OKLAHOMA HEALTH CARE AUTHORITY
AMENDED BOARD MEETING
June 22, 2022, 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://okhca.zoom.us/webinar/register/WN_Eh0oidfHSYu2cTbBELB0mg
Telephone: 1-669-900-6833 Webinar ID: 815 5101 2613

*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. Consent Agenda…..... Marc Nuttle, Chair

   a) Approval of the March 30, 2022 OHCA Board Meeting Minutes (Attachment "A")
   b) Discussion and Possible Vote to Approve the State Plan Amendment Rate Committee Rates pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:1-3-4 (Attachment "B")
   c) 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 "C")

3. Chief Executive Officer's Report ..... Kevin Corbett, Chief Executive Officer

4. State Medicaid Director Report ..... ….Traylor Rains, State Medicaid Director

   a) Member Moment
   b) Delivery System Key Provisions (Attachment "D")

5. Chief of Staff Report……..Ellen Buettner, Chief of Staff

   a) Legislative Liaison Report (Attachment "E")……Katelynn Burns, Director of Public Affairs Legislative Liaison

6. Discussion of Report from the Pharmacy Advisory Committee and Possible Recommendations Action Regarding: ..... …Corey Finch, M.D. Chair, 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 "F"):

      i. Elepsia™ XR [Levetiracetam Extended-Release (ER) Tablet] and Eprontia™ (Topiramate Oral Solution)
      ii. Winlevi® (Clascoterone 1% Cream)
      iii. Dojolvi® (Triheptanoin)
      iv. Qulipta™ (Atogepant)
      v. Erwinase® (Crisantaspase), Erwinaze® (Asparaginase Erwinia Chrysanthemi), Oncaspar® (Pegaspargase), Rylaze™ [Asparaginase Erwinia Chrysanthemi (Recombinant)-rywn], and

Scemblix® (Asciminib)

vi. Zynlonta® (Loncastuximab Tesirine-lply)
vii. Voxzogo™ (Vosoritide)
viii. Releuko™ (Filgrastim-ayow)
ix. Lampit® (Nifurtimox)
x. Brexafemme® (Ibrexafungerp)
xi. Ponvory™ (Ponesimod)
xii. Nexviazyme® (Avalglucosidase Alfa-ngpt)
xiii. Kerendia® (Finerenone), Rezvoglar™ (Insulin Glargine-aglr), and Semglee® (Insulin Glargine-yfgn)
xiv. Exkivity® (Mobocertinib), Lumakras™ (Sotorasib), and Rybrevant® (Amivantamab-vmjw)

7. Discussion of Report from the Compliance Advisory Committee ..... Phil Kennedy, Chair, Compliance Advisory Committee

   a) Presentation of the SFY 2023 Budget Work Program by Aaron Morris, Chief Financial Officer (Attachment "G")
   b) Discussion and Possible Vote on the SFY 2023 Budget Work Program pursuant to 63 O.S. Section 5008(B)(3)

8. Discussion of Report of Administrative Rules Advisory Committee and Possible Action Regarding Agency Rulemaking (Attachment "H") ..... Susan Dell'Osso, Chair, Administrative Rules Advisory Committee

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

      i. APA WF # 22-03 Clinical Trials Routine Services and Dental Out-of-State Services
      ii. APA WF # 22-07 Tribal Residential Substance Use Disorder (SUD) Policy Updates
      iii. APA WF # 22-08 Hospice Benefit for Expansion Population
      iv. APA WF # 22-10 Long-Term Care Facility (LTC) Pay-for-Performance (PFP) Program

9. Adjournment ..... Marc Nuttle, Chair

NEXT BOARD MEETING
September 21, 2022 at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Attachment A

MINUTES OF AN AMENDED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
March 30, 2022
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on March 30, 2022 at 3:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on March 25, 2021 at 12:00 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Hupfeld called the meeting to order at 3:03 p.m.

BOARD MEMBERS PRESENT: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Cruzan, Member Dell'Osso, Member DeMarco, Member Finch, Member Kennedy, Member Sharpe

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

a) Approval of the November 17, 2021, OHCA Board Meeting Minutes (Attachment "A")

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

FOR THE MOTION: Vice-Chairman Yaffe, Member Case, Member Dell'Osso, Member DeMarco, Member Kennedy,

ABSTAINED: Chairman, Nuttle, Member Cruzan, Member Finch, Member Sharpe

CEO Corbett stated that the Compliance Committee reviewed the below items and provided a recommendation for approval.

b) Discussion and Vote to Approve the State Plan Amendment Rate Committee Rates pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:1-3-4 (Attachment "B")
c) Discussion and Vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds pursuant to 63 O.S. Section 5006(A)(2) under OAC 317:10-1-16. (Attachment "C")

    i. IT Consulting Services

d) Discussion and Vote to Approve the OHCA Internal Audit Charter (Attachment "D")

MOTION: Member DeMarco moved for approval of the Consent Agenda, with the exception of item 2a, as published. The motion was seconded by Member Dell'Osso.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Cruzan, Member Dell'Osso, Member DeMarco, Member Finch, Member Kennedy, Member Sharpe

ITEM 3 / CHIEF EXECUTIVE OFFICER'S REPORT
Kevin Corbett, Chief Executive Officer

CEO Corbett provided an update on COVID-19, Expansion, Public Health Emergency, Medicaid Delivery System, and Team Member Recognition. CEO Corbett opened up with a welcome to the new board members: Dr. Corey Finch, Dr. Cruzan, and Mr. Thomas Sharpe.

COVID-19 – Infections within the agency have been low and we currently have no team members reporting positive cases. To help mitigate COVID exposure, OHCA has offered staff flexible work arrangements. This flexible work schedule has also allowed OHCA to continue service to members despite other disruptions. Recently, due to the severe weather, many state agencies experienced a reduction of service for several days. In contrast, most, if not all, the OHCA team was able to work from home to continue serving members. OHCA staff participated in this year's Energage Survey, which

resulted in OHCA being selected as one of the top workplaces in Oklahoma. OHCA is one of three state agencies selected.

Medicaid Expansion – OHCA is nine (9) months into the launch of Medicaid Expansion in Oklahoma. As of today, OHCA has approximately 180,000 new adults eligible for health services through SoonerCare. This is on top of the approximately 90,000 members previously enrolled in SoonerCare that now qualify to be designate as an expansion member, in which we receive additional federal funding support. Expansion efforts was a joint effort by the team at OHCA and so many other community partners including fellow state agencies, provider community, local churches, libraries, homeless organizations, neighbors and current SoonerCare members, and other volunteers. To date, close to 70% of the new expansion members have received health services under SoonerCare. On average, close to 3 different types of services and the utilization is growing each month. Early on, OHCA made some projections during the planning of Expansion including expansion enrollment and cost for the first year. Enrollment is in line with the projections, while cost is less than what was projected. However, current monthly utilization cost is more in line with what was projected. Vice-Chairman Yaffe asked if there was a percentage for utilization? CEO Corbett stated that OHCA would do that over a brief period. Vice-Chairman Yaffe asked if there has been a challenge in sub-specialist. CEO Corbett said there are pockets of the weak system.

Public Health Emergency (PHE) – At the beginning of the PHE, OHCA took a number of steps to increase its ability to serve members. OHCA also too advantage of additional federal funding that was available through the Families First Coronavirus Act. This funding allowed Oklahoma, like many other states, to receive an additional 6.0% for all claims throughout the PHE with certain agreed to conditions like continuous coverage. With the PHE expected to expire shortly, all states will be required to cease the continuous coverage for any members who are deemed ineligible at that time and begin a disenrollment process. It is believed that OHCA has in excess of 200,000 members that would not be eligible outside of the PHE. OHCA team is working diligently to develop a plan to unwind continuous coverage which includes some early communication with members, providers, community partners, and others. With the expiration of the PHE will also come the termination of the 6.2% funding. While OHCA has used a portion of the funding to cover the cost of additional services put in place as well as the cost of continuous coverage, OHCA will also be required to use some of the funding to cover the cost of service expected to incur during the unwinding period of ineligible members. Updates to the board will be provided as the unwinding process begins.

Medicaid Delivery System – OHCA has been working with the Legislative Working Group and provider groups to consider options to move the delivery system from a fee for service to an outcome-based system. Those efforts have led to proposed legislation SB 1337, which is currently being considered in the House and we expect to see additional revisions before it becomes final and subject to vote. As part of SB 1337 are amendments to the laws created by SB 131 from last year.

Staff Announcements – Melody Anthony, State Medicaid Director, and Chief Operating Officer, has informed Mr. Corbett of her intent to retire effective September 1, 2022. As part of her plan has been to develop her successor, Traylor Rains. Mr. Rains will become State Medicaid Director effective April 1, 2022. Ms. Anthony will continue in the Chief Operating Officer role through her retirement date, focusing a substantial amount of her time planning for the PHE unwinding.

ITEM 4 / CHIEF OPERATING OFFICER'S REPORT
Melody Anthony, State Medicaid Director/Chief Operating Officer

Ms. Anthony provided two member moment stories and introduced Traylor Rains to provide a board PHE Overview.

Mr. Rains provided an overview of Disaster Relief-Related Federal Authorities Post the PHE Expiration. Information provided included an executive summary, Disaster-Related Flexibilities that are ARP-Mandated Temporary Federal Authority, Federal Disaster-Relief Requests Terminating with the PHE, and 1915(c) HCBS Disaster-Relief Requests Pending Post-PHE Status. For more detailed information, see Attachment "E" in the board packet.

Vice-Chairman Yaffe asked if there was a type of bridge program that could be put in place for those that do not fall in the expansion population. Mr. Rains stated there is not since all of OHCA's programs are aligned around the 138% of the FPL mark. OHCA is looking at third party vendors that could further assist with care management.

ITEM 5 / LEGISLATIVE LIAISON REPORT
Katelynn Burns, Director of Public Affairs, Legislative Liaison

Ms. Burns provided an update on a few bills. Last Thursday, March 24, there was a deadline for all bills to pass off the floor of their origin. Bills that passed will now go to the opposite chamber for the process again.

SB 239 – a request bill that was introduced last year that puts the state on equal footing with other payers and amount that the state can recoup.

SB 1323 – allows for self-funded and self-insured health care plans recognized by the insurance department and meets certain standards to qualify under Medicaid premium assistance program, Insure Oklahoma.

SB 1337 – Delivery system bill

SB 1369 – creates the Health Care Transparency Act of 2022. It makes changes to the HIE program. It also includes language related to the all claims pair database for insurance companies that will feed into the HIE.

SB 1467 – requires OHCA to conduct annual review of all medications and forms of treatment for sickle cell disease.

SB 1661 – establishes standards for non-state government owned medical facilities.

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

Terry Cothran, D.Ph., Senior Pharmacy Director

Mr. Cothran provided a Pharmacy Overview which included information on drug price increases impacting Medicaid spend, Pharmacy numbers for the State Fiscal Year (SFY) 0021, Drug rebate totals for SFY 2021, Drug Rebates, Rebate Programs, Pharmacy Operations, Pharmacy Management Consultants (PMC), High-Cost Drugs per Unit, Top 10 High Utilization Drugs, Prior Authorization Data (CY 21), and Update on Opioid Utilization. For more detailed information, see Attachment "F" in the board packet.

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

i. Jakafi® (Ruxolitinib) and Rezurock™ (Belumosudil)
ii. Bylvay™ (Odevixibat)
iii. Lupkynis™ (Voclosporin) and Saphnelo™ (Anifrolumab-fnia)
iv. Abecma® (Idecabtagene Vicleucel), Farydak® (Panobinostat), and Pepaxto® (Melphalan Flufenamide)
v. Jemperli® (Dostarlimab-gxly)
vi. Opzelura™ (Ruxolitinib 1.5% Cream)
vii. Livmarli™ (Maralixibat)
viii. Byooviz™ (Ranibizumab-nuna Intravitreal Injection) and Susvimo™ (Ranibizumab Intravitreal Implant)
ix. Empaveli™ (Pegcetacoplan)
x. Evkeeza® (Evinacumab-dgnb) and Leqvio® (Inclisiran)
xi. Myfembree® (Relugolix/ Estradiol/Norethindrone)
xii. Tyrvaya™ (Varenicline Nasal Spray)

MOTION: Vice-Chairman Yaffe moved for approval of item 6i-xii, as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Cruzan, Member Dell'Osso, Member Finch, Member Kennedy, Member Sharpe

ABSTAINED: Member DeMarco

ITEM 7 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE

Phil Kennedy, Chair of the Compliance Advisory Committee

Member Kennedy provided an overview of the February and March Compliance Committee meetings.

The total budget variance through December 31, 2021 was $43.3 million, of which, $40 million is attributed to Medicaid Expansion. Budget Hearings took place earlier this year. The budget was presented to the House on January 25, 2022 and to the Senate on January 26, 2022. OHCA staff is working to be compliant with the National Correct Coding Initiative. Phase II is currently in testing phase. There have been no major issues but the go live date was still push to May 2nd, 2022. The Office of Inspector General recently released the payment error rate report for audits across states. Member Kennedy introduced Amber Smith, Director of Internal Audits. Member Case asked why the financials only go back to December.

CFO Morris stated that system issues delayed financial reporting. Finance staff are in the process of catching up on administrative expenditures. Hope to have a more updated financial report at the next board meeting. Vice-Chairman Yaffe requested that new financial be sent to the board, should they become available prior to the next meeting. Member Case asked for confirmation that OHCA has not experienced any cyber security attacks. CEO Corbett stated OMES Cyber Security Command Center has been very active with OHCA and other state agencies.

ITEM 8i-xliii / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING

Susan Dell'Osso, Chairwoman of the Administrative Rules Advisory Committee

Member Dell'Osso asked Mr. Rains to present the below rules.

a) Consideration and Possible Action 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 "H"):

i. APA WF 22-01 Non-Emergency Transportation (NEMT) Driver Compliance
ii. APA WF 22-02 Independent Clinical Psychologist Services for Adults

MOTION: Vice-Chairman Yaffe moved for approval of item 8ai-ii, as emergency in nature. The motion was seconded by Member Dell'Osso.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Cruzan, Member Dell'Osso, Member DeMarco, Member Finch, Member Kennedy, Member Sharpe

OTION: Member Dell'Osso moved for approval of the emergency rules listed in item 8a.i-ii, as published. The motion was seconded by Member Case.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Cruzan, Member Dell'Osso, Member DeMarco, Member Finch, Member Kennedy, Member Sharpe

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

iii. APA WF 21-01 Reimbursing Federally Qualified Health Centers (FQHCs) for Long-Acting Reversible Contraceptives (LARCs) Outside of the Encounter Rate
iv. APA WF 21-02A OHS ADvantage Waiver Services and State Plan Personal Care Services
v. APA WF 21-02B OHS ADvantage Waiver Services and State Plan Personal Care Services
vi. APA WF 21-04 Diabetes Self-Management Education and Support (DSMES) Services
vii. APA WF 21-05A Medicaid Expansion and Durable Medical Equipment
viii. APA WF 21-05B Medicaid Expansion
ix. APA WF 21-06 Insure Oklahoma and Timely Filing
x. APA WF 21-07 Payments from Trusts for Clothing Expenses Not Counted as Income
xi. APA WF 21-08 Statewide HIE (OKSHINE)
xii. APA WF 21-09 Supplemental Hospital Offset Payment Program (SHOPP) Revisions
xiii. APA WF 21-10 Transitioning Developmental Disabilities Services Division (DDSD) Members back into the Money Follows the Person (MFP) Demonstration
xiv. APA WF 21-11 Indian Health Service, Tribal and Urban Indian (I/T/U) Shared Savings Program
xv. APA WF 21-12 Purchasing Rules Revisions
xvi. APA WF 21-13 Grievance Procedures and Process Rule Revisions
xvii. APA WF 21-14 Expansion Adults into SoonerCare Choice
xviii. APA WF 21-15 Ensuring Access to Medicaid Act
xix. APA WF 21-16 Hospital Presumptive Eligibility (HPE) for Expansion Adults
xx. APA WF 21-17 Dental Revisions
xxi. APA WF 21-19 Appeals to the Chief Executive Office (CEO)/Administrative Law Judge (ALJ)
xxii. APA WF 21-20 Alternative Treatments for Pain Management
xxiii. APA WF 21-22 Title XXI Dental Revision for Pregnant Women
xxiv. APA WF 21-26 COFA Migrant Medicaid Extension and Afghan Refugees Eligibility Determinations
xxv. APA WF 21-27 Timely Filing Policy Cleanup
xxvi. APA WF 21-28 Qualified Medicare Beneficiary Plus (QMBP) Policy Clarification

xxvii. APA WF 21-29 Partial Hospitalization Program (PHP) Services for Adults
xxviii. APA WF 21-30 Eliminate Community Based Extended (CBE) and Community Based Transitional (CBT) Levels of Care
xxix. APA WF 21-31 Applied Behavior Analysis (ABA) Revisions
xxx. APA WF 21-32 Obstetric (OB) Ultrasound Coverage
xxxi. APA WF 21-33 Improve 340B Shared Savings Methodology
xxxii. APA WF 21-34 Reimbursement methodology for Providers of Certified Community Behavioral Health (CCBH) Services
xxxiii. APA WF 21-35 Lodging and Meals Revisions
xxxiv. APA WF 21-37 Private Duty Nursing (PDN) Revisions
xxxv. APA WF 21-38A Developmental Disabilities Services (DDS) Updates for Specialized Foster Care, Agency Companion, Employment Services and Self-Directed Services
xxxvi. APA WF 21-38B Developmental Disabilities Services (DDS) Updates for Specialized Foster Care, Agency Companion, Employment Services and Self-Directed Services
xxxvii. APA WF 21-39 Laboratory Services
xxxviii. APA WF 21-40 Pregnant Women Copayment Language Cleanup
xxxix. APA WF 21-41A Outdated/Obsolete Policy Language Cleanup
xl. APA WF 21-41B Outdated/Obsolete Policy Language Cleanup
xli. APA WF 21-42 Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC) Visit Limitation Revisions
xlii. APA WF 21-43 Opioid Treatment Provider (OTP) Policy Changes
xliii. APA WF 21-45 Referrals for Specialty Services Revisions

MOTION: Member Dell'Osso motioned for approval of the 41 permanent rules listed in item 8b.iii-xliii as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Cruzan, Member Dell'Osso, Member DeMarco, Member Finch, Member Kennedy, Member Sharpe

ITEM 14 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

MOTION: Member Kennedy moved for approval for adjournment. The motion was seconded by Member DeMarco.

FOR THE MOTION: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Cruzan, Member Dell'Osso, Member DeMarco, Member Finch, Member Kennedy, Member Sharpe

Meeting adjourned at 4:08 p.m., 3/30/2022

NEXT BOARD MEETING
June 22, 2022
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

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OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

REGULAR NURSING FACILITIES RATE INCREASE

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) fee for Regular Nursing Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to facilities. Additionally, the change allows OHCA to calculate the annual reallocation of the pool for the "Direct Care" and "Other Cost" components of the rate as per the State Plan. This change also proposes a revision to the Pay-for-Performance (PFP) program by requiring facilities that receive a scope and severity tag deficiency of "I" or greater to forfeit PFP incentive payment for any quarter they are out of compliance.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing Facilities calls for the establishment of a prospective rate which consists of four components. The current components are as follows:
   A. Base Rate Component is $123.22 per patient day.
   B. A Pay for Performance (PFP) Component defined as the dollars earned under this incentive payment program with an average payment of $5.00 per patient day.
   C. An "Other Cost" Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and PFP Components by the total estimated Medicaid days for the rate period. This component once calculated is the same for each facility.
   D. A "Direct Care "Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and PFP Components to the facilities. This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the 70%

pool of funds to each facility (on a per day basis) based on their relative expenditures for direct care costs.

The current combined pool amount for “Direct Care” and “Other Cost” components is $251,196,155. The current Quality of Care (QOC) fee is $15.31 per patient day.

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

There is no change in methodology; however, there is a rate change for Regular Nursing Facilities because of the required annual recalculation of the Quality of Care (QOC) fee and reallocation of the pool for “Direct Care” and “Other Cost” components of the rate as per the State Plan. This change will also revise the Pay-for-Performance (PFP) program by requiring facilities that receive a scope and severity tag deficiency of "I" or greater to forfeit PFP incentive payment for any quarter they are out of compliance. The new Base Rate Component will be $123.47 per patient day. The new combined pool amount for “Direct Care” and “Other Cost” components will be $242,806,077. The new Quality of Care (QOC) fee will be $15.56 per patient day.

6. **BUDGET ESTIMATE.**

The estimated budget impact for SFY2023 will be an increase in the total amount of $4,131,457; with $1,338,592 in state share coming from the increased QOC Fee (which is paid by providers).

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**

The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular Nursing Facilities:

- An increase to the base rate component from $123.22 per patient day to $123.47 per patient day.
- A change to the combined pool amount for “Direct Care” and “Other Cost” Components from $251,196,155 to $242,806,077 for the annual reallocation of the Direct Care Cost Component as per the State Plan

9. **EFFECTIVE DATE OF CHANGE.**

July 1, 2022, pending CMS approval.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITES RATE INCREASE

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) fee for nursing facilities serving residents with AIDS per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to the facilities. This change also proposes a revision to the Pay-for-Performance (PFP) program by requiring facilities that receive a scope and severity tag deficiency of "I" or greater to forfeit PFP incentive payment for any quarter they are out of compliance.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current rate for this provider type is $225.94 per patient day. The Quality of Care (QOC) fee is $15.31 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for nursing facilities serving residents with AIDS because of the required annual recalculation of the Quality of Care (QOC) fee. This change will also revise the Pay-for-Performance (PFP) program by requiring facilities that receive a scope and severity tag deficiency of "I" or greater to forfeit PFP incentive payment for any quarter they are out of compliance. The rate for this provider type will be $226.97 per patient day. The recalculated Quality of Care (QOC) fee will be $15.56 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2023 will be an increase in the total amount of $8,399; with $2,721 in state share coming from the increased QOC Fee (which is paid by the facilities).

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:
   - An increase to the AIDS rate from $225.94 per patient day to $226.97 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2022, pending CMS approval.

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

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

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

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

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.
   The current rate for this provider type is $ $131.09 per patient day.
   The Quality of Care (QOC) fee is $7.89 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for Regular ICF/IID facilities because of the annual recalculation of the Quality of Care (QOC) fee.
   The proposed rate for this provider type is $ $135.61 per patient day.
   The recalculated Quality of Care (QOC) fee is $9.38 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2023 will be an increase in the total amount of $835,799; with $270,799 in state share coming from the increased QOC Fee (which is paid by providers).

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular ICF/IID facilities:
   - An increase in rate from $131.09 per patient day to $135.61 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2022, pending CMS approval.

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

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

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

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

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Acute ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.
   The current rate for this provider type is $165.80 per patient day.
   The Quality of Care (QOC) fee is $9.79 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for Acute ICF/IID facilities because of the annual recalculation of the Quality of Care (QOC) fee.
   The proposed rate for this provider type is $166.61 per patient day.
   The recalculated Quality of Care (QOC) fee is $10.05 per patient.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2023 will be an increase in the total amount of $254,810; with $82,558 $in state share coming from the increased QOC Fee (which is paid by providers).

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:
   - An increase in rate from $165.80 per patient day to $166.61 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2022, pending CMS approval.

RATE INCREASES FOR INDEPENDENT PSYCHOLOGIST SERVICES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   ODMHSAS seeks to implement rate increases for select independent psychologist services that currently fall below 80% of 2021 Medicare rates. ODMHSAS recommends increasing the current reimbursement rates that fall below 80% of the CY 2021 Medicare Physician Fee Schedule to equal 80% of the CY 2021 Medicare Physician Fee Schedule rates.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Current rates for these services are:

Service	Rate	Unit
Assessment	$127.61	Event
Family Psychotherapy with Patient Present	$77.33	Session
Family Psychotherapy without Patient Present	$64.47	Session
Psychotherapy, 30 minutes	$53.36	30 min
Psychotherapy, 45 minutes	$69.95	45 min
Psychotherapy, 60 minutes	$102.67	60 min
Interactive Complexity Add-On	$4.11	Event
Interpretation of results of evaluations	$73.26	Event

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   Proposed rates for these services are:

Service	Rate	Unit
Assessment	$139.76	Event
Family Psychotherapy with Patient Present	$80.36	Session
Family Psychotherapy without Patient Present	$77.57	Session
Psychotherapy, 30 minutes	$60.35	30 min
Psychotherapy, 45 minutes	$79.98	45 min
Psychotherapy, 60 minutes	$118.10	60 min
Interactive Complexity Add-On	$11.64	Event
Interpretation of results of evaluations	$93.29	Event

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY23 is $634,402 total/$190,574 state share. ODMHSAS attests that it has adequate funds to cover the state share of the projected cost of services per fiscal year.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The ODMHSAS has determined that this change will have a positive impact in that the rate increases support the independent psychologist provider network.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The ODMHSAS requests the SPARC to approve the proposed rate increases for select independent psychologist services.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2022, contingent upon CMS approval

RATE INCREASES FOR OUTPATIENT BEHAVIORAL HEALTH AGENCIES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   ODMHSAS seeks to implement rate increases for select services that are currently reimbursed less through SoonerCare than through ODMHSAS state funds. Other select services are increased due to lack of lack increases in recent years.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Current rates for these services are:

Service	Rate	Unit
Individual Psychotherapy	$17.70 (LBHP)/$15.92 (Cand.)	15 min
Family Psychotherapy	$17.70 (LBHP)/$15.92 (Cand.)	15 min
Individual Assertive Community Treatment (ACT)	$32.11	15 min
Individual Community Recovery Support/Recovery Support Specialist	$9.75	15 min
Group Community Recovery Support/Recovery Support Specialist	$1.45	15 min
Group Psychosocial Rehabilitation/PSR Model (DMH providers)	$4.08 adults/$3.89 children	15 min
Group Psychosocial Rehabilitation-Illness Management and Recovery (DMH providers)	$3.89	15 min
Group Psychosocial Rehabilitation (private providers)	$2.72 adults/$3.89 children	15 min
Screening and Referral*	$25.32	Event

*Currently there is no established rate for complex screenings and ODMHSAS seeks to implement an enhanced rate for complex screening and referral services.

5. NEW METHODOLOGY OR RATE STRUCTURE.

Proposed rates for these services are:

Service	Rate	Unit
Individual Psychotherapy	$19.03 (LBHP)/$17.13 (Cand.)	15 min
Family Psychotherapy	$19.03 (LBHP)/$17.13 (Cand.)	15 min
Individual Assertive Community Treatment (ACT)	$38.53	15 min
Individual Community Recovery Support/Recovery Support Specialist	$11.70	15 min
Group Community Recovery Support/Recovery Support Specialist	$2.90	15 min
Group Psychosocial Rehabilitation/PSR Model (DMH providers)	$5.71 adults/$5.45 children	15 min
Group Psychosocial Rehabilitation-Illness Management and Recovery (DMH providers)	$5.45	15 min
Group Psychosocial Rehabilitation (private providers)	$3.81 adults/$5.45 children	15 min
Screening and Referral, Complex*	$75.00	Event

*Currently there is no established rate for complex screenings and ODMHSAS seeks to implement an enhanced rate for complex screening and referral services.

Increase amounts were developed through several means: 1) matching or nearly matching the rate paid for ODMHSAS funded services; 2) increasing rates by 20% to account for increased costs since the last rate update; or 3) increasing group services based on provider feedback on costs to provide services.

For complex screening and referral, the current rate of $25 (rounded to the nearest dollar) was multiple by three based on the estimated time required to complete a complex screening versus a non-complex screening.

6. BUDGET ESTIMATE.

The estimated budget impact for SFY23 is $12,335,499 total/$3,862,017 state share. ODMHSAS attests that it has adequate funds to cover the state share of the projected cost of services per fiscal year.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The ODMHSAS has determined that this change will have a positive impact in that the rate increases support the outpatient behavioral health provider network.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The ODMHSAS requests the SPARC to approve the proposed rate increases for select outpatient behavioral health agency services.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2022, contingent upon CMS approval

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RATE INCREASES FOR RESIDENTIAL LEVEL OF CARE SUBSTANCE USE DISORDER SERVICES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   ODMHSAS seeks to implement rate increases for residential level of care services for substance use disorder. Proposed rates are based on analysis of other states' rates for similar services and align with proposed rates for these services when reimbursed through ODMHSAS state funds.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Current rates for these services are:

Service	Rate	Unit
Halfway House Services, Adults	$46	Day
Halfway House Services, Adolescents	$63	Day
Residential Treatment, Adults	$85	Day
Residential Treatment, Adolescents	$135	Day
Residential Treatment, Co-Occurring	$100	Day
Intensive Residential Treatment, Adults	$160	Day
Intensive Residential Treatment, Adolescents	$160	Day
Medically Supervised Withdrawal Management, Adults	$200	Day
Medically Supervised Withdrawal Management, Adolescents	$200	Day

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   Proposed rates for these services are:

Service	Rate	Unit
Halfway House Services, Adults	$75	Day
Halfway House Services, Adolescents	$75	Day
Residential Treatment, Adults	$140	Day
Residential Treatment, Adolescents	$160	Day
Residential Treatment, Co-Occurring	$160	Day
Intensive Residential Treatment, Adults	$180	Day
Intensive Residential Treatment, Adolescents	$180	Day

Medically Supervised Withdrawal Management, Adults	$300	Day
Medically Supervised Withdrawal Management, Adolescents	$300	Day

Proposed rates are based on analysis of other states' rates for similar services and align with proposed rates for these services when reimbursed through ODMHSAS state funds.

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY23 is $2,910,114 total/$291,039 state share. ODMHSAS attests that it has adequate funds to cover the state share of the projected cost of services per fiscal year.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The ODMHSAS has determined that this change will have a positive impact in that the rate increases support the residential level of care substance use disorder provider network.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The ODMHSAS requests the SPARC to approve the proposed rate increases for residential level of care substance use disorder services.

9. **EFFECTIVE DATE OF CHANGE.**
July 1, 2022, contingent upon CMS approval

ADVANTAGE WAIVER & STATE PLAN PERSONAL CARE SERVICES RATE INCREASES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   Oklahoma Human Services is seeking to implement a provider rate increase pursuant to 1915(c) Home and Community-Based Services Waiver Instructions and Technical Guidance.

   The Oklahoma Legislature appropriated and specifically funded a 25% rate increase for providers contracted with Oklahoma Human Services (OHS) to support those organizations providing services to Oklahoma's seniors and physically disabled adults. These organizations provide direct care and nutrition services in a highly competitive labor market. Without this additional support, staffing shortages could result in adverse health and safety outcomes for the individuals served. OHS is proposing a rate increase of 25% on payments for ADvantage waiver services with a commensurate rate increase for State Plan Personal Care (SPPC) services.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate structure for ADvantage Waiver and SPPC services provided in the proposed rate changes are fixed and uniform rates established through the State Plan Amendment Rate Committee process, with the following waiver requirements:
   - Consumer-directed rates for Personal Services Assistance and Advanced Personal Services Assistance are to be within 80% to 95% of the corresponding rates for Personal Care Services and Advanced Supportive/Restorative Services, respectively.
   - Assisted Living Services are configured based on a modifier of the SPPC rate equivalent to 11.636, 15.702, and 21.964 for Standard, Intermediate and High tier levels, respectively.
   - The proposed rates are consistent with both waiver requirements and the 25% rate increase.

   Services and current rates are listed below:

State Plan Services	Code	Unit Type	Current Rate
State Plan Personal Care	T1019	15-min	$4.21
Personal Care – Individual Provider	T1019	15-min	$2.21
State Plan Skilled Nursing - Assessment/Evaluation	T1001	per visit	$62.40

AD*vantage* Waiver Services	Code	Unit Type	Current Rate
Adult Day Health	S5100-U1	15-min	$2.08
Adult Day Health - Therapy	S5105-TG	Session	$11.70
Adult Day Health - Personal Care	S5105	Session	$8.27
Adult Day Health - Laundry	S5105_U1	session	$7.80
Case Management	T1016	15-min	$15.29
Case Management - Very Rural	T1016-TN	15-min	$21.89
Transitional Case Management	T1016-U3	15-min	$15.29
Transitional Case Management - Very Rural	T1016-TN-U3	15-min	$21.89
Personal Care	T1019	15-min	$4.21
Advanced Supportive/Restorative Assistance	T1019-TF	15-min	$4.52
In-Home Respite	T1005	15-min	$4.21
Extended In-Home Respite	S9125	per diem	$175.55
Registered Nurse Skilled Nursing	G0299	15-min	$15.60
Licensed Practical Nurse Skilled Nursing	G0300	15-min	$14.56
Extended State Plan Registered Nurse Skilled Nursing	G0299-TF	15-min	$15.60
Extended State Plan Licensed Practical Nurse Skilled Nursing	G0300-TF	15-min	$14.56
Nursing Assessment/Evaluation	T1002	15-min	$15.60
Assisted Living Tier 1 Services	T2031	per diem	$48.99
Assisted Living Tier 2 Services	T2031-TF	per diem	$66.11
Assisted living Tier 3 Services	T2031-TG	per diem	$92.47
Consumer-Directed Personal Assistance Services	S5125	15-min	$3.56
Consumer-Directed Advanced Personal Services Assistance	S5125-TF	15-min	$4.27
Consumer-Directed Goods & Services	T2025	15-min	$1.04
Home Delivered Meals	S5170	per meal	$5.15
Hospice Care	S9126	per diem	$123.80

ADvantage Waiver Services	Code	Unit Type	Current Rate
Physical Therapy	G0151	15-min	$20.80
Occupational Therapy	G0152	15-min	$20.80

5. NEW METHODOLOGY OR RATE STRUCTURE.

The new rates are based on a 25% increase of existing rates.

State Plan Services	Code	Unit Type	Current Rate	New Rate
State Plan Personal Care	T1019	15-min	$4.21	$5.26
Personal Care – Individual Provider	T1019	15-min	$2.21	$2.76
State Plan Skilled Nursing - Assessment/Evaluation	T1001	per visit	$62.40	$78.00

ADvantage Waiver Services	Code	Unit Type	Current Rate	New Rate
Adult Day Health	S5100-U1	15-min	$2.08	$2.60
Adult Day Health - Therapy	S5105-TG	session	$11.70	$14.63
Adult Day Health - Personal Care	S5105	session	$8.27	$10.34
Adult Day Health - Laundry	S5105_U1	session	$7.80	$9.75
Case Management	T1016	15-min	$15.29	$19.11
Case Management - Very Rural	T1016-TN	15-min	$21.89	$27.36
Transitional Case Management	T1016-U3	15-min	$15.29	$19.11
Transitional Case Management - Very Rural	T1016-TN-U3	15-min	$21.89	$27.36
Personal Care	T1019	15-min	$4.21	$5.26
Advanced Supportive/Restorative Assistance	T1019-TF	15-min	$4.52	$5.65
In-Home Respite	T1005	15-min	$4.21	$5.26
Extended In-Home Respite	S9125	per diem	$175.55	$219.44
Registered Nurse Skilled Nursing	G0299	15-min	$15.60	$19.50
Licensed Practical Nurse Skilled Nursing	G0300	15-min	$14.56	$18.20
Extended State Plan Registered Nurse Skilled Nursing	G0299-TF	15-min	$15.60	$19.50
Extended State Plan Licensed Practical Nurse Skilled Nursing	G0300-TF	15-min	$14.56	$18.20
Nursing Assessment/Evaluation	T1002	15-min	$15.60	$19.50
Assisted Living Tier 1 Services	T2031	per diem	$48.99	$61.24
Assisted Living Tier 2 Services	T2031-TF	per diem	$66.11	$82.64

ADvantage Waiver Services	Code	Unit Type	Current Rate	New Rate
Assisted living Tier 3 Services	T2031-TG	per diem	$92.47	$115.59
Consumer-Directed Personal Assistance Services	S5125	15-min	$3.56	$4.45
Consumer-Directed Advanced Personal Services Assistance	S5125-TF	15-min	$4.27	$5.34
Consumer-Directed Goods & Services	T2025	15-min	$1.04	$1.30
Home Delivered Meals	S5170	per meal	$5.15	$6.44
Hospice Care	S9126	per diem	$123.80	$154.75
Physical Therapy	G0151	15-min	$20.80	$26.00
Occupational Therapy	G0152	15-min	$20.80	$26.00

6. **BUDGET ESTIMATE.**
   In state fiscal year SFY2023, the total increase will be $32,126,729 with a state share of $8,214,805. In SFY2024, the total increase will be $43,668,907 with a state share of $14,148,726.
   OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The rate increase will have a positive impact on access to care as providers are able to meet increased labor costs.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   Oklahoma Human Services requests the State Plan Amendment Rate Committee approve the proposed 25% rate increases.

