



OKLAHOMA
Health Care Authority

Oklahoma Health Care Authority

Strategic Plan FY 2027-31

October 1, 2026

Submitted by: Aaron Morris, Interim Chief Executive Officer

Agency Introduction

The Oklahoma Health Care Authority (OHCA), founded in 1993, administers the state's Medicaid program, the Employees Group Insurance Division (EGID), the state health information exchange (HIE) and Insure Oklahoma.

SoonerCare, Oklahoma's Medicaid program, is a federal and state health coverage program that provides medical benefits to uninsured or underinsured low-income individuals. Medicaid guarantees coverage for basic health and long-term care services based on specific eligibility guidelines. Eligibility categories include the aged, blind and disabled (ABD); families qualifying under federal Temporary Assistance to Needy Families (TANF) guidelines; qualified Medicare beneficiaries, including adults who qualify as a part of Medicaid expansion; Tax Equity and Fiscal Responsibility Act (TEFRA) children; women with breast and cervical cancer; and certain children and pregnant women. Medicaid programs are funded with a combination of federal and state dollars.

In early 2024, children, including foster children; low-income parents; pregnant women; and nondisabled adults (19-64) transitioned to a new Medicaid delivery model. **SoonerSelect**, the state's managed care program, empowers eligible members to select health and dental plans offered by contracted entities. American Indian/Alaskan Native members can opt in to SoonerSelect. The Children's Specialty Program serves children involved in the juvenile justice system, children in foster care and children receiving adoption assistance.

On July 1, 2024, **EGID** transitioned to OHCA. EGID provides group health, dental, life and disability insurance for employees of state agencies, school districts and other governmental units of the state of Oklahoma.



Agency Vision, Mission and Values

Vision: Our vision is for Oklahomans to be healthy and to have access to quality healthcare services regardless of their ability to pay.

Mission: Our mission is to responsibly purchase state- and federally-funded healthcare in the most efficient and comprehensive manner possible; to analyze and recommend strategies for optimizing the accessibility and quality of healthcare; and to cultivate relationships to improve the health outcomes of Oklahomans.

Key Principles: Passion for Purpose | Empowerment and Accountability | Transparency | Best in Class and Solution-Oriented | Servant Leadership



Section I: Agency Environment



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- Groups served by the agency
 - Expected changes in service
 - Challenges
 - Expenditures, Budget & FTE
 - Total
 - Federal
 - Appropriations

Groups of People Served by the Agency

	Group Served	Services Received	Estimated Changes in Group Served (within next 5 years)
1	Children and adults who qualify for the Temporary Assistance for Needy Families program	Full Medicaid benefits	591,091 enrolled as of August 2026. In SFY2026, 676,613 unique members were served. Enrollment is expected to be flat. This group transitioned from a fee-for-service delivery system to a capitated, risk-based delivery system (SoonerSelect) on April 1, 2024, for medical care and Feb. 1, 2024, for dental. Tribal members can join SoonerSelect (opt-in) but are not required to.
2	Aged, blind and disabled (ABD) population, including long-term care, HCBS waiver groups and TEFRA	Full Medicaid benefits	159,351 enrolled as of August 2026. In SFY2026, 168,706 unique members were served. Enrollment is expected to be flat. This population is statutorily excluded from SoonerSelect.
3	Medicaid expansion adult population, adults ages 19-64 whose income is at or below 133% (138% with 5% disregard) FPL	Full Medicaid benefits	253,031 members enrolled as of August 2026. In SFY2026, 321,409 unique members served. Enrollment is expected to decrease due to implementation of work requirements. This group transitioned from a fee-for-service delivery system to a capitated, risk-based delivery system (SoonerSelect) on April 1, 2024, for medical care and Feb. 1, 2024, for dental. Tribal members can join SoonerSelect (opt-in) but are not required to. New federal H.R. 1 eligibility requirements, including retroactive coverage, more frequent redeterminations, and work requirements, are expected to impact enrollment.
4	Insure Oklahoma premium assistance program participants (employer-sponsored insurance serves individuals up to and including 227% of FPL)	Premium assistance to access employer-sponsored insurance	3,651 members enrolled as of August 2026. OHCA assists with premiums, paid to approved private insurance companies. Enrollment is expected to be flat.
5	HealthChoice Population	HealthChoice offers health, dental, life, and disability benefits for state employees, local governments, teachers, retirees, and their dependents	95,217 primary members and 55,220 dependents enrolled in the HealthChoice health plans that are offered to active member and pre-Medicare retirees, and 28,634 total lives enrolled in the HealthChoice health plans offered to Medicare retirees. Enrollment is expected to increase in the health plans since one carrier elected not to offer their product for 2027. The HealthChoice Dental plan enrollment was 83,125 members and 43,011 dependents. This population remains relatively stable. The HealthChoice Disability plan enrollment also remains stable and is approximately 35,700 members. All as of June 2026.



Groups of People Served by the Agency, cont.

	Group Served	Services Received	Estimated Changes in Group Served (within next 5 years)
6	SoonerPlan serves individuals with income is between 133% and 185% (138% with 5% disregard to 210% converted to MAGI) FPL	Title XIX Medicaid limited benefit plan for family planning coverage	12,809 members enrolled as of August 2026. In SFY2026, 4,551 unique members served. (Many members who are enrolled in this program do not receive services in a particular year.) Enrollment is expected to be flat. FPL was increased to 185% (210% converted to MAGI and applicable disregards) effective January 2024.
7	Oklahoma Cares Breast and Cervical Cancer (BCC) program serves women who do not qualify for SoonerCare and who need treatment for BCC or precancerous conditions	Full Medicaid benefits	33 members enrolled as of August 2026. In SFY2026, 67 unique members served. Enrollment is expected to be flat.
8	Soon-to-be-Sooners provides services for the unborn child up to 185% FPL (210% converted to MAGI and applicable disregards)	Title XXI (Separate CHIP) benefit plan which provides healthcare benefits to and for the benefit of the unborn child	2,307 as of August 2026. In SFY2026, 6,338 unique members served. Enrollment is expected to be flat.
9	Dually eligible for Medicare and Medicaid population	Approximately 75% of dual eligible individuals receive Medicaid benefits through a fee-for-service delivery system. For the remainder of the dual eligible individuals, Medicaid only pays their Medicare coinsurance & deductibles.	120,569 as of August 2026. In SFY2026, 110,280 unique members served. Enrollment is expected to be flat. Approximately 80% of the population is also included in the ABD population.



