Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE

# AGENDA

November 7th, 2019
1:00 PM – 3:30 PM

Charles Ed McFall Board Room

I. Welcome, Roll Call, and Public Comment Instructions: **Chairman, Steven Crawford, M.D.**

II. Action Item: Approval of Minutes of the September 5th, 2019: **Medical Advisory Committee Meeting**

III. Public Comments (2 minute limit)

IV. MAC Member Comments/Discussion

V. SoonerCare Operations Update: **Melinda Thomason, Senior Director for Stakeholder Engagement**

VI. Proposed Rule Changes: Presentation, Discussion, and Vote: **Sandra Puebla, Director of Federal & State Authorities**

**A. 19-03 Registered Behavior Technicians (RBTs)**
**B. 19-09 SUPPORT Act**
**C. 19-18 HR6 Opioid Standards and Drug Utilization Review (DUR) Requirements**
**D. 19-19A&B Step Therapy Exception Process**
**E. 19-20 Pharmacy Revisions and American Indians/Alaska Natives (AI/AN) Cost Sharing Exemptions**

VII. New Business: **Chairman, Steven Crawford, M.D.**

**A.** Election of Chairman and Vice-Chairman

VIII. Future Meeting:
January 9, 2020
March 12, 2020
May 14, 2020
July 9, 2020
September 10, 2020
November 12, 2020

IX. Adjourn

Oklahoma Health Care Authority
MEDICAL ADVISORY COMMITTEE
MINUTES of the September 5th, 2019 Meeting
4345 N. Lincoln Blvd., Oklahoma City, OK 73105

**I. Welcome, Roll Call, and Public Comment Instructions:**

Chairman, Dr. Steven Crawford called the meeting to order at 1:00 PM.

***Delegates present were*****:** Ms. Debra Billingsly, **Ms**. Mary Brinkley, Dr. Erin Balzer, Dr. Joe Catalano, Mr. Brett Coble, Dr. Steven Crawford, Ms. Wanda Felty, Dr. Arlen Foulks, Ms. Terrie Fritz, Mr. Mark Jones, Ms. Annette Mays, Mr. James Patterson, Ms. Toni Pratt-Reid, Mr. Traylor Rains, Dr. Edd Rhoades, Dr. Jason Rhynes, Ms. Carrie Slatton-Hodges, Dr. Dwight Sublett, Mr. Jeff Tallent, and Dr. Paul Wright.

**Alternates present were**: Ms. Sarah Baker, Mr. Don Flinn, Ms. Sandra Harrison, and Mr. Fullbright, providing a quorum.

***Delegates absent without an alternate were*****:** Mr. Victor Clay, Mr. Steve Goforth, Dr. Lori Holmquist-Day, Dr. Daniel Post, Mr. Raymond Smith, and Dr. Whitney Yeates.

**II. Approval of the July 18th, 2019 Minutes**

Medical Advisory Committee

**The motion to approve the minutes was by Mr. Jeff Tallent and seconded by Dr. Joe Catalano and passed unanimously.**

**III. Public Comments (2 minute limit):**

There were no public comments made at this meeting.

**IV. MAC Member Comments/Discussion:**

Chairman, Dr. Steven Crawford, discussed the changes made to the OHCA Board agenda, and the option to have the MAC agenda mirror the new and updated board agenda.

**V. Financial Report:**

Tasha Black, Senior Director of Financial Services

Ms. Black presented the financial report ending in June 2019. OHCA ended the year under budget in both revenues and expenditures. Program expenditures were under budget by $13.2 million and, $6.4 million for administrative spending. In revenues we were under budget in tobacco tax collection and fees by $5 million, and over budget in drug rebates and medical refunds totaling 2.5 million, with a positive variance of $17.1 million. For more detailed information, see item 5 in the MAC agenda.

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## VI. SoonerCare Operations Update:

Melinda Thomason, Senior Director for Stakeholder Engagement

Ms. Thomason gave an update on a new initiative taking place in SoonerCare Operations. For the past month and a half, Insure Oklahoma, and Member Services, have been involved in a cross training to better serve our members. They have both been receiving special support training from business enterprises.

## VII. Access Monitoring Review Plan (ARMP)

Sandra Puebla, Director of Federal & State Authorities

As presented at the July 18, 2019 Medical Advisory Committee (MAC) meeting, federal regulation at 42 CFR 447.203 directs State Medicaid programs to analyze and monitor access to care for Medicaid fee-for-service programs through an Access Monitoring Review Plan (AMRP). An AMRP demonstrates access to care by measuring the following: enrollee needs; the availability of care and providers; utilization of services; characteristics of the enrolled members; and estimated levels of provider payment from other payers. Further, the AMRP includes the State's access to care analyses conducted for State Plan amendments that reduced and/or restructured payment rates that could diminish access to care which were promulgated and approved within the previous three years. The AMRP must be taken through consultation with the Medical Advisory Committee and be published and made available to the public for a period of no less than 30 days prior to being submitted to the Centers for Medicare & Medicaid Services (CMS). The State's second AMRP was posted to the Agency's website for a public review period on August 27, 2019 through September 26, 2019. The plan will ultimately be submitted to CMS on or before Monday, September 30, 2019. As with 2016 AMRP, the updated plan identified no access issues during the prior three years.

## VIII. Proposed Rule Changes: Presentation, Discussion, and Vote:

Sandra Puebla, Director of Federal & State Authorities

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, January 8, 2019, Tuesday, June 18, 2019, Tuesday, July 2, 2019, and Tuesday, September 3, 2019 in the Charles Ed McFall Boardroom of the Oklahoma Health Care Authority (OHCA).

APA WF # 19-06 will be posted for public comment through October 4, 2019. APA WF # 19-08 was posted for public comment from August 5, 2019 through September 4, 2019. APA WF # 19-13 A&B will be posted for public comment through September 17, 2019. APA WF # 19-16 will be posted for public comment through September 16, 2019.

**19-06 Diabetes Self-Management Training (DSMT) Services —** The proposed revisions will establish DSMT as a new benefit in the SoonerCare program. DSMT is an educational disease management benefit designed to teach members how to successfully manage and control his/her diabetes. The proposed revisions will outline member eligibility, program coverage and limitations, provider requirements, and reimbursement.
**Budget Impact: The proposed changes will potentially result in an estimated annual total cost of $144,057 with a state share of $50,262 for State Fiscal Year (SFY) 2020.**
**The rule change motion to approve was by Dr. Joe Catalano and seconded by Ms. Toni Pratt-Reid and passed unanimously.**

**19-08 Telehealth Services —** The proposed revisions to telehealth policies are to comply with Oklahoma Senate Bill (SB) 575, which amended 25 Oklahoma Statutes (O.S.), Section 2004 and 2005. Revisions outline and further define the following requirements for telehealth services: parental consent; confidentiality and security of protected health information; services provided or received outside of Oklahoma that may require prior authorization; and that services provided must be within the scope of the practitioner's license or certification. Revisions also define that program restrictions and coverage for telehealth services mirror those which exist for the same services when not provided through telehealth; however, the rule also outlines that only certain telehealth codes are reimbursable by SoonerCare.
**Budget Impact: The proposed changes will result in a budget impact of $332,330 of which $115,950 is the state share.**
**The rule change motion to approve was by Dr. Arlen Foulks and seconded by Ms. Sandra Harrison and passed unanimously with one abstention from Mr. Brett Coble.**

**19-13A&B Long-Term Care Facilities Revisions —** The proposed revisions will bring OHCA into compliance with Senate Bill (SB) 280. Revisions will increase rates and recalculate the Quality of Care fee for regular nursing facilities and nursing facilities serving residents with Acquired Immune Deficiency Syndrome (AIDS). Revisions will establish new quality measures and criteria, as well as, recalculate the incentive reimbursement rate plan for nursing facilities participating in the paid-for-performance program. In addition, revisions will direct certain redistribution of funds; update staffing ratios; establish an advisory group; implement an administrative appeals process for disputed nursing facility cost reporting adjustments; streamline the audit process; and increase the personal needs allowance for residents of nursing homes and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs).
**Budget Impact: The estimated budget impact for the remainder of SFY2020 will be an increase in the total amount of $95,819,280; with $32,559,391 in state share ($4,400,309 of the state share is from QOC fees paid by providers). The estimated budget impact for SFY2021 will be an increase in the total amount of $127,759,040; with $43,412,522 in state share ($6,286,156 of the state share is from QOC fees paid by providers).**
**The rule change motion to approve was by Ms. Toni Pratt-Reid and seconded by Ms. Mary Brinkley and passed unanimously with one abstention from Mr. Brett Coble.**



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**19-16 Behavioral Health Targeted Case Management (TCM) Updates —** The proposed revisions, requested by the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS), increases the TCM limits that are reimbursable by SoonerCare. The TCM limits will be increased from sixteen (16) units per member per year to twelve (12) units per member per month. Other revisions will align case management policy with current practice and correct grammatical errors.
**Budget Impact: The proposed changes will potentially result in an estimated annual total cost for SFY20 of $6,425,397 with a state share of $2,183,350 and an SFY21 total cost of $8,567,136 with a state share of $2,833,152. The state share will be paid by ODMHSAS.**
**The rule change motion to approve was by Mr. Jeff Tallent and seconded by Dr. Joe Catalano and passed unanimously.**

**IX. New Business: Chairman, Steven Crawford, M.D.**
There was no new business addressed.

**X. Future Meeting**
November 7th, 2019

**XI. Adjournment**
There was no dissent and the meeting was adjourned at 1:50p.m.

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# OHCA Monthly Metrics
# November 2019
# (September 2019 Data)

## SOONERCARE ENROLLMENT/EXPENDITURES

| Delivery System | | | Enrollment September 2019 | Children September 2019 | Adults September 2019 | Enrollment Change | Total Expenditures September | PMPM September 2019 |
|---|---|---|---|---|---|---|---|---|
| **SoonerCare Choice Patient-Centered Medical Home** | | | **523,924** | **438,148** | **85,776** | **-9,675** | **$107,656,191** | |
| | *Lower Cost* | *(Children/Parents; Other)* | 482,046 | 425,073 | 56,973 | -9,148 | $60,465,702 | $125 |
| | *Higher Cost* | *(Aged, Blind or Disabled; TEFRA; BCC)* | 41,878 | 13,075 | 28,803 | -527 | $47,190,488 | $1,127 |
| **SoonerCare Traditional** | | | **238,835** | **86,525** | **152,310** | **5,349** | **$211,056,146** | |
| | *Lower Cost* | *(Children/Parents; Other; Q1; SLMB)* | 121,874 | 81,661 | 40,213 | 4,433 | $79,175,395 | $650 |
| | *Higher Cost* | *(Aged, Blind or Disabled; LTC; TEFRA; BCC & HCBS Waiver)* | 116,961 | 4,864 | 112,097 | 916 | $131,880,751 | $1,128 |
| **Insure Oklahoma** | | | **18,278** | **490** | **17,788** | **-549** | **$7,153,173** | |
| | *Employer-Sponsored Insurance* | | 13,066 | 298 | 12,768 | -428 | $4,566,264 | $349 |
| | *Individual Plan* | | 5,212 | 192 | 5,020 | -121 | $2,586,908 | $496 |
| **SoonerPlan** | | | **28,444** | **2,238** | **26,206** | **-255** | **$204,750** | $7 |
| **TOTAL** | | | **809,481** | **527,401** | **282,080** | **-5,130** | **$326,070,260** | |

