OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
August 24, 2017 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
OKC, OK

A G E N D A

Items to be presented by Ed McFall, Chairman

1. Call to Order / Determination of Quorum

2. Action Item – Approval of the June 29, 2017 OHCA Board Meeting Minutes

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

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

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

4. Discussion Item – Chief Executive Officer's Report

   a) All-Star Introduction
      - May All-Star – Halley Kinder, System Analyst III (Lisa Gifford
      - June All-Star – Lisa Montgomery, Financial Analyst III (Carrie Evans)

   b) Financial Update – Carrie Evans, Chief Financial Office

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

   d) Legislative Update – Cate Jeffries, Legislative Liaison

   e) Health Management Program (HMP)/Chronic Care Unit Update – Della Gregg, HMP Manager

   f) Obstetric Outreach – Shelly Patterson, Assistant Director of Provider/Medical Home Services

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

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

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

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

   Action Item – a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of ***all Emergency Rules*** in item six 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.

OHCA Initiated

a) REVOKING agency rules at OAC 317:30-3-88 to remove references to the issuing/mailing of member identification cards. This policy change is the result of the Oklahoma Health Care Authority no longer printing and/or issuing plastic medical identification cards. Members now have access to print their medical identification card from their online member account, or non-online enrollment members can visit their local county Oklahoma Department of Human Services office to obtain a printed card. Providers can verify the member's eligibility online via the Eligibility Verification System.
Budget Impact: Revisions will result in a total budget savings of $96,000 (CY).

(Reference APA WF # 17-05A)

b) AMENDING agency rules at OAC 317:35-7-40, 317:35-9-75, 317:35-15-7, 317:35-17-12, and 317:35-19-22 to remove references that refer to the issuing/mailing of member medical identification cards. This policy change is the result of the Oklahoma Health Care Authority no longer printing and/or issuing plastic cards. Members now have access to print their medical identification card from their online member account, or non-online enrollment members can visit their local county Oklahoma Department of Human Services (OKDHS) office to obtain a printed card. Providers can verify the member's eligibility online via the Eligibility Verification System. Additionally, revisions update language to reflect how the OKDHS notifies members of eligibility and ineligibility determinations for medical services by mailing out computer-generated notification forms. Finally, the policy revisions update the language for the medical and financial certification processes for the OKDHS ADvantage Program.
Budget Impact: The budget impact is identified in APA WF #17-05A.

(Reference APA WF # 17-05B)

c) AMENDING agency rules at OAC 317:30-3-57, 317:30-5-72, 317:30-5-72.1, and 317:30-5-77.2 to remove coverage of optional non-prescription drugs for adults. (Insulin, nicotine, replacement products for smoking cessation, and family planning products are not optional.) Additionally, compounded prescriptions will require a prior authorization for allowable cost exceeding a pre-determined limit. Finally, revisions correct the number of prescriptions allowed for adults receiving services under the 1915(c) Home and Community-Based Services Waivers from two (2) to three (3), to reflect current coverage.
Budget Impact: Revisions that remove coverage of optional non-prescription drugs for adults will result in a total budget savings of $825,000 for SFY 2018; state share $338,992.50; federal share $486,007.50.

(Reference APA WF # 17-06)

ODMHSAS Initiated

d) AMENDING agency rules at OAC 317:30-5-241.6 to establish yearly limits on the amount of basic case management/resource coordination that is reimbursable by SoonerCare on a fee-for-service basis. The current limit of twenty-five (25) units per member per month basic case management/resource coordination will be reduced to sixteen (16) units per member per year. A process for authorizing up to twenty-five (25) units per member per month will be used for individuals who demonstrate the medical need for additional units. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health and Substance Abuse Services' operations budget for the remainder of SFY 2018 in order to meet the balanced budget requirements as mandated by state law. Without the recommended revisions, the Depart is at risk of exhausting its state appropriated dollars required to maintain the State's Medicaid Behavioral Health Program.

ODMHSAS Budget Impact: Revisions will result in a total budget savings to ODMHSAS for SFY 2018 of $8,447,984 Total; $3,500,000 state share.

(Reference APA WF # 17-09)

Item to be presented by Jill Ratterman, Clinical Pharmacist

7. 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 **Austedo™ (Deutetrabenazine) and Xenazine® (Tetrabenazine)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

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

c) Consideration and vote to add **Carac® (Fluorouracil 0.5% Cream), GoNitro™ (Nitroglycerin Sublingual Powder), Soltamox® (Tamoxifen Citrate Oral Solution), Taytulla™ (Norethindrone Acetate/Ethinyl Estradiol Capsules & Ferrous Fumarate Capsules), Tirosint®-SOL (Levothyroxine Sodium Oral Solution), Xatmep™ (Methotrexate Oral Solution), Zovirax® (Acyclovir Ointment and Suspension), Xerese® (Acyclovir/Hydrocortisone Cream), & Denavir® (Penciclovir Cream)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

d) Consideration and vote to add **Aczone® (Dapsone Gel) and Tazorac® (Tazarotene Cream and Gel)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Ed McFall, Chairman

8. 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).

Discussion of pending contractual litigation
Discussion of agency employment action

9. New Business

10. ADJOURNMENT

NEXT BOARD MEETING
September 14, 2017
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A REGULARLY SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
June 29, 2017
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on June 28, 2017 at 12:31 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on June 23, 2017 at 1:09 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:05 p.m.

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

OTHERS PRESENT:	OTHERS PRESENT:
David Dude, American Cancer Society	Cynthia Reynolds, eCapitol
Catherine Sweeney, Journal Record	Carmen Johnson, OHCA
Rick Snyder, OHA	Jerry Kramer, OHCA
Dwyna Vick, OHCA	Virginia Ragan, SOFS
Terry Cothran, CoP	Tiffany Lyon, OHCA
Will Widman, DXC	Melissa Hughes, RRCS
Stan Ruffner, OHCA	Nickie White-Rankin, VWR Consulting
Tasha Black, OHCA	Josh Richards, OHCA
Kasie Wren, OHCA	Kim Bogard, Takeda Oncology
Justin Wingerter, The Oklahoman	Clay Taylor, Oklahoma Lobby Group
Mia Smith, OHCA	Tammy Vaughn, Southwestern OK Family Services
Mike Herndon, OHCA	Gloria LaFitte, OHCA
Jimmy Witcosky, OHCA	Kambra Reddick, OHCA
Harvey Reynolds, OHCA	Kyle Janzen, OHCA
Jean Ann Ingram, SOFS	LeKenya Antwine, OHCA
Gargi Sharma, OUHSC	Kelli Brodersen, OHCA
Fred Oraene, OHCA	Lewis Robinson, OHCA
Brenda Teel, Chickasaw Nation	Sherris Harris-Ososanya, OHCA
David Ward, OHCA	Ameika Miller, OHCA
Kari Galipp, OUHSC	Katie Morgan, OUHSC

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

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

MOTION:	Member Bryant moved for approval of the May 25, 2017 board meeting minutes as published.
FOR THE MOTION:	Chairman McFall
ABSTAINED:	Vice-Chairman Armstrong, Member Robison
BOARD MEMBERS ABSENT:	Member Case, Member McVay, Member Nuttle

ITEM 3a / FINANCIAL UPDATE
Gloria Hudson, Director of General Accounting

Ms. Hudson reported on the financial transactions through the month of April. OHCA continues to run under budget in program spending by $6 million state dollars and administration by 4 million state dollars. OHCA's revenues are over budget in drug rebate by $1.8 million and still under budget in overpayments and settlements by 1 Million state dollars and in tobacco tax collection and fees by negative 1.1 million state dollars. OHCA will continue to remain under budget. For the month of May, program spending and administration will continue to run under budget and drug rebate will remain over budget. For more detailed information, see Item 3a in the board packet.

ITEM 3b / MEDICAID DIRECTOR'S UPDATE
Garth Splinter, Deputy Chief Executive Officer

Dr. Splinter provided an update for May 2017 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program including total in-state providers. Dr. Splinter discussed charts provided for dual enrollees and long-term care members and SoonerCare Medical Home enrollment. For more detailed information, see Item 3b in the board packet.

ITEM 3c / LEGISLATIVE/BUDGET UPDATE
Lindsey Bateman, Assistant Director of Government Relations

Ms. Bateman provided a legislative and budget update which included information on FY18 Appropriations, SB 845: Health Care Enhancement Fund, FY 2018 Shortfall, and Federal Landscape. For more detailed information, see item 3c in the board packet.

ITEM 3d / PROGRAM INTEGRITY AUDIT UPDATE
Josh Richards, Director of Provider Audits

Mr. Richards provided a Program Integrity audit update which included information on how audits are initiated, types of referrals, peer to peer comparison and data-mining. For more detailed information, see item 3d in the board packet.

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

There were no recommendations regarding conflicts.

ITEM 5A-D / CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE
Tywanda Cox, Chief of Federal and State Policy

a) Consideration and Vote for a rate change to increase the base rate component to $107.79 for Regular Nursing Facilities and increase the pool amount for these facilities in the state plan for the "Other" and "Direct Care" components to $160,636,876. In SFY2018, this change has an estimated total dollar increase of $3,329,018, of which $1,367,893 is state share coming from the increased Quality of Care Fee, which is paid by the facilities.

b) Consideration and Vote for a rate change to increase the base rate component to $200.01 for the Acquired Immune Deficiency Syndrome (AIDS) rate for Nursing Facilities. In SFY2018, this change has an estimated total dollar increase of $7,016 of which $2,883 is state share coming from the increased Quality of Care Fee, which is paid by the facilities.

c) Consideration and Vote for a rate change to increase the base rate to $157.03 for Acute (16 Beds or Less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). In SFY2017, this change has an estimated total dollar increase of $129,929, of which $53,388 is state share coming from the increased Quality of Care Fee, which is paid by the facilities.

d) Consideration and Vote for a rate change to increase the base rate to $122.77 for Regular Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). In SFY2017, this change has an estimated total dollar increase of $79,253, of which $32,565 is state share coming from the increased Quality of Care Fee, which is paid by the facilities.

MOTION:	Vice-Chairman Armstrong moved for approval of Items 5a-d as published. The motion was seconded by Member Bryant.
FOR THE MOTION:	Chairman McFall, Member Robison
BOARD MEMBERS ABSENT:	Member Case, Member McVay, Member Nuttle

ITEM 6A-C / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT. THE AGENCY REQUESTS THE ADOPTION OF THE FOLLOWING:
Nancy Nesser, Pharmacy Director

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

OHCA Initiated

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

(Reference APA WF # 17-01)

ODMHSAS Initiated

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

(Reference APA WF # 17-04A)

c) AMENDING agency rules at OAC 317:35-23-2 and 317:35-23-3 to include a fourth population to be served in the Money Follows the Person (MFP) demonstration. The intent of the change is to develop an implementation plan to transition eligible individuals from Psychiatric Residential Treatment Facilities (PRTF) back into the community. Oklahoma's MFP Demonstration for PRTF transitioning will focus on transitioning youth 16 to 18 years of age who have been in an inpatient psychiatric residential facility for 90 or more days during an episode of care. The individuals must meet criteria for Level 3 on the Individual Client Assessment Record or meet the criteria of Serious Emotional Disturbance. They may also show critical impairment on a caregiver rated Ohio Scales (score of 25 and above on the Problems Subscale, or a score of 44 and below on the Functioning Subscales). In addition, the individuals will be eligible for transitional and community-based services and medications under Oklahoma's Living Choice Program. Services will be provided in accordance with an individualized plan of care under the direction of appropriate service providers. Revisions also replace the term Intermediate Care Facility for Mentally Retarded with Intermediate Care Facility for Individuals with Intellectual Disabilities.
ODMHSAS Budget Impact: The budget impact is listed in APA WF #17-04A.

(Reference APA WF # 17-04B)

MOTION FOR EMERGENCY RULES: Member Robison moved for approval of Emergency Rules as published. The motion was seconded by Member Bryant.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong

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

MOTION: Member Bryant moved for approval of Item 6a-c as published. The motion was seconded by Vice-Chairman Armstrong

FOR THE MOTION: Chairman McFall, Member Robison

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

ITEM 7 / CONSIDERATION AND VOTE OF THE STATE FISCAL YEAR 2018 BUDGET WORK PROGRAM
Tasha Black, Director of Budget and Fiscal Planning

For more detailed information, see item 7 in the board packet.

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

FOR THE MOTION: Chairman McFall, Member Bryant

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

ITEM 8 / CONSIDERATION AND VOTE OF THE DISEASE REGISTRY EXPENDITURE OF AUTHORITY
Tiffany Lyon, Director of Procurement and Contracts

For more detailed information, see item 8 in the board packet.

MOTION: Member Robison 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 Case, Member McVay, Member Nuttle

ITEM 9 / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION REVIEW BOARD UNDER 63 OLAHOMA STATUTES 5030.0.
Nancy Nesser, Pharmacy Director

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

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

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

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

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

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

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

MOTION: Member Robison moved for approval of Item 9 as published. The motion was seconded by Vice-Chairman Armstrong

FOR THE MOTION: Chairman McFall, Member Bryant

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

ITEM 10 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4)
Nicole Nantois, Chief of Legal Services

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

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

FOR THE MOTION: Chairman McFall, Member Robison

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

ITEM 11 / NEW BUSINESS

There was no new business.

ITEM 12 / ADJOURNMENT

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

FOR THE MOTION: Chairman McFall, Member Bryant

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

Meeting adjourned at 2:30 p.m., 06/29/2017

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

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

FINANCIAL REPORT

For the State Fiscal Year Ended June 30, 2017
Submitted to the CEO & Board

- Revenues for OHCA through June, accounting for receivables, were **$3,986,402,294** or **1.3% under** budget.
- Expenditures for OHCA, accounting for encumbrances, were **$4,002,172,607 or 1.6% under** budget.
- The state dollar budget variance through June is a **positive $11,953,866.**
- The budget variance is primarily attributable to the following (in millions):

Expenditures:		
Medicaid Program Variance		14.9
Administration		8.4
SFY 2018 Dedicated Carryover		(20.0)
Revenues:		
Drug Rebate		6.3
Taxes and Fees		0.1
Overpayments/Settlements		2.3
Total FY 17 Variance	**$**	**12.0**

ATTACHMENTS

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
For the Fiscal Year Ended June 30, 2017

REVENUES	FY17 Budget YTD	FY17 Actual YTD	Variance	% Over/ (Under)
State Appropriations	$ 1,007,923,715	$ 1,007,923,715	$ -	0.0%
Federal Funds	2,308,004,911	2,257,395,406	(50,609,506)	(2.2)%
Tobacco Tax Collections	48,824,405	49,541,128	716,723	1.5%
Quality of Care Collections	78,038,320	77,336,221	(702,099)	(0.9)%
Prior Year Carryover	27,584,042	27,584,042	-	0.0%
SFY 2018 Dedicated Carryover	-	(20,000,260)	(20,000,260)	100.0%
Federal Deferral - Interest	168,334	168,334	-	0.0%
Drug Rebates	289,921,061	305,682,952	15,761,891	5.4%
Medical Refunds	40,502,796	42,839,942	2,337,146	5.8%
Supplemental Hospital Offset Payment Program	220,309,661	220,309,661	-	0.0%
Other Revenues	17,531,073	17,621,153	90,080	0.5%
TOTAL REVENUES	**$ 4,038,808,318**	**$ 3,986,402,294**	**$ (52,406,024)**	**(1.3)%**

EXPENDITURES	FY17 Budget YTD	FY17 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	**$ 58,013,190**	**$ 51,250,093**	**$ 6,763,097**	**11.7%**
ADMINISTRATION - CONTRACTS	**$ 101,864,429**	**$ 86,330,370**	**$ 15,534,059**	**15.2%**
MEDICAID PROGRAMS				
Managed Care:				
SoonerCare Choice	41,144,343	42,017,858	(873,515)	(2.1)%
Acute Fee for Service Payments:				
Hospital Services	921,501,958	904,976,096	16,525,863	1.8%
Behavioral Health	19,882,016	20,288,086	(406,070)	(2.0)%
Physicians	427,103,707	411,224,989	15,878,718	3.7%
Dentists	128,588,912	126,957,229	1,631,683	1.3%
Other Practitioners	53,735,330	53,428,872	306,458	0.6%
Home Health Care	18,472,976	17,037,908	1,435,068	7.8%
Lab & Radiology	35,866,801	32,221,470	3,645,331	10.2%
Medical Supplies	47,146,589	48,608,724	(1,462,135)	(3.1)%
Ambulatory/Clinics	185,171,261	189,158,982	(3,987,721)	(2.2)%
Prescription Drugs	559,917,410	560,013,240	(95,829)	(0.0)%
OHCA Therapeutic Foster Care	62,636	(81,907)	144,543	0.0%
Other Payments:				
Nursing Facilities	560,565,843	551,179,702	9,386,141	1.7%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	62,034,311	61,096,850	937,461	1.5%
Medicare Buy-In	168,686,738	168,452,322	234,416	0.1%
Transportation	65,348,281	66,001,208	(652,926)	(1.0)%
Money Follows the Person-OHCA	353,369	232,376	120,994	0.0%
Electonic Health Records-Incentive Payments	18,554,088	18,554,088	-	0.0%
Part D Phase-In Contribution	99,112,467	99,411,265	(298,798)	(0.3)%
Supplemental Hospital Offset Payment Program	482,985,755	482,985,755	-	0.0%
Telligen	10,277,520	10,773,850	(496,330)	(4.8)%
Total OHCA Medical Programs	**3,906,512,314**	**3,864,538,961**	**41,973,353**	**1.1%**
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	**$ 4,066,479,315**	**$ 4,002,119,424**	**$ 64,359,891**	**1.6%**
REVENUES OVER/(UNDER) EXPENDITURES	**$ (27,670,997)**	**$ (15,717,130)**	**$ 11,953,866**	

