

OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
January 20, 2021 at 3:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

A G E N D A

1. Call to Order / Determination of Quorum.....Stan Hupfeld, Chair
2. Public Comment.....Stan Hupfeld, Chair
3. Consent Agenda.....Stan Hupfeld, Chair
 - a) Approval of the November 12, 2020 OHCA Board Meeting Minutes (Attachment “A”)
 - b) Approval of State Plan Amendment Rate Committee Rates (Attachment “B”)
 - c) Approval of Expenditure of Funds Contracts
 - i. Third Party Liability (Attachment “C”)
4. Chief Executive Officer’s Report.....Kevin Corbett, Chief Executive Officer
5. Chief of Staff’s Report.....Ellen Buettner, Chief of Staff
6. Chief Operating Officer’s Report.....Melody Anthony, Chief Operating Officer
State Medicaid Director
 - a) Expansion Update (Attachment “D”)
7. Approval of Expenditure of Funds Contracts.....Aaron Morris
Chief Financial Officer
 - a) External Quality Review (Attachment “E”)
 - b) SoonerSelect/SoonerSelect Children (Attachment “F”)
 - c) SoonerSelect Dental (Attachment “G”)
 - d) Health Information Exchange (Attachment “H”)
8. Discussion of Report from the Legislative.....Alex Yaffe
Advisory Committee Chair, Legislative Advisory Committee
9. Discussion of Report from the.....Phil Kennedy
Compliance Advisory Committee Chair, Compliance Advisory Committee
10. Discussion of Report from the.....Jean Hausheer, M.D.
Administrative Rules Advisory Committee and Chair, Administrative Rules Advisory Committee
Possible Action Regarding Agency Rulemaking (Attachment “I”)
 - a) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the
Administrative Procedures Act. OHCA Requests the Adoption of the Following Permanent Rules
(see Attachment “I”):
 - i. **APA WF # 20-01 High-Investment Drugs Carve-Out** — ADDING agency rules at **OAC 317:30-5-42.20 and 317:30-5-47.6** and AMENDING **OAC 317:30-3-31, 317:30-5-42.1, and 317:30-5-47**
 - ii. **APA WF # 20-02 Retroactive Eligibility** — AMENDING agency rules at **OAC 317:35-6-60** and ADDING agency rules at **OAC 317:35-6-60.2**
 - iii. **APA WF # 20-03 Treatment of Lottery or Gambling Winnings for Income Eligibility** — AMENDING agency rules at **OAC 317:35-6-51** and ADDING agency rules at **OAC 317:35-6-55**

- iv. **APA WF # 20-05 Continuation of Services Pending Appeals** — ADDING agency rules at **OAC 317:2-1-2.6**
- v. **APA WF # 20-06B Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit** — AMENDING agency rules at **OAC 317:35-18-6**
- vi. **APA WF # 20-06D Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit** — AMENDING agency rules at **OAC 317:50-1-14**
- vii. **APA WF # 20-11 Medicare Part C (Medicare Advantage)** — AMENDING agency rules at **OAC 317:30-3-25**

11. Discussion of Report from the PharmacyTerry Cothran, D.Ph.
 Advisory Committee and Possible Action Regarding Senior Director of Pharmacy Services
 Drug Utilization Board Recommendations

a) Consideration and Vote on 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) (Attachment “J”):

- i. Mycapssa® (octreotide)
- ii. Zejula® (niraparib)
- iii. Trikafta® (elexacaftor/tezacaftor/ivacaftor and ivacaftor)
- iv. Evrysdi™ (risdiplam)
- v. Cystadrops® (cysteamine 0.37% ophthalmic solution) and Cystaran™ (cysteamine 0.44% ophthalmic solution)

12. Adjournment.....Stan Hupfeld, Chair

NEXT BOARD MEETING
 March 17, 2021
 TBD

MINUTES OF AN AMENDED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
November 12, 2020
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on November 10, 2020 at 5:00 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 November 6, 2020 at 5:14 p.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 4:02 p.m.

BOARD MEMBERS PRESENT: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry (4:05 p.m.), Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin

ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF CONSENT AGENDA WHICH INCLUDES:

- a) Approval of the Minutes from September 16, 2020 OHCA board meeting
- b) Ernst & Young MMIS Assessment
- c) Ernst & Young PeopleSoft Assessment
- d) Health Management Associates Contract Extension

MOTION: Vice-Chairman Yaffe moved for approval of item A listed in the Consent Agenda, as published. The motion was seconded by Member Hausheer.

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

BOARD MEMBER ABSTAINED: Member Boyd

MOTION: Member Hausheer moved for approval of items B, C, and D listed in the Consent Agenda, as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Nuttle, Member Shamblin

ITEM 3 / CHIEF EXECUTIVE OFFICER'S REPORT

Kevin Corbett, Chief Executive Officer

CEO Corbett spoke on the recent passing of former Board Chairman Ed McFall. Member Case read the Governor's Commendation, which read, "For his passion for public health, demonstrated by over 50 years of service of faithfully dedicating his time and expertise to improve health care in Oklahoma. Ed loved life to the fullest and will always be remembered for his contagious smile and boisterous laugh – and selfless, giving heart. The State of Oklahoma mourns his loss – but gratefully acknowledges his service that spanned decades and is epitomized by excellence, accomplishments and leadership. Signed October 30, 2020, by Governor Kevin Stitt."

MOTION: Member Case motioned the approval to send the Governor's Commendation to Ed McFall's family. Vice-Chairman Yaffe seconded the motion.

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

BOARD MEMBER ABSENT: Member Shamblin

CEO Corbett provided an update on OHCA current operating environment, first quarter 2021 highlights, Managed Care and Expansion progress, fiscal year 2022 budget and goals, and HIE update.

Operating Environment: OHCA continues to operate in a state of flexibility, with many teammates continuing to work from home. Leadership continues to monitor conditions and remains vigilant in the precautions taken while working in the building, including mask protocols, distancing in group setting and continued sanitation measures. To date, 18 OHCA employees have contracted the virus of which only 6 were working in the building at the time of infection. For the 6 employees working in the building, employees in close contact were notified, tested and quarantined at home. Town hall meetings continue to be held every week to stay connected and informed, but also to address matters and issues on the minds of our teammates.

OHCA lost power for four days due to the recent ice storm and was officially closed for two of those days. OHCA's call center provider's facility was also without power for a few days. Employees that had power were able to work, however at a lower level and with slower response times. In light of this recent event, OHCA is reevaluating its business continuity plan focused on physical dependencies and alternatives, further technology flexibilities and counterparty continuity plans to ensure essential services are maintained for our members.

Quarter Highlights: CEO Corbett shared a touching member moment that included OHCA, ODMHSAS, OKDHS, and partners at the Mental Health Association and Youth Villages and their efforts to ensure this member and their family has safe housing. Also presented were the OHCA quarterly measures, which included information on enrollment, utilization, financials, prior authorizations, and agency stats and provider networks.

Managed Care and Expansion Update: The RFPs were completed and released for response from interested parties on October 15, 2020. Over 500 questions were received and responded to last week. All documents for the RFP, responses to the RFI as well as the RFP questions submitted and associated answers are available on the OHCA website. RFP responses are due December 15, 2020. Responses received will be evaluated over the following six weeks and award of the contracts will be in early February.

Expansion remains on track with start date of July 1, 2021. Enrollment and engagement/communication plans for expansion are being finalized and will be shared with the board at the next meeting. Funding remains to be decided for the state share of \$164 million.

HIE Update: The evaluation panel concluded its evaluations of the HIE proposals. The expected award is scheduled to take place by the end of 2020 or shortly after. The initial focus will be on the state's Medicaid providers with a goal of working with all health agencies and providers in the state. Carter Kimble has been selected to assume the role of Executive Director of HIE and will take responsibility for its implementation and operations.

ITEM 4 / DISCUSSION OF REPORT FROM THE LEGISLATIVE ADVISORY COMMITTEE

Alex Yaffe, Chair of the Legislative Advisory Committee

Committee Chairman Yaffe expressed his gratitude to OHCA staff and their dedicated work in assisting the legislature explore expansion funding. Chairman Yaffe also stated that with the CARES Act expiring at the end of December, which could possibly leave OHCA funding COVID testing.

ITEM 5 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE

Phil Kennedy, Chair of the Compliance Advisory Committee

Committee Chairman Kennedy provided an update of the Compliance Advisory Committee Meeting which was held November 10, 2020. The update included information on OHCA's financials and current audits.

Financials: OHCA's financials through the month of September show that program variances continue to be significant as they were in fiscal year 2020. For fiscal year 2021, OHCA anticipated large increases in enrollment and an increase in spend. Administrative expenditures are almost flat, with operating expenses under budget and contracts over budget. In total, expenditures are almost \$119 million under budget. Due to the lower than expected expenditure, federal revenues were also under budget by \$82 million while other revenues remain strong. The total revenue variance is \$72 million under budget. Total budget variance through September is \$46,542,859. Due to the large budget to actual variance, a revision with update projections based on recent trends will be submitted in December. OHCA continues to accumulate cash reserves due to the possible extension of the enhanced FMAP and a lower than expected unemployment rate.

Audit: OHCA is working on implementation of corrective actions for all eligibility audit findings with still a few outstanding. There are two eligibility related findings that still need corrective action. The pregnancy related finding has a solution identified, but requires system changes before implementation. The second finding is still awaiting guidance from CMS.

ITEM 6i-xi / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING

Jean Hausheer, M.D., Chair of Administrative Rules Advisory Committee

- a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the Promulgation of the **Emergency Rule** in Attachment "A" in Accordance with 75 O.S. § 253.
- b) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Emergency Rules (see Attachment "E"):
 - i. **APA WF # 20-04 Electronic Visit Verification — ADDING agency rules at *Oklahoma Administrative Code (OAC) 317:30-3-34.***
 - ii. **APA WF # 20-13 Child Support Cooperation Exemption for Recipients of Indian Health Services — AMENDING agency rules at *OAC 317:35-5-7 and 317:35-5-44.***
 - iii. **APA WF # 20-14 Therapy Assistants and Clinical Fellows — AMENDING agency rules at *OAC 317:30-5-290.1, 317:30-5-291, 317:30-5-291.1, 317:30-5-293, 317:30-5-295, 317:30-5-296, 317:30-5-297, 317:30-5-299, 317:30-5-482, 317:30-5-641, 317:30-5-675, 317:30-5-676, 317:30-5-677, 317:30-5-680, and 317:30-5-1023.***
 - iv. **APA WF # 20-15A Residential Substance Use Disorder (SUD) Treatment Coverage — AMENDING agency rules at *OAC 317:25-7-13.***
 - v. **APA WF # 20-15B Residential Substance Use Disorder (SUD) Treatment Coverage — AMENDING agency rules at *OAC 317:30-5-95, 317:30-5-95.1, 317:30-5-95.42, 317:30-5-96.3, 317:30-5-241.6 and 317:30-5-268* and ADDING agency rules at *OAC 317:30-5-95.43 through 317:30-5-95.49.***
 - vi. **APA WF # 20-16 SUPPORT Act Medication-Assisted Treatment and Opioid Treatment Programs — AMENDING agency rules at *OAC 317:30-5-9* and ADDING agency rules at *OAC 317:30-5-241.7.***
 - vii. **APA WF # 20-19A Appeals Language Cleanup — AMENDING agency rules at *OAC 317:2-1-2, 317:2-1-2.5, 317:2-1-13, and 317:2-1-14.***
 - viii. **APA WF # 20-19B Appeals and Incorrect References Language Cleanup — AMENDING agency rules at *OAC 317:30-5-131.2 and 317:30-5-1020.***
 - ix. **APA WF # 20-20 Pay-for-Performance (PFP) Program — AMENDING agency rules at *OAC 317:30-5-136.1.***
 - x. **APA WF # 20-21 Employment Services Offered through Developmental Disabilities Services — AMENDING agency rules at *OAC 317:40-7-7 and 317:40-7-15.***
 - xi. **APA WF # 20-27 Specialty PRTF Staffing and Admission Revisions — AMENDING agency rules at *OAC 317:30-5-95.24.***

MOTION:

Vice-Chairman Yaffe moved for approval of Item 6ai-xi as published. The motion was seconded by Member Shamblin.

FOR THE MOTION:

Chairman Hupfeld, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy

BOARD MEMBER ABSENT:

Member Nuttle

MOTION:

Vice-Chairman Yaffe moved for approval of Item 6bi-xi as published. The motion was seconded by Member Shamblin.

FOR THE MOTION:

Chairman Hupfeld, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy

BOARD MEMBER ABSENT:

Member Nuttle

ITEM 7i-iv / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION BOARD RECOMMENDATIONS

Randy G. Curry, D.Ph., Chair of 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 “F”)

- i. Koselugo™ (Selumetinib), Pemazyre™ (Pemigatinib), and Qinlock™ (Ripretinib)
- ii. Enhertu® (Fam-Trastuzumab Deruxtecan-nxki), Phesgo™ (Pertuzumab/Trastuzumab/Hyaluronidase-zzxf), Trodelvy™ (Sacituzumab Govitecan-hziy), and Tukysa™ (Tucatinib)
- iii. Rubraca® (Rucaparib)
- iv. Adakveo® (Crizanlizumab-tmca), Oxbryta® (Voxelotor), and Reblozyl® (Luspatercept-aamt)

MOTION:

Member Hausheer moved for approval of Item 7i-iv as published. The motion was seconded by Member Boyd.

FOR THE MOTION:

Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Kennedy, Member Shamblin

BOARD MEMBER ABSENT:

Member Nuttle

ITEM 8 / DISCUSSION AND POSSIBLE ACTION REGARDING OHCA BOARD MEETING DATES AND TIMES FOR CLENDAR YEAR 2021

Stanley Hupfeld, OHCA Board Chairman

MOTION:

Member Hausheer moved for approval of the 2021 OHCA Board Meeting Dates and Times as published. The motion was seconded by Member Case.

FOR THE MOTION:

Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Kennedy, Member Shamblin

BOARD MEMBERS ABSENT:

Member Nuttle

ITEM 9 / DISCUSSION AND POSSIBLE ACTION: ELECTION OF THE OHCA 2021 BOARD OFFICERS (item was voted on after item 3.

MOTION:

Member Nuttle moved for approval of Stanley Hupfeld as OHCA Board Chairman. The motion was seconded by Vice-Chairman Yaffe.

FOR THE MOTION:

Chairman Hupfeld, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Shamblin

MOTION:

Member Case moved for approval of Alex Yaffe as OHCA Board Vice-Chairman. The motion was seconded by Member Curry

FOR THE MOTION:

Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin

ITEM 10 / ADJOURNMENT

MOTION:

Member Boyd moved for approval for adjournment. The motion was seconded by Member Hausheer.

FOR THE MOTION:

Chairman Hupfeld, Vice-Chairman Yaffe, Member Case, Member Curry, Member Kennedy, Member Shamblin

BOARD MEMBER ABSENT:

Member Nuttle

Meeting adjourned at 5:00 p.m., 1/12/2020

NEXT BOARD MEETING
January 20, 2021
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

DRAFT

STATE PLAN AMENDMENT RATE COMMITTEE**PER DIEM BASE RATE INCREASE FOR PSYCHIATRIC RESIDENTIAL
TREATMENT FACILITIES SERVING SPECIALTY POPULATIONS****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) proposes an increase to the per diem base rate paid to private Specialty Psychiatric Residential Treatment Facilities (PRTFs) with 17 beds or more serving individuals under 21 with co-occurring psychiatric disorders and intellectual and/or developmental disabilities. The increase is proposed to help support infrastructure for specialty providers serving children with specialized treatment needs, with a goal of increasing access to these specialized services within the state and decreasing out of state placements.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

There is an established per diem base rate of \$340.04 for these services.

5. NEW METHODOLOGY OR RATE STRUCTURE.

The new per diem base rate proposed is \$550.00.

6. BUDGET ESTIMATE.

The estimated budget impact for SFY2021 is \$1,845,954 total/\$574,760 state share (6 months). The estimated budget impact for SFY2022 is \$15,313,074 total/\$4,084,115 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 increase to the per diem base rate will support infrastructure for additional facilities that provide specialty care for individuals under 21.

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



STATE PLAN AMENDMENT RATE COMMITTEE

The ODMHSAS requests the SPARC to approve the proposed per diem base rate increase for Psychiatric Residential Treatment Facilities (PRTFs) serving individuals under 21 considered specialty populations.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2021, Pending CMS Approval

STATE PLAN AMENDMENT RATE COMMITTEE**PER DIEM BASE RATE REINSTATEMENT FOR PSYCHIATRIC
RESIDENTIAL TREATMENT FACILITIES****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) proposes to reinstate the per diem base rates paid to standard and extended private Psychiatric Residential Treatment Facilities (PRTFs) with 17 beds or more serving individuals under 21. The per diem rates for these facilities were decreased in May 2016 by 15%. The rate increase/reinstatement will restore the rates to the amounts prior to the decrease and will help maintain existing infrastructure for these facilities.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

There is an established per diem base rate of \$286.08 for these services for Standard PRTFs and \$271.61 for Community-Based Extended PRTFs.

5. NEW METHODOLOGY OR RATE STRUCTURE.

The new per diem base rate proposed is \$336.57 for Standard PRTFs and \$319.54 for Community-Based Extended PRTFs. These rates equal the per diem rates established prior to the rate reduction in May 2016.

6. BUDGET ESTIMATE.

The estimated budget impact for SFY2021 is \$1,173,880 total/\$339,368 state share (6 months). The estimated budget impact for SFY2022 is \$2,347,759 total/\$751,518 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 per diem base rate increase/reinstatement will help maintain infrastructure for facilities that provide residential care to individuals under 21.



STATE PLAN AMENDMENT RATE COMMITTEE

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

The ODMHSAS requests the SPARC to approve the proposed per diem base rate increase for Psychiatric Residential Treatment Facilities (PRTFs) serving individuals under 21.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2021, Pending CMS Approval

STATE PLAN AMENDMENT RATE COMMITTEE

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 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-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, overtime costs, 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 April 1, 2020 through September 30, 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
 - o Registered Nurse Skilled Nursing – Home Health Setting
 - o Registered Nurse Skilled Nursing – Extended State Plan
 - o Licensed Practical Nursing – Home Health Setting
 - o Licensed Practical Nursing – Extended State Plan
-

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- o Personal Care Services
- o Advanced Supportive/Restorative
- o In-home Respite (less than 8 hours)
- o In-home Extended Respite (8+ hours)
- Adult Day Health Services
 - o Adult Day Health
 - o Personal Care in Adult Day Health
- Assisted Living Services
 - o Assisted Living Standard Tier
 - o Assisted Living Intermediate Tier
 - o 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 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 *ADvantage* 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:
 - o Personal Care Services
 - o Respite Services
 - o Nursing Facility Respite Services
 - Fixed and uniform rates established through the State Plan Amendment Rate Committee process. Services of this type include:
 - o Nursing
 - o Adult Day Health Care
 - o Advanced Supportive/Restorative Assistance
-

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- 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	Proposed Rate	Total Cost 6 Months
Registered Nurse Skilled Nursing – Home Health Setting	G0299	15 min	\$18.72	\$367,698

STATE PLAN AMENDMENT RATE COMMITTEE

SERVICE DESCRIPTION	SERVICE CODE	SERVICE UNIT	Proposed Rate	Total Cost 6 Months
Registered Nurse Skilled Nursing – Extended State Plan	G0299 TF	15 min	\$18.72	\$0
Licensed Practical Nursing – Home Health Setting	G0300	15 min	\$17.47	\$443,092
Licensed Practical Nursing – Extended State Plan	G0300 TF	15 min	\$17.47	\$349
Personal Care Services	T1019	15 min	\$5.05	\$39,708,804
Advanced/Supportive Restorative Assistance	T1019 TF	15 min	\$5.42	\$512,228
In-home Respite (less than 8 hours)	T1005	15 min	\$5.05	\$86,794
In-home Extended Respite (8+ hours)	S9125	Per day	\$210.66	\$4,213
Adult Day Health Services	S5100 U1	15 min	\$2.50	657,988
Personal Care in Adult Day Health	S5105	Per day	\$9.92	\$2,609
Assisted Living Services – Standard Tier	T2031	Per day	\$58.79	\$35,392
Assisted Living Services – Intermediate Tier	T2031 TF	Per day	\$79.33	\$54,976
Assisted Living Services – High Tier	T2031 TG	Per day	\$110.96	\$6,675,576
Hospice Services	S9126	Per day	\$148.56	\$338,717
Nursing Facility Respite Services	120	Per day	\$214.66	\$56,670

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 waived care for the six-month period beginning 04/01/2020 and ending on 09/30/2020.

The 20% retroactive temporary rate adjustment results in a total cost of \$48,945,105.51, which is an increase of \$8,537,760.32 over the current base rate. Of this amount, \$6,334,164.38 is Federal funding and \$2,203,595.94 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.



STATE PLAN AMENDMENT RATE COMMITTEE

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 April 1, 2020 and an ending date of September 30, 2020.

9. EFFECTIVE DATE OF CHANGE.

Retroactive April 1, 2020, ending September 30, 2020

STATE PLAN AMENDMENT RATE COMMITTEE

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-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, 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 April 1, 2020 through September 30, 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
-

STATE PLAN AMENDMENT RATE COMMITTEE

- 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, and 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



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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

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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 6 MTHS
ADULT DAY CARE	S5100	15 Min	\$ 2.50	\$ 373,630.91
AGENCY COMPANION – CLOSE	S5126 U1	1 Day	\$ 120.43	\$ 98,275.60
AGENCY COMPANION - CLOSE - THERAPEUTIC LEAVE	S5126 U1 TV	1 Day	\$ 120.43	\$ 401.44
AGENCY COMPANION – ENHANCED	S5126	1 Day	\$ 156.62	\$ 365,267.75
AGENCY COMPANION - ENHANCED - THERAPEUTIC LEAVE	S5126 TV	1 Day	\$ 156.62	\$ 2,636.50
AGENCY COMPANION - Pervasive Level	S5126 TF	1 Day	\$ 171.29	\$ 257,000.63

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AGENCY COMPANION - Pervasive Level - THERAPEUTIC LEAVE	S5126 TF TV	1 Day	\$ 171.29	\$ 2,398.03
DAILY LIVING SUPPORTS	T2033	1 Day	\$ 192.19	\$ 11,456,214.00
DAILY LIVING SUPPORTS – Telehealth	T2033 GT	1 Day	\$ 192.19	\$ -
DAILY LIVING SUPPORTS - THER LEAVE	T2033 TV	1 Day	\$ 192.19	\$ 38,582.54
ES - CENTER BASED PREVOCATIONAL SVS	T2015 U1	1 Hour	\$ 6.24	\$ 419,030.24
ES - COMMUNITY BASED PREVOCATIONAL SERVICES	T2015 TF	1 Hour	\$ 12.48	\$ 211,662.16
ES - COMMUNITY BASED INDIVIDUAL SERVICES	T2015 U4	1 Hour	\$ 20.21	\$ 380,447.93
ES - EMPLOYMENT SPECIALIST	T2019	15 Min	\$ 7.54	\$ 2,372.92
ES - ENHANCED COMMUNITY BASED PREVOCATIONAL	T2015	1 Hour	\$ 16.62	\$ 54,318.32
ES - JOB COACHING - GROUP OF 4-5	T2019 TF	15 Min	\$ 4.16	\$ 1,801,263.35
ES - JOB COACHING - GROUP OF 2-3	T2019 HQ	15 Min	\$ 4.50	\$ 30,391.50
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 4-5	T2019 TG	15 Min	\$ 4.85	\$ 163,187.39
ES - ENHANCED JOB COACHING SERVICES - GROUP OF 2-3	T2019 TG-HQ	15 Min	\$ 5.18	\$ 14,730.34
ES - JOB COACHING INDIVIDUAL SERVICES	T2019 U4	15 Min	\$ 7.50	\$ 278,304.01
ES - JOB COACHING INDIVIDUAL SERVICES – Telehealth	T2019 U4 GT	15 Min	\$ 7.50	\$ 3,429.78
ES - JOB STABILIZATION / EXTENDED SERVICES	T2019 U1	15 Min	\$ 1.73	\$ 5,593.54
ES - PRE-VOC. HTS - SUPP. SUPPORTS	T2015 TG	1 Hour	\$ 15.72	\$ 261,055.98
GROUP HOME ALT. LIVING HOME, 4 BED	T1020	1 Day	\$ 364.42	\$ 960,294.56
GROUP HOME COMM. LIVING HOME, 6 BED	T1020	1 Day	\$ 208.10	\$ 830,525.72
GROUP HOME COMM. LIVING HOME, 7 BED	T1020	1 Day	\$ 178.46	\$ 27,379.35
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	\$ 9,179.90
GROUP HOME COMM. LIVING HOME, 11 BED	T1020	1 Day	\$ 136.97	\$ 18,216.74
GROUP HOME COMM. LIVING HOME, 12 BED	T1020	1 Day	\$ 135.41	\$ 20,886.68

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GROUP HOME, 6 BED	T1020	1 Day	\$ 90.48	\$ 905,123.64
GROUP HOME, 7 BED	T1020	1 Day	\$ 77.38	\$ 19,595.47
GROUP HOME, 8 BED	T1020	1 Day	\$ 67.70	\$ 265.17
GROUP HOME, 9 BED	T1020	1 Day	\$ 61.78	\$ -
GROUP HOME, 10 BED	T1020	1 Day	\$ 57.10	\$ 31,149.89
GROUP HOME, 11 BED	T1020	1 Day	\$ 53.35	\$ 15,085.28
GROUP HOME, 12 BED	T1020	1 Day	\$ 50.23	\$ 53,451.03
HOMEMAKER	S5130	15 Min	\$ 4.80	\$ 46,815.40
HOMEMAKER – EVV	S5130 32	15 Min	\$ 4.80	\$ 78,634.40
HOMEMAKER RESPITE	S5150	15 Min	\$ 4.80	\$ 174,814.80
HOMEMAKER RESPITE – EVV	S5150 32	15 Min	\$ 4.80	\$ 23,333.60
HTS - HABILITATION TRAINING SPECIALIST	T2017	15 Min	\$ 5.05	\$ 11,720,588.00
HTS - HABILITATION TRAINING SPECIALIST - EVV	T2017 32	15 Min	\$ 5.05	\$ 2,031,758.63
HTS - HABILITATION TRAINING SPECIALIST – Telehealth	T2017 GT	15 Min	\$ 5.05	\$ -
HTS - NO SUPV AGENCY – INDEPENDENT	T2017 U1	15 Min	\$ 2.28	\$ -
INTENSIVE PERSONAL SUPPORTS	T2017 TF	15 Min	\$ 5.05	\$ 456,249.91
NURSING EXTENDED DUTY	T1000	15 Min	\$ 8.11	\$ 353,650.08
NURSING INTERMITTENT SKILLED	T1001	1 Visit	\$ 63.02	\$ 147,045.50
NURSING - REGISTERED NURSE	G0299	15 Min	\$ 18.72	\$ 28,930.20
NURSING - LICENSED PRACTICAL NURSE	G0300	15 min	\$ 17.47	\$ 8,588.94
NURSING - LICENSED PRACTICAL NURSE – Telehealth	G0300 GT	15 min	\$ 17.47	\$ 87.36
RESPITE – MAXIMUM	S5151	1 Day	\$ 94.85	\$ 165.98
RESPITE IN - AGENCY COMPANION – CLOSE	S5151	1 Day	\$ 147.89	\$ 123.24
RESPITE IN - AGENCY COMPANION - ENHANCED	S5151	1 Day	\$ 184.08	\$ 874.38
RESPITE IN - AGENCY COMPANION - Pervasive	S5151	1 Day	\$ 198.74	\$ 1,093.09
RESPITE IN - GROUP HOME, 6 BED	S5151	1 Day	\$ 118.44	\$ 246.75
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	\$ -

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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	\$ 211,240.22
SPECIALIZED FOSTER CARE CHILD-CLOSE	S5145 U1	1 Day	\$ 36.00	\$ -
SPECIALIZED FOSTER CARE CHILD-MAX.	S5145	1 Day	\$ 67.39	\$ 75,698.06

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 waived care from April 1, 2020 through September 30, 2020.

