AMENDMENT TEN TO THE CONTRACT BETWEEN OKLAHOMA HEALTH CARE AUTHORITY AND AETNA BETTER HEALTH OF OKLAHOMA, INC.

WHEREAS, the Oklahoma Health Care Authority (OHCA) issued a series of official SoonerSelect memoranda communicating required programmatic, operational, and contractual changes to Aetna Better Health of Oklahoma, Inc. (Contractor);

WHEREAS, such memoranda were effective upon issuance and implemented operationally by the Contractor as directed by OHCA;

WHEREAS, certain provisions described in those memoranda were not formally incorporated into the Contract;

WHEREAS, OHCA and Contractor also desire to clarify, refine, and update certain Contract provisions to align with current program operations and administrative practices;

WHEREAS, the annual term of the Contract for State Fiscal Year (SFY) 2026 will expire on June 30,2026;

WHEREAS, the Contract has four remaining one-year options to renew that OHCA may exercise; and

WHEREAS, the capitation rates require adjustment for SFY 2027.

NOW THEREFORE, this Amendment Ten to the Contract under Purchase Order Number 8079004725:
(1) formally incorporates and codifies applicable memoranda issued by OHCA;
(2) includes additional clarifications, refinements, and administrative updates necessary to align the Contract with current operations;
(3) renews the Contract for an additional year; and
(4) updates capitation rates for SFY 2027.

The following revisions are hereby incorporated into the Contract:

Section 1.2.6 Contract Term

Section 1.2.6 shall be replaced in its entirety by the following:

> In accordance with Article X of the Oklahoma State Constitution, this initial Contract shall begin upon Notice of Award and terminate on June 30,2025. OHCA may renew this Contract for five (5) additional one (1) year periods. OHCA's renewal shall be contingent upon the needs of OHCA and funding availability, as more fully discussed below, and is at the sole discretion of OHCA. The engagement under this Contract and any purchase order issued under this Contract are contingent upon sufficient appropriations being made by the federal government, the Oklahoma State Legislature or other appropriate government entity. Notwithstanding any language to the contrary in this Contract or in any purchase order or other document,
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> OHCA may terminate its obligation under this Contract if sufficient appropriations are not made by the legislature or other appropriate governing entity to pay amounts due for multiple year agreements. OHCA's decision whether sufficient appropriations are available shall be accepted by the Contractor and shall be final and binding. OHCA may choose to exercise an extension for up to one hundred eighty (180) Days beyond the final renewal option period at the Contract pricing rate; if so elected by OHCA, Contractor and OHCA shall execute a document reflecting such extension. If this option is exercised,

OHCA shall notify the Contractor in writing prior to the Contract end date.

OHCA may choose to exercise subsequent extensions, up to one hundred eighty (180) Days each, by mutual agreement and at the Contract pricing rate, to facilitate the finalization of related terms and conditions of a new Contract or as needed for transition to a new Contractor. Payment terms for any renewal period shall be administered in accordance with Section 1.3: "Payments to Contractor" of this Contract.

The Contractor shall have certain obligations that will survive Contract expiration. These obligations are described in the relevant sections of the Contract, including but not limited to Section 1.26: "Termination" of this Contract.

The initial Rating Period shall be fifteen (15) months (April 1, 2024 through June 30, 2025). Each subsequent Rating Period shall be twelve (12) months (July 1-June 30).

Section 1.2.6.1 Contract Renewal

The following language will be added under a new section titled "*Section 1.2.6.1: Contract Renewal*":

> Pursuant to the terms of the original Agreement, OHCA hereby exercises its option to renew the contract for an additional one-year term. The new Contract period shall begin on July 1, 2026 and end on June 30, 2027, unless terminated earlier in accordance with the Agreement.
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> To exercise an annual option to renew this Contract, OHCA may issue a written change order to the original purchase order to the Contractor. The renewal will become effective upon mutual signature. The decision to renew is based on the needs of the OHCA, funding availability, and is at the sole discretion of the OHCA. The Contract may also be renewed by an amendment to this Section 1.2.6.1.

Section 1.4.5 Oklahoma Presence

Section 1.4.5 shall be revised as follows:

The following language shall be added as a new bulleted item after the paragraph ending with '*…t. UM Director*':

u. Managed Care Directed Payments Specialist/Manager/Director

The remaining language of Section 1.4.5 remains unchanged.

Section 1.4.6.2 Key Staff

Section 1.4.6.2 shall be revised as follows:

The following language shall be added as a new bulleted item after the paragraph starting with '*...v. UM Director. . .'* and ending with '*…is responsible for ensuring all utilization reviews are in compliance with the terms of the Contract*':

w. Managed Care Directed Payments Specialist/Manager/Director who shall be responsible for supporting the development, implementation, and monitoring of directed payment programs within managed care organizations. Key Responsibilities include: Communication with providers in regard to managed care directed payments, coordinate and manage directed payment programs in alignment with regulatory requirements, analyze financial and

utilization data to support payment initiatives, collaborate with internal teams, providers, and State agencies to ensure program success, monitor program performance and prepare reports for leadership and regulatory bodies, and assist with audits, compliance reviews, and documentation requirements.

The remaining language of Section 1.4.6.2 remains unchanged.

Section 1.5.2 Mandatory Enrollment Populations

Section 1.5.2 shall be revised as follows:

Effective July 1, 2026, following the paragraph that states '*The following Eligibles will be mandatorily enrolled in the SoonerSelect Children's Specialty Program if they do not make another selection*', and ending with "*on the SoonerCare application after initial SoonerSelect Program implementation*", new bulleted items 'c-f' are added in accordance with 56 O.S. § 4002.2. No items are being deleted.

c. Children involved in a Family Centered Services (FCS) case through the Child Welfare Services division of the Department of Human Services;

d. Children in the custody of the Department of Human Services and placed at home under court supervision;

e. children who are placed at home in a trial reunification plan administered by the Department of Human Services; and

f. Medicaid enrolled parents and guardians whose children are in an FCS case, are in trial reunification, or are in the custody of the Department of Human Services in foster care or under court supervision.

The remaining language of Section 1.5.2 remains unchanged.

Section 1.5.4 Eligibles Opting Out of SoonerSelect Children's Specialty Program

Section 1.5.4 shall be replaced in its entirety as follows:

The following eligibles may opt-out of Enrollment in the SoonerSelect Children's Specialty Program and enroll with theContractor or other CE:

a. FFCC;

b. Children Receiving Adoption Assistance (AA);

c. Children involved in a Family Centered Services (FCS) case through the Child Welfare Services division of the Department of Human Services;

d. Children in the custody of the Department of Human Services and placed at home under court supervision;

e. Children who are placed at home in a trial reunification plan administered by the Department of Human Services; and

f. Medicaid enrolled parents and guardians whose children are in an FCS case, are in trial reunification, or are in the custody of the Department of Human Services in foster care or under court supervision.

Section 1.5.5 Excluded Populations

Section 1.5.5 shall be revised as follows:

Following the paragraph that states '*The following Eligibles will be excluded from Enrollment in SoonerSelect: . .* ', a new bulleted item 'm' is added. No items are being deleted.

m. Individuals enrolled in the SoonerPlan program receiving family planning services only.

The remaining language of Section 1.5.5 remains unchanged.

Section 1.6.2.3 Initial Contractor Selection Process

Section 1.6.2.3 shall be replaced in its entirety as follows:

OHCA, at its discretion, may allow up to thirty (30) Days for Eligibles to select a CE prior to the Enrollee's start of coverage under the SoonerSelect Program. Subsequent to program implementation, SoonerCare Applicants eligible for the SoonerSelect Program will have an opportunity to select a CE on their application. Eligibles who do not make an election within the allowed timeframe will be assigned to a CE in accordance with the rules outlined in Section 1.6.2.4: "Auto Assignment" of this Contract.

Section 1.6.5 Annual and Special Enrollment Periods

Section 1.6.5 shall be revised as follows:

The paragraph beginning with '*Enrollees will be informed…*' and ending with '*…of this Contract.*' shall be replaced with the following:

Enrollees will be informed that if they do not request a new CE, they will remain in their current CE. Only Enrollees who elected to make a change during the OEP will be permitted to change CEs during the first ninety (90) Days of the new Enrollment period in accordance with the process outlined in Section 1.6.4: "Enrollment Lock-In Period" of this Contract. Enrollees who do not select a new CE during the OEP will remain in their current CE and will not be eligible for the ninety (90) Day change period, unless otherwise required by State or federal law.

The remaining language of Section 1.6.5 remains unchanged.

Section 1.7.1.3 Behavioral and Physical Health Integration

Section 1.7.1.3 shall be revised as follows:

The paragraph beginning with '*The Contractor shall develop strategies…*' and ending with '*…shall develop policies and procedures to:*' shall be replaced with the following:

The Contractor shall develop strategies to integrate behavioral and physical health services with an emphasis on the integration of treatment for co-occurring mental health and SUDs. The Contractor shall ensure such strategies include appropriate care coordination and continuity of care for Justice Involved Youth (JIY), including post-release transitions. The Contractor shall develop policies and procedures to:

The following language shall be added as a new bulleted item after the paragraph that begins with *'j. Promote and support…'* and ends with '*. . .within specialty behavioral health settings*.':

k. For JIY, behavioral health services following release shall be provided within the managed care delivery system (i.e., carved into managed care), including access to services delivered by Certified Community Behavioral Health Clinics (CCBHCs), as applicable.

The remaining language of Section 1.7.1.3 remains unchanged.

