure may be performed for any member every 36 months. An examination should precede any radiographs, and chart documentation must include radiographic interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if not seen by a dentist for more than six months. An examination should precede any radiographs, and chart documentation must include radiographic interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

(C) **Emergency examination/limited oral evaluation.** This procedure is not compensable within two months of a periodic oral examination or if the member is involved in active treatment unless trauma or acute infection is the presenting complaint. This procedure is only compensable to the same dentist or practice for two visits prior to an examination being completed.

(D) **Radiographs (x-rays).** To be SoonerCare compensable, x-rays must be of diagnostic quality and medically necessary. A clinical examination must precede any radiographs, and chart documentation must include member history, prior radiographs, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified x-rays of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical radiograph must include at least 3 millimeters beyond the apex of the tooth being x-rayed. Panoramic films and full mouth radiographs (minimum of 12 periapical films and two

posterior bitewings) are allowable once in a three year period and must be of diagnostic quality. Individually listed intraoral radiographs by the same dentist/dental office are considered a complete series if the fee for individual radiographs equals or exceeds the fee for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through 18 years of age and is compensable once every 36 months if medical necessity is documented.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) the child is five years of age or under;

(II) 70 percent or more of the root structure remains; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) primary teeth treated with pulpal therapy, if the above conditions exist;

(II) primary teeth where three surfaces of extensive decay exist; or

(III) primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.

(iv) Placement of a stainless steel crown is allowed once for a minimum period of 24 months. No other restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(H) **Stainless steel crowns for permanent teeth**. The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are the treatment of choice for:

(I) posterior permanent teeth that have completed endodontic therapy if three or more surfaces of tooth is destroyed;

(II) posterior permanent teeth that have three or more surfaces of extensive decay; or

(III) where cuspal occlusion is lost due to decay prior to age 16 years.

(ii) Preoperative periapical x-rays and/or written documentation explaining the extent of decay must be available for review, if requested.

(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of 24 months. No other restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(I) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies and pulpal debridement are allowable once per lifetime. Pre-and post-operative periapical x-rays must be available for review, if requested. Therapeutic pulpotomies and pulpal debridement is available for the following:

(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;

(II) Tooth numbers O and P before age 5 years;

(III) Tooth numbers E and F before 6 years;

(IV) Tooth numbers N and Q before 5 years;

(V) Tooth numbers D and G before 5 years.

(ii) Therapeutic pulpotomies and pulpal debridement are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(J) **Endodontics.** Payment is made for the services provided in accordance with the following:

(i) This procedure is allowed when there are no other missing anterior teeth in the same arch requiring replacement.

(ii)The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two anterior and/or two posterior root canals.

(iv) Pre and post-operative periapical x-rays must be available for review.

(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

(vi) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(vii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(K) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post-operative bitewing x-rays must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Pre and post-operative x-rays must be available.

(L) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation or general anesthesia. The medical need for this service must be documented in the member's record.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and /or the dentist, it must be medically necessary.

(M) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or Mineral Trioxide Aggregate materials, not a cavity liner or chemical used for dentinal hypersensitivity. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(N) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after 60 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(O) **Smoking and Tobacco Use Cessation Counseling.** Smoking

and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, nurse midwives, Oklahoma State Health Department and FQHC nursing, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS) staff in addition to other appropriate services rendered. Chart documentation must include a separate note, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.8. Eligibility regarding long-term care services

(a) **Home Property**. In determining eligibility for long-term care services for applications filed on or after January 1, 2006, home property is excluded from resources unless the individual's equity interest in his or her home exceeds $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000).

(1) Long-term care services include nursing facility services and other long-term care services. For purposes of this Section, other long-term care services include~~ services detailed in (A) through (B) of this paragraph.~~:

(A) A level of care in any institution equivalent to nursing facility services; and

(B) Home and community-based services furnished under a waiver.

(2) An individual whose equity interest exceeds $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning in 2011, rounded to the nearest $1,000) is not eligible for long-term care services unless one of the following circumstances applies:

(A) The individual has a spouse who is lawfully residing in the individual's home;

(B) The individual has a child under the age of twenty-one who is lawfully residing in the individual's home;

(C) The individual has a child of any age who is blind or permanently and totally disabled who is lawfully residing in the individual's home; or

(D) The denial would result in undue hardship. Undue hardship exists when denial of SoonerCare long-term care services based on an individual's home equity exceeding $500,000 would deprive the individual of medical care such that the individual's health or life would be endangered; or of food, clothing, shelter, or other necessities of life.

(E) An individual may reduce their total equity interest in the home through the use of a reverse mortgage or home equity loan.

(3) Absence from home due to nursing facility care does not

affect the home exclusion as long as the individual intends to return home within 12 months from the time he/she entered the facility. The OKDHS Form 08MA010E, Acknowledgment of Temporary Absence/Home Property Policy, is completed at the time of application for nursing facility care when the applicant has home property. After an explanation of temporary absence, the member, guardian, or responsible person indicates whether there is or is not intent to return to the home and signs the form.

(A) If at the time of application the applicant states he/she does not have plans to return to the home, the home property is considered a countable resource. For members in nursing facilities, a lien may be filed in accordance with OAC 317:35-9-15 and OAC 317:35-19-4 on any real property owned by the member when it has been determined, after notice and opportunity for a hearing, that the member cannot reasonably be expected to be discharged and return home. However, a lien is not filed on the home property of the member while any of the persons described in OAC 317:35-9-15(b)(1) and OAC 317:35-19-4(b)(1) are lawfully residing in the home:

(B) If the individual intends to return home, he/she is advised that:

(i) the 12 months of home exemption begins effective with the date of entry into the nursing home regardless of when application is made for SoonerCare benefits, and

(ii) after 12 months of nursing care, it is assumed there is no reasonable expectation the member will be discharged from the facility and return home and a lien may be filed against real property owned by the member for the cost of medical services received.

(C) "Intent" in regard to absence from the home is defined as a clear statement of plans in addition to other evidence and/or corroborative statements of others.

