OKLAHOMA HEALTH CARE AUTHORITY
AMENDED BOARD MEETING
June 26, 2026, at 1:00 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_ot2aWaarRo-Q8J53VKsJog
Telephone: 1-669-216-1590 Webinar ID: 161 164 8639

*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 25, 2026, OHCA Board Meeting Minutes……..…..…..Marc Nuttle, Chair

3. Chief Executive Officer Report……..…..……..Clay Bullard, Chief Executive Officer

    a) Member Moment

4. State Medicaid Director Update……...……..Melissa Miller, State Medicaid Director

5. Discussion of Report from the Pharmacy……..……Jeffrey Cruzan, MD
   Advisory Committee and Possible Action Regarding Chair, 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 317:30-5-77.2(e) (Attachment “A”):

Item:	Drug Name:	Used For:
i.	Cardamyst™ (Etripamil Nasal Spray)	Paroxysmal Supraventricular Tachycardia (PSVT)
ii.	Yutrepia™ (Treprostinil Powder for Inhalation)	Pulmonary Hypertension (PH)
iii.	Komzifti™ (Ziftomenib) Lymphir™ (Denileukin Diftitox-cxdl) Lunsumio VELO™ (Mosunetuzumab-axgb) Nilotinib D-Tartrate Phyrago™ (Dasatinib)	Acute Myeloid Leukemia (AML) Cutaneous T-Cell Lymphoma (CTL) Follicular Lymphoma (FL) Chronic Myeloid Leukemia (CML) Multiple types of Leukemia
iv.	Fesilty™ (Fibrinogen, Human-chmt)	Congenital Fibrinogen Deficiency (CFD)
v.	Waskyra™ (Etuvetidigene Autotemcel)	Wiskott-Aldrich Syndrome (WAS)
vi.	Palsonify™ (Paltusotine) Vykat™ XR [Diazoxide Choline Extended Release (ER)] Yuviwel® (Navenpegritide)	Acromegaly Hyperphagia of Prader Willi Syndrome (PWS) Achondroplasia
vii.	Nypozi™ (Filgrastim-txid)	Neutropenia
viii.	Tryptyr® (Acoltremon 0.003% Ophthalmic Solution	Dry Eye Disease (DED)

ix.	Clindesse® (Clindamycin Phosphate 2% Vaginal Cream)	Bacterial Vaginosis (BV)
x.	Avgemsi™ (Gemcitabine) Emrelis™ (Telisotuzumab Vedotin-tllv) Ensacove™ (Ensartinib) Hernexeos® (Zongertinib) Hyrnuo® (Sevabertinib) Ibtrozi™ (Taletrectinib) Rybrevant Faspro™ (Amivantamab/Hyaluronidase-lpui)	Non-Small Cell Lung Cancer (NSCLC)
xi.	Voyxact® (Sibeprenlimab-szsi)	Primary Immunoglobulin A Nephropathy (IgAN)
xii.	Ityisma® (Onasemnogene Abeparvovec-brve)	Spinal Muscular Atrophy (SMA)
xiii.	Jascavd® (Nerandomilast)	Pulmonary Fibrosis (PF)
xiv.	Rethymic® (Allogeneic Processed Thymus Tissue-agdc)	Congenital Athymia (CA)
xv.	Eydenzelt® (Aflibercept-boay)	Age-Related Macular Degeneration (AMD)

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

   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 "B")

      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
      v. Program of All Inclusive Care for the Elderly
      vi. Lodging & Meals Rate Change

   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 "C")

      New Contracts:
      i. Automated Third-Party Verification Data
      ii. Identity Proofing / Fraud Prevention Solution
      iii. AI Document Processing for Overall Medicaid System and CEV
      iv. Mobile App for Medicaid Services
      v. Health Information Exchange
      vi. EGID Bundled Services
      vii. Non-Emergency Medical Transportation (new contract and extension)
      viii. Rural Health Transformation: PACE Expansion & Stabilization Agreement

      Amendments:
      ix. Consulting Services – Rural Health Transformation PACE Technical Assistance

x. Closed Loop Electronic Referral System (CLERS)
xi. MMIS Contract Services CEV
xii. MMIS Contract Services Compliance

Renewals:
xiii. Customer Relationship Management (CRM) Call Center
xiv. Technical Consultant for the Medicaid Management Information System (MMIS) Modernization and Transformation Management Office (TMO) Year Three
xv. Consulting Services – Managed Care Actuary
xvi. Consulting Services – Federal Compliance Consultant
xvii. Customer Management Data Analytics Software Subscription Services
xviii. EGID Member Eligibility and Premium Accounting Services Software

c) Presentation, Discussion and Possible Action of the SFY 2027 Budget Work Program pursuant to 63 O.S. Section 5008(B)(3) by Clay Bullard, Chief Executive Officer (Attachment "D")

7. Discussion of Report from the……..……..…….Kevin Corbett
Managed Care Oversight Committee Chair, Managed Care Oversight Committee

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

i. APA WF # 26-07 Nonpayment for Certain Gender Transition Procedures
ii. APA WF # 26-10A&B Justice-Involved Youth Reentry
iii. APA WF # 26-03 HR1 Alien Eligibility

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

10. Adjournment……..…….Marc Nuttle, Chair

NEXT BOARD MEETING
September 16, 2026, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

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MINUTES OF REGULAR BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
March 25, 2026
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 25, 2026, at 2:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of statutory public notice, the agency placed its agenda on its website on March 20, 2026, at 12:00 p.m.

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

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

BOARD MEMBER ABSENT: Member Christ

ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON THE JANUARY 21, 2026, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Vice-Chairman Yaffe moved for approval of the January 20, 2026, board meeting minutes, as published. The motion was seconded by Member Case.

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

BOARD MEMBER ABSENT: Member Christ

ITEM 3 / CHIEF EXECUTIVE OFFICER UPDATE
Clay Bullard, Chief Executive Officer

CEO Bullard updated the board on his recent trip to DC as part of CMS's Rural Health Transformation, all states were represented at the meeting. He also shared that CMS highlighted Oklahoma and North Carolina leaders in terms of how Oklahoma put together its structure and contracting. CEO Bullard stated that OHCA received a letter from the AG's office regarding two recently approved rules, dental and telehealth. Due to process errors, OHCA decided to withdraw those rules. OHCA also received a letter from OHA and several other associations, which resulted in the OHCA Managed Care Oversight committee being created. CEO Bullard stated that he personally met with each signer of the letter, individually.

CEO Bullard provided an update on the budget, stating that the legislature have changed their tune on OHCA's budget as of late. Melissa Miller, State Medicaid Director, and her team have gone through every program that OHCA offers to determine where adjustments could be made. It was made clear that using the rate preservation fund is not an option, which leads OHCA to a couple of things: first option would be to utilize the premium tax for programs and basic budget needs. This option would pull about $475 million out of the SHOPP program. The other option would be to eliminate the 340B pharmacy program and end the adult dental program. If OHCA moves forward with both options, that will leave a $70 to $80 million deficit, which will require a rate cut of about 5-8%.

Lastly, CEO Bullard stated that DOC has been asked to move out of the building. They currently have staff on the second the third floors. They are in the process of finding a location so OHCA staff can move back into the building. OHCA anticipates DOC to move out sometime this Fall.

Carolyn Reconnu-Shoffner, Deputy Director of Clinical Services, provided this month's member moment.

ITEM 4 / STATE MEDICAID DIRECTOR UPDATE
Melissa Miller, State Medicaid Director

Ms. Miller provided an update on a few items including Managed Care, H.R.1 implementation, and operations.

Managed Care – One of the items discussed in OHA's letter was about Certified Community Behavioral Health Clinics (CCBHCs) receiving, potentially, payments that were inappropriate. OHCA staff worked with Vice-Chairman Yaffe to investigate the issue. It was discovered that the complexity of the CCBHC billing led to some procedural nuances that did

allow provider incentive payments to be paid to fee-for-service locations that were located at the same location as a CCBHC. A letter was sent to all the CCBHCs letting them know that effectively this fiscal year, they will not be eligible for those payments for those specific locations. It is estimated that OHCA will recoup about half a million dollars. The recouped funds will then be distributed with the last payment of the provider's incentive payment for this year, which should occur about October. OHCA has also created a universal roster to make it easier to enroll individual providers with each entity with the MCEs.

H.R.1 Implementation – OHCA continues to participate in ongoing conversations around implementation issues with CMS, as well as other states. OHCA is still waiting for final regulatory language; however, we are still being told it should be June. OHCA is participating in two-week calls with CMS, updating them on technology implementation and all of the pieces with that. As a reminder, she stated that work requirements are expected to affect approximately 86,000 expansion members, and the 6-month redetermination is expected to affect almost all of OHCA's expansion members, about 190,000. The most imminent change from H.R.1 is the change in the definition of a qualified alien. Effective October 1, about 4,000 refugees will no longer meet the definition and will be ineligible. OHCA has a TA request out to CMS asking if this would apply to women and children, as they are typically subject to a 12-month continuous eligibility requirement. It was also confirmed that Insure Oklahoma will not be subject to the work requirements

Operations – OHCA's AI chatbot will go-live within the next month, as early as April 6th. The chatbot is expected to reduce some of the initial calls. OHCA is working on filling the vacancies

ITEM 5 / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE

Dr. Jeff Cruzan, Pharmacy Committee Member

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

Item:	Drug Name:	Used For:
i.	Keytruda Qlex™ (Pembrolizumab/Berahyaluronidase Alfa-pmph) Opdivo Qvantig™ (Nivolumab/Hyaluronidase nyhy)	Multiple Cancer Diagnoses
ii.	Imaavy™ (Nipocalimab-aahu)	Myasthenia Gravis (MG)
iii.	Wayrilz™ (Rilzabrutinib)	Chronic Immune Thrombocytopenia (ITP)
iv.	Zepbound® (Tirzepatide)	Obstructive Sleep Apnea (OSA)
v.	Redemplo® (Plozasiran)	Familial Chylomicronemia Syndrome (FCS)
vi.	Polyethylene Glycol 3350 (PEG 3350/Sodium Sulfate/Sodium Chloride/Potassium Chloride/Sodium Ascorbate/Ascorbic Acid for Oral Solution (generic MoviPrep®)	Bowel Preparation before Colonoscopy
vii.	Gomekli® (Mirdametinib) Papzimeos™ (Zopapogene Imadenovec-drba) Romvimza™ (Vimseltinib)	Neurofibromatosis Type 1 (NF1) Recurrent Respiratory Papillomatosis (RRP) Tenosynovial Giant Cell Tumors (TGCT)

MOTION: Member Jolley moved for approval of item 5a.i-vii as published. The motion was seconded by Member Corbett.

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

BOARD MEMBER ABSENT: Member Christ

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

ITEM 6 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Phillip Kennedy, Compliance Committee Chair

Financials - For the period ending January 31st, 2026, the OHCA’s expenditures were 3.6% under budget while revenues were 2.9% under budget. This gives the agency a positive budget variance of $42 million. We continue to focus on timely collection of receivables while monitoring our cash flow. Regarding the provider incentive payments, OHCA is changing the frequency from every three months to every two months to provide better cash flow to providers.

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

    i. Non-Emergency Medical Transportation
    ii. Health Management Program

MOTION:	Member Christ moved to approve item 5a.i as published. The motion was seconded by Member Corbett.
FOR THE MOTION:	Chairman Nuttle, Vice-Chairman Yaffe, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy
BOARD MEMBER ABSENT:	Member Jolley, Member Leland

For more detailed information, see Attached “B” of the board packet.

ITEM 7 / DISCUSSION OF REPORT FROM THE MANAGED CARE OVERSIGHT COMMITTEE
Kevin Corbett, Managed Care Oversight Committee Chair

Member Corbett stated that the committee had met twice prior to this board meeting. Adding that in the two meetings, the committee approved the charter and were able to get a better understanding of what the current monitoring strategy that OHCA has put in place, and the monitoring activities. The committee is also considering adding other additional measures to the oversight process, which includes the level of grievances and escalations that are occurring, the attribution of members to providers, program integrity results, cost-saving initiatives and results.

ITEM 8 / DISCUSSION OF REPORT OF THE STRATEGIC PLANNING & OPERATIONAL ADVISORY COMMITTEE
Marc Nuttle, OHCA Board Chairman

Chairman Nuttle stated that the committee spent the majority of the time discussing the budget.

ITEM 9 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

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

Meeting adjourned at 3:52 p.m., 3/25/2026.

NEXT BOARD MEETING
May 20, 2026
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – March 11, 2026, April 8, 2026, and June 10, 2026

Vote Item	Drug	Used for	Cost*	Notes
1	Cardamyst™ (Etripamil Nasal Spray)	• **Paroxysmal Supraventricular Tachycardia (PSVT):** PSVT is a type of abnormal heart rhythm. It occurs when a short circuit rhythm develops in the upper chamber of the heart. This results in a regular but rapid heartbeat that starts and stops abruptly. *11 members with PSVT*	• $1,649 per treatment *Budget impact estimate: $41,225 per year*	• Approved in adults
2	Yutrepia™ (Treprostinil Powder for Inhalation)	• **Pulmonary Hypertension (PH):** PH is a type of high blood pressure that affects the arteries in the lungs and the right side of the heart. In some patients PH slowly gets worse and may be life-threatening. *235 members with PH*	• $332,521 per year *Budget impact estimate: $1,662,605 per year*	• Other cheaper therapies required first[¥]
3	Komzifti™ (Ziftomenib)	• **Acute Myeloid Leukemia (AML):** AML is a cancer of the blood and bone marrow. The word "acute" in AML means the disease tends to get worse quickly. *33 members with AML*	• $582,000 per year *Budget impact estimate: $1,746,000 per year*	• Not first line[±]
	Lymphir™ (Denileukin Diftitox-cxdl)	• **Cutaneous T-Cell Lymphoma (CTL):** CTL is a heterogeneous group of T-cell neoplasms involving the skin. *5 members with CTL*	• $925,650 per year *Budget impact estimate: $925,650 per year*	• Not first line[±]
	Lunsumio VELO™ (Mosunetuzumab-axgb)	• **Follicular Lymphoma (FL):** FL is a common type of slow growing type non-Hodgkin lymphoma which	• $526,061 per year *Budget impact estimate: $1,578,183 per year.*	• Not first line[±]

		affects white blood cells called lymphocytes. *95 members with FL*		
	Nilotinib D-Tartrate	• **Chronic Myeloid Leukemia (CML):** CML is a slowly progressing blood and bone marrow disease that usually occurs during or after middle age and rarely occurs in children. *103 members with CML*	• $126,684 per year *Budget impact estimate none*	• Other cheaper therapies required first[¥]
	Phyrago™ (Dasatinib)	• **Multiple types of Leukemia:** Leukemia is cancer of the body's blood-forming tissues, including the bone marrow and the lymphatic system.	• $218,956 per year *Budget impact estimate none*	• Other cheaper therapies required first[¥]
4	Fesilty™ (Fibrinogen, Human-chmt)	• **Congenital Fibrinogen Deficiency (CFD):** CFD is a group of rare inherited coagulation disorders characterized by bleeding symptoms ranging from mild to severe resulting from reduced quantity and/or quality of circulating fibrinogen. Fibrinogen is essential for blood clotting and wound healing. *Estimating 2 members with CFD*	• $5,852 per dose *Budget impact estimate: $58,520 per year*	• Approved in adults and pediatrics
5	Waskyra™ (Etuvetidigene Autotemcel)	• **Wiskott-Aldrich Syndrome (WAS):** WAS is a rare X-linked disorder which classically includes the characteristic triad of immunodeficiency, thrombocytopenia (low platelet count), and eczema. It can be severe. Patients with WAS tend to develop autoimmune disorders and lymphoma or other cancers, often	• N/A *Budget impact estimate: N/A*	• First gene therapy approved for WAS

		leading to an early death. *1 member with WAS*		
6	Palsonify™ (Paltusotine)	• **Acromegaly:** Acromegaly is a disorder that occurs when your body makes too much growth hormone which can lead to type 2 diabetes, high blood pressure, and heart disease among other things. *18 adults with diagnosis*	• $289,980 per year *Budget impact estimate: $1,449,900 per year*	• Other cheaper therapies required first[¥]
	Vykat™ XR [Diazoxide Choline Extended-Release (ER)]	• **Hyperphagia of Prader Willi Syndrome (PWS):** Hyperphagia is an intense, persistent sensation of hunger. It is a hallmark of PWS. PWS is a rare genetic disorder also characterized by growth hormone deficiency, possible learning disabilities, and behavior challenges. *6 members using treatments*	• $493,905 per year *Budget impact estimate: $2,963,430 per year*	• Approved in 4 years and up
	Yuviwel® (Navepegritide)	• **Achondroplasia:** Achondroplasia is a genetic condition affecting a protein in the body called the fibroblast growth factor receptor. This protein begins to function abnormally, slowing down the growth of bone in the cartilage of the growth plate. This leads to shorter bones, abnormally shaped bones and shorter stature. *17 pediatric members with diagnosis*	• $512,265 per year *Budget impact estimate: $512,265 per year*	• Approved for ages 2 years and up
7	Nypozi™ (Filgrastim-txid)	• **Neutropenia:** Neutropenia involves having lower-than-normal levels of neutrophils (a type of white blood cell) in the blood which increases the	• $8,130 per year *Budget impact estimate: none*	• Other cheaper therapies required first[¥]

		risk of infections. It is common in patients receiving cancer treatments. *3,266 members with diagnosis*		
8	Tryptyr® (Acoltremon 0.003% Ophthalmic Solution)	• **Dry Eye Disease (DED):** DED is a chronic and progressive condition in which the eye does not produce enough tears or when tears composition is off balance and does not function properly. *12,450 members with DED*	• $10,130 per year *Budget impact estimate: $202,600*	• Other cheaper therapies required first[¥]
9	Clindesse® (Clindamycin Phosphate 2% Vaginal Cream)	• **Bacterial Vaginosis (BV):** BV is a condition that happens when there is too much of certain bacteria in the vagina, causing an imbalance. *14,263 members with BV*	• $139 per course *Budget impact estimate: $20,850 per year*	• Other cheaper therapies required first[¥]
10	Avgemsi™ (Gemcitabine)	• **Non-Small Cell Lung Cancer (NSCLC):** NSCLC is the most common type of lung cancer. NSCLC grows slowly compared to small cell lung cancer. *1,688 unique members with lung cancer diagnosis*	• $153,505 per year *Budget impact estimate: none*	• Other cheaper therapies required first[¥]
	Emrelis™ (Telisotuzumab Vedotin-tllv)		• $581,568 per year *Budget impact estimate: $1,163,136 per year*	• Not first line[±]
	Ensacove™ (Ensartinib)		• $251,510 per year *Budget impact estimate: $503,020 per year*	• Must have certain biomarkers
	Hernexeos® (Zongertinib)		• $390,010 per year *Budget impact*	• Must have certain biomarkers

	Hyrnuo® (Sevabertinib) Ibtrozi™ (Taletrectinib) Rybrevant Faspro™ (Amivantamab/Hyaluronidase-lpuj)		*estimate: $780,020 per year* • $288,000 per year *Budget impact estimate: $576,000 per year* • $375.084 per year *Budget impact estimate: $750,168 per year* • $450,730 per year *Budget impact estimate: $901,460 per year*	• Not first line± • Must have certain biomarkers • Must have certain biomarkers
11	Voyxact® (Sibeprenlimab-szsi)	• **Primary Immunoglubulin A Nephropathy (IgAN):** IgAN is a type of kidney disease where antibodies build up in the kidneys and cause damage to the glomeruli (small filters inside the kidneys). *8 members using other IgAN therapies last year*	• $390,000 per year *Budget impact estimate: $780,000 per year*	• Must be 18 years and older
12	Itvisma® (Onasemnogene Abeparvovec-brve)	• **Spinal Muscular Atrophy (SMA):** SMA represents a group of genetic neuromuscular disorders that cause certain muscles to become weak and waste away (atrophy). SMA involves the loss of a specific type of nerve cell in the spinal cord called lower motor neurons, or anterior horn cells. These cells control muscle movement. *72 members with SMA over 2 years old*	• $2,590,000 per 1 time treatment *Budget impact estimate: $12,950,000 per year*	• Approved for 2 years and older

13	Jascayd ® (Nerandomilast)	• **Pulmonary Fibrosis (PF):** PF is a lung disease that occurs when lung tissue becomes damaged and scarred. This thickened, stiff tissue makes it harder for the lungs to work properly. PF worsens over time. *32 members using other PF medications last year*	• $194,637 per year *Budget impact estimate: $973,185 per year*	• Other cheaper therapies required first¥
14	Rethymic® (Allogeneic Processed Thymus Tissue–agdc)	• **Congenital Athymia (CA):** CA is an ultra-rare disease characterized by the absence of a functioning thymus. Patients with CA have profound immunodeficiency and increased susceptibility to infections. *Estimating 2 members with CA*	• $2,800,000 per 1 time treatment *Budget impact estimate: $2,800,000 per year*	• Only treatment center is at Duke Children's Hospital
15	Eydenzelt® (Aflibercept-boav)	• **Age-Related Macular Degeneration (AMD):** AMD is a common condition and is a leading cause of vision loss for older adults. AMD happens when aging causes damage to the macula which is the part of the eye that controls sharp, straight-ahead vision. *262 members using other AMD medications last year*	• N/A *Budget impact estimate: N/A*	• Other aflibercept products available without a PA

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.
*Costs do not reflect rebated prices or net costs
¥Other cheaper therapies required first: There are other treatment options available with or without a prior authorization (PA) which will be required for the member to try and fail before a PA would be issued for this new therapy.
±Not first line: The patient must have failed treatment with other therapy first per FDA approval.

Pharmacy Agenda Items

Recommendation 1: Vote to Prior Cardamyst™

The Drug Utilization Review Board recommends the prior authorization Cardamyst™ (Etripamil Nasal Spray) with the following criteria:

Cardamyst™ (Etripamil Nasal Spray) Approval Criteria:

1. An FDA approved indication of the conversion of acute symptomatic episodes of paroxysmal supraventricular tachycardia (PSVT) to sinus rhythm; and
2. Member must 18 years of age or older; and
3. Member must not have any of the contraindications for use of Cardamyst™, including:
    a. Hypersensitivity to Cardamyst™ or any of its components; and
    b. New York Heart Association (NYHA) Class II to IV heart failure; and
    c. Wolff-Parkinson-White (WPW), Lown-Ganong-Levine (LGL) syndromes, or manifest pre-excitation (delta wave) on a 12-lead electrocardiogram (ECG); and
    d. Sick sinus syndrome without a permanent pacemaker; and
    e. Second degree atrioventricular (AV) Mobitz 2 block or higher degree of AV block; and
4. Prescriber must verify the member or caregiver will be counseled on all of the following:
    a. PSVT symptoms; and
    b. Timing of Cardamyst™ administration in relation to the onset of the PSVT episode; and
    c. The proper storage and administration of Cardamyst™; and
    d. When to contact a health care provider or seek emergency medical attention; and
5. Prescriber must verify members with a history of hypotensive episodes or those at increased risk for hemodynamic instability will be monitored appropriately when initiating Cardamyst™; and
6. Must be prescribed by, or in consultation with, a cardiologist or a specialist with expertise in the treatment of PSVT; and
7. Approvals will be for up to 6 cartons (i.e., 12 nasal spray devices) per year; and
    a. A quantity limit of 1 carton (i.e., 2 nasal spray devices) per 30 days will apply; or
    b. For requests exceeding the quantity limit, clinical documentation (i.e., recent office notes) supporting the need for additional supply must be provided for consideration of a quantity limit override; and
8. Subsequent approvals may be granted if the prescriber documents the member has responded well to treatment and continues to require treatment with Cardamyst™.

Recommendation 2: Vote to Prior Authorize Yutrepia™

The Drug Utilization Review Board recommends the prior authorization Yutrepia™ (Treprostinil Powder for Inhalation) with the following criteria:

Yutrepia™(Treprostinil Powder for Inhalation) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
    a. Pulmonary arterial hypertension (PAH); or
    b. Pulmonary hypertension associated with interstitial lung disease (PH-ILD); and
        i. Diagnosis of PH-ILD must be confirmed by right-sided heart catheterization; and
2. Medical supervision by a pulmonary specialist or cardiologist; and
3. For a diagnosis of PAH:
        a. Member must have previous failed trials of at least 1 of each of the following categories or have a contraindication to use of all alternatives:
    ii. Revatio® (sildenafil) or Adcirca® (tadalafil); and
    iii. Letairis® (ambrisentan) or Tracleer® (bosentan)

Recommendation 3: Vote to Prior Komzifti™, Lymphir™, Lunsumio VELO™, Nilotinib D-Tartrate, and Phyrago™

The Drug Utilization Review Board recommends the prior authorization of Komzifti™ (Ziftomenib), Lymphir™ (Denileukin Diftitox-cxdl), Lunsumio VELO™ (Mosunetuzumab-axgb), Nilotinib D-Tartrate, and Phyrago™ (Dasatinib) with the following criteria:

Komzifti™ (Ziftomenib) Approval Criteria [Acute Myeloid Leukemia (AML) Diagnosis]:

1. Diagnosis of AML; and
2. Disease is relapsed or refractory; and
3. Disease is positive for a susceptible nucleophosmin 1 (NPM1) mutation; and
4. Member has no satisfactory alternative treatment options; and
5. Member is 18 years of age or older.

Lymphir™ (Denileukin Diftitox-cxdl) Approval Criteria [Cutaneous T-Cell Lymphoma Diagnosis]:

1. Diagnosis of relapsed or refractory stage I-III cutaneous T-cell lymphoma; and
2. Member must be 18 years of age or older; and

3. Expression of CD25 on ≥20% of malignant cells by immunohistochemistry (IHC); and
4. Has received at least 1 prior systemic therapy.

Lunsumio VELO™ (Mosunetuzumab-axgb) Approval Criteria [Follicular Lymphoma (FL) Diagnosis]:

1. Diagnosis of FL; and
2. Relapsed or refractory disease after ≥2 lines of systemic therapy.

Nilotinib D-Tartrate Approval Criteria [Chronic Myeloid Leukemia (CML) Diagnosis]:

1. Diagnosis of CML; and
2. Member must have 1 of the following:
    a. Newly diagnosed chronic, accelerated, or blast phase CML; or
    b. Philadelphia chromosome positive (Ph+) CML chronic phase (CP) resistant or intolerant to prior tyrosine-kinase inhibitor (TKI) therapy; or
    c. Post-hematopoietic stem cell transplant; and
3. A patient-specific, clinically significant reason the member cannot use
4. Tasigna® (nilotinib) must be provided.

Phyrago™ (Dasatinib)) Approval Criteria [Philadelphia Chromosome Positive (Ph+) Acute Lymphoblastic Leukemia
(ALL) Diagnosis]:

1. Diagnosis of Ph+ ALL; and
2. Member must have 1 of the following:
    a. Upfront therapy (including induction and consolidation) in combination with multi-agent chemotherapy or as a single agent; or
    b. Maintenance therapy including:
        i. As a single agent if unfit for additional therapies; or
        ii. As a single agent if member previously received blinatumomab plus a tyrosine kinase inhibitor (TKI); or
        iii. In combination with vincristine and prednisone, with or without methotrexate and mercaptopurine; or
        iv. Post-hematopoietic stem cell transplantation; or
    c. Relapsed/refractory disease as a single agent or in combination with multi-agent chemotherapy; and
3. Member does not have the following mutations of BCR-ABL1: T315I/A, F317L/V/I/C, or V299L; and
4. A patient-specific, clinically significant reason why the member cannot use generic dasatinib (Sprycel®) must be provided.

Phyrago™ (Dasatinib) Approval Criteria [Chronic Myeloid Leukemia (CML) Diagnosis]:

1. Diagnosis of CML; and
2. Member must have 1 of the following:
    a. Chronic, accelerated, or blast phase CML; or
    b. Post-hematopoietic stem cell transplantation; and
3. A patient-specific, clinically significant reason why the member cannot use generic dasatinib (Sprycel®) must be provided.

Phyrago™ (Dasatinib) Approval Criteria [SoftTissue Sarcoma – Gastrointestinal Stromal Tumors (GIST) Diagnosis]:

1. Diagnosis of soft tissue sarcoma – GIST; and
2. Used for gross residual disease (R2 resection), unresectable primary disease, tumor rupture, or recurrent/metastatic disease; and
3. Used as second-line therapy as single agent; and
4. Member has progressive disease after treatment with avapritinib; and
5. PDGFRA exon 18 mutations that are insensitive to imatinib (including D842V); and
6. A patient-specific, clinically significant reason why the member cannot use generic dasatinib (Sprycel®) must be provided.

