OKLAHOMA HEALTH CARE AUTHORITY
SPECIAL SCHEDULED BOARD MEETING
May 21, 2019 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 Stan Hupfeld, Interim Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the April 1, 2019 OHCA Board Meeting Minutes

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

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

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

4. Discussion Item – Chief Executive Officer's Report

   a) All-Star Recognition
      - January All-Star – Lisa Cates, Administrative Assistant
      - February All-Star – Peter Onema, Long Term Care Manager
      - March All-Star - Rachel Jones, Population Care Management Coordinator

   b) Financial Update – Aaron Morris, Chief Financial Officer

   c) Medicaid Director's Update – Melody Anthony, Chief Operating Officer

   d) Chief Medical Officer Update – Mike Herndon, Chief Medical Officer

   e) Legislative Update – Audra Cross, Legislative Liaison

   f) SFY 2018 Oklahoma Single Audit Findings – Amber Smith, Audit Manager

   g) 2018 Health Access Network (HAN) Evaluation – Melinda Thomason, Senior Director for Stakeholder Engagement; Cindy Bacon, Partnership for Healthy Central Communities HAN; Matt Maxey, OSU HAN; Rachel Mix OU Sooner HAN

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

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

Item to be presented by Carrie Evans, Deputy Chief Executive Officer

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

A. Consideration and Vote for a rate method change for Maternal Depression Screenings. The proposed revisions will add fee-for-service coverage and reimbursement language for maternal depression screenings (CPT code 96161) at Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well-child visits. A fee-for-service reimbursement of $5.00 per screening was selected and is in line with reimbursement offered by other states. The estimated budget impact for the remainder of SFY2020 will be an increase of $143,053 total; of which $49,911 is state share. The estimated budget impact for SFY2021 will be an increase of $342,936 total; of which $113,409 is state share.

B. Consideration and Vote for a rate method change for Enhanced Payments for State University Employed or Contracted Physicians. The proposed payment methodology for State University Employed or Contracted Physicians is 175% of the Medicare Physician Fee Schedule. The estimated annual budget impact will be an increase of $51,067,779 total; of which $17,817,548 is state share. The state share will be paid by the University of Oklahoma and Oklahoma State University.

C. Consideration and Vote for a rate method change for Rural Health Clinics. The proposed payment methodology for hospital-based rural health clinic services is paid at the provider's encounter rate established by Medicare that is in effect for the date of service. The proposed methodology or independent rural health clinics is paid at the rural health clinic payment limit established by CMS that is in effect for the date of service. The estimated annual budget impact will be an increase of $17,657,446 total; of which $6,160,683 is state share.

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

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

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

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

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

A. ADDING agency rules at ***OAC 317:30-5-263 through 317:30-5-268*** will incorporate new rules to sustain the certified community behavioral health clinics (CCBHC) project beyond its demonstration period in Oklahoma. The services provided include nine types of behavioral health treatment services, with an emphasis on the provision of 24-hour crisis care, utilization of evidence based practices, care coordination, and integration with physical health. The proposed rules will outline CCBHC member eligibility, provider participation requirements, and program scope.
Budget Impact: As these rules represent the sustainability plan for a current demonstration project, there are no new immediate costs to the Oklahoma Health Care Authority (OHCA) or the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) for implementation and enforcement of the proposed rule. However, ODMHSAS estimates a FFY 2020 net fiscal impact for CCBHCs, as $35.6M ($23.5M Federal / 12.1M State).

(Reference APA WF # 19-02)

B. AMENDING agency rules at ***OAC 317:30-5-355.1, 317:30-5-357, 317:30-5-376, 317:30-5-664.1, 317:30-5-1076, 317:30-5-1090, and 317:30-5-1154*** and ADDING agency rules at ***OAC 317:30-3-65.12*** will establish coverage and reimbursement for Applied Behavior Analysis (ABA) services as an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. The proposed

language will define scope of service, provider criteria and credentialing requirements, medical necessity, intervention criteria, and extension requests for continued services. Other revisions will involve limited rewriting aimed at clarifying text and updating outdated policy sections.
Budget Impact: The proposed changes would potentially result in a combined federal and state spending of $11,455,015 total with $4,969,759 in state share for FFY19 and FFY20.

(Reference APA WF # 19-03)

C. AMENDING agency rules at ***OAC 317:35-5-26*** and ADDING agency rules at ***OAC 317:35-5-67*** to comply with the federal regulation at 42 CFR § 435.916(d), which requires a prompt redetermination of eligibility whenever information is received about a change in a member's circumstances that may affect eligibility. In accordance with the new policy, a member's eligibility will be terminated if his or her mail is returned to the agency as unforwardable, with address unknown, and the Oklahoma Health Care Authority has made a reasonable but unsuccessful attempt to verify the member's current address. Per 42 CFR §§ 431.213 and 431.231, advance notice is not required to be given to the member when eligibility is terminated due to returned mail; however notice will be sent to the member by mail and email, if the agency has an email address on file. Notice will also be posted to the member's online SoonerCare account. If the member's whereabouts become known within the eligibility period, eligibility will be reinstated. Rules and procedures for terminating eligibility due to returned mail are employed by other states' Medicaid agencies, including those of Alabama, Arizona, Ohio, New Jersey, New York, Oregon, and Colorado.
Budget Impact: Agency staff has determined that the impact of the proposed rule changes on the budget is unknown, however, savings are expected to be realized as members that have not provided a current address lose eligibility.

(Reference APA WF # 19-04)
Item to be presented by Burl Beasley, Pharmacy Director

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

   a) Inbrija™ (Levodopa Inhalation) and Osmolex ER™ (Amantadine Extended-Release) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   b) Epidiolex® (Cannabidiol), Diacomit® (Stiripentol), and Sympazan™ (Clobazam Oral Film) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   c) Gamifant® (Emapalumab-lzsg) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   d) Firdapse® (Amifampridine) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   e) Takhzyro™ (Lanadelumab-flyo) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   f) Copiktra™ (Duvelisib) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

   g) Lutathera® (Lutetium Lu 177 Dotatate) and Vitrakvi® (Larotrectinib) to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Stan Hupfeld, Interim Chairman

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

   Discussion of Pending Contractual Litigation
   Discussion of Pending Class Action Litigation
   Discussion of Pending Declaratory Relief Litigation

10. Action Item – Election of the Oklahoma Health Care Authority 2019 Board Officers

11. Action Item – Approval of the 2019 Special Board Meetings

12. New Business

13. ADJOURNMENT

NEXT BOARD MEETING
June 25, 2019
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
April 1, 2019
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 March 28, 2018 at 5:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on March 22, 2019 at 11:36 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Becky Pasternik-Ikard called the meeting to order at 9:08 a.m.

BOARD MEMBERS PRESENT: Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin

OTHERS PRESENT:

Elio De Los Santos, Maximus
Kyle Janzen, OHCA
Katelynn Burns, OHCA
Kambra Reddick, OHCA
Nelson Solomon, OHCA
Kelly Hughes, OHCA
Kelli Brodersen, OHCA
Lisa Montgomery, OHCA
Karen Egesdal, OU CoP
Kimberly Jones, OHCA
Jennifer King, OHCA
Tewanna Edwards, OHCA
Vanessa Andrade, OHCA
Jennifer Wynn, OHCA
Traylor Rains-Sims, ODMHSAS
Mike Herndon, OHCA
Jo Stainsby, OHCA
Ray Hester, DDS
Audra Cross, OHCA
Monika Lutz, OHCA
Irene Sanderson, OHCA
Aimee Merick, OHCA
Avis Hill, OHCA
Mike Fogarty
Rick Snyder, OHA
Misty McGaugh, OKDHS

OTHERS PRESENT:

Daryn Kirkpatrick, OHCA
Tasha Black, OHCA
Gloria LaFitte, OHCA
Yasmine Barve, OHCA
Shantice Atkins, OHCA
Kevin Haddock, OHCA
Johnney Johnson, OHCA
Jean Krieske, OHCA
Cody Middleton, OHCA
Kimrey McGinnis, OHCA
Jimmy Witcosky, OHCA
David Ward, OHCA
Sarai Connell, PMC/OU CoP
Aaron Morris, OHCA
Melissa Abbott, PMC
Mary Brinkley, OHCA
Regina Chace, DDS
MaryAnn Martin, OHCA
Stephanie Mavredes, OHCA
Melanie Lawrence, OHCA
Kathryn McNutt, The Oklahoman
Nicole Collins, OHCA
Wes Glinsmann, OSMA
Harvey Reynolds, OHCA
Fred Mensah, OHCA

ITEM 2 / ELECTION OF THE OKLAHOMA HEALTH CARE AUTHORITY INTERIM 2019 BOARD OFFICERS

MOTION: Member Nuttle moved for approval of Stanley Hupfeld as Interim Chairman. The motion was seconded by Member Case

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Hausheer, Member Kennedy, Member Shamblin

MOTION: Member Nuttle moved for approval of Alex Yaffe as Interim Vice-Chairman. The motion was seconded by Member Case

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Hausheer, Member Kennedy, Member Shamblin

ITEM 3A / FINANCIAL UPDATE
Aaron Morris, Chief Financial Officer

Mr. Morris gave a brief update on OHCA's January financials. OHCA's revenues were 1.1 percent, $26.6 million under budget. The ending cash balance for January 2019 is $125,343,642. This amount includes Supplemental Hospital Offset Payment Program (SHOPP, Quality of Care (QOC), Deferral account and Insure Oklahoma. Overall, OHCA expenditures were 1.5 percent, $40.3 million under budget. The revenue to expenditure variance increased from positive $356,849 to positive $10,668,863. Financial reports through February are not complete, but preliminary numbers show that positive variance will decrease. OHCA is running over budget in drug rebates by $6.7 million state dollars and under budget in tobacco tax revenues by $2.6 million state dollars. OHCA is running over budget in medical refunds by $964,269 state dollars. For more detailed information, see Item 3b in the board packet.

ITEM 3B / MEDICAID DIRECTOR'S UPDATE
Melody Anthony, Deputy State Medicaid Director

Ms. Anthony provided an update for March 2019 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program and total in-state providers. Ms. Anthony also presented charts showing monthly trend for providers, monthly enrollment and a monthly trend in enrollment for Choice, Traditional and Insure Oklahoma, trend for total members and how it relates to the unemployment rate and enrollment by state fiscal year. For more detailed information, see Item 3d in the board packet.

ITEM 4 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts

ITEM 5A-E / CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE
Josh Richards, Director of Program Integrity

A. Consideration and Vote for a rate and rate method change to the Residential Behavior Management Services (RBMS) providers. There are seven levels of RBMS rates (C, D, D+, E, E+, Enhanced E, and ITS). The per diem rate consists of staff, facility, operational, and administrative cost. The allocation of cost is split between Medicaid and Title IV-E funding using a direct care cost adjustment factor. The estimated budget impact for the remainder of SFY2020 will be an increase of $5,309,136 total; of which $1,804,045 is state share paid by the Oklahoma Department of Human Services. The estimated budget impact for the remainder of SFY2020 will be an increase of $1,323,638 total; of which $449,772 is state share paid the Oklahoma Office of Juvenile Affairs.

MOTION: Member Hausheer moved for approval of Item 5a as published. The motion was seconded by Vice-Chairman Yaffe.

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Kennedy, Member Nuttle, Member Shamblin

B. Consideration and Vote for a rate method change for Partial Hospitalization Programs (PHP). The current reimbursement rate is $42.80 per hour. The new reimbursement rate of $160.50 per day is based on the 2010 Medicare cost assumptions for PHP services. This is based on a blend of a 3.5 hour treatment day and a 4 hour treatment day. This change is estimated to be budget neutral.

MOTION: Vice-Chairman Yaffe moved for approval of Item 5b as published. The motion was seconded by Member Hausheer

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Kennedy, Member Nuttle, Member Shamblin

C. Consideration and Vote for a rate and rate method change for Certified Community Behavioral Health Clinics (CCBHC) to change from a demonstration grant to a State Plan covered service. CCBHC currently receive a fixed PMPM reimbursement rate for every individual who has at least one qualifying visit in the month. There is

a standard CCBHC (or base) rate and five Separate Reimbursement Rates for Special Populations (SPPOP). The proposed methodology will be two separate reimbursement rates for special populations, instead of the current five. The net increase to ODMHSAS for the three months remaining in SFY2019 is $1,683,210 total, $618,222 state share which will be paid by ODMHSAS. Due to the rebasing and change in methodology for special populations, the estimated SFY2020 budget impact is a savings to ODMHSAS of $259,849 total, $90,661 state share.

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

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Hausheer, Member Shamblin

D. Consideration and Vote for a rate and rate method change for intensive Therapeutic Foster Care (ITFC). This is a new program so there is no current methodology. ITFC is treatment focused program that serves children in the custody in a family setting that utilizes a team approach of professionals including therapist, care coordinators, and the foster parent to provide the services. The rate is a per diem rate that encompasses the cost of providing a foster home environment (IV-E compensable activities) along with the evidenced based and trauma informed therapies and treatments (Title XIX compensable activities). The Title XIX portion of the rate is $141.93. The state share will be paid by DHS and is cost neutral by reducing the number of beds in TFC to fund ITFC.

MOTION: Member Hausheer moved for approval of Item 5d as published. The motion was seconded by Member Shamblin

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Kennedy, Member Nuttle

E. Consideration and Vote for a rate method change for Medicare Part A and Part B crossover claims. The methodology of paying Medicare crossover claims is not changing, but the State Plan is being updated to align with current practice. Due to a provider type and specialty change for psychiatric hospitals and Psychiatric Residential Treatment Facilities (PRTF), Medicare crossover claims were paying incorrectly. The original intent was to pay psychiatric hospitals and PRTFs the same way as hospitals, as that was their previous provider type. Psychiatric hospitals and PRTFS are paid 75% of deductible and 25% of coinsurance for Medicare Part A crossover claims. Medicare medical services and dialysis are receiving payment of 100% of deductible and 46.25% of coinsurance for Medicare Part B crossover claims. Payment for Indian Health Services (IHS) clinics and transportation services are made at 100% of deductible and 100% of coinsurance for Medicare Part B crossover claims. The proposed State Plan amendment is budget neutral as this proposed amendment is being submitted to align with current practice.

MOTION: Vice-Chairman Yaffe moved for approval of Item 5e as published. The motion was seconded by Member Hausheer

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Kennedy, Member Nuttle, Member Shamblin

ITEM 6A-S / 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

Nicole Nantois, Chief of Legal

A. AMENDING agency rules at ***OAC 317:30-5-20, 317:30-5-40.1 and 317:30-5-42.10*** will strengthen the language delineating medical necessity, and compensable and non-compensable lab services. Additional revisions will clarify that the OHCA does not pay for all lab services listed in the Centers for Medicare and Medicaid Services (CMS) fee schedule but only those that are medically necessary in addition to the four other conditions required for payment.

Budget Impact: Agency staff has determined that the proposed rule changes will result in a budget savings by further delineating medical necessity.

(Reference APA WF # 18-01)

MOTION:	Member Case moved for approval of Item 6A as published. The motion was seconded by Member Hausheer
FOR THE MOTION:	Chairman Hupfeld, Vice-Chairman Yaffe, Member Kennedy, Member Nuttle, Member Shamblin

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

OHCA Initiated

B. AMENDING agency rules at ***OAC 317:30-5-123*** will incorporate new language to clarify that the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) will be used for diagnostic purposes of a mental illness and/or intellectual disability in Medicaid certified nursing facility admissions. Further, revisions will reflect WF 18-15 policy changes made to the appeals rules to extend the length of time in which an appeal can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action. Lastly, revisions will also involve limited rewriting aimed at clarifying text, eliminating redundancies, and updating outdated terminology.

Budget Impact: Budget neutral

(Reference APA WF # 18-07A)

C. AMENDING agency rules at ***OAC 317:35-19-8*** will incorporate new language to clarify that the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) will be used for diagnostic purposes of a mental illness and/or intellectual disability for admission to a Medicaid certified nursing facility. Additional revisions will involve limited rewriting aimed at clarifying text, eliminating redundancies, and updating outdated terminology.

Budget Impact: Budget neutral

(Reference APA WF # 18-07B)

D. ADDING agency rules at ***OAC 317:30-3-33*** will establish a new section addressing suspended claims review and/or prepayment review. This policy will align the agency with state and federal laws that require the OHCA to safeguard against unnecessary utilization of medical supplies and services. Additionally, the revisions will help to ensure that payments are consistent, efficient, economical, and provide good quality of care. Please refer to 42 United States Code § 1396a(a)(30)(A); 42 Code of Federal Regulations § 447.45(f); and, 56 Oklahoma Statutes § 1010.4(B)(5). These revisions will help ensure that reimbursements are for medically necessary, correctly and/or appropriately billed, medical supplies and services. The changes define and explain the various reviews that may be performed by the OHCA or its contractor before OHCA pays a claim.

Budget Impact: It is expected that these types of reviews will achieve significant savings, the exact amount of which cannot be quantified at this time.

(Reference APA WF # 18-09)

E. AMENDING agency rules at ***OAC 317:30-3-19.4*** will establish application fees required by federal law for providers enrolling or re-enrolling in Medicaid. The revisions will define providers who are exempted from the

application fee as individual physician or non-physician practitioners; providers who enrolled with and paid the fee to Medicare; and providers who enrolled with and paid the fee to another state Medicaid agency. Additional revisions will outline provider screening and enrollment requirements designed to help defend against Medicaid provider fraud, waste, and/or abuse. Provider screening requirements are outlined according to three categorical screening levels: limited-risk, moderate-risk, and high-risk. Examples of screening requirements are licensure verification, on-site visits, and fingerprint-based background checks.

Budget Impact: Agency staff estimates that the proposed rule change will generate revenue due to the application/screening fees. Per federal law, the collected fees shall be used for the cost of conducting screenings

(Reference APA WF # 18-13)

F. AMENDING agency rules at ***OAC 317:35-5-41, 317:35-5-41.1, 317:35-5-41.2, 317:35-5-41.3, 317:35-5-41.8, 317:35-5-41.9*** and ADDING agency rules at ***OAC 317:35-5-41.12*** will update policy on resources that are disregarded by federal law due to Oklahoma transitioning from a 209(b) state to a Supplemental Security Income (SSI) criteria state for determination of eligibility for SSI related eligibility groups such as the Aged, Blind, and Disabled (ABD).

Budget Impact: Budget neutral

(Reference APA WF # 18-14)

G. AMENDING agency rules at ***OAC 317:2-1-2, 317:2-1-6, 317:2-1-7, 317:2-1-10, 317:2-1-11, 317:2-1-12, 317:2-1-13, 317:2-1-14 and 317:2-1-16*** will change all of the agency's appeals rules to extend the length of time that appeals can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action. Additionally, the revisions will add Supplemental Hospital Offset Payment Program (SHOPP) appeals to the list of other grievance procedures and processes.

Budget Impact: Budget neutral

(Reference APA WF # 18-15A)

H. AMENDING agency rules at ***OAC 317:30-3-2.1, 317:30-5-95.31, 317:30-5-136, 317:30-5-136.1 and 317:30-5-746*** will change all of the agency's appeals rules to extend the length of time that appeals can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action.

Budget Impact: Budget neutral

(Reference APA WF # 18-15B)

I. AMENDING agency rules at ***OAC 317:35-19-16*** will change all of the agency's appeals rules to extend the length of time that appeals can be submitted from twenty (20) days to thirty (30) days of the date of an adverse agency action.

Budget Impact: Budget neutral

(Reference APA WF # 18-15C)

J. AMENDING agency rules at ***OAC 317:35-22-2.1*** will provide non-emergency transportation (NET) to pregnant women covered under the Title XXI State Plan (Soon-to-be-Sooners and Soon-to-be-Sooners Maintenance of Effort populations). Under federal parity law requirements, children covered by the Children's Health Insurance Program (CHIP), including those in the unborn child category, must have the same access to secretary-approved coverage of all Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits including

health care, diagnostic services, treatment, and other measures to correct or ameliorate defects and physical and mental illness and conditions as per the approved State Plan.

Budget Impact: The agency anticipates that the proposed changes would potentially result in a budget impact of approximately $15,094 total, with $5,266 in state share for SFY 2020.

(Reference APA WF # 18-16)

K. AMENDING agency rules at ***OAC 317:30-3-65.4*** will add coverage and reimbursement language for maternal depression screenings at Early and Periodic Screening, Diagnostic and Treatment (EPSDT) at well-child visits. Providers will be reimbursed for conducting a maternal depression screening at the child's well-child visit. The policy will also reiterate how the Oklahoma Health Care Authority adopts and utilizes the American Academy of Pediatrics' Bright Futures periodicity schedule including for the maternal depression screenings. Additionally, the proposed revisions will update the child abuse section to provide a more thorough explanation of how to report abuse and neglect including clarifying text, and updating outdated citations.

Budget Impact: The agency anticipates that the proposed changes would potentially result in a budget impact of approximately $128,748 total with $43,749 in state share for SFY2020.

(Reference APA WF # 18-17)

M. AMENDING agency rules at ***OAC 317:30-3-31 and 317:30-5-95.24;*** ADDING agency rules at ***OAC 317:30-3-89, 317:30-3-90, and 317:30-3-91;*** AMENDING and RENUMBERING agency rules at ***OAC 317:30-3-64 to OAC 317:30-3-92*** will add a Part 6 to Chapter 30 in policy titled "Out-of-State Services." The new part will define and clarify coverage and reimbursement for services rendered by providers that are physically located outside of Oklahoma. Additions will delineate out-of-state services, provider participation requirements, prior authorizations, documentation/medical records requirements and will outline reimbursement criteria for out-of-state providers who do not accept the payment rate established through the State Plan. Additionally, the "payment for lodging and meals" section will be moved under the new Part 6. Finally, revisions will strike out old out-of-state policy then replace with references directing to the new part.

Budget Impact: It is expected that the new policy's reimbursement methodology will achieve significant savings, the exact amount of which cannot be quantified at this time.

(Reference APA WF # 18-24)

N. AMENDING agency rules at ***OAC 317:30-3-19.5 and 317:30-5-664.8*** will eliminate references to sections that have been revoked. The sections were revoked in past rulemaking sessions. However, language in other parts of the Chapter referring to these sections were inadvertently missed. Further revisions will correct misspelled words and grammatical mistakes for better flow and understanding.

Budget Impact: Budget neutral

(Reference APA WF # 18-25)

O. AMENDING agency rules at ***OAC 317:30-5-96.6*** will streamline crossover payments of Medicare/Medicaid dual eligible individuals for Part A and B services. Further revisions will also involve limited rewriting aimed at clarifying text, eliminating redundancies, and updating outdated terminology.

Budget Impact: Budget neutral

(Reference APA WF # 18-27)

P. AMENDING agency rules at ***OAC 317:30-5-95.33*** will comply with federal regulations by assuring that members under twenty-one (21) years of age who are residing in qualified inpatient psychiatric settings have access to a

full range of medically necessary Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services. Revisions will also emphasize that EPSDT services are accessible, regardless of whether such services are listed on the member's individual plan of care.

Budget Impact: Budget neutral

(Reference APA WF # 18-28)

Q. AMENDING agency rules at ***OAC 317:30-5-664.3*** and ADDING agency rules at ***OAC 317:30-5-664.4*** will reinstate administrative rules to allow and better define multiple encounters at Federally Qualified Health Centers (FQHCs). Additional revisions will establish guidelines for these multiple encounters. Finally, revisions will update/remove outdated language in order to reflect current business practices and to provide consistency throughout policy.

Budget Impact: The agency predicts that the budget impact is nominal. Thus, the agency estimates this change to be budget neutral.

(Reference APA WF # 18-30)

MOTION: Member Hausheer moved for approval of Item 6B-Q as published. The motion was seconded by Member Kennedy

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Nuttle, Member Shamblin

DHS Initiated

R. AMENDING agency rules at ***OAC 317:40-7-5, 317:40-7-6, 317:40-7-15 and 317:40-7-21*** will add new language to provide general clarification that when a home-based business is established through the Oklahoma Department of Rehabilitation (OKDRS) services, Developmental Disabilities Services (DDS) stabilization services are utilized when the OKDRS end. In addition, new language will provide guidelines for the Personal Support Team to follow when the required thirty (30) hours of employment services through Home and Community-Based Service (HCBS) waivers is not met. Examples of these services include community-based services, center-based services, employment training specialist intensive training services, and job coaching services. Finally, revisions will include removal of outdated language relating to the exception process for employment services through the HCBS waiver and will update obsolete acronyms.

