OKLAHOMA HEALTH CARE AUTHORITY
SPECIAL BOARD MEETING
November 20, 2019 at 1:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd. OKC, OK

A G E N D A

1. Call to Order / Determination of Quorum……Stan Hupfeld, Chair

2. Public Comment……....Stan Hupfeld, Chair

3. Consent Agenda……..Stan Hupfeld, Chair

    a) Approval of the September 18, 2019 OHCA Board Meeting Minutes
    b) Approval of Expenditure of Funds Contracts
        i. Asset Verification System Services
        ii. Independent Verification & Validation
        iii. Medicaid Consulting Services
        iv. Medicaid Information Technology Architecture RFP
        v. Information Technology Consulting Contract
        vi. Sickle Cell Disease Consulting
        vii. Health Information Exchange Contract Increase
        viii. Ground Emergency Medical Transportation
        ix. PeopleSoft Statewide Contract

4. Chief Executive Officer's Report…….Kevin Corbett, Chief Executive Officer

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

6. Chief Operating Officer's Report…….Melody Anthony, Chief Operating Officer
   State Medicaid Director

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

8. Discussion of Report from the Administrative……..……..……..Jean Hausheer, MD
   Rules Advisory Committee and Possible Action Chair, Administrative Rules Advisory Committee
   Regarding Agency Rulemaking (Attachment "A")

    a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the Promulgation of the **Emergency Rules** in Attachment "A" in Accordance with 75 O.S. § 253.

    b) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. OHCA Requests the Adoption of the Following Emergency Rules (see Attachment "A"):

        i. Registered Behavior Technicians (RBT) as Qualifed Providers of Applied Behavior Analysis Services: ADDING agency rules at ***Oklahoma Administrative Code* (*OAC) 317:30-3-65.12*** and AMENDING agency rules at ***OAC 317:30-5-355.1, 317:30-5-357, 317:30-5-376, 317:30-5-664.1, 317:30-5-1076, 317:30-5-1090 and 317:30-5-1154***
        ii. Diabetes Self-Management Training (DSMT) Services: AMENDING agency rules at ***OAC 317:30-5-42.1*** and ADDING agency rules at ***OAC 317:30-5-1080 through 317:30-5-1084***

iii. Suspension of Eligibility During Incarceration for Specific Medicaid Populations, as Required by Federal Law: ADDING agency rules at ***OAC 317:35-6-45***

iv. Newly Required Drug Utilization Review Board (DUR) Activities To Better Monitor Opioid Prescription and Dispensation: AMENDING agency rules at ***OAC 317:30-5-86***

v. Step Therapy Protocol Exceptions: AMENDING agency rules at ***OAC 317:2-1-2*****,** ***317:2-1-13*****,** ***OAC 317:30-5-77.2*****,** ***and 317:30-5-77.3*****;** REVOKING agency rules at ***OAC 317:2-1-6*****;** ADDING agency rules at ***OAC 317:2-1-18 and OAC 317:30-5-77.4*****.**

vi. Removal of Prescription Limits for Frequently Monitored Prescription Drugs and Medication-Assisted Treatment (MAT) Drugs: AMENDING agency rules at ***OAC 317:30-3-5, 317:30-5-72 and 317:30-5-77.1***

9. Discussion of Report from the Pharmacy Advisory Committee and Possible Action Regarding Drug Utilization Board Recommendations……Randy Curry Chair, Pharmacy Advisory Committee

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

      i) Zolgensma® (Onasemnogene Abeparvovec-xioi)
      ii) Bryhali™ (Halobetasol Propionate 0.01% Lotion), Duobrii™ (Halobetasol Propionate/Tazarotene 0.01%/0.045% Lotion), and Lexette™ (Halobetasol Propionate 0.05% Foam)
      iii) Sorilux® (calcipotriene 0.005% foam)
      iv) Herzuma® (Trastuzumab-pkrb), Kanjinti™ (Trastuzumab-anns), Ontruzant® (Trastuzumab-dttb), Piqray® (Alpelisib), Talzenna® (Talazoparib), and Trazimera™ (Trastuzumab-qyyp)
      v) Nubeqa® (Darolutamide)

10. Discussion and Possible Action……Stan Hupfeld, Chair
    OHCA Board Meeting Dates,
    Times and Locations for Calendar Year 2020

11. Discussion and Possible Action……Stan Hupfeld, Chair
    Elections of the OHCA 2020 Board Officers

12. Discussion and Possible Action……Stan Hupfeld, Chair
    Possible Executive Session as Recommended by the Chief of Legal Services and Authorized by the Open Meeting Act, 25 O.S. § 307(B)(4) and (7), To Discuss Confidential Legal Matters, Including Pending State and Federal Litigation.

13. Adjournment……Stan Hupfeld, Chair

NEXT BOARD MEETING
January 22, 2020
Oklahoma Health Care Authority
Oklahoma City, OK

MINUTES OF A SPECIAL BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
September 18, 2019
Oklahoma Health Care Authority Boardroom
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on September 17, 2019 at 12:55 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on September 12, 2019 at 8:29 a.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Hupfeld called the meeting to order at 1:00 p.m.

BOARD MEMBERS PRESENT: Chairman Hupfeld, Vice Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Hausheer, Member Kennedy, Member Nuttle, Member Shamblin (1:12pm)

OTHERS PRESENT:

Josh Richards, OHCA
Stephanie Mavredes, OHCA
Tyler Talley, eCap
Kambra Reddick, OHCA
Fred Mensah, OHCA
Katelynn Burns, OHCA
Glenda Blanton, OHCA
Robert Evans, OHCA
Kyle Janzen, OHCA
Carmen Johnson, OHCA
Kimrey McGinnis, OHCA
Tasha Black, OHCA
Bert Bailey, OHCA
Kathleen Power, Regis College
Rick Snyder, OHA
Connie Cook, OHCA
Sheila Bertleson, OHCA
Sasha Teel, OHCA
Eboni Bolds, OHCA
Kim Potter, OHCA
Carrie Slatton-Hodges, ODMHSAS
Mia Smith, OHCA
Courtney Barrett, OHCA

OTHERS PRESENT:

Lisa Montgomery, OHCA
Melanie Lawrence, OHCA
David Peters, Daybreak Family Services
Aaron Morris, OHCA
Jenifer Wynn, OHCA
Kim Helton, OHCA
Will Widman, DXC
Vanessa Andrade, OHCA
Nathan Valentine, OHCA
Gloria LaFitte, OHCA
Nichole Burland, OHCA
April Anonsen, OHCA
Braden Mitchell, OHCA
Jimmy Witcosky, OHCA
Daryn Kirkpatrick, OHCA
Lisa Spain, DXC
Harvey Reynolds, OHCA
Calvin Cole, OHCA
Peter Onema, OHCA
David Ward, OHCA
Brenda Teel, Chickasaw Nation
Irene Sanderson, OHCA
Monika Lutz, OHCA

ITEM 2 / DISCUSSION OF THE CREATION OF OHCA ADVISORY COMMITTEES
Chairman Hupfeld

Chairman Hupfeld introduced the remaining four advisory committees.

