OKLAHOMA HEALTH CARE AUTHORITY
REGULAR BOARD MEETING
June 25, 2025, at 2:00 P.M.
Oklahoma Health Care Authority
4345 N. Lincoln Blvd.
Oklahoma City, OK. 73105

A G E N D A

Public access via Zoom:
https://www.zoomgov.com/webinar/register/WN_MVOYqswnT9eIvmlbQlGmcw
Telephone: 1-669-216-1590 Webinar ID: 160 167 0479

*Please note: Since the physical address for the OHCA Board Meeting has resumed, any livestreaming option provided is provided as a courtesy. Should such livestreaming option fail or have technical issues, the OHCA Board Meeting will not be suspended or reconvened because of this failure or technical issue.

1. Call to Order / Determination of Quorum……...Marc Nuttle, Chair

2. Discussion and Vote on the May 21, 2025, OHCA Board Meeting Minutes……..…….…Marc Nuttle, Chair

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

    a) Member Moment

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

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

    a) Discussion and Possible Vote on Recommendations Made by the Drug Utilization Review Board Pursuant to 63 O.S. § 5030.1, § 5030.3 To Add the Following Drugs to the Utilization and Scope Prior Authorization Program under OAC 317:30-5-77.2(e) (Attachment "C"):

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

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

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

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

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

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

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

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

8. Adjournment……..…….Marc Nuttle, Chair

NEXT BOARD MEETING
September 17, 2025, at 2:00PM
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

MINUTES OF AMENDED BOARD MEETING
OF THE HEALTH CARE AUTHORITY BOARD
May 21, 2025
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, Oklahoma

Manner and Time of Notice of Meeting: A statutorily required public meeting notice was placed on the front door of the Oklahoma Health Care Authority on May 19, 2025, at 4:26 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of statutory public notice, the agency placed its agenda on its website on May 20, 2025, at 2:00 p.m.

Pursuant to a roll call of the members, a quorum was declared to be present, and Chairman Nuttle called the meeting to order at 2:01 p.m.

BOARD MEMBERS PRESENT: Chairman Nuttle, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy, Member Jolley, Member Leland

BOARD MEMBER ABSENT: Vice-Chairman Yaffe

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

MOTION: Member Jolley moved for approval of the March 26, 2025, board meeting minutes, as published. The motion was seconded by Member Case.

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

BOARD MEMBER ABSENT: Vice-Chairman Yaffe

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

CEO Buettner invited Stephanie Valentine, Therapy Link Solution, to present this month's member moment.

CEO Buettner highlighted OHCA's Passion for Purpose Key Principle, recognizing OHCA's Behavioral Health team as well as those involved in OHCA's Care Coordination Services NEMT, and those that do the work to connect members with care every day. CEO Buettner also recognized Tanesha Hooks, who leads OHCA's Behavioral Health department. She has been leading in the Cross Systems of Hope Initiative that been spearheaded by the First Lady.

Key Initiatives Update:

- Senior Staff Recruitment: CEO Buettner introduced OHCA's new Chief Operating Officer, Sherri White. She also congratulated Carolyn Reconnu-Shoffner and Christina Foss for their promotions. Carolynn will be taking lead of Care Coordination and all things clinical for the agency as the Chief Clinical Officer. Christina, with her policy experience both at the state and federal level, will take on the responsibilities of State Medicaid Director.
- SoonerSelect Update: CEO Buettner stated that since the March Board meeting, OHCA celebrated its one-year anniversary of the medical program. Stephanie Mavredes will provide a more detailed report of the SoonerSelect Dental one-year anniversary out of the Strategic Planning report. OHCA continues to move forward on schedule with the implementation of its MCO compliance tool that was brought to OHCA by Accenture.
- Federal Updates: CEO Buettner stated that OHCA is cautiously optimistic in the proposals that were released by the Federal Government last week. At the Federal level, there have also been conversations around curbing fraud, waste, and abuse.
- Program Integrity: CEO Buettner stated that nationwide, fraud, waste, and abuse diverts billions of dollars from people who need the services. The National Medicaid Improper payment rate last year was a little over 5%. OHCA's strong audit process has put OHCA at 1.95% error rate: putting Oklahoma as the leader in the nation on this.
- Budget and Legislation: CEO Buettner stated that there appears to be a budget deal between the House, Senate, and Governor. OHCA's Finance team is currently reviewing the deal and will provide an update at an upcoming meeting. The current amount proposed to be appropriated to the agency is approximately $26 million less than originally requested, which represents the amount OHCA requested to cover the drop in FMAP next year. CEO Buettner highlighted Tasha Black and Sally Tucker for their work in supporting DMH in a recent financial analysis.

Stakeholder Engagement:

- FreshRx: Legislation recently passed directing OHCA to work toward implementing Food as Medicine Programs. OHCA is currently working with Ms. Martin and a coalition of folks on avenues and funding opportunities.
- Oklahoma Pediatric Therapy Advocacy Group: CEO Buettner thanked Ms. Valentine and her colleagues for their proactive communication, and ideas about how both can work together to support this community.

.

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

ITEM 4 / STATE AND FEDERAL UPDATE

Christina Foss, Chief of Staff

State Update: Ms. Foss stated that all of OHCA's requests bills have moved through session and made it to the Governor. Three of OHCA's request bills are in law and just waiting for the EGID cleanup bill to become law. Budget bills were released on Sunday. OHCA received $1.41 billion in state appropriations, which is $26 million less than originally requested. The JCAB bills that were released on Sunday have been heard in House and Senate committees, one chamber, and will be heard in the other chamber tomorrow, so all budget items should be done this week. The General Appropriations bill includes a supplemental for the Department of Mental Health, which will be effective immediately, whereas the rest of the GA bill will be effective July 1st for the next fiscal year. OHCA has a budget line item this year that specified that the increase OHCA receive of $100 million is for program growth. There was also a bill that made changes to the rate preservation fund, which would allow OHCA to use the rate preservation fund for the sole purpose of maintaining provider rates. The premium tax JCAB bill clarifies that the premium tax dollars that MCOs pay goes directly to the agency to help fund the programs. Lastly, there is a JCAB bill that deals with provider audits. The intent of this bill is focused on the home and community-based service providers and prohibits the agency from using methods like extrapolation on those audits.

Federal Update: Ms. Foss stated that the reconciliation package has passed through the budget committee. The House Speaker would like to get a vote on the House floor ahead of Memorial Day. Ms. Foss noted that a lot of the more conservative members are pushing on moving up some of the timelines, so some of the effective dates could change. Limiting provider tax and state directed payments are two of the items that OHCA is watching closely. Other items that were in the bill include: excluding noncitizens from eligibility, more frequent eligibility checks, cost-sharing, modifying retroactive coverage decrease, moratorium on implementation of rule relating to staffing standards for LTC facilities under Medicare and Medicaid programs, prohibiting reimbursing community health providers like Planned Parenthood, and mandatory work requirements. With community engagement requirements, OHCA has constitutional language around Oklahoma's expansion population. The bill also has several exemptions that much up with the exemptions Oklahoma has in state law. The House Energy and Commerce Committee projected a $10 million annual decrease in total expenditures for Oklahoma. There are a lot of operational impacts to consider from our agency, but the OHCA team is already working on a lot of those questions. Ms. Foss highlighted the requirements and who they would not apply to. Member Corbett asked if there is a coordinated state effort to look at all of this to help determine the impact to the state. Chairman Nuttle stated that that has been addressed in DOGE and the report will be issued on May 28th, which will include a new baseline for Oklahoma.

ITEM 5 / DISCUSSION OF REPORT FROM THE PHARMACY ADVISORY COMMITTEE

Dr. Jeff Cruzan, Pharmacy Committee Member

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

Item:	Drug Name:	Used For:
i.	Aucatzyl® (Obecabtagene Autoleucel) Danziten™ (Nilotinib) Grafapex™ (Treosulfan) Revuforj® (Revumenib) Rytelo® (Imetelstat)	Acute Lymphoblastic Leukemia (ALL) Chronc Myeloid Leukemia (CML) Acute Myeloid Leukemia (AML) Acute Leukemia (AL) Myelodysplastic Syndromes (MDS)
ii.	Kebilidi™ (Eladocagene Exuparvovec-tneq)	Aromatic L-Amino Acid Decarboxylase (AADC) Deficiency
iii.	Crenessity™ (Crinecerfont)	Congenital Adrenal Hyperplasia (CAH)

iv.	Ctexli™ (Chenodiol) Iqirvo® (Elafibranor) Livdelzi® (Seladelpar)	Cerebrotendinous Zanthomatosis (CTX) Primary Biliary Cholangitis (PBC) PBC

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

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

BOARD MEMBER ABSENT: Vice-Chairman Yaffe

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

ITEM 6 / DISCUSSION OF REPORT FROM THE COMPLIANCE ADVISORY COMMITTEE
Phil Kennedy, Compliance Advisory Committee Chairman

Chairman Kennedy provided the Compliance Committee Update, which included information on OHCA Financials, Program Integrity, and the State Plan Amendment Rate Committee Rate.

OHCA Financials: For the period ending March 31st, 2025, the OHCA's expenditures were 0.2% over budget while revenues were 0.5% over budget. This gives the agency a negative budget variance of $18 million. We continue to focus on timely collection while monitoring our cash flow as we spend our cash reserves from Fund 340.

Program Integrity: PERM is finalized, but we will not receive the final report until closer to the end of the calendar year. As mentioned during our last meeting, Oklahoma ended with no errors related to eligibility or data processing and only 3 errors of the 349 claims reviewed for the medical review portion. Based on dollars in review, the dollars in error equaled 0.03% of total dollars reviewed by the auditor.

For the third quarter, Data Analytics closed 277 cases totaling $1,360,256. Clinical Provider Audits closed 13 audits totaling $2,290,613 in overpayments. This brings the total to 1,542 cases closed this fiscal year totaling $6,914,544.

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

    i. Customer Relationship Management

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

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

BOARD MEMBER ABSENT: Vice-Chairman Yaffe

b) Discussion and Possible Action regarding payments made on behalf of other state agencies for Medicaid services

The committee had a robust discussion surrounding the contractual arrangements OHCA has with other state agencies in the administration of the Medicaid program. As this board is aware, OHCA pays approximately $530M in state funds to pay claims on behalf of other state agencies and invoices those agencies for the state share. When including federal funds, other state agencies spend totals approximately $1.8B that this agency is ultimately responsible for. This has been a long-standing arrangement that was directed at various points in time by the legislature.

While this board has for years expressed concern about the financial and compliance risks posed on this agency and this board as a result of these arrangements, the recent financial troubles at the Department of Mental Health and the resulting effect on OHCA's finances have elevated these concerns to a critical point where action is needed.

Therefore, it is the recommendation of this committee, first, to formally request the legislature return the Medicaid funding from the Department of Mental Health to the Health Care Authority. Second, this committee recommends directing our CEO to conduct an analysis of Medicaid funding at all other state agencies and to provide recommendations to this board on the appropriate structure to ensure financial oversight, compliance with state law, federal regulations and audit requirements, and to recommend any operational efficiencies that could be gained by consolidating these funds.

MOTION:	Member Cruzan moved to approve item 6b as published. The motion was seconded by Member Case.
FOR THE MOTION:	Chairman Nuttle, Member Case, Member Christ, Member Corbett, Member Cruzan, Member Kennedy, Member Jolley, Member Leland
BOARD MEMBER ABSENT:	Vice-Chairman Yaffe

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

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

Chairman Nuttle asked Stephanie Mavredes, Deputy State Medicaid Director, to provide a presentation of SoonerSelect Dental: A Year in Review. Ms. Mavredes provided an overview of the Dental program, which included information on the SoonerSelect Dental Program, Enrollment, Reporting, Year One Achievements, Value-Added Benefits, CE Outreach and Community Involvement, and What is Next.

For More detailed information, see Attachment "E" of the board packet.

ITEM 8 / PROPOSED EXECUTIVE SESSION AS RECOMMENDED BY THE OHCA GENERAL COUNSEL AND AUTHORIZED BY THE OPEN MEETINGS ACT, 25 OKLAHOMA STATUTES §307(B) (4).
Marc Nuttle, OHCA Board Chairman

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

ITEM 9 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

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

Meeting adjourned at 4:14 p.m., 5/21/2025.

NEXT BOARD MEETING
June 25, 2025
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

Attachment B

OKLAHOMA
Health Care Authority

Senate Finance Committee Medicaid reconciliation policies

Overview of Key Changes

Significant changes that the Senate has proposed to make to the House Medicaid language include, but are not limited to:

Provider tax provisions at Sec. 71120 including:

- Freezing provider taxes at current levels in all states
- Phasing down hold harmless thresholds for provider taxes other than for skilled nursing facilities and intermediate care facilities in expansion states from 6% to 3.5% over a specified period of years
- Capping the hold harmless threshold at 6% for provider taxes in non-expansion states

Managed care directed payments (SDPs) provisions at Sec. 71121 including:

- Capping any new SDP submissions 110% of Medicare for non-expansion states and 100% of Medicare for expansion states
- Requiring already approved SDPs to be reduced by 10 percentage points per year starting in 2027 until they are no greater than the above percentages of Medicare rates

Provisions related to Medicaid coverage of immigrant populations including:

- Significant new limitations on groups that have historically been eligible for regular Medicaid services (Sec. 71110)
- Reduction of the 90% federal match rate to a state's regular match rate for emergency Medicaid coverage of people who would, but for their immigration status, qualify for the expansion group (Sec. 71112)

Community engagement provisions at Sec. 71124 including:

- Certain changes to the populations that are exempt from the requirements, notably including parents, guardians and caretaker relatives of children (requirements now apply to those caring for children age 14 and under, as

opposed to House language of 19 or under) and individuals who must travel for an extended period to access services that are not locally available
- An option for states to seek CMS approval of a good faith effort extension of the implementation deadline
- A new prohibition on use of contractors that have a financial relationship with the health plan that is providing a beneficiary's coverage to confirm compliance with community engagement requirements
- Additional implementation resources for state systems changes

Changes to the PERM language (Sec. 71106) including:

- Removing specific reference to PERM, MEQC, and HHS OIG audits and instead indicating that any audits conducted by the Secretary will factor into the calculation of a Medicaid program's error rate
- Permitting the Secretary to waive the penalty for errors related to eligible individuals, including errors calculating the payment level for long-term care and paperwork errors o Limiting the restriction on the Secretary's ability to waive the penalty to ineligible individuals
- Clear indication of which portions of the Medicaid reconciliation language do and do not apply to the US territories

Removal of sections of the House language (House-passed HR1 section numbers below), including:

- Sec. 44105, Medicaid provider screening
- Sec. 44201, Addressing waste, fraud and abuse in ACA exchanges
- Sec. 44301, Exclusion for orphan drugs
- Sec. 44302, Streamlined eligibility process of out-of-state Medicaid and CHIP providers
- Sec. 44303, Delay of DSH reductions

Attachment C

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings – May 14, 2025 and June 11, 2025

Vote Item	Drug	Used for	Cost*	Notes
1	Alhemo® (Concizumab-mtci) Beqvez™ (Fidanacogene Elaparvovec-dzkt) Hympavzi™ (Marstacimab-hncq) Qfitlia™ (Fitusiran)	• **Hemophilia:** Hemophilia is a rare blood clotting disorder where the patient is missing certain blood clotting factors which are necessary for the body to form blood clots to stop bleeding. There are 2 main types, hemophilia A and hemophilia B. *119 members utilizing hemophilia products*	• $1,255,600 per year *Budget impact estimate: $3,766,800 per year* • $3,500,000 per 1 time treatment *Budget impact estimate: none* • $795,600 per year *Budget impact estimate: $3,978,000 per year* • $968,400 per year *Budget impact estimate: $1,936,800 per year*	• Only used in patients with an inhibitor • Manufacturer will stop commercialization in the US market • Only used in patients without inhibitors • Used in both patients with and without inhibitors
2	Agamree® (Vamorolone) Duvyzat™ (Givinostat)	• **Duchenne Muscular Dystrophy (DMD):** DMD is one of the most severe forms of inherited muscular dystrophies. It is the most common hereditary neuromuscular disease. Mutations in the dystrophin gene lead to progressive muscle fiber degeneration and weakness. *11*	• $217.512 per year *Budget impact estimate: $217,512 per year* • $1,141,732 per year *Budget impact estimate: $2,283,466 per year*	• Other cheaper therapies required first[¥] • Approved in patients 6 years and older

		members currently using DMD treatments		
3	Ocrevus Zunovo™ (Ocrelizumab/Hyaluronidase-ocsq)	• **Multiple Sclerosis (MS):** MS is an unpredictable disease of the central nervous system. MS disrupts the flow of information within the brain, and between the brain and body. An individual's experience with MS may change from day to day and year to year. Symptoms also vary from person to person and can include: fatigue, memory difficulties, mood changes, mobility issues, numbness, pain, tingling, and vision impairment *240 members with diagnosis*	• $ 82,564 per year *Budget impact estimate: $577,948 per year*	• Only given twice a year
4	Xolremdi® (Mavorixafor)	• **WHIM Syndrome:** Warts, hypogammaglobulinemia, immunodeficiency, myelokathexis (WHIM) syndrome is an ultra-rare and difficult-to-diagnose primary immunodeficiency in which individuals are susceptible to life-threatening bacterial infections and to human papillomavirus (HPV) infections. *No members with diagnosis*	• $523,872 per year *Budget impact estimate: none*	• First FDA approved treatment for WHIM
5	Journavx™ (Suzetrigine)	• **Moderate to Severe Pain:** Moderate pain is generally considered 4-7 while severe pain is 7-10 on a 0-10 pain scale with 0 being no pain and 10 being the worst possible pain. *70,500 members utilized ibuprofen last year*	• $449 per course of treatment *Budget impact estimate: $112,500 per year*	• FDA approved for 14 days short term use

6	Adzynma (ADAMTS13, Recombinant-krhn)	• **Congenital Thrombotic Thromobocytopenic Purpura (cTTP):** cTTP is a rare genetic condition of microangiopathic hemolytic anemia that causes blood clots in small blood vessels which can lead to organ injury. *3 members with diagnosis*	• $281,216 per year *Budget impact estimate: $940,992 per year*	• Used to prevent or treat acute TTP episodes
	Alvaiz® (Eltrombopag)	• **Thrombocytopenia (TP):** TP is the condition when you don't have enough platelets in your blood. Platelets are small blood cells that clot your blood after you get any cut or scrape that bleeds or a bigger injury. These cells stick together, which stops bleeding. *32 members with diagnosis*	• $448,502 per year Budget impact estimate: $7,176,038 per year	• Not first line±
7	Axtle™ (Pemetrexed)	• **Non-Small Cell Lung Cancer (NSCLC):** NSCLC is the most common type of lung cancer. It happens when normal cells in your lungs change and grow out of control. NSCLC grows slowly compared to small cell lung cancer. But it can spread to other parts of your body before you develop noticeable symptoms. *1,745 members with a lung cancer diagnosis*	• $120,870 per year *Budget impact estimate: none*	• Other cheaper therapies required first¥
	Bizengri® (Zenocutuzumabzbco)	• **NSCLC**	• $617,496 per year: *Budget impact estimate: $9,262,440 per year*	• Not first line±
	Imdelltra™ (Tarlatamab-dlle)	• **Extensive Stage Small Cell Lung Cancer (ES-SCLC):** ES-SCLC is	• $390,000 per year	• Not first line±

		regarded as a refractory carcinoma associated with extremely rapid disease progression. *1,745 members with a lung cancer diagnosis*	*Budget impact estimate: $5,850,000 per year*	
	Lazcluze™ (Lazertinib)	• **NSCLC**	• $218,376 per year *Budget impact estimate:* $6,521,280 per year	• Used as first line therapy in combination with other medications
	Tecentriq Hybreza™ (Atezolizumab/ Hyaluronidase-tqjs)	• **NSCLC**	• $191,280 per year *Budget impact estimate: none*	• Approved in patients 18 years of age and older
8	Daxxify® (DaxibotulinumtoxinA-lanm)	• **Cervical Dystonia (CD):** CD is a painful condition in which the neck muscles contract involuntarily, causing the head to twist or turn to one side. Cervical dystonia can also cause the head to uncontrollably tilt forward or backward. *190 members with diagnosis*	• $3,588 per year *Budget impact estimate: $17,940 per year*	• Also approved for improving appearance of glabellar lines which is considered cosmetic and not covered by SoonerCare
9	Merilog™ (Insulin Aspart-szjj)	• **Diabetes Mellitus (DM):** DM refers to a group of diseases that affect how the body uses blood sugar. Chronic diabetes conditions include type 1 diabetes and type 2 diabetes. Long-term complications of diabetes develop gradually. The longer the patient has diabetes — and the less controlled their blood sugar — the higher the risk of complications. Eventually, diabetes complications	• $1,961 per year *Budget impact estimate: $176,490 per year*	• Other cheaper therapies required first¥

		may be disabling or even life-threatening. *15,441 members utilizing insulin*		
10	Sofdra™ (Sofpironium 12.45% Topical Gel)	• **Primary Axillary Hyperhidrosis (PAH):** Hyperhydrosis is excessive sweating that affects patients' quality of life, resulting in social and work impairment and emotional distress. PAH is bilaterally symmetric, focal, excessive sweating of the axillae not caused by other underlying conditions. *74 pediatric members with diagnosis*	• $11,640 per year *Budget impact estimate: $93,120 per year*	• Other cheaper therapies required first[¥]
11	Enzeevu™ (aflibercept-abzv) Opuviz™ (aflibercept-yszy) Yesafili™ (aflibercept-jbvf)	• **Age Related Macular Degeneration (AMD):** AMD is an eye disease that can blur your central vision. It happens when aging causes damage to the macula — the part of the eye that controls sharp, straight-ahead vision. The macula is part of the retina (the light-sensitive tissue at the back of the eye). *295 members utilizing with diagnosis*	• N/A • N/A • N/A	• Other cheaper therapies required first[¥] • Other cheaper therapies required first[¥] • Other cheaper therapies required first[¥]
12	Crexont® [Carbidopa/Levodopa Extended-Release (ER) Capsule] Onapgo™ (Apomorphine Injection for Continuous Infusion)	• **Parkinson's Disease (PD):** PD is a movement disorder of the nervous system that worsens over time. PD symptoms may include tremor, slowed movement, rigid muscles, poor posture and balance, loss of automatic movement, speech changes, writing changes, and nonmotor symptoms such as sleep problems and depression. *390*	• $8,942 per year *Budget impact estimate: $89,420 per year* • $103,536 per year *Budget impact estimate: $517,680 per year*	• Other cheaper therapies required first[¥] • Other cheaper therapies required first[¥]

	Vyalev™ (Foscarbidopa/ Foslevodopa Injection for Continuous Infusion)	*members utilizing carbidopa/levodopa products*	• $235,800 per year *Budget impact estimate:* $1,179,000 per year	• Other cheaper therapies required first¥
13	Vanrafia™ (Atrasentan)	• **Primary Immunoglobulin A Nephropathy (IgAN):** IgAN is a rare disease that causes kidney damage when your own immune system produces antibodies in your kidneys. *6 members with diagnosis*	• $160,275 per year *Budget impact estimate: $160,275 per year*	• Approved on an accelerated pathway through the FDA.

