OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
December 11, 2024, 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_UorSDpGkTDW8Dywb5_Xt2w
Telephone: 1-669-216-1590 Webinar ID: 160 990 4758

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

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

2. Discussion and Vote on the September 17, 2024, OHCA Board Meeting Minutes……..…..….Marc Nuttle, Chair

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

    a) Member Moment

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

5. Chief Administrative Officer……..……Elizabeth Cooper, Chief Administrative Officer

6. Chief of Staff Report……Christina Foss, Chief of Staff

7. Discussion of Report from the Pharmacy Advisory Committee and Possible Action Regarding Drug Utilization Review Board Recommendation:……..……Jeff Cruzan, MD Member, Pharmacy Advisory Committee

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

Item:	Drug Name:	Used For:
i.	Filsuvez® (birch triterpenes 10% topical gel)	Epidermolysis Bullosa (EB)
ii.	Kisunla™(donanemabazbt)	Alzheimer's Disease (AD)
iii.	Defencath® (taurolidine/heparin)	Prevention of Dialysis Catheter-Related Blood Stream Infections
iv.	Wegovy® (semaglutide)	Risk Reduction of Major Adverse Cardiovascular Disease (MACE)
v.	Avzivi® (bevacizumab-tnjn) Fruzagla® (fruquintinib)	Colorectal Cancer (CC)
vi.	Accrufer® (ferric maltol)	Iron Deficiency Anemia (IDA)
vii.	Exblifeb® (cefepime/enmetazobactam) Meropenem 2 gram Nitrofurantoin 50mg/5ml Suspension Zevtera® (ceftobiprole/medocaril sodium	Various Infections

viii.	Penicillamine 250mg tablet Trientine HCl 500mg capsule	Wilson's Disease (WD)
ix.	Eohilia™ (budesonide oral suspension)	Eosinophilic Esophagitis (EoE)
x.	Hercessi™ (trastuzumab-strf) Truqap™ (capivasertib)	Breast Cancer (BC)
xi.	Wainua™ (eplonterse)	Polyneuropathy of Hereditary Transthyretin-Mediated Amyloidosis (haTTR-PN)
xii.	Rivfloza® (nedosiran)	Primary Hyperoxaluria Type 1 (PH1)
xiii.	Casgevy™ (exagamglogene autotemcel) Lyfgenia® (lovotibeglogene autotemcel) Xromi® (hydroxyurea oral solution) Vafseo® (vadadustat)	Sickle Cell Disease (SCD) Anemia of Chronic Kidney Disease (CKD)

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

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

    i. APA WF #24-13 PACE Licensure Policy
    ii. APA WF #24-14 Hospice Benefit Expansion
    iii. APA WF #24-18 Third Party Liability (TPL) for School Based Services
    iv. APA WF #24-19 Updating Abortion Policy
    v. APA WF #24-21 Certified Registered Nurse Anesthetist (CRNA) Rate Increase
    vi. APA WF #24-24 Medication Assisted Treatment (MAT) Clarification
    vii. APA WF #24-25 Psychological Testing Limit Increase
    viii. APA WF #24-34 Community Health Services

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

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

12. OHCA Board Meeting Dates and Times for Calendar Year 2025 (Attachment E)……Marc Nuttle, Chair

13. Adjournment……Marc Nuttle, Chair

NEXT BOARD MEETING
January 15, 2025, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

MINUTES OF AMENDED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
September 17, 2024
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on September 16, 2024 at 1:45 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on September 13, 2024 at 4:35 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Nuttle called the meeting to order at 2:02 9.m.

BOARD MEMBERS PRESENT: Chairman Nuttle, Vice-Chairman Yaffe (2:03p), Member Case, Member Corbett, Member Cruzan, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Member Christ, Member Jolley

ITEM 2 / PUBLIC COMMENT
Chairman Nuttle, OHCA Board Chairman

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

1. Austin Trent, CRNA
2. Stephen Gray, DDS
3. Joni Bruce, Oklahoma Family Network

ITEM 3 / DISCUSSION AND POSSIBLE VOTE ON THE AUGUST 12, 2024, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Member Cruzan moved for approval of the August 12, 2024, board meeting minutes, with the correction. The motion was seconded by Member Corbett

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Cruzan, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Member Christ, Member Jolley

ITEM 4 / CHIEF EXECUTIVE OFFICER REPORT
Ellen Buettner, Chief Executive Officer

CEO Buettner invited Lisa Gifford, Aetna Better Health of Oklahoma Executive Director, to present this month's member moment.

CEO Buettner highlighted the recipients of this year's Key Principles awards that were presented at the July Looking Back, Looking Forward event. The awards were presented to individual staff and teams that hit on one of OHCA's Key Principles.

Traction – CEO Buettner presented the SFY25 Traction 1-Year Goals, which included the following:

- Health Outcomes – Expand Fee for Service School-Based Services, PCMH Redesign, Diabetic outreach to diabetic members.
- Operational Excellence – Implement monitoring oversight tool, Implement V3locity for EGID member self-service, Develop a quality review process.
- Fiscal Responsibility – Map and document all contracting processes, Implement call center AI, Implement audit process for death-match reviews.
- High Performing Teams – Reduce PDN appeal backlog, Streamline contracted entity communication, Assign subject matter experts for all agency website sections.

Stakeholder Engagement – CEO Buettner highlighted the various engagements with our external stakeholders, including discussions with the Oklahoma Hospital Association around how to improve access to care in rural Oklahoma, especially when talking about improving maternal health outcomes. The same conversations have been ongoing with the Oklahoma Osteopathic Association. Lastly, CEO Buettner updated the board on the recent Legislative Office of Fiscal Transparency (LOFT) rapid review of OHCA's finances. LOFT had a few highlights which included the increased federal funding and the need for expansion funding moving forward and the importance of eligibility determinations being timely.

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

ITEM 5 / STATE MEDICAID DIRECTOR REPORT
Traylor Rains, State Medicaid Director

Mr. Rains provided a State Medicaid Director update, which included information on SoonerSelect Achievements, What's New and Noteworthy, and School-Based Services Expansion.

SoonerSelect Achievements – As of September, total enrollment for SoonerSelect Medical is 579,830, for SoonerSelect Children Specialty is 19,841, and for SoonerSelect Dental is 627,009. Mr. Rains stated that the reason there is a discrepancy between the medial and dental plans is because there was an uptake of the Tribal population in choosing a dental plan. For Reimbursements, OHCA has reimbursed over $872 million across all the plans since April 1st. In total, over 490,000 unduplicated members have been served in SoonerSelect since April 1st.

New and Noteworthy – OHCA has partnered with ODMHSAS to pursue funding for the Innovation in Behavioral Health Model. The grant application has been refined and resubmitted and will give OHCA and ODMHSAS the opportunity to focus on integrating primary care and medical services in the behavioral health provider side. OHCA will focus on the certified community addiction recovery clinic side, as well as other private outpatient behavior health providers. Mr. Rains also highlighted the opportunity to apply for the Transforming Maternal Health Model Grant. This grant would focus on building out the array of services available to pregnant moms and kiddos, including expanding the area of certified midwives and birthing centers, and figuring out ways to incentivize OBGYNs to practice in Oklahoma to fill the maternal health deserts.

School-Based Services Expansion – OHCA was awarded the grant for school-based services in collaboration with the State Department of Education. The grant will focus on giving schools the education they need to know how to provide services and how to bill SoonerCare for those services.

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

ITEM 6 / CHIEF ADMINISTRATIVE OFFICER REPORT
Elizabeth Cooper, Chief Administrative Officer

Ms. Cooper updated the board on the recent first floor agency remodel. The remodel will create new collaborative spaces, conference rooms, secured areas, access areas, and additional workspaces.

ITEM 7 / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE
Dr. Jeff Cruzan, Pharmacy Committee Member

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

Item	Drug Name:	Used For:
i.	Lantidra™	Type 1 Diabetes Mellitus (T1DM)
ii.	Izervay™	Geographic Atrophy (GA)
iii	Rezzayo™	Invasive Candidiasis (IC)
iv.	Augtyro™ Pemrydi RTU®	Non-Small Cell Lung Cancer (NSCLC)
v.	Rezdiffra™	Noncirrhotic Nonalcoholic Steatohepatitis (NASH)
vi.	Various Special Formulations: Clindacin® ETZ Kit	Acne Vulgaris

	Lodoco® Motpoly XR™ PoKonza™ Suflave™	Myocardial Infarction (MI) Prevention Seizures Hypokalemia Colon Cleanse
vii.	Qalsody® Rilutek®	Amyotrophic Lateral Sclerosis (ALS)
viii.	Liqrev® Opsynvi® Winrevair™	Pulmonary Arterial Hypertension (PAH)
ix.	Akeega® Anktiva®	Prostate Cancer (PC) Bladder Cancer (BC)

MOTION: Member Corbett moved for approval of item 7ai-ix, as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Cruzan, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Member Christ, Member Jolley

ITEM 8 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Phil Kennedy, Compliance Advisory Committee Chairman

Chairman Kennedy provided the Compliance Committee Update, which included information on OHCA Financials, Program Integrity, the State Plan Amendment Rate Committee Rates, and the Expenditure of Authority Contract.

OHCA Financials: For the fiscal year ended June 30, 2024, the OHCA's expenditures were 2.7% under budget while revenues were 2.2% under budget. This gives the agency a year end positive budget variance of $41.2 million. Our receivables from sister agencies are current and we continue to focus on timely collection while monitoring our cash flow.

Program Integrity: Program Integrity Provider Audits ended SFY 2024 with 1,491 completed audits and a final identified overpayment of $4,592,584.60. In SFY 2024, Clinical Provider Audits closed 49 comprehensive clinical audits with a total identified overpayment of $3,060,051.77. Of this total, $1,238,830.50 reflect the final overpayment following appeals and settlements in coordination with OHCA's legal department. In this same fiscal year, Data Analytics closed 609 audits, with a total identified overpayment of $1,530,785.79. In SFY 2024, 833 Payment Accuracy Measurement (PAM) and State Auditor and Investigator (SAI) audits were completed. Of these, 816 had no errors. The remaining 17 audits resulted in an overpayment of $1,747.04. Member Case asked if the overpayment totals could be presented as percentages instead of dollar amounts as they are small percentages of all total claims. Mr. Morris stated that OHCA could do that moving forward.

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

The Compliance Committee reviewed the SPARC items listed below and had a lengthy discussion regarding item 8.a.v (CRNA Rate Increase). After discussion, the committee found the SPARC amendments proposed were required to administratively align rates with the directives of the Legislature through either statutory direction and/or approval of previously approved budget work plan submissions and therefore recommends adoption of the items listed below.

i. Advantage Waiver Service Increase
ii. Developmental Disabilities Services Increase
iii. Money Follows the Person/Living Choice Increase
iv. Acute Tracheostomy Add-On Rate for Nursing Facilities

MOTION: Vice-Chairman Yaffe moved to approve item 8.a.i-iv as published. The motion was seconded by Chairman Nuttle.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Cruzan, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Member Christ, Member Jolley

v. Certified Registered Nurse Anesthetist (CRNA) Rate Increase – Vice-Chairman Yaffe asked for a general outline of the discussion regarding this rate. Member Kennedy stated that discussions around the CRNA rate change began in September 2023. The various committees under OHCA, as well as the public, have seen this presented committee and board meetings. This item was also presented in OHCA's budget request to the legislature. OHCA staff presented the budget work program at the June 24th, 2024, compliance meeting and the June 26th, 2024, board meeting. Member Corbett added that access is the critical point that we're trying to achieve. Chairman Nuttle asked Member Corbett, as a technical matter, was it in his opinion that this is a vote to sustain or advance a prior budget commitment. Member Corbett stated that as he understands it with regards to what the State Plan Amendment Committee is responsible for is to essentially implement the rate that has been previously approved, whether statutorily or through other legislative processes, which in this case is the budget. Vice-Chairman Yaffe stated that he believes there should be discussions about all provider rates as the agency moves forward. To Vice-Chairman Yaffe's point, CEO Buettner committed to having continued discussions about this.

MOTION: Member Leland moved to approve item 8.a.v, as published. The motion was seconded by Member Corbett.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Cruzan, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Member Christ, Member Jolley

Member Kennedy presented the following Expenditure of Authority Contract.

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

i. Customer Relationship Management (CRM) – Vice-Chairman Yaffe asked if this was a new service or a continuation of a current service. CEO Buettner stated that this is a rebid of OHCA's call center.

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

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Cruzan, Member Kennedy, Member Leland

BOARD MEMBERS ABSENT: Member Christ, Member Jolley

ITEM 9 / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING

Tanya Case, Chair, Administrative Rules Advisory Committee

Member Case asked Traylor Rains, State Medicaid Director, to provide a brief overview of the rules listed below. Member Case asked if increasing parental hours could be considered later. Mr. Rains stated yes and added that OHCA added the additional family component to the rules for the first time. OHCA recognized during chart reviews that that was a missing essential component. OHCA will evaluate that over time and then eventually add it.

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

i. APA WF #24-22 High-Acuity Tracheostomy Rate for Nursing Facilities
ii. APA WF #24-23 Applied Behavioral Analysis Policy Revisions
iii. APA WF #24-26A Developmental Disabilities Services
iv. APA WF #24-26B Developmental Disabilities Services

v. APA WF #24-20 Pharmacists as Providers
vi. APA WF #24-27 Hospital Provision of Emergency Opioid Antagonist

MOTION:	Member Cruzan motioned to approve the declaration of a compelling public interest for the promulgation of the emergency rules in item 9i-vi. The motion was seconded by Member Leland.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Cruzan, Member Kennedy, Member Leland
BOARD MEMBERS ABSENT:	Member Christ, Member Jolley
MOTION:	Member Corbett moved to approve the emergency rules listed in item 9i-vi as published. The motion was seconded by Vice-Chairman Yaffe.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Cruzan, Member Kennedy, Member Leland
BOARD MEMBERS ABSENT:	Member Christ, Member Jolley

ITEM 10 / DISCUSSION OF REPORT OF THE STRATEGIC PLANNING & OPERATIONAL ADVISORY COMMITTEE
Marc Nuttle, OHCA Board Chairman

Chairman Nuttle provided an overview of the items discussed at the September 16th Strategic Planning Committee meeting, which included updates on the Patient Centered Medical Home Redesign, Chief Technology Officer/HIE Update, Operational Metrics, SoonerSelect, and Traction. Member Corbett asked what level of reporting or compliance OHCA is finding its partners adhering to. CEO Buettner stated that OHCA is currently in the process of creating a monitoring and oversight process, but in the interim, those discussions are occurring in the Strategic Planning Committee meeting and would be happy to share with the rest of the board.

ITEM 11 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE OHCA GENERAL COUNSEL AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4).
Marc Nuttle, OHCA Board Chairman

MOTION:	Vice-Chairman Yaffe moved to go into Executive Session. The motion was seconded by Kennedy.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Cruzan, Member Kennedy, Member Leland
BOARD MEMBERS ABSENT:	Member Christ, Member Jolley
MOTION:	Member Case moved to leave Executive Session. The Motion was seconded by Member Kennedy
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Corbett, Member Cruzan, Member Kennedy, Member Leland
BOARD MEMBERS ABSENT:	Member Christ, Member Jolley

ITEM 12 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

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

Meeting adjourned at 3:48 p.m., 9/17/2024.

NEXT BOARD MEETING
December 11, 2024
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

CHIEF EXECUTIVE OFFICER REPORT

Ellen Buettner

December 11, 2024

oklahoma complete health™

SoonerSelect

OHCA KEY PRINCIPLES

PASSION FOR PURPOSE

Our purpose is to facilitate quality health care services regardless of ability to pay and create opportunities for our members to attain healthy outcomes.

EMPOWERMENT & ACCOUNTABILITY

We follow through on commitments and take responsibility for our decisions, prioritizing member needs, fiscal stewardship and respect for others.

TRUST & TRANSPARENCY

We are committed to principles of open government by providing consistent and accurate communication to our members, stakeholders and the public.

BEST IN CLASS & OUTCOME-DRIVEN

We strive each day to find ideas and solutions that will drive positive health outcomes for Oklahoma.

SERVANT LEADERSHIP

We strive to help each member of our team achieve personal and professional success. We lead by example for our co-workers, members and stakeholders.

KEY INITIATIVES - PROGRAMMATIC

- Enhancement of School Based Services
- Juvenile Re-Entry Waiver
- Correctional Re-Entry Waiver
- Public Health Emergency Unwind Closeout
- Primary Care and Rural Health Redesign Initiatives

KEY INITIATIVES - ADMINISTRATIVE

- EGID Move
- Energage Survey
- Call Center Metrics
- Utilization Management Efforts

TRACTION 1-YEAR GOALS FY25

HEALTH OUTCOMES

- Expand fee-for-service school-based services to all Medicaid-eligible students
- Submit a framework plan for the redesigned patient-centered medical home delivery system focused on aligning with the non-SoonerSelect populations.
- Outreach to 20% of aged, blind and disabled diabetic members identified by the data model

OPERATIONAL EXCELLENCE

- Implement a monitoring oversight tool for automation of contracted entity report submission and collection and dashboarding
- Implement V3locity for EGID member self-service
- Develop a quality review process to ensure quality of care standards for SoonerCare members with autism spectrum disorder

FISCAL RESPONSIBILITY

- Map and document all professional services contracting processes to optimize contracting
- Implement call center AI to improve average call answer time to less than 1 minute
- Utilize U.S. Department of Treasury death-match software and implement an audit process to initiate the first death-match reviews of the capitated payments to contracted entities

HIGH-PERFORMING TEAMS

- Reduce the private duty nursing appeal backlog by one-third in each of Q2, Q3, and Q4
- Streamline contracted entity communication by implementing electronic communication methods
- Assign subject matter experts for all agency website sections to review the agency website for accuracy and updates

STAKEHOLDER ENGAGEMENT

- Contracted Entities CEOs
- Oklahoma Hospital Association
- Oklahoma Osteopathic Association
- Great Salt Plains Health Center
- St. Mary's Regional Health Center
- Integris Health Enid
- OSU Center for Heath Sciences
- George Kaiser Family Foundation
- Tulsa Chamber Health Task Force
- OU Health Behavioral Health Center
- Joint Agency Leadership Meetings
- Oklahoma Association of Health Plans
- OU Health Sciences Center
- Primary Care Taskforce with OHA, Duncan Regional Hospital and SSM Health
- Legislative Leadership Meetings

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

MEDICAID DIRECTOR UPDATE

DECEMBER 11, 2024

SOONERSELECT UPDATE

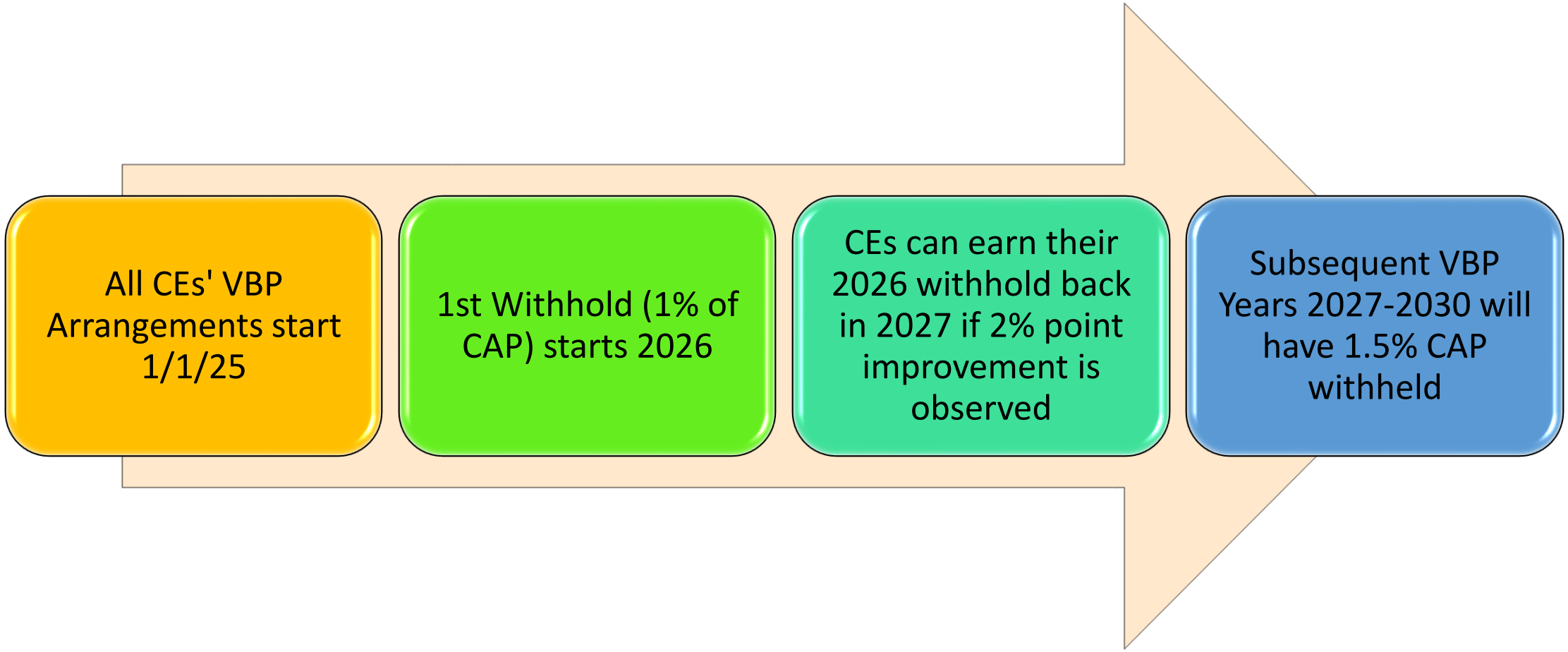
QUALITY WITHHOLD PROGRAM

- CEs' VBP arrangements with providers will operationalize the Quality Withhold Program by incentivizing the quality measures in the withhold program.
- All CEs' will set performance targets for select withhold measures to be incentivized in their VBP arrangements. As providers hit the improvement targets set by the CEs, providers will get rewarded with incentive payments in the first 1-2 years of the VBP programs.
- Subsequent years may result in more complex VBP arrangements such as shared savings.

QUALITY WITHHOLD PROGRAM

- Quality Measure Set:
  - Childhood Immunization Status
  - Well-Child Visits in the First Thirty (30) Months of Life
  - Screening for depression and follow-up for 12–17-year-olds
  - Child and Adolescent Well-Care Visits
  - Prenatal and Postpartum Care: Timeliness of Prenatal Care
  - Prenatal and Postpartum Care: Postpartum Care
  - Controlling high blood pressure
  - Emergency Department Utilization
  - Follow-Up After Hospitalization for Mental Illness: Ages Six (6) to Seventeen (17)
  - Follow-Up After Emergency Department Visit for Mental Illness: Age Eighteen (18) and Older
  - Glycemic Status Assessment
  - Plan All Cause Readmissions
  - *Developmental Screening for 3-6 year-olds – CSP only.

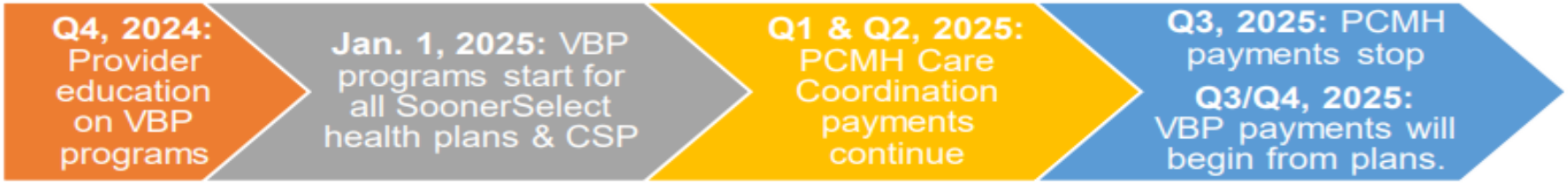
QUALITY WITHHOLD PROGRAM



TRANSITION TO VALUE BASED PAYMENTS

- VBP programs will incentivize quality and improve health outcomes by rewarding value instead of volume. Our goal is to achieve better care, smarter spending and healthier people.
- Providers participating in the current PCMH model will continue receiving monthly PCMH roster payments for SoonerSelect patients through June 30, 2025.
- In quarter 3 of 2025, providers will begin receiving incentive payments based on VBP.
- For providers continuing to serve SoonerCare Choice members, the current PCMH and Excel incentive models remain in effect for the SoonerCare Choice portion of providers' panels

TRANSITION TO VALUE BASED PAYMENTS



- Examples of a VBP could be:
  - Paying providers for data reporting to ensure robust baseline quality data and continued access to important outcomes data for quality improvement efforts.
  - Paying providers for making demonstrated clinical improvements in targeted quality measures or hitting targeted benchmarks.
  - Paying providers for helping programs reduce costs by preventing poor outcomes, increasing efficiencies, improving care coordination, and reducing unnecessary services.

SOONERSELECT MONITORING AND OVERSIGHT

MONITORING AND OVERSIGHT VENDOR AWARDED

- Implementation activities will kick off December 9
- Comprehensive end to end platform providing real time data analysis through dashboarding and other reports
- Day to day business support activities
- Clearly defined exit strategy for OHCA to achieve self sufficiency in managing CE oversight functions

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

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – September 11, 2024, October 9, 2024 **and November 13, 2024**

Vote Item	Drug	Used for	Cost*	Notes
1	Filsuvez® (birch triterpenes 10% topical gel)	• **Epidermolysis Bullosa (EB):** EB is a group of rare genetic diseases that cause the skin to be fragile and to blister easily. Severe forms of the recessive subtype may lead to eye damage, tooth loss, blistering inside the mouth and gastrointestinal tract, and fusing together of the fingers or toes. *4 members with diagnosis*	• $655,173 per year	• Can be very painful
2	Kisunla™ (donanemab-azbt)	• **Alzheimer's Disease (AD):** AD is the most common type of dementia. It is a progressive disease beginning with mild memory loss and possibly leading to loss of the ability to carry on a conversation and respond to the environment. *Estimated 5 members would qualify for therapy*	• $36,171 per year	• Usually diagnosed after 65 years of age
3	Defencath® (taurolidine/heparin)	• **Prevention of dialysis catheter-related blood stream infections:** Patients undergoing hemodialysis often use a catheter for the filtration process which can lead to risk of bloodstream infection. Reducing the risk of microbial infection through a patient's catheter can reduce the risk of bloodstream infections. *Estimated 240 members getting a dialysis catheter per year*	• 77,996 per year	• Approved for adults
4	Wegovy® (semaglutide)	• **Risk Reduction of Major Adverse Cardiovascular Disease (MACE):**	• $16,896 per year	• Not first line

		MACE includes acute myocardial infarction (AMI), stroke, and cardiovascular mortality. *Estimated 3,900 members over 45 who are obese and have cardiovascular disease*		
5	Avzivi® (bevacizumab-tnjn) Fruzaqla® (fruquintinib)	• **Colorectal Cancer (CC):** CC starts in the colon or the rectum. *Estimated 1,000 members with CC*	• NA • $327,600 per year	• Other options available • Not first line
6	Accrufer® (ferric maltol)	• **Iron Deficiency Anemia (IDA):** IDA is a common type of anemia; a condition in which blood lacks adequate healthy red blood cells. Red blood cells carry oxygen to the body's tissues. *18,785 members with IDA*	• $6,465 per year	• Cheaper formulations available
7	Exblifeb® (cefepime/ enmetazobactam) Meropenem 2 gram Pivya®(pivmecillinam) Nitrofurantoin 50mg/5ml Suspension Zevtera® (ceftobiprole medocaril sodium)	• **Various Infections:** • *2,415 members with diagnosis for treatment in the last year* • *77 members with the diagnosis for treatment in the last year* • *11,700 members with diagnosis for treatment in the last year* • *11,700 members with diagnosis for treatment in the last year* • *6,500 members with diagnosis for treatment in the last year*	• NA • $98 per day • NA • $1,465 per day • NA	• Other treatment available • Cheaper options available • Other treatment available • Cheaper options available • Other options available
8	Penicillamine 250 mg tablet	• **Wilson's Disease (WD):** WD is a genetic disorder that prevents the body from removing extra copper, causing copper to build up in the liver,	• $134,006 per year • $82,022 per year	• Cheaper options available

	Trientine HCl 500 mg capsule	brain, eyes, and other organs. Without treatment, high copper levels can cause life-threatening organ damage. *20 members with WD diagnosis*		• Cheaper options available
9	Eohilia™ (budesonide oral suspension)	• **Eosinophilic Esophagitis (EoE):** EoE is an allergic condition that happens in the esophagus. The esophagus becomes inflamed and does not contract properly. It can get narrowed and develop rings or abscesses. *624 members with EoE diagnosis*	• $5,418 per 3-month course of treatment	• Other treatments first line
10	Hercessi™ (trastuzumab-strf) Truqap™ (capivasertib)	• **Breast Cancer (BC):** BC can start from different parts of the breast. Breast cancer occurs almost entirely in women, but men can get breast cancer, too. *868 with BC diagnosis*	• NA • $297,989 per year	• Other options available • Not first line
11	Wainua™ (eplonterse)	• **Polyneuropathy of Hereditary Transthyretin-Mediated amyloidosis (hATTR-PN):** hATTR-PN is a rare disease due to mutations in the gene encoding transthyretin (TTR) and characterized by multisystem extracellular deposition of amyloid, leading to dysfunction of different organs and tissues. *5 members with hATTR-PN diagnosis*	• $54,583 per year	• Approved for adults
12	Rivfloza® (nedosiran)	• **Primary Hyperoxaluria type 1 (PH1):** PH1 is a rare disorder that mainly affects the kidneys. In people with PH1, there is an overproduction of oxalate which is deposited in the kidneys and urinary tract. It combines with calcium, forming the main component of kidney and bladder	• $754,560 per year	• Approved for patients 9 years and up

		stones (calcium oxalate). Symptoms may include recurrent kidney stones, blood in the urine, urinary tract infections, and possible kidney failure. *9 members with PH1 diagnosis*		
13	Casgevy™ (exagamglogene autotemcel) Lyfgenia® (lovotibeglogene autotemcel) Xromi® (hydroxyurea oral solution) Vafseo® (vadadustat)	• **Sickle Cell Disease (SCD):** SCD is a group of inherited red blood cell disorders. With SCD, the hemoglobin forms into stiff rods within the red blood cells. This changes the shape of the red blood cells (RBCs). The cells are supposed to be disc-shaped, but instead they are crescent, or sickle, shaped. The sickle-shaped cells are not flexible and cannot change shape easily. This causes many RBCs to burst leading to anemia, or the sickled cells can stick to vessel walls which in turn can cause blockages that slow or stop blood flow. The lack of blood flow can cause severe sudden pain. *197 members may qualify for gene therapies based on claims.* • **Anemia of Chronic Kidney Disease (CKD):** Anemia is a common complication of CKD in which the blood has a lower than normal amount of red blood cells needed to carry oxygen to the body. *2,100 members on dialysis*	• $2,200,000 per 1 lifetime treatment • $3,100,000 per 1 lifetime treatment • NA • 30,672 per year	• Gene therapy • Gene therapy • Other options available • Other treatment options available

*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 Filsuvez®

The Drug Utilization Review Board recommends the prior authorization of Filsuvez® (Birch Triterpenes 10% Topical Gel) with the following criteria:

Filsuvez® (Birch Triterpenes 10% Topical Gel) Approval Criteria:

1. An FDA approved indication for the treatment of wounds in patients 6 months of age and older with dystrophic epidermolysis bullosa (DEB) or junctional epidermolysis bullosa (JEB); and
2. Diagnosis must be confirmed by a pathogenic variant in the COL7A1 gene for DEB or biallelic pathogenic variants in the COL17A1, ITGA3, ITGA6, ITGB4, LAMA3, LAMB3, or LAMC2 genes for JEB (results of genetic testing must be submitted); and
3. Filsuvez® must be prescribed by a dermatologist or other specialist with expertise in the treatment of DEB or JEB (or an advanced care practitioner with a supervising physician who is a dermatologist or other specialist with expertise in the treatment of DEB or JEB); and
4. Member must have the presence of open partial-thickness wounds associated with DEB or JEB for ≥21 days; and
5. Filsuvez® must be applied to open partial-thickness wounds at dressing changes at least once every 4 days or up to once daily; and
6. Prescriber must attest that member and/or caregiver has been counseled on the appropriate administration and storage of Filsuvez® based on package labeling including that each sterile tube is for one-time use only; and
7. Member and/or caregiver has been advised on possible hypersensitivity reactions with Filsuvez® and to discontinue use and contact the prescriber if symptoms of a hypersensitivity reaction develop; and
8. Filsuvez® will not be approved for concomitant use with Vyjuvek® (beremagene geperpavec-svdt); and
9. A maximum approval quantity of 1 tube (23.4 grams) per day or 702 grams per 30 days will apply; and
    a. A quantity limit override will be considered for approval of quantities greater than 1 tube per day if the provider documents the number and size of wounds being treated to justify the need for a larger quantity; and
10. Initial approvals will be for 3 months. Subsequent approvals will be for 1 year and may be granted if the prescriber documents the member is responding well to treatment as indicated by the presence of wound healing and the prescriber must confirm Filsuvez® will not be applied to closed wounds.

