OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
May 23, 2016 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK

A G E N D A

Items to be presented by Tony Armstrong, Vice-Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the March 24, 2016 and April 28, 2016 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

   - February 2016 All-Star – Cody Middleton, Administrative Support Officer (Tywanda Cox)
   - March 2016 All-Star – LeKenya Antwine, Waiver Development & Reporting Director (Tywanda Cox)
   - April 2016 All-Star – Brent Johnson, Sr. Research Analyst (Tywanda Cox)

   b) Financial Update – Carrie Evans, Chief Financial Officer

   c) Medicaid Director's Update – Becky Pasternik-Ikard, State Medicaid Director

      1.) Insure Oklahoma (IO) and Recent Program Enhancements – Melissa Pratt, IO Administrator

   d) Legislative Update – Emily Shipley, Director of Government Relations

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 Carrie Evans, Chairperson of the State Plan Amendment Rate Committee

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

   a) Consideration and Vote Upon the Recommendations of the State Plan Amendment Rate

Committee. The Agency requests the adoption of the following recommendations:

A. Consideration and vote to implement an across-the-board rate reduction in the amount of an up to 25.00% to SoonerCare providers. The proposed reduction excludes services paid for by other state agencies, services provided under a waiver, Complex Rehabilitation Technology Products, Child Abuse Exams, Non-Emergency Transportation, Insure Oklahoma, payments for drug ingredients, physician supplied drugs, services provided to Native Americans through Indian Health Services Indian/Tribal/Urban (ITU) Clinics, and Private Duty Nursing. Nursing Homes are included in the cuts, but are considered in later agenda items. While this list of exclusions is fairly comprehensive it is not exhaustive. In SFY2017, these changes have an estimated total dollar savings of up to $403,603,407, of which up to $160,634,156 is state savings.

B. Consideration and vote to implement a payment methodology change to consider the Medicare paid amount as payment in full for all crossover claims, excluding pharmacy, physician administered drugs, and services provided by Indian/Tribal/Urban (ITU) Clinics. In SFY2017, these changes have an estimated total dollar savings of $84,761,623, of which $33,735,126 is state savings.

C. Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Regular Nursing Facilities by up to 25.00%. The new Base Rate Component will be no lower than $98.28 per patient day. The new combined pool amount for "Direct Care" and "Other" Component will be no lower than $126,078,309. The new Quality of Care (QOC) fee will be no lower than $10.10 per patient day. In SFY2017, these changes have an estimated total dollar savings of up to $87,273,327, of which up to $34,734,784 is state savings.

D. Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Regular (more than 16 beds) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) by up to 25.00%. The new Base Rate Component will be no lower than $97.23 per patient day. The new Quality of Care (QOC) fee will be no lower than $6.05 per patient day. In SFY2017, these changes have an estimated total dollar savings of up to $4,495,200, of which up to $1,789,090 is state savings.

E. Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Acute (16 beds or less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) by up to 25.00%. The new Base Rate Component will be no lower than $122.65 per patient day. The new Quality of Care (QOC) fee will be no lower than $7.39 per patient day. In SFY2017, these changes have an estimated total dollar savings of up to $8,185,542, of which up to $3,257,846 is state savings.

F. Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Nursing Facilities for Individuals with Acquired Immune Deficiency Syndrome (AIDS) by up to 25.00%. The new Base Rate Component will be no lower than $167.59 per patient day. The new Quality of Care (QOC) fee will be no lower than $10.10 per patient day. In SFY2017, these changes have an estimated total dollar savings of up to $229,505, of which up to $91,343 is state savings.

G. Consideration and vote to implement a rate change to reduce the reimbursement rates for the Ventilator Add-On for Nursing Facilities provider by up to 25.00%. The new Ventilator Add-On rate will be no lower than $107.59 per patient day. In SFY2017, these changes have an estimated total dollar savings of up to $1,580,035, of which up to $628,854 is state savings.

b) Consideration and Vote of the Board to Grant CEO, Nico Gomez, the Authority to Reverse or Modify the Board's Vote and Decision in 6(a).

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

7. Action Item – Consideration and Vote of Authority for Expenditure of Funds

   a) Consideration and Vote of Authority for Expenditure of Funds for New Venture Fund

Item to be presented by Nancy Nesser, Pharmacy Director

8. 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 **Uptravi® (Selexipag)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   b) Consideration and vote to add **Cerezyme® (Imiglucerase), Elelyso® (Taliglucerase Alfa), Vpriv® (Velaglucerase Alfa), Cerdelga® (Eliglustat), and Zavesca® (Miglustat)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   c) Consideration and vote to add **Elestrin® (Estradiol Gel 0.06%)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   d) Consideration and vote to add **Evzio® (Naloxone Auto-Injector)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Tony Armstrong, Vice-Chairman

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

   a) Discussion of employment, hiring, appointment, promotion, demotion, discipline or resignation of an employee

      - Discussion of agency employment action

10. New Business

11. ADJOURNMENT

NEXT BOARD MEETING
June 30, 2016
Oklahoma Health Care Authority
Charles Ed McFall Boardroom
4345 N. Lincoln Blvd.
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
March 24, 2016
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 March 23, 2016 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 March 22, 2016 at 8:45 a.m.

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

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

BOARD MEMBERS ABSENT: Member Nuttle, Member McVay

OTHERS PRESENT:
Jolene Ring, OPHA
Melissa Hughes, RRCS
Vikas Jain, St. Anthony
Holly Howard, TARC
Aaron Jaramillo, Xerox
Jim Claflin, OHCA
Becky Ikard, OHCA
Charles Brodt, HPE
Ryan Morlock, OHCA
Tatiana Reed, OHCA
Jackie Keyser, OHCA
Ray Hester, DHS
Anne Roberts, Integris
Jean Ann Ingram, SOFS
Kim Barly, Integris BH
Brenda Garrett, TARC
Benny Vanatta, Eyemart
Rebecca Moore, OAHCP
LeKenya Antwine, OHCA
Maria Maule, Governor's office
Karen Beam, OHCA
Courtney Barrett, OHCA

OTHERS PRESENT:
Stephanie Stuckert, SOFS
Lanette Long, St. Anthony
Jordan Gruenberg, RRCS
Tyler Talley, eCapitol
Marquetta Frye, Maxim Healthcare
David Dude, American Cancer Society
Kimrey McGinnis, OHCA
Aaron Morris, OHCA
Adolph Maren, OHCA
Jennifer King, OHCA
Harvey Reynolds, OHCA
Terry Cothran, COP
Virginia Ragan, SOFS
Don Henderson, Integris
Jared Hyler, Rock Road Counseling Services
Jason Shanks, Eyemart
Rick Snyder, OHA
Ashley Herron, OHCA
Carmen Johnson, OHCA
Mary Brinkley, LeadingAge OK
Robert Durrell, BCBSOK

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD FEBRUARY 11, 2016.

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

MOTION: Member Case moved for approval of the February 11, 2016 board meeting minutes as published. The motion was seconded by Member Robison.

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

NICO GOMEZ, CHIEF EXECUTIVE OFFICER'S REPORT

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

The following OHCA All-Stars were recognized.

- December 2015 All-Star – Linda Callaway, Community Strategist (Lisa Gifford)
- January 2016 All-Star – Ryan Morlock, Statistician (Lisa Gifford)

ITEM 3b / FINANCIAL UPDATE
Gloria Hudson, Director of General Accounting

Ms. Hudson reported on the final financial transactions through the month of January. She said that the state dollar budget variance is a positive $10.8 million and this variance is $2 million higher than the prior month. We are under budget in expenditures by .3% for $2.7 million state dollars and in administration by 6.95 for $2.7 million state dollars. Ms. Hudson reported that we are over budget in drug rebate collections by 5.6% for $3 million state dollars, tobacco tax collections and fees by 9.4% for $2.5 million state dollars and under budget in settlements and overpayments by 1% for a negative amount of $0.1 million state dollars. She noted that on March 16th, OHCA filed a revised budget to accommodate the additional revenue reduction of 4%. For more detailed information, see Item 3b in the board packet.

Mr. Gomez said the agency is balancing the additional revenue failure announced earlier in the month, bringing the total to an overall 7% reduction for FY2016. He anticipates that we will take the claims of the cycle that are going to run into June and move them back into July. He added that deficit totals at about $25 million, would be spread over 12 months as opposed to three. Mr. Gomez credited the board's actions in approving a 3% across the board provider rate cut in December as to why OHCA currently remains in the green.

ITEM 3c / MEDICAID DIRECTOR'S UPDATE
Becky Pasternik-Ikard, State Medicaid Director

Ms. Ikard provided an update for January 2016 data that included a report on the number of SoonerCare enrollment trends for various populations over a 13 month period from January 2015 through January 2016. She discussed the charts provided for information on dual enrollees & Long-term care members, enrollment for children and adult in SoonerCare and Insure Oklahoma enrollment. For more detailed information, see Item 3c in the board packet.

Ms. Ikard recognized Melody Anthony as the new Deputy State Medicaid Director.

ITEM 3d / LEGISLATIVE UPDATE
Emily Shipley, Director of Government Relations

Ms. Shipley stated that the Legislature is considering 858 active bills. She mentioned that OHCA is currently tracking 84 bills that have a direct impact. Ms. Shipley discussed SB1340 and HB2803 and reviewed the remaining Senate and House deadlines. For more detailed information, see Item 3d in the in the board packet.

ITEM 4 / 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.A-CC / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT. THE AGENCY REQUESTS THE ADOPTION OF THE FOLLOWING PERMANENT RULES:
Tywanda Cox, Chief of Federal and State Policy

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

Ms. Cox stated that we are pulling Item 6a.O from this agenda.