ADD NEW Section 1.7.2.4.6 Pharmacy Stop Loss Program

The following language will be added under a new section titled "*Section 1.7.2.4.6: Pharmacy Stop Loss Program*":

> OHCA will operate a Pharmacy Stop Loss Program. The objective of the program is to remove the risk of excessive Enrollee-level pharmacy claims for all participating Contractors. One hundred percent (100%) of an Enrollee's annual prescription drug costs above a $500,000 attachment point will be calculated separately for each Contractor in which the member is enrolled in a given year. The $500,000 attachment point is used for an annual Contract. Such Claims will be referred to as pharmacy stop loss Claims. The amount to be used in the computation of an Enrollee's annual prescription drug costs will be the Contractor paid amount after reduction by any Medicare/third-party liability (TPL) payment. An Enrollee's annual prescription drug costs must include retail and mail order prescriptions, as well as prescription drugs administered in a physician's office or outpatient hospital setting as long as a National Drug Code (NDC) is included on the claims submission. Prescription drugs administered in an inpatient hospital setting will be included if they meet the following requirements:
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> 1. The drug (NDC included) and drug cost are itemized and identifiable on the claim and the claim is not paid as a bundled payment; and
>
> 2. The drug is classified by the FDA as a cell and gene therapy with the requirement that the therapy is only available to be administered in an inpatient setting.
>
> The Contractor will notify OHCA of all Enrollees whose prescription drug costs have exceeded the $500,000 attachment point during the Contract year. Each Contractor will send OHCA semi-annual reports documenting pharmacy stop loss Claims. The first report must be submitted within thirty (30) calendar days of the end of the second quarter of the Contract year to allow for thirty (30) days of runout (i.e., by January 30). The second report must be submitted within four (4) months following the end of the fourth quarter to allow for one hundred and twenty (120) days of runout and to ensure reasonable time for outstanding physician and outpatient Hospital Claims (i.e., by October 30). OHCA will review the amounts reported semi-annually and provide notice to each Contractor if additional information is required. OHCA will reimburse the pharmacy stop loss Claims to each Contractor on the total Contractor- and Enrollee-level NDC-based claims exceeding $500,000 twice per year following report submission and approval.
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> All pharmacy stop loss Claims are subject to medical review by OHCA. OHCA also reserves the right to perform Audits on pharmacy stop loss Claims. Terms of the Audit process will be disclosed prior to implementation of the Audits, providing the Contractor with appropriate advance notice.

Section 1.7.7.1 Handling Enrollee Requests for NEMT

Effective July 1, 2026, Section 1.7.7.1 shall be revised in its entirety as follows:

> The Contractor shall operate a reservation system for Enrollees to schedule NEMT services via the following modes, at minimum:
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> a. Toll-free telephone line;
>
> b. Email;

c. Website; and

d. Mobile application.

The Contractor shall ensure the availability of NEMT, at minimum, from 8:00 am to 8:00 pm Central Time, Monday through Saturday.

Section 1.7.7.2 NEMT Covered Services

Effective July 1, 2026, Section 1.7.7.2 shall be revised in its entirety as follows: t

Contractor shall provide NEMT to Enrollees to access all SoonerCare covered services in accordance with 42 C.F.R. § 440.170. Contractors are required to ensure necessary transportation and to use the most appropriate form of transportation for the Enrollee. This includes all benefits for which the Contractor is responsible, as well as benefits which are covered by SoonerCare but not the responsibility of the Contractor as outlined in Section 1.7.4: "Excluded Benefits" of this Contract. NEMT services shall be provided to children and their families as part of Medicaid's EPSDT benefit in accordance with State Health Official (SHO) Letter, 24-005 Section I.ii, including transportation of a parent, family member, or caregiver of Enrollees under the age of 21 when the Enrollee is receiving residential or facility based care and the presence of the parent, family member, or caregiver is necessary so that they can actively participate in the treatment for the direct benefit of the child. A Contractor, at its sole discretion, may offer additional NEMT services as a Value-Added Benefit

Section 1.7.7.4 NEMT Modes of Transportation

Effective July 1, 2026, Section 1.7.7.4 shall be revised as follows:

Following the paragraph that states "*The Contractor shall provide ...*" and ending with "*Minimum available modes of transportation shall include*:" a new bulleted "g" is added. No items are being deleted.

g. Contractor may only use specialized "medical" programs offered by Transportation Network Companies (TNCs) for Enrollees who do not require special assistance. Any use of TNCs must comply with Section 1902(a)(87) of the Social Security Act, including all federal requirements related to provider exclusions, licensure, drug-related violations, and required disclosures. This provision does not authorize or require the use of TNCs and applies only if the Contractor elects to utilize a TNC in the future.

The remaining language of Section 1.7.7.4 remains unchanged.

Section 1.7.7.5 NEMT Pick-Up and Drop-Off Times

Effective July 1, 2026, the following requirement is added to the end of this section in accordance with CMS guidance and OHCA direction:

Contractor must allow for pick up locations from the Enrollees' home, other locations where the Enrollee is residing or receiving medically necessary services, schools, or other service or facility locations. Special consideration and flexibilities shall be given to meet specific and special population needs including in the event of disaster or emergency, for Enrollees who are unhoused or housing insecure, and to meet the unique needs of tribal organizations.

The remaining language of Section 1.7.7.5 remains unchanged.

ADD NEW Section 1.7.9.1 Aetna Better Health of Oklahoma's In Lieu Of Services – Intensive

Outpatient Program (IOP)

The following language will be added under a new section titled "*Section 1.7.9.1 Aetna Better Health of Oklahoma's In Lieu of Services – Intensive Outpatient Program (IOP)*":

The Contractor shall offer mental health (MH) Intensive Outpatient Program (IOP) services as an In Lieu of Service (ILOS) for Enrollees requiring structured, non-residential mental health treatment that exceeds traditional outpatient care. This ILOS is designed for ongoing, step-down care for individuals who need more support than traditional outpatient mental health treatment but does not require full-time supervision or hospitalization. This ILOS is intended to expand access to medically necessary behavioral health services not currently covered under the State Plan and is implemented pursuant to 42 CFR § 438.3(e)(2).

A. Service Description

The Contractor's IOP ILOS provides structured behavioral health treatment for several hours per day, several days per week, while allowing participants to live at home and maintain daily routines. This is less intensive than inpatient care and Partial Hospitalization Program (PHP), and more intensive than standard outpatient therapy. Unlike the emergency room, which is for acute crises and immediate stabilization, this ILOS is designed for ongoing, step-down care for individuals who need more support than traditional outpatient but do not require full-time supervision or hospitalization.

B. Eligible Enrollee Population

This ILOS is available for a range of age groups depending on the provider's structure and clinical focus. The key is age-appropriateness depending on the specific program's staffing, therapeutic modalities, and ability to meet developmental needs. The Contractor's ILOS will cover Enrollees ages 5 and older.

It is available for Enrollees who require a higher level of behavioral health care and meet clinical criteria for intensive outpatient treatment, including, but not limited to:

- Enrollees needing more structured alternative to outpatient therapy
- Children/adolescents who require services between PHP and day treatment levels of care

C. Service Specifications

- The codes, code descriptions and rates are denoted below:

Procedure Code	Service Description	Rates	Frequency Allowed	Billing Requirements
S9480	Intensive Outpatient Psychiatric Services, Per Diem	$165 per day	May be billed daily up to three (3) days per week.	**CMS 1500**: Rev code 0905 (MH) and/or 0906 (SUD) are not required. **UB**: Rev code 0905 (MH) or
H0015	Intensive Outpatient			

	Psychiatric Services, SUD, Per Diem			0906 (SUD) required in addition to procedure code S9480 or H0015

- **Age Limits**: 5 and older
- **Program Requirements:** Provide a minimum of 3 hours per day of treatment, 3 days a week. Available Monday through Friday. Must follow an individualized treatment plan.
- **Statewideness**: Services will be available statewide with no geographic or demographic limitations if the member meets medical necessity criteria for the ILOS.
- **Prior Authorization**: Prior Authorization is required using medical necessity criteria per MCG and based on an episode of care. The initial authorization will be for 18 units over a six-week period and then subject to Medical Director review after 3 months of consecutive treatment.
- **Provider Types**:
    - Community Mental Health Centers
    - Community behavioral health providers
    - Freestanding inpatient psychiatric facilities (delivering outpatient services)
    - Substance Use Disorder (SUD) treatment providers/programs

D. Reporting Requirements

- The Contractor shall submit reporting to OHCA, in a format and manner as defined in the SoonerSelect Reporting Manual, that includes, at a minimum:
    - Number of Enrollees authorized and served under this ILOS
    - Utilization by procedure code
    - Clinical outcomes and Enrollee feedback (as available)
    - Estimated cost savings and comparative analysis versus equivalent covered State Plan services.

Section 1.7.12 School-Based Services

Section 1.7.12 shall be revised as follows:

The last paragraph of this section is deleted and replaced as follows:

School-based services shall not be implemented into the SoonerSelect Program until July 1, 2027.

> Until implementation is complete, school-based services shall continue to be processed and reimbursed directly through OHCA in accordance with existing reimbursement practices. Beginning July 1, 2027, Contractor shall reimburse OHCA-enrolled qualified school providers for covered school-based services.

The remaining language and standards in Section 1.7.12 shall remain unchanged.

Section 1.7.12.1 SoonerStart

Section 1.7.12.1 shall be revised as follows:

The last paragraph of this section is deleted and replaced as follows:

> SoonerStart services shall not be implemented into the SoonerSelect Program until July 1, 2027. Until implementation is complete, SoonerStart services shall continue to be processed and reimbursed through OHCA in accordance with current reimbursement practices. Beginning July 1, 2027, Contractor shall reimburse OHCA-enrolled SoonerStart providers for covered services.

All remaining language and standards in Section 1.7.12.1 shall remain unchanged.

Section 1.8.6.3 Timeliness Standards

Section 1.8.6.3, under the Standard Authorizations header, shall be revised as follows:

The paragraph beginning with '*The Contractor shall decide…*' and ending with '*…to make a determination on the Prior Authorization*' shall be replaced as follows:

> In accordance with 42 CFR § 438.210 and 56 O.S. §4002.6, the Contractor shall decide standard Prior Authorization requests as expeditiously as the SoonerSelect Enrollee's health requires and in no event later than seven (7) calendar days after receipt of the request for service.

