

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

AGENDA

Items to be presented by Tony Armstrong, Vice-Chairman

1. Call to Order / Determination of Quorum
2. Action Item – Approval of the November 9, 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) Financial Update – Carrie Evans, Chief Financial Officer
 - b) Medicaid Director’s Update – Garth Splinter, Deputy Chief Executive Officer
 - c) Legislative Update – Cate Jeffries, Interim Legislative Liaison

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

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

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

6. Action Item – Consideration and Vote Upon the Recommendations of the State Plan Amendment Rate Committee
 - a) Consideration and vote to implement a method change for outpatient hospital dental and ENT rates effective 1/1/2018. The new rate for these services will be cost based and will equalize the rates to improve access for dental services to be rendered in the hospital setting. The estimated budget impact for SFY 2018 is estimated to be \$0.
 - b) Consideration and vote to reinstate the 9.00% across-the-board rate reduction to SoonerCare providers that was to go into effect on 12/1/2017. The proposed reduction excludes complex rehabilitation technology provider services, long-term care facilities, child abuse exams, non-emergency transportation, Insure Oklahoma, payments for drug ingredients, physician supplied drugs, services provided under a waiver, services paid for by other state agencies, services provided to Native Americans through Indian Health Services Indian/Tribal/Urban (ITU) Clinics, and private duty nursing, emergency transportation, FQHCs/RHCs, Choice Care Coordination, and Programs of All-inclusive Care for the Elderly (PACE). While this list of exclusions is fairly comprehensive it is not exhaustive. The estimated budget impact for the remainder of SFY 2018 will be an increase in the total amount of \$68,409,743; of which \$28,342,157 is state savings.

- c) Consideration and vote to implement an across-the-board rate reduction in the amount of 6.00% to SoonerCare providers effective 1/1/2018. The proposed reduction excludes complex rehabilitation technology provider services, long-term care facilities, child abuse exams, non-emergency transportation, Insure Oklahoma, payments for drug ingredients, physician supplied drugs, services provided under a waiver, services paid for by other state agencies, services provided to Native Americans through Indian Health Services Indian/Tribal/Urban (ITU) Clinics, and private duty nursing, emergency transportation, FQHCs/RHCs, Choice Care Coordination, and Programs of All-inclusive Care for the Elderly (PACE). While this list of exclusions is fairly comprehensive it is not exhaustive. The estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$38,005,413; of which \$15,745,643 is state savings.
- d) Consideration and vote to implement a payment methodology change to pay 0% of the Medicare Part A and Part B coinsurance and deductible on crossover claims to nursing facilities. This was previously approved to take effect on 12/1/2017. The new effective date will be 1/1/2018. The updated estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$2,936,027; of which \$1,216,396 is state savings.
- e) Consideration and vote to reinstate the 4.00% rate reduction for Regular Nursing Facilities that was to go into effect on 12/1/2017. The reinstated Base Rate Component will be \$107.79 per patient day. The reinstated combined pool amount for "Direct Care" and "Other" Component will be \$160,636,876. The estimated budget impact for the remainder of SFY 2018 will be an increase in the total amount of \$10,669,304; of which \$4,384,017 is state savings.
- f) Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Regular Nursing Facilities by 1.00% effective 1/1/2018. The new Base Rate Component will be \$107.73 per patient day. The new combined pool amount for "Direct Care" and "Other" Component will be \$158,498,444. The estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$2,222,772; of which \$913,337 is state savings.
- g) Consideration and vote to reinstate the 4.00% rate reduction for Regular (more than 16 beds) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) providers that was to go into effect on 12/1/2017. The reinstated Base Rate Component will be \$122.77 per patient day. The estimated budget impact for the remainder of SFY 2018 will be an increase in the total amount of \$444,759; of which \$182,752 is state savings.
- h) Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Regular (more than 16 beds) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) by 1.00% effective 1/1/2018. The new Base Rate Component will be \$121.70 per patient day. The estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$92,658; of which \$38,073 is state savings.
- i) Consideration and vote to reinstate the 4.00% rate reduction for Acute (16 beds or less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) providers that was to go into effect on 12/1/2017. The reinstated Base Rate Component will be \$157.03 per patient day. The estimated budget impact for the remainder of SFY 2018 will be an increase in the total amount of \$789,944; of which \$324,588 is state savings.
- j) Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Acute (16 beds or less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) by 1.00% effective 1/1/2018. The new Base Rate Component will be \$155.63 per patient day. The estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$164,572; of which \$67,623 is state savings.
- k) Consideration and vote to reinstate the 4.00% rate reduction for services provided by Nursing Facilities for Individuals with Acquired Immune Deficiency Syndrome (AIDS) that was to go into effect on 12/1/2017. The reinstated Base Rate Component will be \$200.01 per patient day. The estimated

budget impact for the remainder of SFY 2018 will be an increase in the total amount of \$31,557; of which \$12,967 is state savings.

- l) Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Nursing Facilities for Individuals with Acquired Immune Deficiency Syndrome (AIDS) by 1.00% effective 1/1/2018. The new Base Rate Component will be \$198.39 per patient day. The estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$6,574; of which \$2,701 is state savings.

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

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

Action Item – a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of **all Emergency Rules** in item seven 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 317:2-1-2 will clarify timelines for appeal decisions. ADDING agency rules at OAC 317:2-1-2.5 will outline expedited appeals timelines and processes that are required by regulation for cases when an appellant's life or health could be in jeopardy. In addition, language that references nursing home wage enhancement will be deleted due to changes in state statute that resulted in the policy being obsolete.

Budget Impact: Budget neutral

(Reference APA WF # 17-10A)

- B. AMENDING agency rules at OAC 317:35-6-62 and 317:35-6-62.1 AND RENUMBERING to OAC 317:35-5-65 and 317:35-5-66. The renumbering of the sections will move the policy regarding notification processes, from the "SoonerCare for Pregnant Women and Families with Children" section to the "Eligibility and Countable Income" section of policy, as the notification policy applies to all SoonerCare programs. Federal regulations require the agency to communicate with all members through the members' choice of electronic format or regular mail. The revisions are necessary per regulation including notification and expedited appeals requirements, to ensure effective communication with all SoonerCare members

Budget Impact: Budget neutral

(Reference APA WF # 17-10B)

- C. REVOKING agency rules at OAC 317:30-5-131.1 will remove wage enhancement language and requirements for specified employees in nursing facilities (NF) serving adults and intermediate care facilities for individuals with intellectual disabilities (ICFs/IIDs). AMENDING agency rules at OAC 317:30-5-131.2 will also remove reference to the wage enhancement language. As a result of the increase of federal minimum wage and the change in rate setting methodology related to wages for employees of NFs serving adults and ICFs/IIDs, Section 5022 and 5022.1 of Title 63 of the Oklahoma Statutes were repealed. The repeal of these Sections results in the OHCA policy being obsolete; therefore, the removal of the language is necessary to comply with state regulation.

Budget Impact: Budget neutral

(Reference APA WF # 17-12)

- D. AMENDING agency rules at OAC 317:30-5-126 will eliminate therapeutic leave days for children and adults who reside in long-term care facilities with the exception of intermediate care facilities serving individuals with intellectual disabilities.

Budget Impact: The OHCA anticipates that the proposed changes would result in approximately \$24,541 state share savings for SFY2018, which would enable OHCA to file a balanced budget.

(Reference APA WF # 17-18)

Item to be presented by Nancy Nesser, Pharmacy Director

8. 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 **Blinicyto® (Blinatumomab), Besponsa® (Inotuzumab Ozogamicin), Bosulif® (Bosutinib), Gleevec® (Imatinib), Iclusig® (Ponatinib), Kymriah™ (Tisagenlecleucel), Synribo® (Omacetaxine), Sprycel® (Dasatinib), and Tassigna® (Nilotinib)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
 - b) Consideration and vote to add **Bavencio® (Avelumab)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
 - c) Consideration and vote to add **Haegarda® [C1 Esterase Inhibitor (Human)]** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
 - d) Consideration and vote to add **Trulance™ (Plecanatide), Xermelo™ (Telotristat Ethyl), Symproic® (Naldemedine), and Motofen® (Difenoxin/Atropine)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
 - e) Consideration and vote to add **Promacta® (Eltrombopag)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).
 - f) Consideration and vote to add **Odactra™ (House Dust Mite Allergen Extract)** to the utilization and scope prior authorization program under OAC 317:30-5-77.2(e).

Item to be presented by Tony Armstrong, Vice-Chairman

9. Action Item – Consideration and Vote Upon the Oklahoma Health Care Authority Board Meeting Dates, Times and Locations for Calendar Year 2018
10. New Business
11. ADJOURNMENT

NEXT BOARD MEETING
January 11, 2018
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A SCHEDULED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
November 9, 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 November 8, 2017 at 12:45 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 November 3, 2017 at 1:27 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 1:04 p.m.

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

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

<u>OTHERS PRESENT:</u>	<u>OTHERS PRESENT:</u>
Tyler Telley, eCaP	Laura Dempsey, Morton Comprehensive Health Services
Scott Cooper, Santa Fe Place (SFP)	John Conway, SFP
Justin, SFP	Sarah Watson, SFP
Steve Watson, SFP	Elio De Los Santos, Maximus
Melissa McCully, OHCA	Tammy Vaughn, Southeastern OK Family Services
David Dude, American Cancer Society	Kasie Wren, OHCA
Mike Van Pelt, Logisticare	Heather Williams, Logisticare
Stan Ruffner, OHCA	Jimmy Witcosky, OHCA
Harvey Reynolds, OHCA	Dwynna Vick, OHCA
Casey Dunham, OHCA	David Ward, OHCA
Fred Mensah, OHCA	Lewis Robinson, OHCA
Kelli Brodersen, OHCA	Susan Classen, Metropolitan BLC
Sarah Baker, OSHA	Jessica Smith, SFP
Jeannie Knight, Aktion Club	Patsy Fleming, SFP
Tina Seiler, Aktion Club	Michael Grey, SFP
Bobbi Garrison, SFP/Aktion Club	Dale Bratzler, OU Physicians
Mike Fogarty	Sandra Puebla, OHCA
Meg Wingerter, The Oklahoman	Rick Snyder, OHA
Carter Kimble, OSU	Kyle Janzen, OHCA
Brett Coble, OAHCP	Tasha Black, OHCA
Kimrey McGinnis, OHCA	Pearl Barnett, DHS – Aging

DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE REGULARY SCHEDULED BOARD MEETING HELD October 12, 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: Vice-Chairman Armstrong moved for approval of the October 12, 2017 board meeting minutes as published. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman McFall, Member Case

ABSTAINED: Member Robison

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

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

Speakers:

- Brett Coble, OAHCP
- John Conway, SFP
- Jessica Smith, SFP
- Tina Seiler, SFP
- Michael Grey, SFP

ITEM 4A / FINANCIAL UPDATE

Gloria Hudson, Director of General Accounting

Ms. Hudson gave a brief update on OHCA's September Financials. OHCA's state dollar budget variance is \$0.6 million dollars. This variance is 7.6 million lower than the prior month. Program administrative services are under budget in Medicaid program spending by 0.3%; however, OHCA is 0.8% under budget in Medicaid program revenues which results in a net effect of negative \$2 million. In administrative services, OHCA is currently under budget by \$1.2 million state dollars. On the revenue side, OHCA is at budget in both drug rebate collections and settlements and overpayments. The agency is over budget in tobacco tax collections and fees by \$1.4 million state dollars. In October, OHCA filed an amended 2018 budget, as required to cover the deficit of the \$70 million dollar loss in state appropriations. In the amended budget, August positive variance of \$8.2 million, 12 million prior year carry over, 2017 general revenue return of 4.6 deferral funds and provider rate cuts were presented in order to fill the deficit. With current projections through October, OHCA should remain at budget. For more detailed information, see Item 4a in the board packet.

ITEM 4B / MEDICAID DIRECTOR'S UPDATE

Melody Anthony, Deputy State Medicaid Director

Ms. Anthony provided an update for September 2017 data that included a report on the number of SoonerCare enrollees in different areas of the Medicaid program including total in-state providers. Ms. Anthony also presented charts showing monthly enrollment and monthly change in enrollment for Choice, Traditional and Insure Oklahoma; as well as charts showing the call volume in both member and provider services. For more detailed information, see Item 4b in the board packet.

ITEM 4C / LEGISLATIVE

Cate Jeffries, Interim Legislative Liaison

Ms. Jeffries gave a brief update regarding the special session which started September 25, 2017. Legislators are still continuing with negotiations. The proposed budget bill which included the cigarette tax, fuel tax, low point beer tax, increase in gross production tax incentive rate did not pass. The measure can be reconsidered within 3 legislative days which could be Monday or Tuesday; depending on whether legislators convene on November 10th. Should no revenue measures move forward, the Senate and House proposed plan B bills that would appropriate some money to the agencies out of general revenue carryover. The Department of Mental Health did receive \$23.3 million dollars from the rainy day fund. It is unclear whether these bills will move forward as there have been comments about putting carryover towards next year's fiscal deficit. On the federal side, OHCA's Children Health Insurance program funding continues to be in question. The House did pass funding reauthorization bill; however, it's unclear whether the Senate will hear it through bipartisan disagreement on the funding offsets. OHCA expects to be able to operate CHIP at current levels through April but it will require that we request redistributed funds from CMS in January. In addition, OHCA is looking at standalone programs which include Soon To Be Sooners, for pregnant women and Insure Oklahoma Employee Sponsored Insurance or Individual Plan as there could be possible eligibility terminations if funding is not reauthorized for those programs.

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 6A-F / 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 to implement an across-the-board rate reduction in the amount of 9.00% to SoonerCare providers. The proposed reduction excludes complex rehabilitation technology provider services, long-term care facilities, child abuse exams, non-emergency transportation, Insure Oklahoma, payments for drug ingredients, physician supplied drugs, services provided under a waiver, services paid for by other state agencies, services provided to Native Americans through Indian Health Services Indian/Tribal/Urban (ITU) Clinics, and private duty nursing, emergency transportation, PFHCs/RHCs, Choice Care Coordination, and Programs of All-inclusive Care for the Elderly (PACE). While this list of exclusions is fairly comprehensive it is not exhaustive. The estimated budget impact for the remainder of SFY 18 will be a decrease in the total amount of \$68,409,743; of which \$28,342,157 is state savings.

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

FOR THE MOTION: Chairman McFall, Member Case, Member Robison

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

- b) Consideration and vote to implement a payment methodology change to pay 0% of the Medicare Part A and Part B coinsurance and deductible on crossover claims to nursing facilities. The estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$3,523,232; of which \$1,459,675 is state savings.

