OKLAHOMA HEALTH CARE AUTHORITY
AMENDED BOARD MEETING
June 28, 2023, at 2:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK. 73105

A G E N D A

Public access via Zoom:
https://www.zoomgov.com/webinar/register/WN_XWUqmYAmRBu0Gcmqtr-y3g
Telephone: 1-669-216-1590 Webinar ID: 161 521 7444

*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 March 22, 2023, OHCA Board Meeting Minutes…….Marc Nuttle, Chair

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

4. Chief of Staff Report (Attachment "A")…….……..Ellen Buettner, Chief of Staff

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

6. 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:
Brimonidine 0.33% Topical Gel	Rosacea: A common chronic skin condition that usually only affects the face and eyes.
Vtama®	Plaque Psoriasis: Psoriasis is a skin disease and comes in several forms.
Zoryve™	Plaque Psoriasis
Tadliq®	Pulmonary Arterial Hypertension: PAH is a specific type of pulmonary hypertension that is caused when the tiny arteries in the lung become thickened and narrowed.
Tyvaso DPI®	
Ztalmy®	Seizure disorders: A seizure is a burst of uncontrolled electrical activity between brain cells (also called neurons or nerve cells) that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness), behaviors, sensations, or states of awareness.
Zonisade™	
Rezlidhia™	Acute Myeloid Leukemia: AML starts in the bone marrow (the soft inner part of certain bones, where new blood cells are made), but most often it quickly moves into the blood, as well. It is the most common type of acute leukemia in adults. AML is also called acute myelogenous leukemia and acute nonlymphocytic leukemia.
Briumvi™	Multiple Sclerosis: A long-lasting (chronic) disease of the central nervous system. It is thought to be an autoimmune disorder, a condition in which the body attacks itself by mistake.
Tascenso ODT®	

Lamzede®	Alpha-mannosidosis: A rare genetic condition characterized by an inability to properly break down certain groups of complex sugars in the body's cells.
Rolvedon™	Febrile Neutropenia: A condition marked by fever and a lower-than-normal number of neutrophils in the blood.
Airsupra™	Asthma: A chronic (long-term) lung disease. It affects your airways, the tubes that carry air in and out of your lungs.
Olpruva™ Pheburane®	Urea Cycle Disorder: A urea cycle disorder is a genetic disorder that results in a deficiency of one of the six enzymes in the urea cycle.
Jaypirca™ Lunsumio™	Mantle Cell Lymphoma: MCL is a type of non-Hodgkin's lymphoma, which is a form of cancer that affects the lymphatic system.
Tzield®	Stage 2 Type 1 Diabetes Mellitus: In T1DM the pancreas does not make or makes very little insulin. In Stage 2 T1DM the patient has autoantibodies attacking the pancreas, has abnormal blood glucose level, but is pre-symptomatic.
Syfovre™	Geographic Atrophy of Age-related Macular Degeneration: AMD is an eye disease that can blur your central vision and can lead to the loss of vision. Geographic atrophy is advanced AMD.
Vivjoa® Ancobon®	Vulvovaginal Candidiasis: VVC is an infection caused by yeast. Systemic Fungal Infections: An internal fungal infection such as sepsis, endocarditis, urinary tract infection, meningitis, etc.
Skyckarys™	Friedreich's ataxia: FRDA is a rare inherited disease which causes progressive damage to the nervous system and movement problems.
Filspari™	Primary Immunoglobulin A Nephropathy: IgAN is a condition which damages the glomeruli inside the kidneys and can cause damage.
Imjudo® Krazati®	Hepatocellular Carcinoma and Non-Small Cell Lung Cancer: HCC is the most common type of primary liver cancer.

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

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

      i. Regular Nursing Facilities Rate Increase
      ii. Acquired Immune Deficiency Syndrome (AIDS) Nursing Facilities Rate Increase
      iii. Regular Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Rate Increase
      iv. Acute (16-Beds-Or-Less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Rate Increase
      v. Private Duty Nursing (PDN) Rate Increase & Overtime Rate
      vi. Doula Services
      vii. Air Ambulance Rate Increases
      viii. Biosimilar Reimbursement
      ix. Developmental Disabilities Services
      x. Behavioral Health Transportation Rates

   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 "E")

      i. Admissions, Discharge, and Transfer (ADT) Data Access and System Support
      ii. System Implementation Support Services
      iii. Analytics

iv. Behavioral Health Home Management Software System
v. Managed Care Playbooks
vi. Customer Relationship Management (CRM)
vii. Peoplesoft Financials Transition Support
viii. OMES PeopleSoft Implementation Statement of Work
ix. Technical Consultant for the Medicaid Management Information System (MMIS) Modernization
x. Third Party Liability (TPL) Systems
xi. Third Party Liability (TPL) Systems Extension
xii. Customer Experience Analytics Tool

c) Presentation of the SFY 2024 Budget Work Program by Aaron Morris, Chief Financial Officer (Attachment "F")

d) Discussion and Possible Vote on the SFY 2024 Budget Work Program pursuant to 63 O.S. Section 5008(B)(3)

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

9. Discussion of Report of Administrative……..…Tanya Case
Rules Advisory Committee and Possible Action Chair, Administrative Rules Advisory Committee
(Attachment "G")

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

i. APA WF # 23-02 Insure Oklahoma Self-Funded/Self-Insured Plans
ii. APA WF # 23-09 Copayment Exemption for Expansion Adults
iii. APA WF # 23-10 Doula Services
iv. APA WF # 23-11 Private Duty Nursing (PDN) Reimbursement and Overtime
v. APA WF # 23-12 Enhanced Payment for Vocational & Day Services Provided in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs)
vi. APA WF # 23-14 Audio-Only Telecommunications Health Service Delivery

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

11. Adjournment.....……..Marc Nuttle, Chair

NEXT BOARD MEETING
September 20, 2023, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

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MINUTES OF AN AMENDED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
March 22, 2023
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on March 21, 2023 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 March 17, 2023 at 12:13 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 2:00 p.m.

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

ITEM 2 / PUBLIC COMMENT

The following members of the public made a public comment:

1. Brian Wilkerson, Oklahoma Disability Law Center
2. Amber Prather, LPC
3. Margaret Meredith
4. Lorien Holman, CEO of Seasons of Change Behavioral Health Services
5. Nercissa Newberry, LPC
6. Sarah VanAlstine, Oklahoma Occupational Therapy Association
7. Cori Loomis, OSMA

ITEM 3 / DISCUSSION AND POSSIBLE VOTE ON THE JANUARY 18, 2023, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Member Christ moved for approval of item 2, as published. The motion was seconded by Member Kennedy.

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

ITEM 4 / CHIEF EXECUTIVE OFFICER'S REPORT
Kevin Corbett, Chief Executive Officer

CEO Corbett introduced Ms. Verna Foust, CEO of Red Rock Behavioral Health Center, who provided an overview of Red Rock Behavioral Health Services.

Rules Process: CEO Corbett provided an overview of the rules process and introduced the members of the Administrative Rules Advisory Committee. He reminded attendees that all OHCA rules go through Tribal Consultation, Medical Advisory Committee, public comment, the Rules Committee, and then the full Board. The legislative deadline for permanent rulemaking is April 1st. The OHCA Board has a statutory duty to approve all rules that OHCA is required to promulgate. Senate Bill 1369 nor the rules proposed today are either suggesting or requiring any provider to violate any existing laws with regard to the provider's responsibility to protect patient confidentiality. No patient data of any kind should be submitted to the Health Information Exchange (HIE) if the patient does not approve it. For Licensed Behavior Health providers, current law requires approval from the patient, in the form of a written consent, to have their information submitted to the HIE.

Managed Care: Two Dental contracts have been awarded and staff are currently in the process of evaluating the Medical and Children's Specialty bid submissions, which should occur in May. OHCA staff are actively working to develop the organization structure for oversight of the contracted entities while also continuing to operate existing populations, ABD, and Native American members. The service needs of the excluded or optional populations are disproportional to the number of members in these groups. There was a change in the expected go-live date, which was communicated, from October 2023 to April 2024. Staff are working as diligently as possible to go as soon as practical.
Public Health Emergency (PHE) and Continuous Coverage Unwinding: As of April 1, 2023, OHCA will begin to disenroll those members that were eligible for coverage by virtue of the PHE. OHCA has been working with CMS to ensure CMS'

expectations are met. Communication on the unwind have been significant with the members, legislators, providers, and community partners. At this time, it is believed that there are about 300,000 members that are currently ineligible and will be disenrolled throughout the unwind process. OHCA will continue to receive the enhance FMAP through the unwind. Estimates show that OHCA will receive about $120 million, which is estimated to be sufficient to cover the cost of coverage during the unwind period. OHCA estimates it will have a surplus from the enhanced FMAP fund of about $600 million. In total, about $1.6 billion has been received, of which $1 billion is OHCA's share. The remainder has been shared with other state agencies, who paid state share of the Medicaid program.

Strategic Planning and Operations Committee: CEO Corbett briefly mentioned the creation of the Strategic Planning and Operational Committee, which will be further discussed during that committee's report out.

Building: OHCA staff have been working on alternatives for our needs, our space needs, as well as other options available for us to pursue. OHCA will have the opportunity to utilize the building and create the opportunity to allow co-locating partners. Ms. Buettner will provide a more detailed update during her report.

Looking Ahead: CEO Corbett provided an update of key upcoming items, key implementations of procurement being one of them. A few procurement items include: MMIS System re-procurement, Financial System, and the Care Management System Implementation.

Other Items: The State is conducting a compensation study, which was directed by the legislature. The results have not been released. OHCA also conducted its own map market study last year and adjusted salaries as needed. OHCA continues to watch the drug market with regards to utilizing existing medications for other medical needs, like Ozempic. It's currently not covered but research is being done.

ITEM 5 / CHIEF OF STAFF REPORT
Ellen Buettner, Chief of Staff

Ms. Buettner provided updates on staff development, OHCA building, litigation and legislative session.

Staff Development: OHCA is working on investing in the team from a competency-based level, from a management and leadership level. Staff are engaging in various activities in terms of leadership development programs, including 360 evaluations at the executive level to ensure OHCA has the right people in the right seats to help lead the organization into its next phase.

OHCA Building: Ms. Buettner announced that the Department of Mental Health and Substance Abuse Services will be co-locating and joining OHCA in this building. Both agencies are working together to finalize the details. Updates will be provided throughout the co-locating process.

Litigation Update: The Equity Group lawsuit, filed in January, that challenged some provisions of the RFP, has been fully briefed. The Hospital Association has filed an amicus brief in support of the OHCA's RFP. The Supreme Court will hear oral arguments regarding the case. The Oklahoma AG's office represents OHCA on this matter. Ms. Buettner extended an invitation to the Board to attend the oral arguments.

Legislative Session: Ms. Foss provided an update on where the OHCA request bills are at in the legislative process. OHCA's four request bills have made it out of their chambers.

SB 744: This bill modifies OHCA's payment structure for ambulance service provider access supplemental payment program for ground emergency transportation providers. It would allow the program to continue in a managed care program as directed payment.

HB 1657: This bill amends the statute to establish a uniform process for enrolling and credentialing health care providers. Currently, the statute directs managed care entities to require provider credentialing through the Department of Health and their universal application. This amendment moves that process under OHCA's purview.

HB 1658: Separates the Medical and Dental Managed Care plans.

HB 1791: This bill would put all lien holders on equal footing regarding the amount that they can be that can be collected from a settlement.

Other bills to note: HB1650 and SB 563 require anesthesia to continue to be reimbursed full or greater to our established scheduled. HB 1688 establishes a payer claims database, as well as, adds additional exemptions that are being discussed today regarding the HIE rules into statute.

ITEM 6 / STATE MEDICAID DIRECTOR'S REPORT
Traylor Rains, State Medicaid Director

Mr. Rains provided an update on Upcoming Federal Regulations Impacting SoonerCare, Maintained PHE Program Flexibilities, State Plan Amendment Requests to CMS, SoonerSelect Update, and Quality Strategy Update.

For more detailed information, see separate presentation on OHCA Board Calendar.

ITEM 7 / CONTINUOUS COVERAGE UNWINDING PRESENTATION
Brandon Keppner, Chief of Operations

Mr. Keppner provided an overview of the Public Health Emergency Unwinding, which included information on the priority groups, disenrollment flow chart, demographic state map, and monthly demographics.

For more detailed information, see Attachment A in the board packet.

ITEM 8i-vii / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING DRUG UTILIZATION BOARD RECOMMENDATIONS
Terry Cothran, Director of Pharmacy Services

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

	Drug Name:	Used For:
i.	Relyvrio™	**Amyotrophic Lateral Sclerosis (ALS),** also known as Lou Gehrig's disease, is a progressive and fatal disease attacking neurons that control voluntary movement.
ii.	Vyvgart®	**Myastenia Gravis** is an autoimmune neuromuscular disorder primarily characterized by muscle weakness and muscle fatigue.
iii.	Vabysmo™	**Neovascular Wet Age-Related Macular Degeneration (Wet AMD)** is a serious type o late AMD. It happens when vascular endothelial protein growth factor makes abnormal blood vessels grow in the wrong place in the back of your eye.
iv.	Kimmtrak® Opdualag™	**Metastatic Melanoma** is a serious type of skin cancer which has spread to another area of the body.
v.	Lytgobi®	**Cholangiocarcinoma i**s also known as bile duct cancer and is a rare form of cancer affecting 8,000 people in the US each year.
vi.	Pedmark® Vijoice®	**Prevent ototoxicity associated with cisplatin therapy** Ototoxicity is the pharmacological adverse reaction affecting the inner ear or auditory nerve. **PIK3CA-Related Overgrowth Spectrum (PROS)** includes a group of rare genetic disorders that leads to overgrowth of various body parts due to mutations in the gene
vii.	Hyftor™	**Facial Angiofibromas Associated with Tuberous Sclerosis Complex (TSC)** Facial angiofibroma is the most predominant cutaneous manifestation of TSC, a rare autosomal dominant genetic disorder.

MOTION: Vice-Chairman Yaffe moved for approval of item 8i-vii, as published. The motion was seconded by Member Cruzan.

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

ITEM 9 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE

Phil Kennedy, Chair, Compliance Advisory Committee

Member Kennedy provided updates on Program Integrity and the financials through January.

Financials: Revenues for OHCA through September were $4.6 million, which was $3.9 million under budget. Federal funds and drug rebate collections were also under budget through January but that is offset in collections from Quality of Care, Medical Refunds, and the hospital provider fee. Expenditures for OHCA were $4.4 billion under budget, which was attributable to small variances throughout all categories of service lines. The state dollar budget variance through January is a positive $7.9 million. A reminder that this report incorporates the most recent budget revision filed to account for increased spend related to the PHE. OHCA submitted the budget revision in early January, increasing the budget $635 million to include: inclusion of Nursing Facility Supplemental Payments by $139 million, inclusion of additional SHOPP distribution of $52 million, and inclusion of a full 12-month impact of the PHE and the continuous coverage mandate of $444 million. These increases were funded by non-state sources including quality of care fee, hospital provider fees, and enhance FMAP. OHCA continues to collect more in EFMAP than the cost to carry the additional members due to the continuous coverage requirement.

Program Integrity: Through December 31, 2023, Program Integrity provider audit collections are on pace to match prior year recoupments. This includes 280 completed audits, with identified overpayments totaling $2.25 million and 97% of the total recouped.

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

    i. Third Party Liability (TPL) Systems

MOTION: Member Kennedy moved for approval of item 9a.i, as published. The motion was seconded by Member Christ.

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

ITEM 10 / DISCUSSION OF REPORT FROM THE STRATEGIC PLANNING AND OPERATIONAL ADVISORY COMMITTEE

Marc Nuttle, Chair, Strategic Planning and Operational Advisory Committee

Chairman Nuttle provided an overview of the committee's first meeting. Managed Care and PHE unwinding updates, as well as discussing operational matters such as both processing and prioritization patterns. The committee also discussed the enhanced FMAP funding and how this could be an opportunity to look at Oklahoma's rural areas and see how they could benefit. Chairman Nuttle stated that is his directive, as Board Chairman of the Health Care Authority, to take action from legislative requirements to dedicate the funds. CEO Corbett accepted that directive. Vice-Chairman Yaffe recommended an investment in sustainable infrastructure. Member Case stated she would like to see this as an opportunity for some public private partnerships to make this even larger.

ITEM 11 / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING

Tanya Case, Interim Administrative Rules Advisory Committee Chairwoman

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

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

i. APA WF # 23-01 State Plan Personal Care Services for Expansion Adults, TEFRA Eligible Children and Certain MAGI Populations
ii. APA WF # 23-05 Notification of Date of Service (NODOS) Timeframe Change
iii. APA WF # 23-06A&B Transition to SoonerSelect

MOTION: Member Kennedy moved to approve that there was significant evidence of the above rules being presented as emergency rules. The motion was seconded by Member Finch.

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

MOTION: Member Case moved to approve the rules listed in item 11a.i-iii as published. The motion was seconded by Vice-Chairman Yaffe.

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

b) Consideration and Possible Action on Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Permanent Rules (Attachment "D")

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

iv. APA WF # 22-01 Non-Emergency Transportation NEMT) Driver Compliance
v. APA WF # 22-02 Independent Clinical Psychologist Services for Adults
vi. APA WF # 22-03 Clinical Trials Services and Dental Out-of-State Services
vii. APA WF # 22-05 Ambulance Service Provider Access Payment Program
viii. APA WF # 22-07 Tribal Residential Substance Use Disorder (SUD) Policy Updates
ix. APA WF # 22-08 Hospice Benefit for Expanded Population
x. APA WF # 22-10 Long-Term Care Facility (LTC) Pay-for-Performance (PFP) Program
xi. APA WF # 22-11 Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Visit and Sick Visit on the Same Day
xii. APA WF # 22-12 Staff Ratios and Staff Licensing Requirements for Out-of-State Psychiatric Providers
xiii. APA WF # 22-13 Allowing Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs) to Render Physician-Required Psychiatric Services
xiv. APA WF # 22-14 Coverage for Donor Human Breast Milk
xv. APA WF # 22-15 Removing Provider Panel Limits in the Patient Centered Medical Home (PCMH)
xvi. APA WF # 22-17 Covering Former Foster Care Youth from Another State
xvii. APA WF # 22-18 Mobile Dental Services
xviii. APA WF # 22-21A&B Increase Income Standard for Pregnant Women and Extend Postpartum Coverage
xix. APA WF # 22-22 Ukrainian Humanitarian Parolees

The following PERMANENT rule HAS previously been approved by the Board and the Governor under EMERGENCY rulemaking. This rule HAS been revised for PERMANENT rulemaking.

xx. APA WF # 22-16 Statewide HIE – Steve Miller, State Coordinator for Health Information Exchange, stated that the rule the board and public are seeing today are a result of the comments received over the last several weeks. Mr. Miller reiterated that it's understood that behavioral health, or any other provider who has a legal obligation to withhold their data, should do so, and not submit their data to the HIE unless they have consent from their patient. Mr. Miller also stated that the opt-out capability is the capability to block all data. The updated rule also allows HIE staff a much broader capability to grant exemptions, which have been stated, as well as broad-based exemptions. Over time, HIE staff have held over 50 public presentations around HIE and continue to do so throughout Oklahoma. Should a patient decide they would like to opt-out, their signed form will not be uploaded to the HIE. Vice-Chairman asked for additional information regarding child abuse and neglect pediatricians. Mr. Miller stated that if the provider decides the information should be marked as sensitive, such as medications and/or diagnosis, then it should be and not transmitted. HIE staff assist providers during the onboarding process with any technical capabilities to be able to do so. Member Cruzan stated he fully understands the provider notes being protected, but to be able to provide the best care for that patient, having medication information is important. Information that marked sensitive will never be sent to the HIE. There are also mechanisms in place for retracting incorrect information.

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

xxi. APA WF # 22-23A&B ADvantage Waiver Rule Changes
xxii. APA WF # 22-24A&B Developmental Disabilities Services (DDS) Policy Changes
xxiii. APA WF # 22-25 Behavioral Health Rules Cleanup
xxiv. APA WF # 22-26 Crisis Intervention Rule Revisions

xxv. APA WF # 22-27 Physician Assistant Rule Revisions
xxvi. APA WF # 22-28 Opioid Treatment Program (OTP) Rule Changes
xxvii. APA WF # 22-29 Laboratory Services Policy Cleanup
xxviii. APA WF # 22-30 Outdated/Obsolete Policy Language Cleanup
xxix. APA WF # 22-31 Eliminate Certificate of Medical Necessity (CMN) Form Requirement for Most Medical Supplies, Equipment, and Appliances

MOTION: Member Finch moved to approve 11b.iv-xix and 11b.xxi-xxix as published. The motion was seconded by Member Kennedy.

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

MOTION: Chairman Nuttle moved to approve 11b.xx as published. The motion was seconded by Member Kennedy.

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

ITEM 12 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE CHIEF OF LEGAL SERVICES AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4).
Marc Nuttle, OHCA Board Chairman

MOTION: Member Cruzan moved to go into Executive Session. The motion was seconded by Member Christ.

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

MOTION: Member Kennedy moved to leave Executive Session. The motion was seconded by Vice-Chairman Yaffe.

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

ITEM 10 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

MOTION: Member Kennedy moved to adjourn. The motion was seconded by Vice-Chairman Yaffee.

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

Meeting adjourned at 5:28 p.m., 3/22/2023

NEXT BOARD MEETING
May 17, 2023
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

OKLAHOMA Health Care Authority | Serving Oklahomans through SoonerCare

LEGISLATIVE UPDATE

Regular Session

OHCA Request Bills

- HB 1657 - Requires the Health Care Authority to streamline the process for Medicaid provider enrollment and credentialing for any fee-for-service and managed care delivery systems.
  Authors: Rep. McEntire, Marcus(R), Sen. Rosino, Paul(R)
  Effective Date: 11/01/2023

- HB 1658 - Requires entities to obtain the appropriate HMO certificate of authority from the Dept of Insurance prior to entering into a contract with the Health Care Authority; EMERGENCY.
  Authors: Rep. McEntire, Marcus(R), Sen. Rosino, Paul(R)
  Effective Date: 05/15/2023

- HB 1791 - Increases the priority of the Health Care Authority in certain lien proceedings and establishes a standard reimbursement formula for payments due to be recovered.
  Authors: Rep. Osburn, Mike(R), Sen. Rosino, Paul(R)
  Effective Date: 11/01/2023

Bills that affect OHCA

- SB 225 - Adjusts certain reporting requirements by the Health Care Authority to the Governor and Legislature to require reporting every fifth year rather than odd-numbered years and creates a school nurse pilot program fund.
  Authors: Sen. Seifried, Ally(R), Rep. Dempsey, Eddy(R)
  Effective Date: 11/01/2023

- SB 292 - Requires health care providers to follow certain standards for syphilis testing during pregnancies, such required testing to be covered by health benefit plans.
  Authors: Sen. Stanley, Brenda(R), Rep. Roe, Cynthia(R)
  Effective Date: 11/01/2023

- SB 444 - Requires health benefit plans that provide mental health or substance abuse disorder benefits to provide reimbursement for benefits that are delivered through certain collaborative care models.

Authors: Sen. Montgomery, John(R), Rep. Miller, Nicole(R)
Effective Date: 11/01/2023

- SB 513 - Requires insurers, including the state's Medicaid program, to cover biomarker testing in certain instances.
  Authors: Sen. Rosino, Paul(R), Rep. Miller, Nicole(R)
  Effective Date: 01/01/2024

- SB 563 - Includes that anesthesia is to continue to be reimbursed equal to or greater than the established Fee Schedule, with value-based payment arrangements possible for services furnished to Medicaid members; EMERGENCY.
  Authors: Sen. Haste, John(R), Rep. McEntire, Marcus(R)
  Effective Date: 05/25/2023

- SB 613 - Prohibits gender affirming treatment and care for any persons under the age of eighteen, physicians to be guilty of unprofessional conduct upon violation.
  Authors: Sen. Daniels, Julie(R), Rep. Hasenbeck, Toni(R)
  Effective Date: 05/01/2023

- SB 712 - Directs the Dept. of Mental Health to provide hospitals with opioid antagonists to be given to persons presenting to emergency departments with the symptoms of an opioid overdose or related disorder upon discharge from the hospital.
  Authors: Sen. Rosino, Paul(R), Rep. McEntire, Marcus(R)
  Effective Date: 11/01/2023

- SJR 22 - Approves certain proposed permanent rules of various state agencies.
  Authors: Sen. Bergstrom, Micheal(R), Rep. Kendrix, Gerrid(R)
  Effective Date: 05/31/2023

Special Session

OHCA Request Bills

- SB 23x - Adjusts provisions related to payment methodology and reimbursement for ground emergency transportation services; EMERGENCY.
  Authors: Sen. Thompson, Roger(R), Rep. Wallace, Kevin(R)
  Effective Date: 06/02/2023

Budget bills that affect OHCA

- SB 32x - Sets budget limits for the Health Care Authority: $30M for HIE connections, $47M for long-term care and ICF/IID rates, $200M for hospitals.
  Authors: Sen. Thompson, Roger(R), Rep. Wallace, Kevin(R)
  Effective Date: 07/01/2023

- HB 1004x – General appropriations bill
  Authors: Sen. Thompson, Roger(R), Rep. Wallace, Kevin(R)
  Effective Date: 07/01/2023

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MEDICAID DIRECTOR UPDATE

JUNE 28, 2023

HEALTH INFORMATION EXCHANGE

HIE UPDATE

- Orion Contract Terminated / Continuity of Services Contract with MyHealth
- RFP in Development for HIE Operations & Data Services – Projected Release Late Summer
- 70+ Public Presentations to date to Associations, Legislators, and Constituents.
- Exemptions Guidelines Published in Early May at https://okshine.Oklahoma.gov
  - 1379 Exemptions requested (75% Multi Category, Most Common Financial and Size)
  - Exemption approvals not released due to Governor not approving rules.
  - New rules developed that relax exemption eligibility, these are working through Approval Process
    - Will likely reduces state-wide participation significantly
  - Once New Emergency HIE Rules are in Place, Exemptions will be released (no need to re-apply)
- SB 32X provided $30M in Appropriation for Provider Connections to the HIE
  - Working through Grant Administration and request process
- HIE Usage Statistics
  - 42,000 Unique Patient Lookups vs. 23,000 same month a year ago
  - Over 22,000 Notifications Sent to providers relating to a patient's status change
  - Over 500 Applications to Join in the Queue
  - Over 650 New Providers added to the HIE in last 6 months (Accessing Portal)
  - HIE Provider Satisfaction Score (NPS +22) [17]Vast Majority scoring a satisfaction rating of a 9 or 10

HIE USER SATISFACTION SURVEY

Q2 2023

Yes, it helps me access information faster to assess if the patient is appropriate for admission to our unit.

- Nurse Practitioner

It helps me track baseline labs such as renal function. It also allows for me to see prior hospitalizations to assist with tracking available Medicare days.

- Intake Coordinator

MyHealth give us access to a more complete medical history.

- Organ Procurement Coordinator

We work with the highest risk clients and using MyHealth has allowed us to connect more clients to needed medical care then before as well as help coordinate their services.

- LPC

MyHealth helps us review and prepare before admissions

- Long Term Care, Care Coordinator

it has been important to be able to look up medications for some patients who don't bring a list and to see blood work findings

- Doctor of Optometry

I accessed the network almost every day and able to get information from other providers that do not send information to me for care of my patients. I also can see study results that have not been sent to me.

- Internal Medicine Provider,

MyHealth makes obtaining medical records so much easier!

- Medical Records Dept

Having access to medical history has been a game changer in deciding if a decedent needs to be a Medical Examiner case once they have been pronounced.

- Medicolegal Death Investigator

MyHealth has meds and hx for people unable to communicate.

- Clinician

We are able to find Imaging and chart notes in MyHealth for Stat Referrals helps our Neurosurgery office.

- Authorization Specialist

MyHealth has helped treat clients with medical and mental health issues more cohesively.

- Care Coordinator

PUBLIC HEALTH EMERGENCY UNWINDING UPDATE

PHE UNWINDING UPDATE

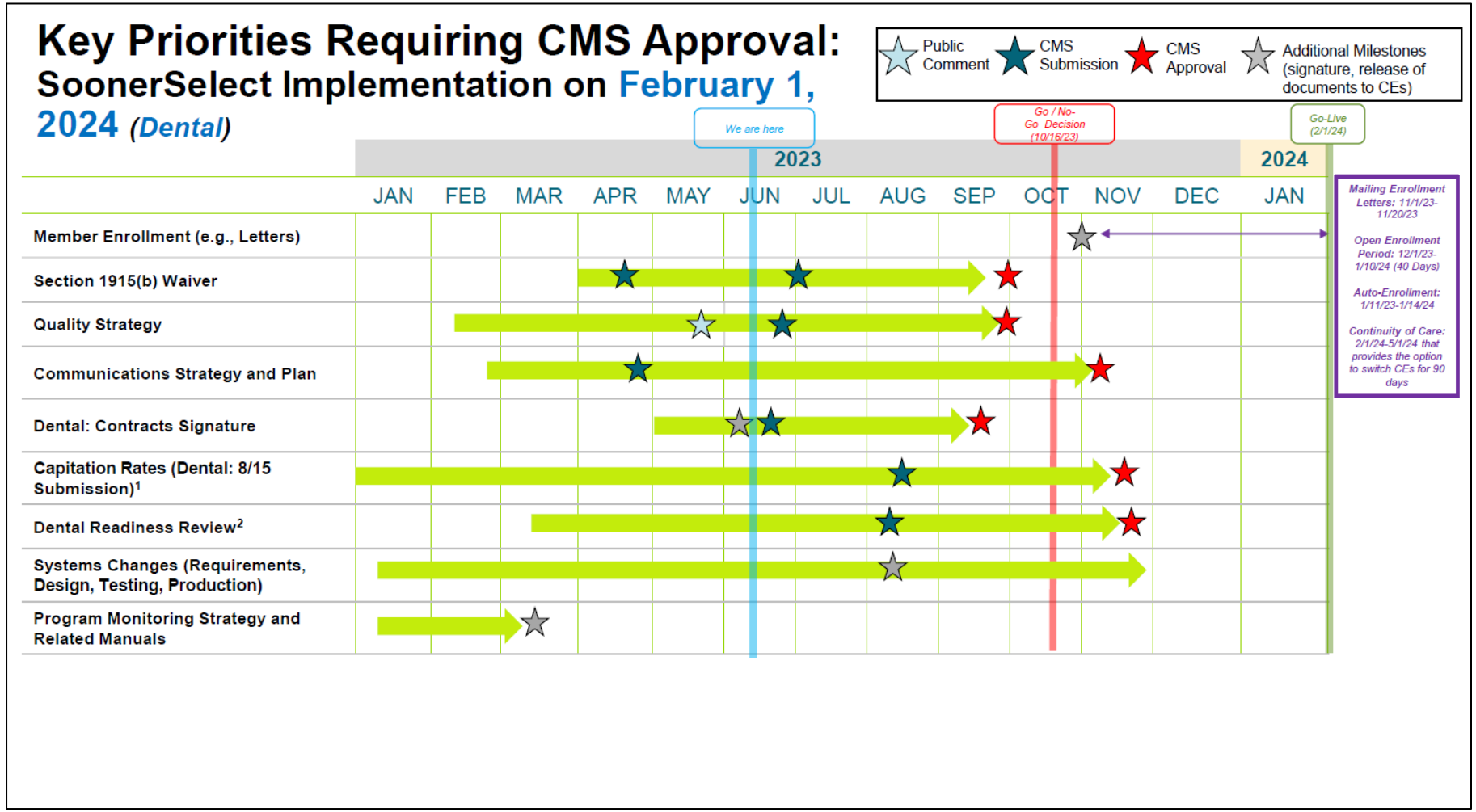
- 54,531 Members unenrolled since May 1.
- Oklahoma's mitigation strategy approved by CMS
- CMS focus on procedural terminations
- Targeted outreach to members identified for unwinding but who appear to still meet income requirements with a focus on families with children.
- New provider engagement strategy to assist with outreach.
- New Unwinding Fast Facts

SOONERSELECT UPDATE

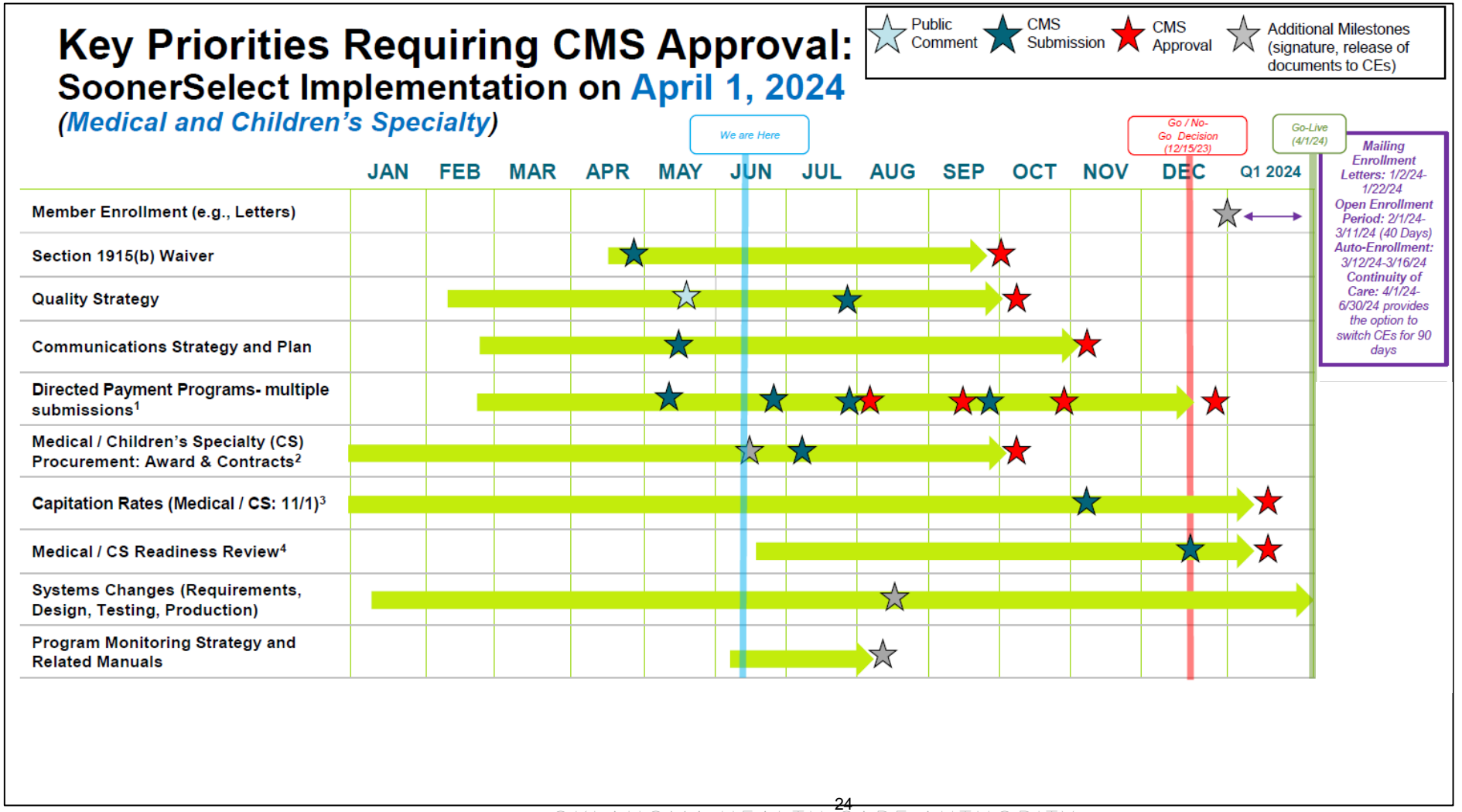
MEDICAL AND CHILDREN'S SPECIALTY AWARDS MADE

- Three statewide medical plans
  - Aetna Better Health of Oklahoma
  - Humana Healthy Horizons of Oklahoma
  - Oklahoma Complete Health
- One statewide Children's Specialty Plan
  - Oklahoma Complete Health
- All awarded plans qualify as provider led entities and have governing bodies comprised of local Oklahoma providers.
- Regional townhalls coming in July!

IMPORTANT MILESTONES DENTAL



IMPORTANT MILESTONES MEDICAL AND CSP



WHAT'S ON THE HORIZON?

LOOKING FORWARD

- Evaluating coverage of pharmaceutical interventions to address obesity
- Increasing income threshold for SoonerPlan from 138% FPL to 205% FPL
- Evaluating impact of legislation requiring coverage of biomarker testing
- Monitoring CMS rulemaking regarding managed care, access to care and Home and Community Based Services

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

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

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Attachment C

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – March 8, 2023 and April 12, 2023

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Brimonidine 0.33% Topical Gel	• **Rosacea:** A common chronic skin condition that usually only affects the face and eyes. Characterized by redness, pimples, and broken blood vessels, rosacea tends to begin after middle age. 23 eligible members	• $6246 per year	• Cheaper options available
	Vtama®	• **Plaque Psoriasis:** Psoriasis is a skin disease and comes in several forms. Plaque psoriasis is the most common. Plaques are raised red patches covered with a whitish buildup of dead skins cells called scale. They usually show up on your elbows, knees, scalp, and lower back, but you can have them anywhere. Plaques often itch or hurt. 2,902 members with diagnosis	• $15,343 per year	• Cheaper options available
	Zoryve™	• **Plaque Psoriasis**	• $9,900	• Cheaper options available
2	Tadliq®	• **Pulmonary Arterial Hypertension:** PAH is a specific type of pulmonary hypertension that is caused when the tiny arteries in the lung become thickened and narrowed. This blocks the blood flow through the lungs which raises the blood pressure in	• $45,468 per year	• Cheaper options available
	Tyvaso DPI®		• $ 271,777 per year	• Cheaper form available without a PA

		the lungs and causes the heart to work harder to pump blood through those narrowed arteries. Over time, the heart loses the ability to effectively pump blood throughout the body. 279 members with diagnosis		
3	Ztalmy® Zonisade™	• **Seizure disorders:** A seizure is a burst of uncontrolled electrical activity between brain cells (also called neurons or nerve cells) that causes temporary abnormalities in muscle tone or movements (stiffness, twitching or limpness), behaviors, sensations, or states of awareness. Seizures are not all alike. 68,516 members with seizure diagnosis. 4 members eligible for Ztalmy	• $291,060 per year • 25,200 per year	• Used in seizures associated with rare genetic disorder. Other treatment options available • Generic capsules available
4	Rezlidhia™	• **Acute Myeloid Leukemia:** AML starts in the bone marrow (the soft inner part of certain bones, where new blood cells are made), but most often it quickly moves into the blood, as well. It is the most common type of acute leukemia in adults. AML is also called acute myelogenous leukemia and acute nonlymphocytic leukemia. 102 members with diagnosis	• $386,400 per year	• Used in relapsed/refractory disease
5	Briumvi™	• **Multiple Sclerosis:** A long-lasting (chronic) disease of the central nervous system. It is thought to be an autoimmune disorder, a	• $59,000 per year • $125,074 per year	• Not appropriate for all types of MS

	Tascenso ODT®	condition in which the body attacks itself by mistake. MS is an unpredictable disease that affects people differently. Some people with MS may have only mild symptoms. Others may lose their ability to see clearly, write, speak, or walk when communication between the brain and other parts of the body becomes disrupted. The disease can be categorized based on severity and frequency. The types are replasing-remitting MS, secondary progressive MS, and primary progressive MS. 966 members with diagnosis		• Other options available
6	Lamzede®	• **Alpha-mannosidosis:** A rare genetic condition characterized by an inability to properly break down certain groups of complex sugars in the body's cells. Affected individuals may have intellectual disability, distinctive facial features, and skeletal abnormalities. 1 member with possible diagnosis	• $1,456,000 per year	• Only treatment available
7	Rolvedon™	• **Febrile Neutropenia**: A condition marked by fever and a lower-than-normal number of neutrophils in the blood. A neutrophil is a type of white blood cell that helps fight infection. 369 members with diagnosis	• $76,500 per year (based cancer treatment is every 3 weeks)	• Used to prevent febrile neutropenia in patients after cancer treatments. Cheaper options available.
8	Airsupra™	• **Asthma:** A chronic (long-term) lung disease. It affects your airways, the tubes that carry air in and out of	• N/A	• Cheaper options available

		your lungs. When you have asthma, your airways can become inflamed and narrowed. This can cause wheezing, coughing, and tightness in your chest. When these symptoms get worse than usual. 51,461 members with diagnosis		
9	Olpruva™ Pheburane®	• **Urea Cycle Disorder:** A urea cycle disorder is a genetic disorder that results in a deficiency of one of the six enzymes in the urea cycle. These enzymes are responsible for removing ammonia from the blood stream. In Urea cycle disorders, nitrogen builds up in the blood in the form of ammonia, a highly toxic substance, resulting in hyperammonemia (elevated blood ammonia). Ammonia then reaches the brain through the blood, where it can cause irreversible brain damage, coma and/or death. 9 members with diagnosis	• N/A • $374,760 per year	• Cheaper option available • Cheaper option available
10	Jaypirca™ Lunsumio™	• **Mantle Cell Lymphoma:** MCL is a type of non-Hodgkin's lymphoma, which is a form of cancer that affects the lymphatic system. Lymphomas are cancers that involve white blood cells and can be divided depending on the type of cell involved, either B-lymphocytes or T-lymphocytes. MCL is a B-cell lymphoma that develops from malignant B-lymphocytes within a	• $252,000 per year • $340,396 per year	• Not first-line therapy • Not first-line therapy

		region of the lymph node known as the mantle zone. 26 members with diagnosis		

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

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Pharmacy Agenda Items

Recommendation 1: Vote to Prior Authorize Brimonidine 0.33% Topical Gel, Vtama®, and Zoryve™

The Drug Utilization Review Board recommends the prior authorization of Brimonidine 0.33% Topical Gel (Generic Mirvaso®), Vtama® (Tapinarof), and Zoryve™ (Roflumilast) with the following criteria:

Brimonidine 0.33% Topical Gel (Generic Mirvaso®) Approval Criteria:

1. An FDA approved diagnosis of persistent (non-transient) facial erythema of rosacea; and
2. Member must be 18 to 20 years of age; and
3. A patient-specific, clinically significant reason why the member cannot utilize clindamycin topical solution (generic), metronidazole 0.75% topical gel and cream, erythromycin 2% topical solution, oral isotretinoin medications, or other generically available preferred oral or topical antibiotic products must be provided; and
4. Must be prescribed by, or in consultation with, a dermatologist (or an advanced care practitioner with a supervising physician who is a dermatologist); and
5. Brand name Mirvaso® is not a covered product; and
6. A quantity limit of 30 grams per 30 days will apply.

Vtama® (Tapinarof 1% Cream) Approval Criteria:

1. An FDA approved diagnosis of plaque psoriasis; and
2. Member must be 18 years of age or older; and
3. Member must have a body surface area (BSA) involvement of ≤20%; and
4. Must be prescribed by, or in consultation with, a dermatologist (or an advanced care practitioner with a supervising physician who is a dermatologist); and
5. Member must have documented trials within the last 6 months for a minimum of 2 weeks that resulted in failure with at least 2 of the following therapies (or have a contraindication or documented intolerance):
    a. An ultra-high to high potency topical corticosteroid (TCS); or
    b. A generic topical calcipotriene product; or
    c. A topical tazarotene product; and
6. Initial approvals will be for the duration of 1 month. Reauthorization may be granted if the prescriber documents the member is responding well to treatment; and
    a. An ultra-high to high potency topical corticosteroid (TCS); or
    b. A generic topical calcipotriene product; or
    c. A topical tazarotene product; and
7. A quantity limit of 60 grams per 30 days will apply.

