

OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
December 8, 2016 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
OKC, OK

AGENDA

Items to be presented by Tony Armstrong, Vice-Chairman

1. Call to Order / Determination of Quorum
2. Action Item – Approval of the October 13, 2016 OHCA Board Meeting Minutes

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

3. Discussion Item – Chief Executive Officer’s Report
 - a) Financial Update – Carrie Evans, Chief Financial Officer
 - b) Medicaid Director’s Update – Garth Splinter, Deputy CEO
 1. SoonerCare Choice Program Update – Melody Anthony, Deputy State Medicaid Director
 2. Health Management Program (HMP) Update – Della Gregg, HMP Manager
 3. Recognition of 2016 Great 100 Nurses Honoree and Nomination for the March of Dimes’ Nurse of the Year Public Health Category , Rebekah Gossett, RN, Population Care Management (PCM) Supervisor – Marlene Asmussen, PCM Director
 - c) Legislative Update – Emily Shipley, Director of Government Relations
 1. Annual Tribal Consultation Update – Dana Miller, Tribal Relations Director

Item to be presented by Burl Beasley, Assistant Pharmacy Director & Mike Herndon, Chief Medical Officer

4. Discussion Item – Pain Management and Opioid Use Update

Item to be presented by Hillary Burkholder, Health Promotions Program Manager

5. Discussion Item – Member Advisory Task Force Update

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

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

Item to be presented by Carrie Evans, Chairperson of the State Plan Amendment Rate Committee

7. Action Item – Consideration and Vote Upon the Recommendations of the State Plan Amendment Rate Committee.
 - a) Consideration and Vote for a Rate and Method Change to Pharmacy Reimbursement Which Includes: A Change From Estimated Acquisition Cost to Actual Acquisition Cost, to Add the Pricing Term Specialty Pharmaceutical Allowable Cost, to Set the Professional Dispensing Fee at \$10.55, and to Set the Rate for I/T/U Pharmacy Claims at the OMB Encounter Rate Effective January 1, 2017. These Changes are Estimated to be Budget Neutral.

Item to be presented by Melinda Thomason, Assistant Director of Health Policy

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

Action Item – a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of **all Emergency Rules** in item eight 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. AMENDING agency rules at OAC 317:30-5-72.1, 317:30-5-78, 317:30-5-87, 317:30-5-1090 and 317:30-5-1098 to comply with regulations that update the reimbursement structure for Indian Health Services, Tribal Programs, Urban Indian Clinics (I/T/U), and non-I/T/U pharmacies. Revisions align reimbursement for covered outpatient drugs with Actual Acquisition Cost and create new pricing terms for specialty pharmaceutical products. Revisions also modify the current dispensing fee to a professional dispensing fee. The revisions will modify the reimbursement structure for I/T/U pharmacies; these pharmacies will be reimbursed at the federal Office of Management and Budget encounter rate, and will receive one payment per member per facility per day regardless of the number of prescriptions dispensed to the member on that day. Revisions also remove limitations for smoking cessation benefits and replace references to old sections of policy with current sections of policy.

Budget Impact: Budget neutral

(Reference APA WF # 16-13)

- B. AMENDING agency rules at OAC 317:2-1-2 and ADDING agency rules at 317:2-1-16 to establish a supplemental payment program for nursing facilities owned and as applicable operated by non-state government owned (NSGO) entities. The proposed revisions establish requirements and criteria for supplemental payments to be made to participating NSGOs up to the allowable Medicare upper payment limit (UPL). In addition, proposed revisions define terms related to the program and set forth criteria and eligibility requirements. Rules are also added to outline cost reporting, change in ownership, disbursement of payment, and appeal requirements.

Budget Impact: There is no cost to the OHCA as the state share will be financed by the NSGO and will be transferred to the state by way of an intergovernmental transfer for claiming of federal financial participation.

(Reference APA WF # 16-16A)

- C. ADDING agency rules at OAC 317:30-5-136 to establish a supplemental payment program for nursing facilities owned and as applicable operated by non-state government owned (NSGO) entities. The proposed revisions establish requirements and criteria for supplemental payments to be made to

participating NSGOs up to the allowable Medicare upper payment limit (UPL). In addition, proposed revisions define terms related to the program and set forth criteria and eligibility requirements. Rules are also added to outline cost reporting, change in ownership, disbursement of payment, and appeal requirements.

Budget Impact: There is no cost to the OHCA as the state share will be financed by the NSGO and will be transferred to the state by way of an intergovernmental transfer for claiming of federal financial participation.

(Reference APA WF # 16-16B)

- D. AMENDING agency rules at OAC 317:30-3-27 to revise language in Chapter 30 to reflect the repeal of 36 O.S. Section 6804, of The Oklahoma Telemedicine Act, which eliminates the informed consent requirement from Oklahoma Statutes.

Budget Impact: Budget neutral

(Reference APA WF # 16-18)

Item to be presented by Nancy Nesser, Pharmacy Director

9. Action Item - Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Under 63 Oklahoma Statutes 5030.3.
- a) Consideration and vote to add **Ocaliva™ (Obeticholic Acid)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
- b) Consideration and vote to add **Millipred™ (Prednisolone Sodium Phosphate Oral Solution 10mg/5mL)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
- c) Consideration and vote to add **Xiidra™ (Lifitegrast 5% Ophthalmic Solution)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
- d) Consideration and vote to add **Allzital® (Butalbital/Acetaminophen 25mg/325mg) & Esgic® Capsules (Butalbital/Acetaminophen/Caffeine 50mg/325mg/40mg)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
- e) Consideration and vote to add **Odomzo® (Sonidegib), Erivedge® (Vismodegib), Keytruda® (Pembrolizumab), Opdivo® (Nivolumab), Yervoy® (Ipilimumab), Tafinlar® (Dabrafenib), Zelboraf® (Vemurafenib), Cotellic® (Cobimetinib), Mekinist® (Trametinib), and Imlygic® (Talimogene Laherparepvec)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
- f) Consideration and vote to add **Relistor® (Methylnaltrexone) Tablets** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
- g) Consideration and vote to add **Synera® (Lidocaine/Tetracaine Topical Patch)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Tony Armstrong, Vice-Chairman

10. Action Item – Consideration and Vote upon the Oklahoma Health Care Authority Board Meeting Dates, Times and Locations for Calendar Year 2017
11. Action Item – Election of the Oklahoma Health Care Authority 2016-2017 Board Officers

12. Discussion Item – Proposed Executive Session as Recommended by the Chief of Legal Services and Authorized by the Open Meetings Act, 25 Oklahoma Statutes § 307(B)(1),(4) and (7).
 - a) Discussion of Pending Supreme Court Litigation
 - b) Discussion of Pending Class Action Litigation
 - c) Discussion of Pending Eligibility Litigation
 - d) Discussion of Pending Contractual Litigation
13. New Business
14. ADJOURNMENT

NEXT BOARD MEETING
January 12, 2017
Oklahoma Health Care Authority
OKC, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
October 13, 2016
Duncan Regional Hospital
Duncan, 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 and Duncan Regional Hospital on October 12, 2016 at 11:45 a.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on October 12, 2016 at 8:00 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:02 p.m.

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

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

OTHERS PRESENT: OTHERS PRESENT:

Lou Ann McFall
Melody Anthony, OHCA
Jennifer King, OHCA

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARLY SCHEDULED BOARD MEETING HELD SEPTEMBER 8, 2016.

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

MOTION: Vice-Chairman Armstrong moved for approval of the September 8, 2016 board meeting minutes as published. The motion was seconded by Member McVay.

FOR THE MOTION: Chairman McFall, Member Bryant

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

BECKY PASTERNIK-IKARD, CHIEF EXECUTIVE OFFICER'S REPORT

ITEM 3a / ALL STARS INTRODUCTION

Becky Pasternik-Ikard, Chief Executive Officer

The following OHCA All-Star was recognized.

- August 2016 All-Star – Natasha Kester, Medical Authorization Analyst (Garth Splinter presented)

ITEM 3b / FINANCIAL UPDATE

Carrie Evans, Chief Financial Officer

Ms. Evans reported on the financial transactions through the month of August. OHCA has a \$1.5 million state dollar variance with \$1.9 million in program spending and \$0.4 million in administration. She reported that drug rebate is \$0.7 million over budget with taxes and fees under \$0.9 million and overpayments and settlements are \$0.6 million under. Ms. Evans predicted that OHCA will be slightly under budget for the month of September. For more detailed information, see Item 3b in the board packet.

ITEM 3c / MEDICAID DIRECTOR'S UPDATE

Garth Splinter, Deputy Chief Executive Officer

Dr. Splinter provided an update for August 2016 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program including Insure Oklahoma numbers. He discussed the per member per month cost by group charts provided. For more detailed information, see Item 3c in the board packet.

ITEM 3c.1 / CMS CMMI CPCP CLASSIC AND CPC+ INITIATIVE UPDATES

Melody Anthony, Deputy State Medicaid Director

Ms. Anthony presented an overview of Comprehensive Primary Care (CPC) current and future status. This included a report on CPC classic regions, provider locations, participation in the Tulsa region, primary focus, CMS shared savings from 2014, CPC+ regions and major differences in CPC classic and CPC+. For more detailed information, see Item 3c.1 in the board packet.

ITEM 4 / STATE FISCAL YEAR 2018 BUDGET REQUEST OVERVIEW

Vickie Kersey, Director of Fiscal Planning & Procurement

Ms. Kersey presented the draft SFY 2018 budget request detail and discussed the priorities and totals for each. For more detailed information, see Item 4 in the board packet.

ITEM 5 / ACCESS MONITORING REVIEW PLAN

Tywanda Cox, Chief of Federal and State Policy

Ms. Cox gave an overview of what an access monitoring review plan is and discussed OHCA's plan which included the history, timeline and next steps for the plan. For more detailed information, see Item 5 in the board packet.

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

Nicole Nantois, Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 7a-d / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT

Tywanda Cox, Chief of Federal and State Policy

7. Action Item – a) Consideration and Vote Upon a Declaration of a Compelling Public Interest for the Promulgation of All Emergency Rules in Item Seven in Accordance with 75 Okla. Stat.

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 Permanent Rules:

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

a) ADDING agency rules at OAC 317:30-3-19.2 to comply with enhanced enrollment screening provisions contained in the Affordable Care Act. The proposed additions outline screening procedures to be followed by provider contracting staff for providers (or anyone with a 5% or more direct or indirect ownership interest in the company) who poses an increased financial risk of fraud, waste or abuse to the SoonerCare program. Rules add information regarding applicants who are seeking new or renewed contract enrollment as being subject to a fingerprint-based criminal background check if they are designated as high risk in accordance with Federal law. Rules also specify types of criminal convictions for which an applicant shall (regarding felonies) or may (regarding misdemeanors) be denied enrollment. Rules also state that there is no right to appeal an OHCA decision denying an application for contract enrollment based on the applicant's criminal history.

Budget Impact: Budget neutral

(Reference APA WF # 16-08)

b) AMENDING agency rules at OAC 317:30-5-2 to clarify licensing provisions and contracting requirements for medical residents, to reinstate the bundled reimbursement structure for obstetrical care, and to clarify direct physician care visit limits. Proposed revisions remove language specific to non-licensed physicians in a training program. The revisions for medical licensure requirements are necessary to comply with federal

regulations that require all ordering or referring physicians be enrolled as participating providers. Rules regarding reimbursement for obstetrical care are amended to reinstate the use of the global CPT codes for routine obstetrical care billing. The reinstatement of the global reimbursement is necessary to prevent an unintended administrative burden to providers. Finally, the proposed revisions regarding direct physician care visit limits clarify that SoonerCare Choice members are exempt from primary care office visits limits. The proposed revision is necessary to comply with current Waiver parameters and to ensure the access to care for Choice members is not impacted.

Budget Impact: Budget neutral

(Reference APA WF # 16-12)

- c) AMENDING agency rules at OAC 317:30-5-22, 317:30-5-226, 317:30-5-229, 317:30-5-356, and 317:30-5-664.8 to reinstate the use of the global care CPT codes for routine obstetrical care billing, which can be used if the provider had provided care for a member for greater than one trimester. The reinstatement of the global reimbursement is necessary to prevent an unintended administrative burden to providers.

Budget Impact: Budget neutral

(Reference APA WF # 16-15A)

- d) AMENDING agency rules at OAC 317:35-5-2 and 317:35-22-2 to reinstate the use of the global care CPT codes for routine obstetrical care billing, which can be used if the provider had provided care for a member for greater than one trimester. The reinstatement of the global reimbursement is necessary to prevent an unintended administrative burden to providers.

Budget Impact: Budget neutral

(Reference APA WF # 16-15B)

MOTION:

Vice-Chairman Armstrong moved for approval of emergency rulemaking for Item 7a as published. The motion was seconded by Member Bryant.

FOR THE MOTION:

Chairman McFall, Member McVay

BOARD MEMBERS ABSENT:

Member Nuttle, Member Case, Member Robison

MOTION:

Vice-Chairman Armstrong moved for approval of Item 7b.a-d as published. The motion was seconded by Member McVay.

FOR THE MOTION:

Chairman McFall, Member Bryant

BOARD MEMBERS ABSENT:

Member Nuttle, Member Case, Member Robison

ITEM 8 / CONSIDERATION AND VOTE OF AUTHORITY FOR AN INCREASE IN EXPENDITURE OF FUNDS FOR CONSULTING SERVICES

Vickie Kersey, Director of Fiscal Planning & Procurement

MOTION:

Member McVay moved for approval of Item 8 as published. The motion was seconded by Vice-Chairman Armstrong.

FOR THE MOTION:

Chairman McFall, Member Bryant

BOARD MEMBERS ABSENT:

Member Nuttle, Member Case, Member Robison

ITEM 9 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4) and (7).

Nicole Nantois, Chief of Legal Services

Ms. Nantois said there was no need for an executive session at this time.

ITEM 10 / NEW BUSINESS

There was no new business.

ITEM 11 / ADJOURNMENT

MOTION:

Member Bryant moved for approval for adjournment. The motion was seconded by Member McVay.

FOR THE MOTION:

Chairman McFall, Vice-Chairman Armstrong

BOARD MEMBERS ABSENT:

Member Nuttle, Member Case, Member Robison

Meeting adjourned at 1:51 p.m., 10/13/16

NEXT BOARD MEETING
November 10, 2016
Northwestern Oklahoma State University
Enid, OK

Lindsey Bateman
Board Secretary

Minutes Approved: _____

Initials: _____

DRAFT



FINANCIAL REPORT

For the Four Months Ended October 31, 2016
Submitted to the CEO & Board

- Revenues for OHCA through October, accounting for receivables, were **\$1,364,403,231** or **1.2% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **\$1,369,736,727** or **1.4% under** budget.
- The state dollar budget variance through October is a **positive \$3,093,788**.
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	5.8
Administration	1.0
Revenues:	
Drug Rebate	(1.3)
Taxes and Fees	(.9)
Overpayments/Settlements	(1.5)
Total FY 17 Variance	\$ 3.1

ATTACHMENTS

Summary of Revenue and Expenditures: OHCA	1
Medicaid Program Expenditures by Source of Funds	2
Other State Agencies Medicaid Payments	3
Fund 205: Supplemental Hospital Offset Payment Program Fund	4
Fund 230: Quality of Care Fund Summary	5
Fund 245: Health Employee and Economy Act Revolving Fund	6
Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund	7

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2017, For the Four Month Period Ending October 31, 2016

REVENUES	FY17 Budget YTD	FY17 Actual YTD	Variance	% Over/ (Under)
State Appropriations	\$ 326,736,702	\$ 326,736,702	\$ -	0.0%
Federal Funds	789,412,451	780,962,072	(8,450,379)	(1.1)%
Tobacco Tax Collections	16,974,650	16,380,275	(594,375)	(3.5)%
Quality of Care Collections	26,156,941	26,045,731	(111,210)	(0.4)%
Prior Year Carryover	17,518,798	17,518,798	-	0.0%
Federal Deferral - Interest	20,069	20,069	-	0.0%
Drug Rebates	81,968,604	78,692,121	(3,276,483)	(4.0)%
Medical Refunds	15,033,619	11,442,775	(3,590,844)	(23.9)%
Supplemental Hospital Offset Payment Program	99,015,499	99,015,499	-	0.0%
Other Revenues	7,896,825	7,589,189	(307,635)	(3.9)%
TOTAL REVENUES	\$ 1,380,734,158	\$ 1,364,403,231	\$ (16,330,926)	(1.2)%
EXPENDITURES	FY17 Budget YTD	FY17 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	\$ 17,842,551	\$ 16,846,172	\$ 996,379	5.6%
ADMINISTRATION - CONTRACTS	\$ 26,790,782	\$ 25,100,749	\$ 1,690,033	6.3%
MEDICAID PROGRAMS				
<u>Managed Care:</u>				
SoonerCare Choice	14,464,946	12,711,477	1,753,469	12.1%
<u>Acute Fee for Service Payments:</u>				
Hospital Services	302,702,049	298,499,454	4,202,595	1.4%
Behavioral Health	6,371,346	6,503,105	(131,759)	(2.1)%
Physicians	137,985,374	134,716,302	3,269,072	2.4%
Dentists	43,984,103	43,662,682	321,421	0.7%
Other Practitioners	17,471,708	18,275,855	(804,147)	(4.6)%
Home Health Care	6,463,541	5,925,553	537,988	8.3%
Lab & Radiology	14,479,380	11,588,248	2,891,132	20.0%
Medical Supplies	15,549,373	15,436,975	112,398	0.7%
Ambulatory/Clinics	57,308,144	57,395,520	(87,376)	(0.2)%
Prescription Drugs	174,285,982	174,411,087	(125,105)	(0.1)%
OHCA Therapeutic Foster Care	38,546	(62,768)	101,314	0.0%
<u>Other Payments:</u>				
Nursing Facilities	191,097,834	187,945,907	3,151,926	1.6%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	21,238,068	20,667,972	570,096	2.7%
Medicare Buy-In	59,191,181	57,525,356	1,665,825	2.8%
Transportation	21,819,194	21,945,327	(126,133)	(0.6)%
Money Follows the Person-OHCA	115,525	51,939	63,586	0.0%
Electronic Health Records-Incentive Payments	6,026,564	6,026,564	-	0.0%
Part D Phase-In Contribution	30,812,294	30,886,111	(73,818)	(0.2)%
Supplemental Hospital Offset Payment Program	219,607,736	219,607,736	-	0.0%
Tolligen	3,425,840	4,069,403	(643,563)	(18.8)%
Total OHCA Medical Programs	1,344,438,726	1,327,789,806	16,648,920	1.2%
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	\$ 1,389,161,441	\$ 1,369,736,727	\$ 19,424,714	1.4%
REVENUES OVER/(UNDER) EXPENDITURES	\$ (8,427,283)	\$ (5,333,496)	\$ 3,093,788	

OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2017, For the Four Month Period Ending October 31, 2016

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	\$ 12,751,674	\$ 12,707,825	\$ -	\$ 40,197	\$ -	\$ 3,652	\$ -
Inpatient Acute Care	420,583,170	194,961,171	162,229	1,118,533	151,600,031	707,002	72,034,205
Outpatient Acute Care	158,266,028	101,385,691	13,868	1,425,229	54,171,746	1,269,493	-
Behavioral Health - Inpatient	22,054,757	3,848,817	-	83,280	13,323,353	-	4,799,307
Behavioral Health - Psychiatrist	3,166,893	2,654,287	-	-	512,606	-	-
Behavioral Health - Outpatient	5,781,812	-	-	-	-	-	5,781,812
Behavioral Health-Health Home	11,866,263	-	-	-	-	-	11,866,263
Behavioral Health Facility- Rehab	77,340,642	-	-	-	-	22,954	77,340,642
Behavioral Health - Case Management	6,057,967	-	-	-	-	-	6,057,967
Behavioral Health - PRTF	21,140,658	-	-	-	-	-	21,140,658
Residential Behavioral Management	6,042,587	-	-	-	-	-	6,042,587
Targeted Case Management	25,813,585	-	-	-	-	-	25,813,585
Therapeutic Foster Care	(62,768)	(62,768)	-	-	-	-	-
Physicians	154,680,604	133,240,501	19,367	(87,690)	-	1,456,433	20,051,993
Dentists	43,673,264	43,659,813	-	10,582	-	2,869	-
Mid Level Practitioners	937,295	929,115	-	7,190	-	989	-
Other Practitioners	17,462,500	17,171,475	148,788	116,749	-	25,488	-
Home Health Care	5,930,354	5,922,911	-	4,802	-	2,642	-
Lab & Radiology	11,840,280	11,512,944	-	252,032	-	75,304	-
Medical Supplies	15,531,133	14,522,278	903,844	94,158	-	10,853	-
Clinic Services	56,767,542	54,728,752	-	284,171	-	53,149	1,701,469
Ambulatory Surgery Centers	2,648,675	2,609,916	-	35,057	-	3,703	-
Personal Care Services	3,758,409	-	-	-	-	-	3,758,409
Nursing Facilities	187,945,907	115,367,587	72,578,320	-	-	-	-
Transportation	21,886,776	21,049,451	825,919	-	-	11,406	-
GME/IME/DME	60,635,271	-	-	-	-	-	60,635,271
ICF/IID Private	20,667,972	16,909,823	3,758,149	-	-	-	-
ICF/IID Public	6,499,727	-	-	-	-	-	6,499,727
CMS Payments	88,411,467	88,141,241	270,226	-	-	-	-
Prescription Drugs	178,629,006	173,554,931	-	4,217,918	-	856,156	-
Miscellaneous Medical Payments	58,551	58,551	-	-	-	-	-
Home and Community Based Waiver	68,553,855	-	-	-	-	-	68,553,855
Homeward Bound Waiver	28,222,069	-	-	-	-	-	28,222,069
Money Follows the Person	90,196	51,939	-	-	-	-	38,257
In-Home Support Waiver	8,633,721	-	-	-	-	-	8,633,721
ADvantage Waiver	61,800,824	-	-	-	-	-	61,800,824
Family Planning/Family Planning Waiver	1,516,749	-	-	-	-	-	1,516,749
Premium Assistance*	21,143,313	-	-	21,143,313	-	-	-
Telligen	4,069,403	4,069,403	-	-	-	-	-
Electronic Health Records Incentive Payments	6,026,564	6,026,564	-	-	-	-	-
Total Medicaid Expenditures	\$ 1,848,824,696	\$ 1,025,022,221	\$ 78,680,709	\$ 28,745,520	\$ 219,607,736	\$ 4,502,094	\$ 492,289,370

* Includes \$21,013,214.80 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2017, For the Four Month Period Ending October 31, 2016

REVENUE	FY17 Actual YTD
Revenues from Other State Agencies	\$ 209,560,351
Federal Funds	308,206,137
TOTAL REVENUES	\$ 517,766,488
EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	\$ 68,553,855
Money Follows the Person	38,257
Homeward Bound Waiver	28,222,069
In-Home Support Waivers	8,633,721
ADvantage Waiver	61,800,824
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	6,499,727
Personal Care	3,758,409
Residential Behavioral Management	4,814,179
Targeted Case Management	22,501,415
Total Department of Human Services	204,822,455
State Employees Physician Payment	
Physician Payments	20,051,993
Total State Employees Physician Payment	20,051,993
Education Payments	
Graduate Medical Education	25,162,701
Graduate Medical Education - Physicians Manpower Training Commission	1,757,289
Indirect Medical Education	33,086,772
Direct Medical Education	628,509
Total Education Payments	60,635,271
Office of Juvenile Affairs	
Targeted Case Management	895,026
Residential Behavioral Management	1,228,408
Total Office of Juvenile Affairs	2,123,434
Department of Mental Health	
Case Management	6,057,967
Inpatient Psychiatric Free-standing	4,799,307
Outpatient	5,781,812
Health Homes	11,866,263
Psychiatric Residential Treatment Facility	21,140,658
Rehabilitation Centers	77,340,642
Total Department of Mental Health	126,986,650
State Department of Health	
Children's First	675,849
Sooner Start	622,698
Early Intervention	1,621,487
Early and Periodic Screening, Diagnosis, and Treatment Clinic	344,545
Family Planning	54,628
Family Planning Waiver	1,460,782
Maternity Clinic	2,709
Total Department of Health	4,782,698
County Health Departments	
EPSDT Clinic	202,025
Family Planning Waiver	1,338
Total County Health Departments	203,363
State Department of Education	60,088
Public Schools	59,721
Medicare DRG Limit	70,000,000
Native American Tribal Agreements	529,492
Department of Corrections	288,327
JD McCarty	1,745,878
Total OSA Medicaid Programs	\$ 492,289,370
OSA Non-Medicaid Programs	\$ 22,079,836
Accounts Receivable from OSA	\$ (3,397,282)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2017, For the For Month Period Ending October 31, 2016

REVENUES	FY 17 Revenue
SHOPP Assessment Fee	\$ 98,986,940
Federal Draws	132,791,902
Interest	28,559
Penalties	-
State Appropriations	(15,100,000)
TOTAL REVENUES	\$ 216,707,402

EXPENDITURES	Quarter	Quarter	FY 17 Expenditures
	7/1/16 - 9/30/16	10/1/16 - 12/31/16	
Program Costs:			
Hospital - Inpatient Care	76,250,540	75,349,490	\$ 151,600,031
Hospital -Outpatient Care	27,213,505	26,958,241	54,171,746
Psychiatric Facilities-Inpatient	6,661,677	6,661,677	13,323,353
Rehabilitation Facilities-Inpatient	257,683	254,922	512,606
Total OHCA Program Costs	110,383,405	109,224,330	\$ 219,607,736

Total Expenditures	\$ 219,607,736
---------------------------	-----------------------

CASH BALANCE	\$ (2,900,334)
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OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2017, For the Four Month Period Ending October 31, 2016

REVENUES	Total Revenue	State Share
Quality of Care Assessment	\$ 26,032,111	\$ 26,032,111
Interest Earned	13,620	13,620
TOTAL REVENUES	\$ 26,045,731	\$ 26,045,731

EXPENDITURES	FY 17 Total \$ YTD	FY 17 State \$ YTD	Total State \$ Cost
Program Costs			
Nursing Facility Rate Adjustment	\$ 71,353,073	\$ 28,020,352	
Eyeglasses and Dentures	92,606	36,367	
Personal Allowance Increase	1,132,640	444,788	
Coverage for Durable Medical Equipment and Supplies	903,844	354,940	
Coverage of Qualified Medicare Beneficiary	344,252	135,188	
Part D Phase-In	270,226	106,118	
ICF/IID Rate Adjustment	1,731,479	679,952	
Acute Services ICF/IID	2,026,671	795,874	
Non-emergency Transportation - Soonerride	825,919	324,338	
Total Program Costs	\$ 78,680,709	\$ 30,897,915	\$ 30,897,915
Administration			
OHCA Administration Costs	\$ 174,120	\$ 87,060	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	-	-	
Mike Fine, CPA	-	-	
Total Administration Costs	\$ 174,120	\$ 87,060	\$ 87,060
Total Quality of Care Fee Costs	\$ 78,854,829	\$ 30,984,974	
TOTAL STATE SHARE OF COSTS			\$ 30,984,974

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

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 245: Health Employee and Economy Improvement Act Revolving Fund
SFY 2017, For the Four Month Period Ending October 31, 2016

REVENUES	FY 16 Carryover	FY 17 Revenue	Total Revenue
Prior Year Balance	\$ 5,199,281	\$ -	\$ 3,102,480
State Appropriations	(2,000,000)	-	-
Tobacco Tax Collections	-	13,472,655	13,472,655
Interest Income	-	45,178	45,178
Federal Draws	246,145	13,124,498	13,124,498
TOTAL REVENUES	\$ 3,445,426	\$ 26,642,330	\$ 29,744,810

EXPENDITURES	FY 16 Expenditures	FY 17 Expenditures	Total \$ YTD
Program Costs:			
Employer Sponsored Insurance		\$ 21,013,215	\$ 21,013,215
College Students/ESI Dental		130,098	51,089
Individual Plan			
SoonerCare Choice		\$ 38,700	\$ 15,197
Inpatient Hospital		1,116,075	438,283
Outpatient Hospital		1,402,898	550,918
BH - Inpatient Services-DRG		78,842	30,961
BH -Psychiatrist		-	-
Physicians		(47,770)	(18,759)
Dentists		10,472	4,112
Mid Level Practitioner		7,190	2,824
Other Practitioners		114,424	44,934
Home Health		2,960	1,163
Lab and Radiology		249,173	97,850
Medical Supplies		88,815	34,877
Clinic Services		278,214	109,255
Ambulatory Surgery Center		35,057	13,767
Prescription Drugs		4,113,783	1,615,483
Miscellaneous Medical		-	-
Premiums Collected		-	(151,401)
Total Individual Plan		\$ 7,488,834	\$ 2,789,464
College Students-Service Costs		\$ 113,374	\$ 44,522
Total OHCA Program Costs		\$ 28,745,520	\$ 23,898,290
Administrative Costs			
Salaries	\$ 32,930	\$ 680,481	\$ 713,411
Operating Costs	15,971	49,434	65,405
Health Dept-Postponing	-	-	-
Contract - HP	294,045	398,679	692,724
Total Administrative Costs	\$ 342,946	\$ 1,128,595	\$ 1,471,541
Total Expenditures			\$ 25,369,831
NET CASH BALANCE	\$ 3,102,480	\$	4,374,979

**OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:**

**Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2017, For the Four Month Period Ending October 31, 2016**

REVENUES	FY 17 Revenue	State Share
Tobacco Tax Collections	\$ 268,802	\$ 268,802
TOTAL REVENUES	\$ 268,802	\$ 268,802

EXPENDITURES	FY 17 Total \$ YTD	FY 17 State \$ YTD	Total State \$ Cost
Program Costs			
SoonerCare Choice	\$ 3,652	\$ 164	
Inpatient Hospital	707,002	31,762	
Outpatient Hospital	1,269,493	57,032	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	1,456,433	65,430	
Dentists	2,869	129	
Mid-level Practitioner	989	44	
Other Practitioners	25,488	1,145	
Home Health	2,642	119	
Lab & Radiology	75,304	3,383	
Medical Supplies	10,853	488	
Clinic Services	53,149	2,388	
Ambulatory Surgery Center	3,703	166	
Prescription Drugs	853,860	38,360	
Transportation	11,406	512	
Miscellaneous Medical	2,296	103	
Total OHCA Program Costs	\$ 4,479,140	\$ 201,225	
OSA DMHSAS Rehab	\$ 22,954	\$ 1,031	
Total Medicaid Program Costs	\$ 4,502,094	\$ 202,257	
TOTAL STATE SHARE OF COSTS			\$ 202,257

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

OHCA Board Meeting December 8, 2016 (October 2016 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

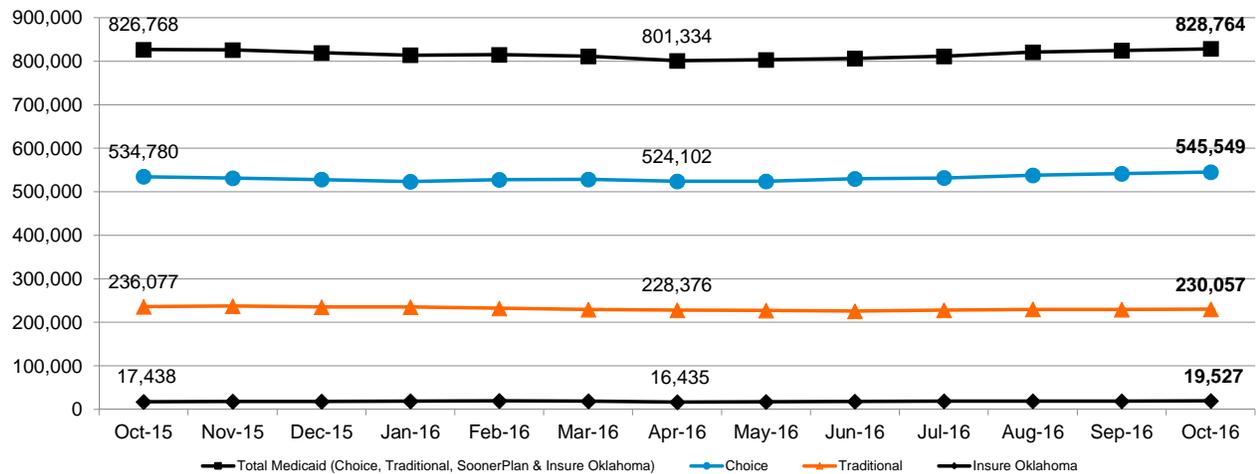
Delivery System		Enrollment October 2016	Children October 2016	Adults October 2016	Enrollment Change	Total Expenditures October 2016	PMPM October 2016	Forecasted October 2016 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home		545,549	450,319	95,230	3,686	\$179,934,327		
	<i>Lower Cost</i>	502,216	436,617	65,599	3,564	\$102,445,151	\$204	\$223
	<i>Higher Cost</i>	43,333	13,702	29,631	122	\$77,489,176	\$1,788	\$1,202
SoonerCare Traditional		230,057	84,905	145,152	233	\$127,264,693		
	<i>Lower Cost</i>	117,253	79,871	37,382	-66	\$37,799,571	\$322	\$354
	<i>Higher Cost</i>	112,804	5,034	107,770	299	\$89,465,121	\$793	\$1,161
SoonerPlan		33,631	2,724	30,907	-70	\$221,303	\$7	\$8
Insure Oklahoma		19,527	556	18,971	357	\$5,816,359		
	<i>Employer-Sponsored Insurance</i>	14,849	346	14,503	275	\$4,274,882	\$288	\$323
	<i>Individual Plan</i>	4,678	210	4,468	82	\$1,541,477	\$330	\$404
TOTAL		828,764	538,504	290,260	4,206	\$313,236,681		

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

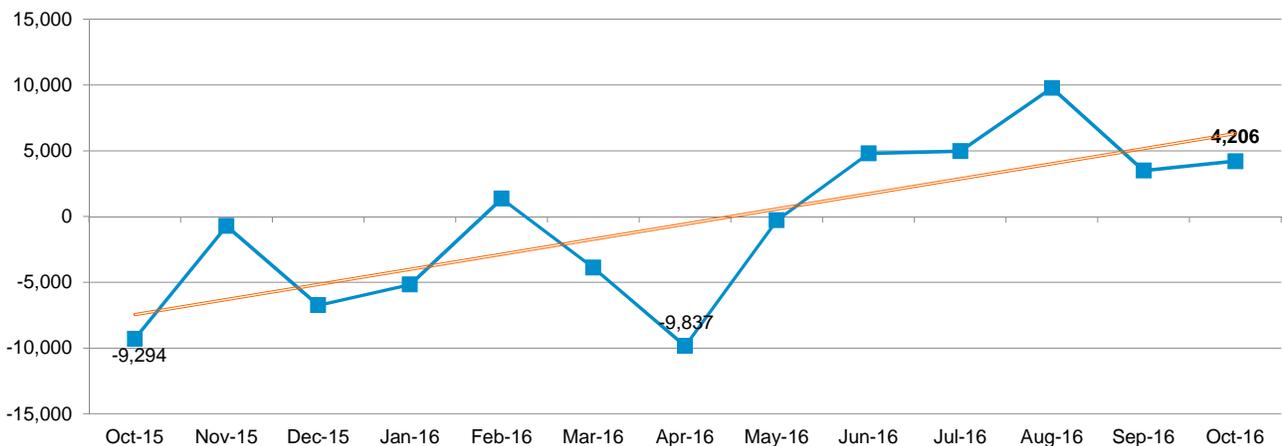
Total In-State Providers: 32,604 (-1,832)			(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)					
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
8,602	962	1,272	199	6,053	668	228	6,171	2,546

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

ENROLLMENT BY MONTH



MONTHLY CHANGE IN ENROLLMENT

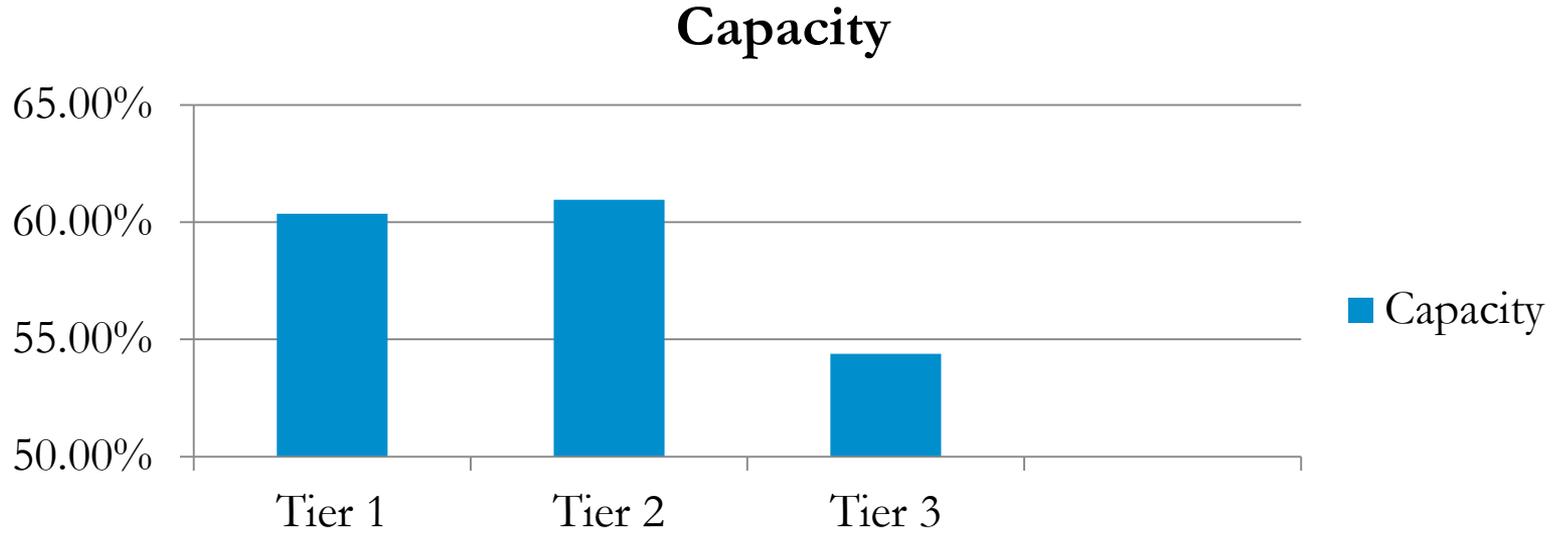


Includes Insure Oklahoma.

