OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
March 26, 2025, at 2:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK. 73105

A G E N D A

Public access via Zoom:
https://www.zoomgov.com/webinar/register/WN_PXd2v-ZfS-mu7mdEuj1WTw
Telephone: 1-669-216-1590 Webinar ID: 160 136 7256

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

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

2. Discussion and Vote on the January 15, 2025, OHCA Board Meeting Minutes……..…..…..….Marc Nuttle, Chair

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

    a) Member Moment

4. Legislative Update..……..……Christina Foss, Chief of Staff

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

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

Item:	Drug Name:	Used For:
i.	Ebglyss™ (Lebrikizumab-lbkz)	Atopic Dermatitis
ii.	Ohtuvayre™ (Ensifentrine)	Chronic Obstructive Pulmonary Disease
iii.	Nemluvio® (Nemolizumab-ilto)	Prurigo Nodularis
iv.	Lenmeldy™ (Atidarsagene Autotemcel) Miplyffa™ (Arimoclomol) Aqneursa™ (Levacetylleucine)	Metachromatic Leukodystrophy (MLD) Niemann-Pick Disease (NPD) NPD
v.	Yorvipath® (Palopegteriparatide)	Hypoparathyroidism
vi.	Fabhalta® (Iptacopan) Piasky® (Crovalimab-akkz) Voydeya™ (Danicopan)	Paroxysmal Nocturnal Hemoglobinuria (PNH) / Immunoglobin A Nephropathy (IgAN) PNH PNH
vii.	Tryngolza™ (Olezarsen)	Familial Chylomicronemia Syndrome (FCS)
viii.	Tevimbra® (Tislelizumab-jsgr) Vyloy® (Zolbetuximab-clzb) Ziihera® (Zanidatamab-hrii)	Metastatic Esophageal Squamous Cell Carcinoma (ESCC) Gastroesophageal Junction Adenocarcinoma (GEJA) Biliary Tract Cancer (BTC)
ix.	Fyarro® (Sirolimus Protein-Bound	Perivascular Epithelioid Cell Tumor (PEComa)

	Particles for Injectable Suspension) Niktimvo™ (Axatilimab-csfr) Ojemda™ (Tovorafenib) Tecelra® (Afamitresgene Autoleucel) Voranigo® (Vorasidenib)	 Chronic Graft-Versus-Host Disease (cGVHD) Low-Grade Glioma (LGG) Synovial Sarcoma (SS) Astrocytoma
x.	Labetalol Hydrochloride 400mg Tablet Nexiclon™ XR [Clonidine Extended-Release (ER)] Tryvio™ (Aprocitentan)	Hypertension (HTN) HTN HTN

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

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

        i. Care Management and Electronic Visit and Verification Services
        ii. Call Center Services

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

    a) The following EMERGENCY rules were not previously adopted and are new to the Board:

        i. APA WF # 25-02 A&B ADvantage Waiver Policy Revisions
        ii. APA WF # 25-03 SoonerSelect Policy Revisions
        iii. APA WF # 25-05 Nursing Facility Durable Medical Equipment (DME) Revision

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

    a) Primary Care Spend Initiative, Sarah Walker, Clinical Outcomes Manager (Attachment "E")

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

NEXT BOARD MEETING
May 21, 2025, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

MINUTES OF AMENDED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
January 15, 2025
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on January 15, 2025, at 2:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of statutory public notice, the agency placed its agenda on its website on January 10, 2025, at 5:05 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Nuttle called the meeting to order at 2:00 p.m.

BOARD MEMBERS PRESENT: Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ Member Corbett, Member Cruzan, Member Kennedy, Member Jolley Member Leland

ITEM 2 / PUBLIC COMMENT
Chairman Nuttle, OHCA Board Chairman

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

1. Mallory Fletcher, BCBA, Public Policy Chair, Oklahoma Association for Behavior Analysis
2. Leslie Williams, BCBA
3. Dr. Nicolle Matthews, PhD, BCBA
4. Joni Bruce, Executive Director of Oklahoma Family Network

ITEM 3 / DISCUSSION AND POSSIBLE VOTE ON THE DECEMBER 11, 2024, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Member Jolley moved for approval of the December 11, 2024, board meeting minutes, as published. The motion was seconded by Member Kennedy.

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

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

CEO Buettner invited Joe Fairbanks, Market President for Humana Health Horizons, to present this month's member moment.

CEO Buettner highlighted OHCA's Best in Class & Outcome-Driven Key Principle, highlighting the Folake Adedeji and the Quality team for their work around the Maternal Health Outcomes Grant, the framework for the transition to value-based care and the conceptual and relational work in partnership with Dr. Zubialde around PCMH.

Key Initiatives Update:

- Programmatic:
    - Transforming Maternal Health Grant – This 10-year grant was awarded to 14 states, including Oklahoma. OHCA partnered with OU and George Kaiser Family Foundation to work on the grant.
    - Innovations in Behavioral Health Model – OHCA is partnering with the Department of Mental Health on a 10-year, $1.25 million behavioral health grant to find innovative ways to use technology to connect people who have behavioral health needs.
    - Workforce Initiatives: OESC – OHCA will be meeting with OESC in the coming weeks to talk through potential opportunities for OHCA to leverage their case management system and their online system to help Medicaid members who are receiving services connect with the workforce.
    - Findhelp Transition – Findhelp is OHCA's closed loop referral system, similar to the DHS Be a Neighbor system. In the interest of making the referral system easier on the everyday Oklahoman to find resources

that aren't state sponsored resources, the program will move permanently under the DHS Office of Faith-Based initiatives.
    - MES Roadmap: Functional Skills Assessment – This is OHCA's 7–10-year runway to completely revamp its MMIS Medicaid Enterprise System. CMS requires OHCA to revamp the system every 10 years. OHCA staff are taking a more modular approach, so OHCA can have flexibility to make changes where needed. An organizational assessment survey will be sent out to staff tomorrow to understand functional skills and then proficiency levels within those skills, so OHCA can identify those opportunities for staff as it moves forward.
- Administrative:
    - Return to Work – The Governor recently issued an executive order regarding return to work. OHCA's HR team, Jennifer Lamb-Hornsby, and Elizabeth Cooper have been working hard on this. OHCA is trying to be creative from a space perspective, since having moved in DOC and the Pardon and Parole Board. More information will be sent out to OHCA staff in the coming weeks.
    - Budget Hearings – OHCA staff have been meeting, informally, with its legislative leadership to talk through budgetary needs for this year and next. The Senate budget hearing is scheduled for January 21st, and the House budget hearing is scheduled on January 30th. Links to each budget hearing will be sent to the board.
    - Interim Staff – CEO Buettner announced that Colby Schaeffer will serve as OHCA's Interim CFO, and Melody will serve as the Interim State Medicaid Director when Traylor Rains leaves at the end of January.

Traction Goals – CEO Buettner highlighted Carolynn Reconnu-Shoffner and her team for conducting additional outreach to OHCA's ABD members who have high diabetic needs to try to manage that population. OHCA is using the new EQ Health Suite to help identify the right numbers for diabetes care, enroll members into care management, get baseline data, and test outcomes to see the change in fulfilling OHCA's diabetes standard of care management. The rocks for quarters one and two have been completed. OHCA is coordinating with the HANs and HMP, who have received a lot of members to start coordinating their care. OHCA's internal Chronic Care Management unit had 196 overall members targeted and successfully enrolled 181 of those members into care management. The total population that the OHCA is working with on this project is about 1,700 members.

Stakeholder Engagement – CEO Buettner highlighted a few of the engagements with various stakeholders. OHCA continues to work closely with the Oklahoma Hospital Association on primary care efforts. OHCA has also been working closely with the Department of Mental Health to look at the sustainability of the CCBHC program from a financial standpoint but also making sure that we're seeing the outcomes that we want to see. CEO Buettner traveled to DC recently, and met with a few members of the Federal delegations, as well as staff from the US Senate Finance Committee to update them on things going on in Oklahoma but also getting their perspective on what to expect from a new Federal Administration. OHCA hosted a legislative deep dive on Jan. 14th with the new House and Senate HHS leadership. Those in attendance include Rep. Kane, who is the House Appropriations Vice-Chair, Rep. Stinson and Rep. Marti, who are the Chair and Vice-Chair in the House Health Committee. Sen. Stanley, who is the Vice-Chair of the Senate HHS Committee, also attended. The deep dive was similar to the New Board Member Orientations but focused on the finances and operations. Lastly, CEO Buettner announced Bradley Downs as OHCA's Legislative Liaison. Mr. Downs will be assisting Ms. Foss at the Capitol.

Member Case asked if the new Chief Legal Counsel could be introduced. CEO Buettner introduced Mike Williams as OHCA's Deputy Chief Administrative Officer. Member Kennedy asked if a number for staff returning to the office has been determined. CEO Buettner asked Ms. Cooper to come to the podium. Ms. Cooper stated that there are 267 spots available for staff, so that will likely be the number of staff returning full-time.

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

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

Mr. Rains provided a State Medicaid Director update, which included information on SoonerSelect Enrollment and Utilization, SoonerSelect Total Expenditures, Transforming Maternal Health Grant, Innovation in Behavioral Health Model Grant, and the Living Choice Program Benchmarks. Mr. Rains also announced that the Monitoring Oversight vendor, Accenture, is now onsite and working with the OHCA team daily.

Regarding SoonerSelect enrollment and utilization, Member Case asked how Oklahoma's numbers compare to the national standard. Mr. Rains stated that he does not have that information readily accessible but would add the comparison moving forward. Regarding the Living Choice Program, Member Case asked if members could transition from a nursing home to an assisted living center; Mr. Rains stated yes.

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

ITEM 6 / LEGISLATIVE UPDATE
Christina Foss, Chief of Staff

Ms. Foss stated that of the 3,500 bills that were requested, over a thousand have been filed. The deadline for bill language is tomorrow, January 16th. After the deadline, OHCA will have a better idea of what the tracking list will look like. Ms. Foss provided a more detailed update on the legislative deep dive that was held at OHCA the day before the board meeting. She stated that the group talked through things like eligibility, coverage, provider network, SoonerSelect, and EGID. OHCA is also working with the Insurance Department on a broader insurance session for committee members, and any new members that want to learn about health insurance in general. The House announced their committees, which have a different structure this year with their new leadership under Speaker Hilbert. All of the House policy bills will be run similar to how appropriations bills have run in the past. They will be double assigned, and the House will have oversight committees, as well as subject matter policy committees. As of right now, OHCA has six request bills; all of which have been approved and filed. Ms. Foss stated that there have been a lot of bills filed increasing and expanding coverage in different areas, as well as bills related to mandates in the Medicaid space. The team is also working on pulling together a one pager for each legislator with SoonerCare information, including number of members, funding going to their district through directed payments and supplemental payments, and provider network. Vice-Chairman Yaffe asked if it would be possible for each board member to get a one pager for their districts that shows similar information. Ms. Foss stated that could be done.

ITEM 7 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Phil Kennedy, Compliance Advisory Committee Chairman

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

OHCA Financials – For the period ended November 30, 2024, the OHCA's expenditures were 3.9% under budget, while revenues were 2.7% under budget. This gives the OHCA a positive budget variance of $45.7 million. OHCA's receivables from sister agencies are current and the finance team continues to focus on timely collection while monitoring its cash flow as cash reserves are being spent from Fund 340.

Program Integrity – For the second quarter of 2025, Provider Audits closed 540 audits totaling a final identified overpayment of $2.2. Of the 674 audits closed, 254 had errors resulting in overpayments and findings. Year to date, Program Integrity has closed a total of 1,214 audits with a final identified overpayment in the amount of $3.2. Program Integrity shared the current standing for the active Payment Error Rate Measurement or PERM audit. PERM has 3 specific areas of review: data processing, medical review, and eligibility. To date, the contractor has identified no errors for data processing or eligibility. Data processing is 49% complete, and eligibility is 94% complete. Medical Review does have 3 errors at this time, with 98% of the sample being completed.

State Plan Amendment Rate Committee Rate –

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

    i. Developmental Disabilities Services Increase

MOTION: Member Jolley moved to approve item 7.a.i as published. The motion was seconded by Member Christ.

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

ITEM 8 / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING
Tanya Case, Chair, Administrative Rules Advisory Committee

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

Member Case requested that the EGID rules, listed in item 8.viii.A-D, be voted on separately, as a group.

viii. Employees Group Insurance Division (EGID)
   A. **Chapter 120** Oklahoma Employees Insurance and Benefits Board
   B. **Chapter 145** Employees Group Insurance Division – Administrative and General Provisions
   C. **Chapter 150** Employees Group Insurance Division – Health, Dental, Vision, and Life Plans
   D. **Chapter 155** Employees Group Insurance Division – HealthChoice Disability Plan

MOTION: Chairman Nuttle moved to approve the permanent rules listed in item 8viii.A-D as published. The motion was seconded by Member Christ.

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

Member Case asked Mr. Rains to provide a brief overview of the Applied Behavioral Analysis Change rule and requested that it be voted on separately. Vice-Chairman Yaffe asked for more clarification. Mr. Rains stated that the current rules are that if it is provided in the school, it must be linked to that person on the IEP. Vice-Chairman Yaffe asked if there is a significant number of children receiving these benefits that are not on an IEP. Mr. Rains stated yes, there are a lot that are not on an IEP. Vice-Chairman asked for a better understanding some of the utilization that may not be appropriate. Mr. Rains stated that OHCA staff have seen inappropriate treatment, practices, overutilization of services, and continuation of excessive treatment hours. There have also been incidents of fraudulent billing services provided in the school setting without the school's knowledge or involvement in developing an IEP. This has led OHCA to create appropriate medical necessity criteria. Member Corbett asked how many kids are currently receiving services today. Mr. Rains looked for Kristine West, Program Integrity Director, who stated that there are about 400 kids that are currently receiving their services. She added that it's about $150,000 per year per child with the amount of treatment they are receiving. There are some kids that receive more than. Vice-Chairman Yaffe asked how many hours does $150,000 annually equate to for care. Ms. West stated that it can be 30-40 hours just for the RBT service within the BCBA who is performing the supervision. Vice-Chairman asked if there is any data that shows members aren't being able to get services. Ms. West stated that she didn't believe so. Mr. Rains added the team has not seen detrimental access issues for this. Vice-Chairman asked if there is an override button if the member needs additional services. Mr. Rains stated that members have the option to go through the appeals process or can submit a reconsideration request. Vice-Chairman asked if the providers are reimbursed differently. Mr. Rains stated that they are not paid differently, it's billed through the school using the school's billing agent, and then the Medicaid dollars will match that. Member Jolley asked if this includes residential placements. Mr. Rains stated no, ABA would not be approvable in any residential setting, because those are all-inclusive payments of per-diem. Member Jolley requested additional information on the amount spent per year per child, as the amount does not make sense. Ms. Kristine corrected per previous statement of 400 children being in the program. That was what OHCA started with. The currently number of children receiving services is about 2,000, but the amounts per year are still consistent with that $100k-$150k per year.

xxiv. APA WF #24-23 Applied Behavioral Analysis (ABA) Change

MOTION: Member Jolley moved to approve the permanent rule listed in 8xxiv, as published. The motion was seconded by Member Christ.

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

ix. APA WF #24-02 Federally Qualified Health Center (FQHC) Substance Use Disorder (SUD) Certification Requirements
x. APA WF #24-03 Collaborative Care Model Reimbursement
xi. APA WF #24-05 Private Duty Nursing (PDN)
xii. APA WF #24-06 Living Choice
xiii. APA WF #24-07 Secure Mental Health Transportation
xiv. APA WF #24-08 Biosimilar Reimbursement
xv. APA WF #24-09 Continuous Eligibility for Children
xvi. APA WF #24-10 Non-Payment of Provider Preventable Conditions (PPC)
xvii. APA WF #24-13 Program of All-Inclusive Care for the Elderly (PACE) Policy
xviii. APA WF #24-14 Hospice Benefit Expansion
xix. APA WF #24-18 Third Party Liability (TPL) for School-Based Services

xxi. APA WF #24-20 Pharmacists as Providers
xxii. APA WF #24-21 Certified Registered Nurse Anesthetists (CRNA) Equalization
xxiii. APA WF #24-22 High Acuity Tracheostomy Rate

xxv. APA WF #24-24 Medication Assisted Treatment (MAT) Clarification
xxvi. APA WF #24-25 Psychological Testing Limit Increase
xxvii. APA WF #24-26A & B Developmental Disabilities Services (DDS)
xxviii. APA WF #24-27 Hospital Provision of Emergency Opioid Antagonist
xxix. APA WF #24-34 Community Health Services

MOTION: Vice-Chairman Yaffe moved to approve the permanent rules listed in 8ix-xix, 8xxi-xxiii, 8xxv-xxix, as published. The motion was seconded by Member Jolley.

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

xx. APA WF #24-19 Updating Abortion Policy

MOTION: Member Jolley moved to approve the permanent rule listed in 8xx, as published. The motion was seconded by Vice-Chairman Yaffe.

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

BOARD MEMBERS ABSTAIN: Member Christ, Member Cruzan, Member Leland

i. APA WF #24-11 Doula Certifying Organization Criteria
ii. APA WF #24-17A & B Electronic Visit Verification Revisions
iii. APA WF #24-28 Crisis Intervention Services Limitations
iv. APA WF #24-29 Diagnosis Clarification for Inpatient Psychiatric Services
v. APA WF #24-30 Updates to Residential Substance Use Disorder (SUD) Policy
vi. APA WF #24-31A & B Removal of Outdated Language
vii. APA WF #24-33 In Lieu of Service or Setting (ILOS)

MOTION: Member Jolley moved to approve the permanent rules listed in 8i-vii, as published. The motion was seconded by Member Cruzan.

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

MOTION: Vice-Chairman Yaffe motioned to approve the declaration of a compelling public interest for the promulgation of the emergency rules in item 9i-viii. The motion was seconded by Member Christ.

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

ITEM 9 / DISCUSSION OF REPORT OF THE STRATEGIC PLANNING & OPERATIONAL ADVISORY COMMITTEE
Marc Nuttle, OHCA Board Chairman

Chairman Nuttle provided an overview of the items discussed at the January 13th Strategic Planning Committee meeting, which included updates on software development for accounting services, comparison between services, and AI. The committee also discussed what the Federal Government may do in this new administration. Chairman Nuttle discussed DOGE and the plan moving forward, stating that it is his intention to be proactive and get the State's recommendations in the aggregate. Member Corbett asked if OHCA should be going through different scenarios that we think might be likely to understand the impact and be prepared of what that might look like. CEO Buettner stated that OHCA has been going through various layers of that type of review over the last year.

ITEM 10 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE OHCA GENERAL COUNSEL AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4).

Marc Nuttle, OHCA Board Chairman

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

ITEM 11 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

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

Meeting adjourned at 4:42 p.m., 1/15/2025.

NEXT BOARD MEETING
March 26, 2025
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – December 11, 2024 and March 12, 2025

Vote Item	Drug	Used for	Cost*	Notes
1	Ebglyss™ (Lebrikizumab-lbkz)	• **Atopic Dermatitis:** AD is a chronic disease that causes inflammation, redness, and irritation of the skin. AD is often called eczema. Moderate to severe AD is associated with a significant disease burden, impacting sleep, quality of life, and treatment needs. *3,600 members with a reported AD diagnosis who are currently 12 years of age or older*	• $65,500 per year *Budget impact estimate: $655,000 per year*	• Other cheaper therapies required first¥
2	Ohtuvayre™ (Ensifentrine)	• **Chronic Obstructive Pulmonary Disease:** COPD is a long-term lung disease that makes it hard to breathe. COPD includes chronic bronchitis and emphysema. *Approx. 500 members with a reported diagnosis who might qualify*	• $35,406 per year *Budget impact estimate: $708.120 per year*	• Other cheaper therapies required first¥
3	Nemluvio® (Nemolizumab-ilto)	• **Prurigo Nodularis:** PN is a chronic skin disorder characterized by multiple, firm, flesh-to-pink colored papules, plaques, and nodules predominantly found on the extensor surfaces of the extremities. These lesions are intensely pruritic and manifest across diverse age groups. *236 members with a reported PN diagnosis*	• $ 110,240 per year *Budget impact estimate: $220,480 per year*	• Other cheaper therapies required first¥

4	Lenmeldy™ (Atidarsagene Autotemcel)	• **Metachromatic Leukodystrophy (MLD**): MLD is a rare hereditary disease characterized by accumulation of fats called sulfatides. This causes the destruction of the protective fatty layer (myelin sheath) surrounding the nerves in both the central nervous system and the peripheral nervous system. It is a serious condition and causes death within 5-6 years in early-onset form. *3 members with MLD diagnosis might qualify for treatment*	• $4,250,000 per 1 time treatment *Budget impact estimate: $4.2M per year*	• FDA approved in pre and early symptomatic MLD in infants and children
	Miplyffa™ (Arimoclomol)	• **Niemann-Pick Disease (NPD):** NPD is a group of rare conditions passed down in families. The conditions affect the body's ability to break down and use fats, such as cholesterol and lipids, inside cells. Because of the buildup of fats, these cells don't work as they should and, over time, the cells die. Niemann-Pick disease can affect the brain, nerves, liver, spleen and bone marrow. Sometimes it can affect the lungs. *No members with a reported diagnosis*	• $1,272,240 per year Budget impact estimate: none	• FDA approved in NPD type C
	Aqneursa™ (Levacetylleucine)	• **NPD**	• $619,718 year *Budget impact estimate: none*	• FDA approved in NPD type C

5	Yorvipath® (Palopegteriparatide)	• **Hypoparathyroidism:** Hypoparathyroidism is an uncommon condition in which the body produces abnormally low levels of parathyroid hormone (PTH). PTH is key to regulating and maintaining a balance of two minerals in the body — calcium and phosphorus. *5 members received therapy for diagnosis*	• $285,025 per year *Budget impact estimate: $1,425,125 per year*	• Other cheaper therapies required first[¥]
6	Fabhalta® (Iptacopan)	• **Paroxysmal Nocturnal Hemoglobinuria (PNH):** PNH is a rare, acquired, life-threatening disease of the blood. The disease is characterized by destruction of red blood cells, blood clots, and impaired bone marrow function. PNH is closely related to aplastic anemia.*13 members have a reported PNH diagnosis* • **Immunoglobin A Nephropathy (IgAN):** IgAN, also known as Berger's Disease, is an autoimmune kidney disease that impairs the kidney's ability to filter leading to kidney failure. *6 members have biopsy proven IgAN*.	• $558,741 per year *Budget impact estimate: $558,741 per year*	• FDA approved for adults only
	Piasky® (Crovalimab-akkz)	• **PNH**	• $459,940 per year *Budget impact estimate: $459,940 per year*	• FDA approved for patients 13 years old and older

	Voydeya™ (Danicopan)	• **PNH**	• $66,096 per year *Budget impact estimate: $132,192*	• FDA approved for adults only. Must be used combination with other treatments
7	Tryngolza™ (Olezarsen)	• **Familial Chylomicronemia Syndrome (FCS):** FCS, also known as hyperlipoproteinemia type 1, is a rare autosomal recessive disorder caused by impaired function in the lipoprotein lipase enzyme leading to disruptions in the normal breakdown of fats in the body causing severe hypertriglyceridemia, triglycerides >880mg/dL. *No members with a reported diagnosis.*	• $644,592 per year *Budget impact estimate: $2,578,368 per year*	• FCS has an estimated prevalence of 1 in 300,000 in the US
8	Tevimbra® (Tislelizumab-jsgr)	• **Metastatic Esophageal Squamous Cell Carcinoma (ESCC):** ESCC occurs predominantly in the upper and mid-esophagus and is associated with smoking and alcohol exposure. It is the most common type of esophageal cancer. *158 members with a reported diagnosis of esophageal cancer*	• $185,776 per year *Budget impact estimate: $3,715,520 per year*	• Also used to treat GEJA
	Vyloy® (Zolbetuximab-clzb)	• **Gastroesophageal Junction Adenocarcinoma (GEJA):** GEJA is a rare type of cancer of the esophagus, the tube that connects your mouth and stomach. *103 members with a reported diagnosis of gastric cancer*	• $291,200 per year *Budget impact estimate: $5,824,000 per year*	• Used in combination with other chemotherapy
	Ziihera® (Zanidatamab-hrii)	• **Biliary Tract Cancer (BTC):** BTC is a rare type of cancer developing in the	• $554,580 per year	• Not first line±

		bile ducts. *16 members with a reported diagnosis of biliary tract cancer*	*Budget impact estimate: $2,772,900 per year*	
9	Fyarro® (Sirolimus Protein-Bound Particles for Injectable Suspension)	• **Perivascular Epithelioid Cell Tumor (PEComa):** PEComas are rare soft tissue tumors. They often form around small blood vessels (perivascular spaces) in various body parts such as the lungs, GI tract, kidneys, liver and uterus. *473 members with a reported diagnosis*	• $542,540 per year *Budget impact estimate: none*	• FDA approved in adults
	Niktimvo™ (Axatilimab-csfr)	• **Chronic Graft-Versus-Host Disease (cGVHD):** cGVHD is a life-threatening complication that can occur after certain stem cell or bone marrow transplants. It may occur after a bone marrow, or stem cell, transplant in which someone receives bone marrow tissue or cells from a donor. *18 members with a reported diagnosis of cGVHD*	• $491,400 per year *Budget impact estimate: $982,800 per year*	• Not first line[±]
	Ojemda™ (Tovorafenib)	• **Low-Grade Glioma (LGG):** LGG are benign tumors and are grade 1 and grade 2 tumors according to WHO classification. These are common in children at a young age and need early diagnosis and prompt treatment for a better prognosis.*90 members with a reported diagnosis of LGG*	• $458,544 per year *Budget impact estimate: none*	• FDA approved in pediatric patients

	Tecelra® (Afamitresgene Autoleucel)	• **Synovial Sarcoma (SS):** SS is a rare type of cancer that tends to occur near large joints, mainly the knees. *No members with diagnosis of SS*	• $727.000 per 1 time treatment *Budget impact estimate: none*	• Not first line±
	Voranigo® (Vorasidenib)	• **Astrocytoma:** Astrocytomas are tumors that typically form in your brain but can develop in your spinal cord as well. Most astrocytomas develop randomly. *369 members with a reported diagnosis*	• $478,572 per year *Budget impact estimate: $2,871,432 per year*	• FDA approved in 12 years and older
10	Labetalol Hydrochloride 400mg Tablet	• **Hypertension (HTN):** HTN (high blood pressure) is when the pressure in your blood vessels is too high (140/90 mmHg or higher). It is common but can be serious if not treated. *93,000 members with a reported diagnosis*	• $1,360 per year *Budget impact estimate: none*	• Other cheaper therapies required first¥
	Nexiclon™ XR [Clonidine Extended-Release (ER)]	• **HTN**	• $6,661 per year *Budget impact estimate: none*	• Other cheaper therapies required first¥
	Tryvio™ (Aprocitentan)	• **HTN**	• $9,299 per year *Budget impact estimate: none*	• Other cheaper therapies required first¥

*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.

¥Other cheaper therapies required first: There are other treatment options available with or without a prior authorization (PA) which will be required for the member to try and fail before a PA would be issued for this new therapy.

±Not first line: The patient must have failed treatment with other therapy first per FDA approval.

Pharmacy Agenda Items

Recommendation 1: Vote to Prior Authorize Ebglyss™

The Drug Utilization Review Board recommends the prior authorization of Ebglyss™ (Lebrikizumab-lbkz) with the following criteria:

Ebglyss™ (Lebrikizumab-lbkz) Approval Criteria:

1. An FDA approved diagnosis of moderate-to-severe atopic dermatitis not adequately controlled with topical prescription therapies or when those therapies are not advisable; and
2. Member must be 12 years of age or older and weigh ≥40kg; and
3. Member must have documented trials within the last 6 months for a minimum of 2 weeks that resulted in failure with both of the following topical therapies (or have a contraindication or documented intolerance):
    a. 1 medium potency to very-high potency Tier-1 topical corticosteroid; and
    b. 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
4. Member's body surface area (BSA) of atopic dermatitis involvement must be provided and the member must have a documented BSA involvement of ≥10% (can apply to member's current BSA or a historical value prior to treatment); and
5. A patient-specific, clinically significant reason the member cannot use Adbry® (tralokinumab-ldrm) and Dupixent® (dupilumab) must be provided; and
6. Must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
7. Requests for concurrent use of Ebglyss™ with other biologic medications will be reviewed on a case-by-case basis and will require patient-specific information to support the concurrent use (Ebglyss™ has not been studied in combination with other biologic therapies); and
8. Initial approvals will be for a quantity limit override for the initial dosing for the duration of 16 weeks; and
9. Reauthorization may be granted for the maintenance dosing of 250mg every 4 weeks for a duration of 1 year if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

Recommendation 2: Vote to Prior Authorize Ohtuvayre™

The Drug Utilization Review Board recommends the prior authorization Ohtuvayre™ (Ensifentrine) with the following criteria:

Ohtuvayre™ (Ensifentrine) Approval Criteria:

1. An FDA approved diagnosis of chronic obstructive pulmonary disease (COPD); and
2. Member must be 18 years of age or older; and

3. Member has moderate to severe disease [i.e., GOLD 2 or GOLD 3 airflow obstruction as demonstrated by forced expiratory volume in 1 second (FEV1) ≥30% and <80% predicted] and is symptomatic [i.e., modified Medical Research Council (mMRC) dyspnea scale grade ≥2]; and
4. Member is inadequately controlled on dual or triple combination long-acting bronchodilator therapy (must have ≥3 claims for long-acting bronchodilators in the previous 6 months); and
5. Member must not be taking Daliresp® (roflumilast) concurrently with Ohtuvayre™; and
6. A quantity limit of 60 ampules (150mL) per 30 days will apply.

Recommendation 3: Vote to Prior Authorize Nemluvio®

The Drug Utilization Review Board recommends the prior authorization of Nemluvio® (Nemolizumab-ilto) with the following criteria:

Nemluvio® (Nemolizumab-ilto) Approval Criteria [Prurigo Nodularis (PN) Diagnosis]:

1) An FDA approved diagnosis of PN for at least 3 months; and
2) Member must have severe pruritus as defined by a Peak Pruritus Numeric Rating Scale (PP-NRS) score of ≥7; and
3) Member must have ≥20 PN lesions; and
4) Member must be 18 years of age or older; and
5) Must be prescribed by a dermatologist, allergist, or immunologist or the member must have been evaluated by a dermatologist, allergist, or immunologist for PN within the last 12 months (or an advanced care practitioner with a supervising physician who is a dermatologist, allergist, or immunologist); and
6) Prescriber must verify that all other causes of pruritus have been ruled out; and
7) Member must have documented trials within the last 6 months for a minimum of 2 weeks that resulted in failure with both of the following therapies (or have a contraindication or documented intolerance):
   a) 1 medium potency to very-high potency Tier-1 topical corticosteroid; and
   b) 1 topical calcineurin inhibitor [e.g., Elidel® (pimecrolimus), Protopic® (tacrolimus)]; and
8) A patient-specific, clinically significant reason why the member cannot use Dupixent® (dupilumab) must be provided; and
9) Requests for concurrent use of Nemluvio® with other biologic medications will be reviewed on a case-by-case basis and will require patient-specific information to support the concurrent use (Nemluvio® has not been studied in combination with other biologic therapies); and
10) The member's recent weight must be provided, and approval quantities will be based on the FDA approved dosing regimen; and
11) Initial approvals will be for the duration of 16 weeks. Reauthorization (for a duration of 1 year) may be granted if the prescriber documents the member is responding well to treatment. Additionally, compliance will be evaluated for continued approval.

Recommendation 4: Vote to Prior Authorize Aqneursa™, Lenmeldy™, and Miplyffa™

The Drug Utilization Review Board recommends the prior authorization Aqneursa™ (Levacetylleucine), Lenmeldy™ (Atidarsagene Autotemcel), and Miplyffa™ (Arimoclomol) with the following criteria:

Lenmeldy™ (Atidarsagene Autotemcel) Approval Criteria:

1. An FDA approved diagnosis of metachromatic leukodystrophy (MLD) confirmed by:
    a. Arylsulfatase A (ARSA) enzyme activity below the normal range in peripheral blood mononuclear cells or fibroblasts (results of assay must be submitted); and
    b. Molecular genetic testing confirming biallelic pathogenic variants in the ARSA gene of known polymorphisms (results of genetic testing must be submitted); or
        i. If novel ARSA variant(s) are identified, a 24-hour urine collection must demonstrate increased urinary excretion of sulfatides (results must be submitted); and
2. Member must have 1 of the following forms of MLD as determined by the prescriber (clinical documentation must be submitted with the request):
    a. Pre-symptomatic late infantile (PSLI) MLD with expected disease onset ≤30 months of age; or
    b. Pre-symptomatic early juvenile (PSEJ) MLD with expected disease onset >30 months and <7 years of age; or
    c. Early symptomatic early juvenile (ESEJ) MLD with disease onset >30 months and <7 years of age; and
3. Member must be younger than 18 years of age; and
4. Must be prescribed by a geneticist, hematologist/oncologist, neurologist, or other specialist with expertise in the treatment of MLD and the administration of Lenmeldy™; and
5. Member must not have a history of prior hematopoietic stem cell transplantation (HSCT); or
    a. If member has had a HSCT, there is no evidence of residual cells of donor origin; and
6. Prescriber must verify the member is clinically stable and eligible to undergo HSCT (HSCT must be appropriate for a member to be treated with Lenmeldy™); and

7. Member must have a negative serology test for human immunodeficiency virus 1 & 2 (HIV-1/HIV-2), hepatitis B virus (HBV),

hepatitis C virus (HCV), human T-lymphotrophic virus 1 & 2 (HTLV-1/HTLV-2), cytomegalovirus (CMV), and mycoplasma prior to apheresis; and

8. Female members of reproductive potential must not be pregnant and must have a negative pregnancy test prior to the start of mobilization, prior to conditioning procedures, and prior to Lenmeldy™ administration; and
9. Male and female members of reproductive potential must use an effective method of contraception from the start of mobilization through at least 6 months after administration of Lenmeldy™; and
10. 1Prescriber must verify male and female members of reproductive potential have been counseled on the potential effects of myeloablative conditioning on fertility and the potential risk of infertility is acceptable to the member or member's caregiver; and
11. Prescriber must verify the member has been evaluated for and counseled on all warnings and precautions related to Lenmeldy™, including the risk of thrombosis and thromboembolic events, serious infections, and veno-occlusive disease; and
12. Prescriber must verify member will be monitored for hematologic malignancies lifelong, with a complete blood count (with differential) performed annually and integration site analysis as warranted for at least 15 years after treatment with Lenmeldy™; and
13. Must be administered at a Lenmeldy™ qualified treatment center, and the receiving facility must have a mechanism in place to track the patient-specific Lenmeldy™ dose from receipt to storage to administration; and
14. Approvals will be for 1 dose per member per lifetime.

Aqneursa™ (Levacetylleucine) Approval Criteria:

1. An FDA approved diagnosis of Niemann-Pick disease type C (NPC) confirmed by molecular genetic testing confirming biallelic pathogenic variants in the NPC1 or NPC2 genes (results of genetic testing must be submitted); and
2. Member must have the presence of at least mild disease-related neurological symptoms; and
3. Must be prescribed by, or in consultation with, a geneticist, neurologist, or other specialist with expertise in the treatment of NPC; and
4. Will not be approved for concomitant use with Miplyffa™ (arimoclomol); and
5. Member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and

6. Females of reproductive potential must have a negative pregnancy test prior to initiation of therapy and must agree to use effectivecontraception during treatment and for 7 days after the last dose of Aqneursa™; and
7. Initial approvals will be for the duration of 6 months, at which time the prescriber must verify the member is responding well to the medication. Subsequent approvals will be for the duration of 1 year if the member is responding well to treatment.

Miplyffa™ (Arimoclomol) Approval Criteria:

1. An FDA approved diagnosis of Niemann-Pick disease type C (NPC) confirmed by molecular genetic testing confirming biallelic pathogenic variants in the NPC1 or NPC2 genes (results of genetic testing must be submitted); and
2. Member must have the presence of at least mild disease-related neurological symptoms; and
3. Must be prescribed by, or in consultation with, a geneticist, neurologist, or other specialist with expertise in the treatment of NPC; and
4. Must be used in combination with Zavesca® (miglustat); and
    a. Zavesca® is brand preferred. Requests for generic miglustat (including Yargesa®) will require a patient-specific, clinically significant reason why the member cannot use the brand formulation; and
5. A patient-specific, clinically significant reason why the member cannot use Aqneursa™ (levacetylleucine) must be provided; and
6. Will not be approved for concomitant use with Aqneursa™; and
7. Member's recent weight must be provided on the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
8. Prescriber must verify that females of reproductive potential have been counseled on the potential risks of embryofetal harm when administered during pregnancy; and
9. Initial approvals will be for the duration of 6 months, at which time the prescriber must verify the member is responding well to the medication. Subsequent approvals will be for the duration of 1 year if the member is responding well to treatment.

Recommendation 5: Vote to Prior Authorize Yorvipath®

Pharmacy Agenda Items
The Drug Utilization Review Board recommends the prior authorization of Yorvipath® (Palopegteriparatide) with the following criteria:

Yorvipath® (Palopegteriparatide) Approval Criteria:

1. An FDA approved diagnosis of hypoparathyroidism; and
2. Member must be 18 years of age or older; and
3. Prescriber must verify the following:
    a. Member has albumin-corrected serum calcium ≥7.8mg/dL and serum 25(OH) vitamin D is within the normal range; and
    b. Serum calcium will be measured within 7-10 days after the first dose and after any dose change in Yorvipath®, active vitamin D, or calcium supplements; and
    c. Member or member's caregiver has been trained by a health care professional on proper storage, preparation, and subcutaneous (sub-Q) administration of Yorvipath®; and
    d. Member must not have acute post-surgical hypoparathyroidism; and
4. Member must be unable to be adequately well-controlled on calcium supplements and active forms of vitamin D alone; and
5. A quantity limit of 2 pre-filled pens [each package contains (2) 14-day pre-filled pens] per 28 days will apply. The maximum covered dose will be 30mcg per day.