The paragraph beginning with '*If the Contractor fails to decide the Standard Prior Authorization . . .*' and ending with ". . . *the Prior Authorization is automatically deemed approved.*" shall be replaced as follows:

> If the Contractor fails to decide the Standard Prior Authorization within seven (7) calendar day timeframe, the Prior Authorization is automatically deemed approved pursuant to Section 1.8.6.3.1 "Deemed Authorized Services" in this Contract,

A new paragraph is added under the Standard Authorizations section as follows:

> If an extension is granted that is not requested by the Enrollee, the Contractor shall provide the Enrollee with a written explanation and information on how to file an Appeal unless the extension does not exceed forty-eight (48) hours beyond the initial seven (7)-day timeframe. Once an extension exceeds forty-eight (48) hours beyond the initial timeframe, the Contractor must issue the required written notice.

The remaining language of Section 1.8.6.3, under the Standard Authorizations header, remains unchanged.

Section 1.8.6.3, under the Expedited Authorizations header, shall be revised as follows:

The paragraph beginning with '*If the Provider indicates…*' and ending with '*…to make a determination on the Prior Authorization*' shall be replaced as follows:

> In accordance with 42 CFR § 438.210 and 56 O.S. §4002.6, if the Provider indicates or if the Contractor is aware that the Enrollee has a need for urgent health care services and that adhering to the standard seven (7) Calendar Day timeframe could jeopardize the Enrollee's life, health or ability to attain, maintain, or gain maximum function, the Contractor shall decide the Prior Authorization for relevant services as expeditiously as necessary and in no event later than seventy-two (72) hours after the receipt of the request for service.

The paragraph beginning with '*If the Contractor fails to decide the Expedited Prior Authorization . . .*' and ending with ". . . *the Prior Authorization is automatically deemed approved.*" shall be replaced as follows:

> If the Contractor fails to decide the Expedited Prior Authorization within seventy-two (72) hour timeframe, the Prior Authorization is automatically deemed approved pursuant to Section 1.8.6.3.1 "Deemed Authorized Services" in this Contract,

The paragraph beginning with '*No extensions are permitted for Expedited Authorizations…*' shall be replaced as follows:

> No extensions are permitted for Expedited Prior Authorizations except as required to comply with 56 O.S. §4002.6 and federal regulations. If an extension is granted that is not requested by the Enrollee, the Contractor shall provide written notice unless the extension does not exceed forty-eight (48) hours beyond the initial seventy-two (72)-hour timeframe. Once an extension exceeds forty-eight (48) hours beyond the initial timeframe, the Contractor must issue the required written notice.

Additionally, the paragraph beginning with '*Prior Authorizations for covered prescription drugs…*' and ending with '*…to make a determination on the Prior Authorization*' shall be replaced as follows:

> Prior Authorizations for covered prescription drugs shall be considered Expedited Prior Authorizations for the purposes of Section 1.8.6.3, but instead of the regular seventy-two (72) hour timeframe for Expedited Prior Authorizations, Contractor must decide Prior Authorizations for covered prescription drugs within twenty-four (24) hours after receipt of the request for service.

The remaining language of Section 1.8.6.3, under the Expedited Authorizations header, remains unchanged.

ADD NEW Section 1.8.6.3.1 Deemed Authorized Services

The following language will be added under a new section titled "*Section 1.8.6.3.1 Deemed Authorized Services)*":

> When a Provider submits all required information for a Prior Authorization request and the Contractor fails to make an authorization decision within the applicable statutory or contractual timeframe, the requested service shall be deemed authorized in accordance with 56 O.S. § 4002.6(E)(2).
>
> For services that are automatically deemed authorized, the Contractor shall:

a. Provide notice to the Enrollee indicating the approval was granted due to applicable timeliness requirements and not based on a clinical review, using the OHCA issued model template.

b. Conduct a retrospective medical necessity review within seven (7) Calendar Days of the automatically deemed approval. The Contractor must document the retrospective medical necessity review outcome, including all clinical rational supporting the determination within the Enrollee's record.

    i. If the retrospective review determines the Enrollee does not meet criteria for continued services, the Contractor must issue a separate notice to the Enrollee, inclusive of all appeal rights, in accordance with Sections 1.18.6.6 Prior Authorization Denial or Limitation and 1.18.6.7 Expedited Prior Authorization Denial of this Contract.

    ii. If the retrospective review determines the service was not medically necessary, the Contractor must identify any claims that were processed and paid for under as a deemed authorized service. The Contractor shall report these associated expenditures in the appropriate section of the Medical Loss Ratio (MLR) report in accordance with the requirements outlined in the SoonerSelect Reporting Manal and applicable report templates. The Contractor may not recoup payments made for services that were rendered prior to issuance of Adverse Benefit Determination following retrospective review.

c. Comply with all reporting requirements or guidance issued by OHCA related to deemed authorizations.

Section 1.8.6.7 Authorization Denials and Peer-to-Peer Review

Section 1.8.6.7 shall be revised in its entirety as follows:

> In accordance with 42 C.F.R. § 438.210(b)(3), any decision to deny a Prior Authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by an individual who has appropriate clinical expertise in addressing the Enrollee's medical or behavioral health needs.
>
> The Contractor shall permit Providers to request a peer-to-peer review for all Prior Authorization denials or authorizations in an amount, duration, or scope less than requested. The Contractor shall provide a prompt opportunity for peer-to-peer conversations with licensed clinical staff of the same or similar specialty relevant to the Enrollee's clinical needs, which shall include, but not be limited to, Oklahoma-licensed clinical staff in accordance with Section 1.8.6.7.1: "Peer-to-Peer Review Requirements"; and establish uniform rules for Medicaid Provider or Enrollee Appeals across all Contractors in accordance with Section 1.18.6: "Adverse Benefit Determinations."

ADD NEW Section 1.8.6.7.1 Peer-to-Peer Review Requirements

The following new subsection is added:

> In accordance with Section 1.8.6.7 "Authorization Denials and Peer-to-Peer Review" of this Contract, Contractor shall permit Providers to request a peer-to-peer review for all Prior Authorization denials or authorizations in an amount, duration, or scope less than requested. Contractor shall make reasonable efforts to contact the requesting Provider to schedule a peer-to-peer review within twenty-four (24) hours of the provider's request. The twenty-four (24) hour

timeframe to schedule a peer-to-peer review begins at the time the requesting Provider initiates the request for peer-to-peer review, not at the time the adverse determination is issued.

The Contractor shall document the good faith attempt to contact the requesting Provider within the twenty-four (24) hour timeframe to schedule the peer-to-peer review. Documentation shall include, but not be limited to, the date and time of each outreach attempt, and the outcome of each attempt. All associated documentation should be maintained within the Contractor's record for the requesting Provider and be made available to OHCA, upon request.

Section 1.9 Care Management and Population Health

Section 1.9 shall be revised as follows:

The following paragraphs are added to the start of this section, before the existing language:

The Contractor shall conduct care management activities necessary to address the clinical and social needs of Enrollees in accordance with this Contract and as otherwise required by OHCA. This includes the provision of additional care management services and targeted programs identified by OHCA to address the needs of specific populations. Such programs may include, but are not limited to, Targeted Case Management services for Justice-Involved Youth (JIY) transitioning from incarceration.

Such programs shall include, but are not limited to, coordination of services for JIY in accordance with Section 5121 of the Consolidated Appropriations Act (CAA) of 2023, including pre-release and post-release care coordination activities in accordance with Section 1.9.8 of this Contract.

Following the paragraph that begins with '*The Contractor shall assign every Enrollee to a risk level…*' and ending with '*…shall consider factors such as*', a new bulleted item 'g' is added. No items are being deleted.

g. Justice-Involved Youth (JIY) Reconnect

The remaining language and standards in Section 1.9 shall remain unchanged.

ADD NEW Section 1.9.8 Targeted Case Management (TCM) for Justice-Involved Youth (JIY)

The following language will be added under a new section titled "*Section 1.9.8: Targeted Case Management (TCM) for Justice-Involved Youth (JIY)*":

The Contractor shall support the delivery and coordination of Targeted Case Management (TCM) services for JIY as directed by OHCA.

JIY are individuals under the age of twenty-one (21), or former foster youth up to age twenty-six (26), who are transitioning from a carceral setting and are eligible for Medicaid services, including those within thirty (30) days prior to or following release.

The Contractor shall coordinate with OHCA, juvenile justice entities, and designated case management providers to ensure appropriate care coordination following the youth's release.

Responsibilities include, but are not limited to:

a. Coordination of care management services following enrollment into the SoonerSelect program;

b. Collaboration with designated TCM providers responsible for initial assessments and care plan development;

c. Coordination of medical, behavioral health, and social service needs identified through the care management process;

d. Ensuring continuity of care for existing services initiated prior to release from incarceration, including school based service needs; and

e. Participation in reporting activities and data sharing processes as required by OHCA.

The Contractor shall ensure staff involved in care management activities for JIY Members receive training on justice-involved populations, trauma-informed care, adolescent development, behavioral health and substance use disorders, and coordination with justice and community partners.

The Contractor shall:

a. Receive and incorporate pre-release screening, diagnostic, and care planning information provided by OHCA and/or designated partners into Contractor care management systems;

b. Coordinate with OHCA and designated TCM providers or partner agencies to support transition planning and care coordination activities;

c. Ensure Contractor care management activities do not duplicate TCM services reimbursed under the Medicaid State Plan;

d. Participate in interdisciplinary case coordination activities, as requested by OHCA;

e. Assign a designated care coordinator within a timeframe established by OHCA upon notification of a JIY Member or release from a carceral setting;

f. Initiate care coordination activities upon notification and adjust activities in response to updated or revised release dates;

g. Ensure no interruption in access to medically necessary services following release, including medications, behavioral health, primary care, dental, and specialty services; and

h. Honor pre-release care plans and scheduled services unless modification is clinically necessary, with appropriate documentation and communication to all relevant parties.

Section 1.10.1 TOC General Provisions

Section 1.10.1 shall be revised as follows:

The following paragraph will be added at the end of this section:

> The Contractor shall support continuity of care for Enrollees transitioning from carceral facilities, including juveniles released from detention or correctional settings, in accordance with the requirements of Section 5121 of the Consolidated Appropriations Act (CAA) of 2023, applicable state policy, and CMS State Health Official guidance (State Health Official Letter #23-004), including coordination of dental services, as specified in Section 1.10.12.1: "Transitions Between Other Settings for Justice-Involved Youth (JIY)" of this Contract.

