OKLAHOMA HEALTH CARE AUTHORITY
AMENDED BOARD MEETING
September 30, 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_nGfEf7TAQ-a2Vecp63v7yA
Telephone: 1-669-216-1590 Webinar ID: 160 566 1770

*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 June 25, 2025, OHCA Board Meeting Minutes……..……..….Marc Nuttle, Chair

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

    a) Member Moment

4. State and Federal Update (Attachment "B")……Christina Foss, Chief of Staff and State Medicaid Director

5. Discussion of Report from the Pharmacy……..…….……Jeffrey Cruzan, MD
   Advisory Committee and Possible Action Regarding Chief Pharmacy Director
   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 317:30-5-77.2(e) (Attachment "C"):

Item:	Drug Name:	Used For:
i.	Avmapki™ Fakzynja™ Co-Pack (Avutometinib and Defactinib)	Ovarian Cancer
ii.	Bucapsol™ (Buspirone Capsule)	Anxiety Disorders
	Carbamazepine 200mg Chewable Tablet	Epilepsy
	Femlyv™ [Norethindrone Acetate/Ethinyl Estradiol Orally Disintegrating Tablet (ODT)]	Contraception
	Focinvez™ (Fosaprepitant Injection)	Nausea and Vomiting
	Imkeldi (Imatinib Oral Solution)	Multiple types of cancer
	IVRA (Melphalan 90mg/mL Injection)	Multiple myeloma
	Myhibbin™ (Mycophenolate Mofetil Oral Suspension)	Organ Rejection (OR) prevention
	Ondansetron 16mg ODT	Nausea and Vomiting
	Tezruly™ (Terazosin Oral Solution)	Benign prostatic hyperplasia (BPH) or Hypertension (HTN)

	Topiramate 50mg Sprinkle Capsule	Epilepsy or Migraine
	Veltassa® (Patiromer) 1g Powder Packet	Hyperkalemia
	Vigafyde™ (Vigabatrin Oral Solution)	Infantile spasms

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 "D")

      i. EGID Third Party Administrator for HealthChoice Plans Contract Renewal
      ii. EGID Pharmacy Benefit Manager Contract Renewal
      iii. OHCA Non-Emergency Medical Transportation Contract

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

      i. Birthing Center Rates
      ii. Functional Family Therapy Service
      iii. Paid Family Caregiver

7. Discussion of Report of the Administrative Rules Advisory Committee and Possible Action (Attachment "F")……..……..……Alex Yaffe Member, Administrative Rules Advisory Committee

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

      i. APA WF # 25-12 Clinic Services Update (Four Walls)
      ii. APA WF # 25-15 340B Program Revisions
      iii. APA WF # 25-16 Provider Attestation Revisions
      iv. APA WF # 25-08 Birthing Centers and Licensed Midwives
      v. APA WF # 25-01 Functional Family Therapy
      vi. APA WF # 25-09 FQHC and RHC Policy Revisions
      vii. APA WF # 25-14 Paid Family Caregiver

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

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

NEXT BOARD MEETING
December 10, 2025, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

MINUTES OF REGULAR BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
June 25, 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 June 25, 2025, at 8:35 a.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 June 24, 2025, at 2:00 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 2:01 p.m.

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

BOARD MEMBER ABSENT: Member Christ

ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON THE MARCH 26, 2025, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Member Jolley moved for approval of the May 21, 2025, board meeting minutes, as published. The motion was seconded by Member Kennedy.

FOR THE MOTION: Chairman Nuttle, Member Case, Member Corbett, Member Cruzan, Member Kennedy, Member Jolley, Member Leland

BOARD MEMBER ABSTAIN: Vice-Chairman Yaffe

BOARD MEMBER ABSENT: Member Christ

ITEM 3 / CHIEF EXECUTIVE OFFICER REPORT
Ellen Buettner, Chief Executive Officer

CEO Buettner invited Tanesha Hooks, Director of Behavioral Health, to present this month's member moment.

CEO Buettner highlighted OHCA's Best in Class & Outcome Driven Key Principle, recognizing OHCA's Legal team, Administrative Law Judges, Medical, Population Care Management, and Elizabeth Cooper, for their work on the PDN backlog. In November 2023, OHCA had 220 appeals that were over 90 days past due. In September 2024, the teams were able to get the backlog down to 134 appeals; and as of today, the teams were able to meet the goal of zero past due PDN appeals.

Key Initiative – Programs:

- SoonerSelect Update: CEO Buettner highlighted the work that Stephanie Mavredes did while stepping in and overseeing the operational aspects of the program. She also highlighted Josh Richards, Jimmy Witcosky, and their teams for the work they have done in preparing the rates and the pre-prints which is OHCA's avenue to get CMS approval for all of the supplemental and enhanced payments. OHCA has received new requests for enhanced or supplemental payments, including for Trauma 1 through St. Francis and OSUMA modifications to the IME State Plan through OU and OSU to get their physicians more enhanced funding towards those programs.
- Federal Updates: CEO Buettner stated that OHCA is monitoring the development of the Reconciliation Bill at the Federal level.
- Food as Medicine: SB 806 directed OHCA to provide nutritional services under its Medicaid program for the purpose of implementing food as medicine. CEO Buettner stated that even though OHCA has a baseline of already providing certain nutritional counseling and support services through its Diabetes Management Program, this bill gives OHCA an avenue to expand that. OHCA is working with OHS and OSDH to collaborate on healthy foods programming, looking at program duplication, and where the agencies can have some synergy. OHCA is exploring In Lieu of Services on the SoonerSelect side, which would not require a State Plan Amendment, but would still need to be submitted to CMS through OHCA's rates and through its contracting process. OHCA has also partnered with FreshRx to apply for a TSET grant to fund a pilot program to measure outcomes around a new Food is Medicine program.
- School Based Services: OHCA is beginning its year two grant with a full implementation of this program, targeted for March 1, 2026, and integrating into SoonerSelect in July 2026. CEO Buettner stated that new grant activities

have been introduced to the school districts who will assist in conducting the regional trainings. OHCA has also partnered with Secretary Nellie Sanders, who is the Secretary of Education for Oklahoma, and the Oklahoma State School Board Association to assist in making the connection with the school districts, teachers, and administrators.

- Budget and Legislation: CEO Buettner highlighted Bradley Downs for his hard work this legislative session. As for budget, OHCA received an appropriation of $1.41 billion, representing a total budget of about $12.5 billion for FY26. OHCA's state appropriation received was about $26 million less than what was originally requested, so about 2% which correlates with the shift in FMAP. CEO Buettner stated that OHCA's Legal and Audit teams have been working through any process modifications needed as a result of HB 2797, which modified OHCA's audit methodology specifically as it related to extrapolation, as well as nullifying previous audits and recoveries that used this methodology. She added that this was discussed at length in the Board's Compliance Committee and that OHCA will keep the board informed on how OHCA will still ensure accountability and compliance with state and federal law, while giving providers the educational support they need to come into compliance.

Key Initiatives – Administrative:

- Employee Relations: CEO Buettner highlighted Jennifer Lamb-Hornsby and Katie Cummings who led OHCA in its recent calibration efforts, which is a time that the staff come together to jointly review employee ratings to ensure that the criteria against which they are being measured are consistently applied across the agency. She added that the end of year turnover data has OHCA's turnover at 8.35%, which is remarkable.
- Contract Performance Review: CEO Buettner highlighted Tasha Black, Sheryl Gibson, Leah Price and others from OHCA's legal and Contracts teams for leading the contracts performance review. Teams from across the agency were brought together to review the contracts, talk about the associated expenditure, and confirm that OHCA is receiving what it needs from the contracts. As a result of the review, the teams were able to reduce contract spending for FY26 by about 7%.
- Traction and Goal Setting: OHCA is beginning its annual goal setting process and focusing on revamping OHCA's 5-year Strategic Plan. There was great discussion in the Board's Strategic Planning and Operational Committee meeting about specific projects such as Food is Medicine, Maternal Health Initiatives, and PCMH Redesign, but also approaching this with a long-term lens and considering what we want to do as a state to address things like Rural Healthcare.
- Shared Medicaid Spend: At the previous Compliance Committee meeting, OHCA and the committee members reviewed the spend that other state agencies pay the state for in the Medicaid program. There was a lot of discussion around the Department of Mental Health because of the conversations happening at the legislature. From a historical perspective, OHCA has not seen payment lags or any sort of issues. OHCA is taking a deeper dive into making potential recommendations to policymakers about what makes sense from a policy perspective about where each state share should live from a programmatic standpoint. OHCA will also consider the compliance risks that are still there. There was also discussion about OHCA doing upfront billing of other state agencies to try to manage the payment lags in the interim until the legislature acts on the actual dollars.

Stakeholder Engagement:

- Oklahoma Osteopathic Association and Independent Physicians Association: OHCA has been working with both associations on provider relations and provider education efforts, with a heightened focus around provider terminations and the audit bill. CEO Buettner highlighted Dr. Roger Thompson, who leads the OOA, and Dr. Kevin Khoury, who leads the Independent Practitioners, for assisting in making connections and translations.
- National Academy of State Health Policy – Health and Human Services Leadership Convening Meeting: CEO Buettner had the opportunity to join other state HHS leaders in D.C. and met with the new head of CMS and one of Dr. Oz's Senior Advisors to discuss the things Oklahoma is doing. A team of state leads spent an hour with Administrator Oz to hear his vision for the administration's priorities. The biggest topics of conversation surrounded the MAHA agenda, addressing chronic conditions, community engagements, and work requirements

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

ITEM 4 / STATE AND FEDERAL UPDATE

Christina Foss, Chief of Staff

Ms. Foss provided an update on School-Based Services, Food is Medicine, Budget Reconciliation Process, and Senate Changes.

For more detailed information, Attachment "B", which has been uploaded to the OHCA Board Page.

ITEM 5 / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE

Dr. Jeff Cruzan, Pharmacy Committee Member

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

Item:	Drug Name:	Used For:
i.	Alhemo® (Concizumab-mtci) Beqvez™ (Fidanacogene Elaparvovec-dzkt) Hympavzi™ (Marstacimab-hncg) Qfitlia™ (Fitusiran)	Hemophilia
ii.	Agamree® (Vamorolone) Duvyzat™ (Givinostat))	Duchenne Muscular Dystrophy (DMD)
iii.	Ocrevus Zunovo™ (Ocrelizumab/ Hyaluronidase-ocsq)	Multiple Sclerosis (MS)
iv.	Xolremdi® (Mavorixafor)	WHIM Syndrome
v.	Journavx™ (Suzetrigine)	Moderate to Severe Pain
vi.	Adzynma (ADAMTS13, Recombinant-krhn) Alvaiz® (Eltrombopag)	Congenital Thrombotic Thrombocytopenic Purpura (cTTP) Thrombocytopenia (TP)

MOTION: Member Jolley moved for approval of item 5ai-vi as published. The motion was seconded by Member Case.

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

BOARD MEMBER ABSENT: Member Christ

For more detailed information, see Attachment "C" of the board packet.

ITEM 6 / 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, Internal Audit, Expenditure of Authority Contracts, and the State Plan Amendment Rate Committee Rate.

OHCA Financials: For the period ending May 31st, 2025, the OHCA's expenditures were 0.9% under budget while revenues were 0.8% under budget. This gives the agency a positive budget variance of $7 million. We continue to focus on timely collection of receivables while monitoring our cash flow.

Internal Audit: The Internal Audit division reported that the Single Audit Corrective Action Plans have been fully implemented for all findings. The Department of Human Services attended the compliance committee meeting and gave details into the actions they have taken to address the outstanding Eligibility findings. Internal audit reported that OHCA Member Audits is performing post-CAP audits of the OHS corrective action plans to ensure they are operating effectively. Internal audit also presented its SFY 2026 Audit Plan for Compliance Advisory Committee approval, which was approved.

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 "D")

i. Consulting Services – Managed Care Actuary

ii. Consulting Services – Federal Compliance Consultant
iii. Technology Services for Health Information Exchange
iv. Technical Consultant for the MMIS Modernization and TMO Implementation, Year Two
v. Customer Management Data Analytics Software Subscriptions Services

MOTION: Member Christ moved to approve item 6a.i-v as published. The motion was seconded by Member Jolley.

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

BOARD MEMBER ABSENT: Vice-Chairman Yaffe

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

i. Regular Nursing Facilities Rate Increase
ii. Acquired Immune Deficiency Syndrome (AIDS) Rate for Nursing Facilities Rate Increase
iii. Regular Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Rate Increase
iv. Acute (16-bed-or-Less) Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) Rate Increase
v. Add-On Rate for Nursing Facilities Serving Acute Tracheostomy Residents
vi. Rate Increase for Partial Hospitalization Program
vii. Reimbursement Rate Increase for T1001 and T1017

For more detailed information, see Attached "E" of the board packet.

MOTION: Member Case moved to approve item 6b.i-v as published. The motion was seconded by Member Jolley.

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

BOARD MEMBER ABSENT: Member Christ

MOTION: Member Corbett moved to approve item 6b.vi-vii contingent upon advance payment from the associated agency. The motion was seconded by Member Jolley.

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

BOARD MEMBER ABSENT: Member Christ

c) Presentation, Discussion, and Possible Action of the SFY 2026 Budget Work Program pursuant to 63 O.S. Section 5008 (B)(3) by Josh Richards, Chief Financial Officer (Attachment "F")

Mr. Richards presented the SFY 2026 Budget Work Program which included information on Appropriations and Budget, Medical Program Growth, Medical Program State and Federal Mandates, Program Assumptions, OHCA Administration, Other State Agency Programs, Revenues, Appropriation and Revenue Summaries, Budget Overview, and Key Takeaways.

For more detailed information, see Attachment "F" of the board packet.

MOTION: Member Jolley moved to approve item 6c as published. The motion was seconded by Member Case.

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

BOARD MEMBER ABSENT: Member Christ

For more detailed information of the contracts, see Attachment “F” of the board packet.

ITEM 7 / DISCUSSION OF REPORT OF THE STRATEGIC PLANNING & OPERATIONAL ADVISORY COMMITTEE
Marc Nuttle, OHCA Board Chairman

Chairman Nuttle stated an very brief overview of what the Strategic Planning and Operational Committee reviews and discusses, adding that the Committee spends about 90% of the meeting reviewing the operational metrics, essentially auditing the metrics to ensure OHCA’s programs are running efficiently. Chairman Nuttle stated that the Committee discussed the 5-year Strategic Plan in great detail, as well as the Federal budget and any other increases that the state may give.

ITEM 8 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

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

Meeting adjourned at 3:49 p.m., 6/25/2025.

NEXT BOARD MEETING
September 17, 2025
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

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Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings –July 9, 2025

Vote Item	Drug	Used for	Cost*	Notes
1	Avmapki™ Fakzynja™ Co-Pack (Avutometinib and Defactinib)	• **Ovarian Cancer (OC):** OC is a growth of cells which forms in the ovaries. *290 members with diagnosis*	• $630,501 per year *Budget impact estimate: $9,457,515 per year*	• Not first line[±]
2	Bucapsol™ (Buspirone Capsule)	• **Anxiety Disorders (AD):** ADs involve more than occasional worry or fear. For people with these disorders, anxiety does not go away, is felt in many situations, and can get worse over time. Examples of anxiety disorders include generalized anxiety disorder, social anxiety disorder (social phobia), specific phobias and separation anxiety disorder. *147,349 members with diagnosis*	• $35,798 per year *Budget impact estimate: none*	• Other cheaper therapies required first[¥]
	Carbamazepine 200mg Chewable Tablet	• **Epilepsy:** also known as a seizure disorder — is a brain condition that causes recurring seizures. There are many types of epilepsy. *17,141 members with diagnosis*	• $4.320 per year *Budget impact estimate: none*	• Other cheaper therapies required first[¥]
	Femlyv™ [Norethindrone Acetate/Ethinyl Estradiol Orally Disintegrating Tablet (ODT)]	• **Contraception:** the prevention of unintended pregnancies. *324,138 adult female members in May 2025*	• $2,562 per year *Budget impact estimate: none*	• Other cheaper therapies required first[¥]

	Focinvez™ (Fosaprepitant Injection)	• **Nausea and Vomiting (N/V):** • N/V associated w/ chemotherapy *131,543 member with N/V diagnosis*	• $430 per treatment Budget Impact estimate: *none*	• Other cheaper therapies required first[¥]

	Imkeldi (Imatinib Oral Solution)	• **Multiple types of cancer:**
		  • Philadelphia positive chronic myeloid leukemia; *92 members*
		  • Philadelphia positive acute lymphoblastic leukemia; *201 members*
		  • Myelodysplastic/myeloproliferative diseases; *168 members*
		  • Aggressive systemic mastocytosis; *0 members*
		  • Hypereosinophilic syndrome and/or chronic eosinophilic; *0 members*
		  • Dermatofibrosarcoma protuberans; *24 members*
		  • Kit+ gastrointestinal stromal tumors (GIST); *0 members*
			• $60,444 per year *Budget Impact estimate: none*	• Other cheaper therapies required first[¥]

	IVRA (Melphalan 90mg/mL Injection)	• **Multiple myeloma (MM**): MM is a cancer that forms in a type of white blood cell called a plasma cell where cancerous plasma cells build up in bone marrow. *236 members with diagnosis*	• $5,500 per dose *Budget Impact estimate: none*	• Other cheaper therapies required first[¥]
	Myhibbin™ (Mycophenolate Mofetil Oral Suspension)	• **Organ Rejection (OR) prevention:** OR occurs when transplanted tissue is rejected by the recipient's immune system, which destroys the transplanted tissue. *1,023 members with diagnosis*	• $23,544 per year *Budget Impact estimate: none*	• Other cheaper therapies required first[¥]

	Ondansetron 16mg ODT	• **Nausea and Vomiting (N/V):**
		  • N/V associated w/ chemotherapy
		  • N/V post-operatively
		  131,543 members with N/V diagnosis
			• $41 per dose
			Budget Impact estimate: none
				• Other cheaper therapies required first[¥]

	Tezruly™ (Terazosin Oral Solution)	• **Benign prostatic hyperplasia (BPH) or Hypertension (HTN): BPH** is also called an enlarged prostate. The prostate is a small gland that helps make semen. It's found just below the bladder, and it often gets bigger as you get older. *6,053 members with diagnosis* **HTN** is also called high blood pressure which is a common condition that affects the body's arteries. *93,584 members with diagnosis*	• $22,824 *Budget Impact estimate: none*	• Other cheaper therapies required first[¥]
	Topiramate 50mg Sprinkle Capsule	• **Epilepsy or Migraine:** A migraine is a headache that can cause intense throbbing pain or a pulsing feeling, usually on one side of the head. It often happens with nausea, vomiting, and extreme sensitivity to light and sound. Migraine attacks can last for hours to days, and the pain can be so bad that it interferes with your daily activities. *27,148 members with diagnosis*	• $12,614 per year *Budget Impact estimate: none*	• Other cheaper therapies required first[¥]
	Veltassa® (Patiromer) 1g Powder Packet	• **Hyperkalemia (HK):** HK is high potassium in the blood, often caused by kidney disease. Symptoms include muscle weakness and heart issues. *4,585 members with diagnosis*	• $12,787 per year *Budget Impact estimate: $25,574 per year*	• Other cheaper therapies required first[¥]

	Vigafyde™ (Vigabatrin Oral Solution)	• **Infantile spasms (IS):** IS is a kind of epilepsy. It usually begins in children who are less than one year old. Children with IS typically have clusters of short seizures. They often exhibit developmental problems. *65 members with diagnosis under age 3*	• $204,768 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 Avmapki™ Fakzynja™ Co-Pack

The Drug Utilization Review Board recommends the prior authorization of Avmapki™ Fakzynja™ Co-Pack (Avutometinib and Defactinib) with the following criteria:

Avmapki™ Fakzynja™ Co-Pack (Avutometinib and Defactinib) Approval Criteria [Ovarian Cancer Diagnosis]:

1. Diagnosis of low-grade serous ovarian cancer; and
2. Disease is recurrent; and
3. Member has KRAS-mutation; and
4. Member has received prior systemic therapy; and
5. Member is 18 years of age or older.

Recommendation 2: Vote to Prior Authorize Bucapsol™, Carbamazepine 200mg Chewable Tablet, Femlyv™, Focinvez™, Imkeldi, IVRA, Myhibbin™, Ondansetron 16mg ODT, Tezruly, Topiramate 50mg Sprinkle Capsule, Veltassa® 1g Powder Packet, and Vigafyde™

The Drug Utilization Review Board recommends the Bucapsol™ (Buspirone Capsule), Carbamazepine 200mg Chewable Tablet, Femlyv™ [Norethindrone Acetate/Ethinyl Estradiol Orally Disintegrating Tablet (ODT)], Focinvez™ (Fosaprepitant Injection), Imkeldi (Imatinib Oral Solution), IVRA (Melphalan 90mg/mL Injection), Myhibbin™ (Mycophenolate Mofetil Oral Suspension), Ondansetron 16mg ODT, Tezruly™ (Terazosin Oral Solution), Topiramate 50mg Sprinkle Capsule, Veltassa® (Patiromer) 1g Powder Packet, and Vigafyde™ (Vigabatrin Oral Solution) with the following criteria:

Bucapsol™ (Buspirone Capsule) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use buspirone tablets, even when the tablets are crushed, must be provided.

Carbamazepine 200mg Chewable Tablet Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use all other forms of carbamazepine that are available without a prior authorization, including using 2 of the 100mg chewable tablets to achieve the 200mg dose, must be provided; and
2. A quantity limit of 720 chewable tablets per 90 days will apply.

Pharmacy Agenda Items

Femlyv™ [Norethindrone Acetate/Ethinyl Estradiol Orally Disintegrating Tablet (ODT)] Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use all alternative formulations of hormonal contraceptives available without a prior authorization must be provided.

Focinvez™ (Fosaprepitant) Approval Criteria:

1. An FDA approved diagnosis; and
2. A recent trial of ondansetron (within the past 6 months) used for at least 3 days or 1 cycle that resulted in an inadequate response is required for authorization in members receiving moderately emetogenic chemotherapy; and
3. No ondansetron trial is required for authorization in members receiving highly emetogenic chemotherapy; and
4. A previously failed trial of IV fosaprepitant (Emend® IV) that resulted in an inadequate response or a patient-specific, clinically significant reason why IV fosaprepitant (Emend® IV) cannot be used must be provided; and
5. Approval length will be based on duration of need.

Imkeldi (Imatinib Oral Solution) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use imatinib tablets, which are available without a prior authorization, must be provided. Imatinib tablets may be dispersed in a glass of water or apple juice to form a suspension for members who cannot swallow the film-coated tablets.

IVRA (Melphalan 90mg/mL) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient specific, clinically significant reason why the member cannot use generic melphalan 50mg/10mL vial which is available without a prior authorization.

Myhibbin™ (Mycophenolate Mofetil Oral Suspension) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use generic Cellcept® (mycophenolate mofetil for oral suspension), which is available without a prior authorization, must be provided.

Ondansetron 16mg Orally Disintegrating Tablet (ODT) Approval Criteria:

1. An FDA approved indication for the prevention of postoperative nausea and vomiting (PONV); and

2. A patient-specific, clinically significant reason why the member cannot use 2 of the 8mg ODTs to achieve the 16mg dose must be provided.

Tezruly™ (Terazosin Oral Solution) Approval Criteria:

1. An FDA approved diagnosis of benign prostatic hyperplasia (BPH) or hypertension (HTN); and
2. A patient specific, clinically significant reason why the member cannot use terazosin capsules must be provided; and
3. For a diagnosis of BPH, a patient specific, clinically significant reason why the member cannot use Rapaflo® (silodosin), which may be opened and sprinkled on applesauce for patients with difficulties swallowing, must be provided; and
4. A quantity limit of 600mL per 30 days will apply.

Topiramate 50mg Sprinkle Capsule Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use other available generic topiramate products, including using 2 topiramate 25mg sprinkle capsules to achieve the 50mg dose, must be provided; and
3. Members 12 years of age and older will require a patient-specific, clinically significant reason why a special formulation product is needed; and
4. A quantity limit of 240 capsules per 30 days will apply.

Veltassa® (Patiromer) Approval Criteria:

1. An FDA approved diagnosis of hyperkalemia; and
2. Medications known to cause hyperkalemia [e.g., aldosterone antagonists, nonsteroidal anti-inflammatory drugs (NSAIDs)] have been discontinued or reduced to the lowest effective dose where clinically appropriate; and
3. A trial of a potassium-eliminating diuretic or documentation why a diuretic is not appropriate for the member; and
4. Documentation of a low potassium diet; and
5. For members 18 years of age and older, a patient-specific, clinically significant reason why the member cannot use Lokelma® (sodium zirconium cyclosilicate) must be provided; and
6. Quantity limits will apply as follows:
    a. 1g Packets: A quantity limit of 120 packets per 30 days will apply; or
    b. 8.4g, 16.8g, and 25.2g Packets: A quantity limit of 30 packets per month will apply.

Vigafyde™ (Vigabatrin Oral Solution) Approval Criteria:

Pharmacy Agenda Items

1. An FDA approved diagnosis of infantile spasms in children 1 month to 2 years of age; and
2. A patient-specific, clinically significant reason why the member cannot use brand name Sabril® (vigabatrin) for oral solution must be provided; and
3. Prescription must be written by, or in consultation with, a neurologist; and
4. Member, prescriber, and pharmacy must all register in the Vigabatrin REMS program and maintain enrollment throughout therapy.

SUBMITTED TO THE C.E.O. AND BOARD ON September 30, 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	Third Party Administrator for HealthChoice Plans – Contract Renewal
Purpose and Scope	EGID respectfully submits this request for formal consideration to renew the Third Party Administrator (TPA) contract for Plan Year 2026 for the self-funded HealthChoice plans administered by EGID, the Department of Rehabilitation Services (DRS), and the Department of Corrections (DOC) plans. The initial Contract was awarded for the period January 01, 2023, through December 31, 2023 (Plan Year 2023) with four (4) one-year options to renew for Plan Years 2024-27. **Summary of Services** • **Claims Administration:** Accurate and timely adjudication of health, dental, and life insurance claims. • **Customer Service:** High-quality support for members, providers, and stakeholders. • **Care & Utilization Management:** Comprehensive utilization review, certification, and case management services to improve outcomes, manage costs, and ensure appropriate access to care. • **Reporting and Analytics:** Delivery of performance metrics and actionable insights to support EGID's oversight and strategic planning. • **Professional Services:** Additional administrative functions necessary to ensure compliance, efficiency, and service continuity. **Interagency Service Provision** This contract is connected to existing interagency agreements. The current Supplier provides these services on behalf of the Department of Rehabilitation Services (DRS) and the Department of Corrections (DOC). This multi-agency arrangement promotes operational consistency and shared service efficiencies across agencies.
Mandate	N/A

Procurement Method	Request for Proposal
External Approvals	N/A
Contract Term	Contract effective date January 1, 2023, through December 31, 2023 with four (4) additional options to renew. Requesting Total-Not-Exceed Amount of $22,500,000.00 to renew the of the third (3rd) option year of the contract, Calendar Year 2026. As stated below, EGID is self-funded through premiums and operates on a calendar year budget.

BUDGET

Amount requested for approval	$22,500,000.00 CY26 Total
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	0% (Not applicable)

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 renewal of the Third Party Administrator described above for **the fourth of five years with a Contract renewal total not-to-exceed amount of $22,500,000.00 for CY26. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract.**

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 days for cause, either 30 or 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 $1,000,000.00 or more, the contract increase shall require additional Board approval.)

Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)
EGID Funding (The HealthChoice plans administered by EGID are self-funded, non-appropriated benefit plans with a budget derived from premiums collected. There is no federal funding or state-appropriated funding for EGID contracts utilizing the premium derived funds. Therefore, the contracts and budget for the contracts do not always follow the state fiscal year.)

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SUBMITTED TO THE C.E.O. AND BOARD ON September 30, 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	EGID Pharmacy Benefit Manager – Contract Renewal
Purpose and Scope	EGID seeks board approval to renew the contract services of a Pharmacy Benefit Management (PBM) firm. The PBM provides management services to maximize the value of the EGID HealthChoice pharmacy benefit for the stakeholders, the providers, and the plan. It directly supports EGID's strategic goals of cost containment, member health optimization, and operational transparency. The contract includes the following components: **Claims Processing:** Adjudicate pharmacy claims and accurately determine drug coverage, members copay, deductible, and coverage and include reviews such as drug utilization review. **Formulary Management:** Create and manage both commercial and Medicare Part D formularies, benefit design, networks, rebate management, clinical program management, and Medication Therapy Management programs. **Pharmacy Networks:** Contract with retail, mail-order, and specialty pharmacies to form networks for both commercial and Medicare Part D. Determine in-network pharmacies and set pass-through pricing reimbursement rates. **Clinical, Utilization Management (UM), & Specialty Programs:** Provide pharmacy programs to ensure medications are used appropriately and cost-effectively. Includes managing high-cost specialty drugs and optimizing treatment protocols. **Rebate Management:** Collect rebates from manufacturers and provide an annual reconciliation of the 100% pass-through of Manufacturer payments and pharmaceutical revenue and minimum guaranteed Manufacturer payments. **Information Technology & Reporting:** Systems and tools used to collect, analyze, and present pharmacy-related data—such as claims, usage patterns, and cost trends. These insights support informed decision-making and performance tracking. **Account Management & Customer Service:** Dedicated support teams and member/provider engagement strategies and support systems. **Regulatory & Contractual Compliance:** Ensuring adherence to state and federal regulations, contract terms, and audit.
Mandate	N/A

Procurement Method	Request for Proposal
External Approvals	N/A
Contract Term	Contract effective date January 1, 2025, through December 31, 2025, with three total options to renew. Requesting a Not-To-Exceed Amount of $5,800,000.00 to renew the first (1st) option year of the contract, January 1, 2026, through December 31, 2026. As stated below, EGID is self-funded through premiums and operates on a calendar year budget.

BUDGET

Amount requested for approval	$5,800,000 CY26 Total
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	0%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to procure the Pharmacy Benefit Manager described above for **the second year of four years with a total not-to-exceed for CY26 of $5,800,000.00. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract.**

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 days for cause, either 30 or 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 $1,000,000.00 or more, the contract

increase shall require additional Board approval.)
Federal Match Percentage(s) (CMS authorizes Federal Match based upon specific criteria, for example, a single Information Technology contract may qualify for 50% administrative match, 75% operational match, and 90% implementation match.)
EGID Funding (The HealthChoice plans administered by EGID are self-funded, non-appropriated benefit plans with a budget derived from premiums collected. There is no federal funding or state-appropriated funding for EGID contracts utilizing the premium derived funds. Therefore, the contracts and budget for the contracts do not always follow the state fiscal year.)

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SUBMITTED TO THE C.E.O. AND BOARD ON SEPTEMBER 30, 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	Non-Emergency Medical Transportation – Contract Award
Purpose and Scope	The Authority seeks to award a contract based on an existing Request for Proposals (RFP) to procure safe, reliable, and efficient transportation for SoonerCare Traditional members to medical appointments and other medically necessary services. This includes accommodations for members with physical and intellectual disabilities. Transportation methods may include van service, stretcher service, taxi, volunteer drivers, public bus, and mileage reimbursement. The contractor must provide transportation to all areas of the State, including remote and underserved regions. Associated meals and lodging services are included for qualifying trips. The contractor will manage a member-friendly and accessible reservation system, which may include telephone, app, and web-based platforms.
Mandate	N/A
Procurement Method	Request for Proposal
External Approvals	n/a
Contract Term	Initial Term: Upon Signature through June 30, 2026. Optional renewals: Up to five (1) year extensions, with the final option ending June 30, 2031. The first year is expected to have a not-to-exceed of $7,540,828.00 while subsequent renewals are estimated at $46,000,000.00 with a potential growth ratio of 5.8%.

BUDGET

Amount requested for Approval	$ 7,540,828.00 SFY26 Total
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Cost Allocation Plan 68.49% $5,164,713.10 Federal Share Total $2,376,114.90 State Share Total

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 for the **total not to exceed the contract of $7,540,828.00 for the initial year** of the contract to procure Non-Emergency Medical Transportation Services. **OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract up to five renewal years for a total of six contract years if subsequently approved by the Board.**

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, either 30 or 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.)
EGID Funding (The HealthChoice plans administered by EGID are self-funded, non-appropriated benefit plans with a budget derived from premiums collected. There is no federal funding or state-appropriated funding for EGID contracts utilizing the premium derived funds. Therefore, the contracts and budget for the contracts do not always follow the state fiscal year.)

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

BIRTHING CENTER RATES

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   Senate Bill 1739 (2024) removed the state license requirement for birthing centers and directed OHCA to cover services provided by freestanding birthing centers, certified nurse midwives, and licensed midwives. The proposed changes allow for coverage of Birthing Center and Licensed Midwives' services for normal, uncomplicated, low-risk births.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   For Physicians providing services for HCPCS Procedure Codes 59400, 59410, 59425, 59426, and 59430 we have established pricing.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed rates for services provided by a Licensed Midwife are 80% of the physician pricing:
   59400: $1,650.73
   59410: $741.26
   59425: $382.72
   59426: $700.57
   59430: $177.42

   The proposed rates to pay the Birthing Center facility fee at 50% of the APC pricing for HCPCS Procedure Code 59409:
   S4005: $1,415.71

6. **BUDGET ESTIMATE.**
   This change will be budget neutral.

