OKLAHOMA HEALTH CARE AUTHORITY
AMENDED BOARD MEETING
September 17, 2024, at 2:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK. 73105

AGENDA

Public access via Zoom:
https://www.zoomgov.com/webinar/register/WN_NVqywA1hS4e4AiHU9ZS21Q
Telephone: 1-669-216-1590 Webinar ID: 161 834 2467

*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. Public Comment……………………………………………………………………………………Marc Nuttle, Chair

3. Discussion and Vote on the August 12, 2024, OHCA Board Meeting Minutes……..…..…….…Marc Nuttle, Chair

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

   a) Member Moment

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

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

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

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

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

vii.	Qalsody® Rilutek®	Amyotrophic Lateral Sclerosis (ALS)
viii.	Liqrev® Opsynvi® Winrevair™	Pulmonary Arterial Hypertension (PAH)
ix.	Akeega® Anktiva®	Prostate Cancer (PC) Bladder Cancer (BC)

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

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

      i. Advantage Waiver Service Increases
      ii. Developmental Disabilities Services Increases
      iii. Money Follows the Person/Living Choice Increase
      iv. Acute Tracheostomy Add-On Rate for Nursing Facilities
      v. Certified Registered Nurse Anesthetist (CRNA) Rate Increase

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

      i. Customer Relationship Management (CRM)

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

      i. APA WF #24-22 High-Acuity Tracheostomy Rate for Nursing Facilities
      ii. APA WF #24-23 Applied Behavioral Analysis Policy Revisions
      iii. APA WF #24-26A Developmental Disabilities Services
      iv. APA WF #24-26B Developmental Disabilities Services
      v. APA WF #24-20 Pharmacists as Providers
      vi. APA WF #24-27 Hospital Provision of Emergency Opioid Antagonist

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

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

12. Adjournment……………………………………………………………………………………………Marc Nuttle, Chair

NEXT BOARD MEETING
December 11, 2024, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

MINUTES OF SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
August 12, 2024
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on August 9, 2024 at 10:59 a.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 August 9, 2024 at 10:59 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Nuttle called the meeting to order at 11:02 a.m.

Due to conflicts in schedule and quorum requirements, the agenda items needed to be taken out of order.

BOARD MEMBERS PRESENT:	Chairman Nuttle, Vice-Chairman Yaffe (11:03), Member Case, Member Christ, Member Corbett, Member Cruzan, Member Jolley, Member Leland
BOARD MEMBERS ABSENT:	Member Kennedy

ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON THE JUNE 26, 2024, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

Member Cruzan had one correction.

MOTION:	Member Jolley moved for approval of the June 26, 2024, board meeting minutes, with the correction. The motion was seconded by Member Case
FOR THE MOTION:	Chairman Nuttle, Member Case, Member Christ, Member Cruzan, Member Jolley, Member Leland
BOARD MEMBER ABSTAIN:	Member Corbett
BOARD MEMBERS ABSENT:	Vice-Chairman Yaffe, Member Kennedy

Chairman Nuttle introduced OHCA's newest board member, and previous OHCA CEO, Kevin Corbett.

ITEM 3 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
John Christ, Compliance Advisory Committee Member

Member Christ invited Josh Richards, Senior Director of General Accounting, to present the State Plan Amendment Rate Committee Rate and provide a brief overview of the Regular Nursing Facility Rate Increase. He added that it is an incentive program of an average amount of $5 a day, based on them hitting certain quality standards.

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

    i. Regular Nursing Facilities Rate Increase – Member Case asked Mr. Richards to provide a quick overview of how the Quality-of-Care Fee works. Mr. Richards stated that the Quality-of-Care Fee is a fee charged to providers, which feed into the pay for performance component and can be matched with federal funding. Member Corbett asked where OHCA is at today relative to five years ago, what level of increase OHCA provided? Mr. Richards stated that in SFY 2021, the rate was at $179.57 per patient day. After the board approves these rate increases, the total per patient day will increase to $244.78, so the rate has increased approximately $65 per patient day over the last five years, with the bulk of that coming in the last two years.

MOTION:	Member Case moved to approve item 3.a.i, as published. The motion was seconded by Member Jolley.

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

BOARD MEMBERS ABSENT: Member Kennedy

Member Christ presented the following Expenditure of Authority Contract.

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

i. Care Management Data Analytics Solution Software Subscription Services – Vice-Chairman Yaffe asked Member Christ to walk the board through what this kind of beta testing period was for and what the results were. Member Christ stated that three years of claims data were uploaded into the software to see if they could start seeing patterns and be able to utilize the data to positively impact patient outcomes. CEO Buettner added that it allows for the ability to share the information with providers. Member Cruzan asked who would be responsible for ensuring the information being provided is correct. CEO Buettner stated that the accountability would lay with OHCA, while working with Gray Matter, to make sure the data is accurate. Member Cruzan also asked how OHCA landed Gray Matter versus any of the other organizations that perform this type of work? CEO Buettner stated that OHCA had been meeting with Gray Matter for several years and brought in Steve Miller, Chief Technology Officer, for a larger Managed Care Oversight Software System. This one was unique in that it would provide information on patient outcomes and create scorecards. Based on observations and the performance OHCA had received from them already, it was decided to move forward with Gray Matter. Member Cruzan asked if they would provide the information to providers, so they will know what needs to be worked on as far as care gaps. CEO Buettner stated that that is the ultimate intent, but it may take time. Over the next year will be to establish the baseline data, so OHCA knows where they are from the beginning and have a good foundation. Member Cruzan asked how this will play into the new Quality Committee that has oversight. CEO Buettner stated that the Quality Committee is there to guide what the expectations are in terms of the quality metrics. Member Case asked who will take the clinical lead. CEO Buettner stated it would be Folake Adedeji from OHCA's internal Quality unit. Member Case asked if this would be for the members remaining with OHCA, such as the ABD population, or if this would also be used for the MCOs. CEO Buettner stated that the primary purpose is for Managed Care oversight. When asked about whether the providers should get unfiltered data that is not coming from the agency or through the Managed Care entities, CEO Buettner stated that providers will be receiving that information, however that is further down the line. At this time, OHCA is focused on the client's baseline data. Vice-Chairman Yaffe asked how long it would be before we received the more robust accountability platform in place. CEO Buettner stated that is in process. OHCA is working with OMES and finalizing those contracts. Once those contracts are finalized, it will take about a year to roll the system out. Vice-Chairman Yaffe asked if we know when we'll get the good and bad points. CEO Buettner stated that OHCA is already receiving reports from the MCOs. The software that OHCA is in the procurement process for that will probably be live next year doesn't preclude OHCA internally from analyzing and receiving that data. OHCA receives hundreds of reports per week from the Managed Care plans, it's just more of an internal view, as opposed to having that software. Member Corbett added that this was a statewide contract, so the vendor was vetted and approved through OMES through a competitive process. He also stated that the board's responsibility is to approve the expenditure, not the selection of the vendor. Vice-Chairman Yaffe stated that while he appreciates that, he does not think you can unmarry those things.

MOTION: Member Jolley moved for approval of item 3.b.i, as published. The motion was seconded by Member Leland.

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

BOARD MEMBERS ABSENT: Member Kennedy

ITEM 4 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

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

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

BOARD MEMBERS ABSENT: Member Kennedy

Meeting adjourned at 11:28 a.m., 8/12/2024.

NEXT BOARD MEETING
September 17, 2024
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _______________

*Initials:*______________

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CHIEF EXECUTIVE OFFICER REPORT

Ellen Buettner

September 17, 2024

OHCA KEY PRINCIPLES

PASSION FOR PURPOSE

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

EMPOWERMENT & ACCOUNTABILITY

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

TRUST & TRANSPARENCY

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

BEST IN CLASS & OUTCOME-DRIVEN

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

SERVANT LEADERSHIP

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

INDIVIDUAL AWARDS

TARA BROWN

Agency Ambassador - EGID

RAINA CASTLE

Employee Champion - EGID

MARCUS AYERS

Agency Ambassador - Medicaid

COREY DOZIER

Employee Champion - Medicaid

INDIVIDUAL AWARDS

JON WOOTEN

Outstanding Supervisor - EGID

BROOKE GRIM

Outstanding Supervisor - Medicaid

EMILY WATHAN

Rising Star - EGID

BRADEN MITCHELL

CEO Award of Excellence - EGID

BEKAH GOSSETT

CEO Award of Excellence - Medicaid

EXCELLENCE IN CORE VALUES

Administrative Services - Medicaid

Former Employee Enrollment Unit - EGID

HIGH PERFORMING TEAMS

ECS & Enrollment Automation Data Integration - Medicaid

Group Management - EGID

FISCAL RESPONSIBILITY ACCOMPLISHMENTS

Pharmacy - Medicaid

Network Management - EGID

OPERATIONAL EXCELLENCE

Finance Long Term Care - Medicaid

Current Employee Enrollment - EGID

EXCELLENCE IN HEALTH OUTCOMES

Chronic Care Management

TRACTION 1-YEAR GOALS FY25

HEALTH OUTCOMES

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

OPERATIONAL EXCELLENCE

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

FISCAL RESPONSIBILITY

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

HIGH-PERFORMING TEAMS

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

STAKEHOLDER ENGAGEMENT

- Health & Human Services agency leadership meetings
- Oklahoma Hospital Association
- OK County Criminal Justice Advisory Council
- Western Governor's Association Health Care Working Group
- Oklahoma Osteopathic Association
- Legislative Office of Fiscal Transparency
- United Way – State Charitable Campaign
- National Association of State Health Policy Advisors Summit

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

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

MEDICAID DIRECTOR UPDATE

SEPTEMBER 17, 2024

SOONERSELECT UPDATE

SOONERSELECT ACHIEVEMENTS

- Enrollment
  - 579,830 members enrolled in a medical plan
  - 19,841 members enrolled in SoonerSelect Children's Specialty Plan
  - 627,009 members enrolled in SoonerSelect Dental.
- Reimbursement
  - $872,869,289 has been reimbursed across all plans since April 1.
    - $756,949,126 has been reimbursed through Medical/CSP
    - $115,920,163 has been reimbursed through SoonerSelect Dental.
- Members Served
  - Over 490,000 unduplicated members have been served in SoonerSelect since April 1.
  - Over 420,000 members have been served through a Medical/CSP Plan
  - Over 240,000 members have been served through a Dental Plan.

WHAT'S ON OUR RADAR?

NEW AND NOTEWORTHY

- Funding Opportunity for the Innovation in Behavioral Health (IBH) Model
  - The IBH Model is focused on improving the quality of care and behavioral and physical health outcomes for adults enrolled in Medicaid and Medicare with moderate to severe mental health conditions and substance use disorder (SUD). Medicare and Medicaid populations experience disproportionately high rates of mental health conditions or substance use disorders (SUDs), or both. As a result, they are more likely to experience poor health outcomes such as frequent visits to the emergency department and hospitalizations, or premature death.
  - The IBH Model supports specialty behavioral health practices in delivering integrated care in outpatient settings. This person-centered approach to addressing whole-person health prioritizes close collaboration with primary care and other physical health providers to support all aspects of a patient's care.
- Funding Opportunity for the Transforming Maternal Health Model
  - TMaH is the newest CMS model designed to focus exclusively on improving maternal health care for people enrolled in Medicaid and Children's Health Insurance Program (CHIP). The model will support participating state Medicaid agencies (SMAs) in the development of a whole-person approach to pregnancy, childbirth, and postpartum care that addresses the physical, mental health, and social needs experienced during pregnancy. The goal of the model is to reduce disparities in access and treatment. The model aims to improve outcomes and experiences for mothers and their newborns, while also reducing overall program expenditures.
  - The model is projected to run for 10 years.

SCHOOL BASED SERVICES EXPANSION

SCHOOL BASED SERVICES EXPANSION

- OHCA is collaboratively working with the Oklahoma State Department of Education to expand the services available to schools to provide and be reimbursed by SoonerCare.
- This expansion would give access to SoonerCare reimbursement for children who do not have an Independent Education Plan (IEP) or Individualized Service Plan (IFSP).
- Increase the amount and type of services reimbursable for Schools as Providers.
- Implementation Date July 1, 2025.

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Attachment C

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – June 12, 2024 and July 10, 2024

Vote Item	Drug	Used for	Cost*	Notes
1	Lantidra™	• **Type 1 Diabetes Mellitus (T1DM):** T1DM is an autoimmune disease that leads to the destruction of insulin-producing pancreatic beta cells. Individuals with T1D require life-long insulin replacement with multiple daily insulin injections daily, insulin pump therapy, or the use of an automated insulin delivery system. *2,880 members with T1DM*	• $300,000 per infusion with up to 3 infusions possible	• Allogenic (donor) pancreatic islet cellular therapy
2	Izervay™	• **Geographic Atrophy (GA):** GA is an advanced form of age-related macular degeneration (AMD), characterized by atrophic lesions that first start in the outer retina and progressively expand to cover the macula and the fovea, the center of the macula, leading to irreversible loss of vision over time. GA is distinct from wet or neovascular AMD (nAMD), the other form of advanced AMD. *311 members with AMD; none with GA*	• $27,300 per year	• Other treatment options available
3	Rezzayo™	• **Invasive Candidiasis (IC):** IC is a serious fungal infection caused by a yeast, Candida. *91 members with IC*	• $9,750 per treatment	• Cheaper treatment options available
4	Augtyro™ Pemrydi RTU®	• **Non-Small Cell Lung Cancer (NSCLC):** NSCLC is the most common type of lung cancer. With this disease, cancer cells originate in the lung tissues. Non-small cell lung cancer grows slowly compared to small cell lung cancer — but it often spreads to other parts of the body by the time it's diagnosed. *1,038 with lung cancer diagnosis (not specific for NSCLC)*	• $348,000 per year • $135,830 per year	• Need to verify therapy is appropriate • Cheaper treatment options available

5	Rezdiffra™	• **Noncirrhotic Nonalcoholic Steatohepatitis (NASH):** Nonalcoholic fatty liver disease (NAFLD) is a condition in which fat builds up in the liver. NASH is a type of NAFLD. With NASH, there is inflammation and liver damage, along with fat in the liver. *1,222 members with NASH*	• $47,401 per year	• First FDA approved medication for NASH
6	Various Special Formulations: Clindacin® ETZ Kit Lodoco® Motpoly XR™ PoKonza™	• **Acne Vulgaris:** Acne is a common chronic skin disease involving blockage and/or inflammation of hair follicles and their accompanying sebaceous gland. *6,050 members with acne* • **Myocardial Infarction (MI) Prevention:** MI also referred to as a heart attack happens when one or more areas of the heart muscle don't get enough oxygen. This happens when blood flow to the heart muscle is blocked. *19,081 members with atherosclerotic heart disease* • **Seizures:** A seizure is a sudden, uncontrolled burst of electrical activity in the brain. It can cause changes in behavior, movements, feelings and levels of consciousness. *1,190 members using immediate release version* • **Hypokalemia:** Hypokalemia is when there are low levels of potassium in the blood. Potassium is a mineral the body needs to work normally. It helps muscles to move (including the heart), cells to get the nutrients	• $8,025 per year • $5,940 per year • $14,997 per year • $20,635 per year	• Cheaper formulations available • Cheaper formulations available • Cheaper formulations available • Cheaper formulations available

	Suflave™	they need, and nerves to send their signals. *20,578 members with hypokalemia* • **Colon Cleanse:** Colon cleanses are used to prepare/clean the bowels prior to colonoscopy and other procedures. *23,435 members had colon screening last year*	• $119 per course	• Cheaper options available
7	Qalsody® Rilutek®	• **Amyotrophic Lateral Sclerosis (ALS):** ALS is a nervous system disease that affects nerve cells in the brain and spinal cord. ALS causes loss of muscle control. The disease gets worse over time. ALS is often called Lou Gehrig's disease. *64 members with ALS*	• $205,197 for the first year • $172 per year	• Given intrathecally • Assuring safe and appropriate use
8	Liqrev® Opsynvi® Winrevair™	• **Pulmonary Arterial Hypertension (PAH):** In PAH blood vessels in the lungs are narrowed, blocked or destroyed. The damage slows blood flow through the lungs. Blood pressure in the lung arteries goes up. The heart must work harder to pump blood through the lungs. The extra effort eventually causes the heart muscle to become weak and fail. *388 members with PAH*	• $33,544 per year • $151,624 per year • $238,000 per year	• Generic tablets available • Cheaper options available • Used in combination with other medications
9	Akeega® Anktiva®	• **Prostate Cancer (PC):** PC develops in the prostate gland, a part of the reproductive system in men. *703 members with PC* • **Bladder Cancer (BC):** BC is a common type of cancer that begins in the cells of the bladder. *324 members with BC*	• $225,000 per year • Up to $751,800 in the first year	• Must be used with other therapies • 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.

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Pharmacy Agenda Items

Recommendation 1: Vote to Prior Authorize Lantidra™

The Drug Utilization Review Board recommends the prior authorization of Lantidra™ (Donislecel-jujn) with the following criteria:

Lantidra™ (Donislecel-jujn) Approval Criteria:

1. An FDA approved diagnosis of type 1 diabetes mellitus (T1DM); and
2. Member must be 18 years of age or older; and
3. Must be prescribed by an endocrinologist (or an advanced care practitioner with a supervising physician who is an endocrinologist); and
4. Member must have had T1DM for ≥5 years and has been receiving intensive insulin management defined as:
    a. Self-monitoring of blood glucose levels at least 3 times per day on average; and
    b. Using insulin pump therapy or using at least 3 insulin injections per day; and
    c. Under the care of a diabetes specialist with at least 3 evaluations in the past 12 months; and
5. Member is exhibiting 1 of the following despite intensive insulin management efforts:
    a. Hypoglycemic unawareness; or
    b. Two or more episodes of severe hypoglycemia, defined as an event with symptoms consistent with hypoglycemia in which the patient requires the assistance of another person and which is associated with a blood glucose level <54mg/dL; or
    c. Two or more hospital visits (inpatient and/or emergency department) for diabetic ketoacidosis over the last year; or
    d. Progressive secondary complications of diabetes as defined by retinopathy, nephropathy, or neuropathy despite efforts at optimal glucose control; and
6. Member must receive concomitant immunosuppression. Lantidra™ is contraindicated in adults who have a contraindication to immunosuppression; and
7. Member is T- and B-cell crossmatch assay negative; and
8. Member must not have any of the following:
    a. Severe cardiac disease defined by 1 of the following:
        i. Recent, within the past 6 months, myocardial infarction; or
        ii. Angiographic evidence of non-correctable coronary artery disease; or
        iii. Evidence of ischemia on functional cardiac exam (with a stress echo test recommended for members with a history of ischemic disease); or
        iv. Heart failure > New York Heart Association (NYHA) II; or

   v. History of stroke within the past 6 months; and

   b. No active infections, including hepatitis C, hepatitis B, human immunodeficiency virus (HIV), or tuberculosis; and
   c. No history of malignancy except squamous or basal skin cancer; and
   d. No concomitant disease or condition that contradicts the procedure or immunosuppression; and
   e. No history of liver disease or renal failure and has not been the recipient of a renal transplant; an
   f. No history of a prior portal vein thrombosis excluding thrombosis limited to second- or third-order portal vein branches; and
   g. C-peptide ≥0.3ng/mL following a 5g arginine intravenous (IV) infusion challenge; and
   h. Insulin requirements >0.7 IU/kg/day; and
   i. Recent hemoglobin A1C (HbA1c) >12%; and

9. Female members of reproductive potential must not be pregnant or breastfeeding and must agree to use effective contraception prior to initiation of immunosuppression and thereafter; and
10. Initial approvals will be for 12 months. Reauthorization may be granted if the prescriber documents the member has not achieved independence from exogenous insulin within 1 year of infusion or may be granted within 1 year after losing independence from exogenous insulin after a previous infusion; and
    a. Prescriber must verify the member is still receiving concomitant immunosuppression; and
11. Lantidra™ must be administered at a manufacturer approved transplant center; and
12. Approvals will be for a maximum of 3 infusions per member per lifetime.

Recommendation 2: Vote to Prior Authorize Izervay™

The Drug Utilization Review Board recommends the prior authorization of Izervay™ (Avacincaptad Pegol) with the following criteria:

Izervay™ (Avacincaptad Pegol) Approval Criteria:

1. An FDA approved indication for the treatment of geographic atrophy (GA) secondary to dry age-related macular degeneration (AMD); and
2. Member must not have ocular or periocular infections or active intraocular inflammation; and
3. Izervay™ must be prescribed and administered by an ophthalmologist, or a physician experienced in intravitreal injections; and

4. Prescribers must verify the member will be monitored for endophthalmitis, retinal detachment, increase in intraocular pressure, and neovascular (wet) AMD; and
5. A patient specific, clinically significant reason why the member cannot use Syfovre® (pegcetacoplan) must be provided; and
6. A quantity limit of (1) 0.1mL single-dose vial per eye once monthly for up to 12 months will apply.

Recommendation 3: Vote to Prior Authorize Rezzayo™

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

Rezzayo™ (Rezafungin Injection) Approval Criteria:

1. An FDA approved diagnosis of candidemia or invasive candidiasis; and
2. Member must be 18 years of age or older; and
3. Prescriber must verify that limited or no alternative treatment options are available; and
4. A patient-specific, clinically significant reason why the member cannot use anidulafungin, caspofungin, or micafungin, which are available without a prior authorization, must be provided; and
5. Member must not have endocarditis, osteomyelitis, or meningitis due to *Candida*; and
6. Must be administered by a health care provider in a setting that is appropriately equipped to administer Rezzayo™; and
7. A quantity limit of 5 vials for 28 days will apply; and
8. A limit of 4 weeks of treatment will apply.

Recommendation 4: Vote to Prior Authorize Augtyro™ and Pemrydi RTU®

The Drug Utilization Review Board recommends the prior authorization of Augtyro™ (Repotrectinib) and Pemrydi RTU® (Pemetrexed) with the following criteria:

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

1. Diagnosis of locally advanced or metastatic NSCLC; and
2. ROS1-positive; and
3. Used as a single agent.

Pemrydi RTU® (Pemetrexed; J9324) Approval Criteria:

1. 1.An FDA approved diagnosis; and

2. 2.A patient-specific, clinically significant reason the member cannot use Alimta® (pemetrexed; J9305), pemetrexed ditromethamine (J9323), and other preferred pemetrexed 25mg/mL solution products (J9294 - Hospira, J9296 - Accord, J9297 – Sandoz, J9314 – Teva, J9322 - Bluepoint) that do not require prior authorization must be provided.

Recommendation 5: Vote to Prior Authorize Rezdiffra™

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

Rezdiffra™ (Resmetirom) Approval Criteria:

1. 1.An FDA approved indication of noncirrhotic nonalcoholic steatohepatitis (NASH); and
2. Member must be 18 years of age or older; and
3. Member must have moderate-to-advanced liver fibrosis (e.g., stage F2 or F3) confirmed by at least 1 of the following (results of the selected test must be submitted with the request):
    a. FibroScan with vibration controlled transient elastography (VCTE) ≥8.5kPa and controlled attenuation parameter (CAP) ≥280dB/m; or
    b. Enhanced Liver Fibrosis (ELF) biochemical test score ≥9; or
    c. Liver biopsy showing stage F2 or F3 fibrosis with NASH; and
4. Member must not have known liver cirrhosis (e.g., stage F4); and
5. Must be used in conjunction with diet and exercise [clinical documentation (e.g., office notes) of member's diet and exercise program must be included with the request]; and
6. Prescriber must attest that metabolic comorbidities are being appropriately managed, including treatment for all of the following, if applicable:
    a. Type 2 diabetes; and
    b. Dyslipidemia; and
    c. Hypertension; and
7. Member must not be taking strong CYP2C8 inhibitors (e.g., gemfibrozil) or OATP1B1/OATP1B3 inhibitors (e.g., cyclosporine) concurrently with Rezdiffra™; and
8. If member is taking a moderate CYP2C8 inhibitor (e.g., clopidogrel) concurrently with Rezdiffra™, prescriber must agree to reduce the dose as required in the package labeling; and
9. If the member is taking a statin, prescriber must agree to adjust the statin dosage (when necessary) and monitor for statin-related adverse reactions; and

10. Must be prescribed by a gastroenterologist or hepatologist (or an advanced care practitioner with a supervising physician who is a gastroenterologist or hepatologist); and
11. Initial approvals will be for the duration of 6 months. Subsequent approvals (for the duration of 1 year) will be approved if the prescriber documents the member is tolerating and responding well to the medication; and
12. A quantity limit of 30 tablets per 30 days will apply.

Recommendation 6: Vote to Prior Authorize Various Special Formulations: Clindacin® ETZ Kit, Lodoco®, Motpoly XR™, PoKonza™, and Suflave™

The Drug Utilization Review Board recommends the prior authorization of Clindacin® ETZ Kit (Clindamycin 1% Swabs and Cleanser), Lodoco® (Colchicine), Motpoly XR™ [Lacosamide Extended-Release (ER) Capsule], PoKonza™ (Potassium Chloride 10mEq Packet for Oral Solution), and Suflave™ [Polyethylene Glycol (PEG)-3350/ Sodium Sulfate/Potassium Chloride/Magnesium Sulfate/Sodium Chloride] with the following criteria:

Clindacin® ETZ Kit (Clindamycin 1% Swabs and Cleanser) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient specific, clinically significant reason the member cannot use the preferred topical clindamycin products including lotion, solution, swabs, or the preferred generic clindamycin gel (generic Cleocin T®) must be provided; and
3. Clindacin® ETZ kit will not be covered for members older than 20 years of age.

Lodoco® (Colchicine) Approval Criteria:

1. An FDA approved indication to reduce the risk of myocardial infarction (MI), stroke, coronary revascularization, and cardiovascular death; and
2. Member must be 18 years of age or older; and
3. Member must have a diagnosis history of clinical atherosclerotic cardiovascular disease (ASCVD); and
    a. Supporting diagnoses/conditions and dates of occurrence signifying established ASCVD must be provided; and
4. Member must already be receiving guideline-directed therapy for atherosclerotic disease, as documented in the member's pharmacy claims history, unless contraindicated; and

5. Lodoco® must be prescribed by a cardiologist or other specialist with expertise in the treatment and management of ASCVD; and
6. Member must not have kidney failure, severe liver disease, or pre-existing blood dyscrasias; and
7. The member must not be taking any P-gp inhibitors (e.g., cyclosporine, ranolazine) or strong CYP3A4 inhibitors (e.g., clarithromycin, itraconazole, ketoconazole) concurrently with Lodoco®; and
8. A patient-specific, clinically significant reason why the member cannot use the 0.6mg tablet, which is available without a prior authorization, must be provided; and
9. A quantity limit of 30 tablets per 30 days will apply.

Motpoly XR™ [Lacosamide Extended-Release (ER) Capsule] Approval Criteria:

1. An FDA approved diagnosis of partial-onset seizures; and
2. Member must weigh ≥50kg; and
3. A patient specific, clinically significant reason why the member cannot use the immediate-release tablets must be provided; and
4. The following quantity limits will apply:
    a. Motpoly XR™ 100mg: 30 capsules per 30 days; or
    b. Motpoly XR™ 150mg and 200mg: 60 capsules per 30 days.

PoKonza™ (Potassium Chloride 10mEq Packet) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use all of the following must be provided:
    a. Potassium chloride tablet; and
    b. Potassium chloride extended-release (ER) dispersible tablet; and
    c. Potassium chloride ER sprinkle capsule; and
    d. Potassium chloride oral solution.

Suflave® [Polyethylene Glycol (PEG)-3350/ Sodium Sulfate/Potassium Chloride/Magnesium Sulfate/Sodium Chloride] Approval Criteria:

1. An FDA approved indication for use in cleansing of the colon as a preparation for colonoscopy; and
2. A patient-specific, clinically significant reason other than convenience why the member cannot use other bowel preparation medications available without prior authorization must be provided; and
3. If the member requires a low volume polyethylene glycol electrolyte lavage solution, Moviprep® is available without prior authorization. Other medications currently available without a prior authorization include: Colyte®, Gavilyte®, Golytely®, and Trilyte®.

Recommendation 7: Vote to Prior Authorize Qalsody® and Rilutek®

The Drug Utilization Review Board recommends the prior authorization of Qalsody® (Tofersen) and Rilutek® (Riluzole Oral Tablet) with the following criteria:

Qalsody® (Tofersen) Approval Criteria:

1. An FDA approved diagnosis of amyotrophic lateral sclerosis (ALS); and
2. Member must have a confirmed pathogenic mutation in the superoxide dismutase 1 (SOD1) gene (results of genetic testing must be submitted); and
3. Member must have weakness attributable to ALS; and
4. Member must be 18 years of age or older; and
5. Must be prescribed by a neurologist or other specialist with expertise in the treatment of ALS (or an advanced care practitioner with a supervising physician who is a neurologist or other specialist with expertise in the treatment of ALS); and
6. Must be administered in a health care facility by a specialist experienced in performing lumbar punctures; and
    a. Qalsody® must be shipped to the facility where the member is scheduled to receive treatment; and
7. Approvals will be for the duration of 6 months. For each subsequent approval, the prescriber must document the member is responding to the medication, as indicated by a slower progression in symptoms and/or slower decline in quality of life compared to the typical ALS disease progression.

Rilutek® (Riluzole Oral Tablet) Approval Criteria:

1. An FDA approved diagnosis of amyotrophic lateral sclerosis (ALS); and
2. Must be prescribed by a neurologist or other specialist with expertise in the treatment of ALS (or an advanced care practitioner with a supervising physician who is a neurologist or other specialist with expertise in the treatment of ALS); and
3. A quantity limit of 60 tablets per 30 days will apply.

Recommendation 8: Vote to Prior Authorize Liqrev®, Opsynvi®, and Winrevair™

The Drug Utilization Review Board recommends the prior authorization of Liqrev® (Sildenafil Oral Suspension), Opsynvi® (Macitentan/Tadalafil), and Winrevair™ (Sotatercept-csrk) with the following criteria:

Liqrev® (Sildenafil Suspension) Approval Criteria:

1. An FDA approved diagnosis of pulmonary arterial hypertension (PAH); and
2. Member must be 18 years of age or older; and
3. Medical supervision by a pulmonary specialist or cardiologist; and
4. A patient-specific, clinically significant reason why the member cannot use generic sildenafil 20mg oral tablets, even when tablets are crushed, must be provided; and
5. A patient-specific, clinically significant reason why the member cannot use generic sildenafil oral suspension (generic Revatio®) must be provided.

Opsynvi® (Macitentan/Tadalafil) Approval Criteria:

1. An FDA approved diagnosis of pulmonary arterial hypertension (PAH); and
2. Member must have previous failed trials of at least 1 medication in each of the following categories or have a contraindication to use of all alternatives:
    a. Adcirca® (tadalafil) or Revatio® (sildenafil); and
    b. Letairis® (ambrisentan) or Tracleer® (bosentan); and
3. Medical supervision by a pulmonary specialist or cardiologist; and
4. Requests for Opsynvi® will also require a patient-specific, clinically significant reason why the member cannot use Opsumit® in combination with generic sildenafil or tadalafil; and
5. Female members and all health care professionals (prescribers and dispensing pharmacies) must be enrolled in the Macitentan-Containing Products Risk Evaluation and Mitigation Strategy (REMS) program; and
6. A quantity limit of 30 tablets per 30 days will apply.

Winrevair™ (Sotatercept-csrk) Approval Criteria:

1. An FDA approved diagnosis of pulmonary arterial hypertension (PAH); and
2. Member must be 18 years of age or older; and
3. Member is currently taking PAH medications from at least 2 of the following categories for ≥90 days or has a contraindication to use of all alternatives:
    a. Phosphodiesterase-5 (PDE-5) inhibitor (e.g., sildenafil, tadalafil) or soluble guanylate cyclase stimulator (e.g., riociguat); or
    b. Endothelin-receptor antagonist (e.g., ambrisentan, bosentan); or
    c. Prostacyclin analogue or receptor agonist (e.g., epoprostenol, treprostinil); and
4. Prescriber must verify that Winrevair™ will be used concurrently with member's current PAH therapies; and

5. Medical supervision by a pulmonary specialist and/or cardiologist; and
6. Prescriber must confirm the member or caregiver has been trained by a health care professional on the preparation, subcutaneous (sub-Q) administration, and proper storage of Winrevair™; and
7. Prescriber must agree to monitor hemoglobin and platelet counts prior to each dose for the first 5 doses and periodically thereafter; and8.
8. Female members of reproductive potential must not be pregnant, must have a negative pregnancy test prior to initiation of therapy, and must agree to use effective contraception during therapy and for at least 4 months after the last dose; 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. A quantity limit of 1 kit every 3 weeks will apply.
    a. Members requiring (2) 45mg or (2) 60mg vials based on their body weight will not be approved for multiple 1-vial kits but should use the 2-vial kits to achieve the dose required.

Recommendation 9: Vote to Prior Authorize Akeega® and Anktiva®

The Drug Utilization Review Board recommends the prior authorization of Akeega® (Niraparib/ Abiraterone) and Anktiva® (Nogapendekin Alfa Inbakicept-pmln) with the following criteria:

Akeega® (Niraparib/Abiraterone Acetate) Approval Criteria [Castration-Resistant Prostate Cancer (CRPC) Diagnosis]:

1. Diagnosis of metastatic CRPC; and
2. Presence of deleterious or suspected deleterious BRCA mutation based upon an FDA-approved test; and
3. Used in conjunction with prednisone; and
4. Used in conjunction with a gonadotropin-releasing hormone (GnRH) analog or prior history of bilateral orchiectomy; and
5. Member has not progressed on prior abiraterone therapy.

Anktiva® (Nogapendekin Alfa Inbakicept-pmln) Approval Criteria [Non-Muscle Invasive Bladder Cancer (NMIBC) Diagnosis]:

1. Diagnosis of NMIBC with carcinoma in situ (CIS); and
2. Cancer is unresponsive to initial Bacillus Calmette-Guerin (BCG) therapy; and
3. Will be used in conjunction with BCG; and
4. Initial approval will be for 6 induction doses; and

5. Subsequent requests must indicate if the member has had a complete response to induction dosing; and
    a. A second induction course (6 doses) may be approved if a complete response is not achieved at month 3; and
6. If complete response is achieved, maintenance dosing may be approved in 6-month intervals up to a maximum of 37 months of treatment.

STATE PLAN AMENDMENT RATE COMMITTEE

ADVANTAGE WAIVER SERVICE 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 Community Living, Aging & Protective Services is seeking to implement an array of provider rate increase. The Oklahoma State Legislature passed legislation requiring the rate increase and provided funding for the rate increase through Senate Bill 1136 with a commensurate rate increase for State Plan Personal Care (SPPC) services. The services are available to recipients on the Medicaid ADvantage Waiver and State Plan Personal Care programs.

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 State Plan Amendment Rate Committee process. The services, current service codes and rates are as follows:

State Plan Services	Service Code			Current Rate
STATE PLAN PERSONAL CARE	T1019			$ 5.26
STATE PLAN SKILLED NURSING ASSESSMENT/EVALUATION	T1001			$ 97.50

ADvantage Waiver Services	Service Code			Current Rate
RN - SKILLED NURSING - HH	G0299			$ 19.50
LPN/LVN - ONLY - SKILLED NURSING - HH	G0300			$ 18.20
ADULT DAY HEALTH	S5100	U1		$ 2.60
PERSONAL CARE - ADULT DAY HEALTH	S5105			$ 10.34

STATE PLAN AMENDMENT RATE COMMITTEE

CDPASS PSA/SELF DIRECTION	S5125			$ 4.45
CDPASS APSA/SELF DIRECTION	S5125	TF		$ 5.34
RN ASSESSMENT/EVALUATION	T1002			$ 19.50
RESPITE IN-HOME	T1005			$ 5.26
CASE MANAGEMENT - STANDARD	T1016			$ 19.11
CASE MANAGEMENT - VR	T1016	TN		$ 27.36
PERSONAL CARE	T1019			$ 5.26
ADVANCED SUPPORTIVE/RESTORATIVE	T1019	TF		$ 5.65
REMOTE SUPPORTS Unpaid Emergency Response	T1019	U1		$ 1.75
REMOTE SUPPORTS Paid Emergency Response	T1019	TG		$ 2.62
RESPITE IN-HOME EXTENDTED	S9125			$ 219.44

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
The new rates are based on the categories describer in Senate Bill 1136.

Description	Service Code			Proposed Rate
STATE PLAN PERSONAL CARE	T1019			$ 6.58
STATE PLAN SKILLED NURSING ASSESSMENT/EVALUATION	T1001			$ 107.25

Description	Service Code			Proposed Rate
RN - SKILLED NURSING - HH	G0299			$ 21.45
LPN/LVN - ONLY - SKILLED NURSING - HH	G0300			$ 20.02

ADULT DAY HEALTH	S5100	U1		$ 2.86
PERSONAL CARE -ADULT DAY HEALTH	S5105			$ 11.37
CDPASS PSA/SELF DIRECTION	S5125			$ 5.56
CDPASS APSA/SELF DIRECTION	S5125	TF		$ 6.68
RN ASSESSMENT/EVALUATION	T1002			$ 21.45
RESPITE IN-HOME	T1005			$ 5.79
CASE MANAGEMENT - STANDARD	T1016			$ 21.02
CASE MANAGEMENT - VR	T1016	TN		$ 30.10
PERSONAL CARE	T1019			$ 6.58
ADVANCED SUPPORTIVE/RESTORATIVE	T1019	TF		$ 7.06
REMOTE SUPPORTS Unpaid Emergency Response	T1019	U1		$ 1.99
REMOTE SUPPORTS Paid Emergency Response	T1019	TG		$ 3.61
RESPITE IN-HOME EXTENDED	S9125			$ 241.38

6. **BUDGET ESTIMATE.**
The estimated budget impact for the remainder of SFY 2025 will be an increase in the total amount of $41,151,289.54; with $13,547,004.52 in state share.
The estimated budget impact for SFY 2026 will be an increase in the total amount of $54,868,386.06; with $18,062,672.69 in state share.
OHS attests that it has adequate funds to cover the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The rate increase is expected to raise wages of Direct Support Professionals (DSP) to bring the rate up to a competitive level and incentive new entrants into the DSP labor force. This will have a positive impact and increase 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 proposed ADvantage provider rate increase at the total and state dollar costs presented.

9. EFFECTIVE DATE OF CHANGE.

October 1, 2024, upon approval by CMS

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?**
Oklahoma Human Services DDS is seeking to implement a wide array of provider rate increases. The Oklahoma State Legislature passed legislation requiring the rate increase and provided funding for the rate increase through Senate Bill 1136.