Recommendation 6: Vote to Prior Authorize Fabhalta®, Piasky®, and Voydeya™

The Drug Utilization Review Board recommends the prior authorization of Fabhalta® (Iptacoptan), Piasky® (Crovalimab-akkz), and Voydeya™ (Danicopan) with the following criteria:

Fabhalta® (Iptacopan) Approval Criteria [Immunoglobulin A Nephropathy (IgAN) Diagnosis]:

1. An FDA approved indication to reduce proteinuria in adults with primary IgAN at risk of rapid disease progression; and
2. The diagnosis of primary IgAN must be confirmed by the following:
    a. Kidney biopsy; and
    b. Secondary causes of IgAN have been ruled out (i.e., IgA vasculitis; IgAN secondary to virus, inflammatory bowel disease, autoimmune disease, or liver cirrhosis; IgA-dominant infection-related glomerulonephritis); and
3. Member must be 18 years of age or older; and
4. Must be prescribed by a nephrologist (or an advanced care practitioner with a supervising physician who is a nephrologist); and

5. Member must be at risk of disease progression as demonstrated by proteinuria ≥0.5g/day; and
6. Member must be on a stable dose of a maximally tolerated angiotensin convert enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB), unless contraindicated or intolerant; and
7. Prescriber and pharmacy must be enrolled in the Fabhalta® Risk Evaluation and Mitigation Strategy (REMS) program and maintain enrollment throughout therapy; and
8. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Subsequent approvals will be for 1 year.

Fabhalta® (Iptacopan) Approval Criteria [Paroxysmal Nocturnal Hemoglobinuria (PNH) Diagnosis]:

1. An FDA approved diagnosis of PNH; and
2. Member must be 18 years of age or older; and
3. Fabhalta® must be prescribed by, or in consultation with, a hematologist, oncologist, or a specialist with expertise in the treatment of PNH; and
4. Prescriber and pharmacy must be enrolled in the Fabhalta® Risk Evaluation and Mitigation Strategy (REMS) program and maintain enrollment throughout therapy; and
5. For members switching from Soliris® (eculizumab) to Fabhalta®, the prescriber must verify the member will start Fabhalta® no later than 1 week after the last dose of Soliris®; and
6. For members switching from Ultomiris® (ravulizumab-cwvz) to Fabhalta®, the prescriber must verify the member will start Fabhalta® no later than 6 weeks after the last dose of Ultomiris®; and
7. Member must not be receiving Fabhalta® in combination with another complement inhibitor used to treat PNH (i.e., Empaveli®, Piasky®, Soliris®, Ultomiris®, Voydeya®); and
8. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Subsequent approvals will be for 1 year.

Piasky® (Crovalimab-akkz) Approval Criteria [Paroxysmal Nocturnal Hemoglobinuria (PNH) Diagnosis]:

1. An FDA approved diagnosis of PNH; and
2. Member must be 13 years of age or older and must weigh ≥40kg; and
3. Piasky® must be prescribed by, or in consultation with, a hematologist, oncologist, or a specialist with expertise in the treatment of PNH; and
4. Prescriber must verify member does not have unresolved Neisseria meningitidis infection; and

5. Prescriber must be enrolled in the Piasky® Risk Evaluation and Mitigation Strategy (REMS) program and maintain enrollment throughout therapy; and
6. For members switching from another C5 inhibitor (i.e., Soliris® or Ultomiris®), the prescriber must verify the first intravenous (IV) loading dose of Piasky® will be administered no sooner than the time of the next scheduled C5 inhibitor dose and member will be monitored for Type III hypersensitivity reactions; and
7. Member must not be receiving Piasky® in combination with another complement inhibitor used to treat PNH (i.e., Empaveli®, Fabhalta®, Soliris®, Ultomiris®, Voydeya®); and
8. A quantity limit override for the loading dose will be approved upon meeting Piasky® approval criteria. A quantity limit of 6mL per 28 days will apply for the maintenance dose; and
9. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Subsequent approvals will be for 1 year.

Voydeya™ (Danicopan) Approval Criteria [Paroxysmal Nocturnal Hemoglobinuria (PNH) Diagnosis]:

1. An FDA approved diagnosis of PNH; and
2. Member must be 18 years of age or older; and
3. Voydeya™ must be prescribed by, or in consultation with, a hematologist, oncologist, or a specialist with expertise in the treatment of PNH; and
4. Member must have been treated with Soliris® (eculizumab) or Ultomiris® (ravulizumab-cwvz) for at least the previous 6 months; and
5. Prescriber must verify member is experiencing clinically significant extravascular hemolysis (EVH) while on Soliris® or Ultomiris®; and
6. Member must remain on treatment with Soliris® or Ultomiris® while on Voydeya™; and
7. Member must not be receiving Voydeya® in combination with another complement protein C3 inhibitor (i.e., Empaveli®) or complement factor B inhibitor (i.e., Fabhalta®) used to treat PNH; and
8. Prescriber must verify member does not have unresolved Neisseria meningitidis infection; and
9. Prescriber must be enrolled in the Voydeya™ Risk Evaluation and Mitigation Strategy (REMS) program and maintain enrollment through therapy; and
10. Initial approvals will be for the duration of 3 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Subsequent approvals will be for 1 year.

Pharmacy Agenda Items

Recommendation 7: Vote to Prior Authorize Tryngolza™

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

Tryngolza™ (Olezarsen) Approval Criteria:

1. An FDA approved indication to reduce triglyceride levels in adults with familial chylomicronemia syndrome (FCS); and
2. Diagnosis of FCS must be confirmed by the following:
    a. Fasting triglyceride levels ≥880mg/dL; and
    b. One of the following:
        i. Genetic testing identifying biallelic pathogenic variants in the LPL, GPIHBP1, APOA5, APOC2, or LMF1 genes (results of genetic testing must be submitted); or
        ii. Familial chylomicronemia score ≥10; or
        iii. North American familial chylomicronemia syndrome score ≥45; or
        iv. History of clinical signs and symptoms associated with FCS (i.e., pancreatitis and/or abdominal pain, eruptive xanthomas, lipemia retinalis, lipemic plasma) and a diagnosis of multifactorial chylomicronemia syndrome (MCS) has been ruled out; and
3. Member must be 18 years of age or older; and
4. Must be prescribed by, or in consultation with, a cardiologist, an endocrinologist, or a specialist with expertise in the treatment of disorders related to severe hypertriglyceridemia; and
5. Prescriber must verify the member is on a low-fat diet of ≤20g of fat per day and will continue the low-fat diet while on treatment with Tryngolza™; and
6. Member or caregiver has been trained by a health care professional on the subcutaneous (sub-Q) administration and proper storage of Tryngolza™; and
7. Initial approvals will be for 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment, as indicated by a reduction in fasting triglyceride levels, decreased episodes of acute pancreatitis, and/or other documentation of a positive clinical response to therapy. Subsequent approvals will be for the duration of 1 year.

Recommendation 8: Vote to Prior Authorize Tevimbra®, Vyloy®, and Ziihera®

Pharmacy Agenda Items

The Drug Utilization Review Board recommends the prior authorization of Tevimbra® (Tislelizumab-jsgr), Vyloy® (Zolbetuximab-clzb), and Ziihera® (Zanidatamab-hrii) with the following criteria:

Tevimbra® (Tislelizumab-jsgr) Approval Criteria [Esophageal Squamous Cell Carcinoma (ESCC) Diagnosis]:

1. Diagnosis of unresectable or metastatic ESCC; and
2. Used in 1 of the following settings:
    a. Used after disease progression on prior systemic chemotherapy; and
        i. Member has not previously failed other programmed death 1 (PD-1) or programmed death ligand 1 (PD-L1) inhibitors; and
        ii. Used as a single agent; or
    b. Used as first-line treatment; and
        i. Tumor expresses PD-L1 ≥1%; and
        ii. Used in combination with platinum-containing chemotherapy.

Tevimbra® (Tislelizumab-jsgr) Approval Criteria [Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of unresectable or metastatic gastric or GEJ adenocarcinoma; and
2. Used in the first-line setting in combination with platinum and fluoropyrimidine-based chemotherapy; and
3. Human epidermal receptor 2 (HER2)-negative disease; and
4. Tumor expresses programmed death ligand 1 (PD-L1) ≥1%.

Vyloy® (Zolbetuximab-clzb) Approval Criteria [Gastric or Gastroesophageal Junction (GEJ) Adenocarcinoma Diagnosis]:

1. Diagnosis of locally advanced unresectable or metastatic gastric or GEJ adenocarcinoma; and
2. Human epidermal growth factor receptor 2 (HER2)-negative; and
3. Claudin (CLDN) 18.2 positive (defined as ≥75% of tumor cells demonstrating moderate to strong membranous CLDN18 immunohistochemical staining); and
4. Used for first-line treatment; and
5. Used in combination with fluoropyrimidine- and platinum-containing chemotherapy; and
6. Member's recent body surface area (BSA) must be provided in order to authorize the appropriate amount of drug required according to package labeling.

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Ziihera® (Zanidatamab-hrii) Approval Criteria [Biliary Tract Cancer (BTC) Diagnosis]:

1. Diagnosis of unresectable or metastatic BTC; and
2. Human epidermal growth factor receptor 2 (HER2)-positive immunohistochemistry (IHC) 3+; and
3. Used for subsequent-line therapy; and
4. As a single agent.

Recommendation 9: Vote to Prior Authorize Fyarro®, Niktimvo™, Ojemda™, Tecelra®, and Voranigo®

The Drug Utilization Review Board recommends the prior authorization of Fyarro® (Sirolimus Protein-Bound Particles for Injectable Suspension), Niktimvo™ (Axatilimab-csfr), Ojemda™ (Tovorafenib), Tecelra® (Afamitresgene Autoleucel), and Voranigo® (Vorasidenib) with the following criteria:

Fyarro® (Sirolimus Protein-Bound Particles for Injectable Suspension) Approval Criteria [Perivascular Epithelioid Cell Tumor (PEComa) Diagnosis]:

1. Diagnosis of locally advanced unresectable or metastatic PEComa; and
2. Member must be 18 years of age or older.

Niktimvo™ (Axatilimab-csfr) Approval Criteria [Chronic Graft Versus Host Disease (GVHD) Diagnosis]:

1. Diagnosis of chronic GVHD; and
2. Has failed at least 2 prior lines of systemic therapy for chronic GVHD; and
3. Member's recent weight must be provided and must be ≥40kg.

Ojemda™ (Tovorafenib) Approval Criteria [Low Grade Glioma (LGG) Diagnosis]:

1. Diagnosis of relapsed or refractory pediatric LGG; and
2. Member must be 6 months to 25 years of age; and
3. Presence of BRAF fusion, BRAF rearrangement, or BRAF V600 mutation; and
4. Member's recent body surface area (BSA) must be provided; and
    a. For members with a BSA ≥0.90m2, requests for the oral suspension formulation will require a patient-specific, clinically significant reason why the member cannot use the tablet formulation.

Tecelra® (Afamitresgene Autoleucel) Approval Criteria [Synovial Sarcoma Diagnosis]:

1. Diagnosis of unresectable or metastatic synovial sarcoma; and

2. Member must be 18 years of age or older; and
3. Has received previous anthracycline or ifosfamide-containing chemotherapy; and
4. HLA-A*02:01P, -A*02:02P, -A*02:03P, or -A*02:06P positive; and
5. Tumor expresses melanoma-associated antigen A4 (MAGE-A4) as detected by an FDA-approved test; and
6. Health care facilities must be able to administer cellular therapies and must be trained in the management of cytokine release syndrome (CRS) and neurologic toxicities; and
7. Approvals will be for 1 dose per member per lifetime.

Voranigo® (Vorasidenib) Approval Criteria [Astrocytoma or Oligodendroglioma Diagnosis]:

1. Diagnosis of grade 2 astrocytoma or oligodendroglioma; and
2. Presence of susceptible isocitrate dehydrogenase-1 (IDH1) or isocitrate dehydrogenase-2 (IDH2) mutation following surgery including biopsy, sub-total resection, or gross total resection.

Recommendation 10: Vote to Prior Authorize Labetalol Hydrochloride 400mg Tablet, Nexiclon™ XR, and Tryvio™

The Drug Utilization Review Board recommends the prior authorization of Labetalol Hydrochloride 400mg Tablet, Nexiclon™ XR [Clonidine Extended-Release (ER)], and Tryvio™ (Aprocitentan) with the following criteria:

Labetalol Hydrochloride 400mg Tablet Approval Criteria:

1. An FDA-approved indication of the management of hypertension; and
2. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use labetalol hydrochloride 200mg tablets, which are available without prior authorization, to achieve a 400mg dose must be provided.

Nexiclon™ XR [Clonidine Extended-Release (ER) Tablet] Approval Criteria:

1. An FDA approved diagnosis of hypertension; and
2. A patient-specific, clinically significant reason why the member cannot utilize clonidine immediate-release tablet and clonidine transdermal patch, which are available without a prior authorization, must be provided; and
3. Request must be for an FDA-approved once-daily dosing regimen, according to package labeling.

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Tryvio™ (Aprocitentan) Approval Criteria:

1. An FDA approved diagnosis of hypertension; and
2. Member has a reported systolic blood pressure of ≥140mmHg confirmed on at least 2 separate blood pressure readings on 2 separate occasions within the last month (documentation of blood pressure readings with dates must be submitted); and
3. Prescriber must rule out other causes of elevated blood pressure including:
    a. Inaccurate readings due to faulty or inappropriate equipment (i.e., cuff size) or improper technique; and
    b. White coat hypertension; and
    c. Prescription non-adherence. Compliance with antihypertensive medications will be evaluated prior to initiation of Tryvio™; and
4. Member must be currently on at least 3 antihypertensive medications at optimal (or maximally tolerated) doses for at least 4 weeks prior to systolic blood pressure reading of ≥140mmHg; and
5. Member must have tried at least 6 different classes of medications, including a diuretic, in the past 12 months that did not yield adequate blood pressure control. Medications can include, but are not limited to, angiotensin I converting enzyme inhibitors (ACEIs), angiotensin II receptor blockers (ARBs), calcium channel blockers (CCBs), direct renin inhibitors (DRIs), beta blockers, alpha blockers, alpha agonists, or diuretics; and
6. Female members of reproductive potential must not be pregnant or breastfeeding during treatment with aprocitentan and must be willing to use an effective method of contraception during treatment and for 1 month after discontinuing aprocitentan; and
7. Female members of reproductive potential must have a negative pregnancy test prior to initiation of aprocitentan and must agree to take pregnancy tests monthly during treatment and for 1 month after discontinuing aprocitentan; and
8. Member, pharmacy, and provider must be registered under the Tryvio™ Risk Evaluation and Mitigation Strategy (REMS) program; and
9. Member must not have elevated aminotransferases >3 times the upper limit of normal (ULN) or moderate to severe hepatic impairment (Child Pugh class B or C); and
10. Prescriber must attest that they will monitor liver transaminase levels during treatment and discontinue Tryvio™ if a sustained, unexplained, clinically relevant elevation occurs or if elevations occur with an increase in bilirubin that is >2 times the ULN; and
11. Member must not have severe anemia prior to initiation of aprocitentan; and
12. A quantity limit of 30 tablets per 30 days will apply; and

Pharmacy Agenda Items

13. Initial approvals will be for the duration of 3 months. After 3 months, compliance with all antihypertensive medications, including aprocitentan, will be evaluated and the provider must provide documentation that the member has had a positive response to treatment, including a decrease in blood pressure. Inadequate compliance or a lack of positive response will result in denial of continuation. Subsequent approvals will be for 1 year.

SUBMITTED TO THE C.E.O. AND BOARD ON MARCH 26, 2025
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Care Management and Electronic Visit and Verification services
Purpose and Scope	Task order-based services to support Care Management and Electronic Visit and Verification (EVV) services. Scopes: Care Management • Provide project support, assistance with vendor management, technical integration oversight, and testing leadership. • Implementation of Care Management Provider/Stakeholder portal that facilitates prior authorization processing and bidirectional provider communication. • Implementation of Care Management system integration with statewide Health Information Exchange and other bidirectional connections. Electronic Visit and Verification • Project support, assistance with procurement planning, post implementation stabilization and CMS certification support services for the replacement of the outdated current EVV system.
Mandate	N/A
Procurement Method	Statewide Release
External Approvals	CMS
Contract Term	Care Management Task Order Extension 1: July 1, 2025 - June 30, 2026 Extension 2: July 1, 2026 - December 31, 2026 EVV Task Order Extension 1: July 1, 2025 - June 30, 2026 Extension 2: July 1, 2026 - December 31, 2026

BUDGET

Amount requested for Approval	**Care Management Task Order** Extension 1: $1,979,296.80 Extension 2: $1,007,770.08 **EVV Task Order** Extension 1: $2,327,697.36 Extension 2: $1,173,695.16 **Total $6,488,459.40**

Federal Match Percentage(s) within the Total Contract Not-to-Exceed	90% $5,839,613.46 of extension amount

RECOMMENDATION

The Authority confirms that the CEO's procurement decision aligns with the budget and available funds. We request Board approval for the task orders totaling **$6,488,459.40**.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON MARCH 26, 2025
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds.

BACKGROUND

Services	Call Center Services
Purpose and Scope	The supplier will manage call center operations, addressing general inquiries from members and providers while ensuring compliance with service standards, including language accessibility. They will provide staffing and training for new OHCA programs, adjusting resources as needed. To support language accessibility, the supplier will offer Spanish-speaking customer service representatives and translation services for other languages, as well as utilize Oklahoma 711 services for hearing-impaired callers. Performance management will include maintaining staffing levels, handling complaints, and ensuring continuous training and monitoring of customer service representatives. Additionally, the supplier will provide IT support, addressing technical issues that impact the call center or Medicaid Management Information System (MMIS). Supplier is responsible for managing personnel in compliance with OHCA requirements, ensuring staff training and adherence to policies.
Mandate	CMS
Procurement Method	Statewide Contract 1118
External Approvals	CMS
Contract Term	Signature of Contract through June 30, 3025 Additional one (4) year options to renew this contract are upon mutual agreement of both Parties.

BUDGET

Amount requested for Approval.	Annual Cost $10,471,113.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Match 75% $7,853,334.75 /25% $2,617,778.25

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to approve the Call Center Services contract as described above for an annual not-to-exceed amount of $10,471,113.00 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 days for cause, 60 days without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by either $1,000,000.00 or 25%, the contract increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)

March 26, 2025 Board
Proposed Rule Amendment Summaries

These proposed **EMERGENCY** rules were presented at Tribal Consultation and were subject to at least a 15-day public comment period and were considered by the Medical Advisory Committee on March 6, 2025.

The Governor will have 45 days to approve or disapprove these rules upon the Agency's submission for gubernatorial review.

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

A. **APA WF # 25-02 A&B *AD*vantage Waiver Policy Revisions –** The proposed emergency rules are necessary to avoid violation of federal law or regulation at 1915(c) of the Social Security Act and 42 CFR Part 441 Subpart G by aligning the *AD*vantage Program policy with the approved 1915(c) Home and Community Based waiver amendment effective, October 1, 2023. Key revisions lower the minimum age from 21 to 19 for program eligibility, modify procedural requirements for obtaining member or representative signatures for home-delivered meals, reformat for clarity, and remove outdated language.

Budget Impact: Budget Neutral

B. **APA WF # 25-03 SoonerSelect Policy Revisions –** The Oklahoma Health Care Authority is proposing an emergency rule revision to avoid violation of federal law or regulation at Sections 1915(b) and 1932(a) of the Social Security Act and 42 CFR 438.54 by aligning SoonerSelect policy with the State's 1915(b) waiver amendment. These proposed changes clarify that members receiving only family planning services through SoonerPlan are excluded from enrollment in the SoonerSelect program. Additionally, the choice period for SoonerSelect enrollees will be changed from 60 days to 30 days. The choice period is the timeframe during which a SoonerSelect enrollee may select a plan. If a selection is not made during this timeframe, the enrollee will be automatically assigned to one of the contracted entities.

Budget impact: Budget Neutral

C. **APA WF # 25-05 Nursing Facility Durable Medical Equipment (DME) Revision** — The proposed emergency changes are necessary to avoid violation of federal law or regulation at 42 U.S.C. Section 1396a(a)(13)(A) by aligning administrative rules with the approved Oklahoma Medicaid State Plan, which states that the cost of DME is included in the nursing facility per diem rate and is not permitted to be billed separately.

Budget impact: Budget Neutral

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 85. ADVANTAGE PROGRAM WAIVER SERVICES

317:30-5-760. ADvantage program

The ADvantage ~~Program~~program is a Medicaid Home and Community Based Services (HCBS) ~~Waiver~~waiver used to finance noninstitutional long-term care services through Oklahoma's Medicaid program for ~~elderly and disabled individuals.~~the elderly, sixty-five (65) years of age and older; and a targeted group of adults with physical disabilities, nineteen (19) to sixty-four (64) years of age who do not have an intellectual disability or a cognitive impairment related to a developmental disability per Oklahoma Administrative Code (OAC) 317:35-9. To receive ADvantage Program services, individuals must ~~meet the nursing facility (NF) level of care (LOC) criteria, be age 65 years or older, or age 21 or older if physically disabled and not developmentally disabled, or if developmentally disabled and between the ages of 21 and 65, not have an intellectual disability or a cognitive impairment related to the developmental disability. ADvantage Program members must~~ be Medicaid eligible and meet eligibility requirements per OAC 317:35-17. The number of ~~members of~~ individuals who may receive ADvantage services is limited.

317:30-5-763. Description of services

Services included in the ADvantage program are:

(1) **Case management.**

(A) Case management services, regardless of payment source, assist a member to gain access to medical, social, educational, or other services that may benefit him or her to maintain health and safety. Case managers:

(i) Initiate and oversee necessary assessments and reassessments to establish or reestablish waiver program eligibility;

(ii) Develop the member's comprehensive person-centered service plan, listing only the services necessary to prevent institutionalization of the member, as determined through the assessments;

(iii) Initiate the addition of necessary services or deletion of unnecessary services, as dictated by the member's condition and available support; and

(iv) Monitor the member's condition to ensure delivery and appropriateness of services and initiate person-centered service plan reviews. Case managers submit an individualized Services Backup Plan, on all initial service plans, annually at reassessment, and on updates as appropriate throughout the year, reflecting risk factors and measures in place to minimize risks. When a member requires hospital or nursing facility (NF) services, the case manager:

(I) Assists the member in accessing institutional care and, as appropriate, periodically monitors the member's progress during the institutional stay;

(II) Helps the member transition from institution to home by updating the person-centered service plan;

(III) Prepares services to start on the date the member is discharged from the

institution; and

(IV) Must meet ADvantage program minimum requirements for qualification and training prior to providing services to ADvantage members.

(B) Providers of ADvantage services for the member or for those who have an interest in or are employed by an ADvantage provider for the member must not provide case management or develop the person-centered service plan, except when the ADvantage Administration (AA) demonstrates the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area, also provides other ADvantage services. Prior to providing services to members receiving Consumer Directed Personal Assistance Services and Supports ~~(CD-PASS),~~(CDPASS), case manager supervisors, and case managers are required to receive training and demonstrate knowledge regarding the ~~CD-PASS~~CDPASS service delivery model, "Independent Living Philosophy," and demonstrate competency in person-centered planning.

(C) Providers may only claim time for billable case management activities, described as:

(i) Any task or function, per Oklahoma Administrative Code (OAC) 317:30-5-763(1)(A) that only an ADvantage case manager, because of skill, training, or authority can perform on behalf of a member; and

(ii) Ancillary activities, such as clerical tasks, including, but not limited to, mailing, copying, filing, faxing, driving time, or supervisory and administrative activities are not billable case management activities. The administrative cost of these activities and other normal and customary business overhead costs are included in the reimbursement rate for billable activities.

(D) Case management services are prior authorized and billed per fifteen (15) minute unit of service using the rate associated with the location of residence of the member served.

(i) Case management services are billed using a standard rate for reimbursement for billable service activities provided to a member who resides in a county with a population density greater than twenty-five (25) persons per square mile.

(ii) Case management services are billed using a very rural/outside providers' service area rate for billable service activities provided to a member who resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile. Exceptions are services to members who reside in Oklahoma Human Services (OKDHS) Community Living, Aging and Protective Services identified zip codes in Osage County adjacent to the metropolitan areas of Tulsa and Washington counties. Services to these members are prior authorized and billed using the standard rate.

(iii) The latest United States Census, Oklahoma counties population data is the source for determination of whether a member resides in a county with a population density equal to, or less than twenty-five (25) persons per square mile or resides in a county with a population density greater than twenty-five (25) persons per square mile.

(2) **Respite.**

(A) Respite services are provided to members who are unable to care for themselves. Services are provided on a short-term basis due to the primary caregiver's absence or need for relief. Payment for respite care does not include room and board costs unless more than seven (7) hours are provided in a NF. Respite care is only utilized when other sources of care and support are exhausted. Respite care is only listed on the service plan when it

is necessary to prevent institutionalization of the member. Units of services are limited to the number of units approved on the service plan.

(B) In-home respite services are billed per fifteen (15) minute unit of service. Within any one (1) day period, a minimum of eight (8) units [two (2) hours] must be provided with a maximum of twenty-eight (28) units [seven (7) hours] provided. The service is provided in the member's home.

(C) Facility-based extended respite is filed for a per diem rate when provided in a NF. Extended respite must be at least eight (8) hours in duration.

(D) In-home extended respite is filed for a per diem rate. A minimum of eight (8) hours must be provided in the member's home.

(3) **Adult day health (ADH) care.**

(A) ADH is furnished on a regularly scheduled basis for one (1) or more days per week in an outpatient setting. It provides both health and social services necessary to ensure the member's optimal functioning. Most assistance with activities of daily living (ADLs), such as eating, mobility, toileting, and nail care are integral to the ADH care service and are covered by the ADH care basic reimbursement rate.

(B) ADH care is a fifteen (15) minute unit of service. No more than eight (8) hours, [thirty-two (32) units] are authorized per day. The number of units of service a member may receive is limited to the number of units approved on the member's approved service plan.

(C) Physical, occupational, and speech therapies are only provided as an enhancement to the basic ADH care service when authorized by the service plan and are billed as a separate procedure. ADH care therapy enhancement is a maximum of one (1) session unit per day of service.

(D) Meals provided as part of this service do not constitute a full nutritional regimen. One (1) meal, that contains at least one-third (1/3) of the current daily dietary recommended intake (DRI), as established by the Food and Nutrition Board of the National Academies of Sciences, Engineering, and Medicine, is provided to those participants who are in the center for four (4) or more hours per day and does not constitute a full nutritional regimen. Member's access to food at any time must also be available in addition to the required meal and is consistent with an individual not receiving Medicaid-funded services and supports.

(E) Personal care service enhancement in ADH is assistance in bathing, hair care, or laundry service, authorized by the person-centered service plan and billed as separate procedures. This service is authorized when an ADvantage waiver member who uses ADH requires assistance with bathing, hair care, or laundry to maintain health and safety. Assistance with bathing, hair care, or laundry is not a usual and customary ADH care service. ADH personal care enhancement is a maximum of one (1) unit per day of bathing, hair care, or laundry service.

(F) OKDHS Home and Community-Based Services (HCBS) waiver settings have qualities defined in Home and Community-Based Services: Waiver Requirements, 42 Code of Federal Regulations, Section (§) 441.301 (c)(4) based on the individual's needs, defined in the member's authorized service plan.

(i) The ADH center is integrated and supports full access of ADvantage members to the greater community, including opportunities to:

(I) Seek employment and work in competitive integrated ADH Center, not a requirement for persons that are retirement age;
(II) Engage in community life;
(III) Control personal resources; and
(IV) Receive services in the community, to the same degree as individuals not receiving ADvantage Program or other Medicaid HBCS waiver services.

(ii) The ADH is selected by the member from all available service options and given the opportunity to visit and understand the options.

(iii) The ADH ensures the member's rights of privacy, dignity, respect, and freedom from coercion and restraint.

(iv) The ADH optimizes the member's initiative, autonomy, and independence in making life choices including, but not limited to:
(I) Daily activities;
(II) The physical environment; and
(III) Social interactions.

(v) The ADH facilitates the member's choice regarding services and supports including the provider.

(vi) Each member has the freedom and support to control his or her own schedules, activities, and access to food at any time.

(vii) Each member may have visitors whenever he or she chooses.

(viii) The ADH center is physically accessible to the member.

(G) ADH centers that are presumed not to be HCBS settings per 42 C.F.R. § 441.301(c)(5)(v) include, ADH centers:
(i) In a publicly- or privately-owned facility providing inpatient treatment;
(ii) On the grounds of or adjacent to a public institution; and
(iii) With the effect of isolating individuals from the broader community of individuals not receiving ADvantage program or another Medicaid HCBS;

(H) When the ADH is presumed not HCBS, according to 42 C.F.R. § 441.301(c)(5)(v), it may be subject to heightened scrutiny by AA, the Oklahoma Health Care Authority (OHCA), and the Centers for Medicare and Medicaid Services (CMS). The ADH must provide evidence that the ADH portion of the facility has clear administrative, financial, programmatic, and environmental distinctions from the institution and comply with additional monitoring by the AA.

(4) **Environmental modifications**.

(A) Environmental modifications are physical adaptations to the home, required by the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety or enable the member to function with greater independence in the home, and that without such, the member would require institutionalization. Adaptations or improvements to the home not of direct medical or remedial benefit to the waiver member are excluded.

(B) All services require prior authorization.

(5) **Specialized medical equipment and supplies.**

(A) Specialized medical equipment and supplies are devices, controls, or appliances specified in the person-centered service plan that enable members to increase their abilities to perform ADLs, or to perceive, control, or communicate with the environment in which they live. Necessary items for life support, ancillary supplies, and equipment

necessary for the proper functioning of such items, and durable and non-durable medical equipment not available under the Oklahoma Medicaid State Plan are also included. This service excludes any equipment or supply items not of direct medical or remedial benefit to the waiver member and necessary to prevent institutionalization.

(B) Specialized medical equipment and supplies are billed using the appropriate HealthCare Common Procedure Code (HCPC). Reoccurring supplies shipped and delivered to the member are compensable only when the member remains eligible for waiver services, continues to reside in the home, and is not institutionalized in a hospital, skilled nursing facility, or nursing home. It is the provider's responsibility to verify the member's status prior to shipping and delivering these items. Payment for medical supplies is limited to the SoonerCare (Medicaid) rate when established, to the Medicare rate, or to actual acquisition cost, plus thirty percent (30%). All services must have prior authorization.

(6) **Advanced supportive/restorative assistance**.

(A) Advanced supportive/restorative assistance services are maintenance services used to assist a member who has a chronic, yet stable condition. These services assist with ADLs that require devices and procedures related to altered body functions. These services are for maintenance only and are not utilized as treatment services.

(B) Advanced supportive/restorative assistance service is billed per fifteen (15) minute unit of service. The number of units of service a member may receive is limited to the number of units approved on the person-centered service plan.

(7) **Nursing.**

(A) Nursing services are services listed in the person-centered service plan that are within the scope of the state's Nurse Practice Act. These services are provided by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed vocational nurse (LVN) under the supervision of an RN licensed to practice and in good standing in the state in which services are provided. Nursing services may be provided on an intermittent or part-time basis or may be comprised of continuous care. The provision of the nursing service works to prevent or postpone the institutionalization of the member.

(B) Nursing services are services of a maintenance or preventative nature provided to members with stable, chronic conditions. These services are not intended to treat an acute health condition and may not include services reimbursable under either the Medicaid or Medicare home health program. This service primarily provides nurse supervision to the personal care assistant or to the advanced supportive/restorative assistance aide and assesses the member's health and prescribed medical services to ensure they meet the member's needs as specified in the person-centered service plan. A nursing assessment/evaluation, on-site visit is made to each member, with additional visits for members with advanced supportive/restorative assistance services authorized to evaluate the condition of the member and medical appropriateness of services. An assessment/evaluation report is forwarded to the ADvantage program case manager and the skilled nurse in accordance with review schedule determined between the case manager and the skilled nurse and outlined in the member's person-centered service plan, to report the member's condition or other significant information concerning each ADvantage member.

(i) The ADvantage program case manager may recommend authorization of nursing services as part of the interdisciplinary team planning for the member's person-centered service plan and/or assessment/evaluation of the:

(I) Member's general health, functional ability, and needs; and/or

(II) Adequacy of personal care and/or advanced supportive/restorative assistance services to meet the member's needs, including providing on-the-job training and competency testing for personal care or advanced supportive/restorative care aides per rules and regulations for the delegation of nursing tasks established by the Board of Nursing in the state in which services are provided.

(ii) In addition to assessment/evaluation, the ADvantage program case manager may recommend authorization of nursing services to:

(I) Prepare a one (1) week supply of insulin syringes for a person who is blind and has diabetes and can safely self-inject the medication but cannot fill his or her own syringe. This service includes monitoring the member's continued ability to self-administer the insulin;

(II) Prepare oral medications in divided daily compartments for a member who self-administers prescribed medications but needs assistance and monitoring due to a minimal level of disorientation or confusion;

(III) Monitor a member's skin condition when a member is at risk for skin breakdown due to immobility or incontinence or the member has a chronic stage II decubitus ulcer requiring maintenance care and monitoring;

(IV) Provide nail care for a member with diabetes or who has circulatory or neurological compromise; and

(V) Provide consultation and education to the member, member's family, or other informal caregivers identified in the person-centered service plan, regarding the nature of the member's chronic condition. Skills training, including return skills demonstration to establish competency, to the member, family, or other informal caregivers as specified in the person-centered service plan for preventive and rehabilitative care procedures are also provided.

(C) Nursing service includes interdisciplinary team planning and recommendations for the member's person-centered service plan development and/or assessment/evaluation or for other services within the scope of the nurse's license, including private duty nursing. Nursing services are billed per fifteen (15) minute unit of service. A specific procedure code is used to bill for interdisciplinary team planning and recommendations for the member's person-centered service plan, but other procedure codes may be used to bill for all other authorized nursing services. A maximum of eight (8) units [two (2) hours], per day of nursing for service plan development and assessment evaluation are allowed. An agreement by a provider to perform a nurse evaluation is also an agreement to provide the Medicaid in-home care services for which the provider is certified and contracted. Reimbursement for a nurse evaluation is denied when the provider that produced the nurse evaluation fails to provide the nurse assessment identified in the Medicaid in-home care services for which the provider is certified and contracted.

(8) **Skilled nursing services.**

(A) Skilled nursing services are listed in the person-centered service plan, within the state's Nurse Practice Act scope, and are ordered by a licensed physician, osteopathic

physician, physician assistant, or advanced practice nurse, and are provided by a RN, LPN, or LVN under the supervision of a RN, licensed to practice and in good standing in the state where services are provided. Skilled nursing services provided in the member's home or other community setting are services requiring the specialized skills of a licensed nurse. The scope and nature of these services are intended for treatment of a disease or a medical condition and are beyond the scope of ADvantage nursing services. These intermittent nursing services are targeted toward a prescribed treatment or procedure that must be performed at a specific time or other predictable rate of occurrence. The RN contacts the member's physician to obtain necessary information or orders pertaining to the member's care. When the member has an ongoing need for service activities requiring more or less units than authorized, the RN must recommend, in writing, that the service plan be revised.

(B) Skilled nursing services are provided on an intermittent or part-time basis, and billed per fifteen (15) minute unit of service. Skilled nursing services are provided when nursing services are not available through Medicare or other sources or when SoonerCare plan nursing services limits are exhausted. Amount, frequency, and duration of services are prior-authorized in accordance with the member's person-centered service plan.

(9) **Home-delivered meals.**

(A) Home-delivered meals provide ~~one (1)~~ up to two (2) meals per day. A home-delivered meal is a meal prepared in advance and brought to the member's home. Each meal must have a nutritional content equal to at least one-third (1/3) of the dietary reference intakes as established by the Food and Nutrition Board of the National Academies of Sciences, Engineering and Medicine. Home-delivered meals are only provided to members who are unable to prepare meals and lack an informal provider to do meal preparation.

(B) Home-delivered meals are billed per meal, with one (1) meal equaling one (1) unit of service. The limit of the number of units a member is allowed to receive is in accordance with the member's person-centered service plan. ~~The provider must obtain a signature from the member or the member's representative at the time the meal is delivered. In the event the member is temporarily unavailable, such as at a doctor's appointment and the meal is left at the member's home, the provider must document the reason a signature was not obtained. The signature logs must be available for review.~~ Providers will redeliver missing meals as reported by the member unless the provider has a reliable mechanism for showing meals were delivered including, but not limited to, a signature of the member or the member's representative; a delivery driver's attestation that delivery occurred; a tracking statement of a common carrier, or delivery invoice of a common carrier. Signatures are not required to verify delivery. Electronic systems for verifying delivery are permitted.

(10) **Occupational therapy services.**

(A) Occupational therapy services are services that increase functional independence by enhancing the development of adaptive skills and performance capacities of members with physical disabilities and related psychological and cognitive impairments. Services are provided in the member's home and are intended to help the member achieve greater independence, enabling him or her to reside and participate in the community. Treatment involves the therapeutic use of self-care, work, and play activities, and may include modification of the tasks or environment to enable the member to achieve maximum independence, prevent further disability, and maintain health. Under a physician's order,

a licensed occupational therapist evaluates the member's rehabilitation potential and develops an appropriate written, therapeutic regimen. The regimen utilizes paraprofessional, occupational therapy assistant services, within the limitations of his or her practice, working under the supervision of a licensed occupational therapist. The regimen includes education and training for informal caregivers to assist with or maintain services when appropriate. The occupational therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Occupational therapy services are billed per fifteen (15) minute unit of service. Payment is not allowed solely for written reports or record documentation.

