OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
December 7, 2023, at 2:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK. 73105

A G E N D A

Public access via Zoom:
https://www.zoomgov.com/webinar/register/WN_F8jDdC8nQS6Fu4okQRK85Q
Telephone: 1-669-216-1590 Webinar ID: 161 063 3606

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

1. Call to Order / Determination of Quorum……...Marc Nuttle, Chair

2. Discussion and Vote on the September 20, 2023, OHCA Board Meeting Minutes……..……Marc Nuttle, Chair

3. Chief Executive Officer Report (Attachment "A")…..……..Ellen Buettner, Chief Executive Officer

    a) Member Moment

4. State Medicaid Director Report (Attachment "B")…….……Traylor Rains, State Medicaid Director

5. Discussion of Report from the Pharmacy……..……...Corey Finch, M.D.
   Advisory Committee and Possible Action Regarding Chair, Pharmacy Advisory Committee
   Drug Utilization Review Board Recommendation:

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

Drug Name:	Used For:
Lumryz™	Narcolepsy
Leqembi™	Alzheimer's Disease
Vyjuvek™	Dystophic Epidermolysis Bullosa
Brixadi™	Opioid Use Disorder
Xacduro®	Pneumonia
Curvrior™	Wilson's Disease
Rebyota™ Vowst™	Clostridioides Difficile Infection (C-Diff)
Orserdu®	Breast Cancer
Elevidys	Duchenne Muscular Dystrophy
Jesduvroq™	Anemia due to Chronic Kidney Disease
Veopoz™	CHAPLE Disease
Ojjaara	Myelofibrosis

6. Discussion of Report from the……..……..……Phillip Kennedy
   Compliance Advisory Committee Chair, Compliance Advisory Committee
   and Possible Action

    a) Discussion and Possible Vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds pursuant to 63 O.S. Section

5006(A)(2) under OAC 317:10-1-16. (Attachment “D”)

i. Customer Relationship Management (CRM)
ii. Population Care Management Software System

7. Discussion of Report of Strategic…….Marc Nuttle
Planning & Operational Advisory Committee Chair, Strategic Planning & Operational Advisory Committee

8. Discussion of Report of Administrative……..…Tanya Case
Rules Advisory Committee and Possible Action Chair, Administrative Rules Advisory Committee
(Attachment “E”)

The following EMERGENCY rules HAVE NOT previously been approved by the Board:

i. APA WF # 23-16A ADvantage Waiver Amendment
ii. APA WF # 23-16B ADvantage Waiver Amendment
iii. APA WF # 23-19 Adult Day Health Services Revisions
iv. APA WF # 23-20 Tax Equity and Fiscal Responsibility Act (TEFRA) Psychological Evaluations and ICF/IID level of Care Reevaluations
v. APA WF # 23-21 Quarterly Payments for Orthodontic Services

9. Discussion and Possible Action……..……Marc Nuttle, Chair
Regarding OHCA Board Meeting Dates and
Times for Calendar Year 2024 (Attachment “F”)

10. Discussion and Possible Action……...…Marc Nuttle, Chair
Election of the OHCA 2024 Board Officers

11. Discussion and Possible Action…….Marc Nuttle, Chair
Possible Executive Session as Recommended by the General Counsel and Authorized by the Open Meeting Act, 25 O.S. § 307(B)(4) , To Discuss Confidential Legal Matters Concerning Pending Litigation

12. Adjournment…….Marc Nuttle, Chair

NEXT BOARD MEETING
January 17, 2024, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

MINUTES OF REGULAR BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
September 20, 2023
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
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 September 15, 2023 at 3:39 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 September 19, 2023 at 11:45 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Nuttle called the meeting to order at 2:00 p.m.

BOARD MEMBERS PRESENT:	Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland
BOARD MEMBERS ABSENT:	Vice Chairman Yaffe, Member Kennedy

ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON THE JULY 17, 2023, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION:	Member Christ moved for approval of the July 17, 2023, board meeting minutes, as published. The motion was seconded by Member Finch.
FOR THE MOTION:	Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Kennedy

ITEM 3 / CHIEF EXECUTIVE OFFICER REPORT
Ellen Buettner, Chief Executive Officer

CEO Buettner invited April Anonsen to provide a member moment.

CEO Buettner provided an update on Managed Care Transition, Public Health Emergency, Budget, and Agency Communication Initiatives.

Managed Care: The transition is moving forward. There is a lot of behind-the-scenes work going on, such as readiness work from the BE and Finance teams. There are also ongoing conversations going on with OHCA's plan partners regarding readiness and ongoing conversations with the provider community including provider town halls. OHCA is also in the process of building out its SoonerSelect Oversight Team, which will be led by Deputy State Medicaid Director, Sandra Puebla and Michele Stafford. OHCA has made six initial hires, all of which are from inside the organization. OHCA plans to have the complete team of about 21 people by November 1st. OHCA held its first Medicaid Quality Advisory Committee in August.

Public Health Emergency: To date, OHCA has disenrolled approximately 150,000 individuals and are still on track to complete the process before the end of the year. CEO Buettner highlighted that of the 150,000 individuals disenrolled, OHCA has only had 100 member appeals filed, which speaks volumes to the compassionate communications that OHCA's team has been able to have with members.

Budget: Work has started for the SFY 2025 budget. OHCA is required to submit its SFY2025 budget to OMES by October 1, 2023. OHCA will have a standard meeting with the Governor's team, Secretary Suter, and some of their budget team so they can understand the expectations. Following that meeting, the team will meet with legislators during the budget hearings, which are scheduled in January. During the budget hearings, legislators will see OHCA's requests.

During the July Special Board meeting, the OHCA Board approved the $2 million methodology. CEO Buettner was pleased to announce that OHCA made the first disbursement.

Communication Initiatives: Traylor Rains and Emily Long worked to release a back-to-school push on PHE, particularly as the team saw procedural disenrollments. Those individuals who were being disenrolled may be eligible but were disenrolled simply because they were not responsive with the materials that were needed to verify. The team wanted to

do an increased push to reach out to those individuals to help them maintain coverage. OHCA was also invited to participate in a monthly segment with a local news station to discuss health-related topics.CEO Buettner had the opportunity to participate in and talk about the work the team is doing at a couple of speaking engagements. The first being the National Governor's Association Workshop related to preparing for future public health emergencies. The second was an agency leaders panel alongside Commissioner Reed and Commissioner Slatton-Hodges.

CEO Buettner added that her and Christina Foss have met with several legislators to keep them updated on what OHCA is working on.

Member Case asked if when CEO Buettner is speaking of the Primary Care Association, is she still speaking of the Trade Association of the FQHCs or is it broader than that? CEO Buettner stated that she is speaking of the Trade Association.

ITEM 4 / STATE MEDICAID DIRECTOR REPORT

Traylor Rains, State Medicaid Director

Mr. Rains provided a State Medicaid Director Update, which included information on Public Health Emergency Unwinding, Public Health Emergency Fast Facts, SoonerSelect Milestones Achieved, Important Dental Milestones, Important Medical and Children Specialty Program Milestones, and Upcoming Items.

Mr. Rains announced that CMS approved OHCA's 1915b Waiver, which is OHCA's main federal authority vehicle to allows OHCA to go to the new delivery system. The team went above and beyond to push the waiver through, without stopping the clock. Weekly meetings were scheduled with CMS Project Officers to ensure they were apprised of every change. Mr. Rains stated that he has never seen a waiver approved in less than 90-days. He recognized Kasie McCarty, Senior Director of Health Policy, and Sandra Puebla, Deputy State Medicaid Director.

Member Case asked if a SoonerSelect town hall will be scheduled in Lawton. Mr. Rains stated that the next town hall will be scheduled in Duncan, on October 18th. Member Case asked if the concerns CMS had regarding the PHE disenrollment have been addressed. Mr. Rains stated that they have.

For more detailed information, see attachment A of the board packet.

ITEM 5 / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION REVIEW BOARD RECOMMENDATIONS

Corey Finch, Chair, Pharmacy Advisory Committee

Action Item – a) Discussion and Possible 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 "B")

Item:	Drug Name:	Used For:
i.	Tzield®	Stage 2 Type 1 Diabetes Mellitus (TIDM)
ii.	Syfovre™	Geographic Atrophy of Age-Related Macular Degeneration
iii.	Vivjoa® Ancobon®	Vulvovaginal Candidiasis (VVC) Systemic Fungal Infections
iv.	Skyckarys™	Friedreich's Ataxia
v.	Filspari™	Primary Immunoglobulin A Nephropathy
vi.	Imjudo® Krazati®	Hepatocellular Carcinoma (HCC) and Non-Small Cell Lung Cancer (NSCLC). NSCLC
vii.	Altuviiio™ Hemgenix®	Hemophilia
viii.	Allopurinol 200mg Aponvie™ Aspruzyo Sprinkle™ Austedo® XR Ermeza™	Gout Postoperative Nausea and Vomiting Chronic Angina Huntington's Disease and Tardive Dyskinesia. Hypothyroidism

	Furoscix®	Fluid Overload in Chronic Heart Failure
	Jylamvo®	Rheumatoid Arthritis
	Primidone 125mg	Seizure Disorder
	Verkazia®	Vernal Keratoconjunctivitis
	Xaciato™	Bacterial Vaginosis
ix.	Daybue™	Rett Syndrome
x.	Joenja®	Activated Phosphoinositide 3-Kinase Delta Syndrome
xi.	Adstiladrin®	Non-Muscle Invasive Bladder Cancer
	Elahere™	Ovarian, Fallopian tube, and Primary Peritoneal Cancer

MOTION: Member Christ moved for approval of item 5ai-xi, as published. The motion was seconded by Member Cruzan.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Kennedy

ITEM 6 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE

Kim Leland, Member, Compliance Advisory Committee

Member Leland asked CFO Aaron Morris to provide a SFY25 Budget Request overview. Mr. Morris stated that the budget request must be submitted to OMES and Legislature on October 1, 2023. A copy of the request was not provided in the board packet, as it is not final yet but wanted to give the Board an idea of what is to come. OHCA's budget is always prioritized, the first being annualizations which is a change in the federal funding formula year over year. That annualization, which is preliminary and not final, is expected to be a change in the FMAP from 67.53 to 68.14. OHCA should receive the final increase in two to three weeks. That increase in FMAP will result in an increase in federal funds of about $18.5 million. As a result, OHCA will decrease its state request by that amount.

The second priority is maintenance which focuses on continuing the program as it is today and how much it will cost to focus on changes in enrollment, utilization, and cost. In SFY 25, OHCA will have two populations, traditional which will be focused on ABD and Managed Care. For the traditional population the expectation Is about a 3.2% increase in total spend and a similar increase in state spend. For the OHCA portion of the population moving into Managed Care, that will be slightly higher at about 4%, which is mostly enrollment related. The maintenance priority will also include continuous coverage for children under 19. This will result in a total cost of $61 million, a significant impact to the state. OHCA also has its 2022 unfunded incentive program for ICFs. The program was successfully implemented and has been self-funded for the last year and a half but will ask the Legislature to provide recurring funds to operate that program moving forward. OHCA will continue participating in Medicare Part D, which is the prescription drug program. It will be a significant impact to the state, as it is a state-only cost, of about $10 million for SFY25. In SFY24, OHCA had a $600 million appropriation decrease, so for SFY25, OHCA will request that funding be restored.

The third priority is one-time funding which are activities that move the needle but on a one-time basis. Mr. Morris stated there were several items that will offset the budget request including, the $200 million to hospitals and $30 million for HIE connection fees. With the move to Managed Care comes a new revenue source, a premium tax. The premiums of Managed Care entities will be subject to a tax of 2.25% of the total. The state will pay the state share of the premium tax to the Managed Care Entities through the CAP. OHCA will draw down the federal funds and the Managed Care entities will pay the state insurance department. This will allow the state agency to benefit from the federal share, which is expected to be about $64 million in additional federal funds. As OHCA moves to Managed Care, the SHOPP changes will result in a lack of funding from the SHOPP fee. The hospitals will pay 4% of that patient revenue and the state has certain obligations of that funding, and those obligations include increased payments for the hospital average commercial rate. The gap between Medicare to average commercial rate is large, so that tax will have to support that gap, and it won't be sufficient to do so in the first couple of years of Managed Care. OHCA will ask the state to fill that gap with state funds. OHCA is also introducing a new provider incentive program, which will provide qualifying providers with an enhanced payment if they participate in Managed Care on all their services.

The fourth priority is mandates. The team is still trying to work through the impact of mandates for the state. The mandate OHCA is really considering is the impact of biomarker testing which was a legislative item that came out of last session.

The fifth priority is program enhancements which are agency initiatives. OHCA will focus on three areas for SFY25, increase Certified Registered Nurse Anesthetists to 100% of Medicare; an add-on rate for nursing facilities; an add-on rate for vent-dependent residents; and expansion of the Applied Behavioral Analysis program.

Mr. Morris also provided a slide on OHCA Appropriation History.

Member Leland presented the below State Plan Amendment Rate Committee Rates and Expenditure of Authority Contracts:

a) Discussion and Possible Vote to Approve the State Plan Amendment Rate Committee Rates pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:1-3-4 (Attachment "C")

   i. ADvantage Waiver – Remote Support Services Rate Increase
   ii. Rate Increases for Acute and Acute II Behavioral Health Facilities

MOTION: Chairman Nuttle moved for approval of item 6ai-ii, as published. The motion was seconded by Member Finch.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Kennedy

b) Discussion and Possible Vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:10-1-16:

   i. Technology Services for Health Information Exchange
   ii. Managed Care Monitoring and Compliance
   iii. Consulting Services
   iv. Connection Fee Reimbursement for Health Information Exchange

MOTION: Chairman Nuttle moved for approval of item 6bi-iv, as published. The motion was seconded by Member Christ.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland

BOARD MEMBERS ABSENT: Vice-Chairman Yaffe, Member Kennedy

ITEM 7 / DISCUSSION OF REPORT OF STRATEGIC PLANNING & OPERATIONAL ADVISORY COMMITTEE
Marc Nuttle, Chair, Strategic Planning & Operational Advisory Committee

Chairman Nuttle provided an overview of the meeting held on September 18, 2023. Chairman Nuttle stated that the purpose of this committee is to anticipate any problems and work through them as a committee, however September's meeting showed everything is moving on track without problems. Chairman Nuttle to lead on scheduling a meeting with Lt. Gov Pinnell to talk about strategic overview of the state budget workforce development, how the Health Care Authority is critical to everything from education to agricultural investments, to the workforce on health, and as previously discussed by the Board, preventative health.

ITEM 8 / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING
Tanya Case, Chair, Administrative Rules Advisory Committee

a) Discussion and Possible Vote on Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act and in accordance with 75 O.S. § 253. OHCA Requests the Adoption of the Following Emergency Rules:

The following EMERGENCY rules HAVE NOT previously been approved by the Board:

   i. APA WF # 23-08 Non-Payment for Provider-Preventable Conditions
   ii. APA WF # 23-13 Secure Mental Health Transportation
   iii. APA WF # 23-15 Biosimilar Reimbursement

iv. APA WF # 23-18 Twelve-Months Continuous Eligibility for Children in Medicaid and CHIP

MOTION:	Member Christ motioned to approve the declaration of a compelling public interest for the promulgation of the emergency rules in item 8. The motion was seconded by Member Cruzan.
FOR THE MOTION:	Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland
BOARD MEMBERS ABSENT:	Vice Chairman Yaffe, Member Kennedy
MOTION:	Member Christ moved to approve the rule listed in item 8a.i-iv as published. The motion was seconded by Member Leland.
FOR THE MOTION:	Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland
BOARD MEMBERS ABSENT:	Vice Chairman Yaffe, Member Kennedy

ITEM 9 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

MOTION:	Member Christ moved to adjourn. The motion was seconded by Member Case.
FOR THE MOTION:	Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland
BOARD MEMBERS ABSENT:	Vice Chairman Yaffe, Member Kennedy

Meeting adjourned at 2:56 p.m., 9/20/2023

NEXT BOARD MEETING
December 7, 2023
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

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MEDICAID DIRECTOR UPDATE

DECEMBER 7, 2023

PUBLIC HEALTH EMERGENCY UNWINDING UPDATE

PHE UNWINDING UPDATE

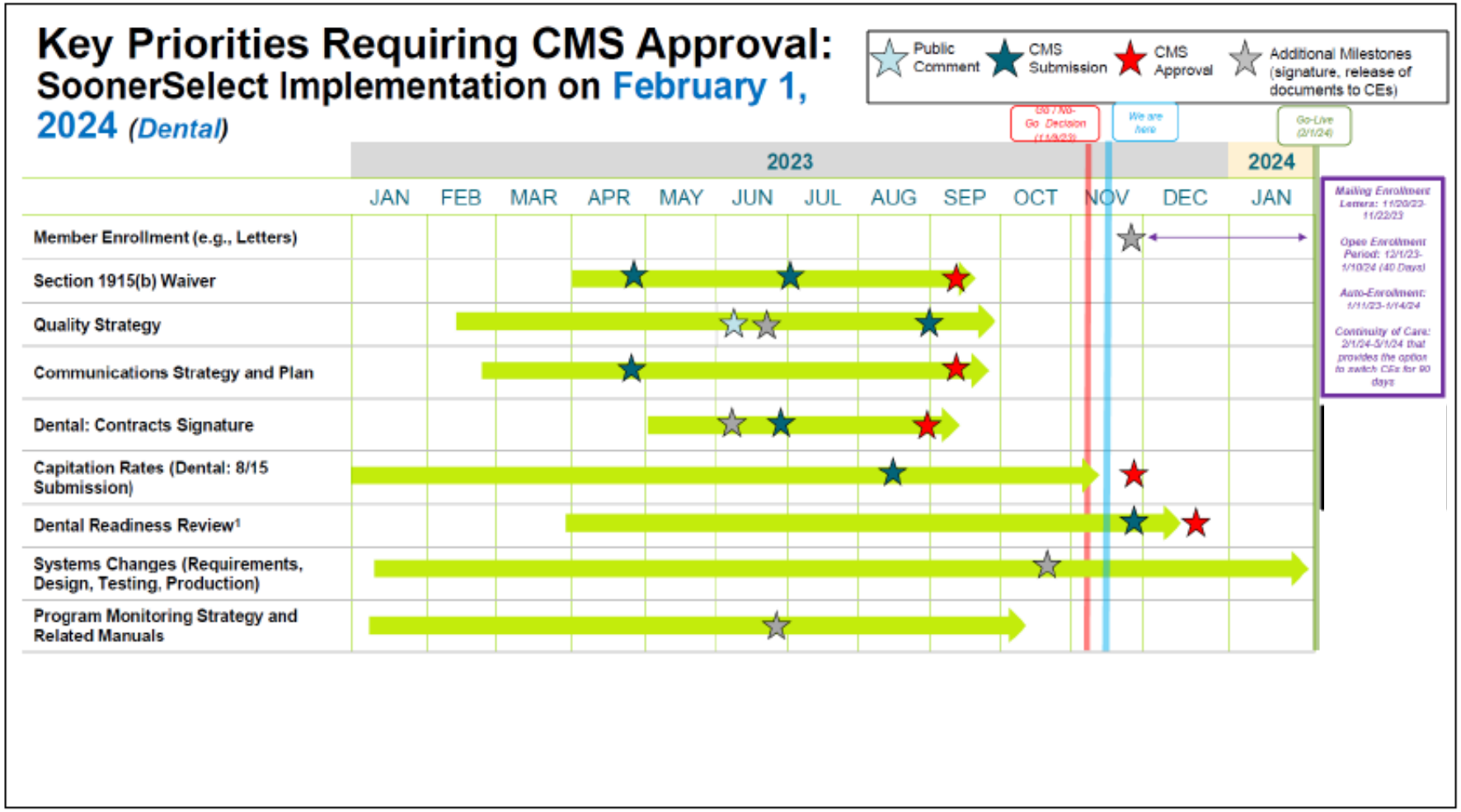
- 290,971 total denials since May (includes MAGI and Non-MAGI)
  - 155,732 of these have been procedural terminations
- Oklahoma's current cumulative monthly procedural termination rate is 34% (cumulative procedural denials as a percentage of total members up for renewal)
- Group 8 had their last day of coverage November 30.
- Pharmacy, Care Coordination, Behavioral Health and the Medical Authorization units culled through groups 7 and 8 and pulled out any highly critical members as well as those in the middle of an episode of care.
- Group 9 is the final unwinding group scheduled for December 31 (expected 30K).

SOONERSELECT UPDATE

MILESTONES ACHIEVED

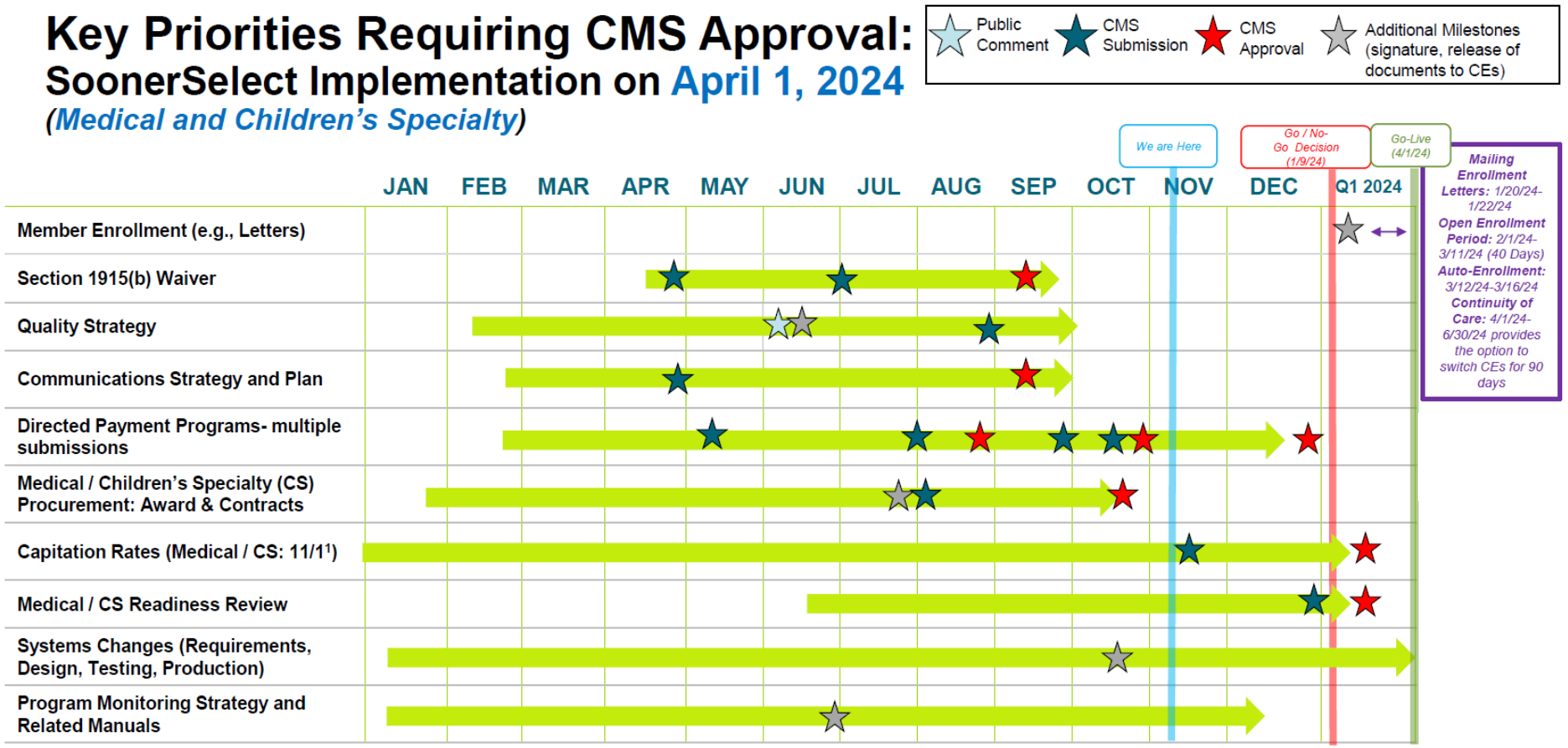
- ✓ Choice counselors hired and trained to receive open enrollment calls and educate members on plan selection
- ✓ Dental enrollment stakeholder toolkit published, and enrollment letters mailed to members November 20
- ✓ Dental open enrollment began December 1
- ✓ Monitoring and Compliance RFP submitted to CMS for approval
- ✓ On-site readiness reviews completed for all 6 plans
- ✓ State readiness report as well as readiness report for both dental plans submitted to CMS
- ✓ Cycle 1 of systems testing complete, and Cycle 2 is well underway
- ✓ All State Directed Payment PrePrints have been submitted to CMS. OHCA has received approval for the following:
  - ✓ Academic medical center
  - ✓ SHOPP Average Commercial Rate
  - ✓ Level 1 Trauma Hospital
- ✓ Capitation rates submitted to CMS for approval and certification
- ✓ SoonerSelect Operations team is fully staffed and onboarded
- ✓ Quality Advisory Committee held second meeting on November 14

IMPORTANT MILESTONES DENTAL



IMPORTANT MILESTONES MEDICAL AND CSP

Key Priorities Requiring CMS Approval:
SoonerSelect Implementation on April 1, 2024
(Medical and Children's Specialty)



PROVIDER INCENTIVE DIRECTED PAYMENT PROGRAM

- Eligible Providers
  - Advance practice nurse, mid-level practitioner, mental health provider and licensed behavioral health practitioners, podiatrist, physician, and anesthesiology assistant
- Incentive pool for initial 15-month rate year = $134,330,110
- Add on payments for certain services to support quality assurance and access improvement initiatives. SBIRT screenings, after hours care, and well visit services are eligible for a $25 increase payment
- Percentage increase on payments for all covered services provided by eligible providers
  - Almost 19% for services billed by an entity that is not HIE-connected
  - The increase for services billed by an HIE-connected entity will be 1.5 times the uniform percentage increase for non-HIE connected entities
  - Only services covered under the Oklahoma Medicaid State Plan, covered by the SoonerSelect medical program, and provided by in-network providers will be eligible for the uniform dollar increase and/or uniform percentage increase amounts.

SOONERCARE OPERATIONS UPDATE

HEPATITIS-C CONNECT TO CARE INITIATIVE

- OHCA is leveraging value-based contracting with AbbVie with the objective of facilitating member access to AbbVie's drug Mavyret for members with a current Hepatitis-C diagnosis.
- OHCA utilization committee identified members with a diagnosis of Hepatitis C with no prior history of treatment
- Dedicated care management staff conducted outreach and care management with identified members
- So far, 25% of the members identified have been connected to curative treatment options. This far exceeds OHCA's initial year 1 goal of 5%.

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

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

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Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – September 13, 2023, October 11, 2023, and November 8, 2023

Vote Item	Drug	Used for	Cost*	Notes
1	Lumryz™	• **Narcolepsy:** A chronic neurological disorder which affects the brain's ability to control sleep-wake cyles. *458 members with this diagnosis*	• $209,520 per year	• Cheaper options available
2	Leqembi™	• **Alzheimer's Disease:** AD is a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks. *Approximately 5 members*	• $26,500 per year	• Used in patients with mild cognitive impairment
3	Vyjuvek™	• **Dystophic Epidermolysis Bullosa:** DEB is a genetic skin disorder causing blistering in the middle layer of skin with minimal trauma which can cause scarring to occur as the blisters clear. People with DEB can also develop fatal skin cancer. *8 members with diagnosis*	• $1,261,000 per year	• No other treatment options
4	Brixadi™	• **Opioid Use Disorder:** OUD is defined in the DSM-5 as a problematic pattern of opioid use leading to clinically significant impairment or distress. OUD was previously classified as Opioid Abuse or Opioid Dependence. *8,500 members utilizing MAT for OUD*	• $21,580 per year	• Medication Assisted Treatment, other MAT options available without a PA
5	Xacduro®	• **Pneumonia:** Pneumonia is an infection that affects one or both lungs. *1,800 members with pneumonia diagnosis recently*	• $26,600 per course of treatment	• Only used in specific bacterial infections
6	Curvrior™	• **Wilson's Disease:** WD is a rare genetic disorder caused by excess copper stored in the body. The disease is progressive and, if left untreated, it may cause liver (hepatic) disease, central nervous system dysfunction, and death. *Approximately 2 members*	• $687,600 per year	• Cheaper treatment options
7	Rebyota™ Vowst™	• ***Clostridioides difficile* infection:** C. Diff is a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon). *Approximately 5-7 members may be eligible per year.*	• $9,000 per treatment • $17,500 per course	• Only used in recurrent C.Diff

8	Orserdu®	• **Breast Cancer:** BC is a disease in which cells in the breast grow out of control. There are different kinds of breast cancer. The kind of breast cancer depends on which cells in the breast turn into cancer. *Approximately 250 members may be eligible*.	• $256,468 per year	• Not first line
9	Elevidys	• **Duchenne Muscular Dystrophy:** DMD is caused by a genetic problem in producing dystrophin, a protein that protects muscle fibers from breaking down when exposed to enzymes. DMD affects mostly boys. *Approximately 3 members may be eligible*	• $3,200,000 per 1 time treatment	• Gene therapy
10	Jesduvroq™	• **Anemia due to Chronic Kidney Disease:** Anemia is a condition in which your blood has a lower-than-normal amount of red blood cells or hemoglobin. Anemia is a common complication of CKD. *Approximately 180 members may be eligible*	• $33,782 per year	• Cheaper options available first
11	Veopoz™	• **CHAPLE Disease:** CHAPLE disease is a genetic condition that affects the immune system. People with CHAPLE disease have severe gastrointestinal problems, like abdominal pain and diarrhea. They are prone to lung infections and severe blood clots. They often have trouble absorbing nutrients in their diets. *Its estimated 10 patients in the US have the disease. OHCA is estimating 0-1 members.*	• $3,600,000 per year	• Ultra-rare
12	Ojjaara	• **Myelofibrosis:** MF is an uncommon type of bone marrow cancer that disrupts the body's normal production of blood cells. *34 members with diagnosis*	• $322,800 per year	• Only used in those with intermediate or high-risk MF

*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.