Recommendation 4: Vote to Prior Authorize Fesilty™

The Drug Utilization Review Board recommends the prior authorization of Fesilty™ (Fibrinogen, Human-chmt) with the following criteria:

Fesilty™ (Fibrinogen, Human-chmt) Approval Criteria:

1. An FDA approved diagnosis of congenital fibrinogen deficiency, including afibrinogenemia or hypofibrinogenemia; and
2. Member must not have dysfibrinogenemia; and
3. Documented plasma fibrinogen activity ≤0.5g/L and antigen ≤0.5g/L; and
4. Fesilty™ must be prescribed by, or in consultation with, a hematologist or a specialist with expertise in treatment of congenital fibrinogen deficiency; and
5. A patient-specific, clinically significant reason why the member cannot use RiaSTAP® [fibrinogen concentrate (human)] or Fibryga® [fibrinogen (human)], which are available without prior authorization must be provided; and
6. Fesilty™ will not be used concomitantly with RiaSTAP® or Fibryga®; and
7. Fesilty™ will be used for the treatment of acute bleeding or for the perioperative management of bleeding; and

8. Approval lengths will be based on duration of need.

Recommendation 5: Vote to Prior Authorize Waskyra™

The Drug Utilization Review Board recommends the prior Waskyra™ (Etuvetidigene Autotemcel) with the following criteria:

Waskyra™ (Etuvetidigene Autotemcel) Approval Criteria:

1. An FDA approved diagnosis of Wiskott-Aldrich Syndrome (WAS); and
2. Diagnosis must be confirmed by molecular genetic testing confirming a mutation in the WAS gene (results of genetic testing must be submitted) and at least 1 of the following:
    a. Severe WAS mutation as indicated by molecular genetic testing; or
    b. Absence of WAS protein (WASP) expression in hematopoietic cells; or
    c. Severe Zhu clinical score of ≥3; and
3. Member must be male; and
4. Member must be 6 months of age or older; and
5. Must be prescribed by a geneticist, hematologist/oncologist, immunologist, or other specialist with expertise in the treatment of WAS and the administration of Waskyra™; and
6. Member must not have a known and available human leukocyte antigen (HLA)-matched related stem cell donor; and
7. Member must not have any contraindications to the use of Waskyra™, including:
    a. Hypersensitivity to the active substance or to any of the excipients; and
    b. Previous treatment with hematopoietic stem cell transplantation (HSCT) within 6 months prior to screening or HSCT with evidence of residual donor cell; and
    c. Previous treatment with hematopoietic stem cell gene therapy; and
    d. Contraindications to the mobilization and the conditioning regimen; and
8. Prescriber must verify the member is eligible to undergo HSCT (i.e., HSCT must be appropriate for a member to be treated with Waskyra™); and
9. Prescriber must verify the member will be monitored for signs and symptoms of the following:
    a. Cytopenia for at least 8 weeks after treatment; and
    b. Engraftment failure after treatment; and
    c. Hepatic veno-occlusive diseases, including assessment of liver function tests for 1 month after infusion; and

   d. Infection before and after treatment with Waskyra™; and
10. Waskyra™ must be administered at a Waskyra™ qualified treatment center, and the receiving facility must have a mechanism in place to track the patient-specific dose from receipt to storage to administration; and
11. Approvals will be for 1 dose per member per lifetime.

Recommendation 6: Vote to Prior Authorize Palsonify™, Vykat™ XR, and Yuviwel®

The Drug Utilization Review Board recommends the prior authorization of Palsonify™ (Paltusotine), Vykat™ XR [Diazoxide Choline Extended-Release (ER)], and Yuviwel® (Navepegritide) with the following criteria:

Palsonify™ (Paltusotine) Approval Criteria:

1. An FDA approved diagnosis of acromegaly confirmed by 1 of the following:
   a. Serum growth hormone (GH) level >1ng/mL after a 2-hour oral glucose tolerance test (OGTT); or
   b. Elevated insulin-like growth factor 1 (IGF-1) (above the age and gender adjusted normal range); and
2. Member has had an inadequate response to surgery or is not a candidate for surgery; and
3. Member must be 18 years of age or older; and
4. Member must have a documented trial with long-acting injectable octreotide or lanreotide depot, which do not require prior authorization, with an inadequate response or a patient-specific, clinically significant reason why both of these are not appropriate for the member must be provided; and
5. A patient-specific, clinically significant reason why the member cannot use Mycapssa® (octreotide) and Signifor® LAR (pasireotide) must be provided; and
6. Must be prescribed by, or in consultation with, an endocrinologist; and
7. Initial approvals will be for the duration of 6 months. Reauthorization (for the duration of 1 year) may be granted if the prescriber documents the member is responding well to treatment.

Vykat™ XR [Diazoxide Choline Extended-Release (ER)] Approval Criteria:

1. An FDA approved diagnosis of Prader-Willi syndrome (PWS) confirmed by chromosome analysis (results of genetic testing must be submitted); and
2. Member must be 4 years of age or older; and

3. Prescriber must confirm member has moderate to severe hyperphagia related to PWS; and
4. Must be prescribed by, or in consultation with, a geneticist, endocrinologist, psychiatrist, or other specialist with expertise in the treatment of PWS; and
5. The member's caregiver has implemented and intends to continue strategies to establish a food-secure environment (e.g., locked food storage); and
6. Prescriber must confirm the member is able to successfully swallow the number of tablets necessary to achieve the target maintenance dose; and
7. Prescriber must confirm the member does not have hepatic impairment or renal impairment; and
8. Fasting plasma glucose and hemoglobin A1c (HbA1c) must be evaluated prior to initiating treatment with Vykat™ XR; and
    a. For members with hyperglycemia, the prescriber must confirm the member's blood glucose has been optimized prior to initiating treatment; and
    b. Prescriber must agree to monitor blood glucose and HbA1c periodically during treatment; and
9. Prescriber must evaluate the potential for drug interactions according to package labeling, prior to and during treatment with Vykat™ XR, and agrees to modify the dose, if necessary; and
10. Member's recent weight (taken within the past month) must be provided to authorize the appropriate amount of drug required according to package labeling; and
11. Initial approvals will be for the duration of 6 months; and
12. Subsequent approvals (for the duration of 6 months) require all the following to be met:
    a. Prescriber must verify the member is tolerating and responding well to the medication as demonstrated by an improvement in hyperphagic symptoms; and
    b. Member has been adherent to therapy; and
    c. Member's recent weight (taken within the past month) must be provided to ensure the requested dose is still appropriate for member's weight.

Yuviwel® (Navepegritide) Approval Criteria:

1. Member must have an FDA approved indication of achondroplasia; and
    a. Diagnosis must be confirmed by genetic testing identifying a pathogenic mutation in the *FGFR3* gene; and
2. Member must be 2 years of age or older; and
3. Prescriber must verify member has open epiphyses; and

4. The member's baseline height (cm) and growth velocity (GV) (cm/year) must be provided; and
5. Yuviwel® must be prescribed by a geneticist, endocrinologist, or other specialist with expertise in the treatment of achondroplasia; and
6. Member's recent weight (taken within the past 3 weeks) must be provided in order to ensure appropriate dosing per package labeling; and
7. Prescriber must verify the member or member's caregiver has been counseled on proper administration and storage of Yuviwel®; and
8. A patient-specific, clinically significant reason (beyond convenience) why the member cannot use Voxzogo® (vosoritide) must be provided; and
9. A quantity limit of 4 kits per 28 days will apply; or
    a. For members weighing ≥56kg, a quantity limit override will be approved for 8 kits per 28 days; and
10. Initial and subsequent approvals will be for the duration of 6 months. For additional approval consideration:
    a. Member's current height must be provided and must demonstrate an improvement in GV from baseline; and
    b. Member's recent weight must be provided and dosing must be appropriate; and
    c. Member should be compliant; and
    d. Prescriber must verify member still has open epiphyses; and
11. Yuviwel® will not be approved following epiphyseal closure.

Recommendation 7: Vote to Prior Authorize Nypozi™

The Drug Utilization Review Board recommends the prior authorization Nypozi™ (Filgrastim-txid) with the following criteria:

Nypozi™ (Filgrastim-txid) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use Granix® (tbo-filgrastim), Neupogen® (filgrastim), or Zarxio® (filgrastim-sndz) 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.

Recommendation 8: Vote to Prior Authorize Tryptyr®

Pharmacy Agenda Items

The Drug Utilization Review Board recommends the prior authorization of Estradiol 0.06% Gel and Tryptyr® (Acoltremon 0.003% Ophthalmic Solution) with the following criteria:

Tryptyr® (Acoltremon 0.003% Ophthalmic Solution) Approval Criteria:

1. An FDA approved indication to treat the signs and symptoms of dry eye disease (DED); and
2. Member must be 18 years of age or older; and
3. Prescriber must verify that environmental factors (e.g., humidity, fans) have been addressed; and
4. Member must have trials with at least 3 over-the-counter (OTC) products for 3 days in the last 30 days that failed to relieve signs and symptoms of dry eyes; and
5. A patient-specific, clinically significant reason why the member cannot use brand name Restasis® (cyclosporine 0.05% ophthalmic emulsion) single-use vials, which are available without a prior authorization, must be provided; and
6. A patient-specific, clinically significant reason why the member cannot use Xiidra® (lifitegrast 5% ophthalmic solution) must be provided; and
7. A quantity limit of 60 single-use vials (1 box) per 30 days will apply.

Recommendation 9: Vote to Prior Authorize Clindesse®

The Drug Utilization Review Board recommends the prior authorization of Clindesse® (Clindamycin Phosphate 2% Vaginal Cream) with the following criteria:

Clindesse® (Clindamycin Phosphate 2% Vaginal Cream) Approval Criteria:

1. An FDA approved diagnosis of bacterial vaginosis; and
2. A patient specific, clinically significant reason why the member cannot use Cleocin® (clindamycin 2% vaginal cream) and Cleocin® vaginal ovules (clindamycin phosphate 2.5g vaginal suppositories), which are available without a prior authorization, must be provided.; and
3. Requests for Clindesse® will require a patient specific, clinically significant reason why the member cannot use Xaciato®.

Recommendation 10: Vote to Prior Authorize Avgemsi™, Emrelis™, Ensacove™, Hernexeos®, Hyrnuo®, Ibtrozi™, and Rybrevant Faspro™

The Drug Utilization Review Board recommends the prior authorization of Avgemsi™ (Gemcitabine), Emrelis™ (Telisotuzumab Vedotin-tllv), Ensacove™ (Ensartinib), Hernexeos® (Zongertinib), Hyrnuo® (Sevabertinib), Ibtrozi™ (Taletrectinib), and Rybrevant Faspro™ (Amivantamab/Hyaluronidase-lpuj) with the following criteria:

Avgemsi™ (Gemcitabine; J9184) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason the member cannot use Gemzar® (gemcitabine – J9201) and other preferred gemcitabine products (J9196 – Accord) that do not require prior authorization must be provided.

Emrelis™ (Telisotuzumab Vedotin-tllv) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of recurrent, advanced, or metastatic non-squamous NSCLC; and
2. Disease with high c-Met/MET protein overexpression, defined as ≥50% of tumor cells with strong staining [immunohistochemistry (IHC) 3+]; and
3. Epidermal growth factor receptor (EGFR) wild-type; and
4. Member has received prior systemic therapy; and
5. ECOG performance status of 0-2; and
6. Used as a single agent; and
7. Member must be 18 years of age or older.

Ensacove™ (Ensartinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of locally advanced or metastatic NSCLC; and
2. Anaplastic lymphoma kinase (ALK) positive; and
3. Used as a single agent; and
4. Member has not previous received an ALK inhibitor.

Hernexeos® (Zongertinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of non-squamous NSCLC; and
2. Disease is unresectable or metastatic; and
3. Disease is positive for HER2 (ERBB2) tyrosine kinase domain activating mutation; and
4. Member must be 18 years of age or older.

Hyrnuo® (Sevabertinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of non-squamous NSCLC; and
2. Disease is locally advanced or metastatic; and
3. Disease is positive for HER2 (ERBB2) tyrosine kinase domain activating mutations; and
4. Member has received prior systemic therapy; and
5. Member is 18 years of age or older.

Ibtrozi™ (Taletrectinib) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of NSCLC; and
2. Disease is locally advanced or metastatic; and
3. Disease is positive for *ROS1* rearrangements; and
4. Members is 18 years of age or older.

Rybrevant Faspro™ (Amivantamab/ Hyaluronidase-lpuj) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of locally advanced or metastatic NSCLC; and
2. Tumor exhibits epidermal growth factor receptor (EGFR) exon 20 insertion mutations; and
    a. As first-line therapy in combination with carboplatin and pemetrexed; or
    b. As a single agent in disease that has progressed on or after platinum-based chemotherapy; or
3. Tumor exhibits EGFR exon 19 deletion or exon 21 L858R mutations; and
    a. As first-line therapy in combination with lazertinib; or
    b. As subsequent therapy in combination with carboplatin and pemetrexed after progression on an EGFR tyrosine kinase inhibitor.

Recommendation 11: Vote to Prior Authorize Voyxact®

The Drug Utilization Review Board recommends the prior authorization of Voyxact® (Sibeprenlimab-szsi) with the following criteria:

Voyxact® (Sibeprenlimab-szsi) Approval Criteria:

1. An FDA approved indication to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk for disease progression; and
2. The diagnosis of primary IgAN must be confirmed by the following:
    a. Kidney biopsy (can refer to a recent or historical biopsy); and
    b. Secondary causes of IgAN have been ruled out (i.e., IgA vasculitis; IgAN secondary to virus, inflammatory bowel disease, autoimmune disease, or liver cirrhosis; IgA-dominant infection-related glomerulonephritis); and
3. Member must be 18 years of age or older; and
4. Must be prescribed by a nephrologist (or an advanced care practitioner with a supervising physician who is a nephrologist); and
5. Member must be at risk of disease progression as demonstrated by proteinuria ≥0.5g/day (or equivalent); and
6. For member self-administration or caregiver administration, the prescriber must verify the member or caregiver will be trained by a health care provider on proper administration and storage of Voyxact®; and

7. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Subsequent approvals will be for 1 year.

Recommendation 12: Vote to Prior Authorize Itvisma®

The Drug Utilization Review Board recommends the prior authorization of Itvisma® (Onasemnogene Abeparvovec-brve) with the following criteria:

Itvisma® (Onasemnogene Abeparvovec-brve) Approval Criteria:

1. An FDA approved diagnosis of spinal muscular atrophy (SMA); and
2. Member must be 2 years of age or older; and
3. Molecular genetic testing confirming biallelic mutations in the survival motor neuron 1 (SMN1) gene (results of genetic testing must be submitted); and
4. Member must be able to sit without support and is unable to walk without assistance (i.e., unable to walk without assistive devices); and
5. Must be prescribed by a neurologist or specialist with expertise in the treatment of SMA (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of SMA); and
6. Member must have baseline anti-AAV9 antibody titers ≤1:50; and
7. Prescriber must agree to monitor liver function tests and platelet counts at baseline and as directed by the package labeling; and
8. Prescriber must agree to administer systemic corticosteroids starting 1 day prior to the Itvisma® infusion and continuing as recommended in the package labeling based on member's liver function; and
9. Itvisma® must be shipped to the facility where the member is scheduled to receive treatment and must adhere to the storage and handling requirements in the package labeling; and
10. Member will not be approved for concomitant treatment with Evrysdi® (risdiplam) or Spinraza® (nusinersen) following Itvisma® infusion (current authorizations for risdiplam or nusinersen will be discontinued upon Itvisma® approval); and
11. Member must not have previously received Zolgensma® (onasemnogene abeparvovec-xioi); and
12. Only 1 Itvisma® infusion will be approved per member per lifetime.

Recommendation 13: Vote to Prior Authorize Jascayd ®

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

Pharmacy Agenda Items

Jascayd® (Nerandomilast) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
   a. Idiopathic pulmonary fibrosis (IPF); or
   b. Progressive pulmonary fibrosis (PPF); and
2. Member must be 18 years of age or older; and
3. Medication must be prescribed by a pulmonologist or pulmonary specialist (or an advanced care practitioner with a supervising physician who is a pulmonologist or pulmonary specialist); and
4. Requests must indicate if Jascayd® will be used as monotherapy or in combination with nintedanib or pirfenidone; and
   a. If combination therapy is being requested, a patient-specific, clinically significant reason why the member requires combination therapy must be provided; and
5. A patient-specific, clinically significant reason why the member cannot use Ofev® (nintedanib) and generic pirfenidone must be provided; and
6. A quantity limit of 60 tablets per 30 days will apply.

Recommendation 14: Vote to Prior Authorize Rethymic®

The Drug Utilization Review Board recommends the prior authorization of Rethymic® (Allogeneic Processed Thymus Tissue–agdc) with the following criteria:

Rethymic® (Allogeneic Processed Thymus Tissue-agdc) Approval Criteria:

1. An FDA approved indication for immune reconstitution in pediatric patients with congenital athymia (CA). Diagnosis must be confirmed by the following (supporting documentation must be submitted):
   a. Flow cytometry documenting <50 naïve T-cells/mm3 (CD45RA+, CD62L+) in the peripheral blood or <5% of total T-cells being naïve in phenotype; and
   b. Clinical, genetic, and/or immunologic findings, including evaluation to exclude severe combined immunodeficiency (SCID); and
2. Member must be younger than 18 years of age; and
3. Member must not have SCID; and
4. Member must not have a pre-existing cytomegalovirus (CMV) infection or pre-existing renal impairment; and
5. Rethymic® must be prescribed by a specialist with expertise in CA and in the administration of Rethymic®; and
6. Prescriber must attest that the member will not receive immunizations until immune function is established; and
7. Documentation of anti-human leukocyte antigen (HLA) antibody screening; and
   a. If the member is positive for anti-HLA antibodies, prescriber must verify the member will receive Rethymic® from a donor who does not express those HLA alleles; and

8. If the member has received a hematopoietic cell transplant (HCT) or a solid organ transplant, the following will be required:
    a. HLA matching; and
    b. Member will receive Rethymic® HLA matched to recipient alleles that were not expressed in the HCT donor to minimize the risk of graft-versus-host disease (GVHD); and
9. Verification that the member will be monitored and the member and/or caregiver will be counseled on all the following after treatment with Rethymic®, as per package labeling:
    a. Lymphoproliferative disorders; and
    b. Transmission of infectious disease; and
    c. Development of autoimmune disorders; and
    d. Development of GVHD; and
    e. Infection control measures and immune prophylaxis; and
10. Prescriber attestation that Rethymic® will be prescribed with immunosuppressive therapy based on disease phenotype and phytohemagglutinin levels; and
11. Member has no history of receiving a previous thymus tissue implantation in their lifetime; and
12. Approval will be for 1 treatment per member per lifetime.

Recommendation 15: Vote to Prior Authorize Eydenzelt®

The Drug Utilization Review Board recommends the prior authorization of Eydenzelt® (Aflibercept-boav) with the following criteria:

Eydenzelt® (Aflibercept-boav) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use Eylea®/Eylea® HD (aflibercept) or Pavblu® (aflibercept-ayyh) 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.

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.

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 $159.56 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 $369,759,658. The current Quality of Care (QOC) fee is $16.65 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however, the rate for Regular Nursing Facilities is changing due to 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. The new Base Rate Component will be $160.48 per patient day. The new combined pool amount for the "Direct Care" and "Other Cost" components will be $398,014,154. The new Quality of Care (QOC) fee will be $17.57 per patient day.

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY 2027 will be an increase in the total amount of $15,551,321, with $5,285,894 in state share. The state share is paid by providers from the increased QOC fees.
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:
- An increase to the base rate component from $159.56 per patient day to $160.48 per patient day.
- An increase to the combined pool amount for "Direct Care" and "Other Cost" Components from $369,759,658 to $398,014,154 for the annual reallocation of the Direct Care Cost Component as per the State Plan.

9. **EFFECTIVE DATE OF CHANGE.**
July 1, 2026, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) 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 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.

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 $290.96 per patient day. The Quality of Care (QOC) fee is $16.65 per patient day

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, the rate for nursing facilities serving residents with AIDS is changing due to the required annual recalculation of the Quality of Care (QOC) fee. The rate for this provider type will be $294.30 per patient day. The recalculated Quality of Care (QOC) fee will be $17.57 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2027 will be an increase in the total amount of $17,966; with $6,107 in state share. The state share is paid by providers from the increased QOC fees.
   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 $290.96 per patient day to $294.30 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2026, 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 provide rate increases to facilities.

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 $173.09 per patient day.
   The Quality of Care (QOC) fee is $10.24 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, the rate for Regular ICF/IID facilities is changing due to the required annual recalculation of the Quality of Care (QOC) fee.
   The proposed rate for this provider type is $174.35 per patient day.
   The Quality of Care (QOC) fee will be $10.65 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2027 will be an increase in the total amount of $147,606; with $50,171 in state share. The state share is paid by providers from the increased QOC fees.
   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 $173.09 per patient day to $174.35 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2026, 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.

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 $209.92 per patient day.
   The Quality of Care (QOC) fee is $11.96 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, the rate for Acute ICF/IID facilities is changing due to the annual recalculation of the Quality of Care (QOC) fee. The proposed rate for this provider type is $213.10 per patient day. The recalculated Quality of Care (QOC) fee is $13.05 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2027 will be an increase in the total amount of $1,110,195; with $377,355 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 $209.92 per patient day to $213.10 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2026, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

PROGRAM OF ALL INCLUSIVE CARE FOR THE ELDERLY

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 Oklahoma Health Care Authority (OHCA) is seeking to implement new reimbursement rates for the Program of All Inclusive Care for the Elderly (PACE), as authorized by House Bill 2268. The reimbursement rates, which are paid to PACE Organizations on a per member per month (PMPM) basis, were determined based upon medical and administrative costs for PACE-eligible beneficiaries receiving long term care services, either in a nursing facility or through the ADvantage 1915c Home- and Community-Based Services (HCBS) waiver program. Separate reimbursement rates are established for beneficiaries who are dually-eligible for Medicare and Medicaid and beneficiaries who are eligible only for Medicaid.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current reimbursement rates are $2,877.65 PMPM for dual-eligible beneficiaries and $4,506.44 Medicaid-only beneficiaries.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The new reimbursement rates are $3,597.06 PMPM for dual-eligible beneficiaries and $5,633.05 Medicaid-only beneficiaries.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2027 will be an increase in the total amount of $7,275,596; with $2,472,975 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 OHCA has determined that this change will have a positive impact by providing increased rate support for PACE organizations.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee approve the proposed rate increases per House Bill 2268

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2026, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

LODGING & MEALS RATE CHANGE

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?**
   Oklahoma Health Care Authority (OHCA) is requesting this rate increase request due to two primary factors: inflationary cost-of-living adjustments and evolving market conditions that have significantly increased vendor operating costs. To maintain the quality of our services and sustain equitable partnerships with our room and board providers, a rate adjustment is necessary. This change ensures our providers can continue to meet operational standards despite rising overhead.

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

CODE	CODE DESCRIPTION	UNIT DESCRIPTION	CURRENT RATE
A0180	Non-Emergency Transportation: Ancillary Lodging-Recipient	1 Unit = 1 Day	$54.00
A0200	Non-Emergency Transportation: Ancillary Lodging-Escort	1 Unit = 1 Day	$54.00

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

CODE	CODE DESCRIPTION	UNIT DESCRIPTION	CURRENT RATE
A0180	Non-Emergency Transportation: Ancillary Lodging-Recipient	1 Unit = 1 Day	$80.00
A0200	Non-Emergency Transportation: Ancillary Lodging-Escort	1 Unit = 1 Day	$80.00

The increase to $80 brings the rate significantly closer to the GSA rate of $116 for Oklahoma County, aligns with rates paid for these services by the SoonerSelect plans (ranging between $80 and $84), and aligns with the maximum FFS rate of $83 that OHCA set for lodging in the 2025 NEMT RFP (EV00000663).

6. **BUDGET ESTIMATE.**

The estimated budget impact for SFY 2027 will be an increase in the total amount of $73,255; with $26,526.93 in state share.

The estimated budget impact for SFY 2028 will be an increase in the total amount of $9,810.25 with $3,091.21 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.**

Should this rate increase be approved, the Oklahoma Health Care Authority (OHCA) will secure essential lodging and meal coverage for the general population of eligible members. This is particularly critical for high-acuity cases, including NICU and PICU families, and individuals undergoing life-sustaining cancer treatments or transplants.

Legal and regulatory mandate: Under 42 CFR § 440.170, federal law defines "travel expenses" as a required component of Medicaid transportation assurance. This includes:

- Member Costs: meals and lodging enroute to and from care, and while receiving care.
- Attendant Costs: transportation, meals, and lodging for an escort when the member's condition requires assistance.

Current Soonercare reimbursement rates have fallen significantly below the general services administration (GSA) federal per diem rates for the Oklahoma City region.

As a result, the current rate is no longer "appropriate" to ensure access to care.

Furthermore, for members under age 21, EPSDT guidance requires the state to provide any medically necessary service to "correct or ameliorate" a condition, regardless of whether it is typically covered in the state plan. Without a rate increase, the shortage of providers willing to accept these rates creates a barrier to care for Oklahoma's most vulnerable children and families.

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 rate change for procedure code A0180 and A0200 from $54 per unit to $80 per unit.

9. **EFFECTIVE DATE OF CHANGE.**

July 1, 2026, upon approval by CMS

Attachment C.i

SUBMITTED TO THE C.E.O. AND BOARD ON June 26, 2026

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	New Contract -- Automated Third-Party Verification Data
Purpose and Scope	Oklahoma Health Care Authority (OHCA) is implementing a comprehensive, automated data verification solution to modernize its Medicaid eligibility determination process. The primary purpose of this initiative is to integrate a specialized suite of automated third-party verification data directly into the OHCA enrollment workflow. OHCA aims to enhance overall operational efficiency and strengthen program integrity by establishing rigorous, automated guardrails to detect, mitigate, and prevent fraud, waste, and abuse (FWA) before benefits are distributed. This integrated suite of solutions will interface seamlessly with the OHCA existing eligibility system, efficiently handle high-volume automated queries, and maintain strict compliance with all relevant federal and state privacy mandates. Furthermore, this verification solution is intended satisfy the contracting requirement under the Oklahoma HOPE Act.
Mandate	56 O.S. §246; 56 O.S. §247
Procurement Method	Statewide Contract
External Approvals	CMS
Contract Term	July 1,2026 through June 30, 2027. There is the potential for additional one-year options to renew.

BUDGET

Amount requested for Approval	SFY 2027 Total: $15,300,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Share: 61.17% -- $9,359,625.00 State Share: 38.83% -- $5,940,375.00

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 a total not-to-exceed of $15,300,000.00 for SFY 2027

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.)

Attachment C.ii

SUBMITTED TO THE C.E.O. AND BOARD ON June 26, 2026

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	New Contract -- Identity Proofing / Fraud Prevention Solution
Purpose and Scope	This request supports the implementation, launch, and ongoing operation of a digital identity verification system to be implemented within OHCA's Medicaid eligibility system. The system will matches user-provided information such as Social Security Number, photo of a government ID, and a live selfie) against official records to ensure the person creating the account is exactly who they say they are. The intent behind this contract is to prevent fraud, waste and abuse from bad actors gaining eligibility.
Mandate	H.R.1 Community Engagement Verification
Procurement Method	Statewide Contract
External Approvals	CMS
Contract Term	Initial Contract effective date July 1, 2026 through June 30, 2027, with 8 options to renew

BUDGET

Amount requested for Approval	SFY 2027 Total: $1,700,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Share: 75.4% -- $ 1,282,500.00 State Share: 24.6% -- $ 417,500.00

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 a total not-to-exceed of $1,700,000.00 for SFY 2027. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract.

Additional Information

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

Attachment C.iii

SUBMITTED TO THE C.E.O. AND BOARD ON June 26, 2026

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	New Contract -- AI Document Processing for Overall Medicaid System and CEV
Purpose and Scope	This request supports the build, launch and ongoing operation of an AI based document processing solution aimed specifically at automating the processing of eligibility documents from members. The solution includes processing documents such as identification type documents, tax, and pay related documents. This solution will be utilized by all populations but is specifically needed to support compliance with new federal Medicaid eligibility rules requiring able-bodied adults ages 19-64 to meet Work or Community Engagement requirements (reporting 80 hours/month). The AI will reduce what can take a human 15-20 minutes to determine eligible income, to a minute or two, as human will final review all the calculations and summaries to ensure.
Mandate	H.R.1 Community Engagement Verification
Procurement Method	Statewide Contract
External Approvals	CMS
Contract Term	Initial Contract effective date July1, 2026 through June 30, 2027, with 8 options to renew

BUDGET

Amount requested for Approval	SFY 2027 Total: $1,950,000.00
Federal Government Efficiency Grant (CMS) **Federal Match Percentage(s) within the Total Contract Not-to-Exceed**	Federal Grant: 77.9% -- $1,518,480.00 Federal Share: 16.6% -- $323,640.00 State Share: 5.5% -- $107,880.00

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 a total not-to-exceed of $1,950,000.00 for SFY 2027. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract.