(11) **Physical therapy services.**

(A) Physical therapy services are those services that maintain or improve physical disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in the member's home and are intended to help the member achieve greater independence to reside and participate in the community. Treatment involves the use of physical therapeutic means, such as massage, manipulation, therapeutic exercise, cold and/or heat therapy, hydrotherapy, electrical stimulation, and light therapy. Under a physician's order, a licensed physical therapist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. Under the Oklahoma Physical Therapy Practice Act, a physical therapist may evaluate a member's rehabilitation potential and develop and implement an appropriate, written, therapeutic regimen without a referral from a licensed health care practitioner for a period not to exceed thirty (30) calendar days. Any treatment required after the thirty (30) calendar day period requires a prescription from a physician or the physician's assistant of the licensee. The regimen utilizes paraprofessional physical therapy assistant services, within the limitations of his or her practice, working under the licensed physical therapist’s supervision. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The licensed physical therapist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Physical therapy services may be authorized as ADH care therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(12) **Speech and language therapy services.**

(A) Speech and language therapy services are those that maintain or improve speech and language communication and swallowing disorders/disability through the evaluation and rehabilitation of members disabled by pain, disease, or injury. Services are provided in an ADH service setting and are intended to help the member achieve greater independence to reside and participate in the community. Services involve the use of therapeutic means, such as evaluation, specialized treatment, or development and oversight of a therapeutic maintenance program. Under a physician's order, a licensed speech and language pathologist evaluates the member's rehabilitation potential and develops an appropriate, written, therapeutic regimen. The regimen utilizes speech

language pathology assistant services within the limitations of his or her practice, working under the supervision of the licensed speech and language pathologist. The regimen includes education and training for informal caregivers to assist with and/or maintain services when appropriate. The speech and language pathologist ensures monitoring and documentation of the member's rehabilitative progress and reports to the member's case manager and physician to coordinate the necessary addition and/or deletion of services, based on the member's condition and ongoing rehabilitation potential.

(B) Speech and language therapy services are authorized as ADH care-therapy enhancement and are a maximum of one (1) session unit per day of service. Payment is not allowed solely for written reports or record documentation.

(13) **Hospice services.**

(A) Hospice services are palliative and comfort care provided to the member and his or her family when a physician certifies the member has a terminal illness, with a life expectancy of six (6) months or less, and orders hospice care. ADvantage hospice care is authorized for a six (6) month period and requires physician certification of a terminal illness and orders of hospice care. When the member requires more than six (6) months of hospice care, a physician or nurse practitioner must have a face-to-face visit with the member thirty (30) calendar days prior to the initial hospice authorization end-date, and re-certify that the member has a terminal illness, has six (6) months or less to live, and orders additional hospice care. After the initial authorization period, additional periods of ADvantage hospice may be authorized for a maximum of sixty (60) calendar day increments with physician certification that the member has a terminal illness and six (6) months or less to live. A member's person-centered service plan that includes hospice care must comply with Waiver requirements to be within total person-centered service plan cost limits.

(B) A hospice program offers palliative and supportive care to meet the special needs arising out of the physical, emotional, and spiritual stresses experienced during the final stages of illness, through the end of life, and bereavement. The member signs a statement choosing hospice care instead of routine medical care with the objective to treat and cure the member's illness. Once the member has elected hospice care, the hospice medical team assumes responsibility for the member's medical care for the illness in the home environment. Hospice care services include nursing care, physician services, medical equipment and supplies, drugs for symptom and pain relief, home health aide and personal care services, physical, occupational and speech therapies, medical social services, dietary counseling, and grief and bereavement counseling to the member and/or the member's family.

(C) A hospice person-centered service plan must be developed by the hospice team in conjunction with the member's ADvantage case manager before hospice services are provided. The hospice services must be related to the palliation or management of the member's terminal illness, symptom control, or to enable the member to maintain ADL and basic functional skills. A member who is eligible for Medicare hospice provided as a Medicare Part A benefit, is not eligible to receive ADvantage hospice services.

(D) Hospice services are billed per diem of service for days covered by a hospice person-centered service plan and while the hospice provider is responsible for providing hospice services as needed by the member or member's family. The maximum total annual reimbursement for a member's hospice care within a twelve (12) month period is limited

to an amount equivalent to eighty-five percent (85%) of the Medicare hospice cap payment, and must be authorized on the member's person-centered service plan.

(14) **ADvantage personal care.**

(A) ADvantage personal care is assistance to a member in carrying out ADLs, such as bathing, grooming, and toileting or in carrying out instrumental activities of daily living (IADLs), such as preparing meals and laundry service, to ensure the member's personal health and safety, or to prevent or minimize physical health regression or deterioration. Personal care services do not include service provision of a technical nature, such as tracheal suctioning, bladder catheterization, colostomy irrigation, or the operation and maintenance of equipment of a technical nature.

(B) ADvantage home care agency skilled nursing staff working in coordination with an ADvantage case manager is responsible for the development and monitoring of the member's personal care services.

(C) ADvantage personal care services are prior-authorized and billed per fifteen (15) minute unit of service, with units of service limited to the number of units on the ADvantage approved person-centered service plan.

(15) **Personal emergency response system (PERS).**

(A) PERS is an electronic device that enables members at high risk of institutionalization, to secure help in an emergency. Members may also wear a portable "help" button to allow for mobility. PERS is connected to the person's phone and programmed to signal, per member preference, a friend, relative, or a response center, once the "help" button is activated. For an ADvantage member to be eligible for PERS service, the member must meet all service criteria in (i) through (vi). The member:

(i) Has a recent history of falls as a result of an existing medical condition that prevents the member from getting up unassisted from a fall;

(ii) Lives alone and without a regular caregiver, paid or unpaid, and therefore is left alone for long periods of time;

(iii) Demonstrates the capability to comprehend the purpose of and activate the PERS;

(iv) Has a health and safety plan detailing the interventions beyond the PERS to ensure the member's health and safety in his or her home;

(v) Has a disease management plan to implement medical and health interventions that reduce the possibility of falls by managing the member's underlying medical condition causing the falls; and

(vi) Will likely avoid premature or unnecessary institutionalization as a result of PERS.

(B) PERS services are billed using the appropriate HCPC procedure code for installation, monthly service, or PERS purchase. All services are prior authorized per the ADvantage approved service plan.

(16) ~~**CD-PASS.**~~**CDPASS.**

(A) ~~CD-PASS~~CDPASS are personal services assistance (PSA) and advanced personal services assistance (APSA) that enables a member in need of assistance to reside in his or her home and community of choice, rather than in an institution; and to carry out functions of daily living, self-care, and mobility. ~~CD-PASS~~CDPASS services are delivered as authorized on the person-centered service plan. The member becomes the employer of record and employs the PSA and the APSA. The member is responsible, with

assistance from ADvantage program administrative Financial Management Services (FMS), for ensuring the employment complies with state and federal labor law requirements. The member/employer may designate an adult family member or friend, who is not a PSA or APSA to the member, as an "authorized representative" to assist in executing the employer functions. The member/employer:

(i) Recruits, hires, and, as necessary, discharges the PSA or APSA;

(ii) Ensures the PSA or APSA has received sufficient instruction and training. If needed, the member/employer will work with the consumer-directed agent/case manager (CDA) to obtain training assistance from ADvantage skilled nurses. Prior to performing an APSA task for the first time, the APSA must demonstrate competency in the tasks in an on-the-job training session conducted by the member, and the member must document the attendant's competency in performing each task in the APSA's personnel file;

(iii) Determines where and how the PSA or APSA works, hours of work, what is to be accomplished and, within individual budget allocation limits, wages to be paid for the work;

(iv) Supervises and documents employee work time; and

(v) Provides tools and materials for work to be accomplished.

(B) The services the PSA may provide include:

(i) Assistance with mobility and transferring in and out of bed, wheelchair, or motor vehicle, or all;

(ii) Assistance with routine bodily functions, such as:

(I) Bathing and personal hygiene;

(II) Dressing and grooming; and

(III) Eating, including meal preparation and cleanup;

(iii) Assistance with home services, such as shopping, laundry, cleaning, and seasonal chores;

(iv) Companion assistance, such as letter writing, reading mail, and providing escort or transportation to participate in approved activities or events. "Approved activities or events," means community, civic participation guaranteed to all citizens including, but not limited to, exercise of religion, voting or participation in daily life activities in which exercise of choice and decision making is important to the member, and may include shopping for food, clothing, or other necessities, or for participation in other activities or events specifically approved on the person-centered service plan.

(C) An APSA ~~provides assistance with ADLs to~~assists a member with a stable, chronic condition with ADLs, when such assistance requires devices and procedures related to altered body function if such activities, in the opinion of the attending physician or licensed nurse, may be performed if the member were physically capable, and the procedure may be safely performed in the home. Services provided by the APSA are maintenance services and are never used as therapeutic treatment. Members who develop medical complications requiring skilled nursing services while receiving APSA services are referred to his or her attending physician, who may order home health services, as appropriate. APSA includes assistance with health maintenance activities that may include:

(i) Routine personal care for persons with ostomies, including tracheotomies, gastrostomies, and colostomies with well-healed stoma, external, indwelling, and

suprapubic catheters that include changing bags and soap and water hygiene around the ostomy or catheter site;

(ii) Removing external catheters, inspecting skin, and reapplication of same;

(iii) Administering prescribed bowel program, including use of suppositories and sphincter stimulation, and enemas pre-packaged only without contraindicating rectal or intestinal conditions;

(iv) Applying medicated prescription lotions or ointments and dry, non-sterile dressings to unbroken skin;

(v) Using a lift for transfers;

(vi) Manually assisting with oral medications;

(vii) Providing passive range of motion (non-resistive flexion of joint) therapy, delivered in accordance with the person-centered service plan unless contraindicated by underlying joint pathology;

(viii) Applying non-sterile dressings to superficial skin breaks or abrasions; and

(ix) Using universal precautions as defined by the Centers for Disease Control and Prevention.

(D) FMS are program administrative services provided to participating ~~CD-PASS~~CDPASS members/employers by AA. FMS are employer-related assistance that provides Internal Revenue Service (IRS) fiscal reporting agent and other financial management tasks and functions, including, but not limited to:

(i) Processing employer payroll, after the member/employer has verified and approved the employee timesheet, at a minimum of semi-monthly, and associated withholding for taxes, or for other payroll withholdings performed on behalf of the member as employer of the PSA or APSA;

(ii) Other employer-related payment disbursements as agreed to with the member/employer and in accordance with the member/employer's individual budget allocation;

(iii) Responsibility for obtaining criminal and abuse registry background checks on prospective hires for PSA or APSA on the member/employer's behalf;

(iv) Providing orientation and training regarding employer responsibilities, as well as employer information and management guidelines, materials, tools, and staff consultant expertise to support and assist the member to successfully perform employer-related functions; and

(v) Making Hepatitis B vaccine and vaccination series available to PSA and APSA employees in compliance with Occupational Safety and Health Administration (OSHA) standards.

(E) The PSA service is billed per fifteen (15) minute unit of service. The number of units of PSA a member may receive is limited to the number of units approved on the person-centered service plan.

(F) The APSA service is billed per fifteen (15) minute unit of service. The number of units of APSA a member may receive is limited to the number of units approved on the person-centered service plan.

(17) **Institution transition services.**

(A) Institution transition services are those services necessary to enable a member to leave the institution and receive necessary support through ADvantage waiver services in his or her home and community.

(B) Transitional case management services are services per OAC 317:30-5-763(1) required by the member and included on the member's person-centered service plan that are necessary to ensure the member's health, welfare, and safety, or to enable the member to function with greater independence in the home, and without which, the member would continue to require institutionalization. ADvantage transitional case management services assist institutionalized members who are eligible to receive ADvantage services in gaining access to needed waiver and other State Plan services, as well as needed medical, social, educational, and other services to assist in the transition, regardless of the funding source for the services to which access is gained. Transitional case management services may be authorized for periodic monitoring of an ADvantage member's progress during an institutional stay and for assisting the member to transition from institution to home by updating the person-centered service plan, including necessary institution transition services to prepare services and supports to be in place or to start on the date the member is discharged from the institution. Transitional case management services may be authorized to assist individuals that have not previously received ADvantage services, but were referred by CAP to the case management provider for assistance in transitioning from the institution to the community with ADvantage services support.

(i) Institution transition case management services are prior authorized and billed per fifteen (15) minute unit of service using the appropriate HCPC procedure code and modifier associated with the location of residence of the member served, per OAC 317:30-5-763(1)(D).

(ii) A unique modifier code is used to distinguish institution transitional case management services from regular case management services.

(C) Institution transition services may be authorized and reimbursed, per the conditions in (i) through (iv).

(i) The service is necessary to enable the member to move from the institution to his or her home.

(ii) The member is eligible to receive ADvantage services outside of the institutional setting.

(iii) Institution transition services are provided to the member within one-hundred and eighty (180) calendar-days of discharge from the institution.

(iv) Services provided while the member is in the institution are claimed as delivered on the day of discharge from the institution.

(D) When the member receives institution transition services but fails to enter the waiver, any institution transition services provided are not reimbursable.

(18) **Assisted living services (ALS).**

(A) ALS are personal care and supportive services furnished to waiver members who reside in a homelike, non-institutional setting that includes twenty-four (24) hour on-site response capability to meet scheduled or unpredictable member needs and to provide supervision, safety, and security. Services also include social and recreational programming and medication assistance, to the extent permitted under State law. The ALS provider is responsible for coordinating services provided by third parties to ADvantage members in the assisted living center (ALC). Nursing services are incidental rather than integral to the provision of ALS. ADvantage reimbursement for ALS includes services of personal care, housekeeping, laundry, meal preparation, periodic nursing evaluations, nursing supervision during nursing intervention, intermittent or unscheduled

nursing care, medication administration, assistance with cognitive orientation, assistance with transfer and ambulation, planned programs for socialization, activities, and exercise, and for arranging or coordinating transportation to and from medical appointments. Services, except for planned programs for socialization, activities, and exercise, are to meet the member's specific needs as determined through the individualized assessment and documented on the member's person-centered service plan.

(B) The ADvantage ALS philosophy of service delivery promotes member choice, and to the greatest extent possible, member control. A member has control over his or her living space and his or her choice of personal amenities, furnishings, and activities in the residence. The ADvantage member must have the freedom to control his or her schedule and activities. The ALS provider's documented operating philosophy, including policies and procedures, must reflect and support the principles and values associated with the ADvantage assisted living philosophy and approach to service delivery emphasizing member dignity, privacy, individuality, and independence.

(C) ADvantage ALS required policies for admission and termination of services and definitions.

(i) ADvantage-certified assisted living centers (ALC) are required to accept all eligible ADvantage members who choose to receive services through the ALC, subject only to issues relating to, one (1) or more of the following:

(I) Rental unit availability;

(II) The member's compatibility with other residents;

(III) The center's ability to accommodate residents who have behavior problems, wander, or have needs that exceed the services the center provides; or

(IV) Restrictions initiated by statutory limitations.

(ii) The ALC may specify the number of units the provider is making available to service ADvantage members. At minimum, the ALC must designate ten (10) residential units for ADvantage members. Residential units designated for ADvantage may be used for other residents at the ALC when there are no pending ADvantage members for those units. Exceptions may be requested in writing subject to the approval of AA.

(iii) Mild or moderate cognitive impairment of the applicant is not a justifiable reason to deny ALC admission. Centers are required to specify whether they are able to accommodate members who have behavior problems or wander. Denial of admission due to a determination of incompatibility must be approved by the case manager and the AA. Appropriateness of placement is not a unilateral determination by the ALC. The ADvantage case manager, the member, or member's designated representative, and the ALC in consultation determine the appropriateness of placement.

(iv) The ALC is responsible for meeting the member's needs for privacy, dignity, respect, and freedom from coercion and restraint. The ALC must optimize the member's initiative, autonomy, and independence in making life choices. The ALC must facilitate member choices regarding services and supports, and who provides them. Inability to meet those needs is not recognized as a reason for determining an ADvantage member's placement is inappropriate. The ALC agrees to provide or arrange and coordinate all services listed in the Oklahoma State Department of Health (OSDH) regulations, per OAC 310:663-3-3, except for specialized services.

(v) In addition, the ADvantage participating ALC agrees to provide or coordinate the

services listed in (I) through (III).

(I) Provide an emergency call system for each participating ADvantage member.

(II) Provide up to three (3) meals per day plus snacks sufficient to meet nutritional requirements, including modified special diets, appropriate to the member's needs and choices; and provide members with twenty-four (24) hour access to food by giving members control in the selection of the foods they eat, by allowing the member to store personal food in his or her room, by allowing the member to prepare and eat food in his or her room, and allowing him or her to decide when to eat.

(III) Arrange or coordinate transportation to and from medical appointments. The ALC must assist the member with accessing transportation for integration into the community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, and control his or her personal resources and receive services in the community to the same degree of access as residents not receiving ADvantage services.

(vi) The provider may offer any specialized service or rental unit for members with Alzheimer's disease and related dementias, physical disabilities, or other special needs the facility intends to market. Heightened scrutiny, through additional monitoring of the ALC by AA, is utilized for those ALC's that also provide inpatient treatment; settings on the grounds of or adjacent to a public institution and/or other settings that tend to isolate individuals from the community. The ALC must include evidence that the ALC portion of the facility has clear administrative, financial, programmatic and environmental distinctions from the institution.

(vii) When the provider arranges and coordinates services for members, the provider is obligated to ensure the provision of those services.

(viii) Per OAC 310:663-1-2, "personal care" is defined as "assistance with meals, dressing, movement, bathing or other personal needs or maintenance, or general supervision of the physical and mental well-being of a person [Title 63 of the Oklahoma Statutes (O.S.), Section (§) 1-1902.17] and includes assistance with toileting." For ADvantage ALS, assistance with "other personal needs" in this definition includes assistance with grooming and transferring. The term "assistance" is clarified to mean hands-on help, in addition to supervision.

(ix) The specific ALS assistance provided along with amount and duration of each type of assistance is based upon the member's assessed need for service assistance and is specified in the ALC's service plan that is incorporated as supplemental detail into the ADvantage comprehensive person-centered service plan. The ADvantage case manager in cooperation with ALC professional staff, develops the person-centered service plan to meet member needs. As member needs change, the person-centered service plan is amended consistent with the assessed, documented need for change in services.

(x) Placement, or continued placement of an ADvantage member in an ALC, is inappropriate when any one (1) or more of the conditions in I through IV exist.

(I) The member's needs exceed the level of services the center provides. Documentation must support ALC efforts to provide or arrange for the required services to accommodate participant needs.

(II) The member exhibits behaviors or actions that repeatedly and substantially interfere with the rights or well-being of other residents, and the ALC documented efforts to resolve behavior problems including medical, behavioral, and increased staffing interventions. Documentation must support the ALC's attempted interventions to resolve behavior problems.

(III) The member has a complex, unstable, or unpredictable medical condition and treatment cannot be developed and implemented appropriately in the assisted living environment. Documentation must support the ALC's attempts to obtain appropriate member care.

(IV) The member fails to pay room and board charges or OKDHS determined vendor payment obligation.

(xi) Termination of residence ensues when inappropriately placed. Once a determination is made that a member is inappropriately placed, the ALC must inform the member, the member's representative, if applicable, the AA, and the member's ADvantage case manager. The ALC must develop a discharge plan in consultation with the member, the member's representative, the ADvantage case manager, and the AA. The ALC and case manager must ensure the discharge plan includes strategies for providing increased services, when appropriate, to minimize risk and meet the higher care needs of members transitioning out of the ALC, when the reason for discharge is inability to meet member needs. When voluntary termination of residency is not arranged, the ALC must provide written notice to the member and to the member's representative, with a copy to the member's ADvantage case manager and the AA. The written notice provides intent to terminate the residency agreement and move the member to an appropriate care provider. The thirty (30) calendar-day requirement must not apply when emergency termination of the residency agreement is mandated by the member's immediate health needs or when the termination of the residency agreement is necessary for the physical safety of the member or other ALC residents. The written involuntary termination of residency notice for reasons of inappropriate placement must include:

(I) A full explanation of the reasons for the termination of residency;

(II) The notice date;

(III) The date notice was given to the member and the member's representative, the ADvantage case manager, and the AA;

(IV) The date the member must leave ALC; and

(V) Notification of appeal rights and the process for submitting appeal of termination of Medicaid ALS to OHCA.

(D) ADvantage ALS provider standards in addition to licensure standards.

(i) **Physical environment.**

(I) The ALC must provide lockable doors on the entry door of each rental unit and an attached, lockable compartment within each member unit for valuables. Members must have exclusive rights to his or her unit with lockable doors at the entrance of the individual or shared rental unit. Keys to rooms may be held by only appropriate ALC staff as designated by the member's choice. Rental units may be shared only when a request to do so is initiated by the member. Members must be given the right to choose his or her roommate.

(II) The member has a legally enforceable agreement, or lease, with the ALC.

The member must have the same responsibilities and protections from eviction as all tenants under the landlord-tenant law of the state, county, city, or other designated entity.

(III) The ALC must provide each rental unit with a means for each member to control the temperature in the residential unit through the use of a damper, register, thermostat, or other reasonable means under the control of the member and that preserves privacy, independence, and safety, provided that the OSDH may approve an alternate means based on documentation that the design of the temperature control is appropriate to the special needs of each member who has an alternate temperature control.

(IV) For ALCs built prior to January 1, 2008, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of two-hundred and fifty (250) square feet; for ALCs built after December 31, 2007, each ALC individual residential unit must have a minimum total living space, including closets and storage areas, of three-hundred and sixty (360) square feet.

(V) The ALC must provide a private bathroom for each living unit that must be equipped with one (1) lavatory, one (1) toilet, and one (1) bathtub or shower stall.

(VI) The ALC must provide at a minimum; a kitchenette, defined as a space containing a refrigerator, adequate storage space for utensils, and a cooking appliance. A microwave is an acceptable cooking appliance.

(VII) The member is responsible for furnishing the rental unit. When a member is unable to supply basic furnishings defined as a bed, dresser, nightstand, chairs, table, trash can, and lamp, or if furnishings pose a health or safety risk, the member's ADvantage case manager in coordination with the ALC, must assist the member in obtaining basic furnishings for the rental unit. The member must have the freedom to furnish and decorate the rental unit within the scope of the lease or residency agreement.

(VIII) The ALC must meet the requirements of all applicable federal and state laws and regulations including, but not limited to, state and local sanitary codes, state building and fire safety codes, and laws and regulations governing use and access by persons with disabilities.

(IX) The ALC must ensure the design of common areas accommodates the special needs of the resident population and that the rental unit accommodates the special needs of the member in compliance with the Americans with Disabilities Act accessibility guidelines per Nondiscrimination on the Basis of Disability By Public Accommodations and in in Commercial Facilities, 28 Code of Federal Regulations, Appendix A, at no additional cost to the member.

(X) The ALC must provide adequate and appropriate social and recreational space for residents and the common space must be proportionate to the number of residents and appropriate for the resident population.

(XI) The ALC must provide appropriately monitored outdoor space for resident use.

(XII) The ALC must provide the member with the right to have visitors of his or her choosing at any time. Overnight visitation is allowed as permissible by

the Landlord/Tenant Agreement.

(XIII) The ALC must be physically accessible to members.

(ii) **Sanitation.**

(I) The ALC must maintain the facility, including its individual rental units in a clean, safe, and sanitary manner, ensuring that they are insect and rodent free, odorless, and in good repair at all times.

(II) The ALC must maintain buildings and grounds in a good state of repair, in a safe and sanitary condition, and in compliance with the requirements of applicable regulations, bylaws, and codes.

(III) The ALC stores clean laundry in a manner that prevents contamination and changes linens at time intervals necessary to avoid health issues.

(IV) The ALC must provide housekeeping in member rental units to maintain a safe, clean, and sanitary environment.

(V) The ALC must have policies and procedures for members' pets.

(iii) **Health and safety.**

(I) The ALC must provide building security that protects members from intruders with security measures appropriate to building design, environmental risk factors, and the resident population.

(II) The ALC must respond immediately and appropriately to missing members, accidents, medical emergencies, or deaths.

(III) The ALC must have a plan in place to prevent, contain, and report any diseases considered to be infectious or are listed as diseases that must be reported to the OSDH.

(IV) The ALC must adopt policies for the prevention of abuse, neglect, and exploitation that include screening, training, prevention, investigation, protection during investigation, and reporting.

(V) The ALC must provide services and facilities that accommodate the needs of members to safely evacuate in the event of fires or other emergencies.

(VI) The ALC must ensure staff is trained to respond appropriately to emergencies.

(VII) The ALC must ensure that fire safety requirements are met.

(VIII) The ALC must offer meals that provide balanced and adequate nutrition for members.

(IX) The ALC must adopt safe practices for meal preparation and delivery.

(X) The ALC must provide a twenty-four (24) hour response to personal emergencies appropriate to the needs of the resident population.

(XI) The ALC must provide safe transportation to and from ALC sponsored social or recreational outings.

(iv) **Staff to resident ratios.**

(I) The ALC must ensure a sufficient number of trained staff are on duty, awake, and present at all times, twenty-four (24) hours a day, and seven (7) days a week, to meet resident's needs and to carry out all processes listed in the ALC's written emergency and disaster preparedness plan for fires and other disasters.

(II) The ALC must ensure staffing is sufficient to meet ADvantage program members' needs in accordance with each member's ADvantage person-centered service plan.

(III) The ALC must have plans in place to address situations where there is a disruption to the ALC's regular work force.

(v) **Staff training and qualifications.**

(I) The ALC must ensure staff has qualifications consistent with their job responsibilities.

(II) All staff assisting in, or responsible for, food service must have attended a food service training program offered or approved by OSDH.

(III) The ALC must provide staff orientation and ongoing training to develop and maintain staff knowledge and skills. All direct care and activity staff receive at least eight (8) hours of orientation and initial training within the first month of employment and at least four (4) hours annually thereafter. Staff providing direct care on a dementia unit must receive four (4) additional hours of dementia specific training. Annual first aid and cardiopulmonary resuscitation (CPR) certification do not count toward the four (4) hours of annual training.

(vi) **Staff supervision.**

(I) The ALC must ensure delegation of tasks to non-licensed staff is consistent and in compliance with all applicable state regulations including, but not limited to, the state's Nurse Practice Act and OSDH Nurse Aide Certification rules.

(II) The ALC must ensure that, where the monitoring of food intake or therapeutic diets is provided at the prescribed services level, a registered dietitian monitors member health and nutritional status.

(vii) **Resident rights.**

(I) The ALC must provide to each member and each member's representative, at the time of admission, a copy of the resident statutory rights listed in 63 O.S. § 1-1918 amended to include additional rights and the clarification of rights as listed in the ADvantage member assurances. A copy of resident rights must be posted in an easily accessible, conspicuous place in the facility. The facility must ensure that staff is familiar with and observes, the resident rights.

(II) The ALC must conspicuously post for display in an area accessible to residents, employees, and visitors, the ALC's complaint procedures and the name, address, and phone number of a person authorized to receive complaints. A copy of the complaint procedure must also be given to each member, the member's representative, or the legal guardian. The ALC must ensure all employees comply with the ALC's complaint procedure.

(III) The ALC must provide to each member and member's representative, at the time of admission, information about Medicaid grievance and appeal rights, including a description of the process for submitting a grievance or appeal of any decision that decreases Medicaid services to the member.

(viii) **Incident reporting.**

(I) The ALC must maintain a record of incidents that occur and report incidents to the member's ADvantage case manager and to the AA, utilizing the AA Critical Incident Reporting form. Incident reports are also made to Adult Protective Services (APS) and to the OSDH, as appropriate, per ALC licensure rules, utilizing the specific reporting forms required.

(II) Incidents requiring report by licensed ALC's are those defined by OSDH, per OAC 310:663-19-1 and listed ~~on~~in the ~~AA~~Provider Question Critical

Incident ~~Reporting form.~~Category.

(III) Reports of incidents must be made to the member's ADvantage case manager and to the AA via electronic submission within one (1) business day of the reportable incident's discovery utilizing the ~~AA~~Provider Question Critical Incident ~~Reporting form.~~Category. When required, a follow-up report of the incident must be submitted via electronic submission to the member's ADvantage case manager and to the AA. The follow-up report must be submitted within five (5) business days of the incident. The final report must be filed with the member's ADvantage case manager and the AA when the investigation is complete, not to exceed ten (10) business days after the incident.

(IV) Each ALC having reasonable cause to believe that a member is suffering from abuse, neglect, exploitation, or misappropriation of member property must make a report to APS as soon as the person is aware of the situation per 43A O.S. § 10-104.A. Reports are also made to OSDH, as appropriate, per ALC licensure rules.

(V) The preliminary incident report must at minimum, include who, what, when, where, and the measures taken to protect the member and resident(s) during the investigation. The follow-up report must, at minimum, include preliminary information, the extent of the injury or damage, if any, and preliminary investigation findings. The final report, at minimum, includes preliminary and follow-up information, a summary of investigative actions representing a thorough investigation, investigative findings and conclusions, and corrective measures to prevent future occurrences. When it is necessary to omit items, the final report must include why such items were omitted and when they will be provided.

(ix) Provision of, or arrangement for, necessary health services. The ALC must:

(I) Arrange or coordinate transportation for members to and from medical appointments; and

(II) Provide or coordinate with the member and the member's ADvantage case manager for delivery of necessary health services. The ADvantage case manager is responsible for monitoring that all health-related services required by the member as identified through assessment and documented on the person-centered service plan, are provided in an appropriate and timely manner. The member has the freedom to choose any available provider qualified by licensure or certification to provide necessary health services in the ALC.

(E) ALCs are billed per diem of service for days covered by the ADvantage member's person-centered service plan and during which the ALS provider is responsible for providing ALS for the member. The per diem rate for ADvantage ALS for a member is one (1) of three (3) per diem rate levels based on a member's need for type of, intensity of, and frequency of service to address member ADLs, instrumental activities of daily living (IADLs), and health care needs. The rate level is based on the Uniform Comprehensive Assessment Tool (UCAT) assessment by the member's ADvantage case manager employed by a case management agency independent of the ALS provider. The determination of the appropriate per diem rate is made by the AA clinical review staff.

(F) The ALC must notify AA ninety (90) calendar days before terminating or not renewing the ALC's ADvantage contract.

(i) The ALC must give notice in writing to the member, the member's representative(s), the AA, and the member's ADvantage case manager ninety (90) calendar days before:

(I) Voluntary cessation of the ALC's ADvantage contract; or

(II) Closure of all or part of the ALC.

(ii) The notice of closure must include:

(I) The proposed ADvantage contract termination date;

(II) The termination reason;

(III) An offer to assist the member secure an alternative placement; and

(IV) Available housing alternatives.

(iii) The facility must comply with all applicable laws and regulations until the closing date, including those related to resident transfer or discharge.

(iv) Following the last move to the last ADvantage member, the ALC must provide in writing to the AA:

(I) The effective date of closure based on the discharge date of the last resident;

(II) A list of members transferred or discharged and where they relocated,; and

(III) The plan for storage of resident records per OAC 310:663-19-3(g), relating to preservation of resident records and the name, address, and phone numbers of the person responsible for the records.

(19) **Remote Support (RS) services**.

(A) **Purpose and scope.** RS services are intended to promote a member's independence and self-direction. RS services are provided in the member's home to reduce reliance on in person support while ensuring the member's health and safety. RS services are included in the member's person-centered service plan and coordination of these services are made through the case manager.

(i) RS services are:

(I) Based on the member's needs as documented and supported by the member's person-centered service plan and person-centered assessments;

(II) Only authorized when submitted on the member's person-centered service plan with the consent of the member, involved household members, and guardian, as applicable;

(III) The least restrictive option and the member's preferred method to meet an assessed need; and

(IV) Provided when the member and the member's Interdisciplinary Team (IDT) agree to the provision of RS services.

(ii) RS services are not a system of surveillance or for provider convenience.

(B) **Service description**. RS services monitor a member by allowing for live, two-way communication between the member and monitoring staff using one (1) or more of the following systems:

(i) Live video feed;

(ii) Live audio feed;

(iii) Motion-sensor monitoring;

(iv) Radio frequency identification;

(v) Web-based monitoring; or

(vi) Global positioning system (GPS) monitoring devices.

(C) **General provider requirements.** RS service providers must have a valid OHCA SoonerCare (Medicaid) provider agreement to provide provider-based RS services to ADvantage HCBS waiver members and be certified by the AA. Requests for applications to provide RS services are made to AA.

(D) **Risk assessment.** Teams will complete a risk assessment to ensure remote supports can help meet the member's needs in a way that protects the right to privacy, dignity, respect, and freedom from coercion. The risk assessment is reviewed, and any issues are addressed prior to the implementation of remote supports general provider requirements.

(i) Remote support providers ensure the member's health and safety by contacting a member's informal support or activating the member's back-up plan when a health or safety issue becomes evident during monitoring.

(ii) The risk assessment and service plan require the team to develop a specific back-up plan to address health, safety and behavioral needs while remote supports are utilized so appropriate assistance can be provided. The RS back-up plan includes how assistance is provided to the member when equipment or technology fails.

(E) **RS guidelines.** Devices or monitors are placed at locations based on the member's individual needs as documented on the member's person-centered service plan and approved by the member and involved family members and guardian, as applicable.

(i) The use of camera or video equipment in the member's bedroom, bathroom, or other private area is prohibited.

(ii) When RS involves the use of audio or video equipment that permits RS staff to view activities or listen to conversations in the residence, the member who receives the service and each person who lives with the member is fully informed of what RS entails. The member's case manager documents consent in the member's person-centered service plan.

(iii) Waiver members have the ability to turn off the remote monitoring device or equipment if they choose to do so. The RS provider educates the member regarding how to turn RS devices off and on at the start of services and as desired thereafter.

(F) **Emergency response staff.**

(i) Emergency response staff are employed by a certified ADvantage Provider with a valid OHCA SoonerCare (Medicaid) contract to provide HCBS to OKDHS HCBS waiver members.

(ii) Informal emergency response persons are unpaid family members or other interested parties who agree to become, and are approved as, an emergency response person by the member and the member's IDT.

(G) **Service limitations.** RS services are limited to twenty-four (24) hours per day. RS services are not provided simultaneously with any other in-home direct care services. However, services may be provided through a combination of remote and in-home services dependent on the member's needs.

(H) **RS service discontinuation**. The member and the member's IDT determine when it is appropriate to discontinue RS services. When RS services are terminated, the RS provider coordinates service termination with the member's case manager to ensure a safe transition.

(20) **Assistive Technology (AT) services.**

(A) AT services include devices, controls, and appliances, specified in the member's person-centered service plan, which enable members to increase their abilities to perform activities of daily living or to perceive, control, or communicate with the environment in which they live.
(B) Devices may include communication technology, such as smart phones and tablets, that allow members to communicate with their providers using video chat to ensure ongoing maintenance of health and welfare.
(C) Only devices that are not covered under the SoonerCare (Medicaid) or Specialized Medical Equipment services are included in this service definition.
(D) Service codes and rates vary based on the nature of the AT device;
(E) AT services may include:
(i) Assessment for the need of AT or auxiliary aids;
(ii) Training the member or provider regarding use and maintenance of equipment or auxiliary aids; and
(iii) Repair of adaptive devices; and
(iv) Equipment provided may include:
(I) Video communication technology that allows members to communicate with providers through video communication. Video communication allows providers to assess and evaluate their members' health and welfare or other needs by enabling visualization of members and their environments. Examples include smart phones, tablets, audiovisual or virtual assistant technology, or sensors; and
(II) The cost of internet services may be augmented through the Emergency Broadband Benefit which is available to waiver members.

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

SUBCHAPTER 9. ICF/IID, HCBW/IID, AND INDIVIDUALS AGE 65 OR OLDER IN MENTAL HEALTH HOSPITALS

PART 1. SERVICES

317:35-9-1. Overview of long-term medical care services; relationship to Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), and other Medicaid services eligibility, and spenddown calculation

(a) ~~**Long Term Medical Care Services**. Long-term medical care for the categorically needy includes care in a nursing facility (refer to OAC 317:35-19), public and private intermediate care facility for the mentally retarded (refer to this subchapter), persons age 65 years or older in mental health hospitals (refer to this subchapter), Home and Community Based Waiver Services for the Intellectually Disabled (refer to this subchapter), and Home and Community Based Waiver Services for frail elderly and a targeted group of adults with physical disabilities age 21 and over who have not been determined to have a developmental disability, an intellectual disability or a related condition (refer to OAC 317:35-17). Personal Care provides services in the own home for categorically needy individuals (refer to OAC 317:35-15). Any time an individual is certified as eligible for Medicaid coverage of long-term care, the individual is also eligible for other Medicaid services. Another application or additional spenddown computation is not required. Spenddown is applied to the first long-term care claim filed. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination must be made to see if eligibility conditions as a Qualified Medicare Beneficiary (QMB) or Specified Low-Income Medicare Beneficiary (SLMB) are met. Another application for QMB or SLMB benefits is not required. Any spenddown computed for long-term care is not applicable to QMB or SLMB coverage.~~Long-term medical care for the categorically needy includes:

(1) Care in a nursing facility, per Oklahoma Administrative Code (OAC) 317:35-19;

(2) Public and private intermediate care facility for individuals with intellectual disabilities, per OAC 317:35-9;

(3) Persons age sixty-five (65) years or older in mental health hospitals, per OAC 317:35-9;

(4) Home and Community Based Waiver Services for the Intellectually Disabled, per OAC 317:35-9;

(5) Home and Community Based Waiver Services for the ADvantage program, per OAC 317:35-17; and

(6) State Plan Personal Care provides services, per OAC 317:35-15.

