OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
June 26, 2024, 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_LrSGU26FTk-laiCFZd02UA#/registration
Telephone: 1-669-216-1590 Webinar ID: 161 623 0418

*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 March 20, 2024, OHCA Board Meeting Minutes……..…..……Marc Nuttle, Chair

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

    a) Member Moment

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

    a) Quality Committee Update – Teresa Huggins

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

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

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

Item:	Drug Name:	Used For:
i.	Alinia® Xdemvy™	Giardia Lamblia and Cryptosporidium Parvum infections Demodex Blepharitis
ii.	Ycanth™ Zelsuvmi™	Molluscum Contagiosum
iii.	Vanfkyta®	Acute Myeloid Leukemia
iv.	Columvi™ Epkinly™	Diffuse Large B-Cell Lymphoma
v.	Roctavian™	Hemophilia A
vi.	Ryzneuta®	Febrile Neutropenia
vii.	Tyruko®	Multiple Sclerosis
viii.	Aphexda®	Mobilization of Stem Cells

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

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

   i. Regular Nursing Facilities Rate Increase
   ii. Acquired Immune Deficiency Syndrome (AIDS) 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

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

   i. Customer Relationship Management (CRM)
   ii. Technical Consultant for the Medicaid Management Information System (MMIS) Modernization and Implementation of the Transformation Management Office – Phase 2
   iii. Third Party Liability (TPL) Systems
   iv. MyHealth

c) Presentation of the SFY 2025 Budget Work Program by Aaron Morris, Chief Financial Officer (Attachment "F")

d) Discussion and Possible Vote on the SFY 2025 Budget Work Program pursuant to 63 O.S. Section 5008(B)(3)

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

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

   i. APA WF # 24-15 Third Party Liability (TPL) Prior Authorization

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

11. Adjournment…….Marc Nuttle, Chair

NEXT BOARD MEETING
September 18, 2024, 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
March 20, 2024
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on March 19, 2024 at 2:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of the statutory public notice, the agency placed its agenda on its website on March 15, 2024 at 3:17 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 2:02 p.m.

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

ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON THE JANUARY 17, 2024, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Member Jolley moved for approval of the January 17, 2024, board meeting minutes, as published. The motion was seconded by Member Christ.

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

ABSTAINED: Vice-Chairman Yaffe

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

CEO Buettner invited Carolyn Reconnu-Shoffner to provide a member moment.

CEO Buettner highlighted Best in Class and Outcome-Driven, which is one of OHCA's Key Principles, while also highlighting staff that earned their Lean Six Sigma Green Belt. The team worked for months, with facilitation from instructors from Francis Tuttle and Datum Solutions, to train on Lean Six Sigma principles of process improvements. The team proactively recruited projects from within the OHCA divisions that ranged from more internal data-driven processes to those that have a more direct member impact. CEO Buettner also update on a few key initiatives and stakeholder engagement.

Key Initiatives:

- SoonerSelect & PHE – CEO Buettner was excited to announce that OHCA was 12 days out to go-live for medical and children's specialty programs. A SoonerSelect Go-Live celebration has been scheduled for April 1st, at OHCA, at 3:30 p.m. She also announced that as of March 19th, OHCA had received approval on all seven directed payments pre-prints. To date, OHCA has done about 86 outreach events in partnership with the plans across the state. We have received a lot of positive feedback from members and providers on the level of customer service they have received, both from the Eligibility & Coverage Services team and the SoonerSelect Office team, as well as from the contracted entities.

- Administrative – CEO Buettner announced that Dr. Corey Finch, now former board member, has resigned his position officially on the board and is our new Secretary of Health and Mental Health. The Governor is actively working on appointing a new board member to fill that vacancy. She added that Allie Friesen was recently appointed as the new Commissioner of the Department of Mental Health and Substance Abuse Services. After further financial discussions with leadership from both agencies, it was discovered that it was not going to be financially advantageous for either agency, so the Department of Corrections will also occupy the third floor. The OHCA HR team held a workshop with the OHCA leadership and extended leadership teams. They are in the process of compiling data to solidify an action for development.

- Legislative – OHCA has participated in a few budget hearings. OHCA had a Senate Health and Human Services Subcommittee Appropriations Meeting, as well as a House Health and Human Services Appropriations Meeting. OHCA was also called in the first week of session to present to the full appropriations meeting, essentially to talk

through the OHCA budget request, what the OHCA needs are for the next year, as the Senate is working on a more transparent budget resolution. Earlier this week, the Senate came out with their proposed budget resolution. The proposal for the Health Care Authority is our request, so there are no concerns with their resolution. The negotiations will now go to the House and include the Governor. SB 1310 and HB 3508 are two vehicles that would move EGID, which is the state employees' health insurance program, from oversight of OMES to OHCA. OHCA is looking into what that would look like from an FTE and oversight standpoint. In terms of the board, EGID has their own advisory board. OHCA continues to monitor the legislation and doing some preliminary thoughts on what it will look like.

- PHE Follow-Up – CMS has initiated their audit on our PHE process. The kickoff meeting took place last week. OHCA staff believe CMS will primarily be looking at compliance with federal regs and guidance in the disenrollment process, specifically focusing on those procedural terminations. OHCA will provide updates as the audit moves forward.

- Traction – CEO Buettner provided an update on the Patient Centered Medical Health redesign for the populations that remain with OHCA. The team will be doing outreach to providers that have a census of over 100,000 aged, blind, and disabled members in their medical home to see how those members would be impacted and what their thoughts are on ways that the process could be improved. Similar work is also being done to assess the effectiveness of the current model for the AI/AN population and using the same principles.

Stakeholder Engagement – CEO Buettner highlighted a few stakeholder engagements, including Countryside Health Services, which is a nursing facility in Warner, Oklahoma, that specializes in trach and vent patients. CEO Buettner, CFO Morris, and COS Foss toured the facility and were able to visit with a few of the residents. She also highlighted a recent meeting with leaders from the George Kaiser Family Foundation and some of their partners from ConnectFirst. Lastly, the inaugural Health and Human Services Intercabinet Meeting took place, which included leadership from OHS, DMH, and OHCA. OSDH will be included in future meetings. Individual leadership team meetings are scheduled with those agencies, but really wanted to work towards more of a stronger collaborative working relationship to really take it to the next level on how we can better serve the members we have in common. Member Case asked CEO Buettner to provide an overview of the Gateway Foundation. CEO Buettner stated Gateway Foundation is an organization in Broken Arrow that provides services to individuals with intellectual disabilities.

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

ITEM 4 / STATE MEDICAID DIRECTOR REPORT
Traylor Rains, State Medicaid Director

Mr. Rains provided a State Medicaid Director Update, which included information on SoonerSelect Milestones Achieved, Provider Survey Update, and new and noteworthy items.

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

ITEM 5 / CHIEF OF STAFF REPORT
Christina Foss, Chief of Staff

Ms. Foss provided a brief update on communication efforts surrounding SoonerSelect and OHCA's legislative priorities.

Communications – Ms. Foss highlighted the outreach over the last couple of months. The team learned a lot of lessons through the PHE and round one of Dental, specifically the timing, how to reach our members best, and how to utilize our traditional channels. OHCA was also able to utilize texting again and saw an increase in enrollment following the initial text being sent. Ms. Foss also highlighted the provider guides that are being created for Medical SoonerSelect. They will be uploaded as soon as the final touches are completed. The team is also working on member resources that will walk them through what to expect when SoonerSelect Medical goes live. Step-by-step videos have also been posted on social media sites and have received 12,000 views. The SoonerSelect team is also working on scheduling webinars with the plans after the go-live to answer any questions in real time.

Legislative Priorities – The three OHCA request bills have advanced from their chamber of origin.

SB 1417 Nursing Facility Reimbursement Methodology: This bill modernizes our reimbursement structure for nursing facilities. It has been a work in progress with OHCA stakeholders and nursing facility associations. This bill gives OHCA an opportunity to revamp its pay for performance structure. It also allows OHCA to focus on some additional quality measures and restructure how that works.

SB 1419 Paid Family Caregiver: This bill creates a paid family caregiver model to help address some of the issues in the PDN space for kids with complex care needs. The caregiver will be under the supervision of a registered nurse employed through a home health agency and will need to go through background checks.

SB 1703 Third Party Liability: This bill allows for a state's prior authorization for a service to suffice as a third-party payer's authorization as well.

HB 3367 Managed Care Law Amendment: This bill, and OHS request bill, would add additional populations within the Children's Specialty Plan.

HB 3556 HIE: This bill changes a "shall" to a "may", so it allows providers to voluntarily be in the HIE rather than mandatory.

HB 3980 Hospice Care: This bill would expand hospice care, which is a benefit already provided, to parent caretakers.

SB1330 Expansion of Services: This bill would expand services to provide coverage of certain fertility and preservations services for those that have a particular diagnosis.

SB 1739 Birthing Centers: This bill allows reimbursement of birthing centers.

SB 1752 Insure Oklahoma: The bill permits self-funded plans to participate in Insure Oklahoma with the idea that companies already participating in the program can also put their self-insured plan into the program.

ITEM 6 / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE

Jeffrey Cruzan, MD, Member of the Pharmacy Advisory Committee

Action Item – 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.	Sohonos™	Fibrodysplasia Ossificans Progressiva
ii.	Miebo™ Vevye®	Dye Eye Disease
iii	Veozah™	Vasomotor Symptoms of Menopause
iv.	Elrexfio™ Talvey™	Multiple Myeloma
v.	Rystiggo® Zilbrysq® Vyvgart® Hytrulo	Myastenia Gravis
vi.	Elfabrio® Opfolda™ Pombiliti™	Fabry Disease Pompe Disease Pompe Disease
vii.	Hepzato Kit™ Zynyz™	Metastatic Uveal Melanoma Merkel Cell Carcinoma
viii.	Iwilfin™ Kepivance® Loqtorzi™ Omisirge®	High-Risk Neuroblastoma Oral Mucositis Nasopharyngeal Carcinoma Neutropenia
ix.	Ogsiveo™	Desmoid Tumor
x.	Renagel® Xphozah®	Hyperphosphatemia

xi.	iDose® TR	Open-Angle Glaucoma

MOTION: Member Jolley moved for approval of item 6ai-xi, as published. The motion was seconded by Member Kennedy.

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

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

Member Kennedy provided the Compliance Committee Update, which included information on OHCA financials, the State Plan Amendment Rate Committee Brief, and Expenditure of Authority Contracts.

Financials – For the period ending January 31, 2024, OHCA's revenues were 1.1% under budget while expenditures were 0.9% under budget. Program expenditures were $19 million under budget, as we start to see lower expenditures from the PHE Unwind. Drug rebates and medical refunds continue to be over budget thanks to the team's efforts to improve and automate the process. All receivables from sister agencies are current as we continue to focus on timely collection while monitoring cash flow.

Internal Audit: Member Kennedy called upon Amber Smith, Director of Internal Audits, to provide an overview of the Single Audit Findings. Ms. Smith stated that the Auditor's office is finalizing the State Fiscal Year 2022 Single Audit this week. During the Compliance meeting, the Auditor's office presented 10 reportable findings, four of which were material weaknesses in internal controls. The OHCA team has already implemented a corrective action for 6 of the 10 findings, and is currently on target to remediate another before June 30th.

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

    i. Per Diem Rate for Freestanding Rehabilitation Hospitals Operated by Units of Government

MOTION: Member Case moved for approval of item 7ai, as published. The motion was seconded by Christ.

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

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

    i. Medicaid Management Information System
    ii. Asset Verification System Services

MOTION: Member Jolley moved for approval of item 7bi-ii, as published. The motion was seconded by Member Christ.

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

ITEM 8 / DISCUSSION OF REPORT OF STRATEGIC PLANNING & OPERATIONAL ADVISORY COMMITTEE
Marc Nuttle, Chair, Strategic Planning & Operational Advisory Committee

Chairman Nuttle stated that the committee met on March 11th and discussed legislative priorities, HIE, and Operations, specifically the call center response rates, which has decreased from an hour to minutes. The committee also discussed AI and how that could be applied. Chairman Nuttle suggested a possible half-day or all-day session to discuss strategic long-range problems coming.

ITEM 9 / DISCUSSION OF REPORT FROM THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION REGARDING AGENCY RULEMAKING
Tanya Case, Chair, Administrative Rules Advisory Committee

Member Case asked Traylor Rains, State Medicaid Director, to provide a brief overview of the rules listed below:

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

i. APA WF 24-03 Collaborative Care Model Reimbursement
ii. APA WF 24-04 Hospital Provision of Opioid Antagonist
iii. APA WF 24-05 Private Duty Nursing (PDN) Coverage Limitations Change
iv. APA WF 24-12 Medication Limits

MOTION:	Vice-Chairman Yaffe motioned to approve the declaration of a compelling public interest for the promulgation of the emergency rules in item 9i-iv. The motion was seconded by Member Christ.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Cruzan, Member Jolley, Member Kennedy, Member Leland
MOTION:	Vice-Chairman Yaffe moved to approve the emergency rules listed in item 9i-iv as published. The motion was seconded by Member Kennedy.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Cruzan, Member Jolley, Member Kennedy, Member Leland

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

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

ITEM 11 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

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

Meeting adjourned at 3:43 p.m., 3/20/2024

NEXT BOARD MEETING
May 15, 2024
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

Initials: _____

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Attachment C

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – March 13, 2024 and April 10, 2024

Vote Item	Drug	Used for	Cost*	Notes
1	Alinia® Xdemvy™	• **Giardia Lamblia and Cryptosporidium Parvum infections:** These specific protozoa can cause diarrhea in patients sometimes referred to as "Traveler's diarrhea". *75 members with these diagnoses* • **Demodex Blepharitis:** DM is caused by a Demodex mite infestation which causes chronic inflammation of the eyelid which in advanced stages may have corneal involvement. *367 members with the diagnosis*	• $780 per 3 days course • $1,850 per course of treatment	• Cheaper treatment options available • DM affects more than 80% of those over 60 years of age
2	Ycanth™ Zelsuvmi™	• **Molluscum Contagiosum:** MC is a fairly common infection caused by a poxvirus (molluscum contagiosum virus) mostly in children. The result of the infection is usually a benign, mild skin disease characterized by growths that may appear anywhere on the body. MC usually resolves on its own within 6-12 months. *Approximately 5,000 members with this diagnosis*	• $5,480 per course of treatment • N/A	• Cheaper treatment options available • Cheaper treatment options available
3	Vanfkyta®	• **Acute Myeloid Leukemia**: AML is a cancer of the blood and bone marrow. It is aggressive and can be life-threatening. AML is the most common leukemia in adults usually affecting people over 60 years of age and older. *106 members with this diagnosis*	• $397,576 per year	• Used in combination with other treatments
4	Columvi™ Epkinly™	• **Diffuse large B-cell lymphoma:** DLBCL is a fast-growing blood cancer and the most common form of non-Hodgkin lymphoma. *101 members with this diagnosis*	• $350,000 for full course of treatment • $388,924 for first year	• Not first line treatment • Not first line treatment

5	Roctavian™	• **Hemophilia A:** HA is a rare a bleeding disorder in which blood does not clot properly. It is usually inherited. *10 members may be eligible to receive treatment*	• $2,446,875 per 1 time treatment	• Effects are waning over time
6	Ryzneuta®	• **Febrile Neutropenia:** FN is the most common serious and common complication of cancer therapy. Patients develop a fever associated with low white blood cells (neutrophils) count. *531 members utilizing other medications for this diagnosis.*	• N/A	• Other treatment options available
7	Tyruko®	• **Multiple Sclerosis:** MS is an autoimmune disease of the central nervous system (CNS) characterized by chronic inflammation, demyelination, gliosis, and neuronal loss. The clinical course of the disease is quite variable, ranging from stable chronic disease to a rapidly evolving and debilitating illness. *350 members with this diagnosis*	• N/A	• Other treatment options available
8	Aphexda®	• **Mobilization of stem cells:** Hematopoietic stem cells naturally traffic out of their bone marrow niches into the peripheral blood. This natural trafficking process can be enhanced with numerous pharmacologic agents (a process termed “mobilization”) and the mobilized stem cells can be collected for transplantation later. *4 members utilizing other medication used for mobilization*	• $23,600 per course of treatment	• Cheaper treatment options available

*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.

Pharmacy Agenda Items

Recommendation 1: Vote to Prior Authorize Alinia® and Xdemvy™

The Drug Utilization Review Board recommends the prior authorization Alinia® (nitazoxanide tablet) and Xdemvy™ (lotilaner ophthalmic solution) with the following criteria:

Alinia® (Nitazoxanide Tablet) Approval Criteria:

1. An FDA approved indication for the treatment of diarrhea caused by Giardia lamblia or Cryptosporidium parvum; and
2. Member must be 12 years of age or older; and
3. For Giardia, member must have a recent trial of metronidazole or tinidazole or a patient-specific, clinically significant reason why the member cannot use metronidazole and tinidazole must be provided; and
4. A quantity limit of 6 tablets per 3 days will apply.

Xdemvy™ (Lotilaner Ophthalmic Solution) Approval Criteria:

1. An FDA approved diagnosis of Demodex blepharitis; and
2. Member must be 18 years or older; and
3. Must be prescribed by an ophthalmologist or optometrist; and
4. Member must meet all of the following in at least 1 eye:
    a. >10 lashes with collarettes present on the upper lid; and
    b. Presence of at least mild erythema of the upper eyelid margin; and
5. Member must agree to remove artificial eyelashes (if present) and forego their use during treatment with Xdemvy™; and
6. A quantity limit of 10mL per 42 days will apply. Approvals will be limited to 1 treatment course per year.

Recommendation 2: Vote to Prior Authorize Ycanth™ and Zelsuvmi®

The Drug Utilization Review Board recommends the prior authorization of Ycanth™ (cantharidin 0.7% solution) and Zelsuvmi® (berdazimer 10.3% gel) with the following criteria:

Ycanth™ (Cantharidin 0.7% Solution) Approval Criteria:

1. An FDA approved indication for the treatment of molluscum contagiosum lesions; and
2. Member must be 2 years of age or older; and
3. Member must meet 1 of the following:
    a. Is immunocompromised; or
    b. Is experiencing itching or pain; or

   c. Has concomitant bacterial infection; or
   d. Has concomitant atopic dermatitis; or
   e. There is concern for contagion (e.g., siblings, daycare) and the spread of lesions cannot be reasonably prevented using good hygiene or covered using a bandage; and
4. Prescriber must attest that it has been at least 6 months since the onset of the current infection unless the member is experiencing severe symptoms; and
5. Member must have a trial of at least 1 of the following procedures or medications for the removal of molluscum contagiosum lesions in the last 6 months:
   a. Cryotherapy; or
   b. Curettage; or
   c. Laser therapy; or
   d. Cimetidine; or
   e. Potassium hydroxide; or
   f. Salicylic acid; and
6. Member must not have lesions exclusively on genitals or around eyes; and
7. Ycanth™ must be administered by a health care professional (HCP) trained in the administration of Ycanth™. Approvals will not be granted for self-administration. Requests must indicate who will administer Ycanth™ and in what setting; and
8. Prescriber must attest that the member or caregiver has been counseled to wash off lesions treated with Ycanth™ with soap and water 24 hours after application and to avoid skin contact with water, including bathing, prior to the 24-hour mark; and
9. Prescriber must attest that the member or caregiver has been counseled on all precautions prior to and during treatment with Ycanth™ that are listed in the package labeling, including avoiding contact with the eyes and mouth and avoiding close contact with open flames, even after the medication has dried; and
10. Approvals will be for a maximum of 12 weeks of therapy; and
11. A quantity limit of 2 applicators every 3 weeks for a maximum of 4 applications will apply; and
12. Reauthorization is not permitted. A new prior authorization request must be submitted, and the member must meet all initial approval criteria for each molluscum contagiosum infection.

Zelsuvmi™ (Berdazimer 10.3% Gel) Approval Criteria:

1. An FDA approved indication for the treatment of molluscum contagiosum lesions; and
2. Member must be 1 year of age or older; and
3. Member must meet 1 of the following:

   a. Is immunocompromised; or
   b. Is experiencing itching or pain; or
   c. Has concomitant bacterial infection; or
   d. Has concomitant atopic dermatitis; or
   e. There is concern for contagion (e.g., siblings, daycare) and the spread of lesions cannot be reasonably prevented using good hygiene or covered using a bandage;
4. Prescriber must attest that it has been at least 6 months since the onset of the current infection unless the member is experiencing severe symptoms; and
5. Member must have a trial of at least 1 of the following procedures or medications for the removal of molluscum contagiosum lesions in the last 6 months:
   a. Cryotherapy; or
   b. Curettage; or
   c. Laser therapy; or
   d. Cimetidine; or
   e. Potassium hydroxide; or
   f. Salicylic acid; and
6. Member must not have lesions exclusively on genitals or around eyes; and
7. Prescriber must attest that the member or caregiver has been counseled on and demonstrates understanding of the proper storage and preparation of Zelsuvmi™; and
8. Prescriber must attest that the member or caregiver has been counseled on and has demonstrated understanding of the proper administration of Zelsuvmi™, including the medication's drying time and avoiding contact with the eyes, mouth, and genital areas; and
9. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use Ycanth™ (cantharidin) must be provided; and
10. Approvals will be for a maximum of 12 weeks of therapy; and
11. A quantity limit of 1 carton (14-gram tube of Zelsuvmi™ and 17 gram tube of hydrogel) every 30 days for a maximum of 3 cartons will apply; and
12. Reauthorization is not permitted. A new prior authorization request must be submitted, and the member must meet all initial approval criteria for each molluscum contagiosum infection.

Recommendation 3: Vote to Prior Authorize Vanflyta®

The Drug Utilization Review Board recommends the prior Vanflyta® (quizartinib) with the following criteria:

Pharmacy Agenda Items

Vanflyta® (Quizartinib) Approval Criteria [Acute Myeloid Leukemia (AML) Diagnosis]:

1. Newly diagnosed AML; and
2. Disease is positive for FLT3 internal tandem duplication (FLT3-ITD) as detected by an FDA-approved test; and
3. Will be used in 1 of the following settings:
    a. In combination with standard anthracycline and cytarabine-based induction; or
    b. In combination with standard cytarabine-based consolidation; or
    c. As maintenance therapy following standard anthracycline and cytarabine-based induction and cytarabine-based consolidation.

Recommendation 4: Vote to Prior Authorize Columvi™ and Epkinly™

The Drug Utilization Review Board recommends the prior authorization Columvi™ (Glofitamab-gxbm) and Epkinly™ (Epcoritamab-bysp) with the following criteria:

Columvi™ (Glofitamab-gxbm) Approval Criteria [Lymphoma Diagnosis]:

1. Diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including large B-cell lymphoma (LBCL) arising from follicular lymphoma; and
2. Has received ≥2 lines of systemic therapy; and
3. Will receive a single dose of obinutuzumab for pre-treatment purposes.

Epkinly™ (Epcoritamab-bysp) Approval Criteria [Lymphoma Diagnosis]:

1. Diagnosis of relapsed or refractory diffuse large B-cell lymphoma (DLBCL) not otherwise specified, including DLBCL arising from indolent lymphomas and/or high-grade B-cell lymphomas; and
2. Has received ≥2 lines of systemic therapy.

Recommendation 5: Vote to Prior Authorize Roctavian™

The Drug Utilization Review Board recommends the prior authorization Roctavian™ (Valoctocogene Roxaparvovec-rvox) with the following criteria:

Roctavian™ (Valoctocogene Roxaparvovec-rvox) Approval Criteria:

1. An FDA approved diagnosis of severe congenital (or X-linked) hemophilia A; and
2. Member must be a male 18 years of age or older; and
3. Member must not have a history of or a recent positive screening of an inhibitor defined as ≥0.6 Bethesda units; and

Pharmacy Agenda Items

4. Member must be on prophylactic therapy with continued frequent breakthrough bleeding episodes or has experienced a life-threatening bleeding episode; and
5. Member must not have acute infections; and
6. Member must not have chronic active infections such as hepatitis B or C; and
7. Member must not have uncontrolled human immunodeficiency virus (HIV) as shown by CD4+ counts ≤200u/L; and
8. Member must not be taking efavirenz; and
9. Member must not have antibodies to AAV5; and
10. Member must not have any of the following:
    a. Significant liver fibrosis:
        i. Defined as ≥3 as rated on a scale of 0-4 on the METAVIR scoring system or equivalent grade on an alternative scale; and
        ii. Measured by ultrasound and elastography or laboratory assessments; or
    b. Liver cirrhosis; or
    c. Significant liver dysfunction with any of the following abnormal lab results:
        i. Alanine aminotransferase (ALT) >1.25x upper limit of normal (ULN); or
        ii. Aspartate aminotransferase (AST) >1.25x ULN; or
        iii. Gamma-glutamyl transferase (GGT) >1.25x ULN; or
        iv. Total bilirubin >1.25x ULN; or
        v. Alkaline phosphatase >1.25x ULN; or
        vi. International normalized ratio (INR) ≥1.4; and
11. Must be prescribed by a hematologist practicing in a federally recognized Hemophilia Treatment Center (HTC) or mid-level practitioner under the supervision of a physician at an HTC; and
12. Prescriber must counsel member to not donate semen, and if member is of reproductive potential then their female partners must agree to prevent or postpone pregnancy for 6 months after treatment with valoctocogene roxaparvovec-rvox; and
13. Valoctocogene roxaparvovec-rvox must be administered in an appropriate clinical setting and member must be monitored for at least 3 hours post infusion; and
14. Prescriber must follow liver enzymes weekly for 26 weeks, every 1 to 2 weeks for weeks 26 through 52, every 3 months in the second year, and every 6 months thereafter; and
15. Prescriber agrees to start corticosteroids (or other immunosuppressives if corticosteroids are contraindicated) as outlined in the package labeling; and

16. Prescriber agrees to monitor factor VIII levels weekly for 26 weeks, every 1 to 2 weeks for weeks 26 through 52, every 3 months in the second year, and every 6 months thereafter; and
17. Approvals will be for 1 treatment per member per lifetime.