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The proposed changes allow for coverage of Birthing Center and Licensed Midwives' services for normal, uncomplicated, low-risk births which will have a positive impact and increase access to care.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate committee to approve the proposed rates for services provided by a Licensed Midwife are 80% of the physician pricing:
59400: $1,650.73
59410: $741.26
59425: $382.72
59426: $700.57
59430: $177.42

The proposed rates to pay the Birthing Center facility fee at 50% of the APC pricing for HCPCS Procedure Code 59409:
S4005: $1,415.71

9. EFFECTIVE DATE OF CHANGE.

November 1, 2025 upon approval by CMS.

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

FUNCTIONAL FAMILY THERAPY SERVICES (FFT)

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   Oklahoma Juvenile Affairs (OJA) and Oklahoma Human Services (OHS) is seeking to add reimbursement rates for the functional family therapy services (FFT). FFT is an empirically grounded, well-documented and highly successful family intervention program for youth at risk or presenting with emotional and behavioral difficulties. The establishment of a reimbursement rate for FFT will ensure families across Oklahoma can participate in this intervention and experience the benefits.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**

   The current rate structure for the services provided in the proposed rate change is a fixed and uniform rate established through the State Plan Amendment Rate Committee process.

State Plan Service	Code	Unit Type	Current Rate
There is no fee structure currently for FFT services.	N/A	N/A	N/A

State Plan Service	Code	Unit Type	Current Rate
There is no fee structure currently for FFT services.	N/A	N/A	N/A

OKLAHOMA Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

5. NEW METHODOLOGY OR RATE STRUCTURE.

The new rate structure for the services provided in the proposed rate change is a fixed and uniform rate established through the State Plan Amendment Rate Committee process.

State Plan Service	Code	Unit Type	Current Rate
Functional Family Therapy for Phase 1 and 2 Agencies	H0036	per 15 min.	$49.31

State Plan Service	Code	Unit Type	Current Rate
Functional Family Therapy for Phase 3 Agencies	H0036	per 15 min.	$56.35

6. BUDGET ESTIMATE.

The estimated yearly budget impact for SFY2026 will be an increase in the total amount of $1,611,319.91 with $540,275.57 of state share and $1,071,044.34 of federal share. SFY2027 will be an increase in the total amount of $3,222,639.82 with $1,080,551.13 of state share and $2,142,088.69 of federal share.

(In SFY2026 Oklahoma Juvenile Affairs will pay $502,950.00 of the state share and Oklahoma Human Services will pay $37,325.57 of state share. In SFY 2027 OJA will pay $1,005,900.00 of state share and OHS will pay $74,651.13 of state share.)

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

7. AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.

The methodology change and rate changes will have a positive impact on care as providers are able to provide FFT services and meet increased labor costs. This FFT service is an intensive intervention that could reduce admissions to higher levels of care or further state involvement.

OKLAHOMA Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

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

OJA and OHS (OKDHS) requests the State Plan Amendment Rate Committee approve the proposed method change and rate increase to allow Functional Family Therapy for Phase 1 and 2 Agencies at $49.31 per 15 minutes and Functional Family Therapy for Phase 3 Agencies at $56.35 per 15 minutes.

9. EFFECTIVE DATE OF CHANGE.

January 1, 2026, upon approval by CMS

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OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

PAID FAMILY CAREGIVER RATE

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The Oklahoma Health Care Authority (OHCA) is seeking to implement a new reimbursement rate for the Paid Family Caregiver (PFC) program as authorized by Senate Bill 56 and codified at 63 O.S. § 5013.2. This new program is designed for children approved for Private Duty Nursing (PDN) who require care beyond personal care services, but which can be safely provided by a trained family caregiver in lieu of the nurse.

   This is necessary as there are some rural families who do not have stable staffing. Parents are then required to make difficult choices of losing their job and possibly home; to ensure that their child receives necessary care. Or in some instances, in single family homes, turning the child into the custody of State of Oklahoma.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   There is currently no rate associated with HCPCS Procedure Code T1004. Paid Family Caregiver (PFC) hours authorized by OHCA and/or SoonerSelect may total up to forty (40) hours per week and are authorized concurrently with, not in addition too, any Private Duty Nursing (PDN) hours authorized by OHCA and/or SoonerSelect.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed rate for HCPCS Procedure Code T1004 is $6.58 per 15-minute unit.

6. **BUDGET ESTIMATE.**
   This change will be budget neutral.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   This will have a positive impact on access to care by allowing personal care services to provide services to other members. Children aged 0-20 who qualify for PDN services may receive up to forty (40) hours per week of PFC services.

In accordance with Oklahoma Nursing Practice Act, § 567.3a, complex care giver may provide care to qualifying members under the direction and supervision of a Registered Nurse or Licensed Practical Nurse, through a home care agency. To be an eligible provider a home health agency must meet the requirements of Oklahoma Administrative Code (OAC) 317:30-5-545, and it must be licensed by the Oklahoma State Health Department (OSDH) as a home care agency.

The complex caregiver must meet the following requirements - be at least 18 years of age; pass criminal and abuse registry background checks.

The complex caregiver, within the agency, must receive eighty (80) hours of training, competency evaluation, and other qualification criteria as a complex caregiver, including but not limited to: Agency New Employee Orientation; Communicating with the Care Team; Documentation; Safety Care; Medications; Respiratory Care; Neurological care; Nutrition; Genitourinary care; Integumentary care; and Social Determinants of Health.
This training was a collaborative effort between OUMC NICU Intensivists, The Children's Center at Bethany, all five Private Duty Nursing Providers, and OHCA.

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

OHCA requests the State Plan Rate Committee approve the proposed rate change for HCPCS Procedure Code T1004 is $6.58 per 15-minute unit.

9. EFFECTIVE DATE OF CHANGE.

March 1, 2026 upon approval by CMS.

September 17, 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 considered by the Medical Advisory Committee on September 4, 2025.

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

The Agency is requesting the effective date to be immediately upon receiving gubernatorial approval for the following items:

APA WF# 25-12 Clinic Services Update (Four Walls) —Effective January 1, 2025, OHCA will implement the mandatory “four walls” exception for clinic services provided by Indian Health Services (IHS) clinics and Tribal clinics, as required by the 2024 Outpatient Prospective Payment System final rule. Services furnished by an IHS or Tribal clinic, outside the “four walls” of the clinic, have been covered as Clinic Services under 42 CFR 440.90 under a temporary exemption. The 2024 OPPS Final Rule made this exemption permanent. This emergency revision removes a provision requiring ITU facilities to be designated as FQHCs to bill for off-site services.

Budget Impact: Budget neutral.

Emergency Justification: The proposed emergency revisions are necessary to comply with changes to 42 CFR 440.90 contained in the CY 2025 Outpatient Prospective Payment System (OPPS) Rule.

APA WF# 25-15 340B Program Revisions — The proposed rule revisions are necessary for compliance with the CMS Cell and Gene Therapy Access Model, currently scheduled to take effect 1/1/2026, and to prevent financial impact resulting from potential loss of rebates. The rule seeks to remove certain high-cost drugs and therapies from the 340B Drug Pricing Program. The 340B program is a federal initiative that allows health care organizations to purchase certain drugs directly from pharmaceutical manufacturers at a discount. The revision creates a 340B Carve Out Drug list, consisting of cell and gene therapies, drugs currently under a value-based agreement, or Brand Preferred Drugs where the cost to the Medicaid program is $500,000 or higher, annually. Drugs on this list would be prohibited from being dispensed or administered to Oklahoma Medicaid Members if purchased at 340B prices.

Budget Impact: Budget neutral, with potential for future cost savings.

Emergency Justification: The proposed emergency rule revision is necessary to comply with deadlines in amendments to an agency’s governing law or federal programs

APA WF# 25-16 Provider Attestation Revisions — The proposed policy changes implement Executive Order 2025-16 (issued July 31, 2025), which directs OHCA to update provider contracting requirements. All SoonerCare providers will be required to submit a signed attestation disclosing whether they or any related entities engage in abortion-related activities, including referral or affiliation. The revisions also specify that OHCA may terminate or decline to renew provider contracts for failure to align with Oklahoma’s public policy objectives or for non-compliance with the Executive Order.

Budget Impact: Budget neutral

Emergency Justification: The proposed emergency revisions are necessary to comply with Executive Order 2025-16, issued pursuant to 75 O.S. § 250.10, requiring OHCA to immediately review and amend provider standards in alignment with state law and policy.

The Agency is requesting an effective date of November 1, 2025, or upon gubernatorial approval for the following item:

APA WF# 25-08 Birthing Centers and Licensed Midwives — The proposed policy changes establish coverage and reimbursement methodologies for birthing centers and licensed midwives. Senate Bill 1739 (2024) ended state licensing of birthing centers and directed OHCA to cover services provided by freestanding birthing centers, certified nurse midwives, and licensed midwives. The proposed changes allow for coverage of birthing center and licensed midwives' services for normal, uncomplicated, low-risk births. Birthing centers must be accredited by the Commission for the Accreditation of Birth Centers (CABC). Licensed midwives must be Certified Midwives or Certified Professional Midwives licensed by the Oklahoma State Department of Health (OSDH) to provide midwifery services. Birthing centers will be reimbursed a facility fee based on the Ambulatory Payment Classification (APC) fee schedule. Licensed midwives will be reimbursed 80% of the physician fee schedule rate for services within their statutory scope of practice. Laboratory and imaging services ordered by licensed midwives will be reimbursed 100% of the physician fee schedule rate. Revisions are also necessary to allow licensed midwives to provide referrals for doula services.

Budget Impact: Budget neutral due to shift in billing provider type

Emergency Justification: The proposed emergency rule revisions are necessary to comply with state law (SB1739 (2024)).

The Agency is requesting an effective date of January 1, 2026, or upon gubernatorial approval for the following items:

APA WF# 25-01 Functional Family Therapy — OHCA, in collaboration with Oklahoma Juvenile Affairs (OJA) and Oklahoma Human Services (OHS), seeks to add coverage for Functional Family Therapy (FFT). FFT is a short-term, evidence-based therapeutic intervention designed to improve family functioning and address behavioral issues in adolescents who are at risk of or engaged in delinquent behavior, substance abuse, or other challenges. The therapy is rooted in a systemic approach, focusing on the relationships within the family rather than treating the individual in isolation. The proposed policy defines eligible populations, eligible providers, referral requirements, service limitations and exclusions.

Budget Impact: The estimated total cost for SFY2026 is $1,611,319.91 with $540,275.57 in state share and SFY2027 is $3,222,639 with $1,080,551 in state share.

Emergency Justification: The proposed emergency rule revisions are necessary to protect public health safety or welfare.

APA WF# 25-09 FQHC and RHC Policy Revisions — The proposed policy changes update the definition of Rural Health Center (RHC) and Federally Qualified Health Center (FQHC) core services. The Consolidated Appropriations Act, 2023 (P.L. 117-328) added Marriage and Family

Therapist (MFT) services and Mental Health Counselor (MHC) services to the definition of RHC/FQHC core services. Those services will be added to the list of RHC/FQHC core services in OHCA policy. The following provider types meet the definition of an MHC: Licensed Professional Counselor (LPC), Licensed Behavioral Health Provider (LBHP), and providers with a Licensed Drug and Alcohol Counselor/Mental Health (LADC-MH) credential. The policy changes also include clarification that certain medical services provided by an optometrist or podiatrist in an RHC or FQHC can be reimbursed the encounter rate.

Budget Impact: TBD

Emergency Justification: The proposed emergency rule revisions are necessary to comply with federal law (P.L. 117-328)

The Agency is requesting an effective date of March 1, 2026, or upon gubernatorial approval for the following items:

APA WF# 25-14 Paid Family Caregiver — In accordance with Senate Bill 56 (2025 Regular Session) and Section 5013.2 of Title 63 of the Oklahoma Statutes, OHCA is proposing emergency policy revisions to implement the Paid Family Caregiver (PFC) program. This new program is intended for children approved for Private Duty Nursing (PDN) who require care beyond personal care services, but which can be safely provided by a trained family caregiver. The caregiver must meet OHCA-established criteria and be employed and trained by a PDN agency. Additional revisions clarify and streamline the prior authorization process for both PDN and PFC services and require service documentation at treatment plan recertification.

Budget Impact: Budget neutral

Emergency Justification: The proposed rule revisions are necessary to comply with state law (SB56 (2025)).

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

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

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

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

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 7. PHARMACIES

317:30-5-87. 340B Drug Discount Program

(a) The 340B Drug Discount Program is a drug-pricing program established under section 256b of Title 42 of the United States Code (U.S.C) under which a manufacturer of covered outpatient drugs agrees that it will not charge a 340B covered entity more than the 340B price for a 340B covered outpatient drug.

(b) Covered entities participating in the 340B Drug Discount Program will adhere to the following provisions outlined in this Section and as defined in 42 U.S.C. §256b. Covered entities must:

(1) Notify the OHCA Pharmacy Department in writing within thirty (30) days of any changes in 340B Program participation, as well as any changes in name, address, National Provider Identification (NPI), SoonerCare Provider Number, etc.

(2) Maintain their status on the Health Resources & Services Administration (HRSA) Medicaid Exclusion File (MEF) and report any changes to the OHCA within thirty (30) days.

(3) Execute a contract addendum with the OHCA in addition to their provider contract.

(4) Drugs designated by OHCA as 340B Carve Out Drugs shall be prohibited from being dispensed or administered to Oklahoma Medicaid members if purchased at 340B prices. Drugs that may be designated by OHCA as 340B Carve Out Drugs are:

(A) Cell and gene therapies;

(B) Drugs currently under a value based agreement; or

(C) Brand Preferred Drugs where the cost to the Oklahoma Medicaid program is $500,000 or higher, annually.

(c) To prevent a duplicate discount, quarterly adjustments will be made to all pharmacy or medical claims for drugs submitted by covered entities when billed using the registered SoonerCare Provider Number on the MEF.

(1) All pharmacy claims submitted by covered entities shall be adjusted by the 340B ceiling price whether purchased through the 340B Program or otherwise.

(2) Medical claims submitted by covered entities with procedure code modifiers indicating the use of the 340B purchased drugs shall be adjusted by the 340B ceiling price. OHCA will adjust each claim by subtracting the 340B ceiling price from the amount reimbursed and multiplying the difference by the quantity submitted. OHCA will use the 340B ceiling price applicable to the quarter in which the claim is paid. Medical claims submitted by covered entities with a procedure code modifier indicating the use of non 340B purchased drugs will not be adjusted by the 340B ceiling price and will be submitted for federal rebates as required by CMS. Covered entities are required to use an appropriate procedure code modifier on all physician administered drug lines when submitting medical claims.

(3) If a 340B covered entity fails to pay quarterly adjustments invoiced by OHCA within forty-five (45) days of receipt, it may result in a debt to the State of Oklahoma subject to applicable interest pursuant to prompt payment methodology at OAC 260:10-3-3.

(4) The quarterly adjustments invoiced, including applicable interest, must be paid regardless of any disputes made by the covered entity. If a covered entity fails to pay OHCA the adjustments invoiced within forty-five (45) days of receipt, the adjustments invoiced and applicable interest will be deducted from the facility's payment.

(d) Contract pharmacies for covered entities may be permitted to bill drug products purchased under the 340B Drug Discount Program to the Oklahoma Medicaid Program when certain conditions are met and an agreement is in place between the OHCA, the contract pharmacy, and the covered entity. These pharmacies will be subject to the recovery process stated in this Section.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-2. Provider agreements

(a) In order to be eligible for payment, providers must have ~~on file with OHCA,~~ an approved Provider Agreement on file with OHCA. Through this agreement, the provider certifies all information submitted on claims is accurate and complete, assures that the State Agency's requirements are met and assures compliance with all applicable Federal and State regulations. These agreements are renewed at least every five (5) ~~5~~ years with each provider.

(b) As a condition of the Provider Agreement, each provider further assures:

(1) **Lobbying restrictions.** ~~The provider further assures~~ ~~compliance~~Compliance with Section 1352, Title 31 of the U.S. Code and implemented at 45 CFR Part 93 which provides that if payments pursuant to services provided under Medicaid are expected to exceed $100,000.00, the provider certifies federal funds have not been used nor will they be used to influence the making or continuation of the agreement to provide services under Medicaid. Upon request, the Authority will furnish a standard form to the provider for the purpose of reporting any non-federal funds used for influencing agreements.

(2) **Debarment status.** That ~~The provider assures~~ in accordance with 31 USC 6101 and Executive Order 12549, the provider is not presently and has not within the last three (3) years been ~~that they are not presently or have not in the last three years been~~ debarred, suspended, proposed for debarment or declared ineligible by any ~~Federal~~federal department or agency.

(3) **Contact Information.** For information regarding Provider Agreements or for problems related to a current agreement, contact the Oklahoma Health Care Authority, Provider Enrollment, P.O. Box 54015, Oklahoma City, Oklahoma 73154, or call 1-800-522-0114 option 5 toll free or 405-522-6205 for the Oklahoma City area, or via e-mail: providerenrollment@okhca.org.

(c) As a condition of participation in the SoonerCare program, providers must also:

(1) Submit a signed attestation disclosing whether they or any related entities engage in abortion-related activities, including whether they:

(A) Perform, refer for, or are affiliated with the performance of abortions not permitted under state law; or

(B) Are under common ownership or control with an entity engaged in abortion-related activities inconsistent with state law.

(2) Acknowledge that failure to comply with these requirements may result in denial, exclusion, non-renewal, or termination from the SoonerCare program.

(3) Cooperate with OHCA credentialing and contracting procedures established to implement Executive Order 2025-16 and Oklahoma's public policy objectives related to unborn life.

317:30-3-19.3. Denial of application for new or renewed provider enrollment contract

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

(1) "**Affiliates**" means persons having a relationship in which any of them directly or indirectly controls or has the ability to control one or more of the others.

(2) "**Applicant**" means providers and/or persons with a five percent or more direct or indirect ownership interest therein, as well as providers' officers, directors, and managing employees.

(3) "**Conviction**" or "**convicted**" means a person has been convicted of a criminal offense pursuant to 42 U.S.C. § 1320a-7(i), or, for civil offenses, has had a judgment of conviction entered against him or her by a Federal, State, or local court, regardless of whether an appeal from the judgment is pending.

(4) "**Person**" means any natural person, partnership, corporation, not-for-profit corporation, professional corporation, or other business entity.

(5) "**Provider**" means any person having or seeking to obtain a valid provider enrollment contract with the Oklahoma Health Care Authority (OHCA) for the purpose of providing services to eligible SoonerCare members and receiving reimbursement therefor.

(b) When deciding whether to approve an application for a new or renewed provider enrollment contract, OHCA may consider the following factors as they relate to the applicant and any of the applicant's affiliates, including, but not limited to:

(1) any false or misleading representation or omission of any material fact or information required or requested by OHCA as part of the application process;

(2) any failure to provide additional information to OHCA after receiving a written request for such additional information;

(3) any false or misleading representation or omission of any material fact in making application for any license, permit, certificate, or registration related to the applicant's profession or business in any State;

(4) any fine, termination, removal, suspension, revocation, denial, consented surrender, censure, sanction, involuntary invalidation of, or other disciplinary action taken against any license, permit, certificate, or registration related to the applicant's profession or business in any State;

(5) any previous or current involuntary surrender, removal, termination, suspension, ineligibility, exclusion, or otherwise involuntary disqualification from participation in Medicaid in any State, or from participation in any other governmental or private medical insurance program, including, but not limited to, Medicare and Workers' Compensation;

(6) any Medicaid or Medicare overpayment of which the applicant has been notified, as determined exclusively by OHCA that was received, but has not made reimbursement, unless such reimbursement is the subject of an OHCA reimbursement agreement that is not in default~~,~~;

(7) any previous failure to correct deficiencies in the applicant's business or professional operations after having received notice of the deficiencies from the OHCA or any State or Federal licensing or auditing authority;

(8) any previous violation of any State or Federal statute or regulation that relates to the applicant's current or past participation in Medicaid, Medicare, or any other governmental or private medical insurance program;

(9) any pending charge or prior conviction of any civil or criminal offense relating to the furnishing of, or billing for, medical care, services, or supplies, or which is considered theft,

fraud, or a crime involving moral turpitude;
(10) any pending charge or prior criminal conviction for any felony or misdemeanor offense that could reasonably affect patient care, including, but not limited to, those offenses listed in OAC 317:30-3-19.4;
(11) any denial of a new or renewed provider enrollment contract within the past two (2) years that was based on the applicant's or an affiliate's prior conduct;
(12) any submission of an application that conceals the involvement in the enrolling provider's operation of a person who would otherwise be ineligible to participate in Medicaid or Medicare;
(13) any business entity that is required to register with a State office or agency in order to conduct its operations therein, including, but not limited to, the Oklahoma Secretary of State, any failure to obtain and/or maintain a registration status that is valid, active, and/or in good standing; ~~and~~
~~(14) any other factor that impacts the quality or cost of medical care, services, or supplies that the applicant furnishes to SoonerCare members, or otherwise influences the fiscal soundness, effectiveness, or efficiency of the OHCA program.~~
(14) any provider, applicant, or affiliate that performs, refers for, or is otherwise affiliated with the performance of abortions not permitted under state law;
(15) any provider, applicant, or affiliate that is under common ownership or control with an entity engaged in abortion-related activities inconsistent with state law;
(16) any failure to provide a signed attestation disclosing whether the provider or any related entity engages in abortion-related activities, as required by Executive Order 2025-16; and
(17) any other factor that impacts the quality or cost of medical care, services, or supplies that the applicant furnishes to SoonerCare members, or otherwise influences the fiscal soundness, effectiveness, or efficiency of the OHCA program.

(c) OHCA shall provide any applicant who is denied a new or renewed provider enrollment contract a written notice of the denial. Any denial shall become effective on the date it is sent to the applicant.
(d) Any OHCA decision to deny a provider's contract application in accordance with this Section shall be a final agency decision that is not administratively appealable.

317:30-3-19.5. Termination of provider agreements

Pursuant to the terms of the Oklahoma Health Care Authority's (OHCA) Standard Provider Agreement, both OHCA and a provider may terminate the agreement without cause on sixty (60) days' notice, or for-cause on thirty (30) days' notice. In addition, OHCA can terminate the agreement immediately in order to protect the health and safety of members, or upon evidence of fraud (including, but not limited to, a credible allegation of fraud as defined by 42 C.F.R. ' 455.2). Conduct that may serve as a basis for a for-cause termination of a provider includes, but is not limited to, any of the following:

(1) **Noncompliance.** The provider is determined not to be in compliance with the enrollment requirements described in Oklahoma Administrative Code (OAC) 317:30-3-2 and 317:30-3-19.3, or in the enrollment application applicable for its provider type. OHCA may, but is not required to, request additional documentation from the provider to determine compliance.
(2) **Provider exclusion, debarment, or suspension.** The provider or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel thereof is:

(A) Excluded from the Medicare, Medicaid, or any other Federal health care program, as defined in 42 C.F.R ' 1001.2; or

(B) Debarred, suspended, or otherwise excluded from participating in any other Federal procurement or nonprocurement program or activity.

(3) **Convictions.** Conviction of the provider or any of its affiliates for a Federal or State offense that OHCA has determined to be detrimental to the best interests of the program and its members. Such offenses may include, but are not limited to, those offenses enumerated in OAC 317:30-3-19.3 and OAC 317:30-3-19.4.

(4) **False or misleading information.** The provider submitted or caused to be submitted misleading or false information on its enrollment application to be enrolled or to maintain enrollment in the SoonerCare program. In addition to termination of a contract, offenders may be referred for prosecution, which could result in fines or imprisonment, or both, in accordance with current law and regulations.

(5) **On-site review.** OHCA determines, upon on-site review, that the provider is no longer operational, able to furnish SoonerCare covered items, or able to safely and adequately render services; or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for SoonerCare members.

(6) **Misuse of billing number.** The provider knowingly sells to or allows another individual or entity to use its billing number. This does not include those providers who enter into a valid reassignment of benefits as specified in 42 U.S.C. ' 1396a(a)(32) or a change of ownership as outlined in 42 C.F.R. ' 455.104(c) (within thirty-five (35) days of a change in ownership).

(7) **Abuse of billing privileges.** The provider submits a claim or claims for services that reasonably could not have been rendered, or that do not accurately reflect those services actually rendered, to a specific individual on the date of service. These instances include, but are not limited to: upcoding; unbundling of services; services that are purportedly provided to a member who has died prior to the date of service; services that are purportedly provided on a date on which the directing physician or member is not in the State or country or is otherwise physically incapable of providing or receiving the service; or the equipment necessary for testing was not present where the testing is said to have occurred, or was incapable of operating correctly at the supposed time of testing.

(8) **Failure to report.** The provider did not comply with the reporting requirements specified in the SoonerCare Provider Agreement or any applicable State and/or Federal statutes or regulations, including without limitation, changes in the provider's licenses, certifications, and/or accreditations provided at the time of enrollment. Providers shall report and update a change in mailing address within fourteen (14) days of such change.

(9) **Failure to document or provide OHCA access to documentation.**

(A) The provider did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.

(B) OHCA may suspend all SoonerCare payments to a provider who refuses or fails to produce for inspection those financial and other records as are required by 42 C.F.R. ' 431.107 and the executed SoonerCare Provider Agreement, until such time as all requested records have been submitted to OHCA for review.

(10) **Adverse audit determinations.** The provider receives an adverse Program Integrity audit that demonstrates fraud, waste, abuse, and/or repeated failure or inability to comply with SoonerCare billing and provision of service requirements.

(11) In accordance with Executive Order 2025-16, OHCA may immediately terminate a provider agreement if the provider or any related entity is determined not to be fully aligned with Oklahoma's objectives related to the protection of unborn life. This includes, but is not limited to:

(1) The provider or any related entity performs, refers for, or is affiliated with the performance of abortions not permitted under state law;

(2) The provider is under common ownership or control with an entity engaged in abortion-related activities inconsistent with state law;

(3) The provider failed to submit a complete and truthful attestation disclosing its involvement in abortion-related activities as required under OAC 317:30-3-2;

(4) OHCA determines, in its sole discretion, that the provider is not fully aligned with the requirements of Executive Order 2025-16.

(5) OHCA determines that the provider is not fully aligned with the requirements of any applicable Executive Order requiring termination of provider agreement for non-compliance.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 19. CERTIFIED NURSE MIDWIVES

317:30-5-229. Reimbursement

In accordance with the Omnibus Budget Reconciliation Act of 1993, effective October 1, 1993, certified nurse midwife services include maternity services, as well as services outside the maternity cycle within the scope of their practice under state law.

~~(1) Medical verification of pregnancy is required. A written statement from the physician or certified nurse midwife verifying the applicant is pregnant and the expected date of delivery is acceptable. Pregnancy may also be verified by submission of a copy of a laboratory report indicating the individual is pregnant.~~

~~(2) Newborn charges billed on the mother's person code will be denied.~~

(~~3~~1) Providers must use ~~OKDHS Form FSS-NB-1 or the eNB1 application on the Secure Website to notify the county DHS office of the child's birth~~the NODOS/NB1 form (found on the OHCA website at https://oklahoma.gov/ohca/providers/forms.html) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the case number and the newborn's name and assigned person code. Newborn charges billed on the mother's person code will be denied.

(42) Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

PART 87. BIRTHING CENTERS

317:30-5-890. Eligible providers

Eligible providers are freestanding birthing centers that are not currently licensed as a hospital and meet the following requirements:

(1) Must be accredited by the Commission for the Accreditation of Birth Centers (CABC);

(2) Have a current contract with the Oklahoma Health Care Authority;

(3) Have a current written agreement with a board-certified Obstetrician-Gynecologist (OB-GYN) to provide coverage for consultation, collaboration, or referral services;

(4) Have a current SoonerCare-contracted clinical director who is a physician, certified nurse midwife (CNM), advanced practice registered nurse (APRN), or licensed midwife and is responsible for establishing patient protocols and other functions as defined in requirements for state licensure. This individual may, or may not, be the physician providing individual

patient coverage for consultation, collaborative, or referral service; and
(5) Have a written agreement with a referral hospital which is a Class II hospital. Class II hospital is defined as a facility with 24-hour availability of OB-GYN and capability of performing a C-section within 30 minutes of the decision to operate. The 30-minute timeframe is subject to each hospital's unique circumstance, logistical issues that include, but are not limited to, obtaining informed consent, transporting the patient, and any other potential problems that may arise.

317:30-5-890.1. Definitions

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

(1) "Birthing center" means a freestanding facility, place, or institution, which is maintained or established primarily for the purpose of providing services of a licensed midwife, certified nurse-midwife, or licensed medical doctor to assist or attend a woman in delivery and birth, and where a woman is scheduled in advance to give birth following a normal, uncomplicated, low-risk pregnancy.

(2) **"Certified Midwife"** means an individual with a non-nursing graduate degree, educated in midwifery, and certified by the American Midwifery Certification Board (AMCB) who is not a Nurse-Midwife.

(3) **"Certified Nurse Midwife"** means a person educated in the discipline of nursing and midwifery, certified by the American College of Nurse-Midwives (ACNM), and licensed by the state to engage in the practice of midwifery and as an Advanced Practice Registered Nurse (APRN).

(4) **"Certified Professional Midwife"** means an individual that graduated from an accredited midwifery program or apprenticeship and is certified by the North American Registry of Midwives (NARM).

(5) **"Licensed Midwife"** means a Certified Professional Midwife or Certified Midwife who is licensed by the state under 59 O.S. § 3040.6 to engage in the practice of midwifery.

(6) **"Low-risk"** means a normal, uncomplicated pregnancy with expectation of a normal, uncomplicated birth as defined by generally accepted criteria of maternal and fetal health.

(7) **"Newborn"** means an infant during the first 28 days following birth.

(8) **"Normal"** means, as applied to pregnancy, labor, delivery, the postpartum period, and the newborn period, circumstances under which a licensed provider has determined that the member does not have a condition that requires obstetrical intervention.

317:30-5-891. Coverage by category

(a) **Adults and children.** Birthing center services for adults are covered and includes admission to the birthing center of low-risk, normal, uncomplicated pregnancies, with an anticipated normal, spontaneous vaginal delivery for the period of labor and delivery.

(b) **Newborn.** Coverage for newborns includes those services within the scope of practice of the provider as defined by state law.

(c) **Individuals eligible for Part B of Medicare.** Birthing center services provided to Medicare eligible recipients should be billed directly to the fiscal agent.

317:30-5-892. Reimbursement

Birthing centers will be reimbursed a facility charge determined by the Ambulatory Payment

Classification (APC) fee schedule maintained by CMS. The facility charge represents payment in full for birthing center services. Separate payment will be made for lab services and midwife or physician obstetrical care, delivery, and postpartum care as appropriate.

317:30-5-893. Billing

Billing for birthing center services will be on UB-04. Claims must be submitted in accordance with guidelines found at OAC 317:30-3-11 and 317:30-3-11.1.

PART 116. LICENSED MIDWIVES

317:30-5-1235. Eligible Providers

Eligible Providers shall:

(1) Have and maintain one of the following midwifery certifications;

(A) Certified Midwife certification issued by the American Midwifery Certification Board (AMCB) or;

(B) Certified Professional Midwife issued by the North American Registry of Midwives (NARM).

(2) Have and maintain a current license by the Oklahoma State Department of Health as described in Section 3040.6 of Title 59 of Oklahoma Statutes and OAC 310:395-7-2; and

(3) Have a current contract with the Oklahoma Health Care Authority (OHCA).

317:30-5-1236. Covered Services

(a) **Adults and children**. OHCA covers medical services (as described in OAC 317:30-5, Part 1, Physicians) provided in a birthing center by a licensed midwife when rendered within their licensure and scope of practice as defined by state law and regulations. Coverage includes obstetrical care such as antepartum care, delivery, postpartum care, and care of the normal newborn.

(b) **Newborns**. OHCA covers medical services for newborns (as described in OAC 317:30-5, Part 1, Physicians) provided in a birthing center by a licensed midwife when rendered within their licensure and scope of practice as defined by state law and regulations. Services are covered for the newborn during the first six (6) weeks following birth, unless care is transferred to a physician or advanced practice registered nurse specializing in the care of infants and children.

(c) **Limitations**. Medical services rendered by licensed midwives are subject to the same limitations described in OAC 317:30-5, Part 1, Physicians. There is no coverage for home births.

317:30-5-1237. Reimbursement

(a) **Payment**. Payment for covered services (as described in OAC 317:30-5-1226) to eligible providers (as described in OAC 317:30-5-1225) shall be made when the same service would have been covered if ordered or performed by a physician.

(1) Payment to licensed midwives is made at 80% of the physician fee schedule for the rendered service. Payment for lab and imaging services ordered by licensed midwives is made at 100% of the physician fee schedule.

(b) **Billing**.

(1) **Adults and children**. Obstetrical care should be billed using the appropriate CPT codes for Maternity Care and Delivery. The date of delivery should be used as the date of service for charges for total obstetrical care. Inclusive dates of care should be indicated on the

claim form as part of the description. The date the patient was first seen must be on the claim form. Payment for total obstetrical care includes all routine care performed by the attending provider. For payment of total OB care, the provider must have provided care for more than one trimester. To bill for prenatal care only, the claim is filed after the member leaves the provider's care. Payment for routine or minor medical problems will not be made separately to the OB provider outside of antepartum visits. The antepartum care during the prenatal care period includes all care by the OB provider except major illness distinctly unrelated to the pregnancy.