Analysis of Expected Changes in Services

	Reason for Change in Services (Statute Name & Statute Reference or Brief Description of Circumstance)	Service Changes Expected (Briefly describe expected changes to services and how it will impact citizens/customers and the agency.)	Expected Fiscal Impact (List expected changes in funding needed by funding source – (\$) Increase or Decrease in Appropriated, Revolving or Federal funds)
1	Federal justice-involved youth requirements; Consolidated Appropriations Act, 2023, §§ 5121	Provide required Medicaid screening/diagnostic services and targeted case management to eligible youth before release from correctional settings, with continued case management after release.	Increase in federal and state Medicaid expenditures for newly required pre-release and transition services; federal matching funds available.
2	SB 1427 (2026); pediatric type 1 diabetes screening	SoonerCare already covers applicable diabetes screening services. Implementation of SB 1427 is expected to increase awareness and use of screening among pediatric members and providers rather than create a new covered benefit.	No direct fiscal impact. A modest increase in expenditures may occur if screening utilization increases because of greater awareness and implementation of the statutory requirements.
3	2027 AMA obstetrical coding changes and related OHCA policy updates	Transition obstetrical services from a bundled billing structure to separate billing codes for individual maternity services, including antepartum, delivery and postpartum care. The change updates provider billing and reimbursement requirements but does not create new covered services.	Expected to be budget neutral or have a limited fiscal impact, subject to final reimbursement methodology and utilization patterns.
4	2027 speech-language pathology CPT coding changes, including deletion of CPT 92507	Update SoonerCare coverage and billing requirements to replace deleted CPT 92507 with the applicable new speech-language pathology procedure codes. Providers will bill more specific codes based on the service furnished. The change is intended to maintain coverage of existing speech-language pathology services under the revised national coding structure.	Fiscal impact expected to be limited or budget neutral, depending on final code coverage, utilization, and reimbursement rates.
5	SMD #23-006 and subsequent CMS guidance	Add non-emergency transportation benefits for 1915(c) waiver populations and add transportation for IMD waiver services and facility-to-facility transport.	Low fiscal impact. 1915(c) populations have received the service historically, but it was provided under the waiver. Some state share will shift to OHCA.



Analysis of Expected Changes in Services: HR 1

	Reason for Change in Services (Statute Name & Statute Reference or Brief Description of Circumstance)	Service Changes Expected (Briefly describe expected changes to services and how it will impact citizens/customers and the agency.)	Expected Fiscal Impact (List expected changes in funding needed by funding source – (\$) Increase or Decrease in Appropriated, Revolving or Federal funds)
6	6-month redeterminations for expansion adults and retroactive coverage limits; Pub. L. 119-21 (2025)	Expansion adults must now actively verify their eligibility at the 6-month mark. Retroactive eligibility limited to 1 month for expansion adults; 2 months for all others. Citizen impact: Potential for coverage disruption or disenrollment if members fail to respond to outreach or no longer meet income thresholds. Agency impact: Significant increase in administrative workload requiring coordinated outreach, processing of verifications, and managing subsequent appeals or re-enrollments.	The fiscal and operational impacts have not yet been determined and will be assessed following implementation, once sufficient trend data are available for analysis.
7	Address verification & duplicate enrollments; Pub. L. 119-21 (2025)	Federal mandate: Under 42 CFR § 435.916, state Medicaid agencies must maintain accurate member address data and establish robust procedures for handling returned mail to prevent inappropriate coverage terminations and ensure proper notice delivery. Citizen impact: Members will experience more reliable communication and fewer accidental coverage losses. However, they may need to take action to confirm their address if a discrepancy is flagged. Agency impact: Reduced overhead and administrative costs associated with returned mail and manual address updates. Requires coordination between the system development team and member services to handle updated workflows.	The fiscal and operational impacts have not yet been determined and will be assessed following implementation, once sufficient trend data are available for analysis.
8	Work requirements; Pub. L. 119-21 (2025)	OHCA is preparing for the work requirements outlined in H.R.1. All expansion adults receiving Medicaid who are 19-64, and do not meet any of the exemptions will be required to either work or perform community service 80 hours per month, participate in a work program or be enrolled in an education program at least half time or have a combination of the above totaling 80 hours per month to be eligible for benefits.	The fiscal and operational impacts have not yet been determined and will be assessed following implementation, once sufficient trend data are available for analysis.



Analysis of Expected Changes in Services: HR 1

	Reason for Change in Services (Statute Name & Statute Reference or Brief Description of Circumstance)	Service Changes Expected (Briefly describe expected changes to services and how it will impact citizens/customers and the agency.)	Expected Fiscal Impact (List expected changes in funding needed by funding source – (\$) Increase or Decrease in Appropriated, Revolving or Federal funds)
9	Alien Medicaid eligibility; Pub. L. 119-21 (2025)	Effective Oct. 1, 2026, limits federal Medicaid and CHIP funding for full-scope coverage to U.S. citizens/nationals and specified noncitizen categories, including lawful permanent residents, Cuban/Haitian entrants, and COFA migrants. Some currently eligible noncitizens will lose full-scope Medicaid coverage and remain eligible only for Emergency Medicaid or another federally permitted coverage pathway, as applicable.	The fiscal and operational impacts have not yet been determined and will be assessed following implementation, once sufficient trend data are available for analysis.
10	Deceased member check; Pub. L. 119-21 (2025)	Federal mandate requires Oklahoma Medicaid agency to cross-check enrollees against the SSA Death Master File at least quarterly to prevent continued coverage for deceased individuals.	The fiscal and operational impacts have not yet been determined and will be assessed following implementation, once sufficient trend data are available for analysis.
11	Cost-sharing for expansion adults; Pub. L. 119-21 (2025)	Beginning Oct. 1, 2028, requires cost-sharing (\$1-\$35 per service) for adults >100% FPL in expansion. Exempts certain services (e.g., primary care, CCBHC) and maintains 5% aggregate cost-sharing limit.	The fiscal and operational impacts have not yet been determined and will be assessed following implementation, once sufficient trend data are available for analysis.
12	Out-of-state member identification and tracking; Pub. L. 119-21 (2025)	Residency Verification and Cross-State Matching: OHCA needs to identify Medicaid members who have moved out of state but remain enrolled in Oklahoma Medicaid, resulting in continued costs under managed care. To address this risk and HR 1 residency verification requirements, OHCA has developed a scope of work with HMS for cross-state matching and residency verification.	The fiscal and operational impacts have not yet been determined and will be assessed following implementation, once sufficient trend data are available for analysis.



