OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
August 11, 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 Approval of June 30, 2016 OHCA Board Meeting Minutes

Item to be presented by Nico Gomez, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Carrie Evans, Chief Financial Officer

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

        1.) High Risk OB Presentation – Marlene Asmussen, PCM/MAU Director

        2.) Recognition of Dr. Leon Bragg – Mike Herndon D.O., Chief Medical Officer

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

Item to be presented by Buffy Heater, Chief Strategy Officer

4. Discussion Item – ABD Care Coordination Update

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 for a rate change to reverse the 3.00% rate reduction for Private Duty Nursing (PDN) services, Emergency Transportation services, Program of All Inclusive Care for the Elderly (PACE) services, and Living Choice Program services effective September 1, 2016. These changes have an estimated annual total dollar increase of $1,949,400, of which $775,861 is state share. These amounts are already included in the SFY2017 OHCA Budget.

    b) Consideration and Vote for a rate change to reverse the 3.00% rate reduction for Medically Fragile Waiver services effective December 1, 2016. This change has an estimated annual total dollar increase of $143,763, of which $57,218 is state share. These amounts are already

included in the SFY2017 OHCA Budget.

c) Consideration and Vote for a rate change for behavioral health assessments for CPT code 90791 to $103.33 for licensed behavior health professionals and $90.41 for licensure candidates effective September 1, 2016. The Oklahoma Department of Mental Health and Substance Abuse Services estimates this change will be budget neutral.

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

7. Action Item – Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act.

Action Item – a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of ***all Emergency Rules*** in item seven in accordance with 75 Okla. Stat. § 253.

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

ODMHSAS Initiated

The following emergency rule HAS previously been approved by the Board. This rule has been REVISED for emergency rulemaking.

A) 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 two in one year. Outpatient behavioral health agencies will now be reimbursed for one initial comprehensive treatment plan and one update thereto bi-annually. These changes were previously made in emergency rules approved by the OHCA Board on April 28, 2016 in rules identified by APA WF#16-06. Rules are now being brought forward for consideration as an emergency rule since the same section of policy was amended by APA WF # 15-30, during the 2016 permanent rulemaking legislative session, and will supersede the emergency rules subsequently approved on April 28. 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.
ODMHSAS 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 # 16-09)

OHCA Initiated

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

B) AMENDING Agency rules at OAC 317:30-5-432.1 and 317:30-5-42.17 to allow SoonerCare contracted providers of vision services to be reimbursed separately for refraction in an eye exam. In addition, revisions allow SoonerCare contracted suppliers of eyeglasses to be paid a fitting fee if the requirements of a fitting fee are met. Previously, reimbursement for refraction was bundled into the payment for the eye exam and reimbursement for fitting was bundled into the payment for the eyeglass materials.
Budget Impact: There is an estimated budget savings of $3,944,720 (state share of

$1,580,255 and federal share of $2,364,465).

(Reference APA WF # 16-02)

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 **Zytiga® (Abiraterone), Jevtana® (Cabazitaxel), Xtandi® (Enzalutamide), Xofigo® (Radium-223 Dichloride), and Provenge® (Sipuleucel-T)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   (b) Consideration and vote to add **Albenza® (Albendazole) and Emverm™ (Mebendazole)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   (c) Consideration and vote to add **OsmoPrep® (Sodium Phosphate Monobasic /Sodium Phosphate Dibasic), Prepopik® (Sodium Picosulfate/ Magnesium Oxide/Citric Acid), Suclear® (Sodium Sulfate/Potassium Sulfate/ Magnesium Sulfate/PEG-3350/Sodium Chloride/Sodium Bicarbonate/Potassium Chloride), and SUPREP® (Sodium Sulfate/Potassium Sulfate/Magnesium Sulfate)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   (d) Consideration and vote to add **Nuvessa™ (Metronidazole Vaginal Gel 1.3%), Zyclara® (Imiquimod Cream), & Kristalose® (Lactulose Packets)**to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   (e) Consideration and vote to add **H.P. Acthar® Gel (Corticotropin Injection)** 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)(4) and (7).

   a) Discussion of Pending Supreme Court Litigation

10. New Business

11. ADJOURNMENT

NEXT BOARD MEETING
September 8, 2016
The Children's Center Rehabilitation Hospital
6800 Northwest 39th Expressway
Bethany, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
June 30, 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 June 29, 2016 at 10:30 a.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on June 27, 2016 at 2:00 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 1:00 p.m.

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

OTHERS PRESENT:	OTHERS PRESENT:
Katie Woodward, OKDMERP	Brian Sargent, OKDMERP
Becky Moore, OAHCP	Shawn Ashley, eCapitol
David Dude, American Cancer Society	Trevor Brown, Oklahoma Watch
Tiffany Lyon, OHCA	Harvey Reynolds, OHCA
Tatiana Reed, OHCA	Josh Bouye, OHCA
Jean Krieske, OHCA	Sherris H-Ososanya, OHCA
Terry Cothran, COP	Judy Goforth Parker, Chickasaw Nation
Brent Wilborn, OKPCA	Jim Claflin, OHCA
Linda Jaco, ABLE Tech	Haley George, OKMERP
Sue Rollice, OAIHS	Mary Brinkley, Leading Age OK
Scott Dennis, OK Allergy	Rick Snyder, OK Hosp. Assn
Melissa McCully, OHCA	Rhonda Mitchell, OHCA
C. Johnson, OHCA	Mike Fogarty
Karen Beam, OHCA	Jillian Coleman, JRLR
Kelli Broderson, OHCA	

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD MAY 23, 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:	Vice-Chairman Armstrong moved for approval of the May 23, 2016 board meeting minutes as published. The motion was seconded by Member Robison.
FOR THE MOTION:	Chairman McFall, Member Bryant
BOARD MEMBERS ABSENT:	Member Nuttle, Member McVay, Member Case

NICO GOMEZ, CHIEF EXECUTIVE OFFICER'S REPORT

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

The following OHCA All-Star was recognized.

- May 2016 All-Star – Tiffany Lyon, Procurement and Contracts Development Manager (Carrie Evans presented).

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

Ms. Evans reported on the final financial transactions through the month of April. She said that the state dollar budget variance is $7.3 million dollars with $3.1 million state for Medicaid program variance and $5.9 million for administration. Ms. Evans reported that we have a positive $3.1 million in drug rebate revenues, taxes and fees are $0.2 million under budget state dollars and settlements and overpayments are positive $1.2 million state dollars. She predicts that we will go slightly under budget in Medicaid spending for the month of June and we are probably going to finish the year slightly over in program spending but with drug rebate and administration, we do anticipate ending the year with about $10 million positive state dollar variance. Ms. Evans reported that we feel we are fully funded for FY17 and expect to have a balanced budget. However there is a concern with the way we receive some of our revenue sources, we are getting $200 million in special cash that doesn't come until December, so we may have some tough timing issues but she will keep the board up to date. This year we received $991 million in state dollars and $100 million of that was in the form of cash. $100 million will come on July 1 to help with the runs the first part of the year. The remainder will come in 12 monthly allotments, except for when we get some tobacco settlement funds at the end of April. We do have to pay one and sometimes two cycles before we get our allotment from the treasurer's office. We also have to bill and collect from all other state agencies of which we pay their portion of the run as well. We pay an average of $100 million per week in claims to providers. 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 April 2016 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program. She noted that Insure Oklahoma numbers are not included in the report due to the extensive system changes that we have been undergoing to include IO in the online enrollment process and enrollment numbers will be available in August. The last reported number for IO was in March being slightly over 19,000. She discussed the charts provided for enrollment of the in-state contracted providers and per member per cost by groups. For more detailed information, see Item 3c in the board packet.

Becky mentioned that Dr. Leon Bragg was recently recognized by Delta Dental of Oklahoma for his role as President of the Medicaid Medicare Children's Health Insurance Program Services Dental Association and National Association. The award recognized Dr. Bragg for his service and leadership. Dr. Bragg will be formally recognized at a later board meeting.

ITEM 3d / BUDGET UPDATE
Nico Gomez, Chief Executive Officer

Mr. Gomez stated that there will be no provider rate cuts in the budget and how pleased he is to be able to say that after what we thought were going to have to be significant cuts. It is a credit to SoonerCare members, health care providers and also the Governor and legislature that negotiated a budget that we could work with. We were about $15 million short but we are able to file a balanced budget. Nico thanked the board's support and guidance as we went through this last session. He mentioned that we have had some administrative tightening in terms of ensuring that we don't have unnecessary travel, expenditures (furniture, support, etc.). He also mentioned that we are in a hiring freeze for non-medical personnel and will continue with that through the end of the year.

Mr. Gomez mentioned that we usually have a Strategic Planning Conference in August, but we will only have our regular August board meeting this year. He said that we may possibly have a conference in January as an alternative.

ITEM 4 / 2015 QUALITY OF CARE IN THE SOONERCARE PROGRAM REPORT (QUALITY MEASURES)
Andy Garnand, Reporting & Statistics Manager

Mr. Garnand gave a report on the HEDIS Quality Measures for children and adolescent's access to primary care physicians. For more detailed information, see Item 3c in the board packet.

He discussed where you can find the Quality of Care report on the OHCA website: http://www.okhca.org/research.aspx?id=87 as well as highlighting a few measures in the report. For more detailed information, please refer to the link provided.

ITEM 5 / OKDMERP, CONNECTING OKLAHOMANS WITH DURABLE MEDICAL EQUIPMENT (DME)
Stan Ruffner, DMEPOS Program Director

Mr. Ruffner gave a presentation explaining and highlighting the Oklahoma Durable Medical Equipment Reuse Program. He stated that the program began 4 years ago and over $2.6 million of medical equipment items have been donated primarily for the general public. He discussed the contract with ABLE Tech, community involvement and SoonerCare support. Mr. Ruffner mentioned to get the word out that we need medical equipment donations.

ITEM 6 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS

Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 7a-f / 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 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.

MOTION: Member Bryant moved for approval of Item 7.a-d as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong

BOARD MEMBERS ABSENT: Member Nuttle, Member McVay, Member Case

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.

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

FOR THE MOTION: Chairman McFall, Member Bryant

BOARD MEMBERS ABSENT: Member Nuttle, Member McVay, Member Case

ITEM 8a / CONSIDERATION AND VOTE OF THE STATE FISCAL YEAR 2017 BUDGET WORK PROGRAM
Vickie Kersey, Director of Fiscal Planning & Procurement

Ms. Kersey presented the Fiscal Year 2017 Budget Work Program. For detailed information, see Item 8a in the board packet.

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

FOR THE MOTION: Chairman McFall, Member Robison

BOARD MEMBERS ABSENT: Member Nuttle, Member McVay, Member Case

ITEM 9a-e / 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 **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).

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

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong

BOARD MEMBERS ABSENT: Member Nuttle, Member McVay, Member Case

ITEM 10 / 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).
Nicole Nantois, Chief of Legal Services

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

MOTION: Vice-Chairman Armstrong moved for approval to move into Executive Session. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Member Bryant

BOARD MEMBERS ABSENT: Member Nuttle, Member McVay, Member Case

ITEM 11 / NEW BUSINESS

There was no new business.

