OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
September 20, 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_Acp2RycHRwqoieeRVR1uOw
Telephone: 1-669-216-1590 Webinar ID: 161 923 9728

*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 July 17, 2023, OHCA Board Meeting Minutes……..…….Marc Nuttle, Chair

3. Chief Executive Officer Report……..Ellen Buettner, Chief Executive Officer

    a) Member Moment

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

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

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

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

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

6. Discussion of Report from the Compliance Advisory Committee and Possible Action……Kim Leland Member, 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 "C")

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

    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 "D")

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

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

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

    <u>The following EMERGENCY rules HAVE NOT previously been approved by the Board:</u>

        i. APA WF # 23-08 Non-Payment for Provider-Preventable Conditions
        ii. APA WF # 23-13 Secure Mental Health Transportation
        iii. APA WF # 23-15 Biosimilar Reimbursement
        iv. APA WF # 23-18 Twelve-Months Continuous Eligibility for Children in Medicaid and CHIP

9. Adjournment……Marc Nuttle, Chair

NEXT BOARD MEETING
December 7, 2023, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

MINUTES OF SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
July 17, 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 July 13, 2023 at 4:15 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 July 13, 2023 at 4:15 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 3:00 p.m.

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

ITEM 2 / PUBLIC COMMENT
Chairman Nuttle, OHCA Board Chairman

The following member of the public made public comment at the board meeting.

1. Jim Gebhart, speaking on behalf of the Oklahoma Hospital Association

ITEM 3 / DISCUSSION AND POSSIBLE VOTE ON THE JUNE 28, 2023, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION:	Vice-Chairman Yaffe moved for approval of the June 28, 2023, board meeting minutes, as published. The motion was seconded by Member Case.
FOR THE MOTION:	Chairman Nuttle, Vice Chairman Yaffe, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland
BOARD MEMBERS ABSENT:	Member Kennedy

ITEM 4 / 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 Rule:

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

i. APA WF # 23-17 Statewide Health Information Exchange (HIE) – Member Case read a letter from Senator John Haste into the record, which read:

OHCA Board Members and Administrative Rules Chair Case,

I write this letter in support of the Health Information Exchange emergency rules. As Senate author of SB 1369, I am appreciative of the steps the Oklahoma Health Care Authority has taken to implement this law to the best of their ability. ***The new rules allow for additional flexibility for providers and requires the agency to grant request exemptions,*** *and above all, it is the agency's role to implement the laws passed by the Legislature.*

The opportunity to improve coordination and address care fragmentation is significant for Oklahomans. ***This is why the Legislature also voted to provide funding for connection costs for providers.*** *My hope is that providers see the value of a statewide health information exchange for patient care, however if any provider seeks to be exempted from the requirements of SB 1369, the new rules*

allow it. ***I believe the HIE has the capacity to provide health care practitioners with information that can save lives across Oklahoma.***

Vice-Chairman Yaffe expressed his appreciation for the hard work of OHCA staff.

Member Case asked that Mr. Miller proceed to the podium to answer any questions the board may have. The Board did not have additional questions.

MOTION:	Member Cruzan motioned to approve the declaration of a compelling public interest for the promulgation of the emergency rule in item 4. The motion was seconded by Member Christ.
FOR THE MOTION:	Chairman Nuttle, Vice Chairman Yaffe, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland
BOARD MEMBERS ABSENT:	Member Kennedy
MOTION:	Vice-Chairman Yaffe moved to approve the rule listed in item 4a.i as published. The motion was seconded by Member Finch.
FOR THE MOTION:	Chairman Nuttle, Vice Chairman Yaffe, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland
BOARD MEMBERS ABSENT:	Member Kennedy

ITEM 5 / DISCUSSION OF REPORT FROM THE STRATEGIC PLANNING AND OPERATIONAL ADVISORY COMMITTEE

Marc Nuttle, Chair, Strategic Planning and Operational Advisory Committee

Chairman Nuttle provided a brief overview of the committee meeting that was held on July 12, 2023 and introduced CEO Corbett to provide an update on the Oklahoma Health Care Authority SB32x Hospital Disbursement Methodology. SB32x mandated OHCA to find a methodology working in concert with the Oklahoma Hospital Association to disperse $200 million. The team worked hard in considering all alternatives, considering all objectives that they thought should be considered, and recognized that not only all hospitals have found themselves in a financial distress, but some probably more than others. OHCA staff felt the need to consider the unique circumstances of a group of hospitals, while at the same time making sure that the hospitals received a fair and equitable share. The methodology being proposed would allow OHCA to disperse not $200 million, but $285 million. There are three ways of dispersing the money:

1. To allocate a portion of that $285 million to the largest group of hospitals on the basis of their percentage participation in the Medicaid program. OHCA also feels there is an opportunity to have a discretionary or a differentiated pool for those that probably have suffered a bit more from a financial standpoint than others. OHCA has suggested that it make an allocation of $25 million to that pool that they can be discretionary participants and receive the $25 million in addition to their share of the Medicaid payment pro rata share.
2. Make an allocation of $25 million to that pool that they can be discretionary participants and receive $25 million in addition to their share of the Medicaid payment pro rata share.
3. Carve out $25 million to allow OHCA to accelerate the amount of supplemental payments that is available to us by the move to Managed Care. To do that in an expeditious manner, at this point in time, OHCA would need to move the go-live date for SoonerSelect a quarter up as long as OHCA has the state share. That is the $25 million that will allow OHCA to bring in another $86 million and distributed to all hospitals on the basis of the ACR methodology that OHCA is proposing for CMS approval.

Meaning, OHCA will have the opportunity to distribute $175 million in a very expeditious way in August, and then the $25 million plus the new $86 million that comes with that would be distributed in April.

Mr. Corbett presented ballpark numbers for the distribution:

- All hospitals would receive 20% of the $200 million.
- For the hospitals that are not part of the differentiated $25 million pool, they will receive 27% of their Medicaid payments. This group is a small group of hospital, about 25 hospitals. The criteria to participate is on the basis that the hospital had a negative operating margin, as well as, have cash resources of less than 45 days on hand.
- Those that participate in the special pool, as well as their share of the distribution for Medicaid payments, will receive 45% of their Medicaid payments.

MOTION: Chairman Nuttle motioned to approve the methodology for the disbursement of $200 million, appropriated by the Legislature for the benefit of Oklahoma hospitals, as recommended by the Oklahoma Health Care Authority and developed in conjunction with the Statewide Hospital Association as directed by SB 32x. The methodology will create a pool of $25 million dispersed to vulnerable hospitals, allocate $150 million proportionally based on total Medicaid payments similar to the existing supplemental hospital offset payment program (SHOPP) methodology, utilize the remaining $25 million to draw down deferral matching funds that accelerate the implementation of a new Medicaid hospital payment program based on commercial reimbursement levels, pending approval from the Centers for Medicare and Medicaid Services (CMS). The methodology allows the agency to expand the initial funding pool and distribute over $285 million to qualifying Oklahoma hospitals. The motion was seconded by Member Leland.

FOR THE MOTION: Chairman Nuttle, Vice Chairman Yaffe, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland

BOARD MEMBERS ABSENT: Member Kennedy

ITEM 6 / CHIEF EXECUTIVE OFFICER'S REPORT
Kevin Corbett, Chief Executive Officer

CEO Corbett notified the Board that staff have concluded the selection of the members for the Quality Advisory Committee as part of SoonerSelect. An official announcement will be made as soon as staff confirm with each selected member of their willingness to serve. CEO Corbett also stated that this board meeting would be his last meeting as CEO of the Health Care Authority. Stating that he informed the Governor of his intent to resign his position as CEO effective July 31st, or until his successor is appointed.

ITEM 7 / 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 Christ moved to go into Executive Session. The motion was seconded by Vice-Chairman Yaffe.

FOR THE MOTION: Chairman Nuttle, Vice Chairman Yaffe, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland

BOARD MEMBERS ABSENT: Member Kennedy

MOTION: Vice-Chairman Yaffe moved to get out of Executive Session. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Nuttle, Vice Chairman Yaffe, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland

BOARD MEMBERS ABSENT: Member Kennedy

ITEM 8 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

MOTION: Member Case moved to adjourn. The motion was seconded by Member Christ.

FOR THE MOTION: Chairman Nuttle, Vice Chairman Yaffe, Member Case, Member Christ, Member Cruzan, Member Finch, Member Leland

BOARD MEMBERS ABSENT: Member Kennedy

Meeting adjourned at 4:07 p.m., 7/17/2023

NEXT BOARD MEETING

DRAFT

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

DRAFT

MEDICAID DIRECTOR UPDATE

SEPTEMBER 20, 2023

PUBLIC HEALTH EMERGENCY UNWINDING UPDATE

PHE UNWINDING UPDATE

- 150,535 Members unenrolled since May 1.
  - 95,739 of these have been procedural terminations
- Procedural terminations delayed for 30 days in June and July. 12,464 individuals retained eligibility due to this 30 day delay.
- Procedural terminations have gone from 87% in April to 30% in August.
- Targeted outreach to members identified for unwinding but who appear to still meet income requirements with a focus on families with children.
- July Unwinding Fast Facts

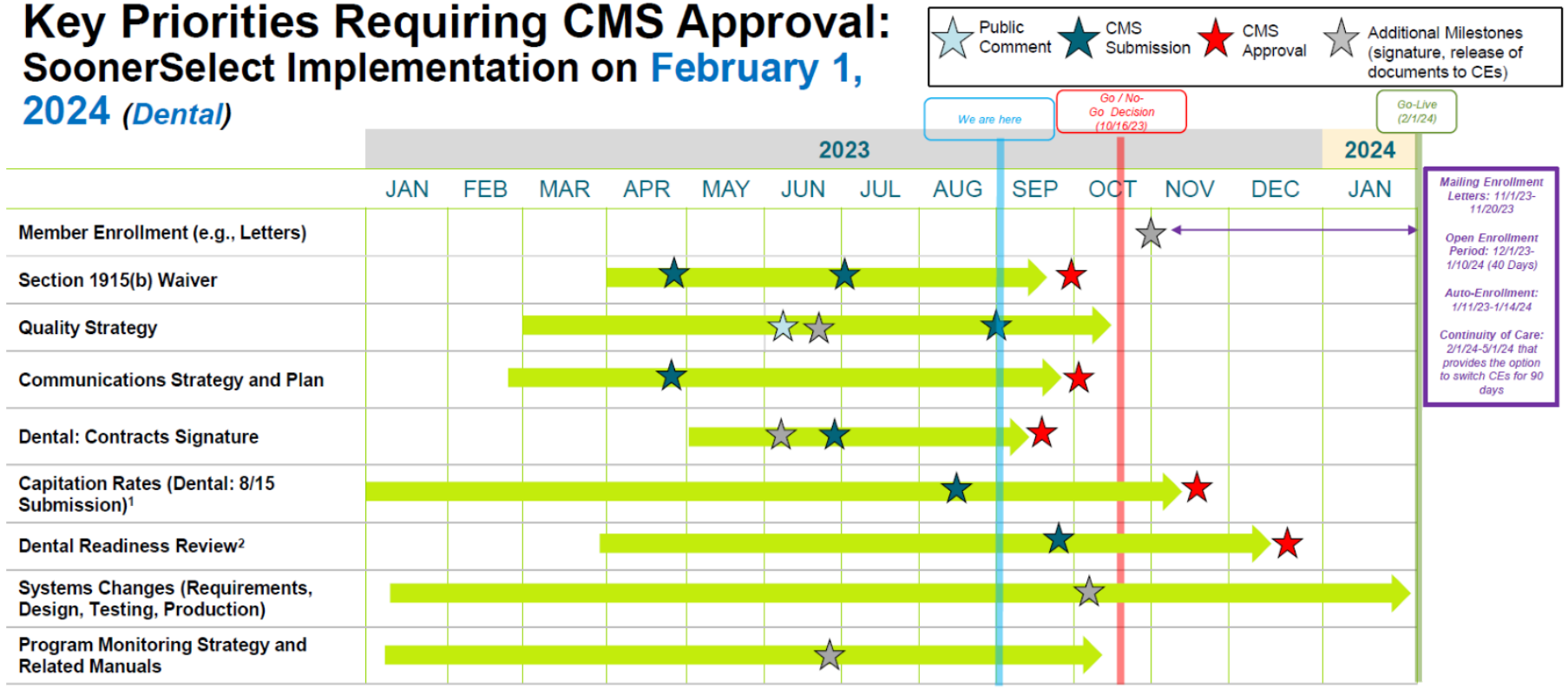
SOONERSELECT UPDATE

MILESTONES ACHIEVED

- ✓ Townhalls in Enid (40 attendees) and Oklahoma City (140 attendees). Next townhall scheduled in Tulsa September 22 at 10am (166 registered).
- ✓ Quality Strategy submitted to CMS
- ✓ Quality Advisory Committee announced, and first meeting held September 12
- ✓ On-site readiness review completed for LIBERTY Dental
- ✓ Trauma Level 1 state directed payment (SDP) preprint approved by CMS August 28.
- ✓ SHOPP SDP preprint submitted to CMS May 12
- ✓ 1915(b) waiver is going through final CMS approval clearance processes
- ✓ Enhanced payment for Oklahoma University Affiliated Professionals preprint submitted to CMS August 1.
- ✓ 78% Completion of desk readiness reviews for Medical and Specialty Plan.
- ✓ HIE Readiness checklist reviewed with SoonerSelect CEs and all are in the process of connecting.

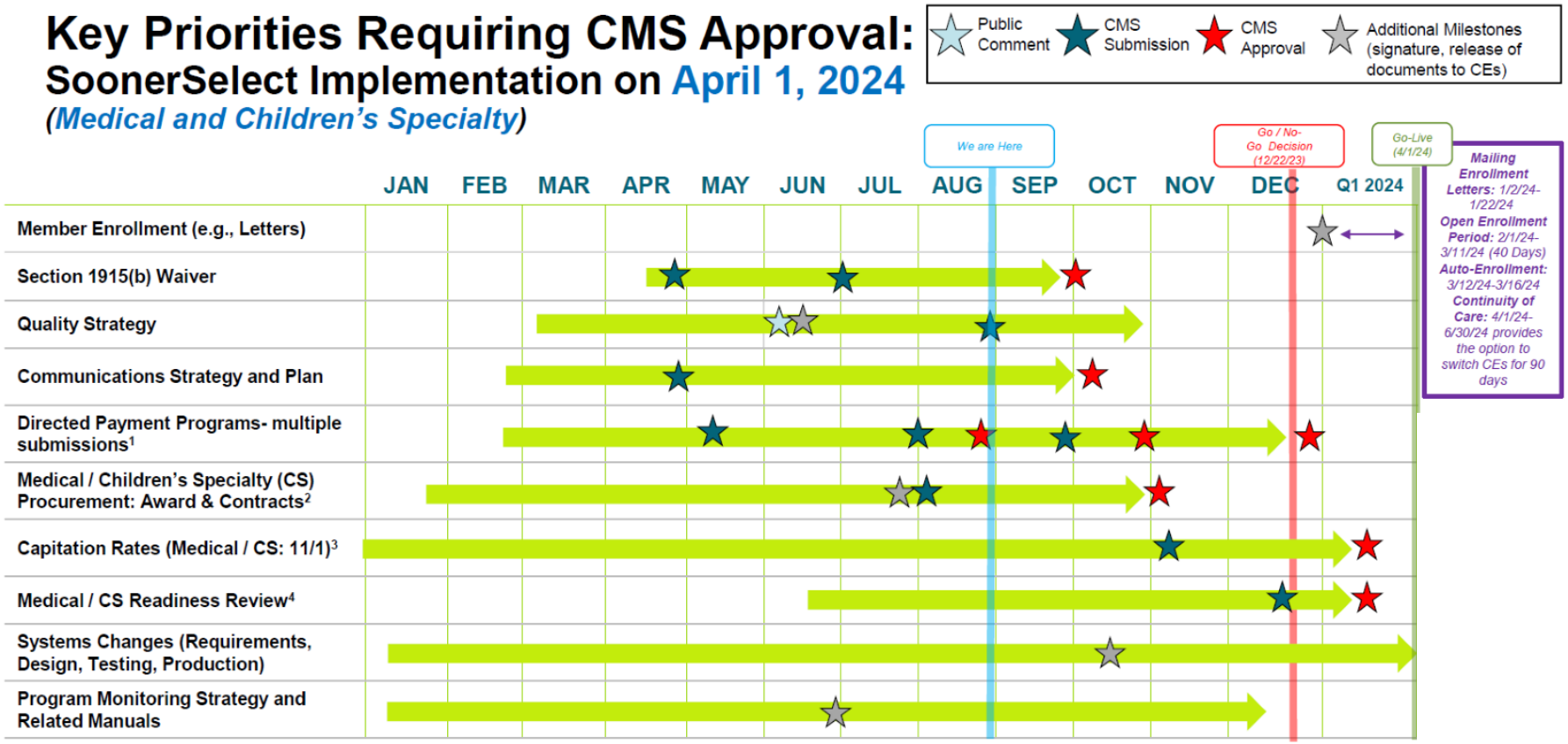
IMPORTANT MILESTONES DENTAL

Key Priorities Requiring CMS Approval: SoonerSelect Implementation on February 1, 2024 *(Dental)*



IMPORTANT MILESTONES MEDICAL AND CSP

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



WHAT'S ON THE HORIZON?

LOOKING FORWARD

- Increasing income threshold for SoonerPlan from 138% FPL to 205% FPL
- Continuous eligibility for children beginning January 1, 2024
- Monitoring CMS rulemaking regarding managed care, access to care and Home and Community Based Services
- Change in frequency of level of care determination for TEFRA members & adding provider types who can conduct TEFRA evaluations.
- Rate increases for inpatient psychiatric 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

Attachment B

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings –June 14, 2023 and July 12, 2023

Vote Item	Drug	Used for	Cost*	Notes
1	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. *Approximately 150 members might need therapy based on incidence of T1DM*	• $193,900 per 14-day course	• Used in stage 2 T1DM to delay onset of stage 3 T1DM in which the patient is symptomatic and hyperglycemic needing insulin therapy
2	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. Most often occurs in older adults. *Approximately 1,300 members might need therapy based on estimated incidence*.	• $30,660 per year	• Preserves retina function
3	Vivjoa® Ancobon®	• **Vulvovaginal Candidiasis:** VVC is an infection caused by yeast, *Candida albicans*. *6 members may qualify.* • **Systemic Fungal Infections:** An internal fungal infection such as sepsis, endocarditis, urinary tract infection, meningitis, etc. *5 members used in the last year*	• $2,808 per treatment • $1.000 per day	• Cheaper options available • Must be used in combination with other antifungal medication
4	Skyckarys™	• **Friedreich's ataxia:** FRDA is a rare inherited disease which causes progressive damage to the nervous system and movement problems. *Approximately 20 members may have diagnosis based on incidence*.	• $370,000 per year	• Approved for those 16 years and older

5	Filspari™	• **Primary Immunoglobulin A Nephropathy:** IgAN is a condition which damages the glomeruli inside the kidneys and can cause damage. *37 members with diagnosis*	• $118.800 per year	• Used to reduce protein in urine to slow kidney decline
6	Imjudo® Krazati®	• **Hepatocellular Carcinoma and Non-Small Cell Lung Cancer**: HCC is the most common type of primary liver cancer. NSCLC is the most common type of lung cancer. *284 members with HCC diagnosis; Approximately 832 members may have NSCLC diagnosis* • **NSCLC:** *Approximately 832 members may have NSCLC diagnosis*	• $39,000-$48,750 per single treatment based on diagnosis • $236,995 per year	• Must be used in combination with other medication • Not first line treatment
7	Altuviiio™ Hemgenix®	• **Hemophilia:** Hemophilia is a rare genetic bleeding disorder in which the blood does not clot properly. This can lead to problems with bleeding too much after an injury or surgery. Patients can also have sudden bleeding inside the body, such as in joints, muscles, and organs which can lead to long term complications. Some bleeding episodes can be life-threatening. There are several different types of hemophilia depending on the gene mutation. *Hemophilia A: 105 members with claims for treatment last year; Hemophilia B: 2 members eligible for gene therapy*	• $51,100 per 4 weeks • $3,500,000 per 1 lifetime treatment	• Factor VIII replacement for Hemophilia A • Gene therapy for Hemophilia B
8	Allopurinol 200mg Aponvie™	• **Gout:** Gout is a type of inflammatory arthritis that causes pain and swelling in your joints. *2,619 members with gout diagnosis* • **Postoperative Nausea and Vomiting:** *290 members with claims for cheaper form of the drug*	• $793 per 30 days • $54 per dose	• Cheaper options available • Cheaper options available

	Aspruzyo Sprinkle™	• **Chronic Angina:** Angina is chest pain which occurs when the heart is working hard enough to need more oxygen, such as during moderate or vigorous exercise or mental stress. The pain can go away when at rest. Angina is considered chronic when it is stable for at least 2 months. *2,007 with angina diagnosis*	• $498 per 30 days	• Cheaper options available
	Austedo® XR	• **Huntington's Disease:** HD is an inherited disorder that causes nerve cells (neurons) in parts of the brain to gradually break down and die. **Tardive Dyskinesia**: TD is a condition where the face, body or both make sudden, irregular movements which the patient cannot control. It can develop as a side effect of medication, most commonly antipsychotic drugs. *73 members with HD diagnosis; 401 members with TD diagnosis*	• $14,161 per 30 days	• Cheaper options available
	Ermeza™	• **Hypothyroidism**: Hypothyroidism happens when the thyroid doesn't create and release enough thyroid hormone into the body. This makes your metabolism slow down, affecting the entire body. *23,140 members with hypothyroidism diagnosis*	• $86 per 30 days	• Cheaper options available
	Furoscix®	• **Fluid Overload in Chronic Heart Failure:** When a patient has heart failure, the heart does not pump out enough blood. This causes fluids to build up in the body. *11,219 members with heart failure diagnosis*	• $6,576 per incident	• Cheaper options available
	Jylamvo®		• N/A	• Other treatment options available

	Primidone 125mg Verkazia® Xaciato™	• **Rheumatoid Arthritis:** RA is an autoimmune and inflammatory disease-causing inflammation (painful swelling) in the affected parts of the body especially in the joints which causes damage over time. *4,835 members with RA diagnosis* • **Seizure Disorder:** 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* • **Vernal Keratoconjunctivitis**: VKC is a seasonally recurring, bilateral, and severe form of allergic inflammation affecting the ocular surface. This relatively uncommon type of allergic eye disease can cause severe damage to the ocular surface, leading to corneal scarring and vision loss if not treated properly. *30 members with VKC diagnosis* • **Bacterial Vaginosis:** BV is caused by an imbalance of the bacteria normally present in the vagina. In women with BV, the normal healthy bacteria (in particular, lactobacilli) are replaced by an overgrowth of other mixed bacteria. *953 members had claims for treatment last year*.	• $134 per 30 days • $1,465 per 30 days • $150per treatment	• Cheaper options available • Cheaper options available • Cheaper options available

9	Daybue™	• **Rett Syndrome:** Rett syndrome is a neurodevelopmental disorder characterized by typical early growth and development, which is then followed by: a slowing of development, loss of mobility or function in the hands, distinctive hand movements, slowed brain and head growth, problems with walking, walking on the toes, or a wide-based gait, seizures, cognitive problems, digestive problems, trouble performing motor functions, including speaking and controlling eye movements (apraxia), breathing difficulties while awake, including breath holding, hyperventilation, and swallowing air. It effects almost exclusively females. The onset is usually around 7 to 18 months. *63 members with diagnosis of Rett Syndrome*	• $911,520 per year	• Only FDA approved treatment
10	Joenja®	• **Activated Phosphoinositide 3-kinase Delta Syndome:** APDS is an inherited condition that affects the way the immune system works. The most common symptoms of APDS are frequent upper respiratory tract infections, sinus infections, ear infections, bronchitis and pneumonia. Over time, frequent ear and respiratory tract infections can lead to permanent hearing loss and scarring of the lungs. *No members with this diagnosis in claims history. Estimated prevalence is 1-2 per 1 million people.*	• $540,000 per year	• Rare disease
11	Adstiladrin®	• **Non-Muscle Invasive Bladder Cancer:** NMIBC is where the cancer cells are only in the inner lining of the bladder. They have not grown through the inner lining and into the deeper muscle layer of the bladder. It is early in its	• $N/A	• Not first line

	Elahere™	development. *26 members with NMIBC diagnosis*. • **Ovarian, fallopian tube, and primary peritoneal cancer:** Ovarian epithelial, fallopian tube, and primary peritoneal cancers all form in the same kind of tissue and are treated in the same way. These cancers are often advanced at diagnosis. *353 members with any of these diagnoses*.	• $527,700 per year	• Not first line

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

Pharmacy Agenda Items

Recommendation 1: Vote to Prior Authorize Tzield®

The Drug Utilization Review Board recommends the prior authorization Tzield® (Teplizumab-mzwv) with the following criteria:

Tzield® (Teplizumab-mzwv) Approval Criteria:

1. An FDA approved diagnosis of stage 2 Type 1 diabetes mellitus (DM). Diagnosis must be confirmed by the following:
    a. Laboratory testing confirming the presence of ≥2 pancreatic islet autoantibodies; and
        i. Documentation must be submitted with results of autoantibody testing; and
    b. Documented evidence of dysglycemia without overt hyperglycemia as demonstrated by an abnormal oral glucose tolerance test (OGTT) meeting 1 of the following:
        i. Fasting plasma glucose ≥100mg/dL and <126mg/dL; or
        ii. 2-hour plasma glucose ≥140 mg/dL and <200mg/dL; or
        iii. 30-, 60-, or 90-minute value on OGTT ≥200mg/dL; and
2. Member must be 8 years of age or older; and
3. Prescriber must confirm that member's clinical history does not suggest a diagnosis of Type 2 DM; and
4. Tzield® must be prescribed by an endocrinologist (or an advanced care practitioner with a supervising physician who is an endocrinologist); and
5. All of the following will be required for initiation of treatment:
    a. Verification that female members of reproductive potential are not pregnant and are currently using reliable contraception; and
    b. Verification that the member has no active infection(s); and
    c. Complete blood counts (CBC) and verification that levels are acceptable to the prescriber; and
    d. Liver function tests and verification that levels are acceptable to the prescriber; and
    e. Verification that all age-appropriate vaccinations have been administered prior to treatment; and
    f. Prescriber must agree to premedicate the member for the first 5 days of dosing and as needed with a nonsteroidal anti-inflammatory drug (NSAID) or acetaminophen, an antihistamine, and/or an antiemetic; and
6. Tzield® must be administered by a health care professional. Approvals will not be granted for self-administration. Prior authorization requests must indicate how Tzield® will be administered; and
    a. Tzield® must be shipped via cold chain supply to the facility where the member is scheduled to receive treatment; or

   b. Tzield® 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 Tzield®; and
7. The member's recent body surface area (BSA) must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
8. A quantity limit of 28mL per 14 days will apply; and
9. Approvals will be for (1) 14-day cycle per member per lifetime.

Recommendation 2: Vote to Prior Authorize Syfovre™

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

Syfovre™ (Pegcetacoplan) Approval Criteria:

1. An FDA approved indication for the treatment of geographic atrophy (GA) secondary to dry age-related macular degeneration (AMD); and
2. Member must not have ocular or periocular infections or active intraocular inflammation; and
3. Syfovre™ must be prescribed and administered by an ophthalmologist, or a physician experienced in intravitreal injections; and
4. Prescriber must verify the member will be monitored for endophthalmitis, retinal detachment, increase in intraocular pressure, intraocular inflammation, and neovascular (wet) AMD; and
5. A quantity limit of (1) 0.1mL single-dose vial per eye every 25 to 60 days will apply.

Recommendation 3: Vote to Prior Authorize Vivjoa® and Ancobon®

The Drug Utilization Review Board recommends the prior authorization Vivjoa® (Oteseconazole) and Ancobon® (Flucytosine) with the following criteria:

Vivjoa® (Oteseconazole) Approval Criteria:

1. An FDA approved indication to reduce the incidence of recurrent vulvovaginal candidiasis (RVVC); and
2. Member must be a female who is not pregnant, not lactating, and not of reproductive potential; and
3. Member has a history of RVVC with at least 3 symptomatic episodes of acute vulvovaginal candidiasis (VVC) in the previous 12 months; and
4. Member has experienced a recurrence of VVC during or following 6 months of fluconazole-only maintenance treatment for RVVC or

member has a contraindication to fluconazole (e.g., hypersensitivity, drug-drug interactions); and
5. Prescriber must verify member will be monitored if taking breast cancer resistance protein (BCRP) substrates (e.g., rosuvastatin, mitoxantrone, methotrexate, topotecan, imatinib, irinotecan); and
6. A quantity limit of 18 capsules per 84 days will apply.

Ancobon® (Flucytosine) Approval Criteria:

1. An FDA approved indication for treatment of systemic fungal infections (e.g., sepsis, endocarditis, urinary tract infection, meningitis, pulmonary) caused by strains of Candida or Cryptococcus.

Recommendation 4: Vote to Prior Authorize Skyclarys™

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

Skyclarys™ (Omaveloxolone) Approval Criteria:

1. An FDA approved diagnosis of Friedreich's ataxia (FRDA); and
    a. Diagnosis must be confirmed by genetic testing identifying a mutation in the frataxin (FXN) gene; and
2. Member must be 16 years of age or older; and
3. Skyclarys™ must be prescribed by, or in consultation with, a neurologist (or an advanced care practitioner with a supervising physician who is a neurologist); and
4. Member must have a left ventricular ejection fraction of ≥40%; and
5. Member must not be taking concomitant strong or moderate CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin) or the prescriber must verify the dose of Skyclarys™ will be adjusted during concomitant use according to package labeling; and
6. Member must not be taking concurrent strong or moderate CYP3A4 inducers (e.g., rifampin, carbamazepine, phenytoin, St. John's wort, long-acting barbiturates, bosentan, efavirenz, etravirine); and
7. Member must not have severe hepatic impairment (Child-Pugh class C); and
8. Prescriber must verify liver function tests (LFTs) (e.g., ALT, AST, bilirubin) will be monitored prior to initiation of Skyclarys™ treatment, every month for the first 3 months of treatment, and periodically thereafter or as clinically indicated; and
9. Prescriber must verify that B-type natriuretic peptide (BNP) will be assessed prior to initiation of Skyclarys™ and cardiac function will be monitored as clinically indicated; and

10. Prescriber must verify lipid parameters will be monitored prior to initiation of Skyclarys™ treatment and periodically thereafter or as clinically indicated; and
11. Female members must not be pregnant, must have a negative pregnancy test prior to initiation of therapy, and must agree to use effective non-hormonal contraception during therapy and for 28 days after discontinuation of therapy; and
12. Approvals will be for the duration of 1 year. For each subsequent approval, the prescriber must document that the member is responding to the medication, as indicated by slower disease progression and/or other documentation of a positive clinical response to therapy; and
13. A quantity limit of 90 capsules per 30 days will apply.

Recommendation 5: Vote to Prior Authorize Filspari™

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

Filspari™ (Sparsentan) Approval Criteria:

1. An FDA approved indication to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression; and
2. The diagnosis of primary IgAN must be confirmed by the following:
    a. Kidney biopsy; and
    b. Secondary causes of IgAN have been ruled out (i.e., IgA vasculitis; IgAN secondary to virus, inflammatory bowel disease, autoimmune disease, or liver cirrhosis; IgA-dominant infection-related glomerulonephritis); and
3. Member must be 18 years of age or older; and
4. Must be prescribed by a nephrologist (or an advanced care practitioner with a supervising physician who is a nephrologist); and
5. Member must be at risk of rapid disease progression as demonstrated by ≥1 of the following, despite 3 months of maximal supportive care:
    a. Urine protein-to-creatinine (UPCR) ratio ≥1.5g/g; or
    b. Proteinuria >0.75g/day; and
6. Member must be on a stable dose of a maximally tolerated angiotensin convert enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB) for at least 3 months, unless contraindicated or intolerant; and
7. Prescriber must verify the member will discontinue use of renin-angiotensin-aldosterone system (RAAS) inhibitors and endothelinreceptor antagonists (ERAs) prior to initiating treatment with Filspari™; and

8. Member must not be taking strong CYP3A4 inhibitors (e.g., itraconazole) or strong CYP3A4 inducers (e.g., rifampin) concomitantly with Filspari™; and
9. Member must not be taking H2 receptor blockers or proton pump inhibitors (PPIs) concomitantly with Filspari™; and
10. If member is using antacids, they must agree to separate antacid and Filspari™ administration by 2 hours; and
11. Prescriber, pharmacy, and member must be enrolled in the Filspari™Risk Evaluation and Mitigation Strategy (REMS) program and maintain enrollment throughout therapy; and
12. A quantity limit of 30 tablets per 30 days will apply.