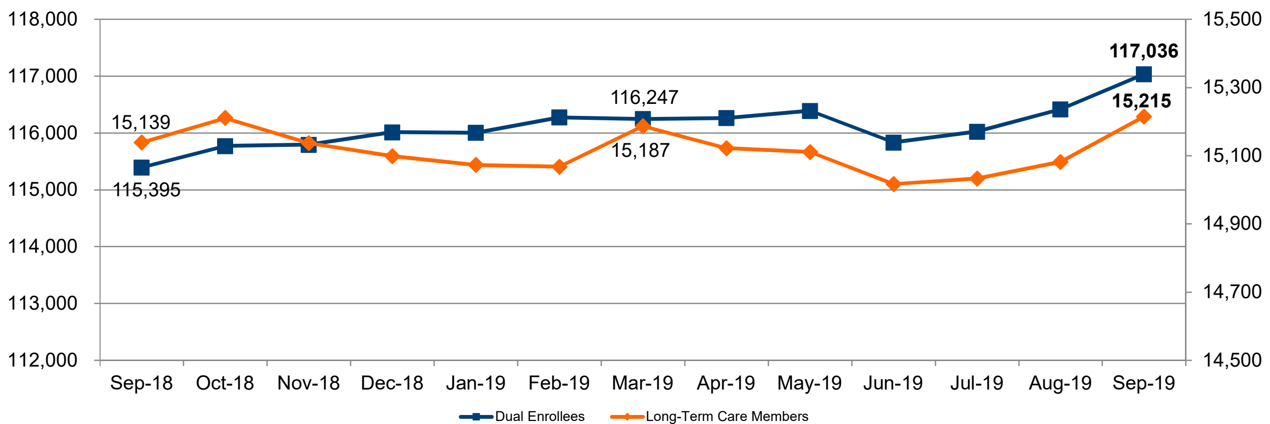
Enrollment totals include all members enrolled during the report month. Members may not have expenditure data. Children are members aged 0 - 20 or for Insure Oklahoma enrolled as Students or Dependents.
Dual Eligibles (Medicare & Medicaid) are in the Traditional delivery system in both the Low Cost (Q1 & SLMB) and High Cost (ABD) groups. OTHER includes DDSD, PKU, Q1, Refugee, SLMB, STBS and TB.

**Total In-State Providers: 43,614** (+5,577)** **(In-State Providers counted multiple times due to multiple locations, programs, types, and specialties)**

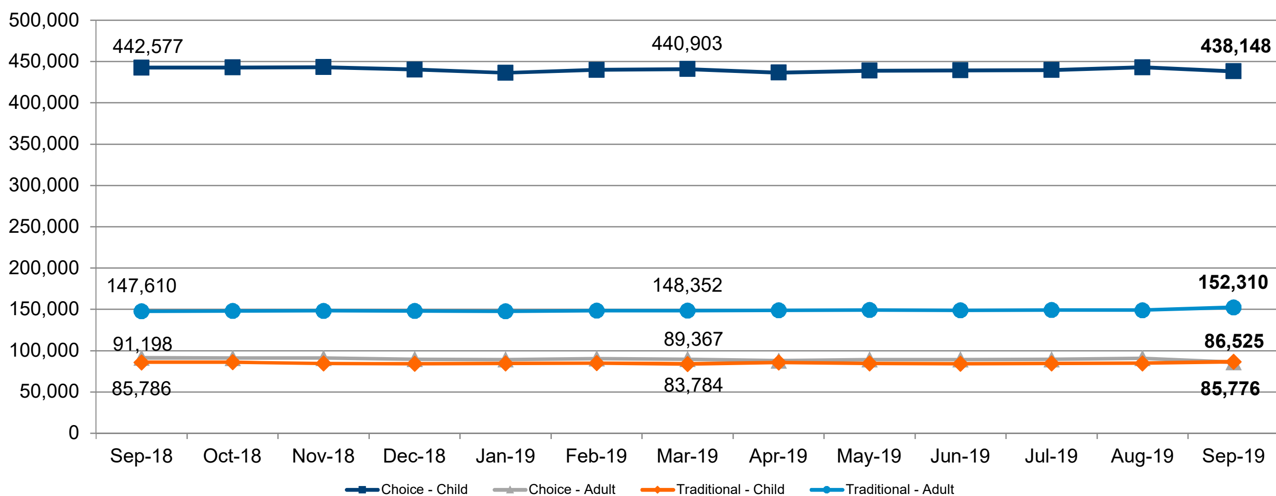
| Physician | Pharmacy | Dentist | Hospital | MH/BH | Optometrist | Extended Care | Total PCPs* | PCMH |
|---|---|---|---|---|---|---|---|---|
| 10,322 | 904 | 1,207 | 159 | 11,744 | 669 | 433 | 7,571 | 2,663 |

*PCPs consist of all providers contracted as a Certified Registered Nurse Practitioner, Family Practitioner, General Pediatrician, General Practitioner, Internist, General Internist, and Physician Assistant.
**Larger than usual increase in September total provider number due to revision in methodology as additional Clinic specialties were added.

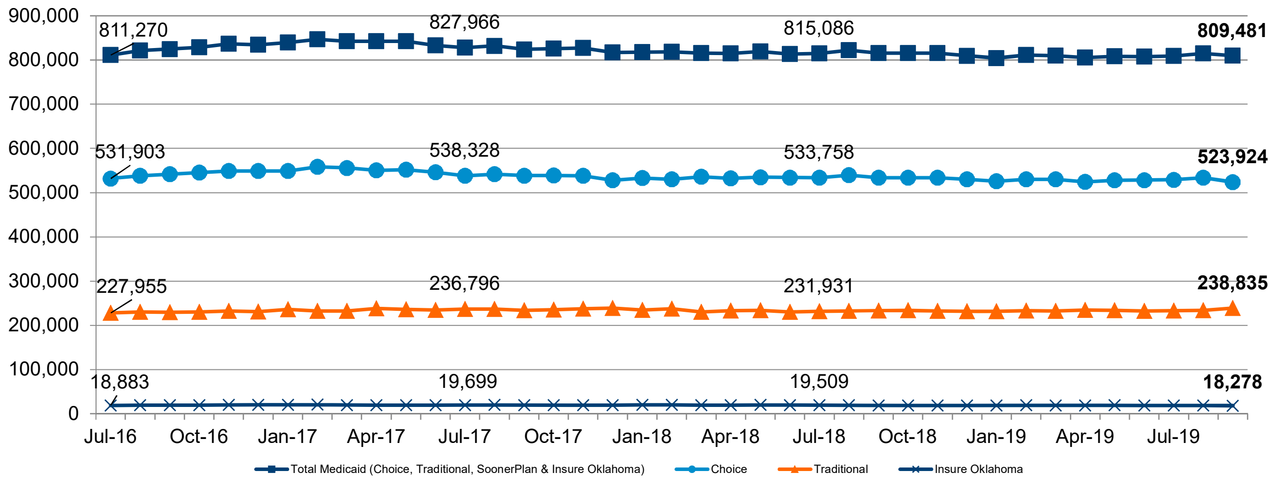
## DUAL ENROLLEES & LONG-TERM CARE MEMBERS

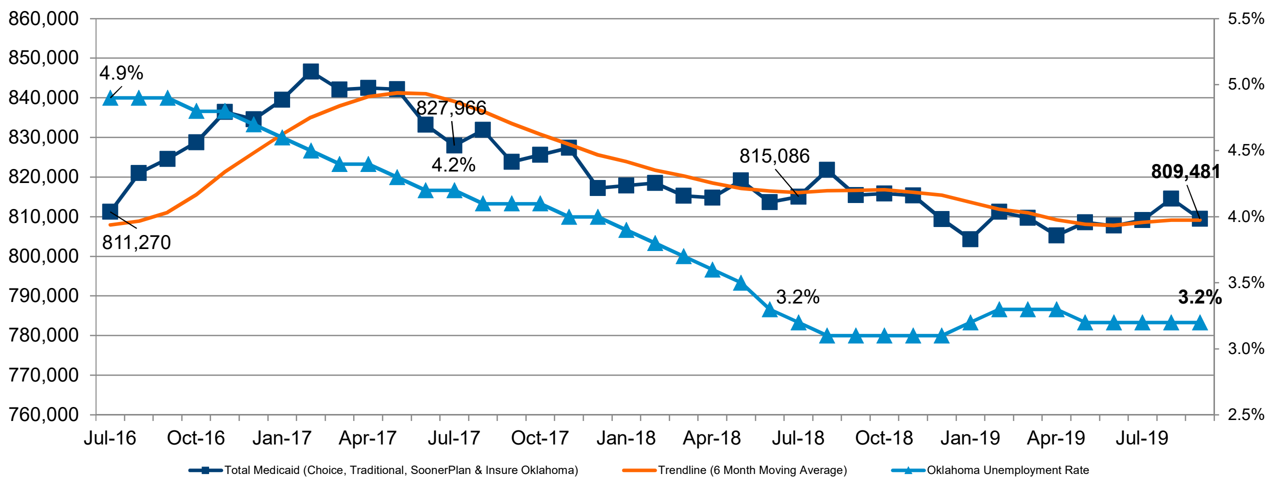



## CHILDREN & ADULTS ENROLLMENT



## ENROLLMENT BY MONTH




Oklahoma Unemployment Rate is from the Bureau of Labor Statistics 'Local Area Unemployment Statistics' (https://www.bls.gov/lau/) and is seasonally adjusted. Data was extracted on 9/26/2018.
In June 2017 there were changes to the passive renewal system criteria that reduced the number of passively renewed members by 2/3rds.