The following permanent rules HAVE previously been approved by the Board and the Governor under Emergency rulemaking. These rules HAVE NOT been revised for Permanent Rulemaking.

A. AMENDING Agency rules at OAC 317:30-3-59 and 317:30-5-42.17 to revise policy payment for general program exclusions for adults and for non-covered services for hospitals to revoke payment for removal of benign skin lesions for adults and eliminate coverage for adult sleep studies.
Budget Impact: Savings were approved during promulgation of the emergency rule; the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 15-04)

B. AMENDING Agency rules at OAC 317:30-5-210.2 to restrict coverage for continuous positive airway pressure devices (CPAP) to children only.
Budget Impact: Savings were approved during promulgation of the emergency rule; the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 15-06)

MOTION: Vice-Chairman Armstrong moved for approval of Item 6a.A & B as published. The motion was seconded by Member Bryant.

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

The following permanent rules HAVE previously been approved by the Board and the Governor under Emergency rulemaking. These rules have been REVISED for Permanent Rulemaking.

C. 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. **The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed:** The proposed Dental policy is revised to mirror new terminology from the Code on Dental Procedures and Nomenclature (CDT) and to clean up outdated language. Revisions also include removing the 36 month language for comprehensive oral evaluations. Appropriate utilization parameters for comprehensive evaluations are identified in the CDT and eliminating limits in policy will allow the agency to continue to align with parameters set forth in the CDT without future promulgation of rules. In addition, a change includes removing language which restricts emergency examination/limited oral evaluation from being performed within two months, the new proposed language will allow dentist to perform emergency evaluations as medically necessary. Proposed revisions also clarify the documentation requirements regarding the 5A's for tobacco cessation counseling, and that one office note signature provided at the end of the visit is sufficient.
Budget Impact: The cost for services rendered for a member to gain organ transplant clearance was approved during promulgation of the emergency rule and no additional cost will be incurred.

The proposed rule to remove restrictions on when dentist can perform emergency examination/limited oral evaluation will result in additional costs to the agency. The rule change has total projected cost of $130,597 with a projected state share of $51,442 for SFY 2017. The agency has identified administrative cost savings that could offset the cost of implementing the proposed policy change. There is an expenditure of approximately $42,000 a year in staff costs to manually process claims for emergency examination/limited oral evaluation. The impact of these administrative dollars could be better utilized by the agency permitting the Dental Services Unit to devote resources to other duties.

(Reference APA WF # 15-01)

D. AMENDING Agency rules at OAC 317:30-5-2, 317:30-5-22, 317:30-5-22.1, 317:30-5-226, 317:30-5-229, 317:30-5-356, and 317:30-5-664.8 to decrease the number of units allowed for ultrasounds from six to three; decrease the number of units 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; and, to decrease the number of ultrasounds currently granted to the Maternal Fetal Medicine (MFM) doctors to assist in the diagnosis of a high risk condition from six to one. These decreases align with the current standards of care and reflect the current number of ultrasounds and biophysical profiles currently being utilized. Additionally, proposed changes to General Coverage policy revokes payment for removal of benign skin lesions for adults and

eliminates coverage for adult sleep studies. **The aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed:** Further proposed revisions to Obstetrical policy amend the reimbursement structure for OB services. Currently the agency utilizes the global care CPT codes for routine obstetrical care billing, which can be used if the provider rendered care for a member for greater than one trimester. The proposed policy will require obstetrical care be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered. The change allows for more accurate tracking of antepartum and postpartum services. Additionally, proposed General Coverage policy is amended to clarify the separate note and signature requirement for providers performing tobacco use cessation counseling. Proposed revisions clarify the separate note requirement must address the 5A's and that the signature is one office note signature provided at the end of the visit. Other revisions to General Coverage policy include striking reimbursement language for clinical fellows or chief residents in an outpatient academic setting. OHCA reimburses chief residents the same as residents and the separate payment distinction based on practice setting is not needed. Further changes include general language clean-up to terms and services to ensure language is consistent throughout Chapter 30.
Budget Impact: Savings identified with decreasing the number of ultrasounds and biophysical profiles/non-stress test for pregnant women, revoking payment for the removal of benign skin lesions for adults, and eliminating coverage for adult sleep studies were approved during the promulgation of the emergency rule. No additional savings or cost will be incurred.

Restructuring the reimbursement for OB services will result in additional savings to the agency. There would be an estimated total savings for SFY 2016 of $3,831,661; total state savings are projected as $1,444,537.

(Reference APA WF # 15-07A)

E. AMENDING Agency rules at OAC 317:30-5-20 and ADDING Agency Rules at OAC 317:30-5-20.1 to establish rules 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 aforementioned changes were approved during promulgation of the emergency rule. The following are proposed changes not previously reviewed:** Further proposed revisions to Urine Drug Screening policy clarifies the difference between quantitative and qualitative testing and when quantitative urine drug screening is an appropriate test to utilize. Changes are also proposed to general laboratory services policy to clarify appropriate billing for detection of individual infectious organisms.
Budget Impact: Savings were approved during promulgation of the emergency rule; the rule change will not result in any additional costs and/or savings to the agency.

(Reference APA WF # 15-08)

MOTION: Member Robison moved for approval of Item 6a.C-E as published. The motion was seconded by Vice-Chairman Armstrong.

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

The following permanent rule HAS NOT previously been approved by the Board.

DHS Initiated

F. AMENDING Agency rules at OAC 317:40-1-1 to allow active military personnel who applied for Home and Community-Based Services (HCBS) in another state to have the application date honored in the state of Oklahoma. Proposed revisions also include language clean up.
DHS Budget Impact: Budget neutral

(Reference APA WF # 15-66)

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

G. AMENDING Agency rules at OAC 317:35-5-2 and 317:35-22-2 to amend the reimbursement structure for OB

services. Currently the agency utilizes the global care CPT codes for routine obstetrical care billing, which can be used if the provider rendered care for a member for greater than one trimester. The proposed policy will require obstetrical care be billed using the appropriate evaluation and management codes for antepartum care, as well as the appropriate delivery only and postpartum care services when rendered. The change allows for more accurate tracking of antepartum and postpartum services.
Budget Impact: Restructuring the payment for OB services will result in savings to the agency which have been identified in WF 15-07A.

(Reference APA WF # 15-07B)

H. AMENDING Agency rules at OAC 317:30-5-432.1 and at OAC 317:30-5-450 to clarify that eyeglasses meant as a backup are not covered, and high-index lenses require prior authorization. Proposed policy changes clarify that members can select eyeglasses with special features that exceed the SoonerCare allowable fee as long as the provider obtains signed consent from the member. The member will be responsible for the excess cost and the provider must be able to dispense standard eyeglasses for which SoonerCare would fully reimburse. Proposed revisions also include language clean up.
Budget Impact: Budget neutral

(Reference APA WF # 15-17)

I. AMENDING Agency rules at OAC 317:30-5-210 and 317:30-5-211.1 to establish focused regulations and policies for Complex Rehabilitation Technology (CRT) products and services to comply with state legislation. The proposed revisions designate specific HCPCS billing codes as CRT and establish specific supplier standards for companies that provide CRT. The revisions establish requirements and restrict the provision of CRT to only qualified CRT suppliers.
Budget Impact: Budget neutral

(Reference APA WF # 15-18)

J. AMENDING Agency rules at OAC 317:30-5-907, 317:30-5-907.1, and 317:30-5-907.3 to define services that fall within the scope of authority for independent diagnostic testing facilities (IDTF). The proposed changes clarify reimbursement for the professional and technical components for rendered services and physician oversight. The language requires that IDTF supervising physicians must: oversee non-physician personnel, monitor the quality of the testing performed, and monitor the operation and calibration of equipment.
Budget Impact: Budget neutral

(Reference APA WF # 15-21)

K. AMENDING Agency rules at OAC 317:30-5-695, 317:30-5-696.1, 317:30-5-698 through 317:30-5-700.1, 317:30-5-704, and 317:30-5-705 to mirror new terminology from the Code on Dental Procedures and Nomenclature (CDT), to clean-up outdated terms, and to add oversight requirements for dentist who supervise certified registered nurse anesthetist during the administration of anesthesia to members. The oversight requirement would align OHCA policy with requirements set forth by the Oklahoma Board of Dentistry. In addition, revisions include updating policy to reflect that diagnosis codes must appear on the dental form when requesting a prior authorization and the removal of language for the recoupment of restoration services. The removal of recoupment language will mirror other policy sections concerning dental services that are silent to the recoupment process. Recoupment for inappropriate restorations will still occur as deemed appropriate by the agency's Program Integrity Division.
Budget Impact: Budget neutral

(Reference APA WF # 15-24)

L. AMENDING Agency rules at OAC 317:30-5-1085, 317:30-5-1086, 317:30-5-1087, 317:30-5-1088, 317:30-5-1089, 317:30-5-1090, 317:30-5-1091, 317:30-5-1093, 317:30-5-1094, 317:30-5-1095, 317:30-5-1096, 317:30-5-1098, 317:30-5-1099, and 317:30-5-1100 to update Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/U) policy for clarity and consistency with other sections of Chapter 30. Proposed revisions update professional staff titles, clarify requirements for providers to contract with OHCA and appear on the IHS listing of tribal facilities, update language to include the use of OHCA's EPE system and clarify professional staff recognized by OHCA. Additional revisions would remove language on telemedicine originating site fees, define homebound individuals, require documentation of treatment and add requirements for licensure candidates.