Analysis of Expected Changes in Services: RHT

	Reason for Change in Services (Statute Name & Statute Reference or Brief Description of Circumstance)	Service Changes Expected (Briefly describe expected changes to services and how it will impact citizens/customers and the agency.)	Expected Fiscal Impact (List expected changes in funding needed by funding source – (\$) Increase or Decrease in Appropriated, Revolving or Federal funds)
13	Telehealth origination site codes; Rural Health Transformation (RHT)	Establish a facility fee for eligible originating sites when a member receives telehealth services. The fee would be paid to the physical site hosting the member and would be separate from the distant-site provider's professional claim. Eligible originating sites include hospitals, outpatient departments, physician/practitioner offices, RHCs, FQHCs, I/T/U clinics, skilled nursing facilities, and public health clinics. The fee would apply only when the originating site provides staff, space, or facility resources to support the telehealth encounter. Services provided when a member is at home, or when no originating-site resources are utilized, would not qualify. Equipment and transmission costs remain non-covered.	Budget impact: The estimated total cost SFY 2026 is \$1,390,222. The estimated total cost for SFY 2027 is \$3,336,531. Total budget estimate: \$4,730,000
14	RHTP year 1: Data and analytics expansion; Rural Health Transformation	As part of the Rural Health Transformation Program, this initiative will strengthen Oklahoma's health information exchange (HIE) infrastructure to improve healthcare access, quality, and outcomes in rural communities. Administered by OHCA's OKSHINE division, the project will develop advanced data analytics capabilities, targeted dashboards, and a statewide data roadmap to enhance HIE functionality and integration. Funding will support technology vendors, data infrastructure development, and pilot use cases focused on maternal health, chronic disease, and rural health outcomes, establishing a stronger data foundation for statewide healthcare transformation and informed decision-making.	Budget impact: Five-year, \$22.7 million subrecipient agreement between the Oklahoma State Department of Health and the Oklahoma Health Care Authority for a data and analytics expansion initiative. Total budget estimate: \$22,732,000



Analysis of Expected Changes in Services: RHT

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15	Practice enablement; Rural Health Transformation	The initiative will support about 150 rural primary care provider (PCP) practices as they transition to sustainable value-based care (VBC) models. Support will include capacity-building funding and technical assistance to strengthen practice infrastructure, risk stratification, payment model development, payer negotiations and governance. The goal is for participating practices to achieve financial sustainability through shared savings, per-member-per-month payments or full capitation. Key milestones include establishing accountable care organizations (ACOs) by Q4 FY26 and advancing participating ACOs to downside-risk arrangements by Q4 FY30. Success will be measured by the percentage of practices with executed VBC contracts and improvements in CMS core preventive care measures.	Budget Impact: The total contract value is \$32,075,000 over a five-year term, beginning Dec. 31, 2025. Total budget estimate: \$32,075,000
16	PACE expansion program; Rural Health Transformation	The initiative will expand the Program of All-Inclusive Care for the Elderly (PACE) accountable care organization (ACO) model in rural Oklahoma to improve healthcare access, quality, and outcomes for seniors. The program helps seniors remain in their homes and communities longer while reducing reliance on high-cost institutional care. It is federally funded by the Centers for Medicare & Medicaid Services (CMS) through the Rural Health Transformation Program.	Budget Impact: The contract has a total potential value of \$34.9 million over a five-year term, with an initial term amount of \$15,165,000. Total budget estimate: \$34,900,000



Analysis of Expected Changes in Services: RHT

	Reason for Change in Services (Statute Name & Statute Reference or Brief Description of Circumstance)	Service Changes Expected (Briefly describe expected changes to services and how it will impact citizens/customers and the agency.)	Expected Fiscal Impact (List expected changes in funding needed by funding source – (\$) Increase or Decrease in Appropriated, Revolving or Federal funds)
17	PCP clinical extension models pilot; Rural Health Transformation	A strategic initiative designed to pilot innovative, value-based clinical extension models aimed at improving healthcare outcomes and management for high-risk Medicaid and dual-eligible populations in rural settings. Administered by OHCA as the subrecipient, the program will scale across two distinct phases — launching an initial cohort of 10 practices in year 2 and expanding to a second cohort of 10 practices in year 4 contingent upon successful pilot benchmarks. OHCA will oversee fund administration, clinical pilot execution, technical assistance, and data-driven outcomes measurement to establish a financially self-sustaining delivery model that commercial and public payers can adopt.	Budget impact: Five-year, \$37.07 million subrecipient agreement between the Oklahoma State Department of Health (OSDH) and the Oklahoma Health Care Authority (OHCA) under the Rural Health Transformation Program. Total budget estimate: \$37,075,000
18	RHTP year 1 - HIE expansion; Rural Health Transformation	Prioritize early provider engagement and system readiness assessments for the 139 Rural Health Clinics (RHCs). Because RHCs represent the largest volume of disconnected facilities (97% offline) and have the lowest baseline technical footprint, they pose the highest risk for implementation delays but offer the greatest potential for reducing duplicate diagnostics.	Budget impact: Five-year, \$29.5 million initiative funded by the Centers for Medicare & Medicaid Services (CMS) through the Rural Health Transformation Program. Total budget estimate: \$29,549,961



Analysis of Expected Changes in Services: RHT

	Reason for Change in Services (Statute Name & Statute Reference or Brief Description of Circumstance)	Service Changes Expected (Briefly describe expected changes to services and how it will impact citizens/customers and the agency.)	Expected Fiscal Impact (List expected changes in funding needed by funding source – (\$) Increase or Decrease in Appropriated, Revolving or Federal funds)
19	EHR expansion; Rural Health Transformation	A targeted initiative aimed at closing the electronic health record (EHR) gap in rural Oklahoma by providing subsidized connections, essential hardware and technical support to approximately 40 unconnected rural facilities, including critical access hospitals, federally qualified health centers (FQHCs) and behavioral health clinics. Administered by OHCA's OKSHINE office, the program's primary objective is to achieve universal EHR coverage to drive statewide health information exchange (HIE) participation and improve care coordination. Success will be measured by the percentage of rural providers actively using connected EHRs, with a long-term sustainability plan where providers transition to absorbing ongoing costs once the initial subsidies expire, incentivized by the proven operational and clinical ROI of HIE integration.	Budget impact: Five-year initiative under the Rural Health Transformation Program, administered by the Oklahoma Health Care Authority (OHCA) as a subrecipient to the Oklahoma State Department of Health. Total budget estimate: \$38,192,000
20	Maternal remote patient monitoring initiative; Rural Health Transformation	A strategic pilot designed to deploy blood pressure (BP) cuffs to approximately 900 high-risk pregnant Medicaid members. Leveraging OHCA's expertise in maternal health management to demonstrate the clinical effectiveness and cost-efficiency of RPM in managing maternal hypertension. Key operational phases include device procurement, comprehensive patient and provider support, and critical integration of RPM data into EHR systems. The ultimate objective is to utilize the gathered outcome data to justify RPM as a permanent, billable Medicaid benefit, culminating in a state plan amendment (SPA) submission in FY31.	Budget impact: Five-year initiative under the Rural Health Transformation Program (RHTP) to improve maternal health outcomes in rural Oklahoma. Total budget estimate: \$3,536,000



