OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
June 29, 2017 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
OKC, OK

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the May 25, 2017 OHCA Board Meeting Minutes

Item to be presented by Becky Pasternik-Ikard, Chief Executive Officer

3. Discussion Item – Chief Executive Officer's Report

    a) Financial Update – Gloria Hudson, Director of General Accounting

    b) Medicaid Director's Update – Garth Splinter, Deputy Chief Executive Officer

    c) Legislative Update – Lindsey Bateman, Assistant Director of Government Relations

    d) Program Integrity Audit Update – Josh Richards, Director of Provider Audits

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

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

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

5. Action Item – Consideration and Vote upon the Recommendations of the State Plan Amendment Rate Committee

    a) Consideration and Vote for a rate change to increase the base rate component to $107.79 for Regular Nursing Facilities and increase the pool amount for these facilities in the state plan for the "Other" and "Direct Care" components to $160,636,876. In SFY2018, this change has an estimated total dollar increase of $3,329,018, of which $1,367,893 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 $200.01 for the Acquired Immune Deficiency Syndrome (AIDS) rate for Nursing Facilities. In SFY2018, this change has an estimated total dollar increase of $7,016 of which $2,883 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 $157.03 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 $129,929, of which $53,388 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 $122.77 for Regular Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). In SFY2017, this change has an estimated total dollar increase of $79,253, of which $32,565 is state share coming from the increased Quality of Care Fee, which is paid by the facilities.

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

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

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

OHCA Initiated

a) AMENDING agency rules at OAC 317:35-5-41.6 to comply with federal regulation. The Fairness in Medicaid Supplemental Needs Trusts adds language into the Social Security Act to give mentally competent disabled individuals the same right to create an exempt trust as a parent, grandparent, guardian, or court. Rules are revised to include these changes in federal regulation. The Fairness Act will apply to trusts established on or after December 13, 2016. Other requirements of these types of trusts, which are exempt from Medicaid resource limits, remain unchanged.
Budget Impact: Budget neutral

(Reference APA WF # 17-01)

ODMHSAS Initiated

b) ADDING agency rules at OAC 317:30-5-1207 to include a fourth population to be served in the Money Follows the Person (MFP) demonstration. The intent of the change is to develop an implementation plan to transition eligible individuals from Psychiatric Residential Treatment Facilities (PRTF) back into the community. Oklahoma's MFP Demonstration for PRTF transitioning will focus on transitioning youth 16 to 18 years of age who have been in an inpatient psychiatric residential facility for 90 or more days during an episode of care. The individuals must meet criteria for Level 3 on the Individual Client Assessment Record or meet the criteria of Serious Emotional Disturbance. They may also show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale, or a score of 44 and below on the Functioning Subscales). In addition, the individuals will be eligible for transitional and community-based services and medications under Oklahoma's Living Choice Program. Services will be provided in accordance with an individualized plan of care under the direction of appropriate service providers.
ODMHSAS Budget Impact: The budget impact is approximately $695,739 total federal dollars, $174,261 state dollars. State share will be paid by the ODMHSAS.

(Reference APA WF # 17-04A)

c) AMENDING agency rules at OAC 317:35-23-2 and 317:35-23-3 to include a fourth population to be served in the Money Follows the Person (MFP) demonstration. The intent of the change is to develop an implementation plan to transition eligible individuals from Psychiatric Residential Treatment Facilities (PRTF) back into the community. Oklahoma's MFP Demonstration for PRTF transitioning will focus on transitioning youth 16 to 18 years of age who have been in an inpatient psychiatric residential facility for 90 or more days during an episode of care. The individuals must meet criteria for Level 3 on the Individual Client Assessment Record or meet the criteria of Serious Emotional Disturbance. They may also show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale, or a score of 44 and below on the Functioning Subscales). In addition, the individuals will be eligible for transitional and community-based services and medications under Oklahoma's Living Choice Program. Services will be provided in accordance with an

individualized plan of care under the direction of appropriate service providers. Revisions also replace the term Intermediate Care Facility for Mentally Retarded with Intermediate Care Facility for Individuals with Intellectual Disabilities.
ODMHSAS Budget Impact: The budget impact is listed in APA WF #17-04A.

(Reference APA WF # 17-04B)

Item to be presented by Tasha Black, Director of Budget and Fiscal Planning

7. Action Item – Consideration and Vote of the State Fiscal Year 2018 Budget Work Program

Item to be presented by Tiffany Lyon, Director of Procurement and Contracts

8. Action Item – Consideration and Vote of the Disease Registry Expenditure of Authority

Item to be presented by Nancy Nesser, Pharmacy Director

9. Action Item – Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under 63 Oklahoma Statutes 5030.0.

a) Consideration and vote to add **Kuvan® (Sapropterin)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) Consideration and vote to add **Lumizyme® (Alglucosidase Alfa Injection)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

c) Consideration and vote to add **Aralast NP™, Glassia®, Prolastin®-C, and Zemaira®(Alpha Proteinase Inhibitors)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

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

e) Consideration and vote to add **ColPrep™ Kit (Sodium Sulfate/ Potassium Sulfate/Magnesium Sulfate)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

f) Consideration and vote to add **Impavido® (Miltefosine)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

g) Consideration and vote to add **Xalkori® (Crizotinib), Zykadia® (Ceritinib), Alecensa® (Alectinib), Alunbrig™ (Brigatinib), Tarceva® (Erlotinib), Gilotrif® (Afatinib), Tagrisso™ (Osimertinib), Cyramza® (Ramucirumab), and Tecentriq® (Atezolizumab)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Ed McFall, Chairman

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

Discussion of contractual litigation
Discussion of Supreme Court litigation

11. New Business

12. ADJOURNMENT

NEXT BOARD MEETING
August 10, 2017
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
May 25, 2017
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on May 24, 2017 at 11:45 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 May 19, 2017 at 11:30 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 2:05 p.m.

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

OTHERS PRESENT:	OTHERS PRESENT:
Tamra Moore, LIFE Senior Services	Sherris Harris-Ososanya, OHCA
Bennie and Christy Barker	Carmen John, OHCA
Tammy C. Vaughn, SE OK Family Services	Josh Bouye, OHCA
James Shean	Elin De Los Santos, Maximus
Samantha Johnson, Preferred Pediatrics	Jennifer King, OHCA
Mary Brinkley, Leading Age OK	Lewis Robinson, OHCA
LeKenya Antwine, OHCA	Samantha Blue, Life Pace
Beverly Couch, OHCA	David Dude, American Cancer Society
Avis Hill, OHCA	Heather and Elijah Yost, SMA Family
Jeanette Brown-Vick, OHCA	Traylor Rains-Sims, ODMHSAS
Jayna Sims, OHCA	Marvin Dale, DXC
Tywanda Cox, OHCA	Brandon Beavers, DXC
Terry Cothren, CoP	Jennifer Benefull, Preferred Pediatrics
Dwyna Vick, OHCA	David Ward, OHCA
Tasha Black, OHCA	Daryn Kirkpatrick, OHCA
Rachel Martin, OHCA	Harvey Reynolds, OHCA
Brenda Teel, Chickasaw Nation	Jean Krieske, OHCA
Gloria Lafitte, OHCA	Vanessa Andrade, OHCA
Tatiana Reed, OHCA	Carter Kimble, OSU
Jimmy Witcosky, OHCA	Rick Snyder, OHA
Mike Fogarty, UHA	Sarah Vanlstine, OKOTA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD March 24, 2017.

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

MOTION:	Member Nuttle moved for approval of the March 24, 2017 board meeting minutes as published. The motion was seconded by Member Bryant.
FOR THE MOTION:	Chairman McFall
ABSTAINED:	Member McVay
BOARD MEMBERS ABSENT:	Vice Chairman Armstrong, Member Case, Member Robison

ITEM 3 / PUBLIC COMMENT ON THIS MEETING'S AGENDA ITEMS BY ATTENDEES WHO GAVE 24 HOUR PRIOR WRITTEN NOTICE
Nicole Nantois, Chief of Legal Services

Speaker: Heather Yost/Family member of SoonerCare Member

ITEM 4a / CORPORATE WOMAN OF THE YEAR AWAD

Ms. Pasternik-Ikard recognized Tywanda Cox for her achievement of the 2017 Corporate Woman of the Year by the Women of Color Expo Award

ITEM 4b / RURAL HEALTH ADVOCATE OF THE YEAR AWARD

Ms. Pasternik-Ikard recognized Chairman McFall for his achievement of the 2017 Rural Health Advocate of the Year Award by the Rural Health Association.

ITEM 4c / ALL-STAR INTRODUCTION

The following OHCA All-Stars were recognized

- March All-Star – Danielle Mills, Member Services Coordinator (Melody Anthony)
- April All-Star – Jayna Sims, Finance Analyst II (Carrie Evans)

ITEM 4d / FINANCIAL UPDATE
Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of March. OHCA continues to run under budget in program spending by 3 million state dollars and administration by 2.9 million state dollars. OHCA's revenues are over budget in drug rebate by $2.7 million and still under budget in taxes and fees and overpayments and settlements. Final numbers for April ran under budget. For more detailed information, see Item 4d in the board packet.