*Costs do not reflect rebated prices or net costs. Costs based on National Average Drug Acquisition Costs (NADAC) or Wholesale Acquisition Costs (WAC) if NADAC unavailable.

N/A = not available at the time of publication.

¥Other cheaper therapies required first: There are other treatment options available with or without a prior authorization (PA) which will be required for the member to try and fail before a PA would be issued for this new therapy.

±Not first line: The patient must have failed treatment with other therapy first per FDA approval.

Pharmacy Agenda Items

Recommendation 1: Vote to Prior Authorize Alhemo®, Beqvez™, Hympavzi™, and Qfitlia™

The Drug Utilization Review Board recommends the prior authorization of Alhemo® (Concizumab-mtci), Beqvez™ (Fidanacogene Elaparvovec-dzkt), Hympavzi™ (Marstacimab-hncq), and Qfitlia™ (Fitusiran) with the following criteria:

Alhemo® (Concizumab-mtci) Approval Criteria:

1. An FDA approved diagnosis of hemophilia A or B with inhibitors; and
2. Member must be 12 years of age or older; and
3. Member's recent weight (taken within the past 3 months) must be provided and must be ≥25kg; and
4. Member must not be undergoing immune tolerance induction (ITI); and
5. Member must not have a history of or be at high risk for thromboembolic events; and
6. Female members of reproductive potential must meet the following:
    a. Must not be pregnant; or
        i. If member is pregnant or becomes pregnant during treatment, the risk to the fetus must be weighed against the benefit to the mother; and
    b. Must agree to use effective birth control during treatment and for at least 7 weeks after the last dose; and
7. Prescriber must agree the member will not be continuing on other prophylactic therapies; and
8. Must be prescribed by a hematologist practicing in a federally recognized Hemophilia Treatment Center (HTC) or mid-level practitioner under the supervision of a physician at an HTC; and
9. Prescriber must verify that the member or caregiver has been trained on the subcutaneous administration and counseled on the storage of Alhemo®; and
10. Prescriber must verify that the member has been counseled on the potential risk of thrombosis and use of bypassing agents at the lowest possible dose for breakthrough bleeding episodes based on severity and location of bleed; and
11. Requests must be for an FDA approved dosing regimen as outlined in the package labeling; and
12. Initial approvals will be for 3 months for the loading dose of 1mg/kg on day 1 and 0.2mg/kg daily until individualization of the maintenance dose has been achieved. Subsequent approvals will be the duration of 1 year if there is documentation of clinical effectiveness.

Beqvez™ (Fidanacogene Elaparvovec-dzkt) Approval Criteria:

1. A diagnosis of severe or moderately severe congenital, X-linked, hemophilia B (FIX ≤2%); and
2. Member must be a male 18 years of age or older; and

Pharmacy Agenda Items

3. Member must not have a history of an inhibitor, or a recent positive screening defined as ≥0.6 Bethesda units prior to administration of fidanacogene elaparvovec-dzkt; and
4. Member must not have neutralizing antibodies to adeno-associated virus serotype Rh74var (AAVRh74var) capsid as detected by an FDA-approved test; and
5. Member must be on prophylactic therapy with continued frequent breakthrough bleeding episodes or has experienced a life-threatening bleeding episode; and
6. Member must have had >50 previous exposure days of treatment with factor IX; and
7. Member must not have any of the following:
    a. Current liver-related coagulopathy; or
    b. Hypoalbuminemia; or
    c. Persistent jaundice; or
    d. Cirrhosis; or
    e. Portal hypertension; or
    f. Splenomegaly; or
    g. Hepatic encephalopathy; or
    h. Hepatic fibrosis; or
    i. Active viral hepatitis; and
8. Members with human immunodeficiency virus (HIV) must not be uncontrolled with antiviral therapy as shown by CD4+ counts ≤200cells/mm^3 or viral load ≥20 copies/mL; and
9. Member must not have received prior treatment with any gene therapy for hemophilia B; and
10. Provider must perform a liver health assessment including:
    a. Enzyme testing (ALT, AST, ALP); and
    b. Hepatic ultrasound and elastography; and
11. Member's recent weight must be provided (taken within the last month) to ensure appropriate dosing; and
12. Prescriber must counsel member not to donate semen, and if member is of reproductive potential, then their female partners must agree to prevent or postpone pregnancy for 6 months after treatment with fidanacogene elaparvovec-dzkt; and
13. Must be prescribed by a hematologist practicing in a federally recognized Hemophilia Treatment Center (HTC) or mid-level practitioner under the supervision of a physician at an HTC; and
14. Fidanacogene elaparvovec-dzkt must be administered in an appropriate clinical setting and member must be monitored for at least 3 hours post infusion; and
15. Prescriber agrees to monitor liver enzymes and the factor IX activity level following administration of fidanacogene elaparvovec-dzkt per the package labeling as follows:
    a. Weeks 1 through 16: once to twice weekly; and
    b. Weeks 17 and 18: weekly; and
    c. Weeks 19 through 52: at weeks 24, 32, 42, and 52; and
    d. Years 2 and 3: quarterly; and

e. Years 4 through 6: twice yearly; and
f. Yearly thereafter; and

16. Prescriber agrees to start corticosteroids as indicated in the package labeling based on liver enzyme results and the factor IX activity level; and
17. Approvals will be for 1 treatment per member per lifetime.

Hympavzi™ (Marstacimab-hncq) Approval Criteria:

1. A diagnosis of moderately severe to severe hemophilia A (FVIII <2%) without inhibitors or moderately severe to severe hemophilia B (FIX activity <2%) without inhibitors; and
2. Member must be 12 years of age or older and weigh at least 35kg; and
3. Member must not have a current inhibitor or documented history of an inhibitor; and
4. For females of reproductive potential:
   a. Member must not be pregnant and must have a negative pregnancy test prior to therapy initiation; and
   b. Member must be willing to use effective contraception during and after treatment for at least 2 months after the last dose; and
5. Member must not have uncontrolled human immunodeficiency virus (HIV) as shown by CD4+ counts ≤200cells/mm^3; and
6. Prescriber must agree the member will not be continuing other prophylactic therapies; and
7. Must be prescribed by a hematologist practicing in a federally recognized Hemophilia Treatment Center (HTC) or mid-level practitioner under the supervision of a physician at an HTC; and
8. Prescriber must verify that the member or caregiver has been trained on the subcutaneous administration and counseled on the storage of Hympavzi™; and
9. Prescriber must verify that the member has been counseled on the use of factor replacement therapy at the lowest possible dose for breakthrough bleeding episodes; and
10. Initial approvals will be for 3 months of therapy. Subsequent approvals will be the duration of 1 year if there is documentation of clinical effectiveness; and
11. Approvals will be for 300mg loading dose followed by 150mg weekly doses. Approvals may be granted for dose escalation to 300mg weekly when the following are met:
    a. Member weighs ≥50kg; and
    b. There have been ≥2 spontaneous bleeding episodes which were treated with factor replacement therapy in the last 6 months despite compliance; and
    c. Absence of inhibitor development.

Qfitlia™ (Fitusiran) Approval Criteria:

Pharmacy Agenda Items

1. A diagnosis of severe hemophilia A or B, with or without factor inhibitors; and
2. Member must be 12 years of age or older; and
3. Member must not have a history of or be at high risk for thromboembolic events; and
4. Member must not have clinically significant liver disease; and
5. Member must not have active hepatitis C; and
6. Member must not have an acute or chronic hepatitis B infection; and
7. Members with human immunodeficiency virus (HIV) must not be uncontrolled with antiviral therapy as shown by CD4+ counts ≤200cells/mm^3 or viral load ≥20 copies/mL; and
8. In a member with a history of symptomatic gallbladder disease, a reason why the member cannot use other available treatments must be provided; and
9. Must be prescribed by a hematologist practicing in a federally recognized Hemophilia Treatment Center (HTC) or mid-level practitioner under the supervision of a physician at an HTC; and
10. Prescriber must agree the member will not be continuing other prophylactic therapies for longer than 7 days after initiation of fitusiran; and
11. Prescriber must agree to perform an FDA-cleared test for antithrombin activity at weeks 4, 12, 20, and 24 and adjust the dosing as outlined in the package labeling; and
12. Prescriber must agree to perform baseline liver tests prior to initiation of fitusiran and monthly for at least 6 months and after any dose increase; and
13. Prescriber must verify that the member or caregiver has been trained on the subcutaneous administration and counseled on the storage of fitusiran; and
14. Prescriber must verify that the member has been counseled on the use of factor replacement therapy or bypassing agent as outlined in the prescribing information for breakthrough bleeding episodes; and
15. Initial approvals will be for 3 months of therapy. Subsequent approvals will be the duration of 1 year if there is documentation of clinical effectiveness.

Recommendation 2: Vote to Prior Authorize Agamree® and Duvyzat™

The Drug Utilization Review Board recommends the prior Agamree® (Vamorolone) and Duvyzat™ (Givinostat) with the following criteria:

Agamree® (Vamorolone Oral Suspension) Approval Criteria:

1. An FDA approved diagnosis of Duchenne muscular dystrophy (DMD) with a confirmed mutation in the *DMD* gene (results of genetic testing must be submitted); and
2. Member must be 2 years of age or older; and
3. Agamree® must be prescribed by, or in consultation with, a prescriber who specializes in the treatment of DMD; and

4. Member must have a minimum 6-month trial of prednisone that resulted in inadequate effects or intolerable adverse effects that are not expected to occur with Agamree® or a patient specific, clinically significant reason why the member cannot use prednisone must be provided; and
5. A patient specific, clinically significant reason why the member cannot use brand name Emflaza® (deflazacort) must be provided; and
6. Prescriber must verify the member has a baseline eye examination; and
7. The member's recent weight must be provided in order to authorize the appropriate amount of drug required according to the package labeling; and
8. For continued authorization, an updated weight must be provided, and the member must have had a repeat eye exam with results that are acceptable to the prescriber; and
9. A quantity limit of 300mL per 40 days will apply.

Duvyzat™ (Givinostat Oral Suspension) Approval Criteria:

1. An FDA approved diagnosis of Duchenne muscular dystrophy (DMD) with a confirmed mutation in the *DMD* gene (results of genetic testing must be submitted); and
2. Member must be 6 years of age or older; and
3. Must be prescribed by a neurologist or specialist with expertise in the treatment of DMD (or an advanced care practitioner with a supervising physician who is a neurologist or specialist with expertise in the treatment of DMD); and
4. Member must be on a stable dose of a corticosteroid (at least 3 months in duration) or a patient-specific, clinically significant reason why corticosteroids are not appropriate for the member must be provided; and
5. Prescriber must verify platelet counts and triglycerides have been evaluated at baseline, and levels are acceptable to the prescriber; and
6. Prescriber must agree to monitor member for adverse reactions such as a decrease in platelet counts, increase in triglycerides, or moderate to severe diarrhea and agree to modify the dose based on the package labeling recommendations, if needed; and
7. If member has underlying cardiac disease or is taking concomitant medications that cause QT prolongation, prescriber must agree to obtain an electrocardiogram (ECG) before initiating treatment with Duvyzat™, during concomitant use, and as clinically indicated; and
8. Approvals will be for the duration of 1 year. For each subsequent approval, the prescriber must document the member is tolerating and benefiting from treatment, as indicated by improvement, stabilization, or a slower progression of disease compared to the typical DMD progression (i.e., improved functional tests, strength, or pulmonary function test); and
9. The member's recent weight must be provided in order to authorize the appropriate amount of drug required according to the package labeling; and
10. A quantity limit of 420mL per 35 days will apply.

OHCA Board Meeting June 25, 2025

Pharmacy Agenda Items

Recommendation 3: Vote to Prior Authorize Ocrevus Zunovo™

The Drug Utilization Review Board recommends the prior authorization of Ocrevus Zunovo™ (Ocrelizumab/Hyaluronidase-ocsq) with the following criteria:

Ocrevus Zunovo™ (Ocrelizumab/ Hyaluronidase-ocsq) Approval Criteria:

1. An FDA approved diagnosis of primary progressive forms of multiple sclerosis (MS) or relapsing forms of MS, to include clinically isolated syndrome, relapsing-remitting disease, and active secondary progressive disease in adults; and
2. Prescriber must be a neurologist (or an advanced care practitioner with a supervising physician that is a neurologist); and
3. Approvals will not be granted for concurrent use with other disease modifying therapies; and
4. Ocrevus Zunovo™ must be administered by a health care professional in a setting with appropriate equipment and personnel to manage anaphylaxis or serious infusion/injection reactions. Approvals will not be granted for self-administration. Prior authorization requests must indicate how the requested product will be administered; and
    a. Ocrevus Zunovo™ must be shipped via cold chain supply to the facility where the member is scheduled to receive treatment; or
    b. Ocrevus Zunovo™ must be shipped via cold chain supply to the member's home and administered by a home health care provider and the member or member's caregiver must be trained on the proper storage of the requested product; and
5. Prescriber must confirm that member will be monitored appropriately per package labeling after each infusion or injection; and
6. Prescriber must verify hepatitis B virus (HBV) testing has been performed prior to initiating ocrelizumab therapy and member does not have active HBV; and
7. Verification from the prescriber that member has no active infection(s); and
8. Verification from the prescriber that female members are not currently pregnant and will use contraception while receiving ocrelizumabtherapy and for 6 months after the last dose ~~infusion~~ of ocrelizumab; and
9. Approvals will be for the duration of 1 year, and compliance will be checked for continued approval.

Recommendation 4: Vote to Prior Authorize Xolremdi®

The Drug Utilization Review Board recommends the prior authorization Xolremdi® (Mavorixafor) with the following criteria:

Xolremdi® (Mavorixafor) Approval Criteria:

Pharmacy Agenda Items

1. An FDA approved diagnosis of warts, hypogammaglobulinemia, infections, and myelokathexis (WHIM) syndrome; and
    a. Diagnosis must be confirmed by the presence of a pathogenic or likely pathogenic genotypic variant of the *CXCR4* gene (results of genetic testing must be submitted); and
2. Member must be 12 years of age or older; and
3. Must be prescribed by, or in consultation with, a hematologist, immunologist, or other specialist with expertise in treatment of WHIM syndrome (or an advanced care practitioner with a supervising physician who is a hematologist, immunologist, or other specialist with expertise in treatment of WHIM syndrome); and
4. The member's recent weight (within the last 3 months) must be provided with the prior authorization request in order to authorize the appropriate amount of drug required according to package labeling; and
5. Female members of reproductive potential must not be pregnant, must have a negative pregnancy test prior to initiation of therapy, and must be willing to use an effective method of contraception during treatment and for at least 3 weeks after discontinuing treatment; and
6. Female members must not be breastfeeding during treatment and for at least 3 weeks after discontinuation of treatment; and
7. Prescriber must agree to counsel the member on proper administration, including taking Xolremdi® on an empty stomach after an overnight fast and at least 30 minutes before food; and
8. Prescriber must verify the member does not have severe renal impairment [creatinine clearance (CrCl) 15-30mL/min] or end-stage renal disease (CrCl <15mL/min); and
9. Prescriber must verify the member does not have moderate or severe hepatic impairment (Child-Pugh B or C); and
10. Prescriber must evaluate the potential for drug interactions, including the need for dose adjustments or increased monitoring of Xolremdi® or the concomitant medication(s), according to package labeling, before initiating and throughout treatment with Xolremdi®; and
11. Prescriber must verify that any modifiable risk factors for QTc prolongation (e.g., hypokalemia, hypomagnesemia) are corrected prior to initiation of therapy; and
12. Prescriber must agree to perform and monitor electrocardiogram (ECG) at baseline and as clinically indicated, thereafter, for patients with risk factors for QTc prolongation (e.g., receiving concomitant medications with known potential to prolong the QTc interval or concomitant medications that increase Xolremdi® exposure); and
13. For members who are using Xolremdi® concomitantly with other medications that are known to increase Xolremdi® exposure and/or prolong the QTc interval [antipsychotic medications (e.g., chlorpromazine, haloperidol, thioridazine, ziprasidone), antibiotics (e.g., moxifloxacin), Class 1A (e.g., quinidine, procainamide) and Class III (e.g., amiodarone, sotalol) antiarrhythmic medications, or any other medications known to prolong the QTc interval] the prescriber must agree to monitor the member for symptoms

of prolonged QTc interval (e.g., syncope, palpitations, seizures) and evaluate the need for a dose reduction based on clinical response; and

14. A quantity limit of 120 capsules per 30 days will apply; and
15. Initial approvals will be for the duration of 6 months. Reauthorization may be granted for the duration of 1 year if the prescriber documents the member is responding well to treatment as indicated by 1 of the following:
    a. Documentation of sustained improvement in absolute neutrophil count (ANC) and/or absolute lymphocyte count (ALC) is provided; or
    b. If the member does not show a sustained improvement in ANC and/or ALC, a clinical rationale for continuation of treatment must be provided for reauthorization.

Recommendation 5: Vote to Prior Authorize Journavx™

The Drug Utilization Review Board recommends the prior authorization Journavx™ (Suzetrigine) with the following criteria:

Journavx™ (Suzetrigine) Approval Criteria:

1. An FDA approved diagnosis of moderate to severe acute pain; and
2. Member must be 18 years of age or older; and
3. The underlying cause of the acute pain must be provided; and
4. Member must have a current numeric pain rating scale (NPRS) score ≥4 (NPRS score must be provided on the request); and
5. Member must not be taking any strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole, ritonavir, clarithromycin); and
6. Member must not have severe hepatic impairment (Child-Pugh class C); and
7. If member is using hormonal contraceptives containing progestins, other than levonorgestrel and norethindrone, prescriber must confirm the member has been counseled to use an additional nonhormonal contraceptive method or an alternative hormonal contraceptive during treatment with Journavx™ and 28 days after Journavx™ discontinuation; and
8. A patient specific, clinically significant reason why the member cannot use other non-opioid pain relievers, including acetaminophen and a non-steroidal anti-inflammatory drug (NSAID), must be provided; and
9. Journavx™ will not be approved for concurrent use with an opioid; and
10. A quantity limit of 30 tablets for a 14-day supply will apply. The use of Journavx™ for acute pain has not been studied for longer than 14 days. Journavx™ will not be approved for use beyond 14 days or for chronic pain.

Recommendation 6: Vote to Prior Authorize Adzynma and Alvaiz®

OHCA Board Meeting June 25, 2025

Pharmacy Agenda Items

Drug Utilization Review Board recommends the prior authorization Adzynma (ADAMTS13, Recombinant-krhn) and Alvaiz® (Eltrombopag) with the following criteria:

Adzynma (ADAMTS13, Recombinant-krhn) Approval Criteria:

1. An FDA approved diagnosis of congenital thrombotic thrombocytopenic purpura (cTTP) confirmed by:
    a. Molecular genetic testing confirming biallelic pathogenic variants in the *ADAMTS13* gene (results of genetic testing must be submitted); and
    b. ADAMTS13 activity testing showing <10% of normal ADAMTS13 activity (results of activity testing must be submitted); and
2. Member's recent weight (within the last 3 weeks) must be provided in order to ensure appropriate dosing in accordance with the package labeling; and
3. For prophylactic therapy, member has a history of ≥1 documented TTP event or is currently receiving prophylactic therapy; and
4. Must be prescribed by, or in consultation with, a hematologist, oncologist, or other specialist with expertise in the treatment of cTTP; and
5. For prophylactic enzyme replacement therapy (ERT):
    a. Initial approvals will be for the duration of 6 months. Subsequent approvals, for the durations of 1 year, may be granted if the prescriber attests that the member is tolerating and responding well to treatment (e.g., improvement in acute and subacute TTP events, TTP manifestations, other clinical symptoms associated with TTP); and
6. For on-demand ERT:
    a. Approvals will be for 1 month; and
    b. If additional days are needed, requests should specify that the acute event has not resolved.

Alvaiz® (Eltrombopag) Approval Criteria [Persistent or Chronic Immune Thrombocytopenia (ITP) Diagnosis]:

1. An FDA approved diagnosis of persistent or chronic ITP; and
2. Member must have a platelet count of $<30 \times 10^9$/L; and
3. Alvaiz® must not be used in an attempt to normalize platelet counts; and
4. Member must be 6 years of age or older; and
5. Member must not have a recent diagnosis of myelodysplastic syndromes; and
6. Previous insufficient response to at least 1 of the following treatments:
    a. Corticosteroids; or
    b. Immunoglobulins; or
    c. Splenectomy; and
7. A patient-specific, clinically significant reason why the member cannot use an alternative thrombopoietin (TPO) receptor agonist available without a prior authorization must be provided; and
8. Prescriber must attest that all other causes of thrombocytopenia, including malignancy and liver disease, have been ruled out; and

9. Prescriber must verify that members will receive baseline and follow-up ocular examinations as recommended in the package labeling; and
10. Prescriber must agree to monitor hepatic function prior to and during treatment with Alvaiz®; and
11. Must be prescribed by, or in consultation with, a hematologist or other specialist with expertise in the treatment of ITP; and
12. Quantity limits will apply based on FDA-approved dosing, up to a maximum of 54mg per day, as follows:
    a. 9mg strength: 30 tablets per 30 days; or
    b. 18mg strength: 90 tablets per 30 days; or
    c. 36mg strength: 30 tablets per 30 days; or
    d. 54mg strength: 30 tablets per 30 days.

Alvaiz® (Eltrombopag) Approval Criteria [Chronic Hepatitis C-Associated Thrombocytopenia Diagnosis]:

1. Member must have diagnosis of chronic hepatitis C-associated thrombocytopenia; and
2. Member must have a platelet count of $<75 \times 10^9$/L; and
3. Member must be 18 years of age or older; and
4. Member must not have a recent diagnosis of myelodysplastic syndromes; and
5. Member must be initiating interferon-based therapy (regimen must be provided); and
6. A patient-specific, clinically significant reason why the member cannot use an alternative thrombopoietin (TPO) receptor agonist available without a prior authorization must be provided; and
7. Prescriber must verify that members will receive baseline and follow-up ocular examinations as recommended in the package labeling; and
8. Prescriber must agree to monitor hepatic function prior to and during treatment with Alvaiz® and concomitant hepatitis C therapy; and
9. Must be prescribed by, or in consultation with, a hematologist or other specialist with expertise in the treatment of hepatitis C-associated thrombocytopenia; and
10. Continuation requests will not be approved once antiviral therapy has been discontinued; and
11. Quantity limits will apply based on FDA-approved dosing, up to a maximum of 72mg per day, as follows:
    a. 9mg strength: 30 tablets per 30 days; or
    b. 18mg strength: 120 tablets per 30 days; or
    c. 36mg strength: 60 tablets per 30 days; or
    d. 54mg strength: 30 tablets per 30 days.

Alvaiz® (Eltrombopag) Approval Criteria [Refractory Severe Aplastic Anemia Diagnosis]:

1. Member must have diagnosis of refractory severe aplastic anemia; and

Pharmacy Agenda Items

2. Member must have a platelet count of ≤30 x 10^9/L; and
3. Member must not have a diagnosis of Fanconi anemia; and
4. Member must be 18 years of age or older; and
5. Member must not have a recent diagnosis of myelodysplastic syndromes; and
6. Member must have a documented trial of immunosuppressive therapy; and
7. A patient-specific, clinically significant reason why the member cannot use an alternative thrombopoietin (TPO) receptor agonist available without a prior authorization must be provided; and
8. Prescriber must verify that members will receive baseline and follow-up ocular examinations as recommended in the package labeling; and
9. Prescriber must agree to monitor hepatic function prior to and during treatment with Alvaiz®; and
10. Must be prescribed by, or in consultation with, a hematologist or other specialist with expertise in the treatment of aplastic anemia; and
11. Quantity limits will apply based on FDA-approved dosing, up to a maximum of 108mg per day as follows:
    a. 9mg strength: 30 tablets per 30 days; or
    b. 18mg strength: 120 tablets per 30 days; or
    c. 36mg and 54mg strengths: 60 tablets per 30 days.