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

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

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

- c) Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Regular Nursing Facilities by 4.00%. The new Base Rate Component will be \$107.55 per patient day. The new combined pool amount for "Direct Care" and "Other" Component will be \$150,326,168. The estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$10,669,304; of which \$4,384,017 is state savings.

MOTION: Member Nuttle moved for approval of Item 6c as published. The motion was seconded by Member Robison

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Case

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

- d) Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Regular (more than 16 beds) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) by 4.00%. The new Base Rate Component will be \$118.50 per patient day. The estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$444,759; of which \$182,752 is state savings.

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

FOR THE MOTION: Chairman McFall, Member Robison

AGAINST THE MOTION: Member Case

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

- e) Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Acute (16 beds or less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) by 4.00%.

The new Base Rate Component will be \$151.44 per patient day. The estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$789,944; of which \$324,588 is state savings.

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

FOR THE MOTION: Chairman McFall, Member Nuttle

AGAINST THE MOTION: Member Case

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

f) Consideration and vote to implement a rate change to reduce the reimbursement rates for services provided by Nursing Facilities for Individuals with Acquired Immune Deficiency Syndrome (AIDS) by 4.00%. The new Base Rate Component will be \$193.53 per patient day. The estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$31,557; of which \$12,967 is state savings.

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

FOR THE MOTION: Chairman McFall, Member Case, Member Robison

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

ITEM 7 / 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

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:

- a) AMENDING agency rules at OAC 317:30-5-1096 will allow Indian Health Services, Tribal Program and Urban Indian Clinics, who are designated as Federally Qualified Health Centers, to be reimbursed at the Office of Management and Budget rate for services provided outside of the four walls of their facilities. These changes are necessary to comply with federal regulations.
Budget Impact: No budget impact.

(Reference APA WF # 17-03)

MOTION: Member Case moved for approval of emergency rulemaking for Item 7a as published. The motion was seconded by Member Robison.

FOR THE MOTION: Chairman McFall, Vice-Chairman Armstrong, Member Nuttle

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

MOTION: Member Case moved for approval of emergency rulemaking for Item 7b.a as published. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman McFall, Vice Chairman, Armstrong, Member Robison

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

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

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

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

ITEM 8 / NEW BUSINESS

There was no new business.

ITEM 9 / ADJOURNMENT

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

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

BOARD MEMBERS ABSENT: Member Bryant, Member McVay

Meeting adjourned at 2:01 p.m., 11/9/2017

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

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____



FINANCIAL REPORT

For the Four Months Ended October 31, 2017
Submitted to the CEO & Board

- Revenues for OHCA through October, accounting for receivables, were **\$1,486,786,704** or **.2% over** budget.
- Expenditures for OHCA, accounting for encumbrances, were **\$1,417,645,554** or **at** budget.
- The state dollar budget variance through October is a **positive \$1,910,513**.
- The budget variance is primarily attributable to the following (in millions):

Expenditures:	
Medicaid Program Variance	(1.7)
Administration	1.1
Revenues:	
Drug Rebate	.2
Taxes and Fees	2.3
Overpayments/Settlements	.0
Total FY 18 Variance	\$ 1.9

ATTACHMENTS

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

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures: OHCA
SFY 2018, For the Four Month Period Ending October 31, 2017

REVENUES	FY18 Budget YTD	FY18 Actual YTD	Variance	% Over/ (Under)
State Appropriations	\$ 372,223,783	\$ 372,223,783	\$ -	0.0%
Federal Funds	798,426,738	797,725,442	(701,296)	(0.1)%
Tobacco Tax Collections	16,380,275	18,636,933	2,256,658	13.8%
Quality of Care Collections	26,151,533	26,327,177	175,644	0.7%
Prior Year Carryover	39,249,967	39,249,967	-	0.0%
Federal Deferral - Interest	88,472	88,472	-	0.0%
Drug Rebates	92,687,913	93,093,895	405,982	0.4%
Medical Refunds	11,119,251	11,223,273	104,022	0.9%
Supplemental Hospital Offset Payment Program	120,769,342	120,769,342	-	0.0%
Other Revenues	7,432,630	7,448,419	15,788	0.2%
TOTAL REVENUES	\$ 1,484,529,905	\$ 1,486,786,704	\$ 2,256,799	0.2%

EXPENDITURES	FY18 Budget YTD	FY18 Actual YTD	Variance	% (Over)/ Under
ADMINISTRATION - OPERATING	\$ 18,521,939	\$ 16,898,155	\$ 1,623,784	8.8%
ADMINISTRATION - CONTRACTS	\$ 33,748,675	\$ 32,481,514	\$ 1,267,161	3.8%
MEDICAID PROGRAMS				
<u>Managed Care:</u>				
SoonerCare Choice	15,558,672	14,182,686	1,375,986	8.8%
<u>Acute Fee for Service Payments:</u>				
Hospital Services	291,805,647	296,918,763	(5,113,116)	(1.8)%
Behavioral Health	6,551,588	6,937,794	(386,207)	(5.9)%
Physicians	126,422,321	126,051,221	371,100	0.3%
Dentists	41,173,000	42,010,444	(837,444)	(2.0)%
Other Practitioners	17,964,231	17,811,904	152,327	0.8%
Home Health Care	5,491,132	5,696,707	(205,575)	(3.7)%
Lab & Radiology	10,374,063	9,155,839	1,218,224	11.7%
Medical Supplies	16,168,773	16,085,035	83,738	0.5%
Ambulatory/Clinics	64,360,647	64,314,207	46,441	0.1%
Prescription Drugs	189,076,332	188,738,889	337,443	0.2%
OHCA Therapeutic Foster Care	4,000	751	3,249	0.0%
<u>Other Payments:</u>				
Nursing Facilities	179,357,512	178,734,797	622,714	0.3%
Intermediate Care Facilities for Individuals with Intellectual Disabilities Private	20,181,958	19,960,670	221,288	1.1%
Medicare Buy-In	57,660,092	57,911,261	(251,169)	(0.4)%
Transportation	21,418,844	21,262,296	156,548	0.7%
Money Follows the Person-OHCA	77,418	90,302	(12,884)	0.0%
Electronic Health Records-Incentive Payments	4,347,174	4,347,174	-	0.0%
Part D Phase-In Contribution	35,844,054	36,143,012	(298,958)	(0.8)%
Supplemental Hospital Offset Payment Program	257,575,295	257,575,295	-	0.0%
Telligen	3,526,520	4,336,840	(810,320)	(23.0)%
Total OHCA Medical Programs	1,364,939,272	1,368,265,885	(3,326,613)	(0.2)%
OHCA Non-Title XIX Medical Payments	89,382	-	89,382	0.0%
TOTAL OHCA	\$ 1,417,299,268	\$ 1,417,645,554	\$ (346,286)	(0.0)%

REVENUES OVER/(UNDER) EXPENDITURES	\$ 67,230,637	\$ 69,141,150	\$ 1,910,513	
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OKLAHOMA HEALTH CARE AUTHORITY
Total Medicaid Program Expenditures
by Source of State Funds
SFY 2018, For the Four Month Period Ending October 31, 2017

Category of Service	Total	Health Care Authority	Quality of Care Fund	HEEIA	SHOPP Fund	BCC Revolving Fund	Other State Agencies
SoonerCare Choice	\$ 14,225,370	\$ 14,178,497	\$ -	\$ 42,684	\$ -	\$ 4,189	\$ -
Inpatient Acute Care	459,826,562	197,140,919	162,229	1,042,438	194,280,621	268,641	66,931,714
Outpatient Acute Care	151,167,657	98,283,690	13,868	1,392,431	50,428,252	1,049,416	-
Behavioral Health - Inpatient	20,335,682	4,385,158	-	116,282	12,219,915	-	3,614,327
Behavioral Health - Psychiatrist	3,199,143	2,552,636	-	-	646,507	-	-
Behavioral Health - Outpatient	4,972,270	-	-	-	-	-	4,972,270
Behavioral Health-Health Home	16,637,215	-	-	-	-	-	16,637,215
Behavioral Health Facility- Rehab	84,589,342	-	-	-	-	22,770	84,589,342
Behavioral Health - Case Management	3,951,728	-	-	-	-	-	3,951,728
Behavioral Health - PRTF	20,204,843	-	-	-	-	-	20,204,843
Behavioral Health - CCBHC	18,053,426	-	-	-	-	-	18,053,426
Residential Behavioral Management	5,200,093	-	-	-	-	-	5,200,093
Targeted Case Management	21,915,600	-	-	-	-	-	21,915,600
Therapeutic Foster Care	751	751	-	-	-	-	-
Physicians	147,940,164	124,608,190	19,367	1,544,631	-	1,423,663	20,344,313
Dentists	42,022,285	42,007,793	-	11,842	-	2,651	-
Mid Level Practitioners	805,661	800,040	-	5,376	-	246	-
Other Practitioners	17,175,544	16,821,468	148,788	163,925	-	41,362	-
Home Health Care	5,697,912	5,695,144	-	1,205	-	1,563	-
Lab & Radiology	9,419,762	9,078,814	-	263,924	-	77,025	-
Medical Supplies	16,193,907	15,173,584	903,844	108,872	-	7,607	-
Clinic Services	65,503,476	62,039,906	-	419,442	-	56,700	2,987,429
Ambulatory Surgery Centers	2,275,660	2,215,388	-	58,059	-	2,213	-
Personal Care Services	3,697,866	-	-	-	-	-	3,697,866
Nursing Facilities	178,734,797	108,271,333	70,455,849	-	-	7,616	-
Transportation	21,266,633	20,413,302	780,422	34,294	-	38,614	-
GME/IME/DME	88,701,999	-	-	-	-	-	88,701,999
ICF/IID Private	19,960,670	16,261,409	3,699,261	-	-	-	-
ICF/IID Public	6,330,799	-	-	-	-	-	6,330,799
CMS Payments	94,054,273	93,803,063	251,209	-	-	-	-
Prescription Drugs	192,705,434	187,858,480	-	3,966,545	-	880,409	-
Miscellaneous Medical Payments	29,957	28,443	-	-	-	1,515	-
Home and Community Based Waiver	65,571,573	-	-	-	-	-	65,571,573
Homeward Bound Waiver	25,763,268	-	-	-	-	-	25,763,268
Money Follows the Person	90,302	90,302	-	-	-	-	-
In-Home Support Waiver	8,064,329	-	-	-	-	-	8,064,329
ADvantage Waiver	55,292,935	-	-	-	-	-	55,292,935
Family Planning/Family Planning Waiver	1,628,495	-	-	-	-	-	1,628,495
Premium Assistance*	18,942,864	-	-	18,942,864	-	-	-
Telligen	4,336,840	4,336,840	-	-	-	-	-
Electronic Health Records Incentive Payments	4,347,174	4,347,174	-	-	-	-	-
Total Medicaid Expenditures	\$ 1,920,834,259	\$ 1,030,392,323	\$ 76,434,838	\$ 28,114,811	\$ 257,575,295	\$ 3,886,199	\$ 524,453,563

* Includes \$18,811,643.34 paid out of Fund 245

OKLAHOMA HEALTH CARE AUTHORITY
Summary of Revenues & Expenditures:
Other State Agencies
SFY 2018, For the Four Month Period Ending October 31, 2017

REVENUE	FY18 Actual YTD
Revenues from Other State Agencies	\$ 220,161,915
Federal Funds	321,302,172
TOTAL REVENUES	\$ 541,464,087
<hr/>	
EXPENDITURES	Actual YTD
Department of Human Services	
Home and Community Based Waiver	\$ 65,571,573
Money Follows the Person	-
Homeward Bound Waiver	25,763,268
In-Home Support Waivers	8,064,329
ADvantage Waiver	55,292,935
Intermediate Care Facilities for Individuals with Intellectual Disabilities Public	6,330,799
Personal Care	3,697,866
Residential Behavioral Management	2,864,123
Targeted Case Management	19,173,819
Total Department of Human Services	186,758,713
 State Employees Physician Payment	
Physician Payments	20,344,313
Total State Employees Physician Payment	20,344,313
 Education Payments	
Graduate Medical Education	50,325,348
Graduate Medical Education - Physicians Manpower Training Commission	2,788,173
Indirect Medical Education	34,013,202
Direct Medical Education	1,575,276
Total Education Payments	88,701,999
 Office of Juvenile Affairs	
Targeted Case Management	726,441
Residential Behavioral Management	2,335,970
Total Office of Juvenile Affairs	3,062,411
 Department of Mental Health	
Case Management	3,951,728
Inpatient Psychiatric Free-standing	3,614,327
Outpatient	4,972,270
Health Homes	16,637,215
Psychiatric Residential Treatment Facility	20,204,843
Certified Community Behavioral Health Clinics	18,053,426
Rehabilitation Centers	84,589,342
Total Department of Mental Health	152,023,150
 State Department of Health	
Children's First	462,965
Sooner Start	1,709,627
Early Intervention	1,521,900
Early and Periodic Screening, Diagnosis, and Treatment Clinic	516,655
Family Planning	64,592
Family Planning Waiver	1,555,428
Maternity Clinic	1,643
Total Department of Health	5,832,810
 County Health Departments	
EPSDT Clinic	243,500
Family Planning Waiver	8,476
Total County Health Departments	251,976
 State Department of Education	-
Public Schools	30,474
Medicare DRG Limit	65,000,000
Native American Tribal Agreements	516,003
Department of Corrections	320,177
JD McCarty	1,611,537
Total OSA Medicaid Programs	\$ 524,453,563
 OSA Non-Medicaid Programs	\$ 29,890,941
Accounts Receivable from OSA	\$ 12,880,417

OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 205: Supplemental Hospital Offset Payment Program Fund
SFY 2018, For the Four Month Period Ending October 31, 2017

REVENUES	FY 18 Revenue
SHOPP Assessment Fee	\$ 120,717,805
Federal Draws	152,674,517
Interest	42,894
Penalties	8,643
State Appropriations	(15,100,000)
TOTAL REVENUES	\$ 258,343,859

EXPENDITURES	Quarter	Quarter	FY 18 Expenditures
	7/1/17 - 9/30/17	10/1/17 - 12/31/17	
Program Costs:			
Hospital - Inpatient Care	98,870,820	95,409,801	\$ 194,280,621
Hospital -Outpatient Care	25,537,046	24,891,206	50,428,252
Psychiatric Facilities-Inpatient	7,574,695	4,645,220	12,219,915
Rehabilitation Facilities-Inpatient	328,886	317,622	646,507
Total OHCA Program Costs	132,311,447	125,263,848	\$ 257,575,295
Total Expenditures			\$ 257,575,295