Pharmacy Agenda Items

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):

a) Lumryz™ (Sodium Oxybate)
b) Leqembi™ (Lecanemab-irmb)
c) Vyjuvek™ (Beremagene Geperpavec-svdt)
d) Brixadi™ (Buprenorphine Extended-Release Injection)
e) Xacduro® (Sulbactam/Durlobactam)
f) Cuvrior™ (TrientineTetrahydrochloride)
g) Rebyota™ (Fecal Microbiota,Live-jslm) and Vowst™ (Fecal Microbiota Spores, Livebrpk)
h) Orserdu® (Elacestrant)
i) Elevidys (Delandistrogene Moxeparvovec-rokl)
j) Jesduvroq™ (Daprodustat)
k) Veopoz™ (Pozelimab-bbfg)
l) Ojjaara (Momelotinib)

For the packet:

Recommendation 1: Vote to Prior Authorize Lumryz™

The Drug Utilization Review Board recommends the prior authorization Lumryz™ (Sodium Oxybate) with the following criteria:

Lumryz™ (Sodium Oxybate) Approval Criteria:

1. An FDA approved diagnosis; and
2. Use of Lumryz™ (sodium oxybate), Sunosi® (solriamfetol), requires previously failed trials (within the last 180 days) with Tier-1 and Tier-2 stimulants from different chemical categories, Provigil®, and Nuvigil®, unless contraindicated, that did not yield adequate results; and
3. Additionally, use of Lumryz™ (sodium oxybate) requires a patient-specific, clinically significant reason (beyond convenience) why the member cannot use Xyrem®; and
4. The diagnosis of obstructive sleep apnea requires concurrent treatment for obstructive sleep apnea; and
5. The diagnosis of shift work sleep disorder requires the member's work schedule to be included with the prior authorization request.

Recommendation 2: Vote to Prior Authorize Leqembi™

The Drug Utilization Review Board recommends the prior authorization of Leqembi™ (Lecanemab-irmb) with the following criteria:

Pharmacy Agenda Items

Leqembi™ (Lecanemab-irmb) Approval Criteria:

1. An FDA approved diagnosis of mild cognitive impairment or mild dementia stage of Alzheimer's disease [stage 3 or stage 4 Alzheimer's disease based on the Global Deterioration Scale (GDS)]. Diagnosis must be confirmed by at least 2 of the following:
    a. Mini-Mental State Exam (MMSE) score between 22 and 30; or
    b. Clinical Dementia Rating Global Score (CDR-GS) equal to 0.5 or 1; or
    c. Montreal Cognitive Assessment (MoCA) score ≥19; or
    d. Quick Dementia Rating System (QDRS) score ≤5; and
2. Member must have presence of amyloid pathology confirmed by a positive amyloid positron emission tomography (PET) scan or cerebral spinal fluid (CSF) test; and
3. Leqembi™ must be prescribed by, or in consultation with, a neurologist (or an advanced care practitioner with a supervising physician who is a neurologist); and
4. Other known medical or neurological causes of dementia have been ruled out (i.e., vascular dementia, dementia with Lewy bodies, frontotemporal dementia, Parkinson's disease dementia); and
5. Member must not have brain hemorrhage, bleeding disorder, or cerebrovascular abnormalities that increase the risk of hemorrhage; and
6. Prescriber must verify member and/or caregiver has been counseled on the risks of amyloid related imaging abnormalities (ARIA) that may occur and testing for ApoE ε4 status has been completed if appropriate; and
7. Member must not be taking anticoagulant or antiplatelet agents except for aspirin or clopidogrel, and the prescriber must attest that the increased safety risks for developing ARIA with the concomitant use have been discussed and are acceptable to the member prior to initiating Leqembi™; and
8. Member must not have had a stroke, transient ischemic attack (TIA), or unexplained loss of consciousness in the past year; and
9. Member must not have any contraindications to brain magnetic resonance imaging (MRI) or PET scans; and
10. Member must not have risk factors for intracerebral hemorrhage, including the following:
    a. Prior cerebral hemorrhage >1cm in greatest diameter; or
    b. >4 microhemorrhages; or
    c. An area of superficial siderosis; or
    d. Evidence of vasogenic edema; or
    e. Evidence of cerebral contusion, aneurysms, vascular malformations, or infective lesions; or

   f. Evidence of multiple lacunar infarcts or stroke involving a major vascular territory, severe small vessel, or white matter disease; and

11. Member must have a recent (within 1 year) brain MRI prior to initiating treatment with Leqembi™ and prior to the 5th, 7th, and 14th infusions; and
12. Prescriber must confirm that the member will be monitored for ARIA during the first 14 weeks and throughout treatment with Leqembi™; and
13. If ≥10 new incident microhemorrhages or >2 focal areas of superficial siderosis [radiographic severe amyloid related imaging abnormalities-hemosiderin deposition (ARIA-H)] are observed on MRI, prescriber must confirm that treatment will be continued with caution and only after a clinical evaluation confirming resolution of symptoms, if present, and a -up MRI demonstrating radiographic stabilization (i.e., no increase in size or number of ARIA-H) have been completed; and
14. Leqembi™ must be administered by a health care professional in a setting with appropriate equipment and personnel to manage anaphylaxis or serious infusion reactions. Approvals will not be granted for self-administration; and
    a. Leqembi™ must be shipped via cold chain supply to the facility where the member is scheduled to receive treatment and stored in the refrigerator; and
15. Member's weight must be provided and have been taken within the last 4 weeks to ensure accurate weight-based dosing; and
16. Initial approvals will be for 6 months. Confirmation that MRIs have been completed and were acceptable to the provider prior to the 5th and 7th infusions is required for continuation; and
17. Subsequent approvals will be for 6 months, and prescriber must document that the member has responded well to therapy compared to pretreatment baseline status as evidenced by improvement, stability, or slowing in cognitive and/or functional impairment using the same baseline test(s) performed at initiation of therapy for each subsequent approval; and
18. Approval quantities will be dependent on the member's weight and dosing based on package labeling; and
19. The maximum dose approvable is 10mg/kg per 14 days; and
20. Approvals will not be granted for concurrent use with other amyloid beta-directed monoclonal antibodies.

Recommendation 3: Vote to Prior Authorize Vyjuvek™

The Drug Utilization Review Board recommends the prior Vyjuvek™ (Beremagene

Geperpavec-svdt) with the following criteria:

Vyjuvek™ (Beremagene Geperpavec-svdt) Approval Criteria:

1. 1.An FDA approved indication for the treatment of wounds in members 6 months of age and older with dystrophic epidermolysis bullosa (DEB); and
2. 2.Diagnosis must be confirmed by a mutation in the collagen type VII alpha 1 chain (COL7A1) gene (results of genetic testing must be submitted); and
3. 3.Vyjuvek™ must be prescribed by a dermatologist or other specialist with expertise in the treatment of DEB (or an advanced care practitioner with a supervising physician who is a dermatologist or other specialist with expertise in the treatment of DEB); and
4. 4.Pharmacy or prescriber must confirm Vyjuvek™ will be prepared by a pharmacist trained in the preparation of Vyjuvek™ prior to administration and must confirm Vyjuvek™ will be shipped to the administering provider via cold chain supply and adhere to the storage and handling requirements in the Vyjuvek™ package labeling; and
5. 5.Vyjuvek™ must be administered by a health care professional (HCP) trained in the administration of Vyjuvek™. Approvals will not be granted for self-administration. Prior authorization requests must indicate who will administer Vyjuvek™ and in what setting (i.e., treatment facility, HCP office, home health); and
6. Prescriber must attest that Vyjuvek™ gel will be dosed per package labeling and applied to the same wound(s) until closed before selecting new wound(s) to treat, and that they will prioritize weekly treatment to previously treated wounds if they re-open; and
7. Prescriber must attest member or caregiver(s) have been counseled on the precautions prior to and during treatment with Vyjuvek™ that are listed in the package labeling, including avoiding direct contact with treated wounds and dressings for 24 hours following administration; and
8. Female members must not be pregnant and must have a negative pregnancy test immediately prior to therapy initiation. Female members of reproductive potential must be willing to use effective contraception while on therapy; and
9. A maximum approval quantity of 1 carton (2.5mL) per week or 4 cartons (10mL) per 28 days will apply; and
10. Initial approvals will be for 3 months. Subsequent approvals will be for 1 year and may be granted if the prescriber documents the member is responding well to treatment as indicated by the presence of wound healing.

Pharmacy Agenda Items

Recommendation 4: Vote to Prior Authorize Brixadi™

The Drug Utilization Review Board recommends the prior authorization of Brixadi™ (Buprenorphine Extended-Release Injection) with the following criteria:

Brixadi™ [Buprenorphine Extended-Release (ER) Injection] Criteria:

1. 1.An FDA approved diagnosis of moderate-to-severe opioid use disorder; and
2. Member must have initiated treatment with a single dose of a transmucosal buprenorphine product or is currently treated with buprenorphine; and
3. Concomitant treatment with opioids (including tramadol) will be denied; and
4. Medication should only be prepared and administered by a health care provider; and
5. A patient-specific, clinically significant reason why the member cannot use the preferred buprenorphine product(s) (buprenorphine/naloxone sublingual tablets) must be provided; and
6. In general, concomitant treatment with transmucosal buprenorphine will not be approved long term; and
7. Approvals will be for the duration of 90 days to allow for concurrent medication monitoring; and
8. A quantity limit of 1 monthly dose per 28 days or 4 weekly doses per 28 days will apply.

Recommendation 5: Vote to Prior Authorize Xacduro®

The Drug Utilization Review Board recommends the prior authorization of Xacduro® (Sulbactam/Durlobactam) with the following criteria:

Xacduro® (Sulbactam/Durlobactam) Approval Criteria:

1. An FDA approved diagnosis of hospital-acquired bacterial pneumonia (HABP) or ventilator-associated bacterial pneumonia (VABP) caused by susceptible isolates of Acinetobacter baumannii-calcoaceticus complex; and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why the member cannot use a carbapenem, ampicillin/sulbactam, polymyxin B, or other cost effective therapeutic equivalent alternative(s); or
4. For members with carbapenem-resistant Acinetobacter baumannii (CRAB), a patient-specific, clinically significant reason why the member cannot use high dose ampicillin/sulbactam in combination with polymyxin B, minocycline, or tigecycline must be provided; and
5. The prescriber must confirm that the member will be treated for other pathogens present, if applicable; and

6. Approval quantity will be based on Xacduro® package labeling and FDA approved dosing regimen(s).

Recommendation 6: Vote to Prior Authorize Cuvrior™

The Drug Utilization Review Board recommends the prior authorization Cuvrior™ (Trientine Tetrahydrochloride) with the following criteria:

Cuvrior™ (Trientine Tetrahydrochloride) Approval Criteria:

1. An FDA approved diagnosis of Wilson's disease; and
    a. Diagnosis must be confirmed by a Leipzig score ≥4; and
2. Member must be 18 years of age or older; and
3. Cuvrior™ must be prescribed by, or in consultation with, a gastroenterologist, hepatologist, or other specialist with expertise in the treatment of Wilson's disease (or an advanced care practitioner with a supervising physician who is gastroenterologist, hepatologist, or other specialist with expertise in the treatment of Wilson's disease); and
4. Member must be clinically stable, de-coppered, and tolerant to penicillamine as indicated by 1 of the following:
    a. Serum non-ceruloplasmin copper (NCC) level 25-150mcg/L; or
    b. Urinary copper excretion (UCE) level 200-500mcg/24 hours; and
5. Prescriber must verify the member will discontinue therapy with penicillamine or other copper chelating agents prior to starting therapy with Cuvrior™; and
6. A patient-specific, clinically significant reason why the member cannot use penicillamine, generic trientine hydrochloride, and Galzin® (zinc acetate), which are available without a prior authorization, must be provided; and
7. A quantity limit of 288 tablets per 28 days will apply.

Recommendation 7: Vote to Prior Authorize Rebyota™ and Vowst™

The Drug Utilization Review Board recommends the prior authorization of Rebyota™ (Fecal Microbiota, Live-jslm) and Vowst™ (Fecal Microbiota Spores, Livebrpk) with the following criteria:

Rebyota™ (Fecal Microbiota, Live-jslm) Approval Criteria:

1. An FDA approved indication for the prevention of recurrence of *Clostridium difficile* infection (CDI) in members 18 years of age or older; and

2. Member must have a diagnosis of at least 2 recurrent CDI episodes (≥3 total CDI episodes); and
3. The most recent CDI episode must be confirmed by a positive stool test for *C. difficile* toxin; and
4. The current CDI episode must be controlled (<3 unformed/loose stools/day for 2 consecutive days); and
5. The prescriber must verify that administration of Rebyota™ will occur 24 to 72 hours following completion of antibiotic course for CDI treatment; and
6. Rebyota™ must be prescribed by, or in consultation with, a gastroenterologist, infectious disease specialist, or a specialist with expertise in the treatment of CDI; and
7. For members at high risk for recurrent CDI (e.g., age ≥65, immunocompromised, clinically severe CDI upon presentation), a patient specific, clinically specific reason why the member cannot use Zinplava™ (bezlotoxumab) must be provided; and
8. The member must not be using Rebyota™ in combination with Vowst™ (fecal microbiota spores, live-brpk) or Zinplava™ (bezlotoxumab); and
9. Initial approvals will be for 1 treatment course. A second treatment course may be considered following a confirmed treatment failure within 8 weeks.

Vowst™ (Fecal Microbiota Spores, Live-brpk) Approval Criteria:

1. An FDA approved indication for the prevention of recurrence of Clostridium difficile infection (CDI) in members 18 years of age or older; and
2. Member must have a diagnosis of at least 2 recurrent CDI episodes (≥3 total CDI episodes); and
3. The most recent CDI episode must be confirmed by a positive stool test for C. difficile toxin; and
4. The current CDI episode must be controlled (<3 unformed/loose stools/day for 2 consecutive days) following 10 to 21 days of antibiotic therapy; and
5. The prescriber must verify that administration of Vowst™ will occur 2 to 4 days following completion of antibiotic course for CDI treatment; and
6. The member must agree to bowel cleanse using magnesium citrate or polyethylene glycol electrolyte solution the day before the first dose of Vowst™; and
7. Vowst™ must be prescribed by, or in consultation with, a gastroenterologist, infectious disease specialist, or a specialist with the expertise in the treatment of CDI; and

8. A patient specific, clinically specific reason (beyond convenience) why the member cannot use Rebyota™ (fecal microbiota, live-jslm) must be provided; and
9. For members at high risk for recurrent CDI (e.g., age ≥65, immunocompromised, clinically severe CDI on presentation), a patient specific, clinically specific reason why the member cannot use Zinplava™ (bezlotoxumab) must be provided; and
10. The member must not be using Vowst™ in combination with Rebyota™ (fecal microbiota, live-jslm) or Zinplava™ (bezlotoxumab); and
11. A quantity limit of 12 capsules for 3 days for 1 treatment course will apply.

Recommendation 8: Vote to Prior Authorize Orserdu®

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

Orserdu® (Elacestrant) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of advanced or metastatic breast cancer; and
2. Estrogen receptor (ER)-positive, human epidermal growth factor receptor 2 (HER2)-negative disease; and
3. Tumor is positive for ESR1-mutation; and
4. Female members must be postmenopausal; and
5. Has progressed after at least 1 prior endocrine therapy.

Recommendation 9: Vote to Prior Authorize Elevidys

The Drug Utilization Review Board recommends the prior authorization of Elevidys (Delandistrogene Moxeparvovec-rokl) with the following criteria:

Elevidys (Delandistrogene Moxeparvovec-rokl) Approval Criteria:

1. An FDA approved diagnosis of Duchenne muscular dystrophy (DMD) with a confirmed mutation in the DMD gene (results of genetic testing must be submitted); and
2. Member must be 4 years through 5 years of age; and
3. Prescriber must attest the member is ambulatory and the results of 1 of the following tests must be submitted:
    a. North Star Ambulatory Assessment (NSAA); or
    b. 6-minute walk test (6MWT); or
    c. 10-meter walk test (10mWT); or
    d. Ascend 4 Steps; or
    e. Time to Rise (TTR); or
    f. 100-meter timed test; and

4. Elevidys must be prescribed by a neurologist or specialist with expertise in the treatment of DMD (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of DMD); and
5. Member's baseline anti-AAVrh74 total binding antibody titers must be <1:400; and
6. Member must not have any deletion in exon 8 and/or exon 9 in the DMD gene; and
7. If the member has a deletion in the DMD gene in exon 1 to 17 and/or exons 59 to 71, the prescriber must verify the member will be monitored for a severe immune-mediated myositis reaction; and
8. Member must not have any active infections and if the member does have an active infection, the prescriber must verify Elevidys infusion will be postponed until infection has resolved; and
9. Prescriber must verify the member will initiate a corticosteroid regimen 1 day prior to the infusion of Elevidys and continue for a minimum of 60 days to reduce the risk of an immune response as specified in the package labeling; and
10. Prescriber must verify liver function tests (LFTs) (e.g., GGT, total bilirubin) will be performed prior to Elevidys administration and will be monitored weekly for the first 3 months following Elevidys infusion then as clinically indicated; and
11. Prescriber must verify troponin-I will be monitored before the Elevidys infusion and weekly for the first month following infusion then as clinically indicated; and
12. Prescriber must verify that platelet counts will be monitored before the Elevidys infusion and weekly for the first 2 weeks following infusion then as clinically indicated; and
13. Member will not be approved for concomitant treatment with exon skipping therapy (e.g., Amondys 45, Exondys 51, Viltepso®, Vyondys 53) following Elevidys infusion (current authorizations for exon skipping therapy will be discontinued upon Elevidys approval); and
14. Member's current weight (kg) taken within the past 3 weeks must be provided on the request to ensure accurate weight-based dosing according to package labeling; and
15. Approvals will be for 1 dose per member per lifetime.

Recommendation 10: Vote to Prior Authorize Jesduvroq™

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

Jesduvroq™ (Daprodustat) Approval Criteria:

Pharmacy Agenda Items

1. An FDA approved indication for the treatment of anemia due to chronic kidney disease (CKD) in adults; and
2. Member must currently be on dialysis and must have been receiving dialysis for ≥4 months; and
3. Prescriber must verify that member does not have uncontrolled hypertension; and
4. Prescriber must verify that member does not have an active malignancy; and
5. Member must not be concurrently taking strong CYP2C8 inhibitors (i.e., gemfibrozil); and
6. Member's pre-treatment hemoglobin (Hgb) must be <11g/dL. Recent Hgb levels must be provided; and
7. Member must be hyporesponsive to an erythropoiesis-stimulating agent (ESA) (or have a contraindication to use), defined as:
    a. No increase in Hgb after 1 month of weight-based dosing; or
    b. 2 increases in ESA dose up to 50% more than previous dose to maintain current Hgb level; and
8. Prescriber must verify that member will not use Jesduvroq™ concomitantly with an ESA; and
9. Initial and subsequent approvals will be for the duration of 12 weeks of treatment. Subsequent approvals will granted if the member meets 1 of the following:
    a. Member has achieved or maintained a clinically meaningful increase in Hgb of ≥1g/dL and the member's Hgb level is <12g/dL; or
    b. If the member has not achieved or maintained a clinically meaningful increase in Hgb of ≥1g/dL, then all of the following will be required:
        i. The dose will be increased as tolerated to a maximum of 24mg per day; and
        ii. The member has not received 24mg per day for >12 weeks without achieving a clinically meaningful increase in hemoglobin of ≥1g/dL; and
        iii. The member's Hgb is <12g/dL; and
10. Jesduvroq™ should be discontinued in members who do not show evidence of a clinically meaningful increase in Hgb by 24 weeks.

Recommendation 11: Vote to Prior Authorize Veopoz™

The Drug Utilization Review Board recommends the prior authorization of Veopoz™ (Pozelimab-bbfg) with the following criteria:

Pharmacy Agenda Items

Veopoz™ (Pozelimab-bbfg) Approval Criteria:

1. An FDA approved diagnosis of CD55-deficient protein-losing enteropathy (PLE) confirmed by all of the following:
    a. Genetic testing identifying biallelic pathogenic mutations in the CD55 gene (results of genetic testing must be submitted); and
    b. A history of PLE; and
2. Member has active disease defined by hypoalbuminemia (serum albumin concentration ≤3.2g/dL) with 1 or more of the following signs or symptoms within the last 6 months: abdominal pain, diarrhea, peripheral edema, or facial edema; and
3. Member must be 1 year of age or older; and
4. Prescriber must verify the member has received the meningococcal vaccine 2 weeks prior to treatment unless urgent treatment is needed; and
5. Veopoz™ must be prescribed by, or in consultation with, a gastroenterologist, geneticist, hematologist, or other specialist with expertise in the treatment of CD55-deficient PLE; and
6. The prescriber must verify that Veopoz™ will be administered by a health care professional; and
7. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
8. Initial approvals will be for the duration of 6 months. Further approval may be granted if the prescriber documents that the member is responding well to treatment as indicated by a normalization of serum albumin or documentation of a positive clinical response to therapy.

Recommendation 12: Vote to Prior Authorize Ojjaara

The Drug Utilization Review Board recommends the prior authorization of Ojjaara (Momelotinib) with the following criteria:

Ojjaara (Momelotinib) Approval Criteria [Myelofibrosis (MF) Diagnosis]:

1. Diagnosis of intermediate or high-risk disease (including MF, polycythemia vera, or post-essential thrombocythemia); and
2. Presence of anemia.

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SUBMITTED TO THE C.E.O. AND BOARD ON DECEMBER 7, 2023

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

BACKGROUND

Services	Customer Relationship Management (CRM)
Purpose and Scope	Maximus assists OHCA with operations of a Customer Relationship Management solution, including a call center for interactions with members or potential members in its health care benefits programs, contracted or potential health care providers, allied agencies and organizations and other interested parties. They will be providing choice counseling services to assist in the transition to managed care.
Mandate	N/A
Procurement Method	Sole Source Extension
External Approvals	CMS
Contract Term	July 1, 2023 through June 30, 2024

BUDGET

Amount requested for Approval	$2,250,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	90%, 50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to increase the existing not-to exceed by $2,250,000.00 for the current contract year for a total not-to-exceed of $11,457,017.00.

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 days for cause, 60 days 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 either $1,000,000.00 or 25%, 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 DECEMBER 7, 2023

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

BACKGROUND

Services	Population Care Management Software System
Purpose and Scope	OHCA plans to initiate a competitive reprocurement to replace the expired service contract for Population Care Management Software. The Oklahoma Health Care Authority (OHCA) will seek proposals for the following services: • Provide a population care management system at the provider and state level that is sortable, filterable, exportable, and allows for stratification of clients by different criteria such as diagnosis, medications, emergency department admissions, crisis center admissions, hospital admissions, comorbid conditions, metabolic screening values, assessment scores, demographics, and performance measures.
Mandate	N/A
Procurement Method	Competitive Bid
External Approvals	OMES
Contract Term	July 1, 2024, through June 30, 2025 with five (5) options to renew

BUDGET

Amount requested for Approval	$3,900,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure the services to administer a Population Care Management Software System as described above for one base year and five (5) renewal periods each funded at $650,000.00 for a total not-to-exceed of $3,900,000.00.

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 days for cause, 60 days 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 either $1,000,000.00 or 25%, 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.)

December 2023 Board
Proposed Rule Amendment Summaries

The Agency is requesting ***EMERGENCY*** approval of the following rule revisions with a proposed effective date of immediately upon Governor's approval or Jan. 1, 2024 or no later than Feb. 1, 2024.

These rules were presented at Tribal Consultation and to the Medical Advisory Committee and were subject to at least a 15-day public review period.

These proposed rules HAVE NOT previously been approved by the Board.

APA WF # 23-16A&B Minimum Age for Enrollment into ADvantage Waiver — The Agency requests emergency approval of rule revisions to avoid violation of federal law and to protect the public health, safety, and/or welfare by lowering the minimum enrollment age from 21 to 19 for individuals eligible for the 1915c Home and Community Based Services (HCBS) ADvantage Waiver program. These revisions align with the ADvantage waiver amendment, recently approved by CMS, to better facilitate the transition for these individuals into the ADvantage program.

Budget Impact: Budget neutral

APA WF # 23-19 Adult Day Health Services Revisions — The Agency requests emergency approval of rule revisions which are necessary to protect the public health, safety, and/or welfare by preventing a decrease in services for those moving from the Developmental Disabilities Services (DDS) wait list to a Home and Community Based Services (HCBS) 1915(c) waiver program. Policy revisions are necessary to maintain the level of support for these individuals by providing the same amount of adult day health they were receiving while on the DDS Aging state-funded services wait list. The maximum number of adult day health units that can be provided in a day will increase from six (6) to eight (8) hours. Additionally, policy revisions will change the name from adult day services to adult day health.

Budget Impact: The estimated budget results in a savings in state funds of $1,020,564 for SFY 2024 and a savings in state funds of $2,041,128 for SFY 2025.

This is a savings to Oklahoma Human Services because the Community Living, Aging, and Protective Services (CAP) program pays for adult day health services with 100% state funds due to those individuals who need eight (8) hours of adult day health per day. With this change, the services will be eligible to receive federal funding through the HCBS program.

APA WF # 23-20 Tax Equity and Fiscal Responsibility Act (TEFRA) Psychological Evaluations and ICF/IID Level of Care Reevaluations — The Agency requests emergency approval of rule revisions to protect the public health, safety, and/or welfare by adding additional provider types to conduct psychological evaluations for TEFRA applicants. In addition to licensed psychologists or school psychologists as currently outlined in policy, certified psychometrists, psychological technicians for a psychologist, and licensed behavioral health professionals will be added to help alleviate wait times for TEFRA approval. Additionally, policy will be revised to reflect a new business process of conducting ICF/IID level of care reevaluations biennially rather than annually.

Budget Impact: The estimated budget impact for SFY 2024 is $83,395, of which $27,078 is state share. The estimated budget impact for SFY 2025 is $166,790, of which $53,390 is state share.

APA WF # 23-21 Quarterly Payments for Orthodontic Services — The Agency requests emergency approval of rule revisions to protect the public health, safety and welfare of SoonerCare members to transition the current orthodontic system from a bulk payment to a quarterly payment protocol. The new payment protocol will be based on twenty-four (24) months with built in progress reports. These emergency revisions will allow the Agency to vastly improve on patient care; ability to track patient progress; transferring of member care; and financial tracking. The proposed new payment protocol will improve member access to care by facilitating and tracking member transfer of care and aligning with shorter treatment time (24 months) for patient and provider due to improved materials and techniques in Orthodontia.

Budget Impact: Budget neutral; the amount of the total will not change.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-41. Home and Community Based Services Waivers for persons with physical disabilities

(a) **ADvantage Waiver**. The ADvantage Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for elderly and disabled individuals in specific waiver areas. To receive ADvantage Program services, individuals must meet the nursing facility level of care criteria, be age ~~65~~sixty-five (65) years or older, or age ~~21~~nineteen (19) or older if disabled. ADvantage Program members must be SoonerCare eligible and reside in the designated service area. The number of members in the ADvantage Waiver is limited.

(b) **Medically Fragile Waiver**. The Medically Fragile Waiver Program is a Medicaid Home and Community Based Services (HCBS) Waiver used to finance non-institutional long-term care services through Oklahoma's SoonerCare program for medically fragile individuals. To receive Medically Fragile Program services, individuals must be at least 19 years of age, be SoonerCare eligible, and meet the ~~OHCA~~Oklahoma Health Care Authority (OHCA) skilled nursing facility (SNF) or hospital level of care (LOC) criteria. Eligibility does not guarantee placement in the program as Waiver membership is limited.

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

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-1. Overview of long-term medical care services; relationship to Qualified Medicare Beneficiary Plus (QMBP), Specified Low-Income Medicare Beneficiary (SLMB), and other Medicaid (SoonerCare) services eligibility

(a) Long-term medical care for the categorically needy includes:

(1) Care in a long-term care facility per Oklahoma Administrative Code (OAC) 317:35-19;

(2) Care in a public or private intermediate care facility for the intellectually disabled (ICF/IID), per OAC 317:35-9;

(3) Care of persons sixty-five (65) years of age and older in mental health hospitals, per OAC 317:35-9;

(4) Home and Community-Based waiver services for persons with intellectual disabilities, per OAC 317:35-9;

(5) Personal Care services, per OAC 317:35-15; and

(6) Home and Community-Based waiver services (ADvantage waiver) for frail elderly, sixty-five (65) years of age and older; and a targeted group of adults with physical disabilities, ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age and older, who do not have an intellectual disability or a cognitive impairment related to a developmental disability per OAC 317:35-17-3.

(b) When an individual is certified as eligible for SoonerCare coverage of long-term care, he or she is also eligible for other SoonerCare services. ADvantage waiver members do not have a copayment for ADvantage services except for prescription drugs. For members residing in an ADvantage assisted living center, any income beyond one-hundred and fifty percent (150%) of the federal benefit rate is available to defray the cost of the assisted living services received. The member is responsible for payment to the assisted living services center provider for days of service, from the first day of each full-month in which services were received, until the vendor pay obligation is met. When an individual is aged, blind, or disabled and is determined eligible for long-term care, a separate eligibility determination must be made for QMBP or SLMB benefits. An ADvantage program member may reside in a licensed assisted living services center only when the assisted living services center is a certified ADvantage assisted living services center provider from whom the member is receiving ADvantage assisted living services.

317:35-17-3. ADvantage program services

(a) The ADvantage program is a Medicaid Home and Community-Based waiver used to finance non-institutional, long-term care services for the elderly and a targeted group of physically disabled adults when there is a reasonable expectation that within a thirty (30) calendar day period, the person's health, due to disease process or disability, would without appropriate services, deteriorate and require long-term care (LTC) facility care to arrest the deterioration. Individuals may not be enrolled in ADvantage for the sole purpose of enabling them to obtain Medicaid eligibility. Eligibility for ADvantage program services is contingent on an individual requiring one (1) or more of the services offered in the waiver, at least monthly, to avoid institutionalization.

(b) The number of individuals who may receive ADvantage services is limited.

(1) To receive ADvantage program services, individuals must meet one of the categories in (A) through (D) of this paragraph. He or she must:

(A) Be sixty-five (65) years of age or older; or

(B) Be ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age with a physical disability; or

(C) Be ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age with a developmental disability, provided he or she does not have a cognitive impairment (intellectual disability); or

(D) Be ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age with a clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or LTC facility level of care services to maintain the treatment regimen to prevent health deterioration.

(2) In addition, the individual must meet criteria in (A) through (C) of this paragraph. He or she must:

(A) Require long-term care facility level of care, per Oklahoma Administrative Code (OAC) 317:35-17-2;

(B) Meet service eligibility criteria, per OAC 317:35-17-3(f); and

(C) Meet program eligibility criteria, per OAC 317:35-17-3(g).

(c) ADvantage members are eligible for limited types of living arrangements. The specific living arrangements are set forth in (1) through (5) of this subsection.

(1) ADvantage program members are not eligible to receive services while residing in an unlicensed institutional living arrangement, such as a room and board home or facility; an institutional setting including, but not limited to, licensed facilities, such as a hospital, a LTC facility, licensed residential care facility, or licensed assisted living facility, unless the facility is an ADvantage assisted living center.

(2) Additional living arrangements in which members may receive ADvantage services are the member's own home, apartment, or independent-living apartment, or a family or friend's home or apartment. A home or apartment unit is defined as a self-contained living space having a lockable entrance to the unit and including a bathroom, food storage and preparation amenities in addition to the bedroom or living space.