ITEM 3 / DISCUSSION AND POSSIBLE VOTE ON APPROVAL OF BOARD MINUTES OF THE SPECIAL BOARD MEETING HELD AUGUST 21, 2019.

The Board routinely reviews and approves a synopsis of all its meetings. The full-length recordings of the meetings of the Board are retained at the Board Offices and may be reviewed upon written request.

MOTION: Member Hausheer moved for approval of the August 21, 2019 board meeting minutes as published. The motion was seconded by Member Curry.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Kennedy, Member Shamblin

ABSTAINED: Member Nuttle

ITEM 4 / ALL-STAR RECOGNITION

- June All-Star – Calvin Cole
- July All-Star – Vanessa Andrade

ITEM 5 / ANNOUNCEMENTS OF CONFLICTS OF INTEREST PANEL RECOMMENDATIONS FOR ALL ACTION ITEMS
Maria Maule, Interim Chief of Legal Services

There were no recommendations regarding conflicts.

ITEM 6A-B / CONSIDERATION AND VOTE OF AUTHORITY FOR EXPENDITURES OF FUND
Kimberely Helton, Professional Services Contracts Manager

a) First Data – Electronic Visit Verification Services (EVV)

MOTION: Member Hausheer moved for approval of Item 6a as published. The motion was seconded by Member Nuttle.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Curry, Member Kennedy, Member Shamblin

b) First Data – Electronic Visit Verification Services (EVV)

This action item will be tabled for a later date

ITEM 7A-E / CONSIDERATION AND VOTE UPON THE RECOMMENDATIONS OF THE STATE PLAN AMENDMENT RATE COMMITTEE
Josh Richards, Director of Program Integrity

a) Consideration and Vote for a rate change to increase the Neonatal, Infant, and Young Child services at 100% of the Medicare Physician Fee Schedule. The estimated budget impact for the remainder of SFY2020 will be an increase of $536,318 total; of which $187,121 is state share. The estimated budget impact for SFY2021 will be an increase of $715,090 total; of which $234,264 is state share.

MOTION: Member Hausheer moved for approval of Item 7a as published. The motion was seconded by Member Curry.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Kennedy, Member Nuttle, Member Shamblin

b) Consideration and Vote to establish a new rate. The Oklahoma Health Care Authority is requesting the establishment of rates for Diabetes Self-Management Training (DSMT) services. The estimated budget impact for the remainder of SFY2020 will be an increase of $109,107 total; of which $37,074 is state share. The estimated budget impact for SFY2021 will be an increase of $218,214 total; of which $72,163 is state share.

MOTION: Member Case moved for approval of Item 7b as published. The motion was seconded by Member Hausheer.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

c) Consideration and Vote for a method change to change some Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) procedure codes to a manual pricing method. The estimated budget impact for SFY2020 and SFY2021 is budget neutral.

MOTION: Member Hausheer moved for approval of Item 7c as published. The motion was seconded by Member Curry.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Kennedy, Member Nuttle, Member Shamblin

d) Consideration and Vote for a rate change to increase the base rate component to $120.57 for Regular Nursing Facilities and update the pool amount for these facilities in the state plan for the "Direct Care" and "Other" components to $220,482,316 due to the passage of Senate Bill 1044 and 280. The estimated budget impact for the remainder of SFY2020 will be an increase of $95,819,280 total; of which $32,559,391 is state share ($4,400,309 of the state share is from the increased QOC fee which is paid by the providers). The estimated budget impact for SFY2021 will be an increase of $127,759,040 total; of which $43,412,522 is state share ($6,286,156 of the state share is from the increased QOC fee which is paid by the providers).

MOTION: Member Hausheer moved for approval of Item 7d as published. The motion was seconded by Member Curry.

FOR THE MOTION: Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Kennedy, Member Nuttle, Member Shamblin

e) Consideration and Vote for a rate change to increase the base rate component to $213.10 for the Acquired Immune Deficiency Syndrome (AIDS) rate for Nursing Facilities. The estimated budget impact for the remainder of SFY2020 will be an increase of $43,781 total; of which $14,877 is state share. The estimated budget impact for SFY2021 will be an increase of $38,653 total; of which $13,134 is state share.

MOTION: Member Hausheer moved for approval of Item 7e as published. The motion was seconded by Vice-Chairman Yaffe.

FOR THE MOTION: Chairman Hupfeld, Member Boyd, Member Case, Member Curry, Member Kennedy, Member Nuttle, Member Shamblin

ITEM 8A-D / CONSIDERATION AND VOTE OF AGENCY RECOMMENDED RULEMAKING PURSUANT TO ARTICLE I OF THE ADMINISTRATIVE PROCEDURES ACT. THE AGENCY REQUESTS THE ADOPTION OF THE FOLLOWING EMERGENCY RULES

Jean Hausheer, M.D., Chair of Administrative Rules Advisory Committee

Action Item – a) Consideration and Vote upon a Declaration of a Compelling Public Interest for the promulgation of *all Emergency Rules* in item nine in accordance with 75 Okla. Stat. § 253.

Action Item – b) Consideration and Vote of Agency Recommended Rulemaking Pursuant to Article I of the Administrative Procedures Act. The Agency Requests the Adoption of the Following Emergency Rules:

The following emergency rules HAVE NOT previously been approved by the Board.

a) AMENDING agency rules at ***Oklahoma Administrative Code (OAC) 317:30-3-27*** to comply with Oklahoma Senate Bill (SB) No. 575, which amended 25 Oklahoma Statutes (O.S.), Sections 2004 and 2005. Revisions outline and further define requirements for telehealth services including 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 estimated budget impact will be $332,330; with $115,950 in state share.

(Reference APA WF # 19-08)

b) ADDING agency rules at ***OAC 317:2-1-17*** to comply with Senate Bill 280. Revisions will implement an administrative appeals process for disputed long-term care facility cost reports and cost report consideration.
Budget Impact: Budget neutral.

(Reference APA WF # 19-13A)

c) AMENDING agency rules at ***OAC 317:30-5-132 and 317:30-5-136.1*** and ADDING agency rules at ***OAC 317:30-5-132.1 and 317:30-5-132.2*** to comply with Senate Bill 280. Revisions provide the OHCA's website location for cost report instructions, establishes procedures for annual cost report submission extension requests for long-term care facilities, outline the processes when, based on onsite audit findings, the cost report may be adjusted, and define allowable and non-allowable costs for long-term care facilities. The proposed policy changes will also establish new quality measures and criteria as well as recalculate the incentive reimbursement rate plan for nursing facilities participating in the pay-for-performance program.
Budget Impact: The estimated budget impact for the remainder of SFY20 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 SFY21 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).

