OKLAHOMA HEALTH CARE AUTHORITY
REGULARLY SCHEDULED BOARD MEETING
September 27, 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 August 24, 2017 OHCA Board Meeting Minutes

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

3. Discussion Item – Chief Executive Officer's Report

   a) Recognition of 2017 Great 100 Nurses Honorees
      - Carolyn Reconnu-Shoffner, RN, BSN, CCM, Assistant Director of Population Care Management (PCM) – Marlene Asmussen, PCM Director
      - Maria Gutierrez, RN, BSN, PCM Supervisor – Marlene Asmussen, PCM Director
      - Becky Pasternik-Ikard, JD, MS, RN, Chief Executive Officer – Garth Splinter, Deputy Chief Executive Officer

   b) All-Star Introduction
      - July All-Star – Bev Reed, Financial Manager II (Carrie)
      - August All-Star – Demetria Bennett, Policy Development Coordinator (Tywanda)

   c) Financial Update – Carrie Evans, Chief Financial Officer

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

   e) Legislative Update – Cate Jeffries, Legislative Liaison

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

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

Item to be presented by Carrie Evans, Chief Financial Officer

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

   a) Consideration and Vote for a rate change to increase the rate paid for private duty nursing (Procedure Code T1000) from $6.30 per 15 min unit ($25.20 / hour) to $7.55 per 15 min unit ($30.20 / hour). The estimated budget impact for state fiscal year 2018 is estimated to be $0. This assumes increased costs from longer inpatient stays if there is no change.

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.

a) AMENDING agency rules at OAC 317:45-11-20 to strengthen program integrity in the Insure Oklahoma Individual Plan. Revisions make it incumbent upon the self-employed applicant to verify self-employment by completing and submitting certain documentation. These revisions will help ensure that self-employed applicants are engaged in routine, for-profit activity, in accordance with Internal Revenue Service guidelines.
Budget Impact: Budget neutral

(Reference APA WF # 17-02

b) AMENDING agency rules at OAC 317:30-3-4.1 and 317:30-3-30 will clarify the authentication of electronic medical records. Current policy that became effective September 1, 2017 requires that the record be authenticated within three (3) days of the provision of the underlying service. New revisions will revert the three (3) day signature language to the policy that was in place on June 25, 2011. The proposed revisions will clarify that the authentication of medical records is expected on the day the record is completed. Additionally, revisions will describe that the signature of the rendering provider and date entry is expected within three (3) business days from the day the record is completed if the record is being transcribed.
Budget Impact: Budget neutral

(Reference APA WF # 17-13)

c) AMENDING agency rules at OAC 317:30-5-696 will clarify dental coverage for adults by amending the rule that limits dental services for adults to “emergency” extractions. The policy was initially intended for emergency extractions and was later revised to medically necessary extractions. The intent of the change was to ensure the emergency extractions were medically necessary; therefore, the policy will revert to the original language to include the term emergency along with reference to where emergency dental care is defined in policy. Additionally, the proposed revisions add new language on the medically necessary images and oral examination that can accompany an emergency extraction.
Budget Impact: Revisions will result in approximately $479,017 of state share savings for eight months of SFY 2018.

(Reference APA WF # 17-14)

Item to be presented by Nancy Nesser, Pharmacy Director

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 **Radicava™ (Edaravone)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

b) Consideration and vote to add **Eucrisa™ (Crisaborole 2% Ointment), Dupixent® (Dupilumab Injection), & Prudoxin™ and Zonalon® (Doxepin 5% Cream)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

c) Consideration and vote to add **Vimizim® (Elosulfase Alfa)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

d) (d) Consideration and vote to add **Rayaldee® (Calcifediol), Parsabiv™ (Etelcalcetide), Zemplar® (Paricalcitol Capsules), and Hectorol® (Doxercalciferol Capsules)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

e) Consideration and vote to add **Brineura™ (Cerliponase Alfa)** 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).

9. New Business

10. ADJOURNMENT

NEXT BOARD MEETING
October 12, 2017
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
August 24, 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 August 23, 2017 at 12:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on August 18, 2017 at 9:30 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman McFall called the meeting to order at 1:04 p.m.

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

OTHERS PRESENT:	OTHERS PRESENT:
Richard DeSirey, A New Way	Marlene Asmussen, OHCA
Denise Easter, OHCA	Jimmy Witcosky, OHCA
Lisa Montgomery, OHCA	Traylor Rains-Sims, ODMHSAS
Brent Wilborn, OKPCA	Meg Wingerter, The Oklahoman
Tyler Telley, eCAP	Marty Wafford, Chickasaw Nation
Kyle Janzen, OHCA	Shelly Patterson, OHCA
Mike Fogarty	Sasha Teel, OHCA
LeKenya Antwine, OHCA	Rachel Martin, OHCA
David Ward, OHCA	Jennifer King, OHCA
Gina Kwiatkowski, OHCA	Jimmy Durant, SSM
Will Widman, DXC	Herman Green, ODMHSAS
David Dude, American Cancer Society	Rick Snyder, OHA
Tammy Vaughn, SOFS	Mary Brinkley, Leading Age Oklahoma
Gloria LaFitte, OHCA	Carmen Johnson, OHCA
Tatiana Reed, OHCA	Sandra Puebla, OHCA
Catherine Sweeney, Journal Record	Kasie Wren, OHCA
Harvey Reynolds, OHCA	Mia Smith, OHCA
Lewis Robinson, OHCA	Sherris Harris-Ososanya, OHCA
Kelli Brodersen, OHCA	Dwyna Vick, OHCA
Valerie Whiteneck, Hearts of Hope	

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD August 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 Robison moved for approval of the August 24, 2017 board meeting minutes as published. The motion was seconded by Member Bryant.
FOR THE MOTION:	Chairman McFall
ABSTAINED:	Member Case, Member McVay, Member Nuttle
BOARD MEMBERS ABSENT:	Vice Chairman Armstrong

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

Speaker: Richard DeSirey/A New Way

ITEM 4a / ALL-STAR INTRODUCTION

The following OHCA All-Stars were recognized

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

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

Ms. Evans reported on the financial transactions through the month of June. OHCA ended the fiscal year with a positive $12 million dollars. OHCA continues to run under budget in program spending by $14 million state dollars and administration by $8.4 million state dollars. OHCA's revenues are over budget in drug rebate by $8.7 million and still under budget in taxes and fees and overpayments and settlements. Final numbers for July ran under budget. OHCA was left with a $70 million dollar shortfall due to the Cigarette Fee bill being called unconstitutional. OHCA has been asked to provide the legislature with an updated cash sheet on when OHCA projects that we will not be able to meet monthly projections. Based on estimates, for the month of January, we could be short about $20 million dollars for the January cycle. For more detailed information, see Item 4b in the board packet.

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

Dr. Splinter provided an update for April 2017 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program including total in-state providers. Dr. Splinter discussed maps showing number of physicians, hospitals, pharmacies, dentists, behavioral health providers and nursing facilities by counties, and their member ratio. For more detailed information, see Item 4c in the board packet.

ITEM 4d / LEGISLATIVE/BUDGET UPDATE
Cate Jeffries, Legislative Liaison

Ms. Jeffries introduced herself and gave a brief update regarding the budget and legislative special session.

ITEM 4e / HEALTH MANAGEMENT PROGRAM (HMP)/CHRONIC CARE UNIT (CCU) UPDATE
Della Gregg, HMP Manager

Ms. Gregg gave a HMP and Chronic Care unit update which included information on Population Care Management, overview of HMP, overview of CCU, program objectives, HMP/CCU outcomes, SFY16 Satisfaction, SFY16 quality of care, SFY16 ED utilization, SFY16 inpatient utilization, SFY16 cost-effectiveness for HMP and CCU, HMP ROI first generation, and HMP/CCU ROI second generation. For more detailed information, see Item 4e in the board packet.

ITEM 4f / OBSTETRIC OUTREACH
Shelly Patterson, Assistant Director of Provider/Medical Home Services

Ms. Patterson gave an Obstetric Outreach update which included information on SoonerCare and pregnancy, health risk assessment, pregnant member letters, tobacco cessation, Population Care Management (PCM), PCM initiatives and Text for Baby (T4B). For more detailed information, see Item 4f in the board packet.

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

There were no recommendations regarding conflicts.