ITEM 4e / MEDICAID DIRECTOR'S UPDATE
Garth Splinter, Deputy Chief Executive Officer

Dr. Splinter provided an update for April 2017 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program including total in-state providers. Dr. Splinter discussed charts provided for dual enrollees and long-term care members and SoonerCare Medical Home enrollment. Dr. Splinter also provided a summary of budget related outreach activity since March 2017. For more detailed information, see Item 4e in the board packet.

ITEM 4f / LEGISLATIVE/BUDGET UPDATE
Austin Marshall, Director of Government Relations

Mr. Marshall stated the Legislative Session is scheduled to adjourn by close of business, May 26, 2017. As it pertains to the OHCA, there are currently 3 pieces of legislation that have been approved by full senate that must also be approved by the full House of Representatives before sending them to the Governor for her approval. Mr. Marshall stated that OHCA is one of 16 state agencies that did not have its budget reduced this fiscal year, however OHCA is still $33 million short of the $69 million asked to maintain services. For more detailed information, see item 4f in the board packet.

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

There were no recommendations regarding conflicts.

ITEM 6 / CONSIDERATION AND VOTE REGARDING REIMBURSEMENT FOR CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHC)
Traylor Rains-Sims, Policy and Planning Director, Oklahoma Department of Mental Health and Substance Abuse Services

For detailed information, see item 6 in the board packet.

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

FOR THE MOTION: Chairman McFall, Member Bryant

BOARD MEMBERS ABSENT: Vice Chairman Armstrong, Member Case, Member Robison

ITEM 7A-E / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION BOARD UNDER 63 OKLAHOMA STATUTES 5030.3

Nancy Nesser, Pharmacy Director

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

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

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

d) Consideration and vote to add **Hydroxyprogesterone Caproate Injection (Generic Delalutin®)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

e) Consideration and vote to add **Giazo® (Balsalazide Disodium Tablets)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

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

FOR THE MOTION: Chairman McFall, Member Nuttle

BOARD MEMBERS ABSENT: Vice Chairman Armstrong, Member Case, Member Robison

ITEM 8 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4)

Nicole Nantois, Chief of Legal Services

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

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

FOR THE MOTION: Chairman McFall, Member McVay

BOARD MEMBERS ABSENT: Vice Chairman Armstrong, Member Case, Member Robison

ITEM 9 / NEW BUSINESS

There was no new business.

ITEM 10 / ADJOURNMENT

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

FOR THE MOTION: Chairman McFall, Member Bryant

BOARD MEMBERS ABSENT: Vice Chairman Armstrong, Member Case, Member Robison

Meeting adjourned at 3:20 p.m., 05/25/2017

NEXT BOARD MEETING
June 29, 2017
Oklahoma Health Care Authority
Oklahoma City, OK

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

FINANCIAL REPORT

For the Ten Months Ended April 30, 2017
Submitted to the CEO & Board

- Revenues for OHCA through April, accounting for receivables, were **$3,447,138,223** or **.5% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,402,578,152 or .8% under** budget.
- The state dollar budget variance through April is a **positive $10,578,326.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		6.0
Administration		4.0
Revenues:		
Drug Rebate		1.8
Taxes and Fees		(1.1)
Overpayments/Settlements		(.1)
Total FY 17 Variance	**$**	**10.6**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2017, For the Ten Month Period Ending April 30, 2017

REVENUES	FY17 Budget YTD	FY17 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 884,419,129	$ 884,419,129	$ -	0.0%
Federal Funds	1,947,674,294	1,928,187,597	(19,486,697)	(1.0)%
Tobacco Tax Collections	40,901,633	40,292,682	(608,951)	(1.5)%
Quality of Care Collections	64,959,849	64,461,968	(497,881)	(0.8)%
Prior Year Carryover	27,584,042	27,584,042	-	0.0%
Federal Deferral - Interest	124,505	124,505	-	0.0%
Drug Rebates	228,144,086	232,685,629	4,541,543	2.0%
Medical Refunds	32,543,821	32,287,877	(255,944)	(0.8)%
Supplemental Hospital Offset Payment Program	220,178,424	220,178,424	-	0.0%
Other Revenues	16,926,508	16,916,370	(10,138)	(0.1)%
TOTAL REVENUES	**$ 3,463,456,290**	**$ 3,447,138,223**	**$ (16,318,068)**	**(0.5)%**

EXPENDITURES	FY17 Budget YTD	FY17 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 47,644,702**	**$ 42,000,235**	**$ 5,644,467**	**11.8%**
ADMINISTRATION - CONTRACTS	**$ 78,651,826**	**$ 72,268,340**	**$ 6,383,486**	**8.1%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	34,622,428	34,539,952	82,476	0.2%
Acute Fee for Service Payments:				
Hospital Services	759,425,509	752,181,328	7,244,181	1.0%
Behavioral Health	16,495,844	16,753,095	(257,252)	(1.6)%
Physicians	349,021,832	343,978,383	5,043,449	1.4%
Dentists	106,411,269	105,417,328	993,941	0.9%
Other Practitioners	44,831,763	45,526,964	(695,201)	(1.6)%
Home Health Care	15,109,223	14,188,326	920,897	6.1%
Lab & Radiology	29,004,142	26,551,121	2,453,021	8.5%
Medical Supplies	39,248,322	40,030,389	(782,066)	(2.0)%
Ambulatory/Clinics	153,566,681	156,608,375	(3,041,694)	(2.0)%
Prescription Drugs	460,314,330	462,169,361	(1,855,031)	(0.4)%
OHCA Therapeutic Foster Care	19,272	(81,907)	101,179	0.0%
Other Payments:				
Nursing Facilities	464,016,926	459,813,474	4,203,452	0.9%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	51,415,277	50,642,037	773,240	1.5%
Medicare Buy-In	139,720,311	139,668,732	51,579	0.0%
Transportation	54,183,525	54,666,095	(482,569)	(0.9)%
Money Follows the Person-OHCA	292,209	180,684	111,525	0.0%
Electonic Health Records-Incentive Payments	15,258,342	15,258,342	-	0.0%
Part D Phase-In Contribution	81,413,775	81,499,843	(86,068)	(0.1)%
Supplemental Hospital Offset Payment Program	478,779,674	478,779,674	-	0.0%
Telligen	9,937,980	9,937,980	-	0.0%
Total OHCA Medical Programs	**3,303,088,636**	**3,288,309,577**	**14,779,059**	**0.4%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 3,429,474,546**	**$ 3,402,578,152**	**$ 26,896,393**	**0.8%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ 33,981,745**	**$ 44,560,071**	**$ 10,578,326**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2017, For the Ten Month Period Ending April 30, 2017

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 34,642,609	$ 34,530,232	$ -	$ 102,657	$ -	$ 9,720	$ -
Inpatient Acute Care	984,139,125	497,453,922	405,572	3,150,852	343,210,127	1,160,327	138,758,324
Outpatient Acute Care	360,873,403	249,868,089	34,670	3,698,625	104,013,272	3,258,748	
Behavioral Health - Inpatient	51,406,477	9,489,148	-	234,767	30,408,458	-	11,274,105
Behavioral Health - Psychiatrist	8,411,765	7,263,948	-	-	1,147,817	-	-
Behavioral Health - Outpatient	14,006,636	-	-	-	-	-	14,006,636
Behaviorial Health-Health Home	31,894,032	-	-	-	-	-	31,894,032
Behavioral Health Facility- Rehab	199,887,916	-	-	-	-	47,682	199,887,916
Behavioral Health - Case Management	15,196,739	-	-	-	-	-	15,196,739
Behavioral Health - PRTF	56,457,196	-	-	-	-	-	56,457,196
Residential Behavioral Management	14,678,639	-	-	-	-	-	14,678,639
Targeted Case Management	59,045,216	-	-	-	-	-	59,045,216
Therapeutic Foster Care	(81,907)	(81,907)	-	-	-	-	-
Physicians	395,845,521	340,068,194	48,417	(272,730)	-	3,861,771	52,139,868
Dentists	105,440,843	105,407,308	-	23,515	-	10,020	-
Mid Level Practitioners	2,314,419	2,292,791	-	20,125	-	1,502	-
Other Practitioners	43,583,943	42,781,675	371,970	351,273	-	79,026	-
Home Health Care	14,199,536	14,180,442	-	11,210	-	7,884	-
Lab & Radiology	27,178,553	26,360,513	-	627,432	-	190,608	-
Medical Supplies	40,262,400	37,746,378	2,259,610	232,012	-	24,401	-
Clinic Services	154,944,814	150,463,338	-	831,039	-	128,041	3,522,397
Ambulatory Surgery Centers	6,117,276	6,006,876	-	100,280	-	10,120	-
Personal Care Services	9,944,302	-	-	-	-	-	9,944,302
Nursing Facilities	459,813,474	281,913,914	177,899,560	-	-	-	-
Transportation	54,560,762	52,424,380	2,061,062	34,853	-	40,468	-
GME/IME/DME	140,667,565	-	-	-	-	-	140,667,565
ICF/IID Private	50,642,037	41,388,117	9,253,921	-	-	-	-
ICF/IID Public	11,339,964	-	-	-	-	-	11,339,964
CMS Payments	221,168,575	220,509,615	658,960	-	-	-	-
Prescription Drugs	473,235,407	460,280,227	-	11,066,046	-	1,889,135	-
Miscellaneous Medical Payments	140,185	140,185	-	-	-	-	-
Home and Community Based Waiver	167,597,538	-	-	-	-	-	167,597,538
Homeward Bound Waiver	68,132,070	-	-	-	-	-	68,132,070
Money Follows the Person	222,785	180,684	-	-	-	-	42,101
In-Home Support Waiver	20,860,713	-	-	-	-	-	20,860,713
ADvantage Waiver	154,521,714	-	-	-	-	-	154,521,714
Family Planning/Family Planning Waiver	3,771,866	-	-	-	-	-	3,771,866
Premium Assistance*	50,139,363	-	-	50,139,363	-	-	-
Telligen	9,937,980	9,937,980	-	-	-	-	-
Electronic Health Records Incentive Payments	15,258,342	15,258,342	-	-	-	-	-
Total Medicaid Expenditures	**$ 4,532,399,796**	**$ 2,605,864,390**	**$ 192,993,742**	**$ 70,351,317**	**$ 478,779,674**	**$ 10,719,453**	**$ 1,173,738,901**