The remaining language and standards in Section 1.10.1 shall remain unchanged.

ADD NEW Section 1.10.3.1 Transition of Care Authorizations Upon Return to OHCA

The following language will be added under a new section titled "*Section 1.10.3.1 Transition of Care Authorizations Upon Return to OHCA*":

> When an Enrollee transitions from a Contractor back to coverage administered directly by OHCA, OHCA shall grant a ninety (90) day transition period during which previously authorized services may continue without additional medical necessity determination, consistent with applicable federal and state transition of care requirements.
>
> If, at the time the Enrollee returns to OHCA, the Enrollee is already receiving services under a ninety (90) day transition of care authorization issued by a Contractor, OHCA shall honor such authorization for a period of up to thirty (30) days from the effective date of the Enrollee's return to OHCA.
>
> This thirty (30) day continuity period is intended to serve as a short-term bridge to ensure uninterrupted care while permitting OHCA to complete and required medical necessity review based on existing authorization records and documentation.
>
> In rare or unique eligibility circumstances not expressly contemplated by this section, OHCA shall determine the appropriate transition of care coverage on a case by case basis, consistent with state and federal law and in a manner that avoids unnecessary disruption of medically necessary services.

Section 1.10.5 Transitions Between Managed Care Entities and Between OHCA and CEs

Section 1.10.5 shall be revised as follows:

The Section title shall be replaced with the following:

> **Section 1.10.5 Transitions Between Contracted Entities (CEs) and Between OHCA and Contractor**

The first paragraph of Section 1.10.5 is hereby replaced in its entirety with the following:

> When an Enrollee transitions from another Contracted Entity (CE) to Contractor, or from Contractor to OHCA, the receiving Contractor and/or OHCA shall be responsible for requesting from the surrendering CE any data necessary to facilitate a seamless transition of care. Such data shall include, but not be limited to, Health Risk Screening results, comprehensive assessments, Care Plans, utilization data, and Provider information. When Contractor receives requests from another CE and/or OHCA for transition-related information regarding a former Enrollee, Contractor shall transmit such information within five (5) Days for data available electronically and within thirty (30) Days for data not stored electronically.

The language in the header of the chart contained in Section 1.10.5 is hereby replaced with the following:

Scenario (Enrollment on Effective Date)	Inpatient Facility and Professional Charges Provided Within Licensed Facility (DRG Hospitals Only)	All Other Covered Services on Effective Date of Enrollment

The remaining language and requirements of Section 1.10.5 shall remain unchanged.

ADD NEW Section 1.10.12.1 Transitions Between Other Settings for Justice-Involved Youth (JIY)

The following language will be added under a new section titled "*Section 1.10.12.1 Transitions Between Other Settings for Justice-Involved Youth (JIY)*":

The Contractor shall support transition of care processes for JIY who become enrolled in the SoonerSelect program following release from incarceration. The Contractor shall ensure a coordinated transition between pre-release case management activities and post-release care management services.

Responsibilities include, but are not limited to:

a. Coordination with OHCA and SoonerSelect Dental Contractors and designated case management providers involved in pre-release planning;
b. Coordination with Reconnect partner agencies, as applicable;
c. Establishing a warm hand-off process between pre-release case management staff and the Contractor's care management team;
d. Ensuring outreach to newly enrolled JIY Enrollees within a timeframe established by OHCA following release, and continuing outreach using multiple modalities as appropriate;
e. Facilitating access to medically necessary physical health, behavioral health, and social support services;
f. Ensuring continuity of medications and previously authorized services when clinically appropriate;
g. Ensuring continuity of care from incarceration to a school-based setting; and
h. Transition of care activities shall align with OHCA enrollment policies and the standard SoonerSelect enrollment timeline consistent with Section 1.6.3 'Enrollment Effective Date' of this Contract.

The Contractor shall participate in OHCA-approved data sharing, reporting, and monitoring activities related to JIY transitions, including those required for CMS evaluation and oversight. The Contractor shall support and document completion of warm handoff activities, which include, but are not limited to:

a. Provider-to-provider communication
b. Confirmation of scheduled services and appointments
c. Member engagement with receiving providers

The Contractor shall adjust care coordination and transition activities in response to updated or revised release dates and reinitiate transition workflows as necessary.

Section 1.11.6 Performance Improvement Projects (PIPs)

Section 1.11.6 shall be revised as follows:

The paragraph beginning with '*Contractors are required to…*' and ending with '*…All PIPs are subject to final approval by OHCA.*' shall be replaced with the following:

> Contractors are required to conduct at least three (3) PIPs annually. For Rating Period One (1), the Contractor shall propose, subject to OHCA's approval, one (1) non-clinical, and two (2) clinical PIPs: one (1) that addresses physical health and one (1) that addresses behavioral health. In subsequent years, PIP topics may be identified by CMS, the Contractor, or OHCA. All PIPs are subject to final approval by OHCA. PIPs may be active for up to three (3) years. An active PIP in continuation from a previous year will be counted towards satisfying the required number of conducted PIPs each year.

All remaining language in Section 1.11.6 shall remain unchanged.

Section 1.12.6 Enrollee ID Card

Section 1.12.6 shall be revised as follows:

The paragraph beginning with '*The Contractor shall distribute…*' and ending with '*…such as durable laminated paper.*' shall be replaced with the following:

> The Contractor shall distribute an Enrollee ID card to each Enrollee in a household within seven (7) Days of receiving the ANSI ASC X 12 834 electronic transactions from OHCA. Contractors must comply with Section 1.12.3.5 'Distribution Guidelines' of this Contract, including all requirements that must be met for the Contractor to utilize electronic delivery of required materials. When/if the Contractor provides a physical ID card at the initial distribution, the Contractor must provide the Enrollee the option to receive an electronic ID card. Physical ID cards must be made out of durable material suitable for everyday use, such as durable laminated paper.

All remaining language in Section 1.12.6 shall remain unchanged.

Section 1.16.1.1 Participating Provider Payment

Section 1.16.1.1 shall be revised as follows:

The paragraph beginning with: "*The Contractor shall ensure that rates…*"and ending with "*…value-based payment arrangements or other alternative payment agreements.*" is hereby replaced in its entirety with the following:

> The Contractor shall ensure that rates for Participating Providers are reasonable to ensure Enrollee access to services, specified at Section 1.14.3: "Time and Distance and Appointment Access Standards" of this Contract, and that they comply with all State and federal provisions regarding rate setting. Pursuant to 56 O.S. § 4002.12, until July 1, 2027, Contractor must adopt the OHCA-established fee schedule at one hundred percent (100%) of the rate in effect at the time the service was rendered as the minimum reimbursement rate for Participating Providers who have not entered into value-based payment arrangements or other alternative payment agreements.

All remaining language and requirements of Section 1.16.1.1 remain unchanged.

Section 1.16.1.12 Value-Based Payments

Section 1.16.1.12 shall be revised as follows:

The table titled '*VBP Target Requires by Contract Year*' is replaced in its entirety as follows:

VBP Target Requires by Contract Year

Contract Year	VBP Target Requirement
1. Apr 2024 - Jun 2025	No VBP Requirement
2. Jul 2025 - Jun 2026	20% of total medical provider payments made under the Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Model (APM) Category 2B (Pay for Reporting) or higher
3. Jul 2026 - Jun 2027	25% of total medical provider payments made under the Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Model (APM) Category 2B (Pay for Reporting) or higher, with at least 50% of the 25% made under APM Category 2C (Pay for Performance)
4. Jul 2027 - Jun 2028	35% of total medical provider payments made under the Health Care Payment Learning & Action Network (HCPLAN) Alternative Payment Model (APM) Category 2B (Pay for Reporting) or higher, with at least 50% of the 35% made under APM Category 2C (Pay for Performance)
5. Jul 2028 - Jun 2029	TBD
6. Jul 2029 - Jun 2030	TBD

The paragraph beginning with: "*The VBP targets will be calculated…*"and ending with:"*… partial compliance with the VBP targets.*" is hereby replaced in its entirety with the following:

> The VBP targets will be calculated using a numerator consisting of total payments made by the Contractor to Participating Providers under VBP Contracts with the relevant APM Categories and a denominator consisting of all Participating Provider payments. Pharmacy provider payments will be excluded from the calculation. The Contractor shall be eligible to earn a portion of the withhold if it demonstrates to OHCA's satisfaction, partial compliance with the VBP targets.

All remaining language and requirements of Section 1.16.1.12 remain unchanged.

Section 1.16.1.12.4.7 Provider Incentive Pool

Section 1.16.1.12.4.7 shall be revised as follows:

The paragraph that begins with '*Each quarter OHCA will…*' and ending with '*…for this payment arrangement*' shall be replaced as follows beginning January 1, 2026:

> On a bi-monthly basis, OHCA will calculate directed payments for all encounters incurred from the start of the managed care rating period through the end of the prior 2-month period, less any directed payments previously calculated for prior periods in the managed care rating period. For each class of eligible professionals, OHCA will calculate a uniform $25 dollar increase for targeted services including Well Visits, After Hours Care, and Screening, Brief Intervention and Referral to Treatment (SBIRT). OHCA will also calculate a uniform percentage increase to base managed care plan payments for professional services. Relevant information for this payment arrangement:

Item ‘e’ within this section shall be replaced in its entirety as follows:

> Every 2 months OHCA will calculate the enhanced payments for encounters incurred. After the provider-level calculations have been completed for the a given period, OHCA will make payments to plans so that plans can make payments to Qualified Providers.

All remaining language and requirements of Section 1.16.1.12.4.7 remain unchanged.

Section 1.18.6.1 General Requirements

Section 1.18.6.1 shall be revised as follows:

The following paragraph shall be added at the end of this section as follows:

> An automatic authorization on a deemed authorized service in accordance with Section 1.8.6.3.1 “Deemed Authorized Services” of this Contract, resulting from Contractor’s failure to meet applicable Prior Authorization (PA) timeliness requirements outlined in Section 1.8.6.3 “Timeliness Standards” of this Contract shall not constitute an Adverse Benefit Determination.