(2) **Newborns**. Providers must complete the NODOS/NB1 form (found on the OHCA website at https://oklahoma.gov/ohca/providers/forms.html) for a newborn child delivered by a SoonerCare member. A claim may then be filed for charges for the newborn under the case number and the newborn's name and assigned person code. Charges billed on the mother's person code for services rendered to the child will be denied.

PART 114. DOULA SERVICES

317:30-5-1217. General coverage

(a) **Covered benefits.**

(1) **Prenatal/postpartum visits.** There is a total of eight (8) visits allowed for the member. The doula must work with the member to determine how best to utilize the benefit to meet the needs of the member.

(2) **Labor and delivery.** There is one (1) visit allowed, regardless of the duration.

(b) **Visit requirements.**

(1) The minimum visit length is sixty (60) minutes.

(2) Visits must be face-to-face.

(A) Prenatal and postpartum visits may be conducted via telehealth.

(B) Labor and delivery services may not be conducted via telehealth.

(c) **Service locations.**

(1) **Prenatal and postpartum.**

(A) Doulas must coordinate directly with the member and their family to determine the most appropriate service location for prenatal and postpartum visits.

(B) Service locations may include the following:

(i) Member's place of residence;

(ii) Doula's office;

(iii) Physician's office;

(iv) Hospital; or

(v) In the community.

(2) **Labor and delivery services.** There is no coverage for home birth(s).

(d) **Referral requirements.** Doula services must be recommended by a physician or other licensed practitioner of the healing arts who is operating within the scope of their practice under State law.

(1) The following providers may recommend doula services:

(A) Obstetricians;

(B) Certified Nurse ~~Midwifes~~Midwives;

(C) Physicians;

(D) Physician Assistants; ~~or~~
(E) ~~Certified Nurse Practitioners.~~Advanced Practice Registered Nurses; or
(F) Licensed Midwives.

(2) The SoonerCare Referral Form must be completed and submitted, noting the recommendation for doula services.

(e) **Prior authorization (PA) requirements.**

(1) A PA is not required to access the standard doula benefit package.

(2) A PA may be submitted, for members with extenuating medical circumstances, if there is need for additional visits beyond the eight (8) prenatal/postpartum visits.

(f) **Medical records requirements.** The medical record must include, but is not limited to, the following:

(1) Date of service;
(2) Person(s) to whom services were rendered;
(3) Start and stop time for the service(s);
(4) Specific services performed by the doula on behalf of the member;
(5) Member/family response to the service;
(6) Any new needs identified during the service; and
(7) Original signature of the doula, including the credentials of the doula.

(g) **Auditing review**. All doula services are subject to post-payment reviews and audits by the OHCA.

(h) **Reimbursement.**

(1) All doula services, that are outlined in Part 114 of this Chapter, are reimbursed per the methodology established in the Oklahoma Medicaid State Plan.

(2) There are no allotted incentive payments.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH SERVICES

317:30-5-240.2. Provider participation standards

(a) **Accreditation and certification status.** Any agency may participate as an Outpatient Behavioral Health (OPBH) provider if the agency is qualified to render a covered service and meets the OHCA requirements for provider participation.

(1) Private, Community-based Organizations must be accredited as a provider of outpatient behavioral health services from one of the accrediting bodies listed in (c)(1) below and be an incorporated organization governed by a board of directors or be certified by the certifying agency in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1, or 3-415;

(2) State-operated programs under the direction of ODMHSAS must be accredited by one of the accrediting bodies or be certified by the certifying agency in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415;

(3) Freestanding Psychiatric Hospitals must be licensed and certified by the State Survey Agency as meeting Medicare psychiatric hospital standards and JCAHO accreditation;

(4) General Medical Surgical Hospitals must be appropriately licensed and certified by the State Survey Agency as meeting Medicare standards, including a JCAHO or AOA accreditation;

(5) Federally Qualified Health Centers/Community Health Centers facilities that qualify under OAC 317:30-5-660;

(6) Indian Health Services/Tribal Clinics/Urban Tribal Clinics facilities that qualify under federal regulation;

(7) Rural Health Clinics facilities that qualify under OAC 317:30-5-355;

(8) Public Health Clinics and County Health Departments;

(9) Public School Systems.

(b) **Certifications.** In addition to the accreditation in paragraph (a) above or ODMHSAS certification in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415, provider specific credentials are required for the following:

(1) Substance Abuse agencies (OAC 450:18-1-1);

(2) Evidence Based Best Practices but not limited to:

(A) Assertive Community Treatment (OAC 450:55-1-1);

(B) Multi-Systemic Therapy (Office of Juvenile Affairs);

(C) Function Family Therapy; and

~~(C)~~(D) Peer Support/Community Recovery Support;

(3) Systems of Care (OAC 340:75-16-46);

(4) Mobile and Facility-based Crisis Intervention (OAC 450:23-1-1);

(5) Case Management (OAC 450:50-1-1);

(6) RBMS in group homes (OAC 377:10-7) or therapeutic foster care settings (OAC 340:75-8-4);

(7) Day Treatment - CARF, JCAHO, ACHC or COA for Day Treatment Services; and

(8) Partial Hospitalization/Intensive Outpatient CARF, JCAHO, ACHC or COA for Partial Hospitalization services.

(c) **Provider enrollment and contracting.**

(1) Organizations who have JCAHO, CARF, COA, ACHC or AOA accreditation or ODMHSAS certification in accordance with 43A O.S. §§ 3-317, 3-323A, 3-306.1 or 3-415 will supply the documentation from the accrediting body or certifying agency, along with other information as required for contracting purposes to the OHCA. The contract must include copies of all required state licenses, accreditation and certifications.

(2) If the contract is approved, a separate provider identification number for each outpatient behavioral health service site will be assigned. Each site operated by an outpatient behavioral health facility must have a separate provider contract and site-specific accreditation and/or certification as applicable. A site is defined as an office, clinic, or other business setting where outpatient behavioral health services are routinely performed. When services are rendered at the member's residence, a school, or when provided occasionally at an appropriate community based setting, a site is determined according to where the professional staff perform administrative duties and where the member's chart and other records are kept. Failure to obtain and utilize site specific provider numbers will result in disallowance of services.

(3) All behavioral health providers are required to have an individual contract with OHCA in order to receive SoonerCare reimbursement. This requirement includes outpatient behavioral health agencies and all individual rendering providers who work within an agency setting. Individual contracting rendering provider qualification requirements are set forth in OAC 317:30-3-2 and 317:30-5-240.3.

(d) **Standards and criteria.** Eligible organizations must meet each of the following:

(1) Have a well-developed plan for rehabilitation services designed to meet the recovery needs of the individuals served.

(2) Have a multi-disciplinary, professional team. This team must include all of the following:

(A) One of the LBHPs;

(B) A Certified Behavioral Health Case Manager II (CM II) or CADC, if individual or group rehabilitative services for behavioral health disorders are provided, and the designated LBHP(s) or licensure candidate(s) on the team will not be providing rehabilitative services;

(C) An AODTP, if treatment of substance use disorders is provided;

(D) A registered nurse, advanced practice nurse, or physician assistant, with a current license to practice in the state in which the services are delivered if Medication Training and Support Service is provided;

(E) The member for whom the services will be provided, and parent/guardian for those under eighteen (18) years of age.

(F) A member treatment advocate if desired and signed off on by the member.

(3) Demonstrate the ability to provide each of the following outpatient behavioral health treatment services as described in OAC 317:30-5-241 et seq., as applicable to their program. Providers must provide proper referral and linkage to providers of needed services if their agency does not have appropriate services.

(A) Assessments and Service Plans;

(B) Psychotherapies;

(C) Behavioral Health Rehabilitation services;

(D) Crisis Intervention services;

(E) Support Services; and
(F) Day Treatment/Intensive Outpatient.

(4) Be available twenty-four (24) hours a day, seven (7) days a week, for Crisis Intervention services.

(5) Provide or have a plan for referral to physician and other behavioral health services necessary for the treatment of the behavioral disorders of the population served.

(6) Comply with all applicable federal and state regulations.

(7) Have appropriate written policy and procedures regarding confidentiality and protection of information and records, member grievances, member rights and responsibilities, and admission and discharge criteria, which shall be posted publicly and conspicuously.

(8) Demonstrate the ability to keep appropriate records and documentation of services performed.

(9) Maintain and furnish, upon request, a current report of fire and safety inspections of facilities clear of any deficiencies.

(10) Maintain and furnish, upon request, all required staff credentials including certified transcripts documenting required degrees.

317:30-5-240.3. Staff credentials

(a) **Licensed behavioral health professional (LBHPs).** LBHPs are defined as any of the following practitioners:

(1) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(2) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (A) through (F). The exemptions from licensure under 59 O.S. ' 1353(4) and (5), 59 O.S. ' 1903(C) and (D), 59 O.S. ' 1925.3(B) and (C), and 59 O.S. ' 1932(C) and (D) do not apply to outpatient behavioral health services.

(A) Psychology;
(B) Social work (clinical specialty only);
(C) Professional counselor;
(D) Marriage and family therapist;
(E) Behavioral practitioner; or
(F) Alcohol and drug counselor.

(3) An advanced practice registered nurse (APRN) certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(4) A physician assistant who is licensed and in good standing in the state in which services are provided and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

(b) **Licensure candidates.** Licensure candidates are practitioners actively and regularly receiving board-approved supervision, and extended supervision by a fully licensed clinician if board's supervision requirement is met but the individual is not yet licensed, to become licensed by one (1) of the areas of practice listed in (2)(A) through (F) above. The supervising LBHP responsible for the member's care must:

(1) Staff the member's case with the candidate;

(2) Be personally available, or ensure the availability of an LBHP to the licensure candidate for consultation while they are providing services;
(3) Agree with the current plan for the member;
(4) Confirm that the service provided by the candidate was appropriate; and
(5) The member's medical record must show that the requirements for reimbursement were met and the LBHP responsible for the member's care has reviewed, countersigned, and dated the service plan and any updates thereto so that it is documented that the licensed professional is responsible for the member's care.

(c) **Certified alcohol and drug counselors (CADCs).** CADCs are defined as having a current certification as a CADC in the state in which services are provided.

(d) **Multi systemic therapy (MST) provider**. Master's level therapist who works on a team established by the Oklahoma Juvenile Affairs Office (OJA) which may include bachelor's level staff.

(e) **Functional family therapy (FFT) provider**. Providers must be part of an active FFT team.

(1) **FFT Team.** An active FFT team must be trained and certified and receive ongoing consultation and monitoring by FFT, LLC. and shall meet the following requirements:

(A) be employed by a certified behavioral health agency; and
(B) be comprised of three (3) to eight (8) full time practitioners with up to one (1) of those practitioners acting in the role of a functional family supervisor. In the event an established team falls below the minimum of three (3) members, the provider agency must actively recruit and train a replacement practitioner to restore the team to compliance.

(2) **Functional Family Practitioner** A practitioner must have a master's degree in psychology, social work, counseling or closely related field. In some cases, upon consultation with FFT LLC, bachelor's level practitioners may be acceptable. An FFT practitioner must:

(A) be certified to provide FFT services through FFT LLC, while adhering to ongoing training, reporting and consultation requirements for direct service of the functional family therapy model implementation; and
(B) maintain a caseload minimum of ten (10) active cases for a full-time FFT practitioner and a minimum of five (5) active cases for a part time FFT practitioner.

(3) **Functional Family Supervisor.** A supervisor must have at minimum, a master's degree in the fields noted above.

(i) An FFT supervisor must have completed all required FFT, LLC. trainings, and the FFT externship; and
(ii) maintain a caseload minimum of five (5) active cases.

~~(e)~~(f) **Peer recovery support specialist (PRSS)/Family peer recovery support specialist (F-PRSS).** The PRSS and F-PRSS must be certified by ODMHSAS pursuant to requirements found in OAC 450:53.

~~(f)~~(g) **Qualified behavioral health aide (QBHA)**. QBHAs must:

(1) Possess current certification as a Behavioral Health Case Manager I;
(2) Have successfully completed the specialized training and education curriculum provided by the ODMHSAS;
(3) Be supervised by a bachelor's level individual with a minimum of two (2) years case management or care coordination experience;
(4) Have service plans be overseen and approved by an LBHP or licensure candidate; and

(5) Function under the general direction of an LBHP, or licensure candidate and/or systems of care team, with an LBHP or licensure candidate available at all times to provide back up, support, and/or consultation.

~~(g)~~(h) **Behavioral health case manager.** For behavioral health case management services to be compensable by SoonerCare, the provider performing the services must be an LBHP, licensure candidate, CADC or have and maintain a current certification as a Behavioral Health Case Manager II (CM II) or Behavioral Health Case Manager I (CM I) from ODMHSAS in accordance with requirements found in OAC 450:50

(1) A Wraparound Facilitator Case Manager must be an LBHP, licensure candidate or CADC that meets the qualifications for CM II and has the following:

(A) Successful completion of the ODMHSAS training for wraparound facilitation within six (6) months of employment; and

(B) Participate in ongoing coaching provided by ODMHSAS and employing agency;

(C) Successfully complete wraparound credentialing process within nine (9) months of beginning process; and

(D) Direct supervision or immediate access and a minimum of one (1) hour weekly clinical consultation with a qualified mental health professional, as required by ODMHSAS.

(2) An Intensive Case Manager must be an LBHP, licensure candidate, or CADC that meets the provider qualifications of a CM II and has the following:

(A) A minimum of two (2) years behavioral health case management experience; and

(B) Crisis diversion experience.

317:30-5-241.8. ~~Multi-systemic therapy (MST)~~Targeted Therapies for Juveniles

(a) Multi-systemic therapy (MST). MST intensive outpatient program services are limited to children within an Office of Juvenile Affairs (OJA) MST treatment program which provides an intensive, family and community-based treatment targeting specific BH disorders in children with SED who exhibit chronic, aggressive, antisocial, and/or substance abusing behaviors, and are at risk for out of home placement. Caseloads are kept low due to the intensity of the services provided.

(1) **Qualified professionals**. All MST services are provided by LBHPs or licensure candidates. Licensure candidate signatures must be co-signed by a fully-licensed LBHP in good standing. Additional team support services may be provided by a behavioral health case manager II (CM II) and/or peer recovery support specialist (PRSS) per OAC 317:30-5-240.3.

(2) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(3) **Limitations**. Services are subject to the following:

(A) Partial billing is not allowed. When only one (1) service is provided in a day, providers should not bill for services performed for less than eight (8) minutes.

(B) MST cannot be billed in conjunction with the following:

(i) Children's psychosocial rehabilitation;

(ii) Partial hospitalization/intensive outpatient treatment;

(iii) Targeted case management;

(iv) Individual, family, and group therapy;

(v) Mobile crisis intervention;

(vi) Peer-to-peer services.

(C) Duration of MST services is between three (3) to six (6) months. Weekly interventions may range from three (3) to twenty (20) hours per week. Weekly hours may be lessened as case nears closure.

(4) **Reimbursement.** MST services are reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

(b) Functional Family Therapy (FFT). Functional Family Therapy is defined as:

(1) **Evidence-based intervention.** FFT is an intensive, short-term, therapeutic model for that offers in-person, face-to-face services in the home to dysfunctional youth experiencing behavioral or emotional problems and their entire family. Referrals for FFT shall be made by the Oklahoma Office of Juvenile Affairs (OJA) or Oklahoma Human Services (OHS). Each referral shall be reviewed and approved by a licensed professional employed by the referring agency prior to the initiation of services. FFT services are provided through a team approach working collaboratively together using the FFT services as defined by FFT LLC.

(2) **Populations.** Target populations are at-risk preadolescents and youth with serious behavioral problems, including but not limited to conduct disorder, violent acting-out, substance use and other identified problematic behaviors. While FFT targets youth eleven (11) to eighteen (18) year-olds, siblings in the home also benefit from FFT services. FFT services are not available for institutionalized individuals.

(3) **Qualified professionals**. All Functional Family Therapy services must be performed or supervised by a fully Licensed Behavioral Health Practitioner (LBHP) or licensure candidate as determined by one of Oklahoma's licensing boards. Licensure candidate signatures must be co-signed by a fully licensed LBHP practitioner in good standing and must meet the FFT provider requirements per OAC 317:30-5-240.3.

(4) **Documentation requirements.** Providers must comply with documentation requirements in OAC 317:30-5-248.

(5) **Coverage and Limitations**. Services are subject to the following:

(A) Intervention ranges from, on average, twelve (12) to sixteen (16) one-hour sessions. Prior authorization is required when services exceed sixteen (16) hours, and again when services exceed thirty (30) hours. The duration of FFT is typically three (3) to five (5) months. Weekly interventions may range from one (1) to three (3) hours per week per family.

(B) FFT Services are not Medicaid compensable when:

(i) The target child is unavailable at the time of service; or

(ii) The target child is residing in an institution.

(C) FFT cannot be billed in conjunction with the following:

(i) Family Therapy; or

(ii) Acute, Acute II/PRTF, and Residential SUD.

(6) **Reimbursement.** FFT services are reimbursed pursuant to the methodology described in the Oklahoma Medicaid State Plan.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 35. RURAL HEALTH CLINICS

317:30-5-354. Definitions

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

"**APRN**" means advanced practice registered nurse.

"**C.F.R.**" means the U.S. Code of Federal Regulations.

"**CLIA**" means the Clinical Laboratory Improvement Amendments.

"**CMS**" means the Centers for Medicare and Medicaid Services.

"**CNM**" means certified nurse midwife.

"Core services" means outpatient services that may be covered when furnished to a patient at the rural health clinic (RHC) or other location, including the patient's place of residence. Services include those defined in OAC 317:30-5-355.2.

"**CP"** means clinical psychologist.

"**CPT**" means current procedural terminology.

"**CSW**" means clinical social worker.

"EPSDT" means the Early and Periodic Screening, Diagnostic and Treatment program for members under twenty-one (21)**.**

"FFS" means the current OHCA's fee-for-service reimbursement rate.

"**HCPCS**" means Healthcare Common Procedure Coding System.

"Marriage and family therapist" has the same meaning given to the term in Section 1861(lll)(2) of the Social Security Act (42 U.S.C § 1395x(lll)(2)).

"Mental Health counselor" has the same meaning given to the term in Section 1861(lll)(4) of the Social Security Act (42 U.S.C § 1395(lll)(4)).

"**OAC**" means the Oklahoma Administrative Code.

"**OHCA**" means the Oklahoma Health Care Authority.

"Other ambulatory services" means other outpatient health services covered under the Oklahoma Medicaid State Plan other than the core services listed in OAC 317:30-5-355.2.

"**PA**" means physician assistant.

"Physician" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury, or a doctor of podiatry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury.

"Physicians' services" means professional services that are performed by a physician at the RHC (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the RHC provides that he or she will be paid by the RHC for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

"**RHC"** means rural health clinic.

"Visit" means a face-to-face encounter between a clinic patient and a physician, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN), Certified Nurse Midwife (CMN), Clinical Psychologist (CP), ~~or~~ Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), or Mental Health Counselor (MHC) whose services are reimbursed under the RHC PPS payment method. Encounters with more than one (1) health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the patient, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment. Services delivered via audio-only telecommunications and reimbursed pursuant to the fee-for-service (FFS) fee schedule do not constitute a visit and/or an encounter.

317:30-5-355.2. Covered services

The Rural Health Center benefit package, as described in 42 C.F.R. § 440.20, consists of RHC services and other ambulatory services.

(1) **RHC services.** RHC services are covered when medically necessary and furnished at the clinic or other outpatient setting, including the member's place of residence, delivered via telehealth, or via audio-only telecommunications pursuant to Oklahoma Administrative Code (OAC) 317:30-3-27 and OAC 317:30-3-27.1.

(A) **Core services.** RHC ~~"~~core~~"~~ services include, but are not limited to:

(i) Services furnished by a physician, Physician Assistant (PA), Advanced Practice Registered Nurse (APRN), Certified Nurse Midwife (~~CMN~~CNM), Clinical Psychologist (CP), ~~or~~ Clinical Social Worker (CSW), Marriage and Family Therapist (MFT), or Mental Health Counselor (MHC).

(ii) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC are covered in accordance with 42 C.F.R §§ 405.2413 and 405.2415, if the service or supply is:

(I) Furnished in accordance with State law;

(II) A type commonly furnished in physicians' offices;

(III) A type commonly rendered either without charge or included in the RHC's bill;

(IV) Furnished as an incidental, although integral, part of a physician's professional services, PA, APRN, CNM, CP ~~or~~ CSW, MFT, or MHC; or

(V) Furnished under the direct supervision of a contracted physician, PA, APRN, or CNM; and

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

(iii) Visiting nurse services to the homebound are covered if:

(I) The RHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(II) The services are rendered to members who are homebound;

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

(IV) The services are furnished under a written plan of treatment as required by 42 C.F.R § 405.2416.

(iv) Certain virtual communication services.

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

(i) Prenatal and postpartum care;

(ii) Screening examination under the EPSDT program for members under twenty-one (21);

(iii) Family planning services; and

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

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

(2) **Other ambulatory services.** Other ambulatory services that may be provided by an RHC include non-primary care services covered by the Oklahoma Medicaid State Plan but are not included in the RHC's core services. These services are separately billable and may be provided by the RHC if the RHC meets the same standards as other contracted providers of those services.

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

(i) Dental services for members under the age of twenty-one (21) provided by a qualified provider other than a licensed dentist;

(ii) Optometric services provided by a qualified provider other than a licensed optometrist;

(iii) Laboratory tests performed in the RHC lab, including the lab tests required for RHC certification;

(I) Chemical examinations of urine by stick or tablet method or both (including urine ketones);

(II) Hemoglobin or hematocrit;

(III) Blood glucose;

(IV) Examination of stool specimens for occult blood;

(V) Pregnancy tests; and

(VI) Primary culturing for transmittal to a certified laboratory.

(iv) Technical component of diagnostic tests such as x-rays and EKGs (interpretation of the test provided by the RHC physician is included in the encounter rate);
(v) Durable medical equipment;
(vi) Transportation by ambulance;
(vii) Prescribed drugs;
(viii) Prosthetic devices (other than dental) which replace all or part of an internal body organ (including colostomy bags) and supplies directly related to colostomy care and the replacement of such devices;
(ix) Specialized laboratory services furnished away from the clinic;
(x) Inpatient services;
(xi) Outpatient hospital services; ~~and~~
(xii) Applied behavior analysis (ABA); and
(xiii) Diabetes self-management education and support (DSMES) services.

(B) Services listed in (2)(A) of this Section, furnished on-site, require a separate provider agreement(s) with the OHCA. Service item (2)(A)(iii) does not require a separate contract when furnished on-site, however, certain conditions of participation apply. (Refer to OAC 317:30-5-361 for conditions.)

317:30-5-356. Coverage for adults

Payment is made to RHCs for adult services as set forth in this Section.

(1) **RHC services.** Payment is made for one (1) encounter per member per day. Payment is also limited to four (4) visits per member per month. This limit may be exceeded if the SoonerCare Choice member has elected the RHC as his/her/their Patient Centered Medical Home/Primary Care Provider. Preventive service exceptions include:

(A) **Obstetrical care.** An RHC should have a written contract with its physician, PA, APRN, or CNM that specifically identifies how obstetrical care will be billed to SoonerCare, in order to avoid duplicative billing situations. The agreement should also specifically identify the physician's compensation for RHC and other ambulatory services.

(i) If the clinic compensates the physician, PA, APRN, or CNM to provide obstetrical care, then the clinic must bill the SoonerCare program for each prenatal visit using the appropriate CPT evaluation and management codes.
(ii) If the clinic does not compensate its practitioners to provide obstetrical care, then the independent practitioner must bill the OHCA for prenatal care according to the global method described in the SoonerCare provider specific rules for physicians, PAs, APRNs and CNMs (refer to OAC 317:30-5-22).
(iii) Under both billing methods, payment for prenatal care includes all routine or minor medical problems. No additional payment is made to the prenatal provider except in the case of a major illness distinctly unrelated to pregnancy.

(B) **Family planning services.** Family planning services are available only to members with reproductive capability. Family planning visits do not count as one (1) of the four (4) RHC visits per month.

(2) **Other ambulatory services.** These services are not considered a part of an RHC visit; therefore, these may be billed to the SoonerCare program by the RHC or service provider on the appropriate claim form. Refer to OAC 317:30-1, General Provisions, and OAC 317:30-3-

57, 317:30-5-59, and 317:30-3-60 for general coverage and exclusions under the SoonerCare program. Some specific limitations are applicable to other ambulatory services as set forth in specific provider rules and excerpted as follows:

~~(A) Coverage under optometrists for adults is limited to treatment of eye disease not related to refractive errors.~~

(~~B~~A) There is no coverage for eye exams for the purpose of prescribing eyeglasses, contact lenses or other visual aids. (See OAC 317:30-5-431.)

317:30-5-359.2. Reimbursement

(a) **Provider-based clinics.** Payments for provider-based clinics will be made for RHC ~~"~~core~~"~~ services listed in OAC 317:30-5-355.2 based on an all-inclusive visit fee established by one of the following:

(1) An interim rate established by calculating a statewide average rate for RHCs in the state; and

(2) The statewide average rate will be updated annually by the increase in the Medicare Economic Index (MEI); or

(3) An Alternative Payment Methodology (APM) established by the RHC periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (a)(1) or (a)(2).

(b) **Independent clinics.** Payments for independent clinics will be made for RHC ~~"~~core~~"~~ services listed in OAC 317:30-5-355.2 based on an all-inclusive visit fee established by one of the following:

(1) An interim rate established by calculating a statewide average rate for RHCs in the state; and

(2) The statewide average rate will be updated annually by the increase in the MEI; or

(3) An APM established by the RHCs periodic rate notification from the Medicare Fiscal Intermediary. In order to receive this rate, the RHC must submit a copy of the periodic rate notification letter for its most recent full cost reporting year received from the fiscal intermediary to the state. The APM rate cannot be lower than mentioned above in (b)(1) or (b)(2).

PART 75. FEDERALLY QUALIFIED HEALTH CENTERS

317:30-5-659. Definitions

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

"**APRN**" means advanced practice registered nurse.

"**C.F.R**" means the U.S. Code of Federal Regulations.

"**CLIA**" means the Clinical Laboratory Improvement Amendments.

"**CMS**" means the Centers for Medicare and Medicaid Services.

"**CNM**" means certified nurse midwife.

"Core services" means outpatient services that may be covered when furnished to a patient at the Center or other location, including the patient's place of residence. Services include those defined in OAC 317:30-5-661.1.

"**CPT**" means current procedural terminology.

"**CSW**" means clinical social worker.

"Encounter" or **"visit"** means a face-to-face contact between an approved health care professional as authorized in the FQHC pages of the Oklahoma Medicaid State Plan and an eligible SoonerCare member for the provision of defined services through a Health Center within a twenty-four (24) hour period ending at midnight, as documented in the patient's medical record.

"FFS" means the current OHCA~~'s~~ fee-for-service reimbursement rate.

"FQHC" means Federally Qualified Health Center.

"**HHS**" means the U.S. Department of Health and Human Services.

"**HRSA**" means the Health Resources and Services Administration.

"Marriage and family therapist (MFT)" has the same meaning given to the term in Section 1861(lll)(2) of the Social Security Act (42 U.S.C § 1395x(lll)(2)).

"Mental health counselor (MHC)" has the same meaning given to the term in Section 1861(lll)(4) of the Social Security Act (42 U.S.C § 1395(lll)(4)).

"Licensed behavioral health professional (LBHP)" means any of the following practitioners:

(A) An allopathic or osteopathic physician with a current license and board certification in psychiatry or board eligible in the state in which services are provided, or a current resident in psychiatry practicing as described in OAC 317:30-5-2.

(B) A practitioner with a current license to practice in the state in which services are provided, within one (1) of the areas of practice listed in (i) through (vi).

(i) Psychology;

(ii) Social work (clinical specialty only);

(iii) Professional counselor;

(iv) Marriage and family therapist;

(v) Behavioral practitioner; or

(vi) Alcohol and drug counselor.

(C) An advanced practice registered nurse certified in a psychiatric mental health specialty, and licensed as a registered nurse (RN) with a current certification of recognition from the board of nursing in the state in which services are provided.

(D) A physician assistant who is licensed and in good standing in the state and has received specific training for and is experienced in performing mental health therapeutic, diagnostic, or counseling functions.

"**OAC**" means the Oklahoma Administrative Code.

"**OHCA**" means the Oklahoma Health Care Authority.

"Other ambulatory services" means other health services covered under the Oklahoma Medicaid State Plan other than the core services listed in OAC 317:30-5-661.1.

"**PA**" means physician assistant.

"Physician" means:

(A) A doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which the function is performed or who is a licensed physician employed by the Public Health Service;

(B) Within limitations as to the specific services furnished, a doctor of dentistry or dental, a doctor of optometry when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury, or a doctor of podiatry when performing medical services that are reasonable and necessary for the diagnosis and

treatment of illness or injury.

"Physicians' services" means professional services that are performed by a physician at the Health Center (or are performed away from the Center, excluding inpatient hospital services) whose agreement with the Center provides that he or she will be paid by the Health Center for such services.

"PPS" means prospective payment system all-inclusive per visit rate method specified in the Oklahoma Medicaid State Plan.

317:30-5-661.1. Coverage of core services

Health Center services are covered for SoonerCare adults and children as set forth in this Part, unless otherwise specified.

(1) Services furnished by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC.

(2) Services and supplies incident to services provided by a physician, PA, APRN, CNM, CP, ~~or~~ CSW, MFT, or MHC are covered in accordance with 42 C.F.R '' 405.2413 and 405.2415, if the service or supply is:

(A) Furnished in accordance with State law;

(B) A type commonly furnished in physicians' offices;

(C) A type commonly rendered either without charge or included in the FQHC's bill;

(D) Furnished as an incidental, although integral, part of ~~a~~ physician, PA, APRN, CNM, CP ~~or~~ CSW, MFT, or MHC services; or

(E) Furnished under the direct supervision of a physician, PA, APRN, or CNM; and

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

(G) "Services and supplies incident to" include but are not limited to services such as minor surgery, reading x-rays, setting casts or simple fractures and other activities that involve evaluation or treatment of a patient's condition. They also include laboratory services performed by the Health Center, specimen collection for laboratory services furnished by an off-site CLIA certified laboratory and injectable drugs.

(3) Visiting nurse services to the homebound are covered if:

(A) The FQHC is located in an area in which the Secretary of Health and Human Services has determined there is a shortage of home health agencies;

(B) The services are rendered to members who are homebound;

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

(D) The services are furnished under a written plan of treatment as required by 42 C.F.R ' 405.2416.

(4) Preventive primary services in accordance with 42 C.F.R ' 405.2448;

(5) Medical nutrition services in accordance with OAC 317:30-5-1075 through 317:30-5-1076; and

(6) Preventive primary dental services.

317:30-5-661.5. Health Center preventive primary care services

(a) Preventive primary care services, as described in 42 C.F.R ' 405.2448, are those health services that:

(1) A Health Center is required to provide as preventive primary health services under section 330 of the Public Health Service Act;

(2) Are furnished by or under the direct supervision of a physician, PA, APRN, CNM, CP, CSW, MFT, MHC or other approved health care professional as authorized in the approved FQHC State Plan pages;

(3) Are furnished by a member of the Health Center's health care staff who is an employee of the Center or provides services under arrangements with the Center; and

(4) Includes only drugs and biologicals that cannot be self-administered.

(b) Preventive primary care services which may be paid for when provided by Health Centers include:

(1) Medical social services;
(2) Nutritional assessment and referral;
(3) Preventive health education;
(4) Children's eye and ear examinations;
(5) Prenatal and post-partum care;
(6) Perinatal services;
(7) Well child care, including periodic screening (refer to OAC 317:30-3-65);
(8) Immunizations, including tetanus-diphtheria booster and influenza vaccine;
(9) Family planning services;
(10) Taking patient history;
(11) Blood pressure measurement;
(12) Weight;
(13) Physical examination targeted to risk;
(14) Visual acuity screening;
(15) Hearing screening;
(16) Cholesterol screening;
(17) Stool testing for occult blood;
(18) Dipstick urinalysis;
(19) Risk assessment and initial counseling regarding risks;
(20) Tuberculosis testing for high risk patients;
(21) Clinical breast exam;
(22) Referral for mammography; and
(23) Thyroid function test.
(24) Dental services (specified procedure codes).

(c) Primary care services do not include:

(1) Health education classes, or group education activities, including media productions and publications, group or mass information programs;

(2) Eyeglasses, hearing aids or preventive dental services (except under EPSDT);

(3) Screening mammography provided at a Health Center unless the Center meets the requirements as specified in OAC 317:30-5-900; and

(4) Vaccines covered by the Vaccines for Children program (refer to OAC 317:30-5-14).