Recommendation 2: Vote to Prior Authorize Kisunla™

The Drug Utilization Review Board recommends the prior authorization of Kisunla™ (Donanemab-azbt) with the following criteria:

Kisunla™ (Donanemab-azbt) Approval Criteria:

1. An FDA approved diagnosis of mild cognitive impairment or mild dementia stage of Alzheimer's disease [stage 3 or stage 4 Alzheimer's disease based on

the Global Deterioration Scale (GDS)]. Diagnosis must be confirmed by at least 2 of the following:
    a. Mini-Mental State Exam (MMSE) score between 20 and 28; or
    b. Clinical Dementia Rating Global Score (CDR-GS) equal to 0.5 or 1; or
    c. Montreal Cognitive Assessment (MoCA) score ≥19; or
    d. Quick Dementia Rating System (QDRS) score ≤5; and
2. Member must have presence of amyloid pathology confirmed by a positive amyloid positron emission tomography (PET) scan or cerebral spinal fluid (CSF) test; and
3. Kisunla™ must be prescribed by, or in consultation with, a neurologist (or an advanced care practitioner with a supervising physician who is a neurologist); and
4. Other known medical or neurological causes of dementia have been ruled out (i.e., vascular dementia, dementia with Lewy bodies, frontotemporal dementia, Parkinson's disease dementia); and
5. Member must not have brain hemorrhage, bleeding disorder, or cerebrovascular abnormalities that increase the risk of hemorrhage; and
6. Prescriber must verify member and/or caregiver has been counseled on the risks of amyloid related imaging abnormalities (ARIA) that may occur and testing for ApoE ε4 status has been completed if appropriate; and
7. Member must not be taking anticoagulant or antiplatelet agents except for aspirin or clopidogrel, and the prescriber must attest that the increased safety risks for developing intracerebral hemorrhage with the concomitant use have been discussed and are acceptable to the member prior to initiating Kisunla™; and
8. Member must not have had a stroke, transient ischemic attack (TIA), or unexplained loss of consciousness in the past year; and
9. Member must not have any contraindications to brain magnetic resonance imaging (MRI) or PET scans; and
10. 1Member must not have risk factors for intracerebral hemorrhage, including the following:
    a. Prior cerebral hemorrhage >1cm in greatest diameter; or
    b. >4 microhemorrhages; or
    c. An area of superficial siderosis; or
    d. Evidence of vasogenic edema; or
    e. Evidence of cerebral contusion, aneurysms, vascular malformations, or infective lesions; or
    f. Evidence of multiple lacunar infarcts or stroke involving a major vascular territory, severe small vessel, or white matter disease; and
11. Member must have a recent (within 1 year) brain MRI prior to initiating treatment with Kisunla™ and prior to the 2nd, 3rd, 4th, and 7th infusions; and
12. Prescriber must confirm that the member will be monitored for ARIA during the first 12 weeks and throughout treatment with Kisunla™; and
13. If ≥10 new incident microhemorrhages or >2 focal areas of superficial siderosis [radiographic severe amyloid related imaging abnormalities-hemosiderin deposition (ARIA-H)] are observed on MRI, prescriber must confirm that treatment will be continued with caution and only after a clinical evaluation confirming resolution of symptoms, if present, and a follow-up MRI

demonstrating radiographic stabilization (i.e., no increase in size or number of ARIA-H) have been completed; and

14. Kisunla™ must be administered by a health care professional in a setting with appropriate equipment and personnel to manage anaphylaxis or serious infusion reactions. Approvals will not be granted for self-administration; and
    a. Kisunla™ must be shipped via cold chain supply to the facility where the member is scheduled to receive treatment and stored in the refrigerator; and
15. Initial approvals will be for 6 months. Confirmation that MRIs have been completed and were acceptable to the provider prior to the 2nd, 3rd, 4th, and 7th infusions is required for continuation; and
16. Subsequent approvals will be for 6 months, and prescriber must document that the member has responded well to therapy compared to pretreatment baseline status as evidenced by improvement, stability, or slowing in cognitive and/or functional impairment using the same baseline test(s) performed at initiation of therapy for each subsequent approval; and
17. Approval quantities will be dependent on dosing based on package labeling; and
18. The maximum approvable dose is 1,400mg per 28 days; and
19. Approvals will not be granted for concurrent use with other amyloid beta-directed monoclonal antibodies.

Recommendation 3: Vote to Prior Authorize Defencath®

The Drug Utilization Review Board recommends the prior authorization of Defencath® (Taurolidine/HeparinCatheter Lock System) with the following criteria:

Defencath® (Taurolidine/Heparin) Approval Criteria:

1. An FDA approved indication of reducing the incidence of catheter-related bloodstream infections (CRBSIs) in adult members with kidney failure receiving chronic hemodialysis (HD) through a central venous catheter (CVC); and
2. Member must be 18 years of age or older; and
3. Must be used for prevention of CRBSIs; and
4. Prescriber must verify Defencath® is used only as a catheter lock solution (CLS) in CVCs and will not be administered systemically or used as a catheter lock flush product (i.e., it must be aspirated from the catheter and discarded prior to the next utilization of the CVC); and
5. Member must not have a known history of heparin-induced thrombocytopenia (HIT) or known hypersensitivity to pork products, taurolidine, heparin, or other components of Defencath®; and
6. A quantity limit of 2 vials per HD session or 24 vials per 28 days will apply; and
    a. For requests exceeding the quantity limit, supporting documentation (e.g., HD schedule, number of CVC lumens, CVC lumen volumes) must be provided for a quantity limit override; and
7. Approvals will be granted for 1 year.

Pharmacy Agenda Items

Recommendation 4: Vote to Prior Authorize Wegovy®

The Drug Utilization Review Board recommends the prior authorization Wegovy® (Semaglutide) with the following criteria:

Wegovy® (Semaglutide) Approval Criteria [Cardiovascular (CV) Risk Reduction Indication Only]:

1. An FDA approved indication to reduce the risk of major adverse cardiovascular (CV) events in members with established CV disease (CVD) and either obesity or overweight; and
    a. Wegovy® will not be approved for obese or overweight members in the absence of established CVD; and
2. Member must be 45 years of age or older; and
3. Member must have established CVD with a history of 1 of the following (documentation must be submitted with the request):
    a. Previous myocardial infarction; or
    b. Previous stroke; or
    c. Symptomatic peripheral arterial disease confirmed by 1 of the following:
        i. Intermittent claudication with ankle-brachial index <0.85 at rest; or
        ii. Peripheral arterial revascularization procedure; or
        iii. Amputation due to atherosclerotic disease; and
4. Member has a body mass index (BMI) ≥27kg/m2; and
5. Member does not have type 1 diabetes mellitus (T1DM) or type 2 diabetes mellitus (T2DM); and
6. Member has a hemoglobin A1C (HbA1c) <6.5%; and
7. Member will not be using Wegovy® in combination with other semaglutide-containing products or any other glucagon-like peptide-1 (GLP-1) receptor agonist; and
8. Member is currently receiving guideline-directed management and therapy (GDMT) for CVD (e.g., antihypertensives, lipid-lowering agents, antiplatelets), as documented in the member's pharmacy claims history, unless contraindicated; and
9. Wegovy® must be used in conjunction with diet and exercise (clinical documentation of member's diet and exercise program must be included with the request); and
10. Initial approvals will be for the titration period to allow initial and escalation dosing. A separate prior authorization request must be submitted for each dose; and
    a. Approvals will be for 4 weeks at a time to allow for proper dose escalation; and
    b. An additional 4 weeks for each dose may be approved for those who experience intolerable adverse effects during dose escalation with proper documentation; and
    c. Members who cannot tolerate dose escalation after an additional 4 week approval will not be approved for continuation; and

Pharmacy Agenda Items

11. Subsequent approvals for the maintenance dose (1.7mg or 2.4mg) will be approved for 1 year if the prescriber documents the following:
    a. Member is tolerating maintenance dosing; and
    b. Member has not developed T1DM or T2DM; and
    c. Member is continuing all of the following in conjunction with Wegovy®:
        i. Reduced calorie diet; and
        ii. Increased physical activity; and
        iii. GDMT for CVD where applicable; and
12. A quantity limit of 4 pens per 28 days will apply; and
13. Wegovy® should be discontinued in members who cannot tolerate at least the 1.7mg once weekly maintenance dosing.

Recommendation 5: Vote to Prior Authorize Avzivi® and Fruzaqla®

The Drug Utilization Review Board recommends the prior authorization of Avzivi® (Bevacizumab-tnjn) and Fruzaqla® (Fruquintinib) with the following criteria:

Avzivi® (Bevacizumab-tnjn) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot useAvastin® (bevacizumab), Mvasi® (bevacizumab-awwb), or Zirabev® (bevacizumab-bvzr), which are available without prior authorization, must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Fruzaqla® (Fruquintinib) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of metastatic CRC; and
2. Previously treated with fluoropyrimidine-, oxaliplatin-, and irinotecan-based chemotherapy; and
3. Previously treated with an anti-vascular endothelial growth factor (VEGF) therapy; and
4. If RAS wild-type disease, previously treated with an anti-epidermal growth factor receptor (EGFR) therapy.

Recommendation 6: Vote to Prior Authorize Accrufer®

The Drug Utilization Review Board recommends the prior authorization of Accrufer® (Ferric Maltol) with the following criteria:

Accrufer® (Ferric Maltol) Approval Criteria:

1. Diagnosis of iron deficiency anemia (IDA); and
2. Lab results verifying IDA must be submitted; and
3. Member must be 18 years of age or older; and

4. Member must have a documented diagnosis of chronic kidney disease (CKD) or inflammatory bowel disease (IBD) (e.g., Crohn's disease, ulcerative colitis); and
5. Documentation of intolerance or inadequate response to over-the-counter (OTC) oral iron therapy after at least 3 months at recommended dosing; and
6. A recent, failed trial of Feraheme® (ferumoxytol), Infed® (iron dextran), or Venofer® (iron sucrose) or a patient-specific, clinically significant reason why the member cannot utilize Feraheme®, Infed®, and Venofer® must be provided; and
7. A patient-specific clinically significant reason why the member cannot utilize all other forms of intravenous (IV) iron must be provided; and
8. Initial approvals will be for the duration of 3 months of treatment. Subsequent approvals (for 3 months of treatment) will require updated recent laboratory results documenting continued IDA.

Recommendation 7: Vote to Prior Authorize Exblifep®, Meropenem 2g Vial, Pivya™, Nitrofurantoin 50mg/5 mL Suspension, and Zevtera®

The Drug Utilization Review Board recommends the prior authorization of Exblifep® (Cefepime/Enmetazobactam), Meropenem 2g Vial, Pivya™ (Pivmecillinam), Nitrofurantoin 50mg/5 mL Suspension, and Zevtera® (Ceftobiprole Medocaril Sodium) with the following criteria:

Exblifep® (Cefepime/Enmetazobactam) Approval Criteria:

1. An FDA approved diagnosis of complicated urinary tract infection (cUTI), including pyelonephritis, caused by designated susceptible microorganisms (culture/sensitivity results must be submitted); and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin/beta-lactamase inhibitor combination (e.g., piperacillin/tazobactam), a carbapenem (e.g., ertapenem, meropenem, imipenem/cilastatin), a cephalosporin (e.g., ceftriaxone, ceftazidime), or other cost-effective therapeutic equivalent alternative(s) must be provided; and
4. Member's recent estimated glomerular filtration rate (eGFR) must be provided to ensure appropriate dosing in accordance with package labeling; and
5. Approval quantity will be based on package labeling and FDA approved dosing regimen(s).

Meropenem 2 Gram Vial Approval Criteria:

1. An FDA approved diagnosis of bacterial meningitis; and
2. Mmber must be 3 months of age or older; and
3. A patient-specific, clinically significant reason why the meropenem 1 gram or 500mg vials, which are available without a prior authorization, cannot be used must be provided.

Pivya™ (Pivmecillinam) Approval Criteria:

1. An FDA approved diagnosis of uncomplicated urinary tract infection caused by designated susceptible isolates of Escherichia coli, Proteus mirabilis, and Staphylococcus saprophyticus (culture/sensitivity results must be submitted); and
2. Member must be a female 18 years of age or older; and
3. Member must not have any of the following contraindications:
    a. Serious hypersensitivity reactions (e.g., anaphylaxis, Stevens-Johnson syndrome) to Pivya™ or to other beta-lactam antibacterial drugs (e.g., penicillins, cephalosporins); and
    b. Primary or secondary carnitine deficiency resulting from inherited disorders of mitochondrial fatty acid oxidation and carnitine metabolism and other inborn errors of metabolism (e.g., methylmalonic aciduria, propionic acidemia); and
    c. Acute porphyria; and
4. Provider must verify that concurrent treatment with valproic acid, valproate, or other pivalate-generating drugs will be avoided due to increased risk of carnitine depletion; or
    a. If concomitant use is necessary, member must be counseled to monitor for and report adverse reactions associated with carnitine depletion (e.g., hypoglycemia, muscle aches, fatigue, confusion); and
5. Pivya™ must not be used when prolonged antibacterial treatment (i.e., longer than the FDA-approved treatment duration of up to 7 days) is necessary; and
6. A patient-specific, clinically significant reason why the member cannot use an appropriate cost-effective, therapeutic alternative (e.g., nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin) must be provided; and
7. A quantity limit of 21 tablets per 7 days will apply.

Nitrofurantoin 50mg/5 mL Suspension Approval Criteria:

1. Member must have a patient-specific, clinically significant reason why the immediate-release formulation and/or other cost effective therapeutic equivalent medication(s) cannot be used.

Zevtera® (Ceftobiprole Medocaril Sodium) Approval Criteria [Acute Bacterial Skin and Skin Structure Infection (ABSSSI) Diagnosis]:

1. An FDA approved diagnosis of ABSSSI caused by designated susceptible microorganisms (culture/sensitivity results must be submitted); and
2. Member must be 18 years of age or older; and
3. A patient-specific, clinically significant reason why the member cannot use vancomycin, linezolid, doxycycline, trimethoprim/sulfamethoxazole, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
4. Approval quantity will be based on package labeling and FDA approved dosing regimen(s).

Pharmacy Agenda Items

Zevtera® (Ceftobiprole Medocaril Sodium) Approval Criteria [Community-Acquired Bacterial Pneumonia (CABP) Diagnosis]:

1. An FDA approved diagnosis of CABP caused by designated susceptible microorganisms (culture/sensitivity results must be submitted); and
2. Member must be 3 months of age or older; and
3. A patient-specific, clinically significant reason why the member cannot use an appropriate beta-lactam (e.g., ceftriaxone, cefotaxime, ceftaroline, ertapenem ampicillin/sulbactam) in combination with a macrolide (e.g., azithromycin, clarithromycin) or doxycycline, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
4. For members who require weight-based dosing, the member's recent weight, taken within the last 3 weeks, must be provided on the prior authorization request in order to authorize the appropriate dose according to package labeling; and
5. Approval quantity will be based on package labeling and FDA approved dosing regimen(s).

Zevtera® (Ceftobiprole Medocaril Sodium) Approval Criteria [Staphylococcus aureus Bloodstream Infection (Bacteremia) (SAB) Diagnosis]:

1. An FDA approved diagnosis of SAB caused by designated susceptible microorganisms (culture/sensitivity results must be submitted); and
2. Member must be 18 years of age or older; and
3. For methicillin-resistant Staphylococcus aureus (MRSA), a patient-specific, clinically significant reason why the member cannot use vancomycin or other cost-effective therapeutic equivalent alternative(s) must be provided; and
4. For methicillin-susceptible Staphylococcus aureus (MSSA), a patient-specific, clinically significant reason why the member cannot use an appropriate beta-lactam (e.g., nafcillin, oxacillin) or other cost-effective therapeutic equivalent alternative(s) must be provided; and
5. Approval quantity will be based on package labeling and FDA approved dosing regimen(s).

Recommendation 8: Vote to Prior Authorize Penicillamine 250mg Tablet and Trientine 500mg Capsule

The Drug Utilization Review Board recommends the prior authorization of Penicillamine 250mg Tablet and Trientine 500mg Capsule with the following criteria:

Penicillamine 250mg Tablet Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use penicillamine 250mg capsule must be provided.

Trientine Hydrochloride (HCl) 500mg Capsule Approval Criteria:

1. An FDA approved diagnosis of Wilson's disease; and

2. A patient-specific, clinically significant reason why the member cannot use trientine HCl 250mg capsule must be provided.

Recommendation 9: Vote to Prior Authorize Eohilia™

The Drug Utilization Review Board recommends the prior authorization of Eohilia™ (Budesonide Oral Suspension) with the following criteria:

Eohilia™ (Budesonide Oral Suspension) Approval Criteria:

1. An established diagnosis of eosinophilic esophagitis (EoE) defined as:
    a. The presence of clinical symptoms of EoE ≥2 times per week (i.e., dysphagia, emesis, epigastric pain); and
    b. Intraepithelial eosinophilia [≥15 eosinophils per high-power field (eos/hpf)] in the esophagus; and
2. Member must be 11 years of age or older; and
3. Must be prescribed by a gastroenterologist, allergist, or immunologist, or the member must have been evaluated by a gastroenterologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a gastroenterologist, allergist, or immunologist); and
4. Member must have a documented trial for a minimum of 8 weeks that resulted in failure with 1 high-dose proton pump inhibitor (i.e., omeprazole 20-40mg twice daily or equivalent in adults or 1-2mg/kg of omeprazole daily or equivalent in children) or have a contraindication or documented intolerance; and
5. A patient specific, clinically significant reason why the member cannot use a swallowed respiratory corticosteroid (e.g., budesonide, fluticasone) must be provided; and
6. Approvals will be for (1) 3-month treatment course; and
7. A quantity limit of 600mL per 30 days will apply; and
8. Eohilia™ will not be approved for maintenance treatment. Reauthorization for additional 3-month treatment course(s) may be considered if the prescriber documents the following;
    a. The member had a positive initial response to Eohilia™; and
    b. Is now experiencing recurrent worsening symptoms of EoE after completing the treatment course with Eohilia™; and
    c. A patient specific, clinically significant reason why the member still cannot use a swallowed respiratory corticosteroid (e.g., budesonide, fluticasone) must be provided.

Recommendation 10: Vote to Prior Authorize Hercessi and Truqap™

The Drug Utilization Review Board recommends the prior authorization of Hercessi (Trastuzumab-strf) and Truqap™ (Capivasertib) with the following criteria:

Pharmacy Agenda Items

Hercessi™ (Trastuzumab-strf), Herzuma® (Trastuzumab-pkrb), Kanjinti® (Trastuzumab-anns) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive breast cancer; and
2. Preferred trastuzumab products include Kanjinti® (trastuzumab-anns) and Trazimera® (trastuzumab-qyyp). Authorization of non-preferred trastuzumab products [Herceptin® (trastuzumab), Herceptin Hylecta™ (trastuzumab/hyaluronidase-oysk), Hercessi™ (trastuzumab-strf), Herzuma® (trastuzumab-pkrb), Ogivri® (trastuzumab-dkst), or Ontruzant® (trastuzumab-dttb)] will also require a patient-specific, clinically significant reason why the member cannot use the preferred trastuzumab products [Kanjinti® (trastuzumab-anns) or Trazimera® (trastuzumab-qyyp)]. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Hercessi™ (Trastuzumab-strf) Approval Criteria [Colorectal Cancer (CRC) Diagnosis]:

1. Diagnosis of human epidermal receptor type 2 (HER2)-positive CRC; and
2. RAS and BRAF mutation negative; and
3. Used in combination with pertuzumab, lapatinib, or tucatinib; and
4. Used in 1 of the following settings:
    a. If first-line therapy, patient should not be a candidate for intensive therapy; or
    b. For the treatment of advanced or metastatic disease following disease progression; and
5. Preferred trastuzumab products include Kanjinti® (trastuzumab-anns) and Trazimera® (trastuzumab-qyyp). Authorization of non-preferred trastuzumab products [Herceptin® (trastuzumab), Hercessi™ (trastuzumab-strf), Herzuma® (trastuzumab-pkrb), Ogivri® (trastuzumab-dkst), or Ontruzant® (trastuzumab-dttb)] will also require a patient-specific, clinically significant reason why the member cannot use the preferred trastuzumab products [Kanjinti® (trastuzumab-anns) or Trazimera® (trastuzumab-qyyp)]. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Hercessi™ (Trastuzumab-strf) Approval Criteria [Metastatic Gastric or Gastroesophageal Junction Adenocarcinoma Diagnosis]:

1. Diagnosis of human epidermal growth factor receptor 2 (HER2)-positive metastatic gastric or gastroesophageal junction adenocarcinoma; and
2. Preferred trastuzumab products include Kanjinti® (trastuzumab-anns) and Trazimera® (trastuzumab-qyyp). Authorization of non-preferred trastuzumab products [Herceptin® (trastuzumab), Hercessi™ (trastuzumab-strf), Herzuma® (trastuzumab-pkrb), Ogivri® (trastuzumab-dkst), or Ontruzant®

(trastuzumab-dttb)] will also require a patient-specific, clinically significant reason why the member cannot use the preferred trastuzumab products [Kanjinti® (trastuzumab-anns) or Trazimera® (trastuzumab-qyyp)]. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Truqap™ (Capivasertib) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of locally advanced or metastatic breast cancer; and
2. Hormone receptor (HR)-positive; and
3. Human epidermal growth factor receptor 2 (HER2)-negative; and
4. Used in combination with fulvestrant; and
5. Contains 1 or more PIK3CA/AKT1/PTEN-alterations as detected by an FDA-approved test; and
6. Member meets 1 of the following:
    a. Progressed following at least 1 endocrine-based regimen in the metastatic setting; or
    b. Progressed within 12 months of completing adjuvant therapy.

Recommendation 11: Vote to Prior Authorize Wainua™

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

Wainua™ (Eplontersen) Approval Criteria:

1. An FDA approved indication for the treatment of polyneuropathy associated with hereditary transthyretin-mediated (hATTR) amyloidosis; and
2. Diagnosis confirmed by genetic testing identifying a transthyretin (TTR) gene mutation (results of genetic testing must be submitted); and
3. Prescriber must verify member is currently experiencing signs and symptoms of polyneuropathy and other causes of polyneuropathy have been ruled out; and
4. Must be prescribed by, or in consultation with, a cardiologist, geneticist, or neurologist (or an advanced care practitioner with a supervising physician who is a cardiologist, geneticist, or neurologist); and
5. Prescriber must confirm the member will take the recommended daily allowance of vitamin A; and
6. Prescriber must confirm the member or caregiver has been trained by a health care professional on the subcutaneous (sub-Q) administration and proper storage of Wainua™; and
7. Prescriber must confirm the member has not undergone a liver transplant; and
8. Wainua™ will not be approved for concomitant use with Amvuttra® (vutrisiran), Onpattro® (patisiran), Tegsedi® (inotersen), Vyndamax® (tafamidis), or Vyndaqel® (tafamidis meglumine); and

9. Approvals will be for the duration of 1 year. Reauthorization may be granted if the prescriber documents the member is responding well to treatment and member has not undergone a liver transplant; and
10. A quantity limit of 0.8mL per 28 days will apply.

Recommendation 12: Vote to Prior Authorize Rivfloza®

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

Rivfloza® (Nedosiran) Approval Criteria:

1. An FDA approved indication for the treatment of primary hyperoxaluria type 1 (PH1) to lower urinary oxalate levels. Diagnosis of PH1 must be confirmed by:
    a. Molecular genetic testing identifying biallelic pathogenic variants in the AGXT gene (results of genetic testing must be submitted); or
    b. Liver biopsy confirming alanine-glyoxylate aminotransferase (AGT) catalytic deficiency if the results of genetic testing are not diagnostic (results of liver biopsy must be submitted); and
2. Member must be 9 years of age or older; and
3. Rivfloza® must be prescribed by a geneticist, nephrologist, urologist, or other specialist with expertise in the treatment of PH1 (or an advanced care practitioner with a supervising physician who is a geneticist, nephrologist, urologist, or other specialist with expertise in the treatment of PH1); and
4. Prescriber must verify the member has an estimated glomerular filtration rate (eGFR) of ≥30mL/min/1.73m2 prior to starting Rivfloza® and must agree to monitor renal function regularly during treatment; and
5. Prescriber must confirm the member has not undergone a liver or kidney transplant; and
6. Member must not have evidence of systemic oxalosis; and
7. Prescriber must verify that Rivfloza® will be administered by a health care professional or, if appropriate, the member or caregiver have been trained on the subcutaneous administration and proper storage of Rivfloza®; and
8. Rivfloza® will not be approved for concomitant use with Oxlumo® (lumasiran); and
9. The member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
10. Initial approvals will be for the duration of 6 months. Further approval may be granted if the prescriber documents that the member is responding well to treatment as indicated by a reduction in urinary oxalate excretion.

Recommendation 13: Vote to Prior Authorize Casgevy™, Lyfgenia®, Vafseo®, and Xromi®

The Drug Utilization Review Board recommends the prior authorization of Casgevy™ (Exagamglogene Autotemcel), Lyfgenia® (Lovotibeglogene Autotemcel), Vafseo® (Vadadustat), and Xromi® (Hydroxyurea oral solution) with the following criteria:

Casgevy™ (Exagamglogene Autotemcel) Approval Criteria [Sickle Cell Disease (SCD) Diagnosis]:

1. An FDA approved diagnosis of SCD with recurrent vaso-occlusive crises (VOCs); and
2. Member must be 12 years of age or older; and
3. Member must have evidence of severe disease as demonstrated by ≥2 severe vaso-occlusive events (VOEs) per year in the last 2 years; and
4. Casgevy™ must be prescribed by a hematologist with expertise in the treatment of SCD and the administration of Casgevy™; and
5. Member has a trial with at least 1 pharmacological treatment option for SCD (i.e., hydroxyurea, L-glutamine, crizanlizumab-tmca); and
6. Member must not have a known and available human leukocyte antigen (HLA)-matched sibling donor; and
7. Member must not have a prior history of hematopoietic stem cell transplantation (HSCT); and
8. Member must not have previously received treatment with Lyfgenia™ (lovotibeglogene autotemcel); and
9. Member must have a negative serology test for human immunodeficiency virus (HIV) prior to apheresis according to package labeling; and
10. Prescriber must verify the member is clinically stable and eligible to undergo HSCT (HSCT must be appropriate for a member to be treated with Casgevy™); and
11. Prescriber must verify the member has discontinued disease modifying therapies 8 weeks prior to mobilization and conditioning; and
12. Prescriber must verify that granulocyte-colony stimulating factor (G-CSF) will not be used for the CD34+ HSC mobilization; and
13. Female members must not be pregnant and must have a negative pregnancy test prior to the start of mobilization, prior to conditioning procedures, and prior to Casgevy™ administration; and
14. Male and female members of reproductive potential must use an effective method of contraception from the start of mobilization through at least 6 months after administration of Casgevy™; and
15. Prescriber must verify male and female members of reproductive potential have been counseled on the potential effects of myeloablative conditioning on fertility and the potential risk of infertility is acceptable to the member; and
16. Prescriber must evaluate the potential for drug interactions, according to package labeling, prior to and after administration of Casgevy™; and
17. Casgevy™ must be administered at a Casgevy™ authorized treatment center, and the receiving facility must have a mechanism in place to track the patient-specific Casgevy™ dose from receipt to storage to administration; and
18. Approvals will be for 1 dose per member per lifetime.

Casgevy™ (Exagamglogene Autotemcel) Approval Criteria [Transfusion-Dependent Beta Thalassemia (TDT) Diagnosis]:

1. An FDA approved diagnosis of TDT; and

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

Lyfgenia® (Lovotibeglogene Autotemcel) Approval Criteria:

1. An FDA approved diagnosis of sickle cell disease (SCD) with a history of vaso-occlusive events (VOEs); and
2. Member must be 12 years of age or older; and
3. Member must have evidence of severe disease as demonstrated by ≥4 severe VOEs in the last 2 years; and
4. Member must not have >2 α-globin gene deletions; and
5. Lyfgenia® must be prescribed by a hematologist with expertise in the treatment of SCD and the administration of Lyfgenia®; and

Pharmacy Agenda Items

6. Member has a trial with at least 1 pharmacological treatment option for SCD (i.e., hydroxyurea, L-glutamine, crizanlizumab-tmca); and
7. Member must not have a known and available human leukocyte antigen (HLA)-matched sibling donor; and
8. Member must not have a prior history of hematopoietic stem cell transplantation (HSCT); and
9. Member must not have previously received treatment with Casgevy™ (exagamglogene autotemcel); and
10. Member must have a negative serology test for human immunodeficiency virus (HIV) prior to apheresis according to package labeling; and
11. Prescriber must verify the member is clinically stable and eligible to undergo HSCT (HSCT must be appropriate for a member to be treated with Lyfgenia®); and
12. Prescriber must verify the member has discontinued disease modifying therapies 8 weeks prior to mobilization and conditioning; and
13. Prescriber must verify that granulocyte-colony stimulating factor (G-CSF) will not be used for the CD34+ HSC mobilization; and
14. Female members must not be pregnant and must have a negative pregnancy test prior to the start of mobilization, prior to conditioning procedures, and prior to Lyfgenia® administration; and
15. Male and female members of reproductive potential must use an effective method of contraception from the start of mobilization through at least 6 months after administration of Lyfgenia®; and
16. Prescriber must verify male and female members of reproductive potential have been counseled on the potential effects of myeloablative conditioning on fertility and the potential risk of infertility is acceptable to the member; and
17. Prescriber must evaluate the potential for drug interactions, according to package labeling, prior to and after administration of Lyfgenia®; and
18. Prescriber must verify member will be monitored for hematologic malignancies lifelong, with a complete blood count (with differential) performed at month 6 and month 12 after treatment with Lyfgenia®, then at least annually thereafter for at least 15 years, and with integration site analysis at months 6, 12, and as warranted; and
19. Lyfgenia® must be administered at a Lyfgenia® qualified treatment center, and the receiving facility must have a mechanism in place to track the patient-specific Lyfgenia® dose from receipt to storage to administration; and
20. A patient-specific, clinically significant reason why the member cannot use Casgevy™ (exagamglogene autotemcel) must be provided; and
21. Approvals will be for 1 dose per member per lifetime.

Vafseo® (Vadadustat) Approval Criteria:

1. An FDA approved indication for the treatment of anemia due to chronic kidney disease (CKD) in adults; and
2. Member must currently be on dialysis and must have been receiving dialysis for ≥3 months; and
3. Prescriber must verify that member does not have uncontrolled hypertension; and

4. Prescriber must verify that member does not have an active malignancy; and
5. Prescriber must verify that liver function tests (LFTs) (e.g., ALT, AST, bilirubin) will be monitored prior to initiation of Vafseo® treatment, every month for the first 3 months of treatment, and periodically thereafter or as clinically indicated; and
6. Member's pre-treatment hemoglobin (Hgb) must be <11g/dL. Recent Hgb levels must be provided; and
7. Member must be hyporesponsive to an erythropoiesis-stimulating agent (ESA) (or have a contraindication to use), defined as:
    a. No increase in Hgb after 1 month of weight-based dosing; or
    b. 2 increases in ESA dose up to 50% more than previous dose to maintain current Hgb level; and
8. Prescriber must verify that member will not use Vafseo® concomitantly with an ESA or another hypoxia-inducible factor prolyl hydroxylase (HIF PH) inhibitor; and
9. Initial and subsequent approvals will be for the duration of 12 weeks of treatment. Subsequent approvals will be granted if the member meets 1 of the following:
    a. Member has achieved or maintained a clinically meaningful increase in Hgb of ≥1g/dL and the member's Hgb level is <12g/dL; or
    b. If the member has not achieved or maintained a clinically meaningful increase in Hgb of ≥1g/dL, then all of the following will be required:
        i. The dose will be increased as tolerated to a maximum of 600mg per day; and
        ii. The member has not received 600mg per day for >12 weeks without achieving a clinically meaningful increase in hemoglobin of ≥1g/dL; and
        iii. The member's Hgb is <12g/dL; and
10. Vafseo® should be discontinued in members who do not show evidence of a clinically meaningful increase in Hgb by 24 weeks.

Xromi® (Hydroxyurea Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of sickle cell anemia; and
2. Xromi® will not require prior authorization for members 6 years of age and younger. For members 7 years of age and older, a patient-specific, clinically significant reason why the member cannot use hydroxyurea capsules or tablets must be provided; and
3. Member must have a history of moderate-to-severe, painful crises; and
4. Prescriber must agree to monitor blood counts every 2 weeks throughout therapy; and
5. Prescriber must agree to monitor the member for the development of secondary malignancies; and
6. Female members must not be pregnant and must have a negative pregnancy test prior to therapy initiation; and
7. Male and female members of reproductive potential must be willing to use effective contraception during and after treatment with Xromi® for at least 6 months after therapy; and

Pharmacy Agenda Items

8. Initial approvals will be for the duration of 12 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment.

This page intentionally left blank

December 11, 2024 Board
Proposed Rule Amendment Summaries

These proposed **EMERGENCY** rules were presented at Tribal Consultation and were subject to at least a 15-day public comment period and was considered by the Medical Advisory Committee on November 7, 2024.

The Governor will have until February 1, 2025, to approve or disapprove these rules upon the Agency's submission for gubernatorial review.

Agency is requesting the effective date to be immediately upon receiving gubernatorial approval.

APA WF # 24-13 PACE Licensure Policy — The proposed rule changes remove the requirement that PACE providers be licensed as an adult day care and clarify regulatory requirements of PACE providers. House Bill 3238 of the 2024 legislative session amended the Adult Day Care Act and the Home Care Act to exempt PACE organizations from the licensure requirements of adult day cares and home health organizations. It also assigned new regulatory authority to the Oklahoma Health Care Authority (OHCA) to enforce federal PACE regulations (42 CFR Part 460) and create administrative rules necessary to do so. These rule changes will reduce the administrative burden on PACE providers and ensure OHCA expectations and requirements are clear. These emergency revisions are necessary protect the public health, safety, or welfare and to avoid violation of state law.

Budget Impact: The proposed changes are budget neutral.

APA WF # 24-14 Hospice Benefit Expansion — The Oklahoma Health Care Authority (OHCA) proposes emergency revisions that are necessary to comply with newly amended state law. Currently, hospice coverage is limited to children, expansion adults, and the dual eligible population. In accordance with House Bill 3980, the proposed revisions will expand hospice coverage to include all full-benefit Medicaid members. Existing criteria and payment methodologies will be applied to any new populations. These emergency revisions are necessary protect the public health, safety, or welfare and to avoid violation of state law.

Budget Impact: The estimated budget impact for SFY 2025, will be an increase in the total amount of $20,277; with $6,675 in state share. The estimated budget impact, for SFY2026 will be an increase in the total amount of $40,554; with $13,350 in state share.

APA WF # 24-18 Third Party Liability (TPL) for School based Services — The Oklahoma Health Care Authority (OHCA) proposes to permit an exception to current TPL rules so that Medicaid is the payor of first resort, or prior to federal IDEA funds, for Medicaid-covered services documented within a student’s an Individualized Education Program (IEP) and (IFSP) in accordance with section 1903(c) of the Social Security Act.

The Agency will then "pay and chase" to recoup the funds from the liable third party. Further, schools can still bill third party payors; however, it will not be required. This change aims to remove barriers for Local Education Agencies (LEA) to access Medicaid payment to support critical services for children with disabilities. These emergency revisions are necessary to avoid violation of federal law or regulation.