(b) Any time an individual is certified as eligible for ~~Medicaid coverage of~~ long-term care SoonerCare coverage, the individual is also eligible for other ~~Medicaid~~ SoonerCare services. Another application or additional spenddown computation is not required. Spenddown is applied to the first long-term care claim filed. Any time an aged, blind or disabled individual is determined eligible for long-term care, a separate determination ~~must be~~ is made to see if eligibility conditions as a ~~Qualified Medicare Beneficiary (QMB)~~QMB or ~~Specified Low-Income Medicare Beneficiary (SLMB)~~SLMB are met. Another application for QMB or SLMB benefits is not required. Any spenddown computed for long-term care is not applicable to QMB

or SLMB coverage.

~~(b)~~(c) ~~**Medicaid recovery.**~~ The State of Oklahoma operates a Medicaid ~~Recovery~~ program to recover cost for services identified in OAC 317:35-9-15. ~~Recovery can be accomplished in two ways: liens against real property or claims made against estates.~~

SUBCHAPTER 17. ADVANTAGE WAIVER SERVICES

317:35-17-4. Application for ADvantage services

(a) **Application procedures for ADvantage services**. If waiver slots are available, the application process initiates when an online application is completed for ADvantage services. A written financial application is not required for an individual who has an active Medicaid case. A financial application for ADvantage services consists of the Medical Assistance Application form. The form is signed by the applicant, parent, spouse, guardian, or someone else acting on the applicant's behalf.

(1) All conditions of financial eligibility must be verified and documented in the case record. When current information already available in the local office establishes financial eligibility, such information may be used by recording source and date of information. If the applicant also wishes to apply for a State Supplemental Payment, either the applicant or his/her guardian must sign the application form.

(2) When Medicaid application is being made, an assessment of resources must be completed. For applicants of the ADvantage waiver, those resources owned by the couple the month the application was made determines the spousal share of resources.

(3) When an application is received from an individual residing in a nursing facility, the applicant is referred to the ~~Oklahoma Health Care Authority (OHCA)~~ Living Choice program ~~as the appropriate entity~~ to assist individuals from nursing facility care.

(A) If ~~OHCA~~ Living Choice determines the applicant is ineligible for services due to the inability to assure health and welfare in a community setting, the individual is also ineligible for ADvantage waiver services.

(B) If ~~OHCA~~ Living Choice determines the applicant does not meet Living Choice eligibility criteria for reasons unrelated to health and welfare, the individual is eligible for the ADvantage waiver if medically and financially approved.

(b) **Date of application**.

(1) The date of application is:

(A) the date the applicant or someone acting in his/her behalf signs the application in the county office; or

(B) the date the application is stamped into the county office when the application is initiated outside the county office; or

(C) the date when the request for Medicaid is made orally and the financial application form is signed later. The date of the oral request is entered in "red" above the date the form is signed.

(2) An exception is when OKDHS has contracts with certain providers to take applications and obtain documentation. After the documentation is obtained, the contracted provider forwards the application and documentation to the OKDHS county office of the applicant's county of residence for Medicaid eligibility determination. The application date is the date the applicant signed the application form for the provider.

(c) **ADvantage ~~waiting list procedures.~~capacity.** ADvantage Program "available capacity" is the number of members that may be enrolled in the Program without exceeding, on an annualized basis, the maximum number authorized by the waiver to be served in the waiver year. ~~Upon notification from the AA that 90% of the available capacity has been exceeded, OKDHS Community Living, Aging and Protective Services notifies OKDHS county offices and contract agencies approved to complete the UCAT that, until further notice, requests for ADvantage services are not to be processed as applications but referred to AA to be placed on a waiting list of requests for ADvantage services. As available capacity permits, but remaining in compliance with waiver limits of maximum capacity, and until an increase in ADvantage available capacity occurs, the AA selects in chronological order (first on, first off) requests for ADvantage from the waiting list to forward to the appropriate OKDHS county office for processing the application. When the waiver capacity exceeds the number on the waiting list and after all persons on the waiting list have been processed, waiting list procedures are suspended.~~ Waitlist procedures are implemented when the maximum number authorized by the waiver to be served in the waiver year is met.

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TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 55. MANAGED CARE

SUBCHAPTER 3. GENERAL PROGRAM INFORMATION

317:55-3-1. Mandatory, voluntary, and excluded populations

(a) **Mandatory populations.** The following SoonerCare Eligibles will be mandatorily enrolled with a CE and DBM under the SoonerSelect Dental and Medical program:

(1) Expansion adults;
(2) Parents and caretaker relatives;
(3) Pregnant women;
(4) Deemed newborns;
(5) Former foster children;
(6) Juvenile justice involved children;
(7) Foster care children;
(8) Children receiving adoption assistance; and
(9) Children.

(b) **Voluntary populations.** SoonerCare Eligible individuals may voluntarily choose to enroll in the SoonerSelect Dental and Medical program through an opt-in process if they are American Indians and/or Alaskan Natives. AI/AN populations will have the option to:

(1) Voluntarily enroll in the DBM and/or CE through an opt-in process;
(2) Enroll in a DBM and/or CE at each open enrollment period, regardless of initial selection or past disenrollment from the DBM and/or CE;
(3) When enrolled, AI/AN populations may:
(A) Receive services from an IHCP;
(B) Choose the IHCP as the Enrollee's provider, if the provider has the capacity to provide such services;
(C) Obtain services covered under the Contract from out-of-network IHCPs when the Enrollee is otherwise Eligible to receive the IHCP's services;
(D) Self-refer for services provided by IHCPs to AI/AN Enrollees;
(E) Obtain services covered under the Contract from out-of-network IHCPs when the AI/AN Enrollee is otherwise Eligible to receive the IHCP's services; and
(F) Disenroll from any DBM and/or CE at any time without cause.

(c) **Excluded populations.** The following individuals are excluded from enrollment in the SoonerSelect program:

(1) Dual-eligible individuals;
(2) Individuals enrolled in the Medicare Savings Program, including Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled Workers (QDW) and Qualified Individuals (QI);
(3) Persons with a nursing facility or ICF-IID level of care, except for Enrollees with a pending level of care determination;
(4) Individuals during a period of presumptive eligibility;
(5) Individuals infected with tuberculosis Eligible for tuberculosis-related services under 42 C.F.R. § 435.215;
(6) Individuals determined Eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213;
(7) Individuals enrolled in a § 1915(c) Waiver;

(8) Undocumented persons Eligible for emergency services only in accordance with 42 C.F.R. § 435.139;
(9) Insure Oklahoma Employee Sponsored Insurance (ESI) dependent children in accordance with the Oklahoma Medicaid State Plan;
(10) Coverage of Pregnancy-Related Services under Title XXI for the benefit of unborn children ('Soon- to-be-Sooners'), as allowed by 42 C.F.R. § 457.10; and
(11) Individuals determined Eligible for Medicaid on the basis of age, blindness, or disability.
(12) Individuals enrolled in the SoonerPlan family planning program.

(d) **Additional eligibility criteria.** For additional eligibility criteria, refer to Chapter 35 Medical Assistance for Adults and Children Eligibility Manual, Subchapter 5 Eligibility and Countable Income.

317:55-3-2. Enrollment and disenrollment process

(a) **Enrollment process.** The OHCA beneficiary support system will provide choice counseling to all potential Enrollees at the time of initial enrollment, during the annual open enrollment period and for Enrollees who disenroll from a CE or DBM for good cause as described in the Contract and in this Section. The OHCA, or its designee, will provide information about individual CE or DBM benefit structures, services, and network providers, as well as information about other Medicaid programs as requested by the Eligible to assist the Eligible in making an informed selection.

(1) **Selection/auto assignment.** During the application process, at OHCA's discretion, an Applicant may have up to ~~sixty (60)~~thirty (30) days to select a contracted CE and DBM of their choice. Applicants who are Eligible to choose a CE and DBM and fail to make an election on the SoonerCare application, within the allotted timeframe, will be assigned to the CE and DBM that is due next to receive an auto assignment.

(2) **Exemptions to auto-assignments**

(A) The OHCA will not make auto-assignments to the CE if:

(i) The CE's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;
(ii) The CE has been excluded from receiving new enrollment due to the application of non-compliance remedies; or
(iii) The CE has failed to meet readiness review requirements.

(B) The OHCA will not make auto-assignments to the DMB if:

(i) The DBM's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;
(ii) The DBM has been excluded from receiving new enrollment due to the imposition of administrative remedies; or
(iii) The DBM has failed to meet readiness review requirements.

(3) **Enrollment effective date**

(A) Eligibles, with the exception of deemed newborns, who select or are assigned to a CE and/or DBM from the first day of the month through the fifteenth day of the month shall be enrolled effective on the first day of the following month.
(B) Eligibles who select or are assigned to a CE and/or DBM on the sixteenth (16th) day of the month through the last day of the month will be enrolled effective on the first day of the second following month.

(C) Prior to these enrollment dates, most Eligibles will be covered by a fee-for-service payment structure administered by OHCA.

(D) Deemed newborns eligible for the CE and/or DBM shall be enrolled effective as of the date of birth, if the newborn's mother also is enrolled in the SoonerSelect program.

(E) Notwithstanding the foregoing, the effective date of enrollment with the CE or DBM shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

(4) **Enrollment lock-in period.** An Enrollee may, within the first ninety (90) days of initial enrollment, request to change enrollment without cause from the CE and/or DBM, or during the ninety (90) days following the date OHCA sends the Enrollee notice of initial enrollment, whichever is later. Enrollees will also be permitted to change CEs and/or DBMs, without cause, at least once every twelve (12) months during the open enrollment period. After the disenrollment period from the CE or DBM has lapsed, the Enrollee will remain enrolled with the CE or DBM until the next annual open enrollment period, unless:

(A) The SoonerSelect Medical Enrollee:

(i) Is disenrolled due to loss of SoonerCare eligibility;

(ii) Becomes a foster child under custody of the state;

(iii) Becomes juvenile justice involved under the custody of the state;

(iv) Is a former foster care or child receiving adoption assistance and opts to enroll in the SoonerSelect Children's Specialty program;

(v) Demonstrates good cause under the following conditions:

(I) The Enrollee moves out of the service area;

(II) The Enrollee requires specialized care for a chronic condition and the Enrollee or Enrollee's representative, the CE, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;

(III) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;

(IV) The Enrollee needs related services to be performed at the same time; not all related services are available within the CE's network; and the Enrollee's primary care provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

(V) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and

(VI) The Enrollee has been enrolled in error, as determined by the OHCA.

(vi) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or

(vii) The OHCA has imposed intermediate sanctions on the CE and allows Enrollees to disenroll without cause.

(B) The SoonerSelect Dental Enrollee:

(i) Is disenrolled due to loss of SoonerCare eligibility;

(ii) Demonstrates good cause under the following conditions:

(I) The Enrollee moves out of the service area;

(II) The plan does not cover the service the Enrollee seeks, because of moral or religious objections;

(III) The Enrollee needs related services to be performed at the same time; not all related services are available within the DBM's network; and the Enrollee's primary care dental provider or another provider determines that receiving the services separately would subject the Enrollee to unnecessary risk;

(IV) For other reasons, including a filed and prevailed grievance related to poor quality of care, lack of access to services covered under the Contract, or lack of access to providers experienced in dealing with the Enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; and

(V) The Enrollee has been enrolled in error, as determined by the OHCA.

(iii) Experiences a temporary loss of eligibility or enrollment which caused the Enrollee to miss the annual disenrollment period, then the Enrollee may disenroll without cause upon reenrollment; or

(iv) The DBM is terminated.

(5) **Annual and special enrollment periods.** Sixty (60) days prior to the start of the Enrollee's annual open enrollment period, the Enrollee shall be notified of the option to maintain enrollment with the current CE and/or DBM or to enroll with a different CE and/or DBM. OHCA, at its sole discretion, may schedule a special open enrollment period, under the following circumstances:

(A) In the event of the early termination of a CE or DBM under the process described in the Contract; or

(B) The loss of a major participating provider(s) places the CE or DBM at risk of failing to meet service accessibility standards and the CE or DBM does not have an acceptable plan for mitigating the loss or finding of non-compliance.

(6) **Enrollment caps.** OHCA, at its sole discretion, may impose a cap on the CE or DBM's enrollment, in response to a request by the CE or DBM or as part of a corrective action in accordance to the respective Contract.

(b) **Disenrollment**. The OHCA shall have sole authority to grant or deny a disenrollment request from the Enrollee, and/or CE or DBM.

(1) **CE or DBM-requested disenrollment**. Pursuant to 42 C.F.R. § 438.56(b)(2), the CE or DBM cannot request a disenrollment based on adverse change in the member's health status or utilization of medically necessary services, diminished mental capacity, or uncooperative or disruptive behavior resulting from their special needs, except when their continued Enrollment with the Contractor seriously impairs the Contractor's ability to furnish services to either this particular Enrollee or other Enrollees.

(A) The CE may only request disenrollment of the Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:

(i) The Enrollee requires specialized care for a chronic condition and the Enrollee or Enrollee's representative, the CE, OHCA and receiving CE agree that assignment to the receiving CE is in the Enrollee's best interest;

(ii) The Enrollee has been enrolled in error, as determined by OHCA;

(iii) The Enrollee has exhibited disruptive behaviors to the extent the CE cannot effectively manage their care, and the CE has made all reasonable efforts to accommodate the Enrollee; or

(iv) The Enrollee has committed fraud, including but not limited to, loaning an identification (ID) card for use by another person.

(B) The DBM may only request disenrollment of the Enrollee only for good cause. The following actions, if found by OHCA, comprise good cause:

(i) The Enrollee has been enrolled in error, as determined by OHCA;

(ii) The Enrollee has exhibited disruptive behaviors to the extent the DBM cannot effectively manage their care, and the DBM has made all reasonable efforts to accommodate the Enrollee; or

(iii) The Enrollee has committed fraud, including but not limited to, loaning an ID card for use by another person.

(2) **Enrollee-requested disenrollment.** Enrollees shall seek redress through the CE's or DBM's grievance process before OHCA will make a determination on an Enrollee's request for disenrollment. The CE or DBM shall accept Enrollee requests for disenrollment orally or in writing. The CE or DBM shall complete a review of the request within ten (10) days of the Enrollee filing the grievance. If the Enrollee remains dissatisfied with the result of the grievance process, the CE or DBM shall refer the disenrollment request to OHCA. The Contractor shall send records gathered during the grievance process to OHCA to facilitate OHCA's decision-making process. Disenrollment requests will be adjudicated by OHCA and, if approved, will become effective on a date established by OHCA.

(A) The Enrollee may request disenrollment from the CE or DBM as allowed by 42 C.F.R. § 438.56(c).

(B) An Enrollee may request disenrollment from the CE or DBM at any time based on any cause listed at 42 C.F.R. § 438.56(d)(2).

(C) An Enrollee may request disenrollment at any time in accordance with (a)(4)(A)(v)(I)-(VI) and (B)(ii)(I)-(V) of this Section and the applicable Contract.

(3) **Disenrollment by OHCA.** The CE or DBM shall report to OHCA, within five (5) business days of learning of any change in an Enrollee's status affecting the Enrollee's eligibility.

(A) The OHCA will initiate disenrollment of SoonerSelect Medical Enrollees under the following circumstances:

(i) Loss of eligibility for Medicaid;

(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Medical program;

(iii) Enrollee becomes enrolled in Medicare;

(iv) Death;

(v) Enrollee becomes a foster child under the custody of the state;
(vi) Enrollee becomes juvenile justice involved under the custody of the state;
(vii) The Enrollee becomes an inmate of a public institution;
(viii) The Enrollee commits fraud or provides fraudulent information; or
(ix) Disenrollment is ordered by a hearing officer or court of law.

(B) The OHCA will initiate disenrollment of SoonerSelect Dental Enrollees under the following circumstances:
(i) Loss of eligibility for Medicaid;
(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;
(iii) Enrollee becomes enrolled in Medicare;
(iv) Death;
(v) The Enrollee becomes an inmate of a public institution;
(vi) The Enrollee commits fraud or provides fraudulent information; or
(vii) Disenrollment is ordered by a hearing officer or court of law.

(4) **Disenrollment effective date**. Consistent with 42 C.F.R. § 438.56(e), except as provided for below, and unless OHCA determines that a delay would have an adverse effect on an Enrollee's health, it is OHCA's intent that a disenrollment shall be effective no later than the first day of the second following month.

(A) Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the Enrollee's health care needs or other matters deemed sufficient to warrant disenrollment under (b)(2) of this Section must be completed within this timeframe. If the CE fails to complete the grievance process in time to permit disenrollment by OHCA, the disenrollment shall be considered approved for the effective date that would have been established had the CE complied with this timeframe. Disenrollment for any of the following reasons shall be effective as of the date that the Enrollee's SoonerSelect Medical program eligibility status changes:
(i) Loss of eligibility for Medicaid;
(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect program;
(iii) Enrollee becomes a foster child under the custody of the state;
(iv) Enrollee becomes JJ Involved under the custody of the state;
(v) Enrollee becomes eligible for Medicare;
(vi) Death;
(vii) Enrollee becomes an inmate of a public institution;
(viii) Enrollee commits fraud or provides fraudulent information;
(ix) Disenrollment is ordered by a hearing officer or court of law; or
(x) Enrollee requiring long-term care.

(I) Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the CE when the level of care determination is finalized.

(II) For additional information regarding nursing facility and ICF-IID stays, refer to the Contract.

(B) Grievance resolution for poor quality of care, lack of access to services covered under the Contract or lack of access to providers experienced in dealing with the SoonerSelect Dental Enrollee's oral health care needs, or other matters deemed sufficient to warrant disenrollment under (b)(2) of this Section must be completed within this timeframe. If the Contractor fails to complete the grievance process in time to permit disenrollment by OHCA, the disenrollment shall be considered approved for the effective date that would have been established had the Contractor complied with this timeframe. Disenrollment for any of the following reasons shall be effective as of the date that the SoonerSelect Dental Enrollee's SoonerSelect Dental program eligibility status changes:

(i) Loss of eligibility for Medicaid;

(ii) Transition to a SoonerCare eligibility group excluded from the SoonerSelect Dental program;

(iii) SoonerSelect Dental Enrollee becomes eligible for Medicare;

(iv) Death;

(v) SoonerSelect Dental Enrollee becomes an inmate of a public institution;

(vi) SoonerSelect Dental Enrollee commits Fraud or provides fraudulent information;

(vii) Disenrollment is ordered by a hearing officer or court of law; or

(viii) SoonerSelect Dental Enrollees requiring long-term care in a nursing facility or ICF-IID shall be disenrolled from the Contractor when the level of care determination being done by the SoonerSelect or SoonerSelect Children's Specialty CEs is complete.

(C) Notwithstanding the foregoing, the effective date of disenrollment from the Contractor shall be the date recorded on the outbound ANSI ASC X 12 834 electronic transaction sent by OHCA.

(c) **Retroactive dual eligibility.** Dual eligibles are excluded from the SoonerSelect program. SoonerSelect Enrollees who become dual eligible individuals will be disenrolled as of their Medicare eligibility effective date.

(1) In the event a SoonerSelect Enrollee becomes retroactively Medicare eligible, the CE or DBM shall recover claims payments made to providers during the months of retroactive Medicare eligibility.

(2) The CE or DBM shall also notify the provider of the requirement to submit the claim to Medicare for reimbursement.

(3) OHCA will recoup the capitation payments paid for months of retroactive Medicare eligibility.

(d) **Re-enrollment following loss of eligibility.** Enrollees who lose and regain eligibility for SoonerSelect Medical or Dental program within a period of sixty (60) days or less will be re-enrolled automatically with their prior CE and/or DBM unless the CE and/or DBM is otherwise suspended or excluded from receiving new Enrollees. Re-enrolled Enrollees will have the right to change CE/DBM in accordance with this Section and the Contract.

(e) **Eligibles voluntarily opting out of SoonerSelect Children's Specialty Program.** FFC and children receiving adoption assistance shall be enrolled in the SoonerSelect Children's Specialty Program. These Eligibles may opt-out of enrollment in the Children's Specialty Program; however, the legal guardian of the Eligible will be required to enroll the Eligible with a CE.

(f) **Non-discrimination**. The CE or DBM may not refuse an assignment or seek to disenroll an Enrollee or otherwise discriminate against Eligible to enroll on the basis of race, color, national origin, sex, sexual orientation, gender identity, health status, need for medical services, or disability and may not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin, sex, sexual orientation, gender identity, or disability. The Contractor also may not discriminate against an Enrollee on the basis of expectations that the Enrollee will require frequent or high-cost care, or on the basis of health status or need for health care services or due to an adverse change in the Enrollee's health in enrollment, disenrollment, or re-enrollment. If the CE or DBM fails to comply with OAC 317:55-3-2, the OHCA may impose any or all the CE intermediate sanctions, found at OAC 317:55-5-10 and the CE Contract, or DBM administrative remedies, found at OAC 317:55-5-11 and the DBM Contract.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 9. LONG TERM CARE

317:30-5-133.2. Ancillary services

~~(a)~~ Ancillary services are those items which are not considered routine services. Ancillary services may be billed separately to the SoonerCare program, unless reimbursement is available from Medicare or other insurance or benefit programs. ~~Coverage criteria, utilization controls and program limitations are specified in Part 17 of OAC 317:30-5. Ancillary services are limited to the following services:~~

~~(1) Services requiring prior authorization:~~

~~(A) External breast prosthesis and support accessories.~~

~~(B) Ventilators and supplies.~~

~~(C) Total Parenteral Nutrition (TPN), and supplies.~~

~~(D) Custom seating for wheelchairs.~~

~~(2) Services not requiring prior authorization:~~

~~(A) Permanent indwelling or male external catheters and catheter accessories.~~

~~(B) Colostomy and urostomy supplies.~~

~~(C) Tracheostomy supplies.~~

~~(D) Catheters and catheter accessories.~~

~~(E) Oxygen and oxygen concentrators.~~

~~(i) PRN Oxygen. Members in nursing facilities requiring oxygen PRN will be serviced by oxygen kept on hand as part of the per diem rate.~~

~~(ii) Billing for Medicare eligible members. Oxygen supplied to Medicare eligible nursing home members may be billed directly to OHCA. It is not necessary to obtain a denial from Medicare prior to filing the claim with OHCA.~~

~~(b) Items not considered ancillary, but considered routine and covered as part of the routine rate include but are not limited to:~~

~~(1) Diapers.~~

~~(2) Underpads.~~

~~(3) Medicine cups.~~

~~(4) Eating utensils.~~

~~(5) Personal comfort items.~~

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PRIMARY CARE SPEND UPDATE

Sarah Walker, Clinical Outcomes Manager

March 2025

REQUIREMENT

- **Primary care spending/expenses.** No later than the end of the fourth (4th) year of the initial contracting period, each Contracted Entity shall be currently spending not less than eleven percent (11%) of its total health care expenses on primary care services.

PRIMARY CARE

"THE PROVISION OF WHOLE-PERSON, INTEGRATED, ACCESSIBLE, AND EQUITABLE HEALTHCARE BY INTERPROFESSIONAL TEAMS WHO ARE ACCOUNTABLE FOR ADDRESSING THE MAJORITY OF AN INDIVIDUAL'S HEALTH AND WELLNESS NEEDS ACROSS SETTINGS AND THROUGH SUSTAINED RELATIONSHIPS WITH PATIENTS, FAMILIES, AND COMMUNITIES."

NATIONAL ACADEMIES OF SCIENCES, ENGINEERING, AND MEDICINE

PROGRESS

Claims Based Primary Care Progress:

- Developed Claims Based Methodology
- Received feedback from Quality Advisory Committee and Internal OHCA Workgroup
- Revised Methodology and Recalculated
- Created Primary Care Dashboard CY20-CY23

Non-Claims Based Primary Care Progress:

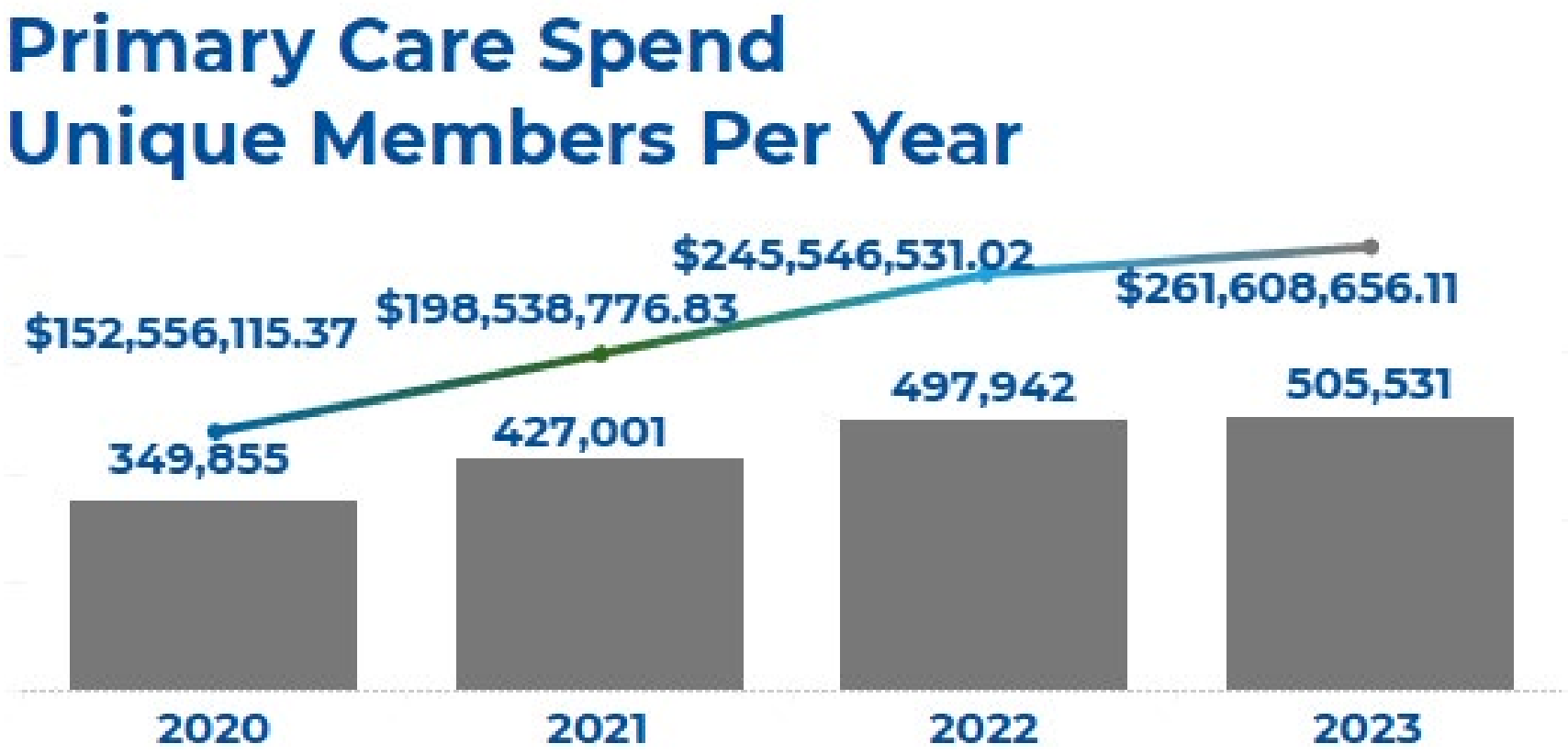
- Formation of Quality Advisory Subcommittee on Primary Care
- Adopted a definition of Primary Care
- Released recommendations for non-claims based spend inclusions

CLAIMS BASED PRIMARY CARE SPEND

Year	Total OHCA Reimbursement*	Total Primary Care Spend	% of Spend that is Primary Care
2020	$2,644,491,744.24	$152,556,115.00	5.77%
2021	$3,456,954,523.17	$198,538,777.00	5.74%
2022	$4,458,107,434.82	$245,546,531.00	5.51%
2023	$5,116,470,105.36	$261,608,656.00	5.11%
Total	$15,676,023,807.59	$858,250,079.00	5.47%

***No ABD or TEFRA, No Dental or Pharmacy as of August 2024**

CLAIMS BASED PRIMARY CARE



CURRENT WORK

Claims Based Primary Care

- Sent Methodology document and tables to CE Chief Medical Officers in February 2025

Non-Claims Based Primary Care

- Sent a request for Value Added Benefit estimates to CE Chief Medical Officers in February 2025
- Internal OHCA workgroup forming to review plan submissions each year
- Subcommittee leadership will continue to review VABs for inclusion

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
mysoonercare.org

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

OPERATIONAL METRICS

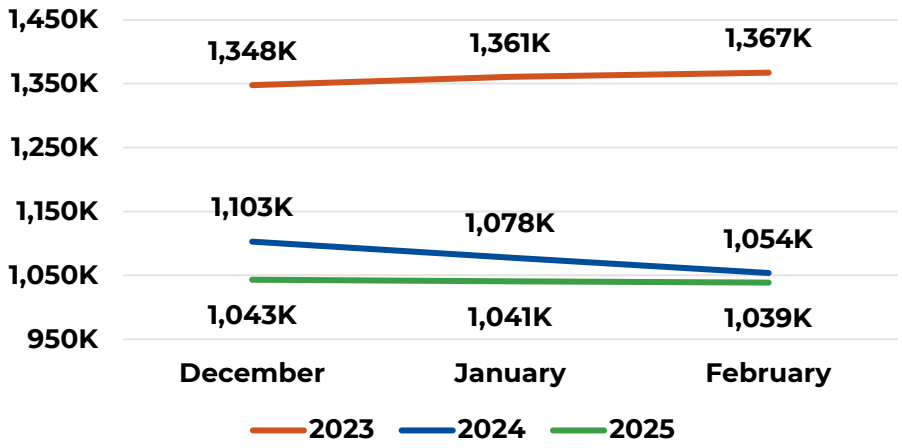
March 2025 Board Meeting

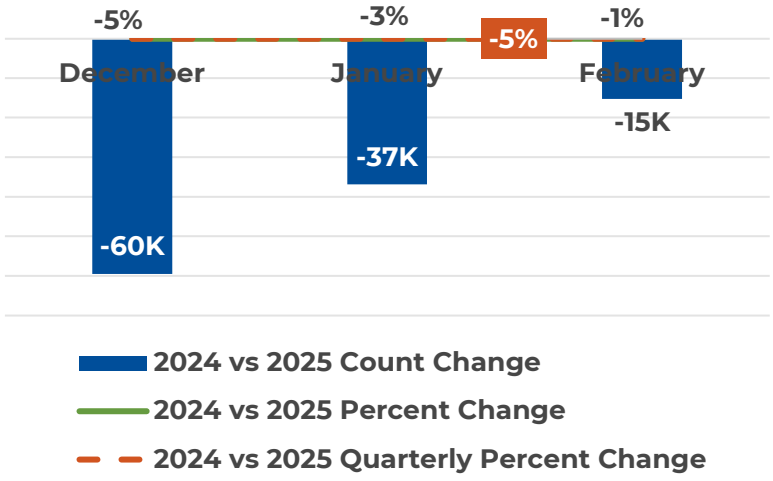
OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

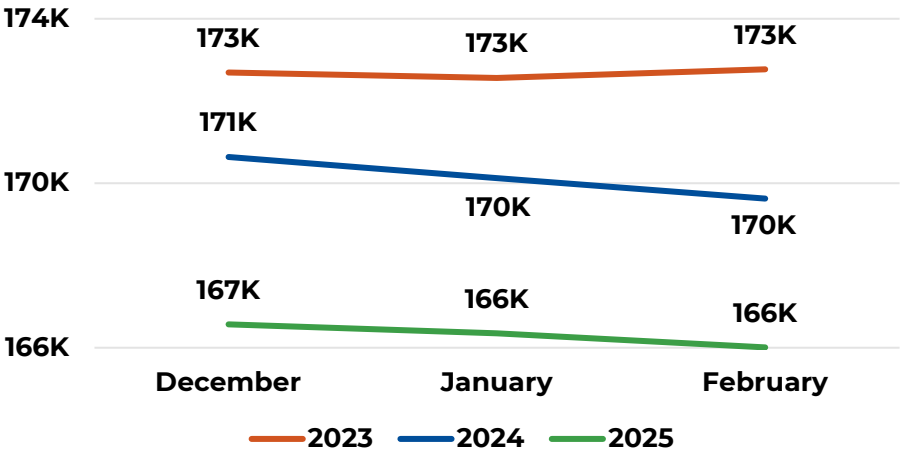
Enrollment & Utilization

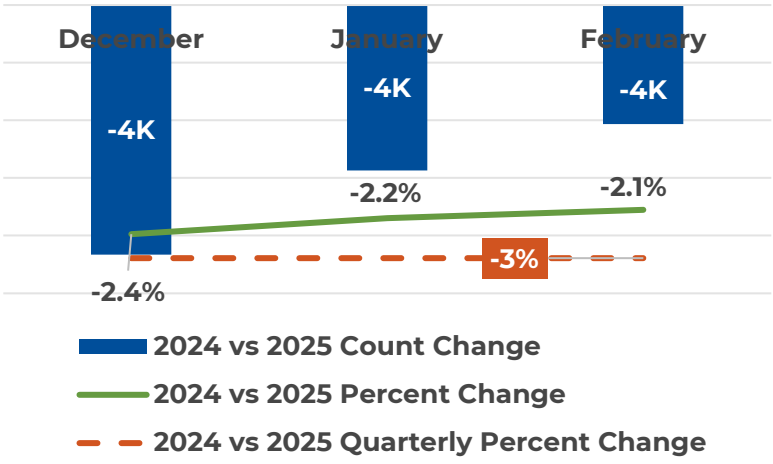
Total Enrolled Members





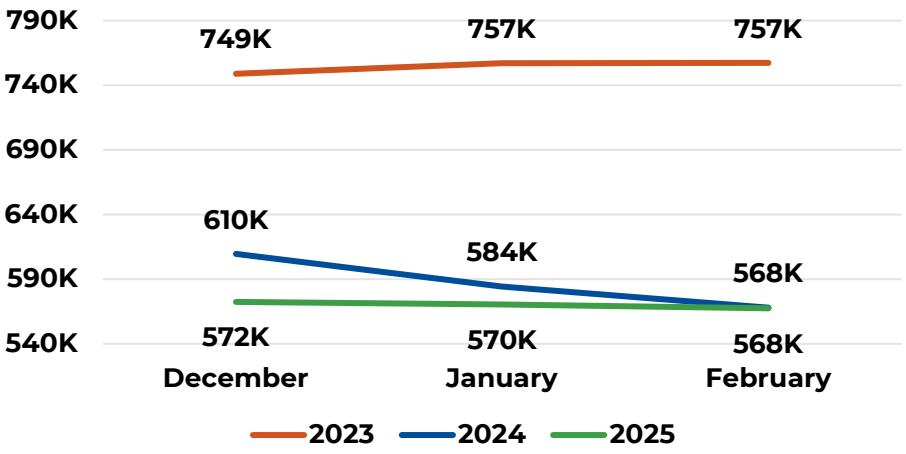
Aged/Blind/Disabled Enrolled

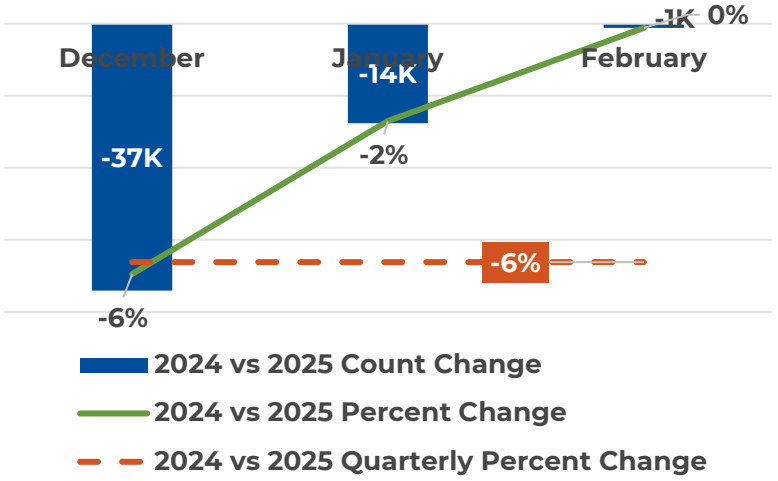




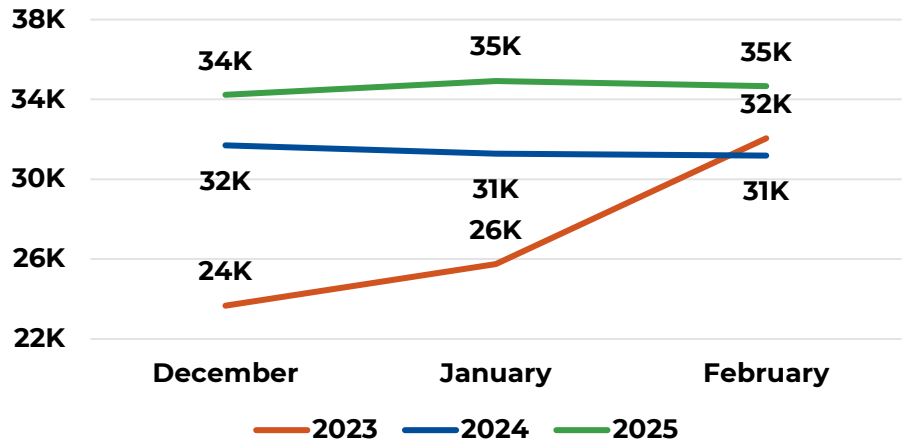
Enrollment & Utilization (Cont.)