All remaining language and requirements of Section 1.18.6.1 remain unchanged.

Section 1.18.6.6 Prior Authorization Denial or Limitation

Section 1.18.6.6 shall be replaced in its entirety as follows:

> In accordance with 42 C.F.R. §§ 438.404(c)(3) and 438.210(d)(1), when the action for which the notice of Adverse Benefit Determination is being provided is a “Standard authorization decision” under 42 C.F.R. § 438.210(d)(1) to deny or limit services, the Contractor shall provide notice to the Enrollee as expeditiously as the Enrollee's condition requires no later than seven (7) Calendar Days after receipt of the request for service. Following any extension granted under Section 1.8.6.3 of this Contract, the Contractor may extend the notice timeframe to the end of the extension timeframe granted under Section 1.8.6.3 if:
>
> - The Enrollee or Provider acting as the Authorized Representative of the Enrollee requests an extension; or
>
> - The Contractor, if OHCA requests justification, demonstrates a need for additional information and how the extension is in the Enrollee’s interest.

Section 1.18.6.7 Expedited Prior Authorization Denial

Section 1.18.6.7 shall be replaced in its entirety as follows:

> In accordance with 42 C.F.R. §§ 438.404(c)(6) and 438.210(d)(2), when the action for which the notice of Adverse Benefit Determination is being provided is an “Expedited authorization decision” under 42 C.F.R. § 438.210(d)(2) to deny or limit services or is an Adverse Benefit Determination made on a Prior Authorization listed as an Expedited Prior Authorization under Section 1.8.6.3 of this Contract, the Contractor shall provide notice to the Enrollee as expeditiously as the Enrollee's condition requires and no later than seventy-two (72) hours after receipt of the request for service or no later than twenty-four (24) hours after receipt of the request for service depending on the decision timeframe permitted in Section 1.8.6.3 of the Contract.

Section 1.18.6.8 Untimely Prior Authorization Decisions

Section 1.18.6.8 shall be replaced in its entirety as follows:

When Prior Authorization decisions are not reached within the applicable timeframes for either Standard Prior Authorizations or Expedited Prior Authorizations, the Prior Authorization is automatically deemed approved in accordance with 56 O.S. § 4002.6(E)(2). The Contractor shall give notice of a request for authorization that has been deemed approved on the date that the timeframe expires. When a Prior Authorization is automatically approved because the decision was untimely, Contractor shall follow the processes and standards in Section 1.8.6.3.1 "Deemed Authorized Services" of this Contract.

Section 1.18.8.4 Contractor State Fair Hearing Support

Section 1.18.8.4 shall be replaced in its entirety as follows:

The Contractor shall ensure that it is represented at all State Fair Hearings before the OHCA Administrative Court by legal counsel licensed to practice law in the State of Oklahoma. Legal counsel shall be responsible for preparation and submission of required documentation, participation in hearings, and coordination with OHCA and the Office of Administrative Hearings.

In addition to legal representation, the Contractor shall maintain a sufficient level of trained staff to provide support in the State Fair Hearing process, including all of the following, at minimum:

a. The Contractor shall provide OHCA with a summary setting forth the following information:

    i. Name and address of the Enrollee, which includes the Enrollee's Authorized Representative, if applicable;

    ii. A summary statement concerning why the Enrollee is filing a request for a State Fair Hearing;

    iii. A brief chronological summary of the Contractor's action in relationship to the Enrollee's request for a State Fair Hearing;

    iv. A statement of the basis of the Contractor's decision;

    v. A citation of the applicable policies relied upon by the Contractor;

    vi. A copy of the notice which notified Enrollee of the decision in question;

    vii. Any applicable correspondence; and

    viii. The name and title of the Contractor's staff who will serve as witnesses at the State Fair Hearing.

b. Ensuring complete and accurate submission of the required State Fair Hearing summary and evidence packet within fifteen (15) Calendar Days of notification of the request for a State Fair Hearing, in accordance with OAC 317:2-3-12(d).

c. Summarizing the arguments presented by the Enrollee, which includes the Enrollee's Authorized Representative, if applicable, and the Contractor in summaries for State Fair Hearings to ensure the dispute and actions by the Enrollee and Contractor are clearly identified. The Contractor shall state the legal basis upon which any dismissal requests are based and include regulations or statutes in support, at minimum, meeting the regulations at 42 C.F.R. § 431.244.

d. Ensuring timely delivery to the Enrollee, which includes the Enrollee's Authorized Representative, if applicable, OHCA, and the Office of Administrative Hearings of State Fair Hearing documentation, as required.

OHCA reserves the right to amend or modify the Contractor State Fair Hearing responsibilities within the confines of the federal regulations, including setting performance targets for State Fair Hearing requests that are resolved upholding the Contractor's original determination, as it deems necessary and appropriate under this Contract.

Section 1.21.7.4 Timeliness Remediation

Section 1.21.7.4 is hereby replaced in its entirety with the following:

Within sixty (60) Days of receipt of notice by OHCA of encounters being denied or rejected, the Contractor must accurately resubmit ninety-five (95%) of all encounters.

Section 1.22.6 Medical Loss Ratio

Section 1.22.6 is updated as follows:

Following the paragraph that begins with '*The Contractor shall calculate and report…*' and ending with '*…the following methodology*', a new bulleted item 'c' is added. The bulleted item currently marked 'c.' in the Contract prior to this Amendment will be marked 'd.' with all subsequent bulleted items being updated accordingly. No bulleted items are deleted.

c. Enrollee-level drug expenses above $500,000 shall not be included in the MLR calculation.

The remaining language and requirements of Section 1.22.6 shall remain unchanged.

Section 1.23.1.10 Covered Benefits Reports

Section 1.23.1.10 shall be revised as follows:

A new reporting requirement is added after the paragraph '*i. Immunization: Data matching and Validation with OSIIS.'* as follows:

j. Pharmacy Stop Loss Program: Semi-annual report on Enrollees whose prescription drug costs have exceeded the $500,000 attachment point during the contract year.

All remaining language and requirements of Section 1.23.1.10 remain unchanged.

Appendix 1A: Acronyms

The following acronyms shall be added to Appendix 1A:

CAA – Consolidated Appropriations Act

FCS – Family Centered Services

JIY – Justice Involved Youth

SHO – State Health Official

TNC – Transportation Network Companies

Appendix 1C: Quality Performance Withhold Program

Appendix 1C shall be revised as follows:

The following language replaces all content under Subsection 4 titled '*SoonerSelect Program Performance Measures*:

> The Contractor shall be responsible for reporting on the applicable CMS Core Set quality measures from the following domains: Primary Care Access & Preventive Care, Maternal & Perinatal Health, Care of Acute and Chronic Conditions**,** and Behavioral Health Care. Dental and Oral Health Services should also be reported for measures where Oral Health Servies metrics apply. A list of the CMS Core Set quality measures can be found here (Child and Adult Health Care Quality Measures | Medicaid)[1].

The following language replaces all content under Subsection 5 titled '*Outcome Measures and Payment Structure*':

> During the first Contract Rating Period, the Contractor shall not be subject to a Performance Withhold and shall put in place all required quality programs, PIPs, and reporting. The Contractor shall have a Performance Withold in Contract Year 2 (see Subsection 2: "Quality Performance Withhold " of this Appendix). Calendar year 2025 will be used as the performance measurement baseline year. Withhold payment opportunities have been established based on OHCA priority areas.
>
> For Quality Withhold Measures reported by Quality Compass, the Contractor shall earn Quality Withholds back by meeting Annual Target Criteria for each measure, as determined by either of the following:
>
> a. *Improvement:* Delivering a two (2) percentage point improvement over the Contractor's previous year performance; or
> b. *Benchmark*: Meeting the NCQA's Quality Compass HEDIS 2026 (MY2025) 50th percentile benchmark for Managed Medicaid Plans.
>
> For Quality Withhold Measures for which NCQA is not a measure steward and those for which NCQA is a measure steward but are not reported by Quality Compass for Managed Medicaid Plans, the Contractor shall earn Quality Withholds back by:

[1] https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-and-child-health-care-quality-measures

a. *Improvement:* Delivering a two (2) percentage point improvement over the Contractor's previous year performance.

Quality Withhold Amounts and Criteria

#	Performance Measure	Sub Measure(s)	Measurement Set/Source	Amount of Capitation Quality Withhold	CY 2025 Baseline Rate	Annual Target Criteria
1a	Well-Child Visits in the First 30 Months of Life (W30-CH)	Well-Child Visits in the First 15 Months. Children who turned 15 months during the measurement year: Six or more well-child visits	CMS Child Core Set	Five and a half percent (5.5%) of total capitation quality withhold.	TBD	Two (2) Percentage Points Improvement or meet the NCQA's Quality Compass HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed Medicaid Plans
1b	Well-Child Visits in the First 30 Months of Life (W30-CH)	Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months during the measurement year: Two or more well child visits	CMS Child Core Set	Five and a half percent (5.5%) of total capitation quality withhold.	TBD	Two (2) Percentage Points Improvement or meet the NCQA's Quality Compass HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed Medicaid Plans
2	Screening for Depression and Follow-up Plan: Ages 12-17 (CDF-CH) (CMS #672)	Total Rate	CMS Child Core Set	11 percent (11%) of total capitation quality withhold	TBD	Two (2) Percentage Point Improvement
3	Child and Adolescent Well Child Visits (WCV-CH)	Total Rate	CMS Child Core Set	11 percent (11%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement or meet the NCQA's Quality Compass