(3) ADvantage program members may receive services in a shelter or similar temporary-housing arrangement that may or may not meet the definition of home or apartment in emergency situations, for a period not to exceed sixty (60) calendar days during which location and transition to permanent housing is sought.

(4) For ADvantage members who are full-time students, a dormitory room qualifies as an allowable living arrangement in which to receive ADvantage services while the member is a student.

(5) Members may receive ADvantage respite services in an LTC facility for a continuous period not to exceed thirty (30) calendar days.

(d) Home and Community-Based waiver services are outside of the scope of Medicaid State Plan services. The Medicaid waiver allows the Oklahoma Health Care Authority to offer certain Home and Community-Based services to an annually capped number of persons, who are categorically needy, per Oklahoma Human Services (OKDHS) Appendix C-1, Schedule VIII. B. 1., and without such services would be institutionalized. The estimated cost of providing an individual's care outside of the LTC facility cannot exceed the annual cost of caring for that individual in a LTC facility. When determining the ADvantage service plan cost cap for an individual, the comparable

Medicaid cost to serve that individual in a LTC facility is estimated.

(e) Services provided through the ADvantage waiver are:

(1) Case management;

(2) Respite;

(3) Adult day health care;

(4) Environmental modifications;

(5) Specialized medical equipment and supplies;

(6) Physical, occupational, or speech therapy or consultation;

(7) Advanced supportive and/or restorative assistance;

(8) Nursing;

(9) Skilled nursing;

(10) Home-delivered meals;

(11) Hospice care;

(12) Medically necessary prescription drugs, within the limits of the ADvantage waiver;

(13) Personal care, State Plan, or ADvantage personal care;

(14) A Personal Emergency Response System (PERS);

(15) Consumer Directed Personal Assistance Services and Supports (CD-PASS);

(16) Institution Transition Services (Transitional Case Management);

(17) Assisted living;

(18) Remote Supports;

(19) Assistive technology; and

(20) SoonerCare medical services for individuals, twenty-one (21) years of age and over, within the State Plan scope.

(f) The OKDHS area nurse or nurse designee determines service eligibility prior to evaluating the Uniform Comprehensive Assessment Tool (UCAT) assessment for long-term care facility level of care. The criteria in (1) through (5) of this subsection are used to make the service eligibility determination, which includes:

(1) An open ADvantage program waiver slot, as authorized by the Centers for Medicare and Medicaid Services (CMS), is available to ensure federal participation in payment for services to the individual. When Oklahoma Human Services Community Living, Aging and Protective Services (CAP) determines all slots are filled, the individual cannot be certified as eligible for ADvantage services, and his or her name is placed on a waiting list for entry when an open slot becomes available.

(2) The ADvantage waiver-targeted service groups are individuals, who:

(A) Are frail and sixty-five (65) years of age and older; or

(B) Are ~~Twenty-one (21)~~nineteen (19) to sixty-four (64) years of age and physically disabled; or

(C) When developmentally disabled and ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age and do not have an intellectual disability or cognitive impairment related to the developmental disability; or

(D) Are ~~twenty-one (21)~~nineteen (19) to sixty-four (64) years of age and not physically disabled but have a clinically documented, progressive, degenerative disease process that responds to treatment and previously required hospital or long-term care facility level of care services to maintain the treatment regimen to prevent health deterioration. The individual must meet criteria, per OAC 317:35-17-3(b)(2)(A) through (C).

(3) An individual is ineligible when posing a physical threat to self or others, as supported by

professional documentation.

(4) An individual is ineligible when members of the household or persons who routinely visit the household pose a threat of harm or injury to the individual or other household visitors, as supported by professional documentation.

(5) An individual is ineligible when his or her living environment poses a physical threat to self or others, as supported by professional documentation where applicable, and measures to correct hazardous conditions or assist the individual to move are unsuccessful or not feasible.

(g) The State, as part of the ADvantage waiver program approval process, ensures CMS that each member's health, safety, or welfare can be maintained in his or her home. When a member's identified needs cannot be met through provision of the ADvantage program or Medicaid State Plan services and other formal or informal services are not in place or immediately available to meet those needs, the individual's health, safety, or welfare in his or her home cannot be ensured. The ADvantage Administration (AA) determines ADvantage program eligibility through the service plan approval process. An individual is deemed ineligible for the ADvantage program based on criteria (1) through (8) of this subsection.

(1) The individual's needs, as identified by the UCAT and other professional assessments, cannot be met through ADvantage program services, Medicaid State Plan services, or other formal or informal services.

(2) One (1) or more members of the individual's household pose a physical threat to themselves, or others as supported by professional documentation.

(3) The individual or other household members use threatening, intimidating, degrading, or use sexually inappropriate language or innuendo or behavior towards service providers, in the home or through other contact or communications, and significant efforts were attempted to correct such behavior, as supported by professional documentation or other credible documentation.

(4) The individual, or the individual's authorized agent, is uncooperative or refuses to participate in service development or service delivery and these actions result in unacceptable increases of risk to the individual's health, safety, or welfare in his or her home, as determined by the individual, the interdisciplinary team, or the AA.

(5) The individual's living environment poses a physical threat to self or others, as supported by professional documentation, and measures to correct hazardous conditions or assist the person to move are unsuccessful or are not feasible.

(6) The individual provides false or materially inaccurate information necessary to determine program eligibility or withholds information necessary to determine program eligibility.

(7) The individual does not require at least one ADvantage service monthly.

(8) The individual, his or her family member(s), associate(s), or any other person(s) or circumstances as relates to care and coordination in the living environment produces evidence of illegal drug activity or substances used illegally as intoxicants. This includes:

(A) The use, possession, or distribution of illegal drugs;

(B) The abusive use of other drugs, such as medication prescribed by a doctor;

(C) The use of substances, such as inhalants including, but not limited to:

(i) Typewriter correction fluid;

(ii) Air conditioning coolant;

(iii) Gasoline;

(iv) Propane;

(v) Felt-tip markers;

(vi) Spray paint;
(vii) Air freshener;
(viii) Butane;
(ix) Cooking spray;
(x) Paint; and
(xi) Glue;

(D) The observed intoxication, consumption, or sensory indicators, such as smell of the use of any drug or intoxicant by the individual, family members, associates, or any other person(s) present at the time care is provided may be construed as evidence indicative of illegal drug activity or intoxication. This includes drug use or intoxicated activity that is menacing to the member or staff providing services;

(E) The observance of drug paraphernalia or any instrument used in the manufacturing, production, distribution, sale, or consumption of drugs or substances including, but not limited to:

(i) Smoking pipes used to consume substances other than tobacco;
(ii) Roach clips containing marijuana cigarettes;
(iii) Needles and other implements used for injecting drugs into the body;
(iv) Plastic bags or other containers used to package drugs;
(v) Miniature spoons used to prepare drugs; or
(vi) Kits used in the production of synthetic controlled substances including descriptive materials that accompany the item, describing or depicting its use.

(F) Instructions, verbal or written, concerning the item or device including, but not limited to, the manner in which the object is labeled and displayed for sale;

(G) The typical use of such items in the community; or

(H) Testimony of an expert witness regarding use of the item.

(h) The case manager provides the AA with professional documentation or other credible documentation to support the recommendation for redetermination of program eligibility. The service providers continue providing services according to the person-centered service plan as provider safety permits until the individual is removed from the ADvantage program. As a part of the procedures requesting redetermination of program eligibility, CAP provides technical assistance to the provider for transitioning the individual to other services.

(i) Individuals determined ineligible for ADvantage program services are notified in writing by CAP of the determination and of their right to appeal the decision.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15) of this Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) through Home and Community-Based Services (HCBS).

(1) **Dental services.** Dental services are provided per Oklahoma Administrative Code (OAC) 317:40-5-112.

(A) **Minimum qualifications.** Dental services providers must have non-restrictive licensure by the Oklahoma State Board of Dentistry to practice dentistry in Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) Oral examinations;

(ii) Medically necessary images;

(iii) Prophylaxis;

(iv) Flouride application;

(v) Development of a sequenced treatment plan that prioritizes:

(I) Pain elimination;

(II) Adequate oral hygiene; and

(III) Restoring or improving ability to chew;

(vi) Routine training of member or primary caregiver regarding oral hygiene; and

(vii) Preventive, restorative, replacement, and repair services to achieve or restore functionality provided after appropriate review when applicable, per OAC 317:40-5-112.

(C) **Coverage limitations.** Dental service coverage is specified in the member's Individual Plan (IP) in accordance with applicable Waiver limits. Cosmetic dental services are not authorized.

(2) **Nutrition services**. Nutrition Services are provided, per OAC 317:40-5-102.

(3) **Occupational therapy services.**

(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants have current, non-restrictive licensure by the Oklahoma Board of Medical Licensure and Supervision. Occupational therapy assistants are supervised by occupational therapists, per OAC 317:30-5-295 (b) (1).

(B) **Service description.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, mealtime assistance, assistive technology, positioning, and mobility. Occupational therapy services may include occupational therapy assistants, within the limits of the occupational therapist's practice.

(i) Services are:

(I) Intended to help the member achieve greater independence to reside and participate in the community; and

(II) Rendered in any community setting as specified in the member's IP. The IP includes a practitioner's prescription.

(ii) For this Section's purposes, a practitioner means medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.

(iii) Service provision includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** For compensable services, payment is made to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant within the occupational therapist's employment. Payment is made in fifteen-minute (15-minute) units, with a limit of four hundred and eighty (480) units per Plan of Care (POC) year. Payment is not allowed solely for written reports or record documentation.

(4) **Physical therapy services.**

(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have current, non-restrictive licensure with the Oklahoma Board of Medical Licensure and Supervision. The physical therapist supervises the physical therapist assistant, per OAC 317:30-5-290.1 (b) (1).

(B) **Service description.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility skeletal and muscular conditioning, assistive technology, and positioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include physical therapist assistants, within the limits of the physical therapist's practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

(ii) Service provision includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** For compensable services, payment is to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within the physical therapist's employment. Payment is made in fifteen-minute (15-minute) units with a limit of four hundred and eighty (480) units per POC. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification to provide psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma State Board of Examiners of Psychologists, or by the licensing board in the state where the service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(B) **Service description.** Psychological services include evaluation, psychotherapy,

consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP. The provider develops, implements, evaluates, and revises the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified in the member's IP.

(i) Services are:

(I) Intended to maximize a member's psychological and behavioral well-being; and

(II) Provided in individual and group formats, with a six-person maximum.

(ii) Service approval is based on assessed needs per OAC 340:100-5-51.

(C) **Coverage limitations.**

(i) Payment is made in fifteen (15) minute units. A minimum of fifteen (15) minutes for each individual and group encounter is required.

(ii) Psychological services are authorized for a period, not to exceed twelve (12) months.

(I) Initial authorization does not exceed one hundred and ninety-two (192) units, forty-eight (48) service hours.

(II) Authorizations may not exceed two hundred and eighty-eight (288) units per POC year unless the DDS Behavior Support Services director or designee makes an exception.

(III) No more than twelve (12) hours of services, forty-eight (48) units, may be billed for PIP preparation. Any clinical document is prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(IV) When revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one (1) revision. The time for preparing the revision is clearly documented and does not exceed four (4) hours.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a psychiatric services provider requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the American Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Service description.** Psychiatric services include outpatient evaluation, psychotherapy, medication and prescription management and consultation, and are provided to eligible members. Services are provided in the community setting specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of thirty (30) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is thirty (30) minutes, with a limit of two hundred (200) units, per POC year.

(7) **Speech-language pathology services.**

(A) **Minimum qualifications.** Qualification as a speech-language pathology services provider requires current, non-restrictive licensure as a speech-language pathologist, speech-language pathology assistant, or speech-language pathology clinical fellow, by the Oklahoma Board of Examiners for Speech-Language Pathology and Audiology, per OAC 317:30-5-675.

(B) **Service description.** Speech therapy includes evaluation, treatment, and consultation in communication, oral motor activities, and/or feeding activities provided to eligible members. Services are intended to maximize the member's community living skills and may be provided in the community setting specified in the member's IP.

(i) The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech or language services or both in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is fifteen (15) minutes, with a limit of two hundred and eighty-eight (288) units, per POC. Payment is not allowed solely for written reports or record documentation.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers complete Oklahoma Human Services (OKDHS) DDS-sanctioned training curriculum. Residential habilitation providers:

(i) Are at least eighteen (18) years of age or older;

(ii) Are specifically trained to meet members' unique needs;

(iii) Have not been convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section (§) 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2) unless a waiver is granted, per 56 O.S. §1025.2; and

(iv) Receive supervision and oversight from contracted-agency staff with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Service description.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment is not made for:

(I) Routine care and supervision family normally provides; or

(II) Services furnished to a member by a person who is legally responsible, per OAC 340:100-3-33.2.

(ii) Family members who provide HTS services meet the same standards as providers who are unrelated to the member. HTS staff residing in the same household as the member may not provide services in excess of forty (40) hours per week. Members who require HTS services for more than forty (40) hours per week use staff members who do not reside in the household, and who are employed by the member's chosen provider agency, to deliver the balance of necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, or improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's

IP clearly specifies the role of the HTS and person providing IPS to ensure there is no service duplication.

(v) Review and approval by the DDS plan of care reviewer is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an OHCA-approved oversight agency. For pre-authorized HTS services, the service:

(I) Provider receives DDS area staff oversight; and

(II) Is pre-approved by the DDS director or his or her designee.

(C) **Coverage limitations.** HTS services are authorized per OAC 317:40-5-110, 317:40-5-111, 317:40-7-13, and 340:100-3-33.1.

(i) A unit is fifteen (15) minutes.

(ii) Individual HTS service providers are limited to a maximum of forty (40) hours per week regardless of the number of members served.

(iii) More than one (1) HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two (2) or more HTSs to the same member during the same hours of a day.

(v) An HTS may receive reimbursement for providing services to only one (1) member at any given time. This does not preclude services from being provided in a group setting where services are shared among group members.

(vi) HTS providers may not perform any job duties associated with other employment including on-call duties, at the same time they are providing HTS services.

(9) **Remote Supports (RS).** RS is provided per OAC 317:40-4-4.

(10) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

(11) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

(12) **Audiology services.**

(A) **Minimum qualifications.** Audiologists have licensure as an audiologist by the Oklahoma Board of Examiners for Speech Pathology and Audiology per OAC 317:30-5-675 (d) (1).

(B) **Service description.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities.

(i) The member's IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with OAC 317:30-5-1 covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(13) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete OKDHS DDS-sanctioned training curriculum;

(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Service description.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are learning and work experiences where the member can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

(ii) Activities include teaching concepts such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Pre-vocational services are delivered to further habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP. Documentation is maintained in the record of each member receiving this service, noting the service is not otherwise available through a program funded under the Rehabilitation Act of 1973 or IDEA.

(iv) Services include:

(I) Center-based prevocational services, per OAC 317:40-7-6;

(II) Community-based prevocational services per, OAC 317:40-7-5;

(III) Enhanced community-based prevocational services per, OAC 317:40-7-12; and

(IV) Supplemental supports, as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one (1) hour and payment is based on the number of hours the member participates in the service. All prevocational services and supported-employment services combined may not exceed the annual costs set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule. The services that may not be provided to the same member at the same time as prevocational services are:

(i) HTS;

(ii) IPS;

(iii) ~~Adult Day Services~~Adult Day Health;

(iv) Daily Living Supports (DLS);

(v) Homemaker; or

(vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services; family counseling; or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training, per OAC 317:40-7-6.

(14) **Supported employment.**

(A) **Minimum qualifications.** Supported employment providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete the OKDHS DDS-sanctioned training curriculum;

(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.5; and

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Services description.** For members receiving HCBS Waiver services, supported employment is conducted in various settings, particularly worksites where persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work, including supervision and training. The supported employment outcome is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level the employer pays for the same or similar work individuals without disabilities perform. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.

(i) When supported-employment services are provided at a worksite where persons without disabilities are employed, payment:

(I) Is made for the adaptations, supervision, and training members require as a result of their disabilities; and

(II) Does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:

(I) Job coaching per OAC 317:40-7-7;

(II) Enhanced job coaching per OAC 317:40-7-12;

(III) Employment training specialist services per OAC 317:40-7-8; and

(IV) Stabilization per OAC 317:40-7-11.

(iii) Supported-employment services furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.

(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA is maintained in each member's record.

(v) Federal financial participation may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:

(I) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

(II) Payments passed through to users of supported-employment programs; or

(III) Payments for vocational training not directly related to a member's supported-employment program.

(C) **Coverage limitations.** A unit is fifteen (15) minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported-employment services combined cannot exceed $27,000, per POC year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The services that may not be provided to the same member, at the same time as supported-employment services are:

(i) HTS;

(ii) IPS;

(iii) ~~Adult Day Services~~Adult Day Health;
(iv) DLS;
(v) Homemaker; or
(vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.

(15) **IPS.**

(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and OKDHS DDS. Providers:
(i) Are eighteen (18) years of age or older;
(ii) Complete OKDHS DDS-sanctioned training curriculum;
(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.2;
(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities; and
(v) Receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.

(B) **Service description.**
(i) IPS:
(I) Are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and
(II) Build on the support level HTS or DLS staff provides by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational and habilitation activities.
(ii) The member's IP clearly specifies the role of HTS and the person providing IPS to ensure there is no service duplication.
(iii) The DDS POC reviewer is required to review and approve services.

(C) **Coverage limitations.** IPS are limited to twenty-four (24) hours per day and are included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

(16) **~~Adult day services~~Adult day health (ADH).**

(A) **Minimum qualifications.** ~~Adult day service~~Adult day health (ADH) provider agencies:
(i) Meet licensing requirements, per 63 O.S. § 1-873 *et seq*. and comply with OAC 310:605; and
(ii) Are approved by the OKDHS DDS director and have a valid OHCA contract for ~~adult day services~~ADH.

(B) **Service description.** ~~Adult day services~~ADH provide assistance with retaining or improving the member's self-help ability adaptive and socialization skills, including the opportunity to interact with peers in order to promote a maximum level of independence and function. Services are provided in a non-residential setting away from the home or facility where the member resides.

(C) **Coverage limitations.** ~~Adult day services~~ADH ~~are~~is furnished four (4) or more hours

per day on a regularly scheduled basis, for one (1) or more days per week. A unit is fifteen (15) minutes for up to a maximum of ~~six (6)~~eight (8) hours daily~~, at which point a unit is one (1) day~~. All services are authorized in the member's IP.

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

SUBCHAPTER 7. MEDICAL SERVICES

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

317:35-7-61.1. Special redetermination procedures for Tax Equity and Fiscal Responsibility Act (TEFRA)

In addition to redetermining the level of care~~ annually~~, the OHCA also conducts an annual cost effectiveness review for all active TEFRA children. If OHCA determines the child does not meet any level of care, is no longer disabled, or the estimated cost of care in the home is greater than the estimated cost of care in an institution, at the appropriate level of care, the case is closed.

SUBCHAPTER 9. ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 5. DETERMINATION OF MEDICAL ELIGIBILITY FOR ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

317:35-9-48.1. Determining ICF/IID institutional level of care for TEFRA children

In order to determine ~~ICF/IID~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) level of care for ~~TEFRA~~Tax Equity and Fiscal Responsibility Act (TEFRA) children:

(1) The child must be age ~~18~~eighteen (18) years or younger and expected to meet the following criteria for at least ~~30~~thirty (30) days.

(A) Applicants under age three (3) must:

(i) ~~have~~Have a diagnosis of a developmental disability; and

(ii) ~~have~~Have been evaluated by the SoonerStart Early Intervention Program or other appropriate healthcare provider, and found to have severe dysfunctional deficiencies with findings of at least two (2) standard deviations in at least two (2) total domain areas.

(B) Applicants age three (3) years and older must:

(i) ~~have~~Have a diagnosis of intellectual disability or a developmental disability; and

(ii) ~~have~~Have received a psychological evaluation by a licensed psychologist, ~~or~~ school psychologist certified by the Oklahoma Department of Education (ODE) within the last ~~12~~twelve (12) months, certified psychometrist, psychological technician of a psychologist, or licensed behavioral health professional (LBHP). The evaluation must include intelligence testing that yields a full-scale intelligence quotient, and a full-scale functional or adaptive assessment that yields a composite functional age. Eligibility for TEFRA ICF/IID level of institutional care requires an IQ of ~~70~~seventy (70) or less, or a full-scale functional assessment indicating a functional age composite that does not exceed fifty (50) percent of the child's chronological age. In no case shall eligibility be granted for a functional age greater than eight (8) years.

(2) Psychological evaluations are required for children who are approved for TEFRA under ICF/IID level of care. Children under evaluation, including both intelligence testing and adaptive/functional assessment, by a licensed psychologist, ~~or~~ school psychologist certified by the ODE, certified psychometrist, psychological technician of a psychologist, or licensed behavioral health professional (LBHP) at ~~age three, age six,~~application, at two (2) years (but no later than three (3) years) after the initial psychological evaluation, and at two (2) years (but no later than three (3) years) after the second psychological evaluation and, if medically necessary, thereafter, to ascertain continued eligibility for TEFRA under the ICF/IID level of institutional care. ~~The psychological evaluation must be completed and submitted to the LOCEU no later than 90 days following the child's third (3rd) and sixth (6th) birthday, and, if medically necessary, thereafter.~~

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 79. DENTISTS

317:30-5-700.1. Orthodontic prior authorization

(a) Orthodontic services are available for members who are SoonerCare-eligible and under eighteen (18) years of age, at the time the request for prior authorization for treatment is received, per Oklahoma Administrative Code 317:30-5-700. The following records and documentation, plainly labeled with the member's full name, recipient identification number (RID), and the orthodontist's name are required for prior authorization of orthodontic services and must be electronically submitted to the Dental Unit of the Oklahoma Health Care Authority (OHCA) Dental Program when the member has a total score of not less than thirty (30) points or meets other eligibility criteria in paragraph (d).

(1) Completed prior authorization requesting all needed treatments;

(2) Complete and scored Handicapping Labio-Lingual Deviation ~~(HDL)~~(HLD) Index with Diagnosis of Angle's classification;

(3) Detailed description of any oral maxillofacial anomaly;

(4) Estimated length of treatment;

(5) Intraoral photographs showing teeth in centric occlusion and/or photographs of trimmed anatomically occluded diagnostic casts. A lingual view of casts may be included to verify impinging overbites;

(6) Cephalometric images with tracing, and panoramic film, with a request for prior authorization of comprehensive orthodontic treatment;

(7) Completed OHCA caries risk assessment form;

(8) If diagnosed as a surgical case, submit an oral surgeon's written opinion that orthognathic surgery is indicated and the surgeon is willing to provide this service; and

(9) Additional pertinent information as determined necessary by the orthodontist or as requested by the OHCA.

(b) All images and required documentation must be submitted electronically in one (1) package. ~~OHCA is not responsible for lost or damaged materials.~~

(c) All records and documentation submitted in a request for prior authorization for orthodontic treatment are reviewed by the OHCA orthodontic consultant for compensability and length of treatment. ~~Any documentation on which a decision is made will not be returned.~~

(d) Some children not receiving a minimum score of thirty (30) on the ~~HDL~~HLD Index may have other conditions to be considered. In the event an orthodontist believes there are other medical, social, or emotional conditions impacting the general health of the child, he/she refers to the conditions listed on the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) exception section found on the HLD. The following guidelines and restrictions apply to other conditions:

(1) Other medical, social, or emotional conditions are limited to those conditions that affect the medical, social or emotional function of the child;

(2) Other medical, social, or emotional conditions are not scored if the sole condition sought to be improved is the cosmetic appearance of the child;

(3) Such other medical, social, or emotional conditions must be demonstrated by objective evidence such as supported documentation outside the child's immediate family (e.g., a child's teacher, primary care physician, behavioral health provider, school counselor);

(4) Objective evidence must be submitted with the HLD;

(5) When such other medical, social, or emotional conditions are reflected on the HLD, the OHCA orthodontic consultant must review the data and use his or her professional judgment to score the value of the conditions; and

(6) The OHCA orthodontic consultant may consult with and utilize the opinion of the orthodontist who completes the form.

(e) If it is determined that the malocclusion is not severe enough to warrant medically necessary orthodontic services or the member's age precludes approval, a computer generated notice is issued to the provider and member with notice of the denial, the reason for the denial, and appeal rights [see Oklahoma Administrative Code (OAC) 317:2-1 for grievance procedures and processes].

(f) Orthodontic treatment and payment for the services are approved within the scope of the SoonerCare program. If orthodontic treatment is approved, a computer generated notice is issued authorizing the first year of treatment.

(1) Approval of orthodontic treatment is given in accordance with the following:

(A) Authorization for the first ~~year~~twelve (12) months of comprehensive orthodontic care begins on the date of banding and includes the placement of appliances, arch wires, and a minimum of six (6) adjustments. It is expected that orthodontic members be seen every four (4) to eight (8) weeks for the duration of active treatment.

(B) ~~Subsequent adjustments will be authorized in one (1) year intervals and the treating orthodontist must provide a comprehensive progress report at the twenty-four (24) month interval.~~Subsequent treatment will be authorized quarterly for the next three (3) quarters. The treating orthodontist must provide a comprehensive progress report for consideration for the fourth and final quarterly approval.

~~(C) All approved treatment is included on the original prior authorization and will include the total payment for that treatment year.~~

(2) Claim and payment are made as follows:

(A) Payment for comprehensive treatment includes the banding, wires, adjustments as well as all ancillary services, lost or broken bracket replacement, including the removal of appliances, and the construction and placing of retainers.

(B) ~~Payment is not made for comprehensive treatment beyond thirty-six (36) months.~~ Payment for comprehensive treatment is considered paid in full at twenty-four (24) months regardless of treatment length.

(g) If the member moves from the geographic area or shows a need to change their provider, then the provider who received the ~~yearly~~first year payment is financially responsible until completion of that member's orthodontic treatment for the current year.

(h) If the provider who received ~~yearly~~the first year payment does not agree to be financially responsible, then the OHCA may recoup funds paid for the member's orthodontic treatment.

(i) All orthodontic services are subject to post-utilization review. This review may include a request by the OHCA to submit medical documentation necessary to complete the review. After

review is completed, these materials are returned to the orthodontist.
(j) Electronic images of casts and/or oral/facial images may be requested by OHCA or representatives of OHCA. Providers will be reimbursed for either the study model or images when obtained for orthodontic evaluation and/or therapy.

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

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

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

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

(3) 3-D model images or photographic images not in compliance with the diagnostic guidelines will not be compensable. The provider may be allowed to resubmit new images that adhere to the diagnostic guidelines. If the provider does not provide appropriate documentation, the request for treatment will be denied.

317:30-5-704. Billing instructions

(a) **HCPCS Codes.** The Oklahoma Health Care Authority (OHCA) utilizes the Medicare Level II Healthcare Common Procedure Coding System (HCPCS) codes. All claim submissions must be in compliance with this coding system.

(b) **Prior authorization.** Where applicable, the appropriate arch, quadrant, or tooth surface and tooth number must be included on the claim. Diagnosis codes are requested to be listed in ~~box 34 of the current American Dental Association (ADA) dental claim form. For mailed prior authorizations, a completed HCA-13D form is required.~~the appropriate field when submitting prior authorizations on the provider portal.

(c) **Images.** Any type of film or prints submitted will not be returned. All images must be dated, mounted and have patient's name, recipient identification number (RID), provider name and provider number.