The 20% temporary increase has a total cost of \$34,471,286.85. Of this amount, \$25,574,247.71 is federal funding and \$8,897,039.14 is 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.



STATE PLAN AMENDMENT RATE COMMITTEE

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 April 1, 2020 and an ending date of September 30, 2020.

9. EFFECTIVE DATE OF CHANGE.

Retroactive to April 1, 2020, ending September 30, 2020.

STATE PLAN AMENDMENT RATE COMMITTEE

DEVELOPMENTAL DISABILITIES SERVICES REMOTE SUPPORTS

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

Method Change

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

Increase

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

DDS wishes to provide two new services related to remote supports. Remote supports are the use of technology to remotely support a service recipient in place of physical staff presence. Remote support services promote independence and decrease reliance on in-person paid staff. The services are available to service recipients on the In-Home Supports Waiver for Adults, Homeward Bound Waiver and Community Based Waiver.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

This is a new service. There is no current methodology.

5. NEW METHODOLOGY OR RATE STRUCTURE.

After assessing data from several states with a similar programs, it was determined Ohio had the most similar service and Oklahoma adopted their rate.

Description	Service Code	Proposed Rate	Annualized
Remote Support Services with paid emergency response staff	T2017 U4	\$2.62 per quarter hour	\$217,984
Remote Support Services with natural supports.	T2017 U4	\$1.45 per quarter hour	\$60,320

6. BUDGET ESTIMATE.

The projected budget impact for SFY2022 is an increase of \$278,304 in total dollars with an \$88,472 state share. The Department of Human Services attests 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.

This will not have a negative impact on access to care.



STATE PLAN AMENDMENT RATE COMMITTEE

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

The Department of Human Services requests the State Plan Amendment Rate Committee approve Remote Support Service with paid emergency response staff and Remote Support Services with unpaid emergency response staff.

9. EFFECTIVE DATE OF CHANGE.

July 1, 2021, pending CMS approval

STATE PLAN AMENDMENT RATE COMMITTEE**DEVELOPMENTAL DISABILITIES SERVICES VALUE BASED INCENTIVE
PAYMENTS****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?

This issue is in line with the Centers for Medicare and Medicaid Services' (CMS) final rule to support individuals to work in competitive integrated settings and Oklahoma Human Services' (OHS) true north goals. The activity supported by this rate empowers and supports Oklahomans with developmental disabilities to live independently and work in competitive integrated employment within their communities. DDS seeks to provide a value-based incentive payment for progress toward competitive integrated employment. This is available to service recipients on the in-home supports waiver for adults, homeward bound waiver and community based waiver.

Value Based Payments are:

- Paid after a service recipient has been receiving the new employment service (as outlined below) for 15 days of employment and employed a minimum of 15 hours weekly;
 - Available to providers when supporting those in the In-Home Supports Waiver for Adults, Homeward Bound Waiver, and Community Waiver; and
 - Delivered in service units of \$500/unit. Providers can receive \$1500 for connecting service recipients to a competitive integrated employment opportunity each plan of care year.
-

STATE PLAN AMENDMENT RATE COMMITTEE

FROM:	TO:	VBP
CENTER-BASED	SMALL GROUP JOB COACHING (4-5) (AFTER 15 DAYS OF EMPLOYMENT)	1 UNIT
		1 UNIT
	SMALL GROUP JOB COACHING (2-3) (AFTER 15 DAYS OF EMPLOYMENT)	2 UNITS
	INDIVIDUAL PLACEMENT JOB COACHING (AFTER 15 DAYS OF EMPLOYMENT)	
COMMUNITY-BASED	SMALL GROUP JOB COACHING (4-5) (AFTER 15 DAYS OF EMPLOYMENT)	1 UNIT
		1 UNIT
	SMALL GROUP JOB COACHING (2-3) (AFTER 15 DAYS OF EMPLOYMENT)	2 UNITS
	INDIVIDUAL PLACEMENT JOB COACHING (AFTER 15 DAYS OF EMPLOYMENT)	
SMALL GROUP (4-5) JOB COACHING	SMALL GROUP JOB COACHING (2-3) (AFTER 15 DAYS OF EMPLOYMENT)	1 UNIT
	INDIVIDUAL PLACEMENT JOB COACHING (AFTER 15 DAYS OF EMPLOYMENT)	2 UNITS
NEW TO SERVICES	INDIVIDUAL PLACEMENT JOB COACHING (AFTER 15 DAYS OF EMPLOYMENT)	3 UNITS
COMMUNITY-BASED	INDIVIDUAL PLACEMENT JOB COACHING (AFTER 15 DAYS OF EMPLOYMENT)	3 UNITS
CENTER-BASED	INDIVIDUAL PLACEMENT JOB COACHING (AFTER 15 DAYS OF EMPLOYMENT)	3 UNITS
INDIVIDUAL PLACEMENT JOB COACHING	STABILIZATION (AFTER 15 DAYS OF EMPLOYMENT)	1 UNIT

STATE PLAN AMENDMENT RATE COMMITTEE

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

This is a new service. There is no current methodology.

5. NEW METHODOLOGY OR RATE STRUCTURE.

The stakeholders recommended a \$500 incentive payment based on costs for marketing and administration for placements.

Description	Service Code	Proposed Rate	Annualized
Value-Based Incentive Payment Service.	New Service	\$500.00 each for up to three units. Note: The units are independent and non-sequential.	\$89,500 (one unit) \$89,000 (two units) \$133,500 (three units)

6. BUDGET ESTIMATE.

The estimated budget impact for SFY2022 is an increase in the amount of \$312,000 total dollars or \$99,184 state share. The Department of Human Services 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 new services will not have a negative impact on access to care.

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

The Department of Human Services requests the State Plan Amendment Rate Committee approve the rate identified above.

9. EFFECTIVE DATE OF CHANGE.

July 1, 2021, pending CMS approval

**SUBMITTED TO THE C.E.O. AND BOARD ON JANUARY 20, 2021
AUTHORITY FOR EXPENDITURE OF FUNDS**

BACKGROUND

Services	Third Party Liability Services
Purpose and Scope	<p>The OHCA is issuing Solicitation in order to obtain proposals from Suppliers to perform Medicaid third party liability (TPL) revenue collection services in accordance with 42 CRF 433.135 et. seq.</p> <p>The Medicaid TPL Program shall:</p> <ul style="list-style-type: none">• Cost avoid claims payment to maximize revenues for OHCA;• Comply with all aspects of 42 CRF 433.135 et. seq., the RFP, and any other applicable State or Federal regulation, rule, or policy;• Coordinate and reduce overlap with existing OHCA Program Integrity initiatives including but not limited to the RAC (Recovery Audit Contractor);• Lessen the accounting and collection work required of OHCA; and• Accept EFT (electronic funds transfers) from third party insurance carriers <p>The Vendor shall assist OHCA in achieving the following goals:</p> <ul style="list-style-type: none">• Maximize revenues to OHCA;• Cost avoid claims before payments are generated;• Lessen the accounting and collection work required of OHCA;• Reduce call volume to onsite TPL staff
Mandate	NA
Procurement Method	Competitive Bid
Award	Single Contractor
External Approvals	OMES
Incumbent Contractor Name & Contract Term	Health Management Systems 07/01/2015 through 6/30/2021
New Contract Term	July 1, 2021 through June 30, 2022 with four (4) options to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	\$22,500,000.00
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RECOMMENDATION

Board approval is requested to procure the Third Party Liability Services described above for 5 years, for a total not-to-exceed \$22,500,000.00.

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.)

SOONERCARE

Melody Anthony, State Medicaid Director

Jan. 20, 2021



SOONERCARE POPULATION

CURRENT COVERAGE:

- Children
- Pregnant women
- Elderly adults
- Disabled adults

EXPANSION COVERAGE:

- Expansion will go into effect on July 1, 2021,
- Approximately 200,000 new adult members, ages 19-64
- New members will know immediately if they are approved for coverage

SOONERCARE

- SPA approvals, Received Dec. 4, 2020
 - **Expansion Spa:** This allows low income adults age 19-64 the ability to enroll in SoonerCare.
 - **Approval for Alternative Benefit Plan:** This states services afforded to the new adult population is identical to current SoonerCare coverage.
 - **FMAP:** This allows the state to receive 90% matching funds for the adult expansion population.

OPERATIONAL READINESS

Current Activity

- Call center staffing needs for increased lives.
- Educational materials development.
- New member outreach materials.

Social Media

Stakeholders

Agency Partner

OPERATIONAL READINESS

April through June:

Call center and agency staff training

Agency Partners Training

- FQHC
- OSDH
- OHS
- Tribal Partners
- State owned CMHC

Ongoing system modifications

OPERATIONAL READINESS

Additional Considerations:

- Provider Capacity
- Increases in Prior Authorization request
- Administrative rule changes
- Reprocessing of current program members
 - Insure Oklahoma
 - SoonerPlan
 - Potential new members already in system
 - Parents of children above current FPL
 - Childless adults that applied but was not eligible



OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

okhca.org
mysoonercare.org

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Agency: 405-522-7300
Helpline: 800-987-7767

**SUBMITTED TO THE C.E.O. AND BOARD ON JANUARY 20, 2021
AUTHORITY FOR EXPENDITURE OF FUNDS**

BACKGROUND

Services	Medical Professional Services
Purpose and Scope	<p>OHCA is seeking a Contractor (s) to perform External Quality Review services as required by 42 CFR §438 Subpart E, and Quality Improvement services as Federally mandated.</p> <p>The contract goal is to determine the degree to which OHCA's administration increases the likelihood of desired health outcomes or its members through its structural and operational characteristics.</p> <p>The OHCA intends to contract with one or multiple MCOs to deliver statewide risk-based managed care services for certain SoonerCare Eligibles and QIO services are required.</p> <p>CMS-Mandated EQR Activities Contractor shall perform the following mandatory EQR activities: *Protocol 1 - Validation of Performance Improvement Projects *Protocol 2 - Validation of Performance Measures *Protocol 3 - Review of Compliance with Medicaid and CHIP Managed Care Regulations *Protocol 4 - Validation of Network Adequacy</p> <p>Enrollment of SoonerCare Eligibles into the SoonerSelect, SoonerSelect Specialty, and SoonerSelect Dental programs will be effective October 1, 2021.</p> <p>The awarded contractor shall perform the mandatory EQR-related activities, including:</p> <ul style="list-style-type: none"> • Retrospective review on a random sample of paid hospital inpatient and outpatient observation claims; • Quality Interventions and Education for OHCA Contracted Medical Providers; and, • Member Satisfaction
Mandate	Federal requirement for External Quality Review.
Procurement Method	Competitive Bid
Award	Single/Multiple Contractor (s)
External Approvals	OMES
Incumbent Contractor Name & Contract Term	Telligen 07/01/2015 through 6/30/2021

New Contract Term | March 15, 2021 through June 30, 2021 with five (5) options to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.

\$16,000,000.00

RECOMMENDATION

Board approval is requested to procure the EQRO/QIO Services described above for period March 15, 2021 thru June 30, 2026, for a total not-to-exceed \$16,000,000.00.

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.)

SUBMITTED TO THE C.E.O. AND BOARD ON JANUARY 20, 2021
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	SoonerSelect and SoonerSelect Children's Specialty RFP
Purpose and Scope	<p>OHCA is seeking a Contractor for the following:</p> <ul style="list-style-type: none">• Improve health outcomes for Oklahomans;• Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume;• Improve SoonerCare Eligibles' access to and satisfaction with necessary services;• Contain costs through better coordinating services; and• Increase cost predictability to the State.
Mandate	The SoonerSelect and SoonerSelect Children's Specialty program has been designed to advance Governor Stitt's plan to transform Oklahoma into a Top Ten state in health outcomes. OHCA is pursuing a comprehensive Medicaid managed care approach that will allow the state to improve the health of Oklahomans.
Procurement Method	Competitive Bid
Award	Multiple Contractors
New Contract Term	Initial Contract effective date February 1, 2021 through June 30, 2021 with five (5) options to renew.

BUDGET

Initial Year February 1, 2021 –June 30, 2021 Zero funds expended for partial year

Total Contract Not-to-Exceed Requested for Approval	\$2,102,453,437.00 First Year (July 1, 2021 – June 30, 2022)
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RECOMMENDATION

Board approval is requested to procure SoonerSelect and SoonerSelect Children's Specialty services described above with a total not-to-exceed of \$2,102,453,437.00 through the end of State Fiscal Year 2022 (June 30, 2022). OHCA will seek approval from the board for each additional year thereafter.

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.)

**SUBMITTED TO THE C.E.O. AND BOARD ON JANUARY 20, 2021
AUTHORITY FOR EXPENDITURE OF FUNDS**

BACKGROUND

Services	SoonerSelect Dental RFP
Purpose and Scope	<p>OHCA is seeking a Contractor for the following:</p> <ul style="list-style-type: none">• Improve health outcomes for Oklahomans;<ul style="list-style-type: none">○ Improving access to oral healthcare including preventive and restorative services;○ Developing high-quality outreach and education materials and regularly scheduled outreach activities for Dental Health Plan Enrollees;○ Building collaborations between medical and dental professionals;• Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume;• Improve SoonerCare Eligibles' access to and satisfaction with necessary services;• Contain costs through better coordinating services; and• Increase cost predictability to the State.
Mandate	<p>The SoonerSelect Dental program has been designed to advance Governor Stitt's plan to transform Oklahoma into a Top Ten state in health outcomes, including oral health. OHCA is pursuing a dental managed care approach that will allow the state to improve the oral health of Oklahomans.</p>
Procurement Method	Competitive Bid
Award	Multiple Contractors
New Contract Term	Initial Contract effective date February 1, 2021 through June 30, 2021 with five (5) options to renew.

BUDGET

Initial Year February 1, 2021 – June 30, 2021

Zero funds expended for partial year

Total Contract Not-to-Exceed Requested for Approval.

\$110,978,067.00/Year (July 1, 2021 – June 30, 2022)

RECOMMENDATION

Board approval is requested to procure SoonerSelect Dental services described above with a total not-to-exceed of \$110,978,067.00 through the end of State Fiscal Year 2022 (June 30, 2022). OHCA will seek approval from the board for each additional year thereafter.

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.)

**SUBMITTED TO THE C.E.O. AND BOARD ON JANUARY 20, 2021
AUTHORITY FOR EXPENDITURE OF FUNDS**

BACKGROUND

Services	State Wide Health Information Exchange
Purpose and Scope	Provide a statewide health information exchange (HIE) to be called the Oklahoma Statewide Health Information Network and Exchange (OKSHINE). Oklahoma is looking to achieve statewide health information exchange to allow health information to flow seamlessly to and from authorized organizations and individuals in Oklahoma. OKSHINE is intended to meet the needs of end users, allowing providers and their patients, hospitals and health systems, purchasers and payers, state health agencies and local health departments, health information business associates, and an increasingly inclusive ecosystem of human service organizations to have secure, accurate data available at the right time and place, for the right purposes. Electronic Master Patient Index (eMPI) has been shifted from OSDH to OHCA and added to this contract from the State Wide Contracting process. This is why the amount has increased from the previous Board approval.
Mandate	Governors Top 5 Initiative
Procurement Method	Competitive Bid
Award	Single Contractor Orion Health
External Approvals	OMES and CMS approval pending
New Contract Term	December 23, 2020 thru June 30, 2021 with 9 options to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.

Contract not to exceed \$70,895,962.00 and is Pending CMS approval. This is an increase from a previously approved amount of \$54,564,472.00 due to the eMPI addition.

Not-to-Exceed considerations

Federal matching considerations will be a blended rate. OHCA expects the first three years to be a matching rate of 90/10. Following years could be 50/50 or 75/25 depending on system certification and CMS Advance Planning Document approvals.

**Federal Match Percentage(s) within the Total Contract Not-to-Exceed
State Share Costs within the Total Contract Not-to-Exceed**

Pricing Methodology

The request for proposal is waiting for CMS Approval at the time of this Board meeting, OHCA expects a combination of hourly rate, price per service, and system hosting costs.

RECOMMENDATION

Board approval is requested to procure the Health Information Exchange services described above through Orion Health, for 10 year, not-to-exceed \$70,895,962.00 and is pending CMS Approval.

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.

Competitive Bid 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.

Pricing Methodologies:

Hourly Rate: Hourly Rate contracts authorize payments based on the number of hours required to perform a service within an established not-to-exceed. Hourly rate contractors cannot bill for more hours than worked, and are not guaranteed to be able to bill for the entire not-to-exceed amount.

Fixed Rate: Fixed rate professional services contracts establish fixed prices based on services performed based on volume estimates, such as completing a prior authorization is valued at X, and costs based on established deliverables. Deliverables may be billed as all-inclusive costs, such as a report, or may include milestones with associated payments, such as a payment for a report for the first draft and another payment upon OHCA approval for the final report. Contractors cannot bill until services are completed.

January Board Proposed Rule Changes

Tribal consultations regarding the following proposed changes were held on Tuesday, January 8, 2019, Tuesday, November 5, 2019, Tuesday, January 7, 2020, Tuesday, March 3, 2020, and Tuesday, July 7, 2020. The proposed rules were presented to the Medical Advisory Committee on Thursday, July 18, 2019, Thursday, March 12, 2020, Thursday, May 14, 2020, and Thursday, September 10, 2020. Additionally, the proposed permanent rules were presented at a public hearing on Tuesday, January 19, 2021.

The proposed rules were posted on the OHCA public website for a comment period.

The following permanent rules HAVE previously been approved by the Board and the Governor under EMERGENCY rulemaking. These rules HAVE NOT been revised for PERMANENT rulemaking.

- A. **APA WF # 20-01 High-Investment Drugs Carve-Out** — ADDING agency rules at **OAC 317:30-5-42.20 and 317:30-5-47.6** and AMENDING **OAC 317:30-3-31, 317:30-5-42.1, and 317:30-5-47** to allow certain high-investment drugs to be reimbursed outside of the inpatient and outpatient hospital payment methodologies. Additionally, the proposed rule changes will require inpatient and outpatient hospitals to seek prior authorization of high-investment drugs and follow applicable requirements and conditions of payment. Lastly, revisions will align policy with current practice and correct grammatical errors.
Budget Impact: Budget neutral.

- B. **APA WF # 20-02 Retroactive Eligibility** — AMENDING agency rules at **OAC 317:35-6-60** and ADDING agency rules at **OAC 317:35-6-60.2** to allow for a retroactive period of eligibility for pregnant women and children. Revisions provide that, in addition to certifying an applicant for coverage from the date of certification forward, the applicant may also be certified for coverage for a retroactive period of three months directly prior to the date of application. Revisions will also specify the requirements that must be met to be eligible for retroactive coverage. The timely filing deadline in OAC 317:30-3-11 will still apply to the filing of any claims.
Budget Impact: The estimated total cost for SFY21 is \$1,518,379 with a state share of \$422,907. The estimated total cost for SFY22 is \$1,518,379 with a state share of \$487,703. The retroactive eligibility rule revisions apply to children and pregnant women.

- C. **APA WF # 20-03 Treatment of Lottery or Gambling Winnings for Income Eligibility** — AMENDING agency rules at **OAC 317:35-6-51** and ADDING agency rules at **OAC 317:35-6-55** to bring the agency into compliance with the Advancing Chronic Care, Extenders and Social Services Act, referred to as the ACCESS Act and included in Public Law No. 115-123 § 53103. The ACCESS Act changed the way qualified lottery winnings or qualified gambling winnings of \$80,000 and above, which are paid out in a single payout option, are treated when determining MAGI-based income eligibility. Previous federal regulations and OHCA rules required that all lump sum income, including lottery and gambling winnings, be counted as income only in the month received. Winnings will still be counted as income against the SoonerCare household in the month received; however, winnings of \$80,000 and above which are paid out in a single payout option will be counted in multiple months and in equal monthly installments against the individual household member receiving the winnings. Lottery winnings that are paid out in installments over a period of time will be treated as recurring income. The formula for counting winnings of

\$80,000 and above is set forth in the new OHCA policy at OAC 317:35-6-55(b) and (c).

Budget Impact: Agency staff has determined that the impact of the proposed rule changes on the budget is unknown as the number of SoonerCare members who will have lottery or gambling winnings is unknown; however, savings could potentially be realized if a member lost eligibility for multiple months due to receipt of lottery or gambling winnings above \$80,000 paid out in a single payout.

