OKLAHOMA HEALTH CARE AUTHORITY
AMENDED BOARD MEETING
June 30, 2021 at 3:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK. 73105

A G E N D A

Public access via Zoom:
https://okhca.zoom.us/webinar/register/WN_aDVZwqwuQnmdhHHuZ-VsUA
Telephone: 1-669-900-6833 Meeting ID: 936 0702 9331

*Please note: Since the physical address for the OHCA Board Meeting has resumed, any livestreaming option provided is provided as a courtesy. Should such livestreaming option fail or have technical issues, the OHCA Board Meeting will not be suspended or reconvened because of this failure or technical issue.

1. Call to Order / Determination of Quorum……Stan Hupfeld, Chair

2. Consent Agenda……..Stan Hupfeld, Chair

    a) Approval of the May 19, 2021 OHCA Board Meeting Minutes(Attachment "A")
    b) Approval of State Plan Amendment Rate Committee Rates pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:1-3-4 (Attachment "B")
    c) Discussion and Vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:10-1-16. (Attachment "C")
        i. Arine Pharmacy Software

3. Chief Executive Officer's Report…….Kevin Corbett, Chief Executive Officer

4. Discussion of Report from the……..……..Phil Kennedy
   Compliance Advisory Committee and Chair, Compliance Advisory Committee
   Possible Action Regarding State Fiscal Year
   2021 Budget Work Program

    a) Presentation of SFY 2022 Budget Work Program by Aaron Morris, Chief Financial Officer (Attachment "D")
    b) Consideration and Vote on SFY 2022 Budget Work Program pursuant to 63 O.S. Section 5008(B)(3)

5. Discussion of Report from the Pharmacy ……Randy Curry
   Advisory Committee and Possible Action Regarding Chair, Pharmacy Advisory Committee
   Drug Utilization Board Recommendations

    a) Consideration and Vote on Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.1, § 5030.3 To Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:2-1-11 (Attachment "E"):

        i. Breyanzi® (Lisocabtagene Maraleucel)
        ii. Cosela™ (Trilaciclib), Gavreto™ (Pralsetinib), Retevmo® (Selpercatinib), Tabrecta™ (Capmatinib), Tepmetko® (Tepotinib), and Zepzelca™ (Lurbinectedin)
        iii. Lyumjev™ (Insulin Lispro-aabc)
        iv. Amondys 45™ (Casimersen), Viltepso® (Viltolarsen), and Vyondys 53™ (Golodirsen)
        v. Verquvo™ (Vericiguat)

6. Discussion of Report of Administrative……..……..…….....Jean Hausheer, M.D.
   Rules Advisory Committee and Possible Action Chair, Administrative Rules Advisory Committee
   Regarding Agency Rulemaking (Attachment "F")

a) Consideration and Vote on a Declaration of a Compelling Public Interest for the Promulgation of the Emergency Rules in Attachment "F" in Accordance with 75 O.S. § 253.

b) Consideration and Vote on Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Emergency Rules (see Attachment "F"):

i. APA WF # 21-07 Payments from Trusts for Clothing Expenses not Counted as Income - The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board.
ii. APA WF # 21-08 Statewide HIE (OKSHINE) - The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; the Oklahoma Health Care Authority Board; and 63 O.S. § 1-133.
iii. APA WF # 21-09 Supplemental Hospital Offset Payment Program (SHOPP) - The Oklahoma Health Care Authority Act, Section 5007 (C)(2) of Title 63 of Oklahoma Statutes; The Oklahoma Health Care Authority Board; 42 Code of Federal Regulations (C.F.R.) §§ 447.272 and 447.321; Oklahoma Senate Bill 1045

7. Discussion and Possible Action……Stan Hupfeld, Chair
Possible Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meeting Act, 25 O.S. § 307(B)(4) and (7), To Discuss Confidential Legal Matters, Including Pending State and Federal Litigation.

8. Adjournment……Stan Hupfeld, Chair

NEXT BOARD MEETING
September 15, 2021
Oklahoma Health Care Authority

ATTACHMENT A

MINUTES OF A REGULAR BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
May 19, 2021
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 May 18, 2021 at 3:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on May 14, 2021 at 11:40 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Hupfeld called the meeting to order at 3:03 p.m.

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

ITEM 2 – PUBLIC COMMENT ON THIS MEETING'S AGENDA ITEMS BY ATTENDEES WHO GAVE 24-HOUR PRIOR WRITTEN NOTICE
Stanley Hupfeld, OHCA Board Chairman

- Reza Kazerooni, PharmD, Director, Evidence & Value Development, Taiho Oncology, Inc.

ITEM 3 – MEMBER MOMENT
Melody Anthony, Chief Operating Officer/State Medicaid Director

Ms. Anthony introduced Dr. Deborah Shropshire, Director of Child Welfare Services at Oklahoma Human Services, who gave an overview of the child welfare system and collaboration with the specialty Managed Care plan.

ITEM 4 / DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF THE MARCH 17, 2021 BOARD MEETING MINUTES:

MOTION:	Member Kennedy moved for approval of the March 17, 2021 Board Meeting Minutes, as published. The motion was seconded by Member Nuttle.
FOR THE MOTION:	Chairman Hupfeld, Member Case, Member Kennedy, Member Nuttle
ABSTAINED:	Member Boyd, Member Curry, Member Shamblin
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Hausheer

ITEM 5 / CHIEF EXECUTIVE OFFICER'S REPORT
Kevin Corbett, Chief Executive Officer

Mr. Corbett provided a COVID and Vaccine update, stating that off the 600 employees at OHCA, only 59 of those were impacted by COVID. A vaccine survey was sent to staff and showed that 80% of staff have receive the vaccine, 10% are still considering receiving the vaccine, and a small portion indicating they have no interest in receiving the vaccine. Ellen will provide a more in depth update regarding the work on our approach to a returning to the building and more normal, yet flexible work arrangement. Most recently, the Governor terminated his executive order and declared the public health emergency over, which has resulted in the termination of the legislative relief to conduct virtual open meetings. Starting in June, all virtual meetings will be in person and follow the Open Meetings protocol that were previously in place.

Mr. Corbett reported that OHCA has received approval from CMS for the Disaster Relief SPA, which will provide federal relief funds to LTC providers to assist them with the additional costs incurred and are continuing to care for OHCA members in LTC facilities. The funds made available total $68 million and equates to an average of $130,000 for each nursing facility. At the May Board meeting, several funding opportunities for the Medicaid program through the American Rescue Plan were presented. OHCA has been analyzing and estimating the impact of the 5% enhanced FMAP and is currently estimated that the 5% will produce additional funds for the Medicaid program of approximately $250 to $260 million per year for the next two years. OHCA, along with other state agencies that participate in the Medicaid program, will share the funds with OHCA estimated to receive approximately $190 million per year for the next two years. There

have been no commitments made for potential use of these however, meaningful discussion and consideration for using a substantial portion of these funds for expansion is occurring. All indications, regarding OHCA's FY22 budget, are that all OHCA budget requests will be approved.

Expansion: Mr. Corbett provided a brief update on Expansion. OHCA will begin accepting applications on June 1, 2021 for eligibility, with benefits for eligible member to begin July 1, 2021. OHCA is working with community partners and providers who play a key role in assisting with online applications and educating new members on how to access services as a new member. Melissa Richey and her team is leading the effort to help spread the word to potential eligible members. Mr. Corbett stated an update on expansion enrollment will be provided at the June 30, 2021 Board meeting.

Managed Care: Mr. Corbett introduced the CEOs of the four medical Managed Care Organizations (MCOs) and three Dental Benefit Plans (DBP):

Joe Cunningham, Blue Cross Blue Shield
Clay Franklin, Oklahoma Complete Health
Megan Haddock, United Health of Oklahoma
Foe Fairbanks, Humana of Oklahoma

Lisa Gifford, Liberty Dental
Joe Vesowate, DentaQuest
Leon Bragg, MCNA

As part of the move to Managed Care, it is recommended that another advisory committee of the board be created. The Quality Advisory Committee will meet quarterly to review the quality performance of the managed care delivery system. OHCA is in the process of developing the charter and bylaws for the committee and will work with the Board Chairman to appoint members of the board to this committee. Mr. Corbett also provided an update on SB131, Managed Care guardrails bill. The bill includes many requirements of the managed care delivery system. OHCA staff have reviewed the bill, as have our managed care partners. While many provisions align with what is currently in place, many provisions are new and require some modification to the implementation plan and contracts if it becomes a law.

HIE: OHCA received approval from CMS to claim federal funds for the implementation. SB574 is in process which will establish the State HIE as the State Designated Entity and creates a certification program for other HIEs to become Certified Statewide HIEs. The bill also directs OHCA to promulgate emergency rules, which are currently being developed.

Operations: Mr. Corbett highlighted a few items from the Board Metric Report, including: enrollment numbers, utilization, and telehealth visits.

ITEM 6 / CHIEF OF STAFF'S REPORT
Ellen Buettner, Chief of Staff

Ms. Buettner introduced OHCA's new General Counsel, Kara Smith and provided updates on Expansion Communications, Return to Work, and

Expansion Communications: OHCA Communications had a soft launch media campaign, which includes media briefings for press, broadcast feature stories, in-studio interviews, and a social media campaign. There will also be a broader statewide campaign will launch on July 1, 2021.

Return to Work Plan: Dara Holmes, Director of Human Resources, has been working with Executive Leadership and their direct reports to finalize a return to work plan that will include flexible work arrangements, hoteling rotations, and new permanent telework staff.

Organizational Development: Ms. Buettner highlighted the Lead Up program which was created based on the feedback received from the annual engagement survey. She reported that there are 23 action items, but the Lead Up program was one that had significant advancement. She also stated that OHCA will be holding an employee family event in June at the Zoo and extended an invitation to the board members.

ITEM 7 / CHIEF OPERATING OFFICER'S REPORT
Melody Anthony, Chief Operating Officer/State Medicaid Director

Ms. Anthony introduced Traylor Rains, Deputy State Medicaid Director, who provided a Managed Care Implementation Update.

Outreach and Education: Mr. Rains stated that as of today, OHCA has held five regional Managed Care Town Halls across the state. OHCA Provider Engagement will also hold trainings for providers. So far, eight trainings have been scheduled for May and June.

Readiness Review: Onsite readiness reviews have been ongoing the month of May and have not resulted in any major findings. Desk reviews of the plans' policies and procedures was completed in April. The plans have until May 28, 2021 to correct any identified deficiencies. The plans submit a staffing report every week to Ms. Anthony and Mr. Rains. It is estimated that the implementation of Managed Care will create about 1,700 Oklahoma based jobs. The implementation workgroups have been meeting weekly since March and have responded to over 1,400 questions from the plans.

CMS Engagement: OHCA is now in the negotiations phase regarding the special terms and conditions of the 1115 Waiver. OHCA staff meet with CMS bi-weekly and also attended the onsite reviews.

OHCA Organizational Changes: OHCA has created the Quality Unit and Monitoring and Oversight unit. Both will be dedicated to Managed Care. For more detailed information, see attachment "B" in the board packet.

ITEM 8 / DISCUSSION OF REPORT FROM THE LEGISLATIVE ADVISORY COMMITTEE
Christina Foss, Legislative Liaison

Ms. Foss provided an update on agency related bills. About 50 JCAB bills were introduced over the weekend, staff are reviewing the language.

SB 1045 will increase the SHOPP rate from 3% to 3.5%-4% and also provided a directed payment structure. The bill has passed the Senate Floor and moves to the House Floor next.

SB 1046 is OHCA's limits bill which has granted some of the budget request items, including: program growth dental benefits, and alternate pain management benefits.

HB 2900 is the General Appropriations bill

HB 2950: creates a supplemental payment program for some private ambulatory service providers. The bill has passed the House Floor and will move to the Senate Floor.

SB 689 will change the MAC structure to reflect federal guidelines. This bill has been signed out of the committee and will move to the Senate Floor.

SB 574: Establishes the structure for State Health Information Exchange passed the Senate Floor and the House has accepted. The bill is on its way to the Governor.

ITEM 9 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Phil Kennedy, Chair of the Compliance Advisory Committee

Committee Chairman Kennedy provided a Finance, Audit, and Business Enterprises update.

Finance: Committee Chair Kennedy provided an overview of the OHCA financials through the end of March. OHCA has a positive variance growth of $8-$9 million through end of fiscal year. The current budget variance is a positive $53 million and is primarily driven by program expenses. OHCA received CMS approval for the Nursing Facility Supplemental Payment and will be funded by the enhanced FMAP. The first installment of $68 million will go out this month. March fund balances were also reviewed. OHCA's cash balance continues to increase due to the enhanced federal funding received. It is estimated that OHCA will end SFY21 with $440 million in its cash balance.

Audit: The remaining three audit findings were discussed during the Compliance meeting. The solution related to findings related to checks receiving control has been implemented. The remaining two findings are still being worked on.

Business Enterprises: System operational readiness reviews for Expansion are scheduled Tuesday, May 26.

a) Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds.

The Compliance Committee discussed each of the contracts and had no concerns circling the nature of the contracts however, they Committee did not make a motion.

i. Behavioral Health Home Management Software System (Attachment "C")

ii. Recovery Audit Contractor (Attachment "D")
iii. Third Party Liability Systems (Attachment "E")
iv. Asset Verification System Services (Attachment "F")
v. Managed Care Program Administration & Performance and Functional Capabilities assessment Phase 2 (Attachment "G")

MOTION: Chairman Kennedy motioned for approval of item 9a.i-v as published. The motion was seconded by Member Curry.

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

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Hausheer

ITEM 10 / DISCUSSION OF REPORT FROM THE STRATEGIC PLANNING ADVISORY COMMITTEE
Robert Boyd, Chair, Strategic Planning Advisory Committee

Committee Chair Boyd provided an overview of the May 10, 2021 Strategic Planning Advisory Committee meeting and introduced the Committee Members: Chairman Hupfeld, Member Tanya Case, and Member Marc Nuttle. The current Strategic Plan is over 130 pages and has no analytical data. Due to Expansion and Managed Care, the Strategic Plan will need to undergo some changes. Committee Chair Boyd referenced the document drafted by himself and Trae Rahill, OHCA Chief Strategy and Innovation Officer, that reflects the organization and strategy of the agency. A more in depth update will be provided at the next board meeting.

ITEM 11i-xi / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION BOARD RECOMMENDATIONS
Randy G. Curry, D.Ph., Chair of the Pharmacy Advisory Committee

Action Item – a) Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.3 to Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e) (see Attachment "H")

i. Inqovi® (Decitabine/ Cedazuridine) and Onureg® (Azacitidine)
ii. Fintepla® (Fenfluramine)
iii. Vyepti® (Eptinezumab-jjmr)
iv. Oxlumo™ (Lumasiran)
v. Zokinvy® (Lonafarnib)
vi. Monjuvi® (Tafasitamab-cxix), Tecartus™ (Brexucabtagene Autoleucel), and Ukoniq™ (Umbralisib)
vii. Sevenfact® [Coagulation Factor VIIa (Recombinant)-jncw]
viii. Bafiertam™ (Monomethyl Fumarate), Kesimpta® (Ofatumumab), and Zeposia® (Ozanimod)
ix. Orladeyo™ (Berotralstat)
x. Barhemsys® (Amisulpride)
xi. Nyvepria™ (Pegfilgrastim-apgf)

MOTION: Member Curry moved for approval of Item 11i-x as published. The motion was seconded by Member Boyd

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

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Hausheer

ITEM 12i-v / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING
Laura Shamblin, M.D., FAAP, Committee Member of the Administrative Rules Advisory Committee

a) Consideration and Vote on a Declaration of a Compelling Public Interest for the Promulgation of the Emergency Rule in Attachment "I" in Accordance with 75 O.S. § 253.

b) Consideration and Vote on Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Emergency Rule (see Attachment "I"):

i. APA WF #21-02 State Plan Personal Care Services
ii. APA WF # 21-03 Remove Reasonable Limits on Amounts for Necessary Medical and Remedial Care not covered under the Oklahoma Medicaid State Plan
iii. APA WF #21-05A Medicaid Expansion and Durable Medical Equipment
iv. APA WF #21-05B Medicaid Expansion
v. APA WF #21-06 Insure Oklahoma (IO) Program Changes and Timely Filing

MOTION: Chairman Hupfeld motioned for approval of item 12a.i-v as published. The motion was seconded by Member Kennedy.

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

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Hausheer

MOTION: Member Kennedy motioned for approval of item 12b.i-v as published. The motion was seconded by Member Curry.

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

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Hausheer

ITEM 13 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4).
Stanley Hupfeld, OHCA Board Chairman

MOTION: Member Boyd moved to go into Executive Session. The motion was seconded by Member Shamblin.

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

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Hausheer

ITEM 14 / ADJOURNMENT

MOTION: Member Boyd moved for approval for adjournment. The motion was seconded by Member Curry.

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

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Hausheer

Meeting adjourned at 4:56 p.m., 5/19/2021

NEXT BOARD MEETING
June 30, 2021
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

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OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

REGULAR NURSING FACILITIES RATE INCREASE

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 change is being made to increase the Quality of Care (QOC) Fee for Regular Nursing Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to facilities. Additionally, the change allows OHCA to calculate the annual reallocation of the pool for the "Direct Care" and "Other Cost" components of the rate as per the State Plan. This change will also adjust the base rate component to reflect the correct amount for durable medical equipment, supplies and appliances.

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 $121.30 per patient day.
   B. A Pay for Performance (PFP) Component defined as the dollars earned under this performance program with average payment of $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 PFP Components by the total estimated Medicaid days for the rate period. This component once calculated is the same for each facility.

   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 PFP Components to the facilities. 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 current

combined pool amount for "Direct Care" and "Other Cost" components is $250,302,699. The current Quality of Care (QOC) fee is $13.15 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 required annual recalculation of the Quality of Care (QOC) fee and reallocation of the pool for "Direct Care" and "Other Cost" components of the rate as per the State Plan. This change will also adjust the base rate component to reflect the correct amount for durable medical equipment, supplies, and appliances. The new Base Rate Component will be $123.22 per patient day. The new combined pool amount for "Direct Care" and "Other Cost" components will be $251,196,155. The new Quality of Care (QOC) fee will be $15.31 per patient day.

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY2022 will be an increase in the total amount of $37,150,369; with $11,802,672 in state share coming from the increased QOC Fee (which is paid by providers).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular Nursing Facilities:
   - An increase to the base rate component from $121.30 per patient day to $123.22 per patient day.

   A change to the combined pool amount for "Direct Care" and "Other Cost" Components from $250,302,699 to $251,196,155 for the annual reallocation of the Direct Care Cost Component as per the State Plan.

9. **EFFECTIVE DATE OF CHANGE.**
July 1, 2021 contingent upon CMS approval.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITES RATE INCREASE

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 change is being made to increase the Quality of Care (QOC) Fee for nursing facilities serving residents with AIDS per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to the facilities. This change will also adjust the AIDS rate to reflect the correct amount for durable medical equipment, supplies and appliances.

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 $215.42 per patient day. The Quality of Care (QOC) fee is $13.15 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 as a result of the required annual recalculation of the Quality of Care (QOC) fee. This change will also adjust the rate to reflect the correct amount for durable medical equipment, supplies and appliances. The rate for this provider type will be $224.05 per patient day. The recalculated Quality of Care (QOC) fee will be $15.31 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2022 will be an increase in the total amount of $71,189; with $22,617 in state share coming from the increased QOC Fee (which is paid by the facilities).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:
   An increase to the AIDS rate from $215.42 per patient day to $224.05 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2021 contingent upon CMS approval.

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

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 change is being made to increase the Quality of Care (QOC) Fee for Regular ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to facilities.

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 $129.01 per patient day.
   The Quality of Care (QOC) fee is $7.64 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for Regular ICF/IID facilities because of the annual recalculation of the Quality of Care (QOC) fee.
   The proposed rate for this provider type is $129.79 per patient day.
   The recalculated Quality of Care (QOC) fee is $7.89 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2022 will be an increase in the total amount of $159,822; with $50,775 in state share coming from the increased QOC Fee (which is paid by providers).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular ICF/IID facilities:
   An increase in rate from $129.01 per patient day to $129.79 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2021 contingent upon CMS approval.

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

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 change is being made to increase the Quality of Care (QOC) Fee for Acute ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to facilities.

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 $164.20 per patient day.
   The Quality of Care (QOC) fee is $9.66 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for Acute ICF/IID facilities as a result of the annual recalculation of the Quality of Care (QOC) fee.
   The proposed rate for this provider type is $164.62 per patient day.
   The recalculated Quality of Care (QOC) fee is $9.79 per patient.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2022 will be an increase in the total amount of $128,439; with $40,805 in state share coming from the increased QOC Fee (which is paid by providers).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:
   An increase in rate from $164.20 per patient day to $164.62 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2021 contingent upon CMS approval.

NURSING FACILITIES SERVING VENTILATOR PATIENT ADD-ON RATE INCREASE

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 change is being made to increase the add-on rate for Nursing Facilities serving ventilator dependent residents. This change will provide adequate funding to these facilities to enable them to procure medical equipment, supplies and appliances for ventilator dependent residents.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Reimbursement for Nursing Facilities serving ventilator residents is limited to the average standard rate paid to Nursing Facilities plus an add-on rate. The add-on rate reflects the additional costs of meeting specialized care needs of ventilator residents. The current ventilator add-on rate is $135.43 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, this rate increase is been implemented to provide adequate funding to Nursing Facilities serving ventilator patients to enable them to procure medical equipment, supplies and appliances for ventilator dependent residents. The new ventilator add-on rate will be $186.64 per patient day.

6. **BUDGET ESTIMATE.**
   There is no budget impact as the rate increase is funded with existing dollars.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Nursing Facilities serving ventilator patients:
   An increase to the ventilator add-on rate from $135.43 per patient day to $186.64 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2021 contingent upon CMS approval.

ADVANTAGE WAIVER SERVICES RATE INCREASES

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?**
   Oklahoma Human Services (OHS) is seeking to implement a provider rate increase pursuant to 1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER INSTRUCTIONS AND TECHNICAL GUIDANCE APPENDIX K: EMERGENCY PREPAREDNESS AND RESPONSE.

   On March 18, 2020, the President signed into law H.R. 6021, the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA *provides a temporary 6.2 percentage point increase to each qualifying state* and territory's Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Social Security Act (the Act) effective January 1, 2020 through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services for COVID-19, including any extensions, terminates.

   To effectively respond to the COVID-19 outbreak, the state requires the flexibility to adjust provider rates to account for the increased risk factors associated with COVID-19, such as overtime costs, to ensure that essential services remain available for AD*vantage* waiver recipients. Oklahoma has deemed it necessary to reimburse providers with an additional retroactive add-on COVID-19 rate. This add-on payment will apply to all services in which face-to-face contact is essential for beneficiary health and safety. The amount of the retroactive add-on payment rate will be for the time period of October 1, 2020 through December 31, 2020 and will not exceed 20% of the provider's current rate. Oklahoma is proposing a retroactive COVID-19 add-on payment for the following services:

- Home Care Services
  - Registered Nurse Skilled Nursing – Home Health Setting
  - Registered Nurse Skilled Nursing – Extended State Plan
  - Licensed Practical Nursing – Home Health Setting
  - Licensed Practical Nursing – Extended State Plans

  - Personal Care Services
  - Advanced Supportive/Restorative
  - In-home Respite (less than 8 hours)
  - In-home Extended Respite (8+ hours)
- Adult Day Health Services
  - Adult Day Health
  - Personal Care in Adult Day Health
- Assisted Living Services
  - Assisted Living Standard Tier
  - Assisted Living Intermediate Tier
  - Assisted Living High Tier
- Hospice Services
- Nursing Facility Respite Services

The COVID-19 pandemic has placed a great amount of financial strain on the provider community. Providers have experienced issues causing non-budgeted overtime costs, increased costs for personal protective equipment and a tightening labor market. The proposed rate increase seeks to temporarily provide additional compensation to providers during the public health emergency.

The services provided by these rates are available to recipients on the AD*vantage* home and community-based services waiver.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate structure for services provided in the proposed rate changes are of two types:

- Utilizing the Medicaid Rate established for State Plan Services. Services of this type include:
  - Personal Care Services
  - Respite Services
  - Nursing Facility Respite Services
- Fixed and uniform rates established through the State Plan Amendment Rate Committee process. Services of this type include:
  - Nursing
  - Adult Day Health Care
  - Advanced Supportive/Restorative Assistance

- Assisted Living Services
- Hospice Services

All services are in 15-minute units except In-home Extended Respite, Personal Care in Adult Day Health, Assisted Living (all tier levels), Hospice, and Nursing Facility Respite, which are all per-diem services.

The services, current service codes and rates are as follows:

SERVICE DESCRIPTION	SERVICE CODE	Service Unit	Current Rate
Registered Nurse Skilled Nursing – Home Health Setting	G0299	15 min	$15.60
Registered Nurse Skilled Nursing – Extended State Plan	G0299 TF	15 min	$15.60
Licensed Practical Nursing – Home Health Setting	G0300	15 min	$14.56
Licensed Practical Nursing – Extended State Plan	G0300 TF	15 min	$14.56
Personal Care Services	T1019	15 min	$4.21
Advanced/Supportive Restorative Assistance	T1019 TF	15 min	$4.52
In-home Respite (less than 8 hours)	T1005	15 min	$4.21
In-home Extended Respite (8+ hours)	S9125	Per day	$175.55
Adult Day Health Services	S5100 U1	15 min	$2.08
Personal Care in Adult Day Health	S5105	Per day	$8.27
Assisted Living Services – Standard Tier	T2031	Per day	$48.99
Assisted Living Services – Intermediate Tier	T2031 TF	Per day	$66.11
Assisted Living Services – High Tier	T2031 TG	Per day	$92.47
Hospice Services	S9126	Per day	$123.80
Nursing Facility Respite Services	120	Per day	$178.88

5. NEW METHODOLOGY OR RATE STRUCTURE.

The new rates are based on a 20% increase of existing rates.

