OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
June 30, 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 Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the Approval of May 23, 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

        - May 2016 All-Star – Tiffany Lyon, Procurement and Contracts Development Manager

    b) Financial Update – Carrie Evans, Chief Financial Officer

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

    d) Budget Update – Nico Gomez, Chief Executive Officer

Item to be presented by Andy Garnand, Reporting & Statistics Manager

4. Discussion Item – 2015 Quality of Care in the SoonerCare Program Report (Quality Measures)

Item to be present by Stan Ruffner, DMEPOS Program Director

5. Discussion Item – OKDMERP, Connecting Oklahomans with Durable Medical Equipment (DME)

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

6. 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

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

    a) Consideration and Vote for a rate change to increase the base rate component to $107.57 for Regular Nursing Facilities and increase the pool amount for these facilities in the state plan for the "Other" and "Direct Care" components to $158,741,836. In SFY2017, this change has an estimated total dollar increase of $4,491,859, of which $1,787,760 is state share coming from the increased Quality of Care Fee, which is paid by the facilities.

b) Consideration and Vote for a rate change to increase the base rate component to $199.19 for the Acquired Immune Deficiency Syndrome (AIDS) rate for Nursing Facilities. In SFY2017, this change has an estimated total dollar increase of $8,758, of which $3,486 is state share coming from the increased Quality of Care Fee, which is paid by the facilities.

c) Consideration and Vote for a rate change to increase the base rate to $156.51 for Acute (16 Beds or Less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). In SFY2017, this change has an estimated total dollar increase of $89,872, of which $35,769 is state share coming from the increased Quality of Care Fee, which is paid by the facilities.

d) Consideration and Vote for a rate change to increase the base rate to $122.32 for Regular Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). In SFY2017, this change has an estimated total dollar increase of $74,855, of which $29,792 is state share coming from the increased Quality of Care Fee, which is paid by the facilities.

e) Consideration and Vote for a rate methodology change for Obstetrical (OB) Services. The current methodology for OB Services is a global structure and rate, inclusive of all antepartum, delivery and postpartum services. The proposed rate methodology for OB services is billing individual visits rendered based on the appropriate evaluation and management CPT code, as well as the delivery and postpartum services provided. This change has an estimated annual total dollar savings of $3,184,277, of which $1,275,621 is state savings.

f) Consideration and Vote for a rate methodology change for reimbursement for eyeglasses. The current rate methodology for eyeglasses and materials/lenses are paid at a set maximum fee rate. The proposed rate methodology is based on reimbursement combinations of several different services, including the additional reimbursements that will be allowed for refraction and fitting fee services. This change has an estimated annual total dollar savings of $3,944,720, of which $1,580,255 is state savings.

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

8. a) Action Item – Consideration and Vote of the State Fiscal Year 2017 Budget Work Program

Item to be presented by Nancy Nesser, Pharmacy Director

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

a) Consideration and vote to add **Zepatier™ (Elbasvir/Grazoprevir)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

(b) Consideration and vote to add **Eloctate™ [Antihemophilic Factor (Recombinant), Fc Fusion Protein], Adynovate® [Antihemophilic Factor (Recombinant), PEGylated], Alprolix® [Coagulation Factor IX (Recombinant), Fc Fusion Protein], Idelvion® [Coagulation Factor IX (Recombinant), Albumin Fusion Protein], Obizur® [Antihemophilic Factor (Recombinant), Porcine Sequence], Corifact® [Factor XIII Concentrate (Human)], Tretten® [Coagulation Factor XIII A-Subunit (Recombinant)], and Coagadex® [Coagulation Factor X (Human)], and Establish Pharmacy Provider Standards of Care** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

(c) Consideration and vote to add **Vaginal Progesterone Products (Crinone® and Endometrin®)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

(d) Consideration and vote to add **Humalog® KwikPen® U-200 (Insulin Lispro), Tresiba® (Insulin Degludec), Ryzodeg® 70/30 (Insulin Degludec/Insulin Aspart), and Basaglar® (Insulin Glargine),** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

(e) Consideration and vote to add **Entresto™ (Sacubitril/Valsartan)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Ed McFall, Chairman

10. 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)(4) and (7).

    a) Discussion of pending contractual litigation and claim

11. New Business

12. ADJOURNMENT

NEXT BOARD MEETING
August 11, 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
May 23, 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 May 20, 2016 at 1:00 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 May 19, 2016 at 1:06 p.m.

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

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

BOARD MEMBERS ABSENT: Chairman McFall

OTHERS PRESENT:
See Attachment

OTHERS PRESENT:

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD MARCH 24, 2016 AND APRIL 28, 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 Robison moved for approval of the March 24, 2016 and April 28, 2016 board meeting minutes as published. The motion was seconded by Member Bryant.

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

NICO GOMEZ, CHIEF EXECUTIVE OFFICER'S REPORT

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

The following OHCA All-Stars were recognized.

- 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)

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

Ms. Evans reported on the final financial transactions through the month of March. She said that the state dollar budget variance is $10 million dollars and the program expenditures were over budget through March by .5% with a state dollar variance of $1.4 million. We are under budget in administration by $7.8 million state dollars. Ms. Evans reported that we have a positive $2.8 million in drug rebate revenues, settlements and overpayments are positive $1.2 million state dollars and taxes and fees are $0.4 million under budget state dollars. She noted that for April we are going to remain under budget through our program spending but will remain positive overall with our underspending of administration and collection and revenues. For more detailed information, see Item 3b in the board packet.

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

Ms. Ikard provided an update for March 2016 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program. She discussed the charts provided for enrollment of the in-state contracted providers. For more detailed information, see Item 3c in the board packet.

ITEM 3c.1 / INSURE OKLAHOMA AND RECENT PROGRAM ENHANCEMENTS
Melissa Pratt, Insure Oklahoma Administrator

Ms. Pratt gave a brief overview of the changes that have taken place within Insure Oklahoma this year. This included information on outreach, online enrollment, Modified Adjusted Gross Income (MAGI), interactive employer portal and employer subsidies. For more detailed information, see Item 3c.1 in the board packet.

Member Case and Nico Gomez commended Melissa and her staff for the work happening within the program. Member Robison asked that if a person cannot apply online, is there another option? Melissa commented that the person can call in to do an application by phone, they can come in to the office where we have a computer available or they can utilize their local library.

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

Ms. Shipley stated that Sine Die Adjournment is no later than 5:00 p.m. on Friday, May 27, 2016. She highlighted HB2267 that is supplemental hospital offset payments and HB2962 related to autism spectrum disorder and noted that we will be working with several other state agencies over the next fiscal year to research and review treatments for this disorder specifically the applied behavioral analysis treatment to analyze the cost and the effectiveness of that treatment. Ms. Shipley said that we are waiting for a budget to be filed to find out our appropriations. For more detailed information, see Item 3d in the in the board packet.

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

There were no speakers for comment.

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

There were no recommendations regarding conflicts.

ITEM 6A-G / CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE
Carrie Evans, Chairperson of the State Plan Amendment Rate Committee

Nico Gomez recommended the Board postpone Item 6 (rates) because there is not an agreed state appropriation for the agency with an approved state budget from the legislature for FY2017. He explained scenarios and mentioned that there is a risk in taking the cuts now because based on the budget, it may have an unnecessary and devastating impact to providers and the members served. There is also a risk in not doing them and based on the budget, we may have to make a cut in a shorter time frame if we wait until June to implement.

The items were removed from the agenda.

ITEM 7a / CONSIDERATION AND VOTE OF AUTHORITY FOR EXPENDITURE OF FUNDS FOR NEW VENTURE FUND
Vickie Kersey, Director of Fiscal Planning & Procurement

MOTION:	Member Case moved for approval of Item 7a as published. The motion was seconded by Member McVay.
FOR THE MOTION:	Vice-Chairman Armstrong, Member Bryant, Member Robison, Member Nuttle

BOARD MEMBERS ABSENT: Chairman McFall

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 **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).

MOTION: Member Nuttle moved for approval of Item 8.a-d as published. The motion was seconded by Member Robison.

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

BOARD MEMBERS ABSENT: Chairman McFall

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

Vice-Chairman Armstrong entertained a motion to go into Executive Session at this time.

MOTION: Member McVay moved for approval to move into Executive Session. The motion was seconded by Member Nuttle.

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

BOARD MEMBERS ABSENT: Chairman McFall

ITEM 10 / NEW BUSINESS

There was no new business.