CASH BALANCE	\$ 768,564
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OKLAHOMA HEALTH CARE AUTHORITY
SUMMARY OF REVENUES & EXPENDITURES:
Fund 230: Nursing Facility Quality of Care Fund
SFY 2018, For the Four Month Period Ending October 31, 2017

REVENUES	Total Revenue	State Share
Quality of Care Assessment	\$ 26,315,100	\$ 26,315,100
Interest Earned	12,077	12,077
TOTAL REVENUES	\$ 26,327,177	\$ 26,327,177

EXPENDITURES	FY 18 Total \$ YTD	FY 18 State \$ YTD	Total State \$ Cost
Program Costs			
Nursing Facility Rate Adjustment	\$ 69,234,610	\$ 27,970,783	
Eyeglasses and Dentures	88,538	35,770	
Personal Allowance Increase	1,132,700	457,611	
Coverage for Durable Medical Equipment and Supplies	903,844	365,153	
Coverage of Qualified Medicare Beneficiary	344,252	139,078	
Part D Phase-In	251,209	101,489	
ICF/IID Rate Adjustment	1,741,221	703,453	
Acute Services ICF/IID	1,958,040	791,048	
Non-emergency Transportation - Soonerride	780,422	315,291	
Total Program Costs	\$ 76,434,838	\$ 30,879,675	\$ 30,879,675
Administration			
OHCA Administration Costs	\$ 177,185	\$ 88,593	
DHS-Ombudsmen	-	-	
OSDH-Nursing Facility Inspectors	129,023	129,023	
Mike Fine, CPA	-	-	
Total Administration Costs	\$ 306,208	\$ 217,616	\$ 217,616
Total Quality of Care Fee Costs	\$ 76,741,046	\$ 31,097,290	
TOTAL STATE SHARE OF COSTS			\$ 31,097,290

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

OKLAHOMA HEALTH CARE AUTHORITY

SUMMARY OF REVENUES & EXPENDITURES:

**Fund 245: Health Employee and Economy Improvement Act Revolving Fund
SFY 2018, For the Four Month Period Ending October 31, 2017**

REVENUES	FY 17 Carryover	FY 18 Revenue	Total Revenue
Prior Year Balance	\$ 7,673,082	\$ -	\$ 4,811,312
State Appropriations	(3,000,000)	-	-
Tobacco Tax Collections	-	15,328,431	15,328,431
Interest Income	-	50,551	50,551
Federal Draws	307,956	11,633,214	11,633,214
TOTAL REVENUES	\$ 4,981,038	\$ 27,012,196	\$ 31,823,508

EXPENDITURES	FY 17 Expenditures	FY 18 Expenditures	Total \$ YTD
Program Costs:			
Employer Sponsored Insurance		\$ 18,811,643	\$ 18,811,643
College Students/ESI Dental		131,220	53,013
Individual Plan			
SoonerCare Choice		\$ 41,292	\$ 16,682
Inpatient Hospital		1,013,951	409,636
Outpatient Hospital		1,380,235	557,615
BH - Inpatient Services-DRG		113,471	45,842
BH -Psychiatrist		-	-
Physicians		1,530,730	618,415
Dentists		10,707	4,326
Mid Level Practitioner		5,294	2,139
Other Practitioners		162,399	65,609
Home Health		1,205	487
Lab and Radiology		257,808	104,154
Medical Supplies		106,608	43,070
Clinic Services		408,225	164,923
Ambulatory Surgery Center		58,059	23,456
Prescription Drugs		3,923,309	1,585,017
Transportation		34,294	13,855
Premiums Collected		-	(217,297)
Total Individual Plan		\$ 9,047,586	\$ 3,437,928
College Students-Service Costs		\$ 124,362	\$ 50,242
Total OHCA Program Costs		\$ 28,114,811	\$ 22,352,826
Administrative Costs			
Salaries	\$ 40,359	\$ 728,720	\$ 769,079
Operating Costs	25,578	26,398	51,975
Health Dept-Postponing	-	-	-
Contract - HP	103,788	204,423	308,211
Total Administrative Costs	\$ 169,725	\$ 959,540	\$ 1,129,266
Total Expenditures			\$ 23,482,092
NET CASH BALANCE	\$ 4,811,312		\$ 8,341,416

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

**Fund 250: Belle Maxine Hilliard Breast and Cervical Cancer Treatment Revolving Fund
SFY 2018, For the Four Month Period Ending October 31, 2017**

REVENUES	FY 18 Revenue	State Share
Tobacco Tax Collections	\$ 305,884	\$ 305,884
TOTAL REVENUES	\$ 305,884	\$ 305,884

EXPENDITURES	FY 18 Total \$ YTD	FY 18 State \$ YTD	Total State \$ Cost
Program Costs			
SoonerCare Choice	\$ 4,189	\$ 1,185	
Inpatient Hospital	268,641	\$ 75,972	
Outpatient Hospital	1,049,416	\$ 296,775	
Inpatient Services-DRG	-	\$ -	
Psychiatrist	-	\$ -	
TFC-OHCA	-	\$ -	
Nursing Facility	7,616	\$ 2,154	
Physicians	1,423,663	\$ 402,612	
Dentists	2,651	\$ 750	
Mid-level Practitioner	246	\$ 70	
Other Practitioners	41,362	\$ 11,697	
Home Health	1,563	\$ 442	
Lab & Radiology	77,025	\$ 21,783	
Medical Supplies	7,607	\$ 2,151	
Clinic Services	56,700	\$ 16,035	
Ambulatory Surgery Center	2,213	\$ 626	
Prescription Drugs	880,409	\$ 248,980	
Transportation	38,614	\$ 10,920	
Miscellaneous Medical	1,515	\$ 428	
Total OHCA Program Costs	\$ 3,863,430	\$ 1,092,578	
OSA DMHSAS Rehab	\$ 22,770	\$ 6,439	
Total Medicaid Program Costs	\$ 3,886,199	\$ 1,099,017	
TOTAL STATE SHARE OF COSTS		\$ 1,099,017	

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

OHCA Board Meeting December, 2017 (October 2017 Data)

SOONERCARE ENROLLMENT/EXPENDITURES

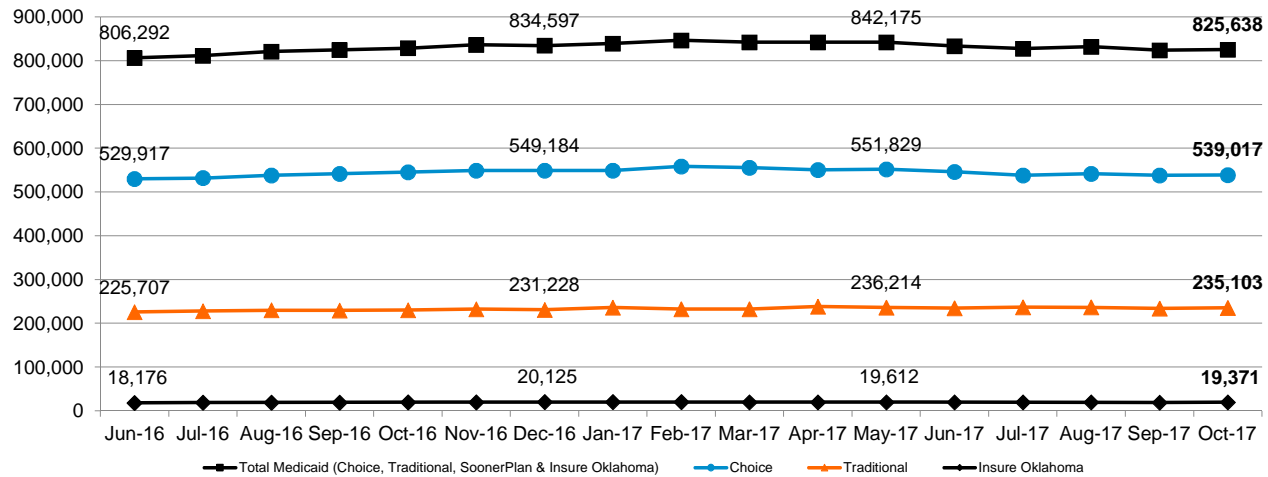
Delivery System		Enrollment October 2017	Children October 2017	Adults October 2017	Enrollment Change	Total Expenditures October 2017	PMPM October 2017	Forecasted October 2017 Trend PMPM
SoonerCare Choice Patient-Centered Medical Home		539,017	445,040	93,977	598	\$149,666,232		
Lower Cost	<i>(Children/Parents; Other)</i>	494,655	430,836	63,819	596	\$107,219,345	\$217	\$215
Higher Cost	<i>(Aged, Blind or Disabled; TEFRA; BCC)</i>	44,362	14,204	30,158	2	\$42,446,887	\$957	\$1,014
SoonerCare Traditional		235,103	87,337	147,766	1,028	\$173,619,714		
Lower Cost	<i>(Children/Parents; Other; Q1; SLMB)</i>	119,698	82,386	37,312	307	\$43,404,225	\$363	\$464
Higher Cost	<i>(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)</i>	115,405	4,951	110,454	721	\$130,215,489	\$1,128	\$1,207
SoonerPlan		32,147	2,612	29,535	72	\$243,118	\$8	\$10
Insure Oklahoma		19,371	463	18,908	108	\$6,790,650		
Employer-Sponsored Insurance		14,176	278	13,898	100	\$4,614,564	\$326	\$342
Individual Plan		5,195	185	5,010	8	\$2,176,086	\$419	\$446
TOTAL		825,638	535,452	290,186	1,806	\$330,319,714		

Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents. Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

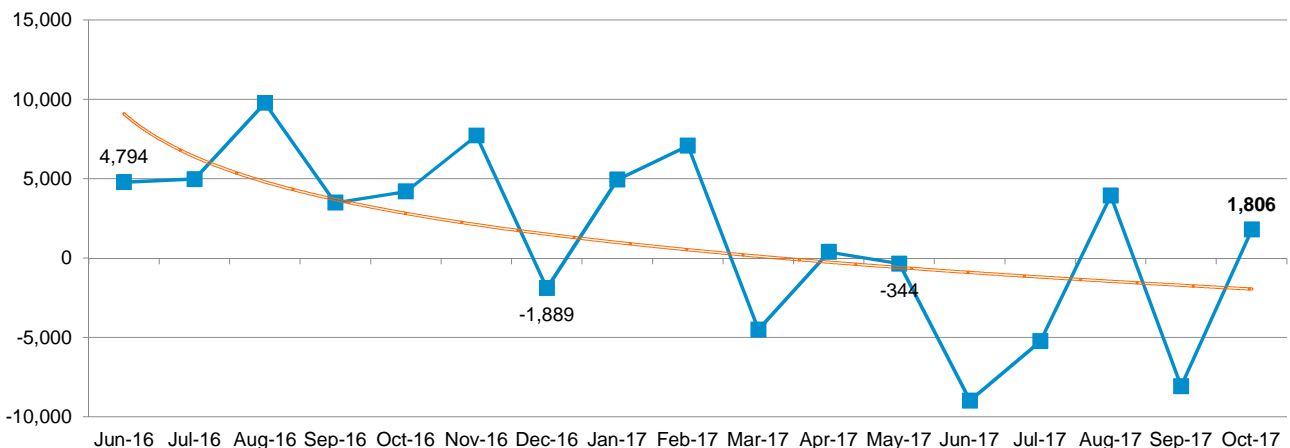
Total In-State Providers: 32,033 (-50) (In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)								
Physician	Pharmacy	Dentist	Hospital	Mental Health	Optometrist	Extended Care	Total PCPs*	PCMH
9,664	980	924	188	3,662	593	403	6,887	2,693

*PCPs consist of all providers contracted as a Certified Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant.

ENROLLMENT BY MONTH



MONTHLY CHANGE IN ENROLLMENT



Includes Insure Oklahoma.

Report for Dec. 1, 2017

1st Extraordinary Session of the 56th Legislature

Oklahoma's special session adjourned sine die Nov. 17 after both chambers passed House Bill 1019. House Bill 1019 was intended to collect dollars from various revolving funds, redistribute the funds to some state agencies and trigger cuts to others. The bill was projected to reduce OHCA's state fiscal year (SFY) 2018 base by approximately \$15 million as opposed to the \$70 million that was planned for in light of the Supreme Court's overturning the smoking cessation fee. The Governor vetoed all but five sections of the bill. OHCA's appropriation after the veto was approximately \$22.9 million. The Governor has stated she intends to call a second special session to continue to look for recurring revenue.

Five bills were passed during the special session:

- **HB 1019X**, a general appropriations bill (partially vetoed);
- **HB 1028X**, requires the Oklahoma State Department of Health to submit a corrective action report to the state legislature;
- **HB 1058X**, requires the Department of Human Services to fully fund the ADvantage waiver and other services;
- **HB 1081X**, appropriates \$23.3 million from Rainy Day Fund to the Oklahoma Department of Mental Health and Substance Abuse Services; and,
- **HB 1085X**, raises gross production tax on certain legacy wells from 4% to 7%.

Upcoming Sessions

The second special session is expected to be called before the second regular session of the 56th legislature, which is set to convene Feb. 5, 2018. The OHCA is currently securing request bills for the regular session.

OUTPATIENT HOSPITAL DENTAL AND ENT RATES

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

Method Change

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

No Impact

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

Dentists throughout the State have notified OHCA of the lack of access to hospital operating rooms due to the low reimbursement rate for dental services under the outpatient hospital payment structure that relies on Medicare rates for rate setting. OHCA has designed a new rate methodology for outpatient hospital dental services and a set of other services with similar costs. The new rate for these services will be cost based and will equalize the rates to improve access for dental services to be rendered in the hospital setting.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

Currently, the agency pays for dental services and certain ENT services provided in an outpatient hospital separately and at a percentage of the Medicare rate.

5. NEW METHODOLOGY OR RATE STRUCTURE.

OHCA proposes to increase the rate paid for certain outpatient dental services provided in an outpatient hospital. These services will be reimbursed on a cost basis effective on or after January 1, 2018. Dental and ear, nose, and throat (ENT) surgical procedures will be classified into a payment group based on specific CPT codes. Historical utilization and a facility specific outpatient cost to charge ratio (CCR) from the hospital Medicare cost report will be used to determine average cost per unit by facility, then in total. The result is an increase in the dental rate and a decrease in certain ENT rates which will make this change budget neutral. All procedures within this payment group will be paid a single rate.

6. BUDGET ESTIMATE.

The estimated budget impact for state fiscal year 2018 is estimated to be \$0.

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 the method change for dental services and certain ENT services to a cost based rate.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

REINSTATEMENT OF ACROSS THE BOARD PROVIDER RATE REDUCTION

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?