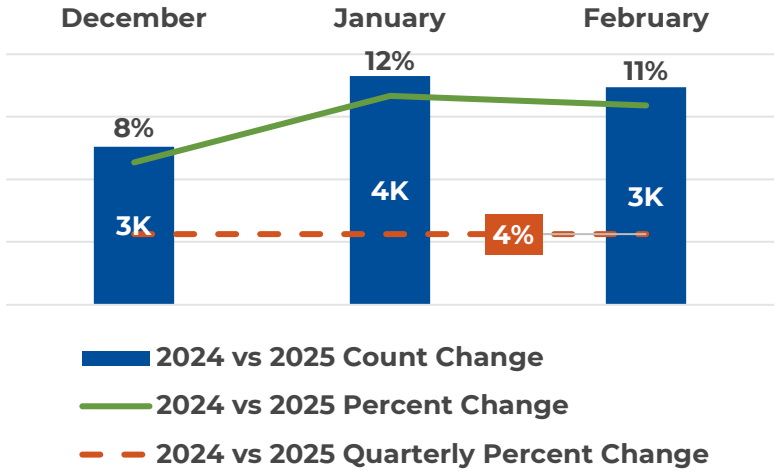
Children & Parent/Caretaker Enrolled





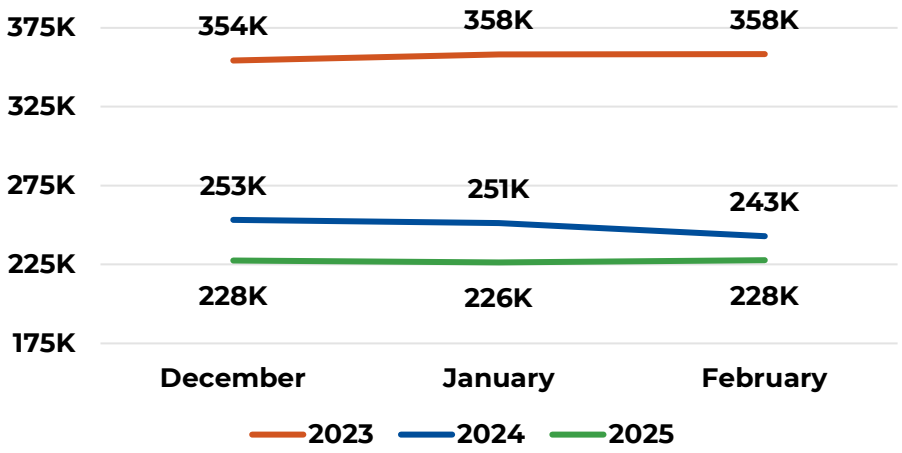
Pregnant (Full Scope) Enrolled

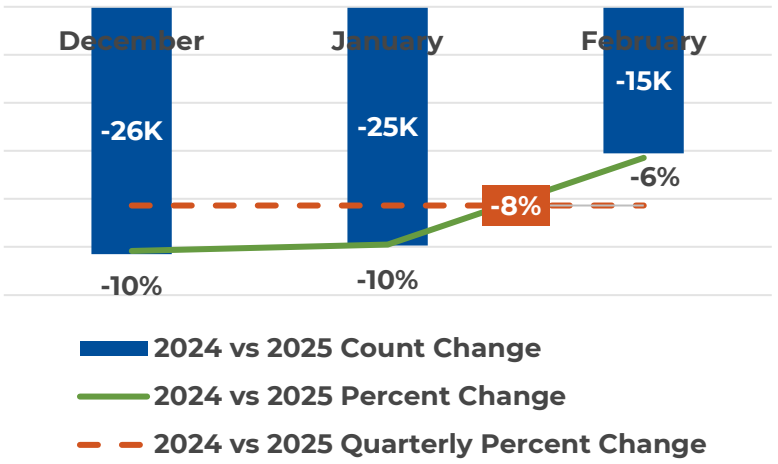




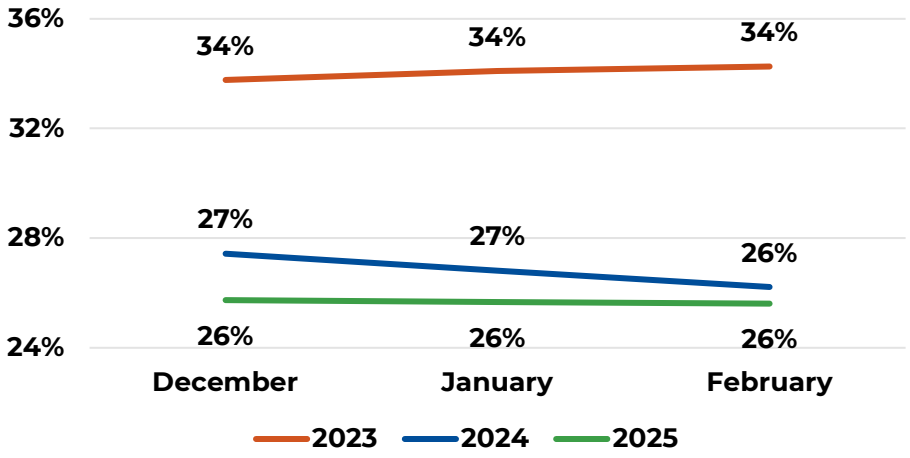
Enrollment & Utilization (Cont.)

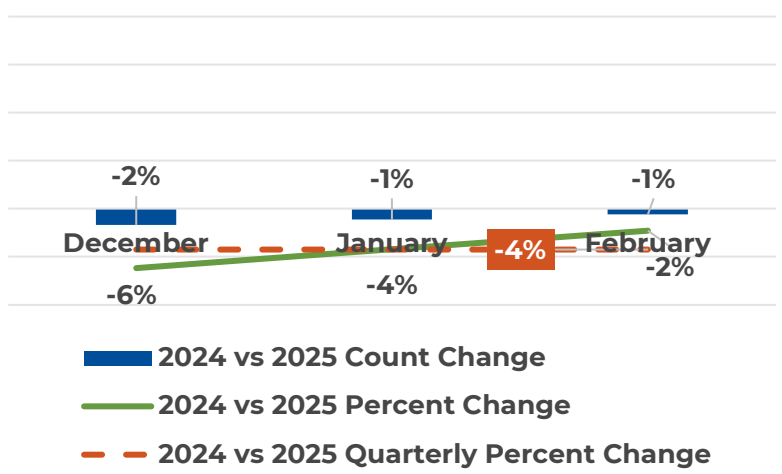
Expansion Enrolled





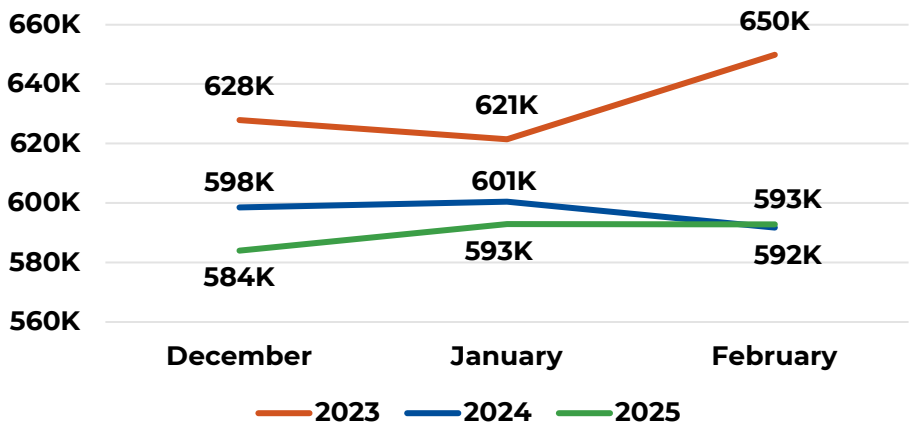
Percent of OK Population Enrolled

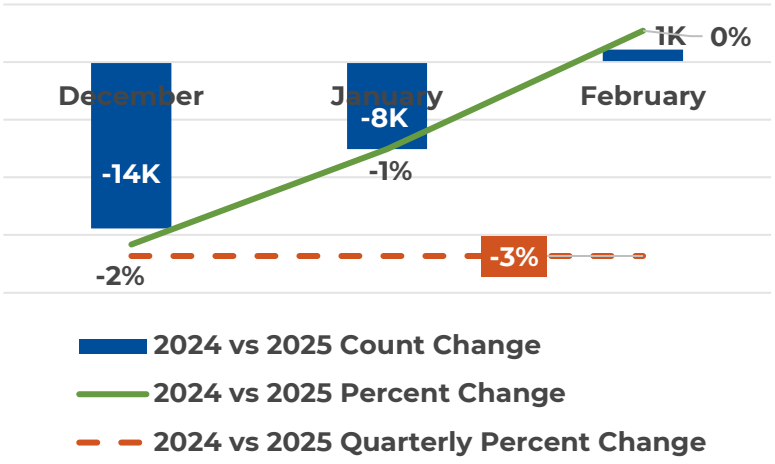




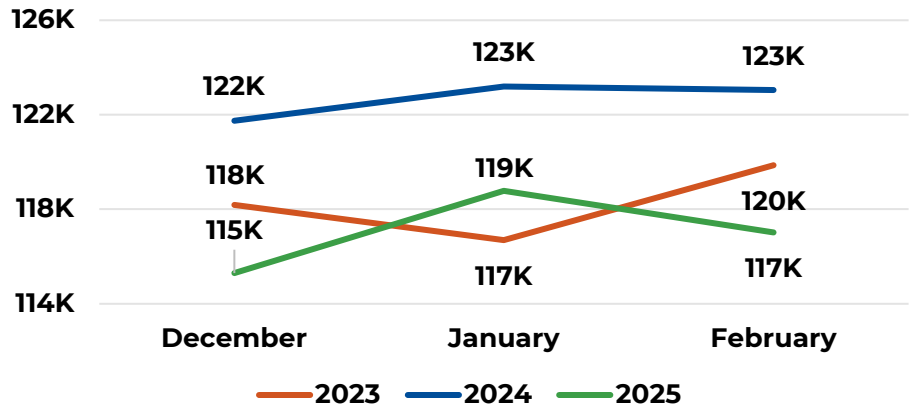
Enrollment & Utilization (Cont.)

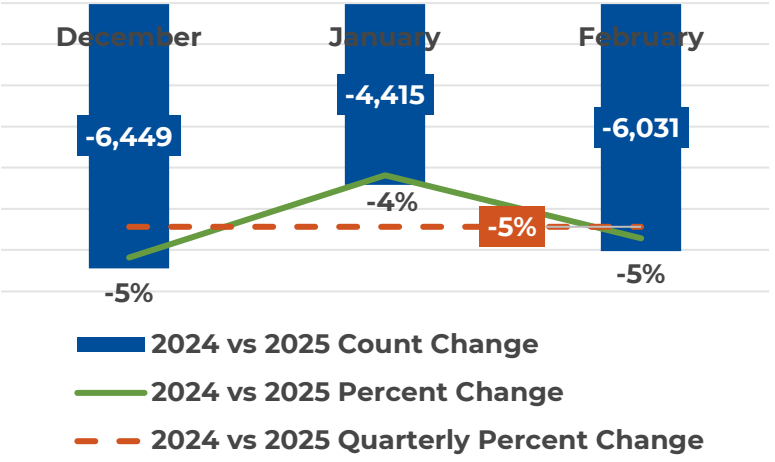
Total Members Utilization





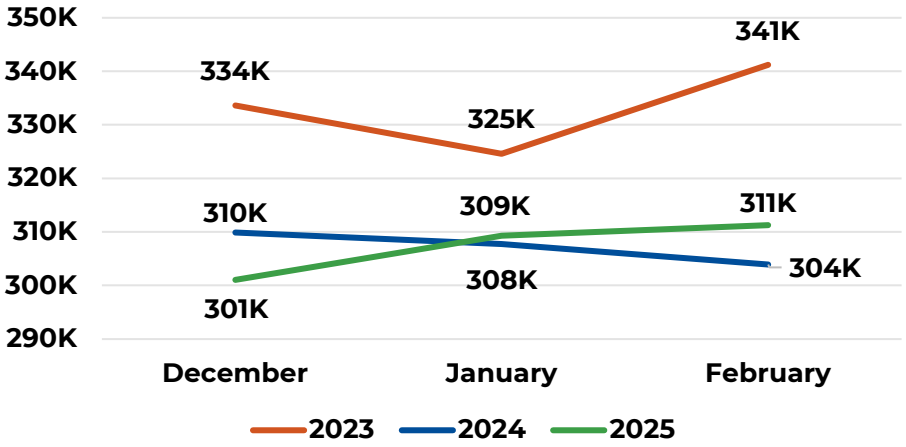
Aged/Blind/Disabled Utilization

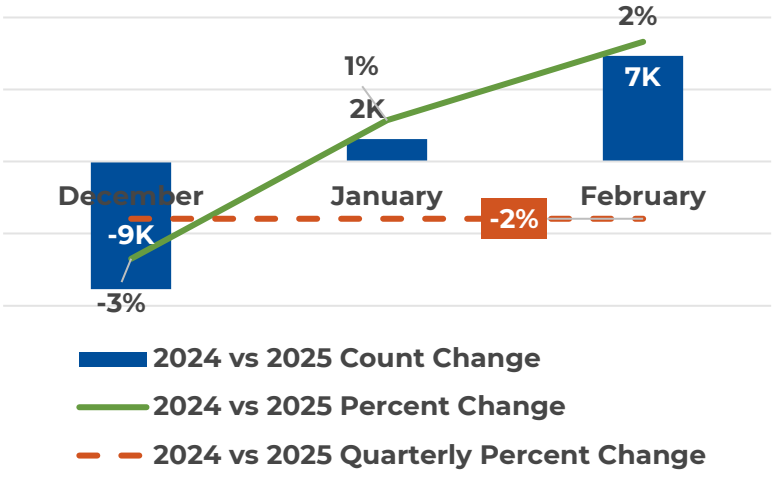




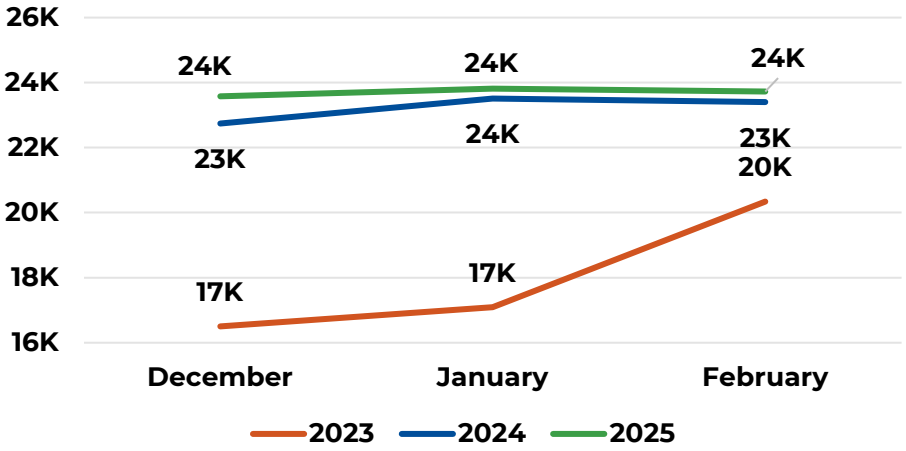
Enrollment & Utilization (Cont.)

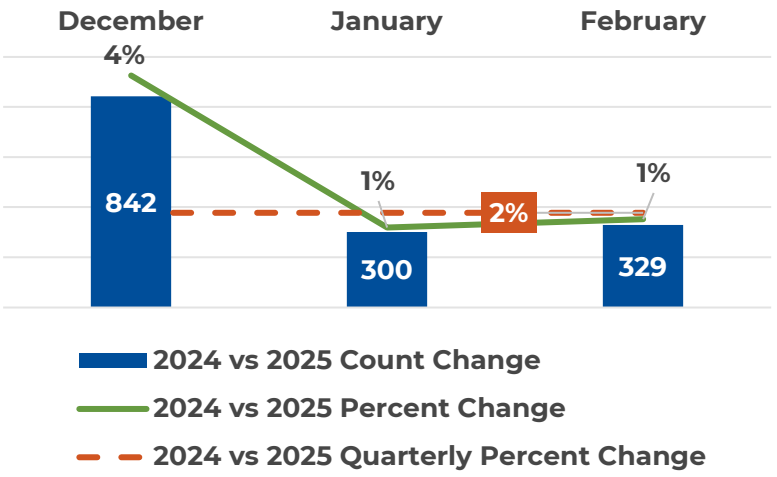
Children & Parent/Caretaker Utilization





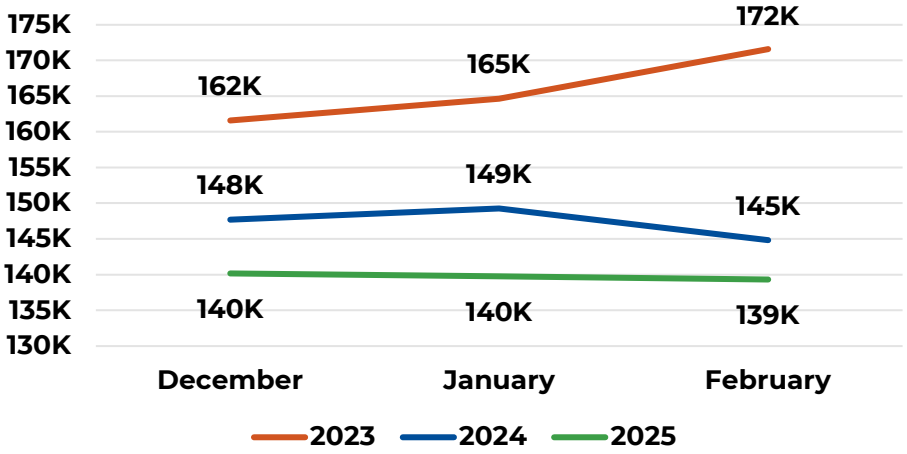
Pregnant (Full Scope) Utilization

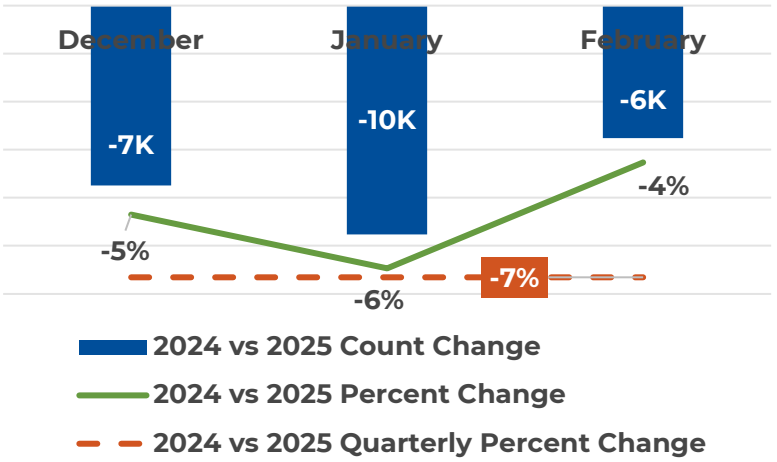




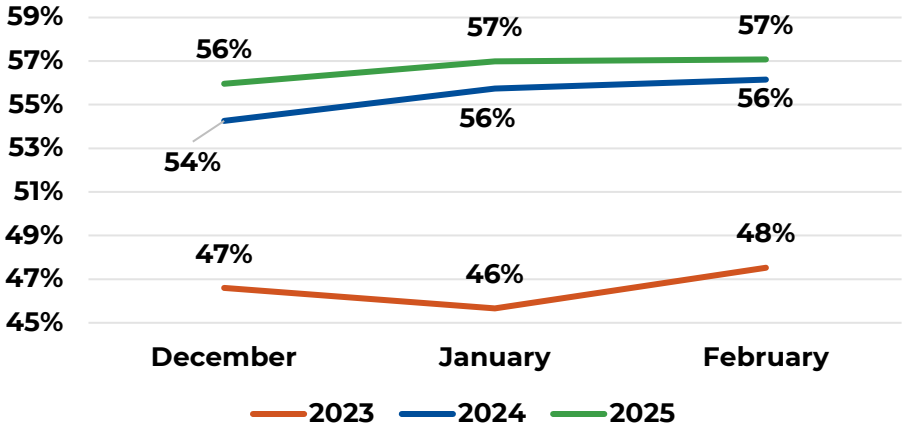
Enrollment & Utilization (Cont.)

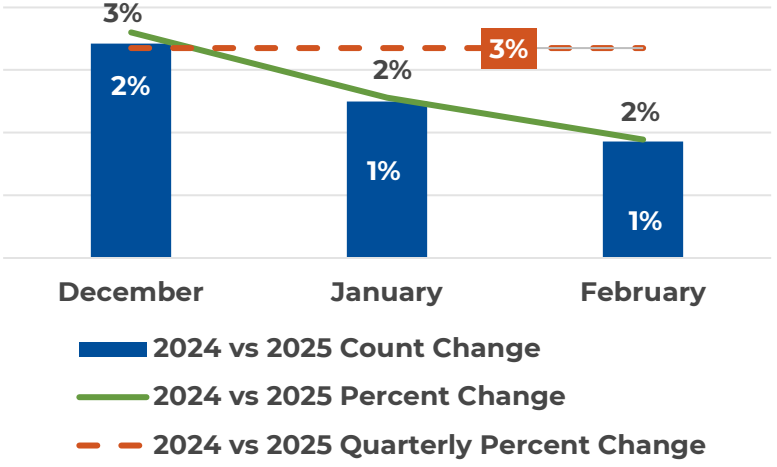
Expansion Utilization





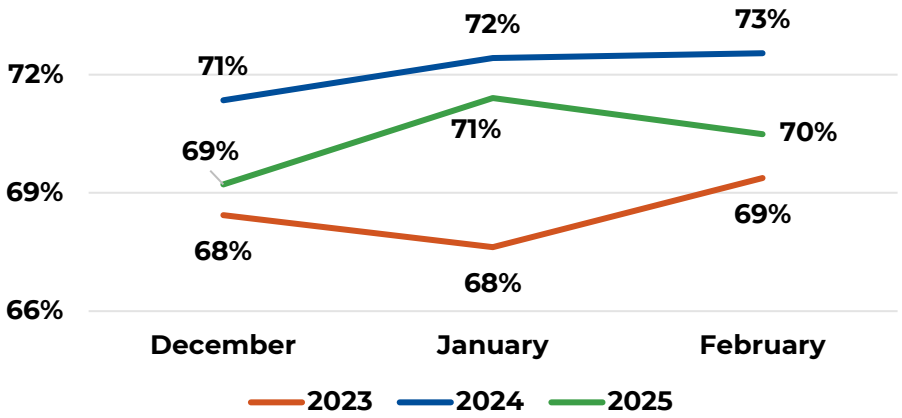
Percent of Total Enrolled Members Utilization

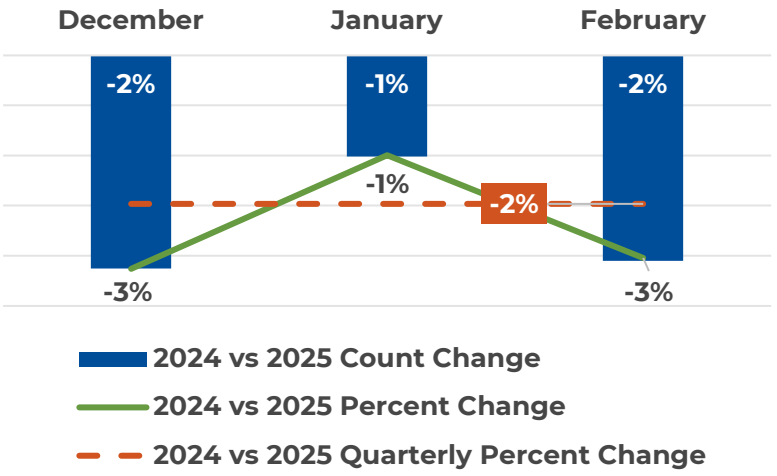




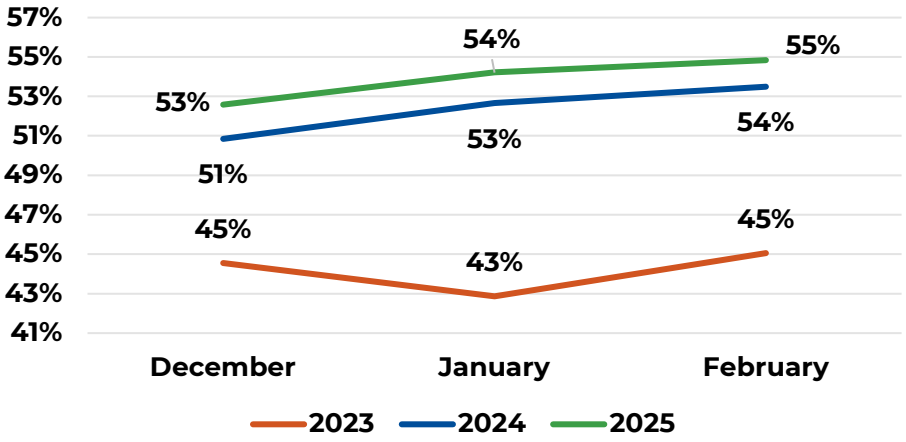
Enrollment & Utilization (Cont.)

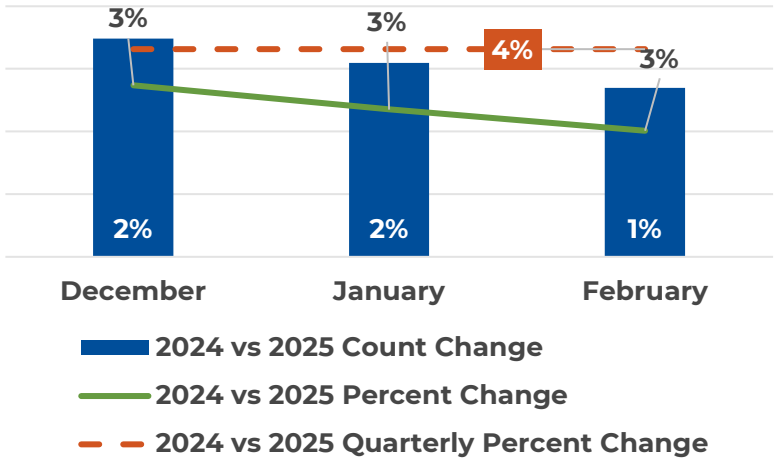
Percent of Aged/Blind/Disabled Enrolled Members Utilization





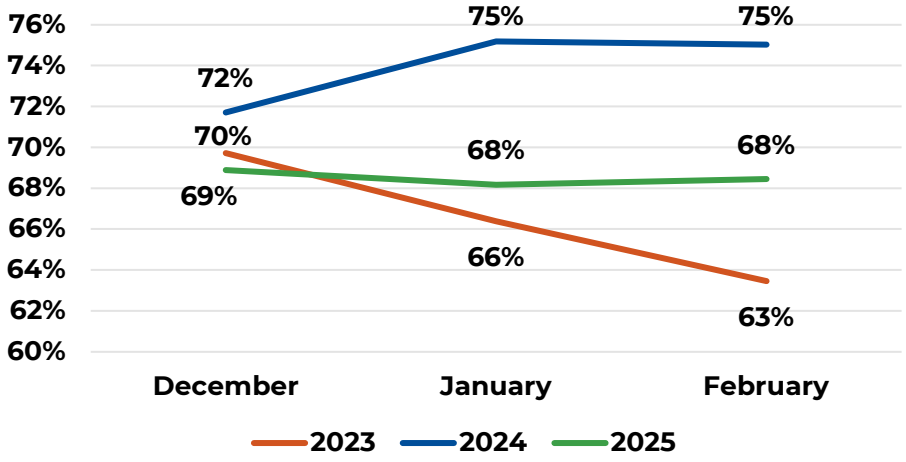
Percent of Children & Parent/Caretaker Enrolled Members Utilization

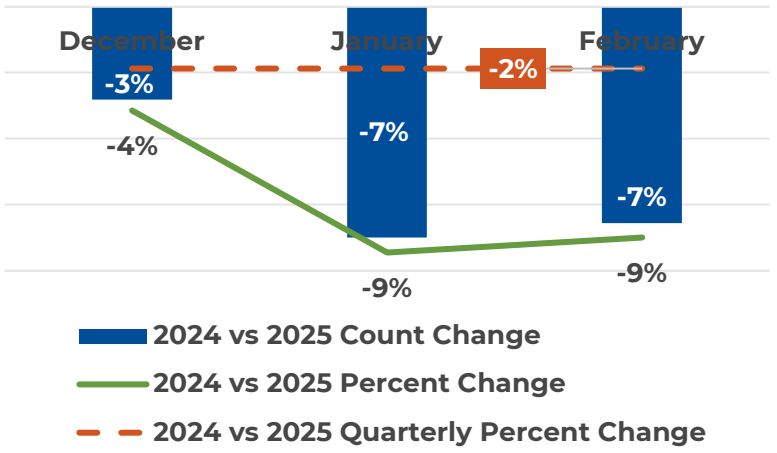




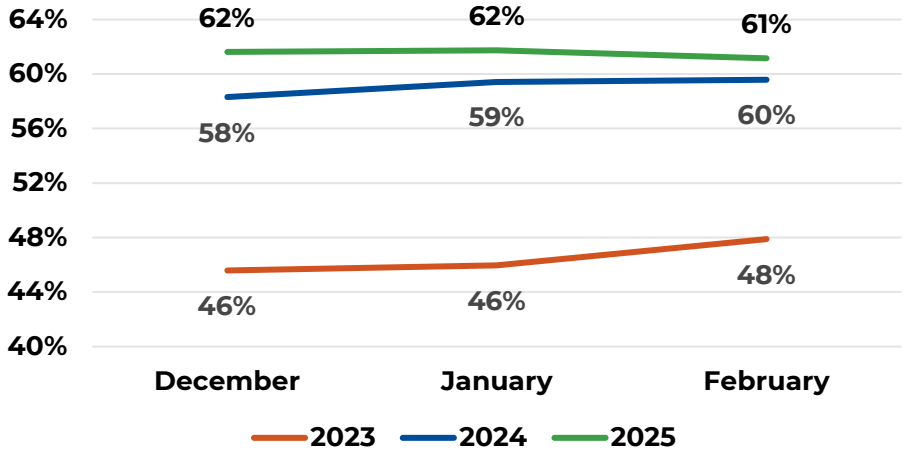
Enrollment & Utilization (Cont.)

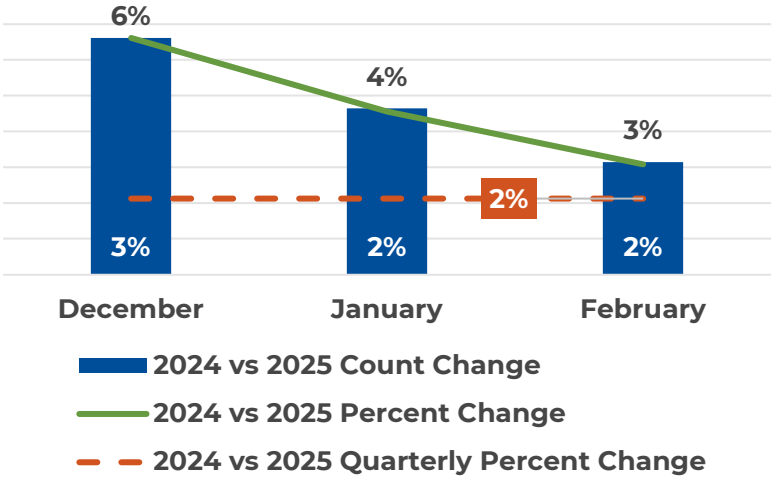
Percent of Pregnant (Full Scope) Enrolled Members Utilization





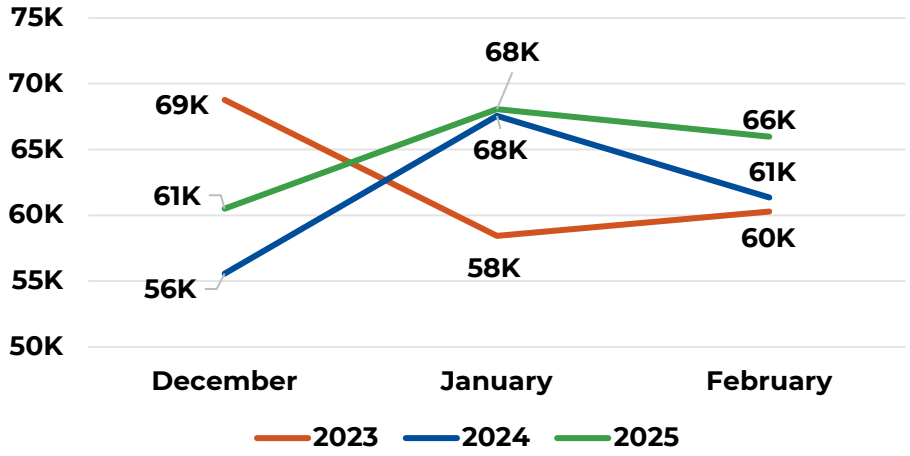
Percent of Expansion Enrolled Members Utilization

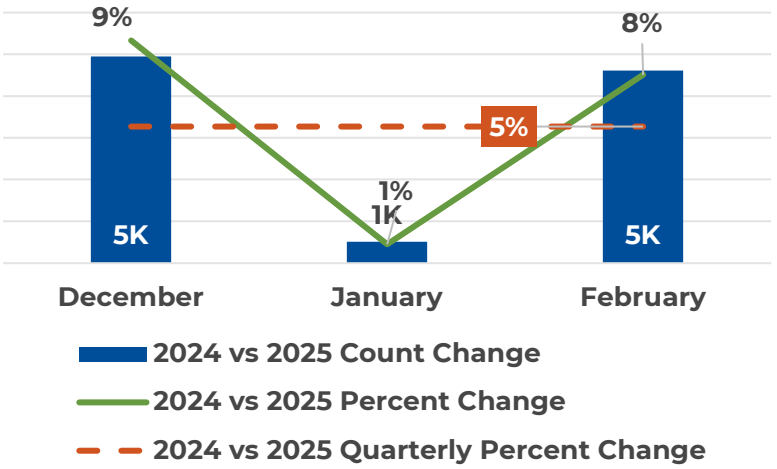




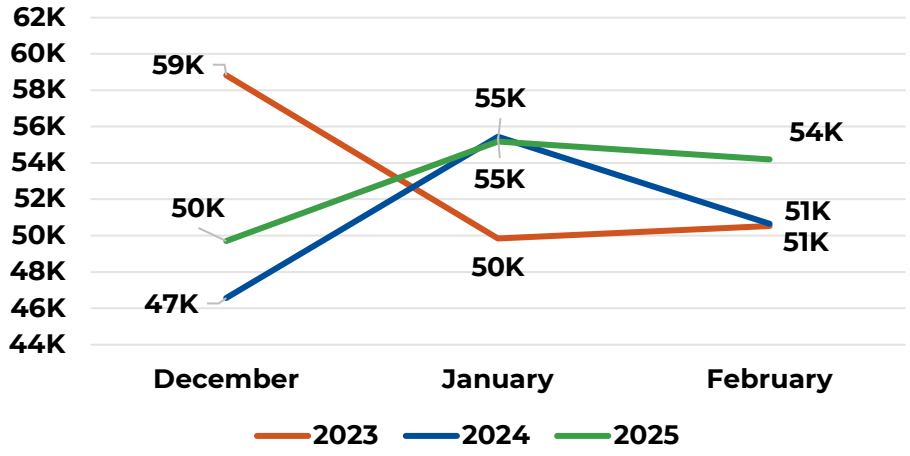
Utilization

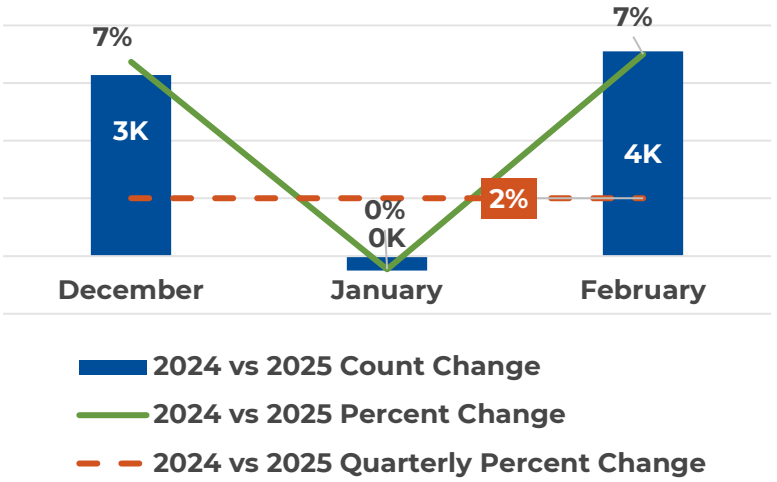
Emergency Department Visits (Claims)





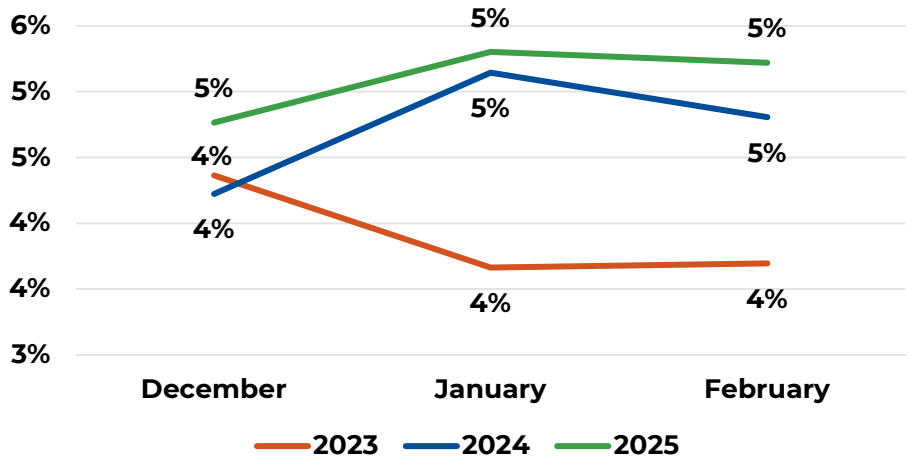
Members Utilizing Emergency Department

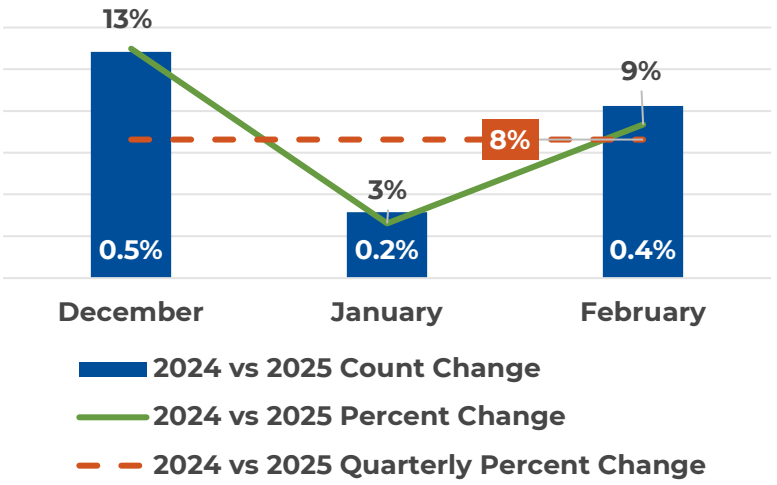




Utilization (Cont.)