Analysis of Expected Changes in Services: RHT

	Reason for Change in Services (Statute Name & Statute Reference or Brief Description of Circumstance)	Service Changes Expected (Briefly describe expected changes to services and how it will impact citizens/customers and the agency.)	Expected Fiscal Impact (List expected changes in funding needed by funding source – (\$) Increase or Decrease in Appropriated, Revolving or Federal funds)
21	Community care platform expansion project; Rural Health Transformation	A targeted initiative designed to scale Oklahoma's existing community referral infrastructure to underserved rural regions. By connecting local health departments, community partners, and rural healthcare providers, the platform establishes a shared digital backbone to track health-related social needs (food, housing, behavioral health) and referral outcomes in real time. The initiative will directly fund license extensions for 39 critical access hospitals and 4 rural emergency hospitals. Key milestones include launching rural integration in Q3 FY26, with a planned transition to a self-sustaining financial model by Q3 FY31 utilizing State Medicaid administrative claiming and organizational subscriptions.	Budget impact: Annual budget of \$410,000 (allocated to \$258,000 for personnel and \$152,000 for startup costs, with zero administrative fees. Total budget estimate: \$2,050,000



Analysis of Expected Changes in Services: MMIS

	Reason for Change in Services (Statute Name & Statute Reference or Brief Description of Circumstance)	Service Changes Expected (Briefly describe expected changes to services and how it will impact citizens/customers and the agency.)	Expected Fiscal Impact (List expected changes in funding needed by funding source – (\$) Increase or Decrease in Appropriated, Revolving or Federal funds)
22	Medicaid Management Information Systems (MMIS) Modernization	The strategic plan is designed to transition the current system to a modern, modular, and data-driven platform over the next five years, with a focus on improving efficiency, compliance, and user experience. The future-state architecture will be API and event-driven, allowing systems to integrate seamlessly. This eliminates brittle point-to-point connections, enables real-time data synchronization, and provides the modularity for OHCA to add or replace systems without disruption. The modernization is organized into five key strategic priority areas: FWA/cost containment: This initiative focuses on implementing robust systems to ensure program integrity and reduce costs. Integration & analytics: Establish a modern data and integration framework. "Gainwell Connect" will create a unified system integration layer for timely and accurate data exchange. iChange modernization: The core transformation of the MMIS platform involves a phased approach to modernize key business functions, including provider enrollment and data management ("provider modernization"), automating business processes ("delivery transformation"), and enhancing customer service tools ("CO/CSR enhancements"). Compliance: Adherence to all federal and state mandates. This includes addressing specific CMS requirements (CMS-0057, ARC/AMPE), upgrading pharmacy systems (NCPDP), and enhancing platform security through multifactor authentication integrated with work requirements verification. Member experience: Enhancing the member experience is a critical outcome of the modernization effort. This includes implementing the work requirements verification system and deploying the "gabby & ICC stack" to provide better service and engagement tools for SoonerCare members.	The fiscal impacts remain undetermined and will be fully assessed following the onboarding of the technical consultant and governance vendor, once RFPs are released and sufficient data becomes available for analysis.



Analysis of Agency Challenges

	Challenge	Current Actions (Briefly describe how the agency is currently addressing the challenge.)	Planned Actions (Briefly describe how the agency plans to address the challenge going forward.)
1	Federal H.R. 1's impact on enrollment and acuity	If work requirements and frequent eligibility checks lead healthier, lower-cost adults to disenroll, the remaining Medicaid population could become disproportionately skewed toward individuals with more severe, high-cost health conditions. This potential shift creates a risk of driving up average patient acuity, which would elevate per-member costs.	OHCA will closely monitor health trends and encounter data.
2	Medicaid and EGID cash reserves below recommended threshold	OHCA pays an average of over \$250 million each week for Medicaid claims. Limited cash on hand creates risk for the latter half of the fiscal year. For EGID at the end of 2025, fund reserves for the health fund were about \$5 million below the recommended \$148 million.	EGID expects to restore reserves through the premium-setting process over the next 3 to 5 years.
3	H.R. 1's effects on supplemental payments and provider taxes	New limits on provider taxes and state-directed payments restrict how states finance their Medicaid share, and health systems will face significant reductions in supplemental reimbursement.	OHCA will work directly with health systems on financial modeling to evaluate the potential impact and explore innovative, alternative financing strategies.
4	Prescription Drug Costs including new cell and gene therapy products	OHCA continues to perform drug utilization review implementing appropriate coverage criteria and appropriate use for the Medicaid members. OHCA also is working with CMMI on the cell and gene therapy sickle cell disease access model and collaborating with other cell and gene therapy companies on value-based agreements and supplemental rebates.	OHCA is participating in the CMS GENEROUS model on Most Favored Nation (MFN) pricing to take advantage of additional rebates (when appropriate) offered by participating manufacturers. OHCA would propose to remove the existing 340B program from Medicaid, which would result in additional rebate collections for the state.



Analysis of Agency Challenges

	Challenge	Current Actions (Briefly describe how the agency is currently addressing the challenge.)	Planned Actions (Briefly describe how the agency plans to address the challenge going forward.)
5	EGID - The No Surprises Act (NSA), part of the 2021 CAA, requires health plans to cover out-of-network emergency and certain nonemergency services at in-network rates, which presents ongoing challenges to billing and reimbursement processes.	The HealthChoice Network Management Team (NM) continues to monitor federal updates for changes in the process while spending significant amounts of time negotiating NSA claims. As of Jan. 1, 2025, NM had received 7 IDRs to negotiate. Between January 2025 and July 2026, EGID paid 3,687 NSA claims and negotiated 1,334 IDRs. During 2025, NSA claims totaled over \$1.6 million per month in negotiated claims. As of mid-year 2026, while IDR volume is decreasing, billed charges continue to increase, rising to \$2.6 million per month currently. While requested amounts have risen over \$1 million per month, settled amounts have risen by only \$450,000. Through diligence and continued learning, the NM team has gained valuable experience in handling these claims. In July 2026, the team prevailed in 50% of claims, far exceeding the industry average of 15%.	HealthChoice will continue to review workload, processes, technology and any legislative updates to address this challenge.
6	Fraud, waste, and abuse	Fraud: Program Integrity (PI) receives and evaluates referrals from internal staff, sister agency staff, providers, contracted entities (CEs), and members. PI opens intakes for review. If evidence of fraud is found, the referral is sent to Attorney General's (AG) Medicaid Fraud Control Unit (MFCU). OHCA and MFCU hold standing monthly meetings. Waste and Abuse: Initial error reports are circulated to the provider to allow for clarification with guidance on future billing. If erroneous billing is found, the funds are reclaimed.	Streamline workflows and enhance our tools through MMIS modernization efforts. OHCA has implemented a process to help identify fraudulent member enrollment activity. From November 2025 to September 2026, it helped identify more than 68,000 fraudulent enrollment cases that were terminated.