**November MAC**
**Proposed Rule Amendment Summaries**

Face-to-face tribal consultations regarding the following proposed changes were held on Tuesday, June 18, 2019, Tuesday, July 2, 2019 and Tuesday, November 5, 2019 in the Charles Ed McFall boardroom of the Oklahoma Health Care Authority (OHCA).

APA work folder 19-03 will be posted for public comment through November 18, 2019. APA work folders 19-09 and 19-18 will be posted for public comment through November 19, 2019. APA work folders 19-19 A&B will be posted for public comment through November 17, 2019. APA work folder 19-20 will be posted for public comment through November 18, 2019.

**19-03 Registered Behavior Technicians (RBTs) —** The proposed revisions will add RBTs as a new SoonerCare provider. The proposed revisions will also outline provider qualifications and other requirements for provision of applied behavior analysis (ABA) services. Other revisions will be made to clarify current provider and reimbursement requirements.

**Budget Impact: The proposed rule change will not result in any additional costs and/or savings to the agency. Budget allocation to establish coverage of and reimbursement for ABA services, including services rendered by RBTs, was approved during promulgation of the emergency rule on July 1, 2019.**

**19-09 SUPPORT Act —** The proposed revisions are in response to recent changes in federal law which require that individuals under the age of twenty-one, or individuals in the former foster care eligibility group under the age of twenty-six, who become incarcerated, shall not have their Medicaid eligibility terminated. Eligibility for the aforementioned populations will instead be suspended for the duration of the incarceration. Additional revisions outline that a redetermination of eligibility, based on information known to the OHCA, will be conducted prior to the inmate's release without requiring a new SoonerCare application. Eligibility will be restored to the date the inmate is released from custody, if the individual meets all other eligibility requirements. The process of restoring eligibility to the date the individual is released from incarceration will involve collaboration between the OHCA, Oklahoma Department of Human Services (DHS), Oklahoma Office of Juvenile Affairs (OJA), and the Oklahoma Department of Corrections (DOC). Of note, coverage and reimbursement of inpatient services while an individual is incarcerated, will not change through these proposed changes.

**Budget Impact: The estimated budget impact for State Fiscal Year (SFY) 2020 will be an increase in the total amount of $227,512; with $77,309 in state share. The estimated budget impact for future years, beginning in SFY 2021, will be an increase in the total amount of $341,268; with $115,963 in state share.**

**19-18 HR6 Opioid Standards and Drug Utilization Review (DUR) Requirements —** The proposed rule changes will comply with 42 USC § 1396a(oo), which requires state Medicaid agencies to implement newly-required DUR activities to better monitor opioid prescribing and dispensing patterns. Opioid safety edits will be implemented to alert pharmacists when potential concerns regarding medications prescribed to members exist; concerns must be resolved before medications can be dispensed to the member. Additionally, a claims review automated process will be in place to identify refills in excess of state limits and monitor concurrent prescribing of opioids, benzodiazepines, and/or antipsychotics. The OHCA will also implement a program to monitor the use of antipsychotic medications by members age eighteen (18) and younger, including children in foster care. Lastly, the OHCA will implement a process to identify

potential fraud and abuse of controlled substances by members, health care professionals prescribing drugs to members, and pharmacies dispensing drugs to members.

**Budget Impact: Budget neutral.**

**19-19A&B Step Therapy Exception Process —** The proposed revisions will comply with Oklahoma Senate Bill (SB) 509, which directs the OHCA to revise current step therapy protocols for medications approved by the Drug Utilization Review (DUR) Board and provide an exception process to the drug step therapy protocol. The exception applies to cases when: the required prescribed drug will likely cause an adverse reaction or harm; the prescription drug will likely be ineffective; the patient has already tried the prescription drug and discontinued use; the prescription drug is not in the best interest of the patient; or the patient is stable on another prescription drug. Revisions will also establish an appeals process for step therapy exception requests that have been denied. Other revisions will correct outdated language.

**Budget Impact: The estimated budget impact for the remainder of SFY20 (6-month impact) will be an increase in the total amount of $15,000,000; with $2,548,500 in state share. The estimated budget impact for SFY21 will be an increase in the total amount of $30,000,000; with $4,875,000 in state share.**

**19-20 Pharmacy Revisions and American Indians/Alaska Natives (AI/AN) Cost Sharing Exemptions —** The proposed revisions will remove prescription limits of certain frequently monitored prescription drugs and medication-assisted treatment (MAT) drugs for opioid use disorder. The proposed revisions will also remove co-payments for MAT drugs. Additional rule revisions will amend prescription quantity limits when a product is on the maintenance drug list. Finally, revisions will align policy regarding cost sharing exemptions for AI/AN members with Oklahoma's Medicaid State Plan language and federal regulation at 42 CFR § 447.56(a)(x). Other revisions will align policy with current practice and correct grammatical errors.

**Budget Impact: The estimated budget impact to remove prescription limits and co-payment requirements for MAT drugs in SFY20 will be an increase in the total amount of $2,951,666; with $514,918 in state share. The estimated budget impact for SFY21 will be an increase in the total amount of $1,161,000; with $188,662 in state share.**

**The estimated budget impact to increase prescription quantity limits when a product is on the maintenance drug list will potentially result in an estimated total savings of $414,251; with $140,762 in state savings for SFY20 (6-month savings) and an estimated annual savings for SFY21 of 828,502; with $269,263 in state savings.**

**The proposed rule change to align SoonerCare rules with the Medicaid State Plan's cost sharing exemptions for AI/AN members is budget neutral for SFY 2020 and 2021. The budget impact for this rule change was observed in SFY 2015.**

**The proposed rule change to align SoonerCare rules with the Medicaid State Plan's cost sharing exemptions for AI/AN members is budget neutral for SFY 2020 and 2021. The budget impact for this rule change was observed in SFY 2015.**

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

**SUBCHAPTER 3. GENERAL PROVIDER POLICIES**

**PART 4. EARLY AND PERIODIC SCREENING, ~~DIAGNOSIS~~DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM/CHILD-HEALTH SERVICES**

**317:30-3-65.12. Applied behavior analysis (ABA) services**

(a) **Purpose and general provisions.** The purpose of this Section is to establish guidelines for the provision of ABA services under the EPSDT benefit.

(1) ABA focuses on the analysis, design, implementation, and evaluation of instructional and other environmental modifications to produce meaningful changes in human behavior. ABA services include the use of direct observation, measurement, and functional analysis of the relations between the environment and behavior. Common ABA-based techniques include, but are not limited to; discrete trial training; pivotal response training; and verbal behavioral intervention.

(2) ABA may be provided in a variety of settings, including home, community, or a clinical setting. It involves development of an individualized treatment plan that includes transition and aftercare planning, and significant family/caregiver involvement.

(3) At an initial assessment, target symptoms are identified. A treatment plan is developed that identifies core deficits and aberrant behaviors, and includes designated interventions intended to address these deficits and behaviors and achieve individualized goals.

(4) Functional behavioral assessment (FBA) may also be a part of any assessment. An FBA consists of:

(A) Description of the problematic behavior (topography, onset/offset, cycle, intensity, severity);

(B) History of the problematic behavior (long-term and recent);

(C) Antecedent analysis (setting, people, time of day, events);

(D) Consequence analysis; and

(E) Impression and analysis of the function of the problematic behavior.

(5) ABA services require prior authorization [refer to Oklahoma Administrative Code (OAC) 317:30-3-31]. These services are designed to accomplish medically necessary management of severe and complex clinical conditions that within a finite and reasonable period of time, the caregiver will be able to

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demonstrate knowledge and ability to independently and safely carry out the established plan of care.

(b) **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 (BACB) and licensed by Oklahoma Department of Human Services' (DHS) 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 is certified by the national-accrediting BACB and certified by DHS 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; and

(4) Human services professional – A practitioner who is licensed by the State of Oklahoma pursuant to (A) – (H), 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 psychologist;

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

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

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

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

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

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(1) A BCBA shall:
(A) Be currently licensed by DHS DDS as a BCBA;
(B) Have no sanctions or disciplinary actions by DHS 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 DHS 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 Title 59 of the Oklahoma Statutes (O.S.), § 1928;
(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.

(d) **Medical necessity criteria for members under twenty-one (21) years of age.** ABA services are considered medically necessary when all of 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:

(A) Pediatric neurologist or neurologist;
(B) Developmental pediatrician;
(C) Licensed psychologist;
(D) Psychiatrist or neuropsychiatrist; or
(E) Other licensed physician experienced in the diagnosis and treatment of autism.

(2) A comprehensive diagnostic evaluation 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-V) 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.

(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 atypical or disruptive behavior within the most recent thirty (30) calendar days that significantly interferes with daily functioning and activities. Such atypical or disruptive behavior may include, but is not limited to:
(A) Impulsive aggression toward others;
(B) Self-injury behaviors; or
(C) Intentional property destruction.

(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.")

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

(e) **Intervention criteria.** Eligible providers must submit an initial prior authorization request to the Oklahoma Health Care Authority (OHCA) or its designated agent and meet the following SoonerCare intervention criteria for ABA services.

(1) The intervention criteria includes a comprehensive behavioral and functional evaluation outlining the behaviors consistent with the diagnosis of ASD and its associated comorbidities. In addition to completing the initial request form, providers will be required to submit a written assessment that will consist 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 behavior. 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) 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.

(2) The ABA treatment will be time limited and must:

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

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

(C) Clearly define in measurable and objective terms the specific target behaviors that are linked to the function of (or reason for) the behavior;

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

(E) Set quantifiable criteria for progress;

(F) Establish and record behavioral intervention techniques that are appropriate to target behaviors. The detailed behavior analytic 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;
(G) Specify strategies for generalization of learned skills;
(H) Document planning for transition through the continuum of interventions, services, and settings, as well as discharge criteria;
(I) 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. Frequency of parental involvement will be determined by the treatment provider and listed on the treatment plan;
(J) 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; and
(K) 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 Plan (IEP), Individualized Service Plan (ISP), or any other individual plan of care.

(f) **ABA extension requests.** Extension requests for ABA services must be submitted to the OHCA or its designated agent. Extension requests must contain the appropriate documentation validating the need for continued treatment and establish the following:
(1) Eligibility criteria in (d) 1-6;
(2) 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;
(3) If progress has not been measurable after two (2) extension requests, a functional analysis will be completed which records the member's maladaptive serious target behavioral symptom(s), and precipitants, as well as makes 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 (psychiatric consults, pediatric evaluation for other conditions) and interventions have been changed, including the number of hours per week of service or setting (higher level of care);



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(5) Parent(s)/legal guardian(s) have received re-training on these changed approaches; and

(6) The treatment plan documents a gradual tapering of higher intensities of intervention and shifting to supports from other sources (i.e., schools) as progress occurs.