SERVICE DESCRIPTION	SERVICE CODE	Service Unit	Current Rate	Proposed Rate	Total Cost for 3 Months
Registered Nurse Skilled Nursing – Home Health Setting	G0299	15 min	$15.60	$18.72	$153,578.88

SERVICE DESCRIPTION	SERVICE CODE	Service Unit	Current Rate	Proposed Rate	Total Cost for 3 Months
Registered Nurse Skilled Nursing – Extended State Plan	G0299 TF	15 min	$15.60	$18.72	$131.04
Licensed Practical Nursing – Home Health Setting	G0300	15 min	$14.56	$17.47	$210,327.94
Licensed Practical Nursing – Extended State Plan	G0300 TF	15 min	$14.56	$17.47	$646.46
Personal Care Services	T1019	15 min	$4.21	$5.05	$19,422,352.26
Advanced/Supportive Restorative Assistance	T1019 TF	15 min	$4.52	$5.42	$224,564.45
In-home Respite (less than 8 hours)	T1005	15 min	$4.21	$5.05	$41,724.47
In-home Extended Respite (8+ hours)	S9125	Per day	$175.55	$210.66	$9,269.04
Adult Day Health Services	S5100 U1	15 min	$2.08	$2.50	$431,198.98
Personal Care in Adult Day Health	S5105	Per day	$8.27	$9.92	$2,490.92
Assisted Living Services – Standard Tier	T2031	Per day	$48.99	$58.79	$0.00
Assisted Living Services – Intermediate Tier	T2031 TF	Per day	$66.11	$79.33	$29,590.84
Assisted Living Services – High Tier	T2031 TG	Per day	$92.47	$110.96	$3,245,364.11
Hospice Services	S9126	Per day	$123.80	$148.56	$166,832.88
Nursing Facility Respite Services	120	Per day	$178.88	$214.66	$20,392.32

6. BUDGET ESTIMATE.

Oklahoma's FFY21 FMAP of 67.99% has been temporarily increased to 74.19% as a result of the FFCRA. OHS has elected to utilize this funding to temporarily increase rates supporting waivered care for the three-month period beginning 10/01/2020 and ending on 12/31/2020.

The 20% retroactive temporary rate adjustment results in a total cost of $23,958,465, which is an increase of $4,170,414 over the current base rate. Of this amount, $3,094,030 is Federal funding and $1,076,384 is State funding.

OHS attests it has adequate funding to pay the state share of the projected increase in service costs related to the one-time rate adjustment of the listed services.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The rate increase will have a positive impact on access to care as providers will be better able to meet increased costs resulting from the COVID-19 public health emergency.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   Oklahoma Human Services requests the State Plan Amendment Rate Committee approve the proposed 20% retroactive rate increase for AD*vantage* waiver providers.

9. **EFFECTIVE DATE OF CHANGE.**
   Retroactive for the time period beginning on October 1, 2020 and ending on December 31, 2020, contingent upon CMS approval.

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DEVELOPMENTAL DISABILITIES SERVICES INCREASES

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?**
   Oklahoma Human Services (OHS) is seeking to implement a provider rate increase pursuant to 1915(C) HOME AND COMMUNITY-BASED SERVICES WAIVER INSTRUCTIONS AND TECHNICAL GUIDANCE APPENDIX K: EMERGENCY PREPAREDNESS AND RESPONSE.

   On March 18, 2020, the President signed into law H.R. 6021, the Families First Coronavirus Response Act (FFCRA) (Pub. L. 116-127). Section 6008 of the FFCRA ***provides a temporary 6.2 percentage point increase to each qualifying state*** and territory's Federal Medical Assistance Percentage (FMAP) under section 1905(b) of the Social Security Act (the Act) effective beginning January 1, 2020 and extending through the last day of the calendar quarter in which the public health emergency declared by the Secretary of Health and Human Services for COVID-192 , including any extensions, terminates.

   To effectively respond to the COVID-19 outbreak the state requires the flexibility to adjust provider rates to account for the increased risk factors associated with COVID-19, overtime and to ensure that essential services remain available for service recipients. Oklahoma has deemed it necessary to reimburse providers with an additional retroactive add on COVID-19 rate. This add on payment will apply to all services in which face to face contact is essential for beneficiary health and safety. The amount of the retroactive add on payment rate will be for the time period of October 1, 2020 through December 31, 2020 and will not exceed 20% of the provider's current rate. Oklahoma is proposing a retroactive COVID-19 add on payment for the following services:

   - Adult Day
   - Agency Companion
   - Daily Living Supports
   - Extended Duty Nursing
   - Group Home

- Habilitation Training Specialist
- Homemaker
- Intensive Personal Supports
- Nursing
- Prevocational
- Respite
- Specialized Foster Care
- Supported Employment

The COVID-19 pandemic has placed a great amount of financial strain on the provider community. Providers have experienced lockdowns causing non-budgeted overtime costs; increased cost for personal protective equipment and a tightening labor market. The proposed rate increase seeks to temporarily provide additional compensation to providers during the public emergency.

The services provided by these rates are available to recipients on the Medicaid In Home Supports Waiver for Children, In-Home Supports Waiver for Adults, Homeward Bound Waiver, Community Waiver.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate structure for services provided in the proposed rate changes are fixed and uniform rates established through the State Plan Amendment Rate Committee process. The services, current service codes and rates are as follows:

SERVICE DESCRIPTION	SERVICE CODE	SERVICE UNIT	CURRENT RATE
ADULT DAY CARE	S5100	15 Min	$2.08
AGENCY COMPANION – CLOSE	S5126 U1	1 Day	$100.36
AGENCY COMPANION - CLOSE - THERAPEUTIC LEAVE	S5126 U1 TV	1 Day	$100.36
AGENCY COMPANION – ENHANCED	S5126	1 Day	$130.52
AGENCY COMPANION - ENHANCED - THERAPEUTIC LEAVE	S5126 TV	1 Day	$130.52
AGENCY COMPANION - Pervasive Level	S5126 TF	1 Day	$142.74
AGENCY COMPANION - Pervasive Level - THERAPEUTIC LEAVE	S5126 TF TV	1 Day	$142.74
DAILY LIVING SUPPORTS	T2033	1 Day	$160.16
DAILY LIVING SUPPORTS – Telehealth	T2033 GT	1 Day	$160.16
DAILY LIVING SUPPORTS - THER LEAVE	T2033 TV	1 Day	$160.16
ES - CENTER BASED PREVOCATIONAL SVS	T2015 U1	1 Hour	$5.20

ES - COMMUNITY BASED PREVOCATIONAL SERVICES	T2015 TF	1 Hour	$10.40
ES - COMMUNITY BASED INDIVIDUAL SERVICES	T2015 U4	1 Hour	$16.84
ES - EMPLOYMENT SPECIALIST	T2019	15 Min	$6.28
ES - ENHANCED COMMUNITY BASED PREVOCATIONAL	T2015	1 Hour	$13.85
ES - JOB COACHING - GROUP OF 4-5	T2019 TF	15 Min	$3.47
ES - JOB COACHING - GROUP OF 2-3	T2019 HQ	15 Min	$3.75
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 4-5	T2019 TG	15 Min	$4.04
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 2-3	T2019 TG-HQ	15 Min	$4.32
ES - JOB COACHING INDIVIDUAL SERVICES	T2019 U4	15 Min	$6.25
ES - JOB COACHING INDIVIDUAL SERVICES - Telehealth	T2019 U4 GT	15 Min	$6.25
ES - JOB STABILIZATION / EXTENDED SERVICES	T2019 U1	15 Min	$1.44
ES - PRE-VOC. HTS - SUPP. SUPPORTS	T2015 TG	1 Hour	$13.10
GROUP HOME ALT. LIVING HOME, 4 BED	T1020	1 Day	$303.68
GROUP HOME COMM. LIVING HOME, 6 BED	T1020	1 Day	$173.42
GROUP HOME COMM. LIVING HOME, 7 BED	T1020	1 Day	$148.72
GROUP HOME COMM. LIVING HOME, 8 BED	T1020	1 Day	$143.78
GROUP HOME COMM. LIVING HOME, 9 BED	T1020	1 Day	$127.66
GROUP HOME COMM. LIVING HOME, 10 BED	T1020	1 Day	$125.58
GROUP HOME COMM. LIVING HOME, 11 BED	T1020	1 Day	$114.14
GROUP HOME COMM. LIVING HOME, 12 BED	T1020	1 Day	$112.84
GROUP HOME, 6 BED	T1020	1 Day	$75.40
GROUP HOME, 7 BED	T1020	1 Day	$64.48
GROUP HOME, 8 BED	T1020	1 Day	$56.42
GROUP HOME, 9 BED	T1020	1 Day	$51.48
GROUP HOME, 10 BED	T1020	1 Day	$47.58
GROUP HOME, 11 BED	T1020	1 Day	$44.46
GROUP HOME, 12 BED	T1020	1 Day	$41.86
HOMEMAKER	S5130	15 Min	$4.00
HOMEMAKER – EVV	S5130 32	15 Min	$4.00
HOMEMAKER RESPITE	S5150	15 Min	$4.00
HOMEMAKER RESPITE – EVV	S5150 32	15 Min	$4.00
HTS - HABILITATION TRAINING SPECIALIST	T2017	15 Min	$4.21
HTS - HABILITATION TRAINING SPECIALIST - EVV	T2017 32	15 Min	$4.21
HTS - HABILITATION TRAINING SPECIALIST - Telehealth	T2017 GT	15 Min	$4.21
HTS - NO SUPV AGENCY - INDEPENDENT	T2017 U1	15 Min	$1.90
INTENSIVE PERSONAL SUPPORTS	T2017 TF	15 Min	$4.21
NURSING EXTENDED DUTY	T1000	15 Min	$6.76
NURSING INTERMITTENT SKILLED	T1001	1 Visit	$52.52
NURSING - REGISTERED NURSE	G0299	15 Min	$15.60
NURSING - LICENSED PRACTICAL NURSE	G0300	15 min	$14.56
NURSING - LICENSED PRACTICAL NURSE - Telehealth	G0300 GT	15 min	$14.56

RESPITE – MAXIMUM	S5151	1 Day	$79.04
RESPITE IN - AGENCY COMPANION - CLOSE	S5151	1 Day	$123.24
RESPITE IN - AGENCY COMPANION - ENHANCED	S5151	1 Day	$153.40
RESPITE IN - AGENCY COMPANION - Pervasive	S5151	1 Day	$165.62
RESPITE IN - GROUP HOME, 6 BED	S5151	1 Day	$98.70
RESPITE IN - GROUP HOME, 7 BED	S5151	1 Day	$87.36
RESPITE IN - GROUP HOME, 8 BED	S5151	1 Day	$79.70
RESPITE IN - GROUP HOME, 9 BED	S5151	1 Day	$74.36
RESPITE IN - GROUP HOME, 10 BED	S5151	1 Day	$70.46
RESPITE IN - GROUP HOME, 11 BED	S5151	1 Day	$67.34
RESPITE IN - GROUP HOME, 12 BED	S5151	1 Day	$64.74
RESPITE IN - COMMUNITY LIVING HOME, 6 BED	S5151	1 Day	$196.30
RESPITE IN - COMMUNITY LIVING HOME, 7 BED	S5151	1 Day	$171.60
RESPITE IN - COMMUNITY LIVING HOME, 8 BED	S5151	1 Day	$166.66
RESPITE IN - COMMUNITY LIVING HOME, 9 BED	S5151	1 Day	$150.54
RESPITE IN - COMMUNITY LIVING HOME, 10 BED	S5151	1 Day	$148.46
RESPITE IN - COMMUNITY LIVING HOME, 11 BED	S5151	1 Day	$137.02
RESPITE IN - COMMUNITY LIVING HOME, 12 BED	S5151	1 Day	$135.72
RESPITE, IN OWN HOME-CLOSE	S9125 TF	1 Day	$28.50
RESPITE, IN OWN HOME-INTERMITTENT	S9125 U1	1 Day	$19.00
RESPITE, IN OWN HOME-MAXIMUM	S9125	1 Day	$57.04
SPECIALIZED FOSTER CARE ADULT-CLOSE	S5140 U1	1 Day	$30.00
SPECIALIZED FOSTER CARE ADULT-MAX.	S5140	1 Day	$56.16
SPECIALIZED FOSTER CARE CHILD-CLOSE	S5145 U1	1 Day	$30.00
SPECIALIZED FOSTER CARE CHILD-MAX.	S5145	1 Day	$56.16

5. NEW METHODOLOGY OR RATE STRUCTURE.

The new rates are based on a 20% increase of existing rates

SERVICE DESCRIPTION	SERVICE CODE	SERVICE UNIT	PROPOSED RATE	TOTAL COST 3 MTHS
ADULT DAY CARE	S5100	15 Min	$ 2.50	$ 160,040.92
AGENCY COMPANION – CLOSE	S5126 U1	1 Day	$ 120.43	$ 42,095.33
AGENCY COMPANION - CLOSE - THERAPEUTIC LEAVE	S5126 U1 TV	1 Day	$ 120.43	$ 171.95
AGENCY COMPANION – ENHANCED	S5126	1 Day	$ 156.62	$ 156,458.64
AGENCY COMPANION - ENHANCED - THERAPEUTIC LEAVE	S5126 TV	1 Day	$ 156.62	$ 1,129.32
AGENCY COMPANION - Pervasive Level	S5126 TF	1 Day	$ 171.29	$ 110,083.55
AGENCY COMPANION - Pervasive Level - THERAPEUTIC LEAVE	S5126 TF TV	1 Day	$ 171.29	$ 1,027.17
DAILY LIVING SUPPORTS	T2033	1 Day	$ 192.19	$ 4,907,150.21
DAILY LIVING SUPPORTS – Telehealth	T2033 GT	1 Day	$ 192.19	$ -

DAILY LIVING SUPPORTS - THER LEAVE	T2033 TV	1 Day	$ 192.19	$ 16,526.43
ES - CENTER BASED PREVOCATIONAL SVS	T2015 U1	1 Hour	$ 6.24	$ 179,487.25
ES - COMMUNITY BASED PREVOCATIONAL SERVICES	T2015 TF	1 Hour	$ 12.48	$ 90,663.29
ES - COMMUNITY BASED INDIVIDUAL SERVICES	T2015 U4	1 Hour	$ 20.21	$ 162,960.92
ES - EMPLOYMENT SPECIALIST	T2019	15 Min	$ 7.54	$ 1,016.42
ES - ENHANCED COMMUNITY BASED PREVOCATIONAL	T2015	1 Hour	$ 16.62	$ 23,266.69
ES - JOB COACHING - GROUP OF 4-5	T2019 TF	15 Min	$ 4.16	$ 771,552.43
ES - JOB COACHING - GROUP OF 2-3	T2019 HQ	15 Min	$ 4.50	$ 13,017.88
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 4-5	T2019 TG	15 Min	$ 4.85	$ 69,899.62
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 2-3	T2019 TG-HQ	15 Min	$ 5.18	$ 6,309.59
ES - JOB COACHING INDIVIDUAL SERVICES	T2019 U4	15 Min	$ 7.50	$ 119,208.63
ES - JOB COACHING INDIVIDUAL SERVICES – Telehealth	T2019 U4 GT	15 Min	$ 7.50	$ 1,469.11
ES - JOB STABILIZATION / EXTENDED SERVICES	T2019 U1	15 Min	$ 1.73	$ 2,395.93
ES - PRE-VOC. HTS - SUPP. SUPPORTS	T2015 TG	1 Hour	$ 15.72	$ 111,820.62
GROUP HOME ALT. LIVING HOME, 4 BED	T1020	1 Day	$ 364.42	$ 411,332.20
GROUP HOME COMM. LIVING HOME, 6 BED	T1020	1 Day	$ 208.10	$ 355,747.06
GROUP HOME COMM. LIVING HOME, 7 BED	T1020	1 Day	$ 178.46	$ 11,727.66
GROUP HOME COMM. LIVING HOME, 8 BED	T1020	1 Day	$ 172.54	$ -
GROUP HOME COMM. LIVING HOME, 9 BED	T1020	1 Day	$ 153.19	$ -
GROUP HOME COMM. LIVING HOME, 10 BED	T1020	1 Day	$ 150.70	$ 3,932.11
GROUP HOME COMM. LIVING HOME, 11 BED	T1020	1 Day	$ 136.97	$ 7,802.95
GROUP HOME COMM. LIVING HOME, 12 BED	T1020	1 Day	$ 135.41	$ 8,946.59
GROUP HOME, 6 BED	T1020	1 Day	$ 90.48	$ 387,700.31
GROUP HOME, 7 BED	T1020	1 Day	$ 77.38	$ 8,393.52
GROUP HOME, 8 BED	T1020	1 Day	$ 67.70	$ 113.58
GROUP HOME, 9 BED	T1020	1 Day	$ 61.78	$ -
GROUP HOME, 10 BED	T1020	1 Day	$ 57.10	$ 13,342.73
GROUP HOME, 11 BED	T1020	1 Day	$ 53.35	$ 6,461.62
GROUP HOME, 12 BED	T1020	1 Day	$ 50.23	$ 22,895.19
HOMEMAKER	S5130	15 Min	$ 4.80	$ 20,052.89

HOMEMAKER – EVV	S5130 32	15 Min	$ 4.80	$ 33,682.23
HOMEMAKER RESPITE	S5150	15 Min	$ 4.80	$ 74,880.10
HOMEMAKER RESPITE – EVV	S5150 32	15 Min	$ 4.80	$ 9,994.71
HTS - HABILITATION TRAINING SPECIALIST	T2017	15 Min	$ 5.05	$ 5,020,392.07
HTS - HABILITATION TRAINING SPECIALIST - EVV	T2017 32	15 Min	$ 5.05	$ 870,282.69
HTS - HABILITATION TRAINING SPECIALIST – Telehealth	T2017 GT	15 Min	$ 5.05	$ -
HTS - NO SUPV AGENCY – INDEPENDENT	T2017 U1	15 Min	$ 2.28	$ -
HTS - SELF DIRECTED SERVICE	T2017 U1 TF	15 Min	$ 5.05	$ -
INTENSIVE PERSONAL SUPPORTS	T2017 TF	15 Min	$ 5.05	$ 195,429.91
NURSING EXTENDED DUTY	T1000	15 Min	$ 8.11	$ 151,482.33
NURSING INTERMITTENT SKILLED	T1001	1 Visit	$ 63.02	$ 62,985.41
NURSING - REGISTERED NURSE	G0299	15 Min	$ 18.72	$ 12,391.95
NURSING - LICENSED PRACTICAL NURSE	G0300	15 min	$ 17.47	$ 3,678.98
NURSING - LICENSED PRACTICAL NURSE – Telehealth	G0300 GT	15 min	$ 17.47	$ 37.42
RESPITE – MAXIMUM	S5151	1 Day	$ 94.85	$ 71.10
RESPITE IN - AGENCY COMPANION – CLOSE	S5151	1 Day	$ 147.89	$ 52.79
RESPITE IN - AGENCY COMPANION - ENHANCED	S5151	1 Day	$ 184.08	$ 374.53
RESPITE IN - AGENCY COMPANION - Pervasive	S5151	1 Day	$ 198.74	$ 468.21
RESPITE IN - GROUP HOME, 6 BED	S5151	1 Day	$ 118.44	$ 105.69
RESPITE IN - GROUP HOME, 7 BED	S5151	1 Day	$ 104.83	$ -
RESPITE IN - GROUP HOME, 8 BED	S5151	1 Day	$ 95.64	$ -
RESPITE IN - GROUP HOME, 9 BED	S5151	1 Day	$ 89.23	$ -
RESPITE IN - GROUP HOME, 10 BED	S5151	1 Day	$ 84.55	$ -
RESPITE IN - GROUP HOME, 11 BED	S5151	1 Day	$ 80.81	$ -
RESPITE IN - GROUP HOME, 12 BED	S5151	1 Day	$ 77.69	$ -
RESPITE IN - COMMUNITY LIVING HOME, 6 BED	S5151	1 Day	$ 235.56	$ -
RESPITE IN - COMMUNITY LIVING HOME, 7 BED	S5151	1 Day	$ 205.92	$ -
RESPITE IN - COMMUNITY LIVING HOME, 8 BED	S5151	1 Day	$ 199.99	$ -
RESPITE IN - COMMUNITY LIVING HOME, 9 BED	S5151	1 Day	$ 180.65	$ -
RESPITE IN - COMMUNITY LIVING HOME, 10 BED	S5151	1 Day	$ 178.15	$ -

RESPITE IN - COMMUNITY LIVING HOME, 11 BED	S5151	1 Day	$ 164.42	$ -
RESPITE IN - COMMUNITY LIVING HOME, 12 BED	S5151	1 Day	$ 162.86	$ -
RESPITE, IN OWN HOME-CLOSE	S9125 TF	1 Day	$ 34.20	$ -
RESPITE, IN OWN HOME-INTERMITTENT	S9125 U1	1 Day	$ 22.80	$ -
RESPITE, IN OWN HOME-MAXIMUM	S9125	1 Day	$ 68.45	$ -
SPECIALIZED FOSTER CARE ADULT-CLOSE	S5140 U1	1 Day	$ 36.00	$ -
SPECIALIZED FOSTER CARE ADULT-MAX.	S5140	1 Day	$ 67.39	$ 90,482.55
SPECIALIZED FOSTER CARE CHILD-CLOSE	S5145 U1	1 Day	$ 36.00	$ -
SPECIALIZED FOSTER CARE CHILD-MAX.	S5145	1 Day	$ 67.39	$ 32,424.48

6. **BUDGET ESTIMATE.**
Oklahoma's FFY21 FMAP of 67.99% has been temporarily increased to 74.19% as a result of the FFCRA. OHS has elected to utilize a portion of this funding to retroactively increase rates supporting waivered care from October 1, 2020 through December 31, 2020.
The 20% temporary increase has a total cost of $14,765,417.49. Of this amount, $10,954,463.24 is federal funding and $3,810,954.25 in state funding.
OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The rate increase will have a positive impact on access to care as providers are able to meet increased costs resulting from the COVID-19 public health emergency.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
OHS requests the State Plan Amendment Rate Committee approve the proposal to implement a 20% temporary rate increase to provide vendors financial relief during the public health emergency with a retroactive start date of October 1, 2020 and an ending date of December 31, 2020.

9. **EFFECTIVE DATE OF CHANGE.**
Retroactive to October 1, 2020 through December 31, 2020, contingent upon CMS approval.

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CARE COORDINATION RATE FOR CCBHC DRUG AND SPECIALTY COURT REFERRALS

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 Department of Mental Health and Substance Abuse Services (ODMHSAS) seeks to implement a care coordination rate for drug and specialty court referrals received by Certified Community Behavioral Health Clinics (CCBHCs). The intent is to support service provision for pharmacological services when members are required to utilize or are otherwise accessing additional services from non-CCBHC providers. This rate was approved by CMS in the Oklahoma Medicaid State Plan in 2019.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   There is no established encounter rate for these services.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The new encounter base rate is $45.00 per encounter for at least 15 minutes of clinical staff time provided per calendar month to non-established clients.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2021 (6 months) is $16,470 total/$2,511 state share. The estimated budget impact for SFY2022 is $45,900 total/$6,997 state share. ODMHSAS attests that it has adequate funds to cover the state share of the projected cost of services per fiscal year.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The ODMHSAS has determined that this change will have a positive impact in that the encounter rate will support provision of vital services for non-established CCBHC members.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The ODMHSAS requests the State Plan Amendment Rate Committee approve the proposed encounter rate for care coordination of drug and specialty court referrals received by Certified Community Behavioral Health Clinics.