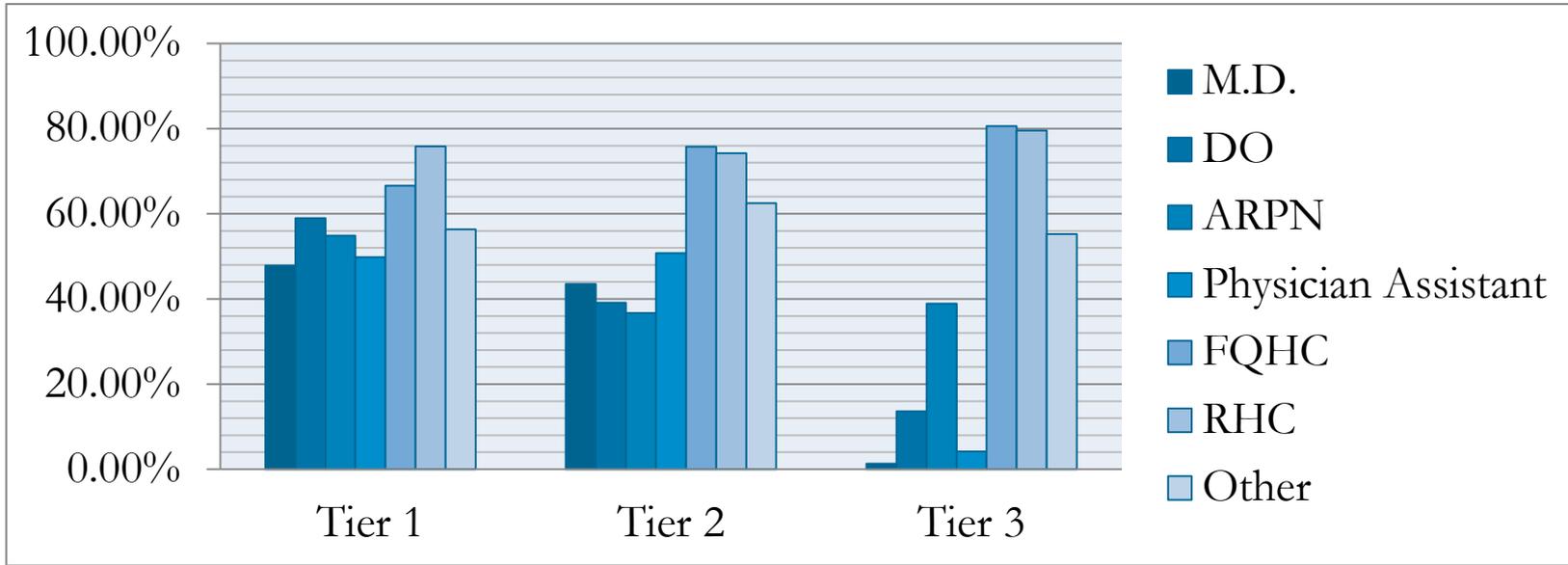
SoonerCare Choice Patient Centered Medical Home

OHCA Board Meeting
December 8, 2016
Melody Anthony, MS,
Deputy State Medicaid Director

Available Capacity by Tier



Capacity by Provider Type



Breakdown by Tier by Age

Kids Only	Adults Only	All Ages	2016 Totals	January 2009
Tier 1 - 167	Tier 1 - 9	Tier 1 - 303	Tier 1 - 479	Tier 1 - 445
Tier 2 - 102	Tier 2 - 6	Tier 2 - 117	Tier 2 - 225	Tier 2 - 223
Tier 3 - 95	Tier 3 - 7	Tier 3 - 86	Tier 3 - 188	Tier 3 - 31

Total Locations 892

Average panel size per location: 550

HAN Total Summary Report - October 2016

Provider Name	Initial Date	Total Membership	Total Number of Providers	Unduplicated Providers	PCMH Locations
Central Communities HAN	July 2011	3,808	30	27	6
OSU Center for Health Sciences	Sept 2011	20,583	189	132	10
OU HAN	July 2010	113,092	2,331	699	88
	Total	137,483	2550	858	104



THANK YOU!

Additional Information

Melody Anthony, MS

Deputy State Medicaid Director

405-522-7360



**SOONERCARE
HEALTH MANAGEMENT PROGRAM
AND
CHRONIC CARE UNIT**

Population Care Management

- Case Management Unit (CMU)
- Health Management Program (HMP)
- Chronic Care Unit (CCU)

HMP Overview

- Medicaid Reform Act of 2006 (HB2842)
- Health coaching
 - ▣ Registered nurses
 - ▣ SoonerCare Choice members with/at risk for chronic conditions
 - ▣ In 2013, transitioned from field-based and telephonic coaching to embedding coaches in select PCMH practices
- Practice facilitation and education for patient centered medical home providers
- Currently administered by Telligen, a national quality improvement and medical management firm

CCU Overview

- In 2013, legislature awarded 6 FTE to expand reach
- Telephonic nurse case management to high risk members not aligned with a practice with an embedded health coach
- Not limited to SoonerCare Choice members
- Special populations such as members with hemophilia, sickle cell, hepatitis C, bariatric surgery candidates, etc.
- Internal unit

Program Objectives

Address physical and behavioral health needs of chronically ill members

Improve member self-management skills

Reduce avoidable acute care services and costs

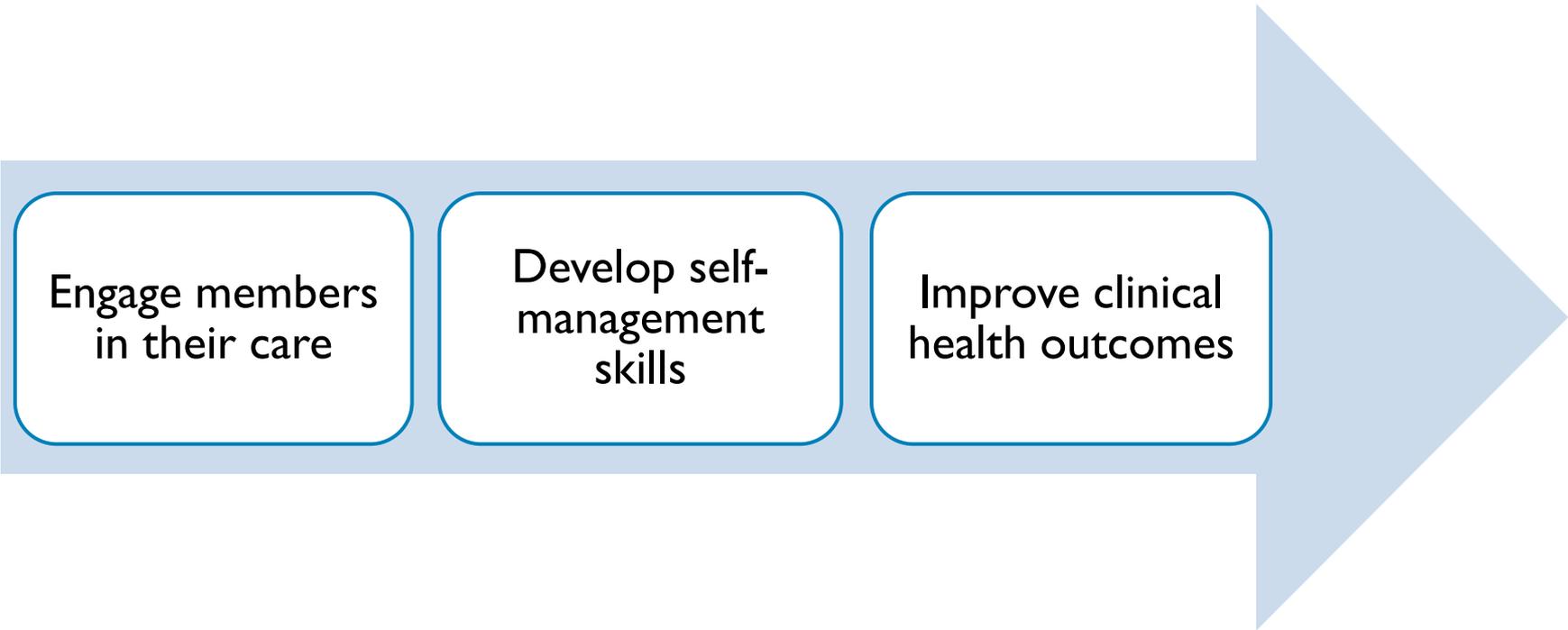
Improve provider management of patients with chronic conditions

Member Goals

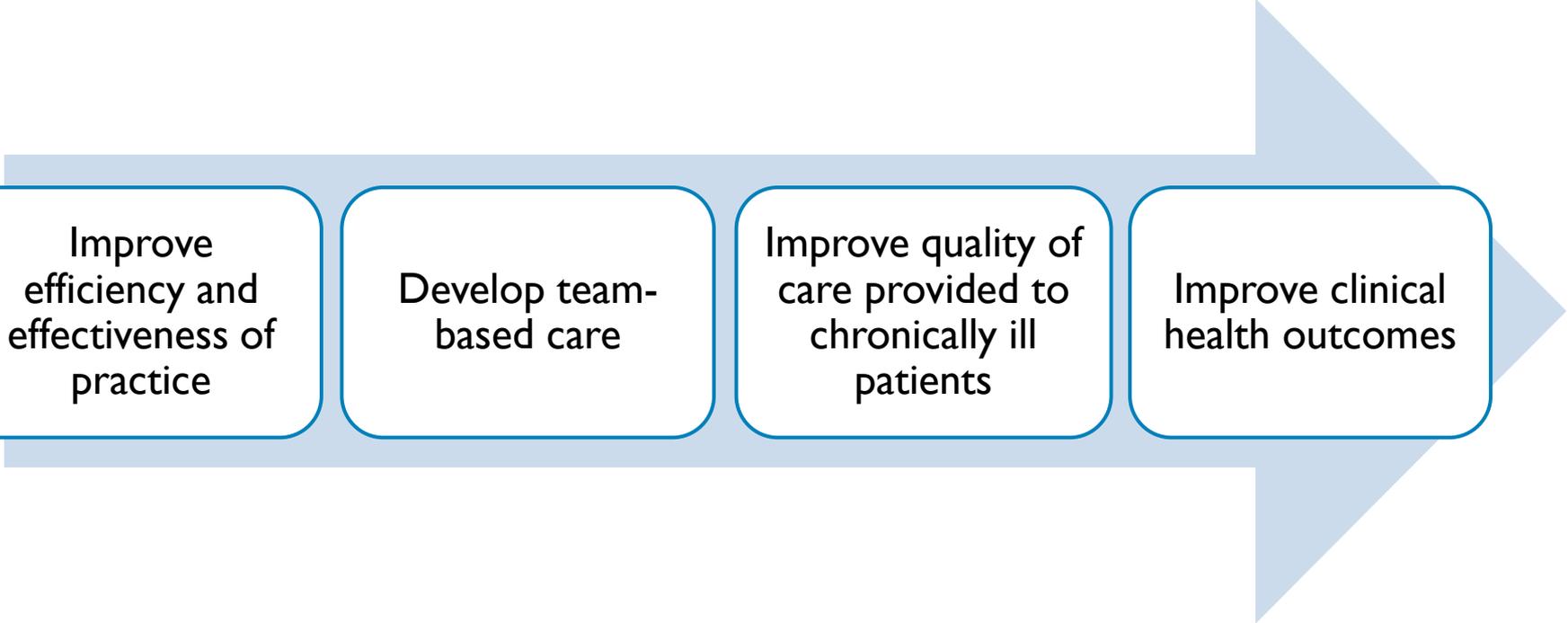
Engage members
in their care

Develop self-
management
skills

Improve clinical
health outcomes



HMP Practice Facilitation



Improve efficiency and effectiveness of practice

Develop team-based care

Improve quality of care provided to chronically ill patients

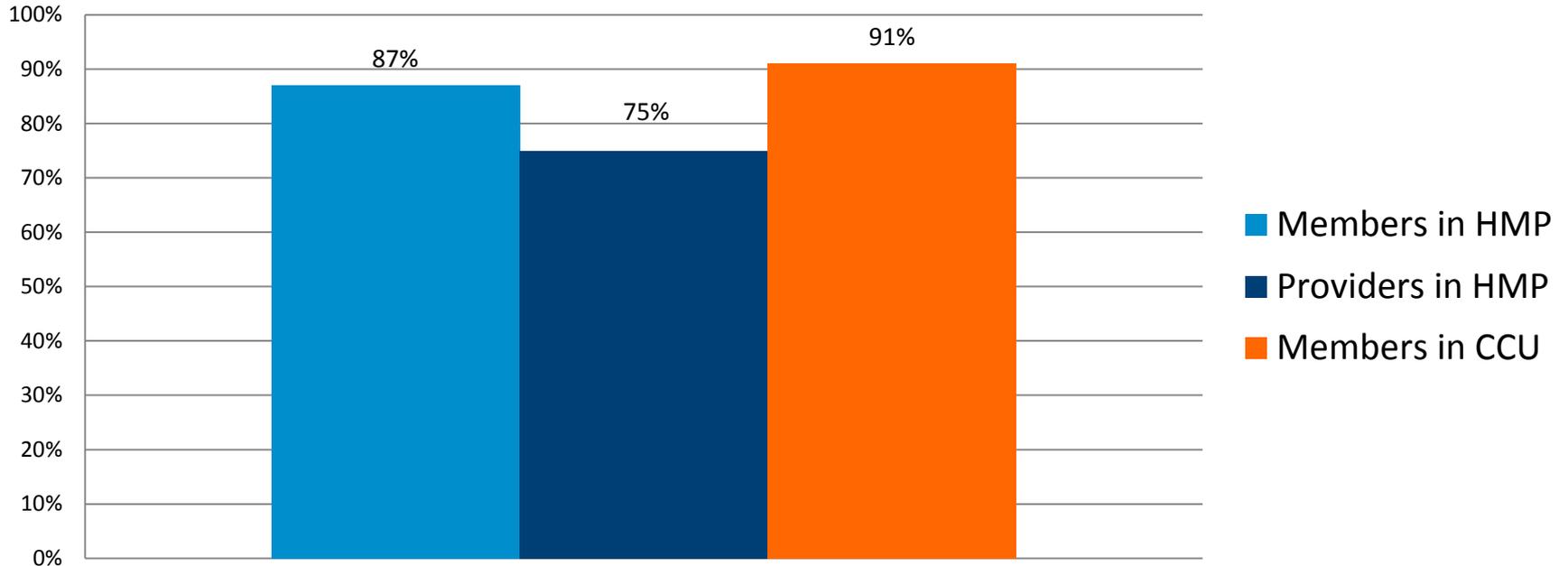
Improve clinical health outcomes

HMP/CCU Outcomes

- Annual external evaluation
- Pacific Health Policy Group (PHPG)
 - ▣ Satisfaction
 - ▣ Quality of care
 - ▣ Utilization
 - ▣ Cost-effectiveness

SFY2015 Satisfaction

"Very Satisfied" with HMP/CCU

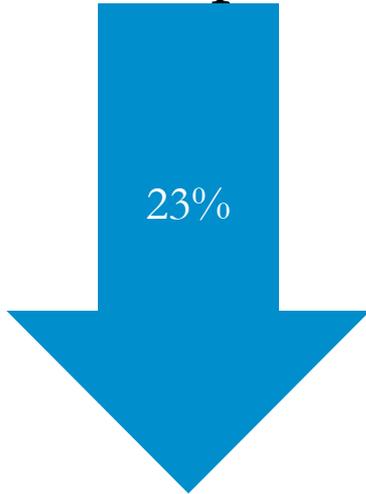


SFY2015 Quality of Care

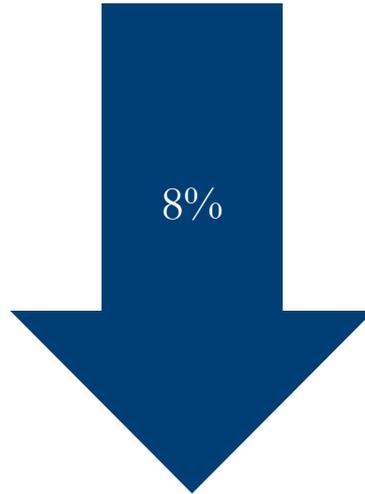
- Participants exceeded comparison group on 17 disease specific HEDIS measures
 - ▣ HMP health coached members – 12 measures
 - ▣ Members assigned to a PCMH with a practice facilitator – 8 measures
 - ▣ CCU members – 10 measures