Recommendation 6: Vote to Prior Authorize Ryzneuta®

The Drug Utilization Review Board recommends the prior Ryzneuta® (Efbemalenograstim Alfa-vuxw) with the following criteria:

Ryzneuta® (Efbemalenograstim Alfa-vuxw) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use Fulphila® (pegfilgrastim-jmdb), Fylnetra® (pegfilgrastim-pbbk), Neulasta® Onpro® (pegfilgrastim), or Ziextenzo® (pegfilgrastimbmez) must be provided; and
3. Neulasta® Onpro® (pegfilgrastim) will be covered as a medical only benefit without prior authorization.

Recommendation 7: Vote to Prior Authorize Tyruko®

The Drug Utilization Review Board recommends the prior Tyruko® (Natalizumab-sztn) with the following criteria:

Tyruko® (Natalizumab-sztn) Approval Criteria:

1. An FDA approved diagnosis of relapsing forms of multiple sclerosis (MS), to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease, or Crohn's disease in adults; and
2. For a diagnosis of MS, the following criteria will apply:
    a. Prescriber must be a neurologist or an advanced care practitioner with a supervising physician who is a neurologist; and
    b. Approvals will not be granted for concurrent use with other disease-modifying therapies; or
3. For a diagnosis of Crohn's disease, the following criteria will apply:
    a. Treatment with at least 2 different first-line therapeutic categories or Crohn's disease that have failed to yield an adequate clinical response, or a patient-specific, clinically significant reason why the member cannot use all available first- and second-line alternatives must be provided; and
4. A patient-specific, clinically significant reason why the member cannot use Tysabri® must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be

moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products; and
5. Prescriber, infusion center, and member must enroll in the Tyruko® Risk Evaluation and Mitigation Strategy (REMS) program; and
6. Compliance will be checked for continued approval every 6 months

Recommendation 8: Vote to Prior Authorize Aphexda®

The Drug Utilization Review Board recommends the prior Aphexda® (Motixafortide) with the following criteria:

Aphexda® (Motixafortide) Approval Criteria:

1. An FDA approved indication for use in combination with filgrastim to mobilize hematopoietic stem cells to the peripheral blood for collection and subsequent autologous transplantation in members with multiple myeloma (MM); and
2. Member must have an oncology diagnosis of MM. This medication is not covered for the diagnosis of leukemia; and
3. Aphexda® must be prescribed by an oncologist; and
4. Member must be 18 years of age or older; and
5. Aphexda® must be given in combination with the granulocyte-colony stimulating factor (G-CSF) filgrastim per package labeling; and
6. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use generic plerixafor must be provided; and
7. The following dosing restrictions will apply (current body weight in kilograms is required):
    a. Recommended dose is 1.25mg/kg actual body weight by subcutaneous injection 10 to 14 hours prior to initiation of apheresis; and
    b. A second dose of Aphexda® can be administered 10 to 14 hours prior to a third apheresis if necessary; and
8. Approvals will be for 2 cycles for the duration of 2 months.

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OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

REGULAR NURSING FACILITIES RATE INCREASE

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) fee for Regular Nursing Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to facilities. Additionally, the change allows OHCA to calculate the annual reallocation of the pool for the "Direct Care" and "Other Cost" components of the rate as per the State Plan. This change will also increase the rate for Regular Nursing Facilities as mandated by Senate Bill 1134 and reallocate the $35 that was added to the base rate in SFY2024 to maintain Public Health Emergency supplemental payment levels to the pool of funds available for "Direct Care" and the "Other Cost" components as per the State Plan.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing Facilities calls for the establishment of a prospective rate that consists of four components. The current components are as follows:
   A. Base Rate Component is $158.56 per patient day.
   B. A Pay for Performance (PFP) Component defined as the dollars earned under the incentive payment program for Nursing Facilities with an average payment of $5.00 per patient day.
   C. An "Other Cost" Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and PFP Components by the total estimated Medicaid days for the rate period. This component once calculated is the same for each facility.
   D. A "Direct Care "Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and PFP Components to the facilities. This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the

70% pool of funds to each facility (on a per day basis) based on their relative expenditures for direct care costs.

The current combined pool amount for "Direct Care" and "Other Cost" components is $251,077,470. The current Quality of Care (QOC) fee is $15.65 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**

There is no change in methodology; however, there is a rate change for Regular Nursing Facilities because of the required annual recalculation of the Quality of Care (QOC) fee and reallocation of the pool for "Direct Care" and "Other Cost" components of the rate as per the State Plan. Also, there is a rate change because of the rate increase mandated by Senate Bill 1134 and the reallocation of the $35 from the base rate to the pool of funds available for the "Direct Care and "Other Cost" components. The new Base Rate Component will be $123.78 per patient day. The new combined pool amount for "Direct Care" and "Other Cost" components will be $503,253,105. The new Quality of Care (QOC) fee will be $15.87 per patient day.

6. **BUDGET ESTIMATE.**

The estimated budget impact for SFY2025 will be an increase in the total amount of $87,371,108; with $28,666,460 in state share.

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

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**

The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular Nursing Facilities:

- A decrease to the base rate component from $158.56 per patient day to $123.78 per patient day.

An increase to the combined pool amount for "Direct Care" and "Other Cost" Components from $251,077,470 to $503,253,105 for the annual reallocation of the Direct Care Cost Component as per the State Plan.

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

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OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITES RATE INCREASE

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) fee for nursing facilities serving residents with AIDS per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds, which provides rate increases to facilities. This change will also increase the AIDS rate as mandated by Senate Bill 1134.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current rate for this provider type is $266.18 per patient day. The Quality of Care (QOC) fee is $15.65 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for nursing facilities serving residents with AIDS because of the required annual recalculation of the Quality of Care (QOC) fee. This change also increases the AIDS rate as mandated by Senate Bill 1134. The rate for this provider type will be $286.32 per patient day. The recalculated Quality of Care (QOC) fee will be $15.87 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2025 will be an increase in the total amount of $142,548; with $46,770 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:
   An increase to the AIDS rate from $266.18 per patient day to $286.32 per patient day.

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

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

REGULAR INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE INCREASE

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) fee for Regular ICF/IID per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provides rate increases to facilities. This change also increases Regular ICF/IID rate as mandated by Senate Bill 1134.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.
   The current rate for this provider type is $155.23 per patient day.
   The Quality of Care (QOC) fee is $9.38 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for Regular ICF/IID facilities because of the required annual recalculation of the Quality of Care (QOC) fee. This change will also increase the Regular ICF/IID rate as mandated by Senate Bill 1134.
   The proposed rate for this provider type is $170.44 per patient day.
   The Quality of Care (QOC) fee will be $9.75 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2025 will be an increase in the total amount of $2,285,123; with $749,749 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular ICF/IID facilities:
   An increase in rate from $155.23 per patient day to $170.44 per patient day.

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

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

ACUTE (16 BED-OR-LESS) INTERMEDIATE CARE FACILITIES FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF/IID) RATE INCREASE

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) Fee for Acute ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds, which provides rate increases to facilities. This change will also increase Acute ICF/IID rate as mandated by Senate Bill 1134.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Acute ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.
   The current rate for this provider type is $186.64 per patient day.
   The Quality of Care (QOC) fee is $10.26 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for Acute ICF/IID facilities because of the annual recalculation of the Quality of Care (QOC) fee. This change also increases the Acute ICF/IID rate as mandated by Senate Bill 1134.
   The proposed rate for this provider type is $206.02 per patient day.
   The recalculated Quality of Care (QOC) fee is $11.00 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY2025 will be an increase in the total amount of $6,681,728; with $2,192,275 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   The Oklahoma Health Care Authority does not anticipate any negative impact on access to care.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:
   An increase in rate from $186.64 per patient day to $206.02 per patient day.

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

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 26, 2024
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Customer Relationship Management (CRM)
Purpose and Scope	Maximus assists OHCA with operations of a Customer Relationship Management solution, including a call center for interactions with members or potential members in its health care benefits programs, contracted or potential health care providers, allied agencies and organizations and other interested parties. Maximus provides choice counseling services, enrollment assistance and other essential call center operations to assist in the transition to managed care. OHCA has been under contract with Maximus since fiscal year SFY19.
Mandate	N/A
Procurement Method	Sole Source Contract Extension
External Approvals	CMS
Contract Term	Executing contract for the period July 1, 2024 through June 30, 2025 (SFY25) which consists of two consecutive 180-day extensions as authorized under the contract. This extension is crucial to ensure uninterrupted services while the department prepares to rebid the contract competitively and award for the state fiscal year 2026 (SFY26).

BUDGET

Amount requested for Approval	$ 10,471,113.10
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	75%

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 extension amount of $10,471,113.09 for SFY25. This approval will authorize the SFY25 extension of the Maximus contract, bringing the new total contract board-approved amount to $58,593,714.09. This approval is essential to maintain the high standards of service during the transition to a new contract for FY26.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 26, 2024
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	Technical Consultant for the Medicaid Management Information System (MMIS) Modernization and Implementation of the Transformation Management Office – Phase 2

Purpose and Scope	OHCA intends to conduct a large-scale overhaul of the legacy MMIS system. Due to the size, scope and complexity of the project, OHCA has elected to procure a consultant to assist in the planning, design and development of the modernization activities. The Oklahoma Health Care Authority (OHCA) is seeking a Contractor for the following services:
	• Execute Phase 2 of the Transformation Roadmap that provides the following:
	  ○ Establish and operate the Transformation Management Office, developing governance, reporting and intake processes across the organization.
	  ○ Develop the Technical and Data Strategy and Governance processes that will drive future state architecture and procurement requirements.
	  ○ Review priority business processes and develop future state processes that leverage automation, RPA and reduce complexity and redundancies to prepare the staff and processes for new technology.
	  ○ Assess the skills and capacity of the team to understand current levels of proficiency and identify skills gaps as it relates to the future technology transformation.
	• Optional Services:
	  ○ TMO execution – year two (2)
	  ○ Implementation of automation into existing processes
	  ○ Execution of ‘Quick Wins’ from the 18-24 month transformation roadmap. May include:
	  ▪ Chatbot capabilities
	  ▪ Frontend member and provider portal design and implementation

Mandate	N/A
Procurement Method	Statewide Release
External Approvals	CMS
Contract Term	Base year with one (1) option to renew.

BUDGET

Amount requested for Approval	$ 5,972,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	90%

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 technical consultant services for MMIS modernization as described above for one base year and one renewal year with a total not-to-exceed of $5,972,000.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 26, 2024
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 Liability (TPL) Systems
Purpose and Scope	Oklahoma Health Care Authority is seeking to begin Third Party Liability (TPL) revenue collection services with ***Health Management Systems (HMS)*** in accordance with 42 CRF 433.135. TPL services are revenue generating for OHCA. HMS service scope includes: • Identify third party liability through data match • Continuously analyze data to identify coverage changes • Implement audits and reviews • Maximize recoveries of billed claims • Denial analysis • Lockbox services
Mandate	Federal law and regulations require that Medicaid pays for services only after liable third parties have met their obligation to pay.
Procurement Method	Competitive Bid
External Approvals	N/A
Contract Term	Initial contract was issued for base year with five option to renew. Initial board approval was issued in SFY 2024 for $10,000,000.00. Resubmitting for July 1, 2024, through June 30, 2025 with four remaining options to renew for a Total-Not-Exceed of $50,000,000.00 for the duration of the contract term (SFY25 through SFY29).

BUDGET

Amount requested for approval	$50,000,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to expend funds for TPL systems contracted through Health Management Services as described above for a total not to exceed cost of $50,000,000.00.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 days for cause, 60 days without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $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.)

Attachment E.iv

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 26, 2024

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	MyHealth
Purpose and Scope	MyHealth shall establish and operate a health information exchange and record locator service to assist the Participants in locating and sharing patient information. MyHealth seeks to reduce the cost and improve the quality and efficiency of health care provided by the Participants through the electronic management and exchange of health information acquired or generated by them in providing, paying for, and reporting on patient care items and services. MyHealth is intended to provide a collaborative framework consistent with HIPAA and other applicable law through which the parties can share information for treatment purposes of individuals seeking healthcare. OHCA Population Care Management staff access medical records through MyHealth as part of the SoonerCare care management process.
Mandate	N/A
Procurement Method	Sole Source Extension
External Approvals	N/A
Contract Term	July 1, 2024, through June 30, 2025, with one (1) option to renew.

BUDGET

Amount requested for Approval	$1,000,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to extend for one (1) year for a total not-to-exceed of $1,000,000.00.

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Additional Information

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

June 26, 2024 Board
Proposed Rule Amendment Summaries

The proposed **EMERGENCY** rule was presented at the **April 30, 2024** Tribal Consultation, was subject to at least a 15-day public comment period, and was considered by the Medical Advisory Committee on May 2, 2024.

The Governor will have until August 10, 2024, to approve or disapprove the rule upon the Agency's submission for gubernatorial review.

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

APA WF # 24-15 Third Party Liability (TPL) Prior Authorization — Section 202 of the Consolidated Appropriations Act (2022) includes a provision requiring states to pass legislation restricting third party insurers from denying a claim solely on the basis of the Medicaid member's failure to obtain a prior authorization for a service, so long as that service is covered under the state plan or a waiver. Senate Bill 1703 of the 2024 legislative session addresses this requirement and the proposed rule revisions will align the third party liability policy with this legislation.

Budget Impact: The estimated total cost for SFY2025 is $250,060 ($167,975 in federal share and $82,085 in state share).

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-24. Third party liability

As the Medicaid Agency, the Oklahoma Health Care Authority (OHCA) is the payer of last resort, with few exceptions. When other resources are available, those resources must first be utilized. Exceptions to this policy are those receiving medical treatment through Indian Health Services and those eligible for the Crime Victims Compensation Act. Guidance for third party liability under the Insure Oklahoma program is found in Oklahoma Administrative Code (OAC) 317:45, Insure Oklahoma.

(1) If a member has coverage by an absent parent's insurance program or any other policy holder, that insurance resource must be used prior to filing a SoonerCare claim. This includes Health Maintenance Organizations (HMO), Preferred Provider Organizations (PPO) and any other insuring arrangements that provide a member access to healthcare. Members must comply with all requirements of their primary insurance as well as SoonerCare requirements in order to take advantage of both coverages. For example, a member must comply with the network restrictions of both the primary and SoonerCare plans~~ as well as prior authorization requirements~~. If the member does not comply with the requirements of the primary plan, he/she will be responsible for the charges incurred. ~~Denials by private insurance companies because the member did not secure a preauthorization or use a participating provider is not a sufficient reason for SoonerCare to make payment~~The state's authorization that an item or service is as covered under the state plan, or a waiver of such plan, shall meet the prior authorization requirements of the primary insurer. If the provider is aware of private insurance or liability, a claim must first be filed with that source. When private insurance information is known to the OHCA, the eligibility verification system will reflect that information. If payment is denied by the primary insurance, except as stated above, the provider must attach the Explanation of Benefits (EOB), stating the reason for the denial, to the claim submitted to the Fiscal Agent. When payment is received from another source, that payment amount must be reflected on the claim form.

(2) It is possible that other resources are available but are unknown to OHCA. Providers will routinely question SoonerCare members to determine whether any other resources are available. In some instances, coverage may not be obvious, for example, the member may be covered by a policy on which he/she is not the subscriber (e.g., a child whose absent parent maintains medical and hospital coverage).

(3) If the provider receives payment from another source after OHCA has made payment, it is necessary that the provider reimburse OHCA for the SoonerCare payment. The provider may retain the primary insurance payment, if any, that represents payment for services that are not covered services under SoonerCare. By accepting the OHCA's payment, the provider agrees to accept it as payment in full and, therefore, cannot retain any portion of other resource money as payment for reduced charges on covered services. Other than SoonerCare copayments, a provider cannot bill a member for any unpaid portion of the bill or for a claim that is not paid because of provider administrative error. If, after reimbursing OHCA and retaining a portion of

the other payment in satisfaction of any non-covered services there is money remaining, it must be refunded to the member.

(4) If a member is covered by a private health insurance policy or plan, he/she is required to inform medical providers of the coverage, including:

(A) provision of applicable policy numbers;

(B) assignment payments to medical providers;

(C) provision of information to OHCA of any coverage changes; and

(D) release of money received from a health insurance plan to the provider if the provider has not already received payment or to the OHCA if the provider has already been paid by the OHCA.

(5) Members are responsible for notifying their providers of the intent to make application for SoonerCare coverage and of any retroactive eligibility determinations. Members may be responsible for any financial liability if they fail to notify the provider of the eligibility determinations and as a result, the provider is unable to secure payment from OHCA.

(6) Members must present evidence of any other health insurance coverage to a medical provider each time services are requested. Members may be responsible for any financial liability if they fail to furnish the necessary information before the receipt of services and as a result, the provider is unable to secure payment from OHCA.

OPERATIONAL METRICS

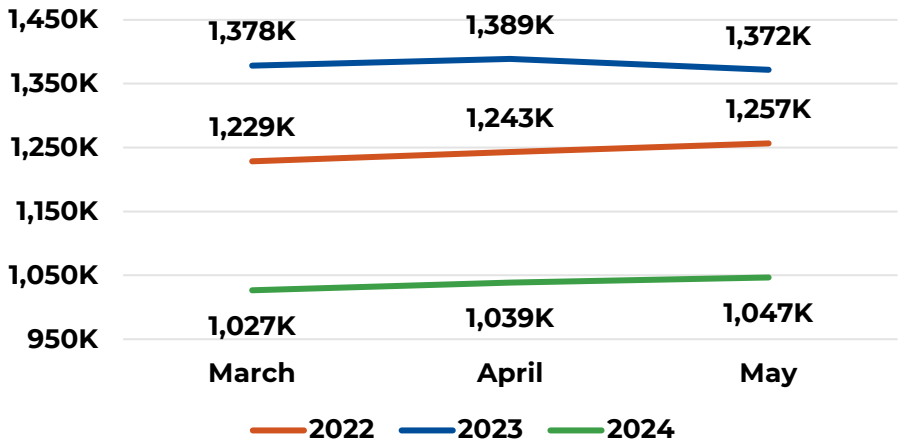
June 2024 Board Meeting

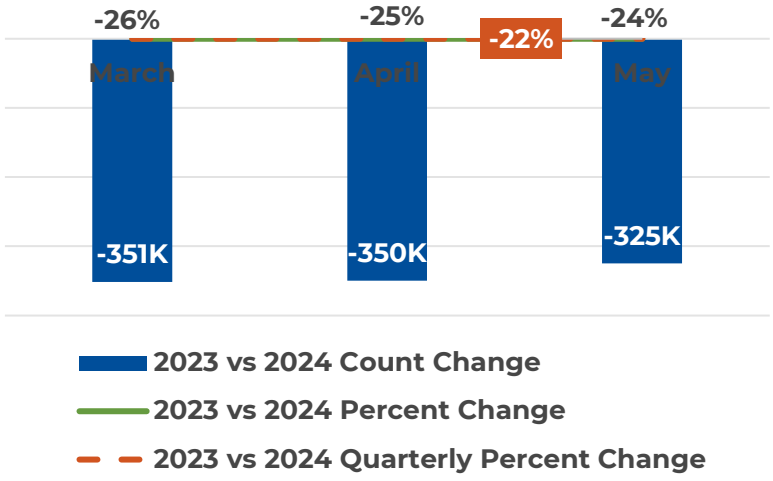
OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

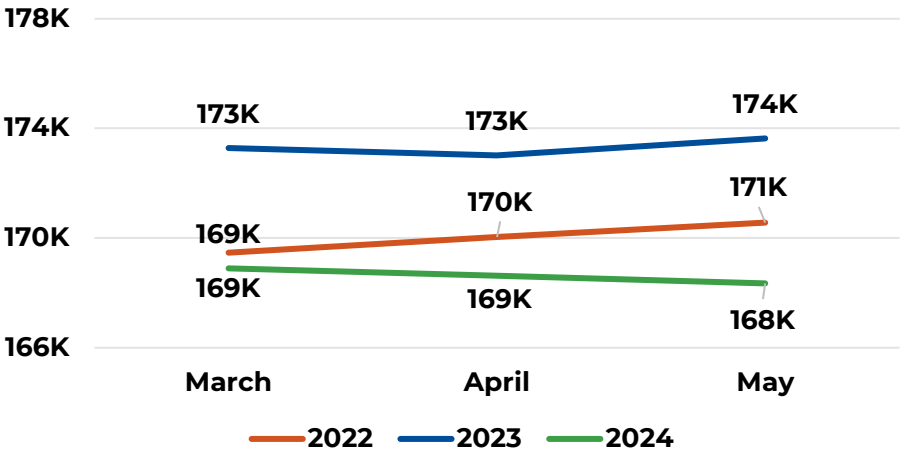
Enrollment & Utilization

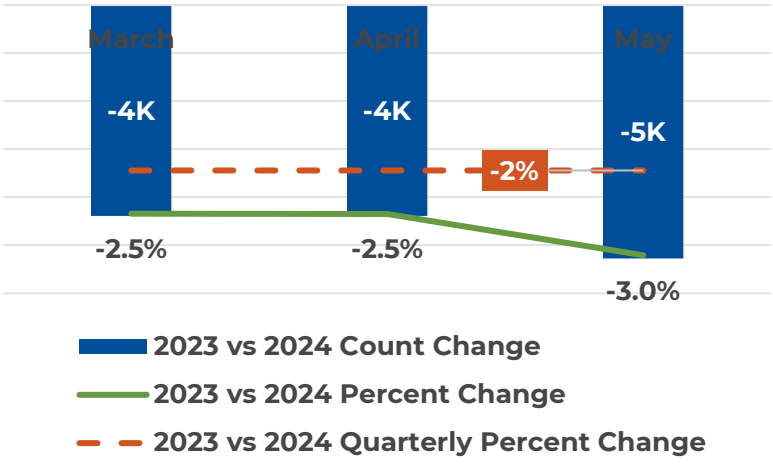
Total Enrolled Members





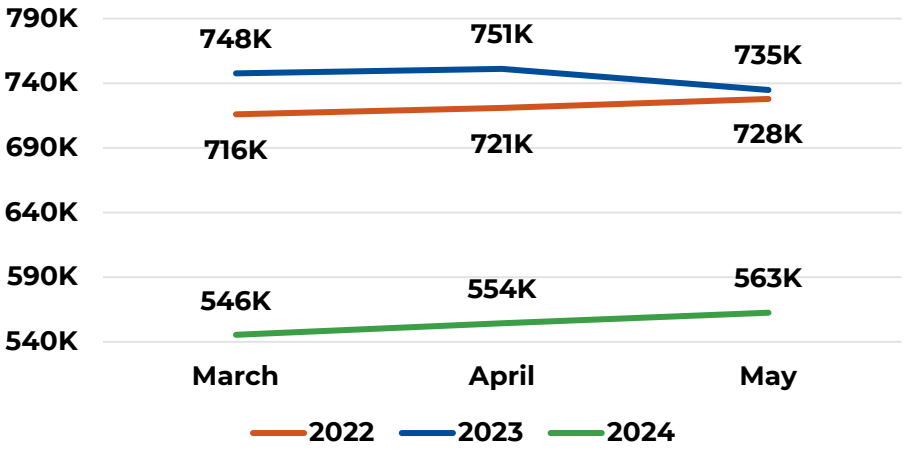
Aged/Blind/Disabled Enrolled

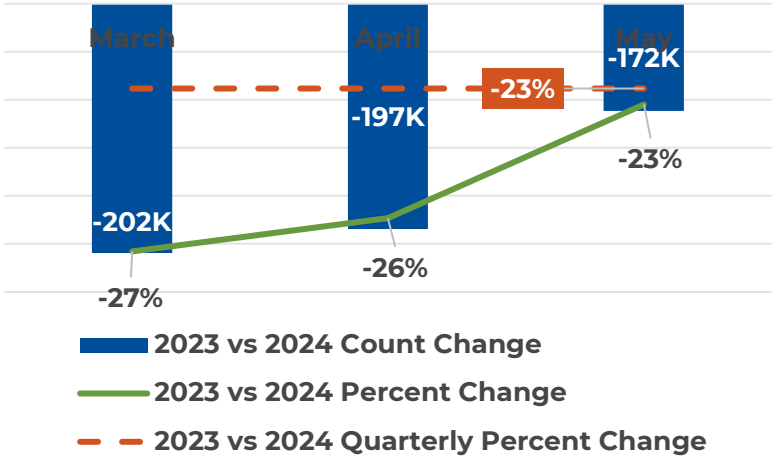




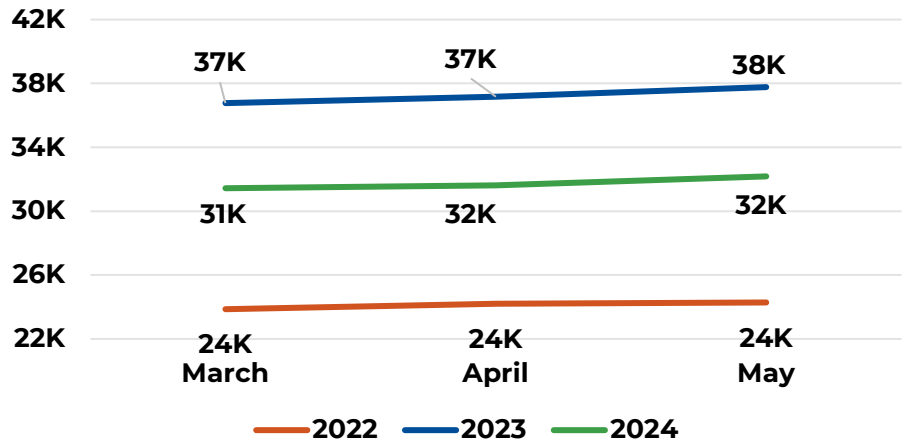
Enrollment & Utilization (Cont.)