(g) **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 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) Reimbursement shall only be made for services that have been prior-authorized by OHCA or its designee.

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

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 35. RURAL HEALTH CLINICS

### 317:30-5-355.1. Definition of services

The ~~RHC~~Rural Health Clinic (RHC) benefit package, as described in Title 42 of the Code of Federal Regulations (CFR), ~~part~~ § 440.20, consists of two (2) components: RHC ~~Services and Other Ambulatory Services~~services and other ambulatory services.

(1) **RHC services.** RHC services are covered when furnished to a member at the clinic or other location, including the member's place of residence. These services are described in this Section.

(A) **Core services.** As set out in ~~Federal Regulations at~~ 42 CFR § 440.20(b), RHC "core" services include, but are not limited to:

(i) Physician's services;

(ii) Services and supplies incident to a physician's services;

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(iii) Services of advanced practice registered nurses ~~(APNs)~~ (APRNs), physician assistants (PAs), certified nurse midwives (CNMs), or specialized advanced practice nurse practitioners;

(iv) Services and supplies incident to the services of ~~APNs~~APRNs and PAs (including services furnished by ~~certified nurse midwives~~CNMs);

(v) Visiting nurse services to the homebound;

(vi) Clinical psychologist (CP) and clinical social worker (CSW) services;

(vii) Services and supplies incident to the services of CPs and CSWs.

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

(i) ~~prenatal~~Prenatal and postpartum care;

(ii) ~~screening~~Screening examination under the Early and Periodic Screening, ~~Diagnosis~~Diagnostic and Treatment (EPSDT) Program for members under ~~21~~twenty-one (21);

(iii) ~~family~~Family planning services;

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

(C) **Services and supplies "incident to".** Services and supplies incident to the service of a physician, ~~physician assistant, advanced practice nurse, clinical psychologist, or clinical social worker~~PA, APRN, CP, or CSW are covered if the service or supply is:

(i) ~~a~~A type commonly furnished in physicians' offices;

(ii) ~~a~~A type commonly rendered either without charge or included in the rural health clinic's bill;

(iii) ~~furnished~~Furnished as an incidental, although integral, part of a physician's professional services; or

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

(D) **Visiting nurse services.** Visiting nurse services are covered if:

(i) ~~the~~The RHC is located in an area in which the Centers

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for Medicare and Medicaid Services (CMS) has determined there is a shortage of home health agencies;

(ii) ~~the~~The services are rendered to members who are homebound;

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

(iv) ~~the~~The services are furnished under a written plan of treatment.

(E) **RHC encounter.** RHC "core" services (including preventive services, i.e., prenatal, EPSDT, or family planning) are part of an all-inclusive visit. A "visit" means a face-to-face encounter between a clinic patient and ~~a~~an RHC health professional ~~(i.e., physicians, physician assistants, advanced practice nurses, certified nurse midwives, clinical psychologists and clinical social workers)~~(physicians, PAs, APRNs, CNMs, CPs, and CSWs). Encounters with more than one (1) health professional and multiple encounters with the same health professional that takes place on the same day and a single location, constitute a single visit except when the member, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Payment is made for one (1) encounter per member per day. Medical review will be required for additional visits for children. Payment is also limited to four (4) visits per member per month for adults.

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

(2) **Other ambulatory services.** ~~A Rural Health Clinic~~An RHC must provide other items and services which are not "RHC services" as described in ~~(a)~~(1) of this Section, and are separately billable ~~to the SoonerCare program~~within the scope of the SoonerCare fee-for-service (FFS) contract. Coverage of services are based upon the scope of coverage under the

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SoonerCare program.

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

(i) ~~dental~~Dental services for members under ~~age 21~~the age of twenty-one (21);

(ii) ~~optometric~~Optometric services;

(iii) ~~clinical~~Clinical lab tests performed in the RHC lab, including the lab tests required for RHC certification;

(iv) ~~technical~~Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);

(v) ~~durable~~Durable medical equipment;

(vi) ~~emergency ambulance transportation~~Transportation by ambulance [refer to Oklahoma Administrative Code (OAC) 317:30-5-335];

(vii) ~~prescribed~~Prescribed drugs;

(viii) ~~prosthetic~~Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(ix) ~~specialized~~Specialized laboratory services furnished away from the clinic;

(x) ~~inpatient~~Inpatient services;

(xi) ~~outpatient~~Outpatient hospital services~~.~~; and

(xii) Applied behavior analysis (ABA) [refer to OAC 317:30-3-65.12].

(xiii) Diabetes self-management training (DSMT) (refer to OAC 317:30-5-1080 - 1084).

(B) Payment is made directly to the RHC on an encounter basis for on-site dental services by a licensed dentist or optometric services by a licensed optometrist for members under ~~age 21~~the age of twenty-one (21). Encounters are billed as one (1) of the following:

(i) **EPSDT dental screening.** An EPSDT dental screening includes oral examination, prophylaxis and fluoride treatment, charting of needed treatment, and, if necessary, x-rays (including two bite wing films). This service must be filed on claim form ADM-36-D for EPSDT reporting purposes.

(ii) **Dental encounter.** A dental encounter consists of all dental treatment other than a dental screening. This service must be billed on the ADM-36-D.

(iii) **Visual analysis.** Visual analysis (initial or yearly) for a child with glasses, or a child who needs

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glasses, or a medical eye exam. This includes the refraction and medical eye health evaluation. Glasses must be billed separately. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(C) Services listed in ~~(a)~~(2)(A), (v)-(viii), of this Section, furnished on-site, require separate provider agreements with the ~~OHCA~~Oklahoma Health Care Authority (OHCA). Service item ~~(a)~~(2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

(D) Other ambulatory services provided off-site by independent practitioners (through subcontracting agreements or arrangements for services not available at the clinic) must be billed to the SoonerCare program by the provider rendering the service. Independent practitioners must meet provider eligibility criteria and must have a current contract with the OHCA.

**317:30-5-357. Coverage for children**

Coverage for rural health clinic (RHC) services and other ambulatory services for children include the same services as for adults in addition to the following:

(1) ~~The receipt of an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) examination by a Medicaid eligible individual under age 21 renders that individual child eligible for all necessary follow-up care, whether or not the medically necessary services are covered under the Medicaid.~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services are covered for eligible members under twenty-one (21) years of age in accordance with Oklahoma Administrative Code (OAC) 317:30-3-65. An EPSDT exam performed by ~~a~~an RHC must be billed on the appropriate claim form with the appropriate ~~Preventative Medicine~~preventive medicine procedure code from the Current Procedural Terminology ~~Manual~~ (CPT) manual. If an EPSDT screening is billed, ~~a~~an RHC encounter should not be billed on the same day. ~~Refer to OAC 317:30-3-47 through 317:30-3-54 for coverages under EPSDT).~~Refer to OAC 317:30-3-65 through 317:30-3-65.12.

(2) Under EPSDT, coverage is allowed for visual screenings and eyeglasses to correct visual defects. Payment is limited to two (2) glasses per year. Any glasses beyond this limit must be prior authorized and determined to be medically necessary.

(3) An EPSDT screening is considered a comprehensive

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examination. A provider billing the Medicaid program for an EPSDT ~~screen~~screening may not bill any other visits for that patient on that same day. It is expected that the screening provider will perform necessary treatment as part of the screening charge. Additional services such as tests, immunizations, etc., required at the time of screening may be billed independently from the screening.

(4) The administration fee for immunizations should be billed if provided at the same time as a scheduled EPSDT examination.

(5) Payment may be made directly to the RHC for the professional services of physician assistants performing EPSDT screenings within the certified RHC. The claim form must include the signature of the supervising physician.

## PART 37. ADVANCED PRACTICE REGISTERED NURSE

### 317:30-5-376. Coverage by category

Payment is made to ~~Advanced Practice Nurse~~advanced practice registered nurses as set forth in this Section.

(1) **Adults.** Payment for adults is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~an advanced practice registered nurse and within the scope of the Oklahoma Health Care Authority (OHCA) medical programs.

(2) **Children.** Payment for children is made for primary care health services, within the scope of practice of ~~Advanced Practice Nurse~~advanced practice registered nurse, to ~~children and adolescents under 21~~members under twenty-one (21) years of age, including ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) screening services~~ and within the scope of the Oklahoma Health Care Authority medical programs~~.

(A) Payment is made to eligible providers for ~~Early and Periodic Screening, Diagnosis and Treatment of individuals under age 21~~EPSDT services to members under twenty-one (21) years of age. Specific guidelines for the EPSDT program including the periodicity schedule are found in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-3-65 through ~~317:30-3-65.11~~317:30-3-65.12.

(B) Comprehensive screening examinations are to be performed by a provider qualified under State law to furnish primary health care services.

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

## PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

### 317:30-5-664.1. Provision of other health services outside of the



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**Health Center core services**

(a) If the Center chooses to provide other ~~SoonerCare~~Oklahoma Medicaid State Plan covered health services which are not included in the Health Center core service definition in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-661.1, the practitioners of those services are subject to the same program coverage limitations, enrollment, and billing procedures described by the OHCA, and these services (e.g., home health services) are not included in the PPS settlement methodology in OAC 317:30-5-664.12.

(b) Other medically necessary health services that will be reimbursed at the fee-for-service (FFS) rate include, but are not limited to:

(1) ~~dental~~Dental services (refer to OAC 317:30-5-696) except for primary preventive dental services;

(2) ~~eyeglasses (OAC 317:30-5-430 and OAC 317:30-5-450)~~Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);

(3) ~~clinical~~Clinical lab tests performed in the Center lab (other than the specific laboratory tests set out for Health Centers' certification and covered as Health Center services);

(4) ~~technical~~Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the Center physician is included as physician professional services);

(5) ~~durable~~Durable medical equipment (refer to OAC 317:30-5-210);

(6) ~~emergency ambulance transportation~~Transportation by ambulance (refer to OAC 317:30-5-335);

(7) ~~prescribed~~Prescribed drugs (refer to OAC 317:30-5-70);

(8) ~~prosthetic~~Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;

(9) ~~specialized~~Specialized laboratory services furnished away from the clinic;

(10) Psychosocial ~~Rehabilitation Services~~rehabilitation services ~~[refer to OAC 317:30-5-241.3]~~(refer to OAC 317:30-5-241.3);~~ and~~

(11) ~~behavioral~~Behavioral health related case management services (refer to OAC 317:30-5-241.6)~~.~~; and

(12) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12).

(13) Diabetes self-management training (DSMT) (refer to OAC 317:30-5-1080 through 317:30-5-1084).