Zoryve™ (Roflumilast 0.3% Cream) Approval Criteria:

1. An FDA approved diagnosis of plaque psoriasis; and
2. Member must be 12 years of age or older; and
3. Member must have a body surface area (BSA) involvement of ≤20%; and
4. Member must not have moderate-to-severe hepatic impairment (Child-Pugh B or C); and
5. Must be prescribed by, or in consultation with, a dermatologist (or an advanced care practitioner with a supervising physician who is a dermatologist); and
6. Member must have documented trials within the last 6 months for a minimum of 2 weeks that resulted in failure with at least 2 of the following therapies (or have a contraindication or documented intolerance):
    a. An ultra-high to high potency topical corticosteroid (TCS); or
    b. A generic topical calcipotriene product; or
    c. A topical tazarotene product; and
7. Initial approvals will be for the duration of 1 month. Reauthorization may be granted if the prescriber documents the member is responding well to treatment; and
8. A quantity limit of 60 grams per 30 days will apply.

Recommendation 2: Vote to Prior Authorize Tadliq® and Tyvaso DPI®

The Drug Utilization Review Board recommends the prior authorization of Tadliq® (Tadalafil Oral Suspension) and Tyvaso DPI® (Treprostinil Powder for Inhalation) with the following criteria:

Tadliq® (Tadalafil Oral Suspension) Approval Criteria:

1. An FDA approved diagnosis of pulmonary arterial hypertension; and
2. Medical supervision by a pulmonary specialist or cardiologist; and
3. A patient-specific, clinically significant reason why the member cannot use generic sildenafil oral suspension must be provided; and
4. An age restriction will apply. Members 7 years of age and older must have a patient-specific, clinically significant reason why the member cannot use generic tadalafil 20mg oral tablets, even when the tablets are crushed; and
5. A quantity limit of 300mL per 30 days (2 bottles) will apply.

Tyvaso DPI® (Treprostinil Powder for Inhalation) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
    a. Pulmonary arterial hypertension (PAH); or

   b. Pulmonary hypertension associated with interstitial lung disease (PH-ILD); and
      i. Diagnosis of PH-ILD must be confirmed by right-sided heart catheterization; and
2. Medical supervision by a pulmonary specialist or cardiologist; and
3. For a diagnosis of PAH:
   a. Member must have previous failed trials of at least 1 of each of the following categories:
      i. Revatio® (sildenafil) or Adcirca® (tadalafil); and
      ii. Letairis® (ambrisentan) or Tracleer® (bosentan); and
   b. A patient-specific, clinically significant reason why Tyvaso® (treprostinil inhalation solution) and Remodulin® (treprostinil injection), which are available without a prior authorization, are not appropriate for the member must be provided; and
4. For a diagnosis of PH-ILD, a patient-specific, clinically significant reason why Tyvaso® (treprostinil inhalation solution), which is available without a prior authorization, is not appropriate for the member must be provided.

Recommendation 3: Vote to Prior Authorize Zonisade™ and Ztalmy®

The Drug Utilization Review Board recommends the prior authorization of Zonisade™ (Zonisamide Oral Suspension) and Ztalmy® (Ganaxolone) with the following criteria:

Ztalmy® (Ganaxolone) Approval Criteria:

1. An FDA approved diagnosis of seizures associated with cyclindependent kinase-like 5 (CDKL5) deficiency disorder (CDD); and
   a. Diagnosis must be confirmed by genetic testing identifying a mutation in the CDKL5 gene that is pathogenic or likely pathogenic; and
2. Member must be 2 years of age or older; and
3. The initial prescription must be written by, or in consultation with, a neurologist; and
4. Member must have failed at least 2 other anticonvulsants; and
5. Members currently stable on Ztalmy® and who have a CDD diagnosis confirmed by genetic testing will be approved for continuation of therapy; and
6. The member's recent weight (kg), taken within the last 3 weeks, must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and

7. Initial approvals will be for the duration of 3 months. For continuation, the prescriber must include information regarding improved response/effectiveness of the medication; and
8. Subsequent approvals will be for the duration of 1 year; and
9. A quantity limit of 1,100mL per 30 days will apply.

Zonisade™ (Zonisamide Oral Suspension) Approval Criteria:

1. An FDA approved indication of adjunctive treatment of partial-onset seizures; and
2. A patient-specific, clinically significant reason why the member cannot use zonisamide capsules must be provided; and
3. A quantity limit of 900mL per 30 days will apply.

Recommendation 4: Vote to Prior Authorize Rezlidhia™

The Drug Utilization Review Board recommends the prior authorization of e Rezlidhia™ (Olutasidenib) with the following criteria:

Rezlidhia™ (Olutasidenib) Approval Criteria [Acute Myeloid Leukemia (AML) Diagnosis]:

1. Relapsed/refractory AML; and
    a. As a single agent; and
    b. Isocitrate dehydrogenase-1 (IDH1) mutation.

Recommendation 5: Vote to Prior Authorize Briumvi™ and Tascenso ODT

The Drug Utilization Review Board recommends the prior authorization of Briumvi™ (ublituximab-xiiy) and Tascenso ODT® (fingolimod ODT) with the following criteria:

Briumvi™ (Ublituximab-xiiy) Approval Criteria:

1. An FDA approved diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults; and
2. Prescriber must be a neurologist (or an advanced care practitioner with a supervising physician that is a neurologist); and
3. Member must have had at least 1 relapse in the previous 12 months; and
4. Approvals will not be granted for concurrent use with other disease-modifying therapies; and
5. Briumvi™ must be administered by a health care professional in a setting with appropriate equipment and personnel to manage anaphylaxis or serious infusion reactions. Approvals will not be granted for self-administration. Prior authorization requests must indicate how Briumvi™ will be administered; and

   a. Briumvi™ must be shipped via cold chain supply to the facility where the member is scheduled to receive treatment; or
   b. Briumvi™ must be shipped via cold chain supply to the member's home and administered by a home health care provider and the member or member's caregiver must be trained on the proper storage of Briumvi™; and
6. Prescriber must confirm that member will be monitored for 1 hour following the first 2 infusions and as indicated for subsequent infusions; and
7. Prescriber must verify hepatitis B virus (HBV) testing has been performed prior to initiating Briumvi™ therapy and member does not have active HBV; and
8. Verification from the prescriber that member has no active infection(s); and
9. Verification from the prescriber that female members are not currently pregnant and will use contraception while receiving Briumvi™ therapy and for 6 months after the last infusion of Briumvi™; and
10. Approvals will be for the duration of 1 year, and compliance will be checked for continued approval.

Tascenso ODT® [Fingolimod Orally Disintegrating Tablet (ODT)] Approval Criteria:

1. An FDA approved diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease; and
2. Prescriber must be a neurologist (or an advanced care practitioner with a supervising physician that is a neurologist); and
3. Member must have had at least 1 relapse in the previous 12 months; and
4. Approvals will not be granted for concurrent use with other disease-modifying therapies; and
5. Prescriber must confirm that member will be observed in the prescriber's office for signs and symptoms of bradycardia for 6 hours after the first dose; and
6. Verification from the prescriber that member has no active infection(s); and
7. Complete blood counts (CBC) and verification that levels are acceptable to the prescriber; and
8. Liver function tests (LFTs) and verification that levels are acceptable to the prescriber; and
9. A patient-specific, clinically significant reason why the member cannot use Gilenya® (fingolimod) capsules must be provided; and
10. Compliance will be checked for continued approval every 6 months.

Recommendation 6: Vote to Prior Authorize Lamzede®

The Drug Utilization Review Board recommends the prior authorization of Lamzede® (velmanase alfa-tycv) with the following criteria:

Lamzede® (Velmanase Alfa-tycv) Approval Criteria:

1. An FDA approved diagnosis of alpha-mannosidosis confirmed by:
    a. Documented lab results verifying alpha-mannosidase activity <11% of normal; or
    b. Molecular genetic testing confirming biallelic pathogenic variants in the MAN2B1 gene; and
2. Member's recent weight (kg) taken within the last 3 weeks must be provided to ensure accurate weight-based dosing; and
3. 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 Lamzede®; and
4. Lamzede® must be administered in a health care setting by a health care provider with appropriate equipment and personnel to manage anaphylaxis. Approvals will not be granted for self-administration; and
    a. Lamzede® must be shipped via cold chain supply to the health care setting where the member is scheduled to receive treatment; and
5. Lamzede® must be prescribed by, or in consultation with, a specialist with expertise in the treatment of lysosomal storage disorders; and
6. Initial approvals will be for the duration of 6 months. Further approval may be granted if the prescriber documents the member is responding well to treatment.

Recommendation 7 : Vote to Prior Authorize Rolvedon™

The Drug Utilization Review Board recommends the prior authorization of Rolvedon™(eflapegrastim-xnst) with the following criteria:

Rolvedon™ (Eflapegrastim-xnst) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use Fylnetra® (pegfilgrastim-pbbk), Granix® (tbo-filgrastim), Neupogen®(filgrastim), Zarxio® (filgrastim-sndz), or Ziextenzo® (pegfilgrastim-bmez) must be provided.

Recommendation 8 : Vote to Prior Authorize Airsupra™

The Drug Utilization Review Board recommends the prior authorization of Airsupra™(albuterol/budesonide)) with the following criteria:

Airsupra™ (Albuterol/Budesonide) Approval Criteria:

1. An FDA approved diagnosis of asthma; and
2. Member must be 18 years of age or older; and
3. Member must be using maintenance therapy per the Global Initiative for Asthma (GINA) guidelines; and
4. A patient-specific, clinically significant reason why the member cannot use a long-acting beta2 agonist (LABA), inhaled corticosteroid (ICS)/LABA combination, or specific individual ICS and short-acting beta2 agonist (SABA) components must be provided; and
5. Initial approvals will be for the duration of 3 months. For continued consideration, prescriber must verify the member has had a positive clinical response to therapy; and
6. Subsequent approvals will be for the duration of 1 year.

Recommendation 9 : Vote to Prior Authorize Olpruva™ and Pheburane®

The Drug Utilization Review Board recommends the prior authorization of Olpruva™ (Sodium Phenylbutyrate Pellets for Oral Suspension) and Pheburane® (Sodium Phenylbutyrate Oral Pellets) with the following criteria:

Olpruva™ (Sodium Phenylbutyrate Pellets for Oral Suspension) Approval Criteria:

1. An FDA approved diagnosis of urea cycle disorder (UCD); and
2. Member must be actively managing UCD with a protein restricted diet; and
3. A patient-specific, clinically significant reason why the member cannot use sodium phenylbutyrate powder and tablets (generic Buphenyl®), which are available without a prior authorization, must be provided; and
4. A patient-specific, clinically significant reason why the member cannot use Pheburane® (sodium phenylbutyrate oral pellets) must be provided; and
5. A maximum daily dose of 20g of sodium phenylbutyrate will apply.

Pheburane® (Sodium Phenylbutyrate Oral Pellets) Approval Criteria:

1. An FDA approved diagnosis of urea cycle disorder (UCD); and
2. Member must be actively managing UCD with a protein restricted diet; and
3. A patient-specific, clinically significant reason why the member cannot use sodium phenylbutyrate powder and tablets (generic Buphenyl®),

which are available without a prior authorization, must be provided; and

4. A maximum daily dose of 20g of sodium phenylbutyrate will apply; and
5. A quantity limit of 1,218g of pellets (equivalent to 588g of sodium phenylbutyrate) per 29 days will apply.

Recommendation 10 : Vote to Prior Authorize Jaypirca™ and Lunsumio™

The Drug Utilization Review Board recommends the prior authorization of Jaypirca™ (Pirtobrutinib) and Lunsumio™ (Mosunetuzumab-axgb) with the following criteria:

Jaypirca™ (Pirtobrutinib) Approval Criteria [Mantle Cell Lymphoma (MCL) Diagnosis]:

1. Diagnosis of MCL; and
2. Relapsed or refractory disease after ≥2 lines of systemic therapy; and
3. Previous treatment must have included a Bruton's tyrosine kinase (BTK) inhibitor (e.g., acalabrutinib, ibrutinib, zanubrutinib).

Lunsumio™ (Mosunetuzumab-axgb) Approval Criteria [Follicular Lymphoma (FL) Diagnosis]:

1. Diagnosis of FL; and
2. Relapsed or refractory disease after ≥2 lines of systemic therapy.

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

REGULAR NURSING FACILITIES RATE INCREASE

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) fee for Regular Nursing Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to facilities. Additionally, the change allows OHCA to calculate the annual reallocation of the pool for the "Direct Care" and "Other Cost" components of the rate as per the State Plan. This change will also increase the base rate by $35 per patient day as mandated by Senate Bill 32X.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing Facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:

   A. Base Rate Component is $123.47 per patient day.

   B. A Pay for Performance (PFP) Component defined as the dollars earned under this incentive payment program with an average payment of $5.00 per patient day.

   C. An "Other Cost" Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and PFP Components by the total estimated Medicaid days for the rate period. This component once calculated is the same for each facility.

   D. A "Direct Care "Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and PFP Components to the facilities. This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the 70% pool of funds to each facility (on a per day basis) based on their relative expenditures for direct care costs. The current combined pool amount for "Direct Care" and "Other Cost" components is $242,806,077. The current Quality of Care (QOC) fee is $15.56 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however, there is a rate change for Regular Nursing Facilities because of the required annual recalculation of the Quality of Care (QOC) fee and reallocation of the pool for "Direct Care" and "Other Cost" components of the rate as per the State Plan. This change also increases the base rate by $35 per patient day as mandated by Senate Bill 32X. The new Base Rate Component will be $158.56 per patient day. The new combined pool amount for "Direct Care" and "Other Cost" components will be $251,077,470. The new Quality of Care (QOC) fee will be $15.65 per patient day.

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY 2024 will be an increase in the total amount of $145,510,949 with $45,850,500 in state share.
OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular Nursing Facilities:
- An increase to the base rate component from $123.47 per patient day to $158.56 per patient day.
- A change to the combined pool amount for "Direct Care" and "Other Cost" Components from $242,806,077 to $251,077,470 for the annual reallocation of the Direct Care Cost Component as per the State Plan.

9. **EFFECTIVE DATE OF CHANGE.**
July 1, 2023, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITES RATE INCREASE

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) fee for nursing facilities serving residents with AIDS per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to facilities. This change will also increase the AIDS rate by $35 per patient day as mandated by Senate Bill 32X.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current rate for this provider type is $229.76 per patient day. The Quality of Care (QOC) fee is $15.56 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for nursing facilities serving residents with AIDS because of the required annual recalculation of the Quality of Care (QOC) fee. This change also increases the AIDS rate by $35 per patient day as mandated by Senate Bill 32X. The rate for this provider type will be $265.16 per patient day. The recalculated Quality of Care (QOC) fee will be $15.65 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2024 will be an increase in the total amount of $259,941; with $81,907 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:
   - An increase to the AIDS rate from $229.76 per patient day to $265.16 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2023, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

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

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase Regular ICF/IID rate by $17 per patient day as mandated by Senate Bill 32X.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.
   The current rate for this provider type is $ $137.53 per patient day.
   The Quality of Care (QOC) fee is $9.38 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, the change is being made to increase Regular ICF/IID rate by $17 per patient day as mandated by Senate Bill 32X.
   The proposed rate for this provider type is $154.53 per patient day.
   The Quality of Care (QOC) fee will remain $9.38 per patient day

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2024 will be an increase in the total amount of $2,764,829; with $871,198 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

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

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular ICF/IID facilities:

- An increase in rate from $137.53 per patient day to $154.53 per patient day.

9. EFFECTIVE DATE OF CHANGE.

July 1, 2023, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

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

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) Fee for Acute ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to facilities. This change will also increase Acute ICF/IID rate by $17 per patient day as mandated by Senate Bill 32X.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Acute ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.
   The current rate for this provider type is $168.35 per patient day.
   The Quality of Care (QOC) fee is $10.05 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for Acute ICF/IID facilities because of the annual recalculation of the Quality of Care (QOC) fee. This change also increases Acute ICF/IID rate by $17 per patient day as mandated by Senate Bill 32X.
   The proposed rate for this provider type is $186.00 per patient day.
   The recalculated Quality of Care (QOC) fee is $10.26 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2024 will be an increase in the total amount of $5,736,870; with $1,807,688 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:
   - An increase in rate from $168.35 per patient day to $186.00 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2023, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

PRIVATE DUTY NURSING (PDN) RATE INCREASE & OVERTIME RATE

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority is requesting a Private Duty Nursing (PDN) (HCPCS Procedure code T1000) rate increase. PDN providers will receive a higher rate of pay for PDN hours that result in over-time rate of pay for nursing staff. The increase is to be applied only for children with ventilators or tracheostomies.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current reimbursement rate for PDN providers is $32.68 per hour or $8.17 per unit. PDN Providers currently receive a supplemental payment of $7.32 per hour/1.83 per unit for PDN hours that result in an over-time rate of pay for nursing staff.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The new reimbursement rate for PDN providers is $40.00 per hour. The new supplemental payment amount is $8.92 per hour/$2.23 per unit for PDN hours that result in over-time rate of pay for nursing staff. The increase is to be applied only for children with ventilators or tracheostomies.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for January 1, 2023 to June 30, 2023 is an increase of $733,401; with $157,241 state share. The estimated budget impact for SFY 24 is an increase of $4,368,349; with $1,420,150 state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of service

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

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee approve the rate increase for PDN (HCPCS Procedure code T1000) to $40.00 per hour and the corresponding overtime rate increase to $8.92 per hour/$2.23 per unit for children with ventilators or tracheostomies

9. EFFECTIVE DATE OF CHANGE.

Made effective January 1, 2023, as per CMS approval.

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

DOULA SERVICES

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate and Method Change

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority is requesting to add for Doula Services for pregnant SoonerCare members.
   A doula or birth worker is a trained professional who provides emotional, physical, and informational support services during the prenatal, labor and delivery, and postpartum periods.
   Doulas are non-clinical and do not provide medical care. Doula services should not replace the services of other licensed and trained medical professionals including, but not limited to physicians, physician assistants, advanced practice registered nurses, and certified nurse midwives.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Currently OHCA does not pay for Doula Services.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The Oklahoma Health Care Authority requests the below Doula Services pricing. HCPCS Procedure Codes 59899 and 59514 will pay 40% of the physician fee schedule rate. HCPCS Procedure Codes 59409, 59612, and 59620 will pay 65% of the physician fee schedule rate. HCPCS Procedure Code 59899 will be based off the rate for HCPCS Procedure Code 99215 and be payable for Doula Services that are 60+ minutes. The limit of this code is 8 per member per pregnancy. All other codes are based off the same procedure code and are limited to one per member per delivery.

Proc Code / Modifier	Proc Code Description	Comparable Proc Code	Physician Pricing	Doula Pricing @ 40%	Doula Pricing @ 65%	Units	Total Cost
59899	Prenatal & Postpartum Visit Billing Codes	99215	$161.13	$ 64.45		8	$ 515.60
59409	Labor & Delivery (VAGINAL DELIVERY ONLY)	59409	$720.84		$468.55		
59514	Labor & Delivery (CESAREAN DELIVERY ONLY)	59514	$813.62	$325.45			
59612	Labor & Delivery (VAGINAL DELIVERY AFTER PREVIOUS CESAREAN DELIVERY)	59612	$811.97		$527.78		
59620	Labor & Delivery (CESAREAN DELIVERY FOLLOWING VAGINAL DELIVERY ATTEMPT AFTER PREVIOUS CESAREAN DELIVERY)	59620	$840.77		$546.50	1	$ 467.07

6. BUDGET ESTIMATE.

The estimated budget impact for SFY 2024 will be an increase in the total amount of $2,734,572; with $861,732 in state share.

The estimated budget impact for SFY 2025 will be an increase in the total amount of $2,734,572; with $887,916 in state share.

OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

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

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee approve the below Doula Services rates.

Proc Code / Modifier	Proc Code Description	Comparable Proc Code	Physician Pricing	Doula Pricing @ 40%	Doula Pricing @ 65%
59899 HD	Prenatal & Postpartum Visit Billing Codes	99215	$161.13	$ 64.45	
59409 HD	Labor & Delivery (VAGINAL DELIVERY ONLY)	59409	$720.84		$468.55
59514 HD	Labor & Delivery (CESAREAN DELIVERY ONLY)	59514	$813.62	$325.45	
59612 HD	Labor & Delivery (VAGINAL DELIVERY AFTER PREVIOUS CESAREAN DELIVERY)	59612	$811.97		$527.78
59620 HD	FOLLOWING VAGINAL DELIVERY ATTEMPT AFTER PREVIOUS CESAREAN DELIVERY)	59620	$840.77		$546.50

9. EFFECTIVE DATE OF CHANGE.

July 1, 2023, pending CMS approval.

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

INCREASE AIR AMBULANCE RATES

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority is requesting to increase rates for air ambulance services to 100% of the Medicare Ambulance Fee Schedule (AFS).

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate for air ambulance services is:
   - HCPCS Procedure Code A0430 (AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (FIXED WING)) is $2,510.50.
   - HCPCS Procedure Code A0431 (AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING)) is $3,352.37.
   - HCPCS Procedure Code A0435 (FIXED WING AIR MILEAGE, PER STATUTE MILE) is $7.69.
   - HCPCS Procedure Code A0436 (ROTARY WING AIR MILEAGE, PER STATUTE MILE) is $23.39.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The legislature appropriated additional funds to University Hospitals Authority to increase air ambulance rates to 100% of the Medicare Ambulance Fee Schedule (AFS). The proposed rate for air ambulance services is:
   - HCPCS Procedure Code A0430 (AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (FIXED WING)) is $3,603.48.
   - HCPCS Procedure Code A0431 (AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING)) is $4,189.59.
   - HCPCS Procedure Code A0435 (FIXED WING AIR MILEAGE, PER STATUTE MILE) is $10.23.

- HCPCS Procedure Code A0436 (ROTARY WING AIR MILEAGE, PER STATUTE MILE) is $27.28.

6. BUDGET ESTIMATE.

The estimated budget impact for SFY 2024 will be an increase in the total amount of $2,097,841; with $661,082 in state share.

The estimated budget impact for SFY 2025 will be an increase in the total amount of $2,097,841; with $681,169 in state share.

The state share will be paid in a quarterly Maintenance of Effort (MOE) payment made by the University Hospitals Authority.

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

This change is expected to have a positive impact on access to care.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee approve the below air ambulance rates to 100% of the Medicare Ambulance Fee Schedule (AFS).

- HCPCS Procedure Code A0430 (AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (FIXED WING)) is $3,603.48.
- HCPCS Procedure Code A0431 (AMBULANCE SERVICE, CONVENTIONAL AIR SERVICES, TRANSPORT, ONE WAY (ROTARY WING)) is $4,189.59.
- HCPCS Procedure Code A0435 (FIXED WING AIR MILEAGE, PER STATUTE MILE) is $10.23.
- HCPCS Procedure Code A0436 (ROTARY WING AIR MILEAGE, PER STATUTE MILE) is $27.28.

9. EFFECTIVE DATE OF CHANGE.

July 1, 2023

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

BIOSIMILAR REIMBURSEMENT

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate and Method Change

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority is requesting a rate and method change for Biosimilar. Medicare changed the rate for certain Biosimilar Biologic drugs from ASP+6% to ASP+8%. ASP is defined as the Average Sales Price. OHCA uses the Medicare rate to reimburse providers for drug products billed through the medical benefit.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Medicare rate of ASP+6% for certain biosimilar biologic drugs

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The Oklahoma Health Care Authority will follow the Medicare rate of ASP+8% for certain biosimilar biologic drugs. This increased rate will be re-evaluated by Medicare after a certain period of time. OHCA's intent is to follow the Medicare published rate for these biosimilar biologic drugs.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2024 will be an increase in the total amount of $19,112.77; with $4,283.17 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

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

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee approve the rate change for certain biosimilar products from ASP+6% to ASP+8%

9. EFFECTIVE DATE OF CHANGE.

July 1, 2023, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

DEVELOPMENTAL DISABILITIES SERVICES RATE CHANGES

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   Oklahoma Human Services is proposing to update the rates for Audiology and Nutrition Services. The rate change is needed to correct an error when calculating the 25% rate increase effective October 1, 2022. The rates for these DDS Waiver Services are being corrected to reflect that they follow the SoonerCare rates and should not have been included in the across-the-board rate increases. These services are available to members in the Homeward Bound Waiver, the Community Waiver, and the In-Home Supports Waiver for adults.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate structure is a fixed and uniform rate established through the SPARC process. The current services, service codes, unit measure and rates are as follows:

PROCEDURE DESCRIPTION	SERVICE CODE	SERVICE UNIT	CURRENT RATE
AUDIOLOGICAL EXAM/TREATMENT (45 MINUTES)	92507	EACH	89.6
AUDIOLOGY COMPREHENSIVE RECOGNITION	92557	EACH	44.49
AUDIOLOGY HEARING AID EVALUATION	92591	EACH	60.31
AUDIOLOGY REFLEX TESTING	92568	EACH	18.10
AUDIOLOGY TYMPANOMETRY	92567	EACH	18.81
AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY AND/OR TESTING OF THE CENTRAL NERVOUS SYSTEM	92585	EACH	150.18

CONDITIONING PLAY AUDIOMETRY	92582	EACH	81.34
EVALUATION OF AUDITORY REHABILITATION STATUS; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION)	92627	EACH	24.66
EVALUATION OF AUDITORY REHABILITATION STATUS; FIRST HOUR	92626	EACH	104.23
EVOKED OTOACOUSTIC EMISSIONS; LIMITED (SINGLE STIMULUS LEVEL, EITHER TRANSIENT OR DISTORTION PRODUCT)	92587	EACH	25.84
HEARING AID CHECK; BINAURAL	92593	EACH	54.43
HEARING AID CHECK; MONAURAL	92592	EACH	54.41
HEARING AID EXAMINATION AND SELECTION; MONAURAL	92590	EACH	60.31
PURE TONE AUDIOMETRY (THRESHOLD); AIR AND BONE	92553	EACH	42.71
PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY	92552	EACH	34.90
SPEECH AUDIOMETRY THRESHOLD	92555	EACH	26.73
SPEECH AUDIOMETRY THRESHOLD; WITH SPEECH RECOGNITION	92556	EACH	42.34
USE OF VERTICAL ELECTRODES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	92547	EACH	10.79
VISUAL REINFORCEMENT AUDIOMETRY (VRA)	92579	EACH	54.28

NUTRITION THERAPY - INITIAL ASSESSMENT & INTERVENTION	97802 U5	15 MINUTES	42.73
NUTRITION THERAPY - RESSESSMENT & INTERVENTION	97803 U5	15 MINUTES	36.75
NUTRITION THERAPY - RESSESSMENT & INTERVENTION - TELEHEALTH	97803 U5 GT	15 MINUTES	37.54

5. **NEW METHODOLOGY OR RATE STRUCTURE.**

The table below contains the services and proposed rates:

PROCEDURE DESCRIPTION	SERVICE CODE	SERVICE UNIT	PROPOSED RATE
AUDIOLOGICAL EXAM/TREATMENT (45 MINUTES)	92507	EACH	71.68
AUDIOLOGY COMPREHENSIVE RECOGNITION	92557	EACH	35.00
AUDIOLOGY HEARING AID EVALUATION	92591	EACH	48.25
AUDIOLOGY REFLEX TESTING	92568	EACH	14.66
AUDIOLOGY TYMPANOMETRY	92567	EACH	15.22
AUDITORY EVOKED POTENTIALS FOR EVOKED RESPONSE AUDIOMETRY AND/OR TESTING OF THE CENTRAL NERVOUS SYSTEM	92585	EACH	120.14
CONDITIONING PLAY AUDIOMETRY	92582	EACH	67.19
EVALUATION OF AUDITORY REHABILITATION STATUS; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITION)	92627	EACH	19.27
EVALUATION OF AUDITORY REHABILITATION STATUS; FIRST HOUR	92626	EACH	82.11
EVOKED OTOACOUSTIC EMISSIONS; LIMITED (SINGLE STIMULUS LEVEL, EITHER TRANSIENT OR DISTORTION PRODUCT)	92587	EACH	20.50

HEARING AID CHECK; BINAURAL	92593	EACH	43.54
HEARING AID CHECK; MONAURAL	92592	EACH	43.53
HEARING AID EXAMINATION AND SELECTION; MONAURAL	92590	EACH	48.25
PURE TONE AUDIOMETRY (THRESHOLD); AIR AND BONE	92553	EACH	35.36
PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY	92552	EACH	29.17
SPEECH AUDIOMETRY THRESHOLD	92555	EACH	22.09
SPEECH AUDIOMETRY THRESHOLD; WITH SPEECH RECOGNITION	92556	EACH	34.77
USE OF VERTICAL ELECTRODES (LIST SEPARATELY IN ADDITION TO CODE FOR PRIMARY PROCEDURE)	92547	EACH	9.14
VISUAL REINFORCEMENT AUDIOMETRY (VRA)	92579	EACH	42.77
NUTRITION THERAPY - INITIAL ASSESSMENT & INTERVENTION	97802 U5	15 MINUTES	33.90
NUTRITION THERAPY - RESSESSMENT & INTERVENTION	97803 U5	15 MINUTES	29.45
NUTRITION THERAPY - RESSESSMENT & INTERVENTION - TELEHEALTH	97803 U5 GT	15 MINUTES	29.45

6. BUDGET ESTIMATE.

This change will be budget neutral as OHS recognized the error and did not implement the previous rate increases.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   Decreasing the rates will have no effect on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   Oklahoma Human Services requests the proposed rates are updated as requested.

9. **EFFECTIVE DATE OF CHANGE.**
   October 1, 2022

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OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

BEHAVIORAL HEALTH TRANSPORTATION RATES

1. **IS THIS A RATE CHANGE OR A METHOD CHANGE?**
   Rate Change

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   ODMHSAS seeks to implement rates for secure behavioral health transports for members alleged to be in a behavioral health crisis, requiring transportation to a treatment facility for the purpose of examination, emergency detention, protective custody, or inpatient services.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   There is currently no methodology or rate structure for these services.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   Proposed rates for these services are:
   - Transports 30 miles and under will be reimbursed $160.00 per encounter, equal to 68.83% of the CY 2021 rate for A0429.
   - Transports over 30 miles will be reimbursed $160.00 per encounter, equal to 68.83% of the CY 2021 rate for A0429, and $2.85 per mile, equal to 38.10% of the CY 2021 rate for A0425.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY24 is $6,153,652 total, of which $1,283,037 is state share.
   ODMHSAS attests that it has adequate funds to cover the state share of the projected cost of services per fiscal year.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The ODMHSAS has determined that this change will have a positive impact in that the rate implementation supports the secure behavioral health transportation network.

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

The ODMHSAS requests the SPARC to approve the proposed rates for secure behavioral health transportation.

9. EFFECTIVE DATE OF CHANGE.

July 1, 2023, contingent upon CMS approval

Attachment E.i

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 28, 2023

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

BACKGROUND

Services	Admission, Discharge, and Transfer (ADT) data access and system support
Purpose and Scope	OHCA staff will access medical records through an existing Health Information Exchange (HIE) that adheres to HIPAA-compliant guidelines. This HIE serves as a collaborative framework for acquiring information necessary for the treatment of individuals seeking healthcare within the SoonerCare program. The supplier is also responsible for providing services to aid participants in locating and sharing patient information.
Mandate	N/A
Procurement Method	Sole Source Extension
External Approvals	N/A
Contract Term	July 1, 2023 through June 30, 2024

BUDGET

Amount requested for Approval	$800,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to extend for one (1) year for a total not-to-exceed of $800,000.00.

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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. (If the not-to-exceed amount exceeds the amount previously approved by either $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment E.ii

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 28, 2023

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

BACKGROUND

Services	System implementation support services
Purpose and Scope	Task order-based services to support system implementation efforts. Scopes: Care Management • Implementation of a robust, full functioning Care Management Solution which also includes risk stratification, and clinical/health analytics • Implementation of Mobile access for OHCA staff, Members, Stakeholders, and Providers • Implementation of the Care Management Solution including services, installation, support, knowledge transfer, and training • Hosting and operation of the Care Management Solution • Support for Member and Provider/Stakeholder portals that provide remote access from a variety of devices and locations • Ongoing maintenance and operation of the Care Management Solution Electronic Visit and Verification • Project support, assistance with procurement planning, post implementation stabilization and CMS certification support services for replacement of the outdated current EVV system
Mandate	N/A
Procurement Method	Statewide Release
External Approvals	CMS
Contract Term	Base year plus two (2) renewals

BUDGET

Amount requested for Approval	$5,027,066.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	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 fund the task order-based contract for Care Management and EVV services for one (1) base year and two (2) renewal periods for a total not-to-exceed of $5,027,066.00.

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. (the not-to-exceed amount exceeds the amount previously approved by either $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment E.iii

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 28, 2023

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

BACKGROUND

Services	Analytics
Purpose and Scope	Software as a Service (SaaS) system that will assist Long-Term Services & Supports (LTSS) to enhance, centralize and coordinate its systems, processes and data by detecting unreported critical incidents and improving program visibility and decision making around health and safety. Project scope includes: • Implementation and configuration tasks • Configuration and Access setup for Analytic Tools • Maintenance and Support
Mandate	N/A
Procurement Method	Statewide Release
External Approvals	N/A
Contract Term	Base year with five (5) options to renew.

BUDGET

Amount requested for approval	$4,943,025.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure an electronic referral system as described above for one base year with a one-time contract fee of $1,844,775.00 and five (5) renewal periods each funded at $619,650.00 for a total not-to-exceed of $4,943,025.00.

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. (If the not-to-exceed amount exceeds the amount previously approved by either $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment E.iv

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 28, 2023

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

BACKGROUND

Services	Behavioral Health Home Management Software System
Purpose and Scope	Extending the current agreement for administration of a Behavioral Health Home Management Software System. The Behavioral Health Home Management Software System is providing electronic communication between the Oklahoma Health Homes, the Oklahoma Health Care Authority, the Oklahoma Department of Mental Health and Substance Abuse Services and the Centers for Medicare and Medicaid Services.
Mandate	N/A
Procurement Method	Sole Source Extension
External Approvals	OMES
Contract Term	July 1, 2023 through June 30, 2024.

BUDGET

Amount requested for Approval.	$556,161.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to extend the services to administer a Behavioral Health Home Management Software System with vendor Bertlesmann-Relias as described above from July 1, 2023 through June 30, 2024 for a total not-to-exceed of $556,161.00.

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. (If the not-to-exceed amount exceeds the amount previously approved by either $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment E.v

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 28, 2023

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

BACKGROUND

Services	Managed Care Playbooks
Purpose and Scope	Completion of up to eighteen (18) playbooks for operationalizing the monitoring and oversight of SoonerSelect Program, SoonerSelect Specialty Children's Program, and SoonerSelect Dental Program.
Mandate	N/A
Procurement Method	Statewide Release
External Approvals	None
Contract Term	Base year plus one (1) renewal

BUDGET

Amount requested for Approval	$1,360,795.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested for Playbook development services for a total not-to-exceed of $1,360,795.00.

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. (If the not-to-exceed amount exceeds the amount previously approved by either $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment E.vi

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 28, 2023

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

BACKGROUND

Services	Customer Relationship Management (CRM)
Purpose and Scope	Operation of a Customer Relationship Management solution including a call center for its interactions with Members or potential Members in its health care benefit programs, contracted or potential health care providers, allied agencies and organizations and other interested parties.
Mandate	N/A
Procurement Method	Sole Source Extension
External Approvals	CMS
Contract Term	July 1, 2023 through June 30, 2024.

BUDGET

Amount requested for Approval	$9,207,017.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50% Admin 75% Eligibility and Enrollment Operations

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 extend the current agreement with Maximus for one (1) year for a total not-to-exceed of $9,207,017.00.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 days for cause, 60 days without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (If the not-to-exceed amount exceeds the amount previously approved by either $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment E.vii

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 28, 2023

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

BACKGROUND

Services	Peoplesoft Financials transition support
Purpose and Scope	Oklahoma Health Care Authority (HCA) will be migrating off of their legacy financials and supply chain applications (Great Plains) and moving to the Office of Management and Enterprise Services (OMES) PeopleSoft financials and supply chain platform. Supplier will work with the State of Oklahoma to migrate The Health Care Authority (HCA) to the OMES PeopleSoft platform.
Mandate	N/A
Procurement Method	Statewide Release
External Approvals	OMES
Contract Term	Base year plus one (1) renewal.

BUDGET

Amount requested for Approval	$3,630,784.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure support the PeopleSoft Financials migration as described above for one base year with a one (1) renewal for a total not to exceed $3,630,784.00.

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. (If the not-to-exceed amount exceeds the amount previously approved by either $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment E.xiii

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 28, 2023
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	OMES PeopleSoft Implementation Statement of Work
Purpose and Scope	The Oklahoma Health Care Authority (OHCA) will be migrating from the legacy financials and supply chain applications and moving to the statewide PeopleSoft financial system and supply chain platform. This will take a full project approach to migrate to the already configured PeopleSoft solution (using the OCI cloud tenant that is already configured), with accommodations for required business process requests from OHCA. The bulk of the project will be configuration where possible, and the consideration of customizations for OHCA/OMES will be explored when standard features are not able to meet the needs. OMES will work with OHCA, System Integrator and Oracle to fully implement OHCA onto PeopleSoft Financials and will require the following Information Services staff: • Quality Specialists • Firewall Technicians • Systems Analyst OMES IS cost to be billed as incurred - $30,100.00 Project Manager: Pass through 12 months - $332,800.00 Oracle resources include: Pass-through $962,440.29 • Security Administrator • PS Administrator • Developers • Transition Manager • Technical Account Manager
Mandate	N/A
Procurement Method	Interagency statement of work (OMES)
External Approvals	OMES PeopleSoft Epro
Contract Term	July 1, 2023 - June 30, 2024

BUDGET

Amount requested for approval	$1,325,340.29
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure the above-referenced services for a 12-month period for a total amount of $1,325,340.29.

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. Contract terms of statewide contract 1056Q shall govern this acquisition. Every statewide 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. 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.)

Attachment E.ix

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 28, 2023
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Technical Consultant for the Medicaid Management Information System (MMIS) Modernization
Purpose and Scope	OHCA intends to conduct a large-scale overhaul of the antiquated MMIS system. Due to the size, scope, and complexity of the project OHCA has elected to procure a consultant to assist in the planning and procurement. The Oklahoma Health Care Authority (OHCA) is seeking a Contractor for the following services: • Provide PMO support, subject matter expertise, testing and advisory services to complete a successful modernization and transformation of the Oklahoma Medicaid Enterprise Systems (MES) which includes both the MMIS and Eligibility & Enrollment system. • Propose staff, methods, and processes to successfully develop a roadmap to fund, acquire, implement, and efficiently utilize a modern MES that meets the goals of the Oklahoma Health Care Authority and the State of Oklahoma and potentially implement approved roadmap and all required processes.
Mandate	N/A
Procurement Method	Statewide Release
External Approvals	CMS
New Contract Term	Base year with one (1) option to renew.

BUDGET

Amount requested for approval	$2,986,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	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 technical consultant services for MMIS modernization as described above for one base year and one renewal year with a total not-to-exceed of $2,986,000.00.

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. (If the not-to-exceed amount exceeds the amount previously approved by either $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment E.x

SUBMITTED TO THE C.E.O. AND BOARD ON June 28, 2023
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Third Party Liability (TPL) Systems
Purpose and Scope	Oklahoma Health Care Authority is seeking Third Party Liability (TPL) revenue collection services in accordance with 42 CRF 433.135. TPL services are revenue generating for OHCA. Scope includes: • Identify third party liability through data match • Continuously analyze data to identify coverage changes • Implement audits and reviews • Maximize recoveries of billed claims • Denial analysis • Lockbox services
Mandate	Federal law and regulations require that Medicaid pays for services only after liable third parties have met their obligation to pay.
Procurement Method	Competitive Bid
External Approvals	N/A
Contract Term	Base year with five (5) options to renew.

BUDGET

Amount requested for approval	$60,000,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to begin the services as described above for one (1) base year and five (5) renewal periods for a total not-to-exceed cost of $60,000,000.00.

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 days 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 $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment E.xi

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 28, 2023

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

BACKGROUND

Services	Third Party Liability (TPL) Systems
Purpose and Scope	Additional funding is requested to pay remaining SFY23 Health Management Systems (HMS) invoicing that supports the Medicaid Third Party Liability (TPL) revenue collection services in accordance with 42 CRF 433.135. TPL services are revenue generating for OHCA. Scope includes: • Identify third party liability through data match • Continuously analyze data to identify coverage changes • Implement audits and reviews • Maximize recoveries of billed claims • Denial analysis • Lockbox services
Mandate	Federal law and regulations require that Medicaid pays for services only after liable third parties have met their obligation to pay.
Procurement Method	Sole Source Extension
External Approvals	N/A
Contract Term	July1, 2022 through June 30, 2023

BUDGET

Amount requested for approval	$2,000,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to increase funding for the Health Management Services agreement as described above for a total not to exceed increase of $2,000,000.00.

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. (If the not-to-exceed amount exceeds the amount previously approved by $1,000,000.00 or 25% more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

Attachment E. xii

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 28, 2023
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Customer Experience Analytics Tool
Purpose and Scope	Website Performance Metrics • Post-Call Interaction Surveys • Dashboard and Call Analytics Measure, evaluate and continuously improve the Soonercare experience for members and providers. Customer journey mapping on the website, call center, and post-transaction satisfaction.
Mandate	N/A
Procurement Method	Statewide contract 1056Q
External Approvals	OMES PeopleSoft Epro
Contract Term	Initial contract year plus 3 renewable option years

BUDGET

Amount requested for approval	Total - $6,394,971.70 Year 1- $1,664,336.70 Year 2- $1,630,045 Year 3- $1,550,295 Year 4- $1,550,295
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure the above-referenced services for one base year and 3 renewable option years for a total not-to-exceed of $6,394,971.70.

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. Contract terms of statewide contract 1056Q shall govern this acquisition. Every statewide 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. 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.)