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Attachment F

2024

JANUARY

Su	Mo	Tu	We	Th	Fr	Sa
31	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	1	2	3
4	5	6	7	8	9	10

Wednesday, Jan. 17th, 2024 · 2:00pm
OHCA Boardroom
4345 N. Lincoln Blvd, OKC

MARCH

Su	Mo	Tu	We	Th	Fr	Sa
25	26	27	28	29	1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1	2	3	4	5	6

Wednesday, Mar. 20th, 2024 · 2:00pm
OHCA Boardroom
4345 N. Lincoln Blvd, OKC

MAY

Su	Mo	Tu	We	Th	Fr	Sa
28	29	30	1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30	31	1
2	3	4	5	6	7	8

Wednesday, May 15th, 2024 · 2:00pm
OHCA Boardroom
4345 N. Lincoln Blvd, OKC

JUNE

Su	Mo	Tu	We	Th	Fr	Sa
26	27	28	29	30	31	1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	1	2	3	4	5	6

Wednesday, Jun. 26th, 2024 · 2:00pm
OHCA Boardroom
4345 N. Lincoln Blvd, OKC

SEPTEMBER

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	1	2	3	4	5
6	7	8	9	10	11	12

Wednesday, Sep. 18th, 2024 · 2:00pm
OHCA Boardroom
4345 N. Lincoln Blvd, OKC

DECEMBER

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31	1	2	3	4
5	6	7	8	9	10	11

Wednesday, Dec. 11, 2024 · 2:00pm
OHCA Boardroom
4345 N. Lincoln Blvd, OKC

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OPERATIONAL METRICS

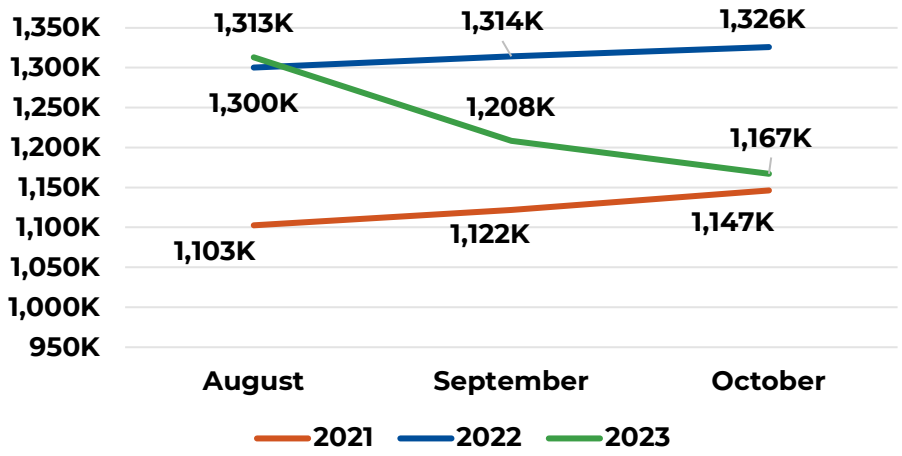
December 2023 Board Meeting

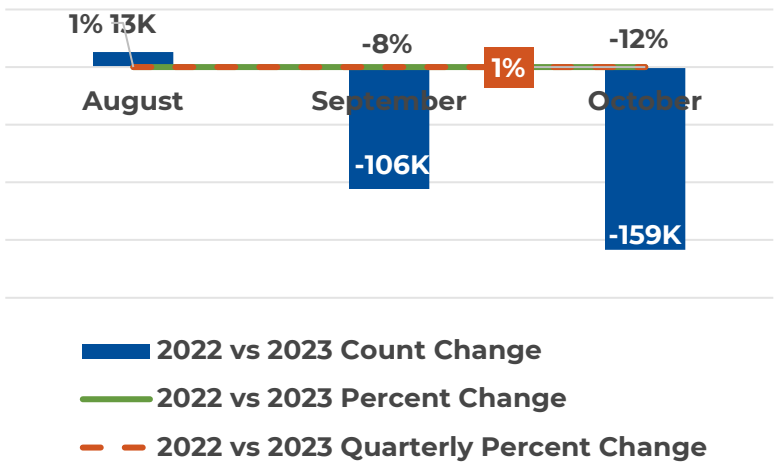
OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

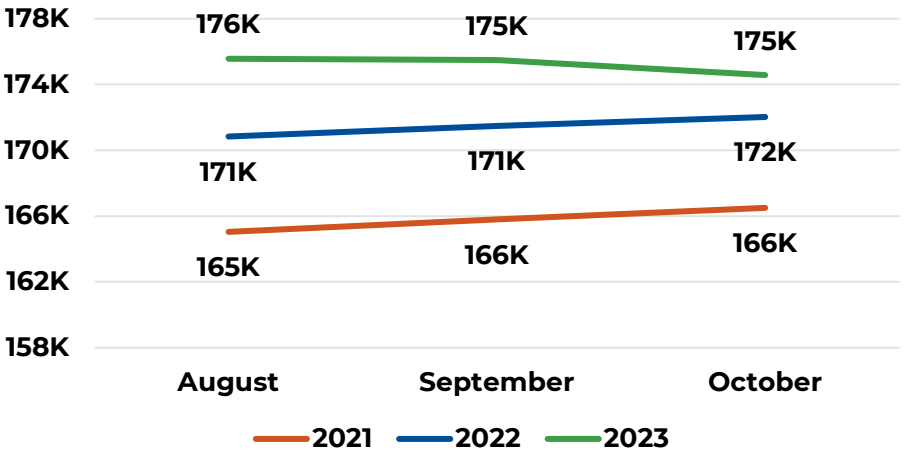
Enrollment & Utilization

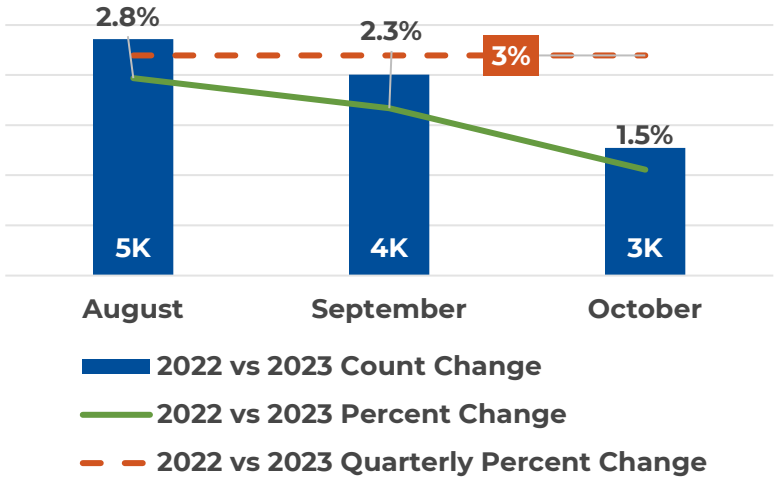
Total Enrolled Members





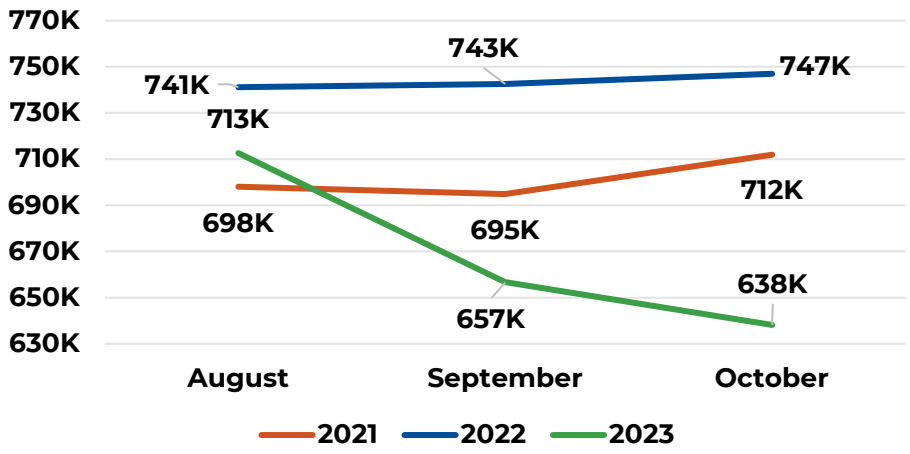
Aged/Blind/Disabled Enrolled

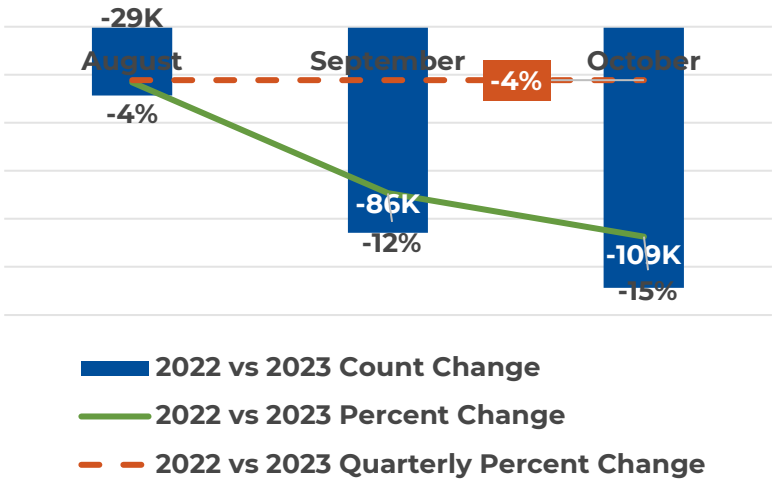




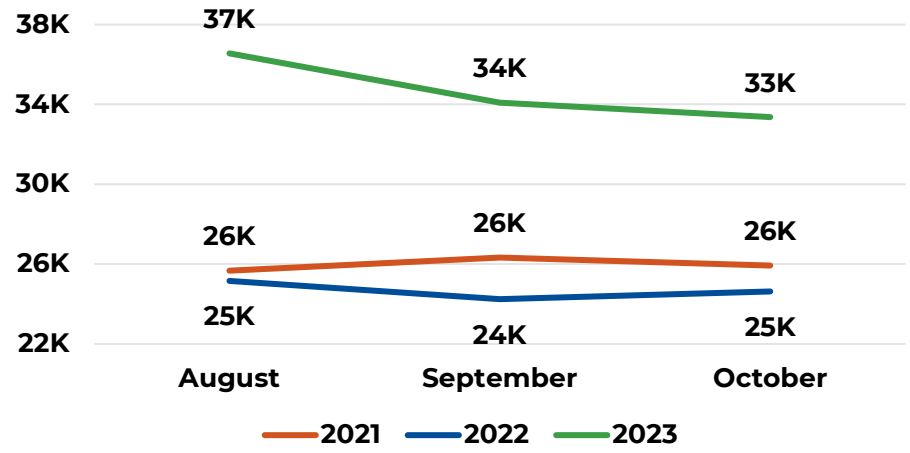
Enrollment & Utilization (Cont.)

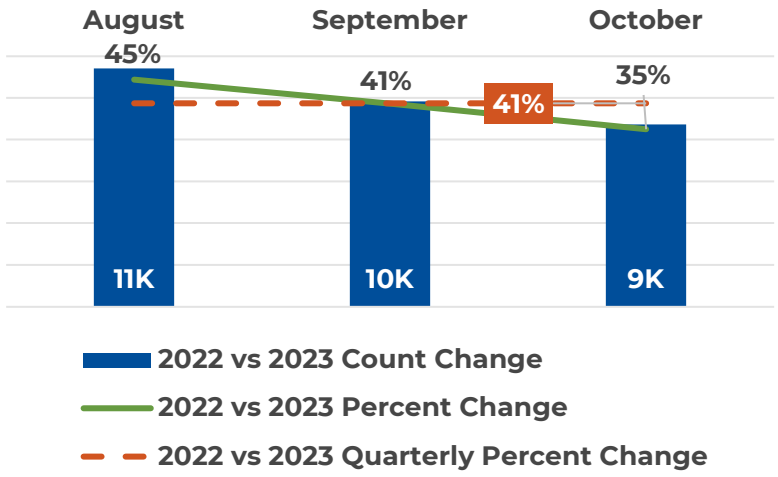
Children & Parent/Caretaker Enrolled





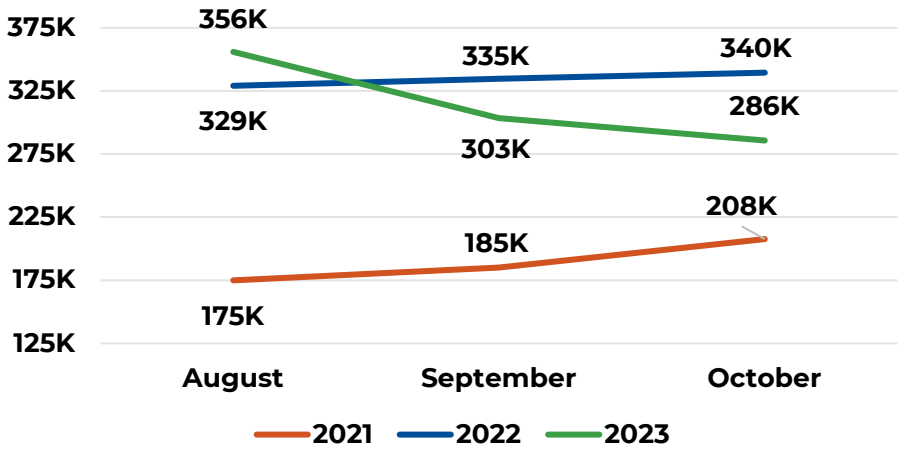
Pregnant (Full Scope) Enrolled

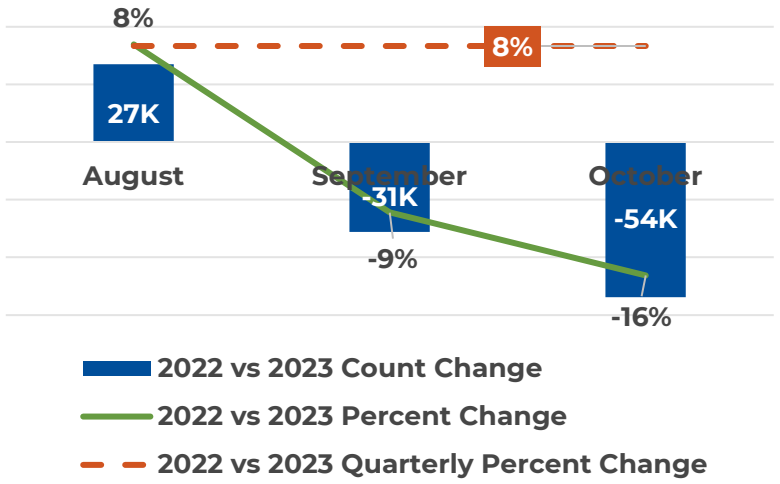




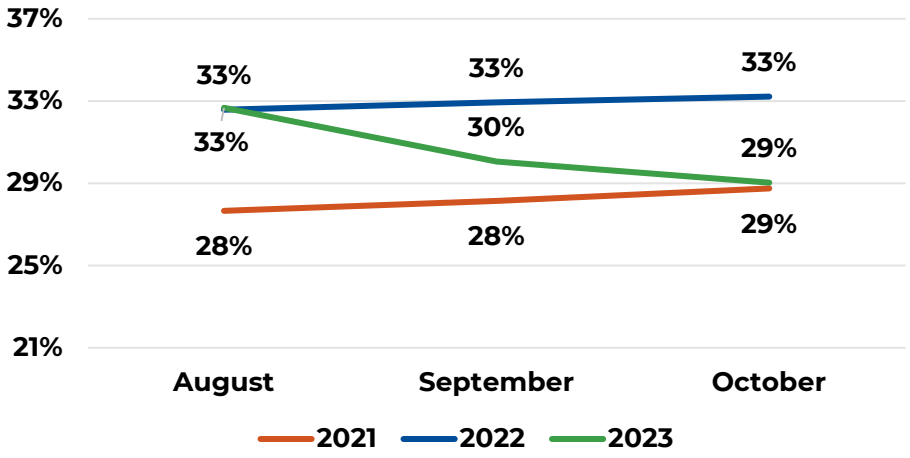
Enrollment & Utilization (Cont.)

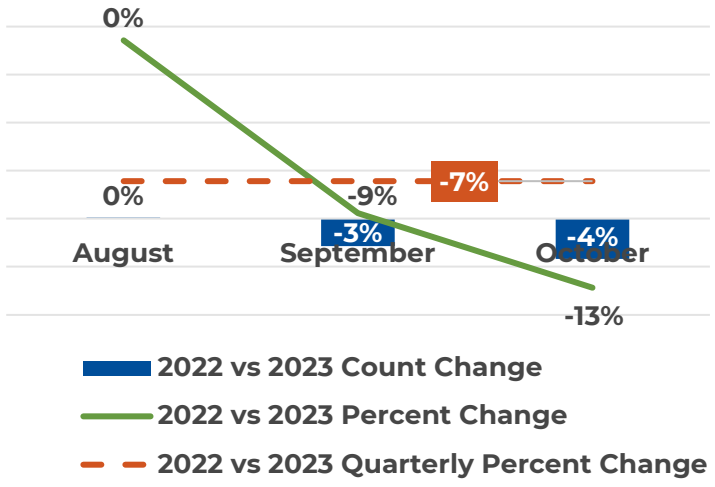
Expansion Enrolled (Effective July 2021)





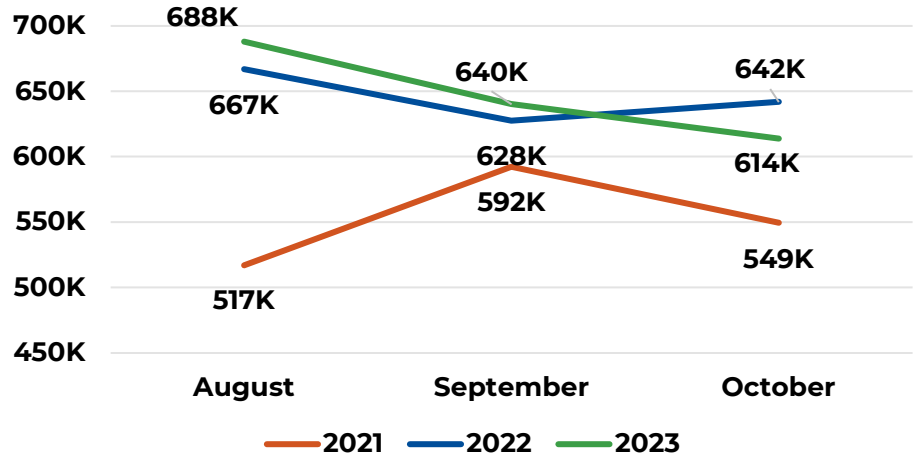
Percent of OK Population Enrolled

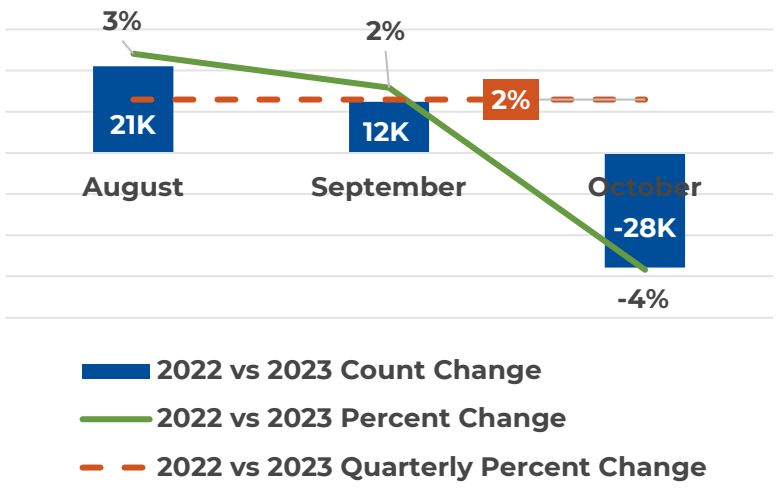




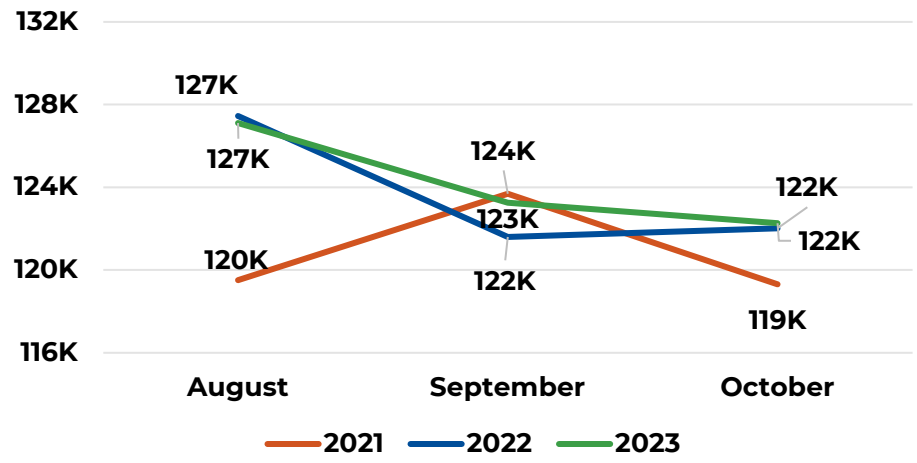
Enrollment & Utilization (Cont.)

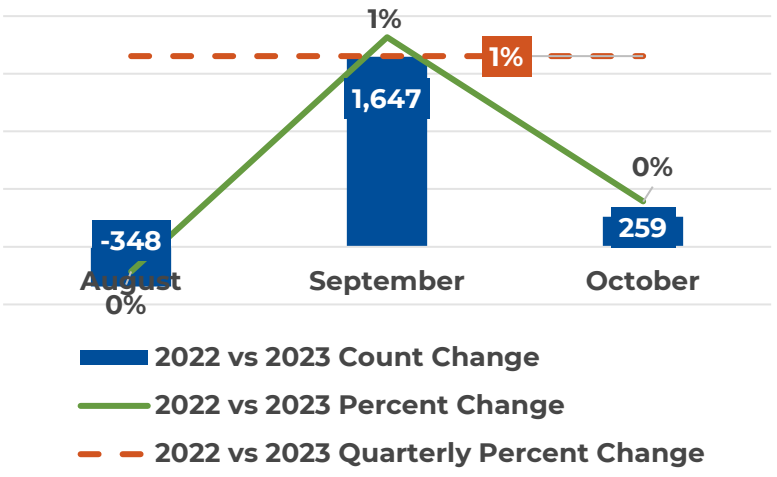
Total Members Utilization





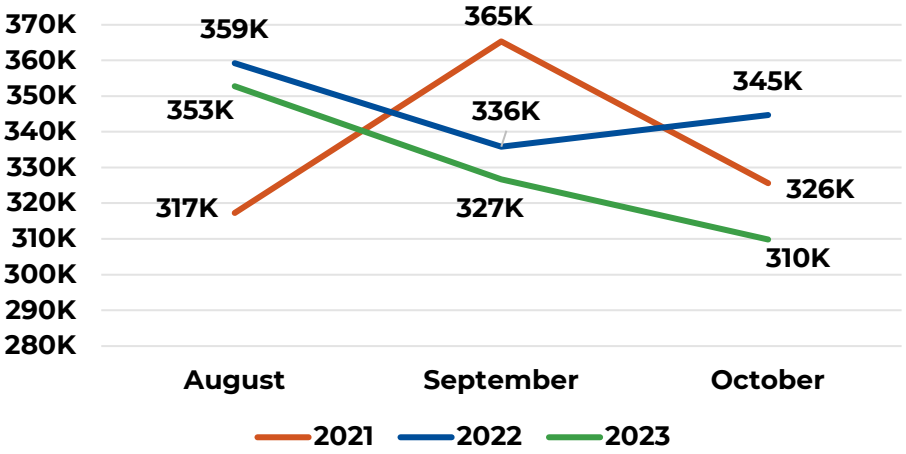
Aged/Blind/Disabled Utilization

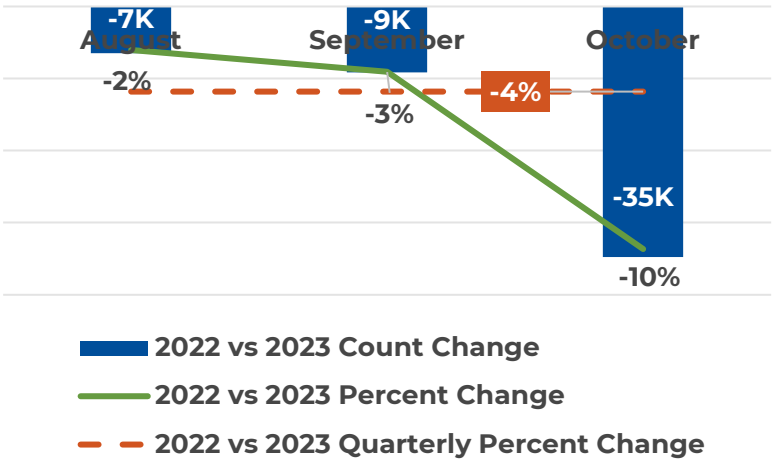




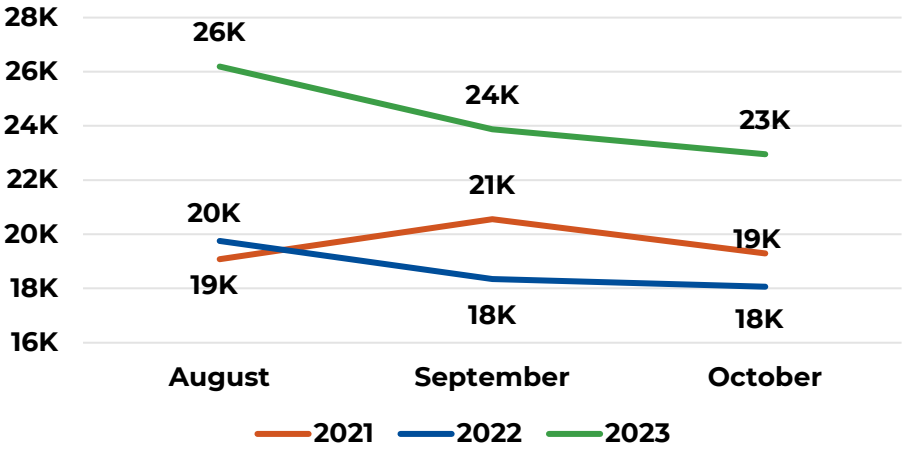
Enrollment & Utilization (Cont.)

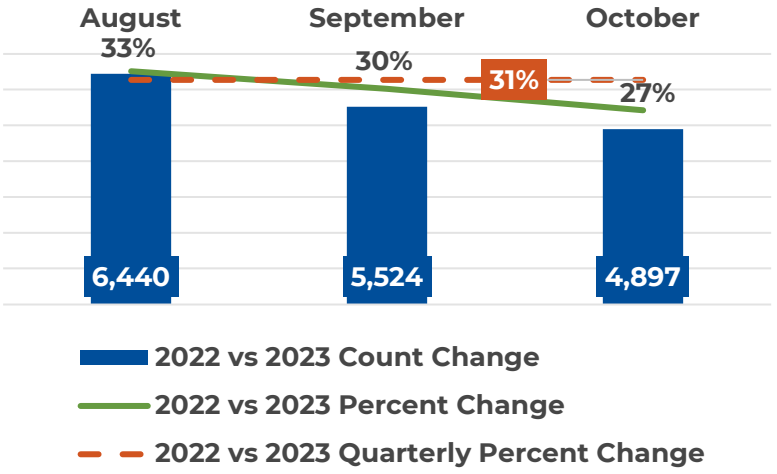
Children & Parent/Caretaker Utilization





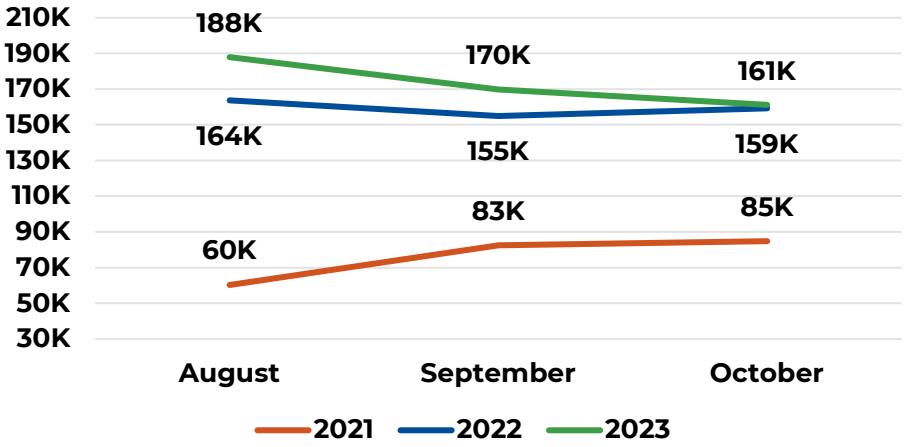
Pregnant (Full Scope) Utilization

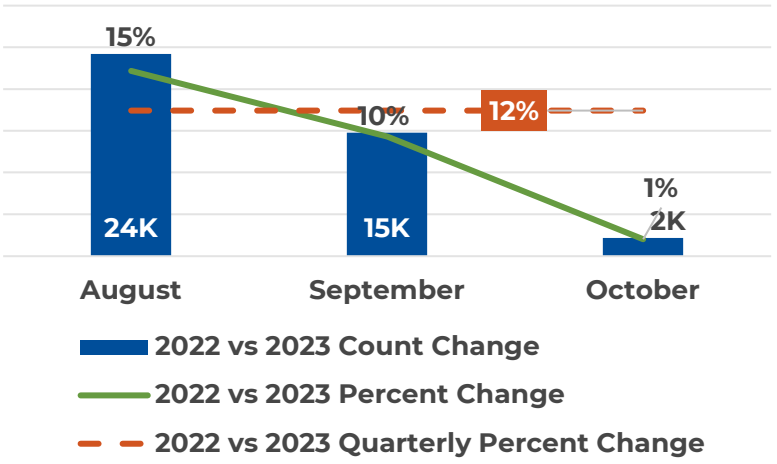




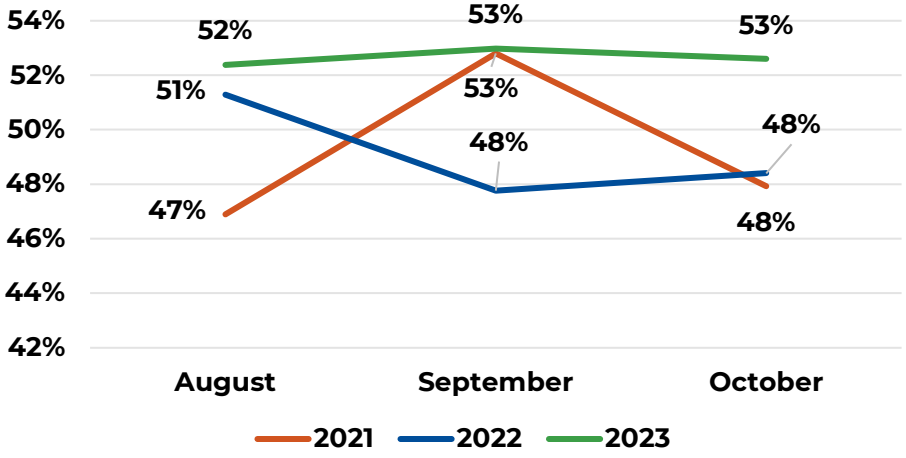
Enrollment & Utilization (Cont.)