ER Utilization

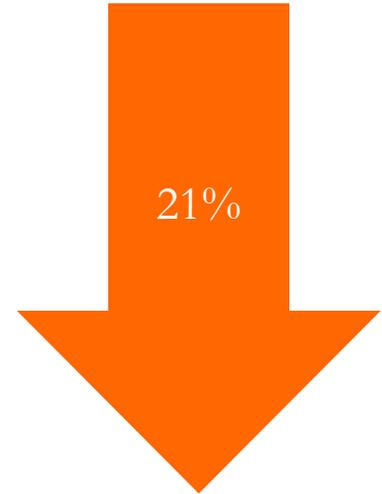
Health
Coaching
Participants



Members in
PCMH with PF

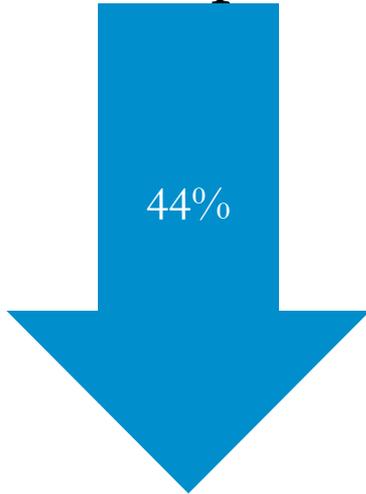


CCU
Participants

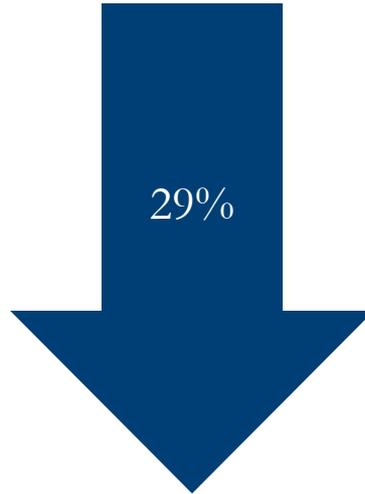


Inpatient Utilization

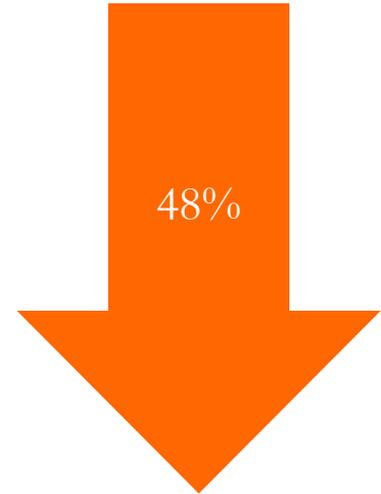
Health
Coaching
Participants



Members in
PCMH with PF



CCU
Participants



SFY2015 HMP Cost-effectiveness

Component	Medical Savings	Administrative Costs	Net Savings	Return on Investment
Health Coaching	\$22,861,281	(\$10,101,726)	\$12,759,555	126.3%
Practice Facilitation	\$34,893,323	(\$6,454,160)	\$28,439,163	440.6%
TOTAL	\$57,754,604	(\$16,555,886)	\$41,198,718	248.8%

SFY2015 CCU Cost-effectiveness

Medical Savings	Administrative Costs	Net Savings	Return on Investment
\$4,078,393	(\$1,380,489)	\$2,697,904	195.4%

Contact:

Della Gregg

HMP Manager

Oklahoma Health Care Authority

405-522-7435

Della.gregg@okhca.org

For more information and full report:

www.okhca.org/studies

www.okhca.org/PCM



**LEGISLATIVE UPDATE for the OHCA BOARD MEETING
DECEMBER 8, 2016**

2016 INTERIM STUDIES

OHCA has been tracking 33 House and Senate interim studies, as they relate to Medicaid, public health and state government operations. As of December 1st, OHCA participated and presented in two of those studies.

The first study was held on September 21, 2016. House Interim Study 16-039, requested by Representative Richard Morrisette, studied the spread of Zika in Oklahoma. In particular, the study looked at how vulnerable populations and those in poverty would be impacted. Becky Pasternik-Ikard represented OHCA before the House Public Health Committee and provided an overview of how the SoonerCare population could be impacted. The SoonerCare program currently covers 305,600 women of childbearing age (10-45); of those, approximately 64,000 are pregnant. The Center for Medicaid and CHIP Services (CMCS) issued a bulletin earlier this year informing states they are not required to cover mosquito repellent; however, if a state does offer the benefit, the 60% federal, 40% state matching rate would apply. Some states, such as Texas, Florida, Virginia, Georgia, began providing repellents via Medicaid dollars immediately following the CMS guidance over the summer. OHCA staff began internal discussions following the interim study on how our program can provide the benefit to women of childbearing age in 2017.

The second interim study the agency participated in, House Interim Study 16-054 “*Addressing the Uninsured*,” was requested by Representative Glen Mulready and held on October 11, 2016. Director Pasternik-Ikard represented OHCA before the House Appropriations & Budget Health Subcommittee, and provided members of the committee with an overview of the basic principles of the Medicaid Rebalancing Act as it was presented during the 2016 legislative session. In addition to the Medicaid Rebalancing Act, Becky summarized other states’ alternatives programs to traditional Medicaid expansion, specifically looking at what Arkansas, Indiana, Kentucky and Tennessee are developing.

56th LEGISLATURE

Following the November 2016 general election, the Senate and House will have several new members amongst their ranks. The 56th Legislature will be largely controlled by the Republican Party; the Senate includes 42 Republicans and 6 Democrats, and the House has 75 Republicans and 26 Democrats.

Also confirmed in November were the leaders for the Senate and House. President Pro Tempore Mike Schulz (R-Altus) and Speaker Charles McCall (R-Atoka) were both elected by their colleagues to lead their respective chambers.

Other leadership positions announced in the Senate include Senator Greg Treat (R-Oklahoma City) as Senate Floor Leader and Senator Kim David (R-Porter) as Senate Appropriations Chairwoman. House leadership positions have not been announced at this time.

UPCOMING DEADLINES FOR THE 2017 LEGISLATIVE SESSION

Thursday, January 19, 2017: Deadline for introduction of bills and joint resolutions in the Senate and House for consideration during the 2017 session

Monday, February 6, 2017: 2nd Session of the 56th Oklahoma Legislature convenes at noon



**TRIBAL GOVERNMENT RELATIONS UPDATE for OHCA BOARD MEETING
DECEMBER 8, 2016**

SoonerCare Tribal Consultation 10th Annual Meeting – October 19, 2016

The OHCA Tribal Government Relations team (along with staff from Provider Services and Office of Health Promotion) planned and facilitated the agency’s tribal consultation 10th annual meeting on October 19, 2016, in Catoosa. Elected tribal leaders of all 39 tribes in the state, Indian Health Service OKC Area Office leadership, and key tribal health care partners were invited to attend the meeting. The purpose of the tribal consultation annual meeting is for OHCA leadership to listen and learn about how to better partner with tribes in an effort to better serve tribal SoonerCare members and communities. The roundtable format of the meeting encourages open discussion and sharing of best practices among OHCA and tribal leaders from throughout the state.

The meeting began with a breakfast that was sponsored by the Southern Plains Tribal Health Board (SPTHB), and was followed by welcoming remarks from OHCA Board Chairman Ed McFall, OHCA Deputy Chief Officer Garth Splinter, and SPTHB Executive Director Jenifer LittleSun. After individual introductions by the attendees, OHCA Tribal Government Relations Director Dana Miller presented the SFY 2016 Tribal Government Relations Annual Report and Consultation Summary. In recognition of the 10th anniversary, a poster (included in your packet) highlighted the collaborative accomplishments between OHCA and tribal partners over the past decade.

Total attendance for the meeting was 78; including 57 tribal leaders and their designees representing 17 tribes. OHCA Board Chairman Ed McFall and Member Ann Bryant along with 19 OHCA staff were also in attendance.

The roundtable discussion highlighted several topics including virtual visits, mental health and substance abuse, recognition of specific tribal health care providers, pharmacy reimbursement, preventive care, elder care, and concern about potential state budget reductions. Information that was learned at the meeting will be used to develop an action plan during the OHCA Tribal Partnership Planning Session on February 22, 2017. The action plan is a joint effort between OHCA and tribal partners to address common goals and produce positive results for the upcoming year.

Tribes and key stakeholders represented

- | | |
|---|--|
| Absentee Shawnee Tribe of Oklahoma | Sac & Fox Nation of Oklahoma |
| Cherokee Nation of Oklahoma | Seminole Nation of Oklahoma |
| Cheyenne and Arapaho Tribes of Oklahoma | United Keetoowah Band of Cherokee Indians |
| Chickasaw Nation of Oklahoma | Wichita and Affiliated Tribes |
| Choctaw Nation of Oklahoma | Indian Health Service |
| Citizen Potawatomi Nation | Oklahoma City Indian Clinic |
| Iowa Tribe of Oklahoma | Indian Health Care Resource Center of Tulsa |
| Kaw Nation of Oklahoma | Southern Plains Tribal Health Board |
| Muscogee (Creek) Nation of Oklahoma | Northeastern Tribal Health System |
| Osage Nation | Oklahoma Health Care Authority |
| Otoe-Missouria Tribe | Office of the Secretary of Native American Affairs |
| Pawnee Nation | |
| Ponca Nation | |

Did you know in the past 10 years, OHCA & Tribal partners, Indian Health Service, and Urban Indian health programs have accomplished:

- ◆ 1st state agency in Oklahoma to have a **formal tribal consultation policy**
- ◆ 1st state in the nation to promulgate policy to allow out-of-state **children residing at Indian boarding schools eligibility for Medicaid**
- ◆ 1st tribal **Program for the All-Inclusive Care of the Elderly (PACE)** in the nation; first PACE in Oklahoma (Cherokee Nation)
- ◆ **Indian health care specific provider contracts**; recognize sovereignty and federal relationship
- ◆ 1st tribal pay-for-product plan in the nation: **Tribal Medicaid Administrative Match (TMAM)**
- ◆ Grant initiatives to address Elder Care (**Tribal Money Follows the Person**) and Prenatal care (**Strong Start-Choctaw Nation and Oklahoma City Indian Clinic**)
- ◆ **SoonerCare online enrollment ITU partnerships**; secure access to eligibility process
- ◆ **Consultation best practices** that are used as a model for other state Medicaid programs and various Oklahoma state agencies
- ◆ **Riverside Dental Event**; collaboration to ensure 500+ children at Riverside Indian School receive annual dental evaluations, education on oral health, and dental tools
- ◆ **SoonerRide tribal addendum** for non-emergency transportation

OHCA is committed to continuing and strengthening effective partnerships with Tribal governments, Indian Health Service, Urban Indian health programs, Southern Plains Tribal Health Board, and tribal community stakeholders.

Together we have proven that collaboration plus meaningful communication equals positive results for all Oklahomans. We look forward to the next 10 years and the countless accomplishments to come!



PAIN MANAGEMENT AND OPIOID USE UPDATE



ABUSE AND DIVERSION – BY THE NUMBERS

- Prescription drug abuse is a national epidemic
- From 2000 to 2014, nearly half a million people died from drug overdoses
- 78 people die every day in the U.S. from opioid-related overdose.*
- 28,647 opioid and heroin deaths 2014*

*Overdose deaths in the United States hit record numbers in 2014 available at: www.cdc.gov/drugoverdose/epidemic/public.html. Accessed May 3, 2016.
Fact sheet available at: <https://www.hhs.gov/sites/default/files/Factsheet-opioids-061516.pdf>. Accessed August 10, 2016.

259M



**259M
prescriptions**

18B



**18 billion
opioid pills**

75



**Enough pills
to give every
American 18
years or older
75 opioid pills
in 2012**

PRESCRIPTION DRUG OVERDOSE IN OKLAHOMA

- 15.8 per 100,000 people unintentional poisoning deaths
- 5th leading cause of death in Oklahoma
 - unintentional injury
 - 2014 State of the State's Health
- 6th highest drug overdose in U.S.

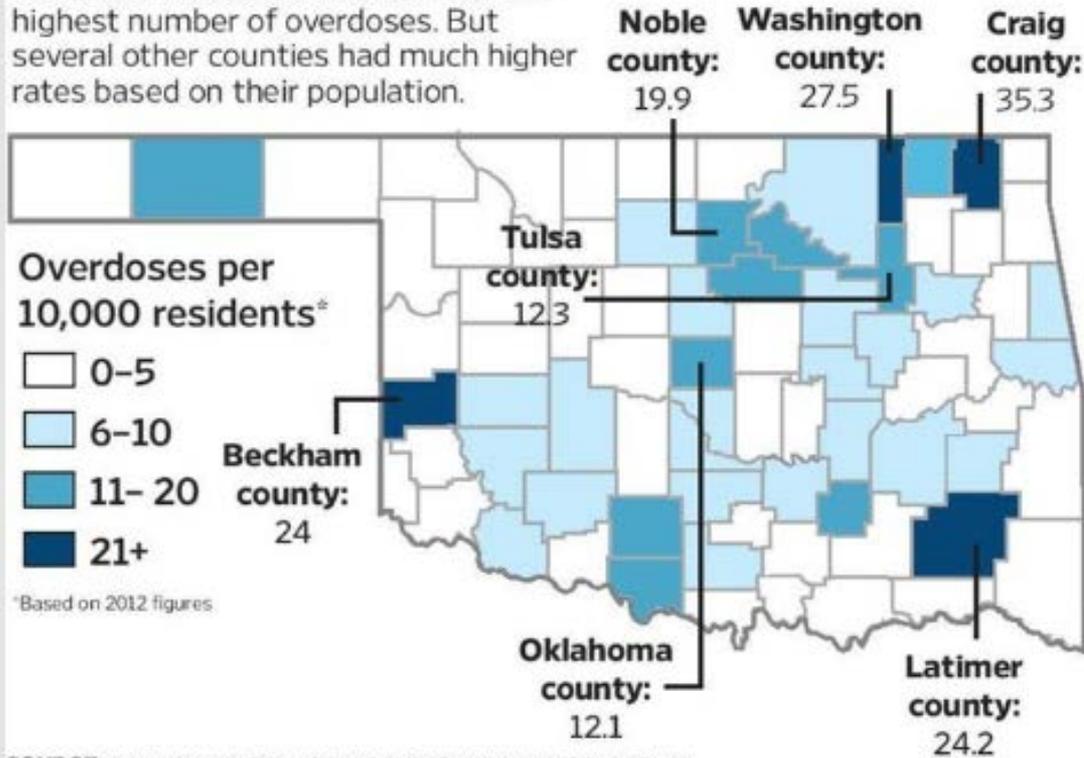
Sources: <https://www.ok.gov/health/pub/boh/state/SOSH%202014.pdf>
<http://www.cdc.gov/vitalsigns/pdf/2014-07-vitalsigns.pdf>. Accessed September 2, 2016.

“PROFITING FROM PAIN”

From The Oklahoman, Dec. 7, 2014

Oklahoma overdoses

Tulsa and Oklahoma counties had the highest number of overdoses. But several other counties had much higher rates based on their population.

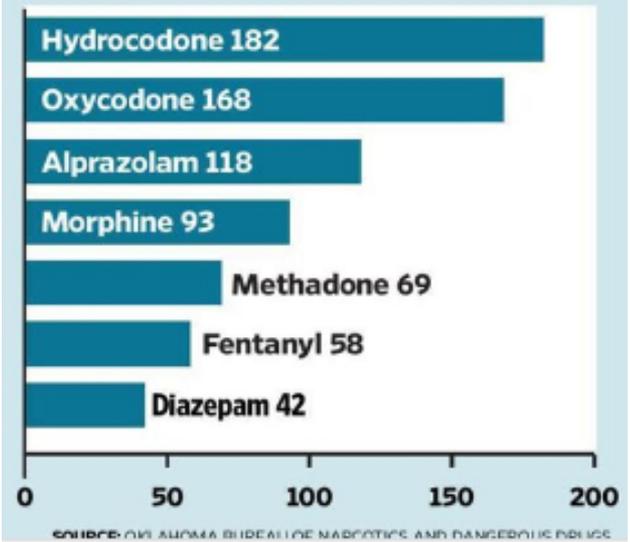


SOURCE: OKLAHOMA BUREAU OF NARCOTICS AND DANGEROUS DRUGS

Source: <http://oklahomawatch.org/series/addicted-oklahoma/> and <http://oklahomawatch.org/2014/12/07/overdoses-in-oklahoma/>. Accessed September 2, 2016.

KILLER PRESCRIPTIONS

Drug overdoses claimed the lives of more than 800 Oklahomans in 2013. Most of the deaths were caused by one or more prescription medications. This chart depicts the number of deaths in which each of the listed drugs was involved. Hydrocodone, oxycodone, morphine, methadone and fentanyl are opiate painkillers. Alprazolam and diazepam are anti-anxiety medicines.