**PART 108. NUTRITION SERVICES**

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**317:30-5-1076. Coverage by category**

Payment is made for ~~Nutritional Services~~nutritional services as set forth in this ~~section~~Section.

(1) **Adults.** Payment is made for six (6) hours of medically necessary nutritional counseling per year by a licensed registered dietician. All services must be prescribed by a physician, physician assistant (PA), advanced practice registered nurse (APRN), or certified nurse midwife (CNW), and be ~~face to face~~face-to-face encounters between a licensed registered dietitian and the member. Services must be expressly for diagnosing, treating or preventing, or minimizing the effects of illness. Nutritional services for the treatment of obesity is not covered unless there is documentation that the obesity is a contributing factor in another illness.

(2) **Children.** Payment is made for medically necessary nutritional counseling as described above for adults. Nutritional services for the treatment of obesity may be covered for children as part of the ~~EPSDT~~Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Additional services which are deemed medically necessary and allowable under federal regulations may be covered by the EPSDT benefit found at OAC 317:30-3-65 ~~and~~through ~~317:30-3-65.11~~317:30-3-65.12.

(3) **Home and ~~Community Based Waiver Services~~community-based services (HCBS) waiver for the ~~Intellectually Disabled~~intellectually disabled.** All providers participating in the ~~Home and Community Based Waiver Services~~HCBS waiver for the intellectually disabled program must have a separate contract with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) to provide ~~Nutrition Services~~nutrition services under this program. All services are specified in the individual's plan of care.

(4) **Individuals eligible for Part B of Medicare.** Payment is made utilizing the Medicaid allowable for comparable services. Services which are not covered under Medicare should be billed directly to OHCA.

(5) **Obstetrical patients.** Payment is made for a maximum of six (6) hours of medically necessary nutritional counseling per year by a licensed registered dietitian for members at risk for or those who have been recently diagnosed with gestational diabetes. The initial consultation may be in a group setting for a maximum of two (2) hours of class time. Thereafter, four (4) hours of nutritional counseling by a licensed registered dietitian may be provided to the individual if deemed medically necessary, which may include a post-partum visit, typically done at ~~6~~six (6) weeks after delivery. All services must be prescribed by a physician, ~~physician assistant, advanced~~

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~~practice nurse or a certified nurse midwife~~PA, APRN, or CNM and be face-to-face between a licensed registered dietitian and the member(s). Services must be solely for the prevention, diagnosis, or treatment of gestational diabetes.

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

### 317:30-5-1090. Provision of other health services outside of the I/T/U encounter

(a) Medically necessary SoonerCare covered services that are not included in the I/T/U outpatient encounter rate may be billed outside the encounter rate within the scope of the SoonerCare fee-for-service (FFS) contract. The services will be reimbursed at the ~~fee-for-service~~FFS rate, and will be subject to any limitations, restrictions, or prior authorization requirements. Examples of these services include, but are not limited to:

(1) ~~durable~~Durable medical equipment [refer to Oklahoma Administrative Code (OAC) 317:30-5-210];

(2) ~~glassese~~Eyeglasses (refer to OAC 317:30-5-431, 317:30-5-432.1 and 317:30-5-451);

(3) ~~ambulance~~Transportation by ambulance (refer to OAC 317:30-5-335);

(4) ~~home~~Home health ~~[refer to OAC 317:30-5-546]~~(refer to OAC 317:30-5-546);

(5) ~~inpatient~~Inpatient practitioner services (refer to OAC 317:30-5-1100);

(6) ~~non-emergency~~Non-emergency transportation ~~[refer to OAC 317:35-3-2]~~(refer to OAC 317:35-3-2);

(7) ~~behavioral~~Behavioral health case management ~~[refer to OAC 317:30-5-241.6]~~(refer to OAC 317:30-5-241.6);

(8) ~~psychosocial~~Psychosocial rehabilitative services ~~[refer to OAC 317:30-5-241.3]~~(refer to OAC 317:30-5-241.3); ~~and~~

(9) ~~psychiatric~~Psychiatric residential treatment facility services~~[refer to OAC 317:30-5, Part 6, Inpatient Psychiatric Hospitals].~~ (refer to OAC 317:30-5-95 through 317:30-5-97);

(10) Applied behavior analysis (ABA) (refer to OAC 317:30-3-65.12); and

(11) Diabetes self-management training (DSMT) (refer to OAC 317:30-5-1080 through 317:30-5-1084).

(b) If the I/T/U facility chooses to provide other ~~SoonerCare~~Oklahoma Medicaid State Plan covered health services which are not included in the I/T/U encounter definition, those service providers must be contracted with ~~OHCA~~the Oklahoma Health Care Authority (OHCA) and bill for those services under their assigned provider number consistent with program coverage

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limitations and billing procedures described by the OHCA.

## PART 112. PUBLIC HEALTH CLINIC SERVICES

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

CHD/CCHD service limitations are:

(1) Child~~ Guidance~~-guidance services ~~(see OAC 317:30-3-65 through OAC 317:30-3-5-65.11 for specifics regarding program requirements).~~(refer to Oklahoma Administrative Code (OAC)317:30-5-1023).

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

(3) Early and Periodic Screening, ~~Diagnosis,~~Diagnostic and Treatment (EPSDT) services ~~(including blood lead testing and follow-up services)~~, including blood lead testing and follow-up services (~~see~~refer to OAC 317:30-3-65 through ~~OAC 30-3-65.11~~317:30-3-65.12 for specific coverage).

(4) Environmental investigations.

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

(6) Immunizations (adult and child).

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

(8) Newborn hearing screening.

(9) Newborn metabolic screening.

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

(11) Public health nursing services.

(12) Tuberculosis case management and directly observed therapy.

(13) Laboratory services.

(14) Targeted case management.

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**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**
**CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY**

**SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN**

**PART 5. DETERMINATION OF ELIGIBILITY FOR SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN**

**317:35-6-45. Eligibility for inmates**

(a) The Oklahoma Health Care Authority (OHCA) shall receive applications from and make eligibility determinations for individuals residing in correctional institutions, including juvenile facilities. However, the SoonerCare program will only pay for services rendered to individuals residing in a correctional institution as specified in Oklahoma Administrative Code (OAC) 317:35-5-26.

(b) In accordance with federal law, including, but not limited to, 42 United States Code (U.S.C.) § 1396a(a)(84), individuals residing in correctional institutions who are under the age of twenty-one (21) or who meet the former foster care child requirements found at OAC 317:35-5-2, shall have their eligibility suspended for the duration of the incarceration period, except for periods of time that inpatient services are provided as specified in OAC 317:35-5-26.

(c) The effective date of the suspension is the calendar day following the date on which an individual described in (b) of this section becomes incarcerated.

(d) A redetermination of eligibility for an individual described in (b) of this section shall be conducted prior to release to determine if the individual continues to meet the eligibility requirements for SoonerCare. A new application will not be required to redetermine eligibility.

(e) Suspended eligibility shall be restored to the release date after a redetermination of eligibility, when:

(1) The Oklahoma Department of Human Services (DHS), using the release date supplied by the Oklahoma Office of Juvenile Affairs (OJA) or the Oklahoma Department of Corrections (DOC), removes the suspension;

(2) The individual reports his or her release to the Oklahoma Health Care Authority (OHCA) within ten (10) calendar days of the release date; or

(3) The individual reports his or her release to OHCA more than ten (10) calendar days from the release date, and there is good cause for the delay in reporting.

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

**SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES**

**PART 5. PHARMACIES**

**317:30-5-86. Drug Utilization Review (DUR) Program**

~~(a) OHCA is authorized by federal statute to conduct prospective and retrospective review of pharmacy claims to insure that prescriptions are:~~

~~(1) appropriate,~~

~~(2) medically necessary, and~~

~~(3) not likely to result in adverse medical results.~~

~~(b) OHCA is authorized to use this program to educate physicians, other prescribers, pharmacists, and patients and also to conserve program funds and personal expenditures and prevent fraud, abuse and misuse of prescriptions.~~

~~(c) OHCA utilizes a DUR Board managed by an outside contractor to review and analyze clinical and economic data available. The DUR Board reviews and makes recommendations based on predetermined standards submitted to them by the OHCA contractor(s) and, in concert with the retrospective review of claims data, makes recommendations for educational interventions, prospective DUR and the prior authorization process.~~

(a) The Oklahoma Health Care Authority (OHCA) Drug Utilization Review (DUR) program is authorized by regulations contained in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90) to conduct prospective and retrospective review of pharmacy claims to ensure that prescriptions are:

(1) Appropriate;

(2) Medically necessary; and

(3) Not likely to result in adverse medical results.

(b) The OHCA is authorized to use this program to educate physicians, other prescribers, pharmacists, and patients and also to conserve program funds and personal expenditures and prevent fraud, abuse, and misuse of prescriptions.

(c) The OHCA utilizes a DUR Board managed by an outside contractor to review and analyze clinical and economic data available. The DUR Board reviews and makes recommendations based on predetermined standards submitted to it by the OHCA contractor(s) and, in concert with the retrospective review of claims data, makes recommendations for educational interventions, prospective DUR, and the prior authorization process.

(d) The DUR Board assesses data on drug use in accordance with predetermined standards, including, but not limited to:

(1) Monitoring for therapeutic appropriateness;

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(2) Overutilization and underutilization;
(3) Appropriate use of generic products;
(4) Therapeutic duplication;
(5) Drug-disease contraindications;
(6) Drug-drug interaction;
(7) Incorrect drug dosage or duration of drug treatment; and
(8) Clinical abuse or misuse.

(e) The DUR Board is comprised of ten (10) members that are appointed according to 63 O.S. § 5030.1. DUR Board members with a conflict of interest with respect to OHCA, Medicaid members, and/or pharmaceutical manufacturers must recuse themselves/abstain from voting on any DUR actions related to the conflict of interest.

(f) The DUR program shall adhere to the provisions of Section 1396a(oo) of Title 42 of the United States Code.

(1) The OHCA has implemented the following claims review requirements:

(A) Opioid safety edits at the point-of-sale, including, but not limited to, day supply, early refills, duplicate fills, quantity limitations, and maximum daily morphine milligram equivalent (MME) safety edits. MME safety edits will automatically decline reimbursement of prescription drugs that exceed an established daily MME limit.

(B) Claims review automated process that monitors concurrent use of opioid(s) with benzodiazepine(s) and/or antipsychotic(s).

(C) The prescriptions in (A) and (B) may be reimbursed upon a showing of medical necessity, as evidenced by a prior authorization approved by OHCA or its designee or contractor.