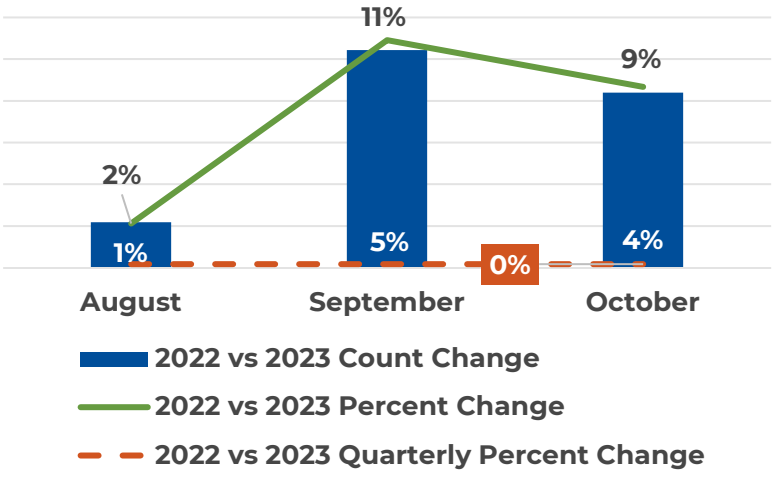
Expansion Utilization (Effective July 2021)





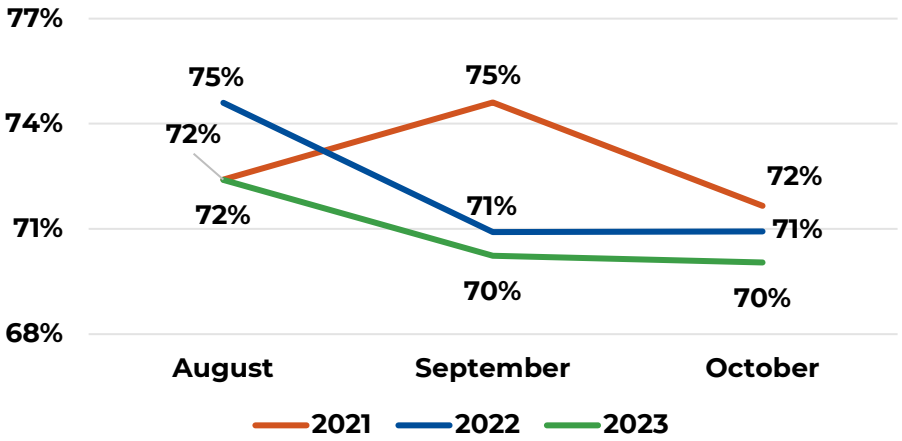
Percent of Total Enrolled Members Utilization

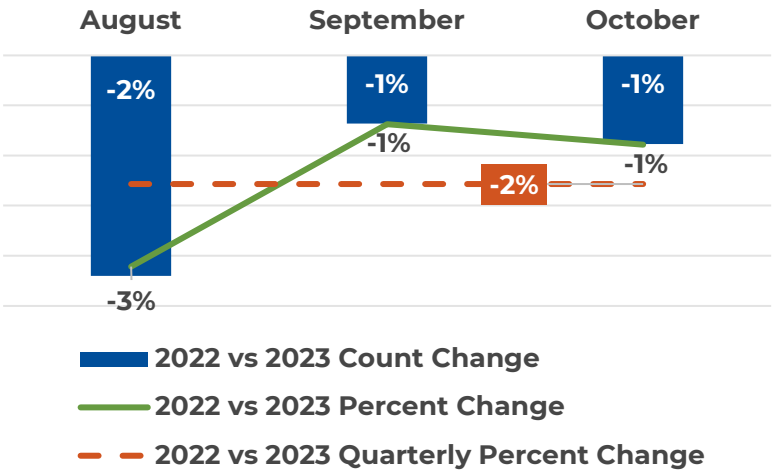




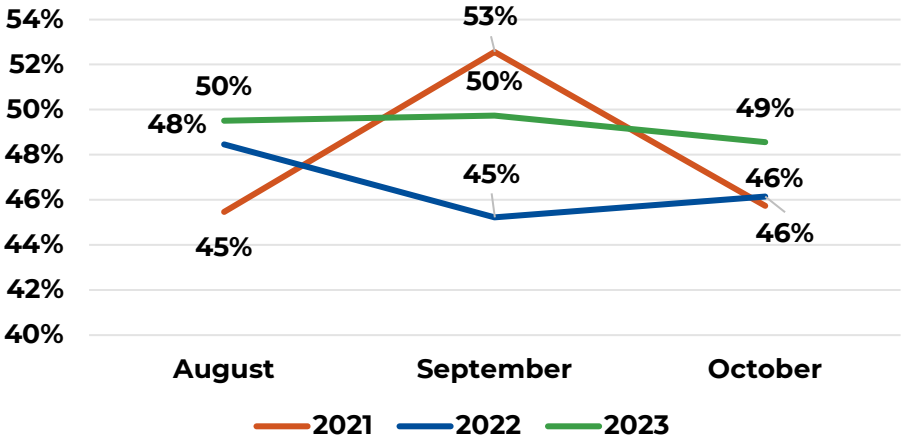
Enrollment & Utilization (Cont.)

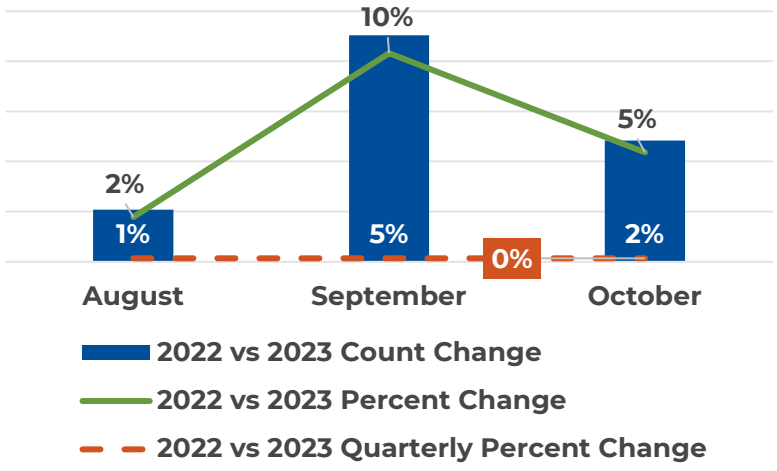
Percent of Aged/Blind/Disabled Enrolled Members Utilization





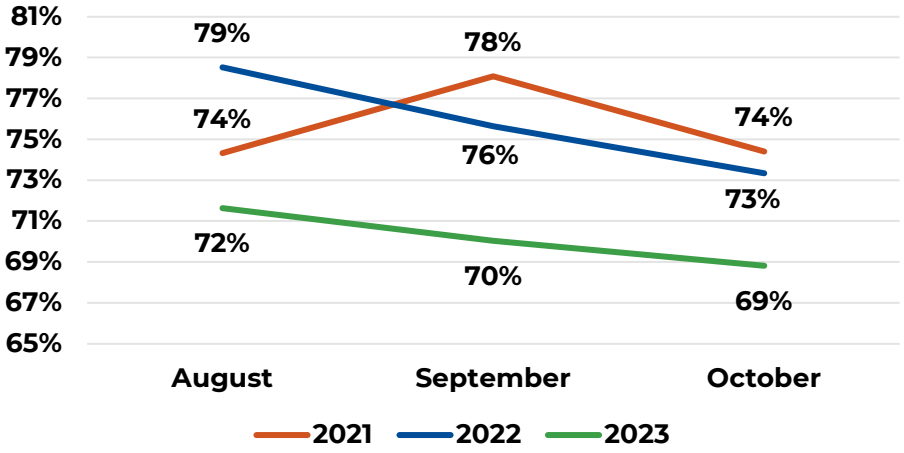
Percent of Children & Parent/Caretaker Enrolled Members Utilization

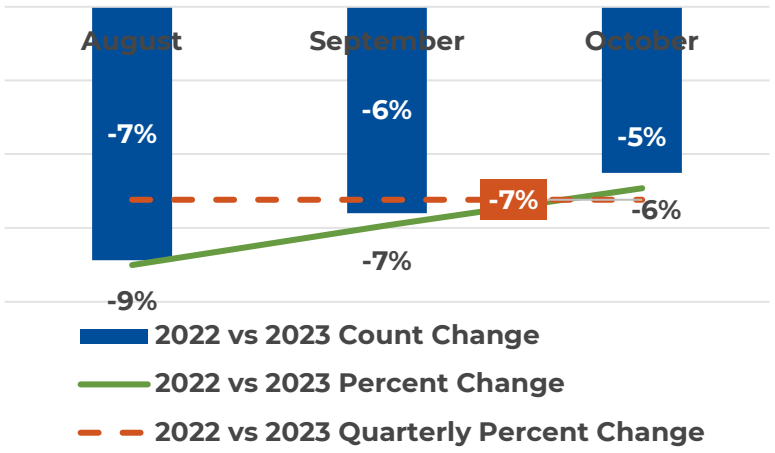




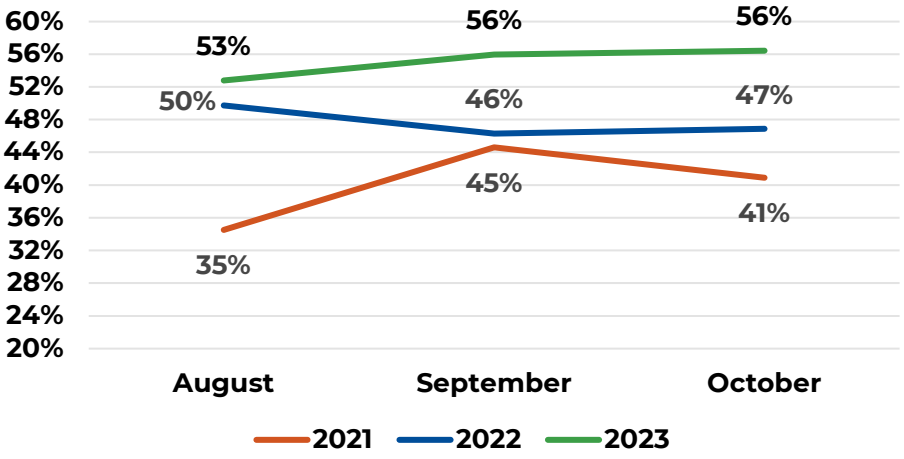
Enrollment & Utilization (Cont.)

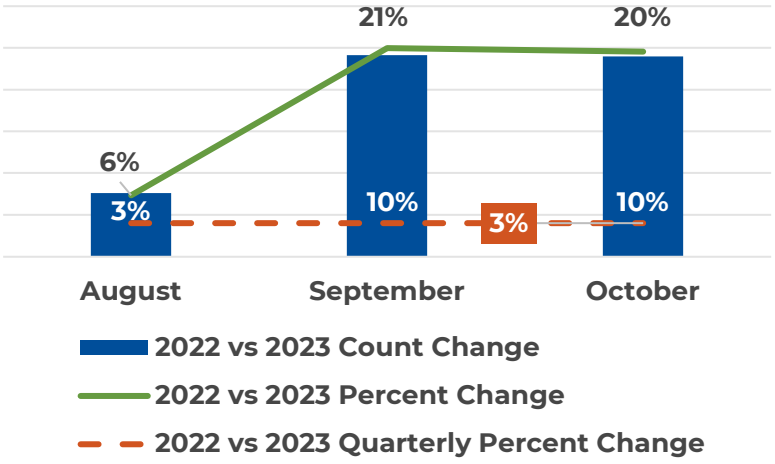
Percent of Pregnant (Full Scope) Enrolled Members Utilization





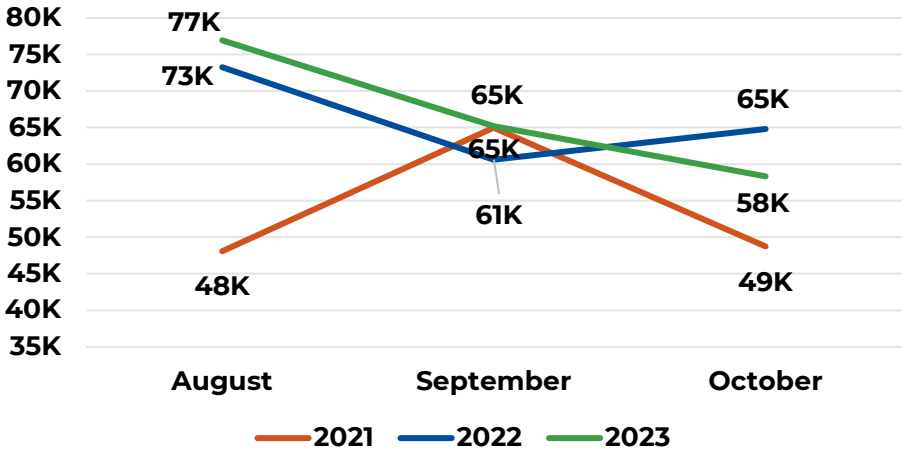
Percent of Expansion Enrolled Members Utilization (Effective July 2021)

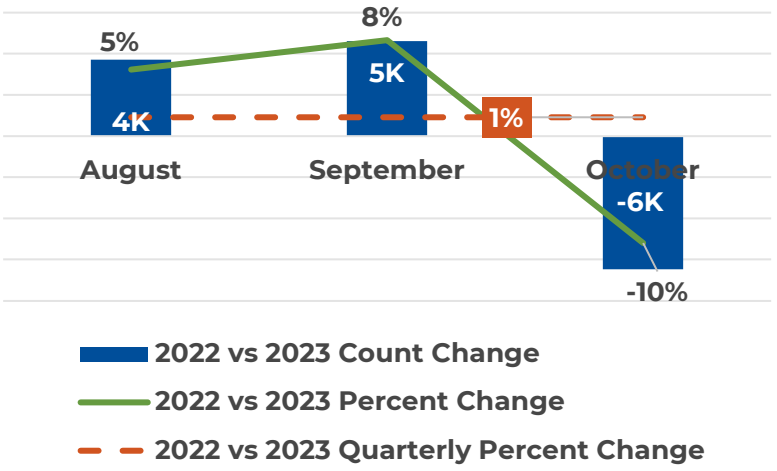




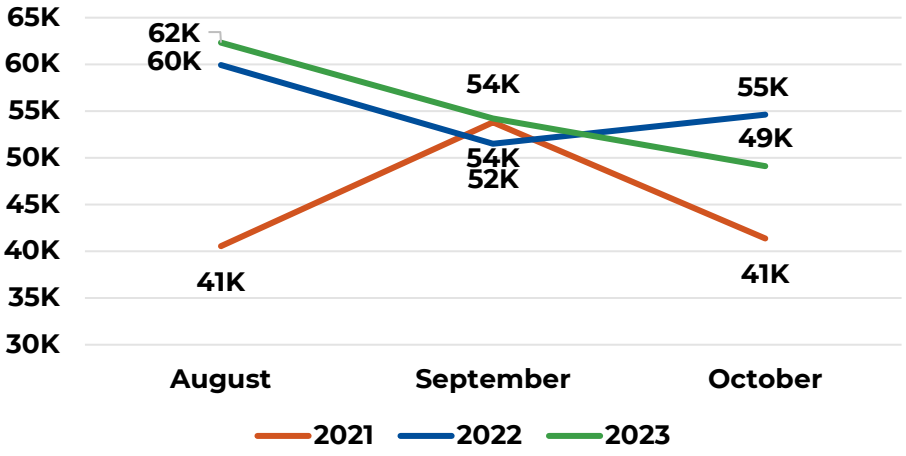
Utilization

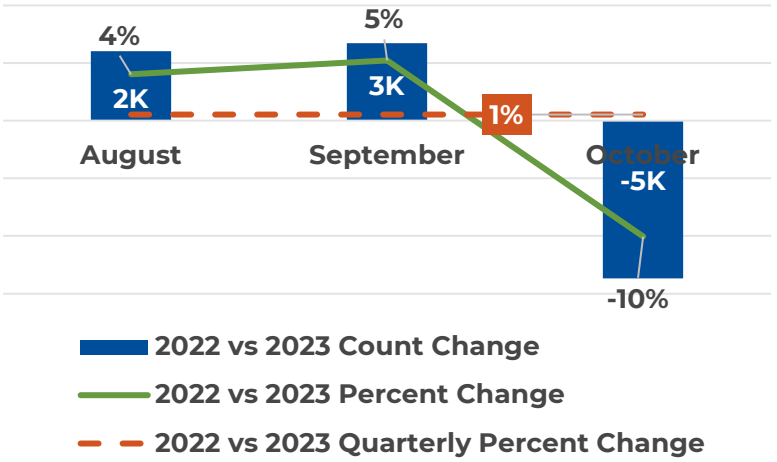
Emergency Department Visits (Claims)





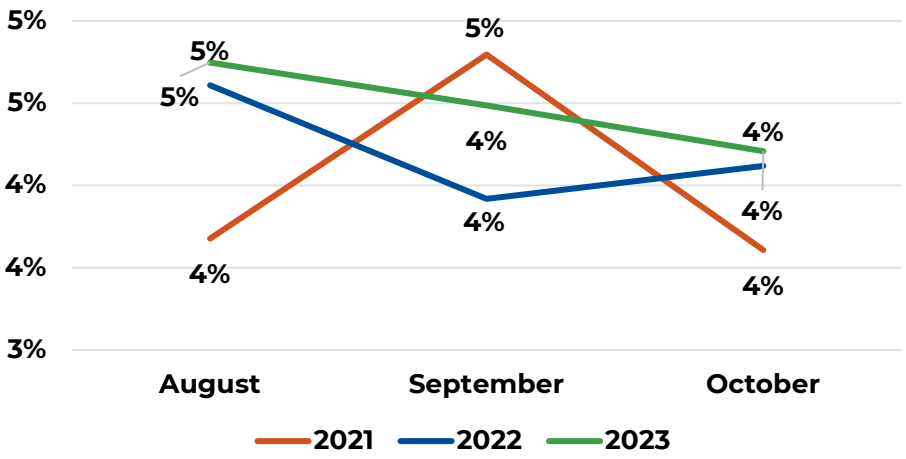
Members Utilizing Emergency Department

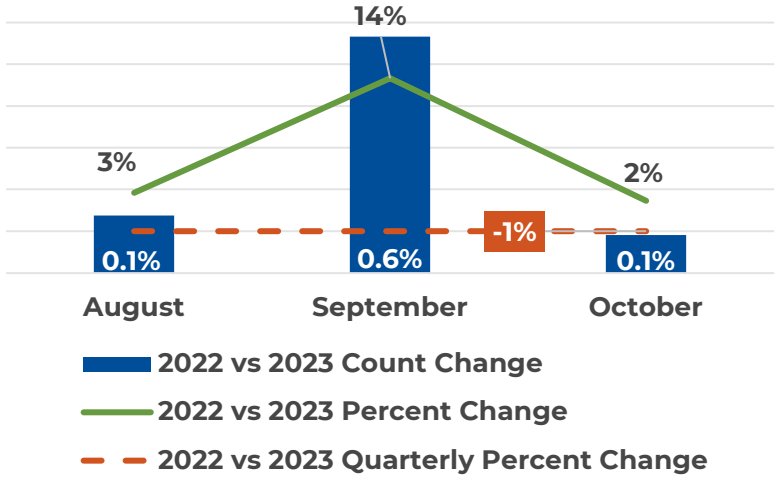




Utilization (Cont.)

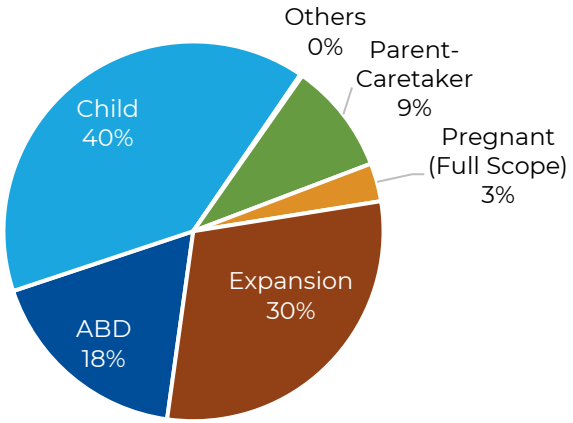
Percent Total Enrolled Using ED



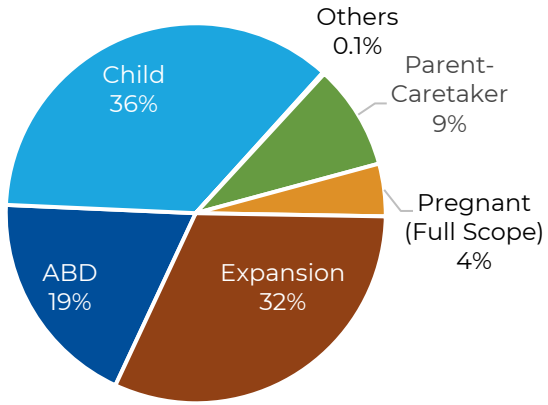


Members Utilizing Emergency Department By Qualifying Group

Q1 2023

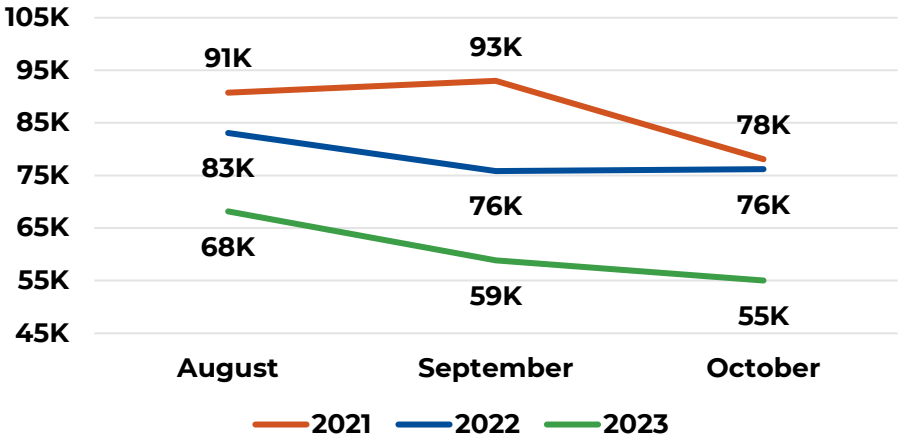


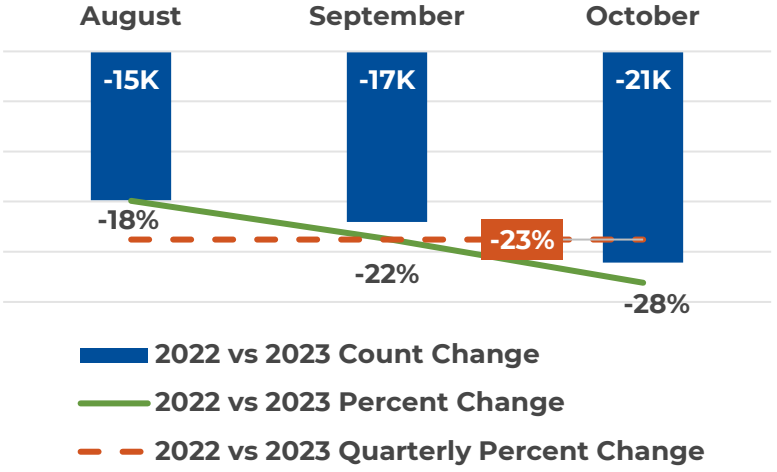
Q1 2024



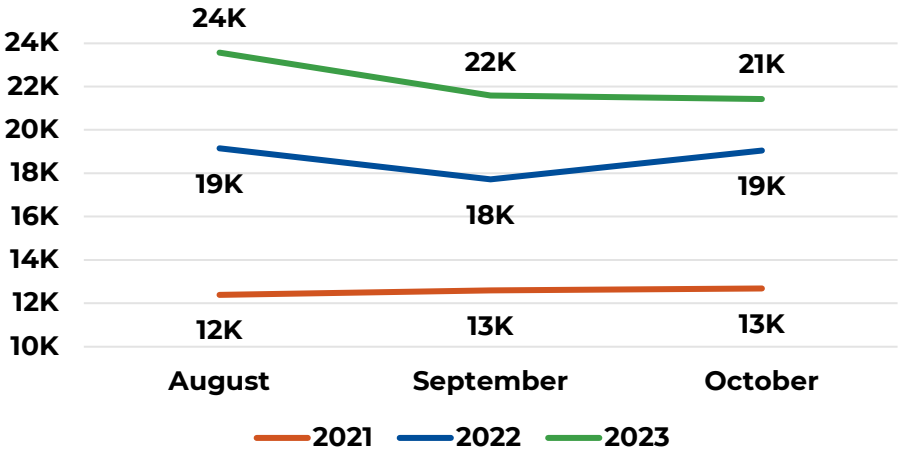
Utilization (Cont.)

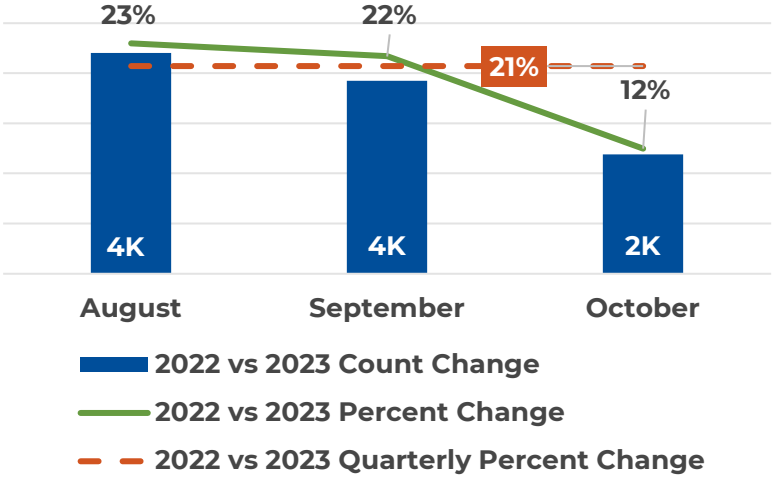
Telemedicine - Total Visits





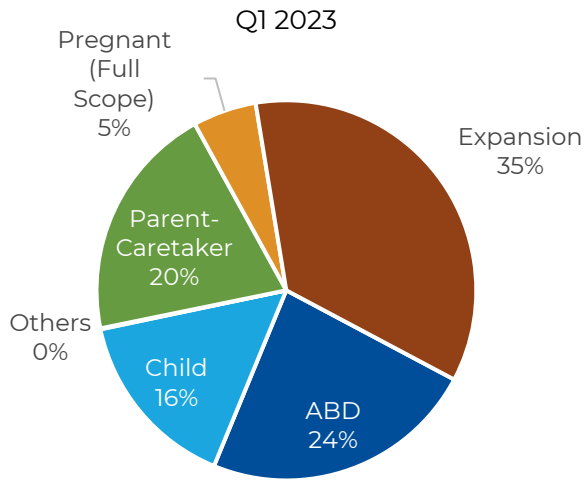
Members With Opioid Claims

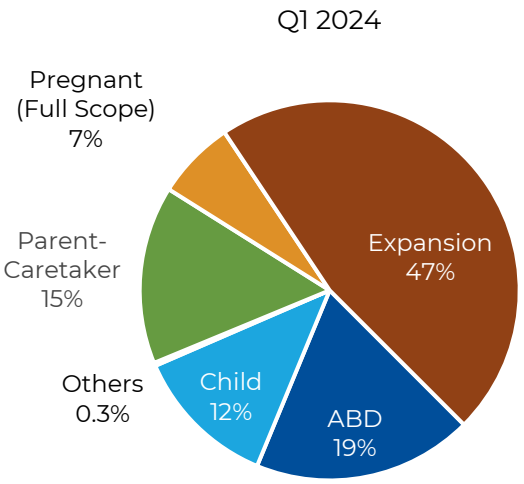




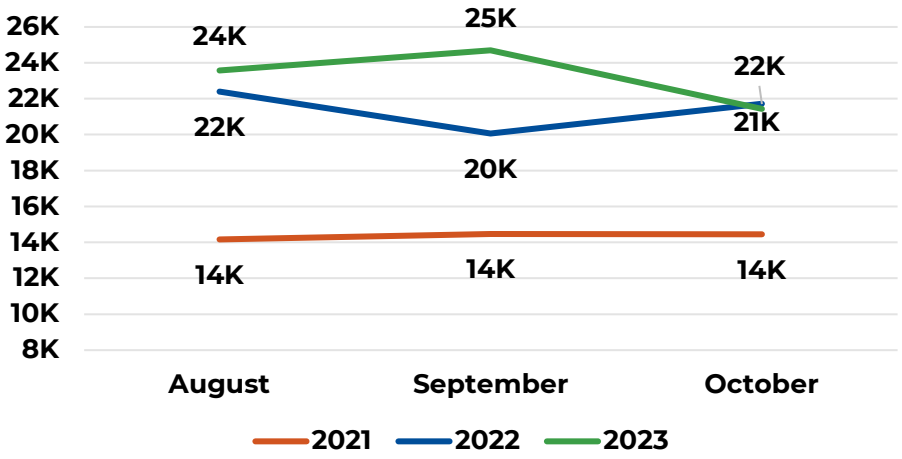
Utilization (Cont.)

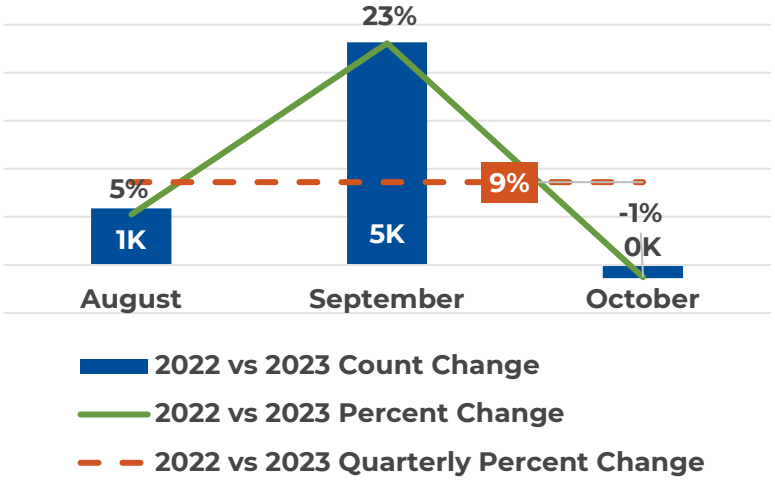
Members With Opioid Claims By Qualifying Group





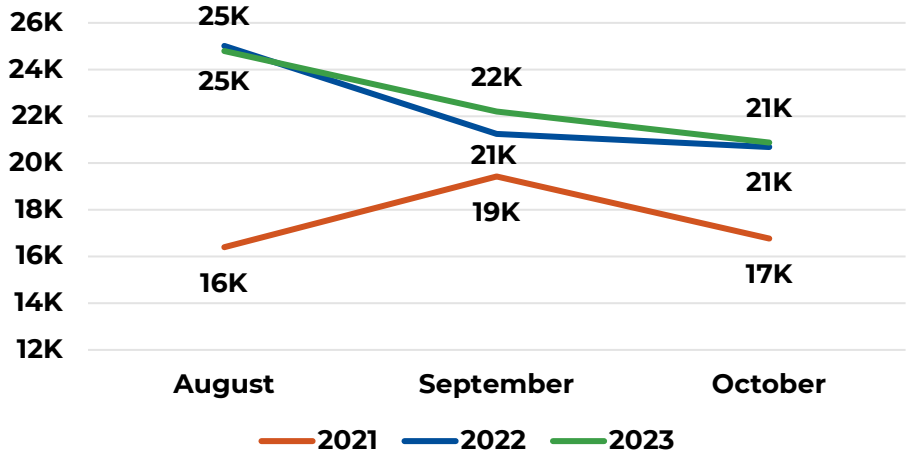
Total Opioid Claims

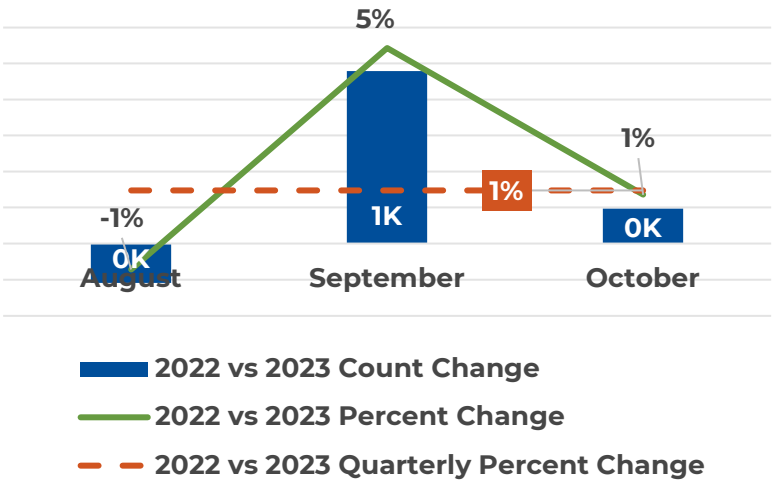




Utilization (Cont.)