Additional Information

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

Attachment C.iv

SUBMITTED TO THE C.E.O. AND BOARD ON June 26, 2026
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	New Contract -- Mobile App for Medicaid Services
Purpose and Scope	This contract supports the build, launch and ongoing operation of a statewide mobile app designed to serve Oklahoma's Medicaid (SoonerCare) population. The app will centralize member tools such as eligibility assistance, ID card access, claims, and provider search. It additionally features live chat with an agent through the members device providing faster access to assistance and reduced load on the current voice-based call center. The app is central to allowing OHCA members to better communicate with the agency through digital channels. Cost savings are expected by lowering reliance on traditional call centers and improving member engagement.
Mandate	N/A
Procurement Method	Statewide Contract
External Approvals	CMS
Contract Term	Initial Contract effective date July 1, 2026 through June 30, 2027, with five (5) options to renew

BUDGET

Amount requested for Approval	SFY 2027 Total: $2,300,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Share: 76.96% -- $1,770,000 State Share: 23.04% -- $530,000.00

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 a total not-to-exceed of $2,300,000.00 for SFY 2027. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 26, 2026

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	New Contract -- Health Information Exchange
Purpose and Scope	The Oklahoma Health Care Authority (OHCA) is seeking to contract with a qualified health information exchange (HIE) organization to operate as the State Designated Entity for Health Information Exchange (SDE) and provide HIE Technology, Capabilities, and Operations. As the Oklahoma State Health Information Network Exchange (OKSHINE) program and the Office of the State Coordinator for Health Information Exchange – as defined in 63 O.S. §§ 1-132.1 – 1-133, OHCA will play an active role as collaborator and coordinator in the implementation of these services. The selected vendor and HIE organization will at a minimum support, maintain, and establish connections with Oklahoma based participants and ensure the information is secure, accurate, and timely. Additionally, the HIE organization will be needed to support three critical projects under the Rural Health Transformation (RHT) Grant.
Mandate	63 O.S. §1-132.1; 63 O.S. §1-133.
Procurement Method	Statewide Contract
External Approvals	N/A
Contract Term	July 1, 2026, through June 30, 2027 (or from date of signature) with subsequent eight (8) one-year options to renew.

BUDGET

Amount requested for Approval	SFY 2027 Total: $43,620,000.00 for SFY27. • RHT Total: $34,700,000.00 • Operations Total: $8,920,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Grant: 79.55% -- $34,700,000.00 State Share: 20.45% -- $8,920,000.00

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 not-to exceed amount of $43,620,000.00 for SFY27. Every following renewal year of the contract, OHCA staff intends to request additional Board approval for $8,920,000.00 plus any future RHTP project amounts.

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, 2026
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	New Contract – EGID Bundled Services.
Purpose and Scope	Funds are requested to award contracts under the RFP EV00000843 posted in January 2026. The RFP is intended to acquire partnering vendor(s) to provide bundled-type episodes of care in order to save HealthChoice plan members from out-of-pocket healthcare costs while providers still meet HealthChoice's standard of care. Pricing has the potential to be based on a combination of Per Employee Per Month (PEPM), Per Member Per Month (PMPM), utilization, or a combination of the aforementioned.
Mandate	N/A
Procurement Method	Request for Proposal (RFP)
External Approvals	N/A
Contract Term	Date of execution through December 31, 2027. There are four (4) annual options to renew.

BUDGET EGID is self-funded through premiums and operates on a calendar year budget.

Amount requested for approval	CY 2027 Total: $8,000,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	N/A

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 EGID bundled services described above for the not-to-exceed amount of $8,000,000.00 for Calendar Year (CY) 2027. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 days for cause, 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.)
EGID Funding (The HealthChoice plans administered by EGID are self-funded, non-appropriated benefit plans with a budget derived from premiums collected. There is no federal funding or state appropriated funding for EGID contracts utilizing the premium derived funds. Therefore, the contracts and budget for the contracts do not always follow the state fiscal year.)

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 26, 2026
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	New Contract and Extension -- Non-Emergency Medical Transportation
Purpose and Scope	The Authority requests approval of two related actions for the Non-Emergency Medical Transportation (NEMT) program to ensure uninterrupted services for SoonerCare members. **Approval of a 90-Day Extension of the Prior NEMT Contract** Following the award of the new NEMT contract, the previous contract must be extended for an additional 90 days in Q1 of SFY27 to support a smooth operational transition. This extension will maintain continuous access to safe, reliable, and efficient transportation for members traveling to medical appointments and other medically necessary services, including those with physical and intellectual disabilities. **Approval of New Contract Funding Through June 30, 2027** The Authority also requests approval of funding for the newly awarded NEMT contract through SFY27, covering services during the period October 1, 2026, through June 30, 2027, Q2 –Q4 of SFY27.
Mandate	N/A
Procurement Method	Request for Proposal (RFP)
External Approvals	N/A
Contract Term	Extension: July 1, 2026, through September 30, 2026. Initial Term: October 1, 2026, through June 30, 2027.

BUDGET

Amount requested for Approval	(Q1) SFY27 Extension: $10,096,022.00 (Q2-Q4) SFY27 New Contract: $37,938,4 SFY Total: $48,034,497.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Share: 68.49% -- $32,898,827.00 State Share: 31.51% -- $15,135,670.00

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested for the **total not to exceed amount of $48,034,497.00 from July 1, 2026, to June 30, 2027,** for the Non-Emergency Medical Transportation Services. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the new contract.

Additional Information

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

Attachment C.viii

SUBMITTED TO THE C.E.O. AND BOARD ON June 26, 2026

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	New Contract(s) -- Rural Health Transformation: PACE Expansion & Stabilization Agreement
Purpose and Scope	The contracts are part of the initiatives under the federal Rural Health Transformation Grant. The purpose of this initiative is to partner with six providers to develop and assist in funding the providers as they develop PACE certification. The intent is to support rural communities across Oklahoma using the PACE model to improve healthcare access, healthcare quality, and healthcare outcomes for PACE Participants. The PACE model provides comprehensive, team-based care that enables participants to remain in their homes and communities longer, improves seniors' quality of life, and reduces the need for higher-cost institutional care. The partner providers will be selected with the assistance of a vendor acting as a technical assistant that is addressed in a separate board document.
Mandate	N/A
Procurement Method	Direct Pass-Through Agreement
External Approvals	CMS
Contract Term	Initial Contract effective date of Contract Execution through October 30, 2026, with 4 options to renew

BUDGET

Amount requested for Approval	FGY 2026 Total: $13,365,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Grant: 100% -- $13,365,000.00

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 a total amount not to exceed $13,365,000.00 for Federal Grant Year (FFY) 2026. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the new contract.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON June 26, 2026

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	Amendment – Consulting Services – Rural Health Transformation PACE Technical Assistance
Purpose and Scope	OHCA requests approval for funds to continue and amend to expand a previously approved consulting contract to provide consulting and technical assistance services in support of the PACE Expansion and Stabilization initiative under the Rural Health Transformation Grant. Services include provider readiness and CMS certification support, infrastructure and mobile clinic deployment planning, financial and actuarial stabilization, workforce and operational technical assistance, tribal outreach and coordination, data analytics integration, and ongoing project management activities necessary to support successful program expansion and operational compliance. The contractor will also continue all contracted services under the original contract.
Mandate	N/A
Procurement Method	Request for Proposal (RFP)
External Approvals	N/A
Contract Term	July 1, 2026, through June 30, 2027. This is the last annual option to renew.

BUDGET

Amount requested for Approval	SFY 2027 Total: $1,800,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Grant: 100% -- $1,800,000.00

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 final option year to renew for a total not-to-exceed of $1,800,000.00

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 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.)

Attachment C.x

SUBMITTED TO THE C.E.O. AND BOARD ON June 26, 2026
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	Amendment -- Closed Loop Electronic Referral System (CLERS)
Purpose and Scope	The purpose of this initiative is to continue and expand the reach of Oklahoma's current closed-loop referral system to provide additional funding and authorize expanding the scope of work to provide licenses to CLERS for forty-four (44) Medicaid-contracted providers related to the CLERS initiative under the federal Rural Health Transformation (RHT) Grant. License distribution shall be limited to providers located within the seventy-five (75) counties designated under the RHT Grant, consisting of all Oklahoma counties excluding Tulsa and Oklahoma Counties. Services shall include 1) integration of the Electronic Records System with existing electronic systems; 2) access to a trusted network of healthcare providers and other entities relevant to each licensed user; 3) access to data in accordance with RHT requirements, as defined during implementation; and 4) provision of all necessary implementation support, training, and sustainability services for Authorized Users.
Mandate	N/A
Procurement Method	Request for Proposal (RFP)
External Approvals	CMS
Contract Term	July 1, 2026, through June 30, 2027.

BUDGET

Amount requested for Approval	SFY 2027 Total: $1,080,400.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Grant: $830,400.00

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 a total amount not to exceed $1,080.400.00 for SFY 2027. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the new contract that costs at least $1,000,000.00.

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 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.)

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 26, 2026

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	Amendment -- MMIS Contract Services
Purpose and Scope	The Oklahoma Health Care Authority (OHCA) requests Board approval of Amendment Fourteen to the contract with the current Medicaid Member Information System (MMIS) vendor. This amendment adds a Community Engagement Verification (CEV) solution to support implementation of federal Medicaid community engagement requirements established under H.R. 1. The solution will verify member compliance with community engagement requirements, support member outreach, integrate with OHCA eligibility systems, and integrate with automated document processing capabilities.
Mandate	House Resolution 1 (H.R. 1)
Procurement Method	RFP
External Approvals	CMS
Contract Term	July 1, 2026, through June 30, 2027, final option year to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	SFY27 Added: $2,000,000.00
Federal Match Costs within the Total Contract Not-to-Exceed;	Federal Grant: 86.88% -- $1,737,524.00 Federal Share: 11.81% -- $236,228.40 State Share: 1.31% -- $26,247.60

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 additional funds of $2,000,000.00 for SFY27 to support the Community Engagement Verification (CEV) solution amended into the contract.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 26, 2026

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	Amendment -- MMIS Contract Services Compliance
Purpose and Scope	The Oklahoma Health Care Authority (OHCA) requests Board approval of Amendment Fifteen to the contract with the current Medicaid Member Information System (MMIS) vendor. This amendment adds and updates security and contractual standards to ensure compliance with recent changes in federal law and regulation. Specifically, this amendment provides NCPDP ePrescribing updates, ARC-AMPE support, CMS-57/9115 enhancements, and support for future fraud waste and abuse (FWA) prevention vendors needing integration into the MMIS.
Mandate	Acceptable Risk Controls for ACA, Medicaid, and Partner Entities (ARC-AMPE); Other various federal regulations and laws.
Procurement Method	RFP
External Approvals	CMS
Contract Term	July 1, 2026, through June 30, 2027, final option year to renew.

BUDGET

Total Contract Not-to-Exceed Requested for Approval.	SFY27 Added: $14,065,311.00
Federal Match Costs within the Total Contract Not-to-Exceed;	Federal Share: 86.15% -- $12,116,804.55 State Share: 13.85% -- $1,948,506.45

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 additional funds of $14,065,311.00 for SFY27 to support the federally required Compliance initiatives amended into the contract.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 26, 2026
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	Renewal -- Customer Relationship Management (CRM) Call Center
Purpose and Scope	OHCA requests approval for the continuation and annual renewal of the contract for the management of a Customer Relationship Management (CRM) Call Center. The CRM Call Center handles inquiries from and interactions with members and prospective members of OHCA's health care benefits programs, contracted or prospective health care providers, allied agencies and organizations, and other relevant stakeholders.
Mandate	N/A
Procurement Method	Statewide Contract
External Approvals	CMS
Contract Term	July 1, 2026, through June 30, 2027. There are two (2) remaining annual options to renew out of three (3) total.

BUDGET

Amount requested for Approval.	SFY 2027 Total: $10,472,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Share:75% -- $7,854,000.00 State Share: 25% -- $2,618,000.00

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 annual contract amount as described above for a not-to-exceed of $10,472,000.00 for SFY27. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 days for cause, 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, 2026

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	Renewal -- Technical Consultant for the Medicaid Management Information System (MMIS) Modernization and Transformation Management Office (TMO) Year Three
Purpose and Scope	This is a continuation of the contract with the consultant OHCA has engaged to assist in the planning, design and execution of the MMIS modernization activities. This work has included the design, development and operations of OHCA's Transformation Management Office (TMO) and execution of a Technology and Data Strategy Project. The TMO is intended to provide greater collaboration and visibility across the Health Care Authority into new and ongoing projects and policy changes. OHCA has elected to continue to leverage a consultant to assist in the day-to-day TMO activities. As part of the MMIS modernization OHCA is executing a Technology and Data Strategy project. Project kickoff was delayed until March 2026. As a result, the project will extend into SFY27 (anticipated completion in August 2026). The Technology and Data Strategy project will lay the foundation for OHCA's approach to system integration and MES modernization architecture.
Mandate	N/A
Procurement Method	Statewide Contract
External Approvals	CMS
Contract Term	July 1,2026 through June 30, 2027.

BUDGET

Amount requested for Approval	SFY 2027 Total: $5,300,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Share: 90% -- $4,770,000.00 State Share: 10% -- $530,000.00

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 continue the existing contract end for one (1) year for a total not-to-exceed of $5,300,000.00. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 26, 2026
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	Renewal -- Consulting Services – Managed Care Actuary
Purpose and Scope	OHCA seeks to continue the existing contract for actuarial consultants for the last option year. The original contract was procured with four contractors to provide consulting services on various policy, contracting, audit and rate-setting issues. The actuarial consultant contractor performs comprehensive analysis, feasibility, determination of budget impact, and evaluation of current and potential OHCA initiatives and programs. The under the renewal, the contractor shall offer the following services: • Analyze impact of policy changes on cost, access, and quality of services • Develop state plan amendments or waivers as needed • Provide financial services including budget neutrality calculations, actuarial certifications, cost impacts, program feasibility, return on investment, long-term financial management, and rate setting for new or existing services • Assess data vulnerability and provide gap analysis of available data versus needed data • Evaluate SoonerCare Health Management Program and Chronic Care Unit, SoonerCare Waiver, SoonerCare Choice Reform, and recommend improvements • Support SoonerSelect compliance, operations and administration • Provide reports and presentations as necessary on the above issues
Mandate	N/A
Procurement Method	Request for Proposal (RFP)
External Approvals	N/A
Contract Term	July 1, 2026 through June 30, 2027 – Final year of contract

BUDGET

Amount requested for Approval	SFY 2027 Total: $3,633,412.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Share: 50% -- $1,816,706.00 State Share: 50% -- $1,816,706.00

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 final option year of the contract at the total not-to-exceed amount of $3,633,412.00 for SFY 2027.

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.)

SUBMITTED TO THE C.E.O. AND BOARD ON June 26, 2026
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	Renewal -- Consulting Services – Federal Compliance Consultant
Purpose and Scope	OHCA seeks to continue the existing contract for consulting services on various policy, contracting, audit and rate-setting issues. The OHCA looks to the contractor to provide expert opinions, recommendations and information relevant to the SoonerCare program. The contractor performs comprehensive analysis, feasibility, determination of budget impact, and evaluation of current and potential OHCA initiatives and programs. The following services are offered with the renewal: • Analyze impact of policy changes on cost, access and quality of services • Develop state plan amendments or waivers as needed • Evaluate OHCA programs and recommend improvements • Provide financial services including budget neutrality calculations, cost impacts, program feasibility, return on investment, and rate setting for new or existing services • Assess data vulnerability and provide gap analysis of available data versus needed data • Provide reports and presentations as necessary on the above issues
Mandate	N/A
Procurement Method	Request for Proposal (RFP)
External Approvals	N/A
Contract Term	July 1, 2026 through June 30, 2027. This is the last annual option to renew.

BUDGET

Amount requested for Approval	SFY 2027 Total: $1,117,000
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal Share: 50% -- $558,500.00 State Share: 50% -- $558,500.00

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 final year of the contract at a total not-to-exceed of $1,117,000.00 for SFY 2027.

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.)

Attachment C.xvii

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 26, 2026

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	Renewal -- Customer Management Data Analytics Software Subscription Services
Purpose and Scope	The Oklahoma Health Care Authority (OHCA) seeks to continue the one-year option on the existing contract that provides value-based care analytics solutions for healthcare payors and providers to support the ongoing efforts of the modernization. The renewal includes the addition of the following Services: i. CMS Measures Reporting ii. Analytic Advisory Services iii. Task Order Governance and Approval iv. Delivery Model and Monthly Hour Allocation
Mandate	N/A
Procurement Method	Statewide Contract
External Approvals	CMS
Contract Term	July 1, 2026, through June 30, 2027.

BUDGET

Amount requested for Approval	SFY 2027 Total: $2,300,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	Federal grant: 21.74% -- $500,000.00 Federal Share: 39.13% -- $900,000.00 State Share: 39.13% -- $900,000.00

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 continue the existing contract for one (1) year for an additional total not-to-exceed of $2,300,000.00.

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 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.)

SUBMITTED TO THE C.E.O. AND BOARD ON June 26, 2026
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	Renewal and Amendment -- EGID member eligibility and premium accounting services software.
Purpose and Scope	This contract is intended to acquire and implement computer software applications to electronically manage EGID's member eligibility information. The software provides premium accounting services, call tracking, and web eligibility services which includes vendor's "Active Workflow module". This software is proprietary and can only be supported by the current vendor. This is an amendment to a Sole Source acquisition executed August 1, 2021. The initial Contract term ends on July 31, 2026. The amendment extends the contract to cover an agreement period from August 1, 2026 to July 31, 2028. The original sole source contract was acquired from a contract that was previously competitively bid under Purchase Order Y030167. A sole source was sought because the implementation and transition to a new vendor is excessively burdensome and expensive on OHCA. This contract is funded solely from EGID funds.
Mandate	N/A
Procurement Method	Sole Source

External Approvals	N/A
Contract Term	Approval for funds sought for August 1, 2026, through July 31, 2027.

BUDGET EGID is self-funded through premiums and operates on a calendar year budget.

Amount requested for approval	Contract Year 2027 Total: $2,000,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	N/A

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 EGID's member eligibility and premium accounting services software described above for the first amended year of two total amended contract years with an annual not-to-exceed amount of $2,000,000.00 for Contract Year 2027. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 days for cause, 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.)
EGID Funding (The HealthChoice plans administered by EGID are self-funded, non-appropriated benefit plans with a budget derived from premiums collected. There is no federal funding or state appropriated funding for EGID contracts utilizing the premium derived funds. Therefore, the contracts and budget for the contracts do not always follow the state fiscal year.)

OKLAHOMA HEALTH CARE AUTHORITY
SFY-2027 BUDGET WORK PROGRAM
Summary by Program Expenditure

Description	SFY-2026	SFY-2027	Inc / (Dec)	% Change
Medical Program				
Managed Care:				
SoonerCare Choice / HAN / PACE	41,089,263	50,714,439	9,625,175	23.4%
SoonerSelect Medical	2,804,657,142	3,035,462,564	230,805,422	8.2%
SoonerSelect CSP	161,858,174	165,339,047	3,480,874	2.2%
SoonerSelect Dental	200,199,922	217,632,398	17,432,476	8.7%
SoonerSelect SFY25 Risk Corridor Payment	-	180,312,910	180,312,910	100.0%
SoonerSelect MY26 Rate Adjustment	-	185,556,023	185,556,023	100.0%
SoonerSelect MY27 Rate Adjustment	-	170,556,023	170,556,023	100.0%
Hospitals	1,159,524,096	1,186,777,391	27,253,295	2.4%
Behavioral Health	16,582,994	16,981,502	398,508	2.4%
Nursing Homes	952,797,458	1,014,868,034	62,070,576	6.5%
Physicians	297,297,104	297,934,479	637,375	0.2%
Dentists	60,637,156	60,100,125	(537,032)	-0.9%
Mid-Level Practitioner	154,362	235,009	80,647	52.2%
Other Practitioners	30,663,899	27,693,905	(2,969,994)	-9.7%
Home Health	32,941,435	36,174,584	3,233,149	9.8%
Lab & Radiology	19,135,003	19,425,714	290,711	1.5%
Medical Supplies	83,800,725	90,202,110	6,401,385	7.6%
Clinic Services	446,385,491	514,439,886	68,054,395	15.2%
Ambulatory Surgery Center	7,867,103	9,189,066	1,321,963	16.8%
Prescription Drugs	965,324,724	1,109,099,005	143,774,280	14.9%
Miscellaneous	300,756	301,046	290	0.1%
ICF/IID	93,345,474	92,446,532	(898,942)	-1.0%
Transportation	138,711,910	179,881,024	41,169,114	29.7%
Medicare Buy-in (Part A & B)	259,557,360	281,948,740	22,391,380	8.6%
Medicare clawback payment (Part D)	146,129,387	159,116,096	12,986,709	8.9%
SHOPP - Supplemental Hosp Offset Pymt.	1,391,853,449	1,392,576,561	723,112	0.1%
Provider Incentive Program	115,089,502	112,473,904	(2,615,598)	-2.3%
Money Follows the Person - Enhanced	1,609,635	2,582,529	972,894	60.4%
Health Management Program (HMP)	12,560,024	11,304,022	(1,256,002)	-10.0%
Non-Title XIX Medical	50,000	50,000	-	0.0%
TOTAL OHCA MEDICAL PROGRAM	9,440,123,549	10,621,374,667	1,181,251,119	12.5%
Insure Oklahoma - Premium Assistance				
Employer Sponsored Insurance - ESI	28,230,478	24,933,829	(3,296,649)	-11.7%
Individual Plan - IP	200,000	200,000	-	0.0%
TOTAL INSURE OKLAHOMA PROGRAM	28,430,478	25,133,829	(3,296,649)	-11.6%
Rural Health Transformation Grant				
Rural Health Transformation - Division 53	9,297,914	56,182,424	46,884,510	504.2%
OHCA Administration				
Operations - Division 10	63,836,277	62,538,873	(1,297,404)	-2.0%
Contracts - Division 30	48,626,036	49,614,237	988,201	2.0%
Insure Oklahoma - Division 40	1,467,659	1,410,989	(56,670)	-3.9%
Grants Management - Division 50	14,914,860	7,774,390	(7,140,470)	-47.9%
EGID - Division 80	53,450,300	59,139,508	5,689,208	10.6%
Business Enterprises - Division 88	136,615,532	181,629,180	45,013,648	32.9%
TOTAL OHCA ADMIN	318,910,664	362,107,177	43,196,513	13.5%
TOTAL OHCA PROGRAMS	**9,796,762,605**	**11,064,798,098**	**1,268,035,493**	**12.9%**
Other State Agency (OSA) Programs				
Oklahoma Human Services (OHS)	971,187,756	1,001,246,504	30,058,749	3.1%
Oklahoma State Dept of Health (OSDH)	5,516,449	6,004,396	487,948	8.8%
The Office of Juvenile Affairs (OJA)	5,600,170	8,621,175	3,021,004	53.9%
University Hospitals (Medical Education Pymnts)	773,757,681	796,547,327	22,789,646	2.9%
Department of Mental Health (ODMHSAS)	829,717,894	936,171,401	106,453,507	12.8%
Department of Education (DOE)	7,838,848	9,209,752	1,370,904	17.5%
Non-Indian Payments	29,897,897	35,223,186	5,325,289	17.8%
Department of Corrections (DOC)	10,870,206	10,502,902	(367,304)	-3.4%
JD McCarty	26,740,880	19,153,667	(7,587,213)	-28.4%
OSA Non-Title XIX	119,095,000	119,095,000	-	0.0%
TOTAL OSA PROGRAMS	**2,780,222,780**	**2,941,775,310**	**161,552,530**	**5.8%**
TOTAL MEDICAID PROGRAM	**12,576,985,385**	**14,006,573,407**	**1,429,588,023**	**11.4%**

OKLAHOMA HEALTH CARE AUTHORITY

SFY-2027 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	SFY-2026	SFY-2027	Inc / (Dec)	% Change
REVENUES				
Federal - Medicaid Traditional	5,795,516,437	6,184,932,530	389,416,093	6.7%
Federal - Medicaid Expansion	2,525,594,275	3,110,256,207	584,661,932	23.1%
Federal - Admin	183,198,293	256,630,984	73,432,691	40.1%
Drug Rebates	773,699,064	803,736,608	30,037,544	3.9%
Medical Refunds	65,834,100	47,733,879	(18,100,222)	-27.5%
NF Quality of Care Fee	102,663,730	110,203,669	7,539,939	7.3%
OSA Refunds & Reimbursements	904,573,670	959,142,335	54,568,665	6.0%
Tobacco Tax	67,525,933	65,501,613	(2,024,320)	-3.0%
MISC / GEMT / ASPAPP Assessment Fee	4,805,203	10,514,823	5,709,620	118.8%
Prior Year Carryover (Fund 200 Admin)	28,415,268	6,870,097	(21,545,171)	-75.8%
Prior Year Carryover (Fund 340 Program)	96,636,158	179,600,487	82,964,328	85.9%
Other Grants	156,160	158,740	2,580	1.7%
Hospital Provider Fee (SHOPP bill)	409,224,691	427,272,848	18,048,157	4.4%
EGID - Funds 290 / 292	53,450,300	59,139,508	5,689,208	10.6%
MCO premium tax	129,109,875	124,018,311	(5,091,564)	-3.9%
Transfer from Rate Preservation Fund	26,041,449	-	(26,041,449)	-100.0%
State Appropriated - OHCA	1,410,540,778	1,660,860,769	250,319,991	17.7%
TOTAL REVENUES	**12,576,985,385**	**14,006,573,407**	**1,429,588,023**	**11.4%**

June 26, 2026 Board
Proposed Rule Amendment Summaries

The following **EMERGENCY** rules were not previously adopted and are new to the Board. All proposed rules were presented at Tribal Consultation and considered by the Medical Advisory Committee.

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

APA WF #26-07 Nonpayment for Certain Gender Transition Procedures — The proposed revisions implement Senate Bill 904, now codified at Section 1-800 of Title 63 of the Oklahoma Statutes. The revision adds language providing that OHCA does not reimburse for or provide coverage of gender transition procedures, as defined by Section 1-800 of Title 63. This prohibition applies regardless of whether the procedure is provided to a minor or an adult. The statutory definition excludes behavioral health services or mental health counseling, medications to treat depression or anxiety, certain medications used to treat precocious or delayed puberty, certain services related to disorders of sex development, treatment of complications, and emergency treatment. The law became effective upon passage and approval pursuant to the emergency clause.

Budget Impact: Budget neutral.

Emergency Justification: These revisions are necessary to avoid violation of state law.

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

APA WF #26-10 A&B Justice-Involved Youth Reentry — The proposed rule revisions implement Section 5121 of the Consolidated Appropriations Act, 2023. The amendment requires states to provide certain Medicaid-covered services to eligible justice-involved youth under age 21, and former foster care youth up to age 26, during the 30 days prior to release from incarceration. Required services include physical and behavioral health screenings and diagnostic services, as well as targeted case management provided 30 days prior to release and 30 days post-release. Planning efforts and services will be coordinated in partnership with the Office of Juvenile Affairs, Department of Corrections, Department of Human Services, and Department of Mental Health and Substance Abuse Services.

Budget Impact: The estimated total cost for SFY27 is $192,625, with $64,294 in state share. The estimated total cost for SFY28 is $466,184, with $155,600 in state share. The state share will be covered by OJA and ODMHSAS.

Emergency Justification: These revisions are necessary to implement the federal mandate, Section 5121 of the Consolidated Appropriations Act, 2023.

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

APA WF #26-03 HR1 Alien Eligibility — The proposed policy revisions align with eligibility changes included in H.R. 1, also referred to as the Working Families Tax Cut legislation. Beginning October 1, 2026, federal financial participation (FFP) will only be available for Medicaid benefits

furnished to United States citizens, lawful permanent residents (LPRs), certain Cuban/Haitian entrants, and citizens of the Freely Associated States covered under the Compact of Free Association (COFA). Most other non-citizens will no longer qualify for full-scope coverage and will be limited to Emergency Medical Assistance.

Budget Impact: The estimated total cost savings for SFY27 is $6,711,978.00, with $2,281,401.32 in state share.

Emergency Justification: The proposed emergency rules are needed for compliance with federal law.

TITLE 317. OKLAHOMA HEALTH CARE AUTHORITY
CHAPTER 30. MEDICAL PROVIDERS-FEE FOR SERVICE
SUBCHAPTER 3. GENERAL PROVIDER POLICIES

317:30-3-1. Creation and implementation of rules; applicability

(a) Medical rules of the Oklahoma Health Care Authority (OHCA) are set by the OHCA Board. The rules are based upon the recommendations of the Chief Executive Officer of the Authority, the Deputy State Medicaid Director, the State Medicaid Director, OHCA Tribal partners and the OHCA Medical Advisory Committee. The State Medicaid Director is responsible for implementing medical policies and programs and directing the Fiscal Agent regarding proper payment of claims.

(b) Payment to practitioners under Medicaid is made for services clearly identifiable as personally rendered services performed on behalf of a specific member. There are no exceptions to personally rendered services unless specifically set out in coverage guidelines.

(c) Payment is made on behalf of Medicaid eligible individuals for services within the scope of the Authority medical programs. Services cannot be paid under Medicaid for ineligible individuals or for services not covered under the scope of medical programs or that do not meet documentation requirements. These claims will be denied, or in some instances upon post-payment review, payment will be recouped. In accordance with Section 1-800 of Title 63 of the Oklahoma Statutes, OHCA does not reimburse for or provide coverage of gender transition procedures.