   The services are available to recipients on the Medicaid 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 State Plan Amendment Rate Committee process. The services, current service codes and rates are as follows:

Description	Service Code			Current Rate
Transportation - Adapted	A0130			1.69
Self-Directed Transportation (Adapted)	A0130	UA		1.86
Skilled Nursing - Registered Nurse	G0299			19.50
Skilled Nursing - Licensed Practical Nurse	G0300			18.20
Adult Day Services	S5100			2.60
Agency Companion - Enhanced	S5126			163.15
Agency Companion - Pervasive	S5126	TF		178.43
Agency Companion - Pervasive - Therapeutic Leave	S5126	TF	TV	178.43

Agency Companion - Enhanced - Therapeutic Leave	S5126	TV		163.15
Agency Companion - Close	S5126	U1		125.45
Agency Companion - Close Therapeutic Leave	S5126	U1	TV	125.45
Homemaker	S5130			5.00
Specialized Family Care Adult - Maximum	S5140			70.20
Specialized Family Care Adult (Maximum) Therapeutic Leave	S5140	TV		70.20
Specialized Family Care Child - Maximum	S5145			70.20
Specialized Family Care Child (Maximum) Therapeutic Leave	S5145	TV		56.16
Respite-Hourly	S5150			5.00
Respite - Maximum	S5151			98.80
Respite in Community Living Group Home 10 bed setting	S5151			185.58
Respite in Community Living Group Home 11 bed setting	S5151			171.28
Respite in Community Living Group Home 12 bed setting	S5151			169.65
Respite in Community Living Group Home 6 bed setting	S5151			245.38
Respite in Community Living Group Home 7 bed setting	S5151			214.50
Respite in Community Living Group Home 8 bed setting	S5151			208.33
Respite in Community Living Group Home 9 bed setting	S5151			188.18
Respite in Agency Companion - Contractor - Close	S5151			154.05
Respite in Agency Companion - Contractor- Enhanced	S5151			191.75
Respite in Agency Companion - Contractor - Pervasive	S5151			207.03

Respite in Group Home - 10 bed setting	S5151			88.08
Respite in Group Home - 11 bed setting	S5151			84.18
Respite in Group Home - 12 bed setting	S5151			80.93
Respite in Group Home - 6 bed setting	S5151			123.38
Respite in Group Home - 7 bed setting	S5151			109.20
Respite in Group Home - 8 bed setting	S5151			99.13
Respite in Group Home - 9 bed setting	S5151			92.95
Respite - Close -	S5151	TF		50.00
Respite - Intermittent	S5151	U1		23.75
Respite, In Own Home - Maximum	S9125			71.30
Respite, In Own Home - Close	S9125	TF		35.63
Respite, In Own Home - Intermittent	S9125	U1		23.75
Nursing - Extended Duty Care	T1000			10.00
Nursing - Intermittent Skilled Care	T1001			65.65
Group Home 6 Bed	T1020			94.25
Group Home Community Living 6 Bed	T1020			94.25
Group Home 7 Bed	T1020			80.60
Group Home Community Living 7 bed	T1020			80.60
Group Home 8 Bed	T1020			70.53
Group Home Community Living 8 bed	T1020			70.53
Group Home 9 Bed	T1020			64.35
Group Home Community Living 9 bed	T1020			64.35

Group Home 10 Bed	T1020			59.48
Group Home 11 Bed	T1020			55.58
Group Home 12 Bed	T1020			52.33
Group Home Alternative Living	T1020			379.60
Group Home Community Living 10 bed	T1020			156.98
Group Home Community Living 11 bed	T1020			142.68
Group Home Community Living 12 bed	T1020			141.05
Enhanced Community-Based Pre-Voc Svc	T2015			17.31
Community-Based Pre-Voc Svc	T2015	TF		13.00
Pre-Voc HTS - Supplemental Supports	T2015	TG		16.38
Center-Based Pre-Vocational Svc	T2015	U1		6.50
Individual Placement in Community-Based, Pre-Vocational	T2015	U4		21.05
Individual Placement in Community-Based, Pre-Vocational - Telehealth	T2015	U4	GT	21.05
HTS - Habilitation Training Specialist	T2017			5.26
HTS - Habilitation Training Specialist - EVV	T2017	32		5.26
Intensive Personal Supports	T2017	TF		5.26
Self Directed HTS	T2017	U1	TF	5.26
Remotes Supports With Paid Staff	T2017	U4		3.28
Remote Supports With Unpaid Staff	T2017	U4		1.81
Employment Specialist	T2019			7.85
Job Coaching GROUPS of 2-3	T2019	HQ		4.69

Job Coaching (Groups of 4-5)	T2019	TF		4.34
Enhanced Job Coaching Service (Groups of 4-5)	T2019	TG		5.05
Enhanced Job Coaching GROUPS of 2-3	T2019	TG	HQ	5.40
Job Stabilization/Extended Svc	T2019	U1		1.80
Individual Placement in Job Coaching, Supported Employment	T2019	U4		7.81
Individual Placement in Job Coaching, Supported Employment - Telehealth	T2019	U4	GT	7.81
Self Directed Individual Placement in Job Coaching, Supported Employment	T2019	U4	TF	Manual
Value-Based Incentive Quality Payment	T2025	UK		625.00
Daily Living Supports	T2033			200.20
Extensive Residential Supports	T2033	TG		929.92
Self-Directed Individual Placement in Community Based Pre-Vocational Services	T2015	U4	UA	21.05
Self-Directed Individual Placement in Community Based Pre-Vocational Services Telehealth	T2015	U4	UA	21.05
Extensive Residential Supports - Therapeutic Leave	T2033	TG	TV	929.92
DLS - Therapeutic Leave	T2033	TV		200.20

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The new rates are based on the categories described in Senate Bill 1136.

Description	Service Code			Proposed Rate
Transportation - Adapted	A0130			1.86
Self-Directed Transportation (Adapted)	A0130	UA		1.69
Skilled Nursing - Registered Nurse	G0299			21.45
Skilled Nursing - Licensed Practical Nurse	G0300			20.02

Adult Day Services	S5100			2.86
Agency Companion - Enhanced	S5126			179.47
Agency Companion - Pervasive	S5126	TF		223.04
Agency Companion - Pervasive - Therapeutic Leave	S5126	TF	TV	223.04
Agency Companion - Enhanced - Therapeutic Leave	S5126	TV		179.47
Agency Companion - Close	S5126	U1		138.00
Agency Companion - Close Therapeutic Leave	S5126	U1	TV	138.00
Homemaker	S5130			6.25
Specialized Family Care Adult - Maximum	S5140			77.22
Specialized Family Care Adult (Maximum) Therapeutic Leave	S5140	TV		77.22
Specialized Family Care Child - Maximum	S5145			77.22
Specialized Family Care Child (Maximum) Therapeutic Leave	S5145	TV		61.78
Respite-Hourly	S5150			5.50
Respite - Maximum	S5151			108.68
Respite in Community Living Group Home 10 bed setting	S5151			204.14
Respite in Community Living Group Home 11 bed setting	S5151			188.41
Respite in Community Living Group Home 12 bed setting	S5151			186.62
Respite in Community Living Group Home 6 bed setting	S5151			269.92
Respite in Community Living Group Home 7 bed setting	S5151			235.95
Respite in Community Living Group Home 8 bed setting	S5151			229.16

Respite in Community Living Group Home 9 bed setting	S5151			207.00
Respite in Agency Companion - Contractor - Close	S5151			169.46
Respite in Agency Companion - Contractor- Enhanced	S5151			210.93
Respite in Agency Companion - Contractor - Pervasive	S5151			227.73
Respite in Group Home - 10 bed setting	S5151			96.89
Respite in Group Home - 11 bed setting	S5151			92.60
Respite in Group Home - 12 bed setting	S5151			89.02
Respite in Group Home - 6 bed setting	S5151			135.72
Respite in Group Home - 7 bed setting	S5151			120.12
Respite in Group Home - 8 bed setting	S5151			109.04
Respite in Group Home - 9 bed setting	S5151			102.25
Respite - Close -	S5151	TF		55.00
Respite - Intermittent	S5151	U1		26.13
Respite, In Own Home - Maximum	S9125			78.43
Respite, In Own Home - Close	S9125	TF		39.19
Respite, In Own Home - Intermittent	S9125	U1		26.13
Nursing - Extended Duty Care	T1000			11.00
Nursing - Intermittent Skilled Care	T1001			72.22
Group Home 6 Bed	T1020			103.68
Group Home Community Living 6 Bed	T1020			103.68
Group Home 7 Bed	T1020			88.66

Group Home Community Living 7 bed	T1020			88.66
Group Home 8 Bed	T1020			77.58
Group Home Community Living 8 bed	T1020			77.58
Group Home 9 Bed	T1020			70.79
Group Home Community Living 9 bed	T1020			70.79
Group Home 10 Bed	T1020			65.43
Group Home 11 Bed	T1020			61.14
Group Home 12 Bed	T1020			57.56
Group Home Alternative Living	T1020			427.05
Group Home Community Living 10 bed	T1020			172.68
Group Home Community Living 11 bed	T1020			156.95
Group Home Community Living 12 bed	T1020			155.16
Enhanced Community-Based Pre-Voc Svc	T2015			19.04
Community-Based Pre-Voc Svc	T2015	TF		14.30
Pre-Voc HTS - Supplemental Supports	T2015	TG		18.02
Center-Based Pre-Vocational Svc	T2015	U1		7.15
Individual Placement in Community-Based, Pre-Vocational	T2015	U4		23.16
Individual Placement in Community-Based, Pre-Vocational - Telehealth	T2015	U4	GT	23.16
HTS - Habilitation Training Specialist	T2017			6.58
HTS - Habilitation Training Specialist - EVV	T2017	32		6.58
Intensive Personal Supports	T2017	TF		6.58
Self Directed HTS	T2017	U1	TF	6.58

Remotes Supports With Paid Staff	T2017	U4		3.61
Remote Supports With Unpaid Staff	T2017	U4	R1	1.99
Employment Specialist	T2019			8.64
Job Coaching GROUPS of 2-3	T2019	HQ		5.16
Job Coaching (Groups of 4-5)	T2019	TF		4.77
Enhanced Job Coaching Service (Groups of 4-5)	T2019	TG		5.56
Enhanced Job Coaching GROUPS of 2-3	T2019	TG	HQ	5.94
Job Stabilization/Extended Svc	T2019	U1		1.98
Individual Placement in Job Coaching, Supported Employment	T2019	U4		8.59
Individual Placement in Job Coaching, Supported Employment – Telehealth	T2019	U4	GT	8.59
Self Directed Individual Placement in Job Coaching, Supported Employment	T2019	U4	TF	-
Value-Based Incentive Quality Payment	T2025	UK		687.50
Daily Living Supports	T2033			225.23
Extensive Residential Supports	T2033	TG		1,046.16
Self-Directed Individual Placement in Community Based Pre-Vocational Services	T2015	U4	UA	23.16
Self-Directed Individual Placement in Community Based Pre-Vocational Services Telehealth	T2015	U4	UA	23.16
Extensive Residential Supports - Therapeutic Leave	T2033	TG	TV	1,046.16
DLS - Therapeutic Leave	T2033	TV		225.23

6. **BUDGET ESTIMATE.**

The estimated budget impact for the remainder of SFY 2025 will be an increase in the total amount of $61,208,811.83; with $20,149,940.85 in state share.

The estimated budget impact for SFY 2026 will be an increase in the total amount of $81,611,749.11; with $26,866,687.81 in state share.

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

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The rate increase is expected to raise wages of Direct Support Professionals to bring the rate up to a competitive level and incentive new entrants into the DSP labor force. This will have a positive impact and increase 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 proposed DDS provider rate increase at the total and state dollar costs presented

9. **EFFECTIVE DATE OF CHANGE.**
October 1, 2024, upon approval by CMS

STATE PLAN AMENDMENT RATE COMMITTEE

MONEY FOLLOWS THE PERSON/OKLAHOMA'S LIVING CHOICE AND MEDICALLY FRAGILE PROVIDER 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?**
   Oklahoma Health Care Authority (OHCA) is seeking to implement a provider rate increase.

   The Oklahoma State Legislature passed legislation requiring the rate increase and provided funding for the rate increase through Senate Bill 1136 for their five 1915(c) waiver HCBS providers contracted with Oklahoma Human Services (OHS). The intent is to standardize provider rates across ALL SIX 1915(c) Home and Community Based Services, State Plan Personal Care and The Money Follows the Person Grant (Oklahoma's Living Choice Program).

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 State Plan Amendment Rate Committee process. The services, current service codes and rates are as follows:

   - Additionally, the proposed rates will be consistent with the 1915(c) HCBS waiver programs operated by OHS.

Description	Program	Current Rate
G0299 - RN - SKILLED NURSING - HH	MFP & MFW	$19.50
G0300 - LPN/LVN - ONLY - SKILLED NURSING - HH	MFP & MFW	$18.20
S5100 – ADULT DAY HEALTH SERVICES	MFP	$2.60
S5105 – PERSONAL CARE – ADULT DAY HEALTH	MFP	$10.34

S5125 – PERSONAL CARE/SELF-DIRECTION	MFP & MFW	$5.26
S5125TF – ADVANCED SUPPORTIVE RESTORATIVE/SELF DIRECTION	MFP & MFW	$5.65
T1000 – PRIVATE DUTY NURSING	MFP & MFW	$10.00
T1002 - RN ASSESSMENT/EVALUATION	MFP & MFW	$19.50
T1005 - RESPITE IN-HOME	MFP & MFW	$5.26
T1016 – CASE MANAGEMENT - STANDARD	MFP & MFW	$19.11
T1016TN – CASE MANAGEMENT - VR	MFP & MFW	$27.36
T1019 - PERSONAL CARE	MFP & MFW	$5.26
T1019TF - ADVANCED SUPPORTIVE/RESTORATIVE	MFP & MFW	$5.65
S9125 – RESPITE IN-HOME EXTENDED	MFP & MFW	$219.44

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The new rates are based on the categories described in Senate Bill 1136.

Description	Program	Proposed Rate
G0299 - RN - SKILLED NURSING - HH	MFP & MFW	$21.45
G0300 - LPN/LVN - ONLY - SKILLED NURSING - HH	MFP & MFW	$20.02
S5100 – ADULT DAY HEALTH SERVICES	MFP	$2.86
S5105 – PERSONAL CARE – ADULT DAY HEALTH	MFP	$11.37
S5125 – PERSONAL CARE/SELF-DIRECTION	MFP & MFW	$6.58
S5125TF – ADVANCED SUPPORTIVE RESTORATIVE/SELF DIRECTION	MFP & MFW	$7.06
T1000 – PRIVATE DUTY NURSING	MFP & MFW	$11.00
T1002 - RN ASSESSMENT/EVALUATION	MFP & MFW	$21.45

T1005 - RESPITE IN-HOME	MFP & MFW	$5.79
T1016 – CASE MANAGEMENT - STANDARD	MFP & MFW	$21.02
T1016TN – CASE MANAGEMENT - VR	MFP & MFW	$30.10
T1019 - PERSONAL CARE	MFP & MFW	$6.58
T1019TF - ADVANCED SUPPORTIVE/RESTORATIVE	MFP & MFW	$7.06
S9125 – RESPITE IN-HOME EXTENDED	MFP & MFW	$241.38

6. **BUDGET ESTIMATE.**
The estimated budget impact for the remainder of SFY 2025 will be an increase in the total amount of $783,677.46; with $248,504.45 in state share.
The estimated budget impact for SFY 2026 will be an increase in the total amount of $1,044,903.28; with $331,339.26 in state share.
OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The rate increase is expected to raise wages of Direct Support Professionals (DSP) to bring the rate up to a competitive level and incentive new entrants into the DSP labor force. This will have a positive impact and increase access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee approve the proposed aligned rate increases

9. **EFFECTIVE DATE OF CHANGE.**
October 1, 2024, upon approval by CMS

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STATE PLAN AMENDMENT RATE COMMITTEE

ADD-ON RATE FOR NURSING FACILITIES SERVING ACUTE TRACHEOSTOMY PATIENTS

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?**
   There are four nursing facilities providing acute tracheostomy care in the state. These facilities reached out to OHCA regarding the need for an add-on rate for acute tracheostomy care, due to the high cost of providing this level of care. Nursing facilities are currently paid the standard nursing facility rate for providing acute tracheostomy care. Acute tracheostomy residents require significantly more resources than regular nursing facility residents. Additional nursing staff and supplies are needed to meet their complex care needs. The add-on rate will help nursing facilities cover the high cost of providing this level of care.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   There is no current rate methodology for acute tracheostomy care.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The acute tracheostomy add-on rate was determined using historical cost data provided by nursing facilities that provide acute tracheostomy care. The add-on rate is the difference between the total cost per patient day for acute tracheostomy care and the average nursing facility rate. The add-on rate for acute tracheostomy care will be $144.79 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2025 will be an increase in the total amount of $1,557,225; with $498,468 in state share.
   The estimated budget impact for SFY 2026 will be an increase in the total amount of $2,076,299; with $664,623 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority anticipates a positive impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving acute tracheostomy residents:
   - An add-on rate for acute tracheostomy care in the amount of $144.79 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   October 1, 2024, upon approval by CMS

STATE PLAN AMENDMENT RATE COMMITTEE

CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA) 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?**
   To increase access to care and help alleviate workforce shortages. CRNA reimbursement will be increased to 100% of the physician fee schedule, from the existing 80%.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   Currently, CRNA’s made 50% or 80% of the fully licensed anesthesiologists.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   For CRNA's practicing in collaboration with a physician or dentist licensed in this state, reimbursement will be increased to 100% of the current OHCA physician fee schedule from the existing 80%. In situations where a CRNA is supervised by a physician the existing 50% reimbursement rate remains in place.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2025 will be an increase in the total amount of $6,642,110; with $1,787,166 in state share.
   The estimated budget impact for SFY 2026 will be an increase in the total amount of $7,970,533; with $2,144,560 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority anticipates a positive impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for CRNA reimbursement:

- For CRNAs practicing in collaboration with a physician or dentist licensed in this state, CRNA reimbursement will be increased to 100% of the current OHCA physician fee schedule.

9. EFFECTIVE DATE OF CHANGE.
September 1, 2024, upon approval by CMS

Attachment E

SUBMITTED TO THE C.E.O. AND BOARD ON SEPTEMBER 17, 2025
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Customer Relationship Management (CRM)
Purpose and Scope	RFP for operations of a Customer Relationship Management solution, including a call center for interactions with members or potential members in its health care benefits programs, contracted or potential health care providers, allied agencies and organizations and other interested parties.
Mandate	N/A
Procurement Method	Competitive Bid
External Approvals	CMS
Contract Term	July 1, 2025, through June 30, 2026

BUDGET

Amount requested for Approval	$9,924,670.31 SFY26 $74,454,34.34 for SFY26 thru SFY32 (7 years)
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	75%, 50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested the not-to exceed amount of $9,924,670.31 for the SFY26 and a total contract not-to-exceed of $74,454,348.34 for seven (7) year contract.

Additional Information

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

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September 17, 2024 Board
Proposed Rule Amendment Summaries

These proposed **EMERGENCY** rules were presented at Tribal Consultation and were subject to at least a 15-day public comment period and was considered by the Medical Advisory Committee on September 12, 2024.

The Governor will have until November 1, 2024, to approve or disapprove these rules upon the Agency's submission for gubernatorial review.

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

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

Budget Impact: The estimated budget impact for SFY2025 will be an increase in the total amount of $6,642,110; with $1,787,166 in state share; for SFY2026 an increase in the total amount of $7,970,533; with $2,144,560 in state share.

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APA WF #24-22 High-acuity Tracheostomy Rate for Nursing Facilities — The Oklahoma Health Care Authority (OHCA) is proposing a new policy to establish an add-on rate for nursing facilities that serve tracheostomy patients who meet the high-acuity criteria. The rate will help to cover the high cost associated with this type of care and is being determined using existing cost data based on four components: direct care and allied staff costs, social and support staff costs, cost of drugs and medical supplies, and general and administrative costs. These emergency revisions are necessary protect the public health, safety, or welfare and to avoid violation of state law.

Budget Impact: The estimated budget impact for SFY2025 is an increase in the total amount of $1,557,225; with $498,468 in state share.

APA WF #24-23 Applied Behavioral Analysis Policy Revisions — The proposed emergency rule revisions update outdated ABA policies to ensure that services meet a standard level of quality for all applicable members. This includes updates to documentation requirements for Behavior Intervention Plans, critical incident reporting, family training requirements, and billing guidelines. Additionally, these rules update the medical necessity criteria and describe various exclusions to treatment. Lastly, language is added to ensure ABA providers do not use restraint, except in extreme and documented

circumstances. These emergency revisions are necessary protect the public health, safety, or welfare.

Budget Impact: The proposed changes are budget neutral.

APA WF #24-26 A&B Developmental Disabilities Services - The proposed revisions update Developmental Disabilities Services (DDS) policy to align with the DDS 1915(c) Home and Community Based Services (HCBS) waiver programs that were recently amended and approved by the Centers for Medicare and Medicaid Services (CMS), effective July 1, 2024. The proposed revisions add the diagnosis of Global Developmental Delay as an acceptable diagnosis for admission to a DDS HCBS waiver for individuals under 6 years of age and clarify that a diagnosis of intellectual disability (ID) is based on the criteria set forth by the Social Security Administration. Other revisions remove the requirement for authorization of community transition services to be issued for the date a member transitions into the community. Additionally, revisions add a new residential service for members in custody of Oklahoma Department of Human Services (OHS) and adult members with extensive behavioral support needs that cannot be safely met with currently available supports. Lastly, revisions permit legally responsible individuals to serve as Habilitation Training Specialists to individuals for whom they are legally responsible. These emergency revisions are necessary protect the public health, safety, or welfare and to avoid violation of state law.

Budget Impact: The estimated budget for SFY 2025 is an increase in the amount of $10,262,939; with $5,717,272 in state share.

DRAFT

APA WF #24-20 Pharmacists as Providers — House Bill 2322 from the 2022 legislative session directed the Oklahoma Health Care Authority to reimburse pharmacists for services rendered within their scope of practice at the same rate paid to other providers for provision of the same services. The proposed additions implement pharmacists' services as a covered benefit to SoonerCare members. The policy additions require pharmacists to be licensed by the Oklahoma State Board of Pharmacy, allows coverage of services within pharmacists' statutory scope of practice, and establishes a reimbursement methodology for pharmacists that is identical to that of physicians. Further, the proposed changes add pharmacists' services to definition of an I/T/U facility encounter, allowing them to be reimbursed at the OMB rate. These emergency revisions are necessary protect the public health, safety, or welfare and to avoid violation of state law.

Budget Impact: (No new impact) This budget impact is expected to effectively be budget neutral due to a shift in billing provider type; no net increase in utilization or cost is expected. The cost of these services is as follows, however there is no net increase in agency expenditure for SFY 2025 is $179,558; with $59,110 in the state share. For SFY 2026, the total is estimated to be $269,336; with $88,665 in the state share.

This proposed **EMERGENCY** rule was adopted by the Board on March 20, 2024 and approved by the Governor on March 27, 2024. Due to previously filed Permanent rule, the changes made with in APA WF #24-04 were superseded and must be readopted.

APA WF #24-27 (Previously #24-04 & #23-23) Hospital Provision of Emergency Opioid Antagonist – As directed by Senate Bill 712, Oklahoma Health Care Authority sought and received federal and state approval to allow the Agency to separately reimburse for opioid antagonists provided to members in an emergency department with symptoms of an opioid overdose, opioid disorder, or any other adverse opioid event related to opioid use. These emergency revisions are necessary protect the public health, safety, or welfare and to avoid violation of state law.

Budget Impact: (No new impact) When this change was presented originally, the estimated budget impact for SFY 2024 was an increase in the total amount of $142,203; with $46,173 in state share. The estimated budget impact for SFY 2025 will be an increase in the total amount of $284,406; with $93,314 in state share.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE FACILITIES

317:30-5-133.3. Nursing home ventilator-dependent and tracheostomy care services

(a) Admission is limited to ventilator-dependent and/or ~~qualified~~high-acuity tracheostomy residents.

(b) The ventilator-dependent resident and/or ~~qualified~~high-acuity tracheostomy resident must meet the current nursing facility level of care criteria. (Refer to OAC 317:30-5-123.)

(c) All criteria must be present in order for a resident to be considered ventilator-dependent:

(1) The resident is not able to breathe without a volume with a backup.

(2) The resident must be medically dependent on a ventilator for life support 6 hours per day, seven days per week.

(3) The resident has a tracheostomy.

(4) The resident requires daily respiratory therapy intervention (i.e., oxygen therapy, tracheostomy care, physiotherapy or deep suctioning). These services must be available 24 hours a day.

(5) The resident must be medically stable and not require acute care services. A Registered Nurse or Licensed Practical Nurse must be readily available and have primary responsibility of the unit at all times.

(d) The resident will also be considered ventilator-dependent if all of the above requirements were met at admission but the resident is in the process of being weaned from the ventilator. This excludes residents who are on C-PAP or Bi-PAP devices only.

(e) All criteria must be present in order for a resident to be considered ~~as~~a high-acuity tracheostomy ~~care qualified~~resident:

(1) The resident is not able to breathe without the use of a tracheostomy.

(2) The resident requires daily respiratory therapy intervention (i.e., oxygen therapy, tracheostomy care, chest physiotherapy, or deep suctioning). These services must be available 24 hours a day.

(3) A Registered Nurse or Licensed Practical Nurse must be readily available and have primary responsibility of the unit.

(f) In addition to the requirements in paragraph (e), high-acuity tracheostomy residents will need to meet at least one of the listed criteria below:

(1) The resident has a Brief Interview for Mental Status (BIMS) Interview score between 00-12 (moderately to severely impaired).

(2) The resident sees a pulmonologist monthly and a respiratory therapist at least once every other week, with a respiratory therapist available on call 24 hours a day.

(3) The resident is nonverbal, comatose, or in a vegetative state.

(4) The resident has a contractures diagnosis that results in limited mobility.

(5) The resident requires total dependency from staff with all aspects of daily care.

(6) The resident is unable to suction themselves.

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(7) The resident requires tracheostomy deep suctioning at an increased frequency of at least 10 times daily due to thick, copious amounts of secretions.
(8) The resident is unable to clear their own secretions and protect their airway.
(9) The resident has been diagnosed with a progressive neurological disorder that results in muscle weakness; this includes, but is not limited to, Amyotrophic Lateral Sclerosis (ALS), Multiple Sclerosis (MS), Alzheimer's, head injuries, or Cerebrovascular Accident (CVA).
(10) The resident requires 5 L/min of oxygen or greater than 40% Fraction of Inspired Oxygen (FIO2).
(11) The resident requires breathing treatments that are at an increased frequency of three or more times daily.
(12) The resident has an artificial opening in the neck for the tracheostomy, and an artificial opening in the abdomen for a gastrostomy tube.
(13) The resident has multiple co-morbidities, resulting in demonstrative complications.

(~~f~~g) Not withstanding the foregoing, a ventilator-dependent or ~~qualified~~high-acuity tracheostomy resident who is in the process of being weaned from ventilator dependence or requiring qualified tracheostomy treatment shall continue to be considered a qualified resident until the weaning process is completed.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 30. APPLIED BEHAVIORAL ANALYSIS (ABA) SERVICES

317:30-5-311. Eligible providers and requirements

(a) **Eligible providers.** Eligible ABA provider types include:

(1) Board certified behavior analyst® (BCBA®) - A master's or doctoral level independent practitioner who is certified by the national-accrediting Behavior Analyst Certification Board, Inc. ® (BACB®) and licensed by the Oklahoma Human Services' (OKDHS) Developmental Disabilities Services Division (DDS) to provide behavior analysis services. A BCBA may supervise the work of board-certified assistant behavior analysts and registered behavior technicians implementing behavior analytic interventions;

(2) Board-certified assistant behavior analyst® (BCaBA®) - A bachelor's level practitioner who are certified by the national-accrediting BACB and certified by OKDHS DDS to provide behavior analysis services under the supervision of a BCBA;

(3) Registered behavior technician™ (RBT®) - A high school level or higher paraprofessional who is certified by the national-accrediting BACB and practices under the close and ongoing supervision of a BCBA. The RBT works under the license number of a BCBA and is primarily responsible for the direct implementation of BCBA designed and prescribed behavior-analytic services~~;~~. RBTs must obtain ongoing supervision for a minimum of five percent (5%) of the hours they spend providing behavioral-analytic services each calendar month. Documentation may be requested by the OHCA in looking at the progress of treatment.

(4) Licensed psychologist - An individual who is licensed and in good standing with the Oklahoma State Board of Examiners of Psychologists and has professional experience in the use of ABA therapy may render behavior analysis services. Refer to OAC 317:30-5-275; and

(5) Human services professional - A practitioner who is licensed by the State of Oklahoma pursuant to (A) - (G), and certified by the national-accrediting BACB, and who is working within the scope of his or her practice, to include:

(A) A licensed physical therapist;

(B) A licensed occupational therapist;

(C) A licensed clinical social worker or social worker candidate under the supervision of a licensed clinical social worker;

(D) A licensed speech-language pathologist or licensed audiologist;

(E) A licensed professional counselor or professional counselor candidate under the supervision of a licensed professional counselor;

(F) A licensed marital and family therapist or marital and family therapist candidate under the supervision of a licensed marital and family therapist; or

(G) A licensed behavioral practitioner or behavioral practitioner candidate under the supervision of a licensed behavioral practitioner.

(b) **Provider criteria.** To direct, supervise, and/or render ABA services, the following conditions shall be met.

(1) A BCBA shall:

(A) Be currently licensed by OKDHS DDS as a BCBA;

(B) Have no sanctions or disciplinary actions by OKDHS DDS or the BACB;
(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(D) Be fully contracted with SoonerCare as a provider.

(2) A BCaBA shall:
(A) Be currently certified by OKDHS DDS as a BCaBA;
(B) Work under the supervision of a SoonerCare-contracted BCBA provider;
(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(D) Be fully contracted with SoonerCare as a provider.

(3) An RBT shall:
(A) Be currently certified by the national-accrediting BACB as an RBT;
(B) Work under the supervision of a SoonerCare-contracted BCBA provider;
(C) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(D) Be fully contracted with SoonerCare as a provider.

(4) A human services professional shall:
(A) Be currently licensed or certified by the State of Oklahoma, in accordance with Section 1928 of Title 59 of the Oklahoma Statutes;
(B) Be currently certified by the national-accrediting BACB;
(C) Have no sanctions or disciplinary actions by the applicable state licensing board or the BACB;
(D) If working under supervision within the scope of his or her practice, have a documented relationship with a fully-licensed human service professional working in a supervisory capacity;
(E) Have no current overpayment(s) due to SoonerCare, and no Medicare or Medicaid sanctions or exclusions from participation in federally funded programs; and
(F) Be fully contracted with SoonerCare as a provider.

(5) All contracted providers must reside in the state of Oklahoma, or within 50 miles of the Oklahoma border as per OAC 317:30-3-89 through 92.
(6) All staff providing ABA services must be contracted with the OHCA.

317:30-5-312. Treatment plan components and documentation requirements

(a) **Treatment plan**. The treatment plan is developed by a BCBA or a licensed psychologist from the clinical assessment, and if applicable, the Functional Behavior Assessment (FBA). The treatment plan shall:

(1) Be person-centered and individualized;
(2) Delineate the baseline levels of target behaviors;
(3) Specify long-term and short-term objectives that are defined in observable, measurable behavioral terms;
(4) Specify criteria that will be used to determine achievement of objectives;
(5) ~~Include assessment(s) and treatment protocols for addressing each of the target behaviors such as including antecedent and consequence interventions, and teaching of replacement skills specific to the function of the identified maladaptive behaviors;~~ Clearly relate to the identified maladaptive behavior and/or should include functional goals and those related to

core deficits of ASD as defined by the DSM, both important to and relevant to the child/youth, family, and directly related to the core deficits of ASD as defined by the DSM.
(6) Include specific functional goals to the child/youth, objectively measurable within a specific time frame, attainable in relation to the child/youth prognosis and developmental level.
(7) Include an operational, behavior definition of the target behavior excesses and deficits, prevention and intervention strategies, schedules of reinforcement, and functional alternative responses to the identified function of the target behavior in the BSP.
(8) Include goals that match the setting for services and include a specific titration plan to fade services over time.
~~(6)~~(9) Clearly identify the schedule of services planned and the individuals responsible for delivering the services, including frequent review of data on target behaviors and adjustments in the treatment plan and/or protocols by the BCBA or licensed psychologist as needed~~;~~.
~~(7)~~(10) Include training and supervision to enable board certified assistant behavior analysts (BCaBAs) and registered behavior technicians (RBTs) to implement assessment and treatment protocols~~;~~, not to include the functional behavior assessment.
~~(8)~~(11) Include date of training, techniques utilized, and ~~support~~supports used to enable parents and other caregivers to participate in treatment planning and successfully reinforce the established treatment plan in the home, clinic, ~~and~~ community~~;~~, and other settings.
(12) Include signatures of the BCBA and parent/legal guardian that reflect an actual date including month, day, and year to be considered valid.
(13) Contain the dates of the PA span for which the ABA services have been approved and include the specific date it was created in the treatment plan.
~~(9)~~(14) Include care coordination involving the parents or caregiver(s), school, state disability programs, and others as applicable; and
~~(10)~~(15) Ensure that services are consistent with applicable professional standards and guidelines relating to the practice of applied behavior analysis as well as state Medicaid laws and regulations.

(b) **Assessments and treatment plans.** Initial assessments allow ABA providers to develop a treatment plan that is unique to the member and include all treatment recommendations and goals.
(1) The ~~functional behavior assessment (FBA)~~clinical assessment serves as a critical component of the treatment plan and is conducted by a board-certified behavior analyst (BCBA) to identify the specific behavioral needs of the member. The clinical assessment may include validated measures such as the Vineland Adaptive Behavior Scales or other appropriate measures that assist in identifying the child/youth's current skill level, aid in development of the treatment plan, and support medical necessity for ABA services.
(2) The FBA related to specific behaviors of concern, to be addressed in a BSP, as clinically indicated. The FBA consists of:
(A) ~~Description~~An operational definition of the problematic behavior (topography, onset/offset, cycle, intensity, and severity);
(B) History of the problematic behavior (long-term and recent);
(C) Antecedent analysis (setting, people, time of day, and events);
(D) Consequence analysis; and
(E) Impression and analysis of the function of the problematic behavior.
~~(2) Other relevant assessments may be submitted in addition to the FBA for review by an OHCA reviewer and/or physician to support medical necessity criteria.~~

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(3) Assessments must be completed by the BCBA.

(c) **Documentation requirements.** ABA providers must:

(1) Document all ABA services in the member's record. Refer to OAC 317:30-5-248;

(2) Retain the member's records necessary to disclose the extent of services. Refer to OAC 317:30-3-15; and

(3) Release the medical information necessary for payment of a claim upon request. Refer to OAC 317:30-3-16.

(4) All assessment and treatment services must include the following:

(A) Date;

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

(C) Signature of the ~~provider~~provider(s) rendering services;

(D) Credentials of ~~provider~~provider(s) rendering services;

(E) Specific problem(s), goals, and/or objectives addressed;

(F) Methods used to address problem(s), goals, and objectives;

(G) Progress made toward goals and objectives;

(H) Patient response to the session or intervention; and

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

(J) ~~Treatment~~ Initial treatment plans or plan updates are not valid until all signatures are present. As used in this subsection, all signatures mean:

(i) The signature and date of acknowledgement of the supervising BCBA or licensed psychologist; and

(ii) The signature and date of ~~assent~~ consent of any minor who is age fourteen (14) or older; and

(iii) The signature of consent of:

(I) A parent or legal guardian of any minor; or

(II) If the minor documents a legal exception to parent or legal guardian consent, the excepted minor.

(iv) All signatures:

(I) Must clearly indicate that the signatories approve of and consent, assent, or acknowledge the treatment plan; and

(II) May be provided on a signature page applicable to both the assessment and the treatment plan, if the signed page clearly indicates approval of and consent, assent, or acknowledgment of both the assessment and the treatment plan.

(III) If member is age fourteen (14) or older and is unable to sign and date documentation, please document this in the record.

317:30-5-313. Medical necessity criteria and covered services for members under twenty-one (21) years of age and frequency and duration

(a) Medical necessity criteria. ABA services are considered medically necessary when all the following conditions are met:

(1) The member is under twenty-one (21) years of age with a definitive diagnosis of an Autism Spectrum Disorder (ASD) from the following providers within the state of Oklahoma or within 50 miles of the Oklahoma Border (as per OAC 317:30-3-89 through 92):

(A) Pediatric neurologist or neurologist;

(B) Developmental pediatrician;

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(C) Licensed psychologist;
(D) Psychiatrist or neuropsychiatrist; ~~or~~
(E) Other licensed physician experienced in the diagnosis and treatment of ASD~~.~~; or
(F) An interdisciplinary team composed of a licensed psychologist, physician, physician assistant (PA) or nurse practitioner (APRN).

(2) A comprehensive diagnostic evaluation or thorough clinical assessment completed by one (1) of the above identified professionals must:

(A) Include a complete pertinent medical and social history, including pre-and perinatal, medical, developmental, family, and social elements; and
(B) Be based on criteria outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the most current version of the DSM for ASD and/or may also include scores from the use of formal diagnostic tests such as the Autism Diagnostic Interview-Revised (ADI-R), Autism Diagnostic Observation Schedule-2 (ADOS-2), Childhood Autism Rating Scale (CARS) or other tools with acceptable psychometric properties. Screening scales are not sufficient to make a diagnosis and will not be accepted as the only formal scale.
(C) A comprehensive diagnostic evaluation or clinical assessment will only need to be completed at the first initiation of ABA services and should be no older than two (2) years old. A member does not require an updated assessment or evaluation annually or bi-annually. However, OHCA may request an additional assessment/evaluation if diagnosis and recommendations are not clearly defined.
(D) If a member changes agencies, the comprehensive diagnostic evaluation or clinical assessment will be required during the initial authorization period.
(E) The OHCA may suggest an updated comprehensive evaluation or clinical assessment during the prior authorization process if there are any significant medical, behavioral health changes, or concerns regarding treatment identified through the ABA prior authorization process.
(F) Comprehensive diagnostic evaluations or clinical assessments will only be accepted from an out-of-state provider if the criteria meet documentation requirements outlined in (2)(a)-(c) and must be provided by one of the outlined providers in (1)(a)-(f).

(3) There must be a reasonable expectation that the member will benefit from ABA. The member must exhibit:

(A) The ability/capacity to learn and develop generalized skills to assist with his or her independence; and
(B) The ability to develop generalized skills to assist in addressing maladaptive behaviors associated with ASD.