9. **EFFECTIVE DATE OF CHANGE.**
   October 1, 2022, contingent upon CMS approval.

ADVANTAGE WAIVER – ASSISTIVE TECHNOLOGY SERVICES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Community Living, Aging and Protective Services (CAP) division of Oklahoma Human Services is seeking to add Assistive Technology services to the ADvantage waiver.

   Assistive Technology services include devices, controls and appliances specified in the member's person-centered service plan which enables them to increase their abilities to perform activities of daily living or to perceive, control or communicate with the environment in which they live. Devices may include communication technology that allows members to communicate with their providers via video or audio chat to ensure ongoing maintenance of health and welfare.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Assistive Technology services are a new service category for the ADvantage waiver. There is no current methodology for the ADvantage waiver program.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed rate structure for Assistive Technology services is consistent with existing Medicaid rules. Only adaptive devices that are not covered under the existing state plan or waiver Environmental Accessibility Modifications or Specialized Medical Equipment services are included in this service definition. Service codes and rates will vary based on the nature of the Assistive Technology device.

6. **BUDGET ESTIMATE.**
   In state fiscal year SFY2023, the total increase will be $3,750,000 with a state share of $958,875. In SFY 2024, the total increase will be $6,250,000, with a state share of $2,025,000.
   OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The addition of Assistive Technology services will not have a negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   Oklahoma Human Services requests the State Plan Amendment Rate Committee approve the request for the addition of Assistive Technology services to the ADvantage waiver.

9. **EFFECTIVE DATE OF CHANGE.**
   October 1, 2022, contingent upon CMS approval.

ADVANTAGE WAIVER – REMOTE SUPPORTS SERVICES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Community Living, Aging and Protective Services (CAP) division of Oklahoma Human Services is seeking to add two new services related to Remote Supports to the ADvantage waiver. Remote Supports involves monitoring of a waiver member by remote staff using audio or video equipment, allowing for live, two-way communication with the member in their residence. Remote Supports is not a system to provide surveillance and HIPAA privacy and security rules apply to all covered service providers. Remote Supports allow for a member to choose the method of service delivery which best suits their needs. This service is less intrusive than requiring the physical presence of another person to meet the needs of the member. Remote supports will promote and enhance the independence and self-reliance of the member and decrease reliance on in-person paid staff.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   These are new services for the ADvantage waiver. There is no current methodology for the ADvantage waiver program.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed rate structure for Remote Supports services are the fixed and uniform rates established through the State Plan Amendment Rate Committee process for use in the Developmental Disabilities Services waivers.

Service	Service Code	Unit Type	New Rate
Remote Support services with paid emergency response staff	T2025-TF	15-min	$2.62
Remote Support services with unpaid emergency response staff	T2025-TF-U4	15-min	$1.75

6. **BUDGET ESTIMATE.**
In state fiscal year SFY2023, the total increase will be $13,634,400 with a state share of $3,486,316. In SFY2024, the total increase will be $22,724,000 with a state share of $7,362,576.
OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
Remote Supports services encourage independence, the promotion of member rights, the dignity of risk, and a member-centered level of health and safety oversight while decreasing reliance on in-person staffing. The addition of the services will not have a negative impact on access to care.

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

9. **EFFECTIVE DATE OF CHANGE.**
October 1, 2022, contingent upon CMS approval.

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

DEVELOPMENTAL DISABILITIES SERVICES INCREASES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   This proposal increases the rate for Extended Duty Nursing. The rate increase is needed to maintain an adequate pool of providers to provide services to waiver members requiring skilled nursing services. The service is available to adult members in the Homeward Bound Waiver and the Community Waiver.

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

Extended Duty Nursing	T1000	$6.76 per 15-minute unit

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The table below indicates the services and per service rate increase proposed:

Extended Duty Nursing	T1000	$10.00 per 15-minute unit

6. **BUDGET ESTIMATE.**
   In SFY2023, the total increase will be $750,000, with a state share of $191,775. In SFY2024, the total increase will be $1,000,000, with a state share of $324,000.
   OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   Increasing the Extended Duty Nursing rate will have a positive impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   Oklahoma Human Services requests the proposed rate for the Extended Duty Nursing waiver service be increased as presented.

9. **EFFECTIVE DATE OF CHANGE.**
   October 1, 2022, contingent upon CMS approval.

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DEVELOPMENTAL DISABILITIES SERVICES INCREASES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   This proposal permanently aligns the Non-Emergency Transportation waiver service with the federal mileage reimbursement rate. This service is available to adult members receiving services through the In Home Supports Waiver, the Homeward Bound Waiver and the Community Waiver.

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

Non-Emergency Transportation	S0215	$0.52 per mile

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The table below indicates the services and per service rate increase proposed:

Non-Emergency Transportation	S0215	$0.625 per mile

6. **BUDGET ESTIMATE.**
   In SFY2023, the total increase will be $550,071, with a state share of $140,653. In SFY2024, the total increase will be $740,095, with a state share of $239,791.
   OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   Aligning the Non-Emergency Transportation services rate with the federal reimbursement rate will have a positive impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   Oklahoma Human Services requests the proposed rate for Non-Emergency Transportation be permanently linked to the federal mileage reimbursement rate as presented.

9. **EFFECTIVE DATE OF CHANGE.**
   October 1, 2022, contingent upon CMS approval.

DEVELOPMENTAL DISABILITIES SERVICES INCREASES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Legislature appropriated funding to Oklahoma Human Services (OHS) to eliminate the waitlist and fund a 25% rate increase for waiver rates. Vendors compete for staff to provide direct care services in a highly competitive labor market. Without additional support, staffing shortages could result in adverse health and safety outcomes for the individuals served. OHS is proposing a rate increase of 25% on payments for the following services:
   - Adult Day
   - Agency Companion
   - Daily Living Supports
   - Extended Duty Nursing
   - Group Home
   - Habilitation Training Specialist
   - Homemaker
   - Intensive Personal Supports
   - Nursing
   - Prevocational
   - Respite
   - Specialized Foster Care
   - Physical Therapy
   - Occupational Therapy
   - Speech Therapy
   - Supported Employment
   - Psychological Services

Services provided by these rates are available to members receiving services from the In Home Supports Waiver for Children, In-Home Supports Waiver for Adults, Homeward Bound Waiver and Community Waiver.

4. CURRENT METHODOLOGY AND/OR RATE STRUCTURE.

The current rate structure for services provided in the proposed rate changes are fixed and uniform rates established through the SPARC. The services, current service codes and rates are as follows:

Procedure Description	Code			Service Unit	Current Rate	Prop Rate
Adult Day Services	S5100			15 Minutes	2.08	2.60
Agency Companion – Close	S5126	U1		Day	100.36	125.45
Agency Companion - Close Therapeutic Leave	S5126	U1	TV	Day	100.36	125.45
Agency Companion – Enhanced	S5126			Day	130.52	163.15
Agency Companion - Enhanced - Therapeutic Leave	S5126	TV		Day	130.52	163.15
Agency Companion – Pervasive	S5126	TF		Day	142.74	178.43
Agency Companion - Pervasive - Therapeutic Leave	S5126	TF	TV	Day	142.74	178.43
Audiological Exam/Treatment (45 minutes)	92507			Each	71.68	89.60
Audiology Comprehensive Recognition	92557			Each	35.59	44.49
Audiology Hearing Aid Evaluation	92591			Each	48.25	60.31
Audiology Reflex Testing	92568			Each	14.48	18.10
Audiology Tympanometry	92567			Each	15.05	18.81

Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous sys.	92585			Each	120.14	150.18
Center-Based Pre-Vocational Svc - waiver funded	T2015	U1		Hour	5.20	6.50
Center-Based Pre-Vocational Svc - waiver funded – Telehealth	T2015	U1	GT	Hour	5.20	6.50
Center-Based Pre-Vocational Svc & TL - state funded	T2015	U1	SE	Hour	5.20	6.50
Community-Based Pre-Voc Svc - waiver funded	T2015	TF		Hour	10.40	13.00
Community-Based Pre-Voc Svc & TL - state funded	T2015	TF	SE	Hour	10.40	13.00
CONDITIONING PLAY AUDIOMETRY	92582			Each	65.07	81.34
Daily Living Supports	T2033			Day	160.16	200.20
Daily Living Supports-Telehealth	T2033	GT		Day	160.16	200.20
DLS - Therapeutic Leave	T2033	TV		Day	160.16	200.20
Employment Specialist	T2019			15 Minutes	6.28	7.85
Employment Specialist – Telehealth	T2019	GT		15 Minutes	6.28	7.85
Enhanced Community-Based Pre-Voc Svc - waiver funded	T2015			Hour	13.85	17.31
Enhanced Community-Based Pre-Voc Svc & TL - state funded	T2015	SE		Hour	13.85	17.31
Enhanced Job Coaching GROUPS of 2-3	T2019	TG	HQ	15 Minutes	4.32	5.40
Enhanced Job Coaching Service (Groups of 4-5)	T2019	TG		15 Minutes	4.04	5.05
EVALUATION OF AUDITORY REHABILITATION STATUS; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITIO	92627			Each	19.73	24.66

EVALUATION OF AUDITORY REHABILITATION STATUS; FIRST HOUR	92626			Each	83.38	104.23
EVOKED OTOACOUSTIC EMISSIONS; LIMITED (SINGLE STIMULUS LEVEL, EITHER TRANSIENT OR DISTORTION PRODUCT	92587			Each	20.67	25.84
Extensive Residential Supports	T2033	TG		Day	929.92	1,162.40
Extensive Residential Supports Therapeutic Leave	T2033	TG	TV	Day	929.92	1,162.40
Family Counseling - Group - Psychotherapy	90853	U1		15 Minutes	5.75	7.19
Family Counseling - Group - Psychotherapy-Telehealth	90853	U1	GT	15 Minutes	5.75	7.19
Family Counseling - Individual (without Client)	90846			15 Minutes	17.24	21.55
Family Counseling - Individual (without Client)-Telehealth	90846	GT		15 Minutes	17.24	21.55
Family Counseling - Individual with Consumer present	90847			15 Minutes	17.24	21.55
Family Counseling - Individual with Consumer present-Telehealth	90847	GT		15 Minutes	17.24	21.55
Group Home 10 Bed	T1020			Day	47.58	59.48
Group Home 11 Bed	T1020			Day	44.46	55.58
Group Home 12 Bed	T1020			Day	41.86	52.33
Group Home 6 Bed	T1020			Day	75.40	94.25
Group Home 7 Bed	T1020			Day	64.48	80.60
Group Home 8 Bed	T1020			Day	56.42	70.53
Group Home 9 Bed	T1020			Day	51.48	64.35
Group Home Alternative Living Home 4 Bed	T1020			Day	303.68	379.60

Group Home Community Living 10 bed	T1020			Day	125.58	156.98
Group Home Community Living 11 bed	T1020			Day	114.14	142.68
Group Home Community Living 12 bed	T1020			Day	112.84	141.05
Group Home Community Living 6 Bed	T1020			Day	173.42	216.78
Group Home Community Living 7 bed	T1020			Day	148.72	185.90
Group Home Community Living 8 bed	T1020			Day	143.78	179.73
Group Home Community Living 9 bed	T1020			Day	127.66	159.58
Hearing Aid Check; Binaural	92593			Each	43.54	54.43
HEARING AID CHECK; MONAURAL	92592			Each	43.53	54.41
HEARING AID EXAMINATION AND SELECTION; MONAURAL	92590			Each	48.25	60.31
Homemaker	S5130			15 Minutes	4.00	5.00
Homemaker-Respite	S5150			15 Minutes	4.00	5.00
Homemaker-Respite-EVV	S5150	32		15 Minutes	4.00	5.00
Homemaker-State Fund	S5130	SE		15 Minutes	4.00	5.00
HTS - Habilitation Training Specialist	T2017			15 Minutes	4.21	5.26
HTS - Habilitation Training Specialist - EVV	T2017	32		15 Minutes	4.21	5.26
HTS - Habilitation Training Specialist - state funded	T2017	SE		15 Minutes	4.21	5.26
HTS - Habilitation Training Specialist-Telehealth	T2017	GT		15 Minutes	4.21	5.26
HTS - No Supervising Agency - Independent	T2017	U1		15 Minutes	1.90	2.38

Individual Placement in Community-Based, Pre-Vocational	T2015	U4		Hour	16.84	21.05
Individual Placement in Community-Based, Pre-Vocational - Telehealth	T2015	U4	GT	Hour	16.84	21.05
Individual Placement in Community-Based, Pre-Vocational, state funded	T2015	U4	SE	Hour	16.84	21.05
Individual Placement in Job Coaching, Supported Employment	T2019	U4		15 Minutes	6.25	7.81
Individual Placement in Job Coaching, Supported Employment - Telehealth	T2019	U4	GT	15 Minutes	6.25	7.81
Individual Placement in Job Coaching, Supported Employment, state funded	T2019	U4	SE	15 Minutes	6.25	7.81
Intensive Personal Supports	T2017	TF		15 Minutes	4.21	5.26
Intensive Personal Supports - state funded	T2017	TF	SE	15 Minutes	4.21	5.26
Job Coaching (Groups of 4-5)	T2019	TF		15 Minutes	3.47	4.34
Job Coaching GROUPS of 2-3	T2019	HQ		15 Minutes	3.75	4.69
Job Stabilization/Extended Svc	T2019	U1		15 Minutes	1.44	1.80
Job Stabilization/Extended Svc - Telehealth	T2019	U1	GT	15 Minutes	1.44	1.80
Nursing - Intermittent Skilled Care	T1001			Visit	52.52	65.65
Nutrition Therapy, Initial Assessment & Intervention	97802	U5		15 Minutes	34.18	42.73
Nutrition Therapy, Reassessment & Intervention	97803	U5		15 Minutes	29.40	36.75
Nutrition Therapy, Reassessment & Intervention-Telehealth	97803	U5	GT	Each	30.03	37.54
Occupational Therapy	G0152			15 Minutes	20.80	26.00
Occupational Therapy-Telehealth	G0152	GT		15 Minutes	20.80	26.00
Physical Therapy	G0151			15 Minutes	20.80	26.00

Physical Therapy-Telehealth	G0151	GT		15 Minutes	20.80	26.00
Pre-Voc HTS - Supplemental Supports & TL - state funded	T2015	TG	SE	Hour	13.10	16.38
Pre-Voc HTS - Supplemental Supports - waiver funded	T2015	TG		Hour	13.10	16.38
Psychological - Cognitive/Behavior Treatment - Group	90853			15 Minutes	10.78	13.48
Psychological - Cognitive/Behavior Treatment - Group - Telehealth	90853	GT		15 Minutes	10.78	13.48
Psychological Services - Therapy	H0004			15 Minutes	21.56	26.95
Psychological Services - Therapy - Telehealth	H0004	GT		15 Minutes	21.56	26.95
PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER	90832			30 Minutes	52.00	65.00
PURE TONE AUDIOMETRY (THRESHOLD); AIR AND BONE	92553			Each	34.17	42.71
PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY	92552			Each	27.92	34.90
Remote Supports With Unpaid Staff	T2017	U4		15 Minutes	1.45	1.81
Remotes Supports With Paid Staff	T2017	U4		15 Minutes	2.62	3.28
Respite - Close -	S5151			Day	40.00	50.00
Respite - Intermittent -	S5151			Day	19.00	23.75
Respite - Maximum	S5151			Day	79.04	98.80
Respite in Agency Companion - Contractor - Close	S5151			Day	123.24	154.05
Respite in Agency Companion - Contractor - Pervasive	S5151			Day	165.62	207.03
Respite in Agency Companion - Contractor- Enhanced	S5151			Day	153.40	191.75
Respite in Agency Companion - Contractor- Enhanced - STATE FUNDED	S5151	SE		Day	153.40	191.75

Respite in Community Living Group Home - 6 bed setting	S5151			Day	196.30	245.38
Respite in Community Living Group Home - 7 bed setting	S5151			Day	171.60	214.50
Respite in Community Living Group Home - 8 bed setting	S5151			Day	166.66	208.33
Respite in Community Living Group Home - 9 bed setting	S5151			Day	150.54	188.18
Respite in Community Living Group Home 10 bed setting	S5151			Day	148.46	185.58
Respite in Community Living Group Home 11 bed setting	S5151			Day	137.02	171.28
Respite in Community Living Group Home 12 bed setting	S5151			Day	135.72	169.65
Respite in Group Home - 10 bed setting	S5151			Day	70.46	88.08
Respite in Group Home - 11 bed setting	S5151			Day	67.34	84.18
Respite in Group Home - 12 bed setting	S5151			Day	64.74	80.93
Respite in Group Home - 6 bed setting	S5151			Day	98.70	123.38
Respite in Group Home - 7 bed setting	S5151			Day	87.36	109.20
Respite in Group Home - 8 bed setting	S5151			Day	79.30	99.13
Respite in Group Home - 9 bed setting	S5151			Day	74.36	92.95
Respite, In Own Home - Close	S9125	TF		Day	28.50	35.63
Respite, In Own Home - Intermittent	S9125	U1		Day	19.00	23.75
Respite, In Own Home - Maximum	S9125			Day	57.04	71.30
Self Directed HTS	T2017	U1	TF	15 Minutes	4.21	5.26
Self-Directed Individual Placement in Job Coaching, Supported Employment	T2019	U4	TF	15 Minutes	6.25	7.81

Skilled Nursing - Licensed Practical Nurse	G0300			15 Minutes	14.56	18.20
Skilled Nursing - Licensed Practical Nurse-Telehealth	G0300	GT		15 Minutes	14.56	18.20
Skilled Nursing - Registered Nurse	G0299			15 Minutes	15.60	19.50
Skilled Nursing - Registered Nurse-Telehealth	G0299	GT		15 Minutes	15.60	19.50
Specialized Family Care Adult - Close	S5140	U1		Day	30.00	37.50
Specialized Family Care Adult - Maximum	S5140			Day	56.16	70.20
Specialized Family Care Child - Close	S5145	U1		Day	30.00	37.50
Specialized Family Care Child - Maximum	S5145			Day	56.16	70.20
SPEECH AUDIOMETRY THRESHOLD	92555			Each	21.38	26.73
SPEECH AUDIOMETRY THRESHOLD; WITH SPEECH RECOGNITION	92556			Each	33.87	42.34
Speech/Language Services	G0153			15 Minutes	19.54	24.43
Speech/Language Services-Telehealth	G0153	GT		15 Minutes	19.54	24.43
Transportation - Adapted	A0130			Mile	1.35	1.69
Use of vertical electrodes (list separately in addition to code for primary procedure)	92547			Each	8.63	10.79
Value-Based Incentive Quality Payment	T2025	UK		Each	500.00	625.00
Vehicle Modification Assessment	T2024			Each	20.80	26.00
VISUAL REINFORCEMENT AUDIOMETRY (VRA)	92579			Each	43.42	54.28

5. NEW METHODOLOGY OR RATE STRUCTURE.

The new rates are based on a 25% increase of existing rates.

Procedure Description	Code			Service Unit	Prop Rate	Net Annual Cost
Adult Day Services	S5100			15 Minutes	2.60	$643,669.22
Agency Companion - Close	S5126	U1		Day	125.45	$234,064.20
Agency Companion - Close Therapeutic Leave	S5126	U1	TV	Day	125.45	$2,025.45
Agency Companion - Enhanced	S5126			Day	163.15	$902,367.33
Agency Companion - Enhanced - Therapeutic Leave	S5126	TV		Day	163.15	$12,732.59
Agency Companion - Pervasive	S5126	TF		Day	178.43	$762,522.34
Agency Companion - Pervasive - Therapeutic Leave	S5126	TF	TV	Day	178.43	$15,600.01
Audiological Exam/Treatment (45 minutes)	92507			Each	89.60	$0.00
Audiology Comprehensive Recognition	92557			Each	44.49	$321.09
Audiology Hearing Aid Evaluation	92591			Each	60.31	$105.27
Audiology Reflex Testing	92568			Each	18.10	$0.00
Audiology Tympanometry	92567			Each	18.81	$73.11
Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous sys.	92585			Each	150.18	$0.00
Center-Based Pre-Vocational Svc - waiver funded	T2015	U1		Hour	6.50	$597,440.87
Center-Based Pre-Vocational Svc - waiver funded - Telehealth	T2015	U1	GT	Hour	6.50	$0.00
Center-Based Pre-Vocational Svc & TL - state funded	T2015	U1	SE	Hour	6.50	$0.00

Community-Based Pre-Voc Svc - waiver funded	T2015	TF		Hour	13.00	$299,098.16
Community-Based Pre-Voc Svc & TL - state funded	T2015	TF	SE	Hour	13.00	$0.00
CONDITIONING PLAY AUDIOMETRY	92582			Each	81.34	$0.00
Daily Living Supports	T2033			Day	200.20	$30,512,716.01
Daily Living Supports-Telehealth	T2033	GT		Day	200.20	$298,263.79
DLS - Therapeutic Leave	T2033	TV		Day	200.20	$1,965.60
Employment Specialist	T2019			15 Minutes	7.85	$389,604.44
Employment Specialist - Telehealth	T2019	GT		15 Minutes	7.85	$0.00
Enhanced Community-Based Pre-Voc Svc - waiver funded	T2015			Hour	17.31	$292,896.26
Enhanced Community-Based Pre-Voc Svc & TL - state funded	T2015	SE		Hour	17.31	$0.00
Enhanced Job Coaching GROUPS of 2-3	T2019	TG	HQ	15 Minutes	5.40	$189,752.88
Enhanced Job Coaching Service (Groups of 4-5)	T2019	TG		15 Minutes	5.05	$161,166.75
EVALUATION OF AUDITORY REHABILITATION STATUS; EACH ADDITIONAL 15 MINUTES (LIST SEPARATELY IN ADDITIO	92627			Each	24.66	$0.00
EVALUATION OF AUDITORY REHABILITATION STATUS; FIRST HOUR	92626			Each	104.23	$0.00
EVOKED OTOACOUSTIC EMISSIONS; LIMITED (SINGLE STIMULUS LEVEL, EITHER TRANSIENT OR DISTORTION PRODUCT	92587			Each	25.84	$0.00
Extensive Residential Supports	T2033	TG		Day	1,162.40	$867,035
Extensive Residential Supports Therapeutic Leave	T2033	TG	TV	Day	1,162.40	$250,000
Family Counseling - Group - Psychotherapy	90853	U1		15 Minutes	7.19	$134.86

Family Counseling - Group - Psychotherapy-Telehealth	90853	U1	GT	15 Minutes	7.19	$0.00
Family Counseling - Individual (without Client)	90846			15 Minutes	21.55	$9,955.84
Family Counseling - Individual (without Client)-Telehealth	90846	GT		15 Minutes	21.55	$860.43
Family Counseling - Individual with Consumer present	90847			15 Minutes	21.55	$30,621.93
Family Counseling - Individual with Consumer present-Telehealth	90847	GT		15 Minutes	21.55	$5,500.58
Group Home 10 Bed	T1020			Day	59.48	$7,190,001.97
Group Home 11 Bed	T1020			Day	55.58	$0.00
Group Home 12 Bed	T1020			Day	52.33	$0.00
Group Home 6 Bed	T1020			Day	94.25	$0.00
Group Home 7 Bed	T1020			Day	80.60	$0.00
Group Home 8 Bed	T1020			Day	70.53	$0.00
Group Home 9 Bed	T1020			Day	64.35	$0.00
Group Home Alternative Living Home 4 Bed	T1020			Day	379.60	$0.00
Group Home Community Living 10 bed	T1020			Day	156.98	$0.00
Group Home Community Living 11 bed	T1020			Day	142.68	$0.00
Group Home Community Living 12 bed	T1020			Day	141.05	$0.00
Group Home Community Living 6 Bed	T1020			Day	216.78	$0.00
Group Home Community Living 7 bed	T1020			Day	185.90	$0.00
Group Home Community Living 8 bed	T1020			Day	179.73	$0.00

Group Home Community Living 9 bed	T1020			Day	159.58	$0.00
Hearing Aid Check; Binaural	92593			Each	54.43	$688.72
HEARING AID CHECK; MONAURAL	92592			Each	54.41	$71.23
HEARING AID EXAMINATION AND SELECTION; MONAURAL	92590			Each	60.31	$0.00
Homemaker	S5130			15 Minutes	5.00	$138,550.89
Homemaker-Respite	S5150			15 Minutes	5.00	$269,421.27
Homemaker-Respite-EVV	S5150	32		15 Minutes	5.00	$18,735.27
Homemaker-State Fund	S5130	SE		15 Minutes	5.00	$0.00
HTS - Habilitation Training Specialist	T2017			15 Minutes	5.26	$23,394,431.99
HTS - Habilitation Training Specialist - EVV	T2017	32		15 Minutes	5.26	$4,318,199.74
HTS - Habilitation Training Specialist - state funded	T2017	SE		15 Minutes	5.26	$0.00
HTS - Habilitation Training Specialist-Telehealth	T2017	GT		15 Minutes	5.26	$0.00
HTS - No Supervising Agency - Independent	T2017	U1		15 Minutes	2.38	$0.00
Individual Placement in Community-Based, Pre-Vocational	T2015	U4		Hour	21.05	$445,950.90
Individual Placement in Community-Based, Pre-Vocational - Telehealth	T2015	U4	GT	Hour	21.05	$0.00
Individual Placement in Community-Based, Pre-Vocational, state funded	T2015	U4	SE	Hour	21.05	$0.00
Individual Placement in Job Coaching, Supported Employment	T2019	U4		15 Minutes	7.81	$493,561.84
Individual Placement in Job Coaching, Supported Employment - Telehealth	T2019	U4	GT	15 Minutes	7.81	$117,091.22
Individual Placement in Job Coaching, Supported Employment, state funded	T2019	U4	SE	15 Minutes	7.81	$0.00

Intensive Personal Supports	T2017	TF		15 Minutes	5.26	$4,240,817.38
Intensive Personal Supports - state funded	T2017	TF	SE	15 Minutes	5.26	$0.00
Job Coaching (Groups of 4-5)	T2019	TF		15 Minutes	4.34	$2,334,788.09
Job Coaching GROUPS of 2-3	T2019	HQ		15 Minutes	4.69	$579,499.00
Job Stabilization/Extended Svc	T2019	U1		15 Minutes	1.80	$55,284.04
Job Stabilization/Extended Svc - Telehealth	T2019	U1	GT	15 Minutes	1.80	$0.00
Nursing - Intermittent Skilled Care	T1001			Visit	65.65	$220,864.51
Nutrition Therapy, Initial Assessment & Intervention	97802	U5		15 Minutes	42.73	$0.00
Nutrition Therapy, Reassessment & Intervention	97803	U5		15 Minutes	36.75	$550,204.70
Nutrition Therapy, Reassessment & Intervention-Telehealth	97803	U5	GT	Each	37.54	$2,591.02
Occupational Therapy	G0152			15 Minutes	26.00	$213,653.36
Occupational Therapy-Telehealth	G0152	GT		15 Minutes	26.00	$442.47
Physical Therapy	G0151			15 Minutes	26.00	$357,692.51
Physical Therapy-Telehealth	G0151	GT		15 Minutes	26.00	$24,156.33
Pre-Voc HTS - Supplemental Supports & TL - state funded	T2015	TG	SE	Hour	16.38	$0.00
Pre-Voc HTS - Supplemental Supports - waiver funded	T2015	TG		Hour	16.38	$535,862.43
Psychological - Cognitive/Behavior Treatment - Group	90853			15 Minutes	13.48	$0.00
Psychological - Cognitive/Behavior Treatment - Group - Telehealth	90853	GT		15 Minutes	13.48	$0.00
Psychological Services - Therapy	H0004			15 Minutes	26.95	$600,903.17

Psychological Services - Therapy - Telehealth	H0004	GT		15 Minutes	26.95	$7,961.47
PSYCHOTHERAPY, 30 MINUTES WITH PATIENT AND/OR FAMILY MEMBER	90832			30 Minutes	65.00	$0.00
PURE TONE AUDIOMETRY (THRESHOLD); AIR AND BONE	92553			Each	42.71	$0.00
PURE TONE AUDIOMETRY (THRESHOLD); AIR ONLY	92552			Each	34.90	$0.00
Remote Supports With Unpaid Staff	T2017	U4		15 Minutes	1.81	$0.00
Remotes Supports With Paid Staff	T2017	U4		15 Minutes	3.28	$0.00
Respite - Close -	S5151			Day	50.00	$12,111.86
Respite - Intermittent -	S5151			Day	23.75	$0.00
Respite - Maximum	S5151			Day	98.80	$0.00
Respite in Agency Companion - Contractor - Close	S5151			Day	154.05	$0.00
Respite in Agency Companion - Contractor - Pervasive	S5151			Day	207.03	$0.00
Respite in Agency Companion - Contractor- Enhanced	S5151			Day	191.75	$0.00
Respite in Agency Companion - Contractor- Enhanced - STATE FUNDED	S5151	SE		Day	191.75	$0.00
Respite in Community Living Group Home - 6 bed setting	S5151			Day	245.38	$0.00
Respite in Community Living Group Home - 7 bed setting	S5151			Day	214.50	$0.00
Respite in Community Living Group Home - 8 bed setting	S5151			Day	208.33	$0.00
Respite in Community Living Group Home - 9 bed setting	S5151			Day	188.18	$0.00
Respite in Community Living Group Home 10 bed setting	S5151			Day	185.58	$0.00
Respite in Community Living Group Home 11 bed setting	S5151			Day	171.28	$0.00

Respite in Community Living Group Home 12 bed setting	S5151			Day	169.65	$0.00
Respite in Group Home - 10 bed setting	S5151			Day	88.08	$0.00
Respite in Group Home - 11 bed setting	S5151			Day	84.18	$0.00
Respite in Group Home - 12 bed setting	S5151			Day	80.93	$0.00
Respite in Group Home - 6 bed setting	S5151			Day	123.38	$0.00
Respite in Group Home - 7 bed setting	S5151			Day	109.20	$0.00
Respite in Group Home - 8 bed setting	S5151			Day	99.13	$0.00
Respite in Group Home - 9 bed setting	S5151			Day	92.95	$0.00
Respite, In Own Home - Close	S9125	TF		Day	35.63	$0.00
Respite, In Own Home - Intermittent	S9125	U1		Day	23.75	$0.00
Respite, In Own Home - Maximum	S9125			Day	71.30	$0.00
Self Directed HTS	T2017	U1	TF	15 Minutes	5.26	$68,195.78
Self-Directed Individual Placement in Job Coaching, Supported Employment	T2019	U4	TF	15 Minutes	7.81	$0.00
Skilled Nursing - Licensed Practical Nurse	G0300			15 Minutes	18.20	$7,397.80
Skilled Nursing - Licensed Practical Nurse-Telehealth	G0300	GT		15 Minutes	18.20	$0.00
Skilled Nursing - Registered Nurse	G0299			15 Minutes	19.50	$38,014.25
Skilled Nursing - Registered Nurse-Telehealth	G0299	GT		15 Minutes	19.50	$0.00
Specialized Family Care Adult - Close	S5140	U1		Day	37.50	$0.00
Specialized Family Care Adult - Maximum	S5140			Day	70.20	$519,552.69

Specialized Family Care Child - Close	S5145	U1		Day	37.50	$0.00
Specialized Family Care Child - Maximum	S5145			Day	70.20	$160,694.24
SPEECH AUDIOMETRY THRESHOLD	92555			Each	26.73	$0.00
SPEECH AUDIOMETRY THRESHOLD; WITH SPEECH RECOGNITION	92556			Each	42.34	$0.00
Speech/Language Services	G0153			15 Minutes	24.43	$189,582.22
Speech/Language Services-Telehealth	G0153	GT		15 Minutes	24.43	$21,140.50
Transportation - Adapted	A0130			Mile	1.69	$287,588.59
Use of vertical electrodes (list separately in addition to code for primary procedure)	92547			Each	10.79	$0.00
Value-Based Incentive Quality Payment	T2025	UK		Each	625.00	$0.00
Vehicle Modification Assessment	T2024			Each	26.00	$0.00
VISUAL REINFORCEMENT AUDIOMETRY (VRA)	92579			Each	54.28	$0.00

6. **BUDGET ESTIMATE.**
   In SFY2023, the total increase will be $62,922,148 with a state share of $16,089,193. In SFY2024, the total increase will be $83,896,197, with a state share of $27,182,368.
   OHS attests it has adequate funding to pay the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The rate increase will have a positive impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   Oklahoma Human Services requests the proposed 25% rate increase be approved as presented.

9. **EFFECTIVE DATE OF CHANGE.**
   October 1, 2022, contingent upon CMS approval.

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SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 22, 2022
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	IT Consulting Services
Purpose and Scope	IT Consulting Services shall provide information technology consulting services as authorized on a project request basis. Contractor provides information technology subject matter experts, project management services, and provides support to OHCA on information technology procurements.
Mandate	Not Applicable
Procurement Method	GSA
Award	N/A
External Approvals	N/A
Incumbent Contractor	NTT Data State Health Consulting, LLC
New Contract Term	July 1, 2022 through June 30, 2023

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$4,000,000.00
90% Federal Match	$3,600,00.00
State Share will be paid by OKHCA	$400,000.00

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure the IT Consulting Services described above for a one year, not-to-exceed $4,000,000.00.