OKLAHOMA HEALTH CARE AUTHORITY

Total Medicaid Program Expenditures
by Source of State Funds
For the Fiscal Year Ended June 30, 2017

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	$ 42,140,405	$ 42,006,127	$ -	$ 122,547	$ -	$ 11,731	$ -
Inpatient Acute Care	1,091,431,180	598,052,399	486,687	3,725,858	348,080,392	1,263,170	139,822,674
Outpatient Acute Care	415,158,056	301,220,915	41,604	4,589,989	105,394,228	3,911,320	
Behavioral Health - Inpatient	54,168,518	11,475,706	-	286,076	28,344,970	-	14,061,765
Behavioral Health - Psychiatrist	9,978,544	8,812,379	-	-	1,166,165	-	-
Behavioral Health - Outpatient	16,738,093	-	-	-	-	-	16,738,093
Behaviorial Health-Health Home	39,291,365	-	-	-	-	-	39,291,365
Behavioral Health Facility- Rehab	244,551,429	-	-	-	-	55,524	244,551,429
Behavioral Health - Case Management	18,310,841	-	-	-	-	-	18,310,841
Behavioral Health - PRTF	67,779,270	-	-	-	-	-	67,779,270
Behavioral Health-CCBHC	553,184	-	-	-	-	-	553,184
Residential Behavioral Management	16,645,365	-	-	-	-	-	16,645,365
Targeted Case Management	70,162,638	-	-	-	-	-	70,162,638
Therapeutic Foster Care	(81,907)	(81,907)	-	-	-	-	-
Physicians	473,740,988	406,511,643	58,101	(226,075)	-	4,655,245	62,742,074
Dentists	126,983,370	126,944,872	-	26,141	-	12,357	-
Mid Level Practitioners	2,739,950	2,712,785	-	25,616	-	1,549	-
Other Practitioners	51,141,863	50,173,643	446,364	427,325	-	94,531	-
Home Health Care	17,049,472	17,028,722	-	11,564	-	9,186	-
Lab & Radiology	33,010,159	31,992,017	-	788,689	-	229,453	-
Medical Supplies	48,880,653	45,867,517	2,711,532	271,929	-	29,675	-
Clinic Services	187,946,865	181,725,315	-	1,020,617	-	162,031	5,038,902
Ambulatory Surgery Centers	7,406,661	7,260,236	-	135,025	-	11,399	-
Personal Care Services	11,917,444	-	-	-	-	-	11,917,444
Nursing Facilities	551,179,702	338,041,633	213,138,069	-	-	-	-
Transportation	65,883,772	63,327,098	2,460,093	50,752	-	45,829	-
GME/IME/DME	141,787,176	-	-	-	-	-	141,787,176
ICF/IID Private	61,096,850	49,947,139	11,149,711	-	-	-	-
ICF/IID Public	12,916,226	-	-	-	-	-	12,916,226
CMS Payments	267,863,588	267,070,342	793,246	-	-	-	-
Prescription Drugs	573,266,703	557,657,158	-	13,253,463	-	2,356,082	-
Miscellaneous Medical Payments	168,188	168,188	-	-	-	-	-
Home and Community Based Waiver	201,337,476	-	-	-	-	-	201,337,476
Homeward Bound Waiver	81,553,902	-	-	-	-	-	81,553,902
Money Follows the Person	274,476	232,376	-	-	-	-	42,101
In-Home Support Waiver	25,135,590	-	-	-	-	-	25,135,590
ADvantage Waiver	186,731,259	-	-	-	-	-	186,731,259
Family Planning/Family Planning Waiver	4,800,380	-	-	-	-	-	4,800,380
Premium Assistance*	59,734,547	-	-	59,734,547	-	-	-
Telligen	10,773,850	10,773,850	-	-	-	-	-
Electronic Health Records Incentive Payments	18,554,088	18,554,088	-	-	-	-	-
Total Medicaid Expenditures	**$ 5,310,702,177**	**$ 3,137,474,240**	**$ 231,285,407**	**$ 84,244,064**	**$ 482,985,755**	**$ 12,849,082**	**$1,361,919,152**

* Includes $59,308,778.57 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY

Summary of Revenues & Expenditures:
Other State Agencies
For the Fiscal Year Ended June 30, 2017

		FY17 Actual YTD
REVENUE		
Revenues from Other State Agencies	$	582,766,836
Federal Funds		841,912,859
TOTAL REVENUES	**$**	**1,424,679,695**
EXPENDITURES		**Actual YTD**
Department of Human Services		
Home and Community Based Waiver	$	201,337,476
Money Follows the Person		42,101
Homeward Bound Waiver		81,553,902
In-Home Support Waivers		25,135,590
ADvantage Waiver		186,731,259
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public		12,916,226
Personal Care		11,917,444
Residential Behavioral Management		12,384,160
Targeted Case Management		61,043,571
Total Department of Human Services		**593,061,728**
State Employees Physician Payment		
Physician Payments		62,742,074
Total State Employees Physician Payment		**62,742,074**
Education Payments		
Graduate Medical Education		100,650,804
Graduate Medical Education - Physicians Manpower Training Commission		5,584,986
Indirect Medical Education		33,086,772
Direct Medical Education		2,464,614
Total Education Payments		**141,787,176**
Office of Juvenile Affairs		
Targeted Case Management		2,580,274
Residential Behavioral Management		4,261,204
Total Office of Juvenile Affairs		**6,841,479**
Department of Mental Health		
Case Management		18,310,841
Inpatient Psychiatric Free-standing		14,061,765
Outpatient		16,738,093
Health Homes		39,291,365
Psychiatric Residential Treatment Facility		67,779,270
Certified Community Behavioral Health Clinics		553,184
Rehabilitation Centers		244,551,429
Total Department of Mental Health		**401,285,947**
State Department of Health		
Children's First		1,587,599
Sooner Start		1,298,123
Early Intervention		4,287,590
Early and Periodic Screening, Diagnosis, and Treatment Clinic		857,391
Family Planning		196,961
Family Planning Waiver		4,580,532
Maternity Clinic		7,412
Total Department of Health		**12,815,607**
County Health Departments		
EPSDT Clinic		712,383
Family Planning Waiver		22,887
Total County Health Departments		**735,270**
State Department of Education		**164,229**
Public Schools		**499,376**
Medicare DRG Limit		**130,345,215**
Native American Tribal Agreements		**2,163,592**
Department of Corrections		**1,291,605**
JD McCarty		**8,185,855**
Total OSA Medicaid Programs	**$**	**1,361,919,152**
OSA Non-Medicaid Programs	**$**	**70,496,031**
Accounts Receivable from OSA	**$**	**7,735,488**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 205: Supplemental Hospital Offset Payment Program Fund

For the Fiscal Year Ended June 30, 2017

REVENUES	FY 17 Revenue
SHOPP Assessment Fee	$ 220,021,686
Federal Draws	290,660,688
Interest	203,422
Penalties	78,119
State Appropriations	(30,200,000)
TOTAL REVENUES	$ 480,763,915

EXPENDITURES	Quarter	Quarter	Quarter	Quarter	FY 17 Expenditures
Program Costs:	7/1/16 - 9/30/16	10/1/16 - 12/31/16	1/1/17 - 3/31/17	4/1/17 - 6/30/17	
Hospital - Inpatient Care	76,250,540	79,633,673	93,218,960	98,977,218	$ 348,080,392
Hospital -Outpatient Care	27,213,505	28,255,867	24,287,348	25,637,507	105,394,228
Psychiatric Facilities-Inpatient	6,661,677	6,824,842	7,283,757	7,574,695	28,344,970
Rehabilitation Facilities-Inpatient	257,683	269,149	310,447	328,886	1,166,165
Total OHCA Program Costs	110,383,405	114,983,531	125,100,513	132,518,306	$ 482,985,755
Total Expenditures					$ 482,985,755

CASH BALANCE	
	$ (2,221,840)

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
For the Fiscal Year Ended June 30, 2017

REVENUES	Total Revenue	State Share
Quality of Care Assessment	$ 77,301,569	$ 77,301,569
Interest Earned	34,652	34,652
TOTAL REVENUES	**$ 77,336,221**	**$ 77,336,221**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
Nursing Facility Rate Adjustment	$ 209,503,269	$ 83,382,301	
Eyeglasses and Dentures	272,340	108,391	
Personal Allowance Increase	3,362,460	1,338,259	
Coverage for Durable Medical Equipment and Supplies	2,711,532	1,079,190	
Coverage of Qualified Medicare Beneficiary	1,032,756	411,037	
Part D Phase-In	793,246	315,712	
ICF/IID Rate Adjustment	5,204,890	2,071,546	
Acute Services ICF/IID	5,944,822	2,366,039	
Non-emergency Transportation - Soonerride	2,460,093	979,117	
Total Program Costs	**$ 231,285,407**	**$ 92,051,592**	**$ 92,051,592**
Administration			
OHCA Administration Costs	$ 546,620	$ 273,310	
DHS-Ombudsmen	235,030	235,030	
OSDH-Nursing Facility Inspectors	520,125	520,125	
Mike Fine, CPA	19,200	9,600	
Total Administration Costs	**$ 1,320,975**	**$ 1,038,065**	**$ 1,038,065**
Total Quality of Care Fee Costs	**$ 232,606,382**	**$ 93,089,657**	
TOTAL STATE SHARE OF COSTS			**$ 93,089,657**

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

Fund 245: Health Employee and Economy Improvement Act Revolving Fund

For the Fiscal Year Ended June 30, 2017

REVENUES	FY 16 Carryover	FY 17 Revenue	Total Revenue
Prior Year Balance	$ 5,199,281	$ -	$ 3,102,480
State Appropriations	(2,000,000)	-	-
Tobacco Tax Collections	-	40,746,938	40,746,938
Interest Income	-	123,437	123,437
Federal Draws	246,145	37,324,712	37,324,712
TOTAL REVENUES	**$ 3,445,426**	**$ 78,195,087**	**$ 81,297,567**

EXPENDITURES		FY 16 Expenditures	FY 17 Expenditures	Total $ YTD
Program Costs:				
	Employer Sponsored Insurance		$ 59,308,779	$ 59,308,779
	College Students/ESI Dental		425,769	169,456
Individual Plan				
	SoonerCare Choice		$ 118,068	$ 46,991
	Inpatient Hospital		3,707,497	1,475,584
	Outpatient Hospital		4,535,130	1,804,982
	BH - Inpatient Services-DRG		274,104	109,093
	BH -Psychiatrist		-	-
	Physicians		(204,757)	(81,493)
	Dentists		25,963	10,333
	Mid Level Practitioner		25,460	10,133
	Other Practitioners		420,612	167,404
	Home Health		9,723	3,870
	Lab and Radiology		771,169	306,925
	Medical Supplies		261,153	103,939
	Clinic Services		998,391	397,359
	Ambulatory Surgery Center		128,938	51,317
	Prescription Drugs		13,066,711	5,200,551
	Transportation		50,075	19,930
	Premiums Collected		-	(573,670)
Total Individual Plan			**$ 24,188,238**	**$ 9,053,249**
	College Students-Service Costs		**$ 321,279**	**$ 127,869**
Total OHCA Program Costs			**$ 84,244,064**	**$ 68,659,353**
Administrative Costs				
	Salaries	$ 32,930	$ 2,095,108	$ 2,128,038
	Operating Costs	15,971	254,814	270,785
	Health Dept-Postponing	-	-	-
	Contract - HP	294,045	1,968,784	2,262,829
Total Administrative Costs		**$ 342,946**	**$ 4,318,706**	**$ 4,661,652**
Total Expenditures				**$ 73,321,005**
NET CASH BALANCE		**$ 3,102,480**		**$ 7,976,563**

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

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

For the Fiscal Year Ended June 30, 2017

REVENUES	FY 17 Revenue	State Share
Tobacco Tax Collections	$ 813,020	$ 813,020
TOTAL REVENUES	**$ 813,020**	**$ 813,020**

EXPENDITURES	FY 17 Total $ YTD	FY 17 State $ YTD	Total State $ Cost
Program Costs			
SoonerCare Choice	$ 11,731	$ 3,268	
Inpatient Hospital	1,263,170	351,919	
Outpatient Hospital	3,911,320	1,089,694	
Inpatient Services-DRG	-	-	
Psychiatrist	-	-	
TFC-OHCA	-	-	
Nursing Facility	-	-	
Physicians	4,655,245	1,296,951	
Dentists	12,357	3,443	
Mid-level Practitioner	1,549	431	
Other Practitioners	94,531	26,336	
Home Health	9,186	2,559	
Lab & Radiology	229,453	63,926	
Medical Supplies	29,675	8,268	
Clinic Services	162,031	45,142	
Ambulatory Surgery Center	11,399	3,176	
Prescription Drugs	2,356,082	656,404	
Transportation	43,076	12,001	
Miscellaneous Medical	2,753	767	
Total OHCA Program Costs	**$ 12,793,558**	**$ 3,564,285**	
OSA DMHSAS Rehab	$ 55,524	$ 15,469	
Total Medicaid Program Costs	**$ 12,849,082**	**$ 3,579,754**	
TOTAL STATE SHARE OF COSTS			**$ 3,579,754**

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

OHCA Board Meeting
August, 2017
(June 2017 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

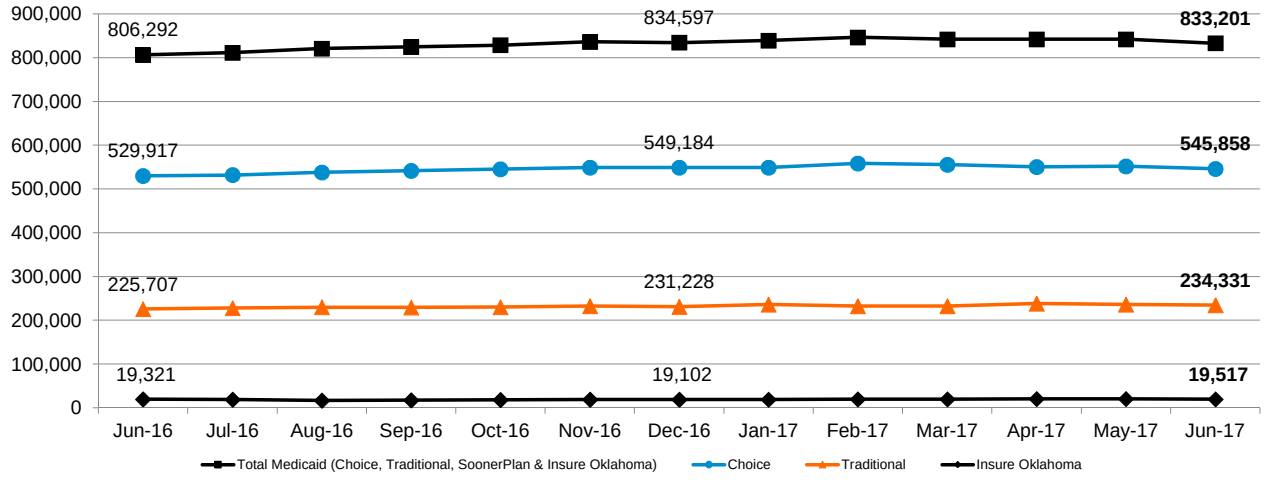
Delivery System			Enrollment June 2017	Children June 2017	Adults June 2017	Enrollment Change	Total Expenditures June 2017	PMPM June 2017	Forecasted June 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**545,858**	**450,339**	**95,519**	**-5,971**	**$137,241,339**		
	Lower Cost	*(Children/Parents; Other)*	501,869	436,320	65,549	-5,978	$98,738,181	$197	$208
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	43,989	14,019	29,970	7	$38,503,158	$875	$923
SoonerCare Traditional			**234,331**	**87,765**	**146,566**	**-1,883**	**$174,408,039**		
	Lower Cost	*(Children/Parents; Other)*	120,678	82,861	37,817	-1,897	$37,933,602	$314	$434
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	113,653	4,904	108,749	14	$136,474,437	$1,201	$1,258
SoonerPlan			**33,495**	**2,758**	**30,737**	**-1,025**	**$318,006**	$9	$9
Insure Oklahoma			**19,517**	**505**	**19,012**	**-95**	**$6,755,189**		
	Employer-Sponsored Insurance		14,449	329	14,120	-249	$4,825,065	$334	$326
	Individual Plan		5,068	176	4,892	154	$1,930,124	$381	$421
TOTAL			**833,201**	**541,367**	**291,834**	**-8,974**	**$318,722,573**		

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

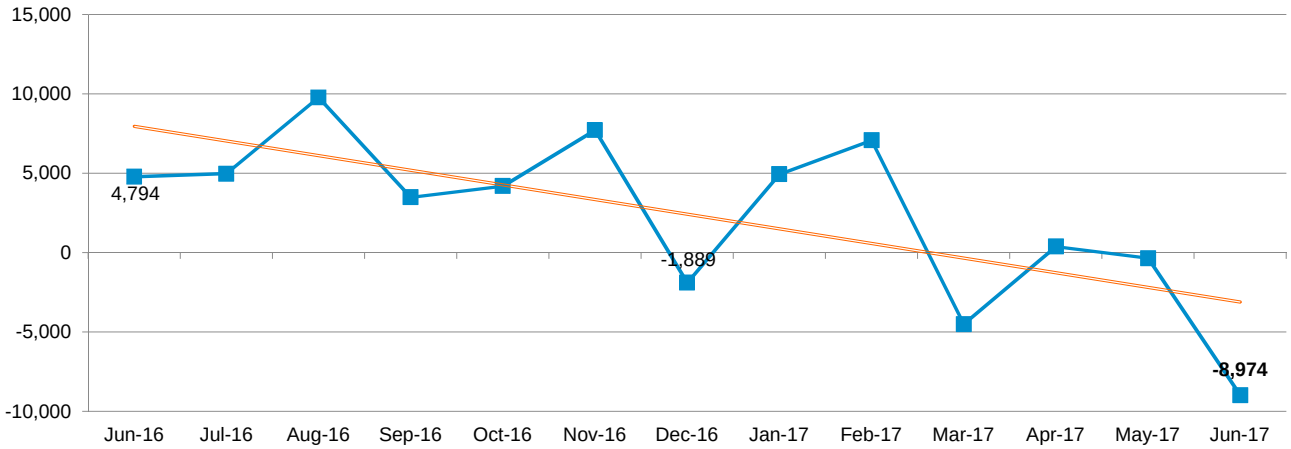
Total In-State Providers: 34,588 (-148) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs	PCMH
9,372	973	1,295	188	6,527	561	387	6,703	2,654