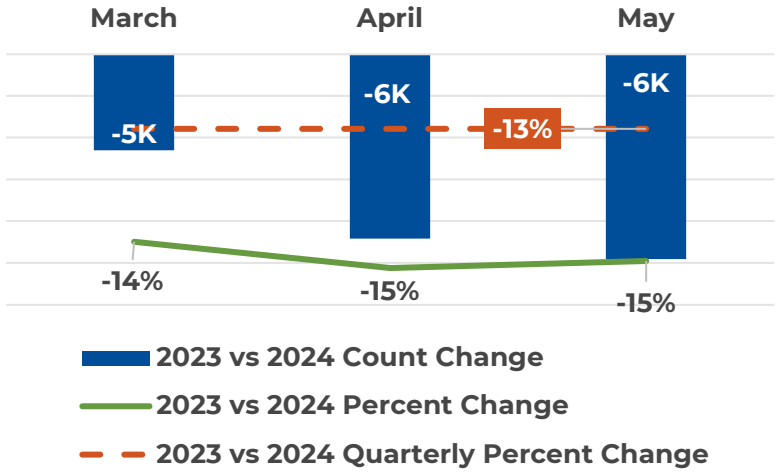
Children & Parent/Caretaker Enrolled





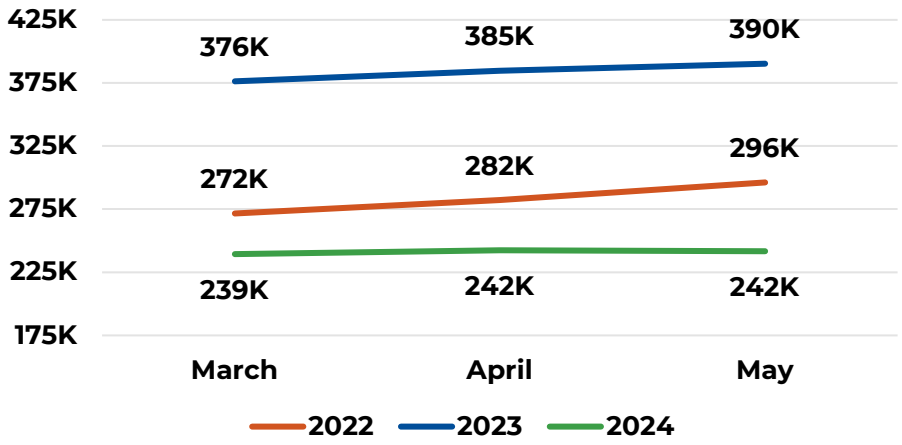
Pregnant (Full Scope) Enrolled

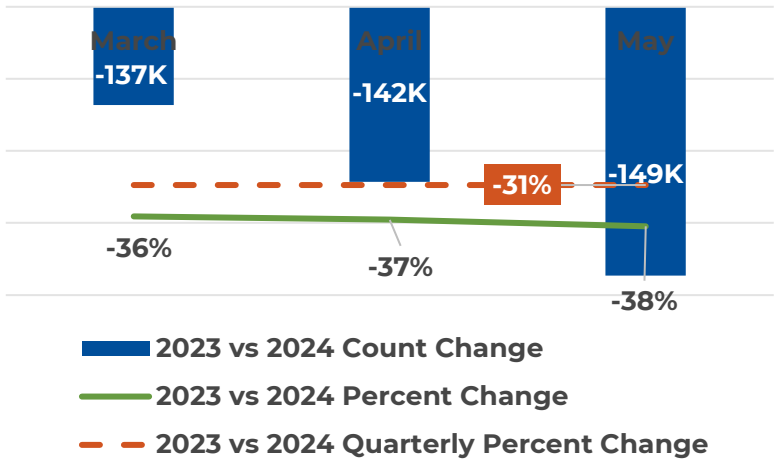




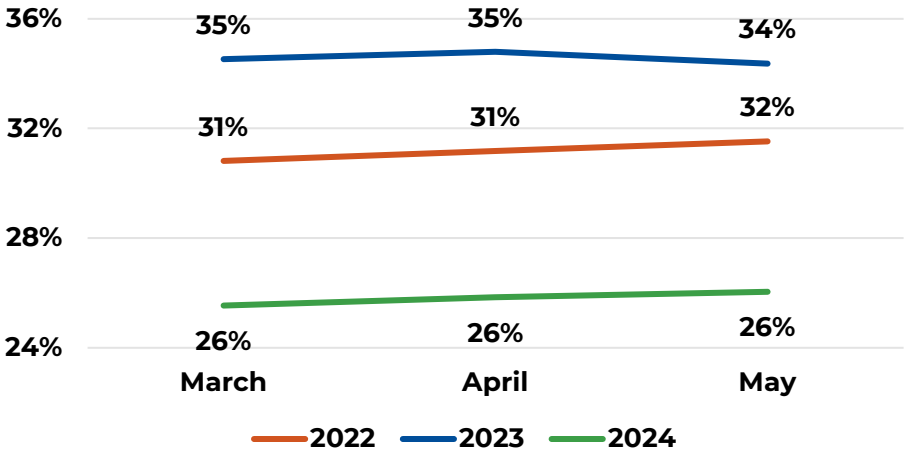
Enrollment & Utilization (Cont.)

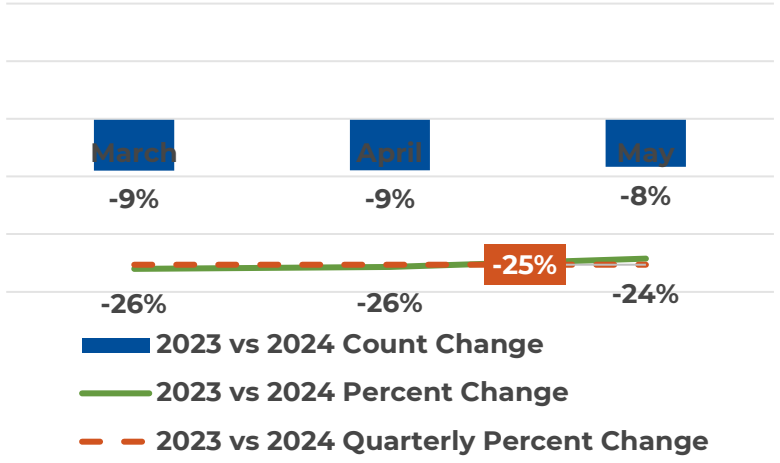
Expansion Enrolled (Effective July 2021)





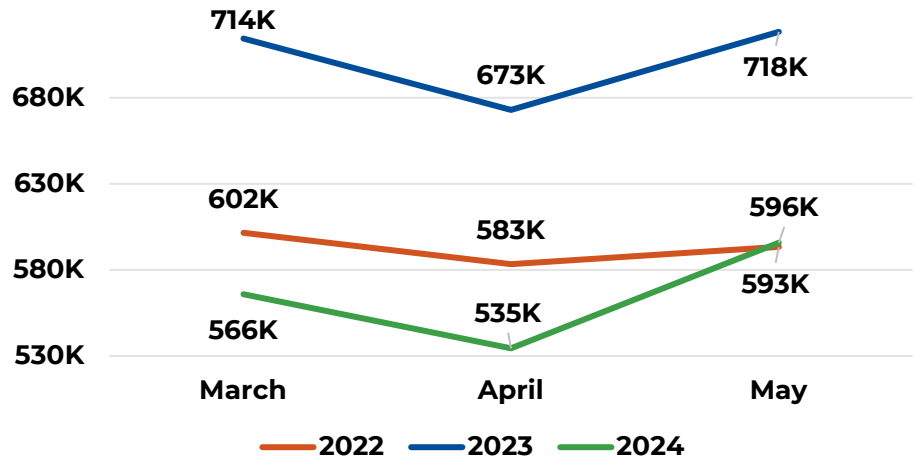
Percent of OK Population Enrolled

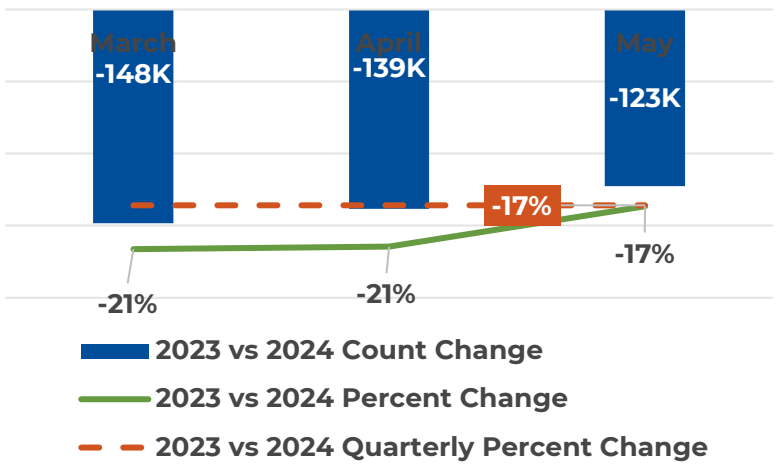




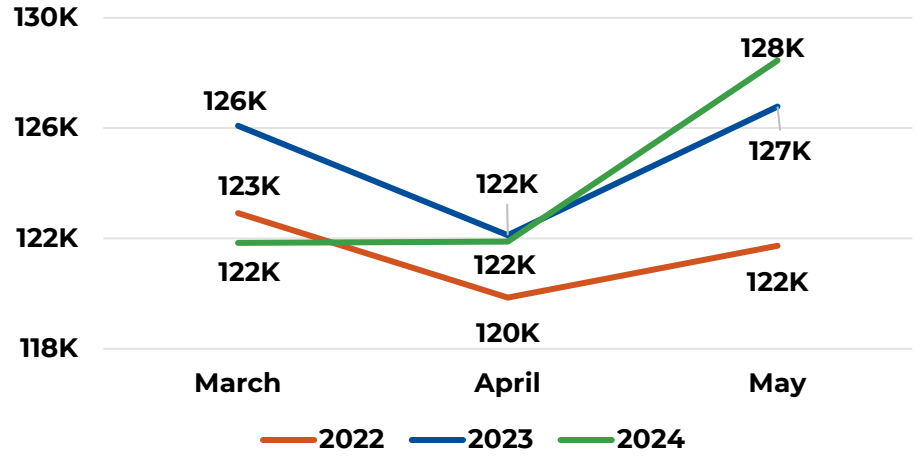
Enrollment & Utilization (Cont.)

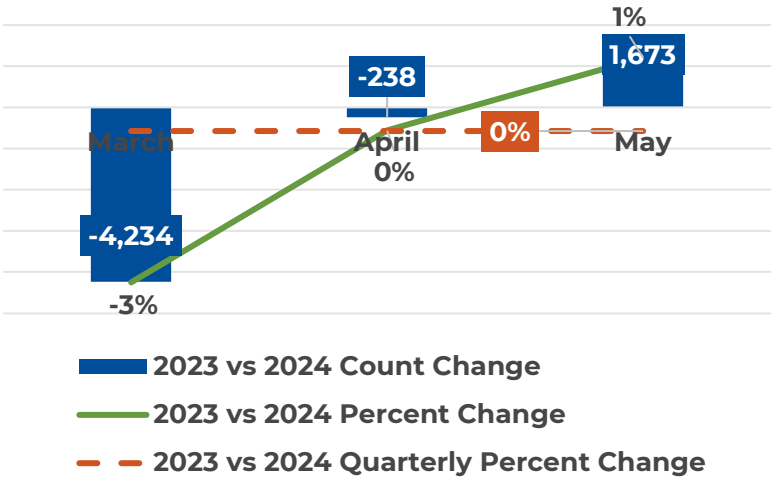
Total Members Utilization





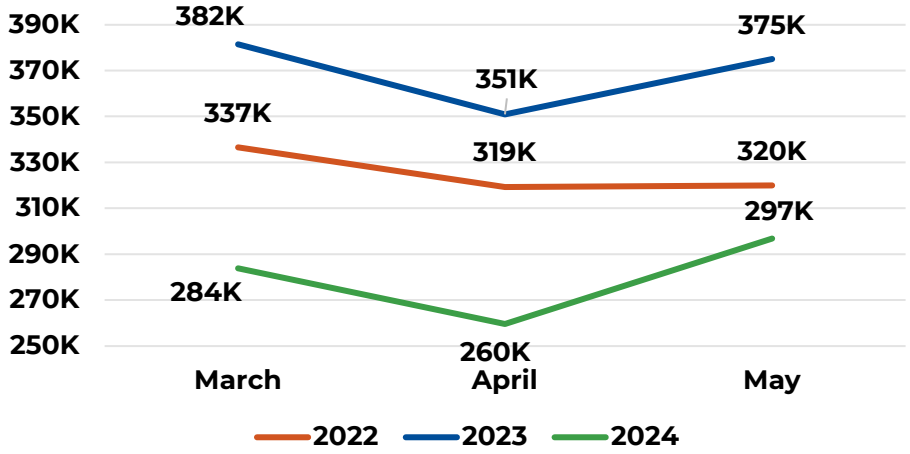
Aged/Blind/Disabled Utilization

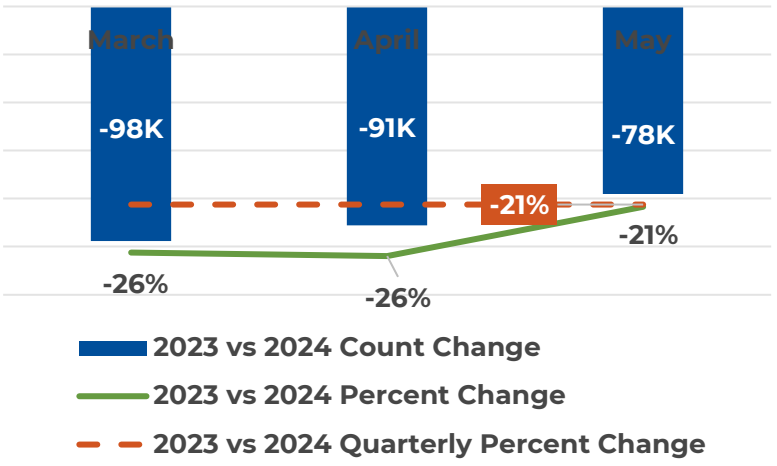




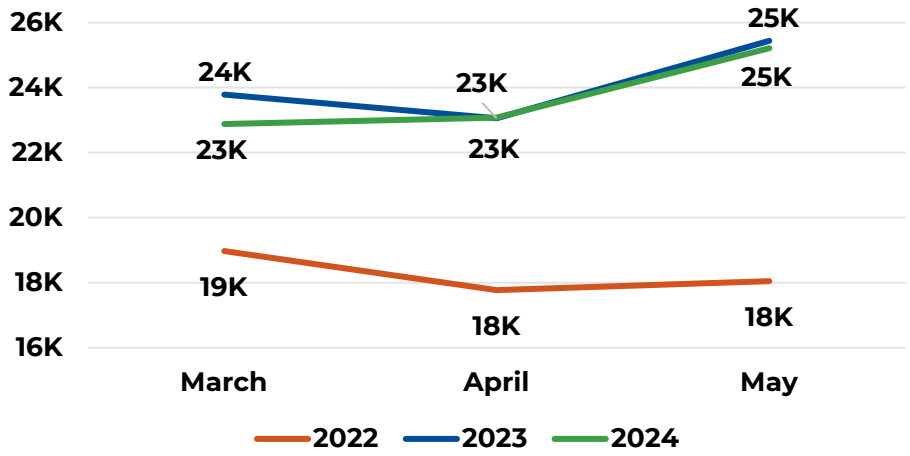
Enrollment & Utilization (Cont.)

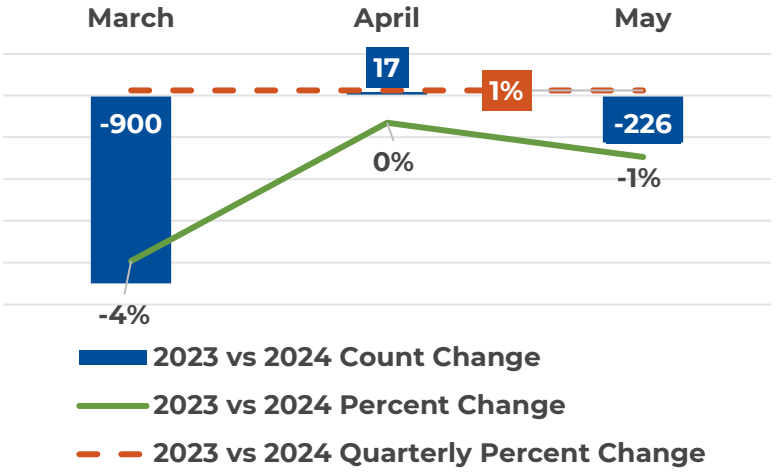
Children & Parent/Caretaker Utilization





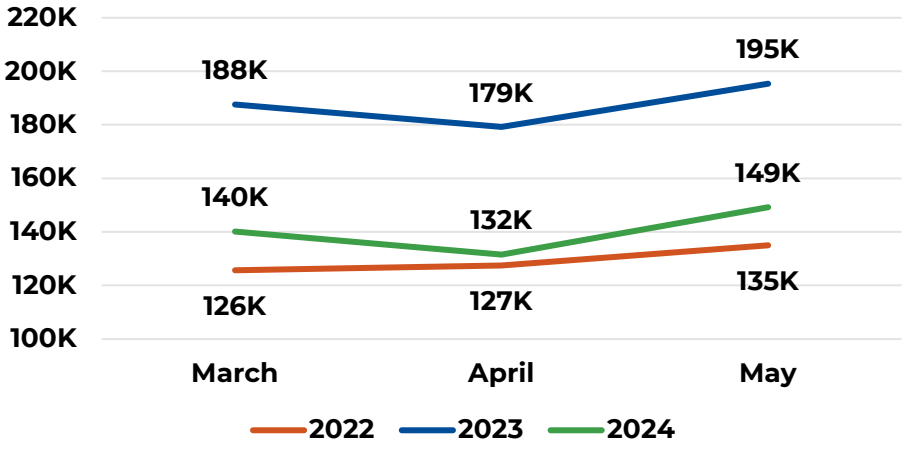
Pregnant (Full Scope) Utilization

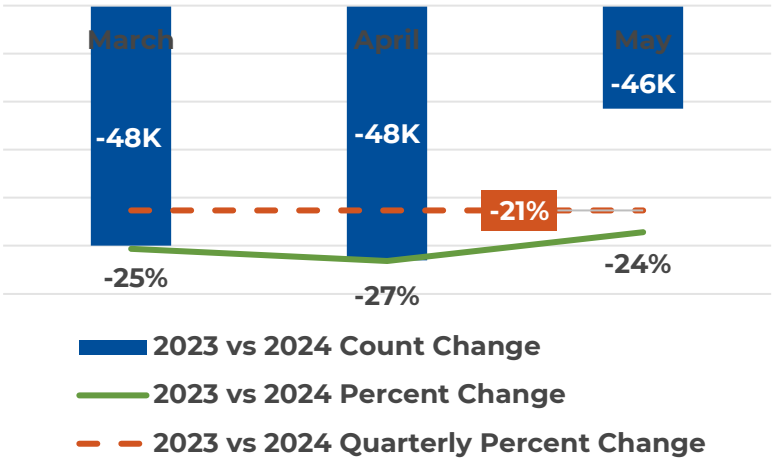




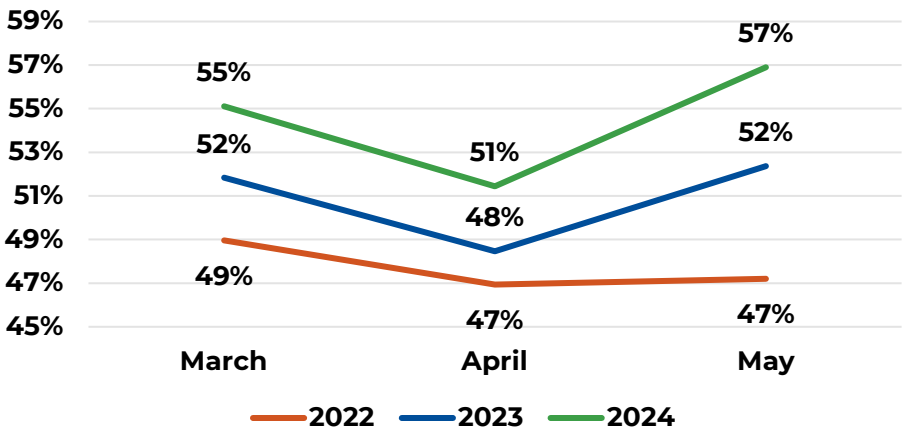
Enrollment & Utilization (Cont.)

