

OKLAHOMA HEALTH CARE AUTHORITY  
AMENDED BOARD MEETING  
January 18, 2023, at 2:00 P.M.  
Samis Education Center  
1200 Children's Avenue, 3<sup>rd</sup> Floor Conference Room  
Oklahoma City, OK. 73104

**A G E N D A**

Public access via Zoom:

[https://www.zoomgov.com/webinar/register/WN\\_ut9dCF-RT26oLCaxL5gBUA](https://www.zoomgov.com/webinar/register/WN_ut9dCF-RT26oLCaxL5gBUA)

Telephone: 1-669-216-1590 Webinar ID: 161 096 8450

\*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 November 16, 2022, OHCA Board Meeting Minutes.....Marc Nuttle, Chair
3. Chief Executive Officer's Report.....Kevin Corbett, Chief Executive Officer
4. Chief of Staff Report.....Ellen Buettner, Chief of Staff
5. State Medicaid Director's Report (Attachment "A").....Traylor Rains, State Medicaid Director
6. Continuous Coverage Unwinding Presentation (Attachment "B").....Brandon Keppner, Chief of Operations
7. 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:
Enjaymo	<b>Cold agglutinin disease</b> is a rare type of autoimmune hemolytic anemia in which the body's immune system mistakenly attacks and destroys its own red blood cells.
Pyrukynd	<b>Pyruvate kinase deficiency</b> is a genetic blood disorder characterized by low levels of an enzyme called pyruvate kinase, which is used by red blood cells
Zynteglo	<b>Transfusion dependent beta thalassemia:</b> Beta thalassemia is a blood disorder that reduces the production of hemoglobin.
Spevigo	<b>Pustular psoriasis</b> is an uncommon form of psoriasis consisting of widespread pustules on an erythematous background.
Tavneos	<b>Anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis</b> is a group of rare diseases involving inflammation of your small to medium-sized blood vessels.
Besremi	<b>Polycythemia vera</b> is a rare, chronic disorder involving the overproduction of blood cells in the bone marrow.
Vonjo	<b>Myelofibrosis</b> is an uncommon type of bone marrow cancer that disrupts your body's normal production of blood cells.
Xenpozyme	<b>Acid sphingomyelinase deficiency (ASMD)</b> is a rare progressive genetic disorder that results from a deficiency of the enzyme acid sphingomyelinase, which is required to break down (metabolize) a fatty substance (lipid) called sphingomyelin.
Carvykti & Tecvavli	<b>Multiple myeloma</b> is a cancer that begins in plasma cells, a type of white blood cell.

Tezspire	<b>Asthma</b> is a chronic (long-term) lung disease.
Adbry & Cibingo	<b>Atopic dermatitis (AD)</b> is a chronic skin condition characterized by patches of dry, inflamed, and itchy skin.
Skysona	<b>Cerebral adrenoleukodystrophy (cerebral ALD, or CALD)</b> is a genetic disorder. It is the childhood-onset form of ALD. ALD leads to the accumulation of very-long-chain fatty acids in the brain and adrenal glands.

8. Discussion of Report from the ..... Phil Kennedy  
Compliance Advisory Committee Chair, Compliance Advisory Committee
- 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. SoonerSelect Medical
  - ii. SoonerSelect Dental
  - iii. SoonerSelect Children's Specialty
  - iv. Social Determinants of Health
  - v. Electronic Visit Verification
9. Discussion of Report of Administrative.....Tanya Case  
Rules Advisory Committee and Possible Action Administrative Rules Advisory Committee Member  
(Attachment "E")
- i. APA WF # 22-11 Early and Periodic Screening, Diagnostic and treatment (EPSDT) Visit and Sick Visit on the Same Day
  - ii. APA WF # 22-21A Increase Income Standard for Pregnant Women and Extend Postpartum Coverage
  - iii. APA WF # 22-21B Increase Income Standard for Pregnant Women and Extend Postpartum Coverage
  - iv. APA WF # 22-22 Ukrainian Humanitarian Parolees
10. Discussion and Possible Action.....Marc Nuttle, Chair  
Possible Executive Session as Recommended by the Director of Legal Services and Authorized by the Open Meeting Act, 25 O.S. § 307(B)(4) and (7), To Discuss Confidential Legal Matters, Including Pending State and Federal Litigation.
11. Adjournment.....Marc Nuttle, Chair

NEXT BOARD MEETING  
March 22, 2023, at 2:00PM  
Oklahoma Health Care Authority  
4345 N. Lincoln Blvd  
Oklahoma City, OK 73105

MINUTES OF AN AMENDED BOARD MEETING  
OF THE HEALTH CARE AUTHORITY BOARD  
November 16, 2022  
Bethany Children's Health Center  
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Bethany Children's Health Center on November 15, 2022 at 2:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on November 10, 2022 at 4:30 p.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 2:01 p.m.

BOARD MEMBERS PRESENT: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Finch, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Member Cruzan, Member Dell'Osso

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

Chairman Nuttle requested that the minutes be voted on separately.

- a) Approval of the September 21, 2022, OHCA Board Meeting Minutes (Attachment "A")

MOTION: Member Sharpe moved for approval of item 2a, of the consent agenda as published. The motion was seconded by Vice-Chairman Yaffe.

BOARD MEMBERS PRESENT: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Finch, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Member Cruzan, Member Dell'Osso

- 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. (Attachment "B")

- i. Third Party Liability Services

MOTION: Member Christ moved for approval of Item 2b of the consent agenda, as published. The motion was seconded by Member Sharpe.

BOARD MEMBERS PRESENT: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Finch, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Member Cruzan, Member Dell'Osso

**ITEM 3 / CHIEF EXECUTIVE OFFICER'S REPORT**

Kevin Corbett, Chief Executive Officer

CEO Corbett provided an update on FY22 highlights, budget, financial position and operating metrics, expansion, and the public health emergency (PHE). CEO Corbett introduced Nico Gomez, CEO of the Bethany Children's Health Center, who provided an overview of the Health Center.

PHE Update: OHCA did not receive the 60-day notice of termination. It is a signal that it will be extended again. The new anticipated termination date is April. It will require OHCA to start the termination process on May 1, 2023. The unwinding plan has been developed and tested. As the termination date nears, a more detailed review of how that process will work. OHCA is working to maintain some of the exceptions, benefits, flexibilities, etc. that were created by the PHE after the PHE has been terminated. The E-FMAP will also be extended an additional 90-days due to the PHE being extended. OHCA met with Legislative Appropriation and Health & Human Services Committee Chairs to update them on where OHCA stood with regard to FMAP enhancement and what OHCA is received to date.

SoonerSelect Update: The RFPs for Medical and Children's Specialty program were released. The RFPs will be open for 90-days. It is OHCA's hope that there will be high interest by provider led entities that was developed by legislation. After the 90-days, OHCA will begin the evaluation process. The timeline will take place after evaluations. OHCA will develop a Quality Advisory Committee. OHCA is going through the process of going through diversity of skills and background. The committee will be made up of 15 members and will advise OHCA and the board. Vice Chairman Yaffe asked if OHCA is considering the implementation of SoonerSelect coinciding with the PHE, should it continue to get extended. CEO Corbett stated the time period to roll out the program is aggressive, but a period of time; as well as the PHE unwind, it is a period of time. There will be overlap regardless. OHCA is working on resourcing plans and supports to ensure they do not collide.

Program Update: Dental rates go into effect October 1<sup>st</sup>, retroactive is awaiting CMS approval. OHCA has Private Duty Nursing rate increases in its budget, looking to expedite that beyond the SFY 2024 period. It has not been presented to CMS at this point. Post-Partum benefits are also moving forward and will go into effect on January 1<sup>st</sup>. Vaccine cost-sharing is being removed. OHCA is also in the process of renewing the SoonerCare Choice waiver that is set to expire on December 31, 2023.

#### **ITEM 4 / CHIEF OF STAFF REPORT**

Kevin Corbett, Chief Executive Officer

Ms. Buettner was not able to attend the meeting, CEO Corbett provided her update.

Legislative Update: OHCA will meet with the legislative committee to discuss what OHCA would like to pursue with regard to the legislature in the next session. On the agenda is a bill that will prioritize Medicaid payments to the agency with regard to third-party liability cases. Provider credentialing is also a topic of discussion. It is process that is currently overseen by the Department of Health. OHCA sees this as an opportunity to create a single, consolidated, credentialing process for Medicaid providers. There are also modifications that will be made for ambulance services providers on the supplemental payment. This will clean up language in a bill that was passed in 2021. OHCA will also clean-up SB1337 only to require a certificate of authority as a pre-paid dental health care plan. Member Case asked if there is any thought to taking the credentialing process and centralizing it for the entire state? CEO Corbett stated he does not know of one at the moment but would provide an update at a later time.

Team Update: OHCA has had a significant increase in response rate and engagement with the Energage survey.

Currently in the process of expanding the Strategic Planning committee to the Strategic Planning and Operational Advisory Committee. This will be a working committee, similar to the other board subcommittees.

#### **ITEM 5 / HEALTH INFORMATION EXCHANGE (HIE) PRESENTATION**

Steve Miller, State Coordinator, Health Information Exchange

Mr. Miller provided an overview of the HIE program which included information on the importance of a HIE, Capabilities, Oklahoma's HIE History, HIE Legislation, Framework, MyHealth, Strategy and Milestone Dates, and KPI's. For more detailed information, see attachment C in the board packet.

#### **ITEM 6i-iv / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION BOARD RECOMMENDATIONS**

Corey Finch, M.D., 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 "D")

- i. Recorlev®(Levoketoconazole) – Treatment for Cushing's Syndrome
- ii. Adlarity®(Donepezil Transdermal System) and Aduhelm® (Aducanumabavwa) – Treatment for Alzheimer's Disease
- iii. Alymsys® (Bevacizumab-maly), Lonsurf® (Trifluridine/Tipiracil), and Stivarga® (Regorafenib) – Treatment for Colon Cancer
- iv. Camzyos™ (Mavacamten) – Treatment for Obstructive Hypertrophic Cardiomyopathy
- v. Herceptin Hylecta™ (Trastuzumab/Hyaluronidase-oysk) – Treatment for Breast Cancer
- vi. Amvuttra™ (Vutrisiran) – Treatment for Polyneuropathy of hATTR

MOTION: Member Case moved for approval of item 6i-vi, as published. The motion was seconded by Member Sharpe.

BOARD MEMBERS PRESENT: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Finch, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Member Cruzan, Member Dell'Osso

**ITEM 7 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE**

Phil Kennedy, Chair, Compliance Advisory Committee

Member Kennedy provided an update on the October and November Compliance Committee meetings.

Financials: Through the month of September 30, 2022, revenues were \$1.97 billion or 3.3% over budget and attributable primarily to federal funds and drug rebate collections. Expenditures were \$1.78 billion or 5% over budget and attributable primarily to Nursing Facility supplemental payments and the impact of the public health emergency and federally mandated continuous coverage requirement. The state dollar budget variance through September is a negative \$21 million. OHCA will likely require a budget revision for the increasing program related costs but expects the increase to be temporary. OHCA will utilize enhanced FMAP to cover the state portion of the increase.

Program Integrity: Through the month of September 2022, Program Integrity completed 210 provider audits, totaling approximately \$1.1 million dollars in overpayments. \$380,000 of those overpayments were from audit appeals worked in conjunction with the OHCA Legal team. 94% of the overpayments are in recovery. For more detailed information, see attachment E in the board packet.

**ITEM 8 / DISCUSSION AND POSSIBLE ACTION REGARDING OHCA BOARD MEETING DATES AND TIMES FOR CALENDAR YEAR 2023**

Marc Nuttle, OHCA Board Chairman

MOTION: Vice-Chairman Yaffe moved for approval of the 2023 OHCA Board Meeting Dates and Times, as published. The motion was seconded by Member Sharpe.

BOARD MEMBERS PRESENT: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Finch, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Member Cruzan, Member Dell'Osso

**ITEM 9 / DISCUSSION AND POSSIBLE ACTION REGARDING ELECTION OF THE OHCA 2023 BOARD OFFICERS**

Marc Nuttle, OHCA Board Chairman

MOTION: Member Case for approval of Marc Nuttle as 2023 OHCA Board Chairman and Alex Yaffe as 2023 OHCA Board Vice-Chairman. The motion was seconded by Member Sharpe.

BOARD MEMBERS PRESENT: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Finch, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Member Cruzan, Member Dell'Osso

**ITEM 10 / ADJOURNMENT**

Marc Nuttle, OHCA Board Chairman

MOTION: Member Case moved to adjourn. The motion was seconded by Vice-Chairman Yaffe.

BOARD MEMBERS PRESENT: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Finch, Member Kennedy, Member Sharpe

BOARD MEMBERS ABSENT: Member Cruzan, Member Dell'Osso

Meeting adjourned at 3:09 p.m., 11/16/2022

NEXT BOARD MEETING  
January 18, 2023  
Oklahoma Health Care Authority  
4345 N. Lincoln Blvd  
Oklahoma City, OK 73105

*Martina Ordonez*  
*Board Secretary*

*Minutes Approved:* \_\_\_\_\_

*Initials:* \_\_\_\_\_

DRAFT

# MEDICAID DIRECTOR UPDATE



# **2023 CONSOLIDATED APPROPRIATIONS BILL**



# IMPACTS ON SOONERCARE

- Enhanced FMAP gradual phase-out through calendar year 2023.
- Continuous eligibility for children covered by Medicaid and CHIP
  - Beginning January 1, 2024, states must provide 12 months of continuous eligibility for children.
- Postpartum coverage extension made permanent
  - When the 12-month postpartum coverage extension was first offered by the American Rescue Plan, it was set to expire after five (5) years. The 2023 Consolidated Appropriations Bill made this option permanent.
- CHIP funding extended through FFY 2029.
- Money Follows the Person grant extended three (3) years through FFY 2027

# IMPACTS ON SOONERCARE

- Screening and referral for juveniles (2025)
  - Medicaid and CHIP will provide physical and behavioral health screenings to eligible juveniles within 30 days of release from an institutional setting, and case management within 30 days pre-release and post-release. Additionally, CHIP coverage may not be terminated while a child is an inmate of a public institution, but can be suspended.
- FFP for juveniles pending disposition of charges (2025)
  - Current federal law prohibits FFP for any inmate of a public institution. Beginning in 2025, a carve-out is allowed for juveniles who are in an institution pending disposition of charges (has been charged with a crime but waiting for the outcome of those charges to be determined).
- States required to maintain searchable and current directory of providers (2025)

# NEW AND UPCOMING PROGRAM CHANGES



# PROGRAM ENHANCEMENTS

- Increased FPL for pregnant women
  - Effective January 1, 2023, the eligibility income threshold for pregnant women was raised from 138% FPL to 205%. For a family of two, this is an annual income of \$38,460.
- Increased postpartum period coverage from 60 days to 12 months (1/1/2023)
- Coverage of doula services for women during pregnancy and postpartum periods (Summer 2023)

# SOONERSELECT UPDATE

# IMPORTANT MILESTONES

- Jan 19 SoonerSelect Dental award announcement
- Jan 20 SoonerSelect Dental readiness work begins
- Feb 8 Medical and Children's Specialty Plan RFPs close.
- Feb 15- April 7 Medical and CSP Evaluations begin and go through
- March OHCA submits federal authority to CMS
- May 29 Anticipated award date for Medical and CSP
- May-Dec Readiness review activities and CMS negotiations



**OKLAHOMA**  
Health Care Authority

## GET IN TOUCH

4345 N. Lincoln Blvd.  
Oklahoma City, OK 73105

[oklahoma.gov/ohca](http://oklahoma.gov/ohca)  
[mysoonerhealthcare.org](http://mysoonerhealthcare.org)

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



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# Public Health Emergency Unwinding



# PUBLIC HEALTH EMERGENCY



# THE PHE & FFCRA

- On Jan. 27, 2020, the U.S. Department of Health and Human Services (HHS) declared a Public Health Emergency (PHE) in response to the outbreak of COVID-19.
- The Families First Coronavirus Response Act (FFCRA) passed in March 2020 contained “maintenance of eligibility” (or continuous eligibility) requirements to help prevent coverage losses during the pandemic.
- The FFCRA provided states with a 6.2 percentage point FMAP increase beginning Jan. 1, 2020, through the last day of the calendar quarter in which the PHE ends.

# CONSOLIDATED APPROPRIATIONS ACT

- The Consolidated Appropriations Act (Omnibus Bill) was signed by President Joe Biden on Dec. 29, 2022.
- The Act decouples the maintenance of eligibility requirement from the PHE beginning April 1, 2023. This means states can begin to end eligibility for those members who are truly ineligible.
- Changes were also made to the increased FMAP so it will be gradually decreased through the unwinding process:
  - 6.2 percentage points through March 31, 2023
  - 5 percentage points through June 30, 2023
  - 2.5 percentage points through Sept. 30, 2023
  - 1.5 percentage points through Dec. 31, 2023

**WHAT HAS  
OHCA BEEN  
DOING?**



# WHAT HAS BEEN DONE

- Since the start of the PHE, OHCA has complied with the continuous eligibility requirement set by CMS.
- When the 90-day extensions were given by HHS, OHCA adjusted the eligibility end date of each PHE-protected member to reflect the new end date of the PHE to ensure no member lost eligibility.

# COMMUNICATIONS – PHASE I

- Phase I started in August 2021 with a communication plan that continues throughout the PHE and unwinding period.
- The goal of Phase I is to:
  - Encourage members to update their information. Many members are ineligible because they have not updated their information.
  - Provide education and communication to stakeholders to ensure consistent messaging regarding the unwinding of PHE.
- **Core messaging:** Make sure we know where to send your benefit information (address, email and phone number). Update your contact information at [MySoonerCare.org](https://MySoonerCare.org).

# PREPARING FOR UNWINDING

- OHCA has communicated and collaborated with partners regularly throughout the PHE, ensuring partners have been informed every step of the way. This will continue as the PHE end date is confirmed and the unwinding plan begins.
- OHCA is increasing call center and internet helpdesk staffing, and the State has hired an additional Eligibility and Coverage Manager to assist with the potential increase of fair hearing requests.



# OHCA'S COMMITMENT

- Oklahoma has developed an unwinding plan for the Public Health Emergency that is intentional and compassionate, considering our most vulnerable members.
- OHCA's unwinding plan maintains the goals of:
  - Keeping eligible members enrolled
  - Minimizing the number of ineligible members
  - Easing member burden
  - Achieving a sustainable renewal schedule
  - Meeting the timeline set forth by federal requirements
- OHCA will do this by prioritizing our most vulnerable members who are in the middle of an episode of care, have chronic health conditions, have children under five years of age, or have higher financial need.

# UNWINDING: RETURN TO NORMAL



# GENERAL UNWINDING REQUIREMENTS

- States have been given 12 months to complete the unwinding.
- All enrolled members must be reprocessed during the 12-month period.
- OHCA will end eligibility for PHE-protected members over the course of 9 months.

# RETURNING TO NORMAL OPERATIONS

- All members will be reprocessed, and eligibility will be redetermined before a member loses coverage.
- Ineligible members will lose coverage gradually according to Oklahoma's 9-month operational unwinding plan that takes into consideration the most vulnerable members.
  - Members in these more vulnerable groups will have coverage terminated later in the 9-month plan
  - Members will receive information about their end date with SoonerCare

# PROTECTING VULNERABLE MEMBERS

Lower Risk Considerations	Higher Risk Considerations
<ul style="list-style-type: none"><li>• Cases with no children under 5</li><li>• Current insurance coverage other than SoonerCare</li><li>• No recent claims</li><li>• Lower financial need (FPL of 228% or higher)</li></ul>	<ul style="list-style-type: none"><li>• Cases with children under 5</li><li>• Members with chronic health conditions</li><li>• Members in the middle of an episode of care</li><li>• No current insurance coverage other than SoonerCare</li><li>• Recent claims</li><li>• Higher financial need (FPL under 228%)</li></ul>

- Ineligible members will be aligned at the case level at the highest risk factor.
- Cases in the higher risk groups will have coverage terminated later in the 9-month plan.

# COMMUNICATIONS – PHASE II

- Phase II begins now.
- The goal of Phase II is to:
  - Educate PHE-protected members, staff, partners and stakeholders on the end of continuous eligibility and available resources.
  - Ensure consistent messaging across all platforms.
- Download the Communications Toolkit at [oklahoma.gov/ohca/about/public-health-emergency](https://oklahoma.gov/ohca/about/public-health-emergency).

# MEMBER COMMUNICATIONS

Ineligible members will receive four notices from OHCA:

1. A one-time letter from OHCA will be mailed to announce the end of continuous eligibility and inform members what that means for them. This letter will be printed on purple paper.
2. When the final end dates are determined for cases, members will receive a letter with their specific end date.
3. Another letter will be sent to members 45 days prior to their scheduled end date to inform them of the reason for loss of eligibility, potentially missing documents, and appeal rights.
4. A final letter will go out 10 days before the member loses eligibility.

# TRANSITIONING FROM SOONERCARE





# TRANSITIONING OUT OF SOONERCARE

If a member no longer qualifies for health coverage from SoonerCare, they will:

- Receive notice of when their Medicaid coverage will end.
  - Losing SoonerCare is a qualifying life event. The notice will provide the verification needed to get health care coverage even if applying outside of the regular yearly enrollment period.
- Receive information on how to file an appeal if the member thinks the cancellation decision was incorrect.
- Have their SoonerCare information transferred to the Federal Marketplace, where they may qualify for financial help to lower the cost of private health insurance.

# HELPING WITH THE TRANSITION

- OHCA is committed to helping members in their transition from SoonerCare to other coverage.
- We are working with Community Partners and Agency Partners across the state, training them on the unwinding process and ensuring they know available resources for members.
- Call center staff at OHCA will also be highly trained on the unwinding process and available resources for members.
- OHCA has posted a PHE Unwind RFP with the goal of finding available solutions to assist in transitioning PHE-protected members from SoonerCare to other affordable insurance coverage and assistance programs.

# PARTNER & MEMBER RESOURCES

- Resources include:
  - In-person marketplace help with Health Navigators
  - Statewide resource lists
  - Dedicated resource webpages for partners
  - Partner Helpline at OHCA
  - Unwinding Toolkit for partners
  - Specialized PHE Unwinding training

# OHCA ONLINE RESOURCES

- OHCA's Public Health Emergency webpage has several resources available:
  - Communications Toolkit for partners
  - OHCA's Unwinding Operational Plan
  - Flyers
  - Social media graphics and alerts
  - FAQs

More resources will be added as they become available.

- <https://oklahoma.gov/ohca/about/public-health-emergency.html>



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## Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – November 9, 2022 and December 14, 2022

<b>Recommendation/ Vote</b>	<b>Drug</b>	<b>Used for</b>	<b>Cost*</b>	<b>Notes</b>
1	Enjaymo™  Pyrukynd®  Zynteglo®	<ul style="list-style-type: none"> <li>• Cold Agglutin Disease</li> <li>• Pyruvate Kinase Deficiency</li> <li>• Transfusion Dependent Beta Thalassemia</li> </ul>	<ul style="list-style-type: none"> <li>• \$327,607 per year</li> <li>• \$331,200 per year</li> <li>• \$2.8 million per 1 time treatment</li> </ul>	<ul style="list-style-type: none"> <li>• Rare disease affecting approximately 1 per million</li> <li>• Rare disease affecting approximately 3-9 per 1 million</li> <li>• Gene Therapy; approximately 3 members might qualify</li> </ul>
2	Spevigo®  Tavneos®	<ul style="list-style-type: none"> <li>• Pustular Psoriasis</li> <li>• ANCA vasculitis</li> </ul>	<ul style="list-style-type: none"> <li>• \$51,133 per dose</li> <li>• \$173,383 per year</li> </ul>	<ul style="list-style-type: none"> <li>• Up to 2 doses</li> <li>• Rare disease affecting approximately 5-10 per 100,000</li> </ul>
3	Besremi®  Vonjo®	<ul style="list-style-type: none"> <li>• Polycythemia Vera</li> <li>• Myelofibrosis</li> </ul>	<ul style="list-style-type: none"> <li>• \$189,488 per year</li> <li>• \$257,155 per year</li> </ul>	<ul style="list-style-type: none"> <li>• Rare disease affecting approximately 50 per 100,00 most often in those over 60 years of age</li> <li>• Rare disease affecting approximately 1.5 per 100,000</li> </ul>
4	Xenpozyme™	<ul style="list-style-type: none"> <li>• Acid sphingomyelinase deficiency</li> </ul>	<ul style="list-style-type: none"> <li>• \$88,275 per year</li> </ul>	<ul style="list-style-type: none"> <li>• Rare disease (fewer than 120 diagnosed in the U.S)</li> </ul>
5	Carvykti™  Tecvayli™	<ul style="list-style-type: none"> <li>• Multiple Myeloma</li> </ul>	<ul style="list-style-type: none"> <li>• \$465,000 per 1 time treatment</li> <li>• \$364,620 per year</li> </ul>	<ul style="list-style-type: none"> <li>• Must have failed 4 or more treatments previously</li> <li>• Must have failed 4 or more treatments previously</li> </ul>

## Oklahoma Health Care Authority Board Meeting – Drug Summary

6	Tezspire®	• Asthma	• \$47,229 per year	• Severe asthma which has not responded to appropriate therapy
7	Adbry™ Cibinqo™	• Atopic Dermatitis	• \$45,208 per year • 58,967 per year	• Not first line treatment • Not first line treatment
8	Skysona®	• Cerebral Adrenoleukodystrophy (CALD)	• \$3 million per 1 time treatment	• Boys 4-17 years of age with early active CALD; There are 3 members with this diagnosis in claims history

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



**Recommendation 1: Vote to Prior Authorize Enjaymo™, Pyrukynd®, and Zynteglo®**

The Drug Utilization Review Board recommends the prior authorization of Enjaymo™ (Sutimlimab-jome), Pyrukynd®(Mitapivat), and Zynteglo® (Betibeglogene Autotemcel) with the following criteria:

**Enjaymo™ (Sutimlimab-jome) Approval Criteria:**

1. An FDA approved diagnosis of primary cold agglutinin disease confirmed by the following:
  - a. Chronic hemolysis; and
  - b. Positive direct antiglobulin (Coombs) test for C3d; and
  - c. Cold agglutinin titer of  $\geq 64$  at 4° Celsius; and
2. Member must have 1 or more symptoms associated with cold agglutinin disease (i.e., symptomatic anemia, acrocyanosis, Raynaud's phenomenon, hemoglobinuria, a major adverse vascular event); and
3. Member has a history of at least 1 documented red blood cell (RBC) transfusion within 6 months of initiation; and
4. Member has a hemoglobin (Hgb) level  $\leq 10\text{g/dL}$ ; and
5. Member has a bilirubin level above the normal reference range; and
6. Enjaymo™ must be prescribed by a hematologist (or an advanced care practitioner with a supervising physician who is a hematologist); and
7. Member has not received rituximab within 3 months of initiation and will not be using rituximab concomitantly with Enjaymo™; and
8. Prescriber must verify the member has been vaccinated against encapsulated bacteria (e.g., *Neisseria meningitidis*, *Streptococcus pneumoniae*, *Haemophilus influenzae*) at least 2 weeks prior to initiation of treatment; and
9. Enjaymo™ must be administered in a health care setting by a health care provider prepared to manage anaphylaxis; and
10. Prescriber must agree to monitor the member for at least 2 hours following the initial infusion for signs or symptoms of an infusion and/or hypersensitivity reaction and for 1 hour following completion of subsequent infusions; and
11. Prescriber must verify the member has no chronic systemic infections [e.g., hepatitis B, hepatitis C, human immunodeficiency virus (HIV)]; and
12. 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
13. Initial approvals will be for 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to therapy, as confirmed by at least 1 of the following:

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- a. Member has had an increase in Hgb level  $\geq 2\text{g/dL}$  from baseline; or
- b. Member has had normalization of Hgb level to  $\geq 12\text{g/dL}$ ; or
- c. Member has had a decreased number of RBC transfusions since initiation of therapy

**Pyrukynd® (Mitapivat) Approval Criteria:**

1. An FDA approved indication of hemolytic anemia in adults with pyruvate kinase (PK) deficiency confirmed by the following:
  - a. Presence of at least 2 variant alleles in the pyruvate kinase liver and red blood cell (PKLR) gene, with at least 1 missense variant; and
    - i. Hemoglobin (Hgb)  $\leq 10\text{g/dL}$ ; or
    - ii. Member has received  $\geq 6$  red blood cell (RBC) transfusions in the past year; and
2. Pyrukynd® must be prescribed by a hematologist (or an advanced care practitioner with a supervising physician who is a hematologist); and
3. Member must not have moderate or severe hepatic impairment; and
4. If Pyrukynd® is to be discontinued, prescriber must verify dose will be tapered gradually according to Pyrukynd® Prescribing Information and member will be monitored for signs of acute hemolysis and worsening anemia; and
5. Prescriber must agree to monitor Hgb levels and follow dose titration and maintenance according to Pyrukynd® Prescribing Information; and
6. Approvals will be for the duration of 6 3 months, after which time the prescriber must provide Hgb levels to support a dose increase or continuation of current dose; and
7. Pyrukynd® should be discontinued in members who do not show evidence of therapeutic benefit (i.e., Hgb increase of  $\geq 1.5\text{mg/dL}$  from baseline, reduction in number of transfusions, improvement in hemolysis laboratory assessments) by week 24. Members will be granted short term approval to allow for gradual tapering per package labeling.