ITEM 12 / ADJOURNMENT

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

Meeting adjourned at 2:36 p.m., 6/30/16

NEXT BOARD MEETING
August 11, 2016
Oklahoma Health Care Authority
OKC, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

*Initials:*_____

FINANCIAL REPORT

For the Fiscal Year Ended June 30, 2016
Submitted to the CEO & Board

- Revenues for OHCA through June, accounting for receivables, were **$3,834,234,757 or .2% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,852,168,962 or .6% under** budget.
- The state dollar budget variance through June is a **positive $15,219,563.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		(1.0)
Administration		6.6
Revenues:		
Drug Rebate		12.0
Taxes and Fees		(3.1)
Overpayments/Settlements		.7
Total FY 16 Variance	**$**	**15.2**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
For the Fiscal Year Ended June 30, 2016

REVENUES	FY16 Budget YTD	FY16 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 883,424,477	$ 882,224,477	$ (1,200,000)	(0.1)%
Federal Funds	2,233,356,269	2,198,945,809	(34,410,460)	(1.5)%
Tobacco Tax Collections	50,190,063	49,518,495	(671,568)	(1.3)%
Quality of Care Collections	76,634,335	76,129,937	(504,398)	(0.7)%
Prior Year Carryover	72,016,727	72,016,727	-	0.0%
Federal Deferral - Interest	275,292	275,292	-	0.0%
Drug Rebates	260,639,960	291,466,957	30,826,997	11.8%
Medical Refunds	44,260,276	46,091,204	1,830,928	4.1%
Supplemental Hospital Offset Payment Program	202,973,635	202,973,635	-	0.0%
Other Revenues	16,797,643	14,592,223	(2,205,420)	(13.1)%
TOTAL REVENUES	**$ 3,840,568,677**	**$ 3,834,234,757**	**$ (6,333,920)**	**(0.2)%**

EXPENDITURES	FY16 Budget YTD	FY16 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 58,103,398**	**$ 50,188,995**	**$ 7,914,403**	**13.6%**
ADMINISTRATION - CONTRACTS	**$ 114,550,412**	**$ 98,161,445**	**$ 16,388,967**	**14.3%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	39,323,551	38,625,283	698,268	1.8%
Acute Fee for Service Payments:				
Hospital Services	884,211,413	894,299,084	(10,087,671)	(1.1)%
Behavioral Health	19,351,088	19,337,396	13,692	0.1%
Physicians	461,642,778	458,936,591	2,706,187	0.6%
Dentists	123,695,984	125,385,426	(1,689,442)	(1.4)%
Other Practitioners	40,721,029	42,501,435	(1,780,406)	(4.4)%
Home Health Care	19,165,840	18,834,088	331,752	1.7%
Lab & Radiology	61,585,904	55,023,596	6,562,308	10.7%
Medical Supplies	44,762,567	45,258,210	(495,644)	(1.1)%
Ambulatory/Clinics	127,856,055	130,526,863	(2,670,809)	(2.1)%
Prescription Drugs	511,265,192	509,473,907	1,791,284	0.4%
OHCA Therapeutic Foster Care	553,805	214,773	339,031	61.2%
Other Payments:				
Nursing Facilities	551,632,884	552,957,144	(1,324,260)	(0.2)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	59,395,109	59,798,145	(403,036)	(0.7)%
Medicare Buy-In	145,002,967	142,393,936	2,609,032	1.8%
Transportation	65,804,265	65,459,113	345,152	0.5%
Money Follows the Person-OHCA	701,638	342,713	358,924	0.0%
Electonic Health Records-Incentive Payments	10,611,425	10,611,425	-	0.0%
Part D Phase-In Contribution	85,364,027	85,481,968	(117,941)	(0.1)%
Supplemental Hospital Offset Payment Program	441,657,505	441,657,505	-	0.0%
Telligen	6,674,228	6,674,228	-	0.0%
Total OHCA Medical Programs	**3,700,979,253**	**3,703,792,830**	**(2,813,577)**	**(0.1)%**
OHCA Non-Title XIX Medical Payments	89,382	25,692	63,690	0.0%
TOTAL OHCA	**$ 3,873,722,445**	**$ 3,852,168,962**	**$ 21,553,483**	**0.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (33,153,768)**	**$ (17,934,206)**	**$ 15,219,563**	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
For the Fiscal Year Ended June 30, 2016

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 38,749,674	$ 38,613,474	$ -	$ 124,389	$ -	$ 11,811	$ -
Inpatient Acute Care	1,087,375,713	602,786,721	486,687	3,457,161	315,633,482	1,684,457	163,327,204
Outpatient Acute Care	391,877,697	285,936,435	41,604	3,768,230	98,768,249	3,363,178	
Behavioral Health - Inpatient	49,162,397	11,275,534	-	235,468	25,964,760	-	11,686,635
Behavioral Health - Psychiatrist	9,352,875	8,061,863	-	-	1,291,012	-	-
Behavioral Health - Outpatient	26,423,232	-	-	-	-	-	26,423,232
Behaviorial Health-Health Home	24,249,799	-	-	-	-	-	24,249,799
Behavioral Health Facility- Rehab	237,980,470	-	-	-	-	68,464	237,980,470
Behavioral Health - Case Management	17,198,620	-	-	-	-	-	17,198,620
Behavioral Health - PRTF	80,200,090	-	-	-	-	-	80,200,090
Residential Behavioral Management	20,760,451	-	-	-	-	-	20,760,451
Targeted Case Management	67,923,841	-	-	-	-	-	67,923,841
Therapeutic Foster Care	214,773	214,773	-	-	-	-	-
Physicians	518,337,566	453,976,947	58,101	735,926	-	4,901,544	58,665,049
Dentists	125,402,706	125,372,436	-	17,280	-	12,989	-
Mid Level Practitioners	2,601,680	2,585,358	-	15,617	-	705	-
Other Practitioners	39,990,598	39,463,690	446,364	75,226	-	5,318	-
Home Health Care	18,846,264	18,824,483	-	12,176	-	9,605	-
Lab & Radiology	56,209,410	54,671,526	-	1,185,814	-	352,070	-
Medical Supplies	45,498,743	42,515,930	2,711,532	240,533	-	30,748	-
Clinic Services	131,139,566	123,429,710	-	584,618	-	150,632	6,974,605
Ambulatory Surgery Centers	7,073,154	6,931,949	-	126,633	-	14,572	-
Personal Care Services	12,307,892	-	-	-	-	-	12,307,892
Nursing Facilities	552,957,144	345,021,411	207,928,213	-	-	7,521	-
Transportation	65,280,859	62,612,918	2,626,055	-	-	41,887	-
GME/IME/DME	111,541,078	-	-	-	-	-	111,541,078
ICF/IID Private	59,798,145	48,899,361	10,898,783	-	-	-	-
ICF/IID Public	25,656,194	-	-	-	-	-	25,656,194
CMS Payments	227,875,903	227,145,644	730,259	-	-	-	
Prescription Drugs	521,105,652	507,688,904	-	11,631,744	-	1,785,003	-
Miscellaneous Medical Payments	178,254	174,986	-	-	-	3,268	-
Home and Community Based Waiver	196,011,774	-	-	-	-	-	196,011,774
Homeward Bound Waiver	83,930,394	-	-	-	-	-	83,930,394
Money Follows the Person	4,086,485	342,713	-	-	-	-	3,743,772
In-Home Support Waiver	24,928,339	-	-	-	-	-	24,928,339
ADvantage Waiver	179,431,936	-	-	-	-	-	179,431,936
Family Planning/Family Planning Waiver	5,246,087	-	-	-	-	-	5,246,087
Premium Assistance*	44,510,087	-	-	44,510,087	-	-	-
Telligen	6,674,228	6,674,228	-	-	-	-	-
Electronic Health Records Incentive Payments	10,611,425	10,611,425	-	-	-	-	-
Total Medicaid Expenditures	**$ 5,128,701,198**	**$ 3,023,832,422**	**$ 225,927,597**	**$ 66,720,904**	**$ 441,657,504**	**$ 12,443,771**	**$1,358,187,464**

* Includes $44,200,365 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
For the Fiscal Year Ended June 30, 2016

		FY16 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	589,078,528
Federal Funds		851,460,266
TOTAL REVENUES	**$**	**1,440,538,793**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	196,011,774
Money Follows the Person		3,743,772
Homeward Bound Waiver		83,930,394
In-Home Support Waivers		24,928,339
ADvantage Waiver		179,431,936
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		25,656,194
Personal Care		12,307,892
Residential Behavioral Management		15,614,191
Targeted Case Management		58,199,091
Total Department of Human Services		**599,823,583**
State Employees Physician Payment		
Physician Payments		58,665,049
Total State Employees Physician Payment		**58,665,049**
Education Payments		
Graduate Medical Education		68,738,103
Graduate Medical Education - Physicians Manpower Training Commission		5,353,295
Indirect Medical Education		32,248,316
Direct Medical Education		5,201,364
Total Education Payments		**111,541,078**
Office of Juvenile Affairs		
Targeted Case Management		2,901,574
Residential Behavioral Management		5,146,260
Total Office of Juvenile Affairs		**8,047,834**
Department of Mental Health		
Case Management		17,198,620
Inpatient Psychiatric Free-standing		11,686,635
Outpatient		26,423,232
Health Homes		24,249,799
Psychiatric Residential Treatment Facility		80,200,090
Rehabilitation Centers		237,980,470
Total Department of Mental Health		**397,738,847**
State Department of Health		
Children's First		1,298,743
Sooner Start		2,396,089
Early Intervention		4,358,116
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,992,672
Family Planning		293,576
Family Planning Waiver		4,921,858
Maternity Clinic		8,144
Total Department of Health		**15,269,199**
County Health Departments		
EPSDT Clinic		693,610
Family Planning Waiver		30,653
Total County Health Departments		**724,263**
State Department of Education		**193,555**
Public Schools		**972,761**
Medicare DRG Limit		**154,033,776**
Native American Tribal Agreements		**1,884,091**
Department of Corrections		**1,434,780**
JD McCarty		**7,858,648**
Total OSA Medicaid Programs	**$**	**1,358,187,464**
OSA Non-Medicaid Programs	**$**	**72,204,978**
Accounts Receivable from OSA	**$**	**(10,146,351)**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

For the Fiscal Year Ended June 30, 2016

REVENUES	FY 16 Revenue
SHOPP Assessment Fee	$ 202,571,118
Federal Draws	270,838,678
Interest	118,968
Penalties	283,550
State Appropriations	(30,200,000)
TOTAL REVENUES	**$ 443,612,313**

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	**$ 1,954,809**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
For the Fiscal Year Ended June 30, 2016