#	Performance Measure	Sub Measure(s)	Measurement Set/Source	Amount of Capitation Quality Withhold	CY 2025 Baseline Rate	Annual Target Criteria
						HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed Medicaid Plans
4a	Prenatal and Postpartum Care: Under Age 21 (PPC02-CH)	Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment	CMS Child Core Set	Two and three-quarter percent (2.75%) of total capitation quality withhold.	TBD	Two (2) Percentage Point Improvement
4b	Prenatal and Postpartum Care: Under Age 21 (PPC02-CH)	Postpartum Care: Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery	CMS Child Core Set	Two and three-quarter percent (2.75%) of total capitation quality withhold.	TBD	Two (2) Percentage Point Improvement
5a	Prenatal and Postpartum Care: Age 21 and Older (PPC02-AD)	Timeliness of Prenatal Care: Percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment	CMS Adult Core Set	Two and three-quarter percent (2.75%) of total capitation quality withhold.	TBD	Two (2) Percentage Point Improvement
5b	Prenatal and Postpartum Care: Age 21 and Older (PPC02-AD)	Percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.	CMS Adult Core Set	Two and three-quarter percent (2.75%) of total capitation	TBD	Two (2) Percentage Point Improvement

#	Performance Measure	Sub Measure(s)	Measurement Set/Source	Amount of Capitation Quality Withhold	CY 2025 Baseline Rate	Annual Target Criteria
				quality withhold.		
6	Controlling High Blood Pressure (CBP-AD)	Total Rate	CMS Adult Core Set	11 percent (11%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement or meet the NCQA's Quality Compass HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed Medicaid Plans
7	Adults' Access to Preventative/ Ambulatory Health Services (AAP) measure	Total Rate	HEDIS	11 percent (11%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement or meet the NCQA's Quality Compass HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed Medicaid Plans
8a	Follow-up after Hospitalization for Mental Illness: Ages Six to 17 (FUH-CH)	Percentage of discharges for which the beneficiary received follow-up within 7 days after discharge	CMS Child Core Set	Two and three-quarter percent (2.75%) of total capitation quality withhold.	TBD	Two (2) Percentage Points Improvement or meet the NCQA's Quality Compass HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed Medicaid Plans
8b	Follow-up after	Percentage of discharges for	CMS Child Core Set	Two and three-	TBD	Two (2) Percentage

#	Performance Measure	Sub Measure(s)	Measurement Set/Source	Amount of Capitation Quality Withhold	CY 2025 Baseline Rate	Annual Target Criteria
	Hospitalization for Mental Illness: Ages Six to 17 (FUH-CH)	which the beneficiary received follow-up within 30 days after discharge		quarter percent (2.75%) of total capitation quality withhold.		Points Improvement or meet the NCQA's Quality Compass HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed Medicaid Plans
9a	Follow-up after Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Percentage of ED visits for which the beneficiary received follow-up within 7 days of the ED visit (8 total days)	CMS Adult Core Set	Two and three-quarter percent (2.75%) of total capitation quality withhold.	TBD	Two (2) Percentage Points Improvement or meet the NCQA's Quality Compass HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed Medicaid Plans
9b	Follow-up after Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	Percentage of ED visits for which the beneficiary received follow-up within 30 days of the ED visit (31 total days)	CMS Adult Core Set	Two and three-quarter percent (2.75%) of total capitation quality withhold.	TBD	Two (2) Percentage Points Improvement or meet the NCQA's Quality Compass HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed Medicaid Plans
10a	Glycemic Status Assessment for Patients with Diabetes (GSD-AD)	Percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) whose most	CMS Adult Core Set	Five and a half percent (5.5%) of total capitation quality	TBD	Two (2) Percentage Points Improvement or meet the NCQA's

#	Performance Measure	Sub Measure(s)	Measurement Set/Source	Amount of Capitation Quality Withhold	CY 2025 Baseline Rate	Annual Target Criteria
		recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: Glycemic Status <8.0%		withhold.		Quality Compass HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed Medicaid Plans
10b	Glycemic Status Assessment for Patients with Diabetes (GSD-AD)	Percentage of beneficiaries ages 18 to 75 with diabetes (type 1 and type 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: Glycemic Status >9.0%. Lower rate preferred.	CMS Adult Core Set	Five and a half percent (5.5%) of total capitation quality withhold.	TBD	Two (2) Percentage Points Improvement or meet the NCQA's Quality Compass HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed Medicaid Plans
11	Plan All-Cause Readmissions (PCR-AD)	O/E Ratio (18-64). Lower ratio preferred	CMS Adult Core Set	12 percent (12%) of total capitation quality withhold	TBD	Two (2) Percentage Points Improvement or meet the NCQA's Quality Compass HEDIS 2026 (MY 2025) 50th percentile benchmark for Managed

#	Performance Measure	Sub Measure(s)	Measurement Set/Source	Amount of Capitation Quality Withhold	CY 2025 Baseline Rate	Annual Target Criteria
						Medicaid Plans

OHCA reserves the right to adjust the measures, number of measures, weighting of measures and performance targets in Future Contract Rating Periods. Such adjustments shall be made through a formal Contract amendment in accordance with the provisions outlined in Section 1.2.8: "Amendments or Modifications" of the Contract.

The remaining sections of Appendix 1C remain unchanged.

Appendix 1E: Consequential and Liquidated Damages

The following contract language for the requirement, performance standard, and liquidated damages in the Appendix 1E table are revised for dates of service on/after January 1, 2026:

Contract Requirement	Performance Standard	Liquidated Damages
Section 1.8.6.3: "Timeliness Standards" Section 1.18.6.6: "Prior Authorization denial or Limitation" Section 1.18.6.7: "Expedited Prior Authorization Denial"	The Contractor fails to comply with the timeliness requirements for processing prior authorizations. Contractor performance will be measured using a Timely Decision Rate (TDR), defined as: TDR = (Number of Timely Determinations ÷ Total Number of Completed Prior Authorization Requests) × 100 For purposes of performance measurement: a. A Timely Determination is a prior authorization decision rendered within the applicable contractual timeframe, prior to any deemed authorized triggers. b. Completed Prior Authorization Requests include all Prior Authorization requests for which final a disposition (approval, denial, or auto approval) is rendered during the measurement period. i. Prior Authorization requests that are	OHCA may assess liquidated damages based on aggregate performance, as determined by the TDR, if a Contractor fails to meet timeliness requirements as measured by the TDR: a. TDR ≥ 98.00%: No damages will be assessed b. TDR 96.00% – 97.99%: Damages assessed at $5,000 per calendar month. c. TDR ≤ 95.99%: Damages assessed at $10,000 per calendar month.

Contract Requirement	Performance Standard	Liquidated Damages
	withdrawn, canceled, or pended beyond the measurement period shall be excluded from the calculation. ii. All Prior Authorization requests processed during the measurement period must be included in the calculation.	

The remaining language in Appendix 1E remains unchanged.

Appendix 1F: List of Deliverables to OHCA

Appendix 1F shall be deleted from the contract. Reference to all necessary requirements and deliverables can be found in the contract and SoonerSelect Reporting Manual.

Appendix 1G: Covered Benefits, 1. Medical and Related Benefits

The following covered benefit shall be added to the table Appendix 1G:

Service	Children (under 21 years old)	Adults (21 years old and over)
Paid Family Caregiver (Effective on or after 3.1.2026) (317:30-5-550; 317:30-5-551; 317:30-5-552; 317:30-5-553; 317:30-5-554; 317:30-5-554.1; 317:30-5-554.2; 317:30-5-554.3; 317:30-5-555; 317:30-5-556; 317:30-5-557; 317:30-5-558; 317:30-5-559; 317:30-5-560.1)	Covered Note: Eligibility for Paid Family Caregiver services is contingent upon an Enrollee having an active, approved Private Duty Nursing (PDN) service authorization.	Not Covered

The remaining language in Appendix 1G remains unchanged.

SoonerSelect Capitation Rates

The attached Appendix B.1 serves to provide capitation rates for the State's SoonerSelect Medical benefits for the following period of July 1, 2026 through June 30, 2027.

The Oklahoma Health Care Authority (OHCA) and the Contractor mutually consent to the capitated rates provided in Appendix B.1, which is attached and incorporated herein.

In the event of any conflict between the terms of this Amendment and any prior version of the Contract, the terms of this Amendment shall control. Except as expressly amended by this Amendment, all other terms and conditions of the Contract shall remain in full force and effect.

Nothing in this Amendment shall be construed to waive federal Medicaid requirements, State Plan provisions, or

applicable federal regulations, all of which shall supersede Contract terms where required by law, nor shall this Amendment be interpreted to waive or limit any rights, remedies, or enforcement authority of OHCA under the Contract, applicable State law, or federal Medicaid regulations.

The parties executing this Amendment represent that they are duly authorized to bind their respective organizations to the terms of this Amendment. This Amendment may be executed in counterparts, each of which shall be deemed an original and all of which together shall constitute one and the same instrument.

This Amendment shall become effective on July 1, 2026, or upon the date of the last signature by both parties, whichever occurs first. All other terms and provisions of the Agreement shall remain unchanged and in full force and effect.

EXECUTED

Lisa Gifford
Lisa Gifford (Jun 25, 2026 14:37:35 CDT)

Jun 25, 2026

Lisa Gifford, Chief Executive Officer
(Or her Authorized Designee)
Aetna Better Health of Oklahoma, Inc.