Total Historic Actual Expenditures (FY 2022-26) and Current Year Budget (FY 2027)

Explanation of Changes and Trends

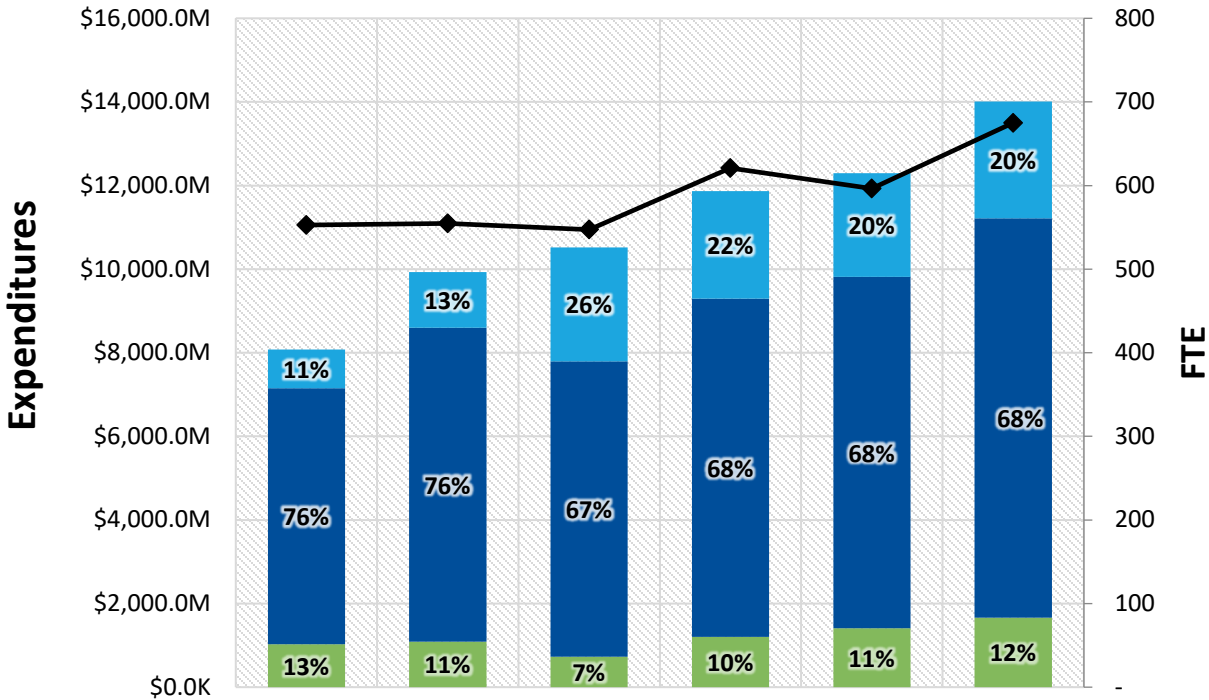
From FY 2022 through FY 2024, enrollment related to SQ 802-mandated Medicaid expansion and the federal public health emergency (PHE) continuous coverage mandate were the primary drivers of a significant increase in the agency’s budget. Other non-recurring factors for FY 2024 included the claims bubble associated with the SoonerSelect transition (\$368M) and the Oklahoma SB32X-mandated hospital payment (\$200M).

The main factors driving the FY 2025 budget increase were state-mandated LTC and HCBS rate increases, along with managed care-directed hospital supplemental payments and provider incentive payments. The 13% increase in actual FTEs resulted from the consolidation with EGID.

FY 2026 key drivers included higher pharmacy costs across FFS and managed care (approximately 9% above FY25), increased long-term care utilization, higher outpatient hospital and clinic service utilization, and rising ABA therapy expenditures.

There is a similar trend in FY 2027. Other key drivers include higher member acuity — particularly within the expansion population — increased LTSS utilization, rising pharmacy costs driven by specialty and diabetes medications, increased Medicare Part A, B, and D premium costs, and the impact of one additional claim week.

Historic Total Actual Expenditures and Current Year Budget



	FY 2022	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027 Current Budget
Appropriated	\$1,030.2M	\$1,089.5M	\$728.6M	\$1,199.4M	\$1,410.5M	\$1,660.9M
Revolving	\$924.5M	\$1,332.9M	\$2,727.7M	\$2,572.3M	\$2,479.4M	\$2,793.9M
Federal	\$6,120.7M	\$7,510.9M	\$7,066.5M	\$8,092.0M	\$8,405.1M	\$9,551.8M
Total	\$8,075.4M	\$9,933.2M	\$10,522.9M	\$11,863.7M	\$12,295.0M	\$14,006.6M
FTE	553	555	547	621	596	675