(4) The member is medically stable and does not require twenty-four (24) hour medical/nursing monitoring or procedures provided in a hospital or intermediate care facility for individuals with intellectual disabilities (ICF/IID).

(5) The member exhibits functional limitations that interfere with participation in daily life and activities that are specific to the core deficits of ASD as outlined in the DSM.

~~(5)~~(6) The member exhibits atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities when applicable. Such atypical or disruptive behavior may include, but is not limited to:

(A) ~~Impulsive aggression~~Aggression toward others;
(B) Self-injury behaviors;

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(C) Elopement that puts the member at risk in the home and/or community (specific examples of elopement as evidenced by dangerous behaviors, i.e., running out the house, into the parking lot, etc.);
(D) PICA (specific examples of PICA as evidenced by eating non-food items that put the member at risk);
~~(C)~~(E) Intentional property destruction; ~~or~~
~~(D)~~(F) Severe disruption in daily functioning (e.g., the individual's inability to maintain in school, child care settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as occupational therapy, speech therapy, additional psychotherapy and/or school/ daycare interventions~~.~~; or
(G) Excessive self-stimulation that significantly disrupts the individual's ability to engage in functional behavior.

~~(6) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") Interventions are intended to strengthen the individual's/parent's/legal guardian's capacity for self care and self sufficiency to decrease interventions in the home by those other than the parent(s)/legal guardian(s).~~
~~(7) It has been determined that there is no less intensive or more appropriate level of service which can be safely and effectively provided.~~

(b) Frequency and duration.

(1) ABA may be delivered at the following frequency and duration levels. Medical necessity is related to symptom severity as defined by the current version of the DSM in addition to guidelines in policy. All levels of intensity of ABA treatment services may be considered depending upon individual case consideration. The following are guidelines. The objectives of ABA therapy will vary per child/youth, and frequency and duration should be based upon the functional goals of treatment, specific needs of the child/youth, response to treatment, and availability of appropriately trained and certified ABA staff. The member must have exhibited these atypical or disruptive behaviors within the most recent thirty (30) calendars days that interferes with the daily functioning and activities. Treatment plans in which the requested frequency exceeds the following service level guidelines will be sent for physician and BCBA consultant review to determine medical necessity.

(A) High frequency (IBI) (greater than thirty (30) hours/week) may be considered when both of the following criteria are met.
(i) Autism Severity Level two (2) or three (3) (per most recent DSM criteria), diagnostic evaluation must be included.
(ii) Goals related to elopement, aggression, self injury, intentional property destruction, or severe disruption in daily functioning (e.g., the individual's inability to maintain in school, childcare settings, social settings, etc.) due to changes in routine activities that have not been helped by other treatments such as occupational therapy, speech therapy, additional psychotherapy and/or school/daycare interventions.
(iii) A Functional Behavioral Assessment (FBA) or Behavioral Intervention Plan (BIP) is required for "High Frequency" level of care.

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(B) Moderate frequency (twenty (20) to thirty (30) hours/week) may be considered when documentation shows two or more of the following:

(i) Autism Severity Level two (2) or three (3) (per most recent DSM criteria), diagnostic evaluation must be included.

(ii) Goals related to addressing moderate challenging behaviors not generally seen as age or developmentally congruent (e.g., biting for a child over three (3) years old, excessive temper tantrums) that moderately to significantly interfere with child participation in home or community activities.

(iii) A Functional Behavioral Assessment (FBA) or Behavioral Intervention Plan (BIP) is required for "Moderate Frequency" level of care.

(C) Targeted/focused frequency (ten (10) to twenty (20) hours a week) may be considered when documentation shows two or more of the following:

(i) Autism Severity Level one (1), two (2), or three (3) (per most recent DSM criteria); diagnostic evaluation must be included.

(ii) Focused on specific targeted clinical issues or goals related to specific targeted skills.

(D) Maintenance/consultative level (five (5) to ten (10) hours per week or less) may be considered when documentation shows all the following:

(i) Autism Severity Level one (1), two (2), or three (3) (per most recent DSM criteria); and

(ii) Goals related to integration of specific skills into daily functioning and documentation substantiates the risk for regression after completion of more intense ABA intervention.

(E) A Functional Behavioral Assessment (FBA) or Behavioral Intervention Plan (BIP) is not required for "Targeted or Maintenance" level of care.

(F) Members discharging from long term PRTF/Acute two (2) level of care may initially require more intensive treatment.

(2) The focus of treatment is not custodial in nature (which is defined as care provided when the member "has reached maximum level of physical or mental function and such person is not likely to make further significant improvement" or "any type of care where the primary purpose of the type of care provided is to attend to the member's daily living activities which do not entail or require the continuing attention of trained medical or paramedical personnel.") Interventions are intended to strengthen the individual's/parent's/legal guardian's capacity for self-care and self-sufficiency to decrease interventions in the home by those other than the parent(s)/legal guardian(s).

(3) A functional behavioral assessment may only be requested every six (6) months and shall be completed by the licensed provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;

(4) It has been determined that there is no less intensive or more appropriate level of service which can be safely and effectively provided.

(5) If the member is exhibiting baseline behaviors (behaviors have not improved within a year of attending at least eighty-five percent (85%) of treatment), OHCA may request additional

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information to support continued treatment.
(6) Discharge plans will be updated each extension request to include realistic criteria for discharge, based on current progress towards goals.
(7) An OHCA discharge notification form shall be submitted when a member has completed treatment or the member has moved to a new provider, or will no longer be returning to care.

317:30-5-314. Prior authorization, service limitations, and exclusions to treatment

(a) **Prior Authorization.** Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent. Prior authorization requests shall be granted ~~up~~by units for one (1) to six (6) months of ABA treatment services as clinically indicated~~ at one (1) time unless a longer duration of treatment is clinically indicated~~. The number of ~~hours~~units authorized may differ from the ~~hours~~units requested on the prior authorization request based on the review by an OHCA reviewer, BCBA contractor, and/or physician. If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization. The provider is responsible for ensuring eligibility, medical necessity, procedural coding, claims submission, and all other state and federal requirements are met. OHCA retains the final administrative review over both authorization and review of services as required by 42 C.F.R. 431.10. The prior authorization request must meet the following SoonerCare criteria for ABA services.

(1) The criteria should include a comprehensive behavioral assessment, FBA, ~~and other supporting assessment(s)~~BSP (if applicable), treatment plan, and the OHCA initial prior authorization template outlining the maladaptive behaviors or core deficits consistent with the diagnosis of ASD and its associated comorbidities. Additional assessments that may be submitted include the: Stress Index for Parents of Adolescents (SIPA); Assessment of Basic Language and Learning (ABLLS-R); Assessment, Evaluation, and Programming System (AEPS); Verbal Behavior Milestone Assessment and Placement Program (VB-MAPP); and Personalized System of Instruction (PSI.) In addition to completing the initial request form, providers ~~will be~~are required to submit documentation that ~~will consist~~consists of the following:

(A) Information about relevant medical status, prior assessment results, response to prior treatment, and other relevant information gathered from review of records and past assessments.

(B) Information gathered from interview of family and/or caregivers, rating scales, and social validity measures to assess perceptions of the client's skill deficits and behavioral excesses, and the extent to which these deficits impede the daily life of the member and the family.

(C) Direct assessment and observation, including any data related to the identified ~~problem~~maladaptive behavior or core deficits. Clinical history from past trauma should be included, if applicable. The analysis of such data serves as the primary basis for identifying pretreatment levels of functioning, developing, and adapting treatment protocols, and evaluating response to treatment and progress towards goals.

(D) Documentation of interviews with parent(s)/caregiver(s) to further identify and define lack of adaptive behaviors and presence of maladaptive behaviors or core deficits.

(E) Length of time that the child/youth has received ABA services as well as previous ABA provider(s).

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~~(D)~~(F) Functional assessment of problem behavior that includes antecedent factors, skill deficits, and consequences contributing to the problem behavior. The treatment plan should address all three (3) areas, including antecedent interventions, teaching replacement skills, and modification of consequences. Other supporting assessments may be additionally submitted for review.

(G) All treatment plans should be signed and dated by the parent(s)/guardian(s) and child/youth, if applicable.

(H) The OHCA initial prior authorization form must be filled out completely or the request will be considered as incomplete.

(2) The prior authorization request for ABA treatment will be time limited ~~for up to thirty (30) hours per week~~ unless ~~other hours are~~ deemed medically necessary and authorized through a prior authorization request and must:

(A) Be a one-on-one encounter (face-to-face between the member and ABA provider) except in the case of family adaptive treatment guidance;

(B) Be child-centered and based upon individualized goals that are strengths-specific, family-focused, and community-based;

(C) Be culturally competent and the least intrusive as possible;

(D) Clearly define in measurable and objective terms the intervention plan so it can address specific target behaviors. The intervention plan should be clearly linked to the identified deficits interfering with the child's participation in daily life activities, and if applicable also related to the identified function of the maladaptive behavior and include antecedent interventions, replacement skills to be taught, and modification of consequences. Additional goals may be identified that are related to the core deficits of ASD and are prioritized based on current research and social significance for the ~~individual~~member.

(E) Record the frequency, rate, symptom intensity/duration, or other objective measures of baseline levels;

(F) Set quantifiable criteria for progress;

(G) Establish and record behavioral intervention techniques that are appropriate to the identified target and/or maladaptive behaviors. The detailed treatment plan utilizes reinforcement and other behavioral principles and excludes the use of methods or techniques that lack consensus about their effectiveness based on evidence in peer-reviewed publications;

(H) Specify strategies for generalization of learned skills beyond the clinical settings such as in the home ~~or other~~, clinic, community, or other natural settings;

(I) Document ~~planning~~plan for transition through the continuum of interventions, services, and settings, as well as discharge criteria. Treatment (behavioral training) will be individualized, and documentation will support the identified skill deficits and atypical or disruptive behavior.

(J) Document the daily schedule by hour and the staff with credentials that will perform each service. If there is a change in staff, identify this in the extension review.

~~(J)~~(K) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings.

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Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;

~~(K)~~(L) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques in the member's medical record. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment. It is expected that child/youth and parent(s)/guardian(s) attend at least eighty-five percent (85%) of treatment each review period, unless due to sickness or other unforeseen circumstances that may occur, to be documented this in the prior authorization request form; and

~~(L)~~(M) Ensure that recommended ABA services do not duplicate, or replicate services received in a member's primary academic education setting or provided within an Individualized Education Program (IEP), Individualized Service Plan (ISP), or any other individual plan of care. Documentation may be requested by the OHCA to support coordination of services with other providers and to prevent overlap and duplication of services including those in school settings.

(N) Identify if member is receiving additional therapies such as occupational therapy (OT), physical therapy (PT), or speech therapy and the timeframes in which this occurs, in relation to ABA services.

(b) Service Limitations.

(1) Settings. The following limitations apply to where ABA services are provided:

(A) ABA services are not allowed in a daycare setting or school setting, without OHCA approval. If approved, it will be time-limited to three (3) months or less. The BCBA shall create and submit a treatment plan that identifies the goals outlined to assist school staff with the members without ABA staff being present throughout the school year.

(B) The treatment plan should show a titration of services to school paraprofessionals/staff through the duration of the prior authorization.

(C) If the child/youth is transitioning into a private school, where IEPs are not legally required, then services will be time-limited to three (3) months or less. The BCBA should create and submit an FBA, treatment plan, or BSP, along with the prior authorization request that identifies the goals to match the setting and a specific plan to fade direct support.

(D) ABA treatment may be rendered via in-person service delivery, telehealth, or a hybrid of in-person and telehealth. The modality selected for delivery of ABA services must be clearly defined in the prior authorization template and treatment plan. If services will be provided via telehealth, the ABA provider must provide the justification of how treatment will be beneficial to the member and parents(s)/guardian(s) when rendered this way.

(E) Documentation of services must be maintained, to include: service rendered, location at which service was rendered, and that service was provided via telehealth. Documentation of services must also follow all other SoonerCare documentation requirements.

(2) Coverage. Services are limited to the following:

(A) Providers may only concurrently bill RBT and supervision hours when the following criteria is outlined in the prior authorization request:

(i) The BCBA or licensed psychologist met with the member and/or parent or guardian and directed the RBT through one (1) or more of the following:

(I) Monitoring treatment integrity to ensure satisfactory implementation of

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treatment protocols;
(II) Directing RBT staff and/or caregivers in the implementation of new or revised treatment protocols;
(III) Selection and development of treatment goals, protocols, and data collection systems;
(IV) Collaboration with family members and other stakeholders;
(V) Creating materials, gathering materials;
(VI) Reviewing data to adjust treatment protocols; and/or
(VII) Development and oversight of transition and discharge planning.

(B) The BCBA or licensed psychologist used behavior training in session as appropriate in supervision of the RBT staff and/or caregivers. Behavioral skills training consists of providing instructions, modeling, rehearsal, and feedback between provider and member.
(C) The functional behavior assessment is reimbursed per authorized units provided by the BCBA, not to exceed thirty-two (32) units (eight (8) hours).
(D) RBT and supervision codes may be reimbursed for ABA individual treatment.
(E) Parent training may be reimbursed for ABA parent/caregiver/family education and training services. This service must be completed by the BCBA or BCaBA and cannot be completed by the RBT.
(F) ABA is not allowed to be billed concurrently during any other therapies (i.e., OT, PT speech, etc.).
(G) ABA hours approved for one CPT code cannot be used in place of another.
(H) All ABA services should be billed under the rendering provider that performed the services.

(3) Exclusions to Treatment. The following services are non-covered benefits of Oklahoma Medicaid:

(A) ABA addressing academic goals.
(B) ABA addressing goals only related to performative social norms that do not significantly impact health, safety, or independence.
(C) Treatment other than at the maintenance or consultative level not expected to result in improvements in the child/youth's level of functioning.
(D) Services that do not require the supervision of or specific skills and judgement of a BCBA to perform.
(E) Services that do not meet accepted standards of practice for specific and effective treatment of ASD.
(F) Services in the school/daycare setting as a shadow, aide, or to provide general support to the child/youth.
(G) ABA evaluation or intervention services provided by a clinic or agency owned or partially owned by the child/youth's responsible adult (e.g., biological, adoptive, or foster parent(s), guardian(s), court-appointed managing conservator(s), or other family member(s) by birth or marriage).
(H) ABA evaluation or intervention services provided directly by the child/youth's responsible adult (e.g., biological, adoptive, or foster parent(s), guardian(s), court-appointed managing conservator(s), other family member(s) by birth or marriage).
(I) Experimental or investigational treatment.
(J) Services or items not generally accepted as effective and/or not within the normal course and duration of treatment.

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(K) Services for the caregiver or provider convenience, for example, as respite care or limiting treatment to a setting chosen by provider for convenience.
(L) ABA authorized for toilet learning/toilet training, OT, or speech therapy.

317:30-5-315. ABA extension requests

Extension requests for ABA services must be submitted to the OHCA or its designated agent.

(1) **Documentation Requirements.** Extension requests must contain the appropriate documentation validating the need for continued treatment and establish and/or document the following:

~~(1)~~(A) Eligibility criteria in OAC 317:30-5-313;
~~(2)~~(B) The frequency of the target behavior has diminished since last review, or if not, there has been modification of the treatment or additional assessments have been conducted;
(C) The daily schedule and staff with credentials that will be performing each service;
(D) Identified positive reinforces and negative reinforcers of targeted behaviors;
(E) A summary of progress towards goals as related to the core deficits and maladaptive behavior identified in the treatment plan;
(F) Updated assessments as appropriate, including an updated, FBA and BIP, updated treatment plan that clearly outlines progress towards goals and any new goals, the OHCA extension prior authorization template outlining the maladaptive behaviors or core deficits consistent with the diagnosis of ASD and its associated comorbidities;

~~(3) A functional analysis shall be completed by the provider when no measurable progress has occurred, or it may be requested by the OHCA. The functional analysis should record the member's serious maladaptive target behavioral symptom(s) and precipitants, and document the modifications of the current treatment plan to address progress, as well as make a determination of the function a particular maladaptive behavior serves for the member in the environmental context;~~
~~(4) Appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);~~
~~(5) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorization;~~
~~(6) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and~~
~~(7) The treatment plan documents a gradual tapering of higher intensities of intervention and transitioning to supports from other sources (i.e., schools) as progress allows.~~
(2) To receive an increase in RBT hours on the first extension request, parent training by the BCBA or BCaBA must be provided at minimum of an hour (1) per week for three (3) months. Start and stop times must be included in the prior authorization request;
(3) Further extension request for an increase in RBT hours will require that parent training has been provided for two (2) hours/week for three (3) months. Start and stop times must be included in the prior authorization request;
(4) Include parent(s)/legal guardian(s) in behavioral training techniques so that they can practice additional hours of intervention on their own. The treatment plan is expected to achieve the parent(s)/legal guardian(s) ability to successfully reinforce the established plan of care and support generalization of skills in the home and community settings. Frequency of

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parental involvement will be determined by the treatment provider and listed on the treatment plan;
(5) Document parent(s)/legal guardian(s) participation in the training of behavioral techniques. Parent(s)/legal guardian(s)' participation is critical to the generalization of treatment goals to the member's environment.
(6) Absence or less than two (2) hours per month of appropriate parent training/involvement documented in the record will result in a reduction of hours and possibly denial of services;
(7) The OHCA extension prior authorization form must be filled out completely, or the request will be considered as incomplete. A summary of the supported documentation must be included in the prior authorization request;
(8) If problem behavior is persistent outside of clinic, please identify the treatment goals/techniques to address these behaviors in the community, home, or other natural environment;
(9) Document appropriate consultations from other staff or experts have occurred (to optimize psychiatric medications and medical treatments to include but not limited to psychiatric consults, pediatric evaluation for other conditions, etc.) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);
(10) The OHCA may suggest appropriate consultation from other staff or experts during the process of prior authorizations;
(11) Identify if member is receiving additional therapies such as occupational therapy (OT), physical therapy (PT), speech therapy, or otherwise and the timeframes in which this occurs, in relation to ABA services;
(12) Extension request may only be submitted seven (7) calendar days prior to the end date of the most recent request. Late submissions may result in a technical denial and loss of days.

317:30-5-316. Reimbursement methodology

SoonerCare shall provide reimbursement for ABA services in accordance with the Medicaid State Plan.

(1) Payment shall only be made to SoonerCare-contracted groups or qualified individual providers who are currently licensed and in good standing. Payment is not made to under supervision ABA practitioners/paraprofessionals, including but not limited to, BCaBAs and RBTs.

(2) Reimbursement for covered ABA procedure codes is for direct service time. Pre and post work for the session are not reimbursed separately. Separate reimbursement for treatment planning, note documentation, report writing, or updating of charts and data sheet is prohibited (other than what is allowable under the functional behavioral assessment procedure code).

~~(2)~~(3) Reimbursement for ABA services is only made on a fee-for-services basis. The maximum allowable fee for a unit of service has been determined by OHCA to be a reasonable fee, consistent with efficiency, economy, and quality of care. ~~Payment for covered services is the lower of the provider's actual billed charges, consistent with the provider's usual and customary charge to the general public for the service, or the maximum allowable per unit of service.~~

~~(3)~~(4) Reimbursement shall only be made for services that have been prior authorized by OHCA or its designee; and performed on an individualized basis and not in a group setting except for family adaptive behavior treatment guidance by a qualified ABA provider ~~(~~outlined in OAC 317:30-5-311~~)~~.

~~(4) Providers may only concurrently bill current Procedural Terminology (CPT) codes when they outline in the prior authorization the following criteria:~~

~~(A) The BCBA or licensed psychologist met with the member and/or parent or guardian and directed the RBT through one (1) or more of the following:~~

~~(i) Monitoring treatment integrity to ensure satisfactory implementation of treatment protocols;~~

~~(ii) Directing RBT staff and/or caregivers in the implementation of new or revised treatment protocols;~~

~~(iii) Selection and development of treatment goals, protocols, and data collection systems;~~

~~(iv) Collaboration with family members and other stakeholders;~~

~~(v) Creating materials, gathering materials;~~

~~(vi) Reviewing data to make adjustments to treatment protocols; and/or~~

~~(vii) Development and oversight of transition and discharge planning.~~

~~(B) The BCBA or licensed psychologist used behavior training in session as appropriate in supervision of the RBT staff and/or caregivers. Behavioral skills training consists of providing instructions, modeling, rehearsal, and feedback between provider and member.~~

(5) Reimbursement for ABA services shall not be made to or for services rendered by a parent, legal guardian, or other legally responsible person.

(6) Services rendered via telehealth must be billed using the appropriate modifier.

(7) Reimbursement is in accordance with the prior authorization and coverage limitation requirements within OAC 317:30-5-314.

317:30-5-317. Restraint, Seclusion and Serious Occurrence Reporting Requirements

Physical restraint is not appropriate during any service provided to SoonerCare clients under the Autism Services benefit except in emergency instances of threat of physical harm to the child/youth or others around them. If restraint is used, it may only occur under the following circumstances and according to the processes outlined below.

(1) Physical restraint may only be implemented by a person trained in the type of restraint being implemented. The training must be documented in the personnel file.

(2) Restraint must be limited to the use of such reasonable force as is necessary to address the emergency.

(3) Restraint must be discontinued at the point at which the emergency no longer exists.

(4) Restraint must be implemented in such a way as to protect the health and safety of the child/youth and others.

(5) Restraint must not deprive the child/youth of basic human necessities.

(6) Documentation must be kept of the up-to-date training for all staff members involved and of each incident that resulted in restraint.

(7) Documentation must be kept identifying the reason, start time/end time, the staff signature, and credentials of who performed the restraint, and date.

(8) A phone call to the parent or guardian must be reported immediately if an injury occurs and documented in the record.

(9) In the event of death or serious injury (i.e., bruising, scratches, etc.), the OHCA critical incident reporting form must be submitted to OHCA no later than 5:00 p.m. Central time the

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following business day.

317:30-5-318. Service Quality Review

(a) A Service Quality Review (SQR, may be requested by OHCA or it's designated agent).
(b) The OHCA will designate the members of the SQR team. The SQR team will consist of one (1) to three (3) team members and will be comprised of LBHPs or registered nurses.
(d) The SQR will include, but not be limited to, review of facility and clinical record documentation, staff training, and qualifications. The clinical record review may consist of records of members currently at the facility as well as records of members for which claims have been filed with OHCA for Applied Behavior Analysis. The SQR includes validation of compliance with policy, which must be met for the services to be compensable.
(e) Following the SQR, the SQR team will report its findings in writing to the facility. A copy of the final report will be sent to the Program Integrity, and if applicable any licensing agencies.
(f) Deficiencies identified during the SQR may result in full or partial recoupment of paid claims. The determination of whether to assess full or partial recoupment shall be at the discretion of the OHCA based on the severity of the deficiencies.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG-TERM CARE FACILITIES

317:30-5-122. Levels of care

(a) This rule sets forth the criteria used to determine whether an individual who is seeking SoonerCare payment for long term care services needs services at the level of Skilled Nursing Facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). The criteria set forth in this Section must be used when determining level of care for individuals seeking SoonerCare coverage of either facility-based institutional long term care services or Home and Community Based Services (HCBS) Waivers.

(b) The level of care provided by a long term care facility or through a HCBS Waiver is based on the nature of the person's needs and the care, services, and treatment required from appropriately qualified personnel. The level of care review is a determination of an individual's physical, mental, and social/emotional status to determine the appropriate level of care required. In addition to level of care requirements, other applicable eligibility criteria must be met.

(1) **Skilled Nursing facility.** Payment is made for the Part A coinsurance and deductible for Medicare covered skilled nursing facility care for dually eligible, categorically needy individuals.

(2) **Nursing Facility.** Care provided by a nursing facility to members who require professional nursing supervision and a maximum amount of nonprofessional nursing care due to physical conditions or a combination of physical and mental conditions.

(3) **Intermediate Care Facility for Individuals with Intellectual Disabilities.** Care for persons with intellectual disabilities or related conditions to provide health and/or habilitative services in a protected residential setting. To qualify for ICF/IID level of care, persons must have substantial functional limitations in three or more of the following areas of major life activity:

(A) **Self-care**. The individual requires assistance, training, or supervision to eat, dress, groom, bathe, or use the toilet.

(B) **Understanding and use of language**. The individual lacks functional communication skills, requires the use of assistive devices to communicate, does not demonstrate an understanding of requests, or is unable to follow two-step instructions.

(C) **Learning**. The individual has a valid diagnosis of intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders. When the individual is seeking SoonerCare coverage of Oklahoma Human Services Developmental Disabilities Services HCBS Waivers they must be:

(i) determined by the Social Security Administration (SSA) to have a disability and a diagnosis of intellectual disability; or

(ii) Be determined by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) to have a disability and a diagnosis of intellectual disability per SSA guidelines or a diagnosis of global developmental delay when accompanied by a Full-Scale Intelligence Quotient less than or equal to 70, plus or

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minus five, when under six (6) years of age as defined in the Diagnostic and Statistical Manual of Mental Disorders

(D) **Mobility**. The individual requires the use of assistive devices to be mobile and cannot physically self-evacuate from a building during an emergency without assistive device.

(E) **Self-direction**. The individual is seven (7) years old or older and significantly at risk in making age appropriate decisions or an adult who is unable to provide informed consent for medical care, personal safety, or for legal, financial, habilitative, or residential issues, and/or has been declared legally incompetent. The individual is a danger to himself or others without supervision.

(F) **Capacity for independent living**. The individual who is seven (7) years old or older and is unable to locate and use a telephone, cross the street safely, or understand that it is unsafe to accept rides, food, or money from strangers. Or an adult who lacks basic skills in the areas of shopping, preparing food, housekeeping, or paying bills.

PART 43. AGENCY COMPANION, SPECIALIZED FOSTER CARE, DAILY LIVING SUPPORTS, GROUP HOMES, EXTENSIVE RESIDENTIAL SUPPORTS, AND COMMUNITY TRANSITION SERVICES

317:30-5-422. Description of services

Residential supports include:

(1) agency companion services ~~(ACS)~~ per Oklahoma Administrative Code (OAC)317:40-5;

(2) specialized foster care ~~(SFC)~~ per OAC 317:40-5;

(3) daily living supports ~~(DLS)~~:

(A) Community Waiver per OAC 317:40-5-150; and

(B) Homeward Bound Waiver per OAC 317:40-5-153;

(4) group home services provided per OAC 317:40-5-152; ~~and~~

(5) extensive residential supports per OAC 317:40-5-154; and

~~(5)~~(6) community transition services (CTS).

(A) Minimum qualifications. The provider must enter into contractual agreements with the Oklahoma Health Care Authority (OHCA) to provide ACS, habilitation training specialist ~~(HTS)~~ services, or DLS, in addition to a contract to provide CTS.

(B) Description of services. CTS is a one-time setup expense for members transitioning from an intermediate care facility for individuals with intellectual disabilities ~~(ICF/IID)~~ or provider-operated residential setting to the member's own home or apartment. The cost per member of CTS cannot exceed limitations set forth by OHCA. The member's name must be on the lease, deed or rental agreement. CTS:

(i) are furnished only when the member is unable to meet such expense and must be documented in the member's Individual Plan (IP);

(ii) include security deposits, essential furnishings, such as major appliances, dining ~~table/chairs,~~tables and chairs, bedroom set, sofa, chair, window coverings, kitchen ~~pots/pans,~~pots and pans, dishes, eating utensils, ~~bed/bath~~bed and bath linens, kitchen dish ~~towel/potholders,~~towels and potholders, a one month supply of laundry/cleaning products, and setup fees or deposits for initiating utility service, including phone, electricity, gas, and water. CTS also includes moving expenses, ~~services/items~~services and items necessary for the member's health and safety, such

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as pest eradication, allergen control, a one-time cleaning prior to occupancy, flashlight, smoke detector, carbon monoxide detector, first aid kit, fire extinguisher, and a tempering valve or other anti-scald device when determined by the Personal Support Team necessary to ensure the member's safety; and

(iii) ~~does~~do not include:

(I) recreational items, such as television, cable, satellite, internet, video cassette recorder (VCR), digital video disc (DVD) player, compact disc (CD) player, MP3 player, gaming system, cell phone or computer used primarily as a diversion or recreation;

(II) monthly rental or mortgage expenses;

(III) food;

(IV) personal hygiene items;

(V) disposable items, such as paper ~~plates/napkins,~~plates and napkins, plastic utensils, disposable food storage bags, aluminum foil, and plastic wrap;

(VI) items that are considered decorative, such as rugs, pictures, bread box, canisters, or a clock;

(VII) any item not considered an essential, one-time expense; or

(VIII) regular ongoing utility charges;

(iv) prior approval for exceptions ~~and/or~~and questions regarding eligible items ~~and/or~~and expenditures are directed to the programs manager for community transition services at ~~DHS DDS state office;~~Oklahoma Human Services Developmental Disabilities Services State Office;

~~(v) authorizations are issued for the date a member transitions;~~

~~(vi)~~(v) may only be authorized for members approved for the Community Waiver; and

~~(vii)~~(vi) may not be authorized for items purchased more than ~~30~~thirty (30) calendar days after the date of transition.

PART 51. HABILITATION SERVICES

317:30-5-482. Description of services

Habilitation services include the services identified in (1) through (15) of this Section. Habilitation services providers must have an applicable agreement with the Oklahoma Health Care Authority (OHCA) to provide Developmental Disabilities Services (DDS) through Home and Community-Based Services (HCBS).

(1) **Dental services.** Dental services are provided per Oklahoma Administrative Code (OAC) 317:40-5-112.

(A) **Minimum qualifications.** Dental services providers must have non-restrictive licensure by the Oklahoma State Board of Dentistry to practice dentistry in Oklahoma.

(B) **Description of services.** Dental services include services for maintenance or improvement of dental health as well as relief of pain and infection. These services may include:

(i) Oral examinations;

(ii) Medically necessary images;

(iii) Prophylaxis;

(iv) Fluoride application;

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(v) Development of a sequenced treatment plan that prioritizes:
(I) Pain elimination;
(II) Adequate oral hygiene; and
(III) Restoring or improving ability to chew;
(vi) Routine training of member or primary caregiver regarding oral hygiene; and
(vii) Preventive, restorative, replacement, and repair services to achieve or restore functionality provided after appropriate review when applicable, per OAC 317:40-5-112.
(C) **Coverage limitations.** Dental service coverage is specified in the member's Individual Plan (IP) in accordance with applicable Waiver limits. Cosmetic dental services are not authorized.
(2) **Nutrition services**. Nutrition Services are provided, per OAC 317:40-5-102.
(3) **Occupational therapy services.**
(A) **Minimum qualifications.** Occupational therapists and occupational therapy assistants have current, non-restrictive licensure by the Oklahoma Board of Medical Licensure and Supervision. Occupational therapy assistants are supervised by occupational therapists, per OAC 317:30-5-295 (b) (1).
(B) **Service description.** Occupational therapy services include evaluation, treatment, and consultation in leisure management, daily living skills, sensory motor, perceptual motor, mealtime assistance, assistive technology, positioning, and mobility. Occupational therapy services may include occupational therapy assistants, within the limits of the occupational therapist's practice.
(i) Services are:
(I) Intended to help the member achieve greater independence to reside and participate in the community; and
(II) Rendered in any community setting as specified in the member's IP. The IP includes a practitioner's prescription.
(ii) For this Section's purposes, a practitioner means medical and osteopathic physicians, physician assistants, and other licensed health care professionals with prescriptive authority to order occupational therapy services in accordance with the rules and regulations governing the SoonerCare program.
(iii) Service provision includes a written report or record documentation in the member's record, as required.
(C) **Coverage limitations.** For compensable services, payment is made to the individual occupational therapist for direct services or for services provided by a qualified occupational therapist assistant within the occupational therapist's employment. Payment is made in fifteen-minute (15-minute) units, with a limit of four hundred and eighty (480) units per Plan of Care (POC) year. Payment is not allowed solely for written reports or record documentation.
(4) **Physical therapy services.**
(A) **Minimum qualifications.** Physical therapists and physical therapist assistants must have current, non-restrictive licensure with the Oklahoma Board of Medical Licensure and Supervision. The physical therapist supervises the physical therapist assistant, per OAC 317:30-5-290.1 (b) (1).
(B) **Service description.** Physical therapy services include evaluation, treatment, and consultation in locomotion or mobility skeletal and muscular conditioning, assistive

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technology, and positioning to maximize the member's mobility and skeletal/muscular well-being. Physical therapy services may include physical therapist assistants, within the limits of the physical therapist's practice.

(i) Services are intended to help the member achieve greater independence to reside and participate in the community. Services are provided in any community setting as specified in the member's IP. The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians and physician assistants in accordance with the rules and regulations covering the OHCA SoonerCare program.

(ii) Service provision includes a written report or record documentation in the member's record, as required.

(C) **Coverage limitations.** For compensable services, payment is to individual physical therapists for direct services or for services provided by a qualified physical therapist assistant within the physical therapist's employment. Payment is made in fifteen-minute (15-minute) units with a limit of four hundred and eighty (480) units per POC. Payment is not allowed solely for written reports or record documentation.

(5) **Psychological services.**

(A) **Minimum qualifications.** Qualification to provide psychological services requires current, non-restrictive licensure as a psychologist by the Oklahoma State Board of Examiners of Psychologists, or by the licensing board in the state where the service is provided. Psychological technicians who have completed all board certification and training requirements may provide services under a licensed psychologist's supervision.

(B) **Service description.** Psychological services include evaluation, psychotherapy, consultation, and behavioral treatment. Service is provided in any community setting as specified in the member's IP. The provider develops, implements, evaluates, and revises the Protective Intervention Protocol (PIP) corresponding to the relevant outcomes identified in the member's IP.

(i) Services are:

(I) Intended to maximize a member's psychological and behavioral well-being; and

(II) Provided in individual and group formats, with a six-person maximum.

(ii) Service approval is based on assessed needs per OAC 340:100-5-51.

(C) **Coverage limitations.**

(i) Payment is made in fifteen (15) minute units. A minimum of fifteen (15) minutes for each individual and group encounter is required.

(ii) Psychological services are authorized for a period, not to exceed twelve (12) months.

(I) Initial authorization does not exceed one hundred and ninety-two (192) units, forty-eight (48) service hours.

(II) Authorizations may not exceed two hundred and eighty-eight (288) units per POC year unless the DDS Behavior Support Services director or designee makes an exception.

(III) No more than twelve (12) hours of services, forty-eight (48) units, may be billed for PIP preparation. Any clinical document is prepared within sixty (60) calendar days of the request. Further, if the document is not prepared, payments are suspended until the requested document is provided.

(IV) When revising a PIP to accommodate recommendations of a required committee review, the provider may bill for only one (1) revision. The time for preparing the revision is clearly documented and does not exceed four (4) hours.

(6) **Psychiatric services.**

(A) **Minimum qualifications.** Qualification as a psychiatric services provider requires a current, non-restrictive license to practice medicine in Oklahoma. Certification by the American Board of Psychiatry and Neurology or satisfactory completion of an approved residency program in psychiatry is required.

(B) **Service description.** Psychiatric services include outpatient evaluation, psychotherapy, medication and prescription management and consultation, and are provided to eligible members. Services are provided in the community setting specified in the member's IP.

(i) Services are intended to contribute to the member's psychological well-being.

(ii) A minimum of thirty (30) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is thirty (30) minutes, with a limit of two hundred (200) units, per POC year.

(7) **Speech-language pathology services.**

(A) **Minimum qualifications.** Qualification as a speech-language pathology services provider requires current, non-restrictive licensure as a speech-language pathologist, speech-language pathology assistant, or speech-language pathology clinical fellow, by the Oklahoma Board of Examiners for Speech-Language Pathology and Audiology, per OAC 317:30-5-675.

(B) **Service description.** Speech therapy includes evaluation, treatment, and consultation in communication, oral motor activities, and/or feeding activities provided to eligible members. Services are intended to maximize the member's community living skills and may be provided in the community setting specified in the member's IP.

(i) The IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, physician assistants, and other licensed professionals with prescriptive authority to order speech or language services or both in accordance with rules and regulations covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** A unit is fifteen (15) minutes, with a limit of two hundred and eighty-eight (288) units, per POC. Payment is not allowed solely for written reports or record documentation.

(8) **Habilitation training specialist (HTS) services.**

(A) **Minimum qualifications.** Providers complete Oklahoma Human Services (OKDHS) DDS-sanctioned training curriculum. Residential habilitation providers:

(i) Are at least eighteen (18) years of age or older;

(ii) Are specifically trained to meet members' unique needs;

(iii) Have not been convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per Section (§) 1025.2 of Title 56 of the Oklahoma Statutes (56 O.S. § 1025.2) unless a waiver is granted, per 56 O.S. §1025.2; and

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(iv) Receive supervision and oversight from contracted-agency staff with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Service description.** HTS services include services to support the member's self-care, daily living, and adaptive and leisure skills needed to reside successfully in the community. Services are provided in community-based settings in a manner that contributes to the member's independence, self-sufficiency, community inclusion, and well-being.

(i) Payment is not made for~~:~~ routine care and supervision family normally provides.

~~(I) Routine care and supervision family normally provides; or~~

~~(II) Services furnished to a member by a person who is legally responsible, per OAC 340:100-3-33.2~~.

(ii) Family members who provide HTS services meet the same standards as providers who are unrelated to the member. Legally responsible individuals, per OAC 340:100-3-33.2, may provide HTS for extraordinary care as determined by the Oklahoma Choice Assessment completed annually by DDS staff. HTS staff residing in the same household as the member may not provide services in excess of forty (40) hours per week. Members who require HTS services for more than forty (40) hours per week use staff members who do not reside in the household, and who are employed by the member's chosen provider agency, to deliver the balance of necessary support staff hours. Exceptions may be authorized, when needed, for members who receive services through the Homeward Bound Waiver.

(iii) Payment does not include room and board or maintenance, upkeep, or improvement of the member's or family's residence.

(iv) For members who also receive intensive personal supports (IPS), the member's IP clearly specifies the role of the HTS and person providing IPS to ensure there is no service duplication.

(v) Review and approval by the DDS plan of care reviewer is required.

(vi) Pre-authorized HTS services accomplish the same objectives as other HTS services, but are limited to situations where the HTS provider is unable to obtain required professional and administrative oversight from an OHCA-approved oversight agency. For pre-authorized HTS services, the service:

(I) Provider receives DDS area staff oversight; and

(II) Is pre-approved by the DDS director or his or her designee.

(C) **Coverage limitations.** HTS services are authorized per OAC 317:40-5-110, 317:40-5-111, 317:40-7-13, and 340:100-3-33.1.

(i) A unit is fifteen (15) minutes.