Budget Impact: Budget neutral

(Reference APA WF # 18-22B)

S. AMENDING agency rules at ***OAC 317:30-5-1041 through 317:30-5-1044 and 317:30-5-1046*** will streamline group home coverage and reimbursement policy language and develop consistency with current practice. The proposed revisions will outline and clarify provider requirements and remove references to any services provided in wilderness camps and Diagnostic and Evaluation (D&E) centers. Finally, revisions will involve limited rewriting aimed at updating outdated terminology.

Budget Impact: The proposed changes would potentially result in a combined federal and state spending of $7,048,848 total with $2,663,063 in state share for SFY2020. The state share will be paid by the Oklahoma Department of Human Services (DHS) and Oklahoma Juvenile Affairs (OJA) for their respective homes.

(Reference APA WF # 18-26)

MOTION: Member Hausheer moved for approval of Item 6R-S as published. The motion was seconded by Member Case

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Kennedy, Member Nuttle, Member Shamblin

L. AMENDING agency rules at ***OAC 317:30-5-2 and 317:30-5-11*** will clarify that when rendering a direct physician service visit in a nursing facility, a psychiatrist or a physician with appropriate behavioral health training is required to perform such service. Additionally, revisions will clarify that other than the two (2) allowable direct physician services visit in a nursing facility, reimbursement for psychiatric services to members residing in a nursing facility is not allowed. Revisions will also reflect WF 18-17 policy changes to update the child abuse section to provide a more thorough explanation of how to report abuse and neglect, including clarifying text, and updating outdated citations. Further, revisions will also reference WF 18-24 out-of-state policy.

Budget Impact: The proposed rule will result in small savings to the agency as it will place limits on any overutilization of services.

(Reference APA WF # 18-23)

MOTION: Member Case moved for approval of Item 6L as published. The motion was seconded by Member Hausheer

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Kennedy, Member Nuttle, Member Shamblin

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

Burl Beasley, Assistant Director of Pharmacy Services

A. **Arikayce® (Amikacin Liposome Inhalation Suspension)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

B. **Revcovi™ (Elapegdemase-lvlr)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

C. **Lokelma™ (Sodium Zirconium Cyclosilicate** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

D. **Tavalisse™ (Fostamatinib), Doptelet® (Avatrombopag), and Mulpleta® (Lusutrombopag)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

E. **Carbaglu® (Carglumic Acid)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

MOTION: Vice-Chairman Yaffe moved for approval of Item 7A-E. The motion was seconded by Member Hausheer

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Kennedy, Member Nuttle, Member Shamblin

ITEM 8 / NEW BUSINESS

There was no new business.

ITEM 9 / ADJOURNMENT

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

FOR THE MOTION: Chairman Hupfeld, Member Case, Member Hausheer, Member Kennedy, Member Shamblin,

Meeting adjourned at 10:40 a.m., 4/1/2019

NEXT BOARD MEETING
May 9, 2019
Oklahoma Health Care Authority
Oklahoma City, OK

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

FINANCIAL REPORT

For the Nine Months Ended March 31, 2019
Submitted to the CEO & Board

- Revenues for OHCA through March, accounting for receivables, were **$3,211,305,716** or **.3% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$3,229,293,813** or **.7% under** budget.
- The state dollar budget variance through March is a positive **$13,822,739.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		10.8
Administration		4.4
Revenues:		
Drug Rebate		1.8
Medical Refunds		.4
Taxes and Fees		(3.6)
Total FY 19 Variance	**$**	**13.8**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2019, For the Nine Month Period Ending March 31, 2019

REVENUES	FY19 Budget YTD	FY19 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 760,381,392	$ 760,381,392	$ -	0.0%
State Appropriations - GME Appropriated Funds	$ 82,533,240	$ 82,533,240	$ -	0.0%
Federal Funds	1,795,421,190	1,784,881,065	(10,540,125)	(0.6)%
Tobacco Tax Collections	36,093,515	32,823,191	(3,270,324)	(9.1)%
Quality of Care Collections	59,381,799	58,776,272	(605,527)	(1.0)%
Prior Year Carryover	20,414,314	20,414,314	-	0.0%
Federal Deferral - Interest	237,190	237,190	-	0.0%
Drug Rebates	264,705,150	269,563,089	4,857,939	1.8%
Medical Refunds	28,117,326	29,108,754	991,427	3.5%
Supplemental Hospital Offset Payment Program	160,632,021	160,632,021	-	0.0%
Other Revenues	11,671,380	11,955,187	283,807	2.4%
TOTAL REVENUES	**$ 3,219,588,519**	**$ 3,211,305,716**	**$ (8,282,803)**	**(0.3)%**

EXPENDITURES	FY19 Budget YTD	FY19 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 44,352,232**	**$ 36,451,820**	**$ 7,900,412**	**17.8%**
ADMINISTRATION - CONTRACTS	**$ 84,220,267**	**$ 76,932,534**	**$ 7,287,733**	**8.7%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	29,442,312	29,431,204	11,108	0.0%
Acute Fee for Service Payments:				
Hospital Services	710,993,491	716,841,600	(5,848,109)	(0.8)%
Behavioral Health	14,678,216	13,192,004	1,486,212	10.1%
Physicians	308,984,681	295,037,955	13,946,726	4.5%
Dentists	96,627,839	96,701,704	(73,865)	(0.1)%
Other Practitioners	40,668,098	39,997,027	671,070	1.7%
Home Health Care	16,106,041	17,832,459	(1,726,418)	(10.7)%
Lab & Radiology	20,399,398	18,691,142	1,708,256	8.4%
Medical Supplies	39,716,073	40,628,476	(912,403)	(2.3)%
Ambulatory/Clinics	173,889,368	186,040,260	(12,150,892)	(7.0)%
Prescription Drugs	488,199,341	475,072,499	13,126,843	2.7%
OHCA Therapeutic Foster Care	124,821	838	123,982	99.3%
Other Payments:				
Nursing Facilities	416,467,059	424,265,765	(7,798,706)	(1.9)%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	46,804,909	47,756,061	(951,152)	(2.0)%
Medicare Buy-In	133,128,739	131,260,237	1,868,502	1.4%
Transportation	53,462,635	51,681,039	1,781,596	3.3%
Money Follows the Person-OHCA	260,249	268,577	(8,328)	(3.2)%
Electonic Health Records-Incentive Payments	2,415,378	2,415,378	-	0.0%
Part D Phase-In Contribution	81,996,597	81,337,638	658,959	0.8%
Supplemental Hospital Offset Payment Program	357,651,130	357,651,130	-	0.0%
Telligen	8,210,205	7,238,251	971,954	11.8%
Total OHCA Medical Programs	**3,040,226,581**	**3,033,341,245**	**6,885,335**	**0.2%**
OHCA Non-Title XIX Medical Payments	67,037	34,974	32,063	0.0%
OHCA Non-Title XIX - GME	82,533,239	82,533,239	(0)	0.0%
TOTAL OHCA	**$ 3,251,399,356**	**$ 3,229,293,813**	**$ 22,105,543**	**0.7%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (31,810,836)**	**$ (17,988,097)**	**$ 13,822,739**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
SFY 2019, For the Nine Month Period Ending March 31, 2019

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 29,498,527	$ 29,423,599	$ -	$ 67,323	$ -	$ 7,605	$ -
Inpatient Acute Care	884,450,031	460,171,885	365,015	2,179,312	267,087,338	789,760	153,856,721
Outpatient Acute Care	336,436,066	251,474,486	31,203	3,312,055	77,609,072	4,009,251	-
Behavioral Health - Inpatient	34,398,604	6,962,404	-	320,087	11,684,610	-	15,431,503
Behavioral Health - Psychiatrist	7,499,711	6,229,600	-	-	1,270,111	-	-
Behavioral Health - Outpatient	11,984,123	-	-	-	-	-	11,984,123
Behaviorial Health-Health Home	32,262,411	-	-	-	-	-	32,262,411
Behavioral Health Facility- Rehab	167,094,141	-	-	-	-	83,661	167,094,141
Behavioral Health - Case Management	2,013,488	-	-	-	-	-	2,013,488
Behavioral Health - PRTF	40,678,351	-	-	-	-	-	40,678,351
Behavioral Health - CCBHC	49,274,135	-					49,274,135
Residential Behavioral Management	8,084,722	-	-	-	-	-	8,084,722
Targeted Case Management	53,204,160	-	-	-	-	-	53,204,160
Therapeutic Foster Care	838	838	-	-	-	-	-
Physicians	346,264,505	291,823,907	43,576	3,775,509	-	3,170,472	47,451,041
Dentists	96,733,625	96,693,900	-	31,920	-	7,805	-
Mid Level Practitioners	1,627,385	1,620,822	-	6,085	-	479	-
Other Practitioners	38,737,257	37,954,646	334,773	361,530	-	86,307	-
Home Health Care	17,841,746	17,826,847	-	9,287	-	5,612	-
Lab & Radiology	19,228,595	18,525,155	-	537,453	-	165,987	-
Medical Supplies	40,792,200	38,568,274	2,033,649	163,724	-	26,553	-
Clinic Services	188,015,995	181,330,907	-	1,265,968	-	194,854	5,224,265
Ambulatory Surgery Centers	4,639,168	4,505,992	-	124,670	-	8,507	-
Personal Care Services	7,892,335	-	-	-	-	-	7,892,335
Nursing Facilities	424,265,765	258,901,949	165,362,725	-	-	1,091	-
Transportation	51,652,200	49,567,069	1,892,672	85,453	-	107,006	-
IME/DME	37,576,644	-	-	-	-	-	37,576,644
ICF/IID Private	47,756,061	39,050,516	8,705,545	-	-	-	-
ICF/IID Public	11,365,776	-	-	-	-	-	11,365,776
CMS Payments	212,597,875	212,262,126	335,750	-	-	-	-
Prescription Drugs	486,282,202	473,105,193	-	11,209,703	-	1,967,305	-
Miscellaneous Medical Payments	114,292	108,311	-	-	-	5,980	-
Home and Community Based Waiver	156,159,632	-	-	-	-	-	156,159,632
Homeward Bound Waiver	59,168,535	-	-	-	-	-	59,168,535
Money Follows the Person	268,577	268,577	-	-	-	-	-
In-Home Support Waiver	18,186,485	-	-	-	-	-	18,186,485
ADvantage Waiver	106,961,801	-	-	-	-	-	106,961,801
Family Planning/Family Planning Waiver	3,174,038	-	-	-	-	-	3,174,038
Premium Assistance*	43,510,421	-	-	43,510,420.95	-	-	-
Telligen	7,238,251	7,238,251	-	-	-	-	-
Electronic Health Records Incentive Payments	2,415,378	2,415,378	-	-	-	-	-
Total Medicaid Expenditures	**$ 4,087,346,053**	**$ -**	**$ 2,486,030,634**	**$ 179,104,907**	**$ 66,960,501**	**$ 357,651,130**	**$ 10,638,235**	**$ 987,044,307**

* Includes $43,184,821.72 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
SFY 2019, For the Nine Month Period Ending March 31, 2019

		FY19
REVENUE		**Actual YTD**
Revenues from Other State Agencies	$	425,304,781
Federal Funds		623,343,773
TOTAL REVENUES	**$**	**1,048,648,554**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	156,159,632
Money Follows the Person		-
Homeward Bound Waiver		59,168,535
In-Home Support Waivers		18,186,485
ADvantage Waiver		106,961,801
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		11,365,776
Personal Care		7,892,335
Residential Behavioral Management		5,123,749
Targeted Case Management		46,786,128
Total Department of Human Services		**411,644,441**
State Employees Physician Payment		
Physician Payments		47,451,041
Total State Employees Physician Payment		**47,451,041**
Education Payments		
Indirect Medical Education		34,965,572
Direct Medical Education		2,611,072
Total Education Payments		**37,576,644**
Office of Juvenile Affairs		
Targeted Case Management		1,770,289
Residential Behavioral Management		2,960,972
Total Office of Juvenile Affairs		**4,731,262**
Department of Mental Health		
Case Management		2,013,488
Inpatient Psychiatric Free-standing		15,431,503
Outpatient		11,984,123
Health Homes		32,262,411
Psychiatric Residential Treatment Facility		40,678,351
Certified Community Behavioral Health Clinics		49,274,135
Rehabilitation Centers		167,094,141
Total Department of Mental Health		**318,738,152**
State Department of Health		
Children's First		541,293
Sooner Start		1,522,638
Early Intervention		3,003,586
Early and Periodic Screening, Diagnosis, and Treatment Clinic		1,269,739
Family Planning		275,422
Family Planning Waiver		2,889,362
Maternity Clinic		964
Total Department of Health		**9,503,004**
County Health Departments		
EPSDT Clinic		506,134
Family Planning Waiver		9,254
Total County Health Departments		**515,388**
State Department of Education		**118,762**
Public Schools		**984,102**
Medicare DRG Limit		**144,535,167**
Native American Tribal Agreements		**1,924,791**
Department of Corrections		**1,633,595**
JD McCarty		**7,687,959**
Total OSA Medicaid Programs	**$**	**987,044,307**
OSA Non-Medicaid Programs	**$**	**59,319,084**
Accounts Receivable from OSA	**$**	**(2,285,164)**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

SFY 2019, For the Nine Month Period Ending March 31, 2019

REVENUES		FY 19 Revenue
SHOPP Assessment Fee		160,493,884
Federal Draws	$	218,743,838
Interest		135,854
Penalties		2,283
State Appropriations		(22,650,000)
TOTAL REVENUES	$	356,725,859

EXPENDITURES	Quarter	Quarter	Quarter	Quarter		FY 19 Expenditures
Program Costs:	7/1/18 - 9/30/18	10/1/18 - 12/31/18	1/1/19 - 3/31/19	4/1/19 - 6/30/19		
Hospital - Inpatient Care	84,988,728	99,052,816	83,045,794		$	267,087,338
Hospital -Outpatient Care	25,649,937	29,135,930	22,823,205			77,609,072
Psychiatric Facilities-Inpatient	3,352,856	3,909,783	4,421,971			11,684,610
Rehabilitation Facilities-Inpatient	416,290	485,439	368,383			1,270,111
Total OHCA Program Costs	114,407,810	132,583,968	110,659,352	-	$	357,651,130
Total Expenditures					$	357,651,130

CASH BALANCE		
	$	(925,272)

*** Expenditures and Federal Revenue processed through Fund 340

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2019, For the Nine Month Period Ending March 31, 2019

REVENUES	Total Revenue	State Share
Quality of Care Assessment	**$ 58,741,660**	**$ 58,741,660**
Interest Earned	**34,612**	**34,612**
TOTAL REVENUES	**$ 58,776,272**	**$ 58,776,272**

EXPENDITURES	FY 19 Total $ YTD	FY 19 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 162,609,626	$ 63,216,256	
Eyeglasses and Dentures	204,098	79,364	
Personal Allowance Increase	2,549,000	991,080	
Coverage for Durable Medical Equipment and Supplies	2,033,649	790,886	
Coverage of Qualified Medicare Beneficiary	774,567	301,229	
Part D Phase-In	335,750	335,750	
ICF/IID Rate Adjustment	4,022,644	1,563,966	
Acute Services ICF/IID	4,682,900	1,819,878	
Non-emergency Transportation - Soonerride	1,892,672	735,964	
Total Program Costs	**$ 179,104,907**	**$ 69,834,372**	**$ 69,834,372**
Administration			
OHCA Administration Costs	$ 402,143	$ 201,072	
DHS-Ombudsmen	109,330	109,330	
OSDH-Nursing Facility Inspectors	158,645	158,645	
Mike Fine, CPA	3,600	1,800	
Total Administration Costs	**$ 673,718**	**$ 470,847**	**$ 470,847**
Total Quality of Care Fee Costs	**$ 179,778,625**	**$ 70,305,218**	
TOTAL STATE SHARE OF COSTS			**$ 70,305,218**

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 2019, For the Nine Month Period Ending March 31, 2019

REVENUES	FY 18 Carryover	FY 19 Revenue	Total Revenue
Prior Year Balance	$ 12,902,064	$ -	$ 6,997,587
State Appropriations	(6,000,000)	-	-
Tobacco Tax Collections	-	26,995,742	26,995,742
Interest Income	-	172,804	172,804
Federal Draws	208,931	27,590,649	27,590,649
TOTAL REVENUES	$ 7,110,995	$ 54,759,195	$ 61,756,781

EXPENDITURES		FY 18 Expenditures	FY 19 Expenditures	Total State $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 43,184,822	$ 43,184,822
	College Students/ESI Dental		325,599	126,890
Individual Plan				
	SoonerCare Choice		$ 65,481	$ 25,475
	Inpatient Hospital		2,176,090	851,037
	Outpatient Hospital		3,220,512	1,261,662
	BH - Inpatient Services-DRG		306,582	118,796
	BH -Psychiatrist		-	-
	Physicians		3,721,604	1,452,141
	Dentists		31,330	12,087
	Mid Level Practitioner		5,634	2,198
	Other Practitioners		358,150	139,671
	Home Health		9,287	3,685
	Lab and Radiology		529,103	206,011
	Medical Supplies		163,168	63,739
	Clinic Services		1,225,933	476,368
	Ambulatory Surgery Center		124,098	48,578
	Prescription Drugs		11,015,052	4,260,042
	Transportation		84,058	32,527
	Premiums Collected		-	(410,235)
Total Individual Plan			$ 23,036,082	$ 8,543,782
	College Students-Service Costs		$ 413,998	$ 161,062
Total OHCA Program Costs			$ 66,960,501	$ 52,016,556
Administrative Costs				
	Salaries	$ 24,543	$ 1,738,409	$ 1,762,952
	Operating Costs	9,662	102,214	111,876
	Health Dept-Postponing	-	-	-
	Contract - HP	79,204	667,841	747,045
Total Administrative Costs		$ 113,409	$ 2,508,464	$ 2,621,873
Total Expenditures				$ 54,638,429
NET CASH BALANCE		$ 6,997,587		$ 7,118,352

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

SFY 2019, For the Nine Month Period Ending March 31, 2019

REVENUES	FY 19 Revenue	State Share
Tobacco Tax Collections	$ 538,806	$ 538,806
TOTAL REVENUES	**$ 538,806**	**$ 538,806**

EXPENDITURES	FY 19 Total $ YTD	FY 19 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 7,605	$ 2,067	
Inpatient Hospital	789,760	211,453	
Outpatient Hospital	4,009,251	1,089,839	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	1,091	287	
Physicians	3,170,472	869,914	
Dentists	7,805	2,112	
Mid-level Practitioner	479	129	
Other Practitioners	86,307	23,340	
Home Health	5,612	1,515	
Lab & Radiology	165,987	44,937	
Medical Supplies	26,553	7,151	
Clinic Services	194,854	53,087	
Ambulatory Surgery Center	8,507	2,273	
Prescription Drugs	1,967,305	534,805	
Transportation	107,006	29,141	
Miscellaneous Medical	5,980	1,587	
Total OHCA Program Costs	**$ 10,554,574**	**$ 2,873,637**	
OSA DMHSAS Rehab	$ 83,661	22,666	
Total Medicaid Program Costs	**$ 10,638,235**	**$ 2,896,303**	
TOTAL STATE SHARE OF COSTS			**$ 2,896,303**

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

OHCA Board Meeting
May 2019
(March 2019 Data)

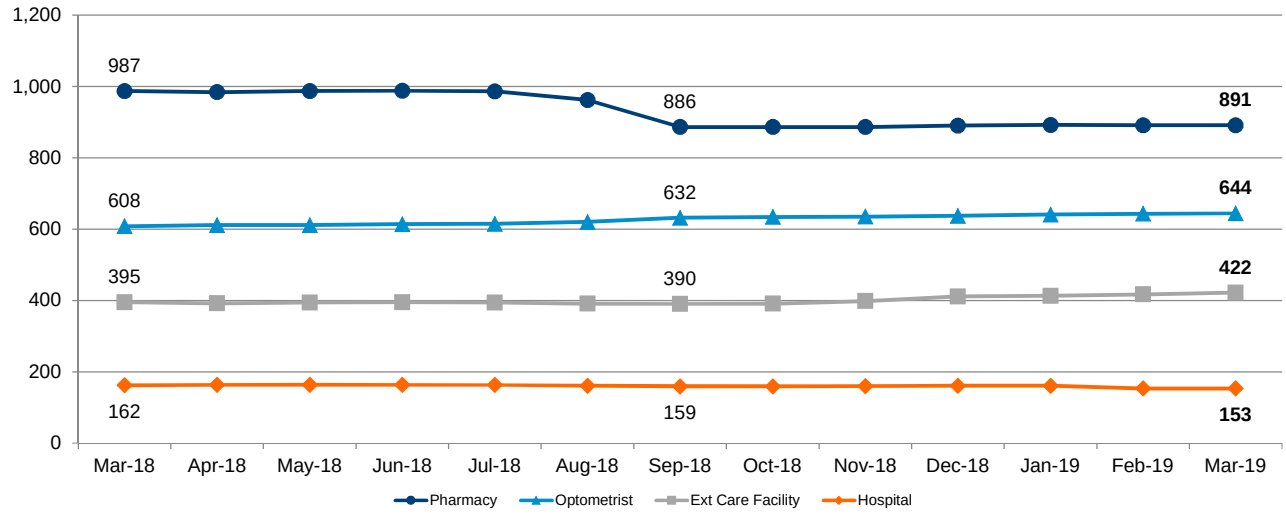
SOONERCARE ENROLLMENT/EXPENDITURES

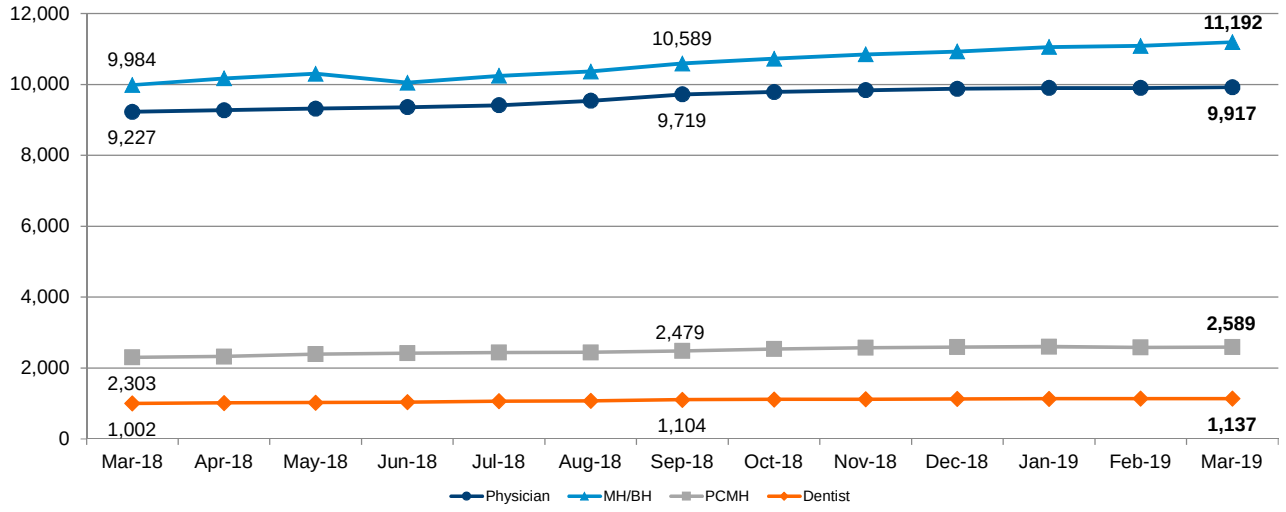
Delivery System			Enrollment March 2019	Children March 2019	Adults March 2019	Enrollment Change	Total Expenditures March 2019	PMPM March 2019
SoonerCare Choice Patient-Centered Medical Home			**530,270**	**440,903**	**89,367**	**171**	**$168,006,947**	
	Lower Cost	*(Children/Parents; Other)*	487,805	427,710	60,095	593	$122,145,494	$250
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	42,465	13,193	29,272	-422	$45,861,453	$1,080
SoonerCare Traditional			**232,136**	**83,784**	**148,352**	**-885**	**$179,758,224**	
	Lower Cost	*(Children/Parents; Other; Q1; SLMB)*	116,404	79,054	37,350	-1,053	$43,222,578	$371
	Higher Cost	*(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)*	115,732	4,730	111,002	168	$136,535,646	$1,180
Insure Oklahoma			**18,824**	**510**	**18,314**	**-450**	**$7,454,093**	
	Employer-Sponsored Insurance		13,609	326	13,283	-399	$4,973,670	$365
	Individual Plan		5,215	184	5,031	-51	$2,480,423	$476
SoonerPlan			**28,516**	**2,308**	**26,208**	**-335**	**$217,242**	$8
TOTAL			**809,746**	**527,505**	**282,241**	**-1,499**	**$355,436,506**	