(d) Payment to practitioners on behalf of Medicaid eligible individuals is made only for services that are medically necessary and essential to the diagnosis and treatment of the patient's presenting problem. Wellness examinations and diagnostic testing are not covered for adults unless specifically set out in coverage guidelines.

(e) The scope of the medical program for eligible children is the same as for adults except as further set out under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service guidelines.

(f) Services, provided within the scope of the Oklahoma Medicaid program, shall meet medical necessity criteria. Requests by qualified providers for services in and of itself shall not constitute medical necessity. The OHCA shall serve as the final authority pertaining to all determinations of medical necessity. Some service limits listed within OAC 317:30 can be exceeded for expansion adults, upon meeting medical necessity as determined by OHCA and in alignment with the Oklahoma Medicaid State Plan. Physical therapy, occupational therapy and speech language pathology have hard limits**,** which are set at forty-five (45) visits for both habilitation and rehabilitation B a cumulative total of 90 visits [fifteen (15) visits of each therapy]. Members must meet medical necessity criteria, prior authorization, and all other documentation requirements. Medical necessity is established through consideration of the following standards:

(1) Services must be medical in nature and must be consistent with accepted health care practice standards and guidelines for the prevention, diagnosis or treatment of symptoms of illness, disease or disability;

(2) Documentation submitted in order to request services or substantiate previously provided services must demonstrate through adequate objective medical records and other supporting records, evidence sufficient to justify the member's need for the service;
(3) Treatment of the member's condition, disease or injury must be based on reasonable and predictable health outcomes;
(4) Services must be necessary to alleviate a medical condition and must be required for reasons other than convenience for the member, family, or medical provider;
(5) Services must be delivered in the most cost-effective manner and most appropriate setting; and
(6) Services must be appropriate for the member's age and health status and developed for the member to achieve, maintain, or promote functional capacity.

(g) Emergency medical condition means a medical condition including injury manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected, by a reasonable and prudent layperson, to result in placing the patient's health in serious jeopardy, serious impairment to bodily function, or serious dysfunction of any bodily organ or part.

(h) Verbal or written interpretations of policy and procedure in singular instances is made on a case-by-case basis and shall not be binding on this Agency or override its policy of general applicability.

(i) The rules and policies in this Part apply to all providers of service who participate in the program.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 21. OUTPATIENT BEHAVIORAL HEALTH AGENCY SERVICES

317:30-5-240.1. Definitions

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

"Accrediting body" means one (1) of the following:

(A) Accreditation Association for Ambulatory Health Care (AAAHC);

(B) American Osteopathic Association (AOA);

(C) Commission on Accreditation of Rehabilitation Facilities (CARF);

(D) Council on Accreditation of Services for Families and Children, Inc. (COA);

(E) The Joint Commission (TJC) formerly known as Joint Commission on Accreditation of Healthcare Organizations;

(F) Accreditation Commission for Health Care (ACHC); or

(G) Other OHCA approved accreditation.

"Adult" means an individual twenty-one (21) and over, unless otherwise specified.

"AOD" means alcohol and other drug.

"AODTP" means alcohol and other drug treatment professional.

"ASAM" means the American Society of Addiction Medicine.

"ASAM patient placement criteria (ASAM PPC)" means the most current edition of the American Society of Addiction Medicine's published criteria for admission to treatment, continued services, and discharge.

"Behavioral health (BH) services" means a wide range of diagnostic, therapeutic, and rehabilitative services used in the treatment of mental illness, substance abuse, and co-occurring disorders.

"BHAs" means behavioral health aides.

"Carceral Facility" means a facility in which an eligible juvenile or former foster care youth is considered an inmate of a public institution under 42 C.F.R. § 435.1010, including but not limited to:

(A) State-owned, operated, or contracted prisons;

(B) Community correction centers and ODOC contracted halfway houses;

(C) City and county jails;

(D) County-operated juvenile detention centers;

(E) Secure detention and treatment facilities;

(F) Tribal jails and tribal-operated juvenile detention facilities;

"Certifying agency" means the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS).

"C.F.R." means Code of Federal Regulations.

"Child" means an individual younger than twenty-one (21), unless otherwise specified.

"Client Assessment Record (CAR)" means the standardized tool recognized by OHCA and ODMHSAS to evaluate the functioning of the member as per the OHCA prior authorization manual on the OHCA'S website at www.oklahoma.gov/ohca.

"CM" means case management.

"Cultural competency" means the ability to recognize, respect, and address the unique needs, worth, thoughts, communications, actions, customs, beliefs and values that reflect an individual's racial, ethnic, age group, religious, sexual orientation, and/or social group.

"DSM" means the most current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

"EBP" means an evidence-based practice per the Substance Abuse & Mental Health Services Administration (SAMHSA).

"EPSDT" means the Early and Periodic Screening, Diagnostic and Treatment benefit for children. In addition to screening services, EPSDT also covers the diagnostic and treatment services necessary to ameliorate acute and chronic physical and mental health conditions.

"FBCS" means facility-based crisis stabilization.

"FSPs" means family support providers.

"ICF/IID" means intermediate care facility for individuals with intellectual disabilities.

"Institution" means an inpatient hospital facility or institution for mental disease (IMD).

"IMD" means institution for mental disease as per 42 C.F.R. § 435.1009 as a hospital, nursing facility, or other institution of more than sixteen (16) beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care and related services. The regulations indicate that an institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases. Title XIX of the Social Security Act provides that, except for individuals under age twenty-one (21) receiving inpatient psychiatric care, Medicaid (Title XIX) does not cover services to IMD patients under sixty-five (65) years of age [Section 1905(a)(24)(B) of the Social Security Act].

"Level of functioning rating" means a standardized mechanism to determine the intensity or level of services needed based upon the severity of the member's condition. The CAR level of function rating scale is the tool that links the clinical assessment to the appropriate level of Mental Health treatment. Either the Addiction Severity Index (ASI) or the Teen Addiction Severity Index (TASI), based on age, is the tool that links the clinical assessment to the appropriate level of Substance Abuse (SA) treatment.

"LBHP" means a licensed behavioral health professional.

"MST" means the EBP Multi-Systemic Therapy.

"OAC" means the publication authorized by 75 Oklahoma Statutes, Sec. 256 known as The Oklahoma Administrative Code, or, prior to its publication, the compilation of codified rules authorized by 75 O.S. § 256(A)(1)(a) and maintained in the Office of Administrative Rules.

"Objectives" means a specific statement of planned accomplishments or results that are specific, measurable, attainable, realistic, and time limited.

"ODMHSAS" means the Oklahoma Department of Mental Health and Substance Abuse Services.

"ODMHSAS contracted facilities" means those providers that have a contract with the ODMHSAS to provide mental health or substance use disorder treatment services, and contract directly with the Oklahoma Health Care Authority to provide outpatient behavioral health services.

"OHCA" means the Oklahoma Health Care Authority.

"OJA" means the Office of Juvenile Affairs.

"O.S." means Oklahoma Statutes.

"RBMS" means residential behavioral management services within a group home or therapeutic foster home.

"Recovery" means an ongoing process of discovery and/or rediscovery that must be self-defined, individualized and may contain some, if not all, of the ten fundamental components of recovery as outlined by SAMHSA.

"PRSS" means peer recovery support specialist.

"SAMHSA" means the Substance Abuse and Mental Health Services Administration.

"Serious emotional disturbance (SED)" means a condition experienced by persons from birth to eighteen (18) that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six (6) months and be expected to persist for a year or longer.

(B) A condition or serious emotional disturbance as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious emotional disturbance.

(C) The child must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of age-appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the juvenile justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers and adults.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence to siblings and/or parents, disregard for safety and welfare or self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations which may result in removal from the family or its equivalent).

(V) Impairment in functioning at school manifested by the inability to pursue educational goals in a normal time frame (e.g., consistently failing grades, repeated truancy, expulsion, property damage or violence toward others).

"Serious mental illness (SMI)" means a condition experienced by persons age eighteen (18) and over that show evidence of points of (A), (B) and (C) below:

(A) The disability must have persisted for six (6) months and be expected to persist for a year or longer.

(B) A condition or serious mental illness as defined by the most recently published version of the DSM or the International Classification of Disease (ICD) equivalent with the exception of DSM "V" codes, substance abuse, and developmental disorders which are excluded, unless they co-occur with another diagnosable serious mental illness.

(C) The adult must exhibit either (i) or (ii) below:

(i) Psychotic symptoms of a serious mental illness (e.g., Schizophrenia characterized by defective or lost contact with reality, often hallucinations or delusions); or

(ii) Experience difficulties that substantially interfere with or limit an adult from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills. There is functional impairment in at least two (2) of the following capacities (compared with expected developmental level):

(I) Impairment in self-care manifested by a person's consistent inability to take care of personal grooming, hygiene, clothes and meeting of nutritional needs.

(II) Impairment in community function manifested by a consistent lack of appropriate behavioral controls, decision-making, judgment and value systems which result in potential involvement or involvement with the criminal justice system.

(III) Impairment of social relationships manifested by the consistent inability to develop and maintain satisfactory relationships with peers.

(IV) Impairment in family function manifested by a pattern of disruptive behavior exemplified by repeated and/or unprovoked violence, disregard for safety and welfare of self or others (e.g., fire setting, serious and chronic destructiveness, inability to conform to reasonable limitations and expectations).

(V) Impairment in functioning at school or work manifested by the inability to pursue educational or career goals.

"Trauma informed" means the recognition and responsiveness to the presence of the effects of past and current traumatic experiences in the lives of members.

317:30-5-241.6. Behavioral health targeted case management

Payment is made for behavioral health targeted case management services as set forth in this Section. The limitations set forth in this Section do not apply to case management provided in programs and service delivery models which are not reimbursed for case management on a fee-for-service basis.

(1) **Description of behavioral health case management services.** Behavioral health case management services are provided to assist eligible individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. Services under behavioral health targeted case management are not comparable in amount, duration and scope. The target groups for behavioral health case management services are persons under age twenty-one (21) who are in imminent risk of out-of-home placement for psychiatric or substance abuse reasons or are in out-of-home placement due to psychiatric or substance abuse reasons, and chronically and/or severely mentally ill adults who are institutionalized or are at risk of institutionalization. All behavioral health case management services will be authorized based on established medical necessity criteria.

(A) The behavioral health case manager provides assessment of case management needs, development of a case management care plan, referral, linkage, monitoring, and advocacy

on behalf of the member to gain access to appropriate community resources. The behavioral health case manager must monitor the progress in gaining access to services and continued appropriate utilization of necessary community resources. Behavioral case management is designed to promote recovery, maintain community tenure, and to assist individuals in accessing services for themselves following the case management guidelines established by ODMHSAS. In order to be compensable, the service must be performed utilizing the Strengths Based model of case management. This model of case management assists individuals in identifying and securing the range of resources, both environmental and personal, needed to live in a normally interdependent way in the community. The focus for the helping process is on strengths, interests, abilities, knowledge and capacities of each person, not on their diagnosis, weakness or deficits. The relationship between the service member and the behavioral health case manager is characterized by mutuality, collaboration, and partnership. Assistive activities are designed to occur primarily in the community but may take place in the behavioral health case manager's office, if more appropriate.

(B) The provider will coordinate transition services with the member and family (if applicable) by phone or face to face, to identify immediate needs for return to home/community no more than seventy-two (72) hours after notification that the member/family requests case management services. For members discharging from a higher level of care than outpatient, the higher level of care facility is responsible for scheduling an appointment with a case management agency for transition and post discharge services. The case manager will make contact with the member and family (if applicable) for transition from the higher level of care other than outpatient back to the community, within seventy-two (72) hours of discharge, and then conduct a follow-up appointment/contact within seven (7) days. The case manager will provide linkage/referral to physicians/medication services, psychotherapy services, rehabilitation and/or support services as described in the case management service plan.

(C) Case managers may also provide crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face to face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care. During the follow-up phase of these referrals or links, the behavioral health case manager will provide aggressive outreach if appointments or contacts are missed within two (2) business days of the missed appointments. Community/home-based case management to assess the needs for services will be scheduled as reflected in the case management service plan, but not less than one (1) time per month. The member/parent/guardian has the right to refuse behavioral health case management and cannot be restricted from other services because of a refusal of behavioral health case management services.

(D) An eligible member/parent/guardian will not be restricted and will have the freedom to choose a behavioral health case management provider as well as providers of other medical care.

(E) In order to ensure that behavioral health case management services appropriately meet the needs of the member and family and are not duplicated, behavioral health case management activities will be provided in accordance with an individualized plan of care.

(F) The individual plan of care must include general goals and objectives pertinent to the overall recovery of the member's (and family, if applicable) needs. Progress notes must relate to the individual plan of care and describe the specific activities to be performed. The individual plan of care must be developed with participation by, as well as, reviewed and signed by the member, the parent or guardian [if the member is under eighteen (18)], the behavioral health case manager, and an LBHP or licensure candidate as defined in OAC 317:30-5-240.3(a) and (b).

(G) SoonerCare reimbursable behavioral health case management services include the following:

(i) Gathering necessary psychological, educational, medical, and social information for the purpose of individual plan of care development.

(ii) Face-to-face meetings with the member and/or the parent/guardian/family member for the implementation of activities delineated in the individual plan of care.

(iii) Face-to-face meetings with treatment or service providers, necessary for the implementation of activities delineated in the individual plan of care.

(iv) Supportive activities such as non-face-to-face communication with the member and/or parent/guardian/family member.

(v) Non-face-to-face communication with treatment or service providers necessary for the implementation of activities delineated in the individual plan of care.

(vi) Monitoring of the individual plan of care to reassess goals and objectives and assess progress and or barriers to progress.

(vii) Crisis diversion (unanticipated, unscheduled situation requiring supportive assistance, face to face or telephone, to resolve immediate problems before they become overwhelming and severely impair the individual's ability to function or maintain in the community) to assist member(s) from progression to a higher level of care.

(viii) Behavioral health targeted case management is available to individuals transitioning from institutions to the community, ~~[~~except individuals who are inmates of public institutions~~]~~. This exclusion does not apply to eligible juveniles under the age of twenty-one (21) and former foster care youth under the age of twenty-six (26) who reside in carceral facilities as defined in OAC 317:30-5-240.1 and are within thirty (30) days of projected release. Individuals are considered to be transitioning to the community during the last thirty (30) consecutive days of a covered institutional stay. This time is to distinguish case management services that are not within the scope of the institution's discharge planning activities from case management required for transitioning individuals with complex, chronic, medical needs to the community. Transition services provided while the individual is in the institution are to be claimed as delivered on the day of discharge from the institution.

(2) **Levels of case management.**

(A) Standard case management/resource coordination services are targeted to adults with serious mental illness or children with serious emotional disturbance, or who have or are at-risk for mental disorders, including substance use disorders (SUD), and their families, who need assistance in accessing, coordination, and monitoring of resources and services. Services are provided to assess an individual's strengths and meet needs in order to achieve stability in the community. Standard case managers have caseloads of thirty (30) to thirty-five (35) members. Standard case management/resource coordination is limited

to twelve (12) units per member per month. Additional units may be authorized up to twenty-five (25) units per member per month if medical necessity criteria for transitional case management are met.

(B) Intensive case management (ICM) is targeted to adults with serious and persistent mental illness in PACT programs. To ensure that these intense needs are met, caseloads are limited to between ten (10) to fifteen (15) members. The ICM shall: be a certified behavioral health case manager II; have a minimum of two (2) years' behavioral health case management experience; have crisis diversion experience; have attended the ODMHSAS six (6) hour ICM training and be available twenty-four (24) hours a day. ICM is limited to fifty-four (54) units per member per month.

(C) Wraparound facilitation case management (WFCM) is targeted to children with significant mental health conditions being treated in a System of Care (SOC) Network who are deemed at imminent risk of out-of-home placement due to psychiatric or SUD reasons and in need of more intensive case management services. It is designed to ensure access to community agencies, services, and people whose functions are to provide the support, training and assistance required for a stable, safe, and healthy community life, and decreased need for higher levels of care. To produce a high-fidelity wraparound process, a facilitator can facilitate between eight (8) and ten (10) families. Staff providing WFCM must meet the requirements for the SOC/WFCM. WFCM is limited to fifty-four (54) units per member per month.

(3) **Excluded services.** SoonerCare reimbursable behavioral health case management does not include the following activities:

(A) Physically escorting or transporting a member or family to scheduled appointments or staying with the member during an appointment;

(B) Managing finances;

(C) Providing specific services such as shopping or paying bills;

(D) Delivering bus tickets, food stamps, money, etc.;

(E) Counseling, rehabilitative services, psychiatric assessment, or discharge planning;

(F) Filling out forms, applications, etc., on behalf of the member when the member is not present;

(G) Filling out SoonerCare forms, applications, etc.;

(H) Mentoring or tutoring;

(I) Provision of behavioral health case management services to the same family by two (2) separate behavioral health case management agencies;

(J) Non-face-to-face time spent preparing the assessment document and the service plan paperwork;

(K) Monitoring financial goals;

(L) Leaving voice or text messages for clients and other failed communication attempts.

(4) **Excluded individuals.** The following SoonerCare members who are receiving similar services through another method are not eligible for behavioral health case management services without special arrangements with the Oklahoma Department of Human Services (OKDHS), OJA, OHCA or ODMHSAS as applicable, in order to avoid duplication in payment. Services/programs include, but may not be limited to:

(A) Members/families (when applicable) for whom at-risk case management services are available through OKDHS and OJA staff;

(B) Members in out-of-home placement and receiving targeted case management services through staff in a foster care or group home setting, unless transitioning into the community;
(C) Residents of ICF/IIDs and nursing facilities unless transitioning into the community;
(D) Members receiving targeted case management services under a Home and Community Based Services (HCBS) waiver program;
(E) Members receiving case management through the ADvantage waiver program;
(F) Members receiving targeted case management available through a Certified Community Behavioral Health Center (CCBHC);
(G) Members receiving case management services through Programs of All-Inclusive Care for the Elderly (PACE);
(H) Members receiving Early Intervention case management (EICM);
(I) Members receiving case management services through certified school-based targeted case management (SBTCM) providers;
(J) Members receiving partial hospitalization services; or
(K) Members receiving MST.

(5) **Filing requirements.** Case management services provided to Medicare eligible members should be filed directly with the fiscal agent.

(6) **Documentation requirements.** The service plan must include general goals and objectives pertinent to the overall recovery needs of the member. Progress notes must relate to the service plan and describe the specific activities performed. Behavioral health case management service plan development is compensable time if the time is spent communicating with the member and it must be reviewed and signed by the member, the behavioral health case manager, and an LBHP or licensure candidate as defined at OAC 317:30-5-240.3(a) and (b). All behavioral health case management services rendered must be reflected by documentation in the records. In addition to a complete behavioral health case management service, plan documentation of each session must include but is not limited to:

(A) Date;
(B) Person(s) to whom services are rendered;
(C) Start and stop times for each service;
(D) Original signature or the service provider [original signatures for faxed items must be added to the clinical file within thirty (30) days];
(E) Credentials of the service provider;
(F) Specific service plan needs, goals, and/or objectives addressed;
(G) Specific activities performed by the behavioral health case manager on behalf of the member related to advocacy, linkage, referral, or monitoring used to address needs, goals, and/or objectives;
(H) Progress and barriers made towards goals, and/or objectives;
(I) Member/family (when applicable) response to the service;
(J) Any new service plan needs, goals, and/or objectives identified during the service; and
(K) Member satisfaction with staff intervention.

(7) **Case management travel time.** The rate for case management services assumes that the case manager will spend some amount of time traveling to the member for the face-to-face service. The case manager must only bill for the actual face-to-face time that they spend with the member and not bill for travel time. This would be considered duplicative billing since the rate assumes the travel component already.

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 24. CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

317:30-5-268. Limitations

(a) The following are non-billable opportunities for CCBHCs serving eligible members:

(1) Employment services;

(2) Personal care services;

(3) Childcare;

(4) Respite services; and

(5) Care coordination.

(b) The following SoonerCare members are not eligible for CCBHC services:

(1) Members residing in a nursing facility or ICF/IID;

(2) Inmates of a public correctional institution~~; and~~ unless the inmate:

(A) Is in the custody of a carceral facility as defined in OAC 317:30-5-240.1; and

(B) Is under the age of twenty-one (21) or a former foster care youth up to the age of twenty-six (26) pursuant to Section 5121 of the Consolidated Appropriations Act of 2023; and

(C) Is within thirty (30) days of projected release and eligible to receive medically necessary screening, diagnostic, and targeted case management services.

(3) SoonerCare members being served by a PACE provider.

CHAPTER 35. MEDICAL ASSISTANCE FOR ADULTS AND CHILDREN-ELIGIBILITY

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

317:35-5-26. Residence requirements; residents of public institutions; homeless persons; and residents of IHS, BIA or Tribal controlled dormitories

(a) **Residence.** To be eligible for SoonerCare services, the applicant must be residing in the State of Oklahoma with intent to remain at the time the medical service is received. A durational residence requirement is not imposed.

(1) Temporary absence from the State, with subsequent returns to the State, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Oklahoma residence.

(2) Oklahoma residence does not include transients or visitors passing through the state but does not preclude persons who do not have a fixed address if intent is established.

(3) Intent to remain or return is defined as a clear statement of plans to remain or return in addition to other evidence and/or corroborative statements of others.

(4) When a non-resident makes application for SoonerCare benefits, the local office provides services necessary to make available to the applicant any SoonerCare services for which he/she might be eligible from his/her state of residence. The local office contacts the state or county of the applicant's residence to explore possible eligibility for medical benefits from the

state and to obtain information needed for the determination of medical eligibility for the services received while in Oklahoma.

(5) If a member's whereabouts are unknown, as indicated by the return of unforwardable agency mail, refer to OAC 317:35-5-67.

(b) **Individuals residing in institutions (correctional facilities and institutions for mental disease).**

The SoonerCare program will only pay for services rendered: ~~to~~

(1) To adults (21 through 64 years of age) who are inpatients in an institution for mental disease (IMD), juveniles in the custody of the Office of Juvenile Affairs who are inmates in a state-owned and operated facility, or inmates in a correctional facility, when these individuals are admitted as an inpatient to a hospital, nursing facility, juvenile psychiatric facility or an intermediate care facility for individuals with intellectual disabilities and meet all other eligibility requirements.

(2) To juveniles under the age of twenty-one (21) and former foster care youth up to the age of twenty-six (26) in the custody of a carceral facility as defined in OAC 317:30-5-240.1 who are eligible to receive targeted case management (TCM) services thirty (30) days prior to projected release and 30 days following release.

(c) **Homeless individuals.** Individuals are not required to have a fixed address in order to be eligible for assistance. Individuals who lack a fixed or regular residence, who have temporary accommodations, i.e., supervised shelters, residence of other individuals, a hallway, bus station, car or other similar places, are considered as "homeless".

(d) **Individuals residing in IHS, BIA or Tribal controlled dormitories.** Individuals that reside in a facility which provides students boarding and lodging on a temporary residential basis for the purpose of attending a Bureau-operated or Indian-controlled contract or public school are considered Oklahoma residents for SoonerCare eligibility purposes.

SUBCHAPTER 6. SOONERCARE FOR PREGNANT WOMEN AND FAMILIES WITH CHILDREN

317:35-6-45. Eligibility for inmates

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

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

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

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

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

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

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

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

(f) Qualifying juveniles under the age of twenty-one (21) and former foster care youth up to the age of twenty-six (26) in the custody of a carceral facility within thirty (30) days of projected release are eligible to receive medically necessary screening, diagnostic, targeted case management, and other covered Medicaid state plan services required under applicable federal law and state plan provisions.

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

SUBCHAPTER 5. ELIGIBILITY AND COUNTABLE INCOME

317:35-5-25. Citizenship/noncitizen status and identity verification requirements

(a) **Citizenship/noncitizen status and identity verification requirements.** Verification of citizenship/noncitizen status and identity is required for all adults and children approved for SoonerCare. An exception is individuals who are initially eligible for SoonerCare as deemed newborns; according to Section 1903(x) of the Social Security Act, they will not be required to further document citizenship or identity at any subsequent SoonerCare eligibility redetermination. They are considered to have provided satisfactory documentation of citizenship and identity by virtue of being born in the United States.

(1) The types of acceptable evidence that verify identity and citizenship include:

(A) United States (U.S.) passport;

(B) Certificate of Naturalization issued by U.S. Citizenship & Immigration Services (USCIS)(Form N-550 or N-570);

(C) Certificate of Citizenship issued by USCIS (Form N-560 or N-561);

(D) Copy of the Medicare card or printout of a Beneficiary Earnings and Data Exchange (BENDEX) or State Data Exchange (SDX) screen showing receipt of Medicare benefits, Supplemental Security Income or disability benefits from the Social Security Administration; or

(E) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, with a photograph of the individual.

(2) The types of acceptable evidence that verify citizenship but require additional steps to obtain satisfactory evidence of identity are listed in subparagraphs (A) and (B). Subparagraph (A) lists the most reliable forms of verification and is to be used before using items listed in (B). Subparagraph (B) lists those verifications that are less reliable forms of verification and are used only when the items in (A) are not attainable.

(A) Most reliable forms of citizenship verification are:

(i) A U.S. public Birth Certificate showing birth in one (1) of the fifty (50) states, the District of Columbia, Puerto Rico (on or after 1/13/1941), Guam (on or after 4/10/1899), the U.S. Virgin Islands (on or after 1/17/1917), American Samoa, Swain's Island, or the Northern Mariana Islands after 11/4/1986. For Puerto Ricans whose eligibility is being determined for the first time on or after October 1, 2010 and using a birth certificate to verify citizenship, the birth certificate must be a certified birth certificate issued by Puerto Rico on or after July 1, 2010;

(ii) A Consular Report of Birth Abroad of a U.S. citizen issued by the Department of Homeland Security or a Certification of Birth issued by the State Department (Form FS-240, FS-545 or DS-1350);

(iii) A U.S. Citizen Identification Card (Form I-179 or I-197);

(iv) A Northern Mariana Identification Card (Form I-873) (Issued by the former INS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before 11/3/1986);

(v) An American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);
(vi) A final adoption decree showing the child's name and U.S. place of birth;
(vii) Evidence of U.S. Civil Service employment before 6/1/1976;
(viii) An Official U.S. Military Record of Service showing a U.S. place of birth (for example a DD-214);
(ix) Tribal membership card or Certificate of Degree of Indian Blood (CDIB) card, without a photograph of the individual, for Native Americans;
(x) Oklahoma voter registration card;
(xi) Other acceptable documentation as approved by OHCA; or
(xii) Other acceptable documentation to the same extent as described and communicated by the United States Citizenship and Immigration Service (USCIS) from time to time.

(B) Other less reliable forms of citizenship verification are:
(i) An extract of a hospital record on hospital letterhead established at the time of the person's birth that was created five (5) years before the initial application date and that indicates a U.S. place of birth. For children under sixteen (16) the evidence must have been created near the time of birth or five (5) years before the date of application;
(ii) Life, health, or other insurance record showing a U.S. place of birth that was created at least five (5) years before the initial application date and that indicates a U.S. place of birth;
(iii) Federal or state census record showing U.S. citizenship or a U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's/member's age; or
(iv) One (1) of the following items that show a U.S. place of birth and was created at least five (5) years before the application for SoonerCare. This evidence must be one (1) of the following and show a U.S. place of birth:
(I) Seneca Indian tribal census record;
(II) Bureau of Indian Affairs tribal census records of the Navajo Indians;
(III) U.S. State Vital Statistics official notification of birth registration;
(IV) An amended U.S. public birth record that is amended more than five (5) years after the person's birth; or
(V) Statement signed by the physician or midwife who was in attendance at the time of birth.

(3) Acceptable evidence of identity that must accompany citizenship evidence listed in (A) and (B) of paragraph (2) of this subsection includes:
(A) A driver's license issued by a U.S. state or territory with either a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;
(B) A school identification card with a photograph of the individual;
(C) An identification card issued by federal, state, or local government with the same information included on driver's licenses;
(D) A U.S. military card or draft record;
(E) A U.S. military dependent's identification card;

(F) A Native American Tribal document including Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph of the individual or other personal identifying information;
(G) A U.S. Coast Guard Merchant Mariner card;
(H) A state court order placing a child in custody as reported by the OKDHS;
(I) For children under sixteen (16), school records may include nursery or daycare records;
(J) If none of the verification items on the list are available, an affidavit may be used for children under sixteen (16). An affidavit is only acceptable if it is signed under penalty of perjury by a parent or guardian stating the date and place of the birth of the child and cannot be used if an affidavit for citizenship was provided.

(b) **Reasonable opportunity to obtain verification.**

(1) The state provides Medicaid to citizens and nationals of the United States and certain noncitizens, including during a reasonable opportunity period pending verification of citizenship, national status, or immigrations status. The reasonable opportunity period begins on the date the notice of reasonable opportunity is received by the individual and extends at minimum ninety (90) days. Receipt by the individual is deemed to occur five (5) days after the date on the notice, unless the individual shows that the notice was not received in the five-day period. The state provides an extension of the reasonable opportunity period if the individual subject to verification is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the state needs more time to complete the verification process. The state begins to furnish benefits to otherwise eligible individuals on the date of application containing the declaration of citizenship or immigration status and throughout the reasonable opportunity period.