* Includes $49,789,913.87 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2017, For the Ten Month Period Ending April 30, 2017

		FY17 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	496,334,445
Federal Funds		725,736,904
TOTAL REVENUES	**$**	**1,222,071,348**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	167,597,538
Money Follows the Person		42,101
Homeward Bound Waiver		68,132,070
In-Home Support Waivers		20,860,713
ADvantage Waiver		154,521,714
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		11,339,964
Personal Care		9,944,302
Residential Behavioral Management		10,749,004
Targeted Case Management		51,559,202
Total Department of Human Services		**494,746,609**
State Employees Physician Payment		
Physician Payments		52,139,868
Total State Employees Physician Payment		**52,139,868**
Education Payments		
Graduate Medical Education		100,650,804
Graduate Medical Education - Physicians Manpower Training Commission		5,077,410
Indirect Medical Education		33,086,772
Direct Medical Education		1,852,579
Total Education Payments		**140,667,565**
Office of Juvenile Affairs		
Targeted Case Management		2,106,261
Residential Behavioral Management		3,929,635
Total Office of Juvenile Affairs		**6,035,895**
Department of Mental Health		
Case Management		15,196,739
Inpatient Psychiatric Free-standing		11,274,105
Outpatient		14,006,636
Health Homes		31,894,032
Psychiatric Residential Treatment Facility		56,457,196
Rehabilitation Centers		199,887,916
Total Department of Mental Health		**328,716,624**
State Department of Health		
Children's First		1,351,900
Sooner Start		642,582
Early Intervention		3,560,519
Early and Periodic Screening, Diagnosis, and Treatment Clinic		692,512
Family Planning		153,834
Family Planning Waiver		3,603,773
Maternity Clinic		7,412
Total Department of Health		**10,012,533**
County Health Departments		
EPSDT Clinic		581,950
Family Planning Waiver		14,259
Total County Health Departments		**596,208**
State Department of Education		**109,981**
Public Schools		**357,353**
Medicare DRG Limit		**130,345,215**
Native American Tribal Agreements		**1,597,940**
Department of Corrections		**974,762**
JD McCarty		**7,438,348**
Total OSA Medicaid Programs	**$**	**1,173,738,901**
OSA Non-Medicaid Programs	**$**	**57,549,952**
Accounts Receivable from OSA	**$**	**9,217,505**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2017, For the Ten Month Period Ending April 30, 2017

REVENUES	FY 17 Revenue
SHOPP Assessment Fee	$ 219,921,664
Federal Draws	288,139,562
Interest	178,641
Penalties	78,119
State Appropriations	(30,200,000)
TOTAL REVENUES	$ 478,117,986

EXPENDITURES	Quarter	Quarter	Quarter	Quarter	FY 17 Expenditures
Program Costs:	7/1/16 - 9/30/16	10/1/16 - 12/31/16	1/1/17 - 3/31/17	4/1/17 - 6/30/17	
Hospital - Inpatient Care	76,250,540	79,946,392	93,024,133	95,602,569	$ 344,823,635
Hospital -Outpatient Care	27,213,505	28,255,818	24,271,974	24,836,782	104,578,079
Psychiatric Facilities-Inpatient	6,661,677	6,824,842	7,150,512	7,574,695	28,211,725
Rehabilitation Facilities-Inpatient	257,683	269,198	310,468	328,886	1,166,235
Total OHCA Program Costs	110,383,405	115,296,250	124,757,088	128,342,931	$ 478,779,674
Total Expenditures					$ 478,779,674

CASH BALANCE	
	$ (661,688)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2017, For the Ten Month Period Ending April 30, 2017

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 64,433,050	$ 64,433,050
Interest Earned	28,919	28,919
TOTAL REVENUES	**$ 64,461,968**	**$ 64,461,968**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 174,861,424	$ 69,507,416	
Eyeglasses and Dentures	227,316	90,358	
Personal Allowance Increase	2,810,820	1,117,301	
Coverage for Durable Medical Equipment and Supplies	2,259,610	898,195	
Coverage of Qualified Medicare Beneficiary	860,630	342,100	
Part D Phase-In	658,960	261,936	
ICF/IID Rate Adjustment	4,327,265	1,720,088	
Acute Services ICF/IID	4,926,656	1,958,346	
Non-emergency Transportation - Soonerride	2,061,062	819,272	
Total Program Costs	**$ 192,993,742**	**$ 76,715,012**	**$ 76,715,012**
Administration			
OHCA Administration Costs	$ 452,649	$ 226,325	
DHS-Ombudsmen	149,654	149,654	
OSDH-Nursing Facility Inspectors	404,441	404,441	
Mike Fine, CPA	12,000	6,000	
Total Administration Costs	**$ 1,018,744**	**$ 786,420**	**$ 786,420**
Total Quality of Care Fee Costs	**$ 194,012,486**	**$ 77,501,432**	
TOTAL STATE SHARE OF COSTS			**$ 77,501,432**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

SFY 2017, For the Ten Month Period Ending April 30, 2017

REVENUES	FY 16 Carryover	FY 17 Revenue	Total Revenue
Prior Year Balance	$ 5,199,281	$ -	$ 3,102,480
State Appropriations	(2,000,000)	-	-
Tobacco Tax Collections	-	33,140,261	33,140,261
Interest Income	-	101,394	101,394
Federal Draws	246,145	31,307,976	31,307,976
TOTAL REVENUES	**$ 3,445,426**	**$ 64,549,631**	**$ 67,652,111**

EXPENDITURES		FY 16 Expenditures	FY 17 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 49,789,914	$ 49,789,914
	College Students/ESI Dental		349,449	138,906
Individual Plan				
	SoonerCare Choice		$ 98,847	$ 39,292
	Inpatient Hospital		3,132,492	1,245,166
	Outpatient Hospital		3,650,457	1,451,057
	BH - Inpatient Services-DRG		223,933	89,013
	BH -Psychiatrist		-	-
	Physicians		(247,384)	(98,335)
	Dentists		23,337	9,276
	Mid Level Practitioner		20,047	7,969
	Other Practitioners		345,870	137,483
	Home Health		9,369	3,724
	Lab and Radiology		612,536	243,483
	Medical Supplies		222,243	88,341
	Clinic Services		812,232	322,862
	Ambulatory Surgery Center		94,193	37,442
	Prescription Drugs		10,899,650	4,332,611
	Transportation		34,523	13,723
	Premiums Collected		-	(470,044)
Total Individual Plan			**$ 19,932,344**	**$ 7,453,063**
	College Students-Service Costs		**$ 279,610**	**$ 111,145**
Total OHCA Program Costs			**$ 70,351,317**	**$ 57,493,028**
Administrative Costs				
	Salaries	$ 32,930	$ 1,723,681	$ 1,756,611
	Operating Costs	15,971	182,135	198,106
	Health Dept-Postponing	-	-	-
	Contract - HP	294,045	1,789,581	2,083,626
Total Administrative Costs		**$ 342,946**	**$ 3,695,397**	**$ 4,038,343**
Total Expenditures				**$ 61,531,371**
NET CASH BALANCE		**$ 3,102,480**		**$ 6,120,740**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2017, For the Ten Month Period Ending April 30, 2017

REVENUES	FY 17 Revenue	State Share
Tobacco Tax Collections	$ 661,235	$ 661,235
TOTAL REVENUES	**$ 661,235**	**$ 661,235**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 9,720	$ 469	
Inpatient Hospital	1,160,327	55,928	
Outpatient Hospital	3,258,748	157,072	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	3,861,771	186,137	
Dentists	10,020	483	
Mid-level Practitioner	1,502	72	
Other Practitioners	79,026	3,809	
Home Health	7,884	380	
Lab & Radiology	190,608	9,187	
Medical Supplies	24,401	1,176	
Clinic Services	128,041	6,172	
Ambulatory Surgery Center	10,120	488	
Prescription Drugs	1,889,135	91,056	
Transportation	37,714	1,818	
Miscellaneous Medical	2,753	133	
Total OHCA Program Costs	**$ 10,671,771**	**$ 514,379**	
OSA DMHSAS Rehab	$ 47,682	$ 2,298	
Total Medicaid Program Costs	**$ 10,719,453**	**$ 516,678**	
TOTAL STATE SHARE OF COSTS			**$ 516,678**

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

OHCA Board Meeting
June 29, 2017
(May 2017 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