(D) At the end of the 12-month period the home property becomes a countable resource unless medical evidence is provided to support the feasibility of the member to return to the home within a reasonable period of time (90 days). This 90-day period is allowed only if sufficient medical evidence is presented with an actual date for return to the home.

(E) A member who leaves the nursing facility must remain in the home at least three months for the home exemption to apply if he/she has to re-enter the facility.

(F) However, if the spouse, ~~minor child(ren) under 18, or relative who is aged, blind or disabled or a recipient of TANF~~minor child under 21, or child who is blind or

permanently disabled resides in the home during the individual's absence, the home continues to be exempt as a resource so long as the spouse~~ or relative~~, minor child, or child who is blind or permanently disabled lives there (regardless of whether the absence is temporary).

~~(G) For purpose of this reference a relative is defined as: son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, half-sister, half-brother, niece, nephew, grandmother, grandfather, aunt, uncle, sister, brother, stepbrother, or stepsister.~~

~~(H)~~(G) Once a lien has been filed against the property of an NF resident, the property is no longer considered as a countable resource.

(b) **Promissory notes, loans, or mortgages**. The rules regarding the treatment of funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are found in (1) through (2) of this subsection.

(1) Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, are treated as assets transferred~~ for less than fair market value in~~, and the value of such note, loan, or mortgage shall be the amount of the outstanding balance due on the note, loan, or mortgage as of the date of the individual's application for medical assistance unless the note, loan, or mortgage meets all of the conditions in paragraphs (A) through (C) of this paragraph.

(A) The note, loan, or mortgage has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration).

(B) The note, loan, or mortgage provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made.

(C) The note, loan, or mortgage prohibits the cancellation of the balance upon the death of the lender.

(2) Funds used to purchase a promissory note, loan, or mortgage for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The note, loan, or mortgage was purchased before February 8, 2006; or

(B) The note, loan, or mortgage was purchased on or after February 8, 2006, and the conditions described in paragraph (1) of this subsection were met.

(c) **Annuities**. Treatment of annuities purchased on or after February 8, 2006.

~~(1) The entire amount used to purchase an annuity on or after~~

~~February 8, 2006, is treated as assets transferred for less than fair market value unless the annuity meets one of the conditions described in (A) through (C) of this paragraph.~~

~~(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986.~~

~~(B) The annuity is purchased with proceeds from:~~

~~(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;~~

~~(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Code of 1986;~~

~~(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Code of 1986.; or~~

~~(C) The annuity:~~

~~(i) is irrevocable and nonassignable;~~

~~(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and~~

~~(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.~~

~~(2) In addition, the entire amount used to purchase an annuity on or after February 8, 2006, is treated as a transfer of assets unless the Oklahoma Health Care Authority is named as the remainder beneficiary either:~~

~~(A) in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or~~

~~(B) in the second position after the community spouse, child under 21 years of age, or disabled child and in the first position if the spouse or a representative of the child disposes of any of the remainder for less than fair market value.~~

(1) The purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the Oklahoma Health Care Authority is named as the remainder beneficiary –

(A) in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or

(B) in the second position after the community spouse, child under 21 years of age, or disabled child and is named in the first position if the spouse or a representative of the child disposes of any such remainder for less than fair market value.

(2) For purposes of determining financial eligibility for long-term care services under this chapter, the term “assets” shall include an annuity purchased by or on behalf of an annuitant who has applied for SoonerCare nursing facility services or other long-term care services unless the annuity meets one of the following conditions.

(A) The annuity is an annuity described in subsection (b) or (q) of Section 408 of the United States Internal Revenue Code of 1986; or

(B) The annuity is purchased with proceeds from:

(i) An account or trust described in subsection (a), (c), or (p) of Section 408 of the United States Internal Revenue Code of 1986;

(ii) A simplified employee pension as defined in Section 408(k) of the United States Internal Revenue Service Code of 1986;

(iii) A Roth IRA described in Section 408A of the United States Internal Revenue Service Code of 1986; or

(C) The annuity:

(i) is irrevocable and nonassignable;

(ii) is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the United States Social Security Administration; and

(iii) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.

(d) **Life Estates**. This subsection pertains to the purchase of a life estate in another individual's home.

(1) The entire amount used to purchase a life estate in another individual's home on or after February 8, 2006, is treated as assets transferred for less than fair market value, unless the purchaser resides in the home for at least one year after the date of the purchase.

(2) Funds used to purchase a life estate in another individual's home for less than its fair market value are treated as assets transferred for less than fair market value regardless of whether:

(A) The life estate was purchased before February 8, 2006; or

(B) The life estate was purchased on or after February, 8, 2006, and the purchaser resided in the home for one year after the date of purchase.

(e) **Oklahoma Long-Term Care Partnership (LTCP) Program.** This subsection pertains to individuals with Oklahoma Long-Term Care Partnership policies. The Oklahoma Insurance Department approves long-term care insurance policies as Long-term Care Partnership Program policies. The face page of the policy document will

indicate if the insurance qualifies as a ~~Long Term~~Long-Term Care Partnership Program policy.

(1) Benefits from the LTCP policy must be exhausted before the individual can be eligible for ~~long term~~long-term care under the SoonerCare program.

(2) Assets in an amount equal to the amount paid out under the LTCP policy can be protected for the insured individual once the LTCP policy benefits are exhausted. Protected assets are disregarded when determining eligibility for the SoonerCare program per 317:35-5-41.9(26). A record of the amount paid on behalf of the policy holder is available through the OHCA or insurance company holding the LTCP policy.

(A) At the time of application for SoonerCare the individual must determine the asset(s) to be protected. The protected asset(s) cannot be changed. If the value of the protected asset(s) decreases, the individual does not have the option to select additional assets to bring the total up to the protected amount.

(B) If the protected asset(s) are income-producing, the income earned while on SoonerCare is counted in accordance with 317:35-5-42.