317:30-5-664.3. FQHC encounters

(a) FQHC encounters that are billed to the Oklahoma Health Care Authority (OHCA) must meet the definition in this Section and are limited to services covered by OHCA. Only encounters provided by an authorized health care professional listed in the approved FQHC State Plan pages within the scope of their licensure trigger a Prospective Payment System (PPS) encounter rate.
(b) An encounter is defined as a face-to-face contact between a health care professional and a member for the provision of defined services through a FQHC within a twenty-four (24) hour period ending at midnight, as documented in the member's medical record. Services delivered via audio-only telecommunications do not constitute an encounter.
(c) An FQHC may bill for one (1) medically necessary encounter per twenty-four (24) hour period when the appropriate modifier is applied. Medical review will be required for additional visits for children. For information about multiple encounters, refer to Oklahoma Administrative Code (OAC) 317:30-5-664.4. Payment is limited to four (4) visits per member per month for adults. This limit may be exceeded if the SoonerCare Choice member has elected the FQHC as his/her/their Patient Centered Medical Home/Primary Care Provider.
(d) Services considered reimbursable encounters (including any related medical supplies provided during the course of the encounter) include:

(1) Medical;
(2) Diagnostic;
(3) Dental, medical and behavioral health screenings;
(4) ~~Vision~~Optometry;
(5) Physical therapy;
(6) Occupational therapy;
(7) Podiatry;
(8) Behavioral health;
(9) Speech;
(10) Hearing;
(11) Medically necessary FQHC encounters with a registered nurse or licensed practical nurse and related medical supplies (other than drugs and biologicals) furnished on a part-time or intermittent basis to home-bound members (refer to OAC 317:30-5-661.3); and
(12) Any other medically necessary health services (i.e. optometry and podiatry) are also reimbursable as permitted within the FQHCs scope of services when medically reasonable and necessary for the diagnosis or treatment of illness or injury, and must meet all applicable coverage requirements.

(e) Services and supplies incident to the services of a physician, PA, APRN, CNM, CP, ~~and~~ CSW, MFT, and MHC are reimbursable within the encounter, as described in 42 C.F.R § 405.2413 and OAC 317:30-5-661.1.
(f) Only drugs and biologicals which cannot be self-administered are included within the scope of this benefit.

317:30-5-664.5. Federally Qualified Health Center (FQHC) encounter exclusions and limitations

(a) Service limitations governing the provision of all services apply pursuant to Oklahoma Administrative Code (OAC) 317:30. Excluded from the definition of reimbursable encounter core services are:

(1) Services provided by an independently Clinical Laboratory Improvement Amendments certified and enrolled laboratory;
(2) Radiology services including nuclear medicine and diagnostic ultrasound services;
(3) Venipuncture for lab tests is considered part of the encounter and cannot be billed separately. When a member is seen at the clinic for a lab test only, use the appropriate Current Procedural Terminology code. A visit for "lab test only" is not considered a Center encounter;
(4) Medical supplies, equipment, and appliances not generally provided during the course of a Center visit such as diabetic supplies. However, gauze, band-aids, or other disposable products used during an office visit are considered as part of the cost of an encounter and cannot be billed separately under SoonerCare;
(5) Supplies and materials that are administered to the member are considered a part of the physician's or other health care practitioner's service;
(6) Drugs or medication treatments provided during a clinic visit are included in the encounter rate. For example, a member has come into the Center with high blood pressure and is treated at the Center with a hypertensive drug or drug samples provided to the Center free of charge are not reimbursable services and are included in the cost of an encounter. Prescriptions are not included in the encounter rate and must be billed through the pharmacy program by a qualified enrolled pharmacy;
(7) Administrative medical examinations and report services;
(8) Emergency services including delivery for pregnant members that are eligible under the Non-Qualified (ineligible) provisions of OAC 317:35-5-25;
(9) SoonerPlan family planning services;
(10) Long-acting reversible contraceptive devices (devices are not considered part of the FQHC encounter rate and can be billed separately);
(11) Optometry and podiatric services other than ~~for dual eligible for Part B of Medicare~~ medical services that are reasonable and necessary for the diagnosis and treatment of illness or injury;
(12) Diabetes self-management education and support (DSMES) services (refer to OAC 317:30-5-1080 through 317:30-5-1084); and
(13) Other services that are not defined in this rule or the Oklahoma Medicaid State Plan.

(b) In addition, the following limitations and requirements apply to services provided by FQHCs:
(1) Physician services are not covered in a hospital; and
(2) Behavioral health case management and psychosocial rehabilitation services are limited to FQHCs enrolled under the provider requirements in OAC 317:30-5-240 and contracted with OHCA as an outpatient behavioral health agency.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY

CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 61. HOME HEALTH AGENCIES

317:30-5-550. Paid Family Caregiver

Paid Family Caregiver (PFC) is a service that allows a family member of the qualifying child, i.e., parent, parent-in-law, sibling, grandparent, guardian, an individual related by blood and/or marriage, and any other individual with a close association that is the equivalent of a family relationship; to work for a home care agency to provide home care services to qualified children under the age of 21. Individuals eligible to be employed as a complex caregiver must be 18 years or older. PFC services are provided:

(1) In the member's primary residence, unless it is medically necessary for the complex caregiver to accompany the individual in the community.

(2) In accordance with the Oklahoma Nursing Practice Act, § 567.3a, complex care giver may provide care to qualifying members under the direction and supervision of a Registered Nurse or Licensed Practical Nurse, through a home care agency.

(A) The complex caregiver may not drive the vehicle during transportation.

(B) PFC services are not available for non-routine extended home absences unrelated to medically necessary treatment or medical care. [Refer to Oklahoma Administrative Code 317:30-5-558(4) and (13)].

(C) PFC hours authorized by OHCA and/or SoonerSelect may total up to forty (40) hours per week and are authorized concurrent with, not in addition too, any PDN hours authorized by OHCA and/or SoonerSelect.

317:30-5-551. Eligible providers

(a) A home health agency that desires to be reimbursed by SoonerCare for paid family caregiver (PFC) must meet the following requirements prior to providing services to eligible SoonerCare members:

(1) The agency must be fully contracted with OHCA as a provider; and,

(2) The agency must meet the requirements of Oklahoma Administrative Code (OAC) 317:30-5-545, and it must be licensed by the Oklahoma State Health Department (OSDH) as a home care agency.

(b) The complex caregiver must meet the following requirements:

(1) be at least 18 years of age;

(2) pass criminal and abuse registry background checks

(c) The complex caregiver, within the agency, must receive eighty (80) hours of training, competency evaluation, and other qualification criteria as a complex caregiver, including but not limited to

(1) Agency New Employee Orientation;

(2) Communicating with the Care Team;

(3) Documentation;

(4) Safety Care;

(5) Medications;
(6) Respiratory Care;
(7) Neurological care;
(8) Nutrition;
(9) Genitourinary care;
(10) Integumentary care; and
(11) Social Determinants of Health

317:30-5-552. Coverage by category

(a) Adults. SoonerCare does not cover adults [twenty-one (21) years of age and over] for paid family caregivers.
(b) Children. SoonerCare does cover children [under twenty-one (21) years of age] if:
(1) The member is eligible for SoonerCare; and
(2) The Oklahoma Health Care Authority (OHCA), in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with Oklahoma Administrative Code (OAC) 317:30-5-560.1.

317:30-5-553. Paid Family Caregiver (PFC) coverage limitations

Coverage limitations at OAC 317:30-5-558 are applicable to all PFC services.

317:30-5-554. How Paid Family Caregiver (PFC) services are authorized

PFC services may be initiated after completion of steps outlined in OAC 317:30-5-559.

317:30-5-554.1. Treatment plan

(a) The treatment plan for a member receiving paid family caregiver services must meet requirements outlined in OAC 317:30-5-560.
(b) The treatment plan will be incorporated into the treatment plan request for members receiving PFC services.

317:30-5-554.2. Prior authorization requirements

Prior authorization requirements outlined in OAC 317:30-5-560.1 applicable to paid family caregiver services.

317:30-5-554.3. Record documentation

Documentation for paid family caregiver services must include the caregiver's credentials and meet all other requirements listed at OAC 317:30-5-560.2.

PART 62. PRIVATE DUTY NURSING

317:30-5-555. Private Duty Nursing (PDN)

PDN is medically necessary care provided on a regular basis by a licensed practical nurse or registered nurse. During any given period of service, a nurse may only provide care to the eligible member. PDN is the level of care that would routinely be provided by the nursing staff of a hospital or skilled nursing facility. PDN services are provided:
(1) In the member's primary residence, unless it is medically necessary for a nurse to accompany the individual in the community.

(A) The individual's place of residence is wherever the individual lives, whether the residence is the individual's own dwelling, a relative's home, or other type of living arrangement. The place of residence cannot include a hospital, nursing facility, or intermediate care facility for
individuals with intellectual disabilities (ICF/IID).

(B) The place of service in the community cannot include the residence or business location of the provider of PDN services unless the provider of PDN is a live-in caregiver.

(2) To assist during transportation to routine, Medicaid compensable health care appointments and/or to the nearest appropriate emergency room.

(A) The private duty nurse may not drive the vehicle during transportation.

(B) PDN services are not available for non-routine extended home absences unrelated to medically necessary treatment or medical care. [Refer to Oklahoma Administrative Code 317:30-5-558(4) and (13)].

317:30-5-556. Eligible providers

(a) A home health agency that desires to be reimbursed by SoonerCare or SoonerSelect for private duty nursing (PDN) must meet the following requirements prior to providing services to eligible SoonerCare members:

(1) The agency must be fully contracted with OHCA as a provider; and,

(2) The agency must meet the requirements of Oklahoma Administrative Code (OAC) 317:30-5-545, and it must be licensed by the Oklahoma State Health Department (OSDH) as a home care agency.

(b) The provider of PDN services, within the agency, must be a licensed practical nurse or a registered nurse who is currently licensed and in good standing in the state in which services are provided.

317:30-5-557. Coverage by category

(a) **Adults.** SoonerCare does not cover adults [twenty-one (21) years of age and over] for private duty nursing (PDN) with the exception of subsection (c).

(b) **Children.** SoonerCare or SoonerSelect does cover children [under twenty-one (21) years of age] if:

(1) The member is eligible for SoonerCare or SoonerSelect; and

(2) The Oklahoma Health Care Authority (OHCA), or OHCA's Contracted Entity, in its discretion, deems the services medically necessary. Medical necessity is determined in accordance with Oklahoma Administrative Code (OAC) 317:30-5-560.1.

(c) **Individuals eligible for Part B of Medicare**. Payment is made utilizing ~~the~~ SoonerCare allowable for comparable services.

(d) **1915(c) home and community-based services (HCBS) waivers.** If private duty nursing services are provided, they will be defined within each waiver and must be prior authorized.

317:30-5-558. Private duty nursing (PDN) coverage limitations

The following provisions apply to all PDN services and provide coverage limitations:

(1) All services must be prior authorized to receive payment from the Oklahoma Health Care Authority (OHCA), or through SoonerSelect. Prior authorization means authorization in advance of services provided in accordance with Oklahoma Administrative Code (OAC) 317:30-3-31 and 317:30-5-560.1;

(2) ~~A treatment plan must be completed by an eligible PDN provider before requesting prior authorization and must be updated at least annually and~~Recertification of a treatment plan is required at least every 60 days to request PDN services in accordance with OAC 317:30-5-560.1 and must:

(A) be signed by the physician [medical doctor (MD), or doctor of osteopathy, (DO)], a physician assistant (PA), or advanced practice registered nurse (APRN)]; and

(B) include documentation for Private Duty Nursing and/or Paid Family Caregiver services covering the previous ten (10) days for ongoing record review.

(3) An assessment by an OHCA ~~care management~~or SoonerSelect nurse is required prior to the authorization for services. The assessment will be conducted by the OHCA through one (1) of the following:

(A) **Telephone**. Audio-only telephonic communication;

(B) **Virtually.** Virtual visits are the standard method of assessment. This is a means to use virtual technology to collect medical and other forms of health data for the purposes of assessment and recommendation; or

(C) **Face-to-face.** In person face-to-face assessments are completed when determined by OHCA to be the most appropriate assessment method. A face-to-face assessment is not completed at the parent or caregiver's request.

(4) Care in excess of the designated hours per week granted in the prior authorization is not SoonerCare compensable. Prior-authorized but unused service hours cannot be accumulated for use at a future date or time. If such hours or services are provided, they are not SoonerCare or SoonerSelect compensable.

(5) Any medically necessary PDN care provided outside of the home must be counted in and cannot exceed the number of hours requested on the treatment plan and approved by OHCA.

(6) PDN services do not include office time or administrative time in providing the service. The time billed is for direct nursing services only.

(7) Staff must be engaged in purposeful activity that directly benefits the member receiving services. Staff must be physically able and mentally alert to carry out the duties of the job. At no time will OHCA or SoonerSelect compensate an organization for nursing staff time when sleeping.

(8) OHCA and SoonerSelect will not approve PDN services if all health and safety issues cannot be met in the setting in which services are provided.

(9) A provider must not misrepresent or omit facts in a treatment plan.

(10) It is outside the scope of coverage to deliver care in a manner outside of the treatment plan or to deliver units over the authorized units of care.

(11) PDN is not authorized in excess of 112 hours per week, not exceeding sixteen (16) hours per day. There may be approval for additional hours for a period not to exceed thirty (30) days, if:

(A) The member has an acute episode that would otherwise require hospitalization or immediately following a hospital stay; or

(B) The primary caregiver is temporarily and involuntarily unable to provide care.

(C) The OHCA or the SoonerSelect Contracted Entity has discretion and the final authority to approve or deny any additional PDN hours and will take into consideration that the additional hours are not to be a substitute for institutionalized care.

(12) Family and/or caregivers and/or guardians (hereinafter, "caregivers") are required to provide some of the nursing care to the member without compensation. PDN services shall not be provided solely to allow the member's caregiver to work or go to school, nor solely to allow respite for the caregiver.

(13) PDN services will not be approved for overnight trips away from the member's primary residence that are unrelated to medically necessary treatment or medical care.

(A) For a member to receive Medicaid-reimbursable PDN services on an overnight trip that is related to medically necessary treatment or medical care, all provisions of this Part must be met. If said trip occurs out of state, OAC 317:30-3-89 through 317:30-3-92 must also be met.

(B) In instances in which the member's family is temporarily absent due to vacations, any additional PDN hours must be paid for by the family~~,~~ or provided by other trained family members without SoonerCare or SoonerSelect reimbursement.

(14) PDN services will not be approved when services are reimbursed or reimbursable by other insurance, other governmental programs, or Medicaid program services that the member receives or is eligible to receive. For example, if a member receives Medicaid-reimbursable PDN services pursuant to an Individualized Education Program (IEP) in a public school, then those PDN school hours will be counted in the member's daily allotment of PDN services.

317:30-5-559. How Private Duty Nursing (PDN) services are authorized

PDN services may be initiated after completion of the following steps:

(1) A treatment plan for the patient has been created by an eligible PDN provider per Oklahoma Administrative Code (OAC) 317:30-5-560;

(2) A prior authorization request is submitted with the appropriate Oklahoma Health Care Authority (OHCA) or to the SoonerSelect Contracted Entity with the required data elements and the treatment plan;

(3) An assessment (telephonic, virtual, or face-to-face) has been conducted by an OHCA care management or SoonerSelect nurse, per OAC 317:30-5-558 (3); and

(4) An OHCA or SoonerSelect physician, or his or her designee, has determined the medical necessity of the service, including but not limited to, scoring the member's needs on the PDN assessment.

317:30-5-560.1. Prior authorization requirements

(a) ~~Authorizations~~For children ages zero to three (0-3), authorizations are provided for a maximum period of six (6) months. For children ages three to twenty (3-20), authorizations are provided for a maximum period of one (1) year.

(b) Authorizations require:

(1) A treatment plan for the member;

(2) An assessment (telephonic, virtual, or face-to-face) has been conducted by an Oklahoma Health Care Authority (OHCA) care management nurse, per Oklahoma Administrative Code (OAC) 317:30-5-558 (2); and

(3) An OHCA or SoonerSelect physician, or his or her designee, to determine medical necessity including use of the OHCA Private Duty Nursing (PDN) assessment.

(c) The number of hours authorized may differ from the hours requested on the treatment plan based on the review by an OHCA or SoonerSelect physician.

(d) If the member's condition necessitates a change in the treatment plan, the provider must request a new prior authorization.

(e) Changes in the treatment plan may necessitate another assessment (telephonic, virtual, or face-to-face) by an OHCA care management nurse.

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OPERATIONAL METRICS

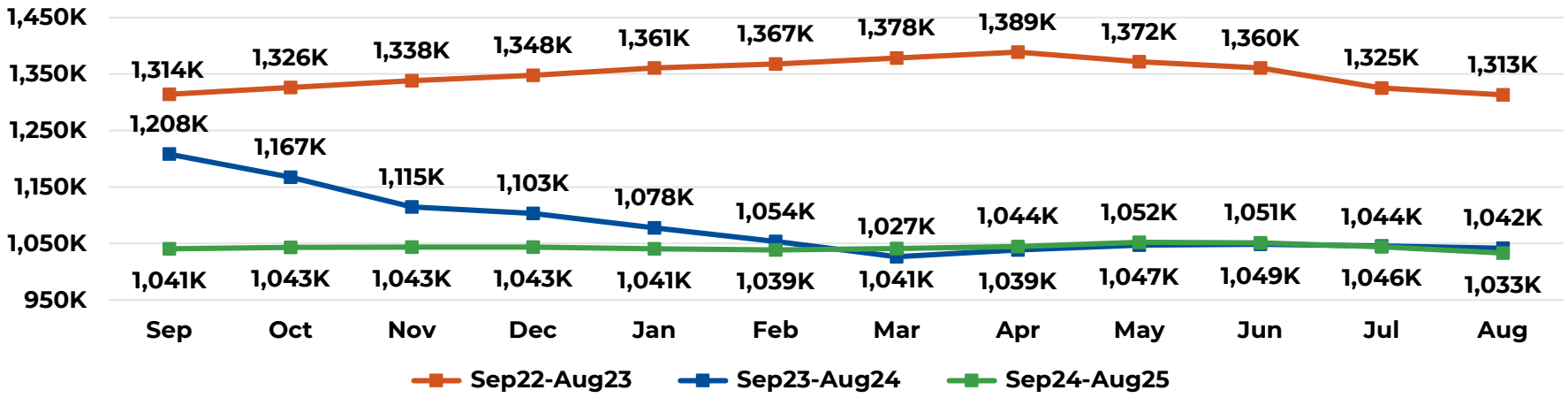
September 2025 Board Meeting

OKLAHOMA HEALTH CARE AUTHORITY

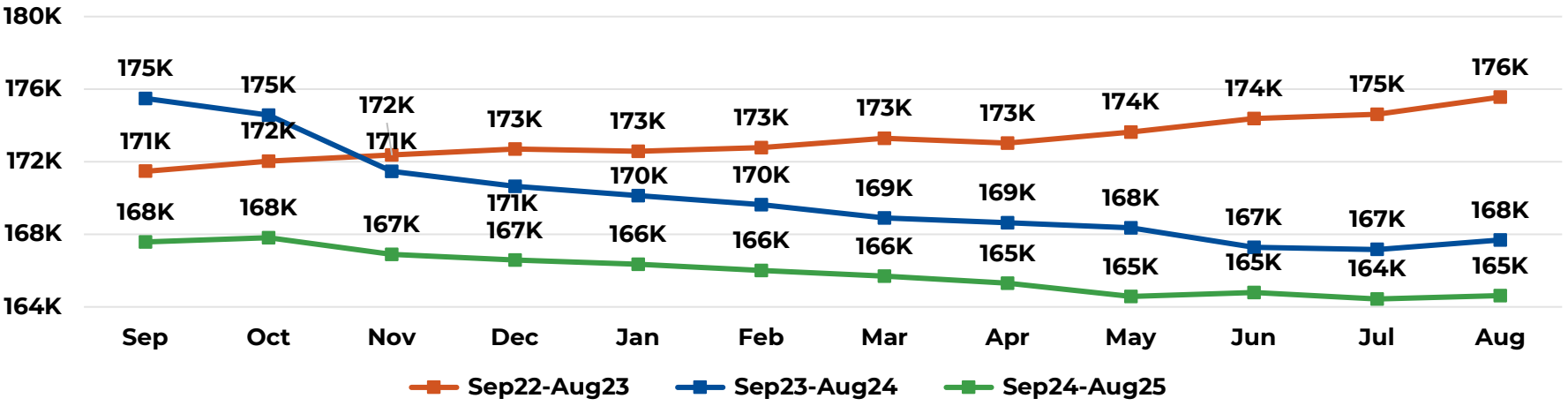
4345 N. LINCOLN BLVD. | OKHCA.ORG |

Enrollment & Utilization

Total Enrolled Members

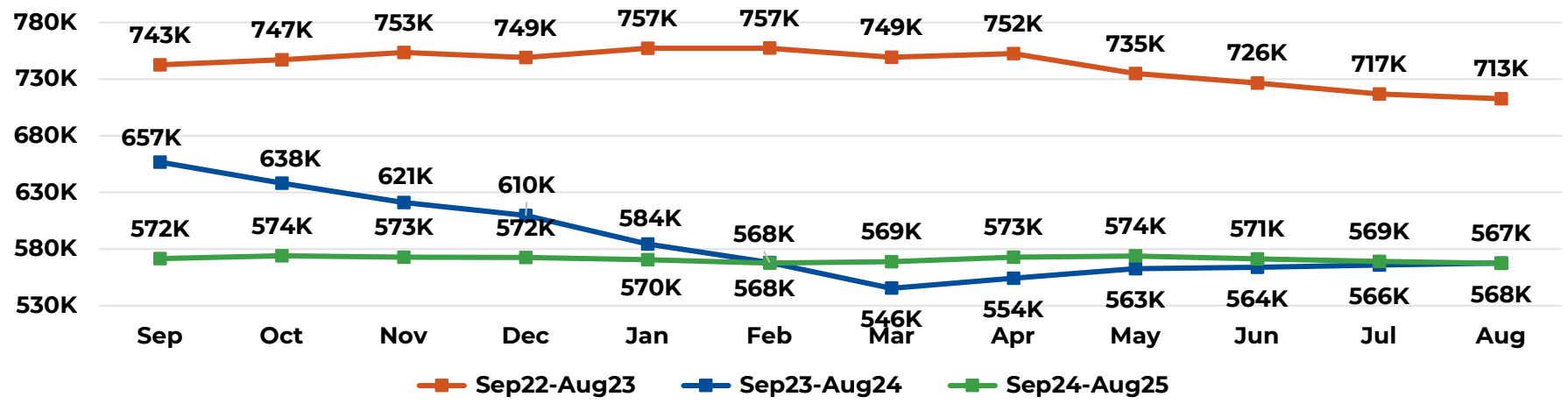


Aged/Blind/Disabled Enrolled Members

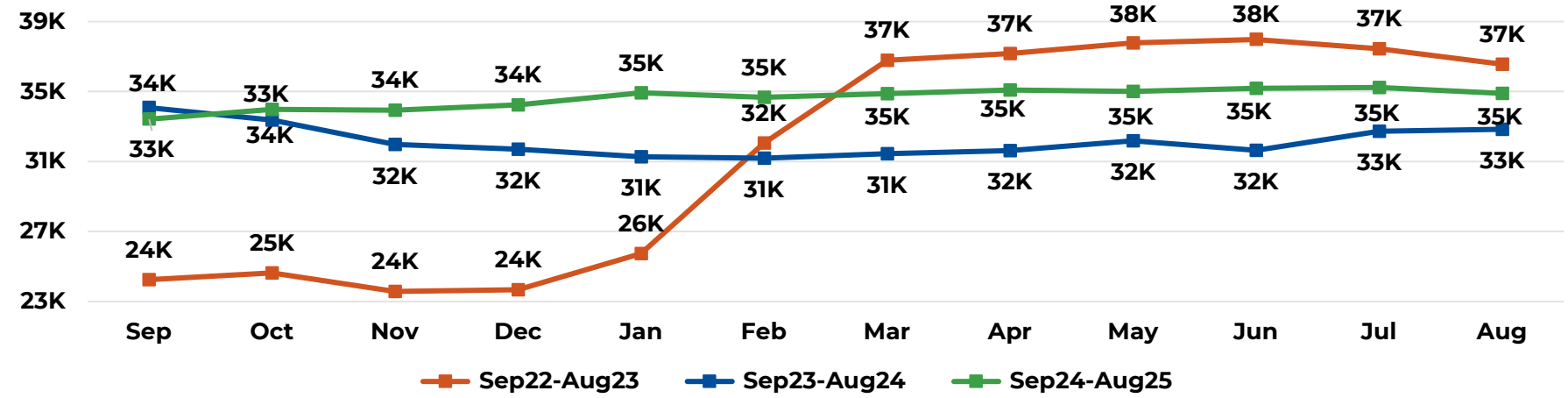


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Enrolled Members

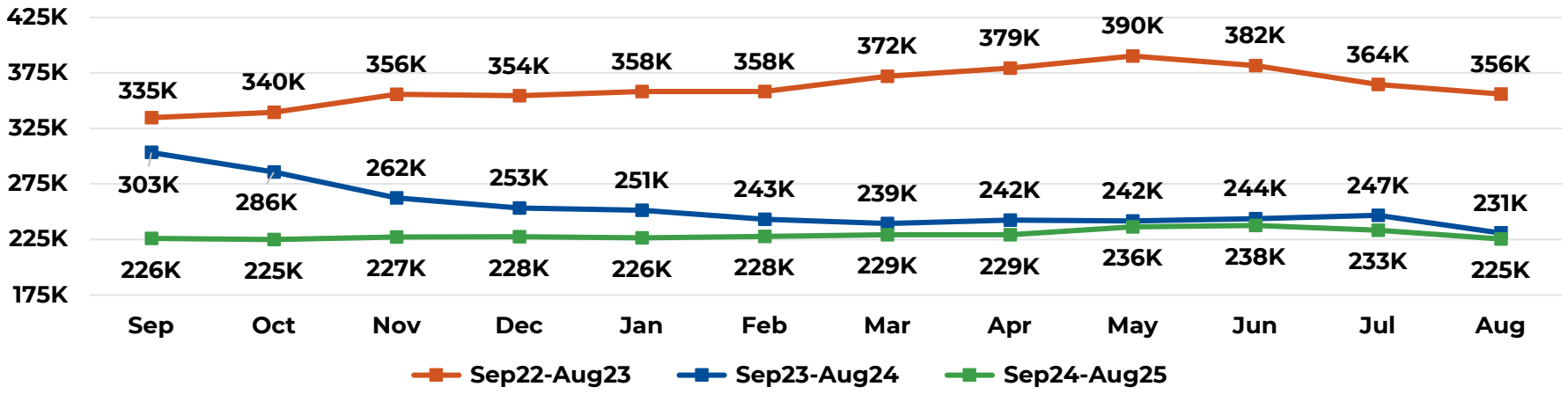


Pregnant (Full Scope) Enrolled Members

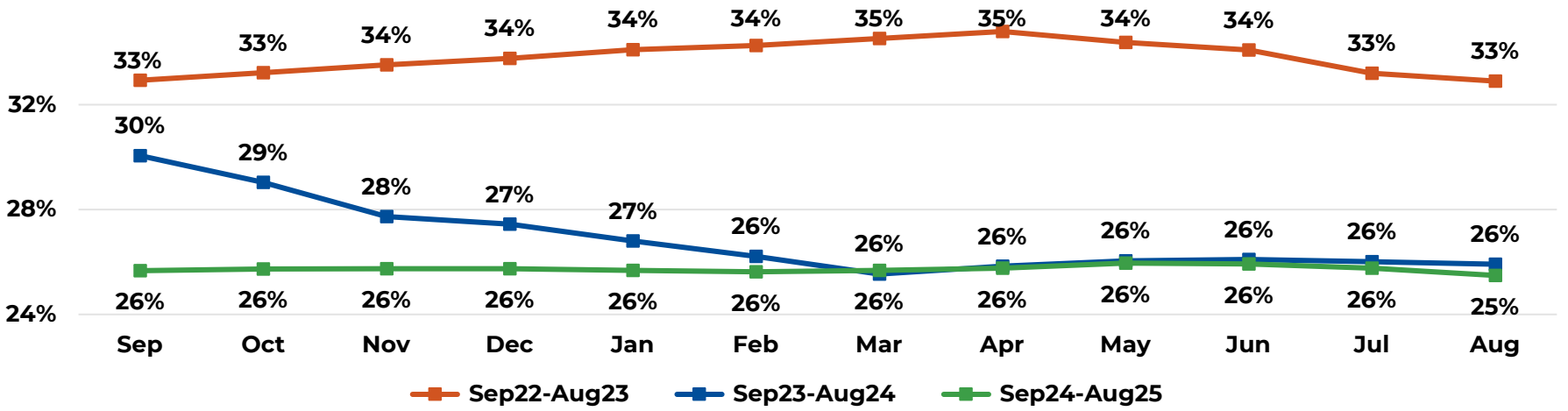


Enrollment & Utilization (Cont.)

Expansion Enrolled Members

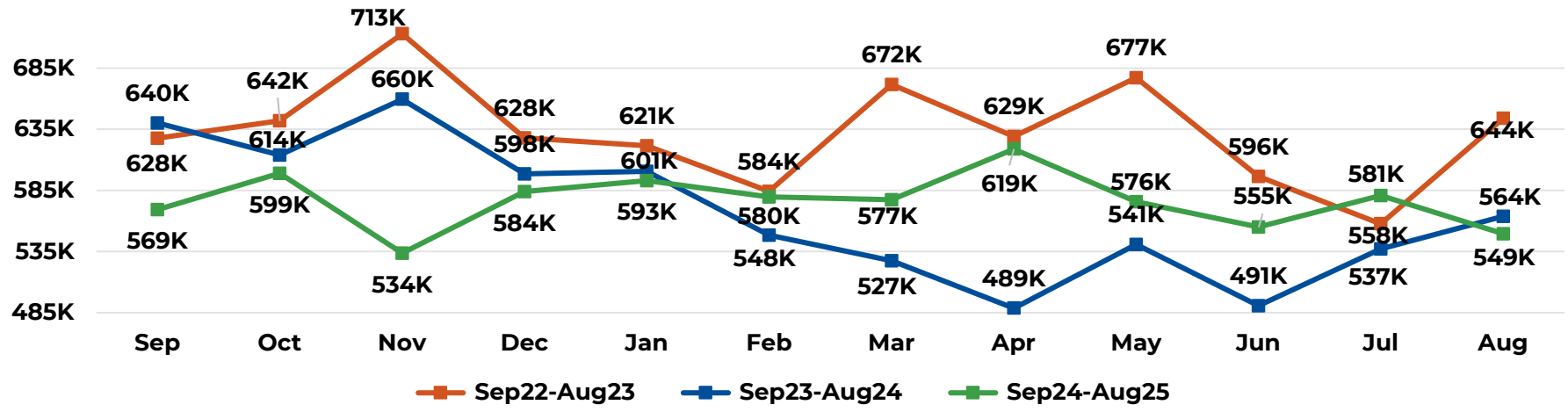


Percent of OK Population Enrolled Members

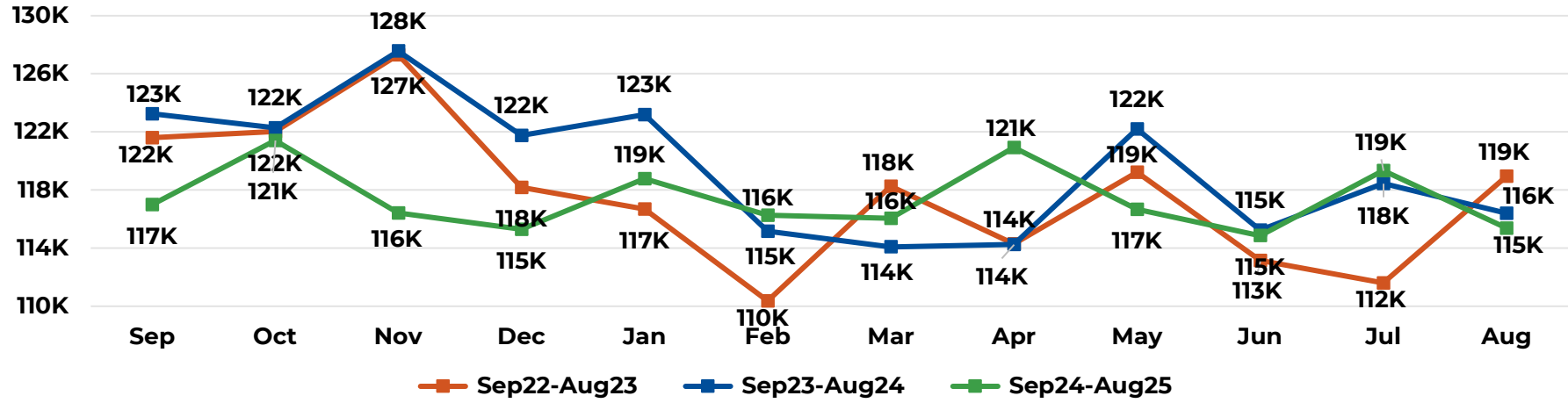


Enrollment & Utilization (Cont.)