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.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

IN-STATE CONTRACTED PROVIDERS

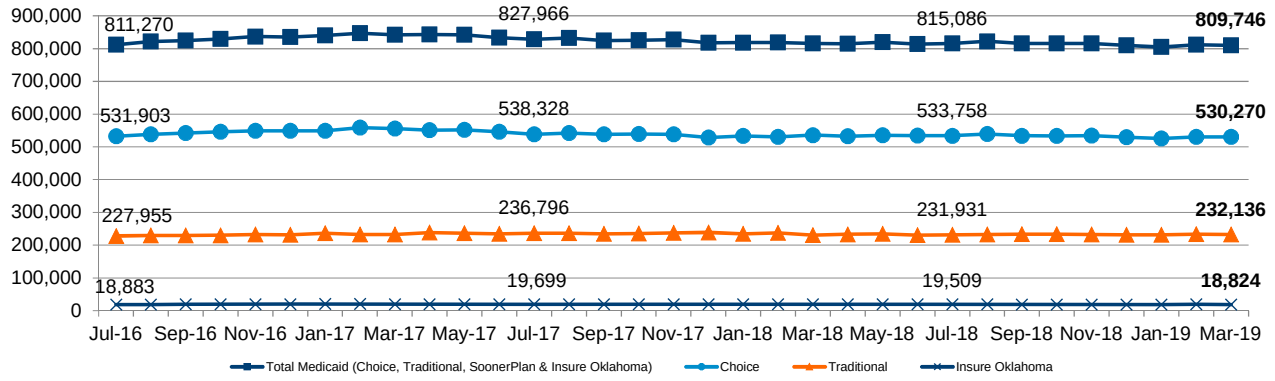
Total In-State Providers: 36,316 (+1,089) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

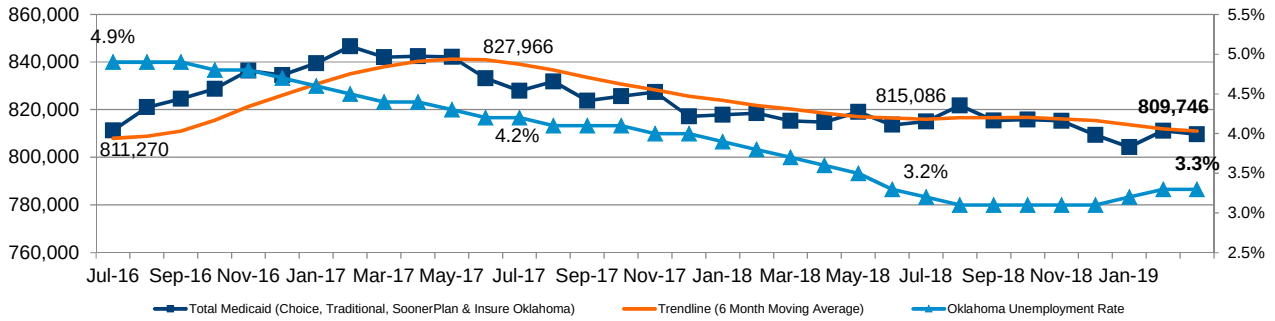




*In general, decreases are due to contract renewal. Decrease during contract renewal period is typical during all renewal periods.
MH/BH is Mental Health and Behavioral Health providers. PCMH is Patient-Centered Medical Home (Choice) providers.

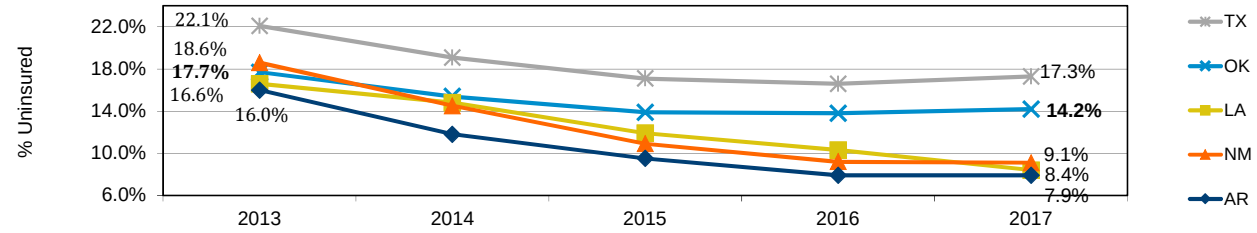
ENROLLMENT BY MONTH



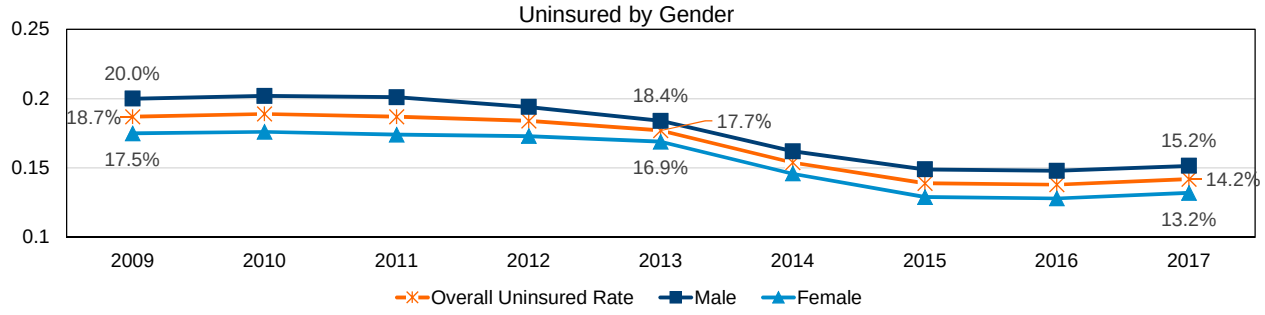


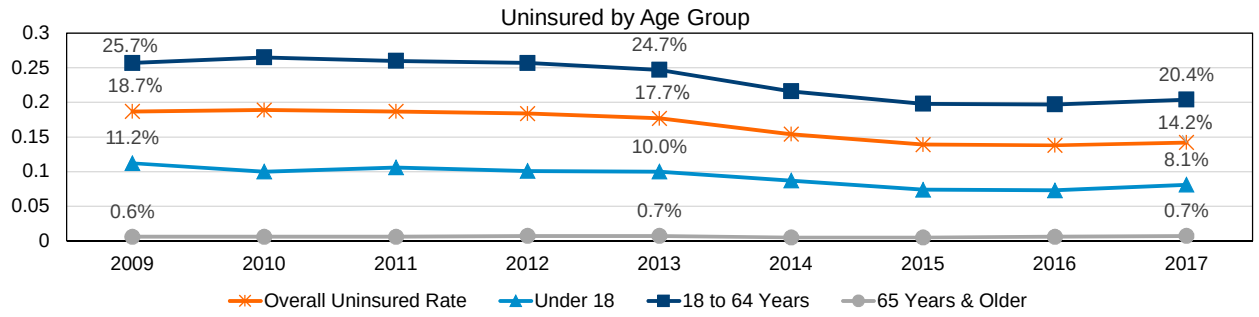
Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted. Data was extracted on August 22, 2018.
In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds.

OKLAHOMA UNINSURED (CALENDAR YEAR)



AR, LA and NM have expanded Medicaid.





CY 2018 Uninsured will be available around October 2019 once data is released by Census.gov.

OHCA Medical Professional Services

Medical / Dental Directors Section

- 4 Full time Physicians / 1 Full time Dentist
  - 1 Chief Medical Officer
  - 1 Sr. Medical Director
  - 2 Medical Directors
  - 1 Dental Director
  - 1 Geneticist
- Consultants
  - 1 Allergy / Pediatrics
  - 1 OB / GYN
  - 1 Optometrist
  - 1 Family Practice
  - 1 Audiologist
  - 1 Podiatrist
  - 1 Orthodontist
  - 2 Dentists

Medical Authorization and Review Section

- Prior Authorization Review
  - 9 Full time nurses / 6 Full time Analysts
    - 1 Director
    - 2 Supervisors
    - 1 Sr. Medical Review Nurse
    - 5 Medical Reviews Nurses
    - 6 Medical Auth Analysts
    - Consultants:
      - 5 PT (with 1 handling DME)
      - 4 SLP Therapists
      - 1 OT
      - 5 Contract Nurses
- Systems Integrity / Suspended claims Review
  - 10 Full time Nurses / 1 Full time Medical Data Analyst / 1 Full time Coding Analyst

Quality Assurance / Quality Improvement Section

- 4 Full time Nurses / 2 Full time Analysts / 1 Full time Coordinator
  - 1 Manager
  - 3 Nurse Case Managers
  - 2 Compliance Analysts
  - 1 QA/QI Coordinator

Medical Administrative Support Services Section

- 5 Full time Nurses / 1 Full time Lead / 1 Full time Analyst
  - 1 Director
  - 4 Medical Administrative Nurses
  - 1 Medical Administrative Lead
  - 1 Medical Data Analyst

Medical / Dental Directors Section

1. Prior authorization for Medical and Dental reviews
2. Medical reviews of complaints related to quality of care
3. Program Integrity (PI) Initial review support and audit reconsideration reviews
4. Coverage research and decision making, procedures, new initiatives, and policy input
5. Misc reviews - BCC, C-sections, Out of State, etc
6. Legal appeal hearings
7. Guideline development support and review
8. Peer-to-peer consultations
9. Medical/Dental expertise and resource for agency

Medical Authorization and Review Section

1. Timely review of PAs to determine medical necessity
   a. Total Lines - 423,099 (2018)
   b. Amendments - 39,673
2. Systems Integrity (SI) retrospective review of claims for medical necessity and coding appropriateness
   a. 153,457 Claim lines reviewed
3. Calls and E-mails - 14,258

Quality Assurance / Quality Improvement Section

1. Receive and review quality of care referrals
2. Member complaints
3. Provider issues - complex issues research to resolution
4. QIO - Quality Improvement Organization Contract Mgmt
   a. External Peer Review - currently 21 cases in progress
   b. Retrospective Hospital Reviews - 1600 claims/mo
5. CAHPS Survey - Consumer Assessment of Healthcare Providers and Systems and PAM - Payment Accuracy Measurement (Annual)
6. QAAG - Quality Assurance Advisory Group
7. State Licensure Action - Review and monitoring
8. PCMH (Patient Centered Medical Home) - Compliance Reviews
   a. 179 in 2018

Medical Administrative Support Services Section

1. Guideline Research and Development
2. Evidence Based Research for coverage determination of new product and technology
   Examples: a. Biologic skin substitutes
   b. Trans Catheter Aortic Valve Replacement
3. Utilization Review - Looking at outliers and areas of rapid utilization increase - Example: Urine Drug Testing - 2011 - $3.7 M / 2014 - $32 M / 2016-18 - $6 M
4. ICD-10, CPT, and HCPCS code review for coverage
5. Coding expertise and resource for agency
6. New project Research & Development - Example: Interqual automation implementation into MAU
7. Policy input and support
8. MPSU - Workflow analysis and reporting - Daily and Monthly

FINDING NO: 2018-008 (Repeat 2017-002)
STATE AGENCY: Oklahoma Health Care Authority
FEDERAL AGENCY: United States Department of Health and Human Services
CFDA NO: 93.767; 93.778
FEDERAL PROGRAM NAME: Children's Health Insurance Program (CHIP); Medicaid Cluster (MAP)
FEDERAL AWARD NUMBER: 1705OK5021; 1705OK0301; 1805OK5021; 1705OK5MAP; 1805OK5MAP
FEDERAL AWARD YEAR: 2017 and 2018
CONTROL CATEGORY: Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Eligibility (*MAP only*)

Criteria: 45 CFR §75.303 states, "The non-Federal entity must:(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)."

The Government Accountability Office (GAO) Standards for Internal Control in the Federal Government 10.03 states, in part, "Transactions are promptly recorded to maintain their relevance and value to management in controlling operations and making decisions. This applies to the entire process or life cycle of a transaction or event from its initiation and authorization through its final classification in summary records. In addition, management designs control activities so that all transactions are completely and accurately recorded."

The GAO Standards for Internal Control in the Federal Government 10.13 states, in part, "Segregation of duties helps prevent fraud, waste, and abuse in the internal control system. Management considers the need to separate control activities related to authority, custody, and accounting of operations to achieve adequate segregation of duties."

Adequate internal controls over access and accountability for resources include (1) limiting access to resources and records to authorized individuals and (2) assigning and maintaining accountability for the custody and use of resources.

Adequate internal controls over separation of duties and supervision include separating key duties and responsibilities in authorizing, processing, recording, and reviewing official agency transactions.

Condition and Context: The Independent Service Auditor's Report on the Service Organization's System (SOC-1) for the period of September 1, 2016 to August 31, 2017 indicated control issues related to the job scheduling and access to data and programs control objectives and related controls for the general computer controls. *This condition only applies to a portion of state fiscal year 2018, July through August of 2017.*

Cause: The service organization did not ensure users were restricted only to either development or production access in the job scheduling, nor did they ensure active users had appropriate access or terminated users were eliminated from the access to data and programs.

Effect: Access to both development and production, and inappropriate user access increases the risk of waste, loss, unauthorized use or misappropriation of state and federal funds.

Recommendation: We recommend the Authority continue to follow-up with the service organization and ensure noted deficiencies are addressed and corrective actions noted in the SOC-1 report are implemented in a timely manner.

Views of Responsible Official(s)
Contact Person: Josh Richards
Anticipated Completion Date: 9/1/2017
Corrective Action Planned: The Oklahoma Health Care Authority had direct communications with our service provider about these deficiencies and their corrective actions during regularly scheduled status meetings. These findings and corrective actions are monitored monthly by the agency Security Governance Committee to ensure actions are taken timely and are appropriate. In addition, the most recent SOC-1 report has been issued with no control issues, indicating these issues have been corrected.

FINDING NO: 2018-023 (Repeat 2017-004)
STATE AGENCY: Oklahoma Health Care Authority
FEDERAL AGENCY: United States Department of Health and Human Services
CFDA NO: 93.778
FEDERAL PROGRAM NAME: Medicaid Cluster (MAP)
FEDERAL AWARD NUMBER: 1705OK5MAP and 1805OK5MAP
FEDERAL AWARD YEAR: 2017 and 2018
CONTROL CATEGORY: Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Eligibility
QUESTIONED COSTS: $36,471

Criteria: 42 CFR §435.916(b) states in part, "The agency must redetermine the eligibility of Medicaid beneficiaries excepted from modified adjusted gross income under §435.603(j) of this part, for circumstances that may change, at least every 12 months".

42 CFR §431.10(c)(2) states, "The Medicaid agency may delegate authority to make eligibility determinations or to conduct fair hearings under this section only to a government agency which maintains personnel standards on a merit basis."

42 CFR §431.10(c)(3)(ii) states in part, "The Medicaid agency must exercise appropriate oversight over the eligibility determinations and appeals decisions made by such agencies ..."

45 CFR §75.303 states, "The non-Federal entity must:(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)."

Additionally, a component objective of generally accepted accounting principles is to provide accurate and reliable information.

Condition and Context: The Authority delegates the Oklahoma Department of Human Services (DHS) to determine eligibility for non-MAGI (modified adjusted gross income) recipients.

- For four of the 72 (5.56%) non-MAGI recipients of Medical Assistance Program payments tested, a redetermination of Medicaid eligibility had not been performed within 12 months of the last eligibility determination or redetermination and benefits were not discontinued after the period of eligibility expired. However, only three of those recipients had claims paid during SFY 2018. The recipient was ineligible for a portion of state fiscal year 2018.
- For four of the 72 (5.56%) non-MAGI recipients of Medical Assistance Program payments tested, the recipient passed away during our audit period; however, the recipient had claims paid with date of service after their date of death. Of those four recipients that passed away during our audit period, three were identified by the Authority for recoupment during their annual death file audit. We will not question the costs of those three recipients.
- The universe included 181,023 non-MAGI recipients with medical expenditures totaling $2,223,304,873. Medical payments for recipients sampled totaled $1,169,275. Questioned costs include all payments for services provided to those four recipients within the time period for which they were ineligible during SFY 2018. Payments for medical expenditures to recipients with non-compliance noted in the sample totaled $61,790, of which $36,471 ($61,790 times the applicable Federal Medical Assistance Percentage (FMAP) rate (59.94% for the exception claims in the first quarter of SFY 18/ 58.57% for the claims in the second, third, and fourth quarters) for each exception claim) is the federal questioned costs.

Cause: The Authority did not exercise appropriate oversight over the eligibility determinations made by DHS to ensure adequate controls are in place to properly close ineligible cases.

Effect: The Authority may be paying for services for which the recipient is not entitled.

Recommendation: We recommend the Authority investigate the recipients identified and, if considered necessary, recoup any funds paid to providers for services for which the recipients were not entitled. We also recommend the Authority take steps to ensure proper oversight over DHS eligibility determinations in order to identify and timely close any ineligible cases.

Views of Responsible Official(s)
Contact Person: Josh Richards
Anticipated Completion Date: June 30, 2019
Corrective Action Planned: OHCA will continue to monitor member eligibility and implement appropriate system changes and internal controls to ensure appropriate eligibility determinations and closures occur to avoid inappropriate payments. The cases related to death match issues are closed and no further payments will occur. OHCA will continue to audit death matches. OHCA will recoup where appropriate, and will reimburse the Federal share for claims paid during periods of ineligibility.

FINDING NO: 2018-025 (Repeat 2017-033)
STATE AGENCY: Oklahoma Health Care Authority
FEDERAL AGENCY: United States Department of Health and Human Services
CFDA NO: 93.778
FEDERAL PROGRAM NAME: Medical Cluster (MAP)
FEDERAL AWARD NUMBER: 1705OK5MAP and 1805OK5MAP
FEDERAL AWARD YEAR: 2017 and 2018
CONTROL CATEGORY: Activities Allowed or Unallowed and Allowable Costs/Cost Principles; Matching
QUESTIONED COSTS: $28

Criteria: 45 CFR §75.403 (Subpart E) states in part, "Costs must…
(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles, and (b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items."

Condition and Context: Medical payments are either direct medical payments that are initiated by the provider or are indirectly related to medical claims and are not initiated by the provider, such as the cost of non-emergency transportation to appointments or capitation payments to primary care providers based on the number of enrolled members. Based on a medical professional's review of 57 direct medical claims initiated by the provider for Medical Assistance Program recipients, one (1.75%) claim had a payment error. The claim billed more units than shown on the supporting documents. For this claim, since the supporting documentation indicated the services provided did not meet Medicaid policy/regulatory requirements and were not adequately supported by medical records or other evidence indicating that the services were actually provided and/or necessary, we will question the costs. The universe included 22,966,923 direct medical payments totaling $4,086,640,272. Payments for direct medical expenditures in our sample totaled $37,191. Payments for direct medical expenditures with non-compliance noted in our sample totaled $47, of which $28 ($47 times the applicable Federal Medical Assistance Percentage (FMAP) rate 59.94% for the exception claim in the first quarter) is the federal questioned costs.

In addition, one (1) claim had documentation errors. The attending physician listed on the claim did not match the physician noted in the medical records provided; however, both physicians are approved contractors with OHCA. For this claim, since the supporting documentation indicated the services provided did meet Medicaid policy/regulatory requirements and were adequately supported by medical records or other evidence indicating that the services were actually provided and/or necessary, we will not question the costs.

Cause: One (1) claim submitted by a provider was not appropriately supported by medical records, and one (1) claim had documentation submitted to the Authority which included documentation errors.

Effect: The Authority may be paying for services that were not performed or were not medically necessary

Recommendation: We recommend the Authority investigate the items identified and, if considered necessary, recoup any funds paid to providers for services that were not supported by medical records.

Views of Responsible Official(s)
Contact Person: Josh Richards
Anticipated Completion Date: June 30, 2019
Corrective Action Planned: OHCA will continue its Clinical Audit and Payment Accuracy Measurement processes to ensure oversight of the program. Regarding these specific findings, the federal share will be returned to CMS.

FINDING NO: 2018-026 (Repeat 2017-034)
STATE AGENCY: Oklahoma Health Care Authority
FEDERAL AGENCY: United States Department of Health and Human Services
CFDA NO: 93.767
FEDERAL PROGRAM NAME: Children's Health Insurance Program
FEDERAL AWARD NUMBER: 1705OK5021, 1805OK5021 and 1705OK0301
FEDERAL AWARD YEAR: 2017 and 2018
CONTROL CATEGORY: Activities Allowed or Unallowed and Allowable Costs/Cost Principles; Matching
QUESTIONED COSTS: $1,670

Criteria: 45 CFR §75.403 (Subpart E) states in part, "Costs must…
(a) Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles, and (b) Conform to any limitations or exclusions set forth in these principles or in the Federal award as to types or amount of cost items."

Condition and Context: Medical payments are either direct medical payments that are initiated by the provider or are indirectly related to medical claims and are not initiated by the provider, such as the cost of non-emergency transportation to appointments or capitation payments to primary care providers based on the number of enrolled members. Based on a medical professional's review of 71 direct medical claims initiated by the provider for Children's Health Insurance Program recipients, three (4.23%) claims had payment errors. One (1) billed claim indicated the provider was unable to complete the procedure, while the other two (2) billed claims were upcoded. For these claims, since the supporting documentation indicated the services provided did not meet Medicaid policy/regulatory requirements and were not adequately supported by medical records or other evidence indicating that the services were actually provided and/or necessary, we will question the costs. The universe included 2,370,445 direct medical payments totaling $316,265,268. Payments for direct medical expenditures in our sample totaled $26,463. Payments for direct medical expenditures with non-compliance noted in the sample totaled $1,777, of which $1,670 ($1777 x the applicable Federal Medical Assistance Percentage (FMAP) rate (94.00%) for each exception claim) is the federal questioned costs.

In addition, three (3) claims had documentation errors. For two (2) of the claims, the attending physician listed on the claim did not match the physician noted in the medical records provided; however, both physicians are approved contractors with OHCA. For one (1) of the claims, a data processing error occurred. For these claims, since the supporting documentation indicated the services provided did meet Medicaid policy/regulatory requirements and were adequately supported by medical records or other evidence indicating that the services were actually provided and/or necessary, we will not question the costs.

Cause: Three (3) claims submitted by a provider were not appropriately supported by medical records, and three (3) claims had documentation submitted to the Authority which included documentation errors.

Effect: The Authority may be paying for services that were not performed or are not medically necessary

Recommendation: We recommend the Authority investigate the items identified and, if considered necessary, recoup any funds paid to providers for services that were not supported by medical records.

Views of Responsible Official(s)
Contact Person: Josh Richards
Anticipated Completion Date: June 30, 2019
Corrective Action Planned: OHCA will continue its Clinical Audit and Payment Accuracy Measurement processes to ensure oversight of the program. Regarding these specific findings, the federal share will be returned to CMS.

FINDING NO: 2018-027
STATE AGENCY: Oklahoma Health Care Authority
FEDERAL AGENCY: United States Department of Health and Human Services
CFDA NO: 93.767; 93.778
FEDERAL PROGRAM NAME: Children's Health Insurance Program (CHIP); Medicaid Cluster (MAP)
FEDERAL AWARD NUMBER: 1705OK5021; 1705OK0301; 1805OK5021; 1705OK5MAP; 1805OK5MAP
FEDERAL AWARD YEAR: 2017 and 2018
CONTROL CATEGORY: Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Eligibility

Criteria: 45 CFR §75.303 states, "The non-Federal entity must:(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)."