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 76,090,544	$ 76,090,544
Interest Earned	39,394	39,394
TOTAL REVENUES	**$ 76,129,937**	**$ 76,129,937**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 204,280,186	$ 79,015,576	
Eyeglasses and Dentures	270,447	104,609	
Personal Allowance Increase	3,377,580	1,306,448	
Coverage for Durable Medical Equipment and Supplies	2,711,532	1,048,821	
Coverage of Qualified Medicare Beneficiary	1,032,756	399,470	
Part D Phase-In	730,259	282,464	
ICF/IID Rate Adjustment	5,214,590	2,017,003	
Acute Services ICF/IID	5,684,193	2,198,646	
Non-emergency Transportation - Soonerride	2,626,055	1,015,758	
Total Program Costs	**$ 225,927,597**	**$ 87,388,795**	**$ 87,388,795**
Administration			
OHCA Administration Costs	$ 515,075	$ 257,538	
DHS-Ombudsmen	279,801	279,801	
OSDH-Nursing Facility Inspectors	400,000	400,000	
Mike Fine, CPA	16,200	8,100	
Total Administration Costs	**$ 1,211,076**	**$ 945,439**	**$ 945,439**
Total Quality of Care Fee Costs	**$ 227,138,673**	**$ 88,334,233**	
TOTAL STATE SHARE OF COSTS			**$ 88,334,233**

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
For the Fiscal Year Ended June 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	-	40,728,644	40,728,644
Interest Income	-	185,557	185,557
Federal Draws	235,637	28,642,727	28,642,727
TOTAL REVENUES	**$ 2,981,872**	**$ 69,556,928**	**$ 71,055,762**

EXPENDITURES		FY 15 Expenditures	FY 16 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 44,200,365	$ 44,200,365
	College Students		309,722	119,801
Individual Plan				
	SoonerCare Choice		$ 119,622	$ 46,270
	Inpatient Hospital		3,443,279	1,331,860
	Outpatient Hospital		3,722,316	1,439,792
	BH - Inpatient Services-DRG		229,747	88,866
	BH -Psychiatrist		-	-
	Physicians		716,240	277,042
	Dentists		13,498	5,221
	Mid Level Practitioner		14,840	5,740
	Other Practitioners		74,315	28,745
	Home Health		12,176	4,710
	Lab and Radiology		1,165,148	450,679
	Medical Supplies		229,877	88,916
	Clinic Services		576,539	223,005
	Ambulatory Surgery Center		126,318	48,860
	Prescription Drugs		11,459,957	4,432,711
	Miscellaneous Medical		-	-
	Premiums Collected		-	(528,314)
Total Individual Plan			**$ 21,903,873**	**$ 7,944,104**
	College Students-Service Costs		**$ 306,944**	**$ 118,726**
Total OHCA Program Costs			**$ 66,720,904**	**$ 52,382,995**
Administrative Costs				
	Salaries	$ 73,467	$ 2,135,366	$ 2,208,833
	Operating Costs	60,069	604,568	664,637
	Health Dept-Postponing	-	-	-
	Contract - HP	1,349,503	9,250,514	10,600,017
Total Administrative Costs		**$ 1,483,038**	**$ 11,990,448**	**$ 13,473,486**
Total Expenditures				**$ 65,856,481**
NET CASH BALANCE		**$ 1,498,834**		**$ 5,199,281**

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
For the Fiscal Year Ended June 30, 2016

REVENUES	FY 16 Revenue	State Share
Tobacco Tax Collections	$ 812,597	$ 812,597
TOTAL REVENUES	**$ 812,597**	**$ 812,597**

EXPENDITURES	FY 16 Total $ YTD	FY 16 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 11,811	$ 1,161	
Inpatient Hospital	1,684,457	165,582	
Outpatient Hospital	3,363,178	330,600	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	7,521	739	
Physicians	4,901,544	481,822	
Dentists	12,989	1,277	
Mid-level Practitioner	705	69	
Other Practitioners	5,318	523	
Home Health	9,605	944	
Lab & Radiology	352,070	34,608	
Medical Supplies	30,748	3,023	
Clinic Services	150,632	14,807	
Ambulatory Surgery Center	14,572	1,432	
Prescription Drugs	1,785,003	175,466	
Transportation	41,887	4,117	
Miscellaneous Medical	3,268	321	
Total OHCA Program Costs	**$ 12,375,308**	**$ 1,216,493**	
OSA DMHSAS Rehab	$ 68,464	$ 6,730	
Total Medicaid Program Costs	**$ 12,443,771**	**$ 1,223,223**	
TOTAL STATE SHARE OF COSTS			**$ 1,223,223**

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
August 11, 2016
(June 2016 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

Delivery System			Enrollment June 2016	Children June 2016	Adults June 2016	Enrollment Change	Total Expenditures June 2016	PMPM June 2016	Forecasted June 2016 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**529,917**	**435,860**	**94,057**	**5,826**	**$132,060,503**		
	Lower Cost	*(Children/Parents; Other)*	486,152	422,078	64,074	5,916	$93,020,211	$191	$212
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,765	13,782	29,983	-90	$39,040,292	$892	$957
SoonerCare Traditional			**225,707**	**81,896**	**143,811**	**-1,679**	**$170,910,778**		
	Lower Cost	*(Children/Parents; Other)*	114,260	76,905	37,355	-1,565	$42,422,245	$371	$368
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	111,447	4,991	106,456	-114	$128,488,534	$1,153	$1,197
SoonerPlan			**32,492**	**2,827**	**29,665**	**-108**	**$206,667**	$6	$7
Insure Oklahoma			**18,176**	**446**	**17,730**	**755**	**$6,098,179**		
	Employer-Sponsored Insurance		13,991	276	13,715	615	$4,480,803	$320	$277
	Individual Plan		4,185	170	4,015	140	$1,617,376	$386	$410
TOTAL			**806,292**	**521,029**	**285,263**	**4,794**	**$309,276,127**		

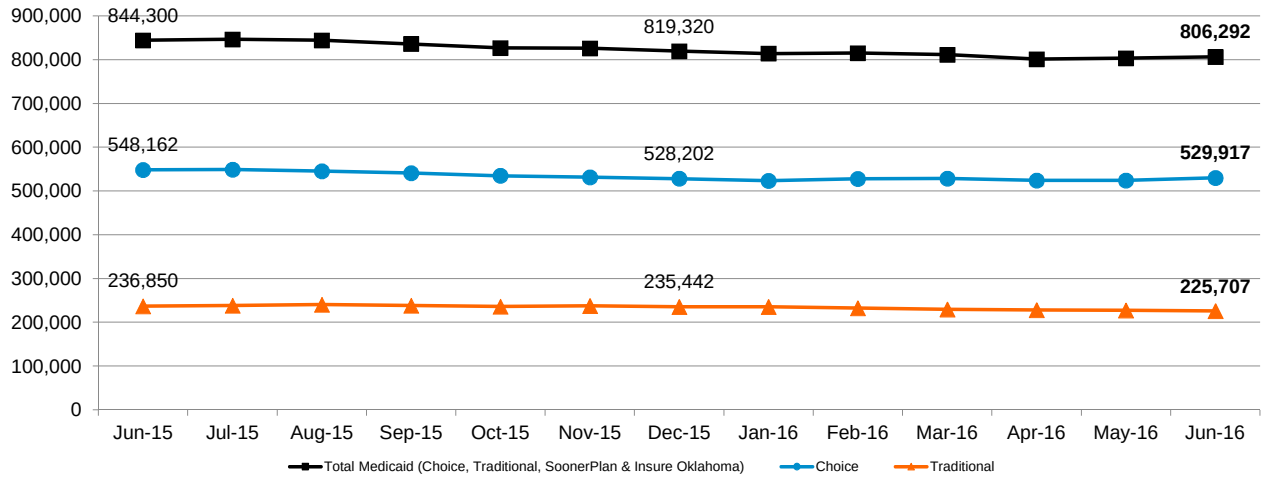
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.

Total In-State Providers: 32,815 (-528) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

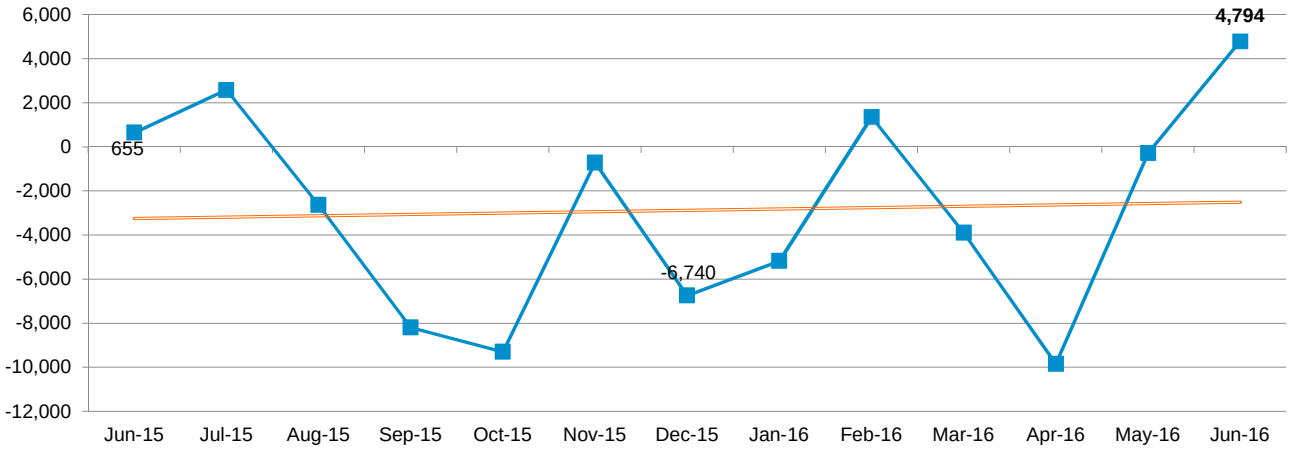
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,896	956	1,250	200	5,818	650	234	6,696	2,574