(2) The following methods of verification are the least reliable forms of verification and should only be used as a last resort:

(A) Institutional admission papers from a nursing facility, skilled care facility or other institution. Admission papers generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth;
(B) Medical (clinic, doctor, or hospital) record created at least five (5) years before the initial application date that indicates a U.S. place of birth. For children under the age of sixteen (16), the document must have been created near the time of birth. Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship;
(C) Written affidavit. Affidavits are only used in rare circumstances. If the verification requirements need to be met through affidavits, the following rules apply:

(i) There must be at least two (2) affidavits by two (2) individuals who have personal knowledge of the event(s) establishing the applicants/member's claim of citizenship;
(ii) At least one (1) of the individuals making the affidavit cannot be related to the applicant or member;
(iii) In order for the affidavit to be acceptable, the persons making them must be able to provide proof of their own citizenship and identity;
(iv) If the individual(s) making the affidavit has information which explains why

evidence establishing the applicant's/member's claim of citizenship does not exist or cannot be readily obtained, the affidavit must contain this information as well;

(v) The State must obtain a separate affidavit from the applicant/member or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained; and

(vi) The affidavits must be signed under penalty of perjury.

(c) **Noncitizen eligibility.** ~~SoonerCare services are provided as described to the defined groups as indicated in this subsection if they meet all other factors of eligibility, including but not limited to residency requirements, and if the relevant noncitizen status is verifiable by federally approved means.~~ SoonerCare services are provided to noncitizens only as described in this subsection, if the individual meets all other applicable eligibility requirements, including but not limited to residency requirements, and the relevant immigration status or category is verified by federally approved means. Effective October 1, 2026, full SoonerCare benefits for noncitizens are limited to individuals for whom federal financial participation is available under Section 1903(v)(5) of the Social Security Act and other applicable federal law.

~~(1) **Unauthorized resident noncitizen.** An unauthorized resident noncitizen is a foreign-born individual who is not lawfully present in the United States, regardless of having had authorization during a prior period. Unauthorized resident noncitizens have formerly been known as "illegal" or "undocumented" immigrants or "aliens". Per 8 U.S.C. 1611(a) and (b)(1)(A) an unauthorized resident noncitizen is ineligible for Title XIX Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an unauthorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate Children's Health Insurance Program (CHIP) for services that benefit the unborn child, if the unborn child meets all eligibility requirements.~~

~~(2) **Authorized resident noncitizen, not qualified.** An authorized resident noncitizen is a foreign-born individual who is lawfully present in the United States (U.S.) and is lawfully residing in the U.S., but who does not meet the definition of qualified noncitizen, per 8 U.S.C. 1611(a) and (b)(1)(A). The Oklahoma Medicaid program does not exercise the CHIPRA 214 option; therefore, an authorized resident noncitizen is ineligible for Title XIX or Title XXI Medicaid benefits except for emergency Medicaid as defined at subparagraph (e) below. However, an authorized resident noncitizen who is pregnant is eligible for benefits under Title XXI separate CHIP for services that benefit the unborn child, if the unborn child meets all eligibility requirements.~~

~~(3) **Qualified noncitizen.** A "qualified noncitizen" is an authorized resident noncitizen who, at the time of applying for Medicaid, has a "qualified noncitizen" immigration status as identified at 8 U.S.C. 1641, as may be amended from time to time. Any qualified noncitizen is eligible for full Title XIX Medicaid benefits after a five-year waiting period beginning on the date of the noncitizen's entry into the U.S. with an immigration status identified as "qualified noncitizen" if the noncitizen meets all other eligibility criteria at the end of the waiting period. During the waiting period, as per 8 U.S.C. 1613(a), any qualified noncitizen is eligible to receive emergency Medicaid as described in subparagraph (e) below if the noncitizen meets all other eligibility requirements, including but not limited to residency requirements.~~

~~(A) **Qualified noncitizen immigration statuses.** Immigration statuses identified by federal law as "qualified noncitizen", as of November 2, 2021, include:~~

~~(i) A noncitizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act [INA], per 8 U.S.C. 1101 et seq.;~~
~~(ii) A noncitizen who is granted asylum under INA section 208, per 8 U.S.C. 1158;~~
~~(iii) A noncitizen who is admitted to the U.S. under INA section 207 refugee, per 8 U.S.C. 1157;~~
~~(iv) A noncitizen who is paroled into the U.S. under INA section 212(d)(5), per 8 U.S.C. 1182(d)(5), for a period of at least one (1) year;~~
~~(v) A noncitizen whose deportation is being withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of division C of Public Law 104B208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104B208);~~
~~(vi) A noncitizen who is granted conditional entry before 1980 pursuant to INA section 203(a)(7), per 8 U.S.C. 1153(a)(7), as in effect prior to April 1, 1980;~~
~~(vii) A noncitizen who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980);~~
~~(viii) A noncitizen who, or whose parent or child, has been battered or subjected to extreme cruelty in the U.S. by a U.S. citizen or lawful permanent resident spouse or parent or by a member of the spouse's or parent's family residing in the same household, except during any period in which the individual responsible for such battery or cruelty resides in the same household or family eligibility unit as the individual subjected to such battery or cruelty and only when the alien meets all of the following requirements:~~

~~(I) The noncitizen, if not the individual subjected to battery or extreme cruelty, had no active participation in the battery or cruelty;~~
~~(II) The noncitizen is a credible victim; and~~
~~(III) The noncitizen is able to show a substantial connection between the need for benefits sought and the batter or extreme cruelty; and~~
~~(IV) The noncitizen has been approved or has a petition pending which sets forth a prima facie case for one of the following: status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); classification under INA 204(a)(1)(B)(ii) or (iii); suspension of deportation under INA 244(a)(3); status as a spouse or child of a U.S. citizen under INA 204(a)(1)(A); or classification under INA 204(a)(1)(B); or cancellation of removal under INA 240A(b)(2).~~

~~(ix) A noncitizen who is or has been a victim of a severe form of trafficking in persons and who has been granted nonimmigrant status under INA 101(a)(15)(T) or who has a pending application that sets forth a prima facie case for eligibility for such immigration status; or~~
~~(x) Beginning December 27, 2020, a noncitizen who lawfully resides in the state in accordance with the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau.~~

~~(B)~~ **~~Five-year wait exception for refugees and asylees.~~**

~~(i) Excepted from the five-year waiting period per 8 U.S.C. 1612(b)(2)(A), the following qualified noncitizens are immediately eligible for a Medicaid determination upon the date:~~

(I) A noncitizen is admitted to the U.S. as a refugee under INA section 207 [INA 207 Refugee], per 8 U.S.C. 1157;

(II) A noncitizen is granted asylum under INA section 208, per 8 U.S.C. 1158;

(III) A noncitizen's deportation is withheld under INA section 243(h), per 8 U.S.C. 1253 (as in effect immediately before the effective date of section 307 of division C of Public Law 104B208) or section 241(b)(3) of such Act, per 8 U.S.C. 1231(b)(3) (as amended by section 305(a) of division C of Public Law 104B208);

(IV) A noncitizen is granted status as a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Education Assistance Act of 1980); or

(V) A noncitizen is admitted to the U.S. as an Amerasian immigrant under the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, section 584.

(ii) This exception to the five-year waiting period expires seven (7) years after the date of action indicated in the list at (c)(3)(B)(i) above. Upon expiration of the exception, the five-year waiting period must be calculated.

(C) **Five-year wait exception for certain permanent resident noncitizens.** The five-year waiting period does not apply and the noncitizen is immediately eligible for a Medicaid determination per 8 U.S.C. 1612(b)(2)(B), if:

(i) The noncitizen is lawfully admitted to the U.S. for permanent residence;

(ii) The noncitizen has either:

(I) worked forty (40) qualifying quarters of coverage as defined under the Act; or

(II) can be credited with such qualifying quarters as provided under 8 U.S.C. 1645; and

(iii) In the case of any such qualifying quarters creditable for any period beginning after December 31, 1996, the noncitizen did not receive any federal means-tested public benefit during any such period.

(D) **Five-year wait exception for veteran and active-duty noncitizens.** As per 8 U.S.C. 1612(b)(2)(C) and 1613, the five-year waiting period does not apply, and the noncitizen is immediately eligible for a Medicaid determination if the noncitizen is a qualified noncitizen who is lawfully residing in the state and is:

(i) A veteran (as defined at INA sections 101, 1101, or 1301, or as described at 38 U.S.C. section 107) with a discharge characterized as an honorable discharge and not on account of noncitizenship and who fulfills the minimum active-duty service requirements of 38 U.S.C. section 5303A(d);

(ii) On active duty (other than active duty for training) in the Armed Forces of the United States; or

(iii) The spouse or unmarried dependent child of an individual described herein as a veteran or active-duty noncitizen; or

(iv) The unremarried surviving spouse of an individual described herein as a veteran or active-duty noncitizen who is deceased, if the marriage fulfills the requirements of 38 U.S.C. section 1304.

(E) **Five-year wait exception for COFA migrants.** Per 8 U.S.C. 1613(b)(3) and as of December 27, 2020, any noncitizen who lawfully resides in the state in accordance with

the Compacts of Free Association between the Government of the United States and the Governments of the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau is, with regard to the Medicaid program, are not subject to the five-year waiting period unless and until the individual=s status is adjusted to lawful permanent resident (LPR), at which time the five year waiting period must be calculated, unless the individual meets a separate exception to the five-year waiting period:

(i) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred before December 27, 2020, then the waiting period begins on the date of adjustment and ends after five (5) years;

(ii) If the individual entered the U.S. before December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period expires on December 27, 2025; and

(iii) If the individual entered the U.S. after December 27, 2020, and the date of adjustment to LPR status occurred after December 27, 2020, the waiting period begins on the date of entry into the U.S. and ends after five (5) years.

(F) **Five-year wait exception for qualified noncitizens receiving SSI.** Per 8 U.S.C. 1612(b)(2)(F), a qualified noncitizen who is receiving benefits under the supplemental security income program (SSI) under Title XVI of the Act shall be eligible for medical assistance under a state plan under Title XIX of the Social Security Act, per 42 U.S.C. 1396 et seq), under the same terms and conditions that apply to other recipients of SSI benefits.

(4) **Special categories of noncitizens and conferred benefits.** For the following noncitizens, federal law has expressly authorized Title XIX Medicaid benefits as described below and at law.

(A) **Certain American Indian / Alaskan Native (AI/AN) noncitizens.** The qualified noncitizen requirement and the five-year waiting period do not apply to any individual who is:

(i) An American Indian born in Canada to whom section 289 of the Immigration and Nationality Act apply, per 8 U.S.C. 1359; or

(ii) A member of a federally recognized Indian tribe as defined at 25 U.S.C. 450b(e).

(B) **Certain Iraqi nationals.**

(i) Public Law 110-181, Section 1244, while in force and as amended from time to time, created a new category of special immigrant for Iraqi nationals, including:

(I) Principal noncitizens who have provided relevant service to the U.S. government, while employed by or on behalf of the U.S. government in Iraq, for not less than 1 year beginning on or after March 20, 2003, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment; (II) The spouse or surviving spouse of a principal noncitizen; and

(III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, extended Iraqi special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009.

(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Iraqi nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];

(C) **Certain Afghan nationals.**

(i) Public Law 111-8, Section 602, while in force and as amended from time to time, created a new category of special immigrant for Afghan nationals, including:

(I) Principal noncitizens who have provided relevant service to the U.S. government or the International Security Assistance Force, while employed by or on behalf of the U.S. government in Afghan, for not less than one (1) year beginning on or after October 7, 2001, and who have experienced or are experiencing an ongoing serious threat as a consequence of that employment;

(II) The spouse or surviving spouse of a principal noncitizen; and

(III) The child of a principal noncitizen.

(ii) Public Law 111-118, Section 8120, while in force and as amended from time to time, amended Public Law 111-8, Section 602, to extend Afghan special immigrant eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above] as of December 19, 2009;

(iii) As of August 3, 2021, pursuant to the Office of Refugee Resettlement Policy Letter 21-07, while in force and as may be amended, Afghan nationals granted special immigrant parole, noncitizens with applications pending for special immigrant status, are also eligible for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [see subparagraph (c)(3)(B) above];

(iv) Pursuant to Public Law 117-43, Section 2502, while in force and as may be amended from time to time, "applicable individuals" have time-limited eligibility for medical assistance to the same extent as INA 207 Refugees are eligible for medical assistance [See subsection (c)(3)(B) above], until March 21, 2023, or the term of parole, whichever is later. In this subparagraph, the term "applicable individual" includes only:

(I) A citizen or national of Afghanistan or a person with no nationality who last habitually resided in Afghanistan, if the individual is paroled into the U.S. between July 31, 2021, and September 30, 2022;

(II) The spouse or child of an individual described at (c)(3)(C)(iv)(I) of this section, if the spouse or child is paroled into the U.S. after September 30, 2022; and

(III) The parent or legal guardian of an individual described at (c)(3)(C)(iv)(I) who is determined to be an unaccompanied child, if the parent or legal guardian is paroled into the U.S. after September 30, 2022.

(D) **Certain Ukrainian nationals**. Public Law 117-128, Section 401, while in force and as amended from time to time, created a new category of special immigrant for Ukraine nationals, including:

(i) A citizen or national of Ukraine, or a person who last habitually resided in Ukraine, who was paroled into the United States between February 24, 2022 and September 30, 2023; or

~~(ii) A citizen or national of Ukraine, or a person who last habitually resided in Ukraine, who was paroled into the United States after September 30, 2023, and is the spouse or child of an individual described in (D)(i)(I) above, or is the parent, legal guardian, or primary caregiver of an individual described in (D)(i)(I) above who is determined to be an unaccompanied child; and~~

~~(iii) The individual's parole has not been terminated by the Secretary of Homeland Security.~~

(1) **Noncitizens eligible for full SoonerCare benefits**. Beginning October 1, 2026, a noncitizen is eligible for full SoonerCare benefits without a five-year waiting period only if the individual is:

(A) a Cuban or Haitian entrant, as defined by federal law;

(B) a Compact of Free Association migrant lawfully residing in the United States in accordance with federal law; or

(C) a lawfully admitted permanent resident who is not subject to the five-year waiting period or who is exempt from that waiting period under applicable federal law.

(2) **Noncitizens eligible for full SoonerCare benefits after the five-year waiting period.** Beginning October 1, 2026, a lawfully admitted permanent resident who is subject to the five-year waiting period is eligible for full SoonerCare benefits only after satisfying the applicable waiting period and all other eligibility requirements under federal and state law.

(3) **Noncitizens ineligible for full SoonerCare benefits.** Beginning October 1, 2026, a noncitizen who is not described in paragraph (1) or (2) of this subsection is not eligible for full SoonerCare benefits, except to the extent coverage is expressly authorized by federal law. Such individuals may be eligible for emergency Medicaid if otherwise eligible under subsection (e) of this section. This paragraph includes, but is not limited to, a noncitizen whose verified immigration status or category is any of the following and who is not otherwise described in paragraph (1) or (2) of this subsection:

(A) a refugee admitted under section 207 of the Immigration and Nationality Act;

(B) an individual granted asylum under section 208 of the Immigration and Nationality Act;

(C) a noncitizen paroled into the United States for a period of at least one (1) year;

(D) a noncitizen granted withholding of deportation or withholding of removal;

(E) a noncitizen granted conditional entry prior to April 1, 1980;

(F) a noncitizen who, or whose parent or child, has been battered or subjected to extreme cruelty, as described by federal law;

(G) a noncitizen granted nonimmigrant status as a victim of trafficking, a noncitizen with a pending application that sets forth a prima facie case for such status, or a victim of a severe form of trafficking in persons and qualifying family members, as described by federal law;

(H) an Amerasian immigrant;

(I) a lawfully residing veteran, active-duty servicemember, or qualifying family member whose eligibility is based solely on that status and who is not otherwise described in paragraph (1) or (2) of this subsection;

(J) an American Indian born in Canada or an American Indian who is a member of a federally recognized tribe, if the individual is not a United States citizen and is

not otherwise described in paragraph (1) or (2) of this subsection;
(K) a certain Afghan parolee described by federal law;
(L) a certain Ukrainian parolee described by federal law; or
(M) any other lawfully residing noncitizen not otherwise described in paragraph (1) or (2) of this subsection.

(4) **Unauthorized resident noncitizens.** An unauthorized resident noncitizen is not eligible for full SoonerCare benefits and may receive emergency Medicaid only, if otherwise eligible.

(d) **Continuing conformance with federal law.** ~~Notwithstanding any other provision of this section, any noncitizen population that federal law or authority, as amended from time to time, identifies as eligible for medical assistance under Title XIX is eligible for such benefits to the same extent, under the same conditions, and for the same period of time as indicated in the relevant federal law or official federal guidance documents, including any amendments to the law or guidance.~~Notwithstanding any other provision of this section, eligibility of noncitizens for full SoonerCare benefits, any applicable waiting period, and the availability of emergency Medicaid shall be determined in accordance with applicable federal law, as amended from time to time, and federal financial participation shall be claimed only to the extent permitted by federal law.

(e) **Emergency Medicaid.** ~~Emergency Medicaid in this section means medical assistance provided to a noncitizen under Title XIX for care and services that are necessary for the treatment of an emergency medical condition, as defined by section 1903(v)(3) of the Act and including labor and delivery but not related to organ transplant procedure, of the noncitizen involved if the noncitizen otherwise meets eligibility requirements for medical assistance under the state plan, including but not limited to residency requirements.~~ Emergency Medicaid means medical assistance provided to a noncitizen under Title XIX for care and services necessary for the treatment of an emergency medical condition, as defined by Section 1903(v)(3) of the Social Security Act, including labor and delivery but not related to an organ transplant procedure, if the noncitizen otherwise meets eligibility requirements under the state plan, including but not limited to residency requirements.

OPERATIONAL METRICS

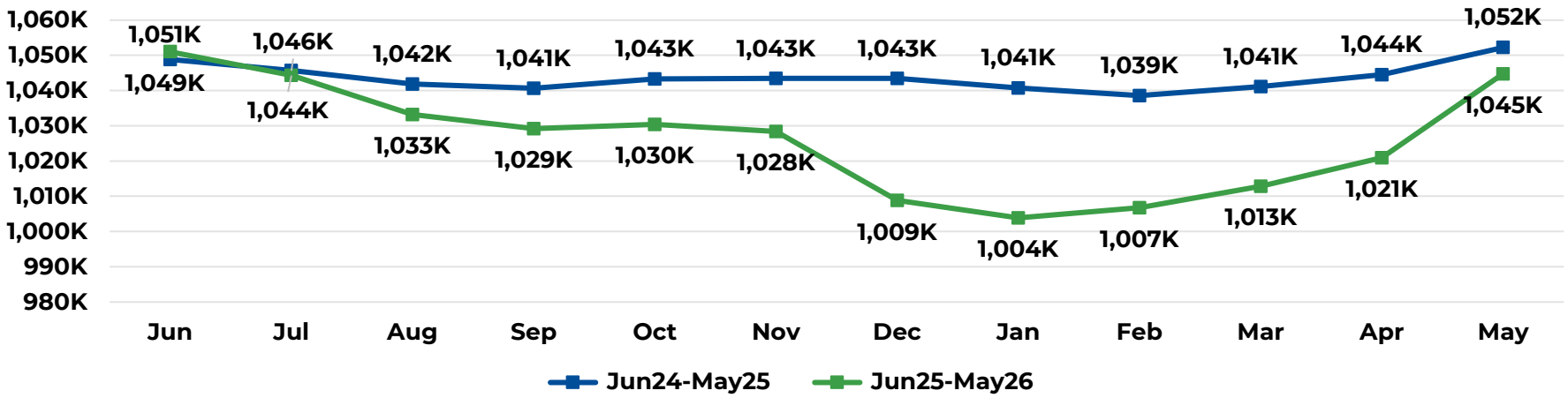
June 2026

OKLAHOMA HEALTH CARE AUTHORITY

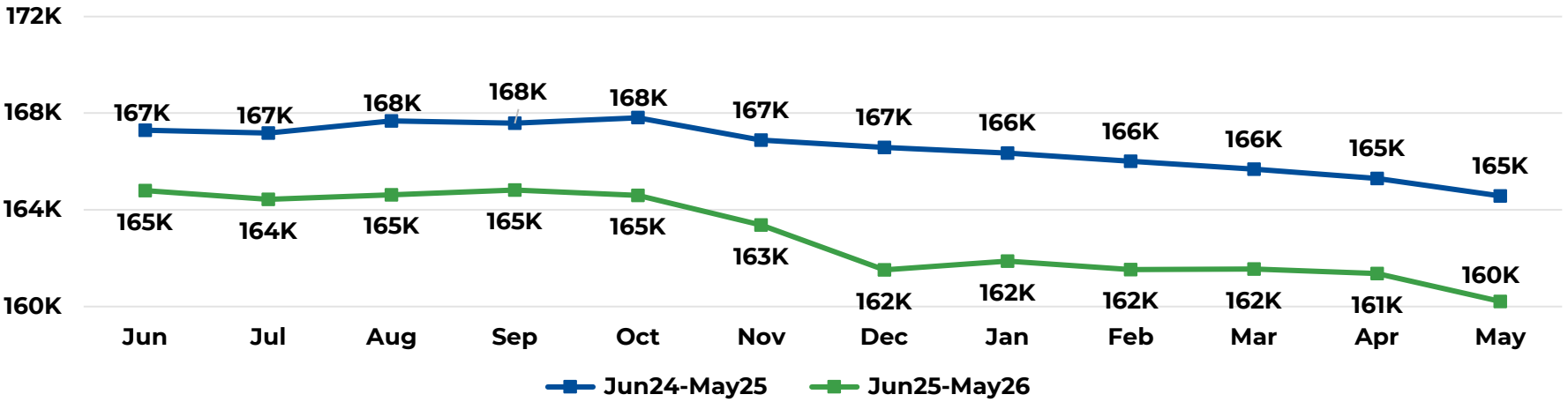
4345 N. LINCOLN BLVD. | OKHCA.ORG |

Enrollment & Utilization

Total Enrolled Members

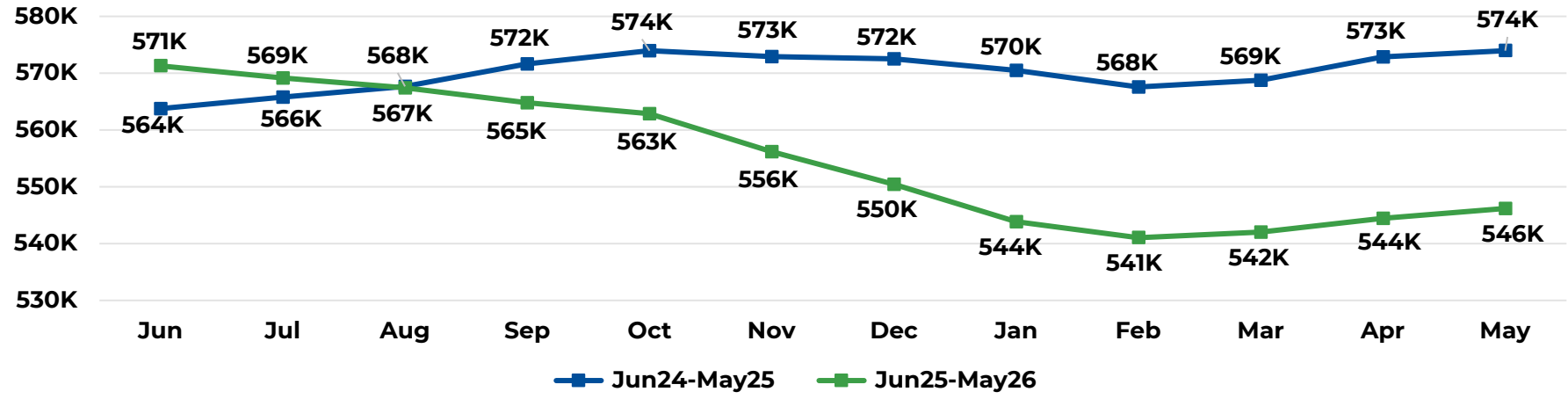


Aged/Blind/Disabled Enrolled Members

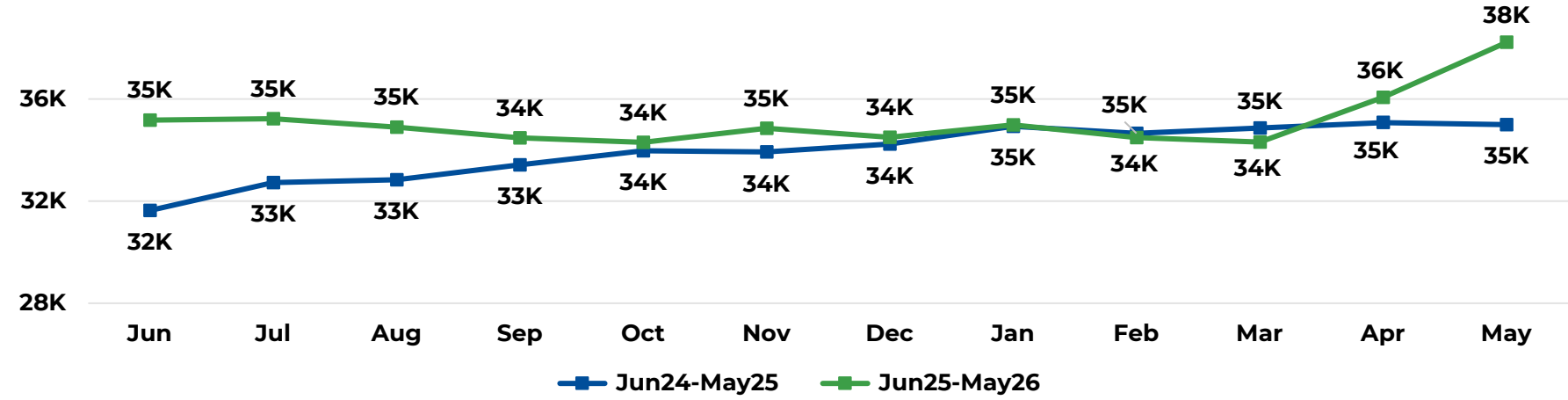


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Enrolled Members

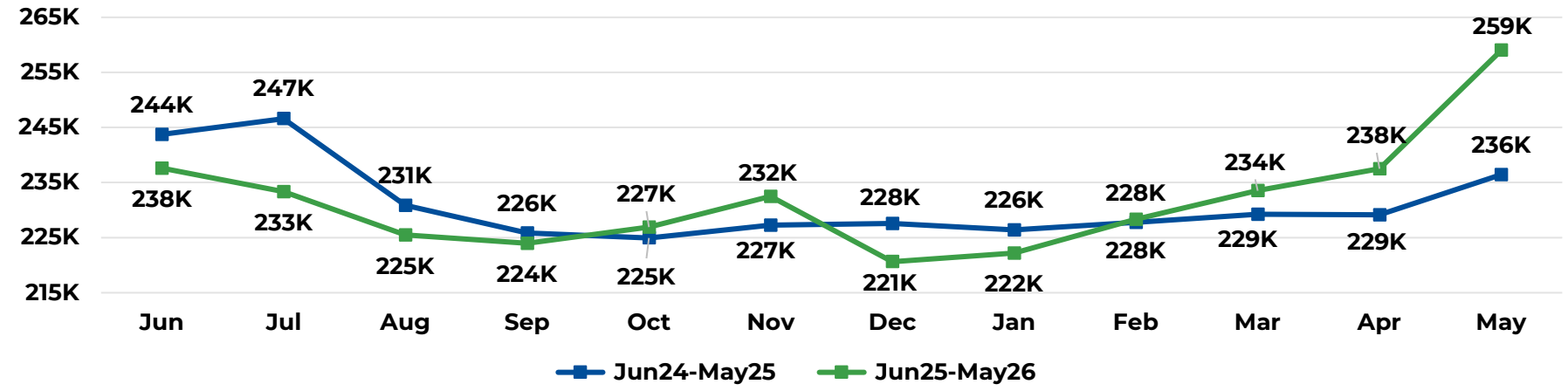


Pregnant (Full Scope) Enrolled Members

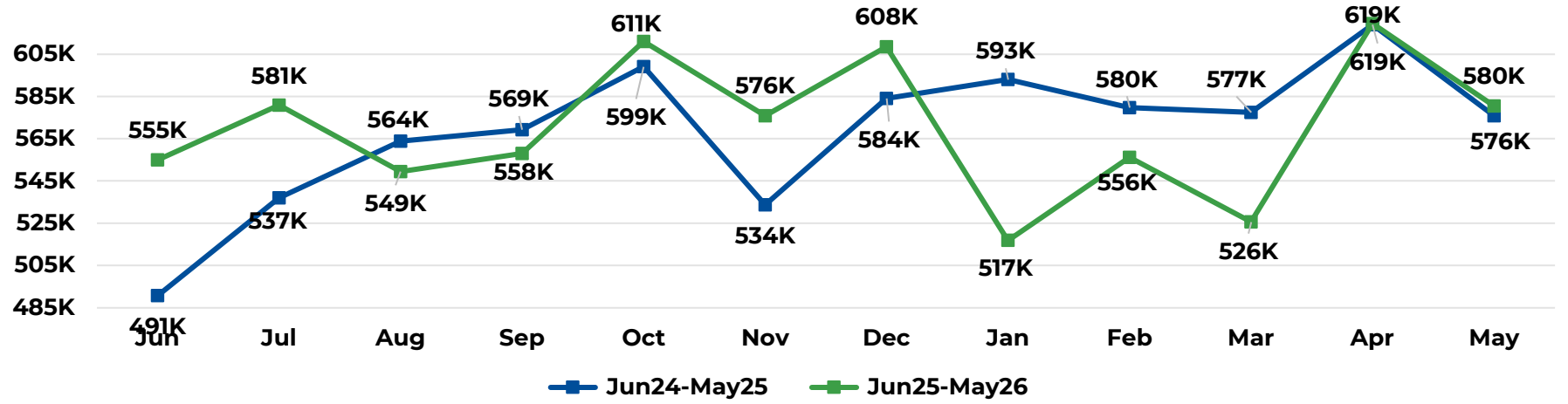


Enrollment & Utilization (Cont.)