ITEM 6 / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT. THE AGENCY REQUESTS THE ADOPTION OF THE FOLLOWING EMERGENCY RULES

Tywanda Cox, Chief of Federal and State Policy

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

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

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

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)

MOTION:	Member Nuttle moved for approval of emergency rulemaking for Item 6a as published. The motion was seconded by Member Case.
FOR THE MOTION:	Chairman McFall, Member Bryant, Member McVay, Member Robison
BOARD MEMBERS ABSENT:	Vice Chairman Armstrong
MOTION:	Member McVay moved for approval of emergency rulemaking for Item 6b.a-c as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Member Bryant, Member Case, Member Nuttle

BOARD MEMBERS ABSENT: Vice Chairman Armstrong

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)

MOTION: Member Robison moved for approval of emergency rulemaking for Item 6b.d as published. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman McFall, Member Bryant, Member McVay,

AGAINST THE MOTION: Member Case

BOARD MEMBERS ABSENT: Vice Chairman Armstrong

ITEM 7A-D / CONSIDERATION AND VOTE REGARDING RECOMMENDATIONS MADE BY THE DRUG UTILIZATION BOARD UNDER 63 OKLAHOMA STATUTES 5030.3
Jill Ratterman, Clinical Pharmacist

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).

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

FOR THE MOTION: Chairman McFall, Member McVay, Member Nuttle, Member Robison

BOARD MEMBERS ABSENT: Vice Chairman Armstrong

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

Nicole Nantois, Chief of Legal Services

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

MOTION:	Member Case moved for approval to move into Executive Session. The motion was seconded by Member Nuttle.
FOR THE MOTION:	Chairman McFall, Member Bryant, Member McVay, Member Robison
BOARD MEMBERS ABSENT:	Vice Chairman Armstrong

ITEM 9 / NEW BUSINESS

There was no new business.

ITEM 10 / ADJOURNMENT

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

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

NEXT BOARD MEETING
September 27, 2017
Oklahoma Health Care Authority
Oklahoma City, OK

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

Oklahoma Health Care Authority Budget Reductions	SFY 18 Federal Savings - (OHCA)	SFY 18 State Savings - (OHCA)	Effective Date	SPA / Rule Change
Program Changes (SFY 2018 Savings)				
Dental Reductions	**677,191**	**479,017**	**10/1/2017**	**No / Yes**
Rule change from medically necessary extractions to emergency extractions only for adults and elimination on coverage of certain codes to comply with policy changes				
Removing Coverage for Cystic Fibrosis Screening	**315,434**	**255,000**	**11/1/2017**	**No / No**
Change will restrict to allow ONLY for diagnostic purposes				
Delay Capitation Payments Until 1st Primary Care Provider (PCP) Visit	**2,828,192**	**2,000,547**	**1/1/2018**	**No / No**
PRIMARY CARE PROVIDERS - Care Coordination per member per month fee will not be paid until Primary Care Provider office visit				
Member Date Specific End Dates	**761,996**	**539,004**	**1/1/2018**	**No / Yes**
ADULTS and CHILDREN - End date member eligibility based on a 12-day rule instead of the end of the month Excludes Aged, Blind, Disabled; Long Term Care; and Insure Oklahoma members				
Total of Program Changes (SFY 2018 Changes)	**4,582,814**	**3,273,568**		
Proposed Program Changes				
Eliminate Reimbursement for Lactation Consultation Services	**14,598**	**10,326**		**Yes / Yes**
PREGNANT WOMEN ONLY - Member-specific support and education regarding breastfeeding, addressing particular issues, and/or managing lactation crisis				
Eliminate Reimbursement for Nutritional Services	**32,656**	**23,099**		**Yes / Yes**
ADULTS and CHILDREN - Coverage for adults services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness				
Eliminate Reimbursement for Genetic Counseling Services	**14,180**	**10,030**		**Yes / Yes**
ADULTS and CHILDREN - Analyze and share information with the member to help them understand and adapt to the medical, psychosocial and familial contributions to potential or realized birth defects				
Eliminate Reimbursement for Therapeutic Leave Days in Long Term Care Facilities	**34,693**	**24,541**		**Yes / Yes**
ADULTS and CHILDREN - LTC Nursing Facility (Max 7 days per CY) excludes Intermedicate Care Facilities - Individuals Intellectual Disabilities (ICF-IID)				
Total of Proposed Program Changes	**96,127**	**67,996**		
Proposed Provider Rate Reductions (Proposed Effective Date December 1, 2017)				
DME Rate Reductions	**-**	**-**	**12/1/2017**	**No / No**
ADULTS and CHILDREN - align rates with Medicare				
Medicare Crossover Coinsurance and Deductible Claims for Dual Eligibles	**13,327,479**	**9,427,309**	**12/1/2017**	**Yes / No**
Hospitals - Change from paying 75% deductible and 25% coinsurance for Part A and Part B to 0% for both	11,263,922	7,967,634		
Nursing Homes - Change from paying 20% Part A and 75% Part B of coinsurance and deductible to 0% for both	2,063,557	1,459,675		
Rate Reductions - Across the Board			**12/1/2017**	**Yes / No**
One Percent (1%)	**4,494,940**	**3,179,535**		
Two Percent (2%)	**8,989,880**	**6,359,070**		
Three Percent (3%)	**13,484,820**	**9,538,605**		
One-Time Savings Items				
Fiscal Year 2017 Carryover		**12,000,000**		
Other Available Funds (Program Changes, Federal Deferral Funds*, SFY 2018 Potential Savings)		**20,000,000**		
Fiscal Year 2017 General Revenue Return		**4,650,843**		
Balance SFY 2018 Budget		**(22,000,000)**		
Total of One-Time Savings Items		**14,650,843**		

*Proposed Program Changes section uses a 1/1/2018 effective date for budget impact calculations. Actual date is TBD if implemented.
*Federal Deferral Funds will be replaced
*2018 Federal matching participation 58.57%
*All optional benefit categories exclude waiver and crossover payments. This estimate DOES NOT account for potential cost shifting to mandatory programs.
Potential "**Shifted Costs**" would be additional spending on OHCA Mandatory Program services such as emergency department, inpatient hospitalization, physician's office, visits, clinics and long term care facility stays. In some cases the shifted costs will far outweigh any reduction in program spending.
EPSDT services may be included in the amounts for these optional groups.

Oklahoma Health Care Authority Budget Reductions	SFY 18 Federal Savings - (OHCA)	SFY 18 State Savings - (OHCA)	Effective Date	SPA / Rule Change
Program Changes (SFY 2018 Savings)				
Dental Reductions	**677,191**	**479,017**	**10/1/2017**	**No / Yes**
Rule change from medically necessary extractions to emergency extractions only for adults and elimination on coverage of certain codes to comply with policy changes				
Removing Coverage for Cystic Fibrosis Screening	**315,434**	**255,000**	**11/1/2017**	**No / No**
Change will restrict to allow ONLY for diagnostic purposes - no change to newborn screening				
Delay Capitation Payments Until 1st Primary Care Provider (PCP) Visit	**2,828,192**	**2,000,547**	**1/1/2018**	**No / No**
PRIMARY CARE PROVIDERS - Care Coordination per member per month fee will not be paid until Primary Care Provider office visit				
Member Date Specific End Dates	**761,996**	**539,004**	**1/1/2018**	**No / Yes**
ADULTS and CHILDREN - End date member eligibility based on a 12-day rule instead of the end of the month Excludes Aged, Blind, Disabled; Long Term Care; and Insure Oklahoma members				
Total of Program Changes (SFY 2018 Changes)	**4,582,814**	**3,273,568**		
One-Time Savings Items				
Fiscal Year 2017 Carryover		**12,000,000**		
Other Available Funds (Program Changes, Federal Deferral Funds*, SFY 2018 Potential Savings)		**20,000,000**		
Fiscal Year 2017 General Revenue Return		**4,650,843**		
Balance SFY 2018 Budget		**(22,000,000)**		
Total of One-Time Savings Items		**14,650,843**		
Proposed Provider Rate Reductions (Proposed Effective Date December 1, 2017)				
DME Rate Reductions	**-**	**-**	**12/1/2017**	**No / No**
ADULTS and CHILDREN - align rates with Medicare				
Medicare Crossover Coinsurance and Deductible Claims for Dual Eligibles	**13,327,479**	**9,427,309**	**12/1/2017**	**Yes / No**
Hospitals - Change from paying 75% deductible and 25% coinsurance for Part A and Part B to 0% for both	11,263,922	7,967,634		
Nursing Homes - Change from paying 20% Part A and 75% Part B of coinsurance and deductible to 0% for both	2,063,557	1,459,675		
Rate Reductions - Across the Board (Exclusions Listed Below)			**12/1/2017**	**Yes / No**
One Percent (1%)	**5,725,066**	**4,049,675**		
Two Percent (2%)	**11,450,132**	**8,099,351**		
Three Percent (3%)	**17,175,198**	**12,149,026**		
Rate Reductions - Across the Board Excluding Nursing Homes (Other Exclusions Listed Below)			**12/1/2017**	**Yes / No**
One Percent (1%)	**4,494,940**	**3,179,535**		
Two Percent (2%)	**8,989,880**	**6,359,070**		
Three Percent (3%)	**13,484,820**	**9,538,605**		