(Reference APA WF # 19-13B)

d) AMENDING agency rules ***OAC 317:30-5-241.6*** will increase targeted case management (TCM) limits that are reimbursable by SoonerCare. The TCM limits will be increased from 16 units per member per year to 12 units per member per month. Other revisions will align case management policy with current practice and correct grammatical errors. The proposed policy revisions herein are made at the request of the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).
Budget Impact: The estimated budget impact for SFY20 will be an increase in the total amount of $6,425,397; with $2,183,350 in state share. The estimated budget impact for SFY21 will be an increase in the total amount of $8,567,136; with $2,833,152 in state share. The state share will be paid by the ODMHSAS.

(Reference APA WF # 19-16)

MOTION:	Member Shamblin moved for approval of Item 8a.a-d as published. The motion was seconded by Member Case.
FOR THE MOTION:	Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Hausheer, Member Kennedy, Member Nuttle
MOTION:	Member Case moved for approval of Item 8b.a-d as published. The motion was seconded by Member Kennedy
FOR THE MOTION:	Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Curry, Member Hausheer, Member Nuttle, Member Shamblin

ITEM 9 / ADJOURNMENT

MOTION:	Member Hausheer moved for approval for adjournment. The motion was seconded by Member Curry.
FOR THE MOTION:	Chairman Hupfeld, Vice-Chairman Yaffe, Member Boyd, Member Case, Member Kennedy, Member Nuttle, Member Shamblin

Meeting adjourned at 1:38 p.m., 9/18/2019

NEXT BOARD MEETING
October 16, 2019
Oklahoma Health Care Authority
Oklahoma City, OK

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 20, 2019
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	Asset Verification System Services (AVS)
Purpose and Scope	The AVS Program will verify the assets of aged, blind, and disabled individuals applying or reapplying for SoonerCare while reporting the assets of the above referenced population and maintain a collegial relationship with the various financial institutions.
Mandate	42 USC 1396w for eligibility determination for the Oklahoma Department of Human Services (DHS).
Procurement Method	Competitive Bid
Award	Single Contractor
External Approvals	OMES
Incumbent Contractor	Public Consulting Group, Inc.
Incumbent Term	07/01/2015 through 6/30/2020
New Contract Term	July 1, 2020 through June 30, 2021 with four (4) options to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$3,000,000.00 The not to exceed is based off of a previous solicitation & award & is paying per verification at a current rate of $3.78.
50% Federal Match Costs within the Total Contract Not-to-Exceed	$1,5000,000.00

RECOMMENDATION

Board approval is requested to procure the Asset Verification System Services described above for five years, for a total not-to-exceed $3,000,000.00.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 20, 2019
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	Independent Verification and Validation (IV&V) Services
Purpose and Scope	OHCA is seeking to obtain Independent Verification and Validation (IV&V) contract(s) to provide IV&V Services for CMS and Oklahoma in support of the CMS required certification activities and guidance found in the Medicaid Enterprise Certification Toolkit (MECT) and the Medicaid Enterprise Enrollment Certification Lifecycle (MEECL).
Mandate	45 CFR §95.626 requiring IV&V services for IT projects authorized for enhanced federal funding.
Procurement Method	Competitive Bid
Award	Single Contractor or Multiple Contractors
External Approvals	OMES and CMS
Incumbent Contractor	Comagine
Incumbent Term	July 1, 2013 through June 30, 2020
New Contract Term	July 1, 2020 through June 30, 2021 with six (6) options to renew

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$17,500,000.00 The not to exceed is based off of a previous solicitation and award which was an average of 2.5 million per year over 7 years. It is an hourly rate.
90% Federal Match Percentage(s) within the Total Contract Not-to-Exceed	$15,750,000.00
10% State Share Costs within the Total Contract Not-to-Exceed	$1,750,000.00

RECOMMENDATION

Board approval is requested to procure the IV&V services described above for seven years with a total not-to-exceed of $17,500,000.00.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 20, 2019
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	Medicaid Consulting
Purpose and Scope	OHCA is seeking a Consultant to facilitate the redesign of the state's healthcare delivery system to improve health outcomes by empowering communities and families that interact with state health programs to reach their peak state of wellness. Items to be considered include: • A whole person approach to health • Payments for outcomes • Redesigning the delivery of services, with consideration towards sustainability in rural areas, individuals with severe mental illness or substance use disorders, and individuals involved with the criminal justice system • Streamlining agency functions • Increasing access to affordable health coverage
Mandate	
Procurement Method	Competitive Bid
Award	Single Contractor or Multiple Contractors
New Contract Term	Date of award and be effective through one (1) year.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$1,500,000.00 The Not to Exceed was established by leadership. It will be a fixed cost payment which will include all reports and deliverables.
50% Federal Match Costs within the Total Contract Not-to-Exceed	$750,000.00

RECOMMENDATION

Board approval is requested to procure the Medicaid Consulting services described above for one year, not-to-exceed $1,500,000.00 total dollars.

Additional Information

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

The Not To Exceed was established by leadership. It will be a fixed cost payment which will include all reports and deliverables.

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 20, 2019
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	Medicaid Information Technology Architecture (MITA)
Purpose and Scope	OHCA is seeking to obtain a Tracking System contract that will assist OHCA with the Center for Medicare and Medicaid Services' (CMS) to support improved systems development and health care management for the Medicaid enterprise is required for CMS certification of all new and enhanced Medicaid Management Information System (MMIS) modules.
Mandate	Not Applicable
Procurement Method	Competitive Bid
Award	Single Contractor
External Approvals	OMES and CMS
Incumbent Contractor Incumbent Term	Not Applicable
New Contract Term	Date of award through June 30, 2020 with seven (7) options to renew

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$1,820,000.00 Not to exceed was established through Market Research in which we asked what we can get and what will it cost us. This will be an hourly rate for a system with Implementation Costs and a Hosting Fee.
90% Federal Match Percentage(s) within the Total Contract Not-to-Exceed	$1,638,000.00
10% State Share Costs within the Total Contract Not-to-Exceed	$182,000.00

RECOMMENDATION

Board approval is requested to procure the MITA Software services described above for eight (8) years with a total not-to-exceed of $1,820,000.00.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 20, 2019
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	NTT DATA State Health Consulting, LLC
Purpose and Scope	NTT Data shall provide information technology consulting services as authorized on a project request basis. Contractor provides information technology subject matter experts, project management services, and provides support to OHCA on information technology procurements.
Mandate	Not Applicable
Procurement Method	General Services Administration (GSA) 70 Authorized Federal Supply List under Contract Number: GS-35F-518GA
New Contract Term	Date of signature with options to renew through December 31, 2021.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$5,000,000.00 Not to exceed based off of anticipated spend approved in an APD (Advanced Planning Document). The PMO consultant rates are established by GSA Contract.
90% Federal Match Percentage(s) within the Total Contract Not-to-Exceed	$4,500,000.00
10% State Share Costs	$500,000.00