OKLAHOMA HEALTH CARE AUTHORITY
SFY-2024 BUDGET WORK PROGRAM
Summary by Program Expenditure

Description	SFY-2023	SFY-2024	Inc / (Dec)	% Change
Medical Program				
Managed Care - Choice / HAN / PACE	57,832,535	62,208,184	4,375,649	7.6%
Hospitals	1,726,054,380	1,775,409,312	49,354,932	2.9%
Behavioral Health	34,609,185	37,817,145	3,207,960	9.3%
Nursing Homes	834,287,396	814,251,241	(20,036,155)	-2.4%
Physicians	629,200,389	644,590,853	15,390,464	2.4%
Dentists	256,047,226	261,690,591	5,643,366	2.2%
Mid-Level Practitioner	1,764,086	1,535,756	(228,330)	-12.9%
Other Practitioners	90,240,545	91,352,777	1,112,232	1.2%
Home Health	30,176,483	34,995,786	4,819,303	16.0%
Lab & Radiology	49,478,098	51,841,591	2,363,493	4.8%
Medical Supplies	101,759,058	106,650,665	4,891,607	4.8%
Clinic Services	660,021,434	688,840,677	28,819,243	4.4%
Ambulatory Surgery Center	12,952,985	14,701,353	1,748,368	13.5%
Prescription Drugs	1,679,892,334	1,777,453,435	97,561,101	5.8%
Miscellaneous	745,305	665,688	(79,617)	-10.7%
ICF/IID	69,672,481	85,152,210	15,479,728	22.2%
Transportation	137,029,520	134,724,792	(2,304,728)	-1.7%
Medicare Buy-in (Part A & B)	245,608,802	249,317,664	3,708,862	1.5%
Medicare clawback payment (Part D)	78,821,702	122,482,029	43,660,327	55.4%
SHOPP - Supplemental Hosp Offset Pymt.	756,274,913	797,048,835	40,773,923	5.4%
Money Follows the Person - Enhanced	608,069	642,469	34,400	5.7%
Health Management Program (HMP)	12,560,024	12,560,024	-	0.0%
Electronic Health Records Incentive Pymts	200,000	200,000	-	0.0%
Mandated Pass-through to Hospitals (SB 32X)	-	200,000,000	200,000,000	100.0%
Non-Title XIX Medical	89,382	89,382	-	0.0%
TOTAL OHCA MEDICAL PROGRAM	7,465,926,333	7,966,222,458	500,296,125	6.7%
Insure Oklahoma - Premium Assistance				
Employer Sponsored Insurance - ESI	44,982,334	46,833,042	1,850,708	4.1%
Individual Plan - IP	500,000	360,000	(140,000)	-28.0%
TOTAL INSURE OKLAHOMA PROGRAM	45,482,334	47,193,042	1,710,708	3.8%
OHCA Administration				
Operations - Division 10	62,627,210	64,072,186	1,444,976	2.3%
Contracts - Division 30	48,712,034	60,882,816	12,170,782	25.0%
Insure Oklahoma - Division 40	1,436,420	1,432,649	(3,771)	-0.3%
Business Enterprises - Division 88	84,901,045	142,168,327	57,267,282	67.5%
Grants Management - Division 50	7,039,603	8,331,030	1,291,427	18.3%
TOTAL OHCA ADMIN	204,716,312	276,887,008	72,170,696	35.3%
TOTAL OHCA PROGRAMS	**7,716,124,978**	**8,290,302,507**	**574,177,529**	**7.4%**
Other State Agency (OSA) Programs				
Oklahoma Human Services (OHS)	758,057,870	765,786,949	7,729,079	1.0%
Oklahoma State Dept of Health (OSDH)	10,029,949	11,385,455	1,355,506	13.5%
The Office of Juvenile Affairs (OJA)	9,566,269	8,641,349	(924,920)	-9.7%
University Hospitals (Medical Education Pymnts)	633,818,907	477,657,473	(156,161,435)	-24.6%
Department of Mental Health (ODMHSAS)	767,001,061	780,337,492	13,336,431	1.7%
Department of Education (DOE)	3,048,701	4,320,942	1,272,241	41.7%
Non-Indian Payments	28,821,631	30,491,386	1,669,755	5.8%
Department of Corrections (DOC)	5,964,731	7,002,476	1,037,745	17.4%
JD McCarty	14,914,102	15,218,005	303,902	2.0%
OSA Non-Title XIX	119,065,000	119,065,000	-	0.0%
TOTAL OSA PROGRAMS	**2,350,288,222**	**2,219,906,526**	**(130,381,696)**	**-5.5%**
TOTAL MEDICAID PROGRAM	**10,066,413,200**	**10,510,209,033**	**443,795,833**	**4.4%**

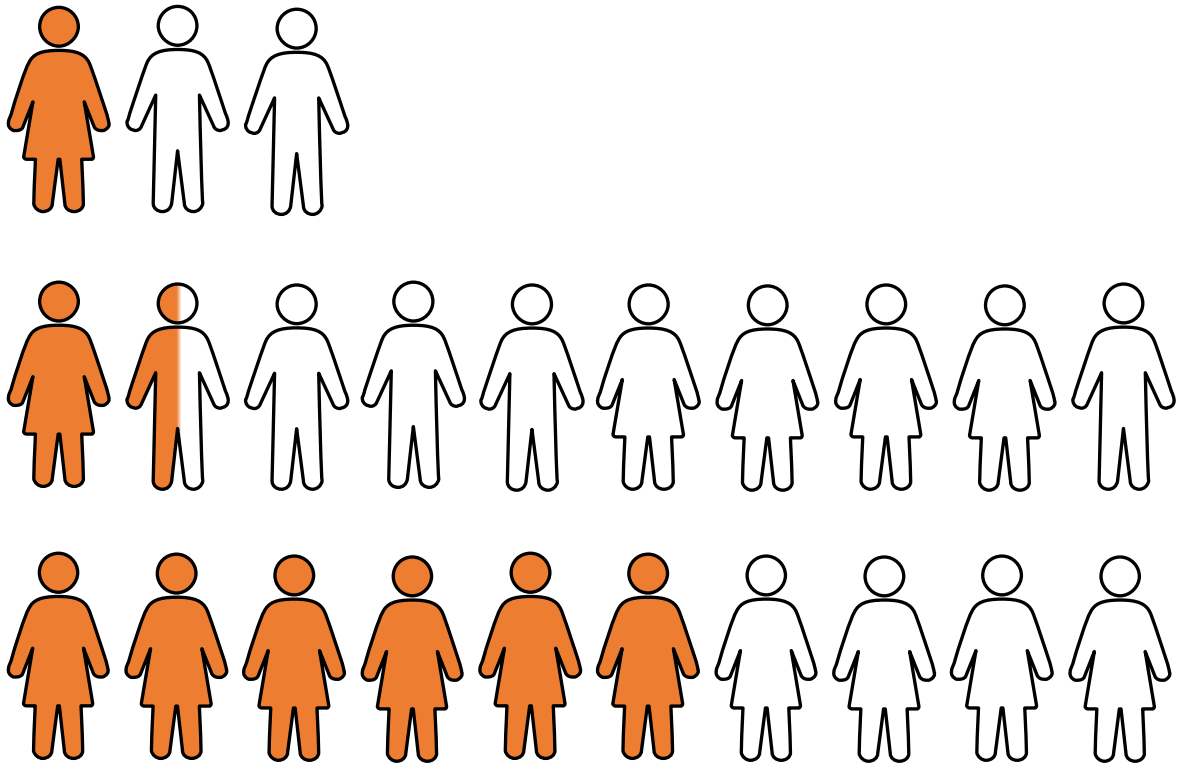
OKLAHOMA HEALTH CARE AUTHORITY
SFY-2024 BUDGET WORK PROGRAM
Summary by Program Expenditure

Description	SFY-2023	SFY-2024	Inc / (Dec)	% Change
REVENUES				
Federal - Medicaid Traditional	5,273,068,395	4,641,802,663	(631,265,733)	-12.0%
Federal - Medicaid Expansion	2,195,711,067	2,352,550,805	156,839,738	7.1%
Federal - admin	126,175,246	156,886,878	30,711,632	24.3%
Drug Rebates	650,620,656	666,844,784	16,224,129	2.5%
Medical Refunds	36,249,709	38,440,794	2,191,085	6.0%
NF Quality of Care Fee	90,767,373	93,623,543	2,856,171	3.1%
OSA Refunds & Reimbursements	554,378,660	689,913,392	135,534,731	24.4%
Tobacco Tax	82,275,894	80,389,048	(1,886,846)	-2.3%
Misc Revenue / ASPAPP Assessment Fee	4,636,559	4,089,128	(547,431)	-11.8%
Prior Year Carryover (Fund 200/340)	17,498,129	737,320,842	719,822,714	4113.7%
Other Grants	576,478	192,480	(383,998)	-66.6%
Hospital Provider Fee (SHOPP bill)	242,598,354	319,551,090	76,952,735	31.7%
State Appropriated:				
OHCA Admin/Program	1,098,603,586	450,836,128	(647,767,458)	-59.0%
SB 32X - HIE state grant funding	-	30,000,000	30,000,000	100.0%
SB 32X - Nursing Homes Rate Increases	-	47,767,458	47,767,458	100.0%
SB 32X - Pass-through to Hospitals	-	200,000,000	200,000,000	100.0%
TOTAL REVENUES	**10,373,160,107**	**10,510,209,033**	**137,048,926**	**1.3%**

OKLAHOMA HEALTH CARE AUTHORITY SFY 2024 BUDGET

BACKGROUND

OKLAHOMA QUICK STAT

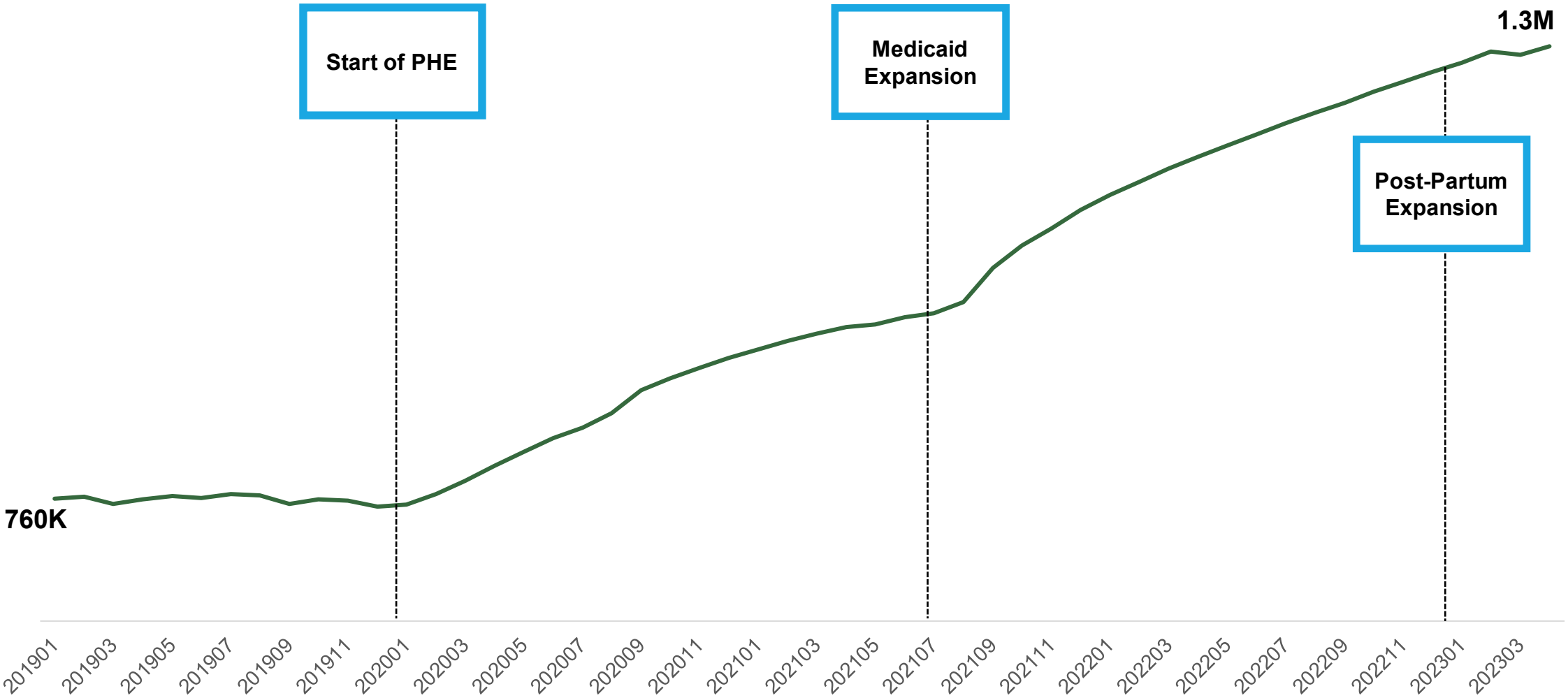


1 of 3
On Medicaid

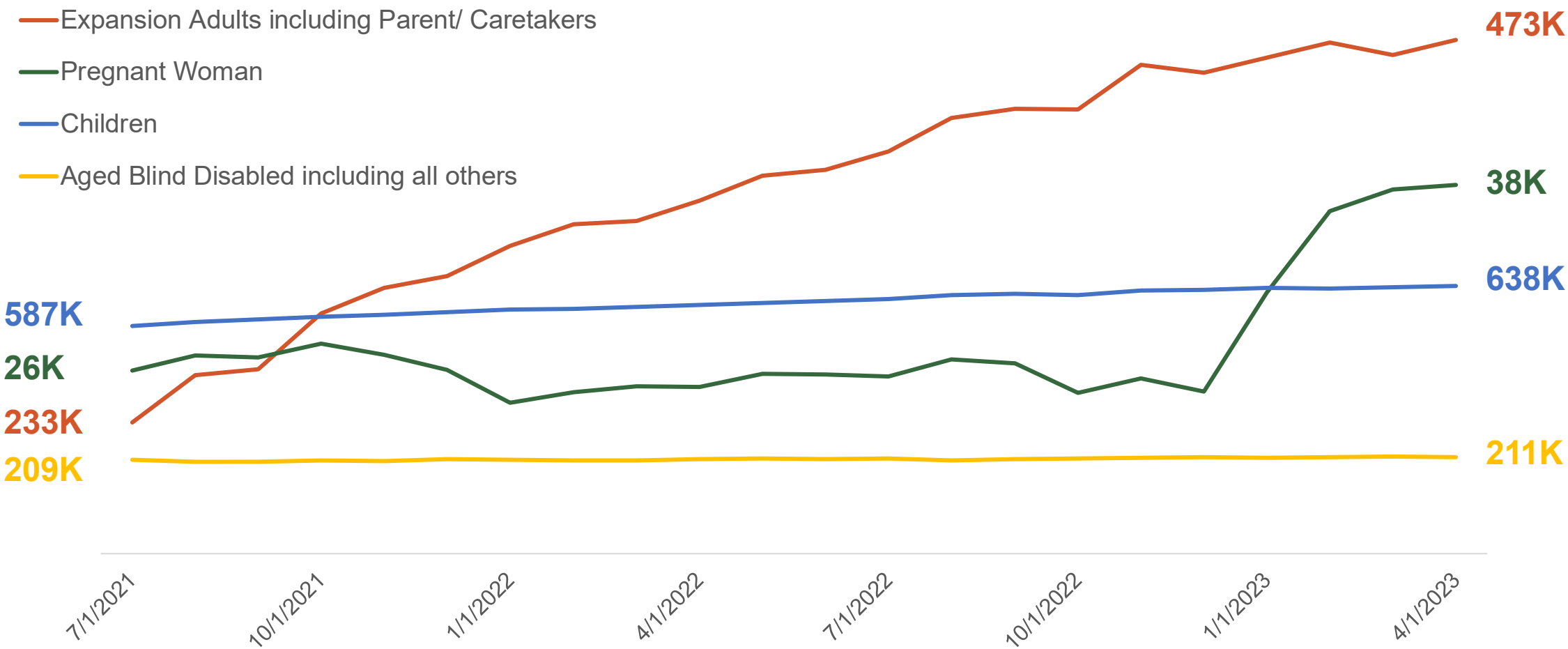
1.5 of 10
State's Uninsured

6 of 10
Pregnancies covered by Medicaid

ENROLLMENT GROWTH

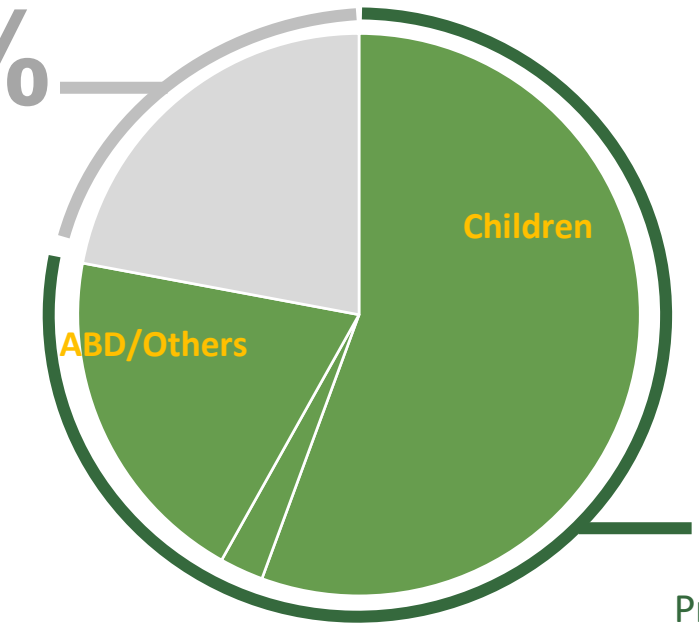


ENROLLMENT INCREASES



MEDICAID ENROLLMENT

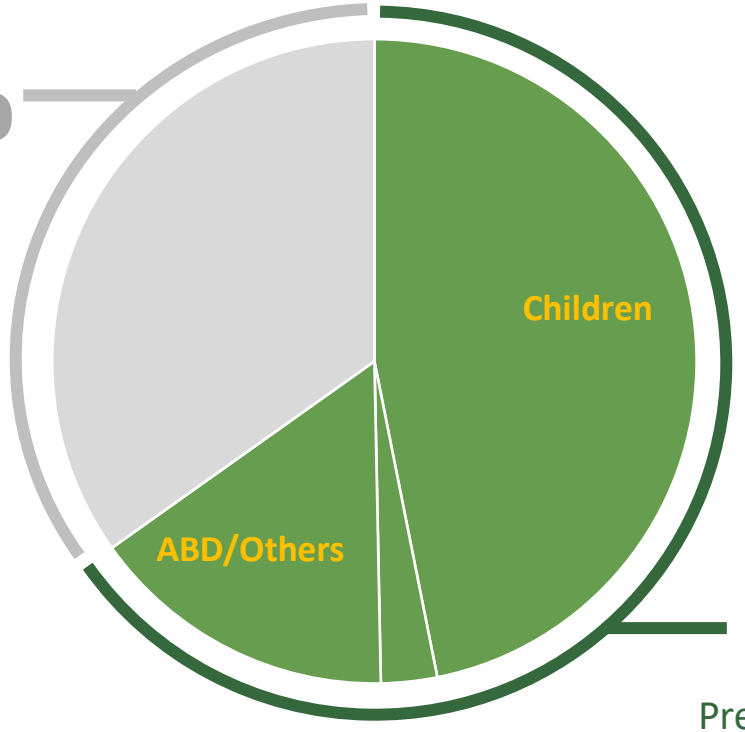
As of July 2021



20%
Parent/
Caretakers

80%
Pregnant woman, Children, and Aged Blind Disabled/All others

As of April 2023



35%
Expansion adults including Parent/ Caretakers

65%
Pregnant woman, Children, and Aged Blind Disabled/All other

Fiscal Year	Budget	Increase/ Decrease %	Total Appropriation	Increase/ Decrease %	FMAP	Percent Appropriation to Budget
2018	$5,737,712,893	1.0%	$1,018,713,566	3.3%	58.91%	17.8%
2019	$5,928,477,640	3.3%	$1,132,465,946	11.2%	61.43%	19.1%
2020	$6,163,200,792	4.0%	$1,000,039,368	-11.7%	65.11%	16.2%
2021	$6,477,455,224	5.1%	$1,000,039,368	0.0%	67.50%	15.4%
2022	$8,194,267,343	26.5%	$1,194,337,303	19.4%	68.23%	14.6%
2023	$10,066,413,200	22.8%	$1,262,741,642	5.7%	67.60%	12.5%
2024	$10,510,209,033	4.4%	$892,741,642	-29.3%	67.49%	8.5%

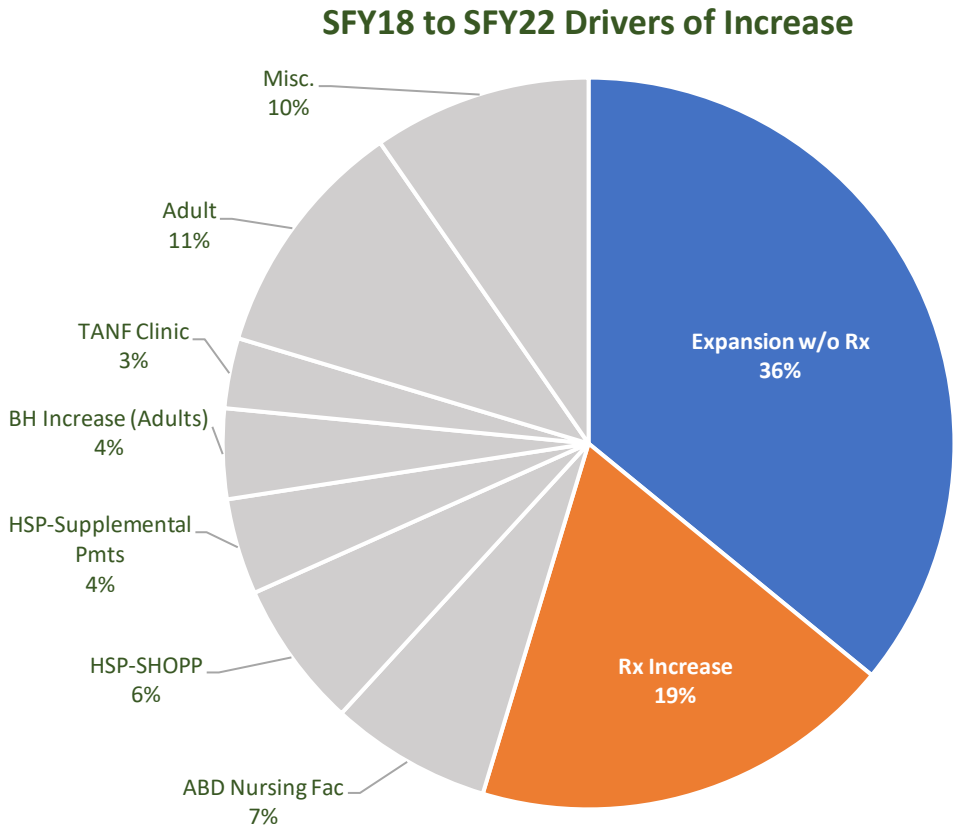
APPROPRIATIONS AND BUDGET

MEDICAL EXPENDITURES

2.5B ~73% of the $2.5B increase occurred between SFY21 and SFY22

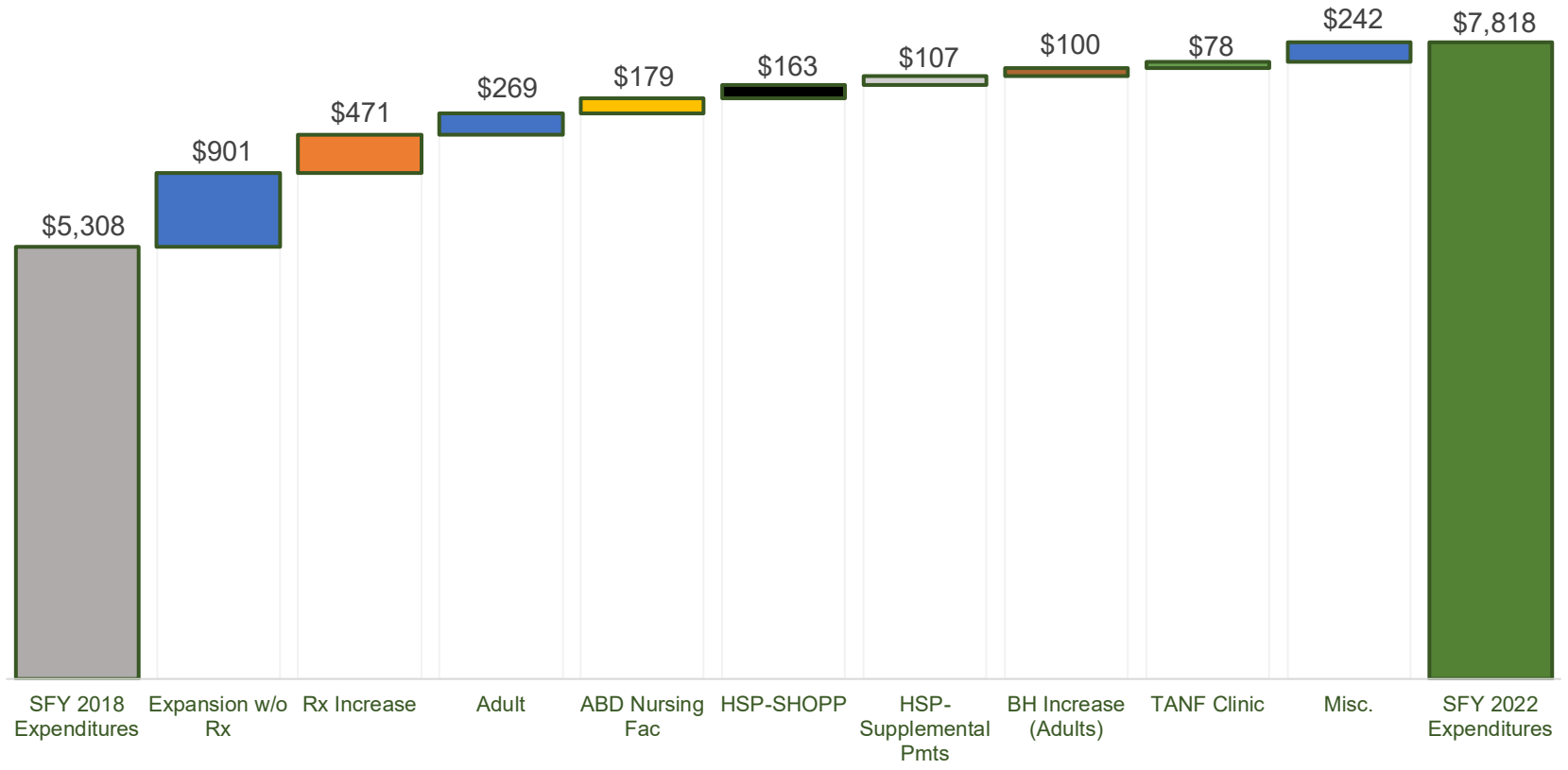
901M **Expansion w/o Rx**
Accounts for ~36% of the increase in expenditures

470M **Rx Increase**
19% of the increase is attributable to prescription drugs

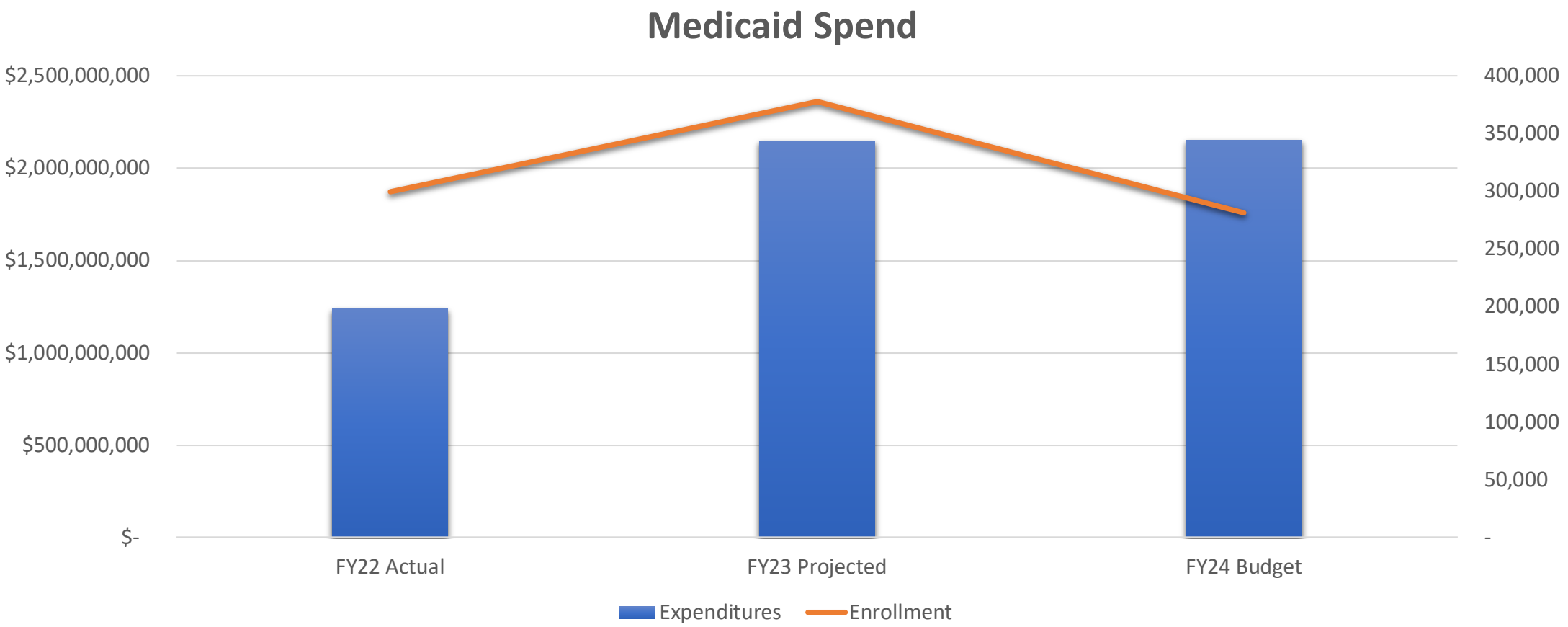


COST DRIVERS FROM SFY18 – SFY22

Medical Expenditure Increase
SFY 2018 - SFY 2022
(in millions)



EXPANSION SPEND



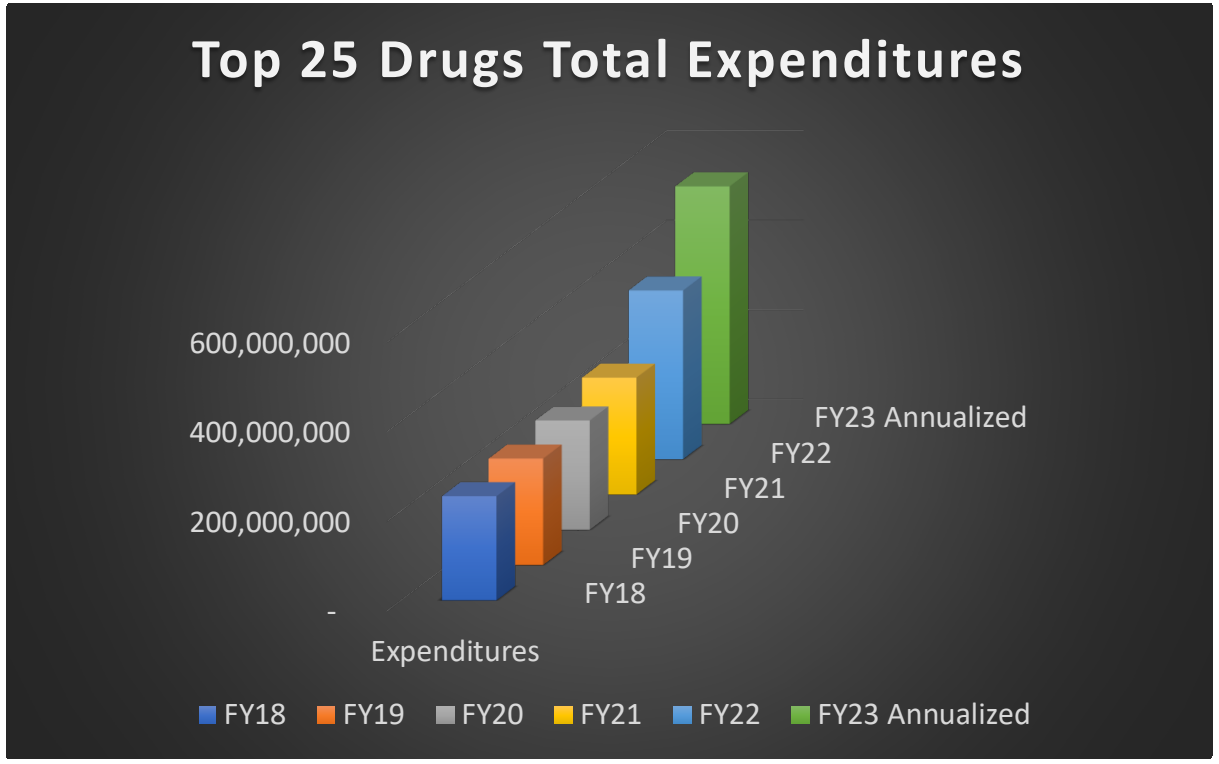
PHARMACY EXPENDITURES

470M

Rx Increase
19% of the increase is attributable to prescription drugs

321M

Expansion Rx
68% of the prescription drug increase is from Expansion.



MEDICAL PROGRAM

Total Budget Increase of $500,296,125 or 6.7%

MEDICAL PROGRAM - RECURRING

Percent Change	Summary of Change	Total Dollar Change
3.1%	FY 2024 Growth	$240,074,809
-5.5%	PHE Unwind (Incl Re-enroll and Lag)	($406,367,976)
-2.3%	Nursing Facility Covid Supplemental	($172,976,682)
2.2%	Mandated LTC Rate Increase SB32X	$167,062,300
0.4%	SHOPP and Other Supplemental Payments	$33,174,275
0.6%	Medicare Parts A, B & D	$47,369,189
0.6%	Indian Health Service Rate and Utilization Inc	$43,176,147
0.2%	Initiatives (Pregnancy Related Expansion, Doula and PDN Rate Increase)	$15,390,266
0.1%	Federal Mandate (Continuous Coverage)	$4,463,262
-0.3%	HOPE Act Initiative Savings	($20,303,417)
-0.7%	**SFY 2024 Decrease**	**($48,937,827)**

MEDICAL PROGRAM – NON-RECURRING

Percent Change	Summary of Change	Total Dollar Change
4.9%	Claims Bubble – Delivery System Transition	$368,214,449
2.7%	Mandated Hospital Payment SB32X	$200,000,000
-0.3%	Financial Cycle Delay	($18,980,497)
7.4%	**SFY 2024 Increase**	**$549,233,952**

MEDICAL PROGRAM

Percent Change	Summary of Change	Recurring	Non-Recurring	Total
6.7%	SFY 2024 Expenditure Increase	($48,937,827)	$549,233,952	$500,296,125

OHCA PROGRAM ASSUMPTIONS

- Program growth is estimated at 3.1% overall based on historical utilization by category of service
- LTC spend decreased due to the end of Public Health Emergency and supplemental payment but offset due to SB32X mandated rate increase
- IHS/Tribal spend in clinic and pharmacies has increased significant, due to both rates and utilization. The expansion population specifically has been high utilizers of IHS and tribal facilities.
- Soonerselect Capitation payments are not included in the analysis but they are built from existing spend and will be incorporated into budget once final

INSURE OKLAHOMA

Total Budget Increase of $1,710,708 or 3.8%

INSURE OKLAHOMA

Percent Change	Program	Total Dollar Change
4.1%	Employer Sponsored Insurance (ESI)	$1,850,708
-28%	Individual Plan (IP)	($140,000)
3.8%	**SFY 2024 Overall Increase**	**$1,710,708**

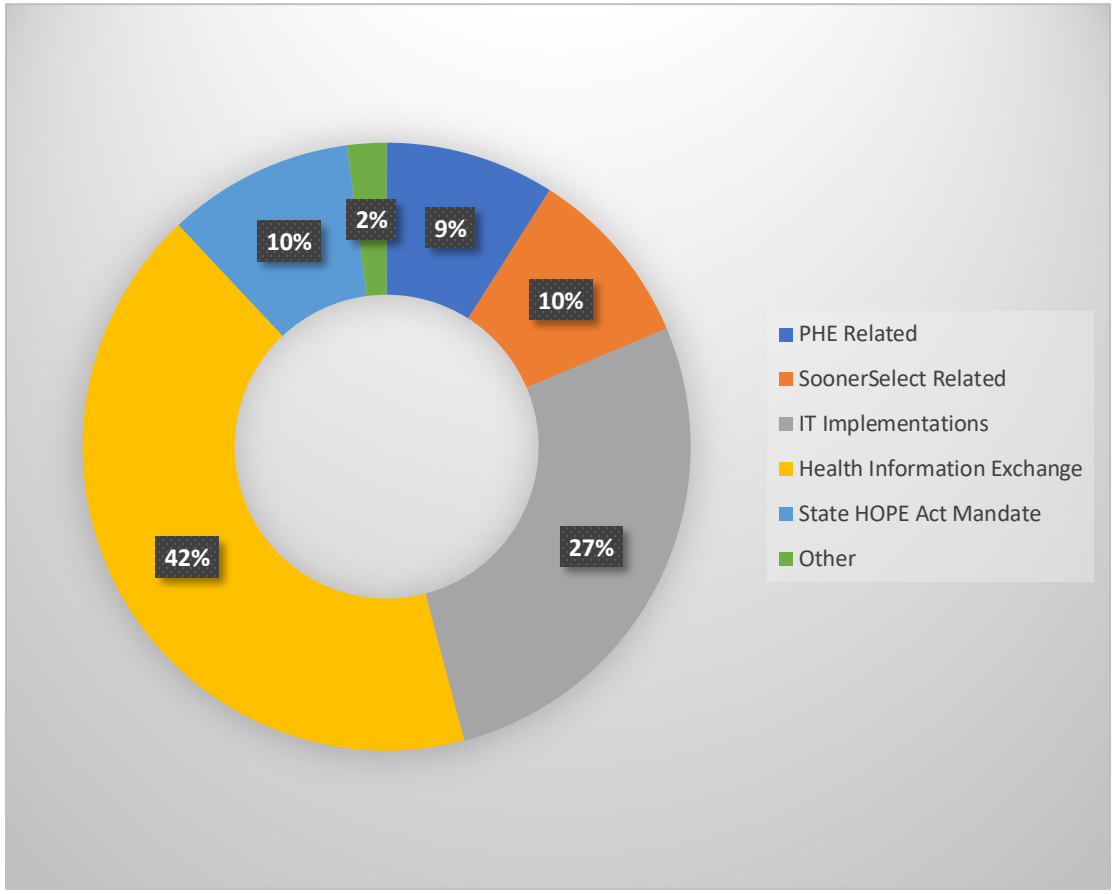
OHCA ADMINISTRATION

Total Budget Increase of $72,170,696 or 35.3%

OHCA ADMINISTRATION

Percent Change	Division	Total Dollar Change
2.3%	Operations (includes IO & Business Enterprises)	$1,444,976
52%	Contracts (IT and non-IT)	$69,438,064
-0.3%	Insure Oklahoma	($3,771)
18.3%	Grants Management	$1,291,427
35.3%	**SFY 2024 Overall Increase**	**$72,170,696**

INCREASE DRIVERS



Drivers by Category	Total Dollar Change
PHE Related Contracts	$6,509,494
SoonerSelect Related Contracts	$6,947,100
IT Implementations	$19,660,046
Health Information Exchange	$30,400,000
State HOPE Act Mandate	$7,145,909
Other	$1,508,147
Total	**$72,170,696**

OHCA ADMINISTRATION ASSUMPTIONS

Operations

- $1.4 million increase attributable to OMES support agreement for PeopleSoft Upgrade
- Flat Salary Budget

Professional Service Contracts

- $12.1 million increase in non-IT contracts with $5.5 million in one-time spend and another $5 million related to enrollment increases
- $57.2 million increase in IT contract
  - $30 million from SB32X mandate of one-time grant funds for HIE connections
  - $10 million related to Medicaid Enterprise System project funds moved from FY 2023 to FY 2024
  - $7.1 million to comply with HOPE Act with anticipated $20 million in program savings
- Identified and utilized contract savings of $1.6M to offset additional funding required in SFY 2024

OTHER STATE AGENCY PROGRAMS

Total Budget Decrease of
$130,381,696 or -5.5%

OTHER STATE AGENCY PROGRAMS

Percent Change	Agency / Program	Total Dollar Change
1.0%	Oklahoma Human Services	$7,729,079
13.5%	Department of Health	$1,355,506
-9.7%	Office of Juvenile Affairs	($924,920)
-24.6%	University Hospital Authority & Trust	($156,161,435)
1.7%	Department of Mental Health & Substance Abuse	$13,336,431
41.7%	Department of Education	$1,272,241
5.8%	Tribal Government	$1,669,755
17.4%	Department of Corrections	$1,037,745
2.0%	JD McCarty	$303,902
0.0%	OSA Non-Title XIX	$0
-5.5%	**SFY 2024 Overall Decrease**	**($130,381,696)**

OSA PROGRAM ASSUMPTIONS

- 2% Program Growth related to program enhancements and rate increases
- Increase Tribal government payments to new providers serving non-Tribal Oklahomans.
- Decreased supplemental payment for OU Health due to moving payments from FY 2024 to FY 2023
- Reduction of payments due to PHE unwind and reduced enrollment

REVENUE

Total Budget Increase of $137,048,926 or 1.3%

APPROPRIATION SUMMARY

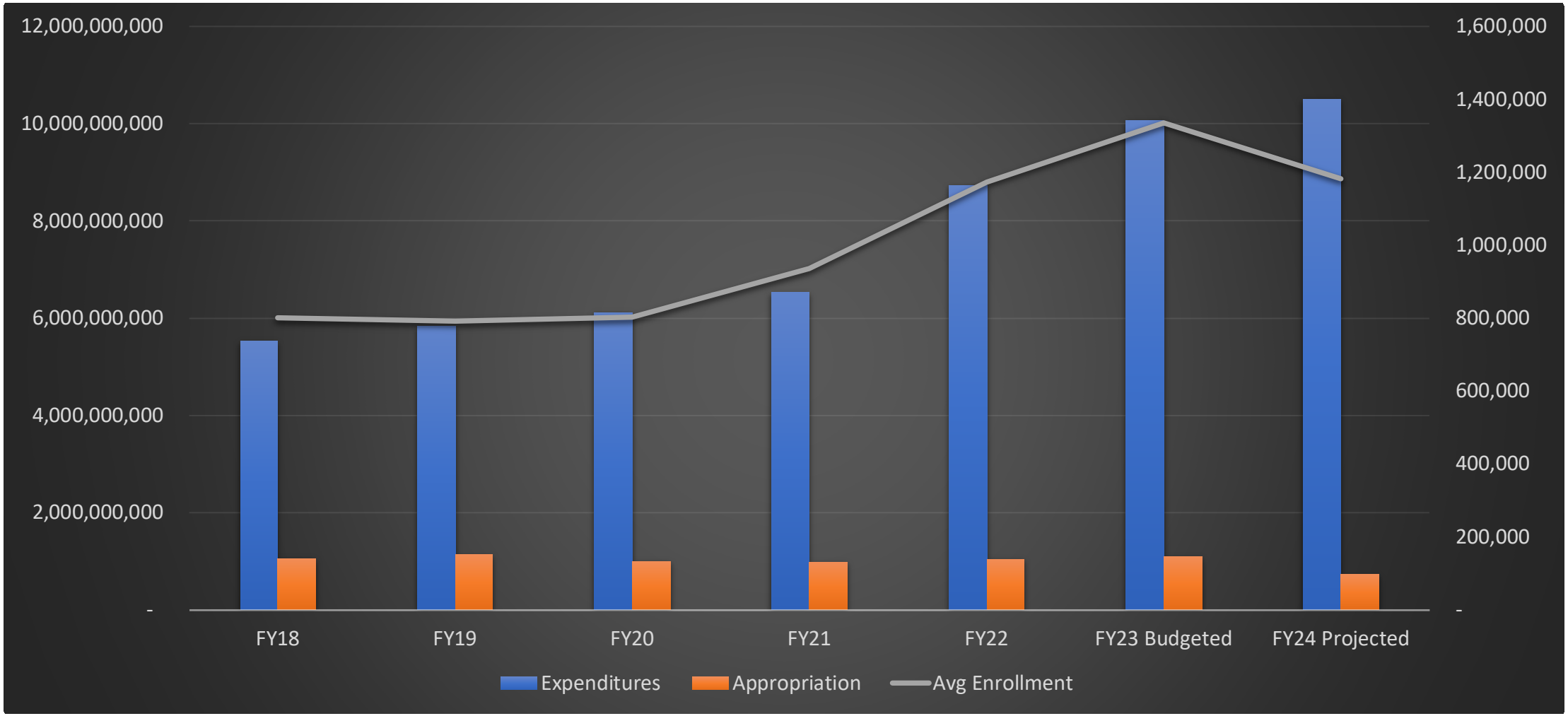
FY 2024 OHCA Appropriation Summary – HB 1004X	
Section 71 (FY 2024 General Revenue)	$598,603,586
Section 72 (FY 2023 General Revenue)	$130,000,000
FY 2023 Appropriation	**$728,603,586**
Section 73 - Transfer to Rate Preservation	**$164,138,054**

Percent Change	Funding Source	Total Dollar Change
-6.4%	Federal – Program	($474,425,995)
24.3%	Federal – Administration	$30,711,632
2.5%	Drug Rebates	$16,224,129
6.0%	Medical Refunds	$2,191,085
3.1%	NF Quality of Care Provider Fee	$2,856,171
24.4%	Other State Agency Refunds & Reimbursements	$135,534,731
-2.3%	Tobacco Tax	($1,886,846)
-11.8%	Miscellaneous Revenue	($547,431)
4113.7%	Prior Year Carryover	$719,822,714
-66.6%	Other Grants	($383,998)
31.7%	Hospital Provider Fee (SHOPP)	$76,952,735
-33.7%	State Appropriations	($370,000,000)
1.3%	**SFY 2024 Overall Increase**	**$137,048,926**

REVENUE ASSUMPTIONS

- Declining Federal Revenue and no revenue surplus for FFCRA & ARPA
- Utilization of over $700 million prior year carryover required due to appropriation deficit
  - $600 million appropriation reduction
  - $47 million for LTC rate increases SB32X
  - Funding for claims bubble
- Other State Agency reimbursements increasing due to reduction in federal funds
- SHOPP revenue growth due to increase in fee as mandated in 2022 SB 1396

BUDGET OVERVIEW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800,000
600,000
400,000
200,000
-
FY18
FY19
FY20
FY21
FY22
FY23 Budgeted
FY24 Projected
Expenditures
Appropriation
Avg Enrollment

GROWTH

SUMMARY

Percent Increase	Expenditures/Revenue	Increase	Total Dollars
4.4%	Expenditures	$443,795,833	$10,510,209,033
1.3%	Revenues	$137,048,926	$10,510,209,033
			$0

KEY TAKEAWAYS

- OHCA appropriation deficit necessitates use of over $700 million from cash reserve
- Significant FY 2024 budget increase mostly attributable to one-time spend including claims bubble related to delivery system reform and state mandates of payments to hospitals ($200 million) and HIE connection fees ($30 million)
- Medicaid program growth projected to be fully offset by enrollment decrease required by the expiration of the Public Health Emergency
- Expiring enhanced FMAP funds means no surplus of revenue due in FY 2024
- OHCA to again reserve over $164 million in additional savings to the rate preservation fund and by the end of year will have savings of almost $500 million

LOOKING FORWARD

- In FY 2025, OHCA and other agency partners will decrease spend associated with the claims bubble ($400 million) and the remaining costs from the PHE unwind ($370 million)
- Spend increases will be from Directed Payment programs mandated in 2022 SB1396, annualizing the federal mandate for continuous coverage for children, growth and other obligations
- OHCA projects a significant FY 2025 appropriation request to include replacement of $600 million deficit, new funding for LTC rate increases, funding for FY 2024 and FY 2025 growth and replacing funds for over expending EFMAP

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

okhca.org
mysoonercare.org

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

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June Board
Proposed Rules Amendment Summaries

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

These proposed ***EMERGENCY*** rules were presented at Tribal Consultation and the Medical Advisory Committee. These changes were subject to at least a 15-day public comment period.