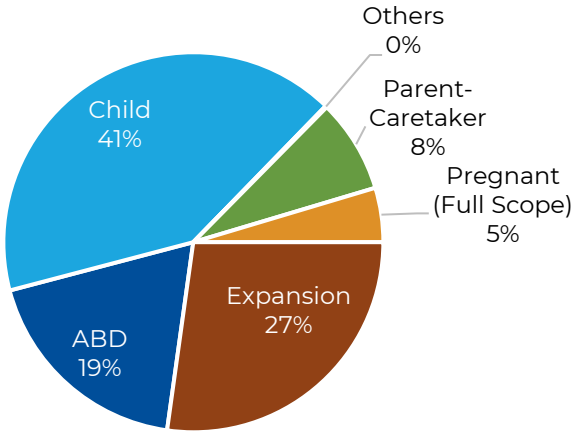
Percent Total Enrolled Using ED



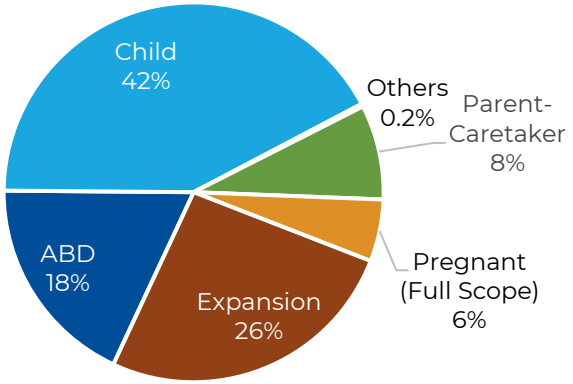


Members Utilizing Emergency Department By Qualifying Group

Q3 2024

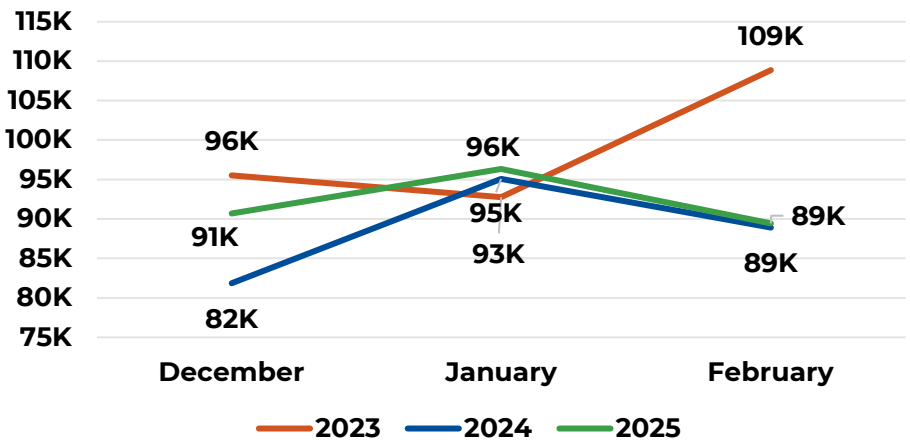


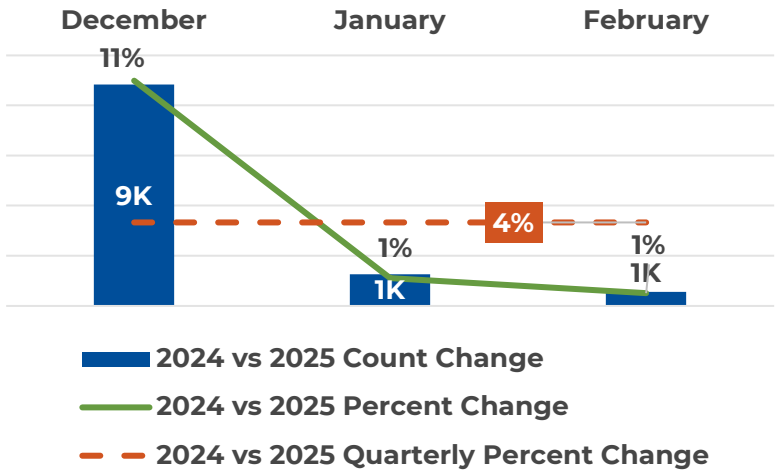
Q3 2025



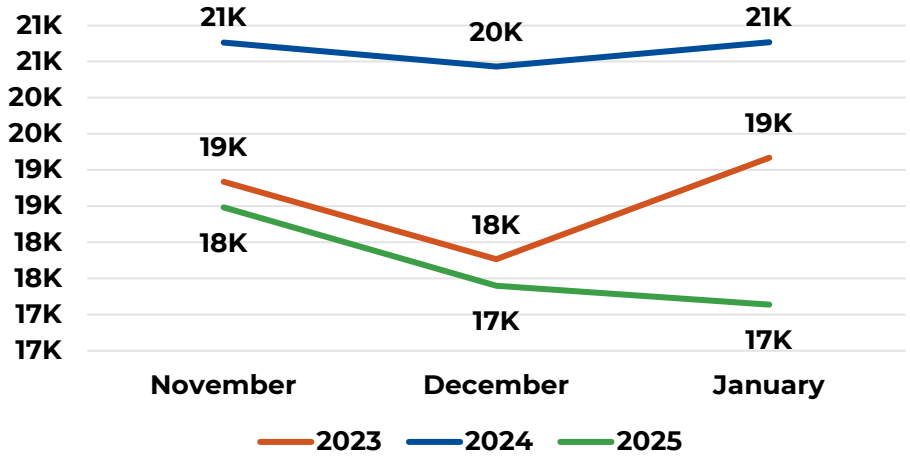
Utilization (Cont.)

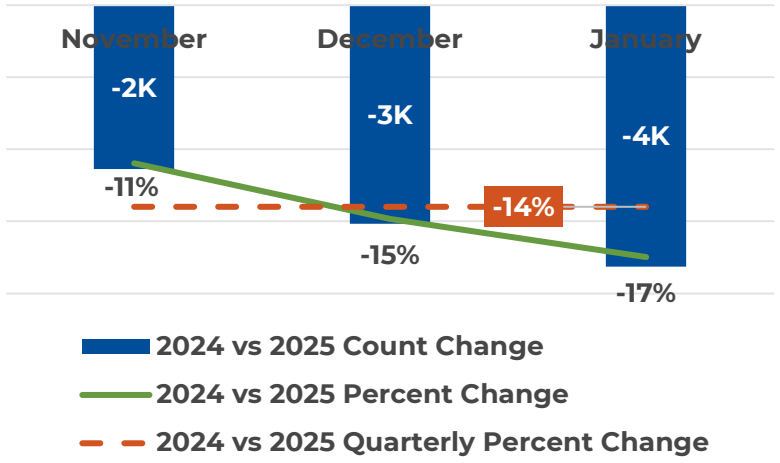
Telemedicine - Total Visits





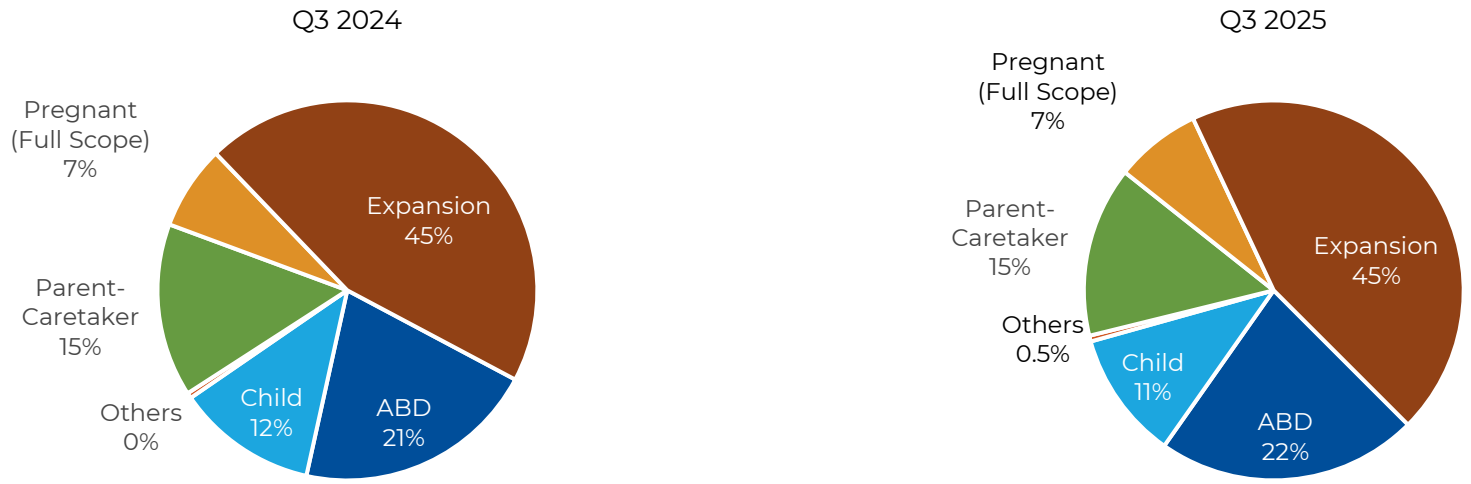
Members With Opioid Claims



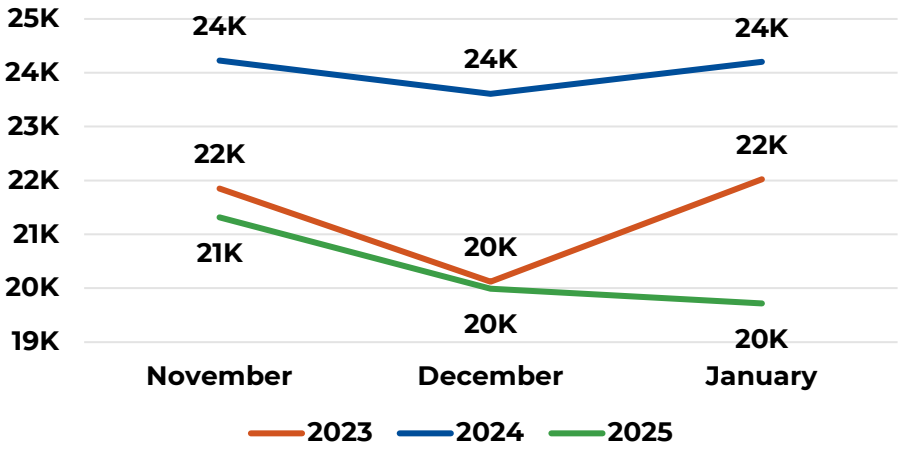


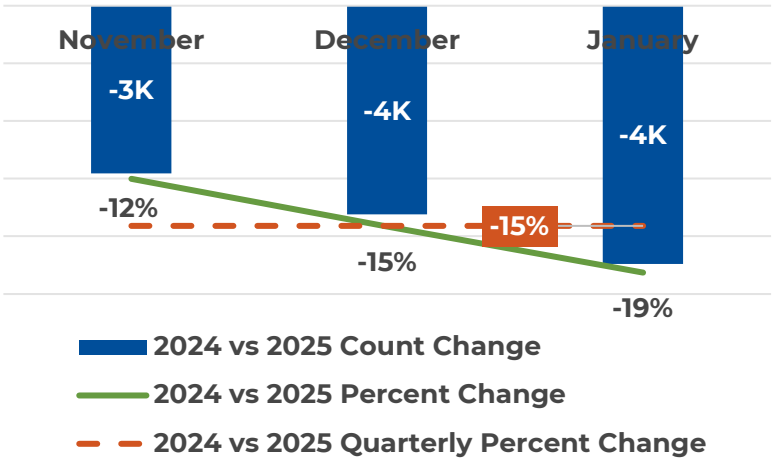
Utilization (Cont.)

Members With Opioid Claims By Qualifying Group



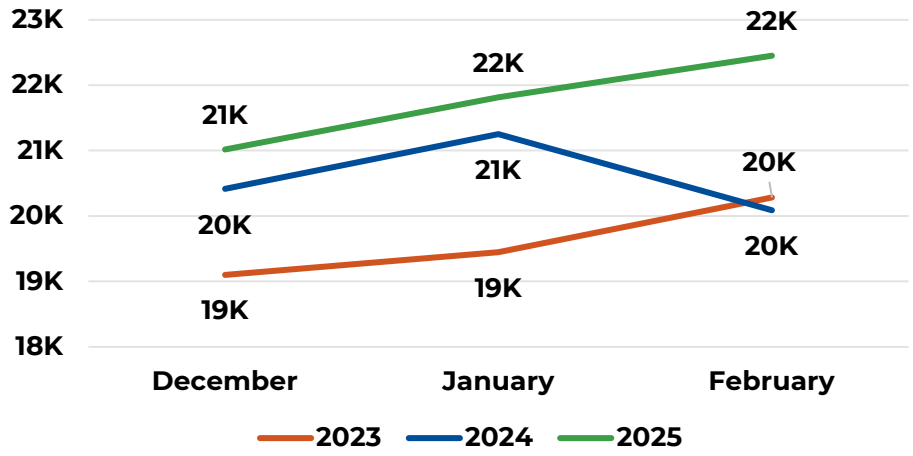
Total Opioid Claims

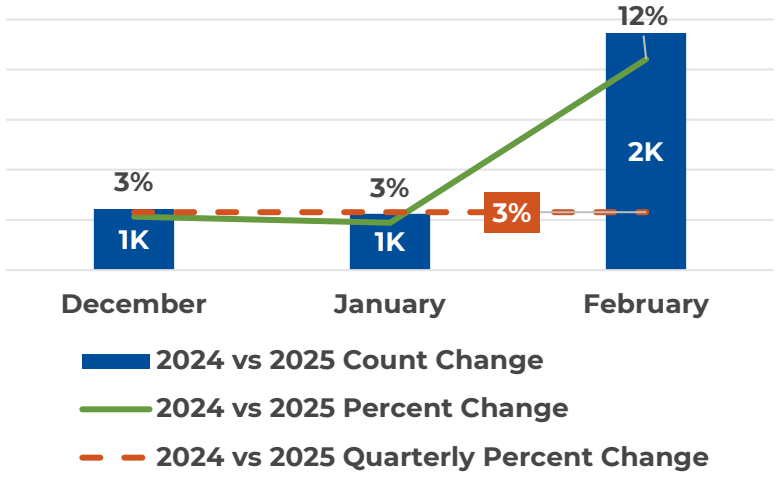




Utilization (Cont.)

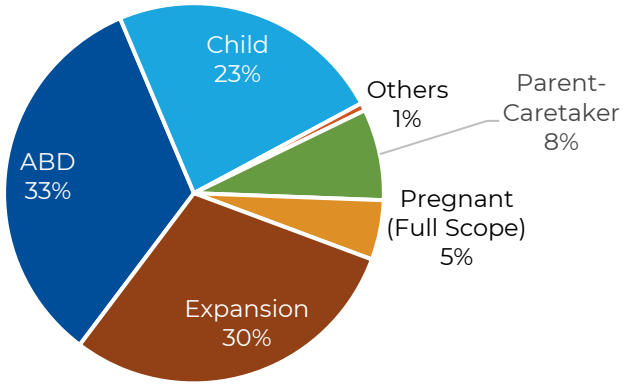
Out of State Services (Non Border County) - Total Members Utilization



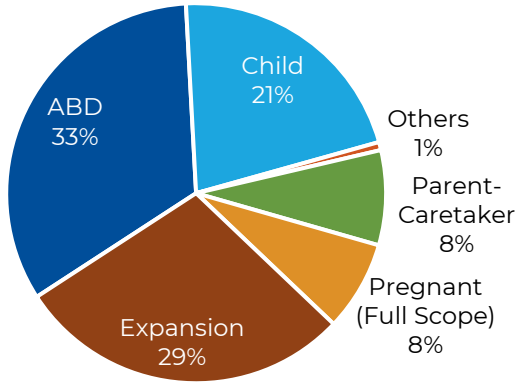


Out of State Services (Non Border County) - Total Members Utilization By Qualifying Group

Q3 2024

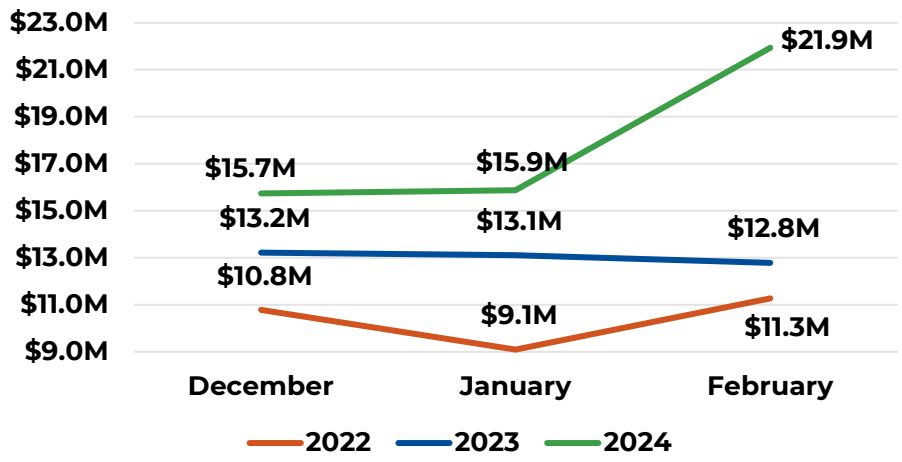


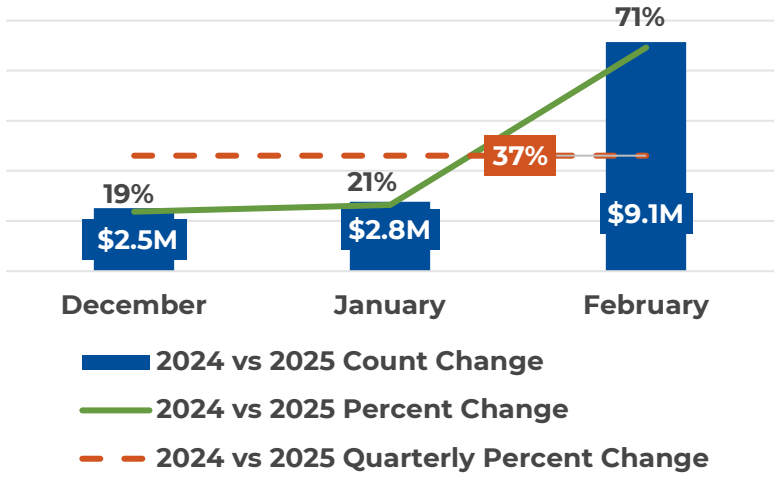
Q3 2025



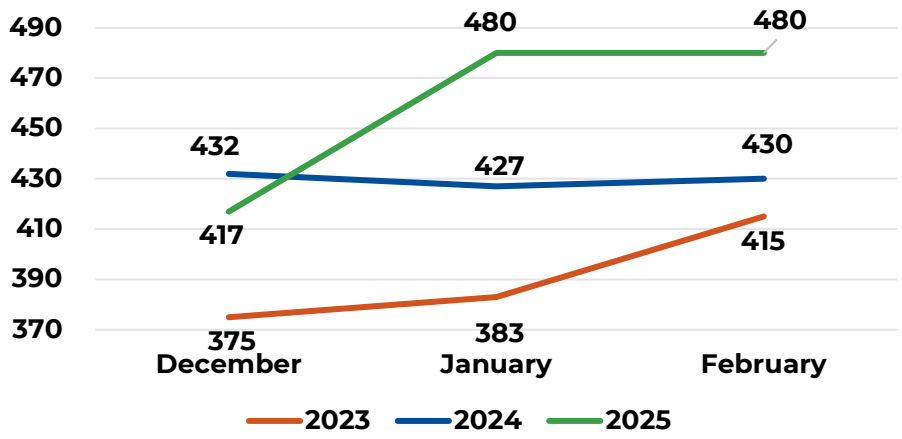
Utilization (Cont.)

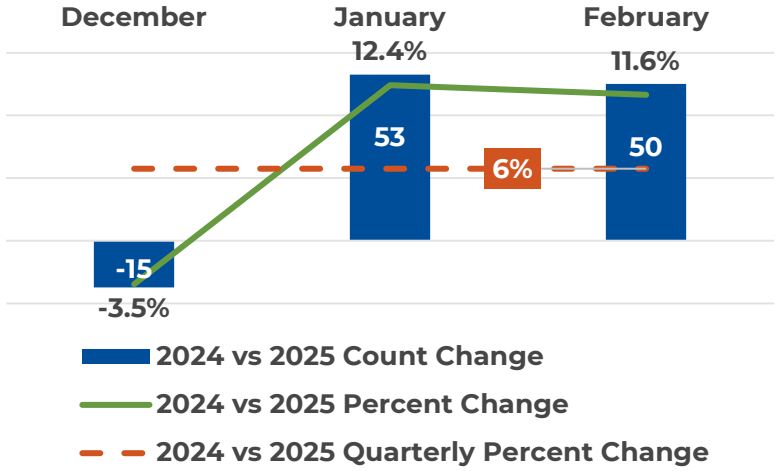
Out of State Services (Non Border County) - Total Reimbursements





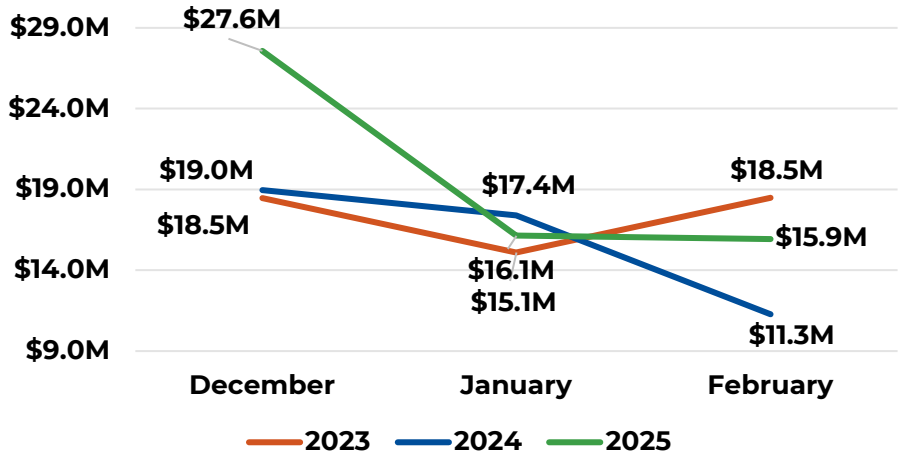
Out of State Services (Non Border County) - Total Active Billing Providers

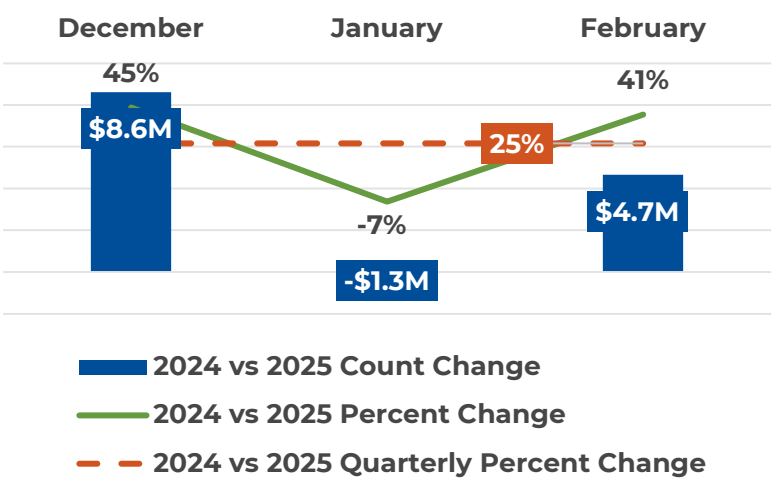




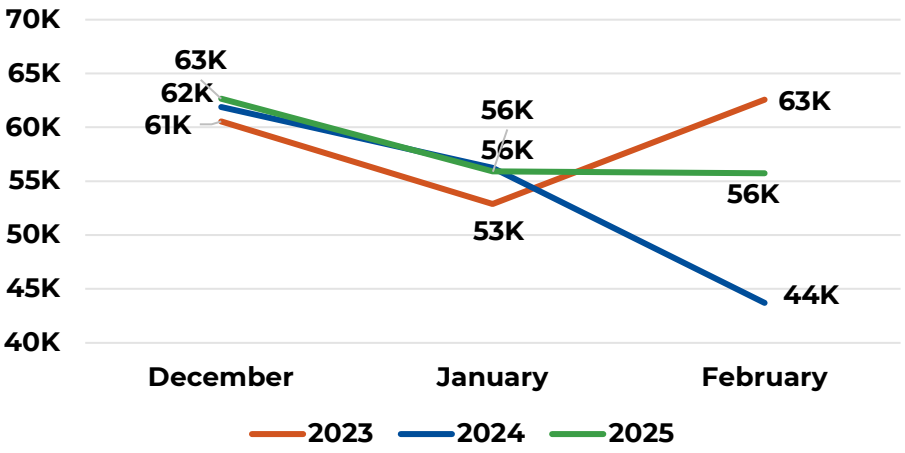
Utilization (Cont.)

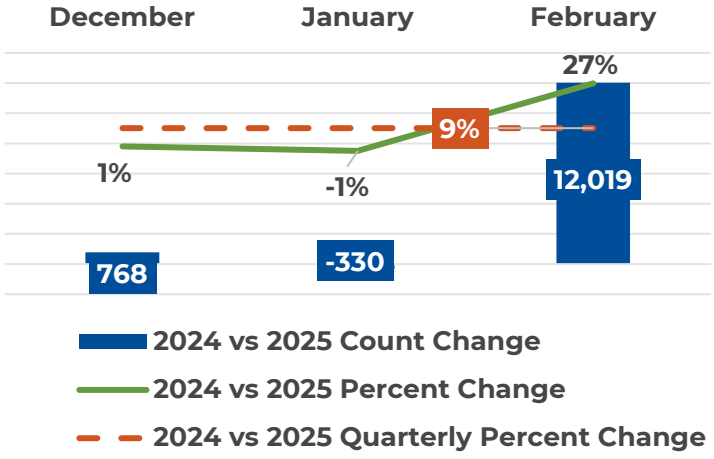
Dental Claims





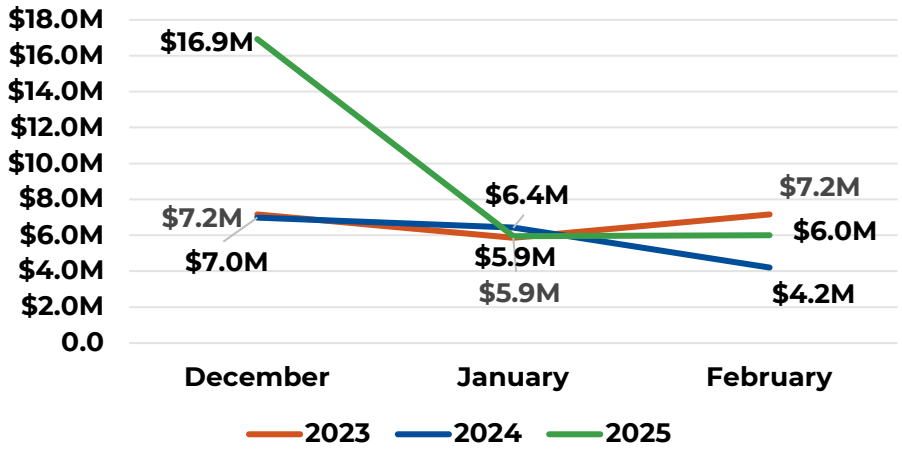
Total Members with Dental Claims

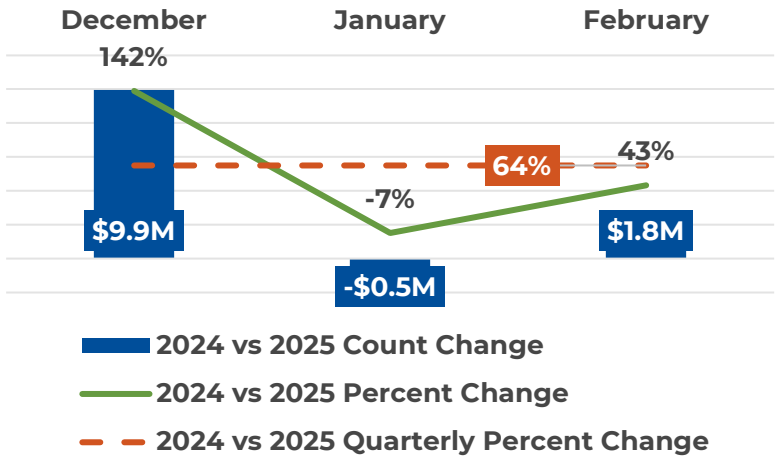




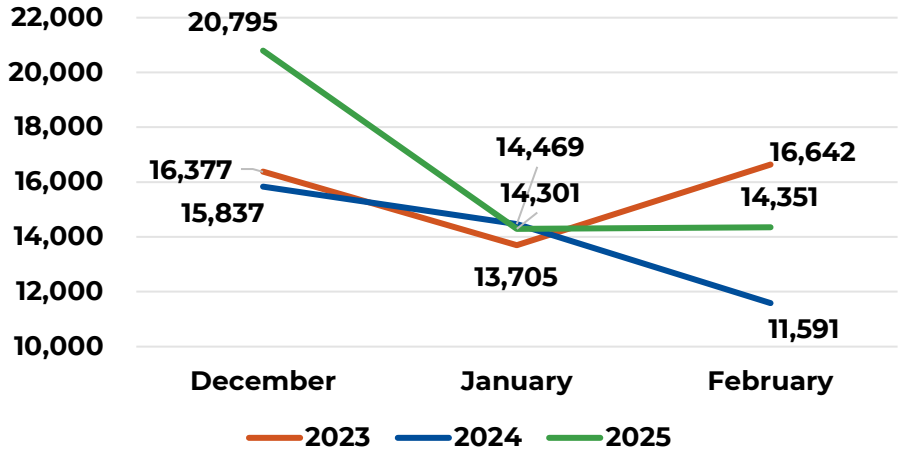
Utilization (Cont.)

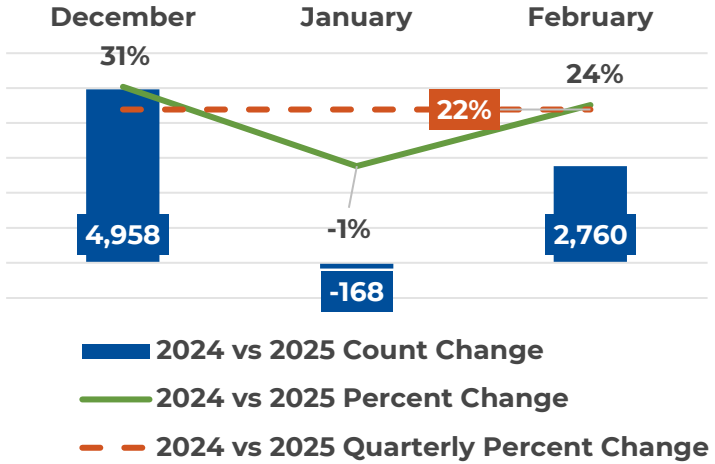
Adult (21 & Over) Dental Claims





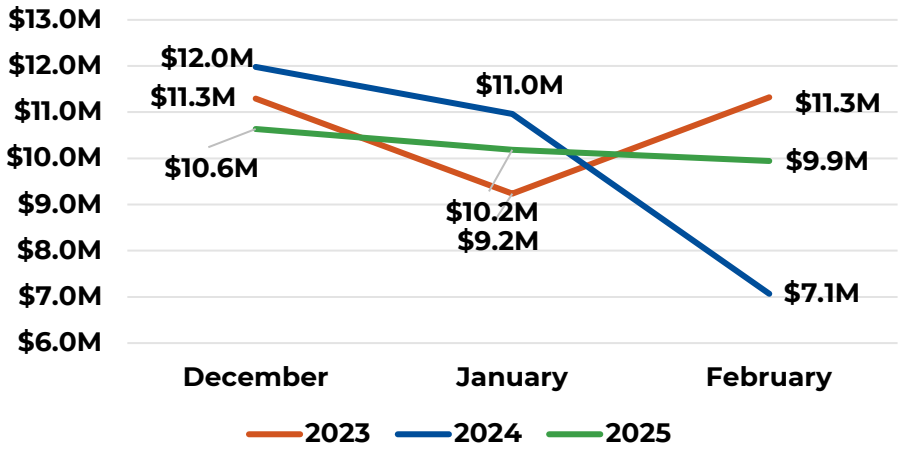
Adults (21 & Over) with Dental Claims

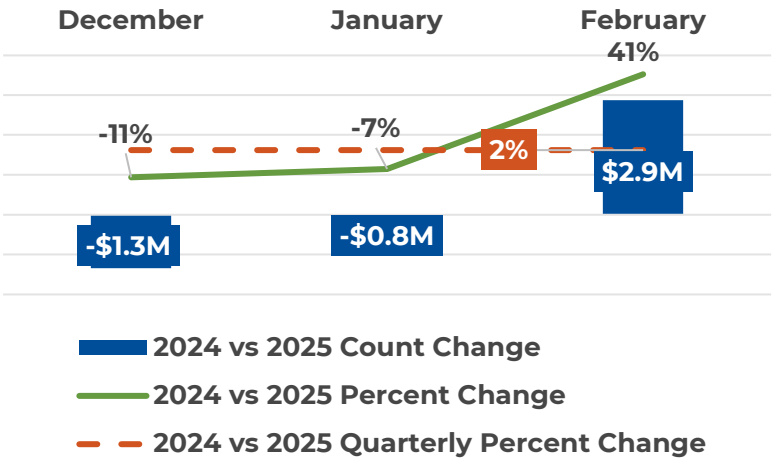




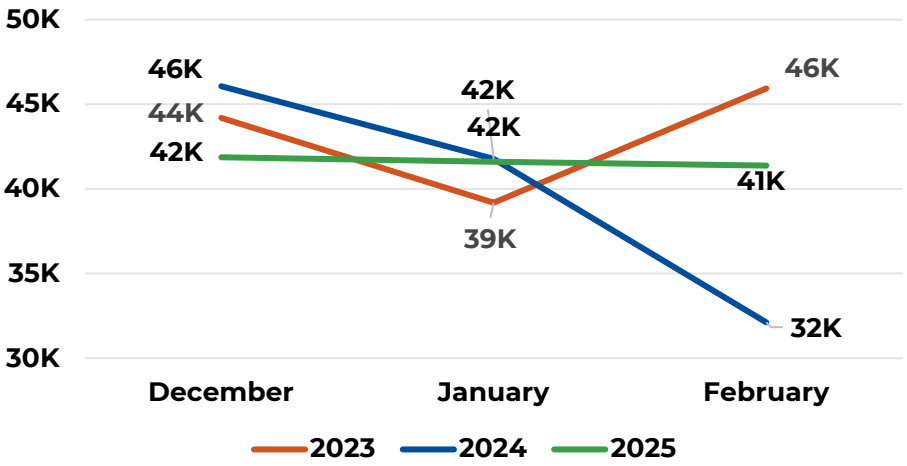
Utilization (Cont.)

