2.1 Health Services Initiatives - Describe if the State will use the health services initiative option as allowed at 42 CFR 457.10. If so, describe what services or programs the State is proposing to cover with administrative funds, including the cost of each program, and how it is currently funded (if applicable), also update the budget accordingly. **(Section 2105(a)(1)(D)(ii)); (42 CFR 457.10)**

Health Service Initiative Request #1:

The Long Acting Reversible Contraceptive (LARC) devices Health Service Initiative (HSI) will address a state-wide effort to promote education to the 18 and younger targeted age group. The initiative will align strategies across agencies as well as private and public payers in order to promote efficient utilization. This effort will increase the target population's access and utilization of LARC devices leading to a decrease in unwanted pregnancies as well as decrease costs to the Medicaid program. The estimated total budget impact for FFY 2016 for this program is $30,000; the federal share for FFY 16 is $28,707 and state share is $1,293. The estimated total budget impact for FFY 2017 for this program is $120,000; the federal share for FFY 17 is $113,952 and the state share is $6,048. The budget has been updated accordingly. This strategy will be part of a larger project already underway and funded by Tulsa Community Foundation and the OHCA; however, the specific strategy mentioned herein is not currently funded.

Health Service Initiative Request #2:

The Long Acting Reversible Contraceptive (LARC) devices Health Service Initiative (HSI) will formulate a concerted effort to address the problem of unwanted pregnancy and promote LARC devices. The State proposes to spearhead a state-wide effort to promote provider education and training regarding LARC devices and align strategies across agencies as well as private and public payers in order to support efficient utilization. The State will contract with an entity to provide training and education for other payers, medical schools, health departments, and stakeholders in order to increase availability and usage of LARC devices while decreasing the barriers of LARC device usage in female Oklahomans under the age of 19. The estimated total budget impact for FFY 2016 for this program is $400,000; the federal share for FFY 16 is $382,760 and the state share is $17,240. The estimated total budget impact for FFY 2017 for this program is $1,600,000; the federal share for FFY 17 is $1,519,360 and the state share is $80,640. The budget has been updated accordingly. This strategy is new and it is not currently funded.

Health Service Initiative Request #3:

Oklahoma leads the nation in non-medical use of prescription painkillers, with more than 8% of the population aged 12 and older abusing/misusing painkillers. It is also one of the leading states in prescription painkiller sales per capita. Both behaviors have resulted in a large number of hospitalizations and overdose deaths among the States' residents. An increasingly popular medication that can prevent the hospitalizations and deaths is Naloxone, which reverses the effects of an opioid overdose and is completely

safe to use. However, the State does not currently have a comprehensive, centralized overdose prevention program to pay for and distribute it. The State has identified 13 high-risk, high-need counties where Naloxone rescue kits will be distributed to at-risk individuals 19 years of age and younger. The rescue kits will be distributed by Comprehensive Community Addiction Recovery Centers (CCARCs) and Opioid Treatment Programs (OTPs) within the identified communities. These two entities will contract with the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) which will provide the funding and training. Monitoring will be provided jointly by the Oklahoma Health Care Authority and ODMHSAS. The estimated total budget impact for FFY 2016 for this program is $294,900; the federal share FFY 16 is $282,190 and the state share is $12,710. The estimated total budget impact for FFY 2017 for this program is $730,700; the federal share for FFY 17 is $693,873 and the state share is $36,827. The budget has been updated accordingly. This strategy is new and it is not currently funded.

Health Service Initiative Request #4:

The Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Human Services (OKDHS) would like to implement an informed and coordinated approach to ensuring quality of care for children in the foster care system that are prescribed psychotropic medications. The methods for achieving this include additional improvements to our current health portal, the creation of an advisory committee of community experts to identify best practices; identification of barriers and improving current data matching; and the development of training and outreach for foster parents, health care providers, and child welfare workers in order to improve services to all children in the foster care system under the age of 19. The estimated total budget impact for FFY 2016 for this program is $115,816; the federal share for FFY 16 is $110,824 and the state share is $4,992. The estimated total budget impact for FFY 2017 for this program is $463,258; the federal share for FFY 17 is $439,910 and the state share is $23,348. The budget has been updated accordingly. This strategy is new and it is not currently funded.

Health Service Initiative Request #5:

The State Medicaid agency is responsible for controlling costs of state purchased health care while assuring that standards of care are met as part of a progressive system. Combining standards of care with current evidence and presenting these in a nonbiased manner is known as Academic Detailing (AD). It is anticipated that the AD program will result in measurable cost savings to OHCA through improved prescribing according to existing evidence and a decrease in the number of prior authorizations submitted. Over the long term, it is expected that improved prescribing will result in improved patient outcome and decreased burden on the healthcare system. The 15-18 month pilot phase of the AD program will be a targeted intervention aimed at improving evidence-based prescribing of Attention Deficit Hyperactivity Disorder (ADHD) medications and atypical antipsychotic medications for Medicaid members under 18 years of age. Counties which have high utilization of the initial target medications will be selected for

the intervention. Prescribers within those counties will be chosen from non-specialists. A specially trained pharmacist will make an appointment with the selected prescriber to go over the guidelines for appropriate prescribing within the targeted therapeutic category and provide resources as needed. The estimated total budget impact for FFY 2016 for this program is $72,523; the federal share for FFY 16 is $69,397 and the state share is $3,126. The estimated total budget impact for FFY 2017 for this program is $290,090; the federal share for FFY 17 is $275,469 and the state share is $14,621. The budget has been updated accordingly. This strategy is new and it is not currently funded.