The Government Accountability Office (GAO) Standards for Internal Control in the Federal Government 10.06 states, "Control activities can be implemented in either an automated or a manual manner. Automated control activities are either wholly or partially automated through the entity's information technology. Automated control activities tend to be more reliable because they are less susceptible to human error and are typically more efficient. If the entity relies on information technology in its operations, management designs control activities so that the information technology continues to operate properly."

The GAO Standards for Internal Control in the Federal Government 11.06 states in part, "Management designs appropriate types of control activities in the entity's information system for coverage of information processing objectives for operational processes."

The GAO Standards for Internal Control in the Federal Government 11.07 states, "Information system general controls (at the entity-wide, system, and application levels) are the policies and procedures that apply to all or a large segment of an entity's information systems. General controls facilitate the proper operation of information systems by creating the environment for proper operation of application controls. General controls include security management, logical and physical access, configuration management, segregation of duties, and contingency planning."

The GAO Standards for Internal Control in the Federal Government 11.12 states, "Security management includes the information processes and control activities related to access rights in an entity's information technology, including who has the ability to execute transactions. Security management includes access rights across various levels of data, operating system (system software), network, application, and physical layers. Management designs control activities over access to protect an entity from inappropriate access and unauthorized use of the system. These control activities support appropriate segregation of duties. By preventing unauthorized use of and changes to the system, data and program integrity are protected from malicious intent (e.g., someone breaking into the technology to commit fraud, vandalism, or terrorism) or error."

Condition and Context: OHCA's Medicaid Management Information System (MMIS) processes medical claims. The MMIS system has over 1,800 edits/audits and validation checks to prevent erroneous payments. The editing process in the MMIS system consists of general data field verifications, provider and recipient eligibility, verification against historical claims data, etc. After discussion with OHCA staff, we determined there was no evidence anyone was monitoring the MMIS edit changes. Certain OHCA employees had the ability to change, create and even deactivate MMIS edits/audits without the review or approval of another individual.

Cause: There is a lack of segregation of duties over changes in edits checks in the MMIS system.

Effect: Lack of segregation of duties over changes in edit checks increases the risk of waste, loss, unauthorized use or misappropriation of state and federal funds.

Recommendation: We recommend OHCA implement internal controls to ensure segregation of duties over changes in edits/audits. These controls should include review and approval by someone other than the individual changing, creating, and deactivating the MMIS edits/audits, and proper monitoring of changes to edits/audits within the MMIS system.

Views of Responsible Official(s)
Contact Person: Brett May
Anticipated Completion Date: 1/31/2019
Corrective Action Planned: Business Enterprise is the system support staff for the business users at OHCA. Within the Business Enterprise Department is the Performance and Electronic Process Unit, which is made up of system analysts. System analysts are referred to as "certain OHCA employees" in the Condition portion of the finding. One of the responsibilities of the system

analysts is to make updates in the MMIS at the request of OHCA business users. Currently, business users will request changes to existing edits to the system analysts. The system analyst will make the update and document who requested the change and why the change was requested. While this does not seem to be a lack of segregation of duties, the system analysts particularly assigned to make these changes do agree there is an opportunity to enhance the current process. This is going to be done by:

1) CO 21575 is being implemented to force a notation in the MMIS when any update is made to an edit. Currently, notes are made but the notes are not required in the system and can be forgotten. This removes the possibility of missing documentation.
2) System Analysts will redirect OHCA business users to the reference file change request system overseen by the System Integrity Unit in the Program Integrity Unit. This will be a central location for requests and approval. Once the system analyst has made the change in production the requester will be informed and instructed to review claims entering the system to properly monitor the change.
   This process will be for changing existing edits and audits and creating new audits. Any new edits would be a result of a Change Order and therefore would not be subject to this process.

FINDING NO: 2018-054
STATE AGENCY: Oklahoma Health Care Authority (OHCA)
FEDERAL AGENCY: United States Department of Health and Human Services
CFDA NO: 93.778
FEDERAL PROGRAM NAME: Medicaid Cluster (MAP)
FEDERAL AWARD NUMBER: 1705OK5MAP; 1805OK5MAP; 1705OK5ADM; 1805OK5ADM
FEDERAL AWARD YEAR: 2017 and 2018
CONTROL CATEGORY: Special Tests and Provisions: Utilization Control and Program Integrity and Medicaid Fraud Control Unit; Activities Allowed or Unallowed; Allowable Costs/Cost Principles; Eligibility
QUESTIONED COSTS: $0

Criteria: 45 CFR §455.13 states, in part, "The Medicaid agency must have (a) Methods and criteria for identifying suspected fraud cases; (b) Methods for investigating these cases. … and (c) Procedures, developed in cooperation with State legal authorities, for referring suspected fraud cases to law enforcement officials."

45 CFR §75.303 states, "The non-Federal entity must:(a) Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and the terms and conditions of the Federal award. These internal controls should be in compliance with guidance in "Standards for Internal Control in the Federal Government" issued by the Comptroller General of the United States or the "Internal Control Integrated Framework", issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO)."

The Government Accountability Office (GAO) Standards for Internal Control in the Federal Government 12.02 states, "Management documents in policies the internal control responsibilities of the organization."

The Government Accountability Office (GAO) Standards for Internal Control in the Federal Government 12.03 states, "Management documents in policies for each unit its responsibility for an operational process's objectives and related risks, and control activity design, implementation, and operating effectiveness. Each unit, with guidance from management, determines the policies necessary to operate the process based on the objectives and related risks for the operational process. Each unit also documents policies in the appropriate level of detail to allow management to effectively monitor the control activity."

The Government Accountability Office (GAO) Standards for Internal Control in the Federal Government 12.04 states,
"Those in key roles for the unit may further define policies through day-to-day procedures, depending on the rate of change in the operating environment and complexity of the operational process. Procedures may include the timing of when a control activity occurs and any follow-up corrective actions to be performed by competent personnel if deficiencies are identified. Management communicates to personnel the policies and procedures so that personnel can implement the control activities for their assigned responsibilities."

The Government Accountability Office (GAO) Standards for Internal Control in the Federal Government 12.05 states, in part, "Management periodically reviews policies, procedures, and related control activities for continued relevance and effectiveness in achieving the entity's objectives or addressing related risks. If there is a significant change in an entity's process, management reviews this process in a timely manner after the change to determine that the control activities are designed and implemented appropriately. … Management considers these changes in its periodic review."

2 CFR 200.508 (d) states, "The auditee must provide the auditor with access to personnel, accounts, books, records, supporting documentation, and other information as needed for the auditor to perform the audit required by this part."

74 Oklahoma Statute (O.S.) § 215 provides our office with the authority to examine any documents necessary in order to complete our audits.

Condition and Context: The Authority has no written policies to ensure violations of Medicaid laws and regulations by providers are identified and referred to an office with authority to prosecute cases of provider fraud. The Legal Division of the Authority stated that they follow 42 CFR §455.12 to §455.23, and routine internal meetings are set up between the Legal Division and Program Integrity to discuss identified questionable providers based on Program Integrity's preliminary findings. If the result of the discussion is to investigate or review further, regular internal meetings within Legal are utilized to further discuss and review the providers before an ultimate decision to refer the provider to the Medicaid Fraud Control Unit (MFCU) is made. However, the State Auditor and Inspector's Office (SAI) was not allowed to access any documentation pertaining to the cases to determine the agency took appropriate steps to investigate and, if appropriate, make a referral. We did obtain a listing of the providers referred to the MFCU and verified with the MFCU that they received the cases.

Cause: The Authority's Legal Division took over the process in which the Authority's Program Integrity previously referred cases to the MFCU. At the time of the change, the procedures changed; however, the policy was not updated. The Authority's Legal Division believes client/attorney confidentiality precludes them from allowing SAI access to the identified suspected cases.

Effect: Without written policies and procedures, the Authority is at risk for inconsistently communicating policies and procedures to staff, including new hires, which could lead to instances of suspected fraud not being referred to the State MFCU. Without access to documentation of the Authority's suspected cases of fraud, SAI was not able to determine the agency took appropriate steps to investigate and appropriately refer cases to the MFCU.

Recommendation: We recommend the Authority develop written policies and procedures to ensure violations of Medicaid laws and regulations by providers are identified and referred to the appropriate office or authority. We also recommend the Authority comply with the requirements of the state and federal laws and regulations to allow SAI access to identified suspected cases in order to perform the applicable audit procedures.

Views of Responsible Official(s)

The Oklahoma Health Care Authority (OHCA) concurs in part and does not concur in part with the finding stated above in the "Condition and Context" section. The OHCA concurs that it does not currently have a written policy or procedure regarding the requirements of 42 C.F.R. §§ 455.12 – 455.23. However, OHCA disagrees that these CFR provisions require the State Medicaid Agency (SMA) to have a ***written*** policy or procedure to implement the CFR requirements. Furthermore, OHCA believes that our internal fraud review methods and criteria comply with the CFR requirements to identify, preliminarily investigate, review, and refer suspected cases of fraud. As partially outlined in the finding above, OHCA's internal methods and criteria are communicated with and known by the Program Integrity (PI) Division, and OHCA has routinely set internal meetings between Legal and PI to discuss questionable providers based on PI's preliminary findings. If the result of the discussion of these meetings is to investigate or review further, then regularly scheduled internal meetings within OHCA Legal are utilized to further discuss and review the providers before an ultimate decision to refer the provider to the Oklahoma Attorney General's Medicaid Fraud Control Unit (MFCU) is made.

The above finding states that the SAI could not determine that the agency took appropriate steps to investigate and, if appropriate, make a referral, although it admitted that that it was able to verify a listing of cases referred by OHCA with a listing of cases received by MFCU. The OHCA believes that the verification of cases referred demonstrates that OHCA has taken appropriate steps to identify, preliminarily investigate, review, and refer suspected cases of fraud to MFCU as required by the applicable CFR provisions. Furthermore, contrary to the statement above in the "Effect" Section, OHCA does not believe that access to its investigatory case files themselves will help to determine if appropriate steps were taken to investigate and appropriately refer suspected cases of fraud to MFCU. The OHCA believes it has provided enough information and documentation to demonstrate that it has a verifiable process for referral and that it does, in fact, comply with that process.

Additionally, OHCA believes that both the attorney-client privilege, including attorney work product and attorney-client communication, and 56 O.S. §1004(D) govern the internal investigatory case files of OHCA. Specifically, 56 O.S. §1004(D), which is part of the Oklahoma Medicaid Program Integrity Act, states, "Records obtained or created by the Authority or the Attorney General pursuant to the Oklahoma Medicaid Program Integrity Act ***shall be classified as confidential information and shall not be subject*** to the Oklahoma Open Records Act or ***to outside review or release by any individual except***, if authorized by the Attorney General, in relation to legal, administrative, or judicial proceeding." (Emphasis added.) The OHCA believes it would be in violation of this specific statute, as well as a breach of the attorney-client privilege doctrine, if it were to allow SAI to review any internal investigatory case file that was created pursuant to this statute.

Lastly, OHCA believes that it is important to note that there is not a finding stating that it does not comply with the CFR requirements to identify, preliminarily investigate, review, or refer suspected cases of fraud. In fact, the finding specifically states that SAI has verified that cases have been referred by OHCA to MFCU. Rather, the finding is that OHCA does not have a ***written*** policy or procedure to implement the CFR requirements.

Contact Person:

Becki Burton
Deputy General Counsel

Anticipated Completion Date:

Although it does not concur that the CFR provisions require the SMA to have a ***written*** policy or procedure to implement the CFR requirements related to credible allegation fraud determinations and referrals, should the United States Department of Health and Human Services, Office of Inspector General (HHS/OIG) ultimately determine that a written policy or procedure is mandatory, OHCA can have a written policy in place within one (1) month of the final determination.

Corrective Action Planned:
As stated above in the "Anticipated Completion Date", should HHS/OIG ultimately determine that a written policy or procedure is mandatory, OHCA can have a written policy in place within one (1) month of the final determination. However, OHCA would request a telephone conference among appropriate representatives of the SAI, HHS/OIG, and OHCA so that all agencies can fully discuss what would constitute a reasonable written policy that would address the concerns of all the agencies involved.

Auditor Response: We were only given a listing of cases referred to the MFCU. No other documentation to support the steps taken between flagging a case of possible fraud and determining which cases should be referred to the MFCU was provided to enable us to determine whether or not they complied with the requirement. In our opinion, the Authority's refusal to provide the necessary documentation for the MFCU case referrals is in direct violation of laws and regulations stated in the criteria above, as well as the Supreme Court's Opinion in 1979 OK AG 251, which was also provided to the Authority by our Legal Counsel during the audit.

FINDING NO: 2018-073
STATE AGENCY: Oklahoma Health Care Authority (OHCA)
FEDERAL AGENCY: United States Department of Health and Human Services
CFDA NO: 93.767; 93.778
FEDERAL PROGRAM NAME: Children's Health Insurance Program (CHIP); Medicaid Cluster (MAP)
FEDERAL AWARD NUMBER: 1705OK0301; 1805OK5021; 1705OK5MAP and 1805OK5MAP
FEDERAL AWARD YEAR: 2017 and 2018
CONTROL CATEGORY: Activities Allowed or Unallowed and Allowable Costs/Cost Principles
QUESTIONED COSTS: $128,048

Criteria: Per 45 CFR §75.303(a), the non-Federal entity must: "Establish and maintain effective internal control over the Federal award that provides reasonable assurance that the non-Federal entity is managing the Federal award in compliance with Federal statutes, regulations, and terms and conditions of the Federal award…"

45 CFR 75.403 (a) *Factors affecting allowability of costs* states, "Except where otherwise authorized by statute, costs must meet the following general criteria in order to be allowable under Federal awards: Be necessary and reasonable for the performance of the Federal award and be allocable thereto under these principles."

45 CFR 75.431 (c) *Compensation – fringe benefits* states, "Such benefits, must be allocated to Federal awards and all other activities in a manner consistent with the pattern of benefits attributable to the individuals or group(s) of employees whose salaries and wages are chargeable to such Federal awards and other activities, and charged as direct or indirect costs in accordance with the non-Federal entity's accounting practices."

A basic objective of Generally Accepted Accounting Principles is to provide accurate, reliable, and timely information.

Condition and Context: The Office of Management and Enterprise Services (OMES) informed agencies in February 2018 that any excess Pathfinder contributions (account code 513300 in the Statewide Accounting System) that went to the OPERS defined benefit plan would not be allowed to be charged to Federal grants. The Federal government maintains that the amount used to fund the defined benefit plan is an overcharge to Federal programs. As a result, OMES informed the agencies they would repay the unallowable costs from inception (state fiscal year 2016) through 2/20/18. However, any agencies charging Federal grants for the unallowable cost after that point would be required to repay on their own.

When reviewing the excess Pathfinder costs for the Authority we noted $128,048 in Pathfinder contributions charged to the referenced Federal grants during SFY 2018. Of the $128,048 of unallowable costs charged to Federal grants for state fiscal year 2018, $43,948 was charged from 2/20/18 to 6/30/18.

Cause: The Authority was unaware it was an unallowable charge until notified by OMES. Also, the Authority did not ensure that charges made to the Federal programs for unallowable costs was discontinued after 2/20/2018.

Effect: Of the total $128,048 in excess Pathfinder contributions overcharged to the Federal programs, and required to be reimbursed to the Federal agency, the Authority is responsible for the amount of $43,948, and OMES is responsible for the amount of $84,100.

Recommendation: We recommend the Authority develop and implement procedures to ensure Pathfinder excess contributions (account 513300) are not charged to Federal grants.

Views of Responsible Official(s)
Contact Person: Susan Crooke
Anticipated Completion Date: October 31, 2019
Corrective Action Planned: New procedures were implemented beginning SFY19 to ensure Pathfinder excess contributions are no longer charged to our Federal grants. Once OMES receives a demand letter from Cost Allocation Services; and the manner in which the repayment is to occur is determined, OHCA will report the appropriate prior period adjustments on the CMS-64 and CMS-21.

Oklahoma Health Care Authority

Health Access Networks Update

In consultation with the PACIFIC HEALTH POLICY GROUP

Revised for May 21, 2019

HANs evaluation overview

- Our beginnings
- Redesign update
- Independent evaluation findings

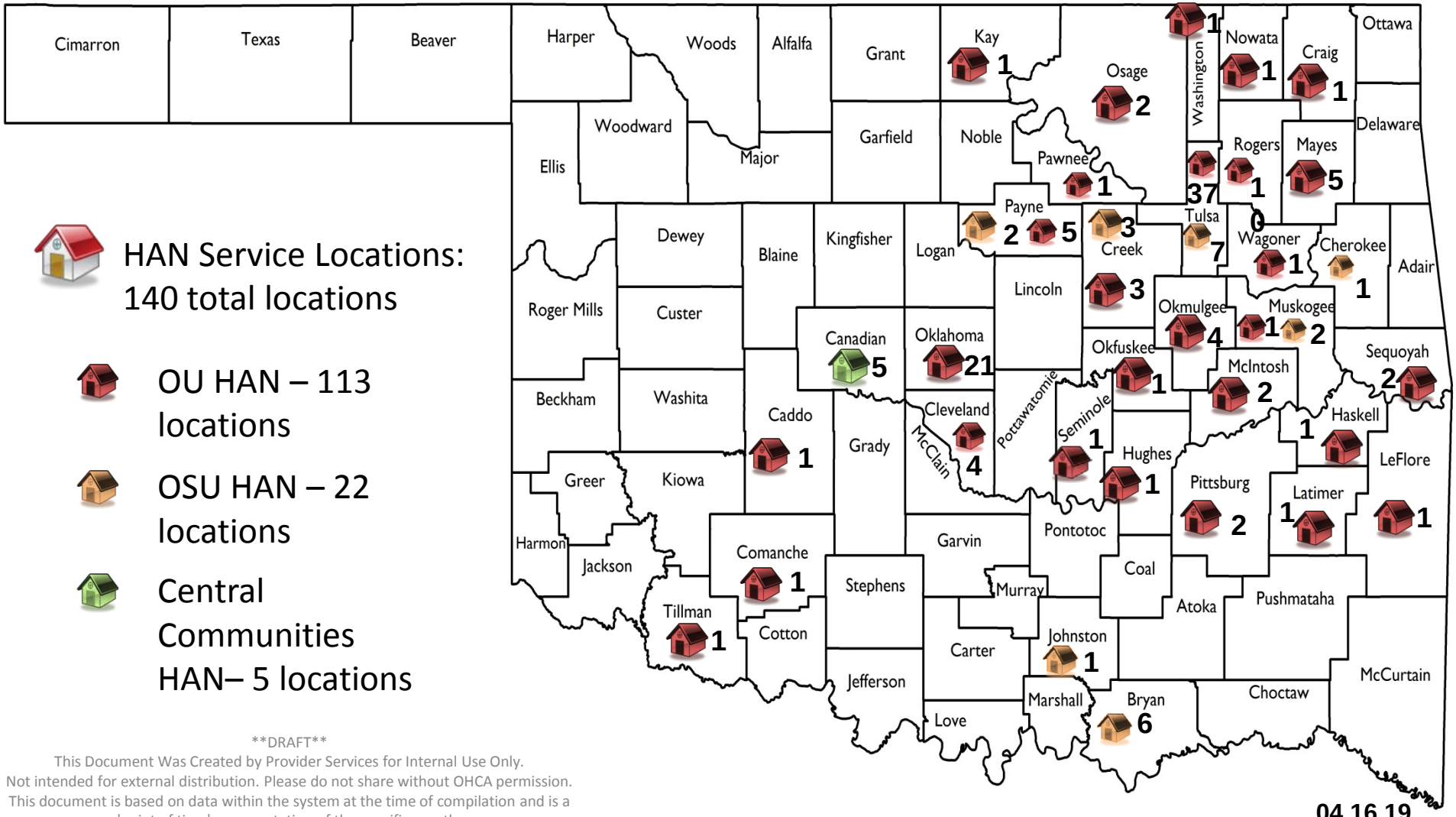
SOONER CARE CHOICE WAIVER

- Three HANs
  - OU Sooner HAN - July 2010
  - Partnership for Healthy Central Communities - July 2011
  - OSU HAN - September 2011

SOONER CARE CHOICE WAIVER

- Enrollment by HAN
  - April 2019 – 179,541 members
    - OU Sooner HAN - 148,891
    - OSU HAN -27,324
    - Central Communities - 3,326

Health Access Network (HAN) Service Locations
April 2019

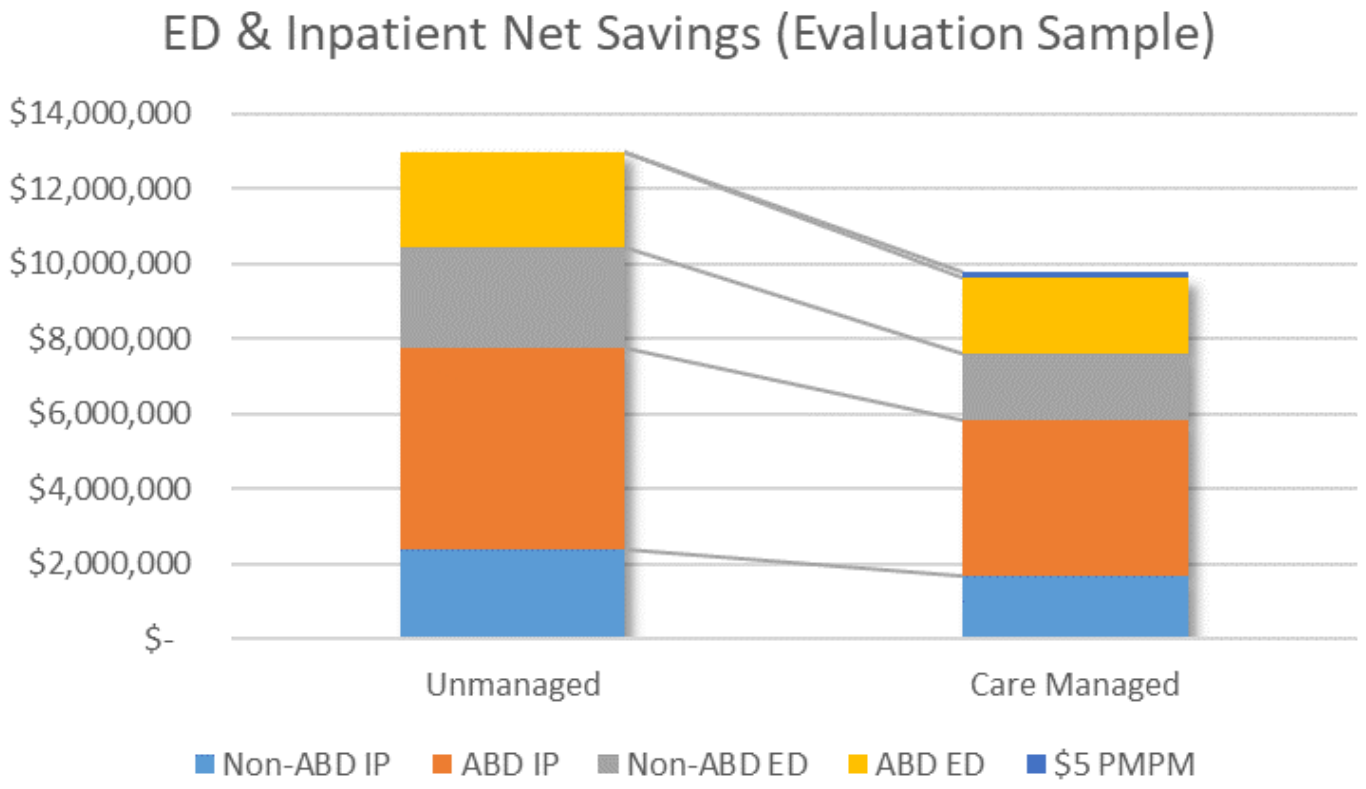


Redesign Tasks – ongoing

- Delete obsolete language in Special Terms & Conditions
- Began with March 5, 2019, Bi-monthly Tribal Consultation for waiver amendment

UTILIZATION ANALYSIS - SAVINGS

- Net ED & IP expenditures for the care managed members included in the evaluation (subset of all care managed members) were $3.2 million lower in the 12 months following initiation of care management than in the prior 12 months



MEMBER SURVEY

- Respondents gave high marks to the help they received from their care manager
  - 87% stated the help was "very important" to them
  - 97% stated they were "very satisfied" with the help
  - 91% stated the help made it easier for them to take care of their own health (or their child's health), with the most common reasons being that the SDOH addressed food insecurity and/or generally helped the member to cope with challenges (see quotes starting on next slide)

MEMBER SURVEY

- I was completely overwhelmed before I started getting help from Karen. Taking care of my son's special needs is very hard. He has a colostomy bag. I didn't know about all of the resources that were available before Karen started helping me. It gives me such a peace of mind knowing that I have her.
- We couldn't afford the test strips to check his blood before. He is on blood thinners and we have to check his blood. This has been a big relief.
- She put us in touch with SoonerSuccess which was life changing for our family. Before we did not do hardly anything, now we know of special needs community events. Janet at SoonerSuccess also helped us get respite care for the twins.