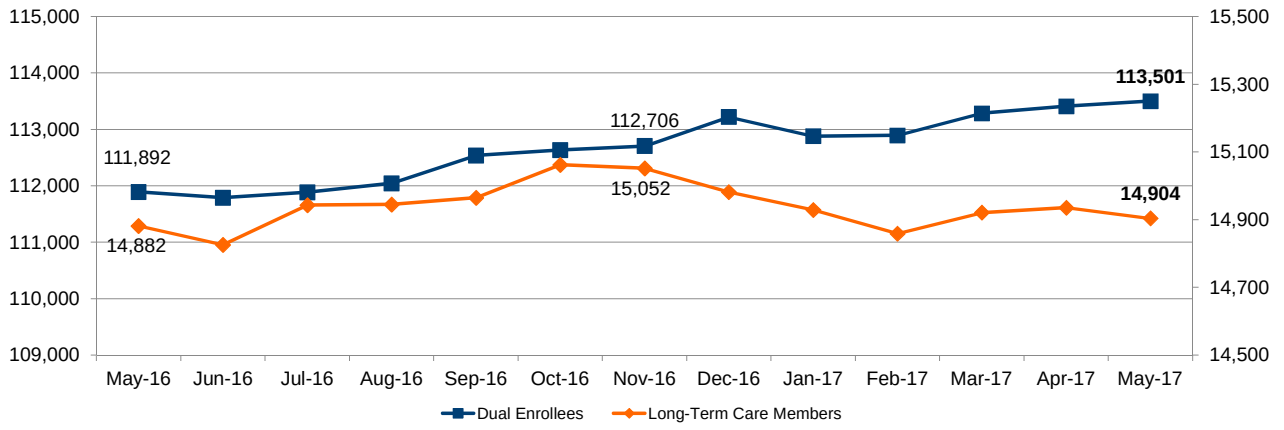
Delivery System			Enrollment May 2017	Children May 2017	Adults May 2017	Enrollment Change	Total Expenditures May 2017	PMPM May 2017	Forecasted May 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**551,829**	**455,112**	**96,717**	**1,345**	**$180,026,502**		
	Lower Cost	*(Children/Parents; Other)*	507,847	441,128	66,719	1,029	$130,528,981	$257	$212
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,982	13,984	29,998	316	$49,497,520	$1,125	$944
SoonerCare Traditional			**236,214**	**89,216**	**146,998**	**-1,994**	**$202,531,314**		
	Lower Cost	*(Children/Parents; Other)*	122,575	84,296	38,279	-1,929	$46,331,650	$378	$468
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	113,639	4,920	108,719	-65	$156,199,664	$1,375	$1,288
SoonerPlan			**34,520**	**2,835**	**31,685**	**251**	**$383,296**	$11	$9
Insure Oklahoma			**19,612**	**541**	**19,071**	**54**	**$7,098,045**		
	Employer-Sponsored Insurance		14,698	377	14,321	106	$4,784,641	$326	$301
	Individual Plan		4,914	164	4,750	-52	$2,313,405	$471	$434
TOTAL			**842,175**	**547,704**	**294,471**	**-344**	**$390,039,157**		

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.

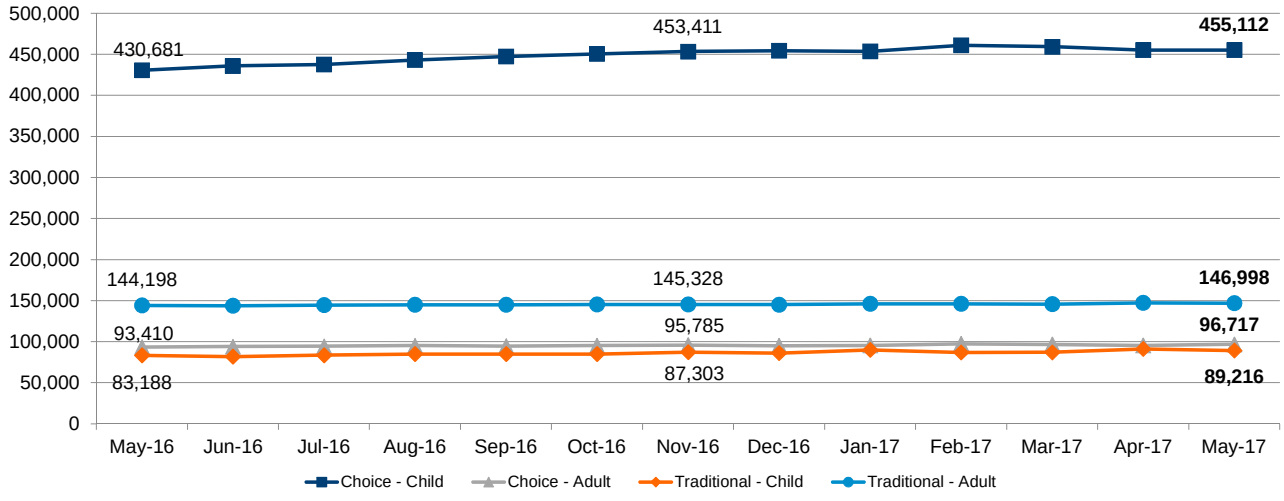
Total In-State Providers: 34,736 (+192) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,350	972	1,290	183	6,471	554	388	6,677	2,638

DUAL ENROLLEES & LONG-TERM CARE MEMBERS



CHILDREN & ADULTS ENROLLMENT



Oklahoma HealthCare Authority

June 2017 Legislative and Budget Update

Lindsey Bateman
Assistant Director of Government Relations

FY 2018 Appropriations

General Revenue	$	854,718,820.00
Special Cash	$	50,000,000.00
Tobacco Settlement	$	11,797,214.00
Cigarette fee*	$	70,000,000.00
HEIIA Fund	$	3,000,000.00
Revolving Fund	$	4,000,000.00
Rainy Day Fund	$	32,000,000.00
Total Appropriations	**$**	**1,025,516,034.00**

SB 845: Health Care Enhancement Fund

This measure levies a new $1.50/pack cigarette fee and appropriates the funding to three agencies for FY 2018:

Agency	Appropriation
OHCA	$70,000,000
ODMHSAS	$75,000,000
OKDHS	$69,000,000

SB 845: Health Care Enhancement Fund, *cont.*

Tobacco companies and vendors challenged the measure in the Oklahoma Supreme Court on June 7. The plaintiffs argue the bill violates several provisions of the Oklahoma Constitution.

The court will hear oral arguments on August 8.

FY 2018 Shortfall

The agency was appropriated $34M less than requested to maintain existing services in FY 2018. OHCA is evaluating all options to minimize the impact to providers and members.

Federal Landscape

- The Senate continues to deliberate the Better Care Reconciliation Act. The act would repeal many provisions of the Affordable Care Act and may impact the Medicaid Program. The measure has been laid over until after the summer recess.

- The Children's Health Insurance Program (CHIP) has not been reauthorized by Congress for the upcoming fiscal year, although legislative committees are holding preliminary discussions beginning later this month.

Contact Information

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Program Integrity

How are providers selected for audit?

Oklahoma HealthCare Authority

ARE ALL PROVIDERS AUDITED?

*Federal Regulations (42 CFR 455.15) state that if the agency receives a complaint of fraud / abuse from any source **OR** identifies any questionable practices, it must conduct a preliminary investigation to determine whether there is sufficient basis to warrant a full review.*

Oklahoma HealthCare Authority

HOW ARE AUDITS INITIATED?

- Referrals
- Peer-to-Peer Comparisons
- Data-Mining

REFERRALS

- Patients
- Family members
- Employees
- Other agencies
- Community members
- Units within OHCA

PEER TO PEER COMPARISON

Software compares all claims of “like” peers

Looks for outliers – billers outside the norm

- More high level claims?
- More claims per patient?
- More patients?
- Billing for services / codes that peers don’t normally bill for?

Oklahoma HealthCare Authority

DATA-MINING

- **Utilizes large amounts of claims data**
- **Ideas?**
  - Fraud Alerts
  - Training Courses
  - Issues in Other States
  - OIG Workplan
  - Completed Audits

Josh Richards

Director of Program Integrity

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Oklahoma HealthCare Authority

REGULAR NURSING FACILITIES RATES

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

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) Fee for Regular Nursing Facilities per 56 O.S. 2011, Section 2002.

   This change allows OHCA to collect additional QOC fees from providers (also referred to as the state share) and match them with federal funds which provides rate increases to the facilities.

   Additionally this will allow OHCA to calculate the annual reallocation of the pool for the "Direct" and "Other Care" components of the rate as per The State Plan.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:
   A. Base Rate Component is $107.57 per patient day.
   B. A Focus on Excellence (FOE) Component defined by the points earned under this performance program ranging from $1.00 to $5.00 per patient day.
   C. An "Other" Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and FOE Component by the total estimated Medicaid days for the rate period. This component once calculated is the same for each facility.

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

The current combined pool amount for "Direct Care" and "Other Component" is $158,741,836 total dollars.

The current Quality of Care (QOC) fee is $11.07 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in the methodology; however there is a proposed rate change for Regular Nursing facilities as a result of the required annual recalculation of the Quality of Care (QOC) fee and the annual reallocation of the pool for the "Direct" and "Other" Care components of the rate as per The State Plan.

The Base Rate Component will be $107.79 per patient day.