- D. **APA WF # 20-05 Continuation of Services Pending Appeals —** ADDING agency rules at **OAC 317:2-1-2.6** to comply with Section 431.230 of Title 42 of the Code of Federal Regulations by describing the conditions in which Medicaid benefits will continue or be reinstated pending an appeal. Additionally, the proposed new rule will describe the application, obligations, and implications for the appellant when Medicaid benefits are continued or reinstated pending an appeal.
Budget Impact: Budget neutral.
- E. **APA WF # 20-06B Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at **OAC 317:35-18-6** to comply with the home health final rule in which the DME and supplies benefit was revised from an optional benefit to a mandatory benefit and was made subject to the scope of the home health benefit. This change is being made to mirror language in federal regulation.
Budget Impact: Budget neutral.
- F. **APA WF # 20-06D Durable Medical Equipment (DME) and Supplies Benefit Moved under the Scope of the Home Health Benefit —** AMENDING agency rules at **OAC 317:50-1-14** to comply with the home health final rule in which the DME and supplies benefit was revised from an optional benefit to a mandatory benefit and was made subject to the scope of the home health benefit. This change is being made to mirror language in federal regulation.
Budget Impact: Budget neutral.
- G. **APA WF # 20-11 Medicare Part C (Medicare Advantage) —** AMENDING agency rules at **OAC 317:30-3-25** to standardize the language in policy regarding the payment of Medicare deductibles, coinsurance, and copays between Medicare Part A, Part B, and Part C.
Budget Impact: Budget neutral

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-31. Prior authorization for health care-related goods and services

(a) Under the ~~Oklahoma~~ SoonerCare program, there are health care-related goods and services that require prior authorization (PA) by the Oklahoma Health Care Authority (OHCA). PA is a process to determine if a prescribed good or service is medically necessary; it is not, however, a guarantee of member eligibility or of SoonerCare payment. All goods or services requiring PA will be authorized on the basis of information submitted to OHCA, including:

(1) ~~the~~The relevant code, as is appropriate for the good or service requested (for example, Current Procedural Terminology (CPT) codes for services; Healthcare Common Procedure Coding System (HCPCS) codes, for durable medical equipment; or National Drug Codes (NDC), for drugs); and/or

(2) ~~any~~Any other information required by OHCA, in the format as prescribed. The OHCA authorization file will reflect the codes that have been authorized.

(b) The OHCA staff will issue a determination for each requested good or service requiring a PA. The provider will be advised of that determination, either through the provider portal, or for requests made for out-of-state services, meals, mileage, transportation and lodging, by letter or other written communication. The member will be advised by letter. Policy regarding member appeal of a denied PA is available at Oklahoma Administrative Code (OAC) 317:2-1-2.

(c) The following is an inexhaustive list of the goods and services that may require a PA, for at least some SoonerCare member populations, under some circumstances. This list is subject to change, with OHCA expressly reserving the right to add a PA requirement to a covered good or service or to remove a PA requirement from a covered good or service.

(1) Physical therapy for children;

(2) Speech therapy for children;

(3) Occupational therapy for children;

(4) High Tech Imaging (for ex. CT, MRA, MRI, PET);

(5) Some dental procedures, including, but not limited to orthodontics (orthodontics are covered for children only);

(6) Inpatient psychiatric services;

(7) Some prescription drugs ~~and/or~~, physician administered, and/or high-investment drugs;

(8) Ventilators;

- (9) Hearing aids (covered for children only);
 - (10) Prosthetics;
 - (11) High risk ~~OB~~Obstetrical (OB) services;
 - (12) Drug testing;
 - (13) Enteral therapy (covered for children only);
 - (14) Hyperalimentation;
 - (15) Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in ~~Oklahoma's~~the Oklahoma Medicaid State Plan;
 - (16) Adaptive equipment for persons residing in private ~~Intermediate Care Facilities for Individuals with Intellectual Disabilities~~intermediate care facilities for individuals with intellectual disabilities (ICF/IID);
 - (17) Some ancillary services provided in a ~~long-term~~long-term care hospital or in a long term care facility;
 - (18) Rental of hospital beds, support surfaces, oxygen and oxygen related products, continuous positive airway pressure devices (CPAP and BiPAP), pneumatic compression devices, and lifts;
 - (19) Allergy testing and immunotherapy;
 - (20) Bariatric surgery;
 - (21) Genetic testing;
 - (22) Out-of-state services; and
 - (23) Meals, travel, and lodging.
- (d) ~~Providers should refer to the relevant Part of OAC 317:30-5 for additional, provider-specific guidance on PA requirements. Providers may also refer to the OHCA Provider Billing and Procedure Manual, available on OHCA's website, and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual to see how and/or where to submit PA requests, as well as to find information about documentation. Providers should refer to the provider-specific Part for PA requirements. For additional PA information and submission requests, providers may refer to the OHCA Provider Billing and Procedure Manual and the SoonerCare Medical Necessity Criteria for Inpatient Behavioral Health Services Manual available at <https://okhca.org>.~~

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.1. Outpatient hospital services

(a) Hospitals providing outpatient hospital services are required to meet the same requirements that apply to the Oklahoma Health Care Authority (OHCA) contracted, non-hospital providers performing

the same services. Outpatient services performed outside the hospital facility are not reimbursed as hospital outpatient services.

(b) Covered outpatient hospital services must meet all of the criteria listed in (1) through (4) of this subsection.

(1) The care is directed by a physician or dentist.

(2) The care is medically necessary.

(3) The member is not an inpatient [refer to Oklahoma Administrative Code (OAC) 317:30-5-41].

(4) The service is provided in an approved hospital facility.

(c) Covered outpatient hospital services are those services provided for a member who is not a hospital inpatient. A member in a hospital may be either an inpatient or an outpatient, but not both (see OAC 317:30-5-41).

(d) In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

(e) Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

(f) Physical, occupational, and speech therapy services are covered when performed in an outpatient hospital-based setting. Coverage is limited to one (1) evaluation/re-evaluation visit (unit) per discipline per calendar year and fifteen (15) visits (units) per discipline per date of service per calendar year. Claims for these services must include the appropriate revenue code(s).

(g) Diabetes self-management ~~training~~ (DSMT) education and support (DSMES) services ~~is~~ are provided to members diagnosed with diabetes. ~~DSMT~~ DSMES services are comprised of one (1) hour of individual instruction (face-to-face encounters between the ~~certified~~ diabetes educator and the member) and nine (9) hours of group instruction on diabetes self-management. Members shall receive up to ten (10) hours of services during the first twelve (12) month period beginning with the initial training date. After the first twelve (12) month period has ended, members shall only be eligible for two (2) hours of individual instruction on ~~DSMT~~ DSMES per calendar year. Refer to OAC 317:30-5-1080 through 317:30-5-1084 for specific provider and program requirements, and reimbursement methodology.

(h) For high-investment drugs, refer to OAC 317:30-5-42.20.

317:30-5-42.20. High-investment drugs - outpatient hospitals

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an outpatient hospital.

(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at <https://okhca.org>. This list may be updated as deemed necessary.

(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the outpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(f)].

(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state outpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state outpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) ~~laboratory~~Laboratory services;

(B) ~~prosthetic~~Prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) ~~technical~~Technical component on radiology services;

(D) ~~transportation~~Transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) ~~pre-admission~~Pre-admission diagnostic testing performed within ~~72~~seventy-two (72) hours of admission; and

(F) ~~organ~~Organ transplants.

(3) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(4) Covered inpatient services provided to eligible members of the ~~Oklahoma~~-SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.

(5) Cases which indicate transfer from one (1) acute care hospital to another will be monitored under a retrospective

utilization review policy to help ensure that payment is not made for inappropriate transfers.

(6) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.

(7) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(8) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed ~~100%~~ one-hundred percent (100%) of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.

(9) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.

(10) All inpatient services are reimbursed per the methodology described in this ~~section~~ Section and/or as approved under the Oklahoma ~~State~~ Medicaid State Plan.

(11) For high-investment drugs, refer to OAC 317:30-5-47.6

317:30-5-47.6. High-investment drugs - inpatient hospitals

(a) The Oklahoma Health Care Authority (OHCA) designates certain high-investment drugs to be reimbursed separately pursuant to the Oklahoma Medicaid State Plan for members receiving services at an inpatient hospital.

(b) The list of OHCA-designated high-investment drugs is set forth on the Pharmacy page of the OHCA website, which is available at <https://okhca.org>. This list may be updated as deemed necessary.

(c) All high-investment drugs require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31], and the inpatient hospital stay continues to be subject to applicable medical necessity criteria requirements [refer to OAC 317:30-3-1(f)].

(d) OHCA-designated high-investment drugs provided to eligible members, when treated in out-of-state inpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state inpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

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

SUBCHAPTER 6. SOONERCARE FOR
PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-6-60. Certification for SoonerCare for pregnant women and families with children

~~An individual determined eligible for SoonerCare may be certified for a medical service provided on or after the date of certification. The period of certification may not be for a retroactive period unless otherwise prior approved by OHCA. The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.~~

(a) General rules of certification.

(1) An individual determined eligible for SoonerCare may be certified for a prospective period of coverage on or after the date of certification.

(2) In accordance with 42 Code of Federal Regulations (C.F.R.) § 435.915 and Oklahoma Administrative Code (OAC) 317:35-6-60.2, an individual may also be determined eligible and certified for a retroactive period of coverage during the three (3) month period directly prior to the date of application. This only applies if the individual received covered medical services at any time during that period, and would have been eligible for SoonerCare at the time he or she received the services, regardless of whether the individual is alive when application for Medicaid is made. An individual may be eligible for the retroactive period even though ineligible for the prospective period.

(3) The individual who is categorically needy and related to pregnancy-related services retains eligibility for the period covering prenatal, delivery, and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

~~(1)~~ **(b) Certification as a TANF (cash assistance) recipient.** A categorically needy individual who is determined eligible for TANF is certified effective the first day of the month of TANF

eligibility.

~~(2)~~ **(c) Certification of non-cash assistance individuals related to the children and parent and caretaker relative groups.** The certification period for the individual related to the children or parent and caretaker relative groups is ~~12~~twelve (12) months. The certification period can be less than ~~12~~twelve (12) months if the individual:

~~(A)~~ (1) ~~is~~Is certified as eligible in a money payment case during the ~~12-month~~twelve-month (12-month) period;

~~(B)~~ (2) ~~is~~Is certified for long-term care during the ~~12-month~~twelve-month (12-month) period;

~~(C)~~ (3) ~~becomes~~Becomes ineligible for SoonerCare after the initial month; or

~~(D)~~ (4) ~~becomes~~Becomes financially ineligible.

~~(i)~~ (A) If an income change after certification causes the case to exceed the income standard, the case is closed.

~~(ii)~~ (B) Individuals, however, who are determined pregnant and financially eligible continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy-related services through the postpartum period.

~~(3)~~ **(d) Certification of individuals related to pregnancy-related services.** The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the two (2) months following the month the pregnancy ends. Financial ~~eligibility~~is eligibility is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

~~(4)~~ **(e) Certification of newborn child deemed eligible.**

~~(A)~~ (1) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for and enrolled in pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one (1) year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one (1). The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.

~~(B)~~ (2) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. ~~No~~ In accordance with 42 C.F.R. § 435.117, no other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at OKDHS/DHS. The referral enables child support services to be initiated.

~~(C)~~ (3) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one (1). If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:

- ~~(i)~~ (A) loses Oklahoma residence; or
- ~~(ii)~~ (B) expires.

~~(D)~~ (4) A newborn child cannot be deemed eligible when the mother's only coverage was presumptive eligibility, and continued eligibility was not established.

317:35-6-60.2. Retroactive eligibility.

(a) Retroactive eligibility, as outlined in this section, shall be available to pregnant women and/or members under the age of nineteen (19). For retroactive eligibility rules related to other SoonerCare population groups, refer to Oklahoma Administrative Code (OAC) 317:35-7-60(b).

(b) In addition to the period of eligibility specified in Oklahoma Administrative Code (OAC) 317:35-6-60, an applicant, or individuals within the applicant's household, shall be eligible for SoonerCare benefits up to three (3) months prior to the date of application if all of the following requirements are met:

(1) The individual for whom retroactive coverage is being requested would have been eligible for SoonerCare coverage if an application for SoonerCare had been made during the retroactive month.

(A) The individual does not have to be eligible for the month of application to be found eligible for one (1) of the three (3) retroactive months.

(B) The eligibility factors (e.g. income, residency, household composition, etc.) are evaluated separately for each retroactive month for which retroactive eligibility is

being requested.

(2) The applicant completes the retroactive eligibility application form and provides, within six (6) months of the date the services were provided, documentation for verification purposes as requested by SoonerCare.

(3) The individual applying for retroactive coverage states that the individual for whom retroactive coverage is being requested received reimbursable SoonerCare services which were provided by a SoonerCare-contracted provider during the retroactive month.

(4) An applicant cannot be approved for retroactive coverage for a month in which his or her application was previously denied.

(c) Per 42 Code of Federal Regulations (CFR) § 435.915(b), if an applicant is determined to be eligible for retroactive coverage at any time during the requested retroactive month, then coverage will begin on the first (1st) day of the month and be effective for the entire month.

(d) If the applicant is applying for SoonerCare benefits due to pregnancy, then the applicant must have been pregnant during the requested retroactive month.

(e) Regardless of retroactive eligibility being granted, the requirement for the claim to be filed timely, per OAC 317:30-3-11, is still in effect.

(f) Retroactive coverage for SoonerCare health services received during a retroactive month will be secondary to any third-party which has primary responsibility for payment. If the individual eligible for retroactive coverage has already paid for the health services, the provider may refund the payment and bill SoonerCare in accordance with the timely filing requirements in OAC 317:30-3-11.

(g) Retroactive coverage for SoonerCare reimbursable health services that require prior authorization shall not be denied solely because of a failure to secure prior authorization. Medical necessity, however, must be established before reimbursement can be made.

(h) Denials of requests for retroactive eligibility may be appealed in accordance with OAC 317:2-1-2(d)(1)(F).

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

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND
FAMILIES WITH CHILDREN

PART 6. COUNTABLE INCOME FOR MAGI

317:35-6-51. Exceptions to Internal Revenue Code rules

(a) The following sources of income are excluded from household income for SoonerCare eligibility under ~~MAGI~~Modified Adjusted Gross Income (MAGI), regardless of whether they are included in MAGI in Section 36B of the Internal Revenue Code:

(1) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses; and

(2) The following types of American Indian / Alaska Native income:

(A) Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;

(B) Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

(i) Rights of ownership or possession in any lands described in Paragraph (a) (2) (A) of this section; or

(ii) Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

(C) Distributions resulting from real property ownership interests related to natural resources and improvements:

(i) Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or

(ii) Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

(D) Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom;

(E) Student financial assistance provided under the Bureau of Indian Affairs education programs; and

(F) Distributions from Alaska Native Corporations and Settlement Trusts.

(b) Amounts received as a lump sum are counted as income only in the month received (see also ~~OAC~~Oklahoma Administrative Code (OAC) 317:35-10-26), with the exception of certain lottery or gambling winnings as specified in OAC 317:35-6-55. If a lump sum amount is received from an income source that is not counted in MAGI according to section 36B(d)(2)(B) of the Internal Revenue Code or the exceptions listed in this section, the amount is not counted.

317:35-6-55. Treatment of qualified lottery or qualified gambling winnings

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

(1) **"Qualified lottery winnings"** means winnings from a sweepstakes, lottery, or pool described in paragraph three (3) of Section 4402 of the Internal Revenue Code of 1986 or a lottery operated by a multistate or multijurisdictional lottery association paid out in a single payout and not in installments over a period of time.

(2) **"Qualified gambling winnings"** means monetary winnings from gambling, as defined by Section (§) 1955(b)(4) of Title 18 of the United States Code (U.S.C.).

(3) **"Undue hardship"** means circumstances resulting from a loss or denial of SoonerCare eligibility that would deprive an individual of medical care, such that the individual's health or life would be endangered, or that would deprive the individual or his or her financially dependent family members of food, clothing, shelter, or other necessities of life.

(b) **Income determinations.** In accordance with 42 U.S.C. § 1396a(e)(14)(K), qualified lottery and gambling winnings shall be considered as income in determining the financial eligibility of individuals whose eligibility is determined based on the application of Modified Adjusted Gross Income (MAGI), as follows:

(1) Winnings less than \$80,000 are counted in the month received;

(2) Winnings greater than or equal to \$80,000, but less than \$90,000, are counted as income over two (2) months, with an equal amount counted in each month;

(3) Winnings greater than or equal to \$90,000, but less than \$100,000, are counted as income over three (3) months, with an equal amount counted in each month;

(4) Winnings greater than or equal to \$100,000 are counted as income over three (3) months, with one (1) additional month for every increment of \$10,000 in winnings received over \$100,000, with an equal amount counted in each month; and

(5) The maximum period of time over which winnings may be

counted is one hundred and twenty (120) months, which would apply to winnings greater than or equal to \$1,260,000.

(c) **Treatment of household members.** Qualified lottery and gambling winnings shall be counted as household income for all household members in the month of receipt; however, the requirement to count qualified lottery and gambling winnings in household income over multiple months applies only to the individual receiving the winnings.

(d) **Undue hardship.** An individual who loses or is denied eligibility due to qualified lottery or gambling winnings may timely file a member appeal, in accordance with Oklahoma Administrative Code 317:2-1-2. If, as part of that appeal, the individual proves by a preponderance of the evidence that loss or denial of eligibility would result in undue hardship, eligibility shall be restored or approved, provided all other conditions of eligibility have been met.

(e) **Notice.** SoonerCare members or applicants who are determined financially ineligible due to the counting of lottery or gambling winnings will receive a notice of the date on which the lottery or gambling winnings will no longer be counted for eligibility purposes. The notice will also inform the member or applicant of the undue hardship exemption and of their opportunity to enroll in a Qualified Health Plan on the Federally Facilitated Exchange.

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

317:2-1-2.6. Continuation of benefits or services pending appeal

(a) In accordance with Section 431.230 of Title 42 of the Code of Federal Regulations, if an Appellant submits a written request for a hearing within ten (10) days of the notice of the adverse agency action, the Appellant may also request that existing benefits or services (hereinafter, collectively referred to as "services") be continued or reinstated until the earlier of dismissal of the appeal, Appellant's withdrawal of the appeal, or an initial hearing decision adverse to the Appellant.

(b) If the Appellant fails to indicate a preference as to continuation or reinstatement of services in a written request for hearing made within ten (10) days of the notice of the adverse agency action, services shall be continued or reinstated. Provided, however, that a SoonerCare member shall not be entitled to continuation or reinstatement of services pending an appeal related to the following:

(1) When a service is denied because the member has exceeded the limit applicable to that service;

(2) When a request for a prior authorization is denied for a prescription drug. However:

(A) The Oklahoma Health Care Authority (OHCA) may authorize a single seventy-two (72) hour emergency supply of the drug, in accordance with Oklahoma Administrative Code (OAC) 317:30-5-77.2;

(B) A SoonerCare provider may initiate a step therapy exception request on behalf of a member, in accordance with OAC 317:30-5-77.4;

(3) When coverage of a prescription drug or service is denied because the requested drug or service is not a category or class of drugs or services covered by OHCA;

(4) When coverage for a prescription drug is denied because the enrollee has been locked into one (1) pharmacy and the member seeks to fill a prescription at another pharmacy; or

(5) When a physician or other licensed health care practitioner has failed to prescribe or order the service or level of service for which continuation or reinstatement is requested.

(c) If services are continued or reinstated during the appeals process and the hearing is not decided in the Appellant's favor, OHCA may seek to recover reimbursement of all services received pending the hearing decision.

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

SUBCHAPTER 18. PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY
(PACE)

317:35-18-6. PACE program benefits

(a) The PACE program offers a comprehensive benefit plan. A provider agency must provide a participant all the services listed in ~~42 CFR 460.92~~ Section (§) 460.92 of Title 42 of the Code of Federal Regulations (C.F.R.) that are approved by the ~~IDT~~ interdisciplinary team (IDT). The PACE benefit package for all participants, regardless of the source of payment, must include but is not limited to the following:

- (1) All SoonerCare-covered services, as specified in the State's approved ~~SoonerCare plan~~ Medicaid State Plan;
- (2) ~~Interdisciplinary assessment~~ IDT and treatment planning ~~;~~ ;
- (3) Primary care, including physician and nursing services ~~;~~ ;
- (4) Social work services ~~;~~ ;
- (5) Restorative therapies, including physical therapy, occupational therapy, and speech-language pathology services ~~;~~ ;
- (6) Personal care and supportive services ~~;~~ ;
- (7) Nutritional counseling ~~;~~ ;
- (8) Recreational therapy ~~;~~ ;
- (9) Transportation ~~;~~ ;
- (10) Meals ~~;~~ ;
- (11) Medical specialty services including, but not limited to the following:
 - (A) Anesthesiology ~~;~~ ;
 - (B) Audiology ~~;~~ ;
 - (C) Cardiology ~~;~~ ;
 - (D) Dentistry ~~;~~ ;
 - (E) Dermatology ~~;~~ ;
 - (F) Gastroenterology ~~;~~ ;
 - (G) Gynecology ~~;~~ ;
 - (H) Internal medicine ~~;~~ ;
 - (I) Nephrology ~~;~~ ;
 - (J) Neurosurgery ~~;~~ ;
 - (K) Oncology ~~;~~ ;
 - (L) Ophthalmology ~~;~~ ;
 - (M) Oral surgery ~~;~~ ;
 - (N) Orthopedic surgery ~~;~~ ;
 - (O) Otorhinolaryngology ~~;~~ ;
 - (P) Plastic surgery ~~;~~ ;
 - (Q) Pharmacy consulting services ~~;~~ ;

- (R) Podiatry-; i
 - (S) Psychiatry-; i
 - (T) Pulmonary disease-; i
 - (U) Radiology-; i
 - (V) Rheumatology-; i
 - (W) General surgery-; i
 - (X) Thoracic and vascular surgery-; i and
 - (Y) Urology.
- (12) Laboratory tests, x-rays, and other diagnostic procedures-; i
- (13) Drugs and biologicals-; i
- (14) Prosthetics, orthotics, ~~durable medical equipment~~, medical supplies, equipment, and appliances, corrective vision devices, such as eyeglasses and lenses, hearing aids, dentures, and repair and maintenance of these items-; i
- (15) Acute inpatient care, including the following:
- (A) Ambulance-; i
 - (B) Emergency room care and treatment room services-; i
 - (C) Semi-private room and board-; i
 - (D) General medical and nursing services-; i
 - (E) Medical surgical/intensive care/coronary care unit-; i
 - (F) Laboratory tests, x-rays, and other diagnostic procedures-; i
 - (G) Drugs and biologicals-; i
 - (H) Blood and blood derivatives-; i
 - (I) Surgical care, including the use of anesthesia-; i
 - (J) Use of oxygen-; i
 - (K) Physical, occupational, respiratory therapies, and speech-language pathology services-; i and
 - (L) Social services.
- (16) Nursing facility (NF) care, including:
- (A) Semi-private room and board;
 - (B) Physician and skilled nursing services;
 - (C) Custodial care;
 - (D) Personal care and assistance;
 - (E) Drugs and biologicals;
 - (F) Physical, occupational, recreational therapies, and speech-language pathology, if necessary;
 - (G) Social services; and
 - (H) Medical supplies, equipment, and appliances.
- (17) Other services determined necessary by the ~~interdisciplinary team~~ IDT to improve and maintain the participant's overall health status.
- (b) The following services are excluded from coverage under PACE:

(1) Any service that is not authorized by the ~~interdisciplinary team~~, IDT, even if it is a required service, unless it is an emergency service.

(2) In an inpatient facility, private room and private duty nursing (PDN) services (unless medically necessary), and non-medical items for personal convenience such as telephone charges and radio or television rental (unless specifically authorized by the ~~interdisciplinary team~~ IDT as part of the participant's plan of care).

(3) Cosmetic surgery, which does not include surgery that is required for improved functioning of a malformed part of the body resulting from an accidental injury or for reconstruction following mastectomy.

(4) Experimental medical, surgical, or other health procedures.

(5) Services furnished outside of the United States, except as follows:

(A) ~~in~~ In accordance with 42 ~~CFR~~ C.F.R. § 424.122 through 42 ~~CFR~~ C.F.R. § 424.124, and

(B) ~~as~~ As permitted under the State's approved Medicaid ~~plan~~ State Plan.

(c) In the event that a PACE participant is in need of permanent placement in a ~~nursing facility~~, NF, a Medicaid premium will be imposed. OKDHS will calculate a vendor co-payment for those participants using the same methodology as is used for any Oklahoma Medicaid member who is accessing ~~nursing facility~~ NF level of care. However, for a PACE participant, the ~~participants~~ participant's responsibility will be to make payment directly to the PACE provider~~r~~, the amount to be specified by the OKDHS worker. There are no other share of costs requirements for PACE.

(d) All PACE ~~Program Benefits~~ program benefits are offered through the duration of the PACE participant's enrollment in the PACE program. PACE enrollment does not cease once a participant's condition necessitates or the PACE IDT recommends that ~~they~~ he or she be institutionalized.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 50. HOME AND ~~COMMUNITY BASED SERVICES WAIVERS~~COMMUNITY-
BASED WAIVER SERVICES

SUBCHAPTER 1. MEDICALLY FRAGILE WAIVER SERVICES

317:50-1-14. Description of services

Services included in the Medically Fragile ~~Waiver~~waiver program are as follows:

(1) Case Management.