Budget Impact: The estimated budget impact for SFY 2025 is an increase in the total amount of $35,253; with $11,605 in state share. The estimated budget impact for SFY2026 is an increase in the total amount of $70,399; with $23,533 in state share.

APA WF # 24-19 Updating Abortion Policy — The proposed revisions align OHCA policy with state law on abortion. Currently, policy includes that abortion services can be accessed in instances of rape, incest, and/or when the mother's life is in danger; however, the exceptions of rape and incest will be removed in accordance with state law. These emergency revisions are necessary to avoid violation of state law.

Budget Impact: The proposed changes are budget neutral.

APA WF # 24-21 CRNA Rate Increase —The OHCA proposes emergency rule revisions to increase access to care and help alleviate workforce shortages by increasing rates for CRNAs practicing within scope of practice, in collaboration with a physician or dentist licensed in this state. Reimbursement will be increased to 100% of the physician fee schedule, from the existing 80%. In situations when the CRNA is practicing under medical direction, reimbursement will remain consistent with established methodology within the Title XIX State Plan, which is 50% of the physician fee schedule. These emergency revisions are necessary protect the public health, safety, or welfare and to avoid violation of state law.

Budget Impact: The estimated budget impact for SFY 2025 is an increase in the total amount of $6,642,110; with $2,183,594 in state share; for SFY 2026 and increase in the total amount of $8,241,531; with $2,750,817 in state share.

APA WF # 24-24 Medication Assisted Treatment (MAT) Clarification — The proposed emergency rule revisions are a request from ODMHSAS to comply with recent federal rule changes at 42 CFR § 8.12. This rule change ensures that refusal of members to participate in treatment services and service phases as described in OAC 317:30-5-241.7(f) will not prohibit individuals from receiving medications from an Opioid Treatment Program. These emergency revisions are necessary protect the public health, safety, or welfare and avoid violation of federal law or regulation.

Budget Impact: The proposed changes are budget neutral.

APA WF # 24-25 Psychological Testing Limit Increase — The proposed emergency rule revisions are a request from ODMHSAS to increase the initial limit on psychological testing hours from eight (8) to ten (10) hours. This change will allow for standard coverage of testing hours for most testing instruments and ensure that members who require psychological testing have sufficient initial coverage. Providers may still request an

additional six (6) hours for complex testing, bringing the total to sixteen (16) hours. These emergency revisions are necessary protect the public health, safety, or welfare.

Budget Impact: The proposed changes have a budget impact state share of $24,463 for SFY25 and $48,927 for SFY26. The state share will be covered by ODMHSAS.

APA WF # 24-34 Community Health Services — The proposed emergency rule changes are a request of Oklahoma State Department of Health (OSDH) to add coverage and reimbursement for Community Health Services provided within a public health clinic. These services are provided by a Community Health Worker (CHW) who work under the Public Health Clinic Services authority and must be ordered by a physician. Services include screening and assessments, health education/coaching, and health system navigation. Eligible providers must obtain a certificate of completion of a C3 core competency-based training offered by OSDH or an affiliated local health department and work and bill under a licensed provider. Eligible members must have a diagnosis of a chronic condition, unmet health-related social need, received a screening, or be pregnant to receive services. These emergency revisions are necessary protect the public health, safety, or welfare.

Budget Impact: The estimated budget impact for SFY 2025 is an increase in the total amount of $130,704; with $43,028 in state share; for SFY 2026 an increase of $871,360; with $285,980 in state share. The state share will be covered by OSDH.

This page intentionally left blank

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

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

317:35-18-4. Provider regulations

(a) The provider must comply with provisions of this Subchapter, ~~and~~ the regulations in 42 CFR, Part 460~~.~~, and all applicable local, state, and federal regulations. The provider must comply with all evaluation, monitoring, oversight, and other activities of the State Administering Agency (OHCA) as described in 42 CFR, Part 460.

~~(b) The provider agency must be licensed by the State of Oklahoma as an adult day care center.~~

~~(c) The provider must meet all applicable local, state, and federal regulations.~~

~~(d)~~(b) The provider must maintain an inquiry log of all individuals requesting Programs of All-Inclusive Care for the Elderly (PACE) services. This log will be available to the OHCA at all times. The log must include:

(1) type of contact;
(2) date of contact;
(3) name and phone number of the individual requesting services;
(4) name and address of the potential participant; and
(5) date of enrollment, or reason for denial if the individual is not enrolled.

(c) Pursuant to 42 CFR 460.70, any entity contracted by the provider to render PACE benefits must comply with the provisions of this Subchapter, the regulations in 42 CFR Part 460, and any other local, state, and federal regulations applicable to the provider.

(d) OHCA reserves the right to deny a provider's application for a new or renewed contract or terminate a contract with a provider as described in OAC 317:30-3-19.3 and OAC 317:30-3-19.5.

(e) PACE programs are license-exempt only when they provide services to PACE participants exclusively.

This page intentionally left blank

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 58. NON-HOSPITAL BASED HOSPICE

317:30-5-531. Coverage ~~for adults~~

(a) **Definition. "Hospice care"** means a comprehensive, holistic program of palliative and/or comfort care and support provided to the member and his/her family when a physician certifies that the member has a terminal illness and has a life expectancy of six (6) months or less.

(b) **Requirements.**

(1) Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.

(2) Hospice care is performed under the direction of a physician as per the member's plan of care in an approved hospital hospice facility, in-home hospice program, or nursing facility.

(c) **Eligibility.** Coverage for hospice services is provided to Medicaid eligible ~~expansion adults only~~members.

~~(1) Expansion adults defined by 42 Code of Federal Regulations § 435.119 who are age nineteen (19) or older and under sixty-five (65), at or below one hundred thirty-three percent (133%) of the federal poverty level (FPL), and who are not categorically related to the aged, blind, or disabled eligibility group are eligible for hospice services.~~

~~(2)~~(1) Hospice care eligibility requires physician certification that the member is terminally ill and includes a medical prognosis with a life expectancy of six (6) months or less if the illness runs its normal course. The terminal prognosis also must be supported by clinical documentation in the medical record. The certification must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, nurse practitioners may re-certify the terminal illness.

~~(3)~~(2) For information regarding hospice provision provided through waivers, refer to Oklahoma Administrative Code (OAC) 317:30-5-763, 317:30-5-1200, and 317:30-5-1202.

(d) **Covered services.** Hospice care services can include but are not limited to:

(1) Nursing care;

(2) Physician services (e.g., physicians employed or working under arrangements made with the hospice);

(3) Medical equipment and supplies;

(4) Drugs for symptom control and pain relief;

(5) Home health aide services;

(6) Personal care services;

(7) Physical, occupational and/or speech therapy;

(8) Medical social services;

(9) Dietary counseling; and

(10) Grief and bereavement counseling to the member and/or family are required but are not

reimbursable.

(e) **Prior authorization.** All services must be prior authorized, and a written plan of care must be established before services are rendered. For medical review purposes, all hospice services will be authenticated in accordance with OAC 317:30-3-30.

(f) **Service election.**

(1) For Medicaid eligible adults, the member or member's legal guardian or authorized representative must sign an election statement, choosing hospice care instead of routine medical care with the objective to treat and cure the member's terminal illness, and by doing so waives his or her right to other Medicaid benefits, except for care not related to the terminal illness and care provided by the attending physician.

(2) For Medicaid eligible children, hospice services are available without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness.

~~(2)~~(3) Once the member, legal guardian, or member's authorized representative has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice.

(g) **Service revocation.**

(1) Hospice care services may be revoked by the member, family, legal guardian, or authorized representative at any time.

(2) Upon revoking the election of Medicaid coverage of hospice care for a particular election period, the member resumes Medicaid coverage of ~~the~~any benefits waived when hospice care was elected.

(3) The member may at any time elect to receive hospice coverage for any other hospice election periods for which he or she is eligible.

(h) **Service frequency.** Hospice care services:

(1) Are available for an initial two (2) ninety-day (90-day) certification periods. After the two (2) initial ninety-day (90-day) periods, a member is allowed an unlimited number of sixty-day (60-day) certification periods during the remainder of the member's lifetime. Each certification period requires a new prior authorization.

(2) Require a hospice physician or nurse practitioner to have a face-to-face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter should take place prior to the one hundred eightieth (180^{th}) day recertification and each subsequent recertification thereafter; and attest that such visit took place.

(i) **Documentation.** Initial documentation requirements for requesting services, documentation requirements for continuation of services, and the full hospice guidelines can be found at OHCA's website, https://oklahoma.gov/ohca.

(j) **Reimbursement.**

(1) SoonerCare shall provide hospice care reimbursement:

(A) For each day that an individual is under the care of a hospice, the hospice will be reimbursed an amount applicable to the level, type and intensity of the services furnished to the individual for that day in accordance with the Oklahoma Medicaid State Plan.

(B) For independent physician direct services in accordance with the Oklahoma Medicaid State Plan.

(2) Through the Oklahoma Medicaid State Plan, the OHCA established payment amounts for

the following categories:

(A) **Routine hospice care.** Member is at home and not receiving hospice continuous care.

(B) **Continuous home care.** Member is not in an inpatient facility and receives hospice on a continuous basis at home; primarily consisting of nursing care to achieve palliation and management of acute medical symptoms during a brief period of crisis only as necessary to maintain the terminally ill patient at home. If less skilled care is needed on a continuous basis to enable the person to remain at home, this is covered as routine hospice care.

(C) **Inpatient respite care.** Member receives care in an approved inpatient facility on a short-term basis for respite.

(D) **General inpatient care.** Member receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed at home.

(E) **Nursing facility (NF)/intermediate care facilities for individuals with intellectual disabilities (ICF/IID) care**. Member receives hospice care in a NF or ICF/IID. Hospice nursing facility or ICF/IID room and board per diem rates are reimbursed to the in-home hospice provider at a rate equal to ninety-five percent (95%) of the skilled nursing facility rate. The hospice provider is responsible for passing the room and board payment through to the NF or ICF/IID. If Medicare is the primary payer of hospice benefits, OHCA will only reimburse the hospice provider for coinsurance and deductible amounts per the Oklahoma Medicaid State Plan and will continue to pay the room and board to the nursing facility.

(F) **Service intensity add-on**. Member receives care by a registered nurse (RN) or social worker when provided in the last seven (7) days of his/her life.

(G) **Other general reimbursement items.**

(i) **Date of discharge**. For the day of discharge from an inpatient unit, the appropriate home care rate is to be paid unless the patient dies as an inpatient. When the patient is discharged as deceased, the inpatient rate, either general or respite, is to be paid for the discharge date.

(ii) **Inpatient day cap**. Payments to a hospice for inpatient care must be limited according to the number of days of inpatient care furnished to Medicaid patients. During the twelve-month (12-month) period beginning October 1 of each year and ending September 30, the aggregate number of inpatient days (both for general inpatient care and inpatient respite care) may not exceed twenty percent (20%) of the aggregate total number of days of hospice care provided to all Medicaid recipients during that same period. This limitation is applied once each year, at the end of the hospices' cap period.

(iii) **Obligation of continuing care**. After the member's Medicare hospice benefit expires, the patient's Medicaid hospice benefits do not expire. The hospice must continue to provide the recipient's care until the patient expires or until the member revokes the election of hospice care.

317:30-5-532. Coverage for children [REVOKED]

~~Hospice is palliative and/or comfort care provided to the member and his/her family when a physician certifies that the member has a terminal illness and has a life expectancy of six months~~

~~or less. A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional and spiritual stresses which are experienced during the final stages of illness and death. Hospice services must be related to the palliation and management of the member's illness, symptom control, or to enable the individual to maintain activities of daily living and basic functional skills.~~

~~(1) Payment is made for home based hospice services for terminally ill individuals with a life expectancy of six months or less when the member and/or family has elected hospice benefits. Hospice services are available to eligible members without forgoing any other service to which the member is entitled under SoonerCare for curative treatment of the terminal illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the terminal illness in the home environment. Hospice providers are not responsible for curative treatments for members that elect such services while on hospice. Hospice care includes nursing care, physician services, medical equipment and supplies, drugs for symptom control and pain relief, home health aide and personal care, physical, occupational and/or speech therapy, medical social services, dietary counseling and grief and bereavement counseling to the member and/or family. Services must be prior authorized.~~

~~(2) Hospice care is available for two 90-day periods and an unlimited number of 60-day periods during the remainder of the member's lifetime. Beginning January 1, 2011, a hospice physician or nurse practitioner must have a face to face encounter with the member to determine if the member's terminal illness necessitates continuing hospice care services. The encounter must take place prior to the 180th day recertification and each subsequent recertification thereafter; and attests that such visit took place. The member and/or the family may voluntarily terminate hospice services. Hospice services must be reasonable and necessary for the palliation or management of a terminal illness or related conditions. A certification that the individual is terminally ill must be completed by the member's attending physician or the Medical Director of an Interdisciplinary Group. Nurse practitioners serving as the attending physician may not certify the terminal illness; however, effective January 1, 2011, nurse practitioners may re-certify the terminal illness.~~

~~(3) Services must be prior authorized. A written plan of care must be established before services are provided. The plan of care should be submitted with the prior authorization request.~~

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-24. Third party liability

As the Medicaid Agency, the Oklahoma Health Care Authority (OHCA) is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services, eligible students on an Individualized Education Program (IEP) or Individual Family Service Plan (IFSP) receiving school-based services and those eligible for the Crime Victims Compensation Act. Guidance for third party liability under the Insure Oklahoma program is found in Oklahoma Administrative Code (OAC) 317:45, Insure Oklahoma.

(1) If a member has coverage by an absent parent's insurance program or any other policy holder, that insurance resource must be used prior to filing a SoonerCare claim. This includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and any other insuring arrangements that provide a member access to healthcare. Members must comply with all requirements of their primary insurance as well as SoonerCare requirements in order to take advantage of both coverages. For example, a member must comply with the network restrictions of both the primary and SoonerCare plans. If the member does not comply with the requirements of the primary plan, he/she will be responsible for the charges incurred. The state's authorization that an item or service is as covered under the state plan, or a waiver of such plan, shall meet the prior authorization requirements of the primary insurer. If the provider is aware of private insurance or liability, a claim must first be filed with that source. When private insurance information is known to the OHCA, the eligibility verification system will reflect that information. If payment is denied by the primary insurance, except as stated above, the provider must attach the Explanation of Benefits (EOB), stating the reason for the denial, to the claim submitted to the Fiscal Agent. When payment is received from another source, that payment amount must be reflected on the claim form.

(2) It is possible that other resources are available but are unknown to OHCA. Providers will routinely question SoonerCare members to determine whether any other resources are available. In some instances, coverage may not be obvious, for example, the member may be covered by a policy on which he/she is not the subscriber (e.g., a child whose absent parent maintains medical and hospital coverage).

(3) If the provider receives payment from another source after OHCA has made payment, it is necessary that the provider reimburse OHCA for the SoonerCare payment. The provider may retain the primary insurance payment, if any, that represents payment for services that are not covered services under SoonerCare. By accepting the OHCA's payment, the provider agrees to accept it as payment in full and, therefore, cannot retain any portion of other resource money as payment for reduced charges on covered services. Other than SoonerCare copayments, a provider cannot bill a member for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error. If, after reimbursing OHCA and

retaining a portion of the other payment in satisfaction of any non-covered services there is money remaining, it must be refunded to the member.

(4) If a member is covered by a private health insurance policy or plan, he/she is required to inform medical providers of the coverage, including:

(A) provision of applicable policy numbers;

(B) assignment payments to medical providers;

(C) provision of information to OHCA of any coverage changes; and

(D) release of money received from a health insurance plan to the provider if the provider has not already received payment or to the OHCA if the provider has already been paid by the OHCA.

(5) Members are responsible for notifying their providers of the intent to make application for SoonerCare coverage and of any retroactive eligibility determinations. Members may be responsible for any financial liability if they fail to notify the provider of the eligibility determinations and as a result, the provider is unable to secure payment from OHCA.

(6) Members must present evidence of any other health insurance coverage to a medical provider each time services are requested. Members may be responsible for any financial liability if they fail to furnish the necessary information before the receipt of services and as a result, the provider is unable to secure payment from OHCA.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-50. Abortions

~~(a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. SoonerCare coverage for abortions to terminate pregnancies that are the result of rape or incest are considered to be medically necessary services and federal financial participation is available specifically for these services.~~

~~(1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.~~

~~(2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the physician must fully complete the Certification for Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest. In cases where an official report of the rape or incest is not available, the physician must certify in writing and provide documentation that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement. The statement explains the reason the rape or incest was not reported. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician and the patient. In cases where a physician provides certification and documentation of a patient's inability to file a report, the Oklahoma Health Care Authority (OHCA) will perform a prepayment review of all records to ensure there is sufficient documentation to support the physician's certification.~~

~~(b) The OHCA performs a look-behind procedure for abortion claims paid from SoonerCare funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under SoonerCare. On a post payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.~~

~~(c) Claims for spontaneous abortions, including Dilation and Curettage do not require certification. The following situations also do not require certification:~~

~~(1) If the physician has not induced the abortion, counseled or otherwise collaborated in inducing the abortion, and~~

~~(2) If the process has irreversibly commenced at the point of the physician's medical intervention.~~

~~(d) Claims for the diagnosis incomplete abortion require medical review. The appropriate diagnosis codes should be used indicating spontaneous abortion, etc.; otherwise the procedure will be denied.~~

(a) Payment of abortion related services is made only in those instances where there is no detectable heartbeat of the fetus, or if, in reasonable medical judgment, the SoonerCare member has a complicating condition that necessitates termination of the pregnancy to avert death or serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions.

(b) For abortions necessary to avert death or irreversible physical impairment of a major bodily function, the physician, must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed to avert death or irreversible physical impairment of a major bodily function. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.

(c) Prior to, or post payment, OHCA may perform a review of abortion related services. These reviews will require that the Agency obtain the applicable medical records.

(d) Claims for services related to fetal demise, including dilation and curettage, do not require the Certification for Medicaid Funded Abortion.

(e) The appropriate diagnosis codes should be used; otherwise, the procedure(s) will be denied.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 69. CERTIFIED REGISTERED NURSE ANESTHETISTS

317:30-5-607. Billing instructions

The CRNA is responsible for entering the correct anesthesia procedure code on the appropriate claim form. Anesthesia codes from the Physicians' Current Procedural Terminology or Medicare assigned codes should be used.

(1) Payment is made only for the major procedure during an operative session.

(2) All anesthesia procedure codes must have a modifier. Without the modifier, the claim will be denied. Payment to the CRNA is ~~limited to 80%~~made at 100% of the physician allowable for anesthesia services ~~without medical direction~~in collaboration with a physician licensed in this state using modifier QZ and 50% of the physician allowable when services are provided under the medical direction of an anesthesiologist using modifier QX.

(3) Certain codes in the Medicine section of the CPT are used to identify extraordinary anesthesia services. Additional payment can be made when applicable for extremes of age, total body hypothermia and controlled ~~hypertension~~hypotension.

(4) All other qualifying circumstances, i.e., physical status, emergency, etc., have been structured into the total allowable for the procedure.

(5) Hypothermia total body or regional is not covered unless medical necessity is documented and approved through review by the Authority's Medical Consultants.

(6) Payment for placement of central venous catheter, injection of anesthesia substance or similar procedures will be made only when the procedure is distinctly separate from the anesthesia procedure.

317:30-5-611. Payment methodology

Payment to the CRNA is ~~limited to 80%~~made at 100% of the physician allowable for anesthesia services performed ~~without medical direction~~in collaboration with a physician licensed in this state and 50% of the physician allowable when services are provided under the medical direction of a licensed physician.

This page intentionally left blank

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-241.7. Medication-assisted treatment (MAT) services for eligible individuals with opioid use disorder (OUD)

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

(1) **"Medication-assisted treatment (MAT)"** means an evidence-based practice approved by the Food and Drug Administration (FDA) to treat opioid use disorder, including methadone and all biological products licensed under federal law for such purpose. MAT also includes the provision of counseling and behavioral therapy.

(2) **"Office-based opioid treatment (OBOT)"** means a fully contracted SoonerCare provider that renders MAT services in OBOT settings. OBOT providers must have capacity to provide all drugs approved by the FDA for the treatment of opioid use disorder, directly or by referral, including for maintenance, detoxification, overdose reversal, and relapse prevention, and appropriate counseling and other appropriate ancillary services.

(3) **"Opioid treatment program (OTP)"** means a program or provider:

(A) Registered under federal law;

(B) Certified by the Substance Abuse and Mental Health Services Administration (SAMHSA);

(C) Certified by ODMHSAS, unless deemed an exempted entity as defined by federal law;

(D) Registered by the Drug Enforcement Agency (DEA);

(E) Registered by the Oklahoma Bureau of Narcotics and Dangerous Drugs (OBNDD); and

(F) Engaged in opioid treatment of individuals by use of an opioid agonist treatment medication, including methadone.

(4) **"Opioid use disorder (OUD)"** means a cluster of cognitive, behavioral, and physiological symptoms in which the individual continues use of opioids despite significant opioid-induced problems.

(5) **"Phase I"** means the first ninety (90) days of treatment.

(6) **"Phase II"** means the second ninety (90) days of treatment.

(7) **"Phase III"** means the third ninety (90) days of treatment.

(8) **"Phase IV"** means the last ninety (90) days of the first year of treatment.

(9) **"Phase V"** means the phase of treatment for members who have been receiving continuous treatment for more than one (1) year.

(10) **"Phase VI"** means the phase of treatment for members who have been receiving continuous treatment for more than two (2) years.

(b) **Coverage**. The SoonerCare program provides coverage of medically necessary MAT services in OTPs, including but not limited to, methadone treatment, to eligible individuals with OUD. An OTP must have the capacity to provide the full range of services included in the definition of MAT

and must document both medication dosing and supporting behavioral health services, including but not limited to, individual, family and group therapy and rehabilitation services. MAT services and/or medications may also be provided in OBOT settings per OAC 317:30-5-9(b)(16).

(c) **OTP requirements.** Every OTP provider shall:

(1) Have a current contract with the OHCA as an OTP provider;

(2) Hold a certification as an OTP from ODMHSAS, unless deemed an exempted entity as defined by federal law;

(3) Hold a certification from the Substance Abuse and Mental Health Services Administration (SAMHSA);

(4) Be appropriately accredited by a SAMHSA-approved accreditation organization;

(5) Be registered with the DEA and the OBNDD; and

(6) Meet all state and federal opioid treatment standards, including all requirements within OAC 450:70.

(d) **Individual OTP providers.** OTP providers include a:

(1) MAT provider who is a physician, physician's assistant (PA), or advanced practice registered nurse (APRN) who may prescribe, dispense, and administer medications in accordance with state and federal law and the Oklahoma Medicaid State Plan.

(2) OTP behavioral health services practitioner who is a practitioner that meets the qualifications in OAC 317:30-5-240.3, except for family support and training providers, qualified behavioral therapy aide providers, multi-systemic therapy providers, and case manager I providers, for the provision of outpatient behavioral health services.

(e) **Intake and assessment**. OTPs shall conduct intake and assessment procedures in accordance with OAC 450:70-3-5 through OAC 450:70-3-7.

(f) **Service phases.** In accordance with OAC 450:70-6-17.2 through OAC 450:70-6-17.8, the OTP shall have structured phases of treatment and rehabilitation to support member progress and to establish requirements regarding member attendance and service participation. The OTP shall utilize ASAM criteria to determine the appropriate level of care during each phase of treatment. Refusal of members to participate in treatment services as prescribed in 317:30-5-241.7(f)(1) through 317:30-5-241.7(f)(5) shall not preclude them from receiving medications from the OTP. The OTP shall document refusal of treatment services in the clinical record. Treatment requirements for each phase shall include, but not limited to, the following:

(1) During phase I, the member shall participate in a minimum of four (4) treatment sessions per month. Available services shall include, but not be limited to, therapy, rehabilitation, case management, and peer recovery support services.

(2) During phase II, the member shall participate in at least two (2) treatment sessions per month. Available services shall include, but not be limited to, therapy, rehabilitation, case management, and peer recovery support services.

(3) During phase III, phase IV and phase V, the member shall participate in at least one (1) treatment session per month. Available services shall include, but not be limited to, therapy, rehabilitation, case management, and peer recovery support services.

(4) During phase VI, the LBHP, licensure candidate or certified alcohol and drug counselor (CADC) determines the frequency of therapy or rehabilitation service sessions with input from the member.

(5) If an OTP is providing MAT medications to members receiving residential substance use disorder services, the required minimum services for the OTP may be delivered by the residential substance use disorder provider. The OTP provider shall document the provision

of these services and the provider delivering such services in the member's service plan.

(g) **Service plans**. In accordance with OAC 450:70-3-8, a service plan shall be completed for each member upon completion of the admission evaluation. The service plan shall be based on the patient's presenting problems or diagnosis, intake assessment, biopsychosocial assessment, and expectations of their recovery.

(1) **Service plan development.** Service plans shall be completed by an LBHP or licensure candidate. Service plans, including updates, must include dated signatures of the person served [if age fourteen (14) or older], the parent/guardian (if required by law), and the LBHP or licensure candidate. If a minor is eligible to self-consent to treatment pursuant to state law, a parent/guardian signature is not required. Service plans completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP. Signatures must be obtained after the service plan is completed.

(2) **Service plan content.** Service plans shall address, but not limited to, the following:

(A) Presenting problems or diagnosis;
(B) Strengths, needs, abilities, and preferences of the member;
(C) Goals for treatment with specific, measurable, attainable, realistic and time-limited;
(D) Type and frequency of services to be provided;
(E) Dated signature of primary service provider;
(F) Description of member's involvement in, and responses to, the service plan and his or her signature and date;
(G) Individualized discharge criteria or maintenance;
(H) Projected length of treatment;
(I) Measurable long and short term treatment goals;
(J) Primary and supportive services to be utilized with the patient;
(K) Type and frequency of therapeutic activities in which patient will participate;
(L) Documentation of the member's participation in the development of the plan; and
(M) Staff who will be responsible for the member's treatment.

(3) **Service plan updates.** Service plan updates shall be completed by an LBHP or licensure candidate. Service updates completed by a licensure candidate must be co-signed and dated by a fully-licensed LBHP. Service plan review and updates shall occur no less than every six (6) months and shall occur more frequently if required based upon the service phase or certain circumstances:

(A) Change in goals and objectives based upon member's documented progress, or identification of any new problem(s);
(B) Change in primary therapist or rehabilitation service provider assignment;
(C) Change in frequency and types of services provided;
(D) Critical incident reports; and/or
(E) Sentinel events.

(4) **Service plan timeframes.** Service plans shall be completed by the fourth visit after admission.

(h) **Progress notes.** Progress notes shall be completed in accordance with OAC 317:30-5-248(3).

(i) **Discharge planning.** All members shall be assessed for biopsychosocial appropriateness of discharge from each level of care using ASAM criteria that includes a list of symptoms for all six (6) dimensions and each of the levels of care, to determine a clinically appropriate placement in the least restrictive level of care. This organized process involves a professional determination by an LBHP or licensure candidate for appropriate placement to a specific level of care based on the

following symptoms and situations:

(1) Acute intoxication and/or withdrawal potential;
(2) Biomedical conditions and complications;
(3) Emotional, behavioral or cognitive conditions and complications;
(4) Readiness to change;
(5) Relapse, continued use or continued problem potential; and
(6) Recovery/living environment.

(j) **Service exclusions.** The following services are excluded from coverage:

(1) Components that are not provided to or exclusively for the treatment of the eligible individual;
(2) Services or components of services of which the basic nature is to supplant housekeeping or basic services for the convenience of a person receiving covered services;
(3) Telephone calls or other electronic contacts (not inclusive of telehealth);
(4) Field trips, social, or physical exercise activity groups;

(k) **Reimbursement.** To be eligible for payment, OTPs shall:

(1) Have an approved provider agreement on file with the OHCA. Through this agreement, the OTP assures that they are in compliance with all applicable federal and state Medicaid law and regulations, including, but not limited to, OHCA administrative rules, ODMHSAS administrative rules, and the Oklahoma Medicaid State Plan.
(2) Obtain prior authorization for applicable drugs and services by the OHCA or its designated agent before the service is rendered by an eligible provider. Without prior authorization for applicable drugs and services, payment is not authorized.
(3) Record the National Drug Code (NDC) number for each drug used in every encounter at the time of billing.
(4) Be reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-241.1 Screening, assessment and service plan

All providers must comply with the requirements as set forth in this Section.

(1) **Screening.**

(A) **Definition.** Screening is for the purpose of determining whether the member meets basic medical necessity and need for further behavioral health (BH) assessment and possible treatment services.

(B) **Qualified professional.** Screenings can be performed by any credentialed staff members as listed under OAC 317:30-5-240.3.

(C) **Target population and limitations.** Screening is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months. To qualify for reimbursement, the screening tools used must be evidence-based or otherwise approved by Oklahoma Health Care Authority (OHCA) and Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) and appropriate for the age and/or developmental stage of the member.

(2) **Assessment.**

(A) **Definition.** Gathering and assessment of historical and current bio-psycho-social information which includes face-to-face contact with the person and/or the person's family or other person(s) resulting in a written summary report, diagnosis and recommendations. All agencies must assess the medical necessity of each individual to determine the appropriate level of care.

(B) **Qualified practitioners.** This service is performed by a licensed behavioral health professional (LBHP) or licensure candidate.

(C) **Target population and limitations.** The BH assessment is compensable on behalf of a member who is seeking services for the first time from the contracted agency. This service is not compensable if the member has previously received or is currently receiving services from the agency, unless there has been a gap in service of more than six (6) months and it has been more than one (1) year since the previous assessment.

(D) **Documentation requirements.** The assessment must include all elements and tools required by the OHCA. In the case of children under the age of eighteen (18), it is performed with the direct, active face-to-face participation of the parent or guardian. The child's level of participation is based on age, developmental and clinical appropriateness. The assessment must include at least one DSM diagnosis from the most recent DSM edition or diagnostic impression. The information in the assessment must contain but is not limited to the following:

(i) Behavioral, including substance use, abuse, and dependence;

(ii) Emotional, including issues related to past or current trauma;

(iii) Physical;

(iv) Social and recreational;
(v) Vocational;
(vi) Date of the assessment sessions as well as start and stop times; and
(vii) Signature of parent or guardian participating in face-to-face assessment. Signatures are required for members over the age of fourteen (14). Signature and credentials of the practitioner who performed the face-to-face behavioral assessment. The signatures may be included in a signature page applicable to both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both.

(3) **Behavioral Health Services Plan Development.**

(A) **Definition.** The Behavioral Health Service Plan is developed based on information obtained in the assessment and includes the evaluation of all pertinent information by the practitioners and the member, including a discharge plan. It is a process whereby an individualized plan is developed that addresses the member's strengths, functional assets, weaknesses or liabilities, treatment goals, objectives and methodologies that are specific and time limited, and defines the services to be performed by the practitioners and others who comprise the treatment team. Behavioral Health Service Plan Development is performed with the direct active participation of the member and a member support person or advocate if requested by the member. In the case of children under the age of eighteen (18), it is performed with the participation of the parent or guardian and the child as age and developmentally appropriate, and must address school and educational concerns and assisting the family in caring for the child in the least restrictive level of care. For adults, it is focused on recovery and achieving maximum community interaction and involvement including goals for employment, independent living, volunteer work, or training. A Service Plan Development, Low Complexity is required every six (6) months and must include an update to the bio-psychosocial assessment and re-evaluation of diagnosis.

(B) **Qualified practitioners.** This service is performed by an LBHP or licensure candidate.

(C) **Time requirements.** Service Plan updates must be conducted face-to-face and are required every six (6) months during active treatment. However, updates can be conducted whenever it is clinically needed as determined by the qualified practitioner and member, but are only compensable twice in one (1) year.

(D) **Documentation requirements.** Comprehensive and integrated service plan content must address the following:

(i) member strengths, needs, abilities, and preferences (SNAP);
(ii) identified presenting challenges, problems, needs and diagnosis;
(iii) specific goals for the member;
(iv) objectives that are specific, attainable, realistic, and time-limited;
(v) each type of service and estimated frequency to be received;
(vi) the practitioner(s) name and credentials that will be providing and responsible for each service;
(vii) any needed referrals for service;
(viii) specific discharge criteria;
(ix) description of the member's involvement in, and responses to, the service plan, and his/her signature and date;

(x) service plans are not valid until all signatures are present [signatures are required from the member, if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the primary LBHP or licensure candidate. The signatures may be included in a signature page applicable to both the assessment and treatment plan if the signature page clearly indicates that the signatories consent and approve of both; and

(xi) all changes in a service plan must be documented in either a scheduled six (6) month service plan update (low complexity) or within the existing service plan through an amendment until time for the update (low complexity). Any changes to the existing service plan must, prior to implementation, be signed and dated by the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the lead LBHP or licensure candidate.

(xii) Amendment of an existing service plan to revise or add goals, objectives, service provider, service type, and service frequency, may be completed prior to the scheduled six (6) month review/update. A plan amendment must be documented through an addendum to the service plan, dated and signed prior to the implementation, by the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the lead LBHP or licensure candidate. A temporary change of service provider may be documented in the progress note for the service provided, rather than an amendment.

(xiii) Behavioral health service plan development, low complexity, must address the following:

(I) update to the bio-psychosocial assessment, re-evaluation of diagnosis service plan goals and/ or objectives;

(II) progress, or lack of, on previous service plan goals and/or objectives;

(III) a statement documenting a review of the current service plan and an explanation if no changes are to be made to the service plan;

(IV) change in goals and/or objectives (including target dates) based upon member's progress or identification of new need, challenges and problems;

(V) change in frequency and/or type of services provided;

(VI) change in practitioner(s) who will be responsible for providing services on the plan;

(VII) change in discharge criteria;

(VIII) description of the member's involvement in, and responses to, the service plan, and his/her signature and date; and

(IX) service plan updates (low complexity) are not valid until all signatures are present. The required signatures are: from the member [if fourteen (14) or over], the parent/guardian [if younger than eighteen (18) or otherwise applicable], and the primary LBHP or licensure candidate.

(E) **Service limitations:**

(i) Behavioral Health Service Plan Development, Moderate Complexity (i.e., pre-admission procedure code group) is limited to one (1) per member, per provider, unless more than one (1) year has passed between services, in which case, one can be requested and performed, if authorized by OHCA or its designated agent.