(2) The OHCA has implemented a program to monitor the appropriate use of antipsychotic prescribing for children/adolescents. The OHCA, or its contractor or designee, regularly reviews a sample of all antipsychotics prescribed to members aged eighteen (18) and younger, including, but not limited to, foster children, that were reimbursed by Medicaid, for safety and appropriate utilization.

(3) The OHCA has implemented a process to identify potential fraud or abuse of controlled substances by members, pharmacies, and prescribing clinicians.

(g) All prescribing clinicians and/or pharmacists shall adhere to appropriate prescribing practices that are consistent with state and federal regulations or may be subject to agency review processes, audits, recoupment, and/or termination of Medicaid contracts [refer to the Oklahoma Administrative Code (OAC), including, but not limited to, 317:30-3-2.1, 317:30-3-19.5, 317:30-3-33, and 317:30-5-70.1].

**TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY**

**CHAPTER 2. GRIEVANCE PROCEDURES AND PROCESS**

**317:2-1-2. Appeals**

(a) **Request for ~~Appeal~~appeals.**

(1) For the purpose of calculating the timeframe for requesting an administrative appeal of an agency action, the date on the written notice shall not be included. The last day of the ~~thirty-day (30-day)~~thirty (30) day timeframe shall be included, unless it is a legal holiday as defined by Title 25 of the Oklahoma Statutes (O.S.) ~~'~~ Section (§) 82.1, or any other day the Oklahoma Health Care Authority (OHCA) is closed or closes early, in which case, the timeframe runs until the close of the next full business day.

(2) An appeals request that an aggrieved member or provider sends via mail is deemed filed on the date that the agency receives it.

(b) **Member ~~Process Overview~~process overview.**

(1) The appeals process allows a member to appeal a decision relating to program benefits. Examples are decisions involving medical services, prior authorizations for medical services, or discrimination complaints.

(2) In order to initiate an appeal, the member must file a LD-1 (Member Complaint/Grievance Form) within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with Oklahoma Administrative Code (OAC) 317:2-1-2(a), above, or, in matters in which a formal notice is not sent by the agency, within thirty (30) days of the date on which the member knew or should have known the facts or circumstances serving as the basis for appeal.

(3) If the LD-1 form is not received timely, the ~~Administrative Law Judge~~administrative law judge (ALJ) will cause to be issued a letter stating the appeal will not be heard. In the case of tax warrant intercept appeals, if the LD-1 form is not received by OHCA within the timeframe pursuant to 68 O.S. ' 205.2, OHCA similarly will cause to be issued a letter stating the appeal will not be heard because it is untimely.

(4) If the LD-1 form is not completely filled out or if necessary documentation is not included, then the appeal will not be heard.

(5) OHCA will advise members that if assistance is needed in reading or completing the grievance form, arrangements will be made to provide such assistance.

(6) Upon receipt of the member's appeal, a fair hearing before the ALJ will be scheduled. The member will be notified in writing of the date and time of the hearing. The member must appear at the hearing, either in person or telephonically.

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Requests for a telephone hearing must be received in writing on OHCA's LD-4_(Request for Telephonic Hearing) form no later than ten (10) calendar days prior to the scheduled hearing date. Telephonic hearing requests will only be granted by the OHCA's ~~Chief Executive Officer~~chief executive officer (CEO) or his/her designee, at his/her sole discretion, for good cause shown, including, for example, the member's physical condition, travel distances, or other limitations that either preclude an in-person appearance or would impose a substantial hardship on the member.

(7) The hearing shall be conducted according to OAC 317:2-1-5. The ALJ's decision may be appealed to the CEO of the OHCA, which is a record review at which the parties do not appear (OAC 317:2-1-13).

(8) Member appeals are ordinarily decided within ninety (90) days from the date on which the member's timely request for a fair hearing is received, unless~~, in accordance with Section 431.244(f) of Title 42 of the Code of Federal Regulations~~:

(A) The ~~Appellant~~appellant was granted an expedited appeal pursuant to OAC 317:2-1-2.5;

(B) The OHCA cannot reach a decision because the ~~Appellant~~appellant requests a delay or fails to take a required action, as reflected in the record;~~ or~~

(C) There is an administrative or other emergency beyond OHCA's control, as reflected in the record~~.~~; or

(D) The appellant filed a request for an appeal of a denied step therapy exception request, pursuant to OAC 317:2-1-18.

(9) Tax warrant intercept appeals will be heard directly by the ALJ. A decision is normally rendered by the ALJ within twenty (20) days of the hearing before the ALJ.

(c) **Provider ~~Process Overview~~process overview**.

(1) The proceedings as described in this subsection contain the hearing process for those appeals filed by providers. These appeals encompass all subject matter cases contained in OAC 317:2-1-2(d)(2).

(2) All provider appeals are initially heard by the OHCA ALJ under OAC 317:2-1-2(d)(2).

(A) In order to initiate an appeal, a provider must file the appropriate LD form within thirty (30) calendar days of the date the OHCA sends written notice of its action, in accordance with OAC 317:2-1-2(a), above. LD-2 forms should be used for Program Integrity audit appeals; LD-3 forms are to be used for all other provider appeals.

(B) Except for OHCA Program Integrity audit appeals, if the appropriate LD form is not received timely, the ALJ will cause a letter to be issued stating that the appeal will not be heard.

(C) A decision ordinarily will be issued by the ALJ within

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forty-five (45) days of the close of all evidence in the appeal.

(D) Unless otherwise limited by OAC 317:2-1-7 or 317:2-1-13, the ALJ's decision is appealable to OHCA's CEO.

(d) **ALJ jurisdiction.** The ALJ has jurisdiction of the following matters:

(1) **Member ~~Appeals~~appeals.**

(A) Discrimination complaints regarding the SoonerCare program;

(B) Appeals which relate to the scope of services, covered services, complaints regarding service or care, enrollment, disenrollment, and reenrollment in the SoonerCare Program;

(C) ~~Fee for Service~~Fee-for-service appeals regarding the furnishing of services, including prior authorizations;

(D) Appeals which relate to the tax warrant intercept system through the OHCA. Tax warrant intercept appeals will be heard directly by the ALJ. A decision will be rendered by the ALJ within twenty (20) days of the hearing;

(E) Proposed administrative sanction appeals pursuant to OAC 317:35-13-7. Proposed administrative sanction appeals will be heard directly by the ALJ. A decision by the ALJ will ordinarily be rendered within twenty (20) days of the hearing before the ALJ. This is the final and only appeals process for proposed administrative sanctions;

(F) Appeals which relate to eligibility determinations made by OHCA; and

(G) Appeals of insureds participating in Insure Oklahoma which are authorized by OAC 317:45-9-8~~.~~; and

(H) Appeals which relate to a requested step therapy protocol exception as provided by 63 O.S. § 7310.

(2) **Provider ~~Appeals~~appeals.**

(A) Whether Pre-admission Screening and Resident Review (PASRR) was completed as required by law;

(B) Denial of request to disenroll member from provider's SoonerCare Choice panel;

(C) Appeals by ~~Long Term Care~~long-term care facilities for administrative penalty determinations as a result of findings made under OAC 317:30-5-131.2(b)(5)(B) and (d)(8);

(D) Appeals of Professional Service Contract awards and other matters related to the Central Purchasing Act pursuant to Title 74 O.S. ' 85.1 et seq.;

(E) Drug rebate appeals;

(F) Provider appeals of OHCA Program Integrity audit findings pursuant to OAC 317:2-1-7. This is the final and only appeals process for appeals of OHCA Program Integrity audit findings;

(G) Oklahoma Electronic Health Records Incentive program appeals related only to incentive payments, incentive

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payment amounts, provider eligibility determinations, and demonstration of adopting, implementing, upgrading, and meaningful use eligibility for incentives;

(H) Supplemental Hospital Offset Payment Program (SHOPP) annual assessment, Supplemental Payment, fees or penalties as specifically provided in OAC 317:2-1-15; and

(I) The Nursing Facility Supplemental Payment Program (NFSPP) and its issues consisting of the amount of each component of the Intergovernmental transfer, the Upper Payment Limit payment, the Upper Payment Limit gap, and the penalties specifically provided in OAC 317:30-5-136. This is the final and only process for appeals regarding NFSPP.

(J) Appeals from any adjustment made to a long-term care facility's cost report pursuant to OAC 317:30-5-132, including any appeal following a request for reconsideration made pursuant to OAC 317:30-5-132.1.

**317:2-1-6. Other grievance procedures and processes [REVOKED]**

~~Other grievance procedures and processes include those set out in Oklahoma Administrative Code (OAC) 317:2-1-7 (Program Integrity Audit Appeals); OAC 317:2-1-9 (OHCA's Designated Agent's Appeal Process for QIO Services); OAC 317:2-1-10 (Drug Rebate Appeal Process); OAC 317:2-1-11 [Medicaid Drug Utilization Review Board (DUR) Appeal Process]; OAC 317:2-1-12 (For Cause and Immediate Provider Contract Termination Appeals Process); OAC 317:2-1-14 (Contract Award Protest Process); and OAC 317:2-1-15 (Supplemental Hospital Offset Payment Program (SHOPP) Appeals).~~

**317:2-1-13. Appeal to the ~~Chief Executive Officer~~chief executive officer**

(a) The Oklahoma Health Care Authority offers approximately forty (40) different types of administrative appeals. Some of the appeals are appealable to the ~~Chief Executive Officer~~chief executive officer (CEO) and some are not. The following appeals may be heard by the CEO following the decision of an ~~Administrative Law Judge~~administrative law judge:

(1) Appeals under Oklahoma Administrative Code (OAC) 317:2-1-2(d)(1)(A) to (d)(1)~~(G)~~(H), with the exception of subsection (d)(1)(E);

(2) Appeals under OAC 317:2-1-2(d)(2)(A) to (d)(2)(I), with the exceptions of subsections (d)(2)(F) and (G); and

(3) Appeals under 317:2-1-10.

(b) Appeals to the CEO must be filed with the OHCA within thirty (30) days of the date of the Order, or decision by OHCA.

(c) No new evidence may be presented to the CEO.

(d) Appeals to the CEO under (a) of this Section may be filed by the provider, member, or agency. The CEO will ordinarily render decisions within sixty (60) days of the receipt of the appeal.



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**317:2-1-18. Step therapy protocol exception appeals**

This rule describes a member's rights to administratively appeal the denial of a requested exception to a step therapy protocol, in accordance with Title 63 of the Oklahoma Statutes (O.S.) ' 7310 and Oklahoma Administrative Code (OAC) 317:30-5-77.4.