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

ENROLLMENT BY MONTH

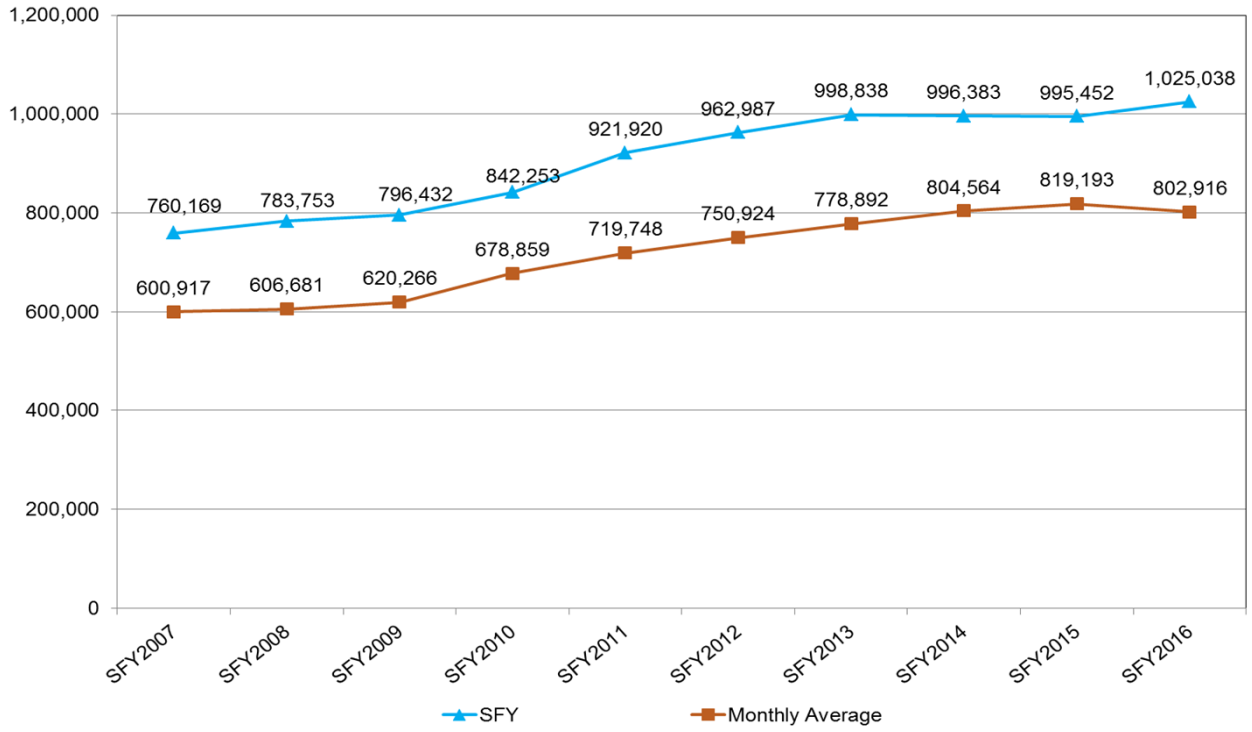


MONTHLY CHANGE IN ENROLLMENT



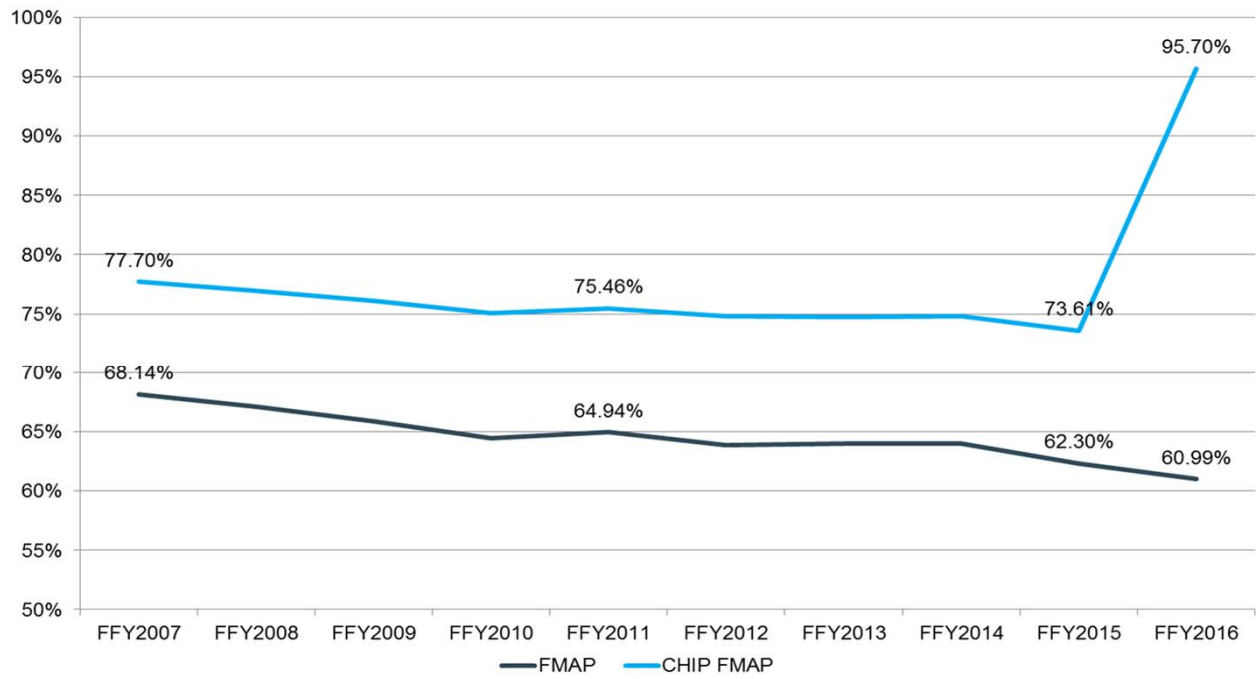
Includes Insure Oklahoma.

UNDUPLICATED SOONERCARE ENROLLMENT PER STATE FISCAL YEAR (EXCLUDES INSURE OKLAHOMA)



Figures exclude Insure Oklahoma. State Fiscal Year (SFY) is July - June. Enrollment is unduplicated.

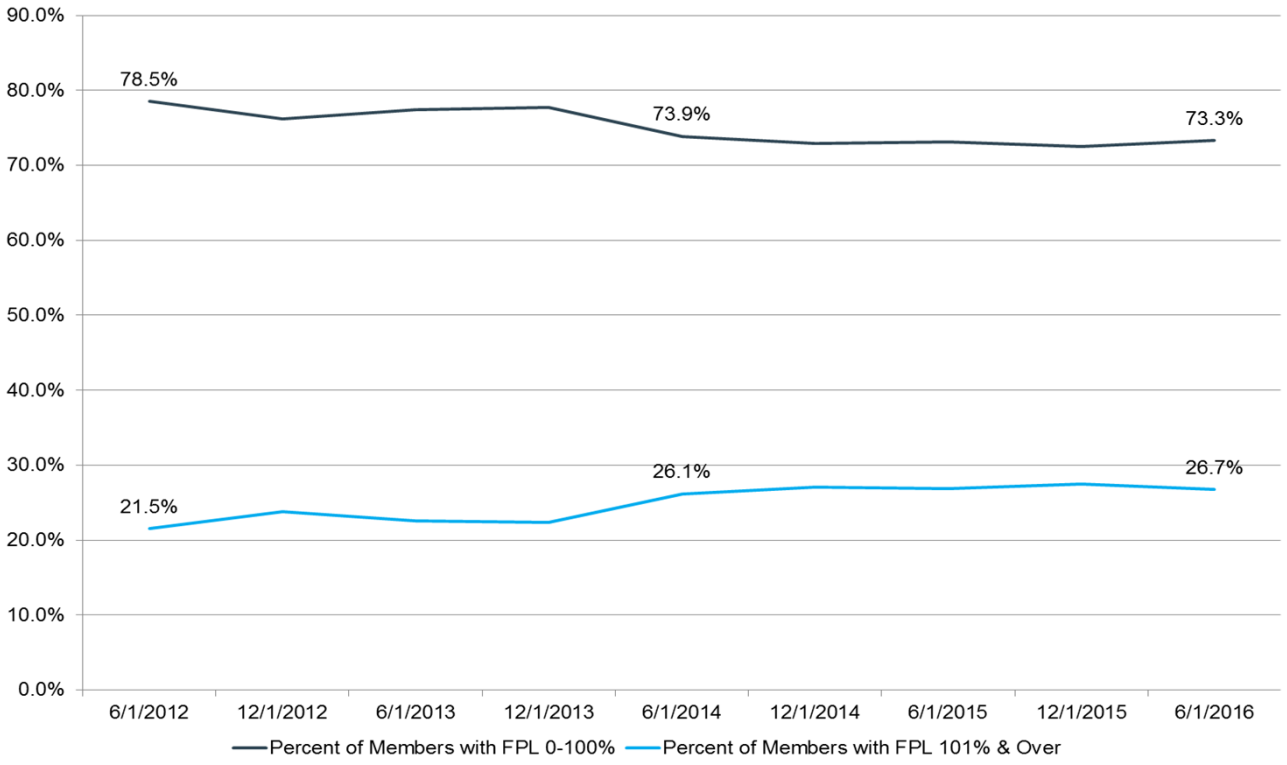
FEDERAL MATCH PERCENTAGE & ENHANCED FEDERAL MATCH PERCENTAGE (CHIP)



*The current CHIP program is authorized through 9/30/2017. If the CHIP program is not reauthorized for 2018 it will result in an approximate $40-50 million loss of federal funds.

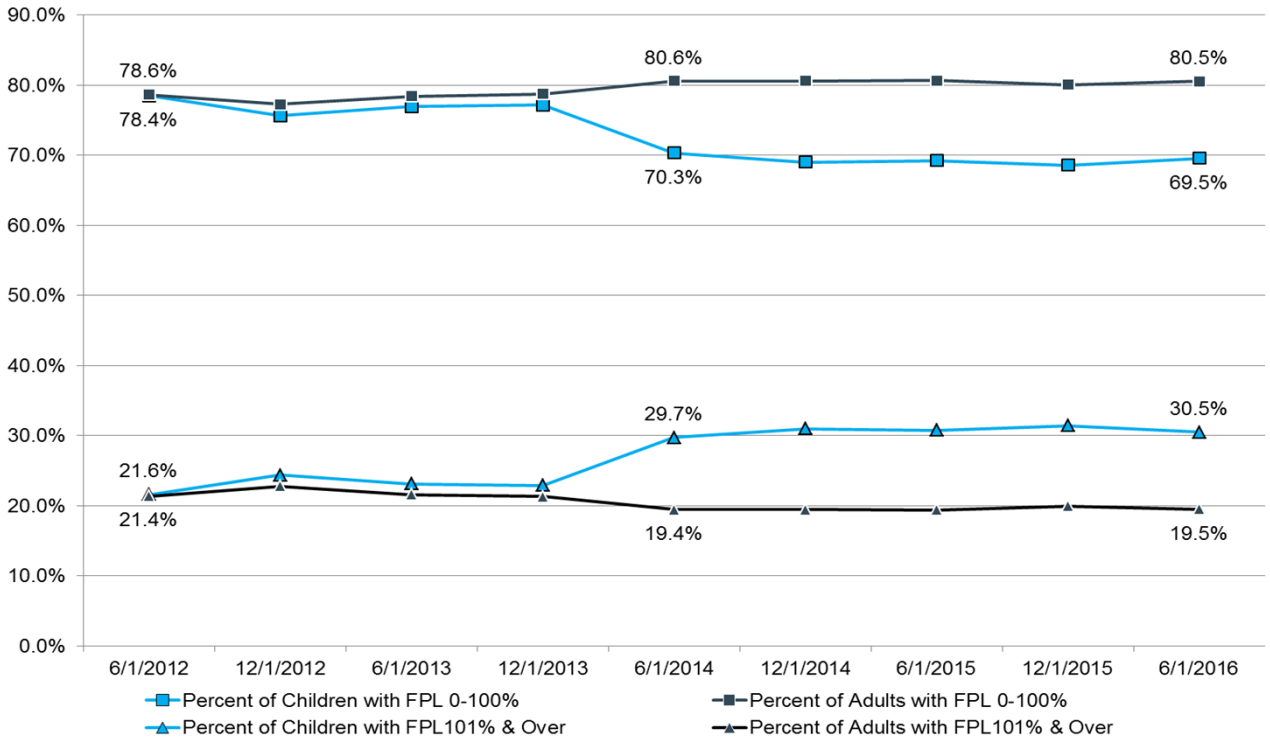
SOONERCARE BY FEDERAL POVERTY LEVEL

SoonerCare Members by Federal Poverty Level



Excludes Insure Oklahoma

SoonerCare Members by Federal Poverty Level & Age



Excludes Insure Oklahoma

POPULATION CARE MANAGEMENT

OHCA Board Meeting
August 11, 2016

Oklahoma HealthCare Authority

POPULATION CARE MANAGEMENT DEPARTMENT

Health Management Program (HMP) – Part of OHCA's chronic disease strategy

Chronic Care Management Unit – Works in tandem with HMP to serve chronic disease population

Case Management Unit – provides episodic, event-based case management services

Oklahoma HealthCare Authority

CASE MANAGEMENT UNIT

Nurses and social service coordinators provide case management for members specifically identified through programs, episodes or events (obstetrics, pediatrics, other populations)

Members are identified through data mining, self-referral, health risk assessment, provider referral, community agency/state partner agency referral, legislative referral, and intra-agency (OHCA) referral

HIGH-RISK OBSTETRICAL (HROB) CASE MANAGEMENT

Members identified for program through medical authorization process (defined list of maternal and fetal diagnoses)

Once approved, members receive enhanced benefit package (ultrasounds, fetal non-stress tests, and biophysical profiles) and case manager follow-up throughout pregnancy

Assistance in accessing resources and services for newborn and patient education

Oklahoma HealthCare Authority

HROB CASE MANAGEMENT OUTCOMES

More than 5,200 women evaluated from 2010 to 2013.