ENROLLMENT BY MONTH

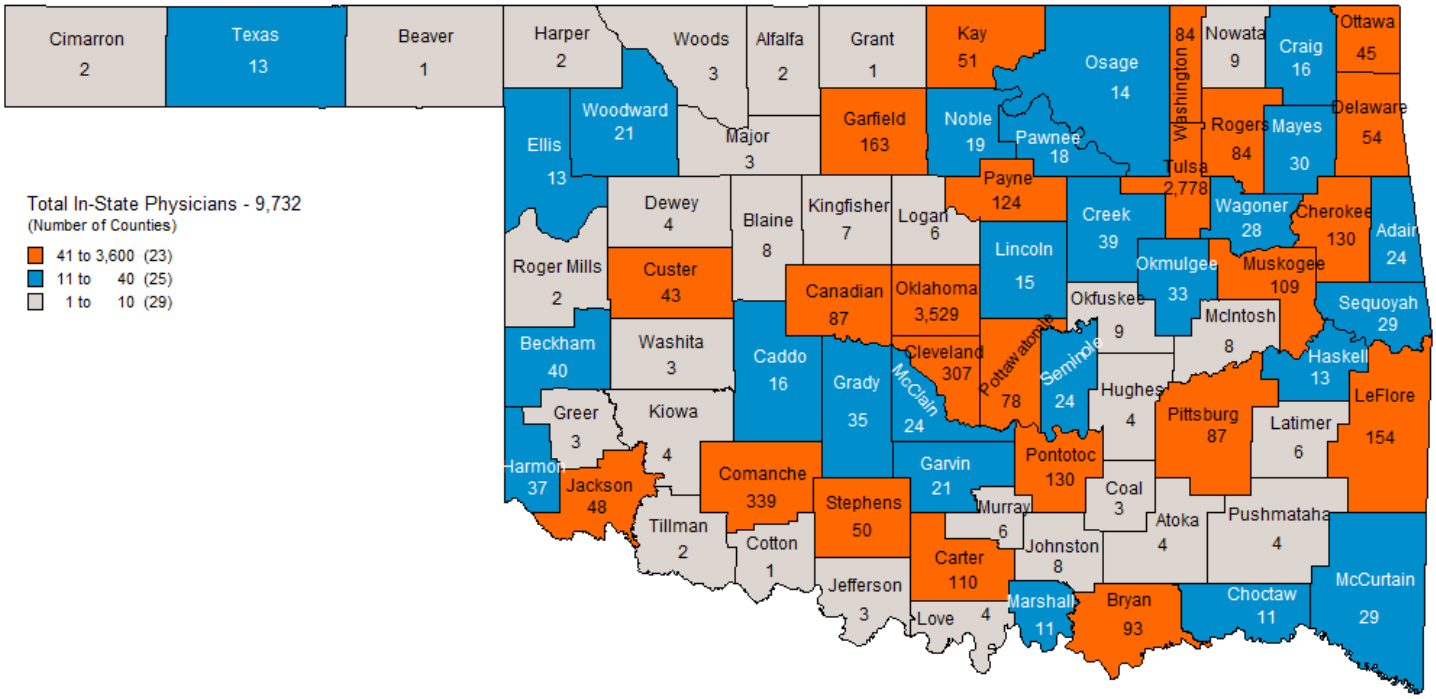


MONTHLY CHANGE IN ENROLLMENT



Includes Insure Oklahoma.

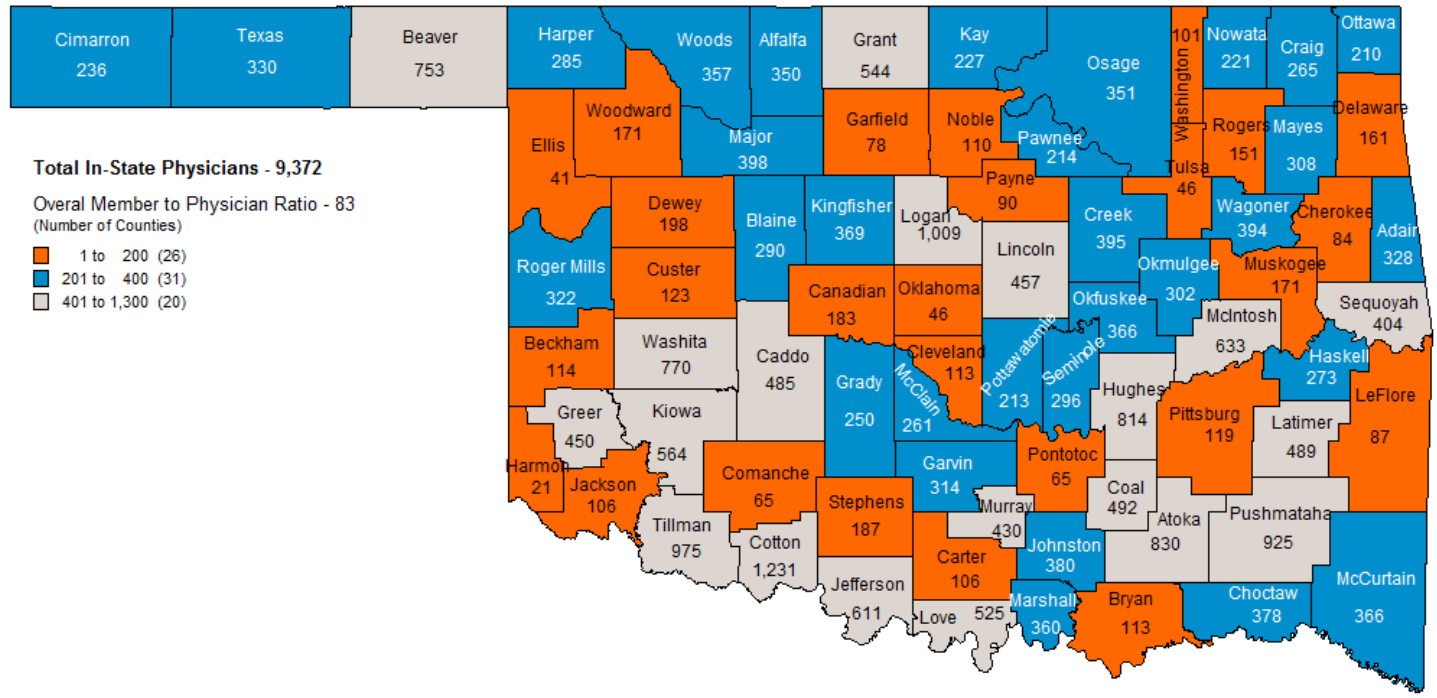
Physician by County - June 2017



Total In-State Physicians - 9,732
(Number of Counties)

- 41 to 3,600 (23)
- 11 to 40 (25)
- 1 to 10 (29)

Member to Physician Ratio - June 2017



Total In-State Physicians - 9,372

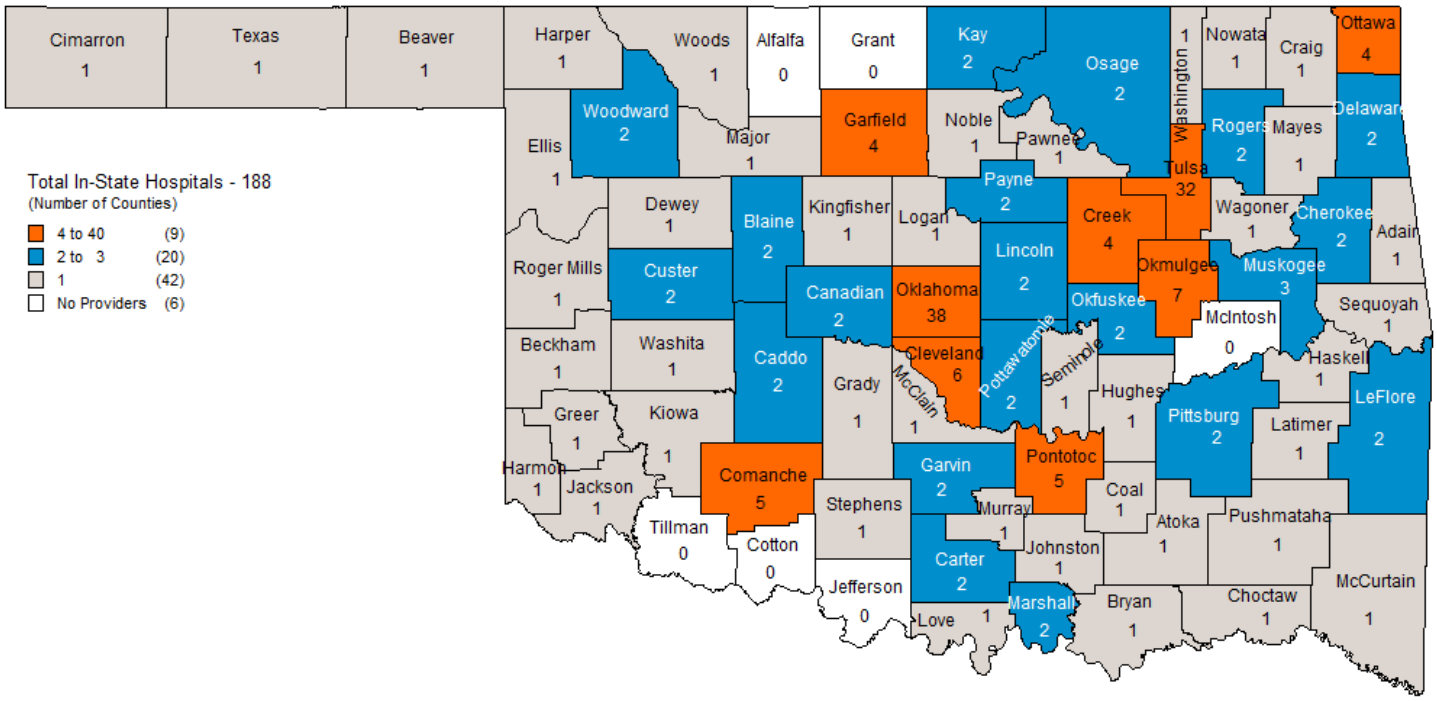
Overal Member to Physician Ratio - 83
(Number of Counties)

- 1 to 200 (26)
- 201 to 400 (31)
- 401 to 1,300 (20)

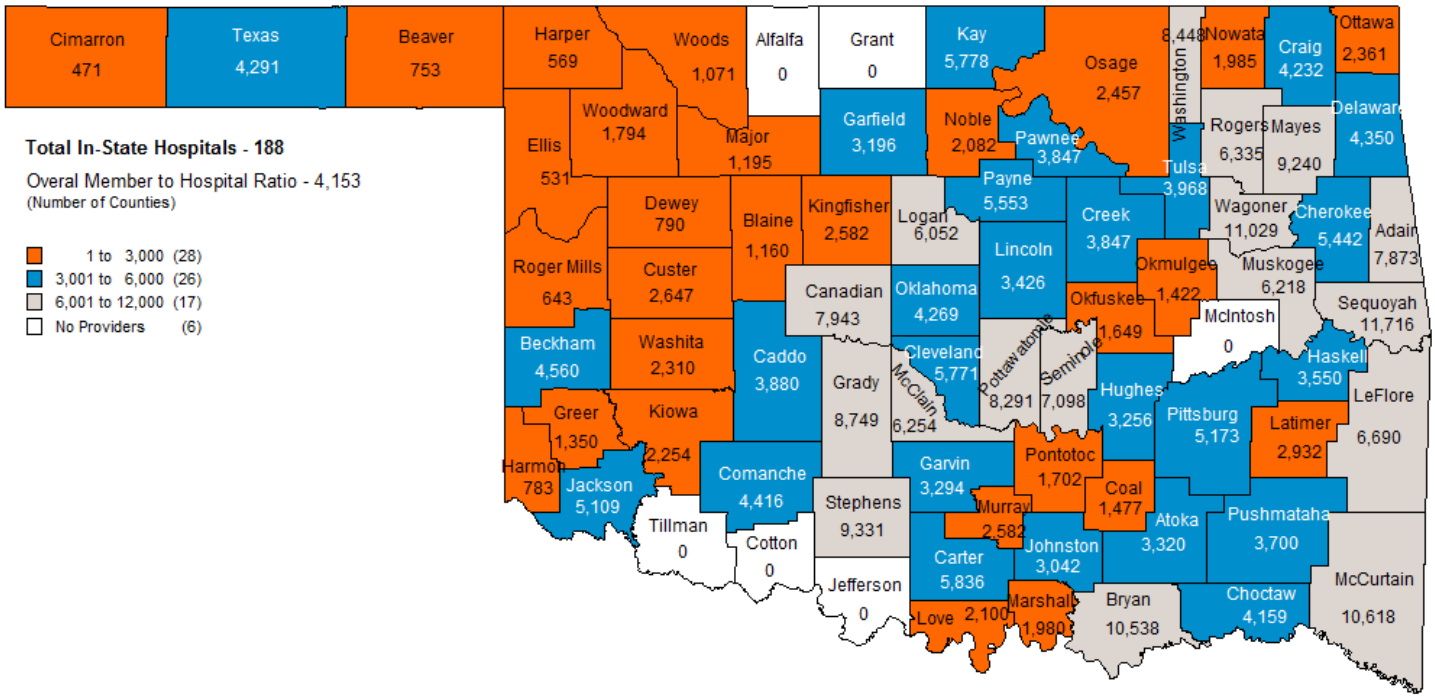
Includes in-state providers only. Excludes 6,984 out-of-state physicians. Excludes Insure Oklahoma and Family Planning members.
Physician counts based on Physician provider type.