RECOMMENDATION

Board approval is requested to procure the NTT Data State Health Consulting, LLC services described above for a total not-to-exceed of $5,000,000.00 total dollars.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 20, 2019
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	Sickle Cell Disease Services
Purpose and Scope	• Review Sickle Cell initiative objectives and current case management efforts of SoonerCare services to identify outreach related to Sickle Cell-Thalassemia Disease and traits. • Provide statewide collaborative efforts with key organizations while preventing duplicative efforts. • Create e-Toolkit outreach resources to educate SoonerCare members and carriers of the Sickle Cell Disease. • Increase self-care management, self-efficacy, better quality of life, and improved health outcomes for Sickle Cell lives and carriers in Oklahoma. • Complete monthly progress reports and a quarterly review to assist OHCA in creating a plan for ongoing and future statewide outreach development and operations.
Mandate	**N/A**
Procurement Method	Competitive Bid
Award	Single Contractor
External Approvals	OMES
Incumbent Contractor **Contract Term**	Supporters of Families w Sickle Cell Disease 10/10/2016 through 6/30/2020
New Contract Term	07/01/2020 through June 30, 2021 with four (4) options to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	**$750,000.00** Not to exceed is based off of a prior solicitation and award and a SS which will be combined into one bid. This contract will be based on an hourly rate for consulting services & fixed rate for deliverables. Prices established through competitive bid process.
50% Federal Match Percentage(s) within the Total Contract Not-to-Exceed	$375,000.00

RECOMMENDATION
Board approval is requested to procure the Sickle Cell Disease Services described above for five years, for a total not-to-exceed of $750,000.00.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 20, 2019
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Contractor	MyHealth
Services	MyHealth shall establish and operate a health information exchange and record locator service to assist the Participants in locating and sharing patient information. MyHealth seeks to reduce the cost and improve the quality and efficiency of health care provided by the Participants through the electronic management and exchange of health information acquired or generated by them in providing, paying for, and reporting on patient care items and services. MyHealth is intended to provide a collaborative framework consistent with HIPAA and other applicable law through which the parties can share information for treatment purposes of individuals seeking healthcare. OHCA Population Care Management staff access medical records through MyHealth as part of the SoonerCare care management process.
Mandate	Not Applicable
Procurement Method	Participation Agreement (We are a participant in the MyHealth Network. It is an agreement we signed with MyHealth acknowledging their Privacy and Security Policies and Procedures). Sole Source
Award	Single Contractor
Contract Term	Date of contract signature, and may be renewed annually until either party terminates the contract.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$260,504.00 annually until terminated Price sheet with a history of increased services. Payments are fixed & paid quarterly.
50% Federal Match Percentage(s) within the Total Contract Not-to-Exceed	$130,252.00

RECOMMENDATION Board approval is requested to procure the MyHealth Inc participating agreement described above for a not-to-exceed of $260,504.00 annual spend. The contract took effect January 1, 2019. The prior contract worth $50,000.00 but was increased to $130,253.00 for the January through June 2019 period when the new contract was implemented. The total annual value of the contract is the $260,504.00. The contract should have been take to Board in December 2018; however, no records of it being taken can be found.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 20, 2019
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Services	Ground Emergency Medical Transport
Purpose and Scope	OHCA is seeking a Contractor for the following: • Development of an Oklahoma Ground Emergency Medical Transport (GEMT) Supplemental Payment Reimbursement Initiative using a Certified Public Expenditure (CPE) methodology; • Development of an online system for completing the annual cost reporting which allows Emergency Medical Services (GEMT) Providers to report salaries, benefits, and other relevant financial information in accordance with The Centers for Medicare and Medicaid Services (CMS) approved methodology; • Completion of an annual cost reconciliation of actual payments compared to the annual cost reports; and • Creation of a Cost Settlement Report that includes the settlement amount for each GEMT Provider.
Mandate	SB1591 requires that eligible SoonerCare providers shall receive the established rate of payment and a supplemental payment, to the extent provided by law, for providing ground emergency medical transportation services. A governmental entity must provide the state share funds for the supplemental payment, and no payments shall be authorized out of the Oklahoma General Revenue Fund for the supplemental payments. The total amount reimbursed by OHCA shall not exceed 100% of actual costs to perform the service.
Procurement Method	Competitive Bid
Award	Single Contractor or Multiple Contractors
New Contract Term	Date of award through June 30, 2020 with five (5) options to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	$5,400,000.00 The Not to Exceed for base year (Date of Award through June 30, 2020) was an estimate calculated at $3 million to providers x 10 % rounded up to $400,000. The next 5 renewal years was estimated at $1 million annually. OHCA will not pay any dollar amount. This will be paid by provider. This will be an hourly rate. The 10% is to pay for the admin amount. .

50% Federal Match Costs within the Total Contract Not-to-Exceed	$2,700,000.00

RECOMMENDATION

Board approval is requested to procure Ground Emergency Medical Transport Consulting services described above for six years with a total not-to-exceed of $5,400,000.00.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 20, 2020
AUTHORITY FOR EXPENDITURE OF FUNDS

BACKGROUND

Contractor Name	Ernst and Young
Purpose and Scope	The Office of Management Enterprise Services has initiated a project to upgrade the required state financial system PeopleSoft from version 5 to version 9.2. The contractor shall assist OHCA determine how to most effectively use the upgraded PeopleSoft by performing the following services: • Conduct Requirements Analysis and Fit Gap Analysis of the current financial business processes to align to the OMES State PeopleSoft Financial Business Processes. • Identify current challenges and pain points of PeopleSoft 9.2 in meeting OHCA's required organizational processes, leading practice business processes, reporting needs and regulatory requirements, and identify efficiencies that can be gained. • Establish a roadmap that identifies next steps to maximize efficiencies and align the OHCA Financial System to the OMES PeopleSoft Financial System through systems and process changes. • Migrate the current OHCA Financial system to the Statewide PeopleSoft Financials system.
Mandate	Not Applicable
Procurement Method	Statewide Contract
External Approvals	Not Applicable
Contract Term	Date of award through June 30, 2020 with one (1) option to renew.

BUDGET

Not-to-Exceed Requested for Approval.	$2,970,000.00 Not to exceed is from an estimate from Statewide vendor. Currently no pricing information received. Expect hourly consulting fees plus potential flat fee for other services.
50% Federal Match Percentage(s) within the Total Contract Not-to-Exceed	$1,485,000.00
Pricing Methodology	Fixed rate by deliverable

RECOMMENDATION

Board approval is requested to procure the PeopleSoft upgrade services described above for two years, not-to-exceed $2,970,000.00 total dollars.

Additional Information

Contract Term, Including all Optional Renewal Years Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 day for cause, 60 day without cause, and non-renewal terminations.
Competitive Bid Total Contract Not-to-Exceed Requested for Approval. Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $125,000.00 or more, the contract increase shall require additional Board approval.
Federal Match Percentage(s) CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.
Pricing Methodologies: **Hourly Rate:** Hourly Rate contracts authorize payments based on the number of hours required to perform a service within an established not-to-exceed. Hourly rate contractors cannot bill for more hours than worked, and are not guaranteed to be able to bill for the entire not-to-exceed amount. **Fixed Rate**: Fixed rate professional services contracts establish fixed prices based on services performed based on volume estimates, such as completing a prior authorization is valued at X, and costs based on established deliverables. Deliverables may be billed as all-inclusive costs, such as a report, or may include milestones with associated payments, such as a payment for a report for the first draft and another payment upon OHCA approval for the final report. Contractors cannot bill until services are completed.