(C) The individual can choose to transfer the protected asset without incurring a transfer of assets penalty.

(D) When determining resource eligibility for a couple when one of them enters the nursing home or applies for a HCBS waiver, the LTCP protected asset(s) are disregarded in determining the total amount of the couple's resources.

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

Agenda
SPARC
August 7, 2015
11:00 a.m.
Ed McFall Board Room

Rate issues to be addressed:

- Mental Health Substance Use Screening…….2
- Independent Practitioners Rate Equalization……...3
- Severe Combined Immunodeficiency Disorder (SCID) Newborn Screen……4-5
- Exome Sequence Analysis……6
- ADvantage and State Plan Personal Care Providers…….7-8
- Developmental Disabilities Service Providers……....9-12

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State Plan Amendment Rate Committee (SPARC)
August 7, 2015
Mental Health Substance Use Screening

1. Is this a "Rate Change" or a "Method Change"?
   Rate Change

1b. Is this change an increase, decrease, or no impact?
   This change involves creating a new rate for a SoonerCare compensable service, so it represents an increase.

2. Presentation of issue – Why is change being made?
   Rules were revised during 2015 permanent rulemaking to add coverage of Mental Health/Substance Use Disorder (MH/SUD) screens provided in outpatient behavioral health agencies. ODMHSAS proposes to reimburse for screens provided by qualified providers using approved evidence based tools at a rate of $25.32 per event.

3. Current methodology and/or rate structure.
   Currently, there is no rate for MH/SUD screens under Title XIX. There is an existing rate of $25.32 per event for services provided by ODMHSAS contractors and reimbursed using 100% ODMHSAS funds.

4. New methodology or rate.
   The new proposed rate is $25.32 per event.

5. Budget estimate.
   Last year ODMHSAS paid $193,054.72 on MH/SUD screens on 9,493 distinct Medicaid clients using 100% state dollars. Pulling Federal Financial Participation (FFP) through SoonerCare would have freed up $120,272 to reinvest into other services (i.e. state savings).

   120,000 clients were provided mental health services through SoonerCare in SFY2015. Assuming 10% uptake in utilization of the new screening code in SFY2016, estimated budget impact would be $303,840 total dollars/$114,547 state dollars.

   Given the savings from receiving FFP for services currently provided with state funds and the estimated budget impact in SFY2016 for new utilization, the budget impact should be near neutral for SFY2016.

6. Agency estimated impact on access to care.
   The Agency has determined that this change will have a positive impact on access to care.

7. Rate or Method change in the form of a motion.
   The Agency requests the State Plan Amendment Rate Committee to approve the proposed reimbursement rate of $25.32 per event for Mental Health/Substance Use Disorder Screens provided in an outpatient behavioral health agency setting.

8. Effective date of change.
   September 1, 2015.

State Plan Amendment Rate Committee (SPARC)
August 7, 2015
Independent Practitioners Rate Equalization

1. Is this a "Rate Change" or a "Method Change"?
   Method Change

1b. Is this change an increase, decrease, or no impact?
   This change represents a decrease in the aggregate reimbursement being made to independently contracted Licensed Behavioral Health Practitioners (LBHPs).

2. Presentation of issue – Why is change being made?
   The Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) proposes to revise the payment methodology for independent Licensed Behavioral Health Practitioners (LBHPs) in order to equalize payment for their services with the payments made for services provided by the same level of provider in an outpatient behavioral health agency setting. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated. This change does not affect the methodology for Physicians, Psychiatrists or Psychologists.

3. Current methodology and/or rate structure.
   The current reimbursement methodology for independently contracted licensed behavioral health professionals (LBHPs) is 72.56% of the CY 2013 Medicare Non-Facility Physician Fee Schedule for psychiatry services.

4. New methodology or rate.
   The proposed methodology is to establish independent LBHP reimbursement rates for Common Procedure Terminology (CPT) codes, which in the aggregate equates to 62.7% of the 2013 non-facility practitioner Medicare Physician Fee Schedule (MPFS) rates.

5. Budget estimate.
   The budget impact of the methodology change is an estimated savings to ODMHSAS in the amount of $2,072,078 Total/$808,110 State.

6. Agency estimated impact on access to care.
   The Agency has determined that this change will have no adverse impact on access to care.

7. Rate or Method change in the form of a motion.
   The Agency requests the State Plan Amendment Rate Committee to approve the proposed reimbursement methodology to establish independent LBHP reimbursement rates for Common Procedure Terminology (CPT) codes, which in the aggregate equates to 62.7% of the 2013 non-facility practitioner Medicare Physician Fee Schedule (MPFS) rates.

8. Effective date of change.
   September 1, 2015.

State Plan Amendment Rate Committee (SPARC)
August 7, 2015
Severe Combined Immunodeficiency Disorder (SCID) Newborn Screen

1. Is this a "Rate Change" or a "Method Change"?
   Method Change to establish a new rate

1b. Is this change an increase, decrease, or no impact?
   This establishment of a new rate will result in increased expenditures.

2. Presentation of issue – Why is change being made?
   The Oklahoma State Department of Health (OSDH) has recently (February 2015) added a new test to the existing state-mandated panel for newborn screening (NBS). This test, which screens for Severe Combined Immunodeficiency Disorder (SCID), was approved as part of the national Recommended Uniform Screening Panel (RUSP) for newborn testing, which includes 31 core disorders and 26 secondary disorders, in May 2010. The OSDH NBS Program has systematically adopted all testing reflected in the nationally-recognized RUSP.

   SCID includes more than 10 genetic disorders characterized by profound defects in both cellular immunity and specific antibody production, and is estimated to occur in about 1/33,000 births. Early identification of the asymptomatic SCID infant during the first few weeks of life is essential for successful treatment, which generally involves allogeneic hematopoietic stem cell transplantation. SCID infants who are treated early have almost 10-fold lower total clinical care costs compared with those treated later. If undiagnosed, SCID infants usually die from severe infections with the first year of life. Unfortunately, while SCID is potentially treatable, it is infrequently recognized prior to the onset of devastating infections.