Projected Federal Funding

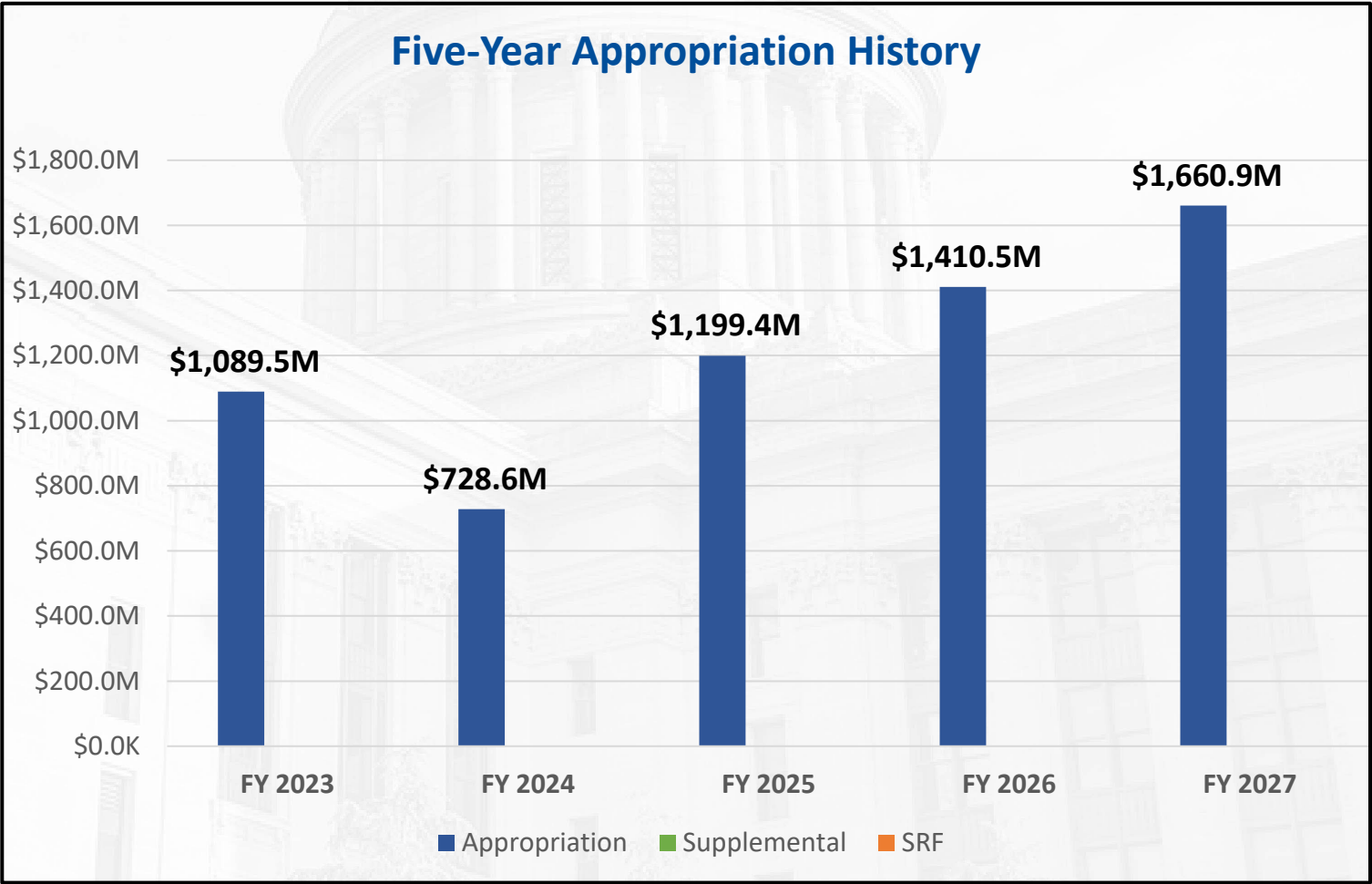
Fiscal Year	Federal Funding (\$) <i>(FY27 should match previous slide)</i>	List Risks with Federal Funding <i>(ex. Anticipate grants ending)</i>	List Opportunities with Federal Funding <i>(ex. Service improvement, improved outcomes)</i>	# FTE estimated to be funded with federal funding*
FY 2027	\$9,551,819,721	- Work requirements: Must begin the 80-hour requirement by 1/1/2029 - Six-month eligibility redeterminations: Begins 1/2027; CBO estimates a 10% reduction in clients after the first six months	- Rural Health Transformation Grant - Service Improvements - Cost Savings	570
FY 2028	\$9,483,382,497	- Work requirements: Must begin the 80-hour requirement by 1/1/2029 - Provider-tax restrictions: Threshold reduced from 6% to 5.5% - State directed payment limits: Must reduce the SDPs by 10% - Six-month eligibility redeterminations: Begins 1/2027; CBO estimates a 10% reduction in clients after the first six months	- Rural Health Transformation Grant - Cost Savings - Service Improvements	570
FY 2029	\$9,788,216,919	- Work requirements: Must begin the 80-hour requirement by 1/1/2029 - Provider-tax restrictions: Threshold reduced to 5% - State directed payment limits: Must reduce the SDPs by 10% - Six-month eligibility redeterminations: Begins 1/2027; CBO estimates a 10% reduction in clients after the first six months	- Rural Health Transformation Grant - Cost Savings - Service Improvements	570
FY 2030	\$10,086,382,964	- Work requirements: Must begin the 80-hour requirement by 1/1/2029 - Provider-tax restrictions: Threshold reduced to 4.5% - State directed payment limits: Must reduce the SDPs by 10% - Six-month eligibility redeterminations: Begins 1/2027; CBO estimates a 10% reduction in clients after the first six months	- Rural Health Transformation Grant - Cost Savings - Service Improvements	570
FY 2031	\$10,389,385,820	- Work requirements: Must begin the 80-hour requirement by 1/1/2029 - Provider-tax restrictions: Threshold reduced to 4% - State directed payment limits: Must reduce the SDPs by 10% - Six-month eligibility redeterminations: Begins 1/2027; CBO estimates a 10% reduction in clients after the first six months	- Rural Health Transformation Grant - Cost Savings - Service Improvements	570



*FTE number includes FTE funded with federal funds and required state match.

Appropriation History

Fiscal Year	Legislated Appropriation (\$) <i>(Includes supplementals and SRF/ARPA if applicable.)</i>
FY 2023	\$1,089,494,387
FY 2024	\$728,603,586
FY 2025	\$1,199,407,747
FY 2026	\$1,410,540,778
FY 2027	\$1,660,860,769



Section II: Strategic Plan



- **Resource analysis**
 - Financials
 - Staffing
 - Savings & Efficiencies
- **Goals & strategies**
 - Goals & strategies
 - Key Performance Metrics
 - Type of Funding

Financial Resource Analysis

Carryover	FY 2023	FY 2024	FY 2025	FY 2026
Total appropriated carryover amount expended (\$)	\$17,498,130	\$738,897,508	\$317,978,239	\$124,778,426

Historical Cash Balances	FY 2023	FY 2024	FY 2025	FY 2026
Year End Revolving Fund Cash Balances (<i>All Revolving Funds</i>)	\$1,464,628,341	\$840,293,561	\$182,548,716	\$177,276,840

Revolving Class Fund # (<i>Unrestricted only</i>)	Revolving Class Fund Name (<i>Unrestricted only</i>)	Current cash balance (\$)*	Projected FY 2027 year-end cash balance (\$)
20000	Administrative Disbursing Fund	\$37,763,073	\$15,963,663
34000	Medicaid Program Disbursing Fund	\$312,306,035	\$25,099,215
29000	EGID – Intra Xfer from Special Account	\$2,817,769	\$1,800,000
29200	EGID – Medical Expense Liability Fund	\$4,492,477	\$4,701,000
		*as of 8/31/26	
	Total Unrestricted Revolving Fund Cash balance:	\$357,379,354	\$47,563,878



Unrestricted funds are those that are not limited by state or federal law, rule, regulation, other legally binding method, or donor restriction.