Recommendation 6: Vote to Prior Authorize Imjudo® and Krazati®

The Drug Utilization Review Board recommends the prior authorization of Imjudo® (Tremelimumab-actl) and Krazati® (Adagrasib) with the following criteria:

Imjudo® (Tremelimumab-actl) Approval Criteria [Hepatocellular Carcinoma (HCC) Diagnosis]:

1. Diagnosis of unresectable HCC; and
2. Used in combination with durvalumab; and
3. Will be approved for a maximum of 1 dose per treatment plan per member.

Imjudo® (Tremelimumab-actl) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of metastatic NSCLC; and
2. No epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), or ROS1 mutations; and
3. Used in combination with durvalumab and platinum-based chemotherapy; and
4. Will be approved for a maximum of 5 doses per treatment plan per member.

Krazati® (Adagrasib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of recurrent, advanced, or metastatic NSCLC; and
2. Presence of KRAS G12C mutation in tumor or plasma specimen as determined by an FDA approved test; and
3. Member has received at least 1 prior systemic therapy; and

4. As a single agent.

Recommendation 7: Vote to Prior Authorize Altuviiio™ and Hemgenix®

The Drug Utilization Review Board recommends the prior authorization of Altuviiio™ [Antihemophilic Factor (Recombinant), Fc-VMF-XTEN Fusion Protein-ehtl] and Hemgenix® (Etranacogene Dezaparvovec-drlb) with the following criteria:

Altuviiio™ [Antihemophilic Factor (Recombinant), Fc-VMF-XTEN Fusion Protein-ehtl] Approval Criteria:

1. An FDA approved indication; and
2. Requested medication must be prescribed by a hematologist specializing in rare bleeding disorders or a mid-level practitioner with a supervising physician that is a hematologist specializing in rare bleeding disorders; and
3. A patient-specific, clinically significant reason why the member cannot use the following must be provided:
    a. Hemophilia A: Advate® or current factor VIII replacement product; or
4. A half-life study must be performed to determine the appropriate dose and dosing interval; and
5. Initial approvals will be for the duration of the half-life study. If the half-life study shows significant benefit in prolonged half-life, subsequent approvals will be for the duration of 1 year.

Hemgenix® (Etranacogene Dezaparvovec-drlb) Approval Criteria:

1. Diagnosis of severe or moderately severe congenital, X-linked, hemophilia B; and
2. 2. Member must not have a history of an inhibitor or a recent positive screening, defined as ≥0.6 Bethesda units, prior to administration of etranacogene dezaparvovec-drlb; and
3. Member must not have an AAV5 neutralizing antibody titer >700; and
4. Member must be a male 18 years of age or older; and
5. Member must be on prophylactic therapy with continued frequent breakthrough bleeding episodes or has experienced a life-threatening bleeding episode; and
6. Member must have had >150 previous exposure days of treatment with factor IX; and
7. Member must not have active hepatitis B or C; and

8. Members with human immunodeficiency virus (HIV) must be controlled with antiviral therapy; and
9. Member must not have received prior treatment with any gene therapy for hemophilia B; and
10. Prescriber must perform baseline liver health assessment including:
    a. Enzyme testing (ALT, AST, ALP); and
    b. Hepatic ultrasound; and
11. Member's recent weight must be provided (taken within the last month) to ensure appropriate dosing; and
12. Must be prescribed by a hematologist practicing in a federally recognized Hemophilia Treatment Center (HTC) or mid-level practitioner under the supervision of a physician at an HTC; and
13. Must be administered in a clinical setting and monitoring performed for at least 3 hours post-infusion; and
14. Prescriber must monitor liver enzymes weekly for 3 months following administration of etranacogene dezaparvovec-drlb and continue monitoring until liver enzymes return to baseline; and
    a. Prescriber must agree to begin corticosteroids if indicated; and
15. Approvals will be for 1 dose per member per lifetime.

Recommendation 8: Vote to Prior Authorize Allopurinol 200mg, Aponvie™, Aspruzyo Sprinkle™, Austedo® XR, Ermeza™, Furoscix®, Jylamvo®, Primidone 125mg Tablet, Verkazia®, Xaciato™

The Drug Utilization Review Board recommends the prior authorization of Allopurinol 200mg Tablet, Aponvie™ (Aprepitant Injectable Emulsion), Aspruzyo Sprinkle™ [Ranolazine Extended-Release (ER) Granules], Austedo® XR (Deutetrabenazine ER Tablet), Ermeza™ (Levothyroxine Oral Solution), Furoscix® (Furosemide On-Body Infusor), Jylamvo® (Methotrexate Oral Solution), Primidone 125mg Tablet, Verkazia® (Cyclosporine Ophthalmic Solution), Xaciato™ (Clindamycin Vaginal Gel) with the following criteria:

Allopurinol 200mg Tablet Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use 2 allopurinol 100mg tablets in place of allopurinol 200mg must be provided.

Pharmacy Agenda Items

Aspruzyo Sprinkle™ [Ranolazine Extended-Release (ER) Granules] Approval Criteria:

1. An FDA approved diagnosis of chronic angina; and
2. A patient-specific, clinically significant reason why the member cannot use ranolazine ER tablets must be provided.

Austedo® XR [Deutetrabenazine Extended-Release (ER) Tablet] Approval Criteria [Huntington's Disease Diagnosis]:

1. An FDA approved diagnosis of chorea associated with Huntington's disease; and
2. Deutetrabenazine must be prescribed by a neurologist (or an advanced care practitioner with a supervising physician who is a neurologist); and
3. A previous trial of Xenazine® (tetrabenazine) or a patient-specific, clinically significant reason why the member cannot use Xenazine® (tetrabenazine) must be provided; and
4. Member must not be actively suicidal or have uncontrolled depression and prescriber must verify member will be monitored for depression prior to starting deutetrabenazine therapy and throughout treatment; and
5. Member must not have hepatic impairment; and
6. Member must not be taking monoamine oxidase inhibitors (MAOIs) or have taken an MAOI within the last 14 days; and
7. Member must not be taking reserpine or have taken reserpine within the last 20 days; and
8. Member must not use another vesicular monoamine transporter 2 (VMAT2) inhibitor (e.g., tetrabenazine, valbenazine) concurrently with deutetrabenazine; and
9. For members who are using deutetrabenazine concomitantly with other medications that are known to prolong the QTc interval [antipsychotic medications (e.g., chlorpromazine, haloperidol, thioridazine, ziprasidone), antibiotics (e.g., moxifloxacin), Class 1A (e.g., quinidine, procainamide) and Class III (e.g., amiodarone, sotalol) antiarrhythmic medications, or any other medications known to prolong the QTc interval] the prescriber must agree to monitor the member for symptoms of prolonged QTc interval (e.g., syncope, palpitations, seizures); and
10. Member must not have congenital long QT syndrome or a history of cardiac arrhythmias; and
11. The daily dose of deutetrabenazine must not exceed 36mg per day if the member is taking strong CYP2D6 inhibitors (e.g., paroxetine, fluoxetine, quinidine, bupropion) or if they are a known poor CYP2D6 metabolizer; and
12. Female members must not be pregnant or breastfeeding; and

13. Approvals will be for the duration of 6 months at which time the prescriber must document that the signs and symptoms of chorea have decreased, and the member is not showing worsening signs of depression.

Austedo® XR [Deutetrabenazine Extended-Release (ER) Tablet] Approval Criteria [Tardive Dyskinesia Diagnosis]:

1. An FDA approved diagnosis of tardive dyskinesia meeting the following DSM-5 criteria:
    a. Involuntary athetoid or choreiform movements; and
    b. History of treatment with dopamine receptor blocking agent (DRBA); and
    c. Symptom duration lasting longer than 4 to 8 weeks; and
2. Member must be 18 years of age or older; and
3. Deutetrabenazine must be prescribed by a neurologist or psychiatrist (or an advanced care practitioner with a supervising physician who is a neurologist or psychiatrist); and
4. Member must not have hepatic impairment; and
5. Member must not be taking monoamine oxidase inhibitors (MAOIs) or have taken an MAOI within the last 14 days; and
6. Member must not be taking reserpine or have taken reserpine within the last 20 days; and
7. Member must not use another vesicular monoamine transporter 2 (VMAT2) inhibitor (e.g., tetrabenazine, valbenazine) concurrently with deutetrabenazine; and
8. For members who are using deutetrabenazine concomitantly with other medications that are known to prolong the QTc interval [antipsychotic medications (e.g., chlorpromazine, haloperidol, thioridazine, ziprasidone), antibiotics (e.g., moxifloxacin), Class 1A (e.g., quinidine, procainamide) and Class III (e.g., amiodarone, sotalol) antiarrhythmic medications, or any other medications known to prolong the QTc interval] the prescriber must agree to monitor the member for symptoms of prolonged QTc interval (e.g., syncope, palpitations, seizures); and
9. Member must not have congenital long QT syndrome or a history of cardiac arrhythmias; and
10. The daily dose of deutetrabenazine must not exceed 36mg per day if the member is taking strong CYP2D6 inhibitors (e.g., paroxetine, fluoxetine, quinidine, bupropion) or if they are a known poor CYP2D6 metabolizer; and
11. Female members must not be pregnant or breastfeeding; and
12. Prescriber must document a baseline evaluation using the Abnormal Involuntary Movement Scale (AIMS); and

13. Approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment as indicated by an improvement from baseline in the AIMS total score (a negative change in score indicates improvement) or documentation of a positive clinical response to therapy.

Ermeza™ (Levothyroxine Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
    a. Hypothyroidism: As replacement therapy in primary (thyroidal), secondary (pituitary), and tertiary (hypothalamic) congenital or acquired hypothyroidism; or
    b. Pituitary Thyrotropin (thyroid-stimulating hormone, TSH) Suppression: As an adjunct to surgery and radioiodine therapy in the management of thyrotropin-dependent well-differentiated thyroid cancer; and
2. A patient-specific, clinically significant reason why the member cannot use all other formulations of levothyroxine including a reason why the member cannot use the levothyroxine tablet formulation, even when the tablets are crushed, must be provided; and
3. Prescriber must verify member has been compliant with levothyroxine tablets at a greatly increased dose for at least 8 weeks; and
4. Prescriber must verify that member has not been able to achieve normal thyroid lab levels despite a greatly increased dose and compliance with levothyroxine tablets.

Furoscix® (Furosemide On-Body Infusor) Approval Criteria:

1. An FDA approved indication for the treatment of congestion due to fluid overload in members with NYHA Class II-III heart failure; and
2. Member must be 18 years of age or older; and
3. Furoscix® must be prescribed by, or in consultation with, a cardiologist or a provider trained in managing acute decompensated heart failure (ADHF); and
4. Member is currently showing signs of fluid overload; and
5. Member has been stable and refractory to at least 1 of the following loop diuretics, at maximally indicated doses:
    a. Bumetanide oral tablets; or
    b. Furosemide oral tablets; or
    c. Torsemide oral tablets; and
6. Prescriber must verify the member will discontinue oral diuretics during the treatment with Furoscix® and will transition back to oral diuretic maintenance therapy when practical; and

7. Prescriber must verify the member is stable and suitable for at-home treatment with Furoscix®, as determined by:
    a. Oxygen saturation ≥90% on exertion; and
    b. Respiratory rate <24 breaths per minute; and
    c. Resting heart rate <100 beats per minute; and
    d. Systolic blood pressure >100mmHg; and
8. Member must have an adequate environment for at-home administration and have been trained on the proper use of Furoscix®; and
9. Member must have a creatinine clearance (CrCl) >30mL/min or an estimated glomerular filtration rate (eGFR) >20mL/min/1.73m2 and no evidence of acute renal failure; and
10. Member must not have any contraindications for use of Furoscix® including anuria, hepatic cirrhosis, or ascites; and
11. Member must not have acute pulmonary edema or other conditions that require immediate hospitalization; and
12. Approvals will be issued per incident of fluid overload; and
13. Reauthorization is not permitted. A new prior authorization request must be submitted, and the member must meet all initial approval criteria for each incident of fluid overload.

Jylamvo® (Methotrexate Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
    a. Acute lymphoblastic leukemia (ALL) as part of a combination chemotherapy maintenance regimen; or
    b. Mycosis fungoides (cutaneous T-cell lymphoma) as a single agent or as part of a combination chemotherapy regimen; or
    c. Relapsed or refractory non-Hodgkin lymphomas as part of a metronomic combination chemotherapy regimen; or
    d. Rheumatoid arthritis; or
    e. Severe psoriasis; and
2. Member must be 18 years of age or older; and
3. A patient-specific clinically significant reason why the oral tablets and the generic injectable formulation cannot be used must be provided.

Primidone 125mg Tablet Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific clinically significant reason why the member cannot split the 250mg tablet to achieve the 125mg dose must be provided.

Verkazia® (Cyclosporine 0.1% Ophthalmic Emulsion) Approval Criteria:

1. An FDA approved indication of vernal keratoconjunctivitis (VKC); and
2. Member has had 1 recurrence of VKC in the last year; and
3. Verkazia® must be prescribed by, or in consultation with, an allergist, optometrist, or ophthalmologist (or an advanced care practitioner with a supervising physician who is an allergist, optometrist, or ophthalmologist); and
4. Prescriber must verify that environmental factors (e.g., sun, wind, salt water) have been addressed; and
5. Member must have a trial of a topical mast cell stabilizer, antihistamine, or combination product or a patient-specific, clinically significant reason why those products are not appropriate must be provided; and
6. A patient-specific, clinically significant reason why the member cannot use cyclosporine 0.05% ophthalmic emulsion single-use vials, which are available without a prior authorization, must be provided; and
7. A quantity limit of 120 single-use vials per 30 days will apply.

Xaciato™ (Clindamycin Vaginal Gel) Approval Criteria:

1. An FDA approved diagnosis of bacterial vaginosis; and
2. A patient specific, clinically significant reason why the member cannot use clindamycin 2% vaginal cream, Clindesse® (clindamycin phosphate 2% vaginal cream), and Cleocin® vaginal ovules (clindamycin phosphate 2.5g vaginal suppositories), which are available without a prior authorization, must be provided.

Recommendation 9: Vote to Prior Authorize Daybue™

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

Daybue™ (Trofinetide) Approval Criteria:

1. Diagnosis of typical Rett syndrome confirmed by all of the following:
    a. Prescriber must verify all clinical diagnostic criteria are met supporting a diagnosis of typical Rett syndrome including:
        i. A period of regression followed by recovery or stabilization; and
        ii. Partial or complete loss of acquired purposeful hand skills; and
        iii. Partial or complete loss of acquired spoken language; and
        iv. Gait abnormalities (impaired/dyspraxic or absence of ability); and

v. Stereotypic hand movements (e.g., hand wringing/squeezing, clapping/tapping, mouthing, washing/rubbing automatisms); and
vi. Lack of brain injury secondary to trauma (peri- or postnatally), neurometabolic disease, or severe infection causing neurological problems; and
vii. Lack of grossly abnormal psychomotor development in the first 6 months of life; and

b. Genetic testing documenting a disease-causing mutation in the MECP2 gene (results of genetic testing must be submitted); and

2. Member must be 2 years of age or older; and
3. Daybue™ must be prescribed by a geneticist, neurologist, or other specialist with expertise in the treatment of Rett syndrome; and
4. Prescriber must agree to counsel members and caregivers on the risks of diarrhea and weight loss associated with Daybue™ and agree to monitor appropriately for these adverse effects; and
5. Prescriber must agree to counsel members and caregivers on proper storage and administration of Daybue™, including the use of a calibrated device for measuring each dose; and
6. Prescriber must verify the member does not have moderate or severe renal impairment; and
7. Member's current weight (kg) taken within the past 3 weeks must be provided on initial and subsequent prior authorization requests to ensure accurate weight-based dosing according to package labeling; and
8. Initial approvals will be for a duration of 3 months. After 3 months of treatment, further approval may be granted if the prescriber documents the member is responding well to treatment. Subsequent approvals will be for a duration of 1 year; and
9. A quantity limit of 3,600mL per 30 days will apply.

Recommendation 10: Vote to Prior Authorize Joenja®

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

Joenja® (Leniolisib) Approval Criteria:

1. An FDA approved diagnosis of activated phosphoinositide 3-kinase (PI3K) delta syndrome (APDS). Diagnosis must be confirmed by the following:
    a. Genetic testing identifying a documented pathogenic variant in either the PIK3CD or PIK3R1 gene (results of genetic testing must be submitted); and

2. Member must be 12 years of age or older and weigh ≥45kg; and
3. Joenja® must be prescribed by, or in consultation with, an immunologist, geneticist, or a specialist with expertise in treatment of APDS; and
4. Female members of reproductive potential must not be breastfeeding, must have a negative pregnancy test prior to initiation, and must agree to use effective contraception during treatment and for 1 week after the final dose of Joenja®; and
5. Member must not have moderate to severe hepatic impairment (ChildPugh class B or C); and
6. Member must not be taking any of the following medications concomitantly with Joenja®:
    a. Strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, clarithromycin); and
    b. Strong or moderate CYP3A4 inducers (e.g., rifampin, carbamazepine, phenytoin, St. John's wort, phenobarbital, primidone); and
    c. CYP1A2 metabolized drugs with a narrow therapeutic range (e.g., tizanidine, theophylline); and
    d. OATP1B1/3 substrates (e.g., statins, bosentan, glyburide, nateglinide, repaglinide, methotrexate, furosemide); and
    e. BCRP transporter substrates (e.g., sulfasalazine, ubrogepant, tenofovir); and
7. Initial approvals will be for the duration of 3 months. Further approval may be granted if the prescriber documents the member is responding well to treatment; and
8. A quantity limit of 60 tablets per 30 days will apply.

Recommendation 11: Vote to Prior Authorize Adstiladrin® and Elahere™

The Drug Utilization Review Board recommends the prior authorization of Adstiladrin® (Nadofaragene Firadenovac-vncg) and Elahere™ (Mirvetuximab Soravtansine-gynx) with the following criteria:

Adstiladrin® (Nadofaragene Firadenovec-vncg) Approval Criteria [Non-Muscle Invasive Bladder Cancer (NMIBC) Diagnosis]:

1. Diagnosis of NMIBC with carcinoma in situ (CIS) with or without papillary tumors; and
2. High-risk disease that was unresponsive to prior Bacillus Calmette-Guérin (BCG) therapy.

Pharmacy Agenda Items

Elahere™ (Mirvetuximab Soravtansine-gynx) Approval Criteria [Ovarian, Fallopian Tube, or Primary Peritoneal Cancer Diagnosis]:

1. Diagnosis of platinum-resistant epithelial ovarian, fallopian tube, or primary peritoneal cancer; and
2. Tumor is folate receptor alpha (FRα) positive; and
3. Member has received 1 to 3 prior systemic treatment regimens.

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OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

ADVANTAGE WAIVER – REMOTE SUPPORTS SERVICES 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 Community Living, Aging and Protective Services (CAP) division of Oklahoma Human Services is seeking to increase the rate for the Remote Supports Service provided under the ADvantage waiver. The ADvantage Waiver remote supports services have not kept pace with commensurate services provided by other 1915(c) waivers. This request is to increase the reimbursement rate for remote supports services to match corresponding rates through other Oklahoma waivers.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Remote Supports service rates are set by fixed, uniform rates, established through the State Plan Amendment Rate Committee process.

Service	Service Code	Unit Type	Current Rate	New Rate
Remote Support services with paid emergency response staff	T1019-TG	15-min	$2.62	$3.28
Remote Support services with unpaid emergency response staff	T1019-U1	15-min	$1.75	$1.81

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   This proposed request is to increase the reimbursement rate for remote supports services through the ADvantage Waiver to match corresponding rates for the same services through the Developmental Disabilities Services (DDS) waivers. Oklahoma Waivers will reimburse for remote supports services at the same rates. This will eliminate competition among waivers for service providers.

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY 2024 will be an increase. For 9 months the total amount of $547,312.50; with a 32.47% state share of the total or $177,712.37 in state share.
OHS 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.**
Oklahoma Waivers will reimburse for remote supports services at the same rates. This will eliminate competition among waivers for service providers.
Remote Supports services encourage independence, the promotion of member rights, the dignity of risk, and a member-centered level of health and safety oversight while decreasing reliance on in-person staffing. The increase in the service rate may increase Members' access to care to for this service.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
Oklahoma Human Services requests the State Plan Amendment Rate Committee approve the request for implementation of Remote Supports services rate increase for the ADvantage waiver

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

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

RATE INCREASES FOR ACUTE AND ACUTE II BEHAVIORAL HEALTH FACILITIES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   In response to provider feedback and based on cost information and regional comparisons, ODMHSAS seeks to implement rate increases for freestanding psychiatric hospitals paid on a per diem basis (Acute level of care). ODMHSAS also seeks to restore the 15% rate reduction for Acute II facilities implemented in 2016 and add a 5% increase to the restored rate.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current per diem rate for freestanding psychiatric hospitals is $596.91. The current per diem rate for Acute II facilities is $293.29.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The new proposed per diem rate for freestanding psychiatric hospitals is $664.91. The new proposed per diem rate for Acute II facilities is $362.30.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY24 (Oct-June) is $9,592,050 total/$2,264,233 state share. The estimated budget impact for SFY25 is $12,789,400 total/$3,018,978 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 increases support the Acute/Acute II provider network.

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

The ODMHSAS requests the SPARC to approve the proposed rate increases for freestanding psychiatric hospitals paid on a per diem (Acute level of care) and Acute II facilities.

9. **EFFECTIVE DATE OF CHANGE.**
October 1, 2023, contingent upon CMS approval

Attachment D.i

SUBMITTED TO THE C.E.O. AND BOARD ON SEPTEMBER 20, 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	Technology Services for Health Information Exchange
Purpose and Scope	The contract establishes a collaborative framework between the Contractor and the Oklahoma Health Care Authority for the provision of Health Information Exchange (HIE) technology services. This Contract serves to ensure seamless continuity of services following the termination of a prior contract until such time that services can be rebid.
Mandate	SB 574 and SB 1369
Procurement Method	Sole Source
External Approvals	N/A
Contract Term	Date of signature through June 30, 2024

BUDGET

Amount requested for Approval	$3,552,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	0%

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 HIE technology services for one (1) year for a total not-to-exceed of $3,552,000.00.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON SEPTEMBER 20, 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 Monitoring and Compliance
Purpose and Scope	OHCA will transition to a new healthcare delivery system, called SoonerSelect, following Governor J. Kevin Stitt's signing of reform bills SB 1337 and SB 1396. Oklahoma Health Care Authority (OHCA) is issuing this Request for Proposal (RFP) seeking submissions from qualified Bidders for Monitoring and Compliance Services to assist in the post-transition to the new healthcare delivery system. OHCA will look toward the Contractor for leadership and expertise in assisting OHCA personnel with day-to-day functionalities during the beginning stages of the Contract. OHCA is expecting to become self-sufficient through on-the-job training and support documentation provided by the Contractor. Additionally, routine reporting, capturing, and analyzing data from Contracted Entities (CEs) is expected to be relayed to OHCA leadership on a regular basis through dashboarding and other methodologies determined appropriate between OHCA and Contractor.
Mandate	N/A
Procurement Method	Competitive Bid
External Approvals	OMES and CMS
Contract Term	Date of award through June 30, 2026 with two (2) options to renew

BUDGET

Amount requested for Approval	$15,000,000.00
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 services for managed care monitoring and compliance with a three (3) year base agreement and two (2) renewal options totaling five (5) service years with a total not-to-exceed of $15,000,000.00

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 days without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by either $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

SUBMITTED TO THE C.E.O. AND BOARD ON SEPTEMBER 20, 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	Consultant Services
Purpose and Scope	Additional funding is requested for the remainder of the contract term of the Consulting Contracts. The awarded contract is currently with four contractors to provide consulting services on various policy, contracting, audit and rate-setting issues. The OHCA looks to these contractors to provide expert opinions, recommendations, and information relevant to the SoonerCare program. The contractor performs comprehensive analysis, feasibility, determination of budget impact, and evaluation of current and potential OHCA initiatives and programs. The current environment requires more data-driven decision making and independent evaluation of performance and costs, therefore resulting in a greater need for these services. • Analyze impact of policy changes on cost, access, and quality of services • Develop state plan amendments or waivers as needed • Evaluate OHCA programs and recommend improvements • Provide financial services including budget neutrality calculations, actuarial certifications, cost impacts, program feasibility, return on investment, long-term financial management, and rate setting for new or existing services • Assess data vulnerability and provide gap analysis of available data versus needed data • Evaluation of SoonerCare Health Management Program and Chronic Care Unit, SoonerCare Waiver, SoonerCare Choice Reform, and SPARK! • Provide reports and presentations as necessary on the above issues
Mandate	N/A
Procurement Method	Competitive bid
External Approvals	N/A
Contract Term	September 1, 2019 through June 30, 2020 with six (6) options to renew

BUDGET

Amount requested for Approval	$13,000,000.00
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 Consulting Services Contracts as described above for a total increase of funding not-to-exceed of $13,000,000.00.

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 days without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by either $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

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SUBMITTED TO THE C.E.O. AND BOARD ON SEPTEMBER 20, 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	Connection Fee Reimbursement for Health Information Exchange (HIE)
Purpose and Scope	The Connection Fee Reimbursement initiative aims to financially support healthcare providers in their transition to the Health Information Exchange (HIE) system. By offsetting the one-time interoperability connection fees, OHCA seeks to encourage widespread adoption of the HIE, ensuring seamless and efficient health data exchange across the state.
Mandate	2023 SB 32X
Procurement Method	Sole Source Contract
External Approvals	N/A
Contract Term	Date of signature through June 30, 2024

BUDGET

Amount requested for Approval	$3,840,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	0%

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 allocate funds for the reimbursement of HIE provider connection fees for one (1) year, with a total not exceeding $3,840,000.00.

Additional Information

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

September 2023 Board
Proposed Rule Amendment Summaries

The Agency is requesting ***EMERGENCY*** approval of the following rule revisions with a proposed effective date of immediately upon Governor's approval or Jan. 1, 2024.

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

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

APA WF # 23-08 Non-Payment for Provider-Preventable Conditions — These emergency revisions are necessary to avoid violation of Section 2702 of the Affordable Care Act that requires state Medicaid agencies to deny payment for a provider-preventable conditions as identified at 42 CFR 447.26. Policy revisions will update the list of conditions that the agency will deny payment for and detail the reporting process for providers. These emergency revisions are also necessary to protect the public health, safety, and/or welfare as they protect Medicaid beneficiaries by prohibiting payments for services related to provider-preventable conditions.

Budget Impact: Budget Neutral

APA WF # 22-13 Secure Mental Health Transportation — These emergency revisions are necessary to avoid violation of state law at Title 43A Oklahoma Statutes (O.S.) § 1-110 and are necessary to protect the public health, safety, and/or welfare. The proposed additions implement secure mental health transportation as a covered benefit for SoonerCare members. Policy will define the service as secure transportation to a facility arranged by a Qualified Transportation Service Provider (QTSP) for the appropriate, medically necessary services to treat members experiencing a behavioral health crisis. Rules will include the specific contracted with the Oklahoma Department of Mental Health & Substance Abuse Services (ODMHSAS) requirements including for, eligible providers (driver/contractor), member program eligibility, covered services, and the distance that will be taken into consideration when transporting members. Finally, additions will state that reimbursement for secure mental health transportation is outlined in the Oklahoma Medicaid State Plan.

Budget Impact: The estimated budget impact, for SFY2024, will be an increase in the total amount of $6,153,652; with $1,939,170 in state share. The estimated budget impact, for SFY2025 will be an increase in the total amount of $6,153,652; with $1,939,170 in state share.

APA WF # 23-15 Biosimilar Reimbursement — These emergency revisions are necessary to avoid violation of federal law at 42 USC 1395w (Section 11403 of the Inflation Reduction Act of 2022). The proposed additions align reimbursement for certain biosimilar products with the Medicare Part B fee schedule. The Inflation Reduction Act (2022) included a provision directing Medicare Part B to increase reimbursement for certain biosimilar products from Average Sales Price (ASP) + 6% to ASP + 8%. Based on CMS guidance, policy will be amended to replace specific references to ASP + 6% with language indicating payment will match the Medicare Part B fee schedule.

Budget Impact: The estimated budget impact, for SFY2023, will be an increase in the total amount of $200,320; with $45,353 in state share. The estimated budget impact, for SFY2024 will be an increase in the total amount of $600,691; with $189,378 in state share.

APA WF # 23-18 Twelve-Months Continuous Eligibility for Children in Medicaid and CHIP — These emergency revisions are necessary to protect the public health, safety, and/or welfare and to avoid violation of federal law at Public Law 117-328. Rules will implement twelve-month continuous eligibility for children in Medicaid and Children's Health Insurance Program (CHIP).

Budget Impact: The estimated total cost for SFY 2024 is $4,463,262 ($3,056,776 in federal share and $1,406,485 in state share). The estimated total cost for SFY 2025 is $54,941,044 ($37,353,042 in federal share and $17,588,002 in state share).

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-62. ~~Serious reportable events - never events~~ Provider Preventable Conditions

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

~~(1) **"Surgical and other invasive procedures"** are defined as operative procedures in which skin or mucous membranes and connective tissues are incised or an instrument is introduced through a natural body orifice. Invasive procedures include a range of procedures from minimally invasive dermatological procedures (biopsy, excision, and deep cryotherapy for malignant lesions) to extensive multi-organ transplantation. They include all procedures described by the codes in the surgery section of the Current Procedural Terminology (CPT) and other invasive procedures such as percutaneous transluminal angioplasty and cardiac catheterization. They include minimally invasive procedures involving biopsies or placement of probes or catheters requiring the entry into a body cavity through a needle or trocar. They do not include use of instruments such as otoscopes for examinations or very minor procedures such as drawing blood.~~

~~(2) A surgical or other invasive procedure is considered to be the wrong procedure if it is not consistent with the correctly documented informed consent for that member.~~

~~(3) A surgical or other invasive procedure is considered to have been performed on the wrong body part if it is not consistent with the correctly documented informed consent for that member including surgery on the right body part, but on the wrong location on the body; for example, left versus right (appendages and/or organs), or at the wrong level (spine).~~

~~(4) A surgical or other invasive procedure is considered to have been performed on the wrong member if that procedure is not consistent with the correctly documented informed consent for that member.~~

~~(b) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs (1) a different procedure altogether; (2) the correct procedure but on the wrong body part; or (3) the correct procedure but on the wrong member. SoonerCare will not cover hospitalizations or any services related to these non-covered procedures. All services provided in the operating room when an error occurs are considered related and therefore not covered. All providers in the operating room when the error occurs, who could bill individually for their services, are also not eligible for payment. All related services provided during the same hospitalization in which the error occurred are not covered. A provider cannot shift financial liability or responsibility for the non-covered services to the member if the OHCA has determined that the service is related to one of the above erroneous surgical procedures.~~

~~(c) **Billing.** For inpatient claims, hospitals are required to bill two claims when the erroneous surgery is reported, one claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable HCPCS~~

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~~modifiers to all lines related to the erroneous surgery. Claim lines submitted with one of the applicable HCPCS modifiers will be line-item denied.~~

~~(d) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an 18-month period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.~~

~~(e) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned erroneous surgery(s).~~

~~(f) **Hospital acquired conditions.** SoonerCare will not reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. See OAC 317:30-3-63 for specific information regarding hospital acquired conditions.~~

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

(1) "**Health care-acquired conditions (HCAC)**" means a condition occurring in any inpatient hospital setting, (identified as a hospital acquired condition by federal regulation and Medicare; other than deep vein thrombosis/pulmonary embolism as related to a total knee replacement or hip replacement surgery in pediatric and obstetric patients.) Medicare's list of hospital acquired conditions is also available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html.