Total Members Served

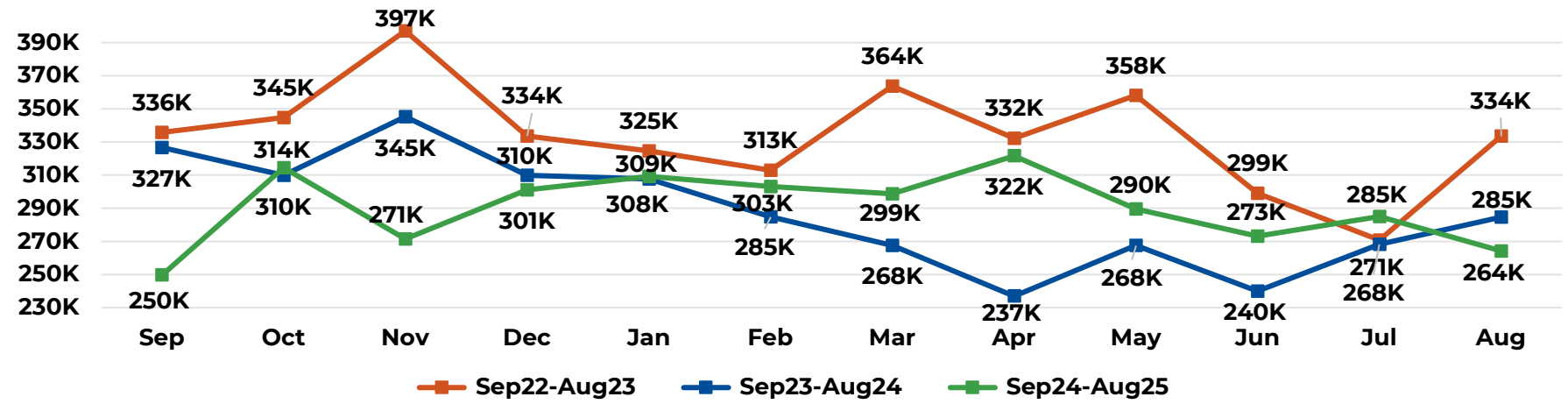


Aged/Blind/Disabled Members Served

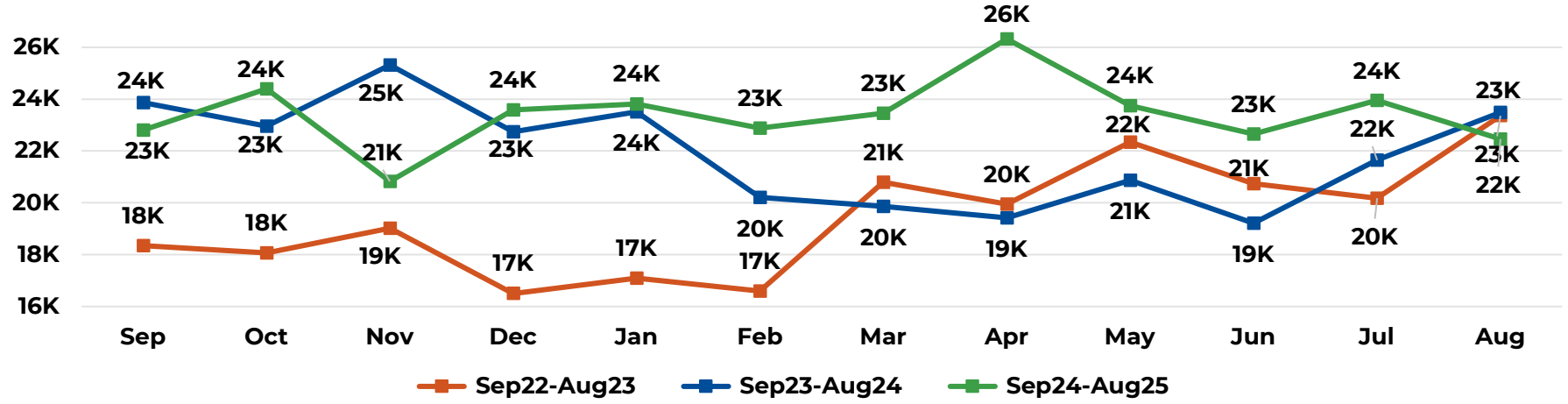


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Members Served

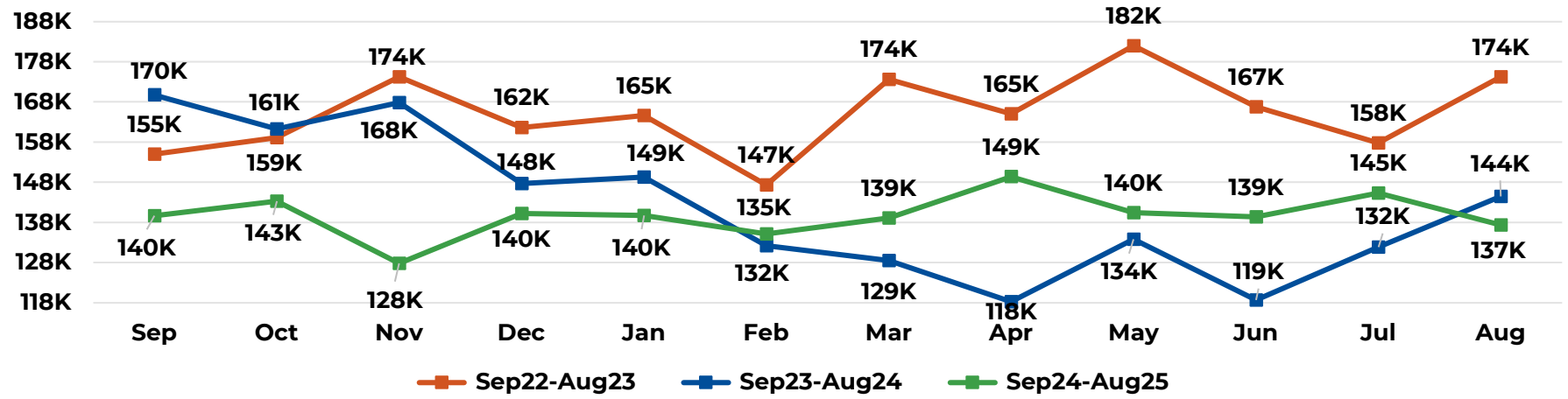


Pregnant (Full Scope) Members Served

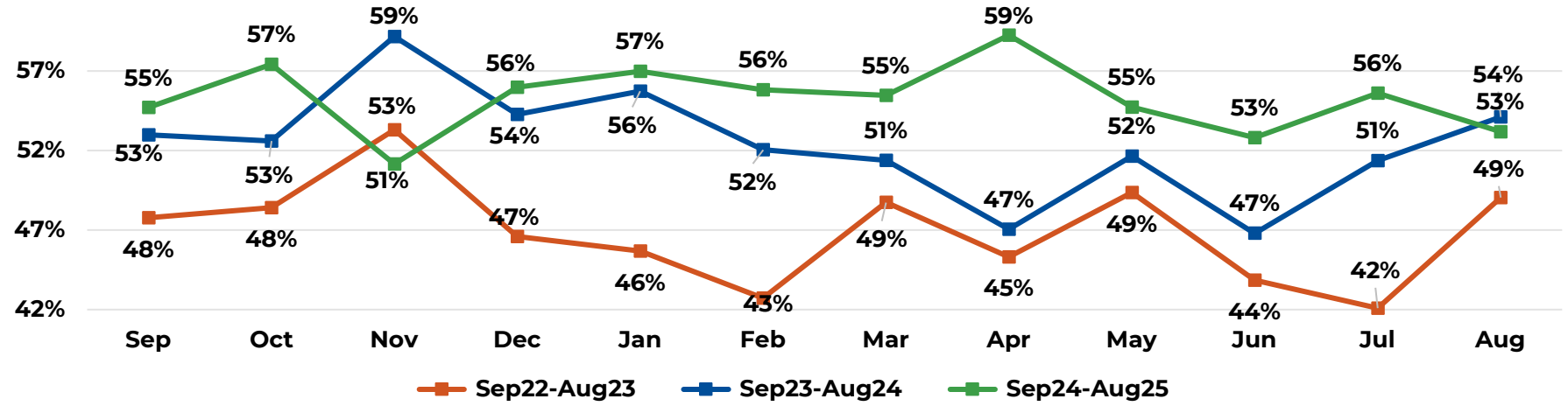


Enrollment & Utilization (Cont.)

Expansion Members Served

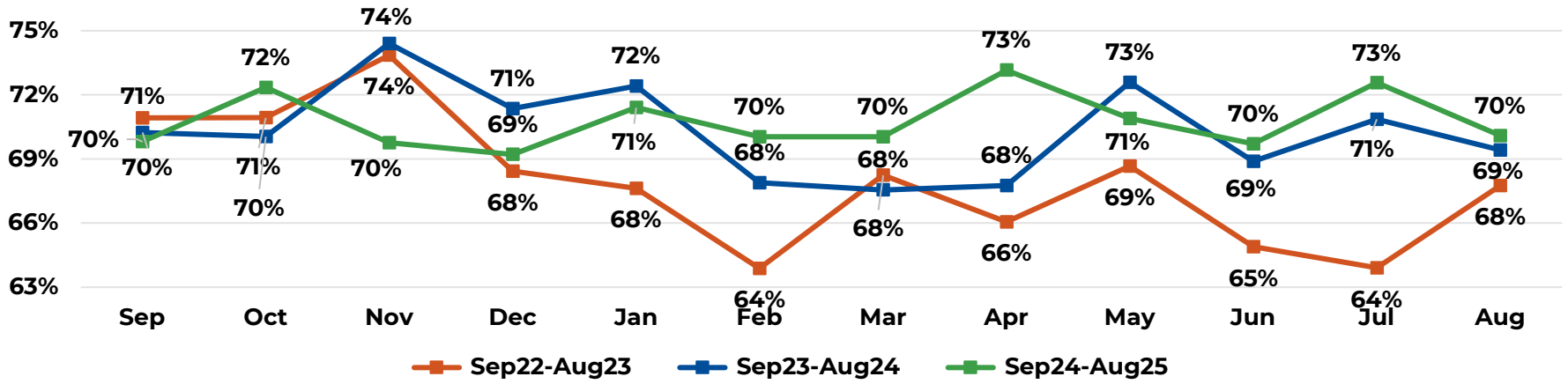


Percent of Total Enrolled Members Served

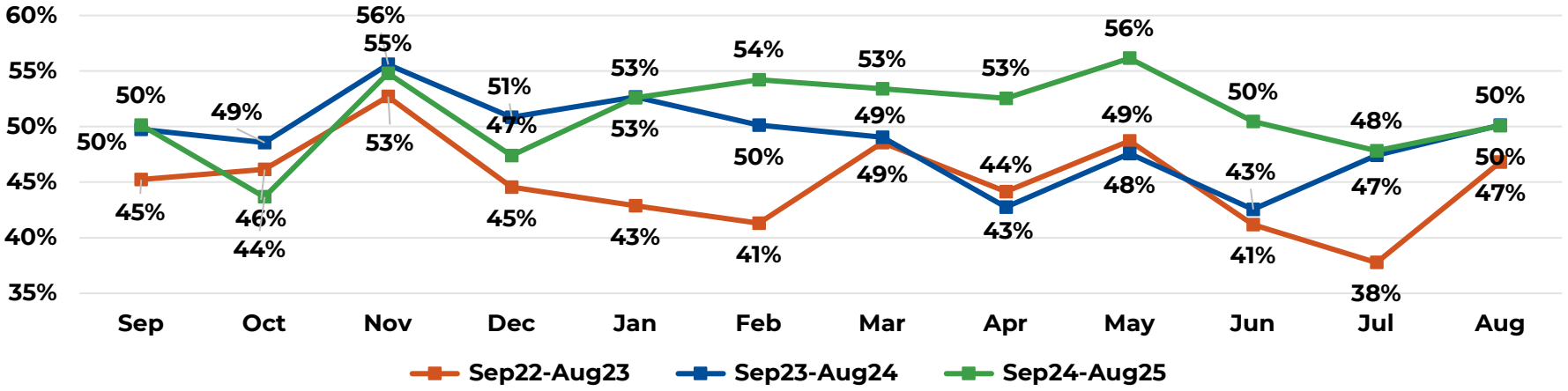


Enrollment & Utilization (Cont.)

Percent of Aged/Blind/Disabled Enrolled Members Served

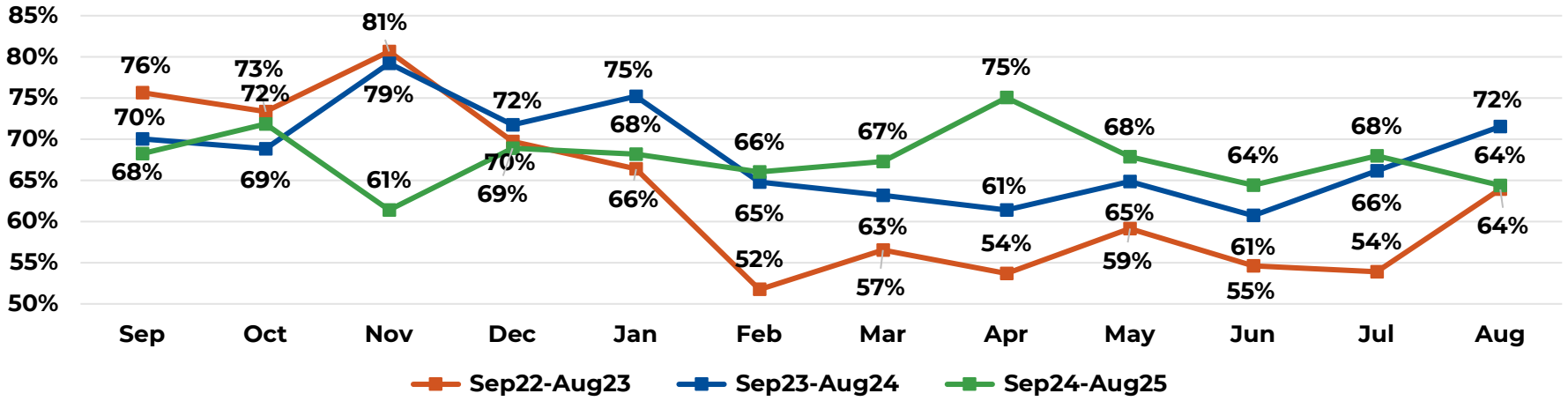


Percent of Children & Parent/Caretaker Enrolled Members Served

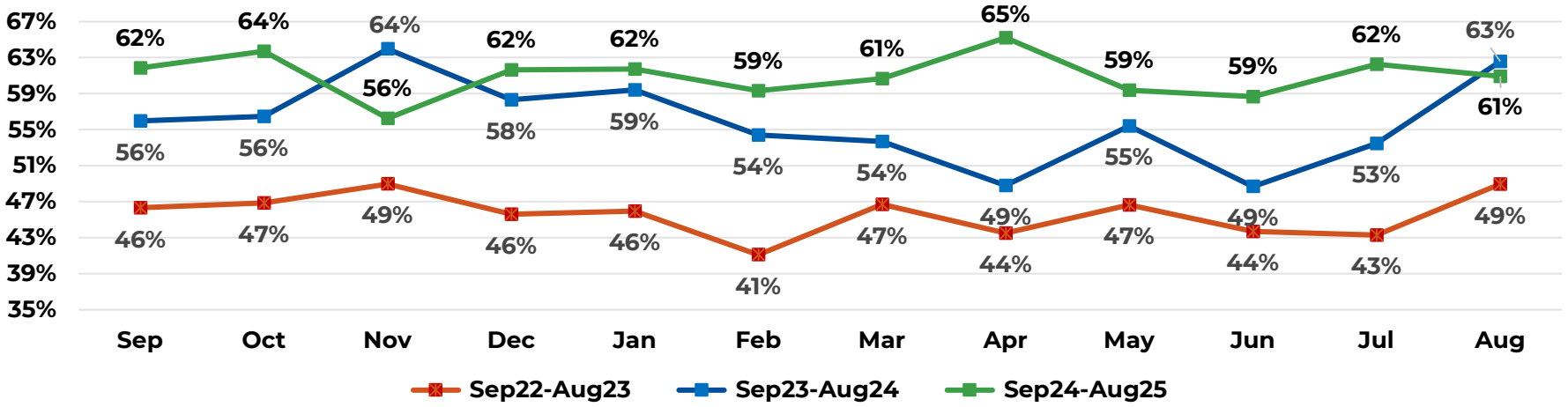


Enrollment & Utilization (Cont.)

Percent of Pregnant (Full Scope) Enrolled Members Served

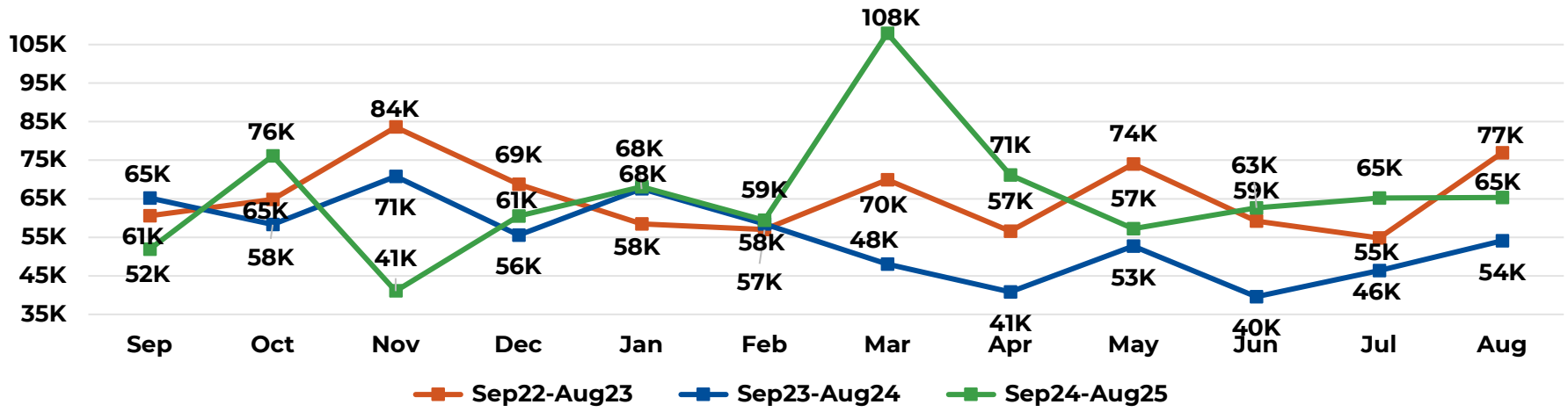


Percent of Expansion Enrolled Members Served

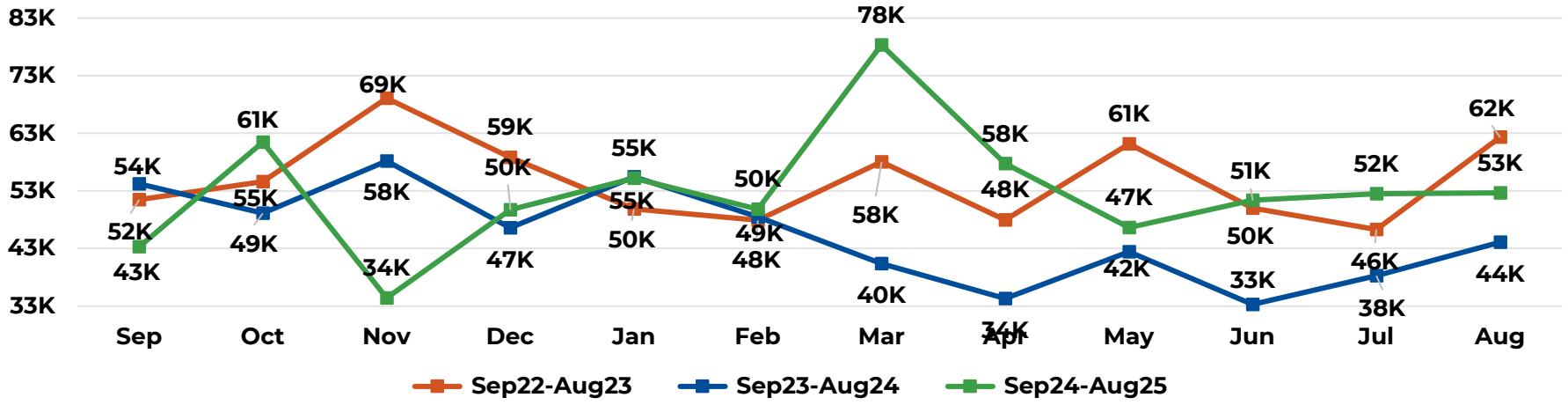


Utilization

Emergency Department - Visits (Claims)

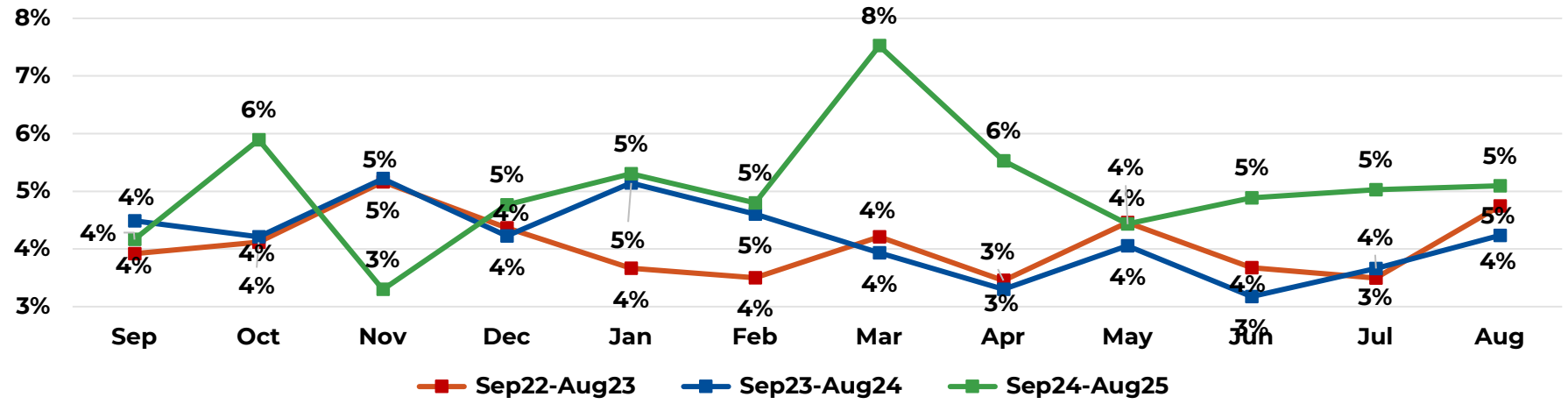


Emergency Department - Members Served



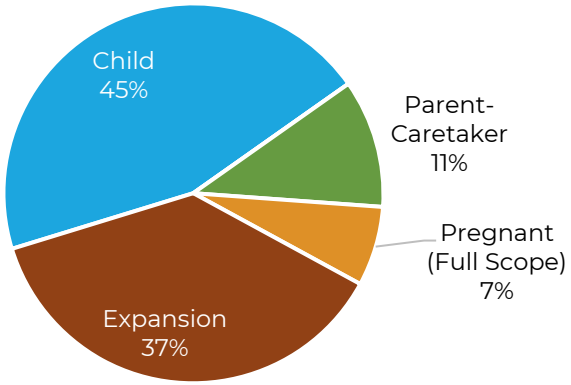
Utilization (Cont.)

Emergecy Department - Percent Total Enrolled Members Served

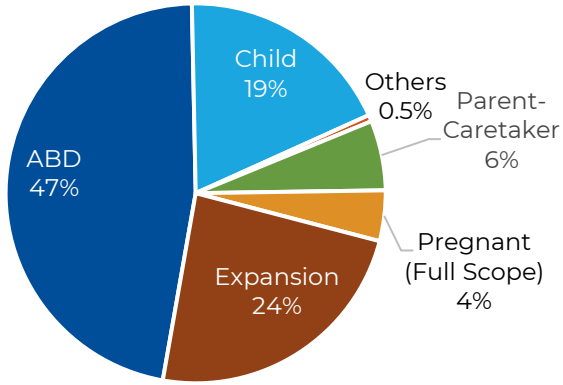


Emergency Department - Members Served By Qualifying Group (Aug2025)

MCE

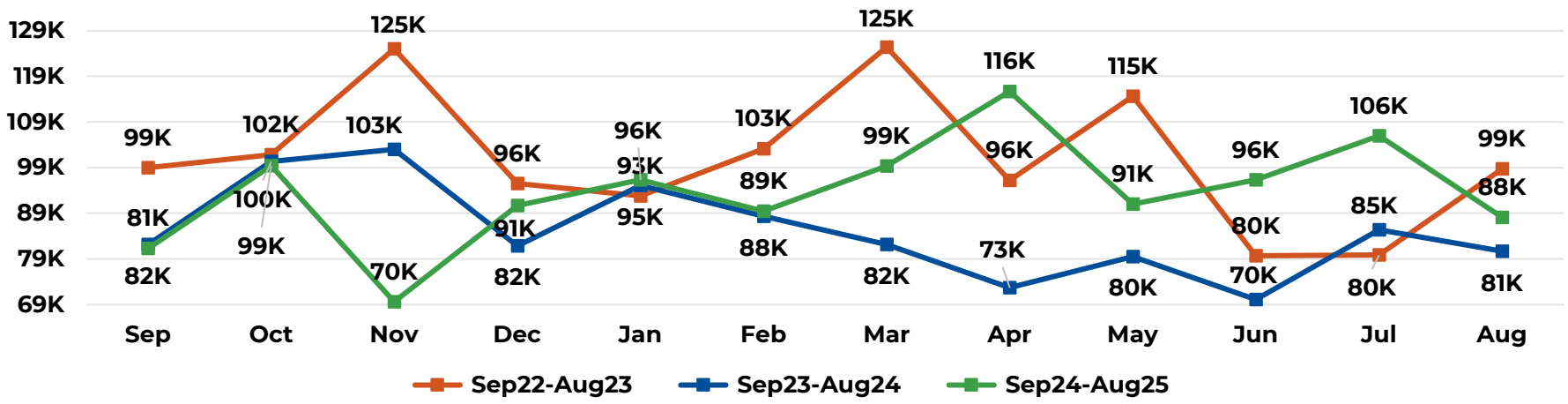


FFS

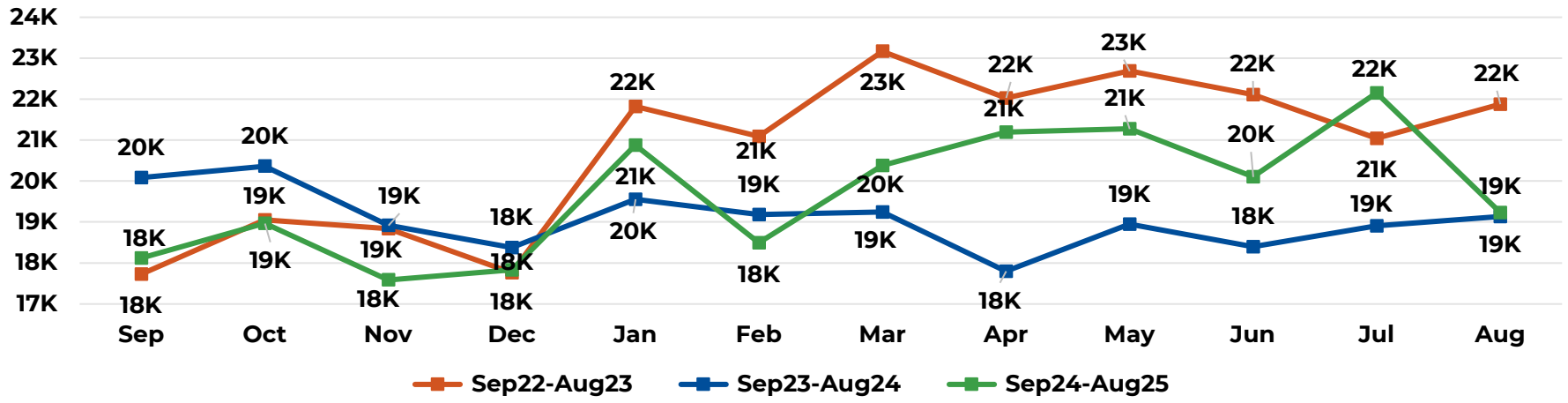


Utilization (Cont.)

Telemedicine - Total Visits (Claims)



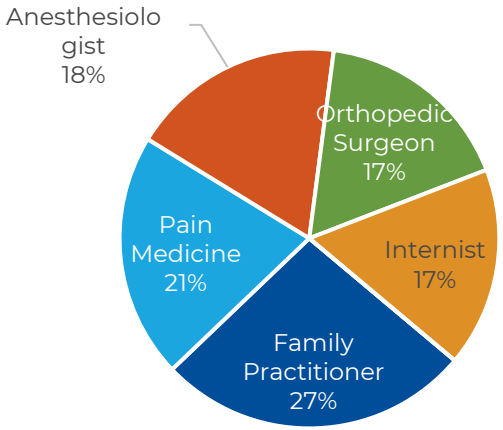
Opioid Claims - Members Served



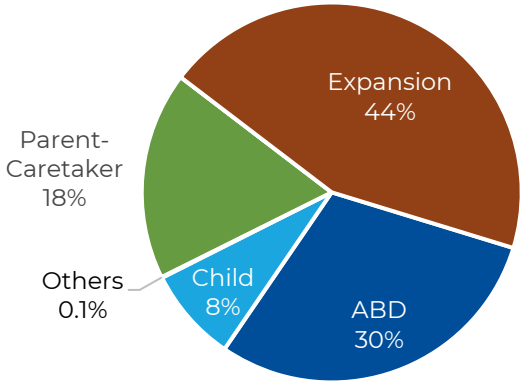
Utilization (Cont.)

Opioid Claims - Members Served By Qualifying Group & Provider Specialty (Aug2025)

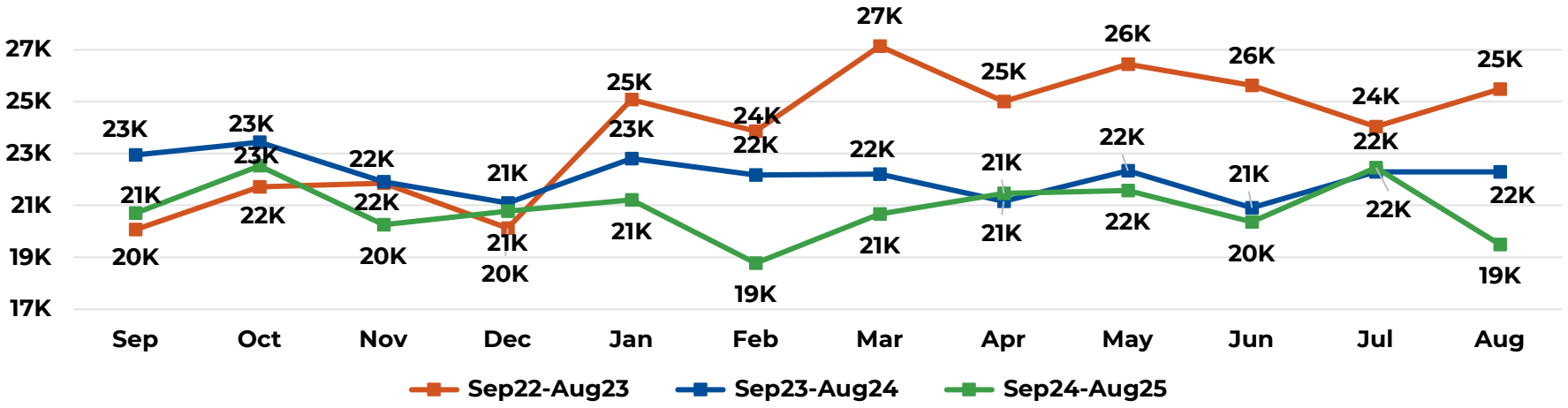
Provider Specialty (Top 5)



Qualifiying Group (All Members)

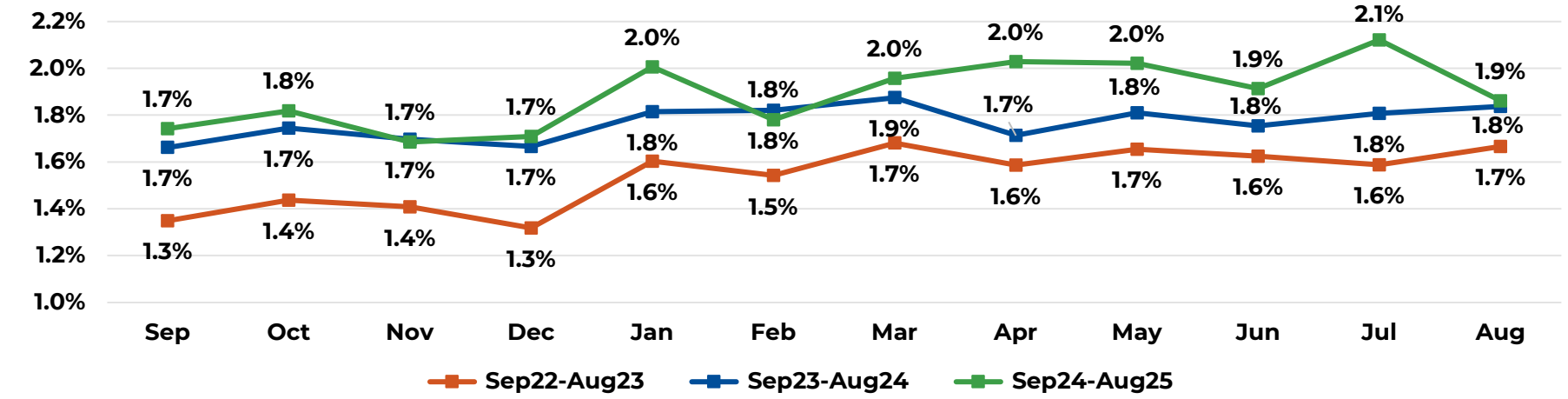


Opioid Claims - Total Claims

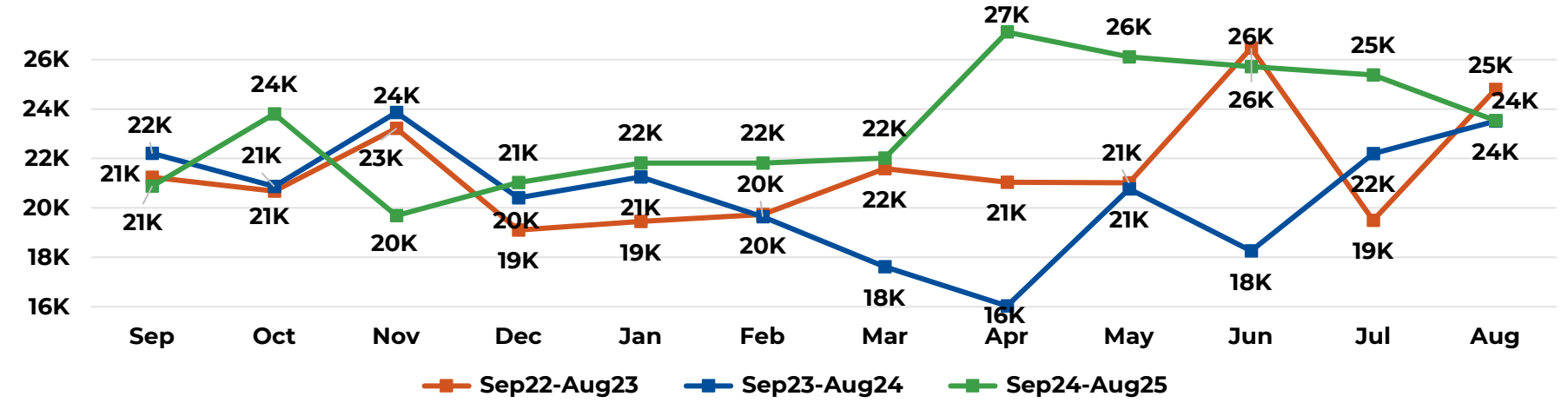


Utilization (Cont.)