(ii) Behavioral Health Service Plan Development, Low Complexity: Service Plan updates are required every six (6) months during active treatment. Updates, however,

can be conducted whenever clinically needed as determined by the provider and member, but are only reimbursable twice in one (1) year. The date of service is when the service plan is complete and the date the last required signature is obtained. Services should always be age, developmentally, and clinically appropriate.

(4) **Assessment/Evaluation testing.**

(A) **Definition.** Assessment/Evaluation testing is provided by a clinician utilizing tests selected from currently accepted assessment test batteries. Test results must be reflected in the Service Plan. The medical record must clearly document the need for the testing and what the testing is expected to achieve.

(B) **Qualified practitioners.** Assessment/Evaluation testing will be provided by a psychologist, certified psychometrist, psychological technician of a psychologist, an LBHP or licensure candidate. For assessments conducted in a school setting, the Oklahoma State Department of Education (OSDE) requires that a licensed supervisor sign the assessment. Each qualified professional must have a current contract with the OHCA.

(C) **Documentation requirements.** All psychological services must be documented in the member's record. All assessment, testing, and treatment services/units billed must include the following:

(i) date;

(ii) start and stop time for each session/unit billed and physical location where service was provided;

(iii) signature of the provider;

(iv) credentials of provider;

(v) specific problem(s), goals and/or objectives addressed;

(vi) methods used to address problem(s), goals and objectives;

(vii) progress made toward goals and objectives;

(viii) patient response to the session or intervention; and

(ix) any new problem(s), goals and/or objectives identified during the session.

(D) **Service Limitations.** Testing for a child younger than three (3) must be medically necessary and meet established child [zero (0) to thirty-six (36) months of age] criteria as set forth in the Prior Authorization Manual. Evaluation and testing is clinically appropriate and allowable when an accurate diagnosis and determination of treatment needs is needed. ~~Eight (8)~~ Ten (10) hours/units of testing per patient over the age of three (3), per provider is allowed every twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this Section must be clearly explained and documented in the medical record. Testing units must be billed on the date the actual testing, interpretation, scoring, and reporting are performed. A maximum of twelve (12) hours of therapy and testing, per day per rendering provider are allowed. A child who is being treated in an acute inpatient setting can receive separate psychological services by a physician or psychologist as the inpatient per diem is for "non-physician" services only. A child receiving residential level treatment in either a therapeutic foster care home, or group home may not receive additional individual, group or family counseling or psychological testing unless allowed by the OHCA or its designated agent. Psychologists employed in state and federal agencies, who are not permitted to engage in private practice, cannot be reimbursed for services as an individually contracted provider. For assessment conducted in a school

setting the OSDE requires that a licensed supervisor sign the assessment. For individuals who qualify for Part B of Medicare, payment is made utilizing the SoonerCare allowable for comparable services. Payment is made to physicians, LBHPs or psychologists with a license to practice in the state where the services is performed or to practitioners who have completed education requirements and are under current board approved supervision to become licensed.

317:30-5-276. Coverage by category

(a) **Outpatient Behavioral Health Services**. Outpatient behavioral health services are covered as set forth in this Section, when provided in accordance with a documented individualized service plan medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise.

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 Code of Code of Federal Regulations 431.10.

(b) **Children.** Coverage for children includes the following services:

(1) Bio-Psycho-Social Assessments. Psychiatric Diagnostic Interview Examination (PDIE) initial assessment or Level of Care Assessment. The interview and assessment is defined as a face-to-face interaction with the member. Psychiatric diagnostic interview examination includes a history, mental status, and a disposition, and may include communication with family or other sources, ordering and medical interpretation of laboratory or other medical diagnostic studies. Only one (1) PDIE is allowable per provider per member. If there has been a break in service over a six (6) month period, then an additional unit of PDIE can be prior authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is

considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the psychologist. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one (1) of the following communication factors is present:

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

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

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

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

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in the psychologist's office, clinic, or other confidential setting. Group therapy is a face to face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six (6) patients for children four years of age up to the age of 18. Groups can include up to eight (8) individuals for members 18-20 years of age. Group therapy must be provided for the benefit of the member four years of age or older as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight family units.

(5) Assessment/Evaluation and testing is provided by a psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. ~~Eight~~Ten hours/units of testing per patient (over the age of three), per provider is allowed every 12 months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Test results must be reflected in the service plan or medical record. The service must clearly document the need for the testing and what the testing is expected to achieve. Testing for a child younger than three must be medically necessary and meet established criteria as set forth in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be

clearly explained and documented in the medical record. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Health and Behavior codes - behavioral health services are available only to chronically and severely medically ill members.

(7) Crisis intervention services for the purpose of stabilization and hospital diversion as clinically appropriate.

(8) Payment for therapy services provided by a psychologist to any one member is limited to eight sessions/units per month. A maximum of twelve (12) sessions/units of therapy and testing services per day per provider are allowed. A maximum of thirty five (35) hours of therapy per week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four (4) week average.

(9) A child may receive psychological testing and evaluation services as separately reimbursable services.

(10) A child receiving Residential Behavioral Management in a foster home, also known as therapeutic foster care, or a child receiving Residential Behavioral Management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or unless allowed by the OHCA or its designated agent.

(c) **Adults.** Coverage for adults is the same as for children. For group therapy, groups can include up to eight individuals for adult members 18 years of age and older.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services program for people with intellectual and developmental disabilities must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

(e) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services.

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare.

317:30-5-281. Coverage by Category

(a) **Outpatient Behavioral Health Services.** Outpatient behavioral health services are covered as set forth in this Section, and when provided in accordance with a documented individualized service plan and/or medical record, developed to treat the identified behavioral health and/or substance use disorder(s), unless specified otherwise**.**

(1) All services are to be for the goal of improvement of functioning, independence, or wellbeing of the member. The services and treatment plans are to be recovery focused, trauma and co-occurring specific. The member must be able to actively participate in the treatment. Active participation means that the member must have sufficient cognitive abilities, communication skills, and short-term memory to derive a reasonable benefit from the treatment.

(2) In order to be reimbursed for services, providers must submit a completed Customer Data Core (CDC) to OHCA or its designated agent. The CDC must be reviewed, updated and resubmitted by the provider every six (6) months. Reimbursement is made only for services provided while a current CDC is on file with OHCA or its designated agent. For further information and instructions regarding the CDC, refer to the Prior Authorization Manual.

(3) Some outpatient behavioral health services may require authorization. For information regarding services requiring authorization and the process for obtaining them, refer to the Prior Authorization Manual. Authorization of services is not a guarantee of payment. The provider is responsible for ensuring that the eligibility, medical necessity, procedural, coding, claims submission, and all other state and federal requirements are met. OHCA does retain the final administrative review over both authorization and review of services as required by 42 CFR 431.10.

(b) **Adults.** Outpatient behavioral health coverage for adults rendered by a LBHP is limited to bio-psycho-social assessments when required by OHCA as part of a preoperative prior authorization protocol for organ transplant or bariatric surgical procedures.

(1) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary. The pre-op evaluation should aim to assess the member's psychological well-being, ability to make informed decisions, and willingness to participate actively in postoperative treatment.

(2) For bariatric preoperative assessments, issues to address include, but are not limited to: depression, self-esteem, stress management, coping skills, binge eating, change in eating habits, other eating disorders, change in social roles, changes associated with return to work/school, body image, sexual function, lifestyle issues, personality factors that may affect treatment and recovery, alcohol or substance use disorders, ability to make lasting behavior changes, and need for further support and counseling.

(c) **Children.** Coverage for children includes the following services:

(1) Bio-psycho-social and level of care assessments.

(A) The interview and assessment is defined as a face-to-face interaction with the member. Assessment includes a history, mental status, full bio-psycho-social evaluation, a disposition, communications with family or other sources, review of laboratory or other pertinent medical information, and medical/clinical consultations as necessary.

(B) Assessments for children's level of care determination of medical necessity must follow a specified assessment process through OHCA or their designated agent. Only one assessment is allowable per provider per member. If there has been a break in service over a six (6) month period, or the assessment is conducted for the purpose of determining a child's need for inpatient psychiatric admission, then an additional unit can be authorized by OHCA, or their designated agent.

(2) Psychotherapy in an outpatient setting including an office, clinic, or other confidential setting. The services may be performed at the residence of the member if it is demonstrated that it is clinically beneficial, or if the member is unable to go to a clinic or office. Individual psychotherapy is defined as a one to one treatment using a widely accepted modality or treatment framework suited to the individual's age, developmental abilities and diagnosis. It may include specialized techniques such as biofeedback or hypnosis. Psychotherapy is considered to involve "interactive complexity" when there are communication factors during a visit that complicate delivery of the psychotherapy by the LBHP. Sessions typically involve members who have other individuals legally responsible for their care (i.e. minors or adults with guardians); members who request others to be involved in their care during the session (i.e. adults accompanied by one or more participating family members or interpreter or language translator); or members that require involvement of other third parties (i.e. child

welfare, juvenile justice, parole/probation officers, schools, etc.). Psychotherapy should only be reported as involving interactive complexity when at least one of the following communication factors is present:

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

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

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

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

(3) Family Psychotherapy is performed in an outpatient setting limited to an office, clinic, or other confidential setting. Family therapy is a face-to-face interaction between a therapist and the patient/family to facilitate emotional, psychological or behavioral changes and promote communication and understanding. Family therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan.

(4) Group and/or Interactive Group psychotherapy in an outpatient setting must be performed in an office, clinic, or other confidential setting. Group therapy is a face-to-face interaction between a therapist and two or more unrelated patients (though there may be siblings in the same group, just not siblings only) to facilitate emotional, psychological, or behavioral changes. All group therapy records must indicate group size. Maximum total group size is six (6) for ages four (4) up to eighteen (18). Groups 18-20 year olds can include eight (8) individuals. Group therapy must be provided for the benefit of the member as a specifically identified component of an individual treatment plan. Multi-family group therapy size is limited to eight (8) family units.

(5) Assessment/evaluation and testing is provided by a psychologist, certified psychometrist, psychological technician of a psychologist or a LBHP utilizing tests selected from currently accepted assessment test batteries. For assessments conducted in a school setting, the Oklahoma State Department of Education requires that a licensed supervisor sign the assessment. ~~Eight (8)~~ Ten (10) hours/units of testing per patient over the age of three (3), per provider is allowed every twelve (12) months. There may be instances when further testing is appropriate based on established medical necessity criteria found in the Prior Authorization Manual. Justification for additional testing beyond allowed amount as specified in this section must be clearly explained and documented in the medical record. Test results must be reflected in the service plan or medical record. The service plan must clearly document the need for the testing and what the testing is expected to achieve. Testing units must be billed on the date the testing, interpretation, scoring, and/or reporting was performed and supported by documentation.

(6) Crisis intervention services for the purpose of stabilization and hospitalization diversion as clinically appropriate.

(7) Payment for therapy services provided by a LBHP to any one member is limited to four (4) sessions/units per month. A maximum of twelve (12) sessions/units of therapy and testing services per day per provider are allowed. A maximum of thirty-five (35) hours of therapy per

week per provider are allowed. The weekly service hour limitation will be calculated using a rolling four (4) week average. Case Management services are considered an integral component of the behavioral health services listed above.

(8) A child receiving residential behavioral management in a foster home, also known as therapeutic foster care, or a child receiving residential behavioral management in a group home, also known as therapeutic group home, may not receive individual, group or family counseling or testing unless allowed by the OHCA or their designated agent.

(d) **Home and Community Based Waiver Services for the Intellectually Disabled.** All providers participating in the Home and Community Based Waiver Services for the intellectually disabled program must have a separate contract with this Authority to provide services under this program. All services are specified in the individual's plan of care.

(e) **Individuals eligible for Part B of Medicare**. Payment is made utilizing the Medicaid allowable for comparable services.

(f) **Nursing Facilities.** Services provided to members residing in nursing facilities may not be billed to SoonerCare**.**

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 112. PUBLIC HEALTH CLINIC SERVICES

317:30-5-1154. County health department (CHD) and city-county health department (CCHD) services/limitations

CHD/CCHD service limitations are:

(1) Child-guidance services (refer to Oklahoma Administrative Code (OAC) 317:30-5-1023).

(2) Dental services (refer to OAC 317:30-3-65.4(7) for specific coverage).

(3) Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, including blood lead testing and follow-up services (refer to OAC 317:30-3-65 through 317:30-3-65.12 for specific coverage).

(4) Environmental investigations.

(5) Family planning and SoonerPlan family planning services (refer to OAC 317:30-5-12 for specific coverage guidelines).

(6) Immunizations (adult and child).

(7) Blood lead testing (refer to OAC 317:30-3-65.4 for specific coverage).

(8) Newborn hearing screening.

(9) Newborn metabolic screening.

(10) Maternity services (refer to OAC 317:30-5-22 for specific coverage).

(11) Public health nursing services.

(12) Tuberculosis case management and directly observed therapy.

(13) Laboratory services.

(14) Targeted case management.

(15) Community health services.

317:30-5-1162. Community Health Services

(a) **Overview.** Community Health Services are a preventive health service to prevent disease, disability and other health conditions or their progression; to prolong life; and/or to promote physical and mental health and efficiency. Community Health Services are furnished by community health workers (CHW). CHWs are trusted members of a community who help address chronic conditions, preventive health care needs, and health-related social needs.

(b) **Settings.** Community Health Services:

(1) Must be performed at the main clinic site, satellite clinic, or mobile clinic site that is open to the public.

(2) Only when an eligible individual does not reside in a permanent dwelling or does not have a fixed home or mailing address can services be provided outside of the clinic, satellite clinic, or mobile clinic.

(c) **Covered Services.** Community Health Services include:

(1) Health education and coaching, in individual or group settings, consistent with established or recognized healthcare standards, to promote beneficiaries' awareness of and engagement in health care and other related services as well as chronic disease self-management methods;

including care planning, setting goals, and creating action plans to address barriers to engaging in care and/or self-management of chronic conditions;

(2) Screening and assessment to uncover the need for services;

(3) Health system navigation and health-related social resource coordination to assist beneficiaries with access to appropriate health care and other related community resources; care coordination services include engaging with beneficiaries and interdisciplinary care teams as a part of a team-based, person-centered approach to support and advocate for physical and mental health including during time-limited episodes of instability.

(d) **Member Eligibility.** In order to receive CHW services, a beneficiary must have services ordered by a physician or other licensed practitioner and must have at least one of the following:

(1) Diagnosis of one or more chronic health conditions including behavioral health conditions;

(2) Self-reported/suspected or documented unmet health-related social need;

(3) Received a screening; and/or

(4) Pregnancy.

(e) **Provider Eligibility.** In order to provide CHW services, an individual shall, in addition to the requirements set forth in 317:30-5-1152:

(1) Be at least eighteen (18) years of age, a legal United States resident, and a resident of Oklahoma;

(2) Be contracted with the State Medicaid Agency or its designee;

(3) Pass a background check;

(4) Obtain a certificate of completion of a C3 core competency-based Community Health Worker training offered by the Oklahoma State Department of Health, Tulsa City County Health Department, and/or Oklahoma City County Health Department; or have two thousand (2,000) documented hours of paid, volunteer, or lived experience;

(5) Have lived experience that aligns with the community being served; and

(6) Work and bill under a licensed provider.

(f) **Limitations.** The following limits exist for community health services.

(1) Individuals may not receive more than two (2) hours or four (4) units per member per day.

(2) Monthly service limits are not to exceed twelve (12) hours or twenty-four (24) units.

(3) Hour limits are constant, regardless of whether services are administered in an individual or group setting.

(4) A visit may consist of multiple units of service on the same date; the time for units of service is added together and rounded up only once per visit.

2025 Strategic Planning & Operational Committee Meetings

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

January 15, 2025 2:00pm

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

June 25, 2025 2:00pm

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

March 19, 2025 2:00pm

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

September 17, 2025 2:00pm

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

May 21, 2025 2:00pm

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

December 10, 2025 2:00pm

OPERATIONAL METRICS

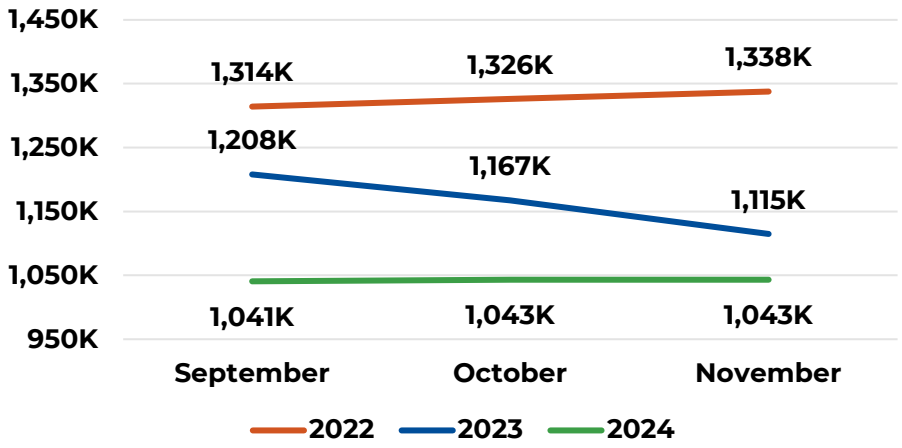
December 2024 Board Meeting

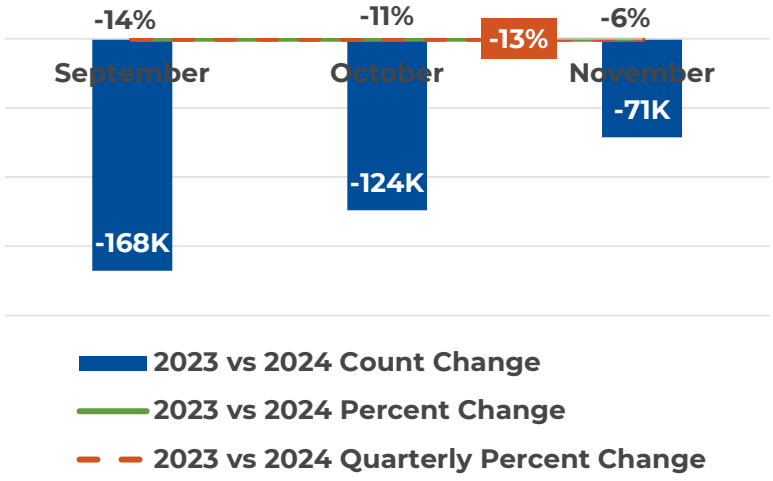
OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

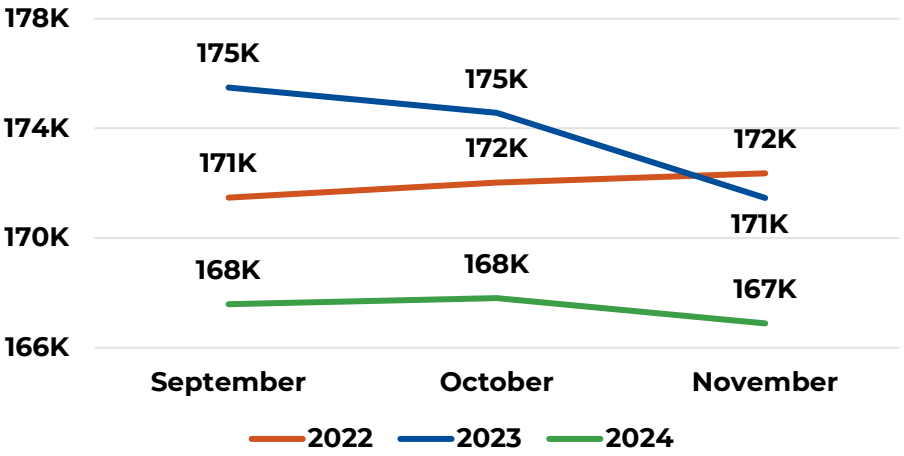
Enrollment & Utilization

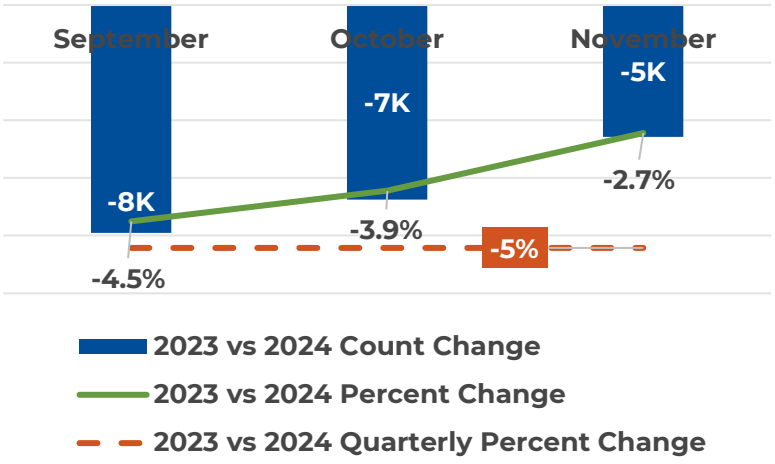
Total Enrolled Members





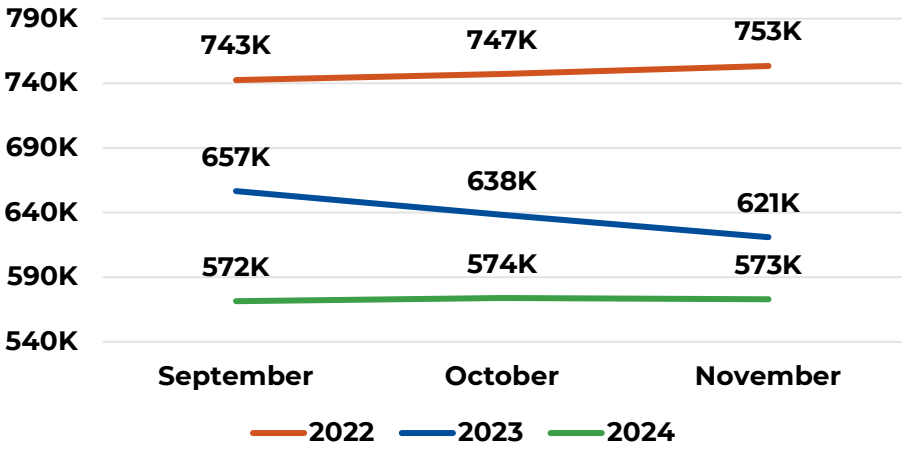
Aged/Blind/Disabled Enrolled

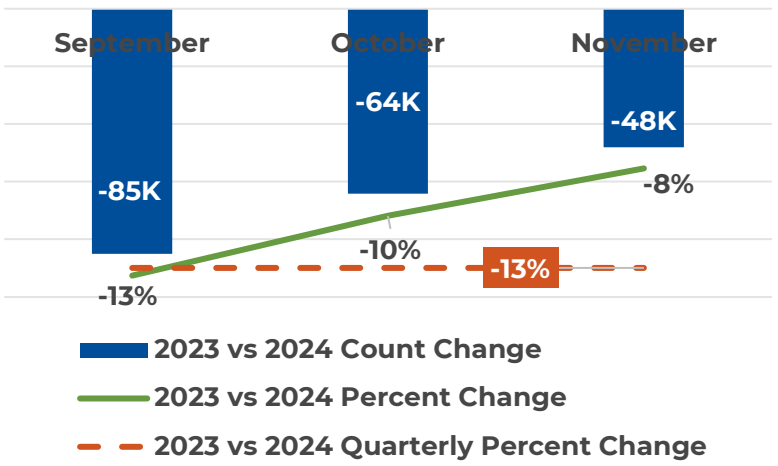




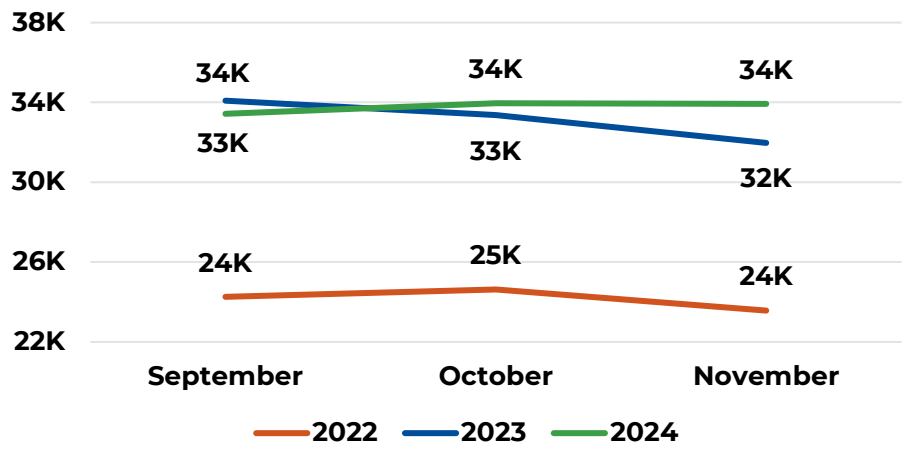
Enrollment & Utilization (Cont.)

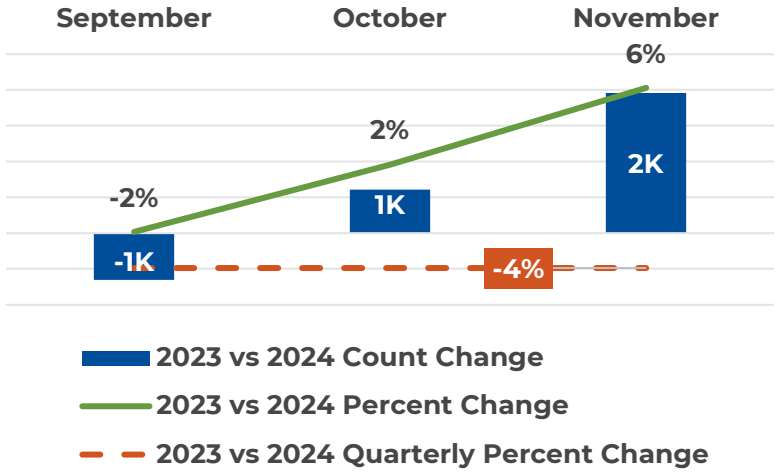
Children & Parent/Caretaker Enrolled





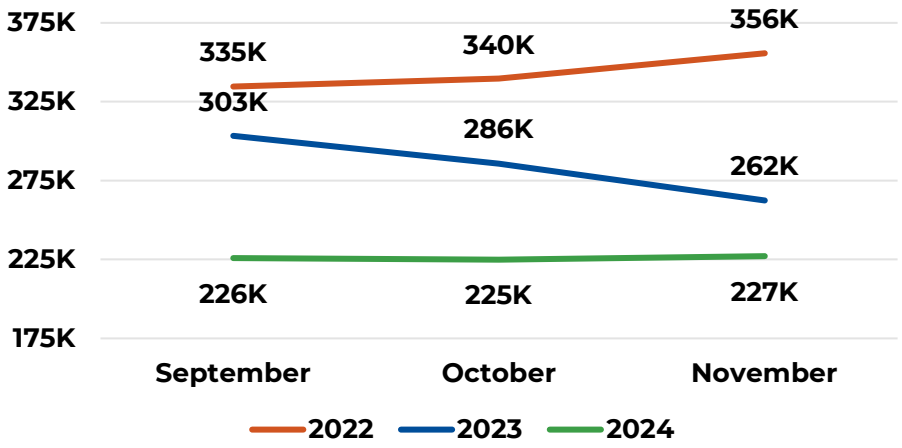
Pregnant (Full Scope) Enrolled

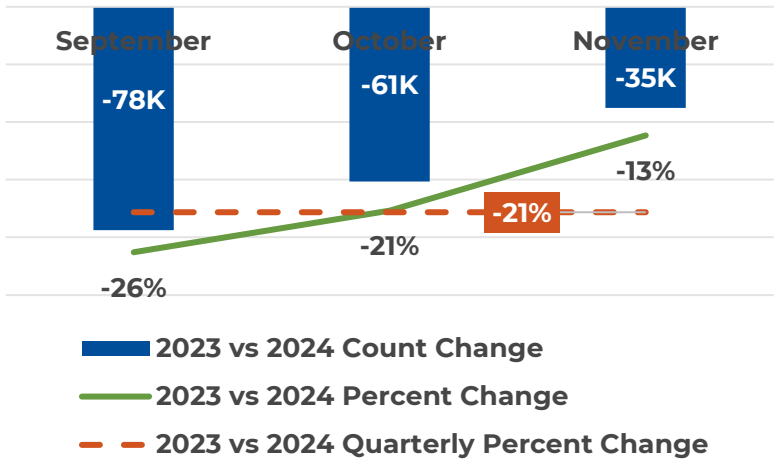




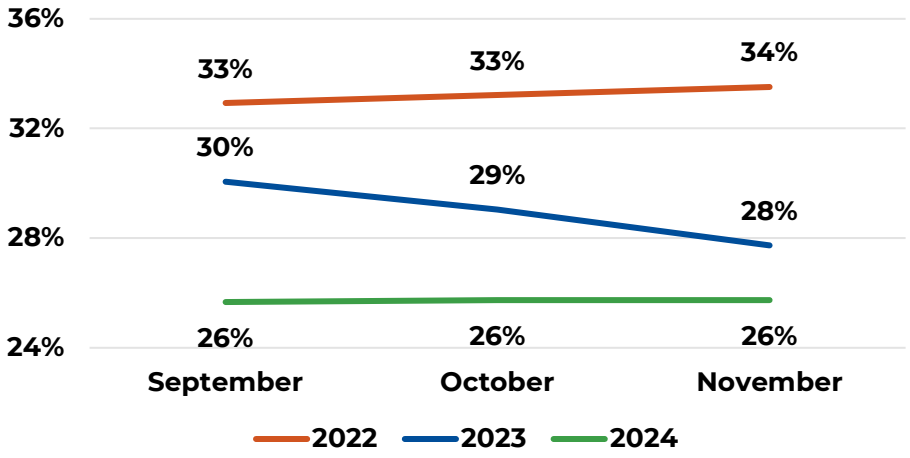
Enrollment & Utilization (Cont.)

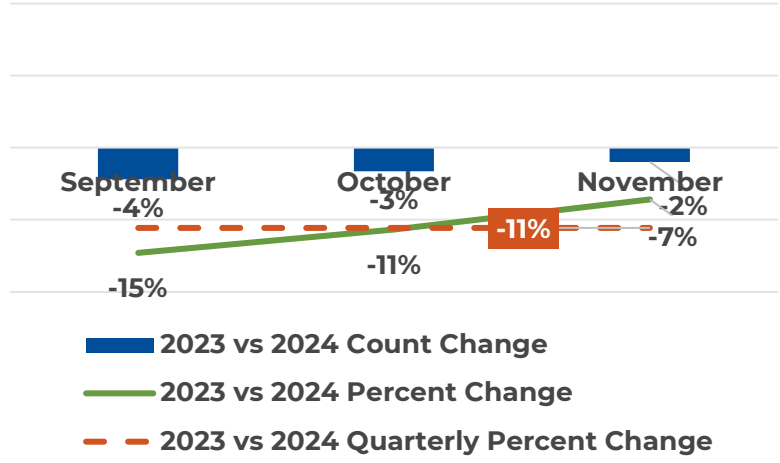
Expansion Enrolled (Effective July 2021)





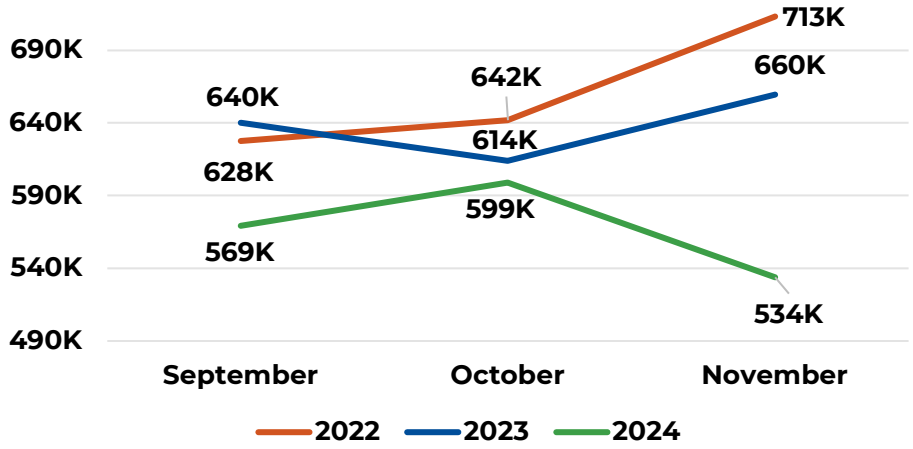
Percent of OK Population Enrolled

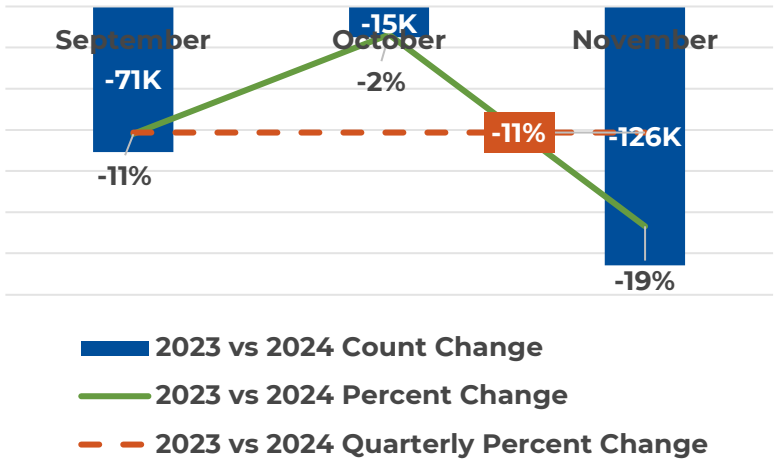




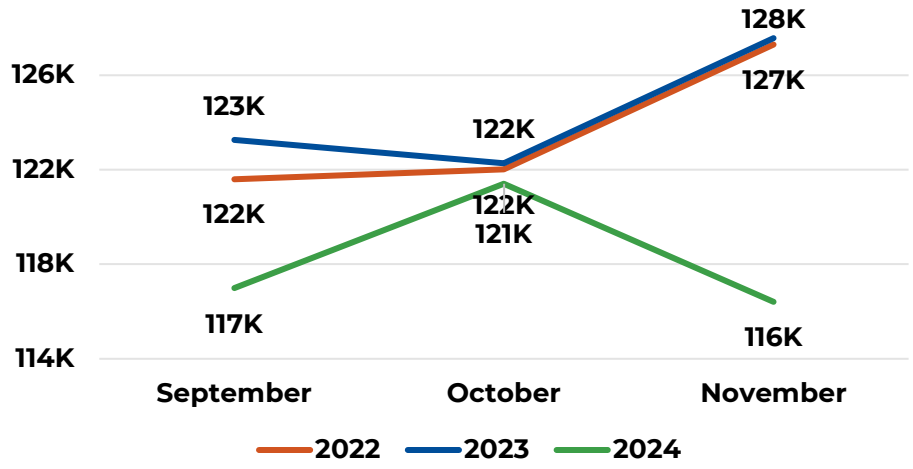
Enrollment & Utilization (Cont.)