**Zynteglo® (Betibeglogene Autotemcel) Approval Criteria:**

1. An FDA approved indication for the treatment of adult and pediatric members with beta thalassemia who require regular red blood cell (RBC) transfusions; and
2. Member must be 4 years of age or older; and
3. Member must weigh  $\geq 6\text{kg}$ ; and

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4. Member must require regular RBC transfusions as demonstrated by the following: a. History of  $\geq 100\text{mL/kg/year}$  transfusions of packed RBCs in the last 2 years; or b.  $\geq 8$  transfusions of packed RBCs per year in the last 2 years; and
5. Zynteglo® must be prescribed by a hematologist with expertise in the treatment of beta thalassemia and the administration of Zynteglo®; and
6. Member must not have a known and available human leukocyte antigen (HLA)-matched sibling donor; and
7. Member must not have a prior history of hematopoietic stem cell transplantation (HSCT); and
8. Member must have a negative serology test for human immunodeficiency virus (HIV) prior to apheresis; and
9. Prescriber must verify the member is clinically stable and eligible to undergo HSCT (HSCT must be appropriate for a member to be treated with Zynteglo®); and
10. Female members must not be pregnant and must have a negative pregnancy test prior to the start of mobilization, prior to conditioning procedures, and prior to Zynteglo® administration; and
11. Male and female members of reproductive potential must use an effective method of contraception from the start of mobilization through at least 6 months after administration of Zynteglo®; and
12. Prescriber must verify male and female members of reproductive potential have been counseled on the potential effects of myeloablative conditioning on fertility and the potential risk of infertility is acceptable to the member; and
13. Prescriber must evaluate the potential for drug interactions, according to package labeling, prior to and after administration of Zynteglo®; and
14. Member will not be approved for treatment with Reblozyl® (luspatercept-aamt) following Zynteglo® infusion (current authorizations for luspatercept-aamt will be discontinued upon Zynteglo® approval); and
15. Prescriber must verify member will be monitored for hematologic malignancies lifelong, with a complete blood count (with differential) performed at month 6 and month 12 after treatment with Zynteglo®, then at least annually thereafter for at least 15 years, and with integration site analysis at months 6, 12, and as warranted; and
16. Zynteglo® must be administered at a Zynteglo® qualified treatment center, and the receiving facility must have a mechanism in place to track the patient-specific Zynteglo® dose from receipt to storage to administration; and
17. Approvals will be for 1 dose per member per lifetime.

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**Recommendation 2: Vote to Prior Authorize Spevigo® and Tavneos®**

The Drug Utilization Review Board recommends the prior authorization of Spevigo® (Spesolimab-sbzo) and Tavneos® (Avacopan) with the following criteria:

**Spevigo® (Spesolimab-sbzo) Approval Criteria:**

1. An FDA approved indication for the treatment of generalized pustular psoriasis (GPP) flares (GPP diagnosis should be verifiable in the member's diagnosis history); and
2. Prescriber must verify at least 1 of the following: a. Member has experienced >1 flare (relapsing GPP); or b. Member has symptoms persisting for >3 months (persistent GPP); and
3. Member must be currently experiencing a moderate-to-severe GPP flare meeting all the following criteria:
  - a. Generalized Pustular Psoriasis Physician Global Assessment (GPPPGA) total score must be provided and must be  $\geq 3$ ; and
  - b. Presence of fresh pustules (new appearance or worsening of pustules); and
  - c. GPPPGA pustulation sub-score must be provided and must be  $\geq 2$ ; and
  - d.  $\geq 5\%$  of body surface area (BSA) covered with erythema and the presence of pustules; and
4. Member must be 21 years of age or older; and
5. Must be prescribed by a dermatologist or other specialist with expertise in the treatment of GPP (or an advanced care practitioner with a supervising physician who is a dermatologist or other specialist with expertise in the treatment of GPP); and
6. Prescriber must submit documentation of negative tuberculosis (TB) test or initiation of anti-TB therapy for latent TB prior to initiation of therapy with Spevigo®; and
7. Prescriber must verify the member does not have any clinically significant active infections and the member will be monitored for active infections prior to each dose of Spevigo®; and
8. Approvals will be for 1 dose of Spevigo®. A second dose of Spevigo® may be approved 1 week after the first dose if the prescriber submits documentation that the member has been evaluated and continues to experience GPP flare symptoms; and
9. A quantity limit of 2 doses per year will apply (the safety and efficacy of additional doses of Spevigo® have not been assessed); and
  - a. Requests for additional doses of Spevigo® to treat new GPP flares occurring within 1 year (after successful resolution of the previous flare) will be reviewed on a case-by-case basis and will require the prescriber to submit patient-specific, clinically significant information documenting the clinical necessity of additional

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treatment despite the lack of adequate safety and efficacy data;  
and

10. Subsequent requests for new GPP flares (after 1 year) will require the member to meet all initial approval criteria, and information regarding the member's response to previous treatment with Spevigo® must be submitted. Members who did not experience resolution of pustules after previous treatment will not be approved for additional use of Spevigo®.

**Tavneos® (Avacopan) Approval Criteria:**

1. An FDA approved diagnosis as adjunctive treatment of adult members with severe active anti-neutrophil cytoplasmic autoantibody (ANCA)-associated vasculitis [granulomatosis with polyangiitis (GPA) or microscopic polyangiitis (MPA)] in combination with standard therapy including corticosteroids; and
2. Member must be 18 years of age or older; and
3. Tavneos® must be used in combination with standard immunosuppressive therapy including corticosteroids; and
4. Prescriber must agree to monitor liver function tests prior to initiating Tavneos®, every 4 weeks after the start of therapy for the first 6 months of treatment, and as clinically indicated thereafter; and
5. Prescriber must agree to screen the member for hepatitis B virus (HBV) infection prior to initiating treatment with Tavneos®; and
6. Prescriber must verify the member has no active, serious infections, including localized infections and will closely monitor member for the development of signs and symptoms of infection during and after treatment with Tavneos®; and
7. A quantity limit of 180 tablets per 30 days will apply.

**Recommendation 3: Vote to Prior Authorize Besremi® and Vonjo®**

The Drug Utilization Review Board recommends the prior authorization of Besremi® (Ropeginterferon Alfa-2b-njft) and Vonjo® (Pacritinib) with the following criteria:

**Besremi® (Ropeginterferon Alfa-2b-njft) Approval Criteria [Polycythemia Vera (PV) Diagnosis]:**

1. Diagnosis of PV; and
2. Used as a single agent.

**Vonjo® (Pacritinib) Approval Criteria [Myelofibrosis (MF) Diagnosis]:**

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1. Diagnosis of intermediate or high-risk primary or secondary MF; and
2. Platelet count <50 x 10<sup>9</sup>/L.

**Recommendation 4: Vote to Prior Authorize Xenpozyme™**

The Drug Utilization Review Board recommends the prior authorization of Xenpozyme™ (Olipudase Alfa-rpcp) with the following criteria:

**Xenpozyme™ (Olipudase Alfa-rpcp) Approval Criteria:**

1. An FDA approved diagnosis of acid sphingomyelinase deficiency (ASMD) type B, or A/B confirmed by:
  - a. Documented lab results verifying <10% of acid sphingomyelinase (ASM) activity from control; or
  - b. Molecular genetic testing confirming a mutation in the SMPD1 gene; and
2. Documentation of baseline AST and ALT within 1 month prior to treatment initiation or within 72 hours prior to treatment escalation; and
3. Member's weight (kg) and body mass index (BMI) within the last 3 weeks must be provided to ensure accurate weight-based dosing; and
  - a. BMI ≤30: The dosage is based on actual body weight (kg); or
  - b. BMI >30: The dosage is based on adjusted body weight; and
4. Female members of reproductive potential must have a negative pregnancy test prior to initiation and must agree to use effective contraception during treatment and for 2 weeks after the final dose of Xenpozyme™; and
5. Prescriber must verify ALT and AST will be assessed to manage the risk of elevated transaminases as directed by the Xenpozyme™ Prescribing Information; and
6. Xenpozyme™ must be administered by a health care provider prepared to manage anaphylaxis. Approvals will not be granted for selfadministration. Prior authorization requests must indicate how Xenpozyme™ will be administered; and
  - a. Xenpozyme™ must be shipped via cold chain supply to the health care facility where the member is scheduled to receive treatment; or
  - b. Xenpozyme™ must be shipped via cold chain supply to the member's home and administered by a home health care provider prepared to manage anaphylaxis, and the member or member's caregiver must be trained on the proper storage of Xenpozyme™; and
    - i. For consideration of home administration by a home health care provider, prescriber must verify member is receiving the maintenance dose and is tolerating the Xenpozyme™ infusion well; and

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7. Xenpozyme™ must be prescribed by, or in consultation with, a specialist with expertise in the treatment of lysosomal storage disorders; 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.

**Recommendation 5: Vote to Prior Authorize Carvykti™ and Tecvayli™**

The Drug Utilization Review Board recommends the prior authorization of Carvykti™ (Ciltacabtagene Autoleucel) and Tecvayli™ (Teclistamab-cqyv) with the following criteria:

**Carvykti™ (Ciltacabtagene Autoleucel) Approval Criteria [Multiple Myeloma Diagnosis]:**

1. Diagnosis of relapsed or refractory multiple myeloma (RRMM):
  - a. Member has received ≥4 prior lines of therapy, including an immunomodulatory agent, a proteasome inhibitor, and an anti-CD38 monoclonal antibody; and
    - i. Induction with or without autologous hematopoietic stem cell transplant and with or without maintenance therapy is considered a single regimen; and
    - ii. Member must have undergone ≥2 consecutive cycles of treatment for each regimen unless progressive disease was seen after 1 cycle; and
  - b. Member must have measurable disease, including at least 1 of the following:
    - i. Serum M-protein ≥0.5g/dL; or
    - ii. Urine M-protein ≥200mg/24hr; or
    - iii. Serum free light chain (FLC) assay: involved FLC ≥10mg/dL (100mg/L); or
    - iv. Bone marrow plasma cells >30% of total bone marrow cells; and
  - c. Member must not have any central nervous system involvement with multiple myeloma; and
2. Health care facilities must be on the certified list to administer chimeric antigen receptor (CAR) T-cells and must be trained in the management of cytokine release syndrome (CRS), neurologic toxicities, and comply with the risk evaluation and mitigation strategy (REMS) requirements; and
3. Approvals will be for 1 dose per member per lifetime.

**Tecvayli™ (Teclistamab-cqyv) Approval Criteria [Multiple Myeloma Diagnosis]:**

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1. Diagnosis of relapsed or refractory multiple myeloma; and
2. Member has received  $\geq 4$  prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent, and an anti-CD38 antibody; and
3. Health care facilities must be trained in the management of cytokine release syndrome (CRS), neurologic toxicities, and comply with the risk evaluation and mitigation strategy (REMS) requirements.

**Recommendation 6: Vote to Prior Authorize Tezspire®**

The Drug Utilization Review Board recommends the prior authorization of Tezspire® (Tezepelumab-ekko) with the following criteria:

**Tezspire® (Tezepelumab-ekko) Approval Criteria:**

1. An FDA approved diagnosis of add-on maintenance treatment for severe asthma; and
2. Member must be 12 years of age or older; and
3. Member must have experienced  $\geq 2$  asthma exacerbations requiring oral or injectable corticosteroids or that resulted in hospitalization in the last 12 months; and
4. Member must have failed a medium-to-high dose inhaled corticosteroid (ICS) used compliantly for at least the past 12 months (for ICS/LABA combination products, the ICS component would meet criteria at an equivalent medium-to-high dose); and
5. Member must have failed at least 1 other asthma controller medication used in addition to the medium to high dose ICS compliantly for at least the past 3 months; and
6. Tezspire® must be administered by a health care provider prepared to manage anaphylaxis; and
7. Tezspire® must be prescribed by an allergist, pulmonologist, or pulmonary specialist, or the member must have been evaluated by an allergist, pulmonologist, or pulmonary specialist within the last 12 months (or an advanced care practitioner with a supervising physician who is an allergist, pulmonologist, or pulmonary specialist); and
8. Initial approvals will be for the duration of 6 months after which time compliance will be evaluated for continued approval; and
9. A quantity limit of 1.91mL (1 single-dose glass vial or single-dose pre-filled syringe) per 28 days will apply.

**Recommendation 7 : Vote to Prior Authorize Adbry™ and Cibinqo™**

The Drug Utilization Review Board recommends the prior authorization of Adbry™ (Tralokinumab-ldrm) and Cibinqo™ (Abrocitinib) with the following criteria:



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**Adbry™ (Tralokinumab-ldrm Injection) Approval Criteria:**

1. An FDA approved diagnosis of moderate-to-severe atopic dermatitis not adequately controlled with topical prescription therapies or when those therapies are not advisable; and
2. Member must be 18 years of age or older; and
3. Member must have a documented trial within the last 6 months for a minimum of 2 weeks that resulted in failure with both of the following topical therapies (or have a contraindication or documented intolerance):
  - a. 1 medium potency to very-high potency Tier-1 topical corticosteroid; and
  - b. 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
4. Adbry™ must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
5. Requests for concurrent use of Adbry™ with other biologic medications will be reviewed on a case-by-case basis and will require patient-specific information to support the concurrent use (Adbry™ has not been studied in combination with other biologic therapies); and
6. Initial approvals will be for the duration of 16 weeks. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

**Cibinqo™ (Abrocitinib) Approval Criteria [Atopic Dermatitis (AD) Diagnosis]:**

1. An FDA approved diagnosis of moderate-to-severe AD not adequately controlled with other systemic drug products, including biologics, or when those therapies are not advisable; and
2. Member must be 18 years of age or older; and
3. Member must have a documented trial within the last 6 months for a minimum of 2 weeks that resulted in failure with both of the following topical therapies (or have a contraindication or documented intolerance):
  - a. 1 medium potency to very-high potency Tier-1 topical corticosteroid; and
  - b. 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
4. Member must have a documented 16-week trial with Adbry™ (tralokinumab-ldrm) or Dupixent® (dupilumab) that resulted in

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- inadequate response (or have a contraindication or documented intolerance); and
5. Requested medication must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
  6. Prescriber must verify the member will not use antiplatelet therapies (e.g., clopidogrel, prasugrel, ticagrelor) concurrently with Cibinqo™, except for low-dose aspirin, during the first 3 months of treatment; and
  7. Cibinqo™ will not be approved for use in combination with other Janus kinases (JAK) inhibitors, biologic immunomodulators, or with other immunosuppressant medications; and
  8. Initial approvals will be for the duration of 3 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

**Recommendation 8: Vote to Prior Authorize Skysona®**

The Drug Utilization Review Board recommends the prior authorization of Skysona® (Elivaldogene Autotemcel) with the following criteria:

**Skysona® (Elivaldogene Autotemcel) Approval Criteria:**

1. An FDA approved diagnosis of early, active cerebral adrenoleukodystrophy (CALD) in male members 4 to 17 years of age; and
2. Diagnosis must be confirmed by all of the following:
  - a. Molecular genetic testing confirming a mutation in the *ABCD1* gene; and
    - i. Members must not have a full deletion of the *ABCD1* gene; and
  - b. Lab results indicating elevated very long-chain fatty acids (VLCFAs); and
  - c. Active central nervous system (CNS) disease established by central radiographic review of brain magnetic resonance imaging (MRI) demonstrating the following:
    - i. Loes score between 0.5 and 9 on the 34-point scale; and
    - ii. Gadolinium enhancement (GdE+) on MRI of demyelinating lesions; and
  - d. Neurological Function Score (NFS) of  $\leq 1$ ; and
3. Skysona® must be prescribed by a neurologist, endocrinologist, or hematologist/oncologist with expertise in the treatment of CALD and the administration of Skysona®; and

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4. Member must not have a known and available human leukocyte antigen (HLA)-matched sibling donor; and
5. Member must not have a prior history of hematopoietic stem cell transplantation (HSCT); and
6. Member must not be taking statins, Lorenzo's oil, or dietary regimens used to lower VLCFA levels; and
7. Member must not have an immediate family member with known or suspected familial cancer syndrome (FCS); and
8. Member must have a negative serology test for human immunodeficiency virus (HIV) prior to apheresis according to the package labeling; and
9. Prescriber must verify the member is clinically stable and eligible to undergo HSCT (HSCT must be appropriate for a member to be treated with Skysona®); and
10. Members of reproductive potential must use an effective method of contraception from the start of mobilization through at least 6 months after administration of Skysona®; and
11. Prescriber must verify members of reproductive potential have been counseled on the potential effects of myeloablative conditioning on fertility and the potential risk of infertility is acceptable to the member or member's caregiver; and
12. Prescriber must evaluate the potential for drug interactions, according to package labeling, prior to and after administration of Skysona®; and
13. Prescriber must verify member will be monitored for hematologic malignancies lifelong, with a complete blood count (with differential) performed at month 6 and month 12 after treatment with Skysona®, then at least annually thereafter for at least 15 years, and with integration site analysis at months 6, 12, and as warranted; and
14. Skysona® must be administered at a Skysona® qualified treatment center, and the receiving facility must have a mechanism in place to track the patient-specific Skysona® dose from receipt to storage to administration; and
15. Approvals will be for 1 dose per member per lifetime.

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**SUBMITTED TO THE C.E.O. AND BOARD ON JANUARY 18, 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**

<b>Services</b>	SoonerSelect Medical
<b>Purpose and Scope</b>	<p>OHCA is seeking a Contractor for the following:</p> <ul style="list-style-type: none"> <li>• Improve health outcomes</li> <li>• Achieve delivery system reform focused on improving health outcomes while maintaining fiscal responsibility</li> <li>• Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume</li> <li>• Improve SoonerCare Eligibles' access to and satisfaction with necessary services</li> <li>• Contain costs through efficient care coordination</li> <li>• Increase cost predictability to the State</li> </ul>
<b>Mandate</b>	The SoonerSelect Medical program has been designed to advance Governor Stitt's plan to transform Oklahoma into a Top Ten state in health outcomes. OHCA is pursuing a medical managed care approach that will allow the state to improve the health of Oklahomans as outlined in SB1337.
<b>Procurement Method</b>	Competitive Bid
<b>External Approvals</b>	CMS
<b>New Contract Term</b>	Initial Contract shall begin upon final execution (signed) of the Contract through June 30, 2025, with five (5) one (1) year renewal periods

**BUDGET**

<b>Amount requested for approval</b>	\$20,226,736,282.00
<b>Federal Match Percentage(s) within the Total Contract Not-to-Exceed</b>	FMAP

**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 for the Medical Managed Care services described above for six (6) years with a total not-to-exceed of \$20,226,736,282.

**Additional Information****Contract Term, Including all Optional Renewal Years**

(Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)

**Total Contract Not-to-Exceed Requested for Approval.**

(Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by \$125,000.00 or more, the contract increase shall require additional Board approval.)

**Federal Match Percentage(s)**

(CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

**SUBMITTED TO THE C.E.O. AND BOARD ON JANUARY 18, 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**

<b>Services</b>	SoonerSelect Dental
<b>Purpose and Scope</b>	<p>The Oklahoma Health Care Authority (OHCA) is seeking a Contractor for the following:</p> <ul style="list-style-type: none"> <li>• Improve health outcomes for Oklahomans.</li> <li>• Improving access to oral healthcare including preventive and restorative services.</li> <li>• Developing high-quality outreach and education materials and regularly scheduled outreach activities for Dental Health Plan Enrollees.</li> <li>• Building collaborations between medical and dental professionals.</li> <li>• Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume;</li> <li>• Improve SoonerCare Eligibles' access to and satisfaction with necessary services;</li> <li>• Contain costs through better coordinating services; and</li> <li>• Increase cost predictability to the State.</li> </ul>
<b>Mandate</b>	As outlined in SB1337
<b>Procurement Method</b>	Competitive bid
<b>External Approvals</b>	CMS
<b>Contract Term</b>	Initial Contract shall begin upon final execution (signed) of the Contract and terminate on June 30, 2024, with options to renew for five (5) additional one (1) year periods.

**BUDGET**

<b>Amount requested for Approval</b>	\$1,104,783,760.00
<b>Federal Match Percentage(s) within the Total Contract Not-to-Exceed</b>	FMAP

**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 SoonerSelect Dental program services as described above for one (1) year plus five (5) additional renewal years for a total not-to-exceed of \$1,104,783,760.00.

**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 \$1,000,000.00 or more, the contract increase shall require additional Board approval.)

**Federal Match Percentage(s)**

(CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)



**SUBMITTED TO THE C.E.O. AND BOARD ON JANUARY 18, 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**

<b>Services</b>	SoonerSelect Children's Specialty
<b>Purpose and Scope</b>	<p>OHCA is seeking a Contractor for the following:</p> <ul style="list-style-type: none"> <li>• Provide medical, behavioral health, and pharmacy services to the following Medicaid populations: children in foster care, former foster care children up to twenty-five (25) years of age, juvenile justice involved children, and children receiving adoption assistance.</li> <li>• Achieve delivery system reform focused on improving health outcomes while maintaining fiscal responsibility</li> <li>• Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume</li> <li>• Improve SoonerCare Eligibles' access to and satisfaction with necessary services</li> <li>• Contain costs through more efficient coordination of services</li> <li>• Increase cost predictability to the State</li> </ul>
<b>Mandate</b>	The SoonerSelect Children's Specialty program has been designed to advance Governor Stitt's plan to transform Oklahoma into a Top Ten state in health outcomes. OHCA is pursuing a managed care approach that will allow the state to improve the health of Oklahoman as outlined in SB1337.
<b>Procurement Method</b>	Competitive Bid
<b>External Approvals</b>	CMS
<b>New Contract Term</b>	Initial Contracts shall begin upon final execution (signed) of the Contract thru June 30, 2025, with five (5) one (1) year renewal periods

**BUDGET**

<b>Amount requested for approval</b>	\$1,488,739,188.00
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**Federal Match Percentage(s) within the Total  
Contract Not-to-Exceed**

FMAP

**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 for the Medical Managed Care services described above for six (6) years with a total not-to-exceed of \$1,488,739,188.

## **Additional Information**

### **Contract Term, Including all Optional Renewal Years**

(Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)

### **Total Contract Not-to-Exceed Requested for Approval.**

(Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by \$125,000.00 or more, the contract increase shall require additional Board approval.)

### **Federal Match Percentage(s)**

(CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

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**SUBMITTED TO THE C.E.O. AND BOARD ON JANUARY 18, 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**

<b>Services</b>	Electronic referral system for license utilizers of the platform to address the social determinants of Sooner Care Members.
<b>Purpose and Scope</b>	<p>To procure access to a Closed Loop Electronic Referral System (CLERS) to coordinate electronic referrals between organizations on a common technology platform for the purpose of addressing the Social Determinants of Health (SDOH) of individuals in need.</p> <p>OHCA is seeking a Contractor for the following:</p> <ul style="list-style-type: none"> <li>• To maintain a CLERS to coordinate electronic referrals between organizations on a common technology platform to enable OHCA, its Authorized Users, SoonerCare contracted health care providers, and Community Based Organization (CBOs) to access the Network.</li> <li>• To provide Customer 240 licenses to use the Service Software within the Territory to be distributed by OHCA staff.</li> </ul>
<b>Mandate</b>	N/A
<b>Procurement Method</b>	Competitive Bid
<b>External Approvals</b>	N/A
<b>Contract Term</b>	Initial Contract effective upon signature through June 30, 2023 with five (5) options to renew.

**BUDGET**

<b>Amount requested for approval</b>	\$3,000,000.00
<b>Federal Match Percentage(s) within the Total Contract Not-to-Exceed</b>	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 electronic referral system for license utilizers of the platform to address the social determinants of Sooner Care Members as described above for one base year and five (5) renewal periods each funded at \$500,000.00 for a total not-to-exceed of \$3,000,000.00.

## **Additional Information**

### **Contract Term, Including all Optional Renewal Years**

(Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)

### **Total Contract Not-to-Exceed Requested for Approval.**

(Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by \$125,000.00 or more, the contract increase shall require additional Board approval.)

### **Federal Match Percentage(s)**

(CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

**SUBMITTED TO THE C.E.O. AND BOARD ON JANUARY 18, 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**

<b>Services</b>	Electronic Visit and Verification (EVV) system and licenses
<b>Purpose and Scope</b>	<p>Oklahoma's goal is to acquire and utilize an Electronic Visit Verification System that adheres to CMS's Open Vendor Model. In accordance with this Open Vendor Model, Oklahoma will establish the EVV processing standards, offer a front-end application for EVV visit data collection, and compile EVV visit-related data from other systems.</p> <p>Supplier will build a robust, customizable, value-based system that can:</p> <ul style="list-style-type: none"> <li>• Incorporate innovative cutting-edge technologies to improve user experiences</li> <li>• Be expandable in the future for additional users and provider agencies</li> <li>• Be flexible to meet State and Federal policy changes</li> <li>• Be collaborative with OHCA staff with respect for the staffing limitations within the Agency and their other commitments</li> </ul>
<b>Mandate</b>	42 U.S. Code § 1396b
<b>Procurement Method</b>	Competitive Bid
<b>External Approvals</b>	CMS
<b>New Contract Term</b>	Initial Contract effective upon signature through June 30, 2023 with four (4) options to renew.

**BUDGET**

<b>Amount requested for approval</b>	\$13,900,000.00
<b>Federal Match Percentage(s) within the Total Contract Not-to-Exceed</b>	50%, 90%

**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 and maintain an EVV reporting system and licenses as described above for up to five (5) years with a base year expense of \$1,900,000.00 and four (4) renewals at \$3,000,000.00 each for a total not-to-exceed of \$13,900,000.00.

**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 day for cause, 60 day without cause, and non-renewal terminations.)

**Total Contract Not-to-Exceed Requested for Approval.**

(Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by \$125,000.00 or more, the contract increase shall require additional Board approval.)

**Federal Match Percentage(s)**

(CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)



## **January Board Proposed Rule Amendment Summaries**

These proposed emergency rules were presented at the Nov. 1, 2022, Tribal Consultation, and at the Jan. 5, 2023, Medical Advisory Committee (MAC) Meeting.

All the proposed rules were subject to a 15-day public comment period.

The Agency is requesting the effective date to be immediately upon receiving gubernatorial approval. The Governor will have until March 6, 2023, to approve or disapprove each rule, upon the Agency's submission for gubernatorial review.

**APA WF # 22-11 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visit and Sick Visit on the Same Day** – Policy will be revised to allow reimbursement for an EPSDT visit and a sick visit that occur on the same date of service, when it is deemed medically appropriate. The revisions will outline the requirements that must be met including, but not limited to, separate documentation/note to justify additional condition(s), information on the appropriate use of Modifier 25, a provider's ability to only claim the additional time required above and beyond the completion of the EPSDT screening, and clarification that any health problem that is encountered in the EPSDT screening and does not require significant additional work will be included in the EPSDT visit and should not be billed separately.

**Budget Impact:** The estimated budget impact, for SFY2023, will be an increase in the total amount of \$418,468; with \$115,665 in state share. The estimated budget impact, for SFY2024 will be an increase in the total amount of \$1,255,404; with \$409,513 in state share.

**APA WF # 22-21A & 22-21B\* Increase Income Standard for Pregnant Women and Extend Postpartum Coverage** – The proposed policy revisions will expand Medicaid eligibility for pregnant women by increasing the federal poverty level (FPL) percentage income standard from 133% to 185%, or 210% FPL once converted to MAGI and applying the applicable MAGI disregards. Additionally, the proposed revisions will extend Medicaid postpartum coverage from sixty (60) days to twelve (12) months. This new coverage option afforded through the American Rescue Plan Act was made permanent with the passing of the 2023 Consolidated Appropriations Act.

**Budget Impact:** The estimated budget impact, for SFY 2023, will be an increase in the total amount of \$6,150,000; with \$1,509,210 in state share. The estimated budget impact, for SFY 2024, will be an increase in the total amount of \$12,300,000; with \$4,054,326 in state share.