*Federal Deferral Funds will be replaced
*2018 Federal matching participation 58.57%
*Exclusions from Across the Board Rate Reductions include:
Emergency Transportation
The Children's Center and JD McCarty
SoonerCare Choice Care Coordination
Complex Rehabilitation Technology
Private Duty Nursing
Payment for drug ingredients / Physician Supplied Drugs (J Codes)
Insure Oklahoma
Federally Qualified Health Centers / Rural Health Centers
Non-Emergency Transportation
Services paid for by Other State Agencies
Services provided to Native Americans through Indian Health Services Indian/Tribal/Urban Clinics

OHCA Board Meeting
September 27, 2017
(July 2017 Data)

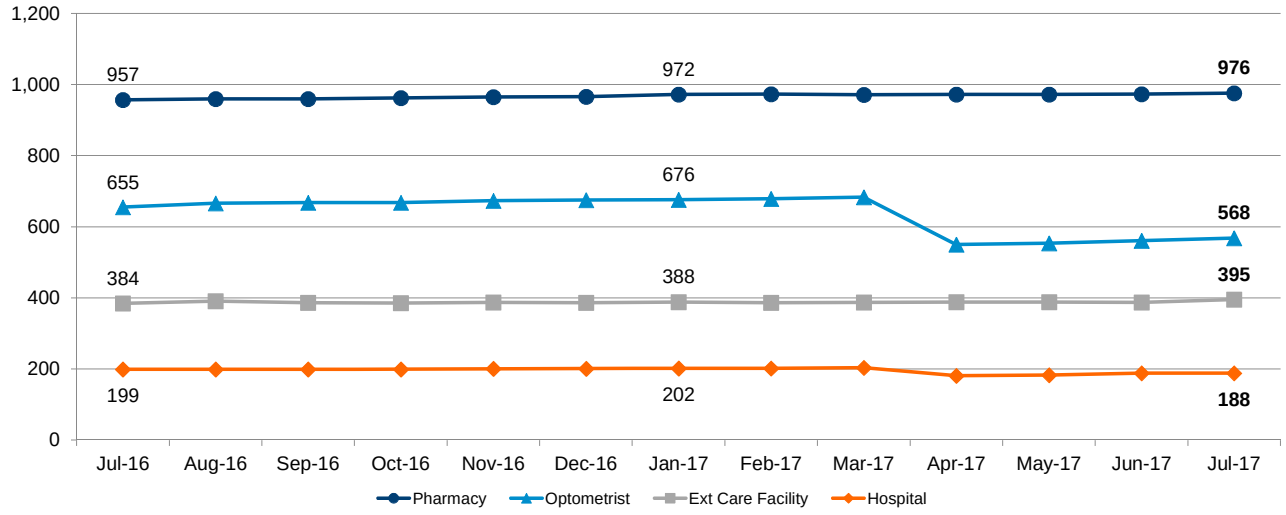
SOONERCARE ENROLLMENT/EXPENDITURES

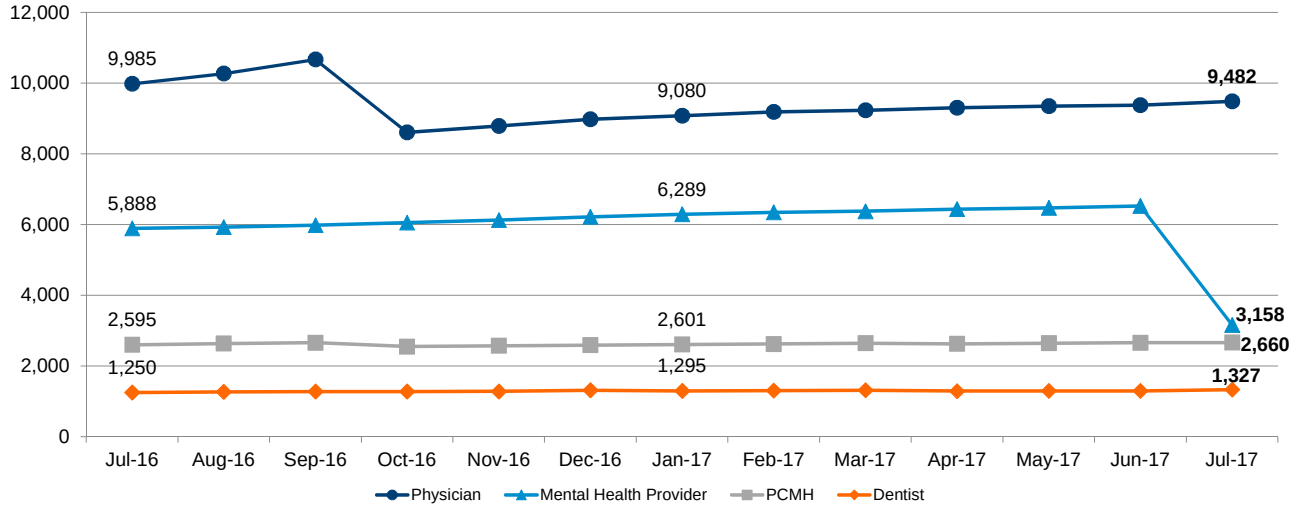
Delivery System			Enrollment July 2017	Children July 2017	Adults July 2017	Enrollment Change	Total Expenditures July 2017	PMPM July 2017	Forecasted Jul 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home			**538,328**	**443,521**	**94,807**	**-7,530**	**$112,988,539**		
	Lower Cost	*(Children/Parents; Other)*	494,236	429,504	64,732	-7,633	$72,057,209	$146	$187
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC)*	44,092	14,017	30,075	103	$40,931,330	$928	$914
SoonerCare Traditional			**236,796**	**89,791**	**147,005**	**2,465**	**$192,437,902**		
	Lower Cost	*(Children/Parents; Other)*	122,760	84,865	37,895	2,082	$64,694,952	$527	$463
	Higher Cost	*(Aged, Blind or Disabled; TEFRA; BCC & HCBS Waiver)*	114,036	4,926	109,110	383	$127,742,950	$1,120	$1,203
SoonerPlan			**33,143**	**2,714**	**30,429**	**-352**	**$251,992**	$8	$9
Insure Oklahoma			**19,699**	**505**	**19,194**	**182**	**$6,726,750**		
	Employer-Sponsored Insurance		14,540	331	14,209	91	$4,655,158	$320	$327
	Individual Plan		5,159	174	4,985	91	$2,071,592	$402	$410
TOTAL			**827,966**	**536,531**	**291,435**	**-5,235**	**$312,405,182**		

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.

IN-STATE CONTRACTED PROVIDERS

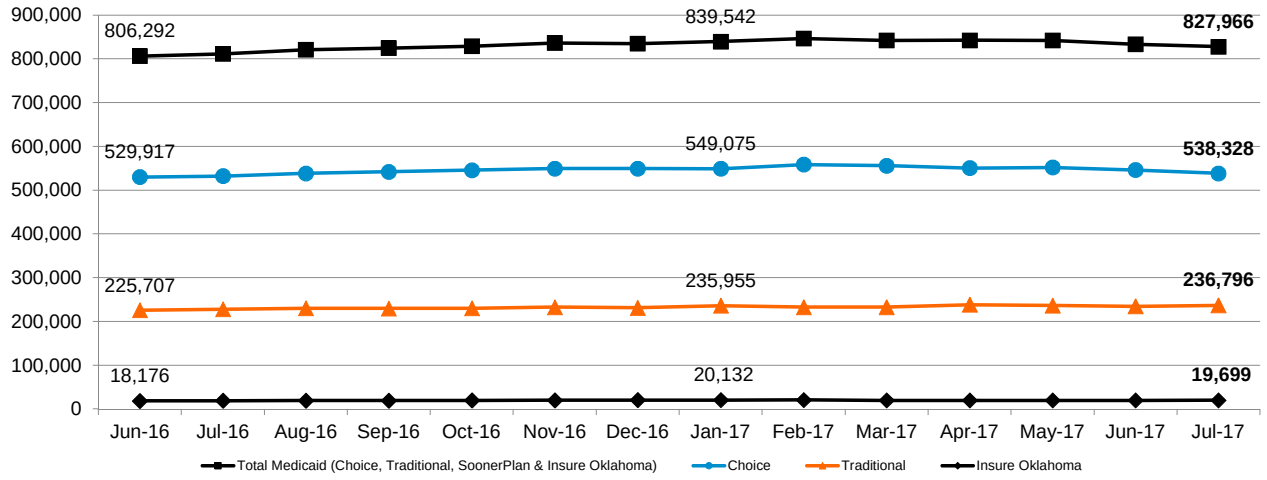
Total In-State Providers: 31,252 (-3336) **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**