The Agency is requesting the effective date to be July 1, 2023 or immediately upon Governor's approval. Upon the Agency's submission for gubernatorial review, the Governor will have until Aug. 12, 2023, to approve or disapprove each rule.

APA WF # 23-02 Insure Oklahoma Self-Funded/Self-Insured Plans — The proposed rules will update Insure Oklahoma policy to comply with Oklahoma Senate Bill 1323, which added language to Title 56 Oklahoma Statutes (O.S.) § 1010.1. The policy additions mirror the bill's language regarding self-funded/self-insured plans to address that qualified benefit plans may become a self-funded or self-insured benefit plan if certain criteria are met.

Budget Impact: Budget neutral

APA WF # 23-09 Copayment exemption for expansion adults — The Affordable Care Act (ACA) requires states to cover preventive services for expansion adults without any cost sharing. The proposed rules will update the list of services exempted from copayments to ensure the ACA requirement is reflected in the rule as well as exempt vaccine administration from cost sharing for all members eligible to incur a copay.

Budget Impact: The estimated budget impact, for SFY2023, will be an increase in the total amount of $81,123; with $8,122 in state share. The estimated budget impact, for SFY2024 will be an increase in the total amount of $81,123; with $8,112 in state share.

APA WF # 23-10 Doula Services — The proposed additions will implement doula services as a covered benefit to SoonerCare members. The policy additions will outline what a doula is and the specific services/requirements including but not limited to, certification requirements from one of the Agency-recognized organizations, a referral from a licensed medical provider (physician, physician's assistant (PA), obstetrician, certified nurse midwife), and be at least 18 years of age. Furthermore, policy will outline that members will have eight doula visits, including one for labor and delivery care. Finally, additions will state that reimbursement for doula services is outlined in the Oklahoma Medicaid State Plan.

Budget Impact: The estimated budget impact for SFY 2024 will be an increase in the total amount of $2,734,572; with $861,732 in state share. The estimated budget impact for SFY 2025 will be an increase in the total amount of $2,734,572; with $887,916 in state share.

APA WF # 23-11 Private Duty Nursing (PDN) Reimbursement and Overtime — The proposed revisions will add clarification regarding the reimbursement for Private Duty Nursing (PDN) services, including when overtime payment is appropriate. Further revisions will state that overtime is only available for nursing staff who are providing services to members with tracheostomies or who are medically dependent on a ventilator for life support at least six (6) hours per day. This excludes members who are on non-invasive C-PAP or Bi-PAP devices only.

Budget Impact: The estimated budget impact, for SFY2023, will be an increase in the total amount of $733,401; with $157,241 in state share. The estimated budget impact for SFY2024 will be an increase in the total amount of $4,368,349; with $1,420,150 in state share.

APA WF # 23-12 Enhanced Payment for Vocational & Day Services Provided in Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) — The proposed revisions will implement changes to comply with Oklahoma Senate Bill 1074 which authorizes the Oklahoma Health Care Authority (OHCA) to implement an enhanced payment program for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) that offer vocational services or day program services or both. The purpose of the enhanced payment is to offset the costs incurred by ICFs/IID in these services as these services are currently funded by donations/charity. The enhanced payment will be in addition to all other reimbursement from the OHCA.

Budget Impact: The estimated budget impact for SFY 2023, will be an increase in the total amount of $2,414,603; with $782,392 in state share. The estimated budget impact for SFY 2024 will be an increase in the total amount of $7,243,810; with $2,347,175 in state share.

APA WF # 23-14 Audio-only Telecommunications Health Service Delivery — The proposed policy revisions allow for the audio-only telecommunications health service delivery for medically necessary covered primary care and other approved health services. Audio-only telecommunications delivery means healthcare services delivered through the use of audio-only technology, permitting real-time communication between a patient and the provider, for the purpose of diagnosis, consultation, or treatment, and does not include the use of facsimile or email nor the delivery of health care services that are customarily delivered by audio-only technology and customarily not billed as separate services by the provider, such as the sharing of laboratory results. The proposed rules include definitions and requirements for service provision and reimbursement.

Budget Impact: The estimated budget impact for SFY 2024, will be an increase in the total amount of $1,759,405; with $554,433 in state share. The estimated budget impact for SFY 2025 will be an increase in the total amount of $1,759,405; with $571,279 in state share.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 45. INSURE OKLAHOMA

SUBCHAPTER 5. INSURE OKLAHOMA QUALIFIED BENEFIT PLANS

317:45-5-1. Qualified Benefit Plan requirements

(a) Participating qualified benefit plans must offer, at a minimum, benefits that include:

(1) ~~hospital~~Hospital services;

(2) ~~physician~~Physician services;

(3) ~~clinical~~Clinical laboratory and radiology;

(4) ~~pharmacy~~Pharmacy;

(5) ~~office~~ visits;

(6) ~~well~~Well baby/well child exams;

(7) ~~age~~Age appropriate immunizations as required by law; and

(8) ~~emergency~~Emergency services as required by law.

(b) The benefit plan, if required, must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. All benefit plans must share in the cost of covered services and pharmacy products in addition to any negotiated discounts with network providers, pharmacies, or pharmaceutical manufacturers. If the benefit plan requires co-payments or deductibles, the co-payments or deductibles cannot exceed the limits described in this subsection.

(1) An annual in-network out-of-pocket maximum cannot exceed $3,000 per individual, excluding separate pharmacy deductibles.

(2) Office visits cannot require a co-payment exceeding $50 per visit.

(3) Annual in-network pharmacy deductibles cannot exceed $500 per individual.

(c) Qualified benefit plans will provide an EOB, an expense summary, or required documentation for paid and/or denied claims subject to member co-insurance or member deductible calculations. The required documentation must contain, at a minimum, the:

(1) ~~provider's~~Provider's name;

(2) ~~patient's~~Patient's name;

(3) ~~date(s)~~Date(s) of service;

(4) ~~code(s)~~Code(s) and/or description(s) indicating the service(s) rendered, the amount(s) paid or the denied status of the claim(s);

(5) ~~reason~~Reason code(s) and description(s) for any denied service(s);

(6) ~~amount~~Amount due and/or paid from the patient or responsible party; and

(7) ~~provider~~Provider network status (in-network or out-of-network provider).

(d) A qualified benefit plan that is participating in the Insure Oklahoma (IO) program as of November 1, 2022 may become a self-funded or self-insured benefit plan if the following conditions are met:

(1) The qualified benefit plan has continuously participated in the premium assistance program without interruption up to the date it becomes a self-funded or self-insured health care plan;

(2) The self-funded or self-insured benefit plan continues to be recognized as a benefit plan by the Oklahoma Insurance Department;

(3) The self-funded or self-insured benefit plan continues to cover all essential health benefits listed in (a) of this section in addition to all other health benefits that are required under

applicable federal laws; and
4) The self-funded or self-inured benefit plan must have a monthly premium assessed and a rate schedule in order to be an approved business with the IO program.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-5. Assignment and cost sharing

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

(1) **"Fee-for-service (FFS) contract"** means the provider agreement specified in Oklahoma Administrative Code (OAC) 317:30-3-2. This contract is ~~the contract~~ between the Oklahoma Health Care Authority (OHCA) and medical providers which provides for a fee with a specified service involved.

(2) **"Outside of the scope of the services"** means all medical benefits outside the set of services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare program.

(3) **"Within the scope of services"** means the set of covered services defined at OAC 317:25-7 and the provisions of the SoonerCare Choice contracts in the SoonerCare program

(b) **Assignment in FFS.** Oklahoma's Medicaid State Plan provides that participation in the medical program is limited to providers who accept, as payment in full, the amounts paid by OHCA plus any deductible, coinsurance, or co-payment required by the State Plan to be paid by the member and make no additional charges to the member or others.

(1) OHCA presumes acceptance of assignment upon receipt of an assigned claim. This assignment, once made, cannot be rescinded, in whole or in part by one party, without the consent of the other party.

(2) Once an assigned claim has been filed, the member must not be billed, and the member is not responsible for any balance except the amount indicated by OHCA. The only amount a member may be responsible for is a co-payment, or the member may be responsible for services not covered under the medical programs. In any event, the member should not be billed for charges on an assigned claim until the claim has been adjudicated or other notice of action received by the provider. Any questions regarding amounts paid should be directed to OHCA, Provider Services.

(3) When potential assignment violations are detected, the OHCA will contact the provider to assure that all provisions of the assignment agreement are understood. When there are repeated or uncorrected violations of the assignment agreement, the OHCA is required to suspend further payment to the provider.

(c) **Assignment in SoonerCare.** Any provider who holds a FFS contract and also executes a contract with a provider in the SoonerCare Choice program must adhere to the rules of this subsection regarding assignment.

(1) If the service provided to the member is outside of the scope of the services outlined in the SoonerCare contract, then the provider may bill or seek collection from the member.

(2) In the event there is a disagreement whether the services are in or out of the scope of the contracts referenced in (1) of this subsection, the OHCA shall be the final authority for this decision.

(3) Violation of this provision shall be grounds for a contract termination in the FFS and SoonerCare programs.

(d) **Cost sharing/co-payment.** Section 1902(a)(14) of the Social Security Act permits states to require certain members to share some of the costs of SoonerCare by imposing upon them such payments as enrollment fees, premiums, deductibles, coinsurance, co-payments, or similar cost sharing charges. OHCA requires a co-payment of some SoonerCare members for certain medical services provided through the FFS program. A co-payment is a charge which must be paid by the member to the service provider when the service is covered by SoonerCare. Section 1916(e) of the Act requires that a provider participating in the SoonerCare program may not deny care or services to an eligible individual based on such individual's inability to pay the co-payment. A person's assertion of their inability to pay the co-payment establishes this inability. This rule does not change the fact that a member is liable for these charges, and it does not preclude the provider from attempting to collect the co-payment.

(1) Co-payment is not required of the following members:

(A) Individuals under age twenty-one (21). Each member's date of birth is available on the REVS system or through a commercial swipe card system.

(B) Members in nursing facilities (NF) and intermediate care facilities for individuals with intellectual disabilities (ICF/IID).

(C) Home and Community-Based Services (HCBS) waiver members except for prescription drugs.

(D) American Indian and Alaska Native members, per Section 5006 of the American Recovery and Reinvestment Act of 2009 and as established in the federally-approved Oklahoma Medicaid State Plan.

(E) Individuals who are categorically eligible for SoonerCare through the Breast and Cervical Cancer Treatment program.

(F) Individuals receiving hospice care, as defined in section 1905(o) of the Social Security Act.

(2) Co-payment is not required for the following services:

(A) Family planning services. This includes all contraceptives and services rendered.

(B) Emergency services provided in a hospital, clinic, office, or other facility.

(C) Services furnished to pregnant women.

(D) Smoking and tobacco cessation counseling and products.

(E) Blood glucose testing supplies and insulin syringes.

(F) Medication-assisted treatment (MAT) drugs.

(G) Vaccine administration.

(H) Preventive services for expansion adults.

(3) Co-payments are required in an amount not to exceed the federal allowable for the following:

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

(C) Ambulatory surgery visits including free-standing ambulatory surgery centers.

(D) Encounters with the following rendering providers:

(i) Physicians;

(ii) Advanced practice registered nurses;

(iii) Physician assistants;

(iv) Optometrists;

(v) Home health agencies;

(vi) Certified registered nurse anesthetists;

(vii) Anesthesiologist assistants;

(viii) Durable medical equipment providers; and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

(F) Crossover claims. Dually eligible Medicare/SoonerCare members must make a co-payment in an amount that does not exceed the federal allowable per visit/encounter for all Part B covered services. This does not include dually eligible HCBS waiver members.

(4) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an aggregate limit of five percent (5%) of the family's income applied on a monthly basis, as specified by the agency.

(5) Providers will be required to refund any co-payment amounts the provider collected from the member in error and/or above the family's aggregate cost sharing maximum.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 114. DOULA SERVICES

317:30-5-1215. General

(a) A doula or birth worker is a trained professional who provides emotional, physical, and informational support services during the prenatal, labor and delivery, and postpartum periods. Doulas are non-clinical and do not provide medical care. Services should not replace the services of other licensed and trained medical professionals including, but not limited to, physicians, physicians assistants, advanced practice registered nurses, and certified nurse midwives.
(b) All Title XIX, CHIP, expansion adult, and Soon-to-be-Sooners (STBS) members who are pregnant or within the postpartum period are eligible for doula services.
(c) Doula services are available for twelve (12) months postpartum, depending on the members continued SoonerCare eligibility.

317:30-5-1216. Eligible providers

(a) **Provider requirements.**
(1) Must be eighteen (18) years of age;
(2) Obtain and maintain a National Provider Identifier (NPI); and
(3) Use the taxonomy number required by the State.
(b) **Certifications.** Possess one of the following certifications:
(1) Birth doula;
(2) Postpartum doula;
(3) Full-spectrum doula;
(4) Community-based doula.
(b) **Certifying organization.** Be certified by one of the State's recognized certifying organizations found at www.oklahoma.gov/ohca/.

317:30-5-1217. General coverage

(a) **Covered benefits.**
(1) **Prenatal/postpartum visits.** There is a total of eight (8) visits allowed for the member. The doula must work with the member to determine how best to utilize the benefit to meet the needs of the member.
(2) **Labor and delivery.** There is one (1) visit allowed, regardless of the duration.
(b) **Visit requirements.**
(1) The minimum visit length is sixty (60) minutes.
(2) Visits must be face-to-face.
(A) Prenatal and postpartum visits may be conducted via telehealth.
(B) Labor and delivery services may not be conducted via telehealth.
(c) **Service locations.**
(1) **Prenatal and postpartum.**
(A) Doulas must coordinate directly with the member and their family to determine the most appropriate service location for prenatal and postpartum visits.

(B) Service locations may include the following:

(i) Member's place of residence;

(ii) Doula's office;

(iii) Physician's office;

(iv) Hospital; or

(v) In the community.

(2) **Labor and delivery services.** There is no coverage for home birth(s).

(d) **Referral requirements.** Doula services must be recommended by a physician or other licensed practitioner of the healing arts who is operating within the scope of their practice under State law.

(1) The following providers may recommend doula services:

(A) Obstetricians;

(B) Certified Nurse Midwifes;

(C) Physicians;

(D) Physician Assistants; or

(E) Certified Nurse Practitioners.

(2) The SoonerCare Referral Form must be completed and submitted, noting the recommendation for doula services.

(e) **Prior authorization (PA) requirements.**

(1) A PA is not required to access the standard doula benefit package.

(2) A PA may be submitted, for members with extenuating medical circumstances, if there is need for additional visits beyond the eight (8) prenatal/postpartum visits.

(f) **Medical records requirements.** The medical record must include, but is not limited to, the following:

(1) Date of service;

(2) Person(s) to whom services were rendered;

(3) Start and stop time for the service(s);

(4) Specific services performed by the doula on behalf of the member;

(5) Member/family response to the service;

(6) Any new needs identified during the service; and

(7) Original signature of the doula, including the credentials of the doula.

(g) **Auditing review**. All doula services are subject to post-payment reviews and audits by the OHCA.

(h) **Reimbursement.**

(1) All doula services, that are outlined in Part 114 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.

(2) There are no allotted incentive payments.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 62. PRIVATE DUTY NURSING

317:30-5-561. Private duty nursing (PDN) payment rates

(a) All PDN services, including overtime, are reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

(b) Overtime payment for PDN services is only available for nursing staff who are providing services to members with tracheostomies or who are medically dependent on a ventilator for life support at least six (6) hours per day. This excludes members who are on non-invasive C-PAP or Bi-PAP devices only.

(c) In accordance with the Department of Fair Labor Standards Act, a worker must receive overtime pay for every hour that is worked over forty (40) hours in a workweek. A workweek is defined as any set seven (7) day period.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-136.2 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID) Enhanced Payment Program

(a) **Overview.** This program provides enhanced payment for private ICFs/IID that provide vocational services or day program services or both. The purpose of the enhanced payment is to offset the costs incurred by ICFs/IID in the provision of vocational services or day program services or both. Residents who qualify for the enhanced program cannot receive the same services or reimbursement under another program.

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

"Day program services" means a life enrichment program that is conducted in a dedicated service location. The organized scheduled programming will vary but must meet the specific program qualifications for participation. Day services programs provide diverse opportunities for residents to participate in the broader community based on the resident's specific care plan.

"Direct costs" means the costs for activities or items associated with day services and/or vocational services programs. These items include salaries and wages of activities staff, day services and vocational staff, and job coaches.

"Other costs" means overhead costs attributable to the provision of day and vocational services. For example, rent, utilities, etc., not already paid for by Medicaid.

"Quality Review Committee" means a committee responsible for the oversight of monitoring and analyzing the accessibility and appropriateness of services being delivered.

"Vocational services" means the provision of paid employment in a structured vocational training program for residents outside of the resident's home. The type of work will vary but each provider must meet the specific program qualifications for participation. Vocational service programs provide pre-vocational services training, that prepare the residents for employment in a structured educational program. These programs will utilize either a certified job coach or a designated staff, to assist a resident eighteen (18) years and older, in achieving gainful employment. Other achievements may include, sheltered employment, ongoing employment support, job skills training and/or workshop experience in the community.

(c) **Care criteria.** Facilities will comply with the following care criteria to receive the enhanced payment:

(1) **Vocational services.** Facilities will provide twenty (20) hours of vocational services to at least forty percent (40%) of their residents each week. Residents must participate at least nine (9) out of twelve (12) weeks.

(2) **Day services.** Facilities will provide twenty (20) hours of day services to at least sixty percent (60%) of the facility's residents who do not participate in the facility's vocational program. Residents must participate at least nine (9) out of twelve (12) weeks.

(d) **Performance Review.** Performance reviews will be completed quarterly to ensure the integrity and accountability of the vocational and/or day treatment services provided. Facilities shall provide documentation as requested and directed by the Oklahoma Health Care Authority (OHCA)

within fifteen (15) business days of request. Program payments will be withheld from facilities that fail to meet performance review standards.

(e) **Appeals.** Facilities can file an appeal related to their performance review with the Quality Review Committee and in accordance with the grievance procedures found at Oklahoma Administrative Code (OAC) 317:2-1-2 and 317:2-1-17.

(f) **Reimbursement methodology and payment.** Reimbursement and payment for the ICF/IID Enhanced Payment Program are provided in accordance with the Oklahoma Medicaid State Plan.

(g) **Cost audit.** Each facility will be audited annually as part of the annual cost report reviews to ensure only allowable costs prescribed by Medicare/Medicaid cost reporting principles are reported. As part of the annual audit, OHCA will ensure that there are no duplicative costs attributable to base rate and the enhanced payments. Payments will be recouped from facilities that report unallowable costs. Additional audits can be conducted anytime at the discretion of the OHCA.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-27. Telehealth

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

(1)**"Remote patient monitoring"** means the use of digital technologies to collect medical and other forms of health data (e.g., vital signs, weight, blood pressure, blood sugar) from individuals in one (1) location and electronically transmit that information securely to health care providers in a different location for assessment and recommendations.

(2)"**School-based services"** means medically necessary health-related and rehabilitative services that are provided by a qualified school provider to a student under the age of twenty-one (21), pursuant to an Individualized Education Program (IEP), in accordance with the Individuals with Disabilities Education Act. See Oklahoma Administrative Code (OAC) 317:30-5-1020.

(3)**"Store and forward technologies"** means the transmission of a patient's medical information from an originating site to the health care provider at the distant site; provided, photographs visualized by a telecommunications system shall be specific to the patient's medical condition and adequate for furnishing or confirming a diagnosis or treatment plan. Store and forward technologies shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

(4)**"Telehealth"** means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a ~~health care~~healthcare provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. Telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission. For audio-only health service delivery, see OAC 317:30-3-27.1.

(5)**"Telehealth medical service"** means, for the purpose of the notification requirements of OAC 317:30-3-27(d)(2), telehealth services that expressly do not include physical therapy, occupational therapy, and/or speech and hearing services.

(b) **Applicability and scope.** The purpose of this Section is to implement telehealth policy that improves access to ~~health care~~healthcare services, while complying with all applicable state and federal laws and regulations. Telehealth services are not an expansion of SoonerCare-covered services, but an option for the delivery of certain covered services. However, if there are technological difficulties in performing an objective, thorough medical assessment, or problems in the member's understanding of telehealth, hands-on-assessment and/or in-person care must be provided for the member. Any service delivered using telehealth technology must be appropriate for telehealth delivery and be of the same quality and otherwise on par with the same service

delivered in person. A telehealth encounter must maintain the confidentiality and security of protected health information in accordance with applicable state and federal law, including, but not limited to, 42 Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164, and 43A Oklahoma Statutes (O.S.) § 1-109. For purposes of SoonerCare reimbursement, telehealth is the use of interactive audio, video, or other electronic media for the purpose of diagnosis, consultation, or treatment that occurs in real-time and when the member is actively participating during the transmission.

(c) **Requirements.** The following requirements apply to all services rendered via telehealth.

(1) Interactive audio and video telecommunications must be used, permitting encrypted, real-time communication between the physician or practitioner and the SoonerCare member. The telecommunication service must be secure and adequate to protect the confidentiality and integrity of the telehealth information transmitted. As a condition of payment the member must actively participate in the telehealth visit.

(2) The telehealth equipment and transmission speed and image must be technically sufficient to support the service billed. If a peripheral diagnostic scope is required to assess the member, it must provide adequate resolution or audio quality for decision making. Staff involved in the telehealth visit need to be trained in the use of the telehealth equipment and competent in its operation.

(3) The medical or behavioral health related service must be provided at an appropriate site for the delivery of telehealth services. An appropriate telehealth site is one that has the proper security measures in place; the appropriate administrative, physical, and technical safeguards should be in place that ensures the confidentiality, integrity, and security of electronic protected health information. The location of the room for the encounter at both ends should ensure comfort, privacy, and confidentiality. Both visual and audio privacy are important, and the placement and selection of the rooms should consider this. Appropriate telehealth equipment and networks must be used considering factors such as appropriate screen size, resolution, and security. Providers and/or members may provide or receive telehealth services outside of Oklahoma when medically necessary; however, prior authorization may be required, per OAC 317:30-3-89 through 317:30-3-91.

(4) The provider must be contracted with SoonerCare and appropriately licensed or certified, in good standing. Services that are provided must be within the scope of the practitioner's license or certification. If the provider is outside of Oklahoma, the provider must comply with all laws and regulations of the provider's location, including health care and telehealth requirements.

(5) If the member is a minor, the provider must obtain the prior written consent of the member's parent or legal guardian to provide services via telehealth, that includes, at a minimum, the name of the provider; the provider's permanent business office address and telephone number; an explanation of the services to be provided, including the type, frequency, and duration of services. Written consent must be obtained annually, or whenever there is a change in the information in the written consent form, as set forth above. The parent or legal guardian need not attend the telehealth session unless attendance is therapeutically appropriate. The requirements of subsection OAC 317:30-3-27(c)(5), however, do not apply to telehealth services provided in a primary or secondary school setting.

(6) If the member is a minor, the telehealth provider shall notify the parent or legal guardian that a telehealth service was performed on the minor through electronic communication whether a text message or email.

(7) The member retains the right to withdraw at any time.

(8) All telehealth activities must comply with Oklahoma Health Care Authority (OHCA) policy, and all other applicable State and Federal laws and regulations, including, but not limited to, 59 O.S. § 478.1.

(9) The member has access to all transmitted medical information, with the exception of live interactive video as there is often no stored data in such encounters.

(10) There will be no dissemination of any member images or information to other entities without written consent from the member or member's parent or legal guardian, if the member is a minor.

(11) A telehealth service is subject to the same SoonerCare program restrictions, limitations, and coverage which exist for the service when not provided through telehealth; provided, however, that only certain telehealth codes are reimbursable by SoonerCare. For a list of the SoonerCare-reimbursable telehealth codes, refer to the OHCA's Behavioral Health Telehealth Services and Medical Telehealth Services, available on OHCA's website, www.okhca.org.

(12) Where there are established service limitations, the use of telehealth to deliver those services will count towards meeting those noted limitations. Service limitations may be set forth by Medicaid and/or other ~~third-party~~third-party payers.

(d) **Additional requirements specific to telehealth services in a school setting.** In order for OHCA to reimburse medically necessary telehealth services provided to SoonerCare members in a primary or secondary school setting, all of the requirements in (c) above must be met, with the exception of (c)(5), as well as all of the requirements shown below, as applicable.

(1) **Consent requirements.** Advance parent or legal guardian consent for telehealth services must be obtained for minors, in accordance with 25 O.S. §§ 2004 through 2005. Additional consent requirements shall apply to school-based services provided pursuant to an IEP, per OAC 317:30-5-1020.

(2) **Notification requirements.** For telehealth medical services provided in a primary or secondary school setting, the telehealth practitioner must provide a summary of the service, including, but not limited to, information regarding the exam findings, prescribed or administered medications, and patient instructions, to:

(A) The SoonerCare member, if he or she is an adult, or the member's parent or legal guardian, if the member is a minor; or

(B) The SoonerCare member's primary care provider, if requested by the member or the member's parent or legal guardian.

(3) **Requirements specific to physical therapy, occupational therapy, and/or speech and hearing services.** Even though physical therapy, occupational therapy, and/or speech and hearing services are not subject to the notification requirements of OAC 317:30-3-27(d)(2), said services must still comply with all other State and Federal Medicaid requirements, in order to be reimbursable by Medicaid. Accordingly, for those physical therapy, occupational therapy, and/or speech and hearing services that are provided in a primary or secondary school setting, but that are not school-based services (i.e., not provided pursuant to an IEP), providers must adhere to all state and federal requirements relating to prior authorization and prescription or referral, including, but not limited to, 42 C.F.R. § 440.110, OAC 317:30-5-291, 317:30-5-296, and 317:30-5-676.

(e) **Reimbursement.**

(1) Health care services delivered by telehealth such as Remote Patient Monitoring, Store and Forward, or any other telehealth technology, must be compensable by OHCA in order to be

reimbursed.

(2) Services provided by telehealth must be billed with the appropriate modifier.

(3) If the technical component of an X-ray, ultrasound or electrocardiogram is performed during a telehealth transmission, the technical component can be billed by the provider that provided that service. The professional component of the procedure and the appropriate visit code should be billed by the provider that rendered that service.

(4) The cost of telehealth equipment and transmission is not reimbursable by SoonerCare.

(5) For reimbursement of audio-only health service delivery, see OAC 317:30-3-27.1.

(f) **Documentation.**

(1) Documentation must be maintained by the rendering provider to substantiate the services rendered.

(2) Documentation must indicate the services were rendered via telehealth, and the location of the services.

(3) All other SoonerCare documentation guidelines apply to the services rendered via telehealth. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

(g) **Final authority.** The OHCA has discretion and the final authority to approve or deny any telehealth services based on agency and/or SoonerCare members' needs.

317:30-3-27.1 Audio-only health service delivery

(a) **Definition.** "Audio-only health service delivery" means the delivery of healthcare services through the use of audio-only telecommunications, permitting real-time communication between a patient and the provider, for the purpose of diagnosis, consultation, and/or treatment. Audio-only health service delivery does not include the use of facsimile, email, or health care services that are customarily delivered by audio-only telecommunications and not billed as separate services by the provider, such as the sharing of laboratory results. This definition includes health services delivered via audio-only when audio-visual is unavailable or when a member chooses audio-only.

(b) **Purpose.** Health services delivered via audio-only telecommunications are intended to improve access to healthcare services, while complying with all applicable state and federal laws and regulations. Audio-only telecommunications is an option for the delivery of certain covered services and is not an expansion of SoonerCare-covered services.

(c) **Applicability and scope.**

(1) Health service delivery via audio-only telecommunications is applicable to medically necessary covered primary care and other approved health services. Refer to the Oklahoma Health Care Authority (OHCA) website, www.okhca.org, for a complete list of the SoonerCare-reimbursable audio-only health services codes.

(2) If there are technological difficulties in performing medical assessment through audio-only telecommunications, then hands-on-assessment and/or in-person care must be provided for the member. Any service delivered using audio-only telecommunications must be appropriate for audio-only delivery and be of the same quality and otherwise on par with the same service delivered in person.

(3) Confidentiality and security of protected health information in accordance with applicable

state and federal law, including, but not limited to, 42 Code of Federal Regulations (CFR) Part 2, 45 CFR Parts 160 and 164, and 43A Oklahoma Statutes (O.S.) § 1-109, must be maintained in the delivery of health services by audio-only telecommunications.

(4) For purposes of SoonerCare reimbursement, audio-only health service delivery is the use of interactive audio technology for the purpose of diagnosis, consultation, and/or treatment that occurs in real-time and when the member is actively participating during the transmission.

(d) **Requirements.** The following requirements apply to all services rendered via audio-only health service delivery:

(1) Interactive audio telecommunications must be used, permitting real-time communication between the physician or practitioner and the SoonerCare member. As a condition of payment, the member must actively participate in the audio-only telecommunications health service visit.

(2) The audio telecommunications technology used to deliver the services must meet the standards required by state and federal laws governing the privacy and security of protected health information (PHI).

(3) The provider must be contracted with SoonerCare and appropriately licensed and/or certified, and in good standing. Services that are provided must be within the scope of the practitioner's license and/or certification.

(4) Either the provider or the member must be located at the freestanding clinic that is providing services pursuant to 42 CFR § 440.90 and Oklahoma Administrative Code (OAC) 317:30-5-575.

(5) If the member is a minor, the provider must obtain the prior written consent of the member's parent or legal guardian to provide services via audio-only telecommunications, that includes, at a minimum, the name of the provider; the provider's permanent business office address and telephone number; and an explanation of the services to be provided, including the type, frequency, and duration of services. Written consent must be obtained annually, or whenever there is a change in the information in the written consent form, as set forth above. The parent or legal guardian need not attend the audio-only telecommunications session unless attendance is therapeutically appropriate.

(6) The member retains the right to withdraw at any time.

(7) All audio-only health service delivery activities must comply with Oklahoma Health Care Authority (OHCA) policy, and all other applicable State and Federal laws and regulations.

(8) A health service delivered via audio-only telecommunications is subject to the same SoonerCare program restrictions, limitations, and coverage which exist for the service when not delivered via audio-only telecommunications.

(9) A health service delivered by audio-only telecommunications must be designated for reimbursement by SoonerCare.

(10) Where there are established service limitations, the use of audio-only telecommunications to deliver those services will count towards meeting those noted limitations. Service limitations may be set forth by Medicaid and/or other third-party payers.

(d) **Reimbursement.**

(1) Health care services delivered via audio-only telecommunications must be compensable by OHCA in order to be reimbursed.

(2) Services delivered via audio-only telecommunications must be billed with the appropriate modifier.

(3) Health care services delivered via audio-only telecommunications are reimbursed pursuant

to the fee-for-service fee schedule approved under the Oklahoma Medicaid State Plan.

(4) An RHC and an FQHC shall be reimbursed for services delivered via audio-only telecommunications at the fee-for-service rate per the fee-for-service fee schedule.

(5) An I/T/U shall be reimbursed for services delivered via audio-only telecommunications at the Office of Management and Budget (OMB) all-inclusive rate.

(6) The cost of audio-only telecommunication equipment and other service related costs are not reimbursable by SoonerCare.

(e) **Documentation.**

(1) Documentation must be maintained by the rendering provider to substantiate the services rendered.

(2) Documentation must indicate the services were rendered via audio-only telecommunications, and the location of the services.

(3) All other SoonerCare documentation guidelines apply to the services rendered via audio-only telecommunications. Examples include but are not limited to:

(A) Chart notes;

(B) Start and stop times;

(C) Service provider's credentials; and

(D) Provider's signature.

(f) **Final authority.** The OHCA has discretion and final authority to approve or deny any services delivered via audio-only telecommunications based on agency and/or SoonerCare members' needs.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.2. Psychotherapy

(a) **Individual psychotherapy.**

(1) **Definition**. Psychotherapy is a ~~face-to-face~~ treatment for mental illnesses and behavioral disturbances, in which the clinician, through definitive therapeutic communication, attempts to alleviate the emotional disturbances, reverse, or change maladaptive patterns of behavior, and encourage growth and development. Insight oriented, behavior modifying and/or supportive psychotherapy refers to the development of insight of affective understanding, the use of behavior modification techniques, the use of supportive interactions, the use of cognitive discussion of reality, or any combination of these items to provide therapeutic change. Ongoing assessment of the member's status and response to treatment as well as psycho-educational intervention are appropriate components of individual therapy. The therapy must be goal directed, utilizing techniques appropriate to the service plan and the member's developmental and cognitive abilities.

(2) **Interactive complexity**. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the qualified practitioner. Sessions typically involve members who have other individuals legally responsible for their care (i.e., minors or adults with guardians); members who request others to be involved in their care during the session (i.e., adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e., child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be

reported as involving interactive complexity when at least one (1) of the following communication factors is present:

(A) The need to manage maladaptive communication (i.e., related to high anxiety, high reactivity, repeated questions, or disagreement) among participants that complicate delivery of care.

(B) Caregiver emotions/behavior that interfere with implementation of the service plan.

(C) Evidence/disclosure of a sentinel event and mandated report to a third party (i.e., abuse or neglect with report to state agency) with initiation of discussion of the sentinel event and/or report with patient and other visit participants.

(D) Use of play equipment, physical devices, interpreter, or translator to overcome barriers to therapeutic interaction with a patient who is not fluent in the same language or who has not developed or lost expressive or receptive language skills to use or understand typical language.

(3) **Qualified practitioners**. Psychotherapy must be provided by an ~~LBHP~~Licensed Behavioral Health Practitioner (LBHP) or licensure candidate in a setting that protects and assures confidentiality.

(4) **Documentation requirements.** Providers must comply with documentation requirements in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-248.

(5) **Limitations**. A maximum of four (4) units per day per member is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. Except for psychotherapy involving interactive complexity as described in this Section, only the member and the qualified practitioner should be present during the session. Individual psychotherapy is not reimbursable for a child younger than the age of thirty-six (36) months. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(b) **Group psychotherapy**.

(1) **Definition**. Group psychotherapy is a method of treating behavioral disorders using the face-to-face psychotherapeutic interaction between the qualified practitioner and two (2) or more individuals to promote positive emotional or behavioral change. The focus of the group must be directly related to the goals and objectives in the individual member's current service plan. This service does not include social or daily living skills development as described under behavioral health rehabilitation services.

(2) **Group sizes**. Group psychotherapy is limited to a total of eight (8) adult [eighteen (18) and over] individuals except when the individuals are residents of an ~~ICF/IID~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) where the maximum group size is six (6). For all children under the age of eighteen (18), the total group size is limited to six (6).

(3) **Multi-family and conjoint family therapy**. Sessions are limited to a maximum of eight (8) families/units. Billing is allowed once per family unit, though units may be divided amongst family members.

(4) **Qualified practitioners**. Group psychotherapy must be provided by an LBHP or licensure candidate. Group psychotherapy must take place in a confidential setting limited to the qualified practitioner, an assistant or co-therapist, if desired, and the group psychotherapy participants.

(5) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(6) **Limitations**. A maximum of six (6) units per day per member is compensable, not to exceed twelve (12) units per week. Group psychotherapy is not reimbursable for a child younger than the age of thirty-six (36) months. Limitations exclude outpatient behavioral health services provided in a foster care setting.

(c) **Family psychotherapy**.

(1) **Definition**. Family psychotherapy is a face-to-face psychotherapeutic interaction between a qualified practitioner and the member's family, guardian, and/or support system. It is typically inclusive of the identified member but may be performed if indicated without the member's presence. When the member is an adult, his/her permission must be obtained in writing. Family psychotherapy must be provided for the direct benefit of the SoonerCare member to assist him/her in achieving his/her established treatment goals and objectives and it must take place in a confidential setting. This service may include the evidence-based practice "Family Psychoeducation". For children under the age of thirty-six (36) months, family psychotherapy is focused on the infant/young child and parent (or primary caregiver) interactions and the relationship needs of the infant/young child.

(2) **Qualified practitioners**. Family psychotherapy must be provided by an LBHP or licensure candidate.

(3) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(4) **Limitations**. A maximum of four (4) units per day per member/family unit is compensable. A cumulative maximum of eight (8) units of individual psychotherapy and family psychotherapy per week per member is compensable. Family psychotherapy for a child younger than thirty-six (36) months must be medically necessary and meet established child [zero (0) through thirty-six (36) months of age] criteria as set forth in the Prior Authorization Manual. Limitations exclude outpatient behavioral health services provided in a foster care setting.

PART 35. RURAL HEALTH CLINICS

317:30-5-354. Definitions

The following words and terms, when used in this Chapter, shall have the following meaning, unless the context clearly indicates otherwise:

"**APRN**" means advanced practice registered nurse.

"**C.F.R.**" means the U.S. Code of Federal Regulations.

"**CLIA**" means the Clinical Laboratory Improvement Amendments.

"**CMS**" means the Centers for Medicare and Medicaid Services.

"**CNM**" means certified nurse midwife.

"Core services" means outpatient services that may be covered when furnished to a patient at the rural health clinic (RHC) or other location, including the patient's place of residence.

"**CP"** means clinical psychologist.

"**CPT**" means current procedural terminology.

"**CSW**" means clinical social worker.

"EPSDT" means the Early and Periodic Screening, Diagnostic and Treatment program for members under twenty-one (21)**.**

"FFS" means the current OHCA's fee-for-service reimbursement rate.

"**HCPCS**" means Healthcare Common Procedure Coding System.

"**OAC**" means the Oklahoma Administrative Code.

"**OHCA**" means the Oklahoma Health Care Authority.

"Other ambulatory services" means other outpatient health services covered under the Oklahoma Medicaid State Plan other than core services.

"**PA**" means physician assistant.

"Physician" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry, or a doctor of podiatry.

"Physicians' services" means professional services that are performed by a physician at the RHC (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the RHC provides that he or she will be paid by the RHC for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

"**RHC"** means rural health clinic.

"Visit" means a face-to-face encounter between a clinic patient and a physician, ~~PA, APRN, CNM, CP or CSW PA~~Physician Assistant (PA), ~~APRN~~Advanced Practice Registered Nurse (APRN), ~~CNM~~Certified Nurse Midwife (CMN), ~~CP~~Clinical Psychologist (CP), or ~~CSW~~Clinical Social Worker whose services are reimbursed under the RHC PPS payment method. Encounters with more than one (1) health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Services delivered via audio-only telecommunications and reimbursed pursuant to the fee-for-service (FFS) fee schedule do not constitute a visit and/or an encounter.

317:30-5-355.2. Covered services

The ~~RHC~~Rural Health Center benefit package, as described in 42 C.F.R. § 440.20, consists of RHC services and other ambulatory services.

(1) **RHC services.** RHC services are covered when medically necessary and furnished at the clinic or other outpatient setting, including the member's place of residence, delivered via telehealth, or via audio-only telecommunications pursuant to Oklahoma Administrative Code (OAC) 317:30-3-27 and OAC 317:30-3-27.1.

(A) **Core services.** RHC "core" services include, but are not limited to:

(i) Services furnished by a physician, ~~PA~~Physician Assistant (PA), ~~APRN~~Advanced Practice Registered Nurse (APRN), ~~CNM~~Certified Nurse Midwife (CMN), ~~CP~~Clinical Psychologist (CP), or ~~CSW~~Clinical Social Worker.

(ii) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, or CSW are covered in accordance with 42 C.F.R §§ 405.2413 and 405.2415, if the service or supply is:

(I) Furnished in accordance with State law;

(II) A type commonly furnished in physicians' offices;

(III) A type commonly rendered either without charge or included in the RHC's bill;

(IV) Furnished as an incidental, although integral, part of a physician's professional services, PA, APRN, CNM, CP or CSW; or

(V) Furnished under the direct supervision of a contracted physician PA, APRN, or CNM; and

(VI) Drugs and biologicals which cannot be self-administered or are specifically covered by Medicare law, are included within the scope of RHC services. Drugs and biologicals commonly used in life saving procedures, such as analgesics, anesthetics (local), antibiotics, anticonvulsants, antidotes and emetics, serums and toxoids are not billed separately.

(iii) Visiting nurse services to the homebound are covered if:

(I) The RHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(II) The services are rendered to members who are homebound;

(III) The member is furnished nursing care on a part-time or intermittent basis by a registered nurse, licensed practical nurse, or licensed vocational nurse who is employed by or receives compensation for the services from the RHC; and

(IV) The services are furnished under a written plan of treatment as required by 42 C.F.R § 405.2416.

(iv) Certain virtual communication services.