The new combined pool amount for "Direct Care" and "Other Care" Component will be $160,636,876 total dollars.

The new Quality of Care (QOC) fee will be $11.29 per patient day.

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY2018 will be an increase in the total amount of $3,329,018; with $1,367,893 in state share coming from the increased QOC Fee (which is paid by the providers).

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

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

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

- An increase in the base rate component from $107.57 per patient day to $107.79 per patient day.
- An increase in the combined pool amount for the "Other Care" and "Direct Care" Components from $158,741,836 to $ $160,636,876 total dollars to account for the annual reallocation of the Direct Care Cost Component as per The State Plan.
- An increase in the Quality of Care fee from $11.07 per patient day to $11.29 per patient day which is paid by the providers.

9. EFFECTIVE DATE OF CHANGE.

July 1, 2017

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) RATES FOR NURSING FACILITIES

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

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

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

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

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day.

   The current rate for this provider type is $199.29 per patient day.

   The Quality of Care (QOC) fee is $11.07 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however there is a rate change for nursing facilities serving residents with AIDS as a result of the required annual recalculation of the Quality of Care (QOC) fee.

   The rate for this provider type will be $200.01 per patient day.

   The recalculated Quality of Care (QOC) fee will be $11.29 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2018 will be an increase in the total amount of $7,016; with $2,883 in state share coming from the increased QOC Fee (which is paid by the facilities).

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:
   - An increase in the AIDS rate from $199.29 per patient day to $200.01 per patient day.
   - An increase in the Quality of Care fee from $11.07 per patient day to $11.29 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2017

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

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

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

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

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

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Acute ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.

   The current rate for this provider type is $156.57 per patient day.

   The Quality of Care (QOC) fee is $9.31 per patient day.

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

   The proposed rate for this provider type will be $157.03 per patient day.

   The recalculated Quality of Care (QOC) fee will be $9.50 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2018 will be an increase in the total amount of $129,929; with $53,388 in state share coming from the increased QOC Fee (which is paid by the facilities).

AGENCY ESTIMATED IMPACT ON ACCESS TO CARE

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:
   - An increase in the rate from $156.57 per patient day to $157.03 per patient day.
   - An increase in the Quality of Care fee from $9.31 per patient day to $9.50 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2017

REGULAR (GREATER THAN 16 BEDS) INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) RATES

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

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

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

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

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

The current rate methodology for Regular ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.

The current rate for this provider type is $122.39 per patient day.

The Quality of Care (QOC) fee is $7.39 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however there is a rate change for Regular ICF/IID facilities as a result of the annual recalculation of the Quality of Care (QOC) fee.

   The proposed rate for this provider type will be $122.77 per patient day.

   The recalculated Quality of Care (QOC) fee will be $7.54 per patient.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2018 will be an increase in the total amount of $79,253; with $32,565 in state share coming from the increased QOC Fee (which is paid by the facilities).

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular ICF/IID facilities:
   - An increase in the rate from $122.39 per patient day to $122.77 per patient day.
   - An increase in the Quality of Care fee from $7.39 per patient day to $7.54 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2017

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.6. Trust accounts

Monies held in trust for an individual applying for or receiving SoonerCare must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, ~~etc.,~~ or the Bureau of Indian Affairs (BIA).

(1) **Availability determinations.** The worker should be able to determine the availability of a trust using the definitions and explanations listed in (2) of this subsection. However, in some cases, the worker may wish to submit a trust to the ~~OKDHS~~Oklahoma Department of Human Services(OKDHS) State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(2) **Definition of terms**. The following words and terms, when used in this paragraph, have the following meaning, unless the context clearly indicates otherwise:

(A) **Beneficiary**. Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(B) **Corpus/principal**. Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(C) **Discretionary powers**. Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(D) **Distributions**. Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(E) **Grantor (trustor/settlor)**. Grantor (trustor/settlor) means the individual who establishes the trust by

transferring certain assets.

(F) **Irrevocable trust**. Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(G) **Pour over or open trust**. Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(H) **Primary beneficiary**. Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(I) **Revocable trust**. Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(J) **Secondary beneficiary**. Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(K) **Testamentary trust**. Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(L) **Trustee**. Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(3) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:

(A) Trust document;

(B) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(C) Documentation reflecting prior disbursements (date, amount, purpose).

(4) **Trust accounts established on or before August 10, 1993**. The rules found in (A) - (C) of this paragraph apply to trust

accounts established on or before August 10, 1993.

(A) **Support trust.** The purpose of a support trust is the provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (i)-(iii) of this subparagraph, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(i) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(ii) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(iii) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(B) **Medicaid Qualifying Trust (MQT).** A Medicaid Qualifying Trust is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts

created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to 12 O.S. 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for SoonerCare, and, whether or not discretion is actually exercised.

(i) **Similar legal device**. MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(ii) **MQT resource treatment**. For revocable MQTs, the entire principal is an available resource to the member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the member can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the member (or to use it for the member's benefit), the entire principal is an available resource to the member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions

do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the member (or to be used for his/her benefit), but those distributions are not made, the member's countable resources increase cumulatively by the undistributed amount.

(iii) **Income treatment.** Amounts of MQT income distributed to the member are countable income when distributed. Amounts of income distributed to third parties for the member's benefit are countable income when distributed.

(iv) **Transfer of resources**. If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the member or using it for the member's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the member, the principal is not an available resource and has, therefore, been transferred).

(C) **Special needs trusts**. Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including SoonerCare benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including SoonerCare benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(5) **Trust accounts established after August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established after August 10, 1993.

(A) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

(i) the individual;

(ii) the individual's spouse;

(iii) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(iv) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(C) There are two types of trusts, revocable trusts and irrevocable trusts.

(i) In the case of a revocable trust, the principal is considered an available resource to the individual. Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the 60 months look back period.

(ii) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made is considered available resources. Payments from the principal or income of the trust is considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the 60 months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(6) **Exempt trusts.** Paragraph (5) of this subsection does not apply to the following trusts:

(A) A trust containing the assets of a disabled individual under the age of 65 which was established for the benefit of such individual by the individual, parent, grandparent,

legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:

(i) The trust may only contain the assets of the disabled individual.

(ii) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the Oklahoma Department of Human Services or the Oklahoma Health Care Authority.

(iii) Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(iv) The exception for the trust continues after the disabled individual reaches age 65. However, any addition or augmentation after age 65 involves assets that were not the assets of an individual under age 65; therefore, those assets are not subject to the exemption.

(v) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of 65.

(vi) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food, clothing and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food, clothing, or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food, clothing, or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.

(vii) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.

(viii) The OKDHS Form 08MA018E, Supplemental Needs

Trust, is an example of the trust. Workers may give the sample form to the member or his/her representative to use or for their attorney's use.

(ix) To terminate or dissolve a Supplemental Needs Trust, the worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: Health Related and Medical Services (HR&MS) explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also required. Health Related and Medical Services notifies ~~OHCA/TPL~~Oklahoma Health Care Authority/Third Party Liability(OHCA/TPL) to initiate the recovery process.

(B) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:

(i) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1 Schedule VIII.B) but less than the average cost of nursing home care per month (OKDHS Appendix C-1 Schedule VIII.B).

(ii) The Trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources cannot be included in the trust.

(iii) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(iv) The trust must retain an amount equal to the member's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee distributes the remainder.

(v) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(vi) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(vii) The State will receive all amounts remaining in the trust up to an amount equal to the total SoonerCare benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(viii) Accumulated funds in the trust may only be used for medically necessary items not covered by SoonerCare, or other health programs or health insurance and a reasonable cost of administrating the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(ix) The trustee may claim a fee of up to 3% of the funds added to the trust that month as compensation.

(x) An example trust is included on OKDHS Form 08MA011E. Workers may give this to the member or his/her representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(xi) To terminate or dissolve a Medicaid Income Pension Trust, the worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason and effective date for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. Health Related and Medical Services notifies OHCA/TPL to initiate the recovery process.

(C) A trust containing the assets of a disabled individual when all of the following are met:

(i) The trust is established and managed by a non-profit association;

(ii) The trust must be made irrevocable;

(iii) The trust must be approved by the Oklahoma Department of Human Services and may not be amended without the permission of the Oklahoma Department of Human Services;

(iv) The disabled person has no ability to control the spending in the trust;

(v) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

(vi) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the members;

(vii) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;

(viii) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of 30% of the amount remaining in the beneficiary's account at the time of the beneficiary's death may be retained by the trust.

(7) **Funds held in trust by Bureau of Indian Affairs (BIA).** Interests of individual Indians in trust or restricted lands are not considered in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(8) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 113. LIVING CHOICE PROGRAM

317:30-5-1207. Benefits for members ages sixteen (16) through eighteen (18) in a psychiatric residential treatment facility

(a) Living Choice program participants, ages sixteen (16) through eighteen (18), may receive a range of necessary home and community based services for one year after transitioning to the community from a psychiatric residential treatment facility (PRTF) setting. In order to be eligible for the Living Choice program, the member must:

(1) Have been in a PRTF facility for 90 or more days during an episode of care; and

(2) Meet Level 3 criteria on the Individual Client Assessment Record; or

(3) Meet the criteria for Serious Emotional Disturbance as defined in OAC 317:30-5-240.1; or

(4) Show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales).

(b) Services must be billed using the appropriate Healthcare Common Procedure Code System and must be medically necessary.