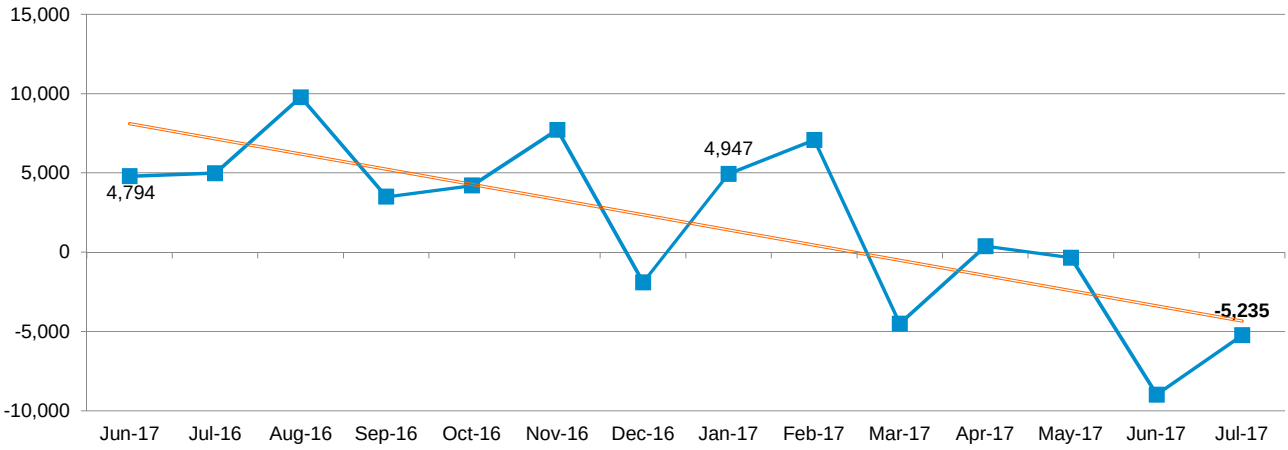


*Decreases are due to contract renewal. Decrease during contract renewal period is typical during all renewal periods.

ENROLLMENT BY MONTH



MONTHLY CHANGE IN ENROLLMENT



PRIVATE DUTY NURSING RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   OHCA proposes to increase the rate paid for private duty nursing (T1000) from $6.30 per 15 min unit ($25.20 / hour) to $7.55 per 15 min unit ($30.20 / hour). The last rate adjustment was in January 2007. Private Duty Nursing (PDN) rates have not kept pace with wage inflation, business expense inflation or home health market basket adjustments as published by CMS. PDN utilizes Registered Nurses and Licensed Practical Nurses to perform their services and due to the low rate there has been a difficulty recruiting and retaining nurses.

   The PDN provider with the largest impact most recently had been in the OKC and Tulsa market since approximately 2004. They closed their Tulsa office in November 2016. At that time, most of their Tulsa area cases were transitioned to management by the OKC office, but a few were absorbed by one of the remaining agencies in Tulsa. In July 2017, they left the Oklahoma market altogether. This required transition of approximately 20 – 25 cases to the remaining PDN agencies. Another agency out of Antlers had provided PDN services to the southeastern portion of the state from mid-2000s until approximately 2012-2013. Our understanding is that they left the PDN market due to the difficulty in attracting and keeping nursing staff. Another agency in Chickasha provided services from 2006 to 2009 and also left the market due to inability to attract staff. Currently, only three organizations remain that provide PDN services to OK Medicaid children.

   The adjustment attempts to better align rates with the current economic situation experienced by this industry in Oklahoma and increase PDN agencies ability to recruit and retain nurses.

   This change will not impact payment for children in state custody.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Currently, the agency pays for private duty nursing services a rate of $6.30 per 15 min unit ($25.20 per hour).

5. NEW METHODOLOGY OR RATE STRUCTURE.

OHCA proposes to increase the rate paid for private duty nursing (T1000) to $7.55 per 15 min unit ($30.20 per hour) effective October 1, 2017. The basis for the new rate is current estimated hourly cost plus five percent.

Currently there is only one rate, regardless of whether the service is provided by a RN or LPN. Based on information from providers, OHCA estimates that the ratio of RNs to LPNs is 24.20%/75.80%. The following table illustrates the formula used to arrive at the proposed rate:

Occupation Category	Provider Cost Estimate	Cost + 5%	Staffing Ratio	Blended Rate Per Hour	Blend Rate Per 15 Min Unit
		Col 2 + 5%		Col 3 x 4	Col 5/ 4
RN	$30.00	$31.80	24.20%	$7.70	$1.92
LPN	$28.00	$29.68	75.80%	$22.50	$5.63
Total				**$30.20**	**$7.55**

6. BUDGET ESTIMATE.

The estimated budget impact for state fiscal year 2018 is estimated to be $0. This assumes increased costs from longer inpatient stays if there is no change. Currently, only three organizations provide PDN services to OK Medicaid children. If there is no rate increase, these organizations will be unable to recruit and retain nurses and OHCA estimates this will lead to a 20% increase in delayed discharges from long term acute care children's hospitals. OHCA does anticipate an increase in utilization with an increased rate due to the addition of nursing staff but there will be a corresponding decrease in hospital days and could result in a net savings to the agency.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The Oklahoma Health Care Authority does not anticipate any negative impact on access to care. The Oklahoma Health Care Authority has appropriate measures in place to monitor any positive or negative impact to access or quality of care, in accordance with requirements at 42 CFR 447.203(b)(6). Currently, there are not enough providers to fulfill the demand for these services. It is believed this rate increase will encourage providers to increase participation and thus have a positive impact on access to care.

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

The agency requests the State Plan Amendment Rate Committee to approve a rate increase to $7.55 per 15 min unit ($30.20 / hour) for all private duty nursing providers.

9. EFFECTIVE DATE OF CHANGE.

October 1, 2017

September Board
Proposed Rule Changes

Face to face tribal consultations regarding the following proposed rule changes were held Tuesday, March 7, 2017 and Tuesday, September 5, 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, May 18, 2017 and Thursday, September 21, 2017.

APA work folder 17-02 was posted on the OHCA public website for a comment period from March 7, 2017 through April 6, 2017. APA work folder 17-13 was posted on the OHCA public website for a comment period from August 30, 2017 through September 21, 2017. APA work folder 17-14 was posted on the OHCA public website for a comment period from September 6, 2017 through September 21, 2017.

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

A. AMENDING agency rules at OAC 317:45-11-20 will strengthen Insure Oklahoma Individual Plan program integrity. Revisions will make it incumbent upon the self-employed applicant to verify self-employment by completing and submitting certain documentation. Revisions will help ensure that self-employed applicants are engaged in routine, for-profit activity, in accordance with Internal Revenue Service guidelines.
Budget Impact: Budget neutral

(Reference APA WF # 17-02)

B. AMENDING agency rules at OAC 317:30-3-4.1 and 317:30-3-30 will clarify the authentication of electronic medical records. Current policy that became effective September 1, 2017 requires that the record be authenticated within three (3) days of the provision of the underlying service. New revisions will revert the three (3) day signature language to the policy that was in place on June 25, 2011. The proposed revisions will clarify that the authentication of medical records is expected on the day the record is completed. Additionally, revisions will describe that the signature of the rendering provider and date entry is expected within three (3) business days from the day the record is completed if the record is being transcribed.
Budget Impact: Budget neutral

(Reference APA WF # 17-13)

C. AMENDING agency rules at OAC 317:30-5-696 will clarify dental coverage for adults by amending the rule that limits dental services for adults to “emergency” extractions. The policy was initially intended for emergency extractions and was later revised to medically necessary extractions. The intent of the change was to ensure the emergency extractions were medically necessary; therefore, the policy will revert to the original language to include the term emergency along with reference to where emergency dental care is defined in policy. Additionally, the proposed revisions add new language on the medically necessary images and oral examination that can accompany an emergency extraction.
Budget Impact: Revisions will result in approximately $479,017 of state share savings for eight months of SFY 2018.

(Reference APA WF # 17-14)

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA

SUBCHAPTER 11. INSURE OKLAHOMA IP

PART 5. INSURE OKLAHOMA IP MEMBER ELIGIBILITY

317:45-11-20. Insure Oklahoma IP eligibility requirements

(a) Oklahoma employed working adults not eligible to participate in an employer's qualified benefit plan, employees of non-participating employers, self-employed, unemployed seeking work, workers with a disability, and qualified college students may apply for the Individual Plan. ~~Applicants cannot obtain IP coverage if they are eligible for ESI. Applicants, unless a qualified college student, must be engaged in employment as defined under state law, must be considered self-employed as defined under federal and/or state law, or must be considered unemployed as defined under state law.~~ Applicants, unless a qualified college student, must be: considered "employed" in accordance with State law, including, but not limited to, 40 O.S. § 1-210; engaged in routine, for-profit activity, if self-employed; or considered "unemployed" in accordance with State law, including, but not limited to 40 O.S. § 1-217. Applicants cannot obtain IP coverage if they are eligible for ESI.