Expansion Enrolled Members

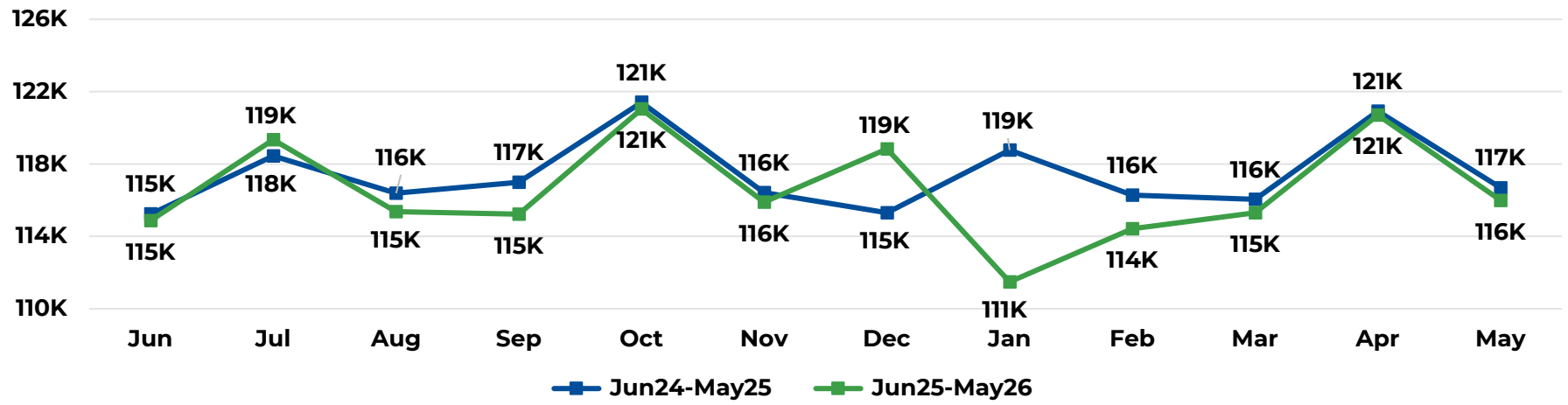


Total Members Served

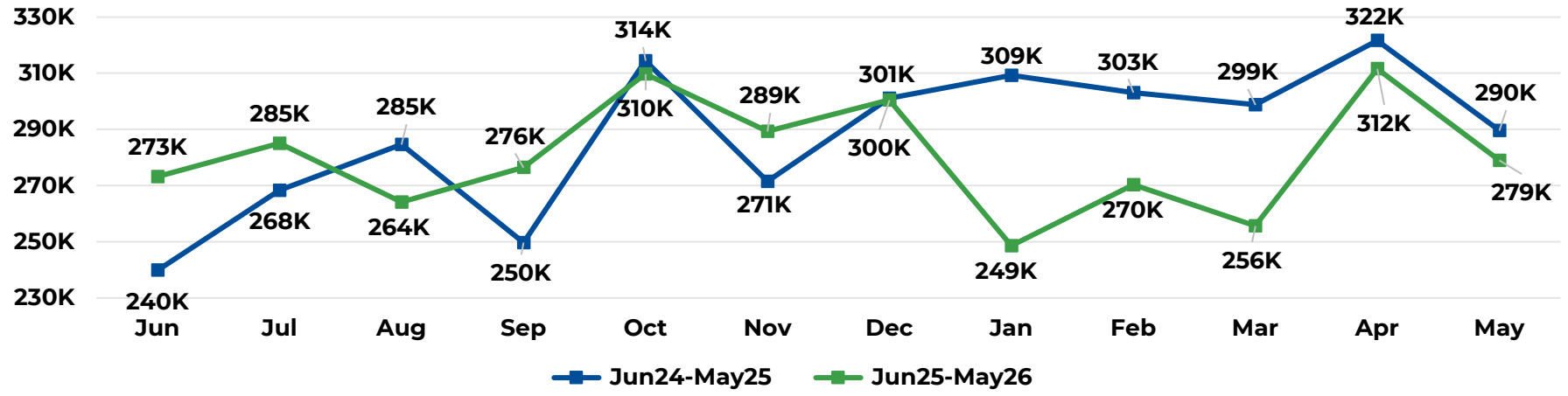


Enrollment & Utilization (Cont.)

Aged/Blind/Disabled Members Served

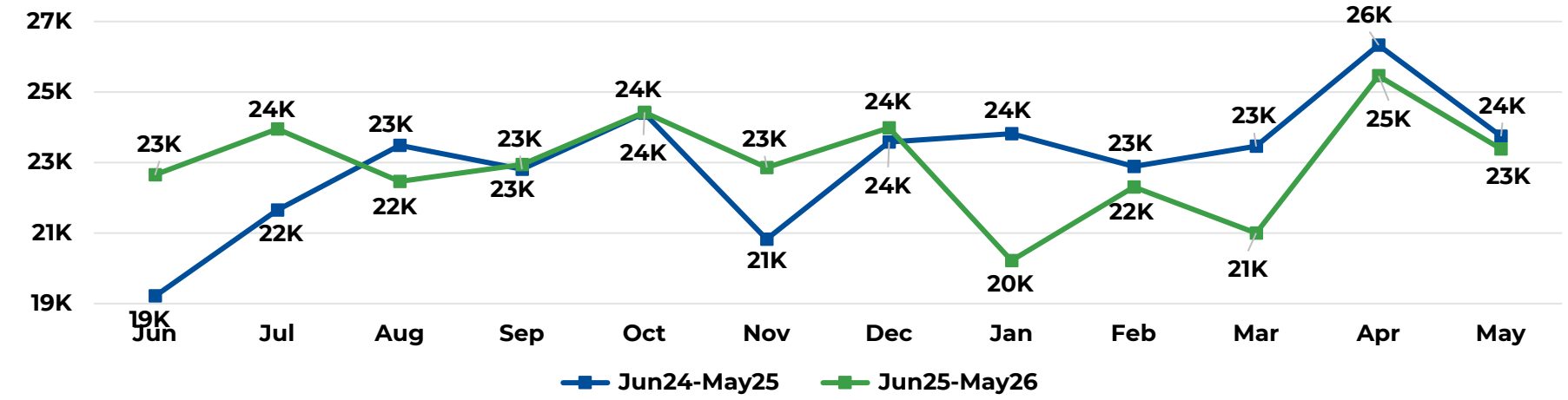


Children & Parent/Caretaker Members Served

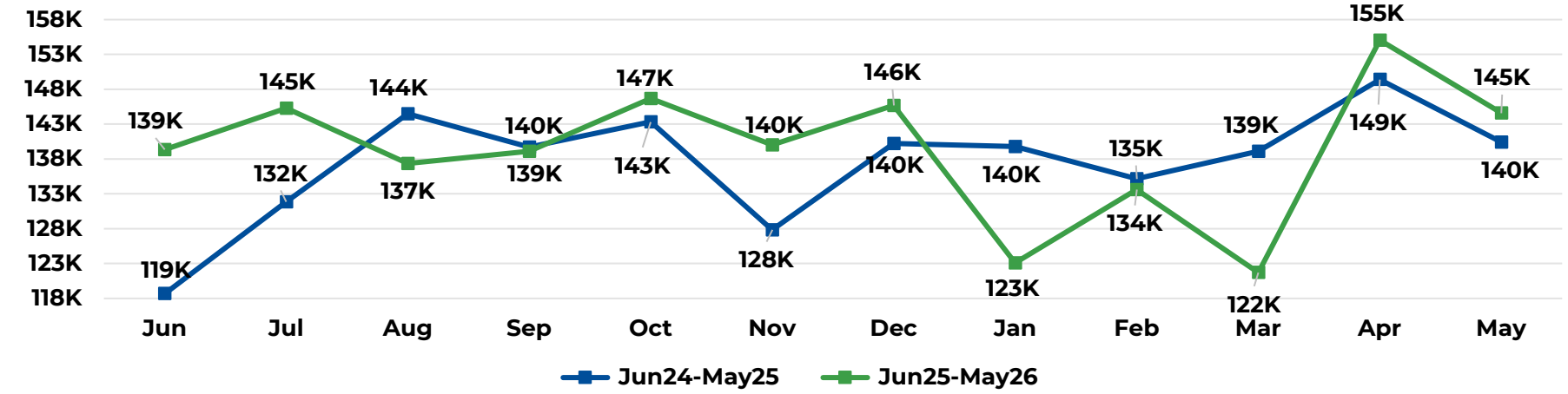


Enrollment & Utilization (Cont.)

Pregnant (Full Scope) Members Served

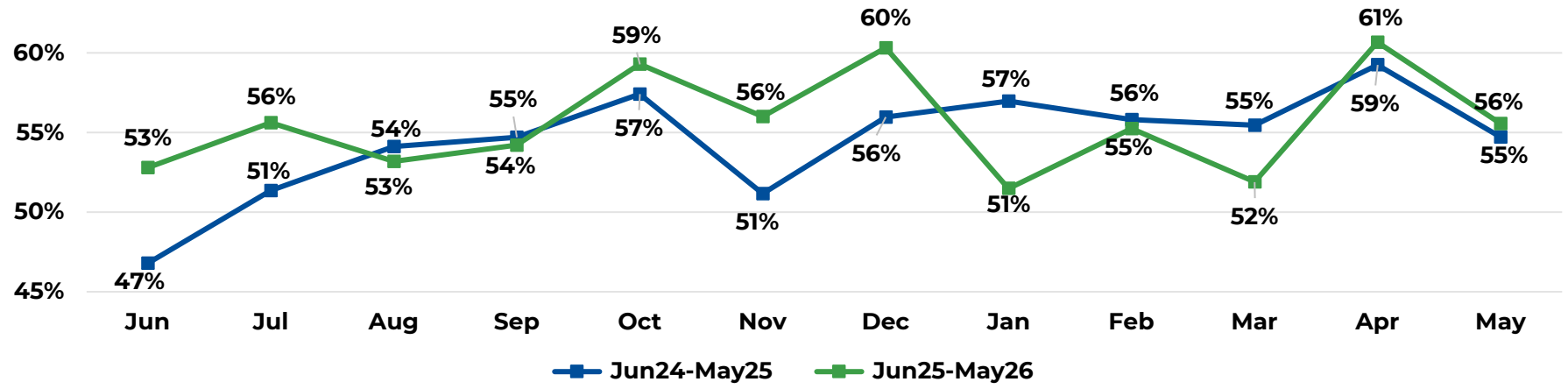


Expansion Members Served

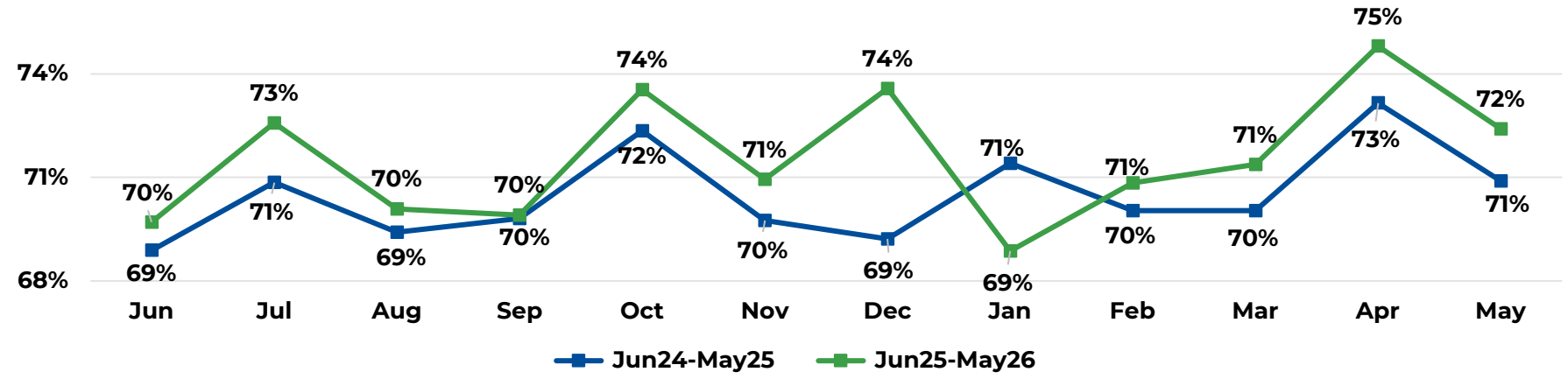


Enrollment & Utilization (Cont.)

Percent of Total Enrolled Members Served

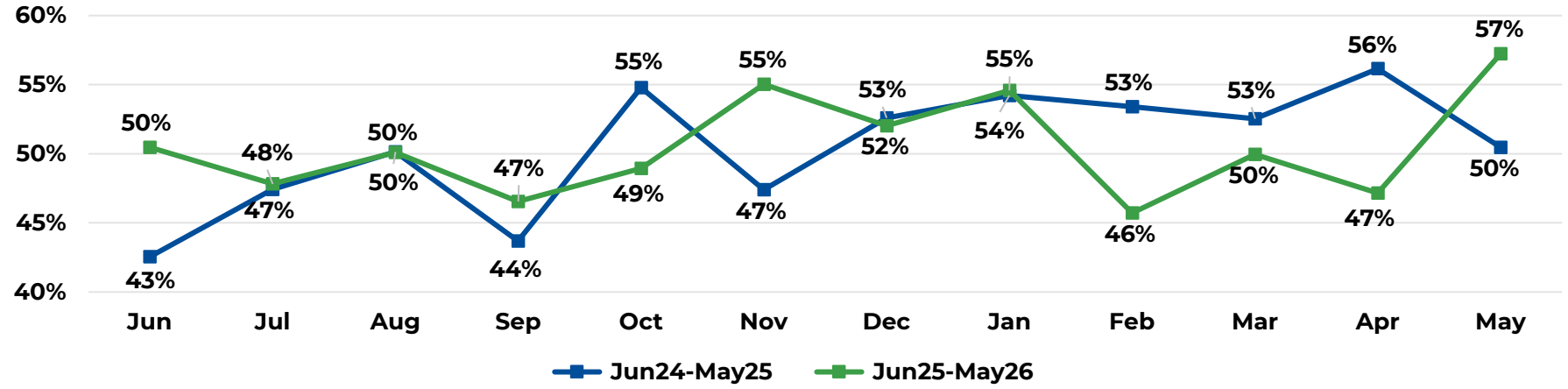


Percent of Aged/Blind/Disabled Enrolled Members Served

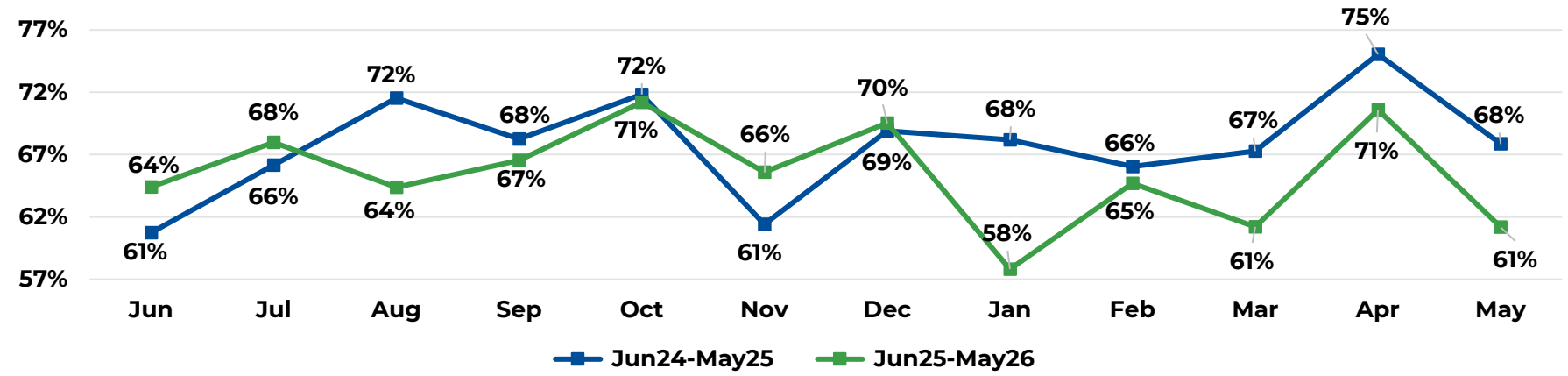


Enrollment & Utilization (Cont.)

Percent of Children & Parent/Caretaker Enrolled Members Served

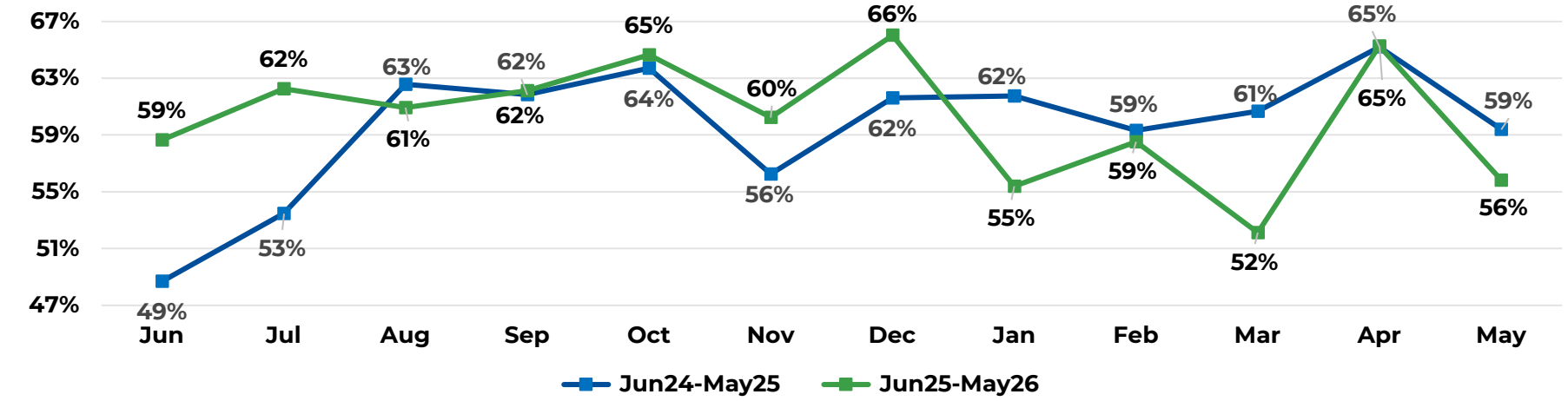


Percent of Pregnant (Full Scope) Enrolled Members Served



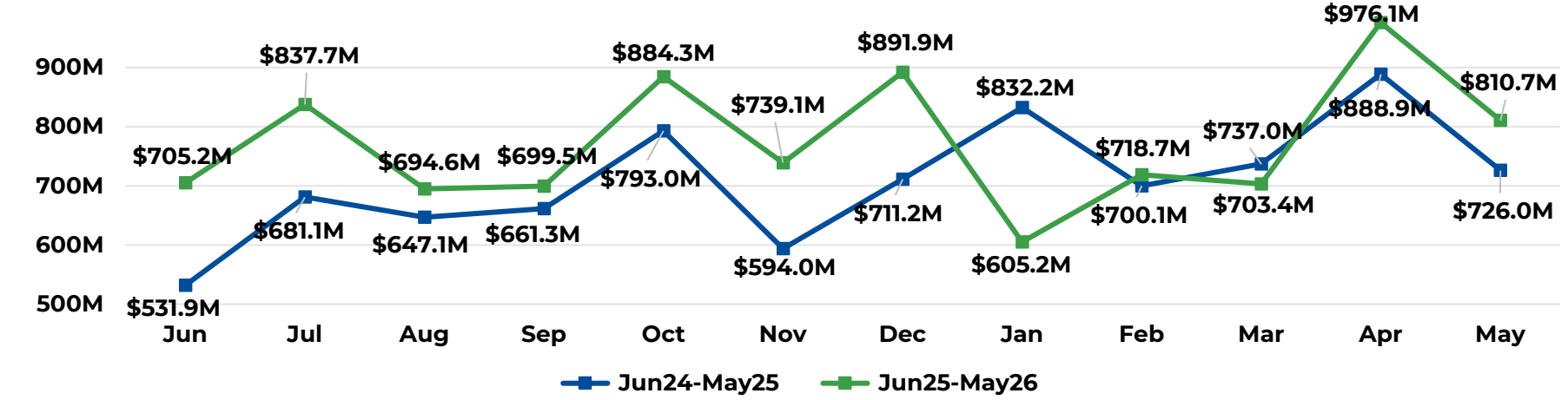
Enrollment & Utilization (Cont.)

Percent of Expansion Enrolled Members Served



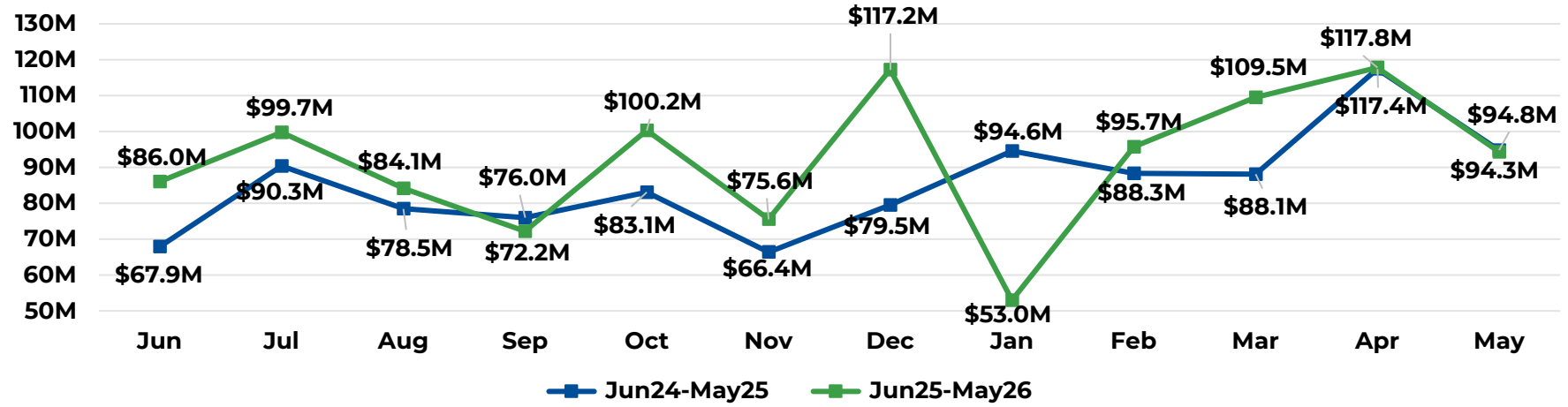
Financials

Total Agency Expenditures

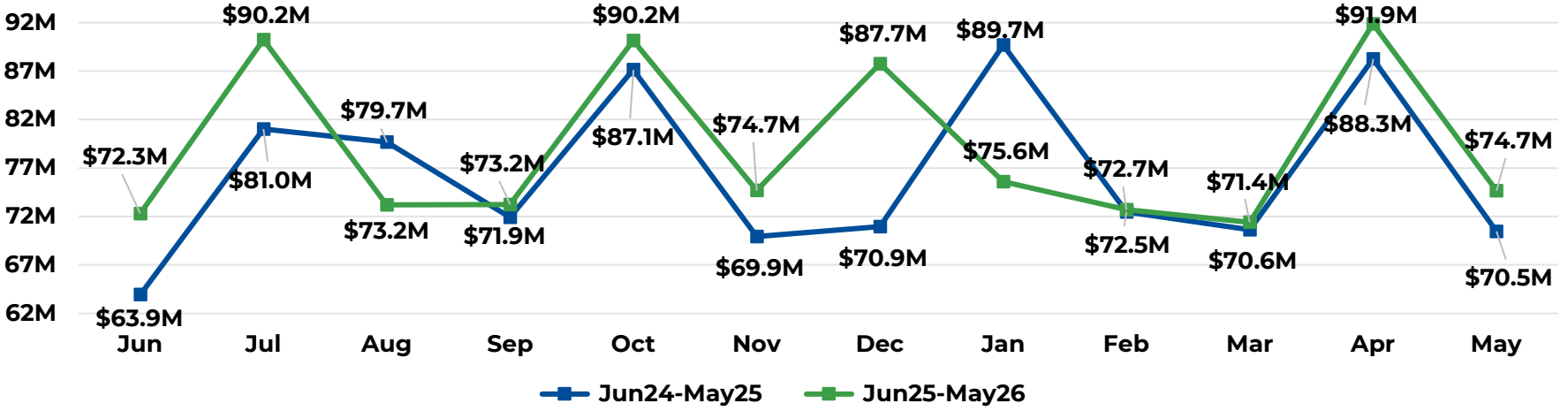


Financials (Cont.)