Proposed revisions include clean-up to remove outdated policy to align with current practice and to clarify I/T/U encounters and outpatient encounters, inpatient practitioner services and prior authorization procedures.
Budget Impact: Budget neutral

(Reference APA WF # 15-28)

M. AMENDING Agency rules at OAC 317:30-5-211.15 to remove specific quantity limits to diabetic testing supplies to replace with more general language about testing supplies being based on insulin use or type of diabetes. Proposed revisions also specify that a prior authorization may be required for supplies beyond the standard allowance.
Budget Impact: Budget neutral

(Reference APA WF # 15-36)

N. AMENDING Agency rules at OAC 317:30-5-131.2 to clarify procedures for the completion and submission of the Quality of Care (QOC) Report. Rules will be amended to correctly list the types of employee positions that are counted in staffing ratios and outline procedures for counting non-direct care workers when those employees are rendering direct care. Language will also be updated to eliminate references to outdated submission methods such as certified mail, diskettes and electronic mail, while adding a requirement to submit QOC reports via the provider portal. Proposed policy will clarify the types of information required in the QOC report and update staff unit terminology.
Budget Impact: Budget neutral

(Reference APA WF # 15-38)

MOTION: Member Case moved for approval of Item 6a.F-N as published. The motion was seconded by Member Robison.

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

P. AMENDING Agency rules at OAC 317:30-3-2.1 to update program integrity audit and review policy to clarify OHCA audit procedures and address issues such as extrapolation, reconsideration and audits. Definitions will be expanded to include universe, sample and error rate. Language will be amended to clarify those items included in the audit/review process, the provider's options after an initial audit/review, and the process for selecting sample claims in a probability sample audit.
Budget Impact: Budget neutral

(Reference APA WF # 15-42)

Q. AMENDING Agency rules at OAC 317:30-3-20 to clarify and make corrections to instructions for the submission of claim inquiries by providers. Proposed changes include title change of section from appeals procedures to claim inquiry procedures, removal of incorrect references to revoked policy, and guidance on the proper form to use for claim inquiries. Proposed policy changes should result in decreased confusion for providers inquiring about payment for services provided to members.
Budget Impact: Budget neutral

(Reference APA WF # 15-43)

R. AMENDING Agency rules at OAC 317:30-5-740, 317:30-5-740.1, 317:30-5-741, 317:30-5-742, 317:30-5-742.2, and 317:30-5-743.1 to replace Inspection of Care language with the more appropriate Service Quality Review language to mirror practice and other policy changes. In addition, minor cleanup changes were made and the term outpatient was removed where referenced regarding behavioral health services to minimize confusion for Therapeutic Foster Care (TFC) providers. Rules are also revised broaden the definition of employment to align with TFC agencies' employment practices with Treatment Parent Specialist (TPS). Current policy language regarding employment status of TPS in a TFC is problematic for TFC agencies as there are different variations of “employment” among the agencies. Changing policy language from “employment” to “employment relationship” will create more inclusive terminology which will reflect the various arrangements TFC agencies have with TPS (i.e., full-time employment, contractual employment, etc.).
Budget Impact: Budget neutral

(Reference APA WF # 15-48)

S. AMENDING Agency rules at OAC 317:35-5-41.1 and 317:35-5-41.6 to modify countable resource rules which stated that home property in a revocable trust retained certain exemptions outlined in another section of policy. Home property in a revocable trust does not retain those exemptions thus it was deleted from policy.
Budget Impact: Budget neutral

(Reference APA WF # 15-50)

T. AMENDING Agency rules at OAC 317:2-1-2 and 317:2-1-13 to correct citations and references to state statutes, specify that policy addresses appeals and not grievances which are addressed in other sections, remove provisions related to the Administrative Law Judge's jurisdiction to match other rules and statutes and language clean-up for clarity and accuracy.
Budget Impact: Budget neutral

(Reference APA WF # 15-52)

U. AMENDING Agency rules at OAC 317:2-1-7 and REVOKING OAC 317:2-1-8 to clarify the purpose of the Program Integrity audit appeal hearings, clarifies which issues are appealable, and streamlines the process of audit appeal hearings. In addition, OHCA proposes to revoke rules in nursing home provider contract appeals policy.
Budget Impact: Budget neutral

(Reference APA WF # 15-53)

V. AMENDING Agency rules at OAC 317:45-1-3, 317:45-1-4, 317:45-3-1, 317:45-3-2, 317:45-5-1, 317:45-5-2, 317:45-7-1, 317:45-7-3, 317:45-7-5, 317:45-7-7, 317:45-7-8, 317:45-9-1, 317:45-9-4, 317:45-9-6, 317:45-9-7, 317:45-9-8, 317:45-11-11, 317:45-11-20, 317:45-11-21, 317:45-11-23, 317:45-11-24, 317:45-11-26, 317:45-11-27, and 317:45-11-28 to clarify inconsistent and conflicting language. Proposed revisions include clean-up to remove outdated policy to align with current business practices. Proposed revisions also add new coverage for emergency transportation for the Insure Oklahoma Individual Plan Members.
Budget Impact: There is no budget impact for language clean-up. The rule change to add emergency transportation has a projected cost of $163,452, with a projected state share of $63,763. This is an average cost of about $40.67 per adult member. This will be funded by the dedicated revenue source for Insure Oklahoma and will not require state appropriations.

(Reference APA WF # 15-54)

W. AMENDING Agency rules at OAC 317:35-18-5 and 317:35-18-8 to provide clarification on enrollment standards for members who voluntarily dis-enroll and wish to transfer from one PACE site to another PACE site to align with current business practices.
Budget Impact: Budget neutral

(Reference APA WF # 15-55)

X. AMENDING Agency rules at OAC 317:30-3-14 to clarify and enhance lock-in procedures. Proposed revisions would strengthen the consequences of not adhering to the lock-in restrictions by sanctioning members who have been locked in with a single prescriber and pharmacy.
Budget Impact: Budget neutral

(Reference APA WF # 15-56)

Y. AMENDING Agency rules at OAC 317:50-1-3, 317:50-1-4, 317:50-1-5, 317:50-1-10, 317:50-1-13, 317:50-1-14, and 317:50-1-16 to assure that the Long Term Care waiver language and policy are the same. Additional revisions are to detail operation and procedural changes that have occurred since receiving the five year renewal.
Budget Impact: Budget neutral

(Reference APA WF # 15-57)

Z. AMENDING Agency rules at OAC 317:30-5-95.25, 317:30-5-95.26, 317:30-5-95.33, 317:30-5-95.34, 317:30-5-95.41, and 317:30-5-95.42 to remove outdated references to Axis I and II diagnosis language to align with changes to the Diagnostic and Statistical Manual of Mental Disorders (DSM). Additional revisions clarify assessment and evaluation criterion and include cleanup to outdated language. Rules are also revised to remove outdated references to the provider manual to reflect current procedures for out-of-state reviews. In addition policy is revised to include Service Quality Review requirements for Ad Hoc reviews.
Budget Impact: Budget neutral

(Reference APA WF # 15-58)

AA. AMENDING Agency rules at OAC 317:2-1-12 to clarify the appeals process for a 30 day for cause and immediate contract termination and to remove references to suspended contracts. Proposed changes also add language to rules addressing 60 day without cause termination. The amendments makes clear that pursuant to contract terms, either party may terminate the contract with a 30 day written notice when it is a for cause termination, or with a 60 day notice if the termination is without cause. Additional changes detail the post-termination panel committee composition and functions, and add language that specifies the timeframe for which a provider must submit a written response to OHCA requesting reconsideration.
Budget Impact: Budget neutral

(Reference APA WF # 15-61)

BB. AMENDING Agency rules at OAC 317:30-5-95.24 to clarify nurse staffing ratio, 24 hour nursing care requirements and to outline supervisions requirements for psychiatric facilities. In addition, revisions clarify that any unit that does not allow clear line of site due to presence of walls or doors is a separate unit. Additionally, revisions include adding a requirement that admission assessments for inpatient psychiatric care both acute and residential levels must be provided in accordance to federal regulations.
Budget Impact: Budget neutral

(Reference APA WF # 15-62)

CC. AMENDING Agency rules at OAC 317:30-5-95.35 and 317:30-5-95.37 to clarify that a candidate for licensure can perform assessments and psychosocial evaluations when appropriate and medically necessary. In addition, revisions clarify that for existing evaluations of 30 days or less, must be reviewed, when a member changes provider or level of care. The evaluation(s) must be updated as necessary and signed and dated by the appropriate level of professional.
Budget Impact: Budget neutral

(Reference APA WF # 15-65)

MOTION: Vice-Chairman Armstrong moved for approval of Item 6a.P-CC as published. The motion was seconded by Member Bryant.

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

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

Nancy Nesser, Member of the State Plan Amendment Rate Committee

a) Consideration and vote to implement a rate change setting the target rate for the Potentially Preventable Readmissions program to 102% for CY 2015 data and decreasing 1% per year until the target is 100% (101% for CY 2016 data, 100% for CY 2017 data and beyond). The penalties assessed for the Hospital PPR program are expected to result in a state fiscal year 2016 budget savings of approximately $1,571,145 total dollars, $612,904 state share.

b) Consideration and vote to implement a rate method change to pay outlier payments on Diagnosis-Related Group (DRG) transfer claim. On July 1, 2015, OHCA implemented a new reimbursement method for DRG transfers. At that time, OHCA stated that outlier payments would not be allowed for the transferring facility. Due to the resulting unintentional and negative impact, OHCA reversed that decision. The transfer payment method is still in place, the only change is outlier payments are allowed when applicable. There is no budget

impact for this change. The anticipated savings from the prior SPARC was never accounted for in the budget since the outlier piece of the transfer policy was never fully implemented.