(b) The eligibility determination will be processed within 30 days from the date the complete application is received. The applicant will be notified of the eligibility decision.

(c) In order to be eligible for the IP, the applicant must:

(1) choose a valid PCP according to the guidelines listed in 317:45-11-22, at the time he/she completes application;

(2) be a US citizen or alien as described in 317:35-5-25;

(3) be an Oklahoma resident;

(4) furnish, or show documentation of an application for, a Social Security number at the time of application for Insure Oklahoma IP benefits;

(5) be not currently enrolled in, or have an open application for SoonerCare or Medicare;

(6) be age 19 through 64;

(7) make premium payments by the due date on the invoice;

(8) not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a) (1)-(2);

(9) be not currently covered by a private insurance policy or plan; and

(10) provide in a timely manner any and all documentation that is requested by the Insure Oklahoma program by the specified due date.

(d) If employed and working for an approved Insure Oklahoma employer who offers a qualified benefit plan, the applicant must

meet the requirements in subsection (c) of this Section and:

(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants do not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits;

(2) be ineligible for participation in their employer's qualified benefit plan due to number of hours worked.

(e) If employed and working for an employer who does not offer a qualified benefit plan, the applicant must meet the requirements in subsection (c) of this Section and have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(1) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(2) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(f) If self-employed, the applicant must meet the requirements in subsection (c) of this Section and:

(1) have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(A) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(B) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(2) must not have full-time employment with any employer who does not meet the eligible employer guidelines listed in 317:45-7-1(a)(1)-(2).

(3) must verify self-employment by completing and submitting to Insure Oklahoma the Self-Employment Attestation Form. In addition,

(A) for any applicant who filed a Federal tax return for the tax year immediately preceding the date of application, he or she must provide a copy of such tax return with all supporting schedules and forms, or

(B) for any applicant exempt from filing a Federal tax return for the previous tax year in accordance with Federal law, including, but not limited to, 26 C.F.R. § 1.6017-1, he or she must submit a completed 12-Month Profit and Loss Worksheet to Insure Oklahoma, as well as any other information requested by Insure Oklahoma that could reasonably be used to substantiate the applicant's regular, for-profit business activity.

(g) If unemployed seeking work, the applicant must meet the requirements in subsection(c) of this Section and the following:

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(2) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(3) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits. Applicant must verify eligibility by providing a most recent copy of their monetary OESC determination letter and a most recent copy of at least one of the following:

(A) A OESC eligibility letter;

(B) A OESC weekly unemployment payment statement, or;

(C) A bank statement showing state treasurer deposit.

(h) If working with a disability, the applicant must meet the requirements in subsection (c) of this Section and the following:

(1) Applicants must have countable income at or below the appropriate standard according to the family size on the Insure Oklahoma IP Income Guidelines form.

(2) Applicants may need to verify eligibility of their enrollment in the Ticket to Work program.

(3) Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits is determined using the MAGI methodology. Unless questionable, the income of applicants does not require verification. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income.

(4) Income is evaluated on a monthly basis for all individuals included in the case for Insure Oklahoma IP Benefits.

(i) IP approved individuals must notify the OHCA of any changes, including household status and income, that might impact individual and/or dependent eligibility in the program within 10 days of the change.
(j) When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.
(k) College students may enroll in the Insure Oklahoma IP program as dependents. Effective January 1, 2016, financial eligibility for Insure Oklahoma IP benefits for college students is determined using the MAGI methodology. See OAC 317:35-6-39 through OAC 317:35-6-54 for the applicable MAGI rules for determining household composition and countable income. Dependent college students must enroll under their parents and all annual gross household income (including parent income) must be included in determining eligibility. Independent college students may apply on their own without parent income included in the household. College student status as dependent or independent is determined by the student's current Free Application for Federal Student Aid (FAFSA). College students must also provide a copy of their current student schedule to prove full-time student status.
(l) Any misleading or false representation, or omission of any material fact or information required or requested by OHCA as part of the Insure Oklahoma application process, may result in, among other things, closure of eligibility pursuant to OAC 317:45-11-27.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-4.1. Uniform Electronic Transaction Act

These rules regulate the format, use, and retention of electronic records and signatures generated, sent, communicated, received, or stored by the Oklahoma Health Care Authority (OHCA), in conformity with the Uniform Electronic Transaction Act, found at Section 15-101 et seq. of Title 12A of the Oklahoma Statutes.

(1) **Use of electronic records and electronic signatures.** The rules regarding electronic records and electronic signatures apply when both parties agree to conduct business electronically. Nothing in these regulations requires parties to conduct business electronically. However, should a party have the capability and desire to conduct business electronically with the OHCA, then the following guidelines must be adhered to:

(A) Only employees designated by the provider's agency may make entries in the member's medical record. All entries in the member's medical record must be dated and authenticated with a method established to identify the author. The identification method may include computer keys, Private/Public Key Infrastructure (PKIs), voice authentication systems that utilize a personal identification number (PIN) and voice authentication, or other codes. Providers must have a process in place to deactivate an employee's access to records upon termination of employment of the designated employee.

(B) When PKIs, computer key/code(s), voice authentication systems or other codes are used, a signed statement must be completed by the agency's employee documenting that the chosen method is under the sole control of the person using it and further demonstrate that:

(i) A list of PKIs, computer key/code(s), voice authentication systems or other codes can be verified;

(ii) All adequate safeguards are maintained to protect against improper or unauthorized use of PKIs, computer keys, or other codes for electronic signatures; and

(iii) Sanctions are in place for improper or unauthorized use of computer key/code(s), PKIs, voice authentication systems or other code types of electronic signatures.

(C) There must be a specific action by the author to indicate that the entry is verified and accurate. Systems

requiring an authentication process include, but are not limited to:

(i) Computerized systems that require the provider's employee to review the document on-line and indicate that it has been approved by entering a unique computer key/code capable of verification;

(ii) A system in which the provider's employee signs off against a list of entries that must be verified in the member's records;

(iii) A mail system that sends transcripts to the provider's employee for review;

(iv) A postcard identifying and verifying the accuracy of the record(s) signed and returned by the provider's employee; or

(v) A voice authentication system that clearly identifies the author by a designated personal identification number or security code.

(D) Auto-authentication systems that authenticate a report prior to the transcription process do not meet the stated requirements and will not be an acceptable method for the authentication process.

(E) The authentication of an electronic medical record (signature and date entry) ~~must occur within three (3) days of the provision of the underlying service, including those instances in which~~ is expected on the day the record is completed. If the electronic medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three (3) business days from the day the record is completed. Before any claim is submitted to OHCA for payment of a provided service, the provider must authenticate the electronic medical records relating to that service.

(F) Records may be edited by designated administrators within the provider's facility. Edits must be in the form of a correcting entry which preserves entries from the original record. Edits must be completed prior to claims submission or no later than forty-five (45) days after the date of service, whichever occurs first.

(G) Use of the electronic signature, for clinical documentation, shall be deemed to constitute a signature and will have the same effect as a written signature on the clinical documentation. The section of the electronic record documenting the service provided must be authenticated by the employee or individual who provided the described service.

(H) Any authentication method for electronic signatures must:

(i) be unique to the person using it;

(ii) identify the individual signing the document by name and title;
(iii) be capable of verification, assuring that the documentation cannot be altered after the signature has been affixed;
(iv) be under the sole control of the person using it;
(v) be linked to the data in such a manner that if the data is changed, the signature is invalidated; and
(vi) provide strong and substantial evidence that will make it difficult for the signer to claim that the electronic representation is not valid.

(I) Failure to properly maintain or authenticate medical records (i.e., signature and date entry) may result in the denial or recoupment of SoonerCare payments.

(2) **Record retention for provider medical records.** Providers must retain electronic medical records and have access to the records in accordance with guidelines found at OAC 317:30-3-15.

(3) **Record retention for documents submitted to OHCA electronically.**

(A) The OHCA's system provides that receivers of electronic information may both print and store the electronic information they receive. The OHCA is the custodian of the original electronic record and will retain that record in accordance with a disposition schedule as referenced by the Records Destruction Act. The OHCA will retain an authoritative copy of the transferable record as described in the Electronic Transaction Act that is unique, identifiable and unalterable.

(i) **Manner and format of electronic signature.** The manner and format required by the OHCA will vary dependent upon whether the sender of the document is a member or a provider. In the limited case where a provider is a client, the manner and format is dependent upon the function served by the receipt of the record. In the case the function served is a request for services, then the format required is that required by a recipient. In the case the function served is related to payment for services, then the format required is that required by a provider.

(ii) **Member format requirements.** The OHCA will allow members to request SoonerCare services electronically. An electronic signature will be authenticated after a validation of the data on the form by another database or databases.