(1) Appeals will be heard by the Oklahoma Health Care Authority (OHCA) administrative law judge (ALJ).

(2) Appeals must be filed by the member within thirty (30) days of the date of the denial of a requested exception. Appeals must be filed electronically using a form LD-5 and must set forth the basis for the appeal. The form LD-5 shall be made available on the OHCA's public website. If the LD-5 is not completely filled out or if necessary documentation is not included, the appeal will not be considered.

(3) Appeals shall be heard at a time and place and in a manner as may be decided by the ALJ. Hearings may be conducted telephonically.

(4) The docket clerk will send the member or his/her authorized representative an electronic notice setting forth the location, date, and time of the hearing.

(5) A member can waive the right to an evidentiary hearing and permit the ALJ to consider and rule on the appeal based upon the parties' submissions.

(6) The member shall have the burden of proof by the preponderance of the evidence standard as defined by the Oklahoma Supreme Court.

(7) Absent exigent circumstances, as defined in OAC 317:30-5-77.4(a), the ALJ shall respond to any request for appeal within seventy-two (72) hours of receipt of the request. In the case of exigent circumstances, the ALJ shall respond within twenty-four (24) hours of receipt. Provided, however, that if the timeframe for response ends on a weekend, or on any other day the OHCA is closed or closes early, including, but not limited to, legal holidays as defined by 25 O.S. § 82.1, the timeframe for response shall run until the close of the next full business day. An appeal request that is not responded to within this timeframe shall be deemed granted.

(8) All orders shall be considered non-precedential decisions.

(9) The hearing shall be digitally recorded.

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

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

## PART 5. PHARMACIES

### 317:30-5-77.2. Prior authorization

(a) **Definition.** The term prior authorization in pharmacy means an approval for payment by ~~OHCA~~the Oklahoma Health Care Authority (OHCA) to the pharmacy before a prescription is dispensed by the pharmacy. An updated list of all products requiring prior authorization is available at the agency's website.

(b) **Process.** Because of the required interaction between a prescribing provider (such as a physician) and a pharmacist to receive a prior authorization, OHCA allows a pharmacist up to thirty (30) calendar days from the point of sale notification to provide the data necessary for OHCA to make a decision regarding prior authorization. Should a pharmacist fill a prescription prior to the actual authorization he/she takes a business risk that payment for filling the prescription will be denied. In the case that information regarding the prior authorization is not provided within the thirty (30) days, claims will be denied.

(c) **Documentation.** Prior authorization petitions with clinical exceptions must be mailed or faxed to the Medication Authorization Unit of OHCA's contracted prior authorization processor. Other authorization petitions, claims processing questions and questions pertaining to ~~DUR~~Drug Utilization Review (DUR) alerts must be addressed by contacting the pharmacy help desk. Authorization petitions with complete information are reviewed and a response returned to the dispensing pharmacy within twenty-four (24) hours. Petitions and other claim forms are available on the OHCA public website.

(d) **Emergencies.** In an emergency situation, the OHCA will authorize a seventy-two (72) hour supply of medications to a member. The authorization for a seventy-two (72) hour emergency supply of medications does not count against the SoonerCare limit described in OAC 317:30-5-72(a)(1).

(e) **Utilization and scope.** There are three (3) reasons for the use of prior authorization: utilization controls, scope controls and product based controls. ~~Product based prior authorizations is~~ Product-based prior authorizations, including step therapy protocols as defined by Title 63 of the Oklahoma Statutes (O.S.) ' 7310(A)(4), are covered in OAC 317:30-5-77.3. The ~~Drug Utilization Review~~DUR Board recommends the approved clinical criteria and any restrictions or limitations.

(1) **Utilization controls.** Prior authorizations that fall under this category generally apply to the quantity of medication or

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duration of therapy approved.

(2) **Scope controls.** Scope controls are used to ensure a drug is used for an approved indication and is clinically appropriate, medically necessary and cost effective.

(A) Medications which have been approved by the FDA for multiple indications may be subject to a scope-based prior authorization when at least one (1) of the approved indications places that drug into a therapeutic category or treatment class for which a prior authorization is required. Prior authorizations for these drugs may be structured as step therapy or a tiered approach as recommended by the ~~Drug Utilization Review~~DUR Board and approved by the OHCA~~ Board of Directors~~.

(B) Prior authorization may be required to assure compliance with FDA approved and/or medically accepted indications, dosage, duration of therapy, quantity, or other appropriate use criteria including pharmacoeconomic consideration.

(C) Prior authorization may be required for certain non-standard dosage forms of medications when the drug is available in standard dosage forms.

(D) Prior authorization may be required for certain compounded prescriptions if the allowable cost exceeds a predetermined limit as published on the agency's website.

**317:30-5-77.3. ~~Product-Based Prior Authorization~~Product-based prior authorization (PBPA)**

~~The Oklahoma Health Care Authority utilizes a prior authorization system subject to their authority under 42 U.S.C. 1396r-8 and 63 O.S. 5030.3(B). The prior authorization program is not a drug formulary which is separately authorized in 42 U.S.C 1396r-8. Drugs are placed into two or more tiers based on similarities in clinical efficacy, side-effect profile and cost-effectiveness after recommendation by the Drug Utilization Review Board and approved by the OHCA Board of Directors. Drugs placed in tier number one generally require no prior authorization. Drugs placed in any tier other than tier number one may require prior authorization.~~

~~(1) Three general exceptions exist to the requirement of prior authorization:~~

~~(A) inadequate response to one or more tier one products,~~

~~(B) a clinical exception for a certain product in the particular therapeutic category, or~~

~~(C) the manufacturer or labeler of a product may opt to participate in the state supplemental drug rebate program to move a product from a higher tier to a lower tier which will remove or reduce the prior authorization requirement for that product.~~

~~(i) After a drug or drug category has been added to the~~

~~Prior Authorization program, OHCA or its contractor may establish a cost-effective benchmark value for each therapeutic category or individual drug. The benchmark value may be calculated based on an average cost, an average cost per day, a weighted average cost per day or any other generally accepted economic formula. A single formula for all drugs or drug categories is not required. Supplemental rebate offers from manufacturers which are greater than the minimum required supplemental rebate will be accepted and may establish a new benchmark rebate value for the category.~~

~~(ii) Manufacturers of products assigned to tiers number two and higher may choose to pay a supplemental rebate to the state in order to remove or reduce a prior authorization requirement on their product or products assigned to the higher tier.~~

~~(iii) Supplemental rebate agreements shall be in effect for one year and may be terminated at the option of either party with a 60 day notice. Supplemental rebate agreements are subject to the approval of CMS. Termination of a Supplemental Rebate agreement will result in the specific product reverting to the previously assigned higher tier in the PBPA program.~~

~~(iv) The supplemental unit rebate amount for a tier two or higher product will be calculated by subtracting the federal rebate amount per unit from the benchmark rebate amount per unit.~~

~~(v) Supplemental rebates will be invoiced concurrent with the federal rebates and are subject to the same terms with respect to payment due dates, interest, and penalties for non-payment as specified at 42 U.S.C. Section 1396r-8. All terms and conditions not specifically listed in federal or state law shall be included in the supplemental rebate agreement as approved by CMS.~~

~~(vi) Drugs or drug categories which are not part of the Product Based Prior Authorization program as outlined in 63 O.S. Section 5030.5 may be eligible for supplemental rebate participation. The OHCA Drug Utilization Review Board shall recommend supplemental rebate eligibility for drugs or drug categories after considering clinical efficacy, side effect profile, cost-effectiveness and other applicable criteria.~~

~~(2) All clinical exceptions are recommended by the Drug Utilization Review Board and demonstrated by documentation sent by the prescribing physician and/or pharmacist.~~

The Oklahoma Health Care Authority (OHCA) utilizes a PBPA system pursuant to its authority under 42 United States Code (U.S.C.)

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Section 1396r-8 and Title 63 of the Oklahoma Statutes (O.S.) § 5030.3(A). The PBPA program, which includes step therapy protocols as defined in 63 O.S. § 7310(A)(4), is not a drug formulary, which is separately authorized in 42 U.S.C. § 1396r-8. In the PBPA system, drugs are placed into two (2) or more tiers based on similarities in clinical efficacy, side-effect profile, and cost-effectiveness, after recommendation by the Drug Utilization Review (DUR) Board and approval by the OHCA Board. Drugs placed in tier one (1) generally require no prior authorization; however, drugs placed in any tier may be subject to prior authorization.

(1) Exceptions to the requirement of prior authorization shall be granted based upon a properly-supported justification submitted by the prescribing provider demonstrating one (1) or more of the bases for exception identified in Oklahoma Administrative Code (OAC) 317:30-5-77.4(b)(3).

(2) The manufacturer or labeler of a product may opt to participate in the state supplemental drug rebate program to move a product from a higher tier to a lower tier which will remove or reduce the prior authorization requirement for that product. Supplemental rebate negotiations are done through Sovereign States Drug Consortium (SSDC); a multi-state purchasing pool.

(A) Supplemental rebate agreements shall be in effect for one (1) year and may be terminated at the option of either party with a sixty (60) day notice. Supplemental rebate agreements are subject to the approval of the Centers for Medicare and Medicaid Services (CMS). Termination of a supplemental rebate agreement will result in the specific product reverting to the previously assigned higher tier in the PBPA program.

(B) Drugs or drug categories which are not part of the PBPA program as outlined in 63 O.S. § 5030.5 may be eligible for supplemental rebate participation. The OHCA DUR Board may recommend supplemental rebate eligibility for drugs or drug categories after considering clinical efficacy, side effect profile, cost-effectiveness, and other applicable criteria.

**317:30-5-77.4. Step therapy exception process**

(a) **Definitions.**

(1) **"Exigent circumstances"** means circumstances in which a delay in receiving a prescription drug will jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.

(2) **"Step therapy"** or **"step therapy protocol"** means a protocol or program that establishes a specific sequence in which prescription drugs for a specified medical condition that are medically appropriate for a particular patient are covered by Medicaid. Step therapy protocols are based upon the



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recommendation of the Drug Utilization Review (DUR) Board, as approved by the Oklahoma Health Care Authority (OHCA) Board.

(3) A **"step therapy exception"** means the process by which a step therapy protocol is overridden in favor of immediate coverage of a SoonerCare provider's selected prescription drug.