70 percent of the women were ages 21-34

15 percent under age 21

In satisfaction surveys, 93.2 percent would recommend the program to a friend

Oklahoma HealthCare Authority

HROB CASE MANAGEMENT OUTCOMES

	SFY2010	SFY2013
Early gestation/low birth weight deliveries	21.6%	16.2%
Neonatal intensive care unit (NICU) admissions	13.9%	13.0%
30-day readmission (mom)	3.4%	2.3%
60-day readmission (mom)	3.9%	2.8%
Emergency Dept. visits (mom) 30 days	11.4%	8.9%
Emergency Dept. visits (mom) 60 days	15.2%	12.8%

AT-RISK OBSTETRICAL CASE MANAGEMENT

Members identified for program through outreach letters **(Pat Brown)** and subsequent positive screening by Member Services Department OR through response to health risk assessment

Full assessment by case manager, linkage to resources, routine follow-up with member throughout pregnancy

Assistance in accessing resources and services for newborn, patient education

Oklahoma HealthCare Authority

AT-RISK OB CASE MANAGEMENT OUTCOMES

1,610 members evaluated

72.5 percent are ages 21-34

12 percent under age 21

In satisfaction surveys, 97 percent would recommend the program to a friend

Oklahoma HealthCare Authority

AT-RISK OB CASE MANAGEMENT OUTCOMES

	SFY2010	SFY2013
30-day readmission (mom)	4.7%	1.4%
60-day readmission (mom)	6.4%	1.4%
Emergency Dept. visits (mom) 30 days	16.9%	11%
Emergency Dept. visits (mom) 60 days	23.3%	13.0%

Oklahoma HealthCare Authority

QUESTIONS?

Full evaluation can be found at:

http://www.okhca.org/research.aspx?id=87

Click on “Studies and Evaluations”

- **2016 - Population Care Management Independent Evaluation**

Oklahoma HealthCare Authority

AUGUST 11th, 2016 OHCA BOARD MEETING

2016 INTERIM STUDIES

The House and Senate will consider 107 interim studies this fall. OHCA is tracking 33 of the studies, as they relate to Medicaid, public health and state government operations. A tracking report of the interim studies the agency will be monitoring is included in your Board Meeting packet.

House - A total of 71 requests were made by House members to Speaker Jeff Hickman's office; although some were combined with other studies due to duplication of requests, all interim study requests were approved. Topics include: healthcare costs and improving outcomes, spread of the Zika virus, addressing the uninsured.

Senate - A total of 36 requests were made by Senate members to President Pro Tempore Brian Bingman's office; all 36 interim study requests were assigned to a standing committee, where the committee chair has the discretion to decide if and when the study will be considered. Topics include: reinstating the uncompensated care fund, innovations of social services, examining TSET.

HB 2962

HB 2962 was signed by Governor Mary Fallin on May 4, 2016. The bill directs OHCA to work with other state agencies (Oklahoma Department of Mental Health and Substance Abuse Services, State Department of Education and Oklahoma State Department of Health) to develop a report on the feasibility and impact of including applied behavior analysis (ABA) therapy as a treatment option for SoonerCare members with autism spectrum disorder. In addition, the bill requires health benefit plans to provide coverage for the screening, diagnosis and treat of autism spectrum disorder, and sets a maximum benefit allowed for ABA treatment.

The interagency workgroup began meeting in early July, and a report will be sent to legislative leaders and the Governor's office by December 31, 2016.

Tribal Consultation Annual Meeting

Please save the date, **Wednesday, October 19, 2016,** for OHCA's 2016 Tribal Consultation Annual Meeting. OHCA will host tribal partners from 9:00 am to 12:00 pm at the Hard Rock Hotel in Catoosa/Tulsa.

An Act

ENROLLED HOUSE
BILL NO. 2962

By: Nelson, Denney, Kannady, Dunnington, Henke, Montgomery, Sherrer, McDaniel (Jeannie), Brown, Kouplen, Condit, Perryman, Cleveland, McBride, Casey, Roberts (Dustin), Kirby, Virgin, Rousselot, Cooksey, Lockhart, Cannaday, Stone, Murdock, Inman, Shelton, Griffith, Ownbey, Vaughan, Wallace, Fisher, Munson, Christian, Echols, Nollan, Wood, Loring, Bennett, Renegar, Lepak, Hoskin, Martin and Morrissette of the House

and

Griffin, Boggs, Thompson, Bass, David, Simpson, Crain, Matthews, Brooks, Fields, Bice, Floyd, Dossett and Pittman of the Senate

An Act relating to autism spectrum disorders; requiring certain coverage for certain treatments; specifying age and coverage limitations; prohibiting termination or refusal of coverage for certain reasons; stipulating limitations; providing certain construction; specifying maximum benefits under certain coverage; directing Oklahoma Insurance Commissioner to annually adjust certain limits; excluding certain payments from certain calculation; mandating inclusion of certain services; permitting insurers to review treatment plans; providing certain applications; requiring certain costs be borne by

insurer; providing certain exceptions; providing definitions; directing certain agencies to conduct certain examination; requiring certain report; directing Oklahoma Health Care Authority to submit certain documents under certain circumstances; providing limitations; providing definitions; amending 36 O.S. 2011, Section 6060.20, which relates to mandated coverage; deleting certain construction; providing exemptions under certain circumstances; specifying certain calculation; providing guidelines for issuance of exemptions; providing for codification; and providing an effective date.

SUBJECT: Autism spectrum disorders

BE IT ENACTED BY THE PEOPLE OF THE STATE OF OKLAHOMA:

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.21 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. For all plans issued or renewed on or after November 1, 2016, a health benefit plan and the Oklahoma Employees Health Insurance Plan shall provide coverage for the screening, diagnosis and treatment of autism spectrum disorder in individuals less than nine (9) years of age, or if an individual is not diagnosed or treated until after three (3) years of age, coverage shall be provided for at least six (6) years, provided that the individual continually and consistently shows sufficient progress and improvement as determined by the health care provider. No insurer shall terminate coverage, or refuse to deliver, execute, issue, amend, adjust or renew coverage to an individual solely because the individual is diagnosed with or has received treatment for an autism spectrum disorder.

B. Except as provided in subsection E of this section, coverage under this section shall not be subject to any limits on the number of visits an individual may make for treatment of autism spectrum disorder.

C. Coverage under this section shall not be subject to dollar limits, deductibles or coinsurance provisions that are less

favorable to an insured than the dollar limits, deductibles or coinsurance provisions that apply to substantially all medical and surgical benefits under the health benefit plan, except as otherwise provided in subsection E of this section.

D. This section shall not be construed as limiting benefits that are otherwise available to an individual under a health benefit plan.

E. Coverage for applied behavior analysis shall be subject to a maximum benefit of twenty-five (25) hours per week and no more than Twenty-five Thousand Dollars ($25,000.00) per year. Beginning January 1, 2018, the Oklahoma Insurance Commissioner shall, on an annual basis, adjust the maximum benefit for inflation by using the Medical Care Component of the United States Department of Labor Consumer Price Index for All Urban Consumers (CPI-U). The Commissioner shall submit the adjusted maximum benefit for publication annually before January 1, 2018, and before the first day of January of each calendar year thereafter, and the published adjusted maximum benefit shall be applicable in the following calendar year to the Oklahoma Employees Health Insurance Plan and health benefit plans subject to this section. Payments made by an insurer on behalf of a covered individual for treatment other than applied behavior analysis shall not be applied toward any maximum benefit established under this section.

F. Coverage for applied behavior analysis shall include the services of the board-certified behavior analyst or a licensed doctoral-level psychologist.

G. Except for inpatient services, if an insured is receiving treatment for an autism spectrum disorder, an insurer shall have the right to review the treatment plan annually, unless the insurer and the insured's treating physician or psychologist agree that a more frequent review is necessary. Any such agreement regarding the right to review a treatment plan more frequently shall apply only to a particular insured being treated for an autism spectrum disorder and shall not apply to all individuals being treated for autism spectrum disorder by a physician or psychologist. The cost of obtaining any review or treatment plan shall be borne by the insurer.

H. This section shall not be construed as affecting any obligation to provide services to an individual under an

individualized family service plan, an individualized education program or an individualized service plan.

I. Nothing in this section shall apply to nongrandfathered plans in the individual and small group markets that are required to include essential health benefits under the federal Patient Protection and Affordable Care Act, Public Law 111-148, or to Medicare supplement, accident-only, specified disease, hospital indemnity, disability income, long-term care or other limited benefit hospital insurance policies.

J. As used in this section:

1. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior;

2. "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the edition that was in effect at the time of diagnosis;

3. "Behavioral health treatment" means counseling and treatment programs, including applied behavior analysis, that are:

a. necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of an individual, and

b. provided by a board-certified behavior analyst or by a licensed doctoral-level psychologist so long as the services performed are commensurate with the psychologist's university training and experience;

4. "Diagnosis of autism spectrum disorder" means medically necessary assessment, evaluations or tests to diagnose whether an individual has an autism spectrum disorder;

5. "Health benefit plan" means any plan or arrangement as defined in subsection C of Section 6060.4 of Title 36 of the Oklahoma Statutes;

6. "Oklahoma Employees Health Insurance Plan" means "Health Insurance Plan" as defined in Section 1303 of Title 74 of the Oklahoma Statutes;

7. "Pharmacy care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications;

8. "Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices;

9. "Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices;

10. "Therapeutic care" means services provided by licensed or certified speech therapists, occupational therapists or physical therapists; and

11. "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed doctoral-level psychologist who determines the care to be medically necessary, including, but not limited to:

a. behavioral health treatment,

b. pharmacy care,

c. psychiatric care,

d. psychological care, and

e. therapeutic care.