PAIN MANAGEMENT AND OPIOID USE INITIATIVES

Pain Management Program

- Toolkit
- Practice Facilitation
- Substance Use Disorder Treatment coverage
- Referral Assistance for SUD treatment

State Plan Workgroup Involvement

- Provider Education
- Prescriber Guidelines

OHCA Pharmacy Activities

- Quantity Limits
- Naloxone
- Lock-in - Patient Restriction Program

OHCA INITIATIVES

- Management Program Update
- Substance Use Disorder Treatment Coverage
- State Plan Workgroup Involvement
- Collaboration with other state agencies
 - State Plan - Reducing Rx Drug Abuse
 - Updated Oklahoma Prescribing Guidelines
 - Increase access to naloxone

PAIN MANAGEMENT PROGRAM

- Provider Toolkit
- Practice Facilitation
- Referral Assistance for Substance Use Disorder (SUD) Treatment
- State Plan – Reducing Prescription Drug Abuse in Oklahoma
- Pain Management Toolkit available at:
<http://www.okhca.org/providers.aspx?id=18411>

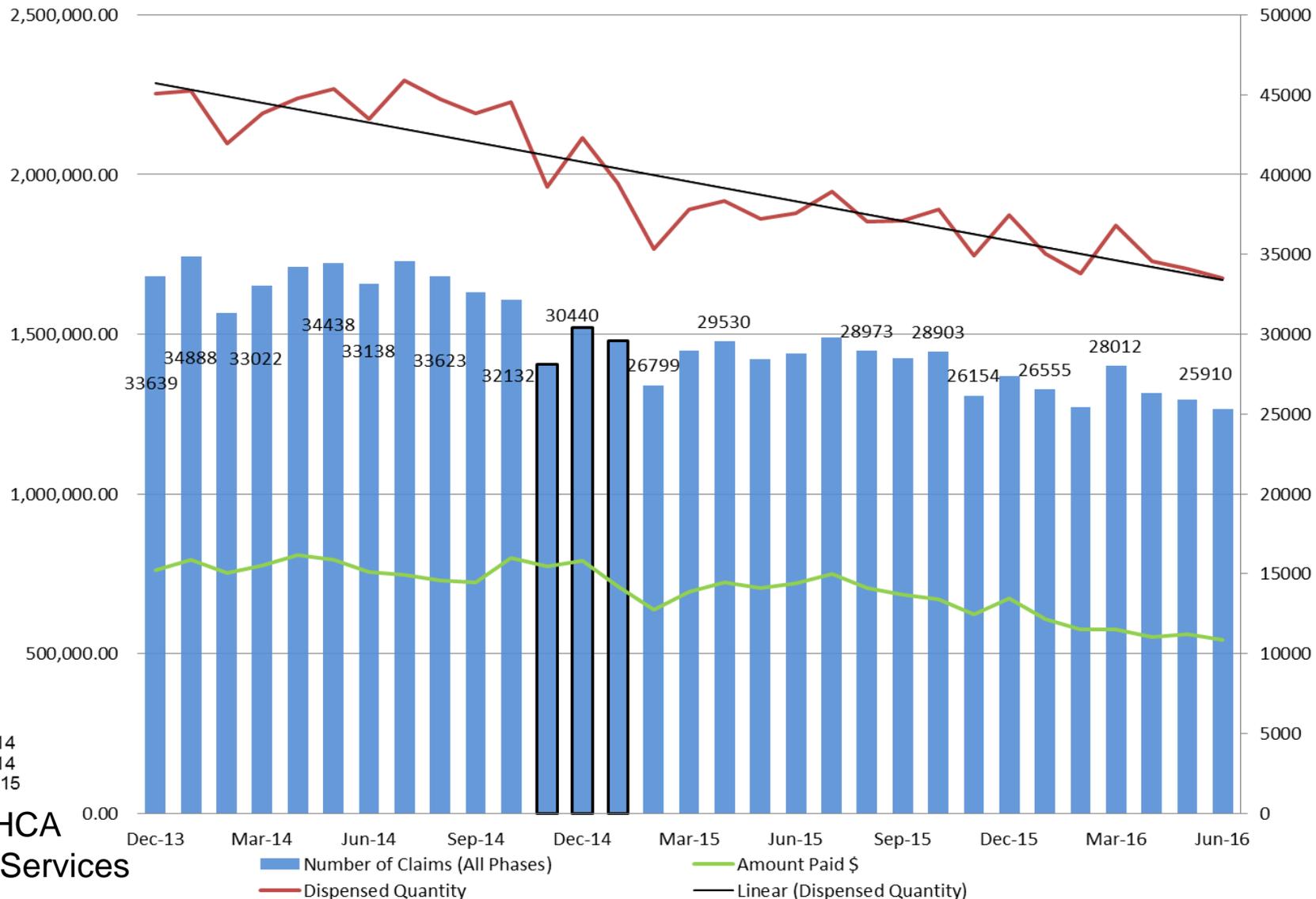
PHARMACY INITIATIVES

UTILIZATION CONTROL TOOLS - OPIOIDS

- Quantity limits
 - No more than 4 per day – Jan 2015
- Early refill limit
 - 90 % of the medication must be used before refill
- Cumulative early refill limits
- Tiered structure for receiving long-acting opioid
- Duplication edits for short-acting and long-acting opioids
- DUR - concomitant use of opioid and benzodiazepines
- Methadone restrictions – January 2017

Quantity Limit Edit - Short-Acting Opioids All Phase* **SUMMARY** December 2013 thru June 2016

Number of Claims, Amount Paid, Quantity Dispensed



Hydrocodone
CII 10/06/2014

***QLE Phase Dates**
Phase 1: 11/10/2014
Phase 2: 12/08/2014
Phase 3: 01/21/2015

Source: OHCA
Pharmacy Services

■ Number of Claims (All Phases)
 — Amount Paid \$
— Dispensed Quantity
 — Linear (Dispensed Quantity)

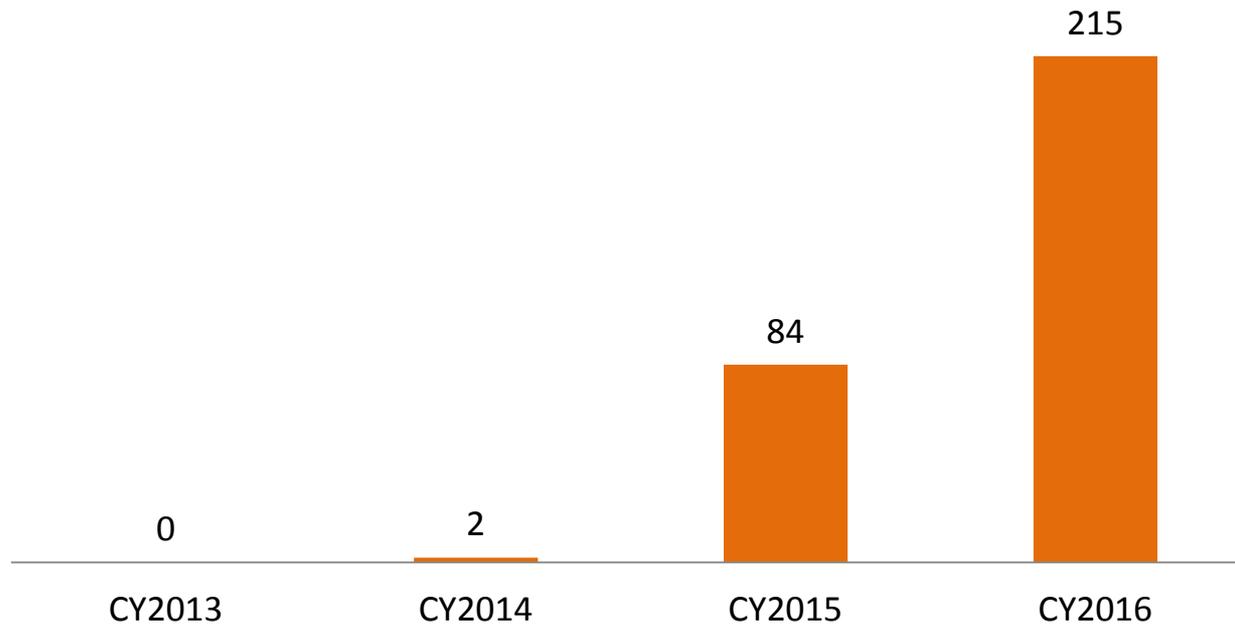
NALOXONE



NALOXONE (CONT.)

- 2014 Okla. legislation passed that allows naloxone to be purchased at pharmacies
 - Collaborative practice agreement
- Oklahoma Department of Mental Health and Substance Abuse Services (ODMHASAS) is working to expand use of naloxone throughout the state
- Opioid Education Naloxone Distribution
 - OHCA partnership HSI CHIP grant

OHCA NALOXONE CLAIMS CY 2013 – CY 2016



Source: OHCA Pharmacy Services. Data valid as of October 31, 2016.

PHARMACY LOCK-IN

Patient review and restriction program



PHARMACY LOCK-IN PROGRAM

SoonerCare Pharmacy-administered program

“Locks” a member into one pharmacy AND
one prescriber

- Pharmacy claims will deny if not from designated providers
- Various medications monitored

Referral by health care providers

- Anonymous
- FAX/Call SoonerCare Pharmacy Helpdesk

PHARMACY INITIATIVES - 2017

- Preventive measures to intervene
 - Pre-lock in
- BH outreach *current* in lock-in members
- Enhance communication
 - Prescribers – flyers, letters, electronic
 - Members – text, social media
- Morphine Milligram Equivalent (MME)
- Mortality Data Review for intervention(s)

SUMMARY – QUESTIONS/COMMENTS

- Continued provider education and outreach
- Participation in local and national work groups
- Internal monitoring of activities
- Continued vigilance and process improvement

Member Advisory Task Force (MATF)

Board Meeting
December 8, 2016



THE HISTORY OF MATF

2007:

OHCA leadership, along with partners, determined need for a state conference.

2008:

OHCA leadership attended the Joining Forces Conference.

2009:

Developed a strategy for gaining support within OHCA structure for family/professional partnership

2011:

First MATF Orientation

2010:

Established contractor to run MATF and created an internal steering committee

WHO IS THE MATF?

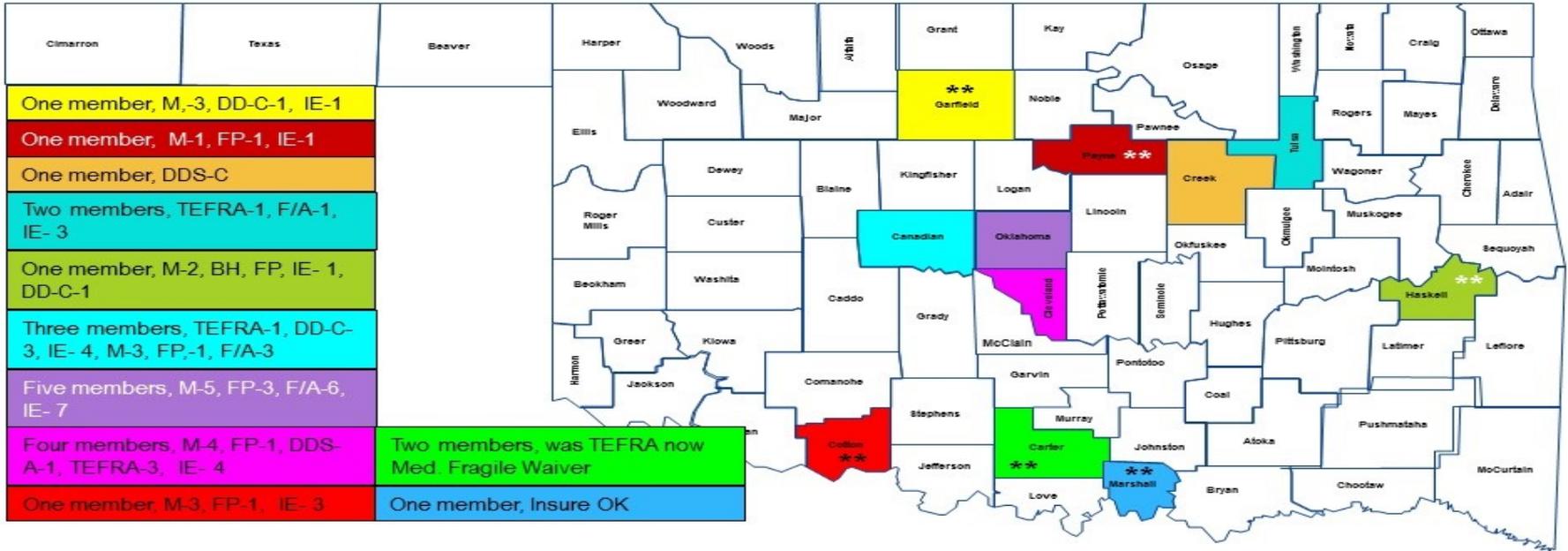


Member Advisory Task Force
Member Mapping

Key:

DD-C-Child with Dis. And IE
 DDS-A-Dev. Dis. Serv. Waiver Adult
 DDS-C-Dev. Dis. Serv. Waiver Child
 BH-Behavioral Health Adult
 F-Family Planning

Foster or CW Adoption-F/A
 IE-Income Eligibility Child
 M-Maternity Benefit
 T-TEFRA Eligibility
 ** Rural



The Member Advisory Task Force is a project of the Oklahoma Health Care Authority in partnership with the Oklahoma Family Network, Oklahoma's Family-to-Family Health Information Center. Co-chairs Hillary Burkholder and Wanda Felty.



PURPOSE

- Consumer (member) engagement
- Two-way dialogue
- Inform agency policy and programmatic decision making
- Members and families feel connected and included in agency decisions

SUCCESES

- SoonerRide
- Communication
 - Member Handbook
 - Brochures
 - MySoonerCare stories
- Strategic Planning conference
- Policy Input
- APP and MATF joint meetings

QUOTES

“The best product is the product that is designed, developed, implemented and evaluated in a partnership with the user of the product. This is best practices and that is what the Member Advisory Task Force is for the Oklahoma Health Care Authority. The MATF's process of including members, staff and administrators of the SoonerCare program in a partnership to improve communication, program and access, has made a huge impact to those accessing SoonerCare. Because of the relationship built at the MATF, the decision makers have made changes to assure quality and access from assure those needing acute care can access transportation to the clinic, to streamlining the application process for children who have significant disabilities or chronic medical conditions to assure those children have access to quality health care.”

“For the first time, I feel as a mother, I have a voice that is heard regarding my kids' health care coverage since becoming a MATF member.”

“MATF is a group of people whose sole purpose it to work with the OK Health Care Authority in order to make SoonerCare even better.”

RECOGNITION

- Montana is interested in pursuing a similar group
- Presentations including: Learning Collaborative on Improving Quality and Access to Care in Maternal and Child Health, multiple AMCHP presentations, Family Voices webinar, National Family Voices Conference, 11 regional institutes in Oklahoma where we were promoting family/professional partnerships beginning in 2012, etc.
- 2015 Partnership Award from the Oklahoma UCEDD-LEND Consumer Advisory Committee

LOOKING FORWARD



CONTACT INFORMATION

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PHARMACY REIMBURSEMENT

1. IS THIS A RATE CHANGE OR A METHOD CHANGE?

Rate and Method Change

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

No Impact

3. PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?

CMS has published a regulation for pharmacy pricing. OHCA needs to take several actions to comply. The first is to align payment for covered outpatient drugs with the Actual Acquisition Cost (AAC) and create a new pricing term for specialty pharmaceutical products. The second is to modify the current dispensing fee to a professional dispensing fee which is added to the pharmacy claims paid at NON-I/T/U pharmacies. The third is to separate I/T/U claims and pay them at the federal OMB encounter rate.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

All pharmacy claims whether from an I/T/U facility or not are currently paid as a dispensing fee of \$3.60 plus the lowest of Average Wholesale Price (AWP) – 12%, Wholesale Acquisition Cost (WAC) + 5.6%, State Maximum Allowable Cost (SMAC), or if lower than the sum of the above, the Usual & Customary (U&C) price to the general public.

5. NEW METHODOLOGY OR RATE STRUCTURE.

A – New ingredient cost methodology – instead of the current Estimated Acquisition Cost (EAC) which is set using the lower of Average Wholesale Price minus 12% or Wholesale Acquisition Cost + 5.6%, OHCA will set the ingredient cost at the Actual Acquisition Cost. This will be set using the National Average Drug Acquisition Cost (NADAC) supplied by CMS. When NADAC is not available, AAC will be set as WAC for brand name drugs and as the lower of State Maximum Allowable Cost (SMAC) or WAC for generic drugs. Specialty drugs not typically dispensed by retail community pharmacies will be reimbursed using a new pricing term, Specialty Pharmaceutical Allowable Cost (SPAC). SPAC will be set using the Medicare Part B price, WAC, and NADAC when available.

B – Professional Dispensing Fee – OHCA will set the Professional Dispensing Fee at \$10.55 per prescription. This rate is derived from the Oklahoma specific data from a national

STATE PLAN AMENDMENT RATE COMMITTEE

survey of the cost of dispensing. The rate has been inflated from 2013 data to reflect the 2016 value.

C – Indian Health Service/Tribal/Urban Indian Clinic (I/T/U) Pharmacy Providers –I/T/U pharmacies will be reimbursed at the OMB encounter rate which is set annually. The pharmacies will receive one fee per member per facility per day regardless of how many prescriptions are dispensed to the individual on that day.

6. BUDGET ESTIMATE.

The new pricing rule is expected to remain budget neutral, if not provide a small savings. Pharmacy claims for generic drugs will generally increase due to the increased dispensing fee and claims for brand drugs will generally decrease due to the decreased ingredient cost. This offset creates a neutral budget effect. The chart below shows examples:

Drug	Quantity	Current	Proposed	Difference
Cetirizine	30	\$6.62	\$12.25	\$5.63
Amoxicillin	30	\$8.13	\$12.93	\$4.80
ProAir Inhaler	1	\$59.58	\$61.78	\$2.20
Vyvanse	30	\$265.79	\$251.64	-\$14.15

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The OHCA does not anticipate any impact on access to care. The OHCA has taken appropriate measures and communicated with different stakeholder groups.

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 changes in pharmacy reimbursement, specifically the change from Estimated Acquisition Cost to Actual Acquisition Cost, to add the pricing term Specialty Pharmaceutical Allowable Cost, to set the Professional Dispensing Fee at \$10.55, and to set the rate for I/T/U pharmacy claims at the OMB encounter rate.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2017

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72.1. Drug benefit

OHCA administers and maintains an Open Formulary subject to the provisions of Title 42, United States Code (U.S.C.), Section 1396r-8. The OHCA covers a drug that has been approved by the Food and Drug Administration (FDA) and whose manufacturers have entered into a drug rebate agreement with the Centers for Medicare and Medicaid Services (CMS), subject to the following exclusions and limitations.

(1) The following drugs, classes of drugs, or their medical uses are excluded from coverage:

- (A) Agents used to promote fertility.
- (B) Agents primarily used to promote hair growth.
- (C) Agents used for cosmetic purposes.
- (D) Agents used primarily for the treatment of anorexia or weight gain. Drugs used primarily for the treatment of obesity, such as appetite suppressants are not covered. Drugs used primarily to increase weight are not covered unless otherwise specified.
- (E) Agents that are investigational, experimental or whose side effects make usage controversial.
- (F) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or designee.
- (G) Agents when used for the treatment of sexual or erectile dysfunction, unless such agents are used to treat a condition, other than sexual or erectile dysfunction, for which the agents have been approved by the Food and Drug Administration.

(2) The drug categories listed in (A) through ~~(E)~~(D) of this paragraph are covered at the option of the state and are subject to restrictions and limitations. An updated list of products in each of these drug categories is included on the OHCA's public website.

(A) Agents used for the systematic relief of cough and colds. Antihistamines for allergies or antihistamine use associated with asthmatic conditions may be covered when medically necessary and prior authorized.

(B) Vitamins and Minerals. Vitamins and minerals are not covered except under the following conditions:

- (i) prenatal vitamins are covered for pregnant women up to age 50;
- (ii) fluoride preparations are covered for persons under 16 years of age or pregnant;
- (iii) vitamin D, metabolites, and analogs when used to treat end stage renal disease are covered;
- (iv) iron supplements may be covered for pregnant women if determined to be medically necessary;
- (v) vitamin preparations may be covered for children less than 21 years of age when medically necessary and furnished pursuant to EPSDT protocol; and
- (vi) some vitamins are covered for a specific diagnosis when the FDA has approved the use of that vitamin for a specific indication.