(2) "**National Quality Forum (NQF)**" means the independent, nonpartisan organization tasked with devising a national strategy to set standards for quality improvement and reporting in the healthcare industry.

(3) "**Other provider preventable conditions (OPPC)**" means the list of serious reportable events in health care as identified by this Section and published by the NQF.

(4) "**Present on admission (POA) indicator"** means a status code the hospital uses on an inpatient claim that indicates if a condition was present at the time the order for inpatient admission occurs.

(5) "**Provider preventable condition (PPC)**" means a condition that meets the definition of a "health care-acquired condition" or an "other provider-preventable condition" as defined in this Section.

(b) **Health care-acquired conditions (HCAC).**

(1) **Payment policy**. In accordance with 42 C.F.R § 447.26, the Oklahoma Health Care Authority (OHCA) will not reimburse health care professionals and inpatient hospitals for the increased incremental cost of inpatient care services that result when a member is harmed by one (1) of the HCACs listed below.

(A) Foreign object retained after surgery;

(B) Air embolism;

(C) Blood incompatibility;

(D) Pressure ulcer stages III & IV;

(E) Falls and trauma; including:

(i) Fracture;

(ii) Dislocation;

(iii) Intracranial injury;

(iv) Crushing injury;

(v) Burn;

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(vi) Electric shock;

(F) Catheter-associated urinary tract infection;

(G) Vascular catheter-associated infection;

(H) Manifestations of poor glycemic control; including:

(i) Diabetic ketoacidosis;

(ii) Nonketotic hyperosmolar coma;

(iii) Hypoglycemic coma;

(iv) Secondary diabetes with ketoacidosis;

(v) Secondary diabetes with hyperosmolarity;

(I) Surgical site infection following:

(i) Coronary artery bypass graft-mediastinitis;

(ii) Bariatric surgery; including:

(I) Laparoscopic gastric bypass;

(II) Gastroenterostomy;

(III) Laparoscopic gastric restrictive surgery;

(iii) Orthopedic procedures; including:

(I) Spine;

(II) Neck;

(III) Shoulder;

(IV) Elbow;

(iv) Cardiac implantable electronic device (CIED)

(J) Deep vein thrombosis and pulmonary embolism following:

(i) Total knee replacement with exceptions for pediatric and/or obstetric cases; or

(ii) Hip replacement with exceptions for pediatric and/or obstetric cases.

(K) Iatrogenic pneumothorax with venous catheterization

(2) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a POA indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator. If a provider in either a fee-for-service or managed care delivery system receives SoonerCare reimbursement for the increased incremental cost of inpatient care services that result when a member is harmed by the HCACs identified in (b)(1) (A)-(K), the provider shall reimburse those costs to the Agency or Contracted Entity.

(3) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of HCACs.

(c) **Other provider preventable condition (OPPC)**

(1) **Payment policy.** In accordance with 42 C.F.R § 447.26, the Agency will not reimburse health care professionals and inpatient hospitals for care related to the treatment of consequences of an OPPC when the condition:

(A) Is identified in the Oklahoma Medicaid State Plan;

(B) Has been found by the State, based upon a review of medical literature by qualified professionals, to be reasonably preventable through the application of procedures supported by evidence-based guidelines;

(C) Is within the control of the hospital;

(D) Has a negative consequence for the member;

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(E) Is auditable; and

(F) Is included on the list of serious reportable events in health care by the National Quality Forum (NQF). Providers are responsible for keeping abreast of any changes to the list of serious reportable events identified by the NQF. The list of serious reportable events in health care, as of the publishing of this rule, includes surgical or invasive procedure events:

(i) Surgical or other invasive procedure performed on the wrong site;

(ii) Surgical or other invasive procedure performed on the wrong patient;

(iii) Wrong surgical or other invasive procedure performed on a patient;

(2) **Billing.** For inpatient claims, hospitals are required to bill two (2) claims when the erroneous surgery is reported, one (1) claim with covered services or procedures unrelated to the erroneous surgery, the other claim with the non-covered services or procedures as a no-payment claim. For outpatient and practitioner claims, providers are required to append the applicable Healthcare Common Procedure Coding System (HCPCS) modifiers to all lines related to the erroneous surgery. Claim lines submitted with one (1) of the applicable HCPCS modifiers will be line-item denied. If a provider in either a fee-for-service or managed care delivery system receives SoonerCare reimbursement for patient care or treatment directly related to an identifiable provider-preventable condition that was not present when the individual initiated treatment with that provider, the provider shall reimburse those costs to the Agency or Contracted Entity.

(3) **Related claims.** Once a claim for the erroneous surgery(s) has been received, OHCA may review member history for related claims as appropriate. Incoming claims for the identified member may be reviewed for an eighteen-month (18-month) period from the date of the surgical error. If such claims are identified to be related to the erroneous surgical procedure(s), OHCA may take appropriate action to deny such claims and recover any overpayments on claims already processed.

(4) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of OPPCs.

(d) **Reporting.** Title 42 of the Code of Federal Regulations, Sections 447, 434 and 438 require providers, in both fee-for-service and managed care delivery systems, to report all PPCs that are associated with claims for SoonerCare payment or with courses of treatment furnished to a SoonerCare member for which Medicaid payment would otherwise be available. The report shall be made to the OHCA regardless of whether the provider seeks SoonerCare reimbursement for services to treat the PPCs. The Agency report form is available for download at https://oklahoma.gov/ohca. Providers must report the following information to the OHCA within 10 days of the occurrence of the event:

(1) Member name and member ID number.

(2) A description of the event.

(3) Dates of services and occurrence of the event.

(4) Attending physician(s).

(5) Facility.

(e) **Liability.** A provider cannot shift financial liability or responsibility for the non-covered services and treatment to the member if the OHCA has determined that the service is related to a PPC.

317:30-3-63. Hospital acquired conditions [REVOKED]

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(a) **Coverage.** The Oklahoma Health Care Authority (OHCA) will no longer reimburse the extra cost of treating certain categories of conditions that occur while a member is in the hospital. For discharges, hospitals will not receive additional payment for cases in which one of the selected conditions was not present on admission. The claim will be grouped to a DRG as if the diagnosis was not present on the claim. The selected conditions that OHCA recognizes are those conditions identified as non-payable by Medicare. OHCA may revise through addition or deletion the selected conditions at any time during the fiscal year. The following is a complete list of the hospital acquired conditions (HACs) currently recognized by OHCA:

(1) Foreign Object Retained After Surgery
(2) Air Embolism
(3) Blood Incompatibility
(4) Pressure Ulcer Stages III & IV
(5) Falls and Trauma
    (A) Fracture
    (B) Dislocation
    (C) Intracranial Injury
    (D) Crushing Injury
    (E) Burn
    (F) Electric Shock
(6) Catheter-Associated Urinary Tract Infection
(7) Vascular Catheter-Associated Infection
(8) Manifestations of Poor Glycemic Control
    (A) Diabetic Ketoacidosis
    (B) Nonketotic Hyperosmolar Coma
    (C) Hypoglycemic Coma
    (D) Secondary Diabetes with Ketoacidosis
    (E) Secondary Diabetes with Hyperosmolarity
(9) Surgical Site Infection Following:
    (A) Coronary Artery Bypass Graft- Mediastinitis
    (B) Bariatric Surgery
        (i) Laparoscopic Gastric Bypass
        (ii) Gastroenterostomy
        (iii) Laparoscopic Gastric Restrictive Surgery
    (C) Orthopedic Procedures
        (i) Spine
        (ii) Neck
        (iii) Shoulder
        (iv) Elbow
(10) Deep Vein Thrombosis and Pulmonary Embolism
    (A) Total Knee Replacement
    (B) Hip Replacement

(b) **Billing.** Hospitals paid under the diagnosis related grouping (DRG) methodology are required to submit a present on admission (POA) indicator for the principal diagnosis code and every secondary diagnosis code for all discharges. A valid POA indicator is required on all inpatient hospital claims. Claims with no valid POA indicator will be denied. For all claims involving inpatient admissions, OHCA will group diagnoses into the proper DRG using the POA indicator.

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~~(c) **Dually eligible members.** SoonerCare will not act as a secondary payer for Medicare non-payment of the aforementioned hospital acquired conditions.~~

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 34. SECURE BEHAVIORAL HEALTH TRANSPORTATION

317:30-5-350. Definitions

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

"Member/eligible member" means any person eligible for SoonerCare and individuals considered to be Medicare/SoonerCare dual eligible.

"Nearest appropriate facility" means a medical facility that is generally equipped and legally permitted to provide the needed care for the illness or injury involved that is the closest in geographical proximity to the member's pickup location.

"OAC" means Oklahoma Administrative Code.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"O.S." means Oklahoma Statutes.

"Qualified Transportation Service Provider" or **"QTSP"** means an ODMHSAS-contracted transportation provider for members requiring transportation to a treatment facility for the purpose of examination, emergency detention, protective custody, or inpatient services in accordance with 43A O.S. § 1-110.

317:30-5-350.1. Program overview

(a) ODMHSAS-contracted Qualified Transportation Service Providers (QTSPs) are required to transport SoonerCare members reasonably believed to be experiencing a behavioral health crisis to and from designated sites/facilities for the purpose of examination, emergency detention, protective custody, or inpatient services in accordance with 43A O.S. § 1-110.

(b) SoonerCare members being transported shall be afforded all rights and privileges guaranteed by the laws and Constitution of the State of Oklahoma and the United States of America. SoonerCare members have the right to be transported in a way that protects their dignity and safety.

(c) Mechanical restraints may only be used in the transportation of members when needed in accordance with 43A O.S. § 1-110 and as defined in the QTSP's contract with ODMHSAS.

317:30-5-350.2. Program eligibility and covered services

(a) SoonerCare members, both children and adults, are eligible for services when medically necessary.

(b) A member must be reasonably believed to be experiencing a behavioral health crisis as evidenced by extreme emotional distress that includes, but is not limited to, an acute episode of mental illness and/or suicidal thoughts and/or behavior that may occur with substance use and other disorders.

(c) Secure behavioral health transportation may be provided when medically necessary for the following:

(1) Transportation to a facility arranged by individuals authorized by ODMHSAS, including but not limited to, hospitals and other mental health facilities;

(2) Facility-to-facility transports; and

(3) Transport of a member seeking voluntary admission to a facility.

(d) Members must be transported to the nearest appropriate facility.

(e) Out-of-state transports are allowable when medically necessary and may require prior approval or authorization by ODMHSAS.

317:30-5-350.3. Service requirements

(a) **Eligible providers.** Service providers must be ODMHSAS-contracted Qualified Transportation Service Providers (QTSPs) and meet the Uniform Transportation Standards for QTSPs described in this Section.

(b) **Driver requirements.** Drivers must:

(1) Be twenty-one (21) years of age or older;

(2) Hold a valid driver's license issued by the State of Oklahoma;

(3) Undergo a criminal background check and not have been convicted of or received a deferred or probated sentence related to any felony crime, a crime involving moral turpitude or a crime of domestic violence; and not have any criminal charges pending in ay court in the State of Oklahoma, another state, in tribal court or pursuant to the United States Code;

(4) Be able to ensure that SoonerCare members who are transported are protected by harm and injuries due to abuse, self-abuse, neglect, sexual incidents, serious injuries and other sources of immediate danger;

(5) Be able to provide emergency care or have an established plan to access emergency care;

(6) Be trained in effective communication skills with persons with mental illness, consumer rights, CPR/First Aid, and confidentiality as prescribed by ODMHSAS prior to completing transports;

(7) Be able to recognize and plan for problematic behaviors in a therapeutic and safe manner and complete a 16-hour Therapeutic Options Course or similar curriculum approved by ODMHSAS prior to completing transports; and

(8) Be familiar with the statutes and standards related to transporting members.

(c) **Vehicle requirements.** Vehicles must:

(1) Be well maintained and in good mechanical condition;

(2) Have the following equipment operational:

(A) Air conditioner;

(B) Heater; and

(C) Chemical-type fire extinguisher, of at least a one-quart capacity, located in the same compartment of the vehicle as the driver.

(3) Have a safety partition between the driver's area and passenger's area;

(4) Have safety locks to prevent a member from exiting a car that is in motion;

(5) Be equipped with, either in the car or on the driver, a two-way radio or cellular telephone that is operational during the entire period of transport; and

(6) If transporting members in wheelchairs, be equipped with the following:

(A) An electrical or hydraulically-operated lift mechanism or a ramp with a non-skid surface;

(B) A means of securing a wheelchair to the inside of the vehicle to prevent any lateral, forward, backward, or vertical motion of the wheelchair within the vehicle;

(C) A rear-view mirror that enables the driver to view any passenger in a wheelchair; and

(D) A door at the rear of the vehicle for an emergency exit.

317:30-5-350.4. Authorization and reimbursement

(a) Secure behavioral health transportation does not require a prior authorization, with the exception of out-of-state transports, which may require prior approval or authorization by ODMHSAS.

(b) Secure behavioral health transportation is reimbursed per the methodology described in the Oklahoma Medicaid State Plan.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 5. PHARMACIES

317:30-5-78. Reimbursement

(a) **Reimbursement.** Reimbursement for pharmacy claims is based on the sum of the ingredient cost plus a professional dispensing fee for brand and generic drugs dispensed by a retail community pharmacy or for a member residing in a long term care facility**.**

(b) **Ingredient Cost.** Ingredient cost is determined by one of the following methods:

(1) **Maximum Allowable Cost.** The State Maximum Allowable Cost (SMAC) is established for certain products which have a Food and Drug Administration (FDA) approved generic equivalent. The SMAC will be calculated using prices from pharmaceutical wholesalers who supply these products to pharmacy providers in Oklahoma. Pharmacies may challenge a specific product's SMAC price by providing information from their wholesaler(s) to certify a net cost higher than the calculated SMAC price and that there is not another product available to them which is generically equivalent to the higher priced product.

(2) **Actual Acquisition Cost.** The Actual Acquisition Cost (AAC) means the cost of a particular drug product to the pharmacy based on a review of invoices or the Wholesale Acquisition Cost (WAC), whichever is lower. The National Average Drug Acquisition Cost (NADAC) is based on a review of invoices and published by Centers for Medicare and Medicaid Services (CMS) and will be used in the determination of AAC.

(3) **Specialty Pharmaceutical Allowable Cost.** Reimbursement for specialty drugs not typically dispensed by a retail community pharmacy and dispensed primarily by delivery, including clotting factor for hemophilia, shall be set as a Specialty Pharmaceutical Allowable Cost (SPAC). The Medicare Part B allowed charge, ~~defined as Average Sales Price (ASP) plus 6%,~~ WAC, and NADAC when available, will be considered in setting the SPAC rate. For the purpose of this section, a drug may be classified as a specialty drug when it has one or more of the following characteristics:

(A) Covered by Medicare Part B;
(B) "5i drug" B Injected, infused, instilled, inhaled, or implanted;
(C) Cost greater than $1,000.00 per claim;
(D) Licensed by the FDA under a Biological License Application;
(E) Special storage, shipping, or handling requirements;
(F) Available only through a limited distribution network; and/or
(G) Does not have a NADAC price from CMS.

(4) **Exceptions.**

(A) Physician administered drugs shall be priced based on a formula equivalent to the Medicare Part B allowed charge~~, defined as ASP plus 6%~~. If a price equivalent to the Medicare Part B allowed charge cannot be determined, a purchase invoice may be supplied by the provider and will be considered in setting the reimbursement.

(B) I/T/U pharmacies shall be reimbursed at the OMB encounter rate as a per member per facility per day fee regardless of the number of prescriptions filled on that day. I/T/U pharmacies should not split prescriptions into quantities less than a one month

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supply for maintenance medications. For this purpose a maintenance medication is one that the member uses consistently month to month.

(C) Pharmacies other than I/T/U facilities that acquire drugs via the Federal Supply Schedule (FSS) or at nominal price outside the 340B program or FSS shall notify OHCA and submit claims at their actual invoice price plus a professional dispensing fee.

(c) **Professional dispensing fee.** The professional dispensing fee for prescribed medication is established by review of surveys. A recommendation is made by the State Plan Amendment Rate Committee and presented to the Oklahoma Health Care Authority Board for their approval. There may be more than one level or type of dispensing fee if approved by the OHCA Board and CMS. A contracted pharmacy agrees to participate in any survey conducted by the OHCA with regard to dispensing fees. The pharmacy shall furnish all necessary information to determine the cost of dispensing drug products. Failure to participate may result in administrative sanctions by the OHCA which may include but are not limited to a reduction in the dispensing fee.

(d) **Reimbursement for prescription claims.** Prescription claims will be reimbursed using the lower of the following calculation methods:

(1) the lower of Actual Acquisition Cost (AAC), State Maximum Allowable Cost (SMAC), or Specialty Pharmaceutical Allowable Cost (SPAC) plus a professional dispensing fee, or

(2) usual and customary charge to the general public. The pharmacy is responsible to determine its usual and customary charge to the general public and submit it to OHCA on each pharmacy claim. The OHCA may conduct periodic reviews within its audit guidelines to verify the pharmacy's usual and customary charge to the general public and the pharmacy agrees to make available to the OHCA's reviewers prescription and pricing records deemed necessary by the reviewers. The OHCA defines general public as the patient group accounting for the largest number of non-SoonerCare prescriptions from the individual pharmacy, but does not include patients who purchase or receive their prescriptions through other third-party payers. If a pharmacy offers discount prices to a portion of its customers (i.e. -10% discount to senior citizens), these lower prices would be excluded from the usual and customary calculations unless the patients receiving the favorable prices represent more than 50% of the pharmacy's prescription volume. The usual and customary charge will be a single price which includes both the product price and the dispensing fee. For routine usual and customary reviews, the pharmacy may provide prescription records for non-SoonerCare customers in a manner which does not identify the customer by name so long as the customer's identity may be determined later if a subsequent audit is initiated. The OHCA will provide the pharmacy notice of its intent to conduct a review of usual and customary charges at least ten days in advance of its planned date of review.

(e) **Payment of Claims.** In order for an eligible provider to be paid for filling a prescription drug, the pharmacy must complete all of the following:

(1) have an existing provider agreement with OHCA,

(2) submit the claim in a format acceptable to OHCA,

(3) have a prior authorization before filling the prescription, if a prior authorization is necessary,

(4) have a proper brand name certification for the drug, if necessary, and

(5) include the usual and customary charges to the general public as well as the actual acquisition cost and professional dispensing fee.

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(f) **Claims.** Prescription reimbursement may be made only for individuals who are eligible for coverage at the time a prescription is filled. Member eligibility information may be accessed by swiping a SoonerCare identification card through a commercial card swipe machine which is connected to the eligibility database or via the Point of Sale (POS) system when a prescription claim is submitted for payment. Persons who do not contract with commercial vendors can use the Member Eligibility Verification System (EVS) at no additional cost.

PART 5. MEDICAL SUPPLIERS

317:30-5-218. Reimbursement

(a) **Medical supplies, equipment and appliances.**

(1) Reimbursement for medical supplies, equipment, and appliances will be made using an amount derived from the lesser of the Oklahoma Health Care Authority (OHCA) maximum allowable fee or the provider's usual and customary charge. The maximum allowable fee is the maximum amount that the OHCA will pay a provider for an allowable procedure. When a code is not assigned a maximum allowable fee for a unit of service, a fee will be established.

(2) The fee schedule will be reviewed annually. Adjustments to the fee schedule may be possible at any time based on efficiency, budget considerations, federal regulations, and quality of care as determined by the OHCA.

(3) Payment for medical supplies, equipment, and appliances will be calculated using the rate methodologies found in the Oklahoma Medicaid State Plan.

(4) Payment is not made for medical supplies, equipment, and appliances that are not deemed as medically necessary or considered over-the-counter.

(5) OHCA does not reimburse medical supplies, equipment, and appliances providers separately for services that are included as part of the payment for another treatment program. For example, all items required during inpatient stays are paid through the inpatient payment structure.

(6) Medical supplies, equipment, and appliance products purchased at a pharmacy are paid the equivalent to the Medicare Part B allowed charge~~, average sales price (ASP) + six percent (6%)~~. When ~~ASP~~ the Medicare Part B allowed charge is not available, an equivalent price is calculated using ASP or wholesale acquisition cost (WAC). If no Medicare, ASP, or WAC pricing is available, then the price will be calculated based on invoice cost.

(b) **Manually-priced medical equipment and supplies.** There may be instances when manual pricing is required. When it is, the following pricing methods will be used:

(1) **Invoice pricing.** Reimbursement is at the provider's documented manufacturer's suggested retail price (MSRP) minus thirty percent (30%) or at the provider's invoice cost plus thirty percent (30%), whichever is the lesser of the two.

(2) **Fair market pricing.** OHCA may establish a fair market price through claims review and analysis. For a list of medical equipment and supplies that are fair market-priced, refer to the OHCA website at www.okhca.org for the fair market value list (Selected medical supplies, equipment, and appliance items priced at fair market price).

(c) **Oxygen equipment and supplies.**

(1) Payment for stationary oxygen systems (liquid oxygen systems, gaseous oxygen systems, and oxygen concentrators) is based on continuous rental, i.e., a continuous monthly payment

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that is made as long as it is medically necessary. The rental payment includes all contents and supplies, e.g., regulators, tubing, masks, etc. Portable oxygen systems are considered continuous rental. Ownership of the equipment remains with the supplier.
(2) Separate payment will not be made for maintenance, servicing, delivery, or for the supplier to pick up the equipment when it is no longer medically necessary. In addition, the provider/supplier will not be reimbursed for mileage.
(3) Payment for oxygen and oxygen equipment and supplies will not exceed the Medicare fee for the same procedure code.
(4) For residents in a long-term care facility, durable medical equipment products, including oxygen, are included in the facility's per diem rate.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 1. GENERAL PROVISIONS

317:35-1-2. Definitions

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

"Acute Care Hospital" means an institution that meets the requirements defined in Section (§) 440.10 of Title 42 of the Code of Federal Regulations (C.F.R.) and:

(A) Is maintained primarily for the care and treatment of patients with disorders other than mental diseases;

(B) Is formally licensed or formally approved as a hospital by an officially designated authority for state standard setting; and

(C) Meets the requirements for participation in Medicare as a hospital.

"Adult" means an individual twenty-one (21) years of age or older, unless otherwise specified by statute, regulation, and/or policy adopted by the Oklahoma Health Care Authority (OHCA). For eligibility criteria policy for children and adults, please refer to Oklahoma Administrative Code (OAC) 317:35-5-2.

"ADvantage Administration (AA)" means the Oklahoma Department of Human Services (OKDHS) which performs certain administrative functions related to the ADvantage Waiver.

"Aged" means an individual whose age is established as sixty-five (65) years or older.

"Agency partner" means an agency or organization contracted with the OHCA that will assist those applying for services.

"Aid to Families with Dependent Children (AFDC)" means the group of low-income families with children described in Section 1931 of the Social Security Act. The Personal Responsibility and Work Opportunity Act of 1996 established the new eligibility group of low-income families with children and linked eligibility income and resource standards and methodologies and the requirement for deprivation for the new group to the State plan for AFDC in effect on July 16, 1996. Oklahoma has elected to be less restrictive for all SoonerCare members related to AFDC. Children covered under Section 1931 are related to the children's group, and adults covered under Section 1931 are related to the parent and caretaker relative group. The Modified Adjusted Gross Income (MAGI) methodology is used to determine eligibility for these groups.

"Alien" is synonymous with the word "noncitizen" and means an individual who does not have United States citizenship and is not a United States national.

"Area nurse" means a registered nurse in the OKDHS Aging Services Division, designated according to geographic areas who evaluates the Uniform Comprehensive Assessment Tool (UCAT) and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services. The area nurse also approves care plan and service plan implementation for Personal Care services.

"Area nurse designee" means a registered nurse selected by the area nurse who evaluates the UCAT and determines medical eligibility for Personal Care, ADvantage Waiver, and Nursing Facility services.

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"Authority" means the OHCA.

"Blind" means an individual who has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.

"Board" means the OHCA Board.

"Buy-in" means the procedure whereby the OHCA pays the member's Medicare premium.

(A) **"Part A Buy-in"** means the procedure whereby the OHCA pays the Medicare Part A premium for individuals determined eligible as Qualified Medicare Beneficiaries Plus (QMBP) who are enrolled in Part A and are not eligible for premium free enrollment as explained under Medicare Part A. This also includes individuals determined to be eligible as Qualified Disabled and Working Individuals (QDWI).

(B) **"Part B Buy-in"** means the procedure whereby the OHCA pays the Medicare Part B premium for categorically needy individuals who are eligible for Part B Medicare. This includes individuals who receive TANF or the State Supplemental Payment to the Aged, Blind or Disabled, and those determined to be Qualified Medicare Beneficiary Plus (QMBP), Specified Low Income Medicare Beneficiaries (SLMB) or Qualifying Individual-1 (QI-1). Also included are individuals who continue to be categorically needy under the PICKLE amendment and those who retain eligibility after becoming employed.

"Caretaker relative" means a person other than the biological or adoptive parent with whom the child resides who meets the specified degree of relationship within the fifth degree of kinship.

"Case management" means the activities performed for members to assist them in accessing services, advocacy and problem solving related to service delivery.

"Categorically needy" means that income and, when applicable, resources are within the standards for the category to which the individual is related.

"Categorically related" or **"related"** means the individual meets basic eligibility requirements for an eligibility group.

"Certification period" means the period of eligibility extending from the effective date of certification to the date of termination of eligibility or the date of the next periodic redetermination of eligibility.

"Child" means an individual under twenty-one (21) years of age, unless otherwise specified by statute, regulation, and/or policy adopted by the OHCA. For eligibility criteria policy for children and adults, please refer to OAC 317:35-5-2.

"Continuous eligibility" means uninterrupted eligibility for the extent of the certification period regardless of any changes in circumstances, unless:

(A) The child turns age nineteen (19);

(B) The child dies;

(C) The child is no longer an Oklahoma resident;

(D) The child becomes incarcerated (per OAC 317:35-6-45 the eligibility is suspended for the duration of the incarceration period for individuals under the age of twenty-one (21) except for periods of time that inpatient services are provided per OAC 317:35-5-26);

(E) The adult parent or caretaker relative on the case requests that the medical benefits are closed;

(F) The state has erred in the eligibility determination;

(G) The child or the adult parent or caretaker relative on the case has committed fraud or perjury in order to become eligible; or

(H) The child becomes categorically related to either the pregnancy eligibility group or

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the former foster care eligibility groups, thereby receiving eligibility based on such category, which is not considered an interruption in continuous eligibility.

"County" means the Oklahoma OKDHS' office or offices located in each county within the State.

"Custody" means the custodial status, as reported by OKDHS.

"Deductible/Coinsurance" means the payment that must be made by or on behalf of an individual eligible for Medicare before Medicare payment is made. The coinsurance is that part of the allowable medical expense not met by Medicare, which must be paid by or on behalf of an individual after the deductible has been met.

(A) For Medicare Part A (Hospital Insurance), the deductible relates to benefits for inpatient services while the patient is in a hospital or nursing facility. After the deductible is met, Medicare pays the remainder of the allowable cost.

(B) For Medicare Part B (Medical Insurance), the deductible is an annual payment that must be made before Medicare payment for medical services. After the deductible is met, Medicare pays eighty percent (80%) of the allowable charge. The remaining twenty percent (20%) is the coinsurance.

"Disabled" means an individual who is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or which has lasted (or can be expected to last) for a continuous period of not less than twelve (12) months.

"Disabled child" means for purposes of Medicaid Recovery a child of any age who is blind, or permanently and totally disabled according to standards set by the Social Security Administration.

"Estate" means all real and personal property and other assets included in the member's estate as defined in Title 58 of the Oklahoma Statutes.

"Expansion adult" means an individual defined by 42 Code of Federal Regulations (C.F.R.) ' 435.119 who is age nineteen (19) or older and under sixty-five (65), at or below 133 percent of the federal poverty level (FPL), and who are not related to the aged, blind, or disabled.

"Gatekeeping" means the performance of a comprehensive assessment by the OKDHS nurse utilizing the UCAT for the determination of medical eligibility, care plan development, and the determination of Level of Care for Personal Care, ADvantage Waiver and Nursing Facility services.

"Ineligible Spouse" means an individual who is not eligible for Supplemental Security Income (SSI) but is the husband or wife of someone who is receiving SSI.

"Lawfully present" means a noncitizen in the United States who is considered to be in lawful immigration status or class.

"Lawfully residing" means the individual is lawfully present in the United States and also meets Medicaid residency requirements.

"Local office" means the Oklahoma OKDHS' office or offices located in each county within the State.

"LOCEU" means the Oklahoma Health Care Authority's Level of Care Evaluation Unit.

"MAGI eligibility group" means an eligibility group whose financial eligibility is determined through the Modified Adjusted Gross Income (MAGI) methodology. The groups subject to MAGI are defined in 42 C.F.R. _ 436.603 and listed in OAC 317:35-6-1.

"Modified Adjusted Gross Income (MAGI)" means the financial eligibility determination methodology established by the Patient Protection and Affordable Care Act (PPACA) in 2009.

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"Medicare" means the federally funded health insurance program also known as Title XVIII of the Social Security Act. It consists of four (4) separate programs. Part A is Hospital Insurance, Part B is Medical Insurance, Part C is Medicare Advantage Plans, and Part D is Prescription Drug Coverage.

(A) **"Part A Medicare"** means Hospital Insurance that covers services for inpatient services while the patient is in a hospital or nursing facility. Premium free enrollment is provided for all persons receiving Old Age, Survivors, and Disability Insurance (OASDI) or Railroad Retirement income who are age sixty-five (65) or older and for those under age sixty-five (65) who have been receiving disability benefits under these programs for at least twenty-four (24) months.

(i) Persons with end-stage renal disease who require dialysis treatment or a kidney transplant may also be covered.

(ii) Those who do not receive OASDI or Railroad Retirement income must be age sixty-five (65) or over and pay a large premium for this coverage. Under Authority rules, these individuals are not required to enroll for Part A to be eligible for SoonerCare benefits as categorically needy. They must, however, enroll for Medicare Part B. Individuals eligible as a QMBP or as a QDWI under Medicaid are required to enroll for Medicare Part A. The Authority will pay Part A premiums for QMBP individuals who do not qualify for premium free Part A and for all QDWI's.

(B) **"Part B Medicare"** means Supplemental Medical Insurance that covers physician and related medical services other than inpatient or nursing facility care. Individuals eligible to enroll in Medicare Part B are required to do so under OHCA policy. A monthly premium is required to keep this coverage in effect.

"Minor child" means a child under the age of eighteen (18).

"Noncitizen" is synonymous with the word "alien" and means an individual who does not have United States citizenship and is not a United States national.

"Nursing Care" for the purpose of Medicaid Recovery is care received in a nursing facility, an intermediate care facility for individuals with intellectual disabilities (ICF/IIDs) or other medical institution providing nursing and convalescent care, on a continuing basis, by professional personnel who are responsible to the institution for professional medical services.

"OCSS" means the OKDHS' Oklahoma Child Support Services (formerly Child Support Enforcement Division).

"OHCA" means the Oklahoma Health Care Authority.

"OHCA Eligibility Unit" means the group within the OHCA that assists with the eligibility determination process.

"OKDHS" means the Oklahoma Department of Human Services which is also referenced in rules as Department of Human Services (DHS) and Office of Human Services (OHS).

"OKDHS nurse" means a registered nurse in the OKDHS Aging Services Division who meets the certification requirements for UCAT Assessor and case manager, and who conducts the uniform assessment of individuals utilizing the UCAT for the purpose of medical eligibility determination. The OKDHS nurse also develops care plans and service plans for Personal Care services based on the UCAT.

"Qualified Disabled and Working Individual (QDWI)" means individuals who have lost their Title II OASDI benefits due to excess earnings but have been allowed to retain Medicare coverage.

"Qualified Medicare Beneficiary Plus (QMBP)" means certain aged, blind or disabled

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individuals who may or may not be enrolled in Medicare Part A, meet the Medicaid QMBP income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual" means certain aged, blind or disabled individuals who are enrolled in Medicare Part A, meet the Medicaid Qualifying Individual income and resource standards and meet all other Medicaid eligibility requirements.