9. **EFFECTIVE DATE OF CHANGE.**
   January 1, 2021

ATTACHMENT C

SUBMITTED TO THE C.E.O. AND BOARD ON June 30, 2021
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available

BACKGROUND

Services	Clinical Pharmacy Services Software
Purpose and Scope	OHCA is seeking a Sole Source Contract Renewal with Arine, Inc. for the following: Clinical pharmacy services software product that incorporates the following: • Analyzes all OHCA Pharmaceutical required data sources including medical claims, pharmacy claims, unique Medicaid formulary structure, OHCA care management programs and behavioral data for medication therapy management; • Incorporates key behavioral data points, including social determinants; • Allows manually entered claims data outside of a data download; • Provides an all-in-one solution to perform provider-level detailing and guidance on an individual patient level, allowing for both provider interventions and patient interventions; • Allows OHCA to determine which interventions are most effective by measuring the financial and clinical impact of each intervention, with direct Return on Investment (ROI); and • Continuously adjusts to OHCA-specific guidance and programs (such as formulary modifications, HMP programs, SoonerRide and other unique benefits) in the software algorithms in a matter of weeks. <u>Services are increased as follows:</u> • 1750 projected Medication Therapy Management (MTM) reviews from 3500 Members ($87,500.00) to 8500 MTM Members ($425,000.00); • Comprehensive Medical Review is increased to 3500 initial calls and/or in-person visits ($262,500.00); and • Follow-up Care is increased to 6500 follow-up calls and/or in-person visits ($162,500.00).
Mandate	Not applicable.
Procurement Method	Sole Source
Award	Single Contractor: Arine, Inc.
Contract Term	Contract Renewal effective date July 1, 2021 through June 30, 2022 with four (4) remaining options to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$850,000.00
50% Federal Match Costs within the Total Contract Not-to-Exceed	$425,000.00
50% State Share Costs within the Total Contract Not-to-Exceed	$425,000.00

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure Clinical Pharmacy Services Software from Arine, Inc. described above for six years of the total contract term which began July 1, 2020 with a total not-to-exceed of $4,550,000.00.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

ATTACHMENT E

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meeting – May 12, 2021

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Breyanzi®	• Lymphoma	• $410,300 per 1 time treatment	• Not first line therapy
2	Cosela™ Gavreto™ Retevmo® Tabrecta™ Tepmetko™ Zepzelca™	• Lung Cancer	• $2,007 per dose • $19,243 per 30 days • $20,600 per 30 days • $18,937 per 28 days • $20,898 per 30 days • $9,402 per dose every 21 days	• Decrease myelosuppression in patients using chemo for lung cancer • Used in a specific lung cancer (RET fusion-positive) • Used in a specific lung cancer (RET fusion-positive) • Used in lung cancer with specific tumor mutation • Used in lung cancer with specific tumor mutation • Not first line
3	Lyumjev™	• Diabetes Mellitus	• $353 per 10 mL vial	• Biosimilar, cheaper product available
4	Amondys 45™ Viltepso® Vynodys 53™	• Duchenne Muscular Dystrophy (DMD)	• $624,000 per year • $586,560 per year • $624,000 per year	• Each product is for a specific DMD gene mutation
5	Verquvo™	• Heart Failure (HF)	• $6,995 per year	• Reduces risk of subsequent HF hospitalizations and cardiovascular death

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable. N/A = not available at the time of publication.

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Recommendation 1: Vote to Prior Authorize Breyanzi®

The Drug Utilization Review Board recommends the prior authorization of Breyanzi® (Lisocabtagene Maraleucel) with the following criteria:

Breyanzi® (Lisocabtagene Maraleucel) Approval Criteria [Lymphoma Diagnosis]:

1. Diagnosis of large B-cell lymphoma; and
2. Relapsed or refractory disease; and
3. Member must have received at least 2 lines of systemic therapy; and
4. Health care facilities must be on the certified list to administer chimeric antigen receptor (CAR) T-cells and must be trained in the management of cytokine release syndrome (CRS), neurologic toxicities, and comply with the risk evaluation and mitigation strategy (REMS) requirements; and
5. A patient-specific, clinically significant reason why Kymriah® (tisagenlecleucel) or Yescarta® (axicabtagene) is not appropriate for the member must be provided.

Recommendation 2: Vote to Prior Authorize Cosela™, Gavreto™, Retevmo®, Tabrecta™, Tepmetko®, and Zepzelca™

The Drug Utilization Review Board recommends the prior authorization of Cosela™ (Trilaciclib), Gavreto™ (Pralsetinib), Retevmo® (Selpercatinib), Tabrecta™ (Capmatinib), Tepmetko® (Tepotinib), and Zepzelca™ (Lurbinectedin) with the following criteria:

Cosela™ (Trilaciclib) Approval Criteria:

1. Diagnosis of extensive-stage small cell lung cancer (ES-SCLC); and
2. Member is undergoing myelosuppressive chemotherapy with 1 of the following:
    a. Platinum (carboplatin or cisplatin) and etoposide-containing regimen; or
    b. Topotecan-containing regimen; and
3. Cosela™ will not be approved for concomitant use with colony-stimulating factors (CSF) [e.g., granulocyte CSF (G-CSF), pegylated G-CSF (peg-G-CSF), granulocyte-macrophage CSF (GM-CSF)] for primary prophylaxis of febrile neutropenia prior to day 1 cycle 1 of chemotherapy.

Gavreto™ (Pralsetinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of NSCLC in adults; and
2. Recurrent, advanced, or metastatic disease; and
3. Rearranged during transfection (RET) fusion-positive tumor.

Gavreto™ (Pralsetinib) Approval Criteria [Thyroid Cancer Diagnosis]:

1. Adult and pediatric members 12 years of age and older; and
2. Diagnosis of advanced or metastatic disease with either:
    a. Rearranged during transfection (RET)-mutant medullary thyroid cancer (MTC) requiring systemic therapy; or
    b. RET fusion-positive thyroid cancer requiring systemic therapy and member is radioactive iodine-refractory (if radioactive iodine is appropriate).

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

1. Diagnosis of recurrent, advanced, or metastatic NSCLC; and
2. Rearranged during transfection (RET) fusion-positive tumor; and
3. As a single-agent.

Retevmo® (Selpercatinib) Approval Criteria [Thyroid Cancer Diagnosis]:

1. Adult and pediatric members 12 years of age and older; and
2. As a single-agent; and
3. Diagnosis of advanced or metastatic disease with either:
    a. Rearranged during transfection (RET)-mutant medullary thyroid cancer (MTC) requiring systemic therapy; or
    b. RET fusion-positive thyroid cancer requiring systemic therapy and member is radioactive iodine-refractory (if radioactive iodine is appropriate).

Tabrecta™ (Capmatinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of recurrent, advanced, or metastatic NSCLC; and
2. Mesenchymal-epithelial transition (MET) exon 14 skipping positive tumor; and
3. As a single-agent.

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

1. Diagnosis of advanced, metastatic, or unresectable NSCLC; and
2. Mesenchymal-epithelial transition (MET) exon 14 skipping positive tumor; and
3. As a single-agent.

Zepzelca™ (Lurbinectedin) Approval Criteria [Small Cell Lung Cancer (SCLC) Diagnosis]:

1. Diagnosis of metastatic SCLC; and

2. Used following disease progression on or after platinum-based chemotherapy.

Recommendation 3: Vote to Prior Authorize Lyumjev™

The Drug Utilization Review Board recommends the prior authorization of Lyumjev™ (Insulin Lispro-aabc 100 Units/mL) with the following criteria:

Lyumjev™ (Insulin Lispro-aabc 100 Units/mL) Approval Criteria:

1. An FDA approved diagnosis of diabetes mellitus; and
2. A patient-specific, clinically significant reason why the member cannot use the brand formulation (Humalog®) must be provided (the brand formulation of Humalog® U-100 is preferred).

Lyumjev™ (Insulin Lispro-aabc 200 Units/mL) Approval Criteria:

1. An FDA approved diagnosis of diabetes mellitus; and
2. Authorization of the 200 units/mL strength requires a patient-specific, clinically significant reason why the member cannot use the 100 units/mL strength (the brand formulation of Humalog® U-100 is preferred).

Recommendation 4: Vote to Prior Authorize Amondys 45™, Viltepso®, and Vyondys 53™

The Drug Utilization Review Board recommends the prior authorization of Amondys 45™ (Casimersen), Viltepso® (Viltolarsen), and Vyondys 53™ (Golodirsen) with the following criteria:

Amondys 45™ (Casimersen), Viltepso® (Viltolarsen), and Vyondys 53™ (Golodirsen) Approval Criteria:

1. An FDA approved diagnosis of Duchenne muscular dystrophy (DMD); and
2. Member must have a confirmed mutation of the *DMD* gene that is amenable to exon skipping for the requested medication (results of genetic testing must be submitted); and
3. Must be prescribed by a neurologist or specialist with expertise in the treatment of DMD (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of DMD); and
4. Prescriber must verify the member's renal function will be appropriately assessed prior to initiation of therapy and monitored during treatment; and

5. Member must be on a stable dose of a corticosteroid (at least 3 months in duration) or a patient-specific, clinically significant reason why corticosteroids are not appropriate for the member must be provided; and
6. A baseline assessment must be provided using at least 1 of the following exams as functionally appropriate:
    a. 6-minute walk test (6MWT); or
    b. Forced vital capacity percent predicted (FVCpp); and
7. The requested exon-skipping therapy will not be approved for concurrent use with any other exon-skipping therapies for DMD; and
8. Initial authorizations will be for the duration of 6 months, at which time the prescriber must verify the member is responding to the medication as demonstrated by clinically significant improvement or maintenance of function from pretreatment baseline status using the same exam as performed at baseline assessment; and
9. Subsequent approvals will be for the duration of 1 year. For yearly approvals, the prescriber must verify the member is responding to the medication as demonstrated by clinically significant improvement or maintenance of function from pretreatment baseline status using the same exam as performed at baseline assessment; and
10. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling.

Recommendation 5: Vote to Prior Authorize Verquvo™

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

Verquvo™ (Vericiguat) Approval Criteria:

1. An FDA approved indication to reduce the risk of cardiovascular death and hospitalization for heart failure (HF) in adults with all of the following:
    a. Chronic symptomatic HF [New York Heart Association (NYHA) Class II, III, or IV]; and
    b. Reduced left ventricular ejection fraction (LVEF) <45%; and
    c. Already receiving guideline-directed medical therapy for HF, as documented in member's pharmacy claims history; and
2. Member has evidence of worsening HF (decompensation) demonstrated by at least 1 of the following:
    a. Hospitalization for HF within the past 6 months; or

    b. Received outpatient intravenous (IV) diuretics within the past 3 months; and
3. Member must be 18 years of age or older; and
4. Member must not be taking concomitant soluble guanylate cyclase (sGC) stimulators (e.g., riociguat); and
5. Female members of reproductive potential must not be breastfeeding, must have a negative pregnancy test prior to initiation of therapy, and must agree to use effective contraception during treatment and for 1 month after the final dose of Verquvo™; and
6. Prescriber must agree to titrate to the target maintenance dose according to package labeling, as tolerated by the member; and
7. Initial approvals will be for the duration of 6 months. Compliance will be checked for continued approval every 6 months; and
8. A quantity limit of 30 tablets per 30 days will apply.

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June Board
Proposed Rule Changes

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

A. APA WF # 21-07 Payments from Trusts for Clothing Expenses not Counted as Income — The proposed revisions update policy regarding trust accounts and countable income for aged, blind, and disabled (ABD) members. In accordance with amended Supplemental Security Income (SSI) rules, payments from the trust to the member or to a third party for the purpose of providing for the member's clothing needs are not countable income in determining Medicaid eligibility, thus requiring an update to OHCA rules.

Budget Impact: Budget neutral

Tribal Consultation: May 4, 2021

Medical Advisory Committee Meeting: May 13, 2021

B. APA WF # 21-08 Statewide HIE (OKSHINE) — The proposed policy is necessary to comply with Senate Bill 574 and Oklahoma Statutes Title 63 § 1-133, which creates the state designated health information exchange, Oklahoma State Health Information Network and Exchange (OKSHINE). The proposed new policy will outline the program description, definitions, user requirements, and needed certifications of OKSHINE. The implementation of OKSHINE will allow for statewide interoperability and the sharing of Medicaid and public health information to a degree never before experienced in Oklahoma.

Budget Impact: The SFY 2021 total cost is $4,052,999 ($3,647,699 in federal share and $405,300 in state share). The SFY 2022 total cost is $16,092,660 ($9,045,165 in federal share and $7,047,495 in state share).

Tribal Consultation: June 8, 2021

Medical Advisory Committee: June 10, 2021

C. APA WF # 21-09 Supplemental Hospital Offset Payment Program (SHOPP) — The proposed changes will amend the Supplemental Hospital Offset Payment Program (SHOPP) policy to comply with Senate Bill 1045.

The proposed changes will define “directed payments” as specific payments made by managed care plans to providers under certain circumstances that assist states in furthering the goals and priorities of their Medicaid programs. The measure provides that funds from SHOPP may be used to fund supplemental or directed payments. Additionally, the changes will modify the assessment calculation methodology from a rate needed to generate an amount up to the sum of certain expenses to a fixed rate. Additionally, the proposed changes renders the portion of the SHOPP fee attributable to certain expenses null and void if federal matching funds for the program become unavailable. The measure also eliminates the termination date of the program and removes a cap on quarterly transfers of funds. Finally, other changes include grammar and language cleanup, alignment of the SHOPP rule with current business practice, and changes needed for the funding of expansion adults and services through managed care.

Budget Impact: There is no cost impact. However, the agency estimates that for SFY2022 there will be an increase in state share of $37,209,936, for SFY2023 there will be an increase in state share of $89,574,388, and for SFY2024 there will be an increase in state share of $135, 766,567.

SB1045 directs OHCA to use the collected state share to fund Medicaid expansion and other programs, if needed

Tribal Consultation: **June 8, 2021**

Medical Advisory Committee: June 10, 2021

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

PART 5. COUNTABLE INCOME AND RESOURCES

317:35-5-41.6. Trust accounts

Monies held in trust for an individual applying for or receiving SoonerCare must have the availability of the funds determined. Funds held in trust are considered available when they are under the direct control of the individual or his/her spouse, and disbursement is at their sole discretion. Funds may also be held in trust and under the control of someone other than the individual or his/her spouse, such as the courts, agencies, other individuals, or the Bureau of Indian Affairs ~~(BIA)~~.

(1) **Availability determinations.** The worker should be able to determine the availability of a trust using the definitions and explanations listed in (2) of this subsection. However, in some cases, the worker may wish to submit a trust to the Oklahoma Department of Human Services (OKDHS) State Office for determination of availability. In these instances, all pertinent data is submitted to Family Support Services Division, Attention: Health Related and Medical Services Section, for a decision.

(2) **Definition of terms.** The following words and terms, when used in this paragraph, have the following meaning, unless the context clearly indicates otherwise:

(A) **Beneficiary.** Beneficiary means the person(s) who is to receive distributions of either income or principal, or on behalf of whom the trustee is to make payments.

(B) **Corpus/principal.** Corpus/principal means the body of the trust or the original asset used to establish the trust, such as a sum of money or real property.

(C) **Discretionary powers.** Discretionary powers means the grantor gives the trustee the power to make an independent determination whether to distribute income and/or principal to the beneficiary(ies) or to retain the income and add it to the principal of the trust.

(D) **Distributions.** Distributions means payments or allocations made from the trust from the principal or from the income produced by the principal (e.g., interest on a bank account).

(E) **Grantor (trustor/settlor).** Grantor (trustor/settlor) means the individual who establishes the trust by transferring certain assets.

(F) **Irrevocable trust.** Irrevocable trust means a trust in which the grantor has expressly not retained the right to terminate or revoke the trust and reclaim the trust principal and income.

(G) **Pour over or open trust.** Pour over or open trust means a trust which may be expanded from time to time by the addition to the trust principal (e.g., a trust established to receive the monthly payment of an annuity, a workers' compensation settlement, a disability benefit or other periodic receivable). The principal may accumulate or grow depending upon whether the trustee distributes the receivable or permits it to accumulate. Generally, the terms of the trust will determine the availability of the income in the month of receipt and the availability of the principal in subsequent months.

(H) **Primary beneficiary.** Primary beneficiary means the first person or class of persons to receive the benefits of the trust.

(I) **Revocable trust.** Revocable trust means a trust in which the grantor has retained the right to terminate or revoke the trust and reclaim the trust principal and income. Unless a trust is specifically made irrevocable, it is revocable. Even an irrevocable trust is revocable upon the written consent of all living persons with an interest in the trust.

(J) **Secondary beneficiary.** Secondary beneficiary means the person or class of persons who will receive the benefits of the trust after the primary beneficiary has died or is otherwise no longer entitled to benefits.

(K) **Testamentary trust.** Testamentary trust means a trust created by a will and effective upon the death of the individual making the will.

(L) **Trustee.** Trustee means an individual, individuals, a corporation, court, bank or combination thereof with responsibility for carrying out the terms of the trust.

(3) **Documents needed.** To determine the availability of a trust for an individual applying for or receiving SoonerCare, copies of the following documents are obtained:

(A) Trust document;

(B) When applicable, all relevant court documents including the Order establishing the trust, Settlement Agreement, Journal Entry, etc.; and

(C) Documentation reflecting prior disbursements (date, amount, purpose).

(4) **Trust accounts established on or before August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established on or before August 10, 1993.

(A) **Support trust.** The purpose of a support trust is the

provision of support or care of a beneficiary. A support trust will generally contain language such as "to provide for the care, support and maintenance of ...", "to provide as necessary for the support of ...", or "as my trustee may deem necessary for the support, maintenance, medical expenses, care, comfort and general welfare." Except as provided in (i)-(iii) of this subparagraph, the amount from a support trust deemed available to the beneficiary is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the beneficiary, assuming the full exercise of discretion by the trustee(s) for distribution of the maximum amount to the beneficiary. The beneficiary of a support trust, under which the distribution of payments to the beneficiary is determined by one or more trustees who are permitted to exercise discretion with respect to distributions, may show that the amounts deemed available are not actually available by:

(i) Commencing proceedings against the trustee(s) in a court of competent jurisdiction;

(ii) Diligently and in good faith asserting in the proceedings that the trustee(s) is required to provide support out of the trust; and

(iii) Showing that the court has made a determination, not reasonably subject to appeal, that the trustee must pay some amount less than the amount deemed available. If the beneficiary makes the showing, the amount deemed available from the trust is the amount determined by the court. Any action by a beneficiary or the beneficiary's representative, or by the trustee or the trustee's representative, in attempting a showing to make the Agency or the State of Oklahoma a party to the proceeding, or to show to the court that SoonerCare benefits may be available if the court limits the amounts deemed available under the trust, precludes the showing of good faith required.

(B) **Medicaid Qualifying Trust (MQT).** A MQT is a trust, or similar legal device, established (other than by will) by an individual or an individual's spouse, under which the individual may be the beneficiary of all or part of the distributions from the trust and such distributions are determined by one or more trustees who are permitted to exercise any discretion with respect to distributions to the individual. A trust established by an individual or an individual's spouse includes trusts created or approved by a representative of the individual (parent, guardian or person holding power of attorney) or the court where the property placed in trust is intended to satisfy or settle a

claim made by or on behalf of the individual or the individual's spouse. This includes trust accounts or similar devices established for a minor child pursuant to 12 Oklahoma Statutes 83. In addition, a trust established jointly by at least one of the individuals who can establish an MQT and another party or parties (who do not qualify as one of these individuals) is an MQT as long as it meets the other MQT criteria. The amount from an irrevocable MQT deemed available to the individual is the maximum amount of payments that may be permitted under the terms of the trust to be distributed to the individual assuming the full exercise of discretion by the trustee(s). The provisions regarding MQT apply even though an MQT is irrevocable or is established for purposes other than enabling an individual to qualify for SoonerCare, and, whether or not discretion is actually exercised.

(i) **Similar legal device**. MQT rules listed in this subsection also apply to "similar legal devices" or arrangements having all the characteristics of an MQT except that there is no actual trust document. An example is the member petitioning the court to irrevocably assign all or part of his/her income to another party (usually the spouse). The determination whether a given document or arrangement constitutes a "similar legal device" should be made by the OKDHS Office of General Counsel, Legal Unit.

(ii) **MQT resource treatment**. For revocable MQTs, the entire principal is an available resource to the member. Resources comprising the principal are subject to the individual resource exclusions (e.g., the home property exclusion) since the member can access those resource items without the intervention of the trustee. For irrevocable MQTs, the countable amount of the principal is the maximum amount the trustee can disburse to (or for the benefit of) the member, using his/her full discretionary powers under the terms of the trust. If the trustee has unrestricted access to the principal and has discretionary power to disburse the entire principal to the member (or to use it for the member's benefit), the entire principal is an available resource to the member. Resources transferred to such a trust lose individual resource consideration (e.g., home property transferred to such a trust is no longer home property and the home property exclusions do not apply). The value of the property is included in the value of the principal. If the MQT permits a specified amount of trust income to be distributed periodically to the member (or to be used for

his/her benefit), but those distributions are not made, the member's countable resources increase cumulatively by the undistributed amount.

(iii) **Income treatment.** Amounts of MQT income distributed to the member are countable income when distributed. Amounts of income distributed to third parties for the member's benefit are countable income when distributed.

(iv) **Transfer of resources.** If the MQT is irrevocable, a transfer of resources has occurred to the extent that the trustee's access to the principal (for purposes of distributing it to the member or using it for the member's benefit) is restricted (e.g., if the trust stipulates that the trustee cannot access the principal but must distribute the income produced by that principal to the member, the principal is not an available resource and has, therefore, been transferred).

(C) **Special needs trusts.** Some trusts may provide that trust benefits are intended only for a beneficiary's "special needs" and require the trustee to take into consideration the availability of public benefits and resources, including SoonerCare benefits. Some trusts may provide that the trust is not to be used to supplant or replace public benefits, including SoonerCare benefits. If a trust contains such terms and is not an MQT, the trust is not an available resource.

(5) **Trust accounts established after August 10, 1993.** The rules found in (A) - (C) of this paragraph apply to trust accounts established after August 10, 1993.

(A) For purposes of this subparagraph, the term "trust" includes any legal document or device that is similar to a trust. An individual is considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established other than by will and by any of the following individuals:

(i) the individual;

(ii) the individual's spouse;

(iii) a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or

(iv) a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(B) Where trust principal includes assets of an individual described in this subparagraph and assets of any other person(s), the provisions of this subparagraph apply to the portion of the trust attributable to the assets of the

individual. This subparagraph applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, and restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of the distribution from the trust.

(C) There are two types of trusts, revocable trusts and irrevocable trusts.

(i) In the case of a revocable trust, the principal is considered an available resource to the individual. Payments from the trust to or for the benefit of the individual are considered income of the individual. Other payments from the trust are considered assets disposed of by the individual for purposes of the transfer of assets rule and are subject to the ~~60~~sixty (60) months look back period.

(ii) In the case of an irrevocable trust, if there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the portion of the principal of the trust, or the income on the principal, from which payment to the individual could be made is considered available resources. Payments from the principal or income of the trust is considered income of the individual. Payments for any other purpose are considered a transfer of assets by the individual and are subject to the ~~60~~sixty (60) months look back period. Any portion of the trust from which, or any income on the principal from which no payment could under any circumstances be made to the individual is considered as of the date of establishment of the trust (or if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for purposes of the asset transfer rules and are subject to the 60 months look back period.

(6) **Exempt trusts.** Paragraph (5) of this subsection does not apply to the following trusts:

(A) A trust containing the assets of a disabled individual under the age of ~~65~~sixty-five (65) which was established for the benefit of such individual by the individual, parent, grandparent, legal guardian of the individual or a court if the State receives all amounts remaining in the trust on the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual. This type of trust requires:

(i) The trust may only contain the assets of the disabled individual.

(ii) The trust must be irrevocable and cannot be amended

or dissolved without the written agreement of the OKDHS or the Oklahoma Health Care Authority (OHCA).
(iii) Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.
(iv) The exception for the trust continues after the disabled individual reaches age ~~65~~sixty-five (65). However, any addition or augmentation after age ~~65~~sixty-five (65) involves assets that were not the assets of an individual under age ~~65~~sixty-five (65); therefore, those assets are not subject to the exemption.
(v) Establishment of this type of trust does not constitute a transfer of assets for less than fair market value if the transfer is made into a trust established solely for the benefit of a disabled individual under the age of ~~65~~sixty-five (65).
(vi) Payments from the trust are counted according to SSI rules. According to these rules, countable income is anything the individual receives in cash or in kind that can be used to meet the individual's needs for food~~, clothing~~ and shelter. Accordingly, any payments made directly to the individual are counted as income to the individual because the payments could be used for food~~, clothing,~~ or shelter for the individual. This rule applies whether or not the payments are actually used for these purposes, as long as there is no legal impediment which would prevent the individual from using the payments in this way. In addition, any payments made by the trustee to a third party to purchase food~~, clothing,~~ or shelter for the individual can also count as income to the individual. For example, if the trustee makes a mortgage payment for the individual, that payment is a shelter expense and counts as income.
(vii) A corporate trustee may charge a reasonable fee for services in accordance with its published fee schedule.
(viii) The OKDHS Form 08MA018E, Supplemental Needs Trust, is an example of the trust. Workers may give the sample form to the member or his/her representative to use or for their attorney's use.
(ix) To terminate or dissolve a Supplemental Needs Trust, the worker sends a copy of the trust instrument and a memorandum to OKDHS Family Support Services Division, Attention: Health Related and Medical Services~~ (HR&MS)~~, explaining the reason for the requested termination or dissolution of the Supplemental Needs Trust, and giving the name and address of the trustee. The name and address of the financial institution and current balance are also

required. Health Related and Medical Services (HRMS) notifies Oklahoma Health Care Authority/Third Party Liability (OHCA/TPL) to initiate the recovery process.

(B) A trust (known as the Medicaid Income Pension Trust) established for the benefit of an individual if:

(i) The individual is in need of long-term care and has countable income above the categorically needy standard for long-term care (OKDHS Appendix C-1 Schedule VIII.B) but less than the average cost of nursing home care per month (OKDHS Appendix C-1 Schedule VIII.B).

(ii) The ~~Trust~~trust is composed only of pension, social security, or other income of the individual along with accumulated income in the trust. Resources cannot be included in the trust.

(iii) All income is paid into the trust and the applicant is not eligible until the trust is established and the monthly income has been paid into the trust.

(iv) The trust must retain an amount equal to the member's gross monthly income less the current categorically needy standard of OKDHS Appendix C-1. The Trustee distributes the remainder.