Additional Information

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

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SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 22, 2022
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Clinical Pharmacy Services Software
Purpose and Scope	OHCA is seeking a Sole Source Contract Renewal with Arine, Inc. for the following: Clinical pharmacy services software product that incorporates the following: • Analyzes all OHCA Pharmaceutical required data sources including medical claims, pharmacy claims, unique Medicaid formulary structure, OHCA care management programs and behavioral data for medication therapy management; • Incorporates key behavioral data points, including social determinants; • Allows manually entered claims data outside of a data download; • Provides an all-in-one solution to perform provider-level detailing and guidance on an individual patient level, allowing for both provider interventions and patient interventions; • Allows OHCA to determine which interventions are most effective by measuring the financial and clinical impact of each intervention, with direct Return on Investment (ROI); and • Continuously adjusts to OHCA-specific guidance and programs (such as formulary modifications, HMP programs, SoonerRide and other unique benefits) in the software algorithms in a matter of weeks. <u>Services are increased as follows:</u> • Medication Therapy Management (MTM) reviews to 9000 MTM Members ($450,000.00) • Comprehensive Medical Review is increased to 4000 initial calls and/or in-person visits ($300,000.00) • Follow-up Care is increased to 8000 follow-up calls and/or in-person visits ($200,000.00) • 1,000 Transition of Care calls and/or in-person visits ($125,000) • 1,000 Targeting Provider education and coordination of prescribing ($125,000)
Mandate	Not applicable
Procurement Method	Sole Source
Award	Single Contractor: Arine, Inc.
Contract Term	Contract Renewal Option Two effective date July 1, 2022 through June 30, 2023 with three (3) remaining options to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$4,900,000.00
50% Federal Match Costs within the Total Contract Not-to-Exceed; 50% State Match	$2,450,000.00

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure services described above for four additional years with a total not-to-exceed of $4,900,000.00.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 22, 2022

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

BACKGROUND

Services	Consultant Services
Purpose and Scope	OHCA is requesting an increase to awarded RFP. The awarded contract is currently with four contractors to provide consulting services on various policy, contracting, audit and rate-setting issues. The OHCA looks to these contractors to provide expert opinions, recommendations, and information relevant to the SoonerCare program. The contractor performs comprehensive analysis, feasibility, determination of budget impact, and evaluation of current and potential OHCA initiatives and programs. The current environment requires more data-driven decision making and independent evaluation of performance and costs, therefore resulting in a greater need for these services. • Analyze impact of policy changes on cost, access, and quality of services • Develop state plan amendments or waivers as needed • Evaluate OHCA programs and recommend improvements • Provide financial services including budget neutrality calculations, actuarial certifications, cost impacts, program feasibility, return on investment, long-term financial management, and rate setting for new or existing services • Assess data vulnerability and provide gap analysis of available data versus needed data • Evaluation of SoonerCare Health Management Program and Chronic Care Unit, SoonerCare Waiver, SoonerCare Choice Reform, and SPARK! • Provide reports and presentations as necessary on the above issues
Mandate	N/A
Procurement Method	RFP
Award	Four Awarded Contractors
Contract Term	Initial Contract effective date September 1, 2019, through June 30, 2026.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$12,000,000
50% Federal Match Costs within the Total Contract Not-to-Exceed; 50% State Match	$6,000,000.

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure the Consulting services described above, for an additional four years not-to-exceed $12,000.000.

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

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 22, 2022
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	**Third Party Liability Services**
Purpose and Scope	Oklahoma Health Care Authority is seeking to extend current contract for ninety (90) days with Health Management Systems for the services to perform Medicaid Third Party Liability (TPL) revenue collection services in accordance with 42 CRF 433.135 et. seq. Pending RFP. The Vendor is assisting OHCA in achieving the following goals: * Maximize revenues to OHCA; * Cost avoid claims before payments are generated; *Lessen the accounting and collection work required of OHCA; * Reduce call volume to onsite TPL staff
Mandate	The Medicaid TPL Program is providing revenue to Oklahoma.
Procurement Method	Amendment
Award	N/A
External Approvals	N/A
Incumbent Contractor Name & Contract Term	Health Management Systems 07/01/2015 through 6/30/2022
Contract Term	July 1, 2022 through October 31,2022

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	**$1,125,000.00**
50% Federal Match Costs within the Total Contract Not-to-Exceed; 50% State Match	**$562,500.00**

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure the Third-Party Liability Services described above for a ninety (90) day extension for a total agreement period not-to-exceed amount of $1,125,000.00.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

OHCA FINAL LEGISLATIVE UPDATE 2022

In 2022, 2332 bills were newly filed this year, and 2531 bills were carried over from last year. In the 2022 session, 402 bills were signed, and 35 bills were vetoed.

The 58th legislative regular session resulted in 5,846 bills filed, and 1,121 bills signed into law as of Sine Die on May 27, 2022.

OHCA BILLS.

SB 1337 was signed into law. SB 1337 codifies the system design for a transformed Medicaid program, which prioritizes access and quality health outcomes for SoonerCare members and creates preferential scoring opportunities for Oklahoma provider led entities to partner with OHCA as contracted entities under this new model. Under the law, contracted entities can include accountable care organizations, provider-led entities, commercial plans and/or dental benefit managers; EMERGENCY.

SB 1467 – Requires the Health Care Authority to conduct an annual review of all medications and forms of treatment for sickle cell disease to determine if such treatments are adequately covered by Medicaid, with a report to the House and Senate.

SB 1369 – Creates the Office of the State Coordinator for Health Information Exchange within the Health Care Authority and requires health care entities to report data to said office; EMERGENCY.

SB 1396 – Makes several adjustments to the supplemental hospital offset payment program and the Health Care Authority's regulations regarding SHOPP; EMERGENCY.

SB 1661 – Establishes standards for nonstate government owned medical facilities within the Medicaid supplement program; EMERGENCY.

OKLAHOMA
Health Care Authority

SB 1323 – Allows self-funded and self-insured health care plans which are recognized by the Insurance Dept. and meet certain standards to qualify under the Medicaid Premium Assistance Program.

HB 2322 – Provides updates to Medicaid coverage to bring it in-line with the Ensuring Access to Medicaid Act; EMERGENCY.

Bills of note related to the health cabinet:

SB 709 – Provides that the State Commissioner of Health serves at the pleasure of the Governor and is exempt from certain qualifications so long as they hold at least a master's degree and certain related experience; EMERGENCY.

SB 1134 – Repeals certain provisions limiting applications for Home and Community Based Medicaid Waiver Services to persons residing in Oklahoma for five-years or more; EMERGENCY.

BUDGET UPDATE:

The FY23 budget agreement, **SB 1040,** and appropriations summary are attached.

The total FY22 appropriation was $8,831,025,743. The total FY23 appropriation is $9,689,883,993; a 9.7% increase.

OHCA's FY23 appropriations is $1,262,741,642; a 5.73% increase.

OHCA's budget limits bill was **SB 1074** and contained the following directives–

- $24,400,658.00 shall be used to replace funding no longer available due to the reduction of federal matching dollars.
- $53,079,162.00 shall be used for the maintenance of programs including but not limited to program growth.
- 3,027,977.00 shall be used for program enhancements.
    - Increased rates for dental services
    - Contractor for therapy prior authorization services
- Implement enhanced payment for certain intermediate care facilities for individuals with intellectual disabilities;

    - Stating purpose and specifying that payment is additional to other reimbursement;
    - Develop qualification criteria and determine payment methodology; requiring OHCA to seek necessary federal approval;
    - Providing for promulgation of rules.
- Authorizing the exemption of unanticipated federal funds from expenditure and budgetary limitations.

OTHER MATTERS OF INTEREST

The Senate and House of Representatives called a second special session on May 18, 2022 for the following purposes:

Expenditure of federal funds pursuant to the American Rescue Plan Act of 2021;

Expenditure of federal funds pursuant to the Infrastructure Investment and Jobs Act;

Matters related to the provisions of the LEAD Act as contained in Enrolled House Bill No. 4455 of the 2nd Session of the 58th Oklahoma Legislature;

Matters related to critical statewide economic development.

The Governor has called a third special session that began Monday, June 13, 2022, solely for the following purposes:

To abolish, reduce, or phase out the state's grocery tax.

To reduce the state personal income tax.

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Appropriations Summary FY'23

5-16-22

	GA Bill FY'22	GA Bill FY'23	Change From Original
Department of Education	$3,164,386,184	$3,181,359,518	0.54%
Regents for Higher Education	$812,819,822	$873,405,811	7.45%
Department of Career & Technology Education	$138,852,412	$142,252,412	2.45%
Oklahoma Center for Adv. Of Science & Technology	$15,296,542	$16,846,542	10.13%
Commissioner of the Land Office	$8,379,276	$6,703,421	-20.00%
Oklahoma School of Science and Math	$6,811,373	$6,516,373	-4.33%
Department of Libraries	$4,346,315	$4,536,315	4.37%
Physician Manpower Training Commission	$6,946,877	$7,236,329	4.17%
State Arts Council	$3,004,205	$3,243,030	7.95%
Oklahoma Educational Television Authority	$3,204,004	$2,879,004	-10.14%
Office of Educational Quality & Accountability	$1,567,209	$1,567,209	0.00%
Board of Private Vocational Scools	$0	$250,000	
OK Teacher's Retirement System	$0	$401,906,190	
TOTAL EDUCATION	$4,165,614,219	$4,648,702,154	11.60%

Department of Transportation	$761,893,663	$783,878,499	2.89%
Oklahoma Tax Commission	$43,844,417	$39,924,417	-8.94%
Office of Management and Enterprise Services	$102,781,593	$147,000,780	43.02%
Legislative Service Bureau	$22,057,008	$30,557,008	38.54%
House of Representatives	$19,183,536	$22,786,198	18.78%
Oklahoma Military Department	$18,911,582	$18,911,582	0.00%
Senate	$11,067,919	$12,780,075	15.47%
State Election Board	$8,617,548	$9,866,548	14.49%
State Auditor and Inspector	$4,300,315	$4,480,315	4.19%
Oklahoma State Treasurer	$3,079,823	$3,079,823	0.00%
Governor	$3,557,940	$3,557,940	0.00%
Aeronautics Commission	$2,000,000	$4,000,000	100.00%
State Ethics Commission	$687,957	$687,957	0.00%
Dep't. of Emergency Management and Homeland Security	$2,476,801	$1,476,801	-40.37%
Lt. Governor	$564,665	$714,665	26.56%
Merit Protection Commission	$383,934	$222,824	-41.96%
Space Industry Development Authority	$400,000	$500,000	25.00%
TOTAL GG&T	$1,005,808,701	$1,084,425,432	7.82%

Oklahoma Health Care Authority	$1,194,337,303	$1,262,741,642	5.73%
Department of Mental Health & Substance Abuse	$321,489,597	$340,077,785	5.78%
Department of Health	$59,337,964	$61,837,964	4.21%
University Hospitals Authority	$86,591,554	$123,566,437	42.70%
Department of Veteran Affairs	$34,316,393	$40,905,247	19.20%
OSU Medical Authority	$60,477,141	$77,348,189	27.90%
J.D. McCarty Center	$4,750,818	$4,755,543	0.10%
TOTAL HEALTH	$1,761,300,769	$1,911,232,806	8.51%

Department of Human Services	$717,585,502	$753,682,964	5.03%
Office of Juvenile Affairs	$94,544,715	$101,626,837	7.49%
Department of Rehabilitative Services	$34,875,002	$35,623,295	2.15%
Commission on Children and Youth	$2,509,414	$2,509,414	0.00%
Office of Disability Concerns	$307,095	$327,095	6.51%
TOTAL HUMAN SERVICES	$849,821,728	$893,769,605	5.17%

Appropriations Summary FY'23

5-16-22

	GA Bill FY'22	GA Bill FY'23	Change from Original
Department of Agriculture	$31,527,896	$45,560,748	44.51%
Department of Commerce	$22,077,680	$24,729,323	12.01%
REAP	$15,475,000	$30,000,000	93.86%
Department of Tourism and Recreation	$23,461,601	$23,988,776	2.25%
Historical Society	$13,192,324	$13,966,665	5.87%
Oklahoma Corporation Commission	$16,876,719	$16,964,255	0.52%
Conservation Commission	$13,726,001	$20,162,988	46.90%
Department of Environmental Quality	$9,027,346	$20,322,643	125.12%
Oklahoma Water Resources Board	$7,205,323	$8,445,323	17.21%
Department of Labor	$3,578,213	$3,578,213	0.00%
Department of Mines	$769,933	$769,933	0.00%
J.M. Davis Memorial Commission	$330,000	$540,000	63.64%
TOTAL NRR	$157,248,036	$209,028,867	32.93%

Department of Corrections	$544,278,904	$552,082,900	1.43%
Department of Public Safety	$102,827,246	$106,445,126	3.52%
District Courts	$68,241,076	$76,911,733	12.71%
District Attorneys and District Attorneys Council	$58,779,782	$70,779,782	20.42%
Supreme Court	$16,223,855	$16,572,582	2.15%
Oklahoma Indigent Defense System	$20,537,878	$24,731,713	20.42%
Oklahoma State Bureau of Investigation	$19,266,849	$27,442,374	42.43%
Office of the Chief Medical Examiner	$19,162,057	$15,206,144	-20.64%
Attorney General	$26,057,968	$32,798,510	25.87%
Oklahoma Bureau of Narcotics and Dangerous Drugs	$3,145,330	$3,145,330	0.00%
Court of Criminal Appeals	$4,022,707	$4,100,297	1.93%
Council on Law Enforcement Education and Training	$3,661,579	$7,321,579	99.96%
Alcoholic Beverage Laws Enforcement Commission	$2,753,659	$2,753,659	0.00%
Pardon and Parole Board	$2,273,400	$2,433,400	7.04%
TOTAL PS&J	$891,232,291	$942,725,130	5.78%

Total FY'22 Appropriation vs. Total FY'23 Appropriation	$8,831,025,743	$9,689,883,993	9.7%

* Appropriations do not include supplementals

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – April 13, 2022 and June 8, 2022

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Elepsia™ XR Eprontia™	• Seizures	• $1,985 per month • $677 per month	• Cheaper generic treatments available
2	Winlevi®	• Acne	• $550 per package	• Cheaper generic treatments available
3	Dojolvi®	• Long Chain Fatty Acid Oxidation Disorders	• $4,875 per package	• Rare disease; cheaper treatments available
4	Qulipta™	• Migraine Headaches	• $991 per 30 days	• Preventative treatment
5	Erwinase® Erwinaze® Oncaspar® Rylaze™ Scemblix®	• Leukemia	• N/A • $20,154 per dose • $44,485 per dose • $21,950 per dose • $17,900 - $89,500 per month	• Used in patient hypersensitive to asparaginase • Used in patient hypersensitive to asparaginase • Used in patient hypersensitive to asparaginase • Used in patient hypersensitive to asparaginase • Not first line
6	Zynlonta®	• Lymphoma	• $23,770 every 3 weeks	• Not first line
7	Voxzogo™	• Achondroplasia	• $323,640 per year •	• Pediatrics still growing
8	Releuko™	• Neutropenia post chemotherapy	• $228 per dose	• Cheaper options available

9	Lampit®	• Chagas Disease	• $540 per treatment	• Tropical disease
10	Brexafemme®	• Antifungal	• 475 per treatment	• Cheaper options available
11	Ponvory™	• Multiple Sclerosis	• $102,240 per year	• Cheaper option available
12	Nexviazyme®	• Pompe Disease	• $20,578 per month	• Rare disease
13	Kerendia® Rezvoglar™ Semglee®	• Diabetes Mellitus	• $6,541 per year • N/A • $269.40 per vial	• Not a treatment for DM but reduces risk of kidney decline & CV outcome in DM patients • Insulin • Insulin
14	Exkivity® Lumakras™ Rybrevant®	• Lung Cancer	• $25,000 per 30 days • $18,436 per 30 days • 25,181 per month	• Not first line • Not first line • Not first line

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

Consideration and Vote Regarding Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.3 To Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e):

a) Elepsia™ XR [Levetiracetam Extended-Release (ER) Tablet] and Eprontia™ (Topiramate Oral Solution)
b) Winlevi® (Clascoterone 1% Cream)
c) Dojolvi® (Triheptanoin)
d) Qulipta™ (Atogepant)
e) Erwinase® (Crisantaspase), Erwinaze® (Asparaginase Erwinia Chrysanthemi), Oncaspar® (Pegaspargase), Rylaze™ [Asparaginase Erwinia Chrysanthemi (Recombinant)-rywn], and Scemblix® (Asciminib)
f) Zynlonta® (Loncastuximab Tesirine-lply)
g) Voxzogo™ (Vosoritide)
h) Releuko™ (Filgrastim-ayow)
i) Lampit® (Nifurtimox)
j) Brexafemme® (Ibrexafungerp)
k) Ponvory™ (Ponesimod)
l) Nexviazyme® (Avalglucosidase Alfa-ngpt)
m) Kerendia® (Finerenone), Rezvoglar™ (Insulin Glargine-aglr), and Semglee® (Insulin Glargine-yfgn)
n) Exkivity® (Mobocertinib), Lumakras™ (Sotorasib), and Rybrevant® (Amivantamab-vmjw)

For the packet:

Recommendation 1: Vote to Prior Authorize Elepsia™ XR and Eprontia™

The Drug Utilization Review Board recommends the prior authorization of Elepsia™ XR [Levetiracetam Extended-Release (ER) Tablet] and Eprontia™ (Topiramate Oral Solution) with the following criteria:

Elepsia™ XR [Levetiracetam Extended-Release (ER) Tablet] Approval Criteria:

1. An FDA approved diagnosis of partial-onset seizures; and
2. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use generic formulations of levetiracetam ER must be provided; and
3. A quantity limit of 60 tablets per 30 days will apply.

Eprontia™ (Topiramate Oral Solution) Approval Criteria:

1. An FDA approved indication of 1 of the following:
   a. Partial-onset or primary generalized tonic-clonic (PGTC) seizures; or
   b. Adjunctive therapy in seizures associated with Lennox-Gastaut syndrome (LGS); or
   c. Prophylaxis of migraine headaches; and
2. A patient-specific, clinically significant reason why the member cannot use topiramate tablets and sprinkle capsules must be provided; and
3. An age restriction of 11 years of age and younger will apply. Members older than 11 years of age will require a patient-specific, clinically significant reason why a special formulation product is needed; and
4. A quantity limit of 473mL per 29 days will apply.

Recommendation 2: Vote to Prior Authorize Winlevi®

The Drug Utilization Review Board recommends the prior authorization of Winlevi® (Clascoterone 1% Cream) with the following criteria:

Winlevi® (Clascoterone 1% Cream) Approval Criteria:

1. An FDA approved indication of acne vulgaris; and
2. Member must be 12 to 20 years of age; and
3. A patient-specific, clinically significant reason why the member cannot use erythromycin 2% topical solution, clindamycin 1% topical solution, benzoyl peroxide, preferred tazarotene formulations, oral isotretinoin medications, and other generically available preferred oral or topical antibiotic products must be provided; and
4. A quantity limit of 60 grams per 30 days will apply.

Recommendation 3: Vote to Prior Authorize Dojolvi®

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

Dojolvi® (Triheptanoin) Approval Criteria:

1. An FDA approved diagnosis of molecularly confirmed long-chain fatty acid oxidation disorder (LC-FAOD); and
2. Molecular testing confirms 1 of the following types of LC-FAOD:
   a. Carnitine-acylcarnitine translocase (CACT) deficiency; or
   b. Carnitine palmitoyltransferase I (CPT I) deficiency; or
   c. Carnitine palmitoyltransferase II (CPT II) deficiency; or
   d. Long-chain 3-hydroxyacyl-CoA dehydrogenase (LCHAD) deficiency; or
   e. Trifunctional protein (TFP) deficiency; or
   f. Very long-chain acyl-CoA dehydrogenase (VLCAD) deficiency; and
3. Prescriber must verify member has a history of at least 1 significant or recurrent manifestation of LC-FAOD (e.g., cardiomyopathy, rhabdomyolysis, hypoglycemia); and

4. Member must have tried and failed dietary management with an alternate medium chain triglyceride (MCT) product (e.g., MCT oil) or a patient-specific, clinically significant reason why dietary management with an alternate MCT product is not appropriate for the member must be provided; and
5. Dojolvi® will not be approved for concomitant use with another MCT product (other MCT products must be discontinued prior to the first dose of Dojolvi®); and
6. Member must not be taking a pancreatic lipase inhibitor concomitantly with Dojolvi®; and
7. Prescriber must verify the member does not have pancreatic insufficiency; and
8. Prescriber must verify that member or member's caregiver has been counseled on the proper storage, preparation, and administration of Dojolvi®, including specific considerations for use in a feeding tube, if applicable; and
9. Dojolvi® must be prescribed by a geneticist or other specialist with expertise in the treatment of LC-FAOD; and
10. Prescriber must verify the member is under the care of a clinical specialist knowledgeable in appropriate disease-related dietary management based on member's specific LC-FAOD and current nutritional recommendations; and
11. The member's daily caloric intake (DCI) must be provided (in kcal) on the prior authorization request to verify appropriate dosing based on package labeling; and
12. Initial approvals will be for the duration of 3 months. After 3 months of treatment, compliance will be required, and the prescriber must verify the member has had a positive response to and is tolerating treatment with Dojolvi®. Additionally, for members who switched from another MCT product due to adverse effects, the prescriber must verify the member has experienced fewer adverse effects with Dojolvi®; and
13. Quantity limits according to package labeling will apply, with the maximum approvable dosing regimen based on a target daily dosage of Dojolvi® up to 35% of the member's total DCI.

Recommendation 4: Vote to Prior Authorize Qulipta™

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

Qulipta™ (Atogepant) Approval Criteria:

1. An FDA approved indication for the preventive treatment of migraine in adults; and
2. Member must be 18 years of age or older; and
3. Member has documented episodic migraine headaches

   a. Episodic migraine: 4 to 14 migraine days per month on average for the past 3 months and must have had a history of migraines for a duration of 12 months or longer; and
4. Non-migraine medical conditions known to cause headache have been ruled out and/or have been treated. This includes, but is not limited to:
   a. Increased intracranial pressure (e.g., tumor, pseudotumor cerebri, central venous thrombosis); or
   b. Decreased intracranial pressure (e.g., post-lumbar puncture headache, dural tear after trauma); and
5. Migraine headache exacerbation secondary to other medication therapies or conditions have been ruled out and/or treated. This includes, but is not limited to:
   a. Hormone replacement therapy or hormone-based contraceptives; and
   b. Chronic insomnia; and
   c. Obstructive sleep apnea; and
6. The member has failed medical migraine preventive therapy with at least 3 agents with different mechanisms of action. Trials must be at least 8 weeks in duration (or documented adverse effects) within the last 365 days. This includes, but is not limited to:
   a. Select antihypertensive therapy (e.g., beta-blocker therapy); or
   b. Select anticonvulsant therapy; or
   c. Select antidepressant therapy [e.g., tricyclic antidepressants (TCA), serotonin and norepinephrine reuptake inhibitors (SNRI)]; and
7. Member is not frequently taking medications that are known to cause medication overuse headaches (MOH or rebound headaches) in the absence of intractable conditions known to cause chronic pain. MOH are a frequent cause of chronic headaches. A list of prescription or non-prescription medications known to cause MOH includes, but is not limited to:
   a. Decongestants (alone or in combination products) (≥10 days/month for >3 months); and
   b. Combination analgesics containing caffeine and/or butalbital (≥10 days/month for >3 months); and
   c. Opioids (≥10 days/month for >3 months); and
   d. Analgesic medications including acetaminophen or non-steroidal anti-inflammatory drugs (NSAIDs) (≥15 days/month for >3 months); and
   e. Ergotamine-containing medications (≥10 days/month for >3 months); and
   f. Triptans (≥10 days/month for >3 months); and
8. Member is not taking any medications that are likely to be the cause of the headaches; and
9. Member must have been evaluated within the last 6 months by a neurologist for migraine headaches and the requested medication (e.g.,

Qulipta™) recommended as treatment (not necessarily prescribed by a neurologist); and
10. Member will not use requested medication concurrently with botulinum toxin for the prevention of migraine or with an alternative calcitonin gene-related peptide (CGRP) inhibitor; and
11. Other aggravating factors that are contributing to the development of episodic/chronic migraine headaches are being treated when applicable (e.g., smoking); and
12. A patient-specific, clinically significant reason why member cannot use Ajovy® (fremanezumab-vfrm) or Emgality® (galcanezumab-gnlm) must be provided,and
13. Initial approvals will be for the duration of 3 months. Compliance and information regarding efficacy, such as a reduction in monthly migraine days, will be required for continued approval. Continuation approvals will be granted for the duration of 1 year; and
14. Quantity limits will apply 30 tablets per 30 days will apply.

Recommendation 5: Vote to Prior Authorize Erwinase®, Erwinaze®, Oncaspar® (Pegaspargase), Rylaze™, and Scemblix®

The Drug Utilization Review Board recommends the prior authorization of Erwinase® (Crisantaspase), Erwinaze® (Asparaginase Erwinia Chrysanthemi), Oncaspar® (Pegaspargase), Rylaze™ [Asparaginase Erwinia Chrysanthemi (Recombinant)-rywn], and Scemblix® (Asciminib) with the following criteria:

Erwinase® (Crisantaspase), Erwinaze® (Asparaginase *Erwinia Chrysanthemi*), and Rylaze™ [Asparaginase *Erwinia Chrysanthemi* (Recombinant)-rywn] Approval Criteria [Acute Lymphoblastic Leukemia (ALL) or Lymphoblastic Lymphoma Diagnosis]:

1. Diagnosis of ALL or lymphoblastic lymphoma; and
2. Used as a component of multi-agent chemotherapy; and
3. Member has a documented hypersensitivity to Escherichia coli-derived asparaginase.

Scemblix® (Asciminib) Approval Criteria [Chronic Myeloid Leukemia (CML) Diagnosis]:

1. Diagnosis of Philadelphia chromosome-positive (Ph+) CML in chronic phase; and
    a. Previously treated with ≥2 tyrosine kinase inhibitors (TKIs); or
    b. Frontline or subsequent therapy in members with the T315I mutation.

Oncaspar® (Pegaspargase) Approval Criteria [Acute Lymphoblastic Leukemia (ALL) Diagnosis]:

1. Diagnosis of ALL; and
2. Used as first line therapy; or
3. May be used to treat members with a hypersensitivity to native forms of L-asparaginase; or
4. Used as systemic central nervous system (CNS)-directed therapy; or
5. Used in relapsed/refractory disease; and
    a. Philadelphia chromosome negative (Ph-); or
    b. Philadelphia chromosome positive (Ph+); and i. Refractory to tyrosine kinase inhibitor (TKI) therapy or used in conjunction with a TKI (if not previously used).

Oncaspar® (Pegaspargase) Approval Criteria [Extranodal NK/T-Cell Lymphoma Diagnosis]:

1. Diagnosis of NK/T-Cell lymphoma; and
2. Member has nasal disease; and
    a. Used as induction therapy; or
    b. Used as additional therapy in members with a positive biopsy following a partial or no response to induction therapy.

Recommendation 6: Vote to Prior Authorize Zynlonta®

The Drug Utilization Review Board recommends the prior authorization of Zynlonta® (Loncastuximab Tesirine-lply) with the following criteria:

Zynlonta® (Loncastuximab Tesirine-lpyl) Approval Criteria [Lymphoma Diagnosis]:

1. Diagnosis of diffuse large B-cell lymphoma (DLBCL) not otherwise specified, or DLBCL arising from low grade lymphoma, or high-grade B-cell lymphoma; and
2. Relapsed or refractory disease after 2 or more lines of systemic therapy; and
3. If previous CD19-directed therapy was used, patient must have a biopsy that shows CD19 protein expression after completion of the CD19-directed therapy; and
4. A patient-specific, clinically significant reason why tafasitamab in combination with lenalidomide is not appropriate for the member must be provided.

Recommendation 7: Vote to Prior Authorize Voxzogo™

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

Voxzogo™ (Vosoritide) Approval Criteria:

1. Member must have an FDA approved diagnosis of achondroplasia; and
    a. Diagnosis must be confirmed by genetic testing identifying a pathogenic mutation in the *FGFR3* gene; and
2. Member must be 5 years of age or older; and
3. Prescriber must verify member has open epiphyses; and
4. The member's baseline height and growth velocity (GV) must be provided; and
5. Voxzogo™ must be prescribed by a geneticist, endocrinologist, or other specialist with expertise in the treatment of achondroplasia (or an advanced care practitioner with a supervising physician who is a geneticist, endocrinologist, or other specialist with expertise in the treatment of achondroplasia); and
6. Member's recent weight (taken within the past 3 weeks) must be provided in order to ensure appropriate dosing in accordance with the Voxzogo™ *Prescribing Information*; and
7. Prescriber must verify the member or member's caregiver has been counseled on proper administration and storage of Voxzogo™, including the need for adequate food and fluid intake prior to each dose; and
8. A quantity limit of 30 vials per 30 days will apply; and
9. Initial and subsequent approvals will be for the duration of 6 months. For additional approval consideration:
    a. Member's current height must be provided and must demonstrate an improvement in GV from baseline; and
    b. Member's recent weight must be provided and dosing must be appropriate; and
    c. Member should be compliant; and
    d. Prescriber must verify member still has open epiphyses; and
10. Voxzogo™ will not be approved following epiphyseal closure.

Recommendation 8: Vote to Prior Authorize Releuko™

The Drug Utilization Review Board recommends the prior authorization of Releuko™ (Filgrastim-ayow) with the following criteria:

Releuko™ (Filgrastim-ayow) Approval Criteria:

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

Recommendation 9: Vote to Prior Authorize Lampit®

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

Lampit® (Nifurtimox) Approval Criteria:

1. An FDA approved diagnosis of Chagas disease (American trypanosomiasis) caused by *Trypanosoma cruzi*; and
2. Member must be younger than 18 years of age and weigh ≥2.5kg; and
3. Lampit® must be prescribed by, or in consultation with, an infectious disease specialist; and
4. Prescriber must agree to counsel the member on the contraindication and potential drug interaction that may occur with concomitant use of Lampit® with alcohol, if applicable, based on the Lampit® *Prescribing Information*; and
5. Female members of reproductive potential must not be pregnant and must have a negative pregnancy test prior to initiating treatment with Lampit®; and
6. Female members of reproductive potential must be willing to use effective contraception during treatment with Lampit® and for 6 months after the last dose; and
7. Male members with female partners of reproductive potential must be willing to use condoms for contraception during treatment with Lampit® and for 3 months after the last dose; and
8. Prescriber must agree to monitor the member's weight every 14 days and adjust the Lampit® dosage accordingly, as recommended in the Lampit® *Prescribing Information*; 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 30 days. For continuation of therapy after 30 days, an updated weight must be provided in order to authorize the appropriate amount of drug required for the remaining 30 days of treatment. The total approval duration will be for 60 days of treatment; and
11. A quantity limit of 270 tablets per 30 days will apply to the 30mg tablets, and a quantity limit of 225 tablets per 30 days will apply to the 120mg tablets.

Recommendation 10: Vote to Prior Authorize Brexafemme®

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

Brexafemme® (Ibrexafungerp) Approval Criteria:

1. An FDA approved diagnosis of vulvovaginal candidiasis (VVC); and
2. Member must be an adult female or a post-menarchal pediatric female; and
3. Prescriber must verify that female members are not pregnant and are currently using reliable contraception; and
4. Member must not be taking concurrent strong or moderate CYP3A4 inducers (e.g., rifampin, carbamazepine, phenytoin, St. John's wort, long-acting barbiturates, bosentan, efavirenz, etravirine); and

5. Authorization consideration requires a patient-specific, clinically significant reason why oral fluconazole and all topical antifungals (prescription and over-the-counter) FDA approved for the treatment of VVC are not appropriate for the member; and
6. A quantity limit of 4 tablets for a 1-day supply will apply.

Recommendation 11: Vote to Prior Authorize Ponvory™

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

Ponvory® (Ponesimod) Approval Criteria:

1. An FDA approved diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, in adults; and
2. Member must not have any contraindications for use of Ponvory® including:
    a. Myocardial infarction (MI), unstable angina, stroke, transient ischemic attack (TIA), decompensated heart failure (HF) requiring hospitalization, or NYHA Class III/IV HF in the last 6 months; or
    b. Presence of Mobitz type II second-degree, third-degree atrioventricular (AV) block, or sick sinus syndrome, unless member has a functioning pacemaker; and
3. Member must not have received prior treatment with alemtuzumab; and
4. Member must not be concurrently using strong CYP3A4 and UGT1A1 inducers (e.g., rifampin, phenytoin, carbamazepine); and
5. Verification from the prescriber that the member has no active infection(s); and
6. Complete blood counts (CBC) and verification that levels are acceptable to the prescriber; and
7. Verification from the prescriber that the member has undergone an electrocardiogram (ECG) to determine whether preexisting conduction abnormalities are present before initiating Ponvory®; and
8. Liver function tests (LFTs) and verification that levels are acceptable to the prescriber; and
9. Verification from the prescriber that the member's blood pressure will be monitored during treatment with Ponvory®; and
10. Verification from the prescriber that the member has undergone an ophthalmic evaluation prior to starting therapy with Ponvory® and the member will be monitored for changes in vision throughout therapy; and
11. Verification from the prescriber that the member has been assessed for medications and conditions that cause reduction in heart rate or AV conduction delays and the member will be followed with appropriate monitoring per package labeling; and

12. Verification from the prescriber that the member has a previous confirmed history of chickenpox or vaccination against varicella. Members without a history of chickenpox or varicella vaccination should receive a full course of the varicella vaccine prior to commencing treatment with Ponvory®; and
13. Female members of reproductive potential must not be pregnant and must have a negative pregnancy test prior to initiation of therapy; and
14. Female members of reproductive potential must be willing to use effective contraception during treatment with Ponvory® and for at least 1 week after discontinuing treatment; and
15. Member must have had an inadequate response to Gilenya® (fingolimod) or a patient-specific, clinically significant reason why fingolimod is not appropriate for the member must be provided; and
16. Compliance will be checked for continued approval every 6 months; and
17. A quantity limit of 30 tablets per 30 days will apply for the 20mg tablet. A quantity limit of 14 tablets per 14 days will apply for the Ponvory® starter pack.

Recommendation 12: Vote to Prior Authorize Nexviazyme®

The Drug Utilization Review Board recommends the prior authorization of Nexviazyme® (Avalglucosidase Alfa-ngpt) with the following criteria:

Nexviazyme® (Avalglucosidase Alfa-ngpt) Approval Criteria:

1. An FDA approved diagnosis of late-onset (non-infantile) Pompe disease [acid alpha-glucosidase (GAA) deficiency]; and
2. Documentation of diagnosis confirmation of GAA enzyme deficiency through specific genetic laboratory test(s); and
3. Prescriber must document presence of symptoms of Pompe disease; and
4. Nexviazyme® must be prescribed by a geneticist or a physician that specializes in the treatment of Pompe disease and/or inherited genetic disorders; and
5. Member's weight must be provided and have been taken within the last 4 weeks to ensure accurate dosing; and
6. Initial approval will be for the duration of 6 months, at which time compliance and information regarding efficacy, such as improvement or stabilization in forced vital capacity (FVC) and/or 6-minute walk test (6MWT), will be required for continued approval. Subsequent authorizations will be for the duration of 1 year.