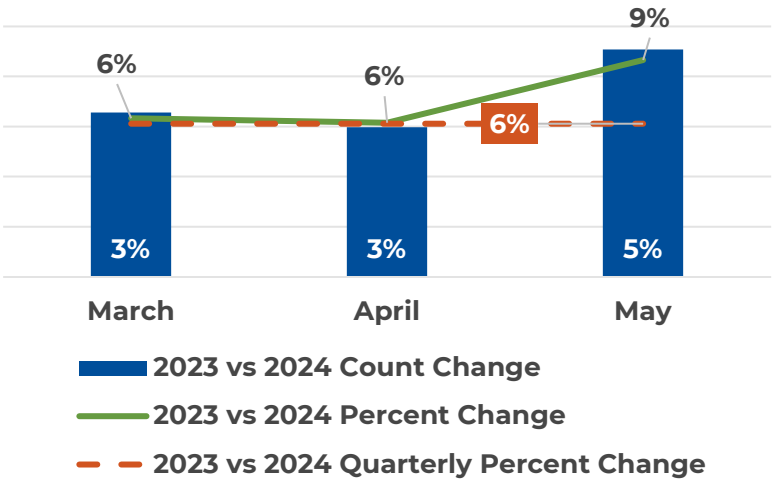
Expansion Utilization (Effective July 2021)





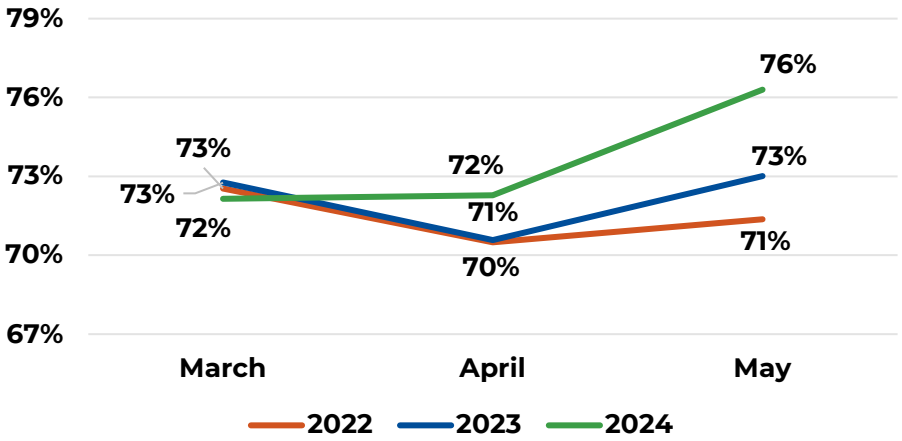
Percent of Total Enrolled Members Utilization

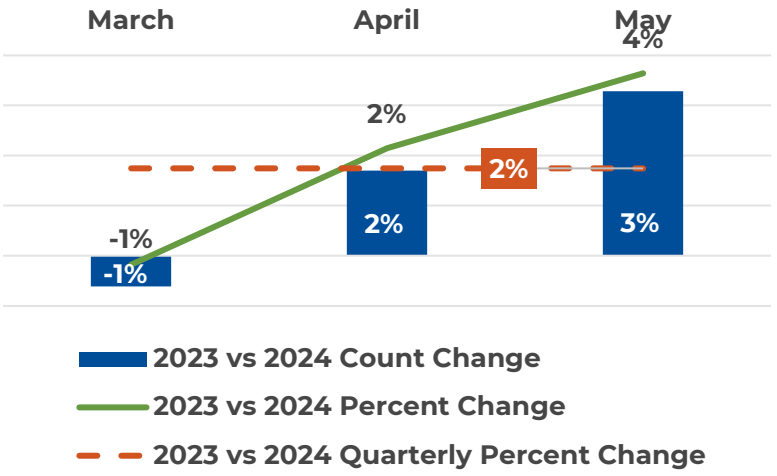




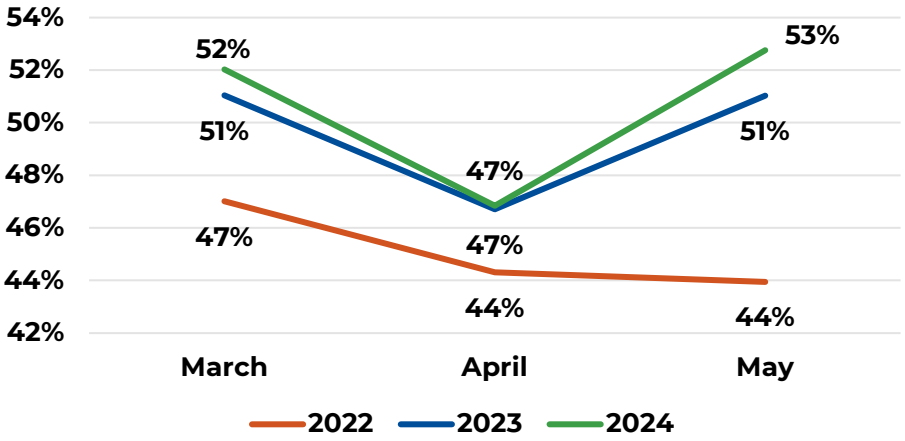
Enrollment & Utilization (Cont.)

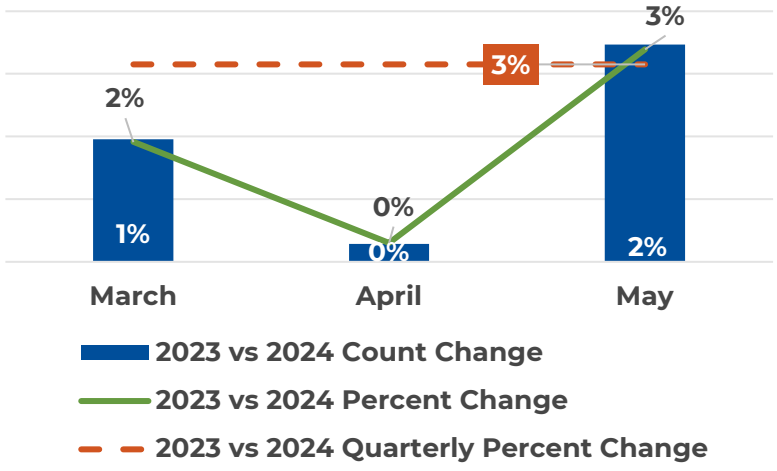
Percent of Aged/Blind/Disabled Enrolled Members Utilization





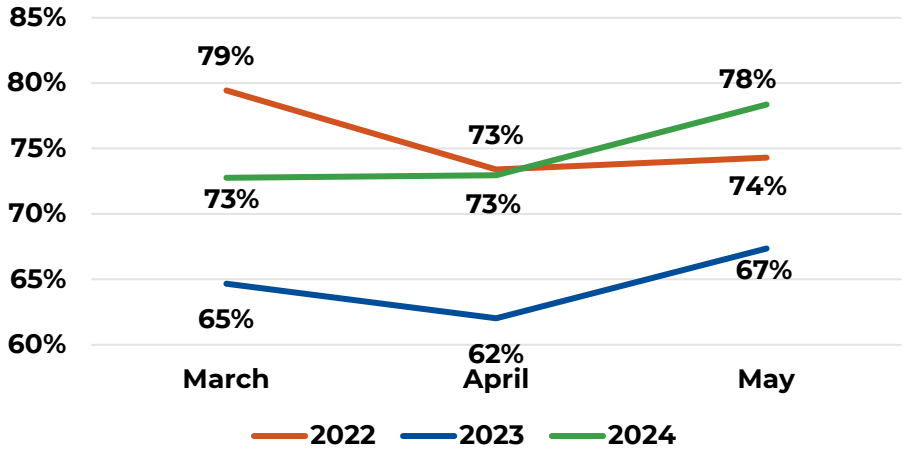
Percent of Children & Parent/Caretaker Enrolled Members Utilization

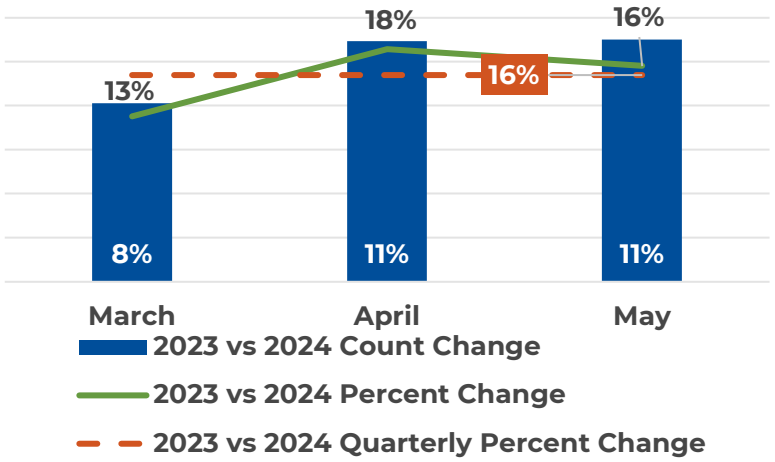




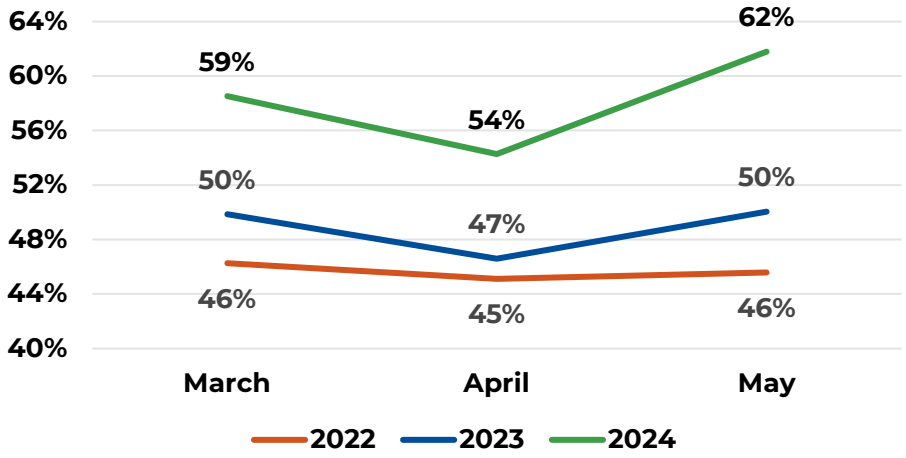
Enrollment & Utilization (Cont.)

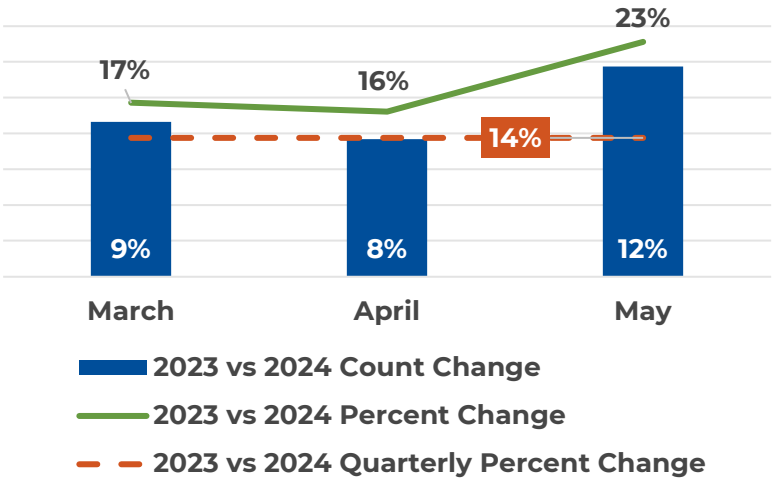
Percent of Pregnant (Full Scope) Enrolled Members Utilization





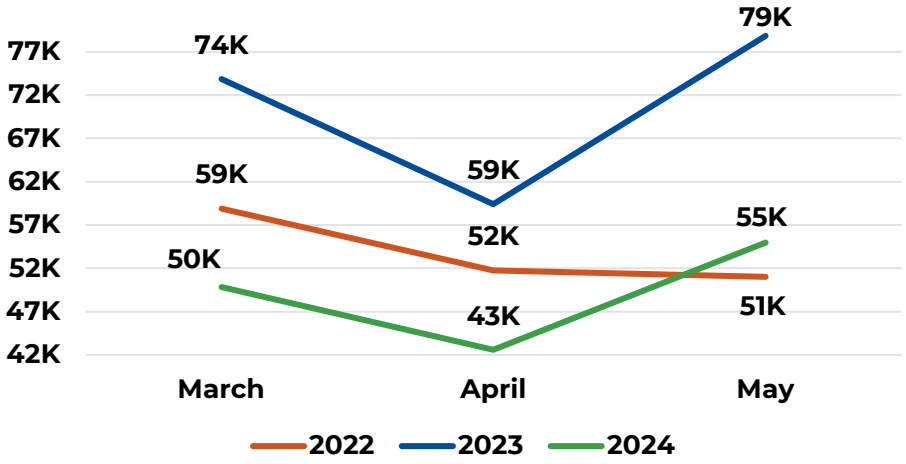
Percent of Expansion Enrolled Members Utilization (Effective July 2021)

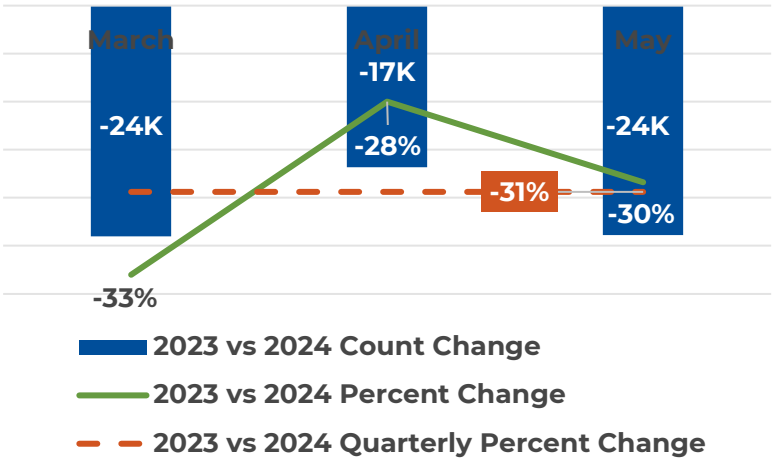




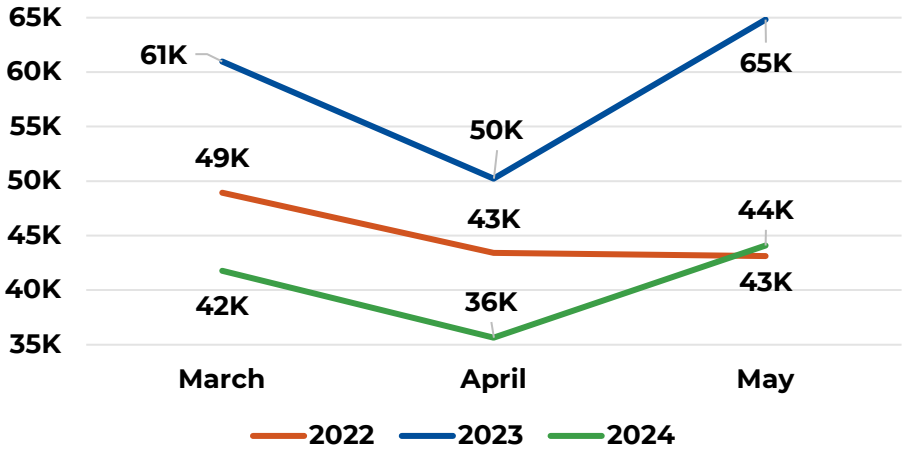
Utilization

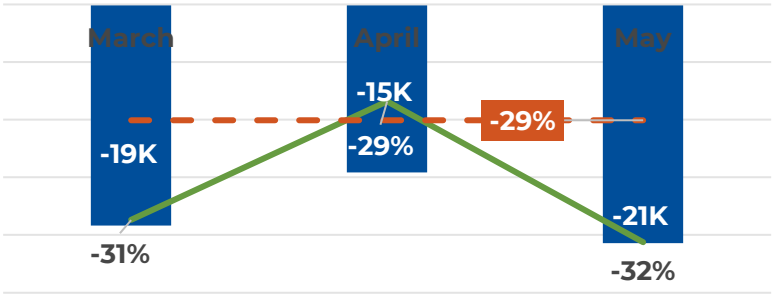
Emergency Department Visits (Claims)





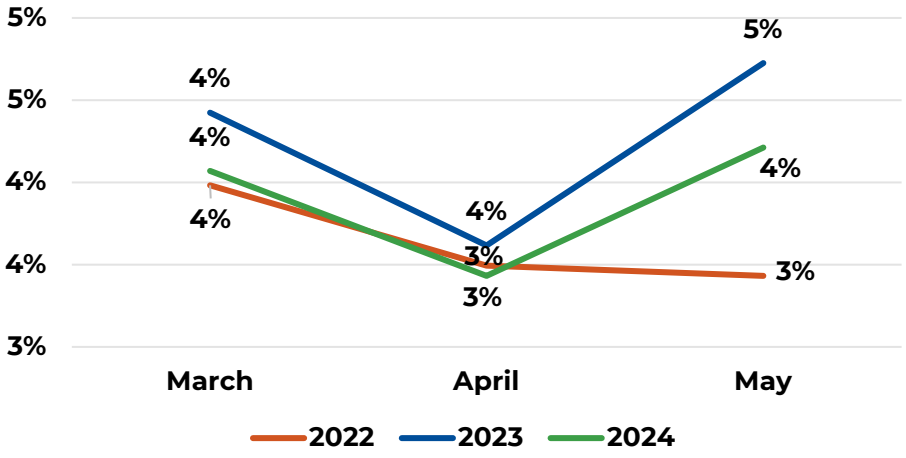
Members Utilizing Emergency Department

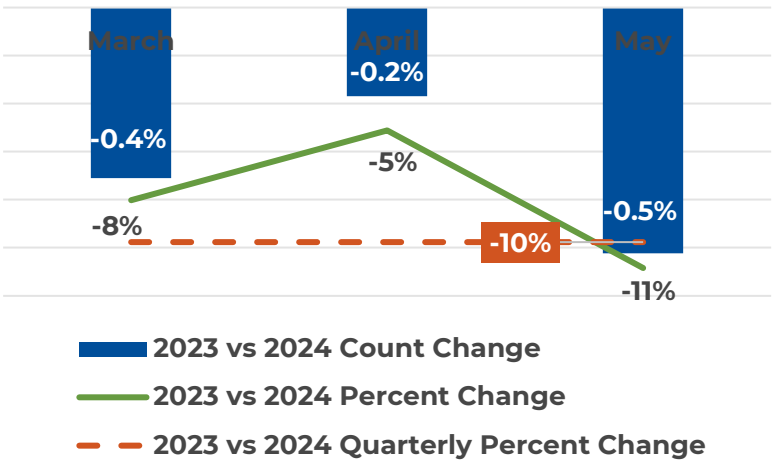




Utilization (Cont.)

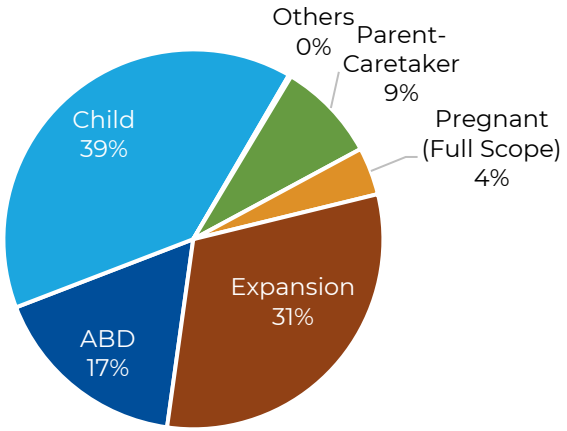
Percent Total Enrolled Using ED



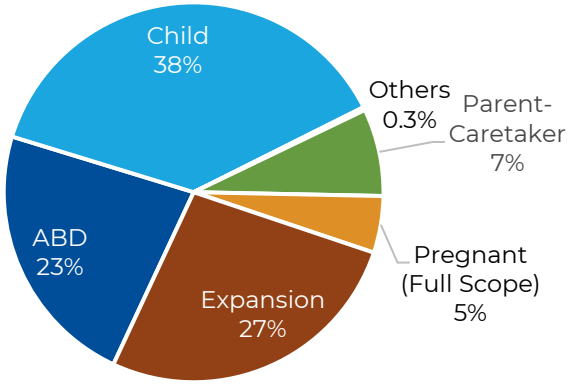


Members Utilizing Emergency Department By Qualifying Group

Q4 2023

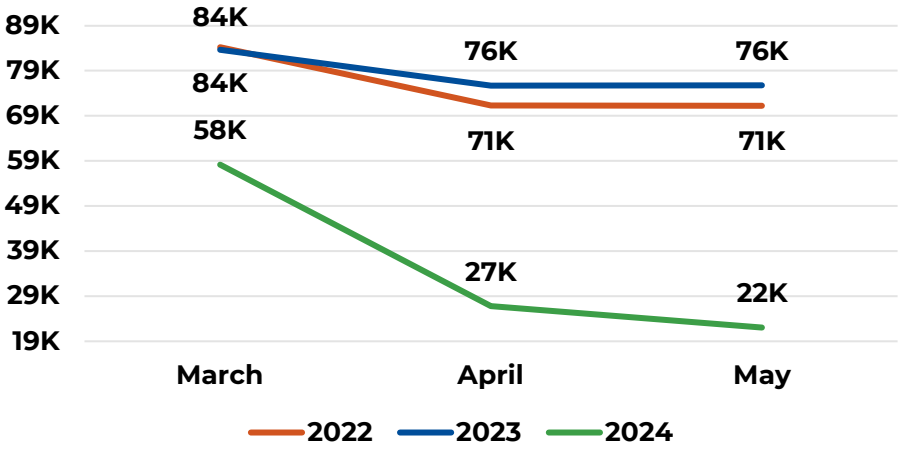


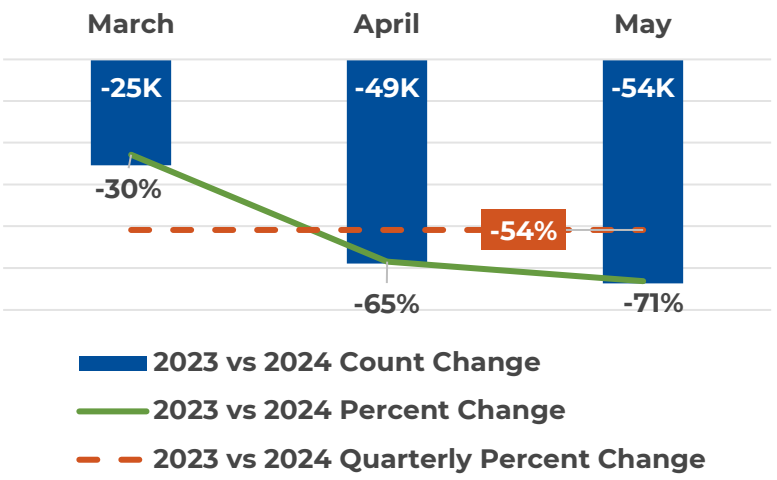
Q4 2024



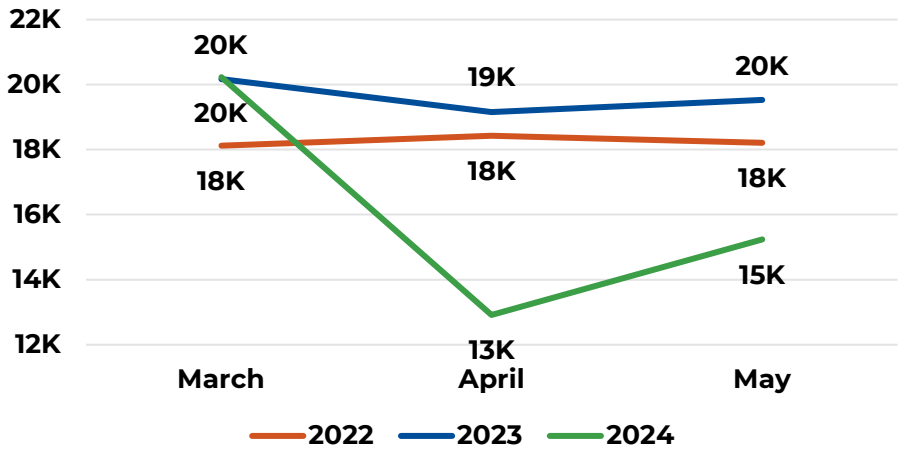
Utilization (Cont.)