(c) All services must be necessary for the individual to live successfully in the community, must be documented in the individual care plan and require prior authorization.

(d) Services that may be provided to members transitioning from a PRTF are found in OAC 317:30-5-252.

(e) Reimbursement will be for a monthly care coordination payment upon successful submission of a claim for one or more of the covered services listed in OAC 317:30-5-252.

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

SUBCHAPTER 23. LIVING CHOICE PROGRAM

317:35-23-2. Eligibility criteria

(a) Adults with disabilities or long-term illnesses, members with intellectual disabilities and members with physical disabilities are eligible to transition into the community through the Living Choice program if they meet all of the criteria in paragraphs (1) through (7) of this subsection.

(1) He/she must be at least 19 years of age.

(2) He/she must reside in ~~an institution (nursing facility or public ICF/MR)~~a nursing facility or public Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) for at least 90 consecutive days prior to the proposed transition date. If any portion of the 90 days includes time in a skilled nursing facility, those days cannot be counted toward the 90 day requirement, if the member received Medicare post-hospital extended care rehabilitative services.

(3) He/she must have at least one day of Medicaid paid long-term care services prior to transition.

(4) If transitioning from an out of state institution, he/she must be SoonerCare eligible.

(5) He/she requires at least the same level of care that necessitated admission to the institution.

(6) He/she must reside in a qualified residence after leaving the institution. A qualified residence is defined in (A) through (C) of this paragraph.

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with a locking entrance/exit, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than four unrelated individuals reside.

(7) His/her needs can be met by the Living Choice program while living in the community.

(8) He/she must not be a resident of a nursing facility or ~~ICF/MR~~ICF/IID in lieu of incarceration.

(b) Youth ages sixteen (16) through eighteen (18) are eligible to transition back into the community from a psychiatric residential treatment facility (PRTF) through the Living Choice program if they meet the following criteria:

(1) Have been in a PRTF facility for 90 or more days during

an episode of care; and
(2) Meet Level 3 criteria on the Individual Client Assessment Record; or
(3) Meet the criteria for Serious Emotional Disturbance as defined in OAC 317:30-5-240.1; or
(4) Show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale or a score of 44 and below on the Functioning Subscales).

317:35-23-3. Participant disenrollment

(a) A member is disenrolled from the program if he/she:
(1) is admitted to a hospital, nursing facility, ~~ICF/MR,~~ ICF/IID, residential care facility or behavioral health facility for more than 30 consecutive days;
(2) is incarcerated;
(3) is determined to no longer meet SoonerCare financial eligibility for home and community based services;
(4) determined by the Social Security Administration or OHCA Level of Care Evaluation Unit to no longer have a disability that qualifies for services under the Living Choice program; or
(5) moves out of state.

(b) Payment cannot be made for an individual who is in imminent danger of harm to self or others.

OKLAHOMA HEALTH CARE AUTHORITY

SFY-2018 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	SFY-2017	SFY-2018	Inc / (Dec)	% Change
Medical Program				
Managed Care - Choice / HAN / PACE	41,144,343	45,574,844	4,430,501	10.8%
Hospitals	921,501,958	861,050,566	(60,451,392)	-6.6%
Behavioral Health	19,944,652	18,895,988	(1,048,664)	-5.3%
Nursing Homes	560,565,843	516,456,945	(44,108,898)	-7.9%
Physicians	427,103,707	391,331,396	(35,772,311)	-8.4%
Dentists	128,588,912	118,837,744	(9,751,167)	-7.6%
Mid-Level Practitioner	2,648,893	2,611,527	(37,366)	-1.4%
Other Practitioners	51,086,437	49,166,897	(1,919,540)	-3.8%
Home Health	18,472,976	15,827,383	(2,645,593)	-14.3%
Lab & Radiology	35,866,801	29,886,163	(5,980,638)	-16.7%
Medical Supplies	47,146,589	46,584,312	(562,277)	-1.2%
Clinic Services	177,885,602	182,714,691	4,829,089	2.7%
Ambulatory Surgery Center	7,285,659	6,730,723	(554,936)	-7.6%
Prescription Drugs	559,917,410	563,025,770	3,108,359	0.6%
Miscellaneous	191,590	150,403	(41,187)	-21.5%
ICF-IID	62,034,311	58,171,526	(3,862,785)	-6.2%
Transportation	65,156,691	62,913,080	(2,243,612)	-3.4%
Medicare Buy-in (Part A & B)	168,686,738	177,764,062	9,077,324	5.4%
Medicare clawback payment (Part D)	99,112,467	110,847,119	11,734,651	11.8%
SHOPP - Supplemental Hosp Offset Pymt.	482,774,622	516,242,406	33,467,784	6.9%
Nursing Home UPL Payments	-	104,283,834	104,283,834	0.0%
Money Follows the Person - Enhanced	353,369	236,807	(116,562)	-33.0%
Health Management Program (HMP)	10,277,520	10,579,560	302,040	2.9%
Electronic Health Records Incentive Pymts	39,788,361	39,788,361	-	0.0%
Non-Title XIX Medical	89,382	89,382	-	0.0%
TOTAL OHCA MEDICAL PROGRAM	3,927,624,835	3,929,761,490	2,136,655	0.1%
Insure Oklahoma - Premium Assistance				
Employer Sponsored Insurance - ESI	55,812,912	62,022,233	6,209,321	11.1%
Individual Plan - IP	29,804,409	27,630,850	(2,173,559)	-7.3%
TOTAL INSURE OKLAHOMA PROGRAM	85,617,321	89,653,083	4,035,762	4.7%
OHCA Administration				
Operations	52,550,020	53,285,176	735,156	1.4%
Contracts	39,827,303	30,870,425	(8,956,878)	-22.5%
Insure Oklahoma Admin	4,031,359	4,072,082	40,723	1.0%
Information Services	64,907,175	73,679,434	8,772,259	13.5%
Grant Mgmt	6,096,142	5,852,082	(244,060)	-4.0%
TOTAL OHCA ADMIN	167,411,999	167,759,199	347,200	0.2%
TOTAL OHCA PROGRAMS	**4,180,654,156**	**4,187,173,773**	**6,519,617**	**0.2%**
Other State Agency (OSA) Programs				
Department of Human Services (OKDHS)	609,163,813	603,243,836	(5,919,978)	-1.0%
Oklahoma State Dept of Health (OSDH)	16,972,849	13,623,998	(3,348,851)	-19.7%
The Office of Juvenile Affairs (OJA)	8,346,893	7,032,296	(1,314,597)	-15.7%
University Hospitals (Medical Education Pymnts)	345,665,493	344,700,756	(964,737)	-0.3%
Physician Manpower Training Commission	6,319,093	6,864,093	545,000	8.6%
Department of Mental Health (DMHSAS)	416,367,703	404,905,141	(11,462,562)	-2.8%
Department of Education (DOE)	3,184,069	1,436,234	(1,747,835)	-54.9%
Non-Indian Payments	1,841,891	2,132,165	290,273	15.8%
Department of Corrections (DOC)	1,631,713	1,348,819	(282,893)	-17.3%
JD McCarty	7,922,686	8,208,720	286,033	0.0%
OSA Non-Title XIX	83,650,000	83,650,000	-	0.0%
TOTAL OSA PROGRAMS	**1,501,066,205**	**1,477,146,058**	**(23,920,147)**	**-1.6%**
TOTAL MEDICAID PROGRAM	**5,681,720,360**	**5,664,319,830**	**(17,400,530)**	**-0.3%**

OKLAHOMA HEALTH CARE AUTHORITY

SFY-2018 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	SFY-2017	SFY-2018	Inc / (Dec)	% Change
REVENUES				
Federal - program	3,167,775,551	3,032,831,094	(134,944,458)	-4.3%
Federal - admin	105,694,316	109,017,990	3,323,674	3.1%
Drug Rebates	289,921,060	316,812,473	26,891,412	9.3%
Medical Refunds	40,502,796	37,811,635	(2,691,161)	-6.6%
NF Quality of Care Fee	78,739,526	78,841,226	101,699	0.1%
OSA Refunds & Reimbursements	649,596,138	665,110,623	15,514,485	2.4%
Tobacco Tax	84,997,069	86,777,306	1,780,238	2.1%
Insurance Premiums	1,568,432	1,910,000	341,568	21.8%
Misc Revenue	265,888	255,904	(9,984)	-3.8%
Prior Year Carryover	26,397,254	20,000,260	(6,396,995)	-24.2%
Other Grants	3,898,137	3,405,353	(492,784)	-12.6%
Nursing Home UPL Fund	-	43,763,800	43,763,800	0.0%
Hospital Provider Fee (SHOPP bill)	222,440,488	242,266,132	19,825,644	8.9%
OHCA Revolving Fund 200 - Transfer	-	6,000,000	6,000,000	
Insure Oklahoma Fund 245 - Transfer	2,000,000	3,000,000	1,000,000	50.0%
State Appropriated	1,007,923,704	1,016,516,034	8,592,330	0.9%
TOTAL REVENUES	**5,681,720,360**	**5,664,319,830**	**(17,400,530)**	**-0.3%**

Submitted to the C.E.O. and Board on June 29, 2017
AUTHORITY FOR EXPENDITURE OF FUNDS
Disease Registry

BACKGROUND

The Board previously approved this contract on March 30, 2015 for Disease Registry. Expenditure of authority is requested to renew the current contract with Care Management Technology (CMT) through 2020 pursuant to the RFP.