Recommendation 13: Vote to Prior Authorize Kerendia®, Rezvoglar™, and Semglee®

The Drug Utilization Review Board recommends the prior authorization of Kerendia® (Finerenone), Rezvoglar™ (Insulin Glargine-aglr), and Semglee® (Insulin Glargine-yfgn) with the following criteria:

Kerendia® (Finerenone) Approval Criteria:

1. An FDA approved indication to reduce the risk of sustained estimated glomerular filtration rate (eGFR) decline, end stage kidney disease, cardiovascular death, non-fatal myocardial infarction, and hospitalization for heart failure in adult members with chronic kidney disease (CKD) associated with type 2 diabetes mellitus (T2DM); and
2. Member must be receiving a maximum tolerated dose of an angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) or have a contraindication to use; and
3. A patient specific, clinically significant reason why the member cannot use a sodium-glucose cotransporter-2 (SGLT-2) inhibitor must be provided; and
4. Member must not be receiving concomitant treatment with strong CYP3A4 inhibitors (e.g., itraconazole, ketoconazole, ritonavir); and
5. Member must not have adrenal insufficiency; and
6. Member must not have severe hepatic impairment (Child Pugh C); and
7. Prescriber must measure serum potassium and eGFR prior to initiation of Kerendia®; and
8. Prescriber must verify serum potassium is not >5.0mEq/L prior to treatment initiation with Kerendia®; and
9. Prescriber must agree to monitor serum potassium levels 4 weeks after a dose adjustment and throughout treatment and adjust the dose accordingly per package labeling; and
10. Initial authorization will be for 4 weeks, after which time serum potassium levels will be required for continued approval; and
11. A quantity limit of 30 tablets per 30 days will apply. The member's eGFR should be provided for initiation of treatment to ensure the correct recommended dose per package labeling. The following initial dose will be approved based on eGFR:
    a. Kerendia® 10mg once daily in members with eGFR 25 to <60mL/min/1.73m^2; or
    b. Kerendia® 20mg once daily in members with eGFR ≥60mL/min/1.73m^2.

Rezvoglar™ (Insulin Glargine-aglr) and Semglee® (Insulin Glargine-yfgn) Approval Criteria:

1. An FDA approved diagnosis of diabetes mellitus; and
2. A patient-specific, clinically significant reason why the member cannot use Lantus® (insulin glargine) or Levemir® (insulin detemir) 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.

Recommendation 14: Vote to Prior Authorize Exkivity®, Lumakras™, and Rybrevant®

The Drug Utilization Review Board recommends the prior authorization of Exkivity® (Mobocertinib), Lumakras™ (Sotorasib), Rybrevant® (Amivantamab-vmjw) with the following criteria:

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

1. Diagnosis of advanced or metastatic NSCLC; and
2. Tumor exhibits epidermal growth factor receptor (EGFR) exon 20 insertion mutations; and
3. Disease has progressed on or after platinum-based chemotherapy; and
4. As a single agent.

Lumakras™ (Sotorasib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of locally advanced or metastatic NSCLC; and
2. Presence of *KRAS G12C* mutation; and
3. Disease has progressed on at least 1 prior systemic therapy; and
4. As a single agent.

Rybrevant® (Amivantamab-vmjw) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of locally advanced or metastatic NSCLC; and
2. Tumor exhibits epidermal growth factor receptor (EGFR) exon 20 insertion mutations; and
3. Disease has progressed on or after platinum-based chemotherapy; and
4. As a single agent.

OKLAHOMA HEALTH CARE AUTHORITY

SFY-2023 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	SFY-2022	SFY-2023	Inc / (Dec)	% Change
Medical Program				
Managed Care - Choice / HAN / PACE	60,853,578	57,081,469	(3,772,109)	-6.2%
Hospitals	1,562,633,274	1,679,903,459	117,270,185	7.5%
Behavioral Health	28,106,530	32,248,019	4,141,489	14.7%
Nursing Homes	674,203,352	659,299,452	(14,903,900)	-2.2%
Physicians	546,643,864	587,630,143	40,986,279	7.5%
Dentists	221,589,927	227,771,928	6,182,000	2.8%
Mid-Level Practitioner	1,398,057	1,762,793	364,737	26.1%
Other Practitioners	65,383,078	73,406,235	8,023,157	12.3%
Home Health	34,533,965	33,656,685	(877,280)	-2.5%
Lab & Radiology	46,020,474	49,377,315	3,356,841	7.3%
Medical Supplies	81,333,531	87,361,516	6,027,985	7.4%
Clinic Services	471,176,263	554,835,522	83,659,259	17.8%
Ambulatory Surgery Center	10,603,211	11,199,132	595,921	5.6%
Prescription Drugs	1,140,274,685	1,352,142,043	211,867,358	18.6%
Miscellaneous	940,878	745,080	(195,798)	-20.8%
ICF/IID	68,060,293	69,481,598	1,421,305	2.1%
Transportation	117,636,075	101,261,858	(16,374,217)	-13.9%
Medicare Buy-in (Part A & B)	225,473,340	247,774,111	22,300,771	9.9%
Medicare clawback payment (Part D)	70,236,151	87,749,292	17,513,141	24.9%
SHOPP - Supplemental Hosp Offset Pymt.	658,156,020	692,461,400	34,305,380	5.2%
Money Follows the Person - Enhanced	211,534	519,680	308,146	145.7%
Health Management Program (HMP)	11,476,928	12,560,024	1,083,096	9.4%
Electronic Health Records Incentive Pymts	450,000	200,000	(250,000)	-55.6%
Non-Title XIX Medical	89,382	89,382	-	0.0%
TOTAL OHCA MEDICAL PROGRAM	6,097,484,390	6,620,518,136	523,033,745	8.6%
Insure Oklahoma - Premium Assistance				
Employer Sponsored Insurance - ESI	44,399,703	44,982,334	582,630	1.3%
Individual Plan - IP	18,150,608	200,000	(17,950,608)	-98.9%
TOTAL INSURE OKLAHOMA PROGRAM	62,550,312	45,182,334	(17,367,978)	-27.8%
OHCA Administration				
Operations	63,384,335	62,241,693	(1,142,642)	-1.8%
Contracts	43,348,506	42,848,420	(500,086)	-1.2%
Insure Oklahoma	1,461,283	1,436,421	(24,862)	-1.7%
Business Enterprises	106,827,255	92,567,252	(14,260,003)	-13.3%
Grant Mgmt	4,534,773	4,666,298	131,525	2.9%
TOTAL OHCA ADMIN	219,556,151	203,760,084	(15,796,067)	-7.2%
TOTAL OHCA PROGRAMS	**6,379,590,853**	**6,869,460,553**	**489,869,701**	**7.7%**
Other State Agency (OSA) Programs				
Department of Human Services (OKDHS)	696,015,270	732,331,041	36,315,770	5.2%
Oklahoma State Dept of Health (OSDH)	7,995,544	7,193,626	(801,918)	-10.0%
The Office of Juvenile Affairs (OJA)	9,401,071	9,540,060	138,989	1.5%
University Hospitals (Medical Education Pymnts)	388,915,399	435,620,424	46,705,025	12.0%
Department of Mental Health (DMHSAS)	556,563,355	586,985,883	30,422,528	5.5%
Department of Education (DOE)	1,928,498	3,040,348	1,111,850	57.7%
Non-Indian Payments	16,589,334	17,614,662	1,025,328	6.2%
Department of Corrections (DOC)	7,513,349	5,911,946	(1,601,403)	-21.3%
JD McCarty	10,689,671	12,540,821	1,851,150	17.3%
OSA Non-Title XIX	119,065,000	119,065,000	-	0.0%
TOTAL OSA PROGRAMS	**1,814,676,490**	**1,929,843,810**	**115,167,320**	**6.3%**
TOTAL MEDICAID PROGRAM	**8,194,267,343**	**8,799,304,363**	**605,037,020**	**7.4%**

OKLAHOMA HEALTH CARE AUTHORITY
SFY-2023 BUDGET WORK PROGRAM
Summary by Program Expenditure

Description	SFY-2022	SFY-2023	Inc / (Dec)	% Change
REVENUES				
Federal - Medicaid Traditional	4,720,528,102	4,670,998,512	(49,529,590)	-1.0%
Federal - Medicaid Expansion	1,305,909,844	1,646,232,360	340,322,517	26.1%
Federal - admin	135,542,976	126,515,492	(9,027,484)	-6.7%
Drug Rebates	495,465,438	543,179,093	47,713,655	9.6%
Medical Refunds	43,009,916	36,249,709	(6,760,207)	-15.7%
NF Quality of Care Fee	91,557,663	90,680,437	(877,225)	-1.0%
OSA Refunds & Reimbursements	412,816,938	531,549,285	118,732,347	28.8%
Tobacco Tax	84,466,644	85,487,776	1,021,132	1.2%
Misc Revenue	649,320	632,412	(16,908)	-2.6%
Prior Year Carryover (Fund 200)	25,562,647	16,198,479	(9,364,168)	-36.6%
Other Grants	546,444	576,478	30,034	5.5%
Hospital Provider Fee (SHOPP bill)	203,865,582	244,655,465	40,789,883	20.0%
Insure Oklahoma Fund 245 - Transfer	5,000,000	-	(5,000,000)	-100.0%
State Appropriated - OHCA	1,030,199,249	1,098,603,586	68,404,337	6.6%
TOTAL REVENUES	**8,555,120,763**	**9,091,559,085**	**536,438,322**	**6.3%**

June Board
Proposed Rules Amendment Summaries

The following work folders were posted on the Oklahoma Health Care Authority (OHCA) public website for a public comment period.

APA WF 22-03 Clinical Trials Routine Services and Dental Out-of-State Services - Proposed rule revisions will strike outdated language and add new language to the formerly named "Clinical Trials" policy OAC 317:30-3-57.1. To comply with new federal guidelines this policy will be renamed "Coverage of routine services in relation to clinical trials" and restructured to address qualifying clinical trials criteria, clinical trials determination standards, routine patient costs, and excluded items. Importantly, new language will be added that states that the Oklahoma Health Care Authority will provide a coverage determination decision for requested and medically necessary routine services within 72-hours for a member participating in a qualifying clinical trial.

Revisions to the out-of-state services policy, at OAC 317:30-3-90, will also add language to assure that clinical trials will be provided in accordance with federal requirements and that clinical trials do not follow all of the out-of-state policy requirements. Final revisions will add a clause regarding the override for prior authorizations that are related to lodging and meals services when they are provided in accordance with an approved clinical trial.

Budget Impact: The proposed rule changes regarding clinical trial routine services are budget neutral. The clinical trials that have taken place to date involved fully contracted SoonerCare providers; providers which are already reimbursed for routine expenses related to clinical trials.

The proposed rule changes, regarding dental out-of-state services, are budget neutral. These services are already being provided.

Proposed Rule Timeline:
60-day Tribal Consultation Period: January 4, 2022 - March 5, 2022
Tribal Consultation: January 4, 2022
Emergency Rule Public Comment Period: April 18, 2022 – May 3, 2022
MAC Meeting: May 12, 2022
Emergency Rule Requested Effective Date: Upon Governor's signature or the 45th day post submission of the rules to the Governor (August 8, 2022)

APA WF 22-07 Tribal Residential Substance Use Disorder (SUD) Policy Updates — The proposed revisions will update policy at Oklahoma Administrative Code 317:30-5-1094 to reflect that I/T/U providers will be reimbursed the outpatient OMB rate for rendered residential SUD services. This policy change aligns with the authority in the Oklahoma Medicaid State Plan and with current business practices.

Budget Impact: Budget neutral

Proposed Rule Timeline:
60-day Tribal Consultation Period: February 15, 2022 – April 16, 2022
Tribal Consultation: March 1, 2022
Emergency Rule Public Comment Period: March 28, 2022 – April 12, 2022
MAC Meeting: May 12, 2022
Emergency Rule Requested Effective Date: Upon Governor's signature or the 45th day post submission of the rules to the Governor (August 8, 2022)

APA WF 22-08 Hospice Benefit for Expanded Population — The proposed rule will add hospice services as a covered benefit for members eligible as expansion adults, described in the Code of Federal Regulations (C.F.R.) Title 42 Section 435.119. The proposed rule will outline hospice coverage, eligibility, reimbursement, provider qualifications/requirements, and prior authorization requirements.

Budget Impact: The proposed rule to add hospice as a covered service for expansion adults may result in an estimated total cost of $584,135, with $58,414 in state share for SFY2022; and a total cost of $778,847, with $77,885 in state share for SFY2023.

Proposed Rule Timeline:
60-day Tribal Consultation Period: April 20, 2021 – June 24, 2021
Tribal Consultation: May 4, 2021
15-Day Emergency Rule Public Comment Period:
- August 18, 2021 – September 2, 2021
- May 3, 2022 – May 17, 2022

MAC Meeting: May 12, 2022
Emergency Rule Requested Effective Date: Upon Governor's signature or the 45th day post submission of the rules to the Governor (August 8, 2022)

APA WF 22-10 Long-term Care Facility (LTC) Pay-for-Performance (PFP) Program — The proposed rule revisions will remove outdated language and add new language to the LTC PFP program payment criteria section. These policy revisions will align with the proposed Oklahoma Medicaid State Plan. The overall purpose of the proposed rule revisions will be to maintain compliance with federal requirements and continuity of processes.

Budget Impact: Budget neutral

Proposed Rule Timeline:
60-day Tribal Consultation Period: April 22, 2022 – June 21, 2022
Tribal Consultation: May 3, 2022
Emergency Rule Public Comment Period: May 3, 2022 – May 18, 2022
MAC Meeting: May 12, 2022
Emergency Rule Effective Date: Upon Governor's signature or the 45th day post submission of the rules to the Governor (August 8, 2022)

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 3. GENERAL MEDICAL PROGRAM INFORMATION

317:30-3-57.1. ~~Clinical trials~~Coverage of routine services in relation to clinical trials

~~(a) **Definition.** A clinical trial is a federally funded study that is either being conducted under an Investigational New Drug (IND) application or is exempt from having an IND application and helps to prevent, detect, or treat cancer or a life-threatening illness, injury, or disease.~~

~~(b) **Medical necessity.** Clinical trials must be determined to be medically necessary for the individual affected member. Documentation in the member's plan of care should support the medical necessity of the clinical trial for the affected individual member and that the clinical trial is for the medical purposes only. Requests for clinical trials in and of itself shall not constitute medical necessity. The Oklahoma Health Care Authority (OHCA) shall serve as the final authority pertaining to all determinations of medical necessity. Refer to Oklahoma Administrative Code (OAC) 317:30-3-1(f) for policy on medical necessity.~~

~~(c) **Documentation/requirements.** All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to justify the member's need for the service, in accordance with OAC 317:30-3-1(f)(2). An OHCA approved clinical trial must include the following:~~

~~(1) The clinical trial does one (1) of the following for the treatment of cancer or a life-threatening illness, injury, or disease:~~

~~(A) Tests how to administer a health care service;~~

~~(B) Tests responses to a health care service;~~

~~(C) Compares effectiveness of a health care service; or~~

~~(D) Studies new uses of a health care service.~~

~~(2) The clinical trial is approved and funded by one (1) of the following:~~

~~(A) Research facilities that have an established peer review program that has been approved by the National Institutes of Health Center (NIH);~~

~~(B) The Centers for Disease Control and Prevention;~~

~~(C) The Agency for Health Care Research and Quality (AHRQ);~~

~~(D) The Centers for Medicare and Medicaid Services (CMS);~~

~~(E) The United State Department of Veterans Affairs (VA);~~

~~(F) The United States Department of Defense (DOD);~~

~~(G) The Food and Drug Administration;~~

~~(H) The United States Department of Energy; or~~

~~(I) Research entities that meet the eligibility criteria for a support grant from a NIH center.~~

~~(3) Is conducted in a facility where the personnel have training and expertise needed to provide the type of care required and there is written protocol for the approved clinical trial;~~

~~(4) Complies with appropriate federal regulations regarding the protection of human subjects; and~~

~~(5) For full guidelines, please refer to www.okhca.org/mau.~~

~~(d) **Routine care costs.**~~

~~(1) The following are included in routine care costs for approved clinical trials and by a SoonerCare contracted provider:~~

~~(A) Costs that are required for the administration of the investigational item or service and are not a covered benefit of the clinical trial;~~

~~(B) Costs regarding the appropriate monitoring of the effects from the item or service; and~~

~~(C) Costs that are necessary for the prevention, diagnosis or treatment of medical complications for a non-covered item or service that was provided in the clinical trial.~~

~~(2) The following are excluded from routine care costs in approved clinical trials:~~

~~(A) The investigational item or service;~~

~~(B) Items or services that the study gives for free;~~

~~(C) Items or services that are only utilized when determining if the individual is eligible for the clinical trial;~~

~~(D) Items or services that are used only for data collection or analysis;~~

~~(E) Evaluations that are designed to only test toxicity or disease pathology;~~

~~(F) Experimental, investigational, and unproven treatments or procedures and all related services provided outside of an approved clinical trial; and~~

~~(G) Any non-FDA approved drugs that were provided or made available to the member during the approved clinical trial will not be covered after the trial ends.~~

~~(3) Applicable plan limitations for coverage for out-of-network and out-of-state providers will apply to routine care costs in an approved clinical trial.~~

~~(4) Applicable utilization management guidelines will apply to routine care costs in an approval clinical trial.~~

~~(e) **Experimental and investigational.** SoonerCare does not cover for medical, surgical, or other health care procedures, which are considered experimental or investigational in nature.~~

(a) **Coverage.** The Oklahoma Health Care Authority (OHCA) will cover routine patient costs provided under a qualifying clinical trial to an eligible member. The OHCA does not:

(1) Determine eligibility for participation in any research study; or

(2) Reimburse for any costs associated in the research study, other than for routine patient costs for clinical studies, as defined in this Section and in the Oklahoma Medicaid State Plan.

(b) **Qualifying clinical trials criteria.**

(1) Clinical trial, as adopted from the National Institute of Health (NIH) definition, means a research study in which one (1) or more human subjects are prospectively assigned to one (1) or more interventions, which may include placebo or other control, to evaluate the effects of those interventions on health-related biomedical or behavioral outcomes.

(2) Pursuant to Section 1905(a)(30) and 1905(gg) of the Act, as amended and added by Division CC, Title II, Section 210 of the Consolidated Appropriations Act, 2021 (Public Law 116-260, Section 210), qualifying clinical trial means a clinical trial, in any clinical phase of development, that is conducted in relation to the prevention, detection, or treatment of any serious or life-threatening disease or condition and is described in any of the following clauses:

(A) The clinical trial is approved, conducted, or supported (which may include funding through in-kind contributions) by one (1) or more of the following:

(i) The National Institutes of Health (NIH);

(ii) The Centers for Disease Control and Prevention (CDC);

(iii) The Agency for Healthcare Research and Quality (AHRC);

(iv) The Centers for Medicare and Medicaid Services (CMS);

(v) A cooperative group or center of any of the entities described above or of the Department of Defense or the Department of Veteran Affairs;

(vi) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants, including guidelines issued after the date of these rules; or

(vii) Any of the following if the clinical trial has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals with no interest in the outcome of the review:

(I) The Department of Veterans Affairs;

(II) The Department of Defense; or

(III) The Department of Energy.

(B) The clinical trial is conducted pursuant to an investigational new drug exemption under section 505(i) of the Federal Food, Drug, and Cosmetic Act or an exemption for a biological product undergoing investigation under section 351(a)(3) of the Public Health Service Act.

(C) The clinical trial is a drug trial that is exempt from being required to have an investigational new drug exemption or an exemption for a biological product undergoing investigation.

(3) Serious disease or condition, as adopted from 21 C.F.R. § 312.300, means a disease or condition associated with morbidity that has substantial impact on day-to-day functioning. Short-lived and self-limiting morbidity will usually not be sufficient, but the morbidity need not be irreversible, provided it is persistent or recurrent. Whether a disease or condition is serious is a matter of clinical judgment, based on its impact on such factors as survival, day-to-day functioning, or the likelihood that the disease, if left untreated, will progress from a less severe condition to a more serious one.

(4) Life-threatening disease or condition, as adopted from 21 C.F.R. § 312.300, means a stage of disease in which there is reasonable likelihood that death will occur within a matter of months or in which premature death is likely without early treatment.

(c) **Clinical trials determination standards.** Pursuant to Section 1905(a)(30) and 1905(gg) of the Act, as amended and added by Division CC, Title II, Section 210 of the Consolidated Appropriations Act, 2021 (Public Law 116-260, Section 210, the OHCA will expedite and complete a coverage determination for routine services under this Section within seventy-two (72) hours of receiving the required attestation as described below. The OHCA will maintain the following standards in any coverage determination under this section:

(1) **Attestation.** The health care provider and principal investigator for the qualifying clinical trial must submit a standardized form attestation to the OHCA regarding the appropriateness of the qualifying clinical trial for the individual member.

(2) **Expedited determination.** Upon receiving the completed required attestation, the OHCA will expedite and complete a coverage determination under this Section within seventy-two (72) hours. All documentation submitted to request services must demonstrate, through adequate objective medical records, evidence sufficient to meet at least one (1) definition in subsection (b)(3)-(4) above for the terms "serious disease or condition" or "life-threatening disease or condition".

(3) **Geographic and network allowance.** The OHCA will determine coverage under this Section without limitation on the geographic location or network affiliation of the health care provider treating the individual member or the principal investigator of the qualifying clinical trial.

(4) **Protocols and proprietary documentation.** The OHCA will determine coverage under this Section without requiring the submission of the protocols of the qualifying clinical trial or any other documentation that may be proprietary or determined by the Secretary to be burdensome to provide.

(5) **Documentation of serious or life-threatening disease or condition.** In determining coverage under this Section, the OHCA will consider existing or newly offered documentation that the individual member has been diagnosed with or is suffering from one (1) or more serious or life-threatening diseases or conditions that are the subject of the qualifying clinical trial as shown in the attestation.

(d) **Routine patient costs.**

(1) **Included items and services.** Routine patient costs include any item or service provided to Medicaid-eligible members under the qualifying clinical trial, including:

(A) Any item or service provided to prevent, diagnose, monitor, or treat complications resulting from participation in the qualifying clinical trial, to the extent that the provision of such items or services to the member would otherwise be covered outside the course of participation in the qualifying clinical trial under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act; and

(B) Any item or service required solely for the provision of the investigational item or services that is the subject of the qualifying clinical trial, including the administration of the investigational item or service.

(2) **Excluded items and services.** The following items and services are excluded from routine patient costs in qualifying clinical trials:

(A) Any investigational item or service that is:

(i) The subject of the qualifying clinical trial; and

(ii) Not otherwise covered outside of the clinical trial under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act; and

(B) Any item or service that is:

(i) Provided to the member solely to satisfy data collection and analysis for the qualifying clinical trial and is not used in the direct clinical management of the member; and

(ii) Not otherwise covered under the Oklahoma Medicaid State Plan or waiver, including a demonstration project under section 1115 of the Act.

PART 6. OUT-OF-STATE SERVICES

317:30-3-90. Out-of-state services

(a) Consistent with Section 431.52 of Title 42 of the Code of Federal Regulations (C.F.R.), an eligible SoonerCare member who is a resident of Oklahoma but who is temporarily out of state, may receive services from an out-of-state provider to the same extent that he or she would receive such services in Oklahoma, if:

(1) Medical services are needed for a medical emergency, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N), or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)]. For any provider, who is not contracted at the time the services are provided, documentation as requested from the Oklahoma Health Care Authority (OHCA) of the emergency must be submitted, including, but not limited to, emergency room reports, medical histories, discharge summaries, and all other relevant medical reports.

(2) Medical services are needed and the member's health would be endangered if he or she were required to return to Oklahoma for medical care and treatment, as determined by the attending physician or other provider (M.D., D.O., P.A., or A.P.R.N), or a dentist [Doctor of Dental Surgery (DDS), or Doctor of Medicine in Dentistry (DMD)]. For any provider, who is not contracted at the time the services are provided, documentation of the nature and possible extent of the endangerment must be submitted as requested from the OHCA.

(3) The Oklahoma Health Care Authority's (OHCA) Chief Medical Officer (CMO), or his or her designee, determines, on the basis of medical advice, that the needed medical services, or necessary supplemental resources, are more readily available in the state where the member is located at the time of needing medical treatment. Prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered~~; or~~.

~~(4) The customary or general practice for members residing in a particular locality within Oklahoma is to use medical resources in another state, and the member is using a provider that is contracted with the OHCA.~~

(b) Per 42 C.F.R. § 431.52, if it is the customary or general practice for SoonerCare members who are residing in a particular locality within Oklahoma to use medical or dental resources in another state, reimbursement is available for services furnished in another State to the same extent that reimbursement for services is furnished within Oklahoma boundaries. The services being rendered must be provided by a provider who is contracted with the OHCA and must be appropriately licensed and in good standing with the state in which they practice.

~~(A)~~(1) Except for out-of-state inpatient psychiatric services, no prior authorization is necessary for services provided in accordance with paragraph ~~(a)~~(4)(b), above, if the member obtains them from an out-of-state provider that is:

~~(i)~~(A) Located in a border state (Arkansas, Colorado, Kansas, Missouri, New Mexico, or Texas) within fifty (50) miles of the Oklahoma border, with exceptions for dental services. The OHCA will allow the member to travel up to one hundred (100) miles of the Oklahoma border to receive dental services; and

~~(ii) Contracted with the OHCA;~~

~~(iii)~~(B) Provided, however, that nothing in this paragraph shall be interpreted to eliminate or otherwise affect a prior authorization requirement established by any other OHCA rule, including, but not limited to, Oklahoma Administrative Code (OAC) 317:30-3-31, that would have to be met if the health care-related good and/or service were provided in Oklahoma.

~~(B)~~(2) In all other instances, prior authorization must be obtained from the OHCA's CMO, or his or her designee, before the services are rendered.

(c) Clinical trials, either in-state or out-of-state, will need to adhere to any federal regulations which provides for certain exceptions to OHCA's out-of-state policy. For the full clinical trials policy, please refer to OAC 317:30-3-57.1.

~~(b)~~(d) Except as provided in subsections (a)(1),(a)(2) ~~and (a)(4)(A),~~(b)(1) and (c), above, SoonerCare will not pay for any services furnished by an out-of-state provider unless prior authorization has been obtained from the OHCA's CMO, or his or her designee, before the services are rendered. Prior authorization for out of state services must be obtained in all instances in which the member is located in Oklahoma at the time the services are determined to be medically necessary.

(1) As part of this authorization process, the following documents must be submitted to the OHCA's CMO, or his or her designee:

(A) Documents sufficient to establish the "medical necessity" of the services requested, as that term is defined by OAC 317:30-3-1(f). See also OAC 317:30-3-31, Prior authorization for health care-related goods and services. Examples of such documents may include, but are not limited to, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, progress notes, hospital charts, and/or other relevant medical records; and

(B) Documents sufficient to establish that the health care needs of the member cannot be met in Oklahoma. Such documents shall include, but not be limited to, a letter from the referring provider that contains:

(i) A clear presentation of the member's medical condition and diagnosis for which out-of-state treatment is requested, including a summary of treatment to date that is supported by the documents in paragraph ~~(b)~~(c)(1)(A), above;

(ii) Names of physicians and/or facilities in Oklahoma that the member has previously been referred to for diagnosis and/or treatment;

(iii) Physicians consulted by the attending physician relative to diagnosis and/or availability of recommended treatment in Oklahoma;

(iv) Recommended treatment or further diagnostic work; and

(v) Reasons why medical care cannot be provided in Oklahoma or the next closest location outside Oklahoma.

(C) Except for emergency medical, behavioral health cases, and as provided in subsections (a)(1),(a)(2) and (b)(1), above, prior authorization requests for out-of-state services must be made in writing with all the necessary documents that show medical necessity and details of the services provided, including but not limited to, relevant medical history, description of services and procedures to be performed, Histories of Present Illnesses (HPIs), physical exams, laboratory reports, imaging reports, and received by the OHCA at least ten (10) calendar days prior to the date services are to be provided in another state or at the discretion of the CMO or his/her designee.

(i) Emergency medical, ~~or~~ behavioral health, and dental cases must be identified as such by the physician or provider in the prior authorization request.

(ii) Any telephone request for prior authorization of out-of-state services will only be accepted in emergency situations, and must be promptly followed by a written request.

(2) Prior authorization requirements for medically necessary lodging, transportation, and/or meals assistance associated with out-of-state services are established in other OHCA rules, including, but not limited to, OAC 317:30-3-92 and 317:30-5-327.1. In accordance with federal regulations, exceptions to prior authorization requirements will be made for members who are participating in a clinical trial that require out-of-state medically necessary services. For the full clinical trials policy, please refer to OAC 317:30-3-57.1.

~~(c)~~(e) The ~~restrictions~~limitations established in subsections (a) through ~~(b)~~(c), above, shall not apply to children who reside outside of Oklahoma and for whom the Oklahoma ~~Department of~~ Human Services (OKDHS) makes Title IV-E adoption assistance payments or Title IV-E foster care maintenance payments.

~~(d)~~(f) Denials of requests for prior authorization may be appealed in accordance with OAC 317:2-1-2(d)(1)(C).

~~(e)~~(g) Out-of-state providers shall, upon request by authorized OHCA representatives, make available fiscal and medical records as required by applicable federal regulations, OHCA rules, and the Provider Agreement. Such records shall be made available for review by authorized OHCA representatives at the OHCA's address in Oklahoma City, Oklahoma.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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

317:30-5-1094. Behavioral health services provided at I/T/Us

(a) **Inpatient behavioral health.** Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified behavioral health needs. ~~Inpatient psychiatric service providers must meet the requirements and applicable limitations, restrictions, or prior authorization requirements set forth in Oklahoma Administrative Code (OAC) 317:30-5-95 through 317:30-5-97.~~

~~(1) The provision of inpatient psychiatric services by Indian Health Services (IHS) facilities are reimbursed at the OMB inpatient encounter rate. Inpatient psychiatric services provided by non-IHS facilities are reimbursed at the established per diem or DRG rate.~~

~~(2) For the provision of residential substance use disorder (SUD) treatment services, I/T/U facilities must be contracted as residential SUD service providers and meet the requirements found at OAC 317:30-5-95.43 through 317:30-5-95.49. Residential SUD treatment services will be reimbursed at the OMB outpatient encounter rate.~~

(1) Inpatient psychiatric service providers must meet the requirements and applicable limitations, restrictions, or prior authorization requirements set forth in Oklahoma Administrative Code (OAC) 317:30-5-95 through 317:30-5-97.

(2) The provision of inpatient psychiatric services by Indian Health Services (IHS) facilities are reimbursed at the OMB inpatient encounter rate. Inpatient psychiatric services provided by non-IHS facilities are reimbursed at the established per diem or DRG rate.

(b) **Outpatient behavioral health**. Services are covered when provided in accordance with a documented individualized service plan developed to treat the identified mental health needs and/or SUD. Outpatient behavioral health services are reimbursed at the I/T/U outpatient encounter rate unless otherwise noted in the section.

(1) A full description of services may be found at OAC 317:30-5-241 and 317:30-5-241.5(d), 317:30-5-241.7. Services may include, but are not limited to:

(A) Mental health and/or substance use assessment/evaluation and testing;
(B) Service plan development;
(C) Crisis intervention services;
(D) Medication training and support;
(F) Individual/interactive psychotherapy;
(G) Group psychotherapy;
(H) Family psychotherapy;
(I) Medication-assisted treatment (MAT) services and/or medication; and
(J) Peer recovery support specialist (PRSS) services.

(2) In order to support access to behavioral health services, these services may be provided in settings outside of the I/T/U. Offsite services must take place in a confidential setting.

(3) For the provision of behavioral health related case management services, I/T/U facilities must be fully contracted with the Oklahoma Health Care Authority (OHCA) as an outpatient behavioral health agency. The provision of these services is considered to be outside of the

I/T/U encounter and will be paid at the current FFS rate. Contracted behavioral health case management providers must comply with the requirements found at OAC 317:30-5-241.6 and are responsible for obtaining all necessary prior authorizations, if needed.

(4) For the provision of psychosocial rehabilitation services, I/T/U facilities must be fully contracted with the OHCA as an outpatient behavioral health agency. The provision of these services is considered to be outside of the I/T/U encounter and will be paid at the current FFS rate. Contracted psychosocial rehabilitation service providers must comply with the requirements found at OAC 317:30-5-241.3 and are responsible for obtaining all necessary prior authorizations, if needed.

(5) Services provided by behavioral health practitioners, such as, licensed clinical social workers (LCSW), licensed marital and family therapists (LMFT), licensed professional counselors (LPC), licensed behavioral health practitioners (LBHP), licensed alcohol and drug counselors (LADC), and licensure candidates are not eligible for direct reimbursement as practitioners. Services provided by the aforementioned practitioners are compensable only when billed by their OHCA-contracted employer and when provided in those clinical settings in which they are currently approved to render services. Licensure candidates must meet the requirements contained in OAC 317:30-5-240.3.

(6) Behavioral health services must be billed on an appropriate claim form using the appropriate procedure code and guidelines. The time indicated on the claim form must be the time actually spent with the member.

(c) **Residential substance use disorder (SUD).** For the provision of residential SUD treatment services, I/T/U facilities must be contracted as SoonerCare providers and meet the requirements found at OAC 317:30-5-95.43 through 317:30-5-95.49. Residential SUD treatment services will be reimbursed at the OMB outpatient encounter rate.

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

317:30-5-530. Eligible providers

~~Non-Hospital Affiliated Hospice entities must be appropriately licensed and have a contract with the Oklahoma Health Care Authority to provide Hospice services.~~

(a) Providers of hospice services will meet applicable state and federal licensing requirements and meet Medicare certification requirements to provide hospice services.

(b) Providers of hospice services will enter into a contractual agreement with the State Medicaid Agency, Oklahoma Health Care Authority (OHCA).

317:30-5-531. Coverage for adults

~~There is no coverage for hospice services provided Medicaid eligible adults except for the hospice provision provided through the ADvantage Waiver.~~

(a) **Definition.** Hospice care is 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.

(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.

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

(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) 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.

(3) 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.

(c) **Covered services.** Hospice care services can include but 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.

(d) **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.

(e) **Service election.**

(1) 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) 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.

(f) **Service revocation.**

(1) Hospice care services may be revoked by the member, 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 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.

(g) **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.

(h) **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.

(i) **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 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.

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

317:30-5-1096. Off-site services

I/T/U covered services provided off-site or outside of the I/T/U setting, including but not limited to hospice services, mobile clinics, or places of residence, are compensable at the OMB rate when billed by an I/T/U that has been designated as a Federally Qualified Health Center. The I/T/U must meet provider participation requirements listed in OAC 317:30-5-1088. I/T/U off-site services may be covered if the services rendered were within the provider's scope of practice and are of the same

integrity of services rendered at the I/T/U facility.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-136.1. Pay-for-Performance (PFP) program

(a) **Purpose.** The PFP program was established through Oklahoma State Statute, Title 56, Section 56-1011.5 as amended. PFP's mission is to enhance the quality of life for target citizens by delivering effective programs and facilitating partnerships with providers and the community they serve. The program has a full commitment to the very best in quality, service and value which will lead to measurably improved quality outcomes, healthier lifestyles, greater satisfaction and confidence for our members.

(b) **Eligible providers.** Any Oklahoma long-term care nursing facility that is licensed and certified by the Oklahoma State Department of Health (OSDH) as defined in Oklahoma Administrative Code (OAC) 317:30-5-120.