HAN leadership

- Rachel Mix, OU Sooner HAN
- Cindy Bacon, Partnership for Healthy Central Communities HAN
- Matt Maxey, OSU HAN

SoonerCare Choice
Performance & Health Improvement

Health Access Networks – Independent Evaluation

PHPG

May 2019

Oklahoma HealthCare Authority

Table of Contents

EXECUTIVE SUMMARY

A. Introduction

The Oklahoma Health Care Authority (OHCA) contracts with three "Health Access Networks" (HANs), as part of the agency's managed system of care for SoonerCare beneficiaries. The HANs are community-based, integrated networks intended to advance program access, quality and cost-effectiveness goals through their support of affiliated PCMH providers. There are three HANs: University of Oklahoma (OU) Sooner HAN; Partnership for Healthy Central Communities (PHCC) HAN; and Oklahoma State University (OSU) HAN.

The HANs offer care management and care coordination to enrolled SoonerCare members with complex health care needs. The HANs also target members who are frequent, and inappropriate, users of the emergency room.

The OHCA retained the Pacific Health Policy Group (PHPG) in 2018 to conduct an independent evaluation of the HAN system as part of a larger study of the SoonerCare program. PHPG evaluated HAN performance in improving access to care and health outcomes among members who were enrolled in care coordination/care management and had received at least one contact (intervention) from a care manager. The evaluation examined all care-managed members, as well as the subset of members who were Aged, Blind or Disabled (ABD). The ABD population, on average, has greater health needs than the non-ABD population.

PHPG evaluated the impact of HAN interventions on inpatient and emergency room utilization and expenditures, by comparing activity in the twelve months preceding care management to the twelve months following initiation of care management. PHPG also evaluated quality-of-care measures specific to members with asthma and diabetes, two prevalent conditions for which the HANs have developed specialized care management initiatives.

In addition to the quantitative evaluation, PHPG conducted telephone surveys of members enrolled with Central Communities who had received assistance with social service needs, or "social determinants of health" (SDOH) that could pose barriers to care. Respondents were asked about the type of assistance they received and its impact on their well-being or the well-being of their child. Central Communities was selected for this portion of the evaluation because of its longstanding efforts with regard to SDOH; PHPG intends to conduct surveys of other HAN members as part of ongoing evaluation activities.

Finally, PHPG evaluated the cost-effectiveness of HAN care management activities by comparing inpatient and emergency room expenditures pre- and post-initiation of care management. The analysis also took into account the $5.00 per member per month (PMPM) fee paid to the HANs for their care management and other activities.

B. Summary of Findings

PHPG evaluated the impact of care management on 1,178 HAN members who were continuously enrolled for at least 24 months during the period covered by the evaluation (January 2015 – June 2018) and had at least one contact with a care manager between January 2016 and June 2017.

Utilization Impact

HAN members generally used inpatient and emergency room services at significantly lower rates in the twelve months following engagement in care management than in the prior twelve months. This was true both for the entire universe of care-managed members and the ABD subset. More specifically:

- The total universe of care-managed members (regardless of reason) experienced a 17 percent decrease in hospital admissions; the ABD subset experienced a 16 percent decrease
- The total universe of care-managed members experienced a 31 percent decrease in emergency room visits; the ABD subset experienced a 20 percent decrease
- Members with asthma experienced a 51 percent decrease in hospital admissions; the ABD subset experienced a 39 percent decrease
- Members with asthma experienced a 36 percent decrease in emergency room visits; the ABD subset experienced a 29 percent decrease
- Members with diabetes experienced a 19 percent decrease in hospital admissions; the ABD subset experienced a 21 percent decrease
- Members with diabetes experienced a four percent decrease in emergency room visits; the ABD subset experienced a three percent increase
- Members classified as "very high utilizers" of the emergency room experienced a 37 percent decrease in ER visits; the ABD subset experienced a 25 percent decrease
- Within this same population, the number of members with 10 or more ER visits in a twelve-month period declined from 48 to 24, while the number with zero ER visits rose from three to 83

> ***"I now know how to handle (my son's) asthma attacks better and we have not gone to the ER as much. This has helped a lot."***

Quality-of-Care

PHPG evaluated the impact of care management on quality-of-care for members with asthma and diabetes. Quality-of-care measures were calculated in accordance with Healthcare Effectiveness Data and Information Set (HEDIS®) specifications, as applicable.

Among members with asthma, PHPG found that percentage with at least one asthma-controlling medication was nearly unchanged, declining by two percent. The number of asthma-controlling medications (prescriptions) per member declined by one percent.

Among members with diabetes, PHPG found that the percentage receiving an LDL-C (cholesterol) screen rose by one percent and the percentage receiving medical attention for nephropathy (kidney function) rose by 12 percent. Conversely, the percentage receiving an HbA1c test was unchanged and the percentage receiving an eye exam declined by five percent.

Overall, no clear trend was identified with respect to quality-of-care measures. This represents an opportunity for improvement through additional member and provider education.

Social Determinants of Health

PHPG surveyed 31 members enrolled in Central Communities (or parents/caretakers of minors) who had received SDOH-related assistance, such as with food, clothing, housing/rent and child care. Respondents gave high marks to their care manager for the relevance and quality of assistance provided. Eighty-seven percent stated the help was "very important" to them and 97 percent stated they were "very satisfied" with the help they received.

"My son's school was not going to let him graduate and she helped me to navigate the school system and get him back on track. I couldn't have done it without her; I was ready to give up."

Ninety-one percent reported that the help received made it easier for them to take care of their own (or their child's) health. The most common reasons cited were that the assistance addressed food insecurity and/or generally aided the member in coping with life challenges.

Care Management Cost-Effectiveness

PHPG evaluated HAN cost-effectiveness by comparing inpatient and ER expenses for care-managed members during the twelve months prior to, and following initiation of care management. PHPG also included the $5.00 PMPM cost for care-managed members in the post-engagement calculation.

Costs were $3.2 million lower in the twelve months following engagement, even after accounting for the $5.00 PMPM fee. The documented savings demonstrate that HAN care management activities are cost-effective and contributing toward improved outcomes for their highest-need members.

1. HAN EVALUATION PURPOSE & SCOPE

A. Introduction

SoonerCare Program

The Oklahoma Health Care Authority (OHCA) is committed as an organization to improving the health and quality of life of SoonerCare members in a cost-effective manner. The OHCA's vision is to effect cultural and behavior changes resulting in healthier Oklahomans, a stable and coordinated provider network and improved outcomes achieved through a focus on preventive care and care coordination.

The OHCA administers the Medicaid program, known as SoonerCare, within a service delivery and care management structure intended to make the most efficient use of public resources to achieve these program goals. SoonerCare operates under a "Section 1115 Research and Demonstration Waiver" from the federal government, which permits the State to provide health and support services to most SoonerCare members through an accountable, or "managed" system of care. The managed care portion of SoonerCare is known as "SoonerCare Choice".

The heart of the SoonerCare Choice managed care system is the Patient Centered Medical Home (PCMH). Under the PCMH model, SoonerCare Choice members select a primary care provider responsible for meeting essential program access and quality of care standards. There were 908 PCMH providers participating in the program in December 2018.

Health Access Networks

In 2010, the OHCA expanded upon the PCMH model by contracting with three "Health Access Networks", or HANs. The HANs are community-based, integrated networks intended to advance program access, quality and cost-effectiveness goals by offering greater care coordination support to affiliated PCMH providers.

The three HANs are: University of Oklahoma (OU) Sooner HAN; Partnership for Healthy Central Communities (PHCC) HAN; and Oklahoma State University (OSU) HAN. Each HAN is a non-profit, administrative entity that works with affiliated providers to coordinate and improve the quality of care provided to SoonerCare Choice members. The HANs receive a nominal $5.00 per member per month (PMPM) payment.

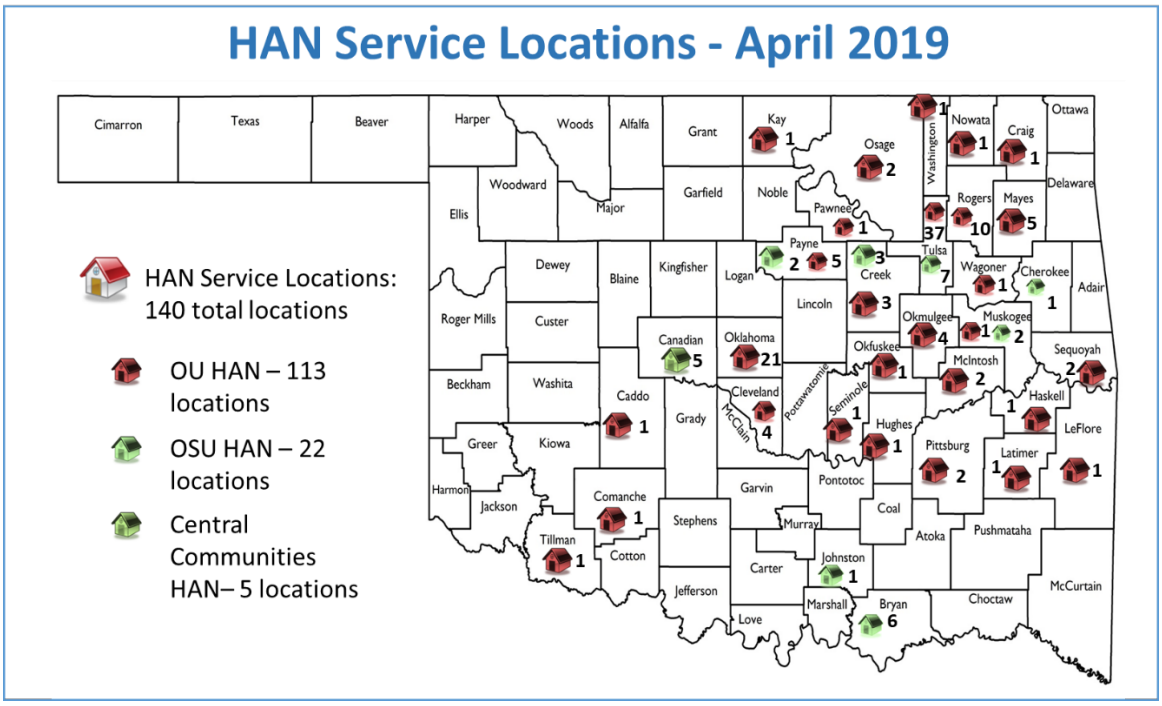
The HANs offer care management and care coordination to enrolled SoonerCare Choice members with complex health care needs. The HANs also work to establish new initiatives to address complex medical, social and behavioral health issues. For example, the HANs have implemented evidence-based protocols for care management of Aged, Blind and Disabled (ABD) members with, or at risk for, complex/chronic health conditions such as asthma and

diabetes. The HANs also target members who are frequent, and inappropriate, users of the emergency room.

In October 2018, total HAN enrollment was 176,323. OU Sooner HAN served approximately 87 percent of the members, followed by OSU HAN with 11 percent and PHCC HAN with two percent. The three HANs in aggregate provided care management to approximately 10,000 members with significant physical, behavioral health and/or social service needs.

The HANs historically have operated in only a portion of the State and have been classified by the federal Centers for Medicare and Medicaid Services (CMS) as a "pilot" program. CMS recently approved statewide expansion of the HANs and the OHCA is collaborating with the HANs to expand geographic coverage and the number of members who receive care management services.

The HANs currently are affiliated with PCMH providers practicing at 140 locations in 34 counties.



B. HAN Evaluation

Evaluation Purpose

The OHCA's overarching goal for the SoonerCare program is to address the health care needs of Oklahomans through provision of high quality, accessible and cost-effective care. The OHCA employs an agency-wide strategic planning process to advance this vision.

The current five-year strategic plan was developed in 2018 and identified the need for a durable OHCA Performance & Health Improvement structure to support quality-related initiatives. The strategic plan also committed to evaluating and tracking agency progress over time.

The OHCA tracks performance across multiple categories that capture the range of agency activities. Two of the most critical are[1]:

- Access to Care, including primary and preventive health services; and
- Care Management, including for chronic conditions prevalent in the SoonerCare population, such as asthma, diabetes, heart failure and hypertension.

Access and Prevention

Access to care is a basic expectation for managed care programs and is fundamental to improving member health and outcomes. If access to primary and preventive care is restricted due to a lack of providers or available appointments, members are more likely to go to the emergency room for services that are better suited to a doctor or nurse practitioner's office. Members also are at greater risk of having medical programs go undetected at an early stage, resulting in higher acuity and costlier treatment, including a greater likelihood of hospitalization.

The OHCA's Patient Centered Medical Homes and Health Access Networks have front-line responsibility for ensuring access to preventive and primary care services. For example, the OHCA has partnered with the HANs to identify and reach-out to members who are frequent users of the emergency room for non-emergent care. The HANs counsel these members and help to connect them to a Patient Centered Medical Home.

Chronic Care Management

Chronic diseases are among the costliest of all health problems. Providing care to individuals with chronic diseases, many of whom meet the federal disability standard, has placed a significant burden on state Medicaid budgets. The federal Centers for Disease Control estimates that total expenditures related to treating selected major chronic conditions in

[1] Other categories include mental health & substance use disorder treatment, long term care and administration & cost containment.

Oklahoma will reach nearly $10.5 billion in 2020. The estimated portion attributable to SoonerCare members will be more than $1.2 billion (state and federal).

The OHCA's objective is to ensure that all SoonerCare members with chronic conditions have access to care management. The Health Access Networks support this objective by providing care management to members with complex/chronic health needs.

The OHCA monitors Performance and Health Improvement to identify favorable or unfavorable trends at both the agency level and with respect to key partners, including the Health Access Networks. The OHCA, through its PHIP strategy, uses evaluation findings to identify priority areas for improvement and assess whether interventions are having the intended impact on performance.

Independent Evaluator

The OHCA has retained the Pacific Health Policy Group (PHPG) to conduct an independent evaluation of the SoonerCare program overall, as well as targeted reviews of major program components, including the Health Access Networks. PHPG is a national consulting firm that specializes in the development and evaluation of health care programs serving publicly-funded populations, including Medicaid beneficiaries.

Evaluation Scope and Methodology

The majority of members served by PCMH providers are healthy children and adolescents. Although the HANs support the activities of aligned PCMH providers across all members, much of their activity is directed toward the subset of members with complex/chronic health care needs and members facing barriers to care. The HANs are responsible for identifying these members and offering care coordination/care management appropriate to the members' needs.

Members with Complex/Chronic Health Care Needs

PHPG examined HAN performance in improving access to care and health outcomes among members with complex/chronic health care needs who were enrolled in care coordination/care management and had received at least one contact (intervention) from a care manager.

The three HANs provided PHPG with care management files that identified member date of enrollment, reason for enrollment and contact/intervention history. PHPG selected members with at least one care management contact between January 2016 and July 2017.

PHPG also obtained SoonerCare paid claims data for January 2015 through June 2018 and eligibility data for July 2015 through June 2018. The eligibility data was used to restrict the evaluation universe to members who had been enrolled continuously[2] in the twelve months

[2] Defined as being enrolled for at least 11 of the 12 months, to allow for brief lapses in coverage due to late re-certification by the member.

preceding and twelve months following the date of the member's first care management contact.

Although the HANs care manage members with a wide variety of conditions, all three have developed specialized programs for members with asthma and two have developed specialized programs for members with diabetes. In addition, the OHCA has asked the HANs to target members who are aged, blind and disabled[3] (ABD) in recognition that a high percentage have chronic conditions and complex needs.

PHPG stratified the evaluation in accordance with these priority groups. Specifically, PHPG evaluated HAN performance with respect to:

- All members enrolled in care management, regardless of condition (total members and ABD subset)
- Members enrolled for care management of asthma (total members and ABD subset)
- Members enrolled for care management of diabetes (total members and ABD subset)

The number of cases evaluated is presented below. Although the table breaks-out case counts by HAN, the evaluation was conducted in the aggregate and was not HAN-specific.

Evaluation Universe – Members with Complex/Chronic Health Needs

HAN	Asthma	Diabetes	Other	Total
Central Comm.	5	--	65	70
OSU HAN	39	32	326	397
OU SoonerHAN	250	168	293	711
Total	**294**	**200**	**684**	**1,178**

PHPG evaluated the impact of HAN interventions on inpatient and emergency room utilization and expenditures, by comparing activity in the twelve months preceding care management to the twelve months following initiation of care management. PHPG also evaluated quality-of-care measures specific to members with asthma and diabetes, as described in greater detail in the next chapter.

Very High Emergency Room Utilizers

PHPG evaluated HAN interventions with members identified as very high utilizers of the emergency room. High emergency room utilization can indicate barriers to care or that a member has underlying needs that have not been addressed adequately by his or her PCMH. High utilization also can be due to a member's lack of understanding as to the importance of seeing the PCMH for non-emergent care.

The OHCA permits each HAN to set a threshold for intervening due to very high emergency room utilization. On average, the members in this category (across the HANs) visited the ER

[3] ABD Medicaid only (not eligible for Medicare)

at an annualized rate of nearly 10 visits per year, prior to intervention. PHPG compared utilization pre- and post-intervention.

The number of cases evaluated is presented below. Once again, although the table breaks-out case counts by HAN, the evaluation was conducted in the aggregate and was not HAN-specific.

Evaluation Universe – Very High ER Utilizers

HAN	Count
Central Communities	79
OSU HAN	22
OU SoonerHAN	436
Total	**537**

Social Determinants of Health

PHPG also conducted a targeted review of the efforts of Central Communities HAN to assist members with social determinants of health (SDOH). In many cases, social determinants (e.g., food or housing insecurity) can present barriers to care if left unaddressed.

PHPG identified 104 members in the Central Communities care management database who had received assistance with SDOH. In some cases, the member received assistance; in other cases, a parent/caretaker received help on behalf of a child, who was the actual SoonerCare member.

PHPG conducted telephone interviews with 33 of the households, inquiring about the type and effectiveness of SDOH assistance received through the HAN. Although qualitative in nature, the respondents provided useful insights into the importance of the assistance in overcoming barriers to care.

This portion of the evaluation was limited to Central Communities, to allow for testing and refinement of the survey instrument. PHPG intends to conduct similar surveys of members in the remaining two HANs as part of ongoing evaluation activities.

2. HAN EVALUATION FINDINGS

A. Introduction

This chapter contains evaluation findings by focus area. Results are presented first for members in the asthma and diabetes subgroups. The third section presents findings for members who are very high ER utilizers. The fourth section includes findings from PHPG's targeted evaluation of Central Communities' SDOH outreach. Except for the SDOH analysis, results are provided both for members in total and for the ABD member subset.

The final section contains data for all care-managed members, regardless of reason for engagement. The section includes an analysis of HAN cost effectiveness that takes into account both the savings achieved by the HANs in care managing members and the monthly $5.00 per member per month payment made by the OHCA for each member enrolled with a HAN.

B. Members with Asthma (Total and ABD Subset)

PHPG evaluated the impact of HAN care management on 294 members (68 ABD and 226 other) assigned to a care manager due to having asthma, either alone or in combination with other conditions. Care management interventions typically included a combination of member education, assistance with medical appointments and addressing barriers to care.

PHPG calculated inpatient hospital and emergency room utilization and expenditures for these members during the twelve months prior to, and twelve months following initiation of care management. PHPG also evaluated two quality-of-care measures related to use of asthma-controlling prescriptions[4].

Inpatient Hospital Utilization

The table on the following page presents inpatient utilization data separately for all care-managed members and for the ABD subset. As it shows, hospital admissions declined by over 50 percent for all members and nearly 39 percent for ABD members in the twelve-month period following initiation of care management. Expenditures also declined, although by a smaller percentage.

[4] All quality-of-care measures in this chapter were calculated in accordance with Healthcare Effectiveness Data and Information Set (HEDIS®) specifications, where applicable. HEDIS is a comprehensive set of standardized performance measures designed to measure health care provider performance.

Members with Asthma – Hospital Utilization Trend

All Members	Prior 12 Months	Subsequent 12 Months	Percentage Change
Inpatient Admissions	201	99	-50.7%
Expenditures	$648,511	$391,041	-39.7%
Admissions per 1,000 Member Months[5]	62.2	30.6	**-50.7%**
ABD Members Only	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
Inpatient Admissions	67	41	-38.8%
Expenditures	$246,092	$229,363	-6.8%
Admissions per 1,000 Member Months	89.6	54.8	**-38.8%**

Emergency Room Utilization

The table below presents ER utilization data for all care-managed members and the ABD subset. As it shows, ER visits declined by nearly 36 percent for all members and approximately 29 percent for ABD members in the twelve-month period following initiation of care management. Expenditures also declined by similar percentages.

Members with Asthma – ER Visit Trend

All Members	Prior 12 Months	Subsequent 12 Months	Percentage Change
ER Visits	1,404	901	-35.8%
Expenditures	$736,022	$501,052	-31.9%
Visits per 1,000 Member Months[6]	434.1	278.6	**-35.8%**
ABD Members Only	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
ER Visits	368	261	-29.1%
Expenditures	$220,570	$175,184	-20.6%
Visits per 1,000 Member Months	492.0	348.9	**-29.1%**

[5] Admissions per 1,000 member months represents the number of members, out of a population of 1,000, who are admitted to the hospital in an average month.
[6] Visits per 1,000 member months represents the number of members, out of a population of 1,000, who visit the ER in an average month.

Quality-of-Care

PHPG evaluated quality-of-care with respect to member use of asthma-controlling medications. The table below presents information on the number and percentage of members with at least one asthma-controlling medication, as well as the average number of prescriptions per member. As it shows, the rates remained relatively steady across the pre- and post-intervention time periods. (Information is for all members – ABD and non-ABD.)

Members with Asthma – Asthma Controlling Medications

Members with at least one asthma-controlling medication	Prior 12 Months	Subsequent 12 Months	Change
Members	239	235	(4)
Percent of Total	81.3%	79.9%	-1.7%
Number of asthma-controlling medications	**Prior 12 Months**	**Subsequent 12 Months**	**Change**
Total Prescriptions	1,670	1,451	(219)
Average Prescriptions per Member	5.7	4.9	-0.8

C. Members with Diabetes (Total and ABD Subset)

PHPG evaluated the impact of HAN care management on 200 members (143 ABD and 57 other) assigned to a care manager due to having diabetes, either alone or in combination with other conditions. Similar to members with asthma, diabetes care management interventions typically included a combination of member education, assistance with medical appointments and addressing barriers to care.

PHPG calculated inpatient hospital and emergency room utilization and expenditures for these members during the twelve months prior to, and twelve months following initiation of care management. PHPG also evaluated four quality-of-care measures related to treatment of persons with diabetes.

Inpatient Hospital Utilization

The table below presents inpatient utilization data for all care-managed members and the ABD subset. As it shows, hospital admissions declined by over 19 percent for all members and nearly 21 percent for ABD members in the twelve-month period following initiation of care management. Expenditures also declined by similar percentages.