7/31/2017

Hospitals by County - June 2017



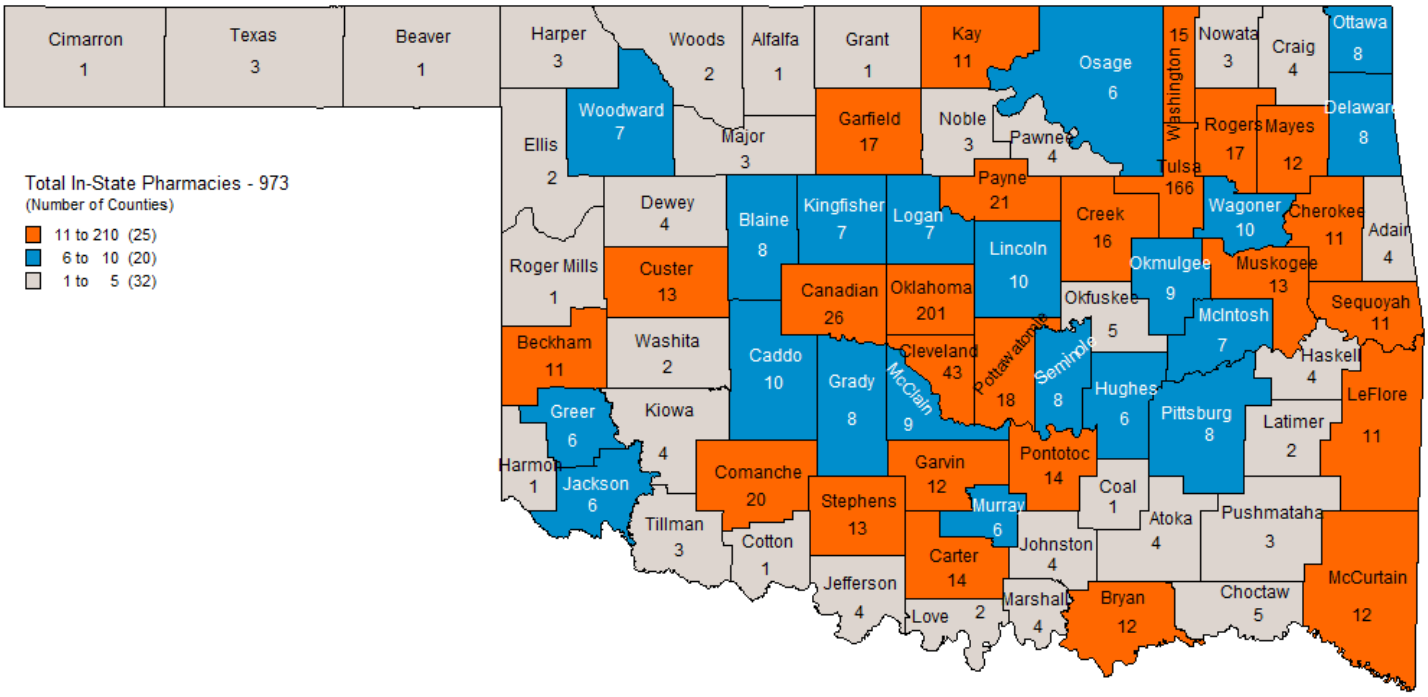
Member to Hospital Ratio - June 2017



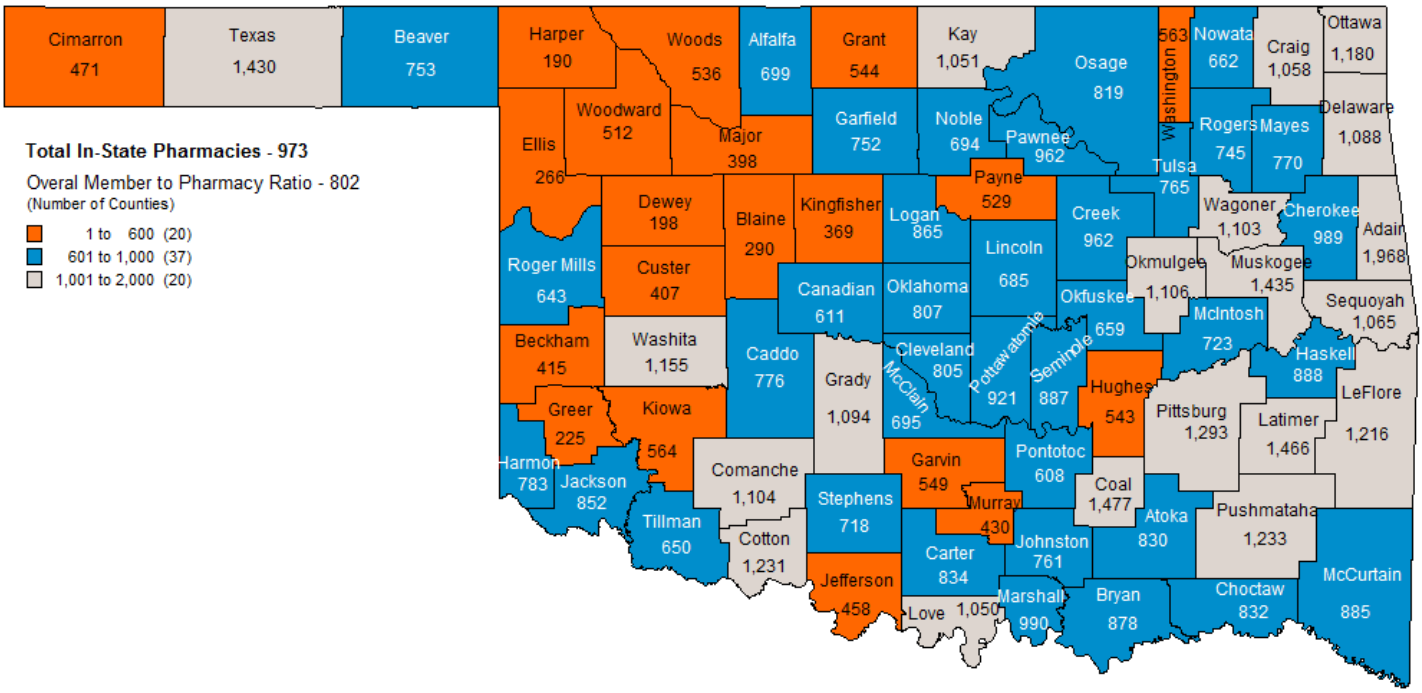
Includes in-state providers only. Excludes 458 out-of-state hospitals. Excludes Insure Oklahoma and Family Planning members.
Hospital counts based on Hospital provider type.

7/31/2017

Pharmacy by County - June 2017



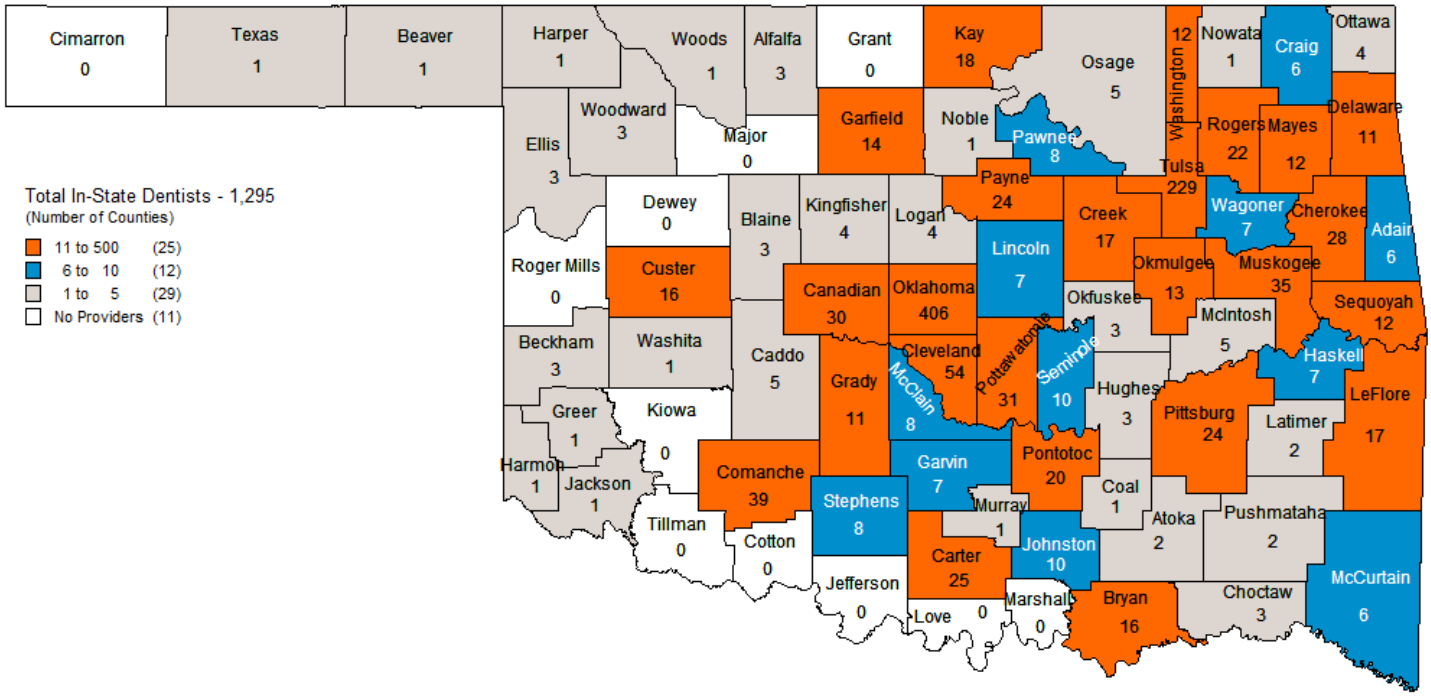
Member to Pharmacy Ratio - June 2017



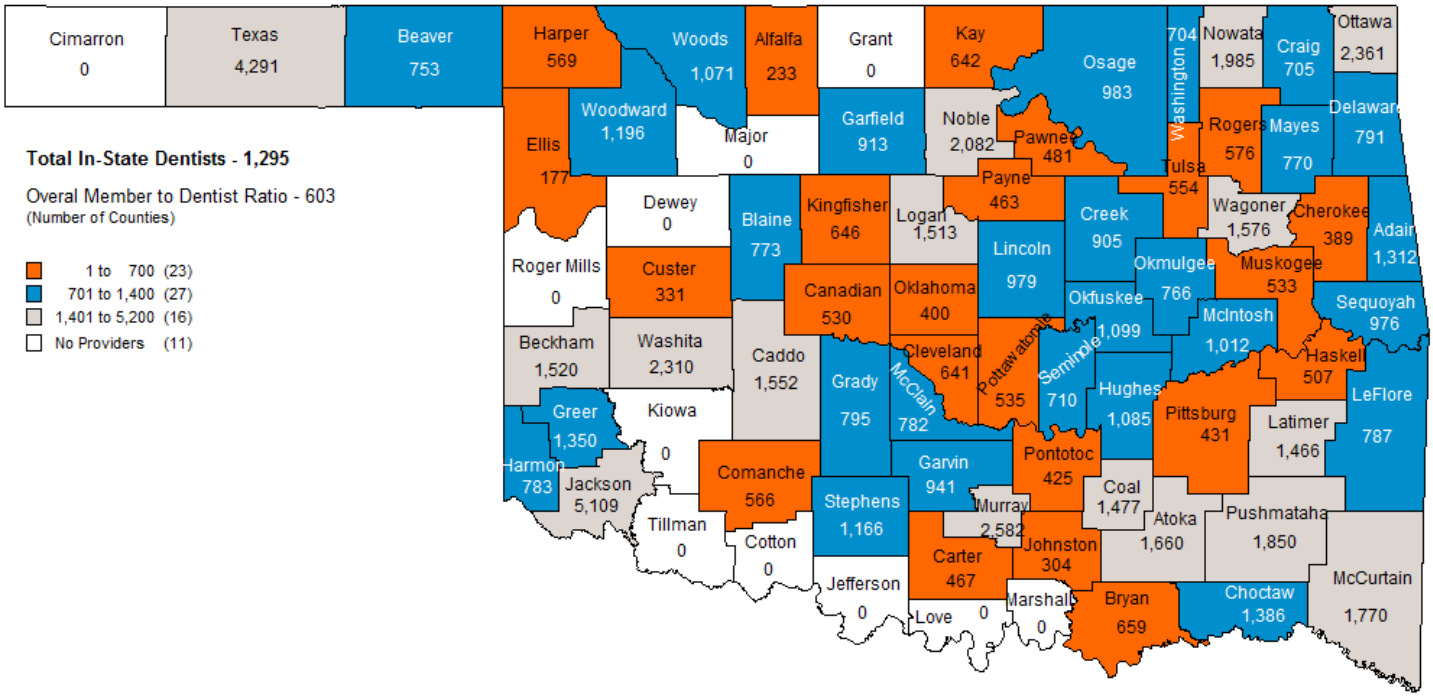
Includes in-state providers only. Excludes 368 out-of-state pharmacies. Excludes Insure Oklahoma and Family Planning members.
Pharmacy counts based on Pharmacy provider type.

7/31/2017

Dentists by County - June 2017



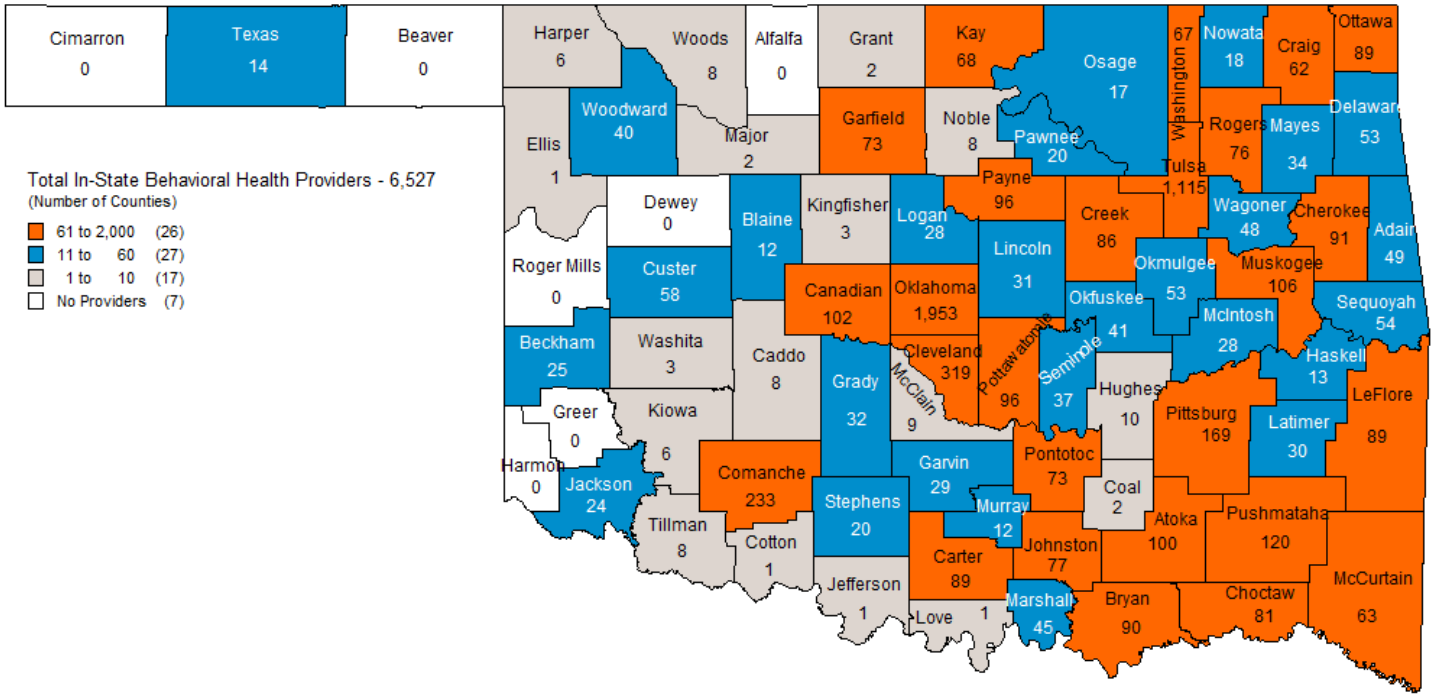
Member to Dentist Ratio - June 2017



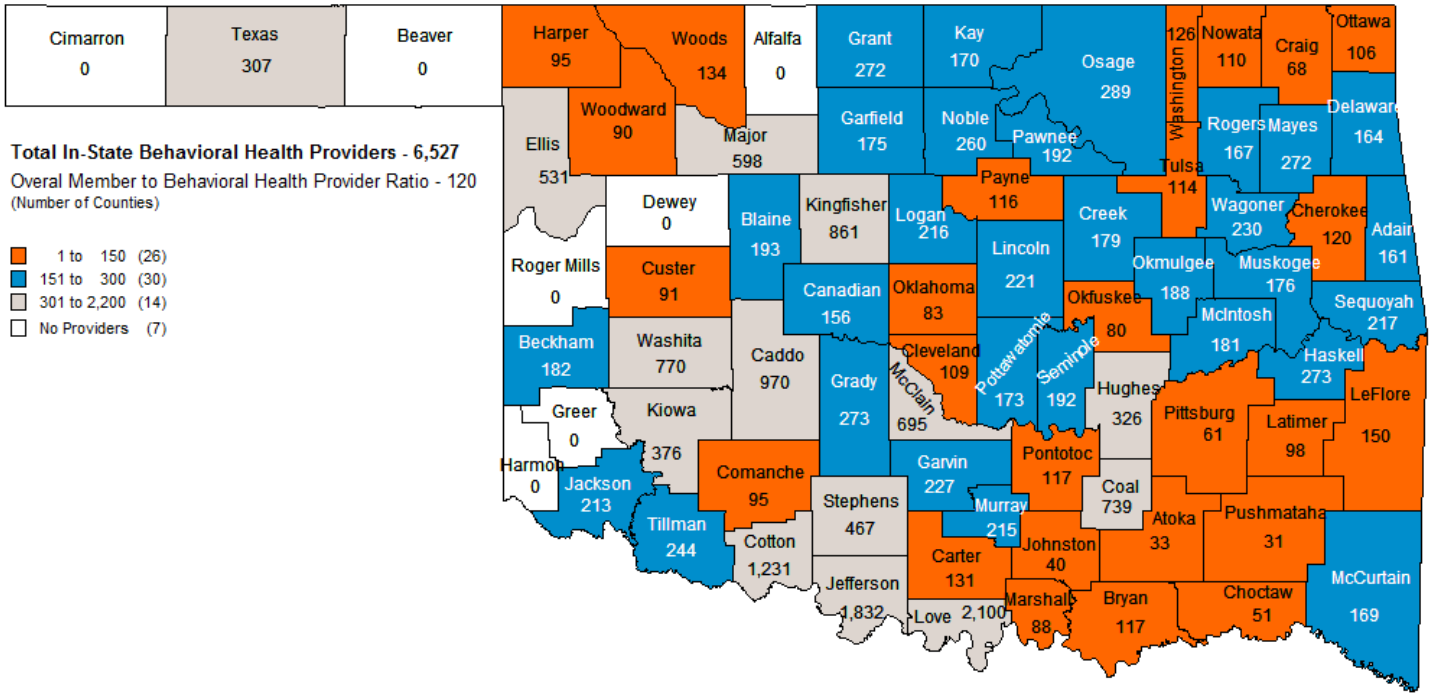
Includes in-state providers only. Excludes 258 out-of-state dentists. Excludes Insure Oklahoma and Family Planning members.
Dentist counts based on Dentist provider type.