(ii) Individual HTS service providers are limited to a maximum of forty (40) hours per week regardless of the number of members served.

(iii) More than one (1) HTS may provide care to a member on the same day.

(iv) Payment cannot be made for services provided by two (2) or more HTSs to the same member during the same hours of a day.

(v) An HTS may receive reimbursement for providing services to only one (1) member at any given time. This does not preclude services from being provided in a group setting where services are shared among group members.

(vi) HTS providers may not perform any job duties associated with other

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employment including on-call duties, at the same time they are providing HTS services.

(9) **Remote Supports (RS).** RS is provided per OAC 317:40-4-4.

(10) **Self Directed HTS (SD HTS).** SD HTS are provided per OAC 317:40-9-1.

(11) **Self Directed Goods and Services (SD GS).** SD GS are provided per OAC 317:40-9-1.

(12) **Audiology services.**

(A) **Minimum qualifications.** Audiologists have licensure as an audiologist by the Oklahoma Board of Examiners for Speech Pathology and Audiology per OAC 317:30-5-675 (d) (1).

(B) **Service description.** Audiology services include individual evaluation, treatment, and consultation in hearing to eligible members. Services are intended to maximize the member's auditory receptive abilities.

(i) The member's IP includes a practitioner's prescription. For this Section's purposes, practitioners are defined as licensed medical and osteopathic physicians, and physician assistants in accordance with OAC 317:30-5-1 covering the OHCA SoonerCare program.

(ii) A minimum of fifteen (15) minutes for encounter and record documentation is required.

(C) **Coverage limitations.** Audiology services are provided in accordance with the member's IP.

(13) **Prevocational services.**

(A) **Minimum qualifications.** Prevocational services providers:

(i) Are eighteen (18) years of age or older;

(ii) Complete OKDHS DDS-sanctioned training curriculum;

(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony per 56 O.S. § 1025.2, unless a waiver is granted per 56 O.S. § 1025.2; and

(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Service description.** Prevocational services are not available to persons who can be served under a program funded per Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) per Section 1401 et seq. of Title 20 of the United States Code.

(i) Prevocational services are learning and work experiences where the member can develop general, non-job, task-specific strengths that contribute to employability in paid employment in integrated community settings.

(ii) Activities include teaching concepts such as communicating effectively with supervisors, co-workers, and customers, attendance, task completion, problem solving, and safety. These activities are associated with building skills necessary to perform work.

(iii) Pre-vocational services are delivered to further habilitation goals that lead to greater opportunities for competitive, integrated employment. All prevocational services are reflected in the member's IP. Documentation is maintained in the record of each member receiving this service, noting the service is not otherwise available

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through a program funded under the Rehabilitation Act of 1973 or IDEA.
(iv) Services include:
(I) Center-based prevocational services, per OAC 317:40-7-6;
(II) Community-based prevocational services per, OAC 317:40-7-5;
(III) Enhanced community-based prevocational services per, OAC 317:40-7-12; and
(IV) Supplemental supports, as specified in OAC 317:40-7-13.

(C) **Coverage limitations.** A unit of center-based or community-based prevocational services is one (1) hour and payment is based on the number of hours the member participates in the service. All prevocational services and supported-employment services combined may not exceed the annual costs set forth in OKDHS Appendix D-26, Developmental Disabilities Services Rates Schedule. The services that may not be provided to the same member at the same time as prevocational services are:
(i) HTS;
(ii) IPS;
(iii) Adult Day Health;
(iv) Daily Living Supports (DLS);
(v) Homemaker; or
(vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services; family counseling; or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training, per OAC 317:40-7-6.

(14) **Supported employment.**
(A) **Minimum qualifications.** Supported employment providers:
(i) Are eighteen (18) years of age or older;
(ii) Complete the OKDHS DDS-sanctioned training curriculum;
(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.5; and
(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities.

(B) **Services description.** For members receiving HCBS Waiver services, supported employment is conducted in various settings, particularly worksites where persons without disabilities are employed, and includes activities that are outcome based and needed to sustain paid work, including supervision and training. The supported employment outcome is sustained paid employment at or above minimum wage, but not less than the customary wage and benefit level the employer pays for the same or similar work individuals without disabilities perform. The paid employment occurs in an integrated setting in the general workforce in a job that meets personal and career goals.
(i) When supported-employment services are provided at a worksite where persons without disabilities are employed, payment:
(I) Is made for the adaptations, supervision, and training members require as a result of their disabilities; and
(II) Does not include payment for the supervisory activities rendered as a normal part of the business setting.

(ii) Services include:
(I) Job coaching per OAC 317:40-7-7;
(II) Enhanced job coaching per OAC 317:40-7-12;
(III) Employment training specialist services per OAC 317:40-7-8; and
(IV) Stabilization per OAC 317:40-7-11.
(iii) Supported-employment services furnished under HCBS Waivers are not available under a program funded by the Rehabilitation Act of 1973 or IDEA.
(iv) Documentation that the service is not otherwise available under a program funded by the Rehabilitation Act of 1973 or IDEA is maintained in each member's record.
(v) Federal financial participation may not be claimed for incentive payment subsidies or unrelated vocational training expenses, such as:
(I) Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;
(II) Payments passed through to users of supported-employment programs; or
(III) Payments for vocational training not directly related to a member's supported-employment program.
(C) **Coverage limitations.** A unit is fifteen (15) minutes and payment is made per OAC 317:40-7-1 through 317:40-7-21. All prevocational services and supported-employment services combined cannot exceed $27,000, per POC year. The DDS case manager assists the member to identify other alternatives to meet identified needs above the limit. The services that may not be provided to the same member, at the same time as supported-employment services are:
(i) HTS;
(ii) IPS;
(iii) Adult Day Health;
(iv) DLS;
(v) Homemaker; or
(vi) Therapy services, such as occupational therapy; physical therapy; nutrition, speech, or psychological services, family counseling, or family training, except to allow the therapist to assess the individual's needs at the workplace or to provide staff training.
(15) **IPS.**
(A) **Minimum qualifications.** IPS provider agencies must have a current provider agreement with OHCA and OKDHS DDS. Providers:
(i) Are eighteen (18) years of age or older;
(ii) Complete OKDHS DDS-sanctioned training curriculum;
(iii) Are not convicted of, pled guilty to, or pled nolo contendere to misdemeanor assault and battery, or a felony, per 56 O.S. § 1025.2 unless a waiver is granted, per 56 O.S. § 1025.2;
(iv) Receive supervision and oversight from a person with a minimum of four (4) years of any combination of college-level education or full-time equivalent experience in serving persons with disabilities; and
(v) Receive oversight regarding specific methods to be used with the member to meet the member's complex behavioral or health support needs.
(B) **Service description.**

(i) IPS:

(I) Are support services provided to members who need an enhanced level of direct support in order to successfully reside in a community-based setting; and

(II) Build on the support level HTS or DLS staff provides by utilizing a second staff person on duty to provide assistance and training in self-care, daily living, and recreational and habilitation activities.

(ii) The member's IP clearly specifies the role of HTS and the person providing IPS to ensure there is no service duplication.

(iii) The DDS POC reviewer is required to review and approve services.

(C) **Coverage limitations.** IPS are limited to twenty-four (24) hours per day and are included in the member's IP, per OAC 317:40-5-151 and 317:40-5-153.

(16) **Adult day health.**

(A) **Minimum qualifications.** Adult day health provider agencies:

(i) Meet licensing requirements, per 63 O.S. § 1-873 *et seq*. and comply with OAC 310:605; and

(ii) Are approved by the OKDHS DDS director and have a valid OHCA contract for adult day health.

(B) **Service description.** Adult day health provide assistance with retaining or improving the member's self-help ability adaptive and socialization skills, including the opportunity to interact with peers in order to promote a maximum level of independence and function. Services are provided in a non-residential setting away from the home or facility where the member resides.

(C) **Coverage limitations.** adult day health is furnished four (4) or more hours per day on a regularly scheduled basis, for one (1) or more days per week. A unit is fifteen (15) minutes for up to a maximum of eight (8) hours daily. All services are authorized in the member's IP.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 40. DEVELOPMENTAL DISABILITIES SERVICES

SUBCHAPTER 1. GENERAL PROVISIONS

317:40-1-1. Home and Community-Based Services (HCBS) Waivers for persons with intellectual disabilities or certain persons with related conditions

(a) **Applicability.** This Section applies to services funded through Medicaid HCBS Waivers per Oklahoma Administrative Code (OAC) 317:35-9-5 and Section 1915(c) of the Social Security Act. Specific Waivers are the In-Home Supports Waiver (IHSW) for Adults, IHSW for Children, Community Waiver, and Homeward Bound Waiver.

(b) **Program provisions.** Each individual requesting services provided through an HCBS Waiver and his or her family or guardian, are responsible for:

(1) Accessing with ~~the~~ Oklahoma ~~Department of~~ Human Services (OKDHS) staff assistance, all benefits available under Oklahoma's Medicaid State Plan or other payment sources prior to accessing funding for those same services under an HCBS Waiver program;

(2) Cooperating in the determination of medical and financial eligibility including prompt reporting of changes in income or resources;

(3) Choosing between services provided through an HCBS Waiver or institutional care; and

(4) Reporting any changes in address or other contact information to OKDHS within thirty (30) calendar days.

(c) **Waiver eligibility.** To be eligible for Waiver services, an applicant must meet the criteria established in (1) of this Subsection and the criteria for one (1) of the Waivers established in (1) through (8) of this Subsection.

(1) **HCBS Waiver services.** Services provided through an HCBS Waiver are available to Oklahoma residents meeting SoonerCare (Medicaid) eligibility requirements established by law, regulatory authority, and policy within funding available through state or federal resources. To be eligible and receive services funded through any of the Waivers listed in (a) of this Section, an applicant must meet conditions, per OAC 317:35-9-5. The applicant:

(A) Must be determined financially eligible for SoonerCare, per OAC 317:35-9-68;

(B) May not simultaneously be enrolled in any other Medicaid Waiver program or receiving services in an institution including a hospital, rehabilitation facility, mental health facility, nursing facility, or residential care home per Section (') 1-820 of Title 63 of the Oklahoma Statutes (O.S.), or Intermediate Care facility for individuals with intellectual disabilities (ICF/IID);

(C) May not be receiving Developmental Disabilities Services (DDS) state-funded services, such as the Family Support Assistance Payment, Respite Voucher Program, sheltered workshop services, community integrated employment services, or assisted living without Waiver supports, per OAC 340:100-5-22.2; and

(D) Must also meet other Waiver-specific eligibility criteria.

(2) **In-Home Supports Waivers (IHSW).** To be eligible for services funded through the IHSW, an applicant must:

(A) Meet all criteria listed in (c) of this Section; and

(B) Be determined by the Social Security Administration (SSA) to have a disability and a diagnosis of intellectual disability; or

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(C) Be determined by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU) to have a disability and a diagnosis of intellectual disability per SSA guidelines or a diagnosis of global developmental delay when accompanied by a Full-Scale Intelligence Quotient (FSIQ) less than or equal to seventy (70), plus or minus five (5), when under six (6) years of age as defined in the Diagnostic and Statistical Manual of Mental Disorders ~~by the Oklahoma Health Care Authority (OHCA) Level of Care Evaluation Unit (LOCEU)~~; and

(D) Be three (3) years of age or older;

(E) Be determined by the OHCA LOCEU to meet the ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122; and

(F) Reside in:

(i) A family member's or friend's home;

(ii) His or her own home;

(iii) An OKDHS Child Welfare Services (CWS) foster home; or

(iv) A CWS group home; and

(vii) Have critical support needs that can be met through a combination of non-paid, non-Waiver, and SoonerCare (Medicaid) resources available to the individual; and HCBS Waiver resources within the annual per capita Waiver limit, agreed on between the State of Oklahoma and the Centers for Medicare and Medicaid Services (CMS).

(3) **Community Waiver.** To be eligible for services funded through the Community Waiver, the applicant must:

(A) Meet all criteria listed in (c) of this Section;

(B) Be determined by the SSA to have a disability and a diagnosis of intellectual disability; or

(C) Have an intellectual ~~disability as defined in the Diagnostic and Statistical Manual of Mental Disorders~~per SSA guidelines or a related condition by DDS and be covered under the State's alternative disposition plan, adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(D) Be determined by the OHCA LOCEU to have a disability and a diagnosis of intellectual disability per SSA guidelines or a diagnosis of global developmental delay when accompanied by an FSIQ less than or equal to seventy (70), plus or minus five (5), when under six (6) years of age as defined in the Diagnostic and Statistical Manual of Mental Disorders ~~or the OHCA LOCEU~~; and

(E) Be three (3) years of age or older; and

(F) Be determined by the OHCA LOCEU, to meet ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122; and

(G) Have critical support needs that can be met by the Community Waiver and cannot be met by IHSW services or other service alternatives, as determined by the DDS director or designee.

(4) **Homeward Bound Waiver.** To be eligible for services funded through the Homeward Bound Waiver, the applicant must:

(A) Be certified by the United States District Court for the Northern District of Oklahoma as a member of the plaintiff class in *Homeward Bound et al. v. The Hissom Memorial Center*, Case No. 85-C-437-E;

(B) Meet all criteria for HCBS Waiver services listed in (c) of this Section; and

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(C) Be determined by SSA to have a disability and a diagnosis of intellectual disability; or

(D) Have an intellectual disability as defined in the Diagnostic and Statistical Manual of Mental Disorders or a related condition, per OAC 317:35-9-45 as determined by DDS, and to be covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act; or

(E) Have a disability as defined in the Diagnostic and Statistical Manual of Mental Disorders by the OHCA/LOCEU; and

(F) Meet ICF/IID Institutional Level of Care requirements, per OAC 317:30-5-122, as determined by the OHCA LOCEU.

(5) **Evaluations and information.** Applicants desiring services through any of the Waivers listed in (a) of this Section participates in diagnostic evaluations and provides information necessary to determine HCBS Waiver services eligibility, including:

(A) A psychological evaluation, by a licensed psychologist that includes:

(i) A full-scale, functional and/or adaptive assessment; and

(ii) A statement of age of onset of the disability; and (iii) Intelligence testing that yields a full-scale, intelligence quotient.

(I) Intelligence testing results obtained at sixteen (16) years of age and older are considered valid of the current status, provided they are compatible with current behavior. Intelligence testing results obtained between seven to sixteen (7 to 16) years of age are considered current for four (4) years when the full-scale intelligence quotient is less than forty (40) and for two (2) years when the intelligence quotient is forty (40) or above.

(II) When an applicant is approved for an HCBS waiver with a diagnosis of global developmental delay, a new psychological evaluation must be conducted and submitted after the child reaches six (6) years of age. Re-evaluation occurs at the beginning of the plan of care year following the child's sixth (6th) birthday, at which time, a diagnosis of Intellectual Disability must be confirmed to continue waiver services.

~~(II)~~(III) DDS may require a current psychological evaluation when a significant change of condition, disability, or psychological status is noted;

(B) A social service summary, current within twelve (12) months of the requested approval date that includes a developmental history; and

(C) A medical evaluation, current within one (1) calendar year of the requested approval date; and

(D) A completed Form LTC-300, ICF/IID Level of Care Assessment; and

(E) Proof of disability per SSA guidelines. When a disability determination is not made by SSA, OHCA LOCEU may make a disability determination using SSA guidelines.

(6) **Eligibility determination.** OHCA reviews the diagnostic reports listed in (2) of this subsection and makes an eligibility determination for DDS HCBS Waivers.

(7) **State's alternative disposition plan.** For individuals who are determined to have an intellectual disability or a related condition by DDS per the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, DDS reviews the diagnostic reports listed in (2) of this subsection and, on behalf of OHCA, makes a determination of eligibility for DDS HCBS Waiver services and ICF/IID level of care.

(8) **Member's choice.** A determination of need for ICF/IID Institutional Level of Care does

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not limit the opportunities of the person receiving services to participate in community services. Individuals are assured of the opportunity to exercise informed choice in the selection of services.

(d) **Request list.** When state DDS resources are unavailable to add individuals to services funded through an HCBS Waiver, persons are placed on a statewide Request for Waiver Services List.

(1) The Request for Waiver Services List is maintained in chronological order, based on the date of receipt of a written request for services on Form 06MP001E, Request for Developmental Disabilities Services. The applicant must submit the required documentation, per Form 06MP001E, Request for Developmental Disabilities Services, for initial consideration of potential eligibility. Active United States Armed Forces personnel, who have a pending HCBS Waiver application in another state for an immediate family member, may be placed on the list with the date they applied in the other state. The person's name is added to the list when he or she provides proof of application date from the other state.

(2) The Request for Waiver Services List for persons requesting services provided through an HCBS Waiver is administered by DDS uniformly throughout the state.

(3) An individual applicant is removed from the Request for Waiver Services List, when he or she:

(A) Is found to be ineligible for services;

(B) Cannot be located by OKDHS;

(C) Does not provide OKDHS-requested information or fails to respond;

(D) Is not an Oklahoma resident at the requested Waiver approval date; or

(E) Declines an offer of Waiver services.

(4) An applicant removed from the Request for Waiver Services List, because he or she could not be located, may submit a written request to be reinstated to the list. The applicant is returned to the same chronological place on the Request for Waiver Services List, provided he or she was on the list prior to January 1, 2015.

(e) **Applications.** When resources are sufficient for initiation of HCBS Waiver services, DDS ensures action regarding a request for services occurs within forty-five (45) calendar days. When action is not taken within the required forty-five (45) calendar days, the applicant may seek resolution, per OAC 340:2-5-61.

(1) Applicants are allowed sixty (60) calendar days to provide information requested by DDS to determine eligibility for services.

(2) When requested information is not provided within sixty (60) calendar days, the applicant is notified that the request was denied, and he or she is removed from the Request for Waiver Services List.

(f) **Admission protocol.** Initiation of services funded through an HCBS Waiver occurs in chronological order from the Request for Waiver Services List, per (d) of this Section based on the date of DDS receipt of a completed request for services, as a result of the informed choice of the person requesting services or the individual acting on the member's behalf, and upon determination of eligibility, per (c) of this Section. Exceptions to the chronological requirement may be made, when:

(1) An emergency situation exists in which the health or safety of the person needing services or of others is endangered and there is no other resolution to the emergency. An emergency exists, when:

(A) The person is unable to care for himself or herself and:

(i) the person's caretaker, 43A O.S. § 10-103:

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(I) Is hospitalized;
(II) Moved into a nursing facility;
(III) Is permanently incapacitated; or
(IV) Died; and
(ii) There is no caretaker to provide needed care to the individual; or
(iii) An eligible person is living at a homeless shelter or on the street;
(B) OKDHS finds the person needs protective services due to ongoing physical, sexual, or emotional abuse or neglect in his or her present living situation, resulting in serious jeopardy to the person's health or safety;
(C) The behavior or condition of the person needing services is such that others in the home are at risk of being seriously harmed by the person. For example, when the person is routinely physically assaultive to the caretaker or others living in the home and sufficient supervision cannot be provided to ensure the safety of those in the home or community; or
(D) The person's medical, psychiatric, or behavioral challenges are such that the person is seriously injuring or harming himself or herself, or is in imminent danger of doing so.
(2) The Legislature appropriated special funds with which to serve a specific group or a specific class of individuals, per HCBS Waiver provisions;
(3) Waiver services may be required for people who transition to the community from a public ICF/IID or children in OKDHS custody receiving services from OKDHS. Under some circumstances Waiver services related to accessibility may be authorized in advance of transition, but may not be billed until the day the member leaves the ICF/IID and enters the Waiver; or
(4) Individuals subject to the provisions of Public Law 100-203 residing in nursing facilities for at least 30-continuous months prior to January 1, 1989, and are determined by Preadmission Screening and Resident Review (PASRR) evaluation conducted per Title 42 Section 483.100 of the Federal Code of Regulations to have an intellectual disability or a related condition, who are covered under the State's alternative disposition plan adopted under Section 1919(e)(7)(E) of the Social Security Act, and choose to receive services funded through the Community or Homeward Bound Waiver.

(g) **Movement between DDS HCBS Waiver programs.** A person's movement from services funded through one (1) DDS-administered HCBS Waiver to services funded through another DDS-administered HCBS Waiver is explained in this subsection.
(1) When a member receiving services funded through the IHSW for children becomes eighteen (18) years of age, services through the IHSW for adults becomes effective.
(2) Change to services funded through the Community Waiver from services funded through the IHSW occurs only when:
(A) A member has critical health and safety support needs that cannot be met by IHSW services, non-Waiver services, or other resources as determined by the DDS director or designee; and
(B) Funding is available, per OAC 317:35-9-5.
(3) Change to services funded through the IHSW from services funded through the Community Waiver may only occur when a member's history of annual service utilization was within the IHSW per capita allowance.

(4) When a member served through the Community Waiver has support needs that can be met within the per capita Waiver allowance of the applicable IHSW and through a combination of non-Waiver resources, the individual may choose to receive services through the IHSW.

(h) **Continued eligibility for HCBS Waiver services.** Eligibility for members receiving services provided through the HCBS Waiver is re-determined by the OHCA LOCEU when a determination of disability was not made by the Social Security Administration. The OHCA LOCEU determines categorical relationship to the SoonerCare disabled category according to Social Security Administration guidelines. OHCA LOCEU also approves the level of care, per OAC 317:30-5-122, and confirms a diagnosis of intellectual disability per ~~the Diagnostic and Statistical Manual of Mental Disorders.~~SSA guidelines.

(1) DDS may require a new psychological evaluation and re-determination of eligibility at any time when a significant change of condition, disability, or psychological status is noted.

(2) Annual review of eligibility requires a medical evaluation that is current within one year of the requested approval date. The medical evaluation must be submitted by the member or the individual acting on his or her behalf thirty (30) calendar days prior to the Plan of Care expiration.

(i) **HCBS Waiver services case closure.** Services provided through an HCBS Waiver are terminated, when:

(1) A member or the individual acting on the member's behalf chooses to no longer receive Waiver services;

(2) A member is incarcerated;

(3) A member is financially ineligible to receive Waiver services;

(4) A member is determined by SSA to no longer have a disability qualifying the individual for services under these Waivers;

(5) A member is determined by the OHCA LOCEU to no longer be eligible;

(6) A member moves out of state or the custodial parent or guardian of a member who is a minor moves out of state;

(7) A member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for more than thirty (30) consecutive calendar days;

(8) The guardian of a member who is a minor or adjudicated adult fails to cooperate during the annual review process, per OAC 340:100-5-50 through 340:100-5-58;

(9) The guardian of a member who is a minor or adjudicated adult fails to cooperate in the implementation of the OKDHS rule or service delivery in a manner that places the health or welfare of the member at risk, after efforts to remedy the situation through Adult Protective Services or Child Protective Services were not effective;

(10) The member is determined to no longer be SoonerCare eligible;

(11) There is sufficient evidence the member or the individual acting on the member's behalf engaged in fraud or misrepresentation, failed to use resources as agreed on in the Individual Plan, or knowingly misused public funds associated with these services;

(12) The member or the individual acting on the member's behalf either cannot be located, did not respond, or did not allow case management to complete plan development or monitoring activities as required, per OAC 340:100-3-27, and the member or the individual acting on the member's behalf:

(A) Does not respond to the notice of intent to terminate; or

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(B) The response prohibits the case manager from being able to complete plan development or monitoring activities as required, per OAC 340:100-3-27;

(13) The member or the individual acting on the member's behalf fails to cooperate with the case manager to implement a Fair Hearing decision;

(14) It is determined services provided through an HCBS Waiver are no longer necessary to meet the member's needs and professional documentation provides assurance the member's health, safety, and welfare can be maintained without Waiver supports;

(15) The member or the individual acting on the member's behalf fails to cooperate with service delivery;

(16) A family member, the individual acting on the member's behalf, other individual in the member's household, or persons who routinely visit, pose a threat of harm or injury to provider staff or official OKDHS representatives; or

(17) A member no longer receives a minimum of one (1) Waiver service per month and DDS is unable to monitor the member on a monthly basis.

(j) **Reinstatement of services.** Waiver services are reinstated when:

(1) The situation resulting in case closure of a Hissom class member is resolved;

(2) A member is incarcerated for ninety (90) calendar days or less;

(3) A member is admitted to a nursing facility, ICF/IID, residential care facility, hospital, rehabilitation facility, or mental health facility for ninety (90) calendar days or less; or

(4) A member's SoonerCare eligibility is re-established within ninety (90) calendar days of the SoonerCare ineligibility date.

SUBCHAPTER 5. MEMBER SERVICES

PART 11. OTHER COMMUNITY RESIDENTIAL SUPPORTS

317:40-5-155 Extensive residential supports (ERS) [NEW]

(a) **Introduction.** ERS are provided by an agency, approved by Developmental Disabilities Services (DDS), that has a valid Oklahoma Health Care Authority contract for the service.

(1) ERS provide up to twenty-four (24) hours per day of direct support services, including the provision of more than one staff when the needs of the member indicate additional supports are required.

(2) ERS provides a level of supervision necessary to keep the member safe in the home and in the community and to assist the member with obtaining desired outcomes identified in the member's Individual Plan (Plan).

(b) **Provider approval criteria**. Prospective providers of ERS must demonstrate a history of effective services and supports to persons with challenging behaviors per OAC 340:100-5-57(c), emotional challenges or community protection needs. Provider approval requires review of historical information, when available, from DDS Quality Assurance Unit and Residential Unit. The DDS director or designee must approve the location of the home prior to the implementation of services. Each prospective provider submits written documentation of:

(1) a history of services to persons who present challenging behaviors, emotional challenges, or community protection needs, including:

(A) past experience;

(B) number of persons served;

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(C) provider's perspective on the greatest challenges in serving persons eligible for ERS services; and
(D) provider's philosophy for service provision;
(2) financial viability through fiscal information when requested, including the anticipated budget related to the rate for ERS services;
(3) service provision plans, including:
(A) anticipated number of homes;
(B) location;
(C) gender to be served;
(D) population to be served; and
(E) availability of psychological, psychiatric, vocational and educational services in the proposed location;
(4) plans for staffing and program coordination; and
(5) staff qualifications, including any additional training provided.

(c) **Services provided.** Services and supports are based on person-centered principles and practices and consistent with OAC 317:40-1-3.
(1) The service includes but is not limited to:
(A) program supervision and oversight, which includes:
(i) 24-hour availability of response staff to:
(I) meet schedules or unpredictable needs in a way that promotes maximum dignity and independence; and
(II) provide supervision, safety and security consistent with the program described in the member's Plan; and
(ii) staff who are available to respond to a crisis to:
(I) help ensure safety; and
(II) assist the member to self-regulate to help prevent placement disruption;
(B) behavioral support, which includes supporting the member in being a valued member of the community. Challenging interactions may include but are not limited to:
(i) physical or verbal aggression;
(ii) sexually unsafe behaviors or actions;
(iii) victimizing other people or animals;
(iv) property destruction;
(v) self-harm;
(vi) suicidal ideations or attempts; and
(vii) stealing or other illegal behavior;
(C) activities of daily living, which includes instruction, hands-on support, supervision, modeling or prompting to:
(i) eat;
(ii) bathe;
(iii) dress;
(iv) toilet;
(v) complete personal hygiene;
(vi) transfer;
(vii) complete housework;
(viii) manage money;
(ix) engage in community safety;

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(x) participate in recreation;
(xi) engage in socialization;
(xii) manage health;
(xiii) manage medication; or
(xiv) attend school and other community-based educational opportunities;
(D) coordinating overall safety and supports in the home;
(E) self-advocacy training and support, which includes, but is not limited to:
(i) training and assistance in supported decision making;
(ii) accessing needed services;
(iii) asking for help;
(iv) recognizing and reporting abuse, neglect, mistreatment, or exploitation of self,
(v) responsibility for one's own actions; and
(vi) participation in all meetings;
(F) development of communication skills;
(G) assistance with:
(i) emergency planning;
(ii) safety planning;
(iii) fire, weather and disaster drills; and
(iv) crisis intervention;
(H) community access support to enhance the abilities and skills necessary for the member to access typical activities and functions of community life.
(i) Accessing the community includes providing a wide variety of opportunities which may include:
(I) development of social, communication and other skills needed to successfully participate in the desired communities;
(II) facilitating and building natural relationships in the desired communities;
(III) participating in community education experiences or training;
(IV) participating in volunteer activities the member finds interesting and desirable;
(V) exploring and understanding available public transportation options; and
(VI) participating in pre-employment and employment activities;
(ii) Services are conducted in a variety of settings in which members interact with individuals without disabilities. Services may include:
(I) social skill development;
(II) adaptive skill development; and
(III) personnel to accompany and support the member in community settings; and
(I) implementation of recommended and approved follow-up counseling, behavioral, or other therapeutic interventions;
(J) implementation of services delivered under the direction of a licensed or certified professional in that discipline including, but not limited to:
(i) family training;
(ii) psychological services;
(iii) counseling services;
(iv) physical therapy;
(v) occupational therapy; and

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(vi) speech therapy;
(K) medical and health care services that are integral to meeting the daily needs of the member, which include, but are not limited to:
(i) routine administration of medications; and
(ii) tending to the medical needs of members;
(L) the provision of staff training per Oklahoma Administrative Code (OAC) 340:100-3-38.14, to meet the specific needs of the member; and
(M) assisting the member in obtaining services and supplies.

(d) **Eligibility.** ERS are provided to members who:
(1) have challenging behaviors, emotional challenges, or community protection needs and require additional supports to enable them to reside successfully in community settings. These services are designed to assist members to acquire, retain and improve the self-help, socialization, and adaptive skills necessary to remain in the community;
(2) have needs that cannot be met in other traditional community settings;
(3) participate in the DDS Community Waiver, per OAC 317:40-1-1;
(4) need community residential services outside the family home;
(5) do not receive:
(A) home-and community-based services options per OAC 340:100-5-22.1;
(B) group home services per OAC 317:40-5-152;
(C) habilitation training specialist per OAC 317:40-5-110;
(D) respite care per OAC 317:30-5-517;
(E) homemaker per OAC 317:30-5-535; and
(F) intensive personal supports per OAC 317:40-5-151; and
(6) are eighteen (18) years of age or older, unless approved by the DDS director or designee.

(e) **Service requirements.** ERS must be:
(1) included in the member's Plan per OAC 340:100-5-51, including a description of the type(s) and intensity of supervision and assistance that must be provided to the member;
(2) authorized in the member's Plan of Care (POC);
(3) provided by the contracted provider agency chosen by the member or guardian;
(4) delivered per OAC 340:100-5-22.1; and
(5) provided directly to the member.

(f) **Home Requirements.** ERS are provided to eligible members living outside the family's home in a home:
(1) licensed by Oklahoma Human Services (OKDHS) Child Care Services when the member is a child in custody of OKDHS, Child Welfare Services; or
(2) leased or owned by the member receiving services.

(g) **Responsibilities of provider agencies.** Each agency providing ERS ensures:
(1) ongoing supports are available as needed when the member is out of the home visiting family and friends, or hospitalized for psychiatric or medical care;
(2) compliance with all applicable DDS policy found at OAC 340:100; and
(3) that trained staff are available to the member as described in the Plan.
(4) a trainer of a nationally recognized person-centered planning program approved by DDS is employed as a member of the provider's leadership team or is contracted with the provider.
(5) A background investigation is conducted on staff per OAC 340:100-3-39.
(6) staff identified to work with children complete a Federal Bureau of Investigation (FBI) national criminal history search, which is based on the staff's fingerprints.

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(h) **ERS claims.** No more than one unit of ERS per day may be billed.

(1) The provider agency claims one unit of service for each day during which the member receives ERS. A day is defined as the period between 12:00 a.m. and 11:59 p.m.

(2) Claims must not be based on budgeted amounts.

(3) When a member changes provider agencies, only the outgoing service provider agency claims for the day that the member moves.

(i) **Therapeutic leave.** ERS provides for therapeutic leave payments to enable the provider agency to retain direct support staff.

(1) Therapeutic leave is claimed when the member does not receive ERS services for 24-consecutive hours from 12:00 a.m. to 11:59 p.m. because of:

(A) a visit with family or friends without direct support staff;

(B) vacation without direct support staff; or

(C) hospitalization, whether direct support staff are present or not. ERS staff may be present with the member in the hospital as approved by the member's Personal Support Team (Team) in the Plan but are not responsible for the care of the patient.

(2) Therapeutic Leave must be authorized and documented in the POC.

(3) A member may receive therapeutic leave for no more than fourteen (14) consecutive days per event, not to exceed sixty (60) calendar days per POC year.

(4) The payment for a day of therapeutic leave is the same amount as the per diem rate for ERS.

(5) To promote continuity of staffing in the member's absence, the provider agency pays the staff member the salary that he or she would have earned if the member was not on therapeutic leave or provides the staff member a temporary, alternative work opportunity.

(j) **Transition.** Teams plan for a service recipient's transition to appropriate services when it is determined ERS is no longer necessary.

(1) Within six months of the service recipient's admission to ERS, the Team develops measurable, reasonable criteria for the service recipient's transition to a less restrictive environment that are:

(A) based on findings of the risk assessment completed by the Team per OAC 340:100-5-56.

(B) included in a written plan submitted to designated DDS State Office staff; and

(C) reviewed at least annually by the Team.

(2) All transitions from ERS must be approved by designated DDS State Office staff. DDS State Office staff may adjust the transition date when necessary.

(k) **DDS-initiated transition.** The DDS director or designee may initiate the transition process for a member receiving ERS who can be effectively served in another residential environment.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 115. PHARMACISTS

317:30-5-1225. Eligible Providers
Eligible Providers shall:

(1) Have and maintain a current license by the Oklahoma State Board of Pharmacy as described in Section 353.9 of Title 59 of Oklahoma Statutes and Title 535 of the Oklahoma Administrative Code, Chapter 10, Subchapter 7.
(2) Have a current contract with the Oklahoma Health Care Authority (OHCA)

317:30-5-1226. Covered Services
(a) OHCA covers medical services (as described in OAC 317:30-5, Part 1, Physicians) provided by a pharmacist when rendered within the licensure and scope of practice of the pharmacist as defined by state law and regulations found at 59 O.S. § 353.1, 59 O.S. § 353.30, OAC 535:10-9-1 through OAC 535:10-9-15, and OAC 535:10-11-1 through OAC 535:10-11-6.
(b) Medical services rendered by pharmacists are subject to the same limitations described in OAC 317:30-5, Part 1, Physicians.

317:30-5-1227. Reimbursement
(a) Payment for covered services (as described in OAC 317:30-5-1226) to eligible providers (as described in 30-5-1225) shall be made when the same service would have been covered if ordered or performed by a physician.
(b) Payment is made per the methodology established in the Oklahoma Medicaid State Plan.

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

317:30-5-1091. Definition of I/T/U services
(a) As described in 42 CFR 136.11(a), the I/T/U services may include hospital and medical care, dental care, public health nursing, preventive care (including immunizations).
(b) Further, 42 CFR 136.11(c) allows that the scope and availability of I/T/U services will depend upon the resources of the facility.
(c) I/T/U services may be covered when furnished to a patient at the clinic or other location, including a mobile clinic, or the patient's place of residence. Provider contracts must meet the provider participation requirements found at OAC 317:30-5-1096.
(d) I/T/U outpatient encounters include but are not limited to:

(1) Physicians' services and supplies incidental to a physician's services;
(2) Within limitations as to the specific services furnished, a doctor of dentistry or oral surgery, a doctor of optometry, or a doctor of podiatry [Refer to Section 1861(r) of the Act for specific limitations];
(3) Services of advanced practice nurses (APNs), physician assistants (PAs), certified nurse

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midwives (CNMs), or specialized advanced practice nurse practitioners;
(4) Services and supplies incidental to the services of APNs and PAs (including services furnished by certified nurse midwives);
(5) Public health nursing services, within the scope of their licensure, include but are not limited to services in the following areas:

(A) Phlebotomy;
(B) Wound care;
(C) Public health education;
(D) Administration of immunizations;
(E) Administration of medication;
(F) Child health screenings meeting EPSDT criteria;
(G) Smoking and Tobacco Use Cessation Counseling;
(H) Prenatal, newborn and postpartum assessments, including case management services for first time mothers; and
(I) General health assessments and management of conditions such as tuberculosis, diabetes and hypertension.

(6) Visiting nurse services to the homebound;
(7) Behavioral health professional services and services and supplies incidental to the services of LBHPs; and
(8) Dental services.
(9) Pharmacists' services found in OAC 317:30-5-1226

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high-cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) Laboratory services;

(B) Prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) Technical component on radiology services;

(D) Transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) Pre-admission diagnostic testing performed within seventy-two (72) hours of admission; and

(F) Organ transplants.

(3) Charges for services or supplies deemed not medically necessary and/or not separately billable may be recouped upon post payment review of outlier payments.

(4) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(5) Covered inpatient services provided to eligible members of the SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.

(6) Cases which indicate transfer from one (1) acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(7) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.