(c) **Quality measure care criteria.** To maintain status in the PFP program, each nursing facility shall submit documentation as it relates to program metrics quarterly or upon the request of the Oklahoma Health Care Authority (OHCA). The program metrics can be found on the OHCA's PFP website or on PFP/Quality of Care (QOC) data collection portal. If any quality metric, listed below, is substituted or removed by Centers of Medicare and Medicaid Services (CMS), an alternative quality metric may be chosen with the support of participating partners. For the period beginning October 1, 2019 and until changed by amendment, qualifying facilities participating in the PFP program have the potential to earn an average of the five dollars ($5.00) quality incentive per Medicaid patient per day. Facility(s) baseline is calculated annually and will remain the same for the twelve (12) month period. Facility(s) will meet or exceed five-percent (5%) relative improvement or the CMS' national average each quarter for the following metrics:

(1) Decrease percent of high risk/unstageable pressure ulcers for long-stay residents.

(2) Decrease percent of unnecessary weight loss for long-stay residents.

(3) Decrease percent of use of anti-psychotic medications for long-stay residents.

(4) Decrease percent of urinary tract infection for long-stay residents.

(d) **Payment.** Payment to long-term care facilities for meeting the metrics will be awarded quarterly. A facility may earn a minimum of one dollar and twenty-five cents ($1.25) per Medicaid patient per day for each qualifying metric. A facility receiving a scope and severity tag deficiency of "I" or greater ~~related to a targeted quality measure in the program is disqualified from receiving an award related to that measure for that quarter.~~from the Oklahoma State Department of Health will forfeit the PFP incentive for the quarter out of compliance.

(1) **Distribution of payment.** OHCA will notify the PFP facility of the quality reimbursement amount on a quarterly basis.

(2) **Penalties.** Facilities shall have performance review(s) and provide documentation upon request from OHCA to maintain program compliance. Program payments will be withheld from facilities that fail to submit the requested documentation within fifteen (15) business days of the request.

(3) **Timeframe.** To qualify for program reimbursement by meeting a specific quality measure, facilities are required to provide metric documentation within thirty (30) days after the end of

each quarter to the OHCA.

(e) **Appeals.** Facilities can file an appeal with the Quality Review Committee and in accordance, with the grievance procedures found at OAC 317:2-1-2(c) and 317:2-1-17.

OPERATIONAL METRICS

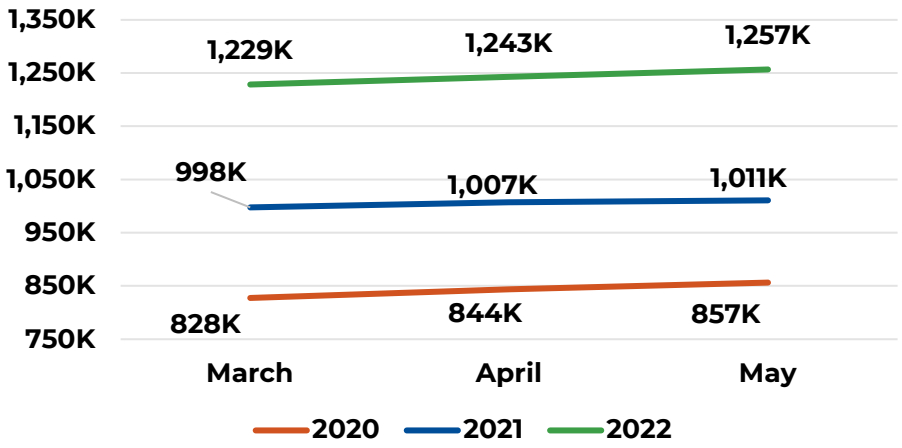
June 2022 Board Meeting

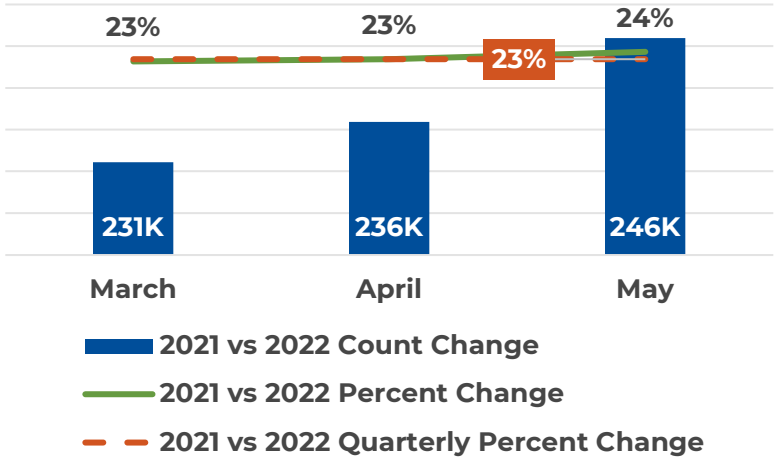
OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

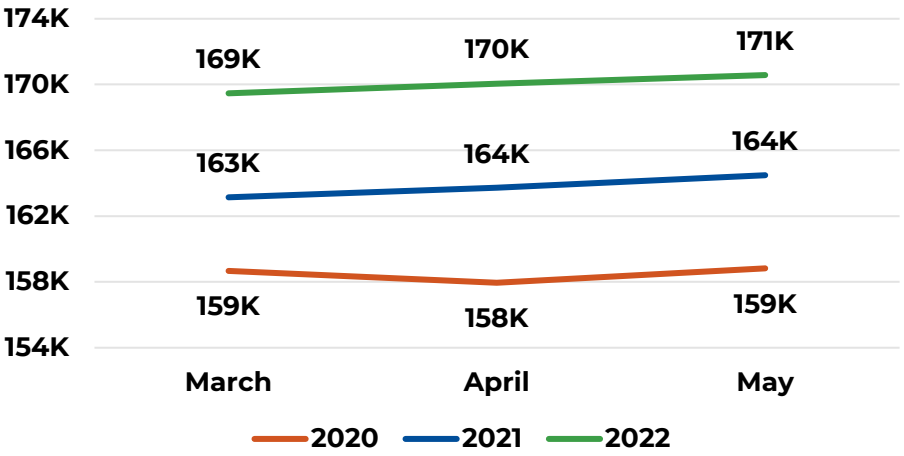
Enrollment & Utilization

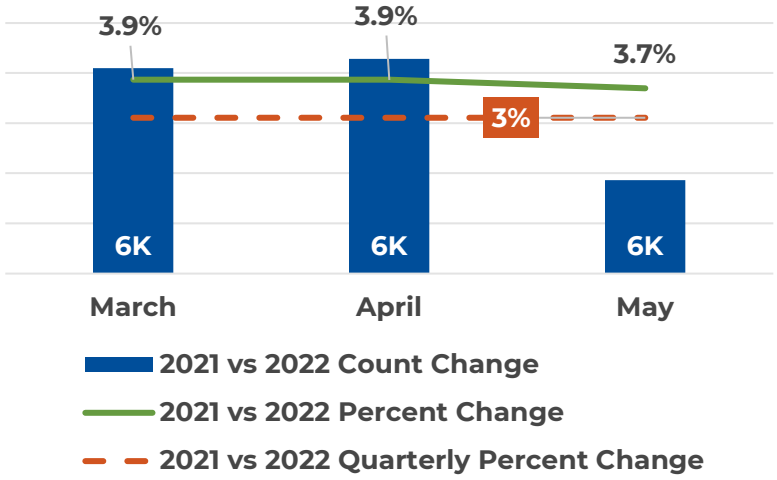
Total Enrolled Members





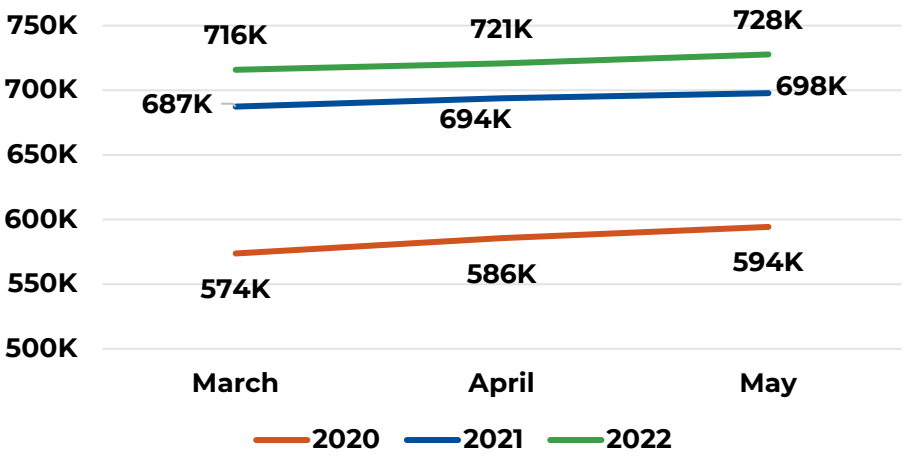
Aged/Blind/Disabled Enrolled

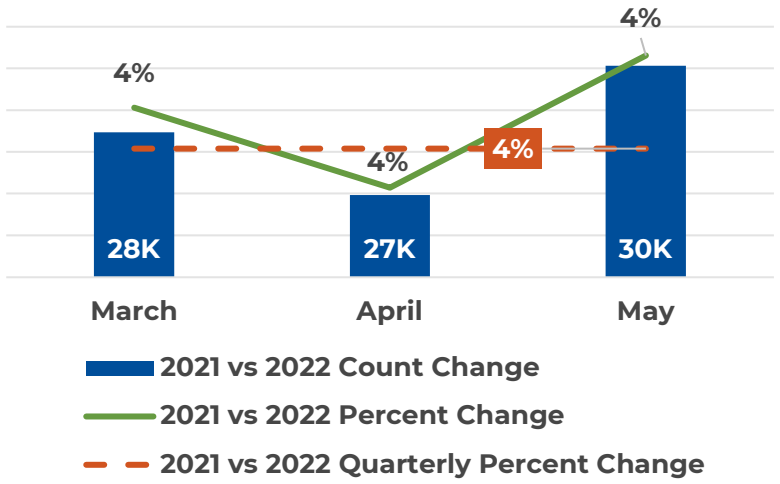




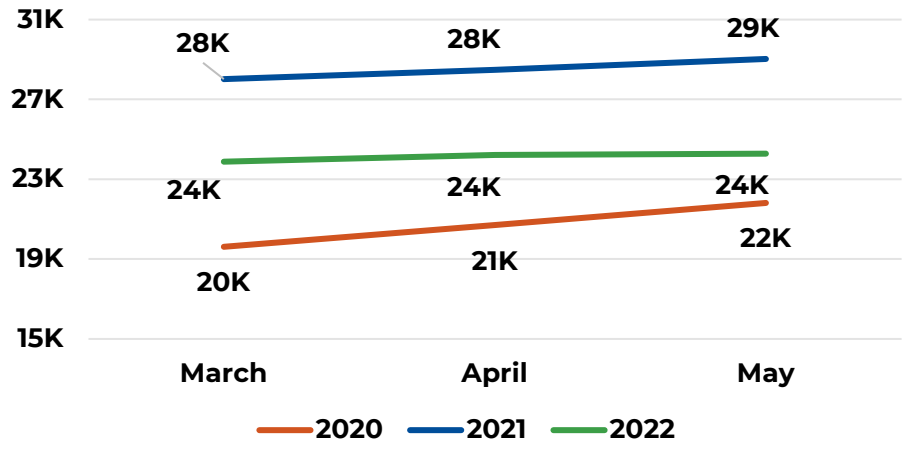
Enrollment & Utilization (Cont.)

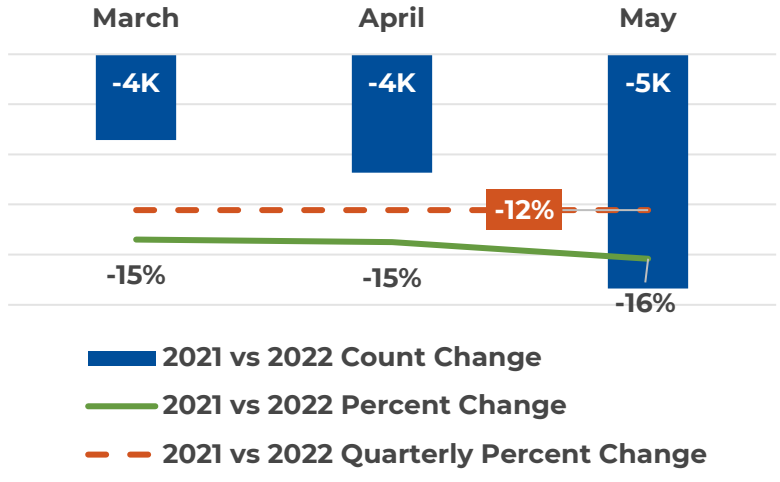
Children & Parent/Caretaker Enrolled





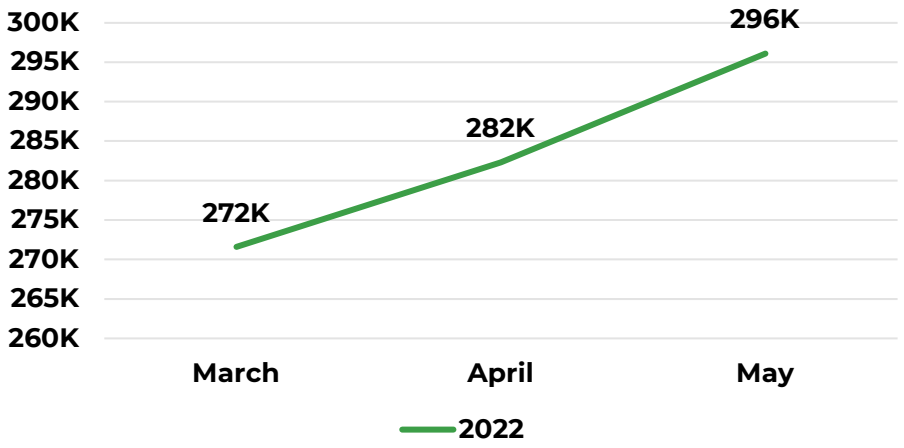
Pregnant (Full Scope) Enrolled

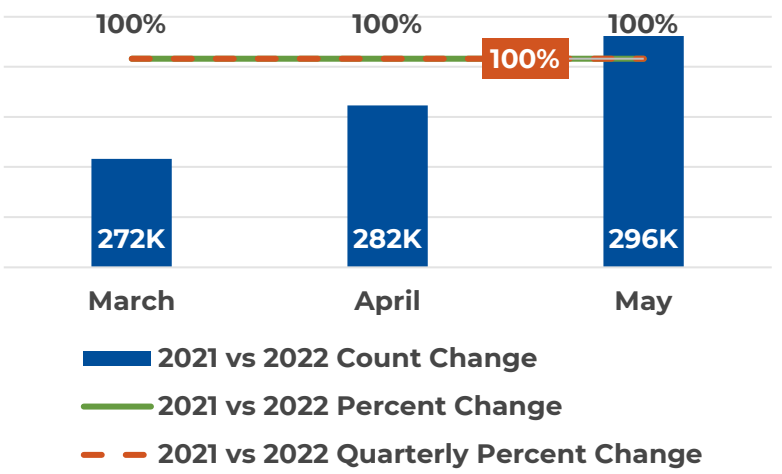




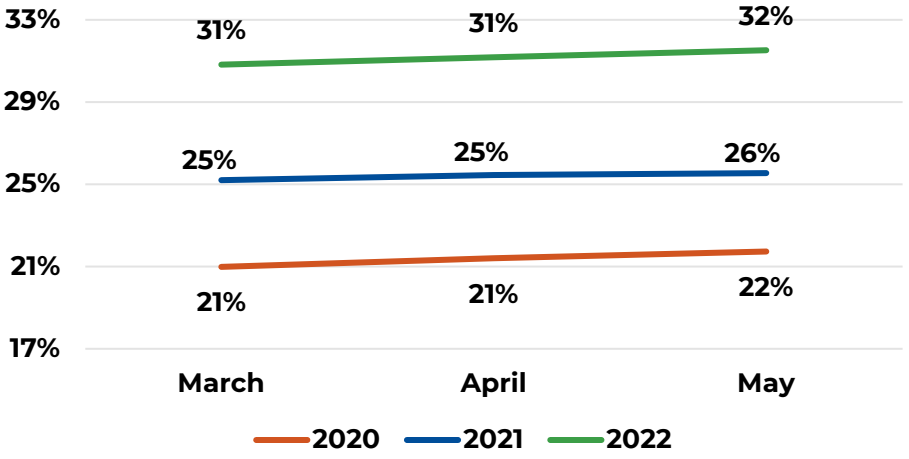
Enrollment & Utilization (Cont.)

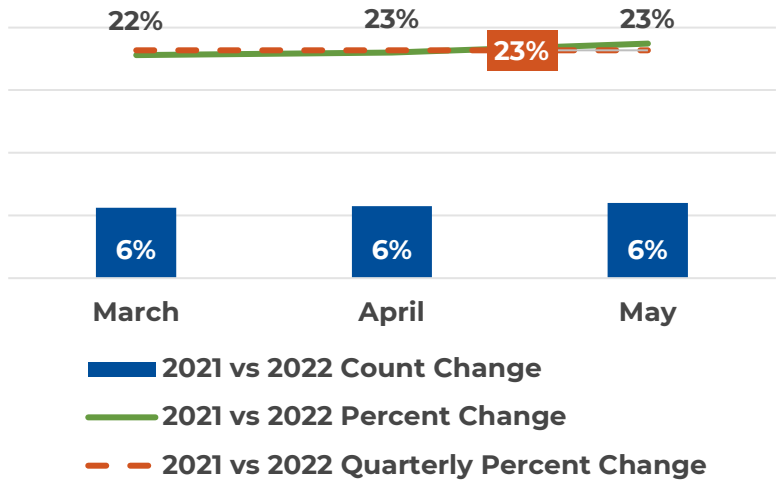
Expansion Enrolled (Effective July 2021)





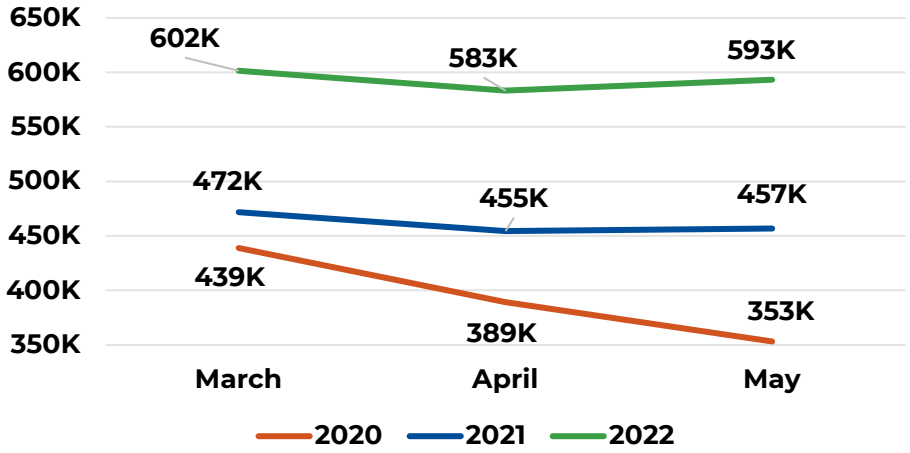
Percent of OK Population Enrolled

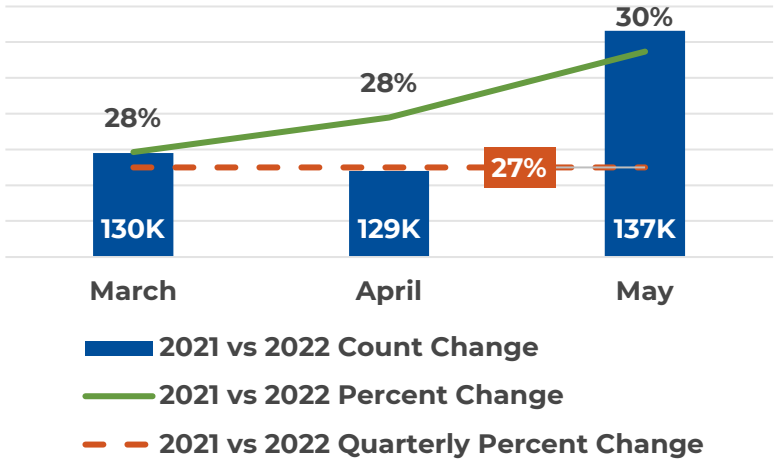




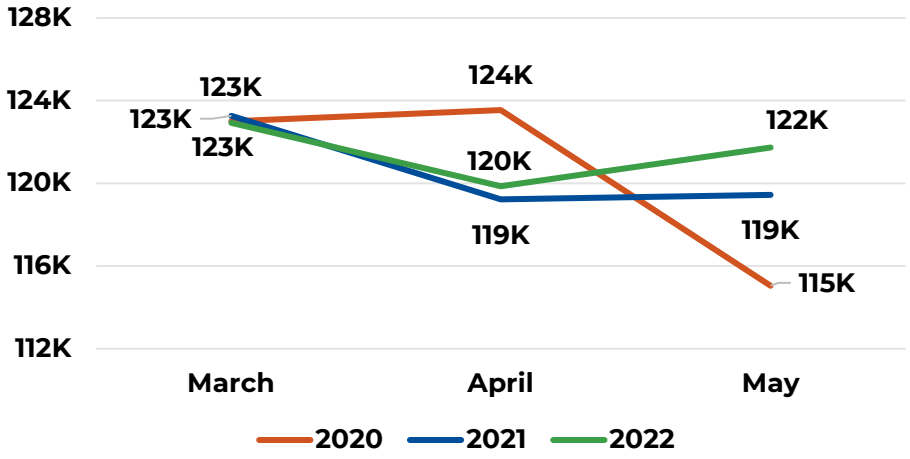
Enrollment & Utilization (Cont.)

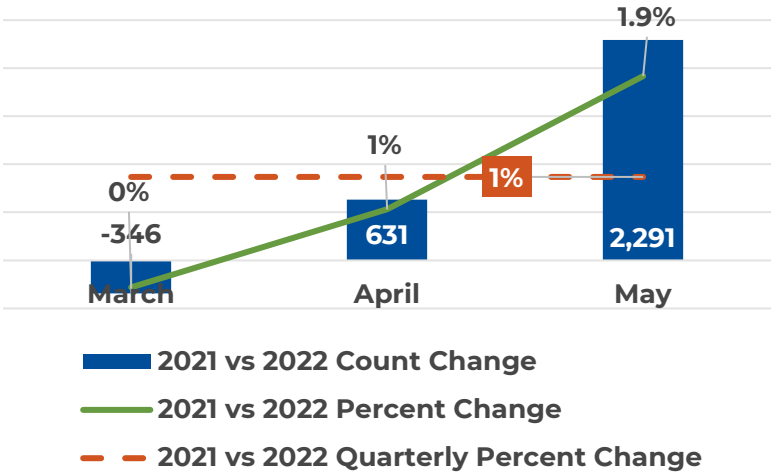
Total Members Utilization



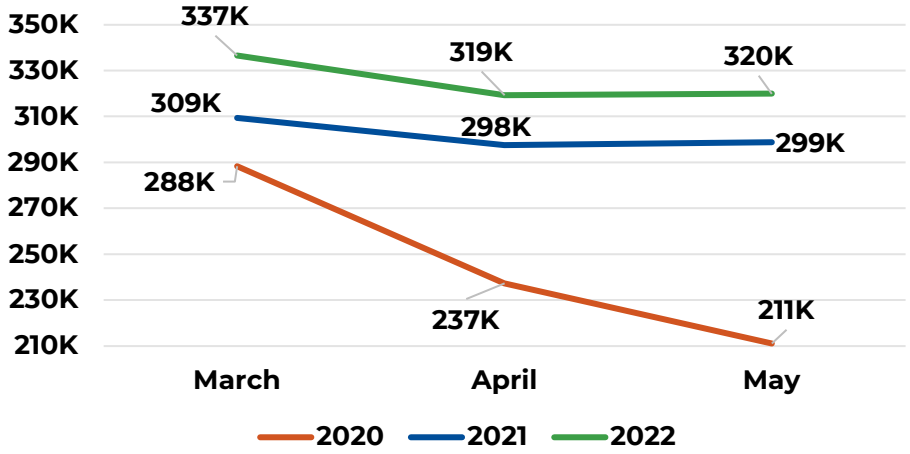


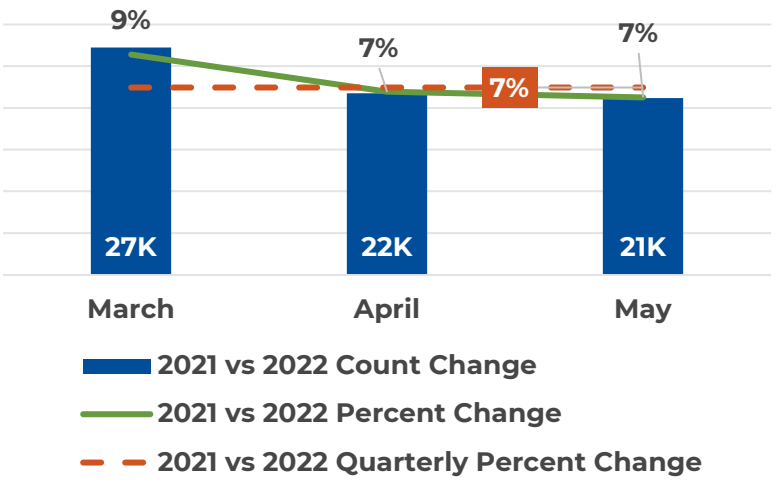
Aged/Blind/Disabled Utilization



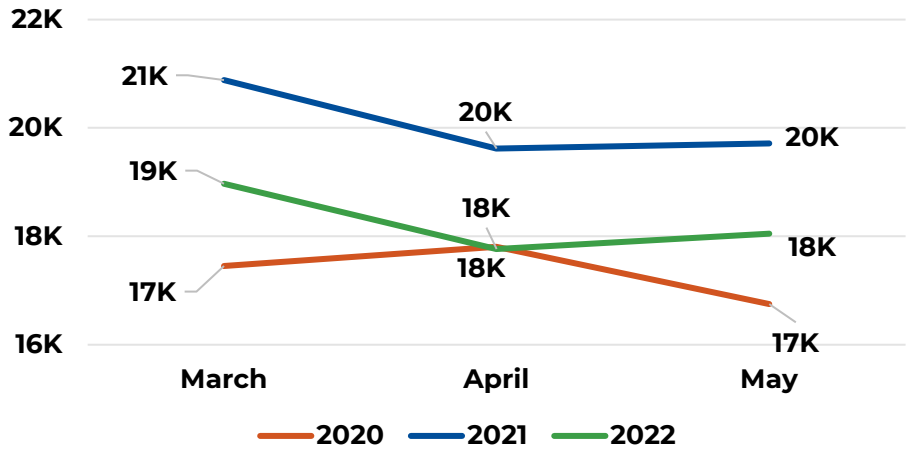


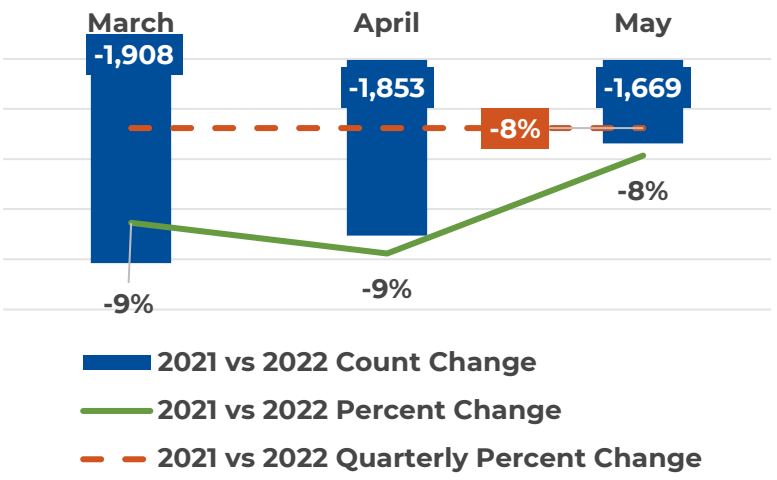
Children & Parent/Caretaker Utilization





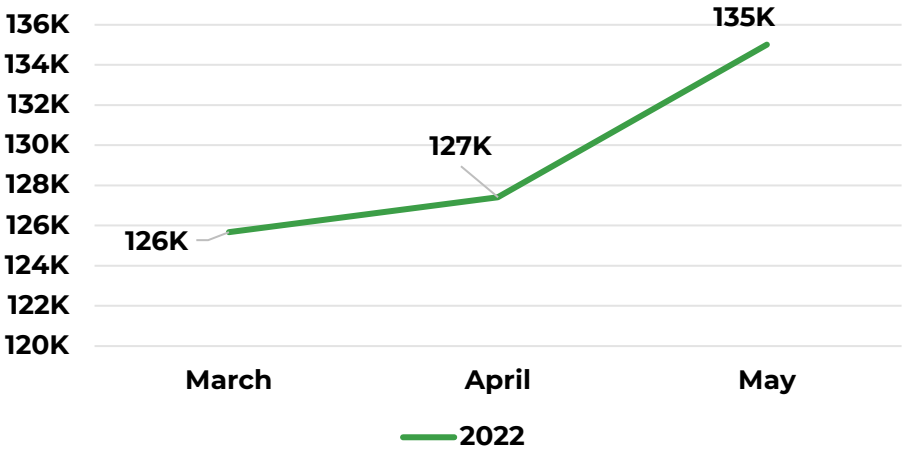
Pregnant (Full Scope) Utilization

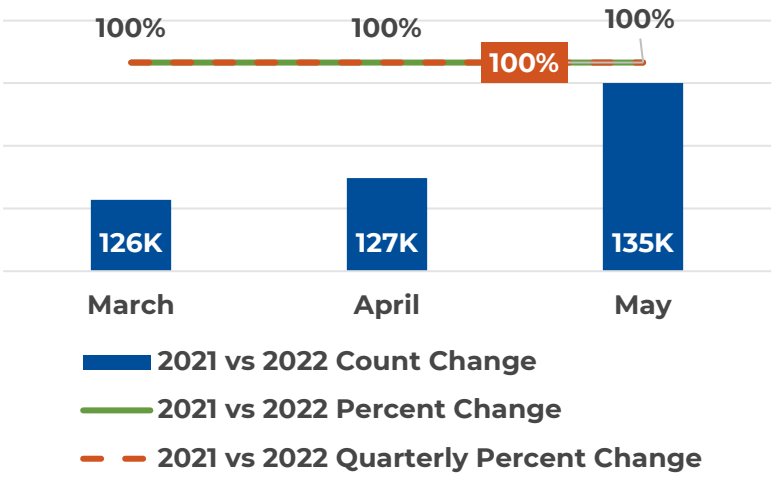




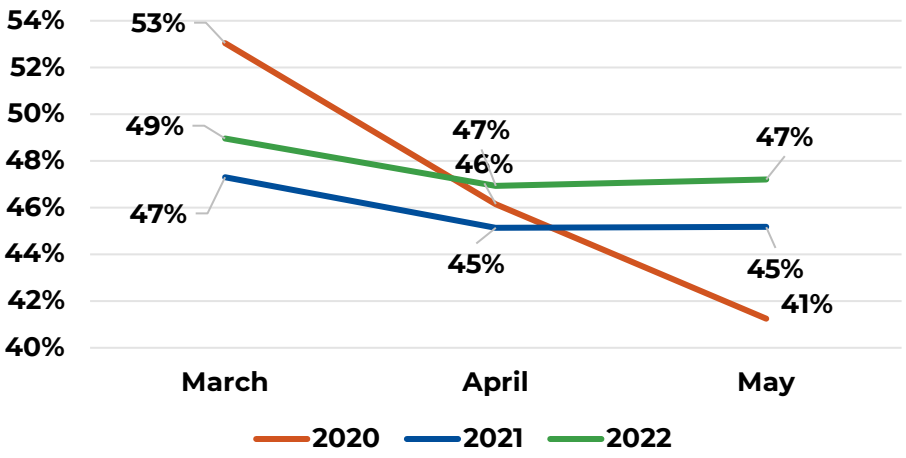
Enrollment & Utilization (Cont.)

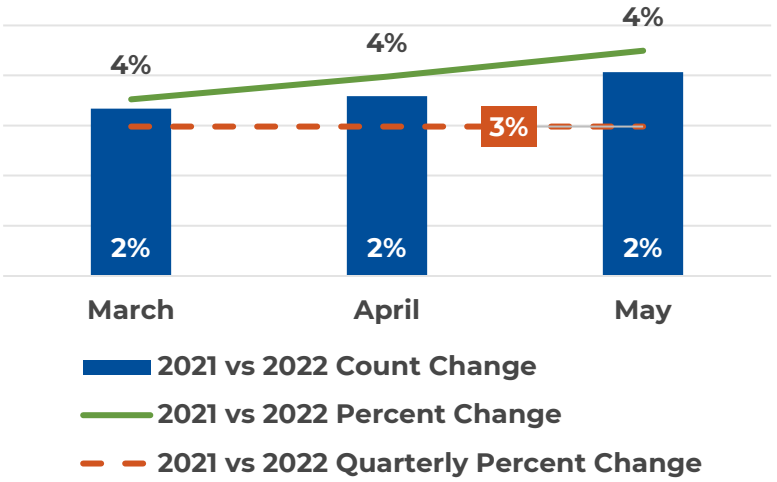
Expansion Utilization (Effective July 2021)





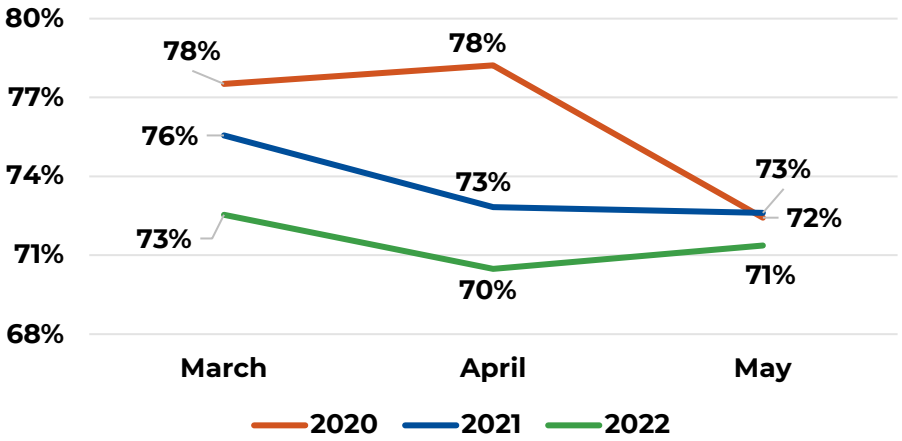
Percent of Total Enrolled Members Utilization

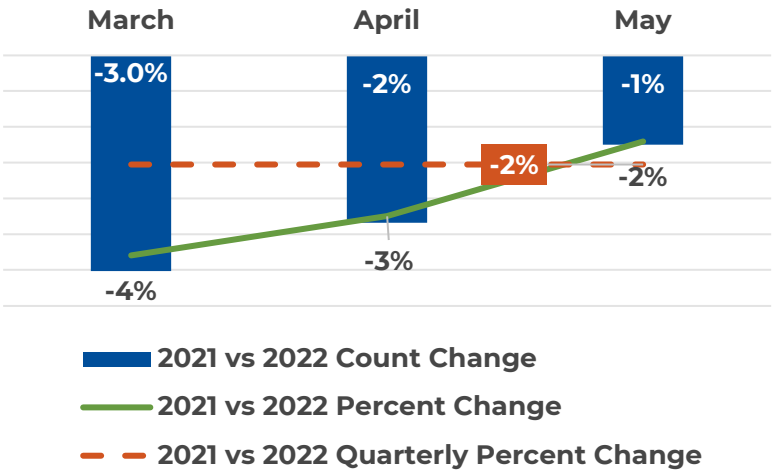




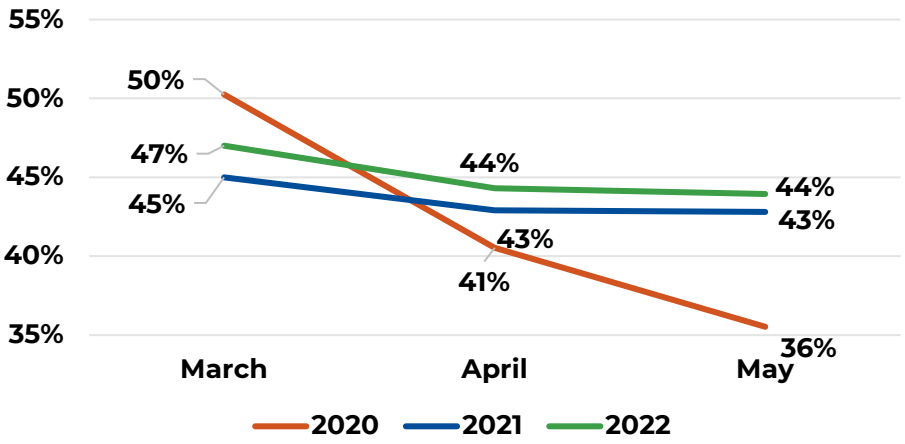
Enrollment & Utilization (Cont.)