**APA WF # 22-22 Ukrainian Humanitarian Parolees** – Policy will be updated to comply with Public Law 117-128, which entitles certain Ukrainian nationals who enter the United States, during a designated period of time, to receive SoonerCare services provided all other eligibility factors are met. Ukrainian humanitarian parolees are eligible for the same benefits available to refugees admitted under Section 207 of the Immigration and Nationality Act, except for the program of initial resettlement.

**Budget Impact:** The estimated budget impact, for SFY 2023, will be an increase in the total amount of \$323,915; with \$62,517 in state share. The estimated budget impact, for SFY 2024, will be an increase in the total amount of \$680,220, with \$211,419 in state share.

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\* Work folders are divided into multiple submissions when the rule proposes to change more than one Chapter of Title 317.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 4. EARLY AND PERIODIC SCREENING, DIAGNOSTIC  
AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES**

**317:30-3-65. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program/Child-health Services**

Payment is made to eligible providers for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services on behalf of eligible individuals under the age of twenty-one (21).

(1) The EPSDT program is a comprehensive child-health program, designed to ensure the availability of, and access to, required health care resources and help parents and guardians of Medicaid-eligible children and adolescents use these resources. An effective EPSDT program assures that health problems are diagnosed and treated early before they become more complex and their treatment more costly. The physician plays a significant role in educating parents and guardians about all services available through the EPSDT program. The receipt of an identified EPSDT screening makes the member eligible for all necessary follow-up care that is within the scope of the SoonerCare program. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) covers services, supplies, or equipment that are determined to be medically necessary for a child or adolescent, and which are included within the categories of mandatory and optional services in Section 1905(a) of Title XIX, regardless of whether such services, supplies, or equipment are listed as covered in Oklahoma's Medicaid State Plan.

(2) Federal regulations also require that the State set standards and protocols for each component of EPSDT services. The standards must provide for services at intervals which meet reasonable standards of medical and dental practice. The standards must also provide for EPSDT services at other intervals as medically necessary to determine the existence of certain physical or behavioral health illnesses or conditions.

(3) SoonerCare providers who perform EPSDT screenings must assure that the screenings they provide meet the minimum standards established by the Oklahoma Health Care Authority in order to be reimbursed at the level established for EPSDT services.

(4) An EPSDT screening is considered a comprehensive examination. ~~A provider billing SoonerCare for an EPSDT screen may not bill any other Evaluation and Management Current Procedure Terminology (CPT) code for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. However, there may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some services as set out in this section may require prior authorization.~~

(A) If a member is receiving an EPSDT screening and an additional focused complaint arises that requires evaluation and management to address the complaint, the provider may deliver all medically necessary care and submit a claim for both the EPSDT screening and the appropriate level of focused service if the following requirements are met:

- (i) The medical issue is significant enough to require additional work to address the issue;
- (ii) The visit is documented on a separate note;

(iii) Appropriate documentation that clearly lists the condition being managed at the time of the encounter and supports the billing of both services; and

(iii) Modifier 25 is added to the appropriate code that indicates that a separate evaluation and management service was provided by the same physician on the same day as the EPSDT screening. All claims submitted with Modifier 25 will be reviewed prior to payment, per Oklahoma Administrative Code (OAC) 317:30-3-33. The following items will be reviewed prior to any payment:

(I) Medical necessity;

(II) Appropriate utilization of Modifier 25; and

(III) All documentation to support both the EPSDT screening and the additional evaluation and management for a focused complaint must be submitted for review.

(iv) All claims are subject to a post payment review by the OHCA's Program Integrity Unit.

(B) When providing evaluation and management of a focused complaint, during an EPSDT screening, the provider may claim only the additional time that is required above and beyond the completion of the EPSDT screening.

(C) An insignificant or trivial problem that is encountered in the process of performing the preventive evaluation and management service and does not require additional work is included in the EPSDT visit and should not be billed/reported.

(5) There may be other additional diagnostic procedures or treatments not normally considered part of a comprehensive examination, including diagnostic tests and administration of immunizations, required at the time of screening. Additional diagnostic procedures or treatments may be billed independently from the screening. Some services as set out in this section may require prior authorization.

~~(5)~~(6) For an EPSDT screening to be considered a completed reimbursable service, providers must perform, and document, all required components of the screening examination. Documentation of screening services performed must be retained for future review.

~~(6)~~(7) All comprehensive screenings provided to individuals under age twenty-one (21) must be filed on HCFA-1500 using the appropriate preventive medicine procedure code or an appropriate Evaluation and Management code from the Current Procedural Terminology Manual (CPT) accompanied by the appropriate "V"well-child exam diagnosis code.

~~(7)~~(8) For EPSDT services in a school-based setting that are provided pursuant to an IEP, please refer to Part 103, Qualified Schools As Providers Of Health-Related Services, in ~~Oklahoma Administrative Code~~OAC 317:30-5-1020 through 317:30-5-1028.

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 3. GENERAL MEDICAL PROGRAM INFORMATION**

**317:30-3-57. General SoonerCare coverage - categorically needy**

The following are general SoonerCare coverage guidelines for the categorically needy:

- (1) Inpatient hospital services.
  - (A) Adult coverage for inpatient hospital stays as described at Oklahoma Administrative Code (OAC) 317:30-5-41.
  - (B) Coverage for members under twenty-one (21) years of age is not limited. All admissions must be medically necessary. All psychiatric admissions require prior authorization for an approved length of stay.
- (2) Emergency department services.
- (3) Dialysis in an outpatient hospital or freestanding dialysis facility.
- (4) Outpatient therapeutic radiology or chemotherapy for proven malignancies or opportunistic infections.
- (5) Outpatient surgical services - facility payment for selected outpatient surgical procedures to hospitals which have a contract with the Oklahoma Health Care Authority (OHCA).
- (6) Outpatient mental health services for medical and remedial care including services provided on an outpatient basis by certified hospital-based facilities that are also qualified mental health clinics.
- (7) Rural health clinic services and other ambulatory services furnished by rural health clinic.
- (8) Optometrists' services - only as listed in Subchapter 5, Part 45, Optometrist specific rules of this Chapter.
- (9) Maternity clinic services.
- (10) Outpatient diagnostic x-rays and lab services. Other outpatient services provided to adults, not specifically addressed, are covered only when prior authorized by the Agency's Medical Authorization Unit.
- (11) Medically necessary screening mammography. Additional follow-up mammograms are covered when medically necessary.
- (12) Long-term care facility services (other than services in an institution for tuberculosis or mental diseases).
- (13) Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT) are available for members under twenty-one (21) years of age to provide access to regularly scheduled examinations and evaluations of the general physical and mental health, growth, development, and nutritional status of infants, children, and youth. Federal regulations also require that diagnosis and treatment be provided for conditions identified during a screening whether or not they are covered under the State Plan, as long as federal funds are available for these services. These services must be necessary to ameliorate or correct defects and physical or mental illnesses or conditions and require prior authorization. EPSDT/OHCA child-health services are outlined in OAC 317:30-3-65.2 through 317:30-3-65.12.
  - (A) EPSDT screening examinations for eligible children by a medical or osteopathic physician, physician assistant, or advanced practice nurse practitioner.

- (B) Diagnostic x-rays, lab, and/or injections when prescribed by a provider.
  - (C) Immunizations.
  - (D) Outpatient care.
  - (E) Dental services as outlined in OAC 317:30-3-65.8.
  - (F) Optometrists' services. The EPSDT periodicity schedule provides for at least one (1) visual screening and glasses each twelve (12) months. In addition, payment is made for glasses for children with congenital aphakia or following cataract removal. Interperiodic screenings and glasses at intervals outside the periodicity schedule for optometrists are allowed when a visual condition is suspected. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
  - (G) Hearing services as outlined in OAC 317:30-3-65.9.
  - (H) Prescribed drugs.
  - (I) Outpatient psychological services as outlined in OAC 317:30-5-275 through 317:30-5-278.
  - (J) Inpatient psychiatric services as outlined in OAC 317:30-5-94 through 317:30-5-97.
  - (K) Transportation. Provided when necessary in connection with examination or treatment when not otherwise available.
  - (L) Inpatient hospital services.
  - (M) Medical supplies, equipment, appliances, orthotics and prosthetics.
  - (N) EPSDT services furnished in a qualified child health center.
- (14) Family planning services and supplies for members of child-bearing age, including counseling, insertion of intrauterine device, implantation of subdermal contraceptive device, and sterilization for members twenty-one (21) years of age and older who are legally competent, not institutionalized and have signed the "Consent Form" at least thirty (30) days prior to procedure. Reversal of sterilization procedures for the purposes of conception is not covered. Reversal of sterilization procedures are covered when medically indicated and substantiating documentation is attached to the claim.
- (15) Physicians' services whether furnished in the office, the member's home, a hospital, a long-term care facility, intermediate care facilities for individuals with intellectual disabilities (ICF/IID), or elsewhere. For adults, payment is made for compensable hospital days described at OAC 317:30-5-41. Office visits for adults are limited to four (4) per month except when in connection with conditions as specified in OAC 317:30-5-9(b).
- (16) Medical care and any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of their practice as defined by state law. See applicable provider section for limitations to covered services for:
- (A) Podiatrists' services;
  - (B) Optometrists' services;
  - (C) Psychologists' services;
  - (D) Certified registered nurse anesthetists;
  - (E) Certified nurse midwives;
  - (F) Advanced practice registered nurses; and
  - (G) Anesthesiologist assistants.
- (17) Freestanding ambulatory surgery centers.
- (18) Prescribed drugs not to exceed a total of six (6) prescriptions with a limit of two (2) brand name prescriptions per month. Exceptions to the six (6) prescription limit are:

- (A) Unlimited medically necessary monthly prescriptions for:
  - (i) Members under the age of twenty-one (21) years; and
  - (ii) Residents of long-term care facilities or ICF/IID.
- (B) Seven (7) medically necessary generic prescriptions per month in addition to the six (6) covered under the State Plan (including three (3) brand name prescriptions) are allowed for adults receiving services under the 1915(c) home and community-based services (HCBS) waivers. These additional medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions are covered with prior authorization.
- (19) Rental and/or purchase of medical supplies, equipment, and appliances.
- (20) Adaptive equipment, when prior authorized, for members residing in private ICF/IID's.
- (21) Dental services for members residing in private ICF/IID's in accordance with the scope of dental services for members under age twenty-one (21).
- (22) For non-expansion adults, prosthetic devices are limited to catheters and catheter accessories, colostomy and urostomy bags and accessories, tracheostomy accessories, nerve stimulators, hyperalimentation and accessories, home dialysis equipment and supplies, external breast prostheses and support accessories, oxygen/oxygen concentrator equipment and supplies, respirator or ventilator equipment and supplies, and those devices inserted during the course of a surgical procedure. There is no coverage for orthotic devices for adults.
- (23) Orthotics and prosthetics are covered for expansion adult members, above the limitations within (22) of this Section, when prescribed by the treating provider (physician, physician assistant, or an advanced practice registered nurse) and medical necessity is documented in accordance with OAC 317:30-5-211.13.
- (24) Standard medical supplies.
- (25) Eyeglasses under EPSDT for members under age twenty-one (21). Payment is also made for glasses for children with congenital aphakia or following cataract removal. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.
- (26) Blood and blood fractions for members when administered on an outpatient basis.
- (27) Inpatient services for members age sixty-five (65) or older in institutions for mental diseases, limited to those members whose Medicare, Part A benefits are exhausted for this particular service and/or those members who are not eligible for Medicare services.
- (28) Long-term care facility services, limited to members preauthorized and approved by OHCA for such care.
- (29) Inpatient psychiatric facility admissions for members are limited to an approved length of stay with provision for requests for extensions.
- (30) Transportation and subsistence (room and board) to and from providers of medical services to meet member's needs (ambulance or bus, etc.), to obtain medical treatment.
- (31) Extended services for pregnant women including all pregnancy-related and postpartum services to continue to be provided, as though the women were pregnant, for ~~sixty (60) days~~ twelve (12) months after the pregnancy ends regardless of the reason, beginning on the last date of pregnancy.
- (32) Long-term care facility services for members under twenty-one (21) years of age.
- (33) Personal care in a member's home, prescribed in accordance with a plan of treatment and rendered by a qualified person under supervision of a registered nurse (RN).
- (34) Medicare Part A, Part B, and Part C deductibles, coinsurance, and copays.

- (35) HCBS for the intellectually disabled.
- (36) Home health services can be provided without a PA for the first thirty-six (36) visits. A PA will be required beyond the 36<sup>th</sup> visit. The visits are limited to any combination of RN and nurse aide visits.
- (37) Medically necessary solid organ and bone marrow/stem cell transplantation services for children and adults are covered services based upon the conditions listed in (A)-(D) of this paragraph:
- (A) All transplantation services, except kidney and cornea, must be prior authorized;
  - (B) All transplant procedures are reviewed and prior authorization is based upon appropriate medical criteria;
  - (C) All organ transplants must be performed at a Medicare approved transplantation center;
  - (D) Procedures considered experimental or investigational are not covered. For more information regarding experimental or investigational including clinical trials, see OAC 317:30-3-57.1; and
  - (E) Donor search and procurement services are covered for transplants consistent with the methods used by the Medicare program for organ acquisition costs.
- (38) HCBS for intellectually disabled members who were determined to be inappropriately placed in a long-term care facility (Alternative Disposition Plan - ADP).
- (39) Case management services for the chronically and/or seriously mentally ill.
- (40) Emergency medical services, including emergency labor and delivery for undocumented or ineligible aliens.
- (41) Services delivered in Federally Qualified Health Centers (FQHCs). Payment is made on an encounter basis.
- (42) Early intervention services for children ages zero (0) to three (3).
- (43) Residential behavior management in therapeutic foster care setting.
- (44) Case management services through the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
- (45) HCBS for aged or physically disabled members.
- (46) Outpatient ambulatory services for members infected with tuberculosis.
- (47) Smoking and tobacco use cessation counseling for children and adults.
- (48) Services delivered to American Indians/Alaskan Natives (AI/AN) in Indian Health Services, Tribal Programs, and Urban Indian Clinics (I/T/Us). Payment is made on an encounter basis.
- (49) OHCA contracts with designated agents to provide disease state management for individuals diagnosed with certain chronic conditions. Disease state management treatments are based on protocols developed using evidence-based guidelines.
- (50) Residential substance use disorder (SUD) services.
- (51) Medication-assisted treatment (MAT) services.
- (52) Diabetes self-management education and support (DSMES).

## **PART 16. MATERNAL AND INFANT HEALTH LICENSED CLINICAL SOCIAL WORKERS**

### **317:30-5-208. Reimbursement**

- (a) Maternal and infant health social work services must be billed using appropriate CPT codes



and guidelines.

(b) SoonerCare does not allow more than ~~32~~thirty-two (32) units (~~15 minutes = 1 unit~~)[fifteen (15) minutes = one (1) unit] during the pregnancy which includes ~~60 days~~twelve (12) months postpartum.

(c) LCSWs that are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

(d) Only the LCSW directly performing the care or a county health department may bill the SoonerCare Program.

(e) The time indicated on the claim form must be the time actually spent with the member.

## **PART 18. GENETIC COUNSELORS**

### **317:30-5-221. Coverage**

(a) Genetic counseling services are covered for SoonerCare members who meet the criteria for receiving medically necessary genetic testing as set forth in 317:30-5-2 (a)(1)(FF) and for pregnant/postpartum SoonerCare members as set forth in this section. Services for pregnant/postpartum SoonerCare members must be referred by a provider involved in the provision of obstetric or pediatric care. Members are eligible for genetic counseling during pregnancy which includes ~~sixty (60) days~~twelve (12) months postpartum. Reasons for genetic counseling include but are not limited to the following:

- (1) Advanced maternal age;
- (2) Abnormal maternal serum first or second screening;
- (3) Previous child or current fetus/infant with an abnormality;
- (4) Consanguinity/incest;
- (5) Parent is a known carrier or has a family history of a genetic condition;
- (6) Parent was exposed to a known or suspected reproductive hazard;
- (7) Previous fetal demise, stillbirth, or neonatal death involving known/suspected abnormalities;
- (8) History of recurrent pregnancy loss; or
- (9) Parent(s) are in an ethnic or racial group associated with an increased risk for specific genetic conditions.

(b) These services may be provided in an office or outpatient setting.

### **317:30-5-222. Reimbursement**

(a) Counseling services must be billed using appropriate CPT codes and guidelines and must be medically necessary. SoonerCare does not allow more than six units (~~30 minutes = 1 unit~~)[thirty (30) minutes = one (1) unit] per pregnancy including ~~60 days~~twelve (12) months postpartum care.

(b) Genetic Counselors who are employed by or remunerated by another provider may not bill the SoonerCare program directly for services if that billing would result in duplicate payment for the same service.

## **PART 20. LACTATION CONSULTANTS**

### **317:30-5-232. Coverage**

Lactation Consultant services are covered for pregnant women and women up to ~~60 days~~twelve (12) months postpartum. SoonerCare members may self-refer or be referred by any

provider. Reasons for lactation services include but are not limited to the following:

- (1) ~~prenatal~~Prenatal education/training for ~~first-time~~first-time mothers;
- (2) ~~women~~Women who have not previously breastfed, have a history of breastfeeding difficulty, have identified risk factors for breastfeeding difficulty or lactation insufficiency (e.g., history of breast surgery, infertility, hormonal imbalance, diabetes, obesity);
- (3) ~~women~~Women expecting an infant with risk factors for ineffective breastfeeding (e.g., preterm, multiples, congenital birth defects);
- (4) ~~latch-on~~Latch-on difficulties;
- (5) ~~low~~Low milk supply;
- (6) ~~breastfeeding~~Breastfeeding a premature baby (~~36~~thirty-six (36) weeks or less gestation);
- (7) ~~breastfeeding~~Breastfeeding multiples; and
- (8) ~~a~~A baby with special needs (e.g., Down Syndrome, cleft lip/or palate).

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

**SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME**

**PART 1. DETERMINATION OF QUALIFYING CATEGORICAL RELATIONSHIP**

**317:35-5-6. Determining categorical relationship to pregnancy-related services**

(a) For applications made prior to January 1, 2014, categorical relationship to pregnancy-related services can be established by determining through medical evidence that the individual is currently or has been pregnant. Pregnancy must be verified by providing medical proof of pregnancy within ~~30~~thirty (30) days of application submission. OKDHS form 08MA005E, Notification of Needed Medical Services, is not required but will be accepted as medical verification. If proof of pregnancy is not provided within ~~30~~thirty (30) days of application submission, SoonerCare benefits will be closed for the pregnant woman at the end of the thirty ~~(30)~~ day period. The expected date of delivery must be established either by information from the applicant's physician or certified nurse midwife or the member's statement.

(b) Effective January 1, 2014, women who are pregnant, including ~~60 days~~twelve (12) months postpartum, are related to the pregnant women group. Pregnancy does not have to be verified unless the declaration that an applicant or member is pregnant is not reasonably compatible with other information available to the agency. The individual must also provide the expected date of delivery.

**SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH  
CHILDREN**

**PART 7. CERTIFICATION, REDETERMINATION, AND NOTIFICATION**

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

**(a) General rules of certification.**

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

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

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

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

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

- (1) Is certified as eligible in a money payment case during the twelve-month (12-month) period;
- (2) Is certified for long-term care during the twelve-month (12-month) period;
- (3) Becomes ineligible for SoonerCare after the initial month; or
- (4) Becomes financially ineligible.
  - (A) If an income change after certification causes the case to exceed the income standard, the case is closed.
  - (B) Individuals, however, who are determined pregnant and financially eligible continue to be eligible for pregnancy-related services through the prenatal, delivery and postpartum period, regardless of income changes. A pregnant individual included in a TANF case which closes continues to be eligible for pregnancy-related services through the postpartum period.

**(d) Certification of individuals related to pregnancy-related services.** The certification period for the individual related to pregnancy-related services will cover the prenatal, delivery and postpartum periods. The postpartum period is defined as the ~~two (2)~~ twelve (12) months following the month the pregnancy ends. Financial eligibility is based on the income received in the first month of the certification period. No consideration is given to changes in income after certification.

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

- (1) Every newborn child is deemed eligible on the date of birth for SoonerCare when the child is born to a woman who is eligible for and enrolled in pregnancy-related services as categorically needy. The newborn child is deemed eligible through the last day of the month the newborn child attains the age of one (1) year. The newborn child's eligibility is not dependent on the mother's continued eligibility. The mother's coverage may expire at the end of the postpartum period; however, the newborn child is deemed eligible until age one (1). The newborn child's eligibility is based on the original eligibility determination of the mother for pregnancy-related services, and consideration is not given to any income or resource changes that occur during the deemed eligibility period.
- (2) The newborn child is deemed eligible for SoonerCare as long as he/she continues to live in Oklahoma. In accordance with 42 C.F.R. § 435.117, no other conditions of eligibility are applicable, including social security number enumeration, child support referral, and citizenship and identity verification. However, it is recommended that social security number enumeration be completed as soon as possible after the newborn child's birth. It is also recommended that a child support referral be completed, if needed, as soon as possible and sent to the Oklahoma Child Support Services (OCSS) division at DHS. The referral enables child support services to be initiated.
- (3) When a categorically needy newborn child is deemed eligible for SoonerCare, he/she remains eligible through the end of the month that the newborn child reaches age one (1). If the child's eligibility is moved from the case where initial eligibility was established, it is required that the newborn receive the full deeming period. The certification period is shortened only in the event the child:
  - (A) ~~loses~~ Loses Oklahoma residence; or
  - (B) ~~expires~~ Expires.

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

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

**SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME**

**PART 3. NON-MEDICAL ELIGIBILITY REQUIREMENTS**

**317:35-5-25. Citizenship/noncitizen status and identity verification requirements**

(a) **Citizenship/noncitizen status and identity verification requirements.** Verification of citizenship/noncitizen status and identity is required for all adults and children approved for SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

(1) The types of acceptable evidence that verify identity and citizenship include:

- (A) United States (U.S.) passport;
- (B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS)(Form N-550 or N-570);
- (C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);
- (D) Copy of the Medicare card or printout of a Beneficiary Earnings and Data Exchange (BENDEX) or State Data Exchange (SDX) screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or
- (E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

- (i) A U.S. public Birth Certificate showing birth in one (1) of the fifty (50) states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986. For Puerto Ricans whose eligibility is being determined for the first time on or after October 1, 2010 and using a birth certificate to verify citizenship, the birth certificate must be a certified birth certificate issued by Puerto Rico on or after July 1, 2010;
- (ii) A Consular Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of Birth issued by the State Department (Form FS-240, FS-545 or DS-1350);
- (iii) A U.S. Citizen Identification Card (Form I-179 or I-197);
- (iv) A Northern Mariana Identification Card (Form I-873) (Issued by the former INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana

Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);

(vi) A final adoption decree showing the child's name and U.S. place of birth;

(vii) Evidence of U.S. Civil Service employment before 6/1/1976;

(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);

(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;

(x) Oklahoma voter registration card;

(xi) Other acceptable documentation as approved by OHCA; or

(xii) Other acceptable documentation to the same extent as described and communicated by the United States Citizenship and Immigration Service (USCIS) from time to time.

(B) Other less reliable forms of citizenship verification are:

(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five (5) years before the initial application date and that indicates a U.S. place of birth. For children under sixteen (16) the evidence must have been created near the time of birth or five (5) years before the date of application;

(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five (5) years before the initial application date and that indicates a U.S. place of birth;

(iii) Federal or state census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or

(iv) One (1) of the following items that show a U.S. place of birth and was created at least five (5) years before the application for SoonerCare. This evidence must be one (1) of the following and show a U.S. place of birth:

(I) Seneca Indian tribal census record;

(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;

(III) U.S. State Vital Statistics official notification of birth registration;

(IV) An amended U.S. public birth record that is amended more than five (5) years after the person's birth; or

(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:

(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

(B) A school identification card with a photograph of the individual;

(C) An identification card issued by federal, state, or local government with the same information included on driver's licenses;

(D) A U.S. military card or draft record;

(E) A U.S. military dependent's identification card;



(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;

(G) A U.S. Coast Guard Merchant Mariner card;

(H) A state court order placing a child in custody as reported by the OKDHS;

(I) For children under sixteen (16), school records may include nursery or daycare records;

(J) If none of the verification items on the list are available, an affidavit may be used for children under sixteen (16). An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

**(b) Reasonable opportunity to obtain verification.**

(1) The state provides Medicaid to citizens and nationals of the United States and certain noncitizens, including during a reasonable opportunity period pending verification of citizenship, national status, or immigration status. The reasonable opportunity period begins on the date the notice of reasonable opportunity is received by the individual and extends at minimum ninety (90) days. Receipt by the individual is deemed to occur five (5) days after the date on the notice, unless the individual shows that the notice was not received in the five-day period. The state provides an extension of the reasonable opportunity period if the individual subject to verification is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the state needs more time to complete the verification process. The state begins to furnish benefits to otherwise eligible individuals on the date of application containing the declaration of citizenship or immigration status and throughout the reasonable opportunity period.

(2) The following methods of verification are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;

(B) Medical (clinic, doctor, or hospital) record created at least five (5) years before the initial application date that indicates a U.S. place of birth. For children under the age of sixteen (16), the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;

(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two (2) affidavits by two (2) individuals who have personal knowledge of the event(s) establishing the applicant's/member's claim of citizenship;

(ii) At least one (1) of the individuals making the affidavit cannot be related to the applicant/member;

(iii) In order for the affidavit to be acceptable, the persons making them must be able to provide proof of their own citizenship and identity;

(iv) If the individual(s) making the affidavit has information which explains why

evidence establishing the applicant's/member's claim of citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Noncitizen eligibility.** SoonerCare services are provided as described to the defined groups as indicated in this subsection if they meet all other factors of eligibility, including but not limited to residency requirements, and if the relevant noncitizen status is verifiable by federally approved means.

(1) **Unauthorized resident noncitizen.** An unauthorized resident noncitizen is a foreign-born individual who is not lawfully present in the United States, regardless of having had authorization during a prior period. Unauthorized resident noncitizens have formerly been known as "illegal" or "undocumented" immigrants or "aliens". Per 8 U.S.C. 1611(a) and (b)(1)(A) an unauthorized resident noncitizen is ineligible for Title XIX Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an unauthorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate Children's Health Insurance Program (CHIP) for services that benefit the unborn child, if the unborn child meets all eligibility requirements.

(2) **Authorized resident noncitizen, not qualified.** An authorized resident noncitizen is a foreign-born individual who is lawfully present in the United States (U.S.) and is lawfully residing in the U.S., but who does not meet the definition of qualified noncitizen, per 8 U.S.C. 1611(a) and (b)(1)(A). The Oklahoma Medicaid program does not exercise the CHIPRA 214 option; therefore, an authorized resident noncitizen is ineligible for Title XIX or Title XXI Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an authorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate CHIP for services that benefit the unborn child, if the unborn child meets all eligibility requirements.

(3) **Qualified noncitizen.** A "qualified noncitizen" is an authorized resident noncitizen who, at the time of applying for Medicaid, has a "qualified noncitizen" immigration status as identified at 8 U.S.C. 1641, as may be amended from time to time. Any qualified noncitizen is eligible for full Title XIX Medicaid benefits after a five-year waiting period beginning on the date of the noncitizen's entry into the U.S. with an immigration status identified as "qualified noncitizen" if the noncitizen meets all other eligibility criteria at the end of the waiting period. During the waiting period, as per 8 U.S.C. 1613(a), any qualified noncitizen is eligible to receive emergency Medicaid as described in subparagraph (e) below if the noncitizen meets all other eligibility requirements, including but not limited to residency requirements.

(A) **Qualified noncitizen immigration statuses.** Immigration statuses identified by federal law as "qualified noncitizen", as of November 2, 2021, include:

(i) A noncitizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act [INA], per 8 U.S.C. 1101 et seq.;

(ii) A noncitizen who is granted asylum under INA section 208, per 8 U.S.C. 1158;

(iii) A noncitizen who is admitted to the U.S. under INA section 207 refugee, per 8 U.S.C. 1157;

- (iv) A noncitizen who is paroled into the U.S. under INA section 212(d)(5), per 8 U.S.C. 1182(d)(5), for a period of at least one (1) year;
- (v) A noncitizen whose deportation is being withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of division C of Public Law 104B208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104B208);
- (vi) A noncitizen who is granted conditional entry before 1980 pursuant to INA section 203(a)(7), per 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;
- (vii) A noncitizen who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);
- (viii) A noncitizen who, or whose parent or child, has been battered or subjected to extreme cruelty in the U.S. by a U.S. citizen or lawful permanent resident spouse or parent or by a member of the spouse's or parent's family residing in the same household, except during any period in which the individual responsible for such battery or cruelty resides in the same household or family eligibility unit as the individual subjected to such battery or cruelty and only when the alien meets all of the following requirements:

- (I) The noncitizen, if not the individual subjected to battery or extreme cruelty, had no active participation in the battery or cruelty;
- (II) The noncitizen is a credible victim; and
- (III) The noncitizen is able to show a substantial connection between the need for benefits sought and the batter or extreme cruelty; and
- (IV) The noncitizen has been approved or has a petition pending which sets forth a prima facie case for one of the following: status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); classification under INA 204(a)(1)(B)(ii) or (iii); suspension of deportation under INA 244(a)(3); status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); or classification under INA 204(a)(1)(B); or cancellation of removal under INA 240A(b)(2).