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

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

ITEM 8 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES §5030.3.

Nancy Nesser, Pharmacy Director

a) Consideration and vote to add **Duopa™ (Carbidopa/Levodopa Enteral Suspension) and Rytary™ (Carbidopa/Levodopa Extended-Release Capsules)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

(b) Consideration and vote to add **Strensiq™ (Asfotase Alfa)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

(c) Consideration and vote to add **Varubi™ (Rolapitant)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

(d) Consideration and vote to add **Xuriden™ (Uridine Triacetate)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

(e) Consideration and vote to add **Spritam® (Levetiracetam), Vimpat® (Lacosamide), Banzel® (Rufinamide), and Fycompa® (Perampanel)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

(f) Consideration and vote to add **Solaraze® (Diclofenac 3% Gel)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

(g) Consideration and vote to add **Uceris® (Budesonide Extended-Release Tablets), Uceris® (Budesonide Rectal Foam), and Various Mesalamine Products** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

(h) Consideration and vote to add **Mitigare™ (Colchicine Capsules) and Zurampic™ (Lesinurad)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Vice-Chairman Armstrong moved for approval of Item 6a-h as published. The motion was seconded by Member Case.

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

ITEM 9 / NEW BUSINESS

There was no new business.

ITEM 10 / ADJOURNMENT

MOTION: Vice-Chairman Armstrong moved for approval for adjournment. The motion was seconded by Member Robison.

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

Meeting adjourned at 2:11 p.m., 3/24/16

It was established that the voting of Item 8 was taken incorrectly as Item **6**a-h instead of Item **8**a-h. General Counsel stated that it was necessary to reconvene the board meeting to vote correctly.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting back to order at 2:17 p.m.

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

BOARD MEMBERS ABSENT: Member Nuttle, Member McVay

ITEM 8 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OKLAHOMA STATUTES §5030.3.

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(h) Consideration and vote to add **Mitigare™ (Colchicine Capsules) and Zurampic™ (Lesinurad)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Member Case moved for approval of **Item 8a-h** as published. The motion was seconded by Vice-Chairman Armstrong.

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

ITEM 10 / ADJOURNMENT

MOTION: Member Bryant moved for approval for adjournment. The motion was seconded by Member Case.

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

Meeting adjourned at 2:21 p.m., 3/24/16

Lindsey Bateman
Board Secretary

Minutes Approved: _____

Initials:_____

MINUTES OF A SPECIAL SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
April 28, 2016
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 April 27, 2016 at 12:30 p.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 April 25, 2016 at 2:27 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:01 p.m.

BOARD MEMBERS PRESENT: Chairman McFall, Member Case, Member Bryant, Member Robison

BOARD MEMBERS ABSENT: Vice-Chairman Armstrong

OTHERS PRESENT:
Sign in sheets attached

OTHERS PRESENT:

ITEM 2 / PUBLIC COMMENT ON THIS MEETING'S AGENDA ITEMS BY ATTENDEES WHO GAVE 24 HOUR PRIOR WRITTEN NOTICE
Nicole Nantois, Chief of Legal Services

There were 7 speakers present.

ITEM 3 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 4 / 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:
Tywanda Cox, Chief of Federal and State Policy

ODMHSAS Initiated

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

A. AMENDING Agency rules at OAC 317:30-5-241.2 to set daily and weekly limits for the amount of individual, group and family psychotherapy that are reimbursable by SoonerCare. The current daily limits of 6 units of individual, 12 units of group and 12 units of family therapies will be reduced to 4 units, 6 units and 4 units respectively. In addition, weekly limits will be imposed that limit the total amount of group therapy in a week to 3 hours and Individual and Family therapy will cumulatively be limited to 2 hours per week. Additionally, revisions include adding language that excludes therapy limitations to outpatient behavioral health services provided in a therapeutic foster care setting. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget for the remainder of SFY 2016 in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Department is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program. We are recommending an effective date of May 1, 2016, or upon governor's approval.
ODMHSAS Budget Impact: Estimated savings to ODMHSAS for SFY2016 is $3,031,168 Total; $1,182,459 State share. Estimated savings to ODMHSAS for SFY 2017 is $36,374,029 Total; $14,189,509 State Share.

(Reference APA WF # 16-04)

MOTION: Member McVay moved for approval of emergency rulemaking for Item 4.A as published. The motion was seconded by Member Nuttle.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

MOTION: Member McVay moved for approval of Item 4.A as published. The motion was seconded by Member Bryant.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

B. AMENDING Agency rules at OAC 317:30-5-281 to reduce the monthly limits of psychotherapy reimbursable by SoonerCare for Licensed Behavioral Health Professionals who choose to practice on their own. The current limit of 8 units/sessions per month will be reduced to 4 units/sessions per month. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget for the remainder of SFY 2016 in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Department is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program. We are recommending an effective date of May 1, 2016, or upon governor's approval.
ODMHSAS Budget Impact: Estimated savings to ODMHSAS for SFY2016 is $305,298 Total; $119,097 State share. Estimated savings to ODMHSAS for SFY 2017 is $3,663,583 Total; $1,429,164 State share.

(Reference APA WF # 16-05)

MOTION: Member Robison moved for approval of emergency rulemaking for Item 4.B as published. The motion was seconded by Member McVay.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

MOTION: Member Nuttle moved for approval of Item 4.B as published. The motion was seconded by Member Bryant.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

C. AMENDING Agency rules at OAC 317:30-5-241.1, for outpatient behavioral health agencies, to reduce the number of SoonerCare compensable service plan updates to one every six months. Outpatient behavioral health agencies will now be reimbursed for one initial comprehensive treatment plan and one update thereto bi-annually. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget for the remainder of SFY 2016 in order to meet the balanced budget requirements as mandated by State law. Without the recommended revisions, the Department is at risk of exhausting its State appropriated dollars required to maintain the State's Medicaid Behavioral Health Program. We are recommending an effective date of May 1, 2016, or upon governor's approval.
ODMHSAS Budget Impact: Estimated savings to ODMHSAS for SFY2016 is $12,817 Total; $5,000 State share. Estimated savings to ODMHSAS for SFY2017 is $205,075; $80,000 State share.

(Reference APA WF # 16-06)

MOTION: Member Case moved for approval of emergency rulemaking for Item 4.C as published. The motion was seconded by Member Robison.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

MOTION: Member Case moved for approval of Item 4.C as published. The motion was seconded by Member Nuttle.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

ITEM 5 / CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE

Carrie Evans, Chairperson of the State Plan Amendment Rate Committee

A. Consideration and vote to implement a rate reduction in the amount of 3.00% to freestanding psychiatric hospitals. These changes have an estimated total dollar savings of $57,249, of which $22,333 is state savings in SFY2016. In SFY2017 these changes have an estimated total dollar savings of $343,501, of which $134,000 is state savings.

MOTION: Member Bryant moved for approval of Item 5.A as published. The motion was seconded by Member Nuttle.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

B. Consideration and vote to implement a rate change to the payment methodology for Common Procedure Terminology (CPT) codes for services provided by Licensed Behavioral Health Practitioners (LBHPs) in independent practice, to 70% of the equivalent fees paid to LBHPs in outpatient behavioral health clinic settings. This is a 30% rate reduction. These changes have an estimated total dollar savings of $889,005, of which $346,801 is state savings in SFY2016. In SFY2017 these changes have an estimated total dollar savings of $5,334,045, of which $2,080,811 is state savings.

MOTION: Member Nuttle moved for approval of Item 5.B as published. The motion was seconded by Member Robison.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

C. Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Psychologists in Independent Practice by 10%. The new rate structure for this provider type will be 87.07 percent of the 2013 Medicare Physician Fee Schedule. These changes have an estimated total dollar savings of $125,608, of which $49,000 is state savings in SFY2016. In SFY2017 these changes have an estimated total dollar savings of $751,089, of which $293,000 is state savings.

MOTION: Member Case moved for approval of Item 5.C as published. The motion was seconded by Member Bryant.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

D. Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Behavioral Health Licensure Candidates in outpatient behavioral health clinics by 10%, to reflect differences in education and training. These changes have an estimated total dollar savings of $1,377,641, of which $537,418 is state savings in SFY2016. In SFY2017 these changes have an estimated total dollar savings of $8,265,862, of which $3,224,513 is state savings.

MOTION: Member McVay moved for approval of Item 5.D as published. The motion was seconded by Member Nuttle.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

E. Consideration and vote to implement a rate change to reduce the reimbursement rates for residential psychiatric services by 15%. These changes have an estimated total dollar savings of $2,243,014, of which $875,000 is state savings in SFY2016. In SFY2017 these changes have an estimated total dollar savings of $13,329,915, of which $5,200,000 is state savings.

MOTION: Member Case moved for approval of Item 5.E as published. The motion was seconded by Member Nuttle.

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

ITEM 6 / NEW BUSINESS

Member Case requested Terri White, from the Oklahoma Department of Mental Health and Substance Abuse Services, make a statement regarding the budget reductions and Commissioner White explained the need and reasoning behind the reductions.