Recommendation 7: Vote to Prior Authorize Axtle™, Bizengri®, Imdelltra™, Lazcluze™, and Tecentriq Hybreza™

Drug Utilization Review Board recommends the prior authorization Axtle™ (Pemetrexed), Bizengri® (Zenocutuzumabzbco), Imdelltra™ (Tarlatamab-dlle), Lazcluze™ (Lazertinib), and Tecentriq Hybreza™ (Atezolizumab/ Hyaluronidase-tqjs) with the following criteria:

Axtle™ (Pemetrexed; J9292) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason the member cannot use Alimta® (pemetrexed; J9305), pemetrexed ditromethamine (J9323), and other preferred pemetrexed 25mg/mL solution products (J9294 - Hospira, J9296 - Accord, J9297 – Sandoz, J9314 - Teva, J9322 - Bluepoint) that do not require prior authorization must be provided.

Bizengri® (Zenocutuzumab-zbco) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of advanced, unresectable or metastatic NSCLC; and
2. Neuregulin 1 (*NRG1*) gene fusion-positive; and
3. Disease progression on or after prior systemic therapy; and
4. Used as single agent.

OHCA Board Meeting June 25, 2025

Pharmacy Agenda Items

Bizengri® (Zenocutuzumab-zbco) Approval Criteria [Pancreatic Cancer Diagnosis]:

1. Diagnosis of advanced, unresectable or metastatic pancreatic adenocarcinoma; and
2. Neuregulin 1 (*NRG1*) gene fusion-positive; and
3. Disease progression on or after prior systemic therapy; and
4. Used as single agent.

Imdelltra™ (Tarlatamab-dlle) Approval Criteria [Extensive Stage Small Cell Lung Cancer (ES-SCLC) Diagnosis]:

1. Diagnosis of ES-SCLC; and
2. Member has disease progression on or after platinum-based chemotherapy; and
3. Healthcare facilities must be trained in the management of cytokine release syndrome (CRS) and neurologic toxicities.

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

1. Diagnosis of locally advanced or metastatic NSCLC; and
2. Tumor exhibits epidermal growth factor receptor (EGFR) exon 19 deletions or exon 21 L858R substitution mutations; and
3. Used as first-line treatment in combination with amivantamab.

Tecentriq Hybreza™ (Atezolizumab/ Hyaluronidase-tqjs) Approval Criteria [Alveolar Soft Part Sarcoma (ASPS) Diagnosis]:

1. Diagnosis of unresectable or metastatic ASPS; and
2. Member must be 2 years of age or older for Tecentriq®; or
3. Member must be 18 years of age or older for Tecentriq Hybreza™.

Tecentriq Hybreza™ (Atezolizumab/ Hyaluronidase-tqjs) Approval Criteria [Hepatocellular Carcinoma (HCC) Diagnosis]:

1. Diagnosis of advanced unresectable or metastatic HCC disease; and
2. Used in combination with bevacizumab; and
3. Member has not received prior systemic therapy; and
4. Member must be 18 years of age or older.

Tecentriq Hybreza™ (Atezolizumab/ Hyaluronidase-tqjs) Approval Criteria [Melanoma Diagnosis]:

1. Unresectable or metastatic disease; and
2. BRAF V600 mutation-positive; and

3. In combination with cobimetinib and vemurafenib; and
4. Member must be 18 years of age or older.

Tecentriq Hybreza™ (Atezolizumab/ Hyaluronidase-tqjs) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of non-squamous NSCLC; and
    a. First-line therapy for metastatic disease; and
    b. The member does not have epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), ROS1, BRAF, MET exon 14 skipping mutation, or RET mutations; and
    c. Used in combination with bevacizumab, paclitaxel, and carboplatin (maximum of 6 cycles) or in combination with paclitaxel (protein bound) and carboplatin; and
    d. Atezolizumab and bevacizumab may be continued after the above combination in members without disease progression (applies to the bevacizumab/paclitaxel/carboplatin regimen); or
2. Diagnosis of NSCLC; and
    a. For first-line therapy for metastatic disease:
        i. Used as a single-agent; and
        ii. Member does not have epidermal growth factor receptor (EGFR), anaplastic lymphoma kinase (ALK), ROS1, BRAF, MET exon 14 skipping, or RET mutations; and
        iii. High programmed death ligand-1 (PD-L1) expression determined by 1 of the following:
            1. PD-L1 stained ≥50% of tumor cells (TC≥50%); or
            2. PD-L1 stained tumor-infiltrating immune cells (IC) covering ≥10% of the tumor area (IC≥10%); or
    b. For subsequent therapy for metastatic disease, meets the following:
        i. Used as a single-agent only; or
3. Diagnosis of stage II or IIIA NSCLC; and
    a. Member has undergone resection and completed platinum-based chemotherapy; and
    b. PD-L1 expression of ≥1% of tumor cells; and
4. Member must be 18 years of age or older.

Tecentriq Hybreza™ (Atezolizumab/ Hyaluronidase-tqjs) Approval Criteria [Small Cell Lung Cancer (SCLC) Diagnosis]:

1. Diagnosis of SCLC; and
2. First-line therapy; and
3. Extensive-stage disease; and
4. Atezolizumab must be used in combination with carboplatin and etoposide; and
5. Member must be 18 years of age or older.

Pharmacy Agenda Items

Recommendation 8: Vote to Prior Authorize Daxxify®

Drug Utilization Review Board recommends the prior Daxxify® (DaxibotulinumtoxinA-lanm) with the following criteria:

Daxxify® (DaxibotulinumtoxinA-lanm) Approval Criteria:

1. A patient-specific, clinically significant reason the member cannot use Botox® or Dysport® must be provided; and
2. Cosmetic indications will not be covered; and
3. A diagnosis of chronic migraine (tension headaches are not a covered diagnosis), neurogenic detrusor overactivity, and non-neurogenic overactive bladder will require manual review (see specific criteria below); and
4. The following indications have been determined to be appropriate and are covered:
    a. Spasticity associated with:
        i. Cerebral palsy; or
        ii. Paralysis; or
        iii. Generalized weakness/incomplete paralysis; or
        iv. Larynx; or
        v. Anal fissure; or
        vi. Esophagus (achalasia and cardiospasms); or
        vii. Eye and eye movement disorders; or
    b. Cervical dystonia.

Recommendation 9: Vote to Prior Authorize Merilog™

Drug Utilization Review Board recommends the prior authorization Merilog™ (Insulin Aspart-szjj) with the following criteria:

Merilog™ (Insulin Aspart-szjj) Approval Criteria:

1. An FDA approved diagnosis of diabetes mellitus; and
2. A patient-specific, clinically significant reason why the member cannot use Novolog® (insulin aspart) or Fiasp® (insulin aspart) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Recommendation 10: Vote to Prior Authorize Sofdra™

Drug Utilization Review Board recommends the prior authorization Sofdra™ (Sofpironium 12.45% Topical Gel) with the following criteria:

Sofdra™ (Sofpironium 12.45% Topical Gel) Approval Criteria:

Pharmacy Agenda Items

1. An FDA approved diagnosis of primary axillary hyperhidrosis; and
2. Member must be 9 to 20 years of age; and
3. Documentation of assessment by a licensed behavior specialist or the prescribing physician indicating the member's hyperhidrosis is causing social anxiety, depression, or similar mental health-related issues that impact the member's ability to function in day-to-day living must be provided; and
4. Member must have failed a trial, at least 3 weeks in duration, with the following:
   a. Xerac® AC (aluminum chloride hexahydrate 6.25% topical solution) or at least 1 over-the-counter Certain Dri® antiperspirant; and
   b. Drysol® (aluminum chloride 20% topical solution); and
5. Prescriber must verify that the member has received counseling on the safe and proper use of Sofdra™; and
6. A quantity limit of 40.2mL per 30 days will apply; and
   Initial approvals will be for the duration of 3 months. Subsequent approvals will be for 1 year if the prescriber documents the member is responding well to treatment.

Recommendation 11: Vote to Prior Authorize Enzeevu™, Opuviz™, and Yesafili™

Drug Utilization Review Board recommends the prior authorization Enzeevu™ (aflibercept-abzv), Opuviz™ (aflibercept-yszy), and Yesafili™ (aflibercept-jbvf) with the following criteria:

Enzeevu™ (Aflibercept-abzv), Opuviz™ (Aflibercept-yszy), and Yesafili™ (Aflibercept-jbvf) Approval Criteria:

1. An FDA approved diagnosis; and
2. A patient-specific, clinically significant reason why the member cannot use Eylea®/Eylea® HD (aflibercept) or Pavblu™ (aflibercept-ayyh) must be provided. Biosimilars and/or reference products are preferred based on the lowest net cost product(s) and may be moved to either preferred or non-preferred if the net cost changes in comparison to the reference product and/or other available biosimilar products.

Recommendation 12: Vote to Prior Authorize Crexont®, Onapgo™, and Vyalev™

Drug Utilization Review Board recommends the prior authorization l) Crexont® [Carbidopa/Levodopa Extended-Release (ER) Capsule], Onapgo™ (Apomorphine Injection for Continuous Infusion), and Vyalev™ (Foscarbidopa/ Foslevodopa Injection for Continuous Infusion) with the following criteria:

Pharmacy Agenda Items

Crexont® [Carbidopa/Levodopa Extended-Release (ER) Capsules] and Approval Criteria

1. An FDA approved diagnosis of Parkinson's disease, post-encephalitic parkinsonism, or parkinsonism that may follow carbon monoxide intoxication or manganese intoxication; and
2. A patient-specific, clinically significant reason why the member cannot use other generic carbidopa/levodopa combinations including Sinemet® CR (carbidopa/levodopa ER tablets); and
3. A patient-specific, clinically significant reason why the member cannot use Rytary® (carbidopa/levodopa ER capsules) must be provided.

Onapgo™ (Apomorphine Injection for Continuous Infusion) Approval Criteria:

1. An FDA approved indication for the treatment of motor fluctuations in patients with advanced Parkinson's disease; and
2. Member must be 18 years of age or older; and
3. Onapgo™ must be prescribed by, or in consultation with, a neurologist; and
4. Prescriber must verify that member has demonstrated a clear responsiveness to treatment with levodopa and is experiencing persistent motor fluctuations with 3 hours or more of "off" time per day despite optimized carbidopa/levodopa therapy; and
5. Member has documented trials that resulted in an inadequate response despite optimized treatment (or documented intolerance or contraindication) with oral carbidopa/levodopa and 1 of the following:
    a. Dopamine agonist (e.g., pramipexole, ropinirole); or
    b. Monoamine oxidase-B (MAO-B) inhibitor (e.g., selegiline, rasagiline); or
    c. Catechol-O-methyltransferase (COMT) inhibitor (e.g., entacapone, tolcapone); or
    d. Amantadine; and
6. Member must not be taking 5-HT_3 antagonists (e.g., ondansetron, granisetron, dolasetron, palonosetron, alosetron) concomitantly with Onapgo™; and
7. Onapgo™ must be used with the Onapgo™ pump and prescriber must verify that the patient or caregiver has been trained on the proper administration of Onapgo™ with the Onapgo™ pump prior to starting treatment; and
8. Onapgo™ will not be approved for concomitant use with Vyalev™ (foscarbidopa/foslevodopa injection for continuous infusion) or Apokyn® (apomorphine injection); and
9. Initial approvals will be for 6 months. For continued authorization, prescriber must verify member demonstrated a positive clinical response to Onapgo™. Subsequent approvals will be for 1 year.

Vyalev™ (Foscarbidopa/Foslevodopa Injection for Continuous Infusion) Approval Criteria:

1. An FDA approved indication for the treatment of motor fluctuations with advanced Parkinson's disease; and
2. Member must be 18 years of age or older; and
3. Must be prescribed by, or in consultation with, a neurologist; and

Pharmacy Agenda Items

4. Prescriber must verify that member has demonstrated a clear responsiveness to treatment with levodopa and is experiencing persistent motor fluctuations with 2 and one-half hours or more of "off" time per day despite optimized carbidopa/levodopa therapy; and
5. Member has documented trials that resulted in an inadequate response despite optimized treatment (or documented intolerance or contraindication) with oral carbidopa/levodopa and 1 of the following:
    a. Dopamine agonist (e.g., pramipexole, ropinirole); or
    b. Monoamine oxidase-B (MAO-B) inhibitor (e.g., selegiline, rasagiline); or
    c. Catechol-O-methyltransferase (COMT) inhibitor (e.g., entacapone, tolcapone); or
    d. Amantadine; and
6. Member must not be taking nonselective monoamine oxidase inhibitors (MAOIs) concomitantly with Vyalev™ or within 2 weeks prior to initiating treatment with Vyalev™; and
7. Vyalev™ must be used with the Vyafuser™ pump and prescriber must verify that the patient or caregiver has been trained on the proper administration of Vyalev™ with the Vyafuser™ pump prior to starting treatment; and
8. Vyalev™ will not be approved for concomitant use with Onapgo™ (apomorphine subcutaneous injection); and
9. Initial approvals will be for 6 months. For continued authorization, prescriber must verify member demonstrated a positive clinical response to Vyalev™. Subsequent approvals will be for 1 year.

Recommendation 13: Vote to Prior Authorize Vanrafia™

Drug Utilization Review Board recommends the prior authorization m) Vanrafia™ (Atrasentan) with the following criteria:

Vanrafia™ (Atrasentan) Approval Criteria:

1. An FDA approved indication to reduce proteinuria in adults with primary immunoglobulin A nephropathy (IgAN) at risk of rapid disease progression; and
2. The diagnosis of primary IgAN must be confirmed by the following:
    a. Kidney biopsy; and
    b. Secondary causes of IgAN have been ruled out (i.e., IgA vasculitis; IgAN secondary to virus, inflammatory bowel disease, autoimmune disease, or liver cirrhosis; IgA-dominant infection-related glomerulonephritis); and
3. Member must be 18 years of age or older; and
4. Must be prescribed by a nephrologist (or an advanced care practitioner with a supervising physician who is a nephrologist); and
5. Member must be at risk of disease progression as demonstrated by proteinuria ≥0.5g/day (or equivalent), despite 3 months of maximal supportive care; and

Pharmacy Agenda Items

6. Member must be on a stable dose of a maximally tolerated angiotensin-converting enzyme (ACE) inhibitor or angiotensin II receptor blocker (ARB) for at least 3 months, unless contraindicated or intolerant; and
7. Females of reproductive potential must have a negative pregnancy test prior to initiation of therapy and must agree to use effective contraception during treatment and for 2 weeks after the last dose of Vanrafia™; and
8. Initial approvals will be for the duration of 6 months. Reauthorization may be granted if the prescriber documents the member is responding well to treatment. Subsequent approvals will be for 1 year.

Attachment D.i

SUBMITTED TO THE C.E.O. AND BOARD ON MAY 25, 2025

Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Consultant Services
Purpose and Scope	Additional funding is requested for the remainder of the contract term of the Consulting Contracts. The awarded contracts are currently with four contractors to provide consulting services on various policy, contracting, audit and rate-setting issues. The OHCA looks to these contractors to provide expert opinions, recommendations, and information relevant to the SoonerCare and SoonerSelect programs. The contractors perform comprehensive analysis, feasibility, determination of budget impact, and evaluation of current and potential OHCA initiatives and programs. The evolving environment continues to demand data-driven decision-making and independent evaluations of performance and costs, leading to a sustained need for these services: • Guidehouse task order -- Guidehouse provides financial services on an ongoing basis, including budget neutrality calculations, actuarial certifications, cost impacts, program feasibility, return on investment, long-term financial management, and rate setting for new or existing SoonerCare and SoonerSelect services.
Mandate	N/A
Procurement Method	Competitive bid
External Approvals	N/A
Contract Term	September 1, 2019 through June 30, 2026 – Final year of contract

BUDGET

Amount requested for Approval	$2,000,000.00 Annual
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to increase funding for Consulting Services Contracts as described above for a total of $2,000,000.00 over the previously approved not-to-exceed amount for SFY26.

Additional Information

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

Attachment D.ii

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 25, 2025

Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Consultant Services
Purpose and Scope	Additional funding is requested for the remainder of the contract term of the Consulting Contracts. The awarded contracts are currently with four contractors to provide consulting services on various policy, contracting, audit and rate-setting issues. The OHCA looks to these contractors to provide expert opinions, recommendations, and information relevant to the SoonerCare and SoonerSelect programs. The contractors perform comprehensive analysis, feasibility, determination of budget impact, and evaluation of current and potential OHCA initiatives and programs. The ongoing consulting services play a crucial role in strengthening the effectiveness, compliance, and financial sustainability of SoonerCare programs, while also advancing patient care and health outcomes. The Pacific Health Policy Group (PHPG) task orders define the evolving support provided to the Oklahoma Health Care Authority (OHCA) across key areas of Medicaid program management, evaluation, and policy development: • Data Governance: PHPG assists OHCA in analyzing quality measures using paid claims data, generating performance reports, and submitting findings to CMS, integrating results into broader evaluations. • Population Care Management: Consultants evaluate SoonerCare programs to assess satisfaction, quality, and cost-effectiveness, reviewing healthcare utilization, contractor performance, and targeted initiatives like opioid management. • Healthcare Quality & Performance: Consultants support reforms in the SoonerCare Choice PCMH delivery system, including payment and reporting system design and the development of quarterly scorecards. • Policy & Program Management (PACE & Finance): Vendors conduct rate-setting activities, provide waiver program design guidance, perform budget neutrality calculations, and ensure CMS compliance through data submissions and amendments. • SoonerCare 1915b Waiver Assessment: Consultants independently evaluate waiver access, quality, and cost-effectiveness, conduct data analysis, and assist OHCA in CMS reporting and regulatory compliance.
Mandate	N/A
Procurement Method	Competitive bid

External Approvals	N/A
Contract Term	September 1, 2019 through June 30, 2026 – Final year of contract

BUDGET

Amount requested for Approval	$1,117,000.00 Annual
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	$558,500.00 /50%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to increase funding for Consulting Services Contracts as described above for a total of $1,117,000.00 over the previously approved not-to-exceed amount for SFY26.

Additional Information

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

Attachment D.iii

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 25, 2025

Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds.

BACKGROUND

Services	Technology Services for Health Information Exchange
Purpose and Scope	The contract establishes a collaborative framework between the Contractor and the Oklahoma Health Care Authority for the provision of Health Information Exchange (HIE) technology services. This Contract serves to ensure seamless continuity of services following the termination of a prior contract until such time that services be negotiated through a statewide contract with the current statewide vendor. This provision of critical HIE services prevents the lapse of these services while Oklahoma Health Care Authority completes the negotiation process.
Mandate	SB 574 and SB 1369
Procurement Method	Sole Source
External Approvals	N/A
Contract Term	July1, 2025 through December 31,2025. This term will include month to month renewal options for the duration of the six months while contract is negotiated and fully executed.

BUDGET

Amount requested for Approval	$4,500,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	0%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to extend the sole source for six months for a total not-to-exceed of $4,500,000.00.

Additional Information

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

Attachment D.iv

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 25, 2025

Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds

BACKGROUND

Services	Technical Consultant for the Medicaid Management Information System (MMIS) Modernization and Implementation of the Transformation Management Office, Year Two.
Purpose and Scope	OHCA intends to conduct a large-scale overhaul of the legacy MMIS system. Due to the size, scope and complexity of the project, OHCA has been working with a consultant to assist in the planning, design and execution of the modernization activities. The Oklahoma Health Care Authority (OHCA) is seeking to execute the one-year option on the existing contract to support the ongoing efforts of the modernization that includes: • Continued operations of the Transformation Management Office (TMO) • Execute the Technical and Data Strategy workstream that will design the governance processes and drive the future state technical and data architecture and develop integration requirements for future module implementations • Enable efficiency through process optimization, improving complexity, redundancy and manual efforts of the team and increasing visibility on processes, workload and execution of processing that improves decision-making ability and user experience. • Execution of 'Quick Wins' from the 18-24 month transformation roadmap, such as front-end member and provider portal design and implementation OHCA launched the Transformation Management Office (TMO) in March 2025. The TMO is intended to provide greater collaboration and visibility across the Health Care Authority into new and ongoing projects and policy changes. OHCA intends to continue the maintenance and operations of the TMO, and due to the resources required, has elected to continue to leverage a consultant to assist in the day-to-day TMO activities. Transformation Management Office – Realized Benefits: • Understanding and visibility to the portfolio of projects, enabling data-driving decision making • Bringing awareness of new mandates, business needs and risks with ongoing projects to all business unit leaders • Visibility into what and how many projects teams are working on • Discussing policy, system, and finance impacts early in the project planning process • Finding opportunities to share technology solutions cross-functionally across business units

	Business Process Optimization – Realized Benefits - Defined future state for four (4) key business areas, including the implementation of ServiceNow workflows and the identification of 13 automation opportunities - Defined high level system requirements for future module RFPs
Mandate	None
Procurement Method	Change Order to Existing Contract
External Approvals	CMS
Contract Term	October 1, 2025 – June 30, 2026

BUDGET

Amount requested for Approval	$8,737,000.00
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	$7,863,300.00/ 90%

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested to extend technical consultant services for the TMO as described above from October 1, 2025 through June 30, 2026 with a total not-to-exceed of $8,737,000.

Additional Information

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

SUBMITTED TO THE C.E.O. AND BOARD ON JUNE 25, 2025
Discussion and vote regarding the Authority's ability to withstand the procurement decision made by the CEO based on the Authority's budget and available funds.

BACKGROUND

Services	Customer Management Data Analytics Software Subscriptions Service.
Purpose and Scope	Gray Matter provides value-based care analytics solutions for healthcare payors and providers. This solution assists OHCA in the optimization of care delivery, medical spend, and achieving better patient outcomes. The tool is currently utilized for all OHCA populations including SoonerChoice, IHS, ABD and SoonerSelect/managed care to monitor and report on quality (HEDIS) measures, as well as analyze utilization and generate provider based scorecards, enabling near real-time analysis and feedback of quality performance. The system also supports medical spend analysis for Avoidable ED, Outpatient Surgery, Avoidable readmissions, Network Leakage, Imaging Steerage, Preventable Admissions and Pharmacy Spend. Currently the system is on SW1050. Renewal of the service is essential to ensure uninterrupted service delivery and maintain compliance with all state and federal regulations. Currently, Gray Matter provides critical operational support to OHCA through the management and operation of its analytics product. The Gray Matter product, delivered through Subscription Services, is aligned with the Analytic Solution Use Case.
Mandate	N/A
Procurement Method	Statewide Contract 1050
External Approvals	N/A
Contract Term	July 1, 2025, through June 30, 2026, with an additional four (4) one-year options to renew.