ITEM 11 / ADJOURNMENT

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

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

BOARD MEMBERS ABSENT: Chairman McFall

Meeting adjourned at 2:04 p.m., 5/23/16

NEXT BOARD MEETING
June 30, 2016
Oklahoma Health Care Authority
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

*Initials:*_____

FINANCIAL REPORT

For the Ten Months Ended April 30, 2016
Submitted to the CEO & Board

- Revenues for OHCA through April, accounting for receivables, were **$3,321,695,094 or .2% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,323,193,501 or at** budget.
- The state dollar budget variance through April is a **positive $7,303,997.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(3.1)
Administration		5.9
Revenues:		
Drug Rebate		3.1
Taxes and Fees		0.2
Overpayments/Settlements		1.2
Total FY 16 Variance	**$**	**7.3**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2016, For the Ten Month Period Ending April 30, 2016

REVENUES	FY16 Budget YTD	FY16 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 757,611,738	$ 757,611,738	$ -	0.0%
Federal Funds	1,920,761,512	1,915,052,960	(5,708,553)	(0.3)%
Tobacco Tax Collections	41,190,846	40,901,633	(289,213)	(0.7)%
Quality of Care Collections	63,791,220	63,604,900	(186,320)	(0.3)%
Prior Year Carryover	72,016,727	72,016,727	-	0.0%
Federal Deferral - Interest	236,733	236,733	-	0.0%
Drug Rebates	208,678,866	216,535,012	7,856,146	3.8%
Medical Refunds	36,319,852	39,470,179	3,150,327	8.7%
Supplemental Hospital Offset Payment Program	202,203,156	202,203,156	-	0.0%
Other Revenues	12,944,232	14,062,057	1,117,824	8.6%
TOTAL REVENUES	**$ 3,315,754,882**	**$ 3,321,695,094**	**$ 5,940,211**	**0.2%**

EXPENDITURES	FY16 Budget YTD	FY16 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 47,386,309**	**$ 41,866,476**	**$ 5,519,833**	**11.6%**
ADMINISTRATION - CONTRACTS	**$ 89,800,688**	**$ 80,962,481**	**$ 8,838,207**	**9.8%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	33,098,951	31,862,573	1,236,378	3.7%
Acute Fee for Service Payments:				
Hospital Services	745,872,782	753,752,299	(7,879,517)	(1.1)%
Behavioral Health	16,445,904	16,278,655	167,249	1.0%
Physicians	389,272,606	390,122,619	(850,013)	(0.2)%
Dentists	105,666,795	107,033,201	(1,366,406)	(1.3)%
Other Practitioners	34,575,872	36,700,904	(2,125,032)	(6.1)%
Home Health Care	16,228,044	16,073,182	154,863	1.0%
Lab & Radiology	51,227,982	48,191,595	3,036,387	5.9%
Medical Supplies	37,895,736	38,288,863	(393,127)	(1.0)%
Ambulatory/Clinics	107,966,369	109,757,561	(1,791,192)	(1.7)%
Prescription Drugs	431,813,131	432,942,120	(1,128,989)	(0.3)%
OHCA Therapeutic Foster Care	417,426	220,475	196,951	47.2%
Other Payments:				
Nursing Facilities	467,648,684	467,835,576	(186,892)	(0.0)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	50,171,554	50,653,887	(482,333)	(1.0)%
Medicare Buy-In	119,315,408	121,414,990	(2,099,583)	(1.8)%
Transportation	54,742,551	54,409,612	332,939	0.6%
Money Follows the Person-OHCA	582,492	320,270	262,221	0.0%
Electonic Health Records-Incentive Payments	6,859,677	6,859,677	-	0.0%
Part D Phase-In Contribution	70,020,909	70,082,533	(61,624)	(0.1)%
Supplemental Hospital Offset Payment Program	441,657,505	441,657,505	-	0.0%
Telligen	5,880,754	5,880,754	-	0.0%
Total OHCA Medical Programs	**3,187,361,132**	**3,200,338,852**	**(12,977,720)**	**(0.4)%**
OHCA Non-Title XIX Medical Payments	9,158	25,692	(16,534)	0.0%
TOTAL OHCA	**$ 3,324,557,287**	**$ 3,323,193,501**	**$ 1,363,786**	**0.0%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (8,802,404)**	**$ (1,498,407)**	**$ 7,303,997**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2016, For the Ten Month Period Ending April 30, 2016

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 31,969,424	$ 31,852,409	$ -	$ 106,851	$ -	$ 10,164	$ -
Inpatient Acute Care	989,921,359	509,638,530	405,572	2,888,263	315,633,482	1,546,842	159,808,669
Outpatient Acute Care	344,095,065	239,205,250	34,670	3,165,462	98,768,249	2,921,434	
Behavioral Health - Inpatient	44,699,666	9,586,731	-	200,673	25,964,760	-	8,947,503
Behavioral Health - Psychiatrist	7,982,936	6,691,924	-	-	1,291,012	-	-
Behavioral Health - Outpatient	23,093,657	-	-	-	-	-	23,093,657
Behaviorial Health-Health Home	19,926,157	-	-	-	-	-	19,926,157
Behavioral Health Facility- Rehab	208,185,239	-	-	-	-	59,581	208,185,239
Behavioral Health - Case Management	14,674,737	-	-	-	-	-	14,674,737
Behavioral Health - PRTF	68,313,313	-	-	-	-	-	68,313,313
Residential Behavioral Management	17,463,706	-	-	-	-	-	17,463,706
Targeted Case Management	55,198,703	-	-	-	-	-	55,198,703
Therapeutic Foster Care	220,475	220,475	-	-	-	-	-
Physicians	440,180,529	385,741,397	48,417	884,469	-	4,332,804	49,173,440
Dentists	107,045,927	107,020,638	-	12,726	-	12,563	-
Mid Level Practitioners	2,149,997	2,137,298	-	11,994	-	705	-
Other Practitioners	34,629,519	34,186,455	371,970	66,619	-	4,476	-
Home Health Care	16,082,824	16,064,509	-	9,642	-	8,673	-
Lab & Radiology	49,215,902	47,883,416	-	1,024,307	-	308,180	-
Medical Supplies	38,496,179	36,003,721	2,259,610	207,316	-	25,532	-
Clinic Services	110,035,552	103,673,529	-	495,130	-	127,738	5,739,155
Ambulatory Surgery Centers	6,063,791	5,944,043	-	107,496	-	12,251	-
Personal Care Services	10,528,784	-	-	-	-	-	10,528,784
Nursing Facilities	467,835,576	292,914,787	174,914,926	-	-	5,863	-
Transportation	54,245,972	52,011,676	2,200,747	-	-	33,549	-
GME/IME/DME	110,157,633	-	-	-	-	-	110,157,633
ICF/IID Private	50,653,887	41,429,427	9,224,460	-	-	-	-
ICF/IID Public	24,076,633	-	-	-	-	-	24,076,633
CMS Payments	191,497,523	190,889,493	608,031	-	-	-	
Prescription Drugs	442,662,130	431,545,045	-	9,720,010	-	1,397,075	-
Miscellaneous Medical Payments	163,640	160,916	-	-	-	2,724	-
Home and Community Based Waiver	165,090,748	-	-	-	-	-	165,090,748
Homeward Bound Waiver	70,849,066	-	-	-	-	-	70,849,066
Money Follows the Person	3,937,166	320,270	-	-	-	-	3,616,896
In-Home Support Waiver	21,087,021	-	-	-	-	-	21,087,021
ADvantage Waiver	150,781,663	-	-	-	-	-	150,781,663
Family Planning/Family Planning Waiver	4,527,326	-	-	-	-	-	4,527,326
Premium Assistance*	31,957,220	-	-	31,957,220	-	-	-
Telligen	5,880,754	5,880,754	-	-	-	-	-
Electronic Health Records Incentive Payments	6,859,677	6,859,677	-	-	-	-	-
Total Medicaid Expenditures	**$ 4,442,437,078**	**$ 2,557,862,369**	**$ 190,068,403**	**$ 50,858,179**	**$ 441,657,504**	**$ 10,810,155**	**$1,191,240,049**

* Includes $31,728,403 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2016, For the Ten Month Period Ending April 30, 2016

		FY16 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	494,102,045
Federal Funds		746,025,133
TOTAL REVENUES	**$**	**1,240,127,178**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	165,090,748
Money Follows the Person		3,616,896
Homeward Bound Waiver		70,849,066
In-Home Support Waivers		21,087,021
ADvantage Waiver		150,781,663
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		24,076,633
Personal Care		10,528,784
Residential Behavioral Management		13,181,842
Targeted Case Management		46,642,104
Total Department of Human Services		**505,854,756**
State Employees Physician Payment		
Physician Payments		49,173,440
Total State Employees Physician Payment		**49,173,440**
Education Payments		
Graduate Medical Education		68,738,103
Graduate Medical Education - Physicians Manpower Training Commission		3,969,850
Indirect Medical Education		32,248,316
Direct Medical Education		5,201,364
Total Education Payments		**110,157,633**
Office of Juvenile Affairs		
Targeted Case Management		2,468,883
Residential Behavioral Management		4,281,864
Total Office of Juvenile Affairs		**6,750,747**
Department of Mental Health		
Case Management		14,674,737
Inpatient Psychiatric Free-standing		8,947,503
Outpatient		23,093,657
Health Homes		19,926,157
Psychiatric Residential Treatment Facility		68,313,313
Rehabilitation Centers		208,185,239
Total Department of Mental Health		**343,140,606**
State Department of Health		
Children's First		1,134,947
Sooner Start		1,987,062
Early Intervention		3,997,500
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,755,657
Family Planning		214,275
Family Planning Waiver		4,287,886
Maternity Clinic		8,144
Total Department of Health		**13,385,471**
County Health Departments		
EPSDT Clinic		606,873
Family Planning Waiver		25,165
Total County Health Departments		**632,038**
State Department of Education		**160,361**
Public Schools		**794,908**
Medicare DRG Limit		**151,783,776**
Native American Tribal Agreements		**1,381,418**
Department of Corrections		**1,060,722**
JD McCarty		**6,964,171**
Total OSA Medicaid Programs	**$**	**1,191,240,049**
OSA Non-Medicaid Programs	**$**	**60,873,482**
Accounts Receivable from OSA	**$**	**11,986,354**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2016, For the Ten Month Period Ending April 30, 2016