(B) **Preventive services.** In addition to the professional services of a physician, and services provided by an APRN, PA, and CNM which would be covered as RHC services under Medicare, certain primary preventive services are covered under the SoonerCare RHC benefit. The services must be furnished by or under the direct supervision of an RHC practitioner who is a clinic employee:

(i) Prenatal and postpartum care;

(ii) Screening examination under the EPSDT program for members under twenty-one (21);

(iii) Family planning services; and

(iv) Medically necessary screening mammography and follow-up mammograms.

(C) **Off-site services.** RHC services provided off-site of the clinic are covered if the RHC has a compensation arrangement with the RHC practitioner. SoonerCare reimbursement is made to the RHC and the RHC practitioner receives his or her compensation from the RHC. The RHC must have a written contract with the physician and other RHC "core" practitioners that specifically identify how the RHC services provided off-site are to be billed to SoonerCare. It is expected that services provided in off-site settings are, in most cases, temporary and intermittent, i.e., when the member cannot come to the clinic due to health reasons.

(2) **Other ambulatory services.** Other ambulatory services that may be provided by an RHC include non-primary care services covered by the Oklahoma Medicaid State Plan but are not included in the RHC's core services. These services are separately billable and may be provided by the RHC if the RHC meets the same standards as other contracted providers of those services.

(A) Other ambulatory services include, but are not limited to:

(i) Dental services for members under the age of twenty-one (21) provided by other than a licensed dentist;

(ii) Optometric services provided by other than a licensed optometrist;

(iii) Laboratory tests performed in the RHC lab, including the lab tests required for RHC certification;

(I) Chemical examinations of urine by stick or tablet method or both (including urine ketones);
(II) Hemoglobin or hematocrit;
(III) Blood glucose;
(IV) Examination of stool specimens for occult blood;
(V) Pregnancy tests; and
(VI) Primary culturing for transmittal to a certified laboratory.

(iv) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);
(v) Durable medical equipment;
(vi) Transportation by ambulance;
(vii) Prescribed drugs;
(viii) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
(ix) Specialized laboratory services furnished away from the clinic;
(x) Inpatient services;
(xi) Outpatient hospital services; and
(xii) Applied behavior analysis (ABA); and
(xiii) Diabetes self-management education and support (DSMES) services.

(B) Services listed in (2)(A) of this Section, furnished on-site, require a separate provider agreement(s) with the OHCA. Service item (2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

PART 64. CLINIC SERVICES

317:30-5-575. General information

(a) **Clinic services.** Clinic services means preventive, diagnostic, therapeutic, rehabilitative, or palliative services that are furnished by a facility that is not part of a hospital but is organized and operated to provide medical care to outpatients. The term includes the following services furnished to outpatients:

(1) Services furnished at the clinic by or under the direction of a physician or a dentist.

(2) Services furnished outside the clinic, by clinic personnel under the direction of a physician, to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address.

(3) Teleheath and audio-only health service delivery requires either the provider or the member to be located at the freestanding clinic that is providing services pursuant to 42 Code of Federal Regulations (CFR) § 440.90. Refer to section Oklahoma Administrative Code (OAC) 317:30-3-27 for telehealth policy and OAC 317:30-3-27.1 for audio-only telecommunication policy.

(b) **Prior authorization.** OHCA requires prior authorization for certain procedures to validate the medical need for the service.

(c) **Medical necessity.** Medical necessity requirements are listed at OAC 317:30-3-1(f).

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-664.3. ~~FQHC~~Federally Qualified Health Center (FQHC) encounters
(a) FQHC encounters that are billed to the ~~OHCA~~Oklahoma Health Care Authority (OHCA) must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by an authorized health care professional listed in the approved FQHC State Plan pages within the scope of their licensure trigger a ~~PPS~~Prospective Payment System (PPS) encounter rate.
(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a twenty-four (24) hour period ending at midnight, as documented in the member's medical record. Services delivered via audio-only telecommunications do not constitute an encounter.
(c) An FQHC may bill for one (1) medically necessary encounter per twenty-four (24) hour period when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-664.4. Payment is limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the FQHC as his/her/their Patient Centered Medical Home/Primary Care Provider.
(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

(1) Medical;
(2) Diagnostic;
(3) Dental, medical and behavioral health screenings;
(4) Vision;
(5) Physical therapy;
(6) Occupational therapy;
(7) Podiatry;
(8) Behavioral health;
(9) Speech;
(10) Hearing;
(11) Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); and
(12) Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHCs scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to the services of a physician, PA, APRN, CNM, CP and CSW are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.
(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

317:30-5-664.10. Health Center reimbursement
(a) In accordance with Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000, reimbursement is provided for core services and other health services at a Health Center facility-specific Prospective Payment System (PPS) rate per visit (encounter) determined according to the methodology described in ~~OAC~~Oklahoma Administrative

Code (OAC) 317:30-5-664.12.
(b) As claims/encounters are filed, reimbursement for SoonerCare Choice members is made for all medically necessary covered primary care and other approved health services at the PPS rate, except for services delivered via audio-only telecommunications which are reimbursed at the fee-for-service (FFS) rate pursuant to the FFS fee schedule.
(c) Primary and preventive behavioral health services rendered by health care professionals authorized in the ~~FQHC~~Federally Qualified Health Center (FQHC) approved state plan pages will be reimbursed at the PPS encounter rate, except for services delivered via audio-only telecommunications which are reimbursed at the FFS rate pursuant to the FFS fee schedule.
(d) Vision services provided by Optometrists within the scope of their licensure for non-dual eligible members and allowed under the Medicaid State Plan are reimbursed pursuant to the SoonerCare ~~fee-for-service~~FFS fee schedule.

PART 110. INDIAN HEALTH SERVICES, TRIBAL PROGRAMS, AND URBAN INDIAN CLINICS (I/T/Us)

317:30-5-1087. Terms and definitions

The following words and terms, when used in this Part, have the following meaning, unless the context clearly indicates otherwise:

(1) **"American Indian/Alaska Native (AI/AN)"** means an individual of Native American descent who has or is eligible for a Certificate of Degree of Indian Blood (CDIB) card.

(2) **"Audio-only health service delivery"** means the delivery of healthcare services through the use of audio-only telecommunications, permitting real-time communication between a patient and the provider, for the purpose of diagnosis, consultation, or treatment, and does not include the use of facsimile or email nor the delivery of health care services that are customarily delivered by audio-only telecommunications and customarily not billed as separate services by the provider, such as the sharing of laboratory results. This definition includes health services delivered via audio-only when audio-visual is unavailable or when a member chooses audio-only.

~~(2)~~(3) **"Behavioral Health services"** means professional medical services for the treatment of a mental health and/or substance use disorder.

~~(3)~~(4) **"CFR"** means the Code of Federal Regulations.

~~(4)~~(5) **"CMS"** means the Centers for Medicare and Medicaid Services.

~~(5)~~(6) **"Encounter"** means a ~~face-to-face~~ contact between a health care professional and an IHS eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a ~~24-hour~~twenty-four (24) hour period ending at midnight, as documented in the patient's record.

~~(6)~~(7) **"Licensed Behavioral Health Professional (LBHP)"** means a licensed psychologist, licensed clinical social worker (LCSW), licensed marital and family therapist (LMFT), licensed professional counselor (LPC), licensed behavioral practitioner (LBP) or licensed alcohol and drug counselor (LADC).

~~(7)~~(8) **"OHCA"** means the Oklahoma Health Care Authority.

~~(8)~~(9) **"OMB rate"** means the Medicaid reimbursement rate negotiated between CMS and IHS. Inpatient and outpatient Medicaid reimbursement rates for I/T/Us are published annually in the Federal Register or Federal Register Notices. The outpatient rate is also known as the

I/T/U encounter rate. The encounter rate is available only to I/T/U facilities that appear on the IHS maintained listing of IHS-operated and Indian health care facilities operating under a 638 agreement. It is the sole responsibility of the facility to petition IHS for placement on this list.

~~(9)~~(10) **"Physician"** means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery or who is a licensed physician employed by the Federal Government in an IHS facility or who provides services in a 638 Tribal Facility.

~~(10)~~(11) **"State Administering Agency (SAA)"** is the Oklahoma Health Care Authority.

(12) **"Telehealth"** means the practice of health care delivery, diagnosis, consultation, evaluation and treatment, transfer of medical data or exchange of medical education information by means of a two-way, real-time interactive communication, not to exclude store and forward technologies, between a patient and a healthcare provider with access to and reviewing the patient's relevant clinical information prior to the telemedicine visit. Telehealth shall not include consultations provided by telephone audio-only communication, electronic mail, text message, instant messaging conversation, website questionnaire, nonsecure video conference, or facsimile transmission.

~~(11)~~(13) **"638 Tribal Facility"** is a facility that is operated by a tribe or tribal organization and funded by Title I or Title III of the Indian Self Determination and Education Assistance Act (Public Law 93-638).

317:30-5-1098. ~~I/T/U~~Indian Health Services, Tribal Programs, and Urban Indian clinics (I/T/Us) outpatient encounters

(a) I/T/U outpatient encounters that are billed to the OHCA must meet the definition in this Section and are limited to services covered by the OHCA. These services include health services included in the State Plan under Title XIX or Title XXI of the Social Security Act.

(1) An I/T/U encounter means a face to face, ~~or~~a telehealth contact, or an audio-only telecommunications contact between a health care professional and an ~~IHS~~Indian Health Services (IHS) eligible SoonerCare member for the provision of medically necessary Title XIX or Title XXI covered services through an IHS or Tribal 638 facility or an urban Indian clinic within a ~~24 hour~~twenty-four (24) period ending at midnight, as documented in the patient's record.

(2) An I/T/U outpatient encounter means outpatient services that may be covered when furnished to a patient by a contracted SoonerCare provider employed by the I/T/U facility and rendered at the I/T/U facility or other location, including the patient's place of residence.

(b) The following services may be considered reimbursable encounters subject to the limitations of the Oklahoma State Plan and include any related medical supplies provided during the course of the encounter:

(1) Medical;
(2) Diagnostic;
(3) Behavioral Health services [refer to OAC 317:30-5-1094];
(4) Dental, Medical and Mental Health Screenings;
(5) Vision;
(6) Physical Therapy;
(7) Occupational Therapy;
(8) Podiatry;
(9) Speech;
(10) Hearing;

(11) Visiting Nurse Service [refer to OAC 317:30-5-1093];
(12) Smoking and Tobacco Use Cessation Counseling;
(13) Other Title XIX or XXI services as allowed under OHCA's SoonerCare State Plan and OHCA Administrative Rules;
(14) Drugs or medication treatments provided during a clinic visit are part of the encounter rate. For example, a member has come into the clinic with high blood pressure and is treated at the clinic with a hypertensive drug or drug sample. Drug samples are included in the encounter rate. Prescription drugs are reimbursed pursuant to OAC 317:30-5-78(b)(4)(B).
(15) Encounters with a registered professional nurse or a licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members; and
(16) I/T/U Multiple Outpatient Encounters.
(A) OHCA will cover one medically necessary outpatient medical encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit with a different diagnosis. Then, a second encounter is allowed.
(B) OHCA will cover one dental encounter per member per day regardless of how many procedures are done or how many providers are seen unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.
(C) OHCA will cover one behavioral health professional outpatient encounter per member per day unless if due to an emergency, the same member returns on the same day for a second visit and has a different diagnosis. Then, a second encounter is allowed.
(D) Each service must have distinctly different diagnoses in order to meet the criteria for multiple I/T/U outpatient encounters.

(c) More than one outpatient visit with a medical professional within a ~~24-hour~~twenty-four (24) hour period for distinctly different diagnoses may be reported as two encounters. This does not imply that if a member is seen at a single office visit with multiple problems that multiple encounters can be billed. For example, a member comes to the clinic in the morning for an immunization, and in the afternoon, the member falls and breaks an arm. This would be considered multiple medical encounters and can be billed as two encounters. However, a member who comes to the I/T/U facility for a diabetic wellness screening and is then referred to a podiatrist within the clinic for diabetes-related follow-up on the same date of service would not be considered a distinctly different diagnosis and can only be billed as a single encounter.
(d) The following services may be considered as separate or multiple encounters when two or more services are provided on the same date of service with distinctly different diagnoses:
(1) Medical Services;
(2) Dental Services;
(3) Mental Health and addiction services with similar diagnoses can only be billed as one encounter. In addition, if the member is also seen for a medical office visit with a mental health or addiction diagnosis, then it is considered a single encounter;
(4) Physical or occupational therapy (PT/OT). If this service is also performed on the same date of service as the medical encounter that determined the need for PT/OT (initial referral), then it is considered a single encounter;
(5) Administration of immunizations. If no other medical office visit occurs on the same date of services; and
(6) Tobacco cessation limited to state plan services. If no other medical or addiction encounter

occurs on the same date of service.

(e) I/T/U outpatient encounters for IHS eligible SoonerCare members whether medical, dental, or behavioral health, are not subject to prior authorization. Other State Plan covered services that the I/T/U facility chooses to provide but which are not part of the I/T/U encounter are subject to all applicable SoonerCare regulations which govern the provision and coverage for that service.

OPERATIONAL METRICS

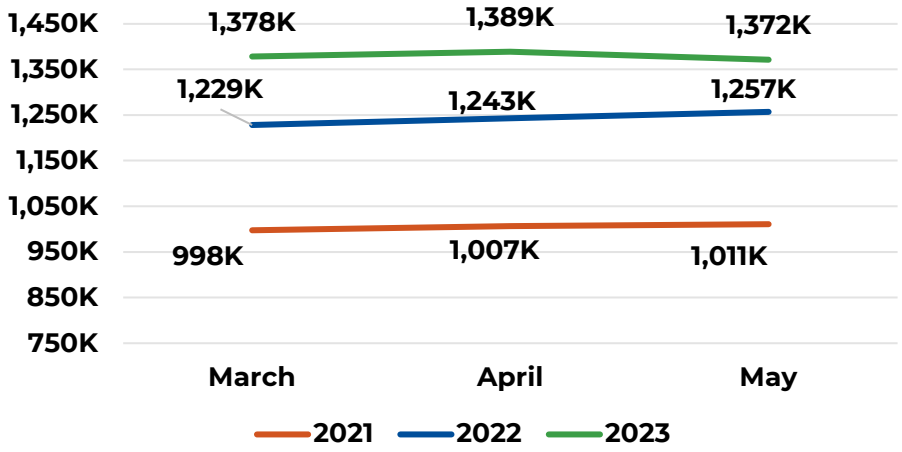
June 2023 Board Meeting

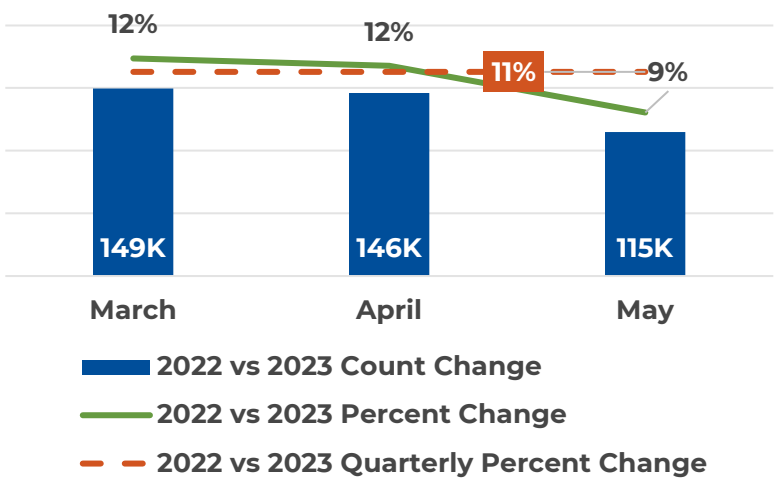
OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

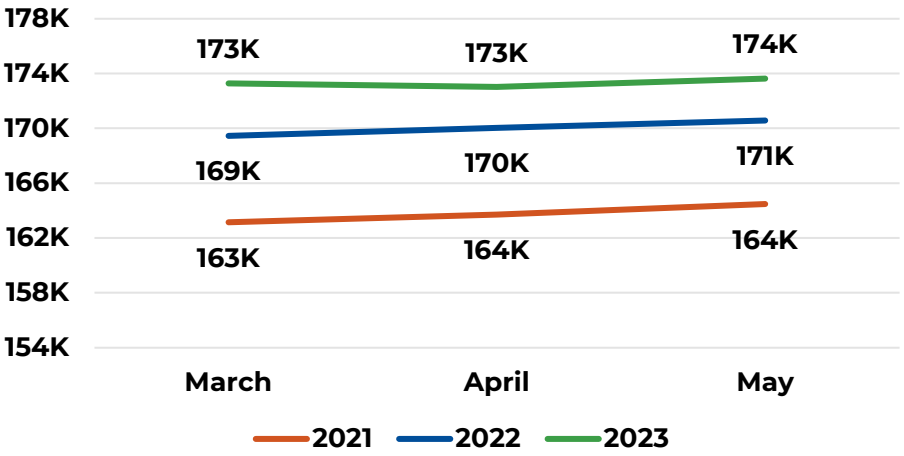
Enrollment & Utilization

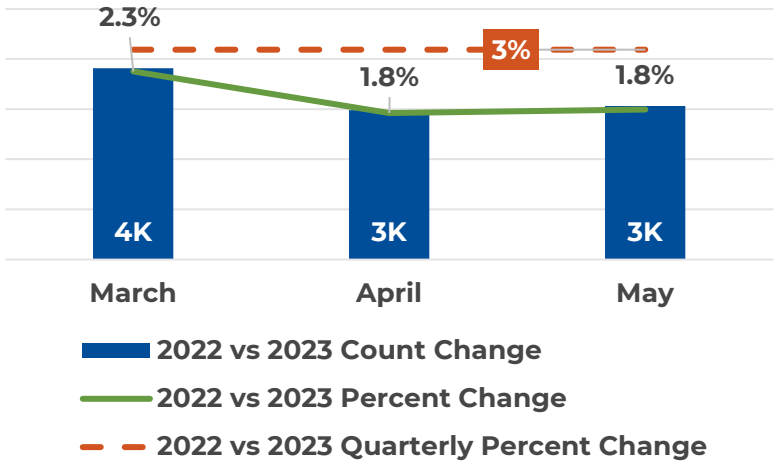
Total Enrolled Members





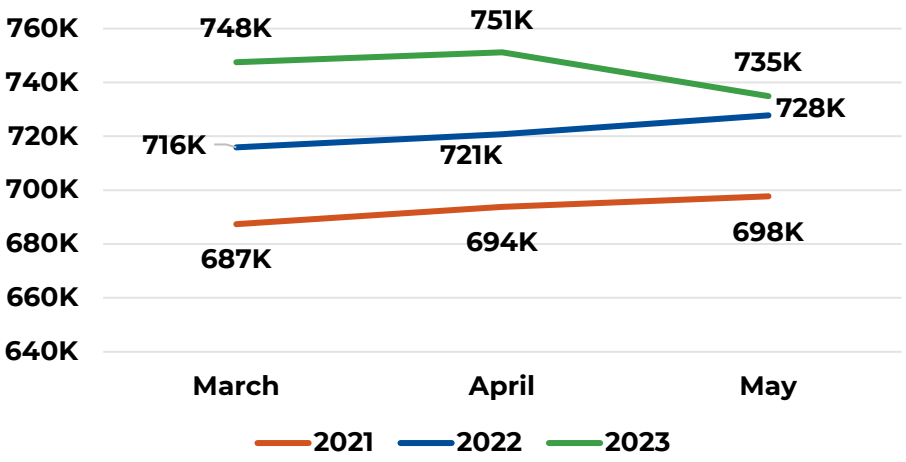
Aged/Blind/Disabled Enrolled

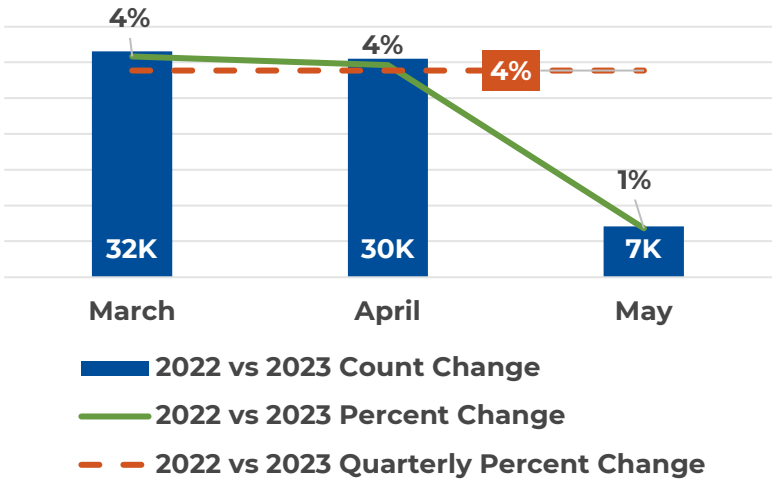




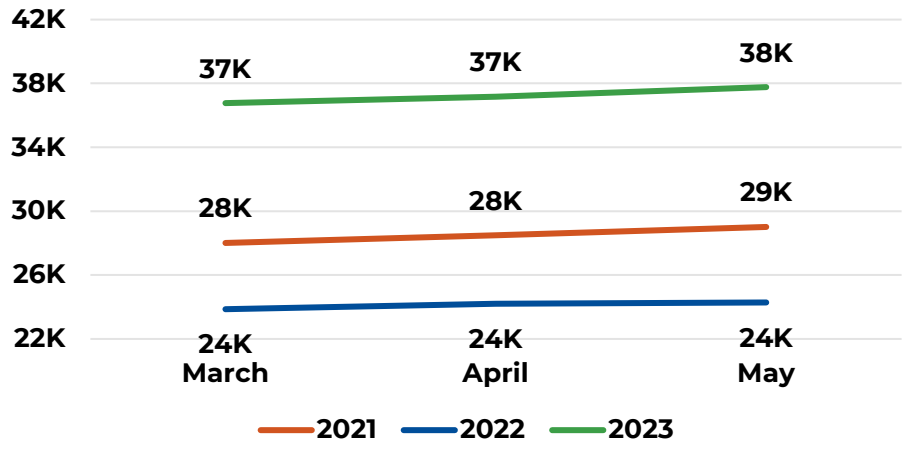
Enrollment & Utilization (Cont.)

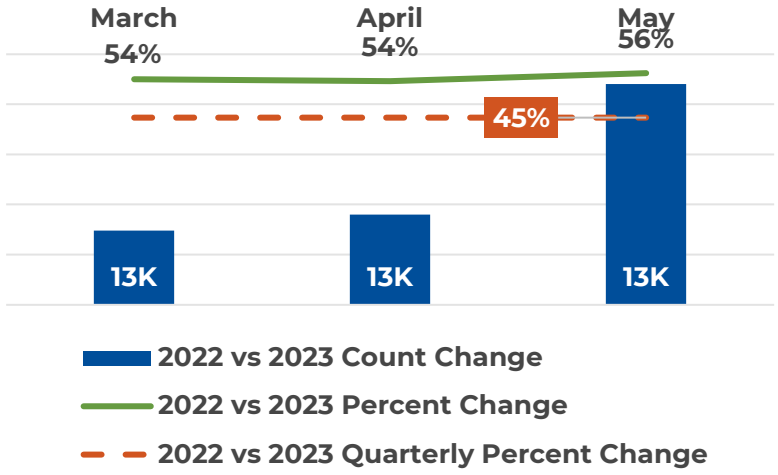
Children & Parent/Caretaker Enrolled





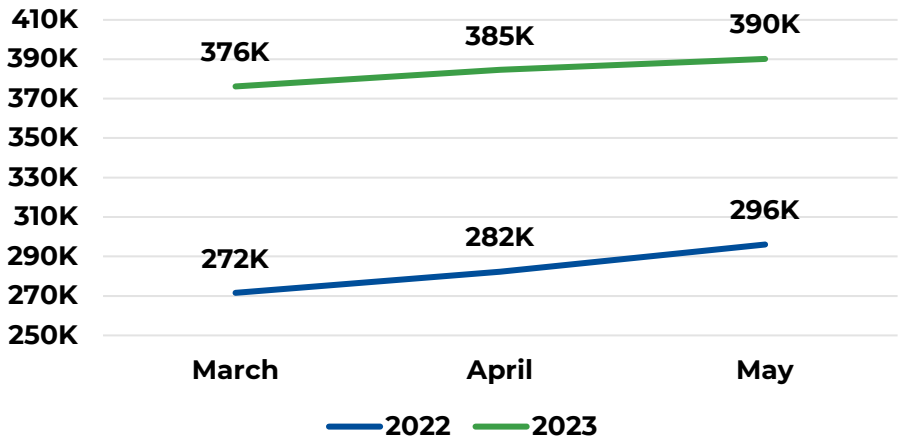
Pregnant (Full Scope) Enrolled

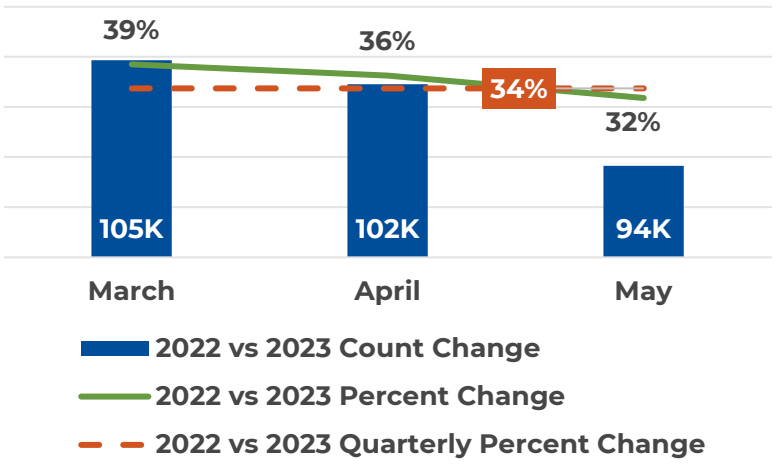




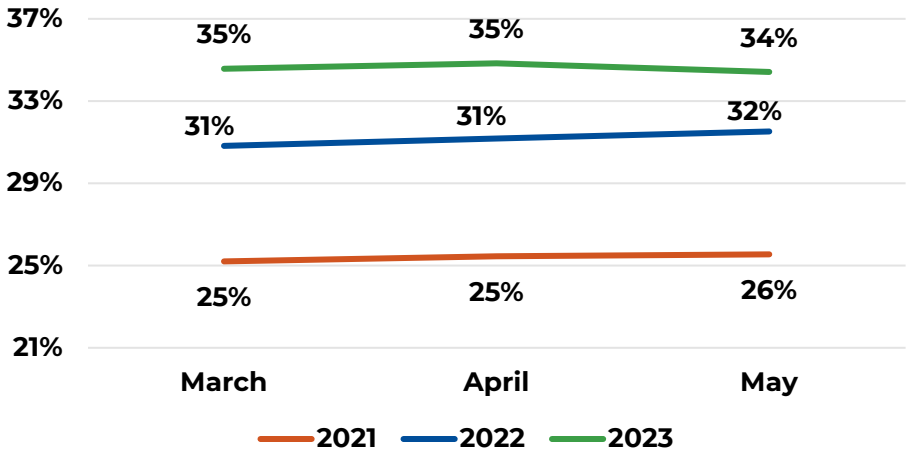
Enrollment & Utilization (Cont.)

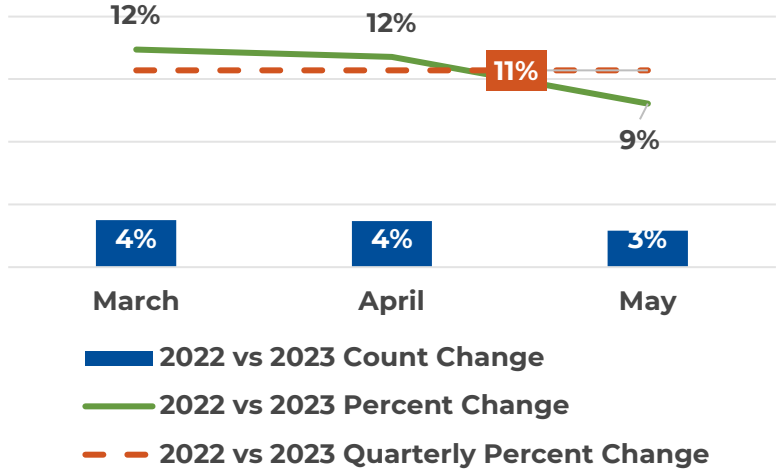
Expansion Enrolled (Effective July 2021)





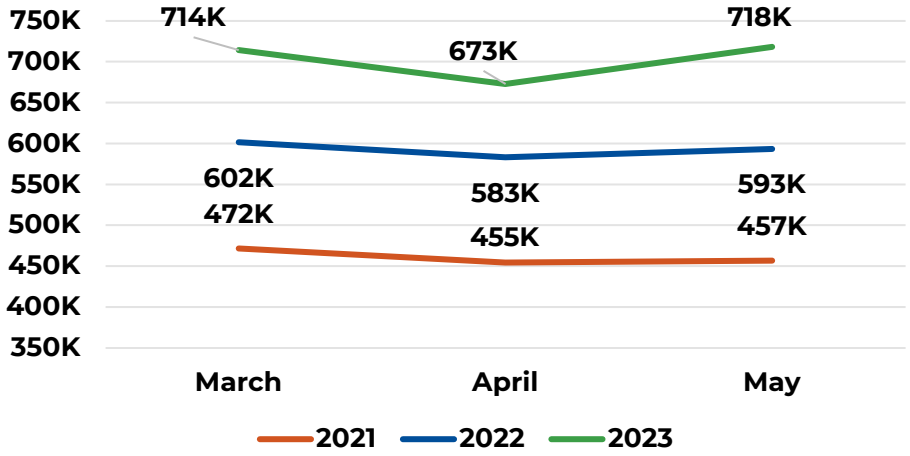
Percent of OK Population Enrolled

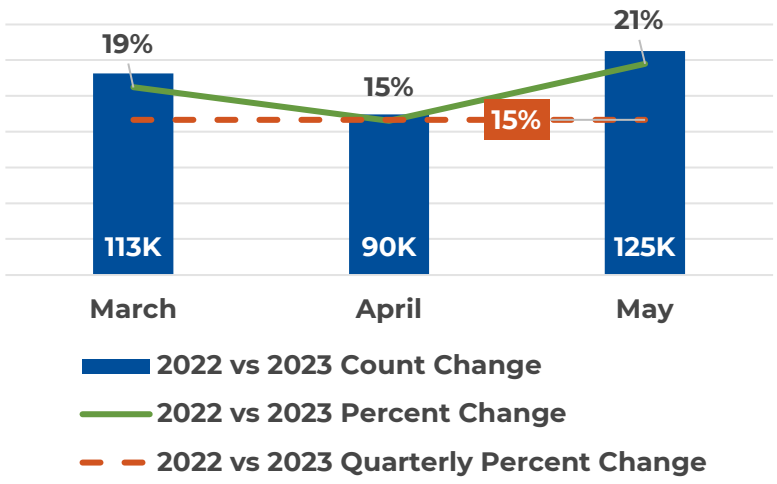




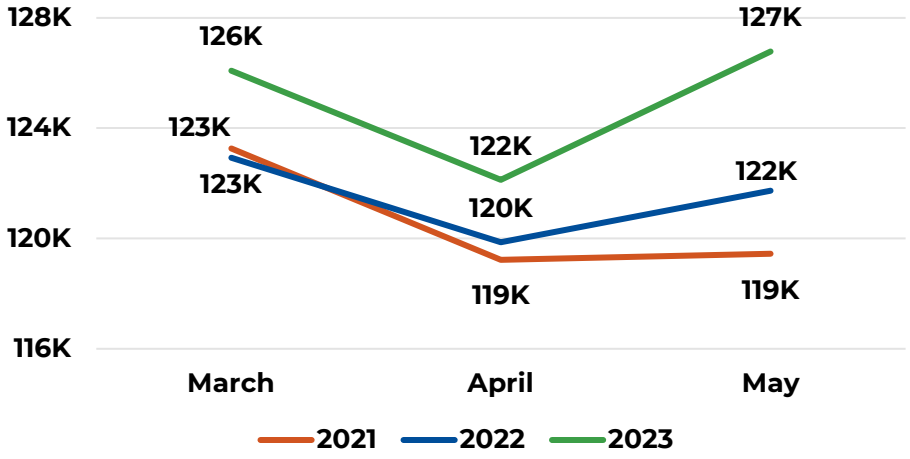
Enrollment & Utilization (Cont.)

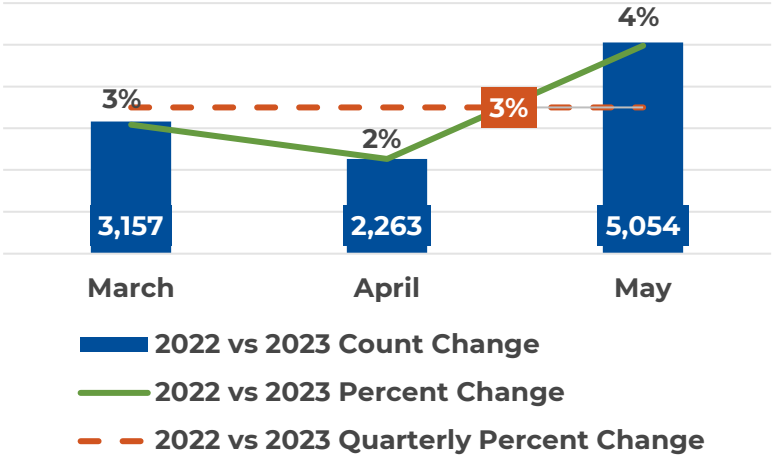
Total Members Utilization





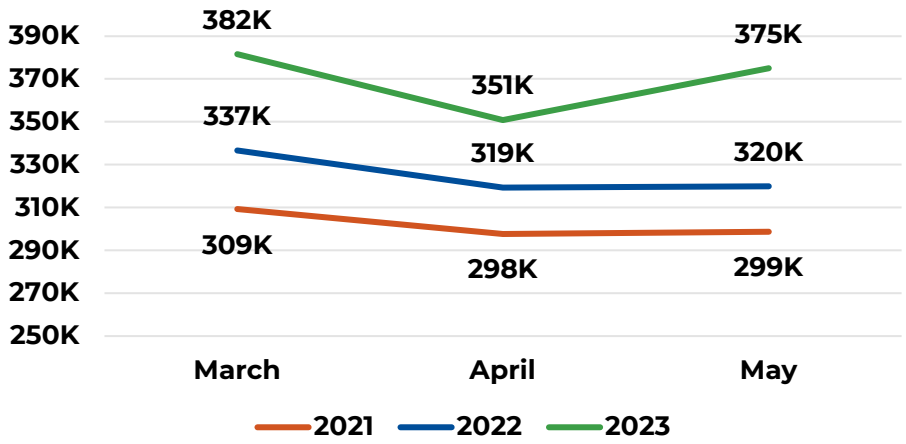
Aged/Blind/Disabled Utilization

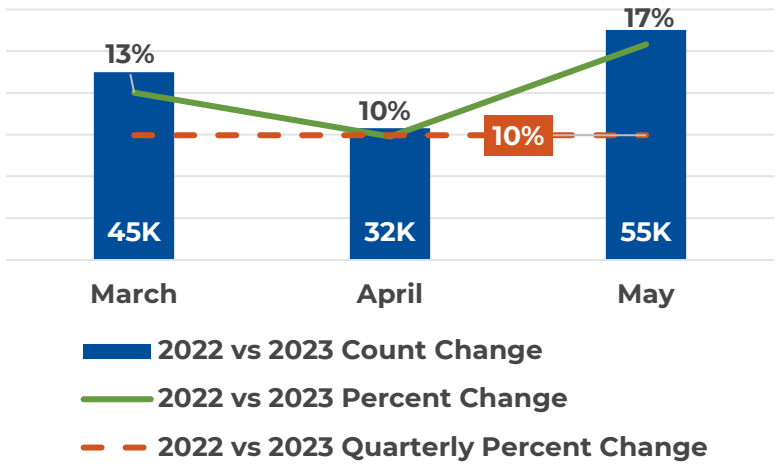




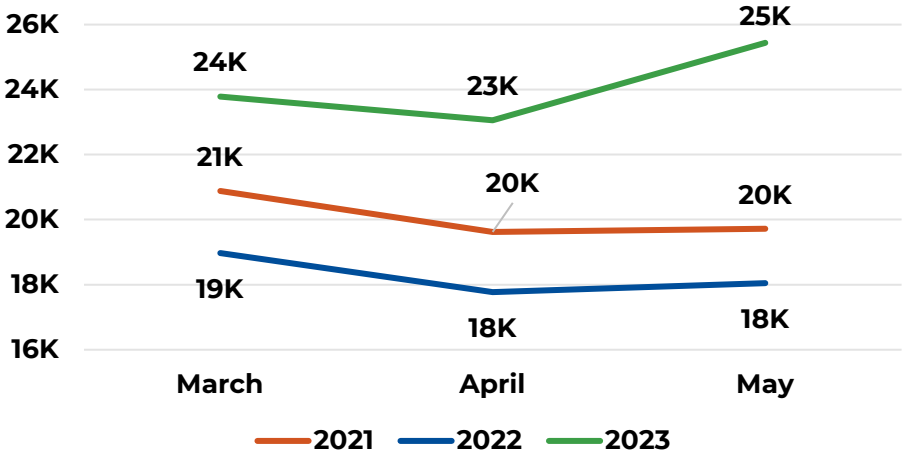
Enrollment & Utilization (Cont.)

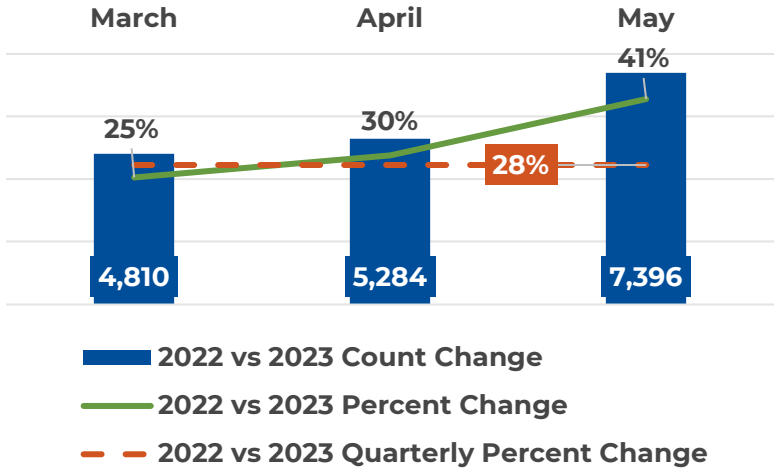
Children & Parent/Caretaker Utilization





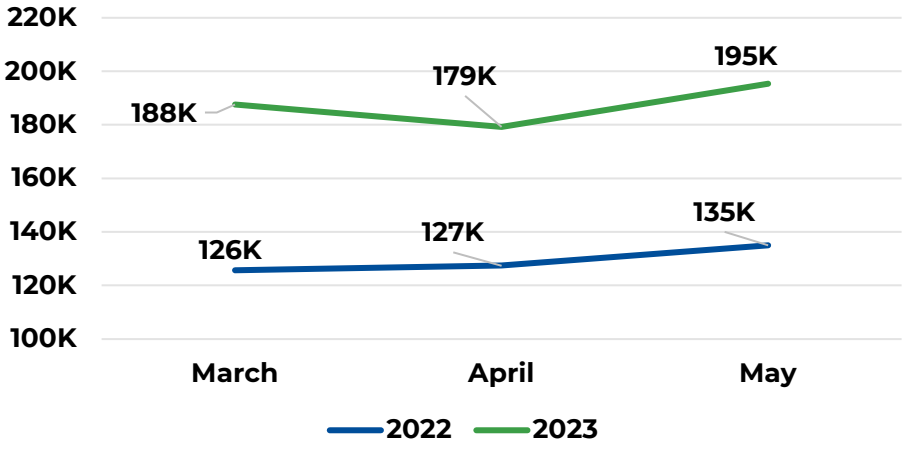
Pregnant (Full Scope) Utilization

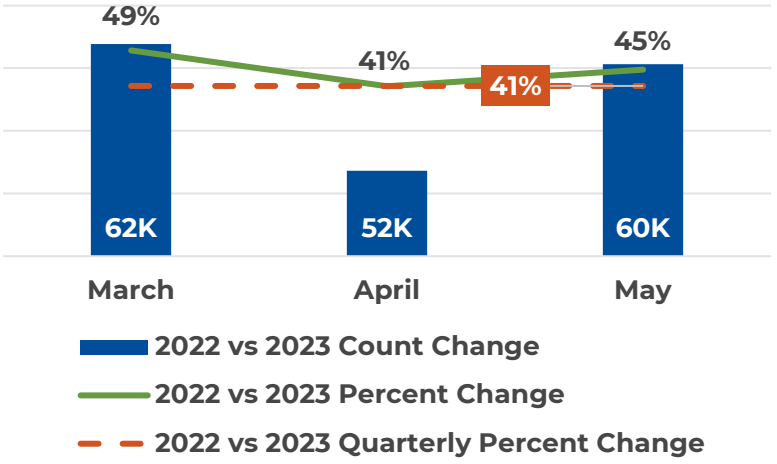




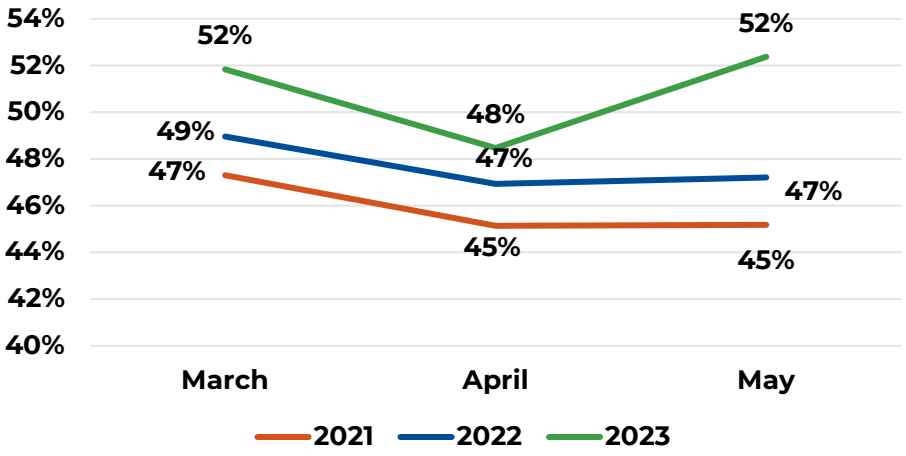
Enrollment & Utilization (Cont.)