The Oklahoma Health Care Authority (OHCA) recommends a revision, a reinstatement in the amount of 9.00%, to the current rates and reimbursement structure in the SoonerCare program.

Federal Requirements:

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

OHCA currently reimburses providers under a variety of different rate structures; diagnostic-related group (DRG), per diem, max fee, percent of Medicare, and a percent of costs are some examples. Our current rates reflect a 3.25% reduction, a 7.75% reduction, a 3.00% reduction, and a 9% reduction from the applicable rate structures, implemented in April of 2010, July 2014, January 2016, and December 2017.

5. NEW METHODOLOGY OR RATE STRUCTURE.

OHCA seeks to reinstate the current rates by 9.00% of the applicable rate structure. The proposed reduction excludes services financed through appropriations to other state agencies, services provided under a waiver, and services where a reduction could severely limit access or not cover costs (in the aggregate). While this list is fairly comprehensive it is not exhaustive.

Exclusions:

- Complex Rehabilitation Technology Provider Services
- Long term care facilities
- Child abuse exams
- Non-emergency transportation
- Insure Oklahoma
- Payments for drug ingredients / physician supplied drugs
- Services provided under a waiver
- Services paid for by other state agencies
- Services provided to Native Americans through Indian Health Services / Indian/Tribal/Urban Clinics
- Private Duty Nursing
- Emergency Transportation
- FQHCs/RHCs
- Choice Care Coordination
- Programs of All-inclusive Care for the Elderly (PACE)

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY 2018 will be an increase in the total amount of \$68,409,743; \$28,342,157 state share.

7. AGENCY ESTIMATED 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the reinstatement of the 9.00% rate reduction for all providers excluding those providers/services that have an exception provision.

9. EFFECTIVE DATE OF CHANGE.

December 1, 2017

ACROSS THE BOARD PROVIDER RATE REDUCTION

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

Rate Change

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

Decrease

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

The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of a 6.00% reduction, to the current rates and reimbursement structure in the SoonerCare program. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

Federal Requirements:

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

OHCA currently reimburses providers under a variety of different rate structures; diagnostic-related group (DRG), per diem, max fee, percent of Medicare, and a percent of costs are some examples. Our current rates reflect a 3.25% reduction, a 7.75% reduction, and a 3.00% reduction from the applicable rate structures, implemented in April of 2010, July 2014, and January 2016.

5. NEW METHODOLOGY OR RATE STRUCTURE.

Effective January 1, 2018, OHCA seeks to decrease the current rates by 6.00% of the applicable rate structure. The proposed reduction excludes services financed through appropriations to other state agencies, services provided under a waiver, and services where a reduction could severely limit access or not cover costs (in the aggregate). While this list is fairly comprehensive it is not exhaustive.

Exclusions:

- Complex Rehabilitation Technology Provider Services
- Long term care facilities
- Child abuse exams
- Non-emergency transportation
- Insure Oklahoma
- Payments for drug ingredients / physician supplied drugs
- Services provided under a waiver
- Services paid for by other state agencies
- Services provided to Native Americans through Indian Health Services / Indian/Tribal/Urban Clinics
- Private Duty Nursing
- Emergency Transportation
- FQHCs/RHCs
- Choice Care Coordination
- Programs of All-inclusive Care for the Elderly (PACE)

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY 2018 will be a decrease in the total amount of \$38,005,413; \$15,745,643 state share.

7. AGENCY ESTIMATED 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the 6.00% rate reduction for all providers excluding those providers/services that have an exception provision.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

NURSING FACILITIES MEDICARE PART A AND B CROSSOVER CLAIMS REDUCTION

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

Method Change

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

Decrease

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

The Oklahoma Health Care Authority (OHCA) recommends a change to the effective date of implementation of the revision to the methodology for payment of Medicare crossover claims to Nursing Facilities. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates:

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The OHCA Board approved on November 9, 2017 to pay 0% of Medicare Part A coinsurance and deductible, and 0% of Medicare Part B coinsurance and deductible on crossover claims to nursing facilities with an effective date of December 1, 2017.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in the proposed rate methodology to pay 0% of Medicare Part A and B coinsurance and deductible on crossover claims to nursing facilities; however, there is a request to change the effective date of the method change from December 1, 2017 to January 1, 2018.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be a decrease in the total amount of \$2,936,027; with \$1,216,396 state share.

7. AGENCY ESTIMATED 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve change of the effective date to implement the method change to pay 0% of Coinsurance and Deductible of Medicare Part A and B Crossover claims to nursing facilities from December 1, 2017 to January 1, 2018.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

REINSTATEMENT OF REGULAR NURSING FACILITIES RATE REDUCTION

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?

The Oklahoma Health Care Authority (OHCA) recommends a revision, a reinstatement in the amount of 4.00% to Regular Nursing Facilities provider rates.

Federal Requirements:

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate methodology for Regular Nursing facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:

- A. Base Rate Component is \$107.55 per patient day.
- B. A Focus on Excellence (FOE) Component defined by the points earned under this performance program ranging from \$1.00 to \$5.00 per patient day.
- C. An “Other Cost” Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and FOE Component by the total estimated Medicaid days for the rate period.
This component once calculated is the same for each facility.
- D. A “Direct Care” Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and FOE Components to the facilities.

STATE PLAN AMENDMENT RATE COMMITTEE

This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the 70% pool of funds to each facility (on a per day basis) based on their relative expenditures for direct care costs.
The combined pool amount for “Direct Care” and “Other Cost” Component is \$150,326,168.

The Quality of Care (QOC) fee is \$11.05 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a rate change for Regular Nursing facilities because of the reinstatement of Regular Nursing Facility rates by 4.00%.

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

The reinstated combined pool amount for “Direct Care” and “Other Cost” Components will be \$160,636,876.

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

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be an increase in the total amount of \$10,669,304; with \$4,384,017 in state share.

7. AGENCY ESTIMATED 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

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

- An increase in the base rate component from \$107.55 per patient day to \$107.79 per patient day.
- An increase in the combined pool amount for the “Other Cost” and “Direct Care” Components from \$150,326,168 to \$160,636,876.

9. EFFECTIVE DATE OF CHANGE.

December 1, 2017

REGULAR NURSING FACILITIES RATE REDUCTION

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

Rate Change

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

Decrease

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

The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of 1.00% reduction to Regular Nursing Facilities provider rates. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

Federal Requirements:

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate methodology for Regular Nursing facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:

- A. Base Rate Component is \$107.79 per patient day.
- B. A Focus on Excellence (FOE) Component defined by the points earned under this performance program ranging from \$1.00 to \$5.00 per patient day.
- C. An "Other Cost" Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and FOE Component by the total estimated Medicaid days for the rate period. This component once calculated is the same for each facility.
- D. A "Direct Care" Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and FOE Components to the facilities. This component is determined separately and is different for each facility.

STATE PLAN AMENDMENT RATE COMMITTEE

The method (as approved in the State Plan) allocates the 70% pool of funds to each facility (on a per day basis) based on their relative expenditures for direct care costs.

The current combined pool amount for “Direct Care” and “Other Cost” Components is \$160,636,876.

The current Quality of Care (QOC) fee is \$11.29 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change for Regular Nursing Facilities because of the proposed 1% decrease to Regular Nursing Facility provider rates.

The new Base Rate Component will be \$107.73 per patient day, a decrease of \$0.06 per patient day.

The new average “Direct Care” Component is \$23.54 per patient day, a decrease of \$0.78 per patient day.

The new “Other Cost” Component is \$10.09 per patient, a decrease of \$0.33 per patient day.

The new combined pool amount for “Direct Care” and “Other Cost” Components will be \$158,498,444.

The Quality of Care (QOC) fee will be \$11.23 per patient day.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be a decrease in the total amount of \$2,222,772; with \$913,337 in state share.

7. AGENCY ESTIMATED 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

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

- A decrease in the base rate component from \$107.79 per patient day to \$107.73 per patient day.
- A decrease in the combined pool amount for the “Other Cost” and “Direct Care” Components from \$160,636,876 to \$158,498,444 to account for the 1% reduction in rates for Regular Nursing Facilities.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

REINSTATEMENT OF REGULAR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE REDUCTION

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?

The Oklahoma Health Care Authority (OHCA) recommends a revision, a reinstatement in the amount of 4.00% to Regular ICF/IID facilities provider rates.

Federal Requirements:

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

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

The current rate for this provider type is \$118.50 per patient day.

The current Quality of Care (QOC) fee is \$7.31 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change for Regular (ICF/IID) facilities because of the reinstatement of Regular ICF/IID facilities rates by 4.00%.

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

The reinstated Quality of Care (QOC) fee will be \$7.54 per patient day.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be an increase in the total amount of \$444,759; with \$182,752 in state share.

7. AGENCY ESTIMATED 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 anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

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

- An increase in the rate from \$118.50 per patient day to \$122.77 per patient day.

9. EFFECTIVE DATE OF CHANGE.

December 1, 2017

REGULAR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE REDUCTION

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

Rate Change

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

Decrease

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

The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of 1.00% reduction to Regular ICF/IID facilities provider rates. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

Federal Requirements:

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

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

The current rate for this provider type is \$122.77 per patient day.

The Quality of Care (QOC) fee is \$7.54 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change for Regular ICF/IID facilities because of the proposed decrease of 1.00% to the rates of this provider type.

The proposed rate will be \$121.70 per patient day.

The Quality of Care (QOC) fee will be \$7.51 per patient.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be a decrease in the total amount of \$ 92,658; with \$38,073 in state share.

7. AGENCY ESTIMATED 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

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

- A decrease in the rate from \$122.77 per patient day to \$121.70 per patient day.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

REINSTATEMENT OF ACUTE (16 BED-OR-LESS) INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE REDUCTION

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?

The Oklahoma Health Care Authority (OHCA) recommends a revision, a reinstatement in the amount of 4.00% to Acute ICF/IID facilities rates.

Federal Requirements:

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

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

The current rate for this provider type is \$151.44 per patient day.

The current Quality of Care (QOC) fee is \$9.17 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change for Acute ICF/IID facilities because of the reinstatement of Acute ICF/IID facilities rates by 4%.

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

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

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be an increase in the total amount of \$789,944; with \$324,588 in state share.

7. AGENCY ESTIMATED 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:

- An increase in the rate from \$151.44 per patient day to \$157.03 per patient day.

9. EFFECTIVE DATE OF CHANGE.

December 1, 2017

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

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

Rate Change

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

Decrease

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

The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of 1.00% reduction to Acute ICF/IID facilities provider rates. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

Federal Requirements:

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

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

The current rate for this provider type is \$157.03 per patient day.

The Quality of Care (QOC) fee is \$9.50 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a proposed rate change for Acute ICF/IID facilities because of the proposed 1.00% decrease to the rates of this provider type.

The proposed rate will be \$155.63 per patient day.

The Quality of Care (QOC) fee will be \$9.46 per patient day.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be a decrease in the total amount of \$164,572; with \$67,623 in state share.

7. AGENCY ESTIMATED 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:

- A decrease in the rate from \$157.03 per patient day to \$155.63 per patient day.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

REINSTATEMENT OF ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITIES RATE REDUCTION

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?

The Oklahoma Health Care Authority (OHCA) recommends a revision, a reinstatement in the amount of 4.00% to nursing facilities serving residents with AIDS provider rates.

Federal Requirements:

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day.

The current rate for this provider type is \$193.53 per patient day.

The current Quality of Care (QOC) fee is \$11.05 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a rate change for nursing facilities serving residents with AIDS because of the reinstatement of rates of this provider type by 4.00%.

The reinstated rate will be \$200.01 per patient day.

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

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be an increase in the total amount of \$31,557; with \$ 12,967 in state share.

7. AGENCY ESTIMATED 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:

- An increase in the AIDS rate from \$193.53 per patient day to \$200.01 per patient day.

9. EFFECTIVE DATE OF CHANGE.

December 1, 2017

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITIES RATE REDUCTION

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

Rate Change

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

Decrease

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

The Oklahoma Health Care Authority (OHCA) recommends a revision, in the amount of 1.00% reduction to nursing facilities serving residents with AIDS provider rates. Changes are necessary to reduce the Agency's spending to balance the state budget in accordance with Article 10, Section 23 of the Oklahoma Constitution, which prohibits a state agency from spending more money than is allocated.

Federal Requirements

State Medicaid programs generally have considerable flexibility in determining the reimbursement methodology and resulting rate for services, within federally-imposed upper limits and specific restrictions. Section 1902(a)(30)(A) of the Social Security Act requires that State Medicaid programs must assure that payment rates :

- Be consistent with efficiency, economy and quality of care;
- Are sufficient to enlist enough providers so that Medicaid care and services are available under the state plan at least to the extent that such care and services are available to the general population in that geographic area.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day.

The current rate for this provider type is \$200.01 per patient day.

The Quality of Care (QOC) fee is \$11.29 per patient day.

5. NEW METHODOLOGY OR RATE STRUCTURE.

There is no change in methodology; however, there is a rate change for nursing facilities serving residents with AIDS because of the proposed 1% decrease to the rates of this provider type.

The proposed rate will be \$ \$198.39 per patient day.

The Quality of Care (QOC) fee will be \$11.23 per patient day.

6. BUDGET ESTIMATE.

The estimated budget impact for the remainder of SFY2018 will be a decrease in the total amount of \$6,574; with \$2,701 in state share.

7. AGENCY ESTIMATED 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). In anticipation of the rate reductions, contracted providers were notified of upcoming budget cuts in an effort by the Oklahoma Health Care Authority to remain transparent during this process.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:

- A decrease in the AIDS rate from \$200.01 per patient day to \$198.39 per patient day.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2018

December Board Proposed Rule Changes

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, September 5, 2017 and Thursday, October 19, 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, November 16, 2017.

APA work folders 17-10A and 17-10B were posted on the OHCA public website for a comment period from September 26, 2017 through October 26, 2017. APA work folder 17-12 was posted on the OHCA public website for a comment period from October 3, 2017 through November 2, 2017. APA work folder 17-18 was posted on the OHCA public website for a comment period from October 17, 2017 through November 16, 2017.

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

- A.** AMENDING agency rules at OAC 317:2-1-2 will clarify timelines for appeal decisions. ADDING agency rules at OAC 317:2-1-2.5 will outline expedited appeals timelines and processes that are required by regulation for cases when an appellant's life or health could be in jeopardy. In addition, language that references nursing home wage enhancement will be deleted due to changes in state statute that resulted in the policy being obsolete.