REVENUES	FY 16 Revenue
SHOPP Assessment Fee	$ 193,398,410
Federal Draws	270,838,678
Interest	95,663
Penalties	283,550
State Appropriations	(22,650,000)
TOTAL REVENUES	**$ 441,966,300**

EXPENDITURES	Quarter	Quarter	Quarter	Quarter	FY 16 Expenditures
Program Costs:	**7/1/15 - 9/30/15**	**10/1/15 - 12/31/15**	**1/1/16 - 3/31/16**	**4/1/16 - 6/30/16**	
Hospital - Inpatient Care	83,225,354	84,459,473	73,479,240	74,469,416	$ 315,633,482
Hospital -Outpatient Care	22,465,442	22,826,470	26,399,405	27,076,932	98,768,249
Psychiatric Facilities-Inpatient	6,265,547	6,748,914	6,418,199	6,532,100	25,964,760
Rehabilitation Facilities-Inpatient	392,213	397,771	248,311	252,717	1,291,012
Total OHCA Program Costs	**112,348,555**	**114,432,629**	**106,545,155**	**108,331,165**	**$ 441,657,504**

Total Expenditures	**$ 441,657,504**

CASH BALANCE	**$ 308,796**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2016, For the Ten Month Period Ending April 30, 2016

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 63,571,070	$ 63,571,070
Interest Earned	33,830	33,830
TOTAL REVENUES	**$ 63,604,900**	**$ 63,604,900**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 171,881,928	$ 66,380,801	
Eyeglasses and Dentures	227,578	87,891	
Personal Allowance Increase	2,805,420	1,083,453	
Coverage for Durable Medical Equipment and Supplies	2,259,610	872,661	
Coverage of Qualified Medicare Beneficiary	860,630	332,375	
Part D Phase-In	608,031	608,031	
ICF/IID Rate Adjustment	4,372,858	1,688,798	
Acute Services ICF/IID	4,851,601	1,873,688	
Non-emergency Transportation - Soonerride	2,200,747	849,929	
Total Program Costs	**$ 190,068,403**	**$ 73,777,627**	**$ 73,777,627**
Administration			
OHCA Administration Costs	$ 438,139	$ 219,069	
DHS-Ombudsmen	192,259	192,259	
OSDH-Nursing Facility Inspectors	400,000	400,000	
Mike Fine, CPA	11,400	5,700	
Total Administration Costs	**$ 1,041,798**	**$ 817,028**	**$ 817,028**
Total Quality of Care Fee Costs	**$ 191,110,201**	**$ 74,594,655**	
TOTAL STATE SHARE OF COSTS			**$ 74,594,655**

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
SFY 2016, For the Ten Month Period Ending April 30, 2016

REVENUES	FY 15 Carryover	FY 16 Revenue	Total Revenue
Prior Year Balance	$ 27,746,235	$ -	$ 1,498,834
State Appropriations	(25,000,000)	-	-
Tobacco Tax Collections	-	33,641,357	33,641,357
Interest Income	-	166,458	166,458
Federal Draws	235,637	20,741,253	20,741,253
TOTAL REVENUES	**$ 2,981,872**	**$ 54,549,068**	**$ 56,047,903**

EXPENDITURES		FY 15 Expenditures	FY 16 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 31,728,403	$ 31,728,403
	College Students		228,817	88,369
Individual Plan				
	SoonerCare Choice		$ 102,606	$ 39,626
	Inpatient Hospital		2,874,381	1,110,086
	Outpatient Hospital		3,123,505	1,206,298
	BH - Inpatient Services-DRG		195,652	75,561
	BH -Psychiatrist		-	-
	Physicians		856,414	330,747
	Dentists		8,944	3,454
	Mid Level Practitioner		11,217	4,332
	Other Practitioners		65,785	25,406
	Home Health		9,642	3,724
	Lab and Radiology		1,006,084	388,550
	Medical Supplies		198,704	76,740
	Clinic Services		488,003	188,467
	Ambulatory Surgery Center		107,248	41,419
	Prescription Drugs		9,581,066	3,700,208
	Miscellaneous Medical		-	-
	Premiums Collected		-	(469,343)
Total Individual Plan			**$ 18,629,252**	**$ 6,725,274**
	College Students-Service Costs		**$ 271,706**	**$ 104,933**
Total OHCA Program Costs			**$ 50,858,179**	**$ 38,646,979**
Administrative Costs				
	Salaries	$ 73,467	$ 1,778,451	$ 1,851,918
	Operating Costs	60,069	537,436	597,504
	Health Dept-Postponing	-	-	-
	Contract - HP	1,349,503	8,296,325	9,645,828
Total Administrative Costs		**$ 1,483,038**	**$ 10,612,212**	**$ 12,095,250**
Total Expenditures				**$ 50,742,229**
NET CASH BALANCE		**$ 1,498,834**		**$ 5,305,673**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2016, For the Ten Month Period Ending April 30, 2016

REVENUES	FY 16 Revenue	State Share
Tobacco Tax Collections	$ 671,190	$ 671,190
TOTAL REVENUES	**$ 671,190**	**$ 671,190**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 10,164	$ 1,111	
Inpatient Hospital	1,546,842	169,070	
Outpatient Hospital	2,921,434	319,313	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	5,863	641	
Physicians	4,332,804	473,576	
Dentists	12,563	1,373	
Mid-level Practitioner	705	77	
Other Practitioners	4,476	489	
Home Health	8,673	948	
Lab & Radiology	308,180	33,684	
Medical Supplies	25,532	2,791	
Clinic Services	127,738	13,962	
Ambulatory Surgery Center	12,251	1,339	
Prescription Drugs	1,397,075	152,700	
Transportation	33,549	3,667	
Miscellaneous Medical	2,724	298	
Total OHCA Program Costs	**$ 10,750,574**	**$ 1,175,038**	
OSA DMHSAS Rehab	$ 59,581	$ 6,512	
Total Medicaid Program Costs	**$ 10,810,155**	**$ 1,181,550**	
TOTAL STATE SHARE OF COSTS			**$ 1,181,550**

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
June 30, 2016
(April 2016 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

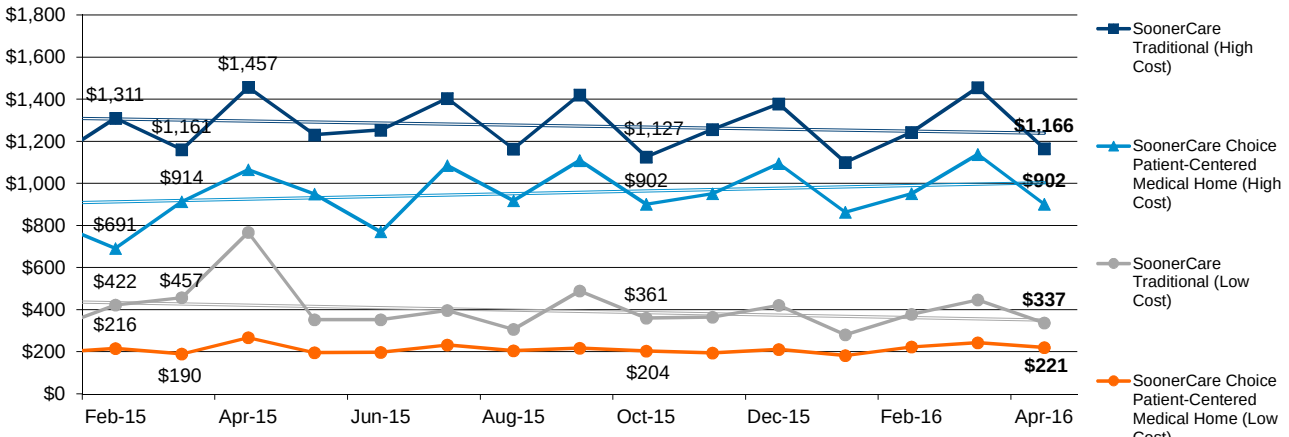
Delivery System			Enrollment April 2016	Children April 2016	Adults April 2016	Enrollment Change	Total Expenditures April 2016	PMPM April 2016	Forecasted April 2016 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**524,102**	**430,818**	**93,284**	**-4,745**	**$145,807,568**		
	Lower Cost	*(Children/Parents; Other)*	480,163	416,879	63,284	-4,516	$106,164,562	$221	$212
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,939	13,939	30,000	-229	$39,643,006	$902	$984
SoonerCare Traditional			**228,376**	**83,822**	**144,554**	**-810**	**$169,513,959**		
	Lower Cost	*(Children/Parents; Other)*	116,718	78,808	37,910	-761	$39,293,962	$337	$330
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	111,658	5,014	106,644	-49	$130,219,997	$1,166	$1,238
SoonerPlan			**32,870**	**2,786**	**30,084**	**-1,680**	**$264,086**	$8	$7
Insure Oklahoma									
	Employer-Sponsored Insurance								
	Individual Plan								
TOTAL (Excludes Insure Oklahoma)			**785,348**	**517,426**	**267,922**	**-7,235**	**$315,585,613**		

Insure Oklahoma numbers are not available due to eligibility system changes.