Staffing Trend Analysis

	FY 2023	FY 2024	FY 2025	FY 2026	FY 2027
Total Budgeted Positions / PINs (#)	609	606	661	683*	675*
Budgeted Vacant PINs (#)	51	48	54	55	81
FTE (as of 6/30)	556	542	627	588	N/A
Turnover Rate (%)	10%	8%	9%	14%	N/A

Explanation of Changes and Trends

Turnover remained relatively stable from FY23 through FY25, ranging from 8% to 10%, before increasing to 14% in FY26. The increase occurred during a period of significant organizational change, including leadership transitions and the continued integration of the EGID division following its addition in FY25. A meaningful share of this turnover reflects attrition through retirements and market conditions, with nursing roles experiencing particular pressure as the agency continues to compete for talent against managed care entities and other healthcare employers offering more competitive compensation. These factors contributed to a changing workforce environment and should be considered when evaluating the FY26 turnover trend.



**Headcount data provided by OMES HCM.*

Savings & Efficiencies (Current or Planned)

Savings or Efficiency Name	Brief description of how savings were achieved	Savings in Unit of Measurement	FY 2026 (Actual \$ Savings)	FY 2027 (Projected \$ Savings)	FY 2028 (Projected \$ Savings)
HealthChoice Drug Savings Review	PBM initiative to help prescribers identify evidence-based clinical opportunities that can drive prescription savings and member health.	Appropriate and cost-effective utilization of drugs	\$4.0 million	\$3.4 million	\$4.6 million
HealthChoice Improving Health Status	Utilization of innovative programs to engage members across multiple health conditions, giving our members access to the right care at the right time.	Improve member health outcomes, reduce avoidable healthcare costs, redirect care to lowest cost site of service.	N/A	\$5 million	\$10 million
Drug Rebates	Ensure timeliness of invoices to drug manufacturers and ensure all rebate eligible drug utilization is included on invoices to collect maximum eligible rebates.	Improvements in rebate collections	\$787 million	\$803 million	\$827 million
Third-Party Liability	Savings are achieved by billing carriers that were identified as possible payers after a claim has already been paid. This includes commercial insurance and Medicare.	Recovered TPL funds	\$49 million	\$50 million	\$50 million



Savings & Efficiencies (Current or Planned)

Savings or Efficiency Name	Brief description of how savings were achieved	Savings in Unit of Measurement	FY 2026 (Actual \$ Savings)	FY 2027 (Projected \$ Savings)	FY 2028 (Projected \$ Savings)
Arine Partnership	Medication therapy management, improving member outcomes and saving costs.	Program cost reduction	\$10 million (CY2023)	\$10.25 million	\$10.5 million
Building Lease	OHCA's ability to telework has enabled the Department of Corrections and Pardon and Parole Board to move into the building that we lease.	Additional lease agreements with DOC and PPB	\$263,041	\$263,041	\$263,041
Contract Savings	Contract reductions & contract cancellations – savings were reallocated to other contracts	Contract reductions	\$17.3 million	\$22 million	\$5.2 million
Provider audits	OHCA's Program Integrity Unit utilizes clinical provider audits, data analytics and payment accuracy audits to identify any fraud, waste, or abuse.	Overpayments or inappropriate payments recouped	\$916,235.46	\$1 million	\$1.1 million

***Provider audits footnote:** Financial metrics have been adjusted to reflect key legislative changes. Pursuant to HB 2797 (effective May 2025), certain audits and provider payment demands were invalidated, reducing realized savings for SFY2026 and lowering future projections. Additionally, forward-looking projections have been adjusted downward to account for administrative and operational constraints placed on the Program Integrity process by SB 1645 (effective January 2027).



Agency Goals and Key Performance Metrics

Goal		Metric	FY 26 Target	FY 26 Actuals	FY 27 Target	FY 31 Target
1	RHT/HR1 Priorities	Project tracking and performance to be overseen by OHCA Transformation Management Office, senior directors and executive leadership.	N/A	N/A	100% compliance with HR1/RHT fiscal and operational conditions of participation	100% compliance with HR1/RHT fiscal and operational conditions of participation
2	Fiscal responsibility: Maintain administrative cost at or below 5% of total annual costs.	Administrative cost as a percent of total annual costs	>3%	1.4%	>3%	>3% (MES Reprocurement)
3	Fiscal responsibility: Maintain program growth below national Medicaid trend	NHE Health Insurance Expenditure Growth Rate (NHE Projections Table 17)	15	4.1	12.6	5.2
4	Fiscal responsibility: Manage EGID healthcare premium cost growth at or below national 5-year rolling avg for HealthChoice High members.	Oklahoma 5-year rolling average compared to national average	2.80%	2.80%	5.97%	4.70%
5a	Health outcomes: Increase primary care services (adults)	Adult healthcare use – preventive care (age 20 & older)	81.3	84.8	85.1	86.4



Agency Goals and Key Performance Metrics

Goal		Metric	FY 26 Target	FY 26 Actuals	FY 27 Target	FY 31 Target
5b	Health outcomes: Increase primary care services (children)	Well-child visits in the first 30 months of life Age: First 15 months Age: 15-30 months Child and adolescent well-care visits	64.2 59.9 40.8	67.8 69.4 37.1	68.6 70.0 40.8	71.7 70.0 55.4
6a	Health outcomes: Decrease emergency department visits (adults) by 2 per 1,000 beneficiary months in FY 25 and an additional 8 by FY 29.	Ambulatory care: Emergency department (ED) visits per 1,000 beneficiary months, adults	75.04	77.04	73.04	65.04
6b	Health outcomes: Decrease emergency department visits (children) by 1 per 1,000 beneficiary month.	Ambulatory care: Emergency department (ED) visits per 1,000 beneficiary months, children	37.75	38.75	36.75	32.75
7	High performing teams: Continuously build and attract high-performing teams through performance management and calibration initiatives, competency and succession development, and promote a culture of collaboration and communication.	Turnover rate <i>Provided by OMES HCM</i>	N/A	14%	14%	12%
8	Operational excellence: Increase operational excellence by instituting monthly management processes for key operational metrics to drive improvement.	Number of operational key performance metrics with identified targets	13	14	15	16
9	Operational excellence: Drive EGID cost and innovation to transform EGID services through technology modernization.	V3locity Portal (Percentage of groups utilizing Member Self Service)	2%	0%	2%	50%



(1) RHT/HR1 Priorities

Brief description of major agency goal

The Oklahoma Health Care Authority is actively modernizing its program delivery systems by strategically implementing U.S. House Resolution 1 (H.R. 1) mandates alongside the CMS-backed Rural Health Transformation Program. Through these dual initiatives, we are aligning state operations with evolving federal standards to support a sustainable healthcare safety net for Oklahoma's rural and vulnerable populations. By integrating advanced automated data verification tools, optimizing provider administrative processes, and strengthening fraud, waste, and abuse (FWA) detection, OHCA is committed to maximizing fiscal stewardship. Ultimately, these efforts shift our delivery model toward results-based, high-value care that supports infrastructure to improve health outcomes for Oklahoma citizens.