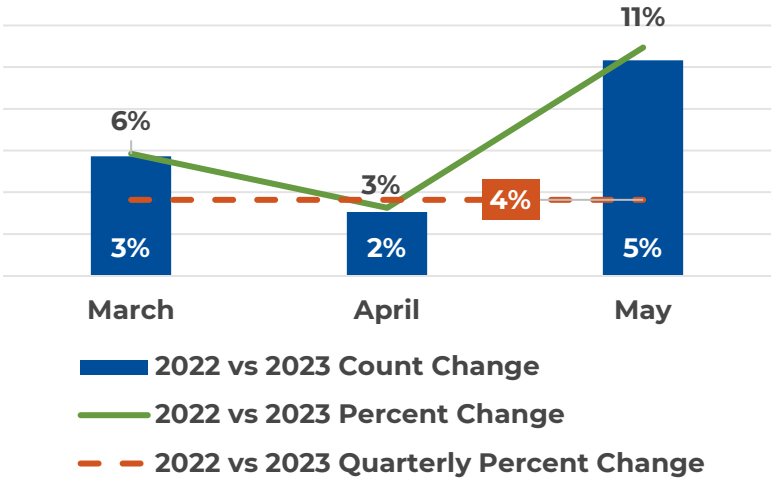
Expansion Utilization (Effective July 2021)





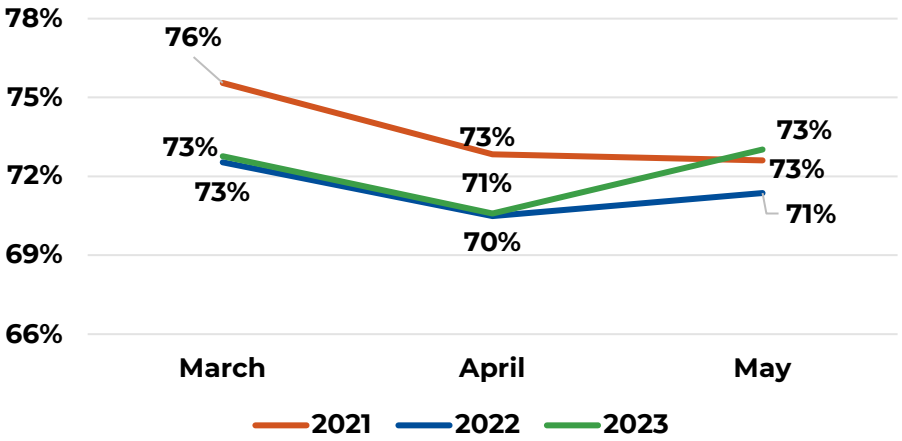
Percent of Total Enrolled Members Utilization

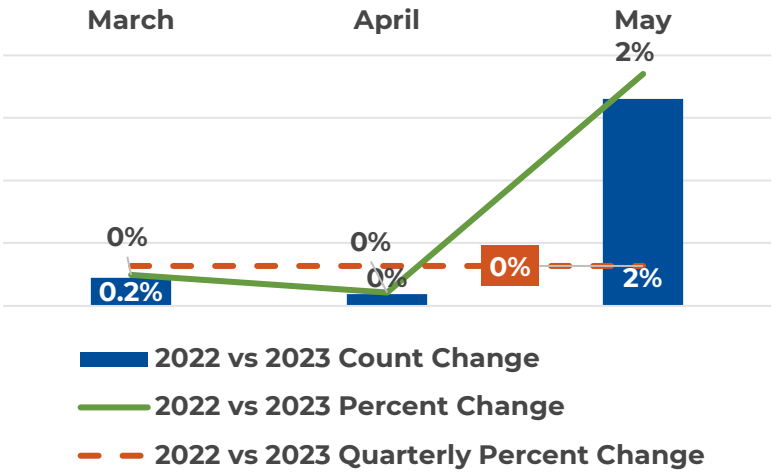




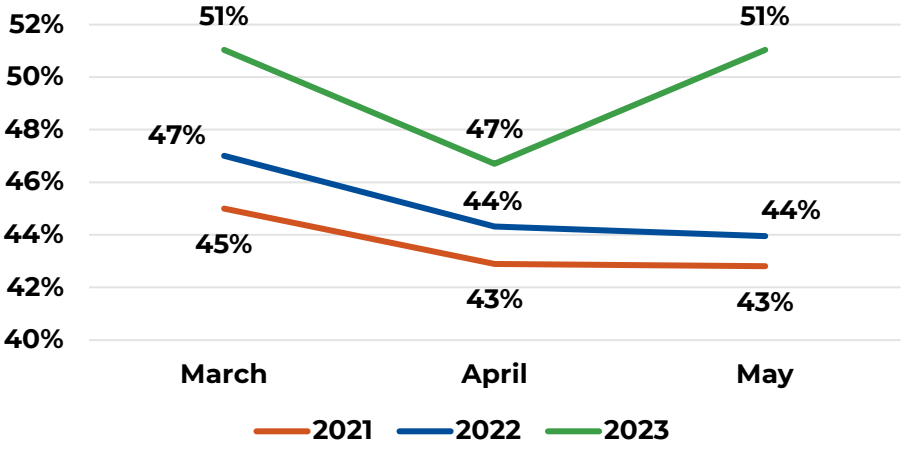
Enrollment & Utilization (Cont.)

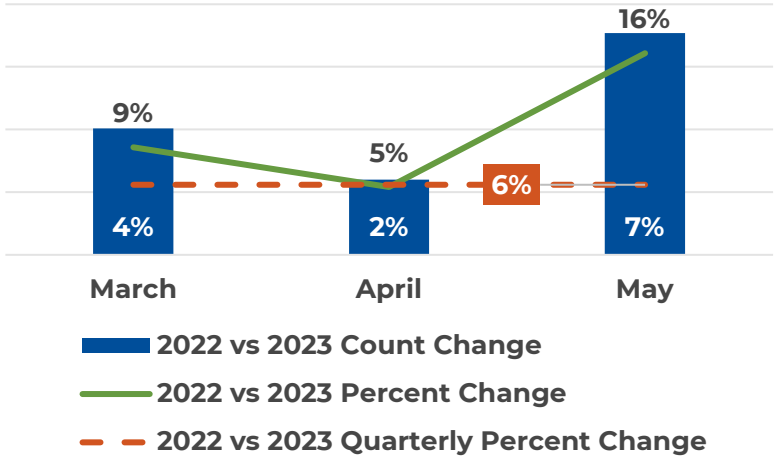
Percent of Aged/Blind/Disabled Enrolled Members Utilization





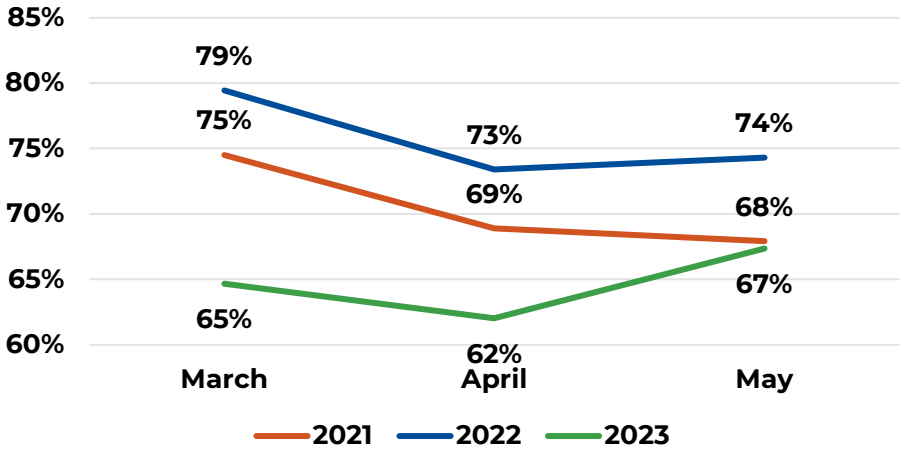
Percent of Children & Parent/Caretaker Enrolled Members Utilization

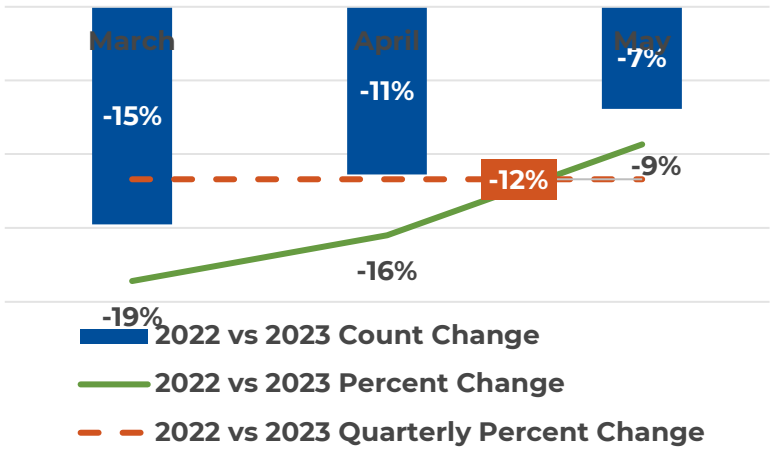




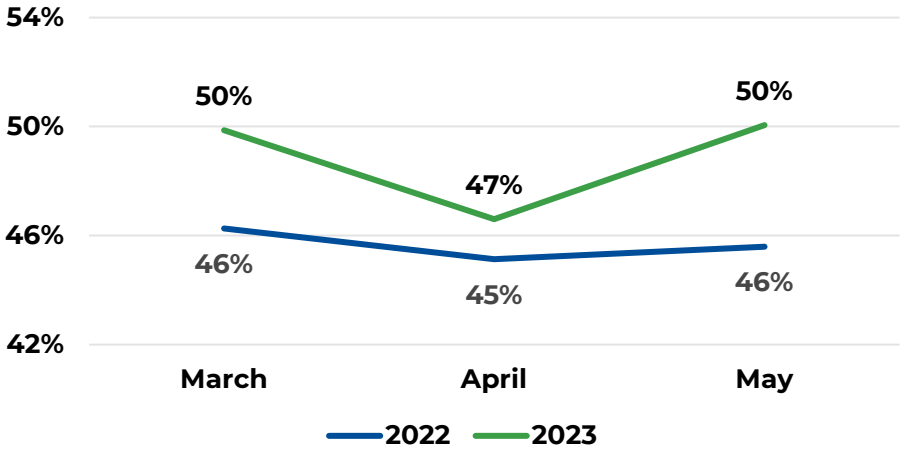
Enrollment & Utilization (Cont.)

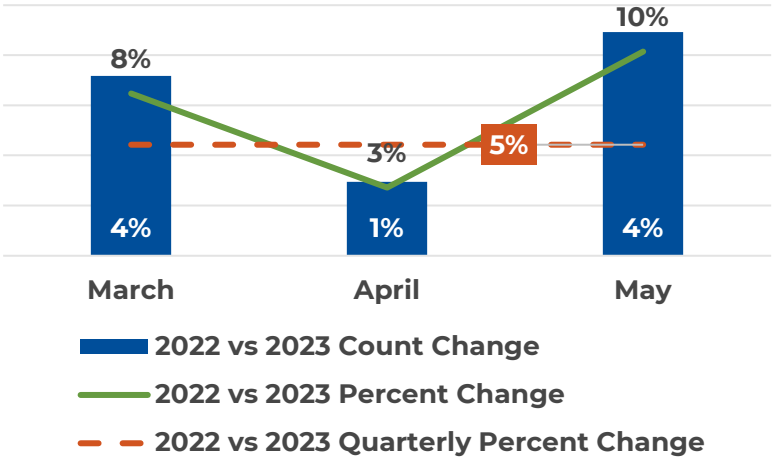
Percent of Pregnant (Full Scope) Enrolled Members Utilization





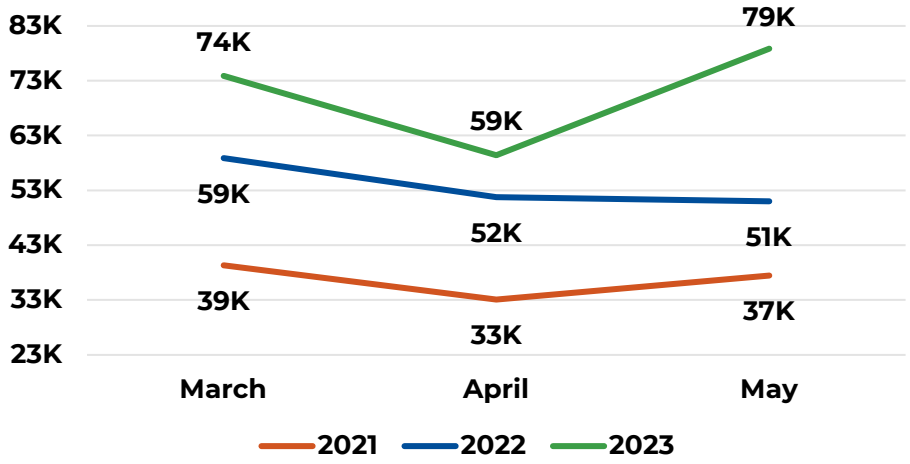
Percent of Expansion Enrolled Members Utilization (Effective July 2021)

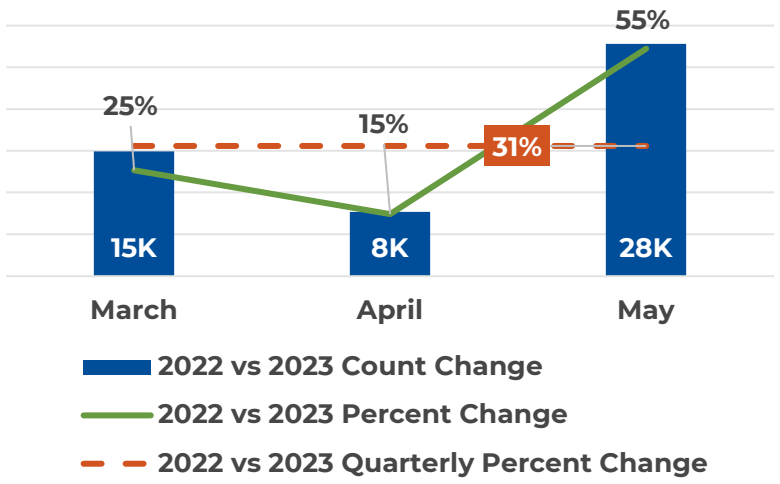




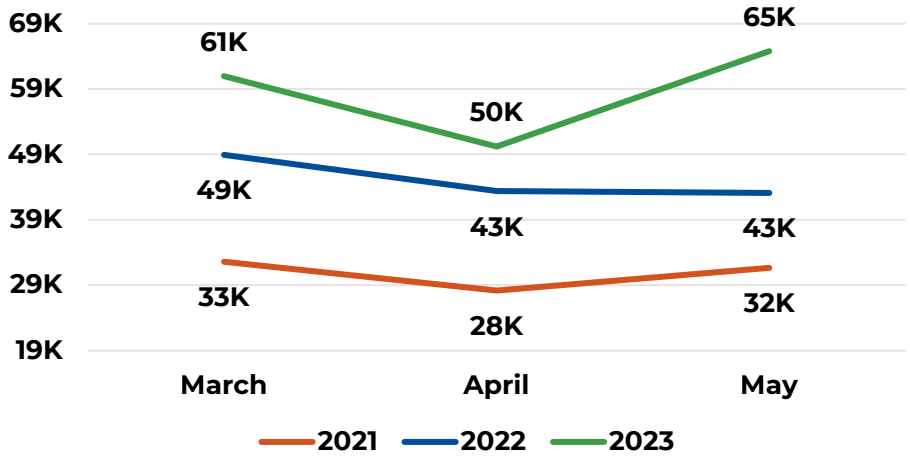
Utilization

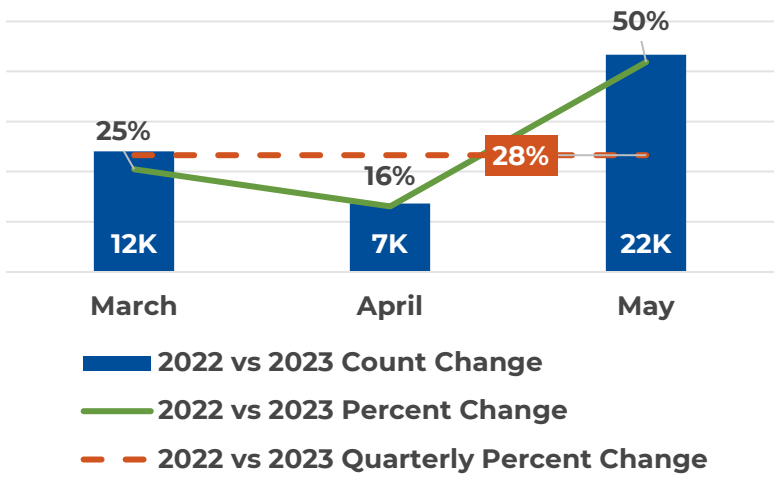
Emergency Department Visits (Claims)





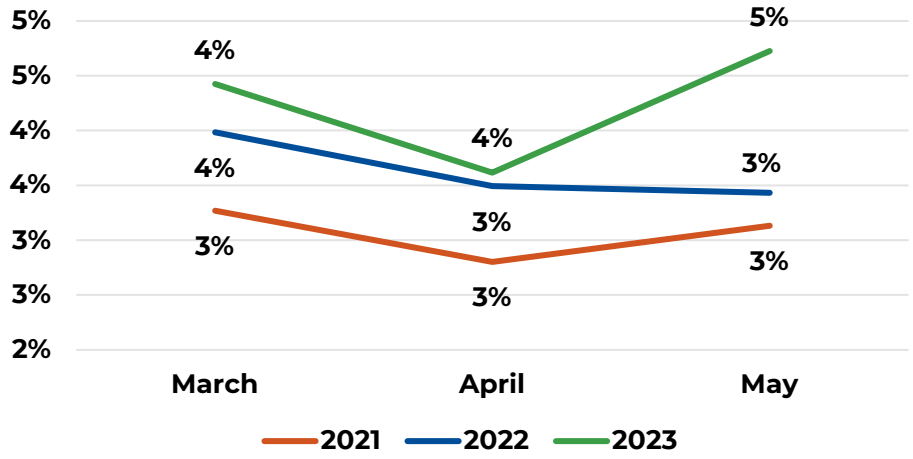
Members Utilizing Emergency Department

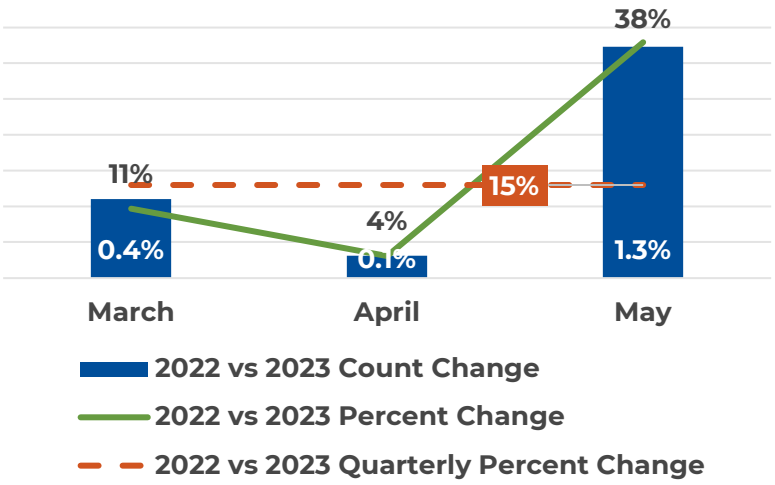




Utilization (Cont.)

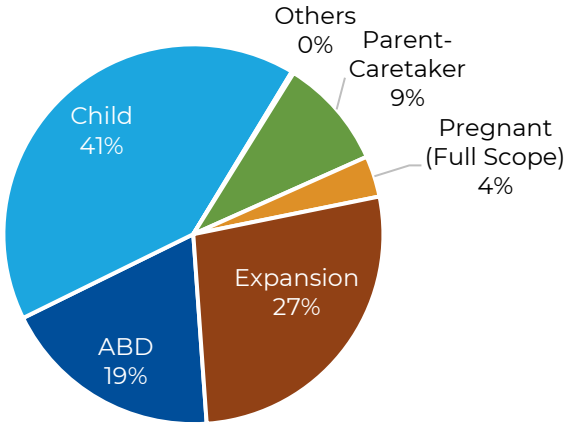
Percent Total Enrolled Using ED



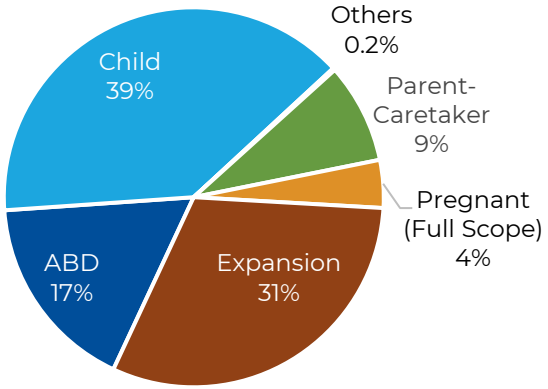


Members Utilizing Emergency Department By Qualifying Group

Q4 2022

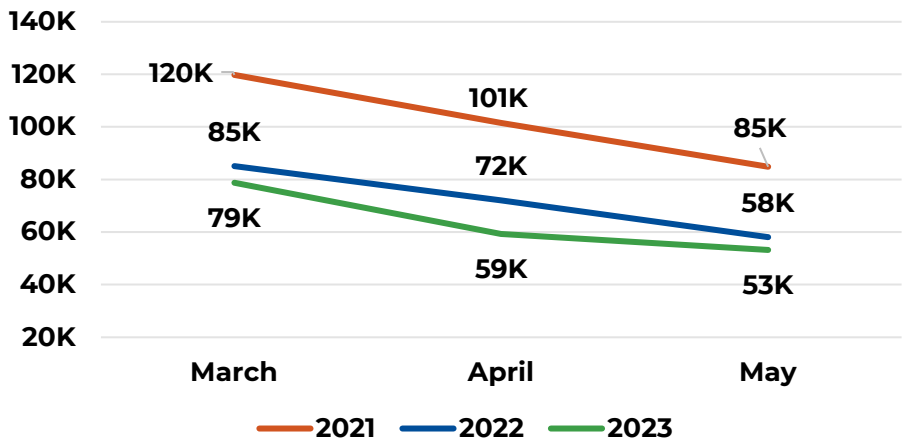


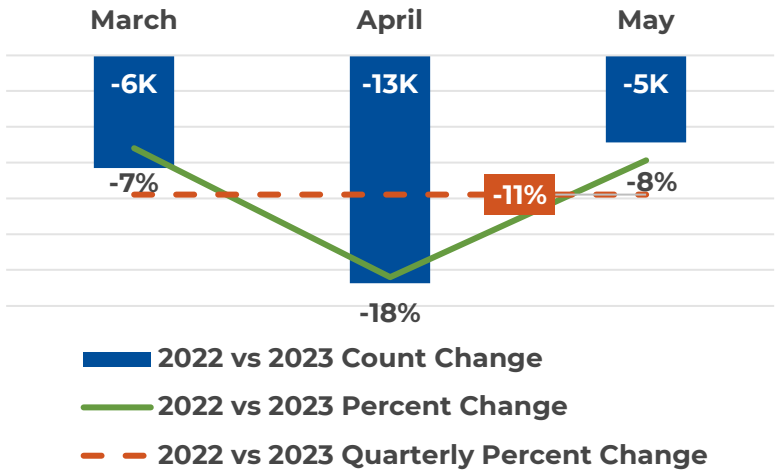
Q4 2023



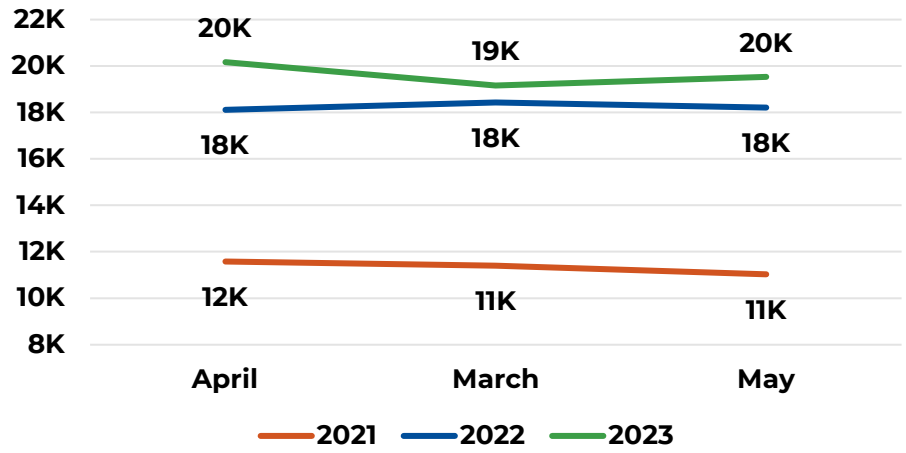
Utilization (Cont.)

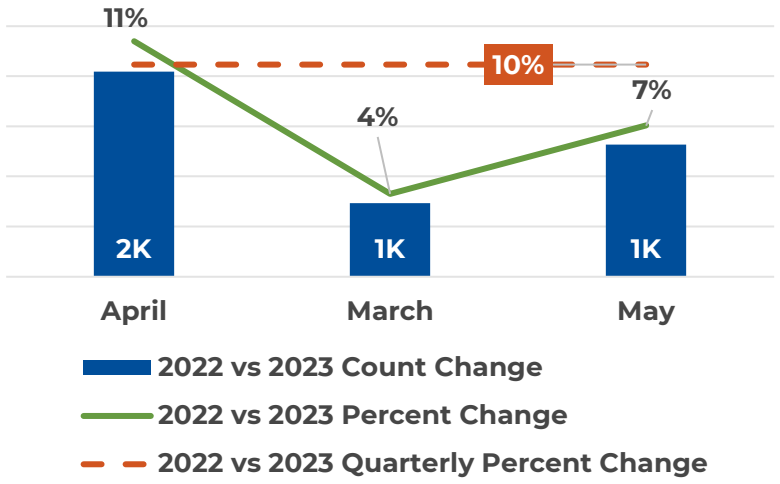
Telemedicine - Total Visits





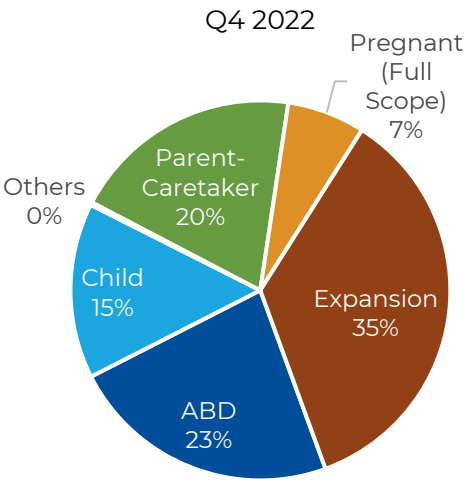
Members With Opioid Claims

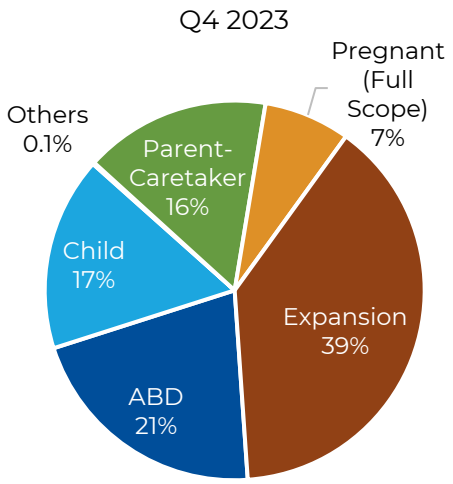




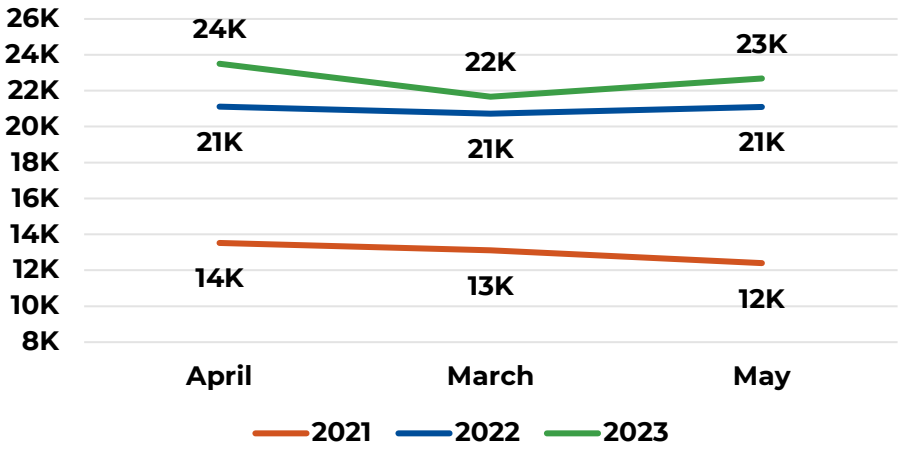
Utilization (Cont.)

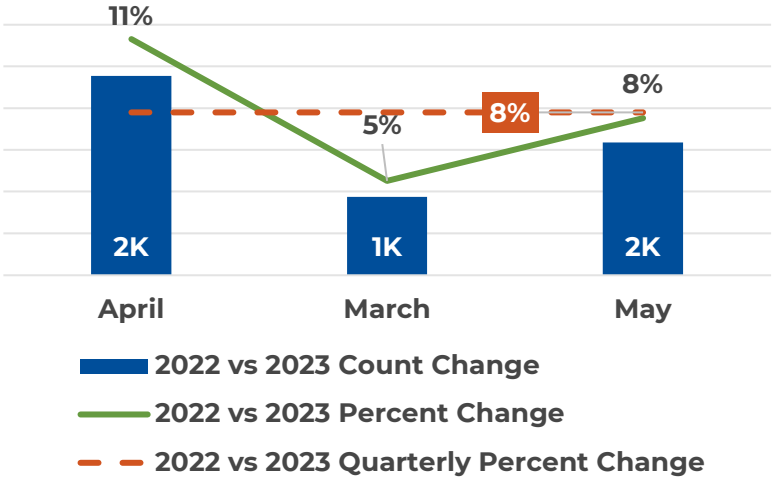
Members With Opioid Claims By Qualifying Group





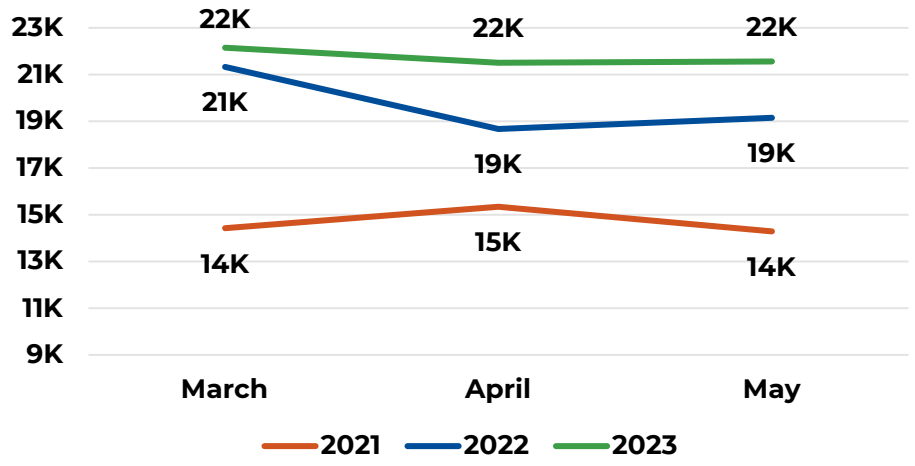
Total Opioid Claims

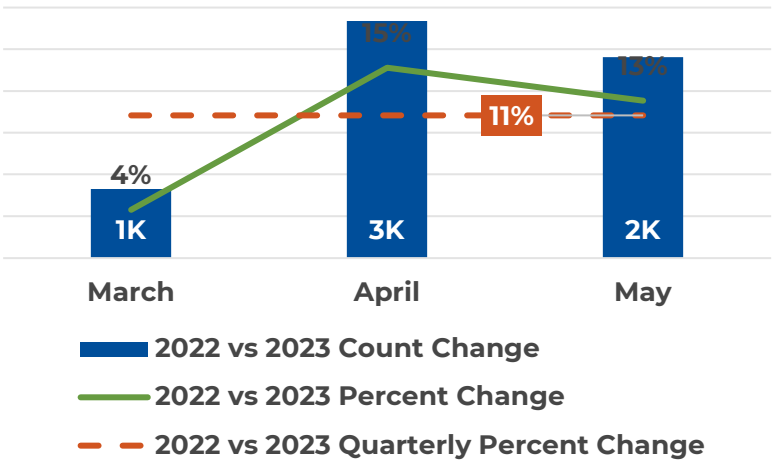




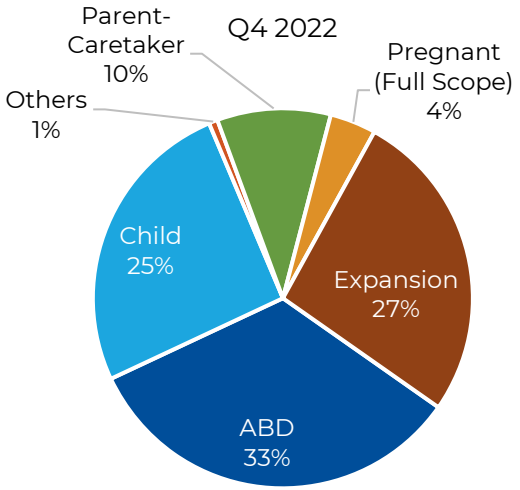
Utilization (Cont.)

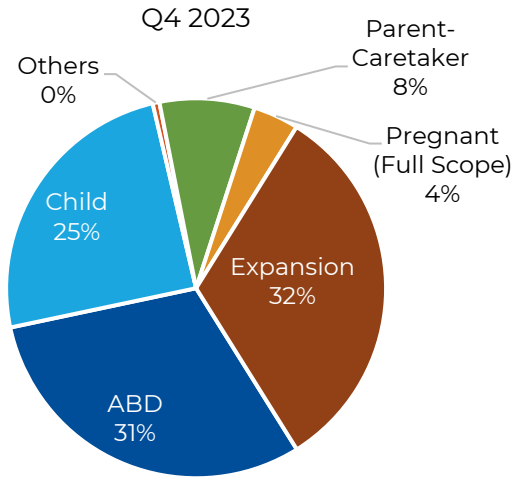
Out of State Services - Total Members Utilization





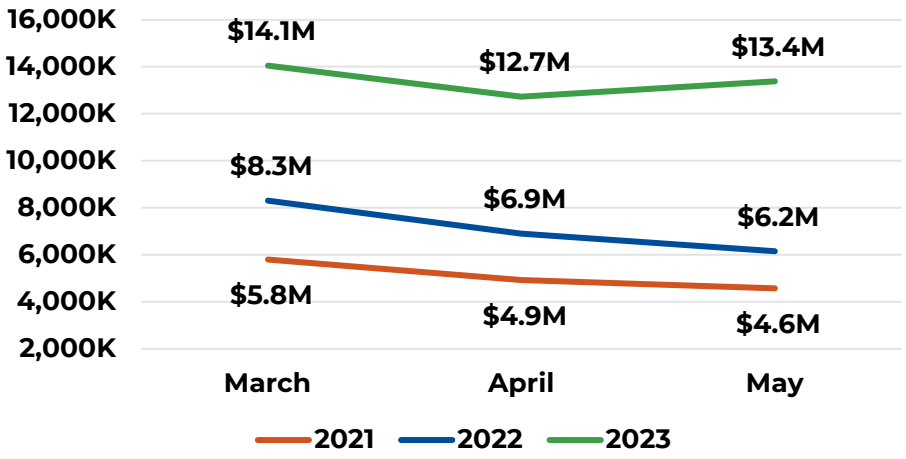
Out of State Services - Total Members Utilization By Qualifying Group

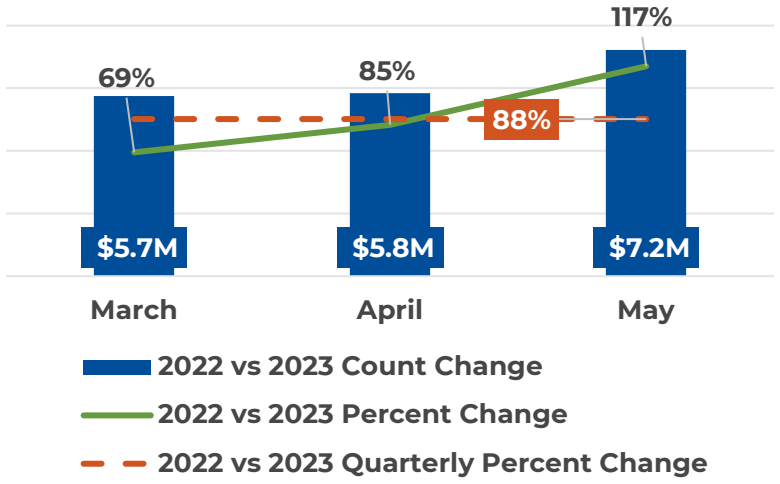




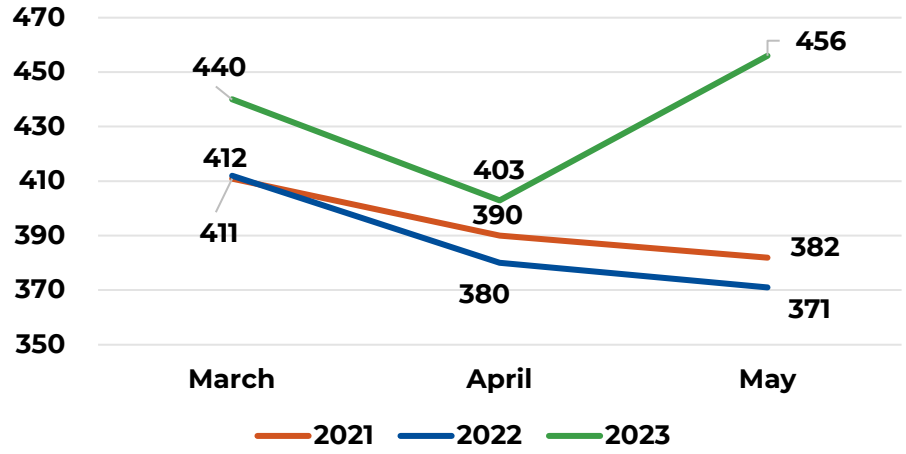
Utilization (Cont.)

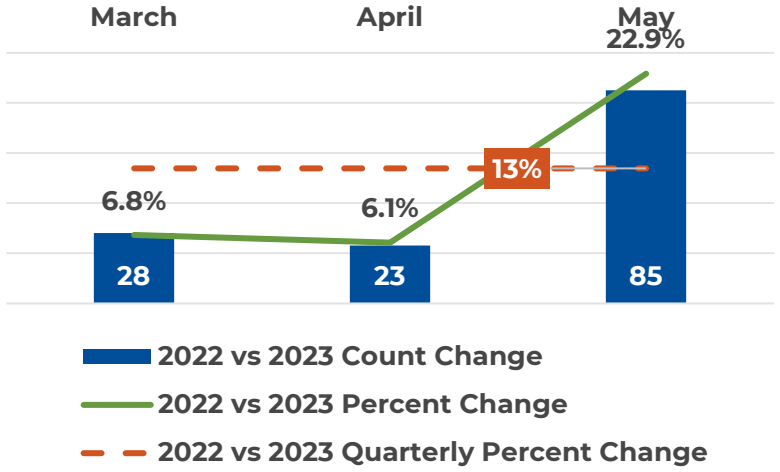
Out of State Services - Total Reimbursements





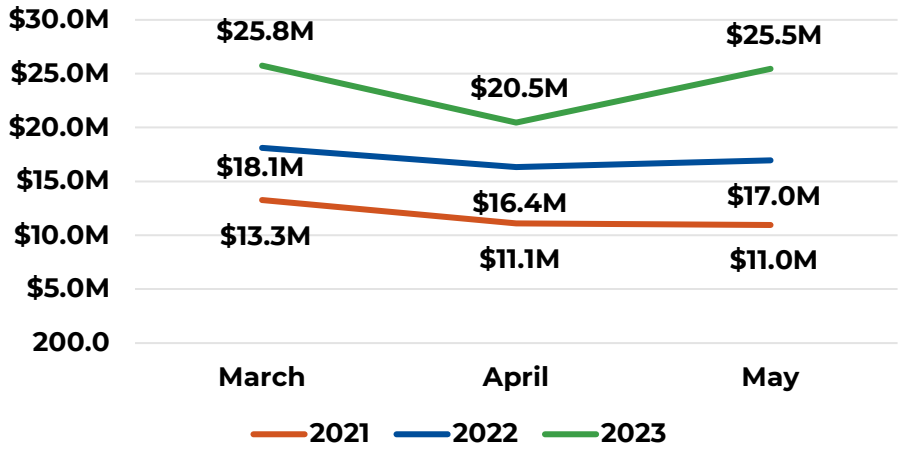
Out of State Services - Total Active Billing Providers

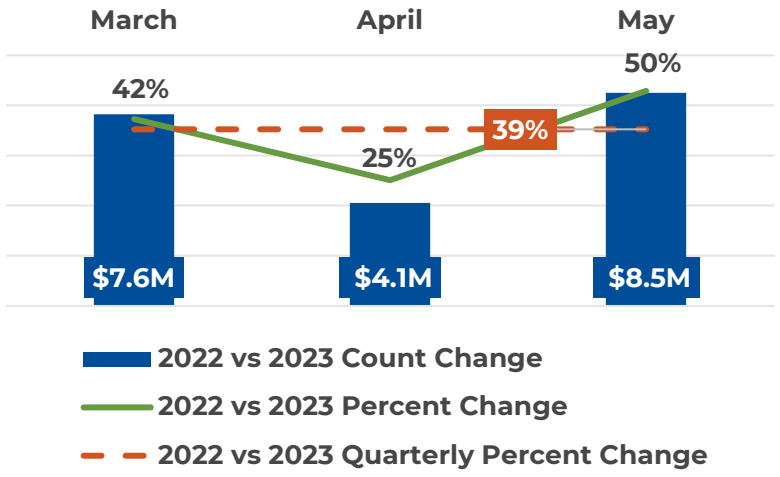




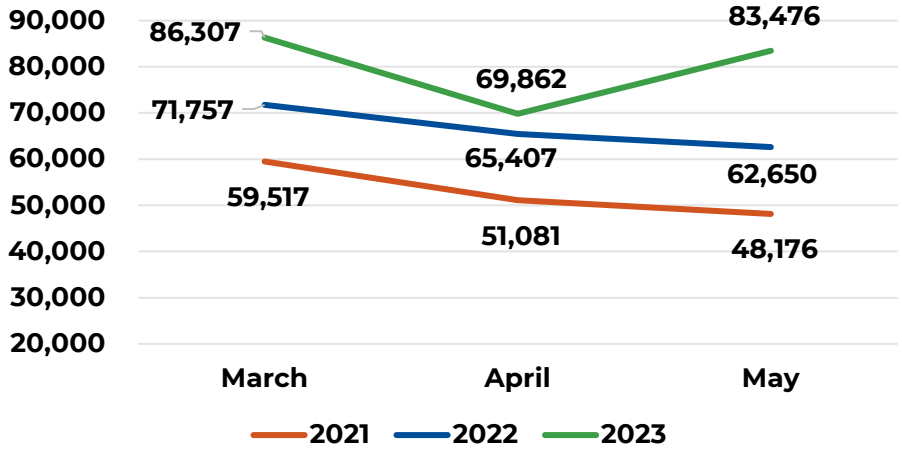
Utilization (Cont.)