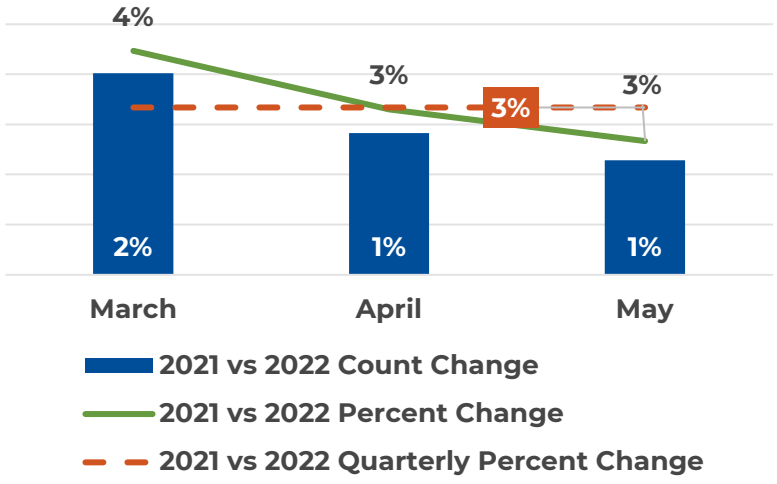
Percent of Aged/Blind/Disabled Enrolled Members Utilization





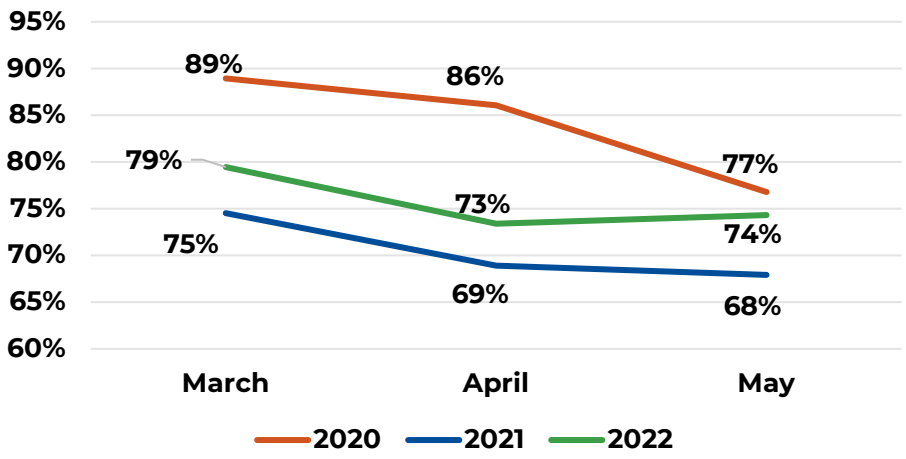
Percent of Children & Parent/Caretaker Enrolled Members Utilization

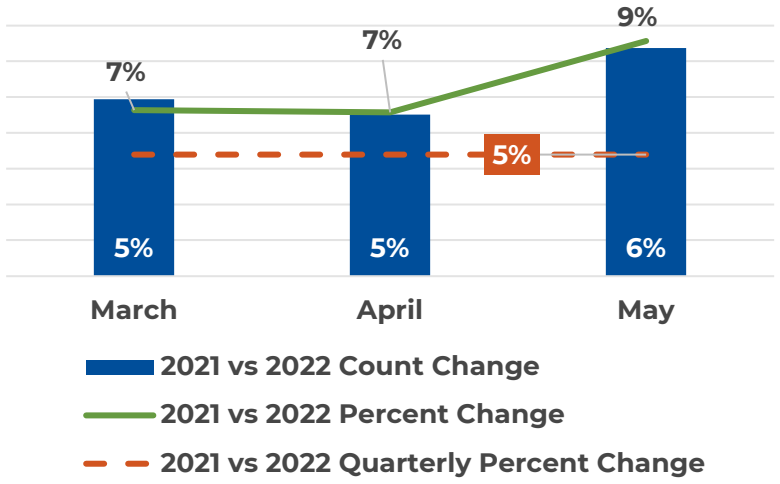




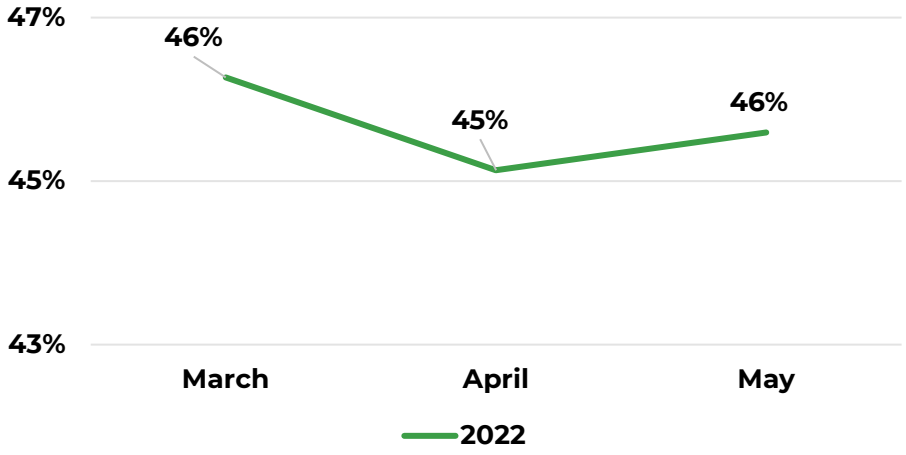
Enrollment & Utilization (Cont.)

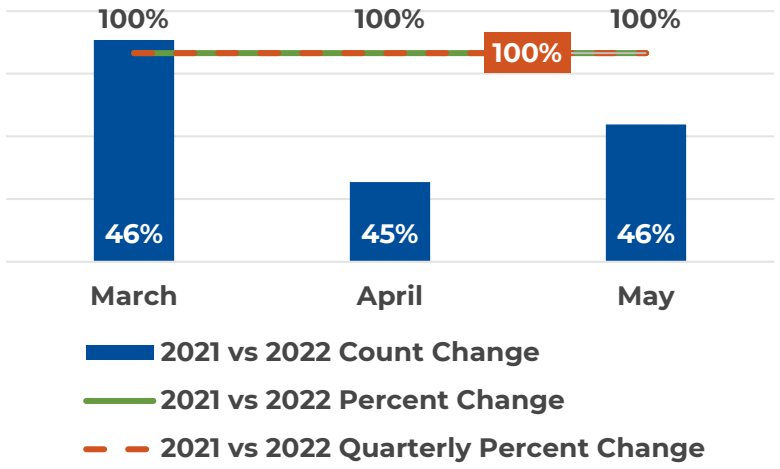
Percent of Pregnant (Full Scope) Enrolled Members Utilization





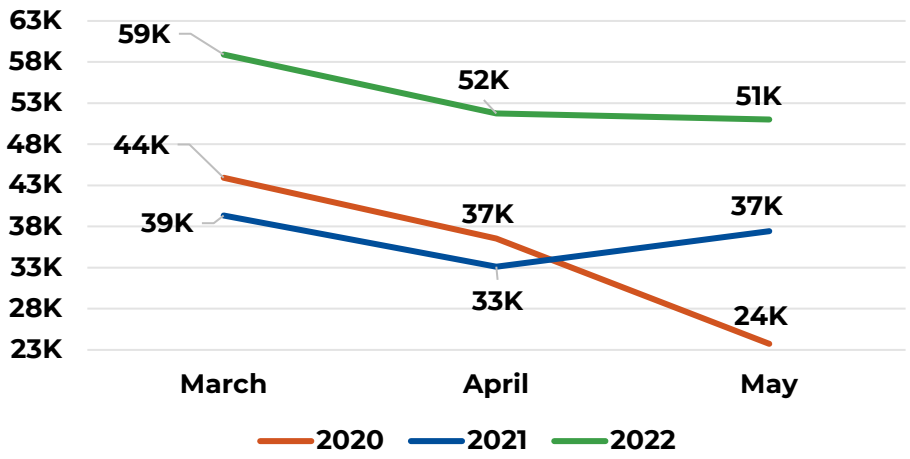
Percent of Expansion Enrolled Members Utilization (Effective July 2021)

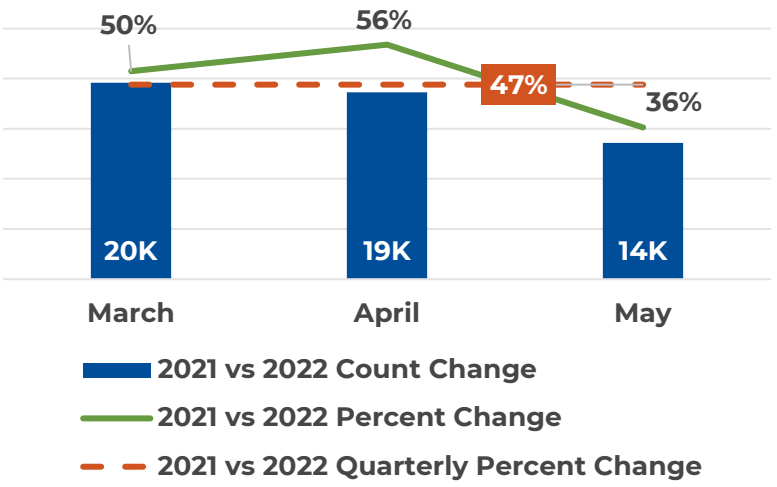




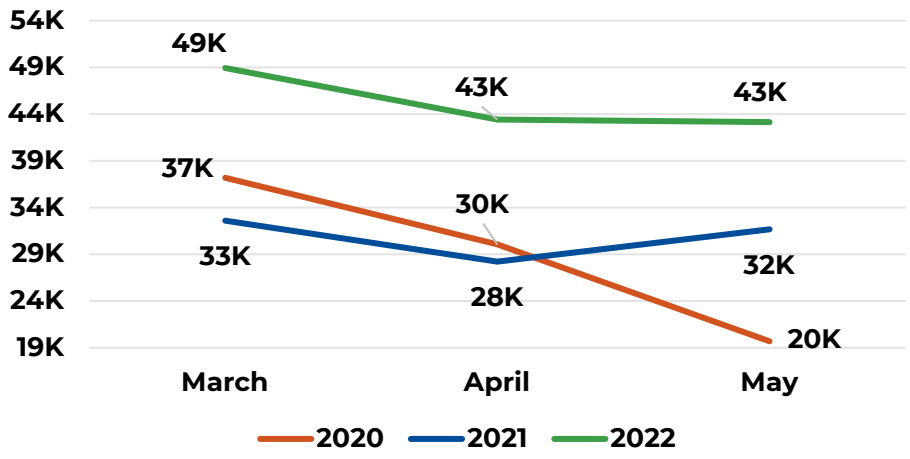
Utilization

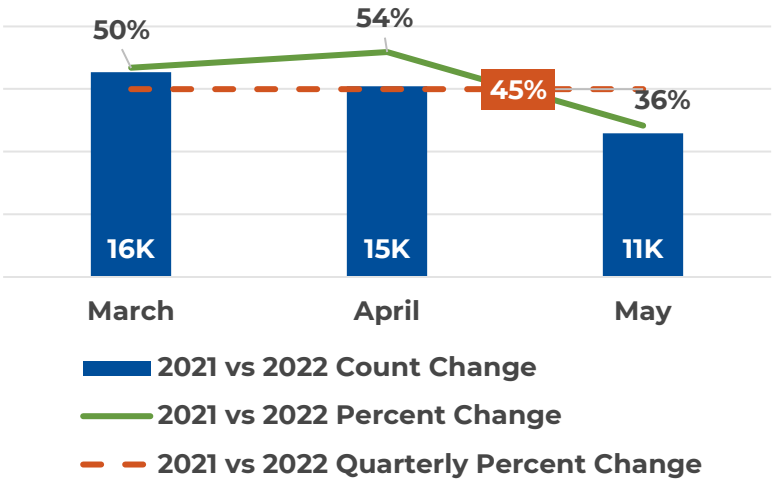
Emergency Department Visits (Claims)





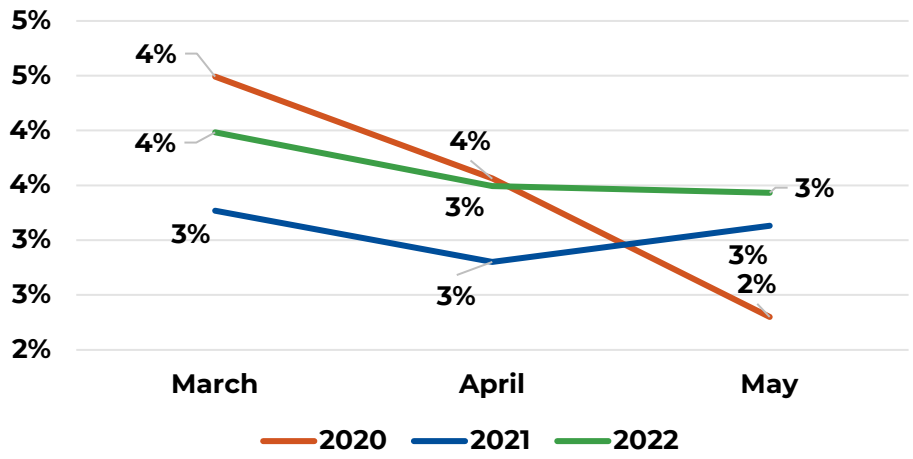
Members Utilizing Emergency Department

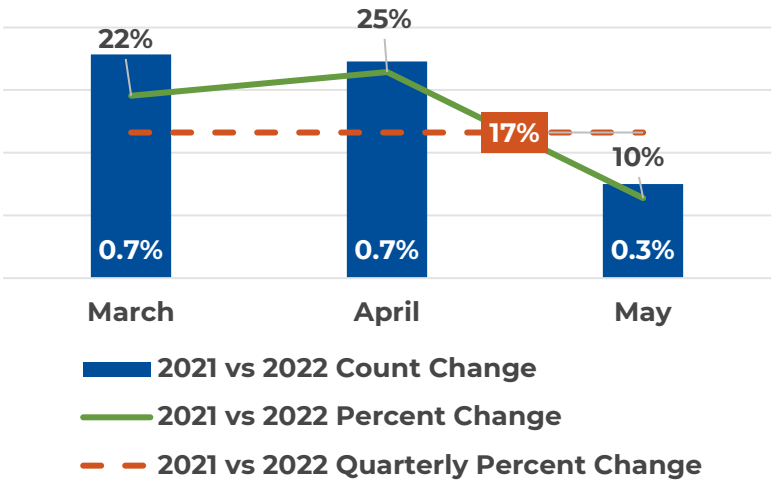




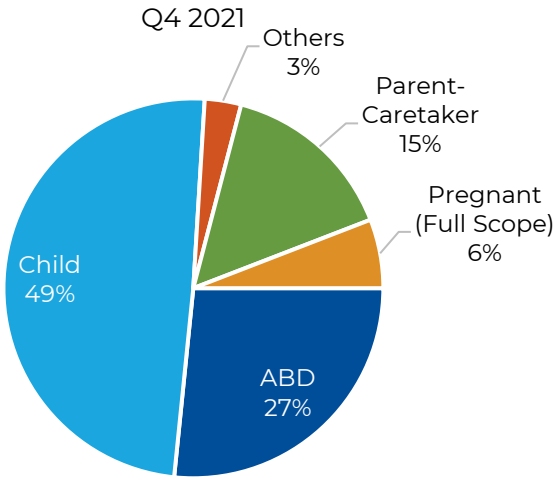
Utilization (Cont.)

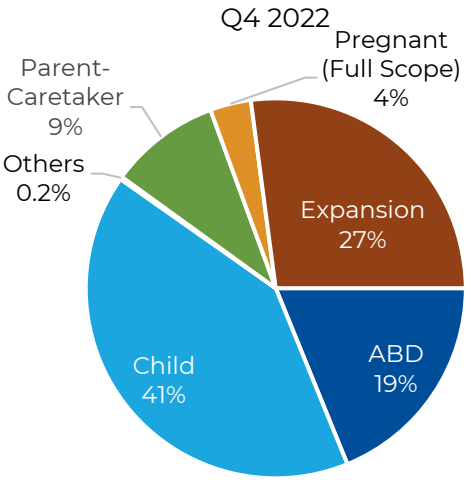
Percent Total Enrolled Using ED





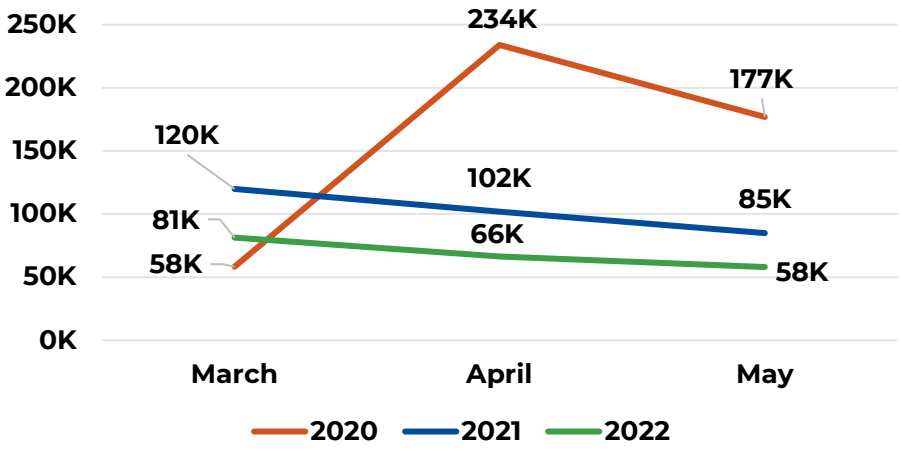
Members Utilizing Emergency Department By Qualifying Group

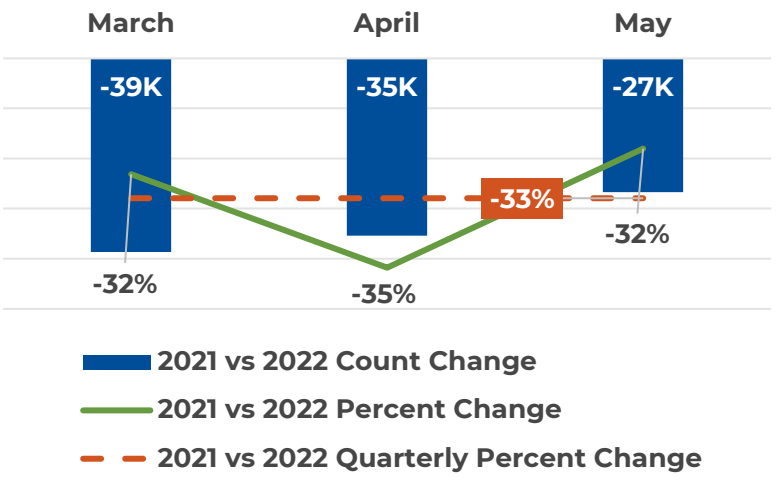




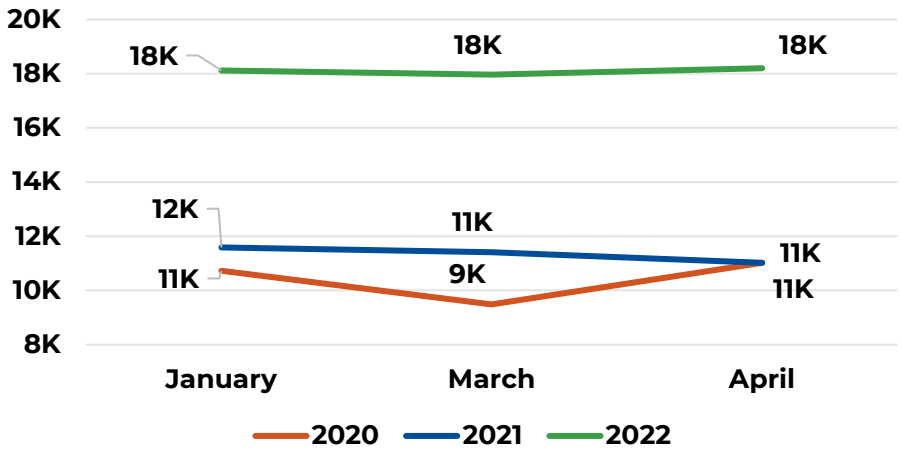
Utilization (Cont.)

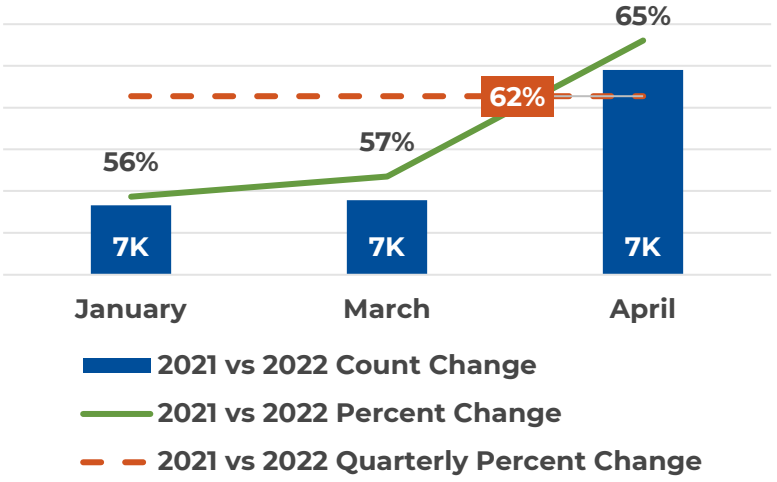
Telemedicine - Total Visits





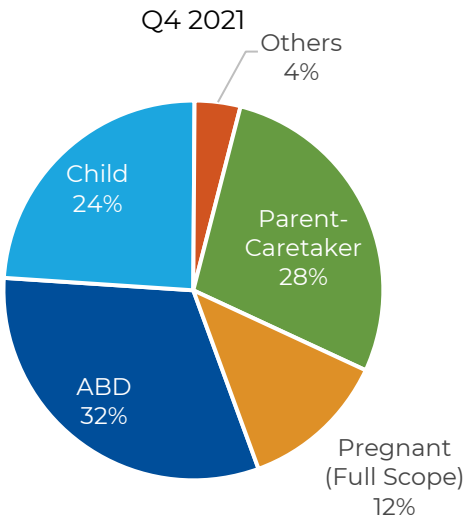
Members With Opioid Claims

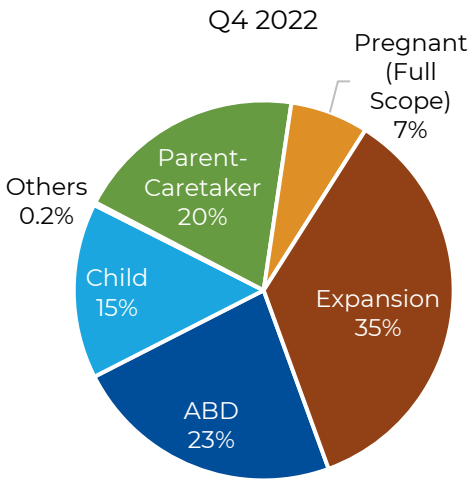




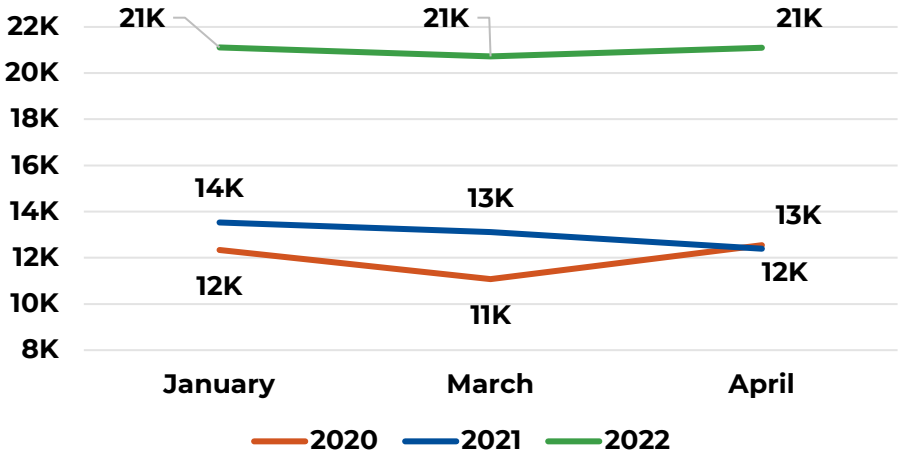
Utilization (Cont.)

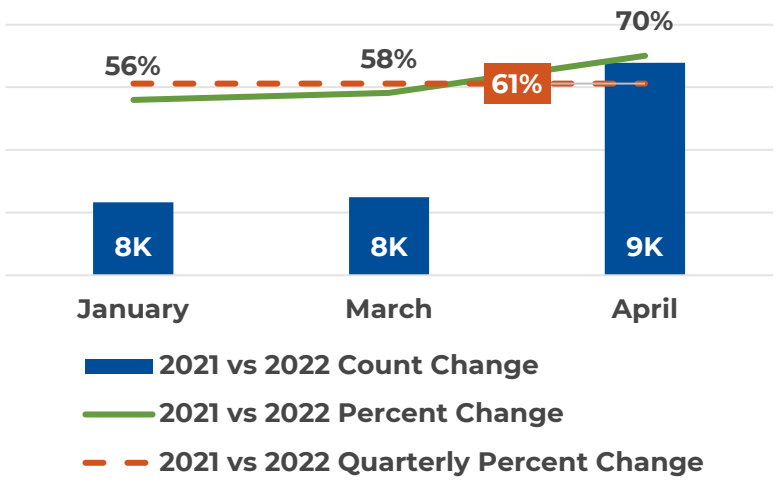
Members With Opioid Claims By Qualifying Group





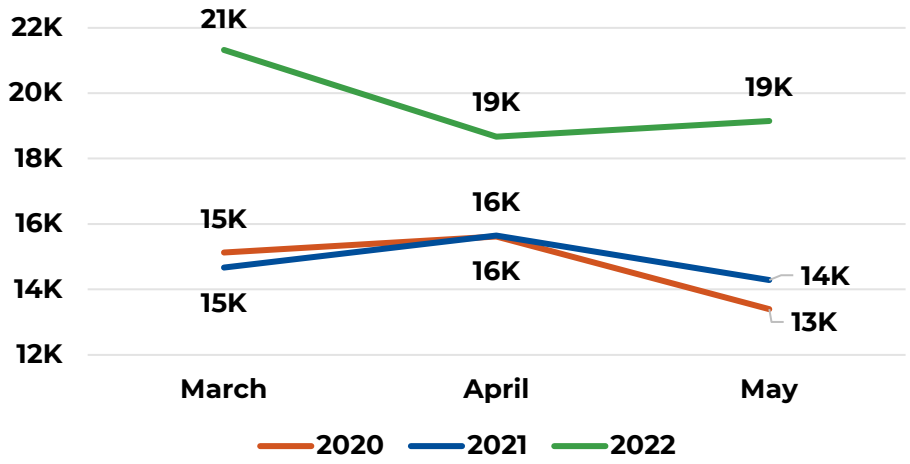
Total Opioid Claims

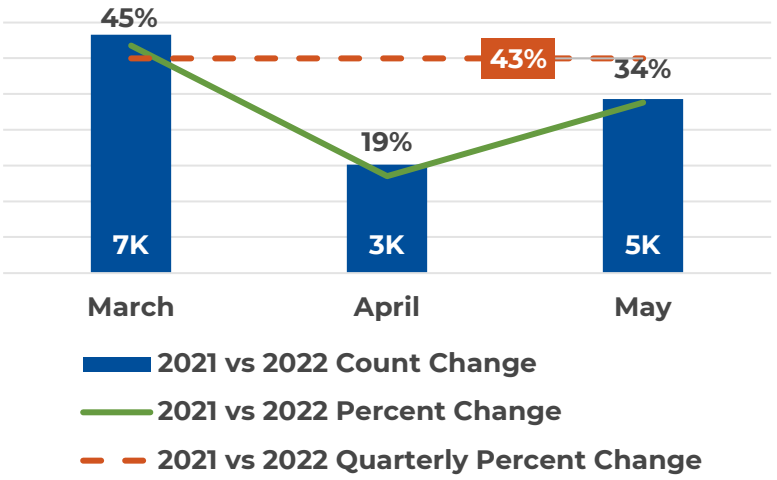




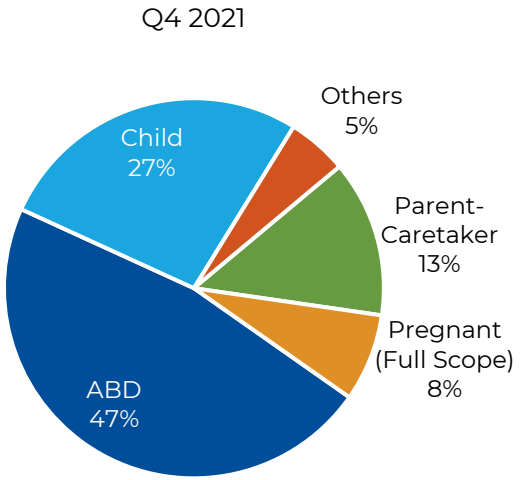
Utilization (Cont.)

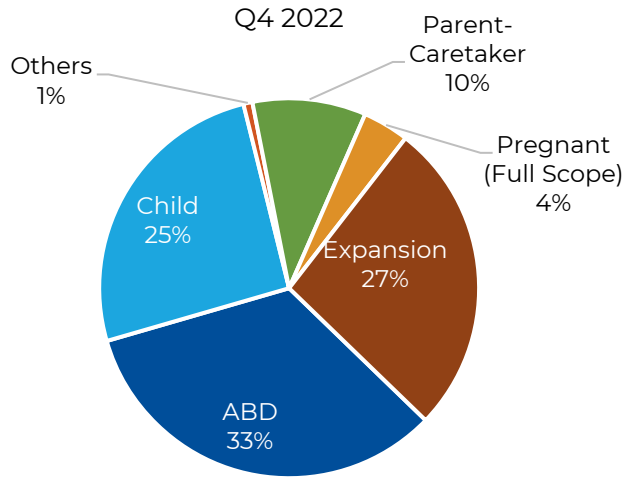
Out of State Services - Total Members Utilization





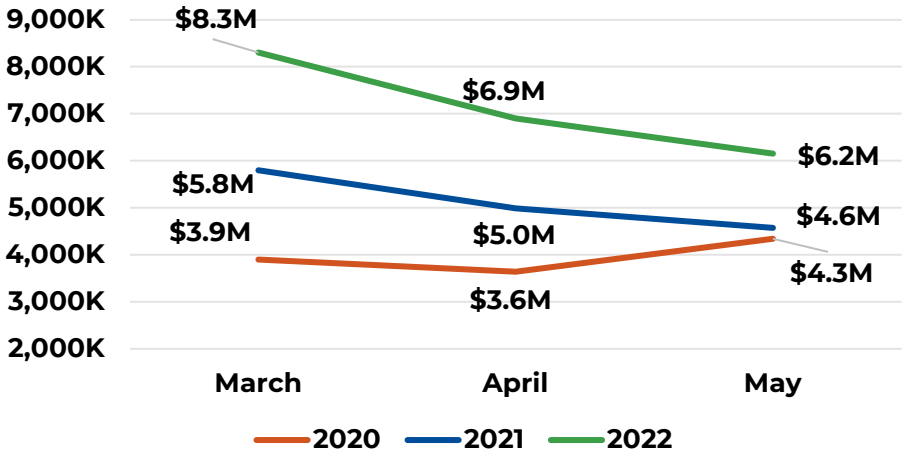
Out of State Services - Total Members Utilization By Qualifying Group

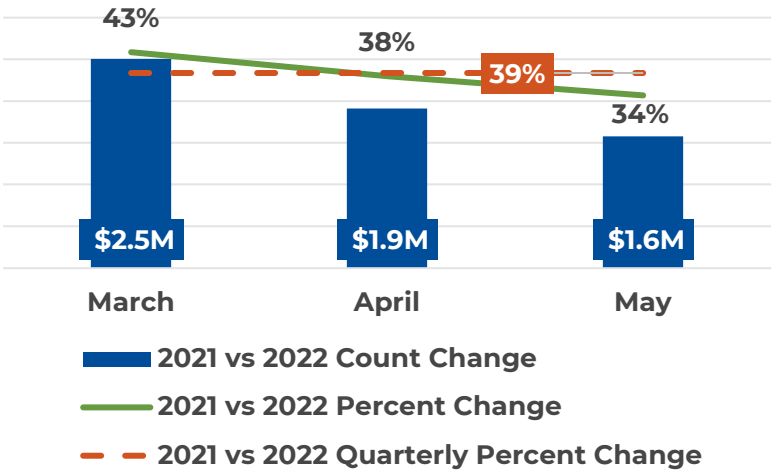




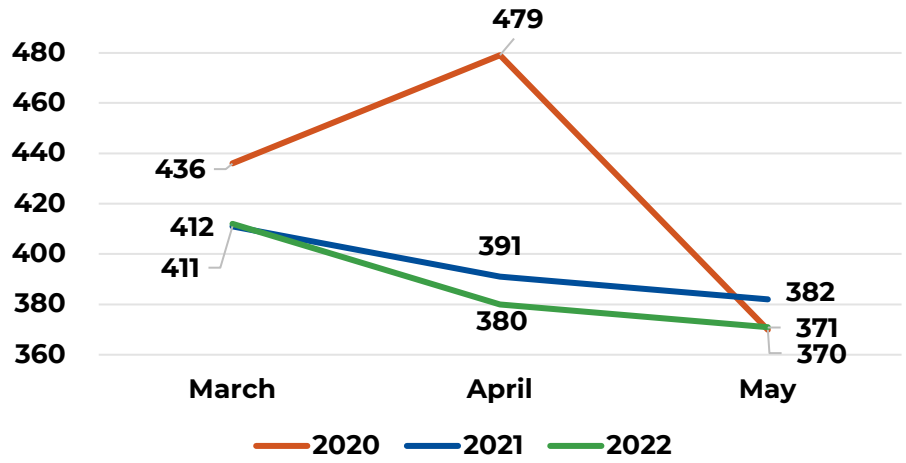
Utilization (Cont.)