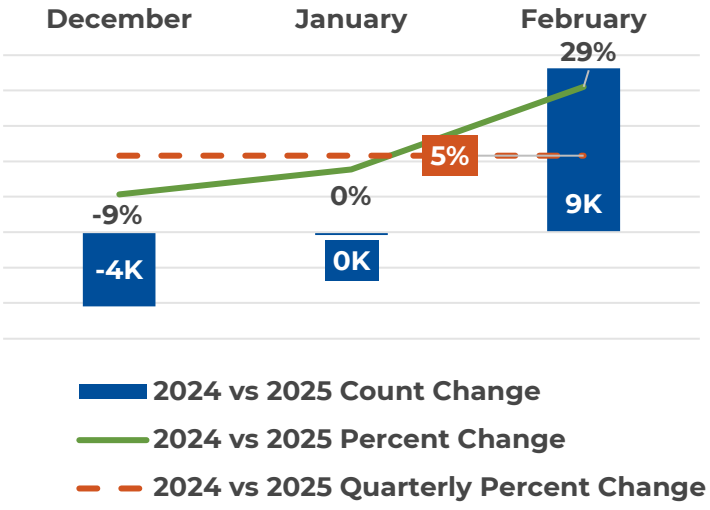
Children (Under 21) Dental Claims





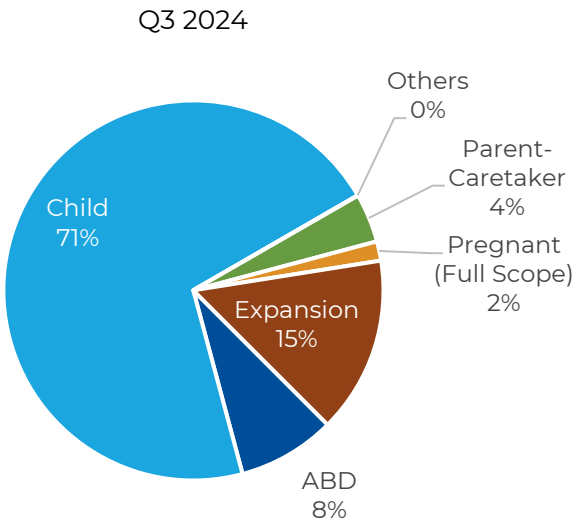
Children (Under 21) with Dental Claims

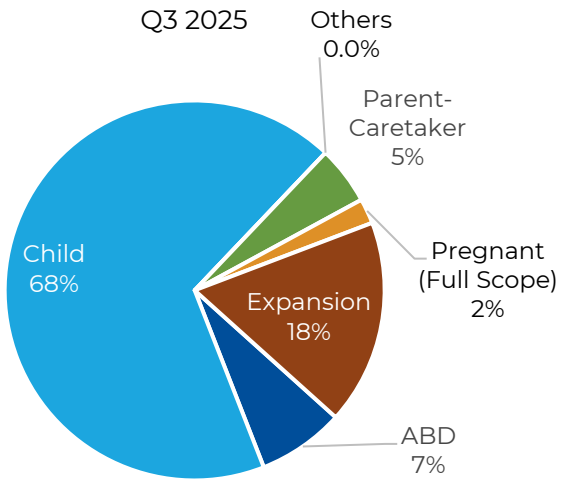




Utilization (Cont.)

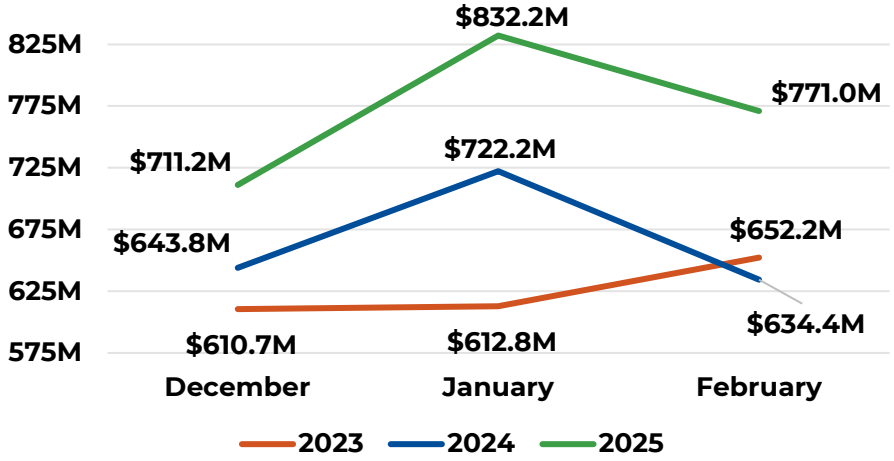
Members With Dental Claims By Qualifying Group

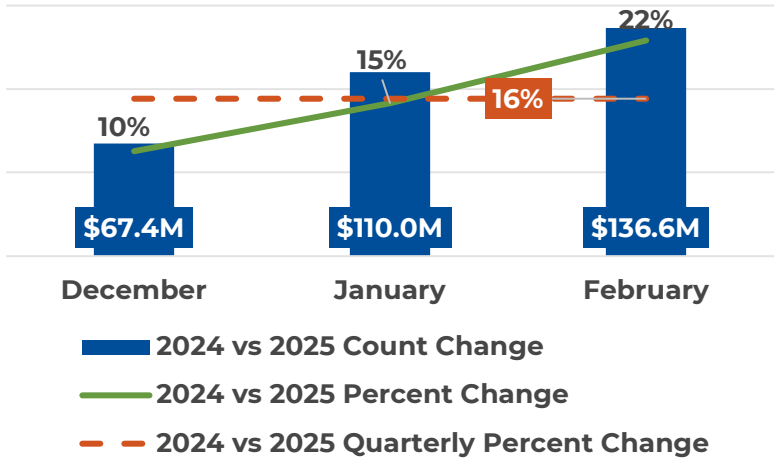




Financials

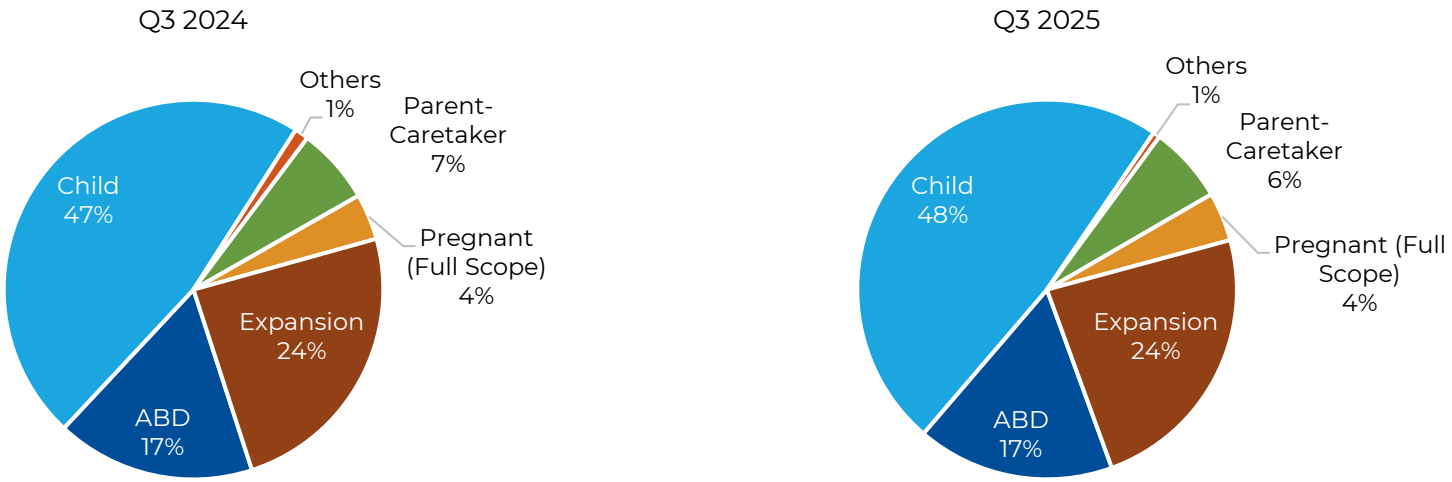
Total Agency Expenditures



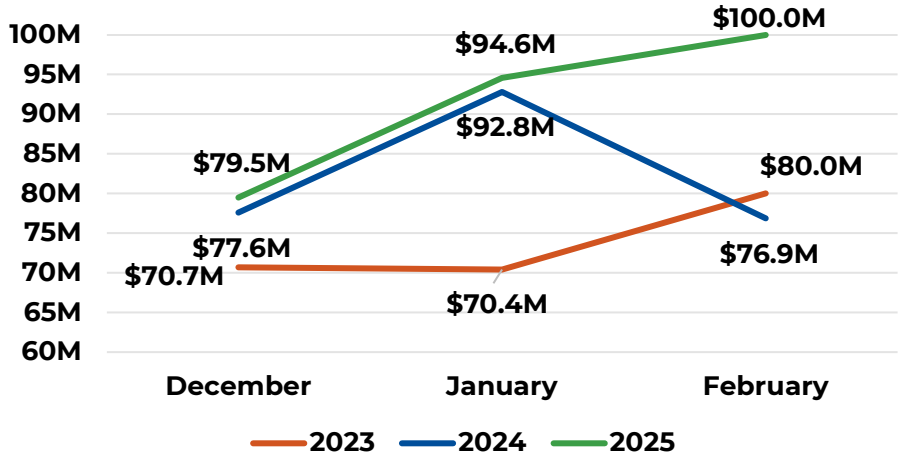


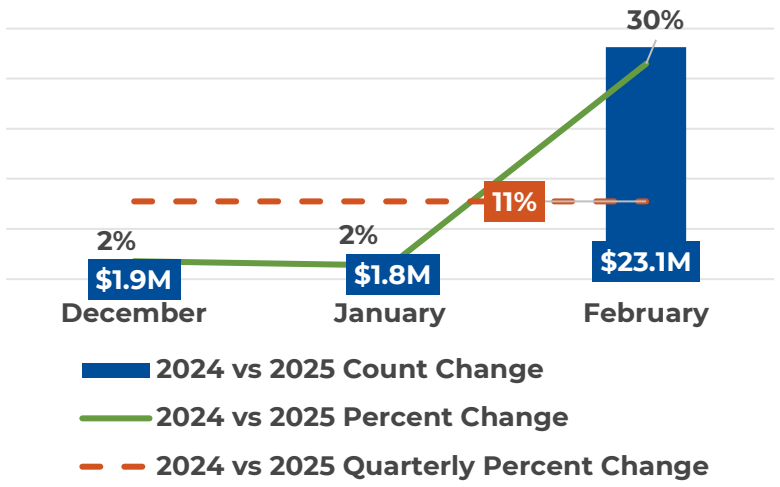
Financials (Cont.)

Total Agency Members Utilization by Qualifying Group



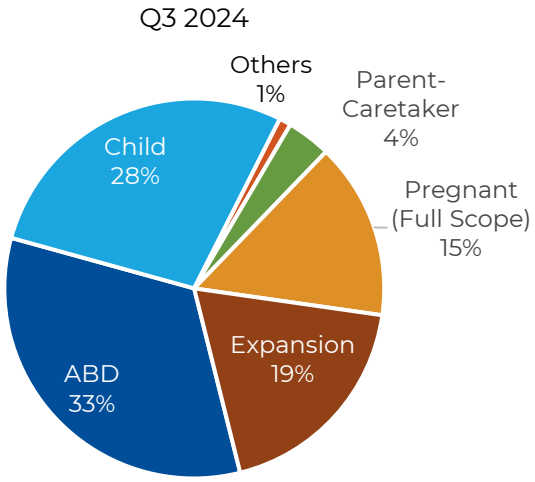
Inpatient Services Expenditures

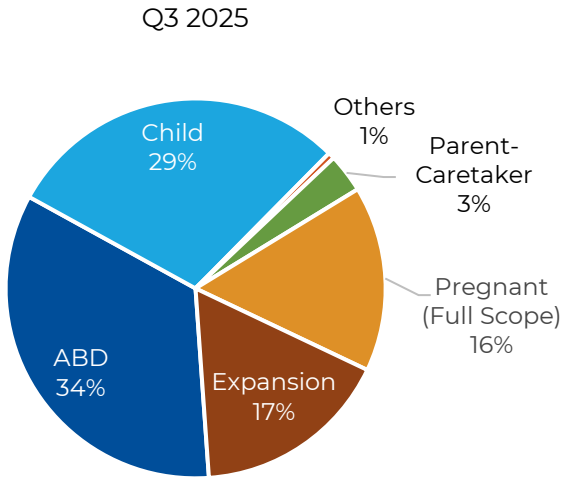




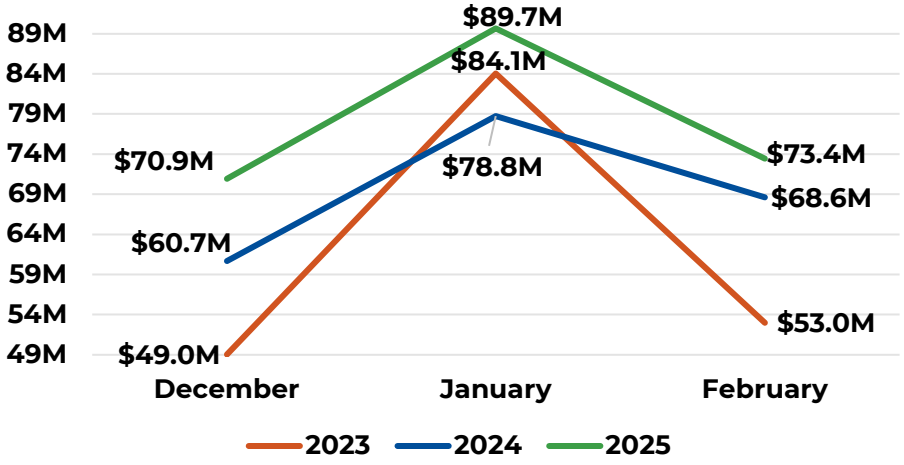
Financials (Cont.)

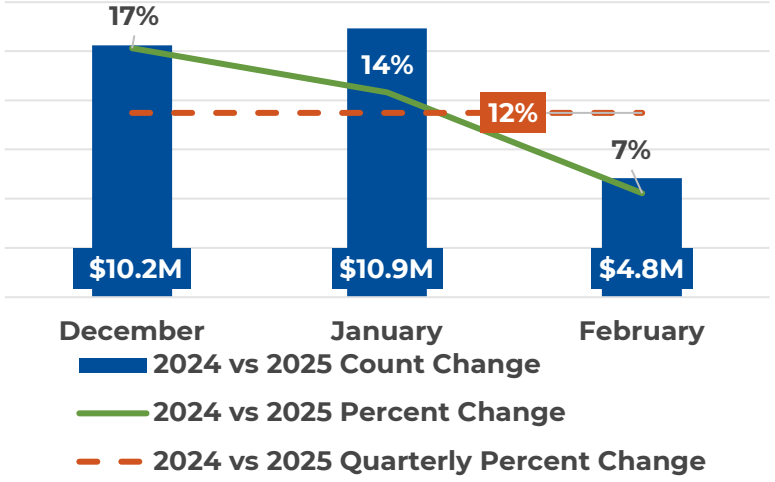
Inpatient Services Members Utilization by Qualifying Group





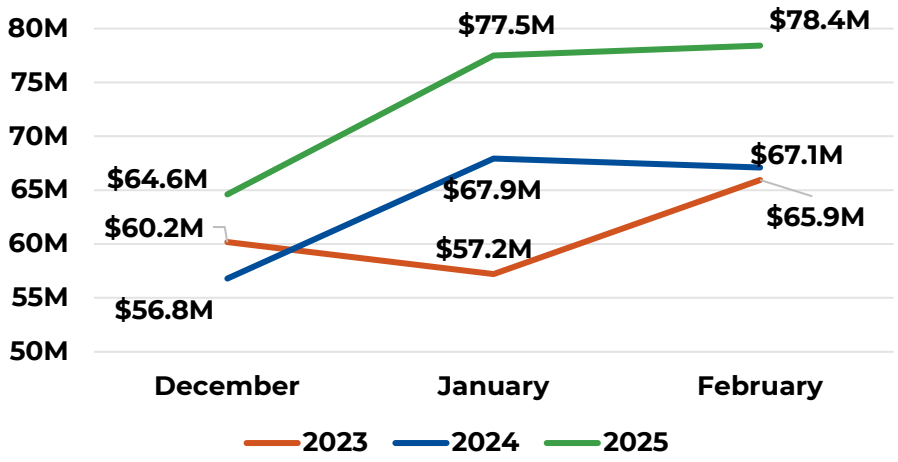
Nursing Facility Expenditures

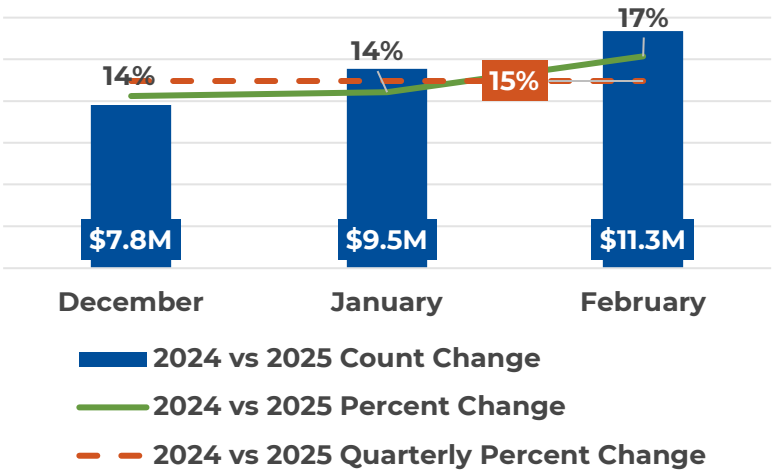




Financials (Cont.)

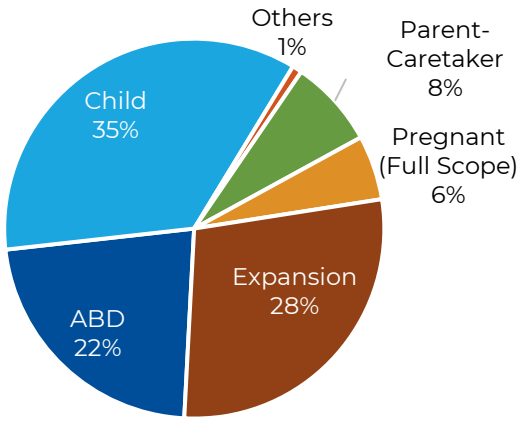
Outpatient Hospital Expenditures



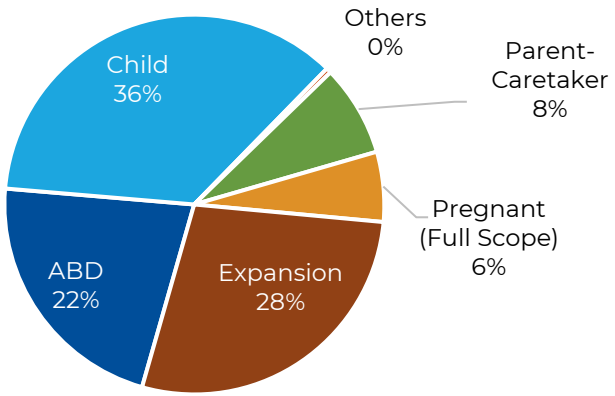


Outpatient Hospital Members Utilization by Qualifying Group

Q3 2024

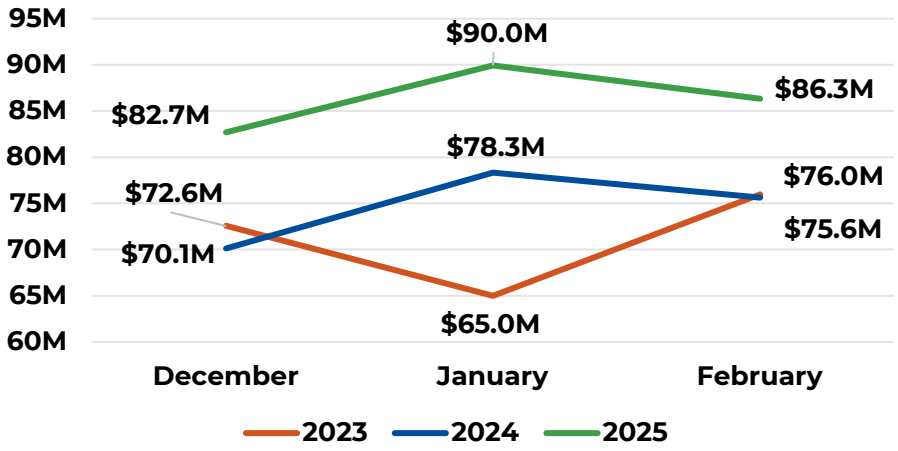


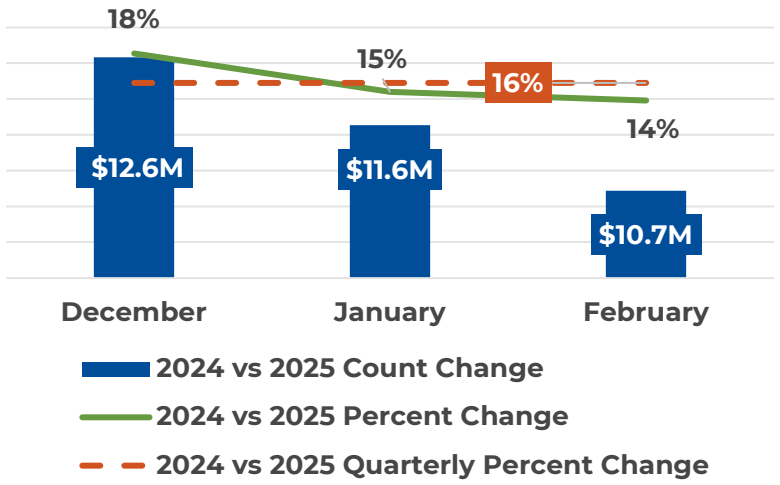
Q3 2025



Financials (Cont.)

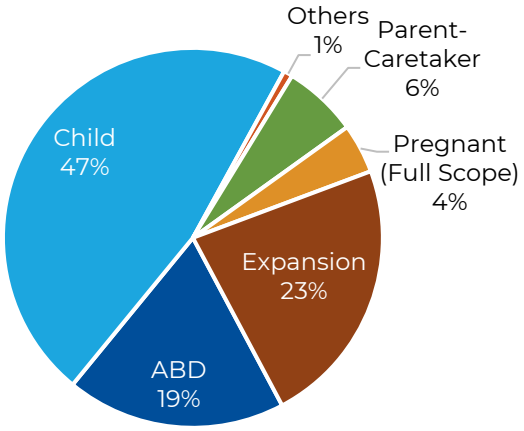
Physician Expenditures



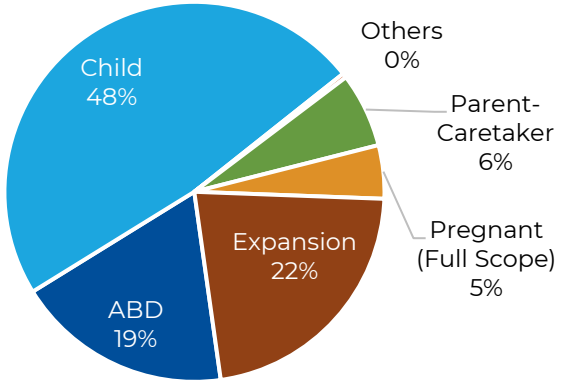


Physician Members Utilization By Qualifying Group

Q3 2024

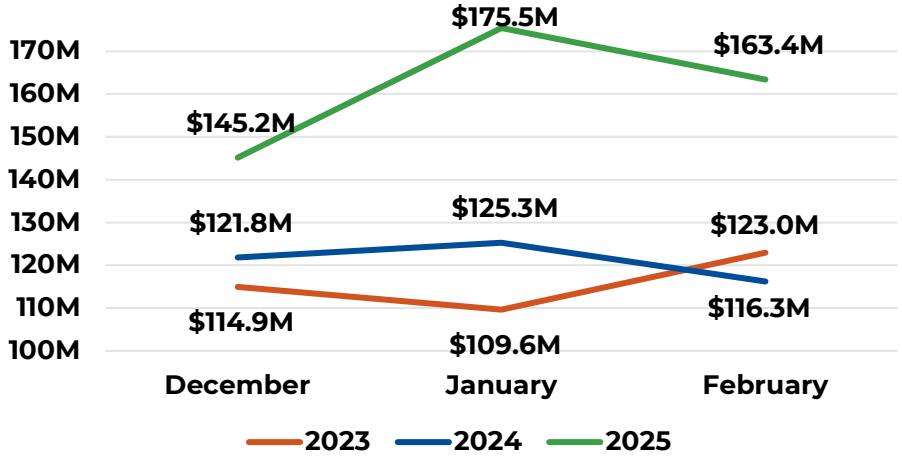


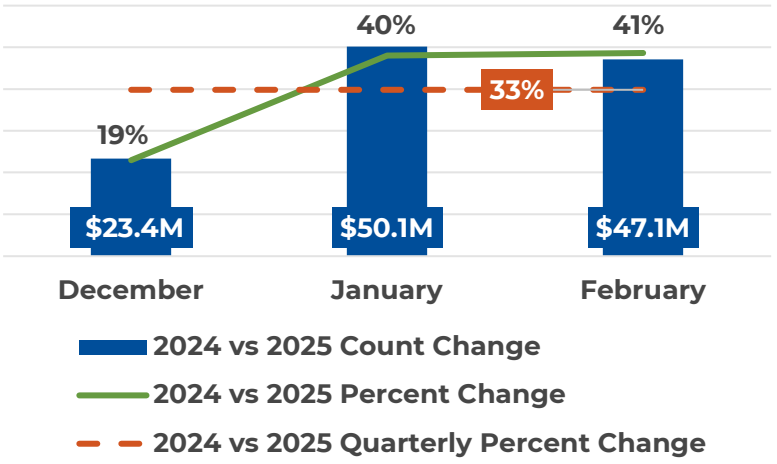
Q3 2025



Financials (Cont.)

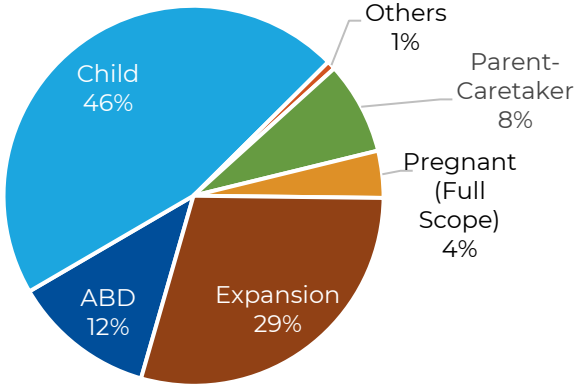
Prescribed Drugs Expenditures



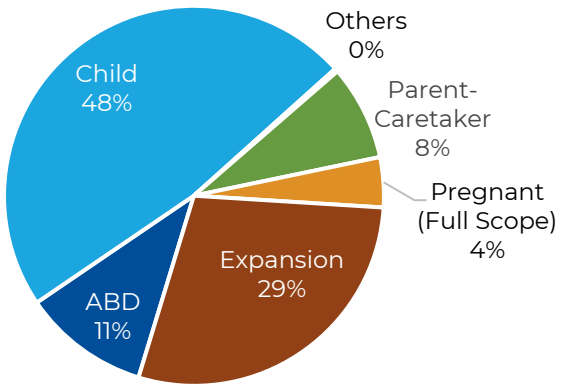


Prescribed Drugs Members Utilization By Qualifying Group

Q3 2024

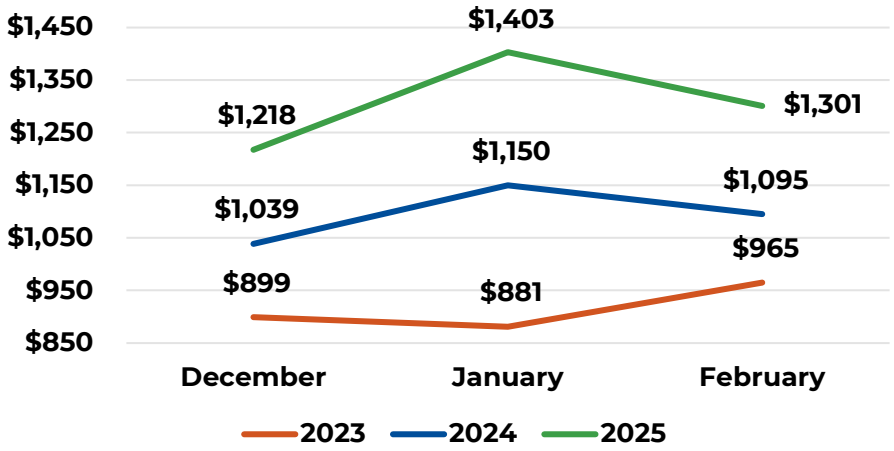


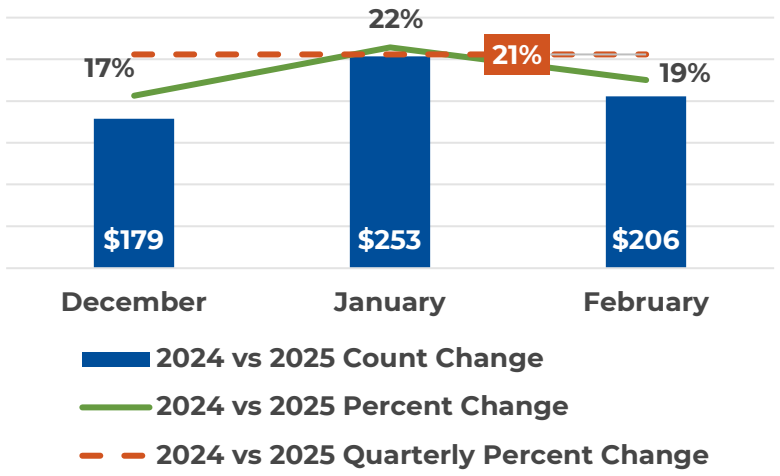
Q3 2025



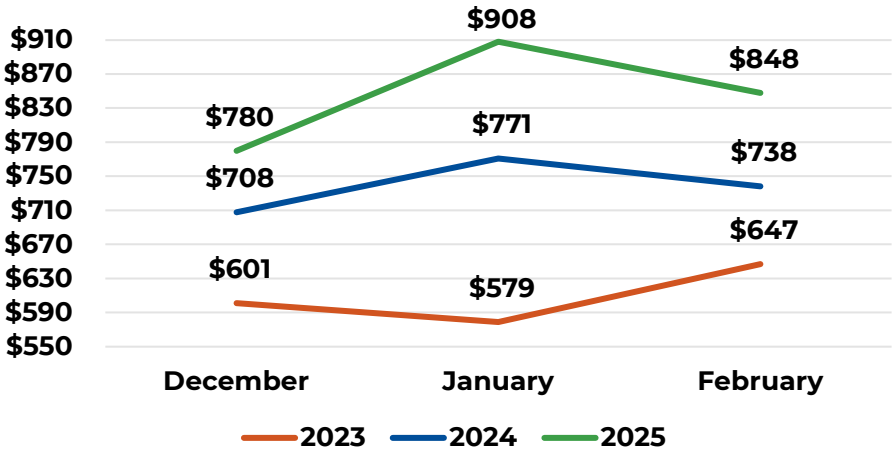
Financials (Cont.)

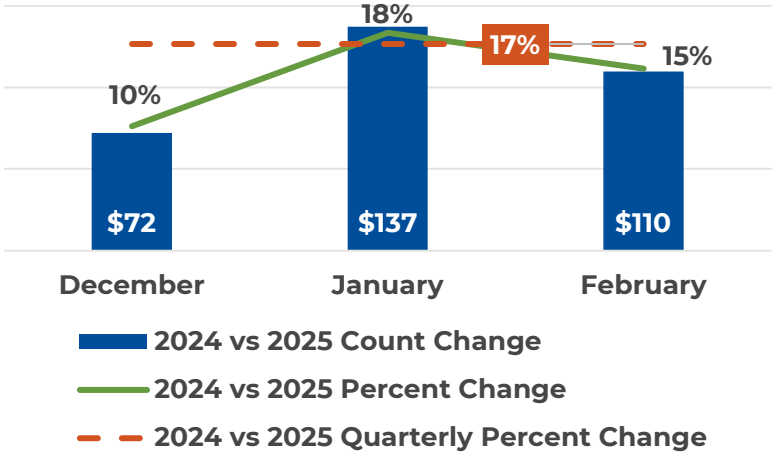
Average Per Total Member Served





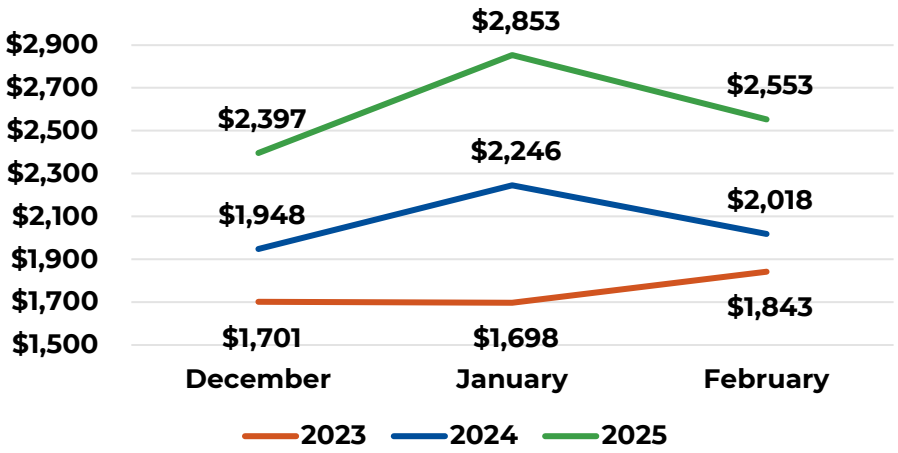
Average Per Child (Under 21) Member Served

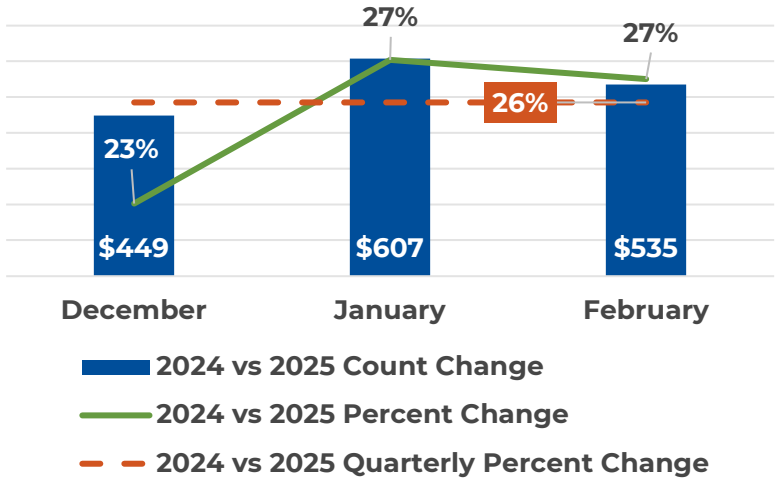




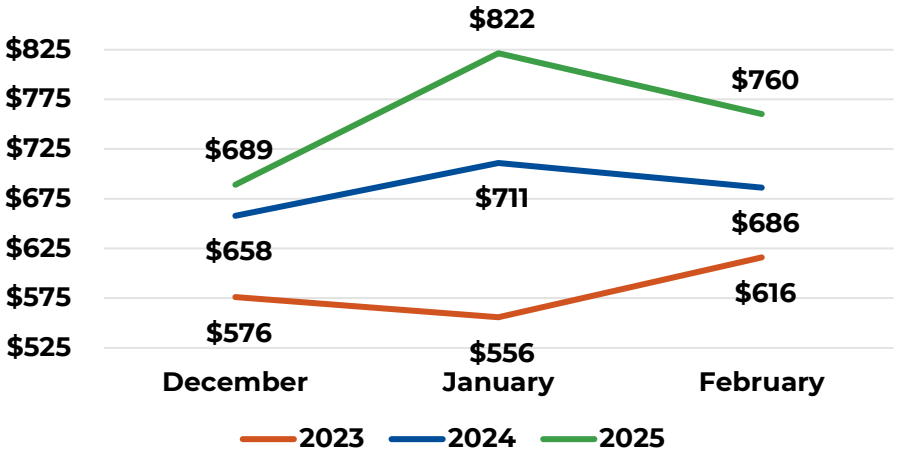
Financials (Cont.)