Health Service Initiative Request #6:

The Oklahoma Health Care Authority (OHCA) and the Oklahoma Department of Health (OSDH) would like to increase blood lead testing rates by educating providers and the public about the importance of the test through a statewide media campaign. Increasing parents' and providers' knowledge about blood lead issues raises the likelihood that the test will be completed. A contract with a marketing firm through an already approved OHCA vendor will conduct target market research, develop campaign materials, and purchase media buys to promote general awareness. In addition to those efforts, a focused educational campaign with providers will be conducted. A comprehensive media and promotional campaign targeting providers and the general public for increasing blood lead screening tests for children in Oklahoma will be designed and implemented. OHCA will work closely with the Oklahoma State Department of Health to develop materials to distribute to providers about the importance of performing blood lead screening tests on all children deemed high risk according to the screen. For the general campaign effort, materials will be developed to be used in a multitude of mediums that may include: television and radio ads, billboards, bus and bus bench ads, promotional items, electronic outreach, and more. The messaging will be strategically placed based on market research for the target audience and will focus on the importance of receiving a blood lead screen test. Additional educational supports may also be explored, such as updating website information on both OHCA and the Oklahoma State Department of Health site, as well as targeted provider outreach through phone calls and in person visits from the OHCA Provider Services unit.

Health Service Initiative Request #7:

In 2015, 88 infants in Oklahoma died before their first birthday due to Sudden Infant Death Syndrome (SIDS) and Sudden Unexpected Infant Death (SUID); an increase from 67 deaths the previous year. This project seeks to decrease the number of infant deaths related to SIDS and SUID by increasing access to a safe sleep environment for newborns. OHCA will work in partnership with the Oklahoma State Department of Health (OSDH) to expand an existing safe sleep initiative in 22 delivery hospitals. The current initiative provides education for nursing staff on infant safe sleep practices. The nurses at the facilities then educate new parents and families on safe sleep practices recommended by the American Academy of Pediatrics (AAP). Additionally, the OSDH is employing a safe sleep pilot in six community sites that provides portable cribs to families of newborns to ensure a safe sleep environment for newborns during the first

year. The new initiative herein, will work to expand the work already in progress and utilize the established community resources and relationships to provide more newborns with a portable crib to increase access to a safe sleep environment and promote safe sleep practices.

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below, including the assumptions on which this budget was based (per member/per month rate, estimated enrollment and source of non-Federal funds). (*Note: This reporting period =Federal Fiscal Year 2015. If you have a combination program you need only submit one budget; programs do not need to be reported separately.)*

COST OF APPROVED CHIP PLAN

Benefit Costs	**2016**	**2017**	**2018**
Insurance payments			
Managed Care	168,624,680	170,310,927	173,035,902
Fee for Service	24,475,656	24,230,900	23,843,205
Total Benefit Costs	193,100,336	194,541,827	196,879,107
(Offsetting beneficiary cost sharing payments)			
Net Benefit Costs	**$193,100,336**	**$194,541,827**	$**196,879,107**

Administration Costs			
Personnel			
General Administration	**6,567,842**	6,633,520	6,739,657
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs			
Other (e.g., indirect costs)			
Health Services Initiatives	**40,625**	5,162,243	5,216,039
Total Administration Costs	**6,608,467**	**11,795,763**	**11,955,696**
10% Administrative Cap (net benefit costs ÷ 9)	**21,455,593**	21,615,759	21,875,456

Federal Title XXI Share	**191,101,354**	195,938,175	196,304,715
State Share	**8,607,449**	10,399,415	12,530,088

TOTAL COSTS OF APPROVED CHIP PLAN	**$199,708,803**	**$206,337,590**	**$208,834,803**

2. What were the sources of non-federal funding used for state match during the reporting period?

- ☒ State appropriations
- ☐ County/local funds
- ☐ Employer contributions
- ☐ Foundation grants
- ☐ Private donations
- X Tobacco settlement
- ☐ Other (specify) **[500]**

3. Did you experience a short fall in CHIP funds this year? If so, what is your analysis for why there were not enough federal CHIP funds for your program? **[1500]**

No

4. In the table below, enter 1) number of eligibles used to determine per member per month costs for the current year and estimates for the next two years; and, 2) per member per month (PMPM) cost rounded to a whole number. If you have CHIP enrollees in a fee for service program, per member per month cost will be the average cost per month to provide services to these enrollees.

	2016		2017		2018	
	# of eligibles	$ PMPM	# of eligibles	$ PMPM	# of eligibles	$ PMPM
Managed Care	111,623	$154	112,739	$153	114,543	$151
Fee for Service	12,017	$191	11,897	$196	11,706	$201

Enter any Narrative text related to Section IV below. **[7500]**

OHCA Finance is now able to distinguish the decreasing adjustments between Managed Care and Fee for Service and the bulk of these adjustments should be taken out of Managed Care expenditures. Therefore, we will see an increase in Fee for Service $PMPM from FFY-2016.