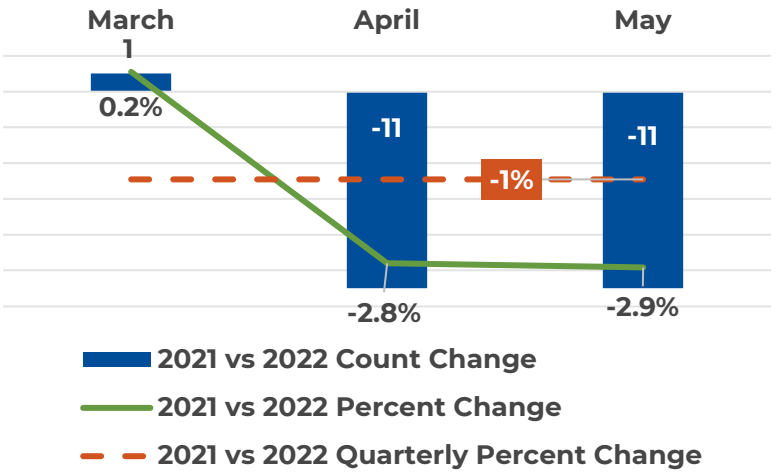
Out of State Services - Total Reimbursements





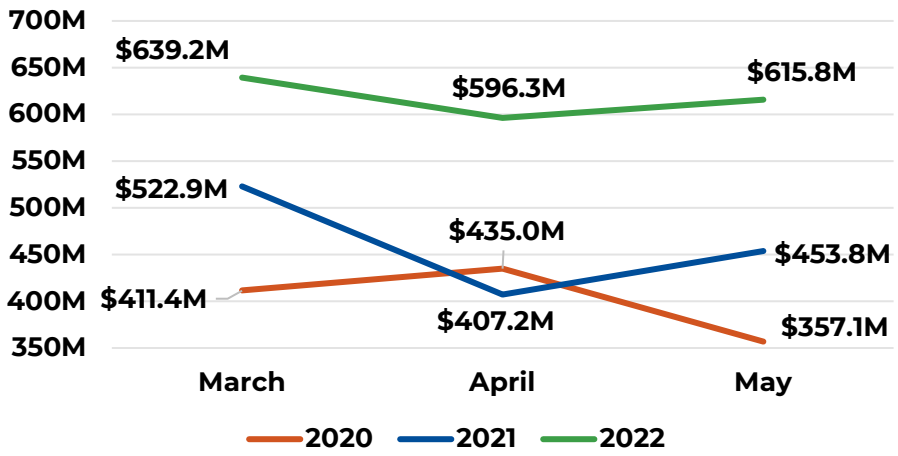
Out of State Services - Total Active Billing Providers

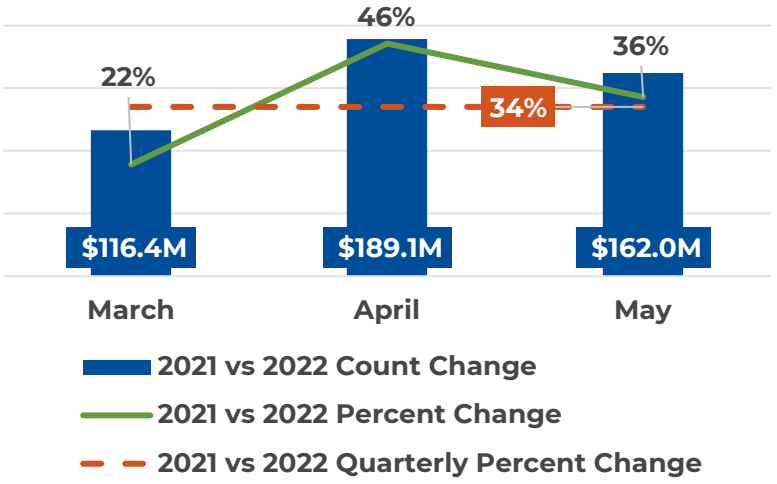




Financials

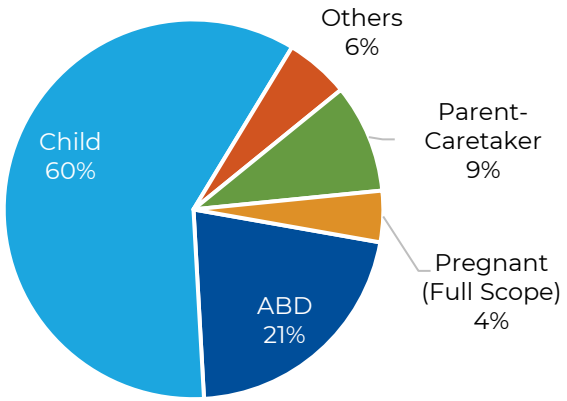
Total Agency Expenditures



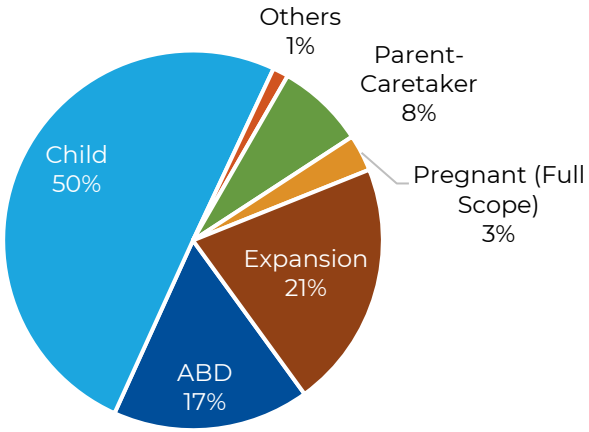


Total Agency Members Utilization by Qualifying Group

Q4 2021

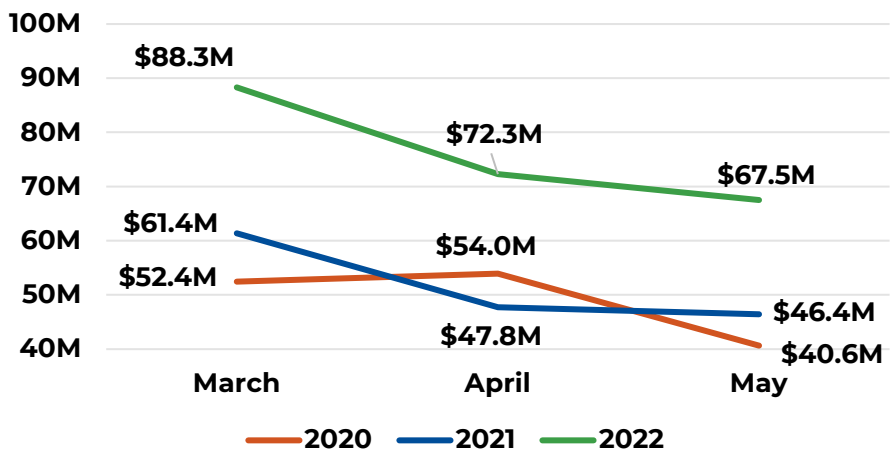


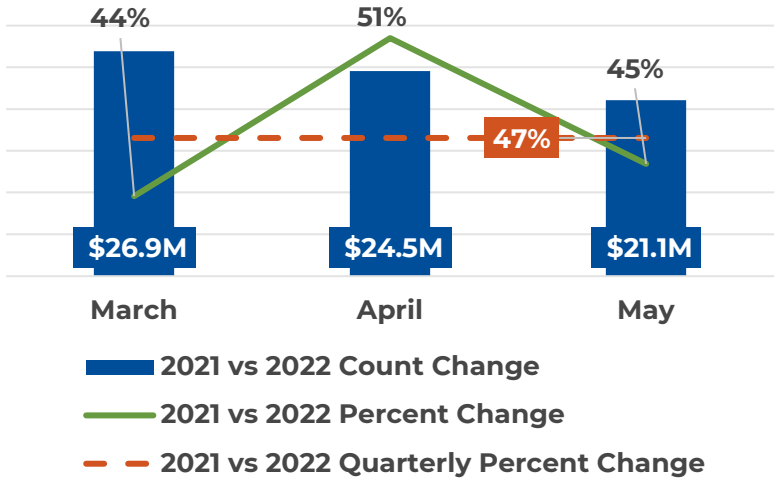
Q4 2022



Financials (Cont.)

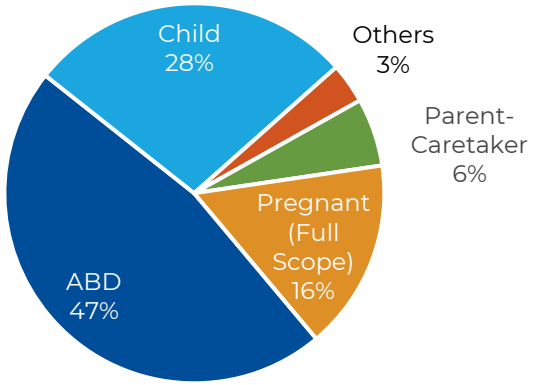
Inpatient Services Expenditures



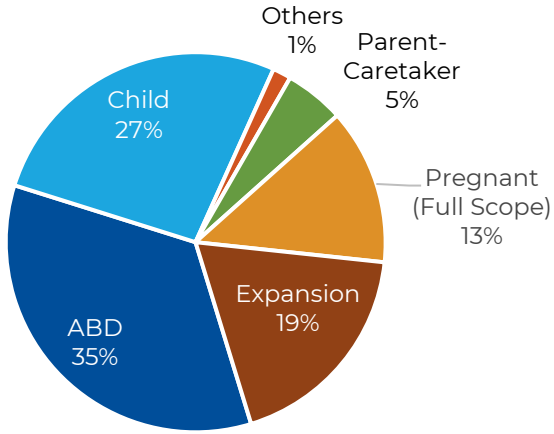


Inpatient Services Members Utilization by Qualifying Group

Q4 2021

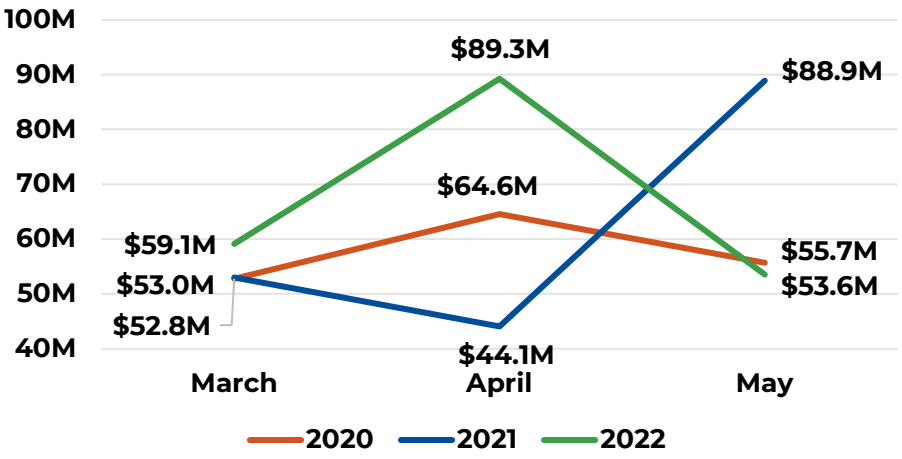


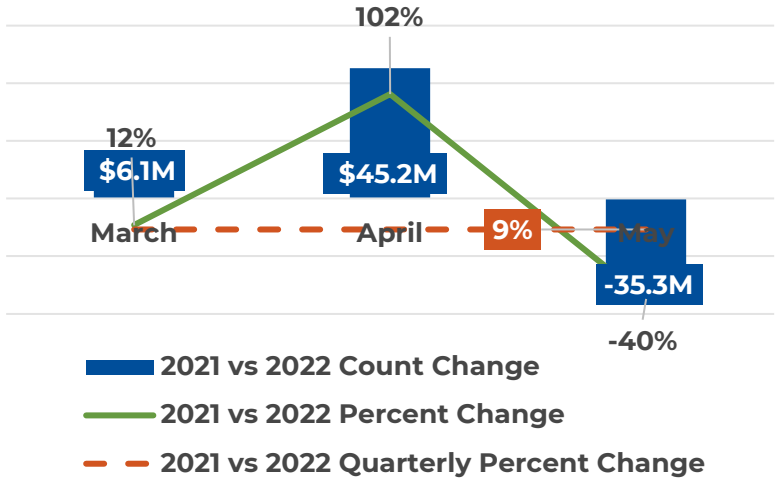
Q4 2022



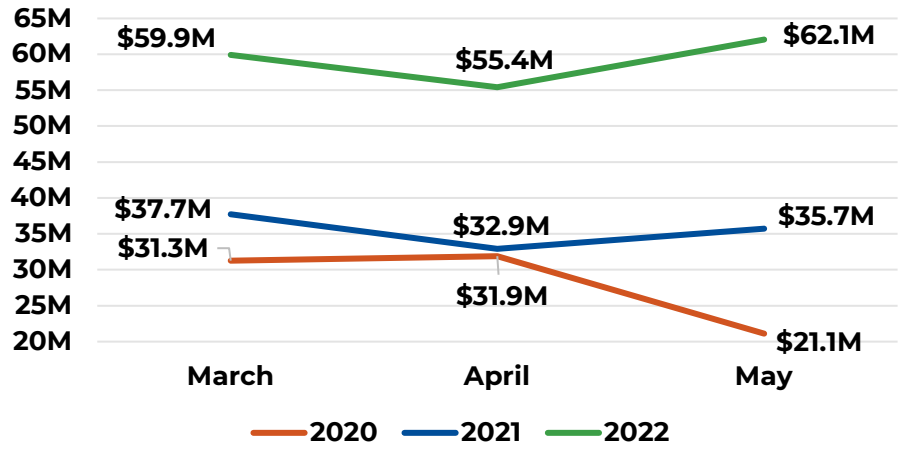
Financials (Cont.)

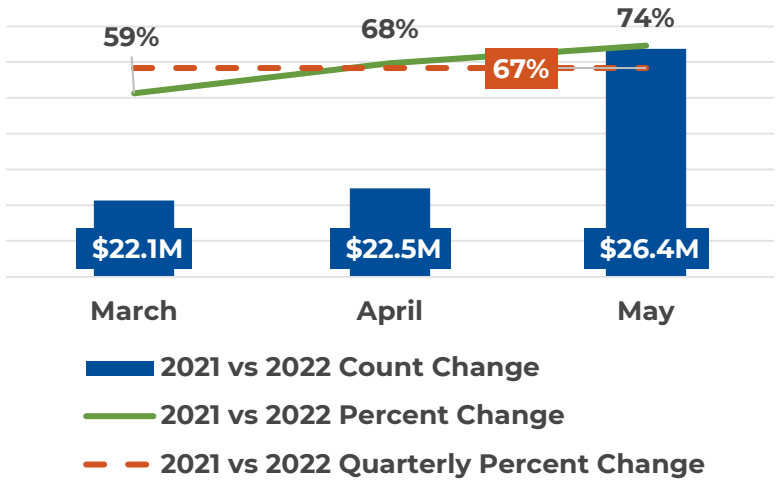
Nursing Facility Expenditures





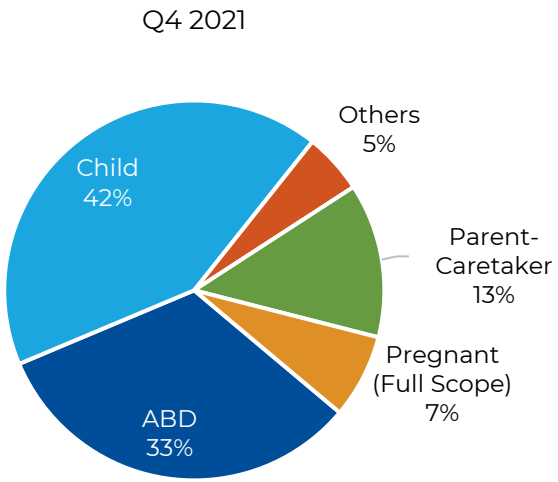
Outpatient Hospital Expenditures

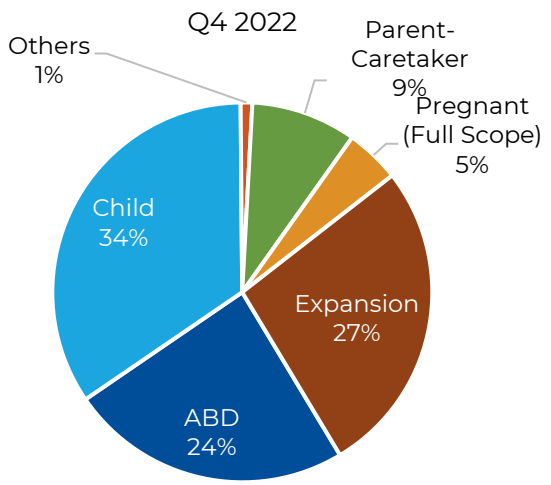




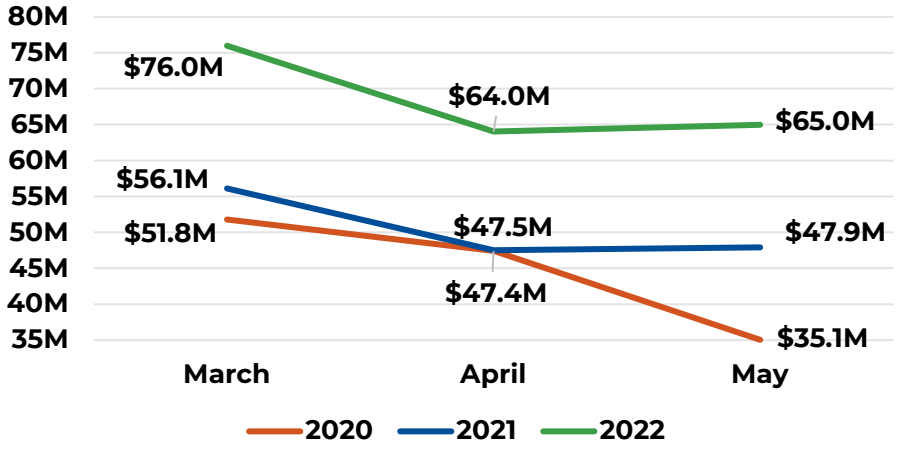
Financials (Cont.)

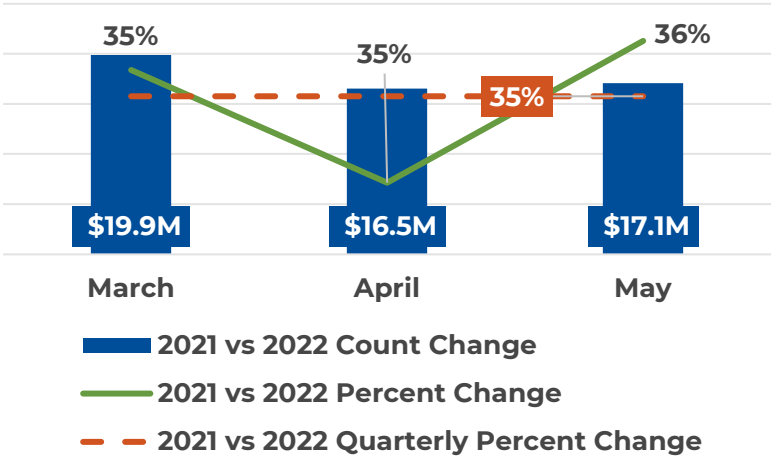
Outpatient Hospital Members Utilization by Qualifying Group





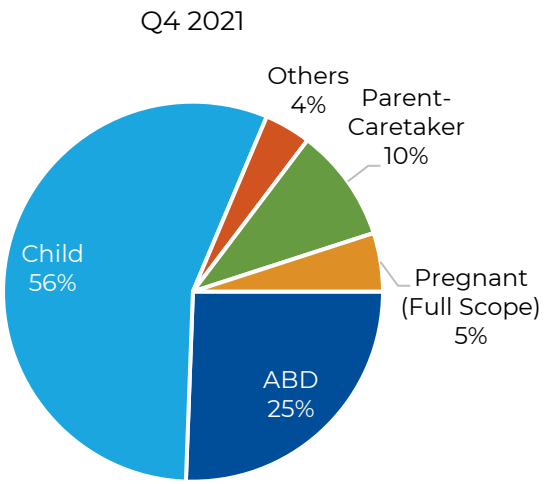
Physician Expenditures

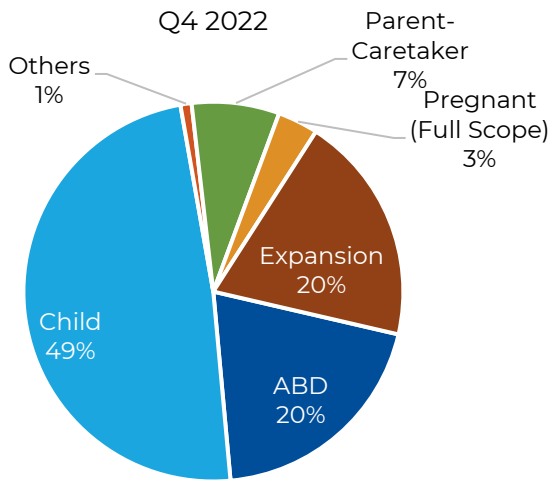




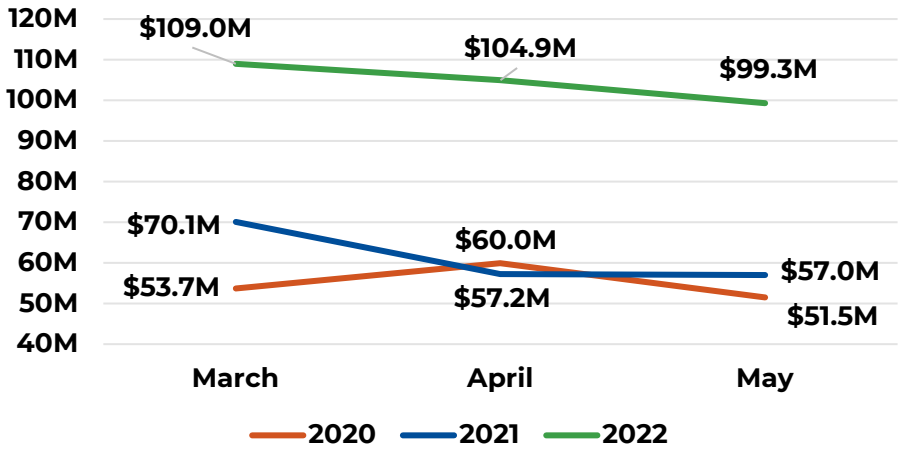
Financials (Cont.)

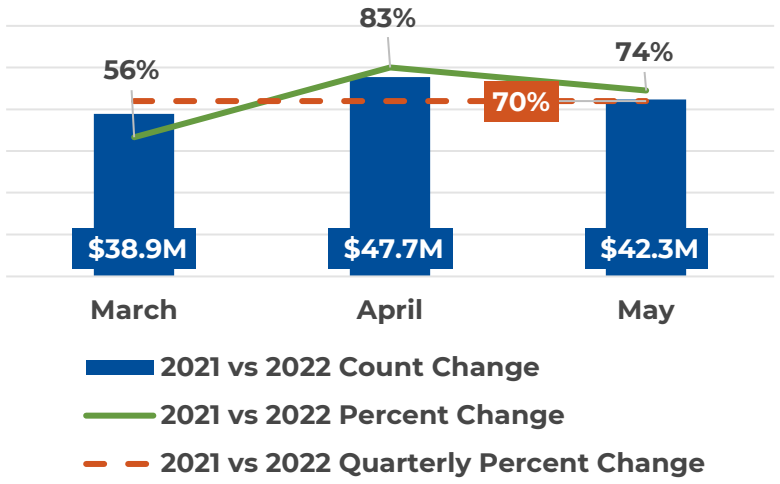
Physician Members Utilization By Qualifying Group





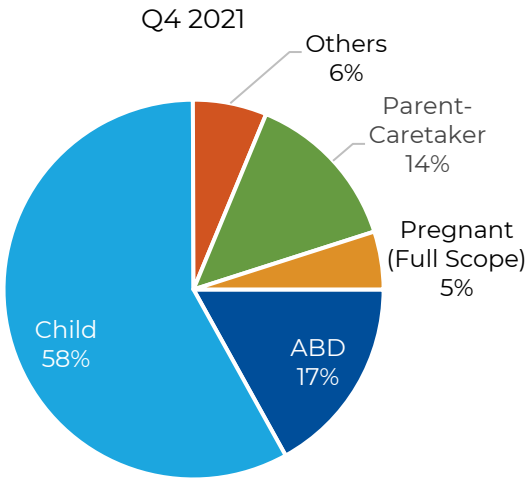
Prescribed Drugs Expenditures

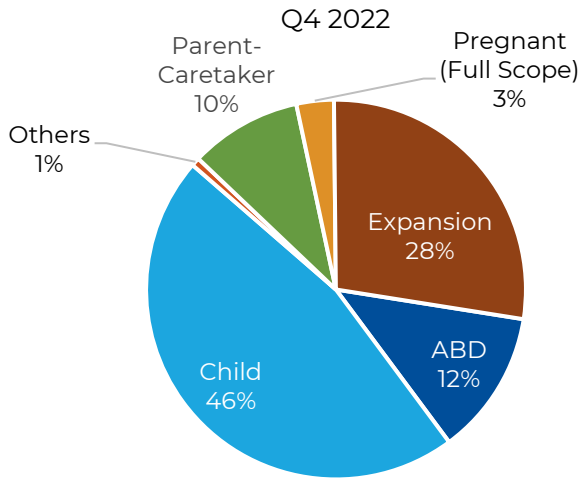




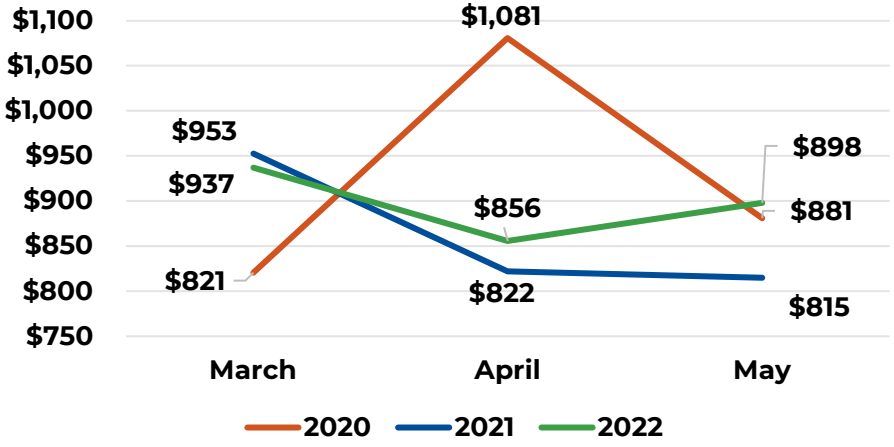
Financials (Cont.)

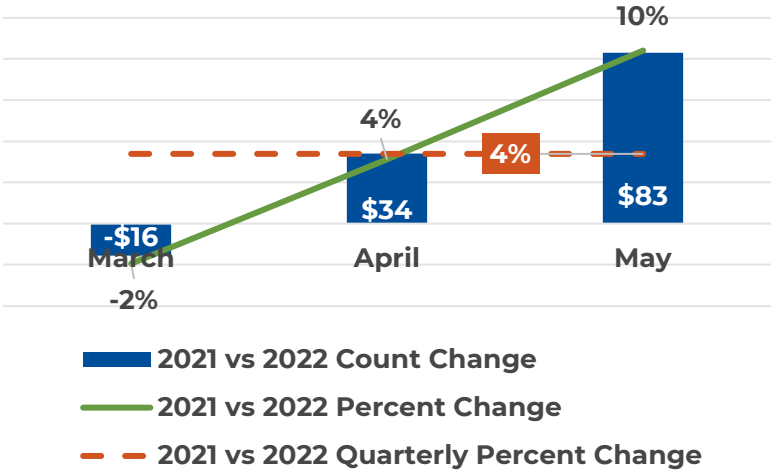
Prescribed Drugs Members Utilization By Qualifying Group





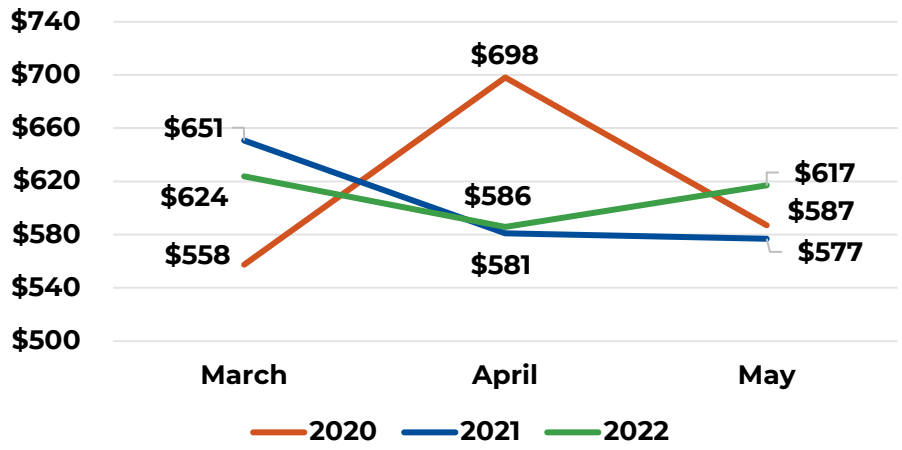
Average Per Total Member Served

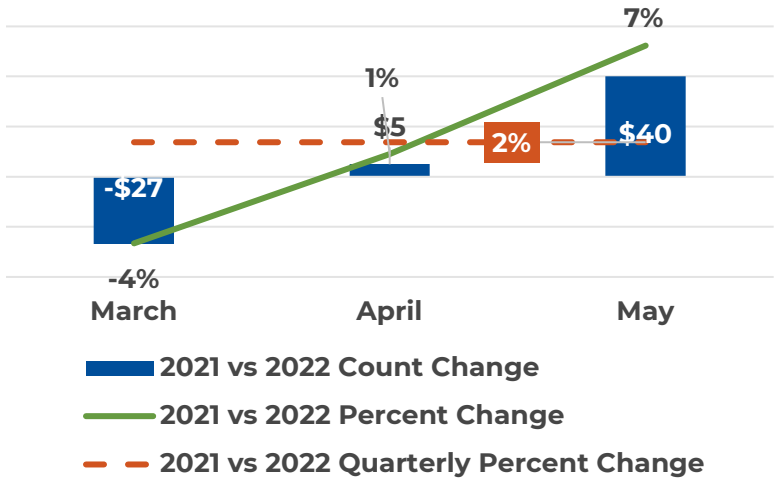




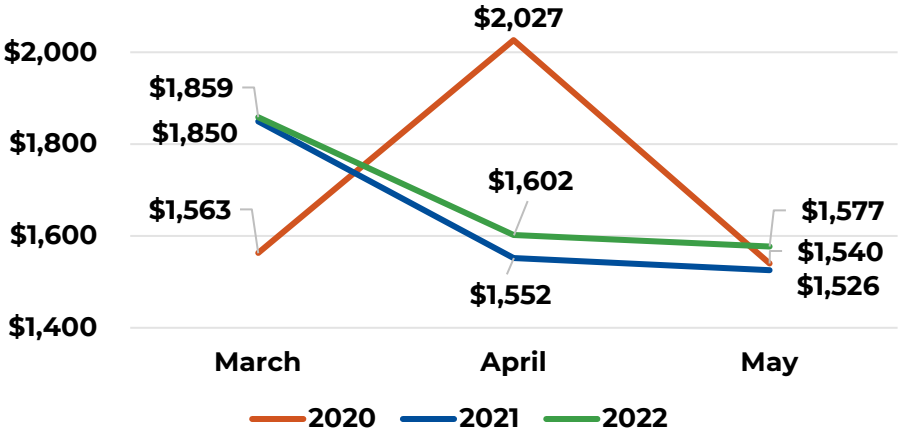
Financials (Cont.)