(8) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(9) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed one-hundred percent (100%) of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.
(10) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.
(11) All inpatient services are reimbursed per the methodology described in this Section and/or as approved under the Oklahoma Medicaid State Plan.
(12) For high-investment drugs, refer to OAC 317:30-5-47.6.
<u>(13) Separate reimbursement may be obtained for provision of two (2) doses of emergency opioid antagonist upon discharge as per state law.</u>

DRAFT

OPERATIONAL METRICS

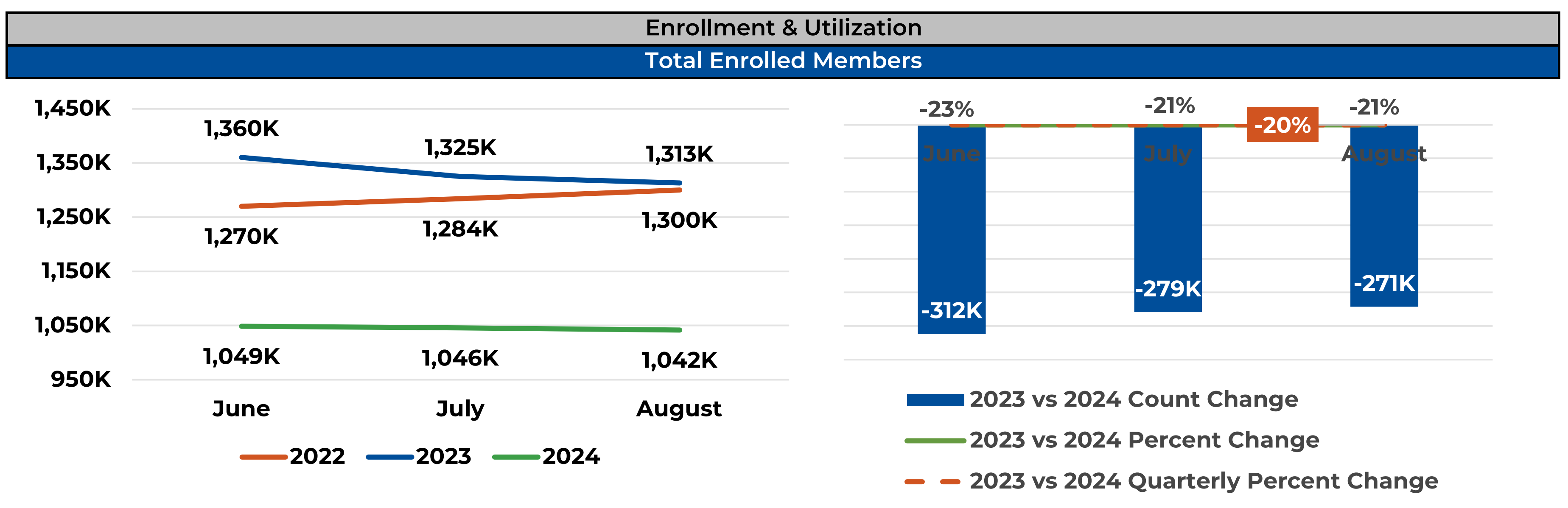
September 2024 Board Meeting

OKLAHOMA HEALTH CARE AUTHORITY

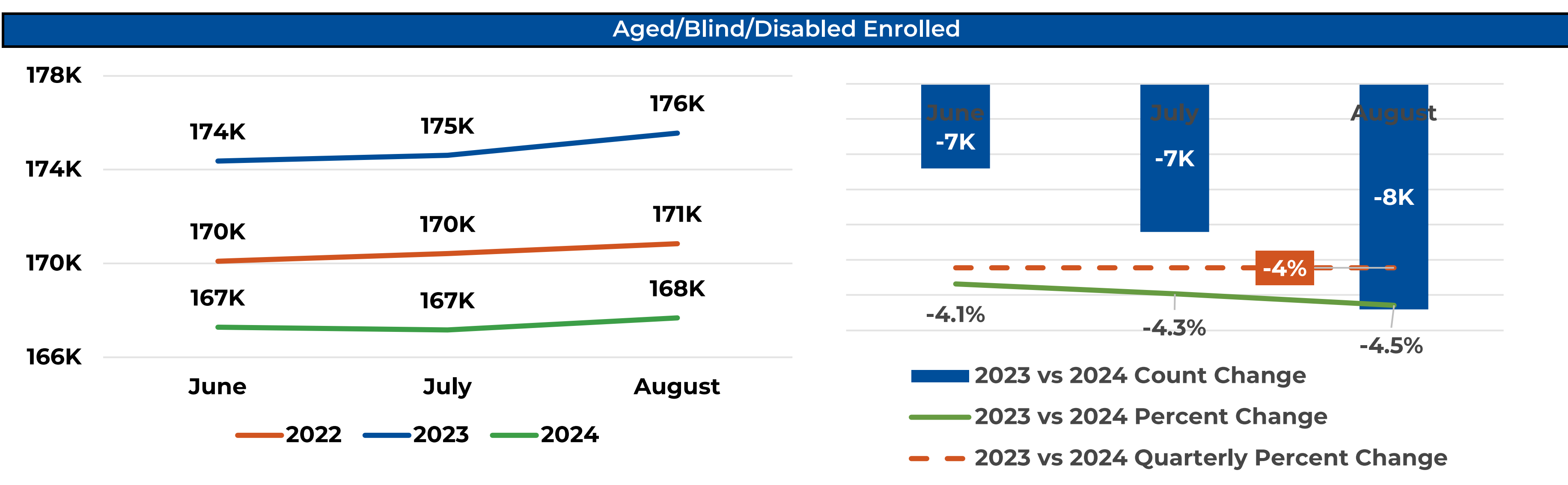
4345 N. LINCOLN BLVD. | OKHCA.ORG |

Enrollment & Utilization

Total Enrolled Members

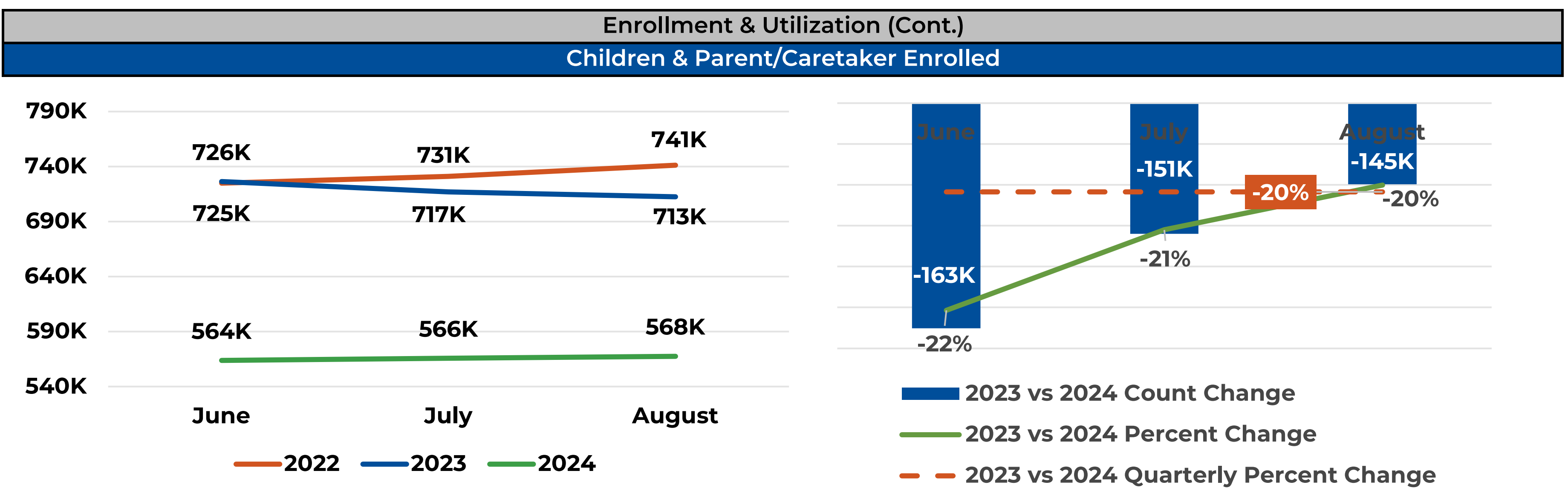


Aged/Blind/Disabled Enrolled

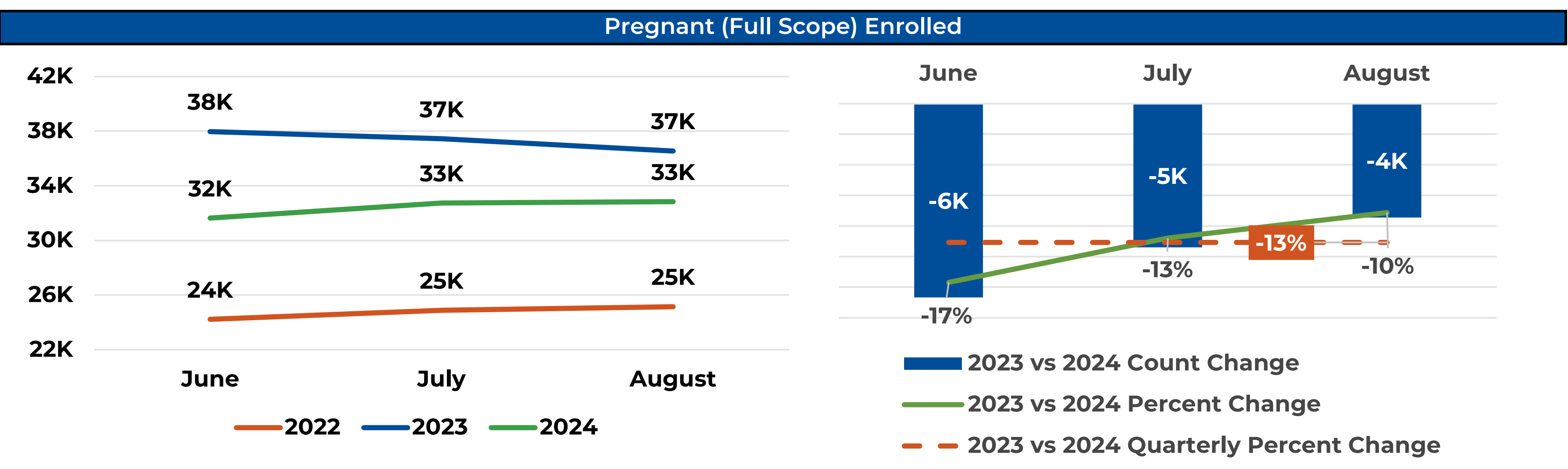


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Enrolled

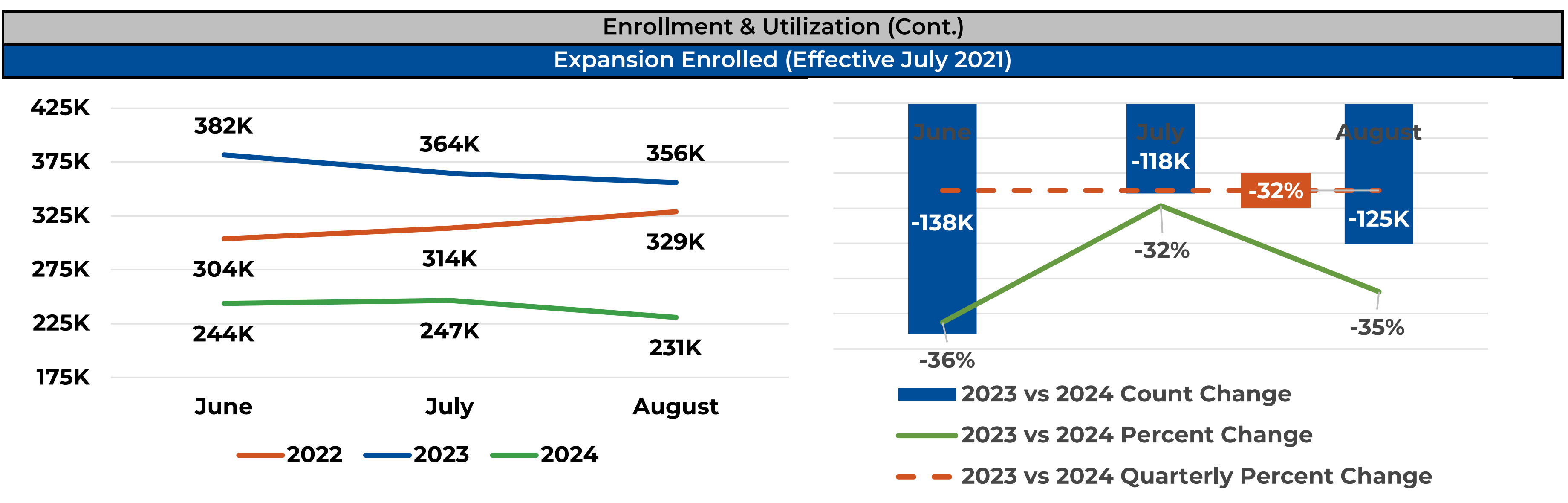


Pregnant (Full Scope) Enrolled

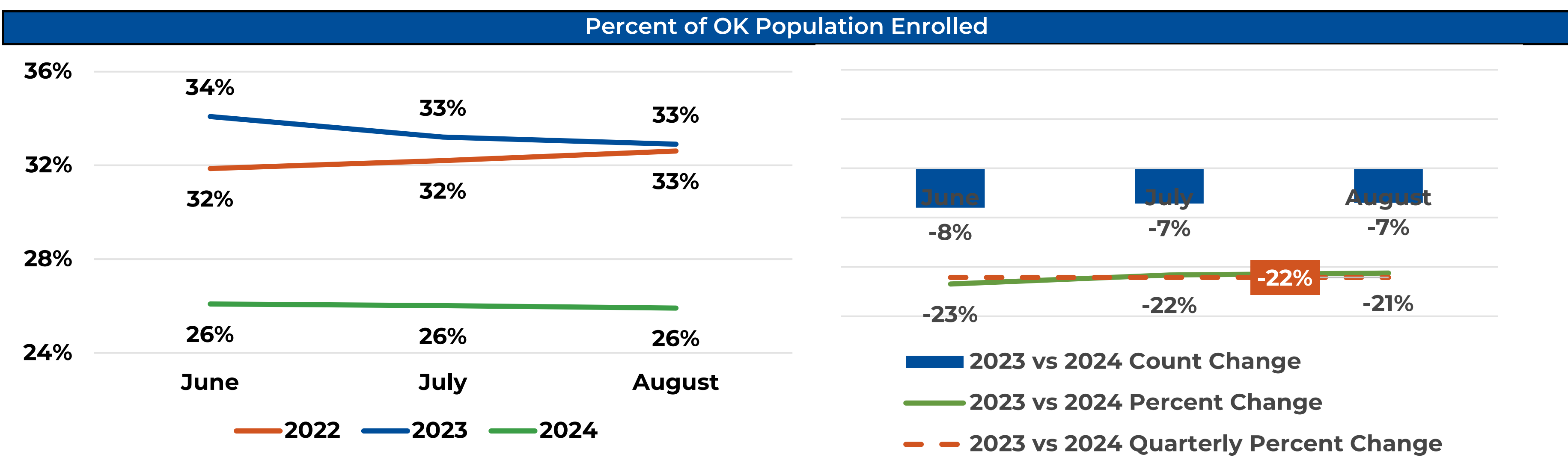


Enrollment & Utilization (Cont.)

Expansion Enrolled (Effective July 2021)

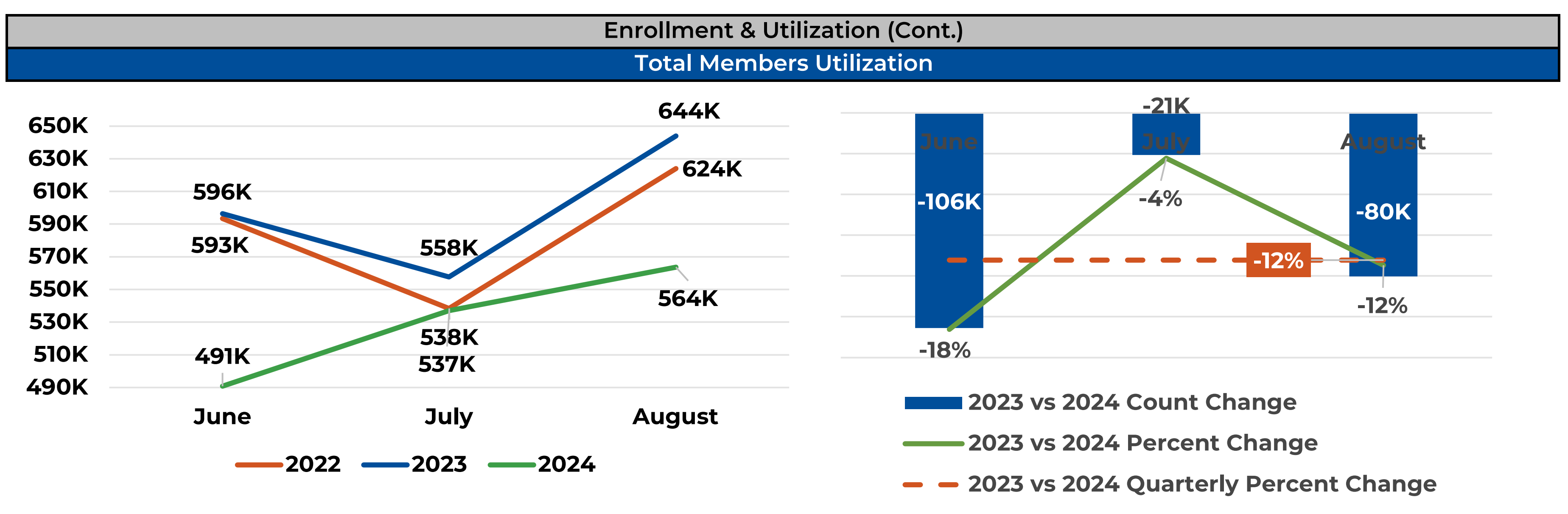


Percent of OK Population Enrolled

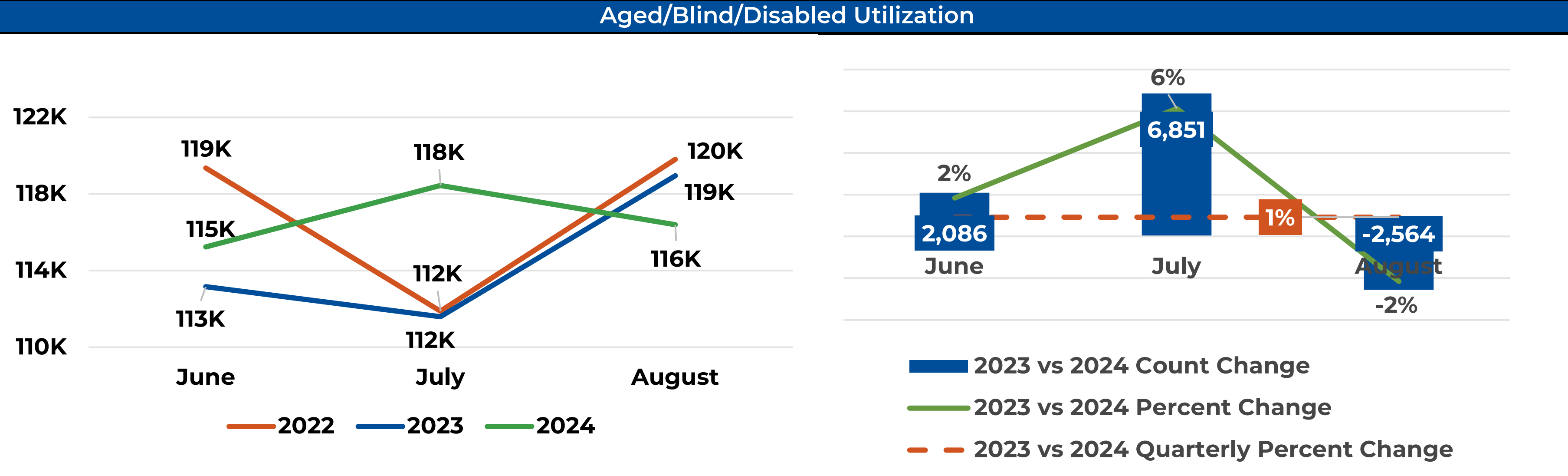


Enrollment & Utilization (Cont.)

Total Members Utilization

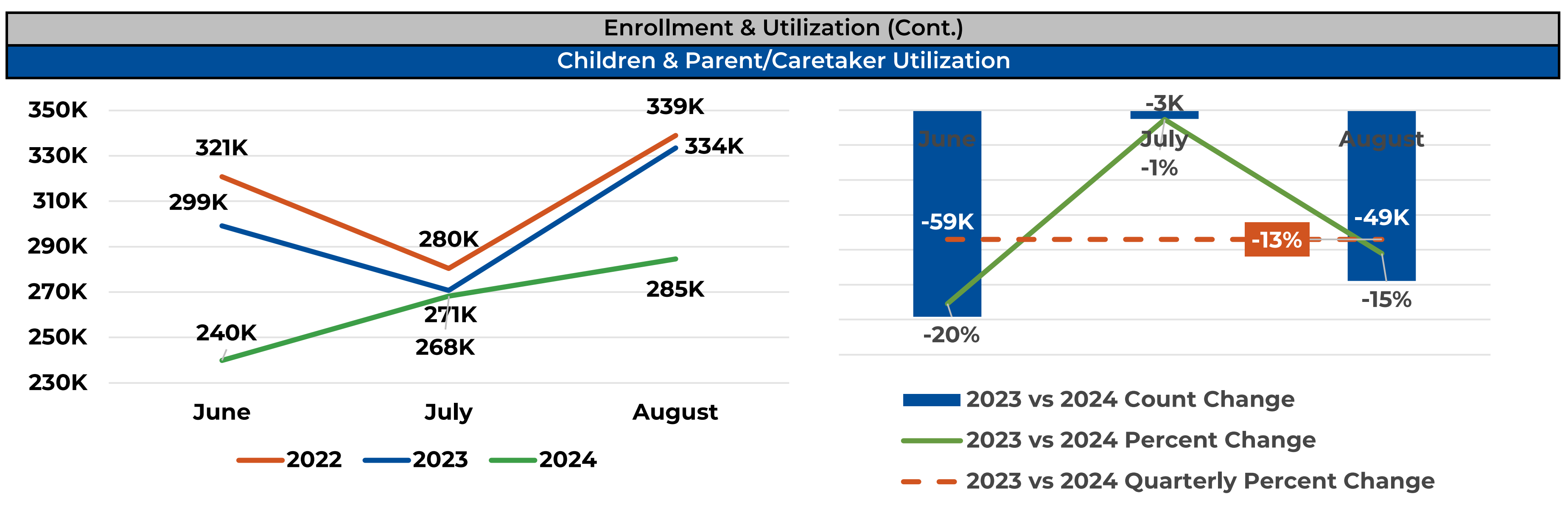


Aged/Blind/Disabled Utilization

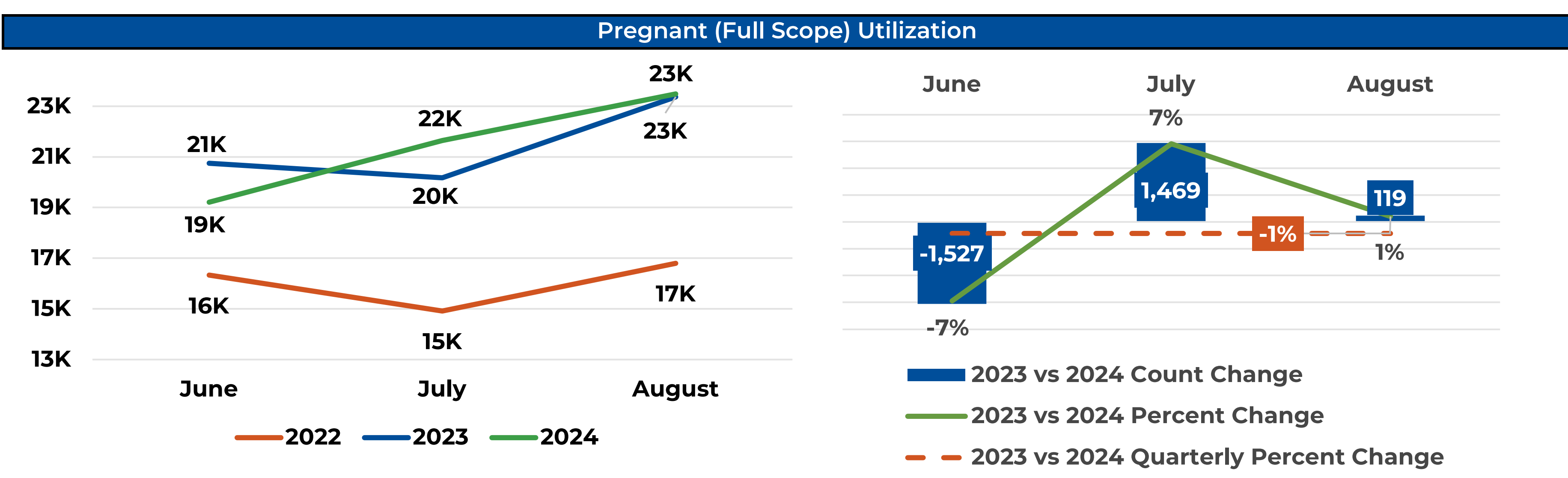


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Utilization

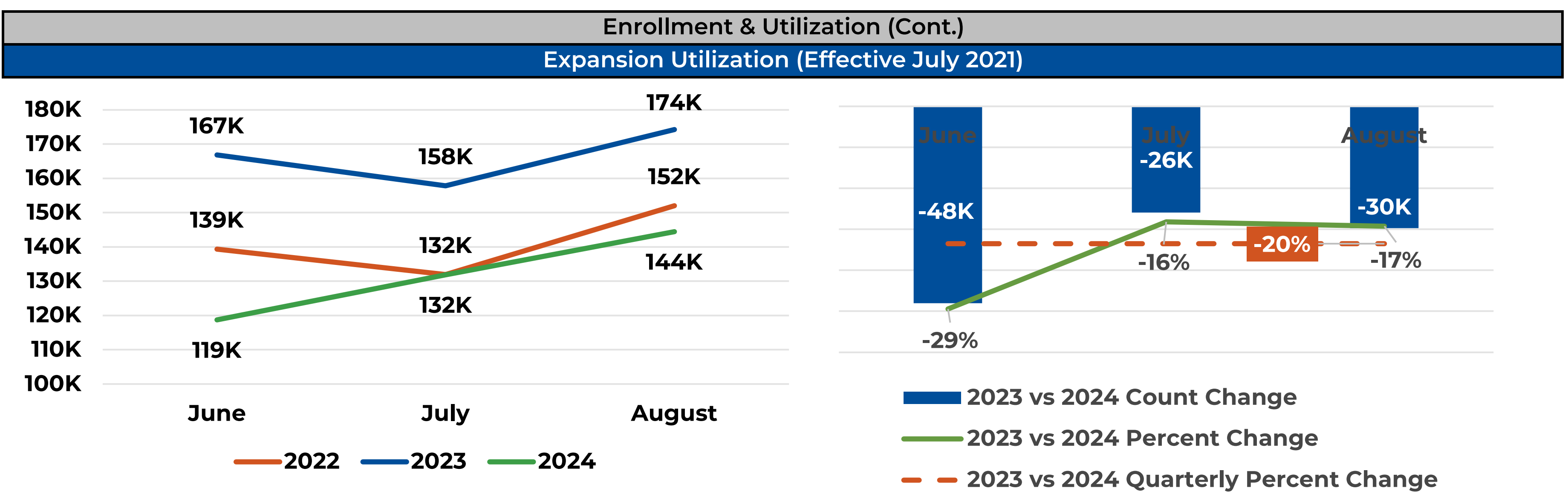


Pregnant (Full Scope) Utilization

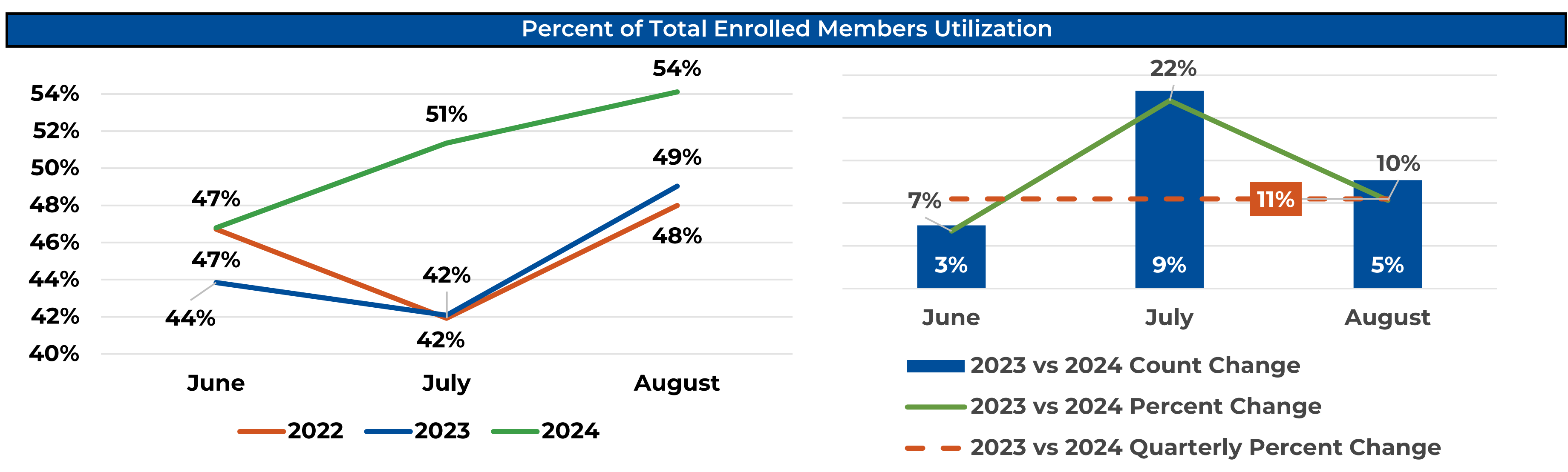


Enrollment & Utilization (Cont.)

Expansion Utilization (Effective July 2021)

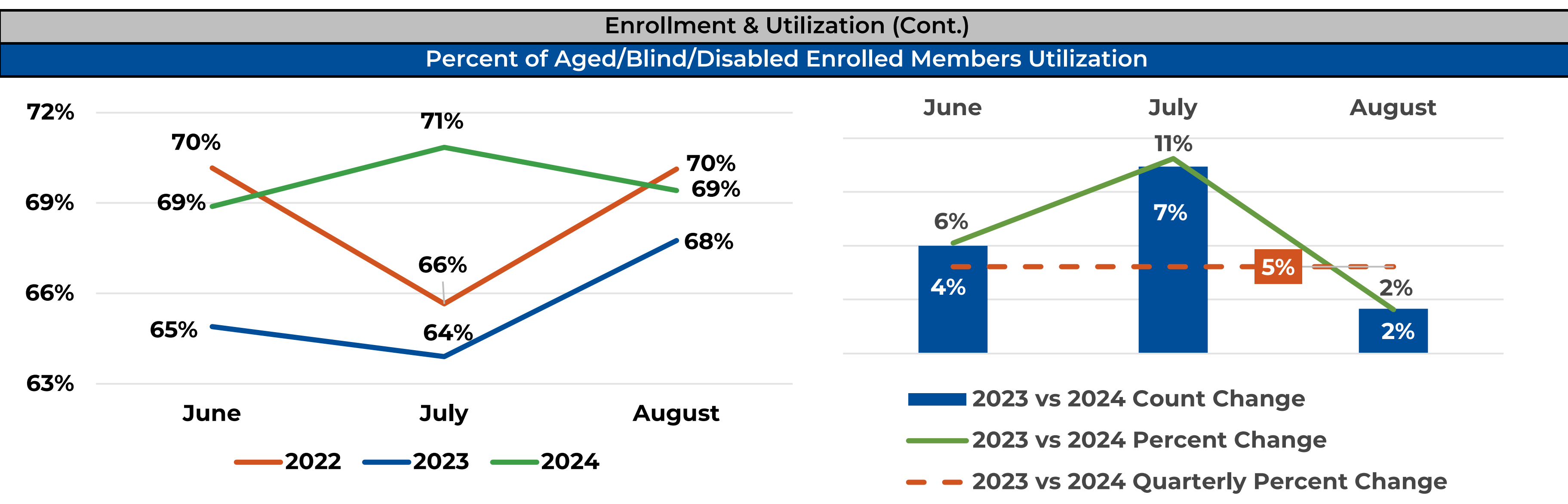


Percent of Total Enrolled Members Utilization

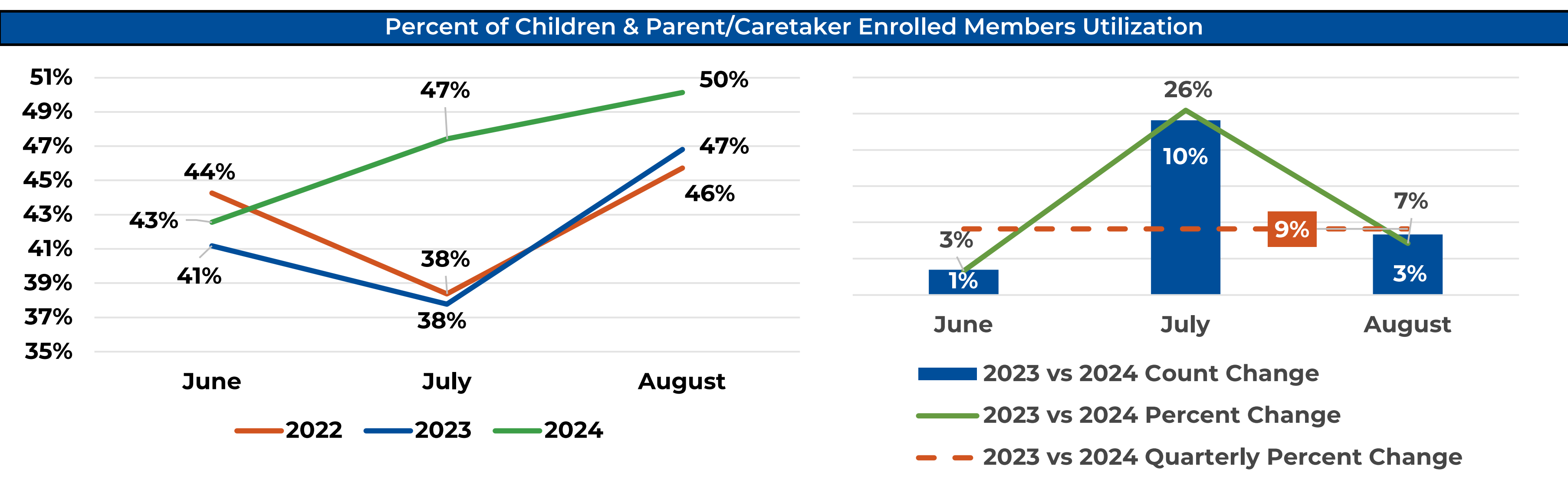


Enrollment & Utilization (Cont.)

Percent of Aged/Blind/Disabled Enrolled Members Utilization

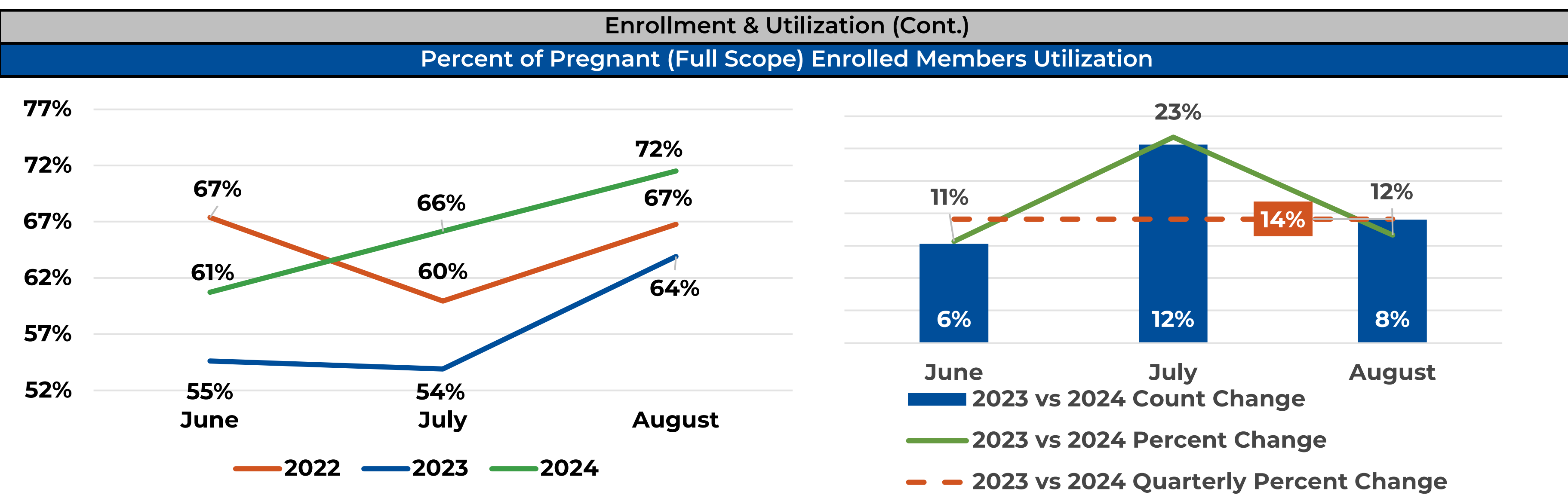


Percent of Children & Parent/Caretaker Enrolled Members Utilization

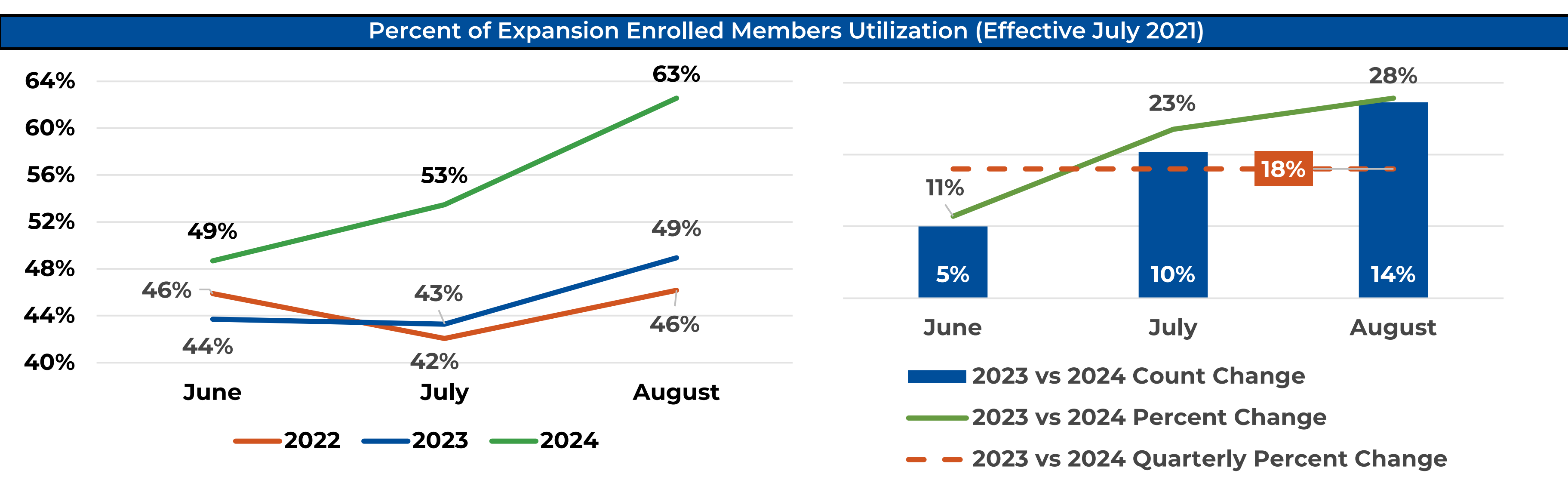


Enrollment & Utilization (Cont.)