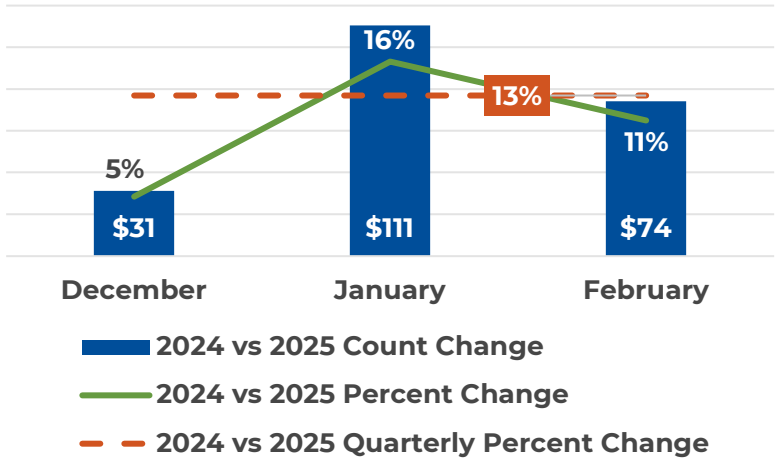
Average Per Aged/Blind/Disabled Member Served





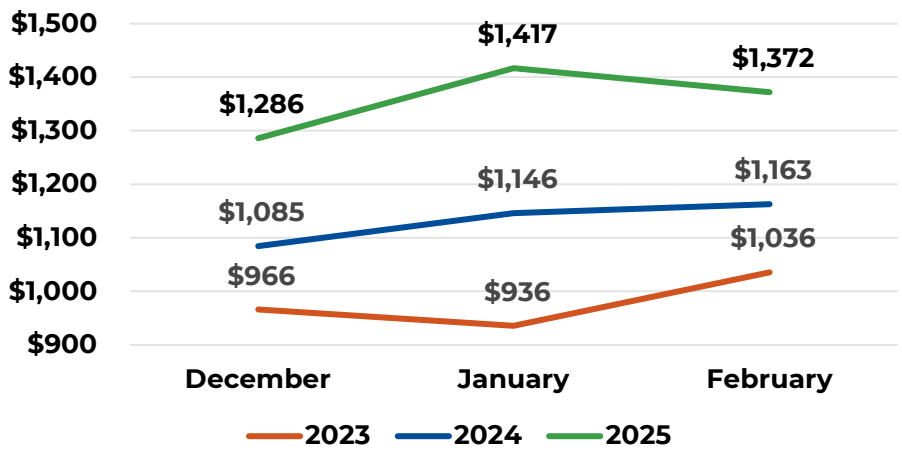
Average Per Children & Parent/Caretaker Member Served

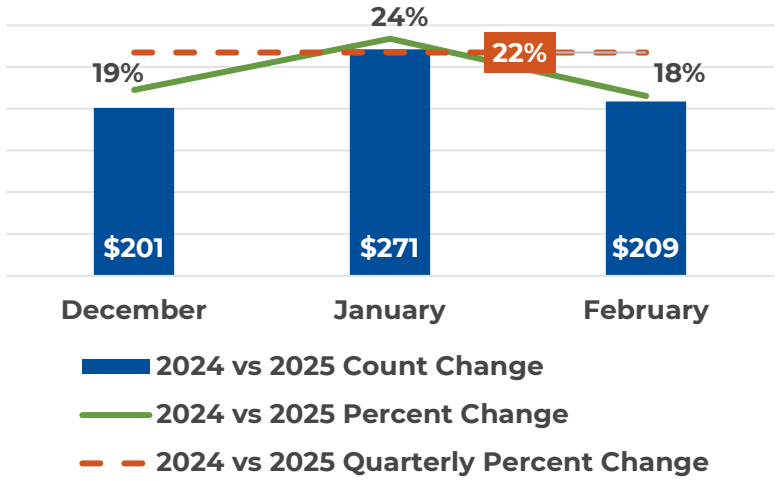




Financials (Cont.)

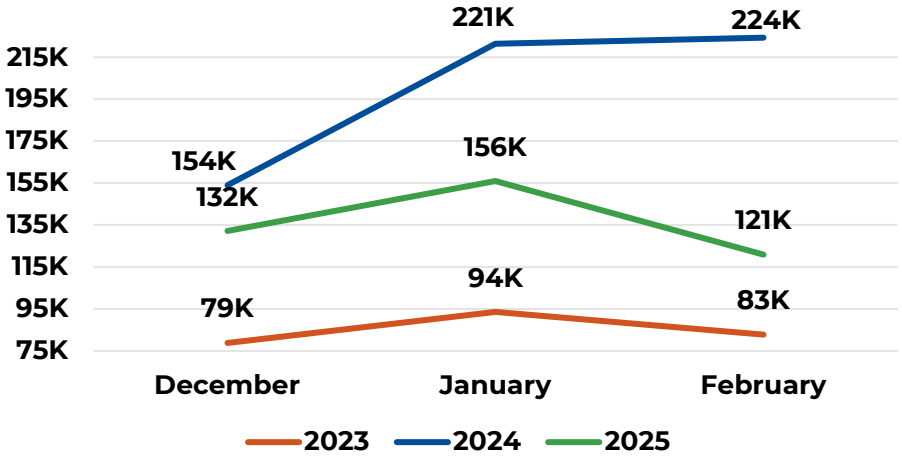
Average Per Expansion Member Served (Effective July 2021)

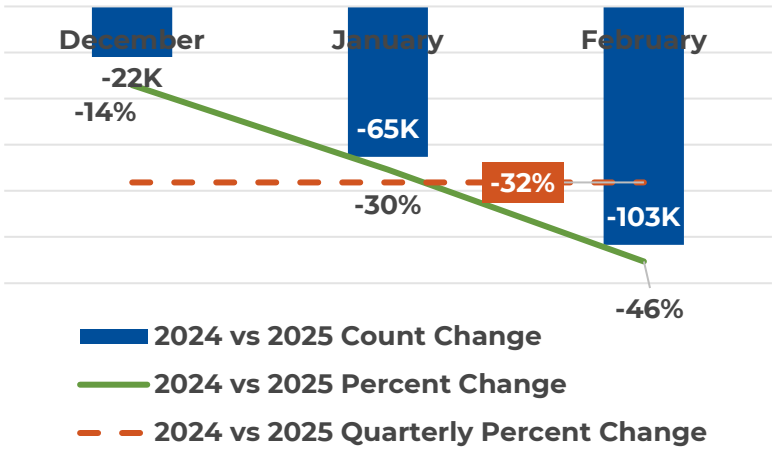




Call Center

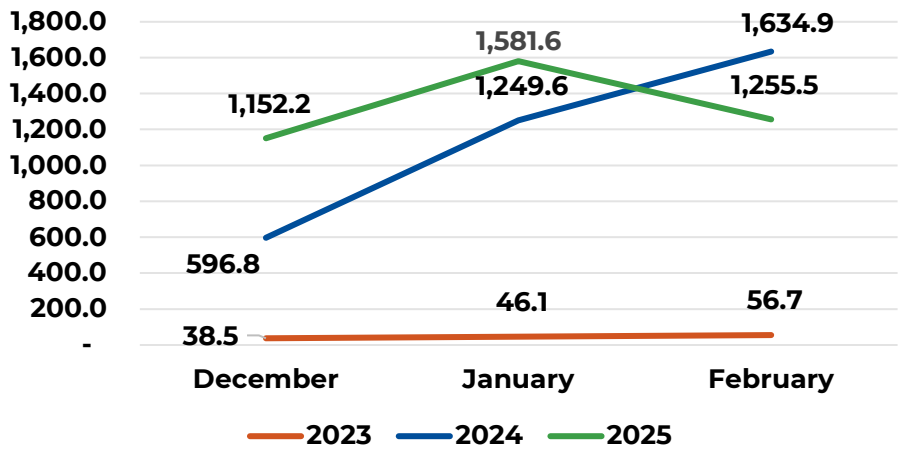
Call Center - Member Calls Answered

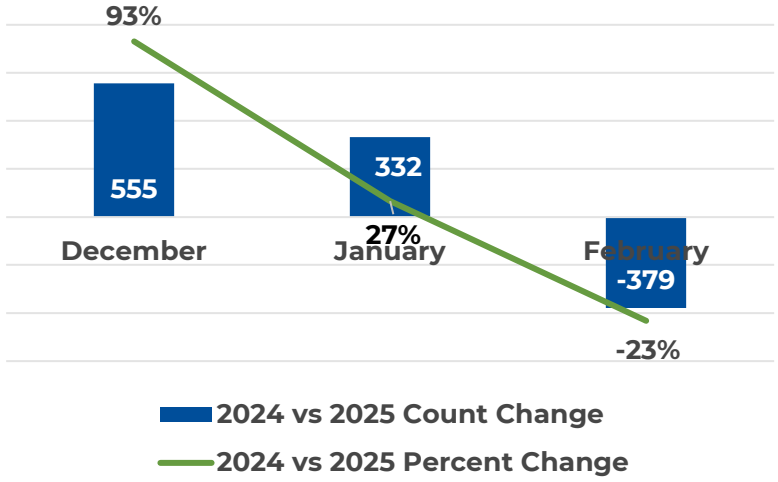




Call Center (Cont.)

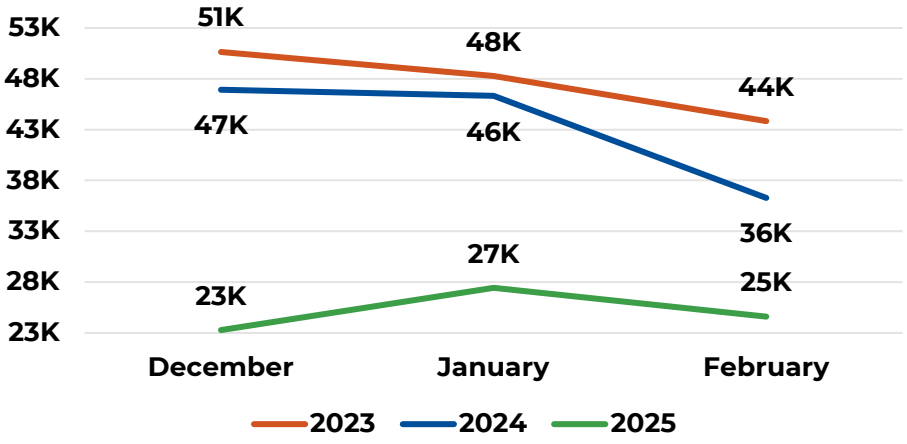
Call Center - Average Wait Time (In Seconds)

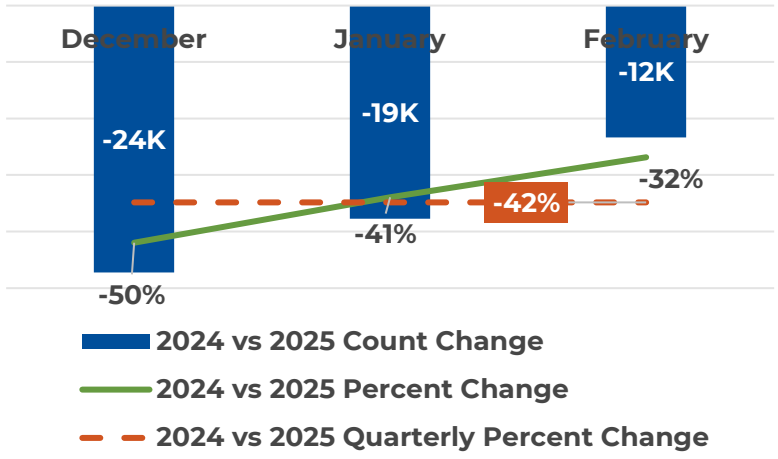




Prior Authorization

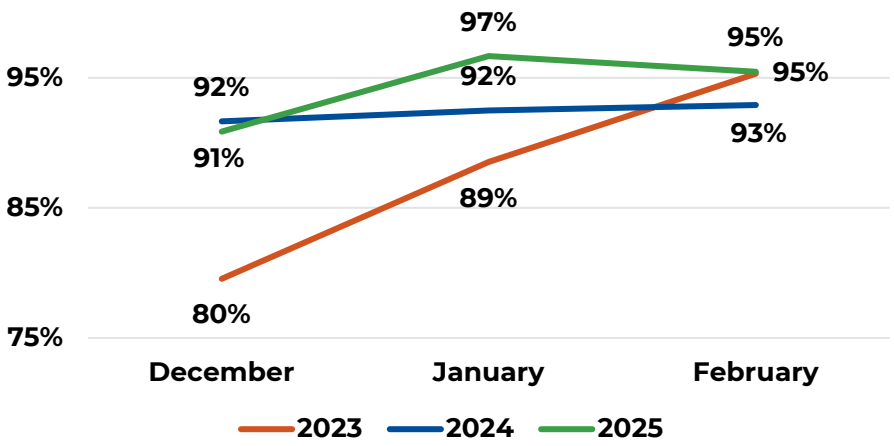
Prior Authorization - Total Combined - Total Completed PA Volume

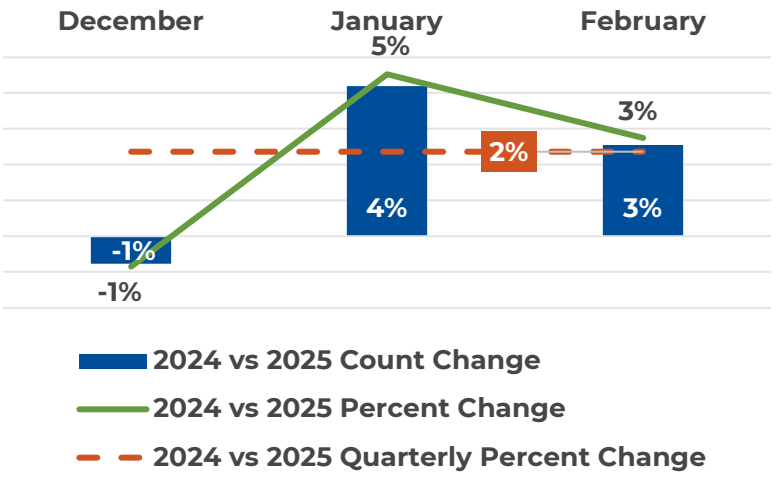




Prior Authorization (Cont.)

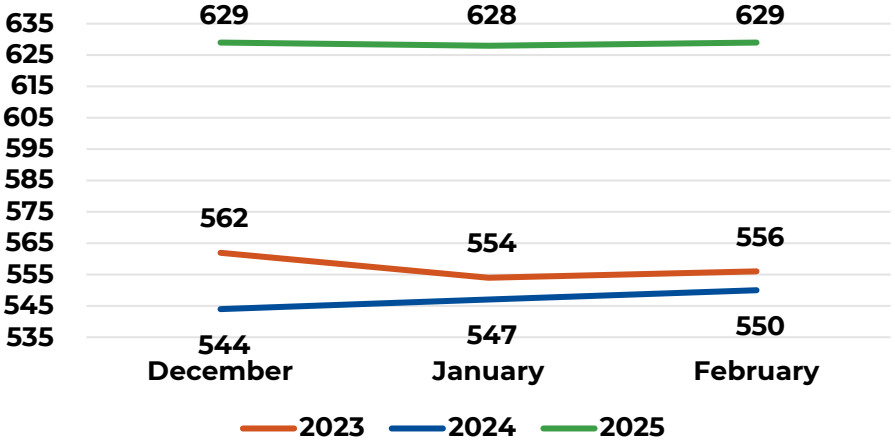
Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

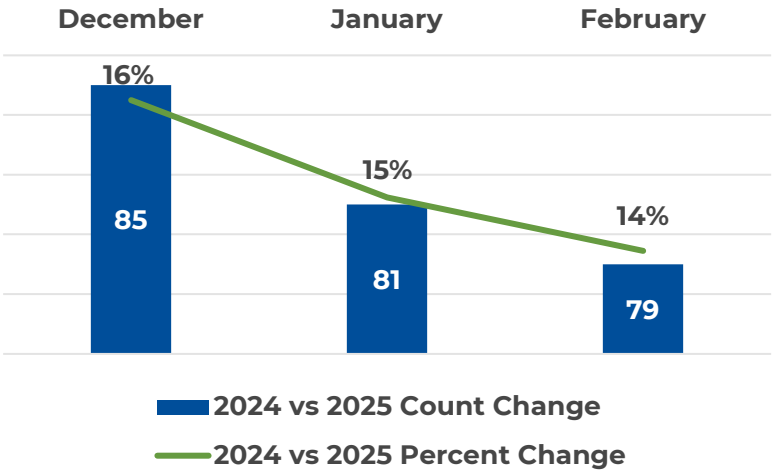




Agency Stats & Provider Network

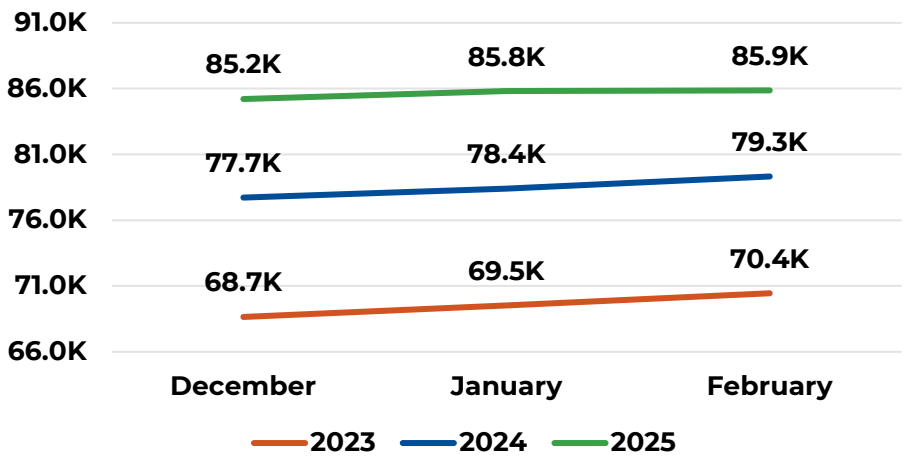
OHCA Admin - Number of FTEs

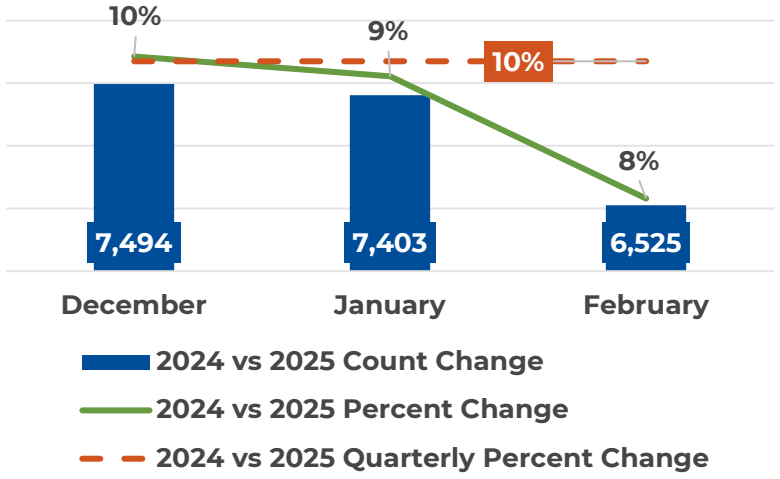




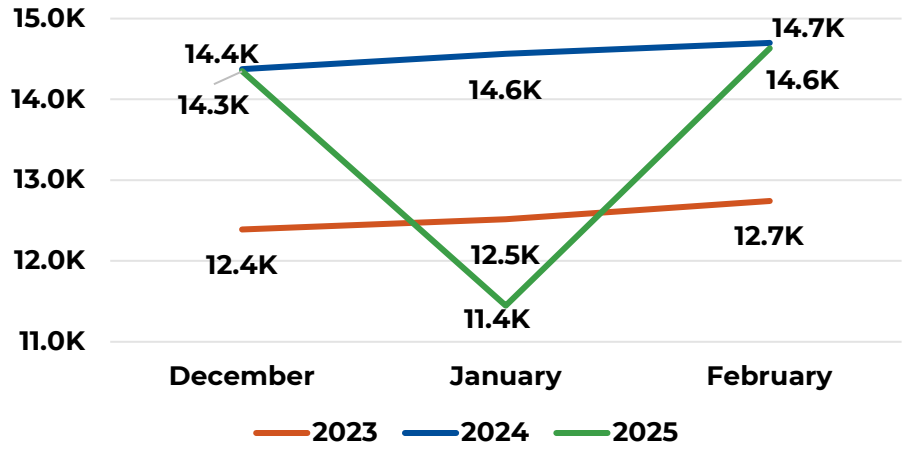
Agency Stats & Provider Network (Cont.)

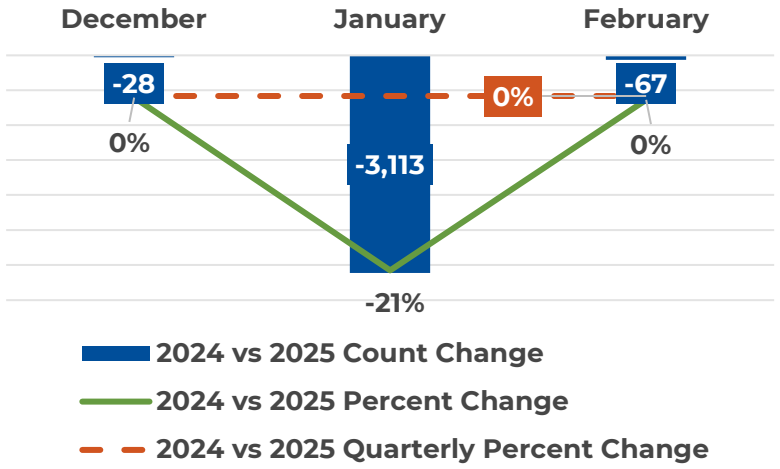
Total Providers





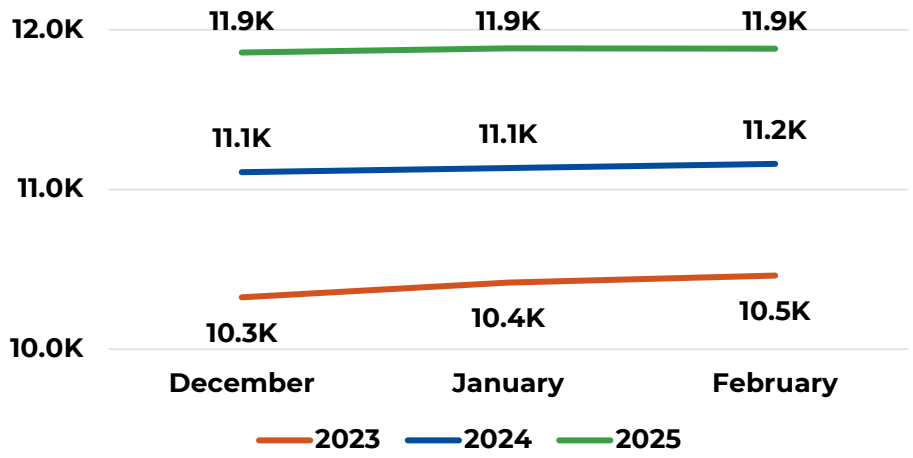
Mental Health Providers (In-State Only)

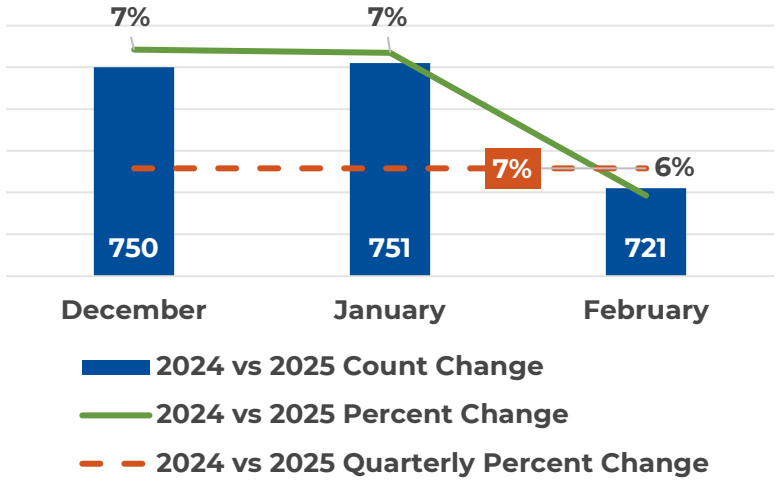




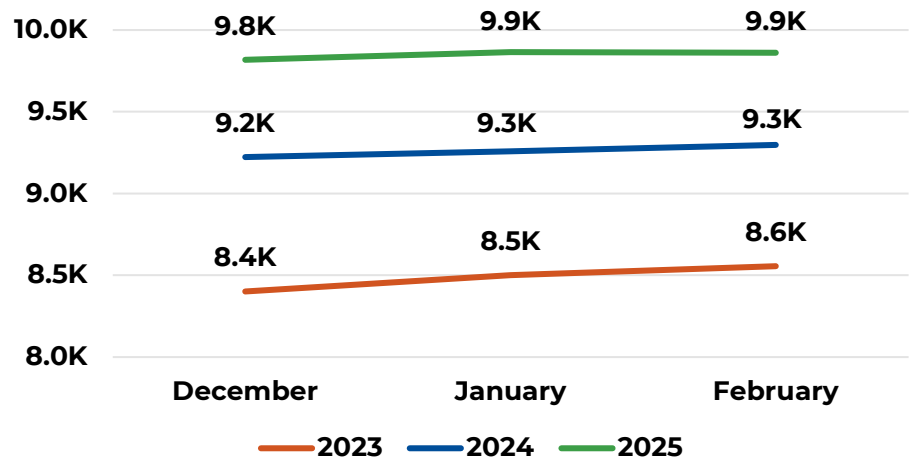
Agency Stats & Provider Network (Cont.)

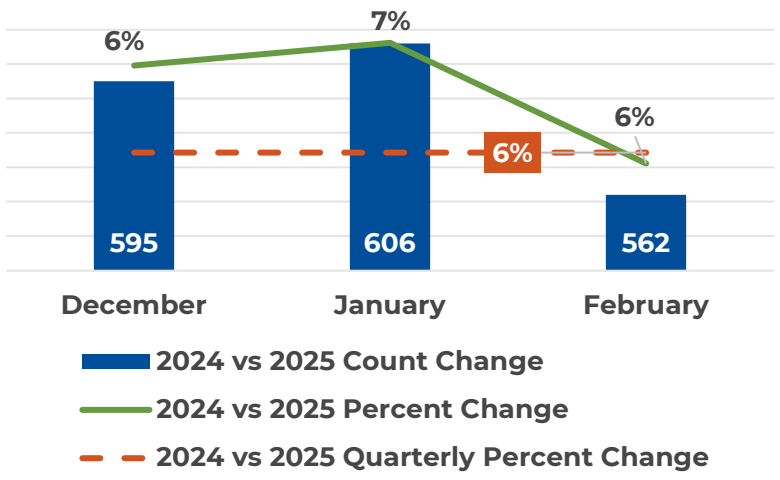
Physicians (In-State Only)





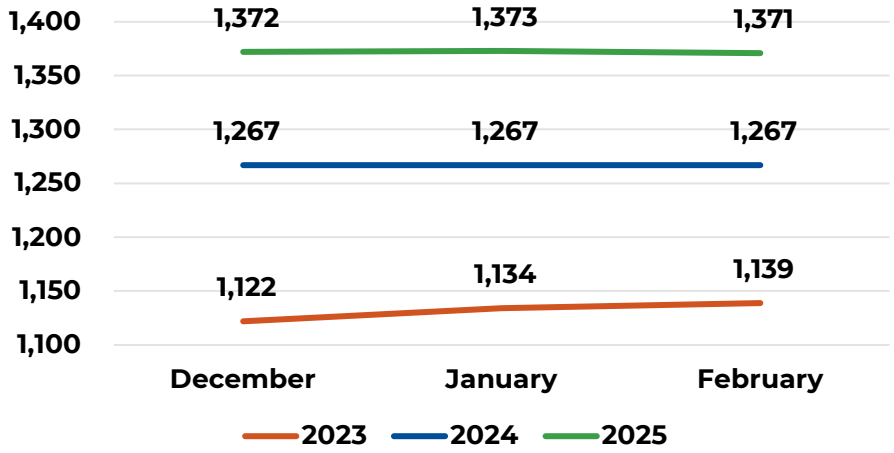
Primary Care Providers (In-State Only)

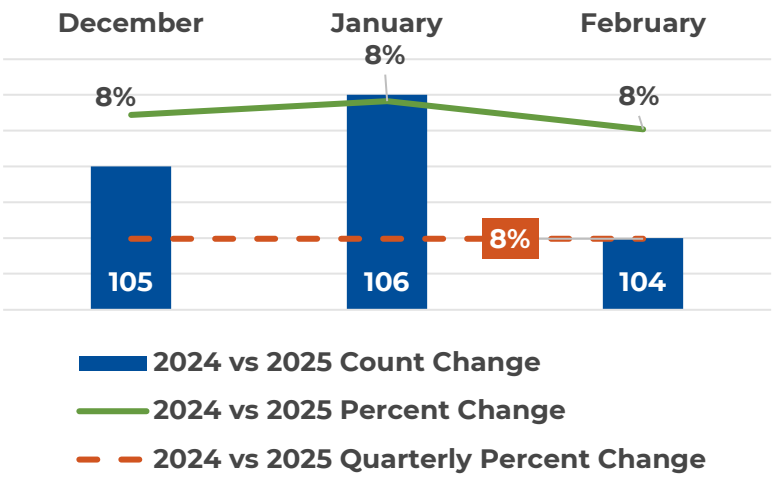




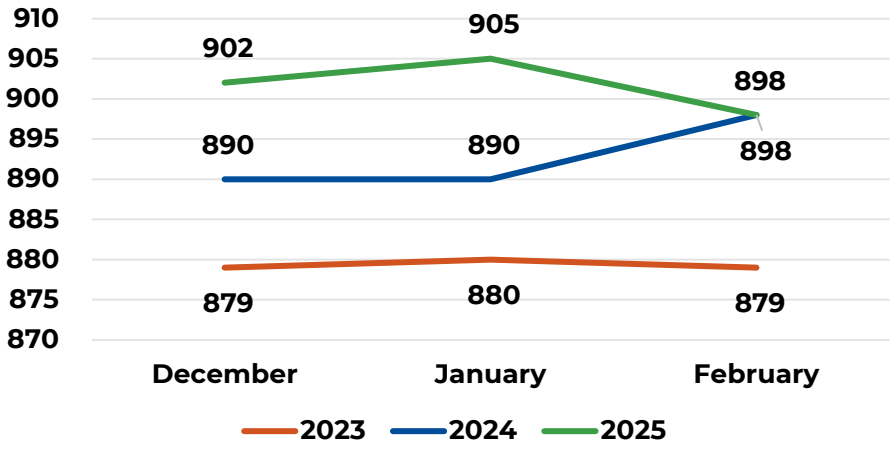
Agency Stats & Provider Network (Cont.)

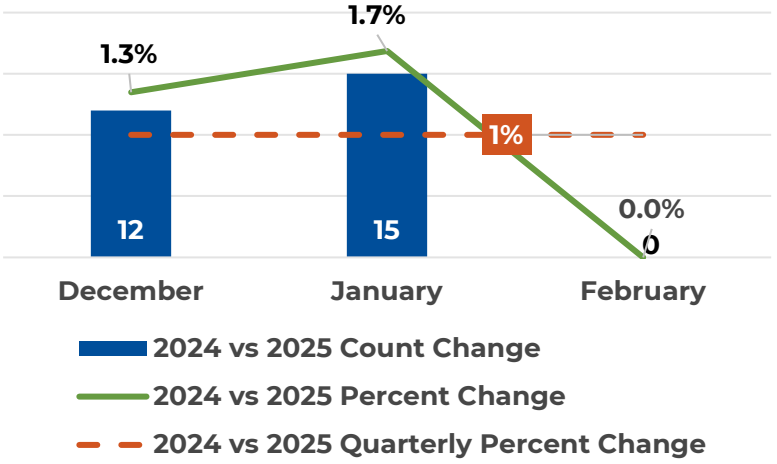
Dentists (In-State Only)





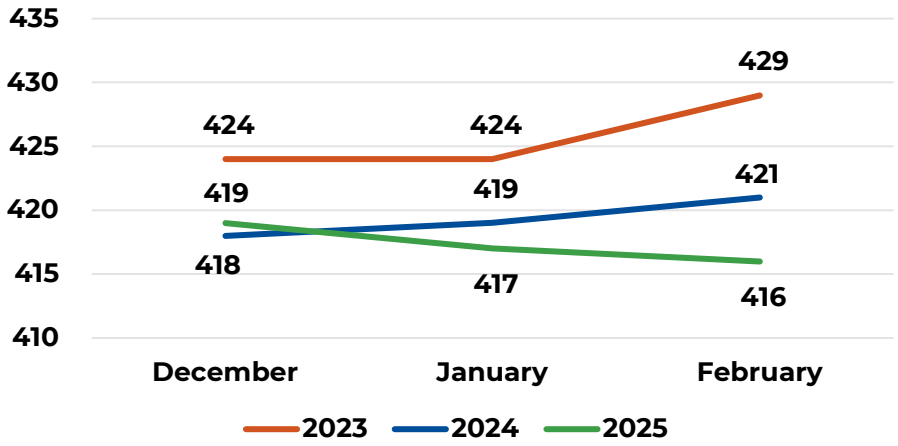
Pharmacy (In-State Only)

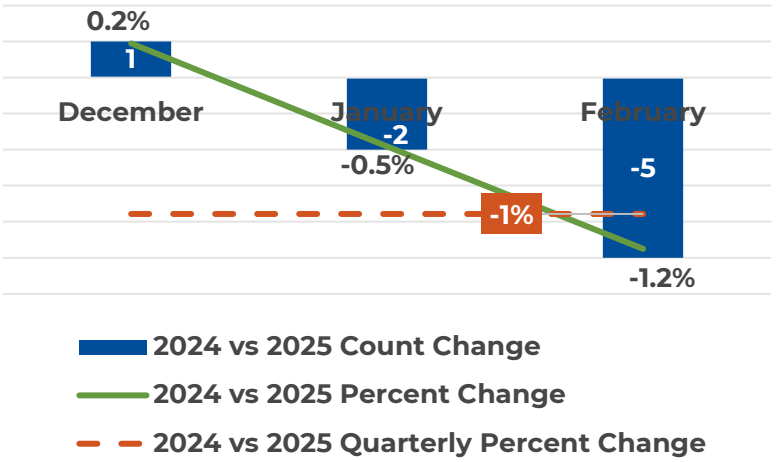




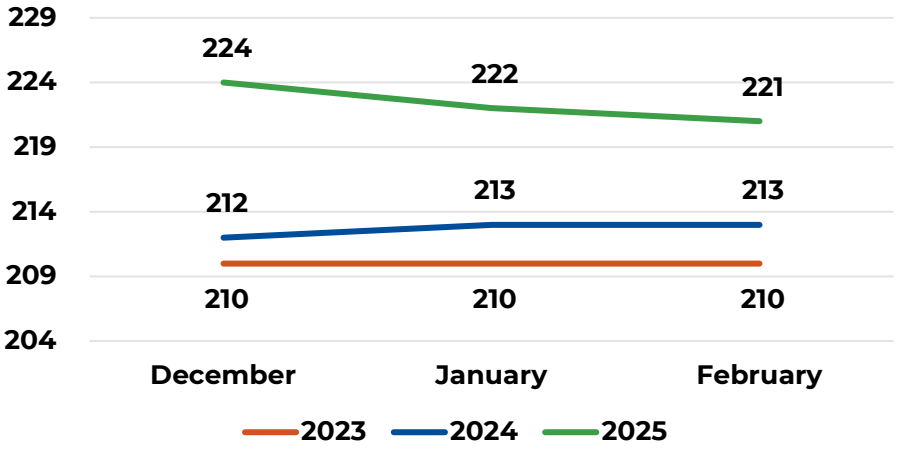
Agency Stats & Provider Network (Cont.)

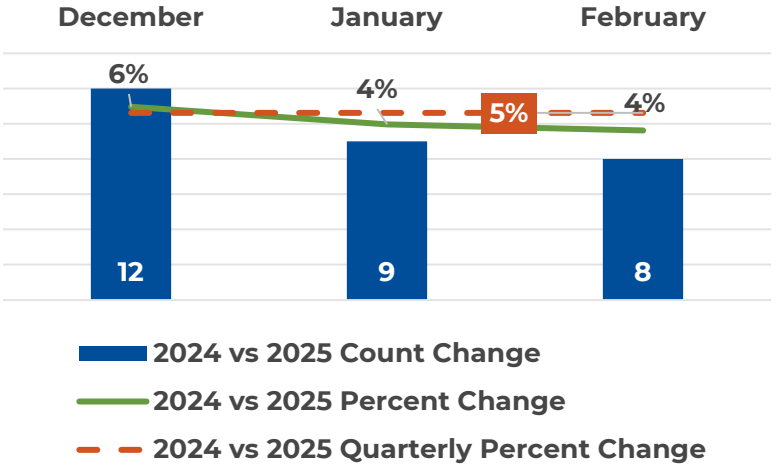
Extended Care Facilities (In-State Only)





Hospitals (In-State Only)





Operational Metrics Query Notes:

Enrollment is any point in time and any length of time enrolled during a month.

Enrollment group (Expansion, ABD, etc.) is based on aid category at time of service.

Payment cycles (number of payment processing weeks) is the main driver of most monthly variances.

Paid claims based on paid dates (FFS or MCE paid claim).

Type of claim (Inpatient, Outpatient, etc.) is based on the claim's category of service.

Emergency department claims based on paid facility claims based on paid dates with revenue codes between 450 and 459.

Opioid data is from the Opioid dashboard MME Calculations files.

Out of state is paid claims based on paid dates. Billing provider is not OK, and address type is service. Results are filtered to just border counties (within 50 miles of border). Data excludes non border county results and specialty pharmacy.

Telemedicine is paid claims based on paid dates. Claim includes procedure codes: Q3014;99441;99442;99443;98966;98967;98968;D9995, or procedure code modifiers GT or 95 or place of service was 02 – telehealth or 10 – telehealth (patients home).

Call center data from Call Center Data_Call Volume Change XLSX (Call Center_Member Calls tab).

Prior Authorization data is based on traditional path PAs. Accelerated path PAs are excluded. Counts include all PA line items (amendments, system added modifiers, etc) and are point in time. Completed PAs are Approved, Cancelled, System Cancelled and Denied. Monthly totals are calculated from the first day of the month to the last Sunday of the month; therefore, monthly totals may not reflect an entire month.

FTE counts from the latest available org chart or from last for a month. Uses agency count OHCA filled number.