SECTION 2. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 1011.12 of Title 56, unless there is created a duplication in numbering, reads as follows:

A. The Oklahoma Health Care Authority, in conjunction with the Department of Mental Health and Substance Abuse Services, the State Department of Health and the State Department of Education shall examine the feasibility of a state plan amendment to the Oklahoma

Medicaid Program for applied behavior analysis treatment of autism spectrum disorders.

B. On or before December 31, 2016, the Authority and partnering agencies shall submit a report to the President Pro Tempore of the Senate, the Speaker of the House of Representatives and the Governor estimating the potential costs to the state, clinical findings, reviews of pilot projects and research from other states on the effects of applied behavioral analysis treatment on autism spectrum disorders.

C. Beginning July 1, 2017, and subject to the availability of funding, the Authority and partnering agencies shall draft a state plan amendment for applied behavior analysis treatment of autism spectrum disorders. The provisions of this subsection shall only apply if the report required by subsection B of this section demonstrates applied behavioral analysis treatment to be evidence-based and essential to qualifying participants in the Oklahoma Medicaid Program.

D. As used in this section:

1. "Applied behavior analysis" means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior;

2. "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorders as defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the edition that was in effect at the time of diagnosis;

3. "Behavioral health treatment" means counseling and treatment programs, including applied behavior analysis, that are:

a. necessary to develop, maintain or restore, to the maximum extent practicable, the functioning of an individual, and

b. provided by a board-certified behavior analyst or by a licensed doctoral-level psychologist so long as the services performed are commensurate with the

psychologist's university training and supervised experience; and

4. "Treatment for autism spectrum disorder" means evidence-based care and related equipment prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed doctoral-level psychologist who determines the care to be medically necessary, including, but not limited to:

a. behavioral health treatment,

b. pharmacy care,

c. psychiatric care,

d. psychological care, and

e. therapeutic care.

SECTION 3. AMENDATORY 36 O.S. 2011, Section 6060.20, is amended to read as follows:

Section 6060.20 A. All individual and group health insurance policies that provide medical and surgical benefits shall provide the same coverage and benefits to any individual under the age of eighteen (18) years who has been diagnosed with an autistic disorder as it would provide coverage and benefits to an individual under the age of eighteen (18) years who has not been diagnosed with an autistic disorder.

B. As used in this section, "autistic disorder" means a neurological disorder that is marked by severe impairment in social interaction, communication, and imaginative ~~plan~~ play, with onset during the first three (3) years of life and is included in a group of disorders known as autism spectrum disorders.

~~C. Nothing in this section shall be construed to require an insurer to provide any benefits for the diagnosis or treatment of any autistic disorder.~~

SECTION 4. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 6060.22 of Title 36, unless there is created a duplication in numbering, reads as follows:

A. 1. A health benefit plan that, at the end of its base period, experiences a greater than one percent (1%) increase in premium costs pursuant to providing applied behavior analysis for treatment of autism spectrum disorders shall be exempt from the provisions of this act.

2. To calculate base-period-premium costs, the health benefit plan shall subtract from premium costs incurred during the base period, both the premium costs incurred during the period immediately preceding the base period and any premium cost increases attributable to factors unrelated to benefits for treatment of autism spectrum disorders.

3. a. To claim the exemption provided for in subsection A of this section a health benefit plan shall provide to the Insurance Commissioner a written request signed by an actuary stating the reasons and actuarial assumptions upon which the request is based.

b. The Commissioner shall verify the information provided and shall approve or disapprove the request within thirty (30) days of receipt.

c. If, upon investigation, the Commissioner finds that any statement of fact in the request is found to be knowingly false, the health benefit plan may be subject to suspension or loss of license or any other penalty as determined by the Commissioner, or the State Commissioner of Health with regard to health maintenance organizations.

SECTION 5. This act shall become effective November 1, 2016.

Passed the House of Representatives the 27th day of April, 2016.

Presiding Officer of the House of Representatives

Passed the Senate the 14th day of April, 2016.

Presiding Officer of the Senate

OFFICE OF THE GOVERNOR

Received by the Office of the Governor this 28th day of April, 2016, at 11:55 o'clock A M.

By: Audrey Rockwell

Approved by the Governor of the State of Oklahoma this 4th day of May, 2016, at 4:30 o'clock P M.

Governor of the State of Oklahoma

OFFICE OF THE SECRETARY OF STATE

Received by the Office of the Secretary of State this 4th day of May, 2016, at 4:40 o'clock P. M.

By: Chris Benge

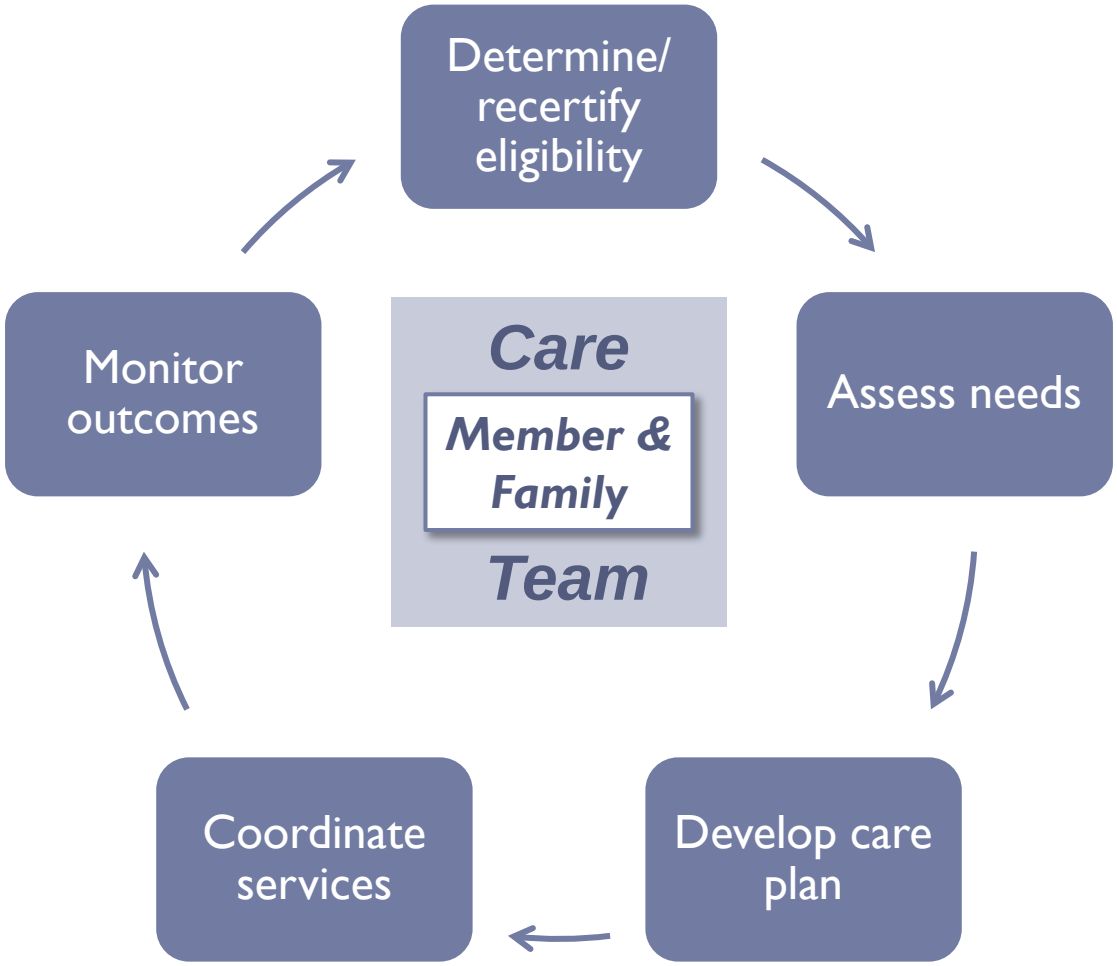
SOONERHEALTH+ UPDATE
OHCA BOARD MEETING

Slides Prepared by THE PACIFIC HEALTH POLICY GROUP
August 11, 2016

HB 1566

"The Oklahoma Health Care Authority shall initiate requests for proposals for care coordination models for aged, blind and disabled persons. Care coordination models for members receiving institutional care shall be phased in two (2) years after the initial enrollment period of a care coordination program."

STAKEHOLDERS - CARE COORDINATION CYCLE



RFP PROCESS – UPDATE

- The SoonerHealth+ draft RFP, including "model contract" standards, is nearing completion
- The draft will be submitted to CMS for review and approval
- Proposal submission requirements and evaluation criteria will be finalized while CMS performs its review of the model contract
- Work on capitation payment rates also is underway

RFP PROCESS – MODEL CONTRACT

- The model contract portion of the RFP contains MCO operational standards
- Model contract operational standards have been informed by:
  - Best practices in other states with existing managed care programs
  - CMS managed care "final rule" requirements
  - Oklahoma stakeholder recommendations

RFP PROCESS – MODEL CONTRACT

- Stakeholders provided recommendations on principles of effective care coordination through meetings and in written submissions
- Both sources were used in development of contract standards
- Many recommendations mirrored the CMS final rule
- Others were based on a desire to maintain what works well in Oklahoma today while closing identified gaps in the current system
- The model contract is 300+ pages and addresses over 20 operational areas

RFP PROCSS – MODEL CONTRACT

Member Related	Provider Related
• Enrollment and Disenrollment • Member Services • Transition of Care • Medical Management • Care and Disease Management • Native American Population • Member Complaints and Appeals	• Provider Network & Service Accessibility • Provider Contracting & Services • Indian Health Care Providers • Claims Processing
	Quality Related
	• Licensure, Administration & Staffing • Quality Improvement • Contractor Performance Standards • Program Integrity/Compliance

Note: Summary is informational only and does not include all model contract sections. CMS-approved contract will contain final sections

RFP - PROPOSAL SUBMISSION

- The proposal submission portion of the SoonerHealth+ RFP will encompass both technical requirements and price
- Technical portion will address:
  - Bidder's proposed region(s) or statewide
  - Licensure/financial
  - Experience and past performance in Oklahoma (if applicable) and other states (if applicable)
  - Approach to meeting model contract requirements ("How will you…")
  - Case studies (clinical, member experience and provider experience)
  - Medicaid/Medicare integration
  - Innovative and "value-added" proposals for serving Coordinated Care Program members and contracting with providers
- Price portion will address capitation rates
- MCOs and providers will <u>not</u> be required to execute contracts as part of MCO proposal submission

Note: Summary of proposal submission requirements is informational only. Final RFP will contain full set of requirements

NEXT STEPS

STEP	TENTATIVE DATES
Finalization and submission of draft model contract to CMS	August 2016
CMS review period	August – October 2016
Release of RFP	November 2016
Written proposals due to OHCA	January 2017 (end of month)
Contract awards	May 2017
Readiness period	June – December 2017
Start of member plan selection	January 2018
Start of Services	April 2018

JOEL NICO GOMEZ
CHIEF EXECUTIVE OFFICER

MARY FALLIN
GOVERNOR

STATE OF OKLAHOMA

OKLAHOMA HEALTH CARE AUTHORITY

SPARC Agenda
August 1, 2016
11:00 AM
OHCA Board Room

Rate issues to be addressed:

1. Reverse 3% Provider Rate Reduction for Specific Services……1-2
   - Living Choice Program
   - Private Duty Nursing (PDN)
   - Emergency Transportation
   - Program of All Inclusive Care for the Elderly (PACE)

2. Reverse 3% Provider Rate Reduction for Medically Fragile Waiver……3-4

3. Reimbursement for Behavioral Health Assessments……5-6

REVERSE 3.00% PROVIDER RATE REDUCTION FOR SPECIFIC SERVICES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, a reversal of the January 2016 3.00% reduction, to the current rates and reimbursement structure in the SoonerCare program. The reversal of the 3.00% reduction will impact only Private Duty Nursing services, Emergency Transportation services, Program of All Inclusive Care for the Elderly (PACE), and Living Choice Program services.