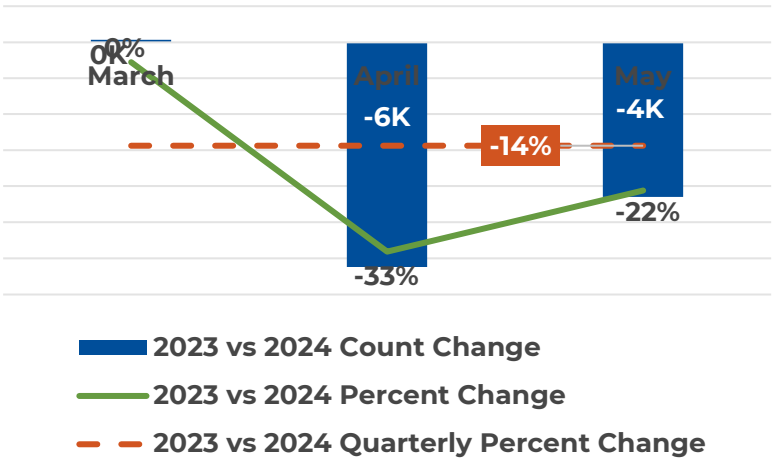
Telemedicine - Total Visits





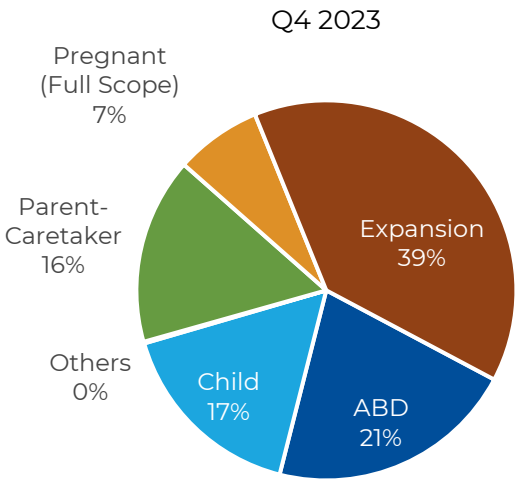
Members With Opioid Claims

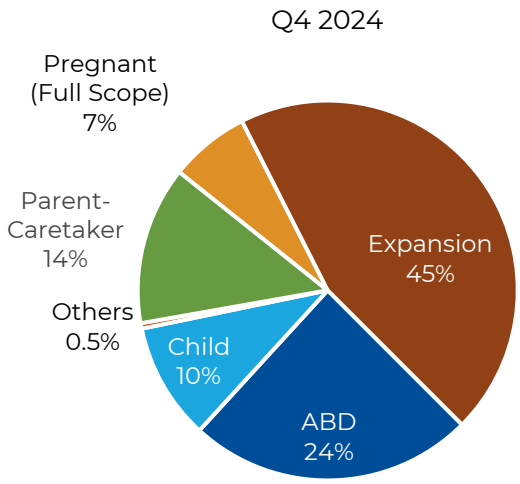




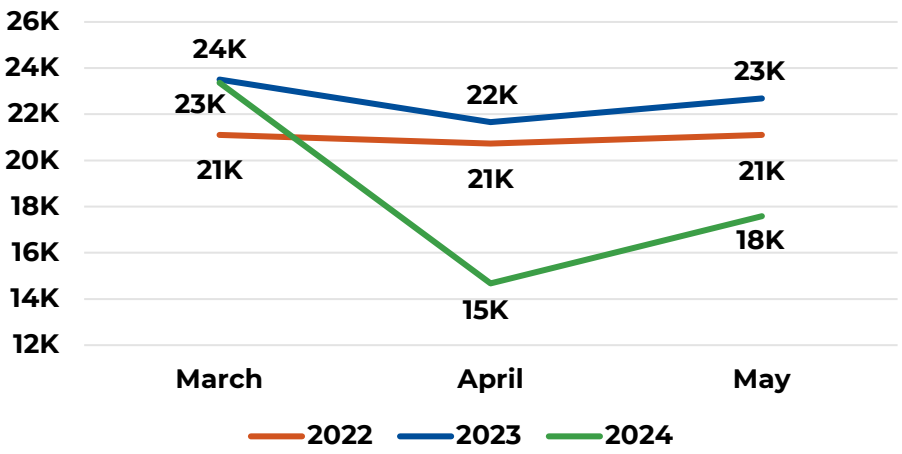
Utilization (Cont.)

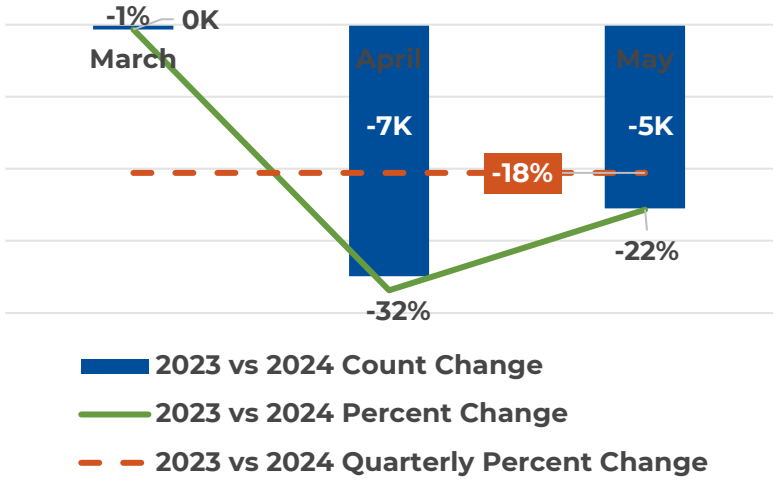
Members With Opioid Claims By Qualifying Group





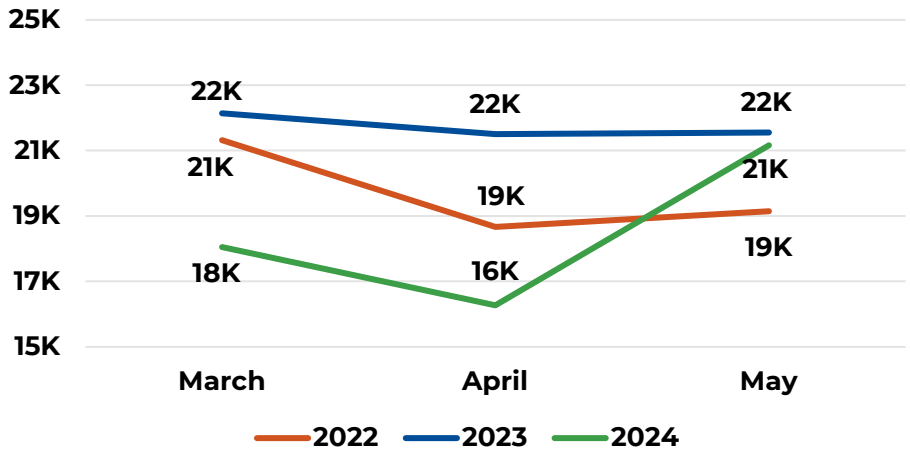
Total Opioid Claims

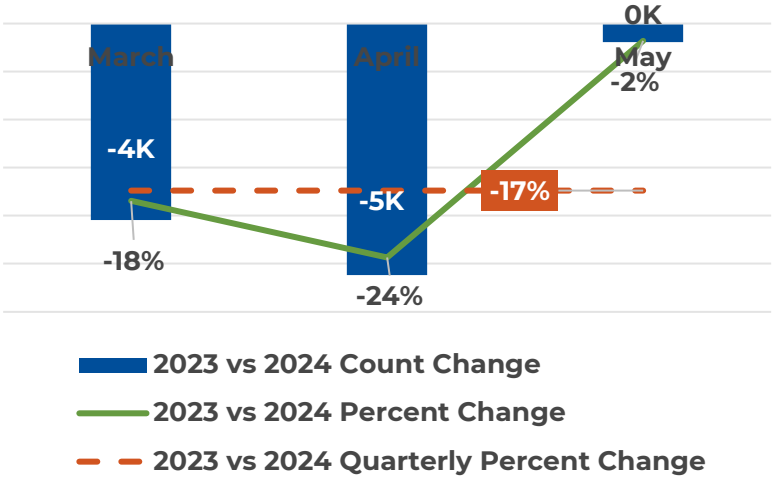




Utilization (Cont.)

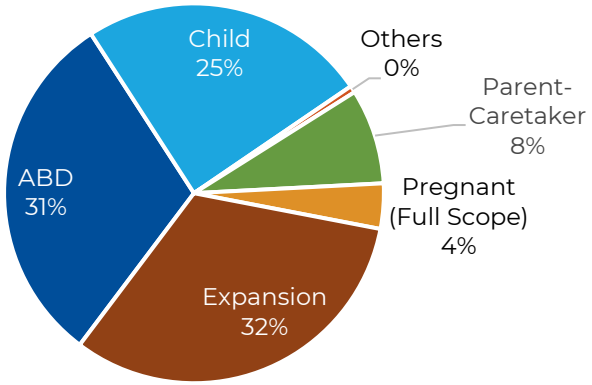
Out of State Services (Non Border County) - Total Members Utilization



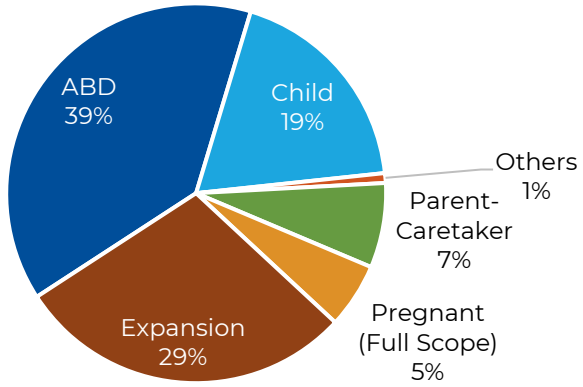


Out of State Services (Non Border County) - Total Members Utilization By Qualifying Group

Q4 2023

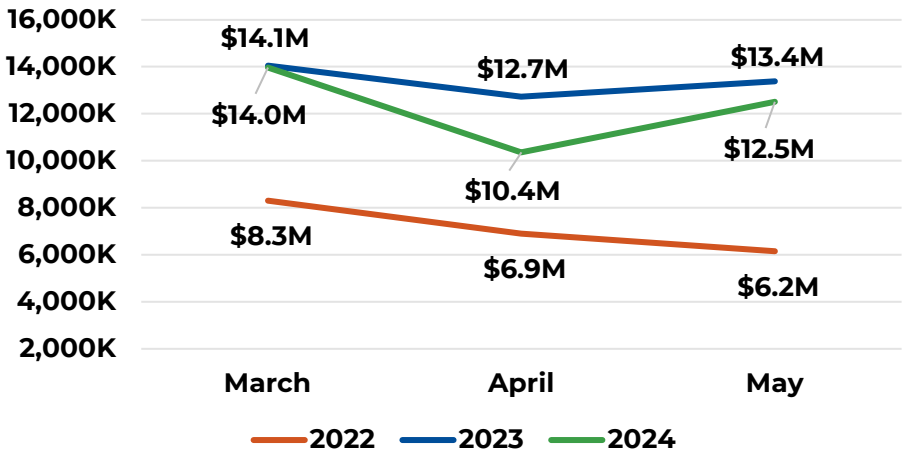


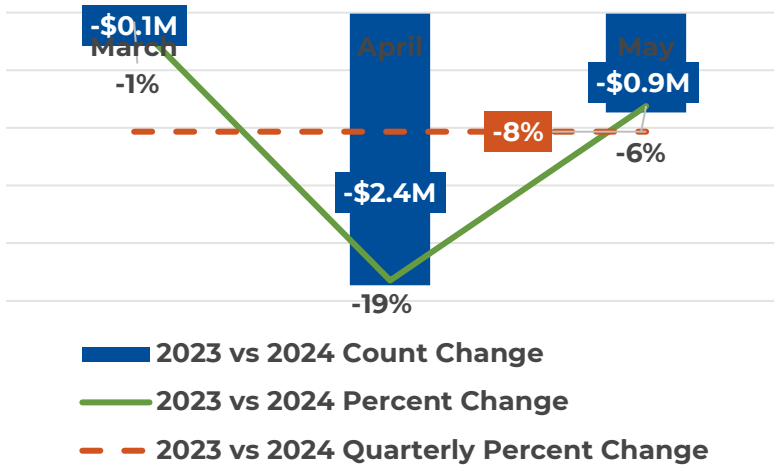
Q4 2024



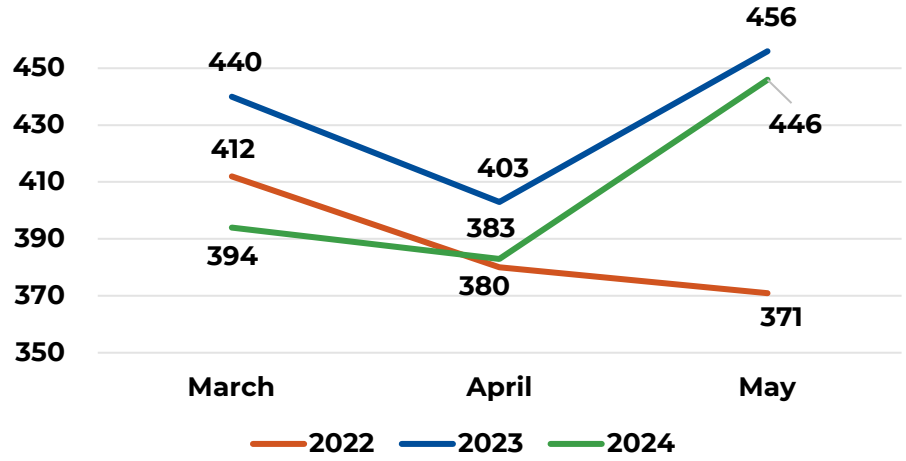
Utilization (Cont.)

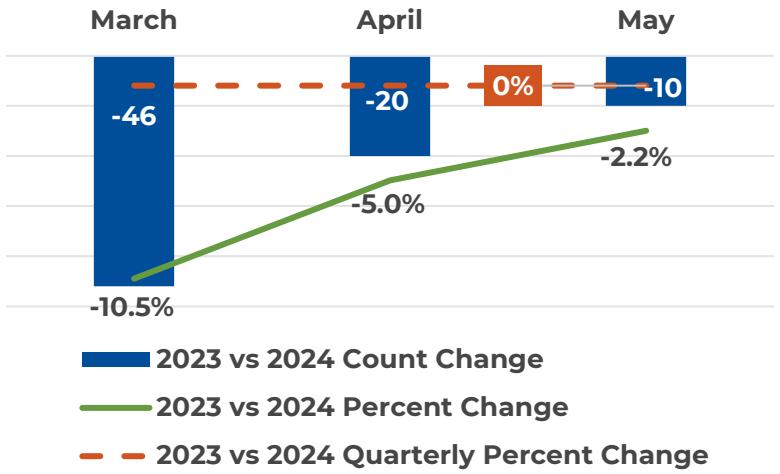
Out of State Services (Non Border County) - Total Reimbursements





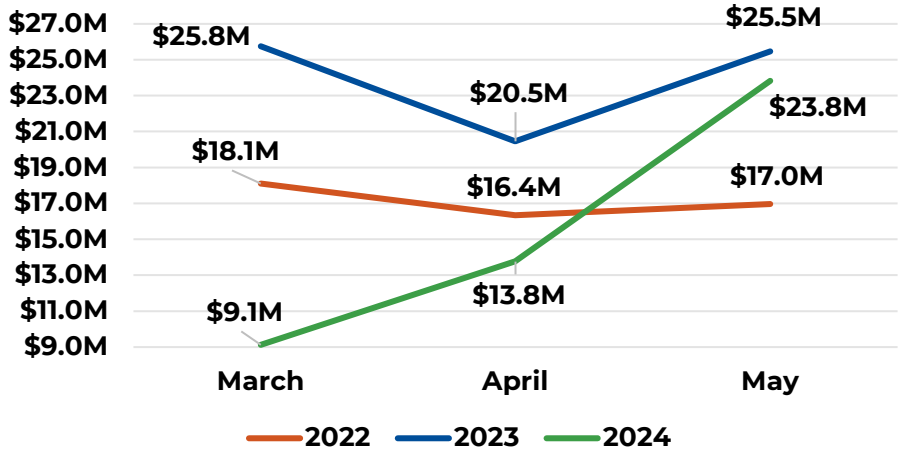
Out of State Services (Non Border County) - Total Active Billing Providers

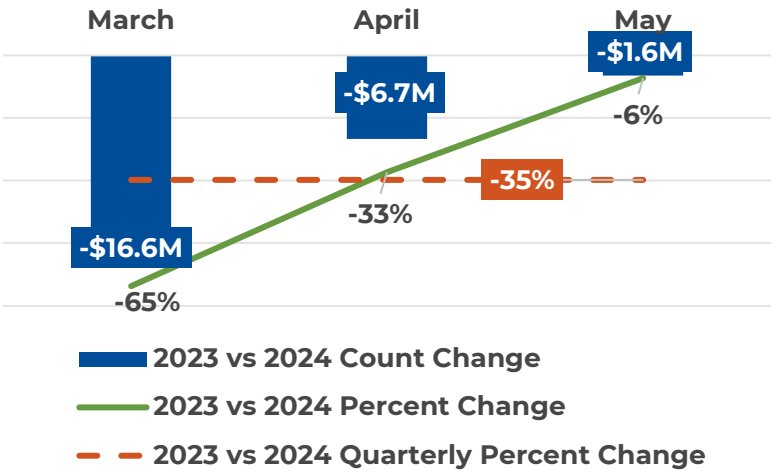




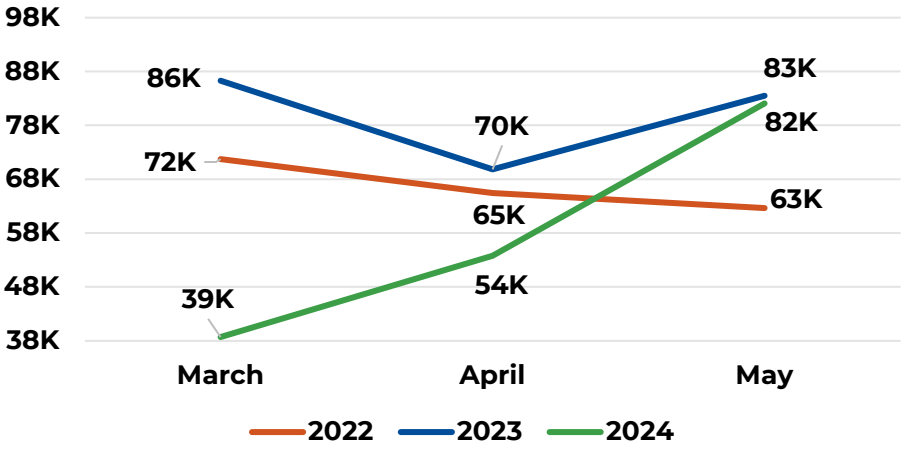
Utilization (Cont.)

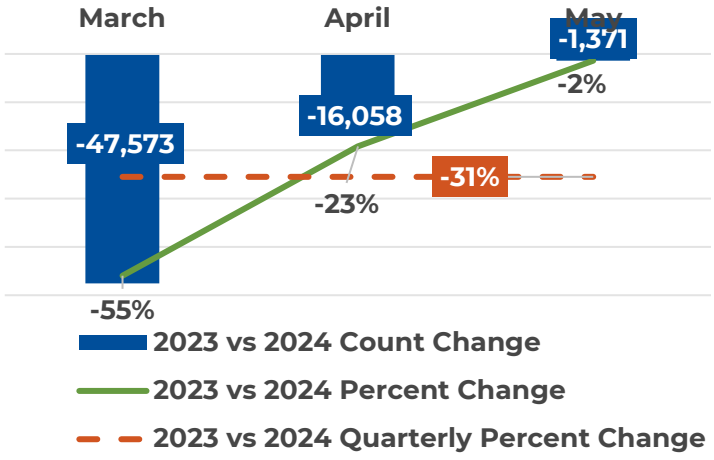
Dental Claims





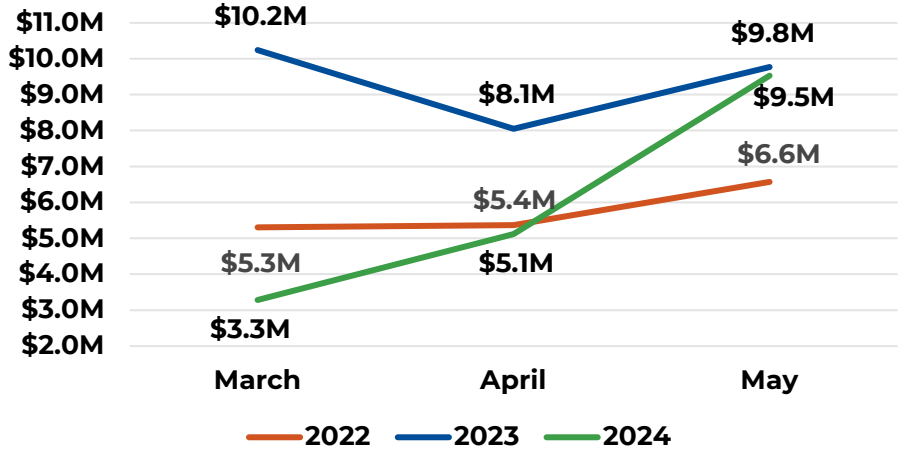
Total Members with Dental Claims

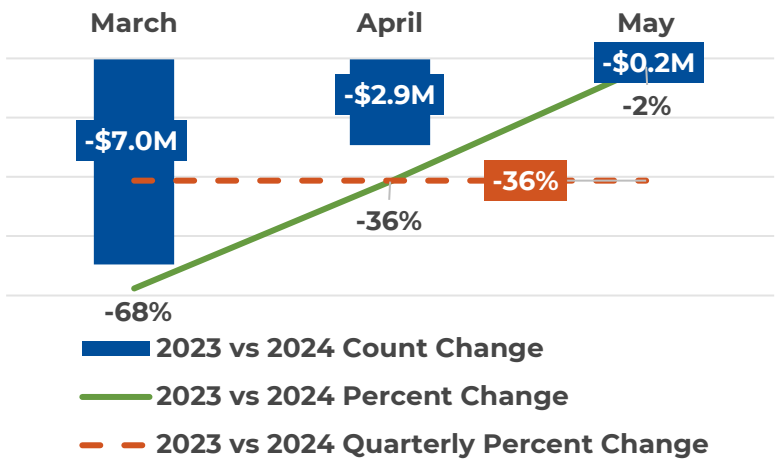




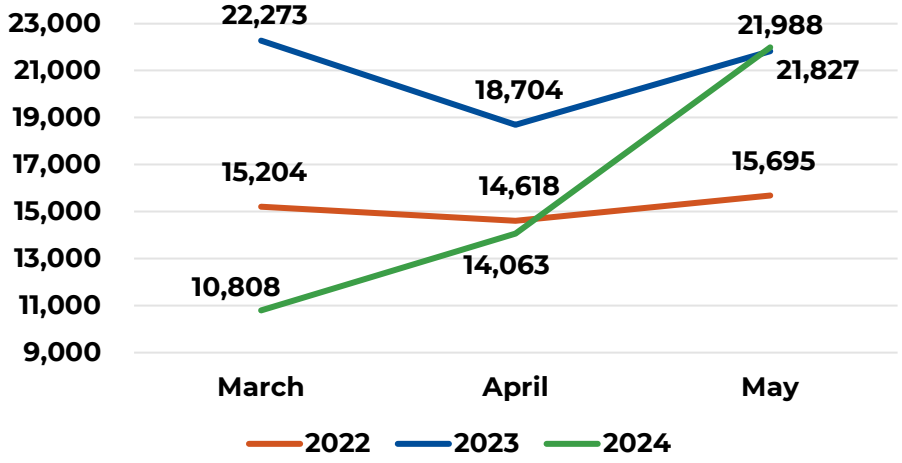
Utilization (Cont.)

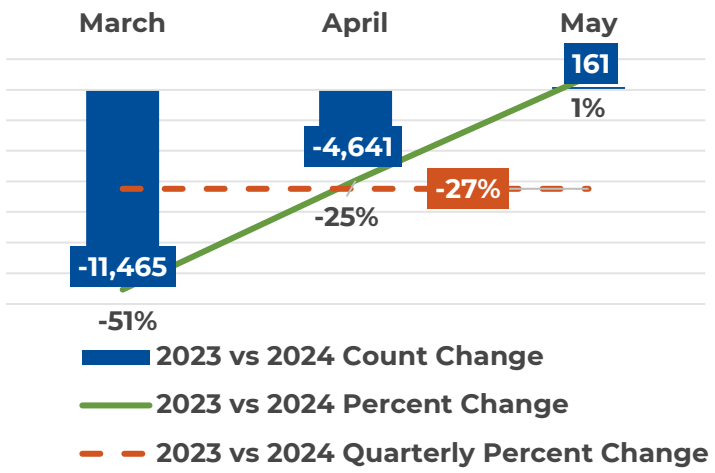
Adult (21 & Over) Dental Claims





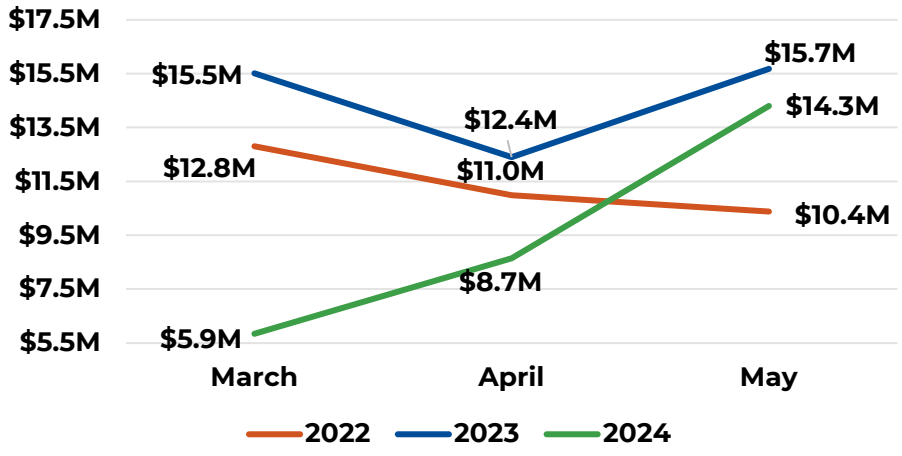
Adults (21 & Over) with Dental Claims

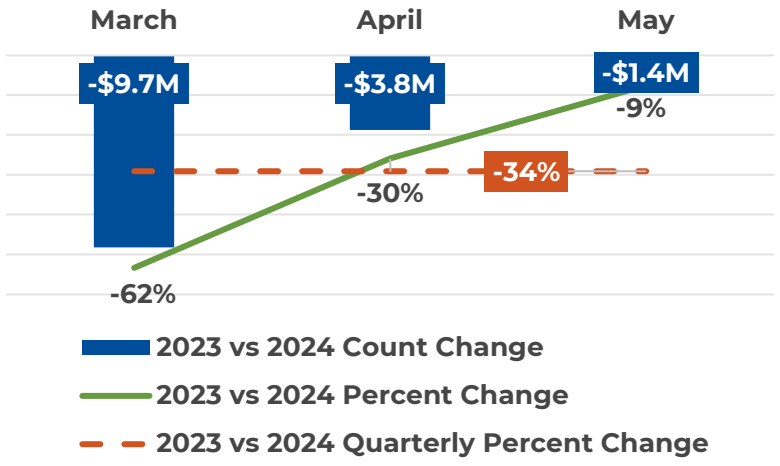




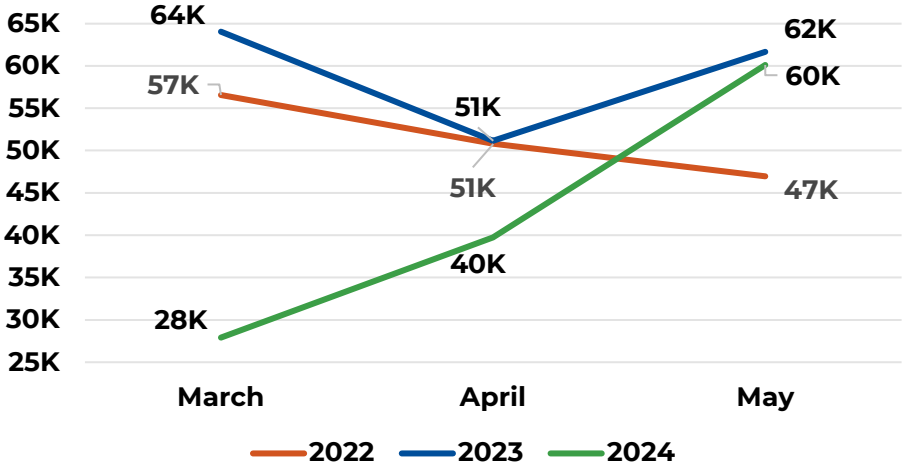
Utilization (Cont.)