(v) The income disbursed from the trust is considered as the monthly income to determine the cost of their care, and can be used in the computations for spousal diversion.

(vi) The trust must be irrevocable and cannot be amended or dissolved without the written agreement of the OHCA. Trust records must be open at all reasonable times to inspection by an authorized representative of the OHCA or OKDHS.

(vii) The State will receive all amounts remaining in the trust up to an amount equal to the total SoonerCare benefits paid on behalf of the individual subsequent to the date of establishment of the trust.

(viii) Accumulated funds in the trust may only be used for medically necessary items not covered by SoonerCare, or other health programs or health insurance and a reasonable cost of administrating the trust. Reimbursements cannot be made for any medical items to be furnished by the nursing facility. Use of the accumulated funds in the trust for any other reason will be considered as a transfer of assets and would be subject to a penalty period.

(ix) The trustee may claim a fee of up to ~~3%~~three percent (3%) of the funds added to the trust that month as compensation.

(x) An example trust is included on OKDHS Form 08MA011E. Workers may give this to the member or his/her

representative to use or for their attorney's use as a guide for the Medicaid Income Pension Trust.

(xi) To terminate or dissolve a Medicaid Income Pension Trust, the worker sends a memorandum with a copy of the trust to OKDHS Family Support Services Division, Attention: HR&MS, explaining the reason and effective date for the requested termination or dissolution of the Medicaid Income Pension Trust, and giving the name and address of the trustee. The name and address of the financial institution, account number, and current balance are also required. ~~Health Related and Medical Services~~HRMS notifies OHCA/TPL to initiate the recovery process.

(C) A trust containing the assets of a disabled individual when all of the following are met:

(i) The trust is established and managed by a non-profit association;

(ii) The trust must be made irrevocable;

(iii) The trust must be approved by the OKDHS and may not be amended without the permission of the OKDHS;

(iv) The disabled person has no ability to control the spending in the trust;

(v) A separate account is maintained for each beneficiary of the trust but for the purposes of investment and management of funds, the trust pools these accounts;

(vi) The separate account on behalf of the disabled person may not be liquidated without payment to OHCA for the medical expenses incurred by the members;

(vii) Accounts in the trust are established by the parent, grandparent, legal guardian of the individual, the individual, or by a court;

(viii) To the extent that amounts remaining in the beneficiary's account on the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts an amount equal to the total medical assistance paid on behalf of the individual. A maximum of ~~30%~~thirty percent (30%) of the amount remaining in the beneficiary's account at the time of the beneficiary's death may be retained by the trust.

(7) **Funds held in trust by Bureau of Indian Affairs ~~(BIA)~~.** Interests of individual Indians in trust or restricted lands are not considered in determining eligibility for assistance under the Social Security Act or any other federal or federally assisted program.

(8) **Disbursement of trust.** At any point that disbursement occurs, the amount disbursed is counted as a non-recurring lump sum payment in the month received. Some trusts generate income

on a regular basis and the income is sent to the beneficiary. In those instances, the income is treated as unearned income in the month received.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-35. Oklahoma State Health Information Network and Exchange (OKSHINE)

(a) **Authority.** This rule is promulgated under the authority granted in Title 63 of the Oklahoma Statutes Section 1-133 (63 O.S. § 1-133). This Section is intended to be read in conjunction with applicable Oklahoma statutes and federal law.

(b) **Applicability and purpose.**

(1) **Applicability.** This section shall apply to and govern the establishment and operation of the statewide health information exchange (HIE), herein referred to as OKSHINE.

(2) **Purpose.** OKSHINE is the state-designated organization that facilitates the exchange of health information to and from authorized individuals and health care organizations in the state for the purpose of improving health outcomes, as per 63 O.S. § 1-133.

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

(1) **OKSHINE** means an organization that oversees, governs, and facilitates health information exchange among health care providers that are not related health care organizations as defined in the Oklahoma Statutes, to improve the security of patient information, coordination of patient care, and the efficiency of health care delivery.

(2) **Participant** means an organization, health care practitioner or institution, health plan, or health care clearinghouse who has executed a written participation agreement (PA) and business associate agreement (BAA) with OKSHINE.

(3) **Participant agreement** means the agreement between OKSHINE and a participant which authorizes the participant to have access to OKSHINE and outlines the policies and procedures for access, protection, and use of the electronic protected health information.

(4) **Oklahoma Statewide Health Information Exchange (OKHIE)** means a certified HIE as referenced in 63 O.S. § 1-133 whose primary business activity is health information exchange.

(d) **OKHIE Certification.** Per 63 O.S. § 1-133, an initial certification and an annual recertification will be required for health information exchanges to qualify as an OKHIE. In order to receive certification, the applying HIE must submit an application

to the Oklahoma Health Care Authority (OHCA) and provide all requested documentation. The application and standards for certification shall be posted on the OHCA OKSHINE public website.

(1) The OHCA shall establish a health information exchange certification with input from stakeholders.

(2) Until such time as the health information exchange certification is established by the OHCA, an OKSHINE or an HIE organization that was previously certified by the Oklahoma Health Information Exchange Trust (OHIET) shall be deemed an OKHIE.

(3) An HIE must provide documentation of certification from OHIET to OHCA in order to receive initial OKHIE certification.

(e) **Fees.**

(1) **Certification fees.** Each health information exchange which applies for certification, will be required to pay annual certification/recertification fees. The OHCA will develop the certification criteria and will publish the criteria and associated fees, when available, on the OHCA OKSHINE public website.

(2) **Participant fees.** Each participant, as defined in this section, will be required to pay an annual participation fee as outlined in the participant agreement. The OHCA will develop the criteria for the fees and will publish the criteria when available. The participant agreement and fee schedule will be posted on the OHCA OKSHINE public website.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-58. Supplemental Hospital Offset Payment Program

(a) **Purpose.** The Supplemental Hospital Offset Payment Program (SHOPP) is a hospital assessment fee that is eligible for federal matching funds when used to reimburse SoonerCare services in accordance with Section 3241.1 of Title 63 of the Oklahoma Statutes (O.S.).

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

(1) **"Base Year"** means a hospital's fiscal year ending in 2009, as reported in the Medicare Cost Report or as determined by the Oklahoma Health Care Authority (OHCA) if the hospital's data is not included in a Medicare Cost Report.

(2) "Directed payments" means payment arrangements allowed under 42 C.F.R. Section 438.6(c) that permit states to direct specific payments made by managed care plans to providers under certain circumstances and can assist states in furthering the goals and priorities of their Medicaid programs.

~~(2)~~(3) **"Fee"** means supplemental hospital offset assessment pursuant to Section (§) 3241.1 of Title 63 of the ~~Oklahoma Statutes~~O.S.

~~(3)~~(4)**"Hospital"** means an institution licensed by the State Department of Health as a hospital pursuant to ~~Section~~§ 1-701.1 of Title 63 of the ~~Oklahoma Statutes~~O.S. maintained primarily for the diagnosis, treatment, or care of patients.

~~(4)~~(5)**"Hospital Advisory Committee"** means the Committee established for the purposes of advising the OHCA and recommending provisions within and approval of any state plan amendment or waiver affecting the Supplemental Hospital Offset Payment Program.

(5) **"NET hospital patient revenue"** means the gross hospital revenue as reported on Worksheet G-2 (Columns 1 and 2, Lines "Total inpatient routine care services", "Ancillary services", "Outpatient services") of the Medicare ~~Cost Report~~cost report, multiplied by hospital's ratio of total net to gross revenue, as reported on Worksheet G-3(Column 1, Line 3)"Net patient revenues"~~)~~ and Worksheet G-2 (Part I, Column 3, Line "Total patient revenues").

(6) **"Medicare ~~Cost Report~~cost report"** means the ~~Hospital Cost Report~~hospital cost report, Form CMS-2552-96 or subsequent

versions.

(7) **"Upper payment limit" (UPL)"** means the maximum ceiling imposed by ~~42 C F R "~~42 Code of Federal Regulations (C.F.R.) §§ 447.272 and 447.321 on hospital Medicaid reimbursement for inpatient and outpatient services, other than to hospitals owned or operated by state government.

(8) **"Upper payment limit gap"** means the difference between the upper payment limit and SoonerCare payments not financed using hospital assessments.

(c) **Supplemental Hospital Offset Payment Program.**

(1) Pursuant to 63 ~~Okla. Stat.~~O.S. §§ 3241.1 through 3241.6 the ~~Oklahoma Health Care Authority (OHCA)~~OHCA is mandated to assess hospitals licensed in Oklahoma, unless exempted under (c) (2) of this Section, a supplemental hospital offset payment fee.

(2) The following hospitals are exempt from the SHOPP fee:

(A) ~~a~~A hospital that is owned or operated by the state or a state agency, or the federal government, as determined by OHCA, using most recent Medicare cost report worksheet S-2, column 1, line 18 or other line that indicates ownership, or by a federally recognized Indian tribe or Indian Health Services, as determined by OHCA, using the most recent IHS/Tribal facility list for Oklahoma as updated by the Indian Health Service Office of Resource Access and Partnerships in Partnership with the Centers for Medicare and Medicaid Services and ~~State~~state operations.

(B) ~~a~~A hospital that provides more than fifty percent (50%) of its inpatient days under a contract with a state agency other than the OHCA, as determined by OHCA, using data provided by the hospital;

(C)~~a~~A hospital for which the majority of its inpatient days are for any one of the following services, as determined by OHCA, using the Inpatient Discharge Data File published by the Oklahoma State Department of Health, or in the case of a hospital not included in the Inpatient Discharge Data File, using substantially equivalent data provided by the hospital:

(i) ~~treatment~~Treatment of a neurological injury;

(ii) ~~treatment~~Treatment of cancer;

(iii) ~~treatment~~Treatment of cardiovascular disease;

(iv) ~~obstetrical~~Obstetrical or childbirth services; or

(v) ~~surgical~~Surgical care except that this exemption will not apply to any hospital located in a city of less than five hundred thousand (500,000) population and for which the majority of inpatient days are for back, neck, or spine surgery.

(D) ~~a~~A hospital that is certified by the Centers for Medicare and Medicaid Services (CMS) as a long term acute hospital,

according to the most recent list of LTCH's published on the CMS http://www.cms.gov/LongTermCareHospitalPPS/08download.asp or as a children's hospital; and

(E) ~~a~~A hospital that is certified by CMS as a critical access hospital, according to the most recent list published by Flex Monitoring Team for Critical Access Hospital (CAH) Information at http://www.flexmonitoring.org/cahlistRA.cgi, which is based on CMS quarterly reports, augmented by information provided by state Flex Coordinators.

(d) **The Supplemental Hospital Offset Payment Program Assessment.**

(1) The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, for each calendar year in an amount calculated as a percentage of each hospital's net hospital patient revenue. ~~The assessment rate until December 31, 2012, is two and one-half percent (2.5%). At no time in subsequent years will the assessment rate exceed four percent (4%).~~The SHOPP assessment is imposed on each hospital, except those exempted under (c) (2) of this Section, in an amount calculated as a percentage of each hospital's net hospital patient revenue. At no time will the assessment rate exceed four percent (4%). For the calendar year ending December 31, 2022, the assessment rate shall be fixed at three percent (3%). For the calendar year ending December 31, 2023, the assessment rate shall be fixed at three and one-half percent (3.5%). For the calendar year ending December 31, 2024 and for all subsequent calendar years shall, the assessment rate exceed shall be fixed at four percent (4%).

~~(2) OHCA will review and determine the amount of annual assessment in December of each year.~~

~~(3)~~(2) A hospital may not charge any patient for any portion of the SHOPP assessment.

~~(4)~~(3) The ~~Method~~method of collection is as follows:

(A) The OHCA will send a notice of assessment to each hospital informing the hospital of the assessment rate, the hospital's net hospital patient revenue calculation, and the assessment amount owed by the hospital for the applicable year.

(B) The hospital has thirty (30) days from the date of its receipt of a notice of assessment to review and verify the hospital's net patient revenue calculation, and the assessment amount.

(C) New hospitals will only be added at the beginning of each calendar year.

(D) The annual assessment imposed is due and payable on a quarterly basis. Each quarterly installment payment is due and payable by the fifteenth day of the first month of the applicable quarter (i.e. January 15th, April 15th, etc.)

(E) Failure to pay the amount by the 15th or failure to have the payment mailing postmarked by the 13th ~~will~~may result in a debt to the State of Oklahoma and is subject to penalties of ~~5%~~five percent (5%) of the amount ~~and interest of 1.25%~~one ~~and a quarter percent (1.25%) per month~~.

(F) If a hospital fails to timely pay the full amount of a quarterly assessment, OHCA ~~will~~may add to the assessment:

(i) ~~a~~A penalty assessment equal to five percent (5%) of the quarterly amount not paid on or before the due date, and

(ii) ~~on~~On the last day of each quarter after the due date until the assessed amount and the penalty imposed under section (i) of this paragraph are paid in full, an additional five percent (5%) penalty assessment on any unpaid quarterly and unpaid penalty assessment amounts.

(iii) ~~the~~The quarterly 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 invoice to the provider, the assessment~~,~~ and applicable penalty~~, and interest~~ will be deducted from the facility's payment. Any change in payment amount resulting from an appeals decision in which a recoupment or additional allocation is necessary will be adjusted in future payments in accordance with ~~OAC~~Oklahoma Administrative Code (OAC) 317:2-1-15 SHOPP appeals.

(iv) If additional allocation or recoupment resulting from an appeal is for the current calendar year and another SHOPP payment is scheduled for the calendar year, an adjustment to the next payment will be calculated. If additional allocation or recoupment is for a prior calendar year, a separate payment/account receivable (AR) will be issued.

(G) The SHOPP assessments excluding penalties and interest are an allowable cost for cost reporting purposes.

(e) **Supplemental Hospital Offset Payment Program Cost Reports.**

(1) The report referenced in paragraph (b)(6) must be signed by the preparer and by the 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 or authorized 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.~~United States Code (U.S.C.) Section 1320a-7b which states, in part,

"Whoever...(2) at any time knowingly and willfully makes or causes to be made any false statement of a material fact for use in determining rights to such benefits or payment...shall (i) in the case of such statement, representation, failure, or conversion by any person in connection with furnishing (by the person) of items or services for which payment is or may be 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~~twenty-five thousand dollars ($25,000) or imprisoned for not more than five (5) 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~~ten thousand dollars ($10,000) or imprisoned for not more than one year, or both."

(4) Net hospital patient revenue is determined using the data from each hospital's applicable Medicare ~~Cost Report~~cost report contained in the Centers for Medicare and Medicaid Services' Healthcare Cost Report Information System (HCRIS) file. The base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g. calendar year 2022 will use 2020 fiscal year cost reports), as contained in the HCRIS file dated June 30 of each year.

~~(A) Through 2013, the base year for assessment shall be the hospital's fiscal year that ended in 2009, as contained in the HCRIS file dated December 31, 2010;~~

~~(B) For years 2014 and 2015, the base year for assessment shall be the hospital's fiscal year that ended in 2012, as contained in the HCRIS file dated June 30, 2013; and~~

~~(C) For subsequent two-year periods the base year for assessment shall be the hospital's fiscal year that ended two years prior (e.g.,2016 & 2017 **B** 2014 fiscal year; 2018 & 2019 **B** 2016 fiscal year), as contained in the HCRIS file dated June 30 of the following year.~~

(5) If a hospital's applicable Medicare ~~Cost Report~~cost report is not contained in the Centers for Medicare and Medicaid Services' HCRIS file, the hospital will submit a copy of the hospital's applicable Medicare ~~Cost Report~~cost report to the ~~Oklahoma Health Care Authority (OHCA)~~OHCA in order to allow the OHCA to determine the hospital's net hospital patient revenue for the base year.

(6) If a hospital commenced operations after the due date for a Medicare ~~Cost Report~~cost report, the hospital will submit its initial Medicare ~~Cost Report~~cost report to ~~Oklahoma Health Care Authority (OHCA)~~OHCA in order to allow the OHCA to determine the hospital's net patient revenue for the base year.

(7) Partial year reports may be prorated for an annual basis.

Hospitals whose assessments were based on partial year cost reports will be reassessed the following year using a cost report that contains a full year of operational data.

(8) In the event that a hospital does not file a uniform cost report under 42 U.S.C., Section 1396a(a)(40), the OHCA will provide a data collection sheet for such facility.

(f) **Closure, merger and new hospitals.**

(1) If a hospital ceases to operate as a hospital or for any reason ceases to be subject to the fee, the assessment for the year in which the cessation occurs is adjusted by multiplying the annual assessment by a fraction, the numerator of which is the number of days in the year during which the hospital is subject to the assessment and denominator of which is 365. Within 30 days of ceasing to operate as a hospital, or otherwise ceasing to be subject to the assessment, the hospital will pay the assessment for the year as so adjusted, to the extent not previously paid.

(2) Cost reports required under (e)(5),(e)(6),or (e)(8) of this subsection for assessment calculation must be submitted to OHCA by September 30 of each year.

(g) **Disbursement of payment to hospitals.**

(1) All in-state inpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to inpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for inpatient hospital services to SoonerCare members, each eligible hospital will receive inpatient hospital access payments each year equal to the hospital's pro rata share of the inpatient supplemental payment pool as reduced by payments distributed in paragraph (1) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for inpatient services divided by the total SoonerCare payments for inpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

<u>(C) Directed payments paid through a managed care organization (MCO) as approved in the CMS-approved 438.6(c) directed payment pre-prints.</u>

(2) All in-state outpatient hospitals are eligible for hospital access payments each year as set forth in this subsection except for those listed in OAC 317:30-5-58 (c) (2):

(A) In addition to any other funds paid to outpatient critical access hospital for services provided to SoonerCare members, each critical access hospital will receive hospital access payments equal to the amount by which the payment for these services was less than one hundred one percent (101%) of the hospital's cost of providing these services.

(B) In addition to any other funds paid to hospitals for outpatient hospital services to SoonerCare members, each eligible hospital will receive outpatient hospital access payments each year equal to the hospital's pro rata share of the outpatient supplemental payment pool as reduced by payments distributed in paragraph (2) (A) of this Section. The pro rata share will be based upon the hospital's SoonerCare payment for outpatient services divided by the total SoonerCare payments for outpatient services of all eligible hospitals within each class of hospital and cannot exceed the UPL for the class.

(3) Medicaid payments to a group of facilities within approved categories may not exceed the upper payment limit in accordance with 42 ~~CFR~~C.F.R. 447.272 (b) (2) and 42 ~~CFR~~C.F.R 447.321 (b) (2). If any audit determines that a class of hospitals has exceeded the inpatient and/or outpatient UPL the overpayment will be recouped and redistributed based on the following methods:

(A) If it is determined prior to issuance of hospital access payments that the pool of hospitals would exceed the upper payment limit estimate of that pool, the amount above the UPL estimate will be allocated to another pool of hospitals that does not exceed the upper payment limit estimate of that pool. The reallocation can be applied to multiple pools if necessary.

(B) If the overpayment cannot be redistributed due to all classes being paid at their UPL, the overpayment will be deposited in to the SHOPP fund.

(4) ~~In order to ensure sufficient funds to make payments effective July 1, 2013 OHCA shall reduce the next quarterly payment by 1.4% (OHCA will pay out 23.6% of the assessment rather than 25%). This reduction will be distributed in the fourth (4th) quarter of the year as soon as all assessments are received. This payment will also be increased by penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate.~~

(5) Effective for all subsequent calendar years the OHCA will distribute payments in the following quarterly percentages: 23.6%, 25%, 25%, 25%. A 5th fifth (5th) payment of 1.4% in the fourth (4th) quarter of each calendar year will also be made as soon as all assessments are received. ~~This payment will also~~

~~be increased by any penalties collected within the year as long as the penalties do not cause the payment to exceed the UPL estimate. If all assessments are r~~received prior to the 4th fourth (4th) quarterly payment being processed the 4th fourth (4th) quarter payment may be adjusted to pay out 26.4% plus accrued penalties.

OPERATIONAL METRICS

June 2021 Board Meeting

OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

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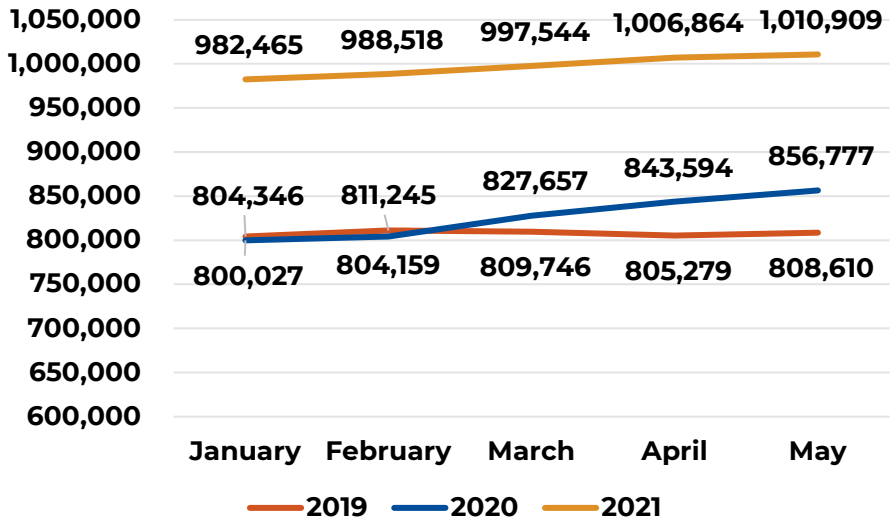
Enrollment & Utilization

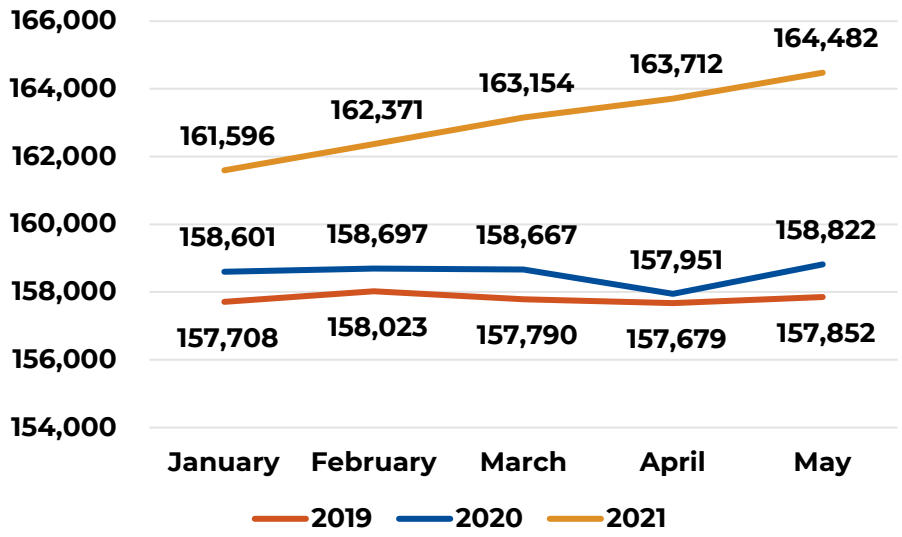
Total Enrolled Members



Month	2019	2020	2021
January	804,346	800,027	982,465
February	811,245	804,159	988,518
March	809,746	827,657	997,544
April	805,279	843,594	1,006,864
May	808,610	856,777	1,010,909

2020 vs 2021	Count Change	Percent Change
January	182,438	23%
February	184,359	23%
March	169,887	21%
April	163,270	19%
May	154,132	18%
2020 vs 2021 Quarterly Percent Change		20%

Aged/Blind/Disabled Enrolled

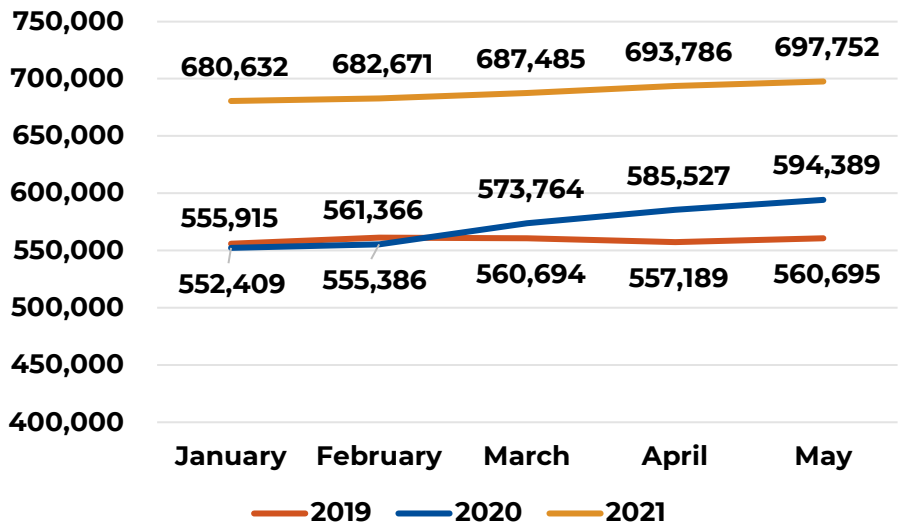


Month	2019	2020	2021
January	157,708	158,601	161,596
February	158,023	158,697	162,371
March	157,790	158,667	163,154
April	157,679	157,951	163,712
May	157,852	158,822	164,482

2020 vs 2021	Count Change	Percent Change
January	2,995	2%
February	3,674	2%
March	4,487	3%
April	5,761	4%
May	5,660	4%
2020 vs 2021 Quarterly Percent Change		1%

Enrollment & Utilization (Cont.)