~~(C) Agents used for smoking cessation. A limited smoking cessation benefit is available.~~

~~(D)~~(C) Coverage of non-prescription or over the counter drugs is limited to:

- (i) Insulin, PKU formula and amino acid bars, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions;
- (ii) certain smoking cessation products;
- (iii) family planning products;
- (iv) OTC products may be covered if the particular product is both cost-effective and clinically appropriate; and
- (v) prescription and non-prescription products which do not meet the definition of outpatient covered drugs, but are determined to be medically necessary.

~~(E)~~(D) Coverage of food supplements is limited to PKU formula and amino acid bars for members diagnosed with PKU, other certain nutritional formulas and bars for children diagnosed with certain rare metabolic conditions when medically necessary and prior authorized.

(3) All covered outpatient drugs are subject to prior authorization as provided in OAC 317-30-5-77.2 and 317:30-5-77.3.

(4) All covered drugs may be excluded or coverage limited if:

- (A) the prescribed use is not for a medically accepted indication as provided under 42 U.S.C. § 1396r-8; or
- (B) the drug is subject to such restriction pursuant to the rebate agreement between the manufacturer and CMS.

317:30-5-78. Reimbursement

~~(a) **Reimbursement.** Reimbursement for pharmacy claims is based on the sum of an estimate of the ingredient cost, plus a dispensing fee.~~

~~(b) **Ingredient Cost.** Ingredient cost is estimated by one of the following methods:~~

~~(1) **Maximum Allowable Cost.**~~

~~(A) The State Maximum Allowable Cost (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing invoices that reflect a net cost higher than the calculated SMAC price and by certifying that there is not another product available to them which is generically equivalent to the higher priced product.~~

~~(B) The Federal Upper Limit (FUL) is established by CMS in accordance with applicable federal laws and regulations.~~

~~(C) Injectable drugs which are dispensed by a retail pharmacy through the Vendor Drug Program shall be priced based on a formula equivalent to the Medicare allowed charge whether they are furnished through the pharmacy program or through the medical program.~~

~~(2) **The Estimated Acquisition Cost.** The Estimated Acquisition Cost (EAC) means the agency's best estimate of the price generally and currently paid by providers for a drug marketed or sold by a particular manufacturer or labeler. EAC is typically based on a benchmark published price plus or minus a percentage. The current benchmark price is the Average Wholesale Price (AWP) as provided by the OHCA's pricing resource. EAC is calculated as AWP minus 12%. The Wholesale Acquisition Cost (WAC) means the price paid by the wholesaler for drugs purchased from the wholesaler's supplier, typically the manufacturer of the drug. Should the AWP no longer be published by the agency's pricing vendor then the agency will use WAC as the benchmark price whereas the EAC will be calculated as WAC + 5.6%.~~

~~(a) **Reimbursement.** Reimbursement for pharmacy claims is based on the sum of the ingredient cost plus a professional dispensing fee for brand and generic drugs dispensed by a retail community pharmacy or for a member residing in a long term care facility.~~

~~(b) **Ingredient Cost.** Ingredient cost is determined by one of the following methods:~~

~~(1) **Maximum Allowable Cost.** The State Maximum Allowable Cost (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing information from their wholesaler(s)~~

to certify a net cost higher than the calculated SMAC price and that there is not another product available to them which is generically equivalent to the higher priced product.

(2) **Actual Acquisition Cost.** The Actual Acquisition Cost (AAC) means the cost of a particular drug product to the pharmacy based on a review of invoices or the Wholesale Acquisition Cost (WAC), whichever is lower. The National Average Drug Acquisition Cost (NADAC) is based on a review of invoices and published by Centers for Medicare and Medicaid Services (CMS) and will be used in the determination of AAC.

(3) **Specialty Pharmaceutical Allowable Cost.** Reimbursement for specialty drugs not typically dispensed by a retail community pharmacy and dispensed primarily by delivery, including clotting factor for hemophilia, shall be set as a Specialty Pharmaceutical Allowable Cost (SPAC). The Medicare Part B allowed charge, defined as Average Sales Price (ASP) plus 6%, WAC, and NADAC when available, will be considered in setting the SPAC rate. For the purpose of this section, a drug may be classified as a specialty drug when it has one or more of the following characteristics:

(A) Covered by Medicare Part B;

(B) "5i drug" - Injected, infused, instilled, inhaled, or implanted;

(C) Cost greater than \$1,000.00 per claim;

(D) Licensed by the FDA under a Biological License Application;

(E) Special storage, shipping, or handling requirements;

(F) Available only through a limited distribution network; and/or

(G) Does not have a NADAC price from CMS.

(4) **Exceptions.**

(A) Physician administered drugs shall be priced based on a formula equivalent to the Medicare Part B allowed charge, defined as ASP plus 6%. If a price equivalent to the Medicare Part B allowed charge cannot be determined, a purchase invoice may be supplied by the provider and will be considered in setting the reimbursement.

(B) I/T/U pharmacies shall be reimbursed at the OMB encounter rate as a per member per facility per day fee regardless of the number of prescriptions filled on that day. I/T/U pharmacies should not split prescriptions into quantities less than a one month supply for maintenance medications. For this purpose a maintenance medication is one that the member uses consistently month to month.

(C) Pharmacies other than I/T/U facilities that acquire drugs via the Federal Supply Schedule (FSS) or at nominal price outside the 340B program or FSS shall notify OHCA

and submit claims at their actual invoice price plus a professional dispensing fee.

(c) ~~Maximum allowable Professional dispensing fee.~~ The maximum allowable professional dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the State Plan Amendment Rate Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products. Failure to participate may result in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.

(d) **Reimbursement for prescription claims.** Prescription claims will be reimbursed using the lower of the following calculation methods:

~~(1) the lower of estimated acquisition cost, Federal Upper Limit (FUL), or State Maximum Allowable Cost (SMAC) plus a dispensing fee, or~~

(1) the lower of Actual Acquisition Cost (AAC), State Maximum Allowable Cost (SMAC), or Specialty Pharmaceutical Allowable Cost (SPAC) plus a professional dispensing fee, or

(2) usual and customary charge to the general public. The pharmacy is responsible to determine its usual and customary charge to the general public and submit it to OHCA on each pharmacy claim. The OHCA may conduct periodic reviews within its audit guidelines to verify the pharmacy's usual and customary charge to the general public and the pharmacy agrees to make available to the OHCA's reviewers prescription and pricing records deemed necessary by the reviewers. The OHCA defines general public as the patient group accounting for the largest number of non-SoonerCare prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers. If a pharmacy offers discount prices to a portion of its customers (i.e. -10% discount to senior citizens), these lower prices would be excluded from the usual and customary calculations unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. The usual and customary charge will be a single price which includes both the product price and the dispensing fee. For routine usual and customary reviews, the pharmacy may provide prescription records for non-SoonerCare customers in a manner which does not identify the customer by name so long as the customer's identity may be determined later if a subsequent audit is initiated. The

OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

(e) **Payment of Claims.** In order for an eligible provider to be paid for filling a prescription drug, the pharmacy must complete all of the following:

- (1) have an existing provider agreement with OHCA,
- (2) submit the claim in a format acceptable to OHCA,
- (3) have a prior authorization before filling the prescription, if a prior authorization is necessary,
- (4) have a proper brand name certification for the drug, if necessary, and
- (5) include the usual and customary charges to the general public as well as the ~~estimated~~ actual acquisition cost and professional dispensing fee.

(f) **Claims.** Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be accessed by swiping a SoonerCare identification card through a commercial card swipe machine which is connected to the eligibility database or via the Point of Sale (POS) system when a prescription claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.

317:30-5-87. 340B Drug Discount Program

(a) The purpose of this Section is to provide special provisions for providers participating in the 340B Drug Discount program. The 340B Drug Discount program special provisions apply to a provider that has asserted it is a "covered entity" or a contract pharmacy for a covered entity under the provisions of 42 U.S.C. § 256b of the United States Code (otherwise known as the 340B Drug Discount Program).

(b) Covered Entities.

- (1) The covered entity must notify OHCA in writing within 30 days of any changes in 340B participation, as well as any changes in name, address, NPI number, etc.
- (2) The covered entity must maintain their status on the HRSA Medicaid exclusion file and report any changes to OHCA within 30 days.
- (3) The covered entity must execute a contract addendum with OHCA in addition to their provider contract.
- (4) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by the covered entity. OHCA will adjust each claim by subtracting the ~~Unit Rebate Amount~~ 340B Ceiling Price from the amount reimbursed and ~~multiplied~~ multiplying the difference by the quantity submitted. All drugs shall be

adjusted by the ~~URA~~ 340B Ceiling Price whether purchased through the 340B program or otherwise when billed using the registered SoonerCare NPI number on the HRSA Medicaid Exclusion File. OHCA will use the ~~Unit Rebate Amount~~ 340B Ceiling Price applicable to the quarter in which the claim is ~~submitted to OHCA for payment paid.~~

(c) Contract pharmacies for covered entities may be permitted to bill drug products purchased under the 340B Drug Discount Program to the Oklahoma Medicaid Program when certain conditions are met and an agreement is in place between OHCA, the contract pharmacy and the covered entity. These pharmacies will be subject to the recovery process stated above.

**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 contract. The services will be reimbursed at the fee-for-service rate, and will be subject to any limitations, restrictions or prior authorization requirements. Examples of these services include but are not limited to:

- ~~(1) pharmaceuticals/drugs;~~
- ~~(2)(1) durable medical equipment;~~
- ~~(3)(2) glasses;~~
- ~~(4)(3) ambulance;~~
- ~~(5)(4) home health;~~
- ~~(6)(5) inpatient practitioner services;~~
- ~~(7)(6) non-emergency transportation [refer to OAC 317:35-3-2];~~
- ~~(8)(7) behavioral health case management [refer to OAC 317:30-5-240 through 317:30-5-249]; [refer to OAC 317:30-5-241.6];~~
- ~~(9)(8) psychosocial rehabilitative services [refer to OAC 317:30-5-240 through 317:30-5-249]; [refer to OAC 317:30-5-241.3]; and~~
- ~~(10)(9) psychiatric residential treatment facility services [refer to OAC 317:30-5-96.3]. [refer to OAC 317:30-5, Part 6, Inpatient Psychiatric Hospitals].~~

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

317:30-5-1098. I/T/U outpatient encounters

(a) I/T/U outpatient encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by the OHCA. These services include health services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

(b) The following words and terms have the following meaning unless the context clearly indicates otherwise:

(1) An I/T/U encounter means a face to face or telemedicine contact between a health care professional and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a 24-hour period ending at midnight, as documented in the patient's record.

(2) An I/T/U outpatient encounter means outpatient services that may be covered when furnished to a patient by a contracted SoonerCare provider employed by the I/T/U facility and rendered at the I/T/U facility or other location, including the patient's place of residence.

(c) The following services may be considered reimbursable encounters subject to the limitations of the Oklahoma State Plan and include any related medical supplies provided during the course of the encounter:

- (1) Medical;
- (2) Diagnostic;
- (3) Behavioral Health services [refer to OAC 317:30-5-1094];
- (4) Dental, Medical and Mental Health Screenings;
- (5) Vision;
- (6) Physical Therapy;
- (7) Occupational Therapy;
- (8) Podiatry;
- (9) Speech;
- (10) Hearing;
- (11) Visiting Nurse Service [refer to OAC 317:30-5-1093];
- (12) Smoking and Tobacco Use Cessation Counseling
- (13) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;
- (14) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug sample. Drug samples are included in the encounter rate. ~~Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;~~ Prescriptions are reimbursed pursuant to OAC 317:30-5-78(b)(4)(B).

(15) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members; and

(16) I/T/U Multiple Outpatient Encounters.

(A) OHCA will cover one medically necessary outpatient medical encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit with a different diagnosis. Then, a second encounter is allowed.

(B) OHCA will cover one dental encounter per member per day regardless of how many procedures are done or how many providers are seen unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(C) OHCA will cover one behavioral health professional outpatient encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.

(D) Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U outpatient encounters.

(d) More than one outpatient visit with a medical professional within a 24-hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a member who comes to the I/T/U facility for a diabetic wellness screening and is then referred to a podiatrist within the clinic for diabetes-related follow-up on the same date of service would not be considered a distinctly different diagnosis and can only be billed as a single encounter.

(e) The following services may be considered as separate or multiple encounters when two or more services are provided on the same date of service with distinctly different diagnoses:

(1) Medical Services;

(2) Dental Services

(3) Mental Health and addiction services with similar diagnoses can only be billed as one encounter. In addition, if the member is also seen for a medical office visit with a mental health or addiction diagnosis, then it is considered a single encounter;

(4) Physical or occupational therapy (PT/OT). If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter;

(5) Administration of immunizations. If no other medical office visit occurs on the same date of services; and

(6) Tobacco cessation limited to state plan services. If no other medical or addiction encounter occurs on the same date of service.

(f) I/T/U outpatient encounters for IHS eligible SoonerCare members whether medical, dental, or behavioral health, are not subject to prior authorization. Other State Plan covered services that the I/T/U facility chooses to provide but which are not part of the I/T/U encounter are subject to all applicable SoonerCare regulations which govern the provision and coverage for that service.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS

317:2-1-2. Appeals

(a) Member Process Overview

(1) The appeals process allows a member to appeal a decision which adversely affects their rights. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to file an appeal, the member files a LD-1 form within 20 days of the triggering event. The triggering event occurs at the time when the Appellant (Appellant is the person who files a grievance) knew or should have known of such condition or circumstance for appeal.

(3) If the LD-1 form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to Title 68 O.S. § 205.2, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out or if necessary documentation is not included, then the appeal will not be heard.

(5) The staff advises the Appellant that if there is a need for assistance in reading or completing the grievance form that arrangements will be made.

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. The member must appear at this hearing and it is conducted according to 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (317:2-1-13).

(7) Member appeals are ordinarily decided within 90 days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 CFR 431.244(f)]

(8) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within 20 days of the hearing before the ALJ.

(b) Provider Process Overview.

(1) The proceedings as described in this subsection contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in

317:2-1-2(c)(2).

(2) All provider appeals are initially heard by the OHCA Administrative Law Judge under 317:2-1-2(c)(2).

(A) The Appellant (Appellant is the provider who files an appeal) files an LD form requesting an appeal hearing within 20 days of the triggering event. The triggering event occurs at the time when the Appellant knew or should have known of such condition or circumstance for appeal. (LD-2 forms are for provider appeals and LD-3 forms are for nursing home wage enhancement grievances.)

(B) If the LD form is not received within 20 days of the triggering event, OHCA sends the Appellant a letter stating the appeal will not be heard because it is untimely.

(C) A decision will be rendered by the ALJ ordinarily within 45 days of the close of all evidence in the case.

(D) Unless an exception is provided in 317:2-1-13, the Administrative Law Judge's decision is appealable to OHCA's CEO under 317:2-1-13.

(c) **ALJ jurisdiction.** The Administrative Law Judge has jurisdiction of the following matters:

(1) Member Appeals:

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) Fee for Service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the Oklahoma Health Care Authority. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the Administrative Law Judge within 20 days of the hearing before the ALJ;

(E) Proposed administrative sanction appeals pursuant to 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(F) Appeals which relate to eligibility determinations made by OHCA;

(G) Appeals of insureds participating in Insure Oklahoma which are authorized by 317:45-9-8(a); and

(2) Provider Appeals:

(A) Whether Pre-admission Screening and Resident Review

(PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by Long Term Care facilities for nonpayment of wage enhancements, determinations of overpayment or underpayment of wage enhancements, and administrative penalty determinations as a result of findings made under 317:30-5-131.2(b)(5), (e)(8), and (e)(12);

(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O. S. § 85.1;

(E) Drug rebate appeals;

(F) Proposed administrative sanction appeals pursuant to 317:30-3-19. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision will normally be rendered by the ALJ within 20 days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(G) Provider appeals of OHCA audit findings pursuant to 317:2-1-7. This is the final and only appeals process for appeals of OHCA audits; and

(H) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives.

(I) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15.

(J) Nursing Facility Supplemental Payment Program (NFSPP) eligibility determinations, the assessed amount for each component of the Intergovernmental transfer, Upper Payment Limit payments, the Upper Payment Limit Gap, and penalties specifically provided in OAC 317:30-5-136. This is the final and only process for appeals regarding NFSPP.

317:2-1-16. Nursing Facility Supplemental Payment Program Appeals

(a) In accordance with OAC 317:30-5-136, OHCA is authorized to promulgate rules for appeals of the Nursing Facility Supplemental Payment Program (NFSPP). The rules in this Section describe those appeal rights.

(1) The following are appealable issues of the program: program eligibility determination, the assessed amount for each component of the Intergovernmental transfer, the Upper Payment Limit (UPL) payment, the Upper Payment Limit Gap payment, and penalties for the providers. This is the final

and only process for appeals regarding NFSP. Suspensions or terminations from the program are not appealable in the administrative process.

(2) Appeals are heard by the OHCA Administrative Law Judge (ALJ).

(3) To file an appeal, the provider (Appellant is the provider who files an appeal) shall file an LD-2 form within twenty (20) days from the date of the OHCA letter which advises the provider of the program eligibility determination, component of intergovernmental transfer (IGT), UPL payment, UPL GAP and/or a penalty. The IGT shall be deducted from the provider's UPL payment if the IGT is unpaid at the time the appeal is filed. Any applicable penalties must also be deducted from the UPL payment regardless of any appeal action requested by the facility. Any change in the payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in the future from any Medicaid payments.

(4) Consistent with Oklahoma rules of practice, all non-state government owned (NSGO) entity must be represented by an attorney licensed to practice within the State of Oklahoma. Attorneys not licensed to practice in Oklahoma must comply with 5 O.S. Art II, Sec. 5, and rules of the Oklahoma Bar Association.

(5) The hearing will be conducted in an informal manner, without formal rules of evidence or procedure. However parties who fail to appear at a hearing, after notification of said hearing date, will have their cases dismissed for failure to prosecute.

(6) The provider has the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.

(7) The docket clerk will send the Appellant and any other necessary party a notice which states the hearing location, date, and time.