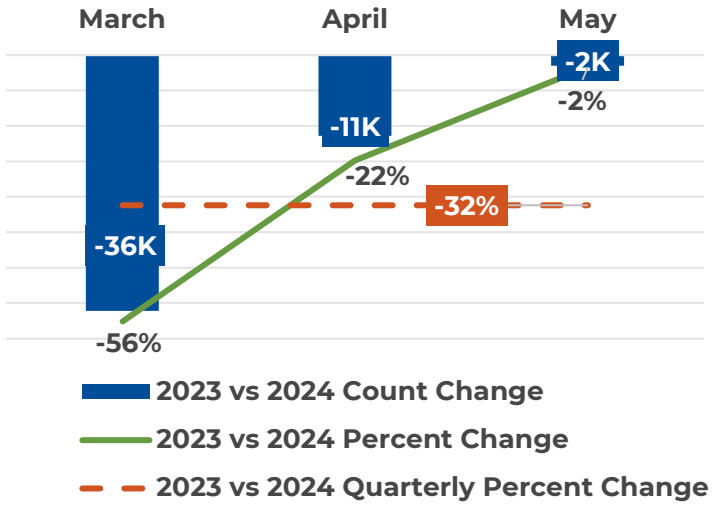
Children (Under 21) Dental Claims





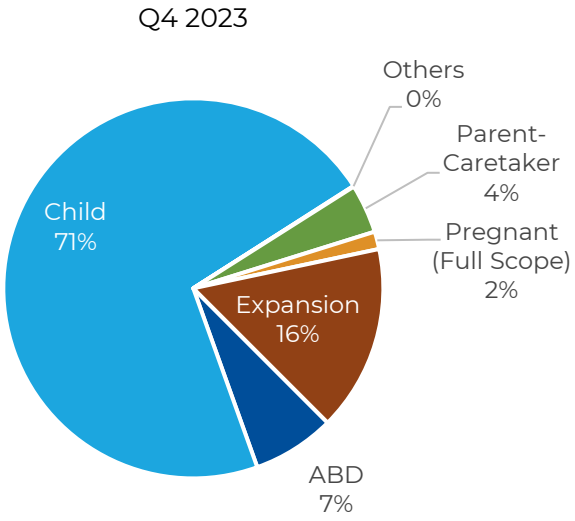
Children (Under 21) with Dental Claims

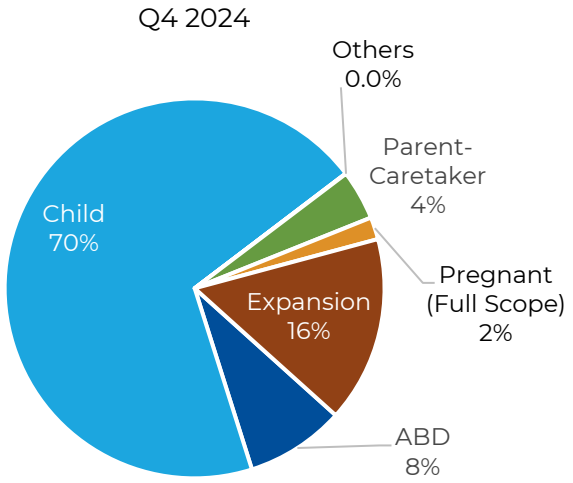




Utilization (Cont.)

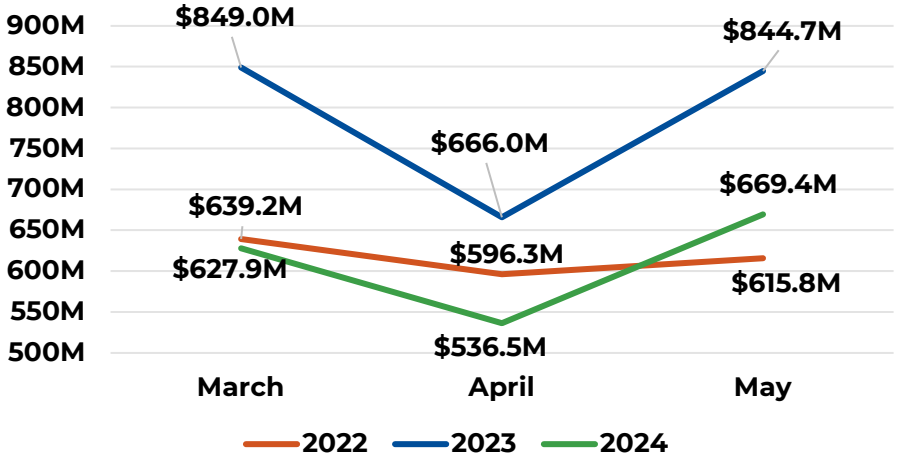
Members With Dental Claims By Qualifying Group

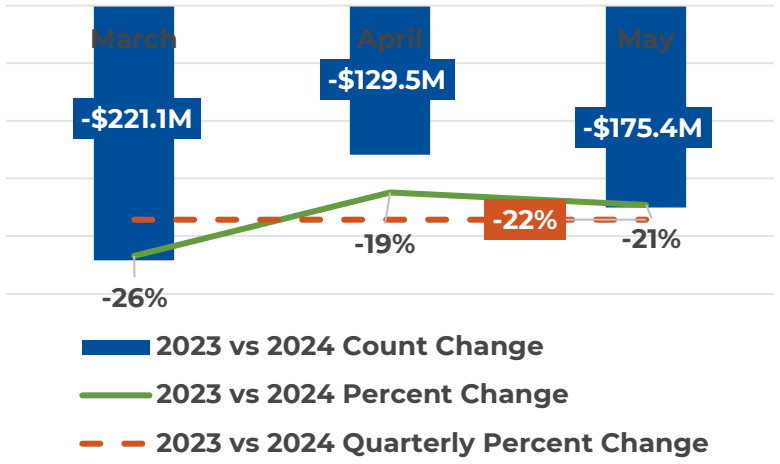




Financials

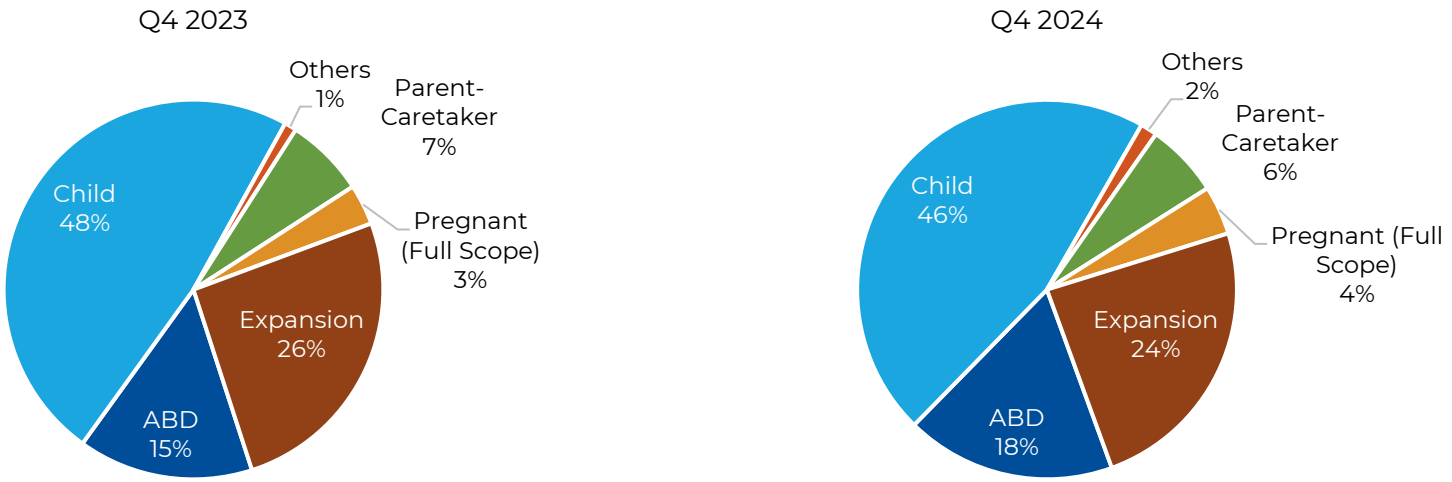
Total Agency Expenditures



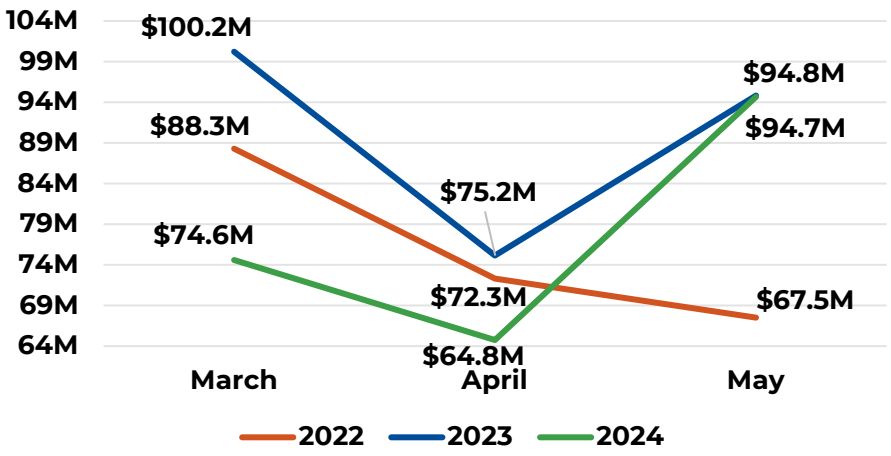


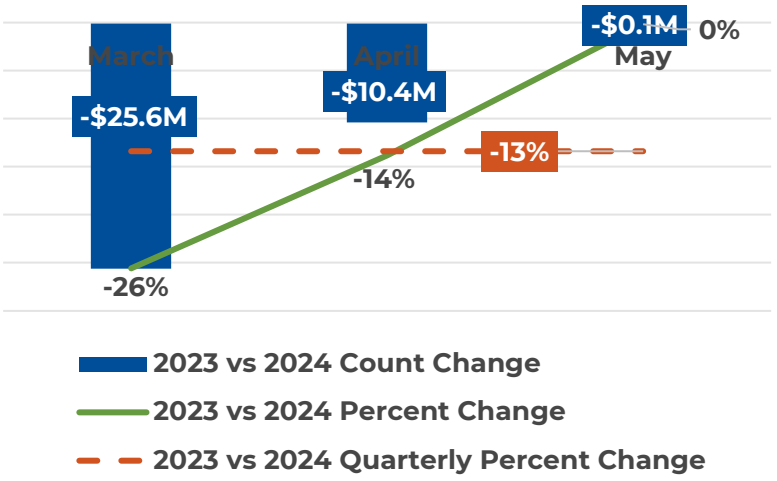
Financials (Cont.)

Total Agency Members Utilization by Qualifying Group



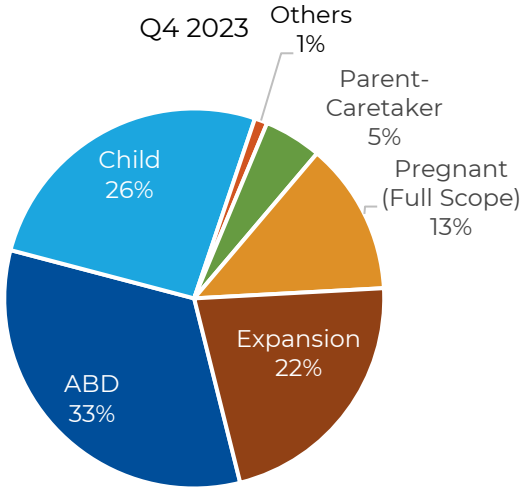
Inpatient Services Expenditures

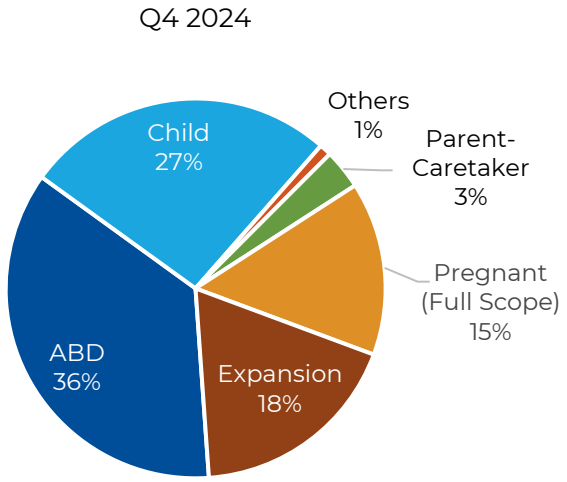




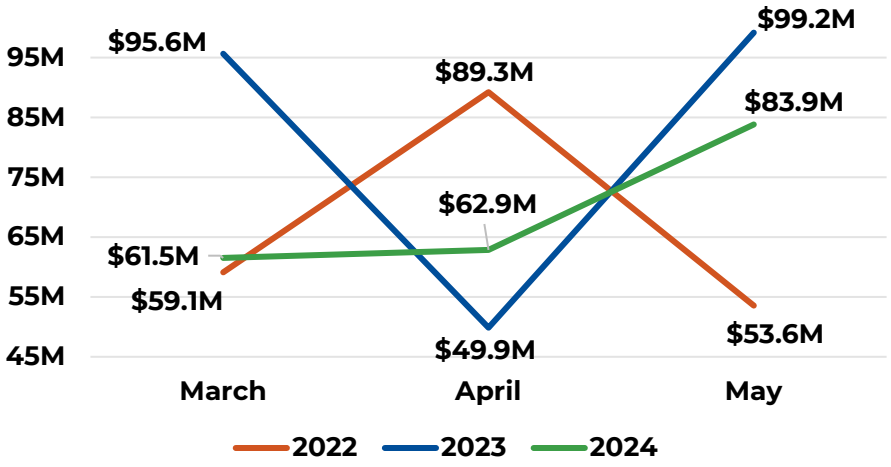
Financials (Cont.)

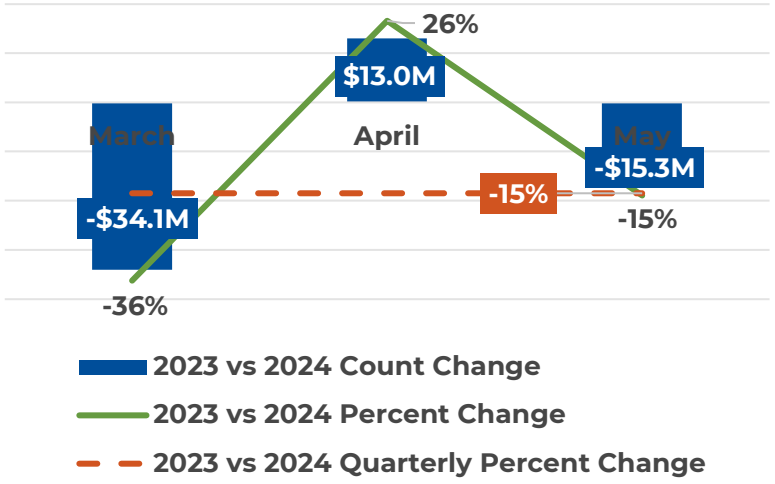
Inpatient Services Members Utilization by Qualifying Group





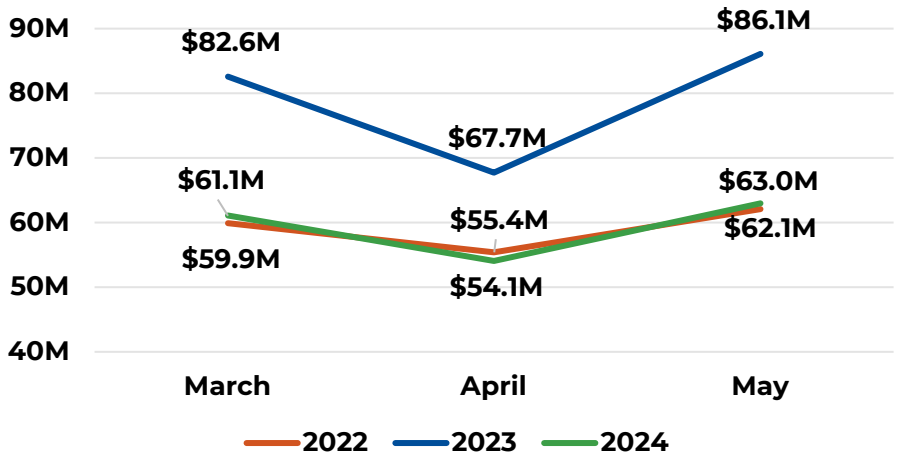
Nursing Facility Expenditures

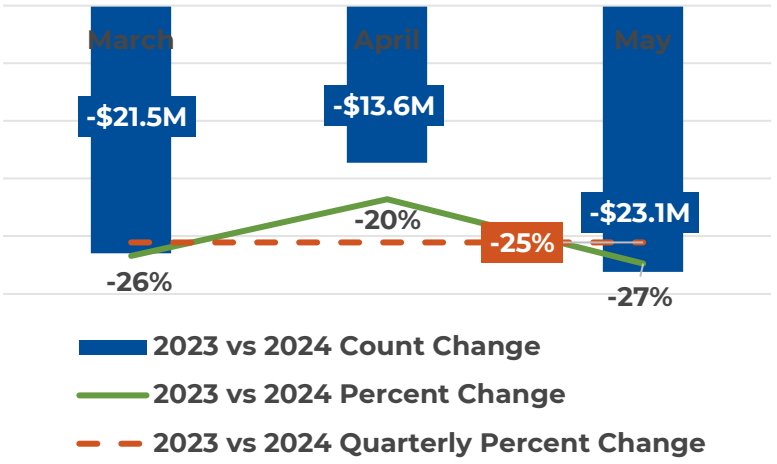




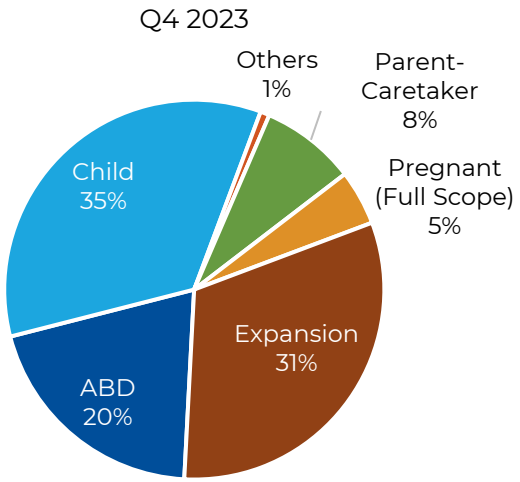
Financials (Cont.)

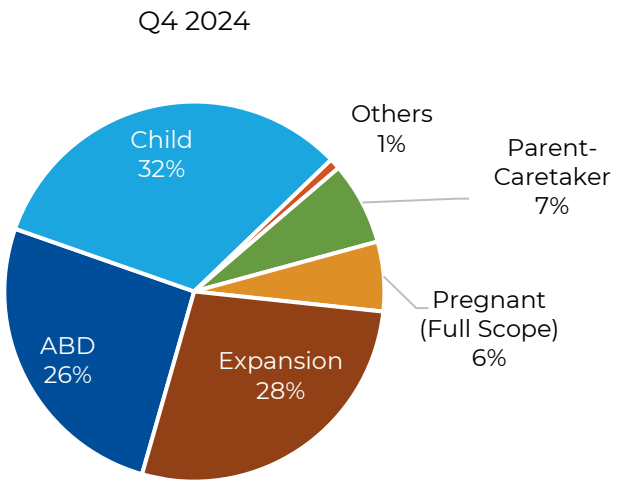
Outpatient Hospital Expenditures





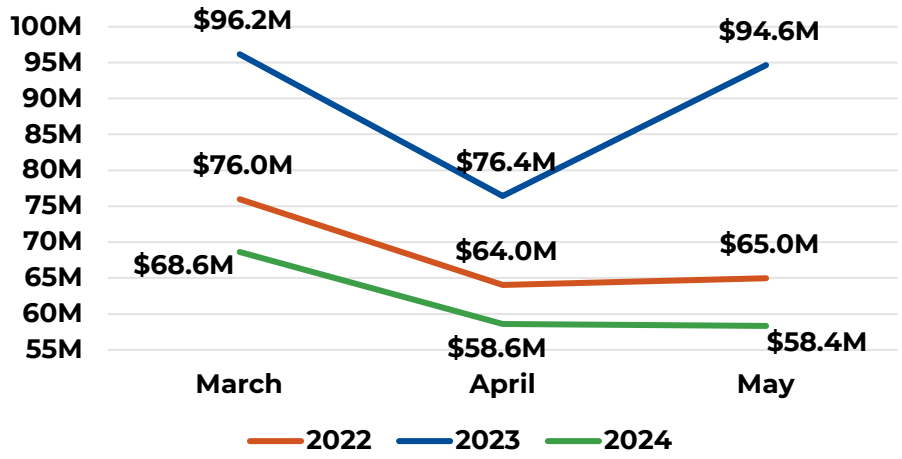
Outpatient Hospital Members Utilization by Qualifying Group

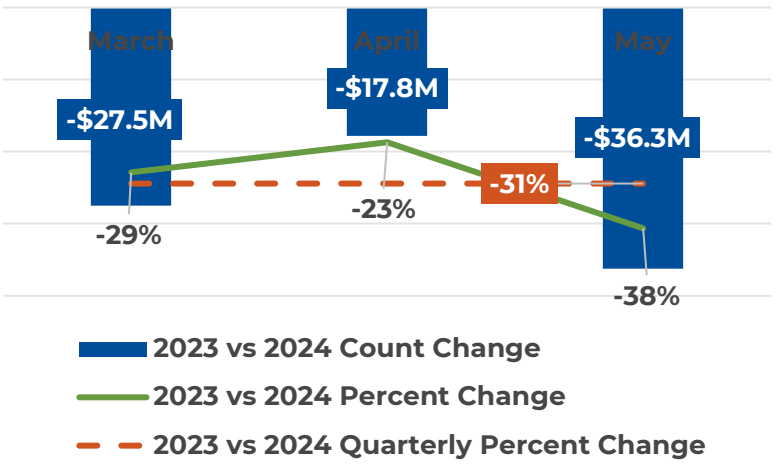




Financials (Cont.)