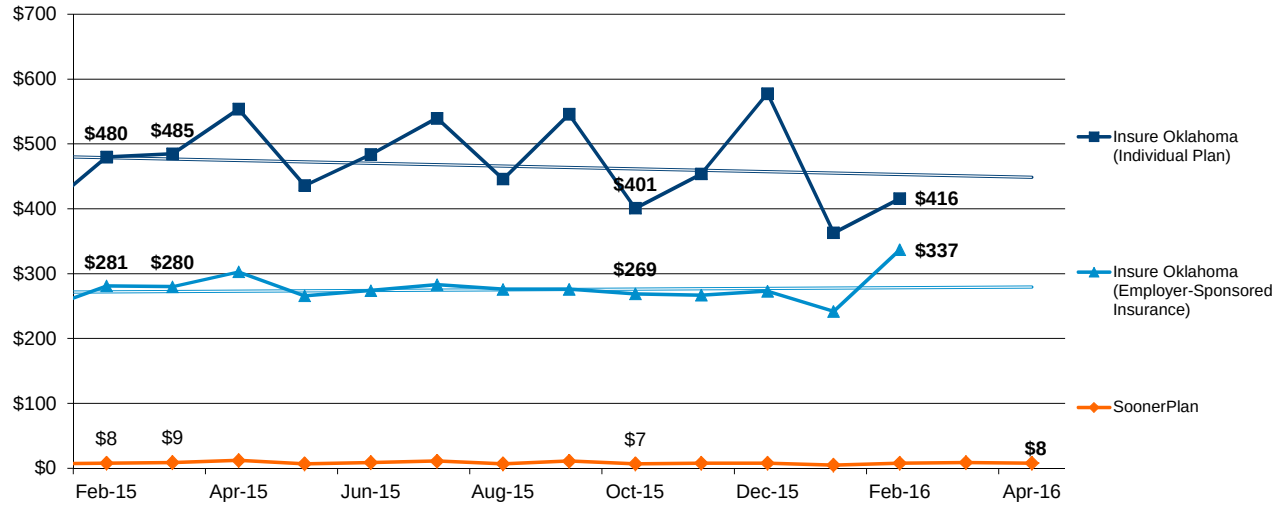
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

Total In-State Providers: 33,182 (+487)			**(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**					
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,889	952	1,235	199	5,674	648	243	6,590	2,559

PER MEMBER PER MONTH COST BY GROUP



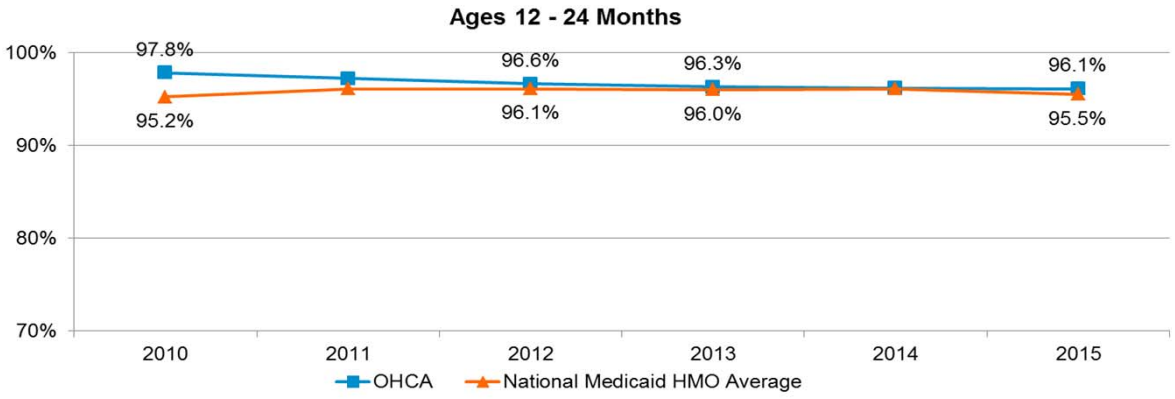
Low Cost includes members qualified under Children/Parents (TANF) and Other; High Cost members qualify under Aged, Blind or Disabled, Oklahoma Cares, TEFRA or a Home and Community-Based Services waiver.

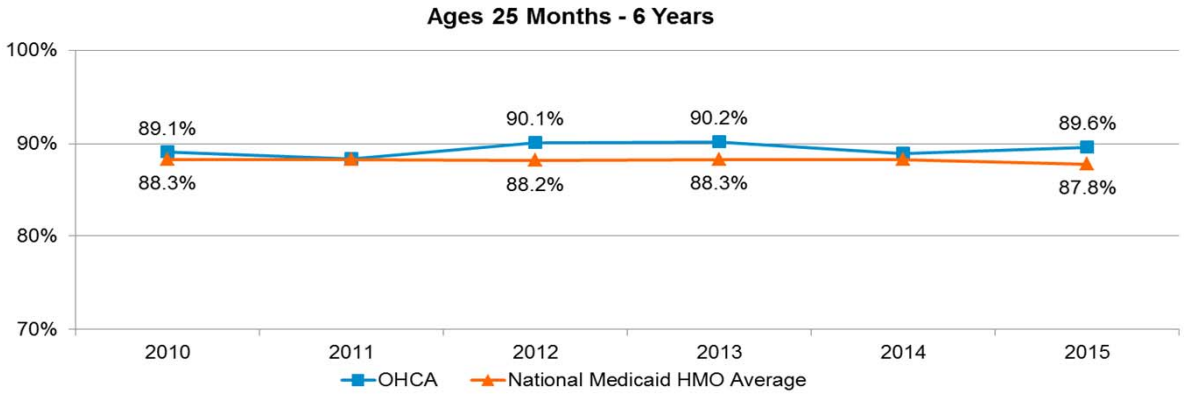


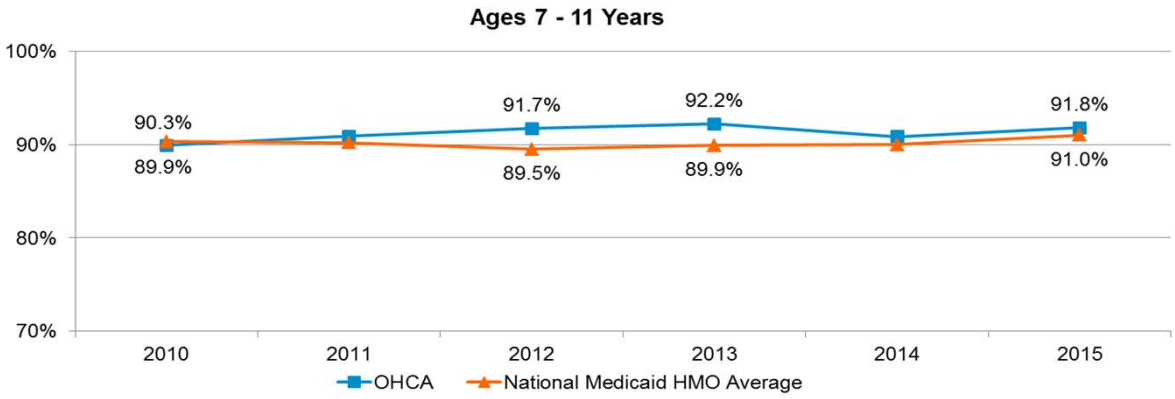
Insure Oklahoma PMPM numbers are not available for March and April due to eligibility changes.

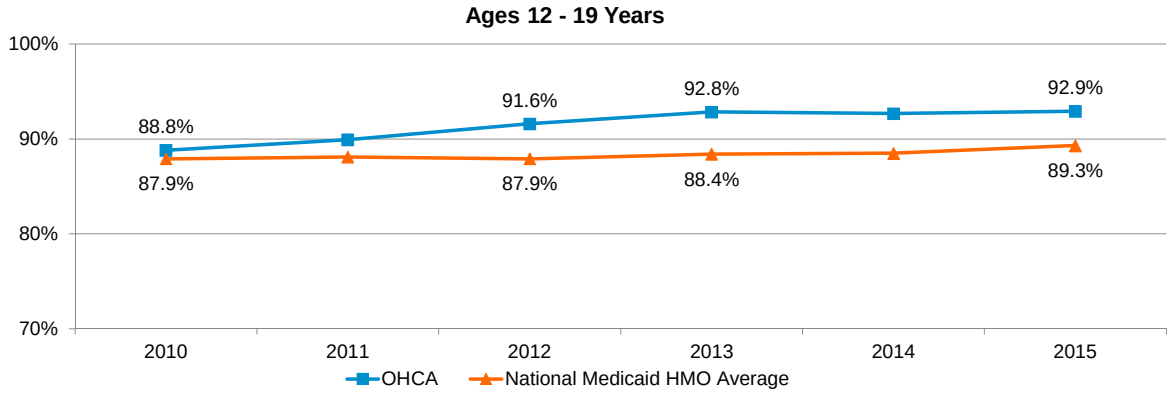
HEDIS QUALITY MEASURES - CHILDREN & ADOLESCENT'S ACCES TO PRIMARY CARE PHYSICIANS

The percentage of members 12 months to 19 years of age who had a visit with a PCP based on specific procedure codes indicating well-child visits. Children 12 months to 6 years had a PCP visit during the measurement year. Children and adolescents 7 to 19 years had a PCP visit during the current or previous measurement year. Members were continuously enrolled during the measurement year(s) with a gap in enrollment of up to 45 days allowed.Year is the reporting year while the data is for the previous year (Reporting year 2015 is 2014 calendar year data).









JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

SPARC Agenda
June 27, 2016
10:00 AM
OHCA Board Room

Rate issues to be addressed:

REGULAR NURSING FACILITIES RATES

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

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

   The increase will have a zero dollar impact to OHCA's budget as the state share that is being paid will come from the Providers by increasing the Quality of Care Fee.

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) Fee for Regular Nursing Facilities per 56 O.S. 2011, Section 2002.
   This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers (also referred to as the state share) and match them with federal funds which provides rate increases to facilities.
   Calculate the annual reallocation of the pool for the "Direct" and "Other Care" components of the rates per The State Plan.

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 total dollars.

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 required annual recalculation of the Quality of Care (QOC) fee and the annual reallocation of the pool for the "Direct" and "Other" Care components of the rates per The State Plan.

The Base Rate Component will be $107.57 per patient day.

The new combined pool amount for "Direct Care" and "Other" Component will be $158,741,836 total dollars.

The new Quality of Care (QOC) fee will be $11.07 per patient day.

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY2017 will be an increase in the total amount of $4,491,859; with $1,787,760 in state share coming from the increased QOC Fee (which is paid by the providers).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

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:

- An increase in the base rate component from $107.29 per patient day to $107.57 per patient day.
- An increase in the combined pool amount for the "Other" and "Direct Care" Components from $155,145,293 to $158,741,836 total dollars to account for the annual reallocation of the Direct Care Cost Component per The State Plan.
- An increase in the Quality of Care fee from $10.79 per patient day to $11.07 per patient day which is paid by the providers.

9. EFFECTIVE DATE OF CHANGE.

July 1, 2016

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITES RATES

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

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

   The increase will have a zero dollar impact to OHCA's budget as the state share that is being paid will come from the Providers by increasing the Quality of Care Fee.

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) Fee for nursing facilities serving residents with AIDS per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers (also referred to as the state share) and match them with federal funds which provides rate increases to facilities.

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 rate for this provider type is $198.22 per patient day.

   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 required annual recalculation of the Quality of Care (QOC) fee.

   The rate for this provider type will be $199.19 per patient day.

   The recalculated Quality of Care (QOC) fee will be $11.07 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2017 will be an increase in the total amount of $8,758; with $3,486 in state share coming from the increased QOC Fee (which is paid by the facilities).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

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:
   - An increase in the AIDS rate from $198.22 per patient day to $199.19 per patient day.
   - An increase in the Quality of Care fee from $10.79 per patient day to $11.07 per patient day.

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

ACUTE (16 BED-OR-LESS) INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATES

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

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

   The increase will have a zero dollar impact to OHCA's budget as the state share that is being paid will come from the Providers by increasing the Quality of Care Fee.

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) Fee for Acute ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers (also referred to as the state share) and match them with federal funds which provides rate increases to facilities.

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 rate for this provider type is $156.19 per patient day.

   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 required annual recalculation of the Quality of Care (QOC) fee.

   The proposed rate for this provider type will be $156.51 per patient day.

   The recalculated Quality of Care (QOC) fee will be $9.31 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2017 will be an increase in the total amount of $89,872; with $35,769 in state share coming from the increased QOC Fee (which is paid by the facilities).

AGENCY ESTIMATED IMPACT ON ACCESS TO CARE

7. The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

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:
   - An increase in the rate from $156.19 per patient day to $156.51 per patient day.
   - An increase in the Quality of Care fee from $9.18 per patient day to $9.31 per patient day.

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

REGULAR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATES

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

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

   The increase will have a zero dollar impact to OHCA's budget as the state share that is being paid will come from the Providers by increasing the Quality of Care Fee.

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) Fee for Regular ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers (also referred to as the state share) and match them with federal funds which provides rate increases to facilities.

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 rate for this provider type is $121.96 per patient day.

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 annual recalculation of the Quality of Care (QOC) fee.

   The proposed rate for this provider type will be $122.32 per patient day.

   The recalculated Quality of Care (QOC) fee will be $7.39 per patient.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2017 will be an increase in the total amount of $74,855; with $29,792 in state share coming from the increased QOC Fee (which is paid by the facilities).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

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:
   - An increase in the rate from $121.96 per patient day to $122.32 per patient day.
   - An increase in the Quality of Care fee from $7.25 per patient day to $7.39 per patient day.

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

UNBUNDLING OF OBSTETRICAL (OB) SERVICES

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 current methodology and reimbursement structure for obstetrical services. Currently, the agency utilizes the global care CPT codes for routine obstetrical care billing. The global CPT codes are allowed if the provider has provided care for a member for greater than one trimester. Bundling all obstetric services rendered utilizing a global CPT code does not allow a complete picture of the services delivered over the antepartum and postpartum period. The agency will now require providers rendering obstetrical services to bill using the appropriate evaluation and management codes for each antepartum provider visit, as well as the appropriate delivery only and postpartum provider visits when rendered. This will ensure OHCA is aware of when a member entered antepartum services, as well as completed the postpartum appointments. Our providers report prenatal care is often not initiated until late in the second or even the third trimester; however, we have no accurate way with the current global payment methodology of tracking the data. In addition, ACOG reports as many as 40% of women do not attend their postpartum appointment and OHCA providers indicate the number may be even higher. Currently 8 other states' utilize an unbundled billing/payment methodology.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Current methodology is based off a global structure and rate, inclusive of all antepartum, delivery and postpartum services.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   New methodology will be billing individual visits rendered based on the appropriate evaluation and management CPT code, as well as the delivery and postpartum services provided. A rule change (OAC 317:30-5-22) will be in effect 9/1/16.

6. **BUDGET ESTIMATE.**
The proposed budget impact is an annual total savings of $3,184,277, assuming each member will enter obstetrical care in the first trimester, obtain the number of ACOG recommended visits for antepartum care, and complete postpartum visits. Annual state savings are projected as $1,275,621.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
No impact on access is expected after discussions and agreements with representatives of the stake holders.

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 new rate methodology change for unbundling obstetrical care services.

9. **EFFECTIVE DATE OF CHANGE.**
This change will be effective September 1, 2016 to coincide with the effective date of the permanent rule referenced above. However, due to the span of prenatal care, this will be applicable to any woman entering prenatal care after September 1, 2016. Providers treating women for prenatal care prior to September 1, 2016 who have not delivered by this date will continue to utilize the global methodology.

REIMBURSEMENT FOR EYEGLASSES

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?**
   It was determined that Oklahoma could achieve a cost savings by combining professional services and the cost of eye glass materials. This would ensure a quality service was provided to our members, access was maintained, and it would keep the services within the state.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Current methodology for eyeglasses and materials/lenses are paid at a set maximum fee rate.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed rates were established by doing a comparative analysis of other state's reimbursement methodologies as well as reviewing competitive bid contracts and wholesale invoices for these products in Oklahoma and the geographical region. After review, the rate is based on reimbursement combinations of several different services, including the additional reimbursements that will be allowed for refraction and fitting fee services. The rates are recommended as follows:

   Total reimbursement for a set of eyeglasses, including refraction and fitting = $83.01

   V2020 = Eyeglass frame = $10.00 per frame
   V2100-V2114 and V2200-V2214 lens = $13.95 per lens (x 2 per one set of eyeglasses)
   V2784 = Polycarbonate lens = $0.00
   92015, refraction = will reimburse at $16.63
   92340, monofocal fitting fee = will reimburse at $28.48

With each set of eyeglasses, the provider would be reimbursed for the refraction performed, the fitting fee, and the materials would be priced separately. Currently 95% of the eyeglasses being made include polycarbonate materials, this would now be required for all eyeglass lens (with the exception of some lens where polycarbonate is not appropriate) and would not be separately reimbursed. These payments will achieve a cost savings, and maintain quality, access to care and keep the services within the state.

6. **BUDGET ESTIMATE.**
   Based on the number of paid claims for SFY2015, once implemented, the proposed budget impact is an annual total savings of $3,944,720, with a state share of $1,580,255. This is in addition to the anticipated total costs savings of $4 million for SFY16 with the previously approved polycarbonate rate adjustment.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   No impact on access is expected after discussions and agreements with representatives of the stake holders.

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 new rate methodology change for procedure code V2020 Eyeglass frame = $10.00 per frame; and V2100-V2114 and V2200-V2214 lens = $13.95 per lens; V2784 will reimburse at $0.00 as all lens would be polycarbonate material, with noted exceptions.

9. **EFFECTIVE DATE OF CHANGE.**
   Effective September 1, 2016 to coincide with implementation of the emergency rules accompanying these changes.