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 3.00% reduction from the applicable rate structures, implemented in January 2016.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   Effective September 1, 2016, OHCA seeks to reverse the 3.00% reduction for the applicable rate structure.

   The reversal of the 3.00% reduction will impact only Private Duty Nursing services, Emergency Transportation services, Program of All Inclusive Care for the Elderly (PACE), and Living Choice Program services.

6. **BUDGET ESTIMATE.**
   Annual cost for the reversal of the 3.00% reduction for Private Duty Nursing services, Emergency Transportation services, Program of All Inclusive Care for the Elderly (PACE), and Living Choice Program services is an increase in the total amount of $1,949,400; $775,861 state share. These amounts are already included in the SFY2017 OHCA Budget.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any impact on 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 accordance with requirements at 42 CFR 447.203(b)(6).

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 reversal of the 3.00% rate reduction for Private Duty Nursing services, Emergency Transportation services, Program of All Inclusive Care for the Elderly (PACE), and Living Choice Program services.

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

REVERSE 3.00% PROVIDER RATE REDUCTION FOR THE MEDICALLY FRAGILE WAIVER

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) recommends a revision, a reversal of the 3.00% reduction, to the current rates and reimbursement for Medically Fragile Waiver services.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current Medically Fragile Waiver rate structure is a fixed and uniform rate configuration established through the State Plan Amendment Rate Committee process. Rates for these services were reduced by 3.00% in April 2016.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   Effective December 1, 2016, OHCA seeks to reverse the 3.00% reduction for Medically Fragile Waiver services.

6. **BUDGET ESTIMATE.**
   Annual cost for the reversal of the 3.00% reduction is an increase in the total amount of $143,763; $57,218 state share. These amounts are already included in the SFY2017 OHCA Budget.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any impact on 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 accordance with requirements at 42 CFR 447.203(b)(6).

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 reversal of the 3.00% rate reduction.

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

REIMBURSEMENT FOR BEHAVIORAL HEALTH ASSESSMENTS

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

2. **IS THIS CHANGE AN INCREASE, DECREASE, OR NO IMPACT?**
   No Impact in the aggregate.

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   Rules were revised during 2016 permanent rulemaking to remove specific minimum time requirements for behavioral health assessment services provided in outpatient behavioral health agencies. Previous rules required at least 1.5 hours in order to bill a low complexity assessment and over 2 hours to bill a moderate complexity assessment. Current reimbursement rates vary based on the complexity of the assessment as well as whether the assessment was performed for an adult or child member. The intent of the rule change was to allow providers more flexibility in providing assessments that may not require over 1.5 hours to complete. This rate change is being proposed in order to create a uniform reimbursement rate for behavioral health assessments regardless of time spent and whether the client is a child or adult.

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

Service	LBHP	Candidate
BH Assessment moderate complexity Child	110.64	99.58
BH Assessment moderate complexity Adult	105.38	94.84
BH Assessment low complexity - Child	82.98	74.68
BH Assessment low complexity - Adult	79.03	71.13

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed rates for behavioral health assessments are $103.33 licensed behavioral health professionals and $90.41 for licensure candidates. These rates equate to 80% and 70% respectively of the CY2016 Medicare Physician Fee Schedule (MPFS) equivalent CPT code 90791 (Psychiatric Diagnostic Evaluation)

6. **BUDGET ESTIMATE.**
   ODMHSAS estimates that this change will be budget neutral.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Agency has determined that this change will have no impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Department of Mental Health and Substance Abuse Services (DMHSAS) requests the SPARC to approve the proposed reimbursement rates for Behavioral Health Assessments provided in an outpatient behavioral health agency setting in the amount of $103.33 per event by licensed behavioral health professionals and $90.41 per event by licensure candidates.

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

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS – FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.1. Screening, assessment and service plan

All providers must comply with the requirements as set forth in this Section.

(1) **Screening**.

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further BH assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population and limitations.** Screening is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months. To qualify for reimbursement, the screening tools used must be evidence based or otherwise approved by OHCA and ODMHSAS and appropriate for the age and/or developmental stage of the member.

(2) **Assessment**.

(A) **Definition**. Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other informants, or group of persons resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified practitioners**. This service is performed by an LBHP or Licensure Candidate.

(C) **Target population and limitations**. The Behavioral Health Assessment ~~by a Non-Physician, moderate complexity,~~ is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six months and it has been more than one year since the previous assessment.

(D) **Documentation requirements**. The assessment must include all elements and tools required by the OHCA. In the case of children under the age of 18, it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition. The information in the assessment must contain but is not limited to the following:

(i) Behavioral, including substance use, abuse, and dependence;

(ii) Emotional, including issues related to past or current trauma;

(iii) Physical;

(iv)Social and recreational;

(v) Vocational;

(vi)Date of the assessment sessions as well as start and stop times;

(vii) Signature of parent or guardian participating in face-to-face assessment. Signature required for members over the age of 14; and

(viii) Signature and credentials of the practitioner who performed the face-to-face behavioral assessment

(3) **Behavioral Health Services Plan Development**.

(A) **Definition**. The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member. It includes a discharge plan. It is a process whereby an individualized plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. Behavioral Health Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of 18, it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or

training. A Service Plan Development, Low Complexity is required every 6 months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

(B) **Qualified practitioners**. This service is performed by an LBHP or Licensure Candidate.

(C) **Time requirements**. Service Plan updates must be conducted face-to-face and are required every six months during active treatment. Updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member, but are only compensable twice in one year.

(D) **Documentation requirements**. Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences(SNAP);

(ii) identified presenting challenges, problems, needs and diagnosis;

(iii) specific goals for the member;

(iv) objectives that are specific, attainable, realistic, and time-limited;

(v) each type of service and estimated frequency to be received;

(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;

(vii) any needed referrals for service;

(viii) specific discharge criteria;

(ix) description of the member's involvement in, and responses to, the service plan, and his/her signature and date;

(x) service plans are not valid until all signatures are present (signatures are required from the member, if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate; and

(xi) all changes in service plan must be documented in a service plan update (low complexity) or within the service plan until time for the update (low complexity). Any changes to the existing service plan must be signed and dated by the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the lead LBHP or Licensure Candidate.

(xii) Updates to goals, objectives, service provider, services, and service frequency, must be documented within the service plan until the six month review/update is due.

(xiii) Service plan updates must address the following:

(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;

(II) progress, or lack of, on previous service plan goals and/or objectives;

(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;

(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(V) change in frequency and/or type of services provided;

(VI) change in practitioner(s) who will be responsible for providing services on the plan;

(VII) change in discharge criteria;

(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and

(IX) service plans are not valid until all signatures are present. The required signatures are: from the member (if 14 or over), the parent/guardian (if younger than 18 or otherwise applicable), and the primary LBHP or Licensure Candidate.

(E) **Service limitations**:

(i) Behavioral Health Service Plan Development, Moderate complexity (i.e., pre-admission procedure code group) are limited to 1 per member, per provider, unless more than a year has passed between services, then another one can be requested and may be authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six months during active treatment. Updates can be conducted whenever needed as determined by the provider and member but are only reimbursable twice in one year. The date of service is when the service plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

(4) **Assessment/Evaluation testing**.

(A) **Definition**. Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Service Plan. The medical record must

clearly document the need for the testing and what the testing is expected to achieve.

(B) **Qualified practitioners**. Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist, an LBHP or Licensure Candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the Oklahoma Health Care Authority.

(C) **Documentation requirements**. All psychological services must be reflected by documentation in the member's record. All assessment, testing, and treatment services/units billed must include the following:

(i) date;

(ii) start and stop time for each session/unit billed and physical location where service was provided;

(iii) signature of the provider;

(iv) credentials of provider;

(v) specific problem(s), goals and/or objectives addressed;

(vi) methods used to address problem(s), goals and objectives;

(vii) progress made toward goals and objectives;

(viii) patient response to the session or intervention; and

(ix) any new problem(s), goals and/or objectives identified during the session.

(D) **Service Limitations**. Testing for a child younger than three must be medically necessary and meet established Child (0-36 months of Age) criteria as set forth in the Behavioral Health Provider Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. Eight hours/units of testing per patient over the age of three, per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Behavioral Health Provider Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of 12 hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician

or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving Residential level treatment in either a therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in State and Federal Agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school setting the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. Individuals who qualify for Part B of Medicare: Payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 45. OPTOMETRISTS

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

(a) When medically necessary, payment will be made for lenses, frames, low vision aids and certain tints for children. Coverage includes lenses and frames to protect children with monocular vision. Coverage includes two sets of non-high-index polycarbonate lenses and frames per year. Any ~~high-index lenses or frames~~glasses beyond this limit must be prior authorized and determined to be medically necessary. All non-high-index lenses must be polycarbonate.

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

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

(d) Providers must accept ~~SoonerCare's payment~~SoonerCare reimbursement as payment in full for services rendered, except when authorized by SoonerCare (e.g., copayments, other cost sharing arrangements authorized by the State).

(1) Providers must be able to dispense standard eyeglasses which SoonerCare would fully reimburse with no cost to the eligible member.

(2) If the member wishes to select eyeglasses with special features which exceed the SoonerCare allowable fee, the member may be billed the excess cost. The provider must obtain signed consent from the member acknowledging that they are selecting eyeglasses that will not be covered in full by SoonerCare and that they will be responsible to pay the excess cost. The signed consent must be included in the member's medical record.