Percent of Pregnant (Full Scope) Enrolled Members Utilization

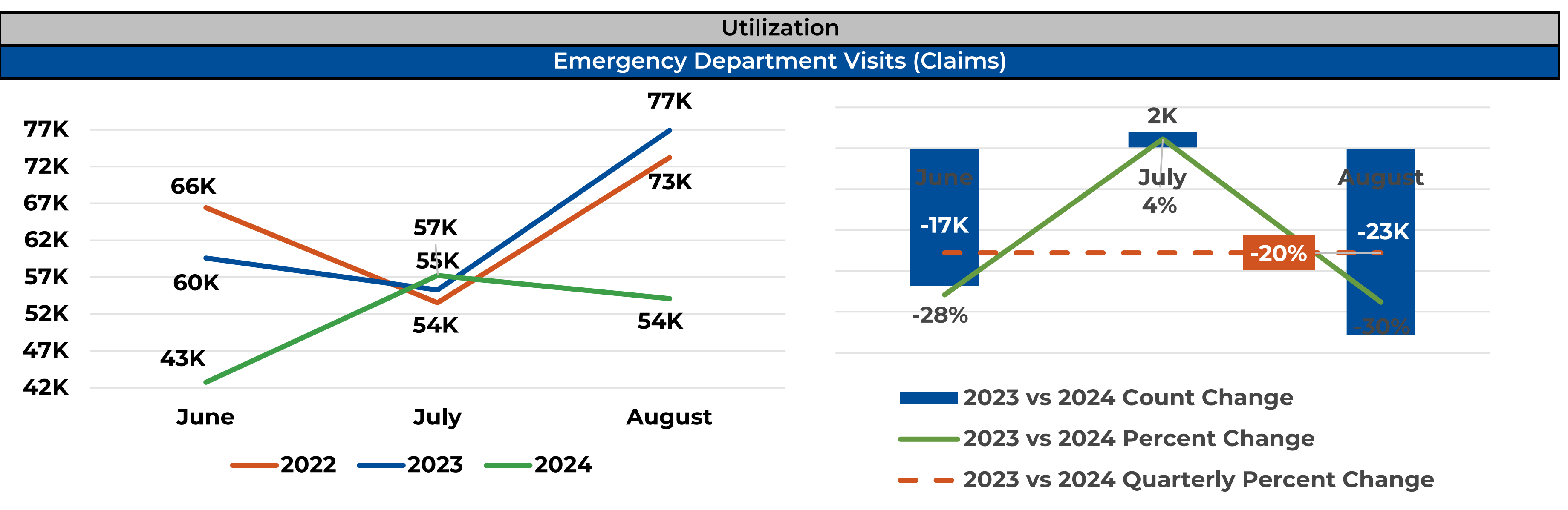


Percent of Expansion Enrolled Members Utilization (Effective July 2021)

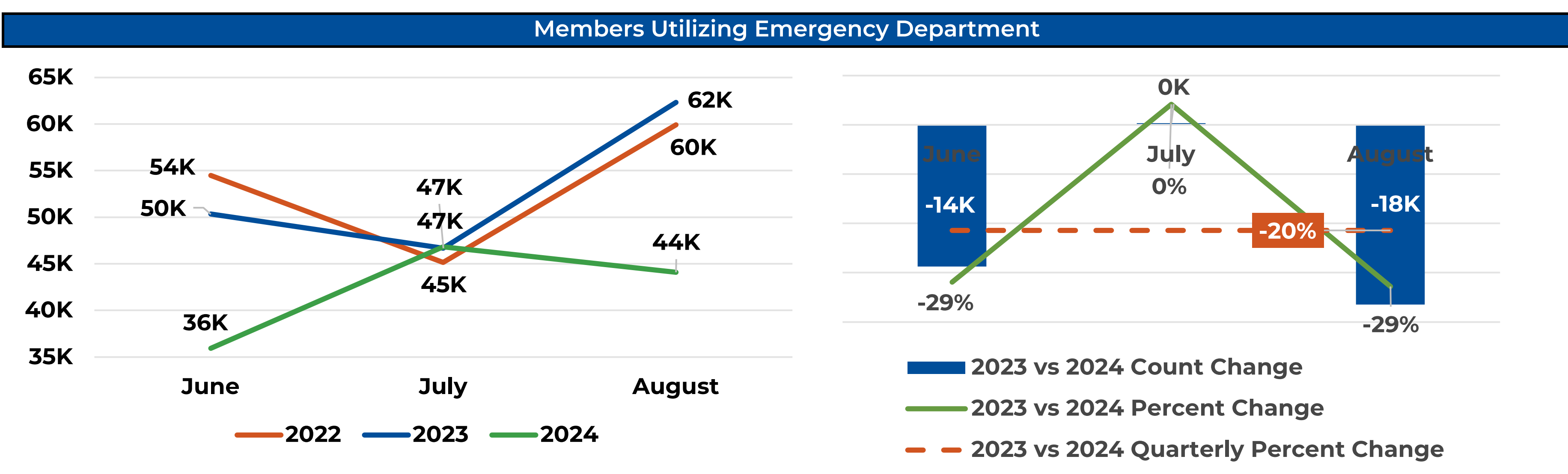


Utilization

Emergency Department Visits (Claims)

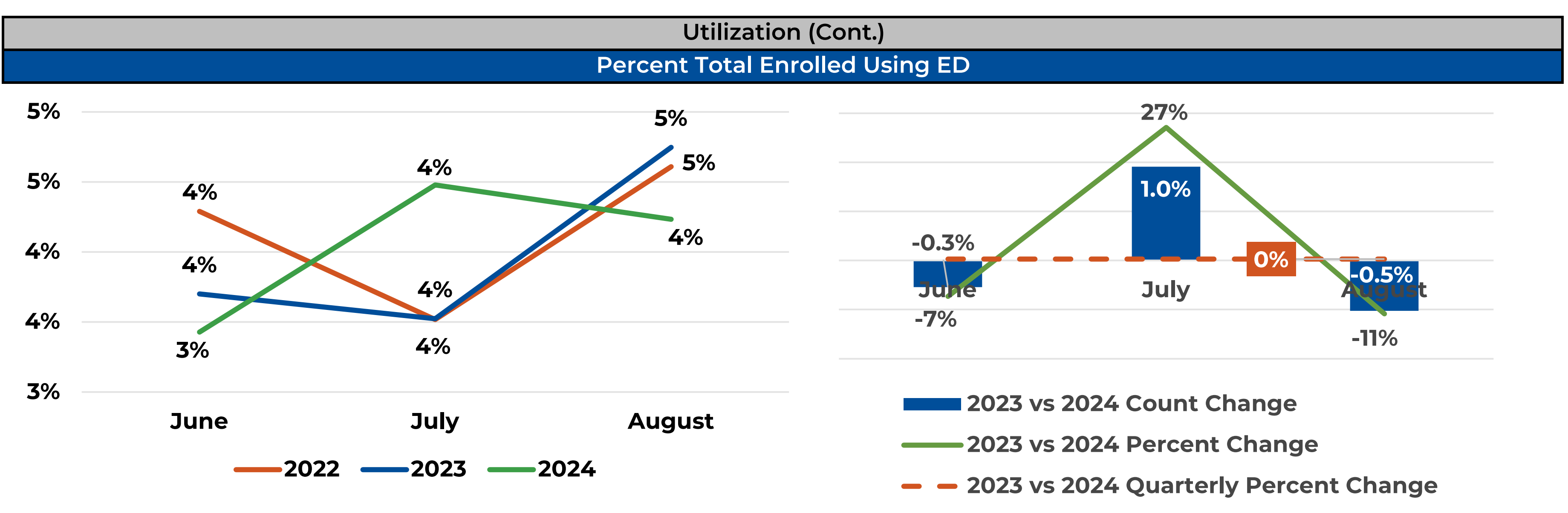


Members Utilizing Emergency Department

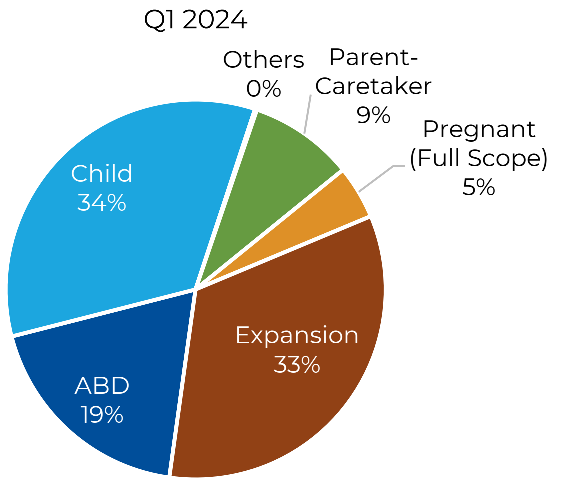


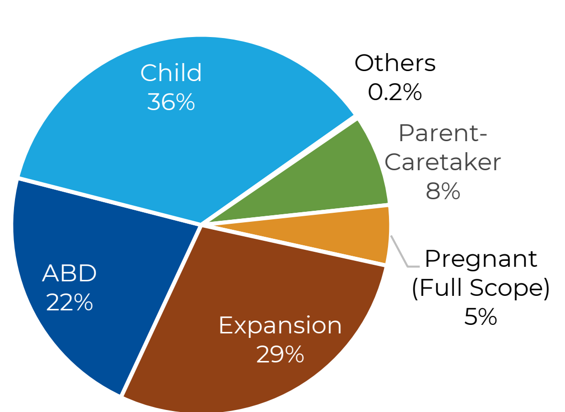
Utilization (Cont.)

Percent Total Enrolled Using ED



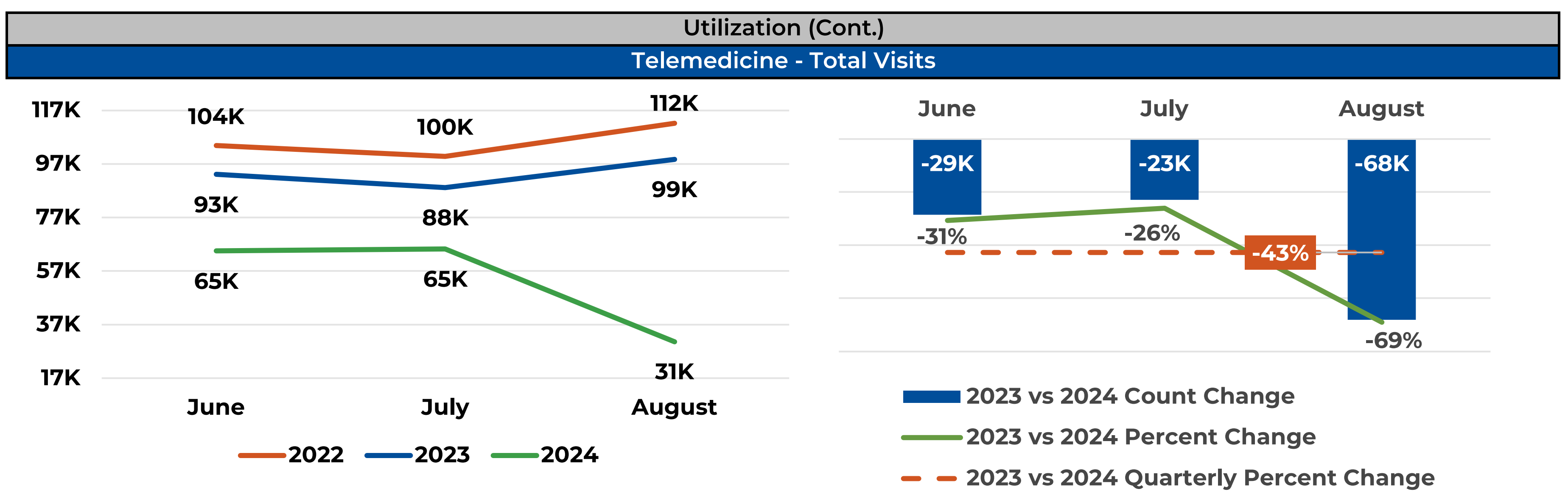
Members Utilizing Emergency Department By Qualifying Group



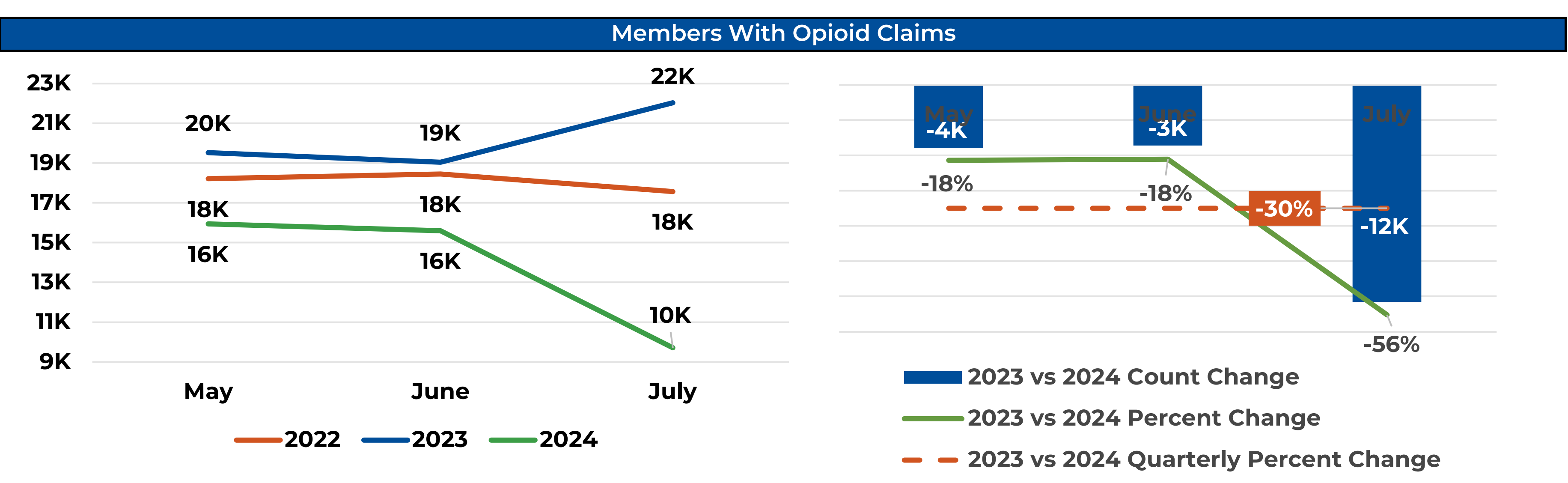


Utilization (Cont.)

Telemedicine - Total Visits

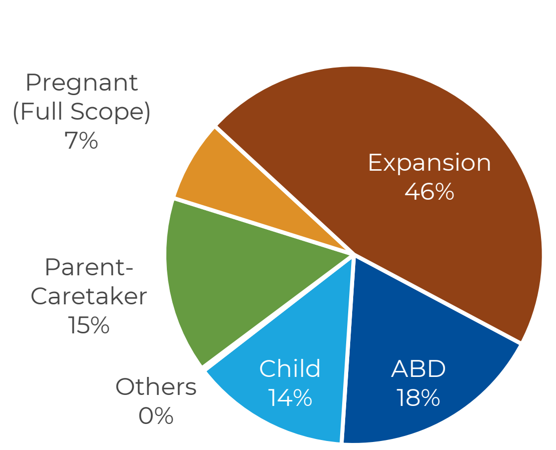


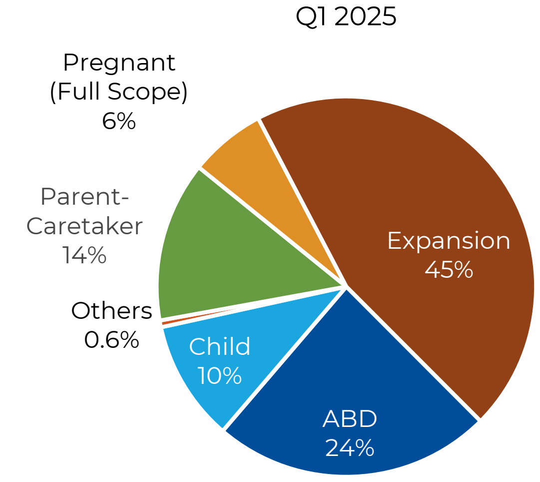
Members With Opioid Claims



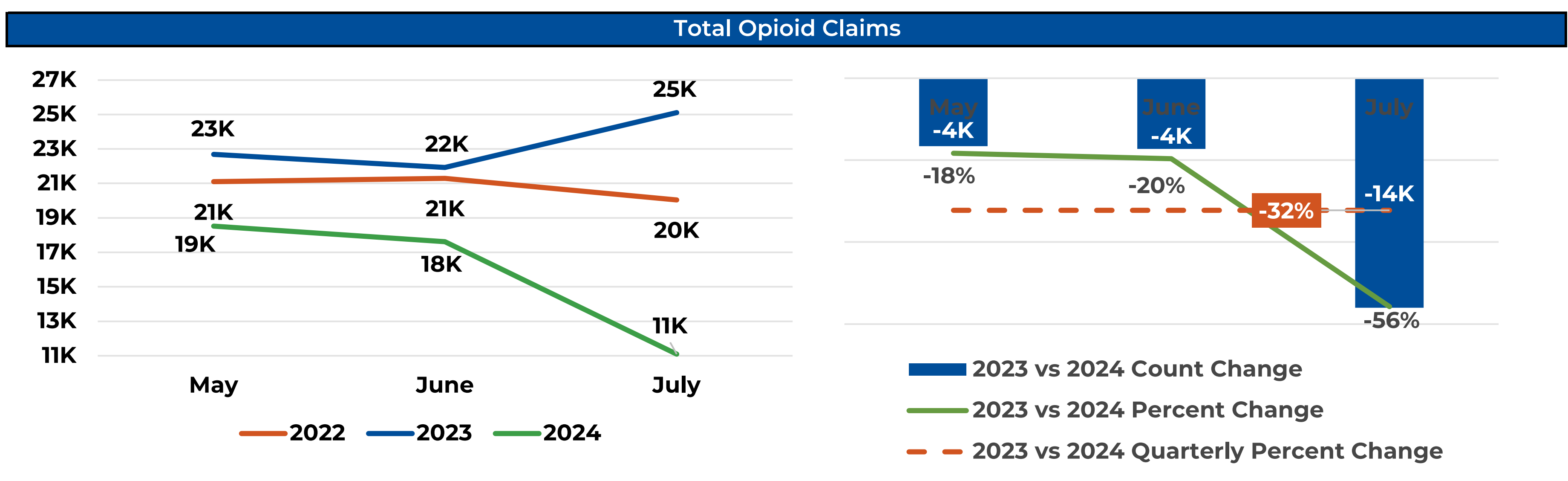
Utilization (Cont.)

Members With Opioid Claims By Qualifying Group



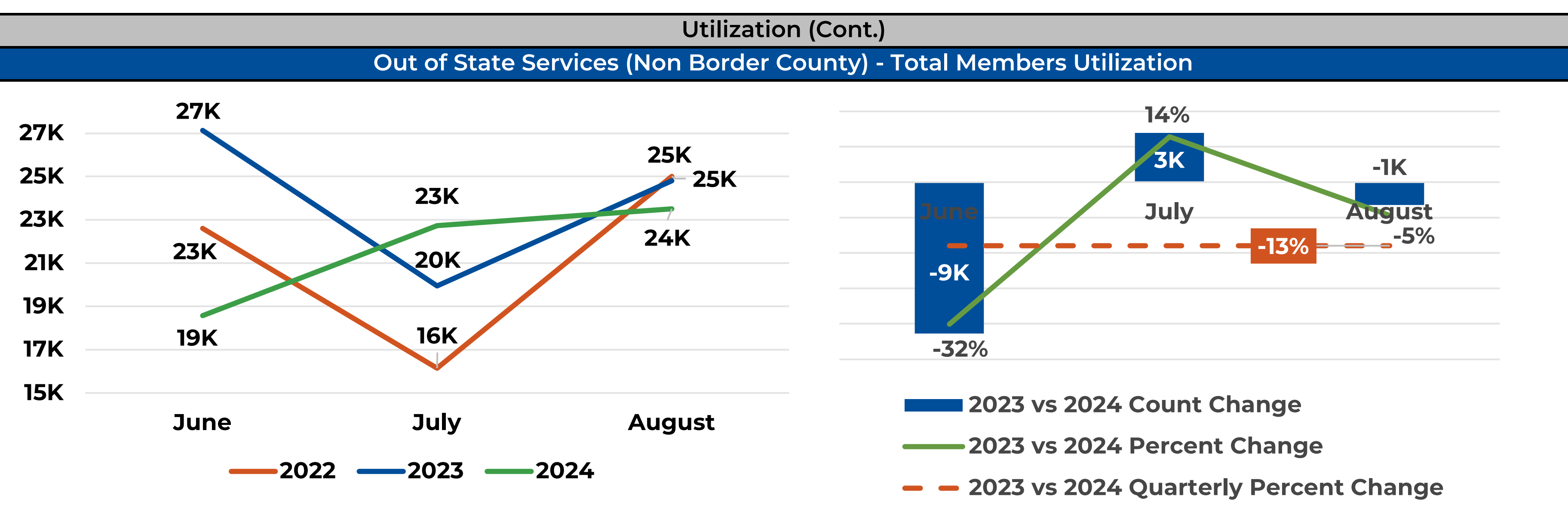


Total Opioid Claims

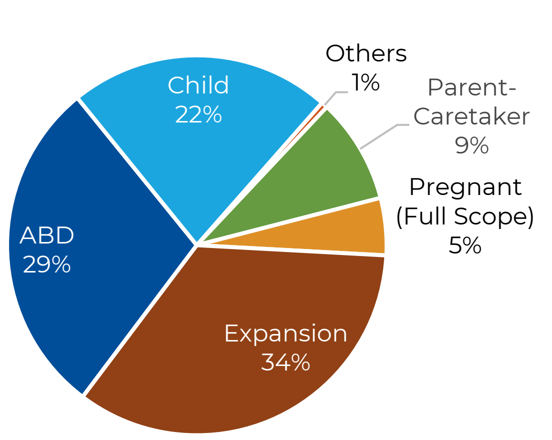


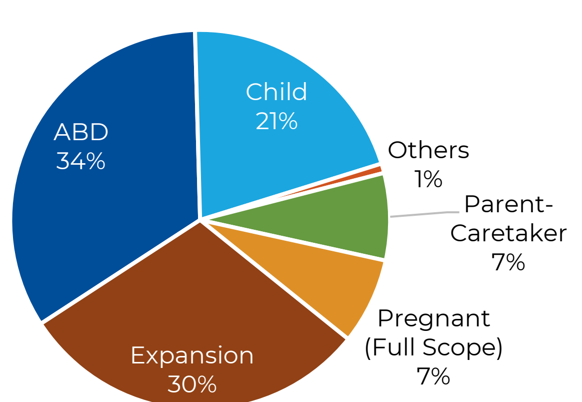
Utilization (Cont.)

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



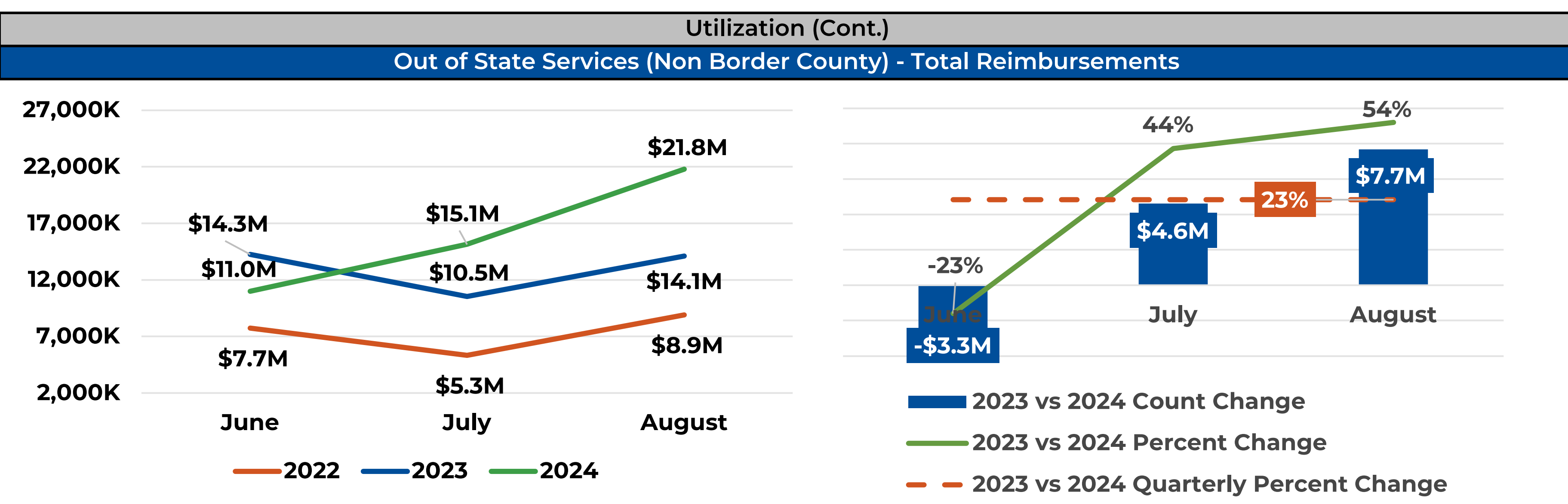
Out of State Services (Non Border County) - Total Members Utilization By Qualifying Group



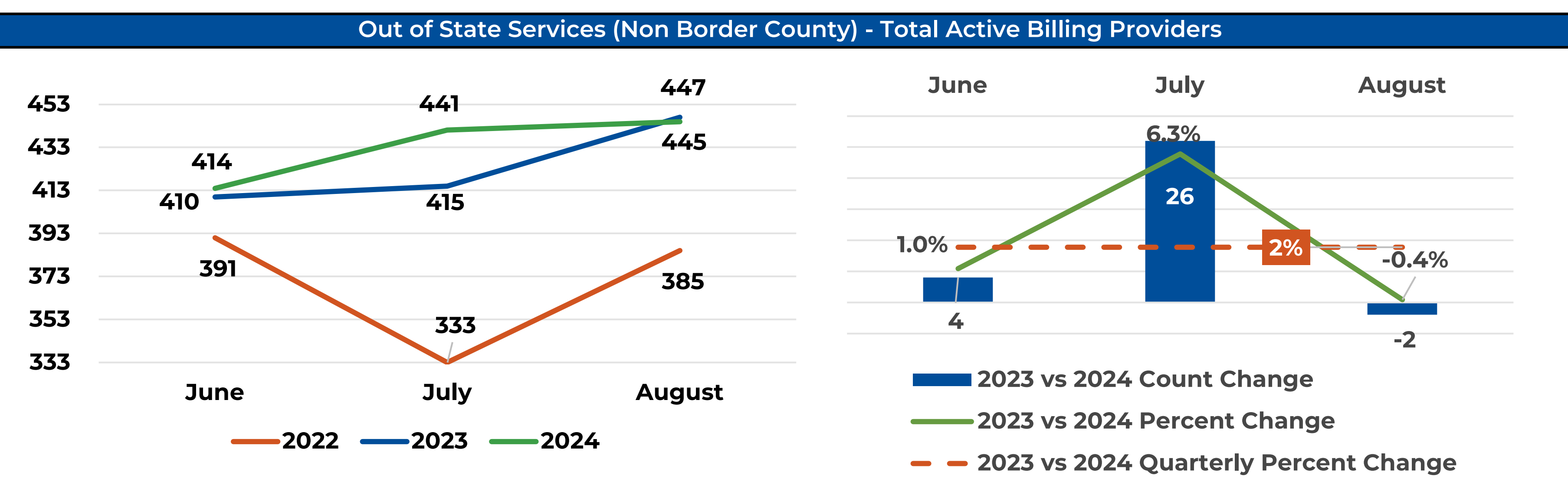


Utilization (Cont.)

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

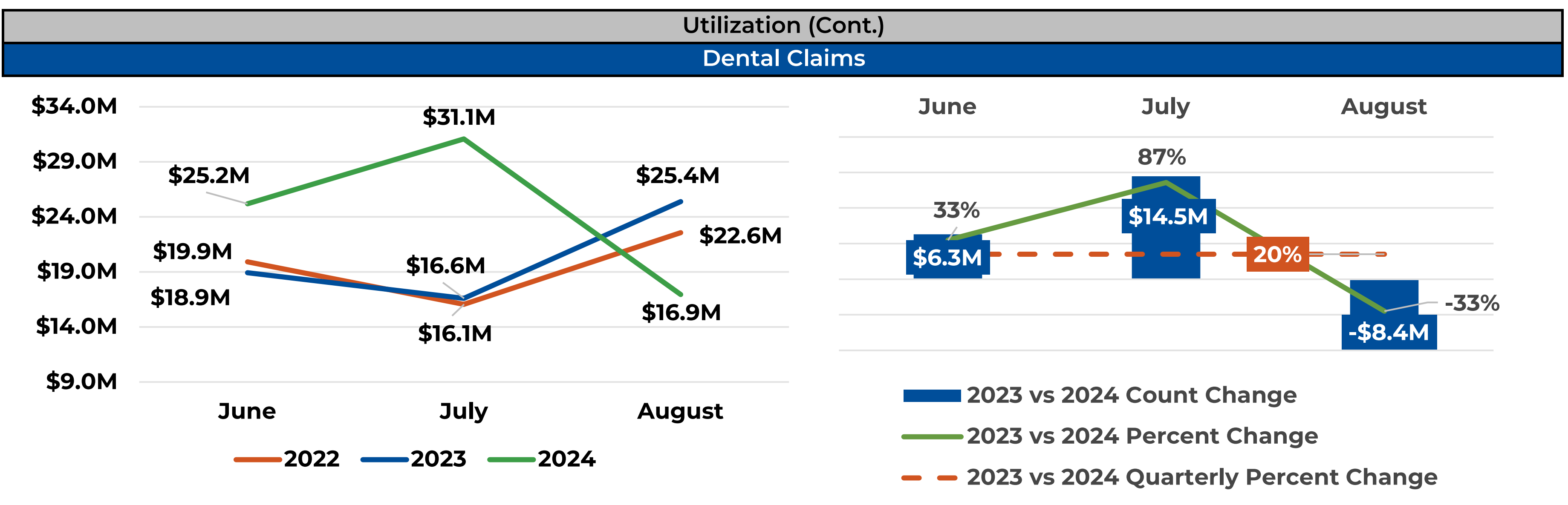


Out of State Services (Non Border County) - Total Active Billing Providers

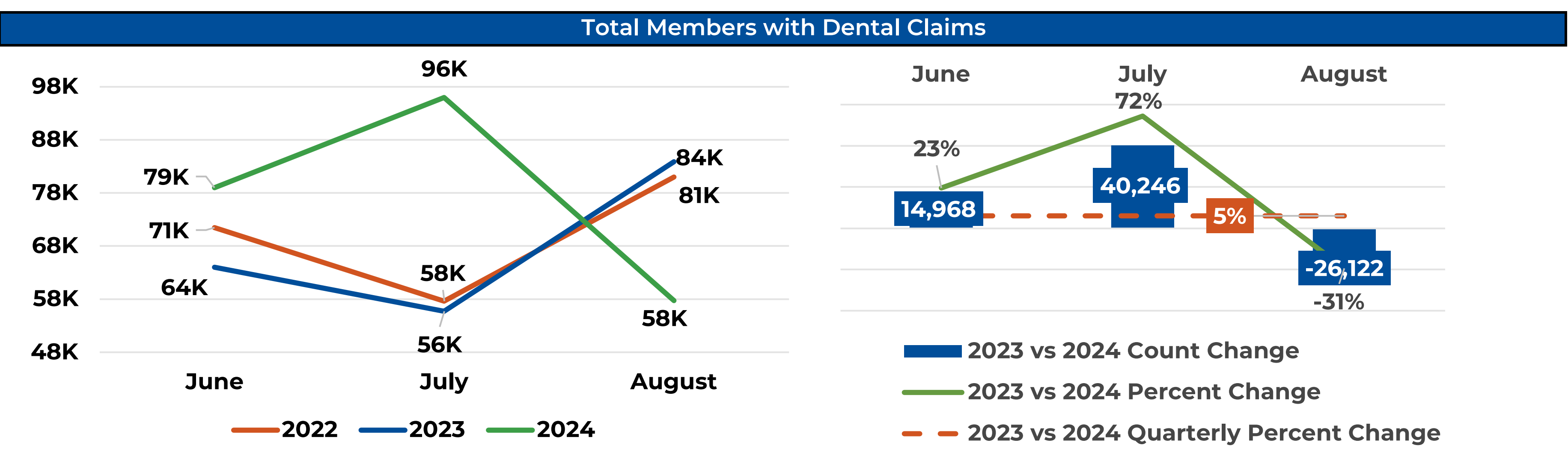


Utilization (Cont.)

Dental Claims

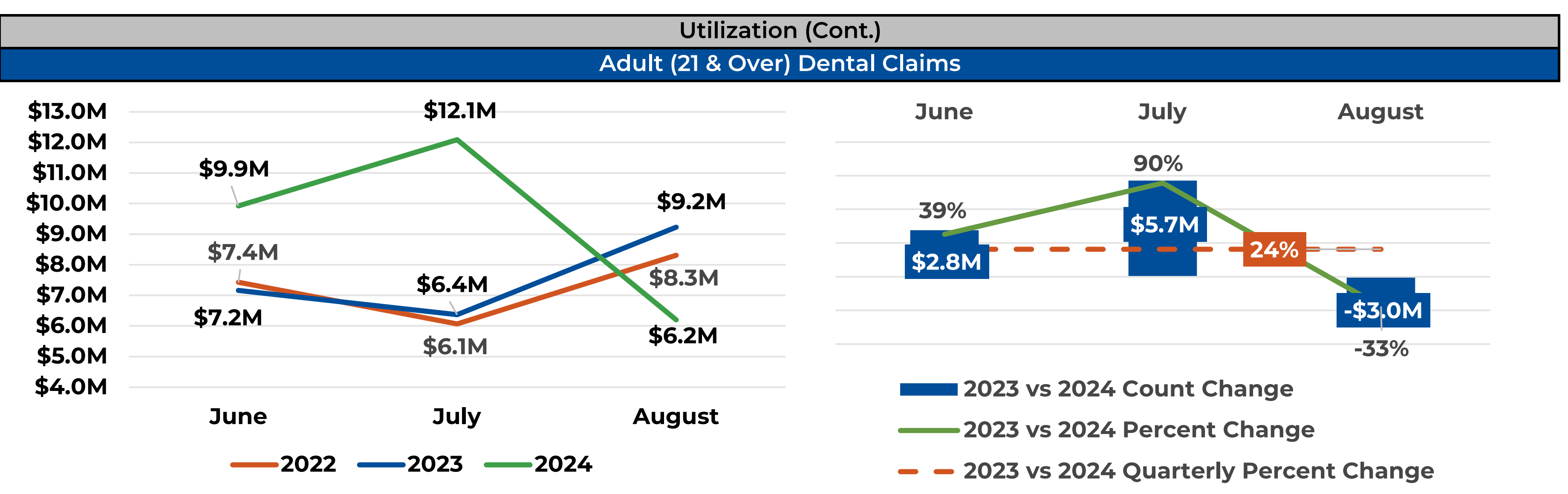


Total Members with Dental Claims

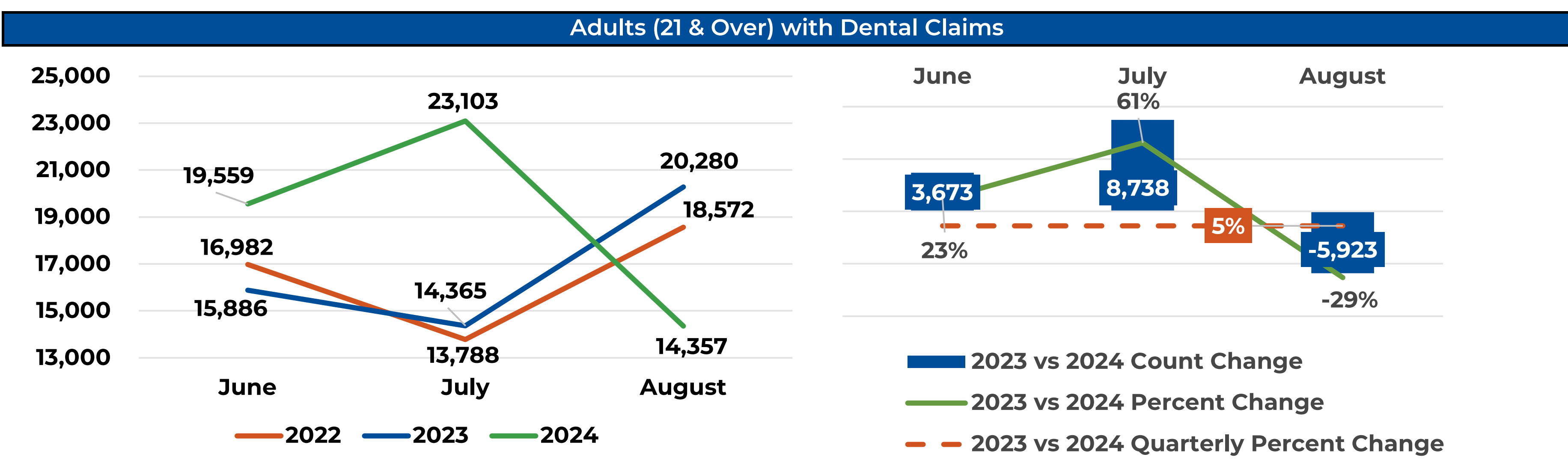


Utilization (Cont.)