"Qualifying Individual-1" means a Qualified Individual who meets the Qualifying Individual-1 income and resource standards.

"Reasonably compatible" means that there is no significant discrepancy between information declared by a member or applicant and other information available to the agency. More specific policies and procedures for determining whether a declaration is reasonably compatible are detailed in Oklahoma's Verification Plan.

"Recipient lock-in" means when a member is restricted to one primary physician and/or one pharmacy. It occurs when the OHCA determines that a SoonerCare member has used multiple physicians and/or pharmacies in an excessive manner over a twelve (12) month period.

"Scope" means the covered medical services for which payment is made to providers on behalf of eligible individuals. The OHCA Provider Manual (OAC 317:30) contains information on covered medical services.

"Specified Low Income Medicare Beneficiaries (SLMB)" means individuals who, except for income, meet all of the eligibility requirements for QMBP eligibility and are enrolled in Medicare Part A.

"TEFRA" means the Tax Equity and Fiscal Responsibility Act of 1982 (Public Law 97-248). TEFRA provides coverage to certain disabled children living in the home who would qualify for SoonerCare if residents of nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs), or inpatient acute care hospital stays are expected to last not less than sixty (60) days.

"Worker" means the OHCA or OKDHS worker responsible for assisting in eligibility determinations.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

PART 7. CERTIFICATION, REDETERMINATION AND NOTIFICATION

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

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

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

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

(3) The individual who is categorically needy and related to pregnancy-related services retains

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eligibility for the period covering prenatal, delivery, and postpartum periods without regard to eligibility for other household members in the case. Eligibility during the postpartum period does not apply to women receiving pregnancy-related coverage under Title XXI.

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

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

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

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

(3) Becomes ineligible for SoonerCare after the initial month, except for children who are eligible for twelve months continuous coverage; or

(4) Becomes financially ineligible.

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

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

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

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

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

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

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

(A) loses Oklahoma residence; or

(B) expires.

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

317:35-6-60.1 Changes in circumstances

(a) **Reporting changes.** Members are required to report changes in their circumstances within ~~10~~ten (10) days of the date the member is aware of the change.

(b) **Agency action on changes in circumstances**. When the agency responsible for determining eligibility for the member becomes aware of a change in the member's circumstances, the agency will promptly redetermine eligibility for all household members whose eligibility is affected by the change.

(c) **Changes reported by third parties.** When the agency receives information regarding a change in the member's circumstances from a third party, such as the Oklahoma Employment Security Commission (OESC) or the Social Security Administration (SSA), the agency will determine whether the information received is reasonably compatible with the most recent information provided by the member.

(1) If the information received is reasonably compatible with the information provided by the member, the agency will use the information provided by the member for determinations and redeterminations of eligibility.

(2) If the information received is not reasonably compatible with the information provided by the member, the agency will determine whether the information received will have an effect on the eligibility of any member of the household.

(A) If the information received has no effect on the eligibility of any member of the household, including the benefit package the member is enrolled in, the agency will take no action.

(B) If the information received has an effect on the eligibility of a member of the household, the agency will request more information from the member, including, but not limited to, an explanation of the discrepancy or verification documenting the correct information regarding the factor of eligibility affected by the information received from a third party.

(C) The agency will give the member proper notice of at least 10 days to respond to the agency's request for information.

(D) If the member does not cooperate in resolving the discrepancy within the timeframe established by the notice, benefits will be terminated.

~~(d) **Exception January to March, 2014.** During the period January to March, 2014, redeterminations due to changes in circumstances will be processed, but the effective date of any termination action taken as a result of changes in household composition or income for individuals in MAGI eligibility groups will be April 1, 2014, or later.~~

(d) **Changes in a continuous eligibility period for children.** During a continuous eligibility period for children, a member must report:

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(1) A change of address for the child; or
(2) If a certified child leaves the home, is institutionalized, or dies.

317:35-6-61. Redetermination of eligibility for persons receiving SoonerCare

(a) A periodic redetermination of eligibility for SoonerCare is required for all members. The redetermination is made prior to the end of the initial certification period and each ~~12~~twelve (12) months thereafter. A deemed newborn is eligible through the last day of the month the newborn child attains the age of one year, without regard to eligibility of other household members in the case.

(b) Effective January 1, 2014, when the agency has sufficient information available electronically to redetermine eligibility, eligibility will be redetermined on that basis and a notice will be sent to the household explaining the action taken by the agency. The member is responsible for notifying the agency if any information used to redetermine eligibility is incorrect. If the agency does not have sufficient information to redetermine eligibility, the agency will send notice to that effect, and the member is responsible for providing the necessary information to redetermine eligibility.

(c) A member's case is closed if he/she does not return the form(s) and any verification necessary for redetermination timely. If the member submits the form(s) and verification necessary for redetermination within ~~90~~ninety (90) days after closure of the case, benefits are reopened effective the date of the closure, provided the member is eligible and benefits were closed because the redetermination process was not completed.

~~(d) Periodic redeterminations scheduled for January to March, 2014 will be rescheduled for April, 2014.~~

(d) SoonerCare does not redetermine the SoonerCare eligibility of a child under 19 years of age whose coverage began on or after January 1, 2024, regardless of changes in income, until the earlier of:

(1) Twelve (12) months; or
(2) The child's nineteenth (19^{th}) birthday.

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OPERATIONAL METRICS

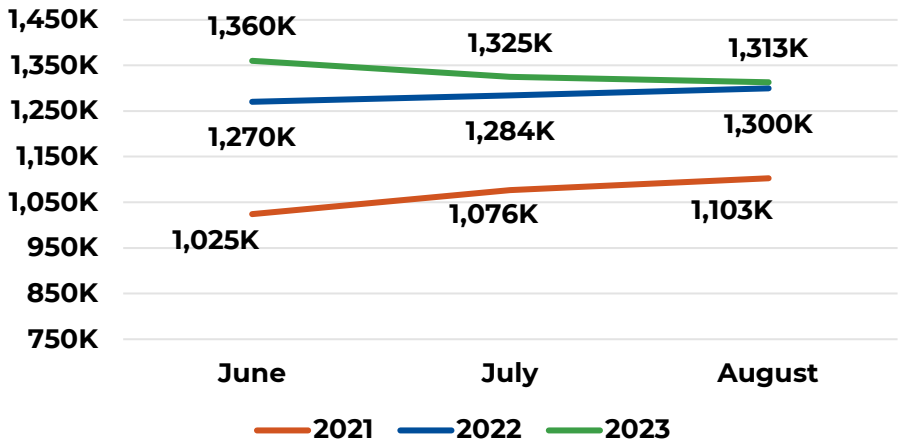
September 2023 Board Meeting

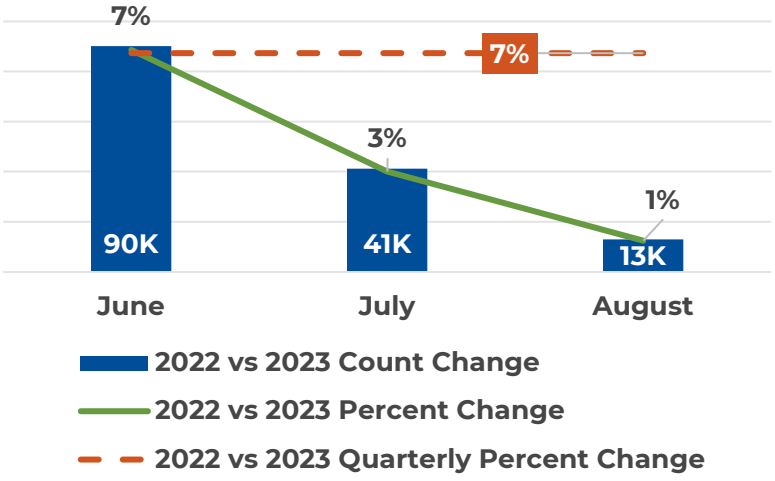
OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

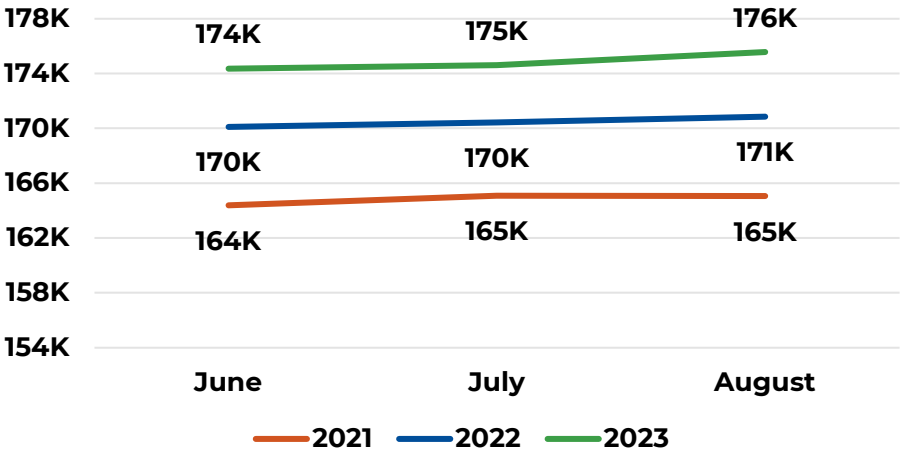
Enrollment & Utilization

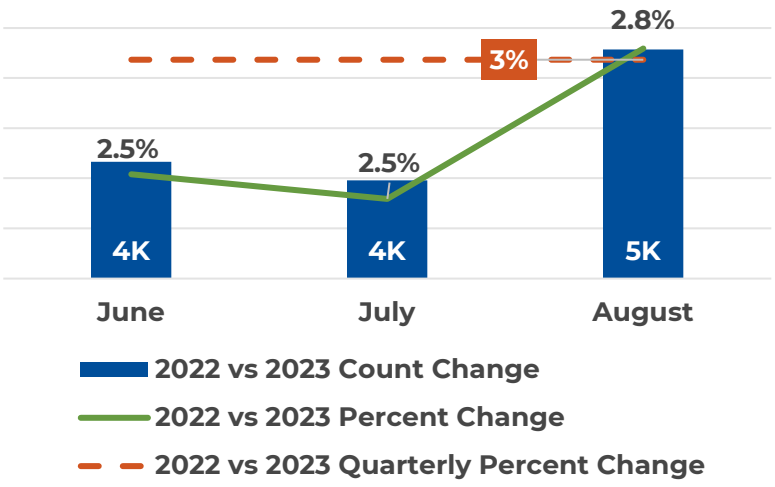
Total Enrolled Members





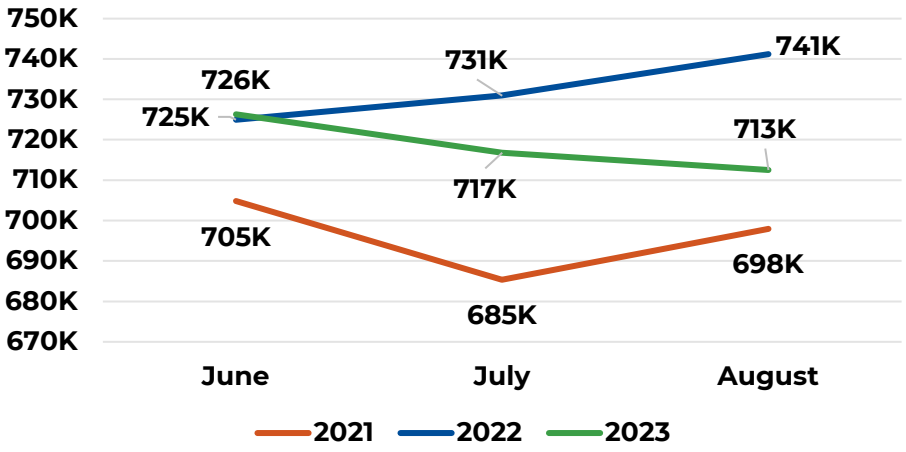
Aged/Blind/Disabled Enrolled

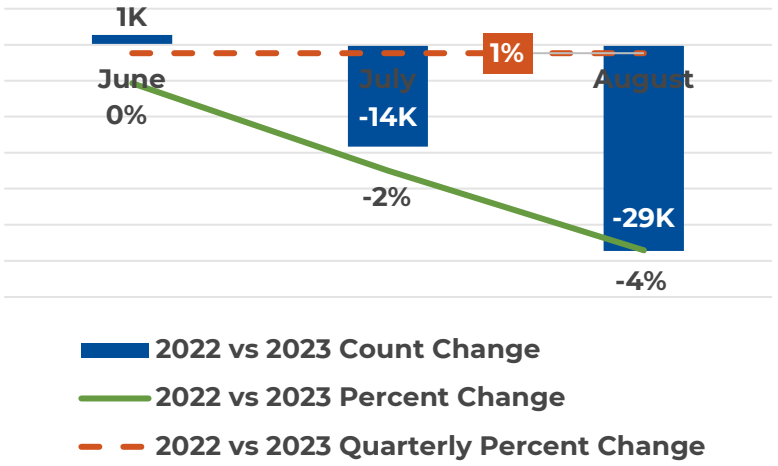




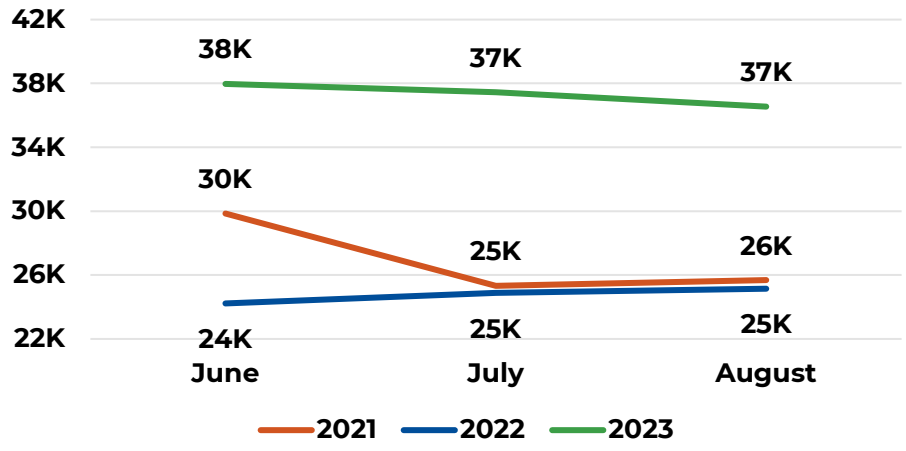
Enrollment & Utilization (Cont.)

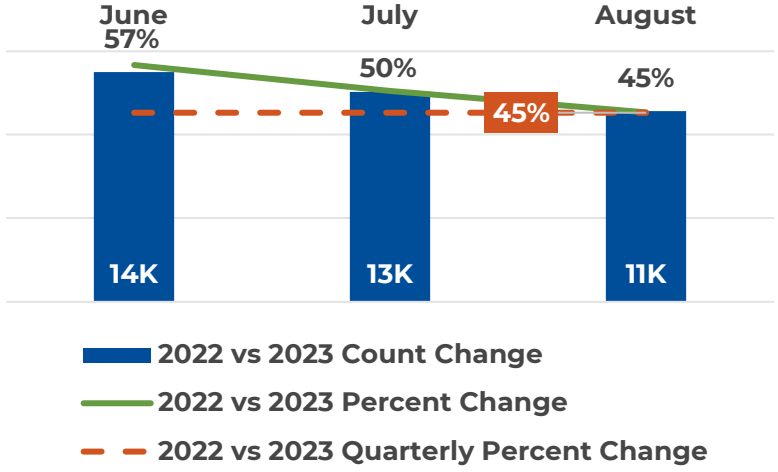
Children & Parent/Caretaker Enrolled





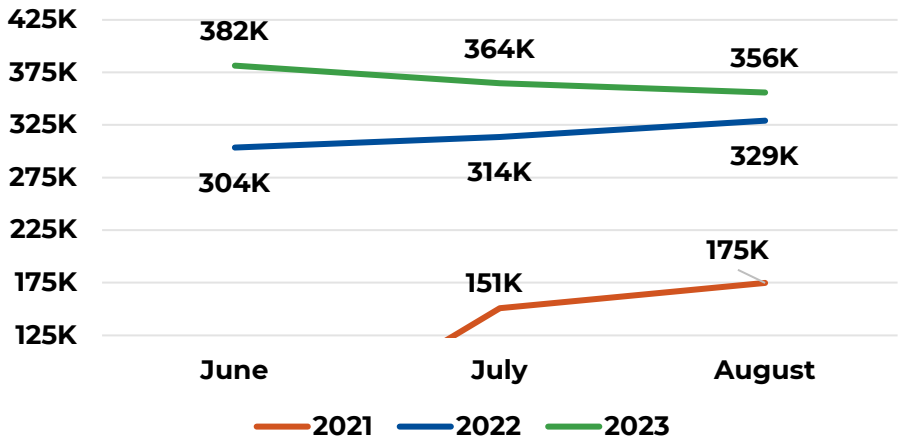
Pregnant (Full Scope) Enrolled

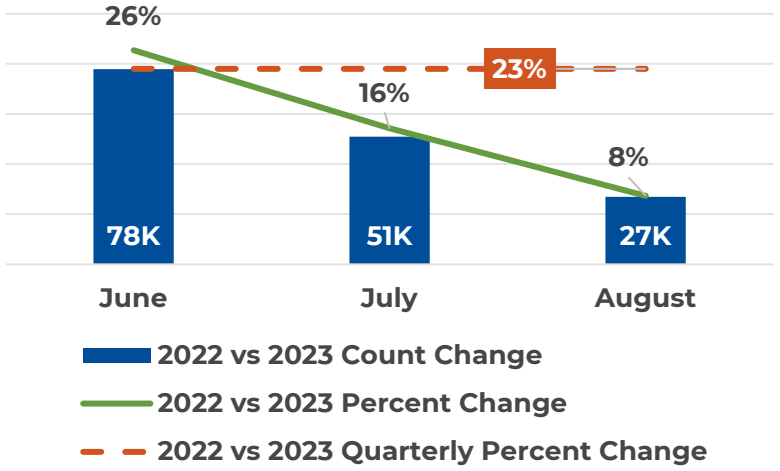




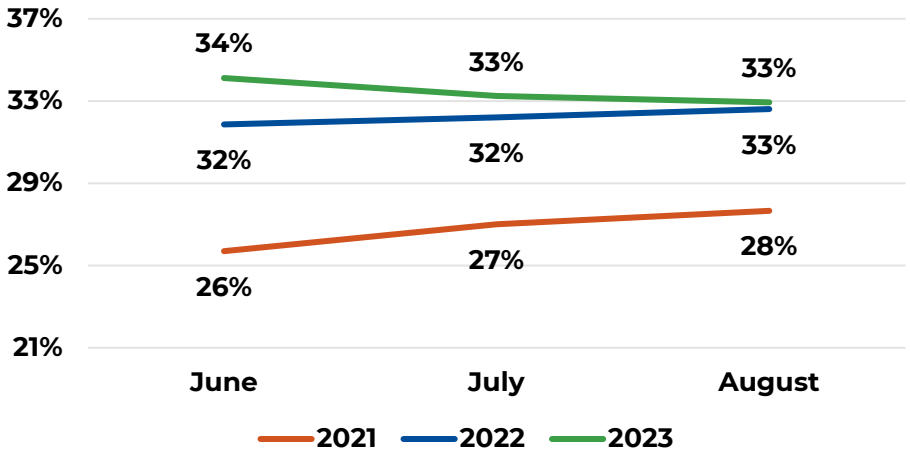
Enrollment & Utilization (Cont.)

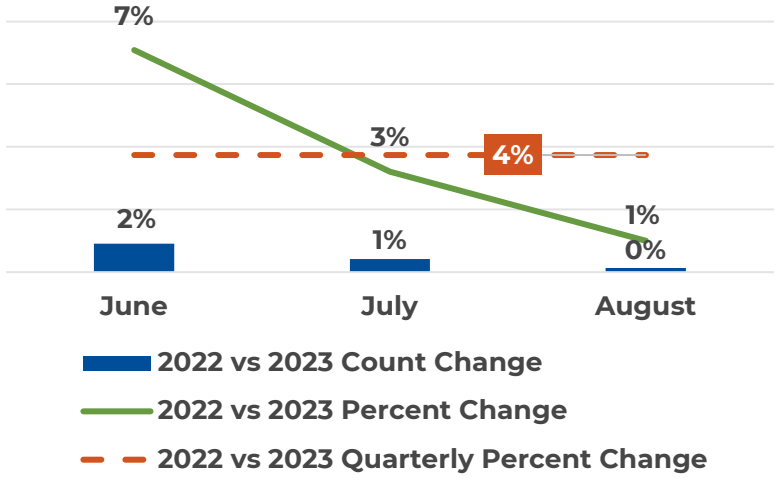
Expansion Enrolled (Effective July 2021)





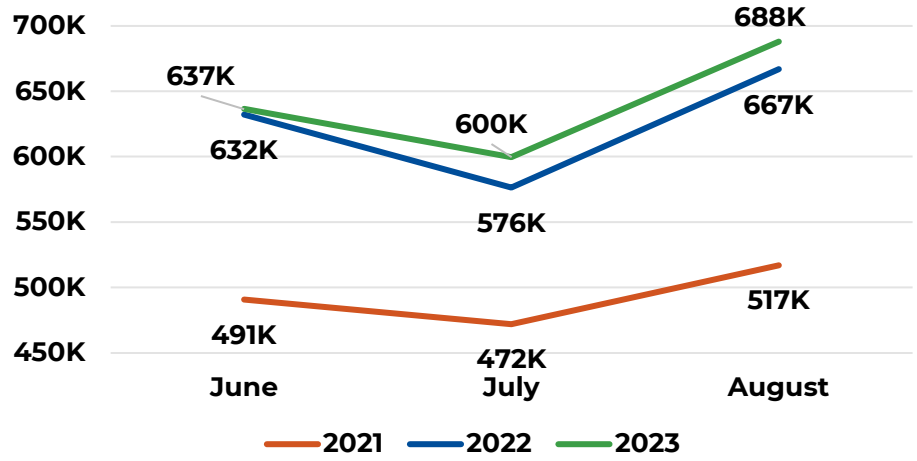
Percent of OK Population Enrolled

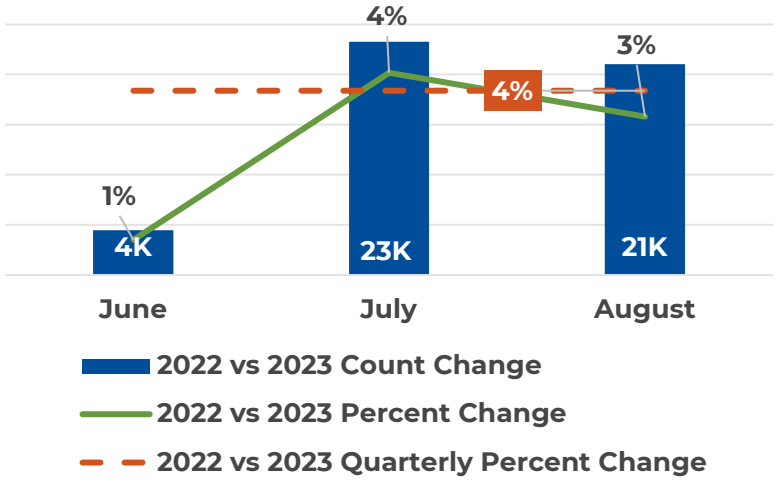




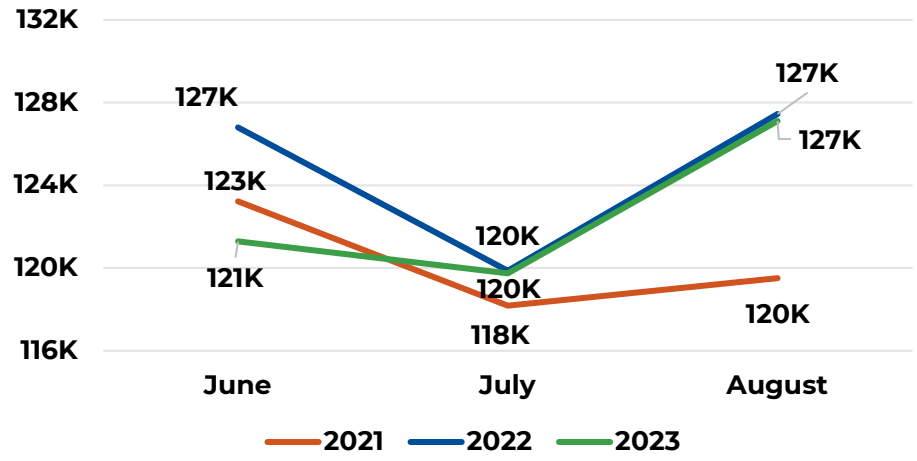
Enrollment & Utilization (Cont.)

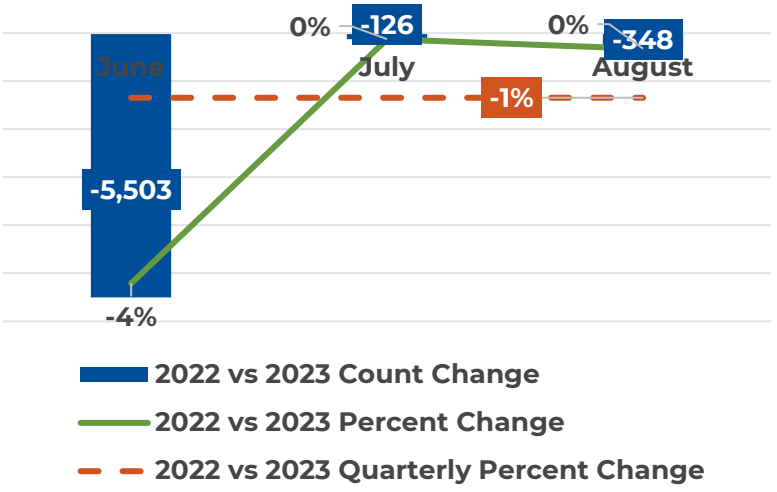
Total Members Utilization





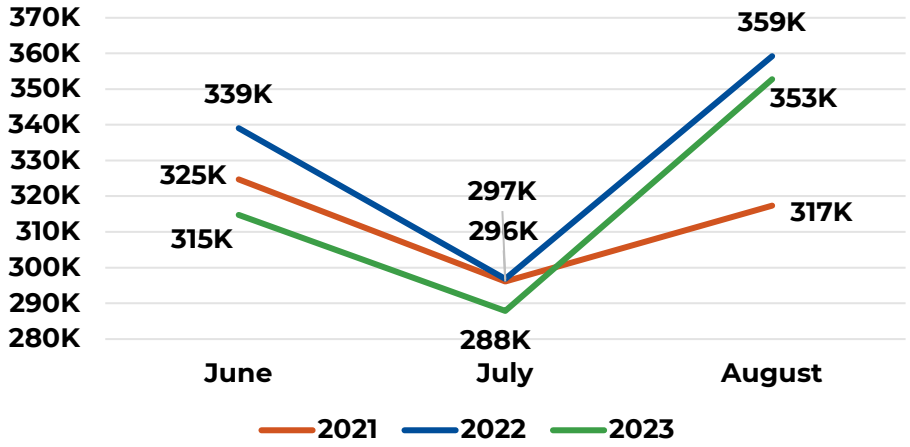
Aged/Blind/Disabled Utilization

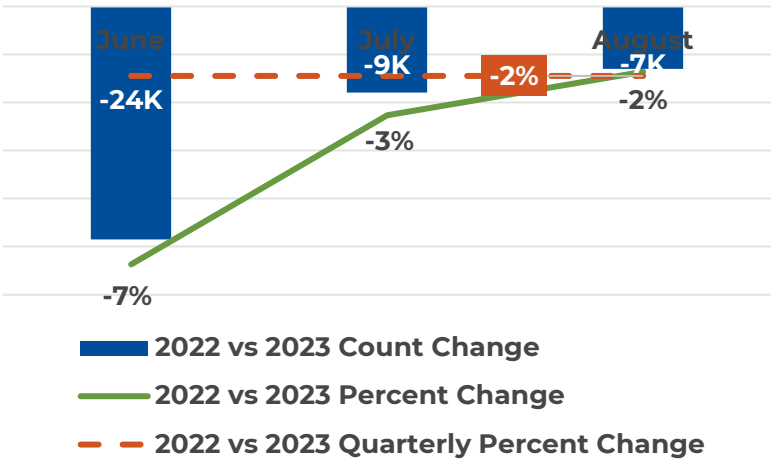




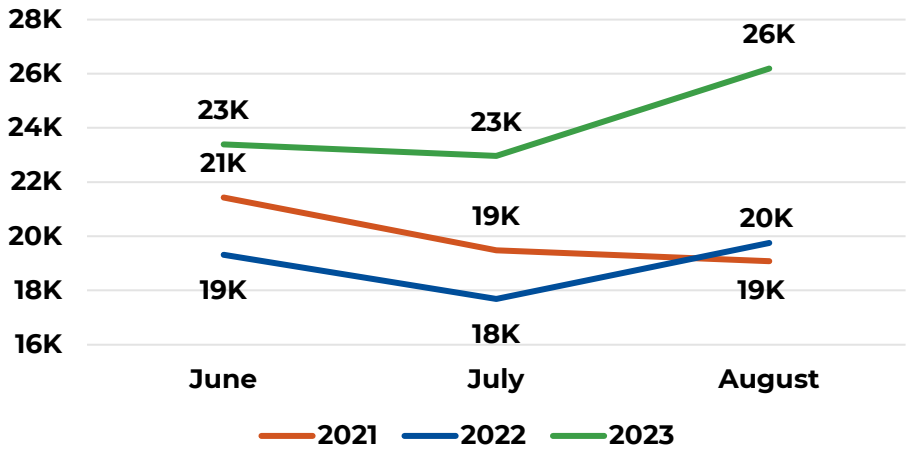
Enrollment & Utilization (Cont.)