Oklahoma HealthCare Authority

All things SoonerCare (in 10 minutes or less)

Melody Anthony
Chief Operating Officer
Nov. 20, 2019

Oklahoma Health Care Authority

OHCA was established by the legislature in 1993 under House Bill 1573. The agency administers the Medicaid (SoonerCare) and Insure Oklahoma programs.

Medicaid is a state and federal partnership that provides coverage for basic health and long-term care services based on income and resources.

Oklahoma's current Medicaid program

- State plan amendment gives OHCA federal authority to administer the state Medicaid program.
- The 1115 demonstration waiver allows us to modify the federal Medicaid requirements to address coverage issues unique to Oklahoma.
  - SoonerCare Choice (patient-centered medical home delivery model).
  - SoonerCare Health Management Program.
  - SoonerCare Health Access Networks.
  - SoonerPlan.
  - Insure Oklahoma program.

Oklahoma's current Medicaid program

- OHCA facilitates state plan amendments for sister agencies. OHCA keeps administrative authority while the sister agency is responsible for the operations component.
- The same applies to 1915(c) home and community-based waivers that allow the Department of Human Services to have the operational authority for the five waiver programs while OHCA keeps the administrative authority.

SoonerCare programs

- Fee for service.
- Managed care.
  - SoonerCare Choice – patient-centered medical home.
    - Care coordination.
    - Increased physician visit limit for adults.
    - SoonerExcel pay for performance.
  - SoonerCare Choice – Indian Health Service, tribal and urban Indian health programs.
  - Insure Oklahoma premium assistance.
  - Program of All-Inclusive Care for the Elderly.

Partial benefit programs

- Pregnancy only.
  - Women residing in Oklahoma who are pregnant but do not qualify for full scope SoonerCare pregnancy benefits.
- Family planning.
  - Limited coverage for men and women. A joint venture with the Oklahoma State Department of Health.

Agency program areas

- Pharmacy.
- Population care management.
- Chronic care unit.

Behavioral health programs

- OHCA reviews and determines medical necessity for prior authorizations related to inpatient services.
- OHCA works with DHS on placement of children in foster care.
- Department of Mental Health and Substance Abuse Services is responsible for all outpatient behavioral health services.
- DMH developed health homes.
- DMH developed certified community behavioral health clinics.

OHCA and external partner shared programs

- Health access networks:
  - OU.
  - OSU.
  - Canadian County.
- Health Management/pain management program:
  - Telligen.
- Pharmacy management consultants:
  - Arine medication management program.
- Oklahoma Cares breast and cervical cancer treatment program:
  - Cherokee Nation, Kaw Nation and Oklahoma State Department of Health.
- Transportation:
  - Logisticare/SoonerRide.

Quality of care in SoonerCare programs

- Adult and child core set measures.
- Consumer Assessment of Healthcare Providers and Systems and other member satisfaction surveys.
- External quality review.
- Performance improvement projects.
- SoonerCare Choice evaluation.
- Health access network evaluation.
- Health Management Program evaluation.
- Chronic care unit evaluation.
- Focus on Excellence.

Health services initiatives

- Long-acting reversible contraceptive education for members.
- LARC education for providers, device promotions.
- Naloxone rescue kits.
- Psychotropic medication use for children in foster care.
- Evidence-based prescribing attention deficit hyperactivity disorder, meds, atypical antipsychotic meds for children under 18.

Health services initiatives

- Sickle cell kits for children ages 6-18.
- LARC for health department locations statewide.
- Reach out and Read program.
  - Developmental screening for first three years of life.

Questions

Melody Anthony

Melody.Anthony@okhca.org

405-522-7360

November Board
Proposed Rule Changes

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). The proposed rules were presented to the Medical Advisory Committee (MAC) on Thursday, November 5, 2019.

APA work folder 19-03 was posted for public comment from November 5, 2019 through November 18, 2019. APA work folder 19-06 was posted for public comment from September 4, 2019 through October 4, 2019. APA work folder 19-09 was posted for public comment from October 21, 2019 through November 18, 2019. APA work folder 19-18 was posted for public comment from November 5, 2019 through November 19, 2019. APA work folders 19-19A and 19-19B were posted for public comment from October 18, 2019 through November 18, 2019. APA work folder 19-20 was posted for public comment from November 5, 2019 through November 18, 2019.

The following emergency rule HAS previously been approved by the Board and the Governor under emergency rulemaking. It has been revised for additional emergency rulemaking.

A. ADDING agency rules at ***Oklahoma Administrative Code* (*OAC) 317:30-3-65.12*** and AMENDING agency rules at ***OAC 317:30-5-355.1, 317:30-5-357, 317:30-5-376, 317:30-5-664.1, 317:30-5-1076, 317:30-5-1090 and 317:30-5-1154*** to add registered behavior technician (RBT) 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.

Per unit, the rate for BCBAs is $23.55; the rate for BCaBAs is $23.55; and the rate for RBTs is $17.35. The reimbursement methodology for all ABA practitioners was approved by the SPARC on June 20, 2019 and by the OHCA Board on June 25, 2019. CMS approved the State Plan Amendment (SPA) establishing reimbursement for BCBAs and BCaBAs on September 23, 2019. The SPA to establish reimbursement for RBTs to provide ABA services (under the supervision of BCBAs) will be submitted to CMS by the end of November with an effective date of January 1, 2020.

(Reference APA WF # 19-03)

The following emergency rules HAVE NOT previously been approved by the Board.

B. AMENDING agency rules at ***OAC 317:30-5-42.1*** and ADDING agency rules at ***OAC 317:30-5-1080 through 317:30-5-1084*** to establish Diabetes Self-management Training (DSMT) as a new benefit in the SoonerCare program for members with diabetes. 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 estimated budget impact for State Fiscal Year (SFY) 2020 will be an increase in the total amount of $144,057; with $50,262 in state share.

(Reference APA WF # 19-06)

C. ADDING agency rules at ***OAC 317:35-6-45*** to comply with recent changes in federal law, which provides that individuals under the age of twenty-one, or individuals under the age of twenty-six in the former foster care eligibility group, who become incarcerated, shall not have their eligibility terminated. Eligibility, for the aforementioned populations, will instead be suspended for the duration of the incarceration. Additionally, 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 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 SoonerCare 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.

(Reference APA WF # 19-09)

D. AMENDING agency rules at ***OAC 317:30-5-86*** to comply with 42 United States Code (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. Other revisions will align and reorganize the DUR policy section with current practice.

Budget Impact: Budget neutral.