(e) Replacement of or additional lenses and frames are allowed when medically necessary. The OHCA does not cover lenses or frames meant as a backup for the initial lenses/frames. Prior authorization is not required unless the number of glasses exceeds two per year. The provider must always document in the patient record the reason for the replacement or additional eyeglasses. The OHCA or its designated agent will conduct ongoing monitoring of replacement frequencies to ensure OHCA

policy is followed. Payment adjustments will be made on claims not meeting these requirements.
(f) A fitting fee will be paid if there is documentation in the record that the provider or technician took measurements of the patient's anatomical facial characteristics, recorded lab specifications and made final adjustment of the spectacles to the visual axes and anatomical topography. A fitting fee can only be paid in conjunction with a pair of covered glasses.
~~(f)~~(g) Bifocal lenses for the treatment of accommodative esotropia are a covered benefit. Progressive lenses, trifocals, photochromic lenses and tints for children require prior authorization and must satisfy the medical necessity standard. ~~Polycarbonate lenses are covered for children when medically necessary.~~ Payment is limited to two glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
~~(g)~~(h) Progressive lenses, aspheric lenses, tints, coatings and photochromic lenses for adults are not compensable and may be billed to the patient.
~~(h)~~(i) Replacement of lenses and frames due to abuse and neglect by the member is not covered.
~~(i)~~(j) Bandage contact lenses are a covered benefit for adults and children. Contact lenses for medically necessary treatment of conditions such as aphakia, keratoconus, following keratoplasty, aniseikonia/anisometropia or albinism are a covered benefit for adults and children. Other contact lenses for children require prior authorization and must satisfy the medical necessity standard.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.17. Non-covered services

In addition to the general program exclusions [OAC 317:30-5-2(a)(2)] the following are excluded from coverage:

(1) Inpatient admission for diagnostic studies that could be performed on an outpatient basis.

(2) Procedures that result in sterilization which do not meet the guidelines set forth in this Chapter of rules.

(3) Reversal of sterilization procedures for the purposes of conception are not covered.

(4) Medical services considered experimental or investigational.

(5) Payment for removal of benign skin lesions for adults.

(6) ~~Refractions and visual~~Visual aids.

(7) Charges incurred while the member is in a skilled nursing

or swing bed.
(8) Sleep studies for adults.

Drug	Used for	Cost	Notes
Zytiga	Prostate cancer	$9,000 per month	metastatic second line
Jevtana		$33,600 per dose	metastatic second line
Xtandi		$9,300 per month	metastatic second line
Xofigo		$91,000/dose x6 doses	metastatic
Provenge		$42,760/dose x 3 doses	metastatic
Albenza	Intestinal worms	$389/ initial course	better price after rebate
Emverm		$354/ initial course	
OsmoPrep	Bowel prep	$190	Compare to $12-$40
Prepopik		$130	
Suclear		$74	
SUPREP		$85	
Nuvessa	Anti-infective	$180	Compare to $92
Zyclara	Skin conditions	$2,200	Compare to $252
Kristalose	Constipation	$200-$800/month	Compare to $9-$36/month
HP Acthar Gel	Infantile spasms	$100,000 + per treatment	

Recommendation 1: Prior Authorize Zytiga® (Abiraterone), Jevtana® (Cabazitaxel), Xtandi® (Enzalutamide), Xofigo® (Radium-223 Dichloride), and Provenge® (Sipuleucel-T)

The Drug Utilization Review Board recommends prior authorization of Zytiga, Jevtana, Xtandi, Xofigo, and Provenge with the following criteria:

Zytiga® (Abiraterone) Approval Criteria:

1. A diagnosis of metastatic, castration-resistant prostate cancer; and
2. Abiraterone must be used in combination with a corticosteroid; and
3. Approvals will be for the duration of three months at which time additional authorization may be granted if the prescriber documents that the member has not shown evidence of progressive disease while on abiraterone therapy.

Jevtana® (Cabazitaxel) Approval Criteria:

1. A diagnosis of metastatic, castration-resistant prostate cancer; and
2. Member must have been previously treated with a docetaxel-containing regimen; and
3. Cabazitaxel should be used in combination with prednisone; and
4. Approvals will be for the duration of three months at which time additional authorization may be granted if the prescriber documents that the member has not shown evidence of progressive disease while on cabazitaxel therapy.

Xtandi® (Enzalutamide) Approval Criteria:

1. A diagnosis of metastatic, castration-resistant prostate cancer; and
2. Approvals will be for the duration of three months at which time additional authorization may be granted if the prescriber documents that the member has not shown evidence of progressive disease while on enzalutamide therapy.

Xofigo® (Radium-223 Dichloride) Approval Criteria:

1. A diagnosis of metastatic, castration-resistant prostate cancer; and
2. Member must have symptomatic bone metastases; and
3. Member must not have known visceral metastatic disease; and
4. Prescriber must verify radium-223 is not to be used in combination with chemotherapy; and
5. Member must have an absolute neutrophil count ≥ 1.5 x 10^9/L, platelet count ≥ 100 x 10^9/L, and hemoglobin ≥10 g/dL; and
6. Approvals will be for the duration of three months at which time additional authorization may be granted if the prescriber documents the following:
    a. The member has not shown evidence of progressive disease while on radium-223 dichloride therapy; and
    b. Member must have an absolute neutrophil count ≥ 1 x 10^9/L, platelet count ≥ 100 x 10^9/L (radium-223 dichloride should be delayed 6 to 8 weeks otherwise).

Recommendation 2: Prior Authorize Albenza® (Albendazole) and Emverm™ (Mebendazole)

The Drug Utilization Review Board recommends the prior authorization of Albenza® (albendazole) and Emverm™ (mebendazole) with the following criteria:

Albenza® (Albendazole) Approval Criteria:

1. A quantity of six tablets per 180 days will process without prior authorization. For infections requiring additional doses, a prior authorization will need to be submitted and the following criteria will apply:
    a. An FDA approved diagnosis of one of the following:
        i. Treatment of parenchymal neurocysticercosis due to active lesions caused by larval forms of the pork tapeworm, *Taenia solium*.
        ii. Treatment of cystic hydatid disease of the liver, lung, and peritoneum, caused by the larval form of the dog tapeworm, *Echinococcus granulosus*.

Emverm™ (Mebendazole) Approval Criteria:

1. An FDA approved diagnosis of any of the following:
    a. Treatment of *Enterobius vermicularis* (pinworm); or
    b. Treatment of *Trichuris trichiura* (whipworm); or
    c. Treatment of *Ascaris lumbricoides* (common roundworm); or
    d. Treatment of *Ancylostoma duodenale* (common hookworm); or
    e. Treatment of *Necator americanus* (American hookworm); and
2. For the treatment of *Enterobius vermicularis* (pinworms), *Ascaris lumbricoides* (common roundworm), *Ancylostoma duodenale* (common hookworm), or *Necator americanus* (American hookworm), a patient-specific, clinically significant reason why a more cost-effective anthelmintic therapy, such as albendazole or pyrantel pamoate, cannot be used must be provided.
3. The following quantity limits will apply:
    a. *Enterobius vermicularis (*pinworms): 2 tablets per 30 days
    b. *Trichuris trichiura* (whipworm): 6 tablets per 30 days
    c. *Ascaris lumbricoides* (common roundworm): 6 tablets per 30 days
    d. *Ancylostoma duodenale* (common hookworm): 6 tablets per 30 days
    e. *Necator americanus* (American hookworm): 6 tablets per 30 days

Recommendation 3: Vote to Prior Authorize OsmoPrep® (Sodium Phosphate Monobasic/Sodium Phosphate Dibasic), Prepopik® (Sodium Picosulfate/ Magnesium Oxide/Citric Acid), Suclear® (Sodium Sulfate/Potassium Sulfate/ Magnesium Sulfate/PEG-3350/Sodium Chloride/Sodium Bicarbonate/Potassium Chloride), and SUPREP® (Sodium Sulfate/Potassium Sulfate/Magnesium Sulfate)

The Drug Utilization Review Board recommends the prior authorization of OsmoPrep®, Prepopik®, Suclear®, and SUPREP® with the following criteria:

OsmoPrep®, Prepopik®, Suclear®, and SUPREP® Approval Criteria:

1. An FDA approved indication for use in cleansing of the colon as a preparation for colonoscopy; and
2. A patient-specific, clinically significant reason other than convenience the member cannot use other bowel preparation medications available without prior authorization.
3. If the member requires a low volume polyethylene glycol electrolyte lavage solution, Moviprep® is available without prior authorization. Other medications currently available without a prior authorization include: Colyte®, Gavilyte®, Golytely®, and Trilyte®.

Recommendation 4: Prior Authorize Nuvessa™ (Metronidazole Vaginal Gel 1.3%), Zyclara® (Imiquimod Cream), & Kristalose® (Lactulose Packets)

The Drug Utilization Review Board recommends the prior authorization of Nuvessa™ (metronidazole vaginal gel 1.3%), Zyclara® (imiquimod), and Kristalose® (lactulose packets for oral solution) with the following criteria:

1. **Nuvessa™ (Metronidazole Vaginal Gel 1.3%) Approval Criteria:**
   a. An FDA approved diagnosis of bacterial vaginosis in non-pregnant women; and
   b. A patient-specific, clinically significant reason why the member cannot use MetroGel-Vaginal® 0.75% (metronidazole vaginal gel 0.75%) or the generic metronidazole oral tablet.

2. **Zyclara® (Imiquimod) 2.5% and 3.75% Cream Approval Criteria:**
   a. An FDA approved diagnosis of actinic keratosis (AK) of the full face or balding scalp in immunocompetent adults or topical treatment of external genital and perianal warts/condyloma acuminata (EGW) in patients 12 years and older; and
   b. Member must be 12 years or older; and
   c. Requests for a diagnosis of molluscum contagiosum in children 2 to 12 years of age will generally not be approved; and
   d. A patient-specific, clinically significant reason why the member cannot use generic imiquimod 5% cream in place of Zyclara® (imiquimod) 2.5% and 3.75%.

3. **Kristalose® (Lactulose Packets for Oral Solution) Approval Criteria:**
   a. A patient-specific, clinically significant reason why the member cannot use the liquid lactulose formulation.

Recommendation 5: Prior Authorize H.P. Acthar® Gel (Corticotropin Injection)

The Drug Utilization Review Board recommends prior authorization of H.P. Acthar Gel with the following criteria:

1. An FDA approved diagnosis of infantile spasms; and
   a. Member must be two years of age or younger; and

    b. Must be prescribed by, or in consultation with, a neurologist or an advanced care practitioner with a supervising prescriber that is a neurologist; or
2. An FDA approved diagnosis of multiple sclerosis (MS); and
    a. Member is experiencing an acute exacerbation; and
    b. Must be prescribed by, or in consultation with, a neurologist or an advanced care practitioner with a supervising prescriber that is a neurologist or a physician that specializes in MS; and
    c. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy (e.g. IV methylprednisolone).
    d. Therapy will be limited to five weeks per approval (three weeks of treatment, followed by taper). Additional approval, beyond the initial five weeks, will require prescriber documentation of response to initial treatment and need for continued treatment; or
3. An FDA approved diagnosis of nephrotic syndrome without uremia of the idiopathic type or that is due to lupus erythematosus to induce a diuresis or a remission; and
    a. Must be prescribed by, or in consultation with, a nephrologist or an advanced care practitioner with a supervising prescriber that is a nephrologist; and
    b. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy (e.g., prednisone); or
4. An FDA approved diagnosis of the following disorders and diseases: rheumatic; collagen; dermatologic; allergic states; ophthalmic; respiratory; and edematous states; and
    a. A patient-specific, clinically significant reason why the member cannot use alternative corticosteroid therapy.