7/24/2017

Behavioral Health Providers by County - June 2017



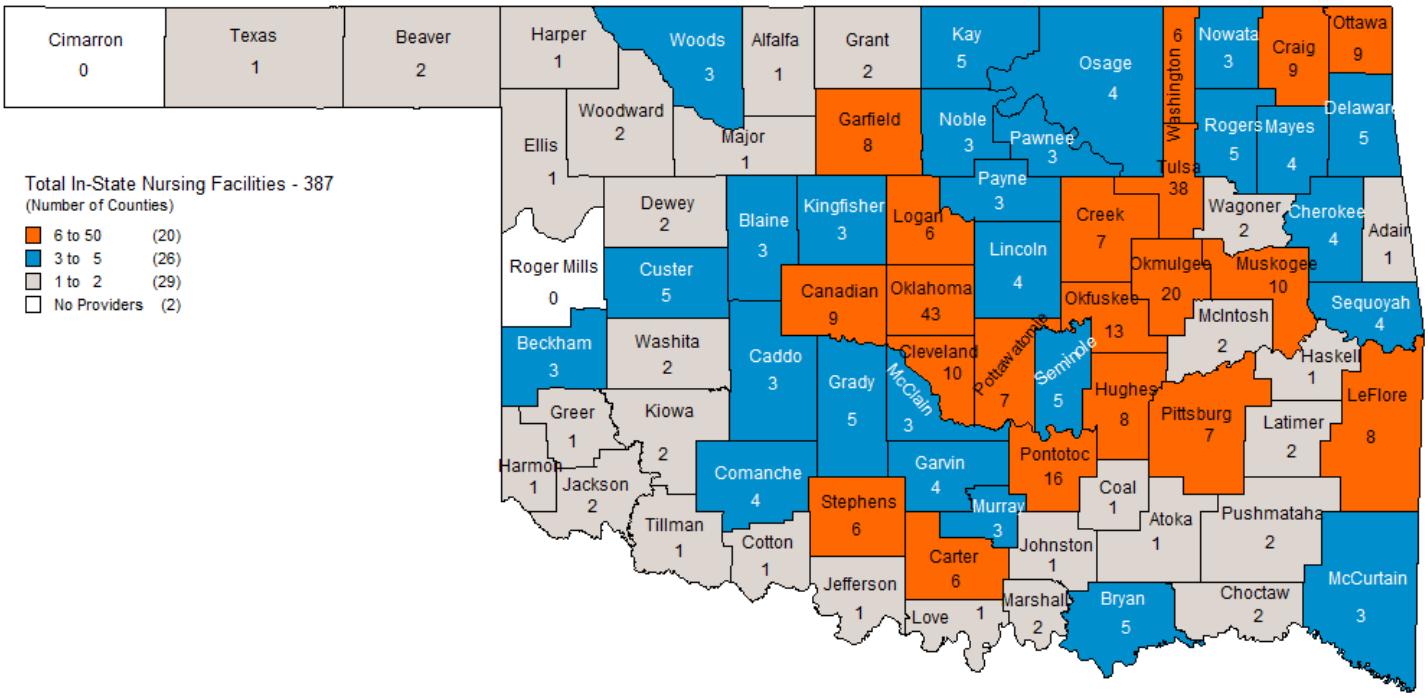
Member to Behavioral Health Provider Ratio - June 2017



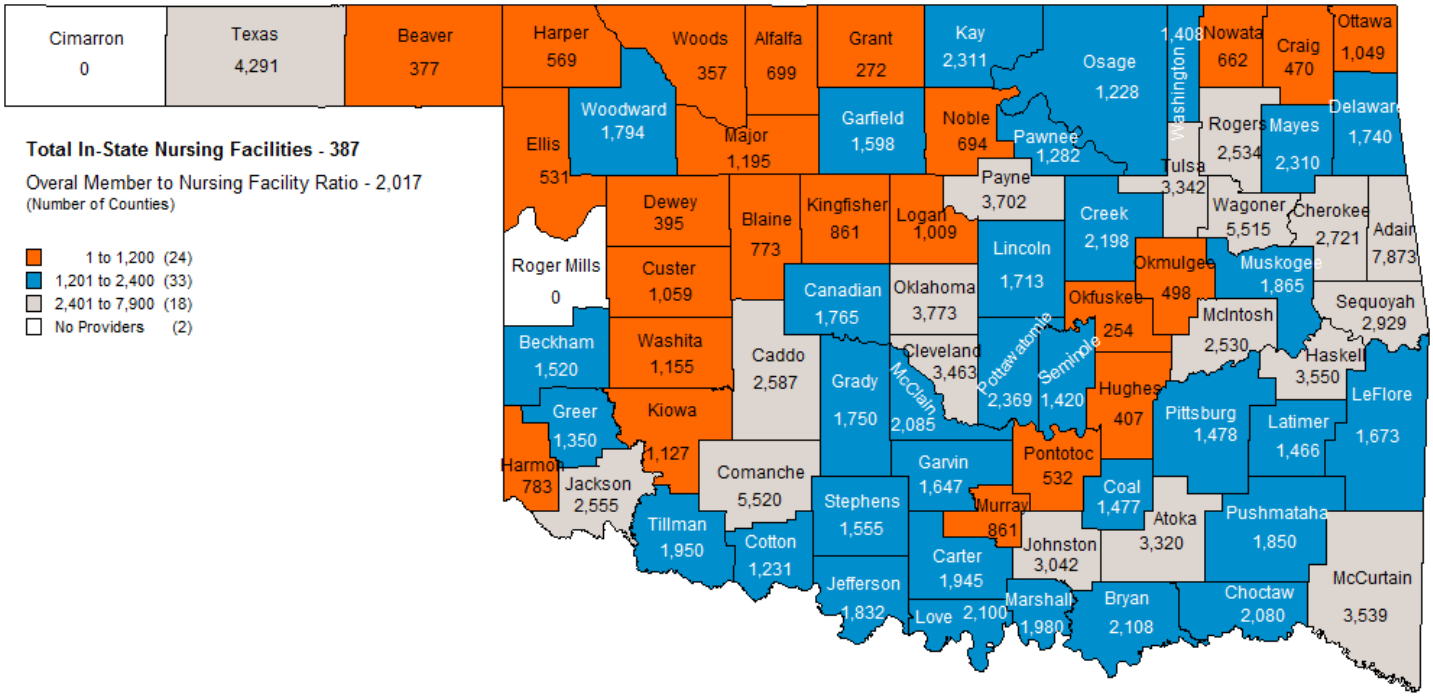
Includes in-state providers only. Excludes 77 out-of-state behavioral health providers. Excludes Insure Oklahoma and Family Planning members.
Behavioral Health Provider counts based on Behavioral Health Provider provider type.

7/31/2017

Nursing Facility by County - June 2017



Member to Nursing Facility Ratio - June 2017



Includes in-state providers only. Excludes 1 out-of-state nursing facility. Excludes Insure Oklahoma and Family Planning members.
Nursing Facility counts based on Extended Care Facility provider type.

7/31/2017

Oklahoma HealthCare Authority

SoonerCare Health Management Program and Chronic Care Unit

August 24, 2017

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 home-based and telephonic coaching to embedded coaches in select PCMH practices
- Practice facilitation and education for PCMH 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

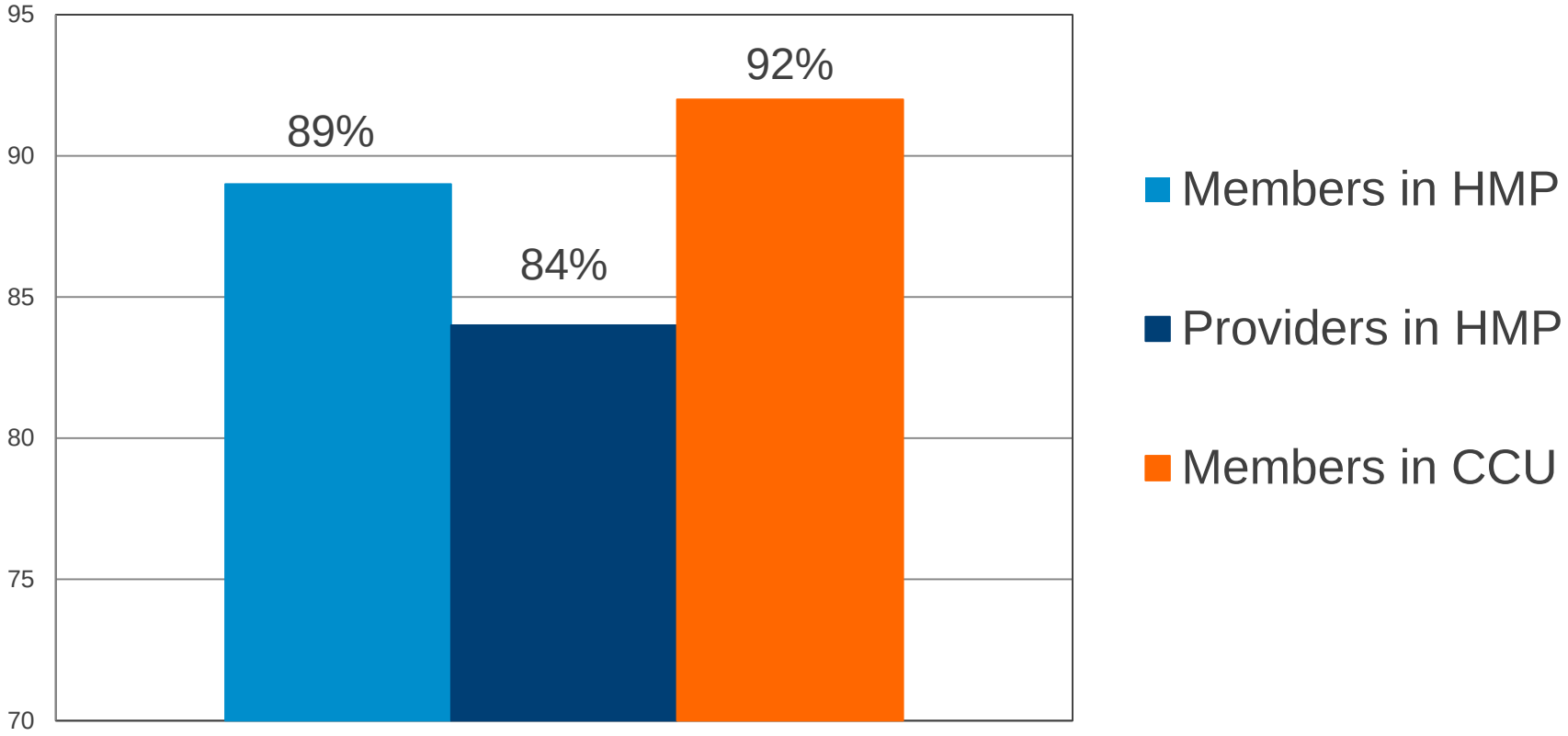
Improve provider management of patients with chronic conditions

HMP/CCU Outcomes

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

SFY2016 Satisfaction

"Very Satisfied" with HMP/CCU

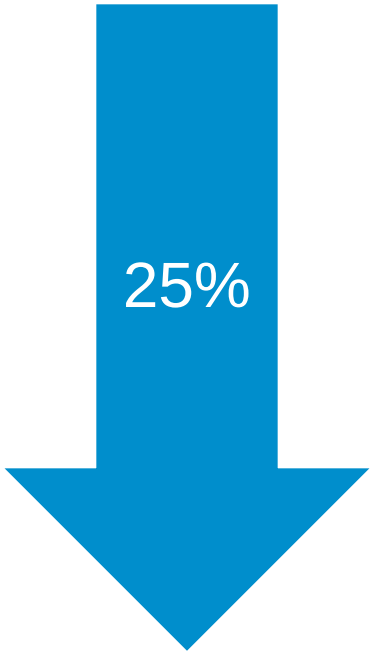


SFY2016 Quality of Care

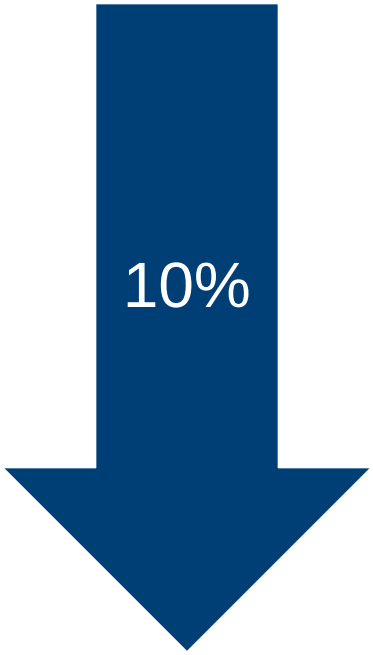
- Participants exceeded comparison group on disease specific HEDIS measures
  - Most impressive results were for members with diabetes
  - Continue to see improvement over previous year(s)

SFY2016 ED Utilization

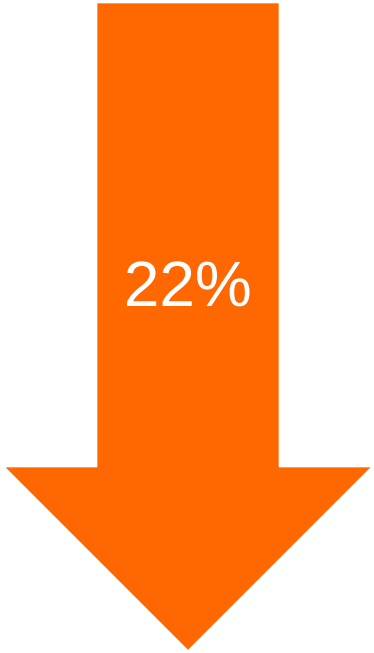
Health Coaching Participants



Members in PCMH with PF

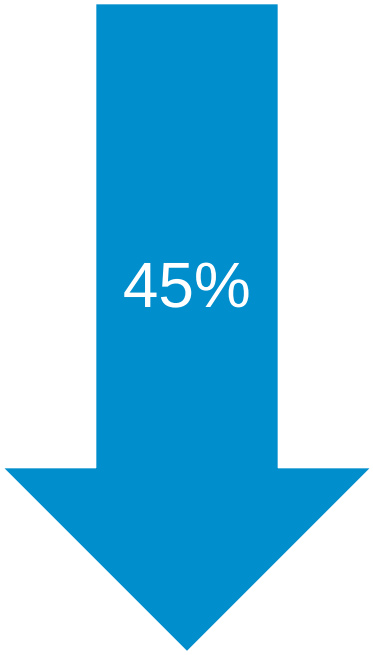


CCU Participants

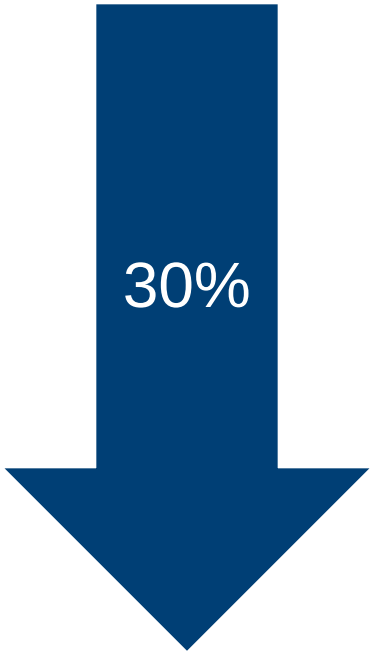


SFY2016 Inpatient Utilization

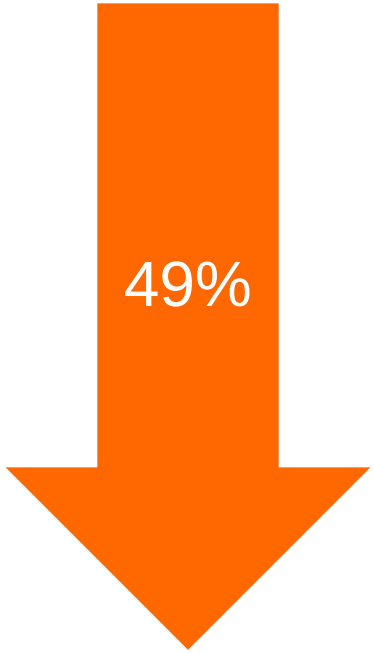
Health Coaching Participants



Members in PCMH with PF



CCU Participants



SFY2016 HMP Cost-effectiveness

Component	Medical Savings	Administrative Costs	Net Savings	Return on Investment
Health Coaching	$43,426,275	($16,447,017)	$26,979,258	164.0%
Practice Facilitation	$55,615,587	($9,956,360)	$45,659,227	458.6%
TOTAL	**$99,041,862**	**($26,403,377)**	$72,638,485	**275.1%**

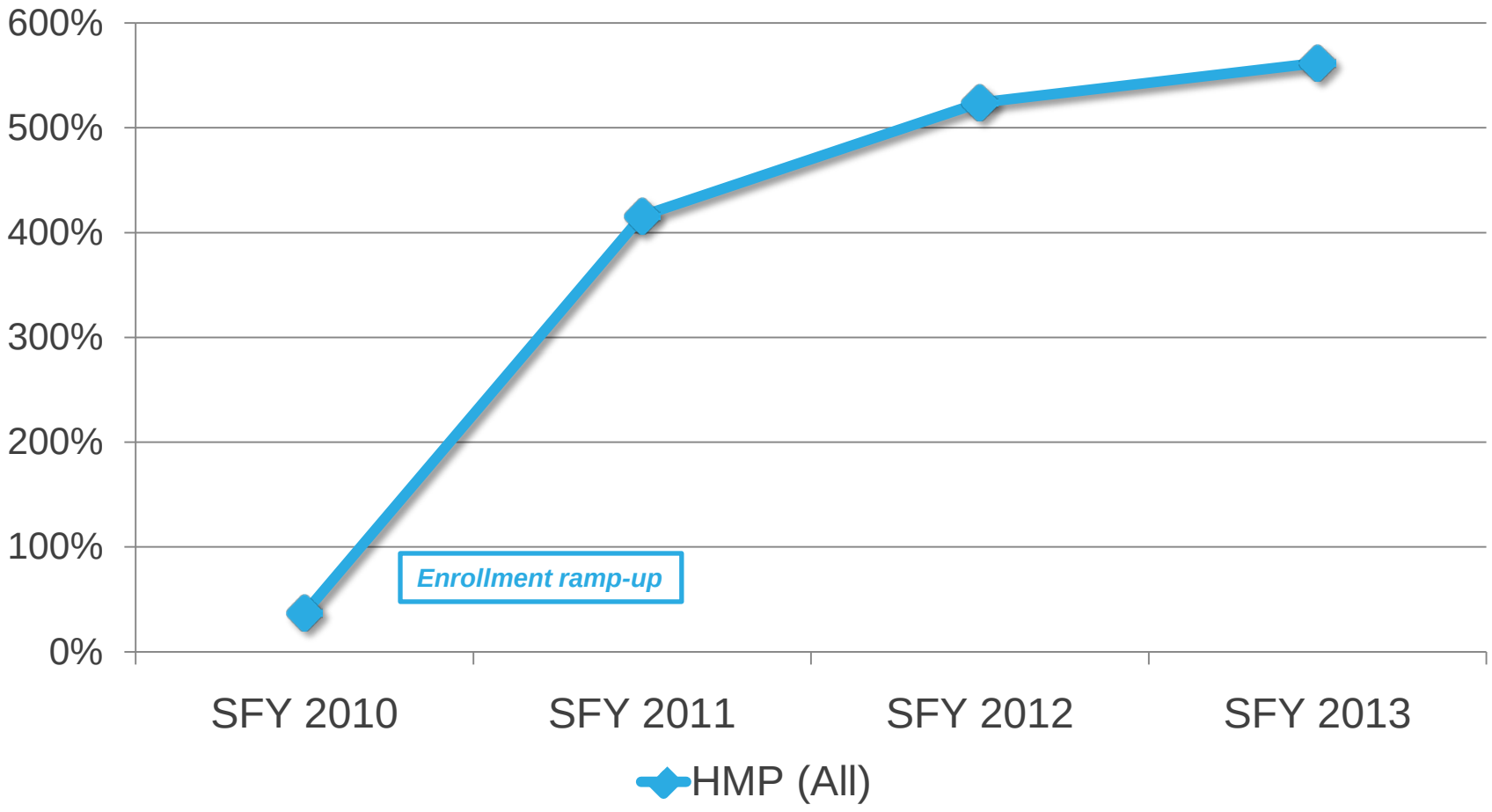
- Health coaching
  - Decrease in all service areas except pharmacy
- Practice facilitation
  - Increase in outpatient hospital and pharmacy services