BUDGET

Amount requested for Approval.	$6,400,000.00 Total Contract Not–to-Exceed
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	$3,200,000.00 / 50%

Additional Information

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

Attachment E

OKLAHOMA Health Care Authority | Serving Oklahomans through SoonerCare

Ellen M. Buettner | Chief Executive Officer **J. Kevin Stitt** | Governor

SPARC SUMMARY

REGULAR NURSING FACILITIES RATE INCREASE

The change is being made to increase the Quality of Care (QOC) fee for Regular Nursing Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds, which provides rate increases to facilities. Additionally, the change allows OHCA to calculate the annual reallocation of the pool for the "Direct Care" and "Other Cost" components of the rate as per the State Plan.

The current Base Rate Component is $158.78 per patient day. The current combined pool amount for "Direct Care" and "Other Cost" components is $351,403,013. The current Quality of Care (QOC) fee is $15.87 per patient day.

The new Base Rate Component will be $159.56 per patient day. The new combined pool amount for "Direct Care" and "Other Cost" components will be $369,759,658. The new Quality of Care (QOC) fee will be $16.65 per patient day.

The estimated budget impact for SFY2026 will be an increase in the total amount of $13,106,612; with $4,374,319 in state share. Effective date of July 1, 2025, pending CMS approval.

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITES RATE INCREASE

The change is being made to increase the Quality of Care (QOC) fee for nursing facilities serving residents with AIDS per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds, which provides rate increases to facilities.

The current rate for this provider type is $287.12 per patient day. The Quality of Care (QOC) fee is $15.87 per patient day.

The new rate for this provider type will be $290.07 per patient day. The recalculated Quality of Care (QOC) fee will be $16.65 per patient day.

The estimated budget impact for SFY2026 will be an increase in the total amount of

$16,821; with $5,615 in state share. Effective date of July 1, 2025, pending CMS approval.

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

The change is being made to increase the Quality of Care (QOC) fee for Regular ICF/IID per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds which provide rate increases to facilities.

The current rate for this provider type is $170.99 per patient day. The Quality of Care (QOC) fee is $9.75 per patient day.

The new rate for this provider type is $172.48 per patient day. The Quality of Care (QOC) fee will be $10.24 per patient day.

The estimated budget impact for SFY 2026 will be an increase in the total amount of $197,700; with $65,992 in state share. Effective date of July 1, 2025, pending CMS approval.

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

The change is being made to increase the Quality of Care (QOC) Fee for Acute ICF/IID Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds, which provides rate increases to facilities.

The current rate for this provider type is $206.52 per patient day. The Quality of Care (QOC) fee is $11.00 per patient day.

The new rate for this provider type is $209.36 per patient day. The recalculated Quality of Care (QOC) fee is $11.96 per patient day.

The estimated budget impact for SFY 2026 will be an increase in the total amount of $982,584; with $327,986 in state share. Effective date of July 1, 2025, pending CMS approval.

ADD-ON RATE FOR NURSING FACILITIES SERVING ACUTE TRACHEOSTOMY RESIDENTS

The change is being made to increase the add-on rate that was previously approved for nursing facilities that serve acute tracheostomy patients. The increase will help facilities cover additional costs incurred in SFY2025.

The add-on rate is the difference between the total cost per patient day for acute tracheostomy care and the average nursing facility rate. The current add-on rate is $144.79.

There is no change in methodology. From 1/1/2025 to 6/30/2025, the add-on will be $339.58 per patient day. Starting 7/1/2025, the add-on will be 144.79 per patient day.

The estimated budget impact for SFY 2025 will be an increase in the total amount of $2,076,299; with $664,623 in state share. The estimated budget impact for SFY 2026 will be an increase in the total amount of $2,076,299; with $693,069 in state share. The effective date of change will be backdated to January 1, 2025, and have been approved by CMS.

RATE INCREASE FOR PARTIAL HOSPITALIZATION PROGRAM

ODMHSAS seeks to implement a rate increase for the daily rate for partial hospitalization program to $180.00 per day from $160.50 per day. PHP providers have requested a rate increase to support this service based on increased costs. Oklahoma has very few PHP providers who provide critical services to primarily children. This is an increase of 12.15%.

The current rate for Proc Code H0035 is $160.50 per day.

The proposed rate for this service is $180 per day.

The estimated budget impact for SFY 2026 will be an increase in the total amount of $1,170,000; with $390,546 in state share. Effective date of July 1, 2025, pending CMS approval.

REIMBURSEMENT RATE INCREASE FOR T1001 AND T1017

OSDH is seeking to amend the reimbursement rate for the Nurse Assessment/Evaluation and Targeted Case Management Visits.

The current rate for State Plan Skilled Nursing Assessment/Evaluation for T1001 is $67.18 per visits and for Targeted Case Management for T1017 is $13.98 per visit.

The new rate for State Plan Skilled Nursing Assessment/Evaluation for T1001 is $95.00 per visits and for Targeted Case Management for T1017 is $18.00 per visit.

The estimated budget impact for SFY 2026 will be an increase in the total amount of $264,908; with $79,472 in state share. Effective date of July 1, 2025, pending CMS approval.

This page intentionally left blank

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

REGULAR NURSING FACILITIES RATE INCREASE

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the Quality of Care (QOC) fee for Regular Nursing Facilities per 56 O.S. 2011, Section 2002. This change allows the Oklahoma Health Care Authority (OHCA) to collect additional QOC fees from providers and match them with federal funds, which provides rate increases to facilities. Additionally, the change allows OHCA to calculate the annual reallocation of the pool for the "Direct Care" and "Other Cost" components of the rate as per the State Plan.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular Nursing Facilities calls for the establishment of a prospective rate that consists of four components. The current components are as follows:
   A. Base Rate Component is $158.78 per patient day.
   B. A Pay for Performance (PFP) Component defined as the dollars earned under the incentive payment program for Nursing Facilities with an average payment of $5.00 per patient day.
   C. An "Other Cost" Component which is defined as the per day amount derived from dividing 30% of the pool of funds available after meeting the needs of the Base and PFP Components by the total estimated Medicaid days for the rate period. This component once calculated is the same for each facility.
   D. A "Direct Care "Component which is defined as the per day amount derived from allocating 70% of the pool of funds available after meeting the needs of the Base and PFP Components to the facilities. This component is determined separately and is different for each facility. The method (as approved in the State Plan) allocates the 70% pool of funds to each facility (on a per day basis) based on their relative expenditures for direct care costs. The current combined pool amount for "Direct Care" and "Other Cost" components is $351,403,013. The current Quality of Care (QOC) fee is $15.87 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
There is no change in methodology; however, there is a rate change for Regular Nursing Facilities because of the required annual recalculation of the Quality of Care (QOC) fee and reallocation of the pool for "Direct Care" and "Other Cost" components of the rate as per the State Plan. The new Base Rate Component will be $159.56 per patient day. The new combined pool amount for "Direct Care" and "Other Cost" components will be $369,759,658. The new Quality of Care (QOC) fee will be $16.65 per patient day.

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY 2026 will be an increase in the total amount of $13,104,612; with $4,374,319 in state share.
OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular Nursing Facilities:
   - An increase to the base rate component from $158.78 per patient day to $159.56 per patient day.
   - An increase to the combined pool amount for "Direct Care" and "Other Cost" Components from $351,403,013 to $369,759,658 for the annual reallocation of the Direct Care Cost Component as per the State Plan.

9. **EFFECTIVE DATE OF CHANGE.**
July 1, 2025, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) NURSING FACILITES RATE INCREASE

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

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

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

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for nursing facilities serving residents with AIDS requires the establishment of a prospective rate which is based on the reported allowable cost per day. The current rate for this provider type is $287.12 per patient day. The Quality of Care (QOC) fee is $15.87 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for nursing facilities serving residents with AIDS because of the required annual recalculation of the Quality of Care (QOC) fee. The rate for this provider type will be $290.07 per patient day. The recalculated Quality of Care (QOC) fee will be $16.65 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2026 will be an increase in the total amount of $16,821; with $5,615 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities serving residents with AIDS:
   - An increase to the AIDS rate from $287.12 per patient day to $290.07 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2025, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

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

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

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

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

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Regular ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.
   The current rate for this provider type is $170.99 per patient day.
   The Quality of Care (QOC) fee is $9.75 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for Regular ICF/IID facilities because of the required annual recalculation of the Quality of Care (QOC) fee.
   The proposed rate for this provider type is $172.48 per patient day.
   The Quality of Care (QOC) fee will be $10.24 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2026 will be an increase in the total amount of $197,700; with $65,992 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Regular ICF/IID facilities:
   - An increase in rate from $170.99 per patient day to $172.48 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2025, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

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

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

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

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

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate methodology for Acute ICF/IID facilities requires the establishment of a prospective rate which is based on the reported allowable cost per day.
   The current rate for this provider type is $206.52 per patient day.
   The Quality of Care (QOC) fee is $11.00 per patient day.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology; however, there is a rate change for Acute ICF/IID facilities because of the annual recalculation of the Quality of Care (QOC) fee.
   The proposed rate for this provider type is $209.36 per patient day.
   The recalculated Quality of Care (QOC) fee is $11.96 per patient day

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2026 will be an increase in the total amount of $982,584; with $327,986 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

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

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for Acute ICF/IID facilities:
   - An increase in rate from $206.52 per patient day to $209.36 per patient day.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2025, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

ADD-ON RATE FOR NURSING FACILITIES SERVING ACUTE TRACHEOSTOMY RESIDENTS

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   The change is being made to increase the add-on rate that was previously approved for nursing facilities that serve acute tracheostomy patients. The increase will help facilities cover additional costs incurred in SFY2025.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The add-on rate is the difference between the total cost per patient day for acute tracheostomy care and the average nursing facility rate. The current add-on rate is $144.79.

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   There is no change in methodology. From 1/1/2025 to 6/30/2025, the add-on will be $339.58 per patient day. Starting 7/1/2025, the add-on will be 144.79 per patient day.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2025 will be an increase in the total amount of $2,076,299; with $664,623 in state share.
   The estimated budget impact for SFY 2026 will be an increase in the total amount of $2,076,299; with $693,069 in state share.
   OHCA attests that it has adequate funds to cover the state share of the projected cost of services.

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

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

The Oklahoma Health Care Authority requests the State Plan Amendment Rate Committee to approve the following for nursing facilities that serve acute tracheostomy patients:

- An increase in add-on rate from $144.79 per patient day to $339.58 per patient day from 1/1/2025 to 6/30/2025.
- A decrease in rate from $339.58 per patient day to $144.79 per patient day starting 7/1/2025.

9. EFFECTIVE DATE OF CHANGE.

Back dated to January 1, 2025, approved by CMS

OKLAHOMA Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

RATE INCREASE FOR PARTIAL HOSPITALIZATION PROGRAM

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   ODMHSAS seeks to implement a rate increase for the daily rate for partial hospitalization program to $180.00 per day from $160.50 per day. PHP providers have requested a rate increase to support this service based on increased costs. Oklahoma has very few PHP providers who provide critical services to primarily children. This is an increase of 12.15%.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate for this service is $160.50 per day.

PARTIAL HOSPITALIZATION	**H0035**	**HH/HF/HV/HH**				**160.50**

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
   The proposed rate for this service is $180 per day.
   - Increase amounts were developed through increasing rates by 12.15% to account for increased costs since the last rate update.

6. **BUDGET ESTIMATE.**
   The estimated budget impact for SFY 2026 will be an increase in the total amount of $1,170,000; with $390,546 in state share.
   ODMHSAS attests that it has adequate funds to cover the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
   ODMHSAS has determined that this change will have a positive impact in that the rate increases support the outpatient behavioral health provider network.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
   ODMHSAS requests the SPARC to approve the proposed rate increase for partial hospitalization program services.

9. **EFFECTIVE DATE OF CHANGE.**
   July 1, 2025, upon approval by CMS

OKLAHOMA
Health Care Authority

STATE PLAN AMENDMENT RATE COMMITTEE

REIMBURSEMENT RATE INCREASE FOR T1001 AND T1017

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

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

3. **PRESENTATION OF ISSUE – WHY IS THIS CHANGE BEING MADE?**
   OSDH is seeking to amend the reimbursement rate for the Nurse Assessment/Evaluation and Targeted Case Management Visits.

4. **CURRENT METHODOLOGY AND/OR RATE STRUCTURE.**
   The current rate structure for the services provided in the proposed rate change is a fixed and uniform rate established through the State Plan Amendment Rate Committee process.

State Plan Service	Code	Unit Type	Current Rate
State Plan Skilled Nursing - Assessment/Evaluation	T1001	per visit	$67.18

State Plan Service	Code	Unit Type	Current Rate
Targeted Case Management	T1017	per visit	$13.98

5. **NEW METHODOLOGY OR RATE STRUCTURE.**
The new rate structure for the services provided in the proposed rate change is a fixed and uniform rate established through the State Plan Amendment Rate Committee process.

State Plan Service	Code	Unit Type	Current Rate
State Plan Skilled Nursing - Assessment/Evaluation	T1001	per visit	$95.00

State Plan Service	Code	Unit Type	Current Rate
Targeted Case Management	T1017	per visit	$18.00

6. **BUDGET ESTIMATE.**
The estimated budget impact for SFY 2026 will be an increase in the total amount of $264,908; with $79,472 in state share.
OSDH attests that it has adequate funds to cover the state share of the projected cost of services.

7. **AGENCY ESTIMATED IMPACT ON ACCESS TO CARE.**
The rate increase will have a positive impact on care as providers are able to meet increased labor costs.

8. **RATE OR METHOD CHANGE IN THE FORM OF A MOTION.**
OSDH requests the State Plan Amendment Rate Committee approve the proposed rate increase.

9. **EFFECTIVE DATE OF CHANGE.**
July 1, 2025, upon approval by CMS

Attachment F

OKLAHOMA HEALTH CARE AUTHORITY FY 2026 BUDGET

APPROPRIATIONS AND BUDGET

Fiscal Year	Budget	Increase/ Decrease %	Total Appropriation	Increase/ Decrease %	FMAP	Percent Appropriation to Budget
2019	$5,928,477,640	3.3%	$1,132,465,946	11.2%	61.43%	19.1%
2020	$6,163,200,792	4.0%	$1,000,039,368	-11.7%	65.11%	16.2%
2021	$6,477,455,224	5.1%	$1,000,039,368	0.0%	67.50%	15.4%
2022	$8,194,267,343	26.5%	$1,194,337,303	19.4%	68.23%	14.6%
2023	$10,066,413,200	22.8%	$1,262,741,642	5.7%	67.60%	12.5%
2024	$10,693,237,573	4.4%	$892,741,642	-29.3%	67.49%	8.3%
2025	$11,195,536,700	4.7%	$1,310,509,100	46.8%	67.19%	11.7%
2026	$12,562,129,214	5.4%	$1,410,540,778	7.6%	66.62%	11.2%

MEDICAL PROGRAM

Total Budget Increase of $433,864,891 or 4.8%

MEDICAL PROGRAM – GROWTH

Summary of Change	Total Dollar Change	Percent Change
Growth Traditional	$276,848,470	3.1%
Growth Expansion	$82,282,419	0.9%
FY 2026 Total Growth	**$359,130,889**	**4.0%**

MEDICAL PROGRAM – STATE AND FEDERAL MANDATES

Summary of Change	Total Dollar Change
Medicare Part A and B Premium Annualized	$21,755,557
Supplemental Payment Increase	$27,983,514
Medicare Part A, B and D Increased Premium	$16,613,972
SoonerRide (Non- Emergency Transportation) Increases	$8,380,959
FY 2026 Total Mandates	**$74,734,002**

PROGRAM ASSUMPTIONS

- Estimated enrollment increase of 7.5%
- Growth is 4% compared to nationwide Medicaid average of 5%
- Soonerselect capitation payments are included in the analysis and are built based on actuarial developed rates
- Increased supplemental payment programs

OHCA ADMINISTRATION

Total Budget Decrease of $23,093,016 or 6.9%

OHCA ADMINISTRATION

Percent Change	Division	Total Dollar Change
1.3%	Operations	$806,959
-12.6%	Contracts (non-IT)	$(7,094,050)
2.5%	Insure Oklahoma	$35,584
-6.4%	EGID	$(3,484,156)
-7.5%	Contracts (IT)	$(10,805,249)
-15.5%	Grants Management	$(2,552,104)
-6.9%	**FY 2026 Overall Decrease**	**$23,093,016**

OTHER STATE AGENCY PROGRAMS

Total Budget Increase of $234,026,506 or 9.2%

OTHER STATE AGENCY PROGRAMS

Summary of Change	Total Dollar Change
Increase in OU/OSU supplemental payments	$112,233,281
DMH program growth	$63,336,275
Annualization of OHS rate increases/growth	$42,397,164
Other Agencies program growth	$16,059,787
FY 2026 OSA Program Change	**$234,026,506**

REVENUE

Total Budget Increase of $640,570,759 or 5.4%

APPROPRIATION SUMMARY

FY 2026 OHCA Appropriation Summary – HB 2766	
SECTION 76 (FY 2026 General Revenue Fund)	$1,031,728,976
SECTION 77 (FY 2024 General Revenue Fund)	$236,040,321
SECTION 78 (Rate Preservation Fund)	$34,597,531
SECTION 79 (FY2026 Health Care Enhancement Fund)	$98,173,950
SECTION 80 (Tobacco Settlement Fund)	$10,000,000
FY 2026 Appropriation	**$1,410,540,778**

REVENUE

Percent Change	Funding Source	Total Dollar Change
5.5%	Federal – Medicaid Traditional	$304,273,279
4.4%	Federal – Medicaid Expansion	$106,267,450
0.2%	Federal – Admin	($305,892)
3.3%	Drug Rebates	$24,424,566
1.8%	Medical Refunds	$1,137,576
-3.8%	NF Quality of Care Fee	($4,017,732)
10.8%	OSA Refunds and Reimbursements	$88,230,493
-5.4%	Tobacco Tax	($3,836,466)
1.5%	Miscellaneous Revenue	$68,716
-46.1%	Prior Year Carryover (200)	($24,350,751)
-63.6%	Prior Year Carryover (340)	($168,576,061)
1.6%	Other Grants	$2,400
8.1%	SHOPP	$30,718,725
-6.4%	EGID	($3,484,156)
74.1%	Premium Tax	$54,945,484
100%	Rate Preservation Fund	$26,041,449
17.4%	State Appropriations	$209,031,678
5.4%	**FY 2026 Overall Increase**	**$640,570,759**

BUDGET OVERVIEW

SUMMARY

Percent Increase	Expenditures/Revenue	Increase	Total Dollars
5.4%	Expenditures	$640,570,759	$12,562,129,214
5.4%	Revenues	$640,570,759	$12,562,129,214
	Difference		**$0**

KEY TAKEAWAYS

- Administrative spend less than 3% of total spend, including EGID
- OHCA continues to increase collection of drug rebates, covering approximately 45% of drug spend
- SFY 2026 Medicaid program growth continues to be impacted by higher trends in utilization and acuity
- Premium tax revenue increase of $55 million

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

okhca.org
mysoonercare.org

Agency: 405-522-7300
Helpline: 800-987-7767

This page intentionally left blank

OKLAHOMA HEALTH CARE AUTHORITY

SFY-2026 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	SFY-2025	SFY-2026	Inc / (Dec)	% Change
Medical Program				
Managed Care:				
SoonerCare Choice / HAN / PACE	41,279,675	41,089,263	(190,412)	-0.5%
SoonerSelect Medical	2,612,011,085	2,804,657,142	192,646,057	7.4%
SoonerSelect CSP	174,551,836	161,858,174	(12,693,662)	-7.3%
SoonerSelect Dental	194,355,694	200,199,922	5,844,228	3.0%
Hospitals	1,132,425,702	1,159,524,096	27,098,394	2.4%
Behavioral Health	15,987,008	16,582,994	595,986	3.7%
Nursing Homes	917,581,958	952,797,458	35,215,500	3.8%
Physicians	282,762,059	297,297,104	14,535,046	5.1%
Dentists	62,447,847	60,637,156	(1,810,691)	-2.9%
Mid-Level Practitioner	147,107	154,362	7,255	4.9%
Other Practitioners	30,658,701	30,663,899	5,198	0.0%
Home Health	32,930,935	32,941,435	10,501	0.0%
Lab & Radiology	21,403,784	19,135,003	(2,268,782)	-10.6%
Medical Supplies	77,393,889	83,800,725	6,406,836	8.3%
Clinic Services	403,887,904	446,385,491	42,497,587	10.5%
Ambulatory Surgery Center	6,169,787	7,867,103	1,697,316	27.5%
Prescription Drugs	913,783,709	965,324,724	51,541,015	5.6%
Miscellaneous	466,661	300,756	(165,905)	-35.6%
ICF/IID	94,994,122	93,345,474	(1,648,647)	-1.7%
Transportation	130,330,951	138,711,910	8,380,959	6.4%
Medicare Buy-in (Part A & B)	232,204,721	259,557,360	27,352,638	11.8%
Medicare clawback payment (Part D)	135,112,497	146,129,387	11,016,890	8.2%
SHOPP - Supplemental Hosp Offset Pymt.	1,368,617,321	1,391,853,449	23,236,128	1.7%
Provider Incentive Program	110,342,116	115,089,502	4,747,386	4.3%
Money Follows the Person - Enhanced	1,562,186	1,609,635	47,450	3.0%
Health Management Program (HMP)	12,560,024	12,560,024	-	0.0%
Electronic Health Records Incentive Pymts	200,000	-	(200,000)	-100.0%
Non-Title XIX Medical	89,382	50,000	(39,382)	-44.1%
TOTAL OHCA MEDICAL PROGRAM	9,006,258,658	9,440,123,549	433,864,891	4.8%
Insure Oklahoma - Premium Assistance				
Employer Sponsored Insurance - ESI	32,408,101	28,230,478	(4,177,622)	-12.9%
Individual Plan - IP	250,000	200,000	(50,000)	-20.0%
TOTAL INSURE OKLAHOMA PROGRAM	32,658,101	28,430,478	(4,227,622)	-12.9%
OHCA Administration				
Operations - Division 10	63,039,317	63,846,276	806,959	1.3%
Contracts - Division 30	56,291,429	49,197,379	(7,094,050)	-12.6%
Insure Oklahoma - Division 40	1,425,855	1,461,439	35,584	2.5%
EGID - Division 80	54,598,679	51,114,523	(3,484,156)	-6.4%
Business Enterprises - Division 88	144,622,524	133,817,275	(10,805,249)	-7.5%
Grants Management - Division 50	16,467,619	13,915,515	(2,552,104)	-15.5%
TOTAL OHCA ADMIN	336,445,423	313,352,407	(23,093,016)	-6.9%
TOTAL OHCA PROGRAMS	**9,375,362,181**	**9,781,906,434**	**406,544,252**	**4.3%**
Other State Agency (OSA) Programs				
Oklahoma Human Services (OHS)	928,790,592	971,187,756	42,397,164	4.6%
Oklahoma State Dept of Health (OSDH)	9,843,798	5,516,449	(4,327,349)	-44.0%
The Office of Juvenile Affairs (OJA)	8,420,773	5,600,170	(2,820,603)	-33.5%
University Hospitals (Medical Education Pymnts)	661,524,401	773,757,681	112,233,281	17.0%
Department of Mental Health (ODMHSAS)	766,381,619	829,717,894	63,336,275	8.3%
Department of Education (DOE)	4,092,172	7,838,848	3,746,676	91.6%
Non-Indian Payments	21,798,356	29,897,897	8,099,540	37.2%
Department of Corrections (DOC)	7,997,037	10,870,206	2,873,169	35.9%
JD McCarty	18,252,526	26,740,880	8,488,354	46.5%
OSA Non-Title XIX	119,095,000	119,095,000	-	0.0%
TOTAL OSA PROGRAMS	**2,546,196,273**	**2,780,222,780**	**234,026,506**	**9.2%**
TOTAL MEDICAID PROGRAM	**11,921,558,455**	**12,562,129,214**	**640,570,759**	**5.4%**