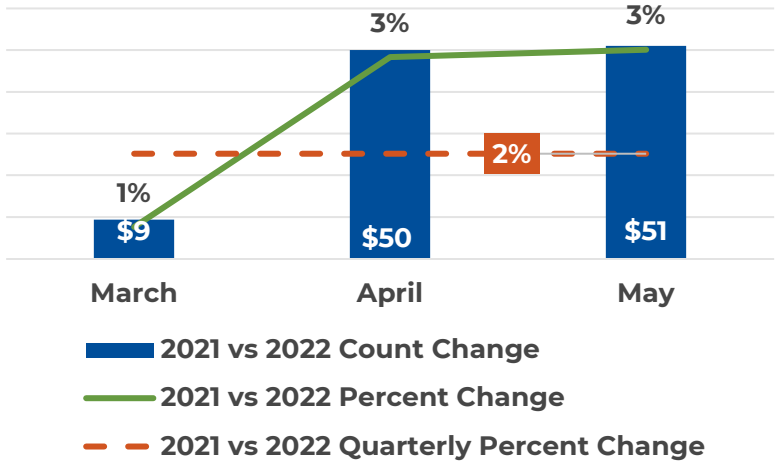
Average Per Child (Under 21) Member Served





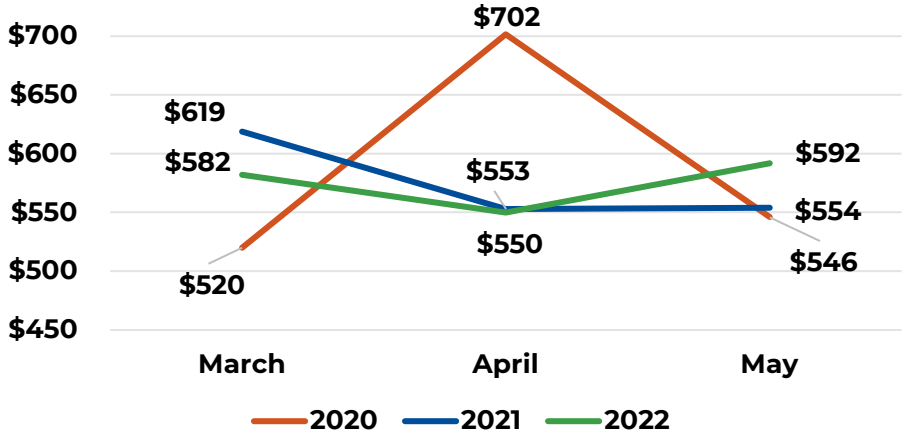
Average Per Aged/Blind/Disabled Member Served

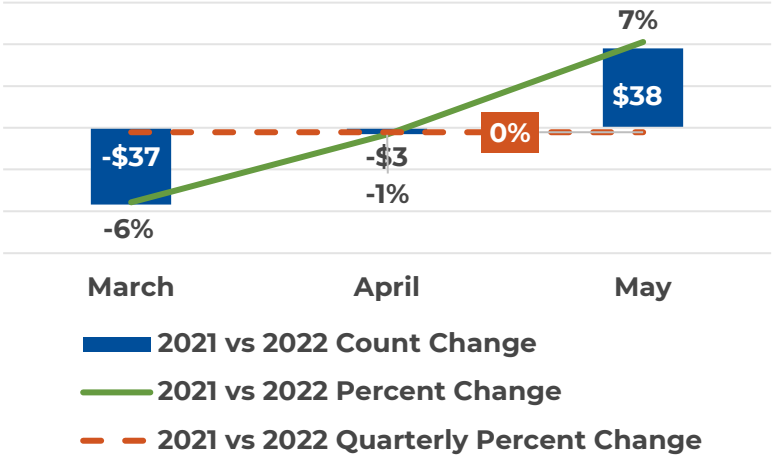




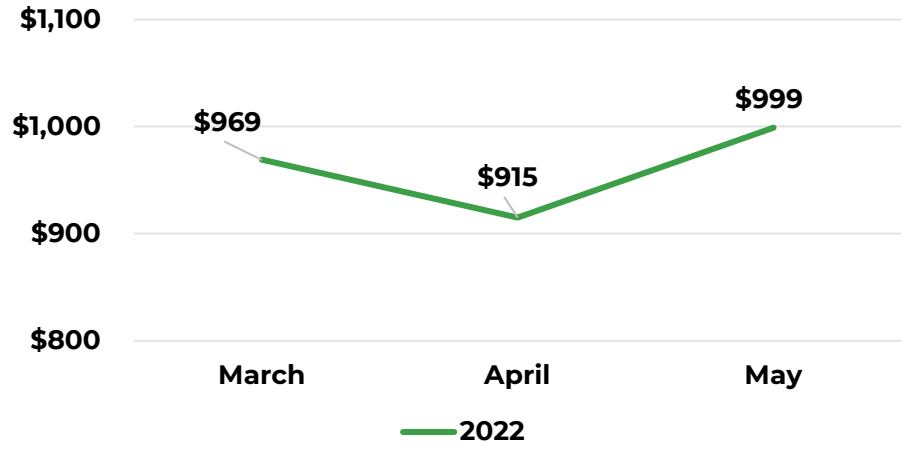
Financials (Cont.)

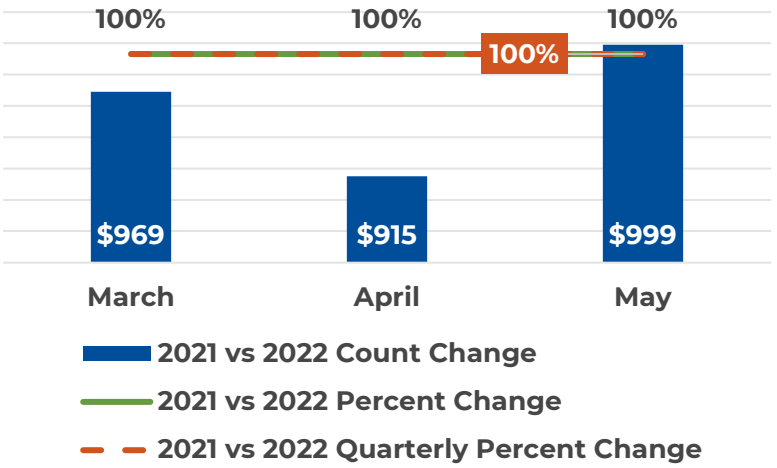
Average Per Children & Parent/Caretaker Member Served





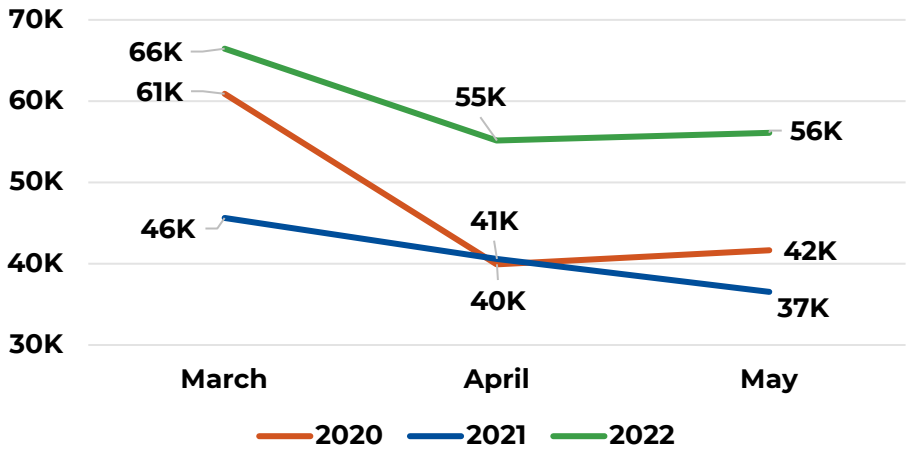
Average Per Expansion Member Served (Effective July 2021)

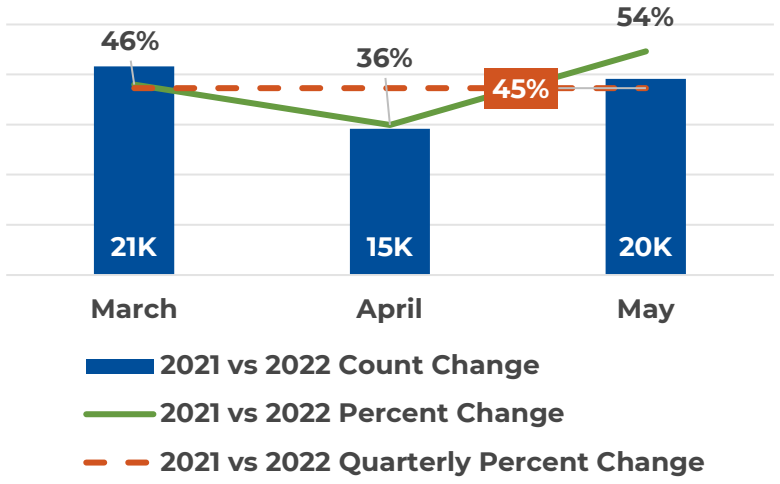




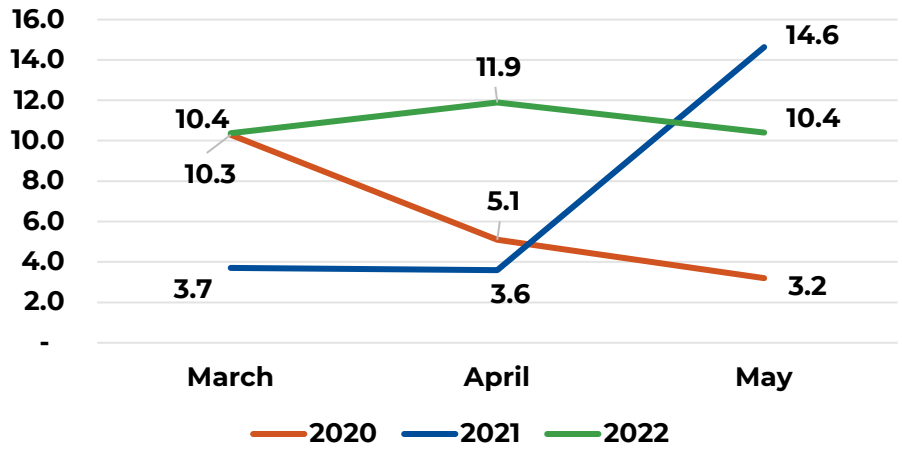
Call Center

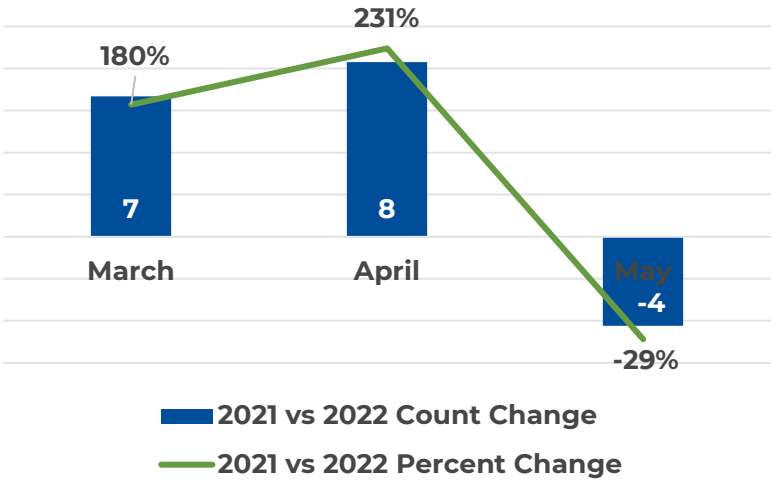
Call Center - Member Calls Answered





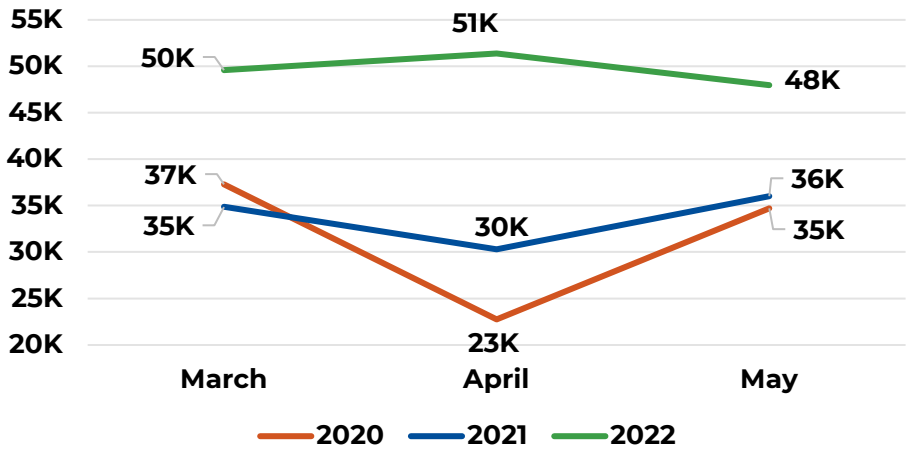
Call Center - Average Wait Time (In Seconds)

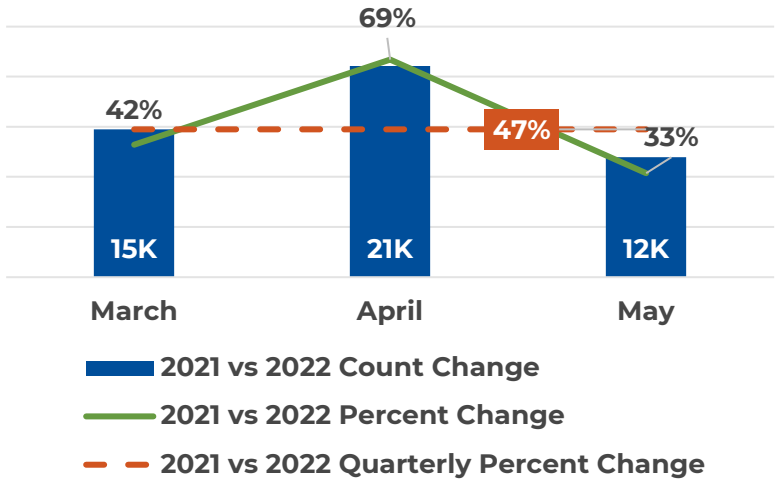




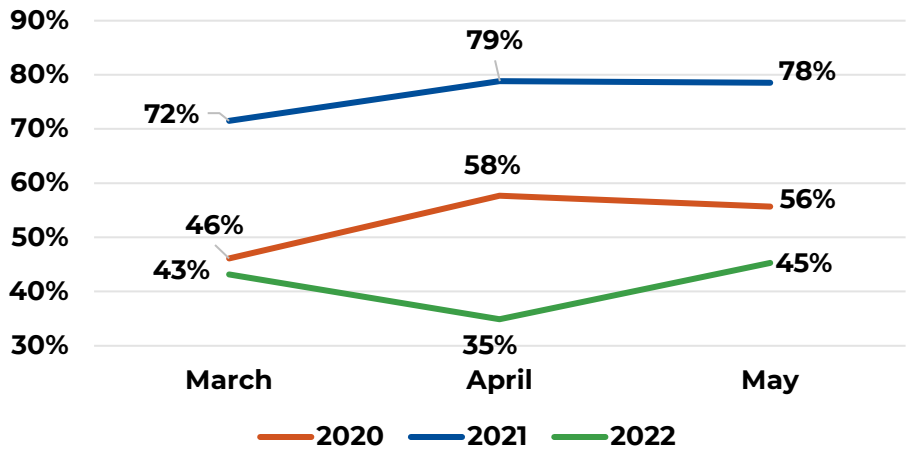
Prior Authorization

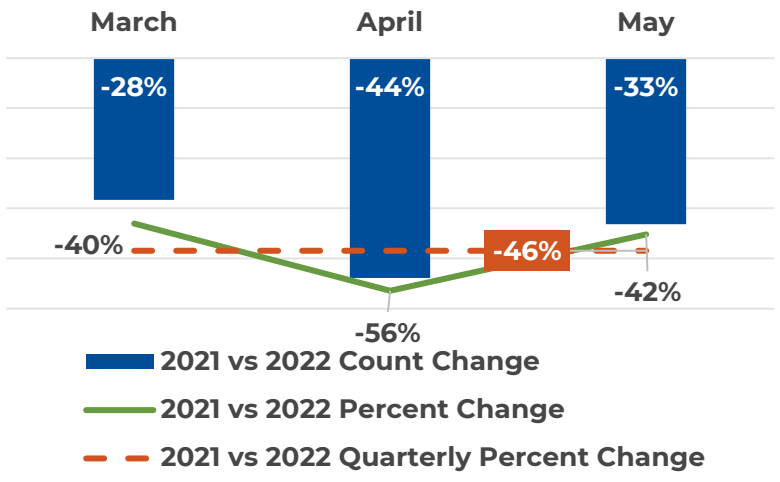
Prior Authorization - Total Combined - Total Completed PA Volume





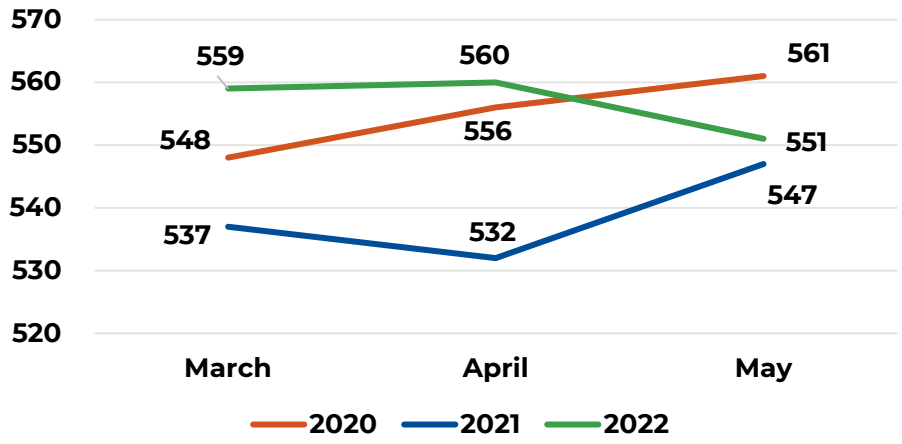
Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

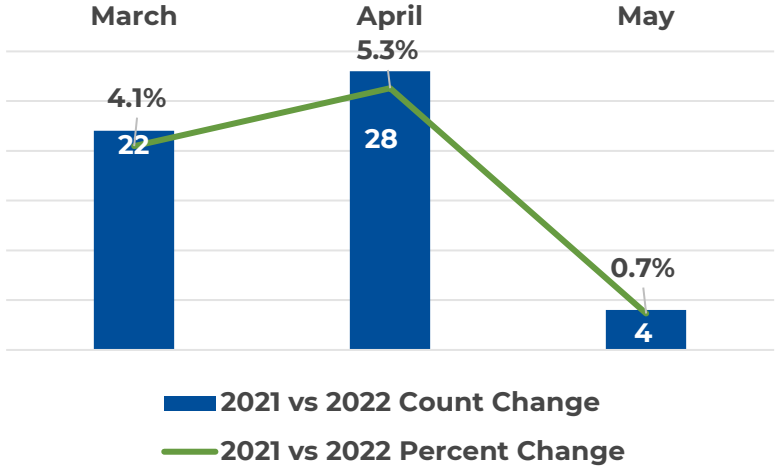




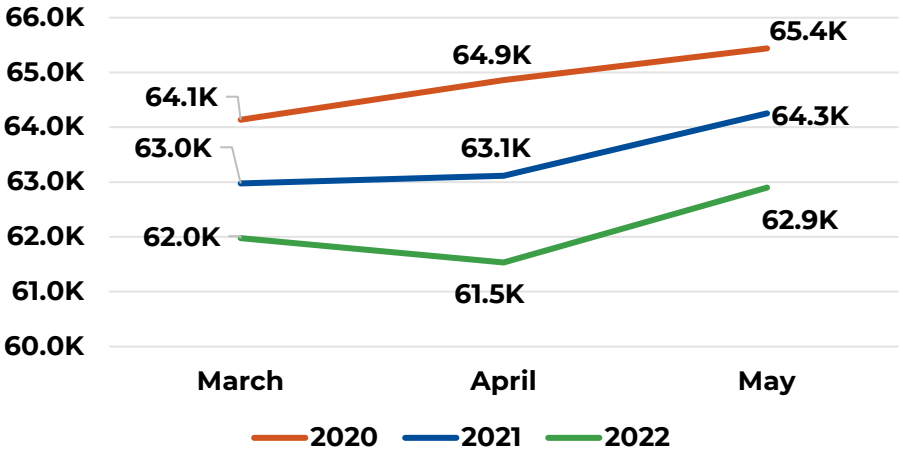
Agency Stats & Provider Network

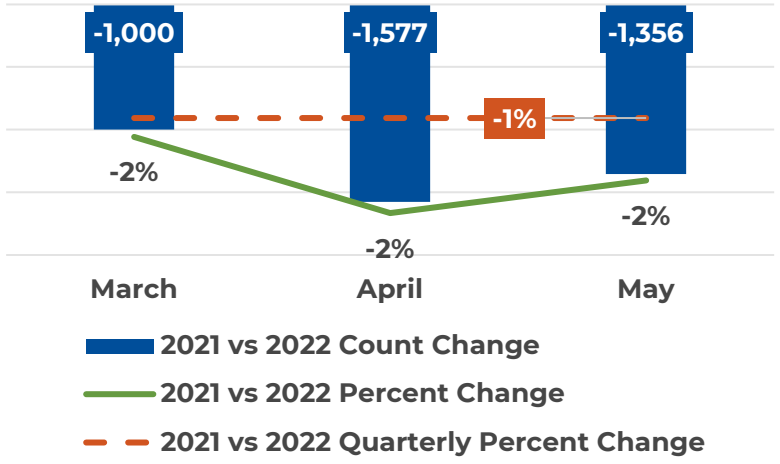
OHCA Admin - Number of FTEs





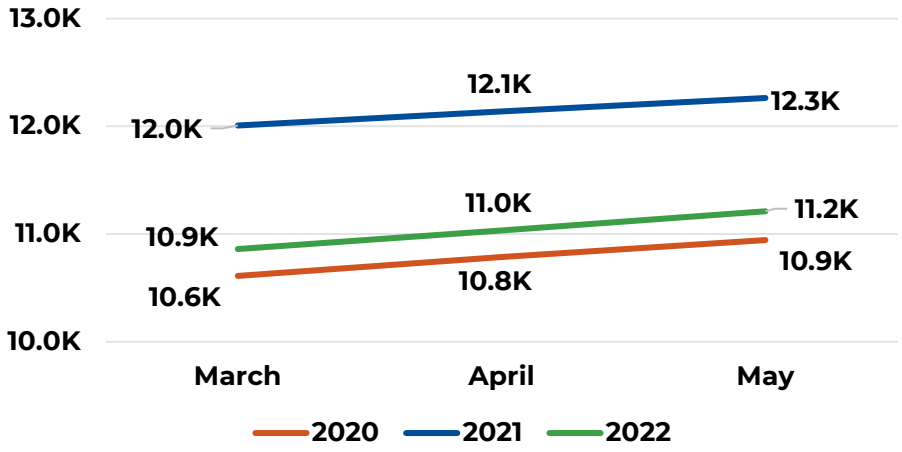
Total Providers

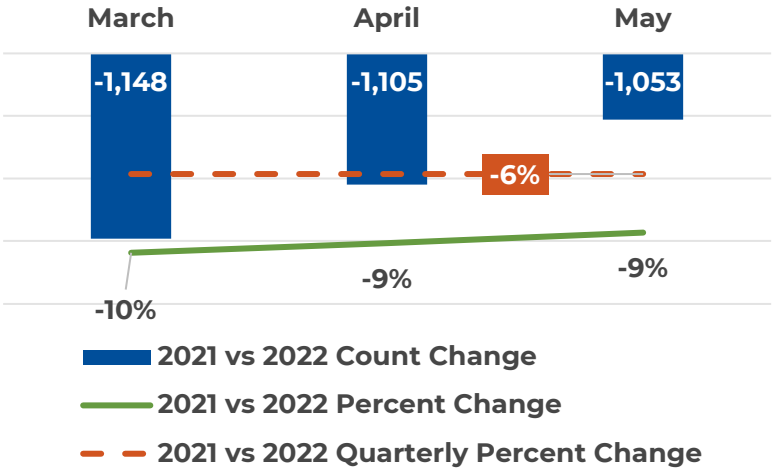




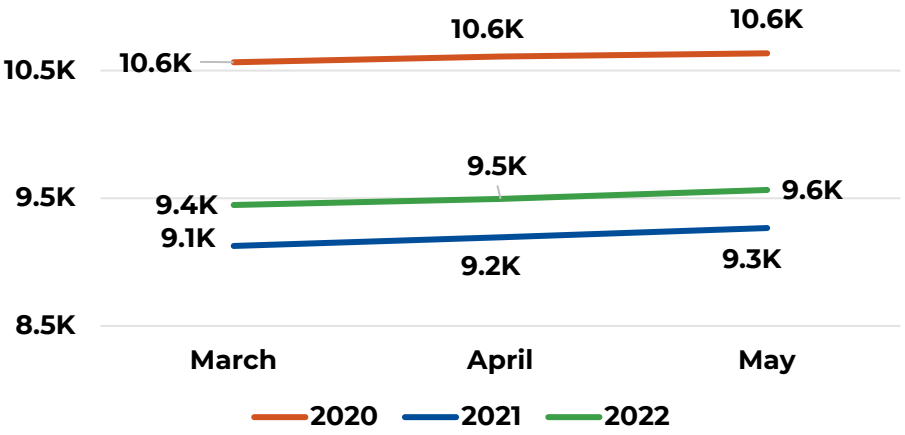
Agency Stats & Provider Network (Cont.)

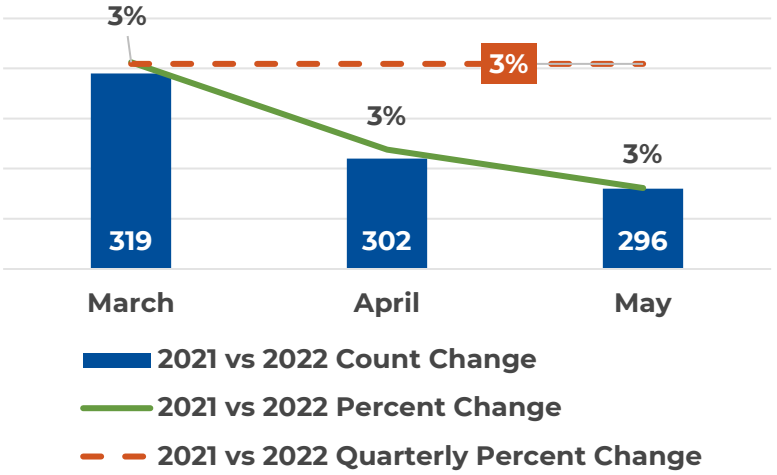
Mental Health Providers (In-State Only)





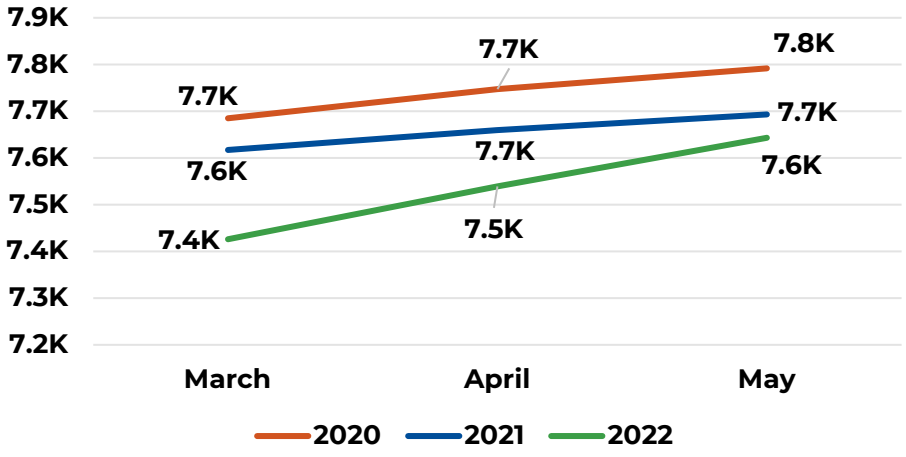
Physicians (In-State Only)

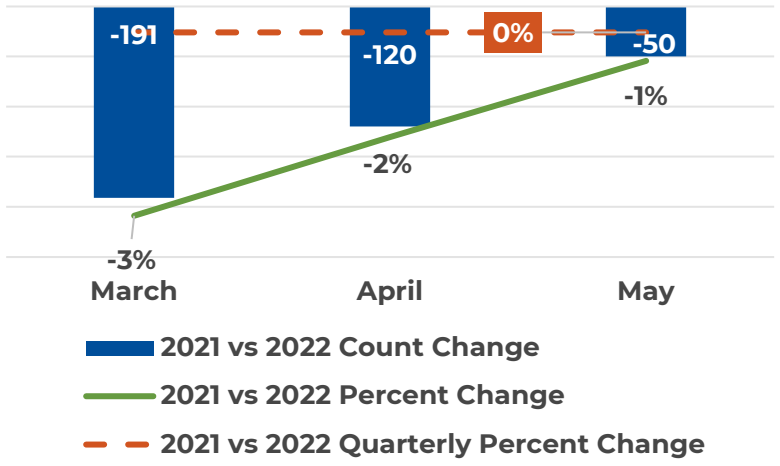




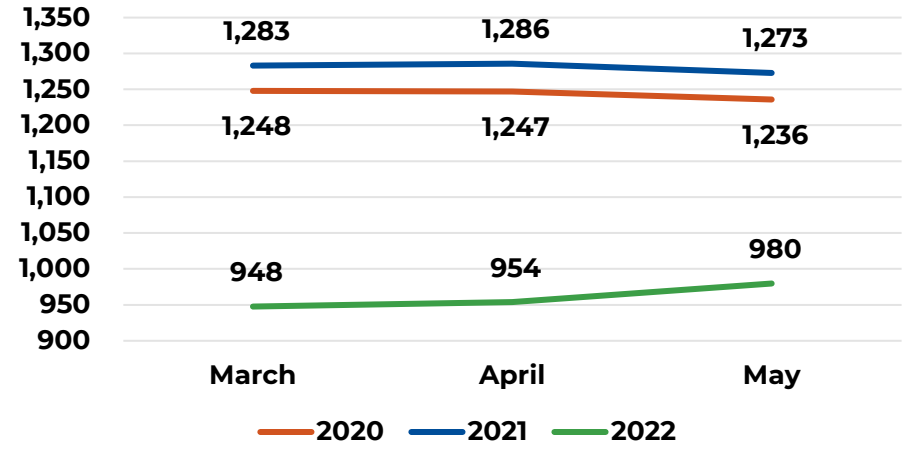
Agency Stats & Provider Network (Cont.)

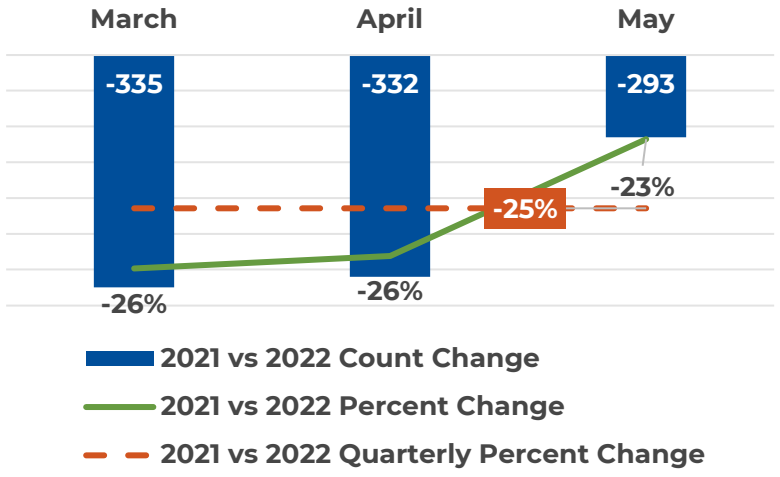
Primary Care Providers (In-State Only)





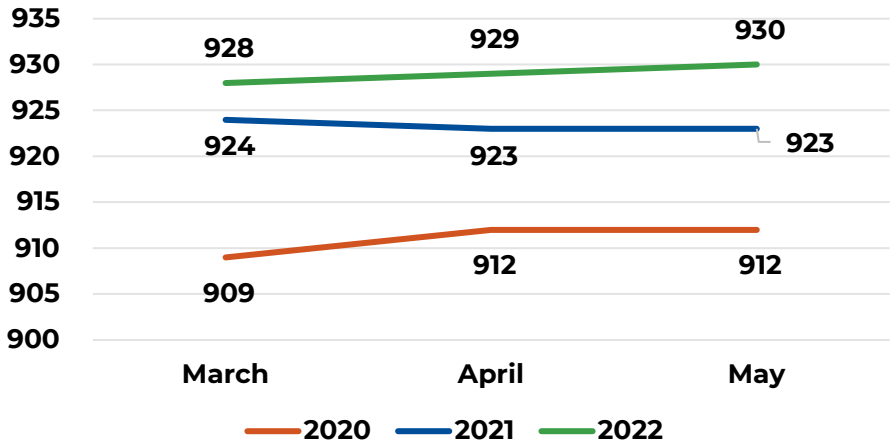
Dentists (In-State Only)

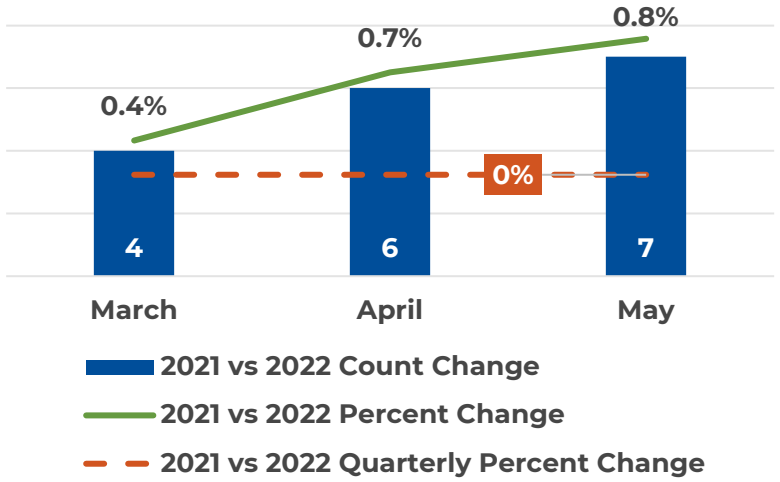




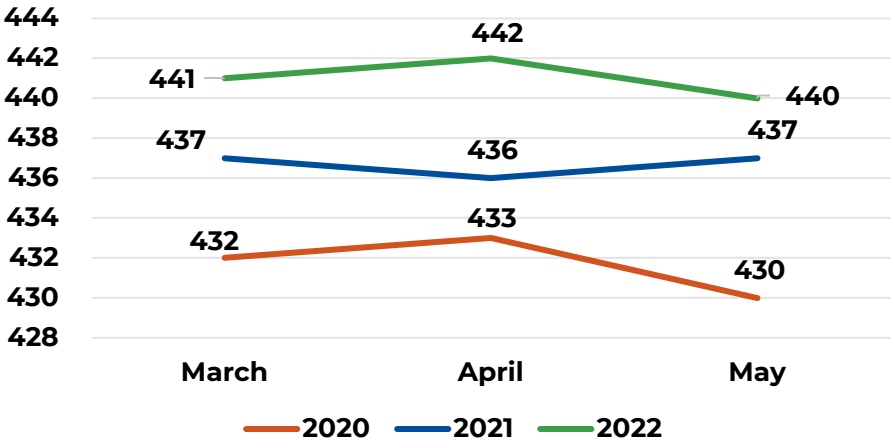
Agency Stats & Provider Network (Cont.)

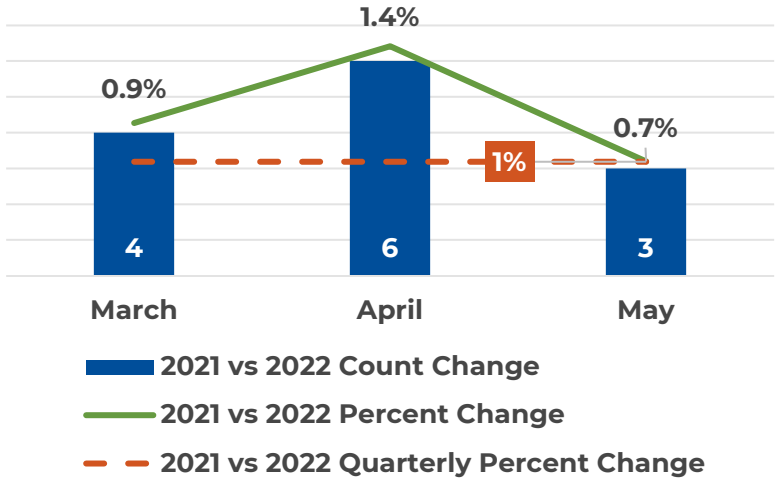
Pharmacy (In-State Only)





Extended Care Facilities (In-State Only)





Agency Stats & Provider Network (Cont.)

Hospitals (In-State Only)