ITEM 7 / ADJOURNMENT

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

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

BOARD MEMBER ABSENT: Vice-Chairman Armstrong

Meeting adjourned at 1:50 p.m., 4/28/16

NEXT BOARD MEETING
May 12, 2016
Oklahoma Health Care Authority
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

*Initials:*_____

Oklahoma HealthCare Authority

OHCA BOARD MEETING / SIGN IN
APRIL 28, 2016

NAME (PLEASE PRINT)	ORGANIZATION
Brian Hemment	Red Rivers Tech Academy
Tyler Talley	eCap
Nicole Stull	TTS
Verna Foust	Red Rock Bhs
Joy Sloan	GCBHS
Lauren Ricken-Hobbs	Concepts
Hannah Vogt	Angels FFN OKC
Linda Gray Murphy	OK Counseling Assn.
	ODMHSAS
Harvey Reynolds	OHCA
David Peters	Daybreak
Robert Darrell	BCBS
Ricky Snyder	OHCA
Carmen Johnson	OHCA
	OH
Merrick Yamada	OUHSC
Bethany Jones	YFC
	New Day Recovery
Sara Reed	OUHSC
LaAnn McFall.	

Oklahoma
Health Care
Authority

OHCA BOARD MEETING / SIGN IN
APRIL 28, 2016

NAME (PLEASE PRINT)	ORGANIZATION
Mike Fogarty	
Virginia Ragan	S.O.F.S.
Jean Ann Ingram	S.O.F.S.
Becky Moore	OAHCP
Taylor Rains Sims	ODMHSAS
Tracy McCalman	Family & Childrens Svcs
Charles Dawley	GLMHC
[illegible] Moore	HOPE CMHC
Marisa Patel	Concepts
Heath [illegible]	Halo [illegible]
Leah S. Taylor	Self
Rich Edwards	ODMHSAS
Sherry Doyle	OrionNet Systems
Darrell [illegible]	CCS
Peter John [illegible]	TPC Out Patient Behavioral Health
Stacy Johnson	[illegible]
Debra Knight	Parent
Carla [illegible]-Hodges	DMH
[illegible]	OHCA
Jim Claflin, MD	OHCA
Jordan Gruenberg	RRCS
Michael Jones	[illegible]
[illegible]	OHCA
[illegible]	SAFY
Ginger Clayton	OHCA

Oklahoma HealthCare Authority

OHCA BOARD MEETING / SIGN IN
APRIL 28, 2016

NAME (PLEASE PRINT)	ORGANIZATION
Brenda Teel	Chickasaw Nation
Stephanie Stuckert	SOFS
Wendy Allard	Clear View Counseling
[illegible]	YCO
Krista Lewis	FCS
Mary Jo Sullivan	CBS
Melissa Shofner	GCBHS
Summer King	HOPE
Brittany Miller	Family Hope House
Leslie Keenan	Family Hope House
[illegible]	[illegible]
John Gilley	NAMI
Brenda Shmidt	Private Practice
Bill [illegible]	OHCA
Gabriella Koch	[illegible]
Will Widman	HPE
Melissa Hughes	Red Road Counseling
Marquetta FRYE	Maxim Healthcare
Tatiana Reza	OHCA
Mic Smith	DACA
Sherris H-Ososanya	OHCA

FINANCIAL REPORT

For the Nine Months Ended March 31, 2016
Submitted to the CEO & Board

- Revenues for OHCA through March, accounting for receivables, were **$2,959,187,850 or .2% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$2,940,557,107 or .2% over** budget.
- The state dollar budget variance through March is a **positive $10,050,343.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(1.4)
Administration		7.8
Revenues:		
Drug Rebate		2.8
Taxes and Fees		(0.4)
Overpayments/Settlements		1.2
Total FY 16 Variance	**$**	**10.0**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2016, For the Nine Month Period Ending March 31, 2016

REVENUES	FY 16 Revenue	State Share
Tobacco Tax Collections	$ 606,964	$ 606,964
TOTAL REVENUES	**$ 606,964**	**$ 606,964**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 9,245	$ 1,079	
Inpatient Hospital	1,482,658	173,026	
Outpatient Hospital	2,586,878	301,889	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	5,863	684	
Physicians	3,986,450	465,219	
Dentists	10,867	1,268	
Mid-level Practitioner	489	57	
Other Practitioners	4,303	502	
Home Health	7,540	880	
Lab & Radiology	278,822	32,539	
Medical Supplies	23,672	2,762	
Clinic Services	116,036	13,541	
Ambulatory Surgery Center	11,392	1,329	
Prescription Drugs	1,216,541	141,970	
Transportation	29,930	3,493	
Miscellaneous Medical	1,866	218	
Total OHCA Program Costs	**$ 9,772,552**	**$ 1,140,457**	
OSA DMHSAS Rehab	$ 53,880	$ 6,288	
Total Medicaid Program Costs	**$ 9,826,431**	**$ 1,146,745**	
TOTAL STATE SHARE OF COSTS			**$ 1,146,745**

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.

OHCA Board Meeting
May 23, 2016
(March 2016 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

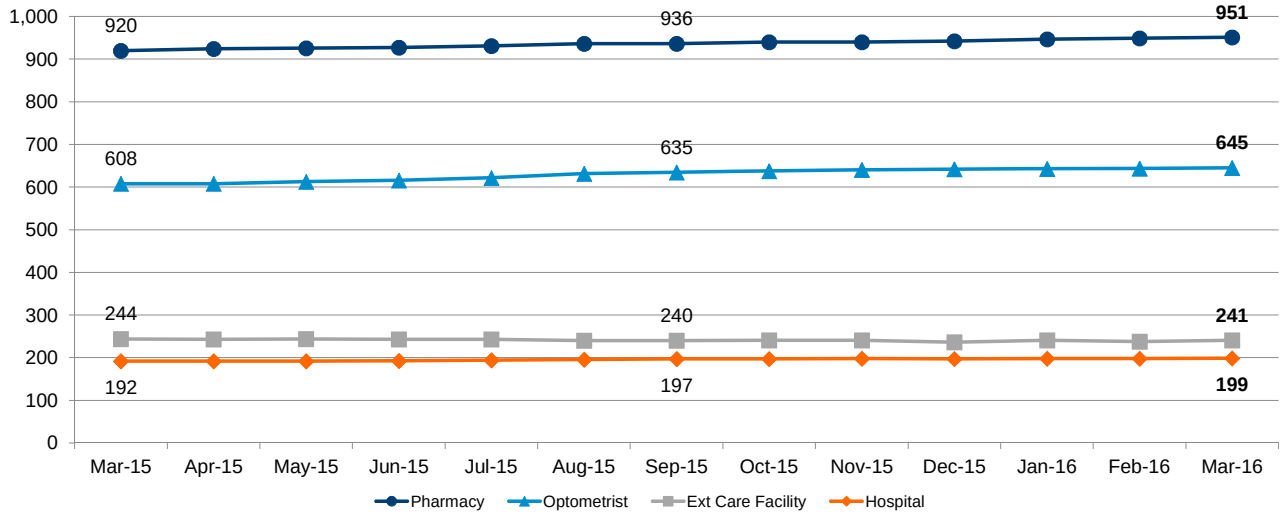
Delivery System			Enrollment March 2016	Children March 2016	Adults March 2016	Enrollment Change	Total Expenditures March 2016	PMPM March 2016	Forecasted Mar 2016 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**528,847**	**434,653**	**94,194**	**668**	**$167,953,592**		
	Lower Cost	*(Children/Parents; Other)*	484,679	420,645	64,034	733	$117,647,580	$243	$213
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	44,168	14,008	30,160	-65	$50,306,012	$1,139	$1,014
SoonerCare Traditional			**229,186**	**83,936**	**145,250**	**-3,124**	**$215,129,106**		
	Lower Cost	*(Children/Parents; Other)*	117,479	78,935	38,544	-3,370	$52,489,653	$447	$345
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	111,707	5,001	106,706	246	$162,639,453	$1,456	$1,288
SoonerPlan			**34,550**	**2,876**	**31,674**	**-1,150**	**$308,420**	$9	$7
Insure Oklahoma			**19,037**	**573**	**18,464**	**-284**	**$2,394,328**		
	Employer-Sponsored Insurance		14,965	373	14,592	-337	N/A*	N/A*	
	Individual Plan		4,072	200	3,872	53	$2,197,435	$540	$461
TOTAL			**811,620**	**522,038**	**289,582**	**-3,890**	**$385,785,447**		

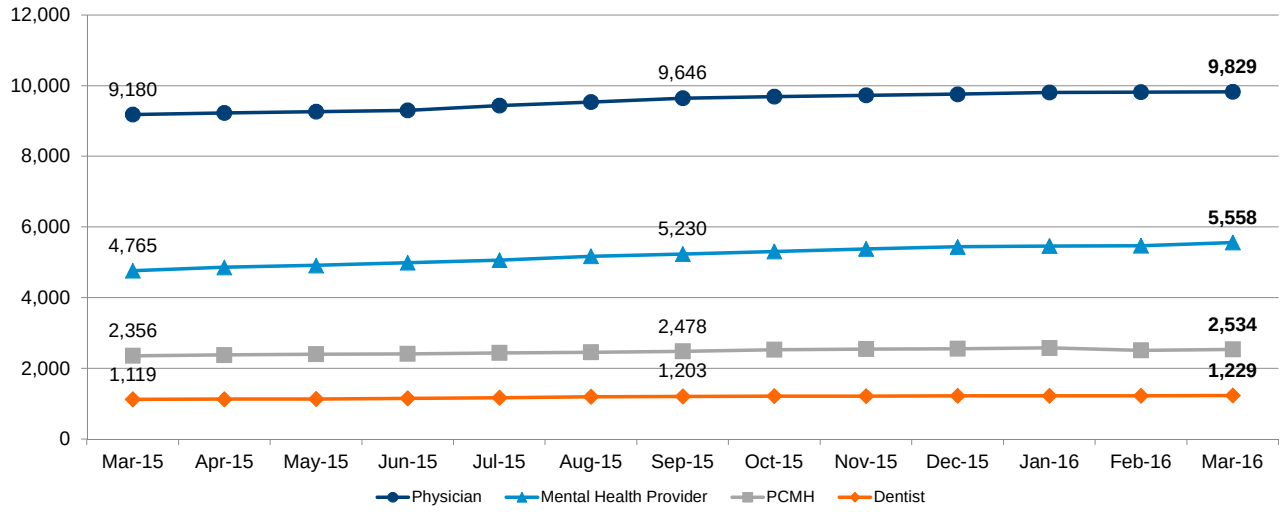
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
*Insure Oklahoma ESI Expenditures and PMPM is currently unavailable due to March employer subsidy payments being delayed as IO is transitioned to a new eligibility system.