(A) Case ~~Management~~management services are services that assist a member in gaining access to medical, social, educational or other services, regardless of payment source of services, that may benefit the member in maintaining health and safety. Case managers initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility. Case managers develop the member's comprehensive service plan, listing only services which are necessary to prevent institutionalization of the member, as determined through assessments. Case managers initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support. Case managers monitor the member's condition to ensure delivery and appropriateness of services and initiate service plan reviews. If a member requires hospital or skilled nursing facility (NF) services, the case manager assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay and helps the member transition from institution to home by updating the service plan and preparing services to start on the date the member is discharged from the institution. Case managers must meet Medically Fragile ~~Waiver~~waiver program minimum requirements for qualification and training prior to providing services to members. Prior to providing services to members choosing to self-direct their services, case managers are required to receive training and demonstrate knowledge regarding the self-directed service delivery model.

(B) Providers may only claim time for billable case management activities described as follows:

(i) A billable case management activity is any task or function defined under ~~OAC~~Oklahoma Administrative Code (OAC) 317:50-1-15(1)(A), that only a Medically Fragile case manager because of skill, training, or authority, can perform on behalf of a member;

(ii) Ancillary activities such as clerical tasks like mailing, copying, filing, faxing, drive time, or supervisory/administrative activities are not billable case management activities, although the administrative cost of these activities and other normal and customary business overhead costs have been included in the reimbursement rate for billable activities. Payment is not allowed for written reports or record documentation.

(C) Case ~~Management~~management services are prior authorized and billed per ~~fifteen-minute~~fifteen (15) minute unit of service using the rate associated with the location of residence of the member served.

(i) ~~Standard rate:~~ Case Management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with population density greater than twenty-five (25) persons per square mile.

(ii) ~~Very rural/difficult service area rate:~~ Case management services are billed using a very ~~rural/difficult~~rural/outside providers' service rate for billable service activities provided to a member who resides in a county with population density equal to or less than twenty-five (25) persons per square mile. An exception would be services to members that reside in ~~OHCA-identified~~OHCA-identified zip codes in Osage county adjacent to metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

(iii) The latest United States Census, Oklahoma Counties population data is the source for determination of whether a member resides in a county with a population density equal to or less than twenty-five (25) persons per square mile, or resides in a county with a population density greater than twenty-five (25) persons per square mile.

(D) Case managers providing case management services to Medically Fragile waiver members must submit monthly monitoring case notes on a monthly basis to the OHCA Medically Fragile ~~Waiver~~waiver staff.

(E) Providers of Home and ~~Community Based Services~~Community-Based waiver services (HCBS) for the member, or those who have an interest in or are employed by a provider of HCBS for the member, must not provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered

service plans in a geographic area also provides HCBS.

(2) Institutional transitional case management.

(A) Institutional Transition case management services are required by the member's service plan, which are necessary to ensure the health, welfare, and safety of the member, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization.

(B) Institutional transition case management services assist institutionalized members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

(C) Institutional transition case management services may be authorized for periodic monitoring of a waiver member's progress during an institutional stay, and for assisting the member's transition from institution to home by updating the services plan, including preparing for necessary services and supports to be in place or to start on the date the member is discharged from the institution.

(3) Respite.

(A) Respite services are provided to members who are unable to care for themselves. They are provided on a short-term basis because of the absence or need for relief of the primary caregiver. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a nursing facility. (NF). Respite care will only be utilized when other sources of care and support have been exhausted. Respite care will only be listed on the service plan when it is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) ~~In-Home Respite~~ In-home respite services are billed per fifteen (15) minute unit service. Within any ~~one-day~~ one (1) day period, a minimum of eight (8) units must be provided with a maximum of ~~28~~ twenty-eight (28) units provided. The service is provided in the member's home.

(C) ~~Facility-Based Extended Respite~~ Facility-based extended respite is filed for a per diem rate, if provided in ~~Nursing Facility.~~ a NF. ~~Extended Respite~~ respite must be at least eight (8) hours in duration.

(D) ~~In-Home Extended Respite~~ respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(4) **Environmental Modifications.**

(A) Environmental ~~Modifications~~modifications are physical adaptations to the home, required by the member's service plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home and without which, the member would require institutionalization. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the ~~Waiver~~waiver member are excluded.

(B) All services require prior authorization.

(C) All services shall be provided in accordance with applicable state and local building codes and conform to the Americans with Disabilities Act Accessibility Guidelines, Title 28 of the Code of Federal Regulations Part 36 Appendix A.

(D) Payment for these services is made on an individual basis following a uniform process approved by the Medicaid agency.

(5) **Specialized Medical Equipment and Supplies.**

(A) ~~Specialized medical equipment and supplies are devices, controls, or appliances~~Medical supplies, equipment, and supplies are specified in the service plan, which enable members to increase their abilities to perform activities of daily living, or to perceive, control, or communicate with the environment in which they live. Also included are items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment and supplies not available under the Medicaid state planMedicaid State Plan. This service excludes any equipment and/or supply items which are not of direct medical or remedial benefit to the Waiver member. This service is necessary to prevent institutionalization.

(B) ~~Specialized medical equipment and supplies~~Medical supplies, equipment, and supplies are billed using the appropriate ~~HCP~~healthcare common procedure code. (HCPC). Reoccurring supplies which are shipped to the member are compensable only when the member remains eligible for ~~Waiver~~waiver services, continues to reside in the home and is not institutionalized in a hospital, skilled ~~nursing facility~~(NF) or nursing home. It is the provider's responsibility to verify the member's status prior to shipping these items. Payment for ~~medical supplies~~medical supplies, equipment, and supplies is limited to the Medicare rate, or the SoonerCare rate, or is determined through manual

pricing. If manual pricing is used, the provider is reimbursed at the provider's documented ~~Manufacturer's Suggested Retail Price~~ manufacturer's suggested retail price (MSRP) minus thirty (30) percent or invoice cost plus thirty (30) percent, whichever is the lesser of the two. (2). OHCA may establish a fair market price through claims review and analysis.

(6) **Advanced Supportive/Restorative Assistance-supportive/restorative assistance.**

(A) ~~Advanced~~ Supportive/Restorative Assistance-supportive/restorative assistance services are maintenance services to assist a member who has a chronic, yet stable, condition. These services assist with activities of daily living which require devices and procedures related to altered body functions. This service is for maintenance only and is not utilized as a treatment service.

(B) ~~Advanced~~ Supportive/Restorative Assistance-supportive/restorative assistance service is billed per fifteen (15) minute unit of service. The number of units of this service a member may receive is limited to the number of units approved on the service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the service plan which are within the scope of the Oklahoma Nursing Practice Act and are provided by a registered professional nurse, or licensed practical or vocational nurse under the supervision of a registered nurse, licensed to practice in the State. Nursing services includes skilled nursing and/or private duty nursing. Skilled nursing is provided on an intermittent or part-time basis. Private duty nursing is individual and continuous care provided to a participant at home by licensed nurses. The provision of the nursing service will work to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventive nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services which would be reimbursable under either Medicaid or Medicare's Home Health program. This service primarily provides nurse supervision to the Personal Care Assistant or to the Advanced Supportive/Restorative Assistance Aide and assesses the member's health and prescribed medical services to ensure that they meet the member's needs as specified in the service plan. A skilled nursing assessment/evaluation on-site visit is made to each member for whom Advanced Supportive/Restorative Assistance services are authorized to

evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation visit report will be made to the Medically Fragile Waiver case manager in accordance with review schedule determined in consultation between the Case Manager and the Skilled Nurse, to report the member's condition or other significant information concerning each advanced supportive/restorative care member.

(i) The case manager may recommend authorization of Skilled Nursing services as part of the interdisciplinary team planning for the member's service plan and/or assessment/evaluation of:

(I) the member's general health, functional ability and needs and/or

(II) the adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides in accordance with rules and regulations for delegation of nursing tasks as established by the Oklahoma Board of Nursing.

(ii) In addition to assessment/evaluation, the case manager may recommend authorization of Skilled Nursing services for the following:

(I) preparing a one (1) week supply of insulin syringes for a blind diabetic, who can safely self-inject the medication but cannot fill his/her own syringe. This service would include monitoring the member's continued ability to self-administer the insulin;

(II) preparing oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) monitoring a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence, or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) providing nail care for the diabetic member or member with circulatory or neurological compromise;

(V) providing consultation and education to the member, member's family and/or other informal caregivers identified in the service plan, regarding the nature of the member's chronic condition. Provide skills training (including return skills demonstration

to establish competency) to the member, family and/or other informal caregivers as specified in the service plan for preventive and rehabilitative care procedures.

(C) Nursing service can be billed for service plan development and/or assessment/evaluation services or, for other services within the scope of the Oklahoma Nursing Practice Act including private duty nursing. Nursing services are billed per fifteen (15) minute unit of service. A specific procedure code is used to bill for assessment/evaluation/service plan development skilled nursing services and other procedure codes are used to bill for all other authorized nursing services. A maximum of eight (8) units per day of skilled nursing for assessment/evaluation and/or service plan development are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement, to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied if the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) Home Delivered Meals.

(A) Home Delivered Meals provide one (1) meal per day. A home delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one third ($1/3$) of the recommended daily allowance as established by the Food and Nutrition Board of the National Academy of Sciences. Meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home Delivered Meals are billed per meal, with one meal equaling one unit of service. The limit of the number of units a member is allowed to receive is limited on the member's service plan. The provider must obtain a signature from the member or the member's representative at the time the meals are delivered. In the event that the member is temporarily unavailable (i.e., doctor's appointment, etc.) and the meal is left, the provider must document the reason a signature is not obtained. The signature logs must be available for review.

(9) Occupational Therapy services.

(A) Occupational Therapy services are those services that increase functional independence by enhancing the development of adaptive skills and performance capacities of

members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the therapeutic use of self-care, work and play activities and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order, a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written therapeutic regimen. The regimen utilizes paraprofessional occupational therapy assistant services, within the limits of their practice, working under the supervision of the licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(10) Physical Therapy services.

(A) Physical Therapy services are those services that prevent physical disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves use of physical therapeutic means such as massage, manipulation, therapeutic exercise, cold or heat therapy, hydrotherapy, electrical stimulation and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional physical therapy assistant services, within the limits of their practice, working under the supervision of the licensed physical therapist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to

coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical Therapy services are billed per fifteen (15) minute units of service. Payment is not allowed solely for written reports or record documentation.

(11) Speech and Language Therapy services.

(A) Speech/Language Therapy services are those that prevent speech and language communication disability through the evaluation and rehabilitation of members disabled by pain, disease or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Services involve use of therapeutic means such as evaluation, specialized treatment, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed Speech/Language Pathologist evaluates the member's rehabilitation potential and develops an appropriate, written therapeutic regimen. The regimen utilizes paraprofessional therapy assistant services within the limits of their practice, working under the supervision of the licensed Speech/Language Pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The Pathologist will ensure monitoring and documentation of the member's rehabilitative progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech/Language Therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(12) Respiratory Therapy Services.

(A) Respiratory therapy services are provided for a member who, but for the availability of in-home respiratory services, would require respiratory care as an inpatient in a hospital or nursing facility. Services are provided in the member's home under the care of a physician who is familiar with the technical and medical components of home ventilator support and the physician must determine medically that in-home respiratory care is safe and feasible for the member. Treatment involves use of therapeutic means such as: evaluation, respiratory treatments, chest physiotherapy, and/or development and oversight of a therapeutic maintenance program. Under a physician's order, a registered respiratory therapist evaluates the member and develops an

appropriate, written therapeutic regimen. The regimen includes education and training for informal caregivers to assist with and/or maintain services, where appropriate. The therapist will ensure monitoring and documentation of the member's progress and will report to the member's case manager and physician to coordinate necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Respiratory ~~Therapy~~therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(13) Hospice Services.

(A) Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has six (6) months or less to live and orders hospice care. Medically Fragile Waiver hospice care is authorized for a six (6) month period and requires a physician certification of a terminal illness and orders of hospice care. If the member requires more than six months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) days prior to the initial hospice authorization end date and re-certify that the member has a terminal illness and has six months or less to live and orders additional hospice care. After the initial authorization period, additional periods of hospice may be authorized for a maximum of sixty (60) days increments with physician certification that the member has a terminal illness and has six months or less to live. A member's service plan that includes hospice care must comply with waiver requirements to be within total service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and during dying and bereavement. The member signs a statement choosing hospice care instead of routine medical care that has the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care services, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement

counseling to the member and/or family. A hospice plan of care must be developed by the hospice team in conjunction with the member's case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills. Hospice may be provided to the member in a Nursing Facility (NF) only when the member is placed in the NF for Medically Fragile Facility Based Extended Respite. Hospice provided as part of Facility Based Extended Respite may not be reimbursed for more than five days during any thirty (30) day period. A member that is eligible for Medicare Hospice provided as a Medicare Part A benefit, is not eligible to receive Medically Fragile hospice services.

(C) Hospice services are billed per diem of service for days covered by a hospice plan of care and during which the hospice provider is responsible for providing hospice services as needed by the member or member's family.

(14) Personal Care.

(A) Personal Care is assistance to a member in carrying out activities of daily living such as bathing, grooming and toileting, or in carrying out instrumental activities of daily living, such as preparing meals and doing laundry, to assure personal health and safety of the individual or to prevent or minimize physical health regression or deterioration. Personal Care services do not include service provision of a technical nature, i.e. tracheal suctioning, bladder catheterization, colostomy irrigation, and operation/maintenance of equipment of a technical nature.

(B) Medically Fragile Home Care Agency Skilled Nursing staff working in coordination with a case manager are responsible for development and monitoring of the member's Personal Care plan.

(C) Personal Care services are prior authorized and billed per fifteen (15) minute unit of service with units of service limited to the number of units on the approved service plan.

(15) Personal Emergency Response System.

(A) Personal Emergency Response System (PERS) is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable help button to allow for mobility. The system is connected to the person's phone and programmed to signal, in accordance with member preference, a friend, a relative or a response center once a help button is activated. The response center is staffed

by trained professionals. For an Medically Fragile program member to be eligible to receive PERS service, the member must meet all of the following service criteria:

- (i) ~~aA~~ recent history of falls as a result of an existing medical condition that prevents the individual from getting up from a fall unassisted;
- (ii) ~~lives~~Lives alone and has no regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;
- (iii) ~~demonstrates~~Demonstrates capability to comprehend the purpose of and activate the PERS;
- (iv) ~~has~~Has a health and safety plan detailing the interventions beyond the PERS to assure the member's health and safety in his/her home;
- (v) ~~has~~Has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and,
- (vi) ~~the~~The service avoids premature or unnecessary institutionalization of the member.

(B) PERS services are billed using the appropriate health care procedure codes for installation, monthly service or purchase of PERS. All services are prior authorized in accordance with the Medically Fragile approved service plan.

(16) **Prescription drugs.** Members are eligible for a maximum of six (6) prescriptions per month with a limit of three (3) brand-name prescriptions. Seven (7) additional generic prescriptions per month are allowed if medically necessary. Medically necessary prescriptions beyond the three (3) brand-name or thirteen (13) total prescriptions will be covered with prior authorization. More information on prescription drugs is provided at OAC 317:30-5-72.

(17) **Self-Direction.**

(A) Self-Direction is a method of service delivery that allows waiver members to determine supports and services they need to live successfully in a home or community based setting. A member choosing Self-Direction is the employer of record for his/her Personal Care and Advanced Supportive/Restorative Care service providers and must have an approved service plan prior to initiation of any Self-Directed activities.

(B) The OHCA uses the following criteria to determine a member's eligibility to participate in the Self-Directed option:

- (i) ~~have~~Have an existing need for Self-Directed services to prevent institutionalization;

(ii) ~~member's~~Member's health and safety with Self-Directed services can reasonably be assured based on a review of service history records and a review of member capacity and readiness to assume employer responsibilities under Self-Direction with any one of the following findings as basis to deny a request for Self-Direction due to inability to assure member health and safety;

(I) ~~the~~The member does not have the ability to make decisions about his/her care or service planning and the member's authorized representative is not willing to assume Self-Directed services responsibilities~~7;~~ or

(II) ~~the~~The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one (1) or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the Personal Care Assistant (PCA) or Advanced Supportive/Restorative (ASR) service provider, or in monitoring and managing health or in preparation for emergency backup~~7;~~ or

(III) ~~the~~The member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention within the past ~~12~~twelve (12) months and does not have an authorized representative with capacity to assist with Self-Direction responsibilities~~7.~~

(C) The member voluntarily makes an informed choice to Self-Direct services. As part of the informed choice, decision making process for Self-Direction, the OHCA staff or the case manager provides consultation and assistance as the member completes a self-assessment of preparedness to assume the role of employer for their ~~Personal Care Assistant~~PCA. The orientation and enrollment process will provide the member with a basic understanding of what will be expected of them under Self-Direction, the supports available to assist them to successfully perform employer responsibilities and an overview of the potential risks involved.

(D) The OHCA uses the following criteria to determine that based upon documentation, a person is no longer able to participate in the Self-Directed services option:

(i) ~~the~~The member does not have the ability to make decisions about his/her care or service planning and the member's authorized representative is not willing to assume Self-Direction responsibilities; or

- (ii) ~~the~~The member is not willing to assume responsibility, or to enlist an authorized representative to assume responsibility, in one or more areas of Self-Direction such as in service planning, or in assuming the role of employer of the PCA or ASR service providers, or in monitoring and managing health or in preparation for emergency backup; or
- (iii) ~~the~~The member has a recent history of self-neglect or self-abuse as evidenced by Adult Protective Services intervention and does not have an "authorized representative" with capacity to assist with Self-Direction responsibilities; or
- (iv) ~~the~~The member abuses or exploits their employee; or
- (v) ~~the~~The member falsifies time-sheets or other work records; or
- (vi) ~~the~~The member, even with case manager and financial management services assistance, is unable to operate successfully within their Individual Budget Allocation (IBA); or
- (vii) ~~inferior~~Inferior quality of services provided by member/employer's employee, or the inability of the member/employer's employee to provide the number of service units the member requires, jeopardizes the member's health and/or safety.

(E) The member may designate a family member or friend as an "authorized representative" to assist in the service planning process and in executing member employer responsibilities. If the member chooses to designate an "authorized representative", the designation and agreement identifying the "willing adult" to assume this role and responsibility is documented with dated signatures of the member, the designee and the member's case manager or the OHCA staff.

- (i) A person having guardianship or legal power of attorney or other court sanctioned authorization to make decisions on behalf of the member has legal standing to be the member's designated "authorized representative".
- (ii) An individual hired to provide Personal Services Assistance to a member may not be designated the "authorized representative" for the member.

(F) Self-Directed Services are delivered as authorized on the service plan and are limited to Personal Care, Respite and Advanced Supportive/Restorative Care. The member employs the ~~Respite~~respite or PCA and/or the ASR provider and is responsible, with assistance from the Administrative Financial Management Services (FMS), for ensuring that the

employment complies with state and federal labor law requirements. The member:

- (i) ~~recruits~~Recruits, hires and, as necessary, discharges the PCA and ASR;
- (ii) ~~provides~~Provides instruction and training to the PCA or ASR on tasks to be done and works with the case manager to obtain skilled nursing services assistance with training when necessary. Prior to performing an ASR provider task for the first time, the ASR must demonstrate competency in the tasks in an on-the-job training session conducted by the member and the member must document the attendant's competency in performing each task in the ASR provider personnel file;
- (iii) ~~determines~~Determines where and how the PCA or ASR works, hours of work, what is to be accomplished and, within IBA limits, wages to be paid for the work;
- (iv) ~~supervises~~Supervises and documents employee work time; and,
- (v) ~~provides~~Provides tools and materials for work to be accomplished.

(G) FMS are program administrative services provided to participating Self-Directed Service employer/members by agencies contracted with the OHCA. FMS are employer related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions including, but not limited to:

- (i) ~~employer~~Employer payroll, at a minimum of semi monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PCA or ASR provider;
- (ii) ~~other~~Other employer related payment disbursements as agreed to with the member and in accordance with the member's IBA;
- (iii) ~~responsibility~~Responsibility for obtaining criminal and abuse registry background checks, on behalf of the member, on prospective hires for PCA or ASR provider;
- (iv) ~~providing~~Providing to the member, as needed, assistance with employer related cognitive tasks, decision-making and specialized skills that may include assistance with IBA planning and support for making decisions including training and providing reference material and consultation regarding employee management tasks such as recruiting, hiring, training and supervising the member's respite or PCA or ASR provider; and

(H) The service of ~~Respite~~respite or PCA is billed per fifteen (15) minute unit of service. The number of units of PCA a member may receive is limited to the number of units approved on the Service Plan.

(I) ASR services are billed per fifteen (15) minute unit of service. The number of units of ASR a member may receive is limited to the number of units approved on the Service Plan.

(J) Self-Directed Services rates are determined using the IBA expenditure accounts determination process for each member. The IBA expenditure accounts determination process includes consideration and decisions about the following:

(i) The IBA expenditure accounts determination constrains total SoonerCare reimbursement for Self-Directed services to be less than expenditures for equivalent services using agency providers.

(ii) The PCA and ASR service unit rates are calculated by the OHCA during the Self-Directed service eligibility determination process. The allocation of portions of the PCA and/or ASR rate to cover salary, mandatory taxes, and optional benefits (including worker's compensation insurance, if available) is determined individually for each member using the Self-Directed services IBA expenditure accounts determination process.

(iii) The IBA Expenditure Accounts Determination process defines the level of program financial resources required to meet the member's need for Self-Directed services. If the member's need for services changes due to a change in health/disability status and/or a change in the level of support available from other sources, the case manager, based upon an updated assessment, amends the service plan to increase Self-Directed service units appropriate to meet additional member need. The OHCA, upon favorable review, authorizes the amended plan and updates the member's IBA. Service amendments based on changes in member need for services do not change an existing PCA or ASR rate. The member, with assistance from the FMS, reviews and revises the IBA expenditure accounts calculation annually or more often to the extent appropriate and necessary.

(18) Self-Directed Goods and Services (SD-GS) .

(A) Self-Directed Goods and Services (SD-GS) are incidental, non-routine goods and services that promote the member's self-care, daily living, adaptive functioning, general household activity, meal preparation and leisure skills needed to reside successfully in the community and do not

duplicate other services authorized in the member's service plan.

(B) These goods and services are purchased from the self-directed budget. All goods and services must be approved by the Medically Fragile waiver staff. Documentation must be available upon request.

(19) Transitional case management.

(A) Transitional case management are one-time billable expenses for members who transition from within the community to the Medically Fragile waiver.

(B) Transitional case management must be reasonable and necessary as determined through the transition plan development process and must be clearly identified in the plan.

(C) Transitional case management assist members that are eligible to receive waiver services in gaining access to needed waiver and other state plan services, as well as needed medical, social, educational, and other services to assist the transition, regardless of the funding source for the services which access is gained.

(D) Transitional case management may be authorized for assisting the member transition to the Medically Fragile Waiver by updating the service plan, including preparing for necessary services and supports to be in place or to start on the date the member is effective with the waiver.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-25. Crossovers ~~(coinsurance and deductible)~~ (deductibles, coinsurance, and copays)

(a) **Medicare Part BA**. Payment is made for Medicare ~~deductible and coinsurance~~ deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

(b) **Medicare Part AB**. Payment is made for Medicare ~~deductible and coinsurance~~ deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

~~(c) **Medicare Advantage Plans**. Payment is made for Medicare HMO copayments. For services offered by Medicare Advantage Plans that revert to traditional Medicare type benefits, payment is made for coinsurance and deductibles according to subsection (a) and (b) in this section.~~

(c) **Medicare Part C (Medicare Advantage Plans)**. Payment is made for Medicare deductibles, coinsurance, and copays on behalf of eligible individuals according to the methodology outlined in the Oklahoma Medicaid State Plan.

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – November 4, 2020

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Mycapssa®	• Acromegaly	• \$66,976 per year	• Not 1 st line treatment
2	Zejula®	• Ovarian Cancer	• \$ 21,776 per 30 days	• 4 th line treatment
3	Trikafta®	• Cystic Fibrosis	• \$286,755 per year	• Treats most common gene mutation
4	Evrysdi™	• Spinal Muscular Atrophy (SMA)	• \$335,112 per year	• First oral treatment
5	Cystadrops® Cystaran™	• Ocular Cystinosis	• \$6,482 per month • \$7,000 per month	• Cysteine crystals may be present in cornea by age 2

*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.