OMES (on behalf of OHCA and ODMHSAS) awarded a State Contract to Care Management Technology (CMT) to administer a Behavioral Health Home Management Software System for the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) through 2020. The Behavioral Health Home Management Software System is electronic communication between the Oklahoma Health Homes, the Oklahoma Health Care Authority, the Oklahoma Department of Mental Health and Substance Abuse Services and the Centers for Medicare and Medicaid Services (CMS).

SCOPE OF WORK

The software system contains:

1. Enrollment and discharge tracking;
2. Compliance;
3. Quality Assurance; and
4. Outcome monitoring the SED and SMI populations.

CONTRACT PERIOD

Original contract period previously approved by the Board: Date of Award thru June 30, 2017

Additional contract periods requested pursuant to the RFP: July 1, 2017 thru June 30, 2018 with two (2) year options to renew.

CONTRACT AMOUNT AND PROCUREMENT METHOD

Additional expenditures are estimated as follows:

State Fiscal Year / Total Increase	Item	Additional Budget	Federal Matching Fund %
SFY 2018 – SFY 2020	CMT Online Solution	$1,950,000.00	50%

- Awarded through competitive bidding conducted by OMES
- State share will be paid by ODMHSAS
- Not to exceed $650,000 per SFY

RECOMMENDATION

- Board approval to expend funds for the services explained above.

Recommendation 1: Prior Authorize Kuvan® (Sapropterin)

The Drug Utilization Review Board recommends the prior authorization of Kuvan® (sapropterin) with the following criteria:

Kuvan® (Sapropterin) Approval Criteria:

1. An FDA approved diagnosis of phenylketonuria; and
2. Documentation of active management with a phenylalanine restricted diet; and
3. Member must not have two null mutations in *trans*; and
4. Initial approvals will be for the duration of 30 days. After which time, the prescriber must verify that the member responded to treatment as defined by laboratory documentation of greater than or equal to a 30% decrease in blood phenylalanine levels from baseline.
    a. If the member was initiated at 10mg/kg/day dose, then a subsequent trial of 20mg/kg/day for a duration of 30 days can be approved. After which time, the prescriber must verify that the member responded to treatment as defined by laboratory documentation of greater than or equal to a 30% decrease in blood phenylalanine levels from baseline.
    b. If the member was initiated at 20mg/kg/day dose, then no additional approvals will be granted after a trial period of 30 days if the member did not respond to treatment as defined by laboratory documentation of greater than or equal to a 30% decrease in blood phenylalanine levels from baseline.
5. Subsequent approvals will be for the duration of one year.

Recommendation 2: Prior Authorize Lumizyme® (Alglucosidase Alfa Injection)

The Drug Utilization Review Board recommends the prior authorization of Lumizyme® (alglucosidase alfa) with the following criteria:

Lumizyme® (Alglucosidase Alfa) Infantile-Onset Approval Criteria:

1. An FDA approved diagnosis of infantile-onset Pompe disease (acid alpha-glucosidase [GAA] deficiency); and
2. Documentation of diagnosis confirmation of GAA enzyme deficiency through specific genetic laboratory test(s); and
3. Lumizyme® must be prescribed by a geneticist or a physician that specializes in the treatment of Pompe disease and/or inherited genetic disorders; and
4. Member's weight must be provided and have been taken within the last four weeks to ensure accurate dosing.

Lumizyme® (Alglucosidase Alfa) Late-Onset (Non-Infantile) Approval Criteria:

1. An FDA approved diagnosis of late-onset (non-infantile) Pompe disease (acid alpha-glucosidase [GAA] deficiency); and
2. Documentation of diagnosis confirmation of GAA enzyme deficiency through specific genetic laboratory test(s); and
3. Provider must document presence of symptoms of Pompe disease; and
4. Lumizyme® must be prescribed by a geneticist or a physician that specializes in the treatment of Pompe disease and/or inherited genetic disorders; and
5. Member's weight must be provided and have been taken within the last four weeks to ensure accurate dosing.

6. Initial approval will be for the duration of six months, at that time compliance and information regarding efficacy, such as improvement or stabilization in Forced Vital Capacity (FVC) and/or 6-minute walk test (6MWT), will be required for continued approval. Additional authorizations will be for the duration of one year.

Recommendation 3: Prior Authorize Alpha$_1$-Proteinase Inhibitors: Aralast NP™, Glassia®, Prolastin®-C, and Zemaira®

The Drug Utilization Review Board recommends the prior authorization of Prolastin®-C, Aralast NP™, Glassia®, and Zemaira® (alpha$_1$-proteinase inhibitor [human]) products with the following criteria based, in part, on cost after rebates:

Prolastin®-C (Alpha$_1$-Proteinase Inhibitor [Human]) Approval Criteria:

1. An FDA approved indication for augmentation and maintenance therapy of patients 18 years of age or older with severe hereditary deficiency of alpha$_1$-antitrypsin (AAT) with clinical evidence of emphysema; and
2. Diagnosis confirmed by all of the following:
    a. Genetic confirmation of PiZZ, PiZ(null), or Pi(null, null) phenotype alpha$_1$-antitrypsin deficiency (AATD) or other alleles determined to increase risk of AATD; and
    b. Serum levels of AAT less than 11µmol/L; and
    c. Documented emphysema with airflow obstruction; and
3. Prescriber must document that member's forced expiratory volume in one second (FEV_1) is less than or equal to 65% predicted; and
4. Must be prescribed by a pulmonary disease specialist or advanced care practitioner specializing in pulmonary disease; and
5. The prescriber must verify the member is a non-smoker; and
6. The prescriber must verify the member does not have antibodies to IgA; and
7. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

Aralast NP™ and Glassia® (Alpha$_1$-Proteinase Inhibitor [Human]) Approval Criteria:

1. An FDA approved indication for augmentation and maintenance therapy of patients 18 years of age or older with severe hereditary deficiency of alpha$_1$-antitrypsin (AAT) with clinical evidence of emphysema; and
2. Diagnosis confirmed by all of the following:
    a. Genetic confirmation of PiZZ, PiZ(null), or Pi(null, null) phenotype alpha$_1$-antitrypsin deficiency (AATD) or other alleles determined to increase risk of AATD; and
    b. Serum levels of AAT less than 11µmol/L; and
    c. Documented emphysema with airflow obstruction; and
3. Prescriber must document that member's forced expiratory volume in one second (FEV_1) is less than or equal to 65% predicted; and
4. Must be prescribed by a pulmonary disease specialist or advanced care practitioner specializing in pulmonary disease; and
5. The prescriber must verify the member is a non-smoker; and
6. The prescriber must verify the member does not have antibodies to IgA; and
7. A patient-specific, clinically significant reason why the member cannot use Prolastin®-C; and
8. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

Zemaira® (Alpha$_1$-Proteinase Inhibitor [Human]) Approval Criteria:

1. An FDA approved indication for augmentation and maintenance therapy of patients 18 years of age or older with severe hereditary deficiency of alpha$_1$-antitrypsin (AAT) with clinical evidence of emphysema; and
2. Diagnosis confirmed by all of the following:

    a. Genetic confirmation of PiZZ, PiZ(null), or Pi(null, null) phenotype alpha$_1$-antitrypsin deficiency (AATD) or other alleles determined to increase risk of AATD; and
    b. Serum levels of AAT less than 11µmol/L; and
    c. Documented emphysema with airflow obstruction; and
3. Prescriber must document that member's forced expiratory volume in one second (FEV_1) is less than or equal to 65% predicted; and
4. Must be prescribed by a pulmonary disease specialist or advanced care practitioner specializing in pulmonary disease; and
5. The prescriber must verify the member is a non-smoker; and
6. The prescriber must verify the member does not have antibodies to IgA; and
7. A patient-specific, clinically significant reason why the member cannot use Prolastin®-C, Aralast NP™, or Glassia®; and
8. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

Recommendation 4: Prior Authorize Elaprase® (Idursulfase)

The Drug Utilization Review Board recommends the prior authorization of Elaprase® (idursulfase) with the following criteria:

Elaprase® (Idursulfase) Approval Criteria:

1. An FDA approved diagnosis of Hunter syndrome (mucopolysaccharidosis type II; MPS II) confirmed by:
    a. Enzyme assay demonstrating a deficiency of iduronate-2-sulfatase enzyme activity; or
    b. Molecular genetic testing confirming a hemizygous pathogenic variant in the *IDS* gene; and
2. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

Recommendation 5: Prior Authorize ColPrep™ Kit (Sodium Sulfate/ Potassium Sulfate/Magnesium Sulfate)

The Drug Utilization Review Board recommends the prior authorization of ColPrep™ Kit with criteria similar to the other prior authorized bowel preparation medications with the following criteria:

ColPrep™ Kit, OsmoPrep®, Prepopik®, 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 6: Prior Authorize Impavido® (Miltefosine)

The Drug Utilization Review Board recommends the prior authorization of Impavido® (miltefosine) with the following criteria:

Impavido® (Miltefosine) Approval Criteria:

1. An FDA approved indication for treatment of:
    a. Visceral leishmaniasis due to *Leishmania donovani*; or

    b. Cutaneous leishmaniasis due to *Leishmania braziliensis*, *Leishmania guyanensis*, or *Leishmania panamensis*; or
    c. Mucosal leishmaniasis due to *Leishmania braziliensis*; and
2. Female members must not be pregnant and female members of reproductive potential must have a pregnancy test prior to therapy initiation. Female members of reproductive potential must be willing to use effective contraception while on therapy and for five months after completion of therapy; and
3. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.
4. A quantity limit of 84 capsules per 28 days will apply.