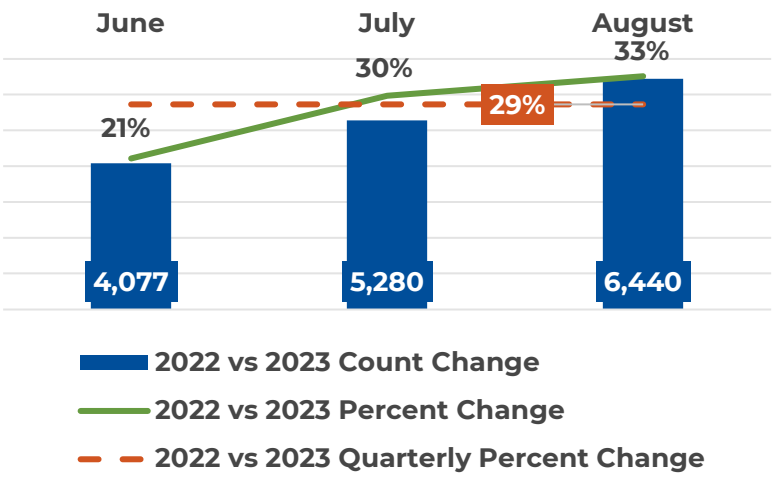
Children & Parent/Caretaker Utilization





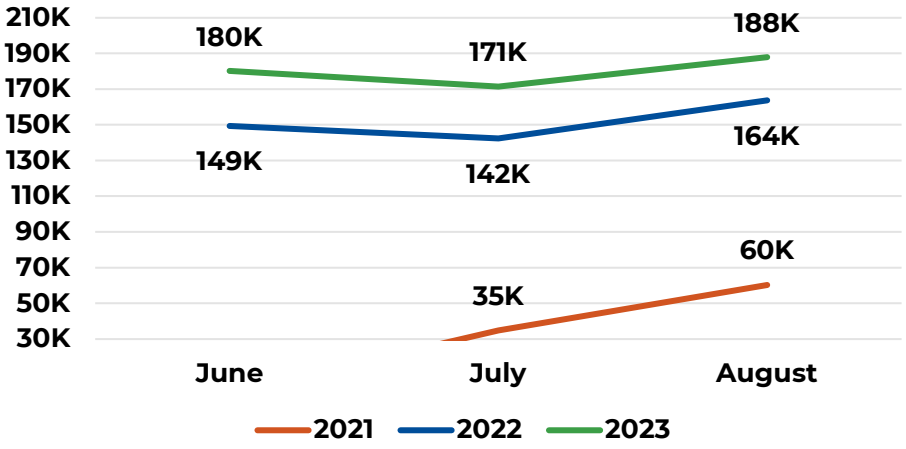
Pregnant (Full Scope) Utilization

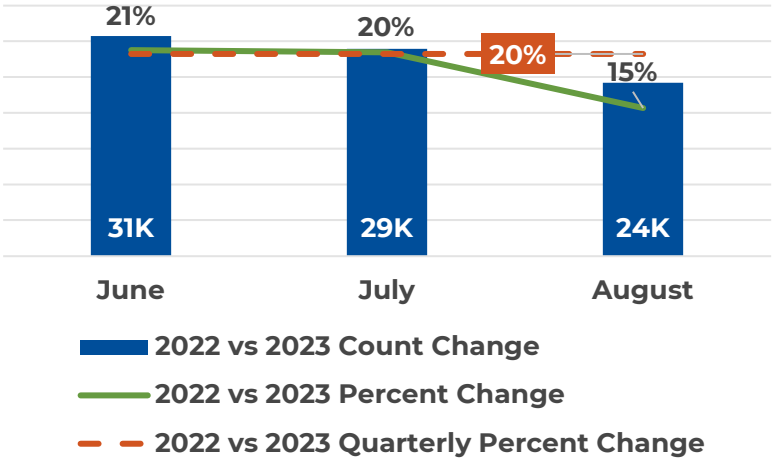




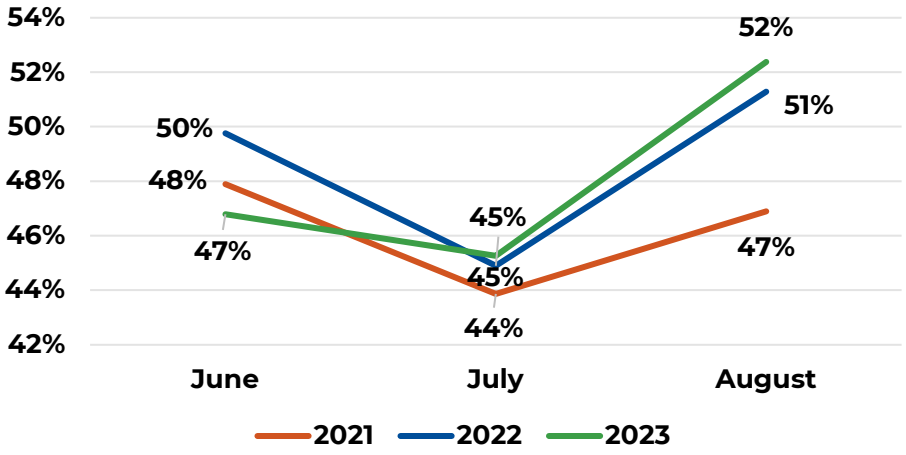
Enrollment & Utilization (Cont.)

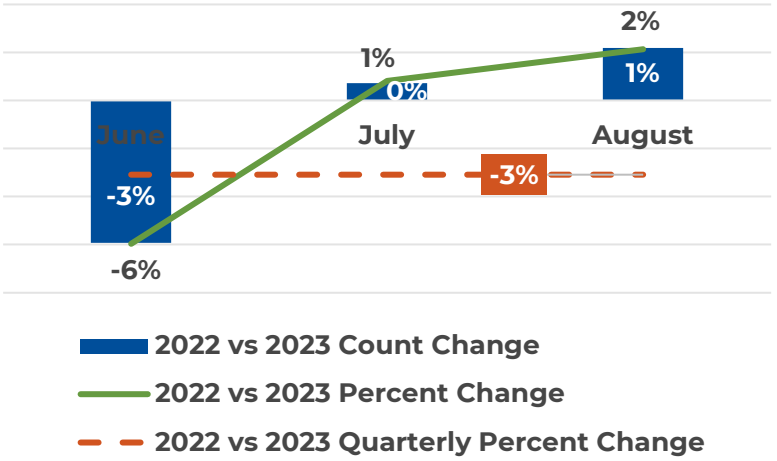
Expansion Utilization (Effective July 2021)





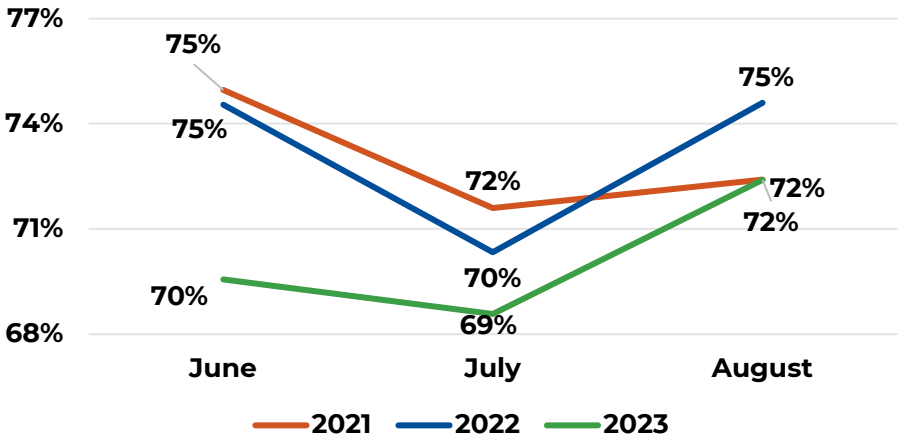
Percent of Total Enrolled Members Utilization

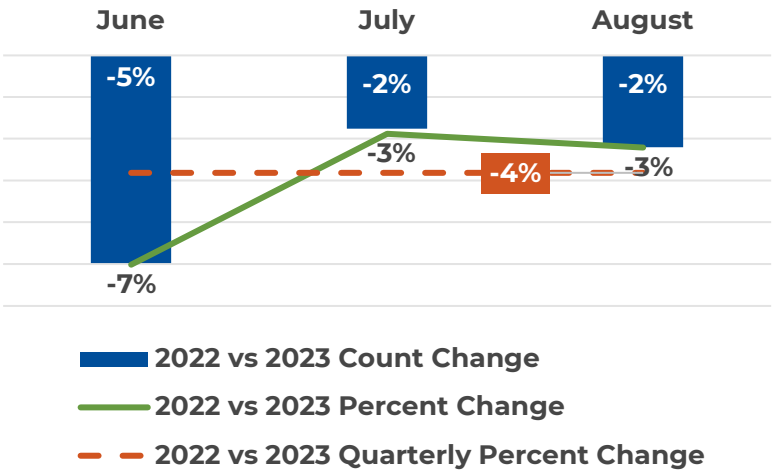




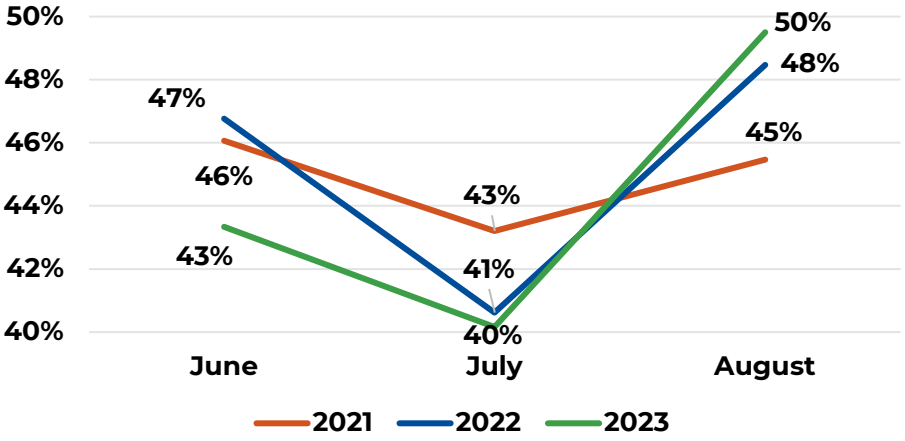
Enrollment & Utilization (Cont.)

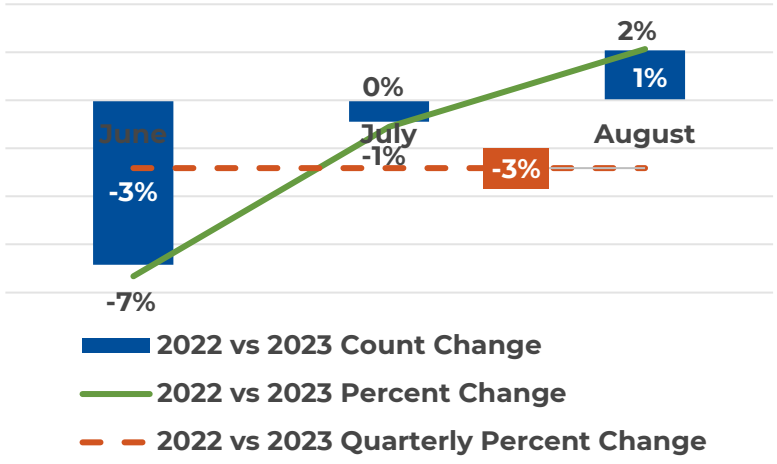
Percent of Aged/Blind/Disabled Enrolled Members Utilization





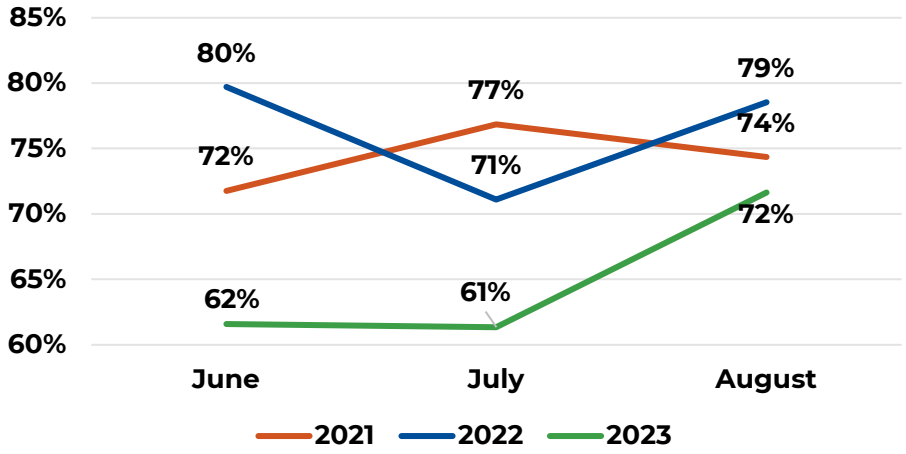
Percent of Children & Parent/Caretaker Enrolled Members Utilization

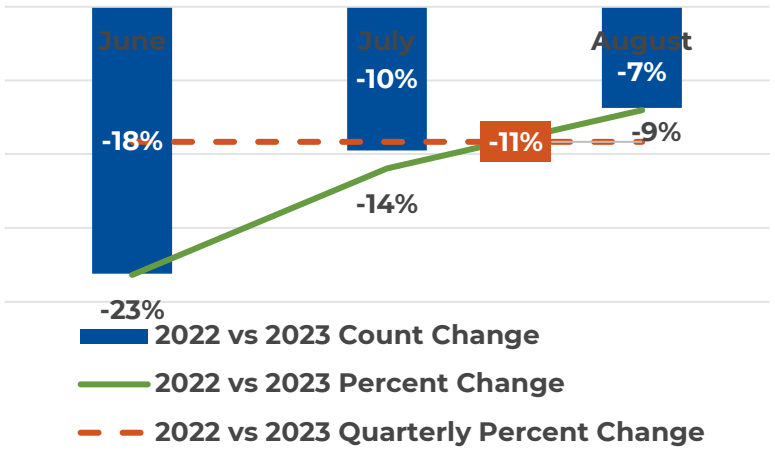




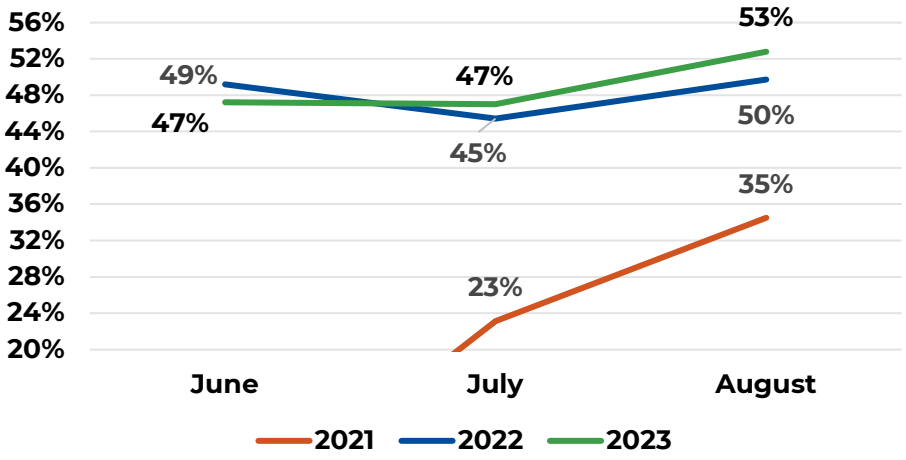
Enrollment & Utilization (Cont.)

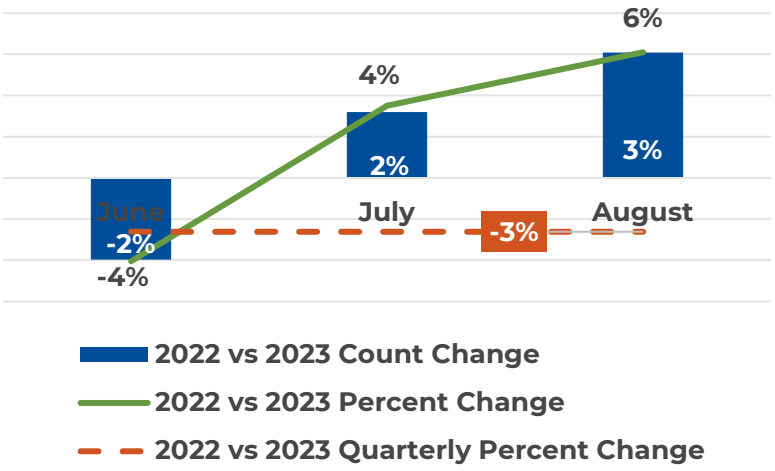
Percent of Pregnant (Full Scope) Enrolled Members Utilization





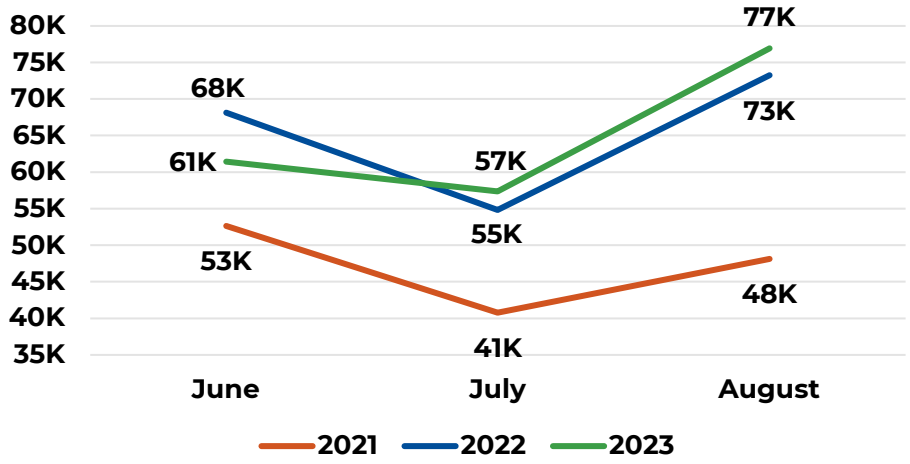
Percent of Expansion Enrolled Members Utilization (Effective July 2021)

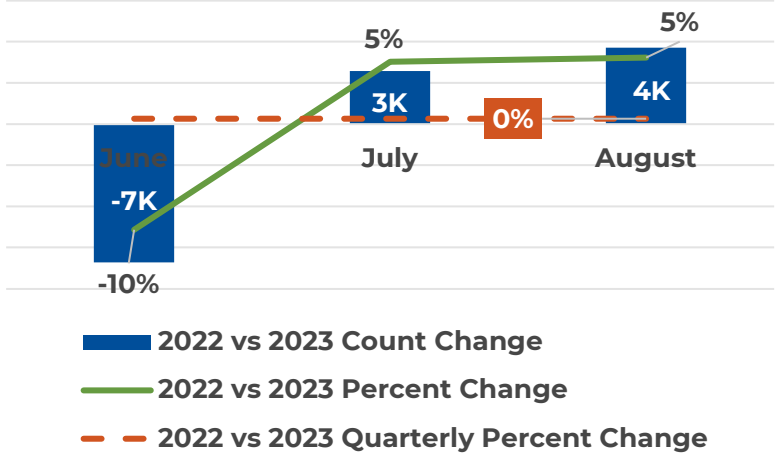




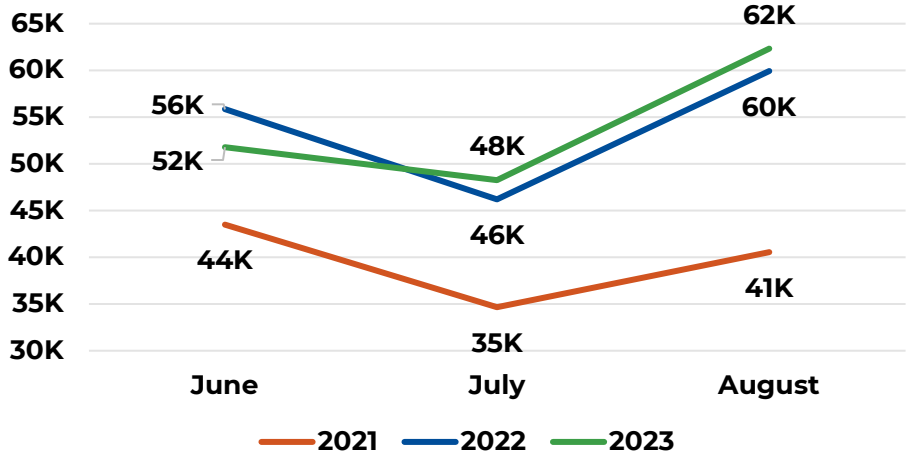
Utilization

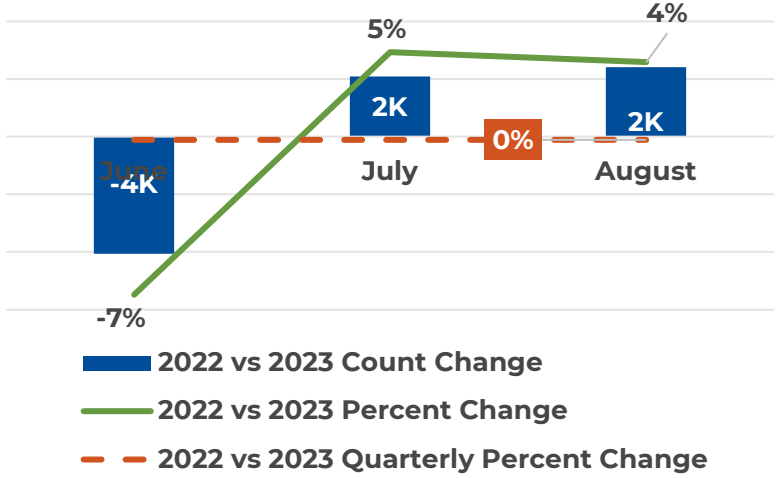
Emergency Department Visits (Claims)





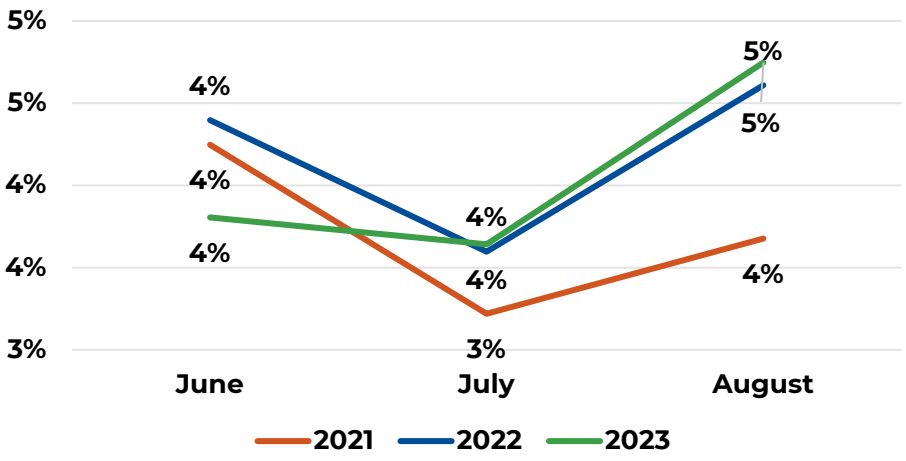
Members Utilizing Emergency Department

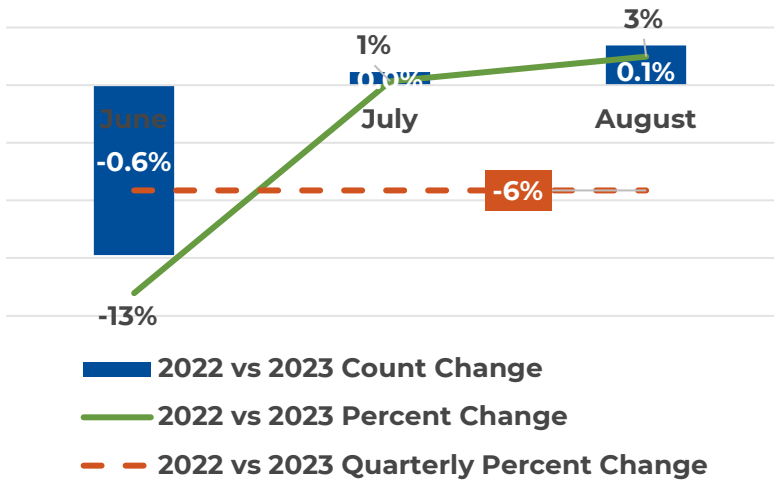




Utilization (Cont.)

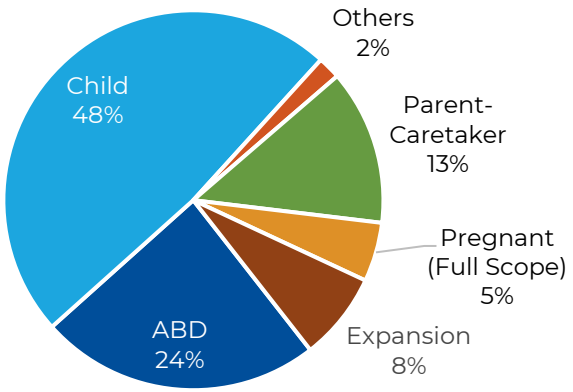
Percent Total Enrolled Using ED



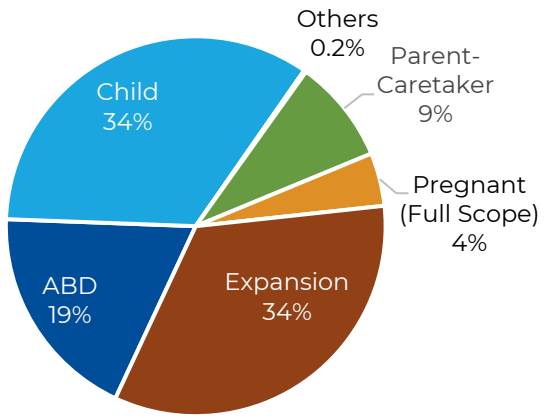


Members Utilizing Emergency Department By Qualifying Group

Q1 2023

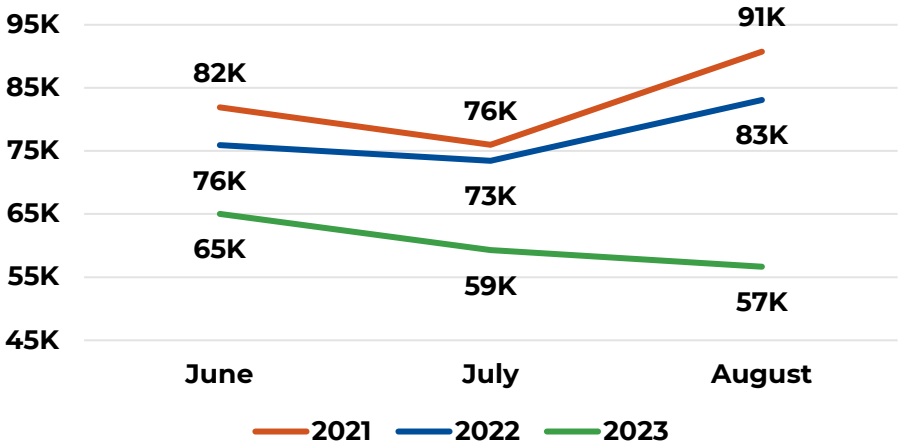


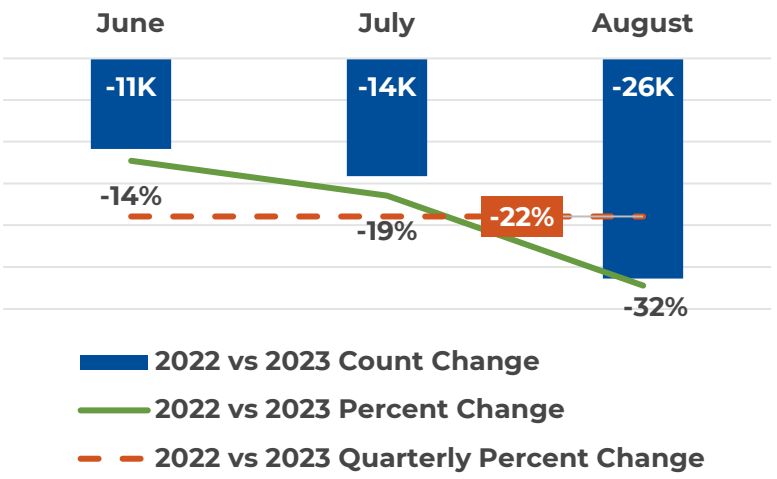
Q1 2024



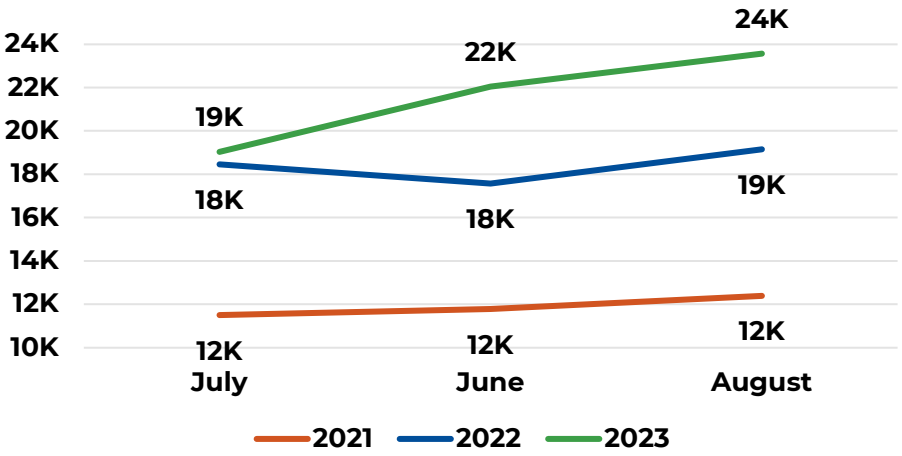
Utilization (Cont.)

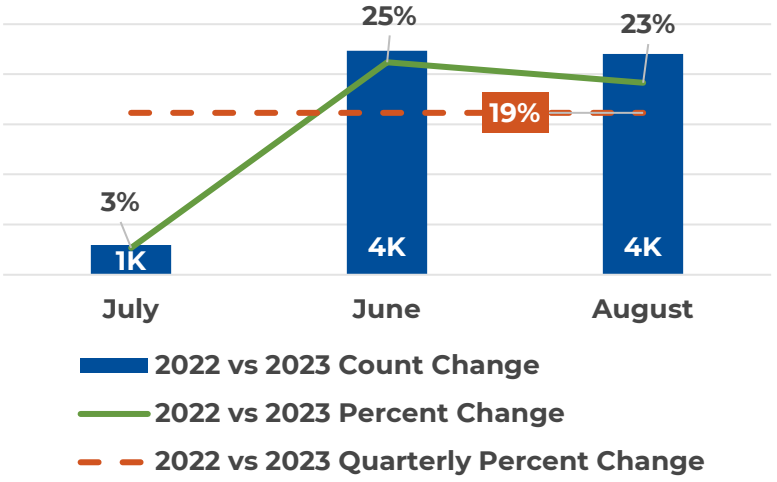
Telemedicine - Total Visits





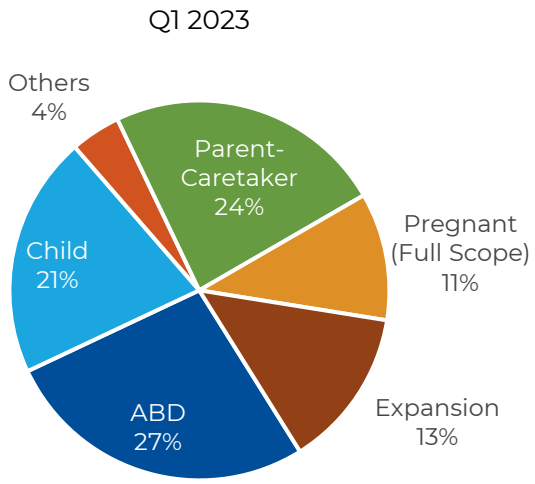
Members With Opioid Claims

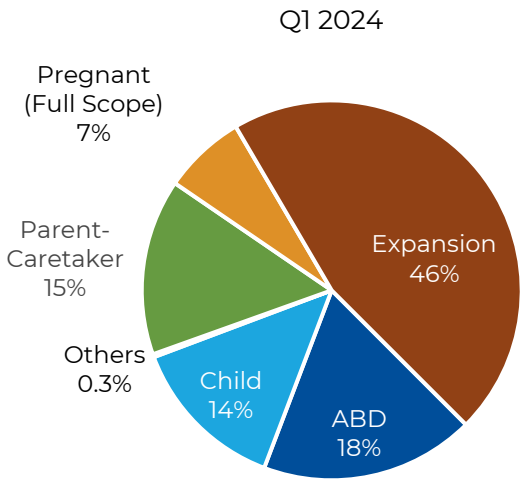




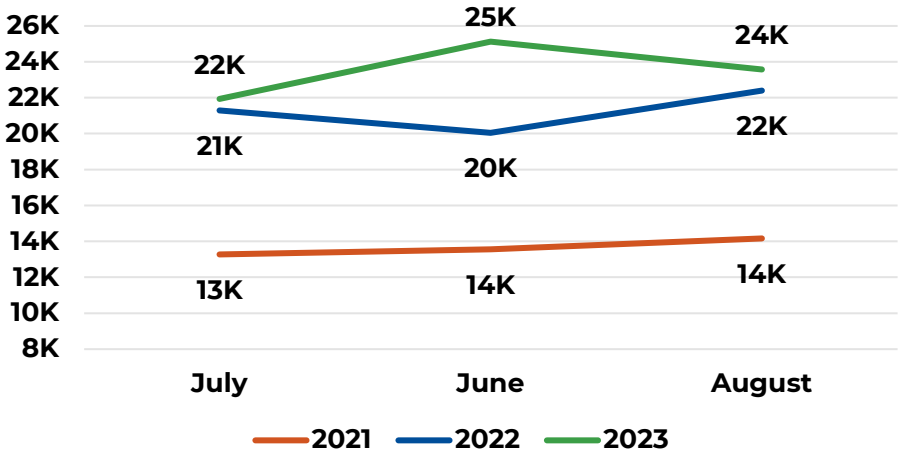
Utilization (Cont.)