Jun 26, 2026

Clay Bullard, Chief Executive Officer
(Or his Authorized Designee)
Oklahoma Health Care Authority

Oklahoma Health Care Authority

SoonerSelect Medical Managed Care Capitation Rates

SFY27 (July 1, 2026 - June 30, 2027)

Estimate IDP: $72,976,588

Withhold: 2.5%

Withhold NRA: 0.83%

Exhibit 1

DRAFT

					a	*b*	*c = a + b*	*d = a x (1-2.5%) + b*	*e = a x (1-0.83%) + b*	f= a x (1-0.83%)			
Region	**Population Group**	**Age/Gender**	**Voluntary**	**Projected Member Months**	**SFY27 (July 1, 2026 - June 30, 2027) Rates before Integrated DPs**	**Integrated Directed Payments w/ admin and risk margin**	**SFY27 Rates Including Intergrated DPs**	**SFY27 (July 1, 2026 - June 30, 2027) Rates incl Integrated DPs, Net of Withhold***	**SFY27 (July 1, 2026 - June 30, 2027) Certified Rates incl Integrated DPs before Withhold**	**SFY27 Certified Rates before Integrated DPs (net of withhold not reasonably achievable)**	**SFY27 (July 1, 2026 - June 30, 2027) Rates before Integrated DPs**	**SFY26 Rates before Integrated DPs and Withhold**	**Difference (SFY26 vs. SFY27 before Integrated DPs)**
EAST	TANF/CHIP Child	Newborn <1	N	48,175	$ 821.87	$ 60.02	$ 881.89	$ 861.35	$ 875.11	$ 815.09	$ 821.87	$ 879.87	-7%
OKC	TANF/CHIP Child	Newborn <1	N	68,700	$ 825.94	$ 48.65	$ 874.59	$ 853.94	$ 867.78	$ 819.13	$ 825.94	$ 956.19	-14%
TULSA	TANF/CHIP Child	Newborn <1	N	50,562	$ 691.63	$ 75.92	$ 767.55	$ 750.26	$ 761.84	$ 685.92	$ 691.63	$ 771.25	-10%
WEST	TANF/CHIP Child	Newborn <1	N	88,563	$ 747.24	$ 46.91	$ 794.15	$ 775.47	$ 787.99	$ 741.08	$ 747.24	$ 820.69	-9%
EAST	TANF/CHIP Child	Newborn <1	Y	9,019	$ 729.10	$ 60.22	$ 789.32	$ 771.10	$ 783.30	$ 723.08	$ 729.10	$ 770.13	-5%
OKC	TANF/CHIP Child	Newborn <1	Y	2,202	$ 618.42	$ 20.78	$ 639.20	$ 623.74	$ 634.10	$ 613.32	$ 618.42	$ 829.07	-25%
TULSA	TANF/CHIP Child	Newborn <1	Y	3,362	$ 652.62	$ 35.19	$ 687.81	$ 671.49	$ 682.43	$ 647.24	$ 652.62	$ 712.44	-8%
WEST	TANF/CHIP Child	Newborn <1	Y	6,146	$ 716.83	$ 38.13	$ 754.96	$ 737.04	$ 749.05	$ 710.92	$ 716.83	$ 798.78	-10%
EAST	TANF/CHIP Child	1-14 Years, Male and Female	N	557,891	$ 333.85	$ 6.21	$ 340.06	$ 331.71	$ 337.31	$ 331.10	$ 333.85	$ 282.43	18%
OKC	TANF/CHIP Child	1-14 Years, Male and Female	N	750,540	$ 295.14	$ 5.87	$ 301.01	$ 293.63	$ 298.58	$ 292.71	$ 295.14	$ 238.33	24%
TULSA	TANF/CHIP Child	1-14 Years, Male and Female	N	572,831	$ 325.29	$ 12.18	$ 337.47	$ 329.34	$ 334.79	$ 322.61	$ 325.29	$ 245.78	32%
WEST	TANF/CHIP Child	1-14 Years, Male and Female	N	1,004,029	$ 299.17	$ 4.14	$ 303.31	$ 295.83	$ 300.84	$ 296.70	$ 299.17	$ 246.79	21%
EAST	TANF/CHIP Child	1-14 Years, Male and Female	Y	58,458	$ 305.85	$ 7.01	$ 312.86	$ 305.22	$ 310.34	$ 303.33	$ 305.85	$ 256.77	19%
OKC	TANF/CHIP Child	1-14 Years, Male and Female	Y	15,837	$ 264.49	$ 4.54	$ 269.03	$ 262.42	$ 266.85	$ 262.31	$ 264.49	$ 207.31	28%
TULSA	TANF/CHIP Child	1-14 Years, Male and Female	Y	22,348	$ 386.01	$ 10.13	$ 396.14	$ 386.49	$ 392.96	$ 382.83	$ 386.01	$ 285.68	35%
WEST	TANF/CHIP Child	1-14 Years, Male and Female	Y	37,169	$ 262.19	$ 4.68	$ 266.87	$ 260.32	$ 264.71	$ 260.03	$ 262.19	$ 215.87	21%
EAST	TANF/CHIP Child	15+ Years, Female	N	68,901	$ 461.93	$ 4.99	$ 466.92	$ 455.37	$ 463.11	$ 458.12	$ 461.93	$ 414.47	11%
OKC	TANF/CHIP Child	15+ Years, Female	N	90,789	$ 305.73	$ 7.98	$ 313.71	$ 306.07	$ 311.19	$ 303.21	$ 305.73	$ 297.12	3%
TULSA	TANF/CHIP Child	15+ Years, Female	N	65,042	$ 363.46	$ 10.57	$ 374.03	$ 364.94	$ 371.03	$ 360.46	$ 363.46	$ 313.80	16%
WEST	TANF/CHIP Child	15+ Years, Female	N	124,531	$ 366.73	$ 4.95	$ 371.68	$ 362.51	$ 368.65	$ 363.70	$ 366.73	$ 343.99	7%
EAST	TANF/CHIP Child	15+ Years, Female	Y	5,287	$ 445.66	$ 6.08	$ 451.74	$ 440.60	$ 448.06	$ 441.98	$ 445.66	$ 413.69	8%
OKC	TANF/CHIP Child	15+ Years, Female	Y	1,663	$ 290.82	$ 5.11	$ 295.93	$ 288.66	$ 293.53	$ 288.42	$ 290.82	$ 284.09	2%
TULSA	TANF/CHIP Child	15+ Years, Female	Y	2,364	$ 474.30	$ 12.47	$ 486.77	$ 474.91	$ 482.86	$ 470.39	$ 474.30	$ 416.86	14%
WEST	TANF/CHIP Child	15+ Years, Female	Y	3,745	$ 340.39	$ 4.66	$ 345.05	$ 336.54	$ 342.24	$ 337.58	$ 340.39	$ 330.93	3%
EAST	TANF/CHIP Child	15+ Years, Male	N	67,137	$ 330.82	$ 3.28	$ 334.10	$ 325.83	$ 331.37	$ 328.09	$ 330.82	$ 262.52	26%
OKC	TANF/CHIP Child	15+ Years, Male	N	87,231	$ 273.06	$ 5.64	$ 278.70	$ 271.87	$ 276.45	$ 270.81	$ 273.06	$ 230.86	18%
TULSA	TANF/CHIP Child	15+ Years, Male	N	61,932	$ 280.02	$ 7.54	$ 287.56	$ 280.56	$ 285.25	$ 277.71	$ 280.02	$ 231.68	21%
WEST	TANF/CHIP Child	15+ Years, Male	N	119,719	$ 280.46	$ 3.62	$ 284.08	$ 277.07	$ 281.77	$ 278.15	$ 280.46	$ 223.00	26%
EAST	TANF/CHIP Child	15+ Years, Male	Y	5,238	$ 270.86	$ 3.17	$ 274.03	$ 267.26	$ 271.80	$ 268.63	$ 270.86	$ 212.36	28%
OKC	TANF/CHIP Child	15+ Years, Male	Y	1,613	$ 248.21	$ 3.68	$ 251.89	$ 245.69	$ 249.84	$ 246.16	$ 248.21	$ 237.25	5%
TULSA	TANF/CHIP Child	15+ Years, Male	Y	2,035	$ 327.13	$ 5.23	$ 332.36	$ 324.18	$ 329.66	$ 324.43	$ 327.13	$ 257.67	27%
WEST	TANF/CHIP Child	15+ Years, Male	Y	3,494	$ 249.84	$ 8.65	$ 258.49	$ 252.24	$ 256.43	$ 247.78	$ 249.84	$ 200.41	25%

Guidehouse

Oklahoma Health Care Authority

SoonerSelect Medical Managed Care Capitation Rates

SFY27 (July 1, 2026 - June 30, 2027)