(iii) **Provider format requirements.** The OHCA will permit providers to contract with the OHCA, check and amend claims filed with the OHCA, and file prior authorization requests with the OHCA. Providers with a

social security number or federal employer's identification number will be given a personal identification number (PIN). After using the PIN to access the database, a PIN will be required to transact business electronically.

(B) Providers with the assistance of the OHCA will be required to produce and enforce a security policy that outlines who has access to their data and what transaction employees are permitted to complete as outlined in the policy rules for electronic records and electronic signatures contained in paragraph two (2) of this section.

(C) Third Party billers for providers will be permitted to perform electronic transaction as stated in paragraph two (2) only after the provider authorizes access to the provider's PIN and a power of attorney by the provider is executed.

(4) **Time and place of sending and receipt.** The provisions of the Electronic Transaction Act apply to the time and place of sending and receipt. Should a power failure, Internet interruption or Internet virus occur, confirmation by the receiving party will be required to establish receipt.

(5) **Illegal representations of electronic transaction.** Any person who fraudulently represents facts in an electronic transaction, acts without authority, or exceeds his or her authority to perform an electronic transaction may be prosecuted under all applicable criminal and civil laws.

317:30-3-30. Signature requirements

(a) For medical review purposes, the Oklahoma Health Care Authority (OHCA) requires that all services provided and/or ordered be authenticated by the author. The method used shall be a handwritten signature, electronic signature, or signature attestation statement. Stamped signatures are not acceptable. Pursuant to Federal and/or State law, there are some circumstances for which an order does not need to be signed.

(1) Facsimile of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.

(2) Orders for clinical diagnostic tests are not required to be signed. If the order for the clinical diagnostic test is unsigned, there must be medical documentation by the treating physician that he/she intended the clinical diagnostic test be performed. This documentation showing the intent that the test be performed must be authenticated by the author via a handwritten or electronic signature.

(3) Orders for outpatient prescription drugs are not required to be signed. If the order for a prescription drug is unsigned, there must be medical documentation by the treating physician that he/she intended that the prescription drug be

ordered. This documentation showing the intent that the prescription drug be ordered must be authenticated by the author via a handwritten or electronic signature.

(b) A handwritten signature is a mark or sign by an individual on a document to signify knowledge, approval, acceptance, or obligation. The authentication of a medical record (signature and date entry) ~~must occur within three (3) days of provision of the underlying service, including those instances in which the electronic medical record is transcribed by someone other than the provider. Before any claim is submitted to the OHCA for payment of a provided service, the provider must authenticate the electronic medical records relating to that service.~~ is expected on the day the record is completed. If the medical record is transcribed by someone other than the provider, the signature of the rendering provider and date entry is expected within three (3) business days from the day the record is completed. Before any claim is submitted to OHCA for payment of a provided service, the provider must authenticate the medical records relating to that service.

(1) If a signature is illegible, the OHCA will consider evidence in a signature log or attestation statement to determine the identity of the author of a medical record entry.

(2) If the signature is missing from an order, the OHCA will disregard the order during the review of the claim.

(3) If the signature is missing from any other medical documentation, the OHCA will accept a signature attestation from the author of the medical record entry.

(c) Providers may include in the documentation they submit a signature log that lists the typed or printed name of the author associated with initials or an illegible signature.

(1) The signature log may be included on the actual page where the initials or illegible signature are used or may be a separate document.

(2) The OHCA will not deny a claim for a signature log that is missing credentials.

(3) The OHCA will consider all submitted signature logs regardless of the date they were created.

(d) Providers may include in the documentation they submit a signature attestation statement. In order to be considered valid for medical review purposes, an attestation statement must be signed and dated by the author of the medical record entry and must contain sufficient information to identify the member.

(1) The OHCA will not consider signature attestation statements where there is no associated medical record entry.

(2) The OHCA will not consider signature attestation statements from someone other than the author of the medical record entry in question.

(3) The OHCA will consider all signature attestation statements that meet the above requirements regardless of the date the attestation was created, except in those cases where the regulations or rules indicate that a signature must be in place prior to a given event or a given date.

(e) Providers may use electronic signatures as an alternate signature method.

(1) Providers must use a system and software products which are protected against modification and must apply administrative procedures which are adequate and correspond to recognized standards and laws.

(2) Providers utilizing electronic signatures bear the responsibility for the authenticity of the information being attested to.

(3) Providers utilizing electronic signatures must comply with OAC 317:30-3-4.1.

(f) Nothing in this section is intended to absolve the provider of their obligations in accordance with the conditions set forth in their SoonerCare contract and the rules delineated in OAC 317:30.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

317:30-5-696. Coverage by category

Payment is made for dental services as set forth in this Section.

(1) **Adults.**

(A) Dental coverage for adults is limited to:

(i) ~~medically necessary~~emergency extractions, as defined in OAC 317:30-5-695. ~~and approved boney adjustments.~~ Tooth extraction must have medical need documented;

(ii) limited oral examinations and medically necessary images associated with the emergency extraction or with a clinical presentation with reasonable expectation that an emergency extraction will be needed;

~~(ii)~~(iii) Smoking and Tobacco Use Cessation Counseling; and

~~(iii)~~(iv) medical and surgical services performed by a dentist or physician to the extent such services may be performed under State law when those services would be covered if performed by a physician.

(B) Payment is made for dental care for adults residing in private Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) and who have been approved for ICF/IID level of care, similar to the scope of services available to individuals under age 21.

(C) Limited dental services are available for members who meet all medical criteria, but need dental clearance to obtain organ transplant approval. Providers must obtain prior authorization before delivery of dental service, with the exception of evaluation and extractions. All requests must be filed on the currently approved American Dental Association (ADA) form and must include diagnostic images, six-point periodontal charting, narratives and comprehensive treatment plans. The OHCA will notify the provider of determination using OHCA Prior Authorization Request Decision form. Prior authorized services must be billed exactly as they appear on the prior authorization request. The following dental services are available:

(i) comprehensive oral evaluation,

(ii) two image bitewings,

(iii) prophylaxis,

(iv) fluoride application,

(v) limited restorative procedures, and
(vi) periodontal scaling/root planing.

(2) **Home and community based waiver services (HCBWS) for the intellectually disabled.** All providers participating in the HCBWS must have a separate contract with the OHCA to provide services under the HCBWS. Dental services are defined in each waiver and must be prior authorized.

(3) **Children.** The OHCA Dental Program provides the basic medically necessary treatment. The services listed below are compensable for members under 21 years of age without prior authorization. All other dental services must be prior authorized. Anesthesia services are covered for children in the same manner as adults. All providers performing preventive services must be available to perform needed restorative services for those members receiving any evaluation and preventive services.

(A) **Comprehensive oral evaluation.** This procedure should precede any images, and chart documentation must include image interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

(B) **Periodic oral evaluation.** This procedure may be provided for a member of record if not seen by any dentist for more than six months. An examination should precede any images, and chart documentation must include images interpretations, caries risk assessment and both medical and dental health history of member. The comprehensive treatment plan should be the final results of this procedure.

(C) **Limited oral evaluation.** This procedure is only compensable to the same dentist or practice for two visits prior to a comprehensive or periodic evaluation examination being completed.

(D) **Images.** To be SoonerCare compensable, images must be of diagnostic quality and medically necessary. A clinical examination must precede any images, and chart documentation must include member history, prior images, caries risk assessment and both dental and general health needs of the member. The referring dentist is responsible for providing properly identified images of acceptable quality with a referral, if that provider chooses to expose and submit for reimbursement prior to referral. Periapical images must include at least three millimeters beyond the apex of the tooth being imaged. Panoramic films and two bitewings are considered full mouth images. Full mouth images as noted above or traditional (minimum of 12 periapical films and two posterior bitewings) are

allowable once in a three year period and must be of diagnostic quality. Individually listed intraoral images by the same dentist/dental office are considered a complete series if the number of individual images equals or exceeds the traditional number for a complete series. Panoramic films are only compensable when chart documentation clearly indicates reasons for the exposure based on clinical findings. This type of exposure is not to rule out or evaluate caries. Prior authorization and a detailed medical need narrative are required for additional panoramic films taken within three years of the original set.

(E) **Dental sealants.** Tooth numbers 2, 3, 14, 15, 18, 19, 30 and 31 must be caries free on the interproximal and occlusal surfaces to be eligible for this service. This service is available through 18 years of age and is compensable once every 36 months if medical necessity is documented.

(F) **Dental prophylaxis.** This procedure is provided once every 184 days including topical application of fluoride.

(G) **Stainless steel crowns for primary teeth.** The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are allowed if:

(I) the child is five years of age or under;

(II) 70 percent or more of the root structure remains; or

(III) the procedure is provided more than 12 months prior to normal exfoliation.