- (ix) A noncitizen who is or has been a victim of a severe form of trafficking in persons and who has been granted nonimmigrant status under INA 101(a)(15)(T) or who has a pending application that sets forth a prima facie case for eligibility for such immigration status; or

- (x) Beginning December 27, 2020, a noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.

**(B) Five-year wait exception for refugees and asylees.**

- (i) Excepted from the five-year waiting period per 8 U.S.C. 1612(b)(2)(A), the following qualified noncitizens are immediately eligible for a Medicaid determination upon the date:

- (I) A noncitizen is admitted to the U.S. as a refugee under INA section 207 [INA 207 Refugee], per 8 U.S.C. 1157;
- (II) A noncitizen is granted asylum under INA section 208, per 8 U.S.C. 1158;
- (III) A noncitizen's deportation is withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of

division C of Public Law 104B208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104B208);

(IV) A noncitizen is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980); or

(V) A noncitizen is admitted to the U.S. as an Amerasian immigrant under the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, section 584.

(ii) This exception to the five-year waiting period expires seven (7) years after the date of action indicated in the list at (c)(3)(B)(i) above. Upon expiration of the exception, the five-year waiting period must be calculated.

(C) **Five-year wait exception for certain permanent resident noncitizens.** The five-year waiting period does not apply and the noncitizen is immediately eligible for a Medicaid determination per 8 U.S.C. 1612(b)(2)(B), if:

(i) The noncitizen is lawfully admitted to the U.S. for permanent residence;

(ii) The noncitizen has either:

(I) worked forty (40) qualifying quarters of coverage as defined under the Act; or

(II) can be credited with such qualifying quarters as provided under 8 U.S.C. 1645; and

(iii) In the case of any such qualifying quarters creditable for any period beginning after December 31, 1996, the noncitizen did not receive any federal means-tested public benefit during any such period.

(D) **Five-year wait exception for veteran and active-duty noncitizens.** As per 8 U.S.C. 1612(b)(2)(C) and 1613, the five-year waiting period does not apply, and the noncitizen is immediately eligible for a Medicaid determination if the noncitizen is a qualified noncitizen who is lawfully residing in the state and is:

(i) A veteran (as defined at INA sections 101, 1101, or 1301, or as described at 38 U.S.C. section 107) with a discharge characterized as an honorable discharge and not on account of noncitizenship and who fulfills the minimum active-duty service requirements of 38 U.S.C. section 5303A(d);

(ii) On active duty (other than active duty for training) in the Armed Forces of the United States; or

(iii) The spouse or unmarried dependent child of an individual described herein as a veteran or active-duty noncitizen; or

(iv) The unremarried surviving spouse of an individual described herein as a veteran or active-duty noncitizen who is deceased, if the marriage fulfills the requirements of 38 U.S.C. section 1304.

(E) **Five-year wait exception for COFA migrants.** Per 8 U.S.C. 1613(b)(3) and as of December 27, 2020, any noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau is, with regard to the Medicaid program, are not subject to the five-year waiting period unless and until the individual's status is adjusted to lawful

permanent resident (LPR), at which time the five year waiting period must be calculated, unless the individual meets a separate exception to the five-year waiting period:

- (i) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred before December 27, 2020, then the waiting period begins on the date of adjustment and ends after five (5) years;
- (ii) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period expires on December 27, 2025; and
- (iii) If the individual entered the U.S. after December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period begins on the date of entry into the U.S. and ends after five (5) years.

**(F) Five-year wait exception for qualified noncitizens receiving SSI.** Per 8 U.S.C. 1612(b)(2)(F), a qualified noncitizen who is receiving benefits under the supplemental security income program (SSI) under Title XVI of the Act shall be eligible for medical assistance under a state plan under Title XIX of the Social Security Act, per 42 U.S.C. 1396 et seq), under the same terms and conditions that apply to other recipients of SSI benefits.

**(4) Special categories of noncitizens and conferred benefits.** For the following noncitizens, federal law has expressly authorized Title XIX Medicaid benefits as described below and at law.

**(A) Certain American Indian / Alaskan Native (AI/AN) noncitizens.** The qualified noncitizen requirement and the five-year waiting period do not apply to any individual who is:

- (i) An American Indian born in Canada to whom section 289 of the Immigration and Nationality Act apply, per 8 U.S.C. 1359; or
- (ii) A member of a federally recognized Indian tribe as defined at 25 U.S.C. 450b(e).

**(B) Certain Iraqi nationals.**

(i) Public Law 110-181, Section 1244, while in force and as amended from time to time, created a new category of special immigrant for Iraqi nationals, including:

- (I) Principal noncitizens who have provided relevant service to the U.S. government, while employed by or on behalf of the U.S. government in Iraq, for not less than 1 year beginning on or after March 20, 2003, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment; (II) The spouse or surviving spouse of a principal noncitizen; and
- (III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, extended Iraqi special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009.

(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Iraqi nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];

**(C) Certain Afghan nationals.**

(i) Public Law 111-8, Section 602, while in force and as amended from time to time, created a new category of special immigrant for Afghan nationals, including:

- (I) Principal noncitizens who have provided relevant service to the U.S. government or the International Security Assistance Force, while employed by or on behalf of the U.S. government in Afghan, for not less than one (1) year beginning on or after October 7, 2001, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment;
- (II) The spouse or surviving spouse of a principal noncitizen; and
- (III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, amended Public Law 111-8, Section 602, to extend Afghan special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009;

(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Afghan nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];

(iv) Pursuant to Public Law 117-43, Section 2502, while in force and as may be amended from time to time, "applicable individuals" have time-limited eligibility for medical assistance [See subsection (c)(3)(B) above], until March 21, 2023, or the term of parole, whichever is later. In this subparagraph, the term "applicable individual" includes only:

- (I) A citizen or national of Afghanistan or a person with no nationality who last habitually resided in Afghanistan, if the individual is paroled into the U.S. between July 31, 2021, and September 30, 2022;
- (II) The spouse or child of an individual described at (c)(3)(C)(iv)(I) of this section, if the spouse or child is paroled into the U.S. after September 30, 2022; and
- (III) The parent or legal guardian of an individual described at (c)(3)(C)(iv)(I) who is determined to be an unaccompanied child, if the parent or legal guardian is paroled into the U.S. after September 30, 2022.

**(D) Certain Ukrainian nationals**

(i) Public Law 117-128, Section 401, while in force and as amended from time to time, created a new category of special immigrant for Ukraine nationals, including:

- (I) A citizen or national of Ukraine, or a person who last habitually resided in Ukraine, who was paroled into the United States between February 24, 2022 and September 30, 2023; or
- (II) A citizen or national of Ukraine, or a person who last habitually resided in Ukraine, who was paroled into the United States after September 30, 2023, and is the spouse or child of an individual described in (D)(i)(I) above, or is the parent, legal guardian, or primary caregiver of an individual described in (D)(i)(I) above who is determined to be an unaccompanied child; and

(III) The individual's parole has not been terminated by the Secretary of Homeland Security.

(d) **Continuing conformance with federal law.** Notwithstanding any other provision of this section, any noncitizen population that federal law or authority, as amended from time to time, identifies as eligible for medical assistance under Title XIX is eligible for such benefits to the same extent, under the same conditions, and for the same period of time as indicated in the relevant federal law or official federal guidance documents, including any amendments to the law or guidance.

(e) **Emergency Medicaid.** Emergency Medicaid in this section means medical assistance provided to a noncitizen under Title XIX for care and services that are necessary for the treatment of an emergency medical condition, as defined by section 1903(v)(3) of the Act and including labor and delivery but not related to organ transplant procedure, of the noncitizen involved if the noncitizen otherwise meets eligibility requirements for medical assistance under the state plan, including but not limited to residency requirements.

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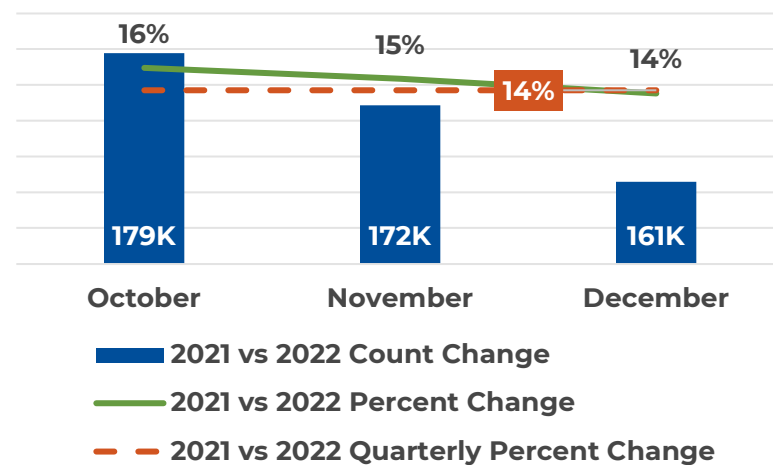
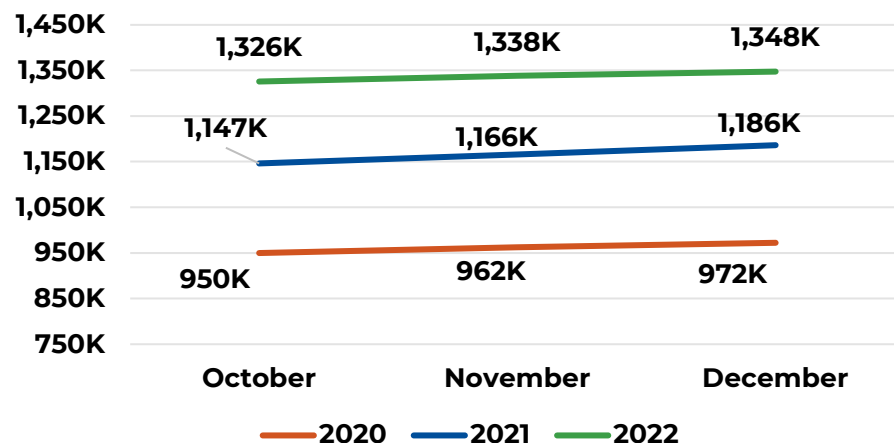


# OPERATIONAL METRICS

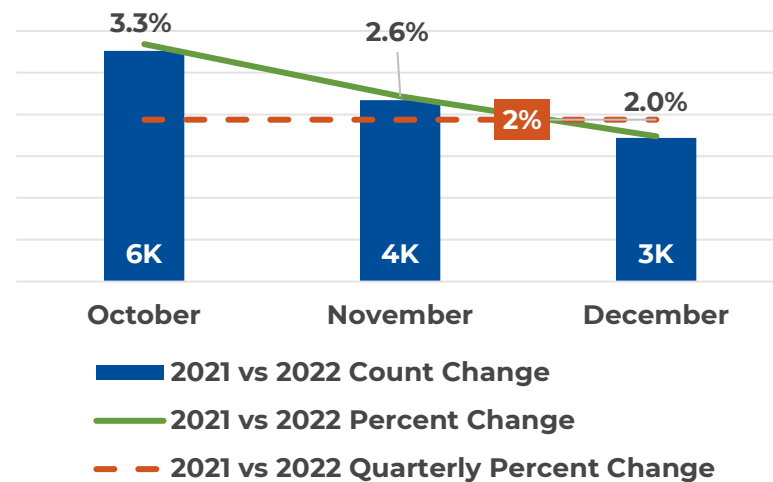
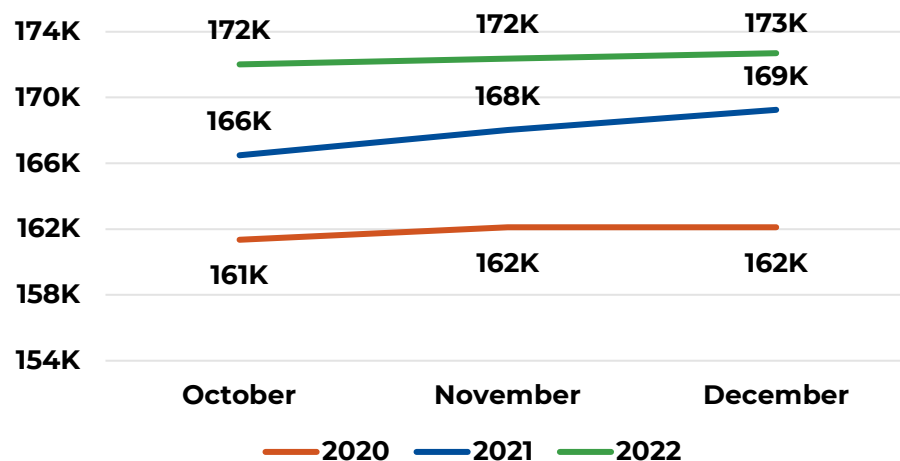
January 2023 Board Meeting

OKLAHOMA HEALTH CARE AUTHORITY  
4345 N. LINCOLN BLVD. | OKHCA.ORG |   

Enrollment & Utilization
Total Enrolled Members

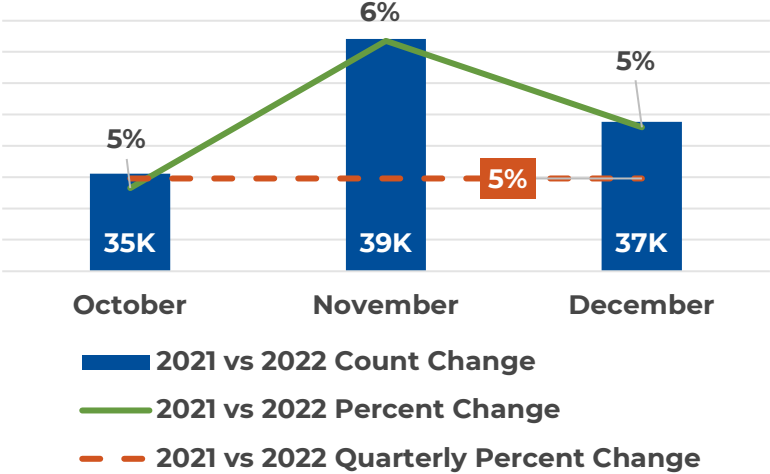
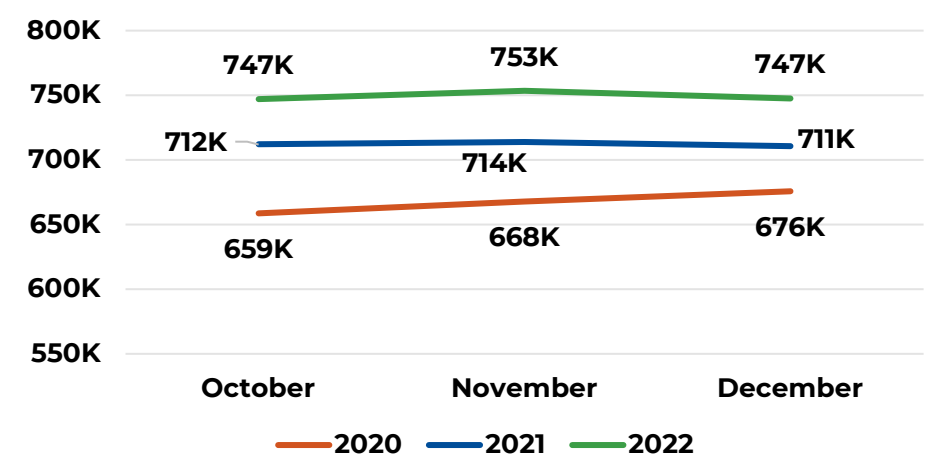


Aged/Blind/Disabled Enrolled
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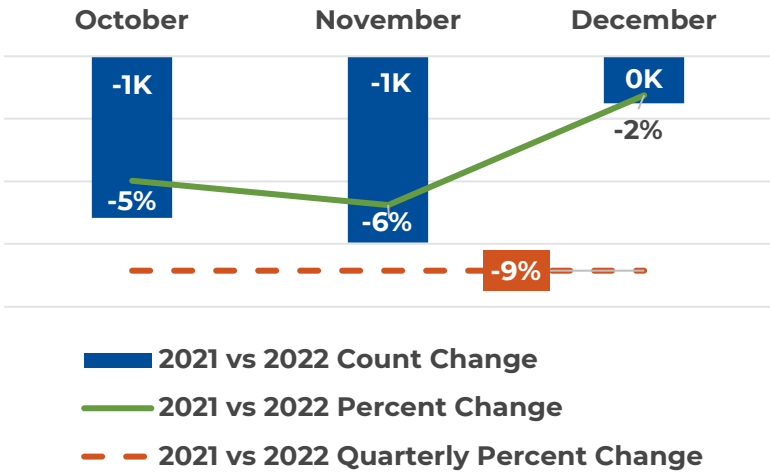
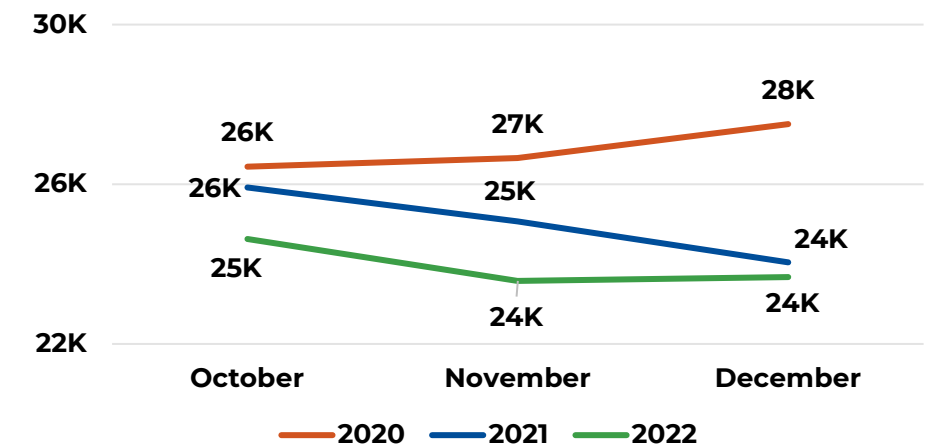


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Enrolled

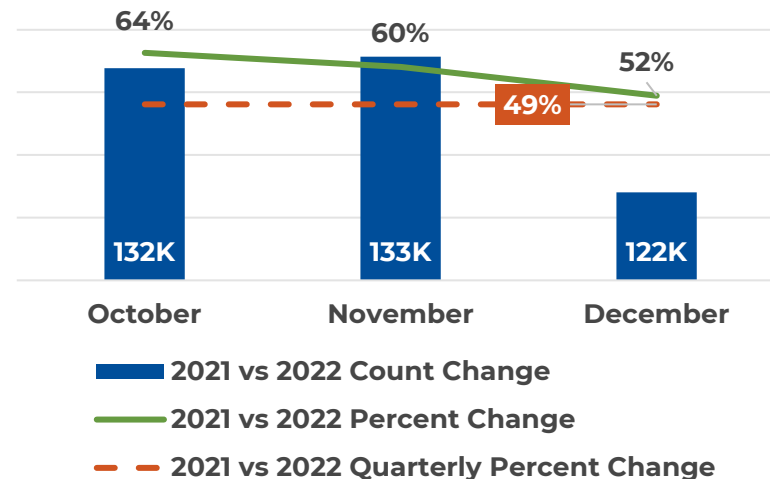
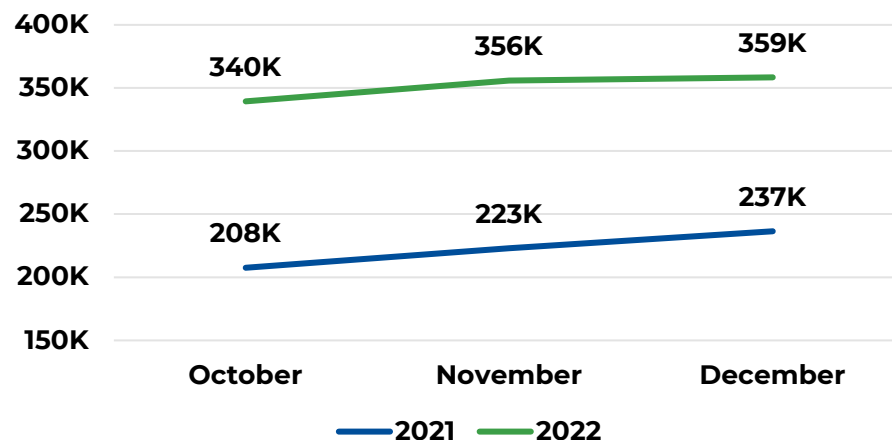


Pregnant (Full Scope) Enrolled

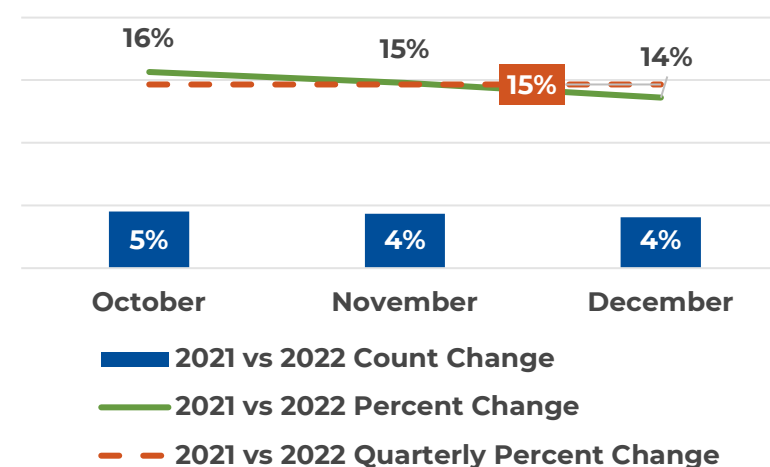
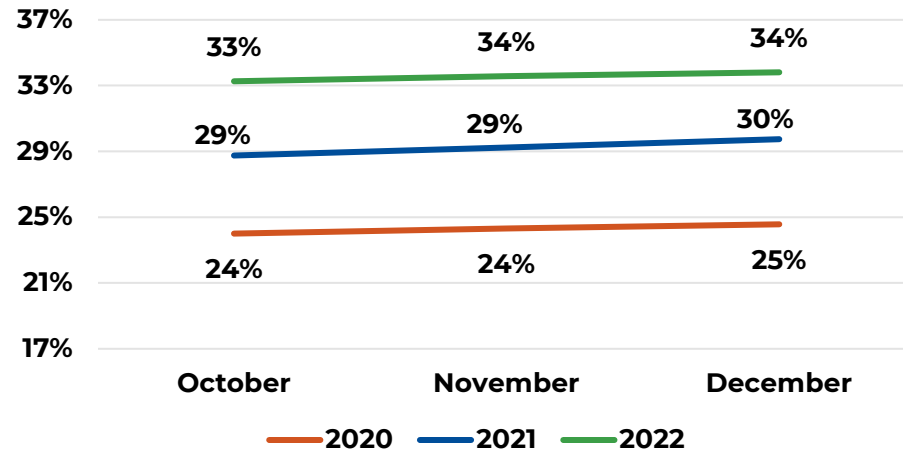


## Enrollment & Utilization (Cont.)

### Expansion Enrolled (Effective July 2021)

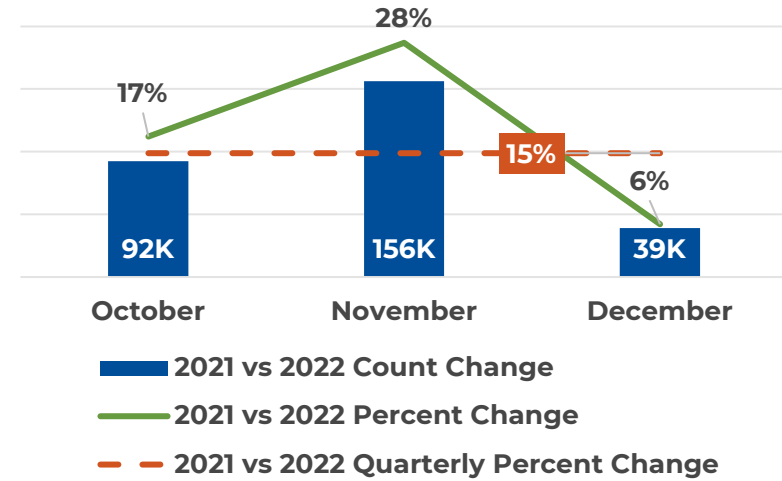
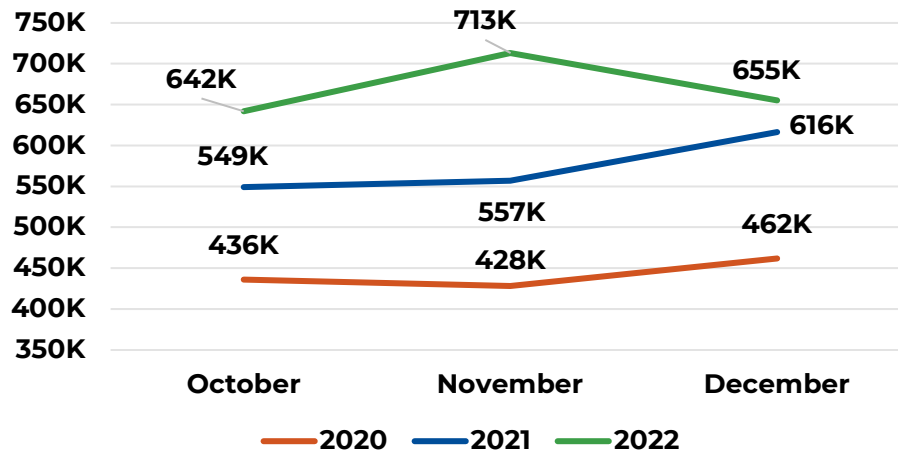


## Percent of OK Population Enrolled

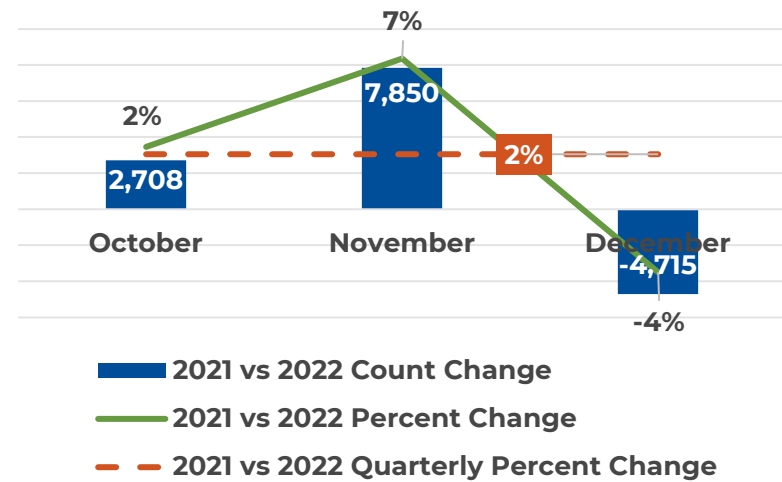
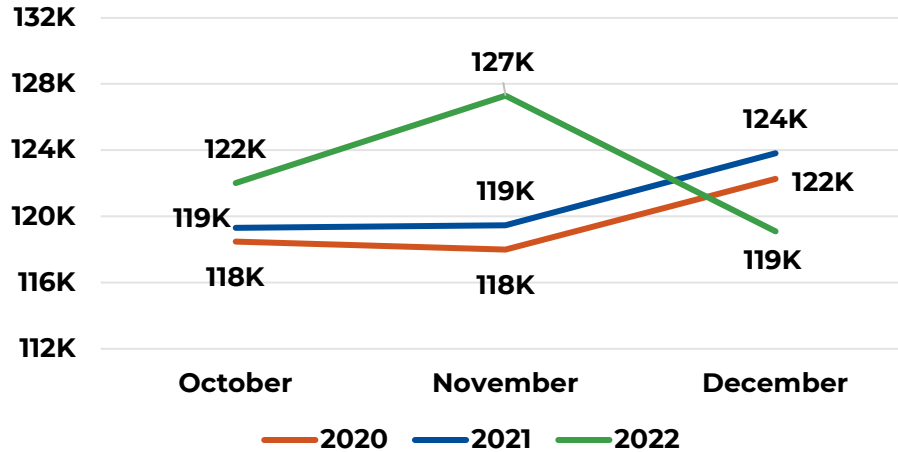