IN-STATE CONTRACTED PROVIDERS

Total In-State Providers: 32,695 (-1370) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

*Decrease in Total Provider count is due to Physician Assistant renewal starting in Feb 2016 and Behavioral Health Provider in Mar 2016. Decrease during contract renewal period is typical during all renewal periods.





Insure Oklahoma 2016

Melissa Pratt, MA, LBP

Oklahoma HealthCare Authority

INSURE OKLAHOMA 2016

- Outreach
- Online Enrollment
- Modified Adjusted Gross Income (MAGI)
- Interactive Employer Portal
- Employer Subsidies

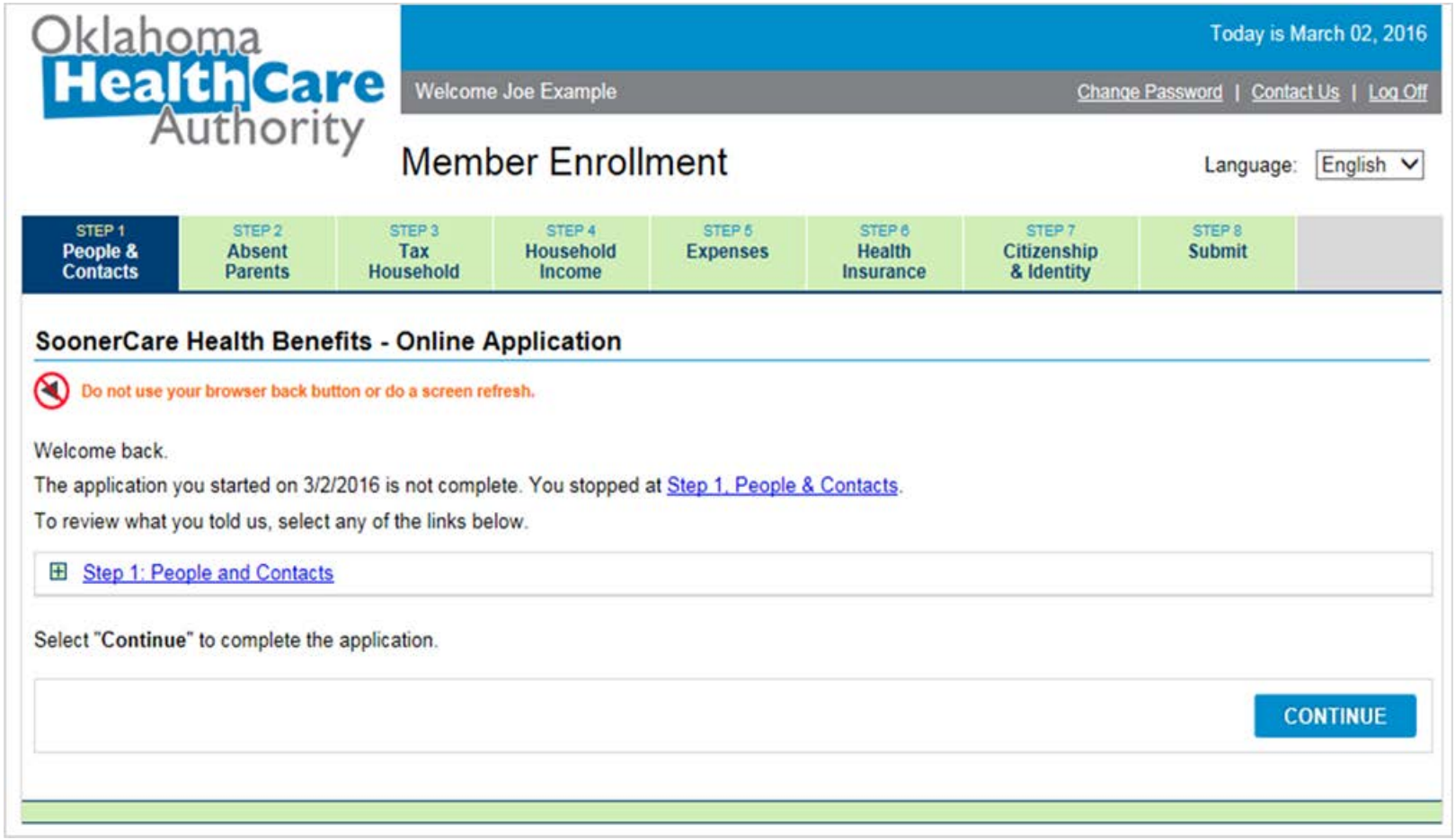
Oklahoma HealthCare Authority

OUTREACH

DATE	TASK
November-Present	Fifteen email newsletters sent to employers, insurance agents and community partners.
February 5	Notification letters sent to employers, ESI members and IP members.
March 2	Agency View webinar hosted for agency partners.
Week of March 7	Reminder letters sent to employers, ESI members and IP members. ESI and IP application guides available online.
March 14	“First” day to reapply for ESI members and IP members.
March 14-31	Targeted social media ads for ESI and IP members; reached 54% of member households. Five webinars hosted for insurance agents and employers. Recorded Employer Portal and Online Enrollment application walkthrough available online.

Oklahoma HealthCare Authority

ONLINE ENROLLMENT



Oklahoma HealthCare Authority

MAGI FOR ESI

2016 Insure Oklahoma Employer-Sponsored Insurance Income Guidelines		
Family Size	Monthly Income	Annual Income
1	$2,247.00	$26,964
2	$3,030.00	$36,360
3	$3,814.00	$45,768
4	$4,597.00	$55,164
5	$5,380.00	$64,560
6	$6,163.00	$73,956

For eligibility beginning 4-1-2016
Updated 3-29-2016

Oklahoma HealthCare Authority

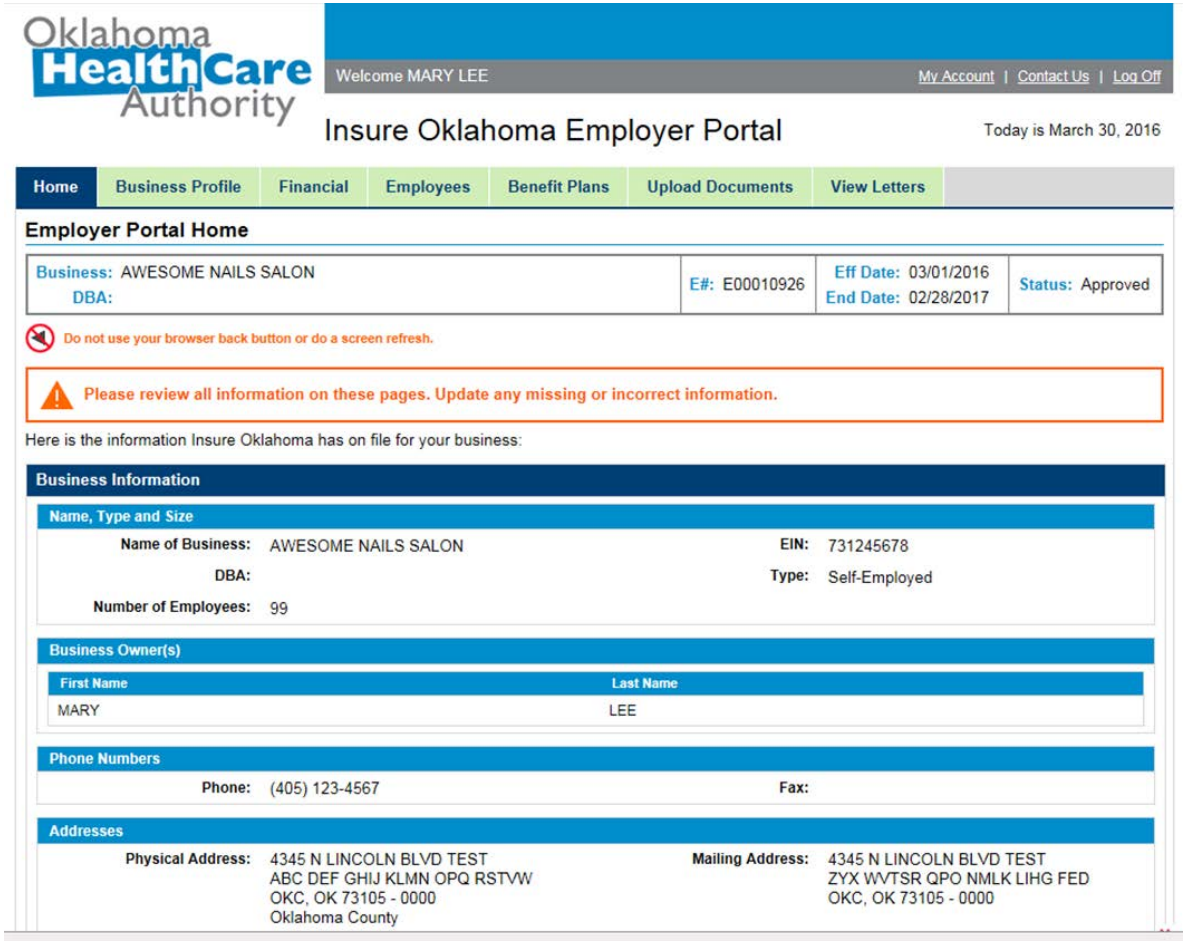
MAGI FOR IP

2016 Insure Oklahoma Individual Plan Income Guidelines		
Family Size	Monthly Income	Annual Income
1	$1,040.00	$12,480
2	$1,402.00	$16,824
3	$1,764.00	$21,168
4	$2,126.00	$25,512
5	$2,489.00	$29,868
6	$2,851.00	$34,212

For eligibility beginning 4-1-2016
Updated 3-29-2016

Oklahoma HealthCare Authority

EMPLOYER PORTAL



Oklahoma HealthCare Authority

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Insure Oklahoma Employer Portal

Today is March 30, 2016

Home | Business Profile | Financial | Employees | Benefit Plans | Upload Documents | View Letters

Employer Portal Home

Business: AWESOME NAILS SALON DBA:	E#: E00010926	Eff Date: 03/01/2016 End Date: 02/28/2017	Status: Approved

Do not use your browser back button or do a screen refresh.