SFY2016 CCU Cost-effectiveness

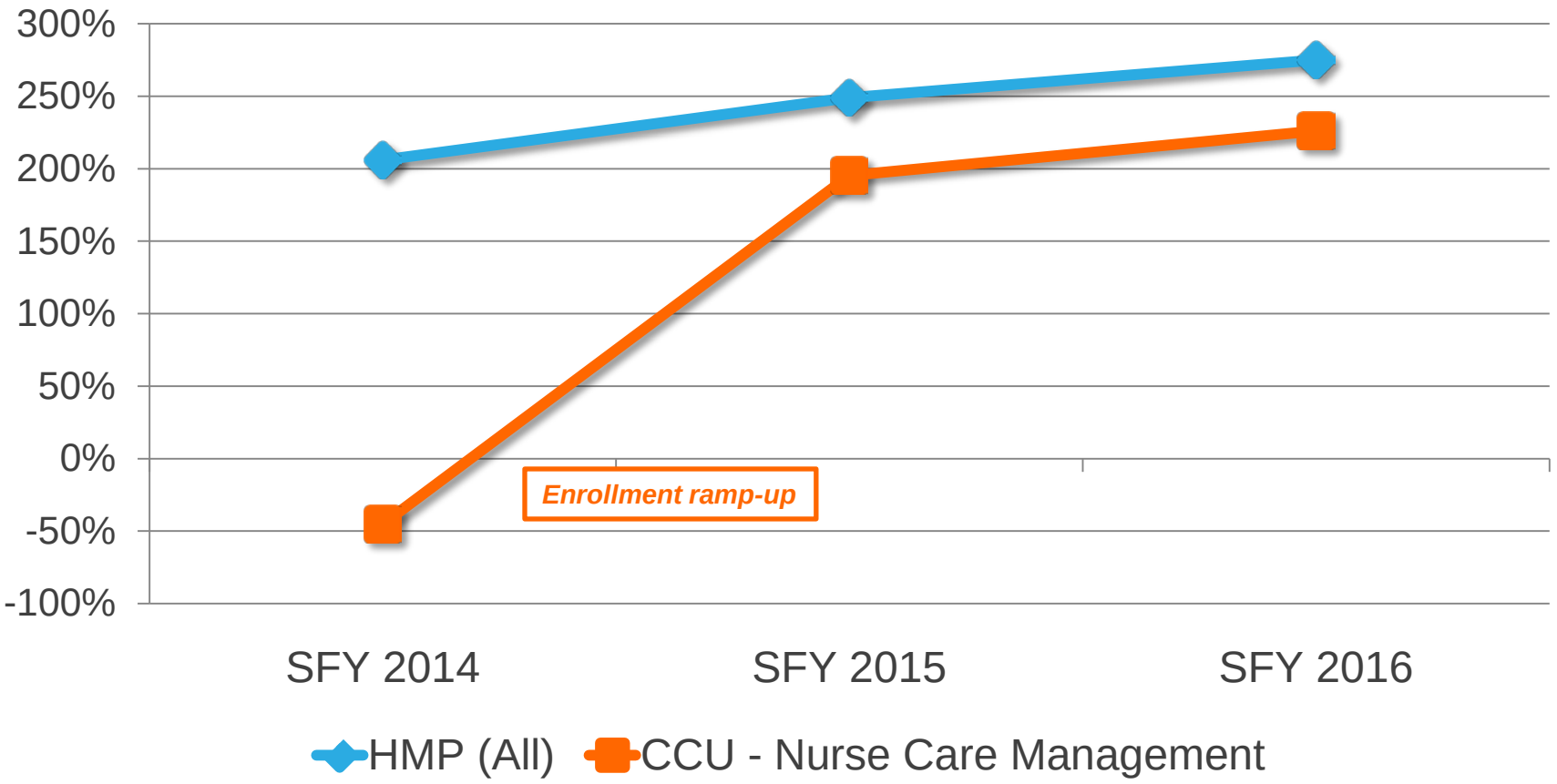
Medical Savings	Administrative Costs	Net Savings	Return on Investment
$6,218,873	($1,906,809)	$4,312,064	**226.1%**

- Decrease in all services types with inpatient and outpatient hospital costs registering the greatest drop

HMP ROI – First Generation



HMP and CCU ROI – Second Generation HMP



Contact:

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For more information and the full report visit:

www.okhca.org/PCM

www.okhca.org/studies

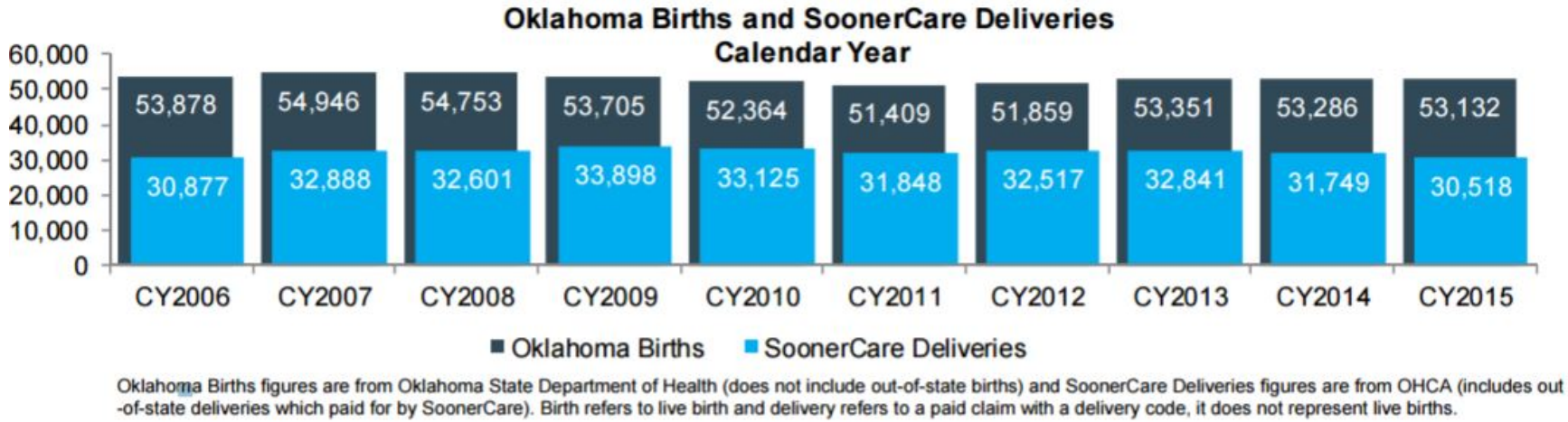
Oklahoma HealthCare Authority

Obstetric Outreach

August 24, 2017/OHCA Board Presentation

Shelly Patterson

SoonerCare and Pregnancy



Oklahoma Births figures are from Oklahoma State Department of Health (does not include out-of-state births) and SoonerCare Deliveries figures are from OHCA (includes out-of-state deliveries which paid for by SoonerCare). Birth refers to live birth and delivery refers to a paid claim with a delivery code, it does not represent live births.

Source: SoonerCare Delivery Fast Facts, October 20, 2016

Risk Identification

Health Risk Assessment

- Voluntary health assessment
- Pregnant members
  - ***Has this member been told they are having problems with this pregnancy?***
  - ***Has this member had problems with a previous pregnancy?***
  - "Yes" response = referral to Population Care Management (PCM)

Pregnant Member Letters

- Recently enrolled pregnant women
  - Education and linkage
  - Identify potential risks for negative birth outcomes
    - ***Has a doctor ever told you that you have diabetes?***
    - ***Have you had any health problems or postpartum depression with a previous pregnancy?***
    - "Yes" response = Referral to OHCA Population Care Management

Tobacco Cessation

- Health risk assessment and pregnant member outreach letters
  - ***Have you smoked cigarettes in the past year?***
  - ***Would you like FREE telephone counseling from the Oklahoma Tobacco Helpline?***

Outreach

Population Care Management

- **Case management services**
  - Assessment
  - Care planning
  - Patient education
  - Care coordination

PCM Initiatives

- **Pregnant members**
  - **High Risk OB—Identified maternal or fetal high risk conditions**
  - **At-risk OB—Members at risk for poor outcomes**

- **Target populations**

  Counties: Atoka, Choctaw, Coal, Garfield, Grant, Greer, Latimer, Lincoln, Jackson, Major, Marshall, McIntosh, and Tillman
  - **Interconception Care—Adolescent mothers**
  - **Infant Mortality Reduction—Infant Care Management**

Health Communication

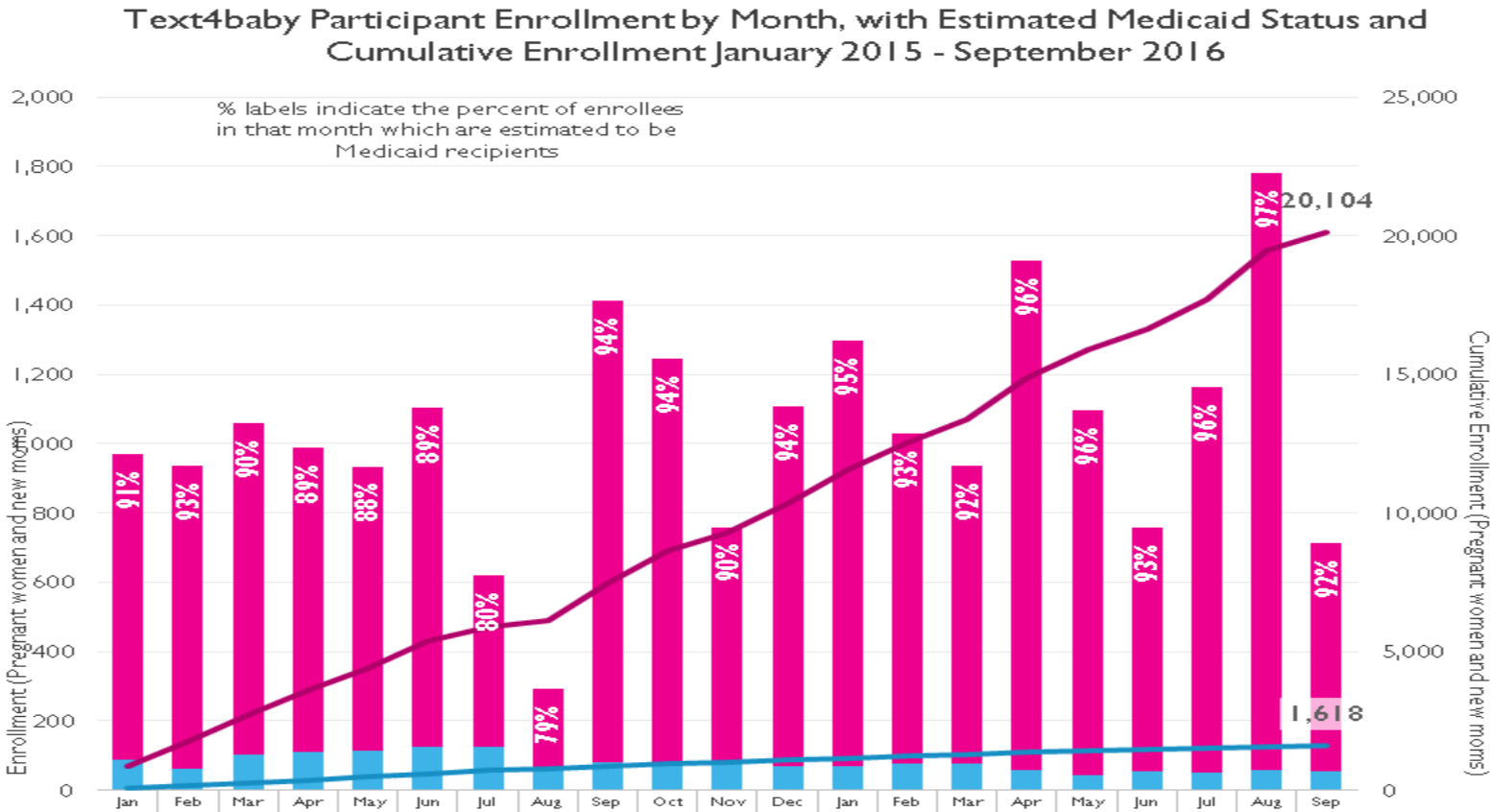
Text for Baby (T4B)

- **Digital support service for pregnancy and baby's first year**
- **English and Spanish**
- **Three messages per week**
- **Changes in mother's knowledge and behavior**
  - Prenatal and postpartum care visits
  - Well-baby visits
  - Immunization

text4baby℠

Text for Baby (T4B)

Oklahoma



	Jan 2015	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan 2016	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Est Medicaid Enrollment	882	875	956	878	821	976	495	230	1,335	1,174	682	1,039	1,227	954	862	1,466	1,053	704	1,113	1,724	658
Est Non Medicaid Enrollment	87	61	101	111	113	126	124	61	78	72	77	69	70	76	75	60	43	52	51	57	54
Cumulative Est Medicaid	882	1,757	2,713	3,591	4,412	5,388	5,884	6,113	7,448	8,622	9,304	10,344	11,570	12,524	13,386	14,853	15,906	16,609	17,722	19,447	20,104
Cumulative Est Non-Medicaid	87	148	249	360	473	599	722	784	862	934	1,011	1,079	1,150	1,226	1,301	1,360	1,403	1,456	1,507	1,563	1,618

Contact

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Provider/Medical Home Services

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August Board
Proposed Rule Changes

Face to face tribal consultations regarding the following proposed rule changes were held Tuesday, May 23, 2017 and Tuesday, July 11, 2017 in the Board Room of the Oklahoma Health Care Authority (OHCA). The proposed rule changes were presented to the Medical Advisory Committee on Thursday, July 20, 2017.

APA work folders 17-05 A&B and 17-06 were posted on the OHCA public website for a comment period from June 15, 2017 through July 14, 2017. APA work folder 17-09 was posted on the OHCA public website for a comment period from June 26, 2017 through July 28, 2017.

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

OHCA Initiated

A. REVOKING agency rules at OAC 317:30-3-88 to remove references to the issuing/mailing of member medical identification cards. This policy change is the result of the Oklahoma Health Care Authority no longer printing and/or issuing plastic medical identification cards. Members now have access to print their medical identification card from their online member account, or non-online enrollment members can visit their local county Oklahoma Department of Human Services office to obtain a printed card. Providers can verify the member's eligibility online via the Eligibility Verification System.
Budget Impact: Revisions will result in a total budget savings of $96,000 (CY).

(Reference APA WF # 17-05A)

B. AMENDING agency rules at OAC 317:35-7-40, 317:35-9-75, 317:35-15-7, 317:35-17-12, and 317:35-19-22 to remove references that refer to the issuing/mailing of member medical identification cards. This policy change is the result of the Oklahoma Health Care Authority no longer printing and/or issuing plastic cards. Members now have access to print their medical identification card from their online member account, or non-online enrollment members can visit their local county Oklahoma Department of Human Services (OKDHS) office to obtain a printed card. Providers can verify the member's eligibility online via the Eligibility Verification System. Additionally, revisions update language to reflect how the OKDHS notifies members of eligibility and ineligibility determinations for medical services by mailing out computer-generated notification forms. Finally, the policy revisions update the language for the medical and financial certification processes for the OKDHS ADvantage program.
Budget Impact: The budget impact is identified in APA WF #17-05A.

(Reference APA WF # 17-05B)

C. AMENDING agency rules at OAC 317:30-3-57, 317:30-5-72, 317:30-5-72.1, and 317:30-5-77.2 to remove coverage of optional non-prescription drugs for adults. (Insulin, nicotine replacement products for smoking cessation, and family planning products are not optional.) Additionally, compounded prescriptions will require a prior authorization for allowable cost exceeding a pre-determined limit. Finally, revisions correct the number of prescriptions allowed for adults receiving services under the 1915(c) Home and Community-Based Services Waivers from two (2) to three (3), to reflect current coverage.
Budget Impact: Revisions that remove coverage of optional non-prescription drugs

for adults will result in a total budget savings of $825,000 for SFY 2018; state share $338,992.50; federal share $486,007.50.