## Enrollment & Utilization (Cont.)

### Total Members Utilization

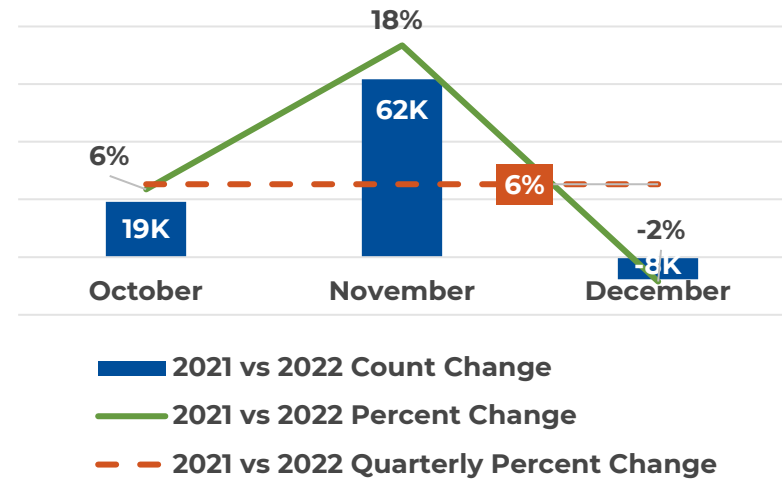
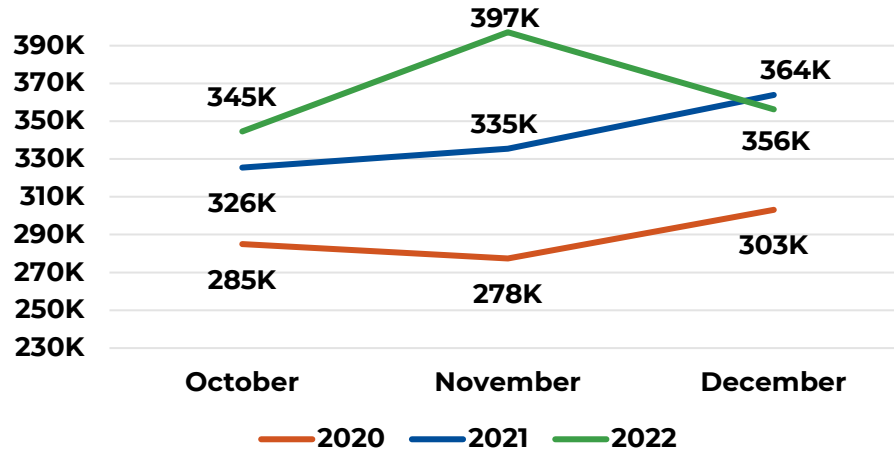


### Aged/Blind/Disabled Utilization

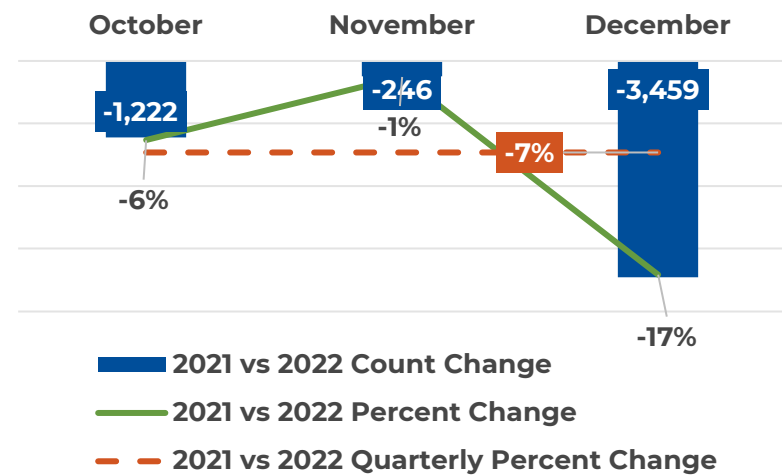
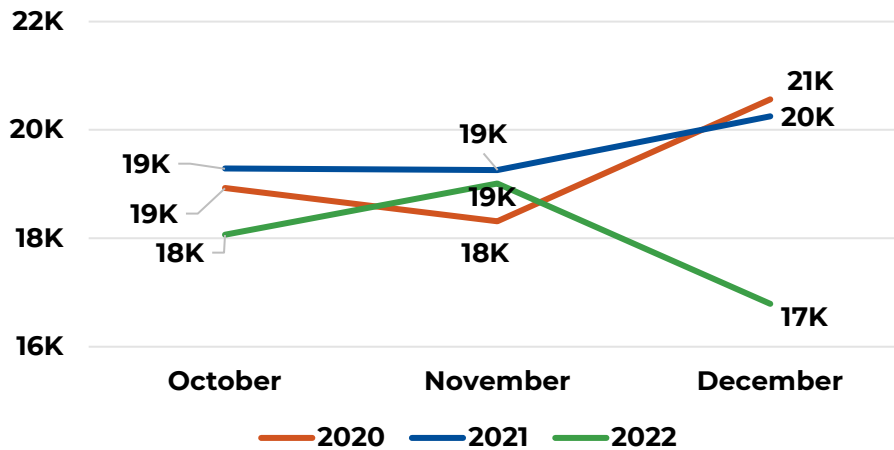


## Enrollment & Utilization (Cont.)

### Children & Parent/Caretaker Utilization

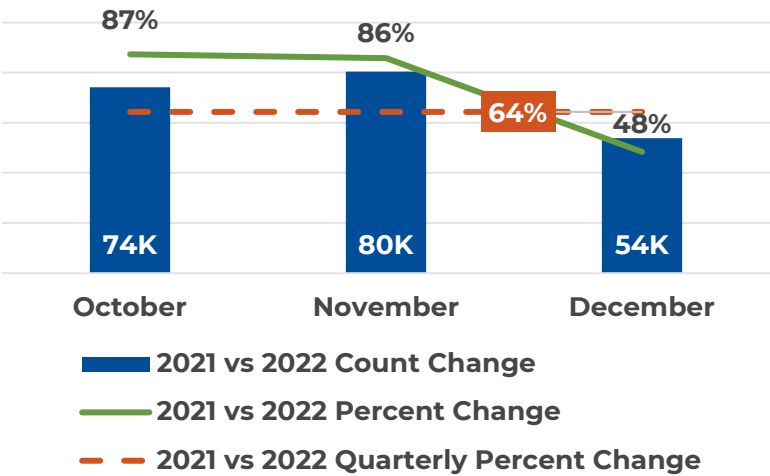
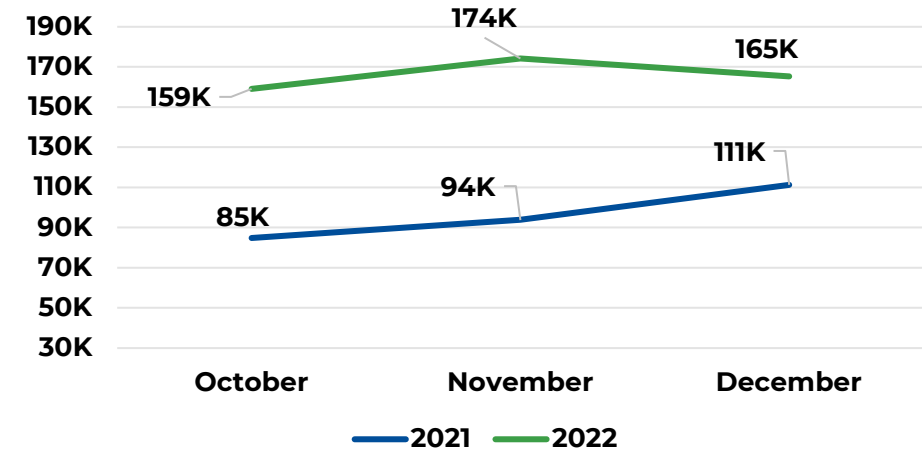


### Pregnant (Full Scope) Utilization

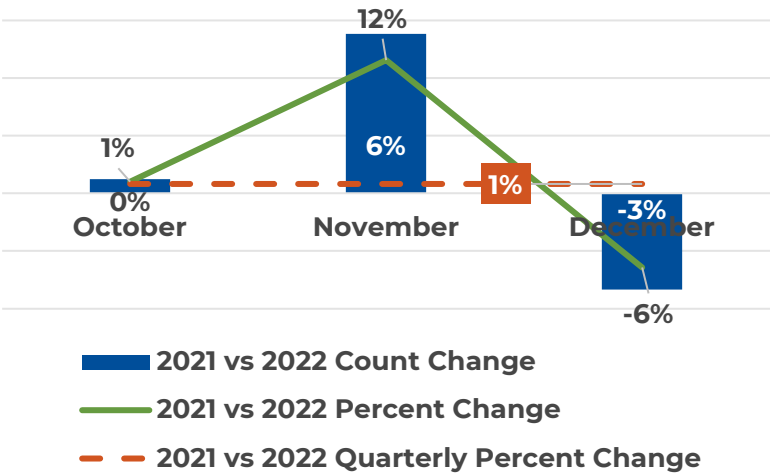
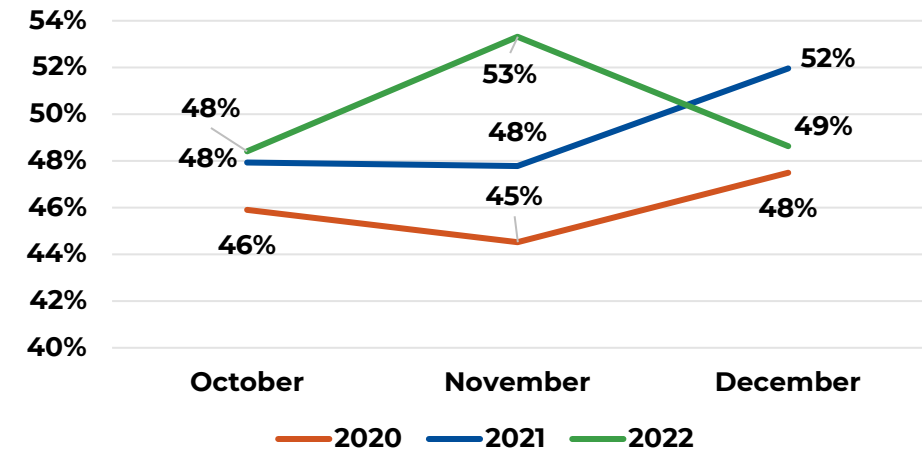


Enrollment & Utilization (Cont.)

Expansion Utilization (Effective July 2021)

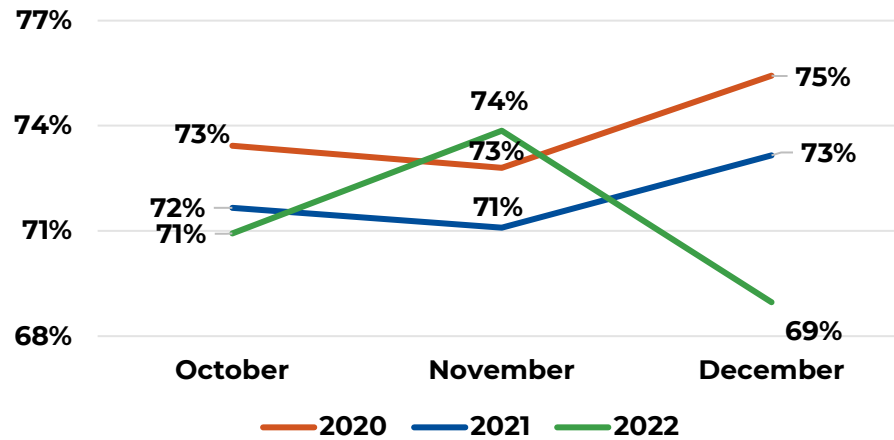


Percent of Total Enrolled Members Utilization

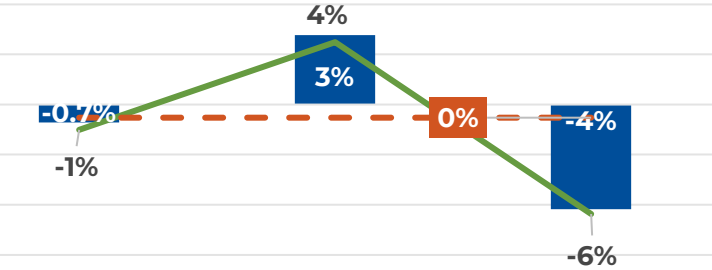


## Enrollment & Utilization (Cont.)

### Percent of Aged/Blind/Disabled Enrolled Members Utilization

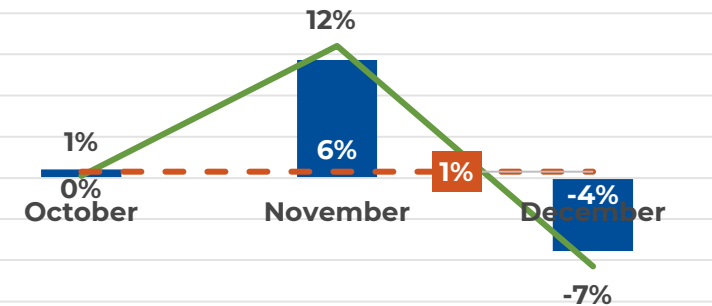
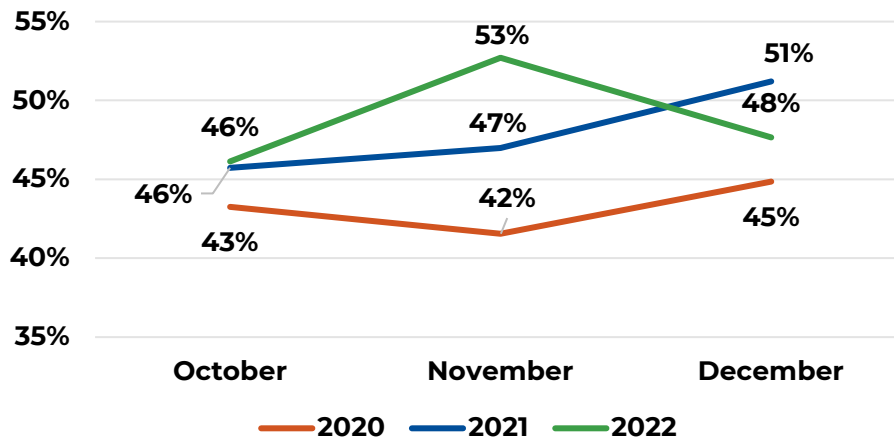


October November December



■ 2021 vs 2022 Count Change  
 — 2021 vs 2022 Percent Change  
 - - 2021 vs 2022 Quarterly Percent Change

### Percent of Children & Parent/Caretaker Enrolled Members Utilization

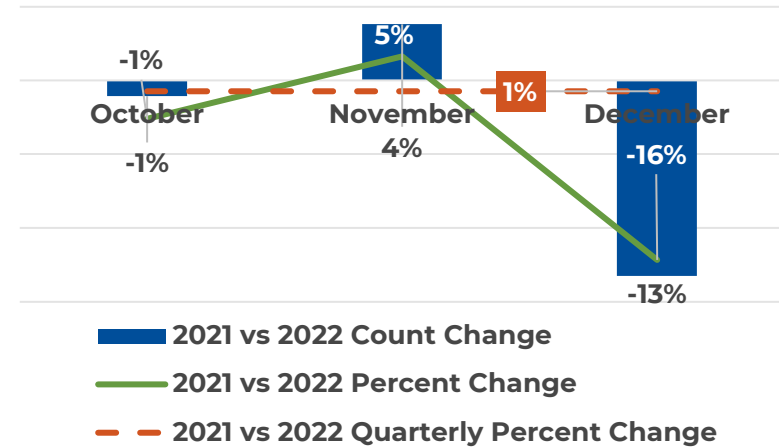
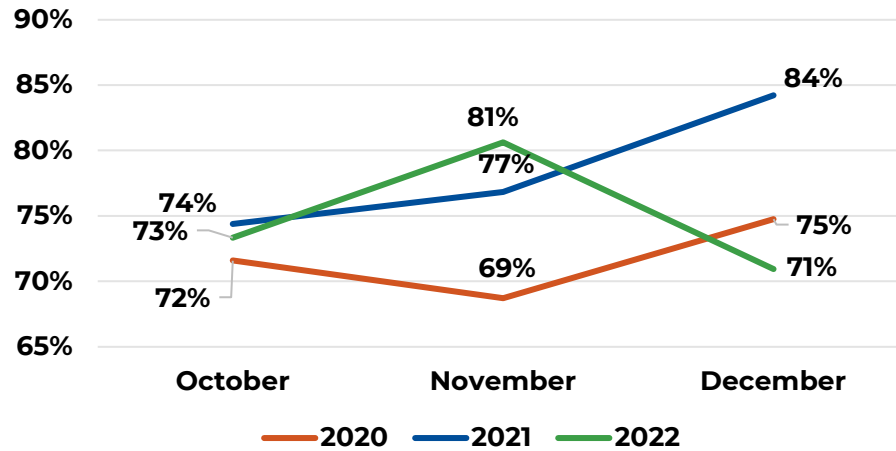


■ 2021 vs 2022 Count Change  
 — 2021 vs 2022 Percent Change  
 - - 2021 vs 2022 Quarterly Percent Change

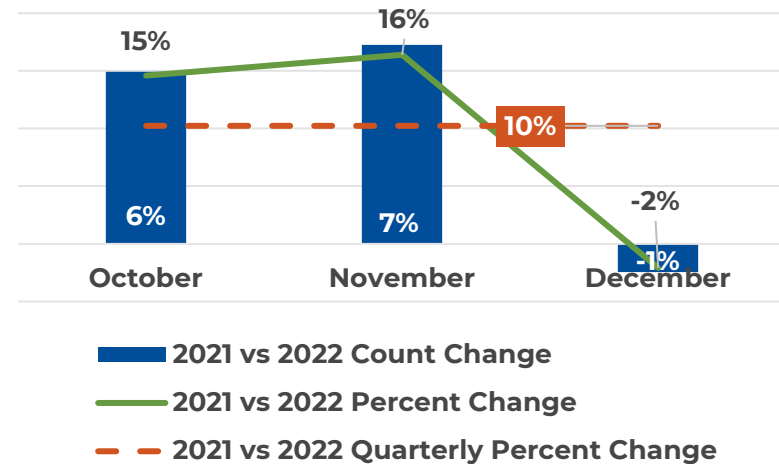
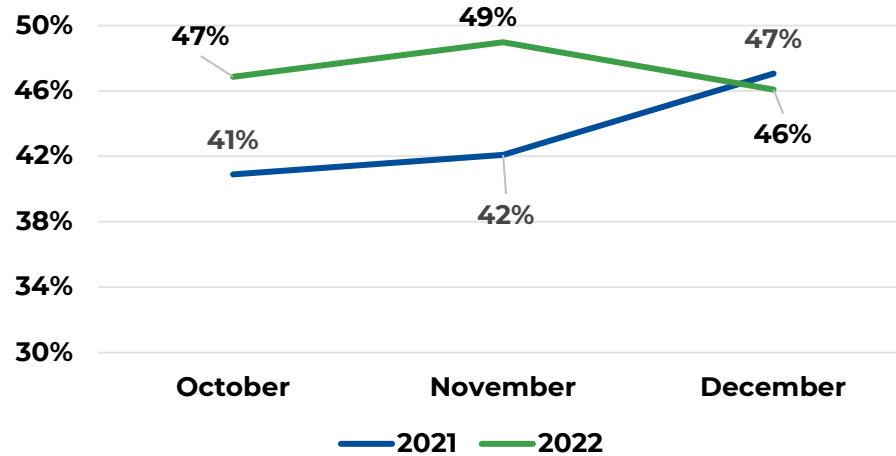


## Enrollment & Utilization (Cont.)

### Percent of Pregnant (Full Scope) Enrolled Members Utilization

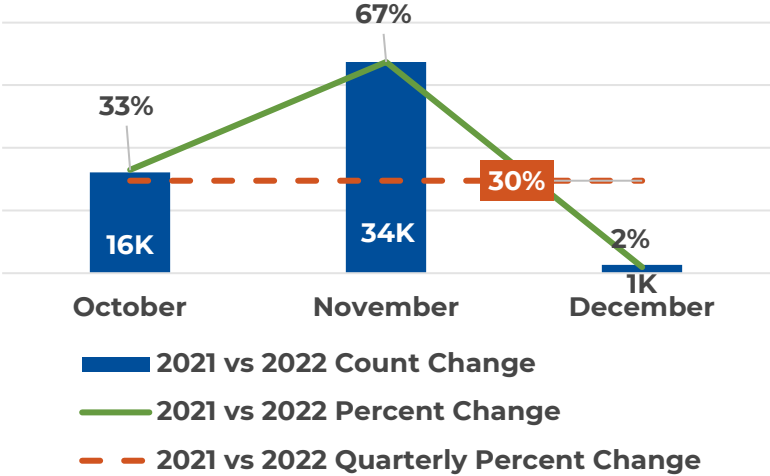
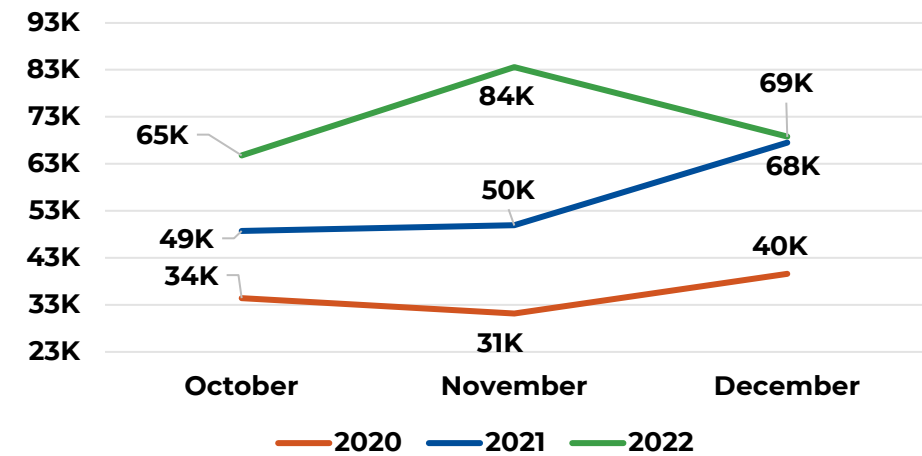


### Percent of Expansion Enrolled Members Utilization (Effective July 2021)

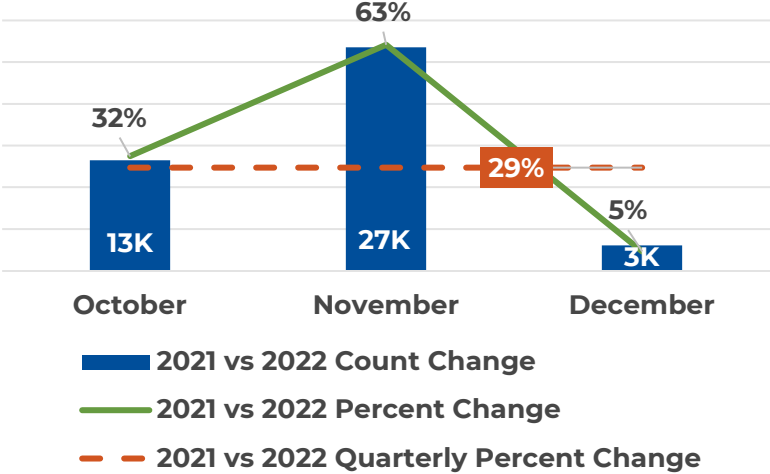
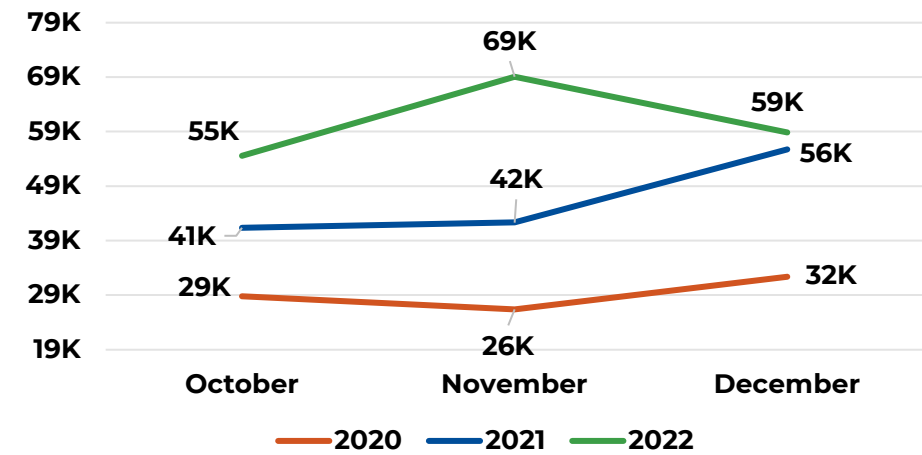


Utilization

Emergency Department Visits (Claims)

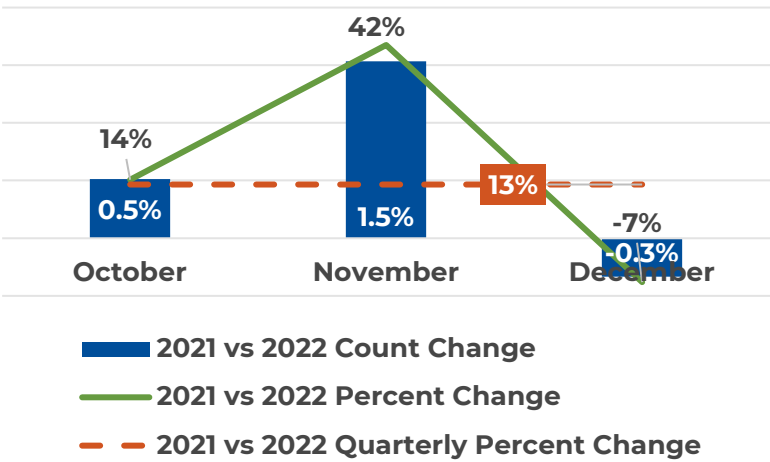
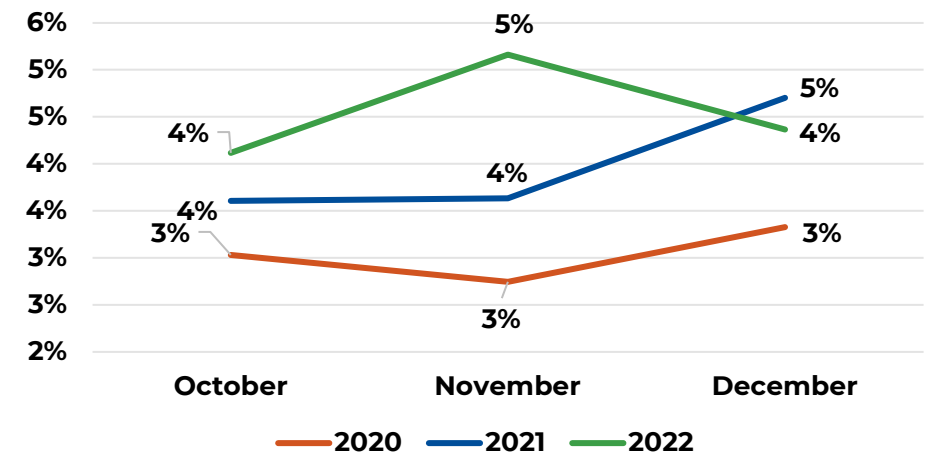


Members Utilizing Emergency Department

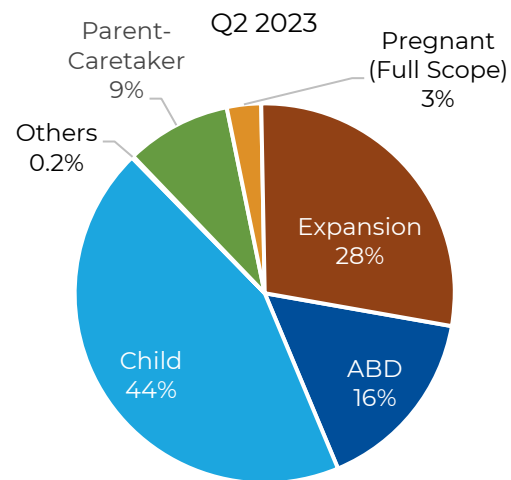
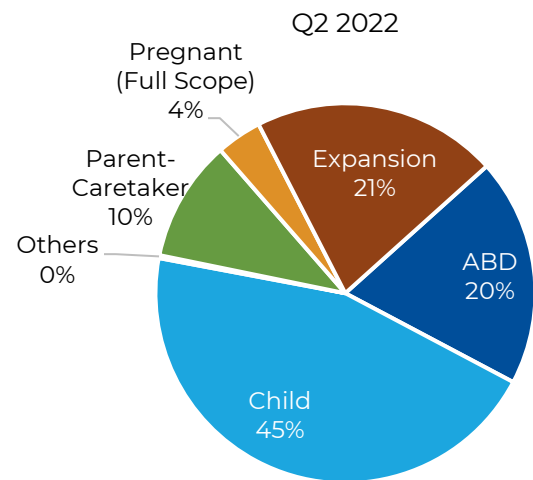


Utilization (Cont.)