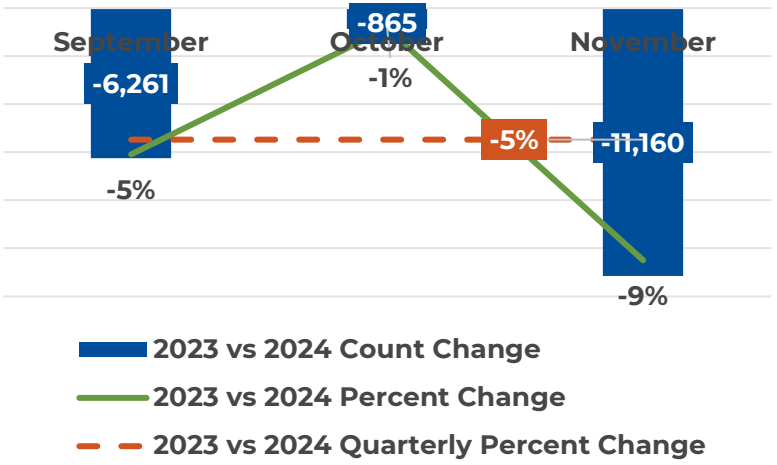
Total Members Utilization





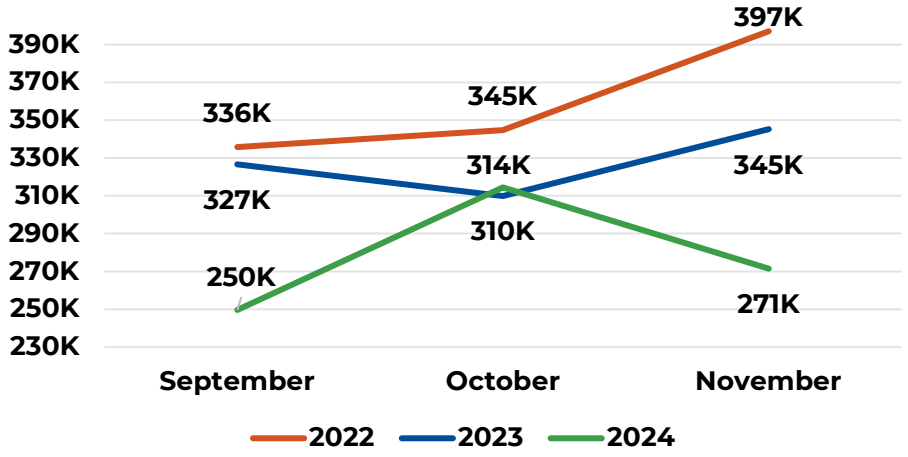
Aged/Blind/Disabled Utilization

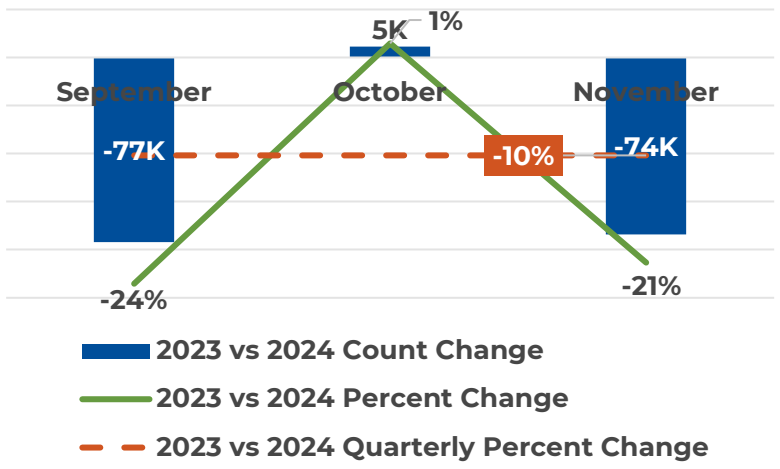




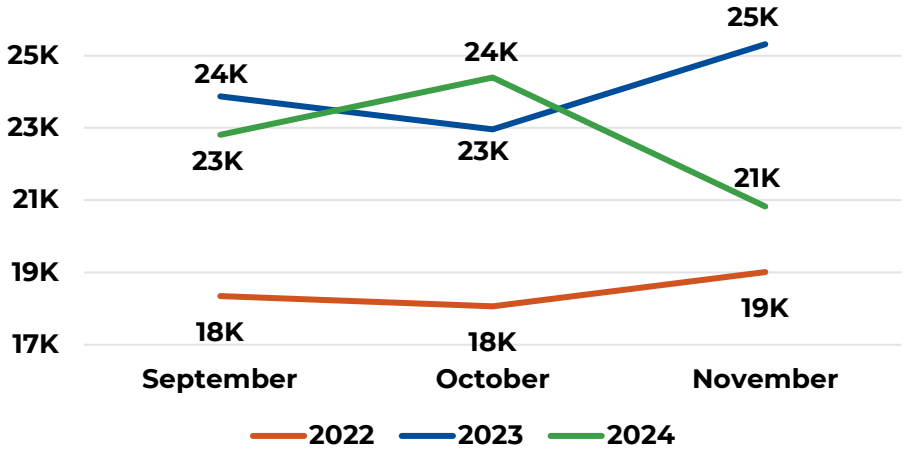
Enrollment & Utilization (Cont.)

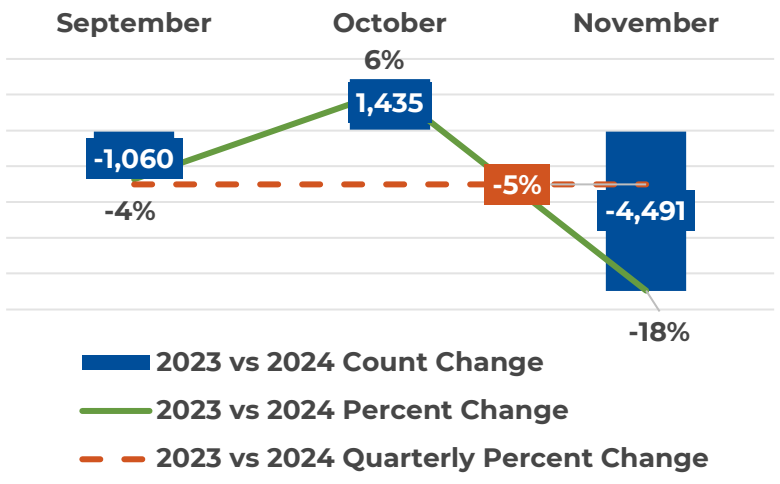
Children & Parent/Caretaker Utilization





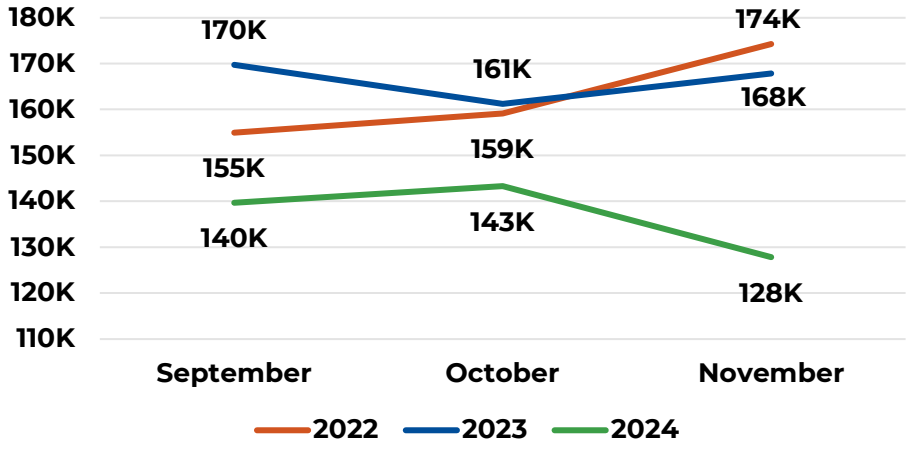
Pregnant (Full Scope) Utilization

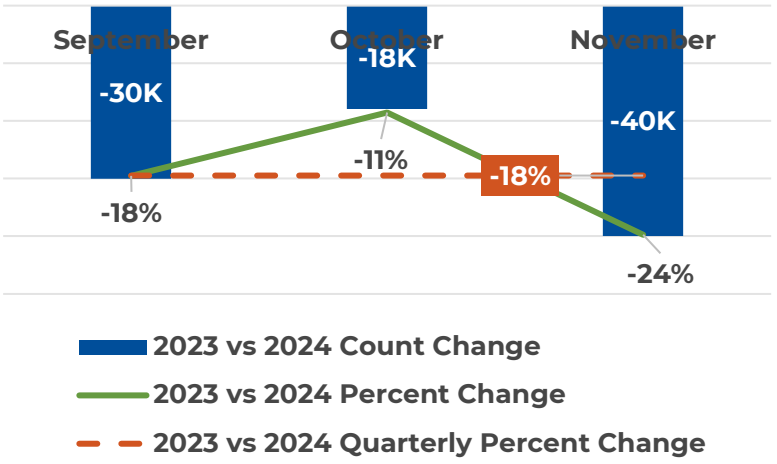




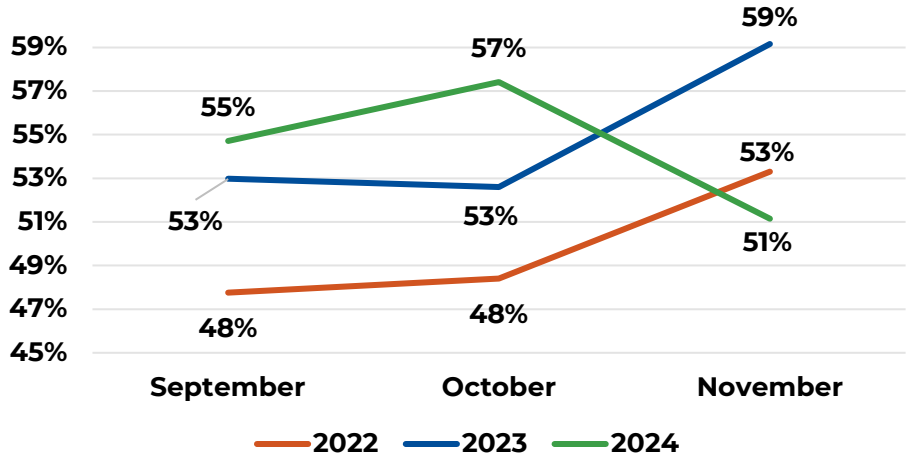
Enrollment & Utilization (Cont.)

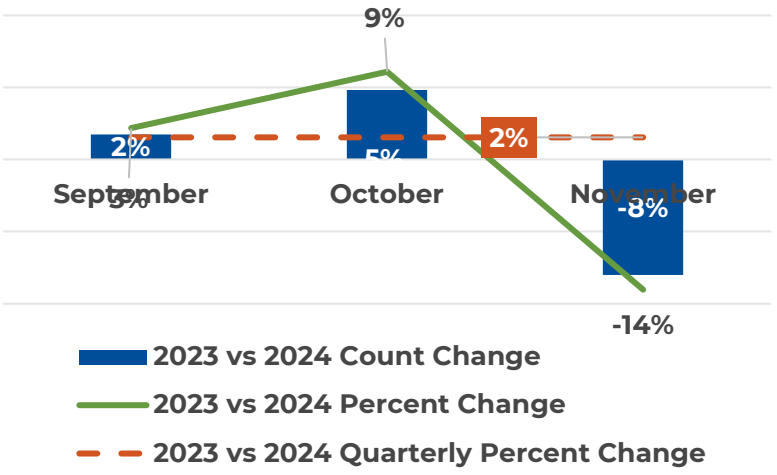
Expansion Utilization (Effective July 2021)





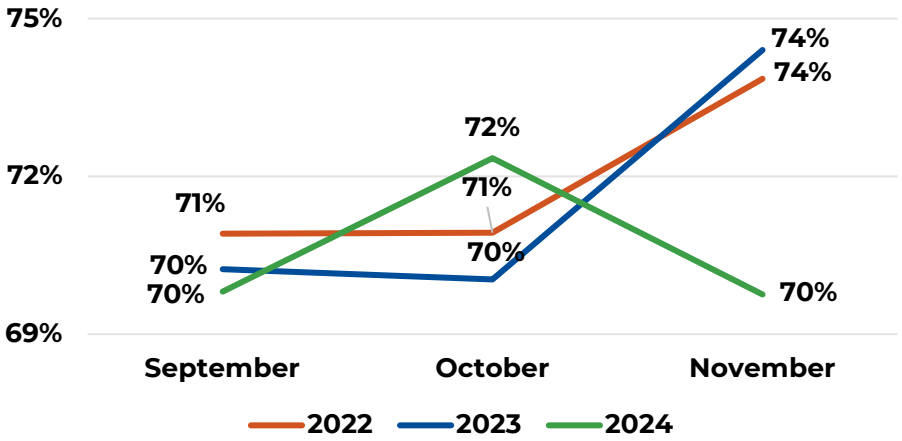
Percent of Total Enrolled Members Utilization

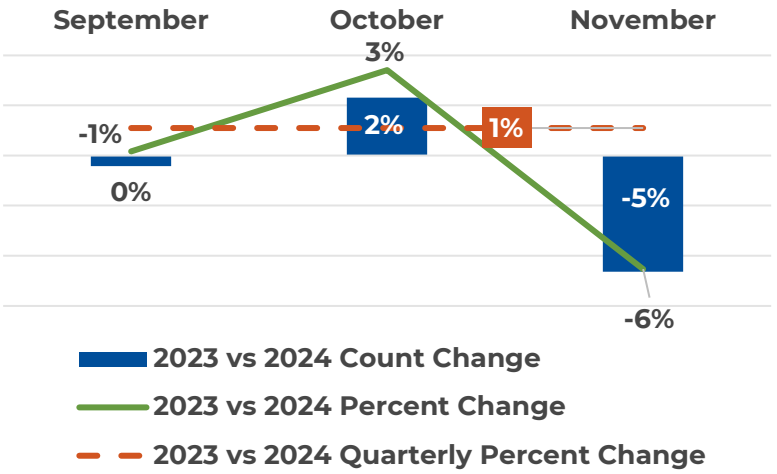




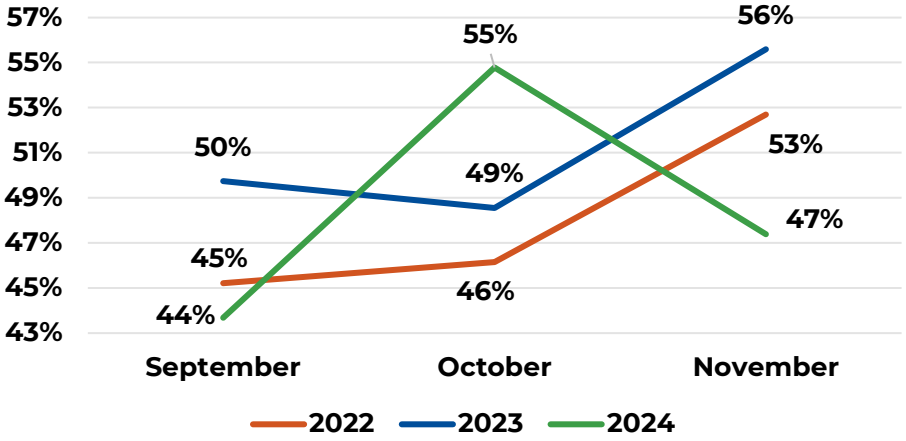
Enrollment & Utilization (Cont.)

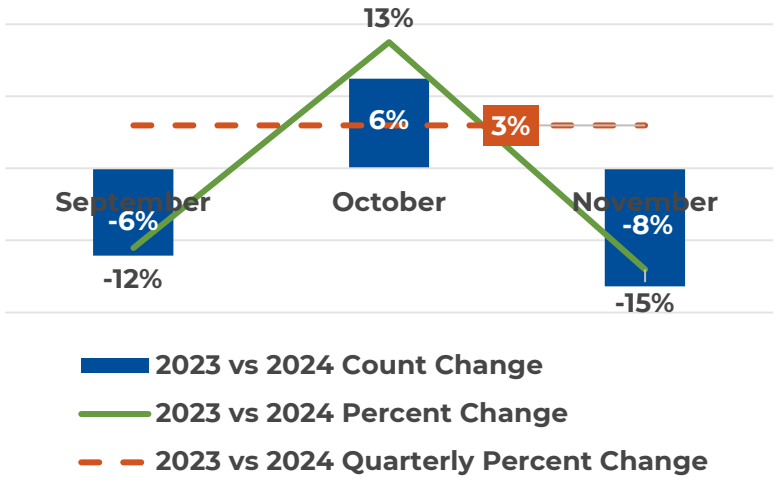
Percent of Aged/Blind/Disabled Enrolled Members Utilization





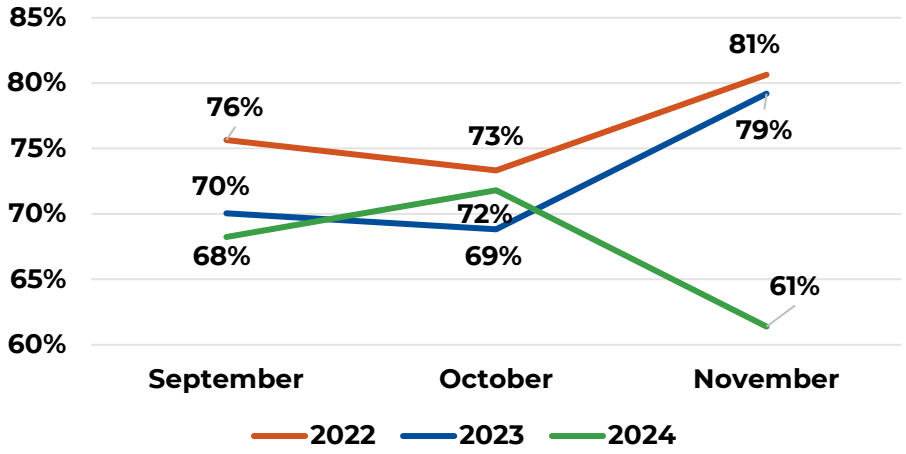
Percent of Children & Parent/Caretaker Enrolled Members Utilization

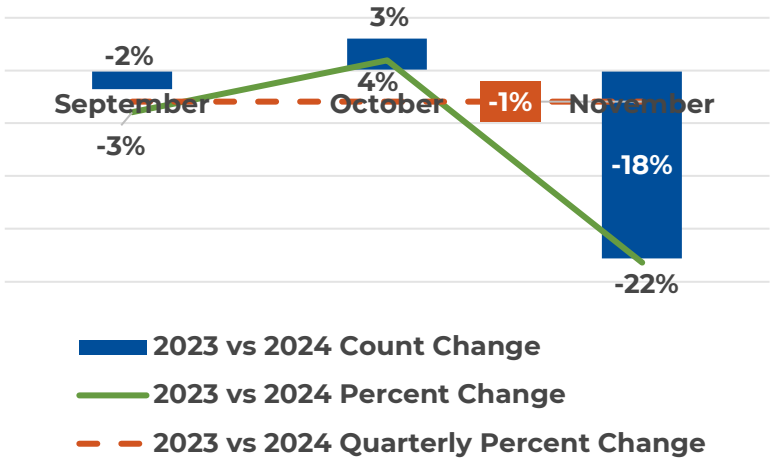




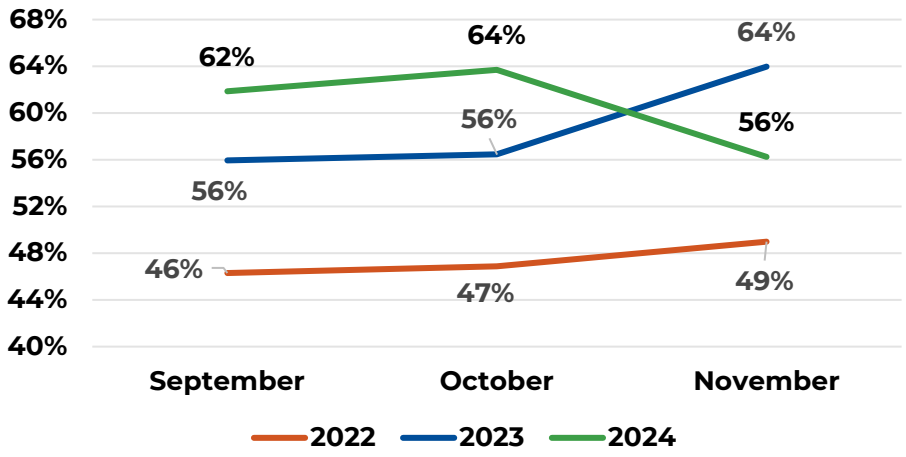
Enrollment & Utilization (Cont.)

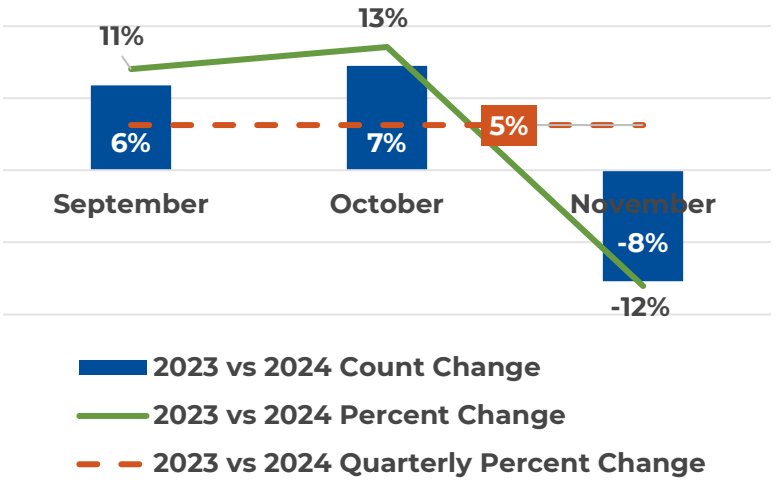
Percent of Pregnant (Full Scope) Enrolled Members Utilization





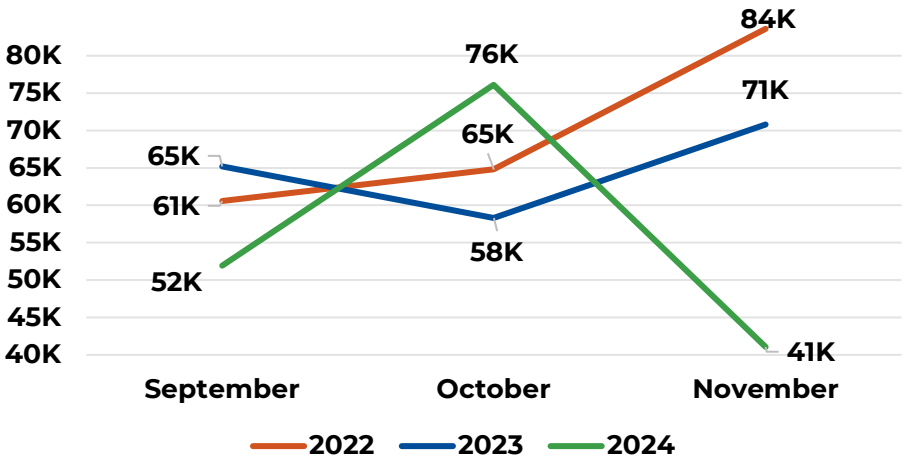
Percent of Expansion Enrolled Members Utilization (Effective July 2021)

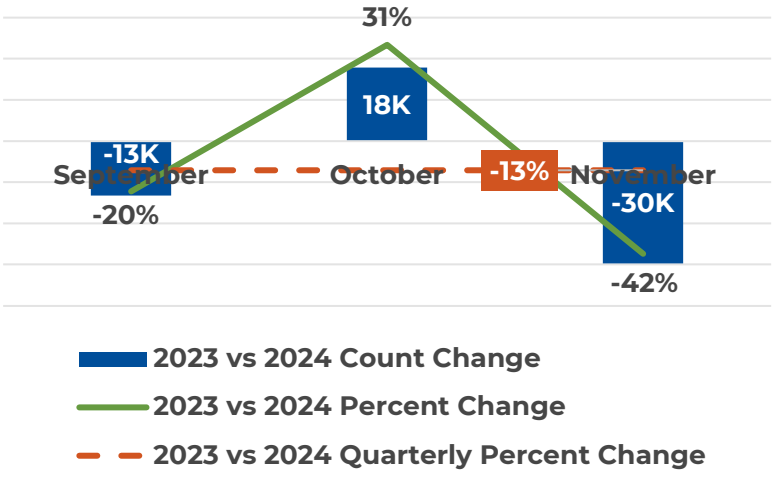




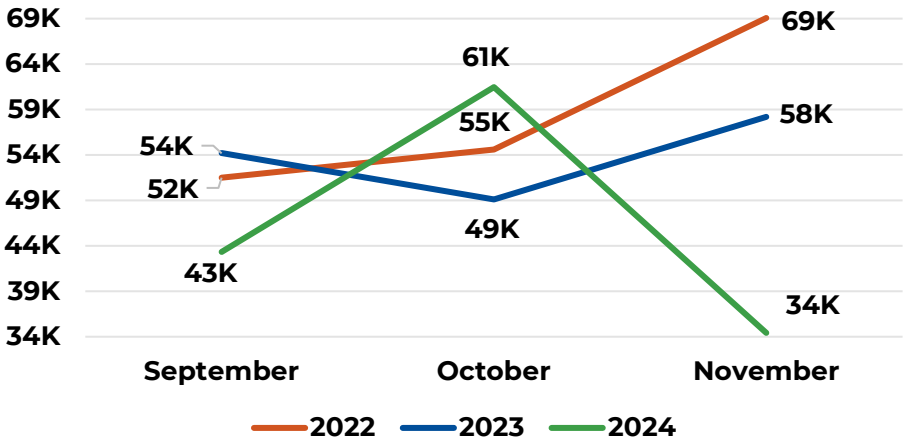
Utilization

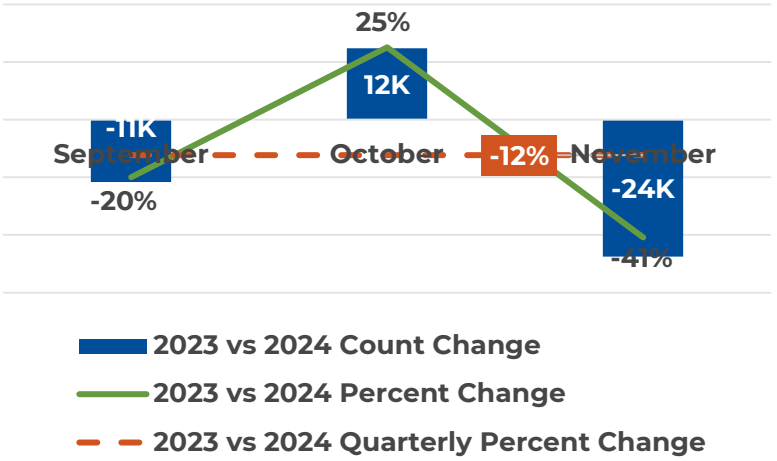
Emergency Department Visits (Claims)





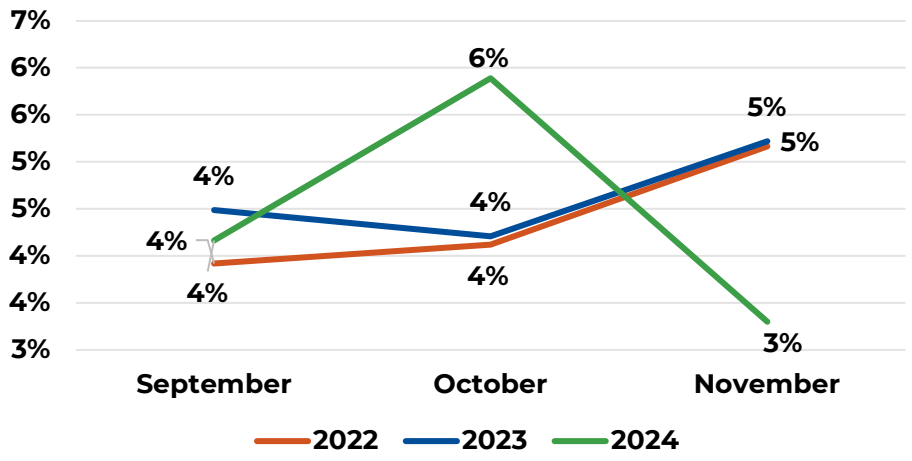
Members Utilizing Emergency Department

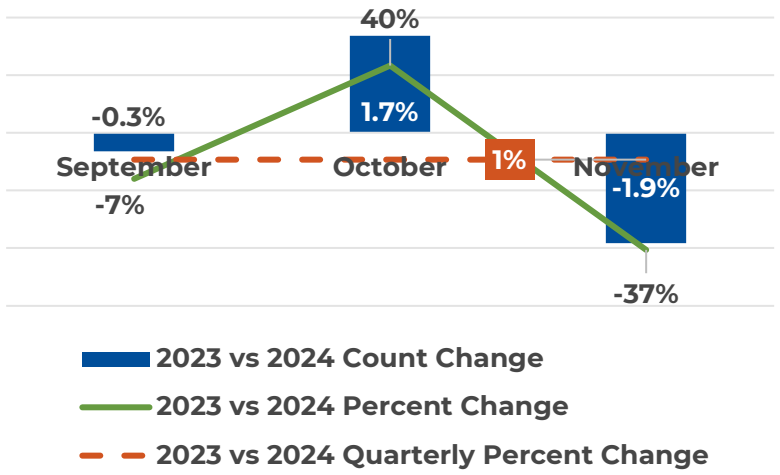




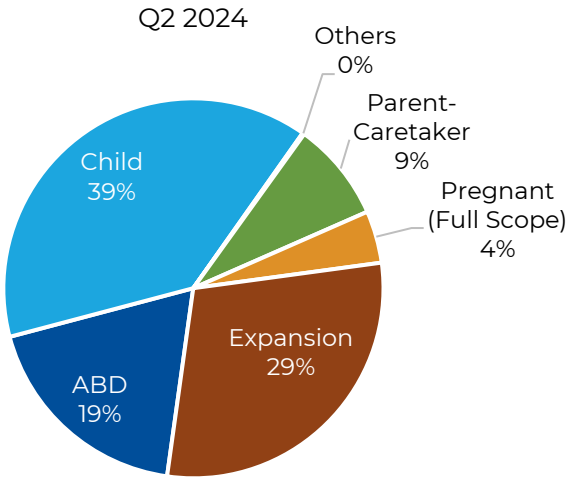
Utilization (Cont.)

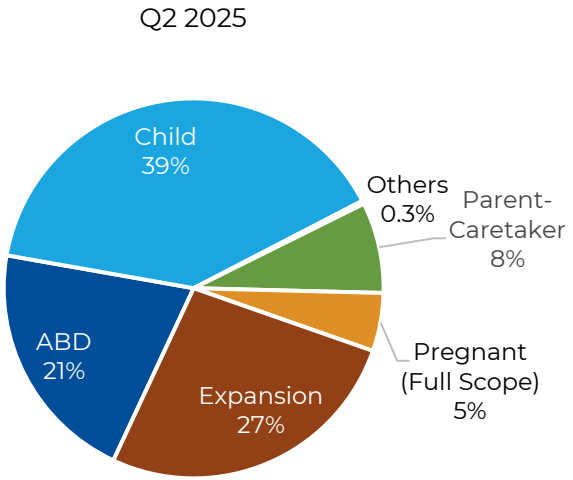
Percent Total Enrolled Using ED





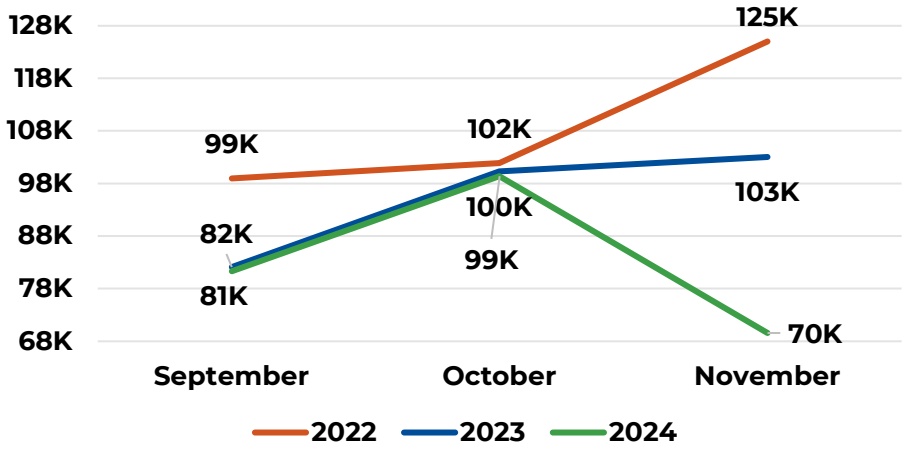
Members Utilizing Emergency Department By Qualifying Group

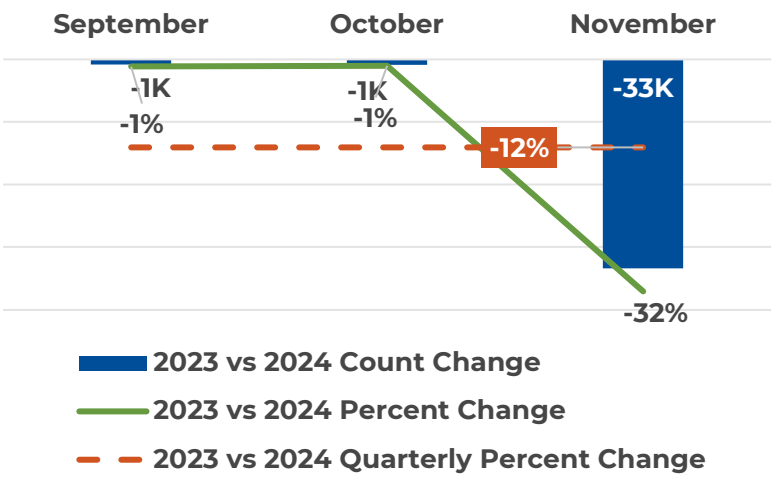




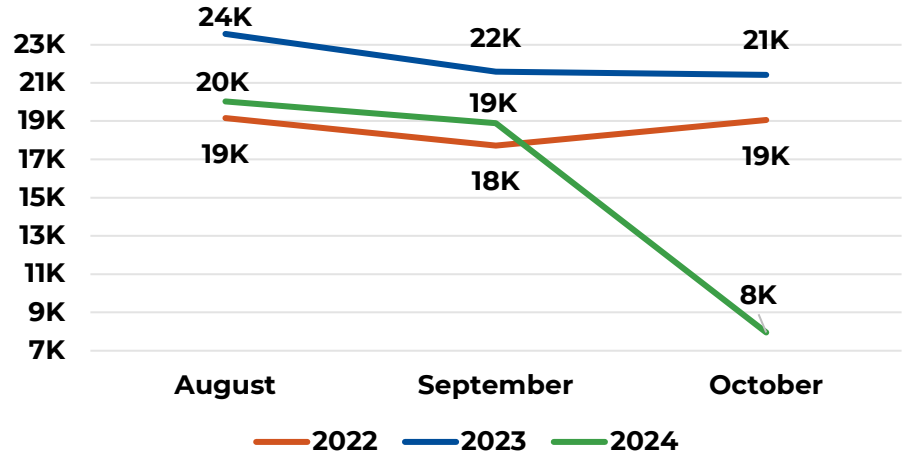
Utilization (Cont.)