Members with Diabetes – Hospital Utilization Trend

All Members	Prior 12 Months	Subsequent 12 Months	Percentage Change
Inpatient Admissions	237	191	-19.4%
Expenditures	$1,799,144	$1,430,826	-20.5%
Admissions per 1,000 Member Months	107.7	86.8%	**-19.4%**
ABD Members Only	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
Inpatient Admissions	192	152	-20.8%
Expenditures	$1,555,403	$1,061,699	-31.7%
Admissions per 1,000 Member Months	122.1	96.6	**-20.8%**

Emergency Room Utilization

The table below presents ER utilization data for all care-managed members and the ABD subset. As it shows, ER visits were relatively flat, declining by four percent for all members and increasing by three percent for ABD members in the twelve-month period following initiation of care management[7]. Expenditures rose modestly over the same period.

Members with Diabetes – ER Visit Trend

All Members	Prior 12 Months	Subsequent 12 Months	Percentage Change
ER Visits	818	784	-4.2%
Expenditures	$686,005	$689,287	0.5%
Visits per 1,000 Member Months	371.8	356.4	**-4.2%**
ABD Members Only	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
ER Visits	535	550	2.8%
Expenditures	$473,989	$512,089	8.0%
Visits per 1,000 Member Months	340.1	349.7	**2.8%**

Quality-of-Care

Diabetes quality-of-care was evaluated through four measures related to the testing/early detection or treatment of diabetes-related complications. Specifically:

- Members receiving an LDL-C test (cholesterol screening)
- Members receiving an HbA1c test (blood sugar screening)
- Members receiving medical attention for nephropathy (kidney function)
- Members receiving a retinal eye exam

The table on the following page presents findings for the measures. As it illustrates, LDL-C and HbA1c activity was stable, while retinal eye exams declined slightly. The most significant change was for nephropathy treatment, which increased by nearly 12 percent. (Information is for all members – ABD and non-ABD.)

[7] Although not presented in the charts, PHPG also analyzed trends at six-months pre- and post-intervention. ER utilization declined 20.4 percent for all members and 13.9 percent for ABD members during this narrower timeframe. The results suggest care management affected ER utilization in the short term but the impact subsidized over time.

Members with Diabetes – Quality-of-Care Measures

Members Receiving LDL-C Test	Prior 12 Months	Subsequent 12 Months	Change
Members	130	131	1
Percent of Total	65.0%	65.5%	0.7%
Members Receiving HbA1c Test	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
Members	160	160	--
Percent of Total	80.0%	80.0%	--
Members Receiving Medical Attention for Nephropathy	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
Members	85	95	10
Percent of Total	42.5%	47.5%	11.8%
Members Receiving Retinal Eye Exam	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
Members	76	72	(4)
Percent of Total	38.0%	36.0%	-5.3%

D. Very High ER Utilizers (Total and ABD Subset)

PHPG evaluated the impact of HAN care management on 537 members (173 ABD and 364 other) assigned to a care manager due to very high ER utilization. Care management interventions typically included a combination of member education about proper use of the ER, assistance with medical appointments and addressing barriers to care.

PHPG calculated emergency room utilization and expenditures for these members during the twelve months prior to, and twelve months following initiation of care management. ER use was measured in terms of visits per 1,000 member months and corresponding expenditures, as well as by visit "tiers" (members with 10 or more visits; members with six or more visits; members with three or more visits; and members with no visits).

Emergency Room Utilization

The table below presents ER utilization data in terms of total visits and visits per 1,000 member months for all care-managed members and the ABD subset. As it shows, ER visits declined by 37 percent for all members and 25 percent for ABD members in the twelve-month period following initiation of care management. Expenditures also declined by similar percentages.

Very High ER Utilizers – ER Visit Trend

All Members	Prior 12 Months	Subsequent 12 Months	Percentage Change
ER Visits	4,672	2,933	-37.2%
Expenditures	$2,772,525	$1,860,529	-32.9%
Visits per 1,000 Member Months	790.9	496.5	**-37.2%**
ABD Members Only	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
ER Visits	2,049	1,536	-25.0%
Expenditures	$1,357,110	$1,033,286	-23.9%
Visits per 1,000 Member Months	346.9	260.0	**-25.0%**

The tables on the following page present average ER visit rates and ER visit activity by "tier" for all members. As they show, the average number of ER visits per member declined from nearly nine in the twelve-month period prior to engagement to fewer than six in the subsequent twelve months. The percentage of members with three, six or 10 or more visits in a twelve-month period also dropped significantly, while over 15 percent of members registered zero visits in the twelve months after initiation of care management.

Very High ER Utilizers – Average Visits per Member

All Members	Prior 12 Months	Subsequent 12 Months	Percentage Change
Visits	4,672	2,933	-37.2%
Average per Member	8.7	5.5	-37.2%

Very High ER Utilizers – Members by Visit "Tier"

Members with 10 or More Visits	Prior 12 Months	Subsequent 12 Months	Percentage Change
Members	48	24	-50.0%
Percentage	8.9%	4.5%	
Members with 6 or More Visits	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
Members	326	167	-48.8%
Percentage	60.7%	31.1%	
Members with 3 or More Visits	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
Members	480	301	-37.3%
Percentage	8.9%	4.5%	
Members with No Visits	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
Members	3	83	2,666.7%
Percentage	0.6%	15.5%	

E. Members with Social Determinant of Health (SDOH) Needs

PHPG identified 104 members in the Central Communities care management database who had received assistance with SDOH, as indicated by care manager notes. This included assistance provided directly to an adult member or to the enrolled child of a parent/caretaker.

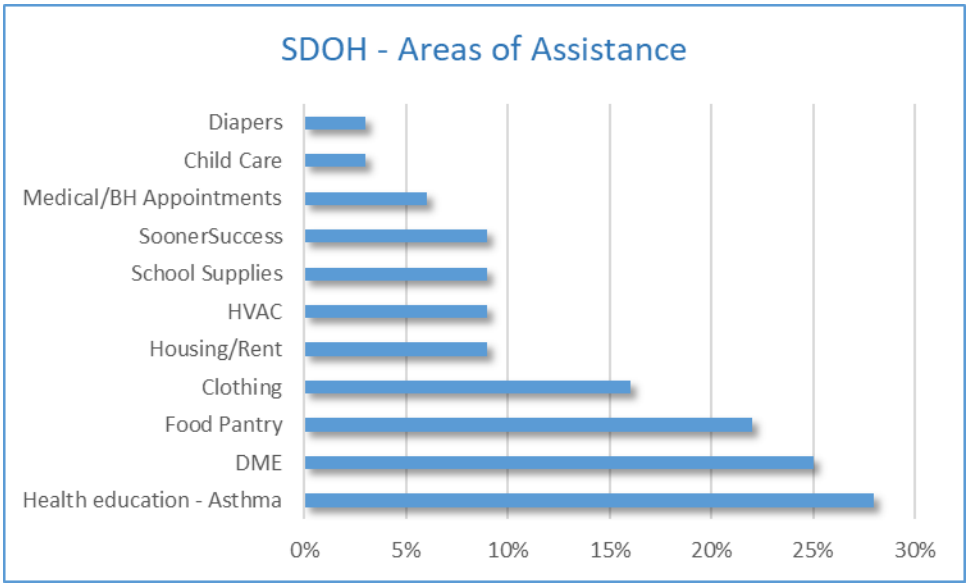
PHPG conducted a telephone survey with 33 of the members in November 2018. The survey explored respondent awareness of the HAN and care manager, the nature of assistance received and the value of this assistance in addressing social service needs and/or reducing barriers to care. Due to the small sample size, results should be considered "qualitative" in nature.

Awareness of HAN

Only five of the respondents reported being familiar with the name "Central Communities" and only two recalled being helped by a Central Communities care manager. However, when given the name of their care manager, 31 of 33 reported knowing and interacting with this individual, suggesting that members identify much more strongly with the person helping them than the HAN itself.

Assistance Provided

Respondents reported receiving help in a variety of areas, some of which had a clinical component. The chart below presents the areas of assistance cited by respondents (multiple responses allowed).



Satisfaction with Assistance

Respondents gave high marks to their care manager for the relevance and quality of assistance provided. Eighty-seven percent stated the help was "very important" to them and 97 percent stated they were "very satisfied" with the help they received.

Ninety-one percent reported that the help received made it easier for them to take care of their own (or their child's) health. The most common reasons cited were that the assistance addressed food insecurity and/or generally aided the member in coping with life challenges.

A representative sample of respondent comments is presented below.

I now know how to handle (my son's) asthma attacks better and we have not gone to the ER as much. This has helped a lot.

My son's school was not going to let him graduate and she helped me navigate the school system to get him back on track. I couldn't have done it without her, I was ready to give up.

She helped us get (my child's) doctor to do lab work in his office instead of going to the lab. It has to be done every three months so this helped us a lot.

Having the diapers given to us for (our daughter) is a huge help. She goes through so many a day that we could not keep up buying them ourselves.

She got us tickets to things going on in our community which was so good. Got us plugged into the community.

F. All Care-Managed Members

PHPG evaluated the impact of HAN care management across all 1,715 care-managed members identified for the evaluation (640 ABD and 1,075 other), including the populations presented in previous sections.

PHPG calculated inpatient hospital and emergency room utilization and expenditures for these members during the twelve months prior to, and twelve months following initiation of care management. PHPG also evaluated HAN cost effectiveness, taking into account both the savings achieved through reductions in utilization and the cost associated with the $5.00 PMPM HAN payment.

Inpatient Hospital Utilization

The table below presents inpatient utilization data for all care-managed members, regardless of reason for engagement, and the ABD subset. As it shows, hospital admissions declined by over 17 percent for all members and over 16 percent for ABD members in the twelve-month period following initiation of care management. Expenditures declined by even greater percentages.

All Care-Managed Members – Hospital Utilization Trend

All Members	Prior 12 Months	Subsequent 12 Months	Percentage Change
Inpatient Admissions	1,568	1,299	-17.2%
Expenditures	$7,731,444	$5,850,746	-24.3%
Admissions per 1,000 Member Months	83.1	68.9	**-17.2%**
ABD Members Only	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
Inpatient Admissions	847	708	-16.4%
Expenditures	$5,339,453	$4,152,400	-22.2%
Admissions per 1,000 Member Months	120.3	100.6	**-16.4%**

Emergency Room Utilization

The table below presents ER utilization data for all care-managed members, regardless of reason for engagement, and the ABD subset. As it shows, ER visits declined by 31 percent for all members and more than 20 percent for ABD members in the twelve-month period following initiation of care management. Expenditures also declined by similar percentages.

All Care-Managed Members – ER Visit Trend

All Members	Prior 12 Months	Subsequent 12 Months	Percentage Change
ER Visits	8,341	5,752	-31.0%
Expenditures	$5,215,645	$3,798,645	-27.2%
Visits per 1,000 Member Months	442.1	304.9	**-31.0%**
ABD Members Only	**Prior 12 Months**	**Subsequent 12 Months**	**Percentage Change**
ER Visits	3,509	2,795	-20.3%
Expenditures	$2,506,557	$2,030,218	-19.0%
Visits per 1,000 Member Months	498.4	397.0	**-20.3%**

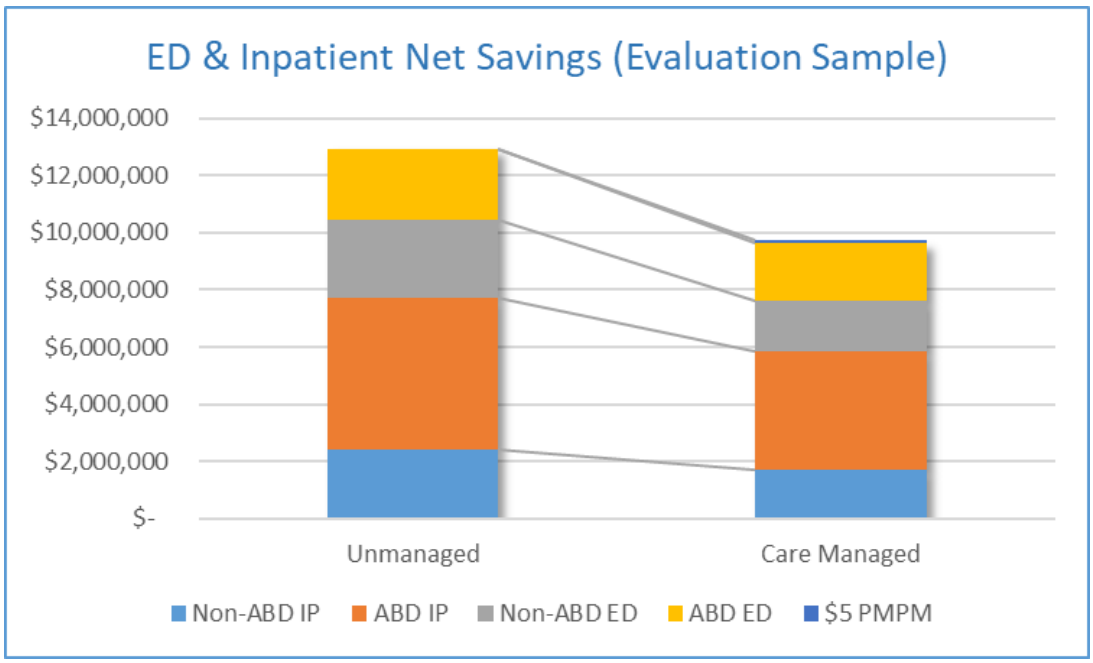
HAN Cost-Effectiveness

PHPG evaluated HAN cost-effectiveness by comparing inpatient and ER expenses for care-managed members during the twelve months prior to, and following initiation of care management. PHPG also included the $5.00 PMPM cost for care-managed members in the post-engagement calculation.

The chart on the following page presents the pre- and post-care management cost comparison. As it illustrates, costs were $3.2 million lower in the twelve months following engagement, even after accounting for the $5.00 PMPM fee.

It should be noted that the analysis was limited to inpatient and ER costs and did not examine other service costs pre- and post-engagement. The analysis also was restricted to members in care management and did not include other HAN members, i.e., those enrolled but not receiving care management during the period of the evaluation.

The documented savings demonstrate that HAN care management activities are cost-effective and contributing toward improved outcomes for their highest-need members.


ED & Inpatient Net Savings (Evaluation Sample)
$14,000,000
$12,000,000
$10,000,000
$8,000,000
$6,000,000
$4,000,000
$2,000,000
$-
Unmanaged
Care Managed
Non-ABD IP
ABD IP
Non-ABD ED
ABD ED
$5 PMPM

MATERNAL DEPRESSION SCREENINGS

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The proposed revisions will add fee-for-service coverage and reimbursement language for maternal depression screenings (CPT code 96161) at Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) well-child visits. The policy will also reiterate how the Oklahoma Health Care Authority adopts and utilizes the American Academy of Pediatrics' Bright Futures periodicity schedule in relation to maternal depression screenings.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Currently this code is set to pay $0.00.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   A fee-for-service reimbursement of $5.00 per screening was selected and is in line with reimbursement offered by other states. This does not apply to facilities receiving an encounter rate.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for the remainder of SFY2020 will be an increase of $143,053 total; of which $49,911 is state share. The estimated budget impact for SFY2021 will be an increase of $342,936 total; of which $113,409 is state share.

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 approve the method change to price CPT code 96161 at $5.00.

9. EFFECTIVE DATE OF CHANGE.

September 1, 2019, pending CMS approval.

ENHANCED PAYMENTS FOR STATE UNIVERSITY EMPLOYED OR CONTRACTED PHYSICIANS

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) would like to change the rate methodology for the State University Employed or Contracted Physicians. The proposed revisions will increase the enhanced payments made for services provided by teaching physicians who are employed by or contracted with state universities.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current payment methodology for State University Employed or Contracted Physicians is 140% of the Medicare Physician Fee Schedule.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed payment methodology for State University Employed or Contracted Physicians is 175% of the Medicare Physician Fee Schedule. The percentage was chosen to not exceed the following payment methodology:
   - An average of the commercial payment from the top five (5) commercial payers for each CPT code were provided to generate the Average Commercial Rate (ACR).
   - Both the Medicare rate and the ACR were multiplied by the Oklahoma Medicaid fee-for-service (FFS) volume of services reimbursed for eligible CPT codes.
   - The statewide Medicare equivalent of the ACR was calculated by dividing the product of ACR and FFS volume by the product of the Medicare and FFS volume.

   To comply with CFR 447.321, an annual upper payment limit demonstration will be submitted to CMS annually to ensure that State University Employed or Contracted Physicians are not paid more than 175% of the average commercial rate in the aggregate.

6. **BUDGET ESTIMATE.**
   The estimated annual budget impact will be an increase of $51,067,779 total; of which $17,817,548 is state share. The state share will be paid by the University of Oklahoma and Oklahoma State University.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate an 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 approve the proposed payment methodology for State University Employed or Contracted Physicians at 175% of the Medicare Physician Fee Schedule.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2019, pending CMS approval.

RURAL HEALTH CLINIC RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) would like to change the rate methodology for Hospital-Based and Independent Rural Health Clinics.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current State Plan payment methodology for Rural Health Clinics is to pay on a per visit basis based on historical cost report data that is trended forward annually by the Medicare Economic Index (MEI).

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed payment methodology for hospital-based rural health clinic services are paid at the provider's encounter rate established by Medicare that is in effect for the date of service. When a hospital-based rural health clinic receives the annual rate notification from CMS for a full cost reporting year, the provider must forward a copy of that notice to the state agency. In the event the provider does not submit the rate notification from CMS, the lesser of the statewide average or the current rate will be used. There is no retroactive cost settlement. The proposed methodology or independent rural health clinics are paid at the rural health clinic payment limit established by CMS that is in effect for the date of service. If the rural health clinic rate exceeds the CMS rate, the rate will be frozen until the CMS rate exceeds the current rate. There is no retroactive cost settlement.

6. **BUDGET ESTIMATE.**
   The estimated annual budget impact will be an increase of $17,657,446 total; of which $6,160,683 is state share.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate a 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 approve the proposed payment methodology for hospital-based and independent rural health clinics.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2019, pending CMS approval.

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

SUBCHAPTER 5 INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 24 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

317:30-5-263. Definitions

The following words or terms, when used in this Part, shall have the following meaning, unless the context clearly indicates otherwise:

"**Advanced practice registered nurse (APRN)**" means a registered nurse in good standing with the Oklahoma Board of Nursing, who has acquired knowledge and clinical skills through the completion of a formal program of study approved by the Oklahoma Board of Nursing and has obtained professional certification through the appropriate national board recognized by the Oklahoma Board of Nursing. APRN services are limited to the scope of their practice as defined in Title 59 of the Oklahoma Statutes (O.S.) § 567.3a and corresponding rules and regulations at Oklahoma Administrative Code (OAC) 485:10.

"**Behavioral health rehabilitation (BHR) services**" means goal-oriented outpatient interventions that target the maximum reduction of mental and/or behavioral health impairments and strive to restore the members to their best possible mental and/or behavioral health functioning.

"**Centers for Medicare and Medicaid Services (CMS)**" means the federal agency within the United States Department of Health and Human Services (HHS) that administers the Medicare program and works in partnership with state governments to administer Medicaid.

"**Certified alcohol and drug counselor (CADC)**" means an individual with an Oklahoma certification as an alcohol and drug counselor.

"**Certified behavioral health case manager (CM)**" means an individual who is certified by the ODMHSAS as a behavioral health case manager pursuant to OAC, Title 450, Chapter 50.

"**Certified community behavioral health clinics (CCBHC)**" means a service delivery model designed to provide a comprehensive range of mental health and/or substance abuse rehabilitative services. Services are furnished by an interdisciplinary and mobile mental health team that functions interchangeably.

"**CFR**" means the Code of Federal Regulations.

"**Facility-based crisis stabilization (FBCS)**" means emergency psychiatric and substance abuse services aimed at resolving crisis situations. The services provided are emergency stabilization,

which includes a protected environment, chemotherapy, detoxification, individual and group treatment, and medical assessment.

"**Family support and training provider (FSP)**" means an individual who provides a system of care that is child-centered with the needs of the child and family dictating the types and mix of services provided, to assist in keeping the family together and preventing an out-of-home placement. FSP providers must:

(A) Have a high school diploma or equivalent;

(B) Be twenty-one (21) years of age and have a successful experience as a family member of a child or youth with serious emotional disturbance, or have lived experience as the primary caregiver of a child or youth who has received services for substance use disorder and/or co-occurring substance use and mental health, or have lived experience being the caregiver for a child with Child Welfare/Child Protective Services involvement;

(C) Successfully complete family support training according to a curriculum approved by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and pass the examination with a score of eighty (80) percent or better;

(D) Pass Oklahoma State Bureau of Investigation (OSBI) background check;

(E) Have treatment plans be overseen and approved by a licensed behavioral health professional (LBHP) or licensure candidate; and

(F) Function under the general direction of an LBHP, licensure candidate or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

"**Illness/wellness management and recovery (IMR/WMR)**" means evidence-based practice models designed to help people who have experienced psychiatric symptoms. Elements include: developing personalized strategies for managing their mental illness and moving forward with their lives; setting and pursuing personal goals; learning information and skills to develop a sense of mastery over their psychiatric illness; and helping clients put strategies into action in their everyday lives.

"**Institution for mental disease (IMD)**" means a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services, as defined by 42 CFR § 435.1010.

"**Intermediate care facility for individuals with intellectual disabilities (ICF/IID)**" means a facility which primarily provides health-related care and services above the level of custodial care

to intellectually disabled individuals but does not provide the level of care available in a hospital or skilled nursing facility.

"**Licensed behavioral health professional (LBHP)**" means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current medical resident in psychiatry;

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the following areas of practice:

(i) Psychology;

(ii) Social work (clinical specialty only);

(iii) Professional counselor;

(iv) Marriage and family therapist;

(v) Behavioral practitioner; or

(vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse, certified in a psychiatric mental health specialty, and licensed as a registered nurse with a current certification of recognition from the board of nursing in the state in which services are provided; or

(D) A physician assistant with a current license to practice and in good standing in the state in which services are provided and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"**Licensure candidate**" means a practitioner who is actively and regularly receiving board approved supervision, and extended supervision by a fully licensed clinician if the board's supervision requirement is met but the individual is not yet licensed, to become licensed in a specific area of practice as outlined in (B)(i) through (vi) above. The supervising LBHP responsible for the member's care must:

(A) Staff the member's case with the candidate;

(B) Be personally available, or ensure the availability of an LBHP to the candidate for consultation while they are providing services;

(C) Agree with the current plan for the member;

(D) Confirm that the service provided by the candidate was appropriate; and

(E) Show that the member's medical record meet the requirements for reimbursement and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

"**OAC**" means Oklahoma Administrative Code, the publication authorized by 75 Oklahoma Statutes (O.S.), Sec. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"**ODMHSAS**" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"**OHCA**" means the Oklahoma Health Care Authority.

"**O.S.**" means Oklahoma Statutes.

"**Peer recovery support specialist (PRSS)**" means an individual certified by ODMHSAS as a peer recovery support specialist pursuant to requirements found in OAC 450:53.

"**Program of All-Inclusive Care for the Elderly (PACE)**" means a home and community based acute and long-term care services program for eligible individuals who meet the medical requirements for nursing facility care and can be served safely and appropriately in the community.

"**Psychiatric residential treatment facility (PRTF**)" means a non-hospital facility contracted with the OHCA to provide inpatient psychiatric services to SoonerCare-eligible members under the age of twenty-one (21), as defined by 42 C.F.R. § 483.352.

"**Psychosocial rehabilitation services (PSR**)" means face-to-face Behavioral Health Rehabilitation services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices.

"**Qualified behavioral health aide (QBHA)**" means a behavioral health aide who must meet requirements described in OAC 317:30-5-240.3.

"**Registered nurse (RN)**" means an individual who is a graduate of an approved school of nursing and is appropriately licensed in the state in which he or she practices.

"**Serious emotional disturbance (SED)**" means a condition experienced by persons from birth to eighteen (18) who have a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria outlined in OAC 317:30-5-240.1.

"**Serious mental illness (SMI)**" means a condition experienced by persons age eighteen (18) and over that have a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment that substantially interferes with or limits one or more major life activities. Specific diagnostic criteria is outlined in OAC 317:30-5-240.1.

"**System of care values**" means a philosophy, which embraces a family-driven, child-centered model of care that integrates and

coordinates the efforts of different agencies and providers to individualize care in the least restrictive setting that is clinically appropriate.