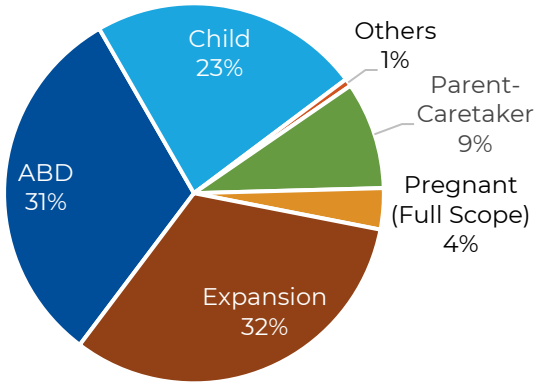
Out of State Services (Non Border County) - Total Members Utilization



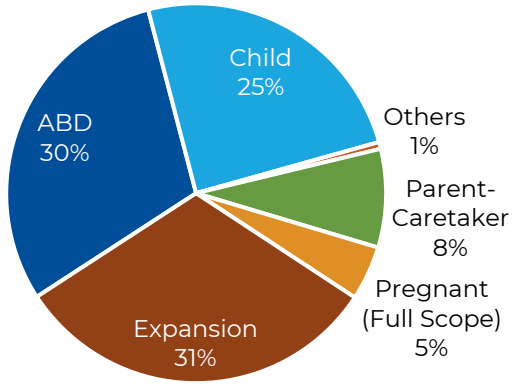


Out of State Services (Non Border County) - Total Members Utilization By Qualifying Group

Q1 2023

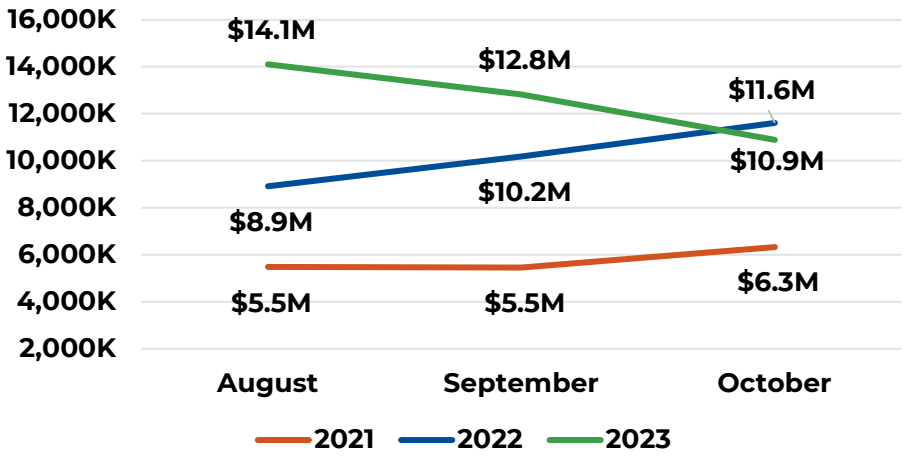


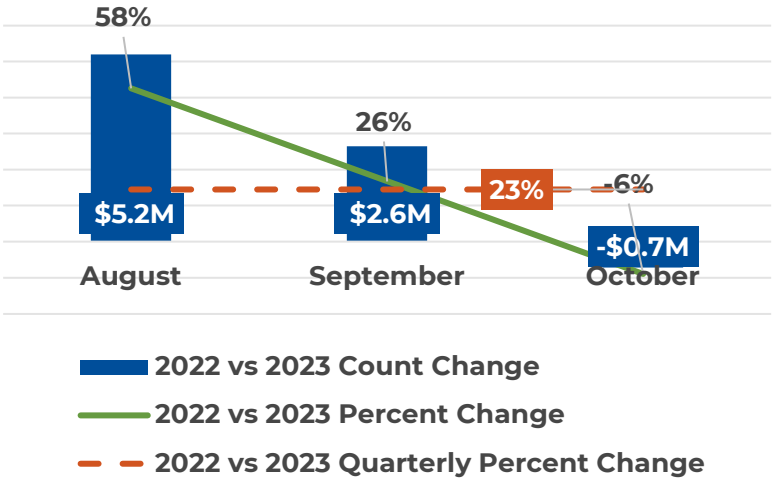
Q1 2024



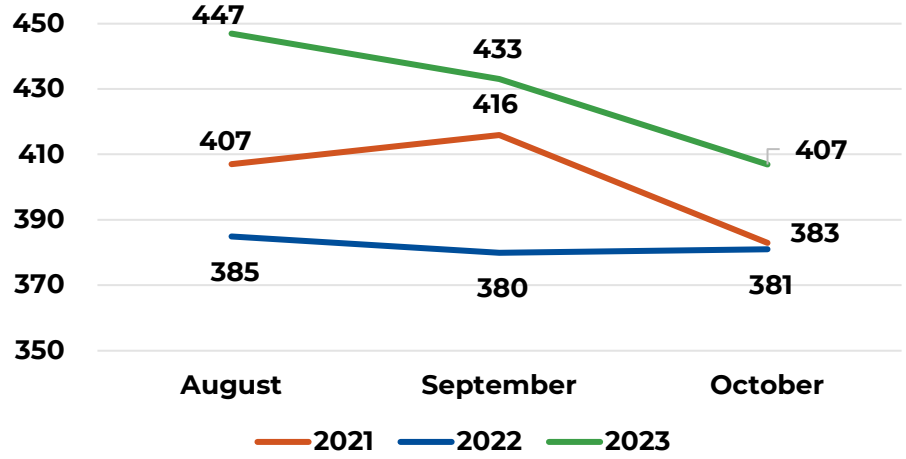
Utilization (Cont.)

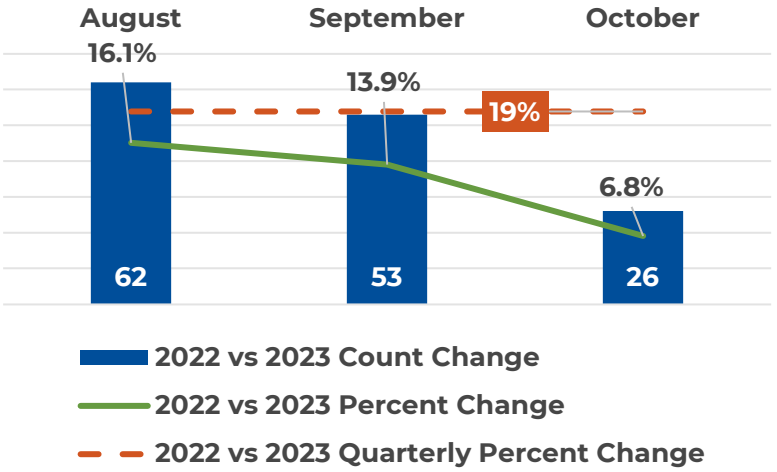
Out of State Services (Non Border County) - Total Reimbursements





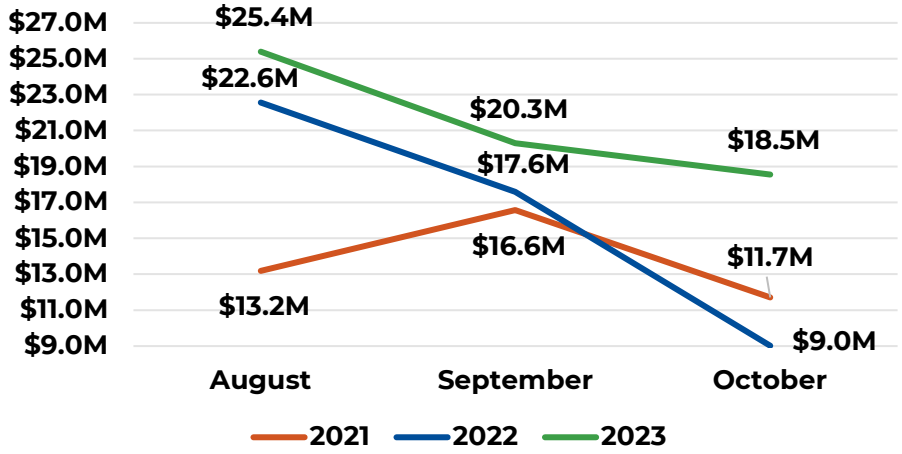
Out of State Services (Non Border County) - Total Active Billing Providers

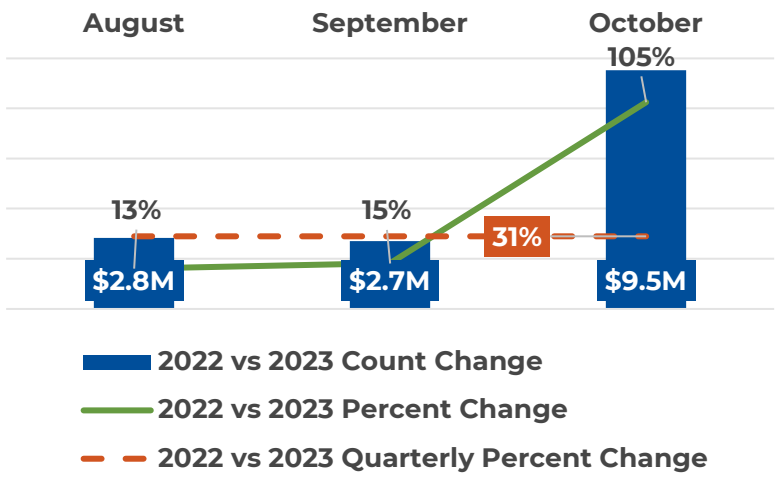




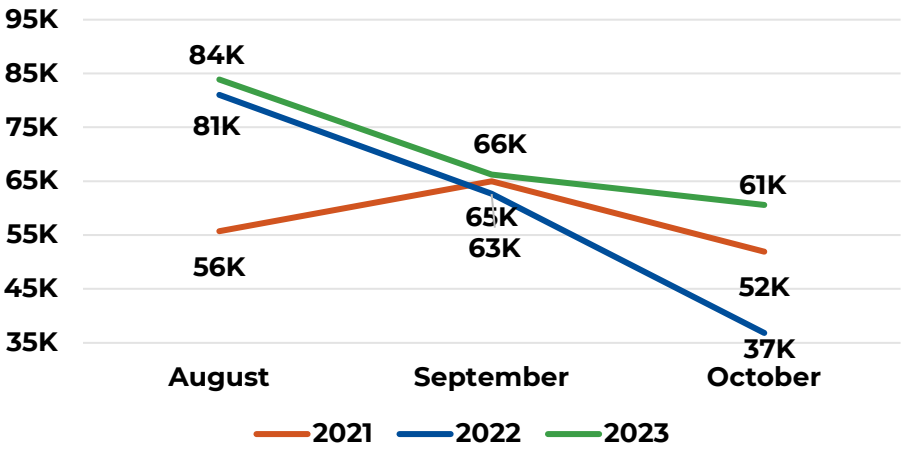
Utilization (Cont.)

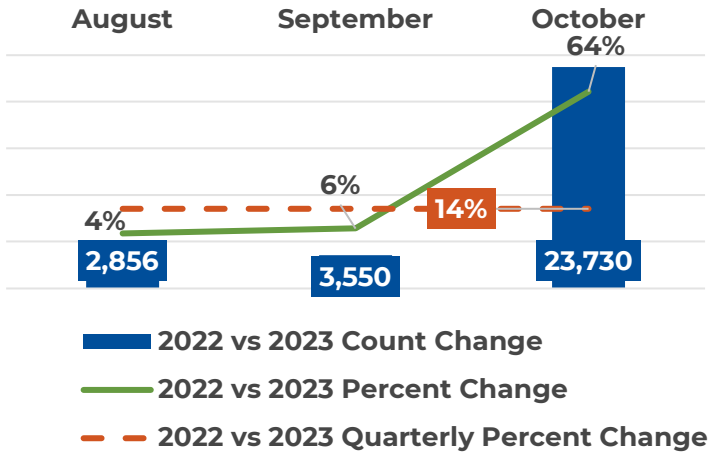
Dental Claims





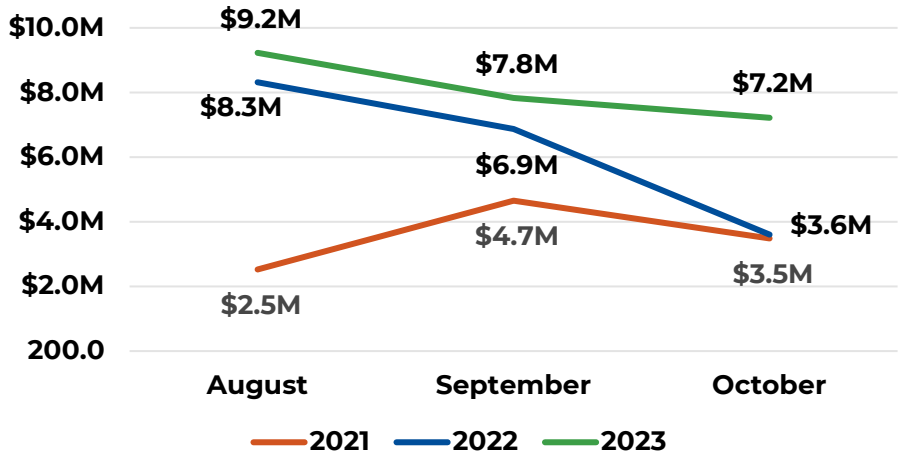
Total Members with Dental Claims

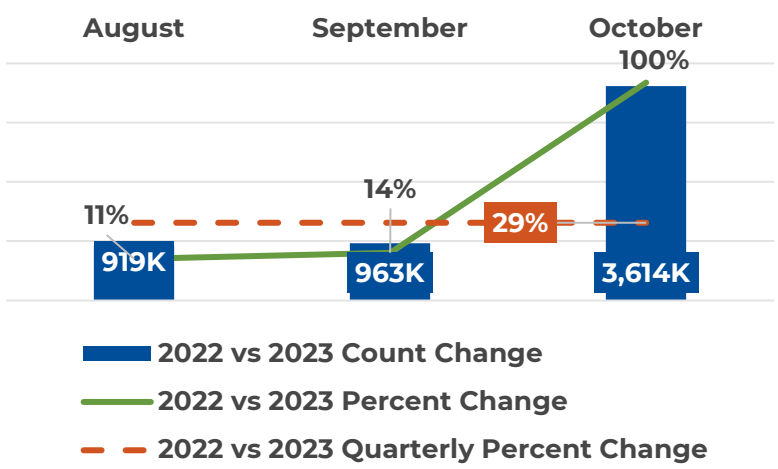




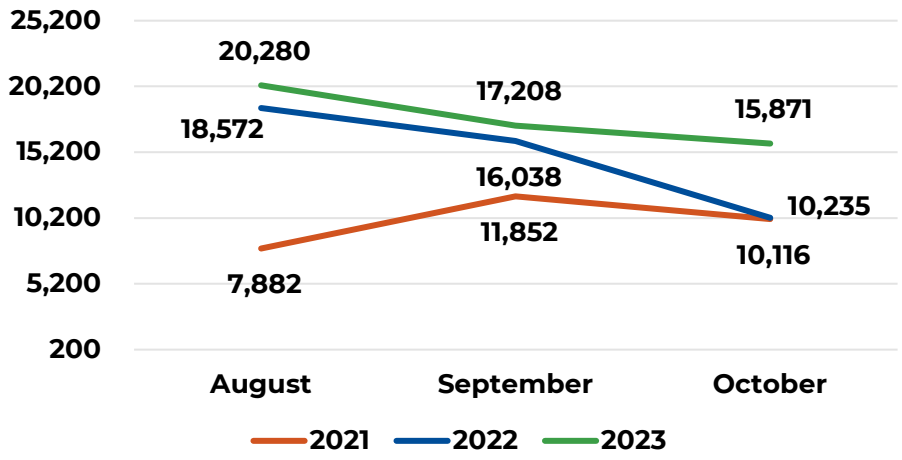
Utilization (Cont.)

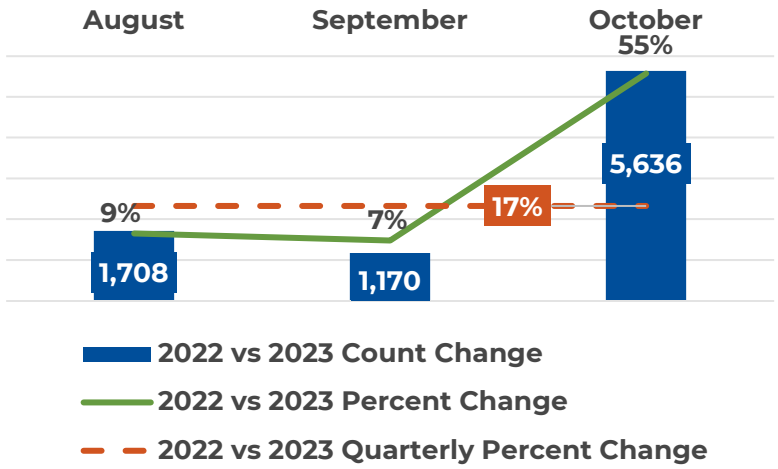
Adult (21 & Over) Dental Claims





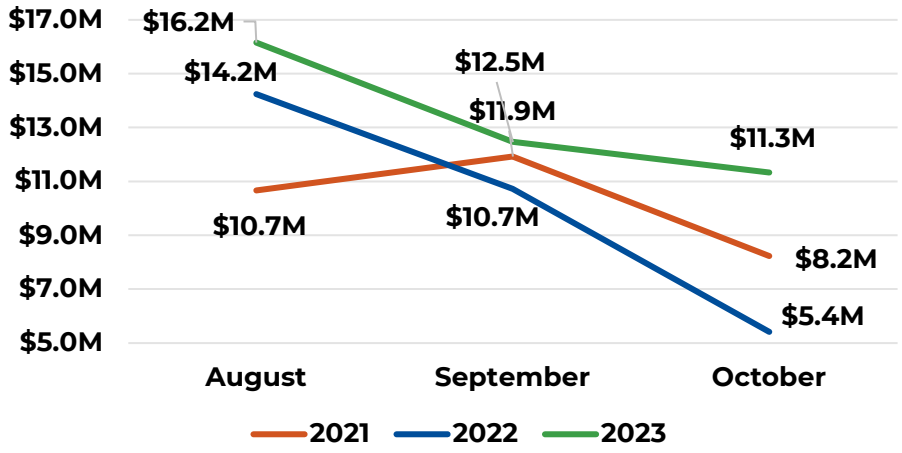
Adults (21 & Over) with Dental Claims

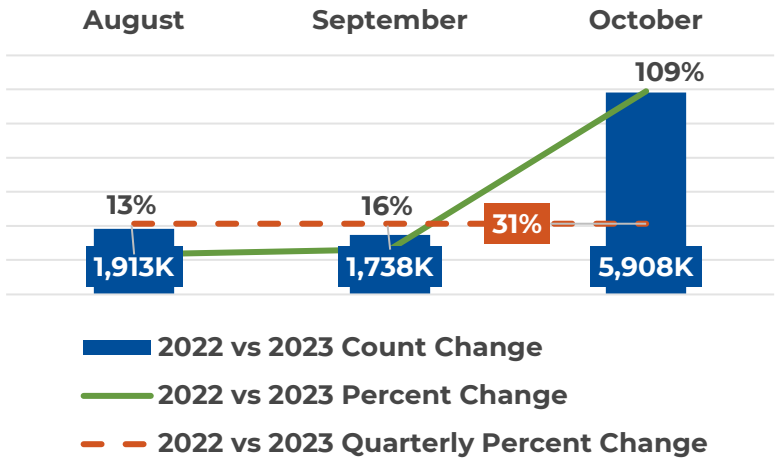




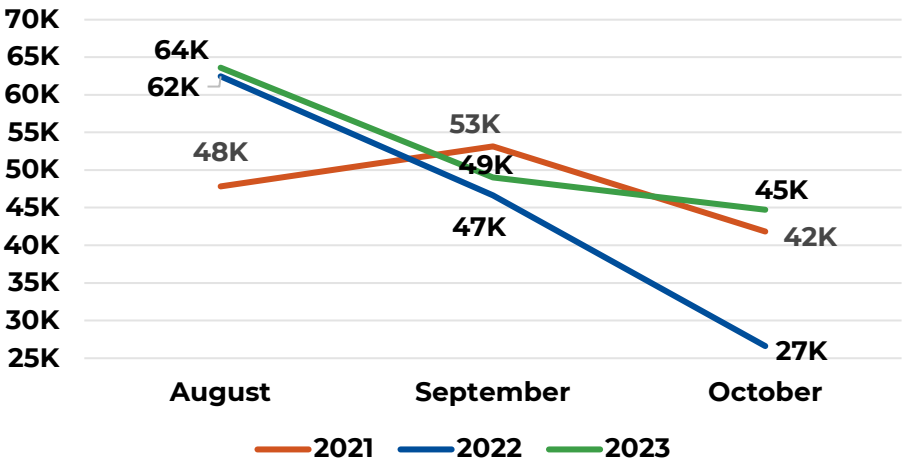
Utilization (Cont.)

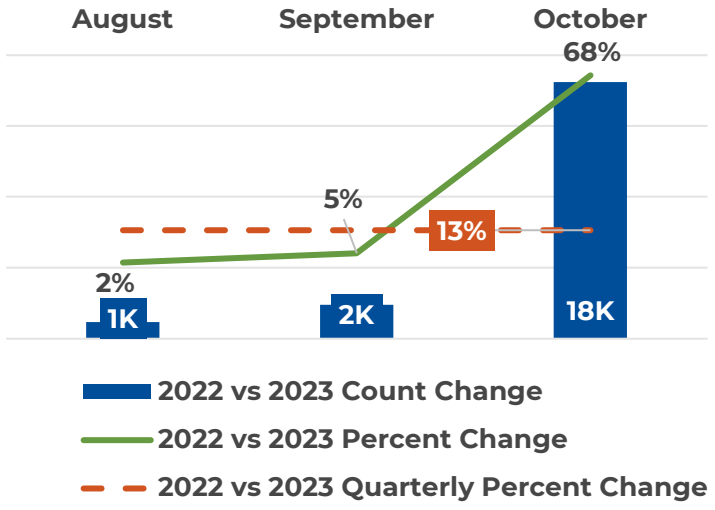
Children (Under 21) Dental Claims





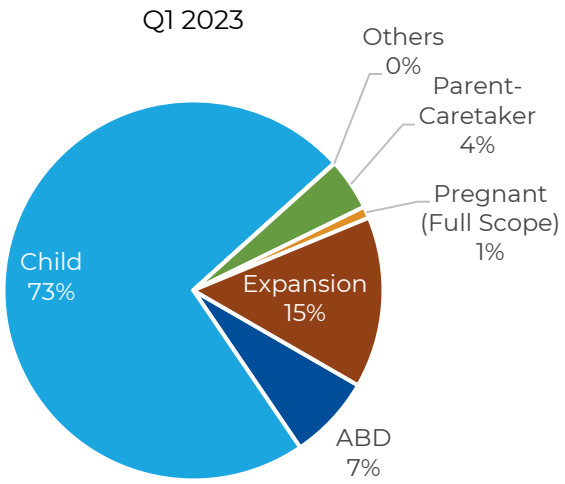
Children (Under 21) with Dental Claims

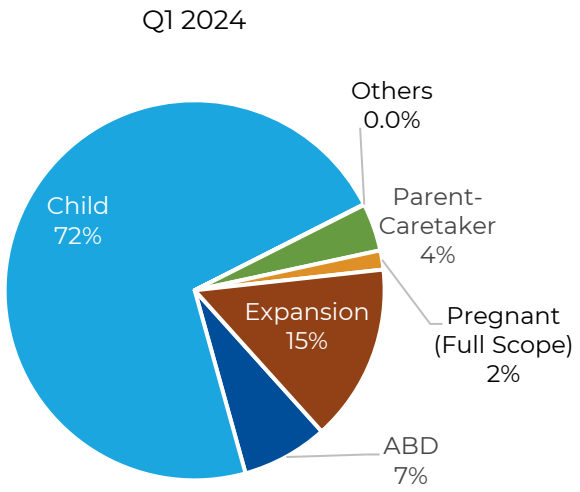




Utilization (Cont.)

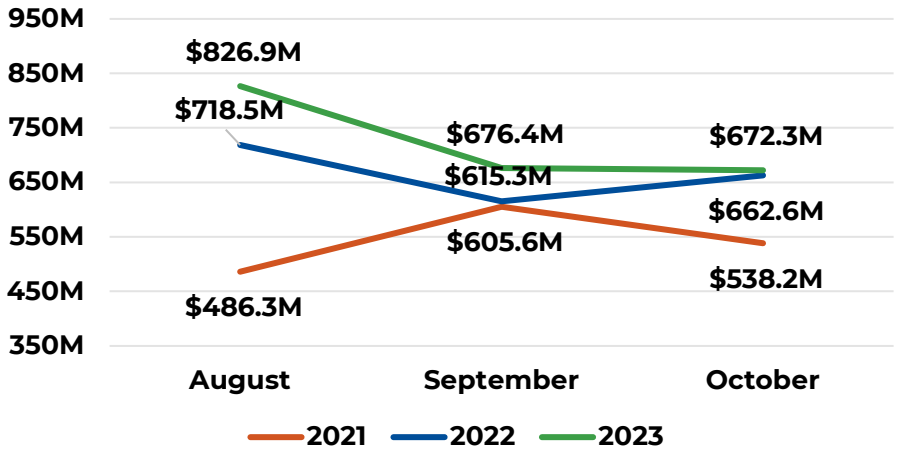
Members With Dental Claims By Qualifying Group

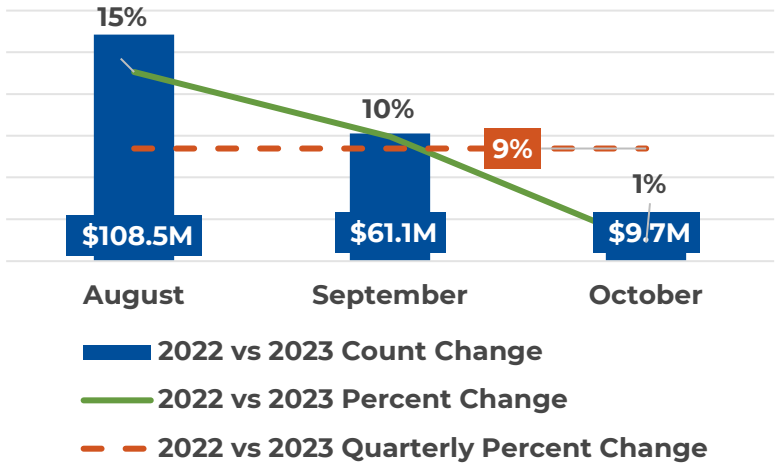




Financials

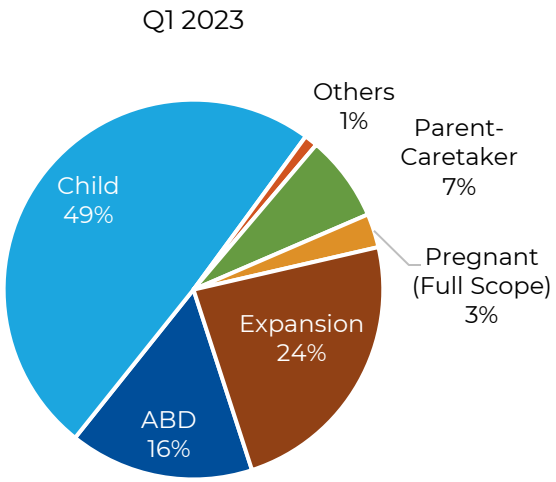
Total Agency Expenditures

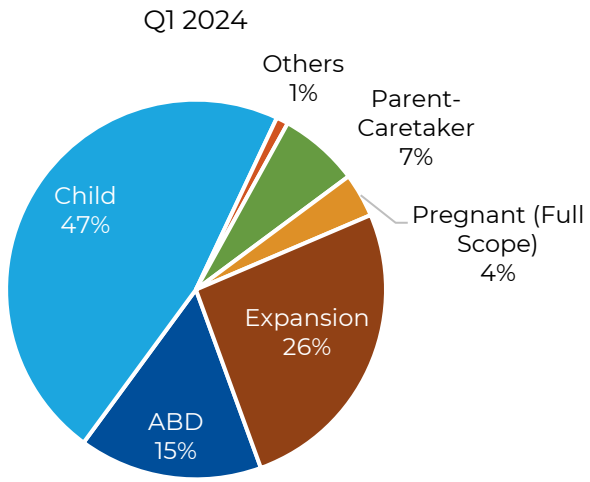




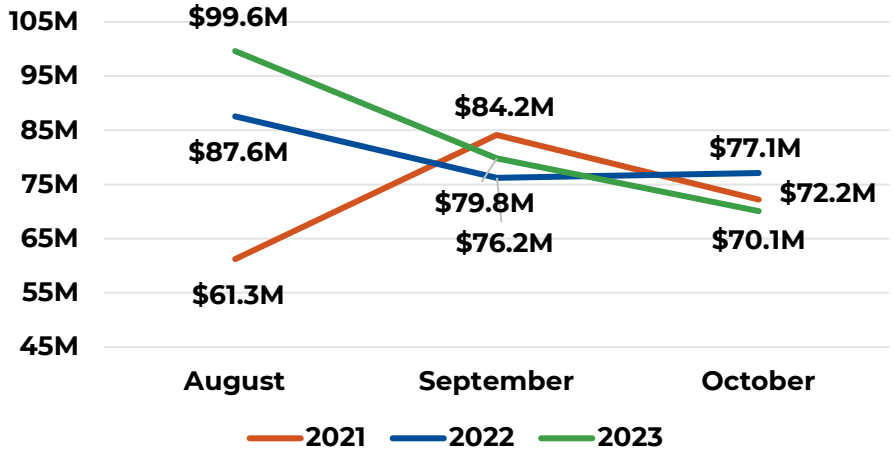
Financials (Cont.)