Adult (21 & Over) Dental Claims

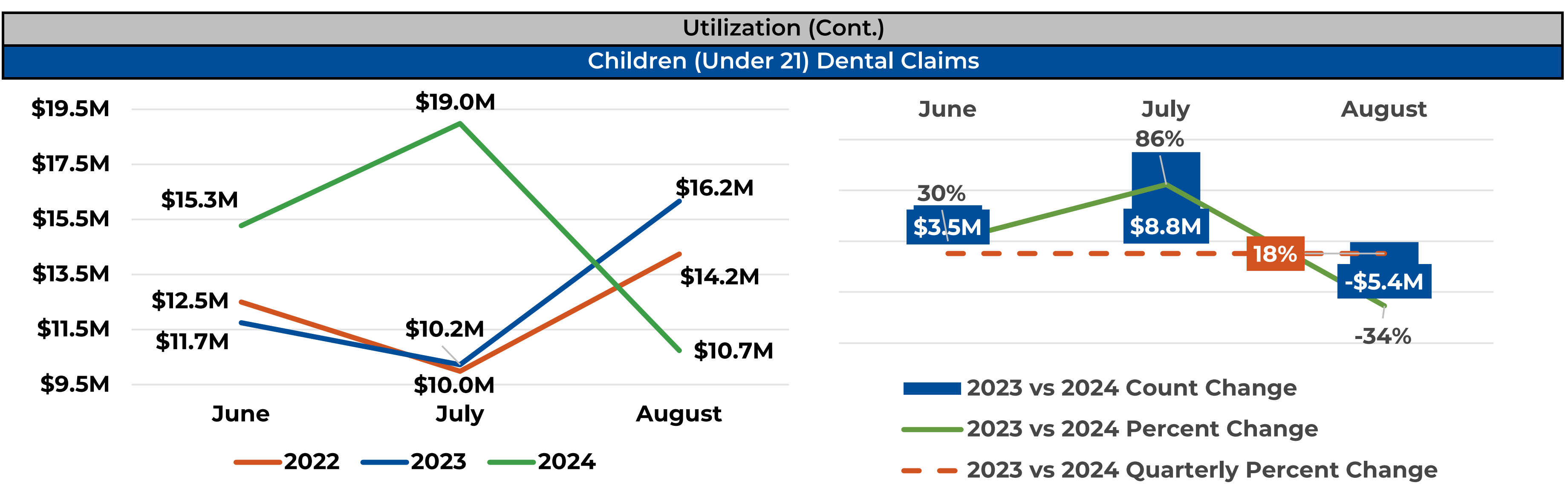


Adults (21 & Over) with Dental Claims

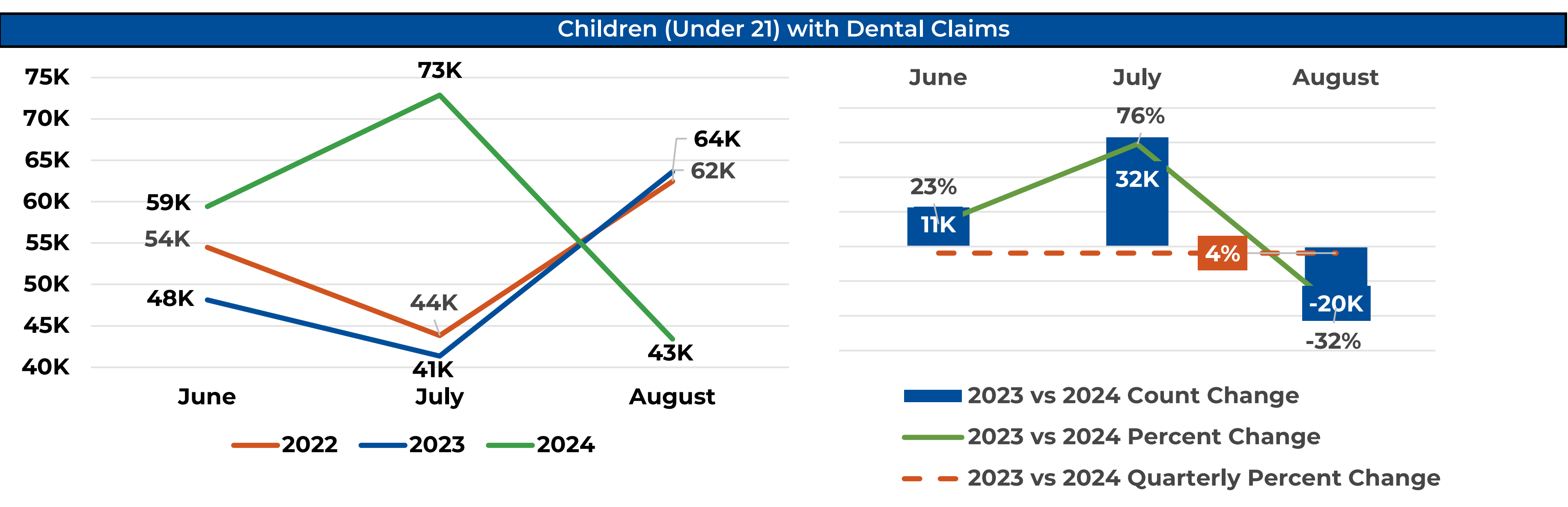


Utilization (Cont.)

Children (Under 21) Dental Claims

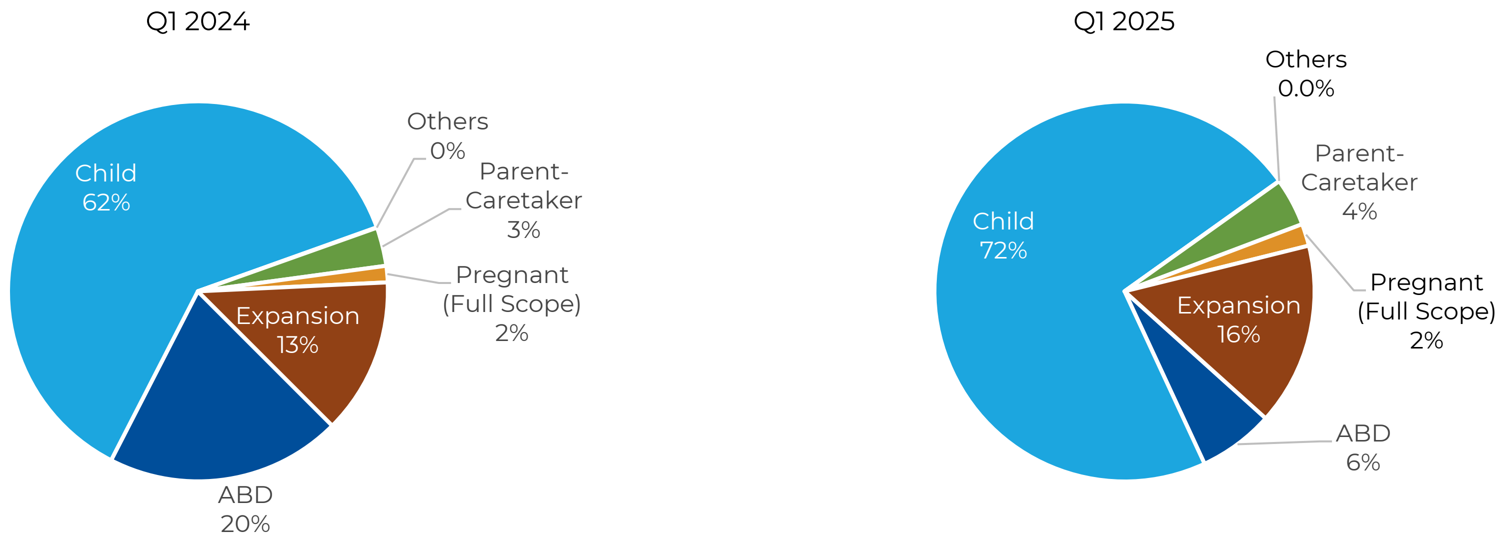


Children (Under 21) with Dental Claims



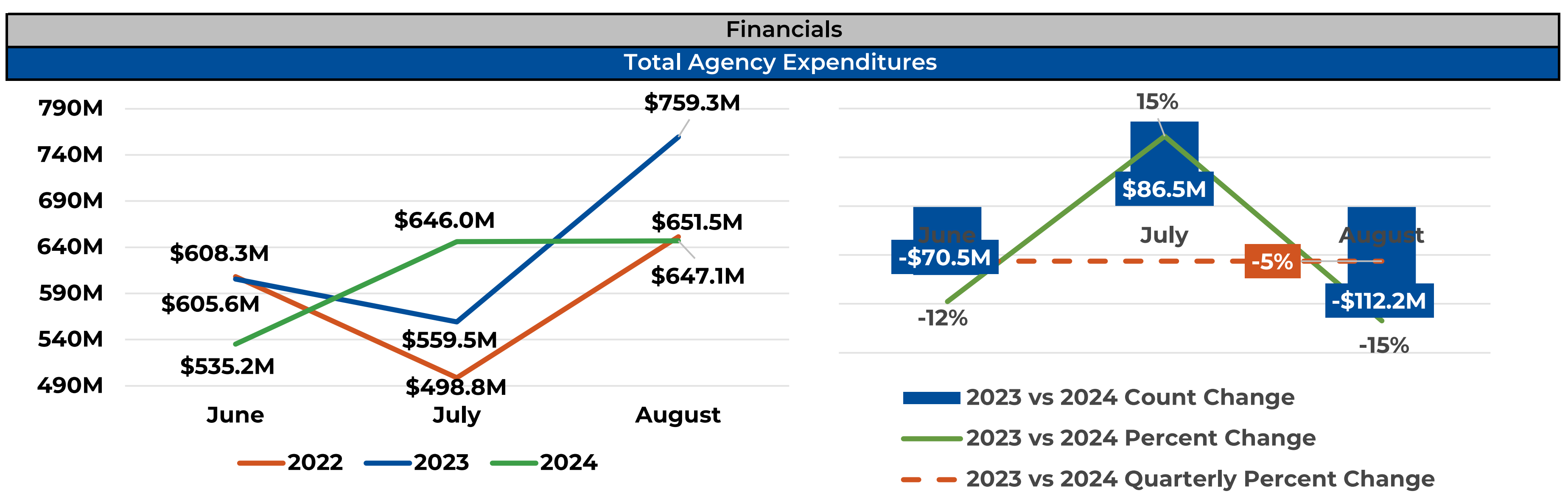
Utilization (Cont.)

Members With Dental Claims By Qualifying Group



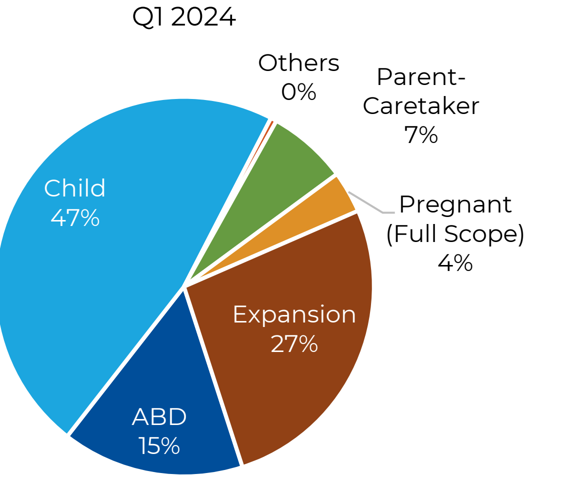
Financials

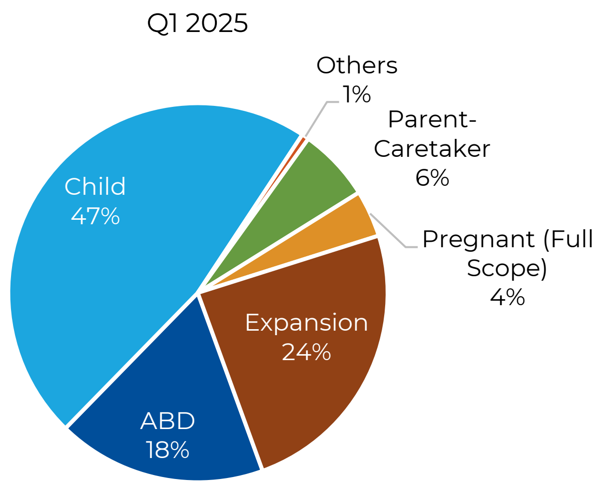
Total Agency Expenditures



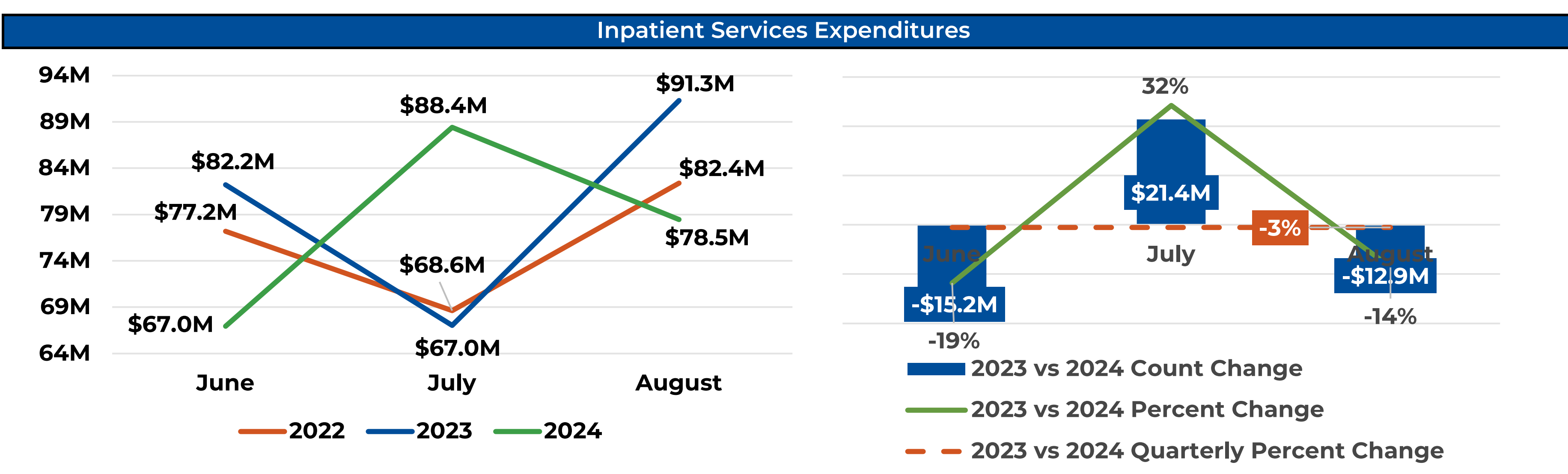
Financials (Cont.)

Total Agency Members Utilization by Qualifying Group



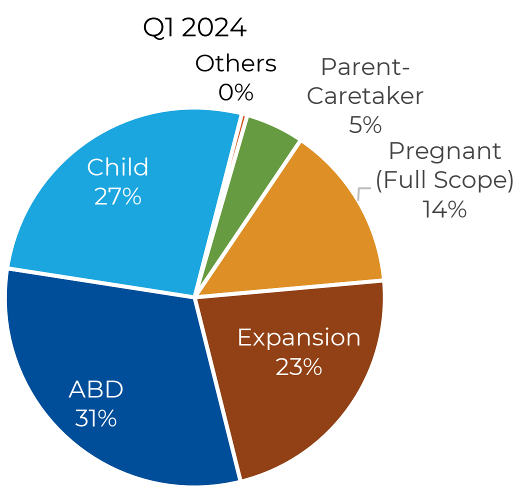


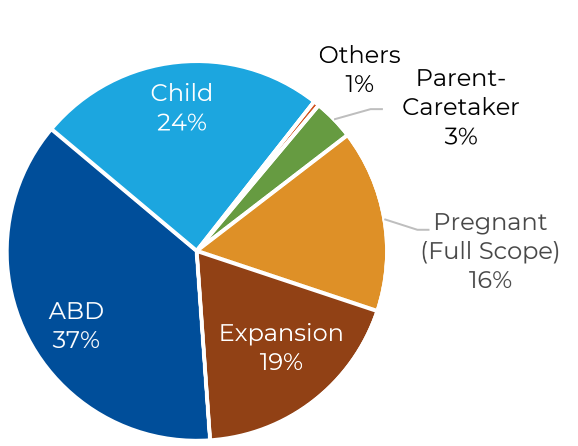
Inpatient Services Expenditures



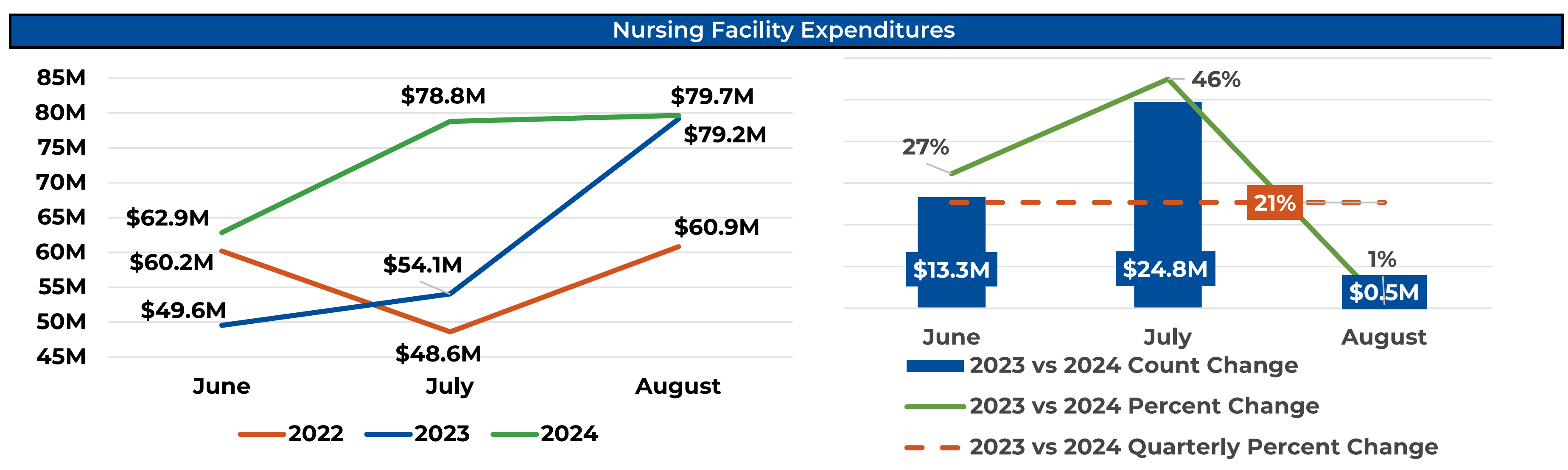
Financials (Cont.)

Inpatient Services Members Utilization by Qualifying Group



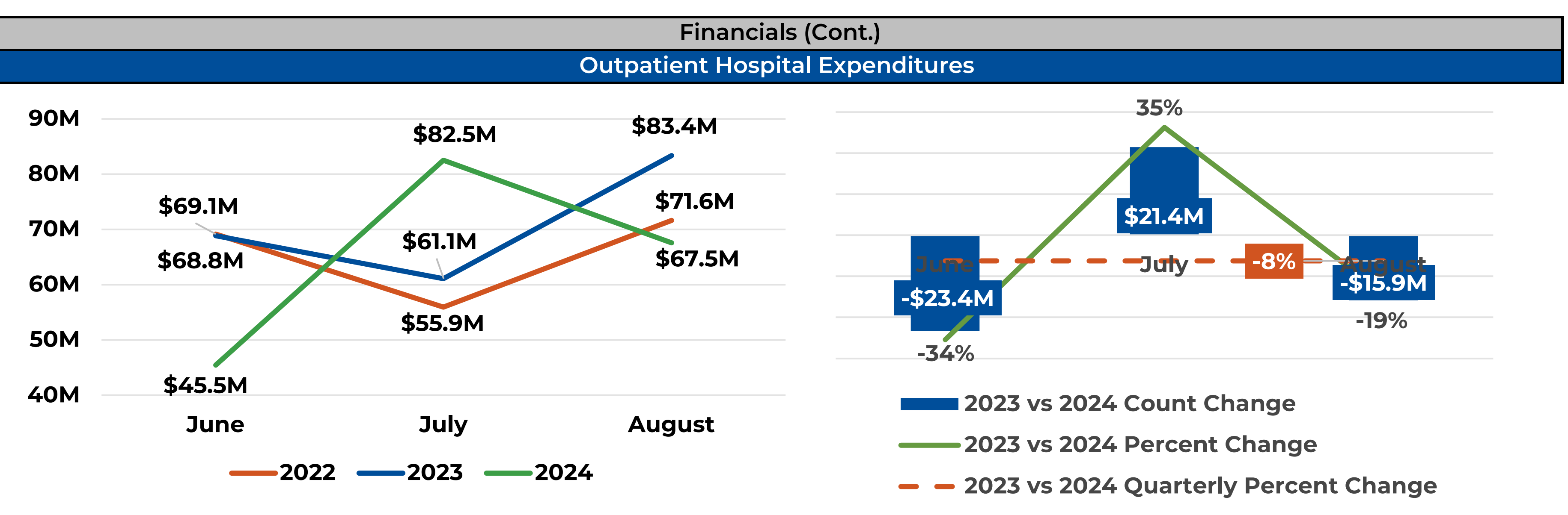


Nursing Facility Expenditures

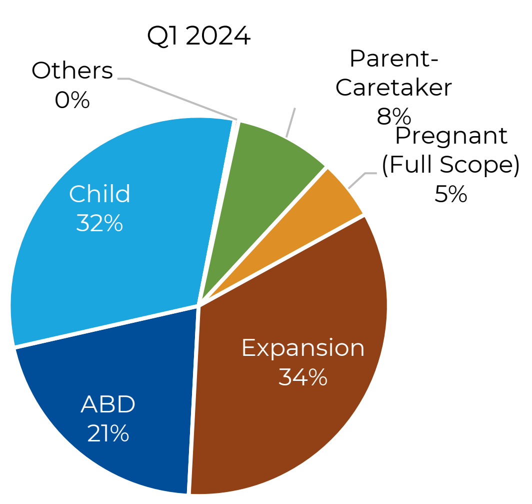


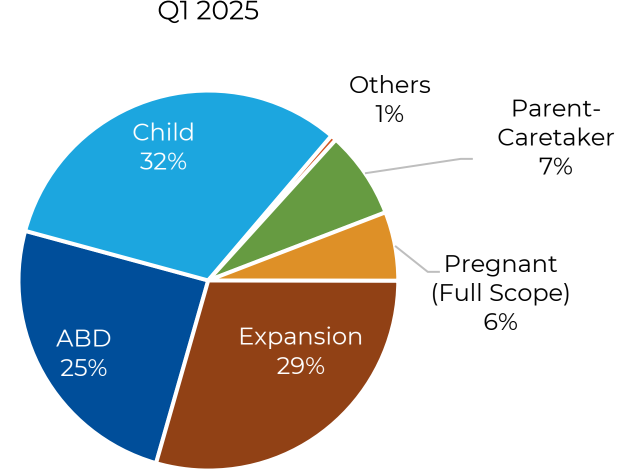
Financials (Cont.)

Outpatient Hospital Expenditures



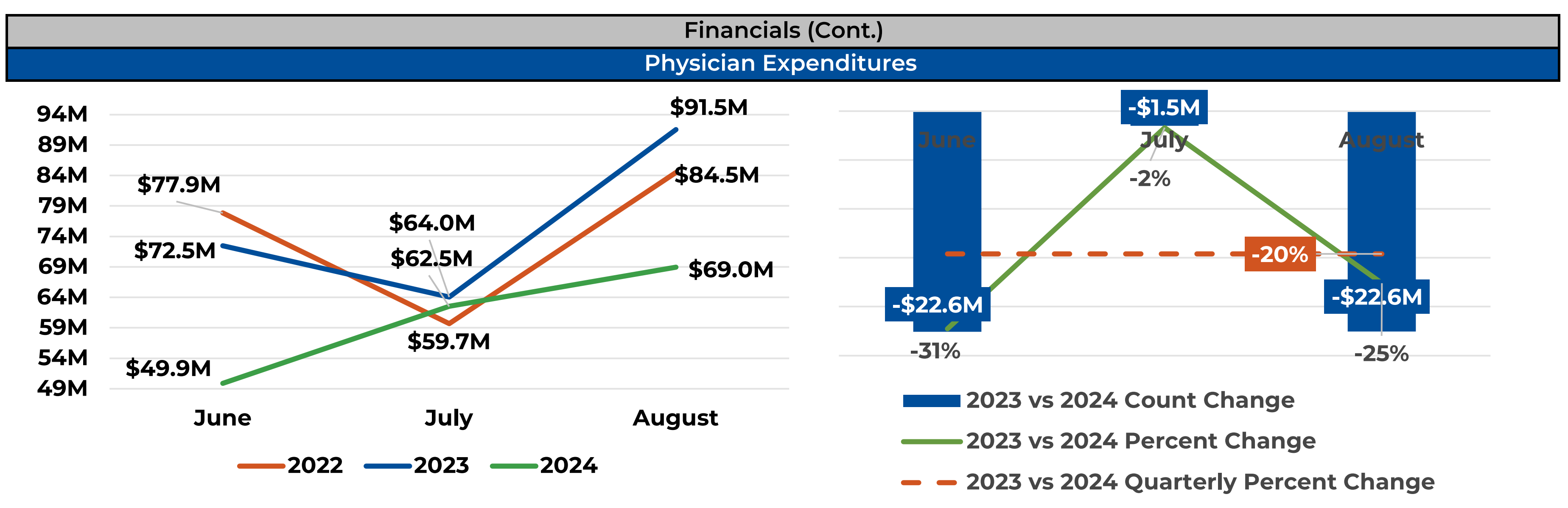
Outpatient Hospital Members Utilization by Qualifying Group



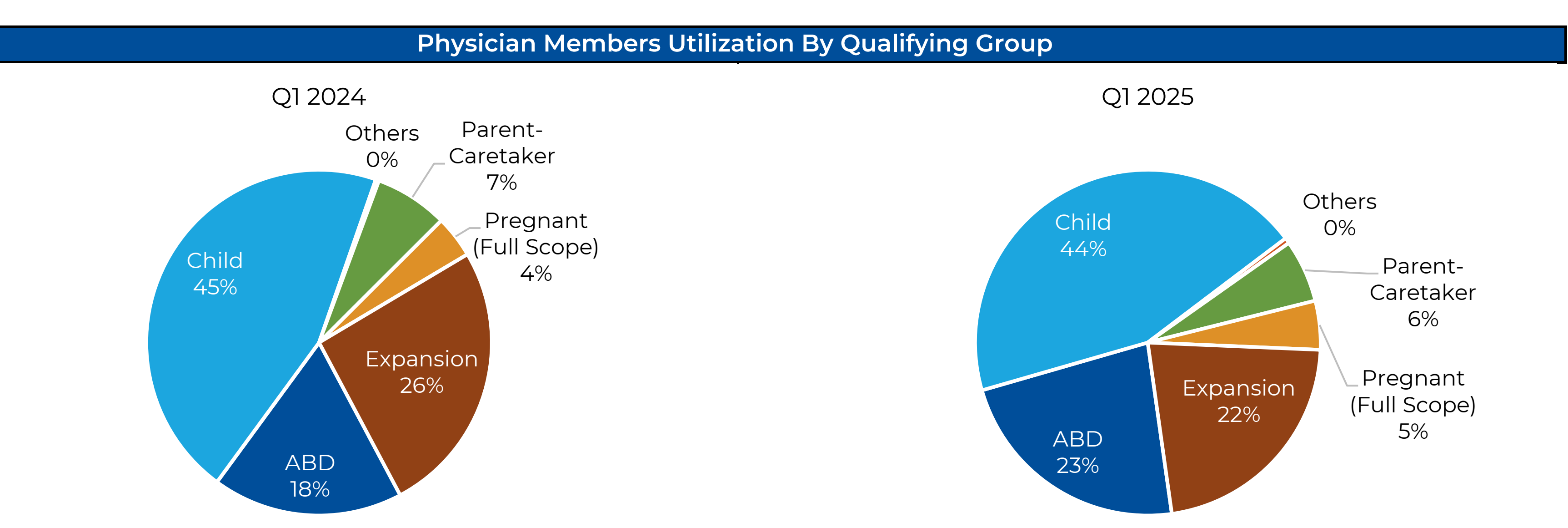


Financials (Cont.)

Physician Expenditures

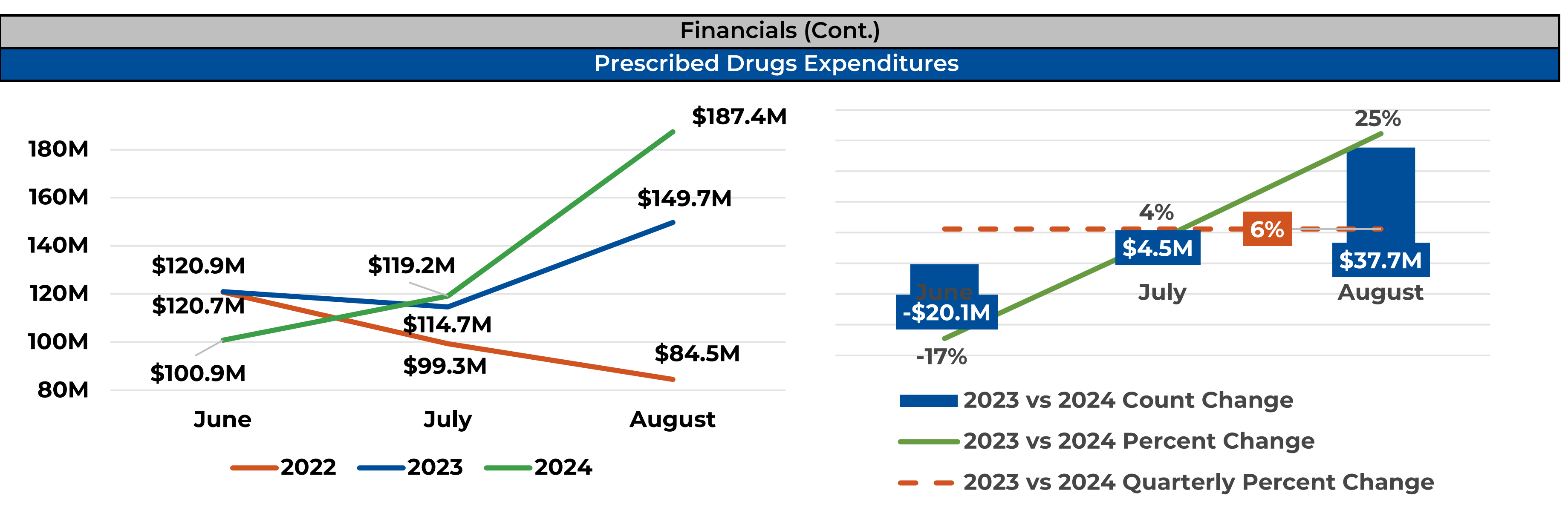


Physician Members Utilization By Qualifying Group

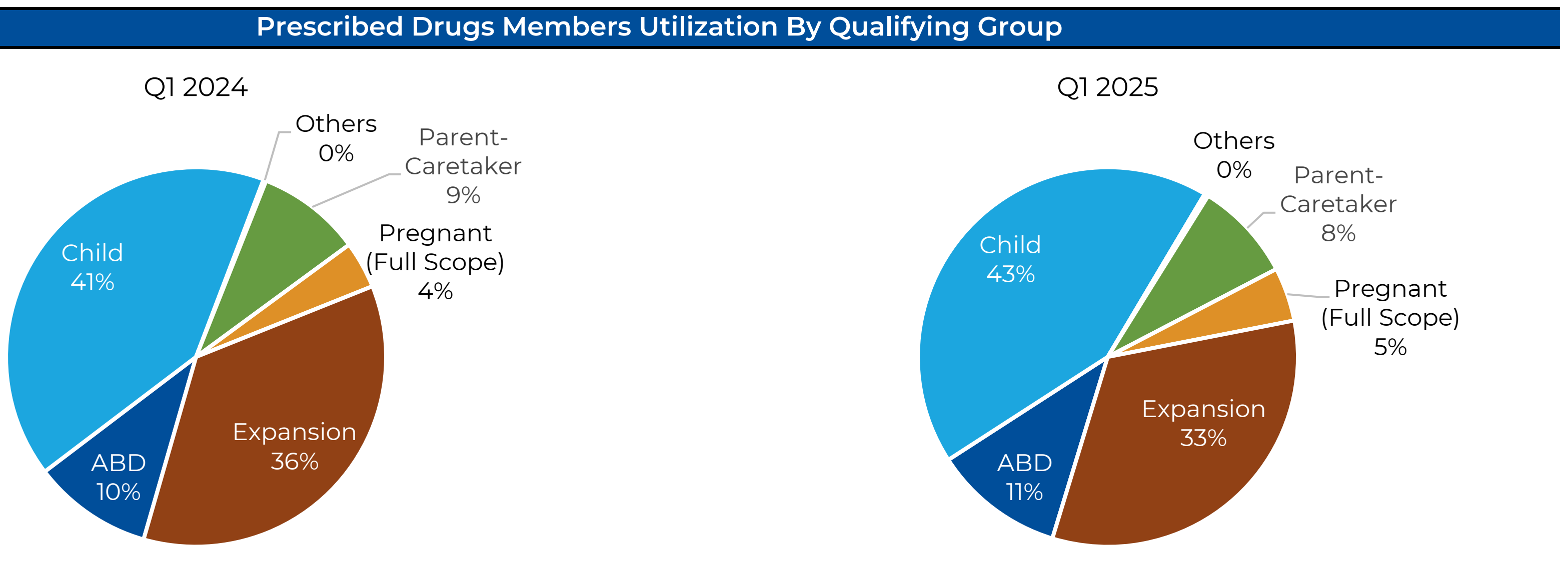


Financials (Cont.)

Prescribed Drugs Expenditures

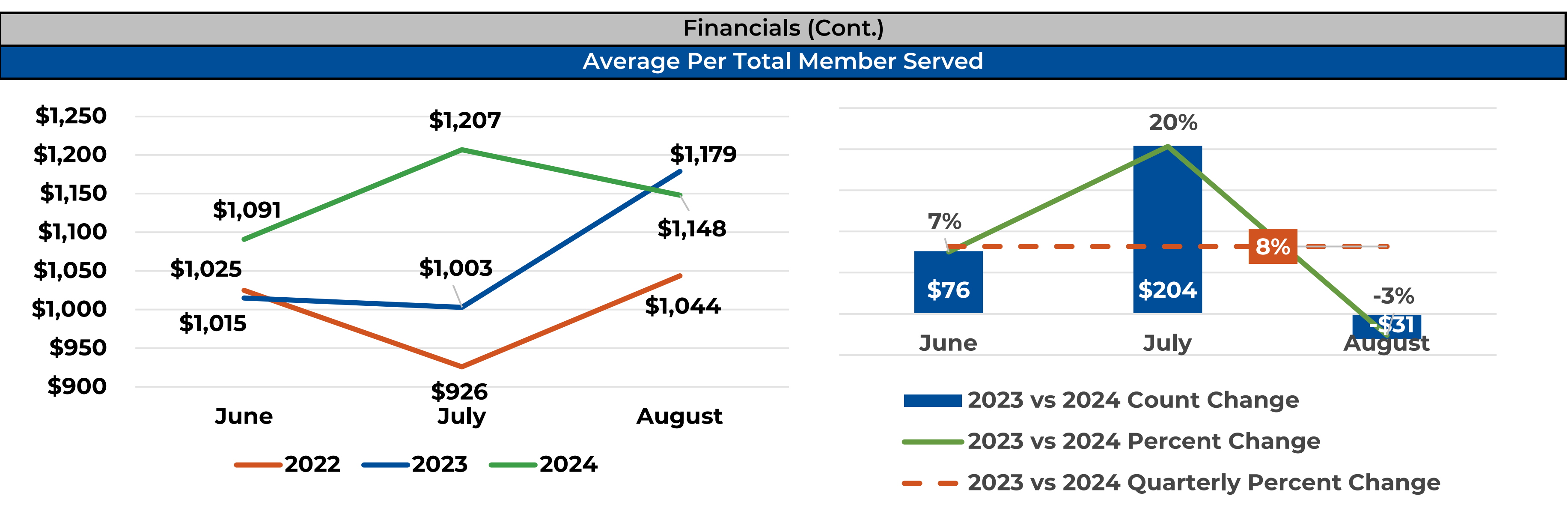


Prescribed Drugs Members Utilization By Qualifying Group

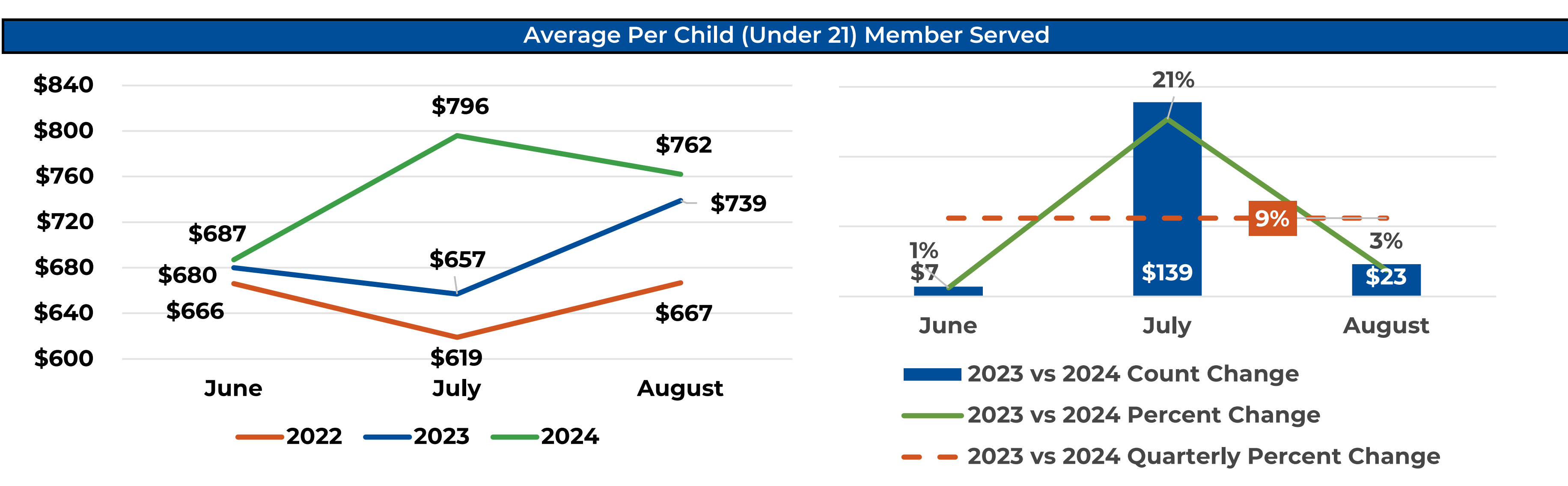


Financials (Cont.)