Please review all information on these pages. Update any missing or incorrect information.

Here is the information Insure Oklahoma has on file for your business:

Business Information

Name, Type and Size

Name of Business:	AWESOME NAILS SALON	EIN:	731245678
DBA:		Type:	Self-Employed
Number of Employees:	99		

Business Owner(s)

First Name	Last Name
MARY	LEE

Phone Numbers

Phone:	(405) 123-4567	Fax:	

Addresses

Physical Address:	4345 N LINCOLN BLVD TEST ABC DEF GHIJ KLMN OPQ RSTVW OKC, OK 73105 - 0000 Oklahoma County	Mailing Address:	4345 N LINCOLN BLVD TEST ZYX WVTSR QPO NMLK LIHG FED OKC, OK 73105 - 0000

Oklahoma HealthCare Authority

QUESTIONS?

Oklahoma HealthCare Authority

MAY 23, 2016 OHCA BOARD MEETING

As of May 16, 2016, there are 651 bills still active for the legislature to consider before sine die. OHCA is now tracking 31 bills. The Governor has signed 30 of our tracked bills, vetoed 1 bill, 4 bills have been sent to her for signage and we have 27 remaining on our tracking list awaiting action.

DIRECT IMPACT BILLS:

- HB2803 – Rep. David Derby, Sen. A.J. Griffin – The bill now creates the Medicaid Rebalancing Act of 2020. It limits Medicaid coverage to 133% of the federal poverty level for nondisabled children and pregnant women when the current maintenance-of-effort expires in 2019. It creates a new individual Insure Oklahoma commercial insurance plan for adults between the ages of 19 and 64 whose incomes do not exceed 133% of the federal poverty level. The plan will include an incentive account and will be suspended if the federal matching rate for the plan drops below 90%.
- HB3210 – Rep. Earl Sears, Sen. Clark Jolley – Increases the cigarette excise tax by $1.50 per pack of cigarettes. Revenue collected from the increase will be credited to the Healthcare Revolving Fund and appropriated at the discretion of the Legislature to agencies for activities eligible to be matched with federal Medicaid dollars or mental health safety net services.

SENATE AND HOUSE REMAING DEADLINE

May 27, 2016: Sine Die Adjournment, No later than 5:00 p.m.

GOVERNOR SIGNING DEADLINES

- The governor has five days from the receipt of a bill, excluding Sundays, to sign or veto the measure while the Legislature is in session. If the governor takes no action, the bill becomes law.
- The governor has 15 days from sine die adjournment to dispose of matters passed during the final week of the legislative session. Assuming the Legislature adjourns May 27, the last Friday in May, the governor would have until June 11 to sign or veto measures.
- After sine die adjournment, bills not signed by the governor are considered vetoed (pocket veto). The governor is not required to give a reason for the veto.

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

25.00% ACROSS-THE-BOARD PROVIDER RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of an up to 25.00% reduction, to the current rates and reimbursement structure in the SoonerCare program. 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.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   OHCA currently reimburses providers under a variety of different rate structures; diagnostic-related group (DRG), per diem, max fee, percent of Medicare, and a percent of costs are some examples. Our current rates reflect a 3.25% reduction, a 7.75% reduction and a 3.00% reduction from the applicable rate structures, implemented in April of 2010, July 2014, and January 2016.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
Effective June 1, 2016, OHCA seeks to decrease the current applicable rates by up to 25.00% of the applicable rate structure.

The proposed reduction excludes services financed through appropriations to other state agencies, services provided under a waiver, and services where a reduction could severely limit access or not cover costs (in the aggregate). Nursing Homes are included in the budget cuts, but are listed in a separate brief. While this list of exclusions is fairly comprehensive it is not exhaustive.

- Complex Rehabilitation Technology Products
- Child Abuse Exams
- Non-Emergency Transportation
- Insure Oklahoma
- Payments for drug ingredients/physician supplied drugs
- Services provided under a waiver
- Services paid for by other state agencies
- Services provided to Native Americans through Indian Health Services Indian/Tribal/Urban Clinics
- Private Duty Nursing

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of up to $403,603,407; up to $160,634,156 state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the up to 25.00% rate reduction for all providers excluding those providers/services that have an exception provision.

9. **EFFECTIVE DATE OF CHANGE.**
   June 1, 2016

MEDICARE CROSSOVER CLAIMS REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Method Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision to the payment methodology to consider the Medicare paid amount as payment in full for all crossover claims, excluding pharmacy, physician administered drugs, as well as services provided by Indian/Tribal/Urban (ITU) Clinics. 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.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   OHCA current methodology pays 75% of deductible and 25% of coinsurance on crossover claims for hospital services.

   OHCA current methodology pays 20% of Medicare Part A and 75% for Medicare part B coinsurance and deductible on crossover claims to nursing homes.

   OHCA current methodology pays 100% of deductible and 46.25% of coinsurance for all other services.

This excludes pharmacy, physician administered drugs, as well as services provided by Indian/Tribal/Urban (ITU) providers, all of which deductible and coinsurance are paid at 100%.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
The proposed methodology is to consider the Medicare paid amount payment in full for all crossover claims, excluding pharmacy, physician administered drugs, as well as services provided by ITU providers.

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of $84,761,623; $33,735,126 state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the method change to pay 0% of Coinsurance and Deductible of Medicare Crossover claims, excluding pharmacy, physician administered drugs, as well as services provided by ITU providers.

9. **EFFECTIVE DATE OF CHANGE.**
June 1, 2016

REGULAR NURSING FACILITIES RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of up to a 25.00% reduction, to the Regular Nursing facilities provider rates. 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.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:
   A. Base Rate Component is $107.29 per patient day.
   B. A Focus on Excellence (FOE) Component defined by the points earned under this performance program range from $1.00 to $5.00 per patient day.
   C. An “Other” Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and FOE Components by the total estimated Medicaid days for the rate period.

D. A "Direct Care "Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and FOE Components to the facilities. This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the 70% pool of funds to each facility (on a per day basis) based on their relative expenditures for direct care.

The current combined pool amount for "Direct Care" and "Other Component" is $155,145,293.

The current Quality of Care (QOC) fee is $10.79 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however, there is a proposed rate change for Regular Nursing facilities as a result of the proposed decrease of up to 25.00% for Regular Nursing Facility provider rates by the Oklahoma Health Care Authority.

The proposed Base Rate Component will be no lower than $98.28 per patient day.

The proposed combined pool amount for "Direct Care" and "Other" Component will be no lower than $126,078,309.

The proposed Quality of Care (QOC) fee will be no lower than $10.10 per patient day.

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of up to $87,273,327; with up to $34,734,784 in state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an

effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. RATE OR METHOD CHANGE IN THE FORM OF A MOTION.

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular Nursing facilities:

- A decrease in the base rate component from $107.29 per patient day to no lower than $98.28 per patient day.
- A decrease in the total pool amount for the "Other" and "Direct Care" Components from $155,145,293 to no lower than $126,078,309 to account for the:
    - Recommended rate reduction of up to 25.00%
    - Annual reallocation of the Direct Care Cost Component per The State Plan.
- A decrease in the Quality of Care fee from $10.79 per patient day to no lower than $10.10 per patient day.

9. EFFECTIVE DATE OF CHANGE.

June 1, 2016

REGULAR (MORE THAN 16 BEDS) INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of up to a 25.00% reduction, to Regular ICF/IID facilities provider rates. 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.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a) (30) (A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**

The current rate methodology for Regular ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current base rate for this provider type is $121.96 per patient day and the Quality of Care (QOC) fee is $7.25 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however, there is a rate change for Regular ICF/IID facilities as a result of the recommendation of up to a 25.00% reduction to provider rates and the annual recalculation of the Quality of Care (QOC) fee.

The proposed base rate for this provider type is no lower than $97.23 per patient day and the proposed Quality of Care (QOC) fee will be no lower than $6.05 per patient day.