OKLAHOMA HEALTH CARE AUTHORITY

SFY-2017 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	SFY-2016	SFY-2017	Inc / (Dec)	% Change
Medical Program				
Managed Care - Choice / HAN / PACE	39,323,551	42,744,343	3,420,792	8.7%
Hospitals	884,211,413	907,092,262	22,880,849	2.6%
Behavioral Health	19,904,893	20,072,563	167,670	0.8%
Nursing Homes	551,632,884	568,565,843	16,932,959	3.1%
Physicians	461,642,778	468,203,707	6,560,929	1.4%
Dentists	123,695,984	125,088,912	1,392,928	1.1%
Mid-Level Practitioner	2,594,298	2,611,893	17,595	0.7%
Other Practitioners	38,126,731	39,886,437	1,759,706	4.6%
Home Health	19,165,840	19,372,976	207,135	1.1%
Lab & Radiology	61,585,904	55,566,801	(6,019,103)	-9.8%
Medical Supplies	44,762,567	45,946,589	1,184,022	2.6%
Clinic Services	120,736,260	129,485,402	8,749,142	7.2%
Ambulatory Surgery Center	7,119,794	7,045,659	(74,135)	-1.0%
Prescription Drugs	511,265,192	535,917,410	24,652,218	4.8%
Miscellaneous	232,857	191,590	(41,267)	-17.7%
ICF-MR Private	59,395,109	62,534,311	3,139,203	5.3%
Transportation	65,571,408	65,156,691	(414,717)	-0.6%
Medicare Buy-in	145,002,967	158,816,738	13,813,771	9.5%
Medicare clawback payment	85,364,027	98,812,467	13,448,441	15.8%
SHOPP - Supplemental Hosp Offset Pymt.	443,932,712	424,368,201	(19,564,511)	-4.4%
Money Follows the Person - Enhanced	701,638	353,369	(348,269)	-49.6%
Health Management Program (HMP)	9,977,280	10,277,520	300,240	3.0%
Electronic Health Records Incentive Pymts	39,788,361	39,788,361	-	0.0%
Non-Title XIX Medical	89,382	89,382	-	0.0%
TOTAL OHCA MEDICAL PROGRAM	3,735,823,831	3,827,989,429	92,165,598	2.5%
Insure Oklahoma - Premium Assistance				
Employer Sponsored Insurance - ESI	49,003,662	52,892,074	3,888,412	7.9%
Individual Plan - IP	36,849,551	29,804,409	(7,045,141)	-19.1%
TOTAL INSURE OKLAHOMA PROGRAM	85,853,212	82,696,483	(3,156,729)	-3.7%
OHCA Administration				
Operations	51,548,159	51,645,504	97,345	0.2%
Contracts	44,020,653	43,157,500	(863,153)	-2.0%
Insure Oklahoma Admin	4,122,785	4,089,019	(33,766)	-0.8%
Information Services	75,120,090	61,560,212	(13,559,878)	-18.1%
Grant Mgmt	3,570,008	4,883,562	1,313,553	36.8%
TOTAL OHCA ADMIN	178,381,695	165,335,796	(13,045,899)	-7.3%
TOTAL OHCA PROGRAMS	**4,000,058,738**	**4,076,021,709**	**75,962,971**	**1.9%**
Other State Agency (OSA) Programs				
Department of Human Services (OKDHS)	619,609,855	609,163,813	(10,446,042)	-1.7%
Oklahoma State Dept of Health (OSDH)	18,811,132	16,972,849	(1,838,283)	-9.8%
The Office of Juvenile Affairs (OJA)	8,802,467	8,346,893	(455,574)	-5.2%
University Hospitals (Medical Education Pymnts)	316,552,328	345,665,493	29,113,166	9.2%
Physician Manpower Training Commission	5,829,093	6,319,093	490,000	8.4%
Department of Mental Health (DMHSAS)	409,386,747	416,367,703	6,980,956	1.7%
Department of Education (DOE)	6,778,341	3,184,069	(3,594,272)	-53.0%
OSU Supplemental / DRG	9,000,000	-	(9,000,000)	-100.0%
Non-Indian Payments	2,114,415	1,841,891	(272,523)	-12.9%
Department of Corrections (DOC)	2,275,212	1,631,713	(643,499)	-28.3%
JD McCarty	7,037,520	7,922,686	885,166	0.0%
OSA Non-Title XIX	92,659,710	83,650,000	(9,009,710)	-9.7%
TOTAL OSA PROGRAMS	**1,498,856,820**	**1,501,066,205**	**2,209,385**	**0.1%**
TOTAL MEDICAID PROGRAM	**5,498,915,558**	**5,577,087,914**	**78,172,356**	**1.4%**

OKLAHOMA HEALTH CARE AUTHORITY

SFY-2017 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	SFY-2016	SFY-2017	Inc / (Dec)	% Change
REVENUES				
Federal - program	3,114,413,567	3,096,251,879	(18,161,688)	-0.6%
Federal - admin	114,520,729	105,045,104	(9,475,625)	-8.3%
Drug Rebates	260,639,960	291,171,060	30,531,101	11.7%
Medical Refunds	44,260,276	45,985,188	1,724,912	3.9%
NF Quality of Care Fee	77,232,726	78,716,089	1,483,363	1.9%
OSA Refunds & Reimbursements	639,929,735	650,216,325	10,286,590	1.6%
Tobacco Tax	86,379,321	83,855,811	(2,523,510)	-2.9%
Insurance Premiums	2,030,244	1,568,432	(461,812)	-22.7%
Misc Revenue	109,894	265,888	155,994	142.0%
Prior Year Carryover	47,016,727	30,652,528	(16,364,199)	-34.8%
Other Grants	3,056,078	3,158,777	102,699	3.4%
Hospital Provider Fee (SHOPP bill)	202,101,821	199,150,317	(2,951,505)	-1.5%
Insure Oklahoma Fund 245 - Transfer	25,000,000	2,000,000	(23,000,000)	-
State Appropriated	882,224,478	989,050,514	106,826,036	12.1%
TOTAL REVENUES	**5,498,915,558**	**5,577,087,914**	**78,172,356**	**1.4%**

Drug	Used for	Cost	Notes
Zepatier	Hepatitis C	$57,700 - $77,400/person	one of the least expensive
Eloctate	Hemophilia A	$9,495/week	Long acting Factor VIII
Adynovate	Hemophilia A	$10,450/week	Long acting Factor VIII
Alprolix	Hemophilia B	$9,852/week	Long acting Factor IX
Idelvion	Hemophilia B	$12,566/week	Long acting Factor IX
Obizur	Acquired Hemophilia A	$228,816/day	Porcine Factor VIII
Corifact	Factor XIII deficiency	$21,767/month	Human Factor XIII
Tretten	Factor XIII deficiency	$36,348/dose	Recombinant Factor XIII
Coagadex	Factor X deficiency	$14,302/dose	Human Factor X
Standards of Care	Pharmacies providing	clotting factor replacement	products
Crinone	Decrease risk preterm birth	$2,345/member	Savings from NICU costs
Endometrin	Decrease risk preterm birth	$2,345/member	savings from NICU costs
Humalog KwikPen	Insulin	$257/month	less expensive choices
Tresiba	Insulin	$250/month	less expensive choices
Ryzodeg 70/30	Insulin	unknown at this time	less expensive choices
Basaglar	Insulin	unknown at this time	less expensive choices
Entresto	heart failure	$4,752/year	may reduce rehospitalization

Recommendation 1: Prior Authorize Zepatier™ (Elbasvir/Grazoprevir)

The Drug Utilization Review Board recommends the prior authorization of Zepatier™ (elbasvir/ grazoprevir) with the following criteria:

Zepatier™ (Elbasvir/Grazoprevir) Approval Criteria:

1. Member must be 18 years of age or older; and
2. An FDA approved diagnosis of Chronic Hepatitis C (CHC) **genotype-1** or **genotype-4**; and
3. Member must have a METAVIR fibrosis score of **F2** or greater or equivalent scoring with an alternative test. Fibrosis testing type and scoring must be indicated on prior authorization request; and
4. Zepatier™ must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated by a gastroenterologist, infectious disease specialist, or transplant specialist for hepatitis C therapy within the last three months; and
5. Hepatitis C Virus (HCV) genotype testing must be confirmed and indicated on prior authorization request; and
6. If the member has genotype-1a, testing results for the presence of virus with NS5A resistance-associated polymorphisms must be indicated on the prior authorization request; and
7. Pre-treatment viral load (HCV-RNA) must be confirmed and indicated on the petition. Viral load should have been taken within the last three months; and
8. The following regimens and requirements based on genotype, polymorphisms, and prior treatment status will apply (all regimens apply to patients with and without cirrhosis, HIV/HCV co-infected patients, and patients with or without renal impairment):
    a. **Genotype-1a, treatment-naïve or peginterferon alfa + ribavirin experienced without baseline NS5A polymorphisms:**
        i. Zepatier™ for 12 weeks
    b. **Genotype-1a, treatment-naïve or peginterferon alfa + ribavirin experienced <u>with</u> baseline NS5A polymorphisms:**
        i. Zepatier™ with weight-based ribavirin for 16 weeks
    c. **Genotype-1b, treatment-naïve or peginterferon alfa + ribavirin experienced:**
        i. Zepatier™ for 12 weeks
    d. **Genotype-1a or -1b, peginterferon alfa + ribavirin + HCV NS3/4A protease inhibitor (e.g., boceprevir, simeprevir, teleprevir) experienced:**
        i. Zepatier™ with weight-based ribavirin for 12 weeks
    e. **Genotype-4, treatment-naïve:**
        i. Zepatier™ for 12 weeks
    f. **Genotype-4, treatment-experienced:**
        i. Zepatier™ with weight-based ribavirin for 16 weeks
    g. New regimens will apply as approved by the FDA
9. Member must sign and submit the Hepatitis C Intent to Treat contract; and