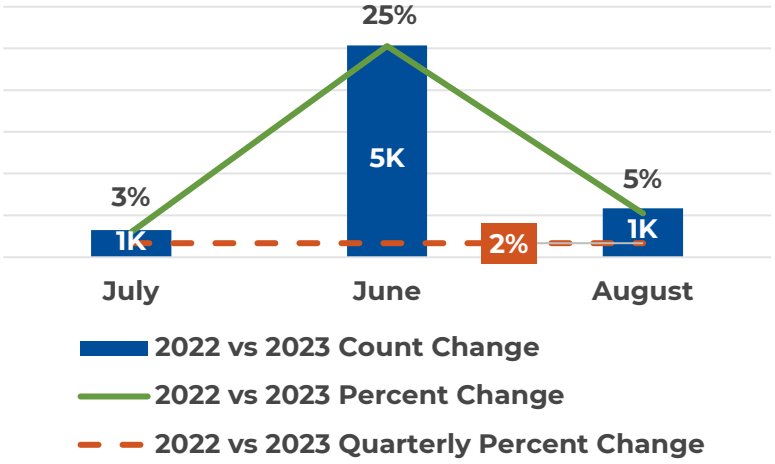
Members With Opioid Claims By Qualifying Group





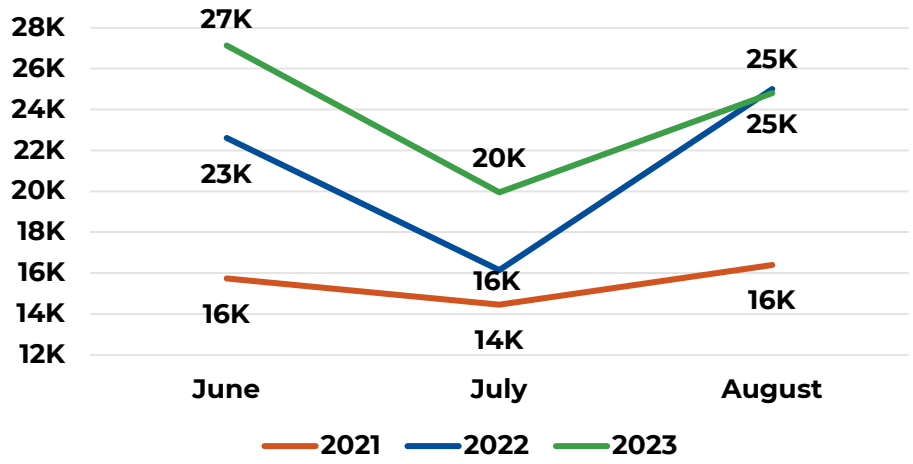
Total Opioid Claims

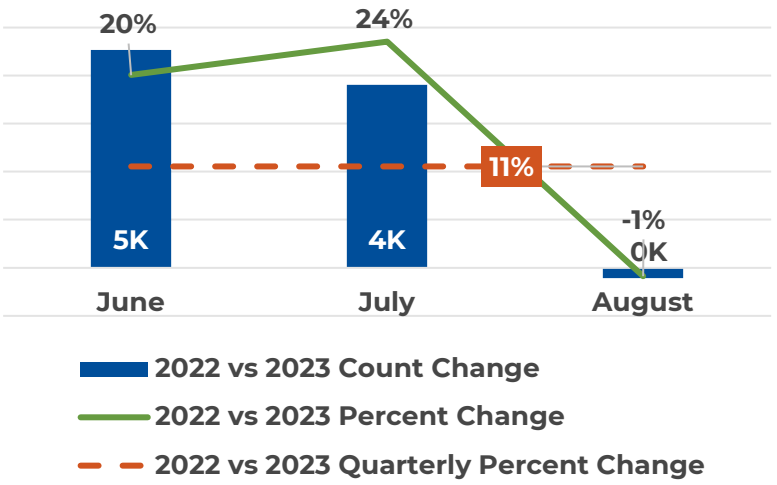




Utilization (Cont.)

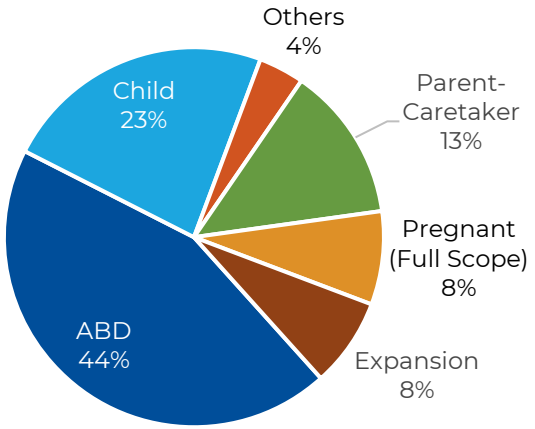
Out of State Services (Non Border County) - Total Members Utilization



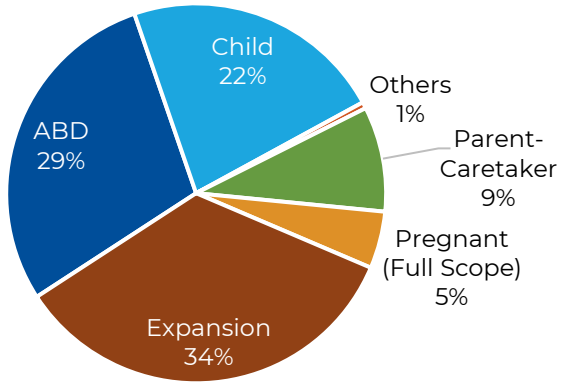


Out of State Services (Non Border County) - Total Members Utilization By Qualifying Group

Q1 2023

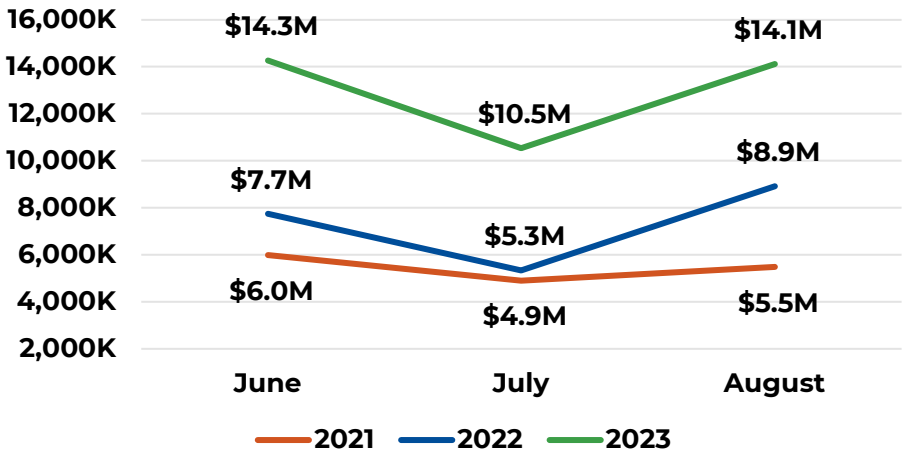


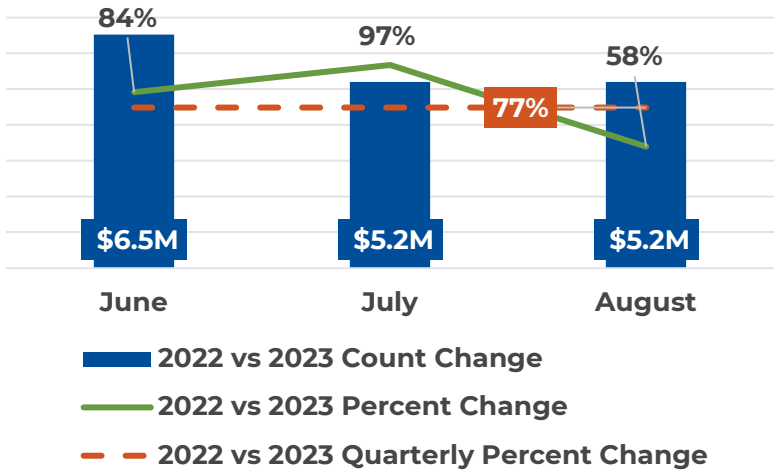
Q1 2024



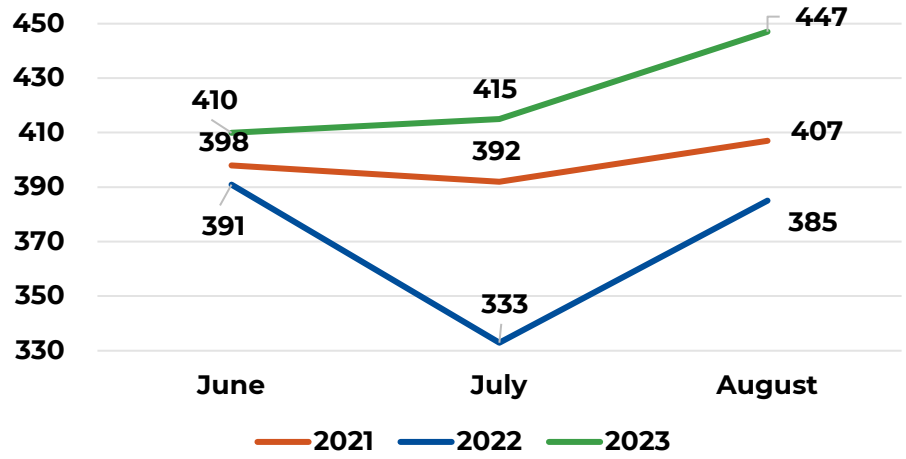
Utilization (Cont.)

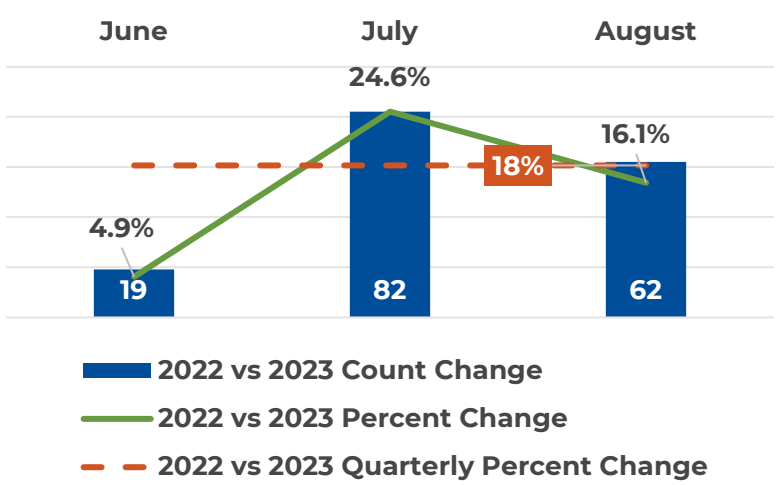
Out of State Services (Non Border County) - Total Reimbursements





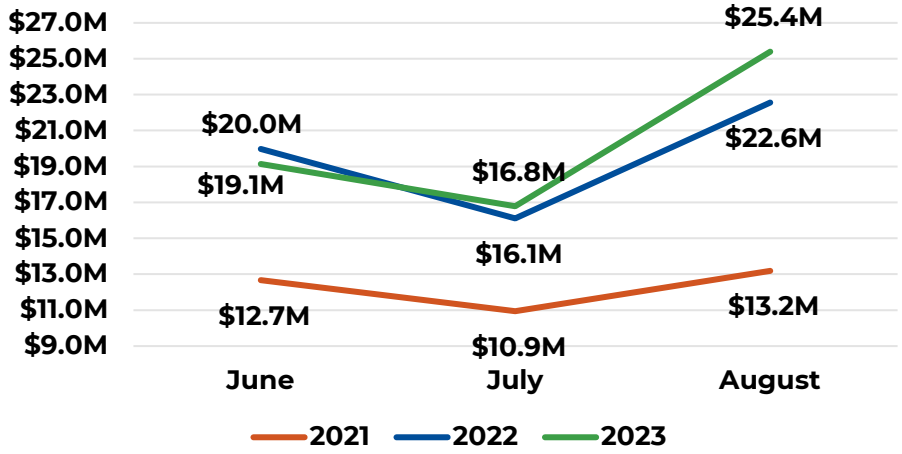
Out of State Services (Non Border County) - Total Active Billing Providers

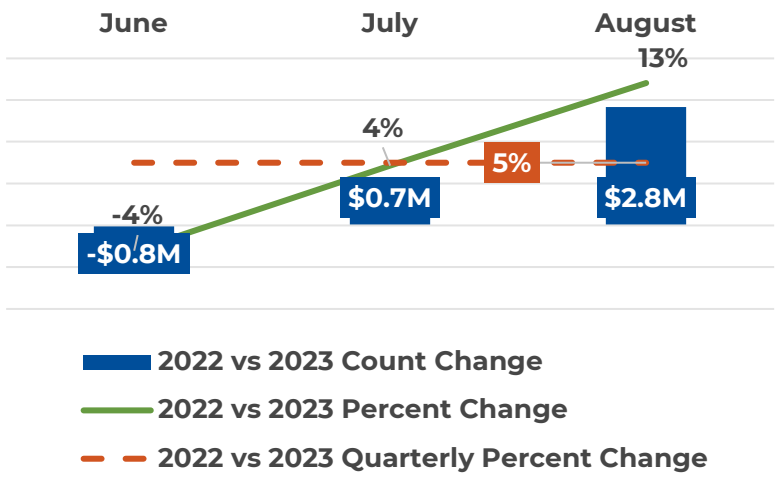




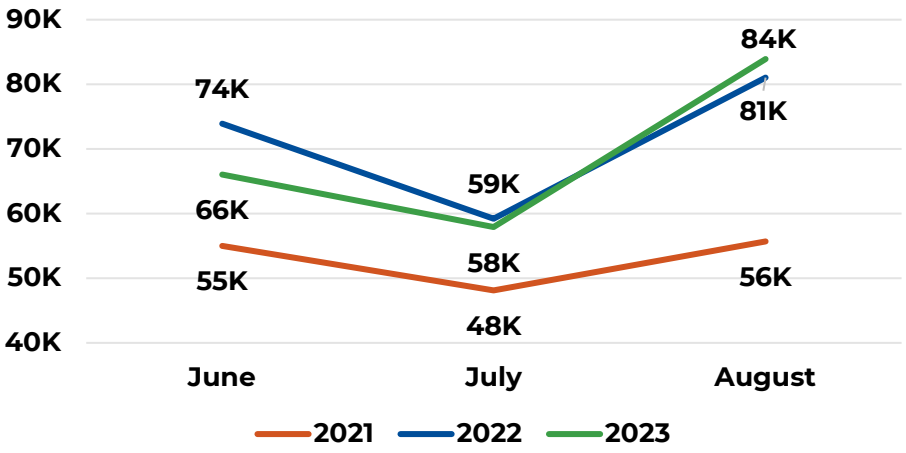
Utilization (Cont.)

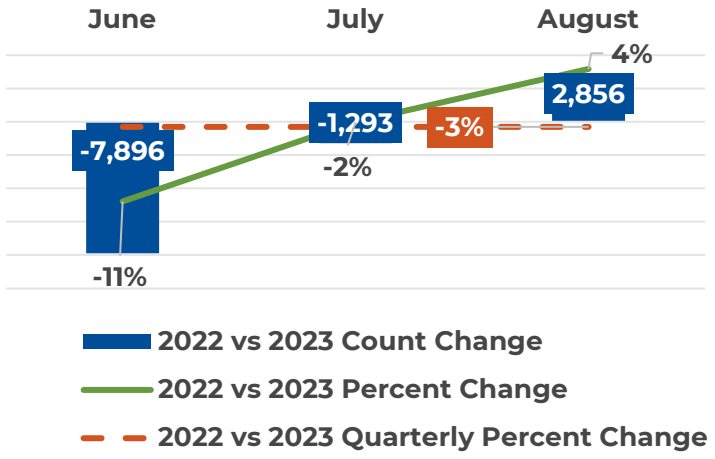
Dental Claims





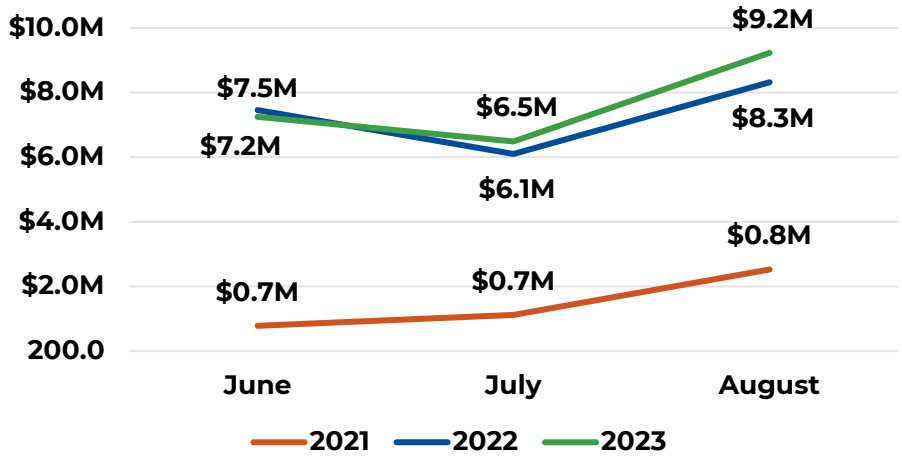
Total Members with Dental Claims

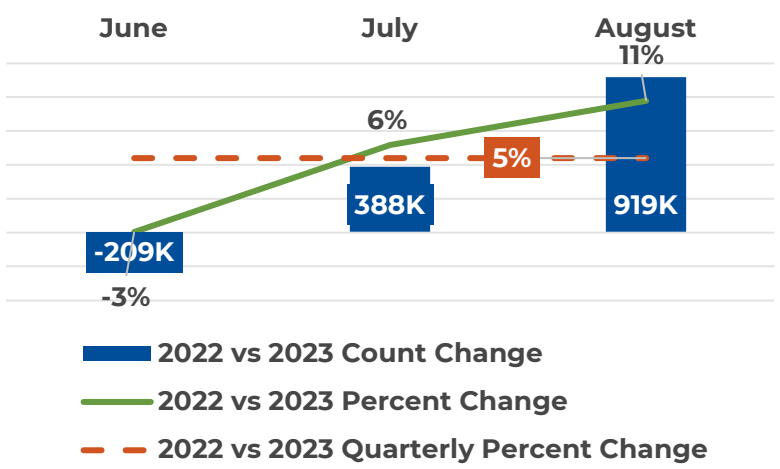




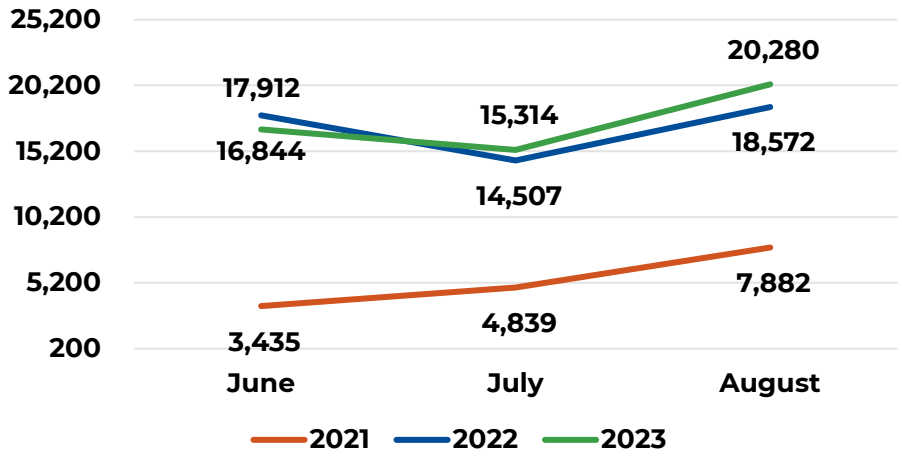
Utilization (Cont.)

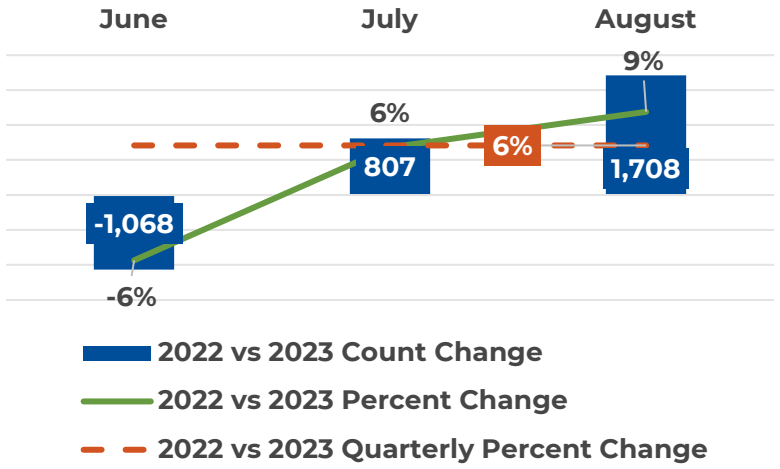
Adult (21 & Over) Dental Claims





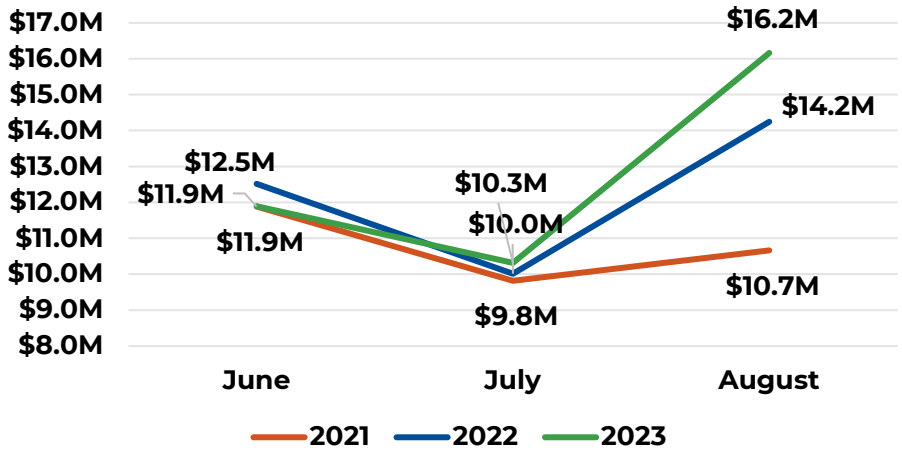
Adults (21 & Over) with Dental Claims

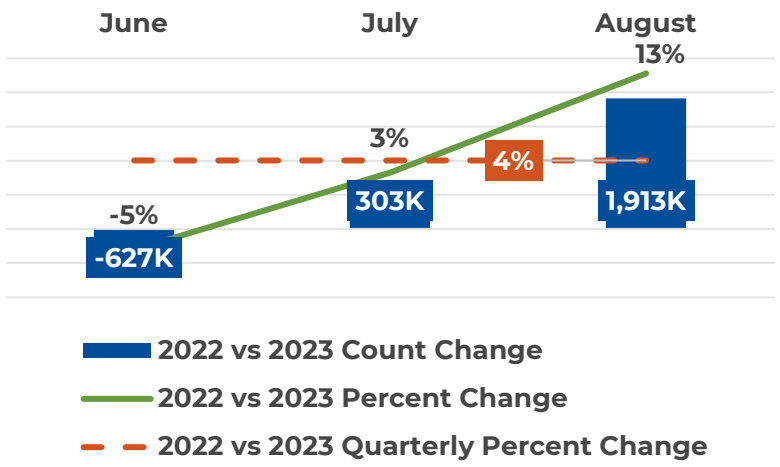




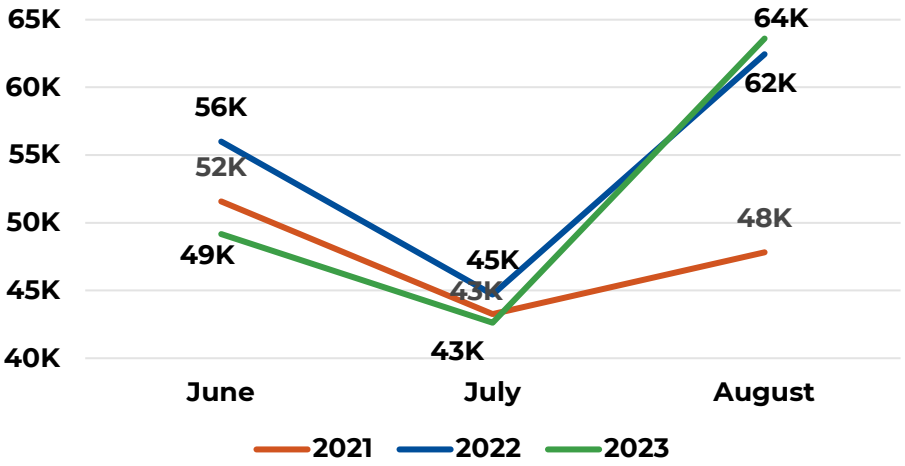
Utilization (Cont.)

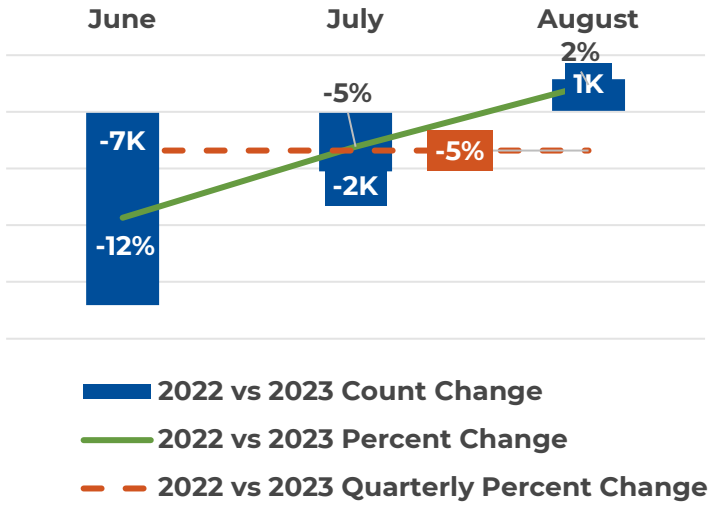
Children (Under 21) Dental Claims





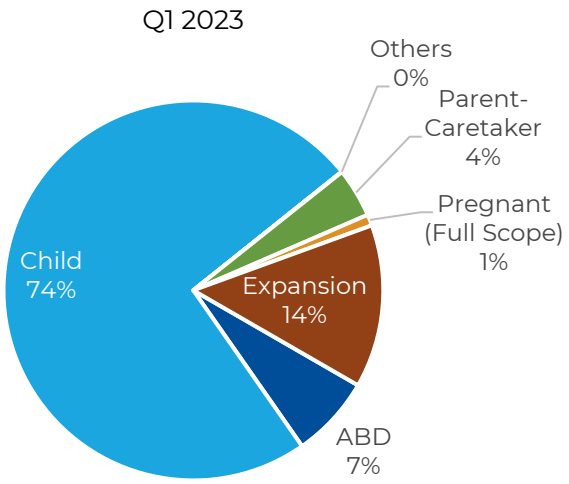
Children (Under 21) with Dental Claims

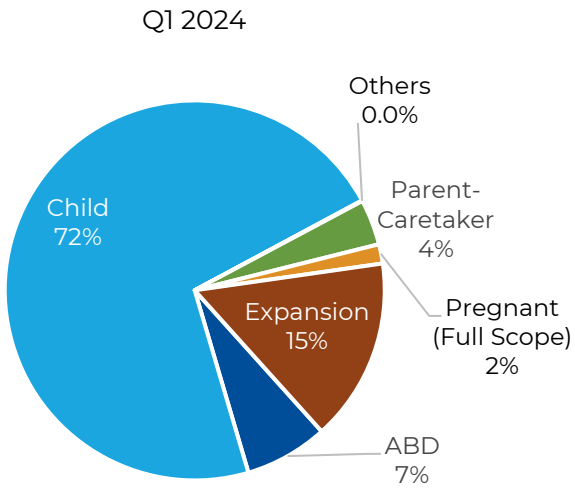




Utilization (Cont.)

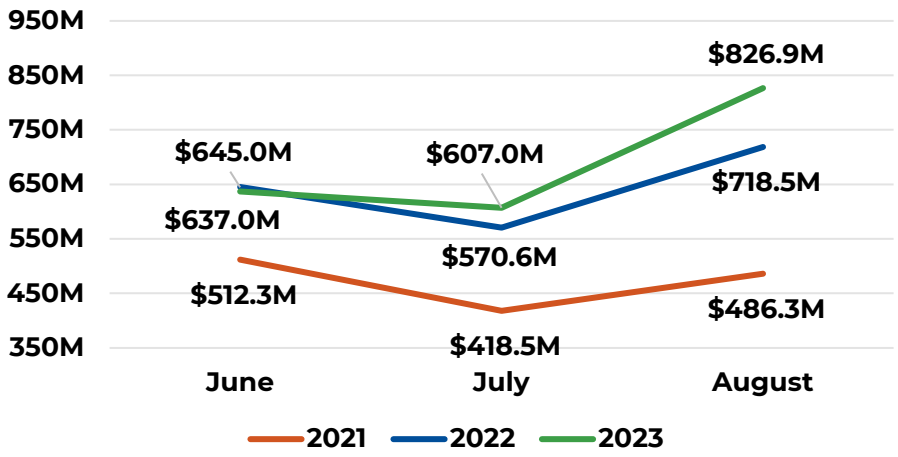
Members With Dental Claims By Qualifying Group

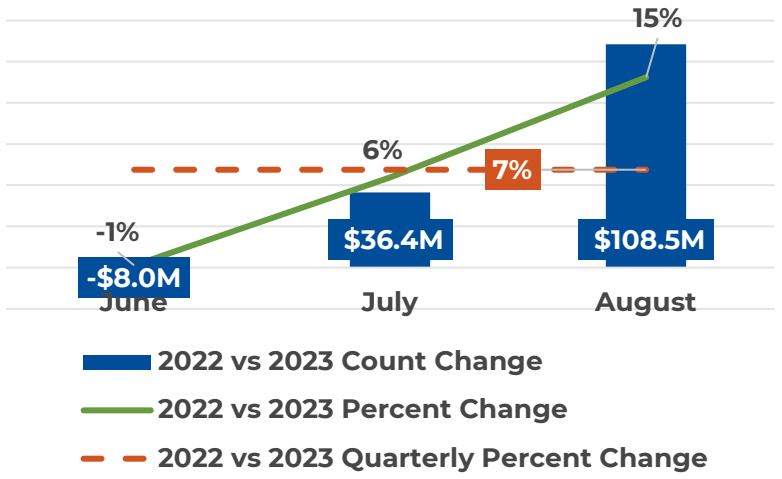




Financials

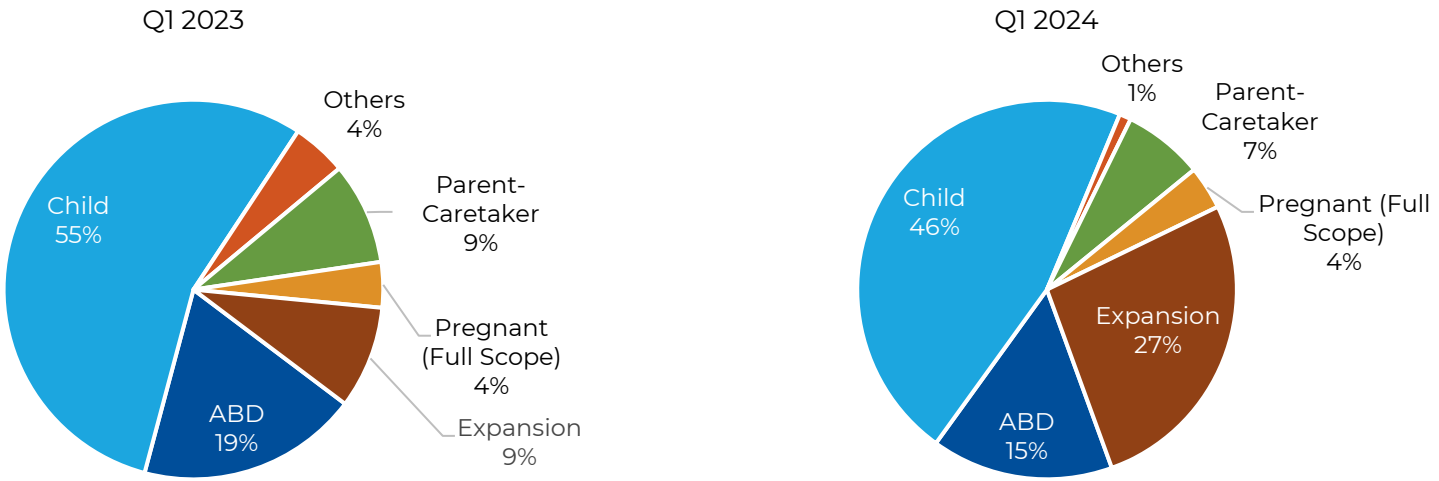
Total Agency Expenditures



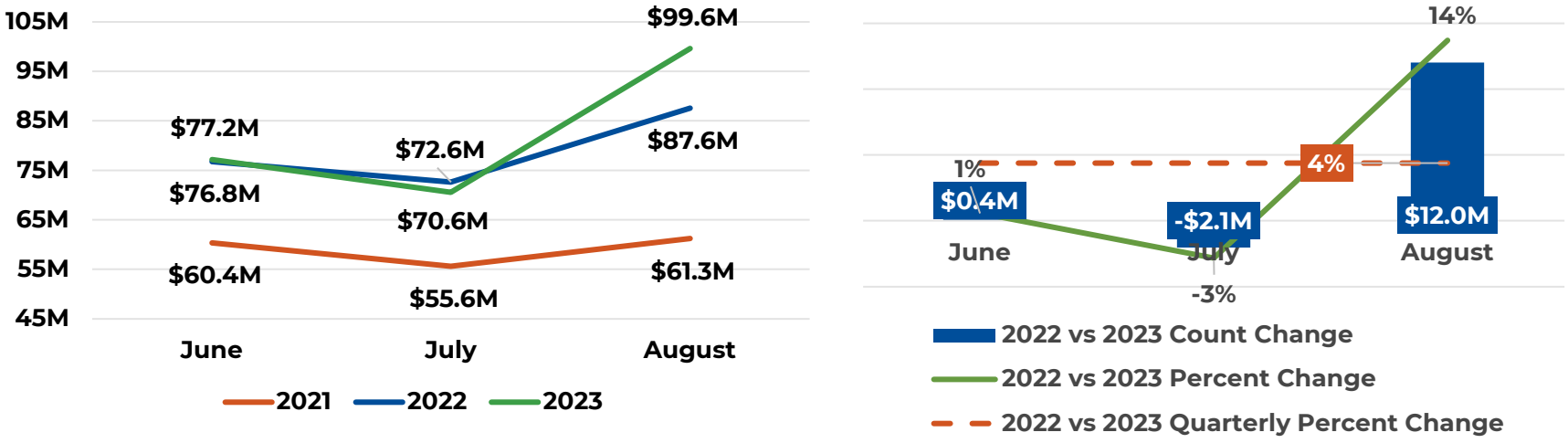


Financials (Cont.)