Brief description of strategy to achieve the goal

1. Advance value-based care and payment reform
2. Establish a unified health data utility
3. Expand access through decentralized & virtual care
4. Integrate upstream care & community support
5. Ensure multi-agency governance & regulatory compliance

Indicator or Metric to measure goal progress

Project tracking and performance to be overseen by OHCA Transformation Management Office, senior directors and executive leadership.

Type of \$ Resource to be Used

This strategic initiative is fully funded through the federal Rural Health Transformation Program (RHT), authorized under Section 102 of HR 1 (Public Law 119-21), which provides Oklahoma with a five-year, \$223.5 million annual award to transition Medicaid providers toward value-based care and modernize health data infrastructure.



(2) Fiscal Responsibility

Brief description of major agency goal
Maintain administrative cost at or below 5% of total annual costs
Brief description of strategy to achieve the goal
1. Implement call center artificial intelligence (AI) to improve average member call time. 2. Workflow analysis of all professional services contracts (PSC) to optimize overall PSC process lifecycle. 3. Medicaid Management Information Systems (MMIS) reprocurement 4. Health information exchange (HIE) contract
Indicator or Metric to measure goal progress
Administrative cost as a percent of total annual costs
Type of \$ Resource to be Used
Existing cash, carryover, planned efficiencies



(3) Fiscal Responsibility

Brief description of major agency goal

Maintain program growth below national Medicaid trend

Brief description of strategy to achieve the goal

1. Continue to provide to the medication therapy management program.
2. Maintain network through adequacy of reimbursement (current 93.63% of Medicare).
3. Continued program integrity activities to identify high-risk providers and services and reduce program costs through provider audits to ensure costs meet program requirements.
4. Maximize quarterly collections through the drug rebate program.

Indicator or Metric to measure goal progress

NHE Health Insurance Expenditure Growth Rate ([available on NHE Projections – Table 17](#))

Type of \$ Resource to be Used

Existing cash, carryover, budget request



(4) Fiscal Responsibility

Brief description of major agency goal

EGID healthcare premium cost growth

Brief description of strategy to achieve the goal

1. Maintain and explore competitive reimbursement strategies for medical and pharmacy benefits.
2. Annual review of plan design.
3. Consistent management of investment portfolio and fund equity balance.
4. Maintain administrative expenses at 5% or less.

Indicator or Metric to measure goal progress

Manage health care premium cost growth at or below national 5-year rolling avg for HealthChoice members (measured by comparing costs of national to Oklahoma 5-year rolling avg.).

Type of \$ Resource to be Used

Member premiums, investment income, and existing cash



(5a) Health Outcomes

Brief description of major agency goal

Increase primary care services (adults)

Brief description of strategy to achieve the goal

1. Provide outreach to engage 20% of the aged, blind, and disabled (ABD) diabetic population in care management.
2. Transforming Maternal Health Model – improve maternal health outcomes.
3. Add Medicaid-eligible pharmacists as OHCA providers.
4. Develop and implement a Food is Medicine program
5. Increase primary care spend to 11%.

Indicator or Metric to measure goal progress

Adult healthcare use – preventive care (20 and older)

Type of \$ Resource to be Used

Planned efficiencies, budget request, grant funding



(5b) Health Outcomes

Brief description of major agency goal

Increase primary care services (children)

Brief description of strategy to achieve the goal

1. Transforming Maternal Health Model – improve maternal health outcomes.
2. Add Medicaid-eligible pharmacists as OHCA providers.
3. Develop and implement a Food is Medicine program

Indicator or Metric to measure goal progress

Well-child visits in the first 30 months of life (W30-CH)

- Age: First 15 months
- Age: 15-30 months
- Child and adolescent well-care visits (WCV-CH)

Type of \$ Resource to be Used

Planned efficiencies, budget request, grant funding



(6a-b) Health Outcomes

Brief description of major agency goal

Decrease emergency department visits (adults and children)

Brief description of strategy to achieve the goal

The Diabetes Empowerment Initiative remains ongoing, with continued outreach to eligible ABD members with diabetes and ongoing refinement of population and eligibility criteria to strengthen care management engagement.

Indicator or Metric to measure goal progress

Ambulatory care: Emergency department (ED) visits per 1,000 beneficiary months, adults/children

Type of \$ Resource to be Used

Planned Efficiencies, Budget Request, Grant Funding



(7) High Performing Teams

Brief description of major agency goal

Improve performance management

Brief description of strategy to achieve the goal

1. Track return on investment of leadership and mentorship program.
2. Focus on improving organizational alignment and operational efficiency through competency development while continuing to advance leadership development efforts.
3. Use performance reviews to identify low performers and initiate corrective action.
4. Implement predictive analytics to identify and develop high performers.
5. Integrate competencies into performance reviews, learning and development.

Indicator or Metric to measure goal progress

Turnover rate and focus on improving organizational alignment and operational efficiency through competency development, while continuing to advance leadership development efforts.

Type of \$ Resource to be Used

Planned efficiencies, existing cash



(8) Operational Excellence

Brief description of major agency goal

Operational excellence: Increase operational excellence by instituting monthly management processes for key operational metrics to drive improvement

Brief description of strategy to achieve the goal

1. Monitoring oversight tool to automate contracted entity report submissions, collections and dashboarding.
2. Implement new AI call center technology.
3. Improve collaboration through provider/member feedback surveys.
4. Maintain the reduction process on the private duty nurse backlog to meet CMS federal mandates.
5. Maintain updated OHCA website for accuracy and compliance.
6. Streamline SoonerSelect contracted entity electronic communications.

Indicator or Metric to measure goal progress

Number of operational key performance metrics with identified targets

Type of \$ Resource to be Used

Existing cash, planned efficiencies, carryover, grant funding



(9) Operational Excellence

Brief description of major agency goal

Drive EGID cost and innovation to transform EGID services through technology modernization

Brief description of strategy to achieve the goal

1. Implement V3locity electronic creation of annual 1099B forms.
2. Train groups/coordinators and members to utilize MSS.
3. Provide excellent customer service to encourage and maintain customer satisfaction with MSS.

Indicator or Metric to measure goal progress

Percentage of groups utilizing digital self service (employer self service and/or member self service).

Type of \$ Resource to be Used

Member premiums, investment income, and existing cash