Percent Total Enrolled Using ED

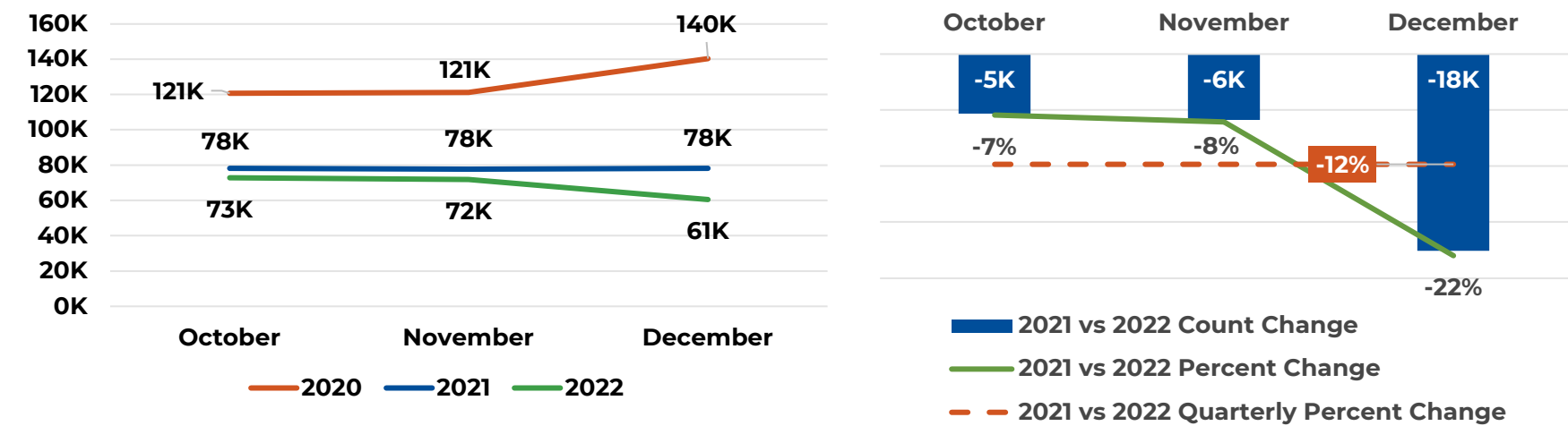


Members Utilizing Emergency Department By Qualifying Group

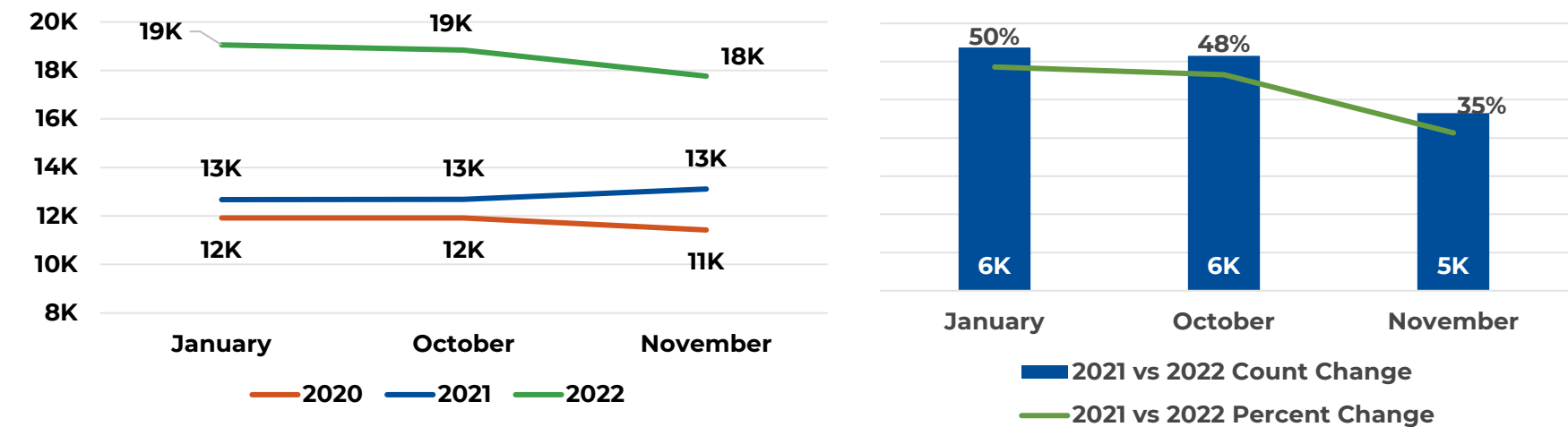


Utilization (Cont.)

Telemedicine - Total Visits



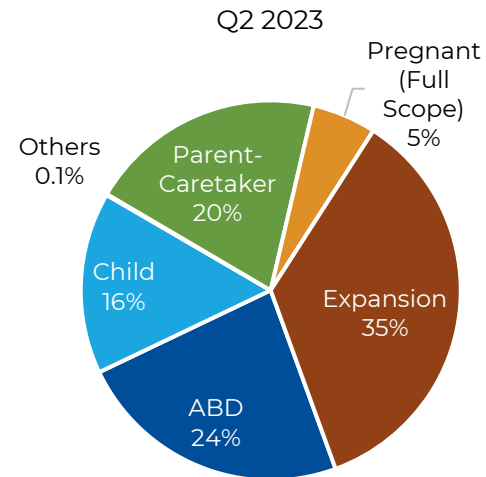
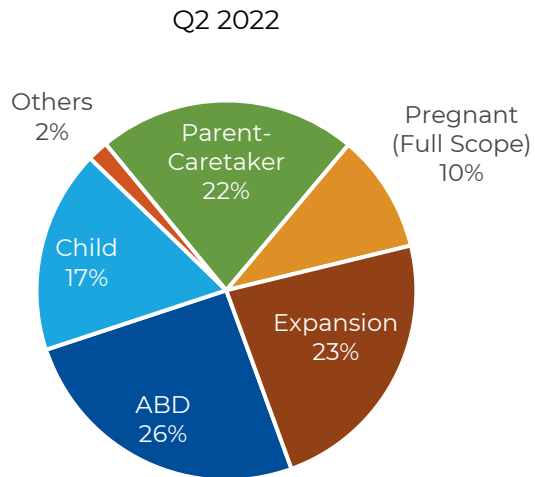
Members With Opioid Claims



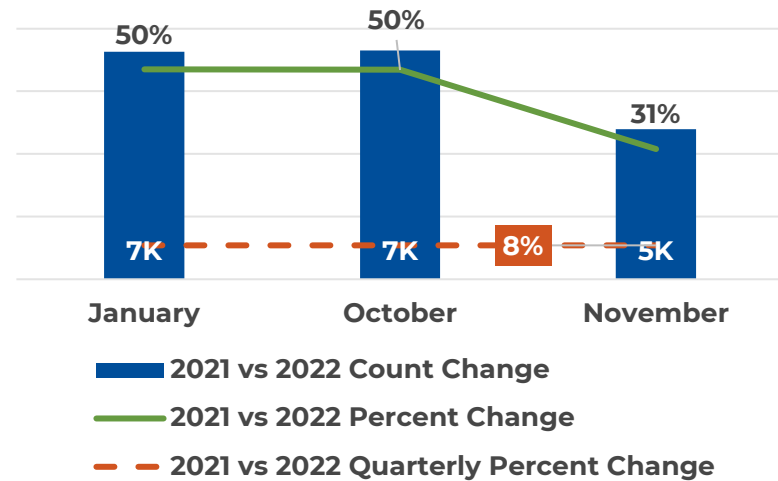
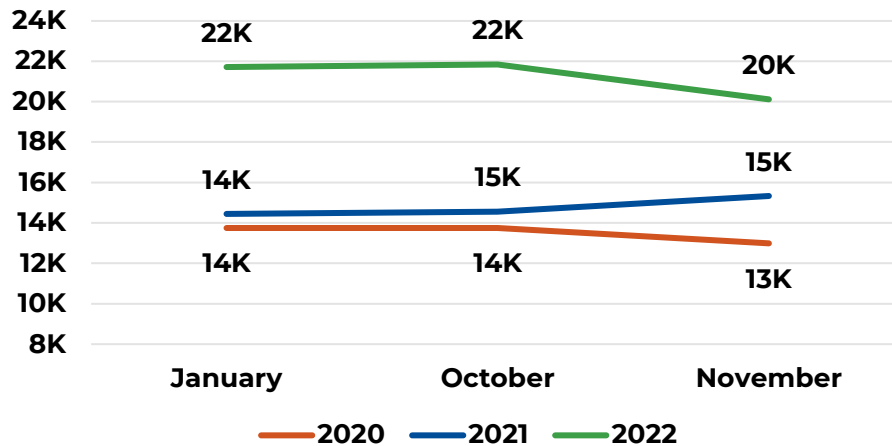
Quarterly Percentage Change unavailable as only had aggregate counts for Oct 2021 and needed actual IDs.

## Utilization (Cont.)

### Members With Opioid Claims By Qualifying Group

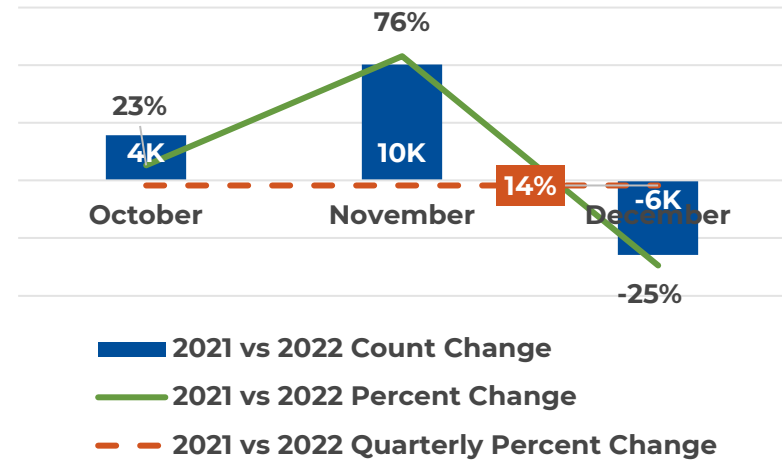
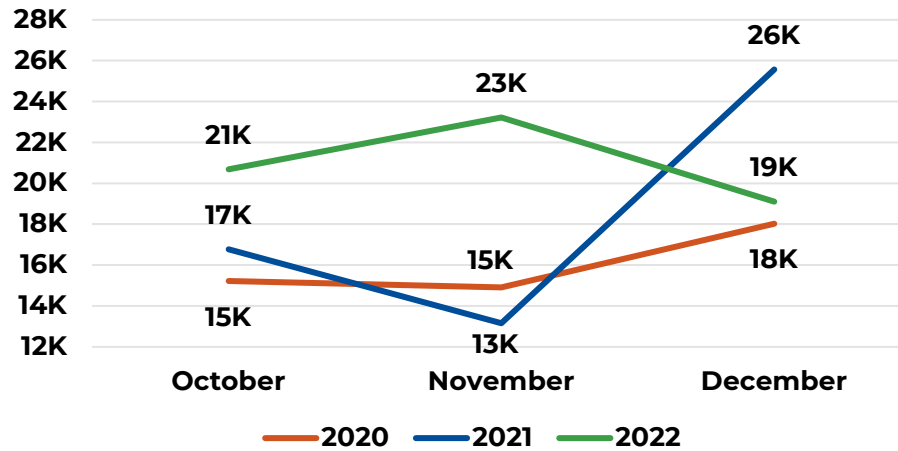


### Total Opioid Claims

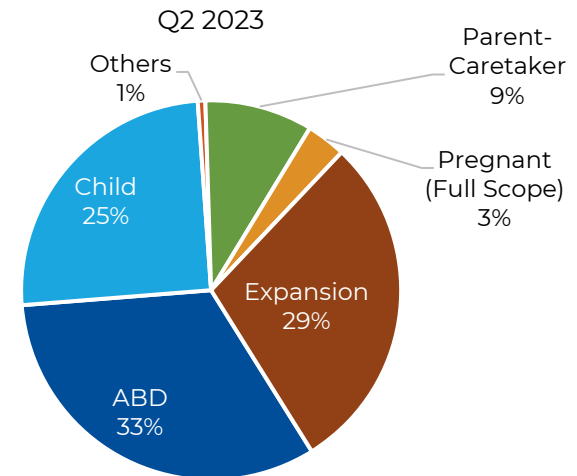
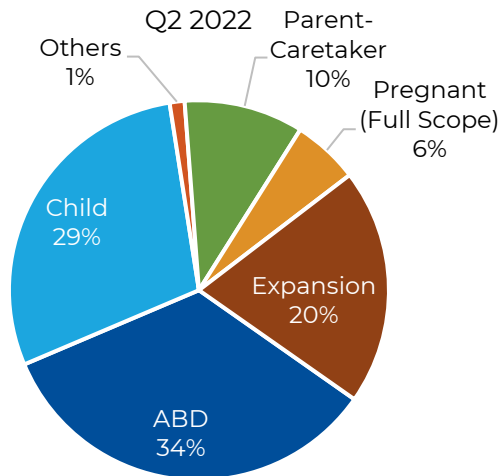


## Utilization (Cont.)

### Out of State Services - Total Members Utilization

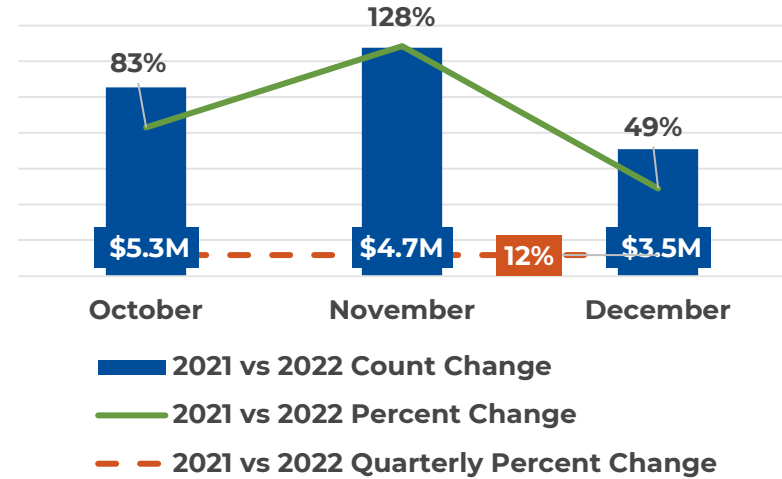
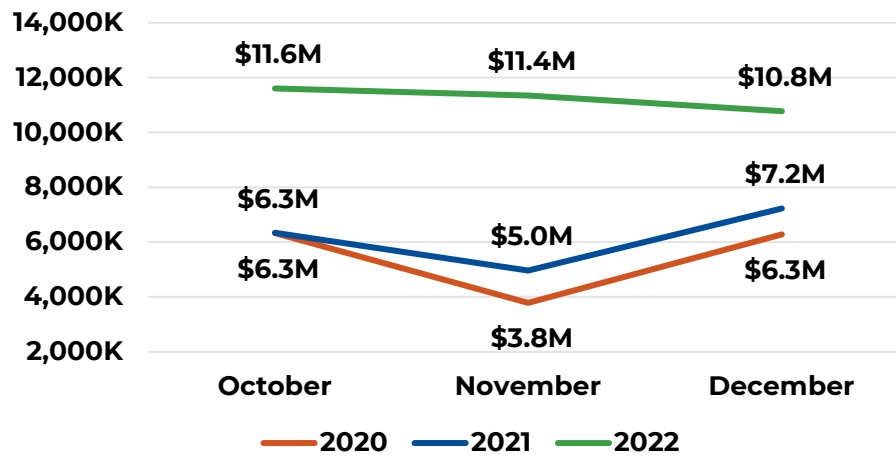


### Out of State Services - Total Members Utilization By Qualifying Group

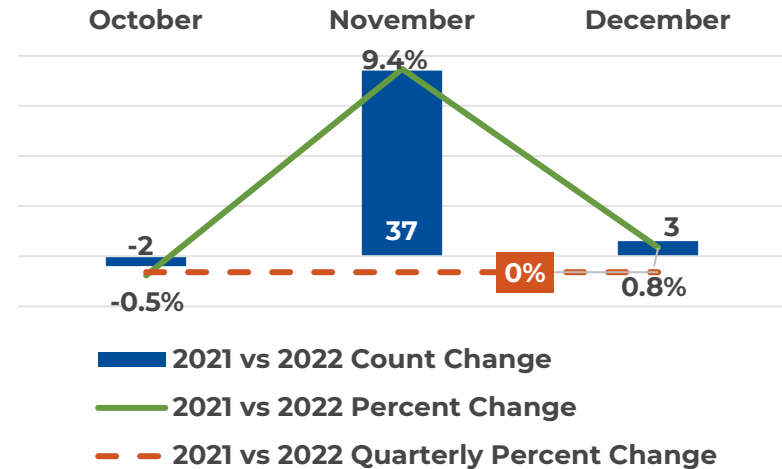
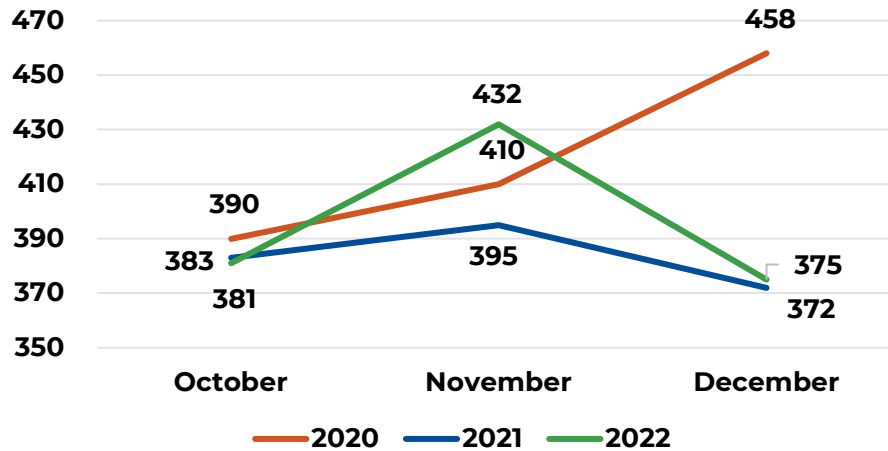


# Utilization (Cont.)

## Out of State Services - Total Reimbursements

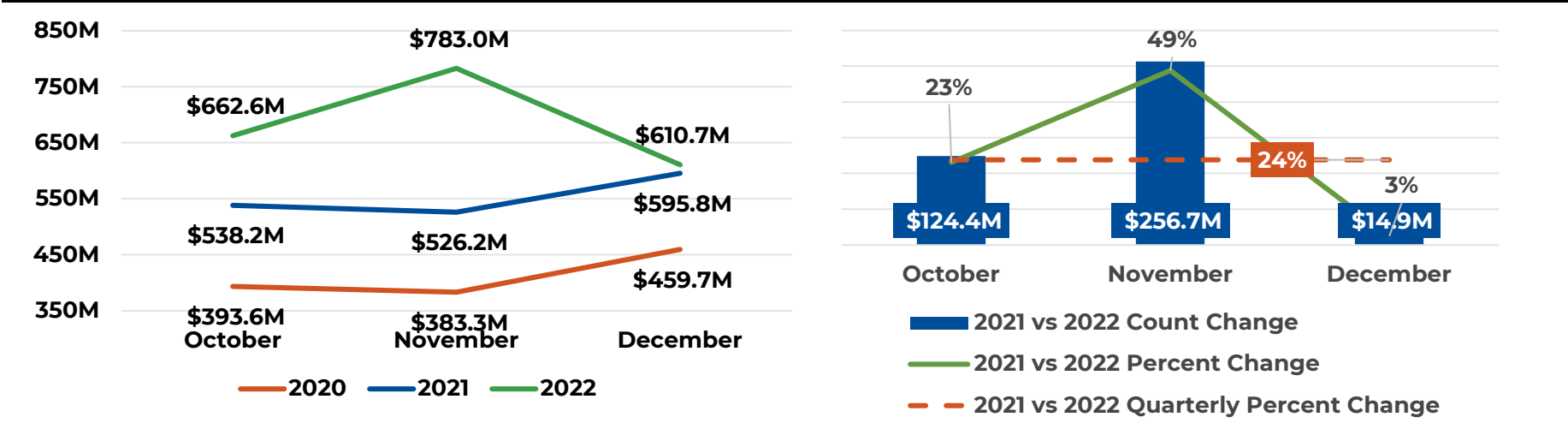


## Out of State Services - Total Active Billing Providers

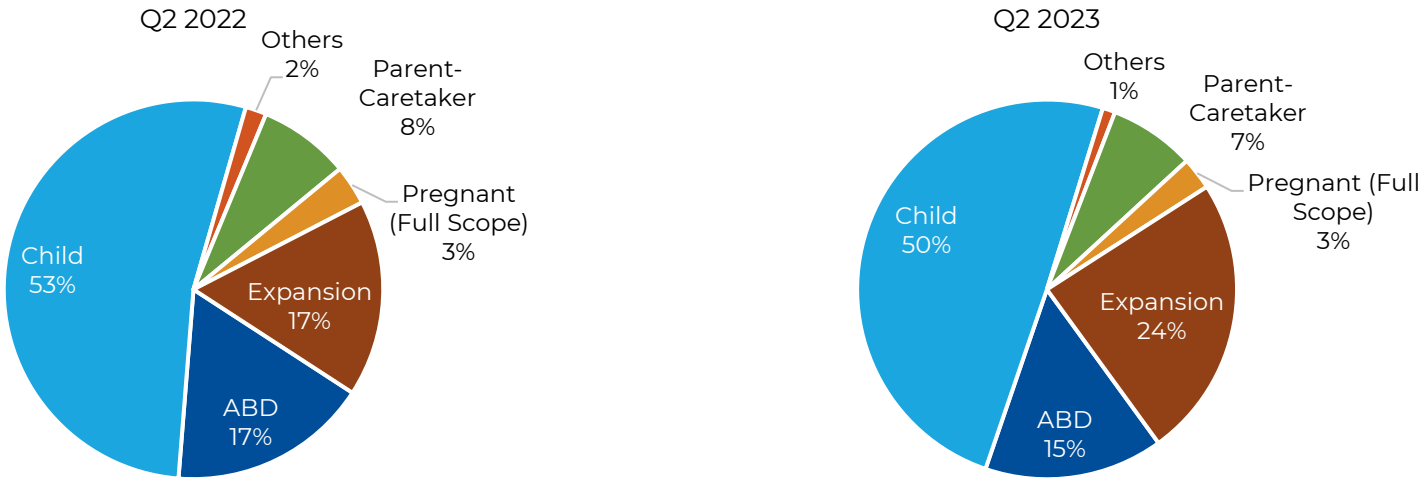


Financials

Total Agency Expenditures



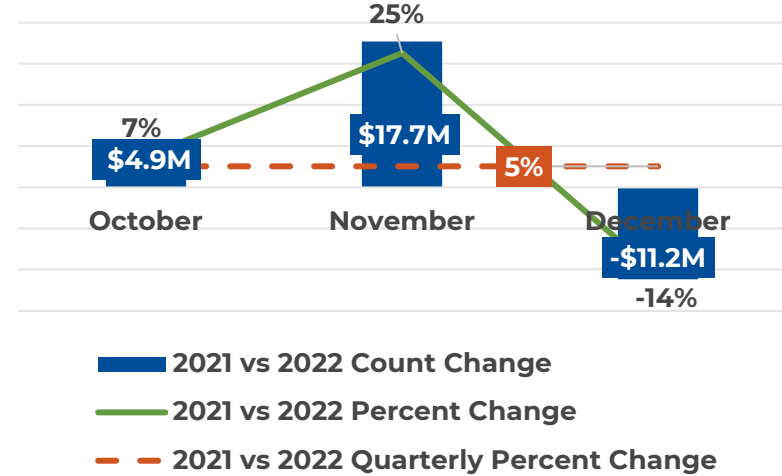
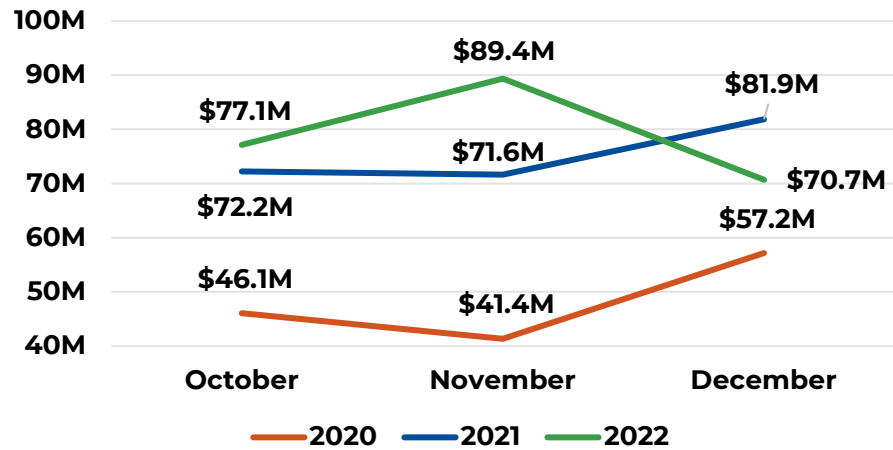
Total Agency Members Utilization by Qualifying Group



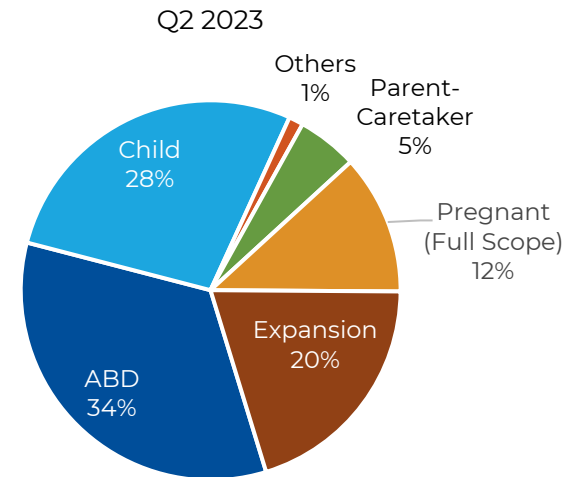
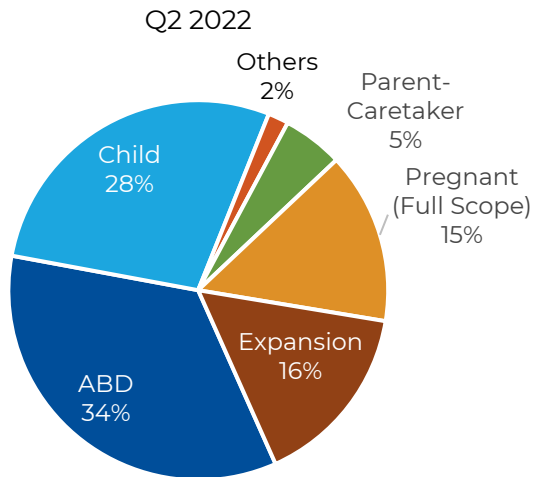