3. Current methodology and/or rate structure.
   This is a new test that has been recently added to the NBS testing panel in Oklahoma; currently, OSDH is neither charging nor getting reimbursed for this test.

4. New methodology or rate.
   The CPT code applicable to SCID testing is 81479, Unlisted Molecular Pathology Procedure. Various cost analyses have been performed by testing facilities for SCID newborn screening, with a range from $5 to $17.00 per test. Charges for SCID newborn screening in the states of Arizona, Washington and Florida were considered when the Oklahoma State Department of Health Board of Health approved a rate for the NBS fee of $6 for SCID.

5. Budget estimate.
   Based on the number of Medicaid claims in the past State Fiscal Year, it is estimated that the increased cost would be approximately $179,000.00 per SFY for Medicaid claims. Claims for basic newborn screening panels, are reimbursed at the detail line level.

6. Agency estimated impact on access to care.
   The OSDH Public Health Lab is currently providing population SCID screening at no cost and receives no specific reimbursement for this test. However, the long term sustainability of testing is dependent upon being able to increase the NBS fee by $6. The benefit to cost ratio for providing SCID testing has been estimated at 4.23, indicating a substantial cost saving to the overall healthcare system by offering SCID screening for newborns.

7. Rate or Method change in the form of a motion.
   The OSDH proposes that the State Plan Amendment Rate Committee approve a rate for SCID newborn screening of $6.

8. Effective date of change.
   October 1, 2015, or later

State Plan Amendment Rate Committee (SPARC)
August 7, 2015
Exome Sequence Analysis

1. Is this a "Rate Change" or a "Method Change"?
   Rate change

1b. Is this change an increase, decrease, or no impact?
   No Impact

2. Presentation of issue – Why is change being made?
   The Oklahoma Health Care Authority (OHCA) recommends adding a rate for a new code (81415) for exome sequence analysis.

3. Current methodology and/or rate structure.
   81415 is a new code for 2015 and it has not been priced by CMS. Before the new code was introduced, OHCA was billed for this service using 1 unit each of 81400, 81401, 81402, 81403, 81404, 81405, 81406, and 81407, and OHCA paid for the service based on our system rates for these codes.

4. New methodology or rate.
   OHCA would like to set the rate for 81415 by cross walking 1 unit each of 81400, 81401, 81402, 81403, 81404, 81405, 81406, and 81407 so that we are paying the same rate as what we paid in 2014. This would give us a default rate of $3,980.73 ($3,672.22 current with budget reductions). It is important to set a system price to be transparent with providers about OHCA's reimbursement for this service (typically this service is billed at a much higher rate than what OHCA pays).

Procedure	Current Rate	Default Rate
81400	$57.94	$62.81
81401	$98.15	$106.40
81402	$122.16	$132.42
81403	$177.54	$192.45
81404	$245.93	$266.59
81405	$475.87	$515.85
81406	$862.76	$935.24
81407	$1,631.87	$1,768.97

5. Budget estimate.
   The rate change will result in no budget impact since the proposal is to set the rate for 81415 at the sum of the rates for the codes that were billed for the service prior to 2015.

6. Agency estimated impact on access to care.
   This rate change should not have a negative impact to access and quality of care to SoonerCare members.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee approve the new rate for exome sequence analysis.

8. Effective date of change.
   August 14, 2015

1. Is this a "Rate Change" or a "Method Change"?
   Rate Change

1b. Is this change an increase, decrease, or no impact?
   Decrease

2. Presentation of issue – Why is change being made?
   The Oklahoma Department of Human Services (OKDHS) has taken action to reduce agency expenditures due to declining state revenues and increased program costs. As a result, OKDHS recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

3. Current methodology and/or rate structure.
   The current services rate structure for services for which a rate reduction is being implemented are fixed and uniform rates established through the State Plan Amendment Rate Committee process. The services and current service codes/rates are as follows:

Description	Service Code	Unit Rate
CD-PASS		
Personal Service Assistant	S5125	$3.32
Advanced Personal Service Assistant	S5125 TF	$3.98
Optional Expense	T2025	$1.00
Case Management		
Case Management-Standard	T1016	$14.25
Case Management-Very Rural	T1016 TN	$20.40
Transitional Case Management-Very Rural	T1016 TN U3	$20.40
Transitional Case Management-Standard	T1016 U3	$14.25
Personal Care		
Personal Care	T1019	$3.92
Advanced Supportive/Restorative	T1019 TF	$4.22
In-Home Respite		
2-7 hours	T1005	$3.92
Extended Respite (1/Day)	S9125	$165.88
Assisted Living		
Standard Care Level	T2031	$45.61
Intermediate Care Level	T2031 TG	$61.55
High Care Level	T2031 TF	$86.10

4. New methodology or rate.
   The table below indicates the services and per service rate decreased proposed to meet the budgetary requirements of SFY16 reflecting ten (10) months.

   OAC 317:30-5-764 ties many ADvantage service rates to the State Plan Personal Care rate. Those service rates determined in policy by the Personal Care rate are indicated in yellow highlight in the table. The proposed rates were determined by a 3.5% reduction to the current

rate for services.