Estimate IDP: $72,976,588

Withhold: 2.5%

Withhold NRA: 0.83%

Exhibit 1

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					a	*b*	*c = a + b*	*d = a x (1-2.5%) + b*	*e = a x (1-0.83%) + b*	f= a x (1-0.83%)			
Region	**Population Group**	**Age/Gender**	**Voluntary**	**Projected Member Months**	**SFY27 (July 1, 2026 - June 30, 2027) Rates before Integrated DPs**	**Integrated Directed Payments w/ admin and risk margin**	**SFY27 Rates Including Intergrated DPs**	**SFY27 (July 1, 2026 - June 30, 2027) Rates incl Integrated DPs, Net of Withhold***	**SFY27 (July 1, 2026 - June 30, 2027) Certified Rates incl Integrated DPs before Withhold**	**SFY27 Certified Rates before Integrated DPs (net of withhold not reasonably achievable)**	**SFY27 (July 1, 2026 - June 30, 2027) Rates before Integrated DPs**	**SFY26 Rates before Integrated DPs and Withhold**	**Difference (SFY26 vs. SFY27 before Integrated DPs)**
EAST	TANF Parent/Caretaker	< 45 Years, Adult Female	N	111,893	$ 704.44	$ 16.24	$ 720.68	$ 703.07	$ 714.87	$ 698.63	$ 704.44	$ 621.94	13%
OKC	TANF Parent/Caretaker	< 45 Years, Adult Female	N	124,201	$ 670.59	$ 31.37	$ 701.96	$ 685.20	$ 696.43	$ 665.06	$ 670.59	$ 576.98	16%
TULSA	TANF Parent/Caretaker	< 45 Years, Adult Female	N	90,212	$ 680.66	$ 39.14	$ 719.80	$ 702.78	$ 714.18	$ 675.04	$ 680.66	$ 590.51	15%
WEST	TANF Parent/Caretaker	< 45 Years, Adult Female	N	187,097	$ 651.08	$ 19.36	$ 670.44	$ 654.17	$ 665.07	$ 645.71	$ 651.08	$ 612.43	6%
EAST	TANF Parent/Caretaker	< 45 Years, Adult Female	Y	14,540	$ 547.97	$ 19.96	$ 567.93	$ 554.23	$ 563.41	$ 543.45	$ 547.97	$ 518.49	6%
OKC	TANF Parent/Caretaker	< 45 Years, Adult Female	Y	4,248	$ 654.12	$ 25.69	$ 679.81	$ 663.45	$ 674.41	$ 648.72	$ 654.12	$ 573.10	14%
TULSA	TANF Parent/Caretaker	< 45 Years, Adult Female	Y	6,155	$ 734.63	$ 40.63	$ 775.26	$ 756.89	$ 769.20	$ 728.57	$ 734.63	$ 611.63	20%
WEST	TANF Parent/Caretaker	< 45 Years, Adult Female	Y	9,571	$ 597.91	$ 19.54	$ 617.45	$ 602.51	$ 612.52	$ 592.98	$ 597.91	$ 589.11	1%
EAST	TANF Parent/Caretaker	< 45 Years, Adult Male	N	22,732	$ 380.47	$ 4.51	$ 384.98	$ 375.47	$ 381.84	$ 377.33	$ 380.47	$ 351.17	8%
OKC	TANF Parent/Caretaker	< 45 Years, Adult Male	N	17,042	$ 349.28	$ 5.52	$ 354.80	$ 346.06	$ 351.92	$ 346.40	$ 349.28	$ 360.42	-3%
TULSA	TANF Parent/Caretaker	< 45 Years, Adult Male	N	13,358	$ 450.73	$ 7.42	$ 458.15	$ 446.88	$ 454.43	$ 447.01	$ 450.73	$ 331.20	36%
WEST	TANF Parent/Caretaker	< 45 Years, Adult Male	N	32,233	$ 379.97	$ 4.46	$ 384.43	$ 374.93	$ 381.30	$ 376.84	$ 379.97	$ 356.43	7%
EAST	TANF Parent/Caretaker	< 45 Years, Adult Male	Y	1,841	$ 344.21	$ 5.21	$ 349.42	$ 340.81	$ 346.58	$ 341.37	$ 344.21	$ 338.85	2%
OKC	TANF Parent/Caretaker	< 45 Years, Adult Male	Y	399	$ 404.55	$ 0.50	$ 405.05	$ 394.94	$ 401.71	$ 401.21	$ 404.55	$ 530.09	-24%
TULSA	TANF Parent/Caretaker	< 45 Years, Adult Male	Y	612	$ 592.82	$ 7.11	$ 599.93	$ 585.11	$ 595.04	$ 587.93	$ 592.82	$ 347.85	70%
WEST	TANF Parent/Caretaker	< 45 Years, Adult Male	Y	1,235	$ 419.52	$ 2.83	$ 422.35	$ 411.86	$ 418.89	$ 416.06	$ 419.52	$ 398.91	5%
EAST	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	18,130	$ 982.27	$ 9.40	$ 991.67	$ 967.11	$ 983.57	$ 974.17	$ 982.27	$ 855.93	15%
OKC	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	17,078	$ 1,121.18	$ 12.17	$ 1,133.35	$ 1,105.32	$ 1,124.10	$ 1,111.93	$ 1,121.18	$ 1,008.67	11%
TULSA	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	13,248	$ 1,082.20	$ 18.80	$ 1,101.00	$ 1,073.94	$ 1,092.07	$ 1,073.27	$ 1,082.20	$ 861.23	26%
WEST	TANF Parent/Caretaker	Adult Male/Female Years 45+	N	25,738	$ 1,096.67	$ 9.13	$ 1,105.80	$ 1,078.39	$ 1,096.75	$ 1,087.62	$ 1,096.67	$ 877.27	25%
EAST	TANF Parent/Caretaker	Adult Male/Female Years 45+	Y	1,594	$ 996.31	$ 16.58	$ 1,012.89	$ 987.98	$ 1,004.67	$ 988.09	$ 996.31	$ 888.66	12%
OKC	TANF Parent/Caretaker	Adult Male/Female Years 45+	Y	423	$ 1,253.22	$ 25.76	$ 1,278.98	$ 1,247.65	$ 1,268.64	$ 1,242.88	$ 1,253.22	$ 1,321.05	-5%
TULSA	TANF Parent/Caretaker	Adult Male/Female Years 45+	Y	661	$ 1,101.89	$ 23.97	$ 1,125.86	$ 1,098.31	$ 1,116.77	$ 1,092.80	$ 1,101.89	$ 1,025.02	7%
WEST	TANF Parent/Caretaker	Adult Male/Female Years 45+	Y	774	$ 981.52	$ 3.09	$ 984.61	$ 960.07	$ 976.51	$ 973.42	$ 981.52	$ 887.58	11%
EAST	Expansion	< 45 Years, Adult Female	N	133,723	$ 721.35	$ 7.11	$ 728.46	$ 710.42	$ 722.51	$ 715.40	$ 721.35	$ 583.95	24%
OKC	Expansion	< 45 Years, Adult Female	N	154,966	$ 644.43	$ 10.01	$ 654.44	$ 638.33	$ 649.12	$ 639.11	$ 644.43	$ 543.50	19%
TULSA	Expansion	< 45 Years, Adult Female	N	113,915	$ 703.46	$ 15.45	$ 718.91	$ 701.33	$ 713.11	$ 697.66	$ 703.46	$ 579.47	21%
WEST	Expansion	< 45 Years, Adult Female	N	232,797	$ 698.17	$ 6.65	$ 704.82	$ 687.37	$ 699.06	$ 692.41	$ 698.17	$ 546.57	28%
EAST	Expansion	< 45 Years, Adult Female	Y	12,896	$ 549.95	$ 5.94	$ 555.89	$ 542.14	$ 551.35	$ 545.41	$ 549.95	$ 476.83	15%
OKC	Expansion	< 45 Years, Adult Female	Y	3,521	$ 648.21	$ 19.92	$ 668.13	$ 651.93	$ 662.78	$ 642.86	$ 648.21	$ 552.63	17%
TULSA	Expansion	< 45 Years, Adult Female	Y	6,569	$ 790.26	$ 15.89	$ 806.15	$ 786.40	$ 799.63	$ 783.74	$ 790.26	$ 630.79	25%
WEST	Expansion	< 45 Years, Adult Female	Y	8,625	$ 650.63	$ 4.42	$ 655.05	$ 638.78	$ 649.68	$ 645.26	$ 650.63	$ 545.62	19%
EAST	Expansion	< 45 Years, Adult Male	N	108,594	$ 607.42	$ 3.72	$ 611.14	$ 595.95	$ 606.13	$ 602.41	$ 607.42	$ 531.67	14%
OKC	Expansion	< 45 Years, Adult Male	N	114,986	$ 635.08	$ 7.08	$ 642.16	$ 626.28	$ 636.92	$ 629.84	$ 635.08	$ 602.45	5%
TULSA	Expansion	< 45 Years, Adult Male	N	90,102	$ 719.15	$ 9.20	$ 728.35	$ 710.37	$ 722.42	$ 713.22	$ 719.15	$ 680.29	6%
WEST	Expansion	< 45 Years, Adult Male	N	168,018	$ 568.87	$ 4.64	$ 573.51	$ 559.29	$ 568.82	$ 564.18	$ 568.87	$ 495.10	15%
EAST	Expansion	< 45 Years, Adult Male	Y	10,469	$ 524.93	$ 6.38	$ 531.31	$ 518.19	$ 526.98	$ 520.60	$ 524.93	$ 470.28	12%
OKC	Expansion	< 45 Years, Adult Male	Y	2,825	$ 727.29	$ 14.13	$ 741.42	$ 723.24	$ 735.42	$ 721.29	$ 727.29	$ 721.97	1%
TULSA	Expansion	< 45 Years, Adult Male	Y	4,873	$ 797.18	$ 10.04	$ 807.22	$ 787.29	$ 800.64	$ 790.60	$ 797.18	$ 745.03	7%
WEST	Expansion	< 45 Years, Adult Male	Y	6,406	$ 579.52	$ 11.42	$ 590.94	$ 576.46	$ 586.16	$ 574.74	$ 579.52	$ 512.59	13%
EAST	Expansion	45+ Years, Male and Female	N	152,587	$ 1,330.96	$ 12.70	$ 1,343.66	$ 1,310.38	$ 1,332.68	$ 1,319.98	$ 1,330.96	$ 1,059.62	26%
OKC	Expansion	45+ Years, Male and Female	N	127,582	$ 1,406.63	$ 17.82	$ 1,424.45	$ 1,389.29	$ 1,412.85	$ 1,395.03	$ 1,406.63	$ 1,135.66	24%
TULSA	Expansion	45+ Years, Male and Female	N	96,546	$ 1,399.98	$ 26.11	$ 1,426.09	$ 1,391.10	$ 1,414.54	$ 1,388.43	$ 1,399.98	$ 1,134.50	23%
WEST	Expansion	45+ Years, Male and Female	N	203,375	$ 1,396.33	$ 11.93	$ 1,408.26	$ 1,373.35	$ 1,396.74	$ 1,384.81	$ 1,396.33	$ 1,081.26	29%
EAST	Expansion	45+ Years, Male and Female	Y	11,757	$ 1,078.03	$ 11.94	$ 1,089.97	$ 1,063.02	$ 1,081.08	$ 1,069.14	$ 1,078.03	$ 914.50	18%
OKC	Expansion	45+ Years, Male and Female	Y	2,635	$ 1,234.49	$ 14.98	$ 1,249.47	$ 1,218.61	$ 1,239.29	$ 1,224.31	$ 1,234.49	$ 986.40	25%
TULSA	Expansion	45+ Years, Male and Female	Y	5,138	$ 1,429.61	$ 22.15	$ 1,451.76	$ 1,416.02	$ 1,439.97	$ 1,417.82	$ 1,429.61	$ 1,157.84	23%
WEST	Expansion	45+ Years, Male and Female	Y	5,414	$ 1,208.49	$ 18.53	$ 1,227.02	$ 1,196.81	$ 1,217.05	$ 1,198.52	$ 1,208.49	$ 949.58	27%
ALL	**ALL**	**ALL**	**ALL**	**6,499,888**	**$ 533.94**	**$ 11.23**	**$ 545.17**	**$ 531.82**	**$ 540.76**	**$ 529.54**	**$ 533.94**	**$ 453.42**	**17.8%**

Composite FY26 Original and FY27 PMPM based on projected FY27 enrollment.

*Withhold does not apply to integrated directed payments in SFY27.