10. Member's pharmacy must submit the Hepatitis C Therapy Pharmacy Agreement for each member on therapy; and
11. The prescriber must verify that they will provide SoonerCare with all necessary labs to evaluate hepatitis C therapy efficacy including Sustained Viral Response (SVR-12); and
12. Member must have no illicit IV drug use or alcohol abuse in the last six months and member must agree to no illicit IV drug use or alcohol use while on treatment and post-therapy; and
13. Must have documentation of initiation of immunization with the hepatitis A and B vaccines; and
14. Member must not have decompensated cirrhosis or moderate-to-severe hepatic impairment (Child-Pugh B and C); and
15. Female members must not be pregnant and must have a pregnancy test immediately prior to therapy initiation. Male and female members must be willing to use two forms of non-hormonal birth control while on therapy (and for six months after therapy completion for ribavirin users); and
16. The prescriber must verify that the member's ALT levels will be monitored prior to treatment initiation, at treatment week eight, and as clinically indicated thereafter (patients receiving 16 weeks of therapy should receive additional ALT levels at treatment week 12); and
17. Member must not be taking the following medications: phenytoin, carbamazepine, rifampin, St. John's wort, efavirenz, atazanavir, darunavir, lopinavir, saquinavir, tipranavir, cyclosporine, nafcillin, ketoconazole, bosentan, etravirine, elvitegravir/cobicstat/ emtricitabine/tenofovir, or modafinil; and
18. All other clinically significant issues must be addressed prior to starting therapy including but not limited to the following: neutropenia, anemia, thrombocytopenia, surgery, depression, psychosis, epilepsy, obesity, weight-management, severe concurrent medical diseases, such as but not limited to, retinal disease, or autoimmune thyroid disease; and
19. Prescribing physician must verify that they will work with the member to ensure the member remains adherent to hepatitis C therapies; and
20. Members must be adherent for continued approval. Treatment gaps of therapy longer than 3 days/month will result in denial of subsequent requests for continued therapy.
21. Approvals for treatment regimen initiation for 12 or 16 weeks of therapy will not be granted prior to the 10th of a month in order to prevent prescription limit issues from affecting the member's compliance.

Recommendation 2: Prior Authorize Eloctate™ [Antihemophilic Factor (Recombinant), Fc Fusion Protein], Adynovate® [Antihemophilic Factor (Recombinant), PEGylated], Alprolix® [Coagulation Factor IX (Recombinant), Fc Fusion Protein], Idelvion® [Coagulation Factor IX (Recombinant), Albumin Fusion Protein], Obizur® [Antihemophilic Factor (Recombinant), Porcine Sequence], Corifact® [Factor XIII Concentrate (Human)], Tretten® [Coagulation Factor XIII A-Subunit (Recombinant)], and Coagadex® [Coagulation Factor X (Human)], and Establish Pharmacy Provider Standards of Care

The DUR Board recommends prior authorization of Eloctate™ [antihemophilic factor (recombinant), Fc fusion protein], Adynovate® [antihemophilic factor (recombinant), PEGylated], Alprolix® [coagulation factor IX (recombinant), Fc fusion protein], Idelvion® [coagulation factor IX (recombinant), albumin fusion protein], Obizur® [antihemophilic factor (recombinant), porcine sequence], Corifact® [factor XIII concentrate (human)], Tretten® [coagulation factor XIII A-subunit (recombinant)], and Coagadex® [coagulation factor X (human)] with the following criteria:

Eloctate™, Adynovate®, Alprolix®, and Idelvion® Approval Criteria:

1. An FDA approved indication; and
2. Requested medication must be prescribed by a hematologist specializing in hemophilia, or a mid-level practitioner with a supervising physician that is a hematologist specializing in hemophilia; and
3. A patient-specific, clinically significant reason why the member cannot use the following:
    a. Hemophilia A: Advate® or current factor VIII replacement product; or
    b. Hemophilia B: Benefix® or current factor IX replacement product; and
4. A half-life study must be performed to determine the appropriate dose and dosing interval.
5. Initial approval will be for the duration of the half-life study. If the half-life study shows significant benefit in prolonged half-life, subsequent approvals will be for the duration of one year.

Obizur® [Antihemophilic Factor (Recombinant), Porcine Sequence] Approval Criteria:

1. An FDA approved indication; and
2. Obizur® must be prescribed by a hematologist specializing in hemophilia, or a mid-level practitioner with a supervising physician that is a hematologist specializing in hemophilia; and
3. A patient-specific, clinically significant reason why the member cannot use Feiba® (anti-inhibitor coagulant complex) or NovoSeven® RT [coagulation factor VIIa (recombinant)]; and
4. A half-life study must be performed to determine the appropriate dose and dosing interval.
5. Initial approval will be for the duration of the half-life study. After a half-life study is performed and appropriate dose and interval is determined, subsequent approvals will be for the duration of one year.

Corifact® [Factor XIII Concentrate (Human)] and Tretten® [Coagulation Factor XIII A-Subunit (Recombinant)] Approval Criteria:

1. An FDA approved indication; and
2. Corifact® or Tretten® must be prescribed by a hematologist specializing in rare bleeding disorders, or a mid-level practitioner with a supervising physician that is a hematologist specializing in rare bleeding disorders; and
3. A half-life study must be performed to determine the appropriate dose and dosing interval.

4. Initial approval will be for the duration of the half-life study and immediate needs. After a half-life study is performed and appropriate dose and interval is determined, subsequent approvals will be for the duration of one year.

Coagadex® [Coagulation Factor X, (Human)] Approval Criteria:

1. An FDA approved indication; and
2. Coagadex® must be prescribed by a hematologist specializing in rare bleeding disorders, or a mid-level practitioner with a supervising physician that is a hematologist specializing in rare bleeding disorders; and
3. A half-life study must be performed to determine the appropriate dose and dosing interval.
4. Initial approval will be for the duration of the half-life study and immediate needs. After a half-life study is performed and appropriate dose and interval is determined, subsequent approvals will be for the duration of one year.

Additionally, the following standards of care are recommended for pharmacies providing clotting factor replacement products:

1. The Provider/Pharmacy shall be licensed as a pharmacy by the Oklahoma State Board of Pharmacy. The Pharmacist-in-Charge must be licensed as a pharmacist in Oklahoma.
2. The Provider/Pharmacy agrees that it will provide the following services:
    a. The Provider/Pharmacy shall be capable of providing a full range of factor products including all available vial sizes.
    b. The Provider/Pharmacy shall provide support services to patients on a "24/7" basis in order to assure availability of appropriate support in the event of an after-hours emergency.
    c. The Provider/Pharmacy staff shall deliver factor within 24 hours (with a delivery goal of four hours) of notification of a need due to a current bleeding episode. If the patient is not having an emergency/current bleeding episode, the Provider/Pharmacy shall deliver factor within three days of notification of need.
    d. The Provider/Pharmacy shall provide all necessary supplies for the appropriate preparation and administration of the factor product as well as appropriate sharps and bio-hazardous disposal unit (to include retrieval and destruction of the disposal unit). If the items are SoonerCare compensable, such items must be billed as durable medical equipment (DME) via a DME contract.
    e. The Provider/Pharmacy must provide access to multilingual interpreters for those patients and families for whom English is not their primary language. Interpreters must be available on a "24/7" basis, in order to assure availability in the event of an after-hours emergency.
    f. Case Management:
        i. Case Management can be performed by a pharmacist, nurse, social worker, or case manager.
        ii. An in-home patient assessment must be performed upon initiation of services and at least yearly thereafter.

1. An assessment must include, at a minimum:
    a. Verification of appropriate and adequate storage; and
    b. A current inventory of factor product and supplies; and
    c. Verification of access to a bio-hazardous waste disposal unit; and
    d. A review of current infusion/treatment records/logs; and
    e. A assessment of educational opportunities to be performed by appropriately trained staff (please refer to 3 b ii below); and
    f. Identification of any adverse events.
2. In the event a patient or caregiver refuses entry to the home, the pharmacy must re-attempt the in-home assessment within three months. If the patient or caregiver continues to deny access, the pharmacy must discuss this issue with the prescribing provider and develop an action plan to verify items set forth in subparagraph 2(f)(ii)(1) above. Documentation must be kept of any refusal, re-attempt, and action plan.
3. The in-home assessment must be completed annually and must be documented and signed by patient or caregiver and pharmacy personnel acknowledging the availability of patient and/or caregiver training and the patient/caregiver's understanding of the items set forth in subparagraph 2(f)(ii)(1) above, together with any additional information discussed.

iii. Regular follow up with the patient via telephone, video call, or in-person. This contact should be at least quarterly and must address, at a minimum:
1. All recent bleeding episodes reported should be forwarded to the prescribing practitioner immediately.
2. Current inventory:
    a. Number of factor doses on hand; and
    b. Expiration dates of vials on hand.
3. Confirmation of factor storage.
4. Adverse events:
    a. If adverse events are reported to a non-clinical case manager, a clinician should become involved immediately.

iv. Coordination of care including nursing, DME, treating practitioner, and all medications, regardless of source.