OKLAHOMA HEALTH CARE AUTHORITY

SFY-2026 BUDGET WORK PROGRAM

Summary by Program Expenditure

Description	SFY-2025	SFY-2026	Inc / (Dec)	% Change
REVENUES				
Federal - Medicaid Traditional	5,491,243,158	5,795,516,437	304,273,279	5.5%
Federal - Medicaid Expansion	2,419,326,825	2,525,594,275	106,267,450	4.4%
Federal - Admin	171,313,861	171,007,969	(305,892)	-0.2%
Drug Rebates	749,274,498	773,699,064	24,424,566	3.3%
Medical Refunds	64,696,524	65,834,100	1,137,576	1.8%
NF Quality of Care Fee	106,681,462	102,663,730	(4,017,732)	-3.8%
OSA Refunds & Reimbursements	816,015,908	904,246,400	88,230,493	10.8%
Tobacco Tax	71,359,598	67,523,133	(3,836,466)	-5.4%
Misc Revenue / ASPAPP Assessment Fee	4,736,487	4,805,203	68,716	1.5%
Prior Year Carryover (Fund 200 Admin)	52,766,019	28,415,268	(24,350,751)	-46.1%
Prior Year Carryover (Fund 340 Program)	265,212,220	96,636,158	(168,576,061)	-63.6%
Other Grants	153,760	156,160	2,400	1.6%
Hospital Provider Fee (SHOPP bill)	378,505,966	409,224,691	30,718,725	8.1%
EGID - Funds 290 / 292	54,598,679	51,114,523	(3,484,156)	-6.4%
MCO premium tax	74,164,391	129,109,875	54,945,484	74.1%
Transfer from Rate Preservation Fund	-	26,041,449	26,041,449	100.0%
State Appropriated - OHCA	1,201,509,100	1,410,540,778	209,031,678	17.4%
TOTAL REVENUES	**11,921,558,455**	**12,562,129,214**	**640,570,759**	**5.4%**

OPERATIONAL METRICS

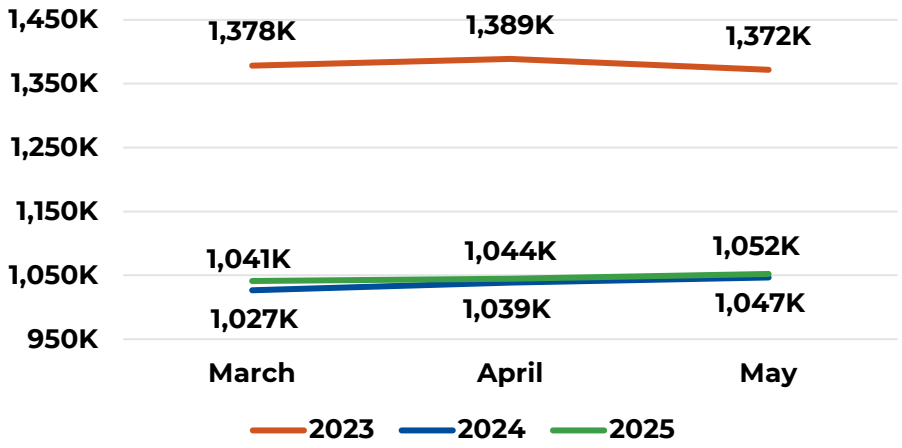
June 2025 Board Meeting

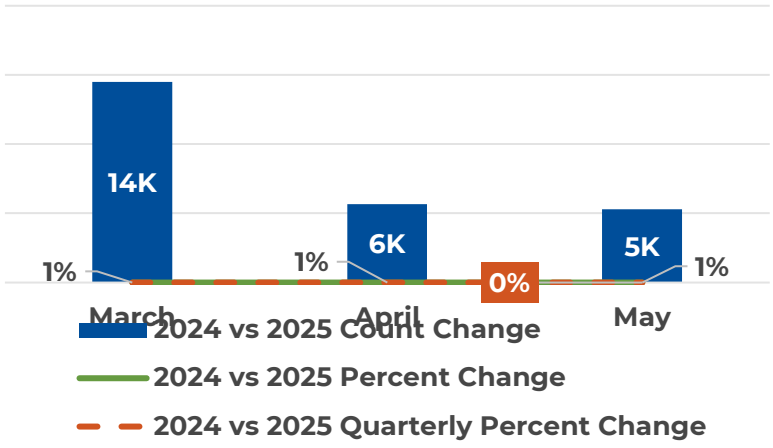
OKLAHOMA HEALTH CARE AUTHORITY

4345 N. LINCOLN BLVD. | OKHCA.ORG |

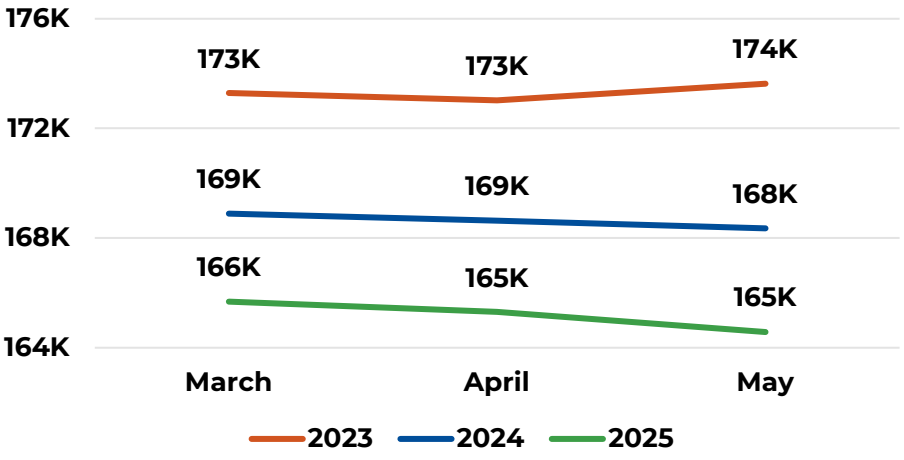
Enrollment & Utilization

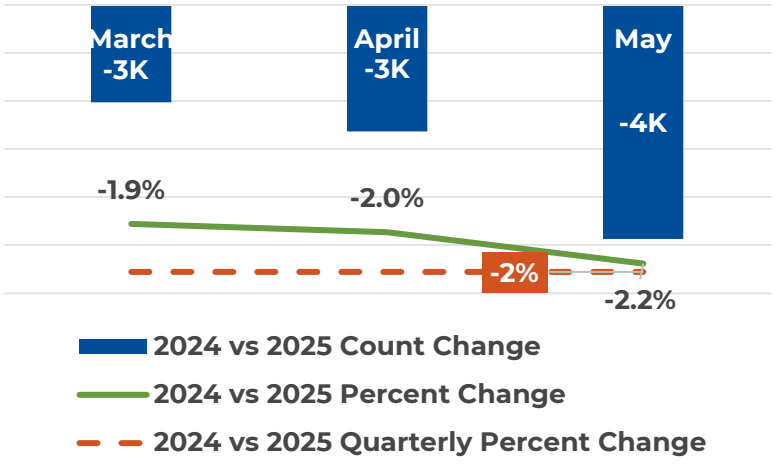
Total Enrolled Members





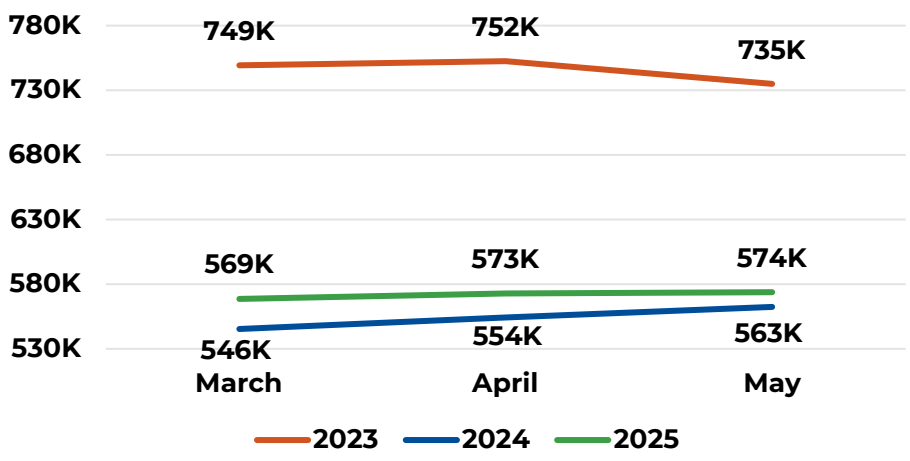
Aged/Blind/Disabled Enrolled

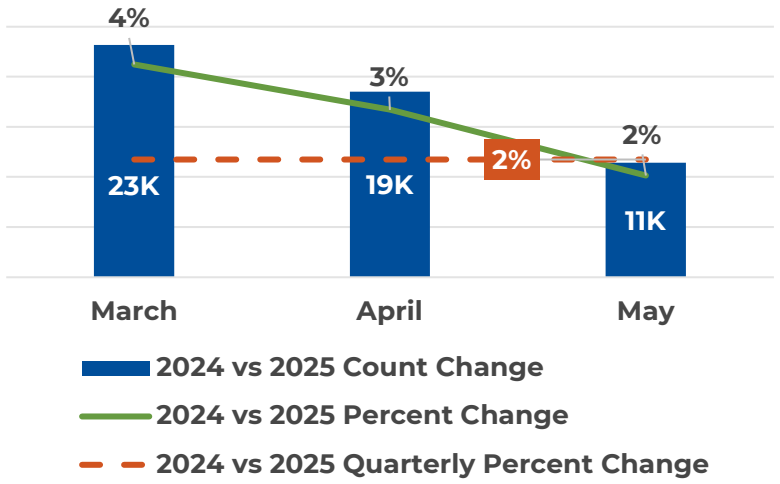




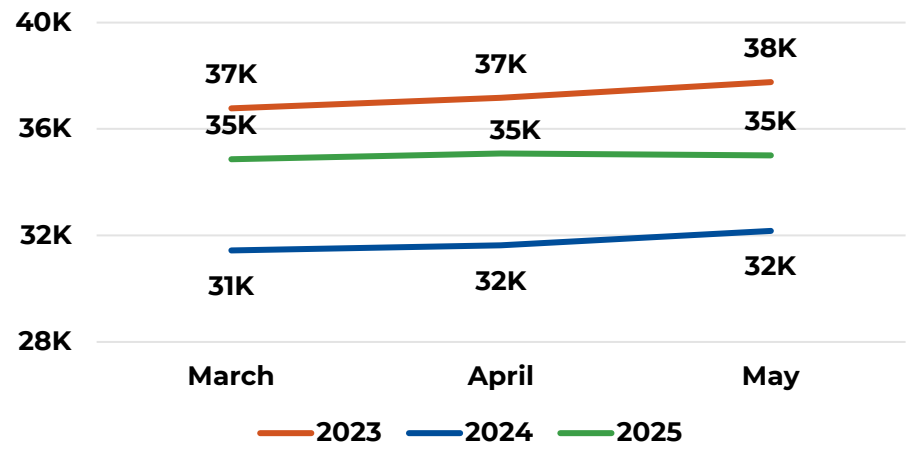
Enrollment & Utilization (Cont.)

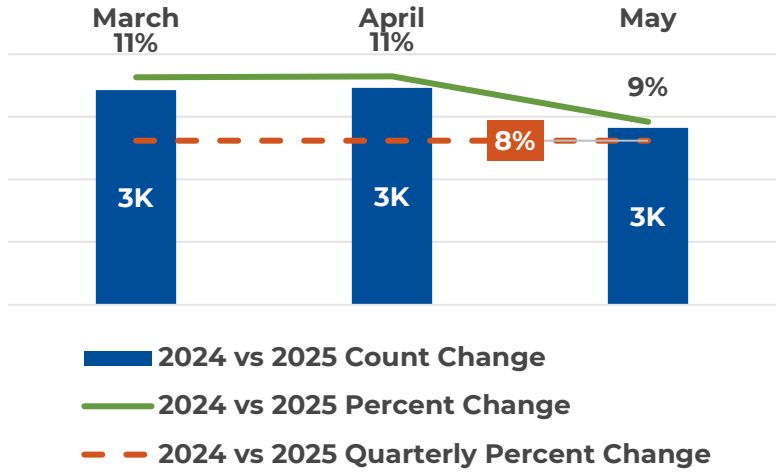
Children & Parent/Caretaker Enrolled





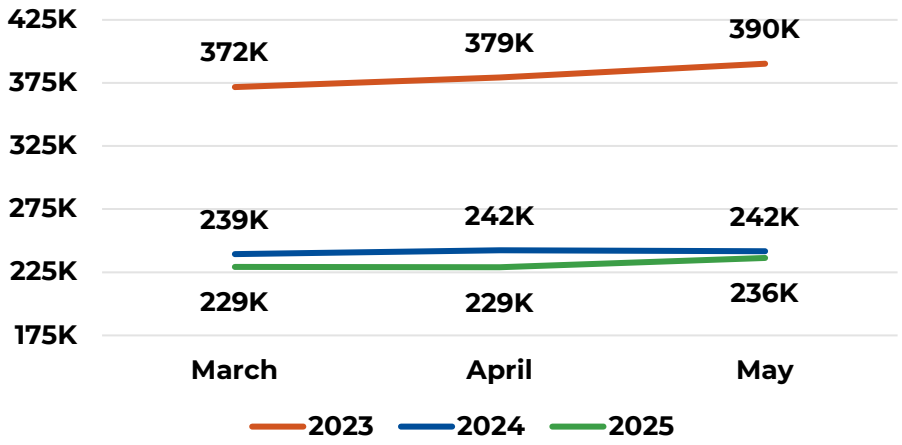
Pregnant (Full Scope) Enrolled

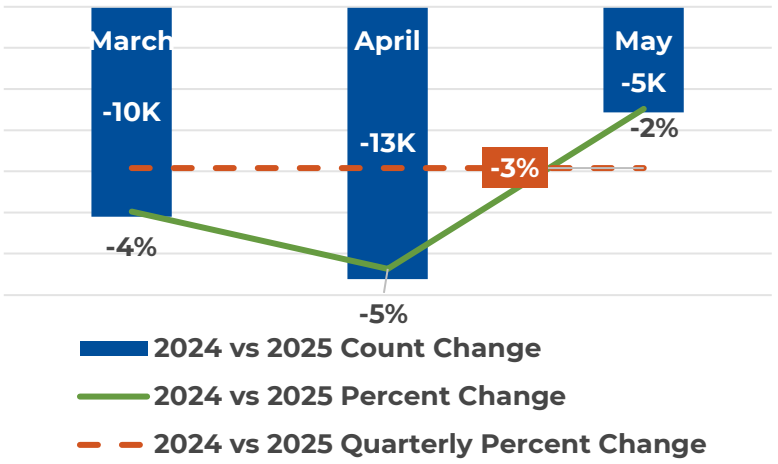




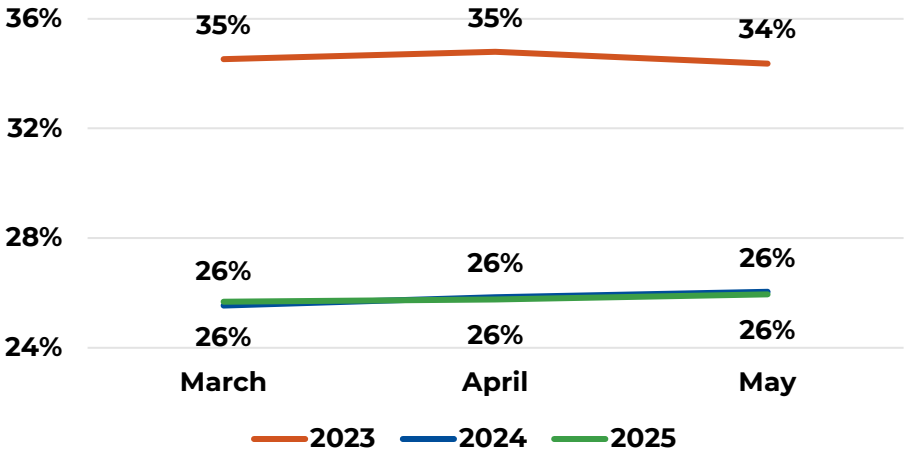
Enrollment & Utilization (Cont.)

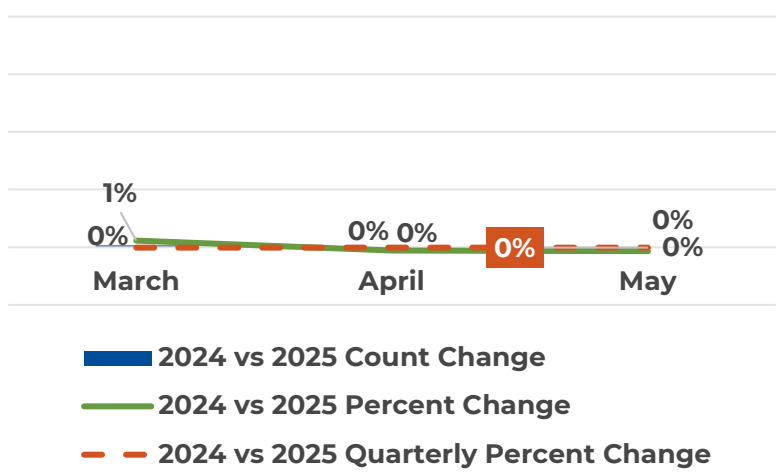
Expansion Enrolled





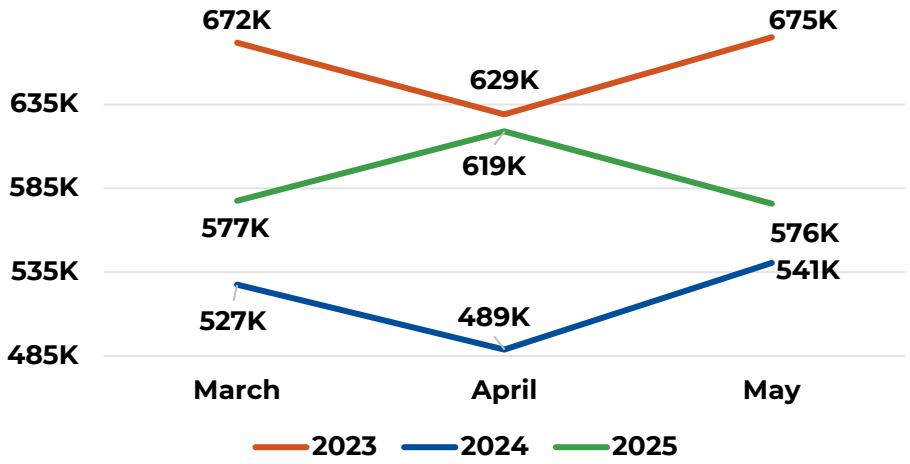
Percent of OK Population Enrolled

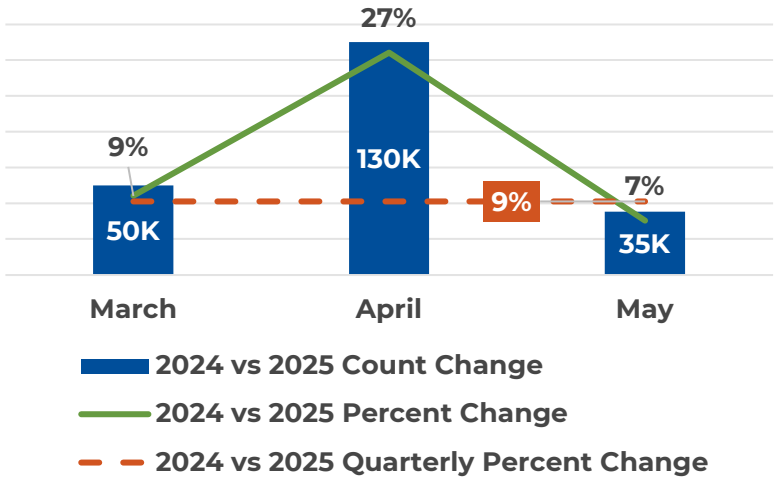




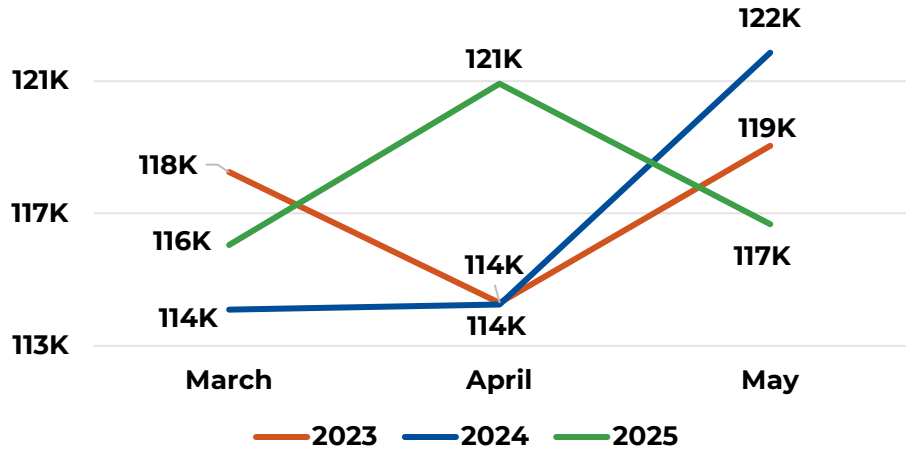
Enrollment & Utilization (Cont.)