(8) The ALJ may:

(A) Identify and rule on issues being appealed which will be determined at the administrative hearing;

(B) Require the parties to state their positions concerning appeal issue(s);

(C) Require the parties to produce for examination those relevant witnesses and documents under their control;

(D) Rule on whether witnesses have knowledge of the facts at issue;

(E) Establish time limits for the submission of motions or memoranda;

(F) Rule on relevant motions, requests and other

procedural items, limiting all decisions to procedure matters and issues directly related to the contested determination resulting from OAC 317:30-5-136;

(G) Rule on whether discovery requests are relevant;

(H) Strike or deny witnesses, documents, exhibits, discovery requests, another requests or motions which are cumulative, not relevant, not material, used as a means of harassment, unduly burdensome, or not timely filed;

(I) Schedule pre-hearing conferences to settle, simplify, or identify issues in a proceeding or to consider other matters that may end the appeal;

(J) Impose appropriate sanctions against any party failing to obey an order of the ALJ;

(K) Rule on any requests for extension of time;

(L) Dismiss an issue or appeal if:

(i) it is not timely filed or is not within the OHCA's jurisdiction or authority;

(ii) it is moot or there is insufficient evidence to support the allegations;

(iii) the appellant fails or refuses to appear for a scheduled meeting; or

(iv) the appellant refuses to accept a settlement offer which affords the relief the party could reasonably expect if the party prevailed in the appeal;

(M) Set and/or limit the time frame for the hearing.

(9) After the hearing:

(A) The ALJ should attempt to make the final hearing decision within ninety (90) days from the date of the hearing and send a copy of the ALJ's decision to both parties outlining their rights to appeal the decision. Any appeal of the final order pursuant to 12 O.S. § 951 must be filed with the District Court of Oklahoma County within 30 days.

(B) It shall be the duty of the Appellant in any District Court appeal to order a written transcript of proceedings to be used on appeal. The transcript must be ordered within thirty (30) days of the filing of an appeal in the District Court and any costs associated with the preparation of the transcript shall be borne by the Appellant.

(10) All orders and settlements are non-precedential decisions.

(11) The hearing shall be digitally recorded and closed to the public.

(12) The case file and any audio recordings shall remain confidential.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-136. Nursing Facility Supplemental Payment Program

(a) **Purpose.** The nursing facility supplemental payment program is a supplemental payment, up to the Medicare upper payment limit, made to a non-state government owned entity that own and as applicable has operating responsibility for a nursing facility(ies).

(b) **Definitions.** The following words and terms, when used in this Section have the following meaning, unless the context clearly indicates otherwise:

(1) **"Funds"** means a sum of money or other resources, as outlined in 42 Code of Federal Regulations 433.51, appropriated directly to the State or local Medicaid agency, or funds that are transferred from other public agencies (including Indian tribes) to the State or local agency and under its administrative control, or funds certified by the contributing public agency as representing expenditures eligible for Federal Financial Participation (FFP).

(2) **"Intergovernmental transfer (IGT)"** means a transfer of state share funds from a non-state government owned entity to the Oklahoma Health Care Authority.

(3) **"Non-state government-owned (NSGO)"** means an entity owned and as applicable operated by a unit of government other than the state and approved by OHCA as a qualified NSGO. Pursuant to federal and OHCA approval an NSGO may include public trusts pursuant to the Trust Authorities established under Oklahoma Statute Title 60.

(4) **"Resource Utilization Groups (RUGs)"** means the system used to set Medicare per diem payments for skilled nursing facilities, as the basis to demonstrate a Medicare payment estimate for use in the upper payment limit calculation.

(5) **"Supplemental payment calculation period"** means the calendar quarter for which supplemental payment amounts are calculated based on adjudicated claims for days of service provided in the qualifying quarter. Note, in the event there are no paid days in the quarter as a result of the time in which the claims are adjudicated, the supplemental payment will be calculated on days billed in a subsequent quarter.

(6) **"Upper payment limit (UPL)"** refers to a reasonable estimate of the amount that would be paid for the services

furnished by a facility under Medicare payment principles.

(c) **Eligible nursing facilities.** A nursing facility that is owned and as applicable under the operational responsibility of an NSGO is eligible for participation when the following conditions are met:

(1) the nursing facility is licensed and certified by the Oklahoma State Department of Health;

(2) the participating NSGO has provided proof that it holds the facility's license and has complete operational responsibility for the facility;

(3) the participating NSGO has filed the certification of eligibility application for the UPL program participation and received approval from OHCA for participation;

(4) the NSGO has signed an attestation that a plan towards the reduction and mitigation of unnecessary Return to Acute Admissions (RTA) will be implemented within six months of program participation;

(5) the facility is an active participant in the Focus on Excellence program; and

(6) the facility and NSGO comply with Care Criteria requirements.

(d) **NSGO participation requirements.** The following conditions are required of the NSGO:

(1) must execute a nursing facility provider contract as well as an agreement of participation with the OHCA;

(2) must provide and identify the state share dollars' source of the IGT;

(3) must pay the calculated IGT to OHCA by the required deadline;

(4) must provide proof of ownership, if applicable (i.e. Change of Ownership) as Licensed Operator of the nursing facility;

(5) must provide OHCA with an executed Management Agreement between the NSGO and the facility Manager;

(6) must provide proof of district authority for nursing facility participants which include proximity requirements of no greater than 150 miles of NSGO. Exceptions may be made at the sole discretion of OHCA; and

(7) must provide per facility, the per patient per Medicaid day (PPMD) IGT within specified timeframe of receipt of the Notice of Program Reimbursement (NPR) as indicated below:

(A) For the first year-\$6.50 PPMD.

(B) For the second year-\$7.50 PPMD.

(C) For the third year-\$8.50 PPMD, or the equivalent of 10% of nursing facility budget of the current fiscal year, whichever is less. This amount excludes any IGT for actual administration cost associated with the nursing home UPL

supplemental program. Any remaining IGT after administration cost will be distributed through the rate setting methodology process. Distribution will occur once escrowed funds reaches an amount sufficient to distribute as determined by OHCA.

(e) **Care Criteria.** Each facility must comply with the below care criteria quality metric:

(1) Facilities must adhere to performance measures outlined in the Focus on Excellence program. The resulting outcome is to improve the quality of care being delivered to members. A written action plan must be developed and must include the following:

(A) the satisfaction survey results;

(B) analysis of satisfaction survey with identification of areas for improvement; and

(C) plan of action towards identified areas of improvement.

(2) Facilities must develop and implement a written plan for the mitigation of unnecessary Return to Acute Admissions (RTA) within six (6) months of participation. The resulting outcome is to improve the efficiency and care avoidance cost to the overall SoonerCare program. A written plan must be developed and must include the following:

(A) the RTA management tool which identifies those residents at high risk for the potential return to acute;

(B) the RTA management tools to support effective communications;

(C) advance directive planning and implementation; and

(D) application of Quality Assurance/Program Integrity (QA/PI) methodology in review of RTAs for the root cause analysis and teaching needs.

(3) Facilities are required to implement a pro-active Pneumonia/Flu Vaccination program which will result in improved vaccination scores above the facility specific baseline at or above the national average, as measured using the CMS Quality Metrics. The resulting outcome is to improve efficiency and care avoidance costs to the overall SoonerCare program. A written plan must be developed and must include the following:

(A) the latest available three quarter average of CMS measure code 411 (% of long-stay residents assessed and appropriately given the seasonal influenza vaccine) and 415 (% of long-stay residents assessed and appropriately given the pneumococcal vaccine) to establish baseline;

(B) the current measure code 411 and 415 score; and

(C) the written plan for flu and pneumonia vaccination program to address new admissions and current residents.

(4) Facilities are required to participate in the Oklahoma Healthy Aging Initiative. The resulting outcome is to improve the quality of care and health of members. Facilities must attest to elevate healthy aging in Oklahoma by implementing a plan that accomplishes at least one of the following strategies:

- (A) preventing and reducing of falls;
- (B) improving of nutrition;
- (C) increasing physical activity; or
- (D) reducing depression.

(5) Facilities are required to demonstrate improvement above the facility specific baseline in the 5-Star Quality Measures Composite scoring. Metrics will be determined based upon CMS Nursing Home Compare composite score over the trailing 12-month period. Facilities with Quality Measures star rating of three (3) or better for the most recent quarter or showing improvement in composite scoring with no two (2) quarters consistently below three (3), will be recognized as meeting the care criteria. The resulting outcome is to improve the quality of care being provided.

(A) Facilities must provide the most recent three (3) quarter average of the CMS quality measure star rating to establish baseline.

(B) Facilities are required to have a star rating of (3) or better or must demonstrate improvement over previous quarter with no two (2) quarters below three (3) stars.

(6) The care criteria measures may be evaluated at the discretion of OHCA on an annual basis after each fiscal year, following implementation of the program. However, OHCA reserves the right to conduct intermittent evaluations within any given year based on the quality, care and safety of SoonerCare members. The evaluation may be conducted by an independent evaluator. In addition, care criteria metrics may be internally evaluated after each fiscal year at the discretion of OHCA, in collaboration with an advisory committee composed of OHCA agency staff and provider representatives. The OHCA may make adjustments to the care criteria measures based on findings and recommendations as a result of the independent or internal evaluation.

(f) Supplemental Payments.

(1) The nursing facility supplemental payments to a NSGO under this program shall not exceed Medicare payment principles pursuant to 42 CFR 447.272. Payments are made in accordance with the following criteria:

(A) The methodology utilized to calculate the upper payment limit is the RUGs.

(B) The eligible supplemental amount is the difference/gap

between the SoonerCare payment and the Medicare upper payment limit as determined based on compliance with the Care Criteria metrics.

(2) The amount of the eligible supplemental payment is associated with improvement of care of SoonerCare nursing facility residents as demonstrated through the care criteria. NSGO participants receive payment under the program based on earned percentages related to the care criteria. The NSGO must meet or exceed at least two (2) of the five (5) established care criteria metrics to be eligible for UPL payment for each quarter. After at least two (2) of the five (5) metrics have been met, the NSGO is eligible for eighty-five percent (85%) of the total eligible UPL amount for participating nursing facilities. The NSGO may qualify for the remaining fifteen percent (15%) of the total UPL by attribution in five percent (5%) increments for each additional care criterion that is met resulting in the full one hundred percent (100%) of the eligible UPL amount.

(g) Change in ownership.

(1) A nursing facility participating in the supplemental payment program must notify the OHCA of changes in ownership (CHOW) that may affect the nursing facility's continued eligibility within thirty (30) days after such change.

(2) For a nursing facility that changes ownership on or after the first day of the SoonerCare supplemental payment limit calculation period, the data used for the calculations will include data from the facility for the entire upper payment limit calculation period relating to payments for days of service provided under the prior owner, pro-rated to reflect only the number of calendar days during the calculation period that the facility is owned by the new owner.

(h) Disbursement of payment to facilities. Facilities must secure allowable Intergovernmental Transfer funds (IGT) from a NSGO to fund the non-federal share amount. The method is as follows:

(1) The OHCA or its designee will notify the NSGO of the non-federal share amount to be transferred by an IGT, via a designated portal and NPR, for purposes of seeking federal financial participation (FFP) for the UPL supplemental payment, within twenty-five (25) business days after the end of the quarter. This amount will take into account the percentage of metrics achieved under the care criteria requirement. The NSGO will have five (5) business days to sign the participant agreement and make payment of the state share in the form of an IGT either in person or via mail. In addition, the NSGO will be responsible to also remit, upon receipt of the NPR, the applicable PPMD IGT in full, pursuant

to (d)(7) above.

(2) If the total transfer and PPMD IGT are received within five (5) business days, the UPL payment will then be disbursed to the NSGO by OHCA within ten (10) business days in accordance with established payment cycles. An IGT that is not received by the date specified by OHCA, or that is not the total indicated on the NPR may be subject to penalty and suspension from the program.

(i) **Penalties/Adjustments.** Failure by an NSGO to remit the full IGT indicated on the NPR by OHCA or its designee within the defined timeframes below indicates the NSGO has voluntarily elected to withdraw participation for that current quarter and may reapply for participation in the program in subsequent quarter(s).

(1) The total IGT must be received within five (5) business days from receipt of the NPR uploaded by OHCA or its designee in the program portal.

(A) Receipt of the total IGT within five (5) business days is not subject to penalty.

(B) The date the NPR is uploaded to the portal is the official date the clock starts to measure the five (5) business days.

(2) Any IGT received after the fifth business day but with an OHCA date stamp or mailing postal mark on or prior to five (5) business days from the official date of the uploaded NPR in the portal will not be subject to penalty; however, payment will be disbursed during the next available OHCA payment cycle.

(3) Any IGT with an OHCA date stamp or mailing postal mark received with a date after five (5) business days of receipt of the NPR, but not exceeding eight (8) business days of receipt of the NPR will be deemed late and subject to a penalty in accordance with (3)(B) below.

(A) Any NSGO that remits payment of the total IGT under the above circumstances will receive payment during the next available OHCA payment cycle including an assessed penalty as described below.

(B) A five percent (5%) penalty will be assessed for total IGT payments received after five (5) business days but within eight business days of receipt of the NPR of assessed amount. The five percent (5%) penalty will be assessed on the total eligible supplemental payment for the quarter in which the IGT is late and assessed to the specific NSGO as applicable.

(C) The OHCA will notify the NSGO of the assessed penalty via invoice. If the provider fails to pay the OHCA the assessed penalty within the time frame noted on the

invoice to the NSGO, the assessed penalty will be deducted from the nursing facility's Medicaid payment. The penalty must be paid regardless of any appeals action requested by the NSGO. Should an appeals decision result in a disallowance of a portion or the entire assessed penalty, reimbursement to the NSGO will be made to future nursing facility Medicaid payments.

(4) If a nursing facility fails to achieve at a minimum, two (2) of the care criteria metrics for two (2) consecutive quarters, the facility will be suspended for two (2) subsequent quarters and will not be eligible to participate in the program during suspended quarters. A facility that has been suspended for a total of four (4) quarters within a two (2) year period due to non-compliance with the Care Criteria will be terminated from the program, and if the facility wishes to participate again, it will be required to reapply. Reentry into the program is at the sole discretion of the OHCA, taking into consideration input from the advisory committee and/or stakeholders. If the facility is readmitted to the program, terms of participation may include a probationary period with defined requirements as it relates to care.

(j) **Appeals.** Applicant and participant appeals may be filed in accordance with grievance procedures found at OAC 317:2-1-2(b) and 317:2-1-16.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-27. Telemedicine

(a) **Applicability and scope.** The purpose of this Section is to implement telemedicine policy that improves access to health care services, while complying with all applicable federal and state statutes and regulations. Telemedicine services are not an expansion of SoonerCare covered services but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective thorough medical assessment or problems in the member's understanding of telemedicine, hands-on-assessment and/or in person care must be provided for the member. Any service delivered using telehealth technology must be appropriate for telemedicine delivery and be of the same quality and otherwise on par with the same service delivered in person. A telemedicine encounter must comply with the Health Information Portability and Accountability Act (HIPAA). For purposes of SoonerCare reimbursement telemedicine is the use of interactive audio, video or other electronic media for the purpose of diagnosis, consultation or treatment that occur in real-time and when the member is actively participating during the transmission. Telemedicine does not include the use of audio only telephone, electronic mail, or facsimile transmission. Transfer of data from one site to another through the use of a camera or similar device that records (stores) an image that is sent (forwarded) via telecommunication to another site for consultation. Asynchronous or "store and forward" applications would not be considered telemedicine but may be utilized to deliver services.

(b) **Conditions.** The following conditions apply to all services rendered via telemedicine.

(1) Interactive audio and video telecommunications must be used, permitting encrypted real-time communication between the physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telemedicine information transmitted. As a condition of payment the member must actively participate in the telemedicine visit.

(2) The telemedicine equipment and transmission speed and image must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telemedicine visit need to be trained in the use of the telemedicine equipment and competent

in its operation.

(3) The medical or behavioral health related service must be provided at an appropriate site for the delivery of telemedicine services. An appropriate telemedicine site is one that has the proper security measures in place; the appropriate administrative, physical and technical safeguards should be in place that ensure the confidentiality, integrity, and security of electronic protected health information. The location of the room for the encounter at both ends should ensure comfort, privacy, and confidentiality. Both visual and audio privacy are important, placement and selection of the rooms should consider this. Appropriate telemedicine equipment and networks must be used considering factors such as appropriate screen size, resolution, and security. Providers and/or members may provide or receive telemedicine services outside of Oklahoma when medically necessary.

(4) The provider must be contracted with SoonerCare and appropriately licensed for the service to be provided. If the provider is outside of Oklahoma, the provider must comply with all laws and regulations of the provider's location, including health care and telemedicine requirements.

~~(5) The health care practitioner must obtain written consent from the SoonerCare member that states he or she agrees to participate in the telemedicine-based office visit. The consent form must include a description of the risks, benefits and consequences of telemedicine and be included in the member's medical record.~~

~~(6)~~(5) If the member is a minor child, a parent/guardian must present the minor child for telemedicine services unless otherwise exempted by State or Federal law. The parent/guardian need not attend the telemedicine session unless attendance is therapeutically appropriate.

~~(7)~~(6) The member retains the right to withdraw at any time.

~~(8)~~(7) All telemedicine activities must comply with the HIPAA Security Standards, OHCA policy, and all other applicable state and federal laws and regulations.

~~(9)~~(8) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

~~(10)~~(9) There will be no dissemination of any member images or information to other entities without written consent from the member.

(c) **Reimbursement.**

(1) Services provided by telemedicine must be billed with the appropriate modifier.

(2) If the technical component of an X-ray, ultrasound or electrocardiogram is performed during a telemedicine transmission, the technical component can be billed by the provider that provided that service. The professional component

of the procedure and the appropriate visit code should be billed by the provider that rendered that service.

(3) The cost of telemedicine equipment and transmission is not reimbursable by SoonerCare.

(d) **Documentation.**

(1) Documentation must be maintained by the rendering provider to substantiate the services rendered.

(2) Documentation must indicate the services were rendered via telemedicine, and the location of the services.

(3) All other SoonerCare documentation guidelines apply to the services rendered via telemedicine. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

(e) The OHCA has discretion and the final authority to approve or deny any telemedicine services based on agency and/or SoonerCare members' needs.