Average Per Total Member Served

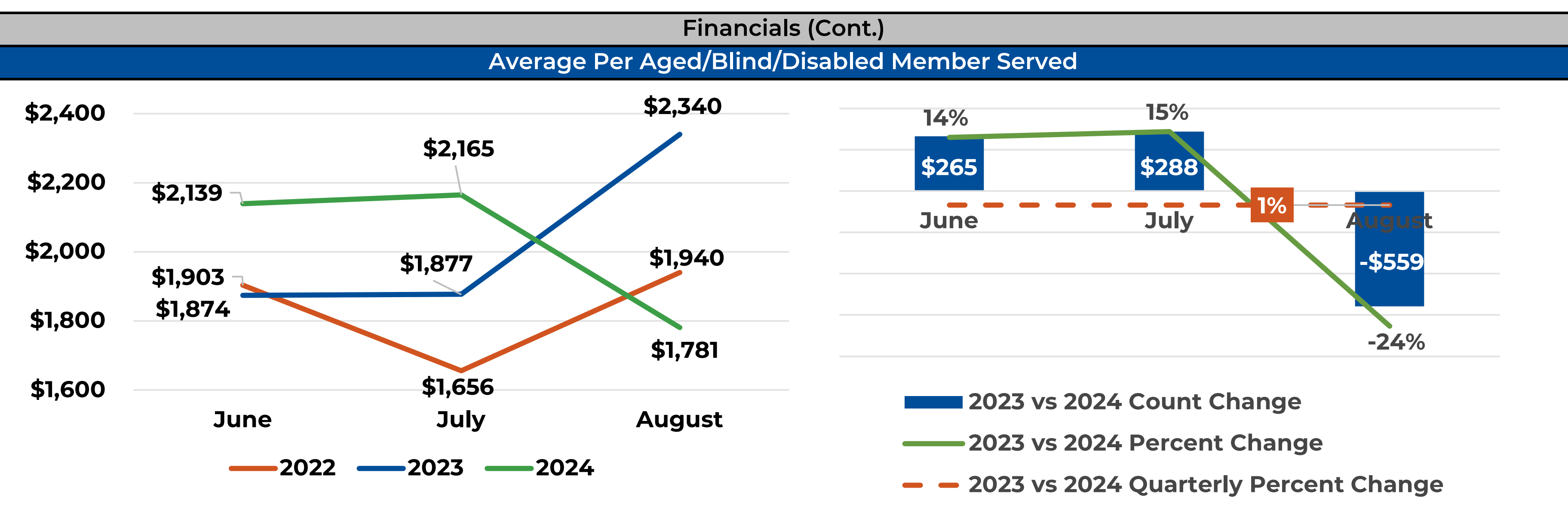


Average Per Child (Under 21) Member Served

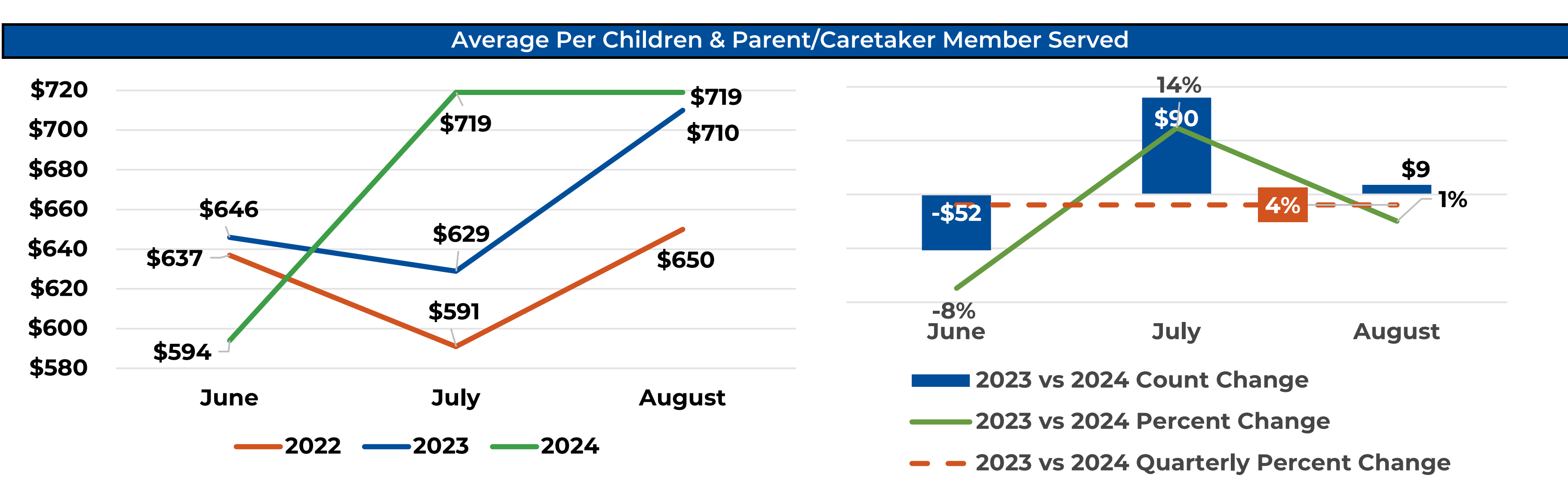


Financials (Cont.)

Average Per Aged/Blind/Disabled Member Served

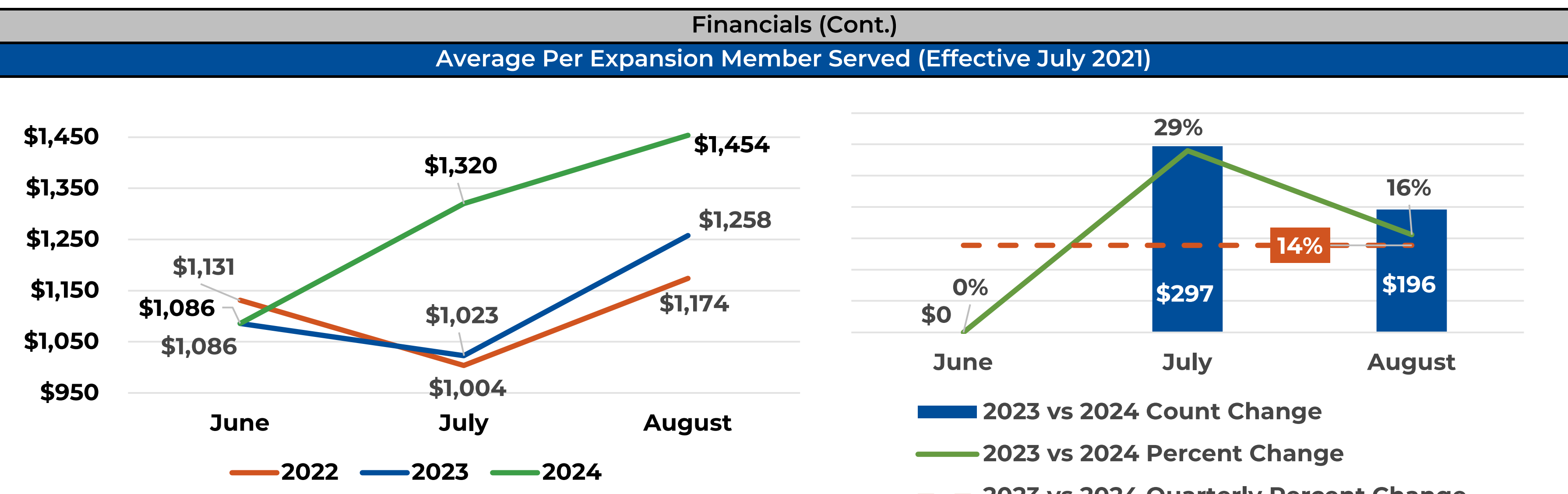


Average Per Children & Parent/Caretaker Member Served



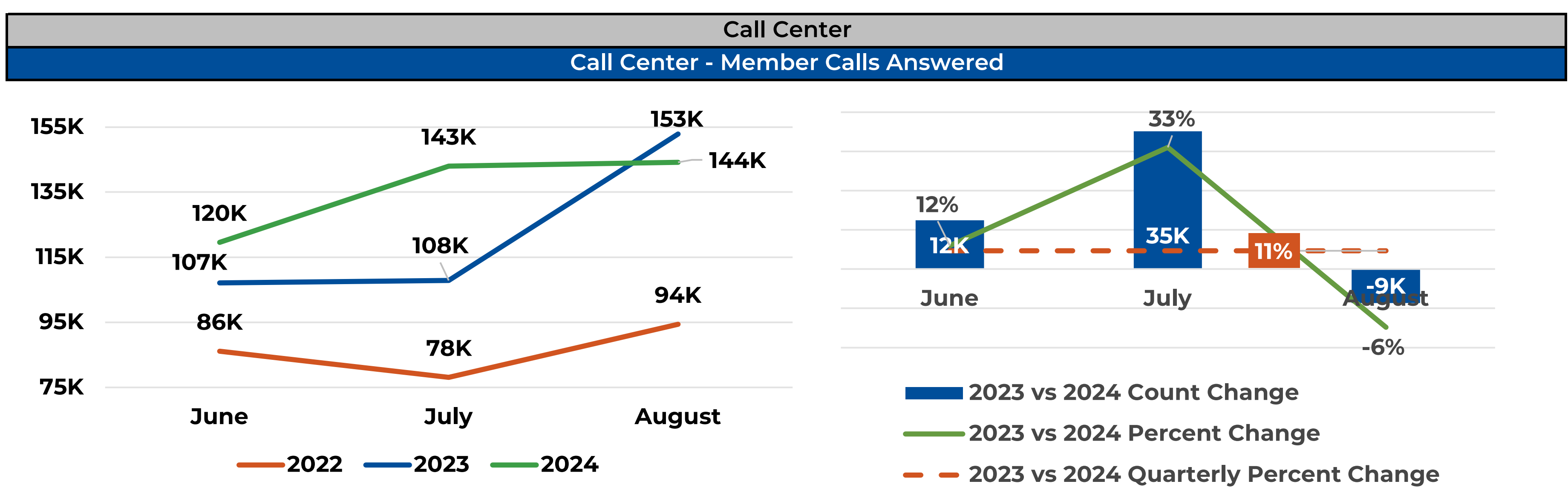
Financials (Cont.)

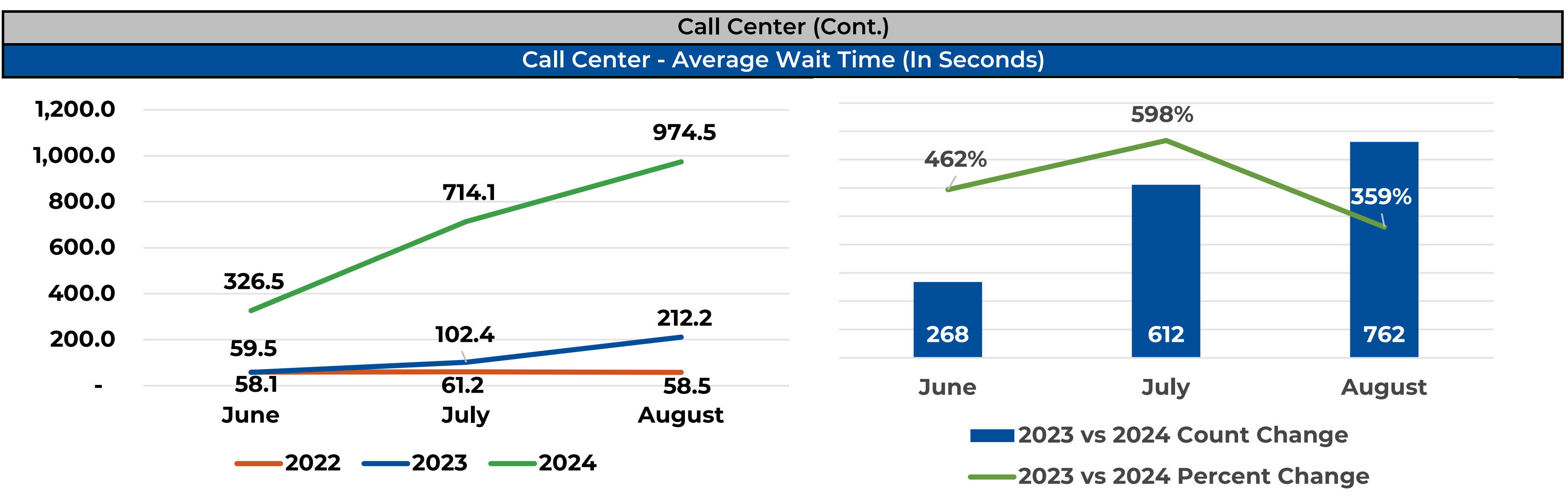
Average Per Expansion Member Served (Effective July 2021)



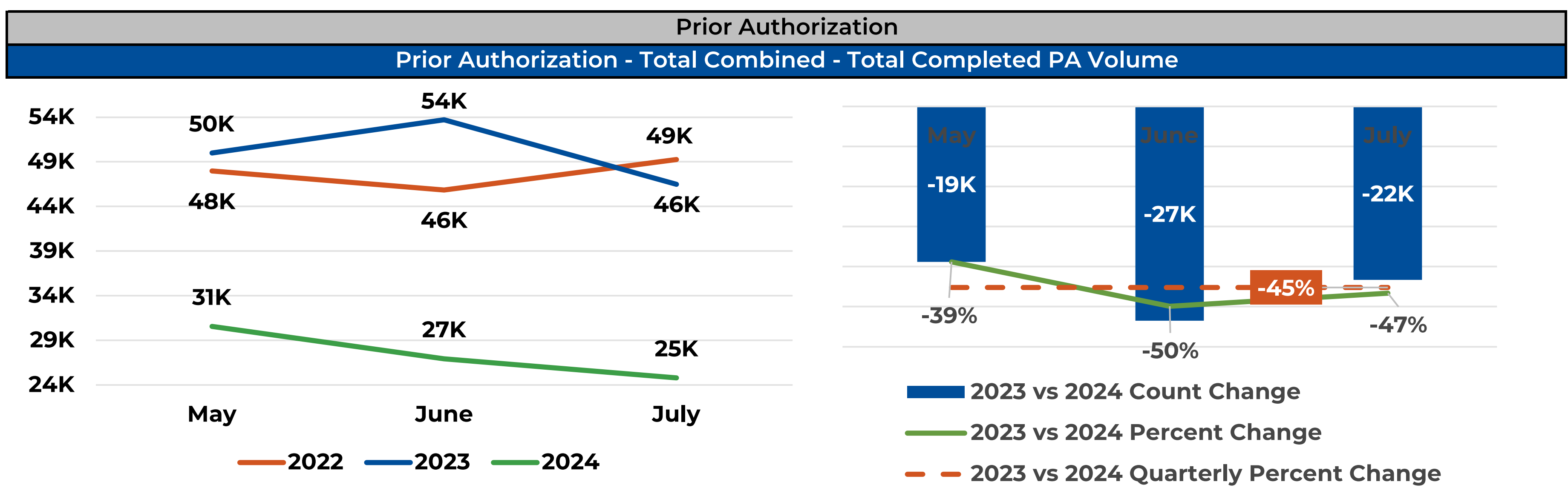
Call Center

Call Center - Member Calls Answered





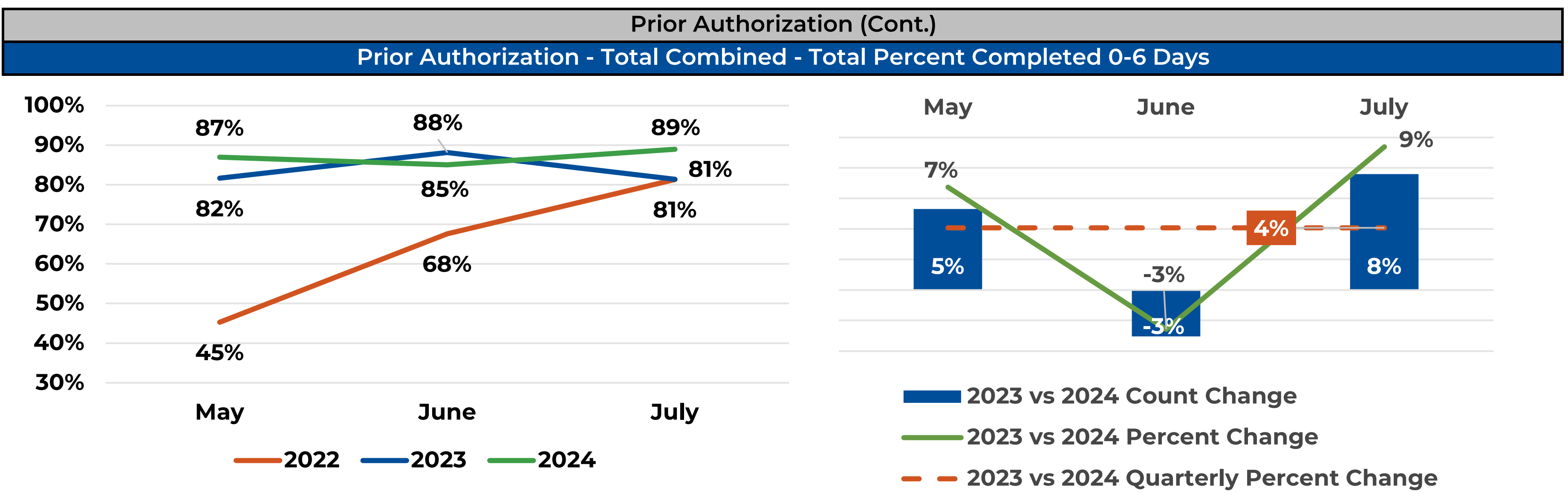
Call Center (Cont.)
Call Center - Average Wait Time (In Seconds)
1,200.0
1,000.0
800.0
600.0
400.0
200.0
-
974.5
714.1
326.5
59.5
102.4
212.2
58.1
61.2
58.5
June
July
August
2022
2023
2024
598%
462%
359%
268
612
762
June
July
August
2023 vs 2024 Count Change
2023 vs 2024 Percent Change



Prior Authorization
Prior Authorization - Total Combined - Total Completed PA Volume
54K
49K
44K
39K
34K
29K
24K
50K
54K
49K
48K
46K
46K
31K
27K
25K
May
June
July
2022
2023
2024
May
June
July
-19K
-27K
-22K
-45%
-39%
-50%
-47%
2023 vs 2024 Count Change
2023 vs 2024 Percent Change
2023 vs 2024 Quarterly Percent Change

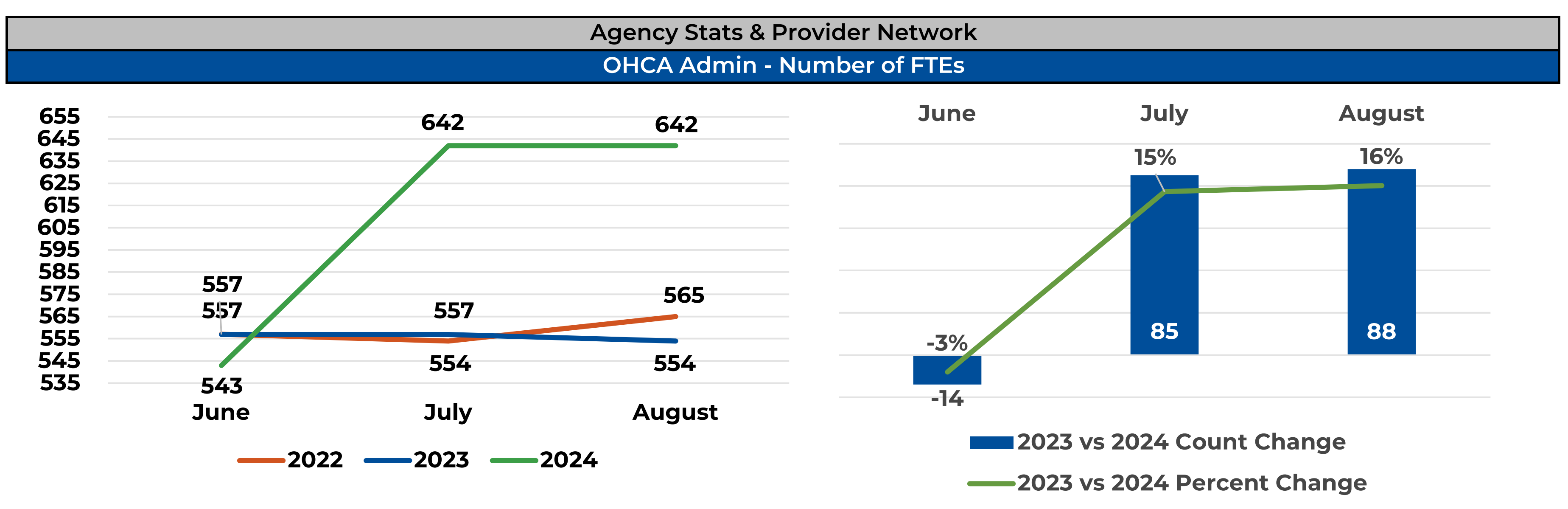
Prior Authorization (Cont.)

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



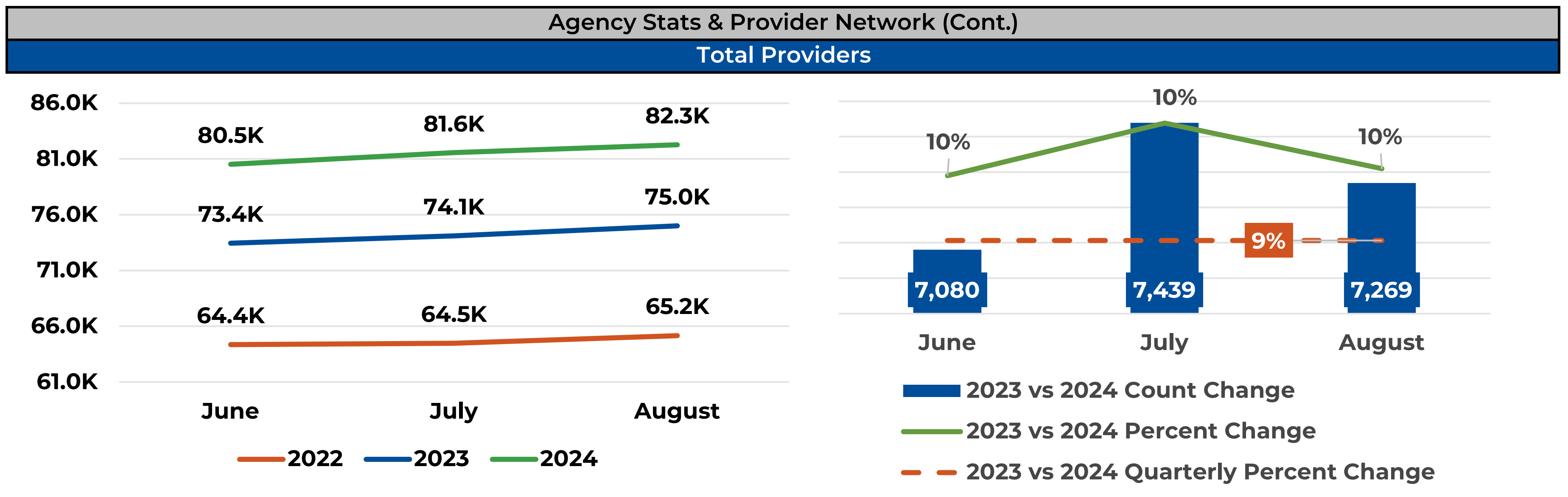
Agency Stats & Provider Network

OHCA Admin - Number of FTEs

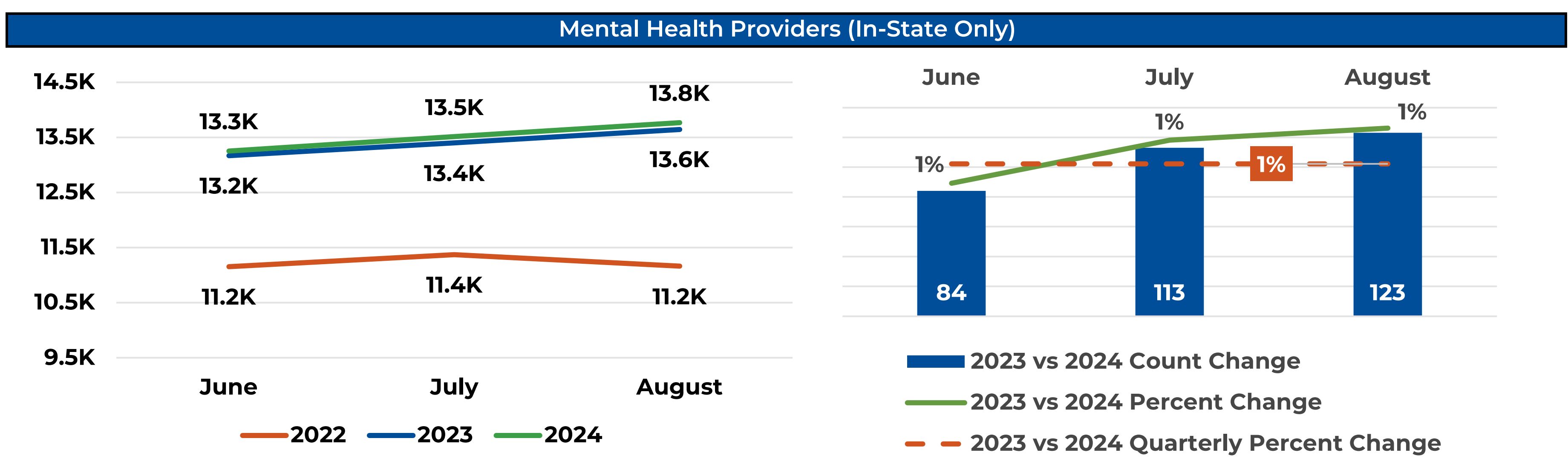


Agency Stats & Provider Network (Cont.)

Total Providers

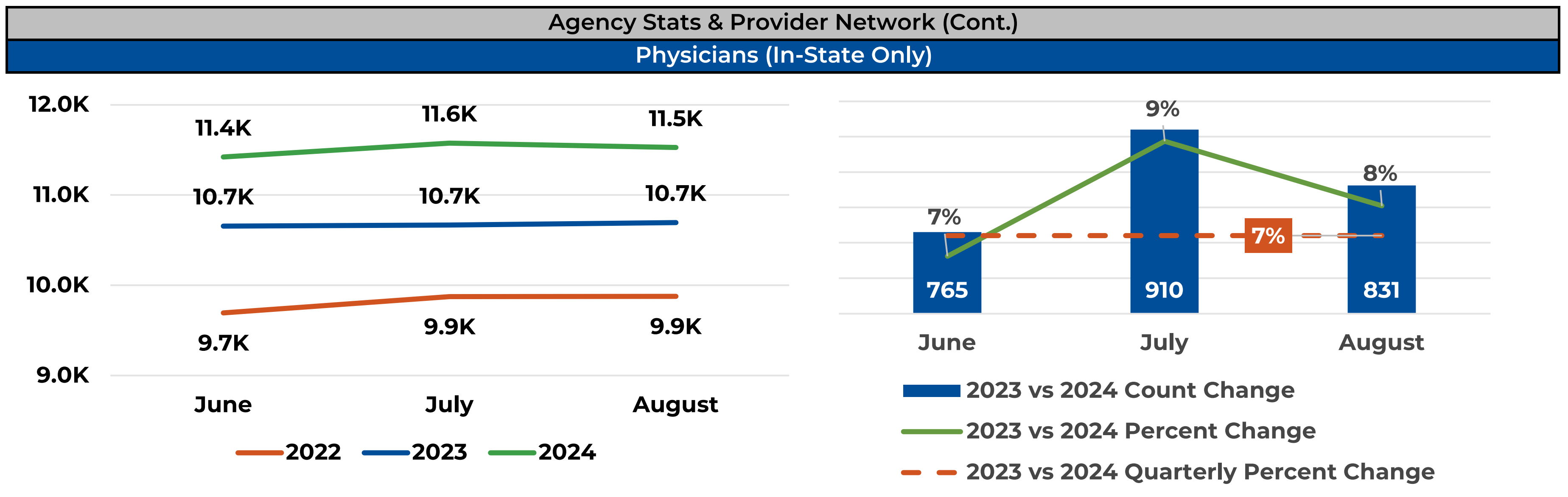


Mental Health Providers (In-State Only)

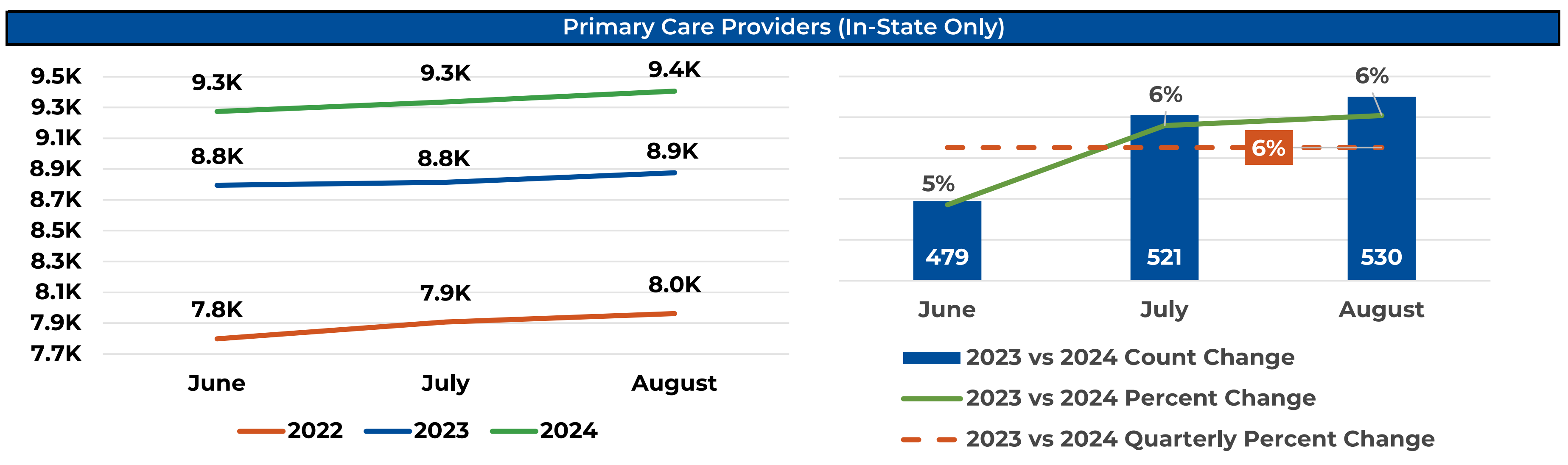


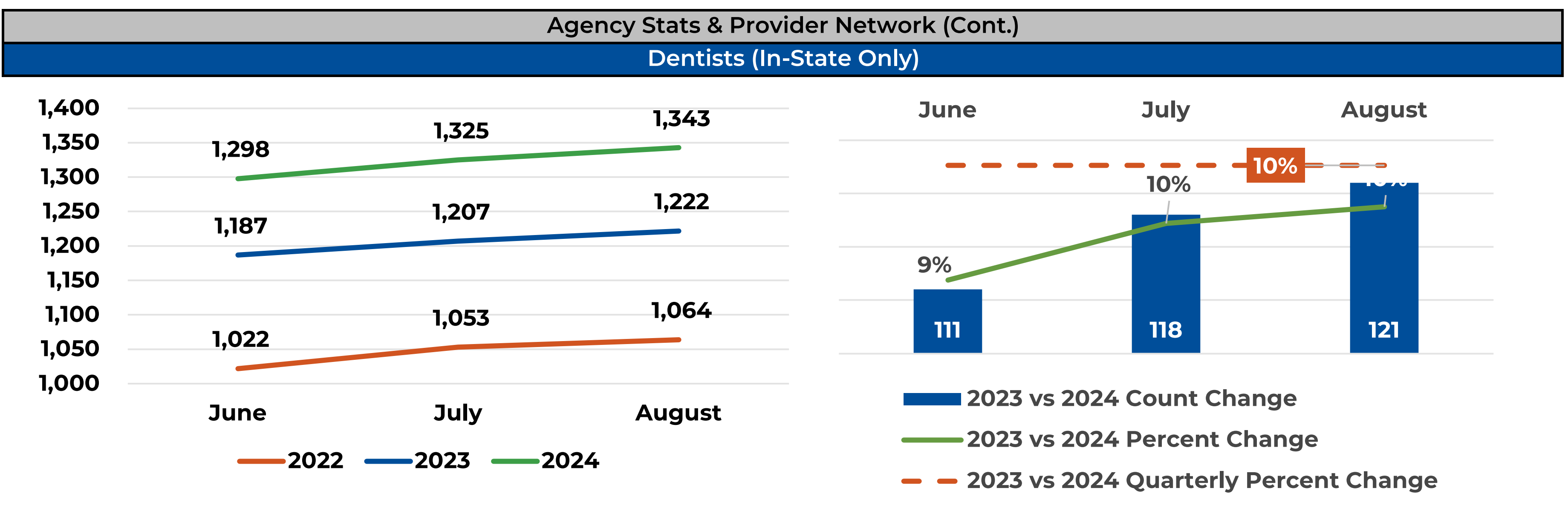
Agency Stats & Provider Network (Cont.)

Physicians (In-State Only)

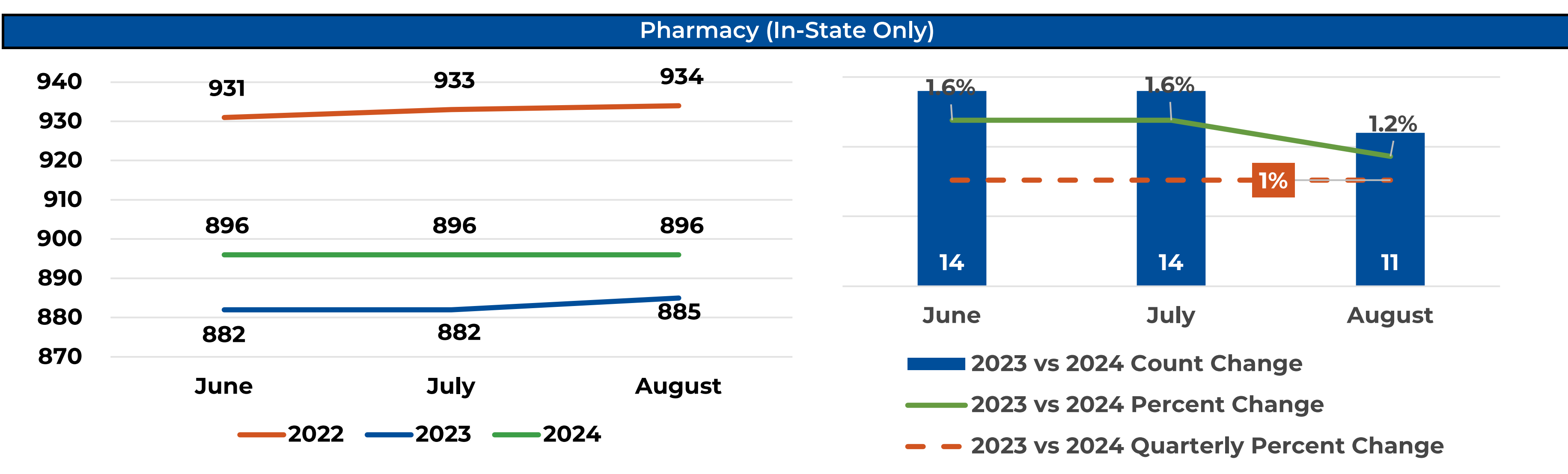


Primary Care Providers (In-State Only)





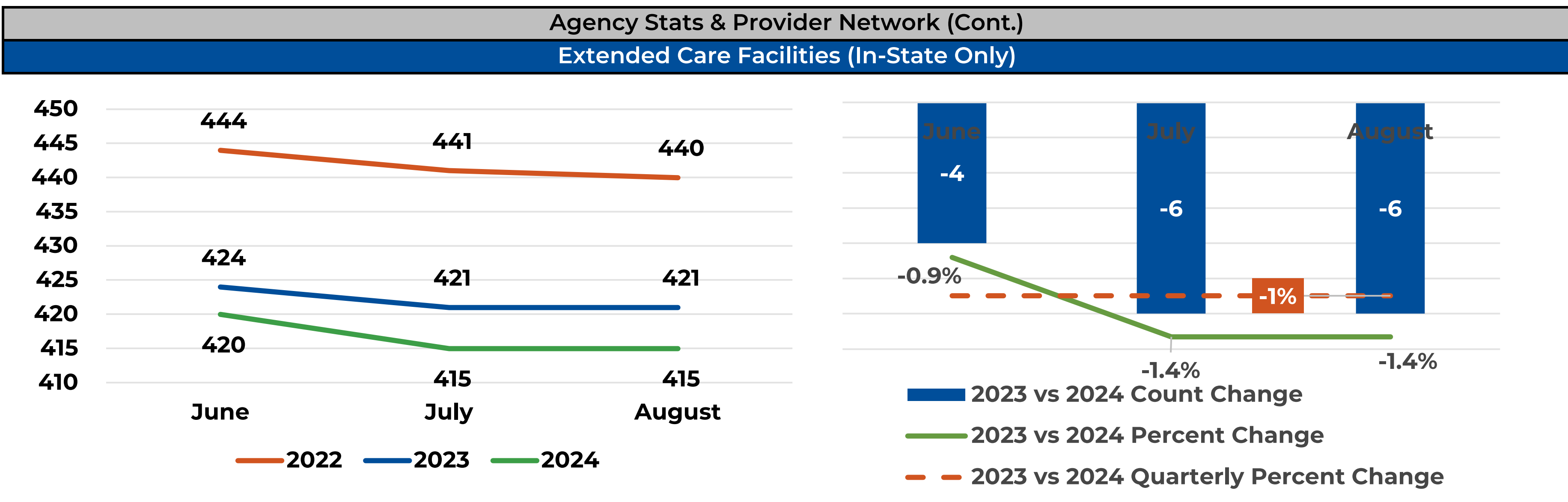
Agency Stats & Provider Network (Cont.)
Dentists (In-State Only)
1,400
1,350
1,300
1,250
1,200
1,150
1,100
1,050
1,000
1,298
1,325
1,343
1,187
1,207
1,222
1,022
1,053
1,064
June
July
August
2022
2023
2024
June
July
August
10%
10%
9%
111
118
121
2023 vs 2024 Count Change
2023 vs 2024 Percent Change
2023 vs 2024 Quarterly Percent Change



Pharmacy (In-State Only)
940
930
920
910
900
890
880
870
931
933
934
896
896
896
882
882
885
June
July
August
2022
2023
2024
1.6%
1.6%
1.2%
1%
14
14
11
June
July
August
2023 vs 2024 Count Change
2023 vs 2024 Percent Change
2023 vs 2024 Quarterly Percent Change

Agency Stats & Provider Network (Cont.)

Extended Care Facilities (In-State Only)



Hospitals (In-State Only)