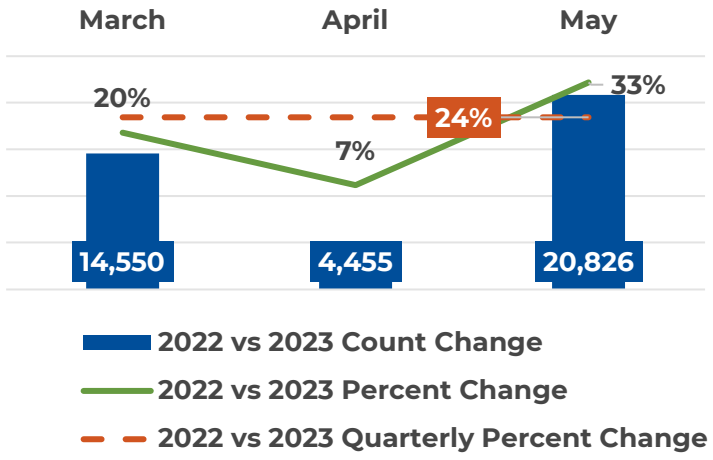
Dental Claims





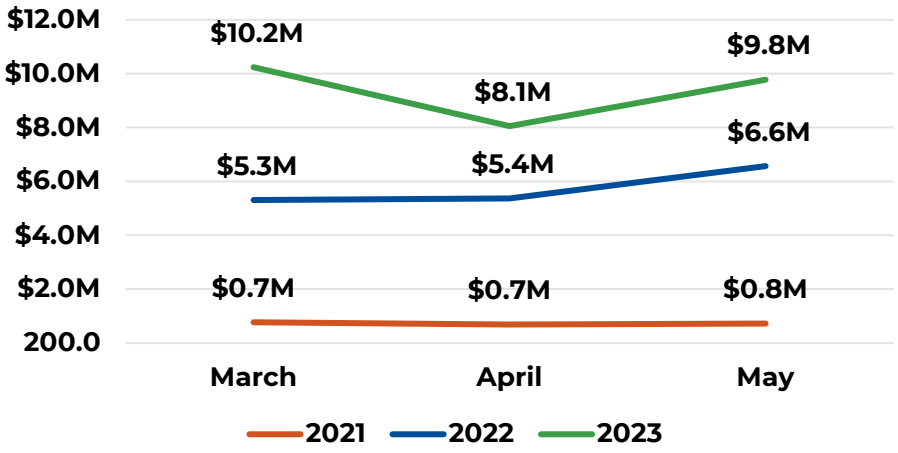
Total Members with Dental Claims

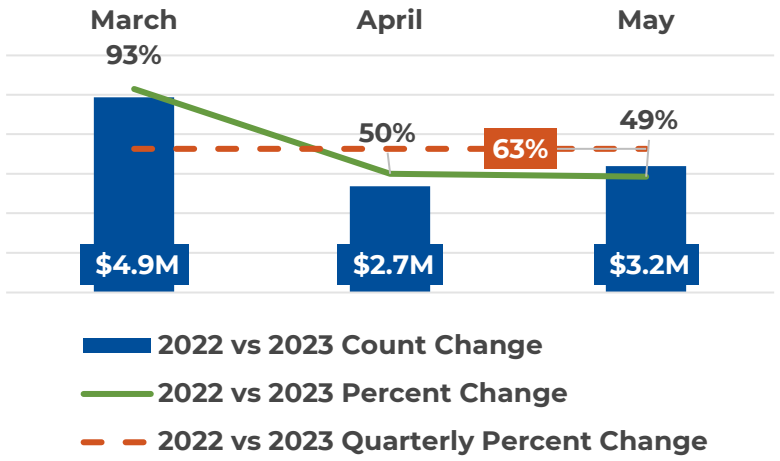




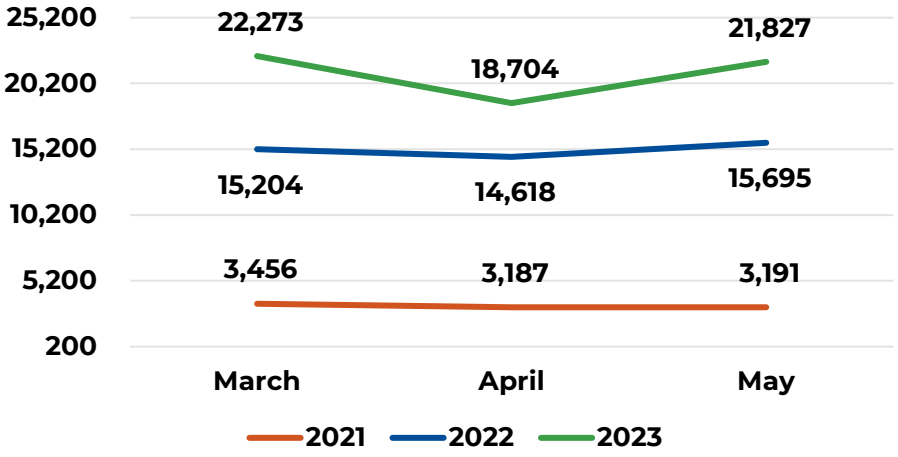
Utilization (Cont.)

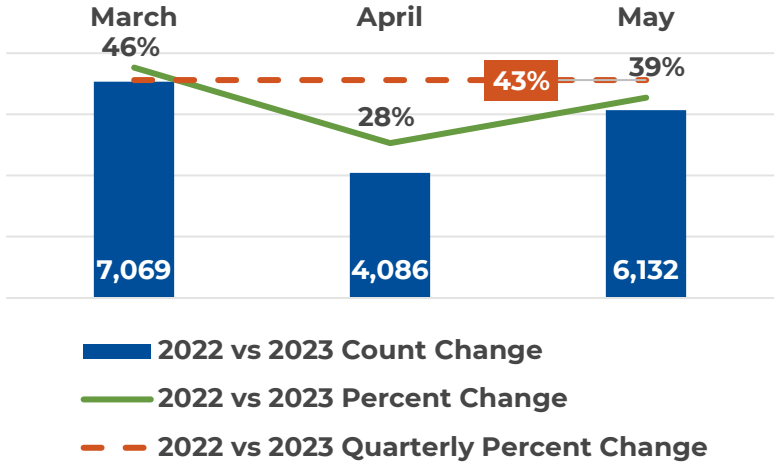
Adult (21 & Over) Dental Claims





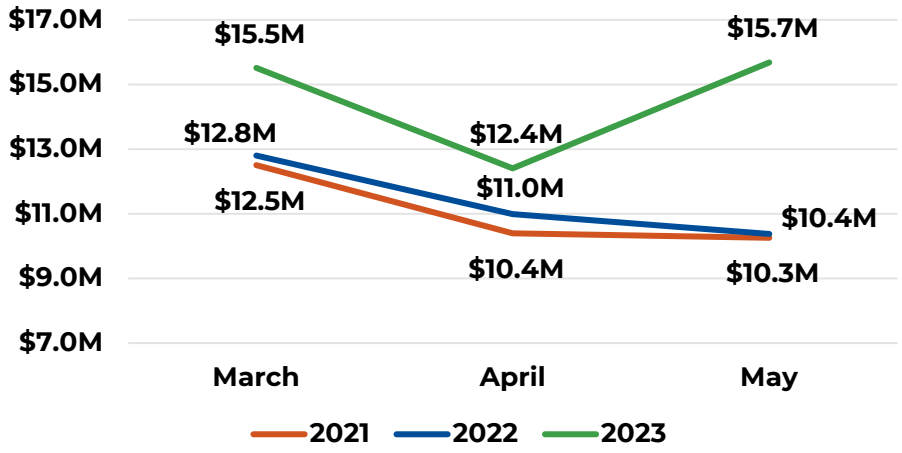
Adults (21 & Over) with Dental Claims

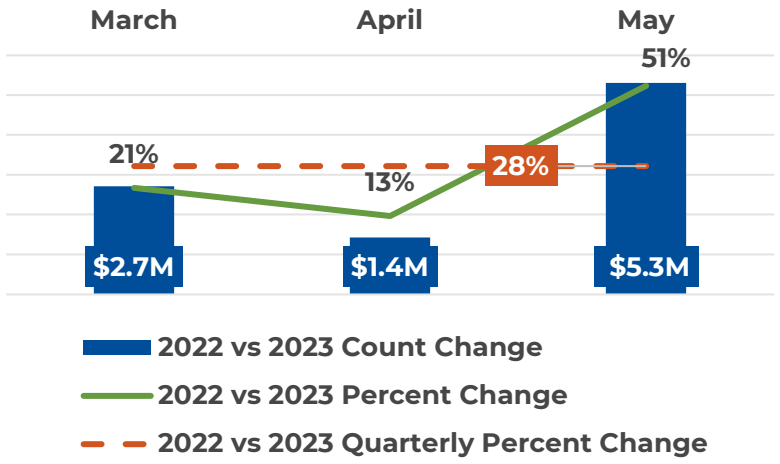




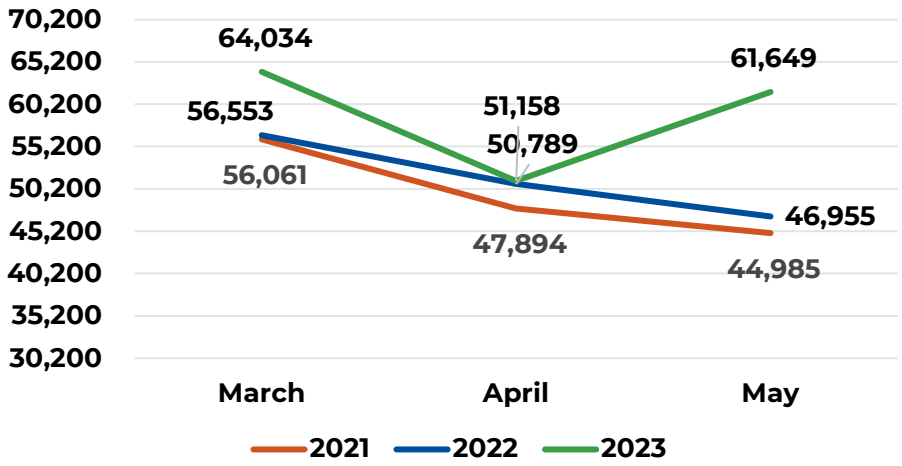
Utilization (Cont.)

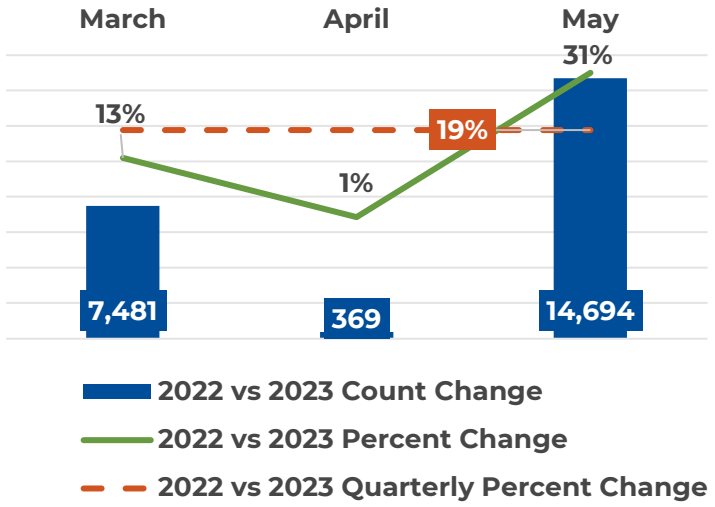
Children (Under 21) Dental Claims





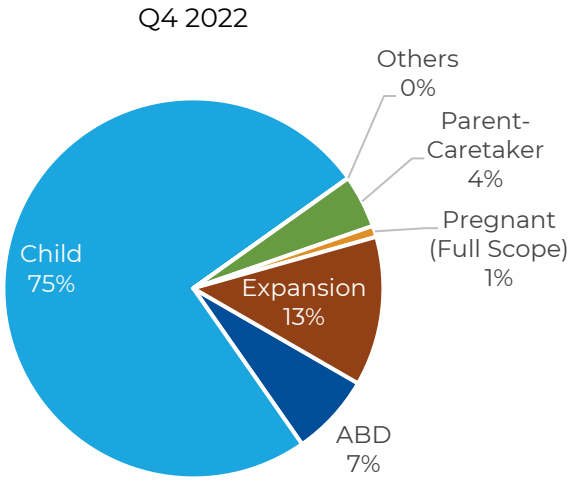
Children (Under 21) with Dental Claims

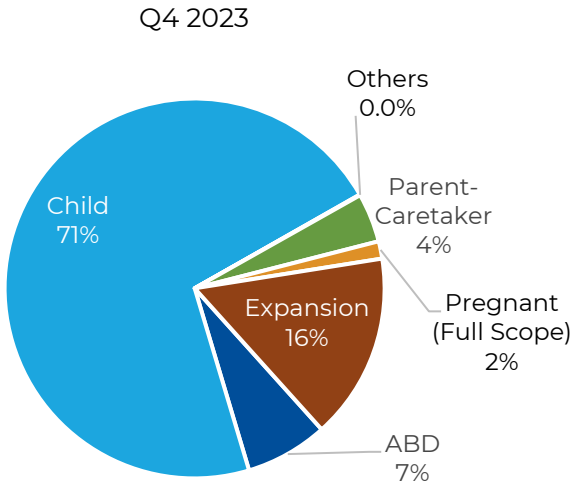




Utilization (Cont.)

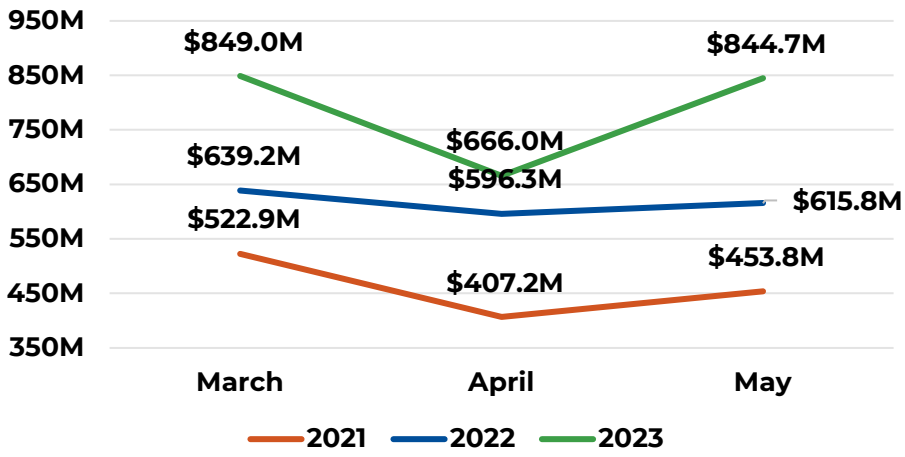
Members With Dental Claims By Qualifying Group

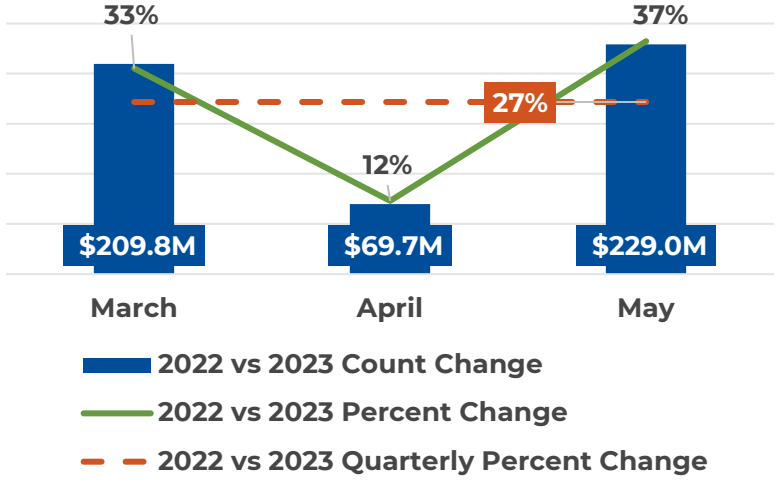




Financials

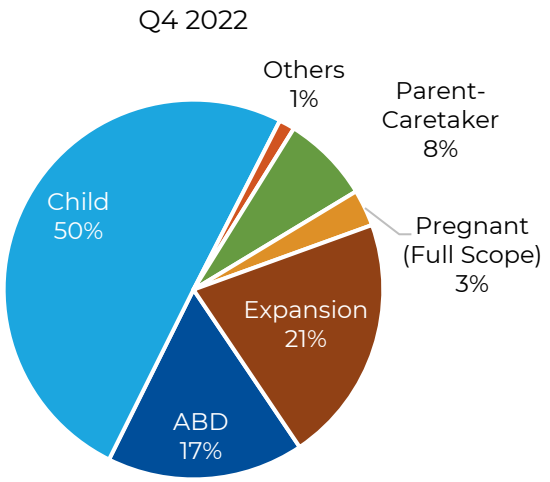
Total Agency Expenditures

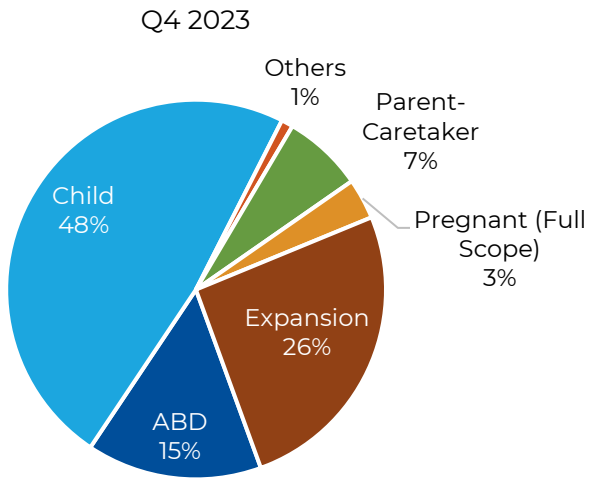




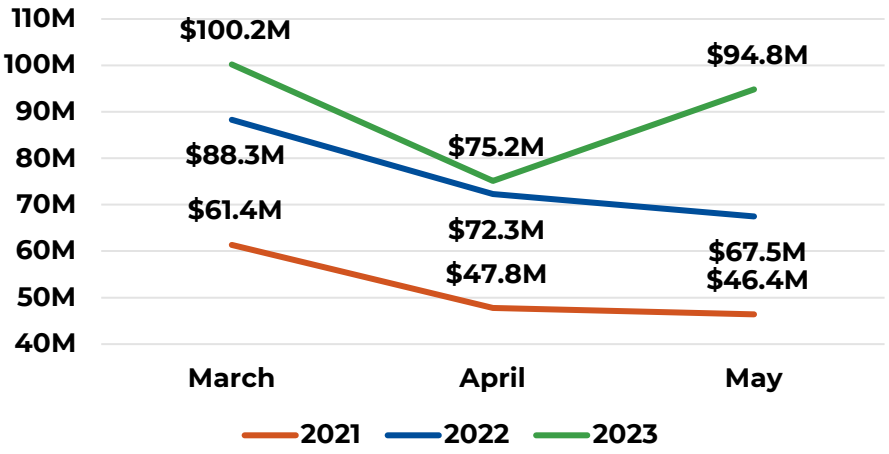
Financials (Cont.)

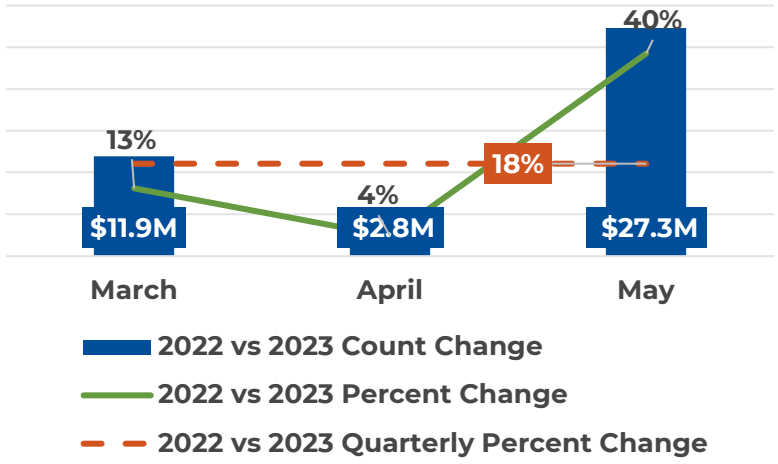
Total Agency Members Utilization by Qualifying Group





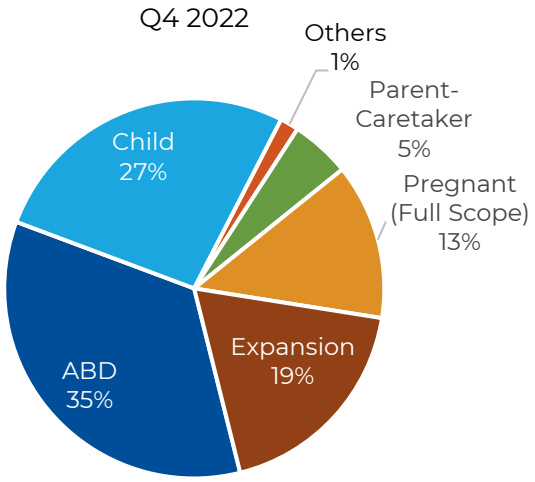
Inpatient Services Expenditures

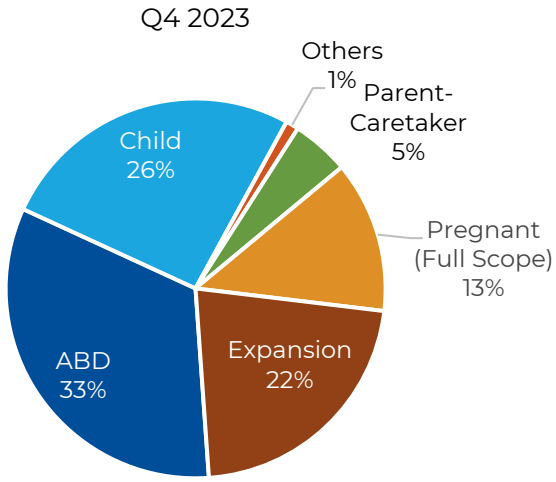




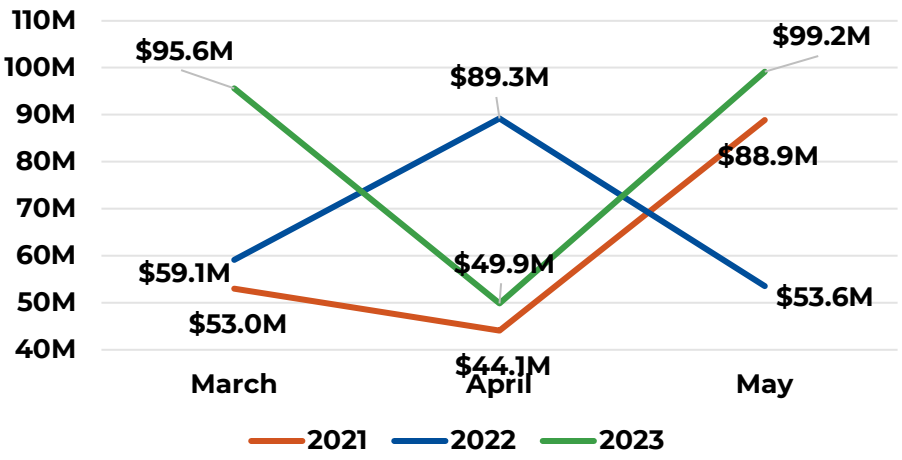
Financials (Cont.)

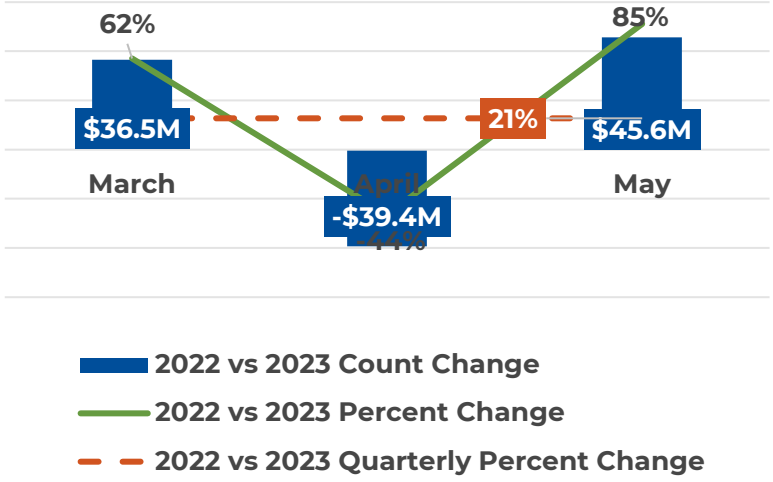
Inpatient Services Members Utilization by Qualifying Group





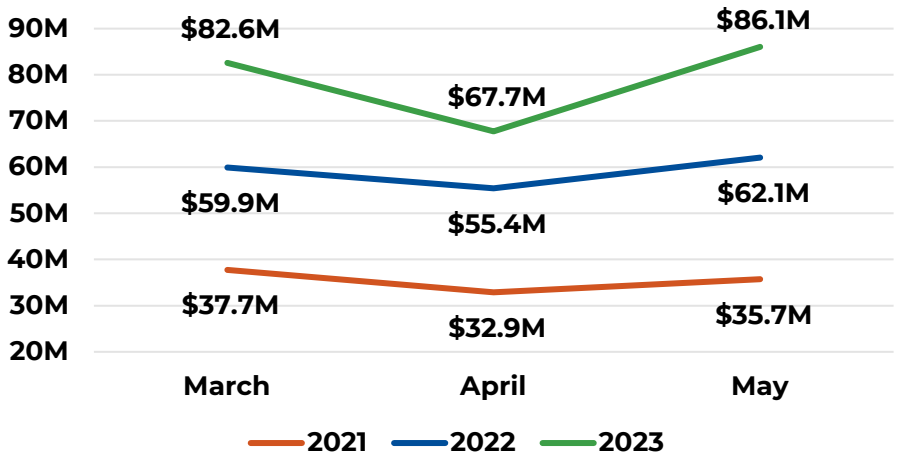
Nursing Facility Expenditures

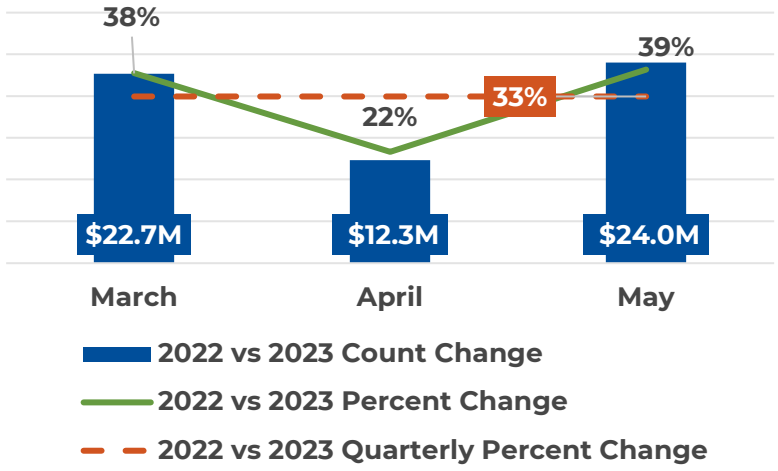




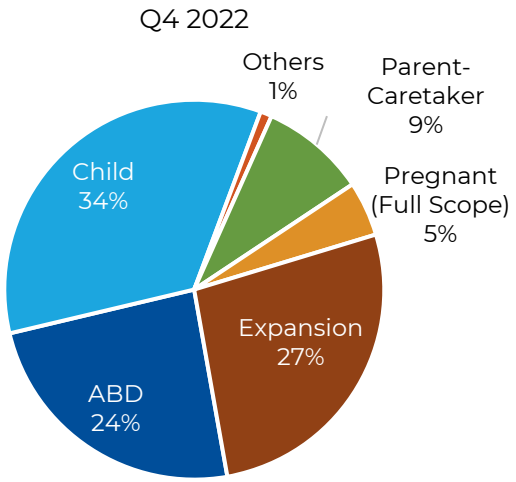
Financials (Cont.)

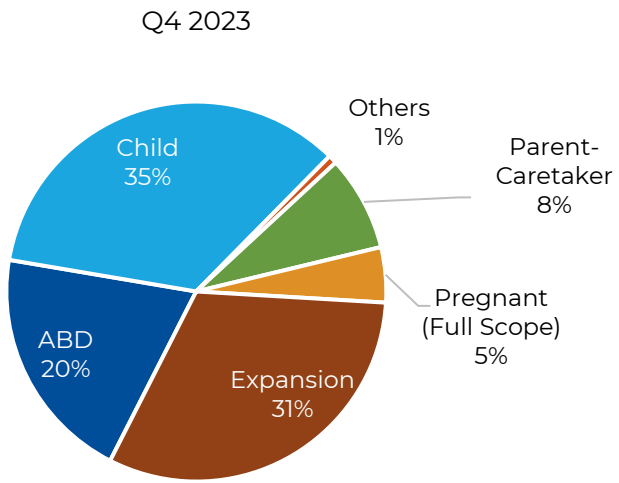
Outpatient Hospital Expenditures





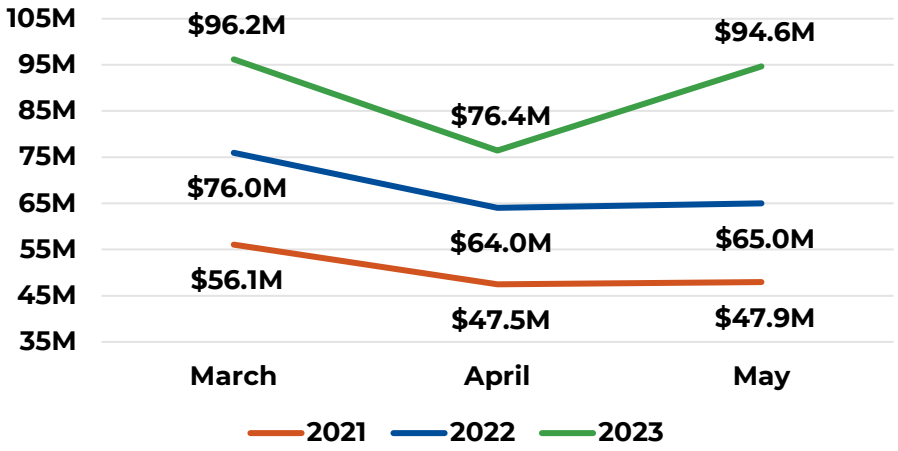
Outpatient Hospital Members Utilization by Qualifying Group

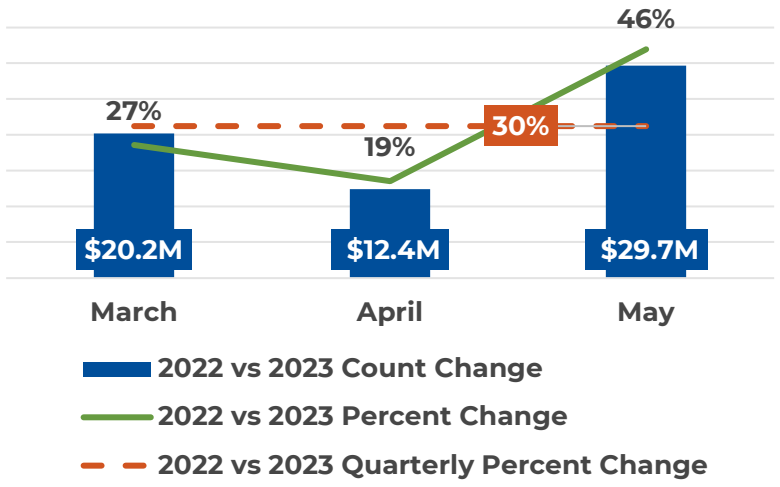




Financials (Cont.)

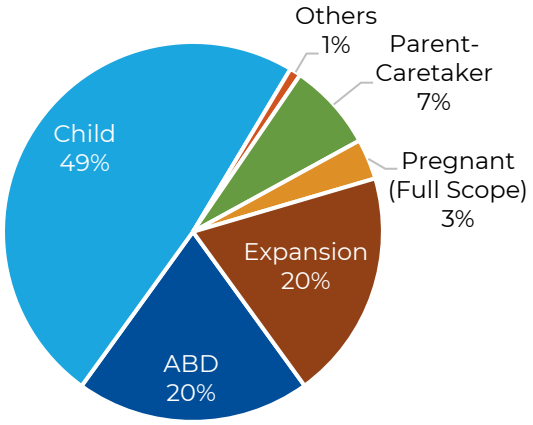
Physician Expenditures



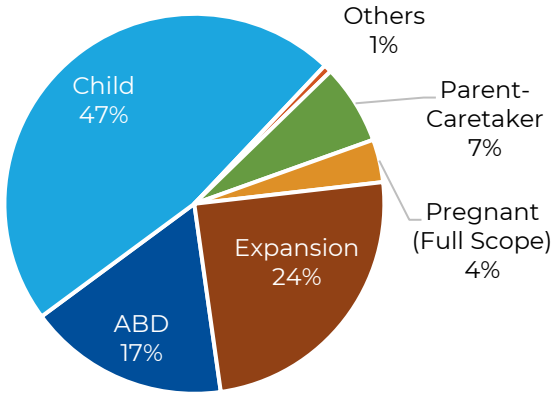


Physician Members Utilization By Qualifying Group

Q4 2022

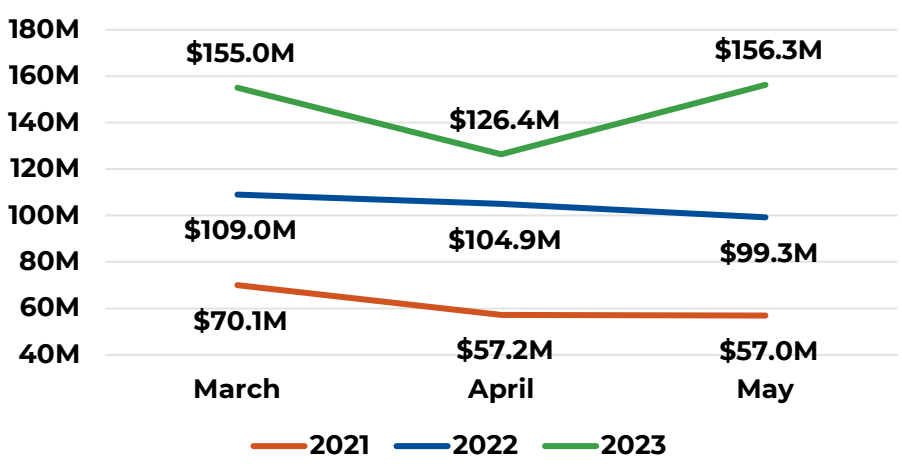


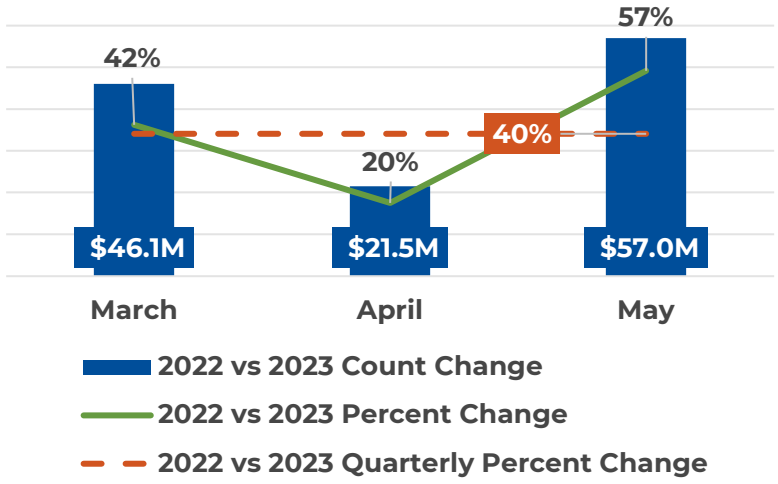
Q4 2023



Financials (Cont.)

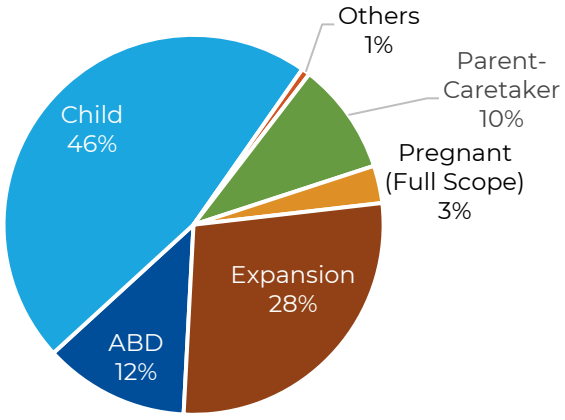
Prescribed Drugs Expenditures



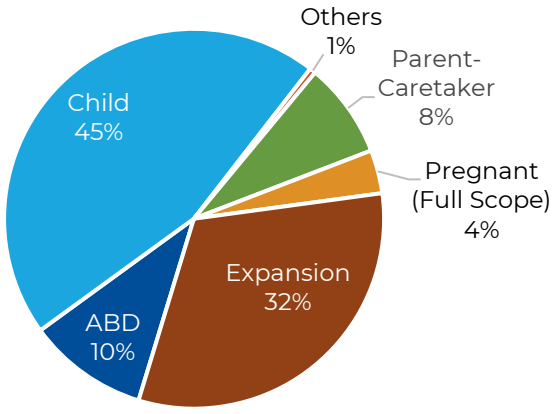


Prescribed Drugs Members Utilization By Qualifying Group

Q4 2022

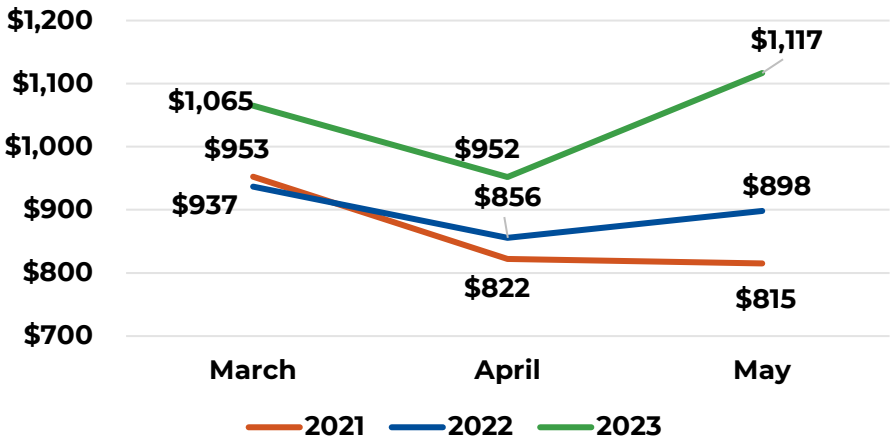


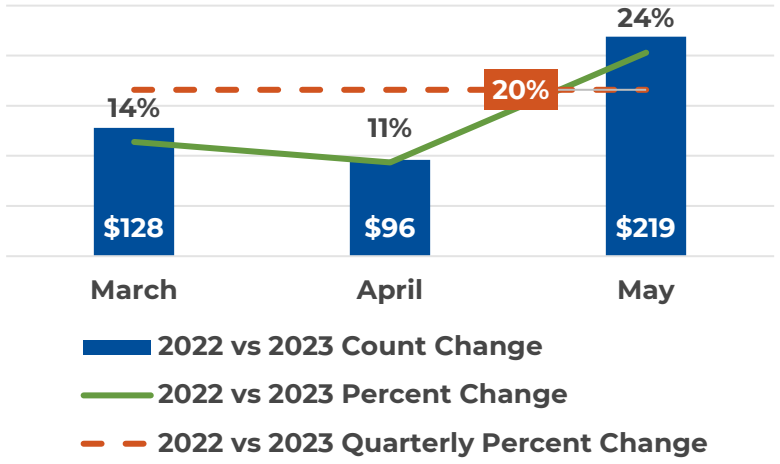
Q4 2023



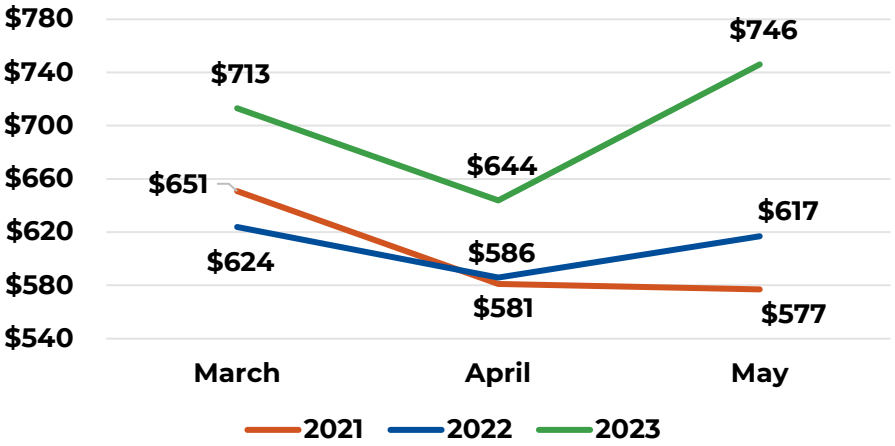
Financials (Cont.)

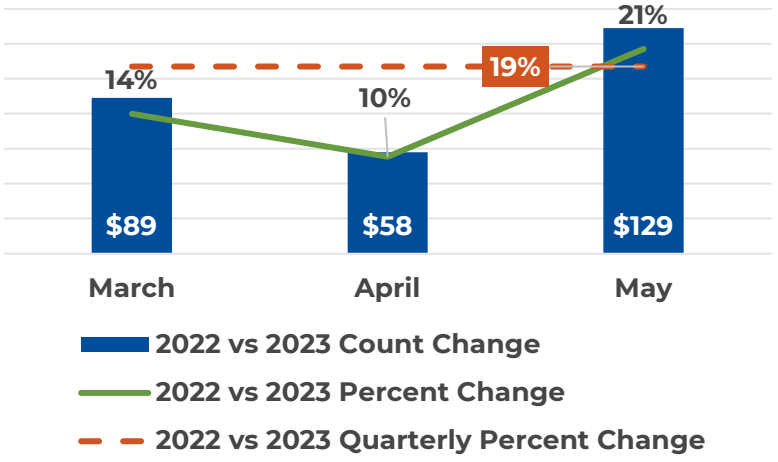
Average Per Total Member Served





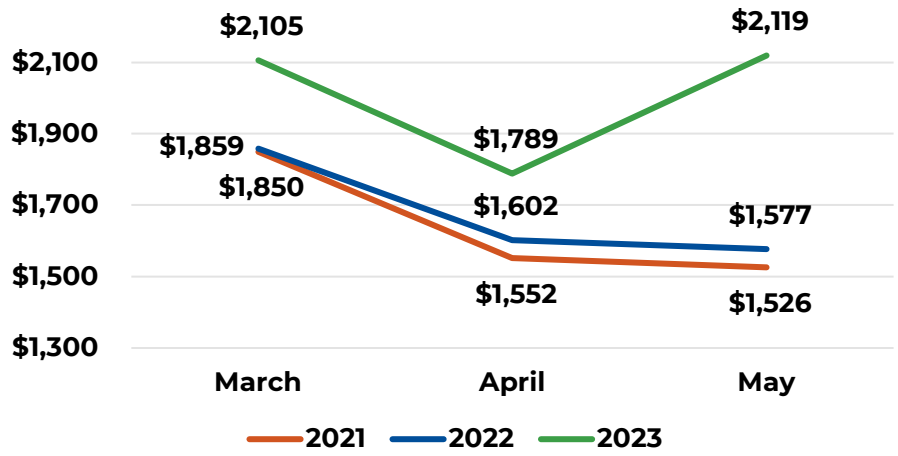
Average Per Child (Under 21) Member Served

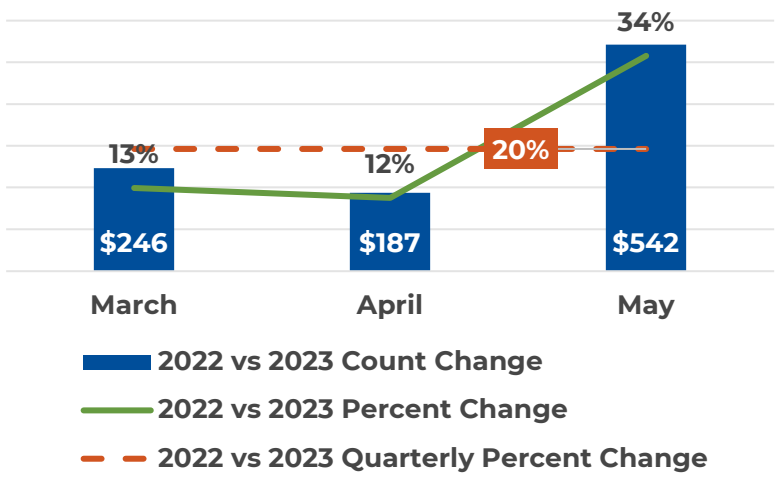




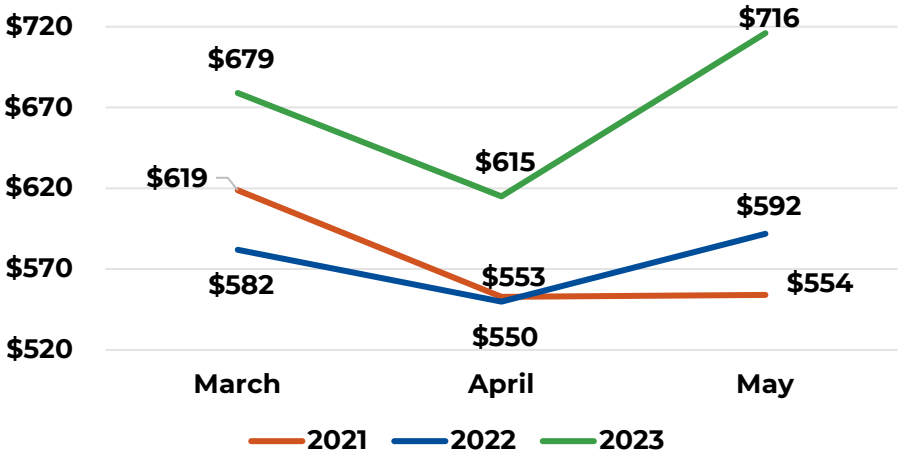
Financials (Cont.)