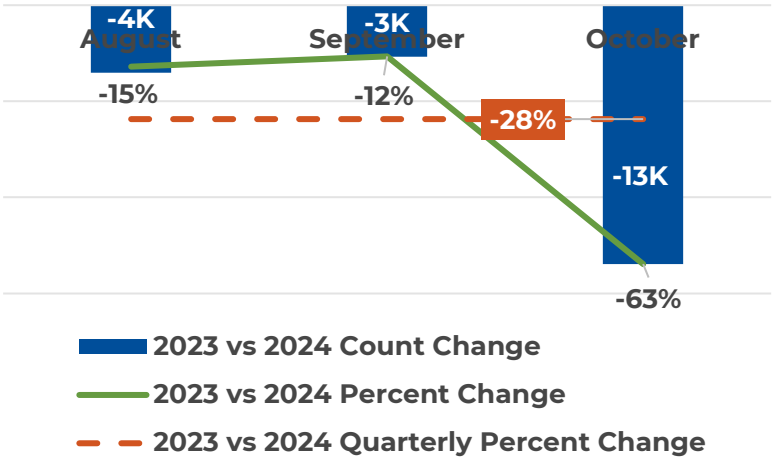
Telemedicine - Total Visits





Members With Opioid Claims

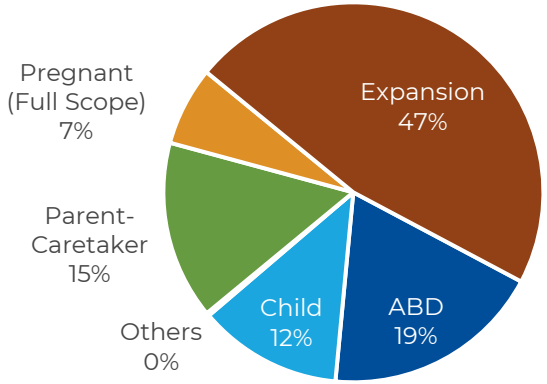




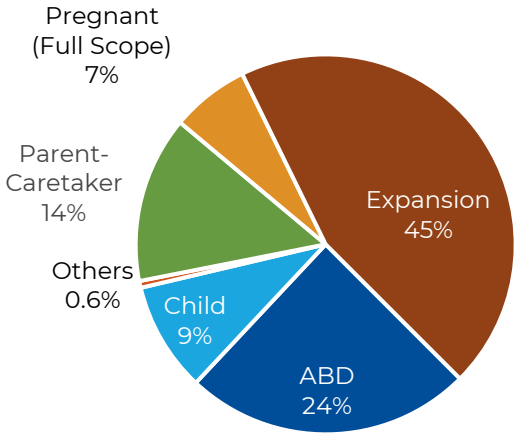
Utilization (Cont.)

Members With Opioid Claims By Qualifying Group

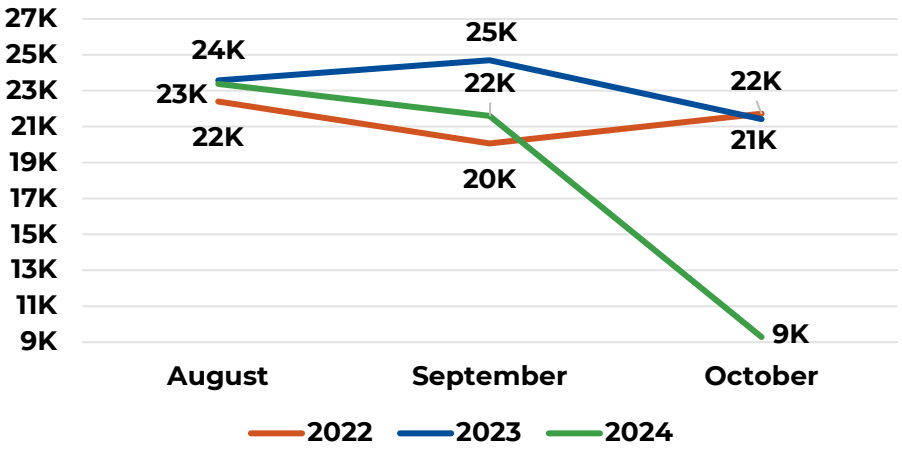
Q2 2024

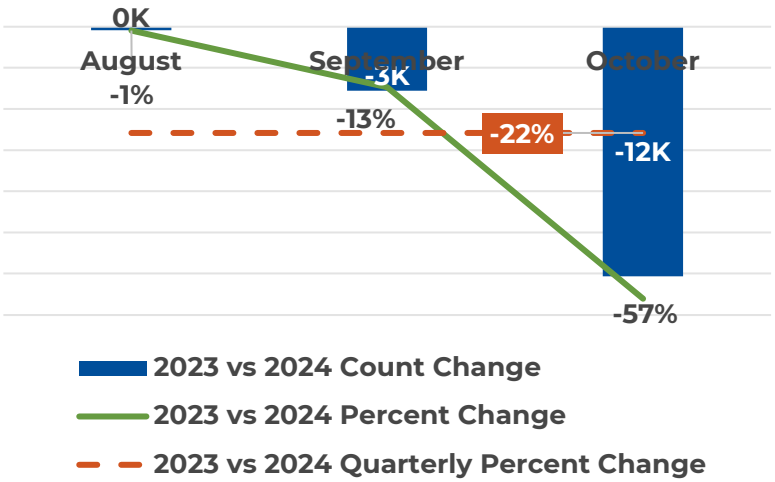


Q2 2025



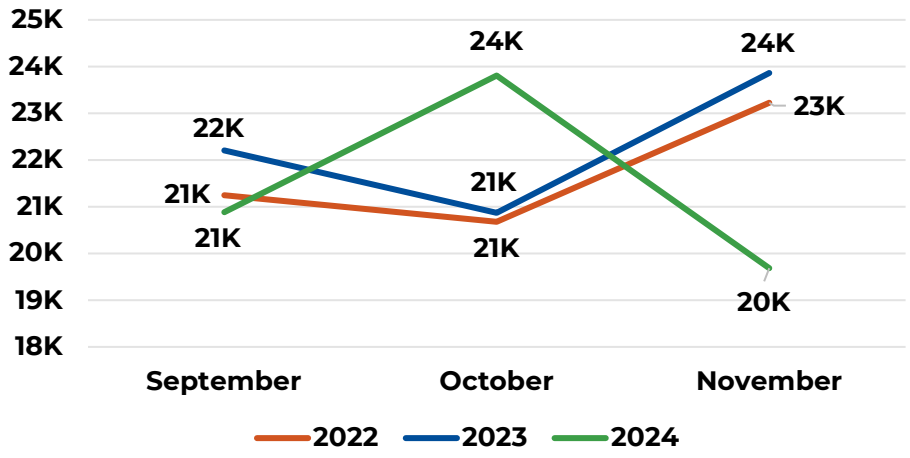
Total Opioid Claims

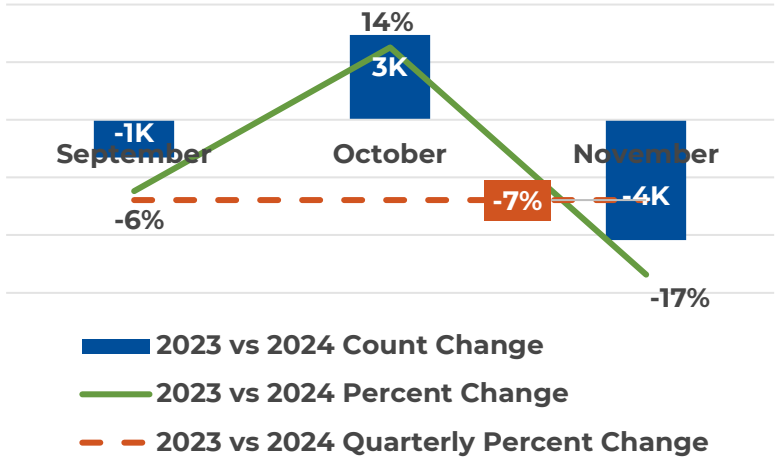




Utilization (Cont.)

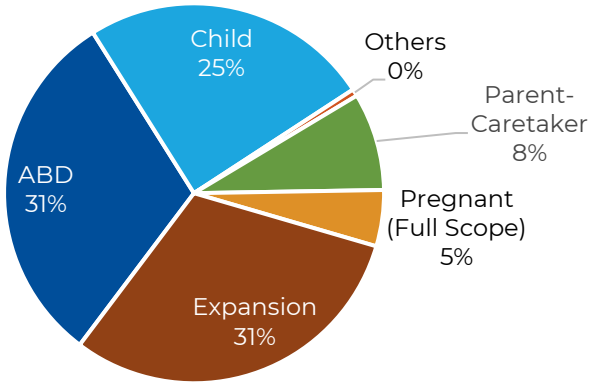
Out of State Services (Non Border County) - Total Members Utilization



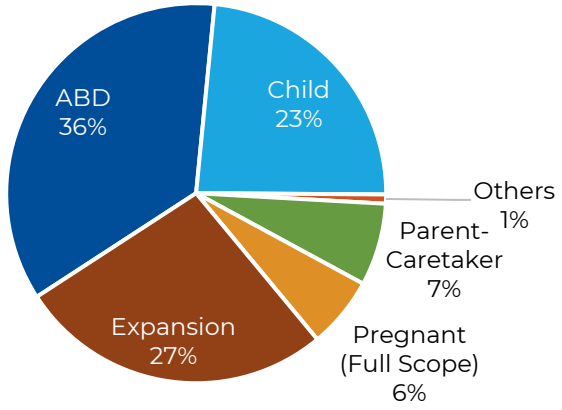


Out of State Services (Non Border County) - Total Members Utilization By Qualifying Group

Q2 2024

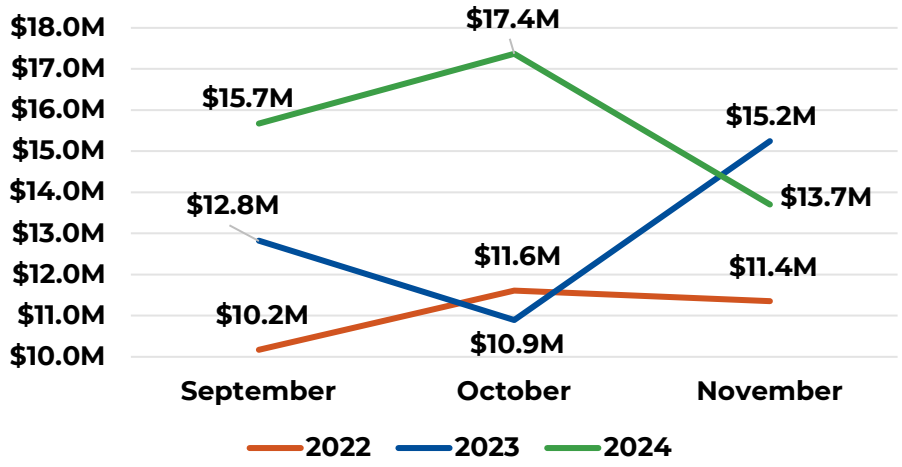


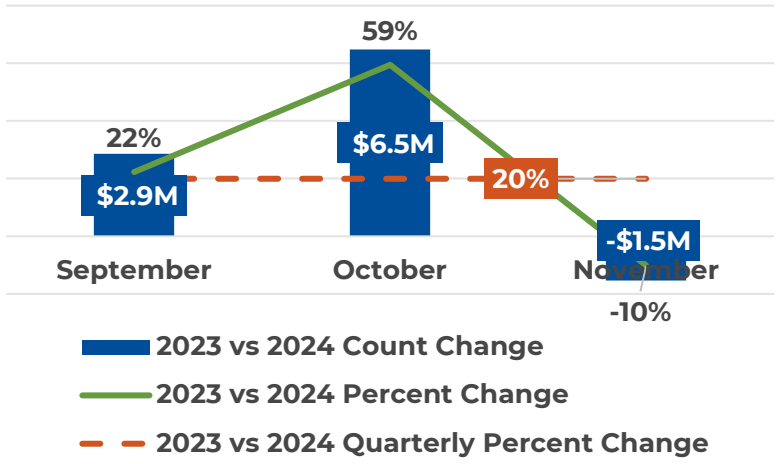
Q2 2025



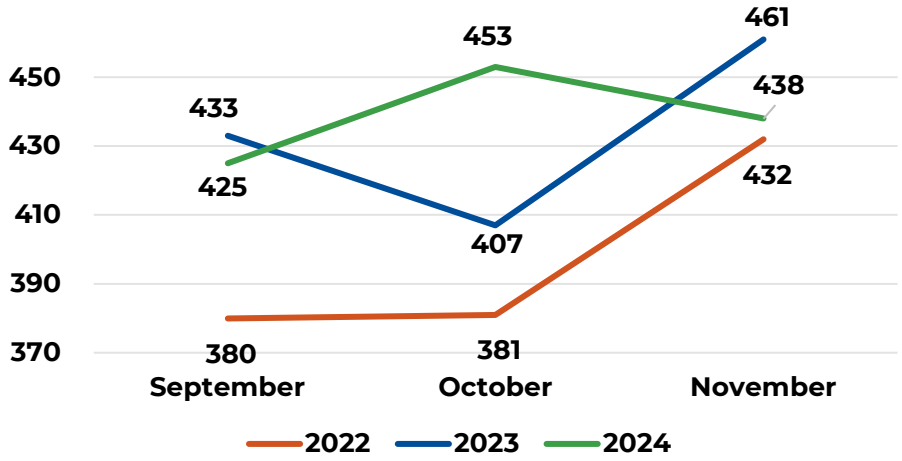
Utilization (Cont.)

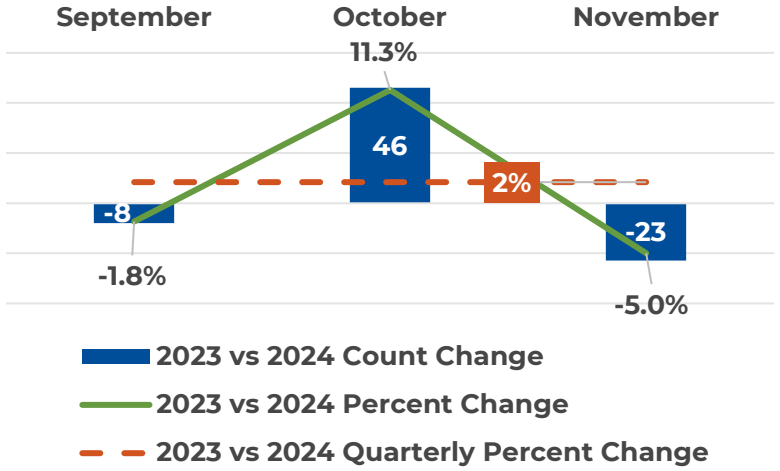
Out of State Services (Non Border County) - Total Reimbursements





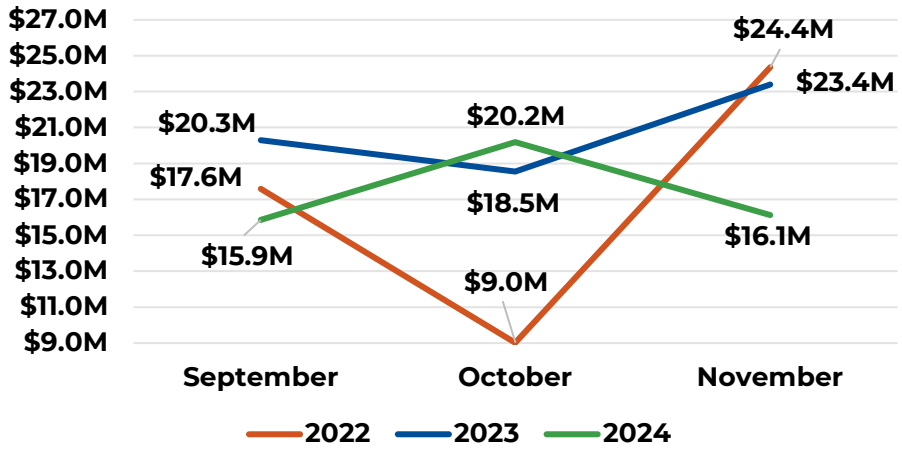
Out of State Services (Non Border County) - Total Active Billing Providers

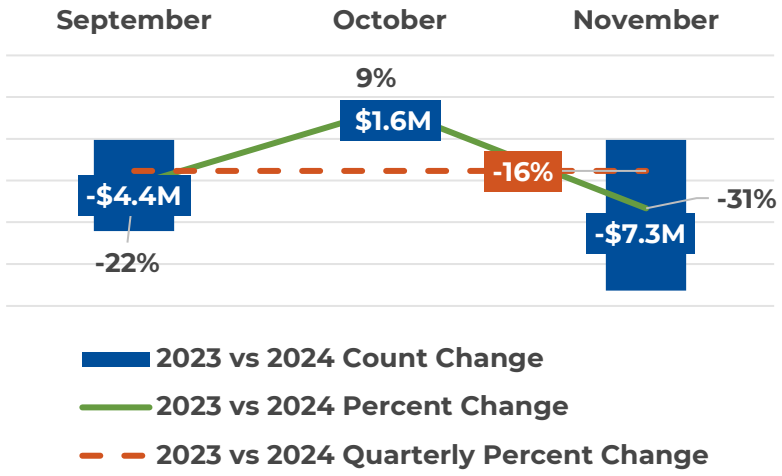




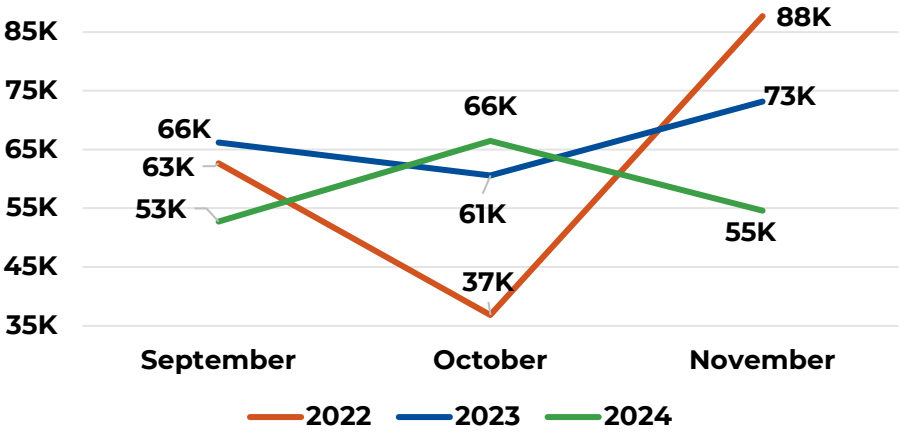
Utilization (Cont.)

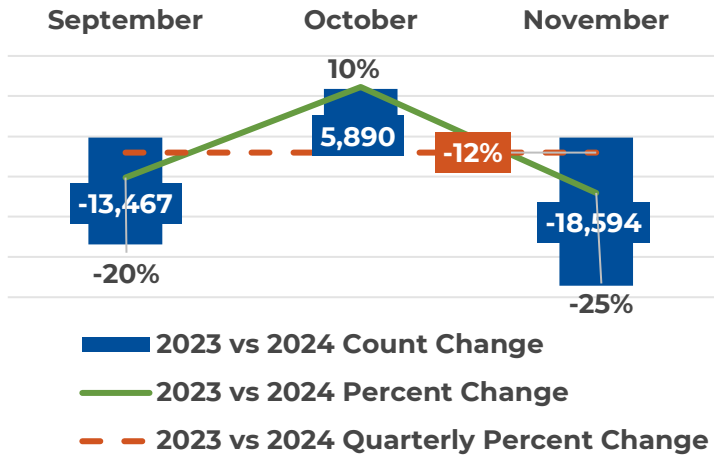
Dental Claims





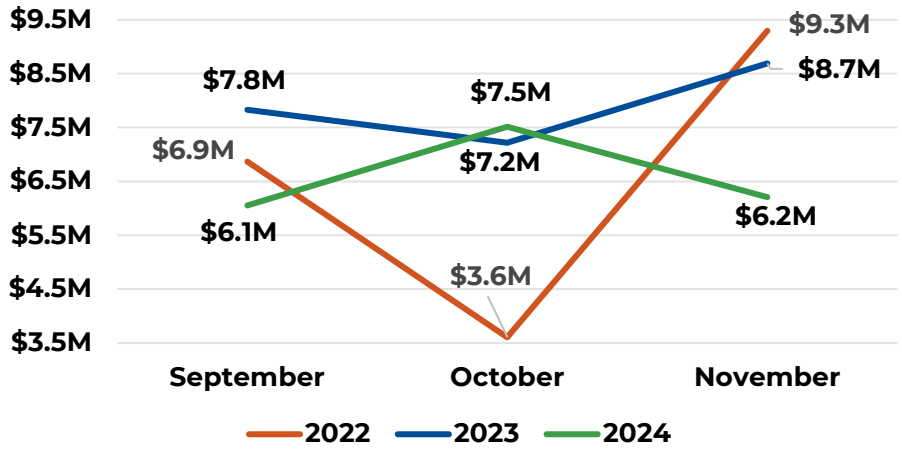
Total Members with Dental Claims

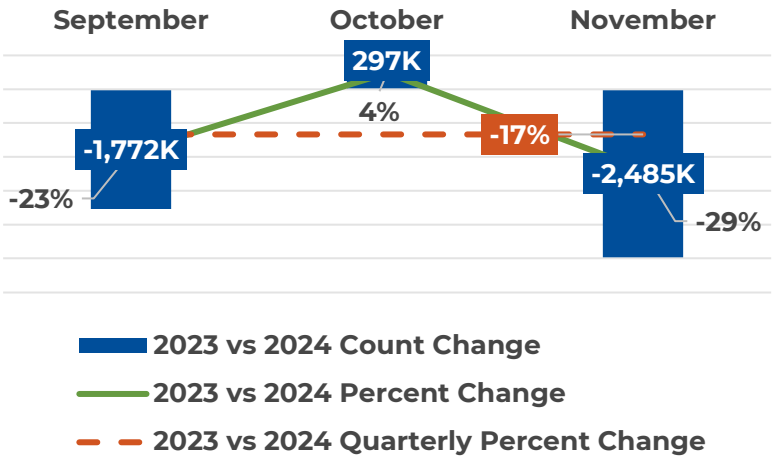




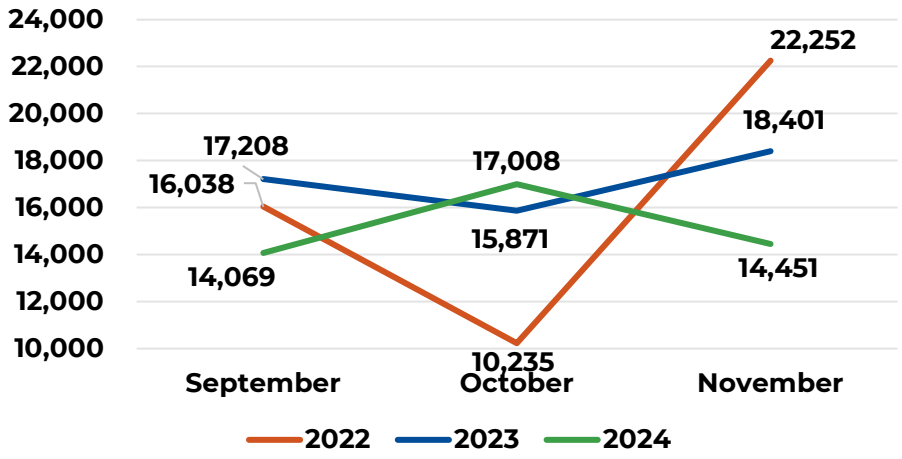
Utilization (Cont.)

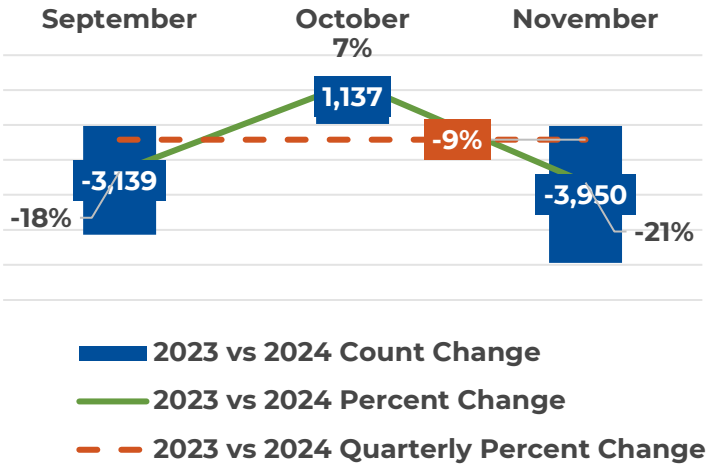
Adult (21 & Over) Dental Claims





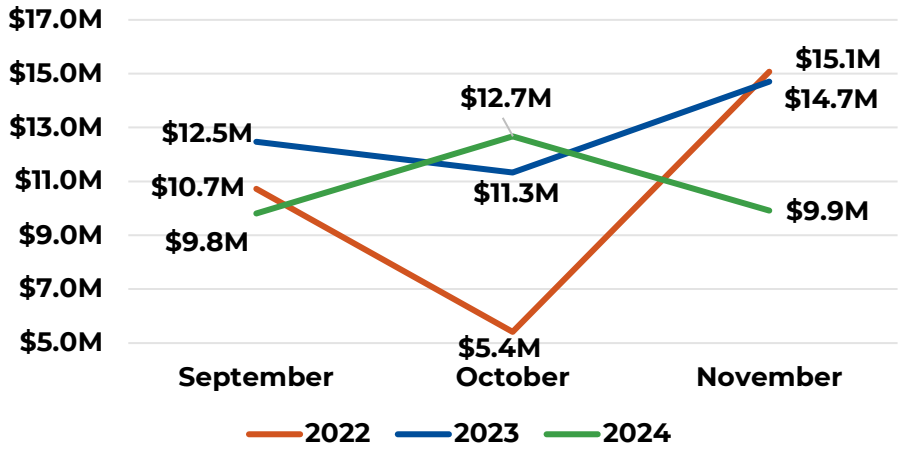
Adults (21 & Over) with Dental Claims

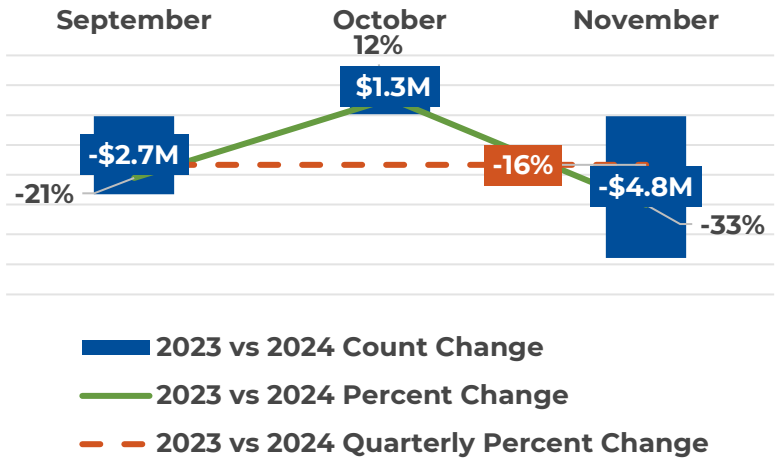




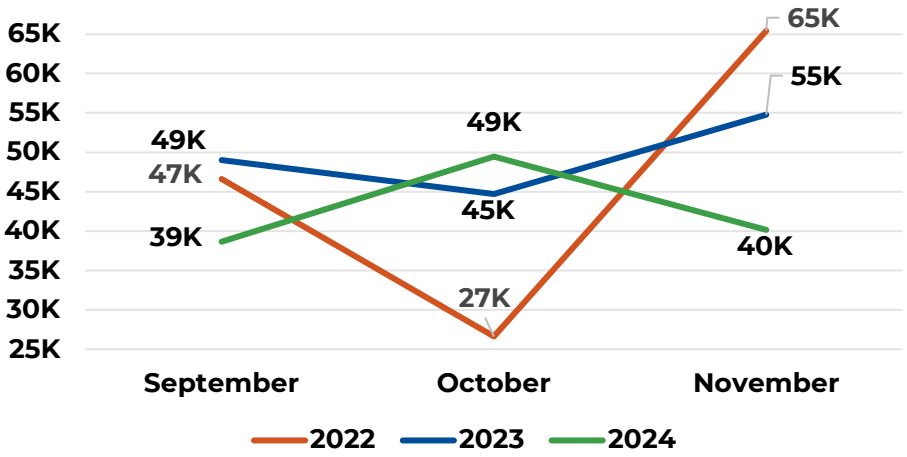
Utilization (Cont.)

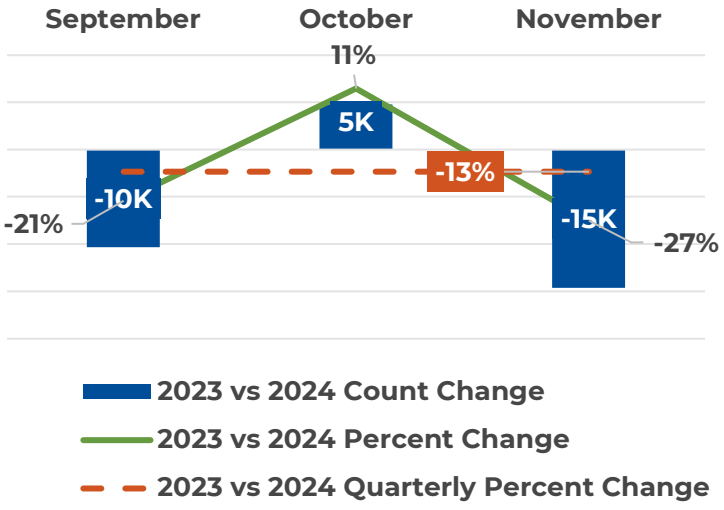
Children (Under 21) Dental Claims





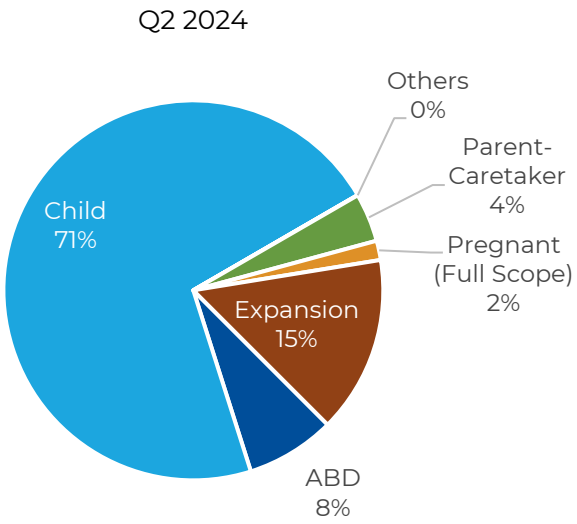
Children (Under 21) with Dental Claims

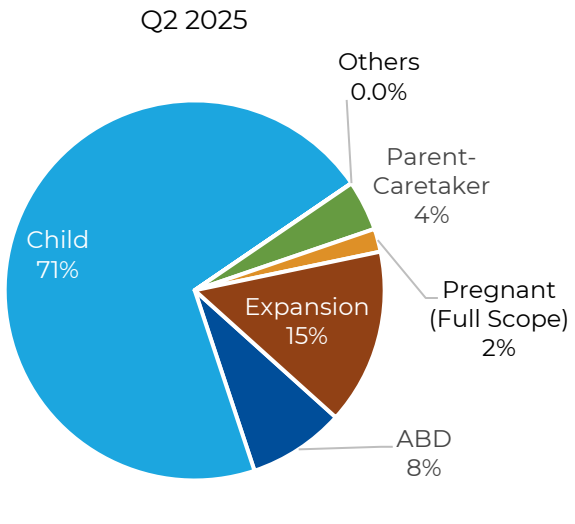




Utilization (Cont.)