(Reference APA WF # 17-06)

ODMHSAS Initiated

D. AMENDING agency rules at OAC 317:30-5-241.6 to establish yearly limits on the amount of basic case management/resource coordination that is reimbursable by SoonerCare on a fee-for-service basis. The current limit of twenty-five (25) units per member per month basic case management/resource coordination will be reduced to sixteen (16) units per member per year. A process for authorizing up to twenty-five (25) units per member per month will be used for individuals who demonstrate the medical need for additional units. These emergency revisions are necessary to reduce the Oklahoma Department of Mental Health Substance Abuse Services' operations budget for the remainder of SFY 2018 in order to meet the balanced budget requirements as mandated by state law. Without the recommended revisions, the Department is at risk of exhausting its state appropriated dollars required to maintain the State's Medicaid Behavioral Health Program.
ODMHSAS Budget Impact: Revisions will result in a total budget savings to ODMHSAS for SFY 2018 of $8,447,984 Total; $3,500,000 state share.

(Reference APA WF # 17-09)

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 5. ELIGIBILITY

317:30-3-88. Medical identification card [REVOKED]

~~(a) Providers should carefully check the permanent plastic identification card utilizing the REVS system or a commercial swipe card system to verify that the patient is eligible.~~

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

SUBCHAPTER 7. MEDICAL SERVICES

PART 5. DETERMINATION OF ELIGIBILITY FOR MEDICAL SERVICES

317:35-7-40. Eligibility as Qualified Medicare Beneficiary Plus

(a) ~~An~~ individual determined to be categorically related to aged, blind or disabled is eligible for Medical Services as a Qualified Medicare Beneficiary Plus (QMBP) if he/she meets the conditions of eligibility shown in paragraphs (1)-(3) of this subsection. For persons age ~~65~~sixty-five (65) and older in mental health hospitals, refer to OAC 317:35-9-7.

(1) The individual's/couple's income and resources do not exceed the standards as shown on DHS Appendix C-1, Schedule VI, of which the income standard is based on ~~100%~~one-hundred (100) percent of the Federal Poverty Level.

(2) Countable income and resources are determined using the same rules followed in determining eligibility for individuals categorically related to ~~Aid to the~~ Aged, Blind or Disabled, except that a $20 general income disregard is applied to either earned or unearned income, but not both. For couples, only one $20 general income disregard is given.

(3) The individual meets all other eligibility conditions for ~~Medicaid~~SoonerCare.

~~(b) Medical identification cards are issued to all individuals determined eligible for QMBP coverage.~~

SUBCHAPTER 9. ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 9. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-9-75. Certification for long-term medical care through ~~ICF/MR~~ICF/IID, ~~HCBW/MR~~HCBW/IID services and to persons age 65 and older in a mental health hospital

(a) **Application date**. If the applicant is found eligible for ~~Medicaid~~SoonerCare, certification may be made retroactive for any service provided on or after the first day of the third month prior to the month of application and for future months. The first month of the certification period must be the first month that medical service was provided and the recipient was determined eligible. ~~An applicant approved for long-term medical care under Medicaid as categorically needy is mailed a permanent Medical Identification Card.~~

(b) **Certification period for long-term medical care**. A certification period of ~~12~~twelve (12) months is assigned for an individual who is approved for long-term care.

SUBCHAPTER 15. PERSONAL CARE SERVICES

317:35-15-7. Certification for Personal Care

(a) **Personal Care certification period.** The first month of the Personal Care certification period must be the first month the member was determined eligible for Personal Care, both financially and medically. When eligibility or ineligibility for Personal Care is established, the local office updates the computer-generated form and the appropriate notice is mailed to the member.

~~(1) As soon as eligibility or ineligibility for Personal Care is established, the local office updates the computer form and the appropriate notice is computer generated. Notice information is retained on the notice file for county use.~~

~~(2) An applicant approved for Personal Care under SoonerCare as categorically needy is mailed a Medical Identification Card.~~

(b) **Financial certification period ~~for Personal Care Services~~.** The financial certification period for Personal Care services is ~~12~~twelve (12) months. Redetermination of eligibility is completed according to the categorical relationship.

(c) **Medical certification period ~~for Personal Care services~~.** A medical certification period of not more than ~~36~~thirty-six (36) months is assigned for an individual who is approved for Personal Care. The certification period for Personal Care is based on the ~~UCAT~~Uniform Comprehensive Tool (UCAT) evaluation and clinical judgment of the ~~OKDHS~~Oklahoma Department of Human Services (DHS) area nurse or designee.

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-12. Certification for ADvantage program services

(a) **Application date**. ~~If~~When the applicant is ~~found~~determined eligible for ~~SoonerCare~~ADvantage, his/her certification ~~may be~~is effective the date ~~of application~~that medical and financial eligibility was determined. ~~The first month of the certification period must be the first month the member was determined eligible for ADvantage, both financially and medically.~~When eligibility or ineligibility for ADvantage program services is established, the worker updates the authorization and the computer-generated notice is mailed to the member and ADvantage Administration (AA).

~~(1) As soon as eligibility or ineligibility for ADvantage program services is established, the worker updates the~~

~~computer form and the appropriate notice is computer generated to the member and the ADvantage Administration (AA). Notice information is retained on the notice file for county use.~~

~~(2) An applicant approved for ADvantage program services is mailed a Medical Identification Card.~~

(b) **Financial certification period~~ for ADvantage program services~~**. The financial certification period ~~for the ADvantage program services~~ is ~~12~~twelve (12) months. ~~Although "medical eligibility number of months" on the computer input record will show 99 months, redetermination of eligibility is completed according to the categorical relationship.~~

~~(c) **Medical Certification period for ADvantage program services**. The medical certification period for ADvantage program services is up to 12 months. Redetermination of medical eligibility is completed by OKDHS in coordination with the annual reauthorization of the member's service plan. An independent redetermination of medical eligibility is completed by the OKDHS Nurse when, depending upon the needs of the member, the medical certification is determined to be less than 12 months, or, at any time documentation supports a reasonable expectation that the member may not continue to meet medical eligibility criteria.~~

(c) **Medical certification period**. The medical certification period is twelve (12) months. Redetermination of medical eligibility by an Oklahoma Department of Human Services (DHS) nurse is:

(1) completed annually in coordination with the annual reauthorization of the member's patient-centered service plan.

(2) completed when documentation is received that supports a reasonable expectation the member may not continue to meet medical eligibility criteria.

SUBCHAPTER 19. NURSING FACILITY SERVICES

317:35-19-22. Certification for ~~NF~~nursing facility (NF)

(a) **Application date**. The date of the application for NF care is most important in determining the date of eligibility. If the applicant is found eligible for ~~Medicaid~~SoonerCare, certification may be made retroactive for any service provided on or after the first day of the third month prior to the month of application and for future months. ~~An applicant approved for long-term medical care under Medicaid as categorically needy is mailed a Medical Identification Card.~~

(b) **Time limited approvals for nursing care**. A medical certification period of a specific length may be assigned for an individual who is categorically related to ~~ABD~~Aged, Blind and

Disabled or ~~AFDC~~Aid to Families with Dependent Children. This time limit is noted on the system. It is the responsibility of the nursing facility to notify the area nurse ~~30~~thirty (30) days prior to the end of the certification period if an extension of approval is required by the client. Based on the information from the NF the area nurse, or nurse designee, determines whether or not an update of the ~~UCAT~~Uniform Comprehensive Tool (UCAT) is necessary for the extension. The area nurse, or nurse designee, coordinates with appropriate staff for any request for further UCAT assessments.

(c) **Certification period for long-term medical care**. A financial certification period of ~~12~~twelve (12) months is assigned for an individual who is approved for long-term care.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57. General SoonerCare coverage - categorically needy

The following are general SoonerCare coverage guidelines for the categorically needy:

(1) Inpatient hospital services other than those provided in an institution for mental diseases.

(A) Adult coverage for inpatient hospital stays as described at OAC 317:30-5-41.

(B) Coverage for members under ~~21~~twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.

(2) Emergency department services.

(3) Dialysis in an outpatient hospital or free standing dialysis facility.

(4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.

(5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with OHCA.

(6) Outpatient ~~Mental~~mental ~~Health~~health ~~Services~~services for medical and remedial care including services provided on an outpatient basis by certified hospital based facilities that are also qualified mental health clinics.

(7) Rural health clinic services and other ambulatory services furnished by rural health clinic.

(8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.

(9) Maternity ~~Clinic~~clinic ~~Services~~services.

(10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the agency's Medical Authorization Unit.

(11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.

(12) Nursing facility services (other than services in an institution for tuberculosis or mental diseases).

(13) Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT) are available for members under ~~21~~twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and

mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA Child Health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.4.

(A) Child health screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

(B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.

(C) Immunizations.

(D) Outpatient care.

(E) Dental services as outlined in OAC 317:30-3-65.8.

(F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each ~~12~~twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(G) Hearing services as outlined in OAC 317:30-3-65.9.

(H) Prescribed drugs.

(I) Outpatient ~~Psychological~~psychological services as outlined in OAC 317:30-5-275 through ~~OAC~~ 317:30-5-278.

(J) Inpatient ~~Psychotherapy~~psychotherapy services and psychological testing as outlined in OAC 317:30-5-95 through ~~OAC~~ 317:30-5-97.

(K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.

(L) Inpatient hospital services.

(M) Medical supplies, equipment, appliances and prosthetic devices beyond the normal scope of SoonerCare.

(N) EPSDT services furnished in a qualified child health center.

(14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members ~~21~~twenty-one (21) years

of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least ~~30~~thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.

(15) Physicians' services whether furnished in the office, the member's home, a hospital, a nursing facility, ICF/IID, or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).

(16) Medical care and any other type of remedial care recognized under ~~State~~state law, furnished by licensed practitioners within the scope of their practice as defined by ~~State~~state law. See applicable provider section for limitations to covered services for:

(A) Podiatrists' services
(B) Optometrists' services
(C) Psychologists' services
(D) Certified Registered Nurse Anesthetists
(E) Certified Nurse Midwives
(F) Advanced Practice Nurses
(G) Anesthesiologist Assistants

(17) Free-standing ambulatory surgery centers.

(18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

(A) unlimited medically necessary monthly prescriptions for:

(i) members under the age of ~~21~~twenty-one (21) years; and

(ii) residents of ~~Nursing Facilities~~nursing facilities or ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~intermediate care facilities for individuals with intellectual disabilities.

(B) seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. These additional medically necessary prescriptions beyond the ~~two~~three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.

(19) Rental and/or purchase of durable medical equipment.

(20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.
(21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age ~~21~~twenty-one (21).
(22) Prosthetic devices limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure.
(23) Standard medical supplies.
(24) Eyeglasses under EPSDT for members under age ~~21~~twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
(25) Blood and blood fractions for members when administered on an outpatient basis.
(26) Inpatient services for members age ~~65~~sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
(27) Nursing facility services, limited to members preauthorized and approved by OHCA for such care.
(28) Inpatient psychiatric facility admissions for members under ~~21~~twenty-one (21) are limited to an approved length of stay effective July 1, 1992, with provision for requests for extensions.
(29) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
(30) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for ~~60~~sixty (60) days after the pregnancy ends, beginning on the last date of pregnancy.
(31) Nursing facility services for members under ~~21~~twenty-one (21) years of age.
(32) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a R.N.

(33) Part A deductible and Part B Medicare Coinsurance and/or deductible.
(34) Home and Community Based Waiver Services for the intellectually disabled.
(35) Home health services limited to ~~36~~thirty-six (36) visits per year and standard supplies for ~~1~~one (1) month in a ~~12~~twelve (12) month period. The visits are limited to any combination of Registered Nurse and nurse aide visits, not to exceed ~~36~~thirty-six (36) per year.
(36) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:

(A) Transplant procedures, except kidney and cornea, must be prior authorized to be compensable.

(B) To be prior authorized all procedures are reviewed based on appropriate medical criteria.

(C) To be compensable under the SoonerCare program, all transplants must be performed at a facility which meets the requirements contained in Section 1138 of the Social Security Act.

(D) Finally, procedures considered experimental or investigational are not covered.

(37) Home and community-based waiver services for intellectually disabled members who were determined to be inappropriately placed in a ~~NF~~nursing facility (Alternative Disposition Plan - ADP).
(38) Case ~~Management~~management services for the chronically and/or severely mentally ill.
(39) Emergency medical services including emergency labor and delivery for illegal or ineligible aliens.
(40) Services delivered in Federally Qualified Health Centers. Payment is made on an encounter basis.
(41) Early Intervention services for children ages ~~0-3~~zero (0) to three (3).
(42) Residential Behavior Management in therapeutic foster care setting.
(43) Birthing center services.
(44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services.
(45) Home and Community-Based Waiver services for aged or physically disabled members.
(46) Outpatient ambulatory services for members infected with tuberculosis.
(47) Smoking and Tobacco Use Cessation Counseling for children and adults.
(48) Services delivered to American Indians/Alaskan Natives

in I/T/Us. Payment is made on an encounter basis.
(49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six (6) covered prescriptions per month with a limit of two (2) brand name prescriptions. A prior authorization may be granted for a third brand name if determined to be medically necessary by OHCA and if the member has not already utilized their six (6) covered prescriptions for the month.

(2) Subject to the limitations set forth in OAC 317:30-5-72.1, ~~OAC~~ 317:30-5-77.2, and ~~OAC~~ 317:30-5-77.3, exceptions to the six (6) medically necessary prescriptions per month limit are:

(A) unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of ~~Nursing Facilities~~nursing facilities or Intermediate Care Facilities for ~~the Mentally Retarded~~Individuals with Intellectual Disabilities; and

(B) seven (7) additional medically necessary prescriptions which are generic products per month to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) Home and Community Based Services Waivers. Medically necessary prescriptions beyond the ~~two~~three (3) brand name or thirteen (13) total prescriptions will be covered with prior authorization.

(3) Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, low-phenylalanine formula and amino acid bars for persons with a diagnosis of PKU, certain carrier or

diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month.

(4) When a brand drug is preferred over its generic equivalent due to lower net cost, that drug shall not count toward the brand limit; however, it will count toward the monthly prescription limit.

(b) **Coverage for children**. Prescription drugs for SoonerCare eligible individuals under ~~21~~twenty-one (21) years of age are not limited in number per month, but may be subject to prior authorization, quantity limits or other restrictions.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

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~~FDA.

(2) The drug categories listed in (A) through (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~~symptomatic 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~~fifty (50);

(ii) fluoride preparations are covered for persons under ~~16~~sixteen (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~~twenty-one (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) 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 for children 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.

(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.

317:30-5-77.2. Prior authorization

(a) **Definition**. The term prior authorization in pharmacy means an approval for payment by OHCA to the pharmacy before a prescription is dispensed by the pharmacy. An updated list of all products requiring prior authorization is available at the agency's website.

(b) **Process**. Because of the required interaction between a prescribing provider (such as a physician) and a pharmacist to receive a prior authorization, OHCA allows a pharmacist up to ~~30~~thirty (30) calendar days from the point of sale notification to provide the data necessary for OHCA to make a decision regarding prior authorization. Should a pharmacist fill a prescription prior to the actual authorization he/she takes a business risk that payment for filling the prescription will be denied. In the case that information regarding the prior authorization is not provided within the ~~30~~thirty (30) days, claims will be denied.

(c) **Documentation.** Prior Authorization petitions with clinical exceptions must be mailed or faxed to the Medication Authorization Unit of OHCA's contracted prior authorization processor. Other authorization petitions, claims processing questions and questions pertaining to DUR alerts must be addressed by contacting the Pharmacy help desk. Authorization petitions with complete information are reviewed and a response returned to the dispensing pharmacy within ~~24~~twenty-four (24) hours. Petitions and other claim forms are available on the OHCA

public website.

(d) **Emergencies.** In an emergency situation the Health Care Authority will authorize a ~~72~~seventy-two (72) hour supply of medications to a member. The authorization for a ~~72~~seventy-two (72) hour emergency supply of medications does not count against the SoonerCare limit described in OAC 317:30-5-72(a)(1).

(e) **Utilization and scope.** There are three reasons for the use of prior authorization: utilization controls, scope controls and product based controls. Product based prior authorization is covered in OAC 317:30-5-77.3. The Drug Utilization Review Board recommends the approved clinical criteria and any restrictions or limitations.

(1) **Utilization controls.** Prior authorizations that fall under this category generally apply to the quantity of medication or duration of therapy approved.

(2) **Scope controls**. Scope controls are used to ensure a drug is used for an approved indication and is clinically appropriate, medically necessary and cost effective.

(A) Medications which have been approved by the FDA for multiple indications may be subject to a scope-based prior authorization when at least one of the approved indications places that drug into a therapeutic category or treatment class for which a prior authorization is required. Prior authorizations for these drugs may be structured as step therapy or a tiered approach as recommended by the Drug Utilization Review Board and approved by the OHCA Board of Directors.

(B) Prior authorization may be required to assure compliance with FDA approved and/or medically accepted indications, dosage, duration of therapy, quantity, or other appropriate use criteria including pharmacoeconomic consideration.

(C) Prior authorization may be required for certain non-standard dosage forms of medications when the drug is available in standard dosage forms.

(D) Prior authorization may be required for certain compounded prescriptions if the allowable cost exceeds a predetermined limit as published on the agency's website.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.6. Behavioral Health Case Management

Payment is made for behavioral health case management services as set forth in this Section. The limitations set forth in this Section do not apply to case management provided in programs and service delivery models which are not reimbursed for case management on a fee-for-service basis.

(1) **Description of behavioral health case management services**. Services under behavioral health case management are not comparable in amount, duration and scope. The target group for behavioral health case management services are persons under age twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be ~~subject to~~ authorized for the target group based on established medical necessity criteria.