Total Agency Members Utilization by Qualifying Group



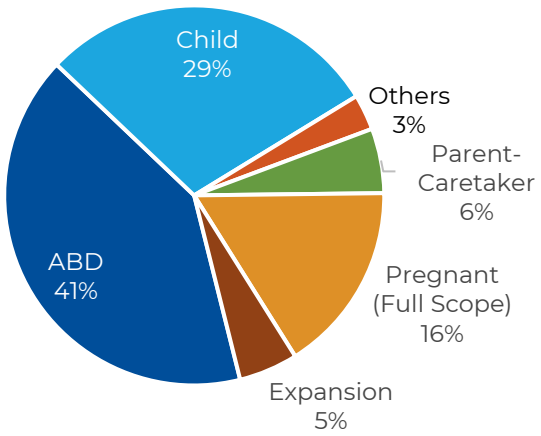
Inpatient Services Expenditures



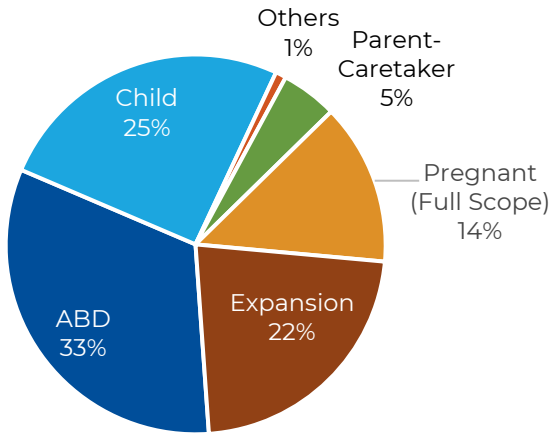
Financials (Cont.)

Inpatient Services Members Utilization by Qualifying Group

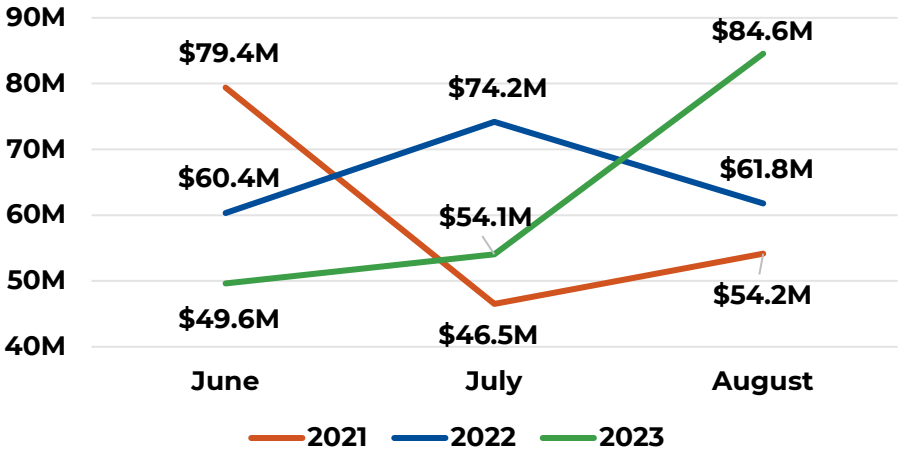
Q1 2023

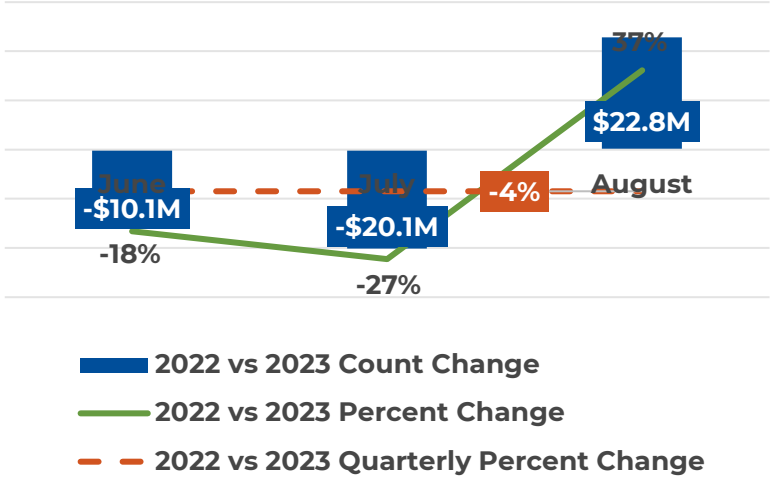


Q1 2024



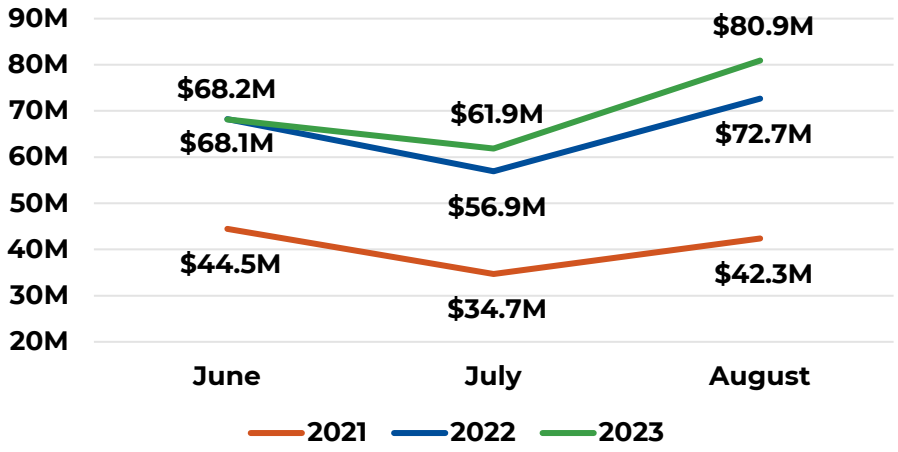
Nursing Facility Expenditures

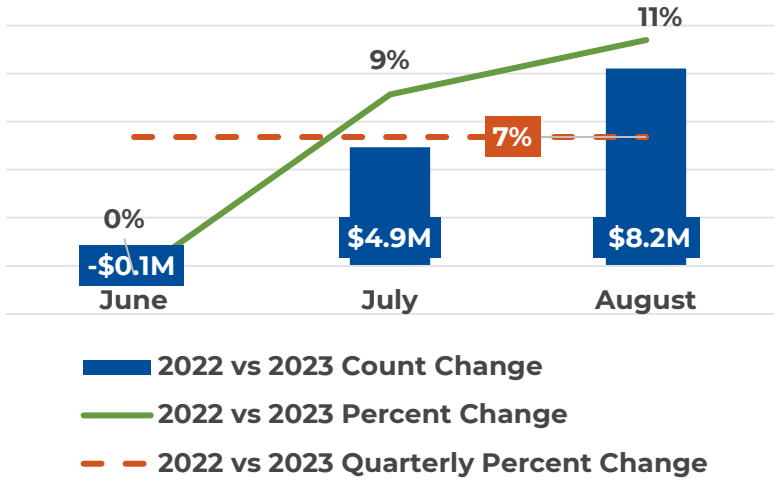




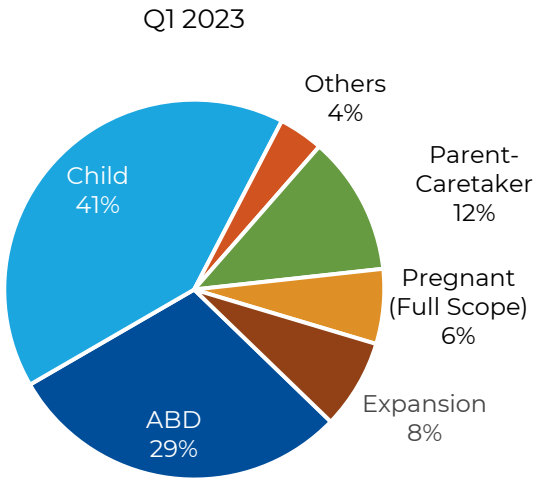
Financials (Cont.)

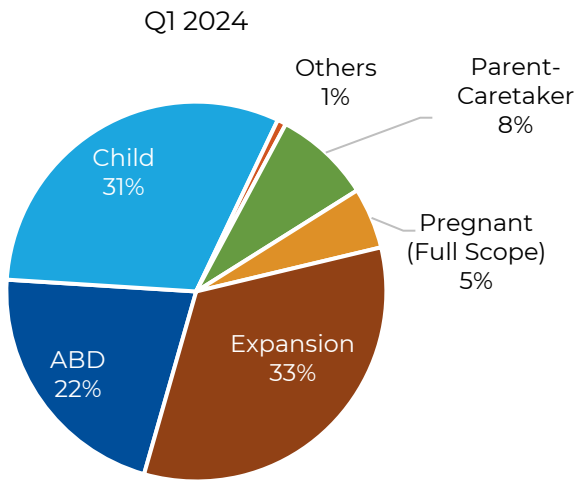
Outpatient Hospital Expenditures





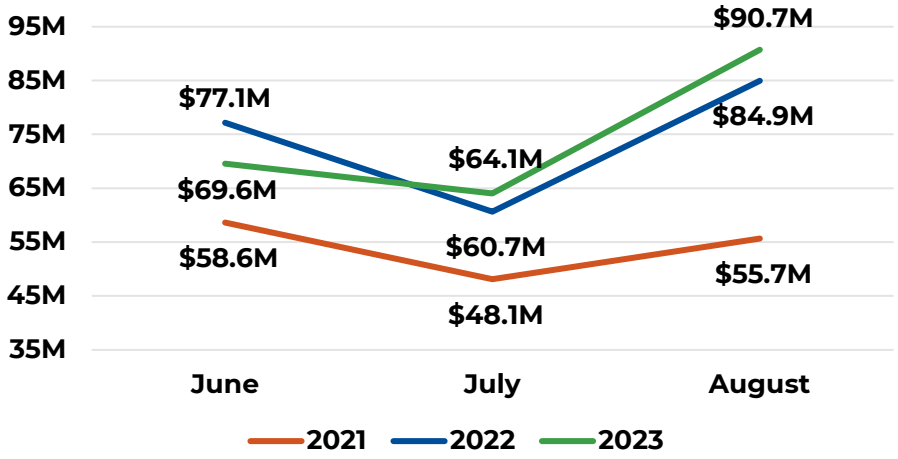
Outpatient Hospital Members Utilization by Qualifying Group

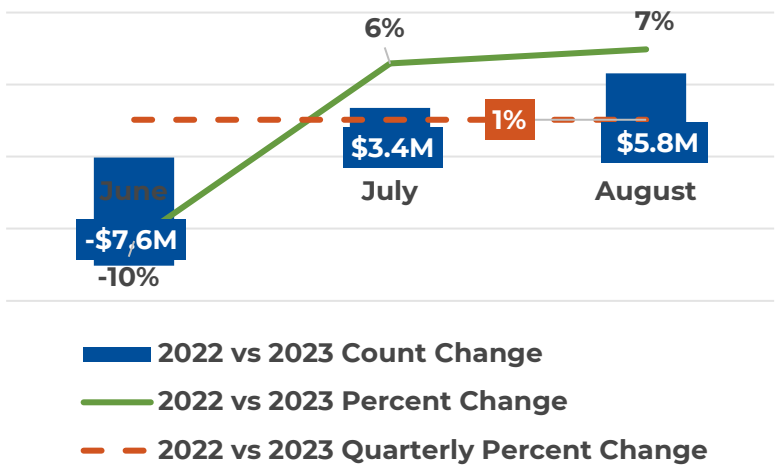




Financials (Cont.)

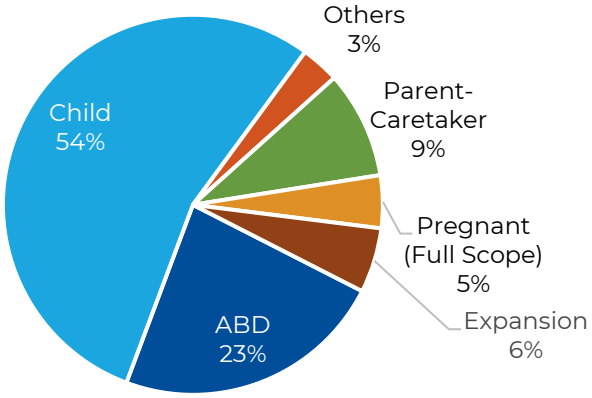
Physician Expenditures



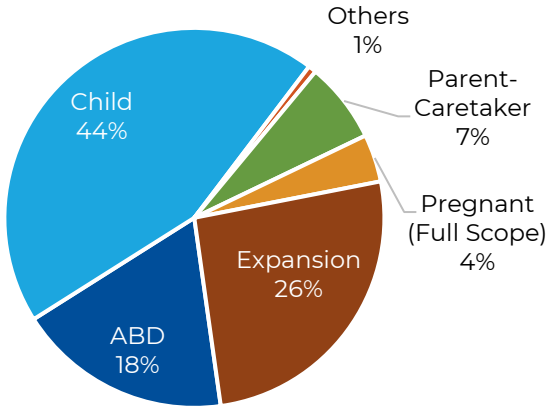


Physician Members Utilization By Qualifying Group

Q1 2023

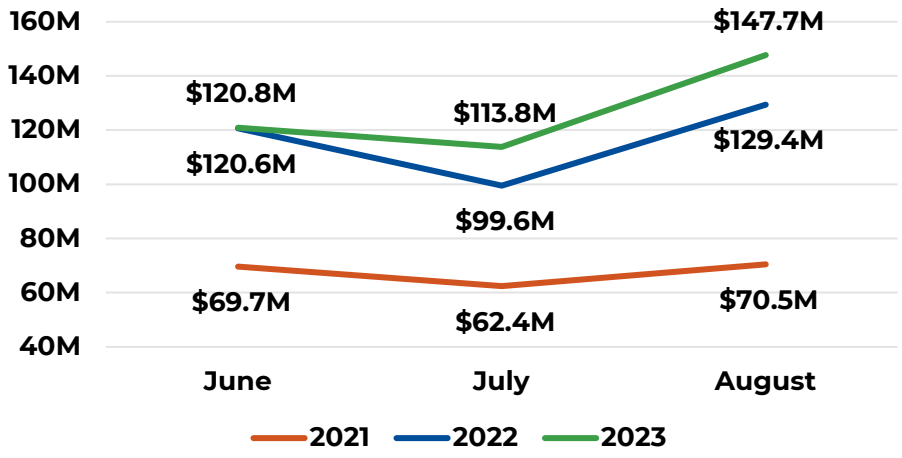


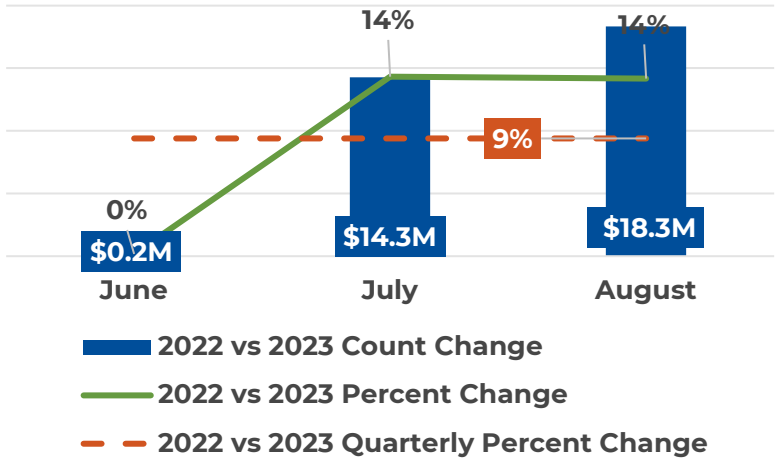
Q1 2024



Financials (Cont.)

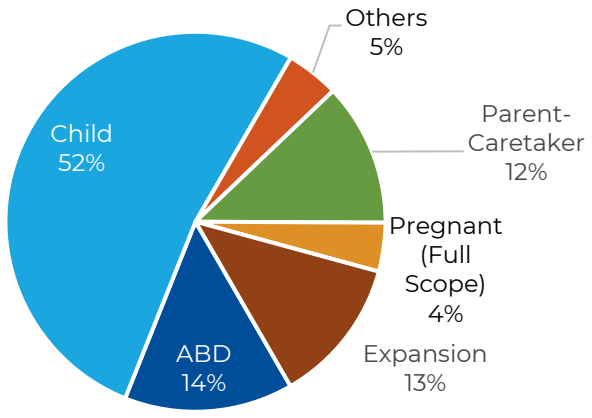
Prescribed Drugs Expenditures



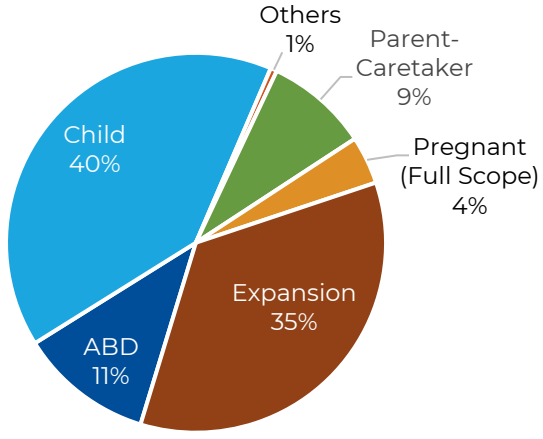


Prescribed Drugs Members Utilization By Qualifying Group

Q1 2023

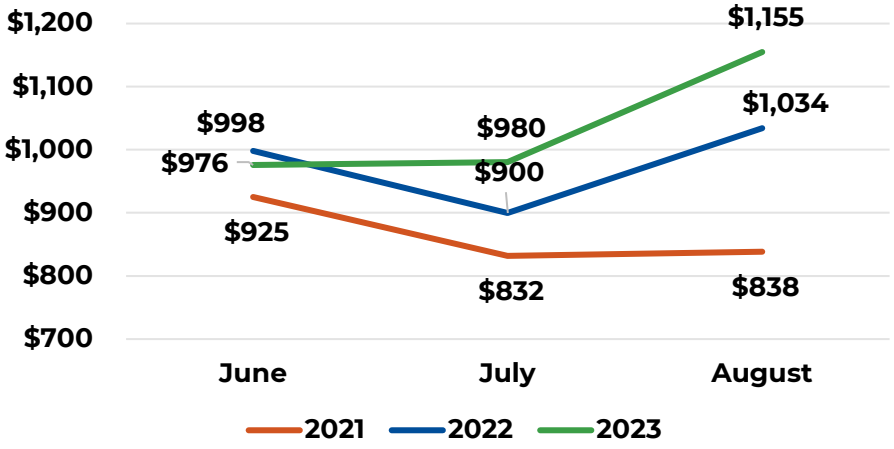


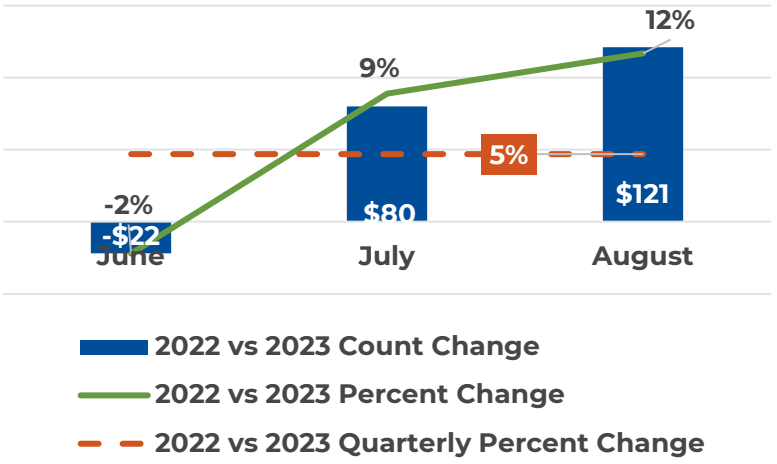
Q1 2024



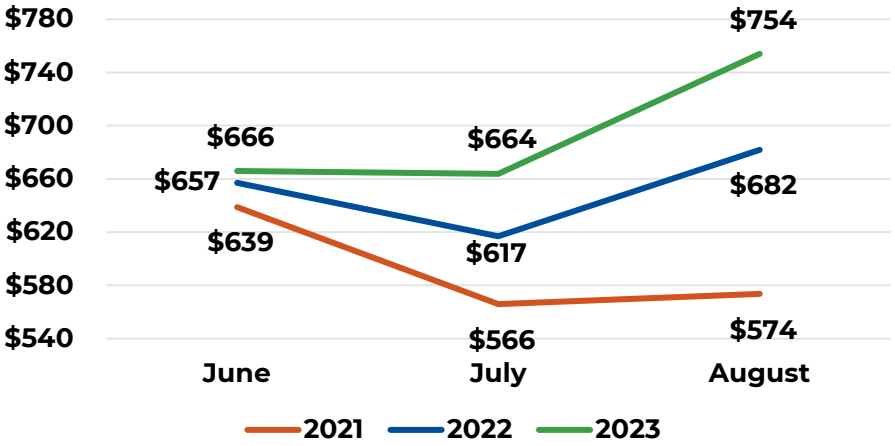
Financials (Cont.)

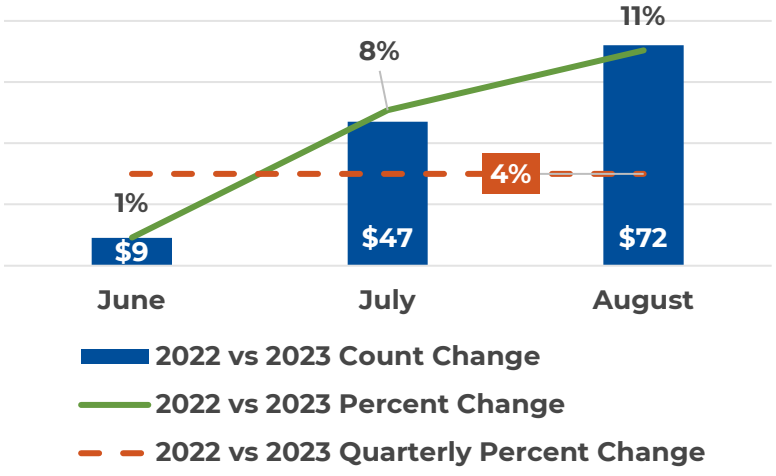
Average Per Total Member Served





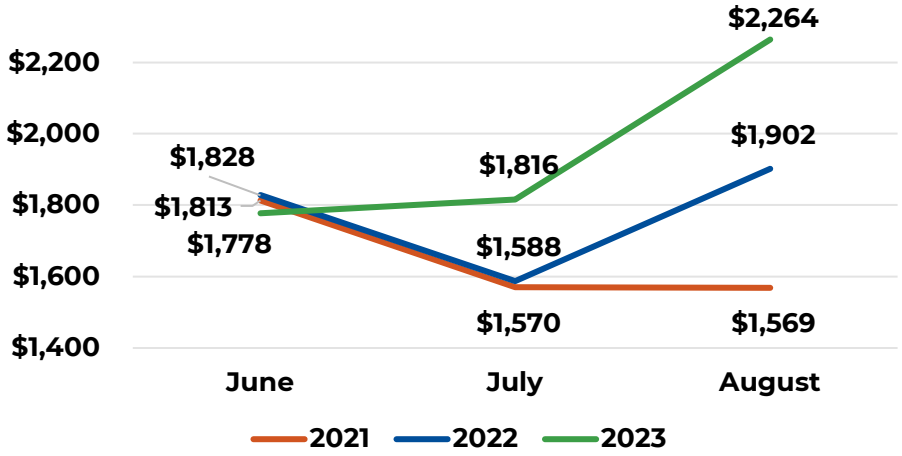
Average Per Child (Under 21) Member Served

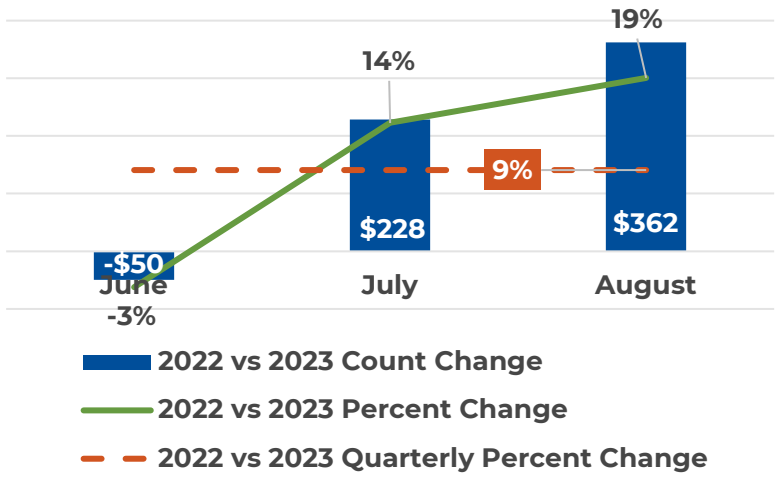




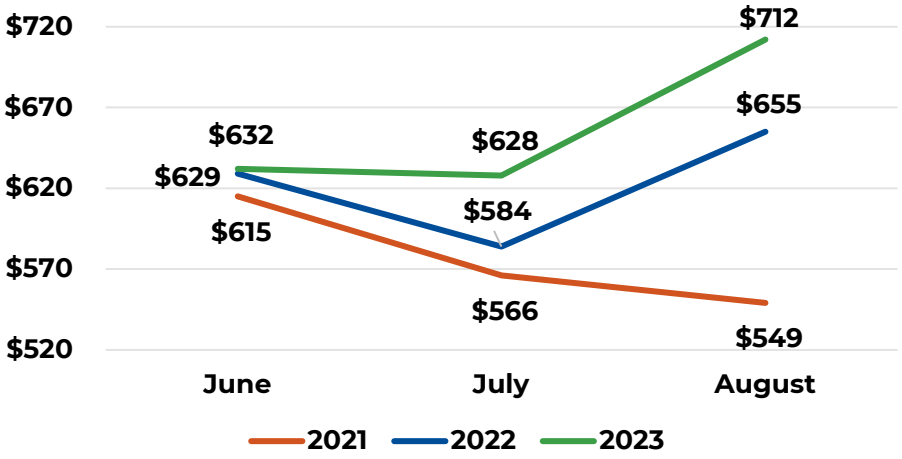
Financials (Cont.)

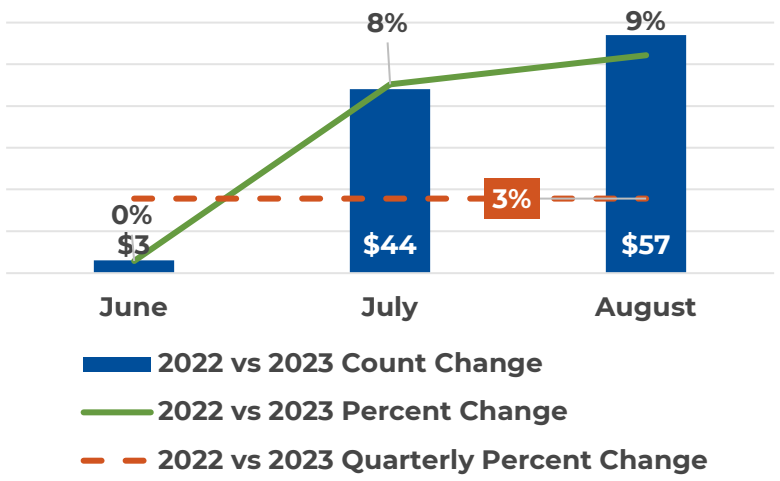
Average Per Aged/Blind/Disabled Member Served





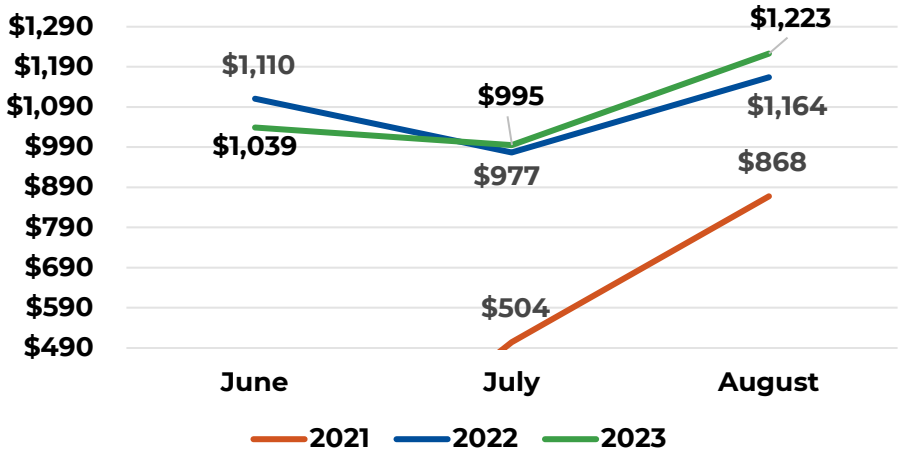
Average Per Children & Parent/Caretaker Member Served

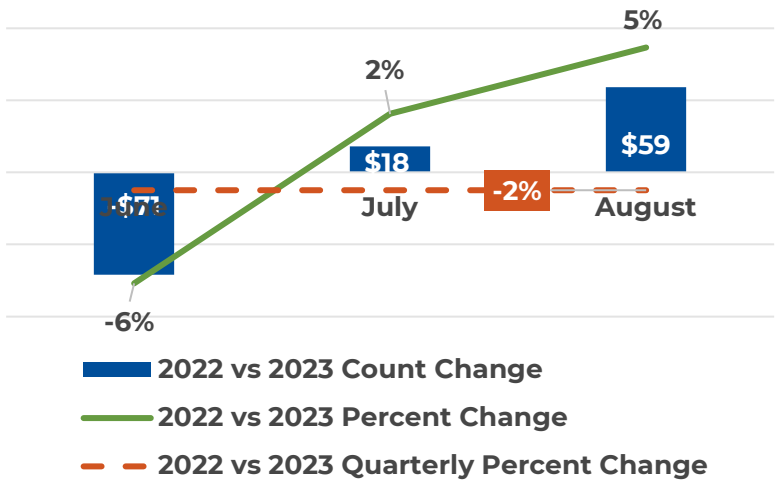




Financials (Cont.)