(b) **Process.** The step therapy exception process shall be initiated by a SoonerCare provider on behalf of a SoonerCare member. An exception can be requested following a denial of a prior authorization request for the specified prescription drug(s), or can be requested at the outset. In either case, the provider shall:

(1) Submit the exception request using the step therapy exception request form, which is available on the OHCA website and/or provider portal; and

(2) Submit with the step therapy exception request form, documentation or other information adequate to support the medical necessity for overriding the otherwise-applicable step therapy protocol for the particular prescription drug.

(3) A properly-supported step therapy exception request will be granted if it demonstrates that any of the following circumstances exists:

(A) The required prescription drug is contraindicated or will likely cause an adverse reaction or physical or mental harm to the patient;

(B) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug;

(C) The patient has tried the required prescription drug while under the patient's current or a previous health insurance plan and such prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event;

(D) The required prescription drug is not in the best interest of the patient, based on medical necessity; or

(E) The patient is stable on a prescription drug selected by the patient's healthcare provider for the medical condition under consideration while on the patient's current or a previous health insurance plan.

(4) The OHCA or its contractor or designee may request additional information that is reasonably necessary to determine whether a step therapy exception request should be granted, as provided by Oklahoma law.

(c) **Notification.**

(1) The OHCA or its contractor or designee shall respond to any step therapy exception request within seventy-two (72) hours of the submission of a completed and properly-supported request. For exigent circumstances, the OHCA shall respond to the exception request within twenty-four (24) hours of receipt.

Provided, however, that if the timeframe for response ends on a weekend, or on any other day the OHCA is closed or closes early, including, but not limited to, legal holidays as defined by 25 O.S. § 82.1, the timeframe for response shall run until the close of the next full business day. Any exception request not responded to within this timeframe shall be deemed granted.

(2) The OHCA shall respond to a request for a step therapy exception by:

(A) Notifying the provider that the request is approved;

(B) Notifying the provider that the request is not approved based on medical necessity;

(C) Notifying the provider that the medical necessity of the requested exception cannot be approved or denied as a result of missing or incomplete documentation or information necessary to approve or disapprove the request;

(D) Notifying the provider that the member is no longer eligible for coverage; or

(E) Notifying the provider that the step therapy exemption request cannot be processed because it was not properly submitted using the required form.

(3) The rejection of a step therapy exception request based upon missing or incomplete documentation or other information, or because it was not properly submitted using the required form is not a denial, and shall not be subject to further appeal. It must, instead, be resubmitted as a new request for exception pursuant to this rule before it will be considered for approval.

(d) **Appeal.** If a step therapy exception request is denied, an appeal may be initiated by the member within thirty (30) days of the denial pursuant to Oklahoma Administrative Code (OAC) 317:2-1-18.

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

## SUBCHAPTER 3. GENERAL PROVIDER POLICIES

## PART 1. GENERAL SCOPE AND ADMINISTRATION

### 317:30-3-5. Assignment and ~~Cost Sharing~~cost sharing

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

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

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

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

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

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

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

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

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required to suspend further payment to the provider.

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

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

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

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

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

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

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

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

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

(D) ~~Native Americans providing documentation of ethnicity in accordance with OAC 317:35-5-25 who receive items and services furnished by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services~~American

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Indian and Alaska Native members, as is established in the federally-approved Oklahoma Medicaid State Plan.

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

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

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

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

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

(C) Services furnished to pregnant women, if those services relate to the pregnancy or to any other medical condition which may complicate the pregnancy, including prenatal vitamins.

(D) Smoking and ~~Tobacco Cessation~~tobacco cessation counseling and products.

(E) ~~Diabetic supplies.~~Blood glucose testing supplies and insulin syringes.

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

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

(A) Inpatient hospital stays.

(B) Outpatient hospital visits.

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

(D) Encounters with the following rendering providers:

(i) Physicians~~,~~;

(ii) Advanced ~~Practice Nurses,~~practice registered nurses;

(iii) Physician ~~Assistants,~~assistants;

(iv) Optometrists~~,~~;

(v) Home ~~Health Agencies,~~health agencies;

(vi) Certified ~~Registered Nurse Anesthetists,~~registered nurse anesthetists;

(vii) Anesthesiologist ~~Assistants,~~assistants;

(viii) Durable ~~Medical Equipment~~medical equipment providers~~,~~; and

(ix) Outpatient behavioral health providers.

(E) Prescription drugs.

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

(4) Medicaid premiums and cost sharing incurred by all individuals in the Medicaid household may not exceed an

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aggregate limit of five percent (5%) of the family's income applied on a monthly basis, as specified by the agency.

## SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES
## PART 5. PHARMACIES

### 317:30-5-72. Categories of service eligibility

(a) **Coverage for adults.** Prescription drugs for categorically needy adults are covered as set forth in this subsection.

(1) With the exception of (2) and (3) of this subsection, categorically needy adults are eligible for a maximum of six (6) covered prescriptions per month with a limit of two (2) brand name prescriptions. A prior authorization may be granted for a third brand name if determined to be medically necessary by OHCA and if the member has not already utilized their six (6) covered prescriptions for the month.

(2) Subject to the limitations set forth in ~~OAC~~Oklahoma Administrative Code (OAC) 317:30-5-72.1, 317:30-5-77.2, and 317:30-5-77.3, exceptions to the six (6) medically necessary prescriptions per month limit are:

(A) ~~unlimited~~Unlimited monthly medically necessary prescriptions for categorically related individuals who are residents of nursing facilities (NF) or ~~ICF/IID~~ intermediate care facilities for individuals with an intellectual disability (ICF/IID); and

(B) ~~seven~~Seven (7) additional medically necessary prescriptions which are generic products per month to the six (6) covered under the State Plan ~~(including three (3) brand name prescriptions)~~[including three (3) brand name prescription] are allowed for adults receiving services under the 1915(c) ~~HCBS Waivers~~Home and Community-Based Services (HCBS) waivers. Medically necessary prescriptions beyond the three (3) brand name or thirteen (13) total prescriptions will be covered with prior authorization.

(3) ~~Drugs exempt from the prescription limit include: Antineoplastics, anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV), certain prescriptions that require frequent laboratory monitoring, birth control prescriptions, over the counter contraceptives, hemophilia drugs, compensable smoking cessation products, naloxone for use in opioid overdose, certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.), and drugs used for the treatment of tuberculosis. For purposes of this Section, exclusion from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed~~

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~~per month.~~For purposes of this Section, exempt from the prescription limit means claims filed for any of these prescriptions will not count toward the prescriptions allowed per month. Drugs exempt from the prescription limit include:

(A) Antineoplastics;

(B) Anti-retroviral agents for persons diagnosed with Acquired Immune Deficiency Syndrome (AIDS) or who have tested positive for the Human Immunodeficiency Virus (HIV);

(C) Frequently monitored prescription drugs. A complete list of the selected drugs considered as frequently monitored can be viewed on the agency's website at www.okhca.org.

(D) Medication-assisted treatment (MAT) drugs for opioid use disorder;

(E) Contraceptives;

(F) Hemophilia drugs;

(G) Compensable smoking cessation products;

(H) Naloxone for use in opioid overdose;

(I) Certain carrier or diluent solutions used in compounds (i.e. sodium chloride, sterile water, etc.);

(J) Drugs used for the treatment of tuberculosis; and

(K) Prenatal vitamins.

(4) When a brand drug is preferred over its generic equivalent due to lower net cost, that drug shall not count toward the brand limit; however, it will count toward the monthly prescription limit.

(b) **Coverage for children.** Prescription drugs for SoonerCare eligible individuals under twenty-one (21) years of age are not limited in number per month, but may be subject to prior authorization, quantity limits or other restrictions.

(c) **Individuals eligible for Part B of Medicare.** Individuals eligible for Part B of Medicare are also eligible for the Medicare Part D prescription drug benefit. Coordination of benefits between Medicare Part B and Medicare Part D is the responsibility of the pharmacy provider. The SoonerCare pharmacy benefit does not include any products which are available through either Part B or Part D of Medicare.

(d) **Individuals eligible for a prescription drug benefit through a Prescription Drug Plan (PDP) or Medicare Advantage - Prescription Drug (MA-PD) plan as described in the Medicare Modernization Act (MMA) of 2003.** Individuals who qualify for enrollment in a PDP or MA-PD are specifically excluded from coverage under the SoonerCare pharmacy benefit. This exclusion applies to these individuals in any situation which results in a loss of Federal Financial Participation for the SoonerCare program. This exclusion shall not apply to items covered at OAC 317:30-5-72.1(2) unless those items are required to be covered by the prescription drug provider in the MMA or subsequent federal action.

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**317:30-5-77.1. Dispensing Quantity**

(a) Prescription quantities ~~are to~~ shall be limited to a ~~34~~thirty-four (34) day supply, except in the following situations:

(1) The Drug Utilization Review (DUR) Board has recommended a different day supply or quantity limit based on published medical data, including the manufacturer's package insert~~, provided the Chief Executive Officer of the OHCA has approved the recommendation~~;

(2) The product is included on the Maintenance List of medications, which are ~~exempt~~exempted from this limit, and may be dispensed up to ~~100 units~~a ninety (90) day supply;

(3) The manufacturer of the drug recommends a dispensing quantity less than a ~~34~~thirty-four (34) day supply;

(b) Refills are to be provided only if authorized by the prescriber, allowed by law, and should be in accordance with the ~~best~~current medical and pharmacological practices. A provider may not generate automated refills unless the member has specifically requested such service. Documentation of this request must be available for review by OHCA auditors.

(c) The ~~Drug Utilization Review~~DUR Board shall develop a Maintenance List of medications which are used in general practice on a continuing basis. These drugs shall be made available through the ~~vendor drug program~~Vendor Drug Program in quantities up to ~~100 units~~a ninety (90) day supply when approved by the prescriber. The ~~Drug Utilization Review~~DUR Board shall review the Maintenance List at least annually.~~ The Maintenance List shall be approved by the Chief Executive Officer of OHCA.~~ When approved by the prescriber, all maintenance medications must be filled at the maximum quantity allowed after a sufficient stabilization period when dispensed to SoonerCare members who do not reside in a ~~long term~~long-term care facility. For members residing in a ~~long term~~long-term care facility, chronic medications, including all products on the Maintenance List, must be dispensed in quantities of not less than a ~~28~~twenty-eight (28) day supply.

(d) For products covered by the Oklahoma Vendor Drug Program, the metric quantity shown on the claim form must be in agreement with the descriptive unit of measure applicable to the specific ~~NDC~~National Drug Code (NDC). Only numeric characters should be entered. Designations, such as the form of drug, i.e., ~~Tabs, Caps, Suppositories,~~tabs, caps, suppositories, etc., must not be used. Products should be billed in a manner consistent with quantity measurements.

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