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of up to $4,495,200; with up to $1,789,090 in state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular ICF/IID facilities:
   - A decrease in the base rate component from $121.96 per patient day to no lower than $97.23 per patient day.
   - A decrease in the Quality of Care fee from $7.25 per patient day to no lower than $6.05 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
June 1, 2016

ACUTE (16 BEDS-OR-LESS) INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of up to a 25.00% reduction, to Acute ICF/IID facility provider rates. 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.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Acute ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current base rate for this provider type is $156.19 per patient day and the Quality of Care (QOC) fee is $9.18 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however, there is a rate change for Acute ICF/IID facilities as a result of the recommendation of up to a 25.00% reduction in provider rates and the required annual recalculation and the Quality of Care (QOC) fee.

The proposed base rate for this provider type is no lower than $122.65 per patient day and the proposed Quality of Care (QOC) fee will be no lower than $7.39 per patient day.

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of up to $8,185,542; with up to $3,257,846 in state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:
   - A decrease in the base rate component from $156.19 per patient day to no lower than $122.65 per patient day.
   - A decrease in the Quality of Care fee from $9.18 per patient day to no lower than $7.39 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
June 1, 2016

NURSING FACILITES SERVING RESIDENTS WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of up to a 25.00% reduction, to nursing facilities serving residents with AIDS rate. 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.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a) (30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current base rate for this provider type is $198.22 per patient day and the Quality of Care (QOC) fee is $10.79 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however, there is a rate change for nursing facilities serving residents with AIDS patients as a result of the recommendation of up to a 25.00% reduction to provider rates and the required annual recalculation of the Quality of Care (QOC) fee.

The proposed base rate for this provider type is no lower than $167.59 per patient day and the proposed Quality of Care (QOC) fee will be no lower than $10.10 per patient day.

6. **BUDGET ESTIMATE.**
The estimated savings for SFY2017 will be a decrease in the total amount of up to $229,505; with up to $91,343 in state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:
   - A decrease in the base rate component from $198.22 per patient day to no lower than $167.59 per patient day.
   - A decrease in the Quality of Care fee from $10.79 per patient day to no lower than $10.10 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
June 1, 2016

VENTILATOR ADD-ON FOR NURSING FACILITIES RATE REDUCTION

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   Decrease

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of up to a 25.00% reduction, to the Ventilator Add-On for nursing facilities provider rates. The change is 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.

   Federal Requirements:
   State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a) (30) (A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:
   - Be consistent with efficiency, economy and quality of care;
   - Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current Ventilator Add-On for nursing facilities rate is $135.43 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for the Ventilator Add-On for nursing facilities as a result of the recommendation of up to a 25.00% reduction to provider rates. The proposed rate will be no lower than $107.59 per patient day.

6. **BUDGET ESTIMATE.**
The estimated savings for SFY 2017 will be a decrease in the total amount of up to $1,580,035; with up to $628,854 in state funds.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Given the uncertainty and potential range (0% to 25%) of any actual rate reduction, the Oklahoma Health Care Authority is unable at this time to determine the nature and extent of any possible impact to access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care. In anticipation of potential rate reductions, the agency initiated discussions with contracted providers in or about January 2016 regarding the possibility of budget reductions due to declining state revenues. These proactive activities were conducted as an effort by the Oklahoma Health Care Authority to remain transparent throughout the process and to give contracted providers ample notice of any impending budget reductions.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve a decrease in the Ventilator Add-On rate for nursing facilities from $135.43 per patient day to no lower than $107.59 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
June 1, 2016

Submitted to the C.E.O. and Board on May 23, 2016
AUTHORITY FOR EXPENDITURE OF FUNDS
New Venture Fund

BACKGROUND

We are requesting authority to issue a sole source contract for State Fiscal Year (SFY) 2017 with New Venture Fund, dba Upstream USA for the services of a consultant with experience in the education and training of long acting reversible contraceptives (LARCs).

SCOPE OF WORK

- Implement provider education in a format, manner and frequency in a complete and timely manner as set forth by OHCA;
- Provide OHCA with implementation updates;
- Provide marketing and training/tutorial materials (electronic templates with artwork, e-mail, monthly newsletter articles, presentations, flyers, etc.);
- Provide in-person customer and technical support for physicians and other end-users utilizing LARCs;
- Focus on shared decision between provider and patient for women under age 19; and
- Build capacity to continue sustainability of LARCs through education and training of health departments, medical schools, and OHCA Medical Homes.

CONTRACT PERIOD

Pending SPA approval from CMS, July 1, 2016 through June 30, 2017 with option to renew through September 30, 2017

CONTRACT AMOUNT

$2,000,000 Federal Match + $100,000 Grant

PROCUREMENT METHOD

- To be awarded through Sole Source
- Anticipated Federal matching funds are 95.69% in FFY 2016 and 94.96% in FFY 2017
- State match through grant from George Kaiser Family Foundation

RECOMMENDATION

Board approval to expend funds as explained above.

Drug	**Used for**	**Cost**	**Notes**
Uptravi	Pulmonary Hypertension	$15,000 - $23,000/month	meds available @ $60/month
Cerezyme	Gaucher Disease	$35,000/month	Types 1 & 3
Elelyso	Gaucher Disease	$35,000/month	Types 1 & 3
Vpriv	Gaucher Disease	$30,000/month	Types 1 & 3
Cerdelga	Gaucher Disease	$13,000-$20,000/month	Type 1
Zavesca	Gaucher Disease	$28,000/month	Type 1 - limited
Elestrin	menopausal symptoms	$200/month	meds available @ $5/month
Evzio	Opioid overdose	$4,000/package	Price jump from $500

Recommendation 1: Prior Authorize Uptravi® (Selexipag)

Uptravi® (Selexipag) Tablets Approval Criteria:

1. An FDA approved diagnosis of pulmonary arterial hypertension (PAH); and
2. Member must be 18 years of age or older; and
3. Previous failed trials of at least one of each of the following categories (alone or in combination):
    a. Revatio® (sildenafil) or Adcirca® (tadalafil); and
    b. Letairis® (ambrisentan) or Tracleer® (bosentan); and
    c. Adempas® (riociguat); and
    d. Orenitram™ (treprostinil); and
4. Medical supervision by a pulmonary specialist and/or cardiologist; and
5. A quantity limit of two tablets daily will apply for all strengths with an upper dose limit of 1,600mcg twice daily.

Recommendation 2: Prior Authorize Cerezyme® (Imiglucerase), Elelyso® (Taliglucerase Alfa), Vpriv® (Velaglucerase Alfa), Cerdelga® (Eliglustat), and Zavesca® (Miglustat)

Cerezyme® (Imiglucerase), Elelyso® (Taliglucerase Alfa), and Vpriv® (Velaglucerase Alfa) Approval Criteria:

1. A diagnosis of symptomatic (e.g., anemia, thrombocytopenia, bone disease, splenomegaly, or hepatomegaly) Type 1 or Type 3 Gaucher disease (GD); and
2. Member's weight (kg) must be provided and have been taken within the last four weeks to ensure accurate weight based dosing; and
3. Prescriber must verify that the member will not take requested therapy concurrently with another therapy for GD.
4. Approvals will be for the duration of six months, at which time the prescriber must verify the patient is responding to the medication.

Cerdelga® (Eliglustat) Approval Criteria:

1. An FDA approved indication of Type 1 Gaucher disease (GD1); and
2. Member is classified as one of the following as detected by an FDA-cleared test:
    a. CYP2D6 extensive metabolizers (EMs); or
    b. CYP2D6 intermediate metabolizers (IMs); or
    c. CYP2D6 poor metabolizers (PMs); and
3. Prescriber must verify that the member will not take Cerdelga® concurrently with another therapy for GD1.
4. For CYP2D6 EMs and IMs, a quantity limit of 56 capsules per 28 days will apply. For CYP2D6 PMs, a quantity limit of 28 capsules per 28 days will apply.
5. Approvals will be for the duration of six months, at which time the prescriber must verify the patient is responding to the medication.

Zavesca® (Miglustat) Approval Criteria:

1. An FDA approved indication of mild/moderate Type 1 Gaucher disease (GD1); and

2. A patient-specific, clinically significant reason why the member cannot use one of the following enzyme replacement therapies:
    a. **Cerezyme®** (imiglucerase); or
    b. **Elelyso®** (taliglucerase alfa); or
    c. **Vpriv® (**velaglucerase alfa); and
3. Prescriber must verify that the member will not take Zavesca® concurrently with another therapy for GD1.
4. A quantity limit of 90 capsules per 30 days will apply.
5. Approvals will be for the duration of six months, at which time the prescriber must verify the patient is responding to the medication.

Recommendation 3: Prior Authorize Elestrin® (Estradiol Gel 0.06%)

Elestrin® (Estradiol Gel 0.06%) Approval Criteria:

1. An FDA approved diagnosis of moderate-to-severe vasomotor symptoms due to menopause; and
2. Member must not have any contraindications for use of Elestrin®; and
3. A patient-specific, clinically significant reason why other topical estradiol formulations (e.g., Divigel®) are not appropriate for the member; and
4. Members greater than 65 years of age will generally not be approved without supporting information; and
5. Approvals will be for the duration of six months to ensure the need for continued therapy is reassessed periodically and the medication is being used for the shortest duration possible; and
6. A quantity limit of 52 grams per 30 days will apply.

Recommendation 4: Vote to Prior Authorize Evzio® (Naloxone Auto-Injector)

Evzio® (Naloxone Auto-Injector) Approval Criteria:

1. An FDA approved diagnosis of potential or risk for opioid overdose; and
2. A patient-specific, clinically significant reason why the member cannot use other formulations of naloxone.

Additionally, the College of Pharmacy recommends further education via letter or newsletter for prescribers and pharmacies who have patients utilizing high-dose opioid analgesics. Education should include the available naloxone medications reimbursable by SoonerCare and the importance of training and access to these medications.