Opioid Claims - Percent Total Enrolled With Opioid Claims



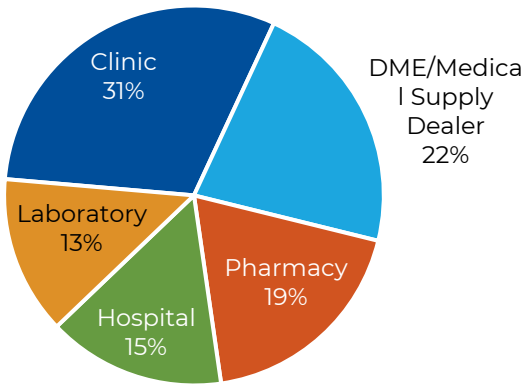
Out of State Services (Non Border County) - Total Members Served



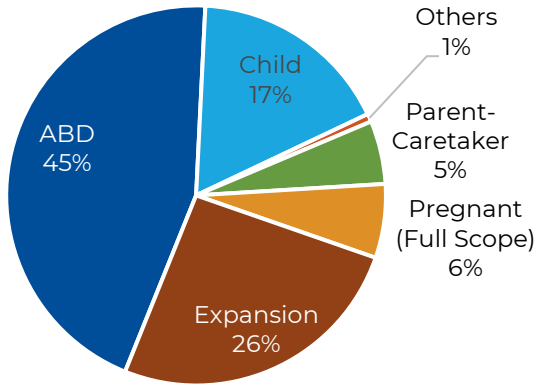
Utilization (Cont.)

Out of State Services (Non Border County) - Total Members Served By Provider Type & Qualifying Group (Aug2025)

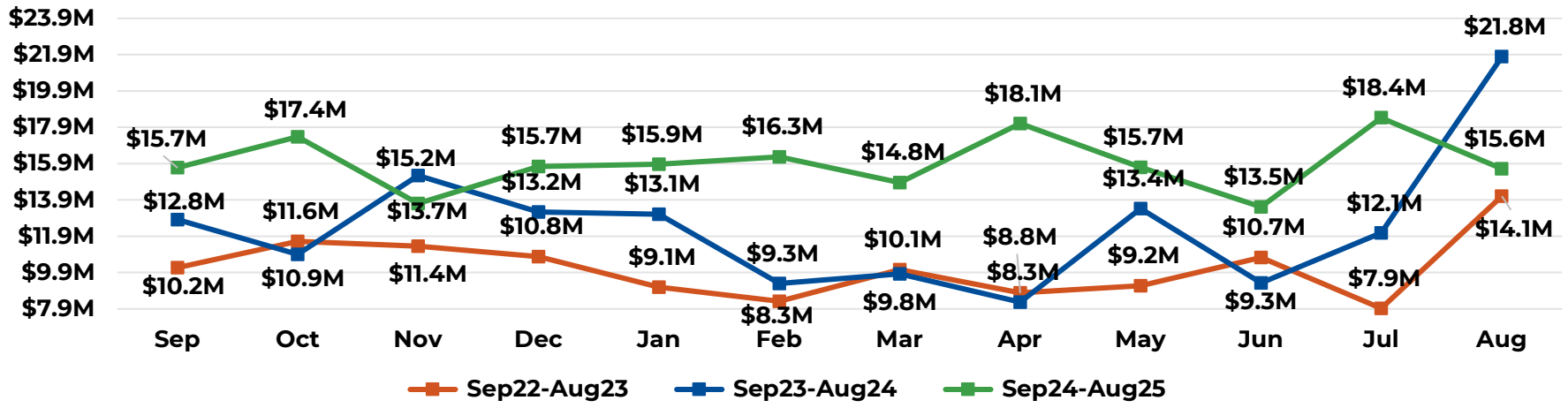
Provider Type (Top 5)



Qualifying Group (All Members)

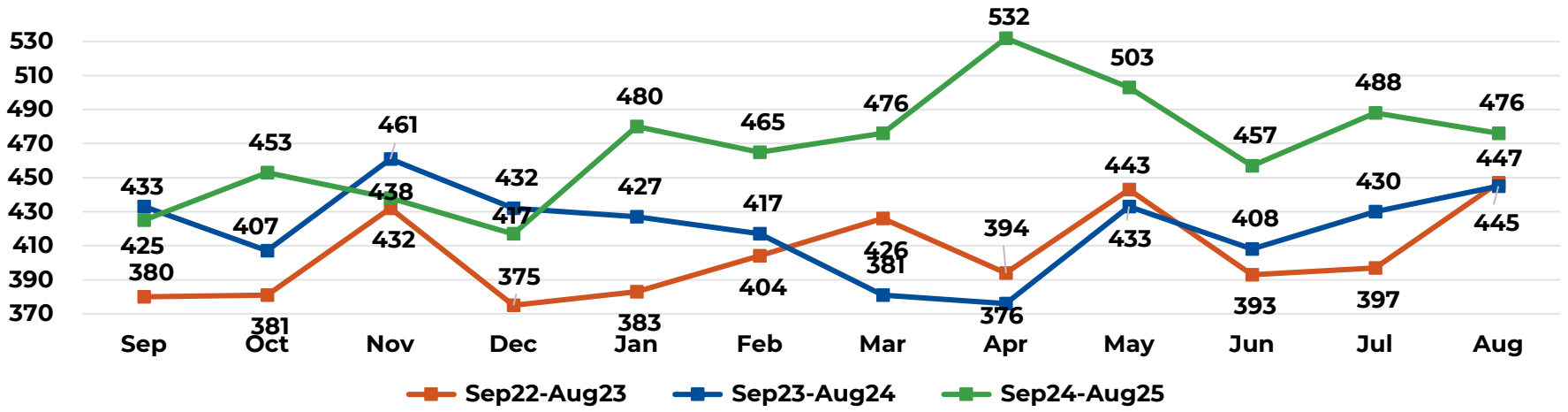


Out of State Services (Non Border County) - Total Expenditures

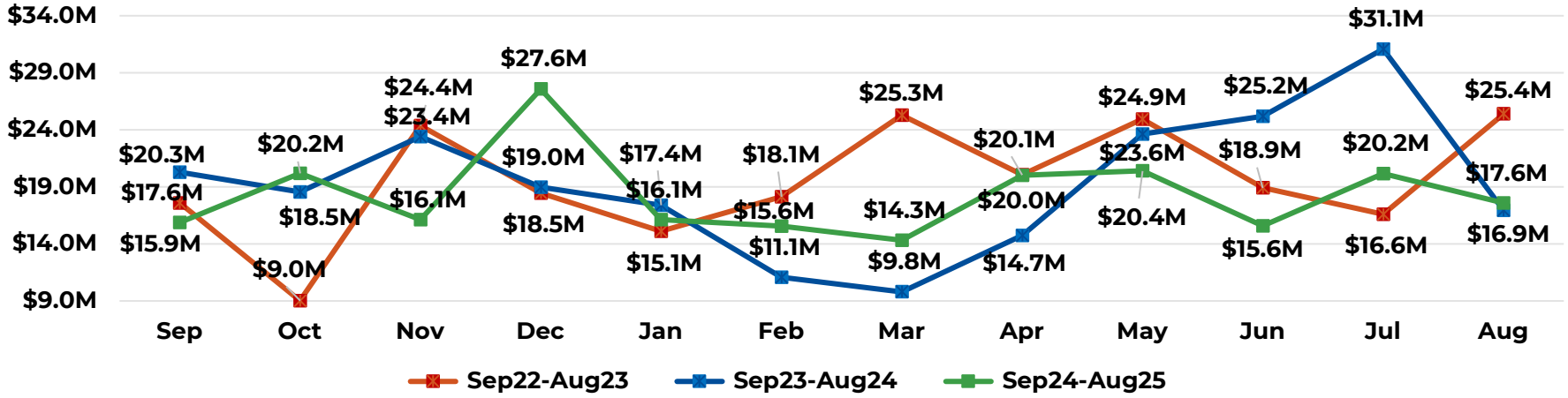


Utilization (Cont.)

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

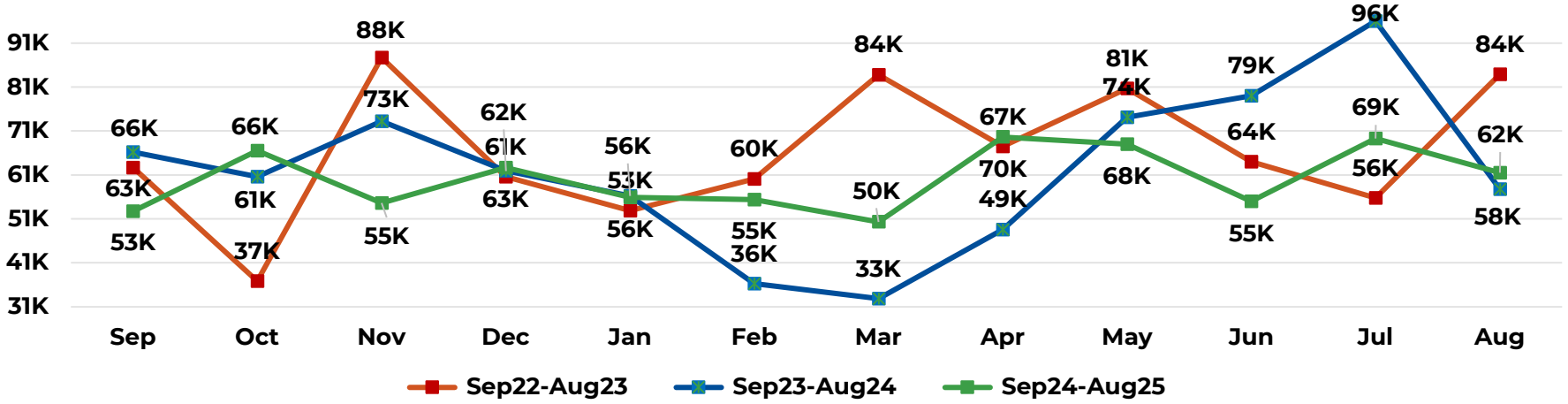


Dental Claims - Expenditures

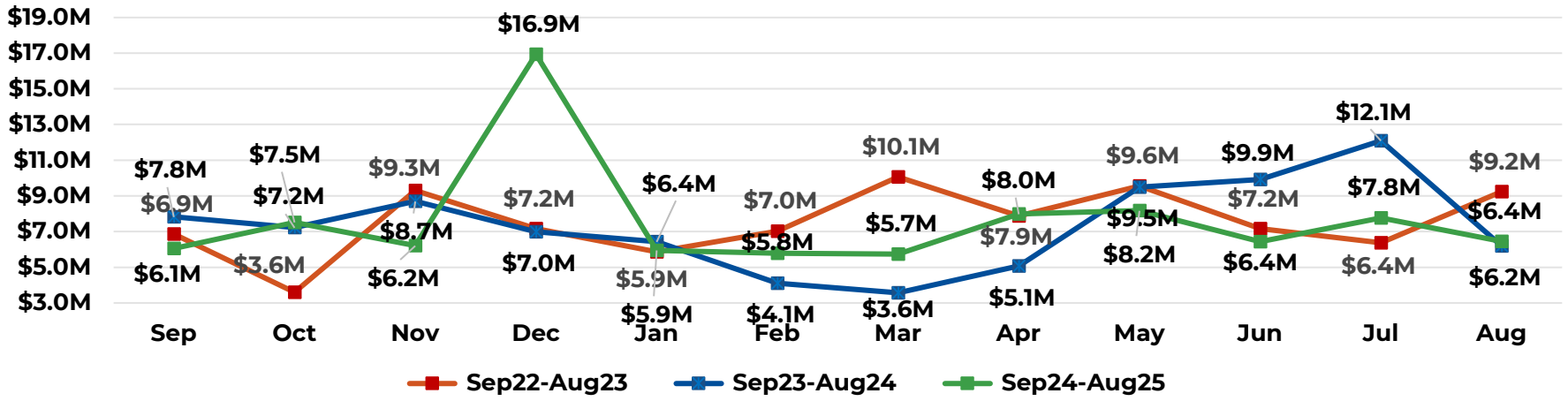


Utilization (Cont.)

Dental Claims - Members Served

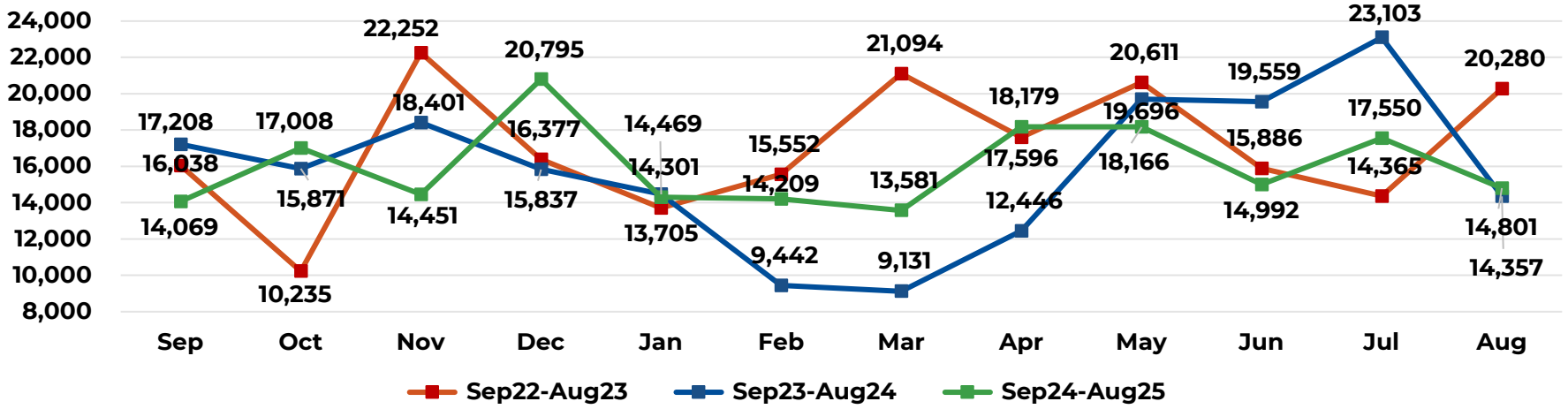


Adult Dental Claims (21 & Over) - Expenditures

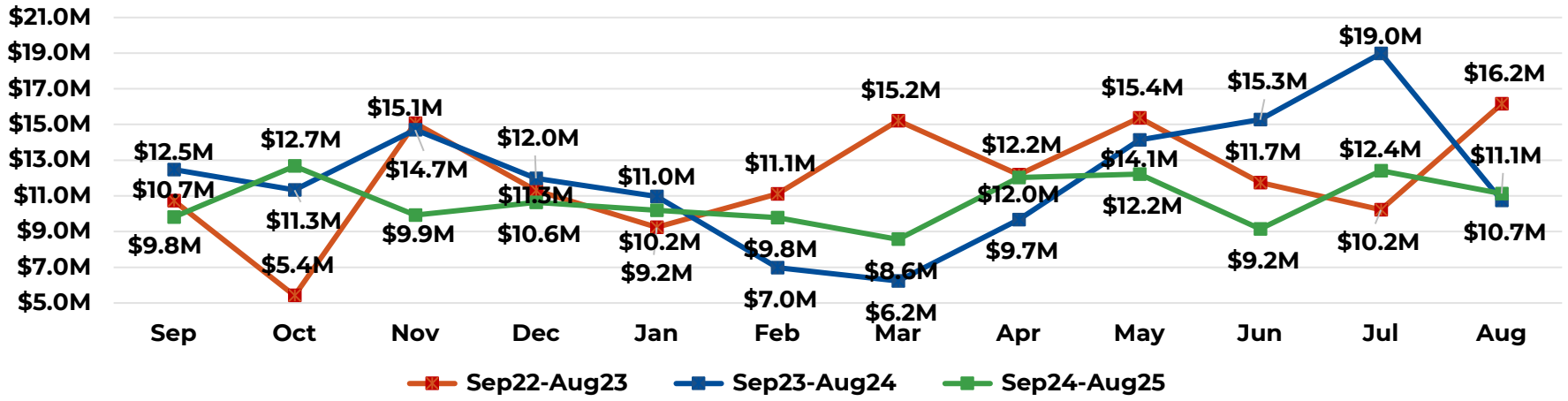


Utilization (Cont.)

Adult Dental Claims (21 & Over) - Members Served

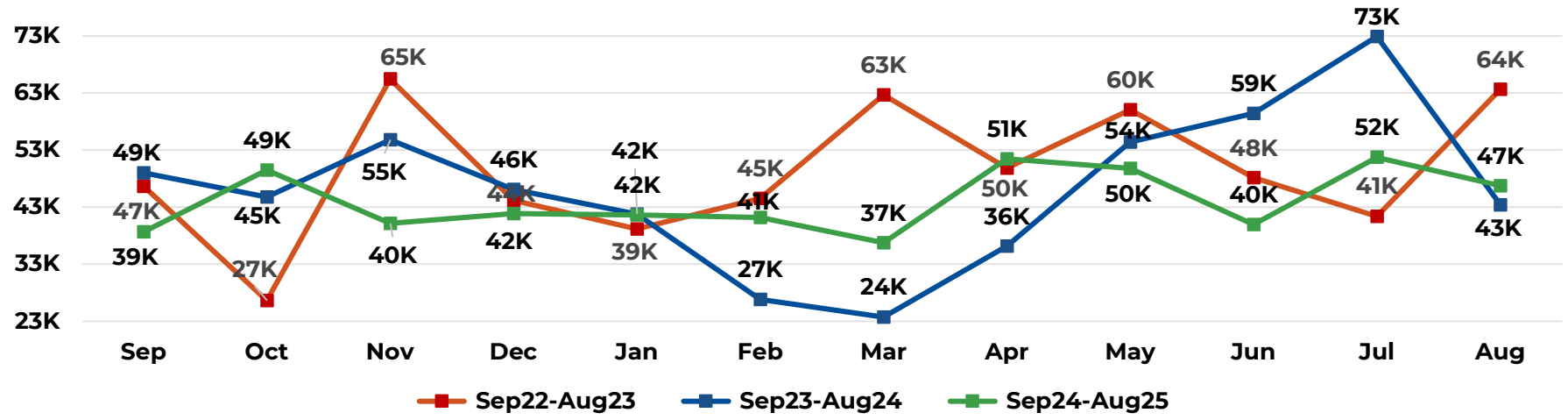


Children Dental Claims (Under 21) - Expenditures

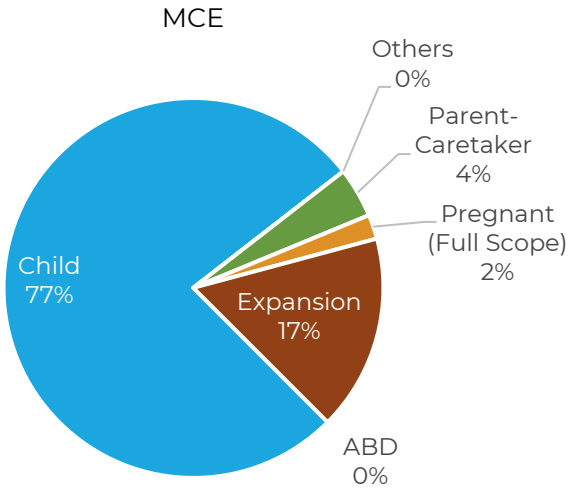


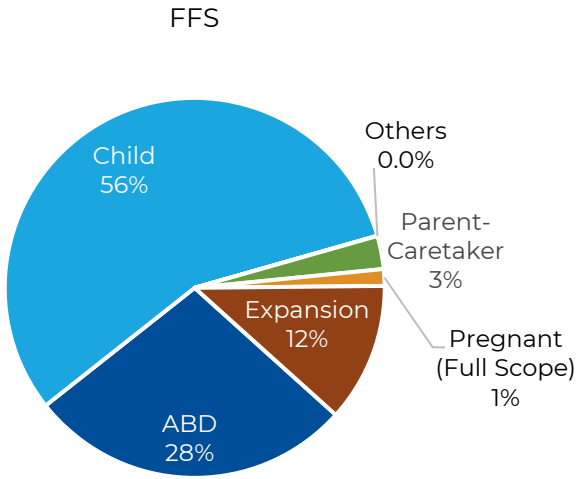
Utilization (Cont.)

Children Dental Claims (Under 21) - Members Served



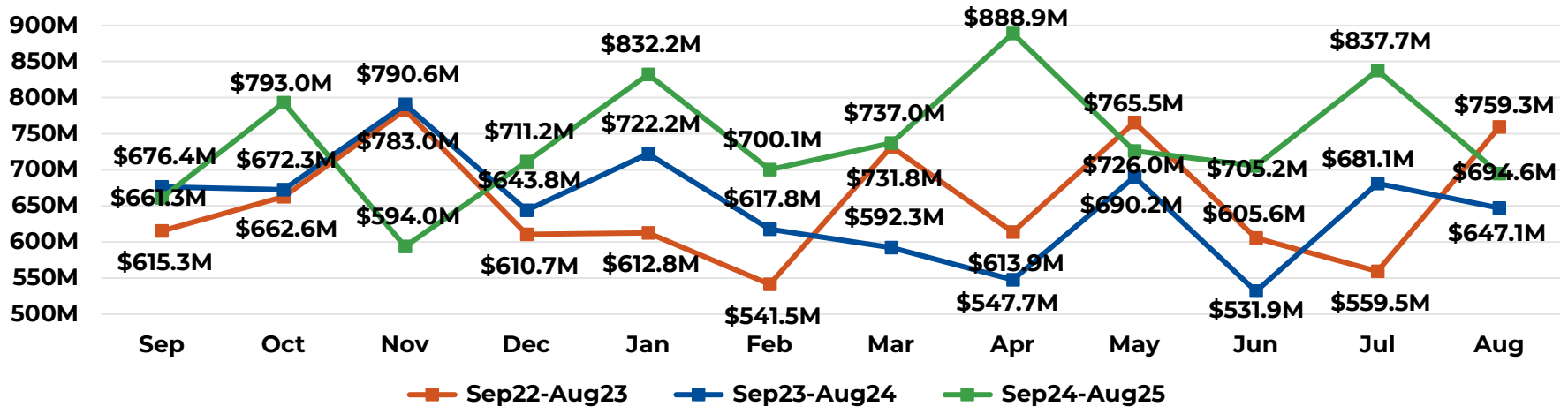
Dental Claims - Members Served By Qualifying Group (Aug2025)



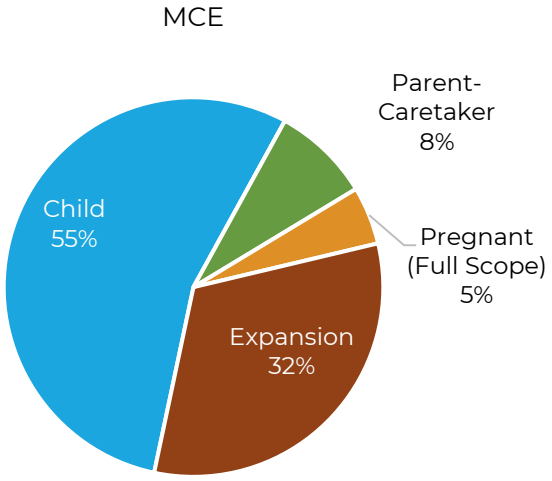


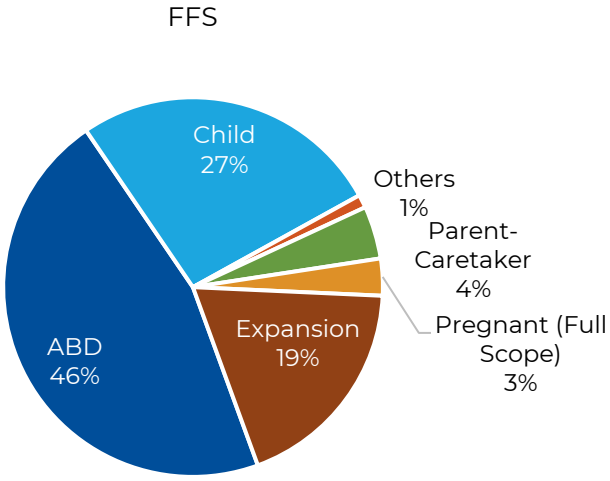
Financials

Total Agency Expenditures



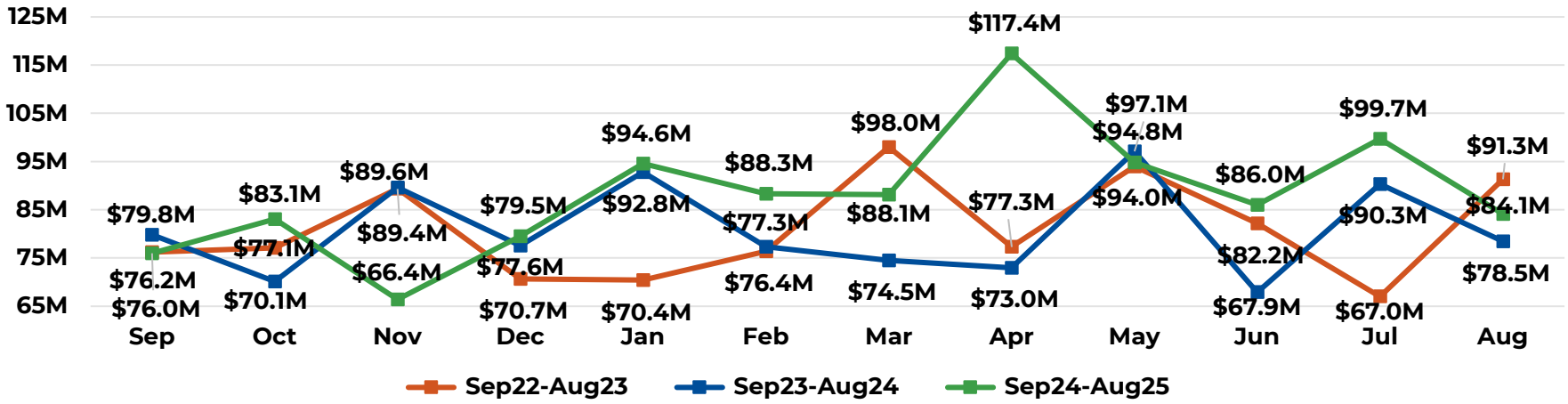
Total Agency Utilization - Members Served By Qualifying Group (Aug2025)





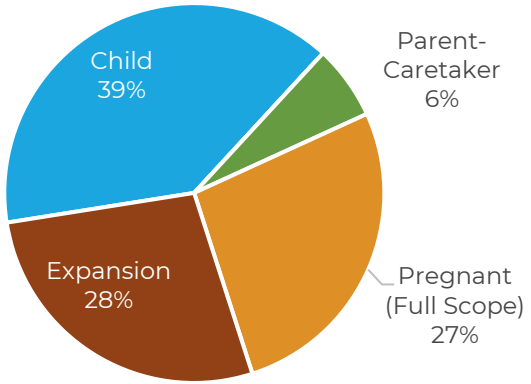
Financials (Cont.)

Inpatient Services - Expenditures

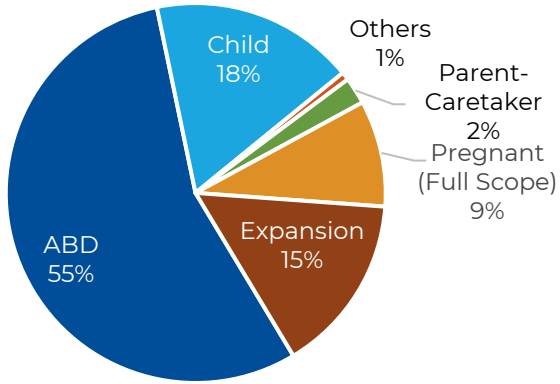


Inpatient Services - Members Served by Qualifying Group (Aug2025)

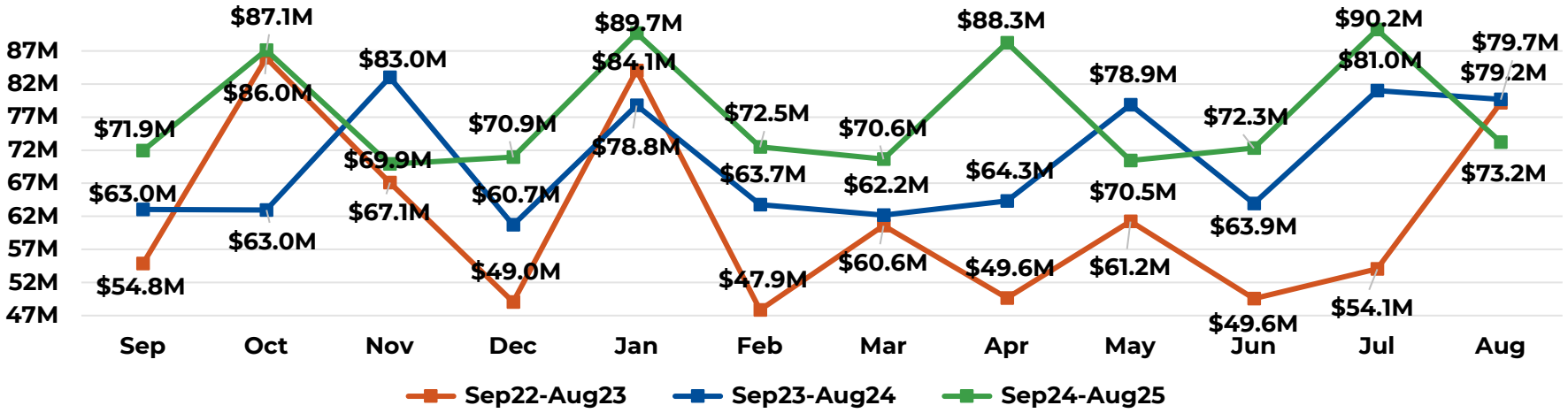
MCE



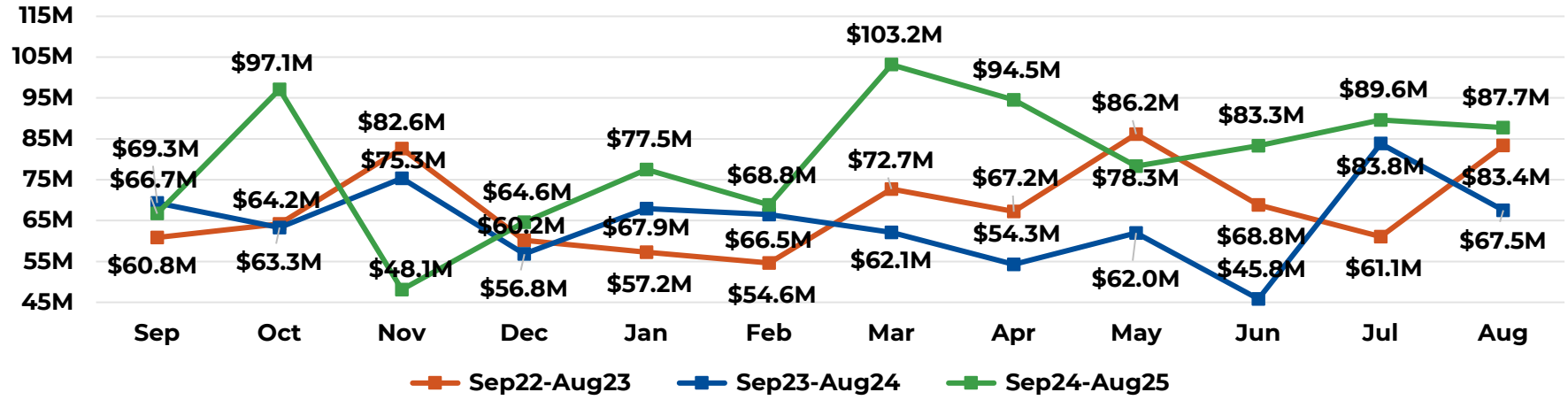
FFS



Nursing Facility Services - Expenditures



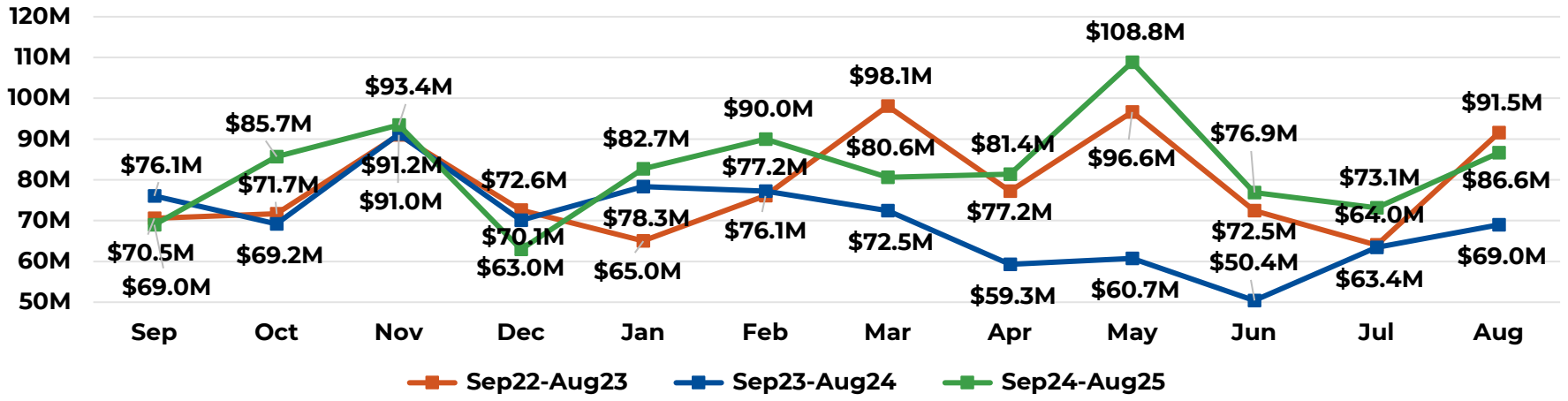
Outpatient Hospital Services - Expenditures



Financials (Cont.)