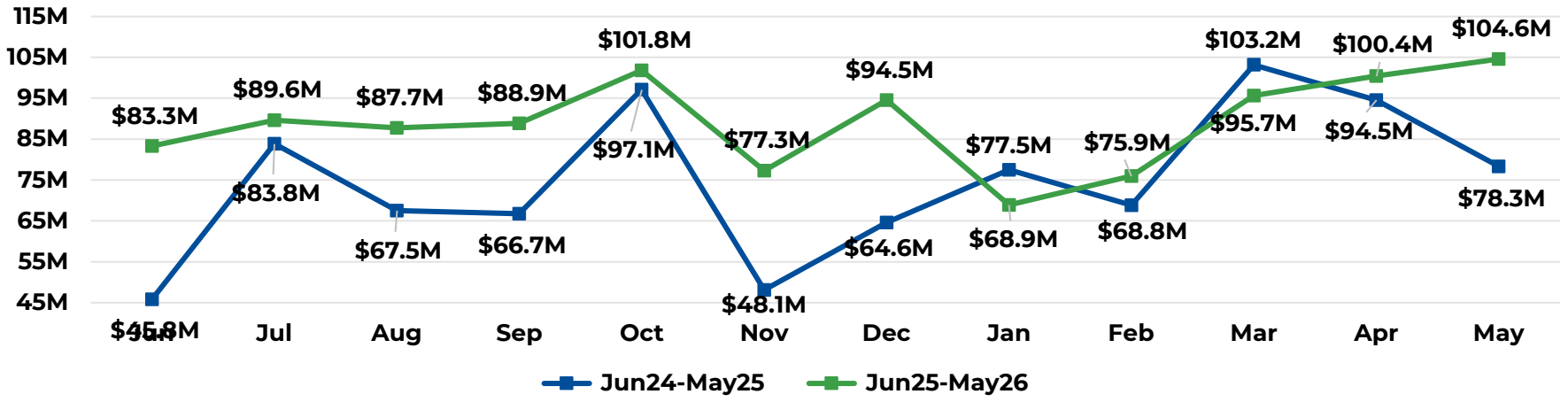
Inpatient Services - Expenditures



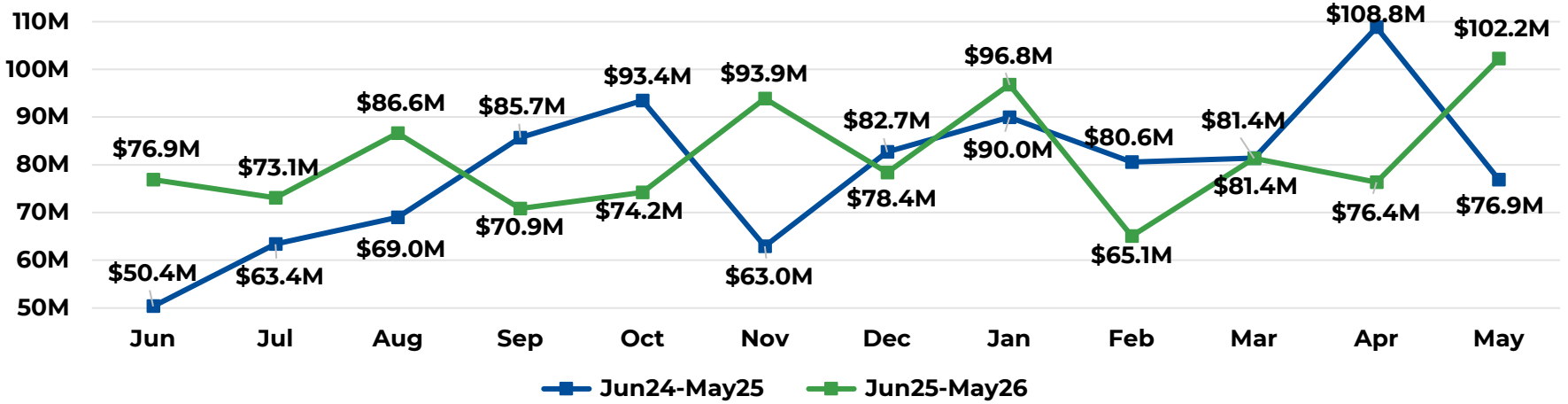
Nursing Facility Services - Expenditures



Outpatient Hospital Services - Expenditures

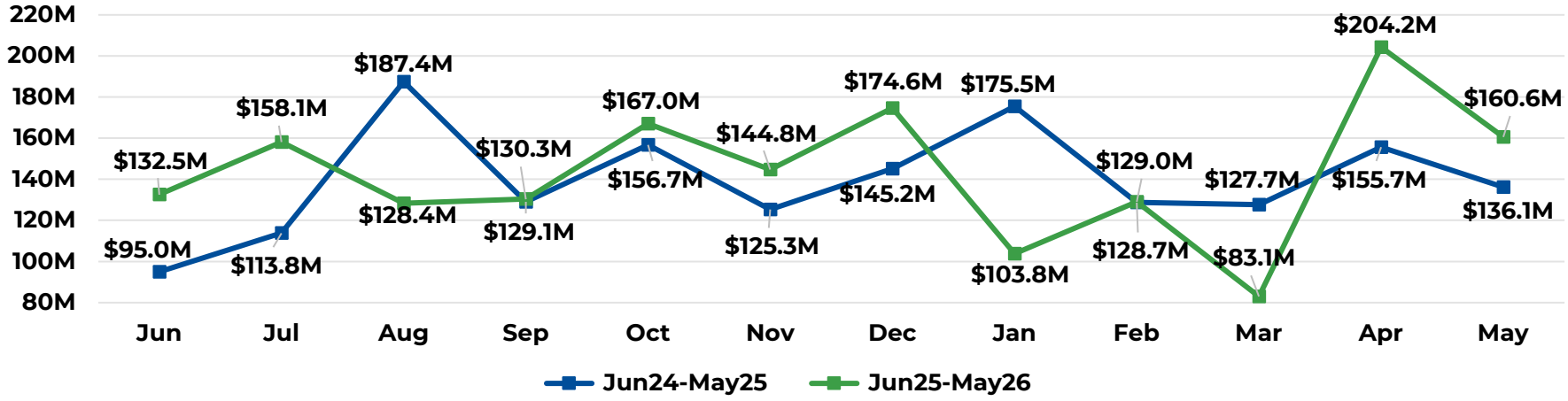


Physician Services - Expenditures

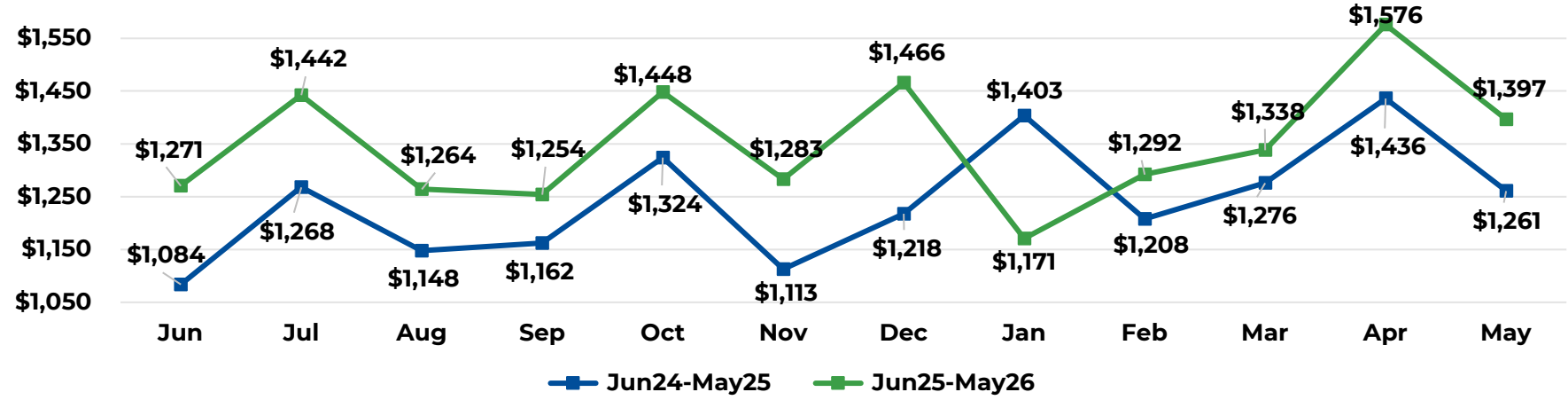


Financials (Cont.)

Prescribed Drugs - Expenditures

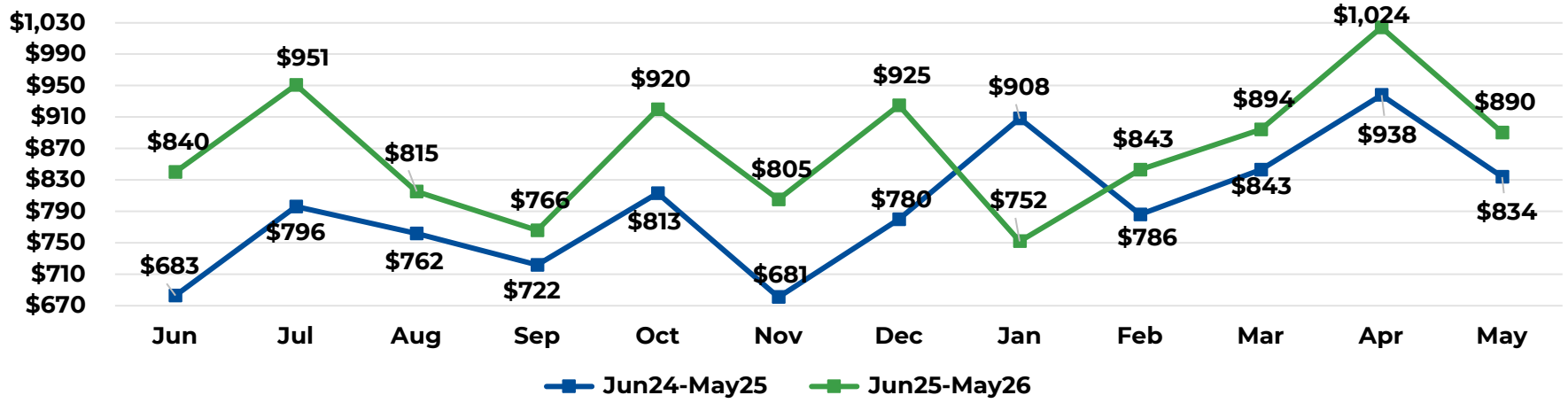


Average Expenditure Per Total Members Served

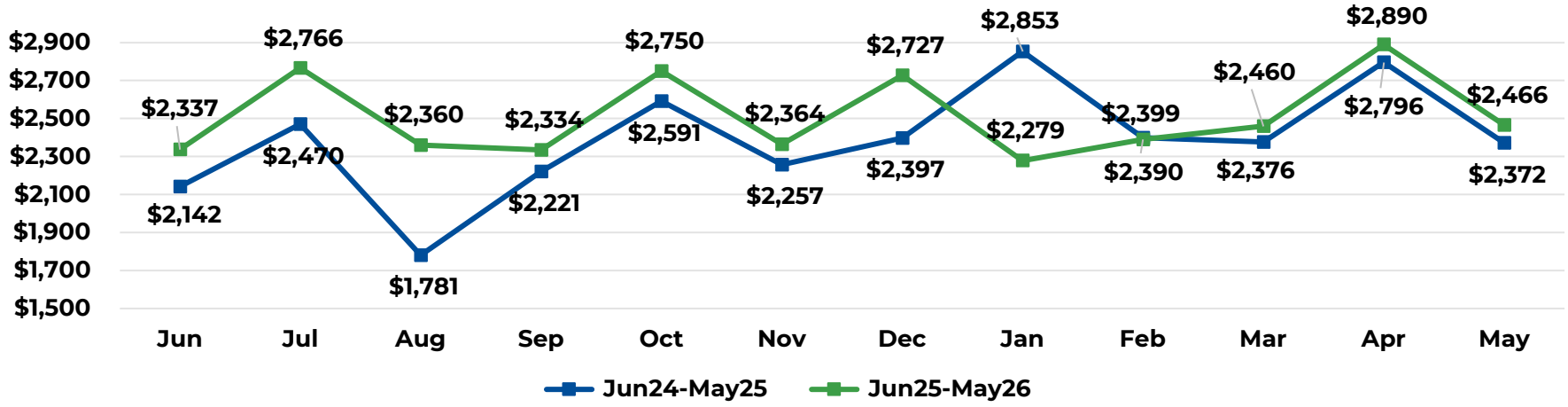


Financials (Cont.)

Average Expenditure Per Child (Under 21) Member Served

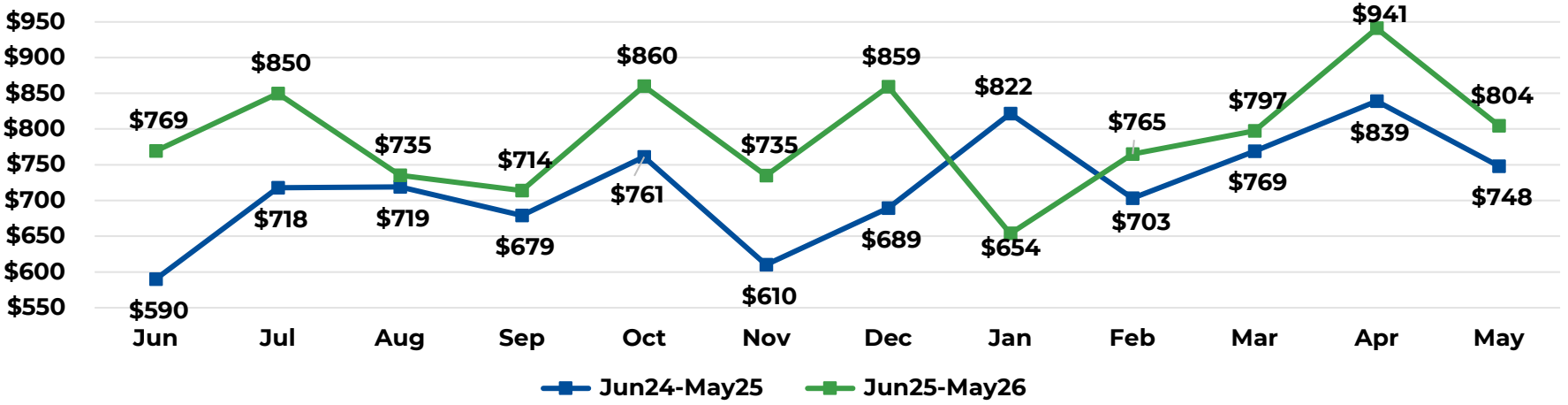


Average Expenditure Per Aged/Blind/Disabled Member Served

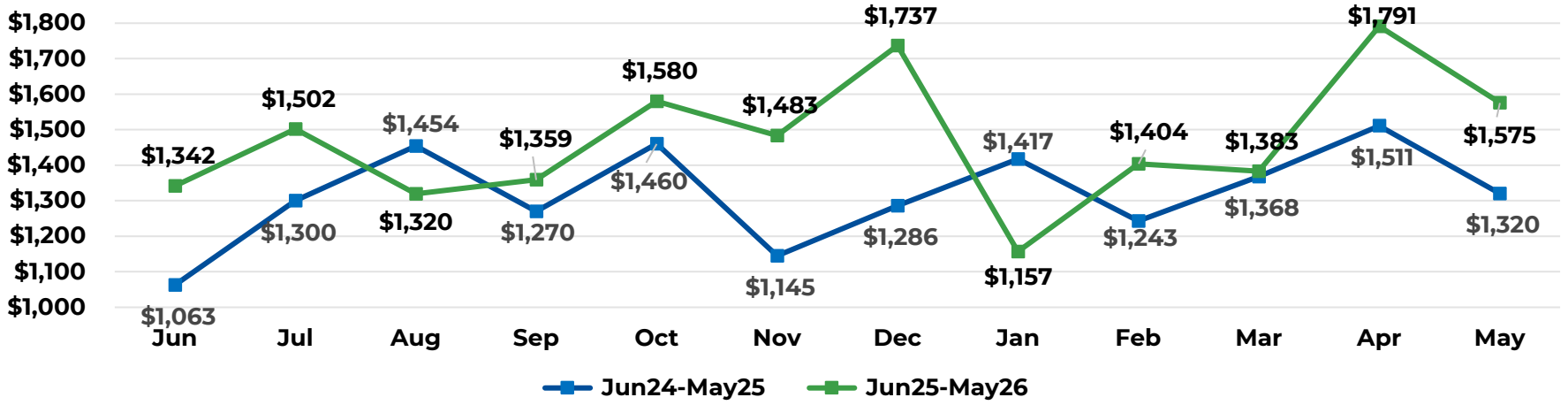


Financials (Cont.)

Average Expenditure Per Children & Parent/Caretaker Member Served

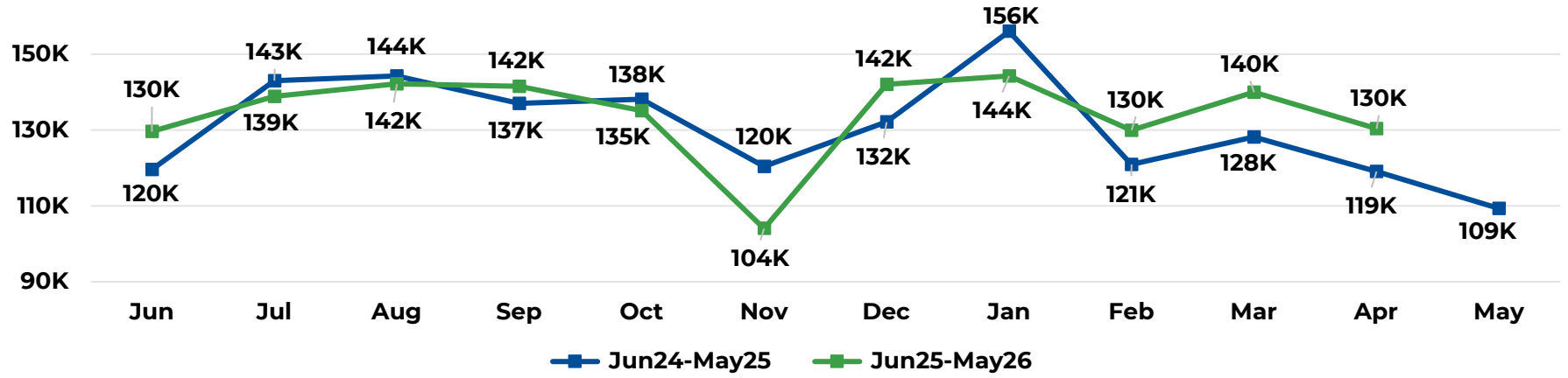


Average Expenditure Per Expansion Member Served

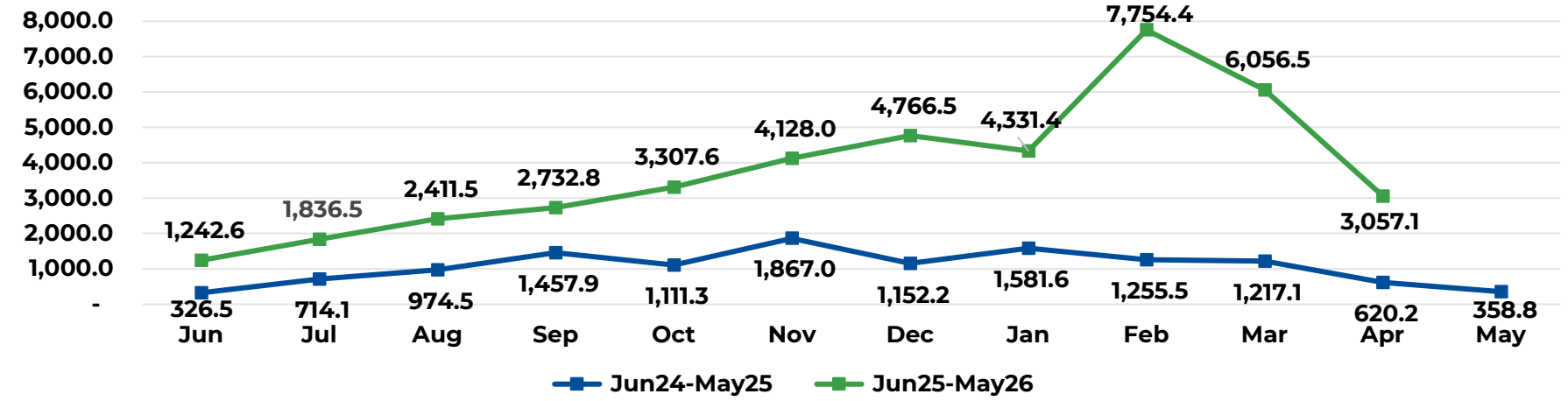


Call Center

Call Center - Member Calls Answered

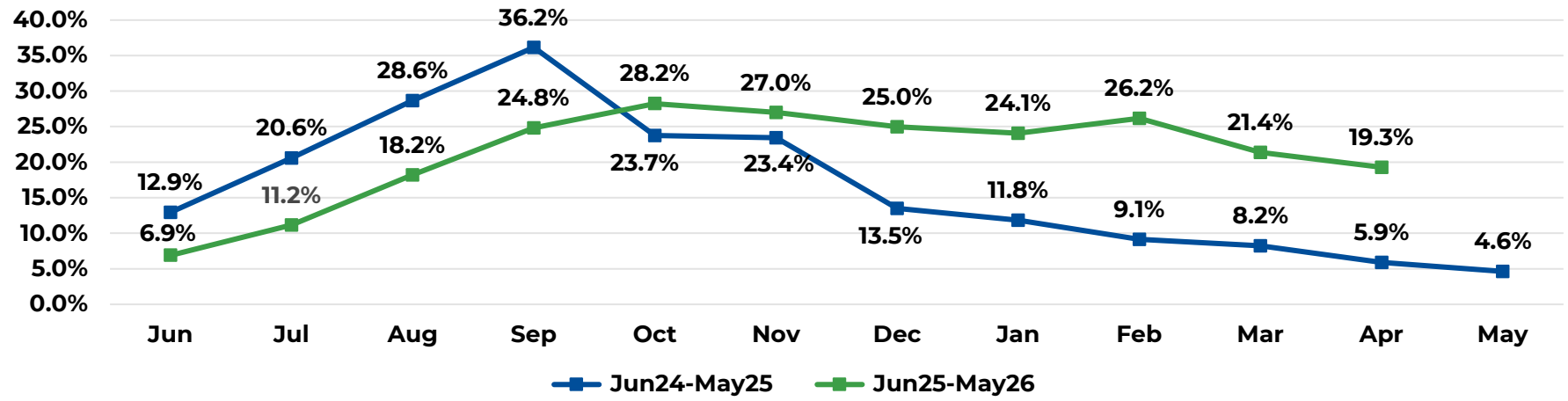


Call Center - Average Wait Time (In Seconds)



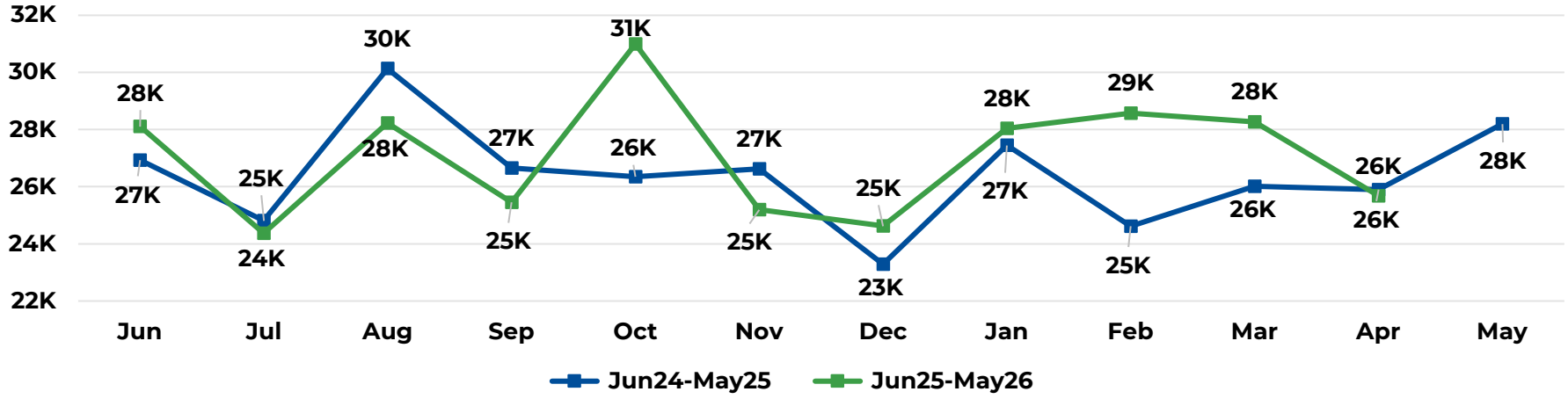
Call Center (Cont.)

Call Center - Abandoned Call Rate



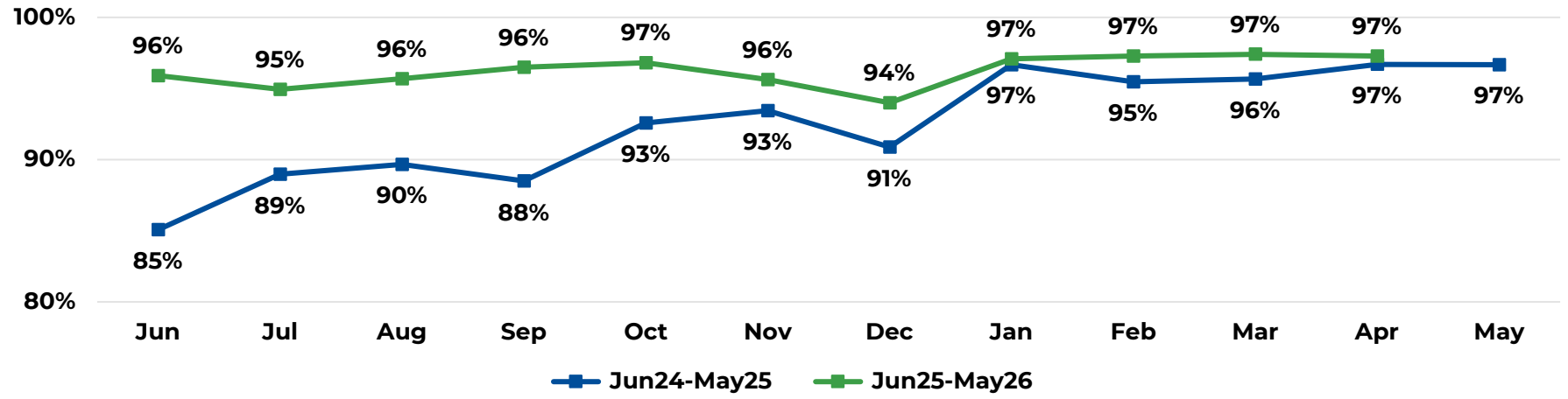
Prior Authorization (Fee-For-Service)

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



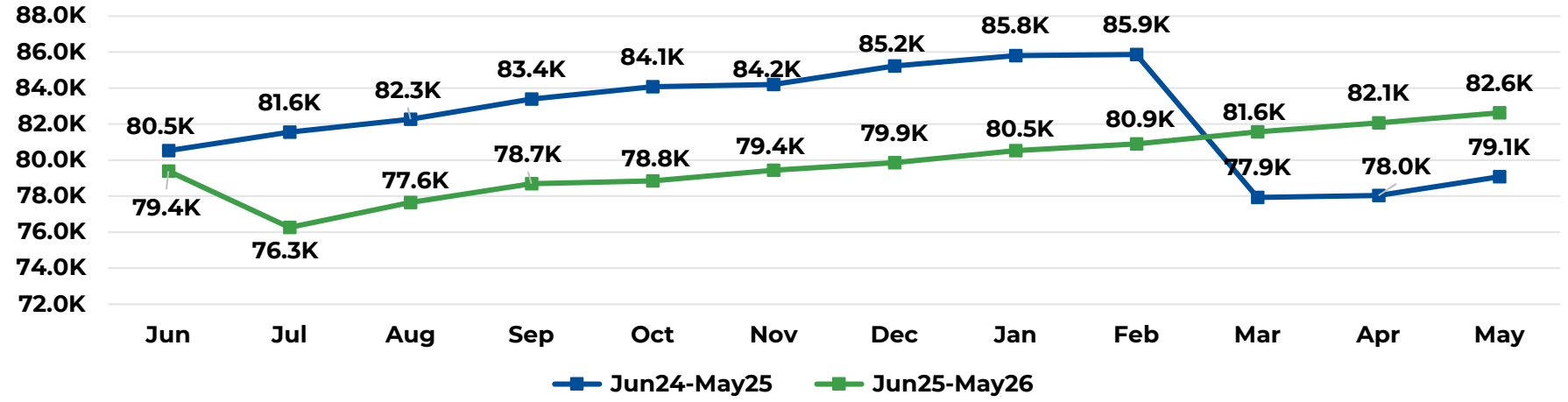
Prior Authorization (Fee-For-Service) (Cont.)