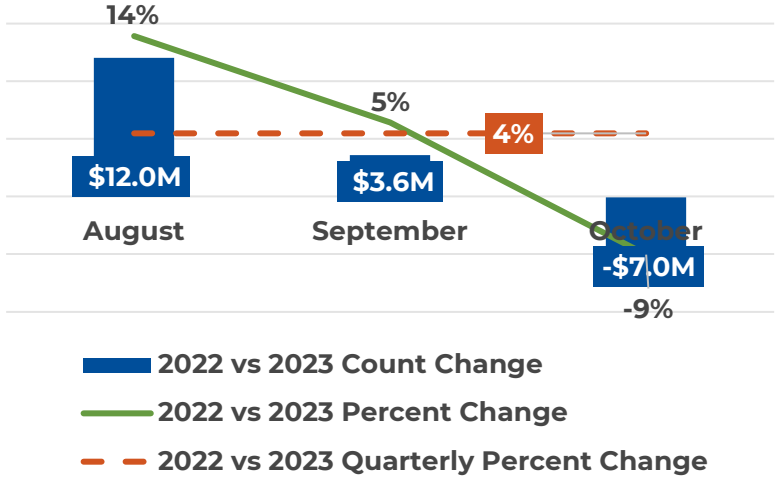
Total Agency Members Utilization by Qualifying Group





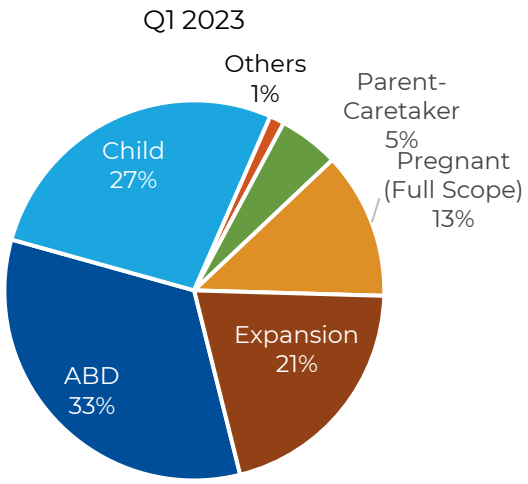
Inpatient Services Expenditures

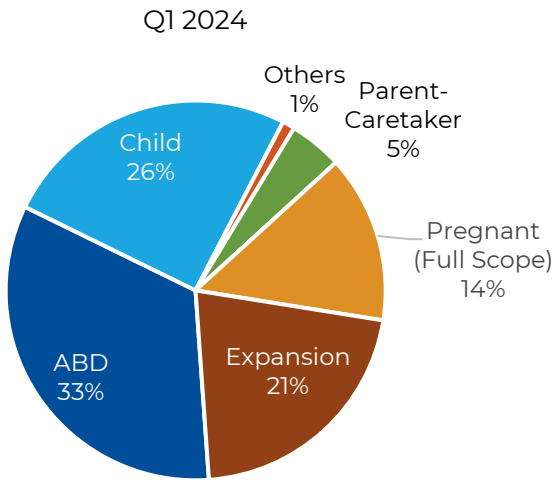




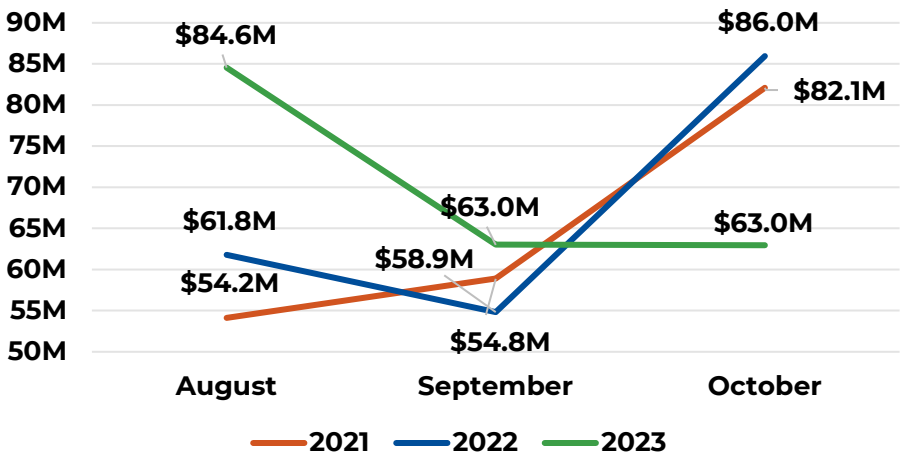
Financials (Cont.)

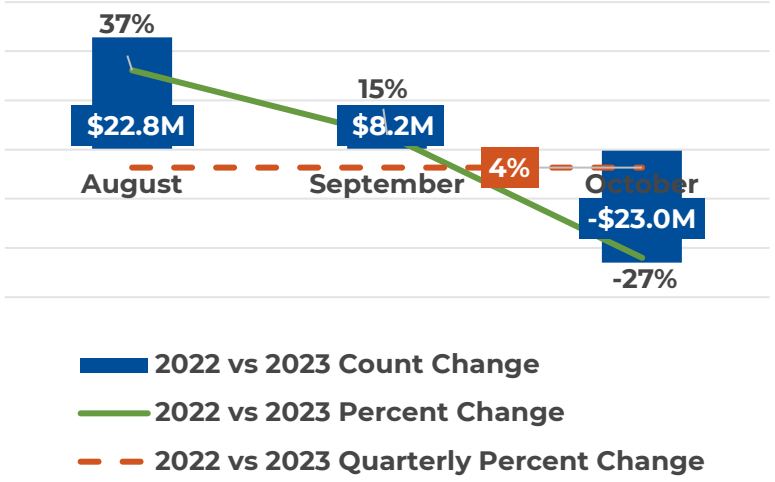
Inpatient Services Members Utilization by Qualifying Group





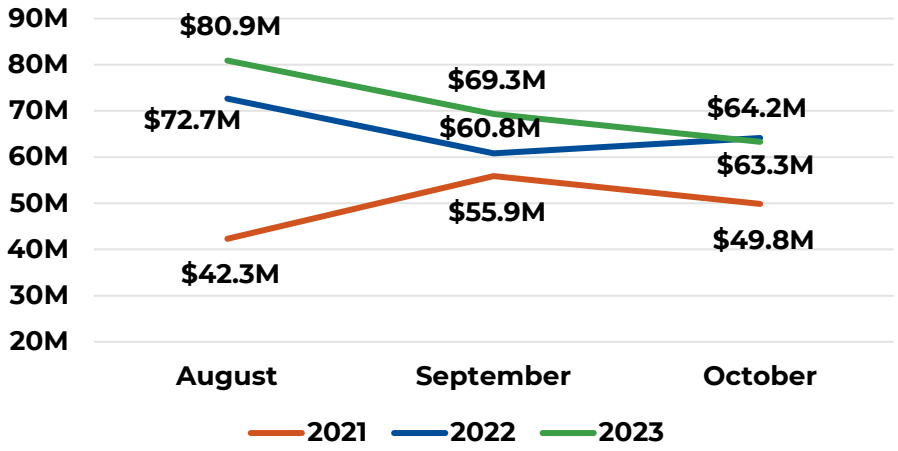
Nursing Facility Expenditures

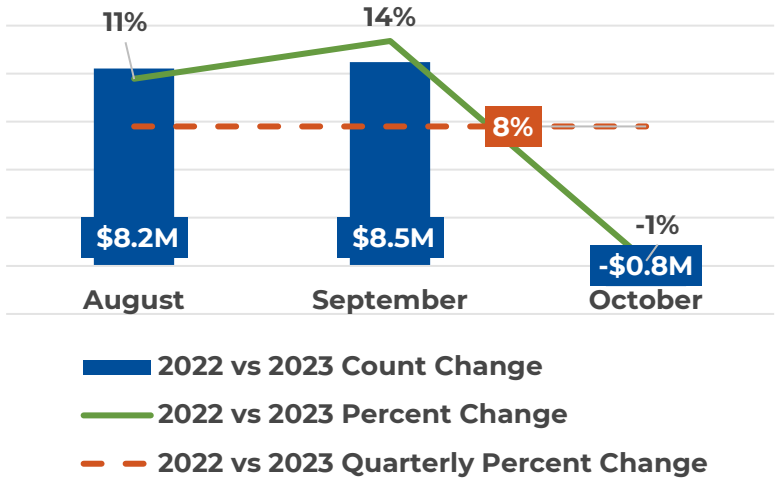




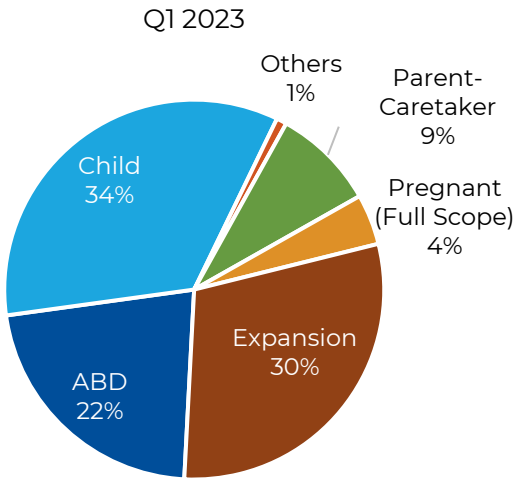
Financials (Cont.)

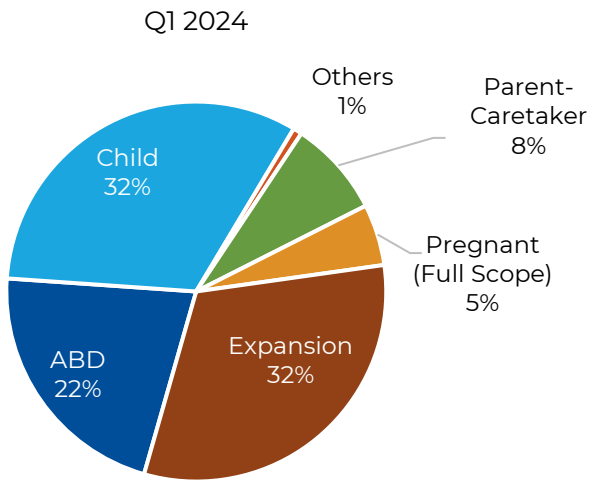
Outpatient Hospital Expenditures





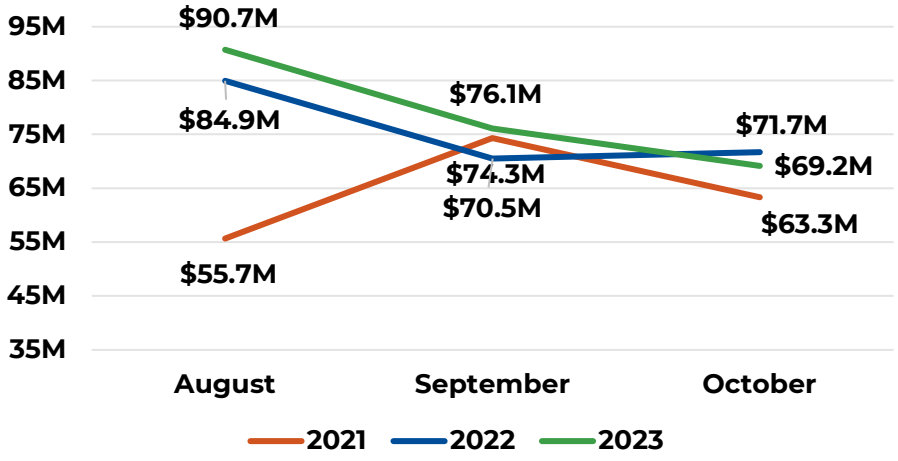
Outpatient Hospital Members Utilization by Qualifying Group

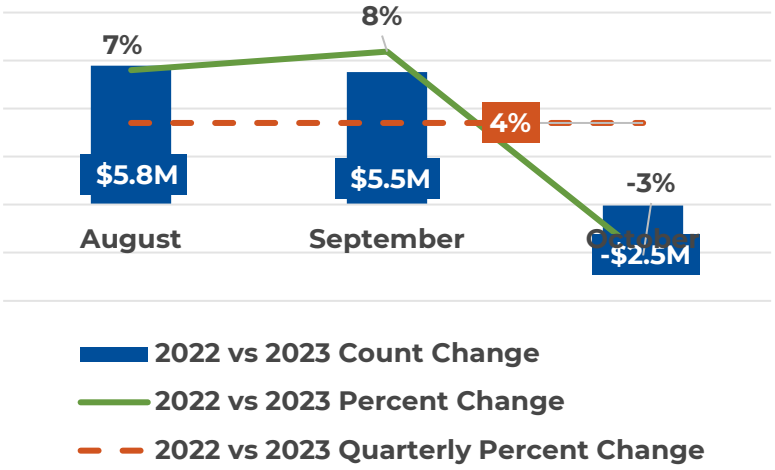




Financials (Cont.)

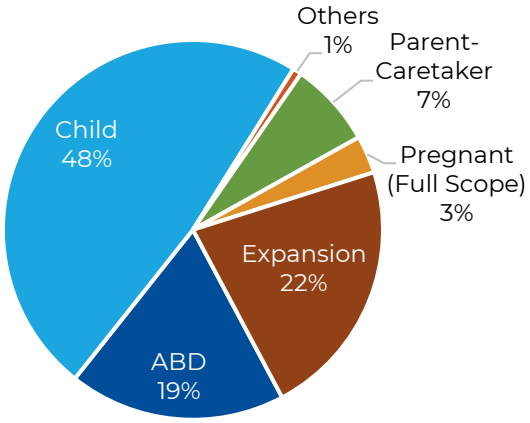
Physician Expenditures



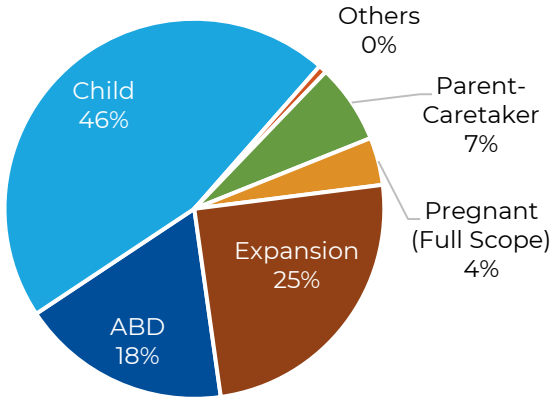


Physician Members Utilization By Qualifying Group

Q1 2023

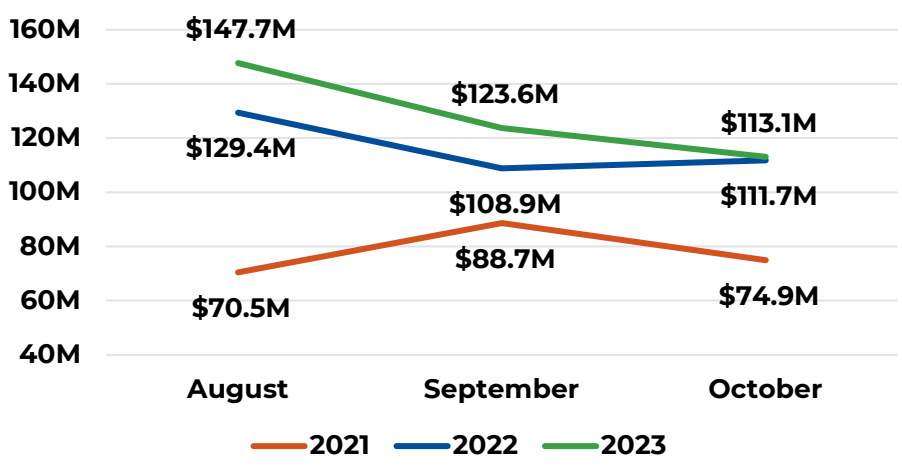


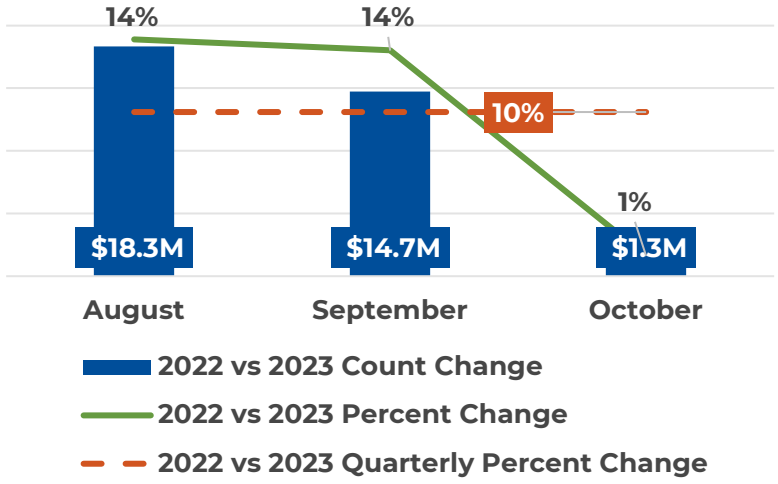
Q1 2024



Financials (Cont.)

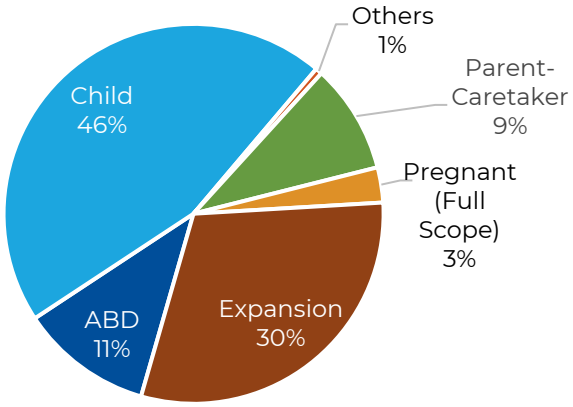
Prescribed Drugs Expenditures



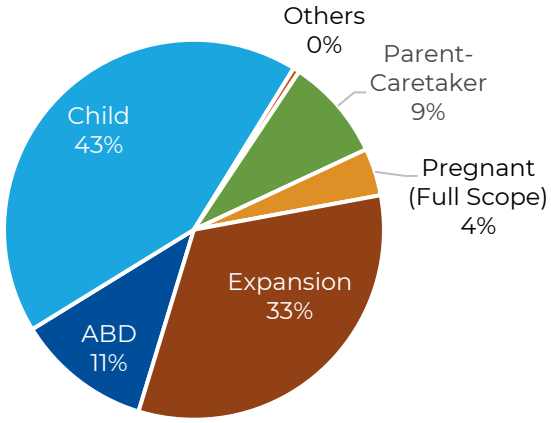


Prescribed Drugs Members Utilization By Qualifying Group

Q1 2023

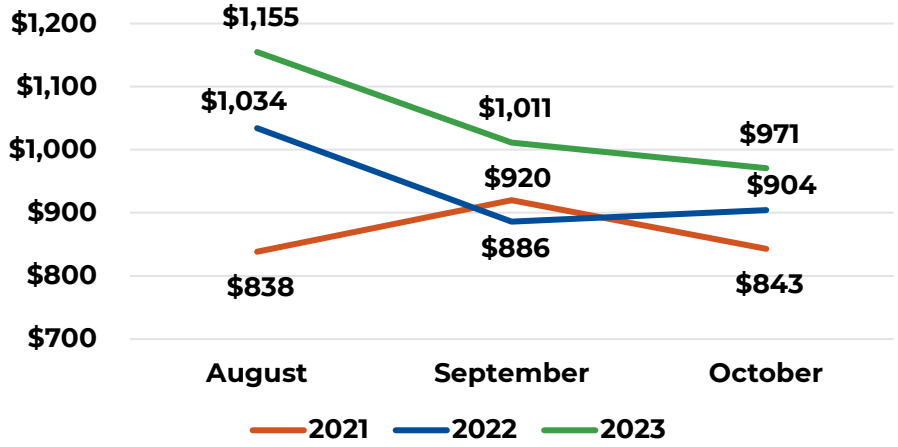


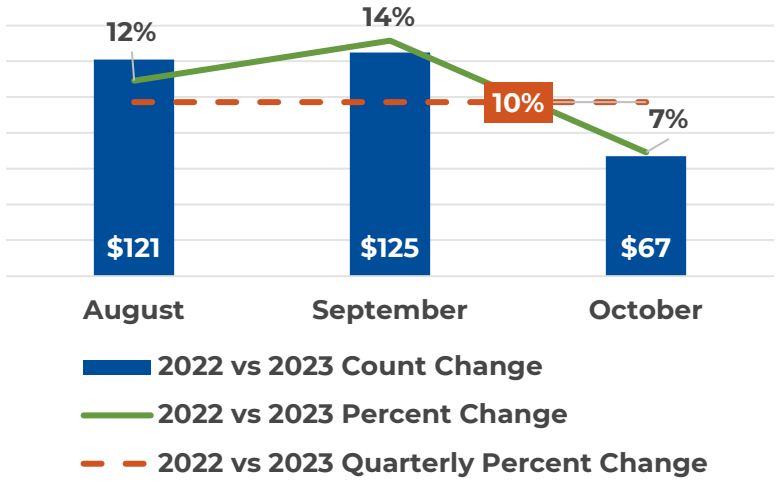
Q1 2024



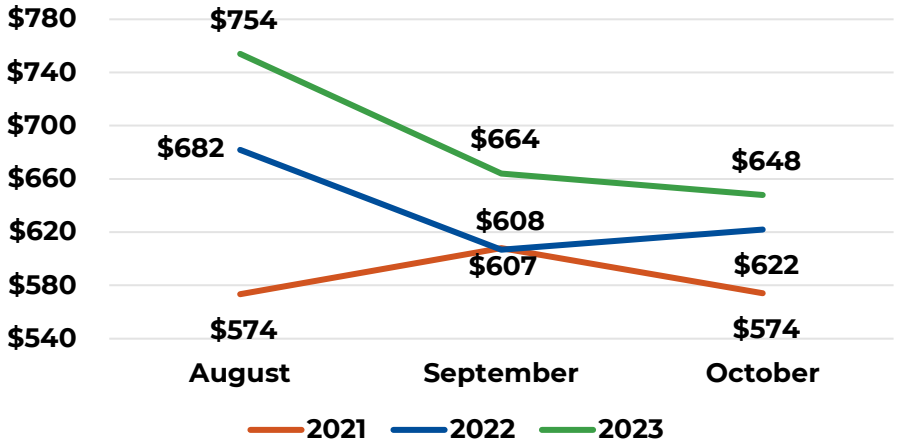
Financials (Cont.)

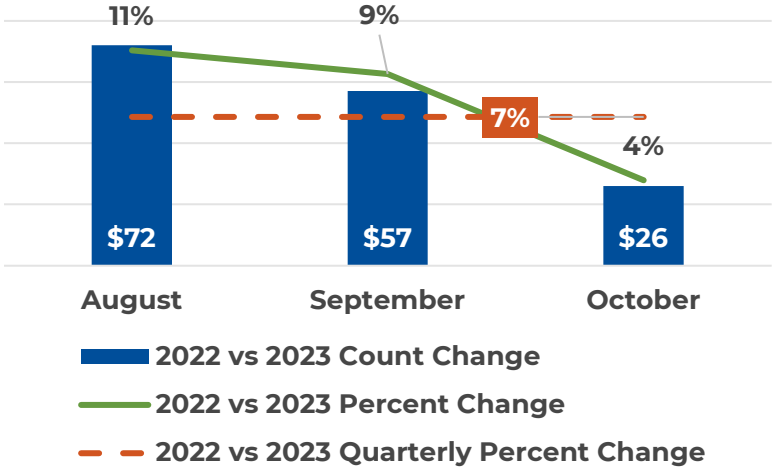
Average Per Total Member Served





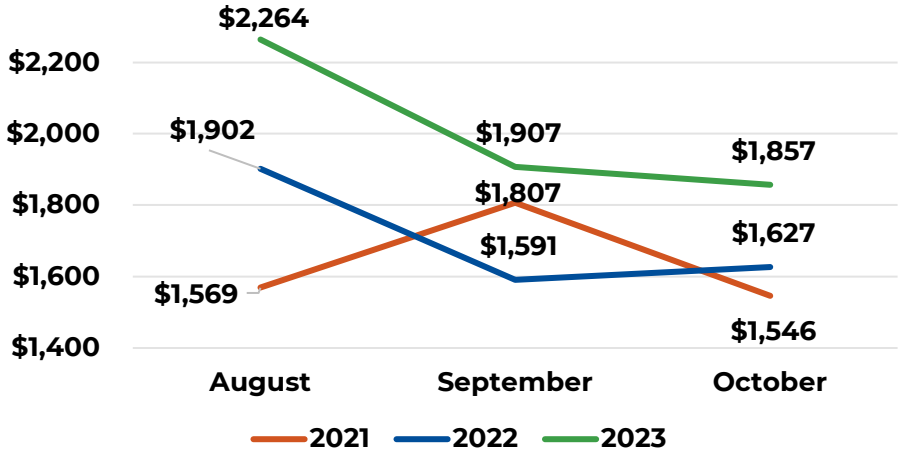
Average Per Child (Under 21) Member Served

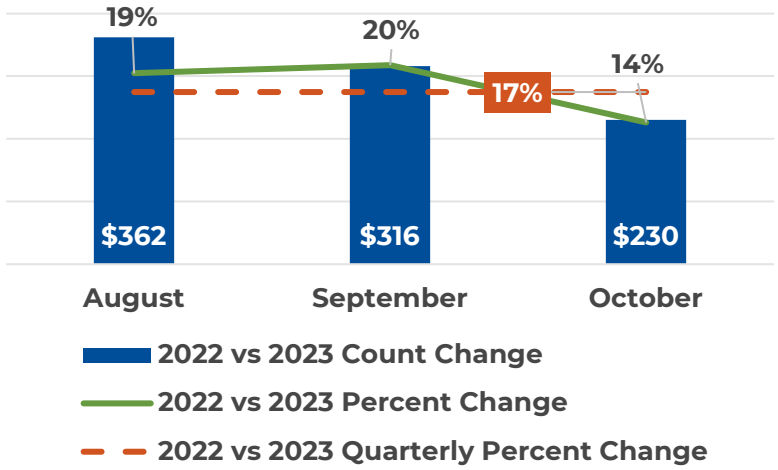




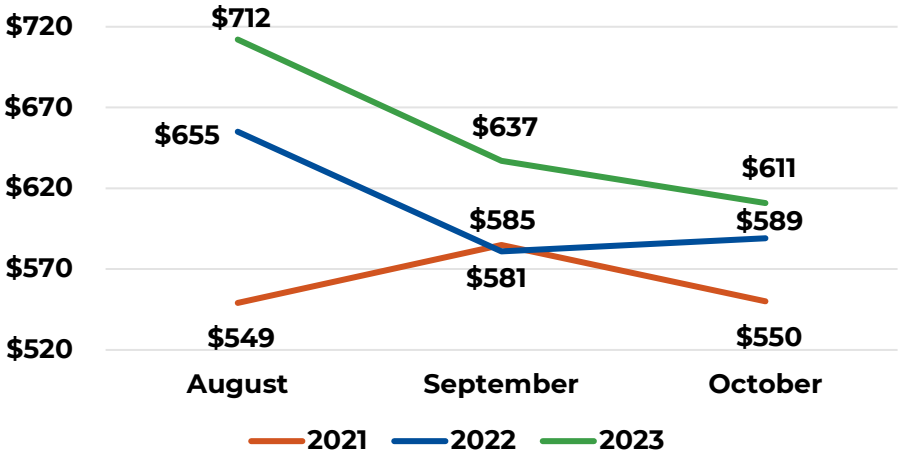
Financials (Cont.)

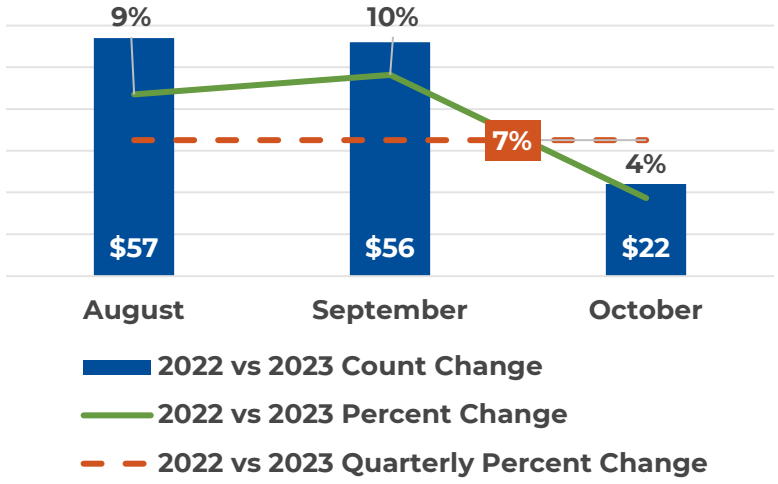
Average Per Aged/Blind/Disabled Member Served





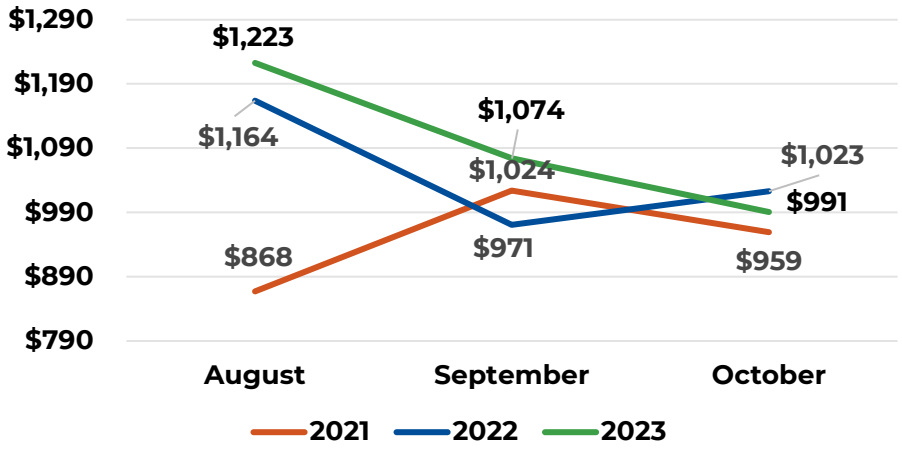
Average Per Children & Parent/Caretaker Member Served

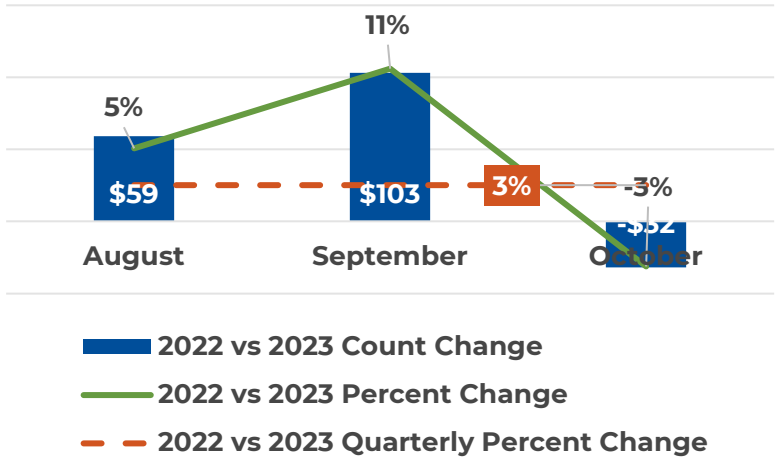




Financials (Cont.)