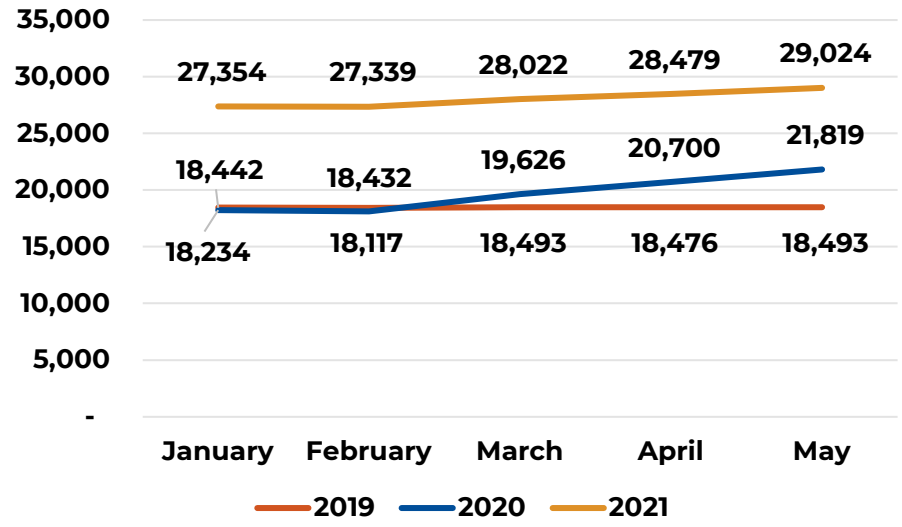
Children & Parent/Caretaker Enrolled



Month	2019	2020	2021
January	555,915	552,409	680,632
February	561,366	555,386	682,671
March	560,694	573,764	687,485
April	557,189	585,527	693,786
May	560,695	594,389	697,752

2020 vs 2021	Count Change	Percent Change
January	128,223	23%
February	127,285	23%
March	113,721	20%
April	108,259	18%
May	103,363	17%
2020 vs 2021 Quarterly Percent Change		21%

Pregnant (Full Scope) Enrolled

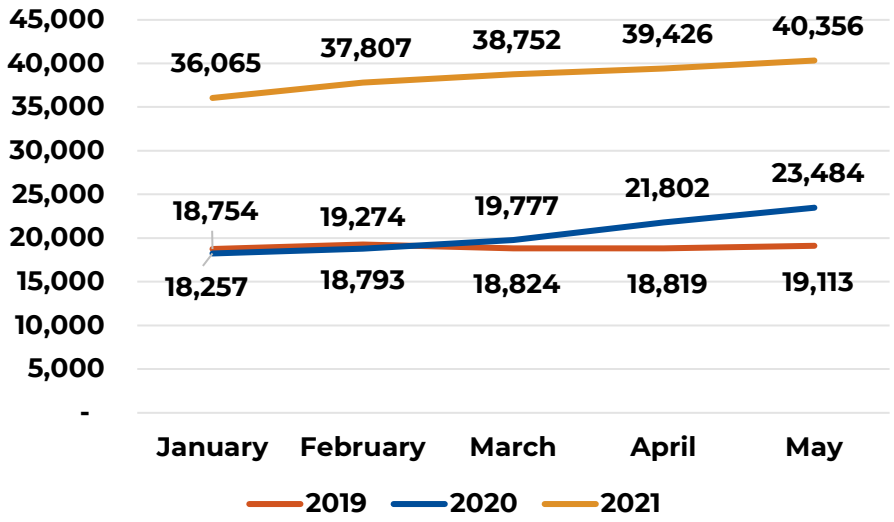


Month	2019	2020	2021
January	18,442	18,234	27,354
February	18,432	18,117	27,339
March	18,493	19,626	28,022
April	18,476	20,700	28,479
May	18,493	21,819	29,024

2020 vs 2021	Count Change	Percent Change
January	9,120	50%
February	9,222	51%
March	8,396	43%
April	7,779	38%
May	7,205	33%
2020 vs 2021 Quarterly Percent Change		48%

Enrollment & Utilization (Cont.)

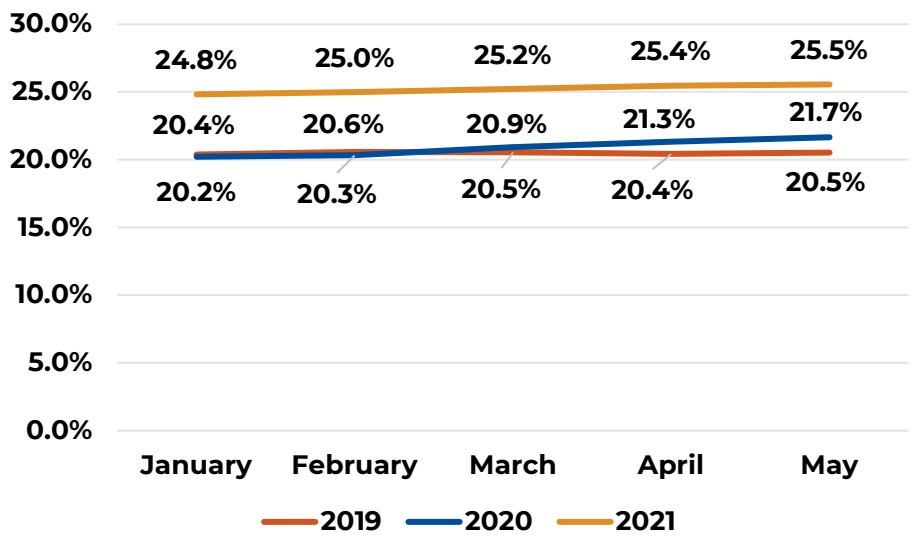
Insure Oklahoma Enrolled



Month	2019	2020	2021
January	18,754	18,257	36,065
February	19,274	18,793	37,807
March	18,824	19,777	38,752
April	18,819	21,802	39,426
May	19,113	23,484	40,356

2020 vs 2021	Count Change	Percent Change
January	17,808	98%
February	19,014	101%
March	18,975	96%
April	17,624	81%
May	16,872	72%
2020 vs 2021 Quarterly Percent Change		96%

Percent of OK Population Enrolled

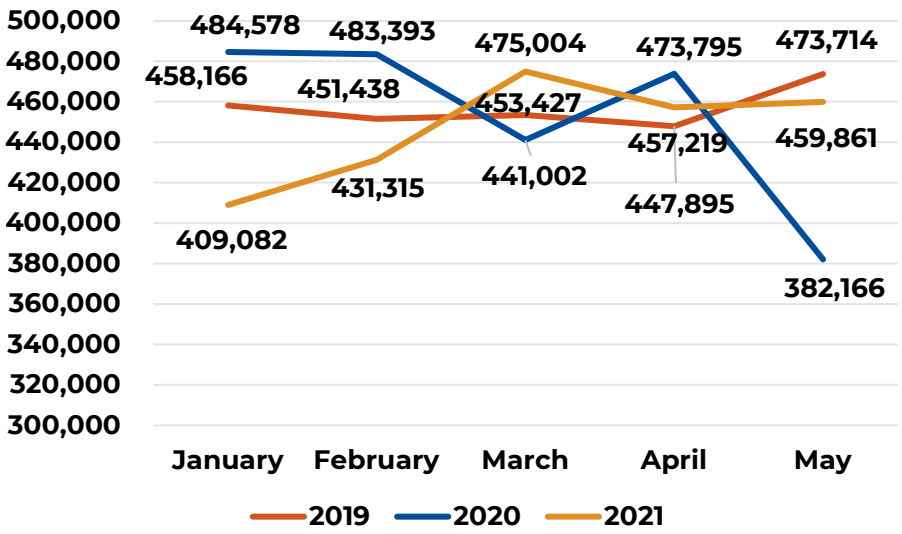


Month	2019	2020	2021
January	20.4%	20.2%	24.8%
February	20.6%	20.3%	25.0%
March	20.5%	20.9%	25.2%
April	20.4%	21.3%	25.4%
May	20.5%	21.7%	25.5%

2020 vs 2021	Count Change	Percent Change
January	4.6%	23%
February	4.7%	23%
March	4.3%	21%
April	4.1%	19%
May	3.9%	18%
2020 vs 2021 Quarterly Percent Change		20%

Enrollment & Utilization (Cont.)

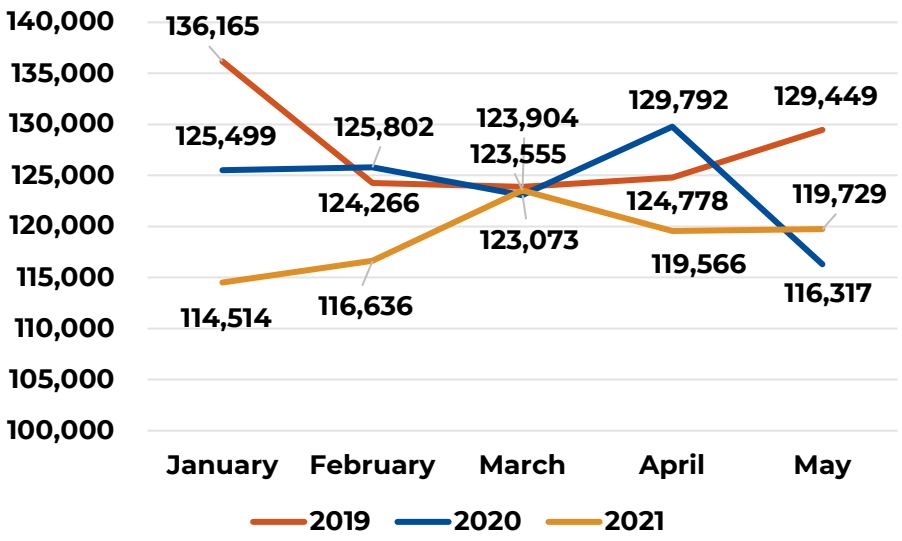
Total Members Utilization



Month	2019	2020	2021
January	458,166	484,578	409,082
February	451,438	483,393	431,315
March	453,427	441,002	475,004
April	447,895	473,795	457,219
May	473,714	382,166	459,861

2020 vs 2021	Count Change	Percent Change
January	(75,496)	-16%
February	(52,078)	-11%
March	34,002	8%
April	(16,576)	-3%
May	77,695	20%
2020 vs 2021 Quarterly Percent Change		-4%

Aged/Blind/Disabled Utilization

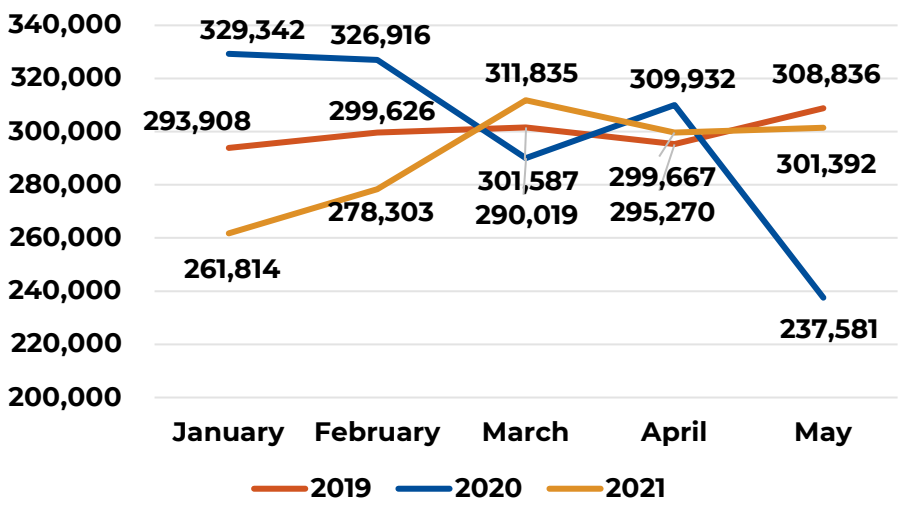


Month	2019	2020	2021
January	136,165	125,499	114,514
February	124,266	125,802	116,636
March	123,904	123,073	123,555
April	124,778	129,792	119,566
May	129,449	116,317	119,729

2020 vs 2021	Count Change	Percent Change
January	(10,985)	-9%
February	(9,166)	-7%
March	482	0%
April	(10,226)	-7.9%
May	3,412	3%
2020 vs 2021 Quarterly Percent Change		-4%

Enrollment & Utilization (Cont.)

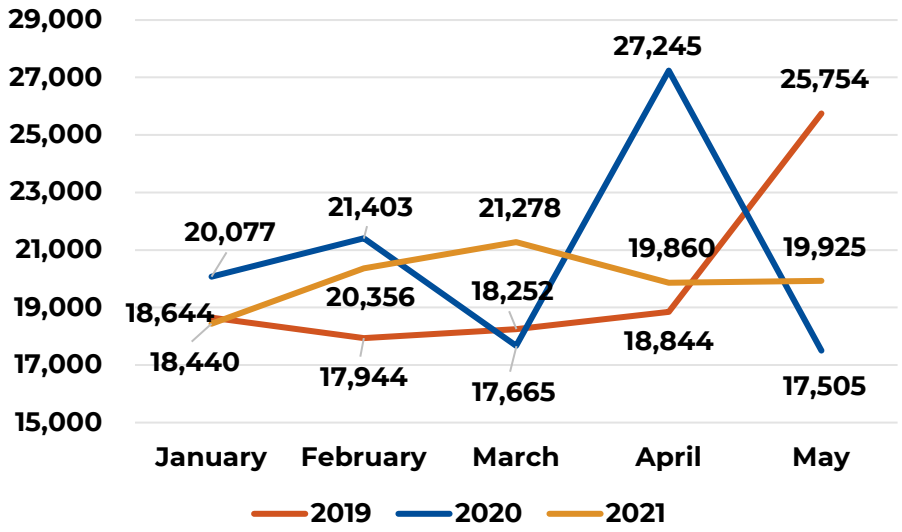
Children & Parent/Caretaker Utilization



Month	2019	2020	2021
January	293,908	329,342	261,814
February	299,626	326,916	278,303
March	301,587	290,019	311,835
April	295,270	309,932	299,667
May	308,836	237,581	301,392

2020 vs 2021	Count Change	Percent Change
January	(67,528)	-21%
February	(48,613)	-15%
March	21,816	8%
April	(10,265)	-3%
May	63,811	27%
2020 vs 2021 Quarterly Percent Change		-6%

Pregnant (Full Scope) Utilization

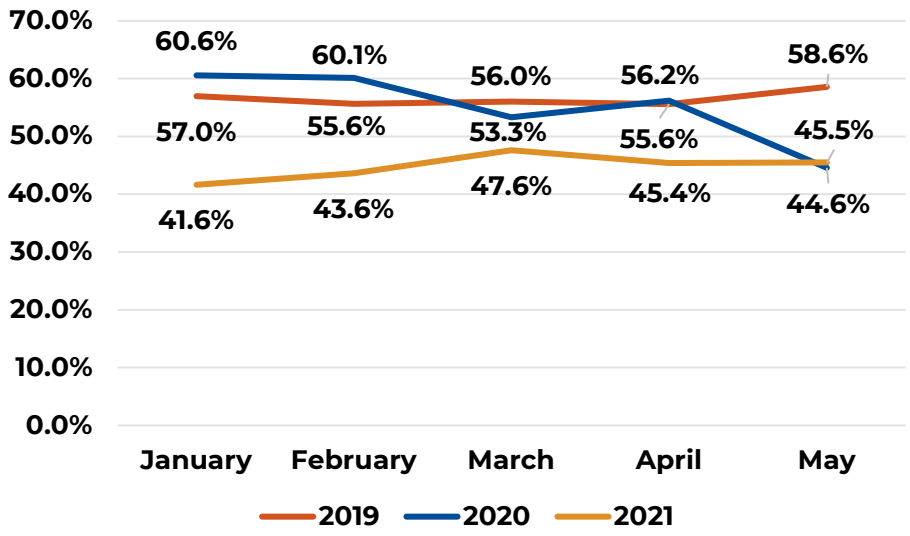


Month	2019	2020	2021
January	18,644	20,077	18,440
February	17,944	21,403	20,356
March	18,252	17,665	21,278
April	18,844	27,245	19,860
May	25,754	17,505	19,925

2020 vs 2021	Count Change	Percent Change
January	(1,637)	-8%
February	(1,047)	-5%
March	3,613	20%
April	(7,385)	-27%
May	2,420	14%
2020 vs 2021 Quarterly Percent Change		-3%

Enrollment & Utilization (Cont.)

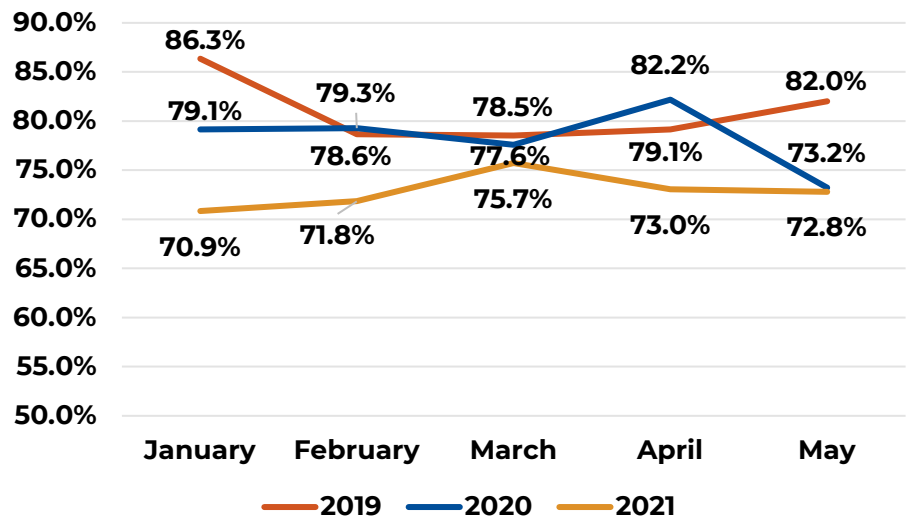
Percent of Total Enrolled Members Utilization



Month	2019	2020	2021
January	57.0%	60.6%	41.6%
February	55.6%	60.1%	43.6%
March	56.0%	53.3%	47.6%
April	55.6%	56.2%	45.4%
May	58.6%	44.6%	45.5%

2020 vs 2021	Count Change	Percent Change
January	-18.9%	-31%
February	-16.5%	-27%
March	-5.7%	-11%
April	-10.8%	-19%
May	0.9%	2%
2020 vs 2021 Quarterly Percent Change		-24%

Percent of Aged/Blind/Disabled Enrolled Members Utilization

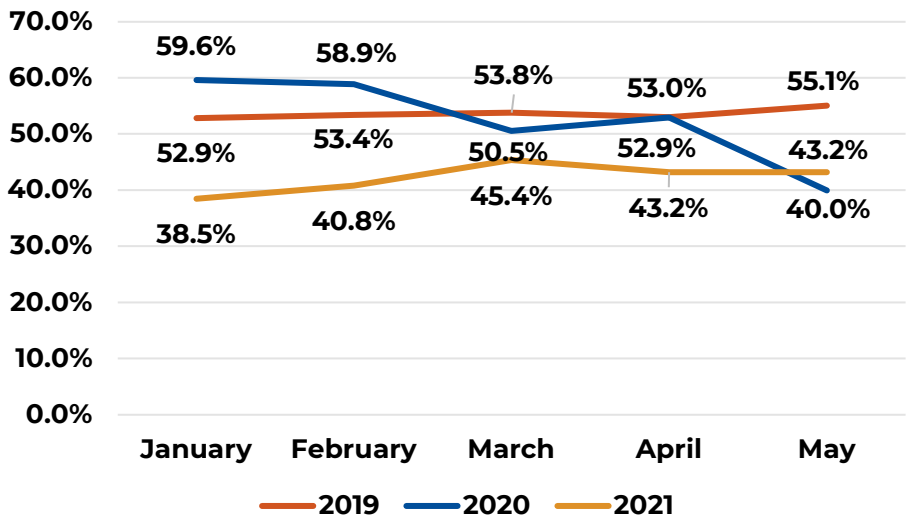


Month	2019	2020	2021
January	86.3%	79.1%	70.9%
February	78.6%	79.3%	71.8%
March	78.5%	77.6%	75.7%
April	79.1%	82.2%	73.0%
May	82.0%	73.2%	72.8%

2020 vs 2021	Count Change	Percent Change
January	-8.3%	-10%
February	-7.4%	-9%
March	-1.8%	-2%
April	-9.1%	-11%
May	-0.4%	-1%
2020 vs 2021 Quarterly Percent Change		-7%

Enrollment & Utilization (Cont.)

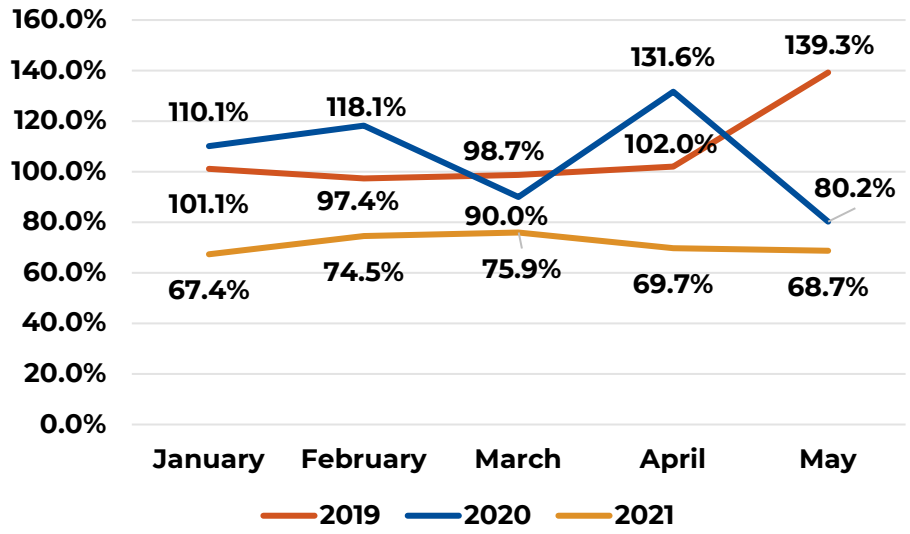
Percent of Children & Parent/Caretaker Enrolled Members Utilization



Month	2019	2020	2021
January	52.9%	59.6%	38.5%
February	53.4%	58.9%	40.8%
March	53.8%	50.5%	45.4%
April	53.0%	52.9%	43.2%
May	55.1%	40.0%	43.2%

2020 vs 2021	Count Change	Percent Change
January	-21.2%	-35%
February	-18.1%	-31%
March	-5.2%	-10%
April	-9.7%	-18%
May	3.2%	8%
2020 vs 2021 Quarterly Percent Change		-26%

Percent of Pregnant (Full Scope) Enrolled Members Utilization

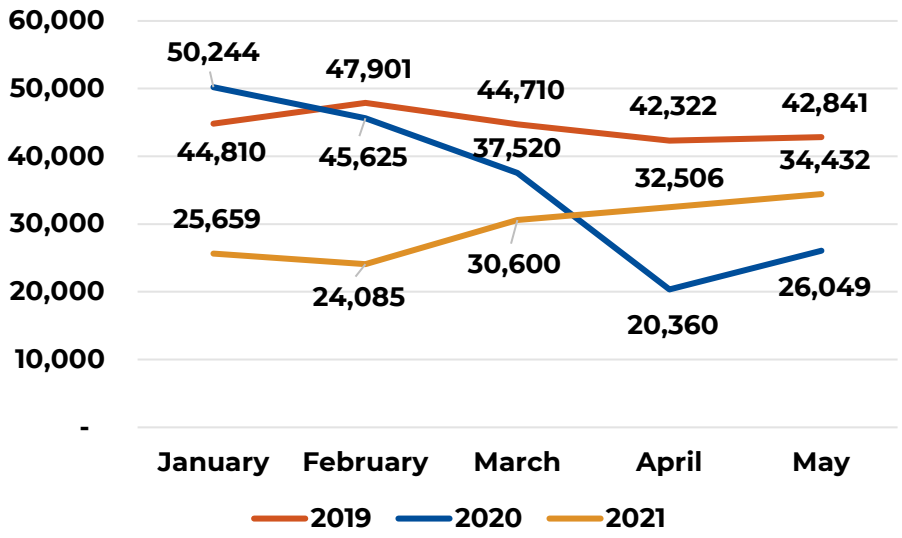


Month	2019	2020	2021
January	101.1%	110.1%	67.4%
February	97.4%	118.1%	74.5%
March	98.7%	90.0%	75.9%
April	102.0%	131.6%	69.7%
May	139.3%	80.2%	68.7%

2020 vs 2021	Count Change	Percent Change
January	-42.7%	-39%
February	-43.7%	-37%
March	-14.1%	-16%
April	-61.9%	-47%
May	-11.6%	-14%
2020 vs 2021 Quarterly Percent Change		-32%