(Reference APA WF 19-18)

E. AMENDING agency rules at ***OAC 317:2-1-2 and 317:2-1-13*****;** REVOKING agency rules at ***OAC 317:2-1-6*****;** ADDING agency rules at ***OAC 317:2-1-18*** to comply with Oklahoma Senate Bill (SB) 509, which directs the OHCA to revise current step therapy protocols for

medications approved by the DUR Board and provide for exceptions 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.

(Reference APA WF # 19-19A)

F. AMENDING agency rules at ***OAC 317:30-5-77.2 and 317:30-5-77.3*****;** ADDING agency rules at ***OAC 317:30-5-77.4*** to comply with Oklahoma Senate Bill (SB) 509, which directs the OHCA to revise current step therapy protocols for medications approved by the DUR Board and provide for exceptions 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 budget impact is listed in APA WF #19-19A.

(Reference APA WF # 19-19B)

G. AMENDING agency rules at ***OAC 317:30-3-5, 317:30-5-72 and 317:30-5-77.1*** will remove prescription limits of certain frequently monitored prescription drugs and medication-assisted treatment (MAT) drugs for opioid use disorder. The proposed rule changes will also remove co-payments for MAT drugs. Additional rule changes will amend prescription quantity limits when a product is on the maintenance drug list. Further revisions will align SoonerCare administrative rules regarding cost sharing exemptions for American Indian and Alaska Natives (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.

(Reference APA WF # 19-20)

APA WF 19-03 FINDING OF EMERGENCY:

The agency requests emergency approval of rule revisions to its current emergency Applied Behavior Analysis (ABA) policy in order to protect the public health, safety, or welfare. The previously approved emergency rule is being amended to add registered behavior technician (RBT) as a new provider specialty. RBTs work under the authority and supervision of a Board-Certified Behavior Analyst (BCBA), and are responsible for the direct implementation of skill-acquisition and behavior treatment plans designed and prescribed by a BCBA.

APA WF 19-06 FINDING OF EMERGENCY:

The agency requests emergency approval of new rules to its individual and providers policy in order to protect the public health, safety or welfare. The approval of the emergency rule would allow the Oklahoma Health Care Authority (OHCA) to add diabetes self-management training (DSMT) as a new benefit for SoonerCare members diagnosed with diabetes. These emergency revisions are necessary to comply with Senate Bill 972, which was signed into law on April 12, 2018. The bill directed the OHCA, beginning on July 1, 2019, to draft a state plan amendment to allow the OHCA to provide DSMT services for SoonerCare members. The emergency rules are necessary to define program coverage and reimbursement, and begin coverage in January 2020.

APA WF 19-09 FINDING OF EMERGENCY:

The agency requests emergency approval of rule revisions to SoonerCare eligibility policy in order to avoid violation of federal law or regulation or other state law. H.R. 6, SUPPORT for Patients and Communities Act became Public Law No. 115-271 effective October 24, 2018. The law is also known as the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act. The law amended Section 1902 of the Social Security Act [42 U.S.C. 1396a(a)(84)]. Section 1001 of the law prohibits termination of Medicaid eligibility for two groups of individuals, whenever those individuals become inmates of a public institution:

- persons under age twenty-one (juveniles); or
- former foster care youth (aged out of foster care) under age twenty-six.

Instead of having their eligibility terminated, their eligibility will be suspended for the duration of the incarceration.

APA WF 19-18 FINDING OF EMERGENCY:

The agency requests emergency approval of revisions to its current policy, in order to avoid violation of federal law. The approval of the HR6 Opioid Standards and Drug Utilization Review (DUR) Requirements emergency rule would allow the Oklahoma Health Care Authority (OHCA) to comply with the newly-required DUR activities in Section 1396a(oo) of Title 42 of the United States Code. The newly-required DUR activities include: the implementation of opioid safety edits at the point-of-sale; a claims review automated process that monitors concurrent use of opioid(s) with benzodiazepine(s) and/or anti-psychotic(s); a program to monitor the use of antipsychotic medication by members aged 18 and younger, including foster children, for safety and appropriate utilization; and a process to identify potential fraud or abuse of controlled substances by members, prescribers, and pharmacies. These emergency revisions are necessary to comply with federal law requirements and to build on existing State activities to encourage the appropriate use, prescribing, and dispensing of opioid medications.

APA WF 19-19 A&B FINDING OF EMERGENCY:

The agency requests emergency approval of new rules and revisions to its current policy, in order to avoid violation of State law. The approval of the Step Therapy Exception Process emergency rule would allow the Oklahoma Health Care Authority (OHCA) to comply with Oklahoma Senate Bill (SB) 509, which directed the OHCA to revise current step therapy protocols for medications approved by the Drug Utilization Review (DUR) Board; provide for exceptions to the step therapy protocol; and establish an appeals process for step therapy exception requests that have been denied. These emergency revisions are necessary to comply with SB 509 requirements. The proposed emergency revisions will allow SoonerCare members, in appropriate cases, to be exempted from the step therapy protocol, ensuring more immediate access to medications prescribed by their doctor.

APA WF 19-20 FINDING OF EMERGENCY:

The agency requests emergency approval of rule revisions to its current pharmacy policy, in order to facilitate access to life-saving medication-assisted treatment (MAT) drugs and to improve member's adherence rates to medications on the maintenance drug list, a list of medications prescribed for chronic, long-term medical conditions. The emergency approval of these rule revisions would allow the Oklahoma Health Care Authority (OHCA) to exempt MAT medications from the prescription limit and copayments requirements, giving members easier access to their life-saving prescriptions. Furthermore, the proposed revisions would allow the OHCA to establish a 90-day supply for medications on the maintenance drug list, which would help lower the cost of care through the decreased number of dispensing fees. Finally, the proposed revisions would align SoonerCare rules regarding cost sharing exemptions for American Indian and Alaska Natives to comply with Oklahoma's Medicaid State Plan and 42 CFR § 447.56(a)(x).

These emergency revisions protect the public health, safety and welfare by facilitating prompt access to life-saving MAT medication (for members including those with an opioid addiction), improving adherence rates and lowering the cost of care for medications on the maintenance drug list, and aligning SoonerCare rules with federal regulations regarding zero copayments for American Indian and Alaska Native members.

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

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.

(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.")

(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);

(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;

(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

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

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

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

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

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

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~~

~~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

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.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-42.1. Outpatient hospital services

(a) Hospitals providing outpatient hospital services are required to meet the same requirements that apply to ~~OHCA~~the Oklahoma Health Care Authority (OHCA) contracted, non-hospital providers performing the same services. Outpatient services performed outside the hospital facility are not reimbursed as hospital outpatient services.

(b) Covered outpatient hospital services must meet all of the criteria listed in (1) through (4) of this subsection.

(1) The care is directed by a physician or dentist.

(2) The care is medically necessary.

(3) The member is not an inpatient ~~(see OAC 317:30-5-41)~~[refer to Oklahoma Administrative Code (OAC) 317:30-5-41].

(4) The service is provided in an approved hospital facility.