3. Educational requirements:
    a. Staff Education:
        i. Staff having contact with the patient via telephone, video calling, or in-person, must be appropriately trained and knowledgeable about hemophilia and other bleeding disorders.
        ii. Two hours of Continuing Education (CE) on hemophilia or other related bleeding disorders must be completed annually. Licensed staff must use accredited CE based on their license type. Non-licensed staff may use non-accredited CE provided by a licensed professional.

1. Staff members, whether employed or contracted by the pharmacy, who are required to complete CE include but are not limited to the following:
    a. Pharmacist in Charge; and
    b. Nurse manager; and
    c. Nurse performing direct patient care; and
    d. Social worker; and
    e. Case Manager (including customer service representatives).
2. Documentation of educational activity completed must be maintained by the pharmacy and must include the CE certificate or date of activity, staff in attendance, and name and license of professional providing activity.

b. Member and Caregiver Education:
    i. Pharmacy staff shall encourage engagement with a comprehensive hemophilia treatment center. Studies have shown better clinical outcomes for those patients engaged with a comprehensive hemophilia treatment center.
    ii. Pharmacy staff must discuss educational needs of the patient with the treating practitioner. Once educational opportunities are identified, the pharmacy staff must provide training for the patients and family members in accordance with the treating physician's or mid-level practitioner's recommendations. All patient efforts must be documented. Areas of education may include but are not limited to the following:
        1. Proper storage for factor products and ancillary supplies; and
        2. Proper disposal of bio-hazardous waste; and
        3. Preparation of factor and supplies; and
        4. Training on self-infusion; and
            a. Prescriber to provide order
                i. Professional licensed nurse (LPN or RN) to train patients or caregivers for peripheral venous access.
                ii. Licensed RN to train patients or caregivers on central line care (e.g. PICC line, InfusaPort, etc.) which includes but is not limited to access, flushing, infusions, and dressing changes.
            b. Training must be in accordance with the MASAC guidelines.
        5. Infusion/treatment record keeping; and
        6. Factor and supply management.

4. Factor Product Dispensing and Delivery:
    a. Prescriptions cannot be filled without an expressed need from the patient, caregiver or prescribing practitioner. Auto-filling is not allowed. If a prescription is written for prophylaxis with additional doses for breakthrough bleeding, then the monthly prophylaxis dispensing should not include further additional doses absent documented use of doses for breakthrough bleeding.

b. Factor products must be packaged in such a way that a patient or caregiver can easily determine what is to be used for each dose:
    i. If the factor dose to be infused only consists of one vial/box, the vial/box should be labeled as such; and
    ii. If the factor dose to be infused consists of two or more vials/boxes then each dose should be packaged as a group of appropriate vials/boxes and labeled as an individual dose.
c. Factor dose dispensed must be within 5% of the prescribed dose.
    i. If unable to provide factor dosing within 5% of prescribed dose, then pharmacy must provide proof of all available vial sizes from the manufacturer at the time dispensing occurred.
    ii. Any dose requiring more than 3 vials/boxes to be used must be approved by the prescribing practitioner and documented.
    iii. Pharmacy staff must, by the 10th of every month, fax or email to the Oklahoma Health Care Authority a record of dispensing for the previous month, to include but not limited to the member's name, SoonerCare ID, date dispensed, prescriber name, product, prescribed dose, units per vial dispensed, quantity of each vial size, how the doses were packaged if more than one vial was to be used per dose, type of treatment (prophylaxis, episodic, or breakthrough), and delivery confirmation with member or caregivers' signature.
d. Any factor product which is short-dated (expiring within 6 months) may only be dispensed after approval from the prescribing practitioner and must be documented.
e. The pharmacy staff must assure appropriate storage of the factor products and supplies including cold chain supply shipping and delivery. The pharmacy must be able to trace the supply chain from manufacturer to patient delivery.
f. The pharmacy must keep records of all lots of factor products dispensed to each patient and notify patient and treating practitioner of any recalls of dispensed factor products. The pharmacy must participate in the National Patient Notification System for clotting factor recalls.
g. The pharmacy provider must have a plan in place for delivery of factor products to the patient in the event of a natural disaster.

5. The Provider/Pharmacy must originally attest to the Oklahoma Health Care Authority these standards of care will be followed and must re-attest yearly.
6. Oklahoma Health Care Authority (OHCA) Auditing:
    a. The OHCA has the right to audit records of the blood clotting factor providers to assure all requirements are being met. The OHCA will audit these records which include but is not limited to the following:
        i. In-home assessment records; and
        ii. Educational information and training provided; and
        iii. Adverse Event records including reports to other state and federal agencies; and
        iv. Sharps and bio-hazardous waste disposal units, delivery proof, and education on proper disposal in patient record; and

v. Patient records, including:
    1. Original Prescriptions; and
    2. Dispensing records (including lot numbers and expiration dates).

b. The pharmacy will be excluded from providing blood factor products if OHCA finds that the pharmacy is out of compliance with the requirements as outlined.

Recommendation 3: Prior Authorize Vaginal Progesterone Products (Crinone® and Endometrin®)

The DUR Board recommends coverage of the following drugs with prior authorization:

Crinone® (Progesterone Vaginal Gel) Approval Criteria:

1. Current singleton pregnancy; and
2. Member must not have history of previous singleton spontaneous preterm delivery (SPTD); and
3. Cervical length of ≤ 20mm; and
4. Gestational age between 20 weeks, 0 days and 26 weeks, 6 days of gestation; and
5. A patient-specific, clinically significant reason why the member cannot use Endometrin® (progesterone vaginal insert).
6. Authorizations will be given for treatment through 36 weeks, 6 days of gestation.
7. Crinone® will not be covered for use with assisted reproductive technology (ART) for female infertility.

Endometrin® (Progesterone Vaginal Insert) Approval Criteria:

1. Current singleton pregnancy; and
2. Member must not have history of previous singleton spontaneous preterm delivery (SPTD); and
3. Cervical length of ≤ 20mm; and
4. Gestational age between 20 weeks, 0 days and 26 weeks, 6 days of gestation.
5. Authorizations will be given for treatment through 36 weeks, 6 days of gestation.
6. Endometrin® will not be covered for use with assisted reproductive technology (ART) for female infertility.

Recommendation 4: Vote to Prior Authorize Humalog® KwikPen® U-200 (Insulin Lispro), Tresiba® (Insulin Degludec), Ryzodeg® 70/30 (Insulin Degludec/Insulin Aspart), and Basaglar® (Insulin Glargine)

The DUR Board recommends the prior authorization of Humalog® KwikPen® U-200 (insulin lispro 200 units/mL), Tresiba® (insulin degludec), Ryzodeg® (insulin degludec/insulin aspart), and Basaglar® (insulin glargine) with the following criteria:

Humalog® KwikPen® U-200 (Insulin Lispro 200 Units/mL) Approval Criteria:

1. A patient-specific, clinically significant reason the member cannot use the 100 unit/mL strength is required for authorization of the 200 unit/mL strength.

Tresiba® (Insulin Degludec) Approval Criteria:

1. An FDA approved diagnosis of diabetes mellitus; and
2. A patient-specific, clinically significant reason why the member cannot use Lantus® (insulin glargine) or Levemir® (insulin detemir).

Ryzodeg® (Insulin Degludec/Insulin Aspart) Approval Criteria:

1. An FDA approved diagnosis of diabetes mellitus; and
2. A patient-specific, clinically significant reason why the member cannot use Lantus® (insulin glargine) or Levemir® (insulin detemir) with Novolog® (insulin aspart).

Basaglar® (Insulin Glargine) Approval Criteria:

1. An FDA approved diagnosis of diabetes mellitus; and
2. A patient-specific, clinically significant reason why the member cannot use Lantus® (insulin glargine) or Levemir® (insulin detemir).

Recommendation 5: Vote to Prior Authorize Entresto™ (Sacubitril/Valsartan)

The DUR Board recommends the prior authorization of Entresto™ (sacubitril/valsartan) with the following criteria:

Entresto™ (Sacubitril/Valsartan) Approval Criteria:

1. An FDA approved diagnosis of chronic heart failure (NYHA Class II, III, or IV); and
2. The prescriber must verify that the member has a left ventricular ejection fraction ≤40%; and
3. The member must be on a maximally tolerated dose of a beta-blocker or have a contraindication to beta-blocker therapy; and
4. The prescriber must verify the member has been on an angiotensin converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) for at least four weeks; and
5. The member must not take an ACE inhibitor while taking Entresto™ as concomitant use is contraindicated; and
6. Members with a diagnosis of diabetes must not be taking aliskiren while taking Entresto™ as concomitant use is contraindicated; and
7. A quantity limit of 60 tablets per 30 days will apply.