Budget Impact: Budget neutral

(Reference APA WF # 17-10A)

- B.** AMENDING agency rules at OAC 317:35-6-62 and 317:35-6-62.1 AND RENUMBERING to OAC 317:35-5-65 and 317:35-5-66. The renumbering of the sections will move the policy regarding notification processes, from the "SoonerCare for Pregnant Women and Families with Children" section to the "Eligibility and Countable Income" section of policy, as the notification policy applies to all SoonerCare programs. Federal regulations require the agency to communicate with all members through the members' choice of electronic format or regular mail. The revisions are necessary per regulation including notification and expedited appeals requirements, to ensure effective communication with all SoonerCare members

Budget Impact: Budget neutral

(Reference APA WF # 17-10B)

- C.** REVOKING agency rules at OAC 317:30-5-131.1 will remove wage enhancement language and requirements for specified employees in nursing facilities (NF) serving adults and intermediate care facilities for individuals with intellectual disabilities (ICFs/IIDs). AMENDING agency rules at OAC 317:30-5-131.2 will also remove reference to the wage enhancement language. As a result of the increase of federal minimum wage and the change in rate setting methodology related to wages for employees of NFs serving adults and ICFs/IIDs, Section 5022 and 5022.1 of Title 63 of the Oklahoma Statutes were repealed. The repeal of these Sections results in the OHCA policy being obsolete; therefore, the removal of the language is necessary to comply with state regulation.

Budget Impact: Budget neutral

(Reference APA WF # 17-12)

- D.** AMENDING agency rules at OAC 317:30-5-126 will eliminate therapeutic leave days for children and adults who reside in long-term care facilities with the exception of intermediate care facilities serving individuals with intellectual disabilities.

Budget Impact: The OHCA anticipates that the proposed changes would result in approximately \$24,541 state share savings for SFY2018, which would enable OHCA to file a balanced budget.

(Reference APA WF # 17-18)

**TITLE 317: OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

317:2-1-2. Appeals

(a) Member Process Overview.

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

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

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

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

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

(6) Upon receipt of the member's appeal, a fair hearing before the Administrative Law Judge (ALJ) will be scheduled. The member will be notified in writing of the date and time for this procedure. ~~The member must appear at this hearing and it is conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the Chief Executive Officer of the OHCA, which is a record review at which the parties do not appear (OAC 317:2-1-13).~~ The member must appear at this hearing, either in person or telephonically. Requests for a telephone hearing must be received in writing on OHCA's LD-4 (Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the hearing date. Telephonic hearing requests will only be granted by the OHCA's Chief Executive Officer (CEO) or his/her designee, at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.

(7) The hearing shall be conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the CEO of the OHCA, which is a record review at which the parties do not appear (OAC 317:2-1-13).

~~(7)~~(8) Member appeals are ordinarily decided within 90~~ninety~~(90) days from the date OHCA receives the member's timely request for a fair hearing unless the member waives this requirement. [Title 42 CFR 431.244(f)], in accordance with 42 CFR § 431.244(f):

(A) The Appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.4;

(B) OHCA cannot reach a decision because the Appellant requests a delay or fails to take a required action, as reflected in the record; or

(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record.

~~(8)~~(9) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within 20~~twenty~~(20) days of the hearing before the ALJ.

(b) Provider Process Overview.

(1) The proceedings as described in this subsection contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(c)(2).

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

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

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

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

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

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

(1) ~~Member Appeals:~~Member Appeals.

(A) Discrimination complaints regarding the SoonerCare program;

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

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

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

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

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

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

(2) ~~Provider Appeals~~: **Provider Appeals.**

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

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

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

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

(E) Drug rebate appeals;

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

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

(H) Supplemental Hospital Offset Payment Program (SHOPP)

annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15.

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

317:2-1-2.5 Expedited appeals [NEW]

(a) An expedited hearing request may be granted within three (3) working days of the request for hearing, if the time otherwise permitted for a hearing as described in OAC 317:2-1-2(a)(8) could jeopardize the Appellant's life or health or ability to attain, maintain, or regain maximum function.

(b) If OHCA determines that the request meets the criteria for an expedited hearing, it shall:

(1) Initiate the hearing process as described in OAC 317:2-1-5; and

(2) All matters relating to the hearing must be heard and disposed of as expeditiously as possible, but no later than three (3) working days after OHCA has received the request for an expedited hearing.

(c) If OHCA determines that the request does not meet the criteria for an expedited hearing, it shall:

(1) Initiate the ordinary hearing process timeframe, in accordance with OAC 317:2-1-2(a)(8); and

(2) Notify the Appellant of the denial orally or through an electronic notice as described in OAC 317:35-5-66. If oral notification is provided, OHCA will follow up with a written notice within three (3) calendar days of the denial.

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

SUBCHAPTER 6. SOONERCARE FOR
PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-62. Notification of eligibility [RENUMBERED TO 317:35-5-65]

~~When eligibility for SoonerCare is established, the appropriate notice is computer generated to the applicant. When the computer file is updated for changes, notices are generated only if there is a change in the eligibility of any household member.~~

317:35-6-62.1. Electronic Notices [RENUMBERED TO 317:35-5-66]

~~(a) The agency allows SoonerCare members the choice to receive SoonerCare notices and information through electronic formats.~~

~~(1) SoonerCare members who elect to receive electronic notices will have this election confirmed by regular mail.~~

~~(2) SoonerCare members will be able to change this election by regular mail, telephone, or through the SoonerCare application.~~

~~(b) The agency will ensure all notices it generates will be posted to the member's individual account within one business day.~~

~~(1) The agency will send an email or other electronic communication alerting SoonerCare members that a notice has been posted to their member account.~~

~~(2) The agency will not include the member's confidential information in the email or electronic communication alert.~~

~~(3) The agency will send a notice by mail within three business days of a failed email or electronic alert that was undeliverable to the member.~~

~~(4) At the member's request, all notices that are posted to the member's account may also be provided through mail.~~

~~(c) Electronic notices that are posted to the member's account which require the member to take certain action, submit additional documentation, or contain eligibility, appeal, or SoonerCare benefits information are considered the same as if the notice was sent by mail to the member.~~

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

**PART 7. APPLICATION, ~~AND~~ ELIGIBILITY DETERMINATION AND
NOTIFICATION PROCEDURES**

317:35-5-65. Notification of eligibility

When eligibility for SoonerCare is established, the appropriate notice is computer generated to the applicant. When the computer file is updated for changes, notices are generated only if there is a change in the eligibility of any household member.

317:35-5-66. Electronic Notices

(a) The agency allows SoonerCare members the choice to receive SoonerCare notices and information through electronic formats.

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(b) The agency will ensure all notices it generates will be posted to the member's individual account within one business day.

(1) The agency will send an email or other electronic communication alerting SoonerCare members that a notice has been posted to their member account.

(2) The agency will not include the member's confidential information in the email or electronic communication alert.

(3) The agency will send a notice by mail within three business days of a failed email or electronic alert that was undeliverable to the member.

(4) At the member's request, all notices that are posted to the member's account may also be provided through mail.

(c) Electronic notices that are posted to the member's account which require the member to take certain action, submit additional documentation, or contain eligibility, appeal, or SoonerCare benefits information are considered the same as if the notice was sent by mail to the member.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. ~~LONG TERM~~LONG-TERM CARE FACILITIES

317:30-5-131.1. Wage enhancement [REVOKED]

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

~~(1) **"Employee Benefits"** means the benefits an employer provides to an employee which include:~~

~~(A) FICA taxes,~~

~~(B) Unemployment Compensation Tax,~~

~~(C) Worker's Compensation Insurance,~~

~~(D) Group health and dental insurance,~~

~~(E) Retirement and pensions, and~~

~~(F) Other employee benefits (any other benefit that is provided by a majority of the industry).~~

~~(2) **"Enhanced"** means the upward adjusted rate as required by Title 63, Section 5022 of Oklahoma Statutes.~~

~~(3) **"Enhancement"** means the upward adjusted rate as required by Title 63, Section 5022 of Oklahoma Statute.~~

~~(4) **"Regular employee"** means an employee that is paid an hourly/salaried amount for services rendered, however, the facility is not excluded from paying employee benefits.~~

~~(5) **"Specified staff"** means the employee positions listed in the Oklahoma Statutes under Section 5022, Title 63 that meet the requirements listed in 42 CFR Section 483.75(e)(1) (8).~~

~~(b) **Enhancement.** Effective May 1, 1997, the OHCA provides a wage and salary enhancement to nursing facilities serving adults and Intermediate Care Facilities for Individuals with Intellectual Disabilities required by Title 63, Section 5022 of Oklahoma Statutes. The purpose of the wage and salary enhancement is to provide an adjustment to the facility payment rate in order for facilities to reduce turnover and be able to attract and retain qualified personnel. The maximum wage enhancement rates that may be reimbursed to the facilities per diem include:~~

~~(1) Three dollars and fifteen cents (\$3.15) per patient day for NFs,~~

~~(2) Four dollars and twenty cents (\$4.20) per patient day for standard private ICFs/IID, and~~

~~(3) Five dollars and fifteen cents (\$5.15) per patient day for specialized private ICFs/IID.~~

~~(c) **Reporting requirements.** Each NF and ICF/IID is required to submit a Nursing and Intermediate Care Facilities Quarterly Wage~~

~~Enhancement Report (QER) which captures and calculates specified facility expenses. The report must be completed quarterly and returned to OHCA no later than 45 days following the end of each quarter. QERs must be filed for the State Fiscal Year (SFY) which runs from July 1 to June 30. The Oklahoma Health Care Authority reserves the right to recoup all dollars that cannot be accounted for in the absence of a report. The QER is designed to capture and calculate specified facility expenses for quarterly auditing by the OHCA. The report is used to determine whether wage enhancement payments are being distributed among salaries/wages, employee benefits, or both for the employee positions listed in (1) through (8) of this subsection. Furthermore, the OHCA reserves the right to recoup all dollars not spent on salaries, wages, employee benefits, or both for the employee positions. The specified employee positions included on the QER are:~~

- ~~(1) Licensed Practical Nurse (LPN),~~
- ~~(2) Nurse Aide (NA),~~
- ~~(3) Certified Medication Aide (CMA),~~
- ~~(4) Social Service Director (SSD),~~
- ~~(5) Other Social Service Staff (OSSS),~~
- ~~(6) Activities Director (AD),~~
- ~~(7) Other Activities Staff (OAS), and~~
- ~~(8) Therapy Aide Assistant (TAA).~~

~~(d) **Timely filing and extension of time.**~~

~~(1) **Quarterly reports.** Quarterly reports are required to be filed within 45 days following the end of each quarter. This requirement is rigidly enforced unless approved extensions of time for the filing of the quarterly report is granted by OHCA. Filing extensions not to exceed 15 calendar days may be granted for extraordinary cause only. A failure to present any of the items listed in (A)-(D) of this paragraph will result in a denial of the request for an extension. The extension request will be attached to the filing of the report after the request has been granted. For an extension to be granted, the following must occur.~~

~~(A) An extension request must be received at the Oklahoma Health Care Authority on or before the 30th day after the end of the quarter.~~

~~(B) The extension must be addressed on a form supplied by the Health Care Authority.~~

~~(C) The facility must demonstrate there is an extraordinary reason for the need to have an extension. An extraordinary reason is defined in the plain meaning of the word. Therefore, it does not include reasons such as the employee who normally makes these requests was absent, someone at the facility made a mistake and forgot to send the form, the facility failed to get documents to some~~

~~third party to evaluate the expenditures. An unusual and unforeseen event must be the reason for the extension request.~~

~~(D) The facility must not have any extension request granted for a period of two years prior to the current request.~~

~~(2) **Failure to file a quarterly report.** If the facility fails to file the quarterly report within the required (or extended) time, the facility is treated as out of compliance and payments made for the quarter in which no report was filed will be subject to a 100% recoupment. The overpayment is recouped in future payments to the facility immediately following the filing deadline for the reporting period. The full overpayment is recovered within a three month period. The Oklahoma Health Care Authority reserves the right to discontinue wage enhancement payments until an acceptable QER (quarterly enhancement report) is received. In addition to the recoupment of payments, the matter of noncompliance is referred to the Legal Division of the OHCA to be considered in connection with the renewal of the facility's contract.~~

~~(3) **Ownership changes and fractional quarter report.** Where the ownership or operation of a facility changes hands during the quarter, or where a new operation is commenced, a fractional quarter report is required, covering each period of time the facility was in operation during the quarter.~~

~~(A) Fractional quarter reports are linked to the legal requirement that all facility reports be properly filed in order that the overall cost of operation of the facility may be determined.~~

~~(B) Upon notice of any change in ownership or management, the OHCA withholds payments from the facility until a fractional quarter report is received and evaluation of payment for the wage enhancement is conducted. In this case the QER is due within 15 days of the ownership or management change.~~

~~(4) **Pay periods and employee benefits reflected in the QER.** Salaries and wages are determined by accruing the payroll to reflect the number of days reported for the month. Unpaid salaries and wages are accrued through the quarter. Any salaries and wages accrued in the previous quarter and paid in the current quarter are excluded. Employee benefits are determined by accruing any benefits paid to coincide with the reporting month. Unpaid employee benefits are accrued through the quarter. Any employee benefits accrued in the previous quarter and paid in the current quarter are excluded. To be included as an allowable wage enhancement expenditure, accrued salaries, wages and benefits must be paid within forty-five (45) days from the end of the reporting quarter.~~

~~(5) **Report accuracy.**— Errors and/or omissions discovered by the provider after the initial filing/approved extension are not considered grounds for re-opening/revisions of previously filed reports. Furthermore, errors and/or omission discovered by the provider after the initial filing/approved extension can not be carried forward and claimed for future quarterly reporting periods.~~

~~(6) **False statements or misrepresentations.**— Penalties for false statements or misrepresentations made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a 7b which states, in part, "(a) Whoever...(2) at any time knowingly and willfully makes or cause to be made any false statement of a material fact for use in determining rights to such benefit or payment... shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with furnishing (by that person) of items or services for which payment is or may be made under this title (42 U.S.C. 1320 et. seq.), be guilty of a felony and upon conviction thereof fined not more than \$25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than \$10,000 or imprisoned for not more than one year, or both."~~

~~(7) **Audits, desk and site reviews.**~~

~~(A) Upon receipt of each quarterly report a desk review is performed. During this process, the report is examined to insure it is complete. If any required information is deemed to have been omitted, the report may be returned for completion. Delays that are due to incomplete reports are counted toward the 45 day deadline outlined in (c) of this Section. At that time the mathematical accuracy of all totals and extensions is verified. Census information may be independently verified through other sources. After completion of the desk review, each report is entered into the OHCA's computerized data base. This facilitates the overall evaluation of the industry's costs.~~