(c) Covered outpatient hospital services are those services provided for a member who is not a hospital inpatient. A member in a hospital may be either an inpatient or an outpatient, but not both (see OAC 317:30-5-41).

(d) In the event a member is admitted as an inpatient, but is determined to not qualify for an inpatient payment based on OHCA criteria, the hospital may bill on an outpatient claim for the ancillary services provided during that time.

(e) Separate payment is made for prosthetic devices inserted during the course of surgery when the prosthetic devices are not integral to the procedure and are not included in the reimbursement for the procedure itself.

(f) Physical, occupational, and speech therapy services are covered when performed in an outpatient hospital based setting. Coverage is limited to one evaluation/re-evaluation visit (unit) per discipline per calendar year and ~~15~~fifteen (15) visits (units) per discipline per date of service per calendar year. Claims for these services must include the appropriate revenue code(s).

(g) Diabetes self-management training (DSMT) is provided to members diagnosed with diabetes. DSMT services are comprised of one (1) hour of individual instruction (face-to-face encounters between the certified diabetes educator and the member) and nine (9) hours of group instruction on diabetes self-management. Members shall receive up to ten (10) hours of services during the first twelve (12) month period beginning with the initial training date. After the first twelve (12) month period has ended, members shall only be eligible for two (2) hours of individual instruction

on DSMT per calendar year. Refer to OAC 317:30-5-1080 through 1084 for specific provider and program requirements, and reimbursement methodology.

PART 109. DIABETES SELF-MANAGEMENT TRAINING

317:30-5-1080. Definitions

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

"ADA" means American Diabetes Association.

"AADE" means American Association of Diabetes Educators.

"CDE" means certified diabetes educator.

"DSMT" means diabetes self-management training.

"OAC" means Oklahoma Administrative Code.

"OHCA" means Oklahoma Health Care Authority.

"Qualified non-physician provider" means a physician assistant or advanced practice registered nurse.

317:30-5-1081. Eligible providers and requirements

(a) Eligible DSMT providers include any of the following professionals:

(1) A registered dietician (RD) who is licensed and in good standing in the state in which s/he practices, and who is:

(A) Certified as a CDE; and

(B) Fully contracted with SoonerCare as a CDE provider.

(2) A registered nurse (RN) who is licensed and in good standing in the state in which s/he practices, and who is:

(A) Certified as a CDE; and

(B) Fully contracted with SoonerCare as a CDE provider.

(3) A pharmacist who is licensed and in good standing in the state in which s/he practices, and who is:

(A) Certified as a CDE; and

(B) Fully contracted with SoonerCare as a CDE provider.

(b) In order to receive Medicaid reimbursement for DSMT services, professional service groups, outpatient hospitals, Indian Health Services, Tribal Programs and Urban Indian Clinics (I/T/Us), Rural Health Clinics (RHCs), and Federally Qualified Health Centers (FQHCs) must have a DSMT program that meets the quality standards of one (1) of the following accreditation organizations:

(1) The ADA; or

(2) The AADE.

(c) All DSMT programs must adhere to the national standards for diabetes self-management education.

(1) Each member of the instructional team must:

(A) Be a CDE; or

(B) Have documentation of at least fifteen (15) hours of recent diabetes education or diabetes management experience.

(2) At a minimum, every instructional team must consist of at least one (1) of the CDE professionals listed in subsection a, above.

(d) All members of the instructional team must obtain the nationally recommended annual continuing education hours for diabetes management.

317:30-5-1082. Scope of services

(a) **General provisions.** The OHCA covers medically necessary DSMT services when all the following criteria are met:

(1) The member has been diagnosed with diabetes by a physician or qualified non-physician provider working within the scope of his/her licensure;

(2) The services have been ordered by a physician or qualified non-physician provider who is actively managing the member's diabetes;

(3) The services are provided by a qualified DSMT provider [Refer to OAC 317:30-5-1081(b)(2)]; and

(4) The program meets the current ADA or ADE training standards.

(b) **Training.** DSMT services shall provide one (1) initial assessment per lifetime. Initial DSMT shall be comprised of up to ten (10) hours [can be performed in any combination of thirty (30) minute increments] of diabetes training within a consecutive twelve (12) month period beginning with the initial training date, including:

(1) One (1) hour of individual instruction, consisting of face-to-face encounters between the CDE and the member; and

(2) Nine (9) hours of group instruction.

(c) **Follow-up DSMT.** After the first twelve (12) month period has concluded, members shall only be eligible for two (2) hours of individual or group DSMT instruction per calendar year.

(d) **Referral.** The physician or qualified non-physician provider managing the member's diabetes must submit a DSMT order that includes:

(1) Diabetes diagnosis;

(2) Plan of care;

(3) Number of initial or follow-up hours needed;

(3) Expected health outcomes; and

(4) Any identified barriers that would require individualized member education.

317:30-5-1083. Coverage by category

The purpose of DSMT services must be to provide the member with the knowledge, skill, and ability necessary for diabetes self-care.

(1) **Adults.** Payment is made for medically necessary DSMT provided by a registered nurse (RN), registered dietitian (RD), or pharmacist certified as a diabetes educator, as described in

OAC 317:30-5-1081.Refer to OAC 317:30-5-1082 for units of DSMT training allowed.

(2) **Children/adolescents.** Payment is made for medically necessary DSMT for members under twenty-one (21) years of age provided by a RN, RD, or pharmacist certified as a diabetes educator, as described in OAC 317:30-5-1081. DSMT coverage for children is the same as for adults. Additional DSMT services may be covered under EPSDT provisions if determined to be medically necessary.

317:30-5-1084 . Reimbursement Methodology

SoonerCare shall provide reimbursement for DSMT services as follow:

(1) Payment shall be made to fully-contracted providers. If the rendering provider operates through an enrolled SoonerCare provider, or is contracted to provide services by an enrolled SoonerCare provider, payment may be made to that enrolled SoonerCare provider.

(2) Reimbursement for DSMT services is only made on a fee-for-service 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.

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 HEALTH BENEFITS 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.

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;

(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.

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

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

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.

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.

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

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.)

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

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.

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

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-Copayments~~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

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

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 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.

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.