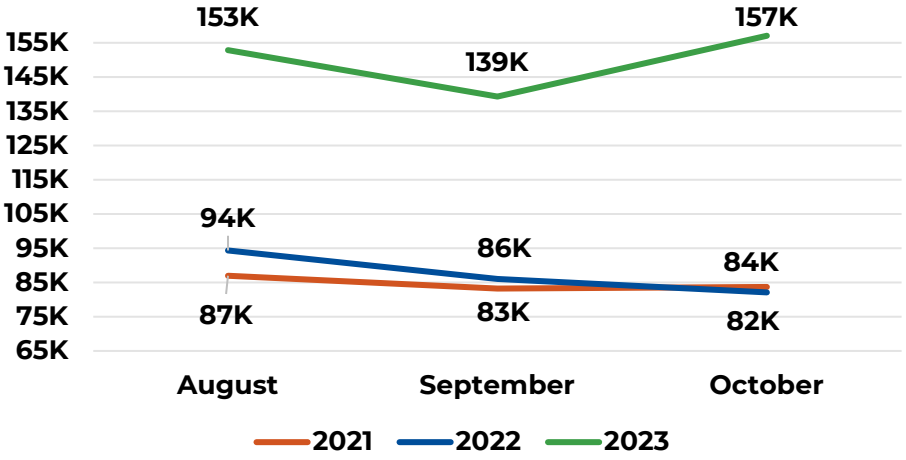
Average Per Expansion Member Served (Effective July 2021)

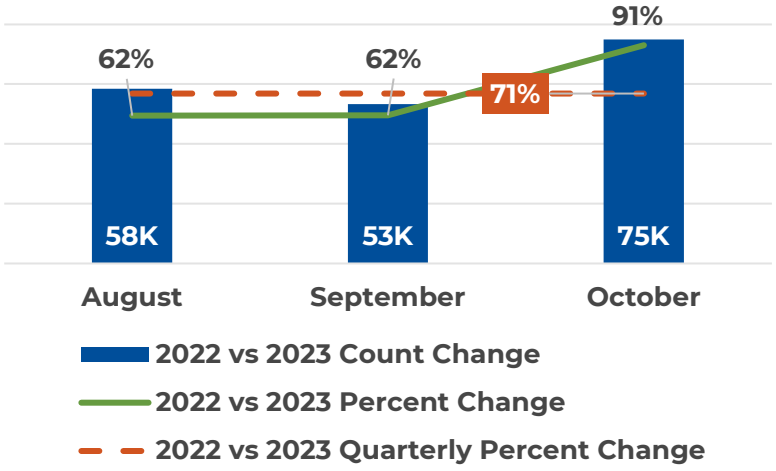




Call Center

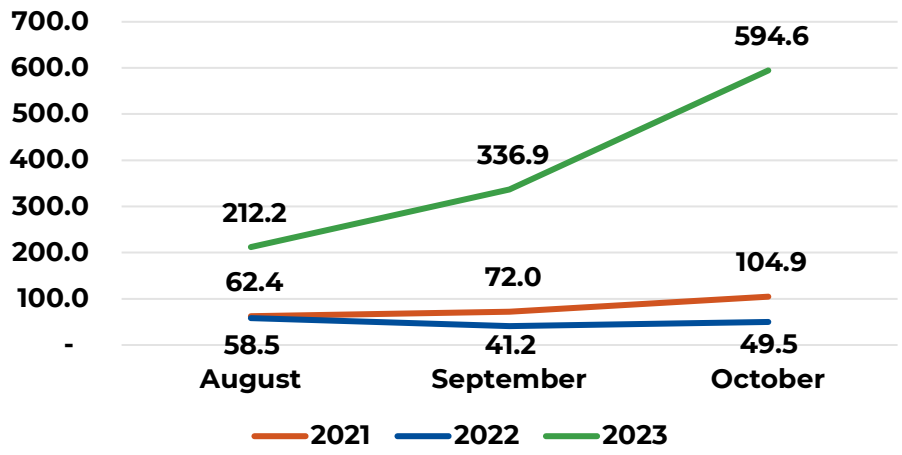
Call Center - Member Calls Answered

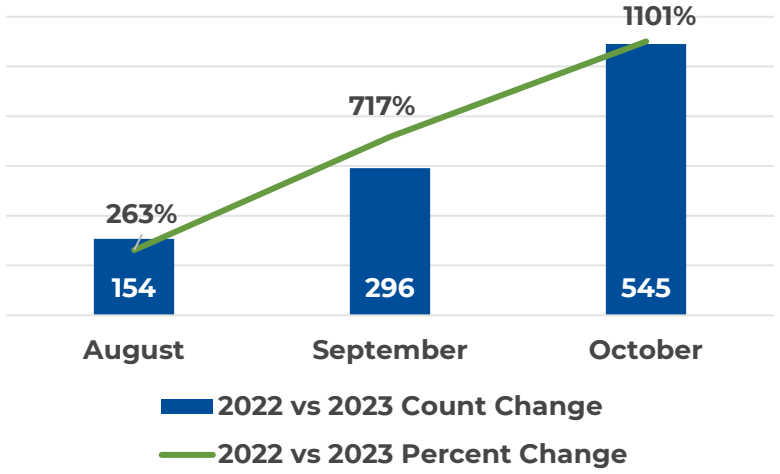




Call Center (Cont.)

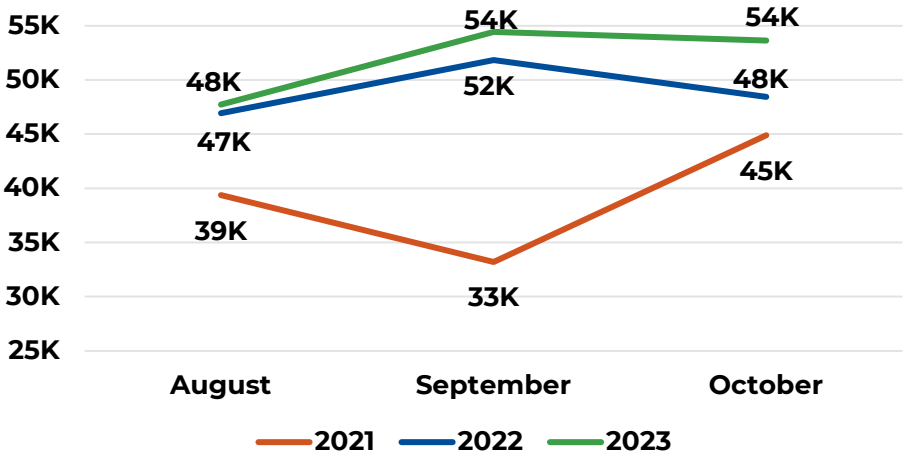
Call Center - Average Wait Time (In Seconds)

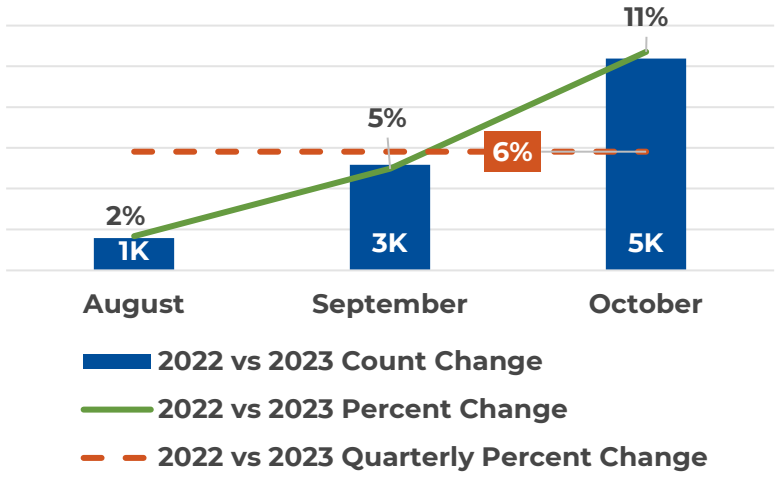




Prior Authorization

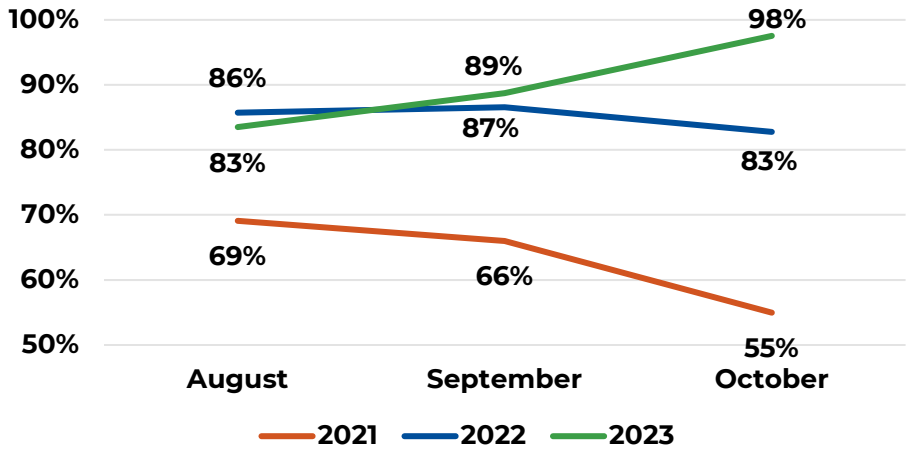
Prior Authorization - Total Combined - Total Completed PA Volume

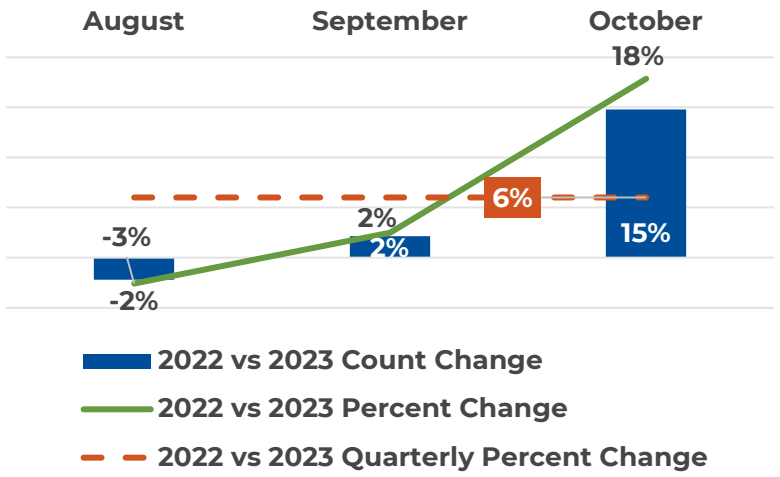




Prior Authorization (Cont.)

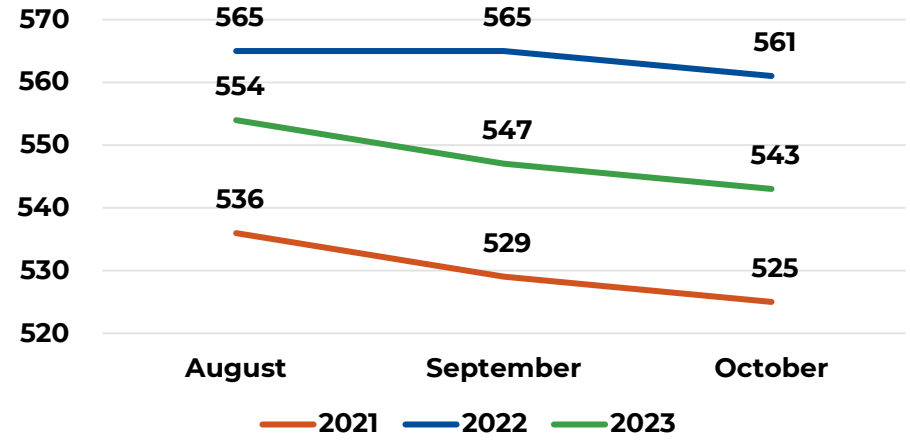
Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

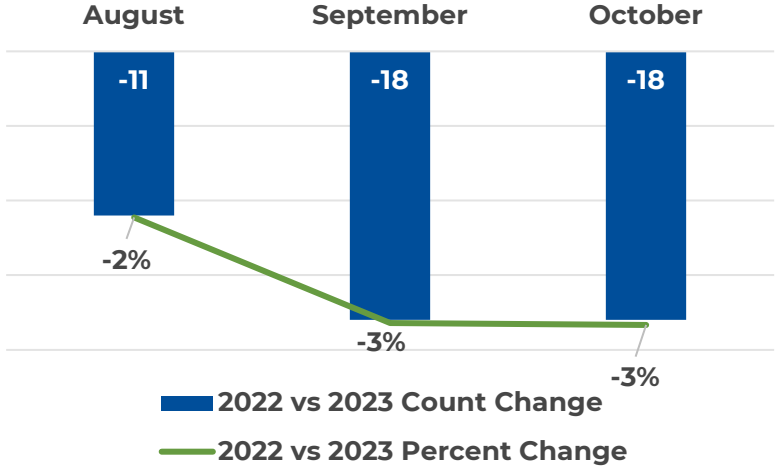




Agency Stats & Provider Network

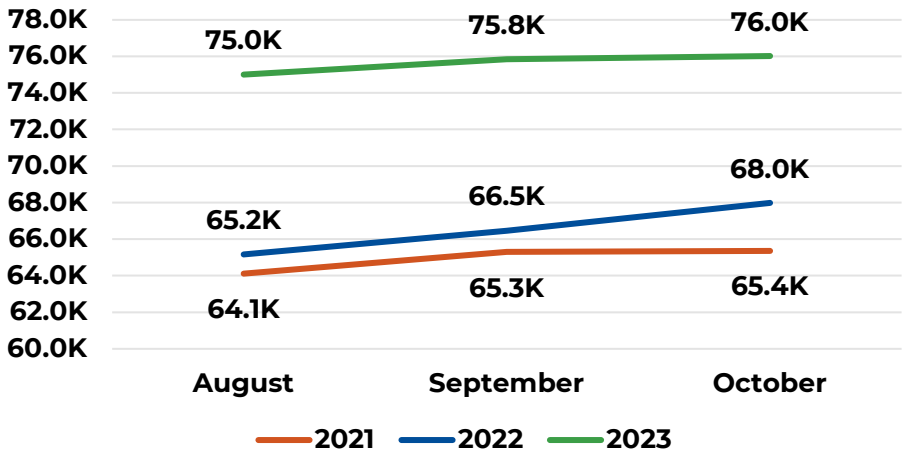
OHCA Admin - Number of FTEs

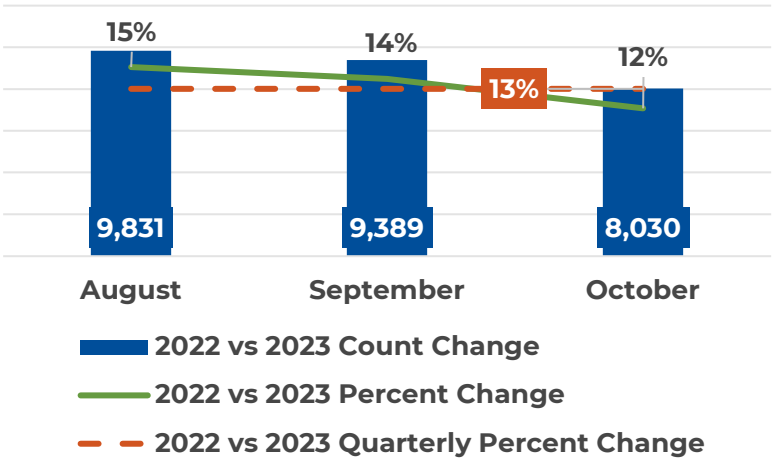




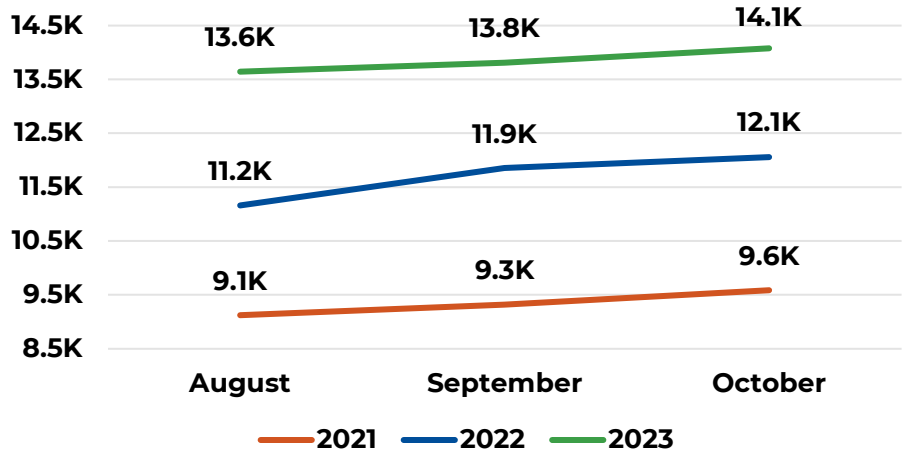
Agency Stats & Provider Network (Cont.)

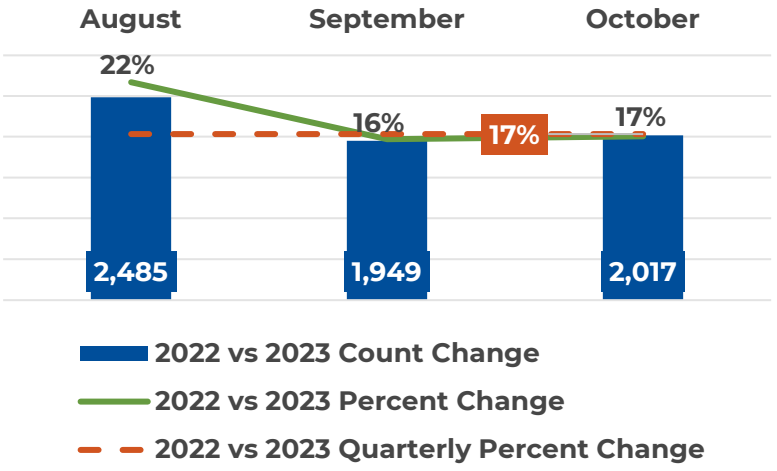
Total Providers





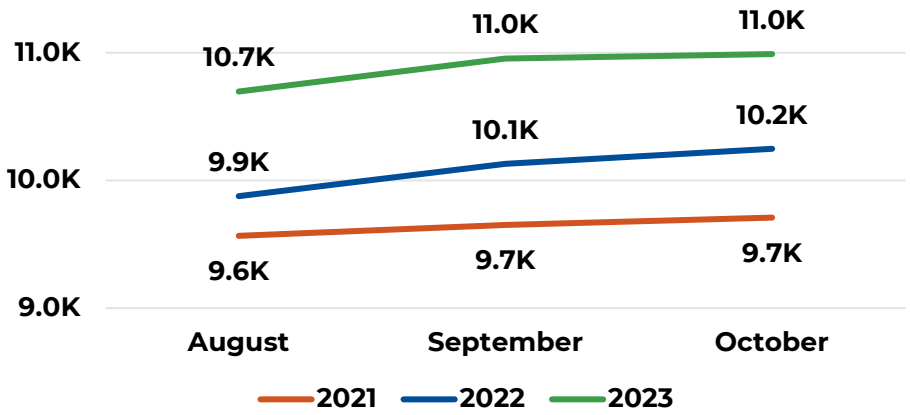
Mental Health Providers (In-State Only)

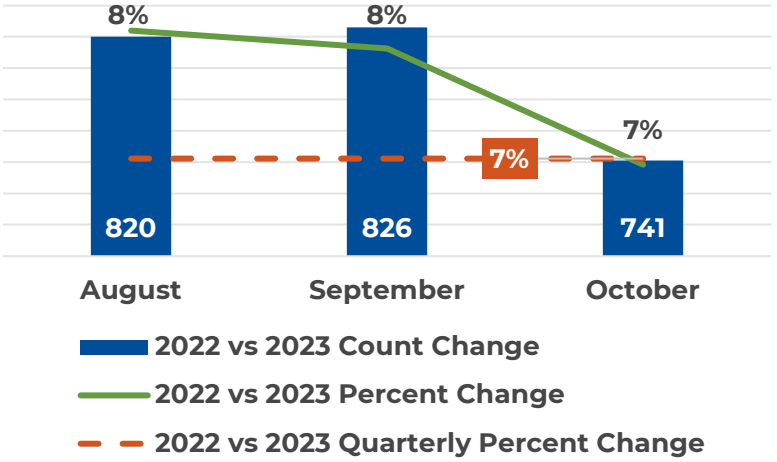




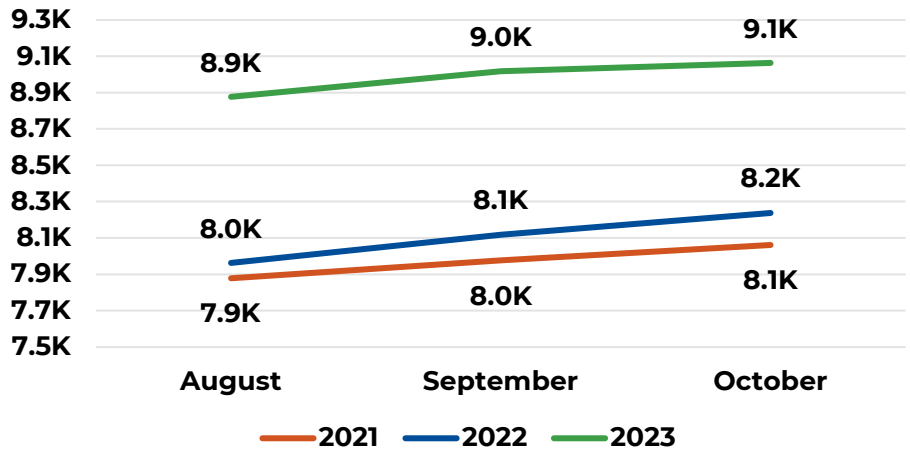
Agency Stats & Provider Network (Cont.)

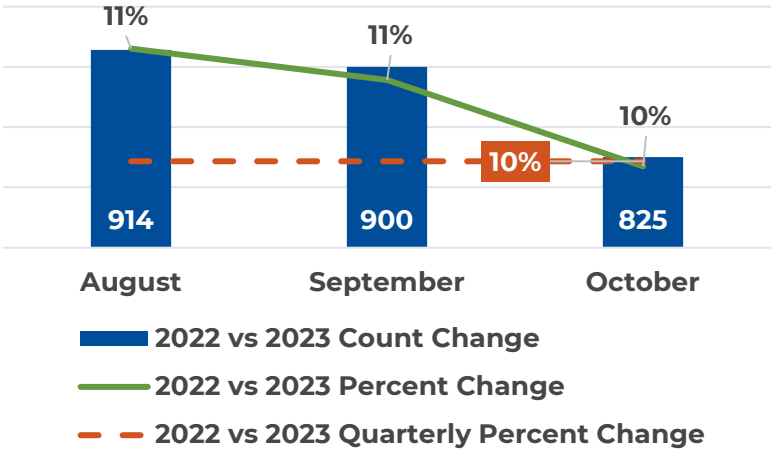
Physicians (In-State Only)





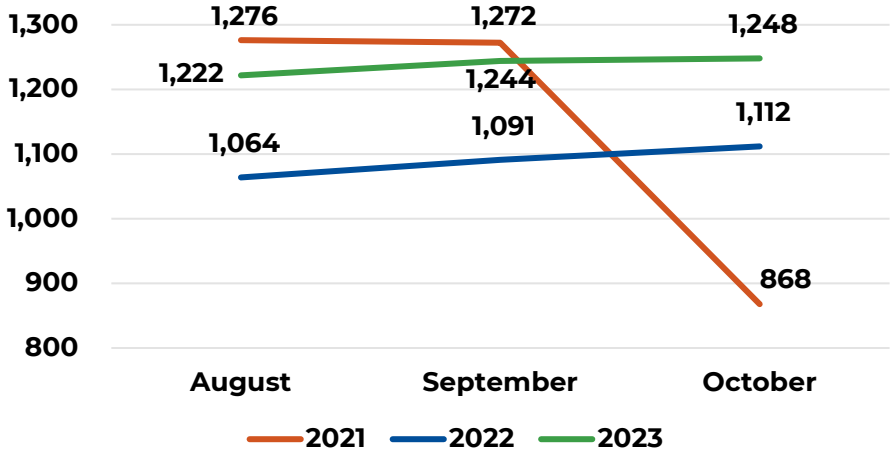
Primary Care Providers (In-State Only)

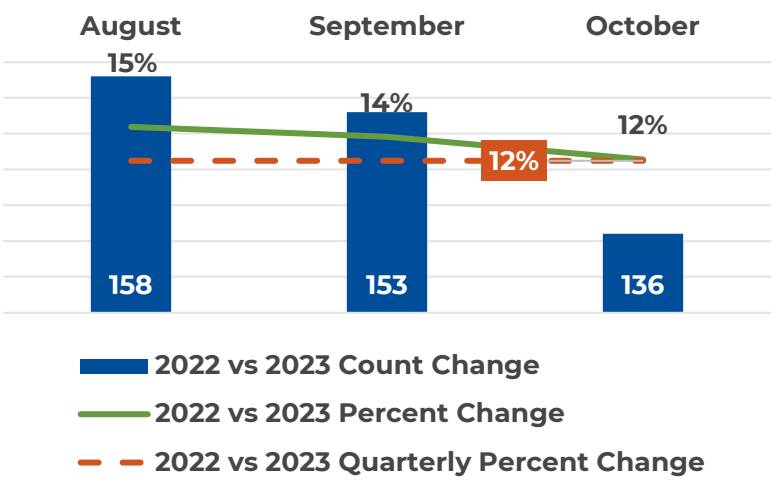




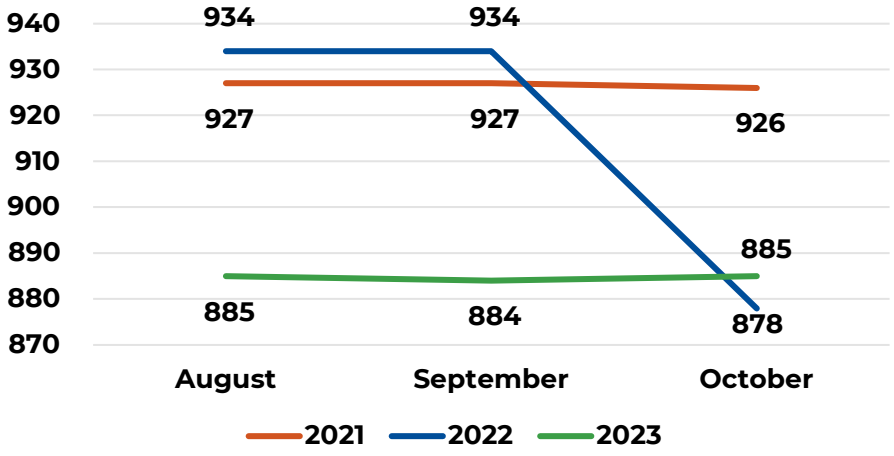
Agency Stats & Provider Network (Cont.)

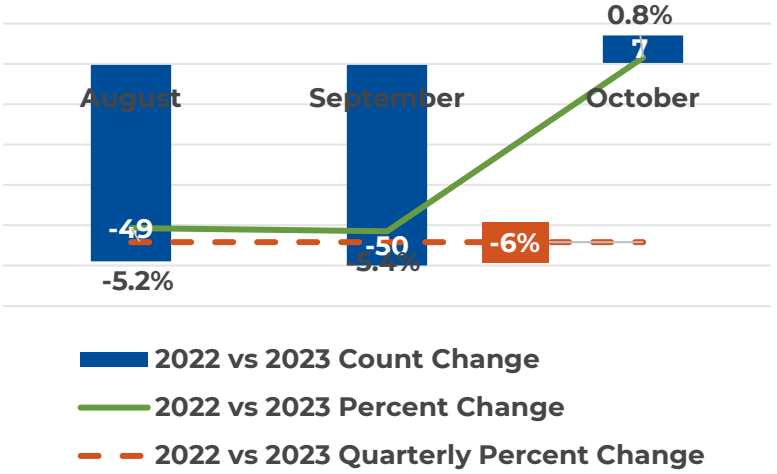
Dentists (In-State Only)





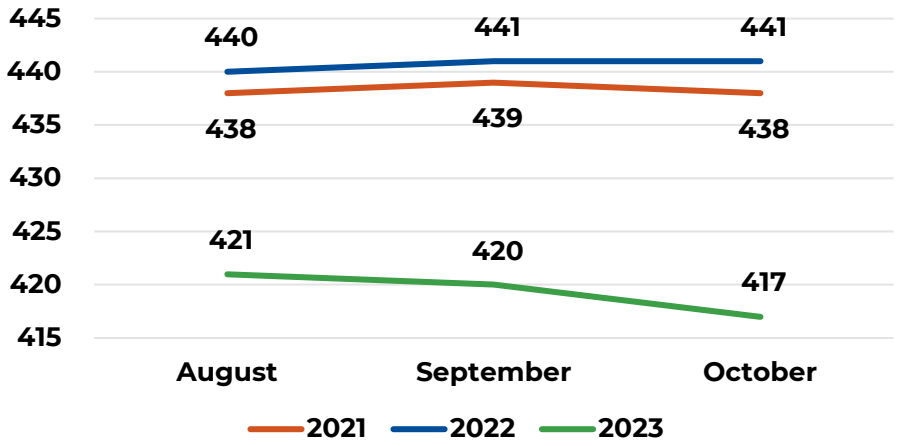
Pharmacy (In-State Only)

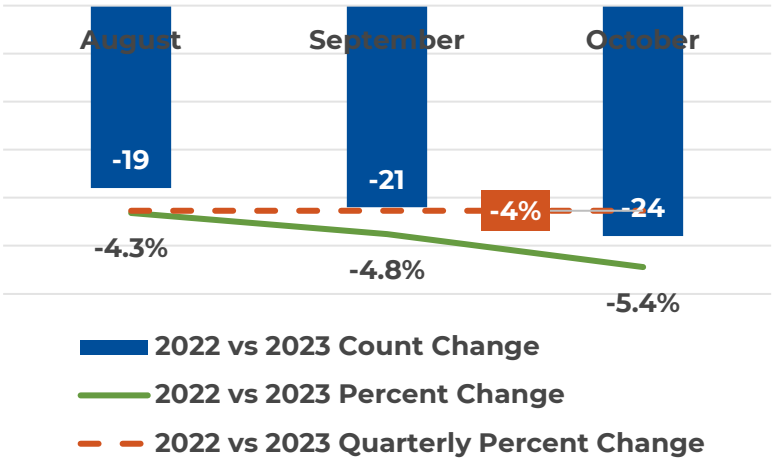




Agency Stats & Provider Network (Cont.)

Extended Care Facilities (In-State Only)





Hospitals (In-State Only)