Utilization

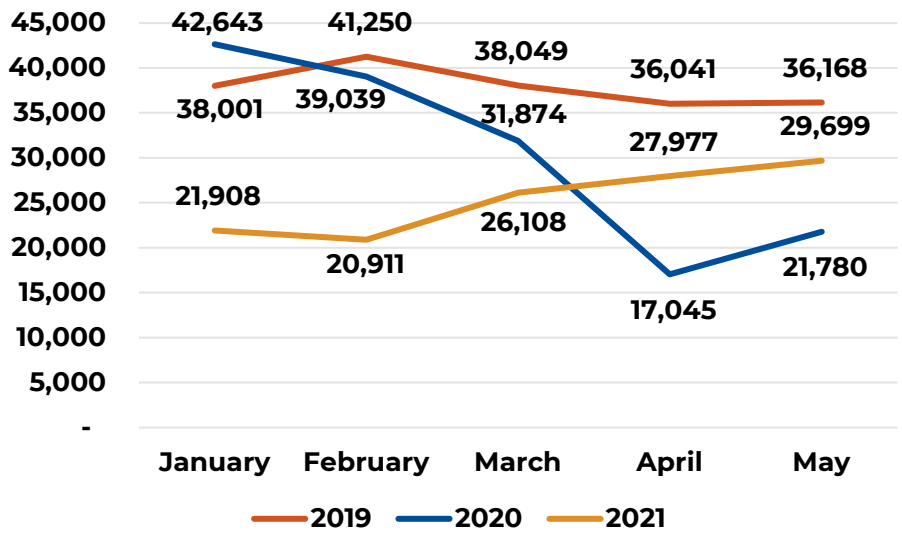
Emergency Department Visits (Claims)



Month	2019	2020	2021
January	44,810	50,244	25,659
February	47,901	45,625	24,085
March	44,710	37,520	30,600
April	42,322	20,360	32,506
May	42,841	26,049	34,432

2020 vs 2021	Count Change	Percent Change
January	(24,585)	-49%
February	(21,540)	-47%
March	(6,920)	-18%
April	12,146	60%
May	8,383	32%
2020 vs 2021 Quarterly Percent Change		-33%

Members Utilizing Emergency Department

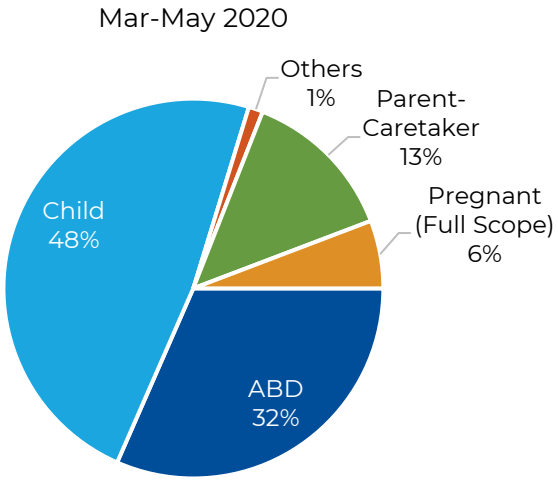


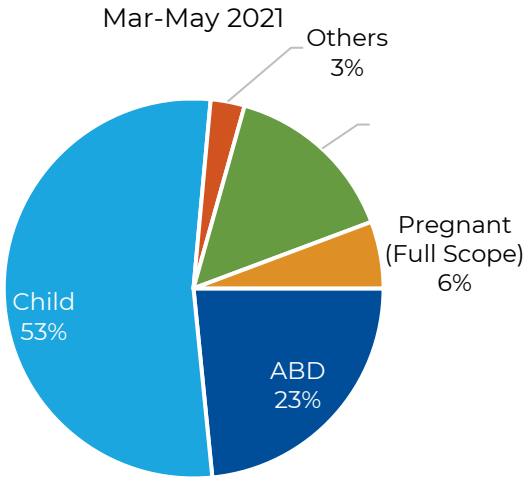
Month	2019	2020	2021
January	38,001	42,643	21,908
February	41,250	39,039	20,911
March	38,049	31,874	26,108
April	36,041	17,045	27,977
May	36,168	21,780	29,699

2020 vs 2021	Count Change	Percent Change
January	(20,735)	-49%
February	(18,128)	-46%
March	(5,766)	-18%
April	10,932	64%
May	7,919	36%
2020 vs 2021 Quarterly Percent Change		-32%

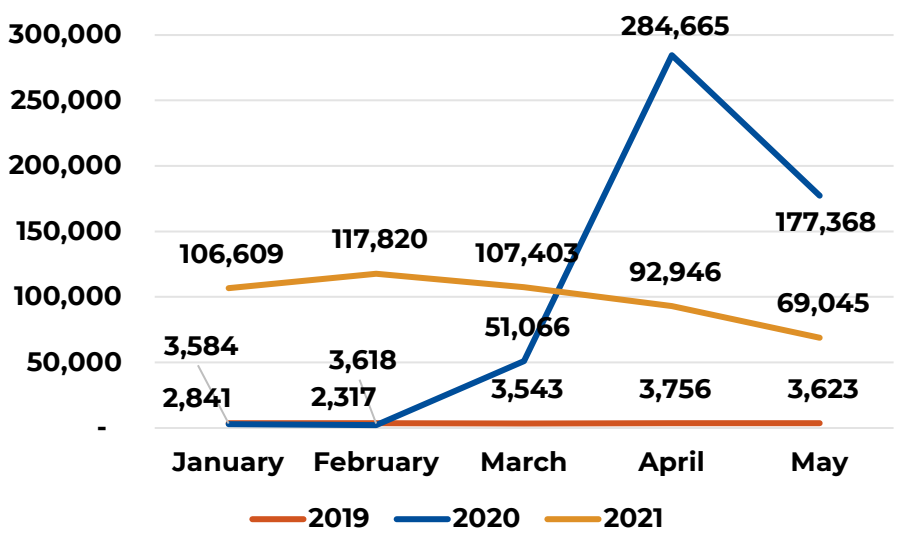
Utilization (Cont.)

Members Utilizing Emergency Department By Qualifying Group





Telemedicine - Total Visits

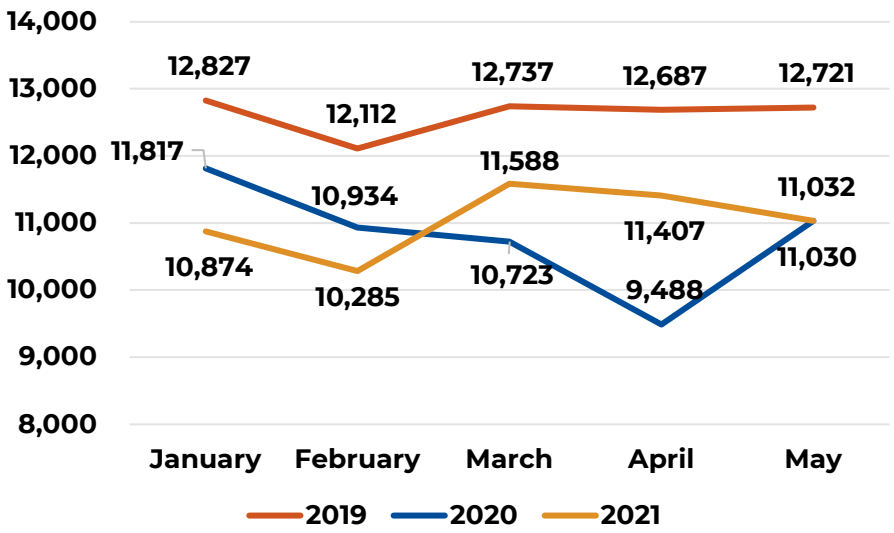


Month	2019	2020	2021
January	3,584	2,841	106,609
February	3,618	2,317	117,820
March	3,543	51,066	107,403
April	3,756	284,665	92,946
May	3,623	177,368	69,045

2020 vs 2021	Count Change	Percent Change
January	103,768	3653%
February	115,503	4985%
March	56,337	110%
April	(191,719)	-67%
May	(108,323)	-61%
2020 vs 2021 Quarterly Percent Change		490%

Utilization (Cont.)

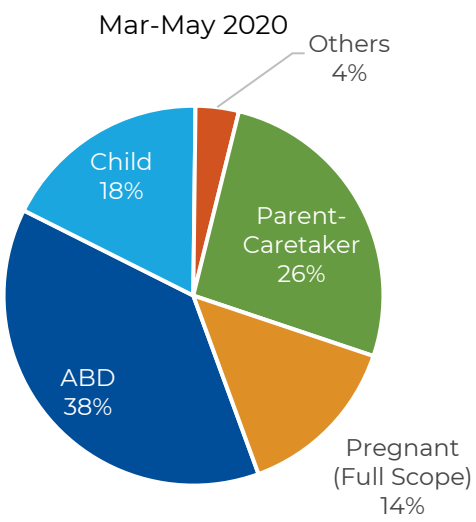
Members With Opioid Claims

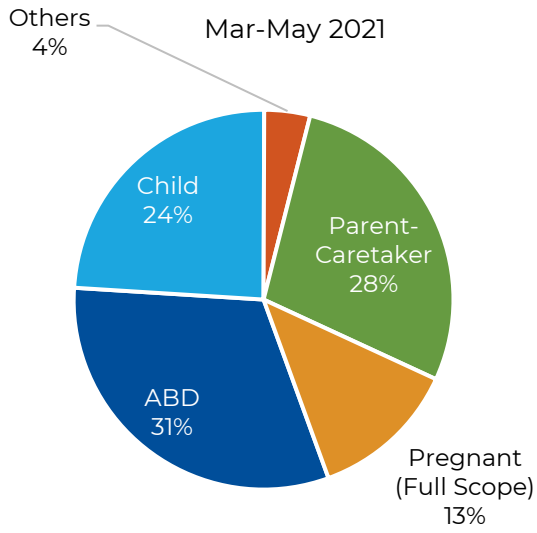


Month	2019	2020	2021
January	12,827	11,817	10,874
February	12,112	10,934	10,285
March	12,737	10,723	11,588
April	12,687	9,488	11,407
May	12,721	11,032	11,030

2020 vs 2021	Count Change	Percent Change
January	(943)	-8%
February	(649)	-6%
March	865	8%
April	1,919	20%
May	(2)	0%
2020 vs 2021 Quarterly Percent Change		0%

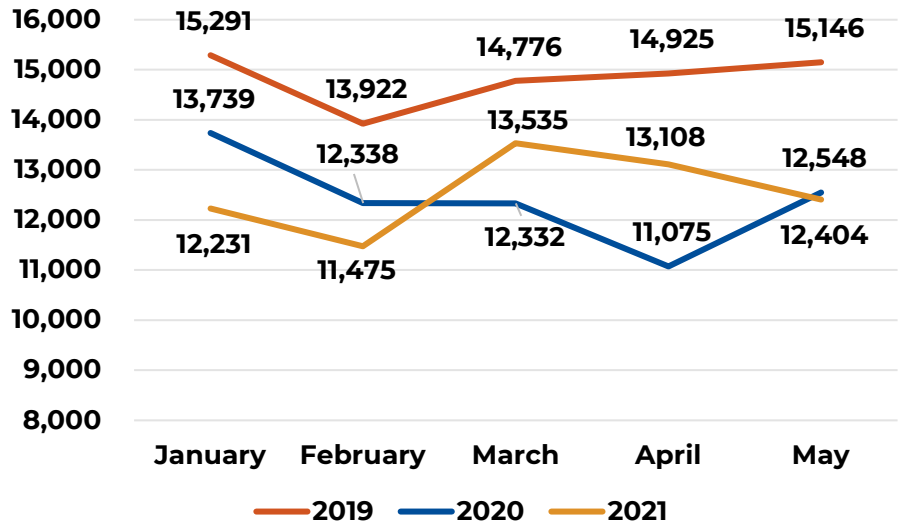
Members With Opioid Claims By Qualifying Group





Utilization (Cont.)

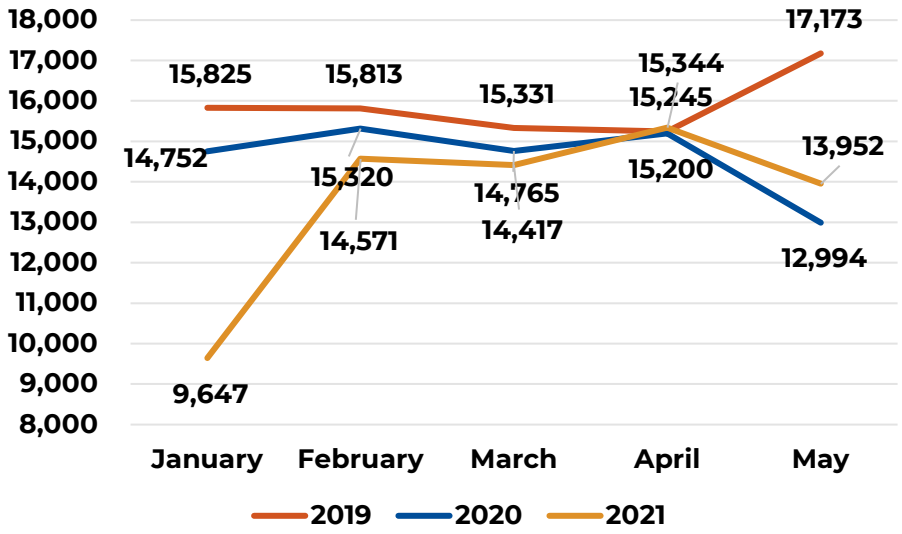
Total Opioid Claims



Month	2019	2020	2021
January	15,291	13,739	12,231
February	13,922	12,338	11,475
March	14,776	12,332	13,535
April	14,925	11,075	13,108
May	15,146	12,548	12,404

2020 vs 2021	Count Change	Percent Change
January	(1,508)	-11%
February	(863)	-7%
March	1,203	10%
April	2,033	18%
May	(144)	-1%
2020 vs 2021 Quarterly Percent Change		-3%

Out of State Services - Total Members Utilization



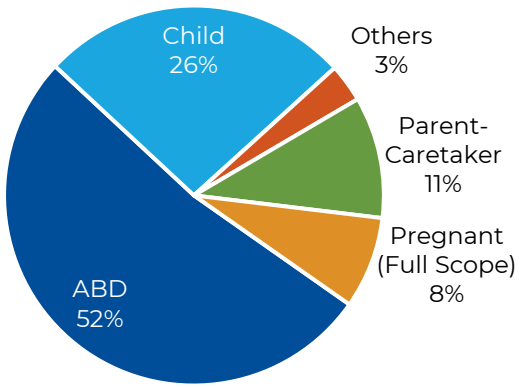
Month	2019	2020	2021
January	15,825	14,752	9,647
February	15,813	15,320	14,571
March	15,331	14,765	14,417
April	15,245	15,200	15,344
May	17,173	12,994	13,952

2020 vs 2021	Count Change	Percent Change
January	(5,105)	-35%
February	(749)	-5%
March	(348)	-2%
April	144	1%
May	958	7%
2020 vs 2021 Quarterly Percent Change		-4%

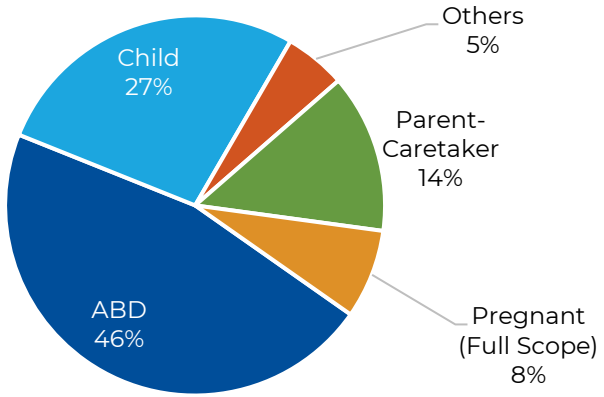
Utilization (Cont.)

Out of State Services - Total Members Utilization By Qualifying Group

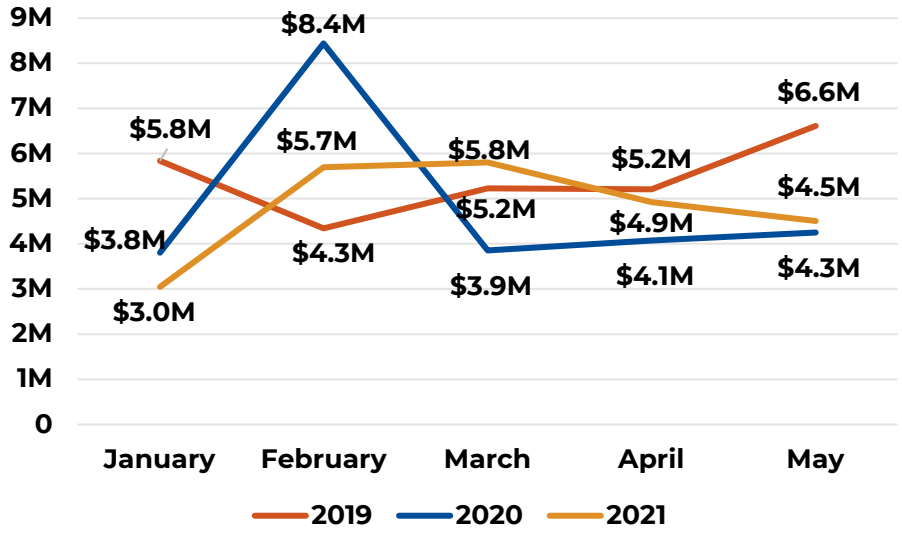
Mar-May 2020



Mar-May 2021



Out of State Services - Total Reimbursements

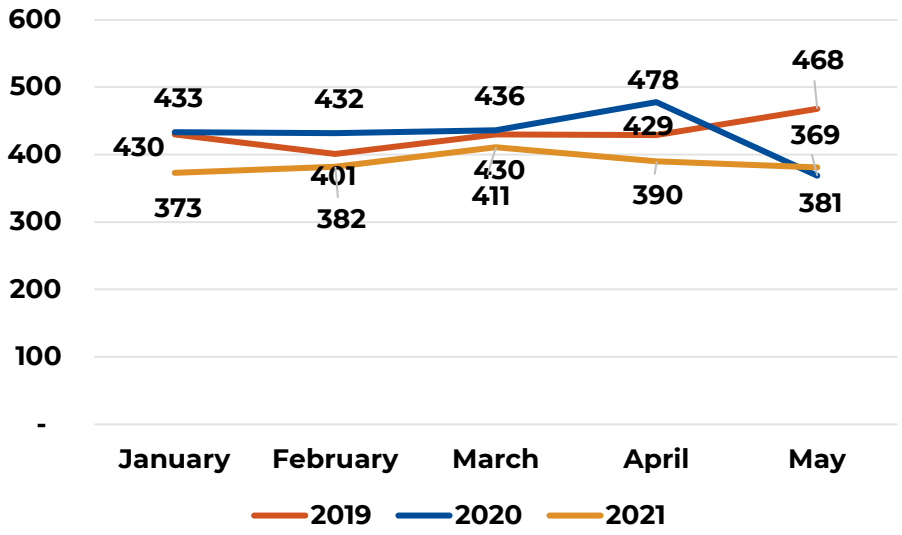


Month	2019	2020	2021
January	$ 5,838,372	$ 3,804,814	$ 3,049,273
February	$ 4,341,786	$ 8,437,822	$ 5,691,778
March	$ 5,230,885	$ 3,853,277	$ 5,807,546
April	$ 5,206,990	$ 4,074,387	$ 4,923,646
May	$ 6,608,751	$ 4,251,862	$ 4,505,079

2020 vs 2021	Count Change	Percent Change
January	$ (755,541)	-20%
February	$ (2,746,044)	-33%
March	$ 1,954,269	51%
April	$ 849,259	21%
May	$ 253,216	6%
2020 vs 2021 Quarterly Percent Change		-10%

Utilization (Cont.)

Out of State Services - Total Active Billing Providers

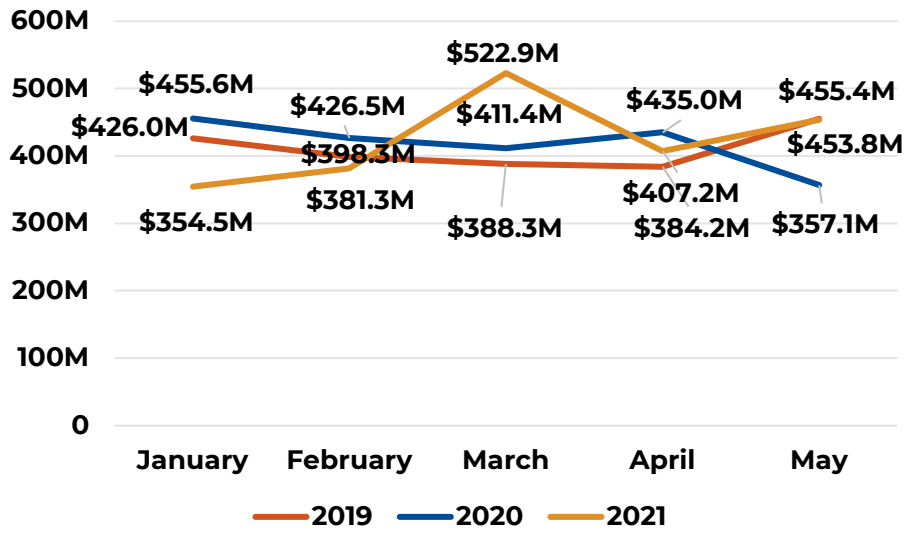


Month	2019	2020	2021
January	430	433	373
February	401	432	382
March	430	436	411
April	429	478	390
May	468	369	381

2020 vs 2021	Count Change	Percent Change
January	(60)	-14%
February	(50)	-12%
March	(25)	-6%
April	(88)	-18%
May	12	3%
2020 vs 2021 Quarterly Percent Change		-11%

Financials

Total Agency Expenditures



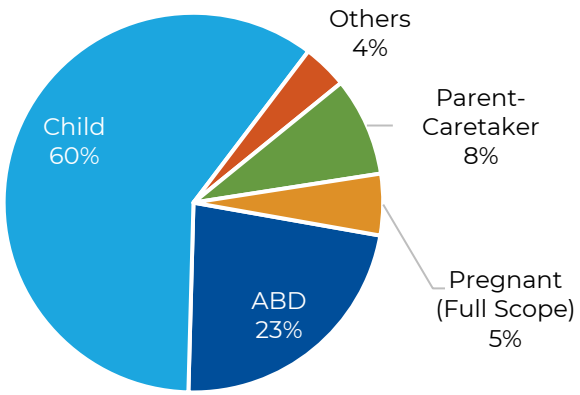
Month	2019	2020	2021
January	$ 426,025,348	$ 455,594,158	$ 354,546,361
February	$ 398,336,677	$ 426,542,165	$ 381,265,704
March	$ 388,325,215	$ 411,416,450	$ 522,868,024
April	$ 384,174,930	$ 434,968,933	$ 407,195,397
May	$ 455,407,541	$ 357,124,655	$ 453,764,121

2020 vs 2021	Count Change	Percent Change
January	$ (101,047,797)	-22%
February	$ (45,276,462)	-11%
March	$ 111,451,574	27%
April	$ (27,773,536)	-6%
May	$ 96,639,467	27%
2020 vs 2021 Quarterly Percent Change		-3%

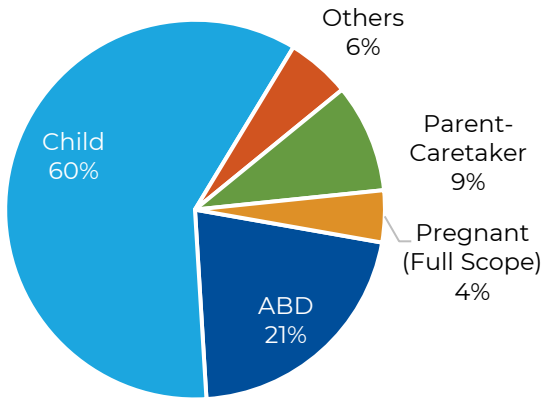
Financials (Cont.)