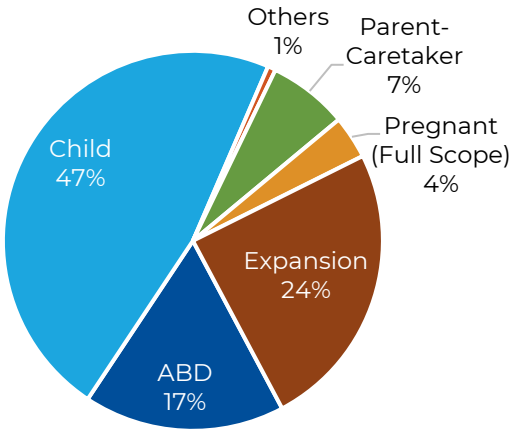
Physician Expenditures



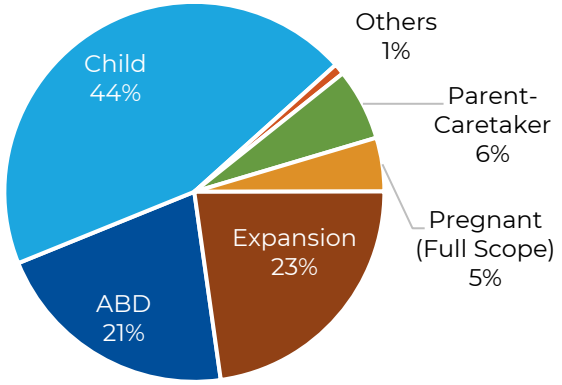


Physician Members Utilization By Qualifying Group

Q4 2023

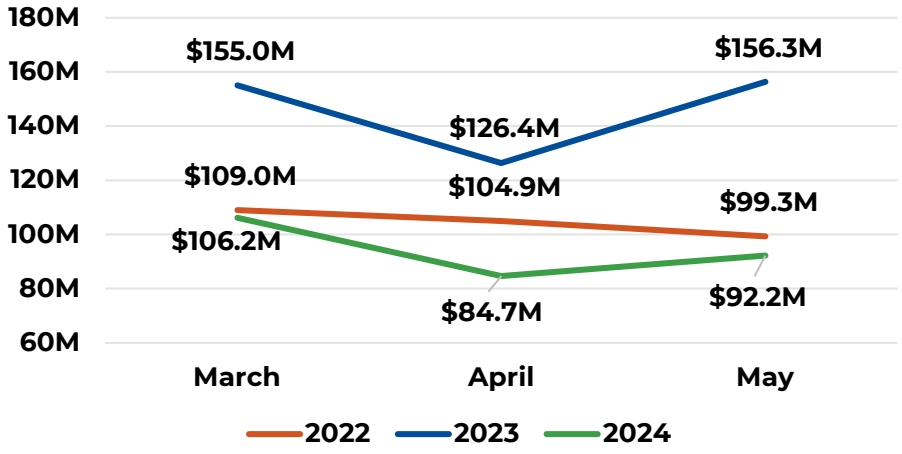


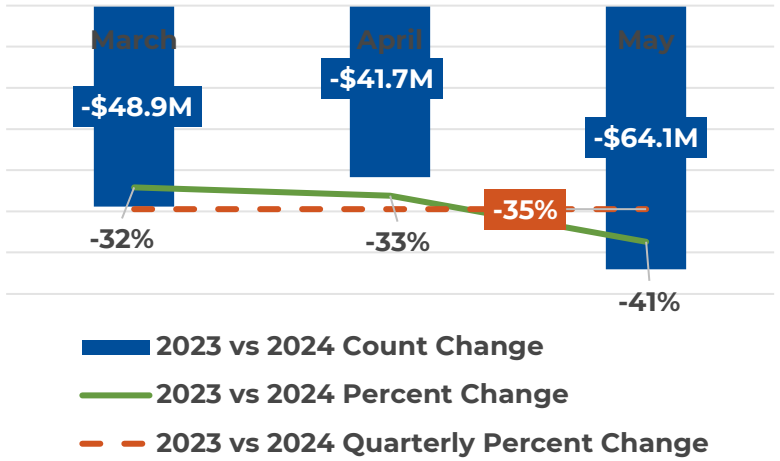
Q4 2024



Financials (Cont.)

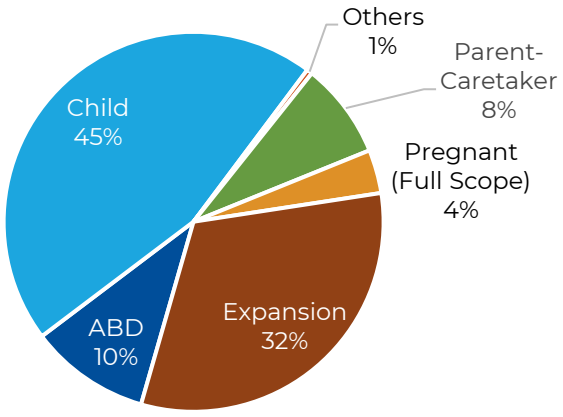
Prescribed Drugs Expenditures



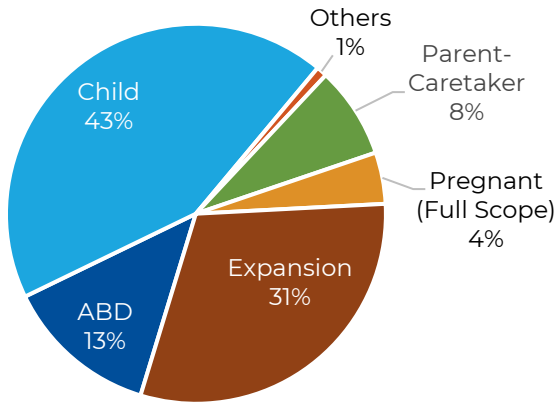


Prescribed Drugs Members Utilization By Qualifying Group

Q4 2023

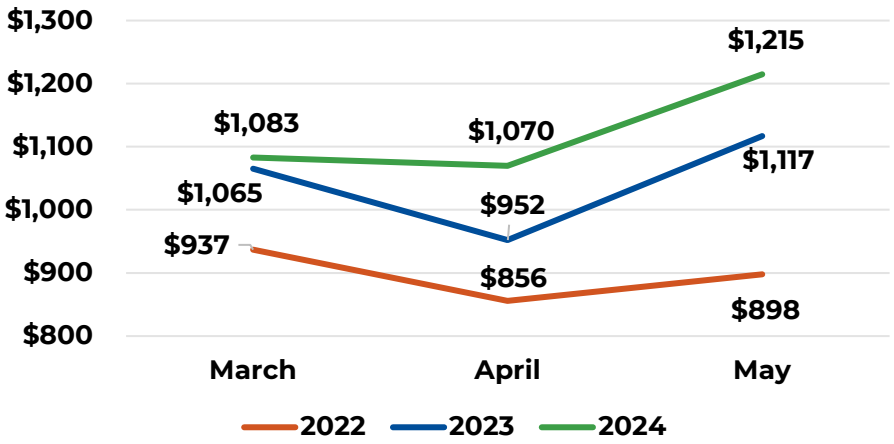


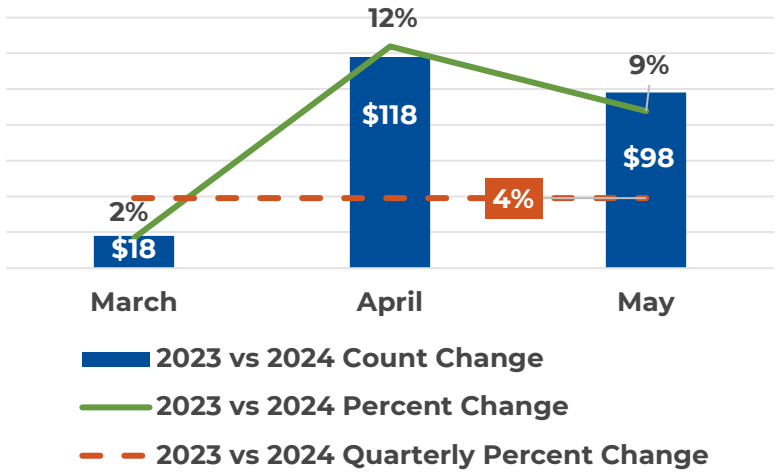
Q4 2024



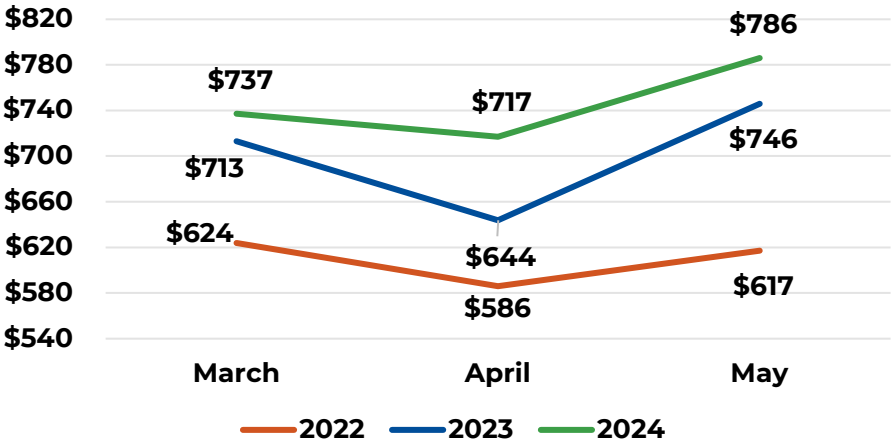
Financials (Cont.)

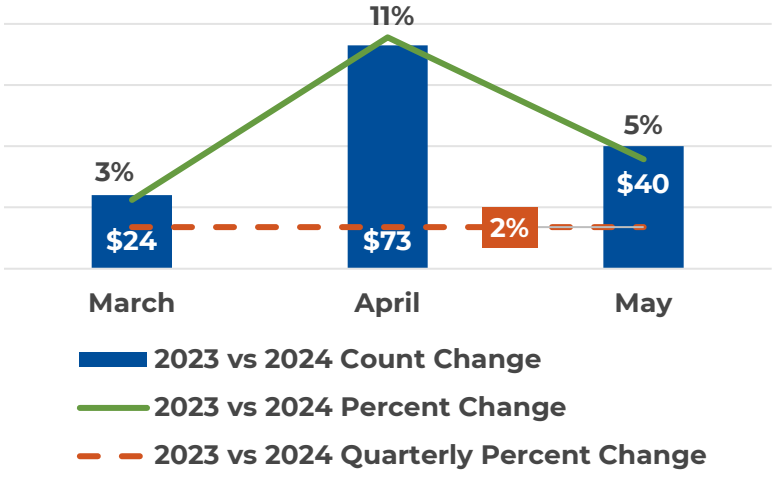
Average Per Total Member Served





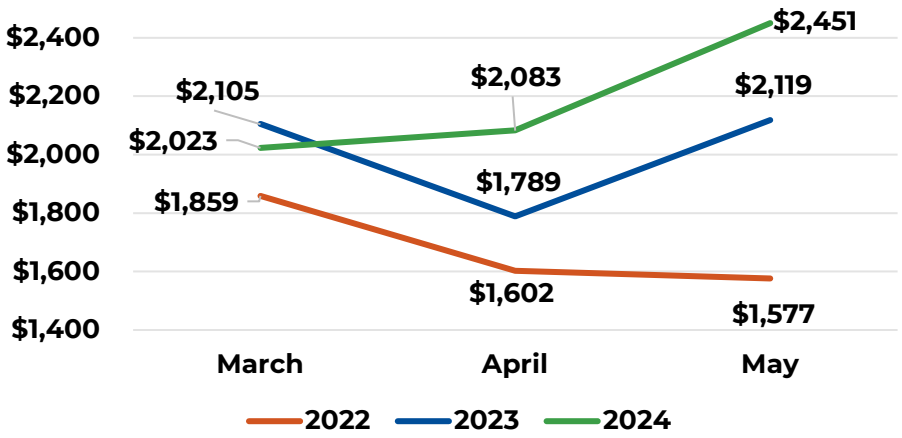
Average Per Child (Under 21) Member Served

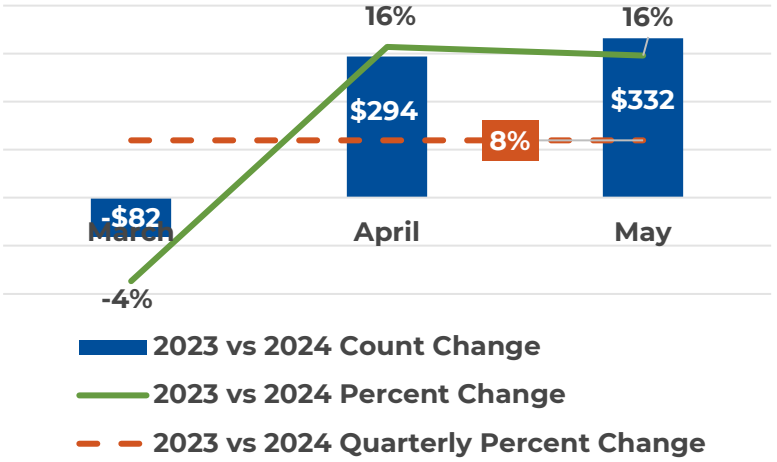




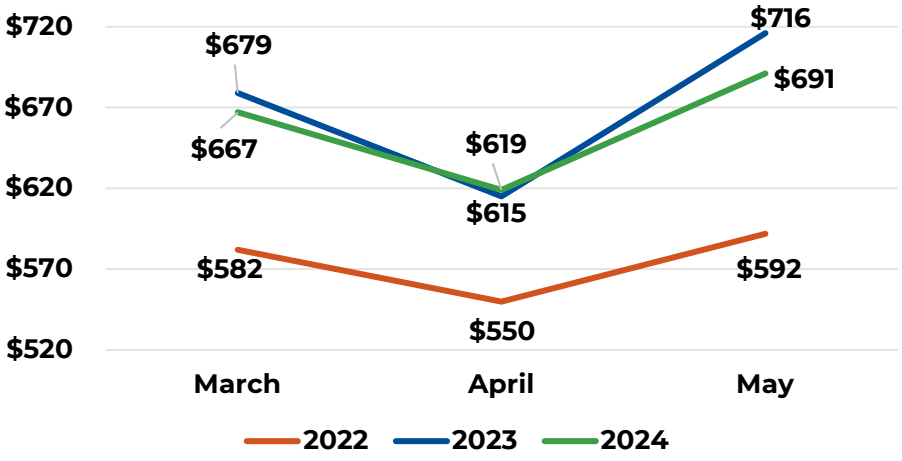
Financials (Cont.)

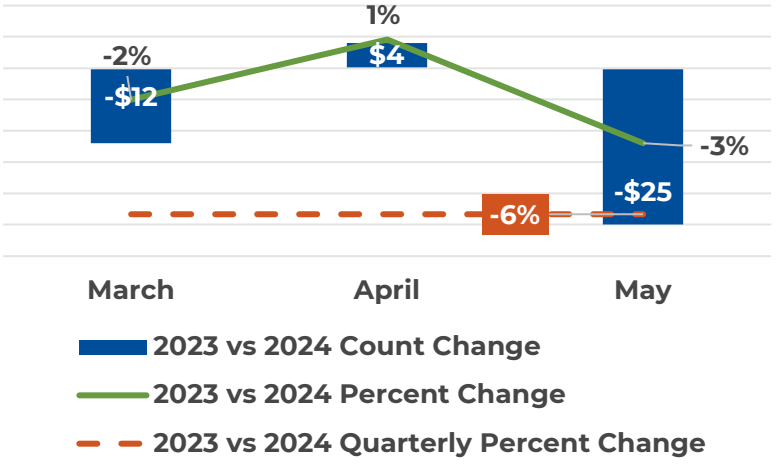
Average Per Aged/Blind/Disabled Member Served





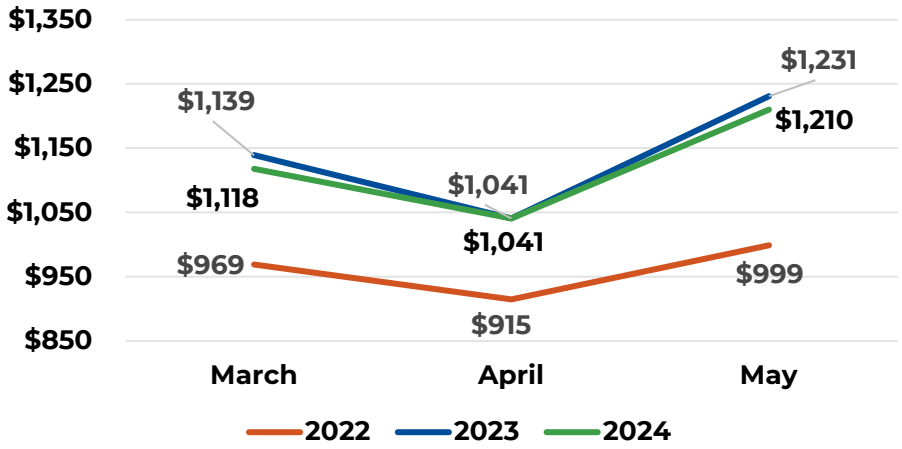
Average Per Children & Parent/Caretaker Member Served

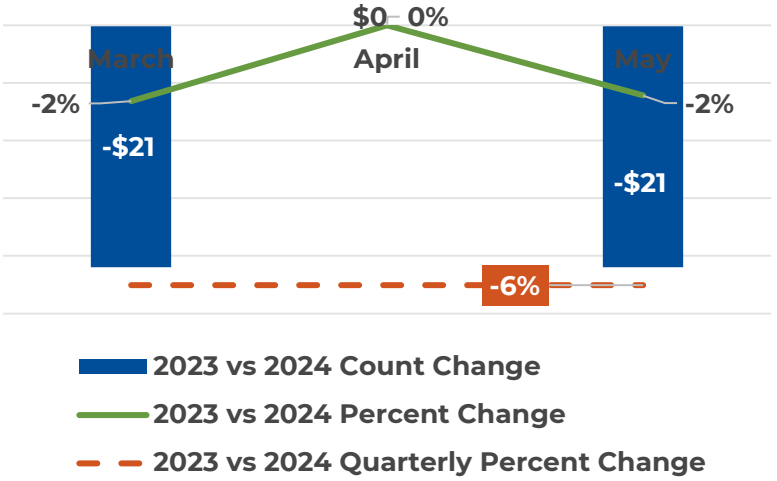




Financials (Cont.)

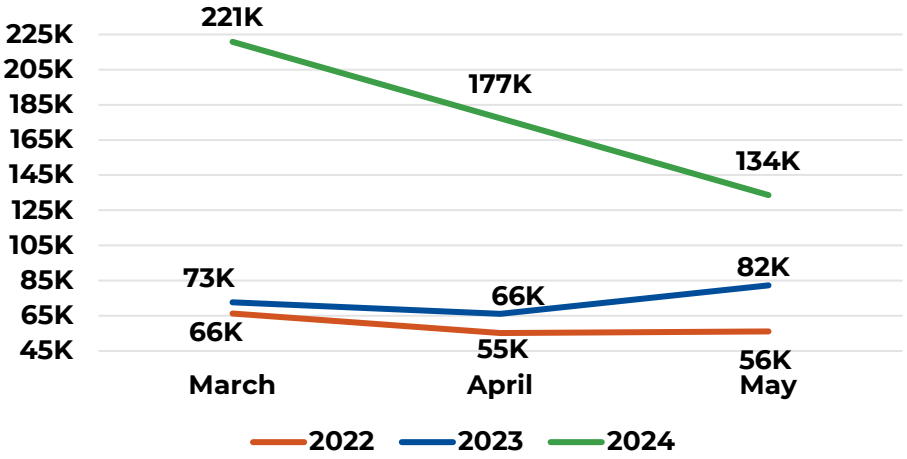
Average Per Expansion Member Served (Effective July 2021)

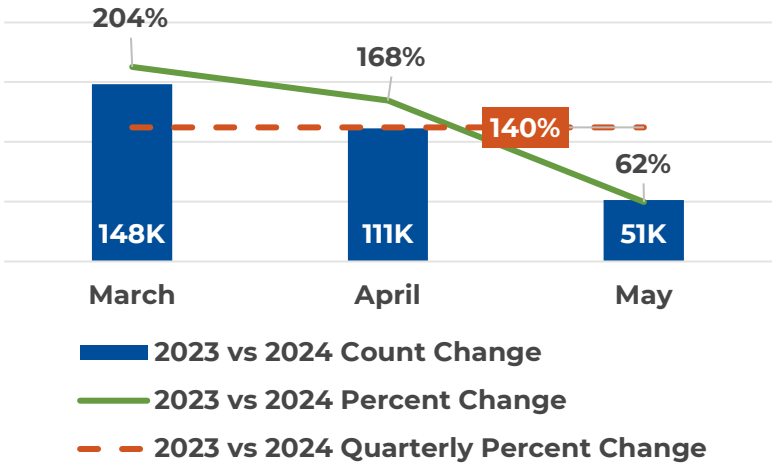




Call Center

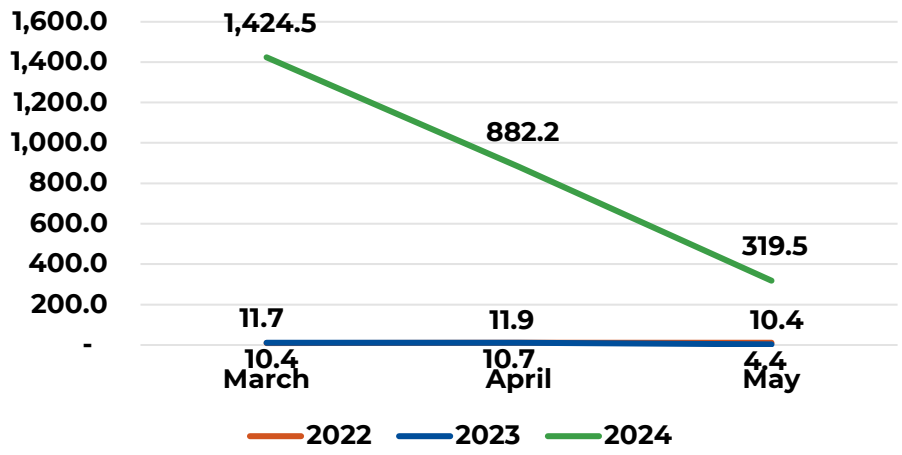
Call Center - Member Calls Answered

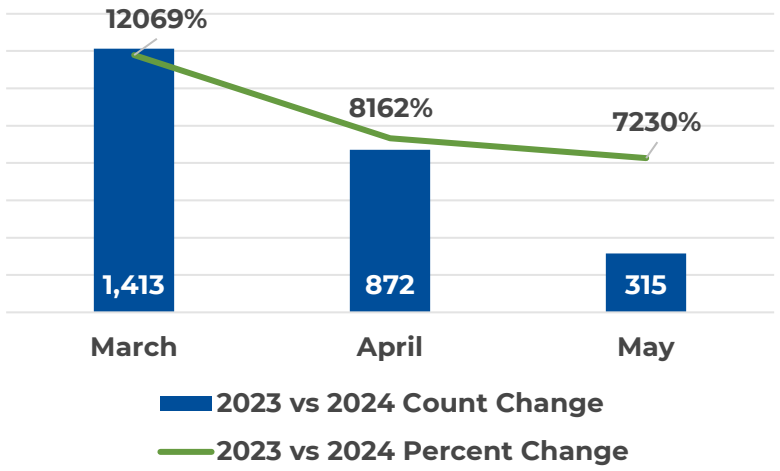




Call Center (Cont.)