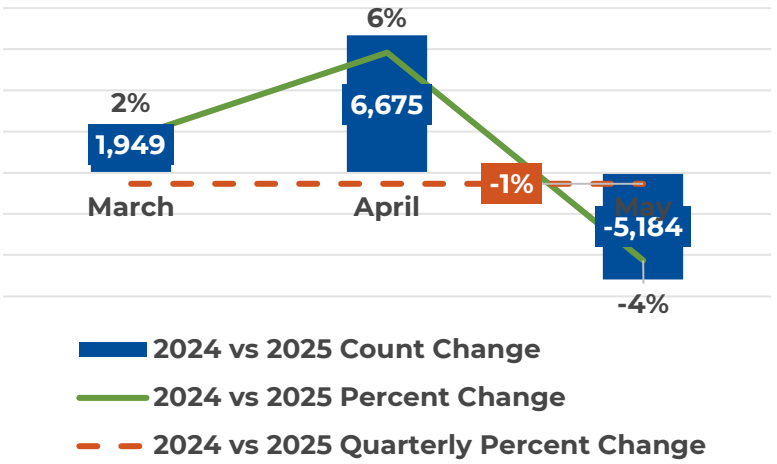
Total Members Utilization





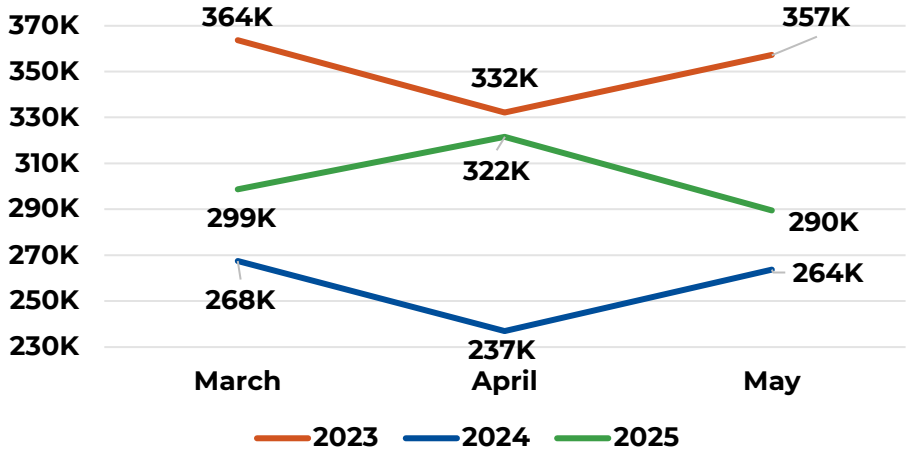
Aged/Blind/Disabled Utilization

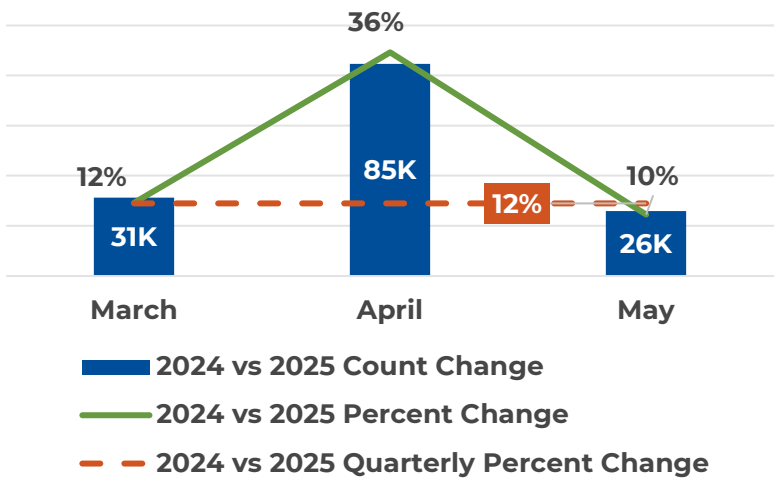




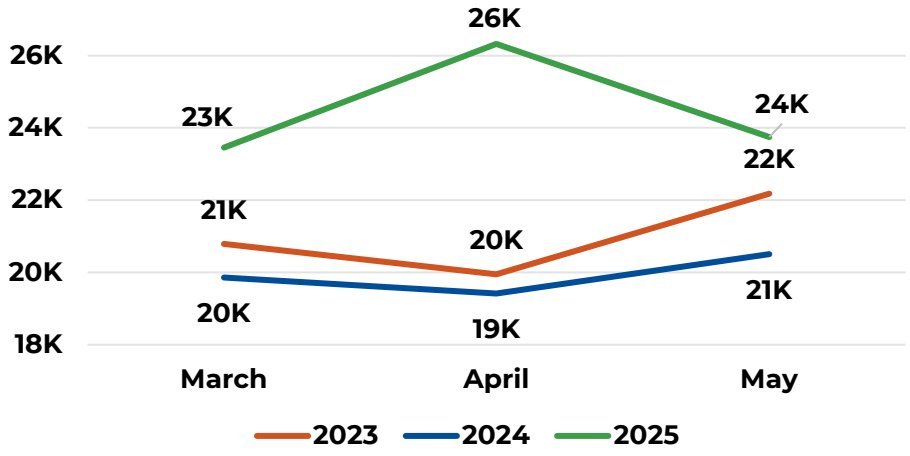
Enrollment & Utilization (Cont.)

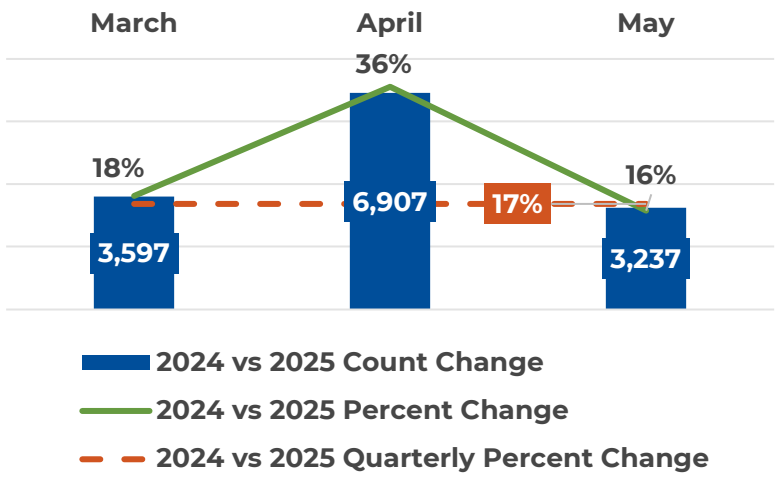
Children & Parent/Caretaker Utilization





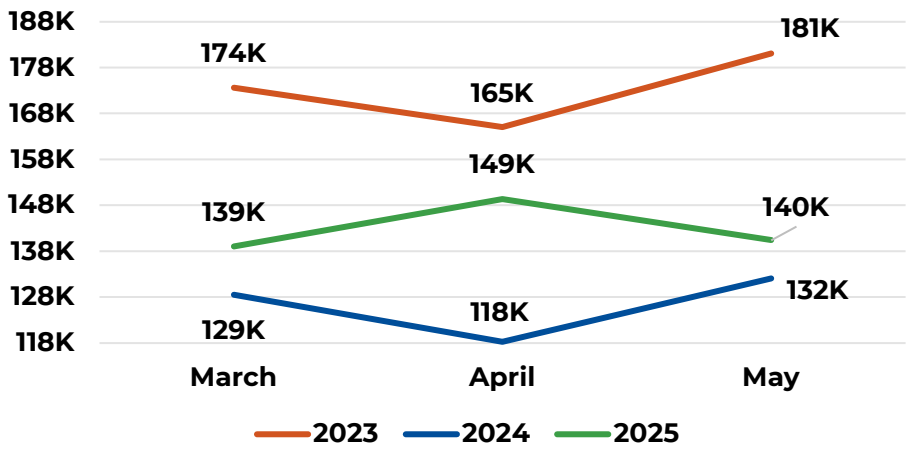
Pregnant (Full Scope) Utilization

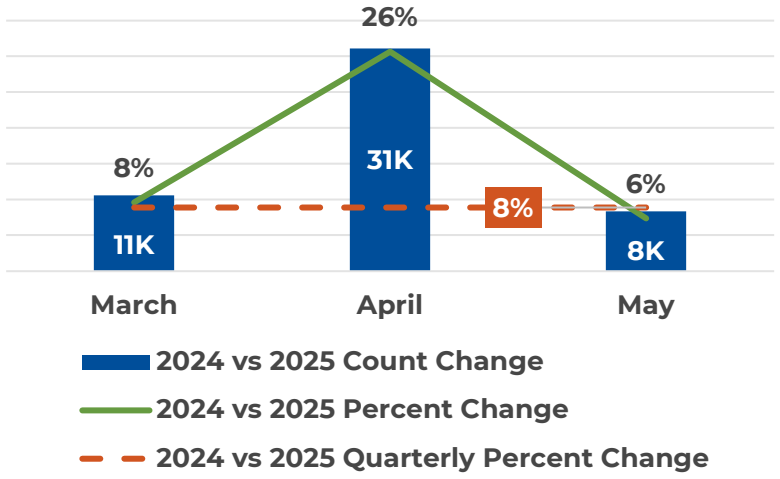




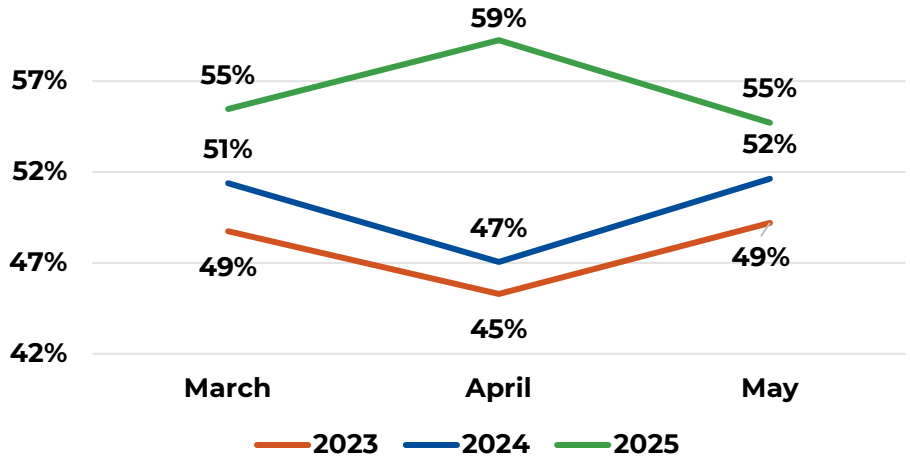
Enrollment & Utilization (Cont.)

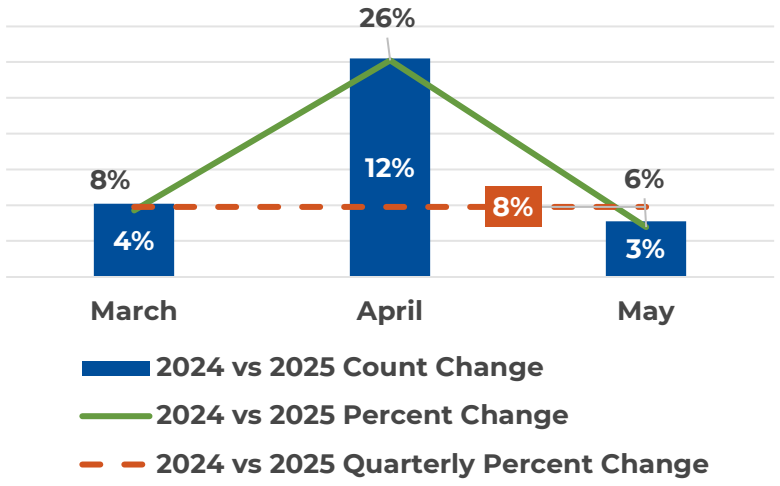
Expansion Utilization





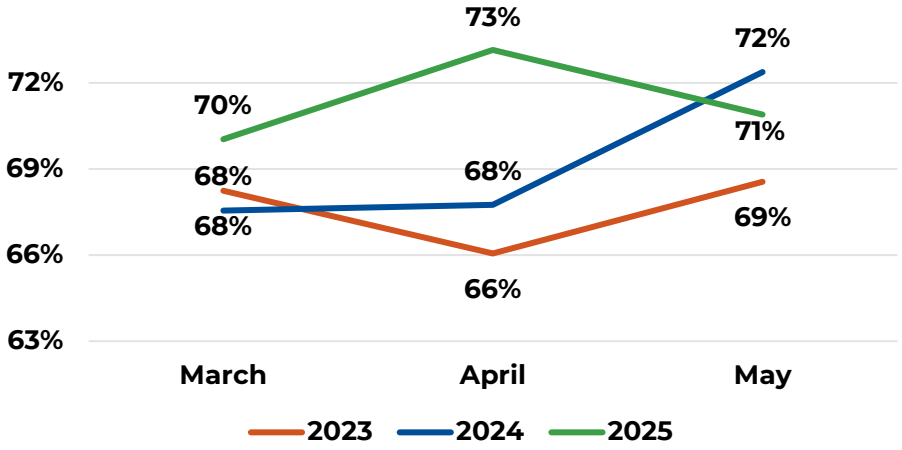
Percent of Total Enrolled Members Utilization

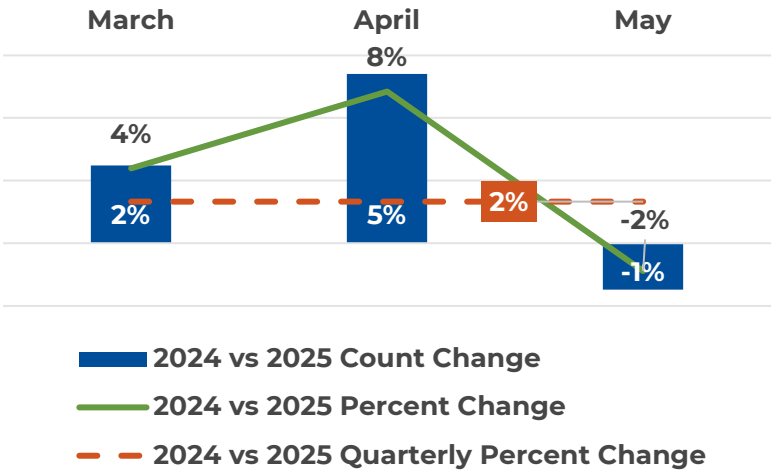




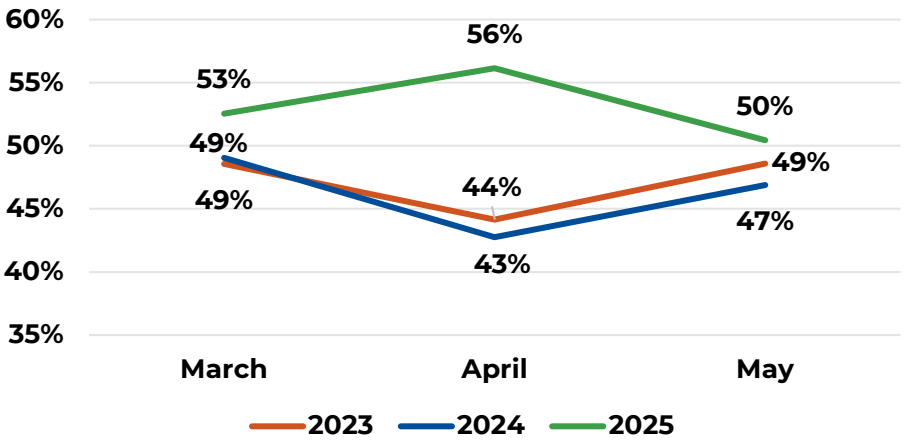
Enrollment & Utilization (Cont.)

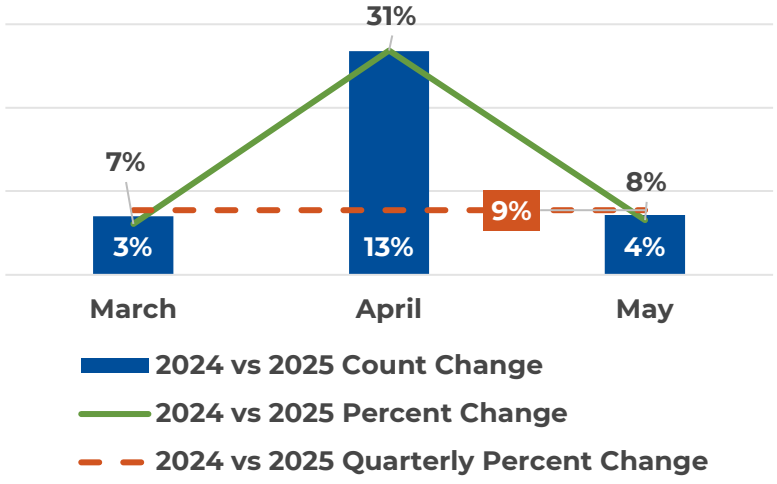
Percent of Aged/Blind/Disabled Enrolled Members Utilization





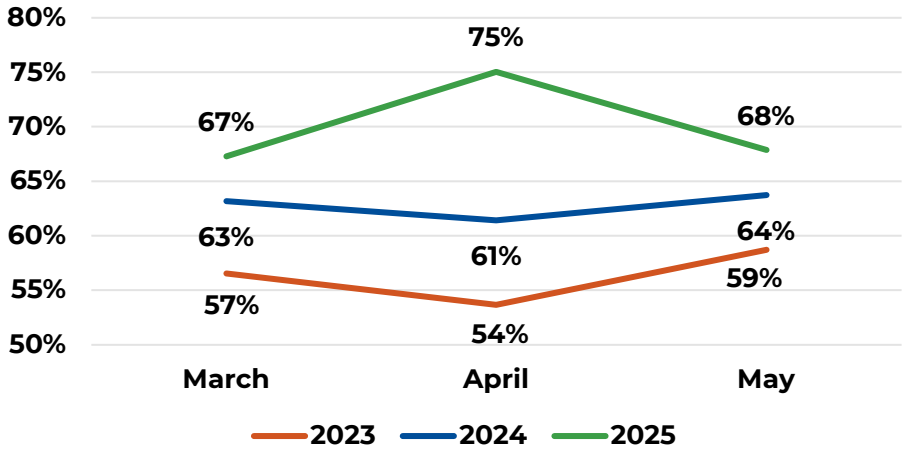
Percent of Children & Parent/Caretaker Enrolled Members Utilization

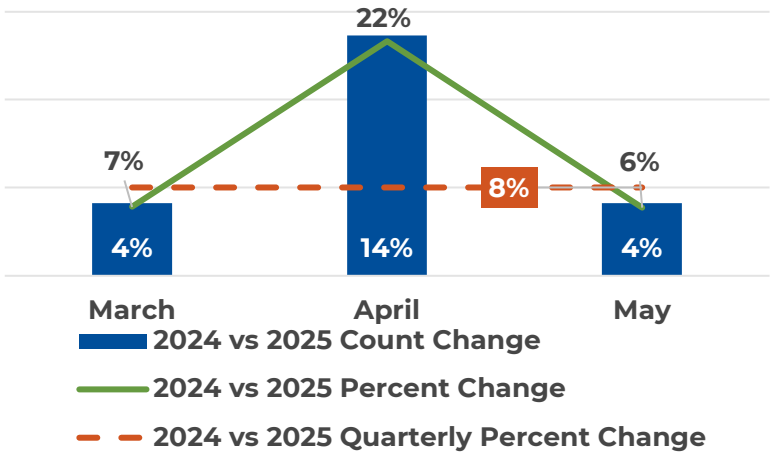




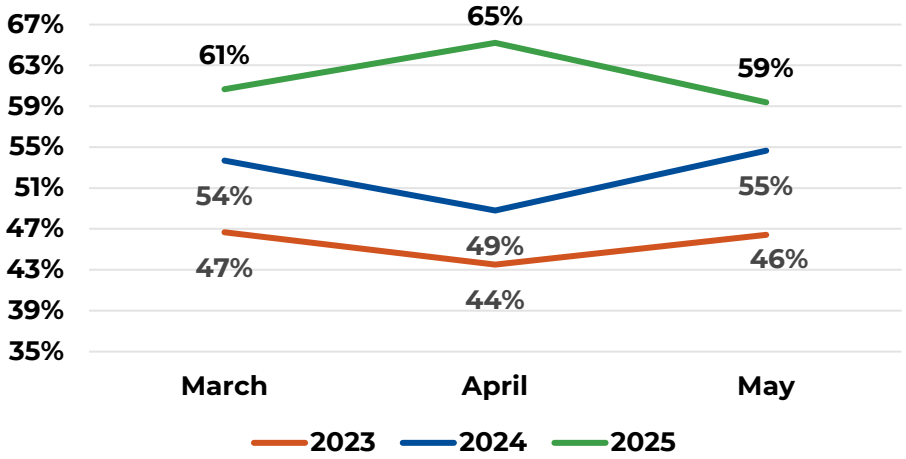
Enrollment & Utilization (Cont.)