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

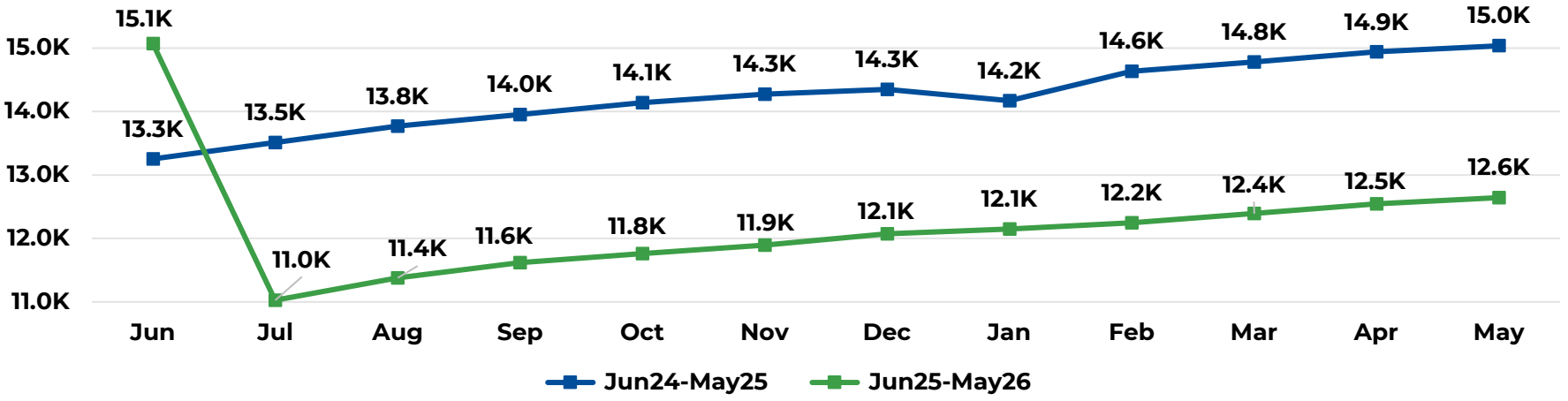


Provider Network

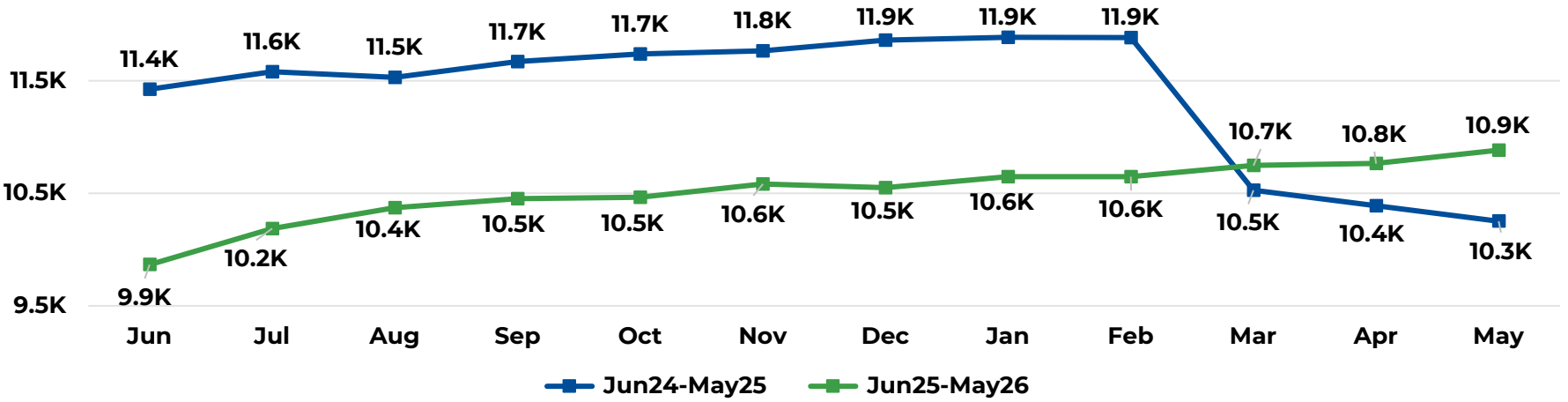
Total Providers Enrolled



Mental Health Providers Enrolled (In-State Only)

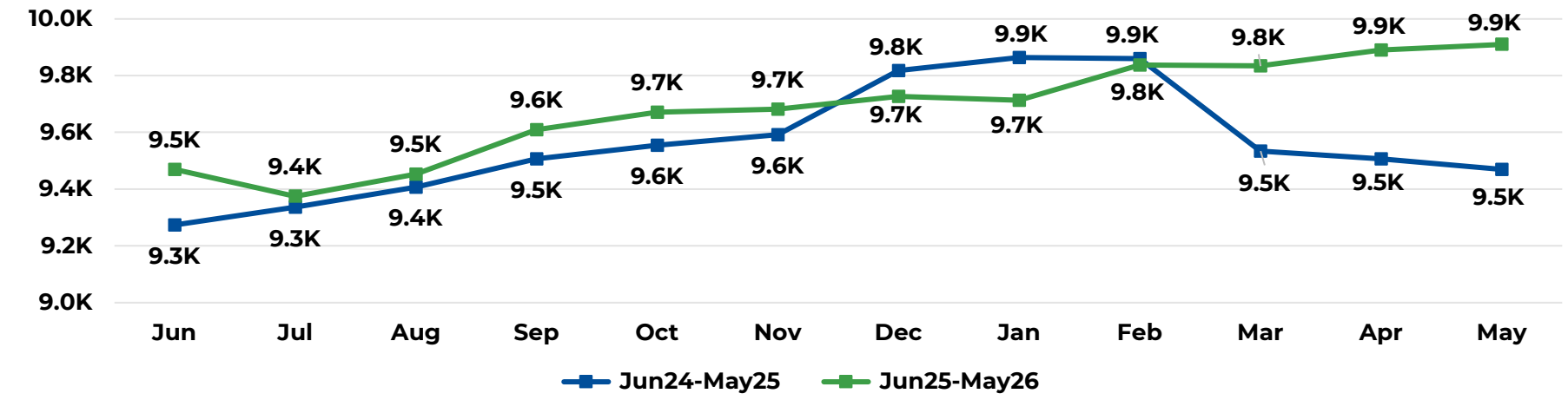


Physicians Enrolled (In-State Only)

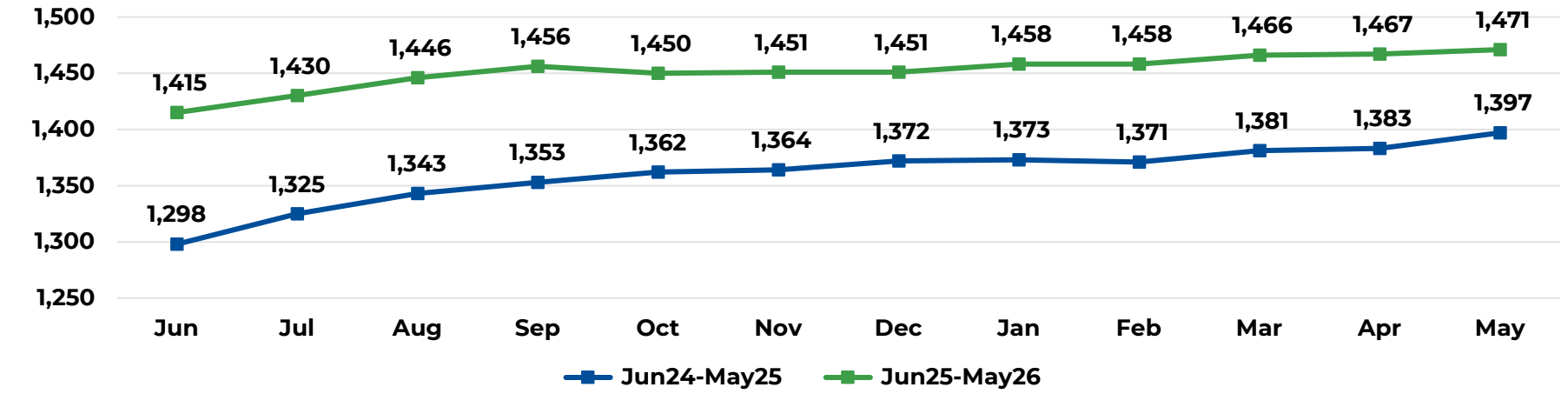


Provider Network (Cont.)

Primary Care Providers Enrolled (In-State Only)

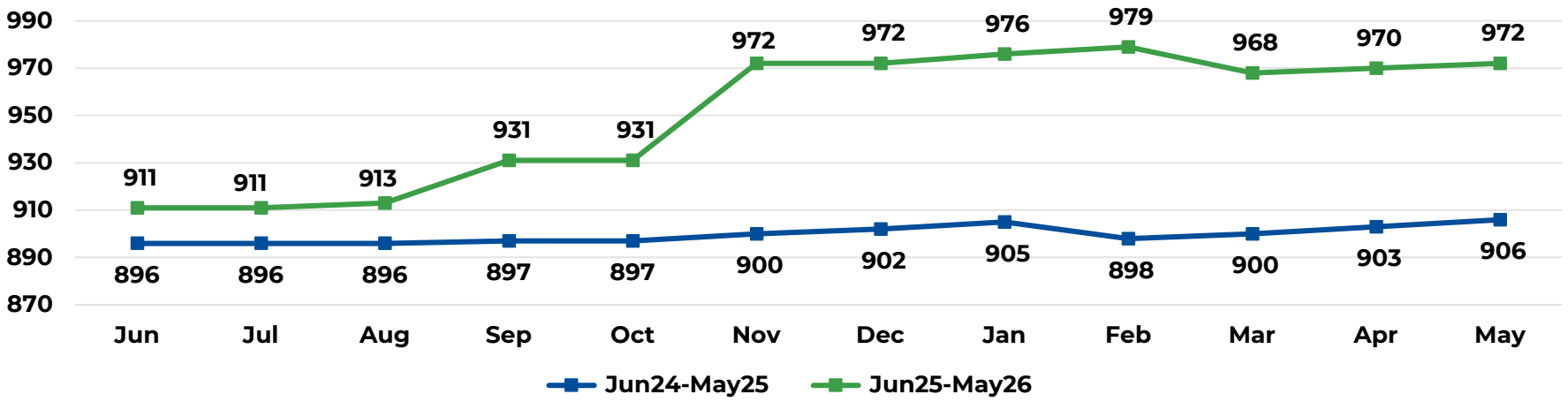


Dentists Enrolled (In-State Only)

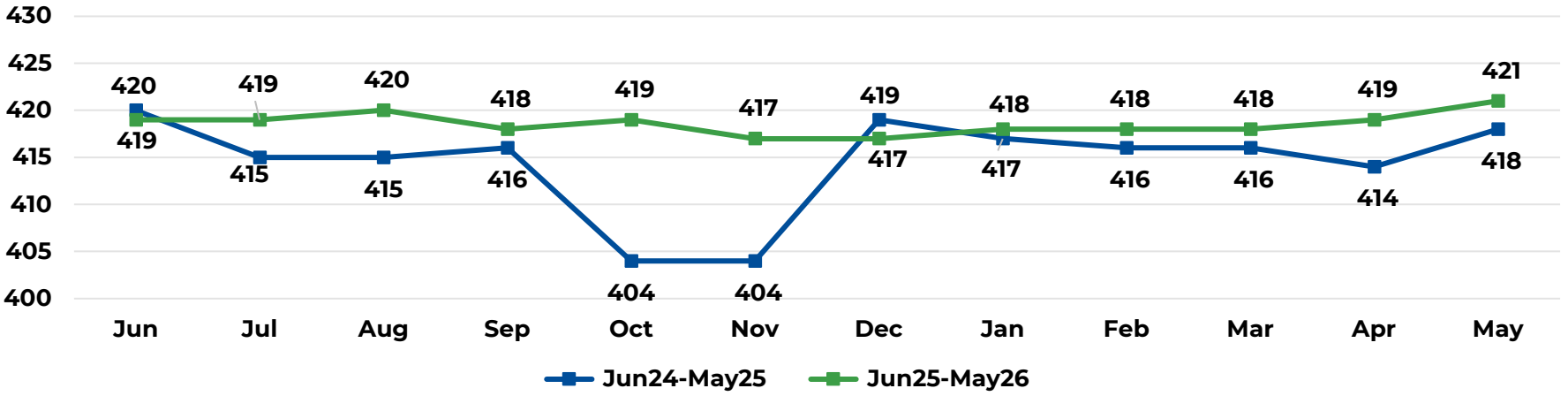


Provider Network (Cont.)

Pharmacy Enrolled (In-State Only)

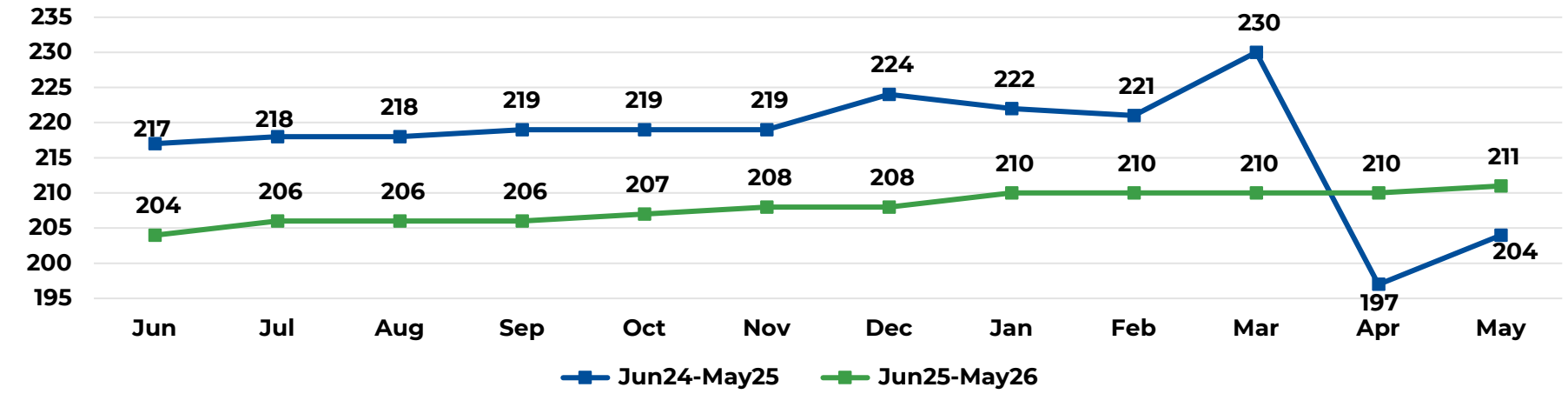


Extended Care Facilities Enrolled (In-State Only)



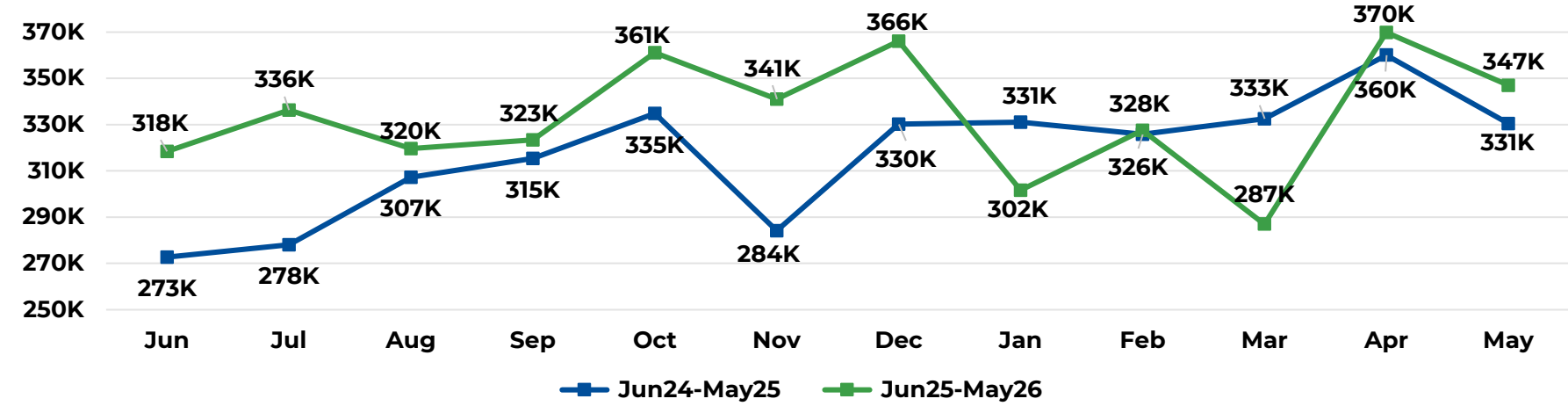
Provider Network (Cont.)

Hospitals Enrolled (In-State Only)



MCE Utilization

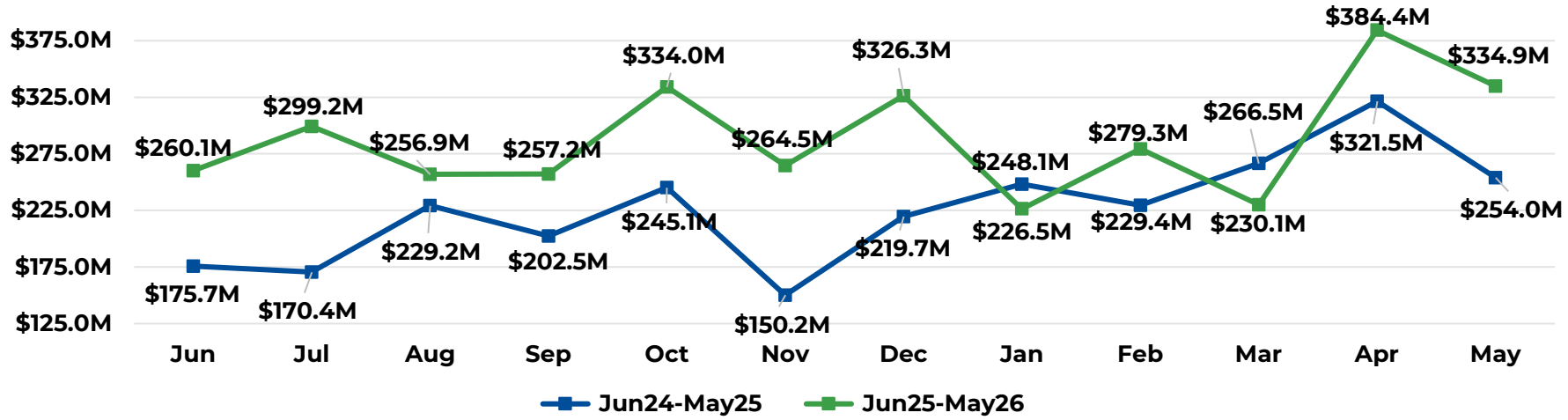
Total MCE Members Served - Medical & Dental (All MCEs)



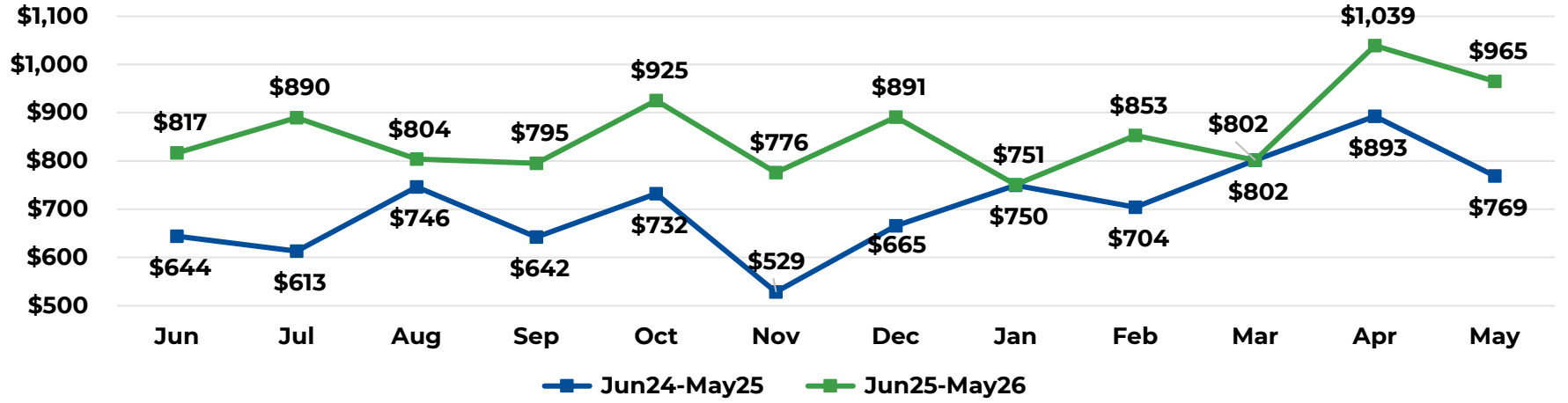
For MCE members served, expenditures and average per member, the data through June 2024 is MCE comparable group which is non ABD members eligible for MCE (Expansion, Parent/Caretaker, Non ABD Children, Full Scope Pregnant, etc.). Excludes tribal members since had low MCE opt-in. Data starting July 2024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

MCE Utilization (Cont.)

Total MCE Expenditures - Medical & Dental (All MCEs)

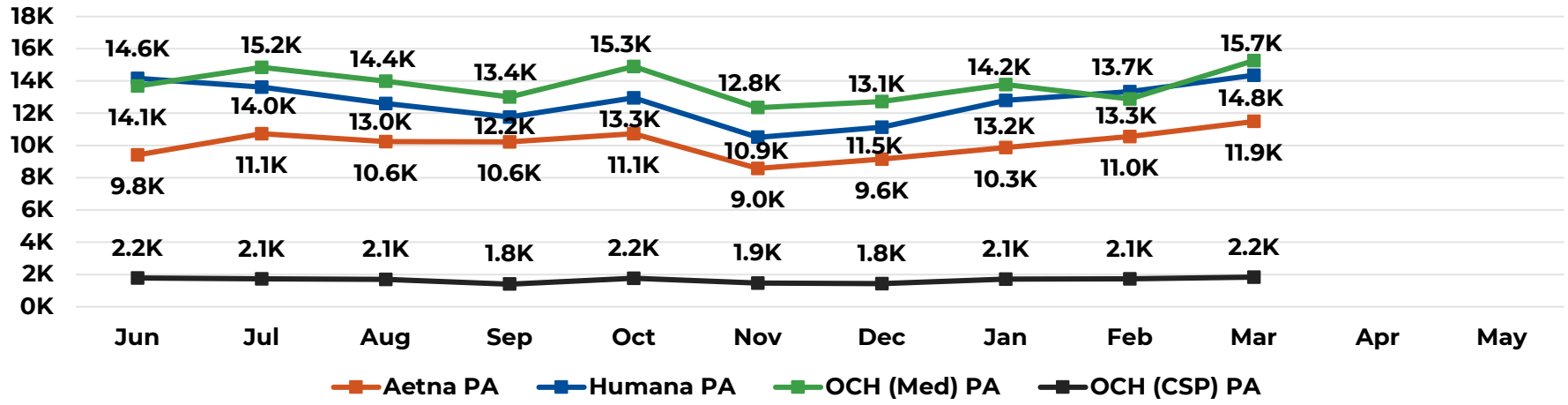


Average Expenditure Per Total MCE Members Served - Medical & Dental (All MCEs)

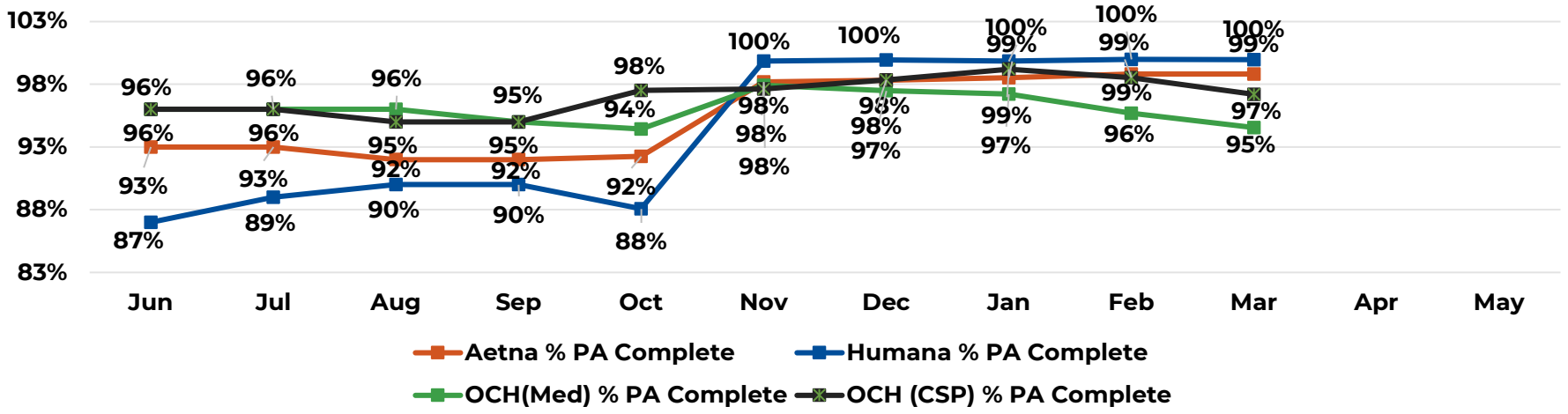


MCE Utilization (Cont.)

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

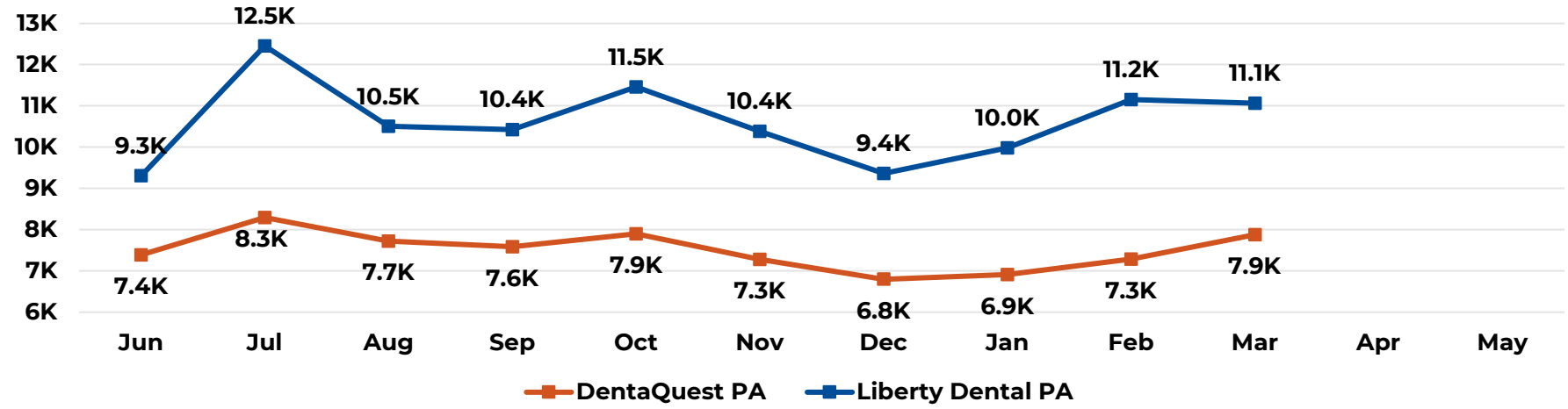


MCE Expedited & Standard Prior Authorization (Medical) - % Completed Within Contractually Allotted Base Time

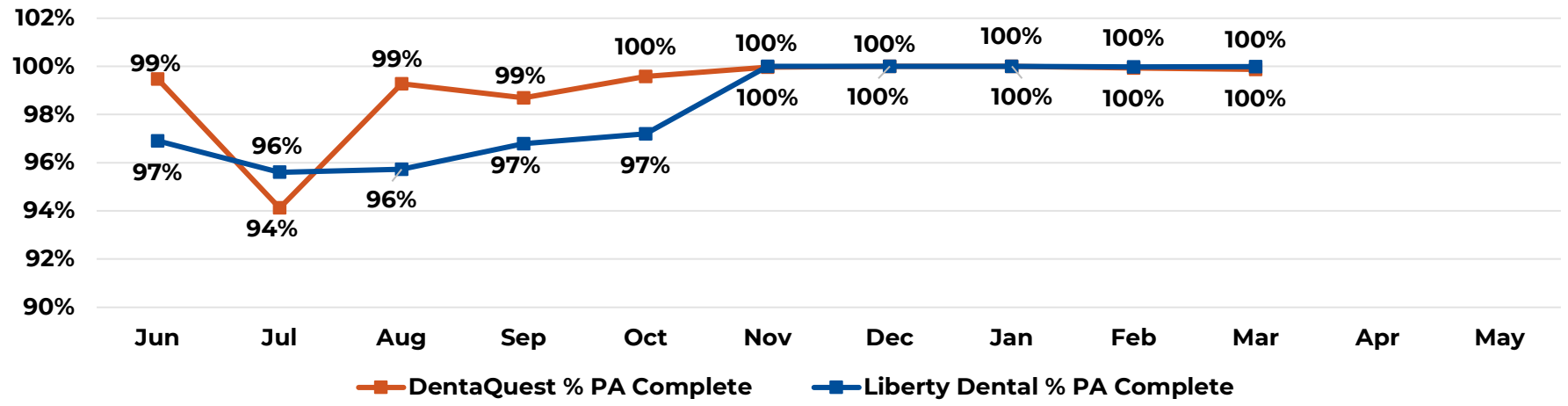


MCE Utilization (Cont.)

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

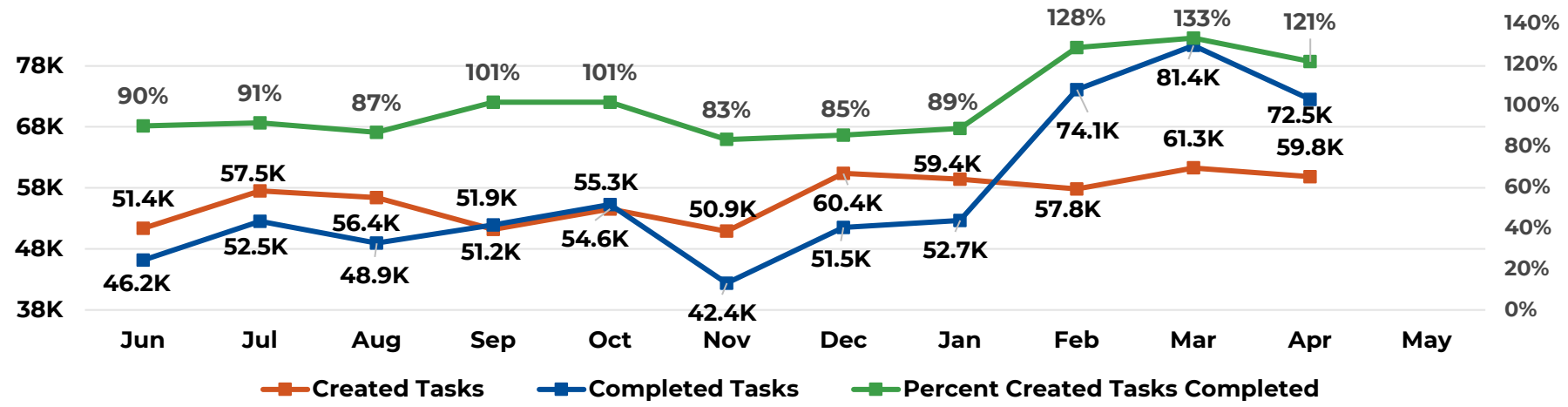


MCE Expedited & Standard Prior Authorization (Dental) - Percent Processed Within Contractually Allotted Base Time



Workflow - Productivity

Created & Completed Tasks



Operational Metrics Query Notes:

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

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

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

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

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

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

Opioid data is from the Opioid dashboard MME Calculations files.

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

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

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

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

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

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

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