(ii) Stainless steel crowns are treatment of choice for:

(I) primary teeth treated with pulpal therapy, if the above conditions exist;

(II) primary teeth where three surfaces of extensive decay exist; or

(III) primary teeth where cuspal occlusion is lost due to decay or accident.

(iii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.

(iv) Placement of a stainless steel crown is allowed once for a minimum period of 24 months. No other restoration on that tooth is compensable during that period of time. A stainless steel crown is not a temporizing treatment to be used while a permanent crown is being fabricated.

(H) **Stainless steel crowns for permanent teeth**. The use of any stainless steel crowns is allowed as follows:

(i) Stainless steel crowns are the treatment of choice

for:

(I) posterior permanent teeth that have completed endodontic therapy if three or more surfaces of tooth is destroyed;

(II) posterior permanent teeth that have three or more surfaces of extensive decay; or

(III) where cuspal occlusion is lost due to decay prior to age 16 years.

(ii) Preoperative periapical images and/or written documentation explaining the extent of decay must be available for review, if requested.

(iii) Placement of a stainless steel crown excludes placement of any other type of crown for a period of 24 months. No other restoration on that tooth is compensable during that period of time.

(I) **Pulpotomies and pulpectomies.**

(i) Therapeutic pulpotomies and pulpal debridement are allowable once per lifetime. Pre-and post-operative periapical images must be available for review, if requested. Therapeutic pulpotomies and pulpal debridement is available for the following:

(I) Primary molars having at least 70 percent or more of their root structure remaining or more than 12 months prior to normal exfoliation;

(II) Tooth numbers O and P before age five years;

(III) Tooth numbers E and F before six years;

(IV) Tooth numbers N and Q before five years;

(V) Tooth numbers D and G before five years.

(ii) Therapeutic pulpotomies and pulpal debridement are allowed for primary teeth if exfoliation of the teeth is not expected to occur for at least one year or if 70 percent or more of root structure is remaining.

(J) **Endodontics.** Payment is made for the services provided in accordance with the following:

(i) This procedure is allowed when there are no other missing anterior teeth in the same arch requiring replacement.

(ii) The provider documents history of member's improved oral hygiene and flossing ability in records.

(iii) Prior authorization is required for members who have a treatment plan requiring more than two anterior and/or two posterior root canals.

(iv) Pre and post-operative periapical images must be available for review.

(v) Pulpal debridement may be performed for the relief of pain while waiting for the decision from the OHCA.

(vi) Providers are responsible for any follow-up treatment required due to a failed root canal therapy for 24 month post completion.

(vii) Endodontically treated teeth should be restored to limited occlusal function and all contours should be replaced. These teeth are not automatically approved for any type of crown.

(K) **Space maintainers.** Certain limitations apply with regard to this procedure. Providers are responsible for recementation of any maintainer placed by them for six months post insertion.

(i) **Band and loop type space maintenance.** This procedure must be provided in accordance with the following guidelines:

(I) This procedure is compensable for all primary molars where permanent successor is missing or where succedaneous tooth is more than 5mm below the crest of the alveolar ridge.

(II) First primary molars are not allowed space maintenance if the second primary and first permanent molars are present and in cuspal interlocking occlusion regardless of the presence or absence of normal relationship.

(III) If there are missing posterior teeth bilaterally in the same arch, under the above guidelines, bilateral space maintainer is the treatment of choice.

(IV) The teeth numbers shown on the claim should be those of the missing teeth.

(V) Post-operative bitewing images must be available for review.

(VI) Bilateral band and loop space maintainer is allowed if member does not have eruption of the four mandibular anterior teeth in position or if sedation case that presents limitations to fabricate other space maintenance appliances.

(ii) **Lingual arch bar.** Payment is made for the services provided in accordance with the following:

(I) Lingual arch bar is used when permanent incisors are erupted and the second primary molar (K or T) is missing in the same arch.

(II) The requirements are the same as for band and loop space maintainer.

(III) Pre and post-operative images must be available.

(L) **Analgesia.** Analgesia services are reimbursable in accordance with the following:

(i) **Inhalation of nitrous oxide.** Use of nitrous oxide

is compensable for four occurrences per year and is not separately reimbursable, if provided on the same date by the same provider as IV sedation, non-intravenous conscious sedation, or general anesthesia. The medical need for this service must be documented in the member's record.

(ii) **Non-intravenous conscious sedation.** Non-intravenous conscious sedation is not separately reimbursable, if provided on the same date by the same provider as analgesia, anxiolysis, inhalation of nitrous oxide, IV sedation, or general anesthesia. Non-intravenous conscious sedation is reimbursable when determined to be medically necessary for documented handicapped members, uncontrollable members or justifiable medical or dental conditions. The report must detail the member's condition. No services are reimbursable when provided primarily for the convenience of the member and/or the dentist, it must be medically necessary.

(M) **Pulp caps.** Indirect and direct pulp cap must be ADA accepted calcium hydroxide or Mineral Trioxide Aggregate materials, not a cavity liner or chemical used for dentinal hypersensitivity. Indirect and direct pulp cap codes require specific narrative support addressing materials used, intent and reasons for use. Application of chemicals used for dentinal hypersensitivity is not allowed as indirect pulp cap. Utilization of these codes is verified by post payment review.

(N) **Protective restorations.** This restoration includes removal of decay, if present, and is reimbursable for the same tooth on the same date of service with a direct or indirect pulp cap, if needed. Permanent restoration of the tooth is allowed after 60 days unless the tooth becomes symptomatic and requires pain relieving treatment.

(O) **Smoking and Tobacco Use Cessation Counseling.** Smoking and Tobacco Use Cessation Counseling is covered when performed utilizing the five intervention steps of asking the member to describe his/her smoking, advising the member to quit, assessing the willingness of the member to quit, assisting with referrals and plans to quit, and arranging for follow-up. Up to eight sessions are covered per year per individual who has documented tobacco use. It is a covered service when provided by physicians, physician assistants, nurse practitioners, certified nurse midwives, Oklahoma State Health Department and FQHC nursing, and Maternal/Child Health Licensed Clinical Social Workers with a certification as a Tobacco Treatment Specialist Certification (CTTS) staff in addition to other

appropriate services rendered. Chart documentation must include a separate note that addresses the 5A's, separate signature, and the member specific information addressed in the five steps and the time spent by the practitioner performing the counseling. Anything under three minutes is considered part of a routine visit.

(P) **Diagnostic casts and oral/facial images**. Diagnostic casts or oral/facial images may be requested by OHCA or representatives of OHCA. If cast or images are received they will be considered supporting documentation and may be used to make a determination for authorization of services. Submitted documentation used to base a decision will not be returned. Providers will be reimbursed for either the study model or images.

(i) Documentation of photographic images must be kept in the client's medical record and medical necessity identified on the submitted electronic or paper claim.

(ii) Oral/facial photographic images are allowed under the following conditions:

(I) When radiographic images do not adequately support the necessity for requested treatment.

(II) When photo images better support medical necessity for the requested treatment rather than diagnostic models.

(III) If a comprehensive orthodontic workup has not been performed.

(iii) For photographic images, the oral/facial portfolio must include a view of the complete lower arch, complete upper arch, and left and right maximum intercuspation of teeth.

(I) Maximum intercuspation refers to the occlusal position of the mandible in which the cusps of the teeth of both arches fully interpose themselves with the cusps of the teeth of the opposing arch.

(II) Intercuspation defines both the anterior-posterior and lateral relationships of the mandible and the maxilla, as well as the superior-inferior relationship known as the vertical dimension of occlusion.

(iv) Study models or photographic images not in compliance with the above described diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

Recommendation 1: Vote to Prior Authorize Radicava™ (Edaravone)

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

Radicava™ (Edaravone) Approval Criteria:

1. An FDA approved diagnosis of amyotrophic lateral sclerosis (ALS); and
2. Member must have been evaluated by a physician specializing in the treatment of ALS within the last three months; and
3. Disease duration of two years or less (for initial approval); and
    a. A prior authorization request with patient-specific information may be submitted for consideration of edaravone for members with disease duration greater than two years, including but not limited to disease progression, specific symptoms related to the disease, activities of daily living currently affected by the disease, or prognosis; and
4. Approvals will be for the duration of six months. For each subsequent approval, the prescriber must document that the member is responding to the medication, as indicated by a slower progression in symptoms and/or slower decline in quality of life compared to the typical ALS disease progression.

Recommendation 2: Vote to Prior Authorize Eucrisa™ (Crisaborole 2% Ointment), Dupixent® (Dupilumab Injection), & Prudoxin™ and Zonalon® (Doxepin 5% Cream)

The Drug Utilization Review Board recommends the prior authorization of Eucrisa™ (crisaborole), Dupixent® (dupilumab), and Prudoxin™ and Zonalon® (doxepin cream) with the following criteria:

Eucrisa™ (Crisaborole Ointment) Approval Criteria:

1. An FDA approved indication for treatment of mild-to-moderate atopic dermatitis (eczema); and
2. Member must be at least 2 years of age or older; and
3. Member must have documented trials within the last six months for a minimum of two weeks that resulted in failure with both of the following therapies (or have a contraindication or documented intolerance):
    a. One Tier-1 topical corticosteroid; and
    b. One topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
4. A quantity limit of one tube per 30 days will apply.
5. Initial approvals will be for the duration of one month. Reauthorization may be granted if the prescriber documents the member is responding well to treatment.