Recommendation 1: Vote to Prior Authorize Mycapssa®

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

Mycapssa® (Octreotide) Approval Criteria:

1. An FDA approved indication for long-term maintenance treatment in members with acromegaly who have responded to and tolerated treatment with octreotide or lanreotide; and
2. Member has elevated insulin-like growth factor-1 (IGF-1) levels for age and/or gender; and
3. Member has a documented trial with injectable octreotide or lanreotide, and the prescriber must verify that the member responded to and tolerated treatment with octreotide or lanreotide; and
4. A patient-specific, clinically significant reason why the member cannot continue treatment with injectable octreotide or lanreotide must be provided; and
5. Mycapssa® must be prescribed by, or in consultation with, an endocrinologist; and
6. Prescriber must document that the member has had an inadequate response to surgery or is not a candidate for surgery; and
7. Initial approvals will be for the duration of 12 months. Reauthorization may be granted if the prescriber documents the member's IGF-1 level has decreased or normalized since initiating treatment; and
8. A quantity limit of 120 capsules per 30 days will apply.

Recommendation 2: Vote to Prior Authorize Zejula®

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

Zejula® (Niraparib) Approval Criteria [Ovarian, Fallopian Tube, or Primary Peritoneal Cancer Diagnosis]:

1. **Single-Agent Treatment of Advanced Recurrent/Refractory Disease:**
 - a. Diagnosis of recurrent or refractory disease; and
 - b. Previous treatment with ≥ 3 prior lines of chemotherapy (prior chemotherapy regimens should be documented on the prior authorization request); and
 - c. Diagnosis is associated with homologous recombination deficiency (HRD) positive status defined by either:
 - i. A deleterious or suspected deleterious BRCA mutation; or
 - ii. Genomic instability and progression >6 months after response to last platinum-based chemotherapy; and
 - d. Used as a single-agent; or

2. Treatment of Advanced Recurrent/Refractory Disease in Combination with Bevacizumab:

- a. Used in combination with bevacizumab for platinum-sensitive persistent disease or recurrence; and
- b. Meets 1 of the following:
 - i. As immediate treatment for serially rising CA-125 in members who previously received chemotherapy, or
 - ii. Evidence of radiographic and/or clinical relapse in members with previous complete remission and relapse ≥ 6 months after completing prior chemotherapy; or

3. Maintenance Treatment of Advanced Disease:

- a. Diagnosis of advanced or recurrent disease; and
- b. Disease must be in a complete or partial response to platinum chemotherapy; and
- c. Used as a single-agent.

Recommendation 3: Vote to Prior Authorize Trikafta®

The Drug Utilization Review Board recommends the prior authorization of Trikafta® (elixacaftor/tezacaftor/ivacaftor and ivacaftor) with the following criteria:

Trikafta® (Elexacaftor/Tezacaftor/Ivacaftor and Ivacaftor) Approval Criteria:

1. An FDA approved diagnosis of cystic fibrosis (CF) in members who have at least 1 *F508del* mutation in the CF transmembrane conductance regulator (*CFTR*) gene; and
2. If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a *CFTR* mutation followed by verification with bi-directional sequencing when recommended by the mutation test's instructions for use; and
3. Member must be 12 years of age or older; and
4. Members using Trikafta® must be supervised by a pulmonary specialist; and
5. If member is currently stabilized on Orkambi® (lumacaftor/ivacaftor) or Symdeko® (tezacaftor/ivacaftor and ivacaftor) and experiencing adverse effects associated with Orkambi® or Symdeko® use, the prescriber must indicate that information on the prior authorization request; and
6. Prescriber must verify that member has been counseled on proper administration of Trikafta® including taking with a fat-containing food; and

7. Prescriber must verify that ALT, AST, and bilirubin will be assessed prior to initiating Trikafta®, every 3 months during the first year of treatment, and annually thereafter; and
8. Prescriber must verify that the member does not have severe hepatic impairment; and
9. Prescriber must verify that pediatric members will receive baseline and follow-up ophthalmological examinations as recommended in the Trikafta® *Prescribing Information*; and
10. Member must not be taking any of the following medications concomitantly with Trikafta®: rifampin, rifabutin, phenobarbital, carbamazepine, phenytoin, and St. John's wort; and
11. A quantity limit of 3 tablets per day or 84 tablets per 28 days will apply; and
12. Initial approval will be for the duration of 3 months, after which time compliance will be required for continued approval. After 6 months of utilization, compliance and information regarding efficacy, such as improvement in forced expiratory volume in 1 second (FEV₁), will be required for continued approval. Additionally after 6 months of utilization, information regarding efficacy as previously mentioned or fewer adverse events than with a previous CFTR therapy must be provided for members who switched from Orkambi® (lumacaftor/ivacaftor) or Symdeko® (tezacaftor/ivacaftor and ivacaftor).

Recommendation 4: Vote to Prior Authorize Evrysdi™

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

Evrysdi™ (Risdiplam) Approval Criteria:

1. An FDA approved diagnosis of spinal muscular atrophy (SMA) in members 2 months of age and older; and
2. Molecular genetic testing to confirm bi-allelic pathogenic variants in the *survival motor neuron 1 (SMN1)* gene; and
3. Member is not currently dependent on permanent invasive ventilation (defined as ≥16 hours of respiratory assistance per day continuously for >21 days in the absence of an acute, reversible illness or a perioperative state); and
4. Evrysdi™ must be prescribed by a neurologist or specialist with expertise in the treatment of SMA (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA); and

5. Prescriber must agree to monitor member's liver function prior to initiating Evrysdi™ and periodically while receiving Evrysdi™ treatment; and
6. Pharmacy must confirm Evrysdi™ will be constituted to an oral solution by a pharmacist prior to dispensing and must confirm Evrysdi™ will be shipped via cold chain supply to adhere to the storage and handling requirements in the Evrysdi™ *Prescribing Information*; and
7. Prescriber must confirm the member or caregiver has been counseled on the proper storage of Evrysdi™ and has been instructed on how to prepare the prescribed daily dose of Evrysdi™ prior to administration of the first dose; and
8. Female members of reproductive potential must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
9. Female members of reproductive potential must be willing to use effective contraception during treatment with Evrysdi™ and for at least 1 month after the last dose; and
10. Prescriber must verify male members of reproductive potential have been counseled on the potential effects on fertility and the potential of compromised male fertility is acceptable; and
11. Member will not be approved for concomitant treatment with Spinraza® (nusinersen); and
12. Member must not have previously received treatment with Zolgensma® (onasemnogene abeparvovec-xioi); and
13. A baseline assessment must be provided using a functionally appropriate exam [e.g., Children's Hospital of Philadelphia Infant Test of Neuromuscular Disorders (CHOP-INTEND), Hammersmith Functional Motor Scale Expanded (HFMSE), Hammersmith Infant Neurological Exam (HINE), Upper Limb Module (ULM) Test]; and
14. Initial authorizations will be for the duration of 6 months, at which time the prescriber must verify the member is compliant with Evrysdi™ and responding to the medication as demonstrated by clinically significant improvement or maintenance of function from pre-treatment baseline status using the same exam as performed at baseline assessment; and
15. Member's recent weight must be provided to ensure accurate dosing in accordance with Evrysdi™ *Prescribing Information*; and
16. A quantity limit of 240mL per 36 days will apply.

Recommendation 5: Vote to Prior Authorize Cystadrops® and Cystaran™

The Drug Utilization Review Board recommends the prior authorization of Cystadrops® (cysteamine 0.37% ophthalmic solution) and Cystaran™ (cysteamine 0.44% ophthalmic solution) with the following criteria:

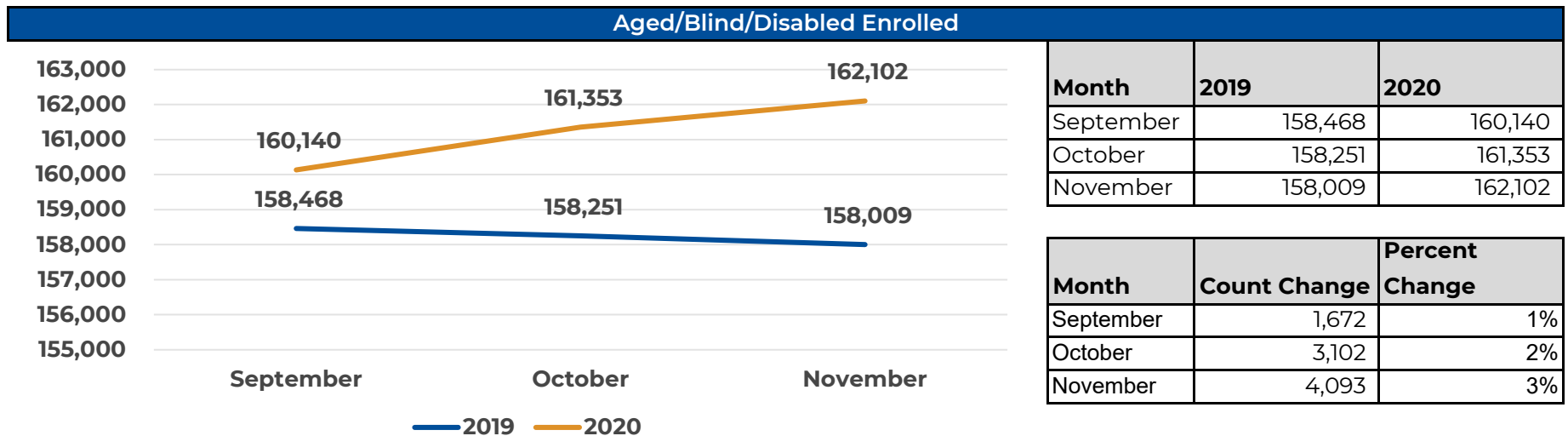
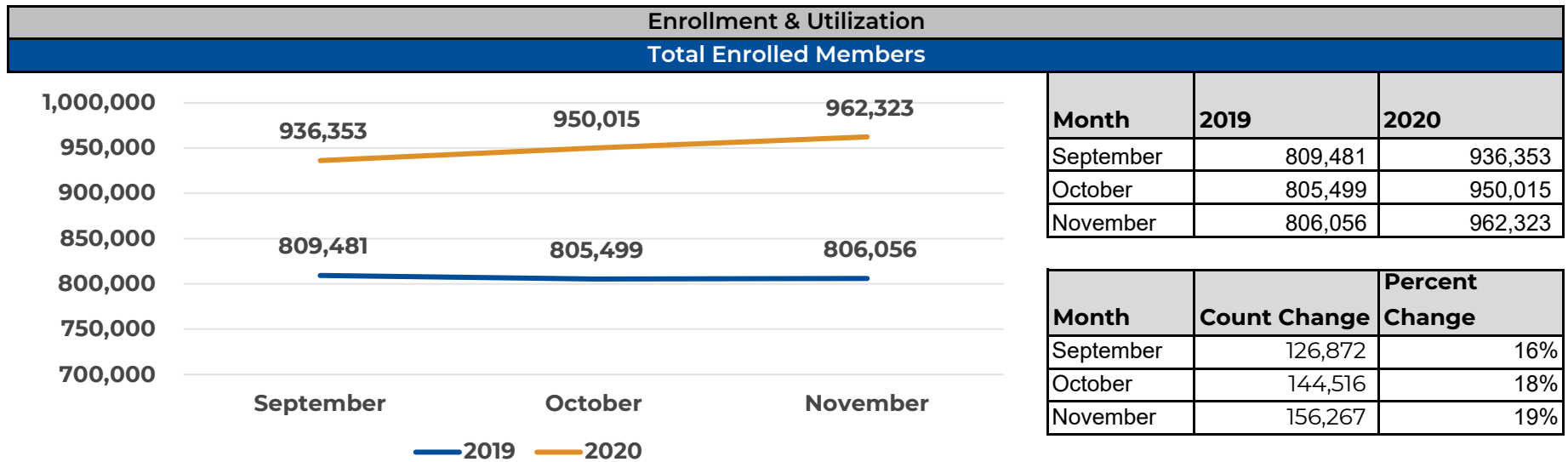
Cystadrops® (Cysteamine 0.37% Ophthalmic Solution) and Cystaran™ (Cysteamine 0.44% Ophthalmic Solution) Approval Criteria:

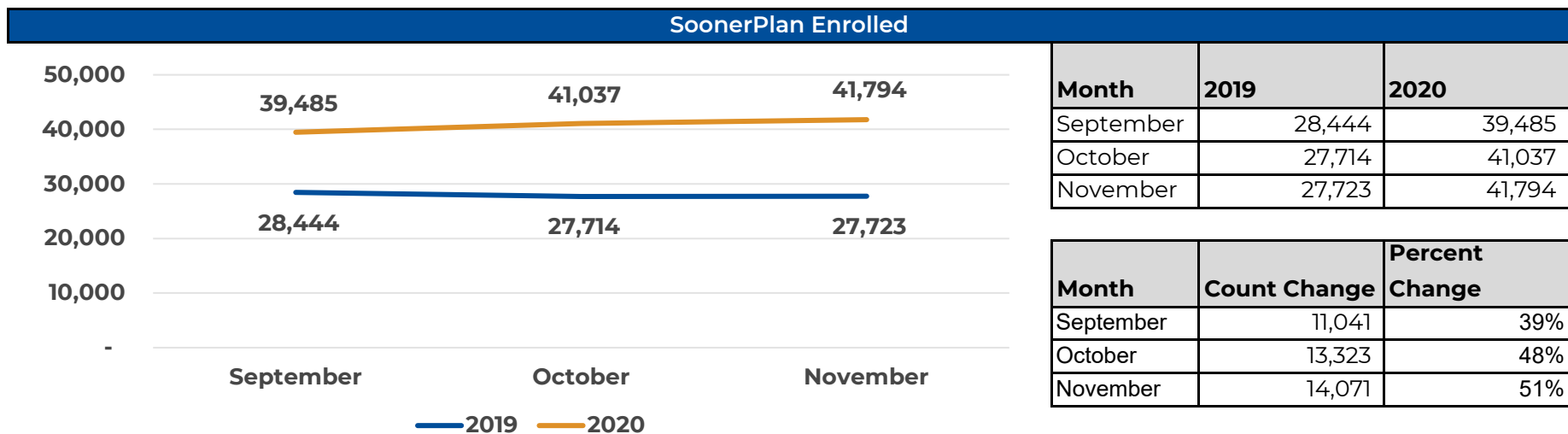
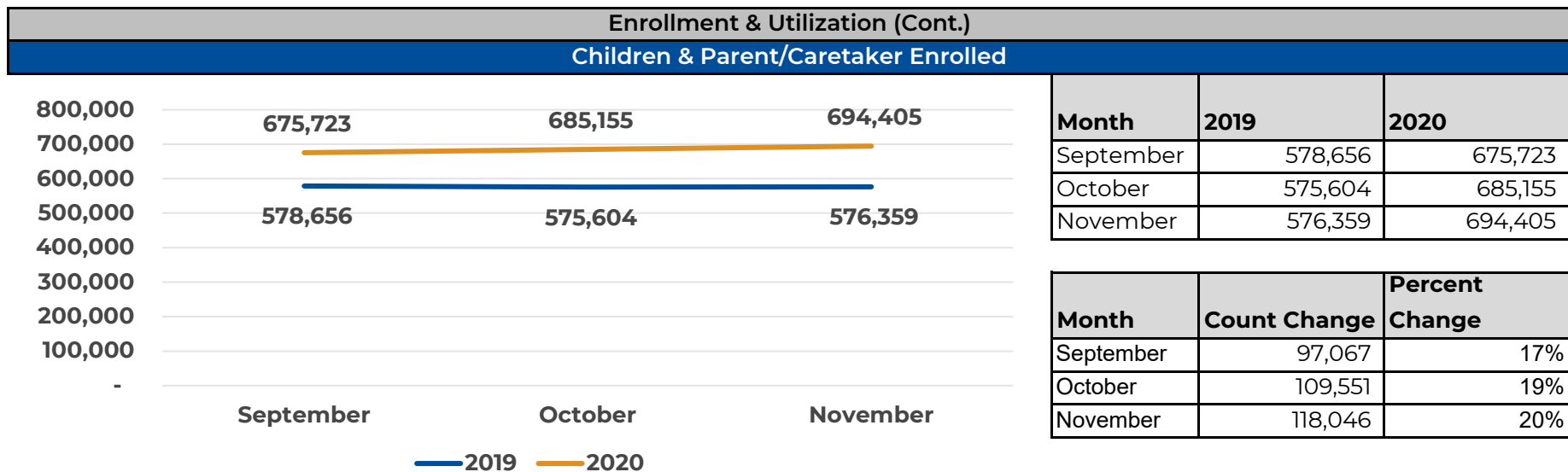
1. An FDA approved indication for the treatment of corneal cystine crystal accumulation in members with cystinosis; and
2. The requested medication must be prescribed by, or in consultation with, an ophthalmologist; and
3. Prescriber must verify that the member has been counseled on the proper storage of the requested medication; and
4. For Cystadrops®, a patient-specific, clinically significant reason (beyond convenience) why the member cannot use Cystaran™ must be provided; and
5. A quantity limit of 4 bottles per month will apply.

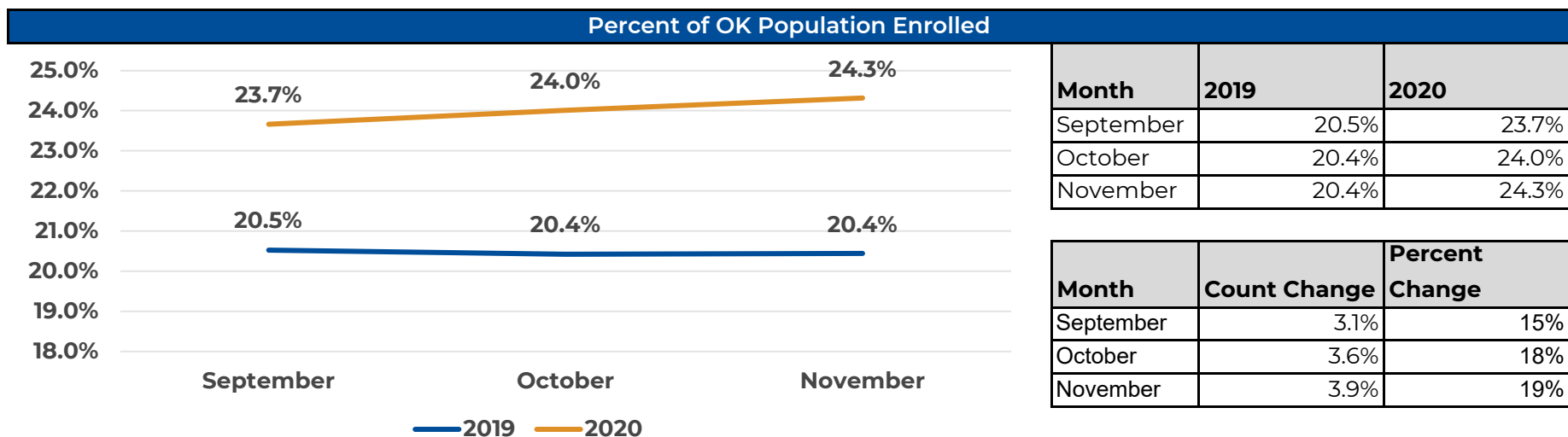
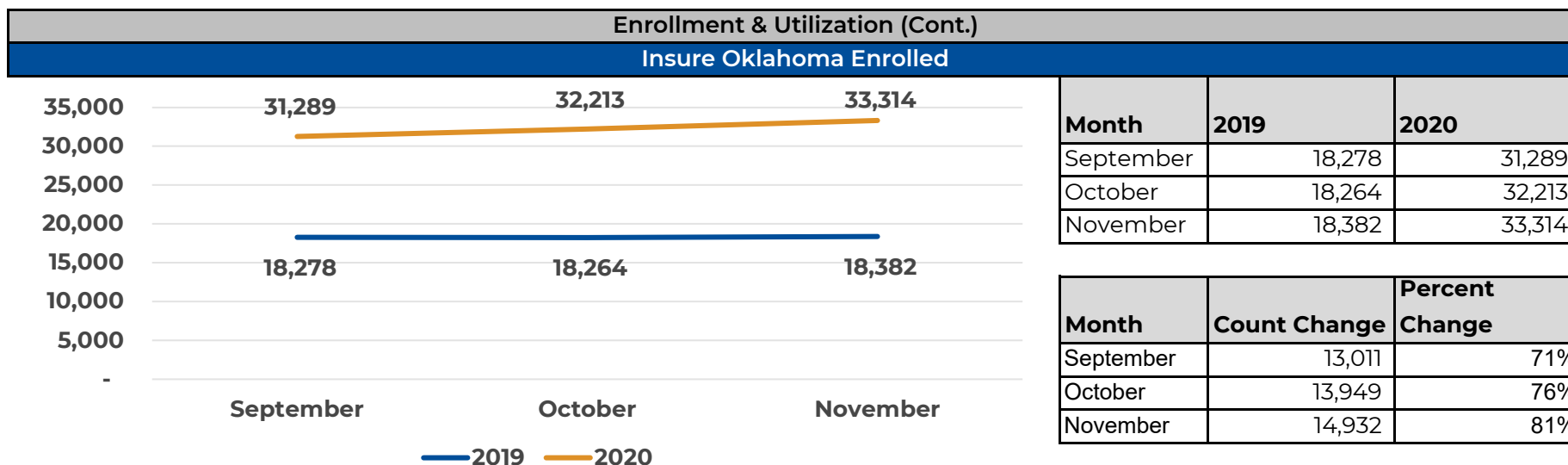


OPERATIONAL METRICS

January 2021 Board Meeting

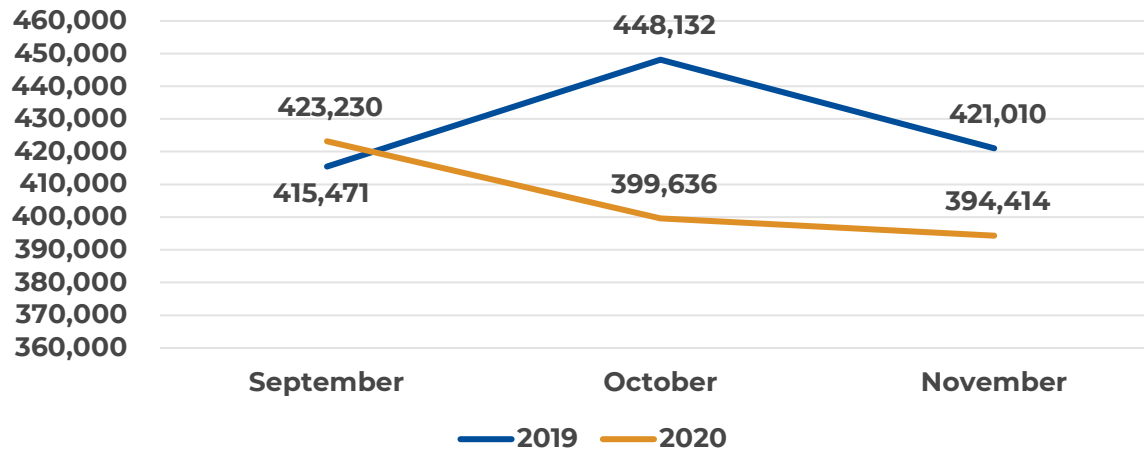






Enrollment & Utilization (Cont.)