(A) Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring and advocacy on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality,

collaboration, and partnership. Assistive activities are designed to occur primarily in the community, but may take place in the behavioral health case manager's office, if more appropriate. The provider will coordinate with the member and family (if applicable) by phone or face-to-face, to identify immediate needs for return to home/community no more than seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan. Case Managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two business days of the missed appointments. Community/home based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(B) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(C) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(D) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of

care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian (if the member is under 18), the behavioral health case manager, and a Licensed Behavioral Health Professional or Licensure Candidate as defined in OAC 317:30-5-240.3(a) and (b).

(E) SoonerCare reimbursable behavioral health case management services include the following:

(i) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(ii) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(iii) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

(iv) Supportive activities such as non-face-to-face communication with the member and/or parent/guardian/family member.

(v) Non face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(vi) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(vii) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face-to-face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(viii) Behavioral Health Case Management is available to individuals transitioning from institutions to the community (except individuals ages 22 to 64 who reside in an institution for mental diseases (IMD) or individuals who are inmates of public institutions). Individuals are considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(2) **Levels of Case Management.**

(A) Resource coordination services are targeted to adults with serious mental illness and children and adolescents with

mental illness or serious emotional disturbance, and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard managers have caseloads of 30 - 35 members. Basic case management/resource coordination is limited to ~~twenty-five (25)~~sixteen (16) units per member per ~~month~~year. Additional units may be authorized up to 25 units per member per month if medical necessity criteria are met.

(B) Intensive Case Management (ICM) is targeted to adults with serious and persistent mental illness (including members in PACT programs) and Wraparound Facilitation Case Management (WFCM) is targeted to children with serious mental illness and emotional disorders (including member in a System of Care Network) who are deemed high risk and in need of more intensive CM services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. To ensure that these intense needs are met, case manager caseloads are limited between 10-15 caseloads. The ICM shall be a Certified Behavioral Health Case Manager, have a minimum of two (2) years Behavioral Health Case Management experience, crisis diversion experience, must have attended the ODMHSAS six (6) hours ICM training, and twenty-four (24) hour availability is required. ICM/WFCM is limited to fifty-four (54) units per member per month.

(3) **Excluded Services**. SoonerCare reimbursable behavioral health case management does not include the following activities:

(A) physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;

(B) managing finances;

(C) providing specific services such as shopping or paying bills;

(D) delivering bus tickets, food stamps, money, etc.;

(E) counseling, rehabilitative services, psychiatric assessment, or discharge planning;

(F) filling out forms, applications, etc., on behalf of the member when the member is not present;

(G) filling out SoonerCare forms, applications, etc.;

(H) mentoring or tutoring;

(I) provision of behavioral health case management services to the same family by two separate behavioral health case management agencies;

(J) non-face-to-face time spent preparing the assessment document and the service plan paperwork;
(K) monitoring financial goals;
(L) services to nursing home residents;
(M) psychotherapeutic or rehabilitative services, psychiatric assessment, or discharge; or
(N) services to members residing in ICF/IID facilities.

(4) **Excluded Individuals**. The following SoonerCare members are not eligible for behavioral health case management services:
(A) children/families for whom behavioral health case management services are available through OKDHS/OJA staff without special arrangements with OKDHS, OJA, and OHCA;
(B) members receiving Residential Behavior Management Services (RBMS) in a foster care or group home setting unless transitioning into the community;
(C) residents of ICF/IID and nursing facilities unless transitioning into the community;
(D) members receiving services under a Home and Community Based services (HCBS) waiver program; or
(E) members receiving services in the Health Home program.

(5) **Filing Requirements.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(6) **Documentation requirements**. The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and a licensed behavioral health professional or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:
(A) date;
(B) person(s) to whom services are rendered;
(C) start and stop times for each service;
(D) original signature or the service provider (original signatures for faxed items must be added to the clinical file within 30 days);
(E) credentials of the service provider;
(F) specific service plan needs, goals and/or objectives addressed;
(G) specific activities performed by the behavioral health case manager on behalf of the child related to advocacy, linkage, referral, or monitoring used to address needs, goals

and/or objectives;

(H) progress and barriers made towards goals, and/or objectives;

(I) member (family when applicable) response to the service;

(J) any new service plan needs, goals, and/or objectives identified during the service; and

(K) member satisfaction with staff intervention.

(7) **Case Management Travel Time**. The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

Recommendation 1: Prior Authorize Austedo™ (Deutetrabenazine) and Xenazine® (Tetrabenazine)

The Drug Utilization Review Board recommends the prior authorization of Xenazine® (tetrabenazine) and Austedo™ (deutetrabenazine) with the following criteria:

Xenazine® (Tetrabenazine) Approval Criteria:

1. Authorization of generic tetrabenazine (in place of brand Xenazine®) will require a patient-specific, clinically significant reason why the member cannot use the brand formulation (brand formulation is preferred); and
2. A diagnosis of one of the following:
   a. Chorea associated with Huntington's disease; or
   b. Tardive dyskinesia; or
   c. Tourette syndrome; and
3. Xenazine® must be prescribed by a neurologist, or a mid-level practitioner with a supervising physician that is a neurologist; and
4. Member must not be actively suicidal or have uncontrolled depression and prescriber must verify member will be monitored for depression prior to starting Xenazine® therapy and throughout treatment; and
5. Member must not have hepatic impairment; and
6. Member must not be taking monoamine oxidase inhibitors (MAOIs) or have taken an MAOI within the last 14 days; and
7. Member must not be taking reserpine or have taken reserpine within the last 20 days; and
8. Member must not use another vesicular monoamine transporter-2 (VMAT2) inhibitor (e.g., deutetrabenazine, valbenazine) concurrently with Xenazine®; and
9. Member must not be taking medications that are known to prolong the QTc interval concomitantly with Xenazine® [antipsychotic medications (e.g., chlorpromazine, haloperidol, thioridazine, ziprasidone), antibiotics (e.g., moxifloxacin), Class 1A (e.g., quinidine, procainamide) and Class III (e.g., amiodarone, sotalol) antiarrhythmic medications, or any other medications known to prolong the QTc interval]; and
10. Patients who require doses of tetrabenazine greater than 50mg per day must be tested and genotyped to determine if they are poor metabolizers (PMs), intermediate metabolizers (IMs), or extensive metabolizers (EMs) by their ability to express the drug metabolizing enzyme, CYP2D6. The following dose limits will apply based on patient metabolizer status:
    a. Extensive and Intermediate CYP2D6 Metabolizers: 100mg divided daily; or
    b. Poor CYP2D6 Metabolizers: 50mg divided daily; and
11. The daily dose of Xenazine® must not exceed 50mg per day if the member is taking strong CYP2D6 inhibitors (e.g., paroxetine, fluoxetine, quinidine, bupropion); and
12. Approvals will be for the duration of six months at which time the prescriber must document that the signs and symptoms of chorea, tardive dyskinesia, or Tourette

syndrome have decreased and the member is not showing worsening signs of depression.

Austedo™ (Deutetrabenazine) Approval Criteria:

1. An FDA approved diagnosis of chorea associated with Huntington's disease; and
2. Austedo™ must be prescribed by a neurologist, or a mid-level practitioner with a supervising physician that is a neurologist; and
3. A previous trial of Xenazine® (tetrabenazine) or a patient-specific, clinically significant reason why the member cannot use brand Xenazine® (tetrabenazine); and
4. Member must not be actively suicidal or have uncontrolled depression and prescriber must verify member will be monitored for depression prior to starting Austedo™ therapy and throughout treatment; and
5. Member must not have hepatic impairment; and
6. Member must not be taking monoamine oxidase inhibitors (MAOIs) or have taken an MAOI within the last 14 days; and
7. Member must not be taking reserpine or have taken reserpine within the last 20 days; and
8. Member must not use another vesicular monoamine transporter-2 (VMAT2) inhibitor (e.g., tetrabenazine, valbenazine) concurrently with Austedo™; and
9. Member must not be taking medications that are known to prolong the QTc interval concomitantly with Austedo™ [antipsychotic medications (e.g., chlorpromazine, haloperidol, thioridazine, ziprasidone), antibiotics (e.g., moxifloxacin), Class 1A (e.g., quinidine, procainamide) and Class III (e.g., amiodarone, sotalol) antiarrhythmic medications, or any other medications known to prolong the QTc interval]; and
10. The daily dose of Austedo™ must not exceed 36mg per day if the member is taking strong CYP2D6 inhibitors (e.g., paroxetine, fluoxetine, quinidine, bupropion) or if they are a known poor CYP2D6 metabolizer; and
11. Approvals will be for the duration of six months at which time the prescriber must document that the signs and symptoms of chorea have decreased and the member is not showing worsening signs of depression.

Recommendation 2: Prior Authorize Ingrezza™ (Valbenazine)

The Drug Utilization Review Board recommends the prior authorization of Ingrezza™ (valbenazine) with the following criteria:

Ingrezza™ (Valbenazine) Approval Criteria:

1. An FDA approved diagnosis of tardive dyskinesia meeting the following DSM-5 criteria:
   a. Involuntary athetoid or choreiform movements; and
   b. History of treatment with dopamine receptor blocking agent (DRBA); and
   c. Symptom duration lasting longer than 4 to 8 weeks; and
2. Member must be 18 years of age or older; and
3. Ingrezza™ must be prescribed by a neurologist or psychiatrist, or a mid-level practitioner with a supervising physician that is a neurologist or psychiatrist; and
4. Member must not be at significant risk for suicidal or violent behavior and must not have unstable psychiatric symptoms; and
5. The daily dose of Ingrezza™ must not exceed 40mg per day if the member is taking strong CYP3A4 inhibitors (e.g., itraconazole, ketoconazole, clarithromycin); and
6. Member must not be taking monoamine oxidase inhibitors (MAOIs); and
7. Member must not be taking other vesicular monoamine transporter 2 (VMAT2) inhibitors (e.g., tetrabenazine, deutetrabenazine); and

8. Female members must not be pregnant or breastfeeding; and
9. Prescriber must document a baseline evaluation using the Abnormal Involuntary Movement Scale (AIMS); and
10. A quantity limit of two 40mg capsules or a total dose of 80mg per day will apply; and
11. Approvals will be for the duration of six months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment as indicated by an improvement from baseline in the AIMS total score (a negative change in score indicates improvement).

Recommendation 3: Prior Authorize Carac® (Fluorouracil 0.5% Cream), GoNitro™ (Nitroglycerin Sublingual Powder), Soltamox® (Tamoxifen Citrate Oral Solution), Taytulla™ (Norethindrone Acetate/Ethinyl Estradiol Capsules & Ferrous Fumarate Capsules), Tirosint®-SOL (Levothyroxine Sodium Oral Solution), Xatmep™ (Methotrexate Oral Solution), Zovirax® (Acyclovir Ointment and Suspension), Xerese® (Acyclovir/Hydrocortisone Cream), & Denavir® (Penciclovir Cream)

The Drug Utilization Review Board recommends the prior authorization of Carac® (fluorouracil 0.5% cream), GoNitro™ (nitroglycerin sublingual powder), Soltamox® (tamoxifen citrate oral solution), Taytulla™ (norethindrone acetate/ethinyl estradiol capsules & ferrous fumarate capsules), Tirosint®-SOL (levothyroxine sodium oral solution), Xatmep™ (methotrexate oral solution), Zovirax® (acyclovir ointment and suspension), Xerese® (acyclovir/hydrocortisone cream), and Denavir® (penciclovir cream) with the following criteria:

Carac® (Fluorouracil 0.5% Cream) Approval Criteria:

1. An FDA approved diagnosis of multiple actinic or solar keratoses of the face and anterior scalp in adults; and
2. Carac® must be prescribed by a dermatologist or an advanced care practitioner with a supervising physician who is a dermatologist; and
3. A patient-specific, clinically significant reason why the member cannot use fluorouracil 5% cream, fluorouracil 5% solution, or fluorouracil 2% solution.

GoNitro™ (Nitroglycerin Sublingual Powder) Approval Criteria:

1. An FDA approved indication of acute relief of an attack or prophylaxis of angina pectoris due to coronary artery disease; and
2. A patient-specific, clinically significant reason why the member cannot use nitroglycerin sublingual tablets or nitroglycerin lingual spray.

Soltamox® (Tamoxifen Citrate 10mg/5mL Oral Solution) Approval Criteria:

1. An FDA approved indication of one of the following:
    a. Treatment of metastatic breast cancer in women and men; or
    b. Adjuvant treatment of node-positive breast cancer in postmenopausal women and for the adjuvant treatment of axillary node-negative breast cancer in women following total mastectomy or segmental mastectomy, axillary dissection, and breast irradiation; or
    c. The reduction in risk of invasive breast cancer in women with ductal carcinoma in situ (DCIS), following breast surgery and radiation; or
    d. To reduce the incidence of breast cancer in women at high risk for breast cancer; and
2. A patient-specific, clinically significant reason why the member cannot use tamoxifen tablets.

Taytulla™ (Norethindrone Acetate/Ethinyl Estradiol Capsules & Ferrous Fumarate Capsules) Approval Criteria:

1. An FDA approved indication to prevent pregnancy in women; and
2. A patient-specific, clinically significant reason why the member cannot use all other generic formulations of norethindrone acetate/ethinyl estradiol tablets with ferrous fumarate tablets.

Tirosint®-SOL (Levothyroxine Sodium Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of one of the following:
    a. Hypothyroidism: As replacement therapy in primary (thyroidal), secondary (pituitary), and tertiary (hypothalamic) congenital or acquired hypothyroidism; or
    b. Pituitary Thyrotropin (Thyroid-Stimulating Hormone, TSH) Suppression: As an adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer; and
2. A patient-specific, clinically significant reason why the member cannot use all other formulations of levothyroxine sodium in the place of oral solution even when tablets are crushed.

Xatmep™ (Methotrexate 2.5mg/mL Oral Solution) Approval Criteria:

1. An FDA approved indication of one of the following:
    a. Treatment of pediatric patients with acute lymphoblastic leukemia (ALL) as a component of a combination chemotherapy maintenance regimen; or
    b. Management of pediatric patients with active polyarticular juvenile idiopathic arthritis (pJIA) who are intolerant of or had an inadequate response to first-line therapy; and

2. A patient-specific, clinically significant reason why the oral tablets or generic injectable formulation cannot be used.

Zovirax® (Acyclovir 5% Ointment) Approval Criteria:

1. An FDA approved indication of management of initial genital herpes or in limited non-life-threatening mucocutaneous herpes simplex virus (HSV) infections in immunocompromised patients; and
2. A patient-specific, clinically significant reason why the member cannot use oral acyclovir, famciclovir, or valacyclovir tablets.

Zovirax® (Acyclovir 200mg/5mL Suspension) Approval Criteria:

1. An age restriction of seven years and younger will apply. Members older than seven years of age will require a patient-specific, clinically significant reason why a special formulation product is needed.

Sitavig® (Acyclovir Buccal Tablets), Xerese® (Acyclovir/Hydrocortisone 5%/1% Cream), and Denavir® (Penciclovir 1% Cream) Approval Criteria:

1. An FDA approved diagnosis of recurrent herpes labialis (cold sores); and
2. A patient-specific, clinically significant reason why the member cannot use oral acyclovir, famciclovir, or valacyclovir tablets.

Recommendation 4: Prior Authorize Aczone® (Dapsone Gel) and Tazorac® (Tazarotene Cream and Gel)

The Drug Utilization Review Board recommends the prior authorization of Aczone® (dapsone gel) and generic tazarotene cream with the following criteria based, in part, on cost after rebates:

Aczone® (Dapsone Gel) Approval Criteria:

1. An FDA approved indication of acne vulgaris; and
2. Member must be 20 years of age or younger; and
3. A previous trial of benzoyl peroxide or a patient-specific, clinically significant reason why benzoyl peroxide is not appropriate for the member; and
4. A previous trial of a topical antibiotic, such as clindamycin or erythromycin, or a patient-specific, clinically significant reason why a topical antibiotic is not appropriate for the member.

Tazorac® (Tazarotene Cream and Gel) Approval Criteria:

1. An FDA approved indication of acne vulgaris or plaque psoriasis; and
2. Female members must not be pregnant and must be willing to use an effective method of contraception during treatment; and
3. Authorization of generic tazarotene (in place of brand Tazorac®) will require a patient-specific, clinically significant reason why the member cannot use the brand formulation (brand formulation is preferred); and
4. For a diagnosis of acne vulgaris, the following must be met:
    a. Member must be 20 years of age or younger; and

        A quantity limit of 60 grams per 30 days will apply.

Drug	Used for	Cost	Notes
Austedo	Huntington's Disease	$9000/30 days	
Xenazine	Huntington's Disease	$15,000/30 days	13 members 2016
Ingrezza	Tardive Diskinesia	$10,000/30 days	
Carac	Skin lesions	$2400/treatment	Less costly forms available
GoNitro	NTG sublingual powder	up to $650/package	Less costly forms available
Soltamox	Tamoxifen liquid	up to $2300/month	Less costly forms available
Taytulla	Oral contraceptive	$150/month	Less costly forms available
Tirosint Solution	Levothyroxine Solution	Not yet known	Less costly forms available
Xatmep	Methotrexate Solution	$190/month	Less costly forms available
Zovirax Ointment	Herpes simplex virus	$345/tube (generic)	Less costly forms available
Zovirax Suspension	Herpes simplex virus	$250/treatment	Less costly forms available
Xerese	Herpes simplex virus	$1100/tube	Less costly forms available
Denavir	Herpes simplex virus	$725/tube	Less costly forms available
Aczone	Acne	$500/month	
Tazorac	Acne/plaque psoriasis	$200-$350/month	