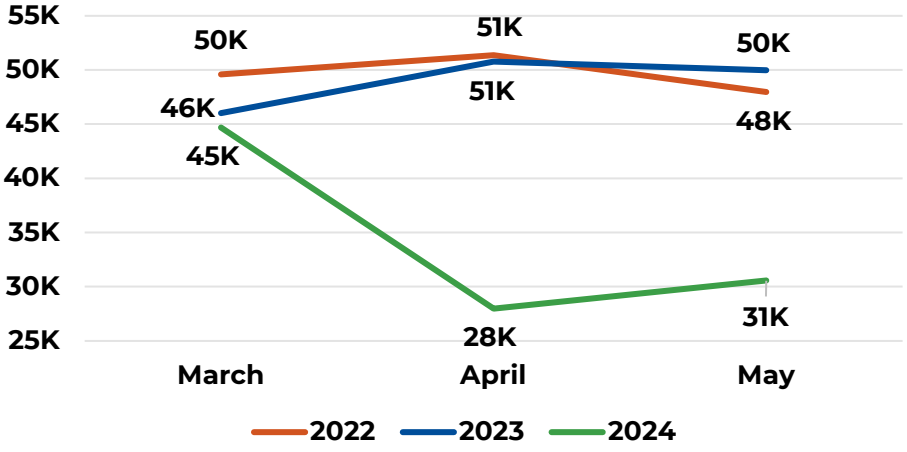
Call Center - Average Wait Time (In Seconds)

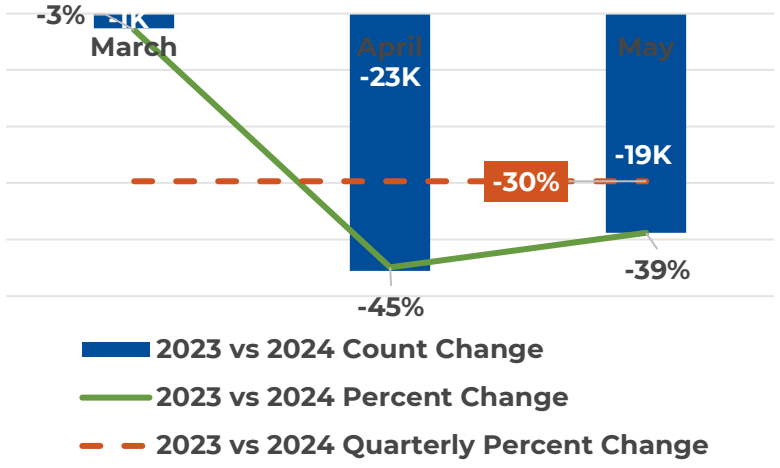




Prior Authorization

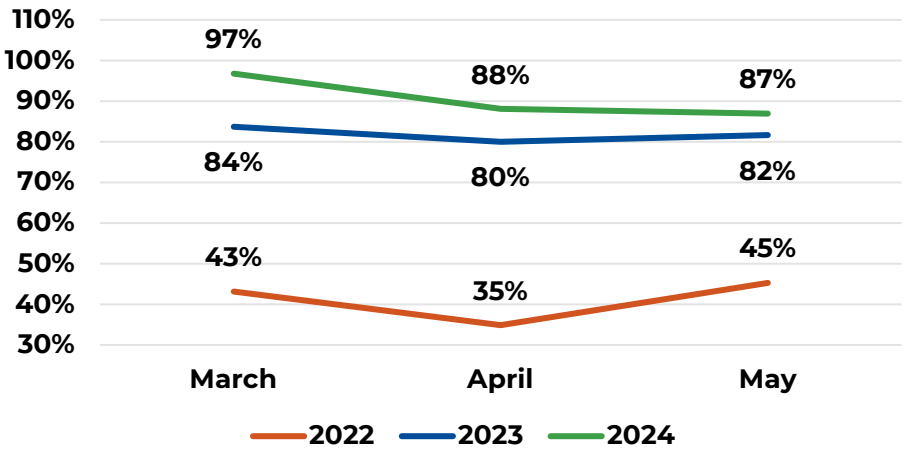
Prior Authorization - Total Combined - Total Completed PA Volume

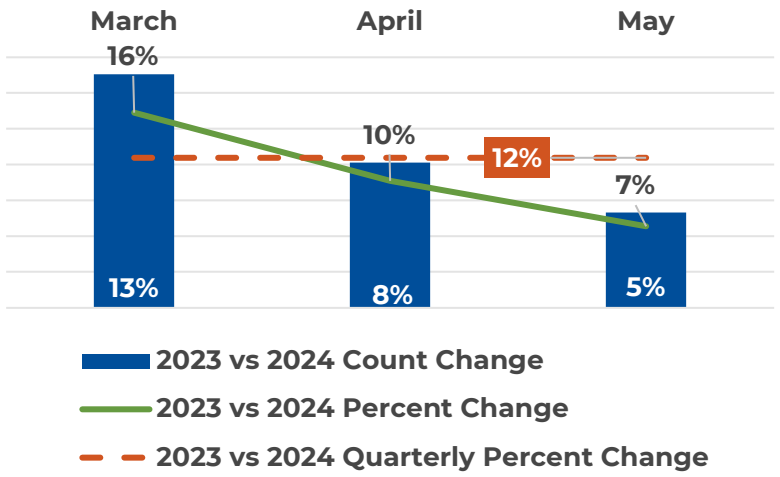




Prior Authorization (Cont.)

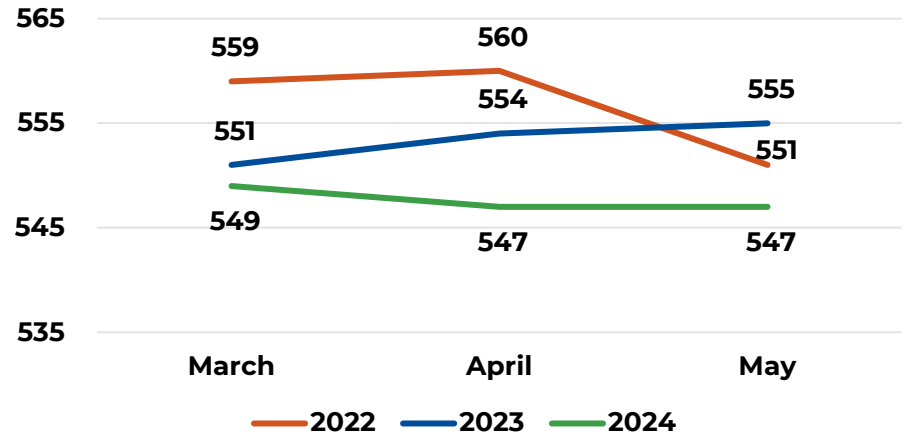
Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

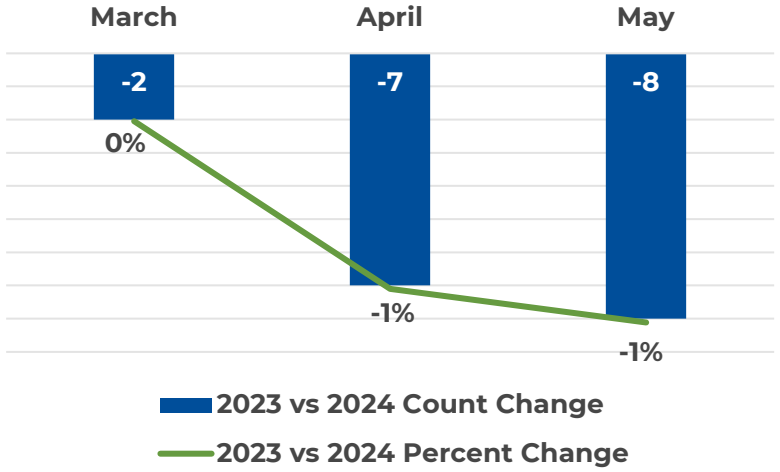




Agency Stats & Provider Network

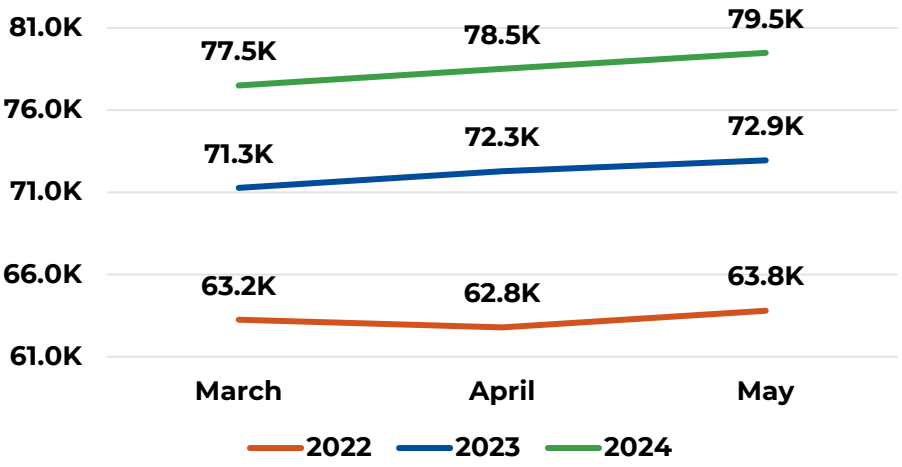
OHCA Admin - Number of FTEs

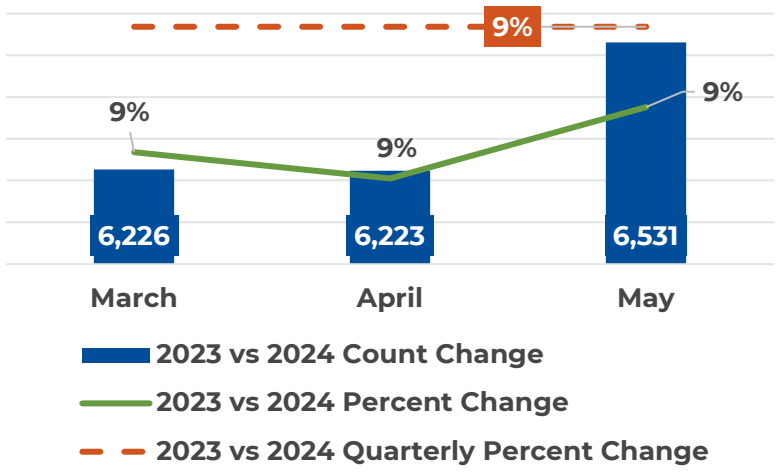




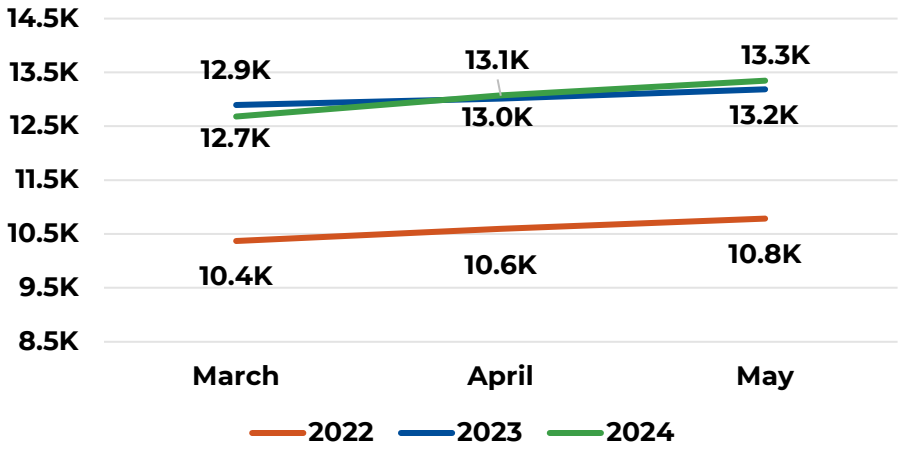
Agency Stats & Provider Network (Cont.)

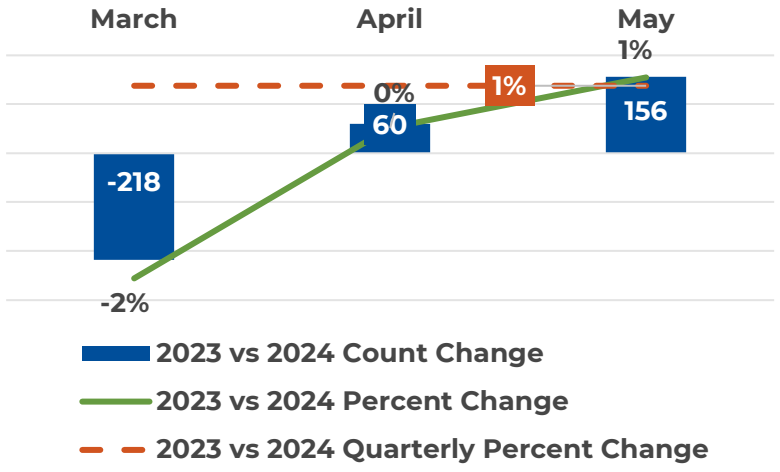
Total Providers





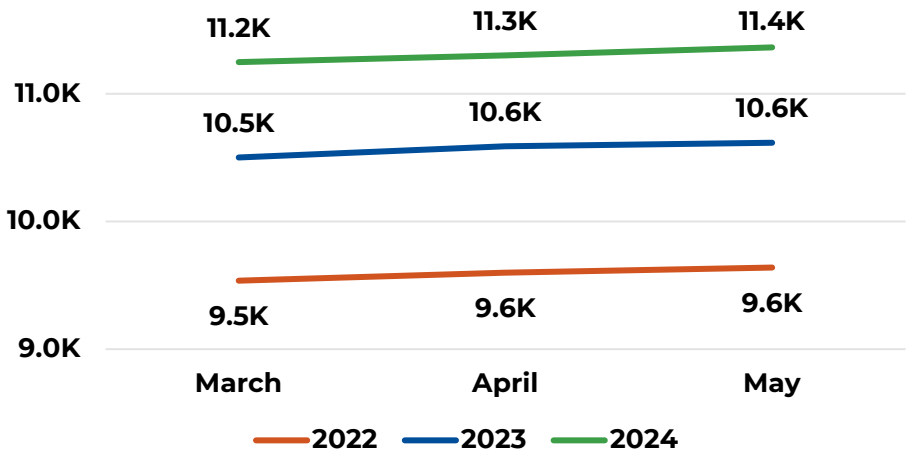
Mental Health Providers (In-State Only)

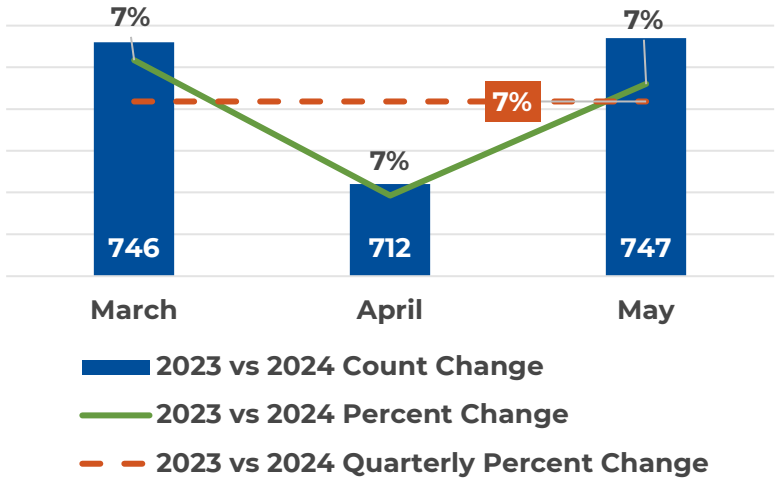




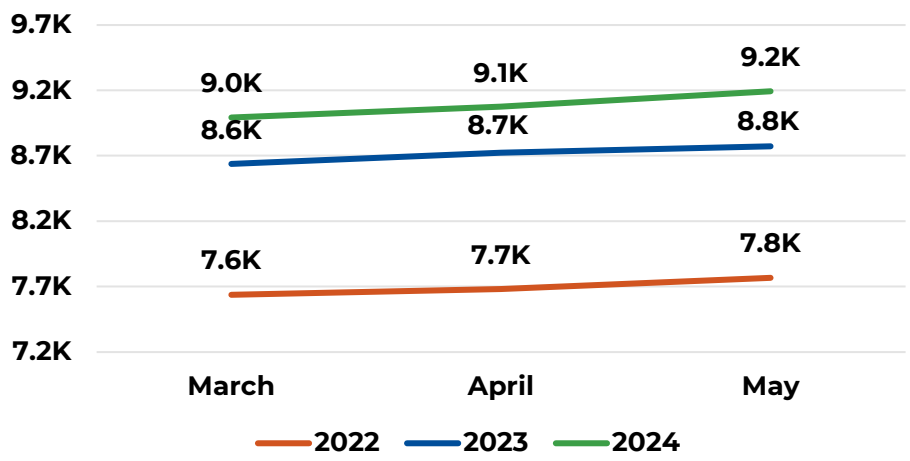
Agency Stats & Provider Network (Cont.)

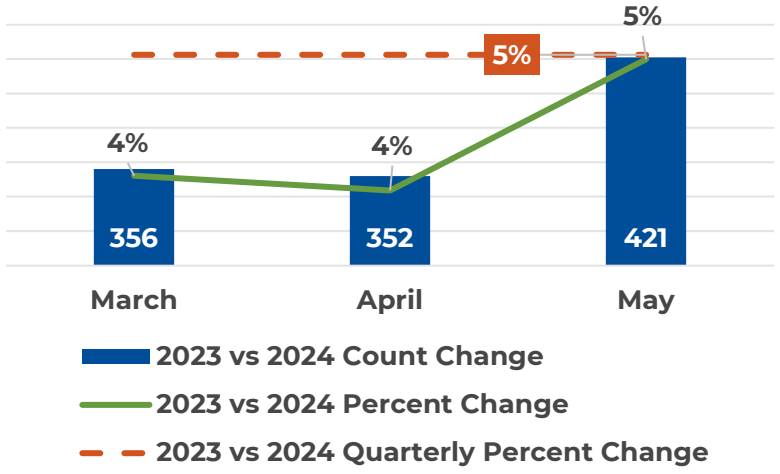
Physicians (In-State Only)





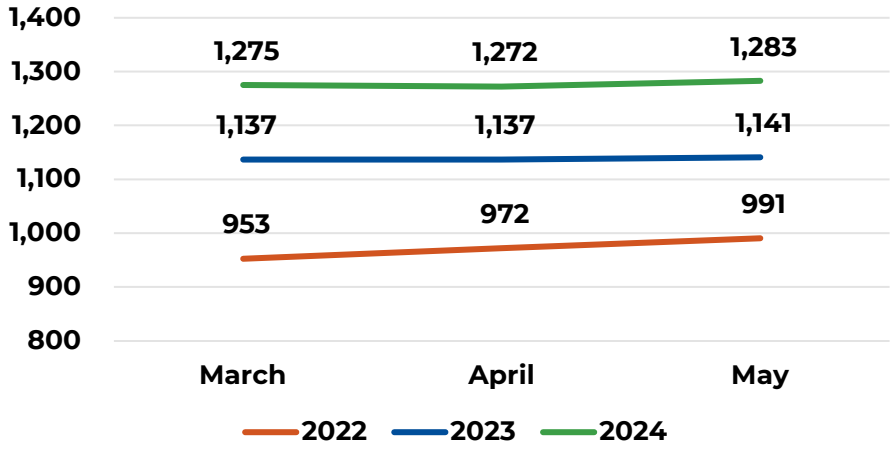
Primary Care Providers (In-State Only)

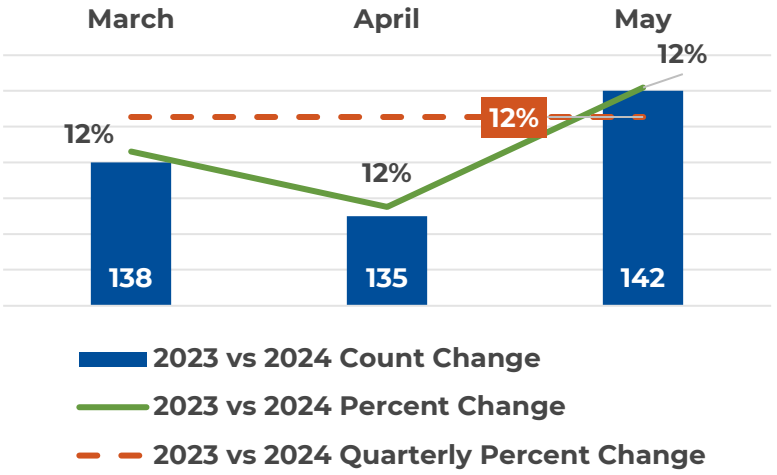




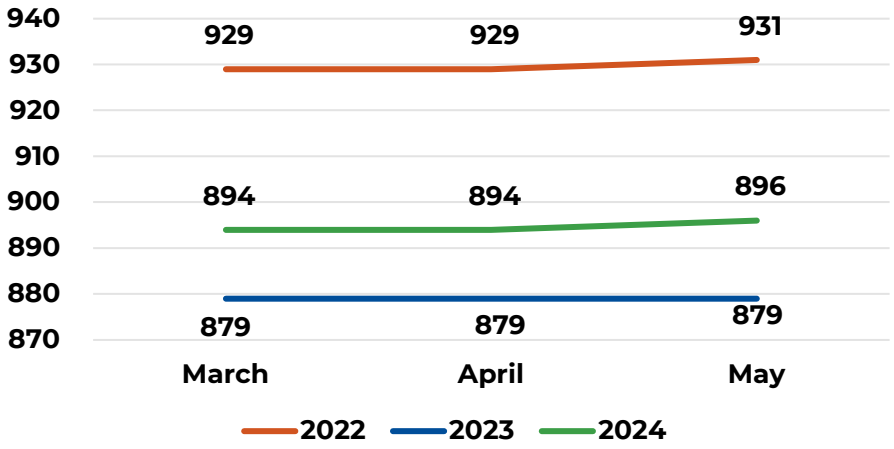
Agency Stats & Provider Network (Cont.)

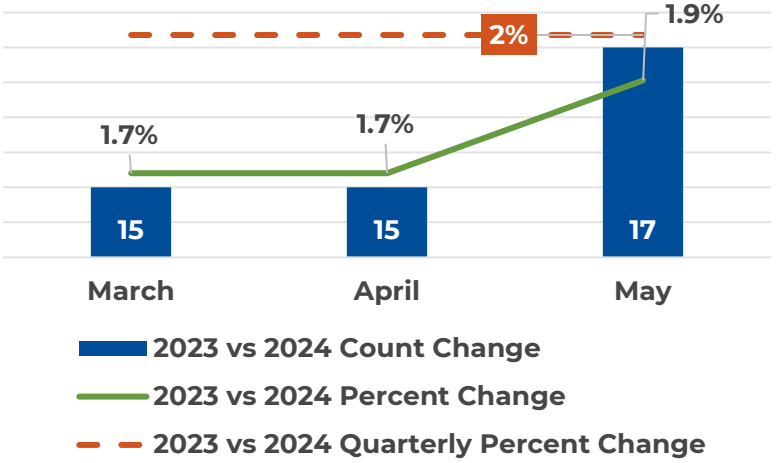
Dentists (In-State Only)





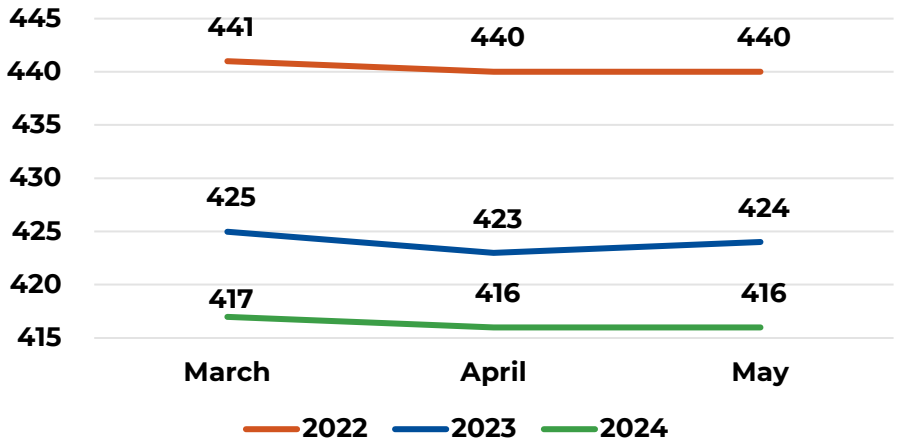
Pharmacy (In-State Only)

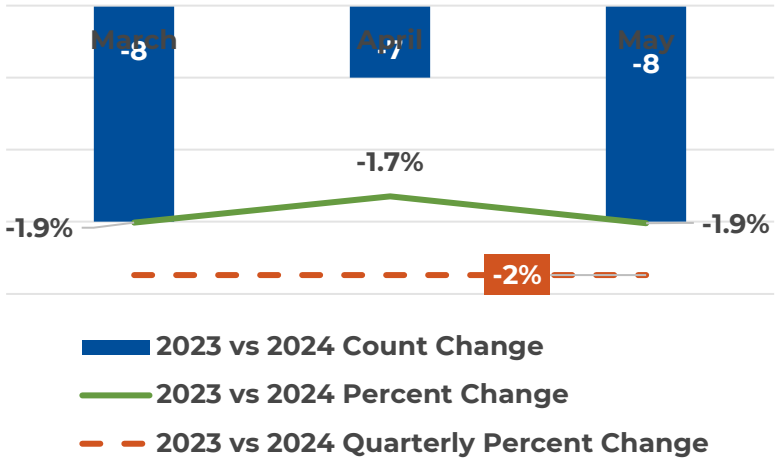




Agency Stats & Provider Network (Cont.)

Extended Care Facilities (In-State Only)





Hospitals (In-State Only)