Total Agency Members Utilization by Qualifying Group

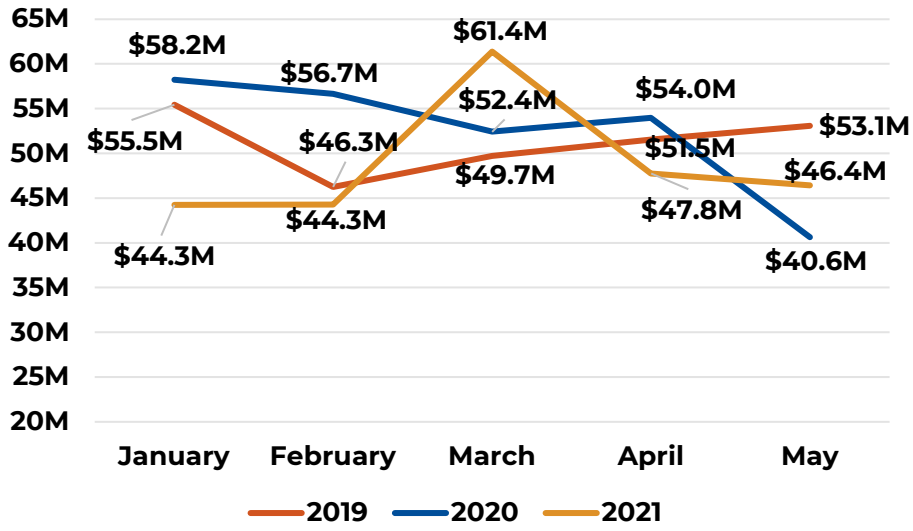
Mar-May 2020



Mar-May 2021



Inpatient Services Expenditures



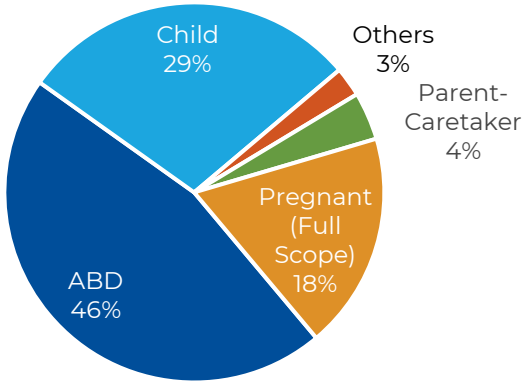
Month	2019	2020	2021
January	$ 55,458,625	$ 58,227,191	$ 44,269,268
February	$ 46,272,661	$ 56,664,871	$ 44,290,006
March	$ 49,704,163	$ 52,426,571	$ 61,385,227
April	$ 51,542,642	$ 53,951,562	$ 47,756,598
May	$ 53,089,188	$ 40,642,828	$ 46,437,959

2020 vs 2021	Count Change	Percent Change
January	$ (13,957,923)	-24%
February	$ (12,374,864)	-22%
March	$ 8,958,656	17%
April	$ (6,194,965)	-11%
May	$ 5,795,132	14%
2020 vs 2021 Quarterly Percent Change		-10%

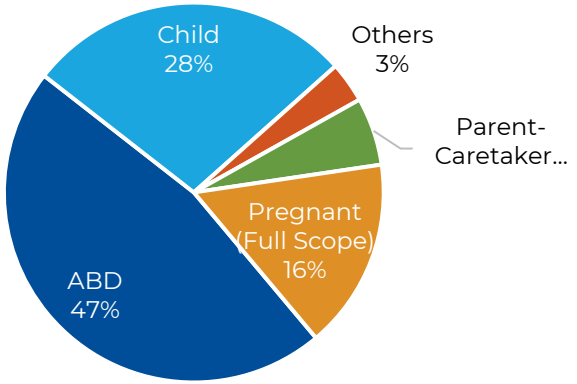
Financials (Cont.)

Inpatient Services Members Utilization by Qualifying Group

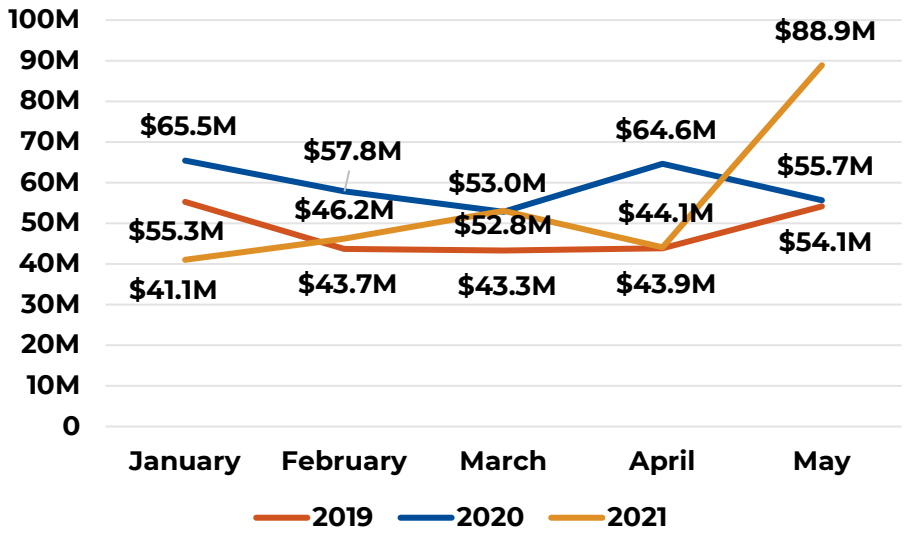
Mar-May 2020



Mar-May 2021



Nursing Facility Expenditures

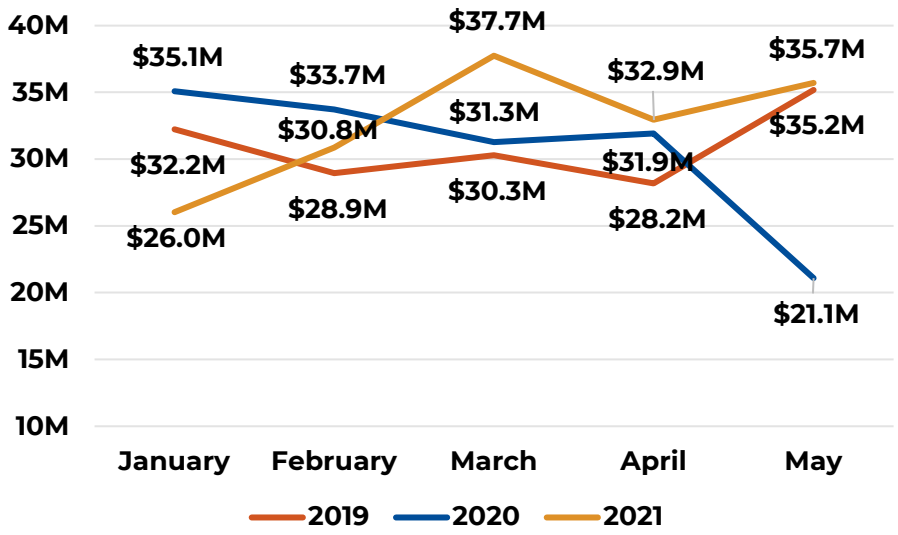


Month	2019	2020	2021
January	$ 55,285,146	$ 65,465,203	$ 41,055,316
February	$ 43,693,332	$ 57,845,196	$ 46,188,590
March	$ 43,333,499	$ 52,810,168	$ 53,021,984
April	$ 43,867,098	$ 64,610,372	$ 44,086,534
May	$ 54,132,066	$ 55,665,067	$ 88,911,385

2020 vs 2021	Count Change	Percent Change
January	$ (24,409,888)	-37%
February	$ (11,656,606)	-20%
March	$ 211,817	0%
April	$ (20,523,838)	-32%
May	$ 33,246,318	60%
2020 vs 2021 Quarterly Percent Change		-20%

Financials (Cont.)

Outpatient Hospital Expenditures

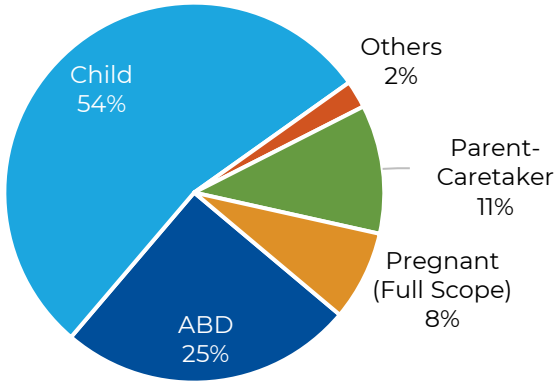


Month	2019	2020	2021
January	$ 32,215,109	$ 35,082,437	$ 26,039,481
February	$ 28,939,776	$ 33,721,724	$ 30,849,240
March	$ 30,289,620	$ 31,274,134	$ 37,748,900
April	$ 28,200,811	$ 31,924,209	$ 32,933,681
May	$ 35,193,551	$ 21,110,975	$ 35,703,013

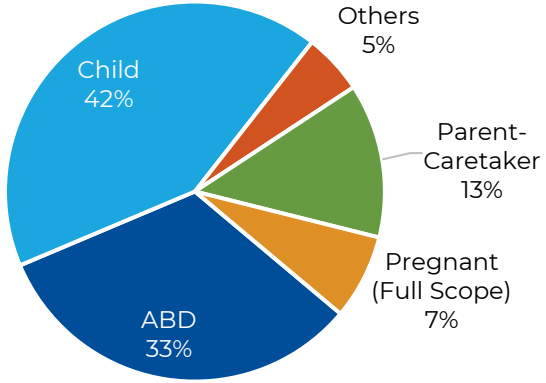
2020 vs 2021	Count Change	Percent Change
January	$ (9,042,956)	-26%
February	$ (2,872,483)	-9%
March	$ 6,474,766	21%
April	$ 1,009,472	3%
May	$ 14,592,039	69%
2020 vs 2021 Quarterly Percent Change		-5%

Outpatient Hospital Members Utilization by Qualifying Group

Mar-May 2020

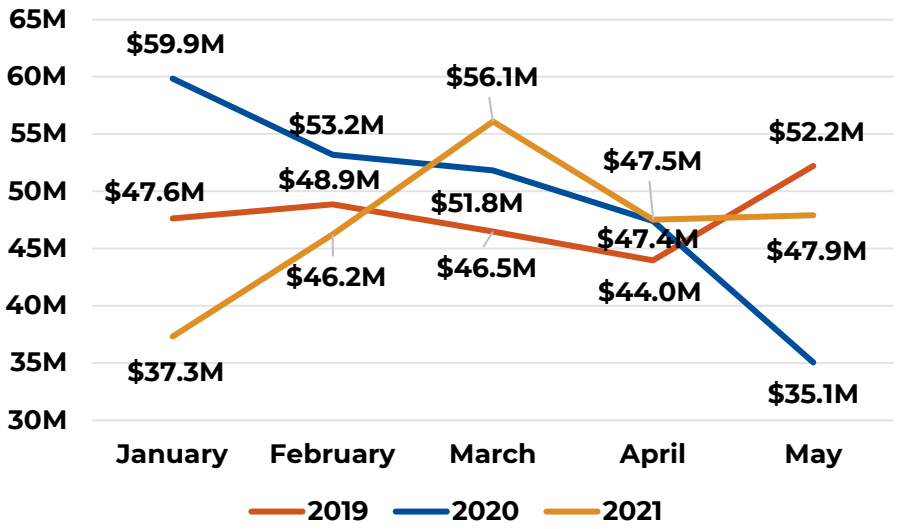


Mar-May 2021



Financials (Cont.)

Physician Expenditures

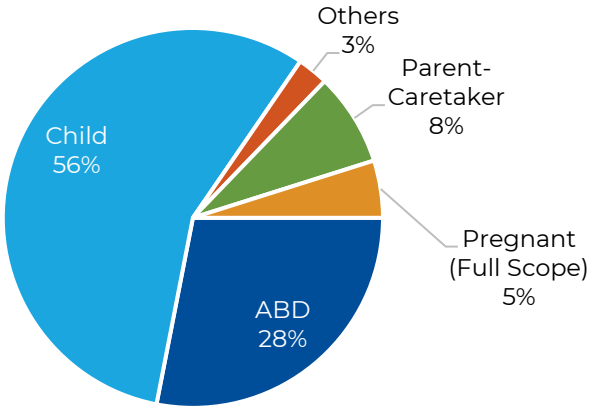


Month	2019	2020	2021
January	$ 47,644,391	$ 59,862,834	$ 37,341,844
February	$ 48,864,939	$ 53,201,300	$ 46,246,182
March	$ 46,493,650	$ 51,822,915	$ 56,109,374
April	$ 43,981,551	$ 47,417,026	$ 47,513,603
May	$ 52,228,371	$ 35,058,620	$ 47,922,548

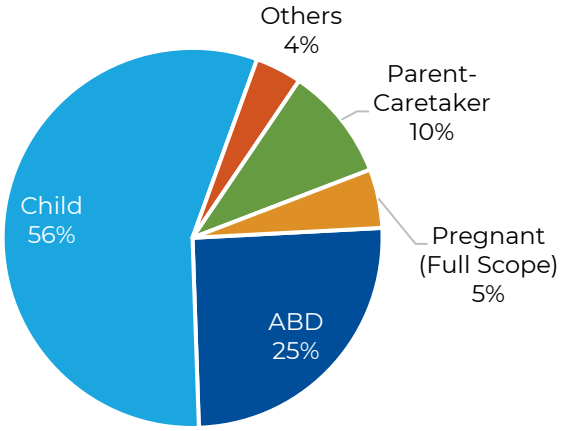
2020 vs 2021	Count Change	Percent Change
January	$ (22,520,991)	-38%
February	$ (6,955,118)	-13%
March	$ 4,286,460	8%
April	$ 96,577	0%
May	$ 12,863,927	37%
2020 vs 2021 Quarterly Percent Change		-15%

Physician Members Utilization By Qualifying Group

Mar-May 2020

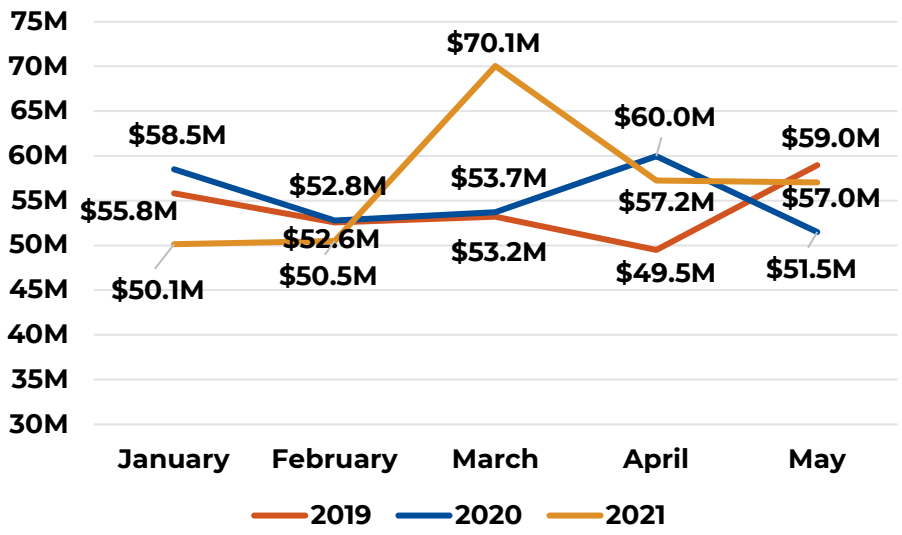


Mar-May 2021



Financials (Cont.)

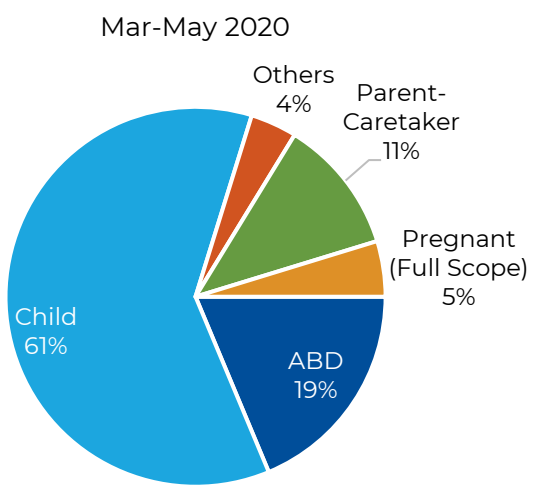
Prescribed Drugs Expenditures

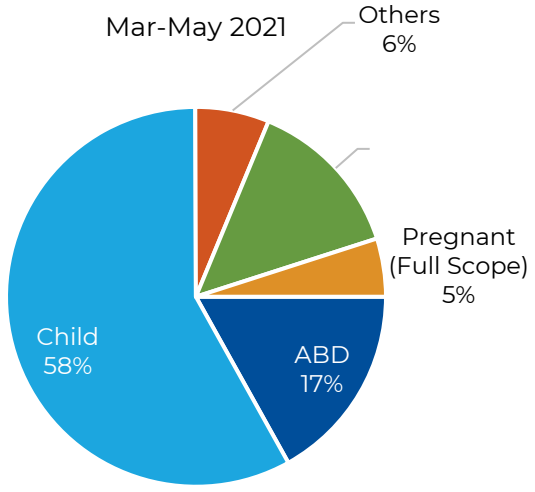


Month	2019	2020	2021
January	$ 55,807,771	$ 58,488,543	$ 50,128,033
February	$ 52,550,598	$ 52,789,059	$ 50,496,271
March	$ 53,196,254	$ 53,694,648	$ 70,073,218
April	$ 49,506,060	$ 59,970,376	$ 57,233,226
May	$ 58,971,481	$ 51,495,583	$ 57,016,313

2020 vs 2021	Count Change	Percent Change
January	$ (8,360,510)	-14%
February	$ (2,292,788)	-4%
March	$ 16,378,570	31%
April	$ (2,737,150)	-5%
May	$ 5,520,730	11%
2020 vs 2021 Quarterly Percent Change		3%

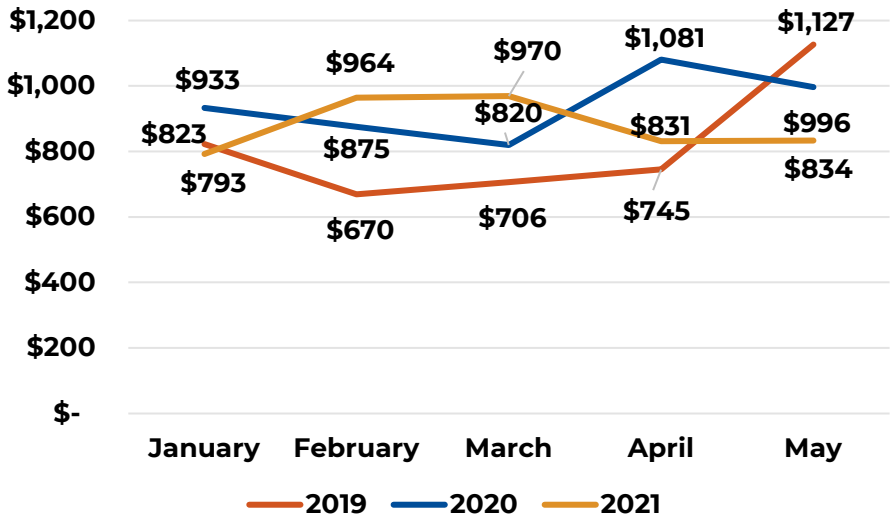
Prescribed Drugs Members Utilization By Qualifying Group





Financials (Cont.)

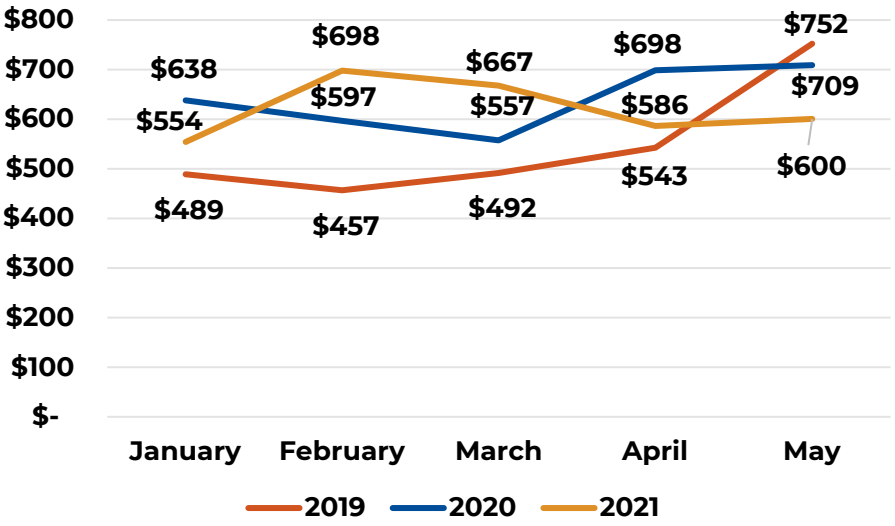
Average Per Total Member Served



Month	2019	2020	2021
January	$ 823	$ 933	$ 793
February	$ 670	$ 875	$ 964
March	$ 706	$ 820	$ 970
April	$ 745	$ 1,081	$ 831
May	$ 1,127	$ 996	$ 834

2020 vs 2021	Count Change	Percent Change
January	$ (140)	-15%
February	$ 89	10%
March	$ 150	18%
April	$ (249)	-23%
May	$ (162)	-16%
2020 vs 2021 Quarterly Percent Change		0%

Average Per Child (Under 21) Member Served

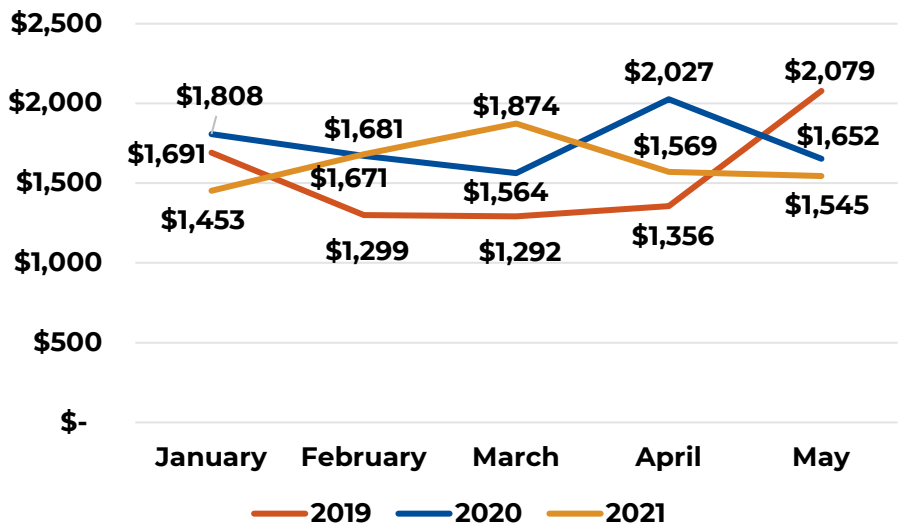


Month	2019	2020	2021
January	$ 489	$ 638	$ 554
February	$ 457	$ 597	$ 698
March	$ 492	$ 557	$ 667
April	$ 543	$ 698	$ 586
May	$ 752	$ 709	$ 600

2020 vs 2021	Count Change	Percent Change
January	$ (83)	-13%
February	$ 102	17%
March	$ 110	20%
April	$ (112)	-16%
May	$ (109)	-15%
2020 vs 2021 Quarterly Percent Change		1%

Financials (Cont.)