Outpatient Hospital Services - Members Served By Qualifying Group (Aug2025)

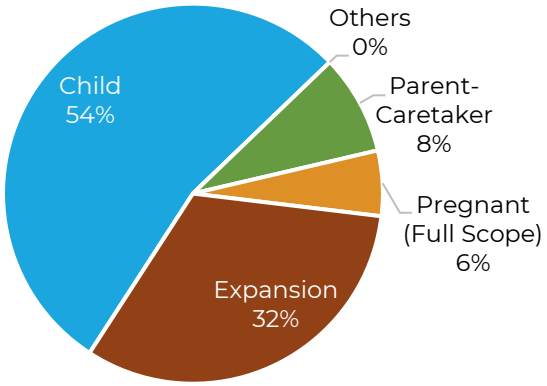
Physician Services - Expenditures



Financials (Cont.)

Physician Services - Members Served By Qualifying Group (Aug2025)

MCE



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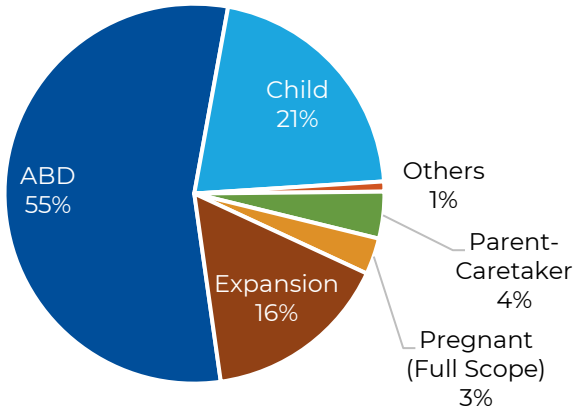
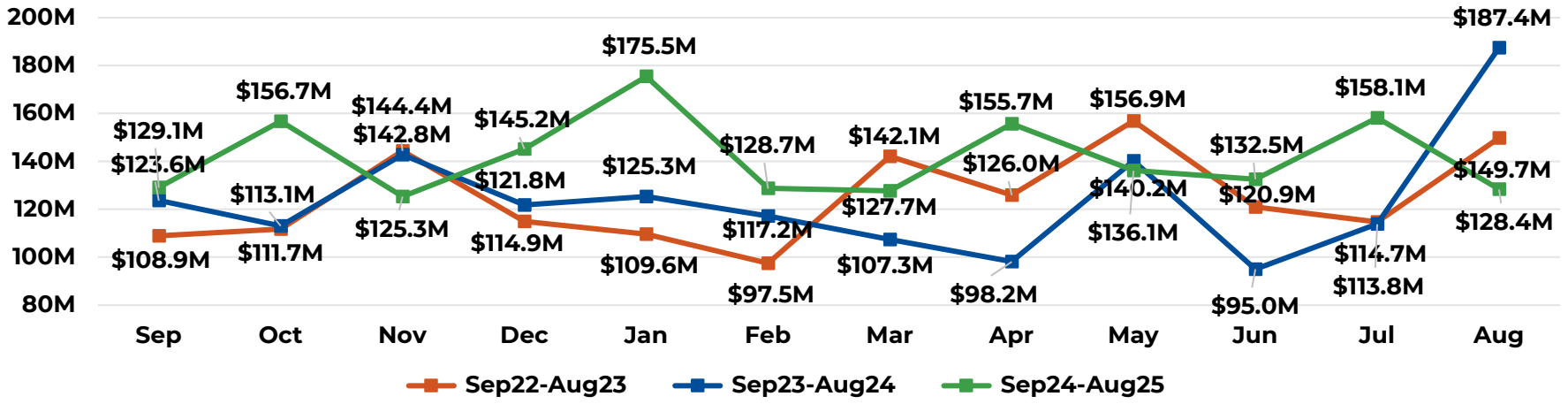


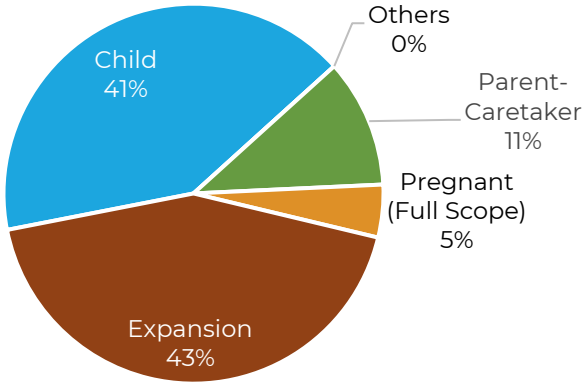
Prescribed Drugs - Expenditures



Financials (Cont.)

Prescribed Drugs - Members Served By Qualifying Group (Aug2025)

MCE



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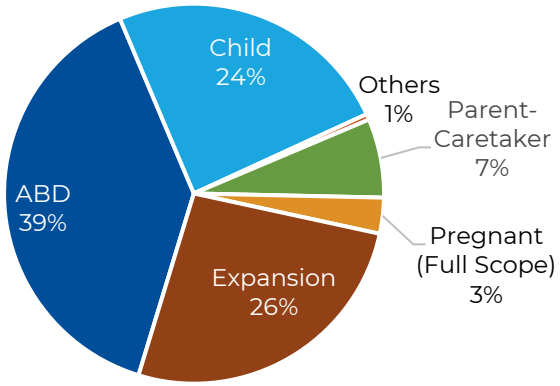
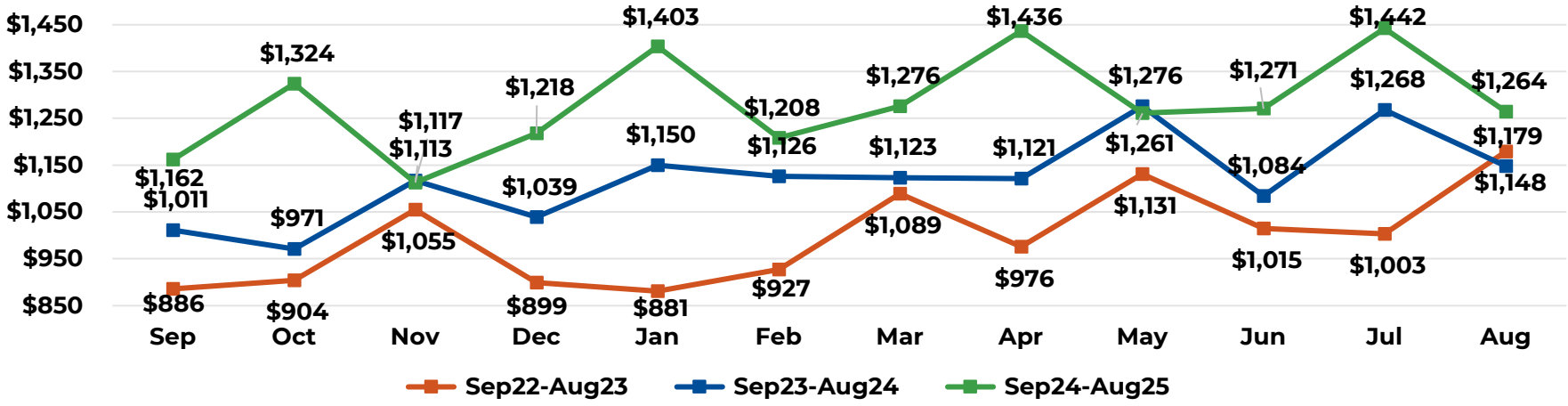
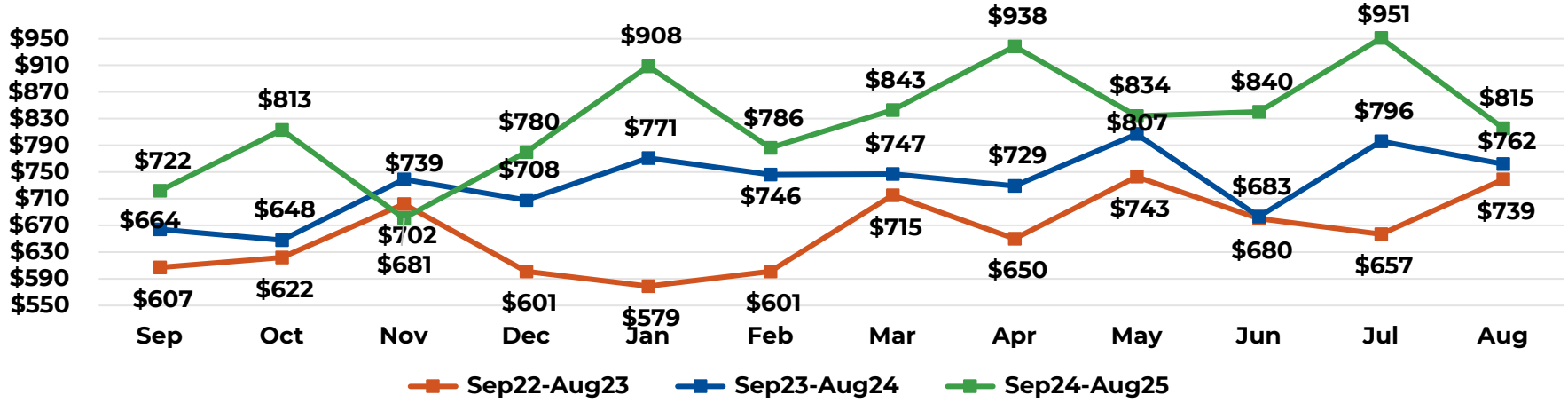


Average Expenditure Per Total Members Served

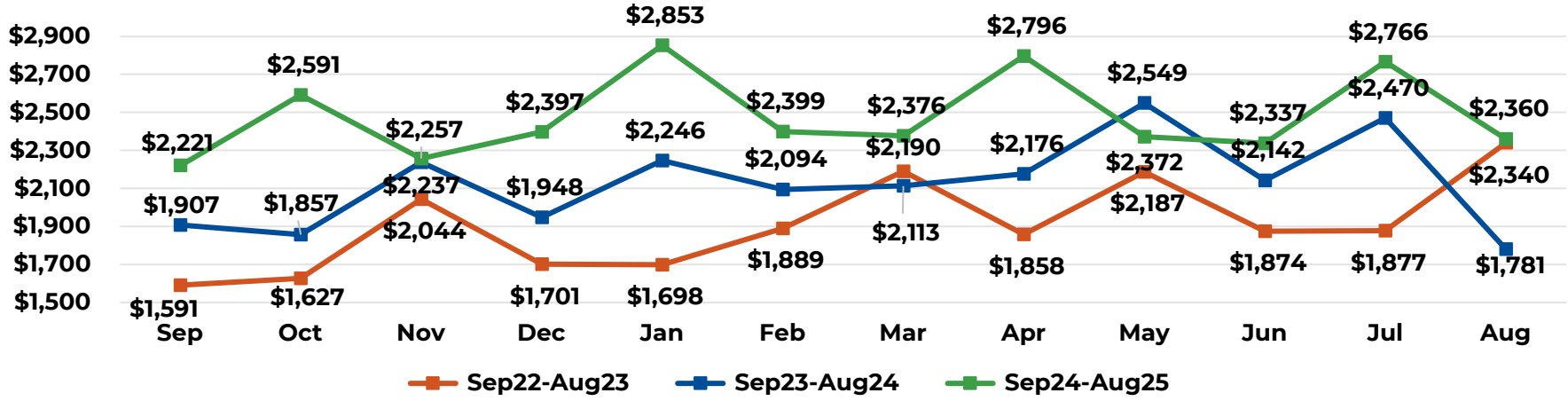


Financials (Cont.)

Average Expenditure Per Child (Under 21) Member Served

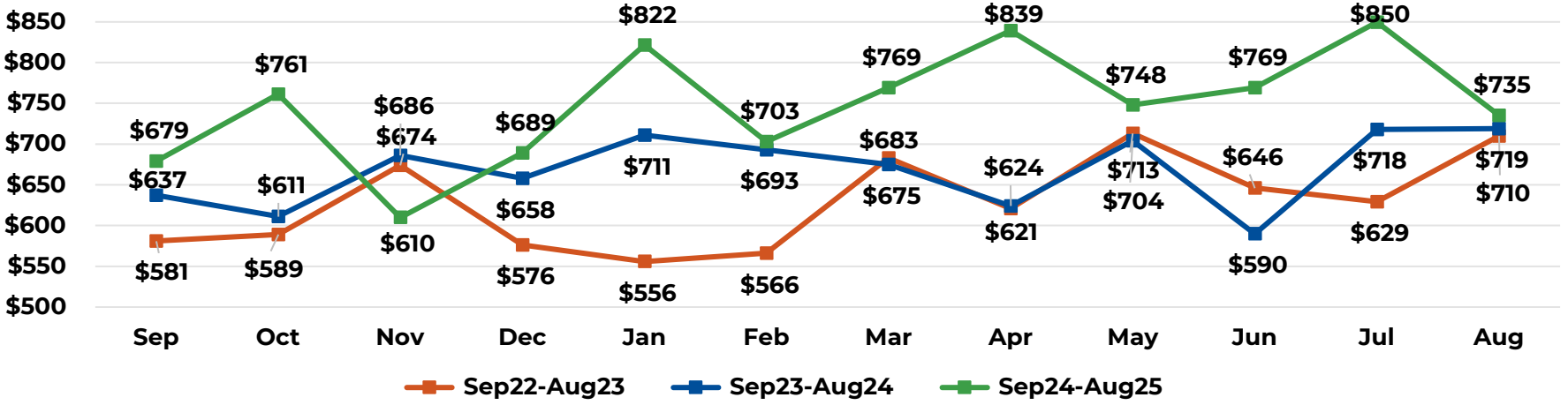


Average Expenditure Per Aged/Blind/Disabled Member Served

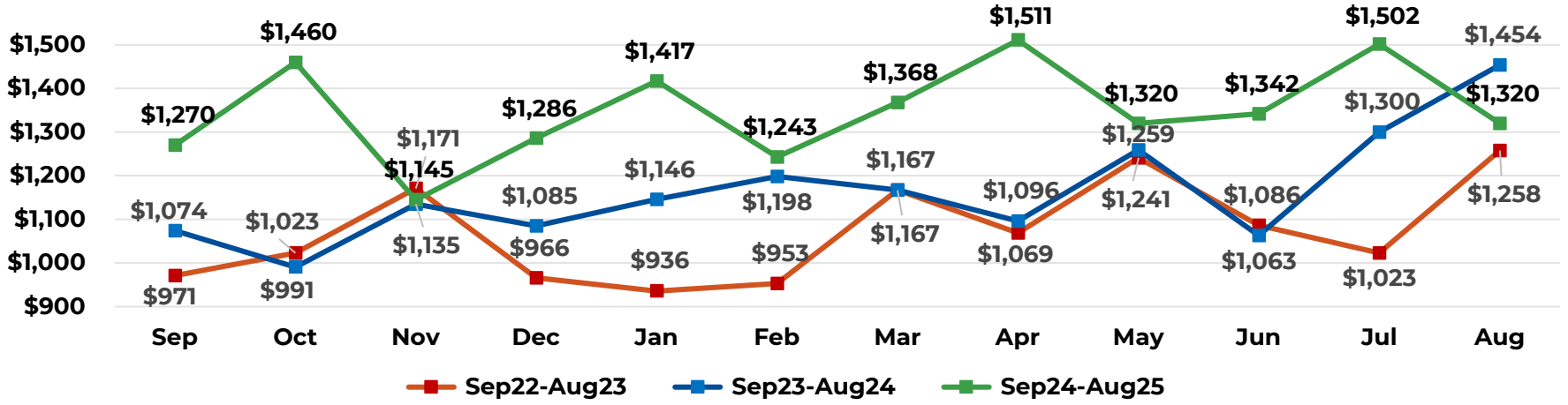


Financials (Cont.)

Average Expenditure Per Children & Parent/Caretaker Member Served

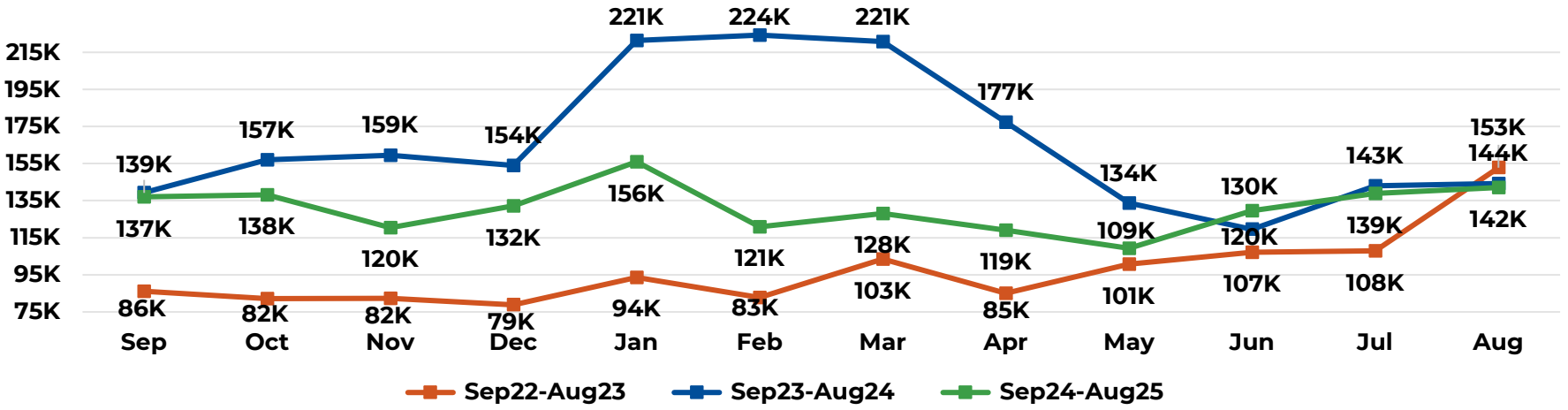


Average Expenditure Per Expansion Member Served

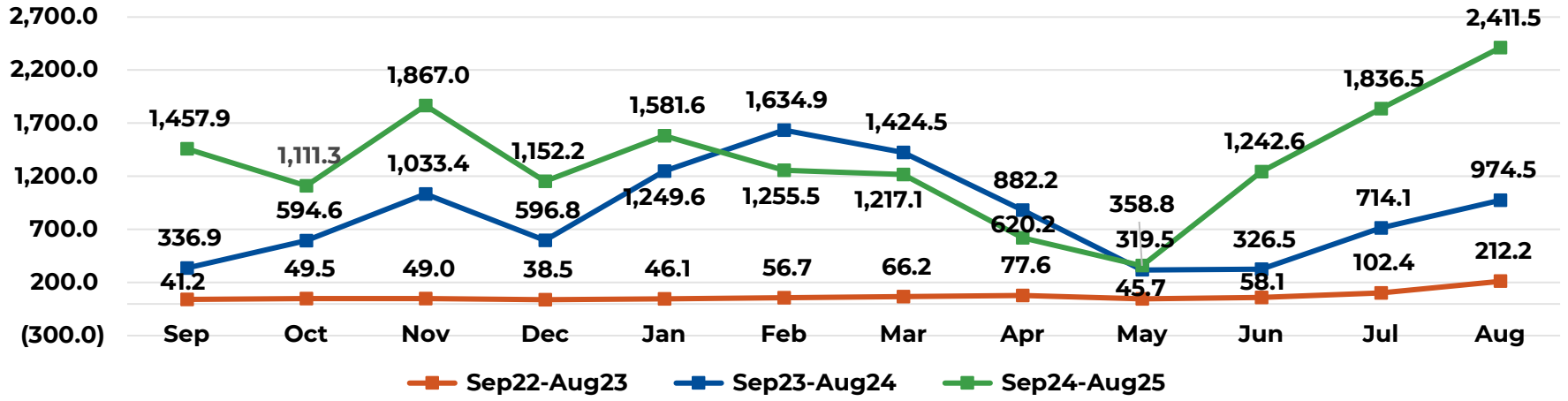


Call Center

Call Center - Member Calls Answered

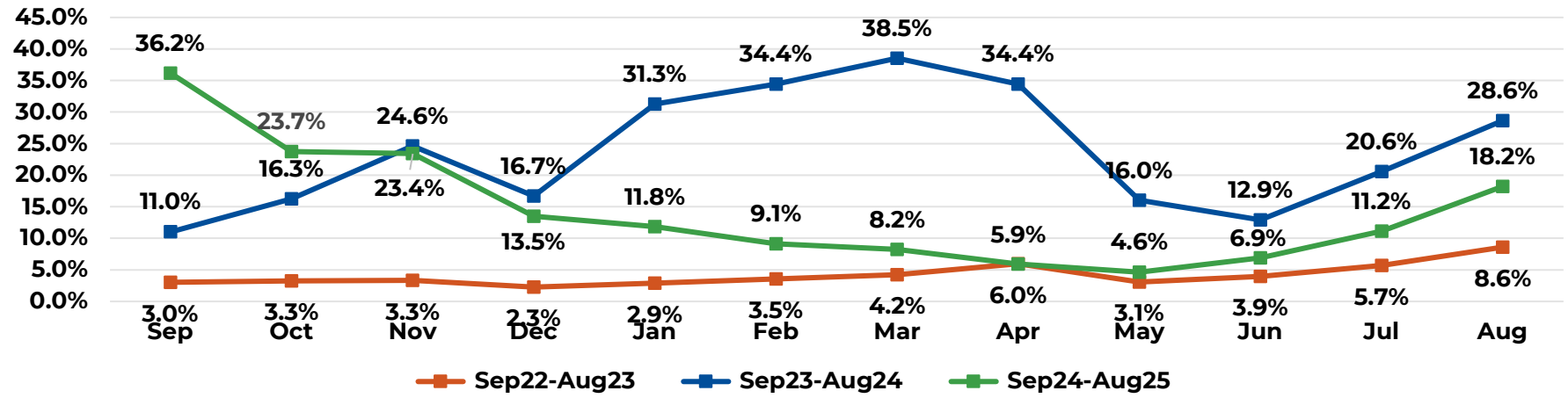


Call Center - Average Wait Time (In Seconds)



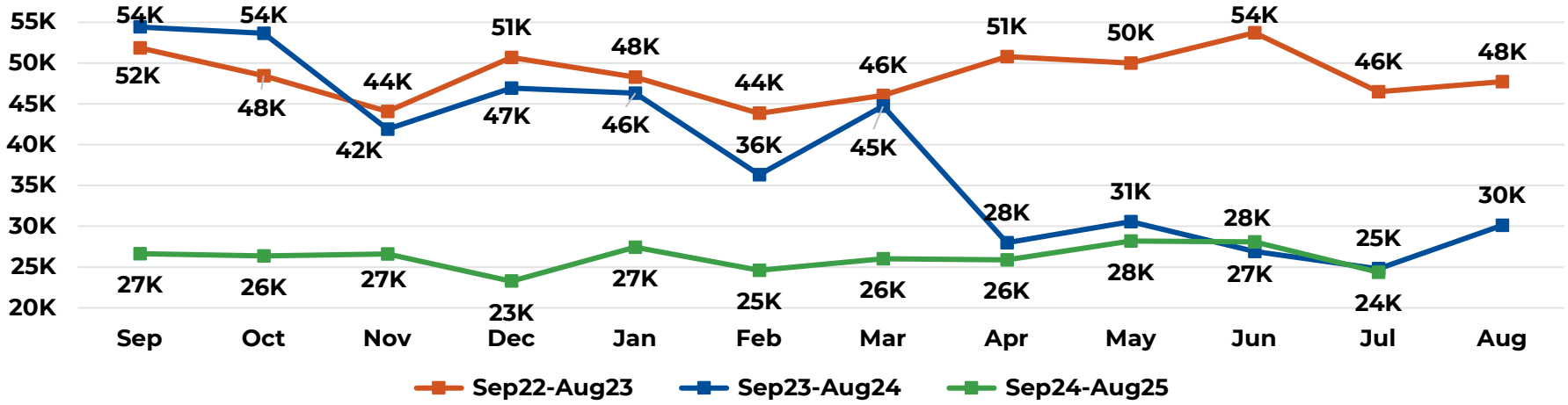
Call Center (Cont.)

Call Center - Abandoned Call Rate



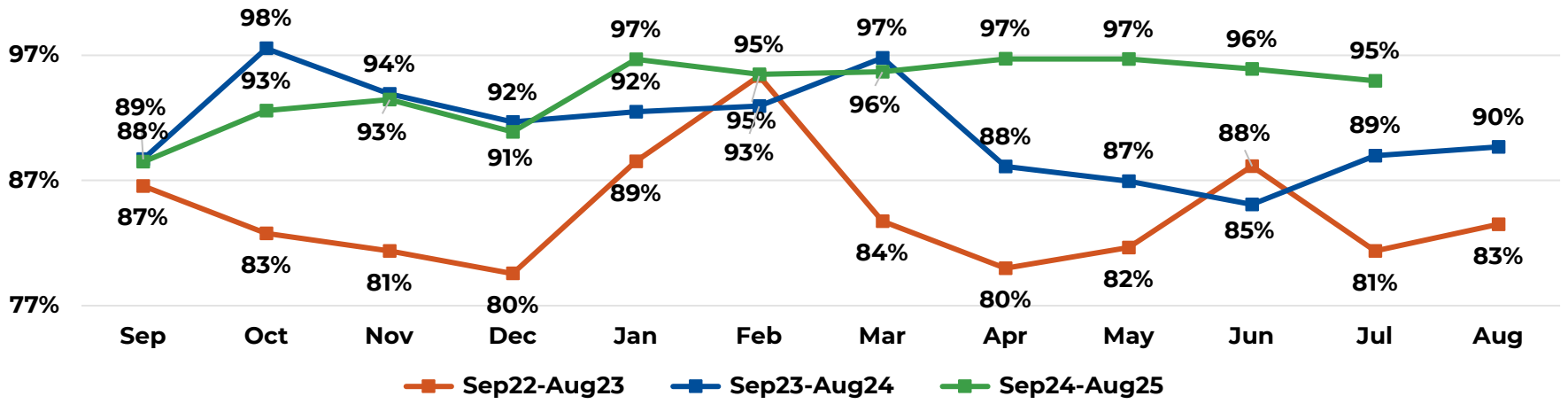
Prior Authorization

Fee-For-Service Prior Authorization - Total Combined - Total Completed PA Volume



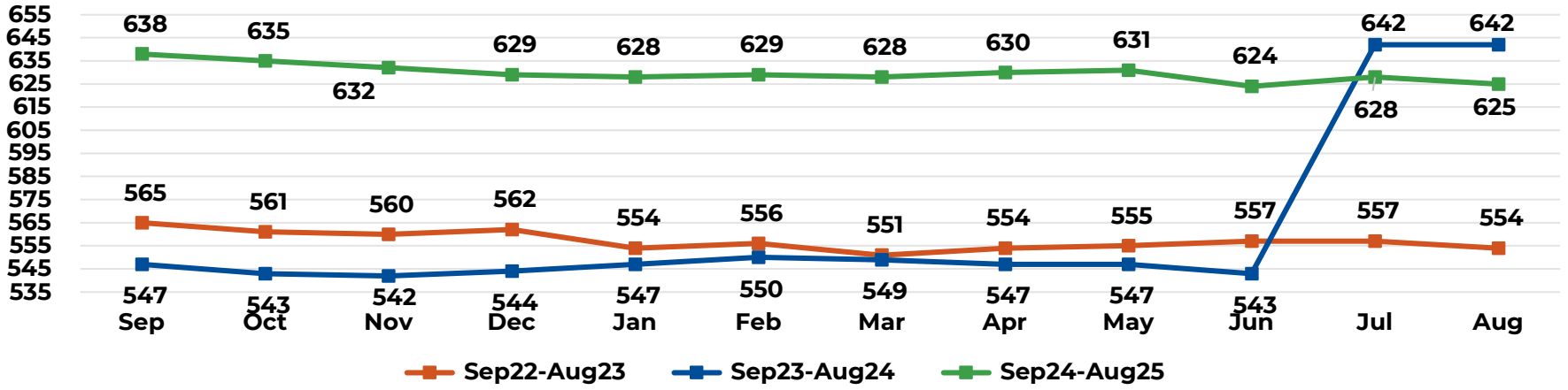
Prior Authorization (Cont.)