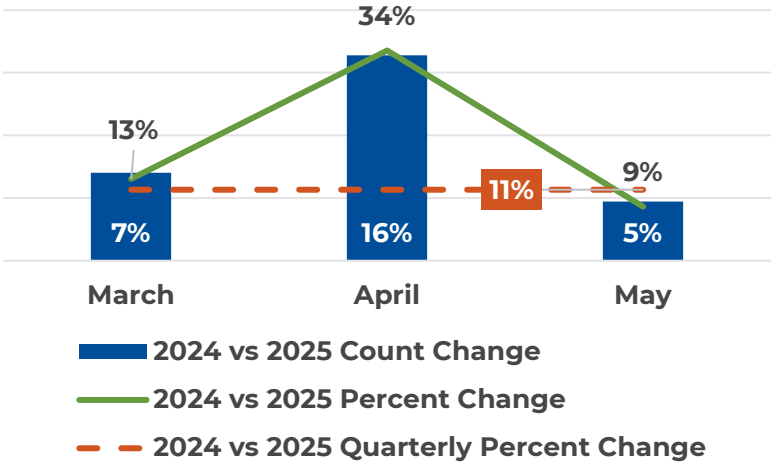
Percent of Pregnant (Full Scope) Enrolled Members Utilization





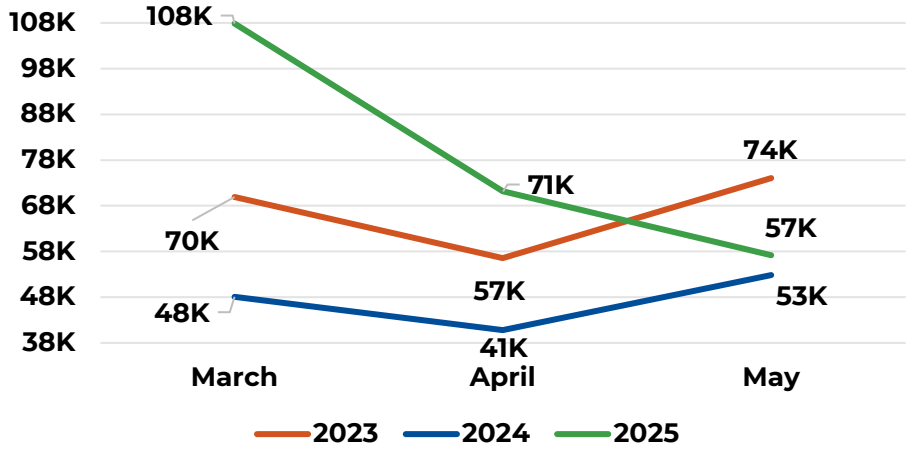
Percent of Expansion Enrolled Members Utilization

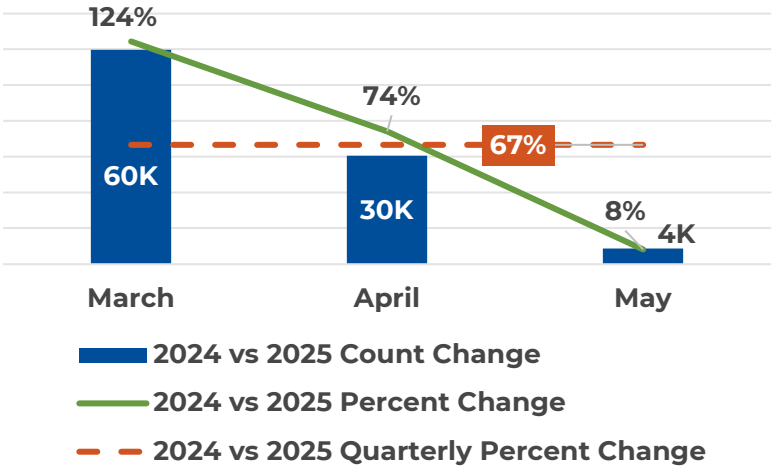




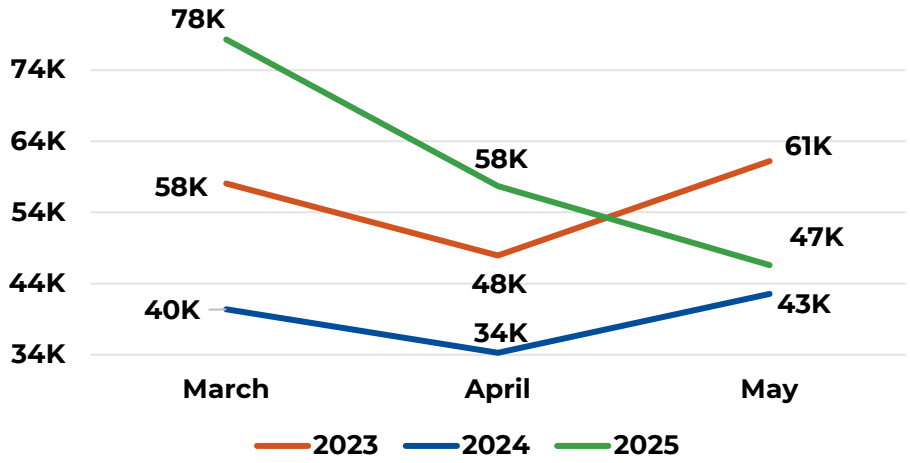
Utilization

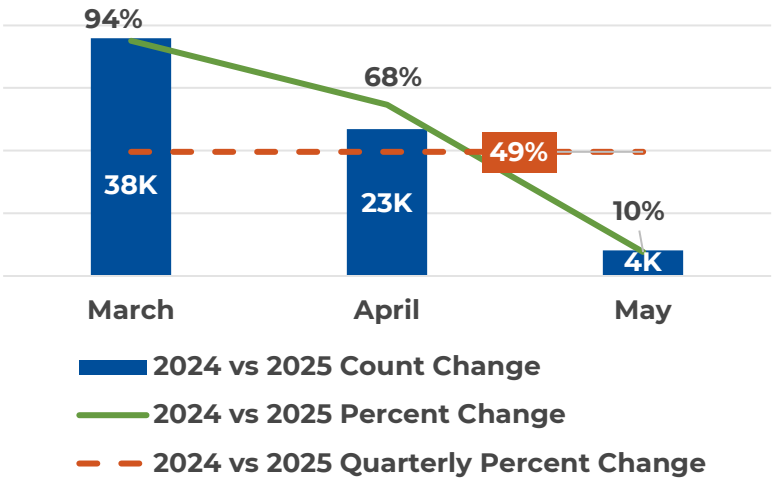
Emergency Department Visits (Claims)





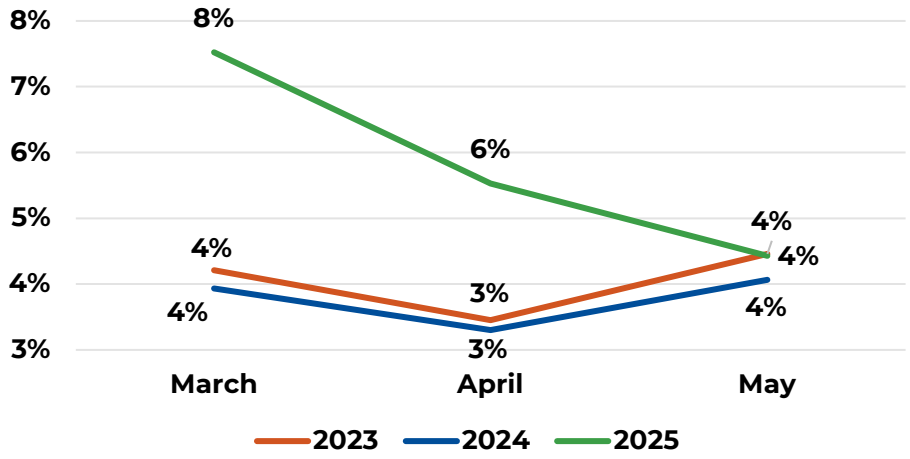
Members Utilizing Emergency Department

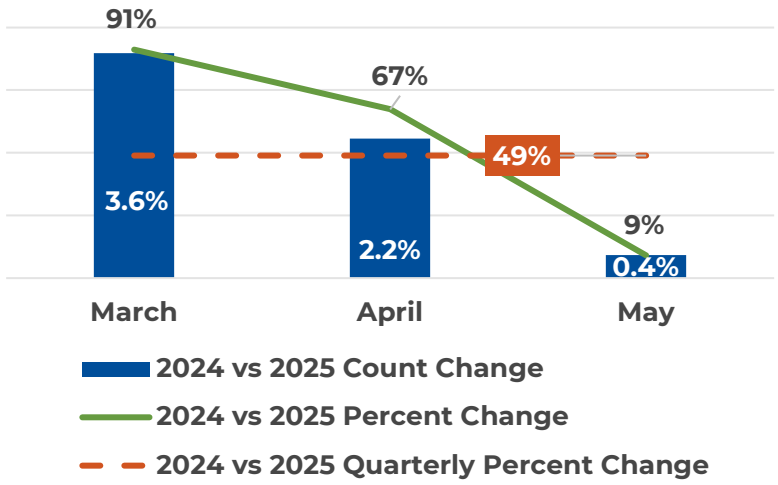




Utilization (Cont.)

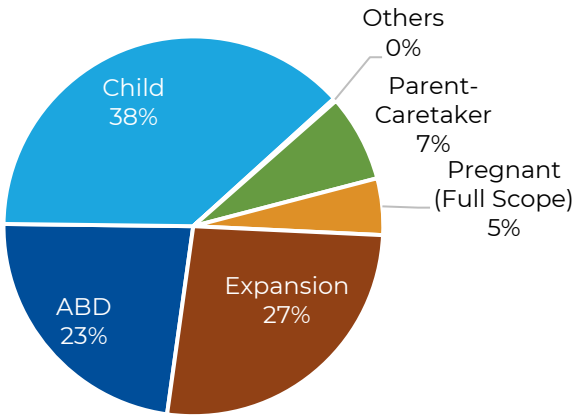
Percent Total Enrolled Using ED



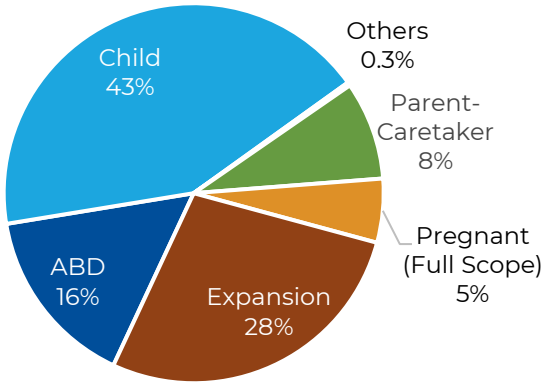


Members Utilizing Emergency Department By Qualifying Group

Q4 2024

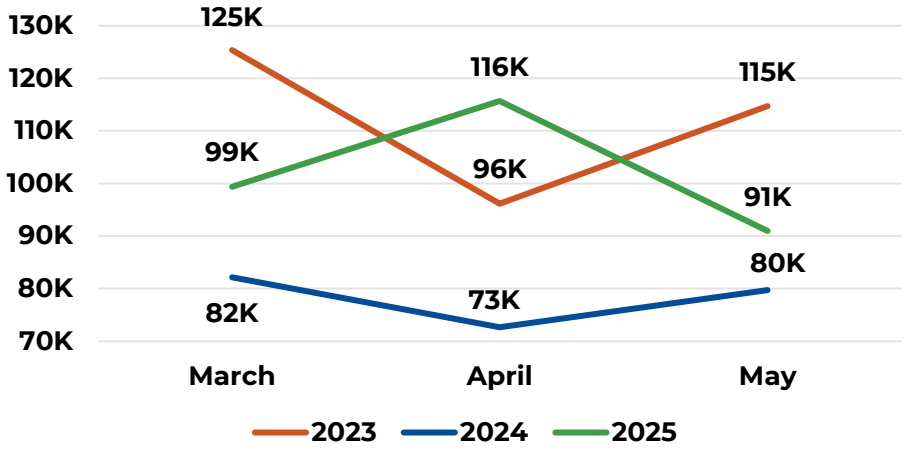


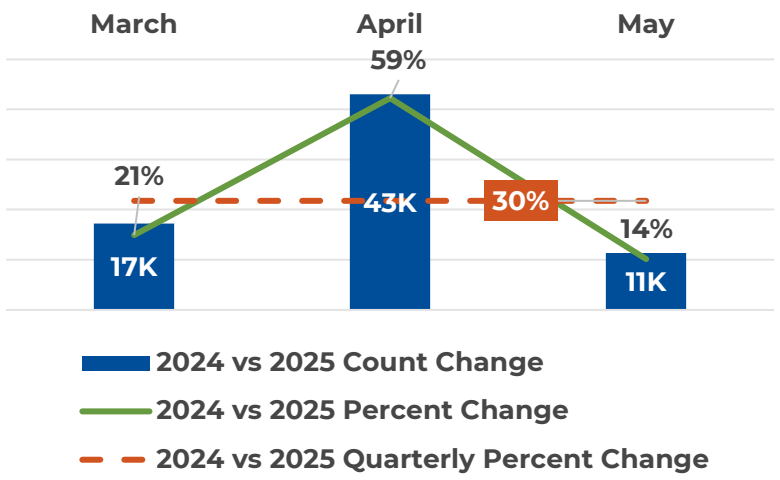
Q4 2025



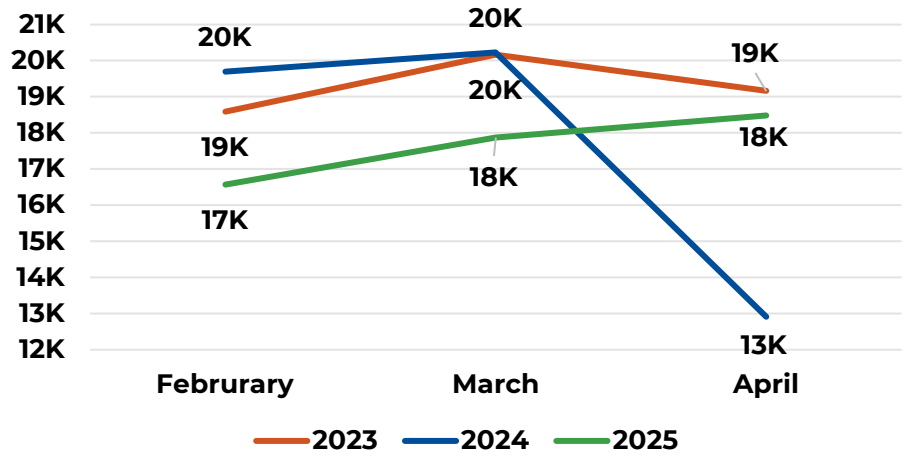
Utilization (Cont.)

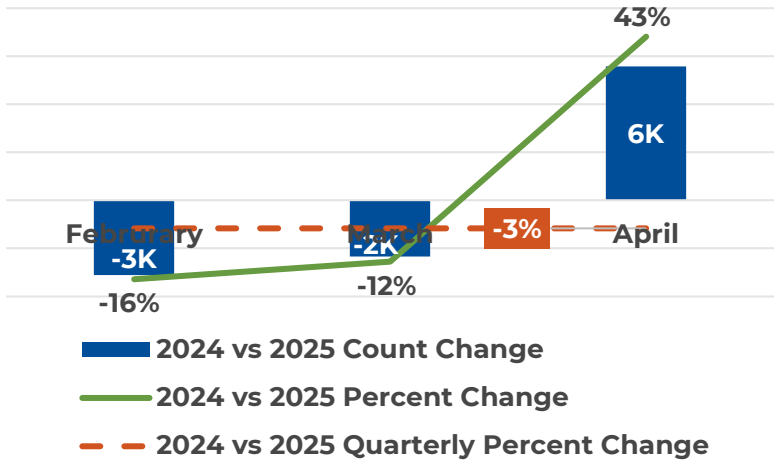
Telemedicine - Total Visits





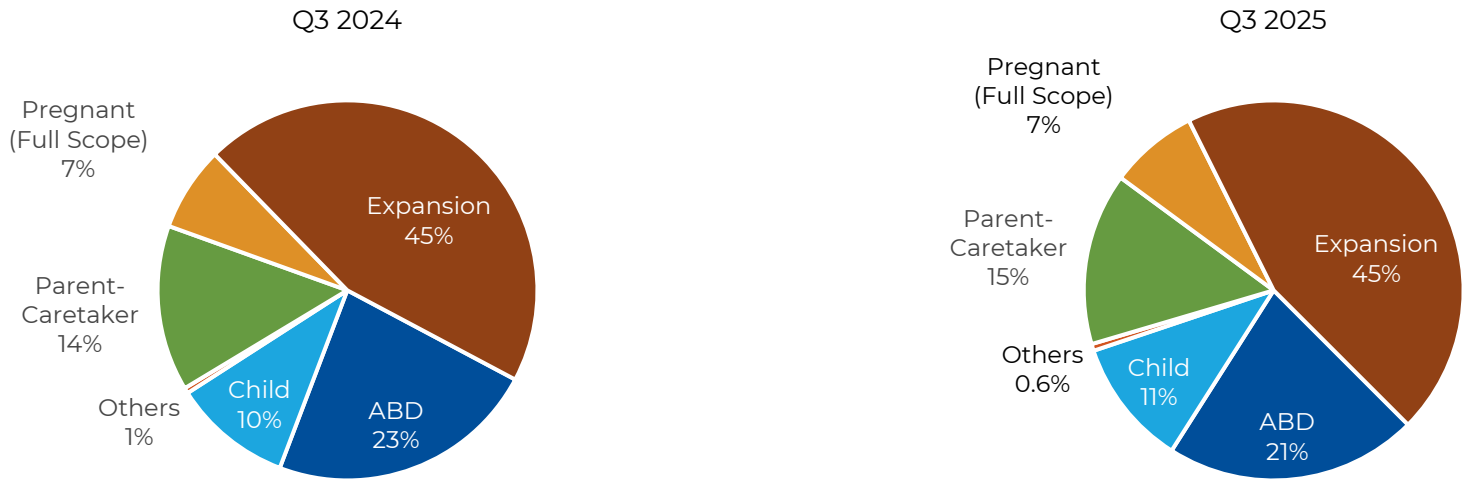
Members With Opioid Claims



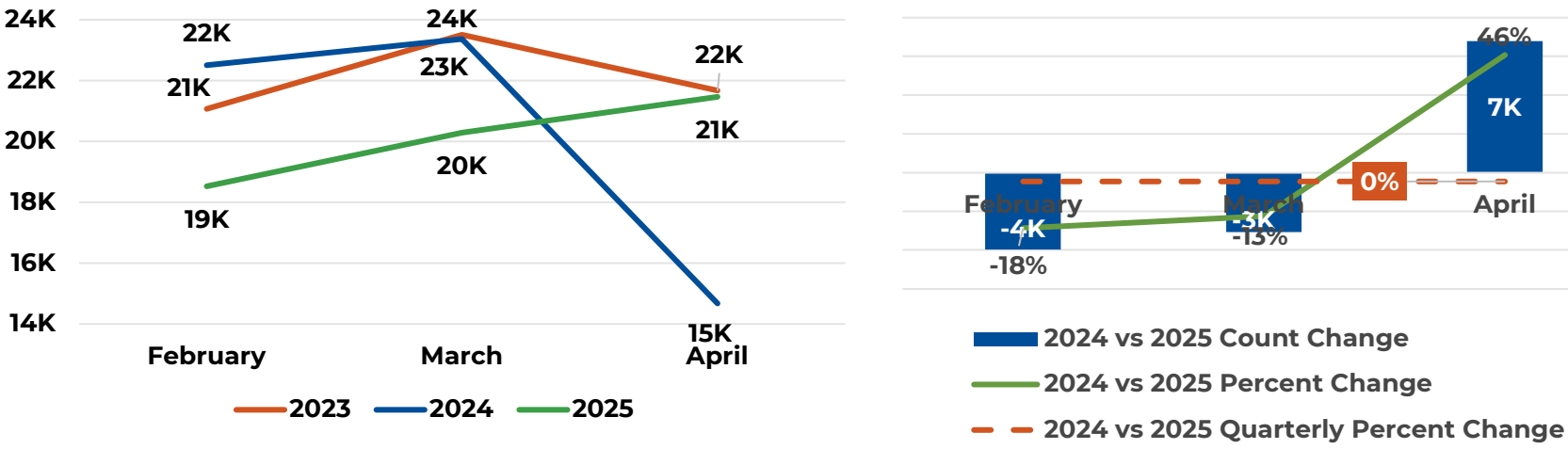


Utilization (Cont.)

Members With Opioid Claims By Qualifying Group

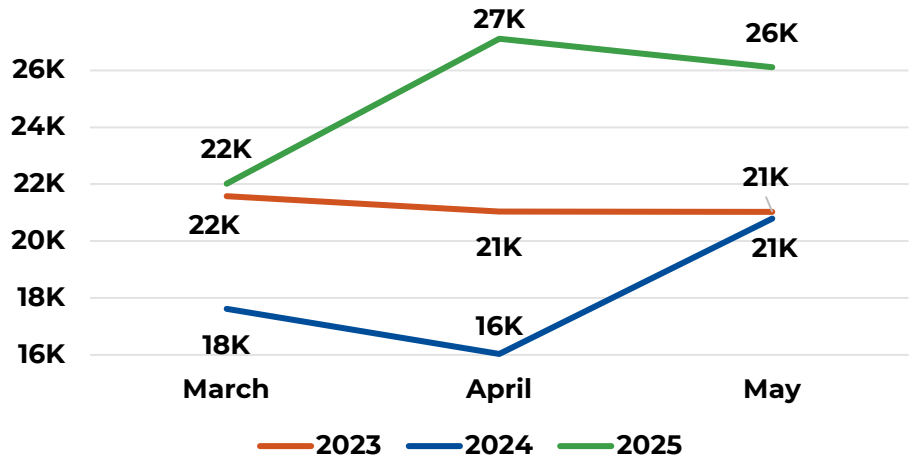


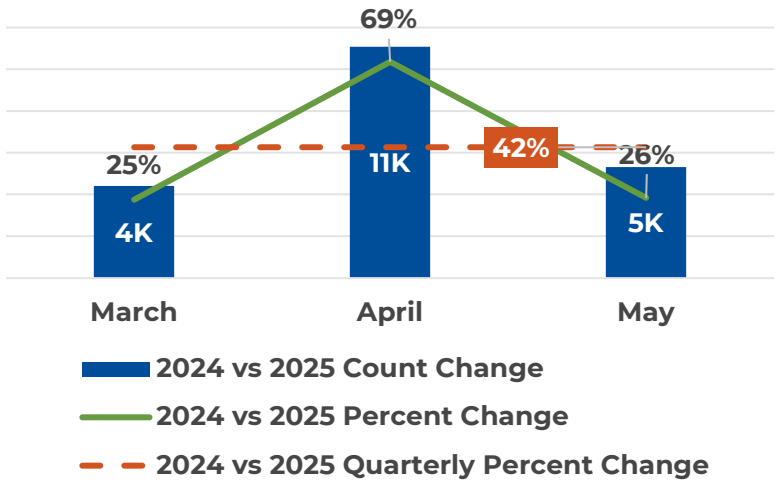
Total Opioid Claims



Utilization (Cont.)

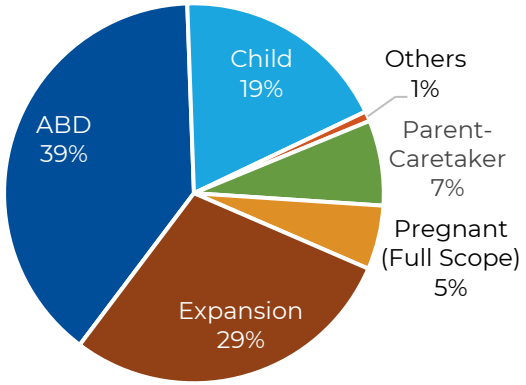
Out of State Services (Non Border County) - Total Members Utilization



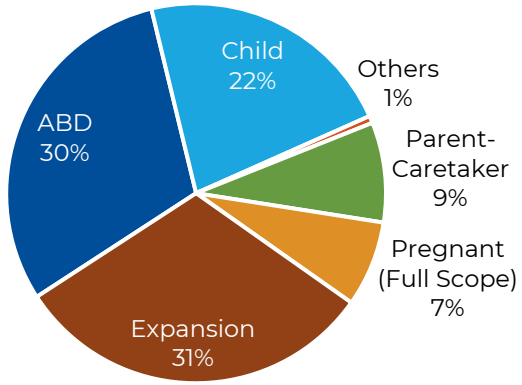


Out of State Services (Non Border County) - Total Members Utilization By Qualifying Group

Q4 2024

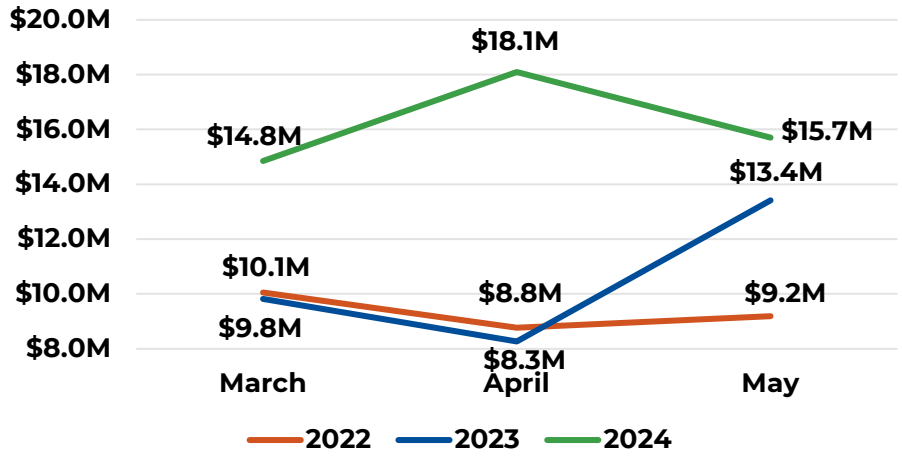


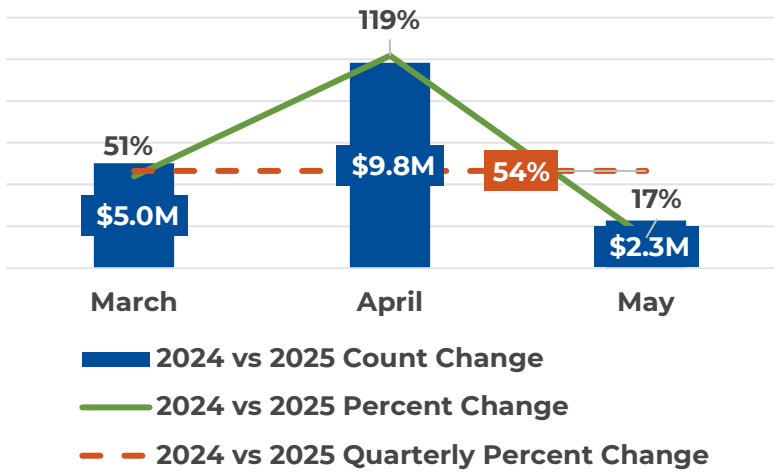
Q4 2025



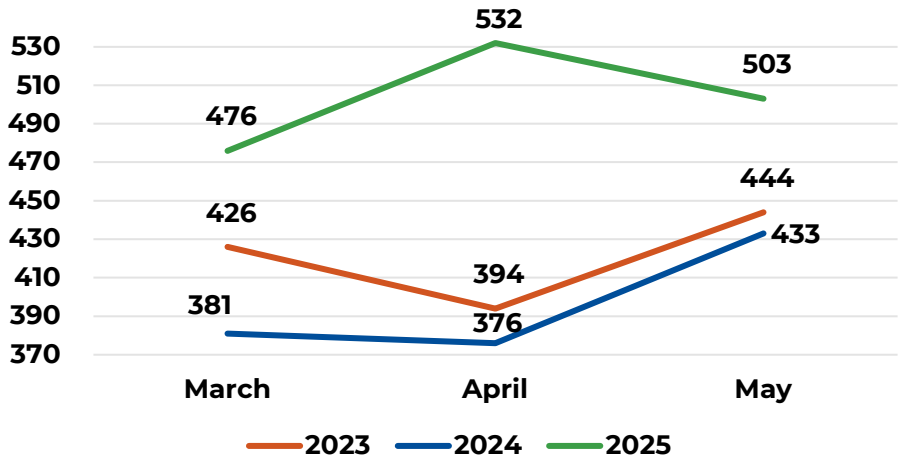
Utilization (Cont.)