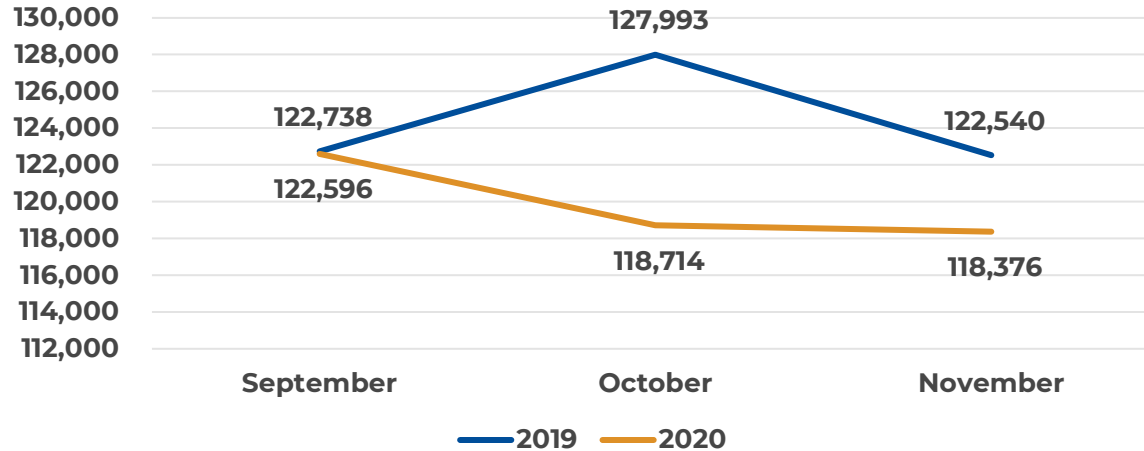
Total Members Utilization



Month	2019	2020
September	415,471	423,230
October	448,132	399,636
November	421,010	394,414

Month	Count Change	Percent Change
September	7,759	2%
October	(48,496)	-11%
November	(26,596)	-6%

Aged/Blind/Disabled Utilization

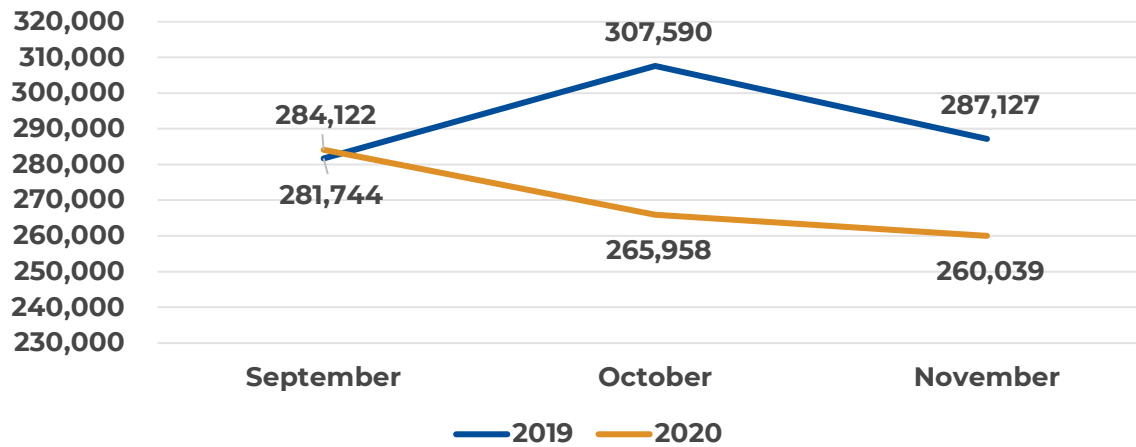


Month	2019	2020
September	122,738	122,596
October	127,993	118,714
November	122,540	118,376

Month	Count Change	Percent Change
September	(142)	0%
October	(9,279)	-7%
November	(4,164)	-3%

Enrollment & Utilization (Cont.)

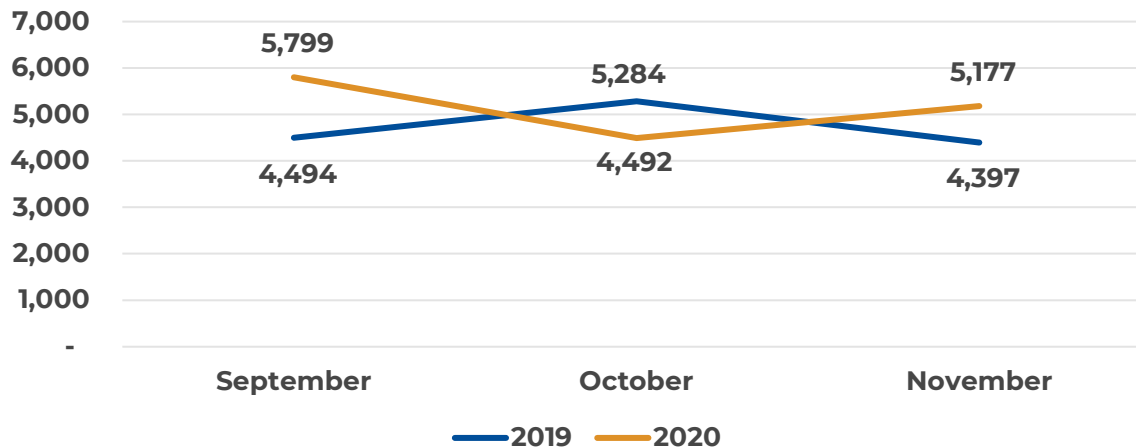
Children & Parent/Caretaker Utilization



Month	2019	2020
September	281,744	284,122
October	307,590	265,958
November	287,127	260,039

Month	Count Change	Percent Change
September	2,378	1%
October	(41,632)	-14%
November	(27,088)	-9%

SoonerPlan Utilization

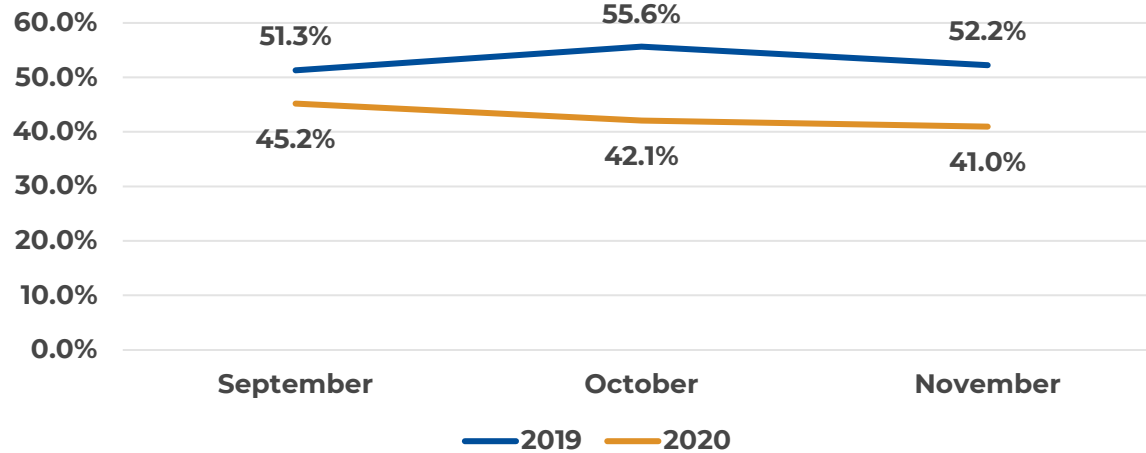


Month	2019	2020
September	4,494	5,799
October	5,284	4,492
November	4,397	5,177

Month	Count Change	Percent Change
September	1,305	29%
October	(792)	-15%
November	780	18%

Enrollment & Utilization (Cont.)

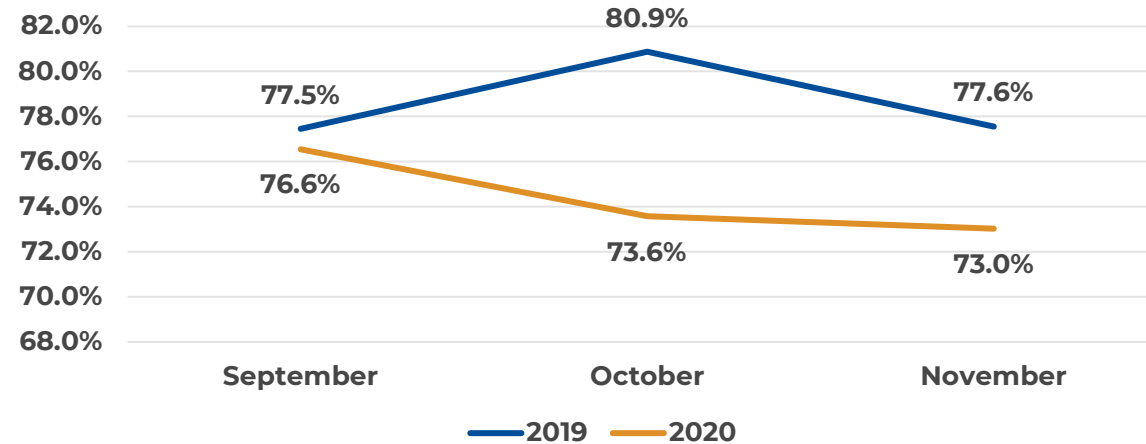
Percent of Total Enrolled Members Utilization



Month	2019	2020
September	51.3%	45.2%
October	55.6%	42.1%
November	52.2%	41.0%

Month	Count Change	Percent Change
September	-6.1%	-12%
October	-13.6%	-24%
November	-11.2%	-22%

Percent of Aged/Blind/Disabled Enrolled Members Utilization

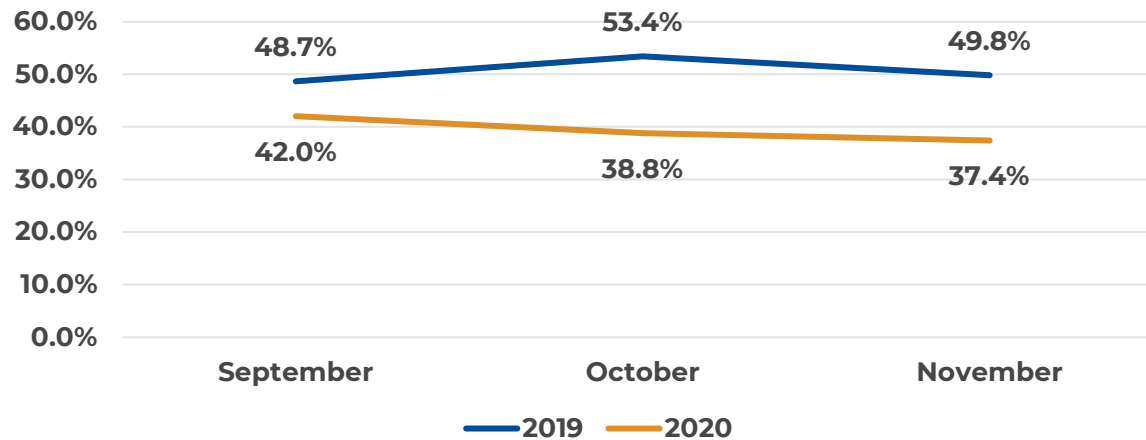


Month	2019	2020
September	77.5%	76.6%
October	80.9%	73.6%
November	77.6%	73.0%

Month	Count Change	Percent Change
September	-0.9%	-1%
October	-7.3%	-9%
November	-4.5%	-6%

Enrollment & Utilization (Cont.)

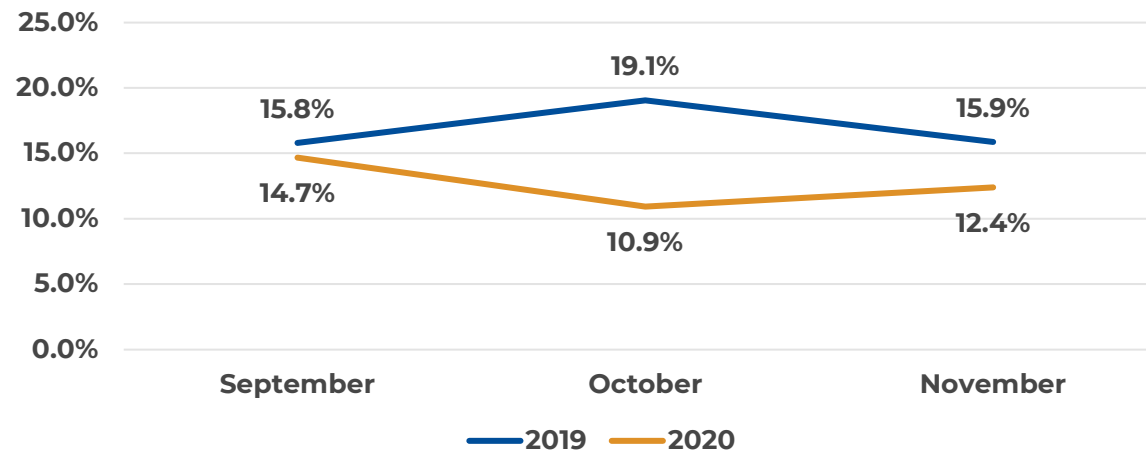
Percent of Children & Parent/Caretaker Enrolled Members Utilization



Month	2019	2020
September	48.7%	42.0%
October	53.4%	38.8%
November	49.8%	37.4%

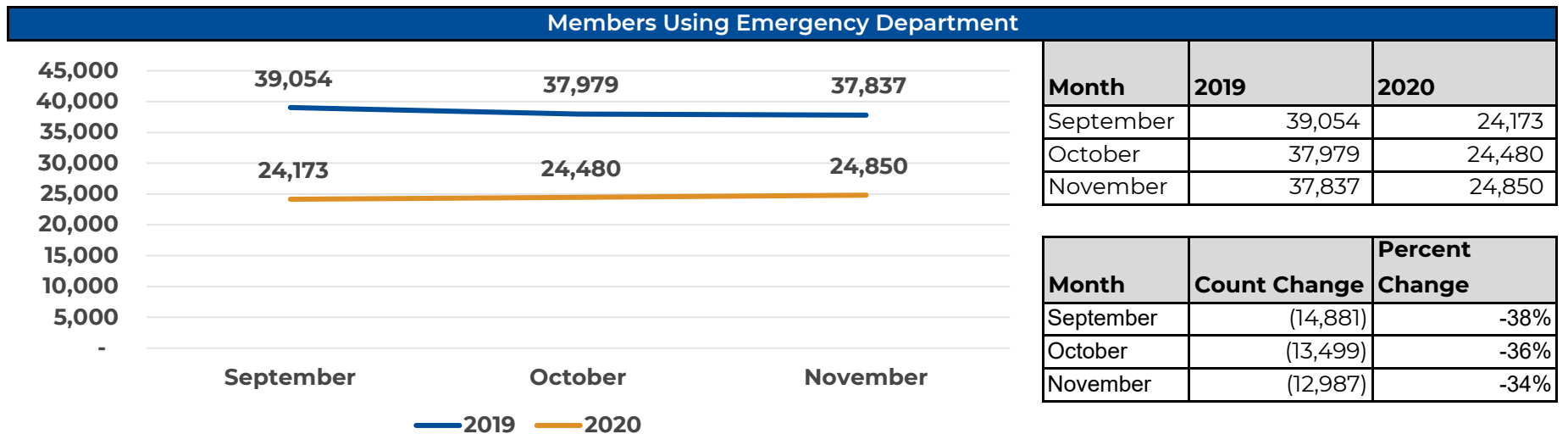
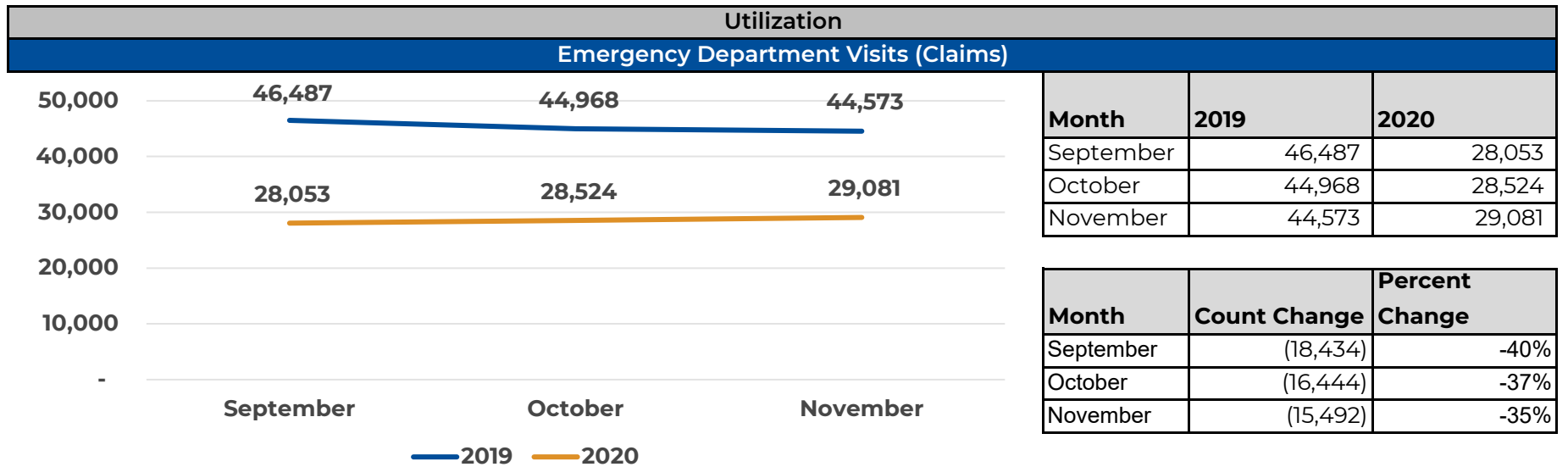
Month	Count Change	Percent Change
September	-6.6%	-14%
October	-14.6%	-27%
November	-12.4%	-25%

Percent of SoonerPlan Enrolled Members Utilization



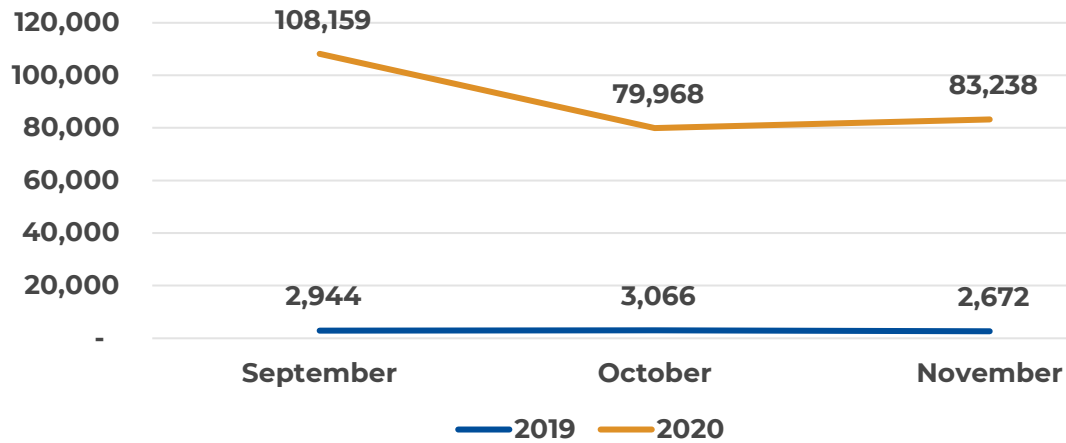
Month	2019	2020
September	15.8%	14.7%
October	19.1%	10.9%
November	15.9%	12.4%

Month	Count Change	Percent Change
September	-1.1%	-7%
October	-8.1%	-43%
November	-3.5%	-22%



Utilization (Cont.)

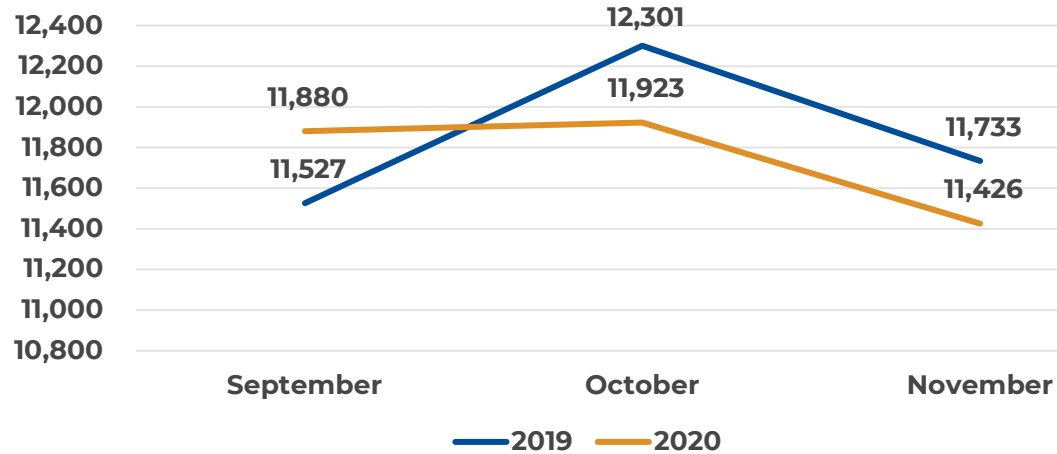
Telemedicine - Total Visits



Month	2019	2020
September	2,944	108,159
October	3,066	79,968
November	2,672	83,238

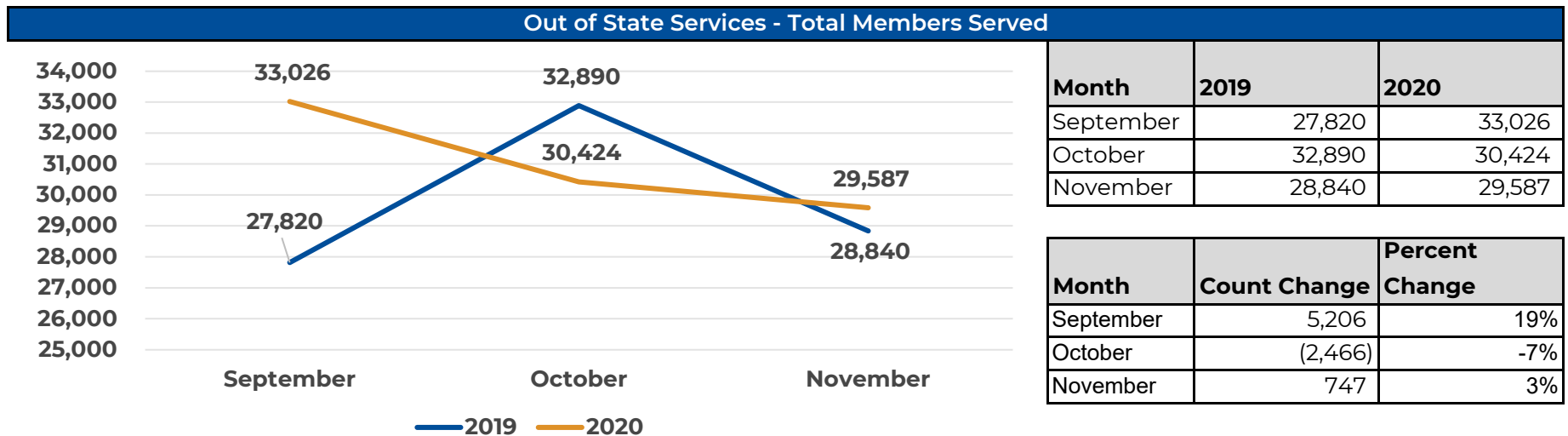
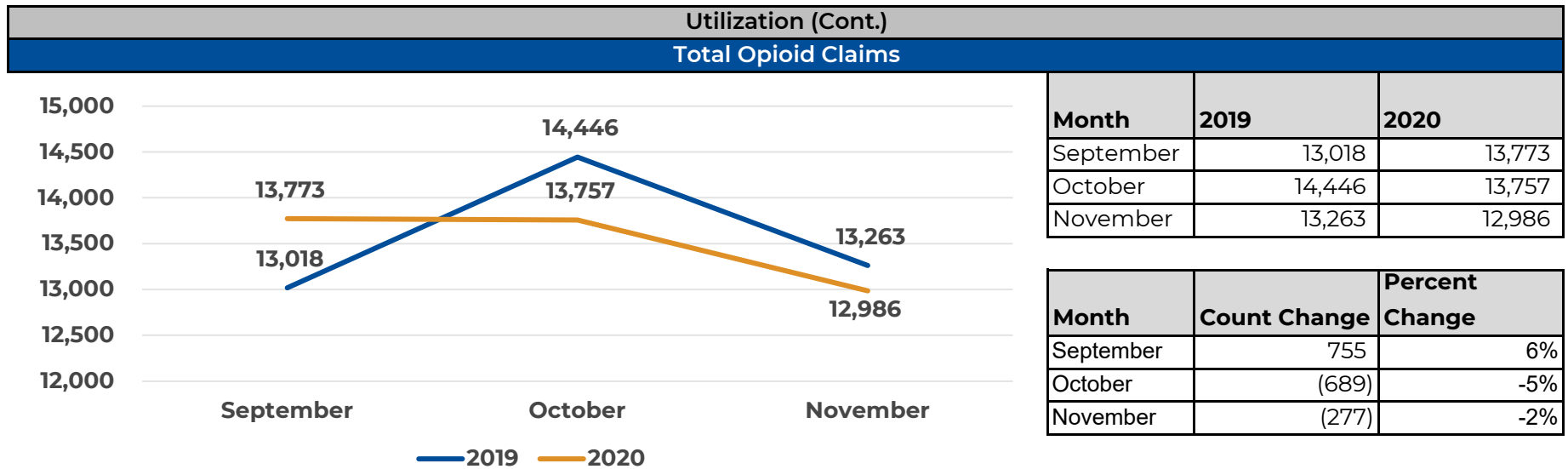
Month	Count Change	Percent Change
September	105,215	3574%
October	76,902	2508%
November	80,566	3015%

Members With Opioid Claims



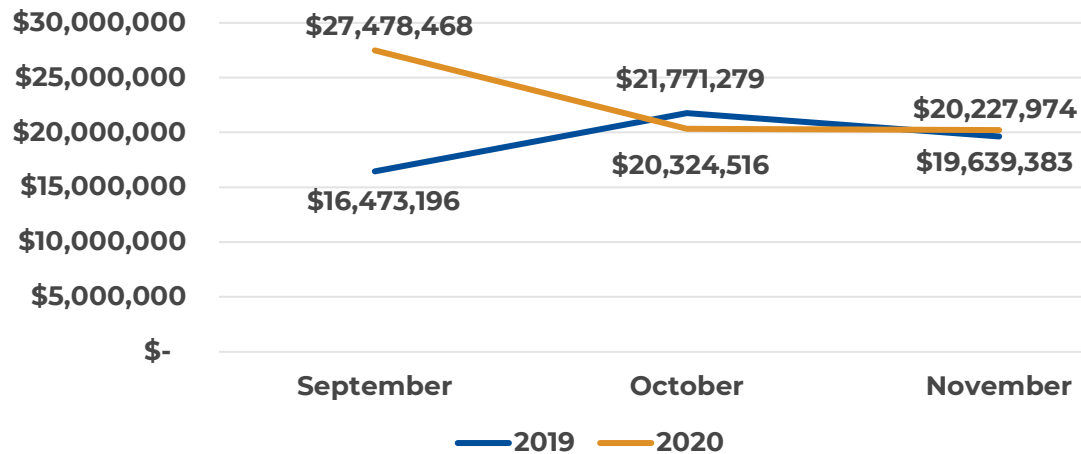
Month	2019	2020
September	11,527	11,880
October	12,301	11,923
November	11,733	11,426

Month	Count Change	Percent Change
September	353	3%
October	(378)	-3%
November	(307)	-3%



Utilization (Cont.)