Recommendation 7: Prior Authorize Xalkori® (Crizotinib), Zykadia® (Ceritinib), Alecensa® (Alectinib), Alunbrig™ (Brigatinib), Tarceva® (Erlotinib), Gilotrif® (Afatinib), Tagrisso™ (Osimertinib), Cyramza® (Ramucirumab), and Tecentriq® (Atezolizumab)

The Drug Utilization Review Board recommends the prior authorization of the following medications with the associated criteria:

Xalkori® (Crizotinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:
1. A diagnosis of metastatic NSCLC (first-line or subsequent therapy); and
2. Anaplastic lymphoma kinase (ALK) or ROS1 positivity; or
3. MET amplification; and
4. Crizotinib must be used as a single-agent only.

Xalkori® (Crizotinib) Approval Criteria [Soft Tissue Sarcoma – Inflammatory Myofibroblastic Tumor (IMT) with Anaplastic Lymphoma Kinase (ALK) Translocation Diagnosis]:
1. A diagnosis of soft tissue sarcoma – IMT; and
2. Anaplastic lymphoma kinase (ALK) positivity; and
3. Crizotinib must be used as a single-agent only.

Zykadia® (Ceritinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:
1. A diagnosis of metastatic NSCLC; and
2. Anaplastic lymphoma kinase (ALK) positivity; and
3. Ceritinib must be used as a single-agent only.

Zykadia® (Ceritinib) Approval Criteria [Soft Tissue Sarcoma – Inflammatory Myofibroblastic Tumor (IMT) with Anaplastic Lymphoma Kinase (ALK) Translocation Diagnosis]:
1. A diagnosis of soft tissue sarcoma – IMT; and
2. Anaplastic lymphoma kinase (ALK) positivity; and
3. Ceritinib must be used as a single-agent only.

Alecensa® (Alectinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:
1. A diagnosis of recurrent or metastatic NSCLC; and
2. Anaplastic lymphoma kinase (ALK) positivity; and
3. Progressed on or intolerant to crizotinib; or
4. Member has asymptomatic disease with rapid radiologic progression on crizotinib; and
5. Alectinib must be used as a single-agent only.

Alunbrig™ (Brigatinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:
1. A diagnosis of metastatic NSCLC; and
2. Anaplastic lymphoma kinase (ALK) positivity; and
3. Progressed on or intolerant to crizotinib; and
4. Brigatinib must be used as a single-agent only.

Tarceva® (Erlotinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. A diagnosis of NSCLC; and
2. Recurrence or metastatic disease; and
3. Epidermal growth factor receptor (EGFR) mutation detected; and
4. Erlotinib must be used as a single-agent only.

Tarceva® (Erlotinib) Approval Criteria [Pancreatic Cancer Diagnosis]:

1. A diagnosis of pancreatic cancer; and
2. Locally advanced unresectable or metastatic disease; and
3. Member must have good performance status (ECOG 0 to 2); and
4. Erlotinib must be used as a first-line agent only; and
5. Erlotinib must be used in combination with gemcitabine.

Tarceva® (Erlotinib) Approval Criteria [Kidney Cancer Diagnosis]:

1. A diagnosis of kidney cancer; and
2. Non-clear cell type; and
3. Relapsed disease or for surgically unresectable stage IV disease; and
4. Erlotinib must be used as a single-agent only.

Tarceva® (Erlotinib) Approval Criteria [Bone Cancer – Chordoma Diagnosis]:

1. A diagnosis of bone cancer – chordoma; and
2. Recurrent disease; and
3. Erlotinib must be used as a single-agent only.

Tarceva® (Erlotinib) Approval Criteria [Pancreatic Adenocarcinoma Diagnosis]:

1. A diagnosis of pancreatic adenocarcinoma; and
2. Locally advanced unresectable disease or metastatic disease; and
3. Member must have good performance status (ECOG 0 to 2); and
4. Erlotinib must be used in combination with gemcitabine.

Gilotrif® (Afatinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

The following criteria must be met when used in the <u>first-line setting:</u>

1. A diagnosis of metastatic NSCLC; and
2. Epidermal growth factor receptor (EGFR) mutation detected; and
3. Afatinib when used in the first-line setting must be used as a single-agent only.

The following criteria must be met when used in the <u>second-line setting:</u>

1. A diagnosis of metastatic NSCLC; and
2. Progressed following platinum-based chemotherapy; and
3. Afatinib when used in the second-line setting may be used as a single-agent or in combination with cetuximab in patients with a known sensitizing EGFR mutation who are T790M negative.

Gilotrif® (Afatinib) Approval Criteria [Head and Neck Cancer Diagnosis]:

1. A diagnosis of head and neck cancer; and
2. Disease progression on or after platinum containing chemotherapy; and
3. Non-nasopharyngeal cancer must be one of the following:
    a. Newly diagnosed T4b, any N, M0 disease, unresectable nodal disease with no metastases, or for patients who are unfit for surgery and performance status (PS) 3; or
    b. Metastatic (M1) disease at initial presentation, recurrent/persistent disease with distant metastases, or unresectable locoregional recurrence or second primary with prior radiation therapy (RT) and PS 0 to 2; or
    c. Unresectable locoregional recurrence without prior RT and PS 3; and
4. Afatinib must be used as a single-agent.

Tagrisso™ (Osimertinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. A diagnosis of NSCLC; and

2. Epidermal growth factor receptor (EGFR) T790M mutation-positive disease; and
3. Following progression on erlotinib, afatinib, or gefitinib for asymptomatic disease, symptomatic brain lesions, or multiple symptomatic systemic lesions; and
4. Osimertinib must be used for subsequent therapy only.

Cyramza® (Ramucirumab) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. A diagnosis of NSCLC; and
2. Subsequent therapy for metastatic disease after progression; and
3. Member must have an ECOG performance status of 0 to 2; and
4. Ramucirumab must be used in combination with docetaxel.

Cyramza® (Ramucirumab) Approval Criteria [Colorectal Cancer Diagnosis]:

1. A diagnosis of colorectal cancer; and
2. Subsequent therapy for metastatic disease after progression on or after prior therapy with bevacizumab, oxaliplatin, and a fluoropyrimidine; and
3. Ramucirumab must be used in combination with an irinotecan based regimen.

Cyramza® (Ramucirumab) Approval Criteria [Esophageal Cancer Diagnosis]:

1. A diagnosis of unresectable, locally advanced, recurrent or metastatic esophageal or esophagogastic junction adenocarcinoma; and
2. Member must have a Karnofsky performance score greater than or equal to 60% or an ECOG performance score of 0 to 2; and
3. Ramucirumab must be used as a single-agent or in combination with paclitaxel.

Cyramza® (Ramucirumab) Approval Criteria [Gastric Cancer Diagnosis]:

1. A diagnosis of gastric cancer; and
2. Member is not a surgical candidate or has unresectable, locally advanced, recurrent or metastatic disease; and
3. Member has a Karnofsky performance score of greater than or equal to 60% or an ECOG performance score of 0 to 2; and
4. Ramucirumab must be used as a single-agent or in combination with paclitaxel.

Tecentriq® (Atezolizumab) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. A diagnosis of NSCLC; and
2. Subsequent therapy for metastatic disease; and
3. Member must have an ECOG performance score of 0 to 2; and
4. Atezolizumab must be used as a single-agent only.

Tecentriq® (Atezolizumab) Approval Criteria [Urothelial Carcinoma]:

1. A diagnosis of locally advanced or metastatic urothelial carcinoma; and
2. Progressed on or following platinum containing chemotherapy or in cisplatin ineligible patients.

Drug	Used for	Cost	Notes
Kuvan	Phenylketonuria	$75,000-180,000/year	26 members 2016
Lumizyme	Pompe Disease	$300,000+/year	1 member 2016
Aralast NP	Chronic pulmonary	$112,000/year	10 members all products
Glassia	disease caused by	$112,000/year	
Prolastin-C	alpha1 antitrysin enzyme	$106,000/year	*Preferred product
Zemaira	deficiency (hereditary)	$112,000/year	
Elaprase	Hunter Syndrome	$160,000-815,000/year	3 members 2016
ColPrep Kit	Colonoscopy prep	Unknown at this time	Generics < $20
Impavido	Leishmaiasis parasite	$32,000-48,500/treatment	No utilization in 2016
Xalkori	Lung cancer	$18,000/month	& other cancers
Zykadia	Lung cancer	$8,500/month	& other cancers
Alecensa	Lung cancer	$16,000/month	
Alunbrig	Lung cancer	$14,000/month	
Tarceva	Lung cancer	$3,000-9,000/month	& other cancers
Gilotrif	Lung cancer	$9,000/month	& other cancers
Tagrisso	Lung cancer	$17,000/month	
Cyramza	Lung cancer	$9,000/cycle	& other cancers
Tecentriq	Lung cancer	$8,600/cycle	& other cancers