"**Wellness recovery action plans (WRAP)**" means a self-management and recovery system designed to:

(A) Decrease intrusive or troubling feelings and behaviors;

(B) Increase personal empowerment;

(C) Improve quality of life; and

(D) Assist people in achieving their own life goals and dreams.

"**Wraparound approach**" means a team-based planning and implementation process to improve the lives of children with complex needs and their families by developing individualized plans of care. The key characteristics of the process are that the plan is developed by a family centered team, is individualized based on the strengths and culture of the child and his or her family, and is driven by needs rather than services.

317:30-5-264. Purpose

Certified community behavioral health clinic is a service delivery model designed to provide a comprehensive range of mental health and substance use disorder services. Services are furnished by an interdisciplinary and mobile mental health team that functions interchangeably to provide the rehabilitation and treatment designed to enable the member to live successfully in the community.

317:30-5-265. Eligible providers

(a) **Agency requirements.** Certified community behavioral health clinics are responsible for providing services to qualifying individuals within the provider's specified service area. Qualifying providers must:

(1) Be certified by the ODMHSAS as a community mental health center under OAC 450:17 and have provider specific credentials from ODMHSAS for CCBHCs (OAC 450:17-5-170 et seq.);

(2) Be under the direction of a licensed physician;

(3) Provide mobile crisis care twenty-four (24) hours, seven (7) days a week and have a twenty-four (24) hours, seven (7) days a week walk-in crisis clinic or a psychiatric urgent care, or have an agreement in place with a State-sanctioned alternative;

(4) Actively use an Office of National Coordinator (ONC) certified Electronic Health Record (EHR) as demonstrated on the ONC Certified Health IT Product List;

(5) Have a contract with a Health Information Exchange (HIE) and demonstrate staff use of obtaining and sending data through the HIE as well as policy stating frequency of use and security

protocols; and

(6) Report on encounter, clinical outcomes, and quality improvement. This includes meeting all federal and State specifications of the required CMS quality measure reporting, as well as performance improvement reports outlining activities taken to improve outcomes.

(b) **Interdisciplinary team.** CCBHCs will utilize an interdisciplinary team of professionals and paraprofessionals to identify an individual's strengths and needs, create a unified plan to empower a person toward self-management, and coordinate the individual's varied healthcare needs. CCBHC teams will vary in size depending on the size of the member panel and acuity of the member. The treatment team includes the member, the family/caregiver of child members, the adult member's family to the extent the member does not object, and any other person the member chooses. Each CCBHC shall maintain a core staff comprised of employed and, as needed, contracted staff, as appropriate to the needs of the member as stated in the member's individual service plan.

(1) Teams shall at a minimum, include the following positions:

(A) Licensed psychiatrist;

(B) Licensed nurse care manager (registered nurse or licensed practical nurse);

(C) Consulting primary care physician, advanced practice registered nurse, or physician assistant;

(D) At least one (1) licensed behavioral health professional and may include additional LBHPs and licensure candidates [see OAC 317:30-5-240.3(a) and (b)];

(E) Certified peer recovery support specialist [see OAC 317:30-5-240.3(e)];

(F) Family support provider for child members [see OAC 317:30-5-240.3(f)]; and

(G) Certified behavioral health case manager II or certified alcohol and drug counselor [see OAC 317:30-5-240.3(c) and (h)].

(2) Optional team members may include the following:

(A) Certified behavioral health case manager I [see OAC 317:30-5-240.3(h)];

(B) Licensed nutritionist;

(C) Occupational therapist; and/or

(D) Occupational therapist assistant.

317:30-5-266. Covered services

Certified community behavioral health clinics provide a comprehensive array of services that create access, stabilize people in crisis, and provide the needed treatment and recovery support services for those with the most serious and complex mental

health and substance use disorders. CCBHCs integrate additional services to ensure an approach to health care that emphasizes recovery, wellness, trauma-informed care, and physical-behavioral health integration. Initial screening, assessment, and diagnosis must be completed in order to receive a covered service. Services must be medically necessary and recommended by an LBHP or licensure candidate (refer to OAC 317:30-5-240.3). Services are covered when provided in accordance with a person-centered and family-centered service plan. Coverage includes the following services:

(1) **Crisis assessment and intervention services.**

(A) **Service requirements.** This service is an immediately available service designed to meet the psychological, physiological, and environmental needs of individuals who are experiencing mental health and/or substance use disorder crises. Services include the following:

(i) Twenty-four (24) hours mobile crisis teams [see OAC 317:30-5-241.4(a) for service definition]. This service is provided by either a team consisting of an LBHP/licensure candidate and a CM II or CADC, or just an LBHP/licensure candidate. Reimbursement is triggered by the LBHP/licensure candidate crisis assessment;

(ii) Emergency crisis intervention service [see OAC 317:30-5-241.4(a) for service definition]. This service is provided by an LBHP/licensure candidate; and

(iii) Facility-based crisis stabilization [see OAC 317:30-5-241.4(b) for service definition], provided directly by the CCBHC or by a State-sanctioned alternative. This service is provided by a team, directed by a physician, and consisting of an LBHP/licensure candidate, licensed nurses, CM II or CADC, and PRSS staff.

(2) **Behavorial health integrated (BHI) services.**

(A) **Service requirements.** This service includes activities provided that have the purpose of coordinating and managing the care and services furnished to each member, assuring a fixed point of responsibility for providing treatment, rehabilitation, and support services. This service includes, but is not limited to:

(i) Care coordination for primary health care, specialty health care, and transitional care from emergency departments, hospitals, and PRTFs;

(ii) Ensuring integration and compatibility of mental health and physical health activities;

(iii) Providing on-going service coordination and linking members to resources;

(iv) Tracking completion of mental and physical health goals in member's comprehensive care plan;

(v) Coordinating with all team members to ensure all

objectives of the comprehensive care plan are progressing;
(vi) Appointment scheduling;
(vii) Conducting referrals and follow-up monitoring;
(viii) Participating in hospital discharge processes; and
(ix) Communicating with other providers and members/family.

(B) **Qualified professionals**. This service is performed by an LBHP/licensure candidate, nurse, CM II or CADC, and/or PRSS staff.

(3) **Person-centered and family-centered treatment planning.**

(A) **Service requirements.** This service is a process in which the information obtained in the initial screenings and assessments are used to develop a treatment plan that has individualized goals, objectives, activities, and services that will enable the member to improve. For children assessed as SED with significant behavioral needs, treatment planning is a wraparound process consistent with System of Care values. A wraparound planning process supports children and youth in returning to or remaining in the community.

(B) **Qualified professionals**. This service is conducted by LBHPs/licensure candidates, nurses, CM II or CADC, and/or PRSS staff. Treatment planning must include the member and involved practitioners.

(4) **Psychotherapy (individual / group / family).**

(A) **Service requirements.** See OAC 317:30-5-241.2 for service definitions and requirements. Fee for service billing limitations do not apply.

(B) **Qualified professionals**. This service is conducted by an LBHP/licensure candidate.

(5) **Medication training and support**.

(A) **Service requirements**. This service includes:
(i) A review and educational session focused on the member's response to medication and compliance with the medication regimen and/or medication administration;
(ii) Prescription administration and ordering of medication by appropriate medical staff;
(iii) Assisting the member in accessing medications;
(iv) Carefully monitoring medication response and side effects; and
(v) Assisting members with developing the ability to take medications with greater independence.

(B) **Qualified professionals**. This service is performed by a registered nurse, APRN, or a physician assistant (PA) as a direct service under the supervision of a physician.

(6) **Psychosocial rehabilitation services (PSR)**.

(A) **Service requirements**. PSR services are face-to-face

behavioral health rehabilitation (BHR) services which are necessary to improve the member's ability to function in the community. They are performed to improve the skills and abilities of members to live independently in the community, improve self-care and social skills, and promote lifestyle change and recovery practices. Rehabilitation services may be provided individually or in group sessions, and they take the format of curriculum-based education and skills training. This service is generally performed with only the member and the qualified provider, but may include a member and the member's family/support system when providing educational services from a curriculum that focuses on the member's diagnosis, symptom management, and recovery. A member who, at the time of service, is not able to cognitively benefit from the treatment due to active hallucinations, substance abuse, or other impairments is not suitable for this service. Family involvement is allowed for support of the member and education regarding his/her recovery but does not constitute family therapy, which requires a licensed provider. Eligibility requirements and billing limits found in OAC 317:30-5-241.3 do not apply.

(B) **Qualified professionals**. This service is solely restorative in nature and may be performed by a behavioral health CM II, CADC, LBHP, or licensure candidate, following development of a service plan and treatment curriculum approved by an LBHP or licensure candidate. The behavioral health CM II and CADC must have immediate access to an LBHP who can provide clinical oversight and collaborate with the qualified PSR provider in the provision of services.

(7) **Psychoeducation and counseling**.

(A) **Service requirements**. This service is designed to restore, rehabilitate, and support the individual's overall health and wellness. Services are intended for members to provide purposeful and ongoing psychoeducation and counseling that are specified in the individual's person-centered, individualized plan of care. Components include:

(i) Delivery of manualized wellness management interventions via group and individual work such as WRAP or IMR/WMR; and

(ii) Emotional support, education, resources during periods of crisis, and problem-solving skills.

(B) **Qualified professionals**. This service is provided by a licensed nurse, licensed nutritionist, or CM II or CADC within the scope of their licensure, certification, and/or training.

(8) **Peer recovery support services.**

(A) **Service requirements**. See OAC 317:30-5-241.5(d) for

service requirements

(B) **Qualified professionals**. PRSS must be certified through ODMHSAS pursuant to OAC 450:53.

(9) **Family support and training.**

(A) **Service requirements**. See OAC 317:30-5-241.5(c) for service requirements.

(B) **Qualified professionals**. Family support providers must be trained/credentialed through ODMHSAS.

(10) **Screening, assessment, and service planning.**

(A) **Service requirements**. See OAC 317:30-5-241.1 for service requirements. Service billing limitations found in OAC 317:30-5-241.1 do not apply.

(B) **Qualified professionals**. Screenings can be performed by any qualified team member as listed in OAC 317:30-5-265(b). Assessment and service planning can only be performed by an LBHP or licensure candidate.

(11) **Occupational therapy.**

(A) **Service requirements.** This service includes the therapeutic use of everyday life activities (occupations) with an individual or groups for the purpose of participation in roles and situations in home, school, workplace, community, and other settings for the purpose of promoting health and wellness. Occupational therapy services are provided to those who have developed an illness, injury, disease, disorder, condition, impairment, disability, activity limitation, or participation restrictions. Occupational therapy addresses the physical, cognitive, psychosocial, sensory, and other aspects of performance in a variety of contexts to support engagement in everyday life activities that affect health, well-being, and quality of life.

(B) **Qualified professionals**. This service is solely restorative in nature and provided by a qualified occupational therapist or occupational therapist assistant who is contracted with the OHCA and appropriately licensed for the service to be provided (see OAC 317:30-5-295).

(C) **Coverage limitations.** In order to be eligible for SoonerCare reimbursement, occupational therapy services must be prior authorized and/or prescribed by a physician or other licensed practitioner of the healing arts, in accordance with State and federal law, including, but not limited to, OAC 317:30-5-296, OAC 317:30-5-1020, and 42 CFR § 440.110.

317:30-5-267. Reimbursement

(a) In order to be eligible for payment, CCBHCs must have an approved provider agreement on file with the OHCA. Through this agreement, the CCBHC assures that OHCA's requirements are met and

assures compliance with all applicable federal and State Medicaid law, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, the Code of Federal regulations, and the Oklahoma State Medicaid Plan. These agreements are renewed annually with each provider.

(b) Reimbursement is made using a provider-specific PPS rate developed based on provider-specific cost report data. The PPS rate varies by category and level of service intensity and is paid when a CCBH program delivers at least one (1) CCBHC covered service, and when a valid individual procedure code is reported for the calendar month. Care coordination services do not trigger a PPS payment when billed alone in a calendar month. For reimbursement purposes, members are categorized as follows, and are assigned to special populations by the State:

(1) Standard population;

(2) Special population 1. This population includes individuals eighteen (18) years of age and over with SMI and complex needs including those with co-occurring substance use disorder (SUD). Individuals between eighteen (18) and twenty-one (21) years of age can be served in either special population 1 or 2 depending on the member's individualized needs; and

(3) Special population 2. This population includes children and youth [ages six (6) through twenty-one (21)] with SED and complex needs, including those with co-occurring mental health and SUD;

(c) Payments for services provided to non-established clients will be separately billable. Non-established CCBH clients are those who receive crisis services directly from the CCBHC without receiving a preliminary screening and risk assessment by the CCBHC and those referred to the CCBHC directly from other outpatient behavioral health agencies for pharmacologic management.

(d) Additional reimbursement may be made to the CCBHC once in the same calendar month as the PPS payment for care coordination provided by CCBHC staff to members who are involved in a drug court or other specialty court program. Physician services provided to these members by the CCBHC are reimbursable using the SoonerCare fee schedule.

(e) Reimbursement rates will be reviewed bi-annually and updated as necessary by the Medicare Economic Index (MEI).

317:30-5-268. Limitations

(a) The following are non-billable opportunities for CCBHCs serving eligible members:

(1) Employment services;

(2) Personal care services;

(3) Childcare and respite services; and

(4) Care coordination.

(b) The following SoonerCare members are not eligible for CCBHC services:

(1) Members receiving care in an Institution for Mental Disease (IMD);

(2) Members residing in a nursing facility or ICF/IID;

(3) Inmates of a public correctional institution; and

(4) SoonerCare members being served by a PACE provider.

(c) SoonerCare members receiving services from a CCBHC are not eligible for enrollment in a SoonerCare behavioral health home.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 4. EARLY AND PERIODIC SCREENING, ~~DIAGNOSIS~~DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES

317:30-3-65.12 Applied Behavior Analysis (ABA) services

(a) **Purpose and general provisions**. The purpose of this Section is to establish guidelines for the provision of ABA services under the EPSDT benefit.

(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include, but are not limited to: discrete trial training; pivotal response training; and verbal behavioral intervention.

(2) ABA may be provided in a variety of settings, including home, community, or a clinical setting. It involves development of an individualized treatment plan that includes transition and aftercare planning, and significant family/caregiver involvement.

(3) At an initial assessment, target symptoms are identified. A treatment plan is developed that identifies the core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and achieve individualized goals.

(4) Functional behavioral assessment (FBA) may also be a part of any assessment. An FBA consists of:

(A) Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity);

(B) History of the problematic behavior (long-term and recent);

(C) Antecedent analysis (setting, people, time of day, events);

(D) Consequence analysis; and

(E) Impression and analysis of the function of the problematic behavior.

(5) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31]. These services are designed to accomplish medically necessary management of severe and complex clinical conditions in which there is a realistic expectation that within a finite and reasonable period of time, the caregiver will be able to demonstrate knowledge and ability

to independently and safely carry out the established plan of care.

(b) **Eligible providers.** Eligible ABA provider types include:

(1) Board Certified Assistant Behavior Analyst (BCaBA) – A bachelor's level practitioner who is certified by the nationally accredited Behavior Analyst Certification Board (BACB) and certified by the Oklahoma Department of Human Services' (DHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services under the supervision of a BCBA;

(2) Board Certified Behavior Analyst (BCBA) – A master's or doctoral level independent practitioner who is certified by the nationally accredited BACB and licensed by DHS DDS to provide behavior analysis services. A BCBA may supervise the work of BCaBA's implementing behavior analytic interventions; or

(3) Human services professional – A practitioner who is licensed or certified by the State of Oklahoma and by the nationally accredited BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist or physical therapy assistant;

(B) An occupational therapist, occupational therapy assistant, or occupational therapy aide;

(C) A licensed clinical social worker, licensed masters social worker, or licensed social work associate;

(D) A psychologist or health service psychologist;

(E) A speech-language pathologist or audiologist;

(F) A licensed professional counselor or licensed professional counselor candidate;

(G) A licensed marital and family therapist or licensed marital and family therapist candidate; or

(H) A licensed behavioral practitioner or licensed behavioral practitioner candidate.

(c) **Provider criteria.** To direct, supervise, and/or render ABA services, the following conditions shall be met.

(1) A BCBA shall:

(A) Be currently licensed by DHS DDS as a BCBA;

(B) Have no sanctions or disciplinary actions by DHS DDS or the BACB;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(2) A BCaBA shall:

(A) Be currently certified by DHS DDS as a BCaBA;

(B) Work under the supervision of a BCBA with the supervisory relationship documented in writing;

(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(D) Be fully contracted with SoonerCare as a provider.

(3) A human services professional shall:

(A) Be currently licensed or certified by the State of Oklahoma, in accordance with Title 59 of the Oklahoma Statutes (O.S.), § 1928;

(B) Be currently certified by the nationally accredited BACB;

(C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;

(D) If working under supervision within the scope of his or her practice, have the supervisory relationship documented in writing;

(E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and

(F) Be fully contracted with SoonerCare as a provider.

(d) **Medical necessity criteria for members under twenty-one (21) years of age**. ABA services are considered medically necessary when all of the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers:

(A) Pediatric neurologist or neurologist;

(B) Developmental pediatrician;

(C) Licensed psychologist;

(D) Psychiatrist or neuropsychiatrist; or

(E) Other licensed physician experienced in the diagnosis and treatment of autism.

(2) A comprehensive diagnostic evaluation completed by one (1) of the above identified professionals must:

(A) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and

(B) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.

(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:

(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and

(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:

(A) Impulsive aggression toward others;

(B) Self-injury behaviors; or

(C) Intentional property destruction.

(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.")

(7) It has been determined that there is no less intensive or more appropriate level of services which can be safely and effectively provided.

(e) **Intervention criteria.** Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent and meet the following SoonerCare intervention criteria for ABA services.

(1) The intervention criteria includes a comprehensive behavioral and functional evaluation outlining the behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit a written assessment that will consist of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.

(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.

(C) Direct assessment and observation, including any data related to the identified problem behavior. The analysis of

such data serves as the primary basis for identifying pretreatment levels of functioning, developing and adapting treatment protocols, and evaluating response to treatment and progress towards goals.

(D) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences.

(2) The ABA treatment will be time limited and must:

(A) Be child-centered and based upon individualized goals that are strengths-specific, family focused, and community based;

(B) Be culturally competent and the least intrusive as possible;

(C) Clearly define in measurable and objective terms the specific target behaviors that are linked to the function of (or reason for) the behavior;

(D) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;

(E) Set quantifiable criteria for progress;

(F) Establish and record behavioral intervention techniques that are appropriate to target behaviors. The detailed behavior analytic treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;

(G) Specify strategies for generalization of learned skills;

(H) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria;

(I) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

(J) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian (s)' participation is critical to the generalization of treatment goals to the member's environment; and

(K) Ensure that recommended ABA services do not duplicate or replicate services received in a member's primary academic education setting, or provided within an Individualized

Education Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care.

(f) **ABA extension requests.** Extension requests for ABA services must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:

(1) Eligibility criteria in (d) 1-6;

(2) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;

(3) If progress has not been measurable after two (2) extension requests, a functional analysis will be completed which records the member's maladaptive serious target behavioral symptom(s), and precipitants, as well as makes a determination of the function a particular maladaptive behavior serves for the member in the environmental context;

(4) Appropriate consultations from other staff or experts have occurred (psychiatric consults, pediatric evaluation for other conditions) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);

(5) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and

(6) The treatment plan documents a gradual tapering of higher intensities of intervention and shifting to supports from other sources (i.e., schools) as progress occurs.

(g) **Reimbursement Methodology.** SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall be made to fully contracted BCBAs and human service professionals who are currently licensed and in good standing. Payment for ABA services rendered by any practitioner who is under supervision at the time the service is provided, shall be made to his or her licensed supervisor. If the rendering practitioner operates through an agency or corporate entity, payment may be made to that agency or entity.

(2) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.

(3) Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee.

(4) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 35. RURAL HEALTH CLINICS

317:30-5-355.1. Definition of services

The ~~RHC~~Rural Health Clinic (RHC) benefit package, as described in Title 42 of the Code of Federal Regulations (CFR), ~~part~~ § 440.20, consists of two (2) components: RHC ~~Services and Other Ambulatory Services~~services and other ambulatory services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. These services are described in this Section.

(A) **Core services.** As set out in ~~Federal Regulations at~~ 42 CFR § 440.20(b), RHC "core" services include, but are not limited to:

(i) Physician's services;

(ii) Services and supplies incident to a physician's services;

(iii) Services of advanced practice registered nurses ~~(APNs)~~(APRNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;

(iv) Services and supplies incident to the services of ~~APNs~~APRNs and PAs (including services furnished by ~~certified nurse midwives~~CNMs);

(v) Visiting nurse services to the homebound;

(vi) Clinical psychologist (CP) and clinical social worker (CSW) services;

(vii) Services and supplies incident to the services of CPs and CSWs.

(B) **Physicians' services.** In addition to the professional services of a physician, and services provided by an ~~APN~~APRN, PA, and ~~NMW~~CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of ~~a~~an RHC practitioner who is a clinic employee:

(i) ~~prenatal~~Prenatal and postpartum care;

(ii) ~~screening~~Screening examination under the Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) Program for members under ~~21~~twenty-one (21);

(iii) ~~family~~Family planning services;

(iv) ~~medically~~Medically necessary screening mammography and follow-up mammograms ~~when medically necessary~~.

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, ~~physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker~~PA, APRN, CP, or CSW are covered if the service or supply is:

(i) ~~a~~A type commonly furnished in physicians' offices;

(ii) ~~a~~A type commonly rendered either without charge or included in the rural health clinic's bill;

(iii) ~~furnished~~Furnished as an incidental, although integral, part of a physician's professional services; or

(iv) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(D) **Visiting nurse services.** Visiting nurse services are covered if:

(i) ~~the~~The RHC is located in an area in which the Centers for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;

(ii) ~~the~~The services are rendered to members who are homebound;

(iii) ~~the~~The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and

(iv) ~~the~~The services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT, or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and ~~a~~an RHC health professional ~~(i.e., physicians, physician assistants, advanced practice nurses, certified nurse midwives, clinical psychologists and clinical social workers)~~(physicians, PAs, APRNs, CNMs, CPs, and CSWs). Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Payment is made for one (1) encounter

per member per day. Medical review will be required for additional visits for children. Payment is also limited to four (4) visits per member per month for adults.

(F) **Off-site services.** RHC services provided off-site of the clinic are covered as long as the RHC has a compensation arrangement with the RHC practitioner that SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The ~~rural health clinic~~RHC must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the ~~rural health clinic~~RHC services provided off-site are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** ~~A Rural Health Clinic~~An RHC must provide other items and services which are not "RHC services" as described in ~~(a)~~(1) of this Section, and are separately billable ~~to the SoonerCare program~~within the scope of the SoonerCare fee-for-service (FFS) contract. Coverage of services are based upon the scope of coverage under the SoonerCare program.

(A) Other ambulatory services include, but are not limited to:

(i) ~~dental~~Dental services for members under ~~age 21~~the age of twenty-one (21);

(ii) ~~optometric~~Optometric services;

(iii) ~~clinical~~Clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification;

(iv) ~~technical~~Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);

(v) ~~durable~~Durable medical equipment;

(vi) ~~emergency ambulance transportation~~Transportation by ambulance (refer to OAC 317:30-5-335);

(vii) ~~prescribed~~Prescribed drugs;

(viii) ~~prosthetic~~Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(ix) ~~specialized~~Specialized laboratory services furnished away from the clinic;

(x) ~~inpatient~~Inpatient services;

(xi) ~~outpatient~~Outpatient hospital services~~.~~; and

(xii) Applied behavior analysis (ABA) [refer to Oklahoma

Administrative Code (OAC) 317:30-3-65.12].