Fee-For-Service Prior Authorization - Total Combined - Total Percent Completed 0-6 Days



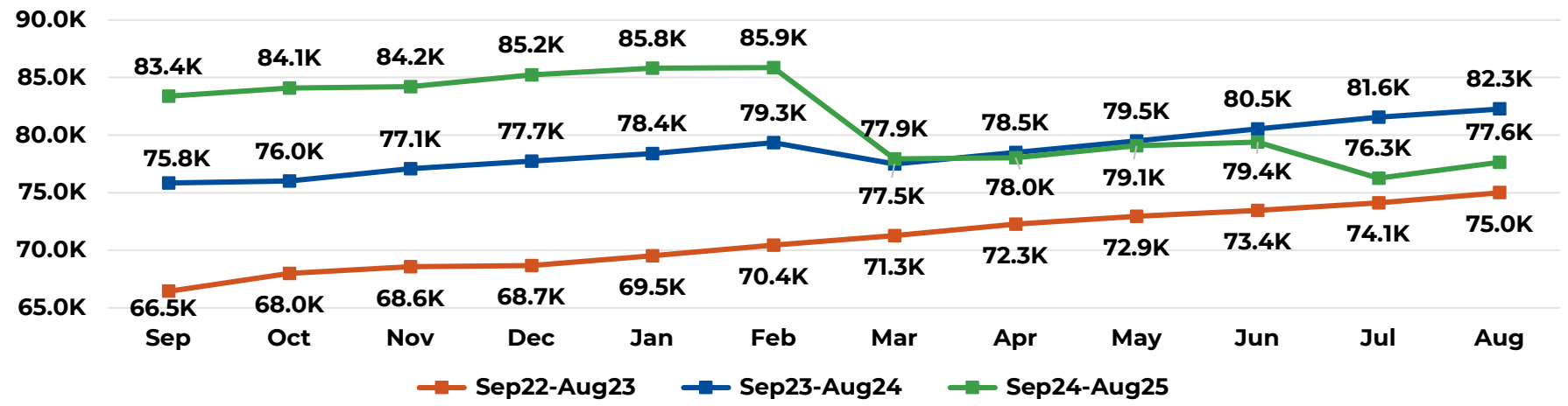
Agency Stats & Provider Network

OHCA Admin - Number of FTEs

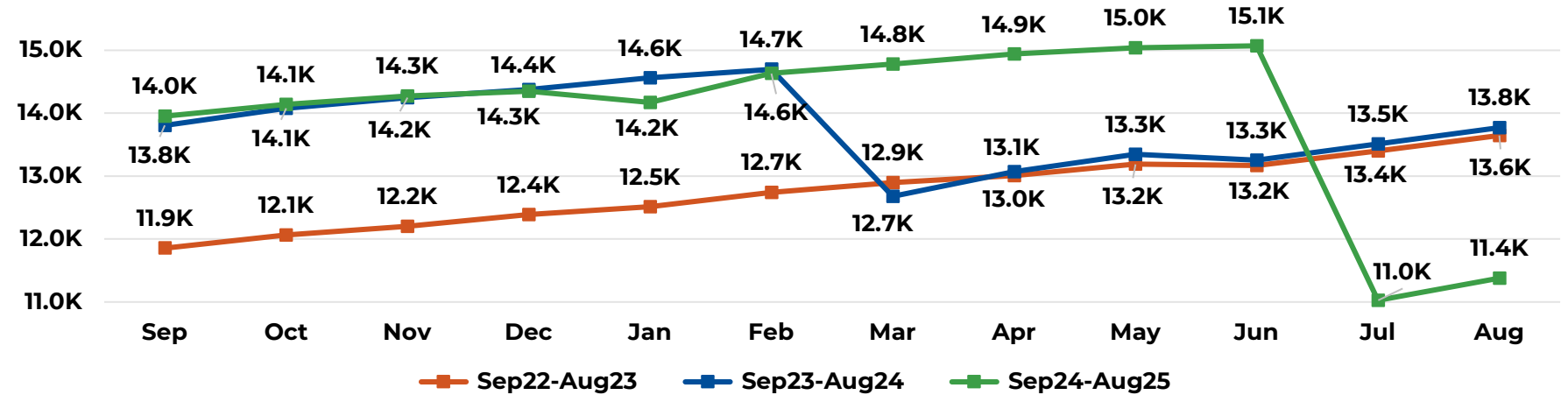


Agency Stats & Provider Network (Cont.)

Total Providers Enrolled (In-State & Out-of-State)

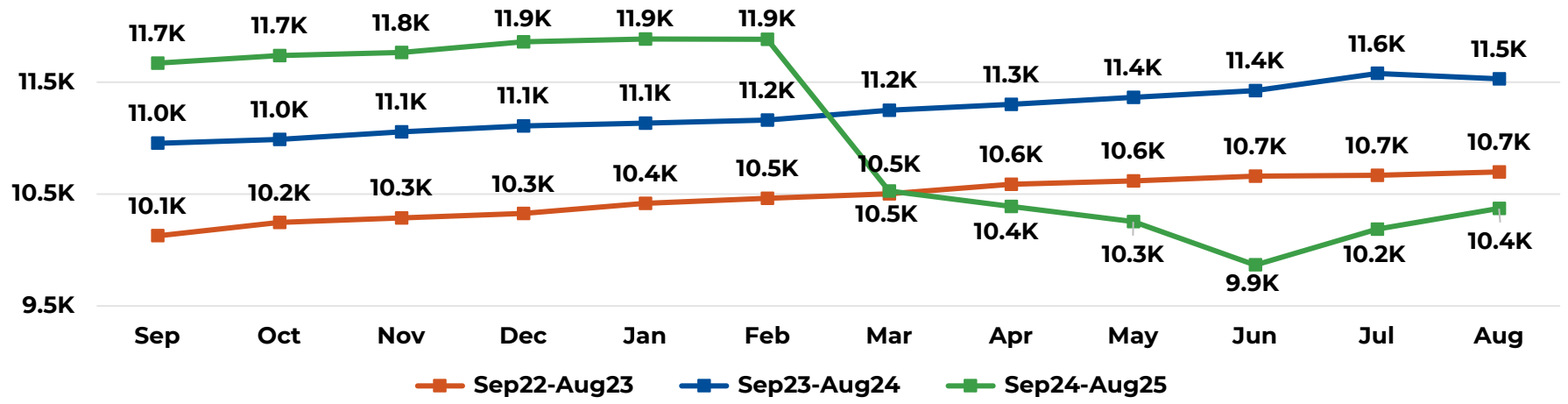


Mental Health Providers Enrolled (In-State Only)

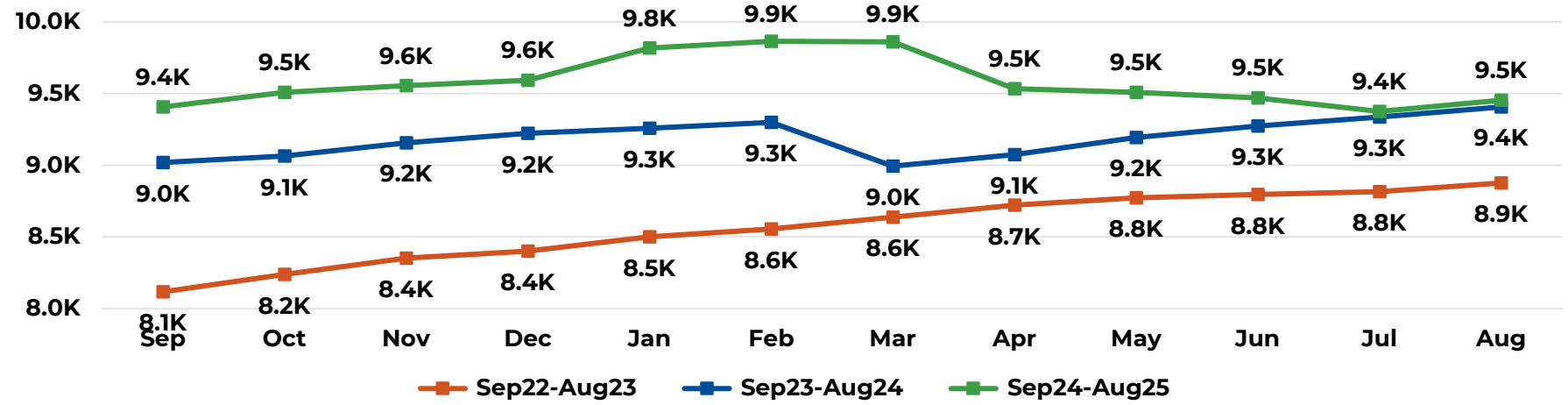


Agency Stats & Provider Network (Cont.)

Physicians Enrolled (In-State Only)

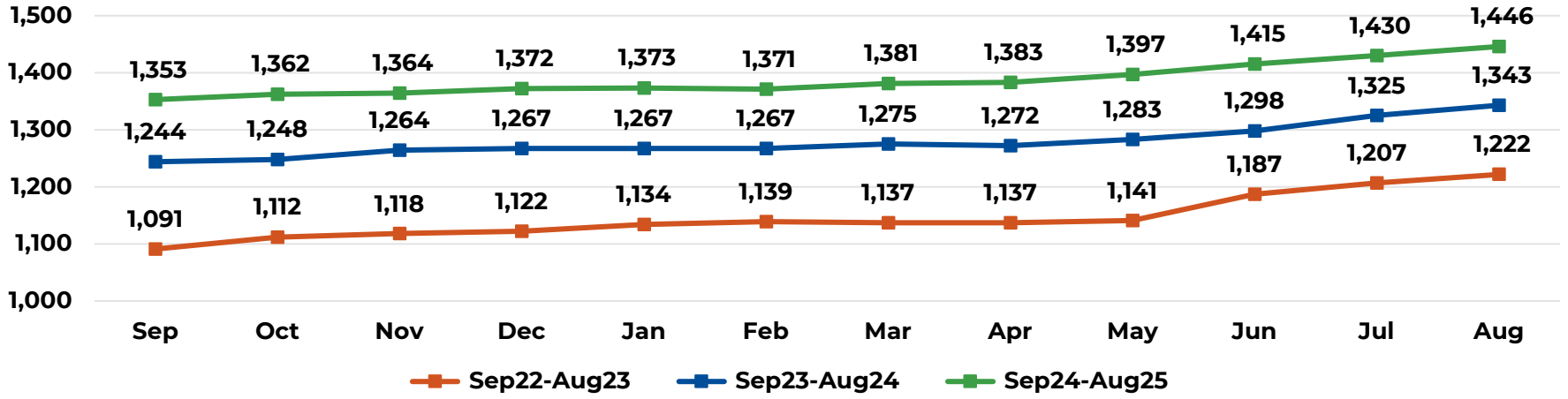


Primary Care Providers Enrolled (In-State Only)

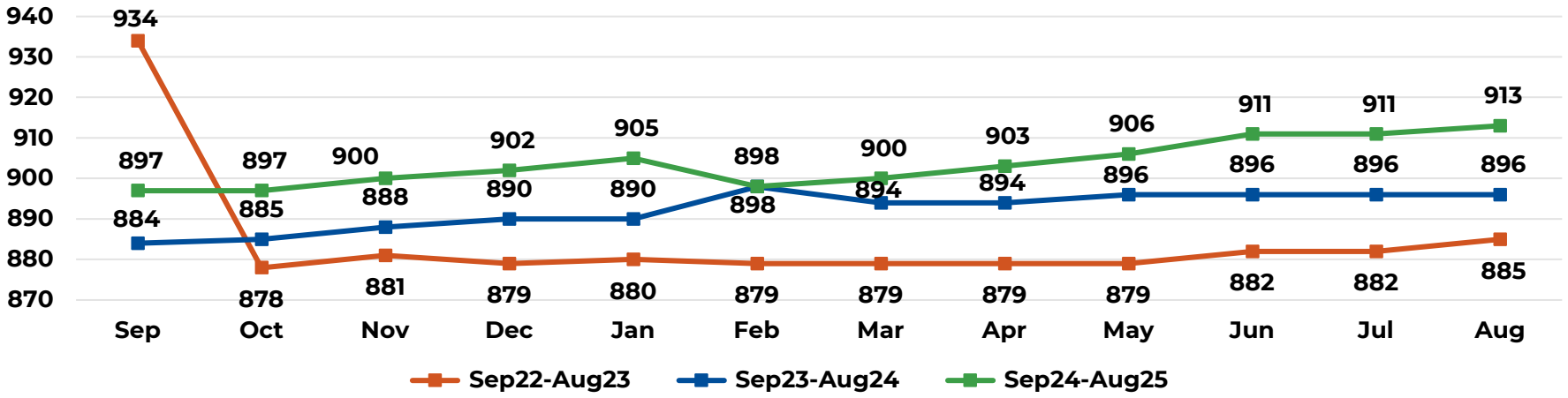


Agency Stats & Provider Network (Cont.)

Dentists Enrolled (In-State Only)

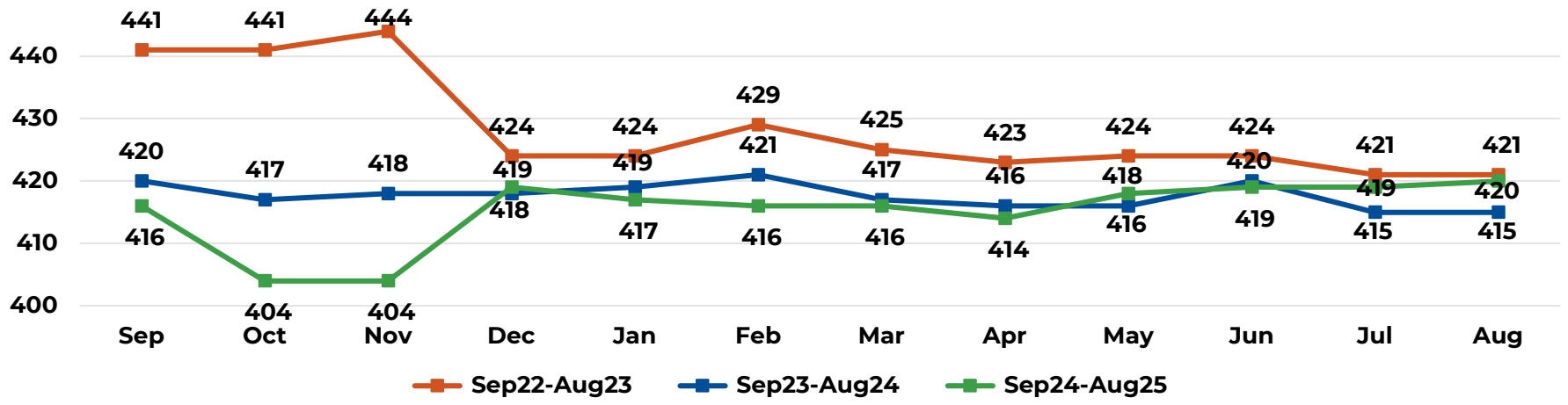


Pharmacy Enrolled (In-State Only)

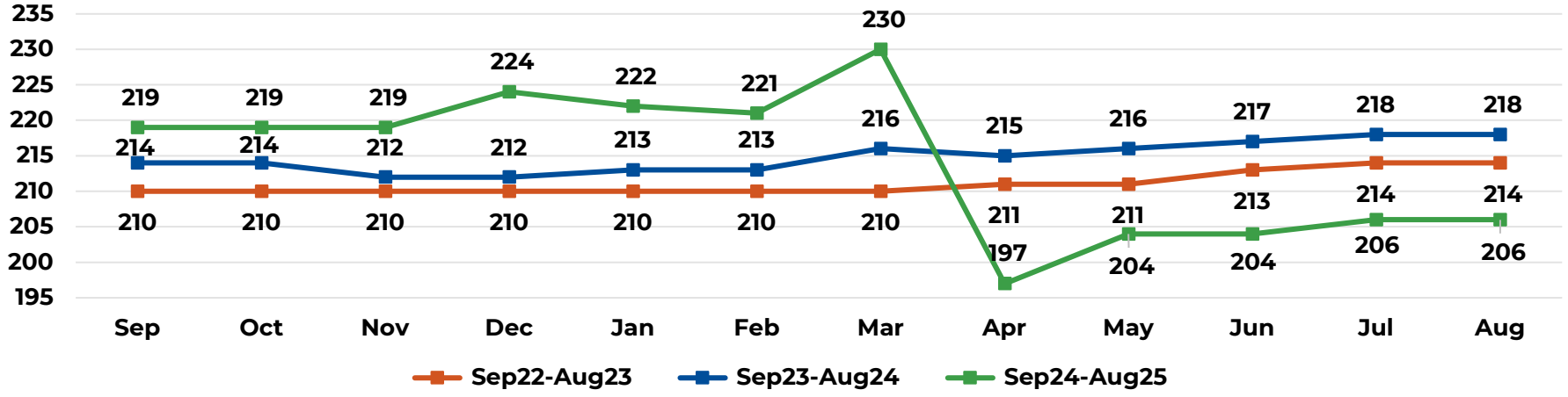


Agency Stats & Provider Network (Cont.)

Extended Care Facilities Enrolled (In-State Only)

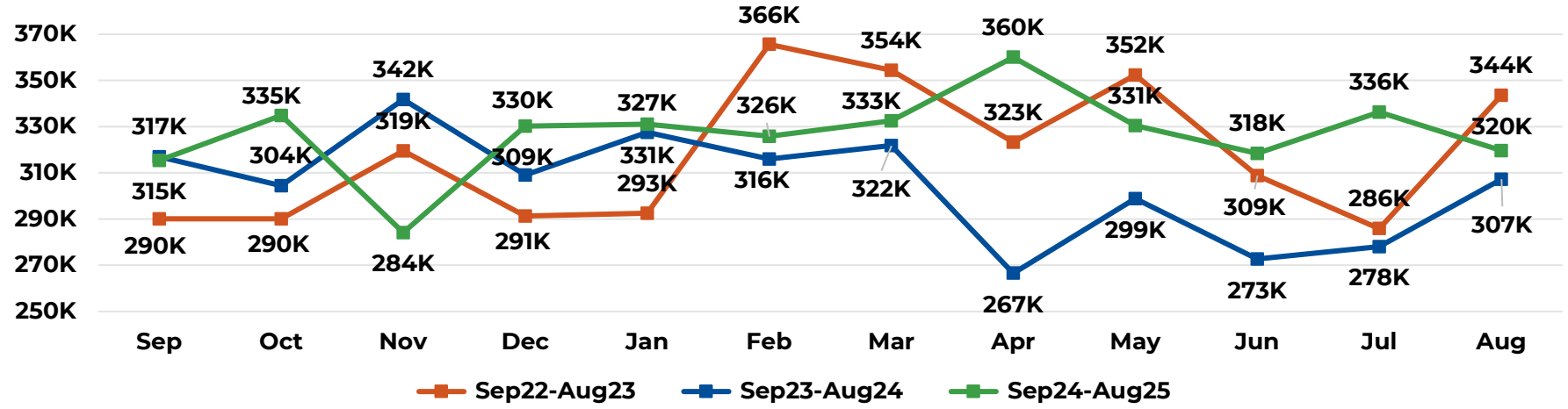


Hospitals Enrolled (In-State Only)



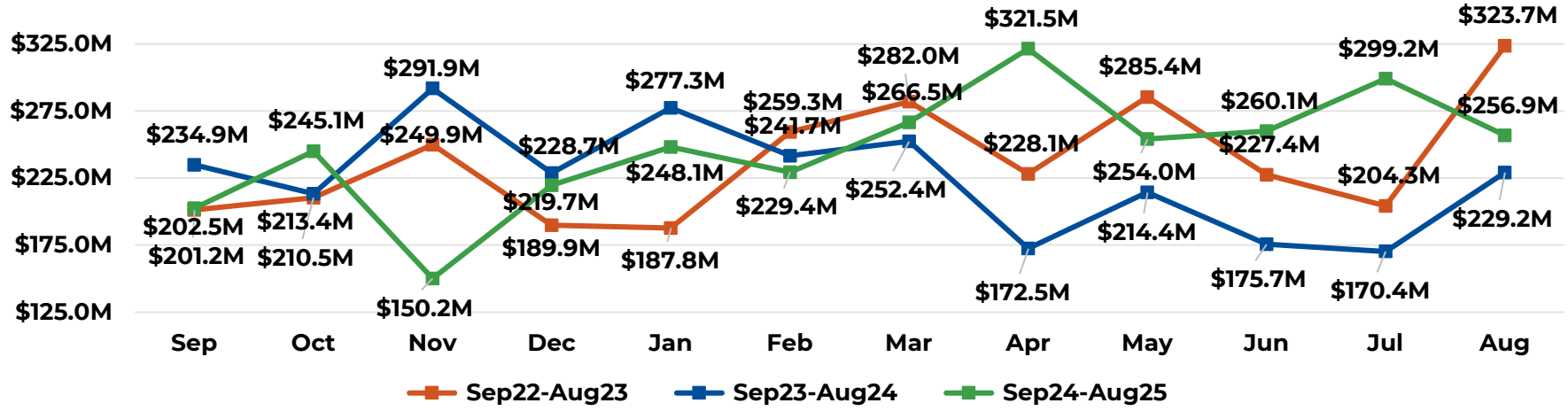
MCE Utilization

Total MCE Members Served - Medical & Dental (All MCEs)



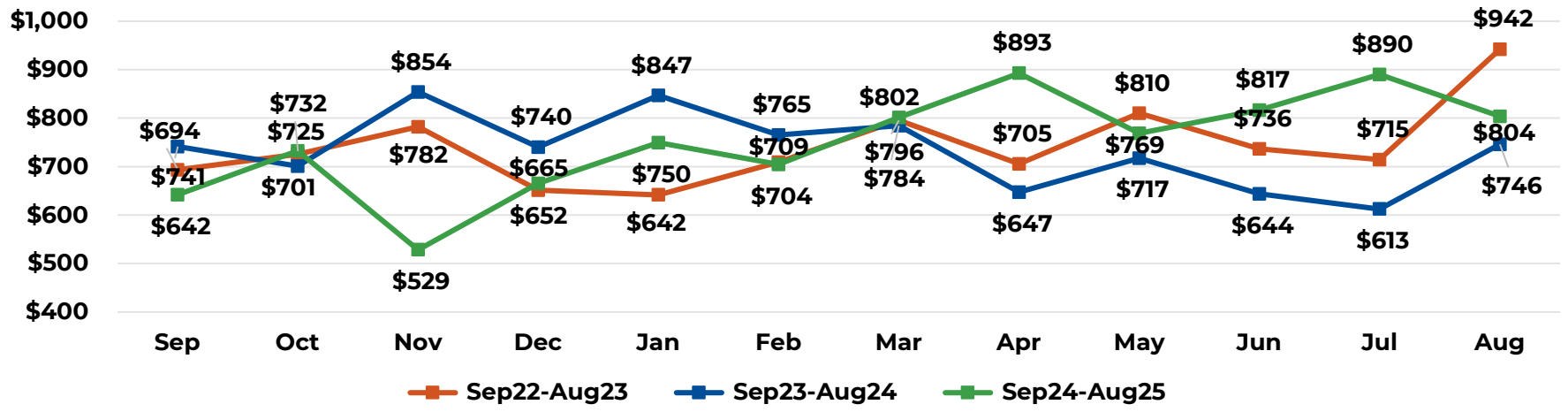
For MCE members served, expenditures and average per member, the data through June 2024 is MCE comparable group which is non ABD members eligible for MCE (Expansion, Parent/Caretaker, Non ABD Children, Full Scope Pregnant, etc.). Excludes tribal members since had low MCE opt-in. Data starting July 2024 is MCE claims based on MCE claim region codes (30, 68).

Total MCE Expenditures - Medical & Dental (All MCEs)

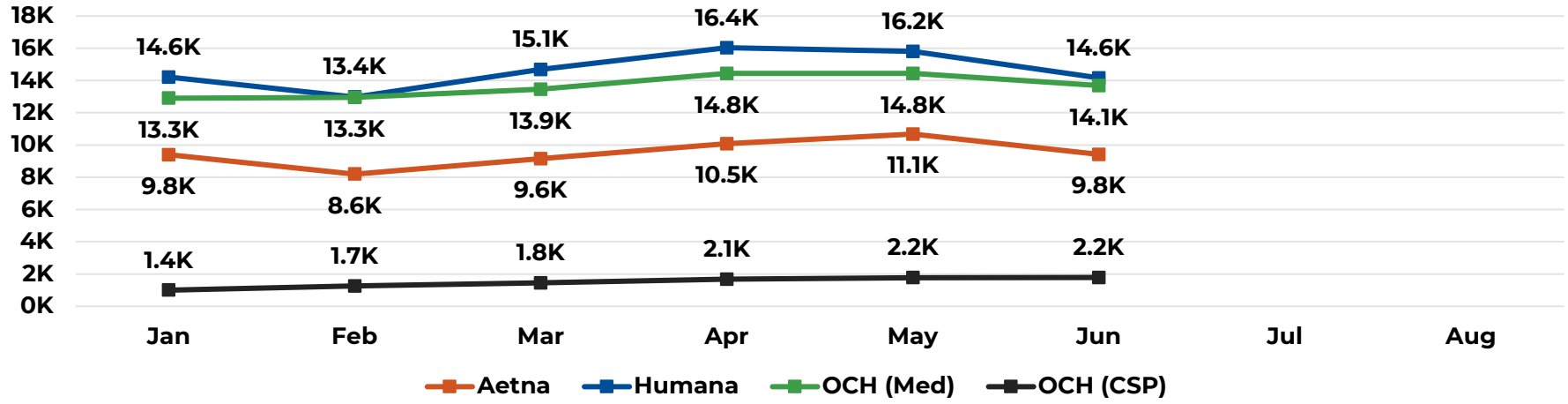


MCE Utilization (Cont.)

Average Expenditure Per Total MCE Members Served - Medical & Dental (All MCEs)

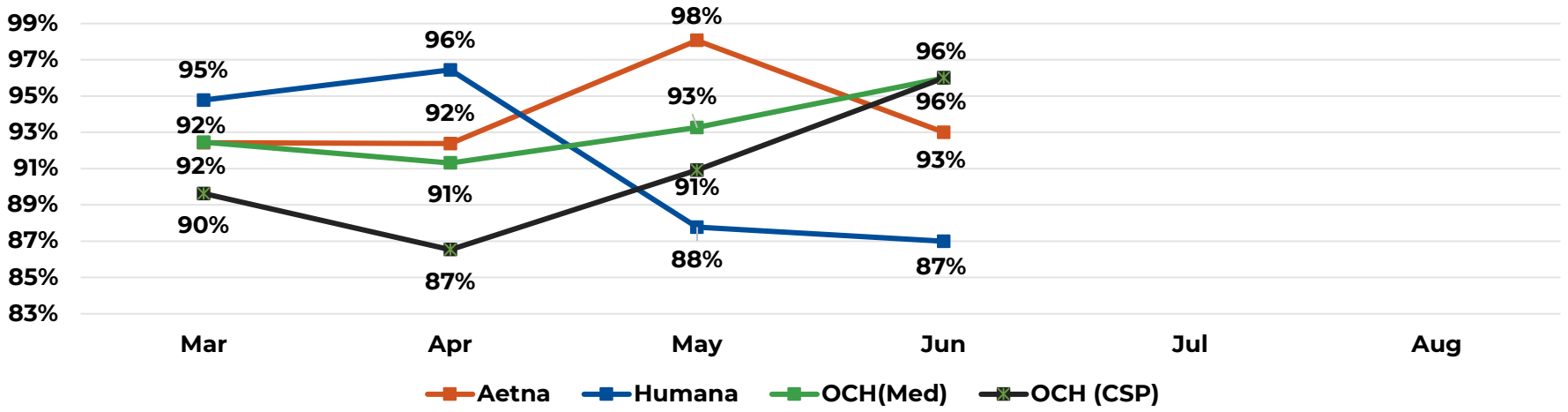


MCE Expedited & Standard Prior Authorization (Medical) - Overall PA Count

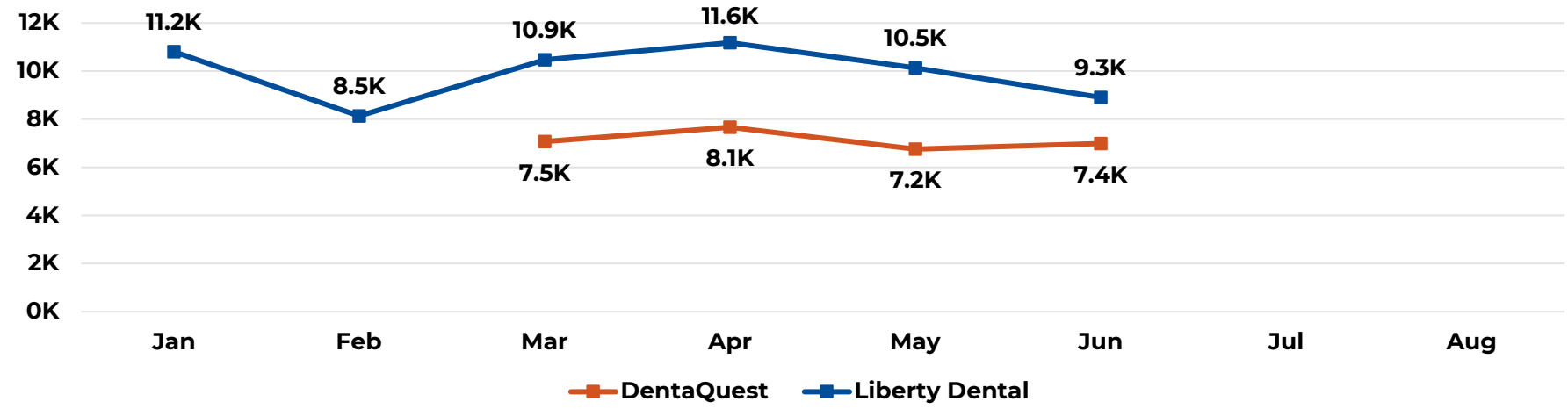


MCE Utilization (Cont.)

MCE Expedited & Standard Prior Authorization (Medical) - % Completed Within Contractually Allotted Base Time

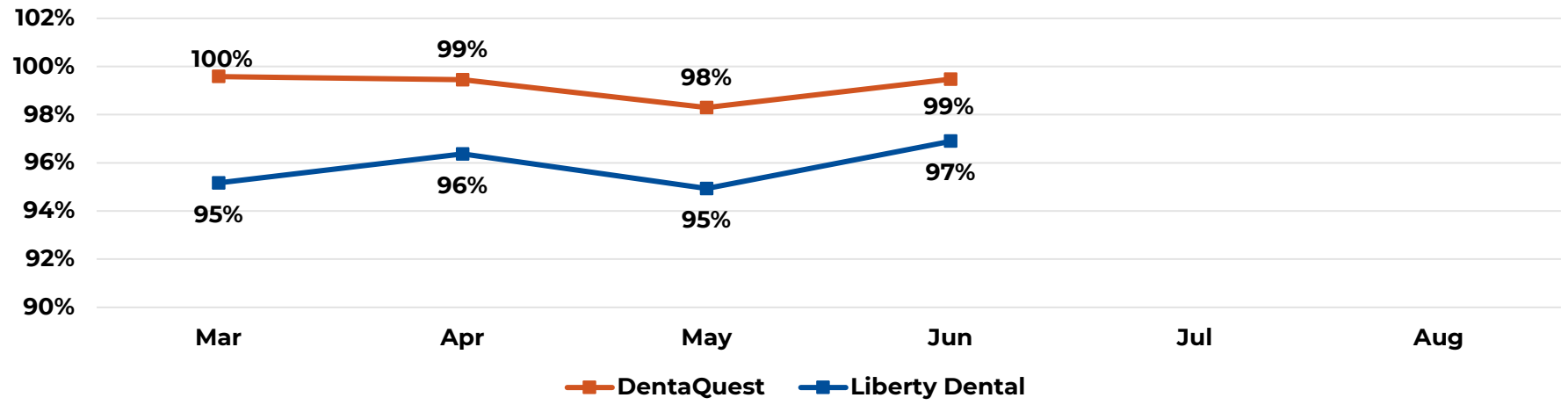


MCE Expedited & Standard Prior Authorization (Dental) - Overall PA Count



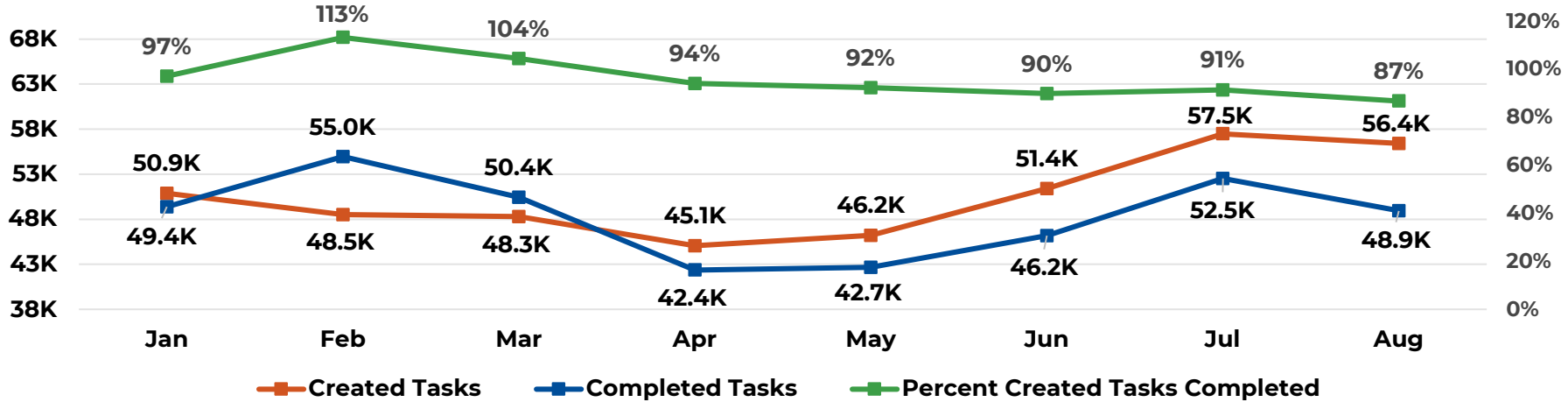
MCE Utilization (Cont.)

MCE Expedited & Standard Prior Authorization (Dental) - Percent Processed Within 72 hrs



Workflow - Productivity

Created & Completed Tasks



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 in 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).

Fee-For-Service Prior Authorization data includes Medical, Therapy, Dental and DME PAs. They are 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.

For MCE members served, expenditures and average per member, the data through June 2024 is MCE comparable group which is non ABD members eligible for MCE (Expansion, Parent/Caretaker, Non ABD Children, Full Scope Pregnant, etc.). Excludes tribal members since had low MCE opt-in. Data starting July 20247 is MCE claims based on MCE claim region codes (30, 68).

MCE Prior Authorization data is from SEL-0500 and DEN-0700.