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meeting – September 11, 2019 and October 9, 2019

Recommendation/ Vote	Drug	Used for	Cost*	Notes
1	Zolgensma®	Spinal Muscular Atrophy	$2,125,000.00 per 1-time infusion.	One (1) infusion per member per lifetime
2	Bryhali™ Duobrii™ Lexette™	Topical Corticosteroids	• $240.00-$400.00 / 100 gm bottle • $825.00 per 100 gm tube • $770.50 - $1,473.00 per can	• Lotion • Lotion • Foam Tier changes for steroid lotions/cream/foam
3	Sorilux®		•	•
4	Herzuma® Kanjinti™ Ontruzant® Trazimera™ Piqray® Talzenna®	Breast Cancer	• N/A • $3,697 per vial (cost varies/weight based) • N/A • N/A • $15,500 per 28 days • $14,580 per month	• 1st four are biosimilars
5	Nubeqa®	Prostate Cancer	• $11,550 per month	•

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

Recommendation 1: Vote to Prior Authorize Zolgensma® with the following criteria

The Drug Utilization Review Board recommends the prior authorization of Zolgensma® with the following criteria:

Zolgensma® (Onasemnogene Abeparvovec-xioi) Approval Criteria:

1. An FDA approved diagnosis of spinal muscular atrophy (SMA) in pediatric patients younger than 2 years of age; and
2. Member must have reached full-term gestational age prior to Zolgensma® infusion; and
3. Molecular genetic testing to confirm bi-allelic mutations in the survival motor neuron 1 (SMN1) gene; and
4. Member is not currently dependent on permanent invasive ventilation (defined as at least 16 hours of respiratory assistance per day continuously for more than 21 days in the absence of an acute, reversible illness or a perioperative state); and
5. Zolgensma® must be prescribed by a neurologist or specialist with expertise in the treatment of SMA (or be an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA); and
6. Member must have baseline anti-AAV9 antibody titers ≤1:50; and
7. Prescriber must agree to monitor liver function tests, platelet counts, and troponin-I at baseline and as directed by the Zolgensma® prescribing information; and
8. Prescriber must agree to administer systemic corticosteroids starting 1 day prior to the Zolgensma® infusion and continuing as recommended in the prescribing information based on member's liver function; and
9. Zolgensma® must be shipped to the facility where the member is scheduled to receive treatment and must adhere to the storage and handling requirements in the Zolgensma® prescribing information; and
10. Member will not be approved for concomitant treatment with nusinersen following Zolgensma® infusion (current authorizations for nusinersen will be discontinued upon Zolgensma® approval); and
11. Member's recent weight must be provided to ensure accurate dosing in accordance with Zolgensma® prescribing information; and
12. Only 1 Zolgensma® infusion will be approved per member per lifetime.

Recommendation 2: Vote to Prior Authorize Bryhali™, Duobrii™ and Lexette™ with the following criteria:

The Drug Utilization Review Board recommends the prior authorization of Bryhali™ (halobetasol propionate 0.01% lotion), and Lexette™ (halobetasol propionate 0.05% foam), and Duobrii™ (halobetasol propionate/tazarotene 0.01%/0.045% lotion) with the following criteria:

1. The placement of Bryhali™ (halobetasol propionate 0.01% lotion) and Lexette™ (halobetasol propionate 0.05% foam) into Tier-3 of the Ultra-High to High Potency category of the TCS PBPA Tier Chart. Current Tier-3 criteria will apply.
2. The prior authorization of Duobrii™ (halobetasol propionate/tazarotene 0.01%/0.045% lotion) with the following criteria:

Duobrii™ (Halobetasol Propionate/Tazarotene 0.01%/0.045% Lotion) Approval Criteria:

1. An FDA approved indication of plaque psoriasis in adults; and
2. Female members must not be pregnant and must be willing to use an effective method of contraception during treatment; and
3. A patient-specific, clinically significant reason why the member cannot use individual components of tazarotene and a topical corticosteroid separately must be provided; and
4. A quantity limit of 100 grams per 30 days will apply.

Recommendation 3: Vote to Prior Authorize Sorilux® with the following criteria:

The Drug Utilization Review Board recommends the prior authorization of Sorilux® (calcipotriene 0.005% foam) with the following criteria:

Sorilux® (Calcipotriene 0.005% Foam) Approval Criteria:

1. An FDA approved indication for the topical treatment of plaque psoriasis of the scalp and body in patients 12 years of age and older; and
2. A patient-specific, clinically significant reason why the member cannot use the generic formulations of topical calcipotriene, which are available without a prior authorization must be provided; and
3. A quantity limit of 120g per 30 days will apply.

Recommendation 4: Vote to Prior Authorize Herzuma®, Kanjinti™, Ontruzant® Piqray®, Talzenna®, and Trazimera™ with the following criteria:

The Drug Utilization Review Board recommends the prior authorization of Herzuma® (Trastuzumab-pkrb), Kanjinti™ (Trastuzumab-anns), Ontruzant® (Trastuzumab-dttb), Piqray® (Alpelisib), Talzenna® (Talazoparib), and Trazimera™ (Trastuzumab-qyyp) with the following criteria:

Herzuma® (Trastuzumab-pkrb), Kanjinti™ (Trastuzumab-anns), Ontruzant® (Trastuzumab-dttb), and Trazimera™ (Trastuzumab-qyyp) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of human epidermal receptor 2 (HER2)-overexpressing breast cancer; and
2. A patient-specific, clinically significant reason why the member cannot use Herceptin® (trastuzumab) must be provided.

Kanjinti™ (Trastuzumab-anns), Ontruzant® (Trastuzumab-dttb), and Trazimera™ (Trastuzumab-qyyp) Approval Criteria [Metastatic Gastric or Gastroesophageal Junction Adenocarcinoma Diagnosis]:

1. Diagnosis of human epidermal receptor 2 (HER2)-overexpressing metastatic gastric or gastroesophageal junction adenocarcinoma; and
2. A patient-specific, clinically significant reason why the member cannot use Herceptin® (trastuzumab) must be provided.

Piqray® (Alpelisib) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of advanced or metastatic breast cancer that has progressed on or after an endocrine-based regimen in men and postmenopausal women; and
2. Disease is hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative; and
3. Presence of PIK3CA-mutated disease; and
4. Must be used in combination with fulvestrant.

Talzenna® (Talazoparib) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of recurrent or metastatic breast cancer; and
2. Disease is human epidermal growth factor receptor 2 (HER2)-negative; and
3. Presence of BRCA 1/2-germline-mutated disease; and
4. Disease is hormone receptor (HR)-negative or HR-positive and endocrine therapy refractory; and
5. Member has symptomatic visceral disease; and
6. Must be used as a single-agent.

Recommendation 5: Vote to Prior Authorize Nubeqa® with the following criteria:

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

Nubeqa® (Darolutamide) Approval Criteria [Castration-Resistant Prostate Cancer (CRPC) Diagnosis]:

1. Diagnosis of non-metastatic CRPC; and
2. Concomitant treatment with a gonadotropin-releasing hormone (GnRH) analog or prior history of bilateral orchiectomy.

2020
Proposed OHCA Board Meetings

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

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

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

January 22, 2020 • 3:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd., OKC OK

March 18, 2020 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd., OKC OK

May 20, 2020 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd., OKC OK

July 15, 2020 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd., OKC OK

September 16, 2020 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd., OKC OK

November 18, 2020 • 1:00 pm
Oklahoma Health Care Authority
4345 N. Lincoln Blvd., OKC OK

July						
Su	Mo	Tu	We	Th	Fr	Sa
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	**15**	16	17	18
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26	27	28	29	30	31	

September						
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27	28	29	30			

November						
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15	16	17	**18**	19	20	21
22	23	24	25	26	27	28
29	30					