~~(B) Announced and/or unannounced site reviews are conducted at a time designated by the OHCA. The purpose of site reviews is to verify the information reported on the QER(s) submitted by the facility to the OHCA. Errors and/or omissions discovered by the OHCA upon the completion of a site review is immediately reflected in future payment(s) to the facility. The OHCA makes deficiencies known to the facility within 30 calendar days. A deficiency notice in no way prevents the OHCA~~

~~from additionally finding any overpayment and adjusting future payments to reflect these findings.~~

~~(8) **Appeals process.**~~

~~(A) If the desk or site review indicates that a facility has been improperly paid, the OHCA will notify the facility that the OHCA will rectify the improper payment in future payments to the facility. Improper payments consist of an overpayment to a facility. The facility may appeal the determination to recoup an alleged overpayment and/or the size of the alleged overpayment, within 20 days of receipt of notice of the improper payment from the OHCA. Such appeals will be Level I proceedings heard pursuant to OAC 317:2-1-2(e)(2). The issues on appeals will be limited to whether an improper payment occurred and the size of the alleged improper payment. The methodology for determining base period computations will not be an issue considered by the administrative law judge.~~

~~(B) Certain exceptional circumstances, such as material expenses due to the use of contract employees, overtime expenses paid to direct care staff, or changes within classes of staff may have an effect on the wage enhancement payment and expense results. Facilities may demonstrate and present documentation of the affects of such circumstances before the administrative law judge.~~

~~(c) **Methodology for the distribution of payments/adjustments.** The OHCA initiates a two part process for the distribution and/or recoupment of the wage enhancement.~~

~~(1) **Distribution of wage enhancement revenue.** All wage enhancement rates are added to the current facility per diem rate. Facilities receive the maximum wage enhancement rate applicable to each facility type.~~

~~(2) **Payment/recoupment of adjustment process.** Initially, all overpayments resulting from the Fourth Quarter of SFY 1997 and the First Quarter of SFY 1998 audits will be deducted from the first month's payment of the Third Quarter of SFY 1998 (January 1998). The Fourth and First Quarter of SFY 1997 and SFY 1998 audit results will be averaged to determine the adjustment. All overpayments as a result of the Second Quarter of SFY 1998 audit will be deducted from the first month's payment of the Fourth Quarter of SFY 1998 (April 1998). Audit results will determine whether or not a facility is utilizing wage enhancement payments that are being added to the facility's per diem rate. When audit results for a given quarter after the Second Quarter of SFY 1998 (October, November, and December 1997) reflect an adjustment, recoupments will be deducted from the facility. Any adjustments calculated will not be recouped during the~~

~~quarter in which the calculation is made, rather, they will be recouped during the following quarter. The recoupments, as a result of an adjustment, will not exceed the wage enhancement revenue received for the quarter in which the audit is conducted. Recoupments will be included in the facility's monthly payment and will not exceed the three month period of the quarter in which it is being recouped.~~

~~(f) **Methodology for determining base year cost.** The information used to calculate Base Year Cost is taken from actual SFY 1995 cost reports submitted, to the OHCA, by the NFs and ICFs/MR that will be receiving a wage enhancement. A Statewide Average Base Cost is calculated for facilities that did not submit a cost report for SFY 1995. Newly constructed facilities that submit a partial year report are assigned the lower of the Statewide Average Base Cost or actual cost. The process for calculating the Base Year Cost, the Statewide Average Base Cost, and the process for newly constructed facilities is determined as follows.~~

~~(1) **Methodology used for determining base year cost.** The methodology for determining the Base Year Cost is determined by the steps listed in (A) through (E) of this paragraph.~~

~~(A) Regular employee salaries are determined by adding the salaries of LPNs, NAs, CMAs, SSDs, OSSS, ADs, OAS, and TAAs.~~

~~(B) Percentage of benefits allowed are determined by dividing total facility benefits by total facility salaries and wages.~~

~~(C) Total expenditures are determined by multiplying the sum of regular employee salaries by a factor of one plus the percentage of benefits allowed in (B) of this subparagraph.~~

~~(D) Base Year PPD Costs are determined by dividing total expenditures, in (3) of this subparagraph by total facility patient days. This information is used to determine statewide average base year cost.~~

~~(E) Inflated Base Year Costs are determined by multiplying Base Year Cost, in (C) of this subparagraph by the appropriate inflation factors. Base Year Expenditures were adjusted from the midpoint of the base year to the midpoint of the rate year using the moving rate of change forecast in the Data Resources, Inc., (DRI) "HCFA Nursing Home without Capital Market Basket" Index as published for the fourth quarter of calendar year 1995. The OHCA uses this same index (DRI) for subsequent years as it becomes available and is appropriate.~~

~~(2) **Methodology used for determining Statewide Average Base Cost.** A Statewide Average Base Cost is calculated for all facilities that did not submit a cost report, to the OHCA,~~

~~for SFY 1995. The steps listed in (A) through (C) of this paragraph are applied to determine the Base Cost in the absence of actual SFY 1995 cost report information.~~

~~(A) Statewide Average Base Year PPD Costs are determined by adding Base Year PPD Cost, calculated in (1)(D) of this subsection, for all facilities that submitted SFY 1995 cost reports, the sum of this calculation is then divided by the number of facilities that submitted cost reports.~~

~~(B) Inflated Base Year PPD Costs are determined by multiplying Statewide Base Year PPD Cost by the appropriate inflation factors. Statewide Base Year PPD Cost was adjusted from the midpoint of the base year to the midpoint of the rate year using the moving rate of change forecast in the Data Resources, Inc., (DRI) "HCFA Nursing Home without Capital Market Basket" Index as published for the fourth quarter of calendar year 1995. The OHCA uses this same index (DRI) for subsequent years as it becomes available and is appropriate.~~

~~(C) The facilities base cost is determined by multiplying the facilities' current quarter census by the inflated statewide average PPD costs calculated in (B) of this unit.~~

~~(g) **Methodology for determining wage enhancement revenue and expenditure results.** The methodology for determining the facilities' wage enhancement revenue and expenditures results are calculated in (1) through (3) of this paragraph.~~

~~(1) **Wage enhancement revenue.** Total wage enhancement revenue received by the facility for the current quarter is calculated by multiplying the facilities total paid Medicaid days for the current quarter by the facilities wage enhancement rate. The Oklahoma Health Care Authority adjusts the computations and results when actual paid Medicaid data for the reporting quarter becomes available.~~

~~(2) **Wage enhancement expenditures.** Total wage enhancement expenditures are determined in a four step process as described in (A) through (D) of this paragraph.~~

~~(A) Total current quarter allowable expenses are calculated. Salaries and wages of specified staff are totaled and added to the applicable percent of customary employee benefits and 100% of the new employee benefits.~~

~~(B) Base period expenditures are calculated. An occupancy adjustment factor is applied to the quarterly average base period cost to account for changes in census.~~

~~(C) Current quarter wage enhancement expenditures are calculated by subtracting allowable base period expenditures (see (B) of this subparagraph) from total current quarter allowable expenses (see (A) of this subparagraph).~~

~~(D) Total wage enhancement expenditures are calculated by adding current quarter wage enhancement expenditures (see (C) of this subparagraph) to prior period wage enhancement expenditures carried forward.~~

~~(3) **Wage enhancement revenue and expenditure results.** Wage enhancement revenue and expenditure results are determined by comparing total wage enhancement revenue (see (1) of this paragraph) to total wage enhancement expenditures (see (2)(D) of this paragraph). Revenue exceeding expenses is subject to recoupment. Expenses exceeding revenue are carried forward to the next reporting period as a prior period wage enhancement expenditure carry over.~~

~~(4) Due to rate increases and increases in the federal minimum wage, wage enhancements to nursing facilities and ICFs/MR are no longer paid.~~

317:30-5-131.2. Quality of care fund requirements and report

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

(1) **"Annualize"** means that the calculations, including, for example, total patient days, gross revenue, or contractual allowances and discounts, is divided by the total number of applicable days in the relevant time period.

(2) **"Direct-Care Staff"** means any nursing or therapy staff who provides direct, hands-on care to residents in a nursing facility and intermediate care facility for individuals with intellectual disabilities pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes, pursuant to OAC 310:675-1 et seq., and as defined in subsection (c) of this Section.

(3) **"Major Fraction Thereof"** means an additional threshold for direct-care-staff-to-resident ratios at which another direct-care staff person(s) is required due to the peak in-house resident count exceeding one-half of the minimum direct-care-staff-to-resident ratio pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes.

~~(4) **"Minimum wage"** means the amount paid per hour to specified staff pursuant to Section 5022.1 of Title 63 of the Oklahoma Statutes.~~

~~(5)~~(4) **"Nursing Facility and Intermediate Care Facility for Individuals with Intellectual Disabilities"** means any home, establishment, or institution or any portion thereof, licensed by the Oklahoma State Department of Health (OSDH) as defined in Section 1-1902 of Title 63 of the Oklahoma Statutes.

~~(6)~~(5) **"Peak In-House Resident Count"** means the maximum number of in-house residents at any point in time during the applicable shift.

~~(7)~~(6) **"Quality of Care Fee"** means the fee assessment created for the purpose of quality care enhancements pursuant to Section 2002 of Title 56 of the Oklahoma Statutes upon each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in this ~~State~~state.

~~(8)~~(7) **"Quality of Care Fund"** means a revolving fund established in the State Treasury pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

~~(9)~~(8) **"Quality of Care Report"** means the monthly report developed by the Oklahoma Health Care Authority (OHCA) to document the staffing ratios, total patient gross receipts, total patient days, and minimum wage compliance for specified staff for each nursing facility and intermediate care facility for individuals with intellectual disabilities licensed in the ~~State~~state.

~~(10)~~(9) **"Service rate"**~~"Rate"~~ means the minimum direct-care-staff-to-resident rate pursuant to Section 1-1925.2 of Title 63 of Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

~~(11)~~ **"Specified staff"** ~~means the employee positions listed in the Oklahoma Statutes under Section 5022.1 of Title 63 and as defined in subsection (d) of this Section.~~

~~(12)~~(10) **"Staff Hours worked"**~~Worked~~ **by Shift"** means the number of hours worked during the applicable shift by direct-care staff.

~~(13)~~(11) **"Staffing ratios"**~~"Ratios"~~ means the minimum direct-care-staff-to-resident ratios pursuant to Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

~~(14)~~(12) **"Total Gross Receipts"** means all cash received in the current Quality of Care Report month for services rendered to all residents in the facility. Receipts should include all Medicaid, Medicare, private pay, and insurance including receipts for items not in the normal per diem rate. Charitable contributions received by the nursing facility are not included.

~~(15)~~(13) **"Total Patient Days"** means the monthly patient days that are compensable for the current monthly Quality of Care Report.

(b) **Quality of care fund assessments.**

(1) The OHCA was mandated by the Oklahoma Legislature to assess a monthly service fee to each licensed nursing facility in the ~~State~~state. The fee is assessed on a per patient day basis. The amount of the fee is uniform for each facility type. The fee is determined as six percent (6%) of the average total gross receipts divided by the total days for each facility type.

(2) Annually, the Nursing Facilities Quality of Care Fee

shall be determined by using the daily patient census and patient gross receipts report received by the OHCA for the most recent available twelve months and annualizing those figures. Also, the fee will be monitored to never surpass the federal maximum.

(3) The fee is authorized through the Medicaid State Plan and by the Centers for Medicare and Medicaid Services regarding waiver of uniformity requirements related to the fee.

(4) Monthly reports of Gross Receipts and Census are included in the monthly Quality of Care Report. The data required includes, but is not limited to, the Total Gross Receipts and Total Patient Days for the current monthly report.

(5) The method of collection is as follows:

(A) The OHCA assesses each facility monthly based on the reported patient days from the Quality of Care Report filed two months prior to the month of the fee assessment billing. As defined in this subsection, the total assessment is the fee times the total days of service. The OHCA notifies the facility of its assessment by the end of the month of the Quality of Care Report submission date.

(B) Payment is due to the OHCA by the 15th of the following month. Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th will result in a debt to the State of Oklahoma and is subject to penalties of ~~10%~~10 percent (10%) of the amount and interest of ~~1.25%~~1.25 percent (1.25%) per month. The Quality of Care Fee must be submitted no later than the 15th of the month. If the 15th falls upon a holiday or weekend (Saturday-Sunday), the fee is due by 5 p.m. ~~(Central Standard Time)~~, Central Standard Time (CST), of the following business day (Monday-Friday).

(C) The monthly assessment, including applicable penalties and interest, must be paid regardless of any appeals action requested by the facility. If a provider fails to pay the OHCA the assessment within the time frames noted on the second invoice to the provider, the assessment, applicable penalty, and interest will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision will be adjusted in future payments. Adjustments to prior months' reported amounts for gross receipts or patient days may be made by filing an amended part C of the Quality of Care Report.

(D) The Quality of Care fee assessments excluding penalties and interest are an allowable cost for OHCA ~~Cost Reporting~~cost reporting purposes.

(E) The Quality of Care fund, which contains assessments collected including penalties and interest as described in this subsection and any interest attributable to

investment of any money in the fund, must be deposited in a revolving fund established in the State Treasury. The funds will be used pursuant to Section 2002 of Title 56 of the Oklahoma Statutes.

(c) **Quality of care direct-care-staff-to resident-ratios.**

(1) All nursing facilities and intermediate care facilities for individuals with intellectual disabilities (ICFs/IID) subject to the Nursing Home Care Act, in addition to other state and federal staffing requirements, must maintain the minimum direct-care-staff-to-resident ratios or direct-care service rates as cited in Section 1-1925.2 of Title 63 of the Oklahoma Statutes and pursuant to OAC 310:675-1 et seq.

(2) For purposes of staff-to-resident ratios, direct-care staff are limited to the following employee positions:

- (A) Registered Nurse
- (B) Licensed Practical Nurse
- (C) Nurse Aide
- (D) Certified Medication Aide
- (E) Qualified Intellectual Disability Professional (ICFs/IID only)
- (F) Physical Therapist
- (G) Occupational Therapist
- (H) Respiratory Therapist
- (I) Speech Therapist
- (J) Therapy Aide/Assistant

(3) The hours of direct care rendered by persons filling non-direct care positions may be used when those persons are certified and rendering direct care in the positions listed in OAC 317:30-5-131.2(c)(2) when documented in the records and time sheets of the facility.

(4) In any shift when the direct-care-staff-to-resident ratio computation results in a major fraction thereof, direct-care staff is rounded to the next higher whole number.