Service Description	Service Code	Reduced Unit Rate	Unit Rate	Decrease
CD-PASS *		-	-	
Personal Service Assistant	S5125	$3.20	$3.32	$0.12
Advanced Personal Service Assistant	S5125 TF	$3.84	$3.98	$0.14
Optional Expense	T2025	$0.97	$1.00	$0.04
Case Management				
Case Management-Standard	T1016	$13.75	$14.25	$0.50
Case Management-Very Rural	T1016 TN	$19.69	$20.40	$0.71
Transitional Case Management-Very Rural	T1016 TN U3	$19.69	$20.40	$0.71
Transitional Case Management-Standard	T1016 U3	$13.75	$14.25	$0.50
Personal Care				
Personal Care	T1019	$3.78	$3.92	$0.14
Advanced Supportive/Restorative	T1019 TF	$4.07	$4.22	$0.15
In-Home Respite *		$0.00		
2-7 hours	T1005	$3.78	$3.92	$0.14
Extended Respite (1/Day)	S9125	$160.07	$165.88	$5.81
Assisted Living				
Standard Care Level	T2031	$44.01	$45.61	$1.60
Intermediate Care Level	T2031 TG	$59.40	$61.55	$2.15
High Care Level	T2031 TF	$83.09	$86.10	$3.01

5. Budget estimate.
   The effective date for the rate decrease is September 1, 2015. The estimated total SFY16 state share for the proposed rate reduction is $1,598,697 with a total Federal plus State SFY16 cost for the service rate reduction of $4,240,577. The dollars estimated reflect ten (10) months. Annualized, those figures are $1,918,436 and $5,088,690.

6. Agency estimated impact on access to care.
   Under (a)(30)(A) of the Medicaid Act, the agency expects an increased impact on access for these services.

7. Rate or Method change in the form of a motion.
   The agency requests the State Plan Amendment Rate Committee to approve the proposed rate decrease to be effective September 1, 2015 upon Board approval.

8. Effective date of change.
   September 1, 2015

State Plan Amendment Rate Committee (SPARC)
August 7, 2015
Developmental Disabilities Services Providers

1. Is this a "Rate Change" or a "Method Change"?
   Rate Change

1b. Is this change an increase, decrease, or no impact?
   Decrease

2. Presentation of issue – Why is the change being made?
   The Oklahoma Department of Human Services (OKDHS) has taken action to reduce agency expenditures due to declining state revenues and increased program costs. As a result, OKDHS recommends the following rate change. This change is being made to comply with the Oklahoma Constitution, Article X, Section 23, which prohibits a state agency from spending more money than is allocated.

3. Current methodology and/or rate structure.
   The current rate structure for services for which a rate reduction is being implemented is a fixed and uniform rate configuration established through the State Plan Amendment Rate Committee process. The services and current service codes and rates are as follows:

Decription	Service Code	Unit Rate
HOMEMAKER	S5130	$3.32
HOMEMAKER - STATE FUND	S5130 SE	$3.32
HOMEMAKER RESPITE	S5150	$3.32
HTS - HABILITATION TRAINING SPECIALIST	T2017	$3.92
HTS - HABILITATION TRAINING SPECIALIST - STATE FUND	T2017 SE	$3.92
HTS - SELF DIRECTED SERVICE	T2017 U1 TF	$3.92-Max
INTENSIVE PERSONAL SUPPORTS	T2017 TF	$3.92
INTENSIVE PERSONAL SUPPORTS - STATE FUND	T2017 TF SE	$3.92
DAILY LIVING SUPPORTS	T2033	$149.19
DAILY LIVING SUPPORTS - THER LEAVE	T2033 TV	$149.19
GROUP HOME		
6 BED	T1020	$70.25
7 BED	T1020	$60.00
8 BED	T1020	$52.50
9 BED	T1020	$48.00
10 BED	T1020	$44.25
11 BED	T1020	$41.50
12 BED	T1020	$39.00
GROUP HOME COMM. LIVING HOME		
6 BED	T1020	$130.00
7 BED	T1020	$125.75
8 BED	T1020	$115.50
9 BED	T1020	$107.50
10 BED	T1020	$101.00
11 BED	T1020	$95.50
12 BED	T1020	$90.25
GROUP HOME ALT. LIVING HOME, 4 BED	T1020	$282.75

State Plan Amendment Rate Committee (SPARC)
August 7, 2015
Developmental Disabilities Services Providers

Decription Cont'd	Service Code	Unit Rate
RESPITE IN - GROUP HOME		
6 BED	S5151	$70.50
7 BED	S5151	$60.00
8 BED	S5151	$52.50
9 BED	S5151	$48.00
10 BED	S5151	$44.25
11 BED	S5151	$41.50
12 BED	S5151	$39.00
RESPITE IN - COMMUNITY LIVING HOME		
6 BED	S5151	$130.00
7 BED	S5151	$125.75
8 BED	S5151	$115.50
9 BED	S5151	$107.50
10 BED	S5151	$101.00
11 BED	S5151	$95.50
12 BED	S5151	$90.25
AGENCY COMPANION (Contractor) - CLOSE	S5126 U4	$93.50
THERAPEUTIC LEAVE	S5126 U4 TV	$93.50
AGENCY COMPANION (Contractor) - ENHANCED	S5126 TG	$121.75
THERAPEUTIC LEAVE	S5126 TG TV	$121.75
AGENCY COMPANION (Contractor) - PERVASIVE	S5136 TG	$133.00
THERAPEUTIC LEAVE	S5136 TG TV	$133.00
AGENCY COMPANION (Contractor) - INTERMITTENT	S5126 U1	65.25
THERAPEUTIC LEAVE	S5126 U1 TV	65.25
RESPITE IN - AGENCY COMPANION (Contractor) - CLOSE	S5151	$93.50
RESPITE IN - AGENCY COMPANION (Contractor) - ENHANCED	S5151	$121.75
RESPITE IN - AGENCY COMPANION (Contractor) - INTERMITTENT	S5151	$65.25
ES - CENTER BASED PREVOCATIONAL SVS	T2015 U1	$4.84
ES - CENTER BASED PREVOCATIONAL SVS - STATE FUND	T2015 U1 SE	$4.84
ES - COMMUNITY BASED PREVOC SERVICES	T2015 TF	$9.68
ES - COMMUNITY BASED PREVOC SERVICES - STATE FUND	T2015 TF SE	$9.68
ES - PRE-VOC. HTS - SUPP. SUPPORTS	T2015 TG	$12.20
ES - PRE-VOC. HTS - SUPP. SUPPORTS - STATE FUND	T2015 TG SE	$12.20
ES - ENHANCED COMMUNITY BASED PREVOC	T2015	$12.92
ES - ENHANCED COMMUNITY BASED PREVOC - STATE FUND	T2015 SE	$12.92
ES - COMMUNITY BASED INDIVIDUAL SERVICES	T2015 U4	$15.68
ES - COMMUNITY BASED INDIVIDUAL SERVICES - STATE FUND	T2015 U4 SE	$15.68
ES - JOB STABILIZATION / EXTENDED SVS	T2019 U1	$1.34
ES - JOB COACHING SERVICE	T2019 TF	$3.23
ES - ENHANCED JOB COACHING SVS	T2019 TG	$3.76
ES - JOB COACHING INDIVIDUAL SVS	T2019 U4	$4.30
ES - JOB COACHING INDIVIDUAL SVS - STATE FUND	T2019 U4 SE	$4.30
ES - EMPLOYMENT SPECIALIST	T2019	$5.87
TRANSPORTATION - MILEAGE	S0215	$0.49
PROFESSIONAL INDIRECT SERV. (TRAVEL)	S0215 SE	$0.49
TRANSPORTATION - ADAPTED - NON_EMERGENCY VAN	A0130	$1.25