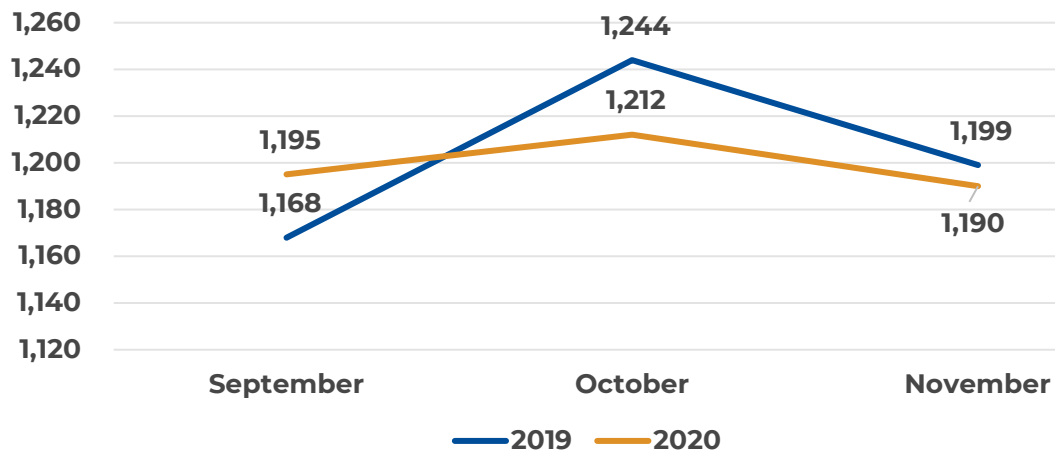
Out of State Services - Total Reimbursements



Month	2019	2020
September	\$ 16,473,196	\$ 27,478,468
October	\$ 21,771,279	\$ 20,324,516
November	\$ 19,639,383	\$ 20,227,974

Month	Count Change	Percent Change
September	11,005,272	67%
October	(1,446,763)	-7%
November	588,590	3%

Out of State Services - Total Active Billing Providers

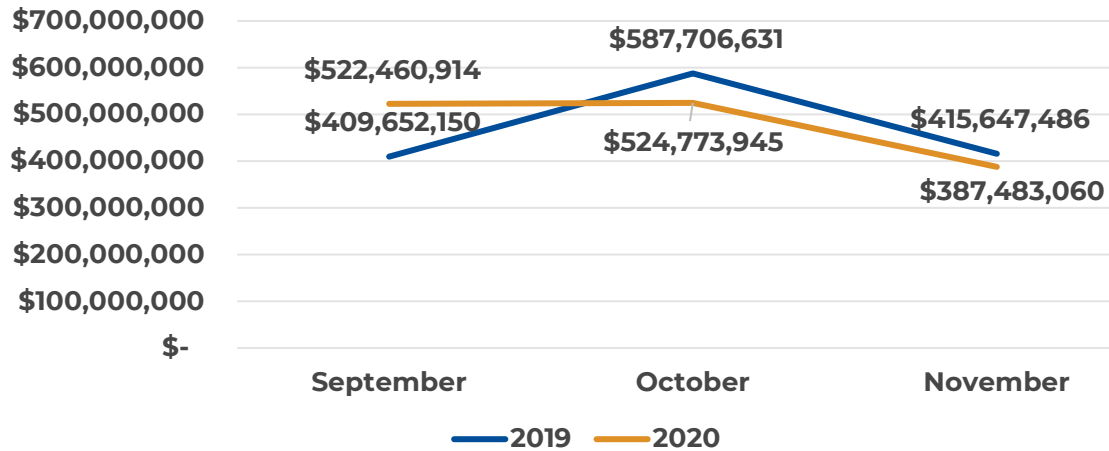


Month	2019	2020
September	1,168	1,195
October	1,244	1,212
November	1,199	1,190

Month	Count Change	Percent Change
September	27	2%
October	(32)	-3%
November	(9)	-1%

Financials

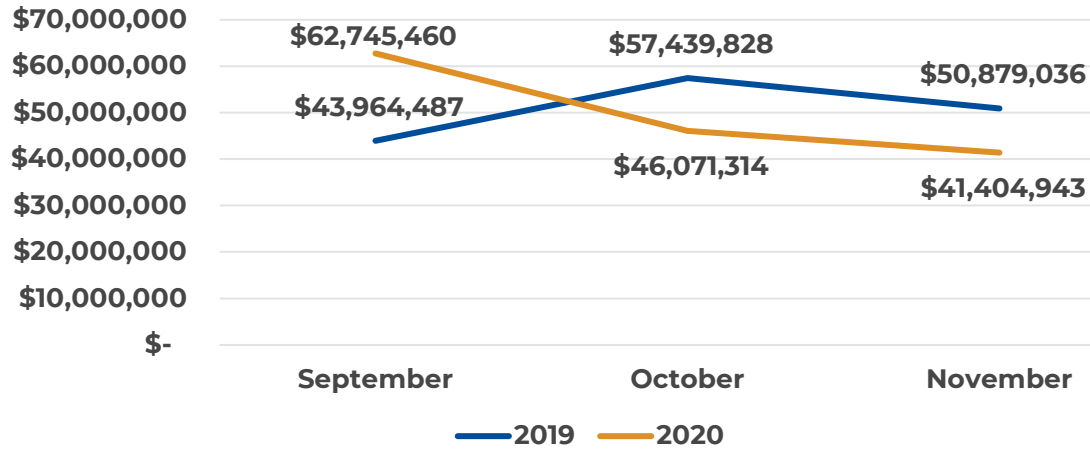
Total Agency Expenditures



Month	2019	2020
September	\$ 409,652,150	\$ 522,460,914
October	\$ 587,706,631	\$ 524,773,945
November	\$ 415,647,486	\$ 387,483,060

Month	Count Change	Percent Change
September	\$ 112,808,764	28%
October	\$ (62,932,686)	-11%
November	\$ (28,164,426)	-7%

Inpatient Services Expenditures

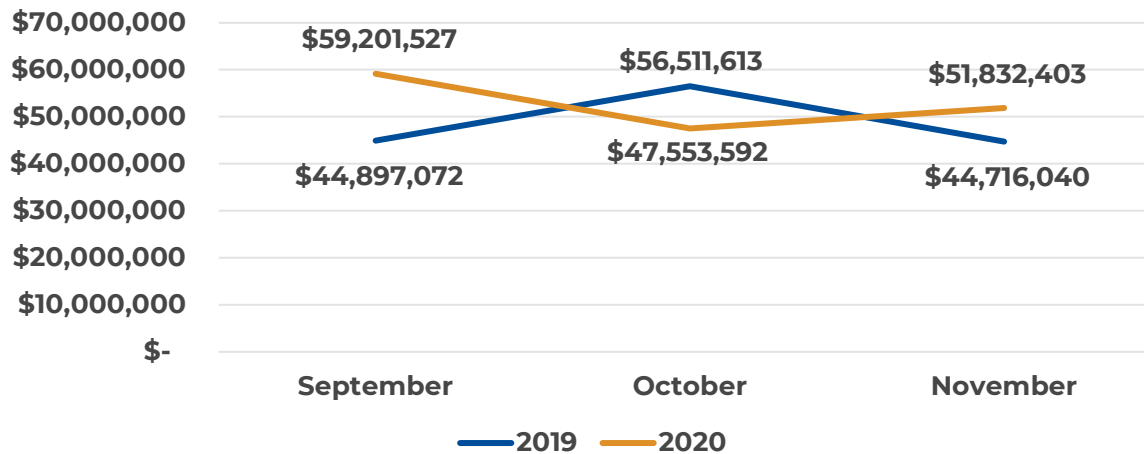


Month	2019	2020
September	\$ 43,964,487	\$ 62,745,460
October	\$ 57,439,828	\$ 46,071,314
November	\$ 50,879,036	\$ 41,404,943

Month	Count Change	Percent Change
September	\$ 18,780,972	43%
October	\$ (11,368,514)	-20%
November	\$ (9,474,093)	-19%

Financials (Cont.)

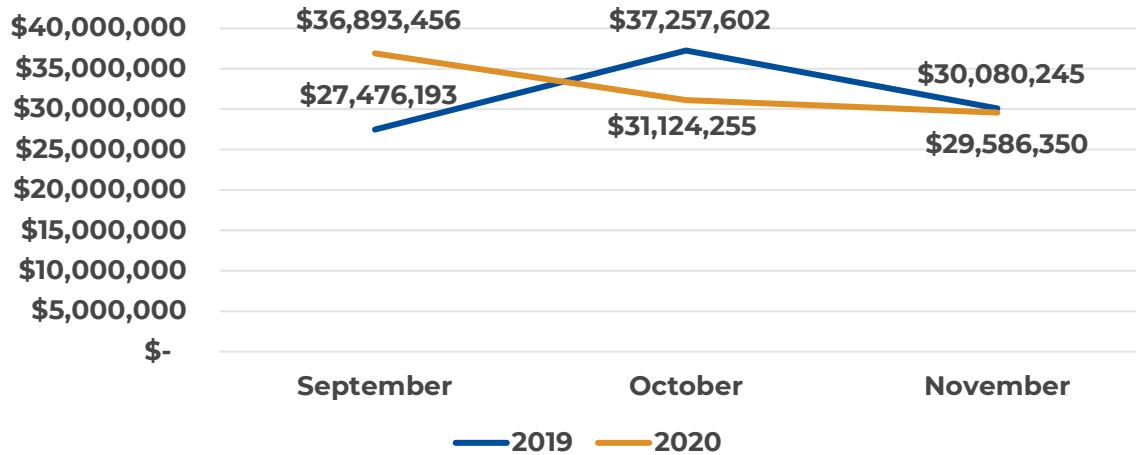
Nursing Facility Expenditures



Month	2019	2020
September	\$ 44,897,072	\$ 59,201,527
October	\$ 56,511,613	\$ 47,553,592
November	\$ 44,716,040	\$ 51,832,403

Month	Count Change	Percent Change
September	\$ 14,304,455	32%
October	\$ (8,958,021)	-16%
November	\$ 7,116,363	16%

Outpatient Hospital Expenditures

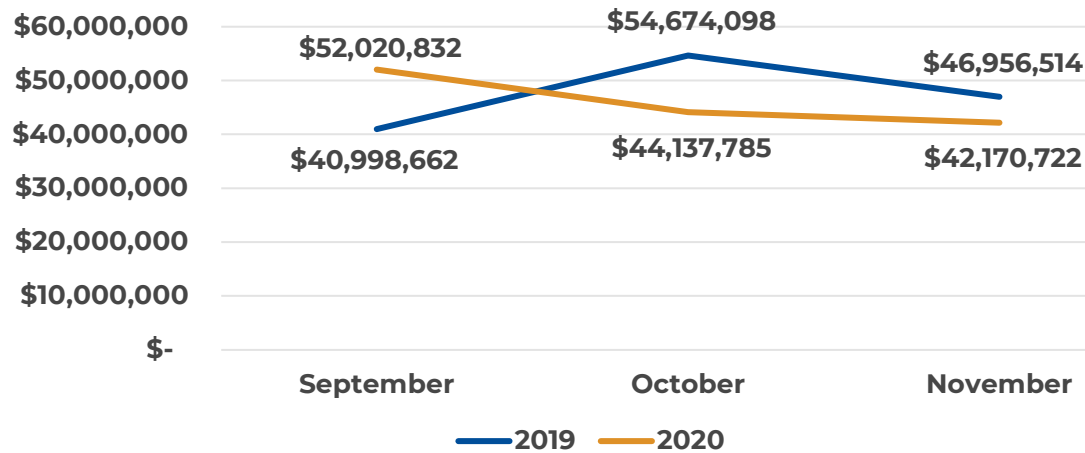


Month	2019	2020
September	\$ 27,476,193	\$ 36,893,456
October	\$ 37,257,602	\$ 31,124,255
November	\$ 30,080,245	\$ 29,586,350

Month	Count Change	Percent Change
September	\$ 9,417,263	34%
October	\$ (6,133,347)	-16%
November	\$ (493,896)	-2%

Financials (Cont.)

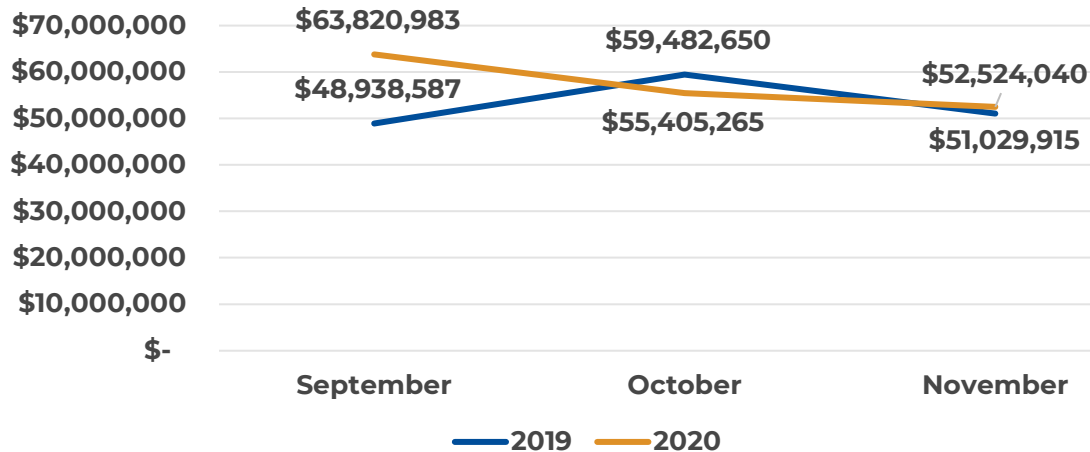
Physician Expenditures



Month	2019	2020
September	\$ 40,998,662	\$ 52,020,832
October	\$ 54,674,098	\$ 44,137,785
November	\$ 46,956,514	\$ 42,170,722

Month	Count Change	Percent Change
September	\$ 11,022,170	27%
October	\$ (10,536,313)	-19%
November	\$ (4,785,792)	-10%

Prescribed Drugs Expenditures

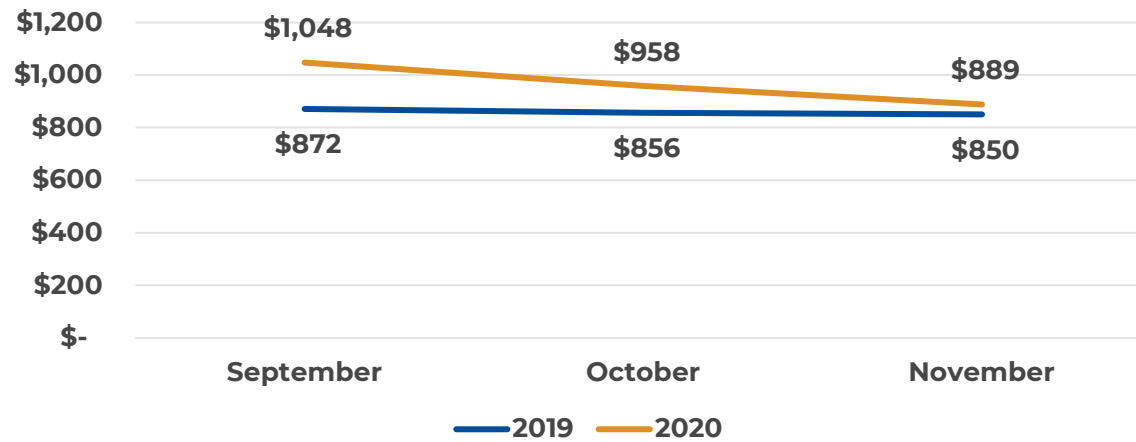


Month	2019	2020
September	\$ 48,938,587	\$ 63,820,983
October	\$ 59,482,650	\$ 55,405,265
November	\$ 51,029,915	\$ 52,524,040

Month	Count Change	Percent Change
September	\$ 14,882,396	30%
October	\$ (4,077,385)	-7%
November	\$ 1,494,125	3%

Financials (Cont.)

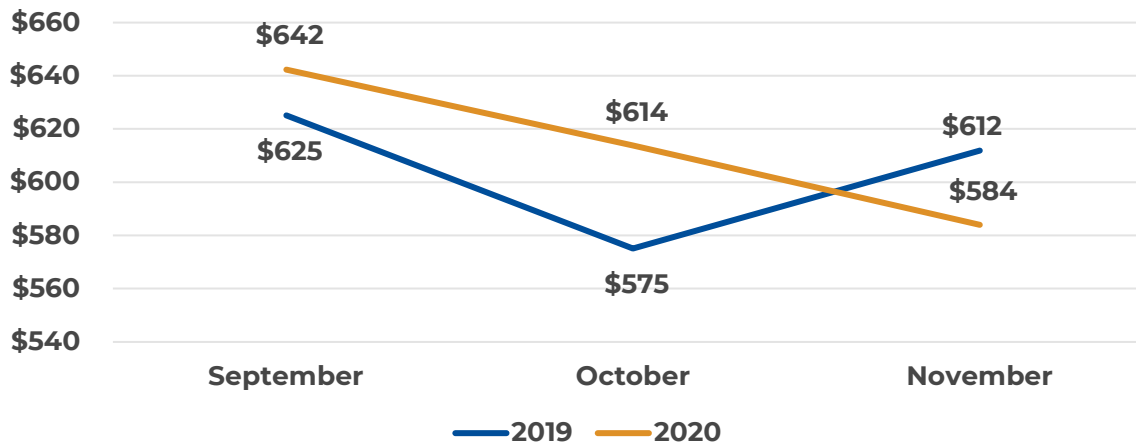
Average Per Average Member Served



Month	2019	2020
September	\$ 872	\$ 1,048
October	\$ 856	\$ 958
November	\$ 850	\$ 889

Month	Count Change	Percent Change
September	\$ 176	20%
October	\$ 102	12%
November	\$ 39	5%

Average Per Child (Under 21) Member Served

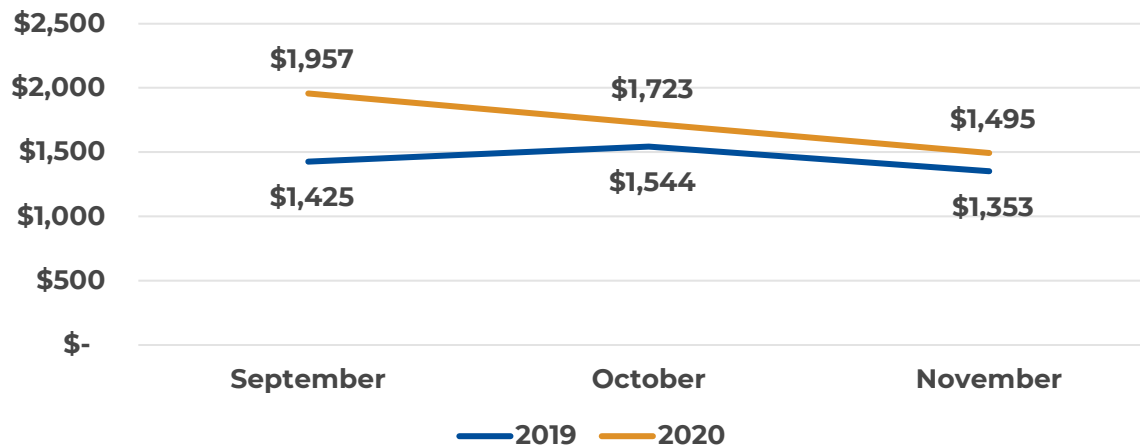


Month	2019	2020
September	\$ 625	\$ 642
October	\$ 575	\$ 614
November	\$ 612	\$ 584

Month	Count Change	Percent Change
September	\$ 17	3%
October	\$ 39	7%
November	\$ (28)	-5%

Financials (Cont.)