(5) To document and report compliance with the provisions of this subsection, nursing facilities and ~~intermediate care facilities for individuals with intellectual disabilities~~ ICFs/IID must submit the monthly Quality of Care Report pursuant to subsection (e) of this Section.

~~(d) **Quality of care minimum wage for specified staff.** All nursing facilities and private intermediate care facilities for individuals with intellectual disabilities receiving Medicaid payments, in addition to other federal and state regulations, must pay specified staff not less than in the amount of \$6.65 per hour. Employee positions included for purposes of minimum wage for specified staff are as follows:~~

- ~~(1) Registered Nurse~~
- ~~(2) Licensed Practical Nurse~~
- ~~(3) Nurse Aide~~

- ~~(4) Certified Medication Aide~~
- ~~(5) Other Social Service Staff~~
- ~~(6) Other Activities Staff~~
- ~~(7) Combined Social Services/Activities~~
- ~~(8) Other Dietary Staff~~
- ~~(9) Housekeeping Supervisor and Staff~~
- ~~(10) Maintenance Supervisor and Staff~~
- ~~(11) Laundry Supervisor and Staff~~

(e)(d) **Quality of care reports.** All nursing facilities and intermediate care facilities for individuals with intellectual disabilities must submit a monthly report developed by the OHCA, the Quality of Care Report, for the purposes of documenting the extent to which such facilities are compliant with the minimum direct-care-staff-to-resident ratios or direct-care service rates.

(1) The monthly report must be signed by the preparer and by the ~~Owner, authorized Corporate Officer, or Administrator~~owner, authorized corporate officer, or administrator of the facility for verification and attestation that the reports were compiled in accordance with this section.

(2) The ~~Owner~~owner or authorized ~~Corporate Officer~~corporate officer of the facility must retain full accountability for the report's accuracy and completeness regardless of report submission method.

(3) Penalties for false statements or misrepresentation made by or on behalf of the provider are provided at 42 U.S.C. Section 1320a-7b.

(4) The Quality of Care Report must be submitted by 5 p.m. (CST) on the 15th of the following month. If the 15th falls upon a holiday or a weekend (Saturday-Sunday), the report is due by 5 p.m. (CST) of the following business day (Monday - Friday).

(5) The Quality of Care Report will be made available in an electronic version for uniform submission of the required data elements.

(6) Facilities must submit the monthly report through the OHCA Provider Portal.

(7) Should a facility discover an error in its submitted report for the previous month only, the facility must provide to the ~~Long-Term~~Long-term Care Financial Management Unit written notification with adequate, objective, and substantive documentation within five business days following the submission deadline. Any documentation received after the five business day period will not be considered in determining compliance and for reporting purposes by the OHCA.

(8) An initial administrative penalty of \$150.00 is imposed

upon the facility for incomplete, unauthorized, or non-timely filing of the Quality of Care Report. Additionally, a daily administrative penalty will begin upon the OHCA notifying the facility in writing that the report was not complete or not timely submitted as required. The \$150.00 daily administrative penalty accrues for each calendar day after the date the notification is received. The penalties are deducted from the Medicaid facility's payment. For ~~100%~~100 percent (100%) private pay facilities, the penalty amount(s) is included and collected in the fee assessment billings process. Imposed penalties for incomplete reports or non-timely filing are not considered for OHCA ~~Cost Reporting~~cost reporting purposes.

(9) The Quality of Care Report includes, but is not limited to, information pertaining to the necessary reporting requirements in order to determine the facility's compliance with subsections (b) and (c) of this Section. Such reported information includes, but is not limited to: total gross receipts, patient days, available bed days, direct care hours, Medicare days, Medicaid days, number of employees, monthly resident census, and tenure of certified nursing assistants, nurses, directors of nursing, and administrators.

(10) Audits may be performed to determine compliance pursuant to subsections (b), ~~(c), and (d)~~and (c) of this Section. Announced/unannounced on-site audits of reported information may also be performed.

(11) Direct-care-staff-to-resident information and on-site audit findings pursuant to subsection (c), will be reported to the OSDH for their review in order to determine "willful" non-compliance and assess penalties accordingly pursuant to Title 63 Section 1-1912 through Section 1-1917 of the Oklahoma Statutes. The OSHD informs the OHCA of all final penalties as required in order to deduct from the Medicaid facility's payment. Imposed penalties are not considered for OHCA Cost Reporting purposes.

(12) If a Medicaid provider is found non-compliant pursuant to subsection (d) based upon a desk audit and/or an on-site audit, for each hour paid to specified staff that does not meet the regulatory minimum wage of \$6.65, the facility must reimburse the employee(s) retroactively to meet the regulatory wage for hours worked. Additionally, an administrative penalty of \$25.00 is imposed for each non-compliant staff hour worked. For Medicaid facilities, a deduction is made to their payment. Imposed penalties for non-compliance with minimum wage requirements are not considered for OHCA ~~Cost Reporting~~cost reporting purposes.

(13) Under OAC 317:2-1-2, ~~Long Term Care~~long-term care facility providers may appeal the administrative penalty

described in (b)(5)(B) and (e)(8) and (e)(12) of this section.

(14) Facilities that have been authorized by the OSDH to implement flexible staff scheduling must comply with OAC 310:675-1 et seq. The authorized facility is required to complete the flexible staff scheduling section of Part A of the Quality of Care Report. The ~~Owner, authorized Corporate Officer, or Administrator~~owner, authorized corporate officer, or administrator of the facility must complete the flexible staff scheduling signature block, acknowledging their OSDH authorization for ~~Flexible Staff Scheduling~~flexible staff scheduling.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-126. Therapeutic leave and Hospital leave

Therapeutic leave is any planned leave other than hospitalization that is for the benefit of the patient. Hospital leave is planned or unplanned leave when the patient is admitted to a licensed hospital. Therapeutic leave must be clearly documented in the patient's plan of care before payment for a reserved bed can be made.

~~(1) Effective July 1, 1994, the nursing facility may receive payment for a maximum of seven (7) days of therapeutic leave per calendar year for each recipient to reserve the bed.~~

~~(2)~~(1) No payment shall be made to a nursing long-term care facility for hospital leave, therapeutic leave with the exception of an Intermediate Care Facility serving Individuals with Intellectual Disabilities (ICF/IID). In addition, no payment shall be made to a long-term care facility for hospital leave.

~~(3)~~(2) ~~The Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID)~~ICF/IID may receive payment for a maximum of 60 days of therapeutic leave per calendar year for each ~~recipient~~member to reserve a bed. No more than 14 consecutive days of therapeutic leave may be claimed per absence. ~~Recipients~~Members approved for ICF/IID on or after July 1 of the year will only be eligible for 30 days of therapeutic leave during the remainder of that year. No payment shall be made for hospital leave.

~~(4)~~(3) Midnight is the time used to determine whether a patient is present or absent from the facility. The day of discharge for therapeutic leave is counted as the first day of leave, but the day of return from such leave is not counted.

~~(5)~~(4) Therapeutic leave balances are recorded on the Medicaid Management Information System ~~(MMIS)~~. When a patient moves to another facility, it is the responsibility of the transferring facility to forward the patient's leave records to the receiving facility.

Drug	Used for	Cost	Notes
Blincyto	Leukemia	\$120,000 per cycle	
Besponda	Leukemia	\$56,100 per cycle	
Bosulif	Leukemia	\$13,500 per month	
Gleevec	Leukemia	\$10,000 per month	
Iclusig	Leukemia	\$16,560 per month	
Kymriah	Leukemia	\$475,000 one time	
Synribo	Leukemia	\$26,000 per month	
Sprycel	Leukemia	\$11,600 per month	
Tasigna	Leukemia	\$12,400 per month	
Bavencio	Skin cancer	\$12,000 permonth	
Haegarda	Hereditary angioedema	\$37,600 per month	
Trulance	Chronic constipation	\$350 per month	
Xermelo	Severe diarrhea	\$5,550 per month	
Symproic	opioid induced constipation	\$314 per month	
Motofen	Diarrhea	\$120 per course	
Promacta	Platelet/bleeding disorders	\$3,000 -\$10,000 per month	
Odactra	House dust mite allergen	Not available	



Recommendation 1: Vote to Prior Authorize Blincyto® (Blinatumomab), Besponsa® (Inotuzumab Ozogamicin), Bosulif® (Bosutinib), Gleevec® (Imatinib), Iclusig® (Ponatinib), Kymriah™ (Tisagenlecleucel), Synribo® (Omacetaxine), Sprycel® (Dasatinib), and Tasigna® (Nilotinib)

Blincyto® (Blinatumomab) Approval Criteria:

1. Blincyto® should be used as a single-agent only; and
2. For one of the following diseases:
 - a. Relapsed/refractory Philadelphia chromosome negative (Ph-) acute lymphoblastic leukemia (ALL); or
 - b. Relapsed/refractory Philadelphia chromosome positive (Ph+) ALL after failure of two Tyrosine Kinase Inhibitors (TKIs); or
 - c. Ph- ALL as consolidation in adult/young adolescent or patients younger than 65 years without substantial comorbidity with persistent or late clearance minimal residual disease positive (MRD+) following a complete response to induction.

Besponsa® (Inotuzumab Ozogamicin) Approval Criteria:

1. Besponsa® must be used as a single-agent only; and
2. Member must have one of the following:
 - a. Relapsed/refractory Philadelphia chromosome negative (Ph-) acute lymphoblastic leukemia (ALL); or
 - b. Relapsed/refractory Philadelphia chromosome positive (Ph+) ALL who are intolerant/refractory to two or more Tyrosine Kinase Inhibitors (TKIs).

Bosulif® (Bosutinib) Approval Criteria [Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL) Diagnosis]:

1. Bosulif® may be authorized for relapsed/refractory ALL either as:
 - a. Single-agent; or
 - b. In combination with an induction regimen not previously given; and
2. Bosulif® must be only used in patients with E255K/V, F317L/VI/C, F359V/C/I, T315A, or Y253H mutations.

Bosulif® (Bosutinib) Approval Criteria [Chronic Myeloid Leukemia (CML) Diagnosis]:

1. Patients with chronic, accelerated, or blast phase CML with resistance or intolerance after primary treatment with either: dasatinib, imatinib, or nilotinib with the following BCR-ABL1 transcript levels:
 - a. 0.01% to 1% at >12 months; or
 - b. >1% to 10% at ≥12 months; or
 - c. >10% at any milestone.

Gleevec® (Imatinib) Approval Criteria [Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL) Diagnosis]:

1. Gleevec® may be approved for one of the following indications:

- a. Upfront therapy (including induction and consolidation) in combination with multi-agent chemotherapy or as a single-agent; or
- b. Maintenance therapy including:
 - i. In combination with vincristine and prednisone, with or without methotrexate and mercaptopurine; or
 - ii. Post-hematopoietic stem cell transplant; or
- c. In relapsed/refractory ALL and as a single-agent or in combination with multi-agent chemotherapy.

Gleevec® (Imatinib) Approval Criteria [Bone Cancer – Chordoma Diagnosis]:

1. Single-agent therapy or in combination with cisplatin or sirolimus for the treatment of recurrent disease.

Gleevec® (Imatinib) Approval Criteria [Chronic Myeloid Leukemia (CML) Diagnosis]:

1. Member must have one of the following:
 - a. Newly diagnosed chronic, accelerated, or blast phase CML; or
 - b. Post-hematopoietic stem cell transplant.

Gleevec® (Imatinib) Approval Criteria [Melanoma Diagnosis]:

1. Member must meet all of the following criteria:
 - a. Gleevec® must be used as a single-agent; and
 - b. Second-line or subsequent therapy for disease progression or after maximum clinical benefit from BRAF targeted therapy; and
 - c. Metastatic or unresectable tumors; and
 - d. Activating mutations of C-KIT; and
 - e. Member must have an ECOG performance status of 0 to 2.

Gleevec® (Imatinib) Approval Criteria [Myelodysplastic Syndrome (MDS) Diagnosis]:

1. Chronic myelomonocytic leukemia (CMML) for 5q31-33 translocations and/or PDGFR β gene rearrangements.

Gleevec® (Imatinib) Approval Criteria [Non-Melanoma Skin Cancers – Dermatofibrosarcoma Protuberans (DFSP) Diagnosis]:

1. Tumors with t(17;22) translocation; and
2. Member must have one of the following:
 - a. Adjuvant therapy for positive surgical margins following excision; or
 - b. Recurrent disease if disease is unresectable or if additional resection would lead to unacceptable functional or cosmetic outcomes; or
 - c. For metastatic disease.

Gleevec® (Imatinib) Approval Criteria [Soft Tissue Sarcoma – Desmoid Tumors (Aggressive Fibromatosis) Diagnosis]:

1. Primary, recurrent, or progressive disease with one of the following:
 - a. Initial treatment for resectable disease; or
 - b. Adjuvant treatment for gross residual disease; or
 - c. Initial treatment for unresectable disease or for disease for which surgery would be unacceptably morbid.

Gleevec® (Imatinib) Approval Criteria [Soft Tissue Sarcoma – Gastrointestinal Stromal Tumors (GIST) Diagnosis]:

1. Primary/preoperative treatment for patients with documented GIST with one of the following:

- a. Resectable with risk of significant morbidity; or
 - b. Unresectable; or
 - c. Recurrent; or
 - d. Metastatic; or
2. Postoperative treatment with one of the following:
- a. Complete resection of primary GIST; or
 - b. Persistent gross residual disease; or
3. Continued treatment for one of the following:
- a. Limited progression; or
 - b. Generalized progression.

Gleevec® (Imatinib) Approval Criteria [Soft Tissue Sarcoma – Pigmented Villonodular Synovitis/Tenosynovial Giant Cell Tumor Diagnosis]:

1. Gleevec® must be used as a single-agent only.

Iclusig® (Ponatinib) Approval Criteria [Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL) Diagnosis]:

1. Member must have one of the following:
 - a. Induction/consolidation with HyperCVAD; or
 - b. Maintenance therapy in combination with vincristine and prednisone, with or without methotrexate and mercaptopurine; or
 - c. Maintenance therapy post-hematopoietic stem cell transplant; or
 - d. Relapsed/refractory disease either as a single-agent, in combination with chemotherapy not previously given, or in patients with T315I mutations.

Iclusig® (Ponatinib) Approval Criteria [Chronic Myeloid Leukemia (CML) Diagnosis]:

1. Member must have one of the following:
 - a. In patients with a T315I mutation; or
 - b. Intolerant or resistant to all other Tyrosine Kinase Inhibitors (TKIs); or
 - c. Post-hematopoietic stem cell transplantation in patients with prior accelerated or blast phase prior to transplant or who have relapsed.