Recommendation 1: Prior Authorize Ocaliva™ (Obeticholic Acid)

The Drug Utilization Review Board recommends the prior authorization of Ocaliva™ (obeticholic acid) with the following criteria:

Ocaliva™ (Obeticholic Acid) Approval Criteria:

1. An FDA approved diagnosis of primary biliary cholangitis (PBC); and
2. Member must have taken ursodeoxycholic acid (UDCA) at an appropriate dose for at least one year and prescriber must confirm a lack of improvement in liver function tests, confirm that PBC is not caused by a superimposed liver disease, confirm that if the member has a superimposed liver disease it is being adequately treated, proper timing of bile acid sequestrants if co-administered with UDCA (four hours before or four hours after), and patient compliance with UDCA; and
3. Ocaliva™ must be taken in combination with UDCA. For Ocaliva™ monotherapy consideration, the prescriber must document a patient-specific, clinically significant reason why the member is unable to take UDCA; and
4. A quantity limit of one tablet daily will apply.

Recommendation 2: Prior Authorize Millipred™ (Prednisolone Sodium Phosphate Oral Solution 10mg/5mL)

The Drug Utilization Review Board recommends the prior authorization of Millipred™ (prednisolone sodium phosphate oral solution 10mg/5mL) with criteria similar to Veripred™ 20 (prednisolone sodium phosphate oral solution 20mg/5mL). The recommended criteria can be seen below with additions noted in red.

Veripred™ 20 (Prednisolone Sodium Phosphate Oral Solution 20mg/5mL) and Millipred™ (Prednisolone Sodium Phosphate Oral Solution 10mg/5mL) Approval Criteria:

1. Authorization of Veripred™ 20 **or** Millipred™ requires a patient-specific, clinically significant reason why the member cannot use a tablet or an alternative strength liquid formulation.

Recommendation 3: Prior Authorize Xiidra™ (Lifitegrast 5% Ophthalmic Solution)

The Drug Utilization Review Board recommends the prior authorization of Xiidra™ (lifitegrast ophthalmic solution) with the following criteria:

Xiidra™ (Lifitegrast Ophthalmic Solution) Approval Criteria:

1. Member must be 17 years of age or older and have an FDA approved diagnosis of dry eye disease (DED); and
2. Prescriber must verify that environmental factors (e.g. humidity, fans) have been addressed; and
3. Member must have trials with at least three over-the-counter (OTC) products for three days in the last 30 days that failed to relieve signs and symptoms of dry eyes; and

4. A patient-specific, clinically significant reason why the member cannot use Restasis® (cyclosporine ophthalmic emulsion), which is available without a prior authorization; and
5. A quantity limit of two vials per day will apply.

Recommendation 4: Prior Authorize Allzital® (Butalbital/Acetaminophen 25mg/325mg) & Esgic® Capsules (Butalbital/Acetaminophen/Caffeine 50mg/325mg/40mg)

The Drug Utilization Review Board recommends the following changes to the Butalbital Products category:

1. The prior authorization of Allzital® (butalbital/acetaminophen 25mg/325mg) with criteria similar to the other butalbital containing medications.
 - a. An FDA approved indication for the treatment of tension-type headache; and
 - b. Member must be 12 years of age or older; and
 - c. Failure within the previous 60 days of the following:
 - i. All available formulations of butalbital/acetaminophen medications that do not require prior authorization (medications available without prior authorization contain butalbital/acetaminophen/caffeine in the standard 50mg/325mg/40mg dose); and
 - ii. Trials of at least two nonsteroidal anti-inflammatory drugs (NSAIDs), unless contraindicated.
2. The prior authorization of Esgic® capsules (butalbital/acetaminophen/caffeine 50mg/325mg/40mg) based on SMAC with the following criteria:
 - a. A patient-specific, clinically significant reason why the member cannot use Fioricet® tablets (butalbital/acetaminophen/caffeine 50mg/325mg/40mg).

Recommendation 5: Vote to Prior Authorize Odomzo® (Sonidegib), Erivedge® (Vismodegib), Keytruda® (Pembrolizumab), Opdivo® (Nivolumab), Yervoy® (Ipilimumab), Tafinlar® (Dabrafenib), Zelboraf® (Vemurafenib), Cotellic® (Cobimetinib), Mekinist® (Trametinib), and Imlygic® (Talimogene Laherparepvec)

The Drug Utilization Review Board recommends Prior Authorization for Odomzo® (Sonidegib), Erivedge® (Vismodegib), Keytruda® (Pembrolizumab), Opdivo® (Nivolumab), Yervoy® (Ipilimumab), Tafinlar® (Dabrafenib), Zelboraf® (Vemurafenib), Cotellic® (Cobimetinib), Mekinist® (Trametinib), Imlygic® (Talimogene Laherparepvec) with the following criteria:

Odomzo® (Sonidegib) Approval Criteria [Basal Cell Carcinoma Diagnosis]:

1. Either of the following criteria must be met for approval:
 - a. Diagnosis of locally advanced basal cell carcinoma (BCC) that has either:
 - i. Recurred following surgery or radiation therapy; or
 - ii. Surgery or radiation is contraindicated; or
 - b. Diagnosis of metastatic basal cell carcinoma.

Erivedge® (Vismodegib) Approval Criteria [Basal Cell Carcinoma Diagnosis]:

1. Either of the following criteria must be met for approval:
 - a. Diagnosis of locally advanced basal cell carcinoma (BCC) that has either:
 - i. Recurred following surgery or radiation therapy; or
 - ii. Surgery or radiation is contraindicated; or
 - b. Diagnosis of metastatic basal cell carcinoma.

Keytruda® (Pembrolizumab) Approval Criteria [Melanoma Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. Diagnosis of unresectable or metastatic melanoma; and
 - b. Pembrolizumab must be used as a single-agent; and
 - c. Patient meets one of the following:
 - i. Pembrolizumab is being used as first-line therapy; or
 - ii. Pembrolizumab is being used as second-line therapy or subsequent therapy for disease progression if not previously used and patient has ECOG performance status 0 to 2; and
 - d. The patient has not previously failed other PD-1 inhibitors [i.e. Opdivo® (nivolumab)].

Keytruda® (Pembrolizumab) Approval Criteria [Hodgkin Lymphoma Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. Diagnosis of relapsed or refractory classical Hodgkin lymphoma; and
 - i. Exception: lymphocyte-predominant Hodgkin lymphoma
 - b. Pembrolizumab must be used as a single-agent; and
 - c. The patient has not previously failed other PD-1 inhibitors [i.e. Opdivo® (nivolumab)].

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

1. All of the following criteria must be met for approval:
 - a. Diagnosis of metastatic NSCLC; and
 - b. The patient has not previously failed other PD-1 inhibitors [i.e. Opdivo® (nivolumab)]; and
 - c. Tumors express PD-L1 (FDA approved test); and
 - d. Patient meets one of the following:
 - i. New diagnosis as first-line therapy (patient has not received chemotherapy to treat disease) if:
 1. Tumor does not express sensitizing EGFR mutations or ALK translocations
 2. ECOG performance status 0 to 1
 - ii. Disease progression on or after platinum-containing chemotherapy (cisplatin or carboplatin); or
 1. Patients with EGFR-mutation-positive should have disease progression on FDA-approved therapy for these aberrations prior to receiving

pembrolizumab. *This does not apply if tumors do not have these mutations*; and

- A. Examples of drugs for EGFR-mutation-positive tumors: osimertinib, erlotinib, afatinib, or gefitinib
2. Patients with ALK genomic tumor aberrations should have disease progression on FDA-approved therapy for these aberrations prior to receiving pembrolizumab. *This does not apply if tumors do not have these mutations*; and
 - A. Examples of drugs for ALK-mutation-positive tumors: crizotinib, ceritinib, or alectinib
3. ECOG performance status 0 to 2.

Keytruda® (Pembrolizumab) Approval Criteria [Head and Neck Cancer Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. Diagnosis of recurrent or metastatic disease; and
 - b. Squamous cell histology; and
 - c. Patient has received prior platinum containing regimen (cisplatin or carboplatin); and
 - d. ECOG performance status 0 to 1; and
 - e. Dose does not exceed 200mg every three weeks.

Opdivo® (Nivolumab) Approval Criteria [Melanoma Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. Diagnosis of unresectable or metastatic melanoma; and
 - b. Nivolumab must be used as a single-agent, or in combination with ipilimumab:
 - i. As first-line therapy for untreated melanoma; or
 - ii. As second-line or subsequent therapy for documented disease progression while receiving or since completing most recent therapy:
 1. If the patient has not previously failed other PD-1 inhibitors [i.e. Keytruda® (pembrolizumab)]; and
 2. Patient has ECOG performance status 0 to 2
- c. Dose as follows:
 - i. Single-agent: 240mg every two weeks
 - ii. In combination with ipilimumab: 1mg/kg, followed by ipilimumab on the same day, every three weeks for four doses, then 240mg every two weeks.

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

1. All of the following criteria must be met for approval:
 - a. Diagnosis of metastatic NSCLC; and
 - b. Tumor histology is one of the following:
 - i. Adenocarcinoma; or
 - ii. Squamous cell; or
 - iii. Large Cell; and
 - c. Nivolumab must be used as a single-agent; and

- d. Disease progression on or after platinum-containing chemotherapy (cisplatin or carboplatin); and
- e. ECOG performance status 0 to 2; and
- f. The patient has not previously failed other PD-1 inhibitors [i.e. Keytruda® (pembrolizumab)]; and
- g. Dose as follows:
 - i. Single-agent: 240mg every two weeks.

Opdivo® (Nivolumab) Approval Criteria [Small Cell Lung Cancer Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. One of the following criteria is met:
 - i. Disease relapsed within six months of initial chemotherapy; or
 - ii. Disease is progressive on initial chemotherapy; and
 - b. Nivolumab must be used as a single-agent or in combination with ipilimumab; and
 - c. ECOG performance status 0 to 2
 - d. The patient has not previously failed other PD-1 inhibitors (i.e. Keytruda® (pembrolizumab)).

Opdivo® (Nivolumab) Approval Criteria [Hodgkin Lymphoma Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. Diagnosis of relapsed or refractory classical Hodgkin lymphoma; and
 - i. Exception: lymphocyte-predominant Hodgkin lymphoma
 - b. Nivolumab must be used as a single-agent; and
 - c. The patient has not previously failed other PD-1 inhibitors [i.e. Keytruda® (pembrolizumab)].

Opdivo® (Nivolumab) Approval Criteria [Renal Cell Cancer Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. Diagnosis of relapsed or surgically unresectable stage IV disease; and
 - b. Tumor histology: predominantly clear cell; and
 - c. Failed prior therapy with one of the following medications:
 - i. Sunitinib; or
 - ii. Sorafenib; or
 - iii. Pazopanib; or
 - iv. Axitinib; and
 - d. Nivolumab must be used as a single-agent; and
 - e. ECOG performance status 0 to 2; and
 - f. The patient has not previously failed other PD-1 inhibitors [i.e. Keytruda® (pembrolizumab)]
 - g. Dose as follows:
 - i. Single-agent: 240mg every two weeks.

Yervoy® (Ipilimumab) Approval Criteria [Unresectable or Metastatic Melanoma Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. ECOG performance status 0 to 2; and

- b. Ipilimumab is used in combination with nivolumab as:
 - i. First-line therapy; or
 - ii. Second-line or subsequent therapy for disease progression if nivolumab was not previously used; and
- c. Ipilimumab is used as a single-agent for one of the following:
 - i. First-line therapy as a single course of four treatments; or
 - ii. Second-line or subsequent lines of therapy as a single course of four treatments; or
 - iii. Retreatment, consisting of a 4-dose limit, for an individual who had no significant systemic toxicity during prior ipilimumab therapy, and whose disease progressed after being stable for greater than six months following completion of a prior course of ipilimumab, and for whom no intervening therapy has been administered; and
- d. Maximum dose of 3mg/kg will apply.

Yervoy® (Ipilimumab) Approval Criteria [Adjuvant Treatment of Melanoma]:

- 1. All of the following criteria must be met for approval:
 - a. Patient has complete resection of melanoma with lymphadenectomy; and
 - b. Patient has Stage III disease with regional nodes of greater than 1 mm and no in-transit metastasis; and
 - c. Ipilimumab must be used as a single-agent; and
 - d. Maximum doses of 10mg/kg will apply.

Yervoy® (Ipilimumab) Approval Criteria [Small Cell Lung Cancer Diagnosis]:

- 1. All of the following criteria must be met for approval:
 - a. One of the following criteria is met:
 - i. Disease relapsed within six months of initial chemotherapy; or
 - ii. Disease is progressive on initial chemotherapy; and
 - b. Used in combination with nivolumab; and
 - c. ECOG performance status 0 to 2.

Tafinlar® (Dabrafenib) Approval Criteria [Melanoma Diagnosis]:

- 1. All of the following criteria must be met for approval:
 - a. Diagnosis of unresectable or metastatic melanoma; and
 - b. BRAF V600E or V600K mutation detected by an FDA-approved test; and
 - i. Not indicated for wild-type BRAF melanoma
 - c. Dabrafenib must be used as a single-agent or in combination with trametinib (Mekinist®); and
 - d. One of the following is met:
 - i. Used as first-line therapy; or
 - ii. Used as second-line therapy or subsequent therapy and patient has an ECOG performance status of 0 to 2.

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

- 1. All of the following criteria must be met for approval:

- a. BRAF V600E or V600K mutation detected by an FDA-approved test; and
 - i. Not indicated for wild-type BRAF NSCLC
- b. Dabrafenib must be used as a single-agent or in combination with trametinib (Mekinist®)
- c. Diagnosis of refractory or metastatic disease.

Zelboraf® (Vemurafenib) Approval Criteria [Melanoma Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. Diagnosis of unresectable or metastatic melanoma; and
 - b. BRAF V600E or V600K mutation detected by an FDA-approved test; and
 - i. Not indicated for wild-type BRAF melanoma
 - c. Vemurafenib must be used as a single-agent or in combination with cobimetinib; and
 - d. One of the following is met:
 - i. Used as first-line therapy; or
 - ii. Used as second-line therapy or subsequent therapy and patient has an ECOG performance status of 0 to 2.

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

1. All of the following criteria must be met for approval:
 - a. BRAF V600E or V600K mutation detected by an FDA-approved test; and
 - i. Vemurafenib is not indicated for wild-type BRAF NSCLC
 - b. Vemurafenib must be used as a single-agent
 - c. Diagnosis of refractory or metastatic disease.

Zelboraf® (Vemurafenib) Approval Criteria [Hairy-Cell Leukemia Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. Vemurafenib must be used as a single-agent; and
 - b. Vemurafenib is being used to treat disease progression following failure of purine analog therapy (i.e. pentostatin, cladribine).

Cotellic® (Cobimetinib) Approval Criteria [Melanoma Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. Diagnosis of unresectable or metastatic melanoma; and
 - b. BRAF V600E or V600K mutation detected by an FDA-approved test; and
 - i. Cobimetinib is not indicated for wild-type BRAF melanoma
 - c. One of the following is met:
 - i. Used as first-line therapy in combination with vemurafenib; or
 - ii. Used as second-line therapy or subsequent therapy with vemurafenib and patient has an ECOG performance status of 0 to 2.

Mekinist® (Trametinib) Approval Criteria [Melanoma Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. Diagnosis of unresectable or metastatic melanoma; and
 - b. BRAF V600E or V600K mutation detected by an FDA-approved test; and

- i. Trametinib is not indicated for wild-type BRAF melanoma.
- c. One of the following is met:
 - i. Used as first-line therapy in combination with dabrafenib; or
 - ii. Used as second-line therapy or subsequent therapy with dabrafenib and patient has an ECOG performance status of 0 to 2; or
 - iii. Used as second-line therapy or subsequent therapy as a single-agent if:
 - 1. Patient was intolerant to prior BRAF inhibitor therapy (dabrafenib, vemurafenib); and
 - 2. No evidence of disease progression on prior BRAF inhibitor therapy (dabrafenib, vemurafenib); and
 - 3. ECOG performance status is 0 to 2.

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

1. All of the following criteria must be met for approval:
 - a. BRAF V600E or V600K mutation detected by an FDA-approved test; and
 - i. Trametinib is not indicated for wild-type BRAF NSCLC
 - b. Trametinib must be used in combination with dabrafenib.
 - c. Diagnosis of refractory or metastatic disease.

Imlygic® (Talimogene Laherparepvec) Approval Criteria [Melanoma Diagnosis]:

1. All of the following criteria must be met for approval:
 - a. Patient has unresectable cutaneous, subcutaneous, or nodal lesions that are recurrent after initial surgery; and
 - i. Talimogene laherparepvec is not indicated with visceral metastases.
 - b. The patient is not immunocompromised or pregnant.

Recommendation 6: Prior Authorize Relistor® (Methylnaltrexone) Tablets

The Drug Utilization Review Board recommends the prior authorization of Relistor® (methylnaltrexone) tablets with the following criteria:

1. An FDA approved diagnosis of opioid-induced constipation (OIC) in members 18 years of age or older with chronic, non-cancer pain who are currently on chronic opioid therapy; and
2. Member must not have known or suspected gastrointestinal obstruction; and
3. Documentation of the underlying cause of chronic pain, or reason why member is on chronic opioid therapy; and
4. Documented and updated colon screening for members greater than 50 years of age; and
5. Documentation of hydration attempts and trials of at least three different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
 - a. One of the three trials must be polyethylene glycol 3350 (PEG-3350); and

- b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
6. A patient-specific, clinically significant reason why member cannot use Amitiza® (lubiprostone) or Movantik® (naloxegol) must be provided; and
7. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment.
8. Relistor® must be discontinued if treatment with the opioid pain medication is also discontinued.
9. A quantity limit of 90 tablets for a 30 day supply will apply.

Recommendation 7: Prior Authorize Synera® (Lidocaine/Tetracaine Topical Patch)

The Drug Utilization Review Board recommends the prior authorization of Synera® (lidocaine/tetracaine topical patch) with the following criteria:

1. Member must be 3 years of age or older; and
2. Member must have an FDA approved need for local dermal analgesia for superficial venous access or superficial dermatological procedures; and
3. A patient-specific, clinically significant reason why the member cannot use EMLA® (lidocaine/prilocaine) cream, which is available without a prior authorization, must be provided; and
4. The total number of procedures must be provided on the prior authorization request; and
5. A quantity limit of two patches per day will apply.

PROPOSED OHCA BOARD MEETINGS/LOCATIONS - 2017

JANUARY						
S	M	T	W	T	F	S
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FEBRUARY						
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MARCH						
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January 12, 2017 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

February 9, 2017 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

March 23, 2017 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

May 11, 2017 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

June 29, 2017 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

August 9, 2017 • Board Meeting • 1:00 pm
August 10, 2017 • SPC • 8:30 am
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

September 14, 2017 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

October 12, 2017 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

November 9, 2017 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

December 14, 2017 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

JULY						
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31						

*Dates in Red are Proposed Board Dates