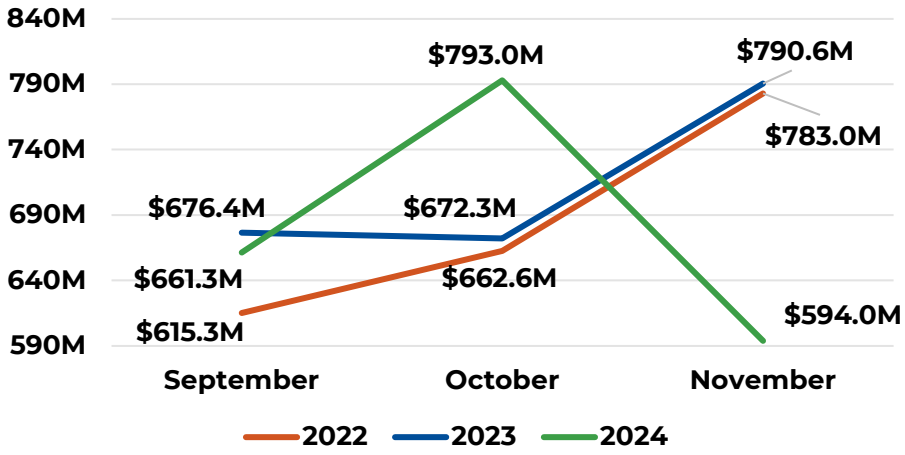
Members With Dental Claims By Qualifying Group

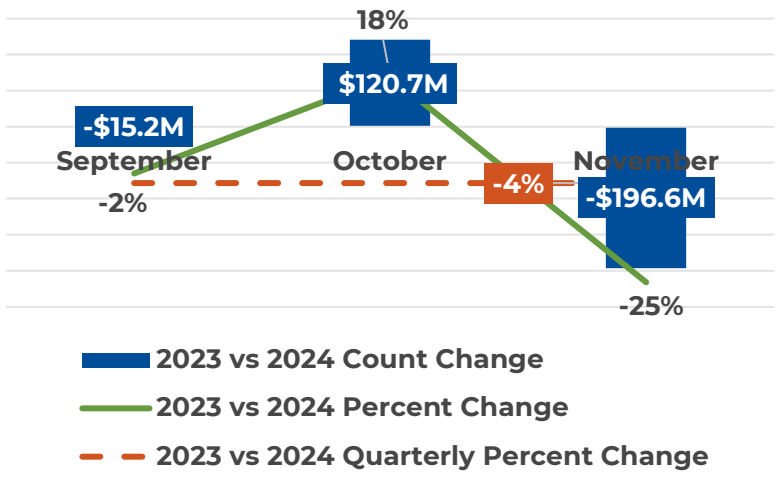




Financials

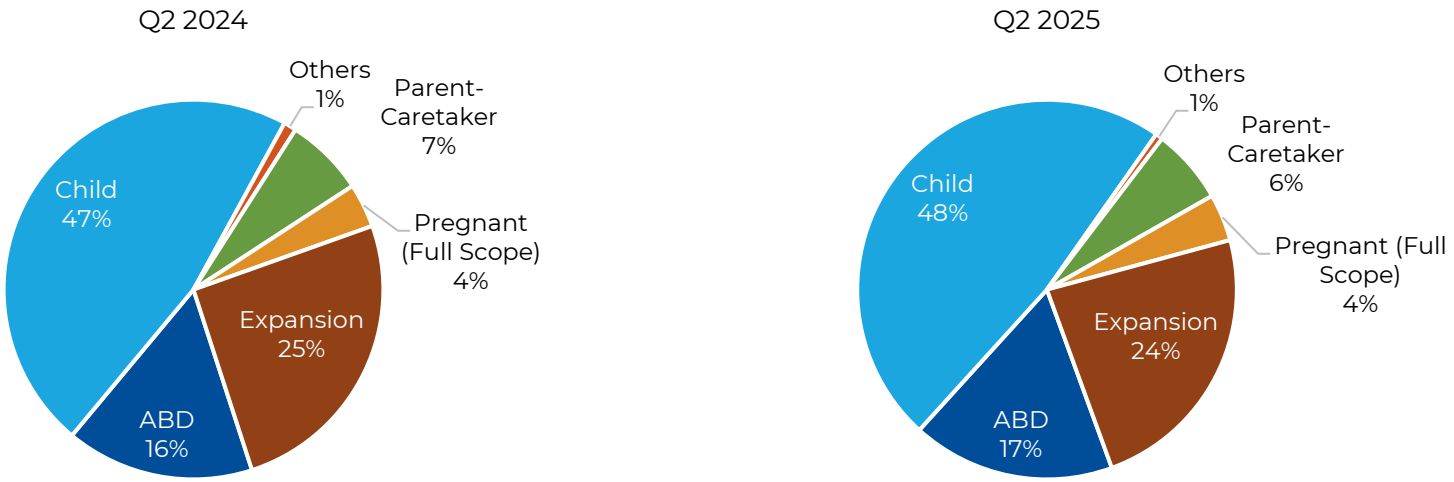
Total Agency Expenditures



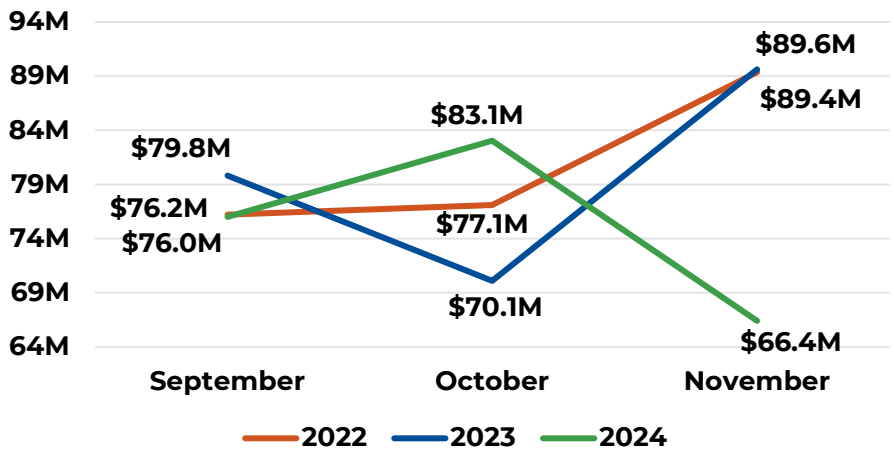


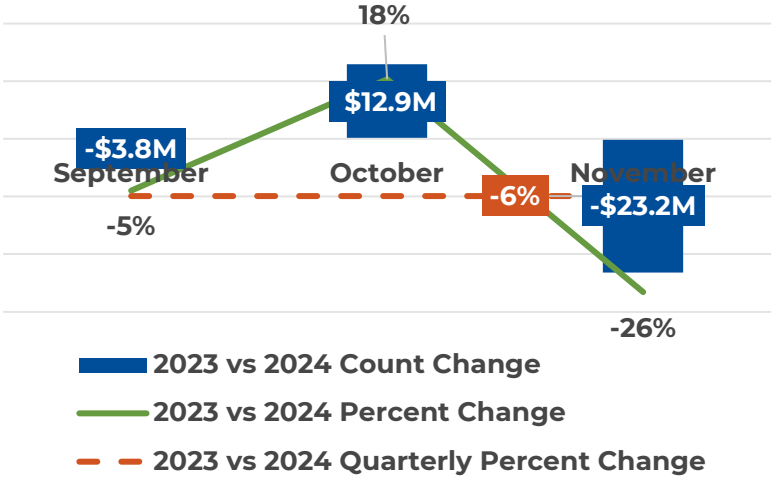
Financials (Cont.)

Total Agency Members Utilization by Qualifying Group



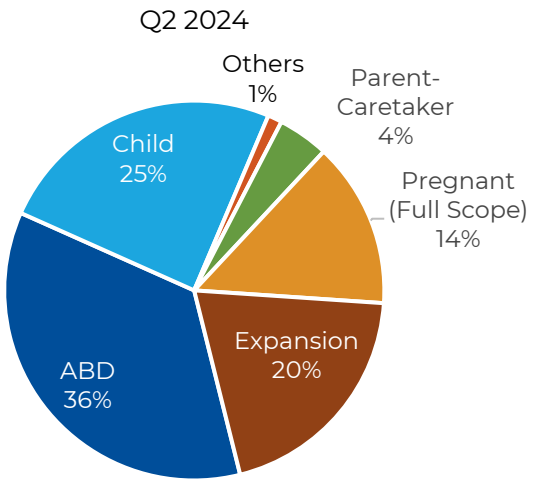
Inpatient Services Expenditures

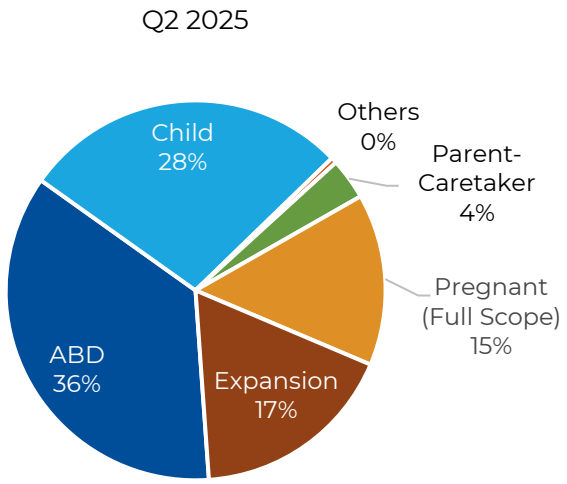




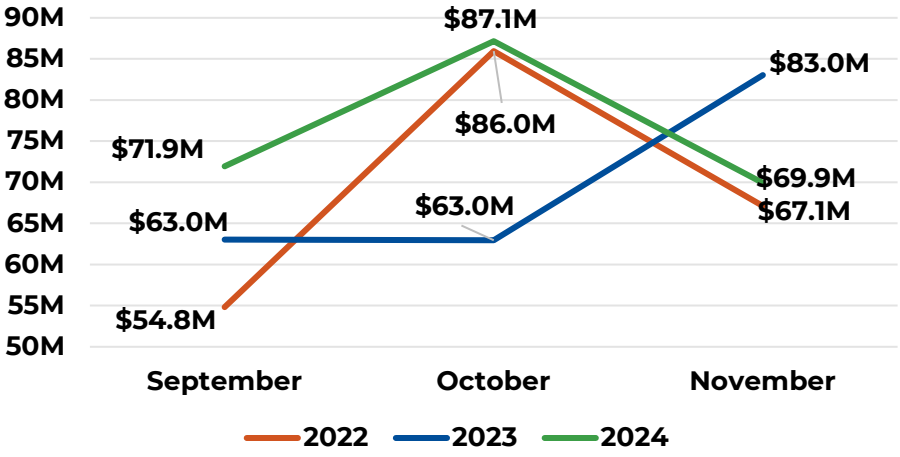
Financials (Cont.)

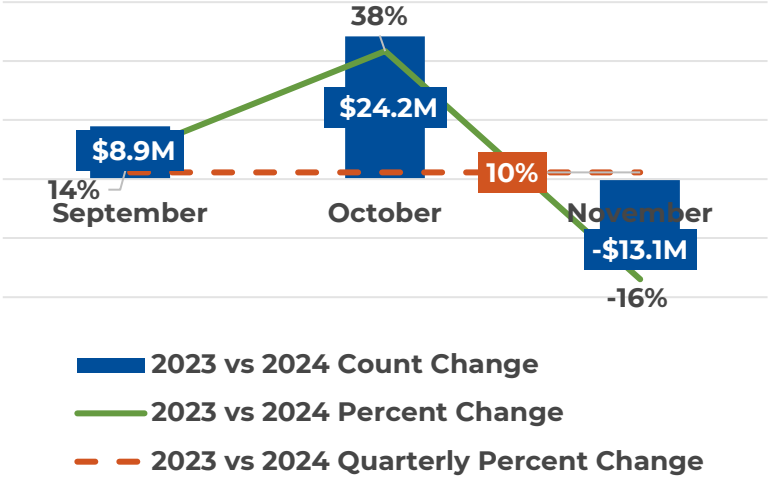
Inpatient Services Members Utilization by Qualifying Group





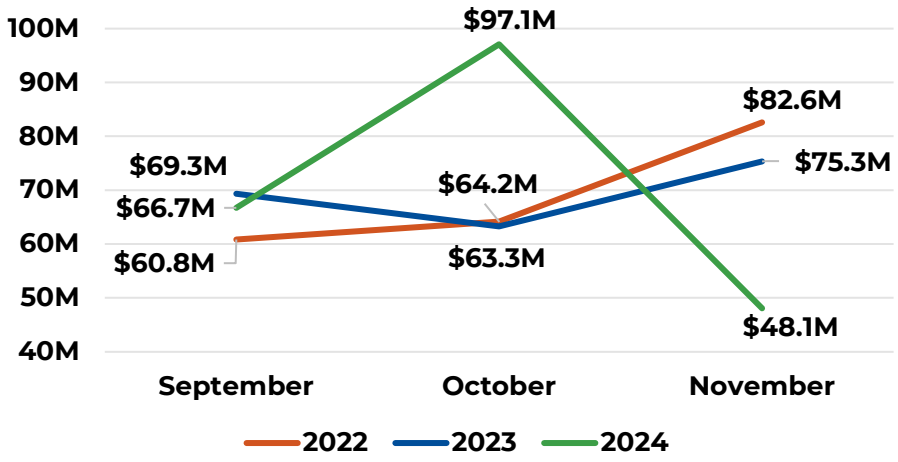
Nursing Facility Expenditures

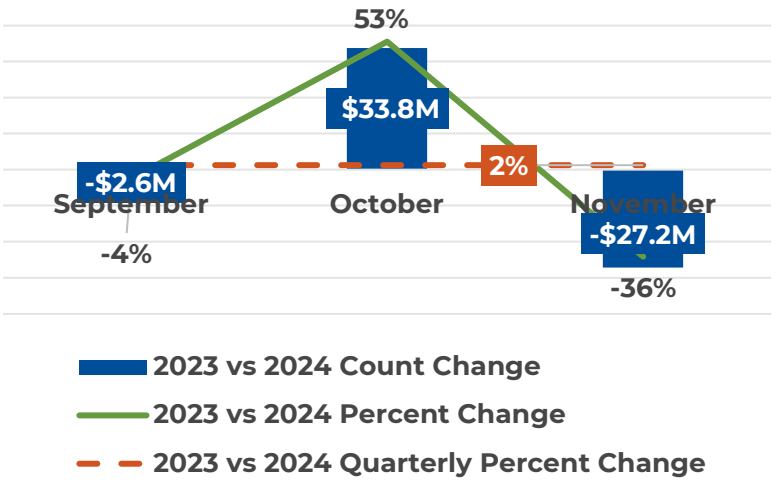




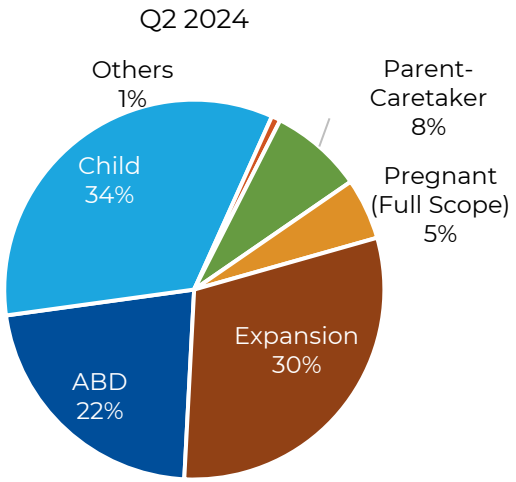
Financials (Cont.)

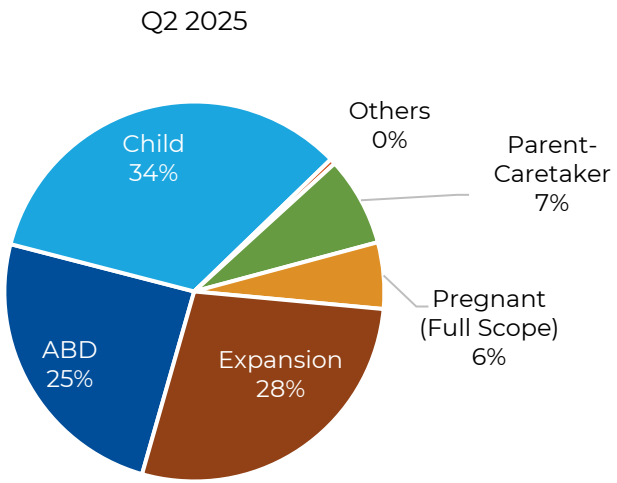
Outpatient Hospital Expenditures





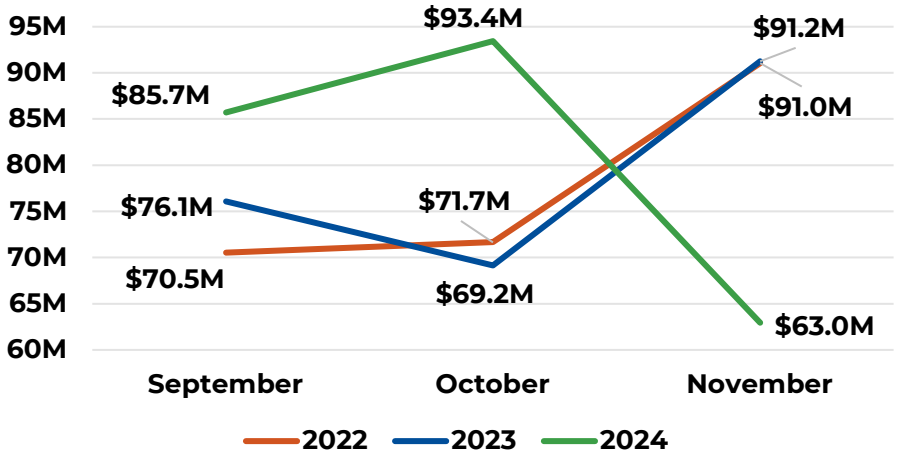
Outpatient Hospital Members Utilization by Qualifying Group

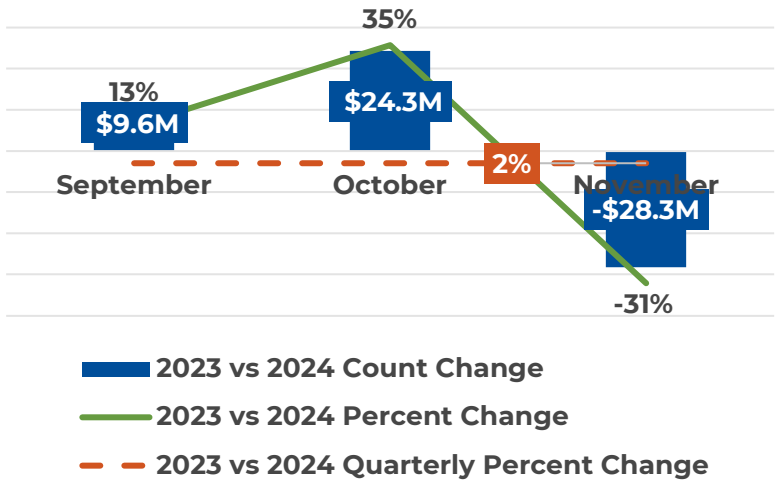




Financials (Cont.)

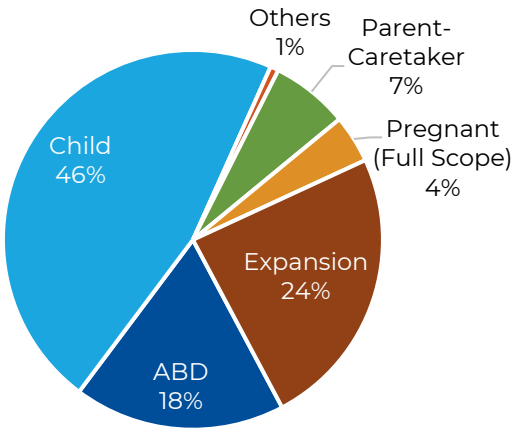
Physician Expenditures



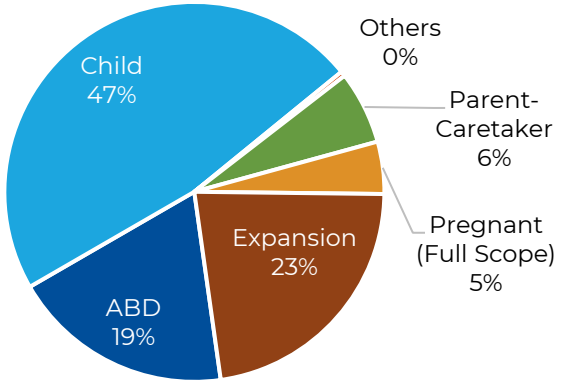


Physician Members Utilization By Qualifying Group

Q2 2024

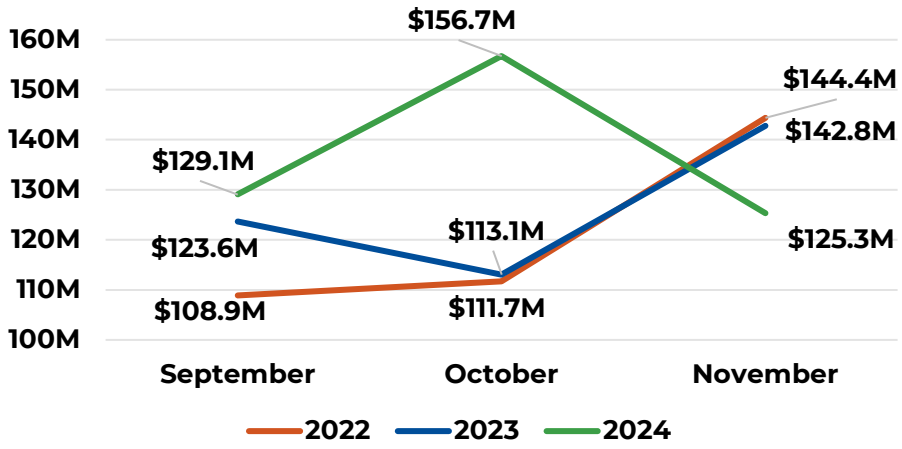


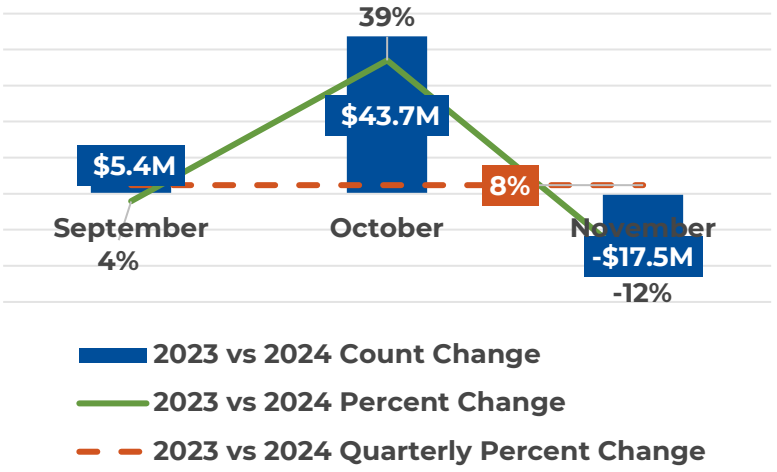
Q2 2025



Financials (Cont.)

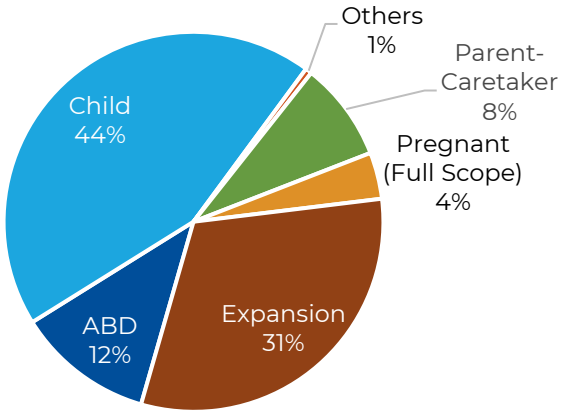
Prescribed Drugs Expenditures



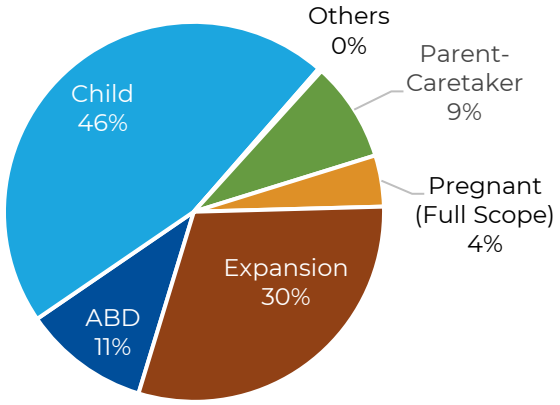


Prescribed Drugs Members Utilization By Qualifying Group

Q2 2024

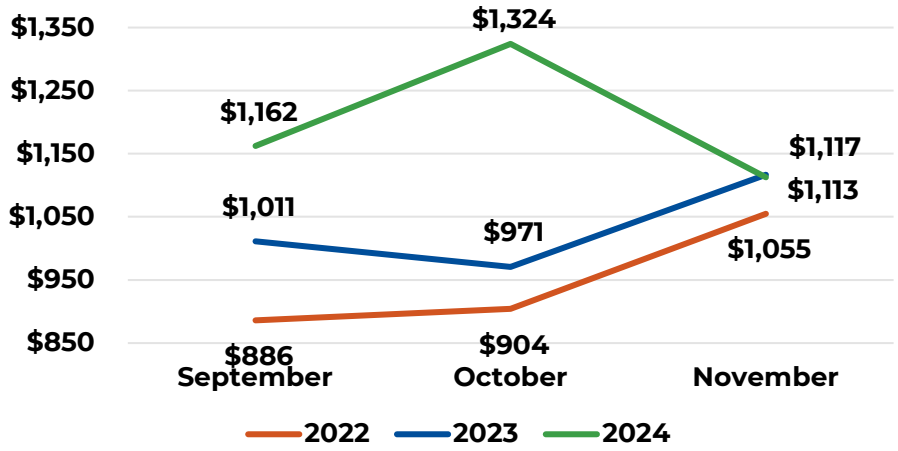


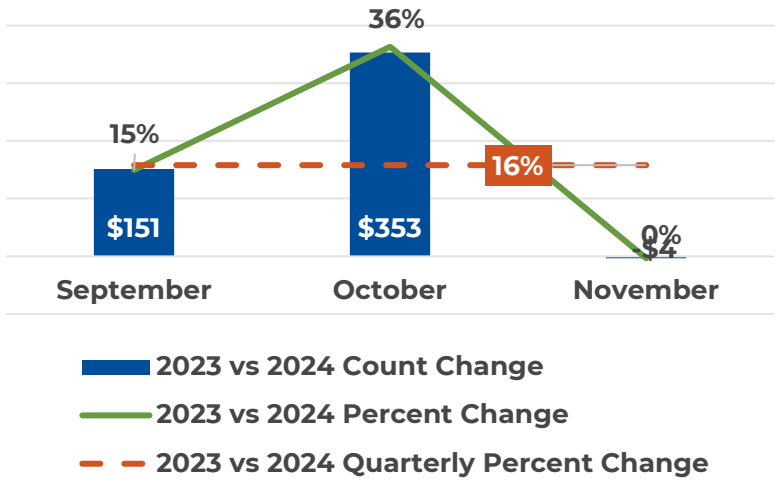
Q2 2025



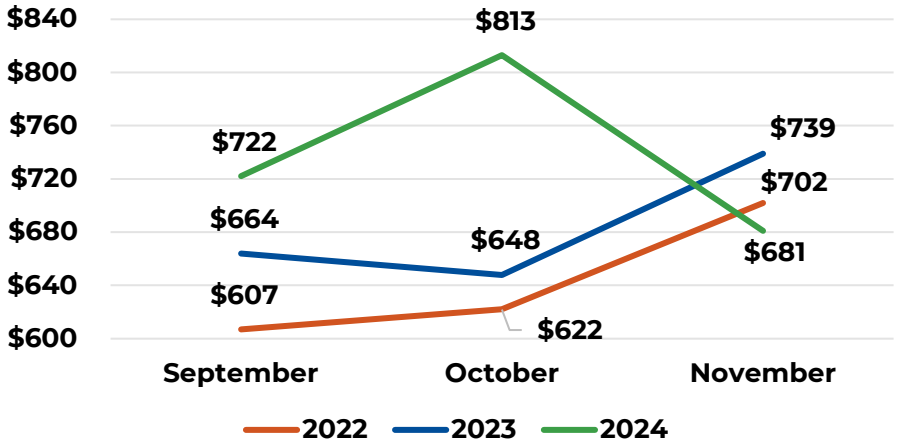
Financials (Cont.)

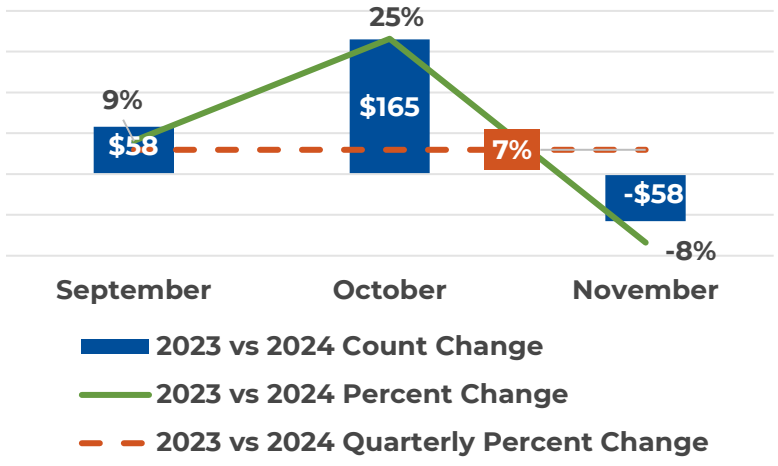
Average Per Total Member Served





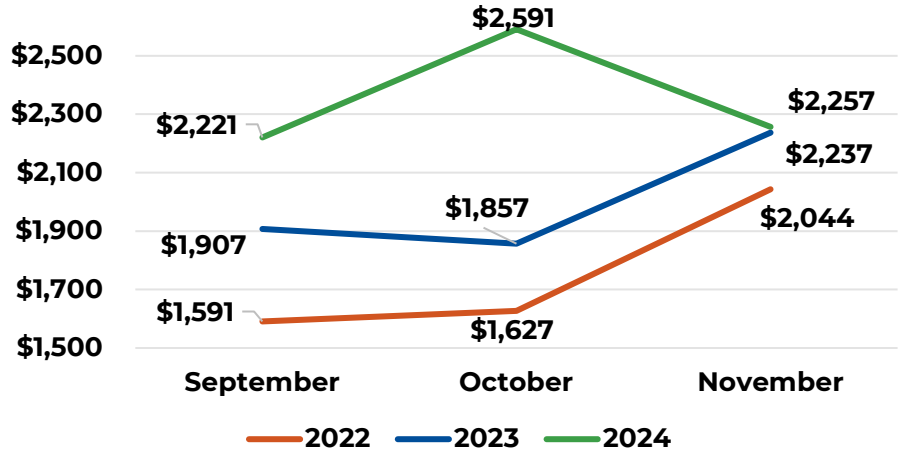
Average Per Child (Under 21) Member Served

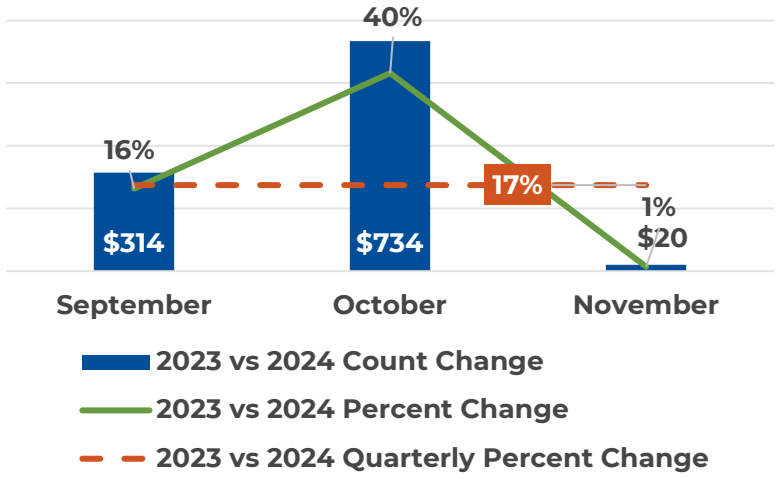




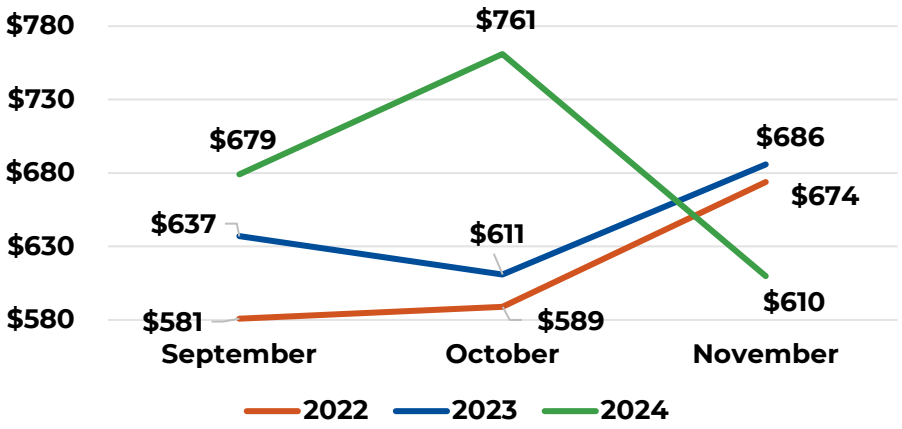
Financials (Cont.)