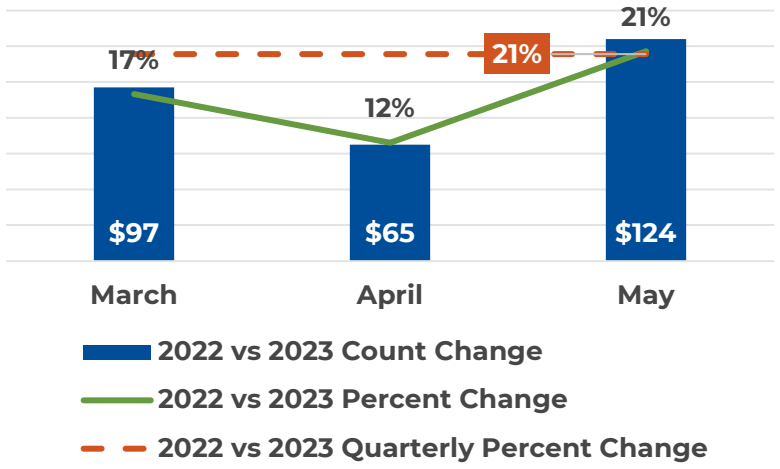
Average Per Aged/Blind/Disabled Member Served





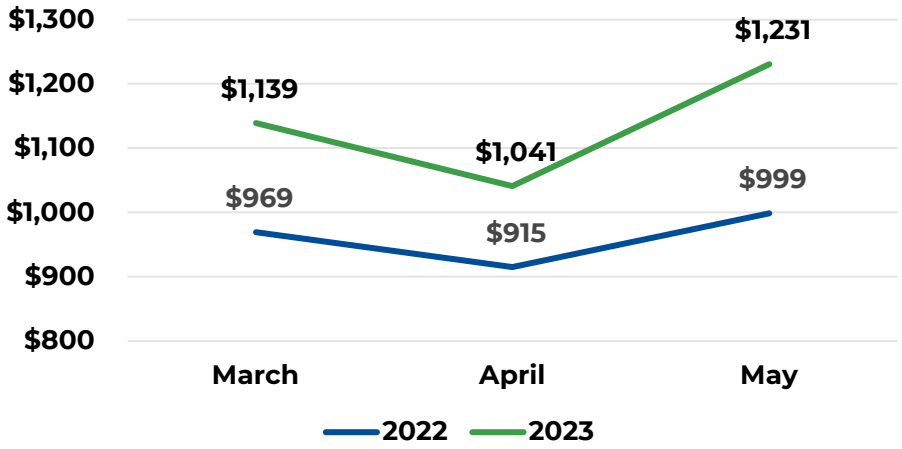
Average Per Children & Parent/Caretaker Member Served

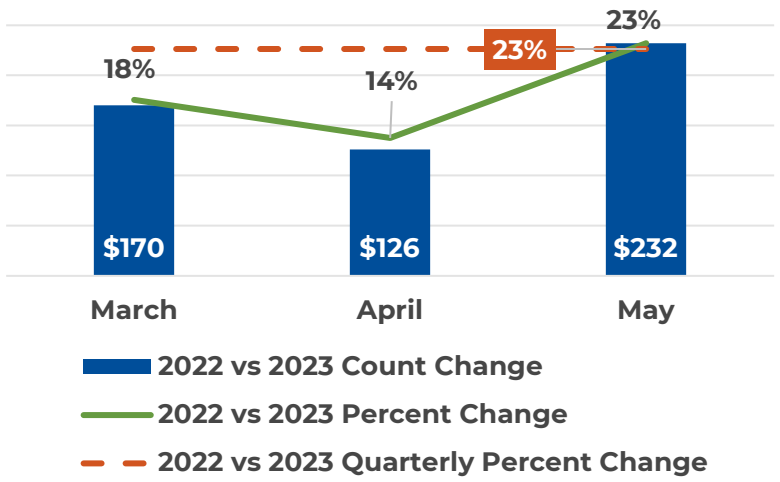




Financials (Cont.)

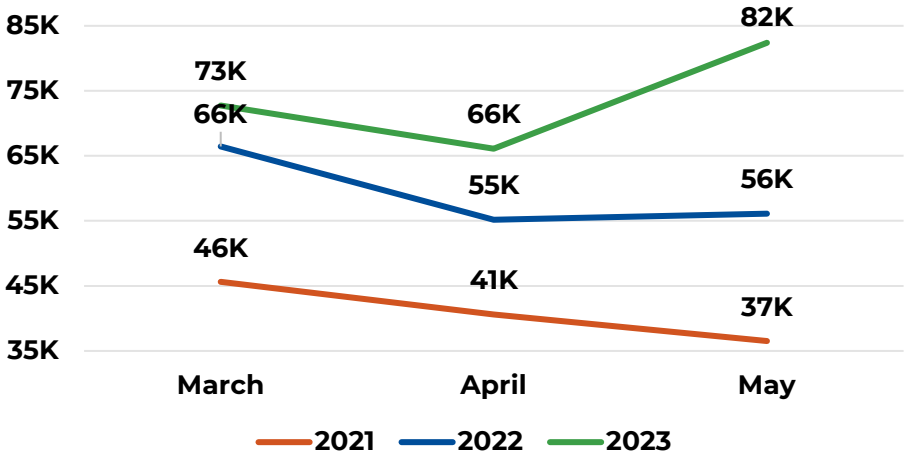
Average Per Expansion Member Served (Effective July 2021)

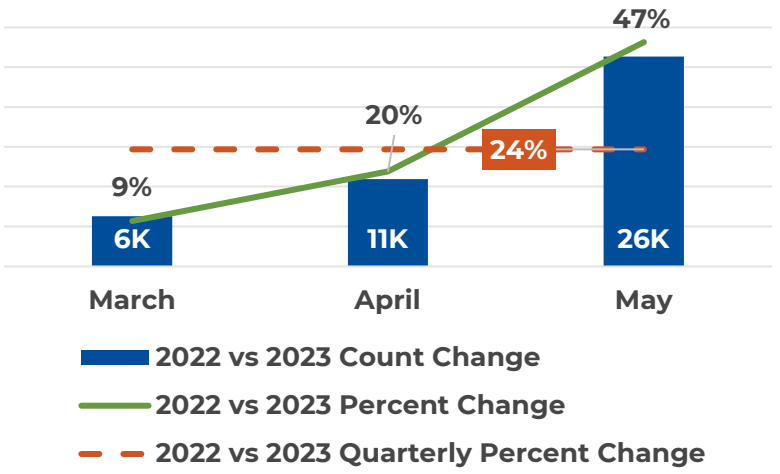




Call Center

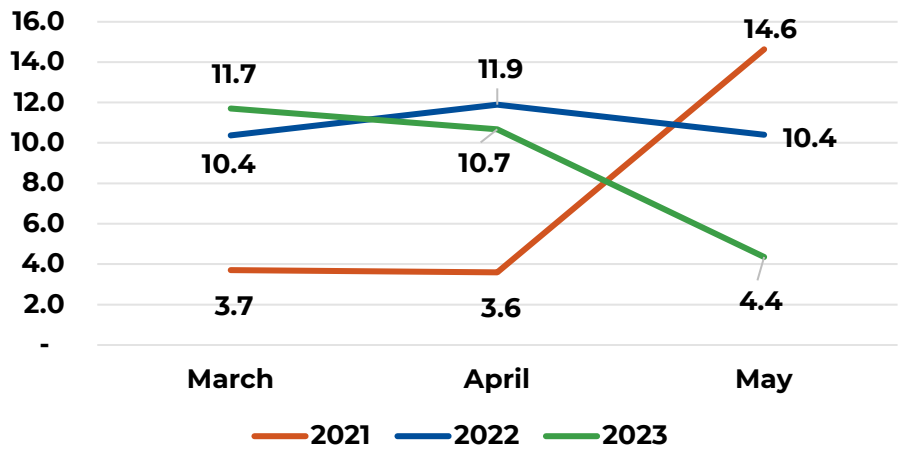
Call Center - Member Calls Answered

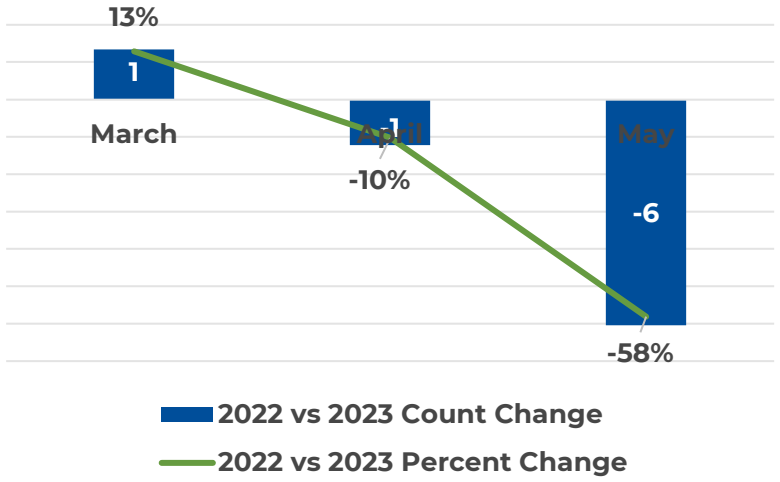




Call Center (Cont.)

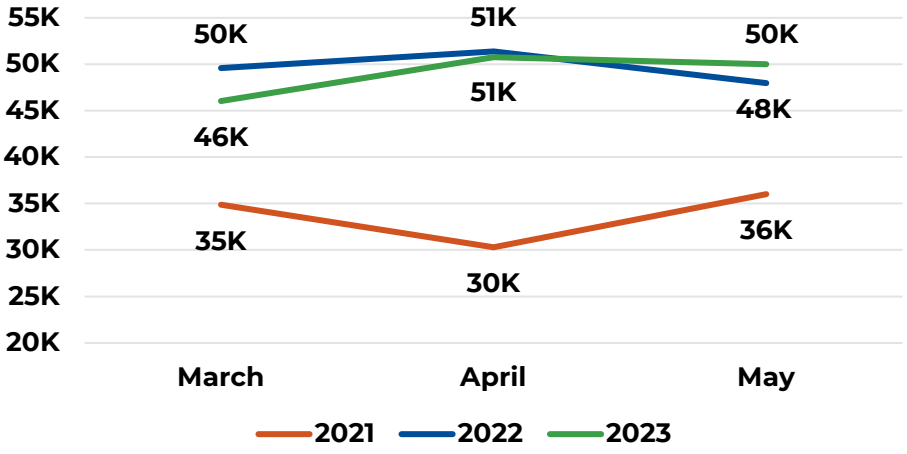
Call Center - Average Wait Time (In Seconds)

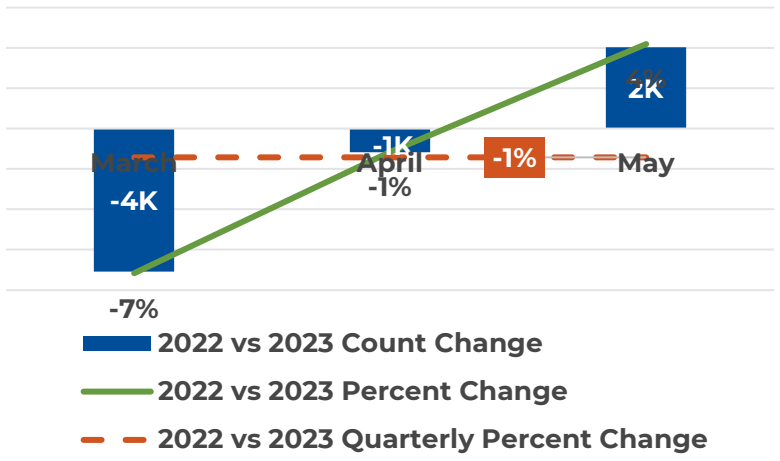




Prior Authorization

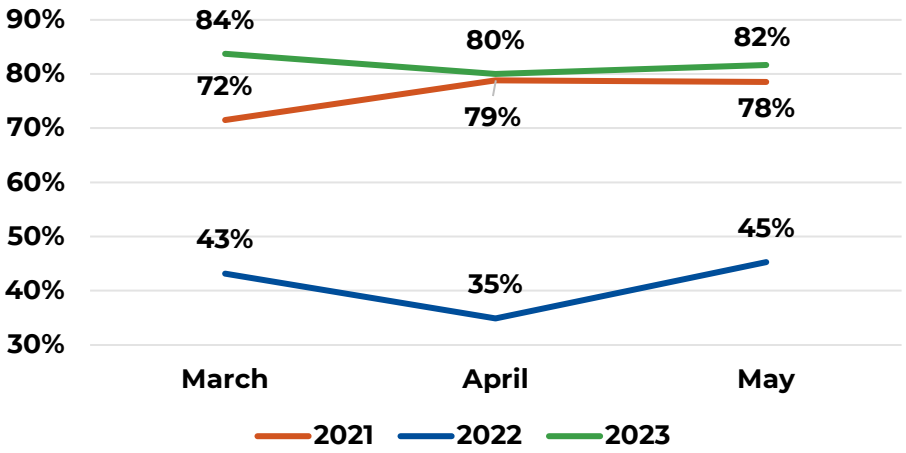
Prior Authorization - Total Combined - Total Completed PA Volume

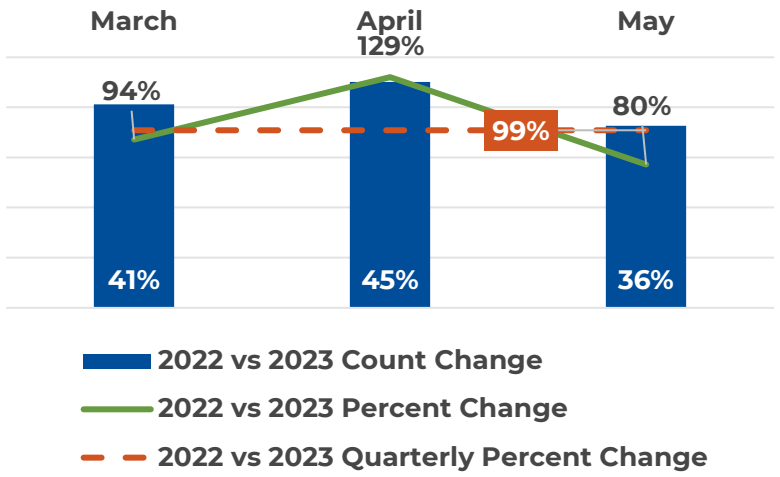




Prior Authorization (Cont.)

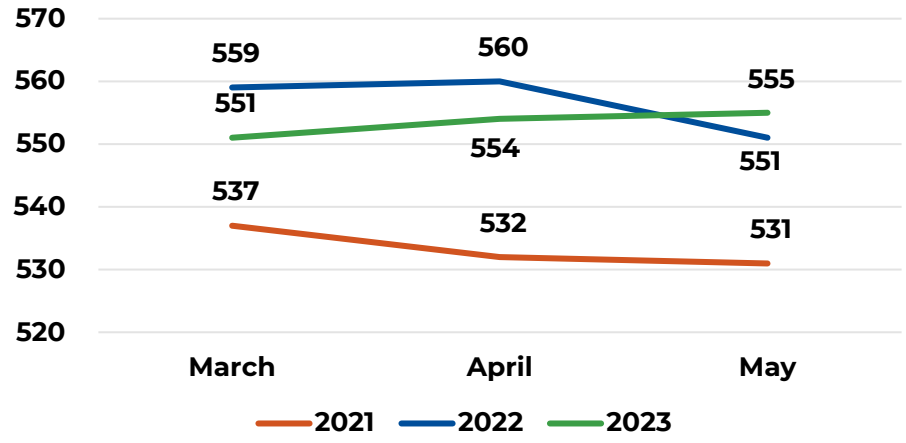
Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

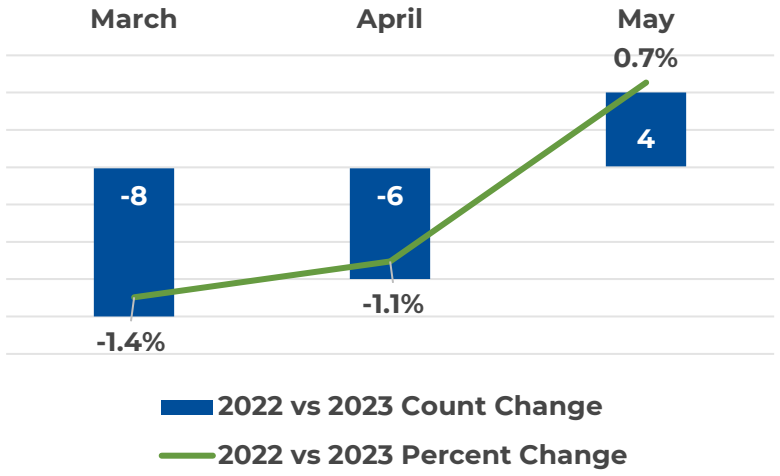




Agency Stats & Provider Network

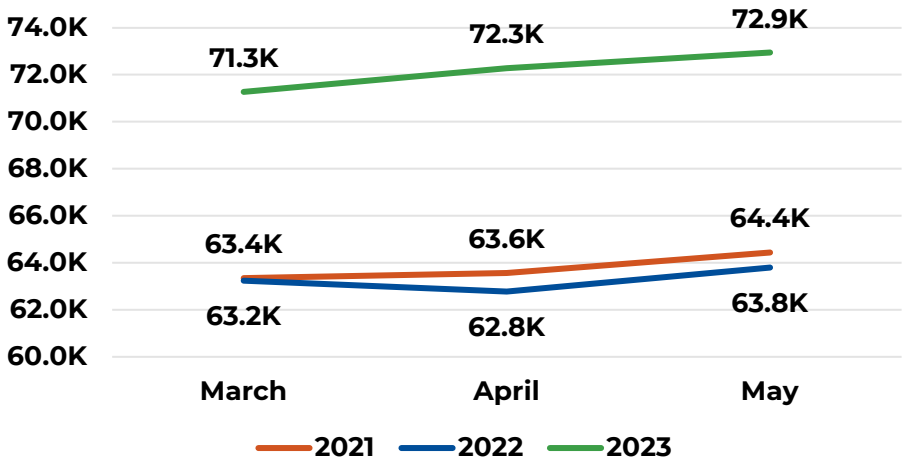
OHCA Admin - Number of FTEs

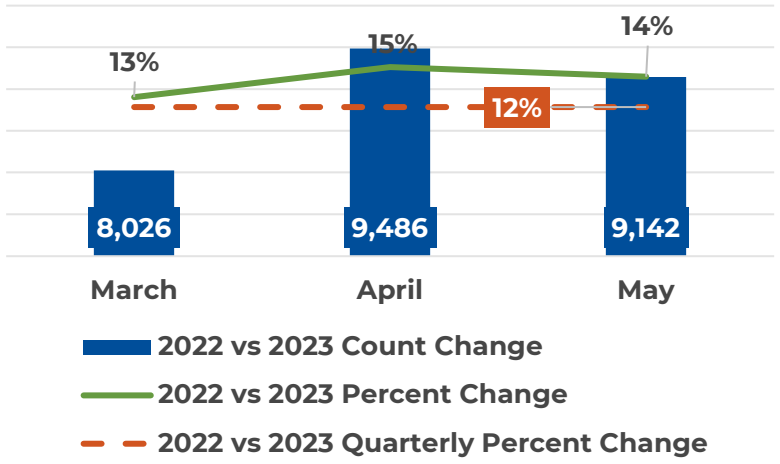




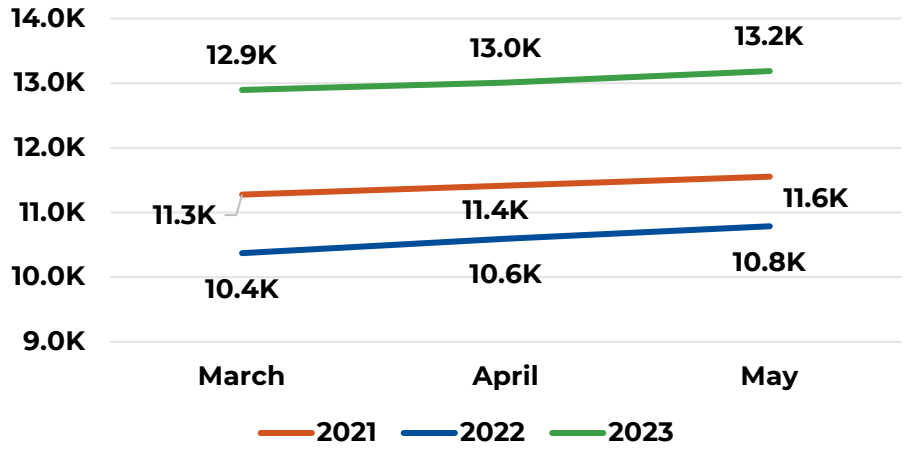
Agency Stats & Provider Network (Cont.)

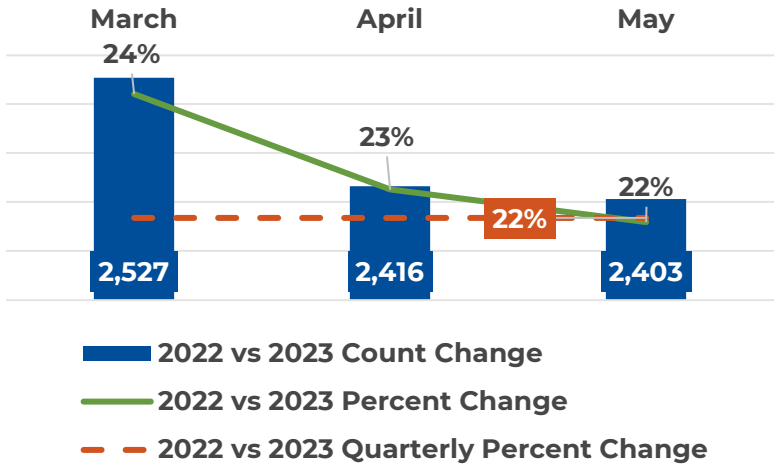
Total Providers





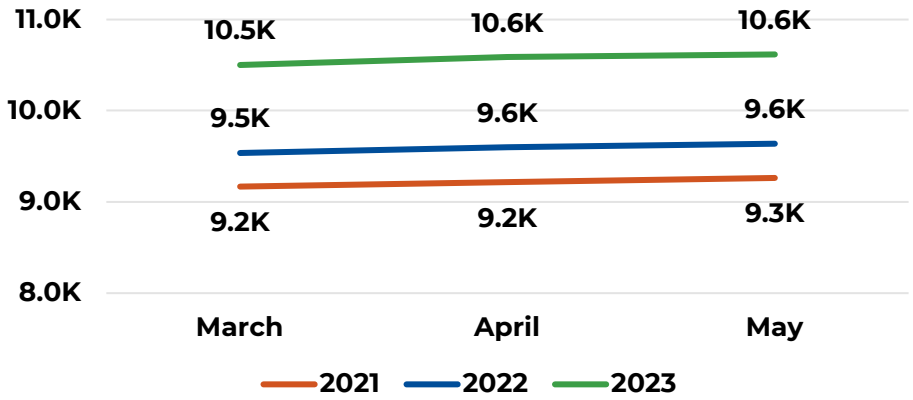
Mental Health Providers (In-State Only)

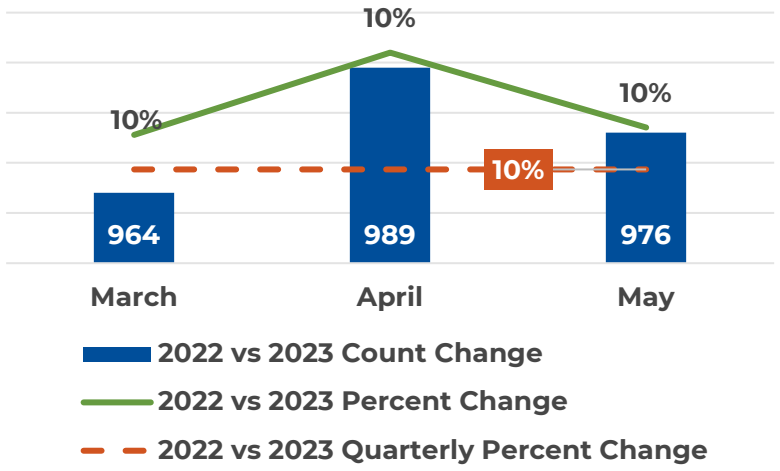




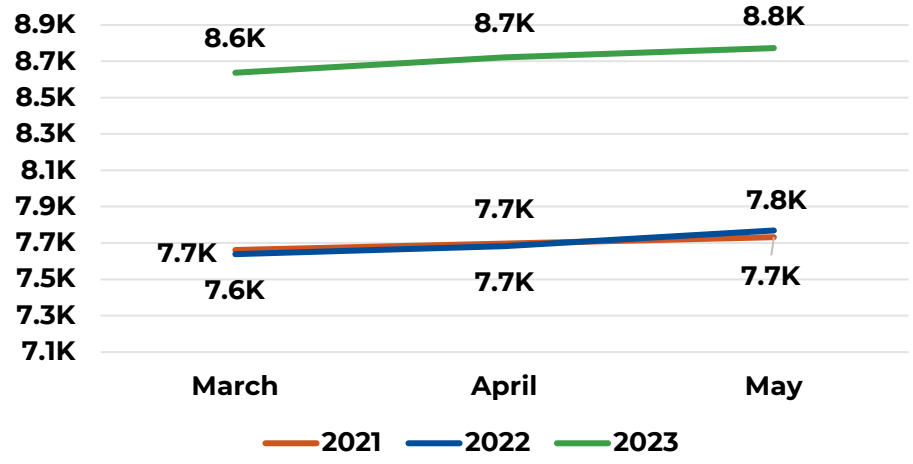
Agency Stats & Provider Network (Cont.)

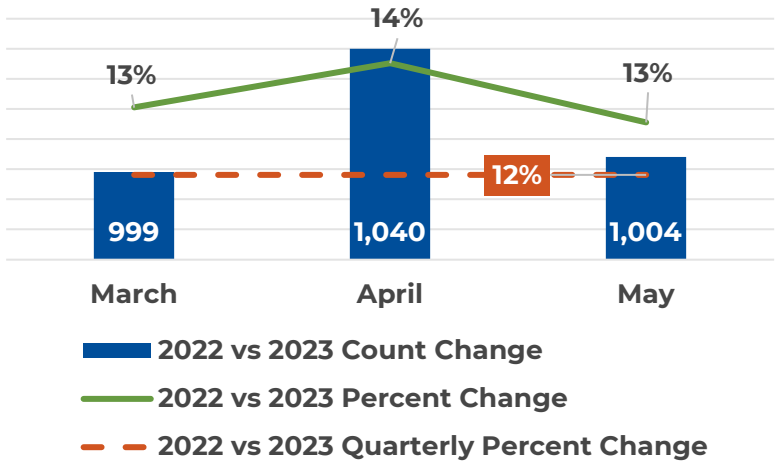
Physicians (In-State Only)





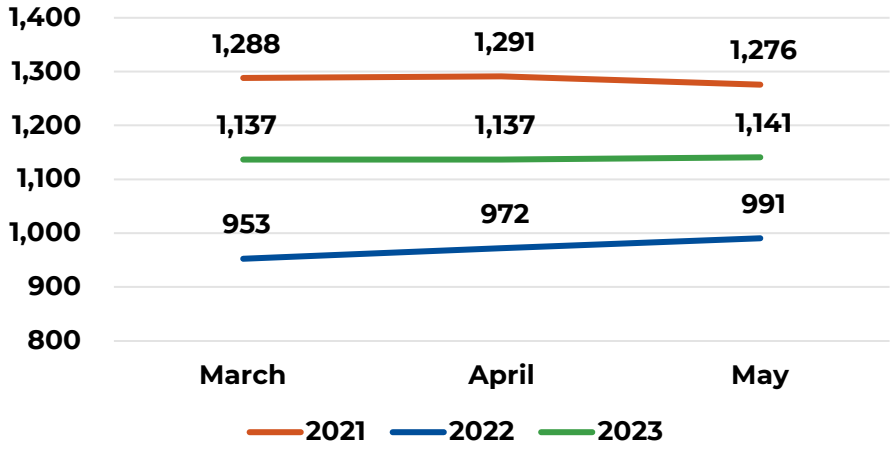
Primary Care Providers (In-State Only)

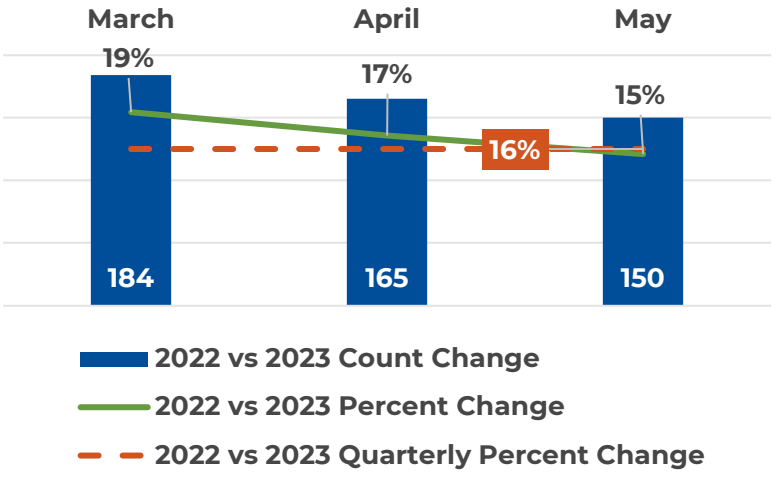




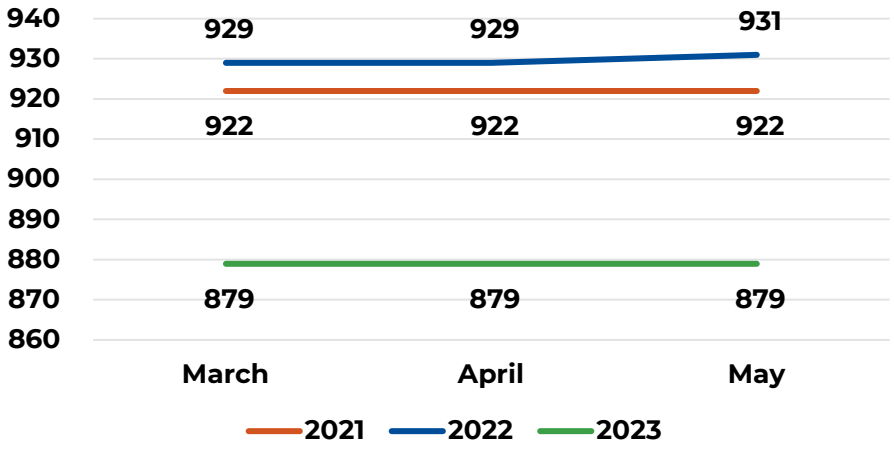
Agency Stats & Provider Network (Cont.)

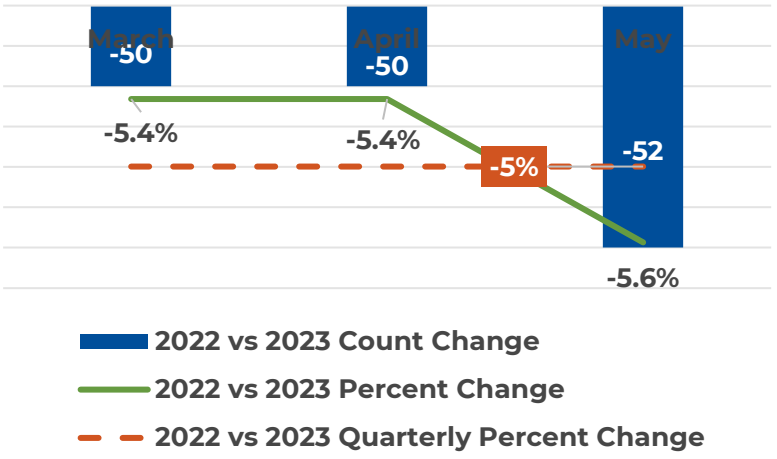
Dentists (In-State Only)





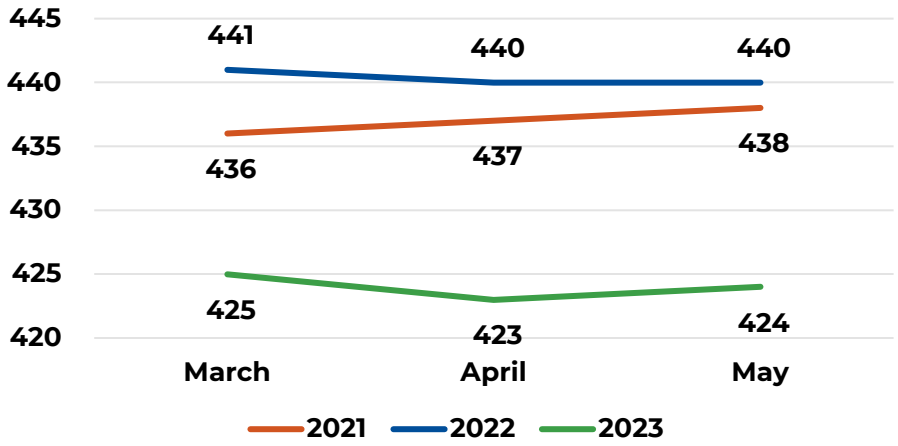
Pharmacy (In-State Only)

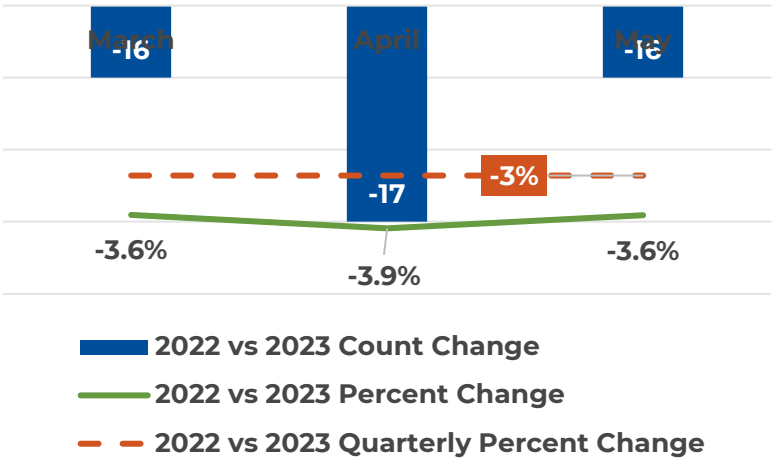




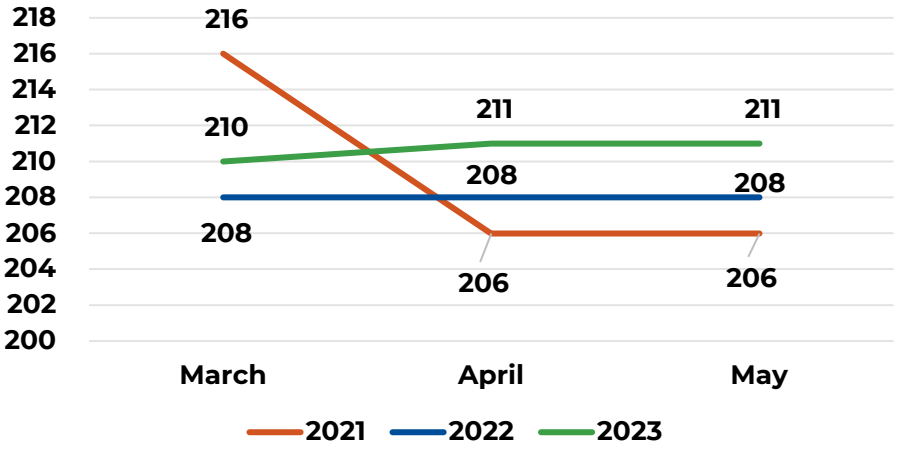
Agency Stats & Provider Network (Cont.)

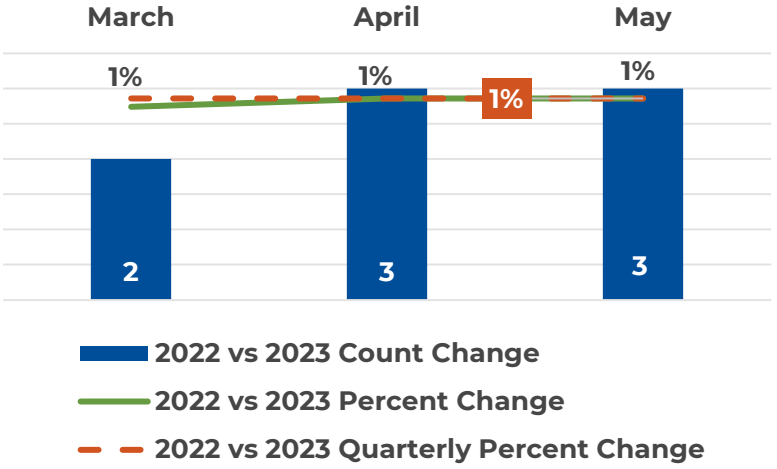
Extended Care Facilities (In-State Only)





Hospitals (In-State Only)





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PHE	TOTAL	Percent	REMAIN (Jun)	Percent	UNWOUND (Apr-May)	Percent
PHE with a Claim	**182,641**	69%	150,129	72%	32,512	59%
PHE with No Claim	**80,931**	31%	58,289	28%	22,642	41%
TOTAL	**263,572**		**208,418**		**55,154**	

PHE by Age Group	TOTAL	Percent	REMAIN (Jun)	Percent	UNWOUND (Apr-May)	Percent
Children Age 0 to 5	**41,515**	16%	40,208	19%	1,307	2%
Children Age 6 to 18	**60,170**	23%	39,107	19%	21,063	38%
Adults Age 19 to 64	**158,803**	60%	126,338	61%	32,465	59%
Adults Age 65 and Over	**3,084**	1%	2,765	1%	319	1%
TOTAL	**263,572**		**208,418**		**55,154**	

PHE by Race	TOTAL	Percent	REMAIN (Jun)	Percent	UNWOUND (Apr-May)	Percent
American Indian or Alaskan N	**33,753**	13%	26,823	13%	6,930	13%
Asian or Pacific Islander	**6,457**	2%	5,175	2%	1,282	2%
Black or African American	**28,412**	11%	23,086	11%	5,326	10%
Caucasian	**152,854**	58%	120,186	58%	32,668	59%
Declined to answer	**19,951**	8%	15,536	7%	4,415	8%
Two or More Races	**22,145**	8%	17,612	8%	4,533	8%
TOTAL	**263,572**		**208,418**		**55,154**	

PHE by Ethnicity	TOTAL	Percent	REMAIN (Jun)	Percent	UNWOUND (Apr-May)	Percent
Hispanic	**41,993**	16%	33,264	16%	8,729	16%
Non-Hispanic	**221,579**	84%	175,154	84%	46,425	84%
TOTAL	**263,572**		**208,418**		**55,154**	

PHE by Sex	TOTAL	Percent	REMAIN (Jun)	Percent	UNWOUND (Apr-May)	Percent
F - Female	**148,397**	56%	120,286	58%	28,111	51%
M - Male	**115,175**	44%	88,132	42%	27,043	49%
TOTAL	**263,572**		**208,418**		**55,154**	

PHE by Qualifying Group	TOTAL	Percent	REMAIN (Jun)	Percent	UNWOUND (Apr-May)	Percent
ABD	**232**	0.1%	200	0.1%	32	0.1%
Children/Parent Caretaker	**141,709**	54%	109,603	53%	32,106	58%
Expansion	**118,389**	45%	97,351	47%	21,038	38%
Insure OK	**3,219**	1%	1,249	1%	1,970	4%
OTHER (Partial Scope Dual &	**23**	0.01%	15	0.01%	8	0.01%
TOTAL	**263,572**		**208,418**		**55,154**	

PHE by Delivery System	TOTAL	Percent	REMAIN (Jun)	Percent	UNWOUND (Apr-May)	Percent
Choice	**162,289**	62%	134,066	64%	28,223	51%
Insure OK	**3,219**	1%	1,249	1%	1,970	4%
Traditional	**98,064**	37%	73,103	35%	24,961	45%
TOTAL	**263,572**		**208,418**		**55,154**	

PHE by TPL	TOTAL	Percent	REMAIN (Jun)	Percent	UNWOUND (Apr-May)	Percent
Major Medical	**32,002**	12%	20,464	10%	11,538	21%
No Major Medical	**231,570**	88%	187,954	90%	43,616	79%
TOTAL	**263,572**		**208,418**		**55,154**	

PHE by Dual Enrollment	TOTAL	Percent	REMAIN (Jun)	Percent	UNWOUND (Apr-May)	Percent
Dual Enrollees	**4,411**	2%	4,040	2%	371	1%

Non Dual Enrollees	**259,161**	98%		204,378	98%		54,783	99%
TOTAL	**263,572**			**208,418**			**55,154**	

PHE by FPL	**TOTAL**	Percent	**REMAIN (Jun)**	Percent	**UNWOUND (Apr-May)**	Percent
0-138%	**56,266**	21%	53,746	26%	2,520	5%
139-200%	**56,913**	22%	52,292	25%	4,621	8%
201-227%	**30,088**	11%	24,483	12%	5,605	10%
228% & Over	**120,300**	46%	77,894	37%	42,406	77%
No Poverty Data	**5**	0%	3	0%	2	0%
TOTAL	**263,572**		**208,418**		**55,154**	