## Financials (Cont.)

### Inpatient Services Expenditures

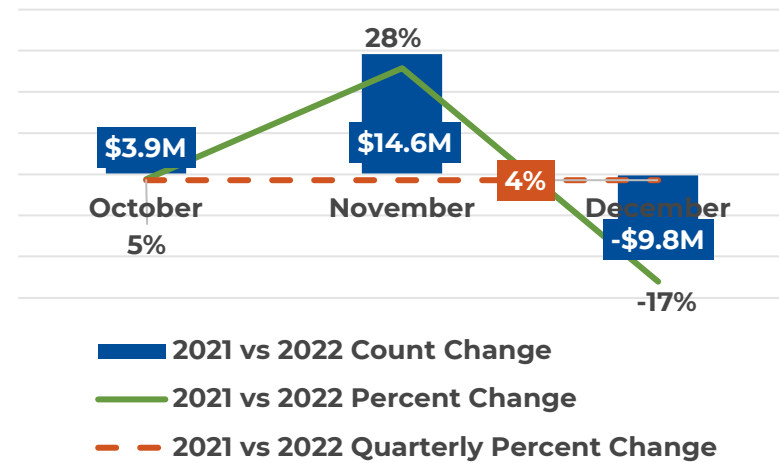
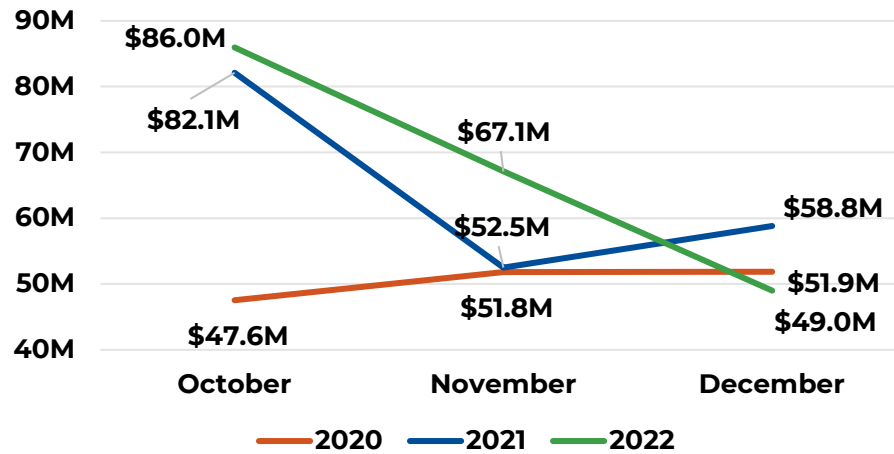


### Inpatient Services Members Utilization by Qualifying Group

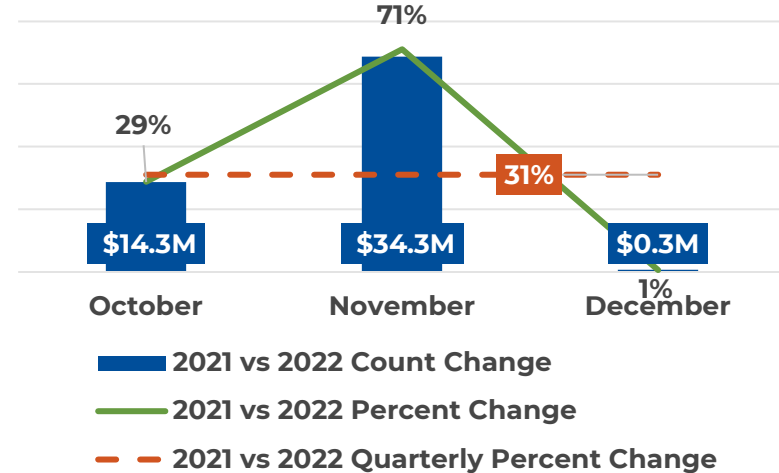
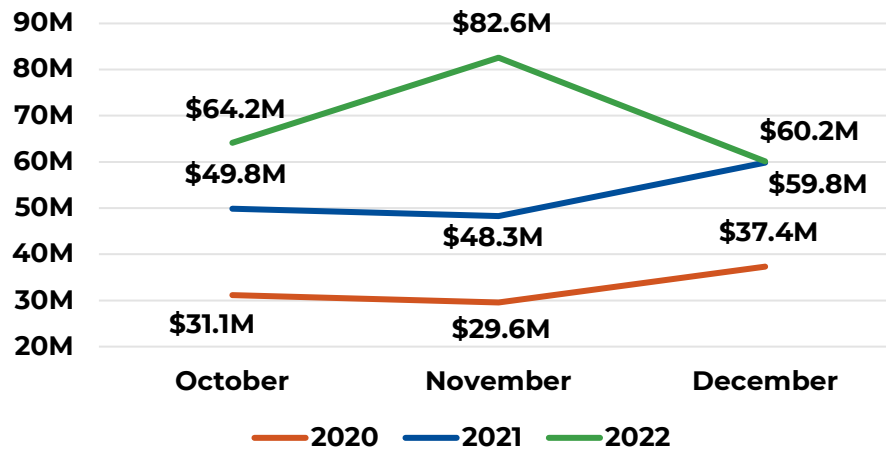


## Financials (Cont.)

### Nursing Facility Expenditures

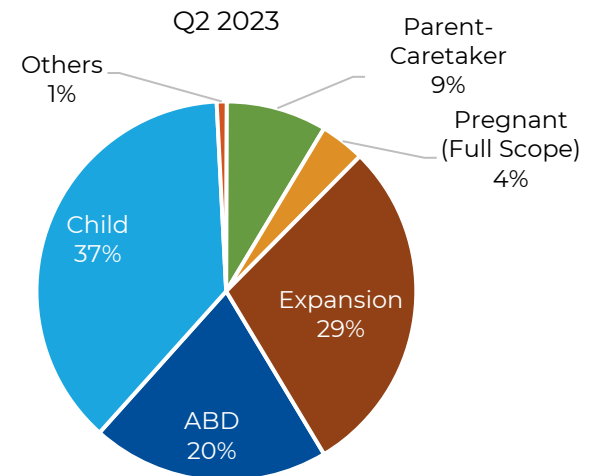
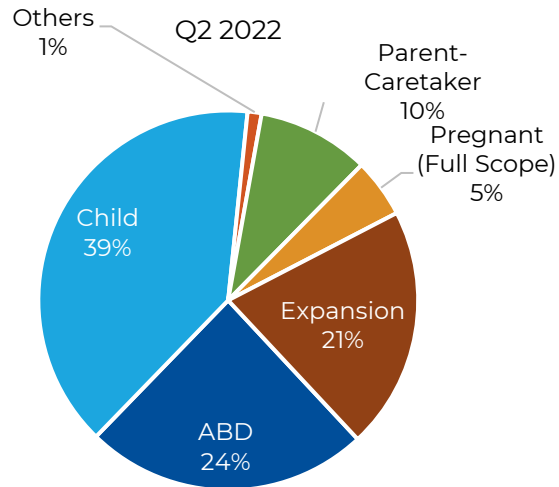


### Outpatient Hospital Expenditures

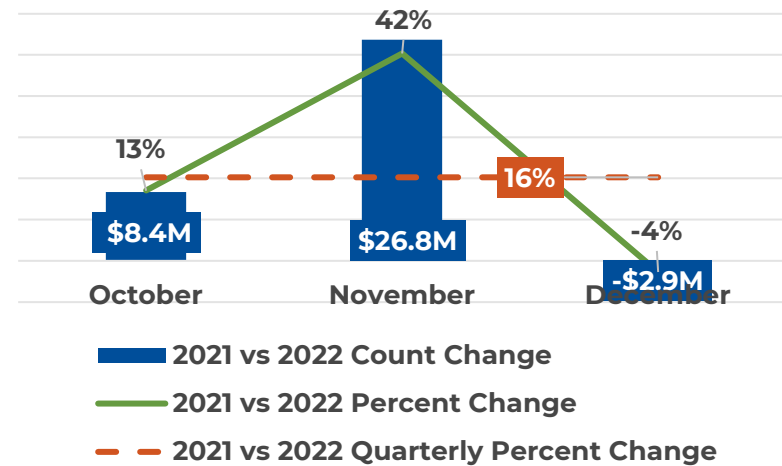
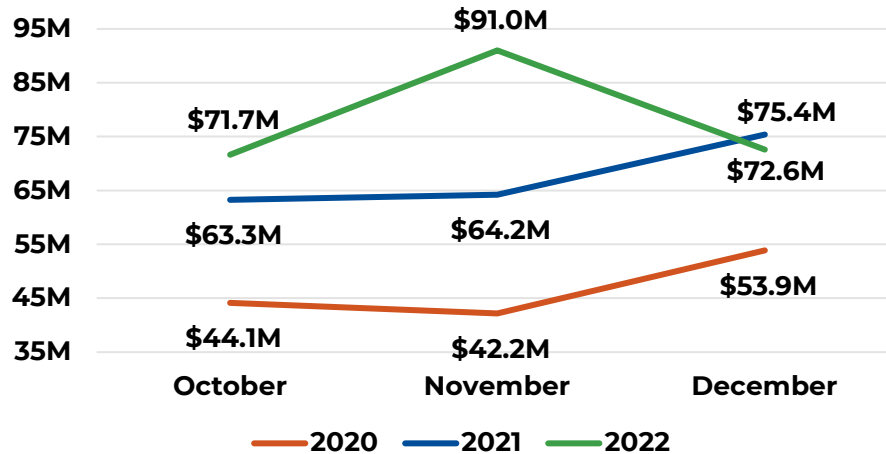


## Financials (Cont.)

### Outpatient Hospital Members Utilization by Qualifying Group

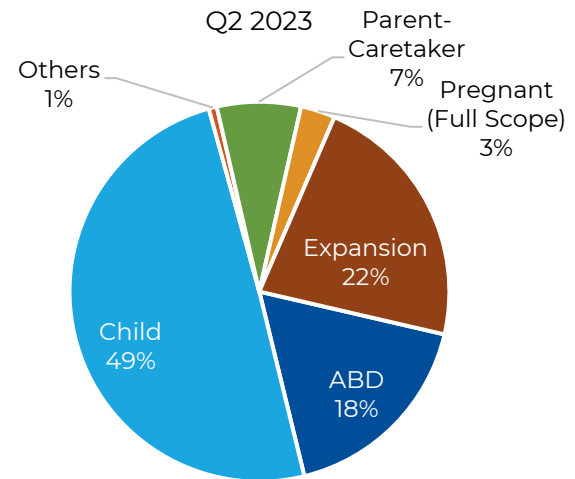
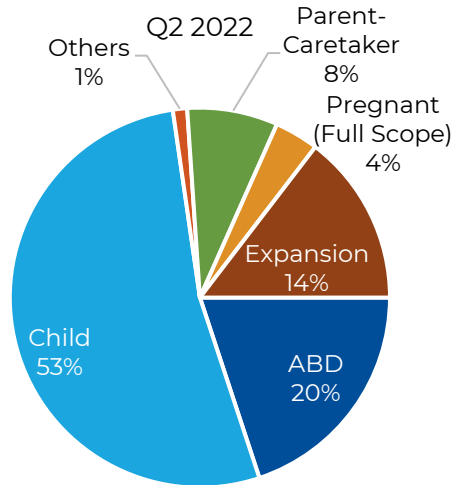


### Physician Expenditures

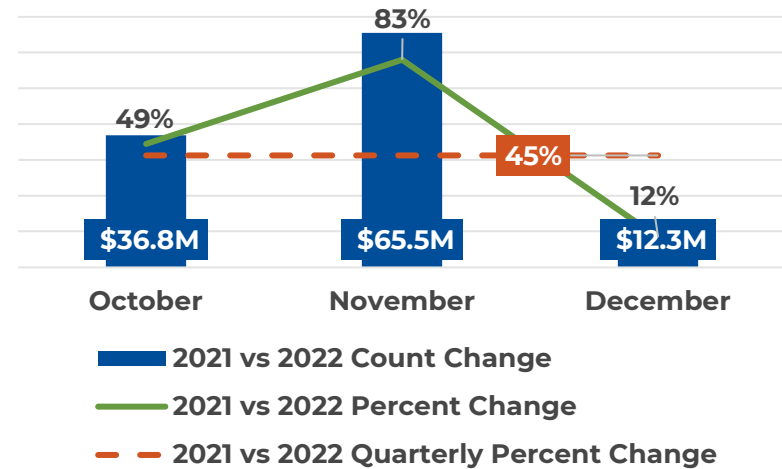
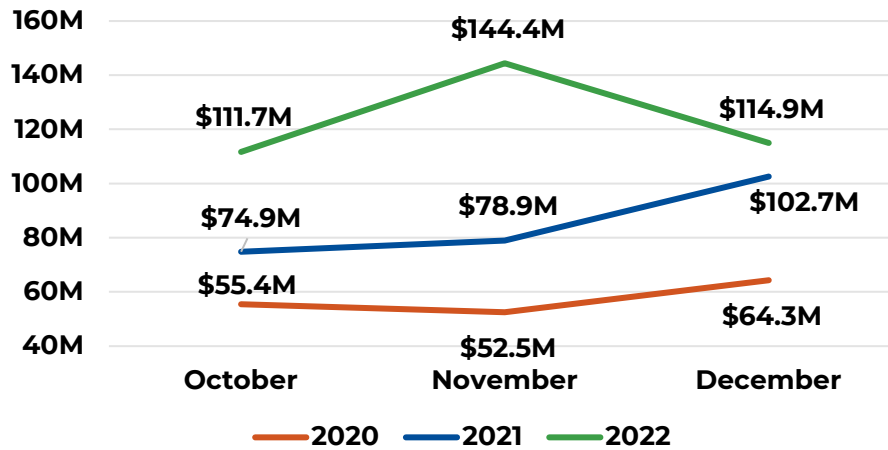


## Financials (Cont.)

### Physician Members Utilization By Qualifying Group

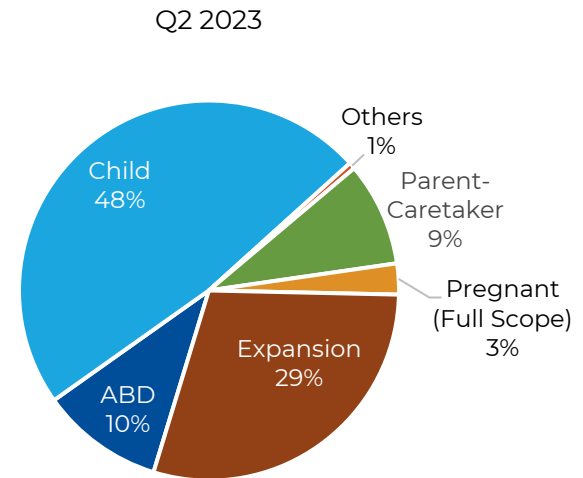
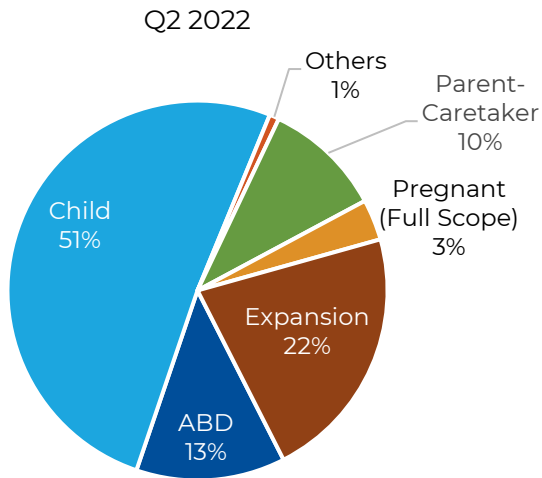


### Prescribed Drugs Expenditures

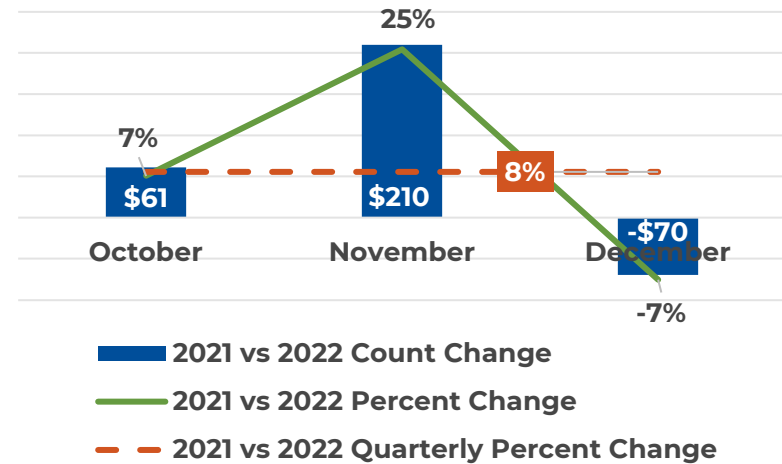
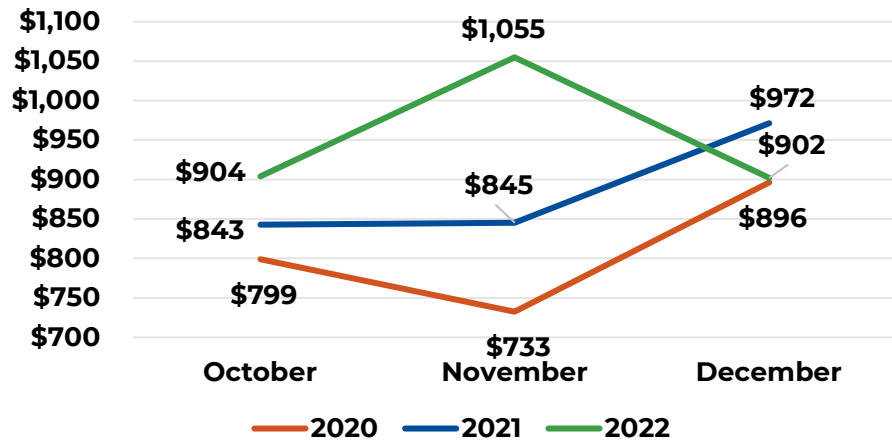


## Financials (Cont.)

### Prescribed Drugs Members Utilization By Qualifying Group

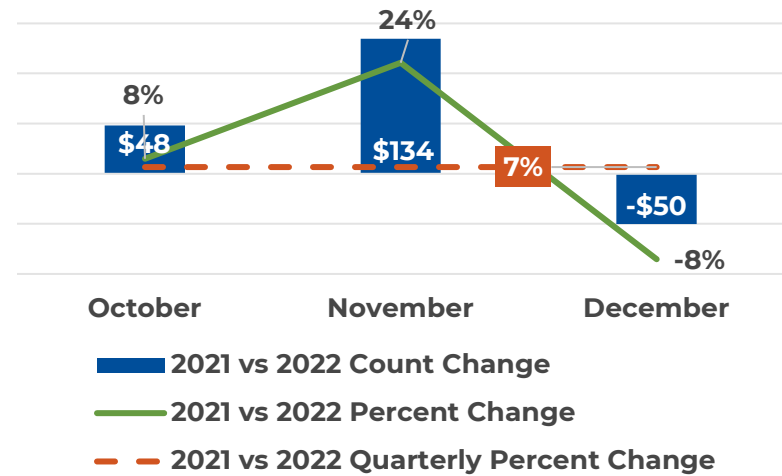
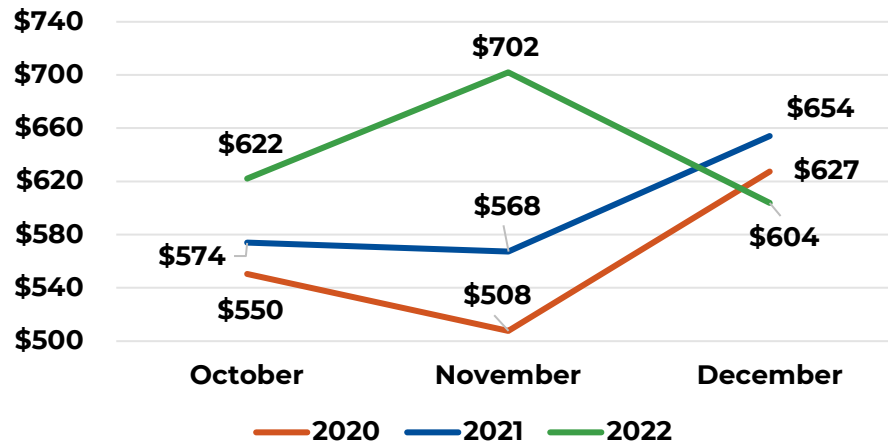


### Average Per Total Member Served

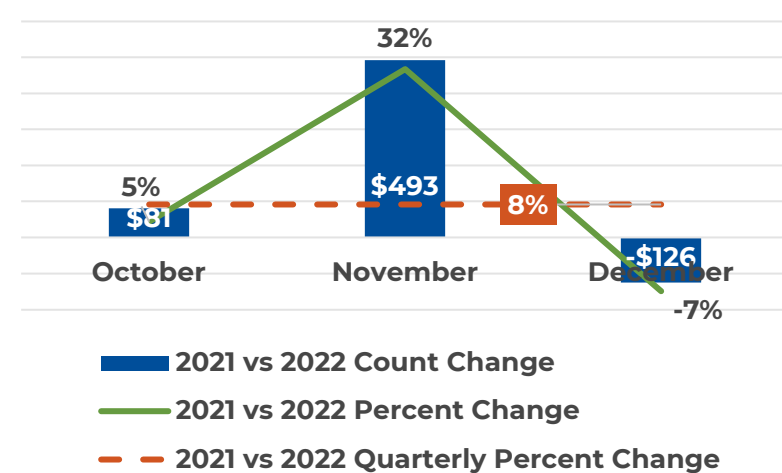
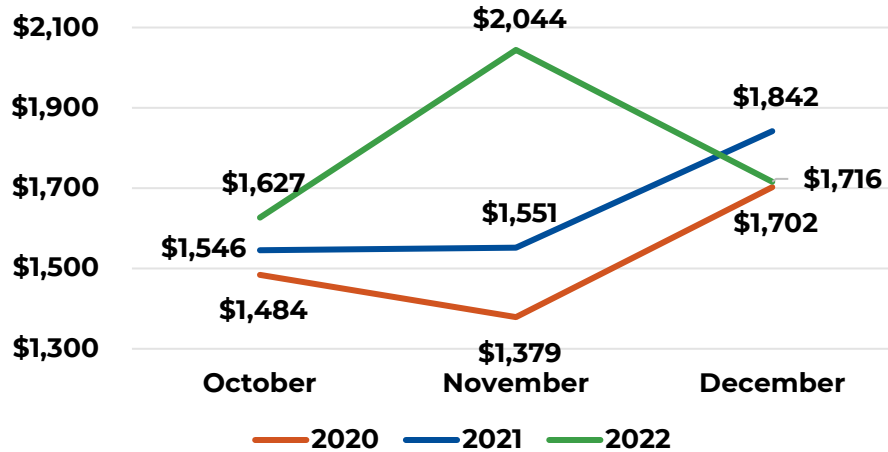


## Financials (Cont.)

### Average Per Child (Under 21) Member Served

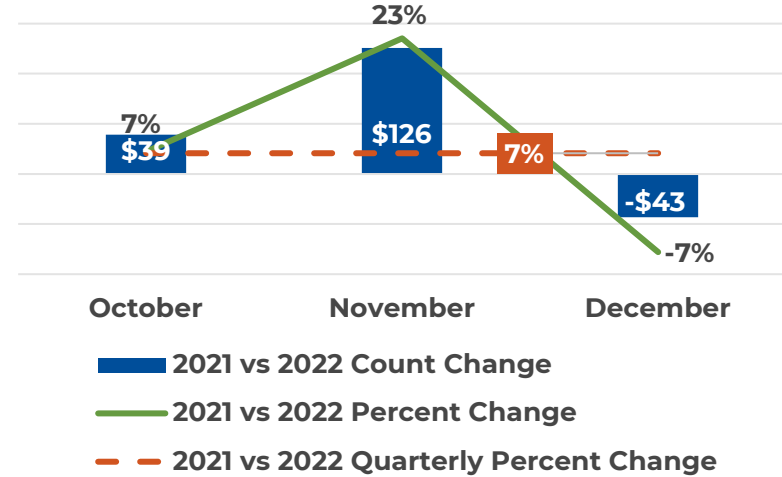
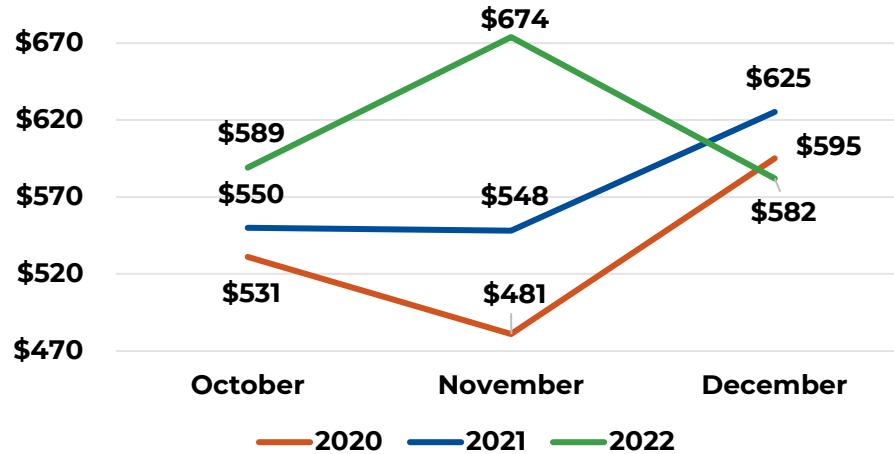


### Average Per Aged/Blind/Disabled Member Served

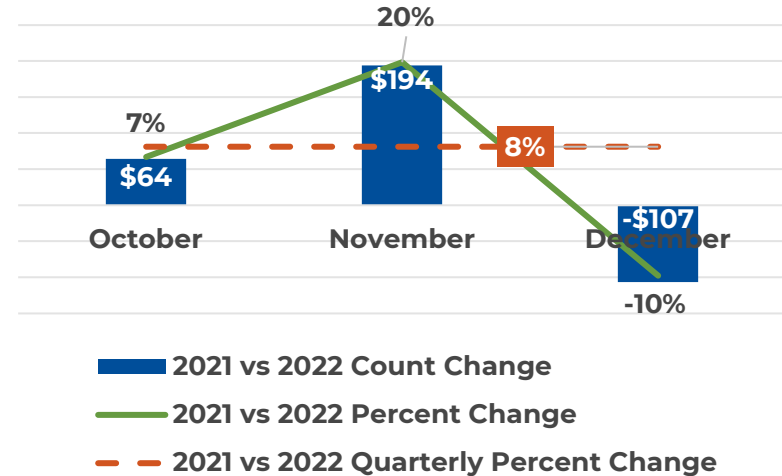
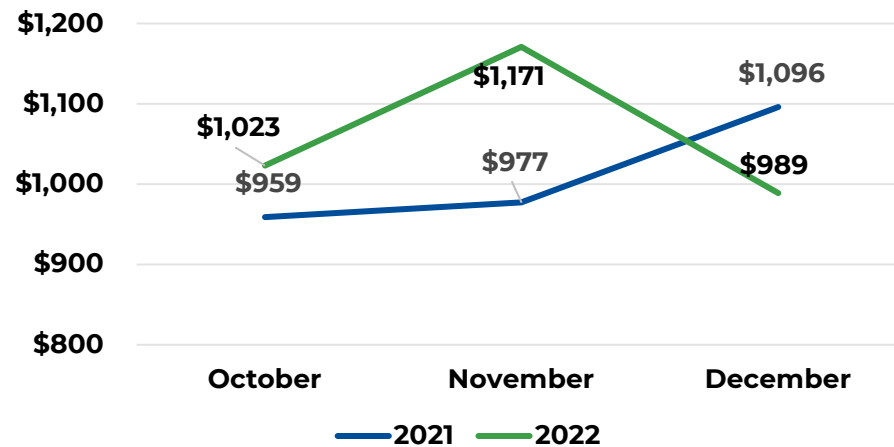