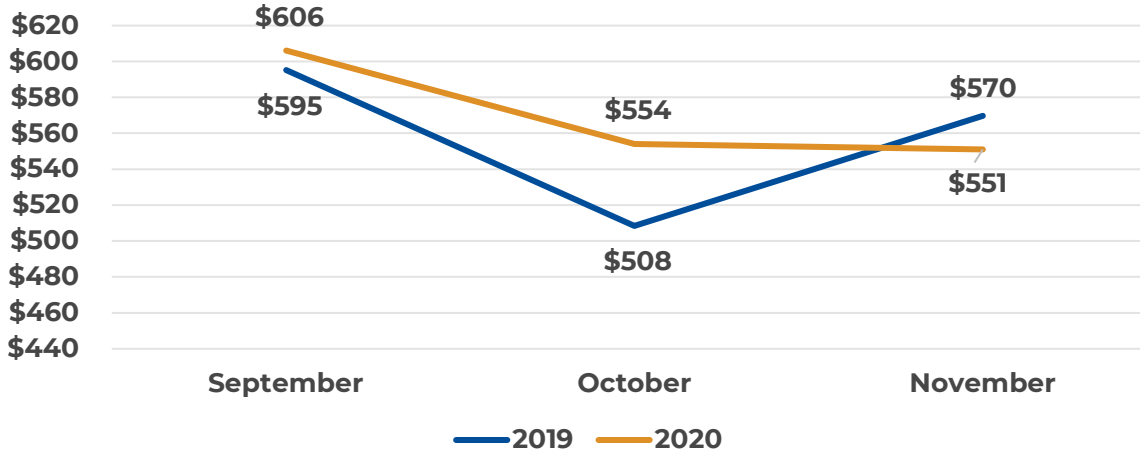
Average Per Aged/Blind/Disabled Member Served



Month	2019	2020
September	\$ 1,425	\$ 1,957
October	\$ 1,544	\$ 1,723
November	\$ 1,353	\$ 1,495

Month	Count Change	Percent Change
September	\$ 532	37%
October	\$ 179	12%
November	\$ 141	10%

Average Per Children & Parent/Caretaker Member Served

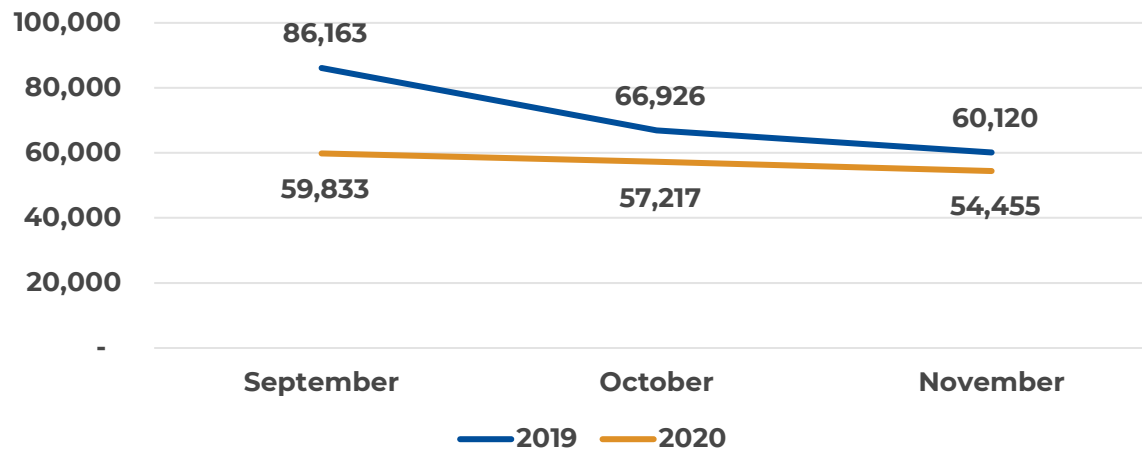


Month	2019	2020
September	\$ 595	\$ 606
October	\$ 508	\$ 554
November	\$ 570	\$ 551

Month	Count Change	Percent Change
September	\$ 11	2%
October	\$ 46	9%
November	\$ (19)	-3%

Call Center

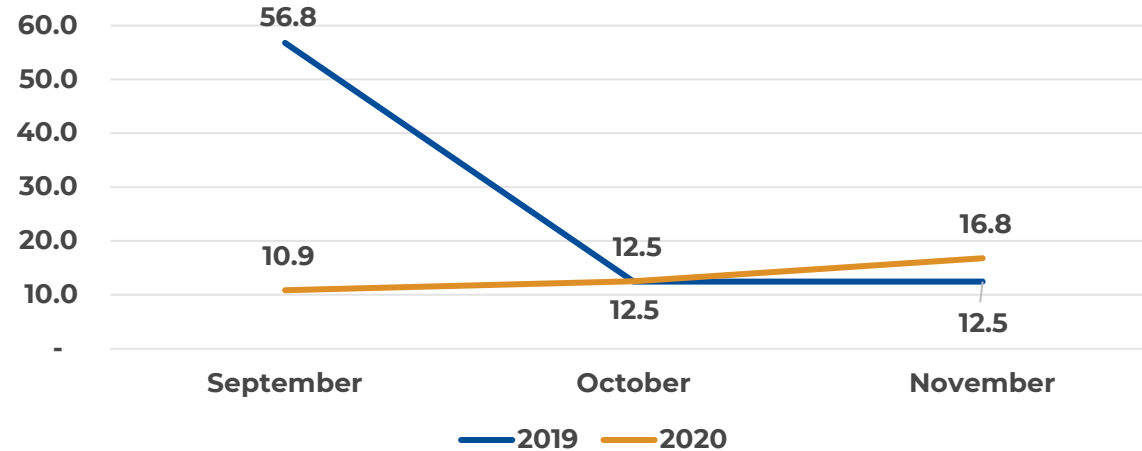
Call Center - Member Calls Answered



Month	2019	2020
September	86,163	59,833
October	66,926	57,217
November	60,120	54,455

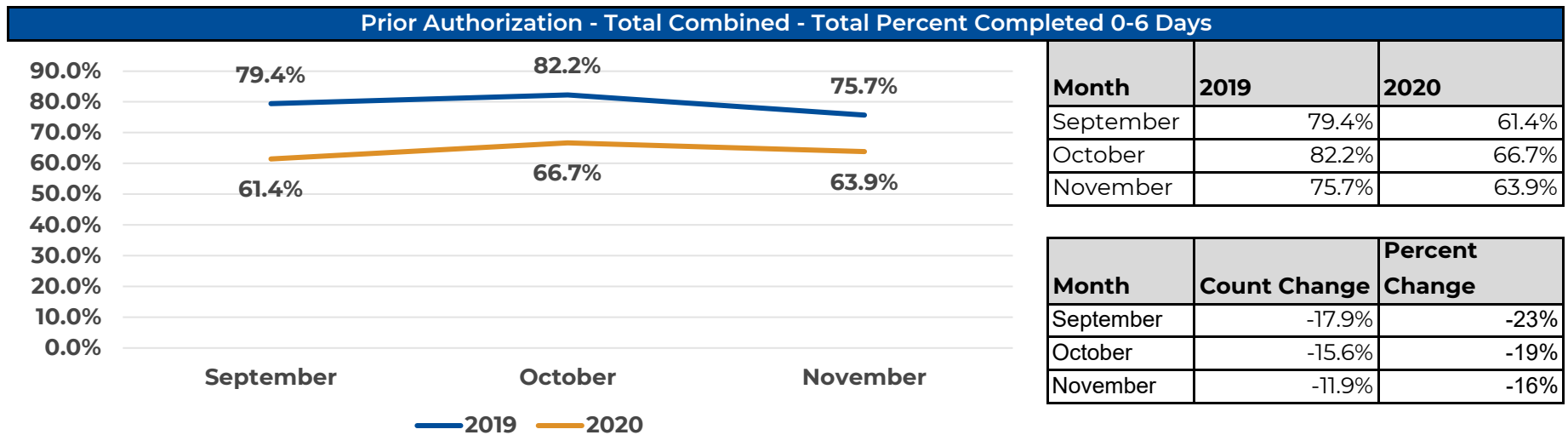
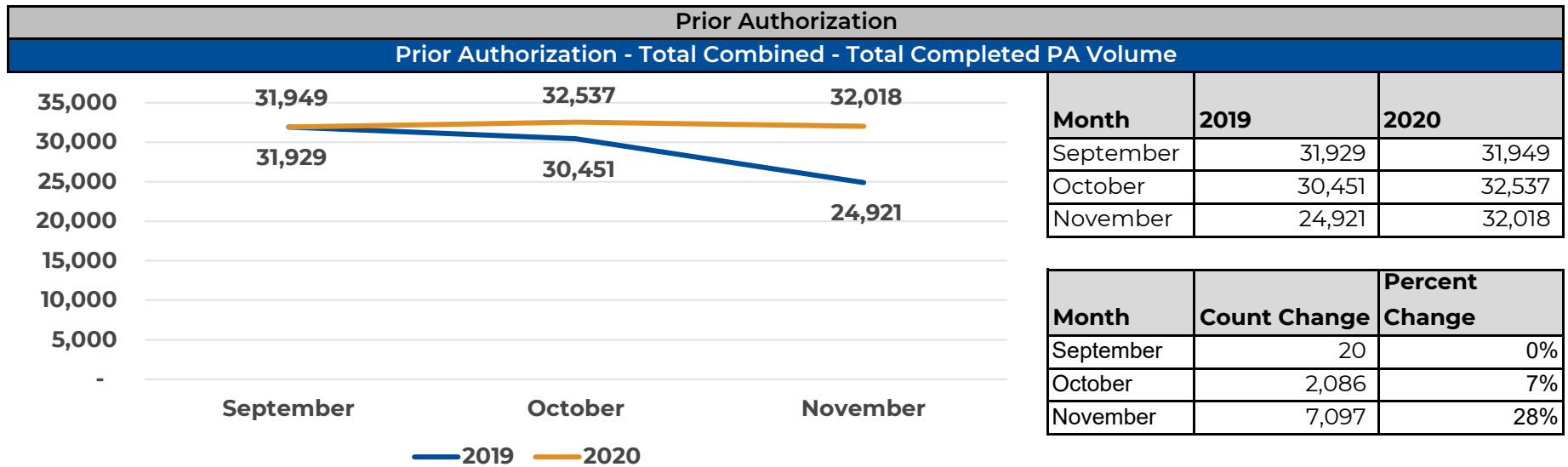
Month	Count Change	Percent Change
September	(26,330)	-31%
October	(9,709)	-15%
November	(5,665)	-9%

Call Center - Average Wait Time (In Seconds)



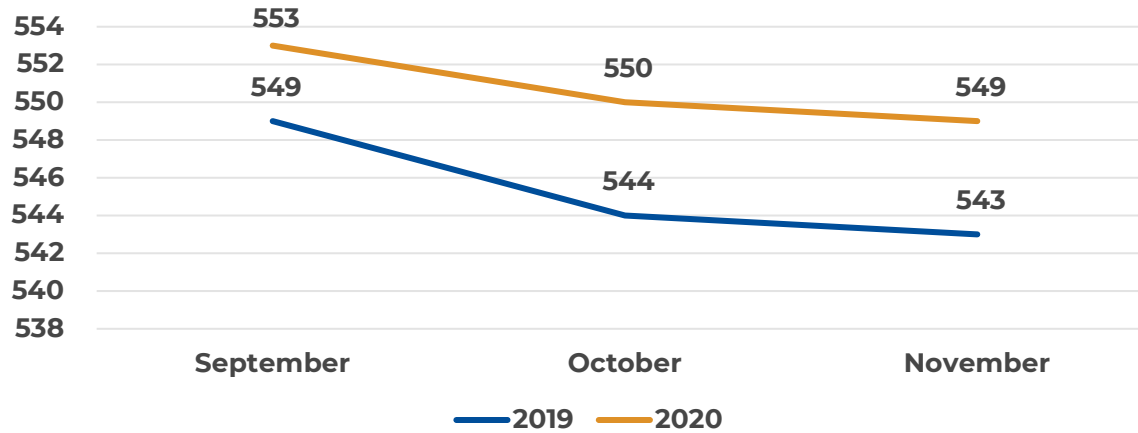
Month	2019	2020
September	56.8	10.9
October	12.5	12.5
November	12.5	16.8

Month	Count Change	Percent Change
September	(46)	-81%
October	-	0%
November	4	35%



Agency Stats & Provider Network

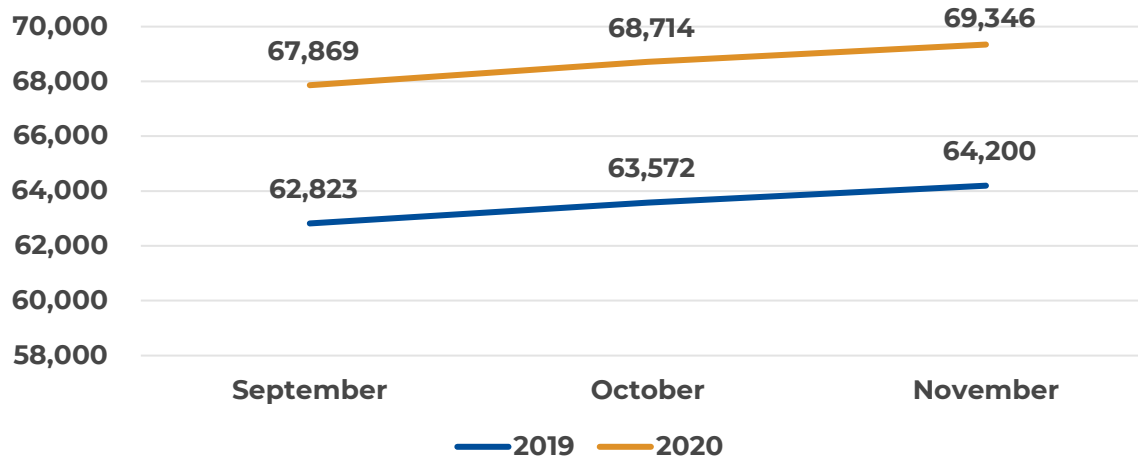
OHCA Admin - Number of FTEs



Month	2019	2020
September	549	553
October	544	550
November	543	549

Month	Count Change	Percent Change
September	4	1%
October	6	1%
November	6	1%

Total Providers

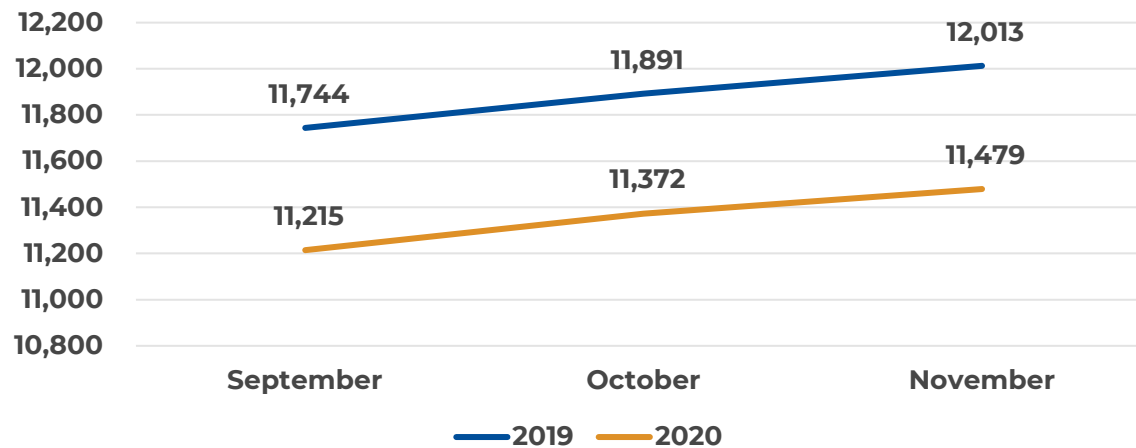


Month	2019	2020
September	62,823	67,869
October	63,572	68,714
November	64,200	69,346

Month	Count Change	Percent Change
September	5,046	8%
October	5,142	8%
November	5,146	8%

Agency Stats & Provider Network (Cont.)

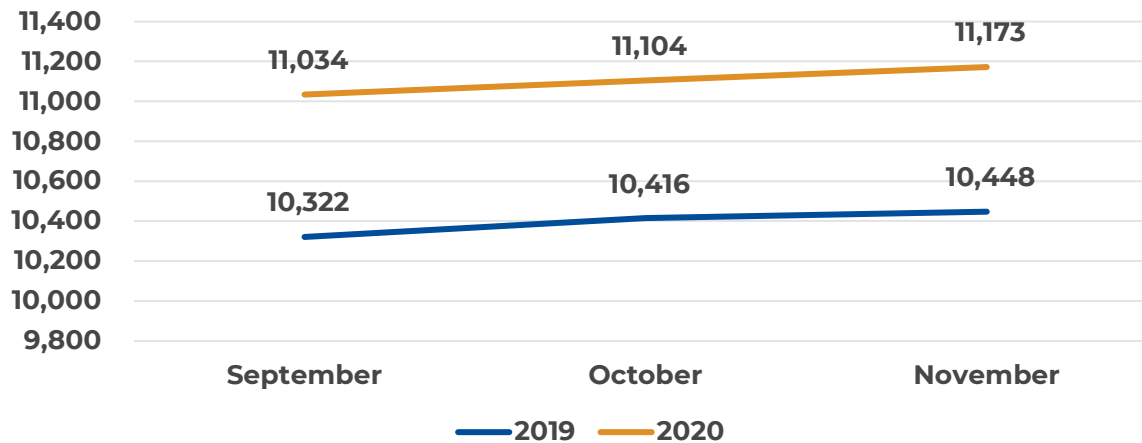
Mental Health Providers



Month	2019	2020
September	11,744	11,215
October	11,891	11,372
November	12,013	11,479

Month	Count Change	Percent Change
September	(529)	-5%
October	(519)	-4%
November	(534)	-4%

Physicians

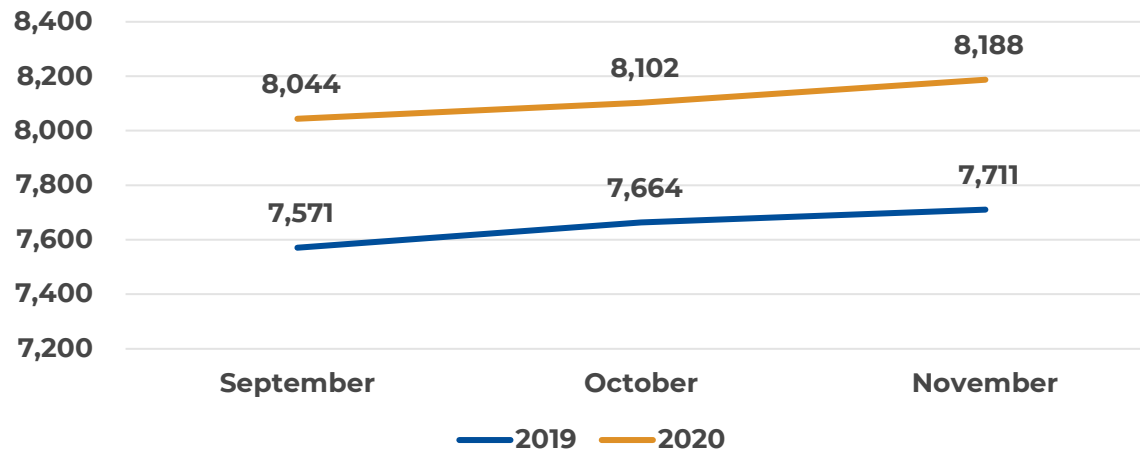


Month	2019	2020
September	10,322	11,034
October	10,416	11,104
November	10,448	11,173

Month	Count Change	Percent Change
September	712	7%
October	688	7%
November	725	7%

Agency Stats & Provider Network (Cont.)

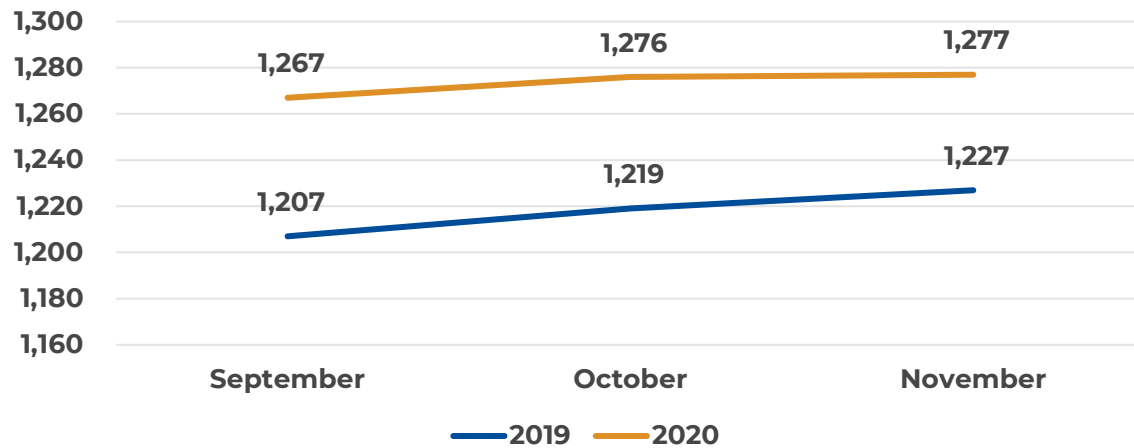
Primary Care Providers



Month	2019	2020
September	7,571	8,044
October	7,664	8,102
November	7,711	8,188

Month	Count Change	Percent Change
September	473	6%
October	438	6%
November	477	6%

Dentists

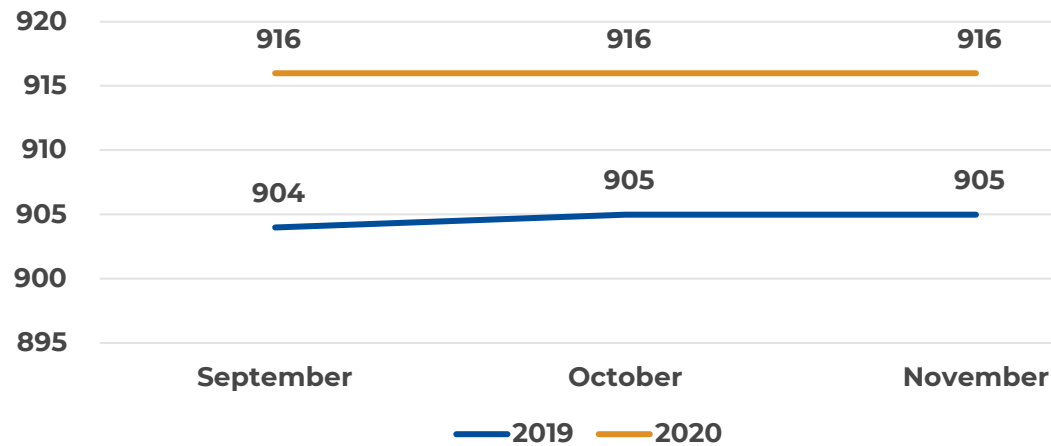


Month	2019	2020
September	1,207	1,267
October	1,219	1,276
November	1,227	1,277

Month	Count Change	Percent Change
September	60	5%
October	57	5%
November	50	4%

Agency Stats & Provider Network (Cont.)

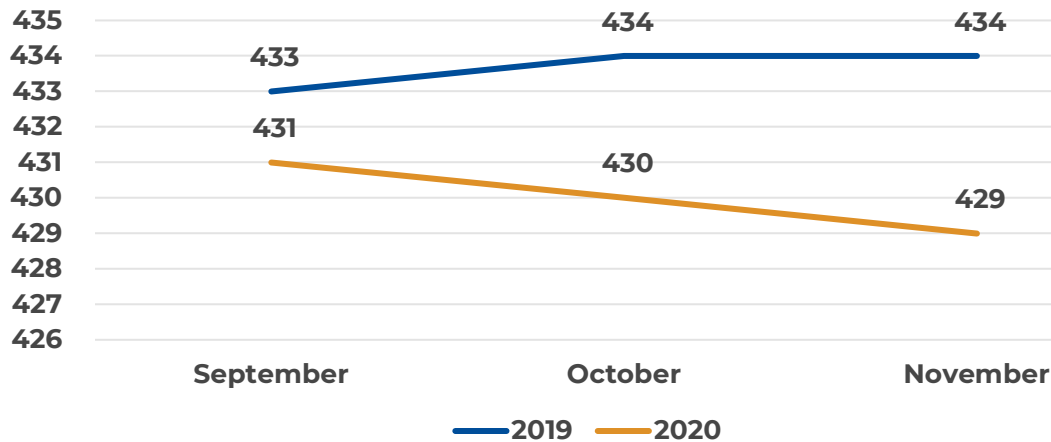
Pharmacy



Month	2019	2020
September	904	916
October	905	916
November	905	916

Month	Count Change	Percent Change
September	12	1%
October	11	1%
November	11	1%

Extended Care Facilities

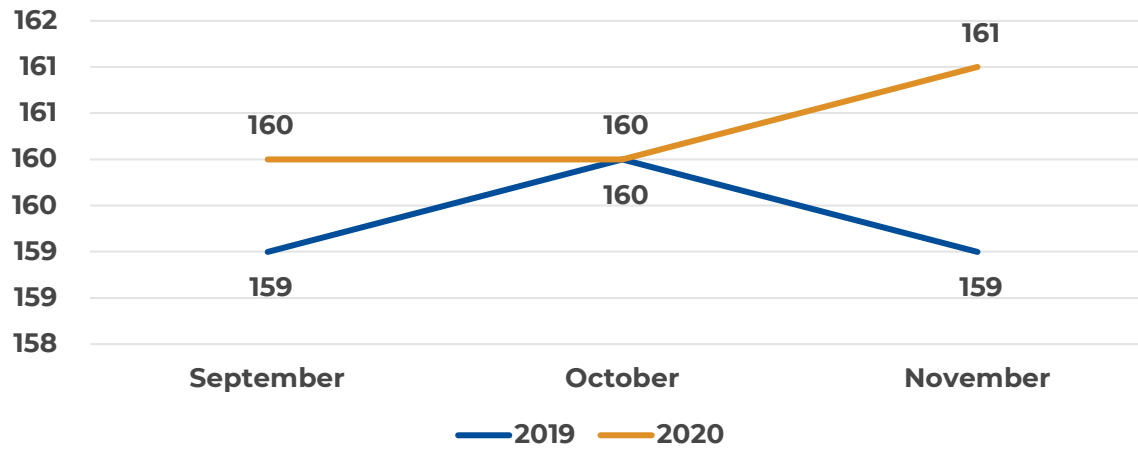


Month	2019	2020
September	433	431
October	434	430
November	434	429

Month	Count Change	Percent Change
September	(2)	0%
October	(4)	-1%
November	(5)	-1%

Agency Stats & Provider Network (Cont.)

Hospitals



Month	2019	2020
September	159	160
October	160	160
November	159	161

Month	Count Change	Percent Change
September	1	1%
October	-	0%
November	2	1%