4. New methodology or rate.

The table below indicates the services and per service rate decreases proposed to meet the budgetary requirements of FY16.

Decription	Service Code	Reduced Unit Rate	Current Unit Rare	Decrease
HOMEMAKER	S5130	$ 3.20	$3.32	$ 0.12
HOMEMAKER - STATE FUND	S5130 SE	$ 3.20	$3.32	$ 0.12
HOMEMAKER RESPITE	S5150	$ 3.20	$3.32	$ 0.12
HTS - HABILITATION TRAINING SPECIALIST	T2017	$ 3.78	$3.92	$ 0.14
HTS - HABILITATION TRAINING SPECIALIST - STATE FUND	T2017 SE	$ 3.78	$3.92	$ 0.14
HTS - SELF DIRECTED SERVICE	T2017 U1 TF	$ 3.78	$3.92-Max	$ 0.14
INTENSIVE PERSONAL SUPPORTS	T2017 TF	$ 3.78	$3.92	$ 0.14
INTENSIVE PERSONAL SUPPORTS - STATE FUND	T2017 TF SE	$ 3.78	$3.92	$ 0.14
DAILY LIVING SUPPORTS	T2033	$ 143.97	$149.19	$ 5.22
DAILY LIVING SUPPORTS - THER LEAVE	T2033 TV	$ 143.97	$149.19	$ 5.22
GROUP HOME				
6 BED	T1020	$ 67.79	$70.25	$ 2.46
7 BED	T1020	$ 57.90	$60.00	$ 2.10
8 BED	T1020	$ 50.66	$52.50	$ 1.84
9 BED	T1020	$ 46.32	$48.00	$ 1.68
10 BED	T1020	$ 42.70	$44.25	$ 1.55
11 BED	T1020	$ 40.05	$41.50	$ 1.45
12 BED	T1020	$ 37.63	$39.00	$ 1.37
GROUP HOME COMM. LIVING HOME				
6 BED	T1020	$ 125.45	$130.00	$ 4.55
7 BED	T1020	$ 121.35	$125.75	$ 4.40
8 BED	T1020	$ 111.46	$115.50	$ 4.04
9 BED	T1020	$ 103.74	$107.50	$ 3.76
10 BED	T1020	$ 97.46	$101.00	$ 3.54
11 BED	T1020	$ 92.16	$95.50	$ 3.34
12 BED	T1020	$ 87.09	$90.25	$ 3.16
GROUP HOME ALT. LIVING HOME, 4 BED	T1020	$ 272.85	$282.75	$ 9.90
RESPITE IN - GROUP HOME				
6 BED	S5151	$ 68.04	$70.50	$ 2.46
7 BED	S5151	$ 57.90	$60.00	$ 2.10
8 BED	S5151	$ 50.66	$52.50	$ 1.84
9 BED	S5151	$ 46.32	$48.00	$ 1.68
10 BED	S5151	$ 42.70	$44.25	$ 1.55
11 BED	S5151	$ 40.05	$41.50	$ 1.45
12 BED	S5151	$ 37.63	$39.00	$ 1.37
RESPITE IN - COMMUNITY LIVING HOME				
6 BED	S5151	$ 125.45	$130.00	$ 4.55
7 BED	S5151	$ 121.35	$125.75	$ 4.40
8 BED	S5151	$ 111.46	$115.50	$ 4.04
9 BED	S5151	$ 103.74	$107.50	$ 3.76
10 BED	S5151	$ 97.46	$101.00	$ 3.54
11 BED	S5151	$ 92.16	$95.50	$ 3.34
12 BED	S5151	$ 87.09	$90.25	$ 3.16

State Plan Amendment Rate Committee (SPARC)
August 7, 2015
Developmental Disabilities Services Providers