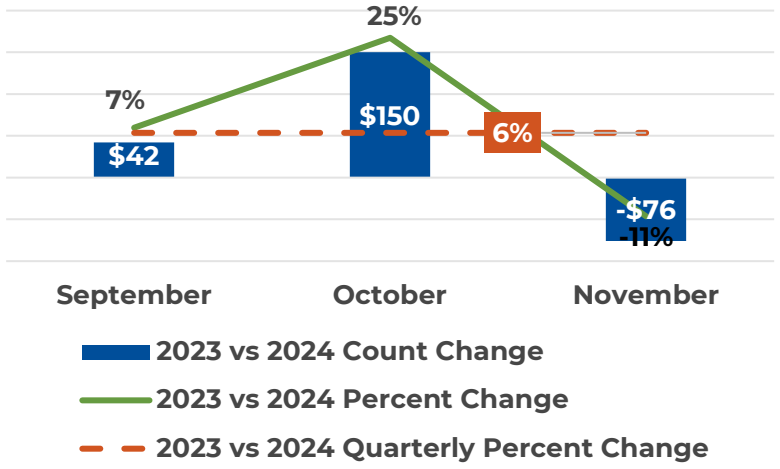
Average Per Aged/Blind/Disabled Member Served





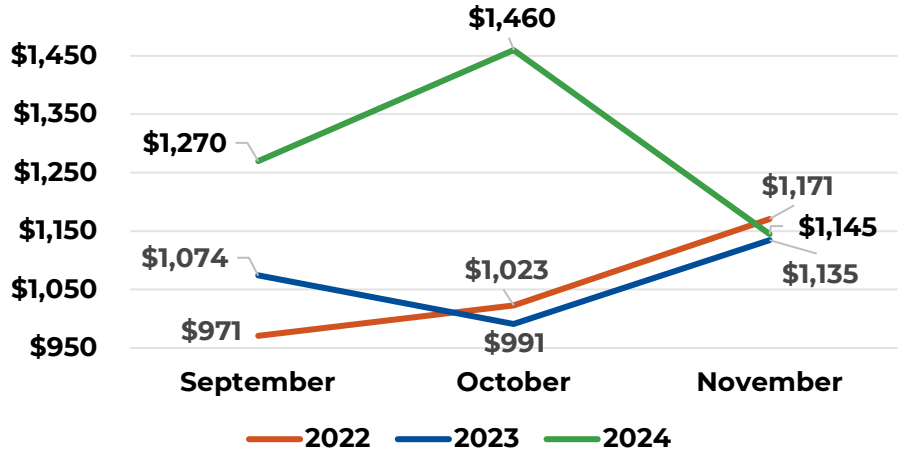
Average Per Children & Parent/Caretaker Member Served

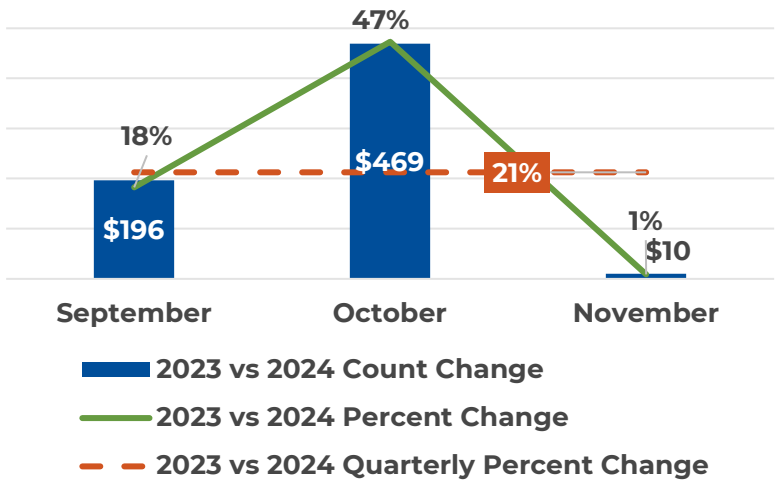




Financials (Cont.)

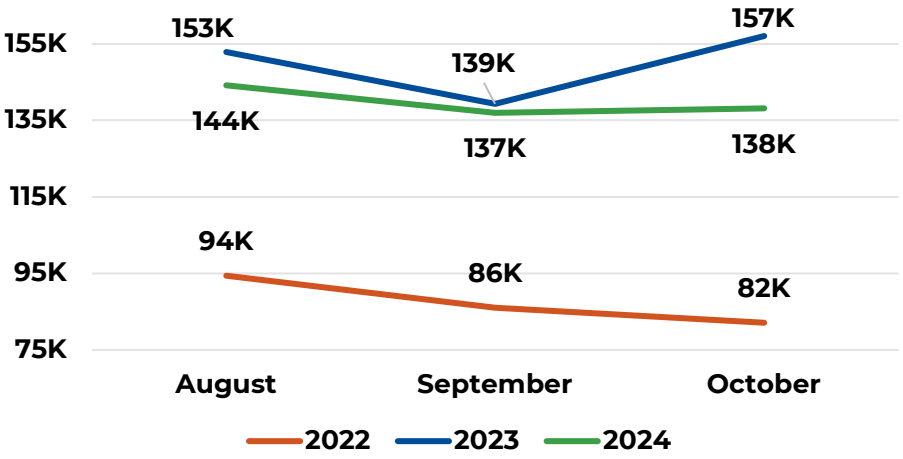
Average Per Expansion Member Served (Effective July 2021)

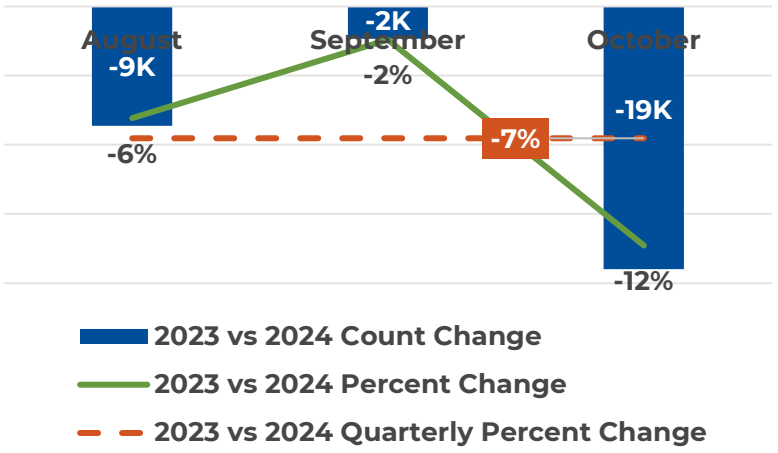




Call Center

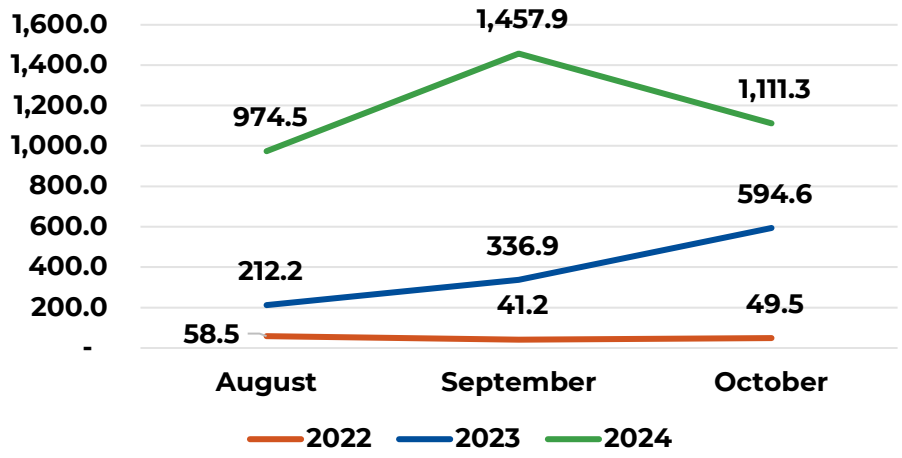
Call Center - Member Calls Answered

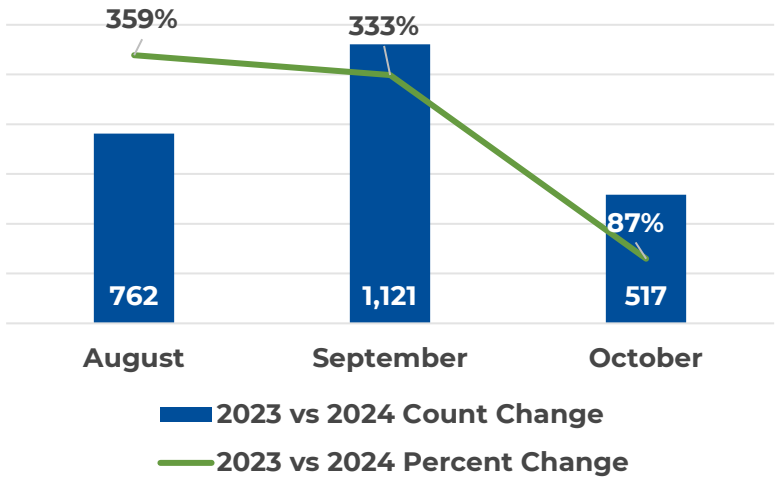




Call Center (Cont.)

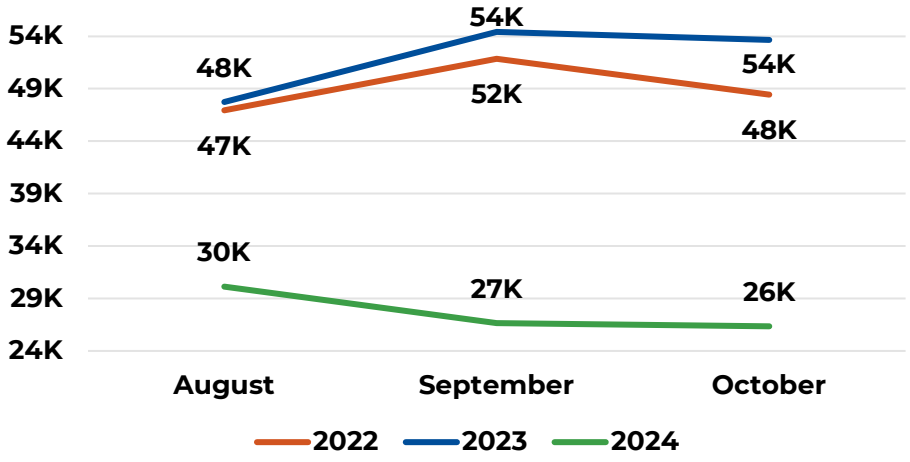
Call Center - Average Wait Time (In Seconds)

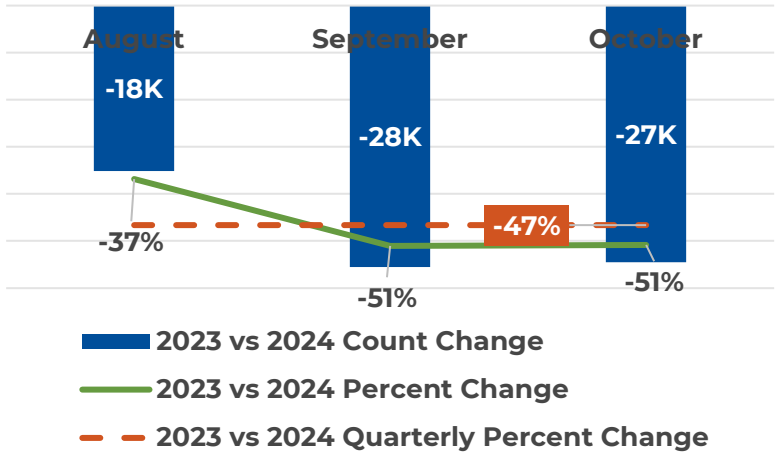




Prior Authorization

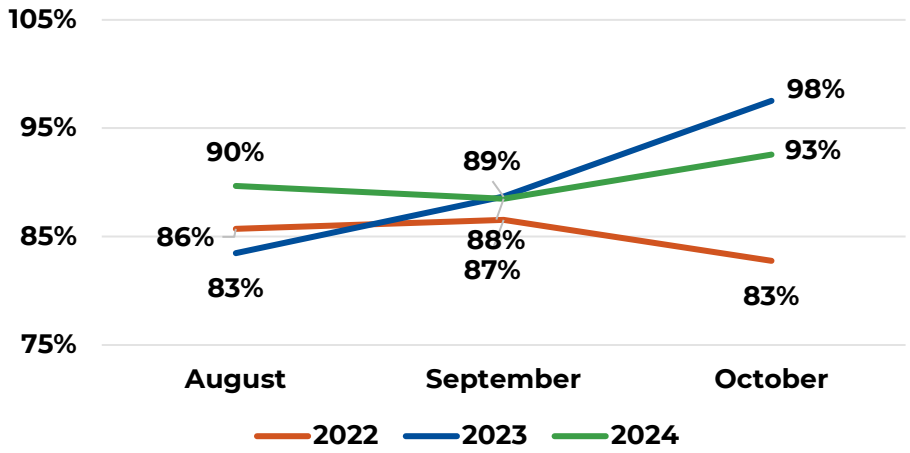
Prior Authorization - Total Combined - Total Completed PA Volume

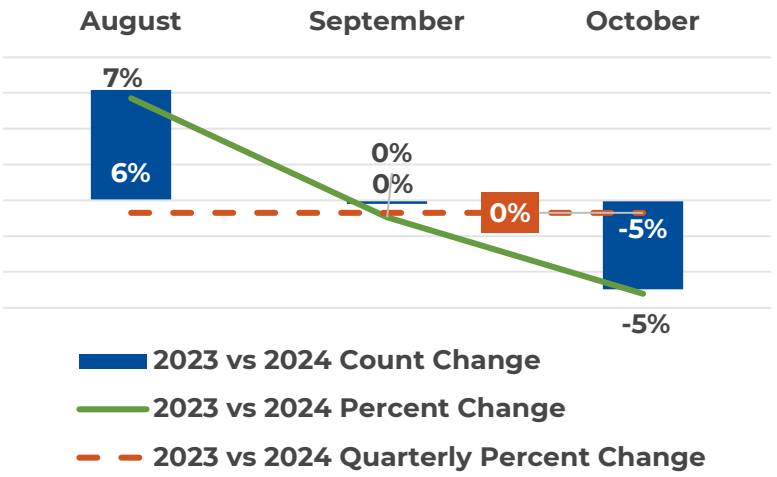




Prior Authorization (Cont.)

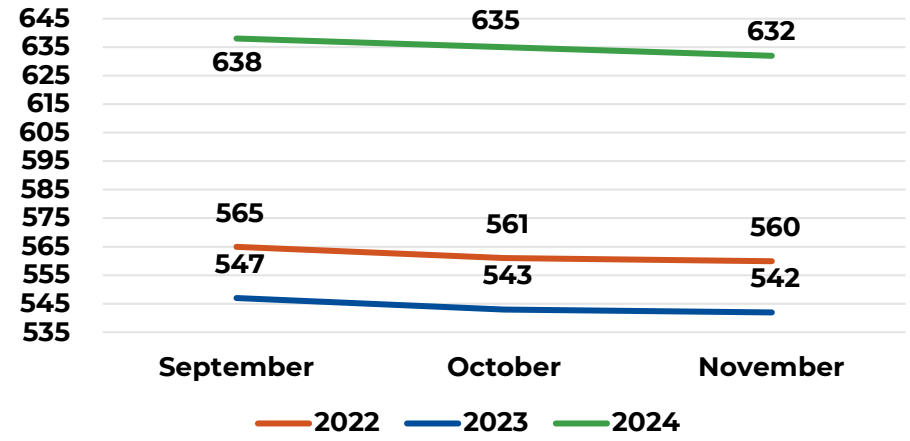
Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

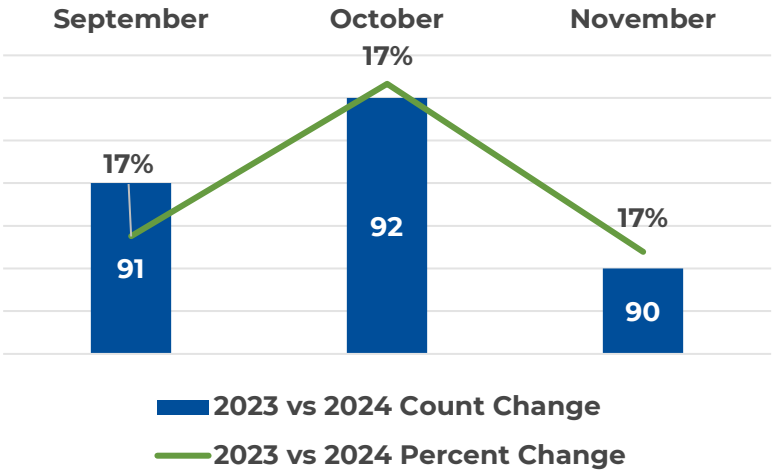




Agency Stats & Provider Network

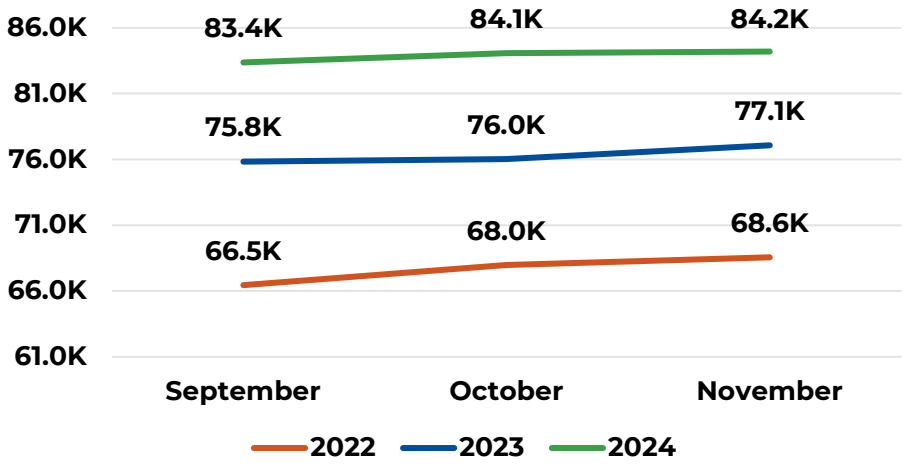
OHCA Admin - Number of FTEs

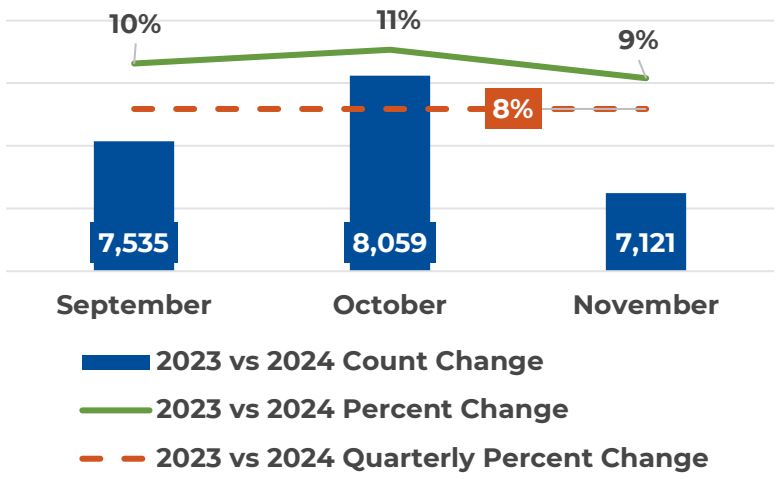




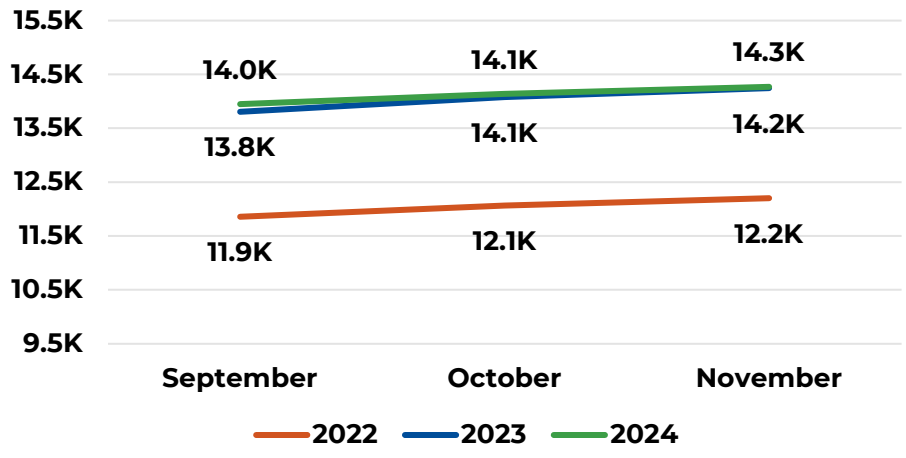
Agency Stats & Provider Network (Cont.)

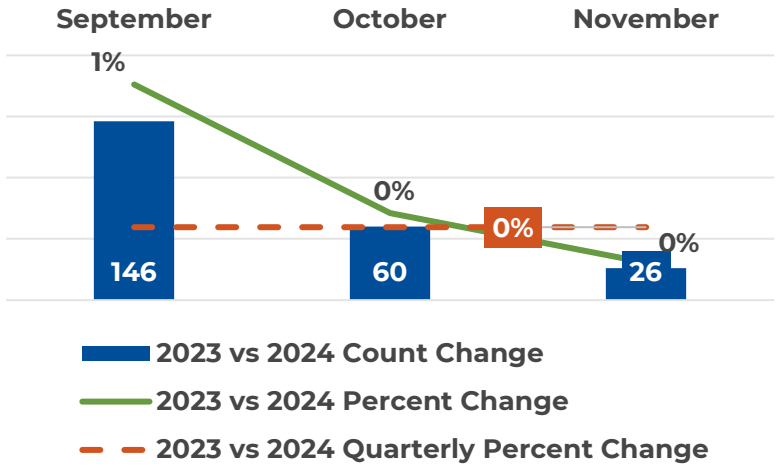
Total Providers





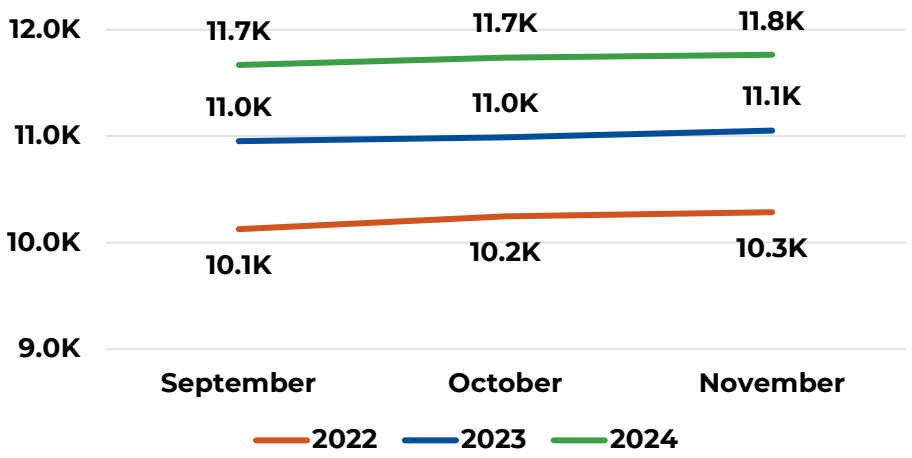
Mental Health Providers (In-State Only)

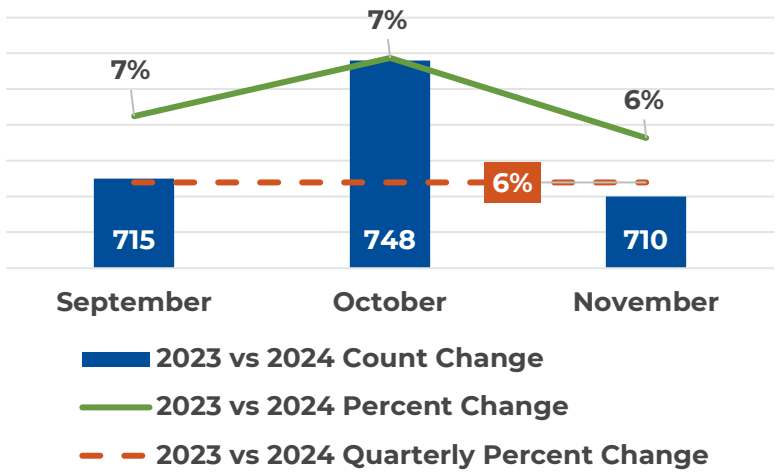




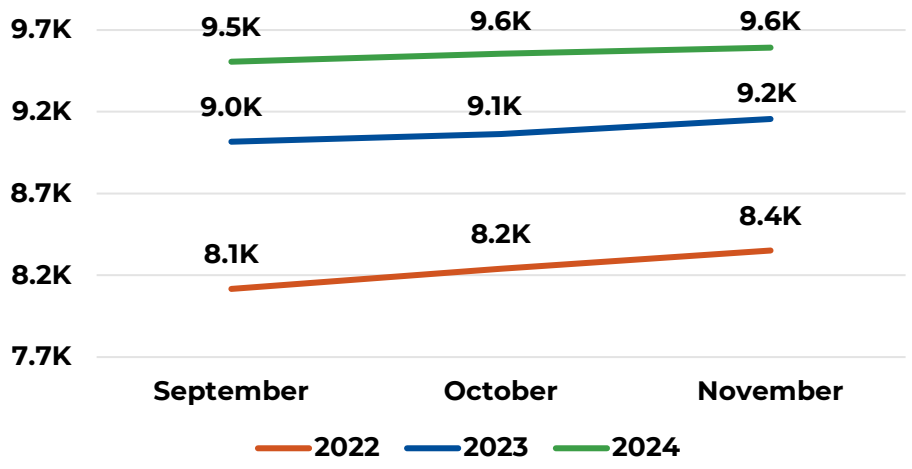
Agency Stats & Provider Network (Cont.)

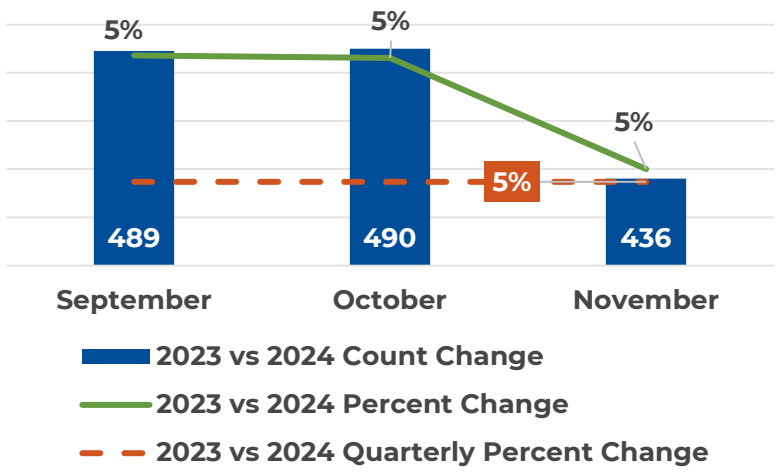
Physicians (In-State Only)





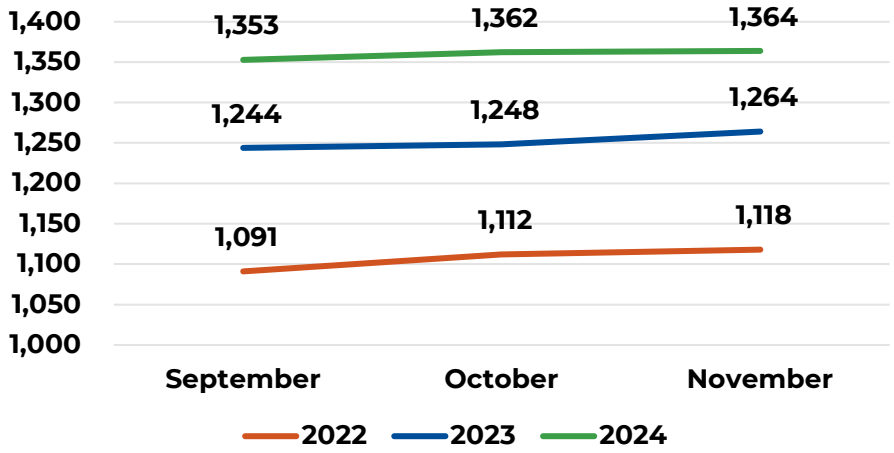
Primary Care Providers (In-State Only)

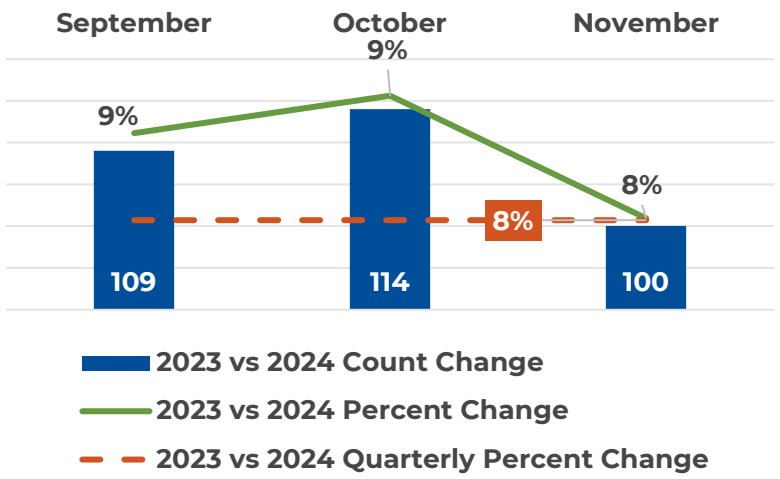




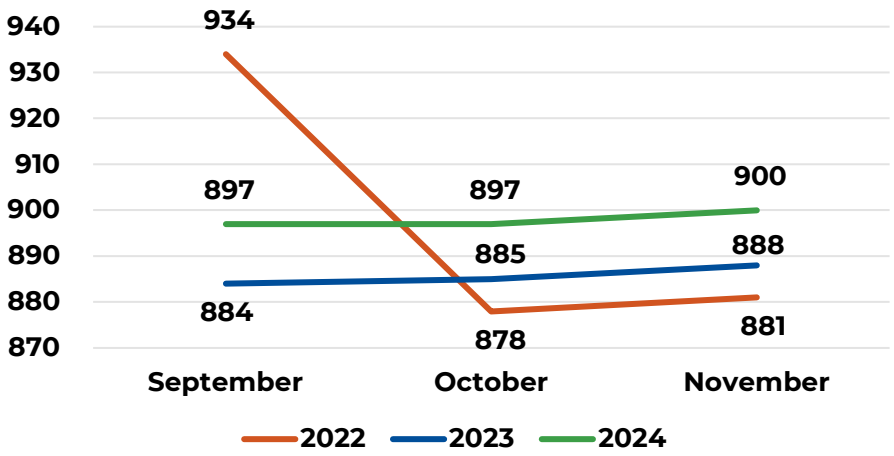
Agency Stats & Provider Network (Cont.)

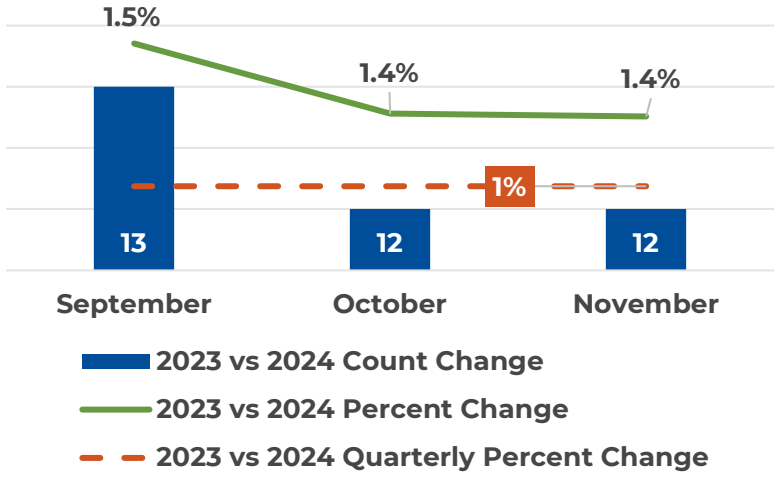
Dentists (In-State Only)





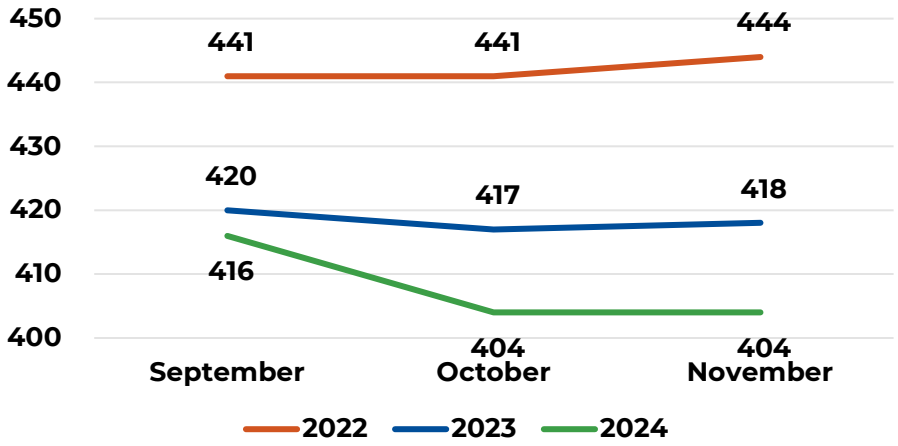
Pharmacy (In-State Only)

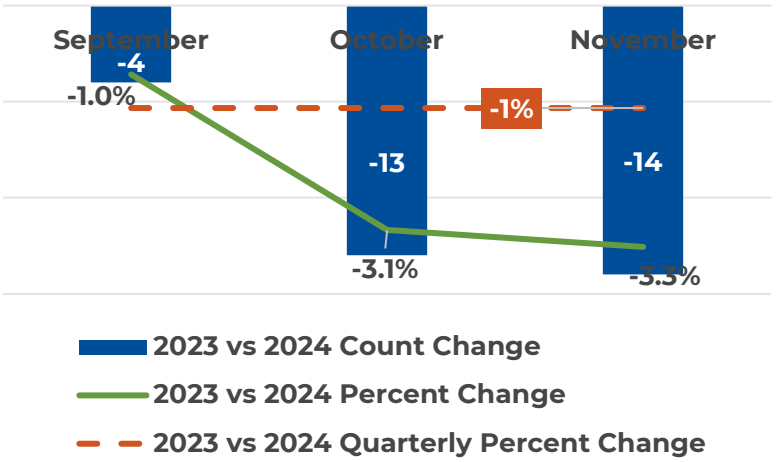




Agency Stats & Provider Network (Cont.)

Extended Care Facilities (In-State Only)





Hospitals (In-State Only)