Dupixent® (Dupilumab Injection) Approval Criteria:

1. An FDA approved diagnosis of moderate-to-severe atopic dermatitis not adequately controlled with topical prescription therapies; and
2. Member must be 18 years of age or older; and
3. Member must have documented trials within the last six months for a minimum of two weeks that resulted in failure with both of the following therapies (or have a contraindication or documented intolerance):
    a. One medium potency to very-high potency Tier-1 topical corticosteroid; and
    b. One topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
4. Dupixent® must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist within the last twelve months (or be an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
5. Requests for concurrent use of Dupixent® with other biologic medications will be reviewed on a case-by-case basis and will require patient-specific information to support the concurrent use. (Dupixent® has not been studied in combination with other biologic therapies.)
6. Initial approvals will be for the duration of 16 weeks. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

Prudoxin™ and Zonalon® (Doxepin Cream) Approval Criteria:

1. An FDA approved diagnosis for the short-term (up to eight days) management of moderate pruritus in patients with atopic dermatitis or lichen simplex chronicus; and
2. Requests for longer use than eight days will not generally be approved. Chronic use beyond eight days may result in higher systemic levels and should be avoided.

Recommendation 3: Vote to Prior Authorize Vimizim® (Elosulfase Alfa)

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

Vimizim® (Elosulfase Alfa) Approval Criteria:

1. An FDA approved diagnosis of Morquio A syndrome (mucopolysaccharidosis type IVA; MPS IVA) confirmed by:
    a. Enzyme assay demonstrating a deficiency of *N*-acetylgalactosamine-6-sulfatase (GALNS) enzyme activity; or
    b. Molecular genetic testing to confirm biallelic pathogenic variants in *GALNS*; and
2. Vimizim® must be administered by a healthcare professional prepared to manage anaphylaxis; and
3. Initial approvals will be for the duration of twelve months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment.
4. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

Recommendation 4: Vote to Prior Authorize Rayaldee® (Calcifediol), Parsabiv™ (Etelcalcetide), Zemplar® (Paricalcitol Capsules), and Hectorol® (Doxercalciferol Capsules)

The Drug Utilization Review Board recommends the prior authorization of Rayaldee® (calcifediol ER capsules), Parsabiv™ (etelcalcetide injection), Zemplar® (paricalcitol capsules), and Hectorol® (doxercalciferol capsules) with the following criteria:

Rayaldee® (Calcifediol ER Capsules) Approval Criteria:

1. An FDA approved indication for treatment of secondary hyperparathyroidism (SHPT) in adults with chronic kidney disease (CKD) stage 3 or 4; and
2. Member must not have CKD stage 5 or end-stage renal disease on dialysis; and
3. Member should have a serum total 25-hydroxyvitamin D level less than 30ng/mL before starting treatment; and
4. Member should have a serum calcium level below 9.8mg/dL before initiating treatment; and
5. Rayaldee® must be prescribed by a nephrologist, endocrinologist, or provider who specializes in the treatment of SHPT; and
6. Member must have a documented failure or clinically-significant reason why the member cannot use available generic vitamin D analogs including calcitriol; and
7. Initial approval will be for 30mcg daily for three months; and
    a. After three months, approval for 60mcg daily for 12 months can be considered if intact parathyroid hormone (iPTH) is above the treatment goal and serum calcium is below 9.8mg/dL, phosphorus is below 5.5mg/dL, and 25-hydroxyvitamin D is below 100ng/mL.
    b. Additional approvals will not be granted if iPTH is persistently abnormally low, serum calcium is consistently above the normal range, or serum 25-hydroxyvitamin D is consistently above 100ng/mL.
8. A quantity limit of 60 capsules per 30 days will apply.

Parsabiv™ (Etelcalcetide Injection) Approval Criteria:

1. An FDA approved indication for the treatment of secondary hyperparathyroidism (SHPT) in adult patients with chronic kidney disease (CKD) on hemodialysis; and
2. Parsabiv™ will not be approved for parathyroid carcinoma, primary hyperparathyroidism, or in patients with CKD who are not on hemodialysis and is not recommended for use in these populations; and
3. Member's corrected serum calcium should be at or above the lower limit of normal (≥ 8.3mg/dL) prior to initiation, dose increase, or re-initiation of Parsabiv™; and
4. Parsabiv™ must be prescribed by a nephrologist, endocrinologist, or provider who specializes in the treatment of SHPT; and
5. Member must have a documented failure or a clinically-significant reason why the member cannot use available generic vitamin D analogs including calcitriol; and
6. Member must have a documented failure or a clinically-significant reason why the member cannot use Sensipar® (cinacalcet); and
7. A quantity limit of 12 vials per month will apply.

Zemplar® (Paricalcitol Capsules) Approval Criteria:

1. Member must be 10 years of age or older; and
2. An FDA approved indication for the prevention and treatment of secondary hyperparathyroidism (SHPT) associated with one of the following:
    a. Chronic kidney disease (CKD) stage 3 or 4; or
    b. CKD stage 5 in patients on hemodialysis or peritoneal dialysis; and
        i. Members with CKD stage 5 should have a corrected total serum calcium equal to or less than 9.5mg/dL before initiating treatment; and

3. Zemplar® must be prescribed by a nephrologist, endocrinologist, or provider who specializes in the treatment of SHPT; and
4. Member must have a documented failure or a clinically-significant reason why the member cannot use other generic vitamin D analogs available without prior authorization including calcitriol and Zemplar® injection; and
5. A quantity limit of 30 capsules per 30 days will apply.

Hectorol® (Doxercalciferol Capsules) Approval Criteria:

1. An FDA approved diagnosis; and
2. Member must have a documented failure or a clinically-significant reason why the member cannot use calcitriol.

Recommendation 5: Vote to Prior Authorize Brineura™ (Cerliponase Alfa)

The Drug Utilization Review Board recommends the prior authorization of Brineura™ (cerliponase alfa) with the following criteria:

Brineura™ (Cerliponase Alfa) Approval Criteria:

1. An FDA-approved diagnosis of late infantile neuronal ceroid lipofuscinosis type 2 (CLN2) also known as tripeptidyl peptidase-1 (TPP-1) deficiency; and
2. Member must have confirmed TPP-1 enzymatic deficiency via enzyme assay, confirmed by molecular analysis; and
3. Member must be at least 3 years of age or older; and
4. Brineura™ must be prescribed by a specialist with expertise in treatment of CLN2 (or be an advanced care practitioner with a supervising physician who is a specialist with expertise in treating CLN2); and
5. Brineura™ must be administered in a healthcare facility by a prescriber who is knowledgeable in intraventricular administration; and
6. Member must not have ventriculoperitoneal shunts or acute intraventricular access device-related complications; and
7. Member must not have documented generalized status epilepticus within 4 weeks of initiating treatment; and
8. Prescriber must verify member's blood pressure and heart rate will be monitored prior to each infusion, during infusion, and post-infusion; and
9. Prescriber must be willing to perform regular 12-lead electrocardiogram (ECG) evaluation at baseline and at least every 6 months and verify that they are acceptable to the prescriber; and
10. A baseline assessment must be performed to assess the Motor plus Language CLN2 score; and
11. Initial authorizations will be for the duration of six months, at which time compliance will be required for continued approval. After 12 months of utilization, the prescriber must verify the member is responding to the medication as demonstrated by a two point or less decline in Motor plus Language CLN2 score from baseline; and

Approval quantity will be based on Brineura™ prescribing information and FDA approved dosing regimen.

Drug	Used for	Cost	Notes
Radicava	ALS	~$142,000/year	~20 members
Eucrisa Ointment	Dermatitis	$570/month	Step therapy
Dupixent Injection	Dermatitis	$2900/month	Step therapy
Prudoxin Cream	Dermatitis	$500+/tube	Step therapy
Zonalon Cream	Dermatitis	$500+/tube	Step therapy
Vimizim	Enzyme deficiency	up to $1.2M/year	No utilization
Rayaldee	Chronic Kidney Disease	$22,000/year	Step therapy
Parsabiv	Chronic Kidney Disease	n/a	Step therapy
Zemplar	Chronic Kidney Disease	$2000-$4300/year	Step therapy
Hectoral	Chronic Kidney Disease	$22,000/year	Step therapy
Brineura	Enzyme deficiency	$468,000/year	No requests yet