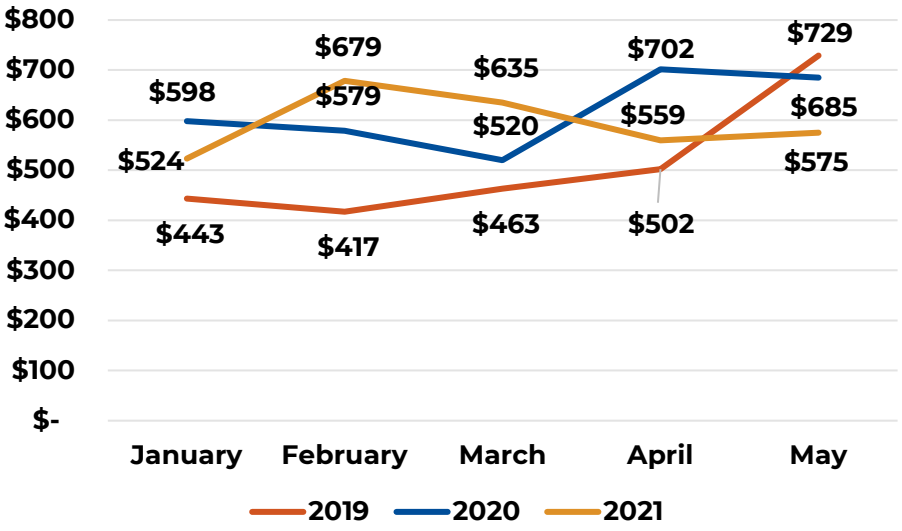
Average Per Aged/Blind/Disabled Member Served



Month	2019	2020	2021
January	$ 1,691	$ 1,808	$ 1,453
February	$ 1,299	$ 1,671	$ 1,681
March	$ 1,292	$ 1,564	$ 1,874
April	$ 1,356	$ 2,027	$ 1,569
May	$ 2,079	$ 1,652	$ 1,545

2020 vs 2021	Count Change	Percent Change
January	$ (355)	-20%
February	$ 11	1%
March	$ 311	20%
April	$ (457)	-23%
May	$ (108)	-7%
2020 vs 2021 Quarterly Percent Change		-2%

Average Per Children & Parent/Caretaker Member Served

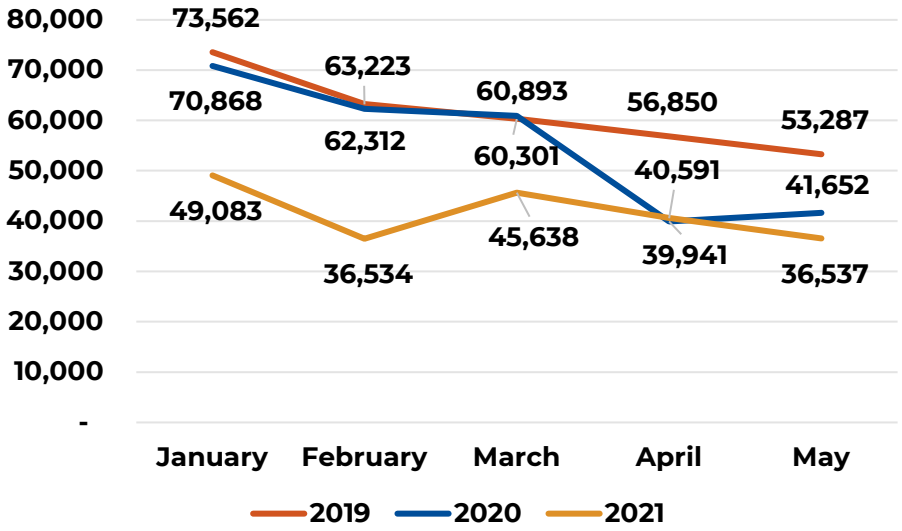


Month	2019	2020	2021
January	$ 443	$ 598	$ 524
February	$ 417	$ 579	$ 679
March	$ 463	$ 520	$ 635
April	$ 502	$ 702	$ 559
May	$ 729	$ 685	$ 575

2020 vs 2021	Count Change	Percent Change
January	$ (74)	-12%
February	$ 100	17%
March	$ 115	22%
April	$ (142)	-20%
May	$ (110)	-16%
2020 vs 2021 Quarterly Percent Change		3%

Call Center

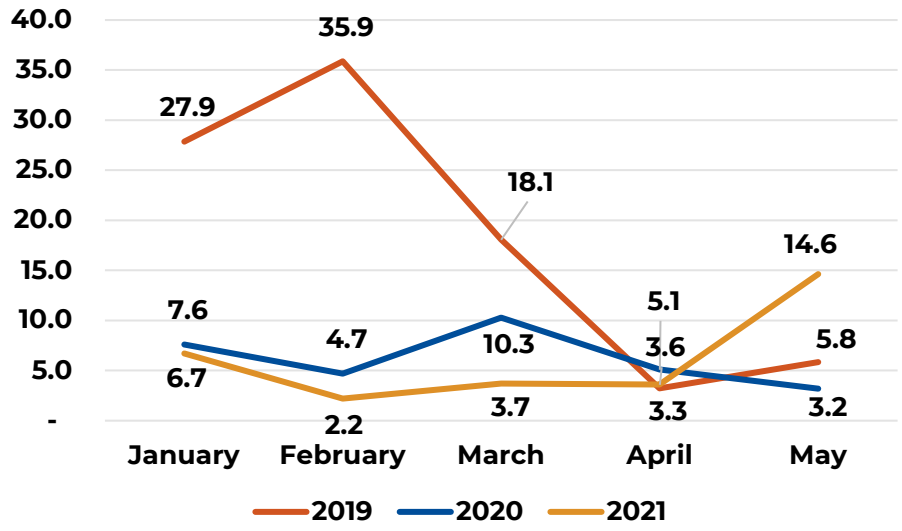
Call Center - Member Calls Answered



Month	2019	2020	2021
January	73,562	70,868	49,083
February	63,223	62,312	36,534
March	60,301	60,893	45,638
April	56,850	39,941	40,591
May	53,287	41,652	36,537

2020 vs 2021	Count Change	Percent Change
January	(21,785)	-31%
February	(25,778)	-41%
March	(15,255)	-25%
April	650	2%
May	(5,115)	-12%
2020 vs 2021 Quarterly Percent Change		-32%

Call Center - Average Wait Time (In Seconds)

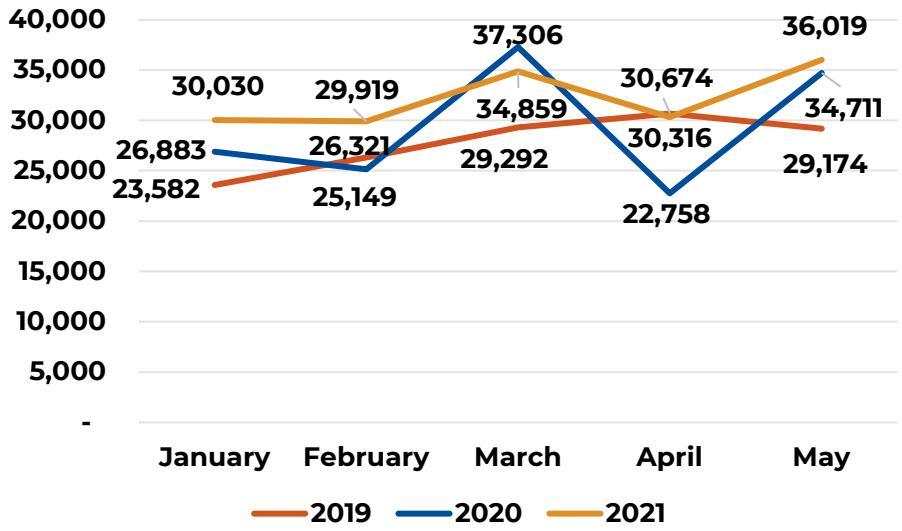


Month	2019	2020	2021
January	27.9	7.6	6.7
February	35.9	4.7	2.2
March	18.1	10.3	3.7
April	3.3	5.1	3.6
May	5.8	3.2	14.6

2020 vs 2021	Count Change	Percent Change
January	(0.9)	-12%
February	(2.5)	-53%
March	(6.6)	-64%
April	(1.5)	-29%
May	11.4	357%
2020 vs 2021 Quarterly Percent Change		N/A

Prior Authorization

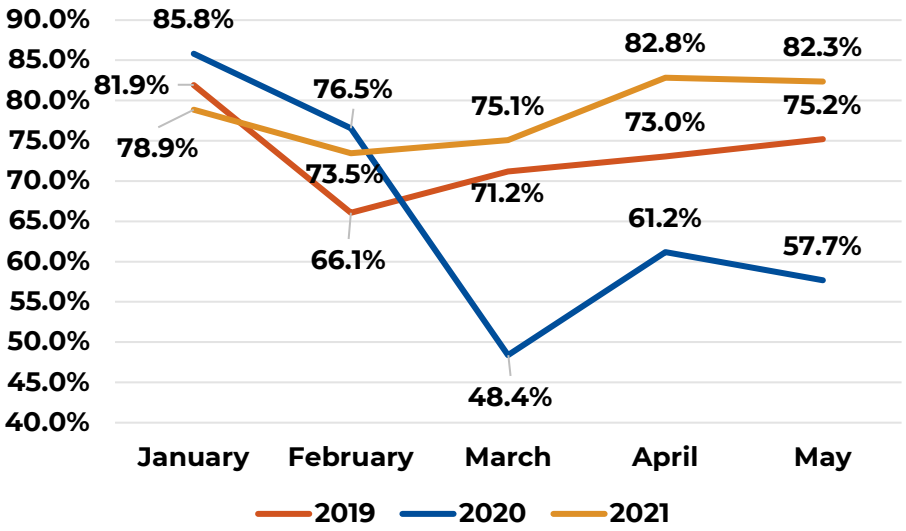
Prior Authorization - Total Combined - Total Completed PA Volume



Month	2019	2020	2021
January	23,582	26,883	30,030
February	26,321	25,149	29,919
March	29,292	37,306	34,859
April	30,674	22,758	30,316
May	29,174	34,711	36,019

2020 vs 2021	Count Change	Percent Change
January	3,147	12%
February	4,770	19%
March	(2,447)	-7%
April	7,558	33%
May	1,308	4%
2020 vs 2021 Quarterly Percent Change		6%

Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

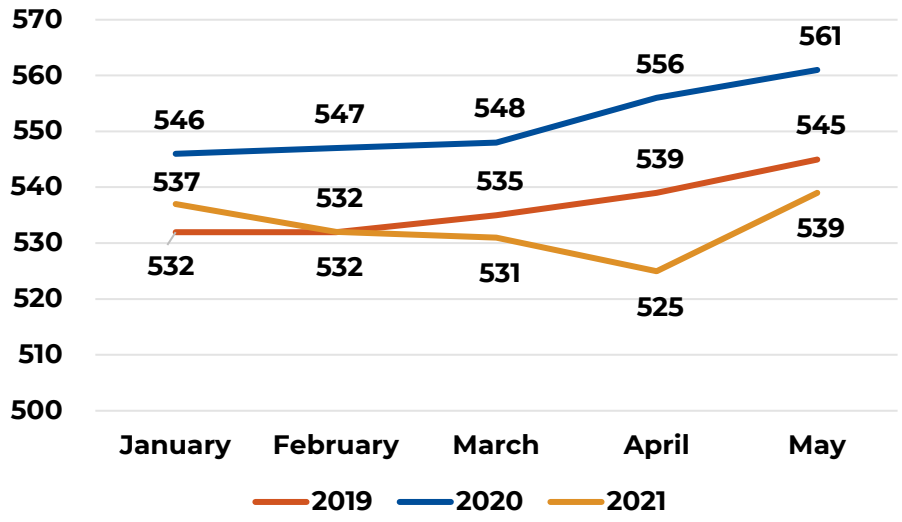


Month	2019	2020	2021
January	81.9%	85.8%	78.9%
February	66.1%	76.5%	73.5%
March	71.2%	48.4%	75.1%
April	73.0%	61.2%	82.8%
May	75.2%	57.7%	82.3%

2020 vs 2021	Count Change	Percent Change
January	-7.0%	-8%
February	-3.1%	-4%
March	26.7%	55%
April	21.6%	35%
May	24.7%	43%
2020 vs 2021 Quarterly Percent Change		15%

Agency Stats & Provider Network

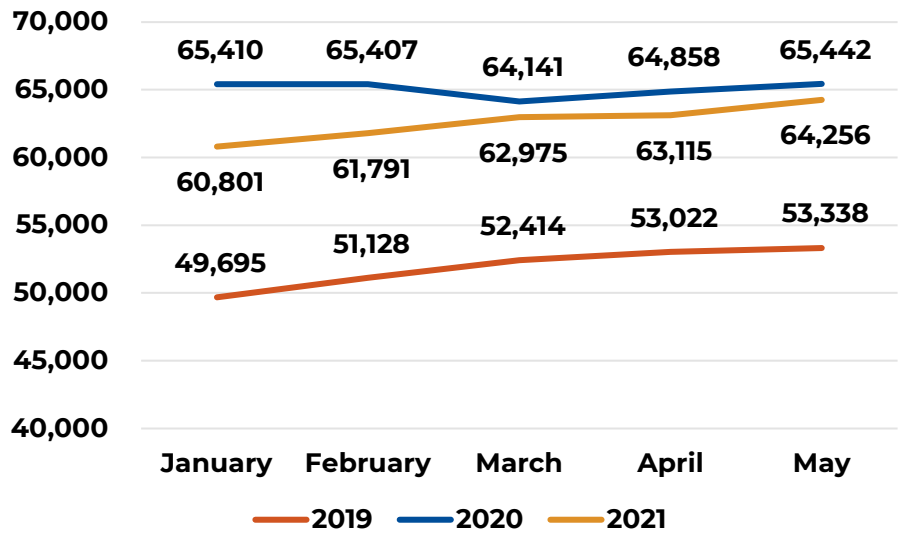
OHCA Admin - Number of FTEs



Month	2019	2020	2021
January	532	546	537
February	532	547	532
March	535	548	531
April	539	556	525
May	545	561	539

2020 vs 2021	Count Change	Percent Change
January	(9)	-2%
February	(15)	-3%
March	(17)	-3%
April	(31)	-5.6%
May	(22)	-4%
2020 vs 2021 Quarterly Percent Change		N/A

Total Providers

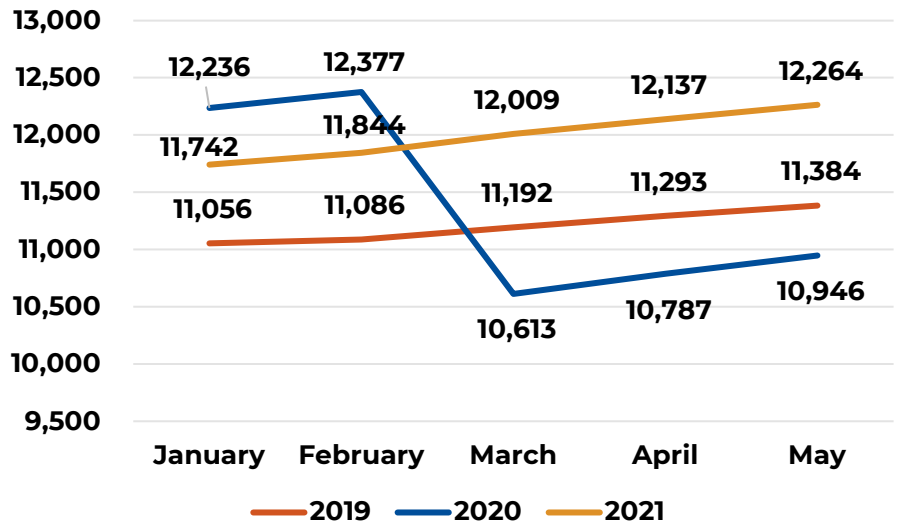


Month	2019	2020	2021
January	49,695	65,410	60,801
February	51,128	65,407	61,791
March	52,414	64,141	62,975
April	53,022	64,858	63,115
May	53,338	65,442	64,256

2020 vs 2021	Count Change	Percent Change
January	(4,609)	-7%
February	(3,616)	-6%
March	(1,166)	-2%
April	(1,743)	-3%
May	(1,186)	-2%
2020 vs 2021 Quarterly Percent Change		-5%

Agency Stats & Provider Network (Cont.)

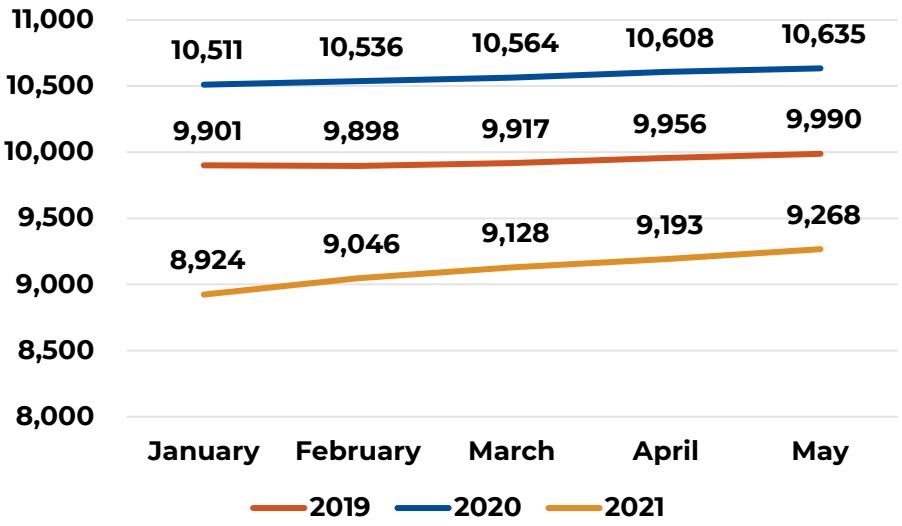
Mental Health Providers (In-State Only)



Month	2019	2020	2021
January	11,056	12,236	11,742
February	11,086	12,377	11,844
March	11,192	10,613	12,009
April	11,293	10,787	12,137
May	11,384	10,946	12,264

2020 vs 2021	Count Change	Percent Change
January	(494)	-4%
February	(533)	-4%
March	1,396	13%
April	1,350	13%
May	1,318	12%
2020 vs 2021 Quarterly Percent Change		-4%

Physicians (In-State Only)

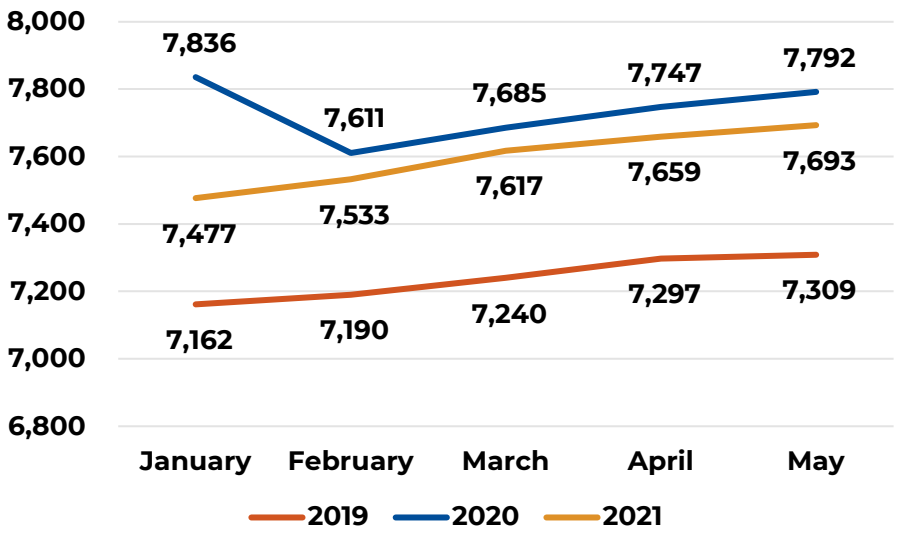


Month	2019	2020	2021
January	9,901	10,511	8,924
February	9,898	10,536	9,046
March	9,917	10,564	9,128
April	9,956	10,608	9,193
May	9,990	10,635	9,268

2020 vs 2021	Count Change	Percent Change
January	(1,587)	-15%
February	(1,490)	-14%
March	(1,436)	-14%
April	(1,415)	-13%
May	(1,367)	-13%
2020 vs 2021 Quarterly Percent Change		-14%

Agency Stats & Provider Network (Cont.)

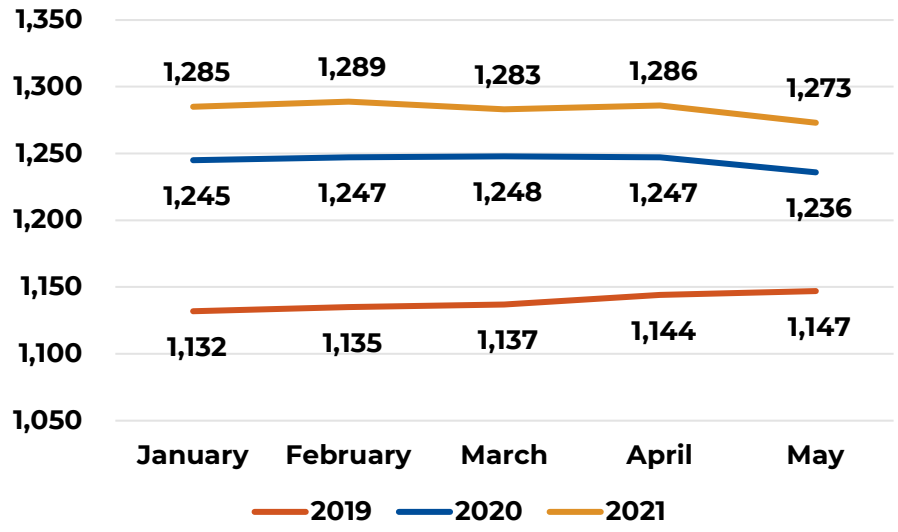
Primary Care Providers (In-State Only)



Month	2019	2020	2021
January	7,162	7,836	7,477
February	7,190	7,611	7,533
March	7,240	7,685	7,617
April	7,297	7,747	7,659
May	7,309	7,792	7,693

	2020 vs 2021 Count Change	Percent Change
January	(359)	-5%
February	(78)	-1%
March	(68)	-1%
April	(88)	-1%
May	(99)	-1%
2020 vs 2021 Quarterly Percent Change		-4%

Dentists (In-State Only)

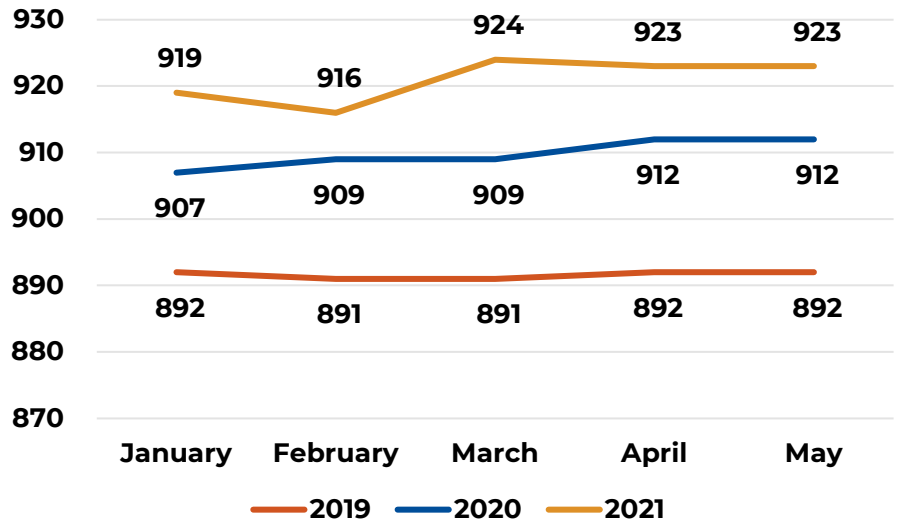


Month	2019	2020	2021
January	1,132	1,245	1,285
February	1,135	1,247	1,289
March	1,137	1,248	1,283
April	1,144	1,247	1,286
May	1,147	1,236	1,273

	2020 vs 2021 Count Change	Percent Change
January	40	3%
February	42	3%
March	35	3%
April	39	3%
May	37	3%
2020 vs 2021 Quarterly Percent Change		4%

Agency Stats & Provider Network (Cont.)

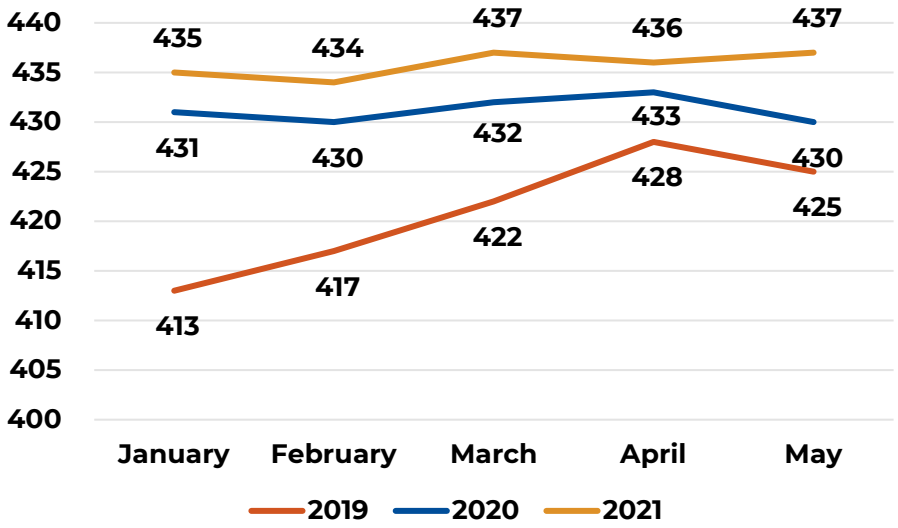
Pharmacy (In-State Only)



Month	2019	2020	2021
January	892	907	919
February	891	909	916
March	891	909	924
April	892	912	923
May	892	912	923

	2020 vs 2021 Count Change	Percent Change
January	12	1%
February	7	1%
March	15	2%
April	11	1%
May	11	1%
2020 vs 2021 Quarterly Percent Change		2%

Extended Care Facilities (In-State Only)

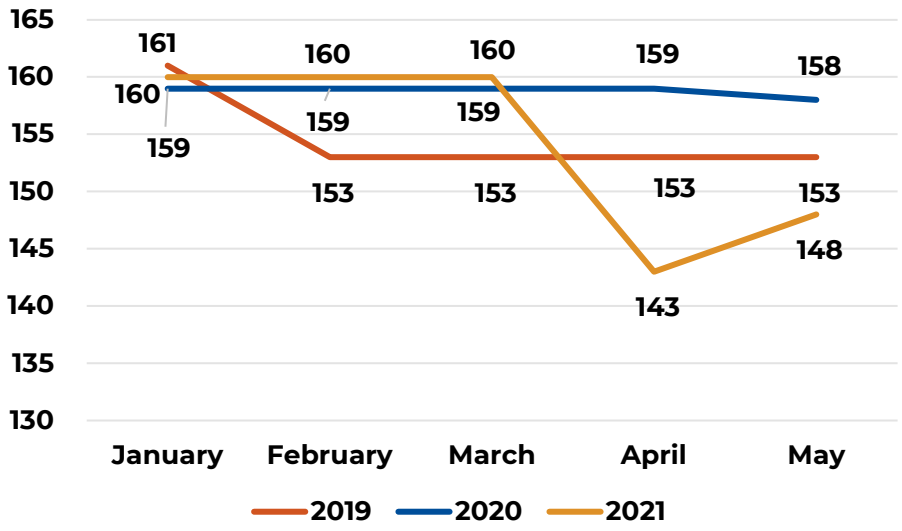


Month	2019	2020	2021
January	413	431	435
February	417	430	434
March	422	432	437
April	428	433	436
May	425	430	437

	2020 vs 2021 Count Change	Percent Change
January	4	1%
February	4	1%
March	5	1%
April	3	1%
May	7	2%
2020 vs 2021 Quarterly Percent Change		1%

Agency Stats & Provider Network (Cont.)

Hospitals (In-State Only)



Month	2019	2020	2021
January	161	159	160
February	153	159	160
March	153	159	160
April	153	159	143
May	153	158	148

2020 vs 2021	Count Change	Percent Change
January	1	1%
February	1	1%
March	1	1%
April	(16)	-10%
May	(10)	-6%
2020 vs 2021 Quarterly Percent Change		1%