Decription Cont'd	Service Code	Reduced Unit Rate	Current Unit Rare	Decrease
AGENCY COMPANION (Contractor) - CLOSE	S5126 U4	$ 90.23	$93.50	$ 3.27
THERAPEUTIC LEAVE	S5126 U4 TV	$ 90.23	$93.50	$ 3.27
AGENCY COMPANION (Contractor) - ENHANCED	S5126 TG	$ 117.49	$121.75	$ 4.26
THERAPEUTIC LEAVE	S5126 TG TV	$ 117.49	$121.75	$ 4.26
AGENCY COMPANION (Contractor) - PERVASIVE	S5136 TG	$ 128.34	$133.00	$ 4.66
THERAPEUTIC LEAVE	S5136 TG TV	$ 128.34	$133.00	$ 4.66
AGENCY COMPANION (Contractor) - INTERMITTENT	S5126 U1	$ 62.97	65.25	$ 2.28
THERAPEUTIC LEAVE	S5126 U1 TV	$ 62.97	65.25	$ 2.28
RESPITE IN - AGENCY COMPANION (Contractor) - CLOSE	S5151	$ 90.23	$93.50	$ 3.27
RESPITE IN - AGENCY COMPANION (Contractor) - ENHANCED	S5151	$ 117.49	$121.75	$ 4.26
RESPITE IN - AGENCY COMPANION (Contractor) - INTERMITTENT	S5151	$ 62.97	$65.25	$ 2.28
ES - CENTER BASED PREVOCATIONAL SVS	T2015 U1	$ 4.67	$4.84	$ 0.17
ES - CENTER BASED PREVOCATIONAL SVS - STATE FUND	T2015 U1 SE	$ 4.67	$4.84	$ 0.17
ES - COMMUNITY BASED PREVOC SERVICES	T2015 TF	$ 9.34	$9.68	$ 0.34
ES - COMMUNITY BASED PREVOC SERVICES - STATE FUND	T2015 TF SE	$ 9.34	$9.68	$ 0.34
ES - PRE-VOC. HTS - SUPP. SUPPORTS	T2015 TG	$ 11.77	$12.20	$ 0.43
ES - PRE-VOC. HTS - SUPP. SUPPORTS - STATE FUND	T2015 TG SE	$ 11.77	$12.20	$ 0.43
ES - ENHANCED COMMUNITY BASED PREVOC	T2015	$ 12.47	$12.92	$ 0.45
ES - ENHANCED COMMUNITY BASED PREVOC - STATE FUND	T2015 SE	$ 12.47	$12.92	$ 0.45
ES - COMMUNITY BASED INDIVIDUAL SERVICES	T2015 U4	$ 15.13	$15.68	$ 0.55
ES - COMMUNITY BASED INDIVIDUAL SERVICES - STATE FUND	T2015 U4 SE	$ 15.13	$15.68	$ 0.55
ES - JOB STABILIZATION / EXTENDED SVS	T2019 U1	$ 1.29	$1.34	$ 0.05
ES - JOB COACHING SERVICE	T2019 TF	$ 3.12	$3.23	$ 0.11
ES - ENHANCED JOB COACHING SVS	T2019 TG	$ 3.63	$3.76	$ 0.13
ES - JOB COACHING INDIVIDUAL SVS	T2019 U4	$ 4.15	$4.30	$ 0.15
ES - JOB COACHING INDIVIDUAL SVS - STATE FUND	T2019 U4 SE	$ 4.15	$4.30	$ 0.15
ES - EMPLOYMENT SPECIALIST	T2019	$ 5.66	$5.87	$ 0.21
TRANSPORTATION - MILEAGE	S0215	$ 0.47	$0.49	$ 0.02
PROFESSIONAL INDIRECT SERV. (TRAVEL)	S0215 SE	$ 0.47	$0.49	$ 0.02
TRANSPORTATION - ADAPTED - NON_EMERGENCY VAN	A0130	$ 1.21	$1.25	$ 0.04

The proposed rates were determined by a 3.5% reduction to the current rate for services.

5. Budget Estimate.
   The estimated annual change is a decrease in the amount of $10,656,595 total dollars; $3,971,713 state share.

6. Agency estimated impact on access to care.
   This rate change should not have a negative impact to access and quality of care to Home and Community Waiver members.

7. Rate of Method change in the form of a motion.
   The Department of Human Services requests the State Plan Amendment Rate Committee approve the proposed rate decrease.

8. Effective date of change.
   September 1, 2015

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

AUTHORITY FOR EXPENDITURE OF FUNDS
Evaluation Consultant for Care Coordination

BACKGROUND

OHCA released a Request for Proposal (RFP) for the services of an evaluation consultant to perform as an expert in ABD Care Coordination models by memorializing and documenting OHCA's widespread initiating, planning, executing, monitoring, and implementing efforts for the ABD Care Coordination project.

The Care Coordination project is derived from the intent of the Legislature and Governor's Office, per House Bill 1566, for OHCA to employ market driven solution(s) toward the aim of providing access to quality care, for less cost, to ABD SoonerCare members.

SCOPE OF WORK

- Examine OHCA's approach and execution of the ABD Care Coordination project;
- Assess cooperation between OHCA and other partners in serving ABD members;
- Assess state and federal regulations and guidance and convey how effectively it was incorporated into OHCA's planning efforts;
- Assess environmental changes experienced during this project, including but not limited to: identifying risks and issues, the degree of success to the mitigation plans, and continued engagement of stakeholders;
- State the feasibility of implementation; and
- Educate OHCA on the interoperability, competition, and duplication with other state and federal programs serving the ABD population.

CONTRACT PERIOD

Date of Award through June 30, 2016 with annual options to renew through June 30, 2018

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Will be awarded through a competitive RFP
- This contract will pay for consultant services through administrative funds
- Federal matching percentage is 50%
- Estimated contract amount: $250,000/year

RECOMMENDATION

- Board approval to procure the services discussed above.

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

AUTHORITY FOR EXPENDITURE OF FUNDS
Development Consultant for Care Coordination

BACKGROUND

OHCA released a Request for Proposal (RFP) for the services of a development consultant to perform as an expert in Care Coordination models by providing advice and recommendations to OHCA and Stakeholders in an objective manner.

The Care Coordination project is derived from the intent of the Legislature and Governor's Office, per House Bill 1566, for OHCA to employ market driven solution(s) toward the aim of providing access to quality care, for less cost, to ABD SoonerCare members.

SCOPE OF WORK

- Research and summarize other state approaches and experiences and have knowledge of national developments from related organizations;
- Represent OHCA in a professional manner by serving as organizer and facilitator of monthly and ad hoc stakeholder meetings;
- Organize and conduct regional focus groups;
- Produce reports to OHCA, stakeholders, elected officials, and/or state agency leaders on progress of the Care Coordination program; and
- Act as a team member in the development, transition planning, and implementation of the RFP for Care Coordination models, including assisting with policy changes or development.

CONTRACT PERIOD

Date of Award through June 30, 2016 with annual options to renew through June 30, 2018

CONTRACT AMOUNT AND PROCUREMENT METHOD

- Will be awarded through a competitive RFP
- This contract will pay for consultant services through administrative funds
- Federal matching percentage is 50%
- Estimated contract amount: $500,000/year

RECOMMENDATION

- Board approval to procure the services discussed above.