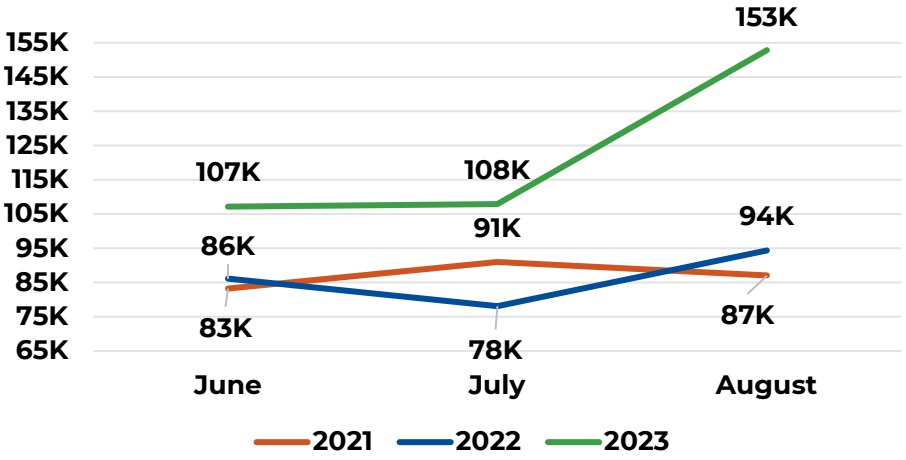
Average Per Expansion Member Served (Effective July 2021)

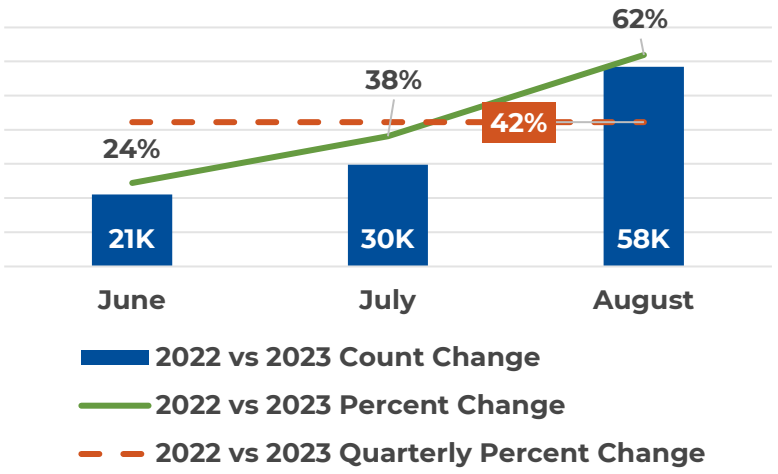




Call Center

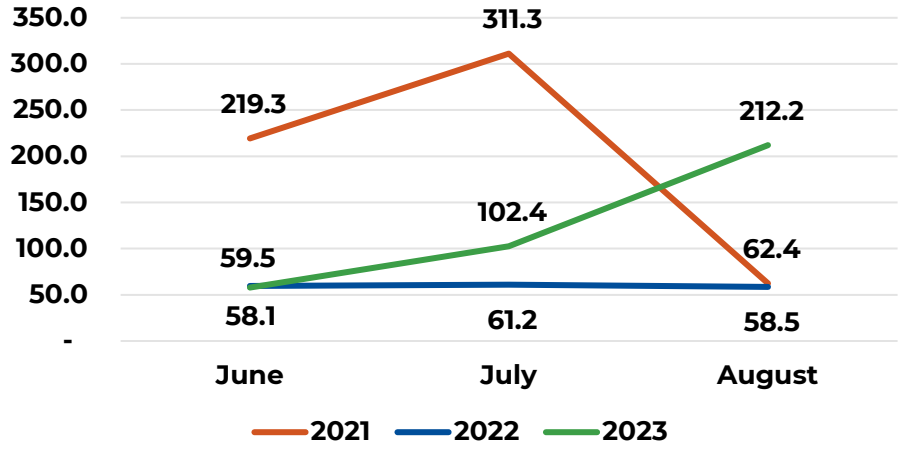
Call Center - Member Calls Answered

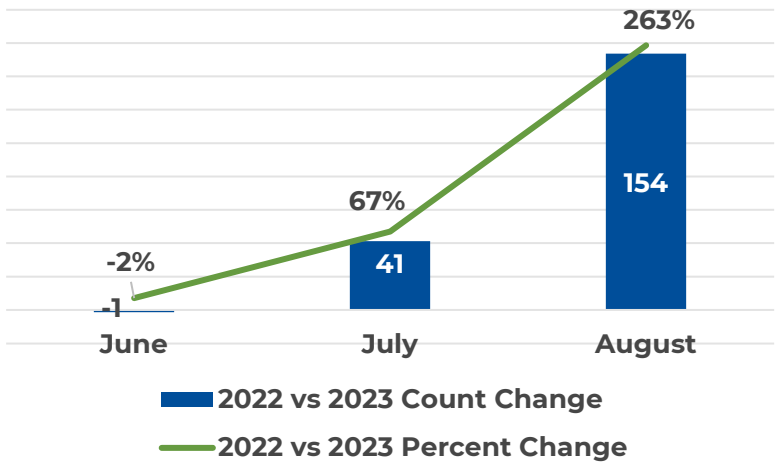




Call Center (Cont.)

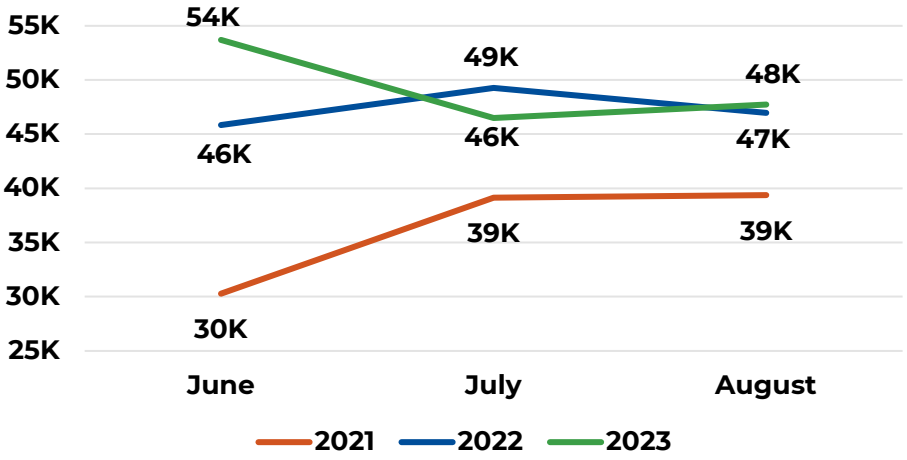
Call Center - Average Wait Time (In Seconds)

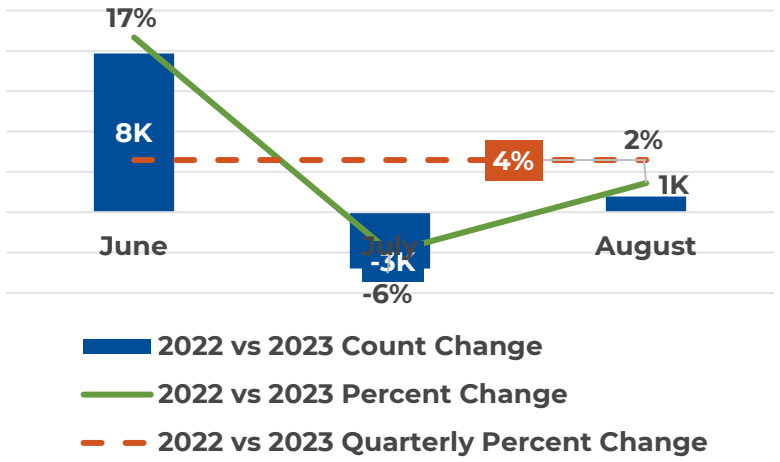




Prior Authorization

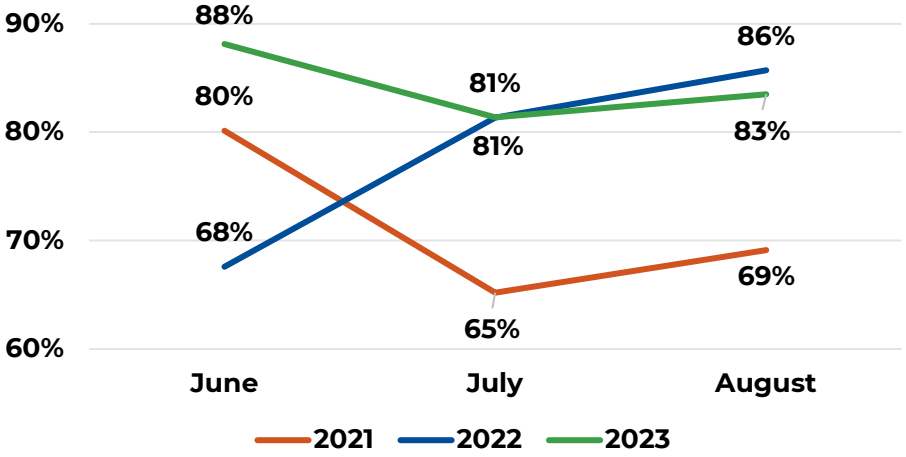
Prior Authorization - Total Combined - Total Completed PA Volume

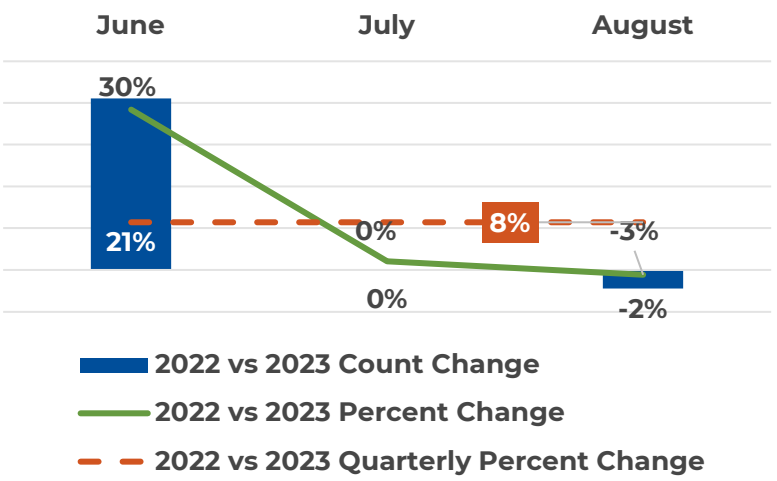




Prior Authorization (Cont.)

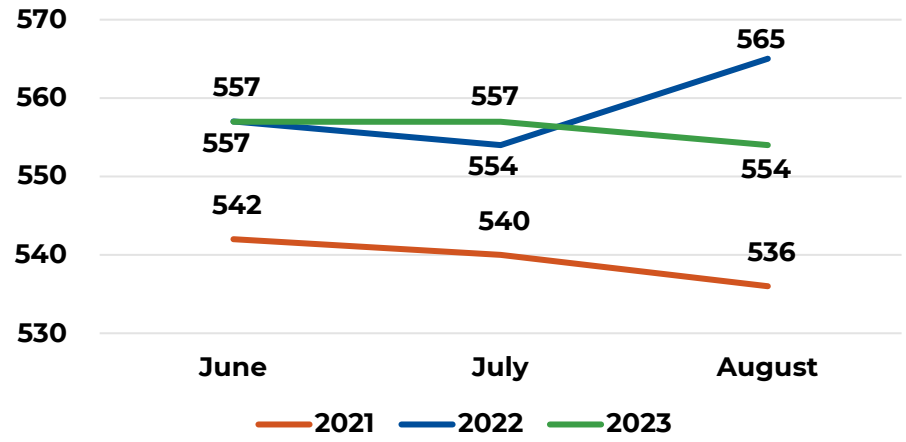
Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

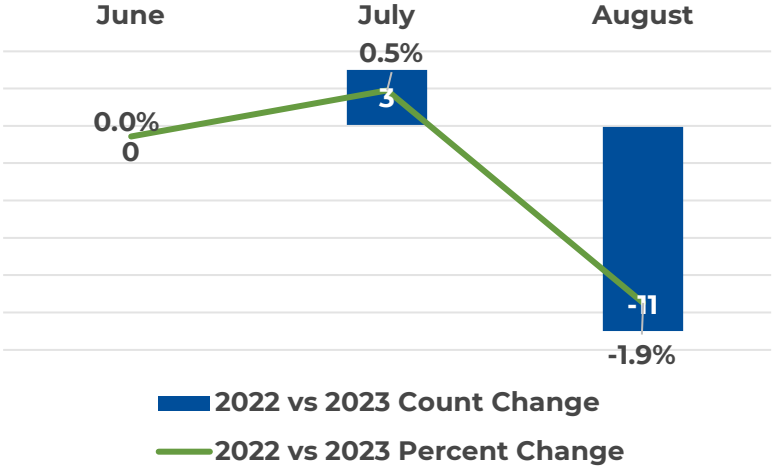




Agency Stats & Provider Network

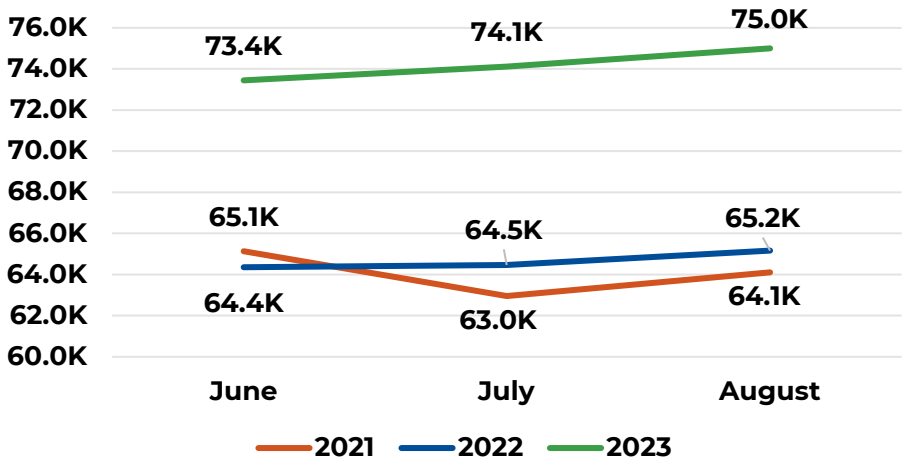
OHCA Admin - Number of FTEs

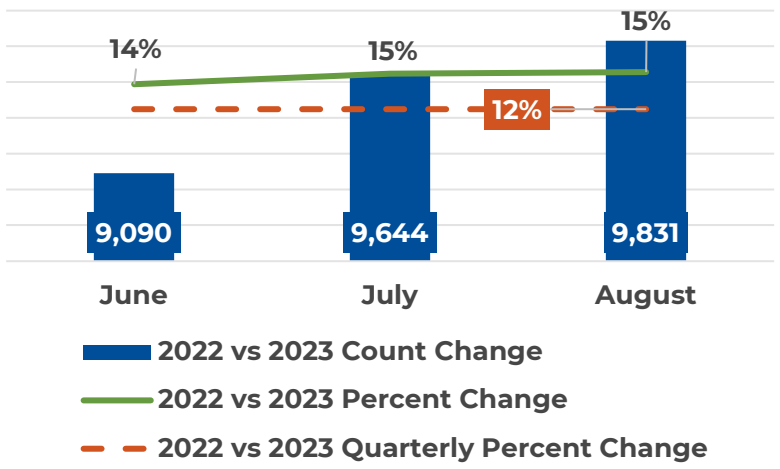




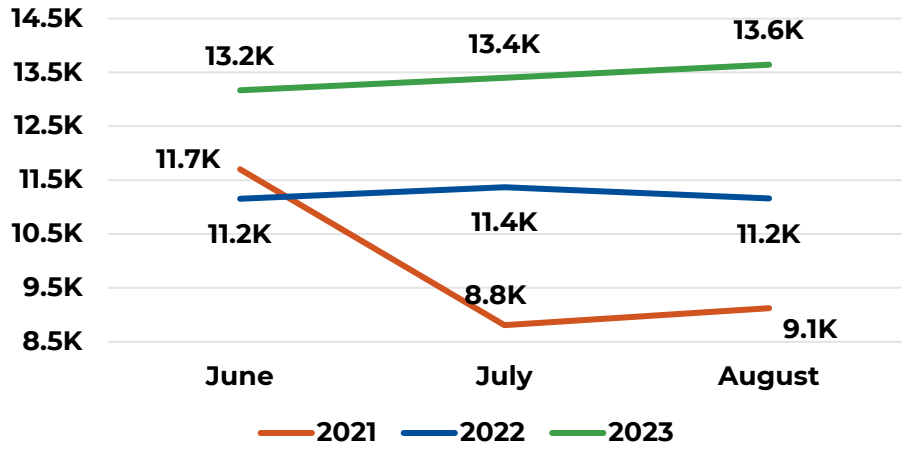
Agency Stats & Provider Network (Cont.)

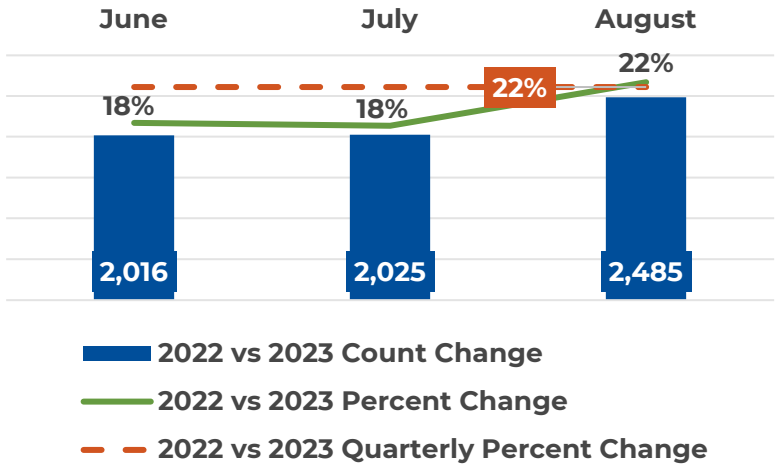
Total Providers





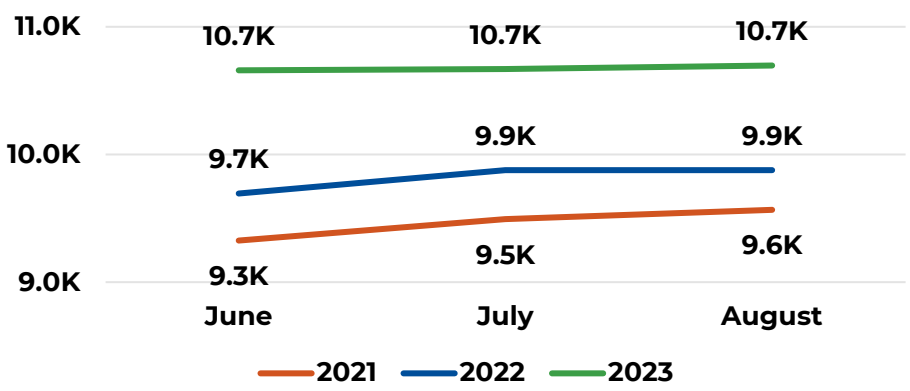
Mental Health Providers (In-State Only)

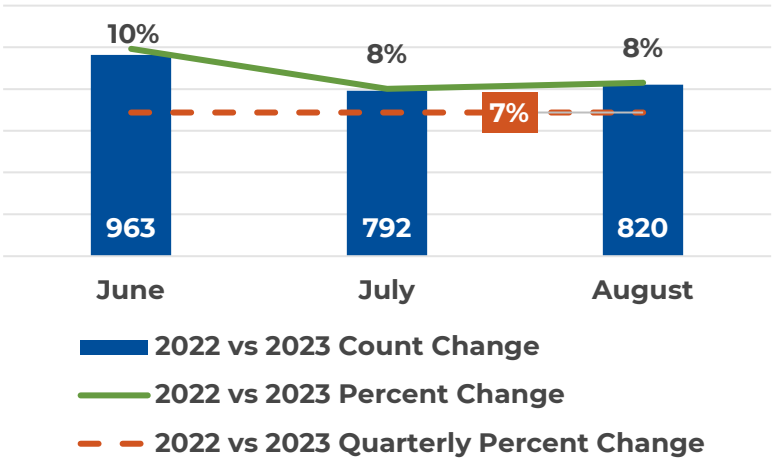




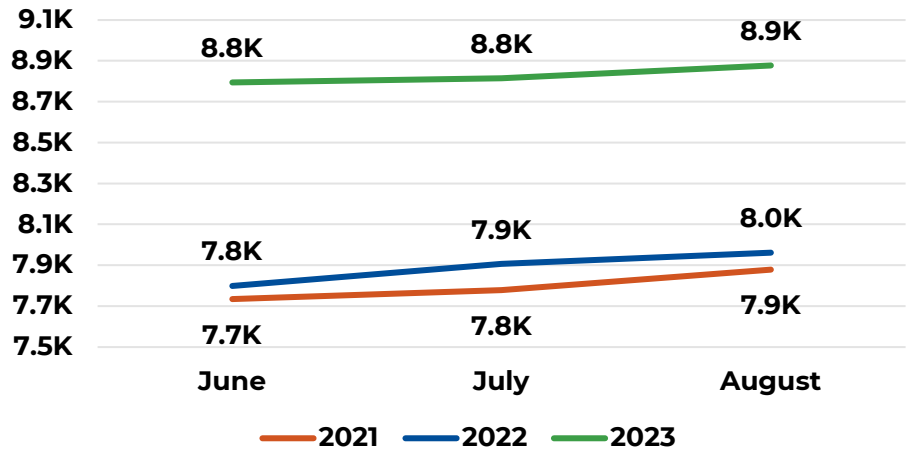
Agency Stats & Provider Network (Cont.)

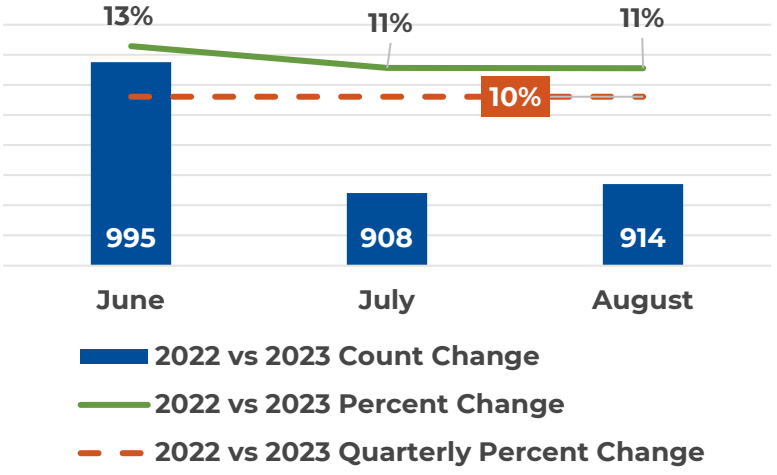
Physicians (In-State Only)





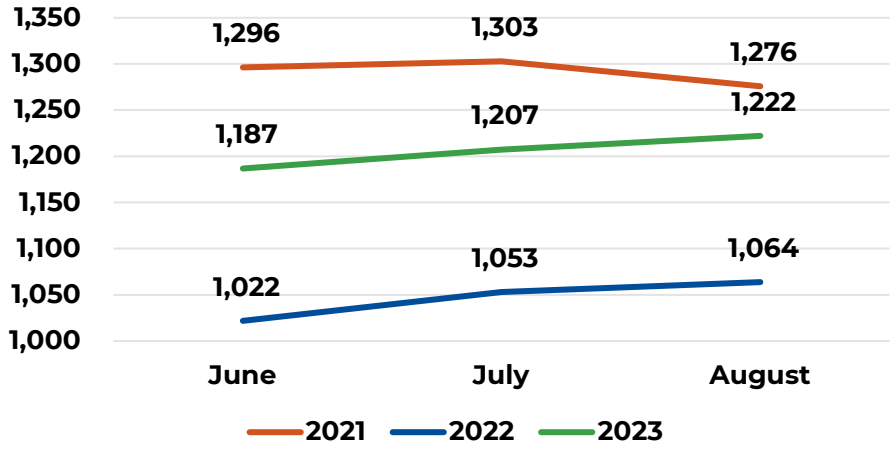
Primary Care Providers (In-State Only)

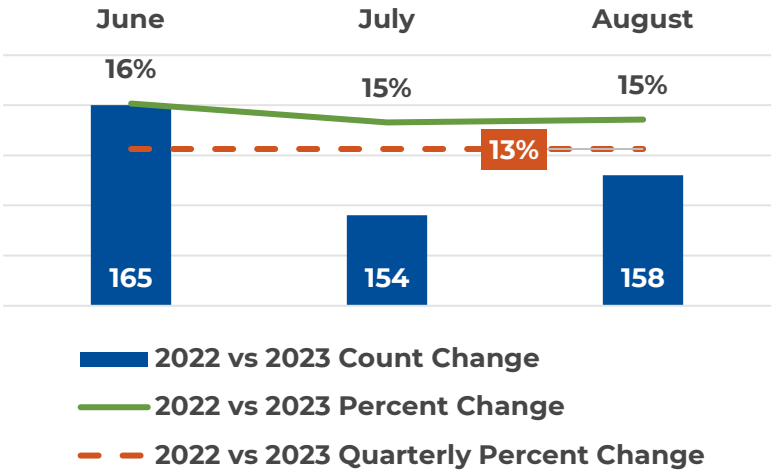




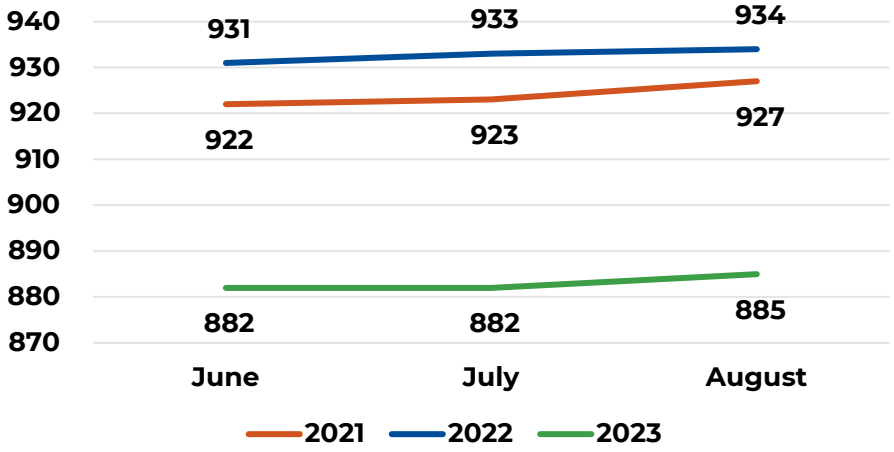
Agency Stats & Provider Network (Cont.)

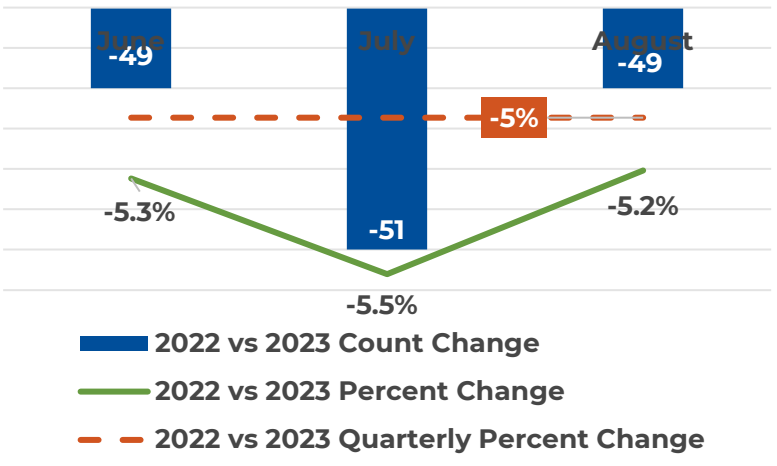
Dentists (In-State Only)





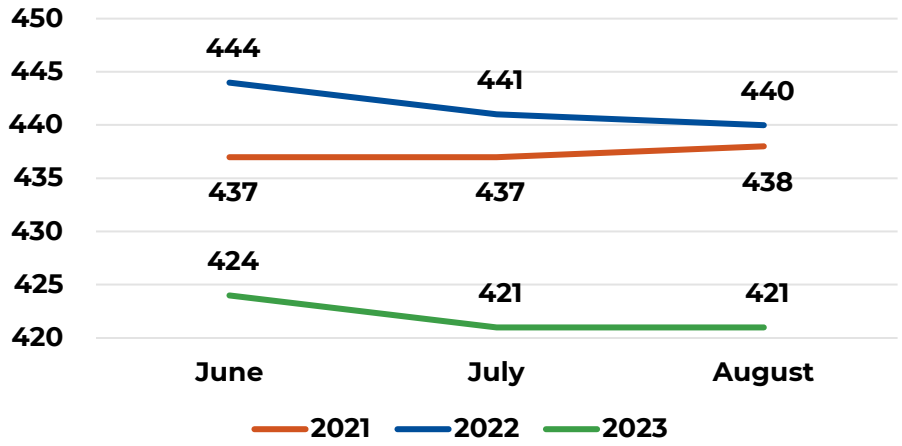
Pharmacy (In-State Only)

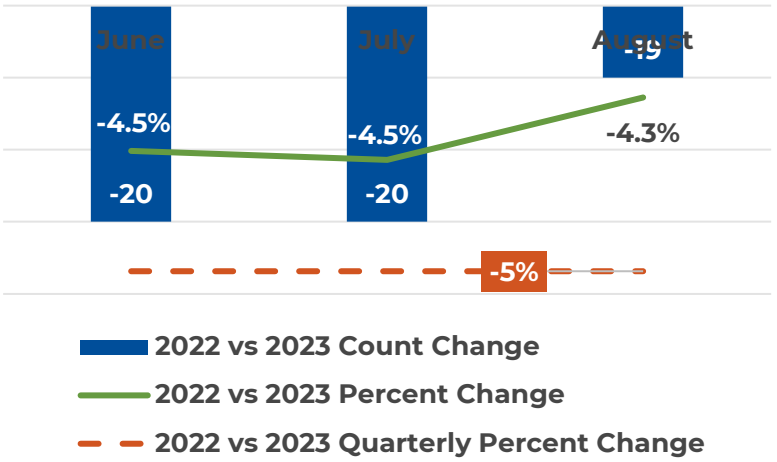




Agency Stats & Provider Network (Cont.)

Extended Care Facilities (In-State Only)





Hospitals (In-State Only)