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under ~~age 21~~the age of twenty-one (21). Encounters are billed as one (1) of the following:

(i) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(ii) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(iii) **Visual analysis.** Visual analysis (initial or yearly) for a child with glasses, or a child who needs glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Glasses must be billed separately. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(C) Services listed in ~~(a)~~(2)(A), (v)-(viii), of this Section, furnished on-site, require separate provider agreements with the ~~OHCA~~Oklahoma Health Care Authority (OHCA). Service item ~~(a)~~(2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

(D) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

317:30-5-357. Coverage for children

Coverage for rural health clinic (RHC) services and other ambulatory services for children include the same services as for adults in addition to the following:

(1) ~~The receipt of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination by a Medicaid eligible individual under age 21 renders that individual child eligible for all necessary follow-up care, whether or not the medically necessary services are covered under the Medicaid.~~Early and

Periodic Screening, Diagnostic and Treatment (EPSDT) services are covered for eligible members under twenty-one (21) years of age in accordance with OAC 317:30-3-65. An EPSDT exam performed by ~~a~~an RHC must be billed on the appropriate claim form with the appropriate ~~Preventative Medicine~~preventive medicine procedure code from the Current Procedural Terminology ~~Manual~~ (CPT) manual. If an EPSDT screening is billed, ~~a~~an RHC encounter should not be billed on the same day. ~~Refer to OAC 317:30-3-47 through 317:30-3-54 for coverages under EPSDT).~~Refer to Oklahoma Administrative Code (OAC) 317:30-3-65 through 317:30-3-65.12.

(2) Under EPSDT, coverage is allowed for visual screenings and eyeglasses to correct visual defects. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(3) An EPSDT screening is considered a comprehensive examination. A provider billing the Medicaid program for an EPSDT ~~screen~~screening may not bill any other visits for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.

(4) The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.

(5) Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

PART 37. ADVANCED PRACTICE NURSE

317:30-5-376. Coverage by category

Payment is made to ~~Advanced Practice Nurse~~advanced practice nurses as set forth in this Section.

(1) **Adults.** Payment for adults is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~advanced practice nurse and within the scope of the Oklahoma Health Care Authority (OHCA) medical programs.

(2) **Children.** Payment for children is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~advanced practice nurse, to ~~children and adolescents under 21~~members under twenty-one (21) years of age, including ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services~~ and within the scope of the Oklahoma Health Care Authority medical programs~~.

(A) Payment is made to eligible providers for ~~Early and~~

~~Periodic Screening, Diagnosis and Treatment of individuals under age 21~~EPSDT services to members under twenty-one (21) years of age. Specific guidelines for the EPSDT program including the periodicity schedule are found in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-65 through ~~317:30-3-65.11~~317:30-3-65.12.

(B) Comprehensive screening examinations are to be performed by a provider qualified under State law to furnish primary health care services.

(3) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.1. Provision of other health services outside of the Health Center core services

(a) If the Center chooses to provide other ~~SoonerCare~~Oklahoma Medicaid State Plan covered health services which are not included in the Health Center core service definition in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment, and billing procedures described by the OHCA, and these services (e.g., home health services) are not included in the PPS settlement methodology in OAC 317:30-5-664.12.

(b) Other medically necessary health services that will be reimbursed at the fee-for-service (FFS) rate include, but are not limited to:

(1) ~~dental~~Dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;

(2) ~~eyeglasses (OAC 317:30-5-430 and OAC 317:30-5-450)~~Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);

(3) ~~clinical~~Clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);

(4) ~~technical~~Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);

(5) ~~durable~~Durable medical equipment (refer to OAC 317:30-5-210);

(6) ~~emergency ambulance transportation~~Transportation by ambulance (refer to OAC 317:30-5-335);

(7) ~~prescribed~~Prescribed drugs (refer to OAC 317:30-5-70);

(8) ~~prosthetic~~Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(9) ~~specialized~~Specialized laboratory services furnished away from the clinic;
(10) Psychosocial ~~Rehabilitation Services~~rehabilitation services ~~[refer to OAC 317:30-5-241.3]~~(refer to OAC 317:30-5-241.3); ~~and~~
(11) ~~behavioral~~Behavioral health related case management services (refer to OAC 317:30-5-241.6)~~.~~; and
(12) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).

PART 108. NUTRITION SERVICES

317:30-5-1076. Coverage by category

Payment is made for ~~Nutritional Services~~nutritional services as set forth in this ~~section~~Section.

(1) **Adults.** Payment is made for six (6) hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant (PA), advanced practice registered nurse (APRN), or certified nurse midwife (CNW), and be ~~face to face~~face-to-face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found at OAC 317:30-3-65 ~~and~~through ~~317:30-3-65.11~~317:30-3-65.12.

(3) **Home and ~~Community Based Waiver Services~~community-based services (HCBS) waiver for the ~~Intellectually Disabled~~intellectually disabled.** All providers participating in the ~~Home and Community Based Waiver Services~~HCBS waiver for the intellectually disabled program must have a separate contract with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) to provide ~~Nutrition Services~~nutrition services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

(5) **Obstetrical patients.** Payment is made for a maximum of six (6) hours of medically necessary nutritional counseling per year by a licensed registered dietitian for members at risk for or those who have been recently diagnosed with gestational diabetes. The initial consultation may be in a group setting for a maximum of two (2) hours of class time. Thereafter, four (4) hours of nutritional counseling by a licensed registered dietitian may be provided to the individual if deemed medically necessary, which may include a post-partum visit, typically done at ~~6~~six (6) weeks after delivery. All services must be prescribed by a physician, ~~physician assistant, advanced practice nurse or a certified nurse midwife~~PA, APRN, or CNM and be face-to-face between a licensed registered dietitian and the member(s). Services must be solely for the prevention, diagnosis, or treatment of gestational diabetes.

PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1090. Provision of other health services outside of the I/T/U encounter

(a) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service (FFS) contract. The services will be reimbursed at the ~~fee-for-service~~FFS rate, and will be subject to any limitations, restrictions, or prior authorization requirements. Examples of these services include, but are not limited to:

(1) ~~durable~~Durable medical equipment [refer to Oklahoma Administrative Code (OAC) 317:30-5-210];

(2) ~~glassese~~Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);

(3) ~~ambulance~~Transportation by ambulance (refer to OAC 317:30-5-335);

(4) ~~home~~Home health ~~[refer to OAC 317:30-5-546]~~(refer to OAC 317:30-5-546);

(5) ~~inpatient~~Inpatient practitioner services (refer to OAC 317:30-5-1100);

(6) ~~non-emergency~~Non-emergency transportation ~~[refer to OAC 317:35-3-2]~~(refer to OAC 317:35-3-2);

(7) ~~behavioral~~Behavioral health case management ~~[refer to OAC 317:30-5-241.6]~~(refer to OAC 317:30-5-241.6);

(8) ~~psychosocial~~Psychosocial rehabilitative services ~~[refer to OAC 317:30-5-241.3]~~(refer to OAC 317:30-5-241.3); ~~and~~

(9) ~~psychiatric~~Psychiatric residential treatment facility services ~~[refer to OAC 317:30-5, Part 6, Inpatient Psychiatric Hospitals].~~(refer to OAC 317:30-5-95 through 317:30-5-98); and

(10) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).

(b) If the I/T/U facility chooses to provide other ~~SoonerCare~~Oklahoma Medicaid State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) and bill for those services under their assigned provider number consistent with program coverage limitations and billing procedures described by the OHCA.

PART 112. PUBLIC HEALTH CLINIC SERVICES

317:30-5-1154. ~~CHD/CCHD~~County health department (CHD)and city-county health department (CCHD) services/limitations

CHD/CCHD service limitations are:

(1) Child~~ Guidance~~-guidance services ~~(see OAC 317:30-3-65 through OAC 317:30-3-5-65.11 for specifics regarding program requirements).~~(refer to Oklahoma Administrative Code (OAC)317:30-5-1023).

(2) Dental services ~~[OAC 317:30-3-65.4(7)].~~(refer to OAC 317:30-3-65.4(7) for specific coverage).

(3) Early and Periodic Screening, ~~Diagnosis,~~Diagnostic and Treatment (EPSDT) services ~~(including blood lead testing and follow-up services)~~, including blood lead testing and follow-up services (~~see~~refer to OAC 317:30-3-65 through ~~OAC 30-3-65.11~~317:30-3-65.12 for specific coverage).

(4) Environmental investigations.

(5) Family ~~Planning~~planning and SoonerPlan ~~Family Planning~~family planning services (~~see~~refer to OAC 317:30-5-12 for specific coverage guidelines).

(6) Immunizations (adult and child).

(7) Blood lead testing (~~see~~refer to OAC 317:30-3-65.4 for specific coverage).

(8) Newborn hearing screening.

(9) Newborn metabolic screening.

(10) Maternity services (~~see~~refer to OAC 317:30-5-22 for specific coverage).

(11) Public health nursing services.

(12) Tuberculosis case management and directly observed therapy.

(13) Laboratory services.

(14) Targeted case management.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS

317:35-5-26. Residence requirements; residents of public institutions; homeless persons; and residents of IHS, BIA or Tribal controlled dormitories

(a) **Residence.** To be eligible for SoonerCare services, the applicant must be residing in the State of Oklahoma with intent to remain at the time the medical service is received. A durational residence requirement is not imposed.

(1) Temporary absence from the State, with subsequent returns to the State, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Oklahoma residence.

(2) Oklahoma residence does not include transients or visitors passing through the state but does not preclude persons who do not have a fixed address if intent is established.

(3) Intent to remain or return is defined as a clear statement of plans to remain or return in addition to other evidence and/or corroborative statements of others.

(4) When a non-resident makes application for SoonerCare benefits, the local office provides services necessary to make available to the applicant any SoonerCare services for which he/she might be eligible from his/her state of residence. The local office contacts the state or county of the applicant's residence to explore possible eligibility for medical benefits from the state and to obtain information needed for the determination of medical eligibility for the services received while in Oklahoma.

(5) If a member’s whereabouts are unknown, as indicated by the return of unforwardable agency mail, refer to OAC 317:35-5-67.

(b) **Individuals residing in institutions (correctional facilities and institutions for mental disease).** The SoonerCare program will only pay for services rendered to adults (21 through 64 years of age) who are inpatients in an institution for mental disease (IMD), juveniles in the custody of the Office of Juvenile Affairs who are inmates in a state-owned and operated facility, or inmates in a correctional facility, when these individuals are admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility or an intermediate care facility for the mentally retarded and meet all other eligibility requirements.

(c) **Homeless individuals.** Individuals are not required to have a

fixed address in order to be eligible for assistance. Individuals who lack a fixed or regular residence, who have temporary accommodations, i.e., supervised shelters, residence of other individuals, a hallway, bus station, car or other similar places, are considered as "homeless".

(d) **Individuals residing in IHS, BIA or Tribal controlled dormitories.** Individuals that reside in a facility which provides students boarding and lodging on a temporary residential basis for the purpose of attending a Bureau-operated or Indian-controlled contract or public school are considered Oklahoma residents for SoonerCare eligibility purposes.

PART 7. APPLICATION AND ELIGIBILITY DETERMINATION PROCEDURES

317:35-5-67. Returned mail

If the member's whereabouts are unknown, as indicated by the return of unforwardable agency mail directed to the member, and the Oklahoma Health Care Authority has made a reasonable attempt to verify the member's current address, the member's eligibility will be discontinued. Notice thereof will be sent to the member by mail and by electronic notice. If the member's whereabouts become known within the eligibility period, eligibility shall be reinstated in accordance with Section 431.231(d) of Title 42 of the Code of Federal Regulations. If the member's whereabouts become known after the eligibility period, a new application will be required.

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board – Drug Summary March 13, 2019 and April 10, 2019

Recommendation	Drug	Used for	Cost*	Notes
1	Inbrija™ Osmolex ER™	Parkinson's Disease	30 days - $4,749.00 Annual $56,988.00 30 days - $900.00 Annual - $10,800.00	Special formulations, alternatives available Levodopa Inhalation Amantadine Extended-Release (ER)
2	Epidiolex® (Cannabidiol), Diacomit® (Stiripentol), and Sympazan™ (Clobazam Oral Film)	Seizures – rare forms of epilepsy Adjuvant therapy for seizures Oral *film*	30 days - $1,852.50 Annual - $22,230.00 Not on market yet 30 days - $3,120.00	First CBD – FDA approved (C-V) Special formulation, other alternatives available
3	Gamifant®	Hemophagocytic lymphohistiocytosis (HLH)	Child - $7,422 - $712,512 min Child $74,220 – $7,125,120.00 (max dose – annual cost)	100 patients ***per year*** in U.S. Weight based dose. Dosed to maintain clinical response
4	Firdapse®	Lambert-Eaton myasthenic syndrome (LEMS)	30 days - $15,410.70 Annual - $184,928.40 $171.23 per tablet	Auto-immune disease associated with cancer (lung) 1:1,000,000 (60% CA)
5	Takhzyro™	Hereditary angioedema (HAE) prophylasis	$22,070.00 per vial 28 days - $44,140.00	Other therapies available, similar costs.
6	Copiktra™	Chronic lymphocytic leukemia (CLL) Small lymphocytic lymphoma	N/A	2nd line treatment refractory/relapsed
7	Lutathera® Vitrakvi®	Gasteroeneropancreatic neuroendocrine tumors Solid tumors with NTRK gene	$195,600.00 for 4 doses 30 days- $32,800.00	(GEP_NETs) Radio-isotope Metastatic or surgery is not an option

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) in NADAC unavailable.

N/A = not available at the time of publication.

Recommendation 1: Vote to Prior Authorize Inbrija™ (Levodopa Inhalation) and Osmolex ER™ [Amantadine Extended-Release (ER)]

The Drug Utilization Review Board recommends the prior authorization of Inbrija™ (levodopa inhalation) and Osmolex ER™ (amantadine ER) with the following criteria:

Inbrija™ (Levodopa Inhalation) Approval Criteria:

1. An FDA approved indication for the treatment of "off" episodes in patients with Parkinson's disease (PD) treated with carbidopa/levodopa; and
2. Member must be taking levodopa/carbidopa in combination with Inbrija™. Inbrija™ has been shown to be effective only in combination with carbidopa/levodopa; and
3. The member must be experiencing motor fluctuations with a minimum of 2 hours of "off" time and demonstrate levodopa responsiveness; and
4. Member must not be taking nonselective monoamine oxidase inhibitors (MAOIs) concomitantly with Inbrija™ or within 2 weeks prior to initiating Inbrija™; and
5. A previous failed trial of immediate-release (IR) carbidopa/levodopa formulations alone or in combination with long-acting carbidopa/levodopa formulations or a reason why supplementation with IR carbidopa/levodopa formulations is not appropriate for the member must be provided; and
6. A quantity limit of 10 capsules for inhalation per day will apply.

Osmolex ER™ [Amantadine Extended-Release (ER)] Approval Criteria:

1. An FDA approved indication for the treatment of Parkinson's disease (PD) or drug-induced extrapyramidal reactions in adults patients; and
2. Member must not have end-stage renal disease (ESRD) [creatinine clearance (CrCl) <15mL/min/1.73m^2]; and
3. A minimum of a 6-month trial of amantadine immediate-release (IR) that resulted in inadequate effects or intolerable adverse effects that are not expected to occur with amantadine ER; and
4. A patient-specific, clinically significant reason why amantadine IR products cannot be used must be provided; and
5. A quantity limit will apply based on FDA approved dosing regimen(s).

Recommendation 2: Vote to Prior Authorize Epidiolex® (Cannabidiol), Diacomit® (Stiripentol), and Sympazan™ (Clobazam Oral Film)

The Drug Utilization Review Board recommends the prior authorization of Epidiolex® (cannabidiol oral solution), Diacomit® (stiripentol), and Sympazan™ (clobazam oral film) with the following criteria:

Epidiolex® (Cannabidiol Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
    a. Lennox-Gastaut syndrome (LGS); or
    b. Dravet syndrome; and
2. Member must be 2 years of age or older; and
3. Initial prescription must be written by, or in consultation with, a neurologist; and
4. For a diagnosis of Dravet syndrome, the member must have failed or be inadequately controlled with at least 1 anticonvulsant; or
5. For a diagnosis of LGS, the member must have failed therapy with at least 3 other anticonvulsants; and
6. Members currently stable on Epidiolex® and who have a seizure diagnosis will be grandfathered; 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; and
8. Initial approvals will be for the duration of 3 months. For continuation, the prescriber must include information regarding improved response/effectiveness of the medication.

Diacomit® (Stiripentol) Approval Criteria:

1. An FDA approved indication of adjunctive therapy in the treatment of seizures associated with Dravet syndrome in members 2 years of age and older; and
2. Initial prescription must be written by, or in consultation with, a neurologist; and
3. Member must have failed or be inadequately controlled with clobazam and valproate; and
4. Member must take clobazam and valproate concomitantly with Diacomit® or a reason why concomitant clobazam and valproate are not appropriate for the member must be provided; and
5. Members currently stable on Diacomit® and who have a seizure diagnosis will be grandfathered; and
6. 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; and
7. For Diacomit® powder for oral suspension, an age restriction of 12 years and younger will apply. Members older than 12 years of age will require a patient-specific, clinically significant reason why the member cannot take the oral capsule formulation; and
8. Initial approvals will be for the duration of 3 months. For continuation, the prescriber must include information regarding improved response/effectiveness of the medication.

Sympazan™ (Clobazam Oral Film) Approval Criteria:

1. An FDA approved indication of adjunctive treatment of seizures associated with Lennox-Gastaut syndrome (LGS) in members 2 years of age and older; and
2. Previous failure of at least 2 non-benzodiazepine anticonvulsants; and
3. Previous failure of clonazepam; and
4. A patient-specific, clinically significant reason why the member cannot use clobazam oral tablets or clobazam oral suspension must be provided; and
5. Initial approvals will be for the duration of 3 months. For continuation, the prescriber must include information regarding improved response/effectiveness of the medication.

Recommendation 3: Vote to Prior Authorize Gamifant® (Emapalumab-lzsg) with the following criteria

The Drug Utilization Review Board recommends the prior authorization of Gamifant® (Emapalumab-lzsg) with the following criteria:

Gamifant® (Emapalumab-lzsg) Approval Criteria:

1. An FDA approved indication for the treatment of adult and pediatric patients with primary hemophagocytic lymphohistiocytosis (HLH) with refractory, recurrent, or progressive disease or who are intolerant to conventional HLH therapy; and
2. Diagnosis of primary HLH must be confirmed by 1 of the following:
    a. Genetic testing confirming mutation of a gene known to cause primary HLH (e.g., *PRF*, *UNC13D*, *STX11*); or
    b. Family history consistent with primary HLH; or
    c. Member meets 5 of the following 8 diagnostic criteria:
        i. Fever; or
        ii. Splenomegaly; or
        iii. Cytopenias affecting at least 2 of 3 lineages in the peripheral blood (hemoglobin <9, platelets <100 x 10^9/L, neutrophils <1 x 10^9/L); or
        iv. Hypertriglyceridemia (fasting triglycerides >3mmol/L or ≥265mg/dL) and/or hypofibrinogenemia (≤1.5g/L); or
        v. Hemophagocytosis in bone marrow, spleen, or lymph nodes with no evidence of malignancy; or
        vi. Low or absent natural killer (NK)-cell activity; or
        vii. Hyperferritinemia (ferritin ≥500mcg/L); or
        viii. High levels of soluble interleukin-2 receptor (soluble CD25 ≥2,400U/mL); and
3. Gamifant® must be prescribed by, or in consultation with, a physician who specializes in the treatment of immune deficiency disorders; and
4. Member must have at least 1 of the following:
    a. Failure of at least 1 conventional HLH treatment (e.g., etoposide, dexamethasone, cyclosporine); or
    b. Documentation of progressive disease despite conventional HLH treatment; or
    c. A patient-specific, clinically significant reason why conventional HLH treatment is not appropriate for the member must be provided; and

5. Prescriber must verify dexamethasone dosed at least 5mg/m^2/day will be used concomitantly with Gamifant®; and
6. Prescriber must verify member has received or will receive prophylaxis for herpes zoster, *Pneumocystis jirovecii,* and fungal infection(s); and
7. Prescriber must verify member will be monitored for tuberculosis (TB), adenovirus, Epstein-Barr virus (EBV), and cytomegalovirus (CMV) every 2 weeks and as clinically indicated; 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; and
9. Approvals will be for the duration of 6 months with reauthorization granted if the prescriber documents the member is responding well to treatment, no unacceptable toxicity has occurred, and the member has not received hematopoietic stem cell transplantation (HSCT).

Recommendation 4: Vote to Prior Authorize Firdapse® (Amifampridine) with the following criteria:

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

Firdapse® (Amifampridine) Approval Criteria:

1. A diagnosis of Lambert-Eaton myasthenic syndrome (LEMS); and
2. Diagnosis must be confirmed by 1 of the following:
   a. A high titer anti-P/Q-type voltage-gated calcium channel (VGCC) antibody assay; or
   b. A confirmatory electrodiagnostic study [e.g., repetitive nerve stimulation (RNS), needle electromyography (EMG), single-fiber electromyography (SFEMG)]; and
3. Firdapse® must be prescribed by, or in consultation with, a neurologist or oncologist; and
4. Member must not have a history of seizures or be taking medications that lower the seizure threshold (e.g., bupropion, tramadol, amphetamines, theophylline); and
5. A quantity limit of 240 tablets per 30 days will apply; and
6. Initial approvals will be for 6 months. Continued authorization will require the prescriber to indicate that the member is responding well to treatment and continues to require treatment with Firdapse®.

Recommendation 5: Vote to Prior Authorize Takhzyro™ (Lanadelumab-flyo)

The Drug Utilization Review Board recommends the prior authorization of Takhzyro™ (Lanadelumab-flyo)

Approval Criteria [Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL) Diagnosis]:

1. Takhzyro™ Dosing:

a. The recommended dose of Takhzyro™ is 300mg sub-Q every 2 weeks (dosing every 4 weeks may be considered in some members); and
b. Prescriber must verify member or caregiver has been trained by a health care professional on proper storage and sub-Q administration of Takhzyro™; and
c. A quantity limit of (2) 300mg/2mL vials per 28 days will apply.

Recommendation 6: Vote to Prior Authorize Copiktra™ (Duvelisib)

The Drug Utilization Review Board recommends the prior authorization of Copiktra™ (Duvelisib) Approval Criteria [Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL) Diagnosis]:

Copiktra™ (Duvelisib) Approval Criteria [Follicular Lymphoma (FL) Diagnosis]:

1. A diagnosis of relapsed or refractory FL; and
2. Progression of disease following 2 or more lines of systemic therapy; and
3. Must be used as a single-agent.

Copiktra™ (Duvelisib) Approval Criteria [Chronic Lymphocytic Leukemia (CLL)/Small Lymphocytic Lymphoma (SLL) Diagnosis]:

1. A diagnosis of relapsed or refractory CLL or SLL; and
2. Progression of disease following 2 or more lines of systemic therapy; and
3. Must be used as a single-agent.

Recommendation 7: Vote to Prior Authorize Lutathera® (Lutetium Lu 177 Dotatate) and Vitrakvi® (Larotrectinib) with the following criteria:

The Drug Utilization Review Board recommends the prior authorization of Lutathera® (Lutetium Lu 177 Dotatate) and Vitrakvi® (Larotrectinib) with the following criteria:

Lutathera® (Lutetium Lu 177 Dotatate) Approval Criteria [Gastroenteropancreatic Neuroendocrine Tumor (GEP-NET) Diagnosis]:

1. Diagnosis of progressive locoregional advanced disease or metastatic disease; and
2. Positive imaging of somatostatin receptor; and
3. Must be used as second-line or subsequent therapy following progression on octreotide or lanreotide; or
4. May be used first-line for treatment of pheochromocytoma/paraganglioma.

Vitrakvi® (Larotrectinib) Approval Criteria [Solid Tumors with Neurotrophic Receptor Tyrosine Kinase (*NTRK*) Gene Fusion Diagnosis]:

1. Diagnosis of a solid tumor with a *NTRK* gene fusion without a known acquired resistance mutation; and
2. Disease is metastatic or surgical resection (or radioactive iodine refractory if thyroid carcinoma) is contraindicated; and

3. Documentation of no satisfactory alternative treatments or progression following acceptable alternative treatments.

2019
Proposed OHCA Special Board Meetings

January

Su	Mo	Tu	We	Th	Fr	Sa
		1	2	3	4	5
6	7	8	9	**10**	11	12
13	14	15	16	17	18	19
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February

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March

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April

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August

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December

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June 25, 2019 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

August 28, 2019 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

September 25, 2019 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

October 23, 2019 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

November 20, 2019 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma

December 18, 2019 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, Oklahoma