Kymriah™ (Tisagenlecleucel) Approval Criteria:

1. All of the following must be met for approval:
 - a. B-Cell precursor acute lymphoblastic leukemia (ALL); and
 - b. Member must be 25 years of age or younger; and
 - c. Refractory or in second or later relapse:
 - i. Philadelphia chromosome negative (Ph-) ALL: must be refractory or with ≥ 2 relapses; or
 - ii. Philadelphia chromosome positive (Ph+) ALL: must have failed ≥ 2 Tyrosine Kinase Inhibitors (TKIs); and
 - d. Therapies to consider prior to tisagenlecleucel if appropriate: clinical trial, multi-agent chemotherapy with or without hematopoietic cell transplantation (HCT), blinatumomab (category 1 recommendation), and inotuzumab (category 1 recommendation).

2. Healthcare facilities must be on the certified list to administer CAR T cells and must be trained in the management of cytokine release syndrome (CRS), neurologic toxicities, and comply with the REMS requirements.

Synribo® (Omacetaxine) Approval Criteria [Chronic Myeloid Leukemia (CML) Diagnosis]:

1. Synribo® must be used as a single-agent only; and
2. Member must have one of the following:
 - a. Primary treatment of advanced phase CML with disease progression to accelerated phase; or
 - b. Post-hematopoietic stem cell transplant in patients who have relapsed; or
 - c. Patients with T315I mutation; or
 - d. Patients who are intolerant or resistant to two or more Tyrosine Kinase Inhibitors (TKIs).

Sprycel® (Dasatinib) Approval Criteria [Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL) Diagnosis]:

1. Member must have one of the following:
 - a. Upfront therapy (including induction and consolidation) in combination with multi-agent chemotherapy or as a single-agent; or
 - b. Maintenance therapy including:
 - i. In combination with vincristine and prednisone, with or without methotrexate and mercaptopurine; or
 - ii. Post-hematopoietic stem cell transplant; or
 - c. Relapsed/refractory as a single-agent or in combination with multi-agent chemotherapy.

Sprycel® (Dasatinib) Approval Criteria [Chronic Myeloid Leukemia (CML) Diagnosis]:

1. Member must have one of the following:
 - a. Newly diagnosed chronic, accelerated, or blast phase CML; or
 - b. Post-hematopoietic stem cell transplant.

Sprycel® (Dasatinib) Approval Criteria [Soft Tissue Sarcoma – Gastrointestinal Stromal Tumors (GIST) Diagnosis]:

1. Member must have all of the following:
 - a. Progressive disease and failed imatinib, sunitinib, or regorafenib; and
 - b. PDGFRA D842V mutation.

Tasigna® (Nilotinib) Approval Criteria [Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia (ALL) Diagnosis]:

1. Member must have one of the following:
 - a. Upfront therapy (including induction and consolidation) in combination with multi-agent chemotherapy or as a single-agent; or
 - b. Maintenance therapy including:
 - i. In combination with vincristine and prednisone, with or without methotrexate and mercaptopurine; or
 - ii. Post-hematopoietic stem cell transplant; or
 - c. Relapsed/refractory as a single-agent or in combination with multi-agent chemotherapy.

Tasigna® (Nilotinib) Approval Criteria [Chronic Myeloid Leukemia (CML) Diagnosis]:

1. Member must have one of the following:

- a. Newly diagnosed chronic, accelerated, or blast phase CML; or
- b. Post-hematopoietic stem cell transplant.

Tasigna® (Nilotinib) Approval Criteria [Soft Tissue Sarcoma – Gastrointestinal Stromal Tumors (GIST) Diagnosis]:

1. Member must have progressive disease and failed imatinib, sunitinib, or regorafenib.

Recommendation 2: Vote to Prior Authorize Bavencio® (Avelumab)

Bavencio® (Avelumab) Approval Criteria [Merkel Cell Carcinoma (MCC) Diagnosis]:

1. A diagnosis of metastatic MCC; and
2. Member must be 12 years of age or older.

Bavencio® (Avelumab) Approval Criteria [Urothelial Carcinoma Diagnosis]:

1. A diagnosis of locally advanced or metastatic urothelial carcinoma; and
2. Disease has progressed during or following platinum-containing chemotherapy or within 12 months of neoadjuvant or adjuvant platinum-containing chemotherapy.

Recommendation 3: Vote to Prior Authorize Haegarda® [C1 Esterase Inhibitor (Human)]

The Drug Utilization Review Board recommends the prior authorization of Haegarda® [C1 esterase inhibitor (human)] similar to the other prior authorized hereditary angioedema (HAE) prophylaxis medications with the following criteria:

Cinryze® (C1 Esterase Inhibitor) and Haegarda® (C1 Esterase Inhibitor) Approval Criteria:

1. An FDA approved diagnosis of hereditary angioedema (HAE); and
2. Must be used for *prophylaxis* of HAE; and
3. History of at least one or more abdominal or respiratory HAE attacks per month, or history of laryngeal attacks, or three or more emergency medical treatments per year; and
4. Not currently taking an angiotensin converting enzyme (ACE) inhibitor or estrogen replacement therapy; and
5. Member meets the following:
 - a. Documented intolerance, insufficient response, or contraindication to attenuated androgens (e.g., danazol, stanozolol, oxandrolone, methyltestosterone); and
 - b. Documented intolerance, insufficient response, or contraindication to antifibrinolytic agents (e.g., ε – aminocaproic acid, tranexamic acid); or
 - c. Recent hospitalization for severe episode of angioedema; and
6. Cinryze® Dosing:
 - a. The recommended dose of Cinryze® is 1,000 units IV every 3 to 4 days, approximately two times per week, to be infused at a rate of 1mL/min; and
 - b. Initial doses should be administered in an outpatient setting by a healthcare provider. Patients can be taught by their healthcare provider to self-administer Cinryze® intravenously; and
 - c. A quantity limit of 8,000 units per month will apply (i.e., two treatments per week or eight treatments per month); or
7. Haegarda® Dosing:

- a. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
- b. A quantity limit of two treatments per week or eight treatments per month will apply

Recommendation 4: Vote to Prior Authorize Trulance™ (Plecanatide), Xermelo™ (Telotristat Ethyl), Symproic® (Naldemedine), and Motofen® (Difenoxin/Atropine)

The College of Pharmacy recommends the prior authorization of Trulance™ (plecanatide), Xermelo™ (telotristat ethyl), Symproic® (naldemedine), and Motofen® (difenoxin/atropine) with the following criteria:

Trulance™ (Plecanatide) Approval Criteria:

1. An FDA approved diagnosis of chronic idiopathic constipation (CIC) in members 18 years of age or older; and
2. Documentation that constipation-causing therapies for other disease states have been discontinued (excluding opioid pain medications for cancer patients); and
3. Documented and updated colon screening for members older than 50 years of age; and
4. Documentation of hydration attempts and trials of at least three different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
 - a. One of the three trials must be polyethylene glycol 3350 (PEG-3350); and
 - b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
5. Approval will initially be for 12 weeks of therapy. Further approval may be granted if the prescriber documents the member is responding well to treatment.
6. A quantity limit of 30 tablets for a 30-day supply will apply.

Xermelo™ (Telotristat Ethyl) Approval Criteria:

1. An FDA approved diagnosis of carcinoid syndrome diarrhea in combination with somatostatin analog (SSA) therapy in adults inadequately controlled by SSA therapy; and
2. Member must be 18 years of age or older; and
3. Member must have been taking a stable dose of SSA therapy for the last three months and be inadequately controlled (four or more bowel movements per day); and
4. Prescriber must verify member will continue taking SSA therapy in combination with Xermelo™; and
5. Approval will initially be for 12 weeks of therapy. Further approval may be granted if prescriber documents member is responding well to treatment.
6. A quantity limit of 90 tablets for a 30-day supply will apply.

Symproic® (Naldemedine) Approval Criteria:

1. An FDA approved diagnosis of opioid-induced constipation (OIC) in members 18 years of age or older with chronic, non-cancer pain who are currently on chronic opioid therapy, including patients with chronic pain related to prior cancer or its treatment who do not require frequent (e.g., weekly) opioid dosage escalation; and
2. Member must not have known or suspected gastrointestinal obstruction; and

3. Documentation of the underlying cause of chronic pain, or reason why the member is on chronic opioid therapy; and
4. Documented and updated colon screening for members older than 50 years of age; and
5. Documentation of hydration attempts and trials of at least three different types of products that failed to relieve constipation. Trials must be within the past 90 days. Products may be over-the-counter (OTC) or prescription (does not include fiber or stool softeners); and
 - a. One of the three trials must be polyethylene glycol 3350 (PEG-3350); and
 - b. Members with an oncology-related diagnosis are exempt from the trial requirements; and
6. A patient-specific, clinically significant reason why member cannot use Amitiza® (lubiprostone) or Movantik® (naloxegol) must be provided; and
7. Approval will initially be for 12 weeks of therapy. Further approval may be granted if the prescriber documents the member is responding well to treatment.
8. Symproic® must be discontinued if treatment with the opioid pain medication is also discontinued.
9. A quantity limit of 30 tablets for a 30-day supply will apply.

Motofen® (Difenoxin/Atropine) Approval Criteria:

1. An FDA approved diagnosis of acute nonspecific diarrhea or acute exacerbations of chronic functional diarrhea; and
2. Member must not be 2 years of age or younger; and
3. Member must not have diarrhea associated with organisms that penetrate the intestinal mucosa (e.g., toxigenic *Escherichia coli*, *Salmonella species*, *Shigella*) or pseudomembranous colitis associated with broad spectrum antibiotics; and
4. A patient-specific, clinically significant reason why the member cannot use Lomotil® (diphenoxylate/atropine) and loperamide must be provided; and
5. A quantity limit of 16 tablets per 2 days will apply.

Recommendation 5: Vote to Prior Authorize Promacta® (Eltrombopag)

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

Promacta® (Eltrombopag) Approval Criteria:

1. An FDA approved indication of chronic immune (idiopathic) thrombocytopenia (ITP); and
 - a. Previous insufficient response to at least one of the following:
 - i. Corticosteroids; or
 - ii. Immunoglobulins; or
 - iii. Splenectomy; and
 - b. Degree of thrombocytopenia and clinical condition increase the risk for bleeding; and
 - c. Must be prescribed by, or in consultation with, a hematologist or oncologist; or

2. An FDA approved indication of thrombocytopenia in patients with chronic hepatitis C (CHC) to allow initiation and maintenance of interferon (IFN)-based therapy; and
 - a. Promacta® must be prescribed by a gastroenterologist, infectious disease specialist, or transplant specialist or the member must have been evaluated by a gastroenterologist, infectious disease specialist, or transplant specialist for hepatitis C therapy within the last three months; and
 - b. Patient must be prescribed IFN for treatment of CHC infection; or
3. An FDA approved indication of severe aplastic anemia (SAA); and
 - a. Previous insufficient response or documented contraindication or intolerance to immunosuppressive therapy; and
 - b. Must be prescribed by, or in consultation with, a hematologist or oncologist; and
4. For the diagnoses of chronic ITP and CHC associated thrombocytopenia, initial approvals will be for the duration of 1 month. For the diagnosis of SAA, initial approvals will be for the duration of 4 months. Subsequent approvals may be authorized if the prescriber documents the member is responding well to therapy and the following criteria is met, based upon member's diagnoses:
 - a. For All Diagnoses:
 - i. Must not have excessive platelet count responses. Promacta® should be discontinued if platelets exceed $400 \times 10^9/L$ after two weeks of therapy at the lowest dose; and
 - ii. Prescriber documents liver function tests are being monitored and levels are acceptable to the prescriber.
 - b. Chronic ITP:
 - i. Documentation that platelet count has increased to a level sufficient to avoid clinically important bleeding or that a dose increase is planned, if not already on maximum dose. Promacta® should be discontinued if the platelet count does not increase to a level sufficient to avoid clinically important bleeding after four weeks of therapy at the maximum daily dose of 75mg.
 - c. CHC-Associated Thrombocytopenia:
 - i. Documentation that member continues to be on antiviral therapy. Promacta® should be discontinued when antiviral therapy is discontinued.
 - d. SAA:
 - i. Documentation that member has had a hematologic response (e.g., increase in platelet count, increase in hemoglobin, increase in absolute neutrophil count, reduction in frequency of platelet or red blood cell transfusions). Promacta® should be discontinued if no hematologic response has occurred after 16 weeks of therapy.

Recommendation 6: Vote to Prior Authorize Odactra™ (House Dust Mite Allergen Extract)

The Drug Utilization Review Board recommends the prior authorization of Odactra™ (house dust mite allergen extract) with the following criteria:

Odactra™ (House Dust Mite Allergen Extract) Approval Criteria:

1. Member must be 18 to 65 years of age; and
2. Member must have a positive skin test (labs required) to licensed house dust mite allergen extracts or *in vitro* testing for IgE antibodies to *Dermatophagoides farinae* or *Dermatophagoides pteronyssinus* house dust mites; and
3. Member must not have severe uncontrolled asthma; and
4. Member must have failed conservative attempts to control allergic rhinitis; and
5. Member must have failed pharmacological agents used to control allergies including the following (dates and duration of trials must be indicated on the prior authorization request):
 - a. Antihistamines: Trials of two different products for 14 days each; and
 - b. Montelukast: One 14-day trial in combination with an antihistamine; and
 - c. Intranasal corticosteroids: Trials of two different products for 21 days each; and
6. The first dose must be given in the physician's office, and the member must be observed for at least 30 minutes post dose; and
7. Member must not be allergic to other allergens for which they are receiving treatment via subcutaneous immunotherapy also known as "allergy shots"; and
8. Member or family member must be trained in the use of an auto-injectable epinephrine device and have such a device available for use at home; and
9. Prescriber must be an allergist, immunologist, or be an advanced care practitioner with a supervising physician that is an allergist or immunologist; and
10. A quantity limit of one tablet daily will apply; and

Initial approvals will be for the duration of six months of therapy, at which time the prescriber must verify the patient is responding well to Odactra™ therapy. Additionally, compliance will be evaluated for continued approval.

2018 PROPOSED OHCA BOARD MEETINGS/LOCATIONS

January						
S	M	T	W	T	F	S
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7	8	9	10	11	12	13
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January 11, 2018 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

February 8, 2018 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

March 23, 2018 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

May 10, 2018 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

June 28, 2018 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

August 9, 2018 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

September 13, 2018 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

October 11, 2018 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

November 8, 2018 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

December 13, 2018 • 1:00 pm
 Oklahoma Health Care Authority
 4345 N. Lincoln Blvd.
 Oklahoma City, Oklahoma

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