## Financials (Cont.)

### Average Per Children & Parent/Caretaker Member Served

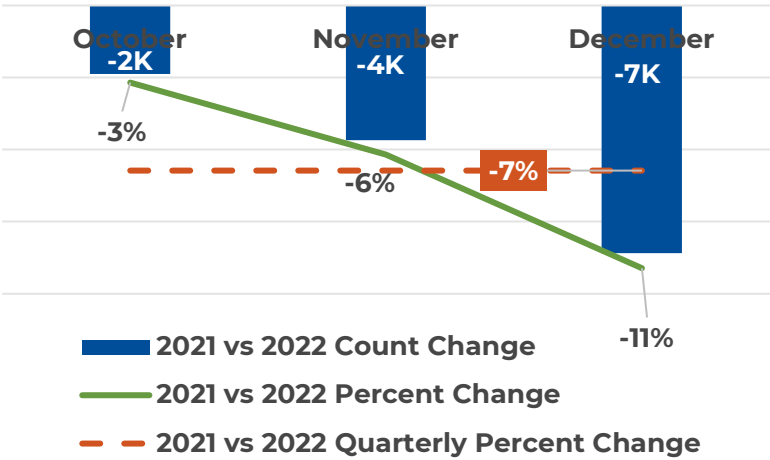
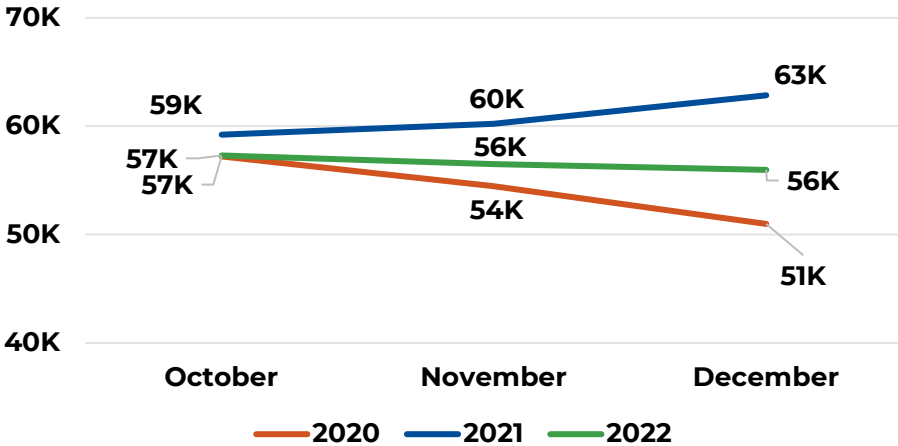


### Average Per Expansion Member Served (Effective July 2021)

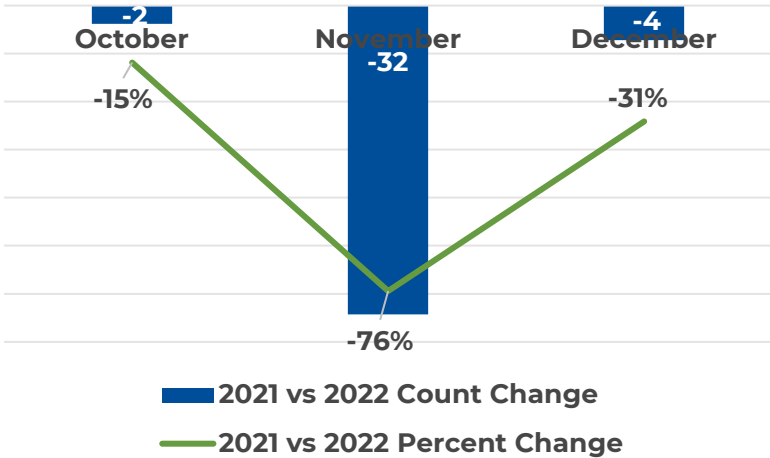
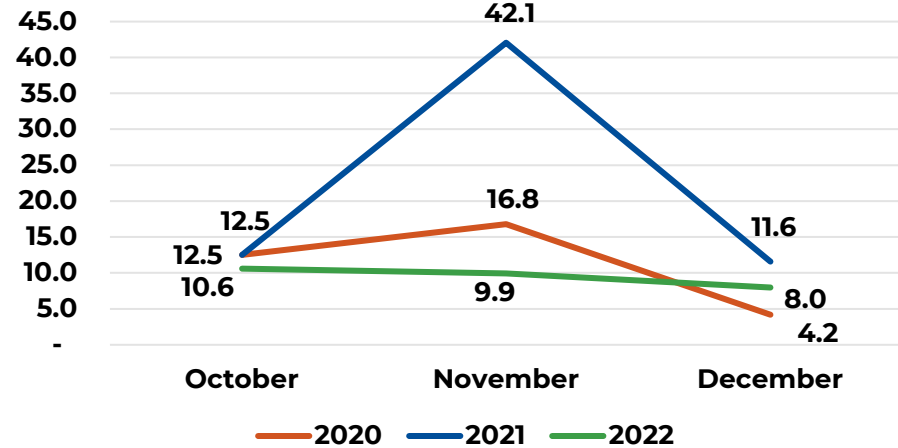


Call Center

Call Center - Member Calls Answered



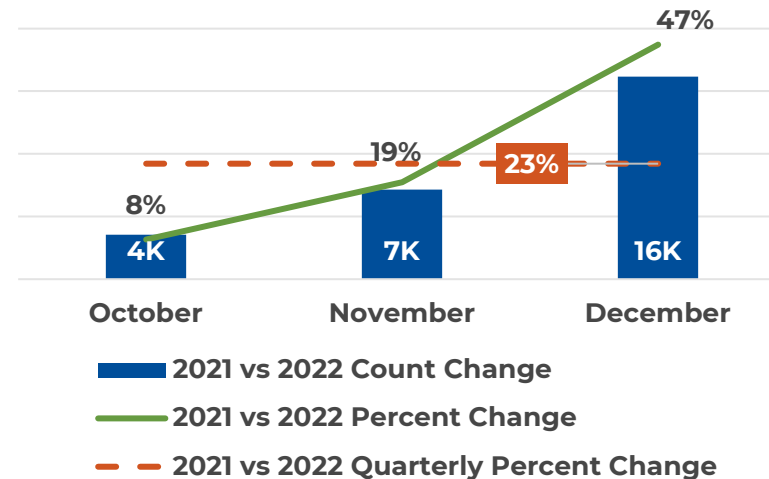
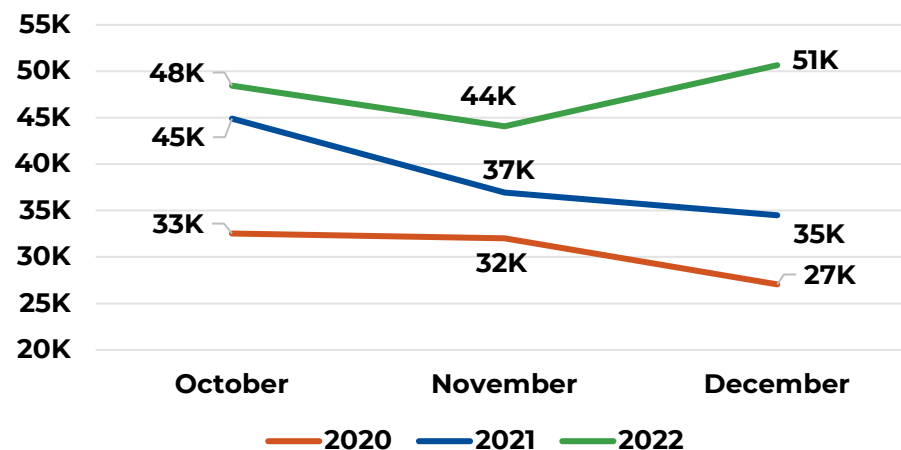
Call Center - Average Wait Time (In Seconds)



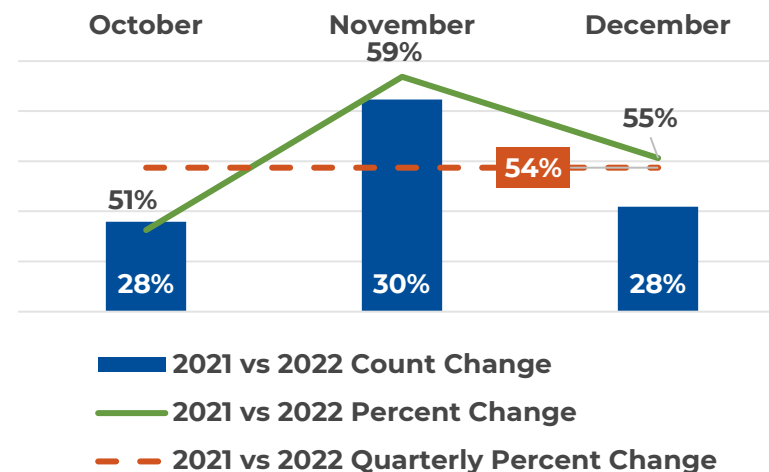
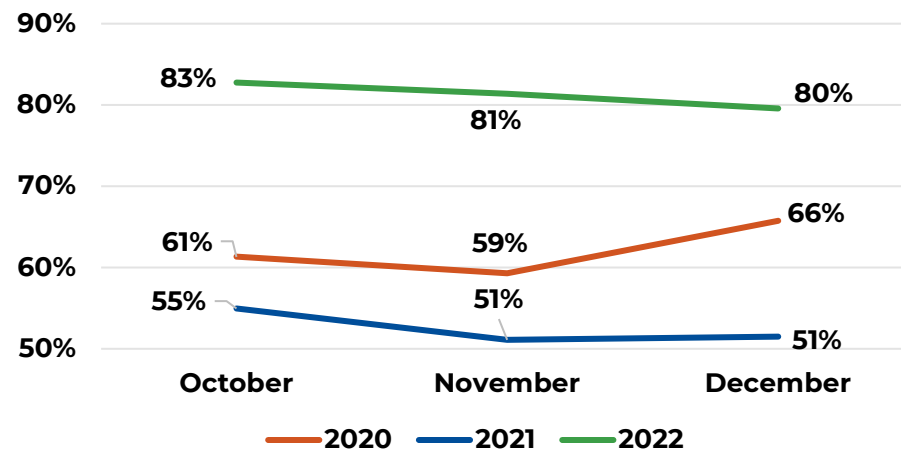


Prior Authorization

Prior Authorization - Total Combined - Total Completed PA Volume

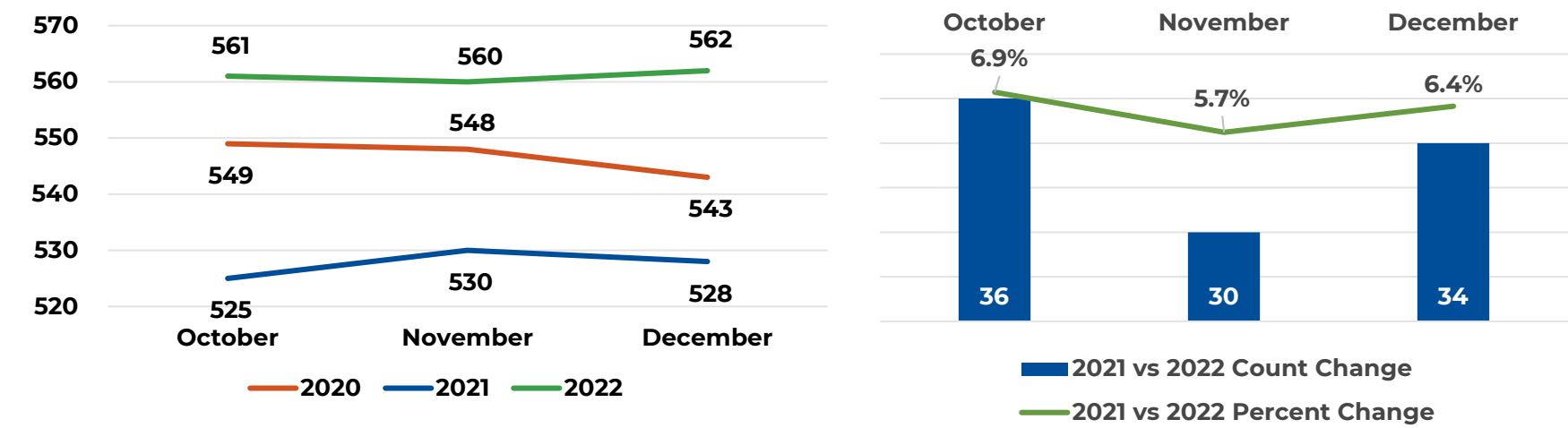


Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

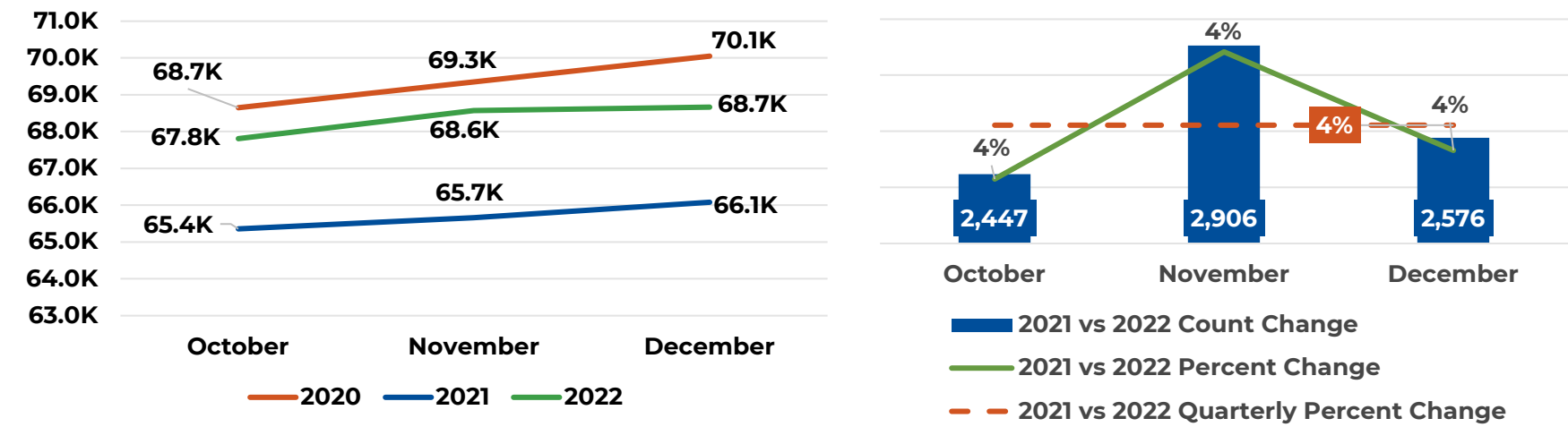


Agency Stats & Provider Network

OHCA Admin - Number of FTEs

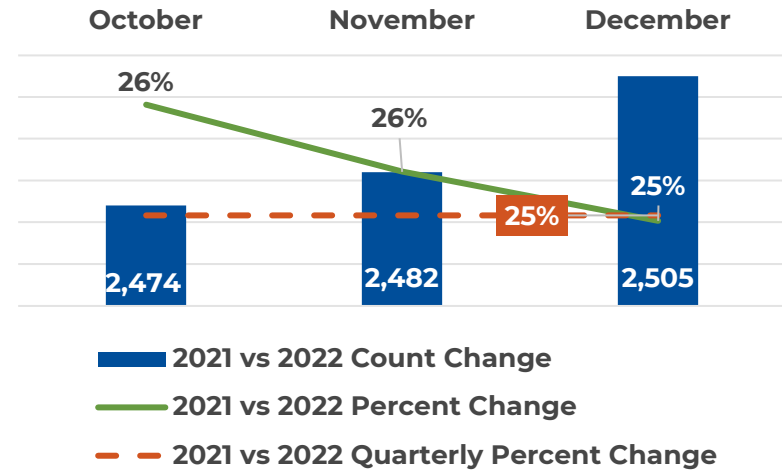
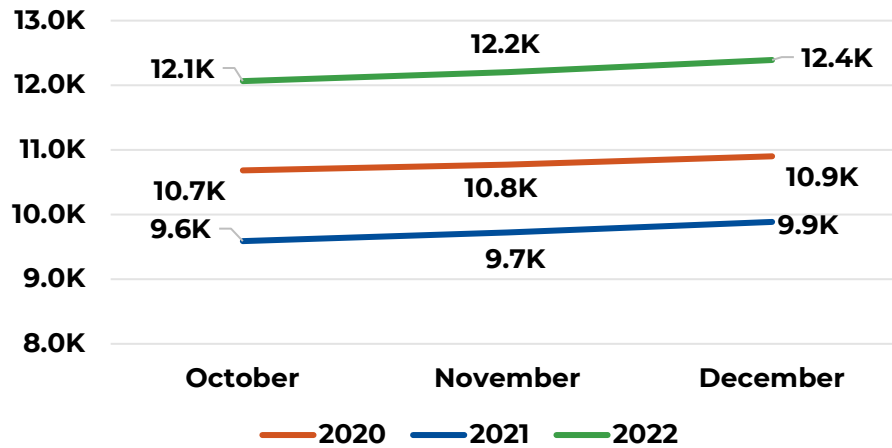


Total Providers

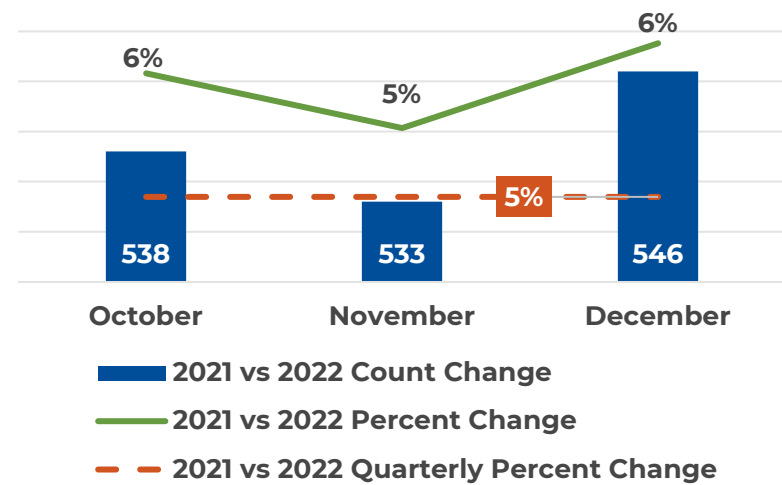
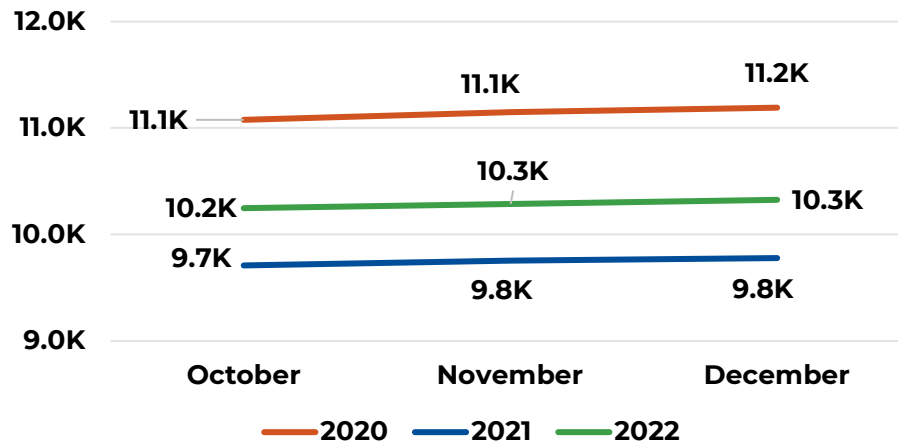


## Agency Stats & Provider Network (Cont.)

### Mental Health Providers (In-State Only)

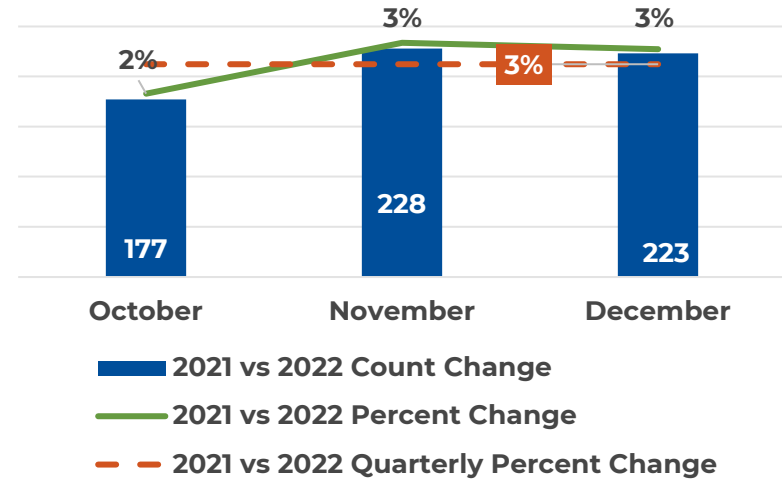
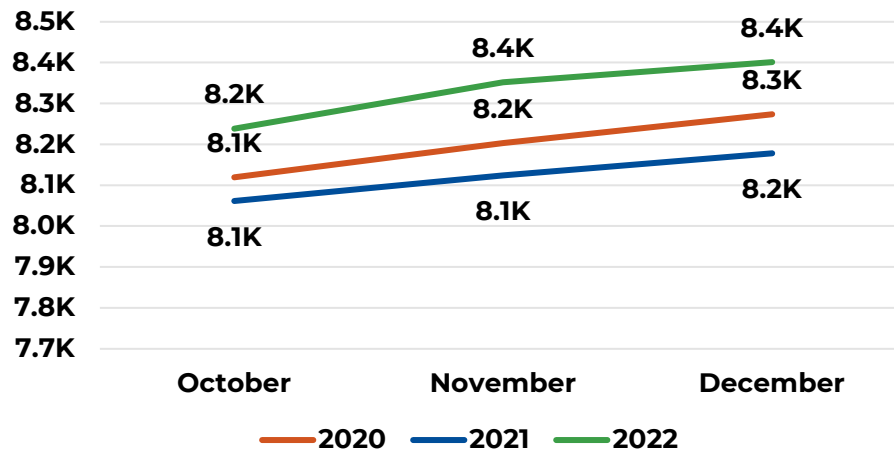


### Physicians (In-State Only)

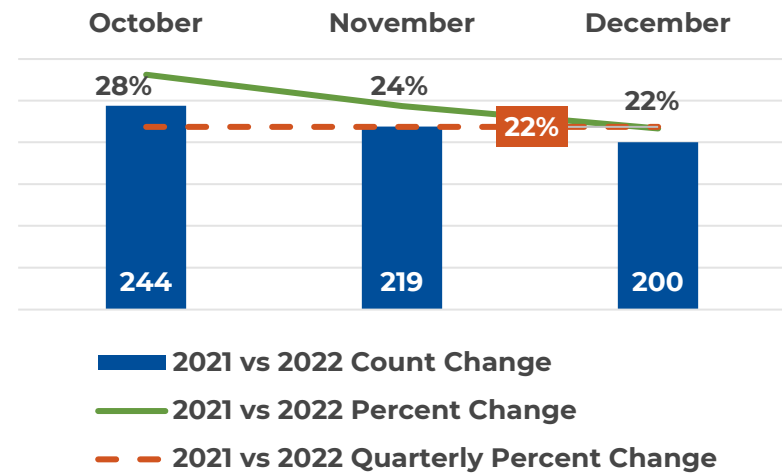
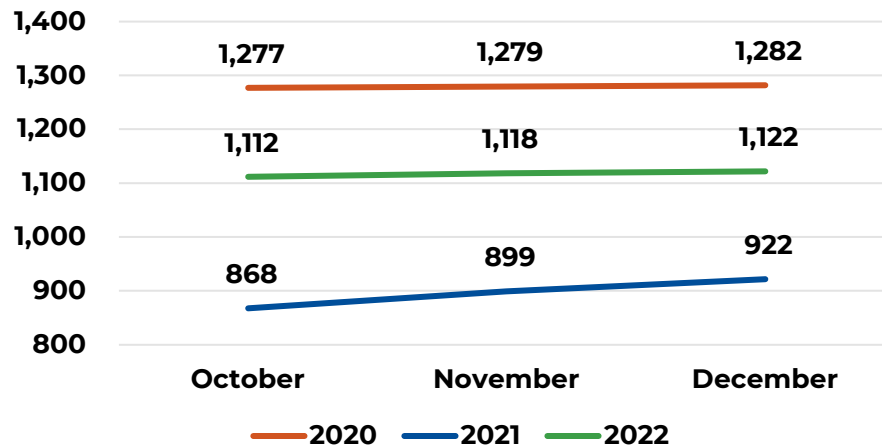


## Agency Stats & Provider Network (Cont.)

### Primary Care Providers (In-State Only)

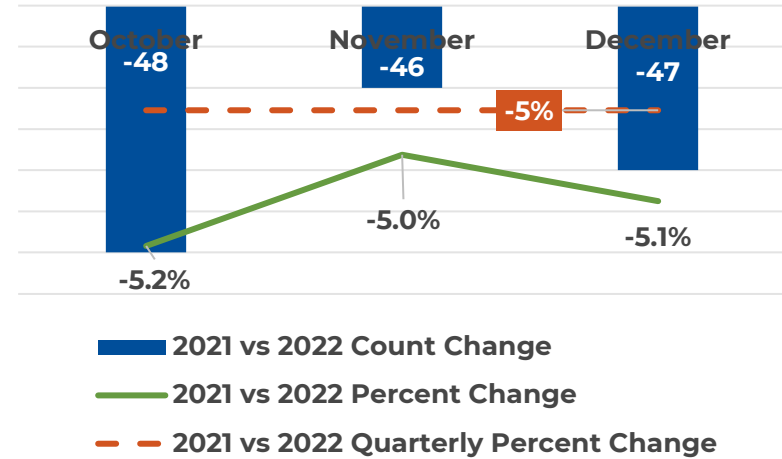
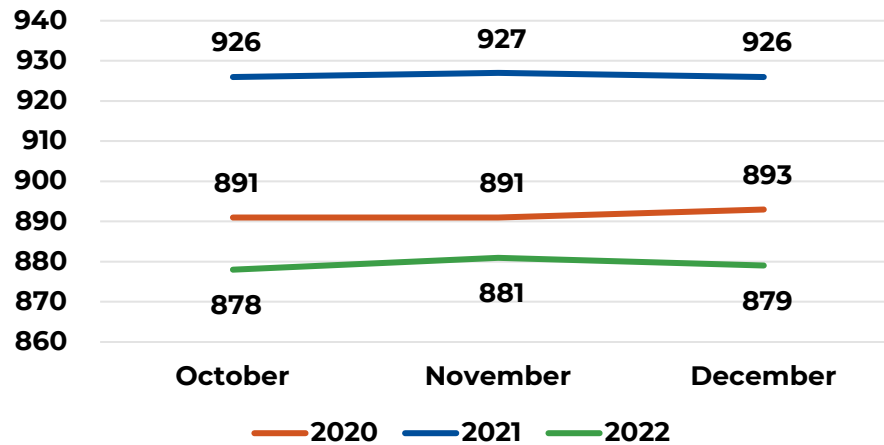


### Dentists (In-State Only)

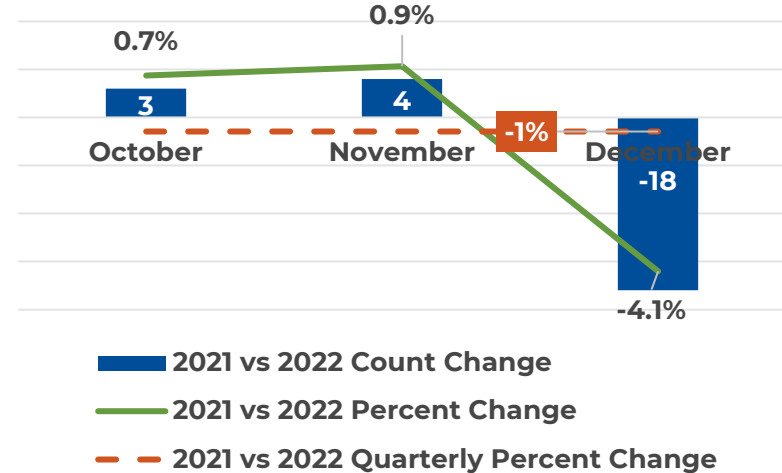
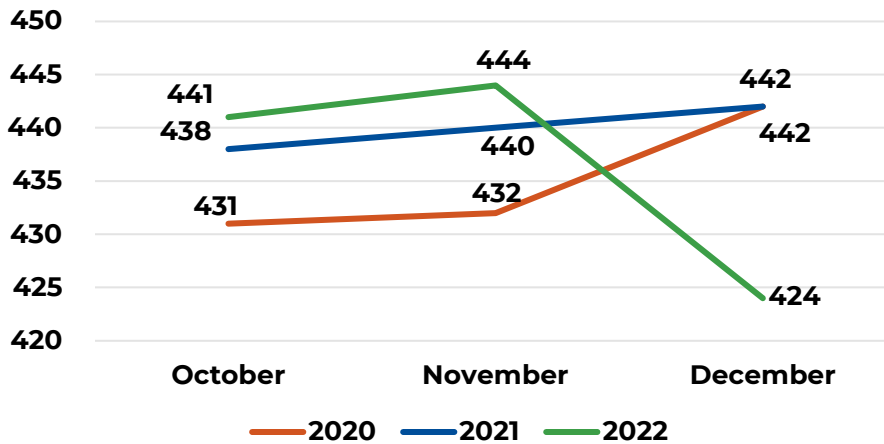


## Agency Stats & Provider Network (Cont.)

### Pharmacy (In-State Only)



### Extended Care Facilities (In-State Only)



# Agency Stats & Provider Network (Cont.)

## Hospitals (In-State Only)