Recommendation 1: Prior Authorize Avycaz™ (Ceftazidime/Avibactam) and Zerbaxa™ (Ceftolozane/Tazobactam)

The Drug Utilization Review Board recommends the prior authorization of Avycaz™ (ceftazidime/avibactam) and Zerbaxa™ (ceftolozane/tazobactam) with the following criteria:

Avycaz™ (Ceftazidime/Avibactam) Approval Criteria:

1. An FDA approved diagnosis of one of the following infections caused by designated susceptible microorganisms:
    a. Complicated intra-abdominal infections (cIAI), used in combination with metronidazole; or
    b. Complicated urinary tract infections (cUTI), including Pyelonephritis; and
2. Member must be 18 years of age or older; and
3. For the diagnosis of cIAI, Avycaz™ must be used in combination with metronidazole; and
4. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin-beta lactamase inhibitor combination (e.g. piperacillin-tazobactam), a carbapenam (e.g. ertapenem, meropenem, imipenem-cilastatin), a cephalosporin (e.g. ceftriaxone, ceftazidime) in combination with metronidazole, or other cost effective therapeutic equivalent medication(s).
5. A quantity limit of 42 vials per 14 days will apply.

Zerbaxa™ (Ceftolozane/Tazobactam) Approval Criteria:

1. An FDA approved diagnosis of one of the following infections caused by designated susceptible microorganisms:
    a. Complicated intra-abdominal infections (cIAI), used in combination with metronidazole; or
    b. Complicated urinary tract infections (cUTI), including Pyelonephritis; and
2. Member must be 18 years of age or older; and
3. For the diagnosis of cIAI, Zerbaxa™ must be used in combination with metronidazole; and
4. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin-beta lactamase inhibitor combination (e.g. piperacillin-tazobactam), a carbapenam (e.g. ertapenem, meropenem, imipenem-cilastatin), a cephalosporin (e.g. ceftriaxone, ceftazidime) in combination with metronidazole, or other cost effective therapeutic equivalent medication(s).
5. A quantity limit of 42 vials per 14 days will apply.

Recommendation 2: Prior Authorize Cholbam™ (Cholic Acid)

The Drug Utilization Review Board recommends the prior authorization of Cholbam™ (cholic acid) with the following criteria:

Cholbam™ (Cholic Acid) Approval Criteria:

1. An FDA approved diagnosis of one of the following:
    a. Treatment of bile acid disorders due to single enzyme defects (SEDs); or
    b. Adjunctive treatment of peroxisomal disorders (PDs) including Zellweger spectrum disorders in patients who exhibit manifestations of liver disease, steatorrhea, or complications from decreased fat-soluble vitamin absorption; and
2. Treatment with Cholbam™ should be initiated and monitored by a hepatologist or pediatric gastroenterologist; and
3. The prescriber must verify that AST, ALT, GGT, alkaline phosphatase, bilirubin and INR will be monitored every month for the first three months, every three months for the next nine months, every six months during the next three years and annually thereafter; and
4. Cholbam™ should be discontinued if liver function does not improve within three months of starting treatment, if complete biliary obstruction develops, or if there are persistent clinical or laboratory indicators of worsening liver function or cholestasis; and
5. Initial approvals will be for the duration of three months to monitor for compliance and liver function tests.
6. Continuation approvals will be granted for the duration of one year.
7. A quantity limit of 120 capsules per 30 days will apply. Quantity limit requests will be based on the member's recent weight taken within the last 30 days.

Recommendation 3: Prior Authorize Natpara® (Parathyroid Hormone Injection)

The Drug Utilization Review Board recommends the prior authorization of Natpara® (parathyroid hormone injection) with the following criteria:

Natpara® (Parathyroid Hormone Injection) Approval Criteria:

1. An FDA approved diagnosis as an adjunct to calcium and vitamin D to control hypocalcemia in patients with hypoparathyroidism; and
    a. Natpara® is not FDA approved for hypoparathyroidism caused by calcium-sensing receptor mutations.
    b. Natpara® is not FDA approved for hypoparathyroidism due to acute post-surgery.
2. Magnesium deficiency must be ruled out; and
3. Member must have pretreatment serum calcium above 7.5mg/dL before starting Natpara®; and
4. Prescriber must verify the member has sufficient 25-hydroxyvitamin D level per standard of care; and
5. Member must be unable to be adequately well-controlled on calcium supplements and active forms of vitamin D alone; and
6. Health care provider and dispensing pharmacy must be certified through the Natpara® Risk Evaluation and Mitigation Strategies (REMS) Program; and
7. A quantity limit of two cartridges (each package contains two 14-day cartridges) per 28 days will apply. The maximum covered dose will be 100mcg per day.

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

June 25, 2015

The Oklahoma Health Care Authority is responsible for the payment of health care expenses for over ONE MILLION of our fellow citizens each year. That health care is provided by over 38,000 health care providers across every county in Oklahoma.

The Board and staff are appropriated funds from the legislature every year to administer programs mandated by state law. As a state agency, we must present a balanced budget to the legislative body each year.

There are very few products and services that the OHCA can reduce or cut completely because they are mandated by The State Plan, therefore the providers end up taking the reductions to support a balanced budget.

The best example of an optional program is pharmacy. If the pharmacy program was cut, the overall cost to the budget would increase dramatically due to increased hospital care for our recipients.

In the last 4 years, the percent of federal match has decreased and the legislature has not appropriated enough money to make up for the decrease of federal funds but the number of recipients and the cost of caring for those recipients continue to increase. The staff of the Oklahoma Health Care Authority has worked diligently and very hard to make a balanced budget each year.

As a member of the Board, I would encourage those 38,000 providers to explain to their legislators the importance of OHCA being completely funded each year.

Sincerely,

Charles Ed McFall
OHCA Chair