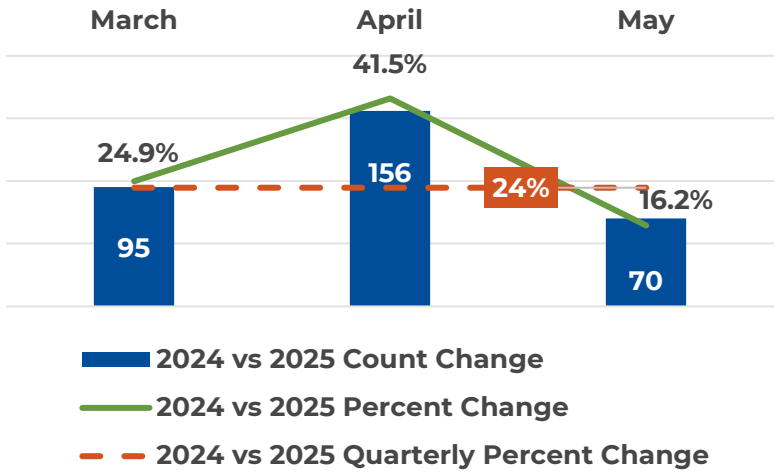
Out of State Services (Non Border County) - Total Reimbursements





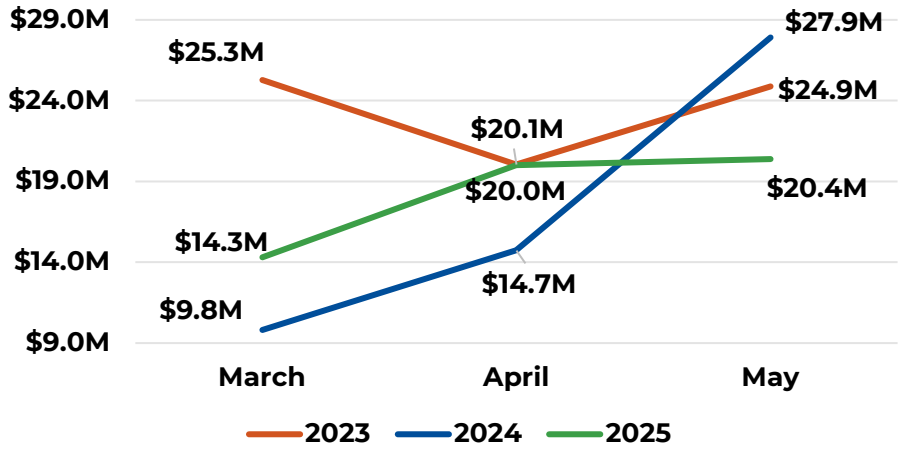
Out of State Services (Non Border County) - Total Active Billing Providers

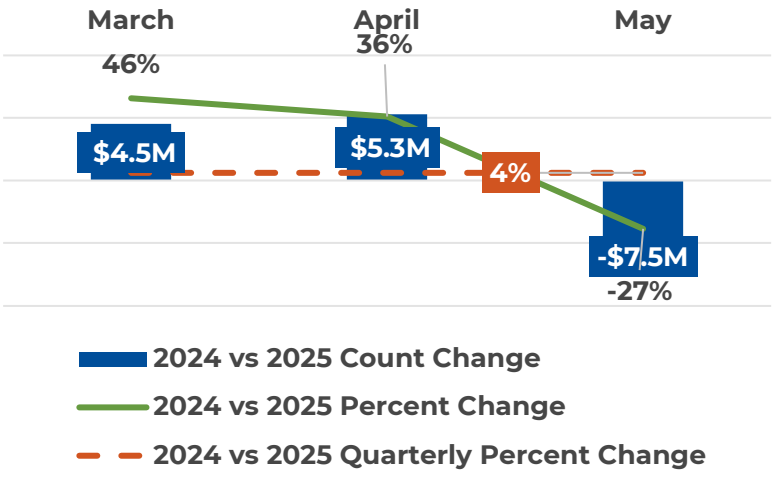




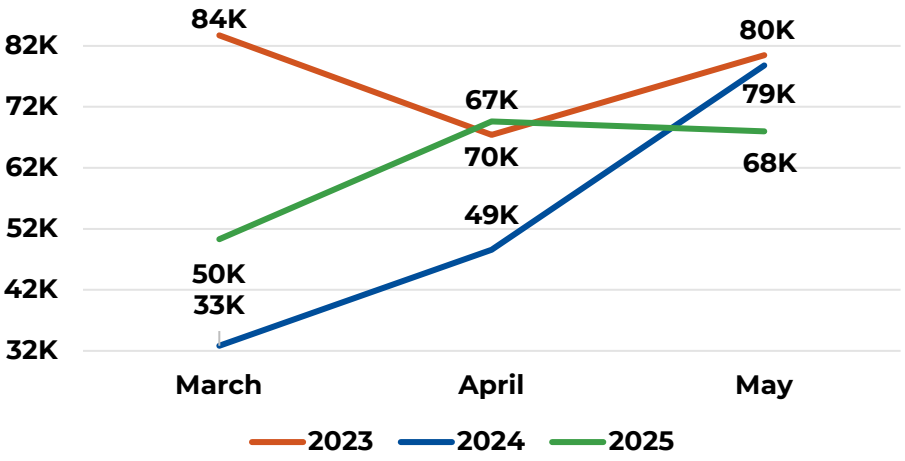
Utilization (Cont.)

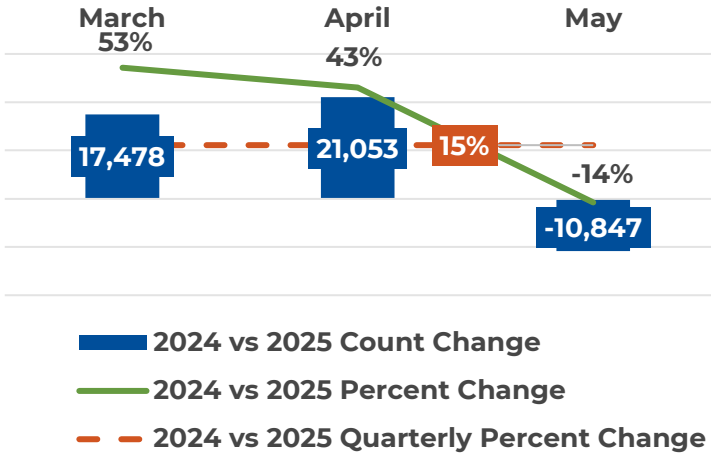
Dental Claims





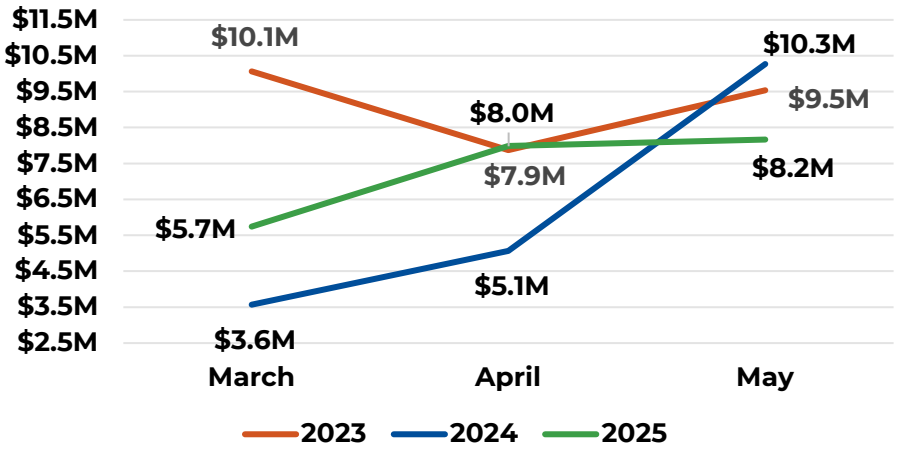
Total Members with Dental Claims

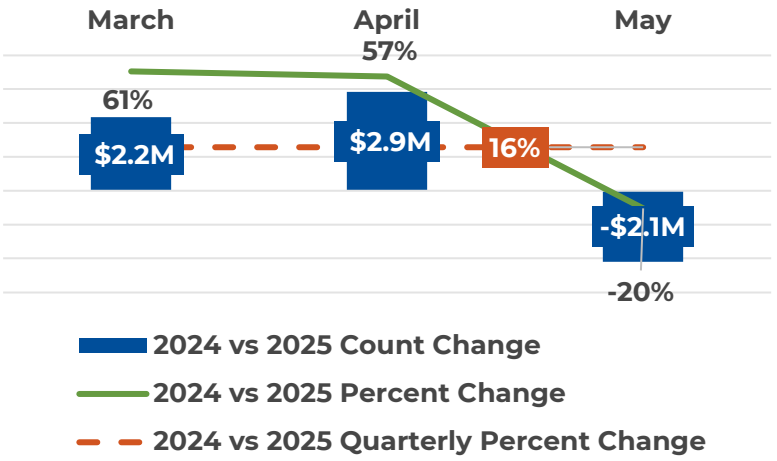




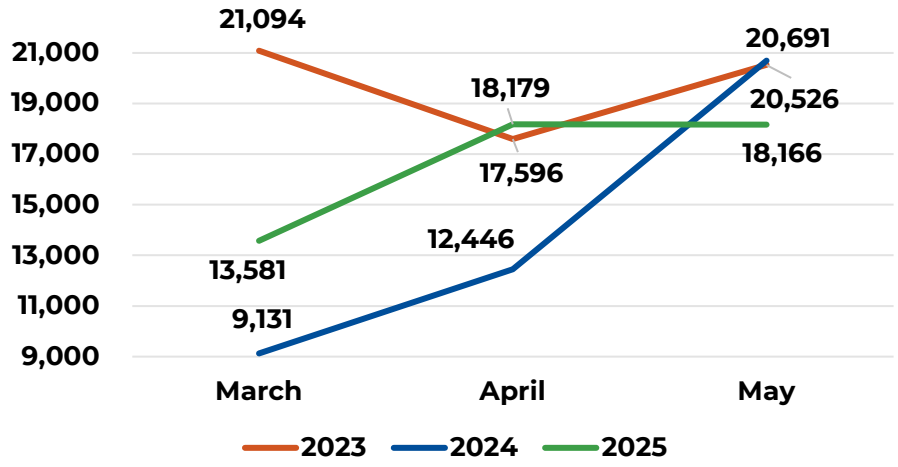
Utilization (Cont.)

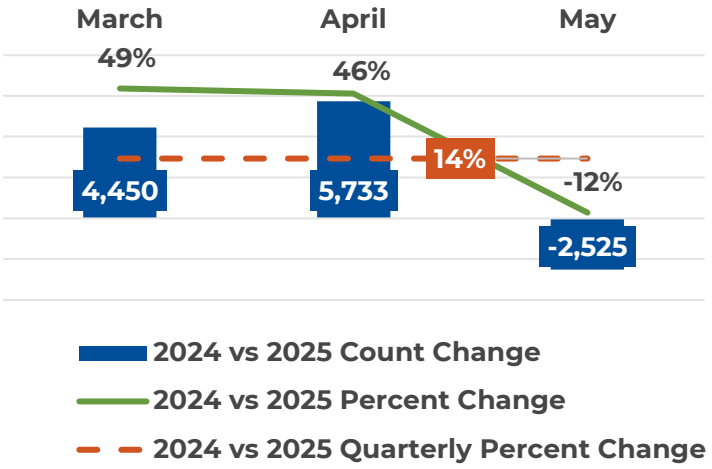
Adult (21 & Over) Dental Claims





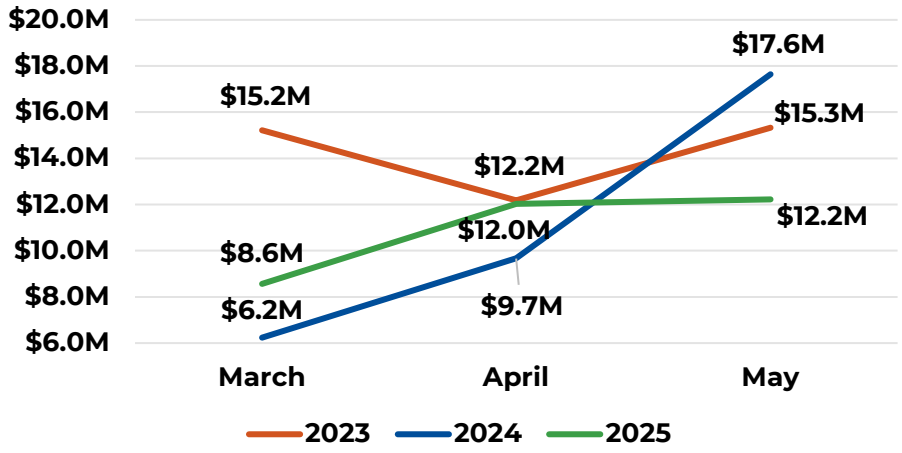
Adults (21 & Over) with Dental Claims

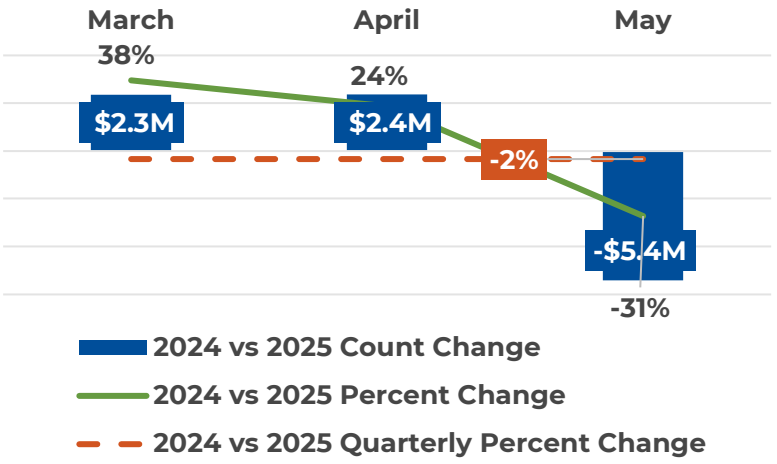




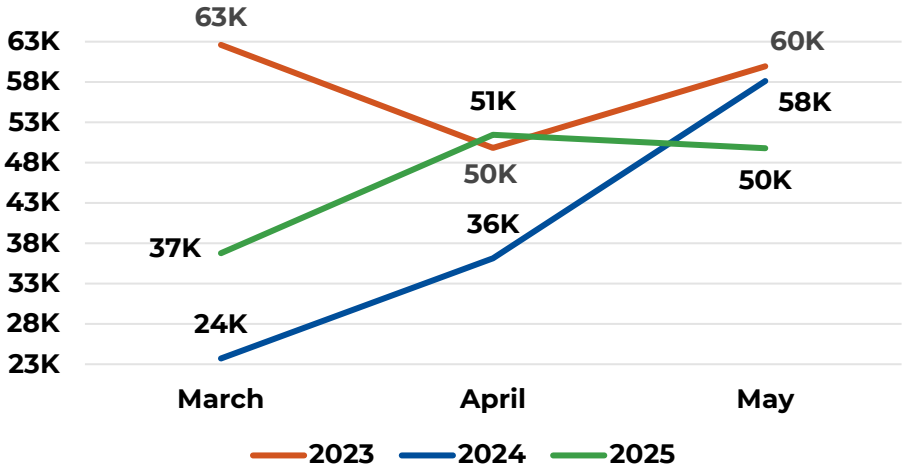
Utilization (Cont.)

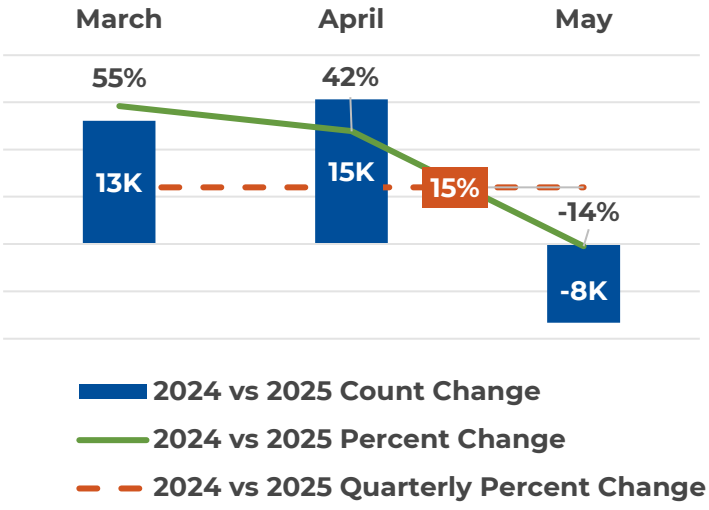
Children (Under 21) Dental Claims





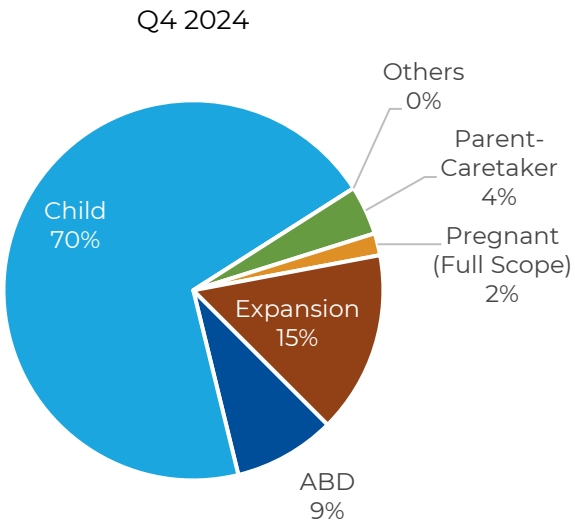
Children (Under 21) with Dental Claims

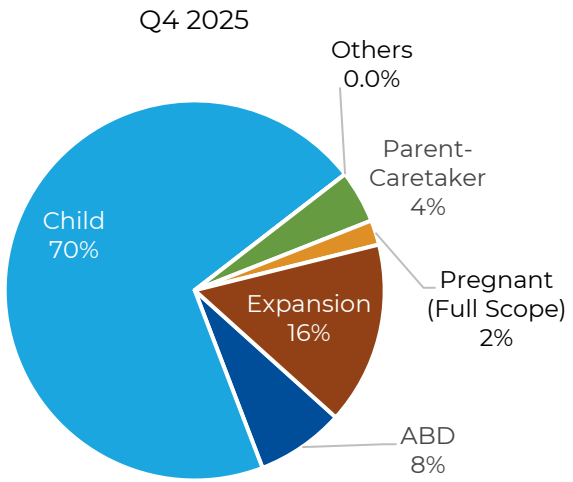




Utilization (Cont.)

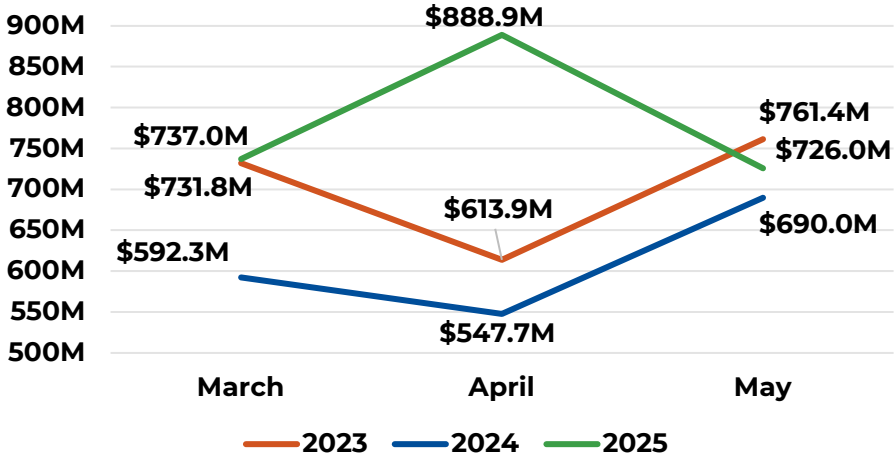
Members With Dental Claims By Qualifying Group

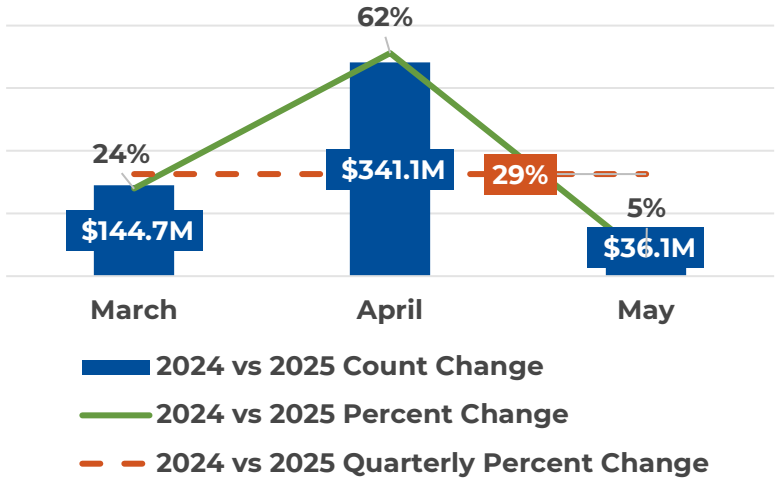




Financials

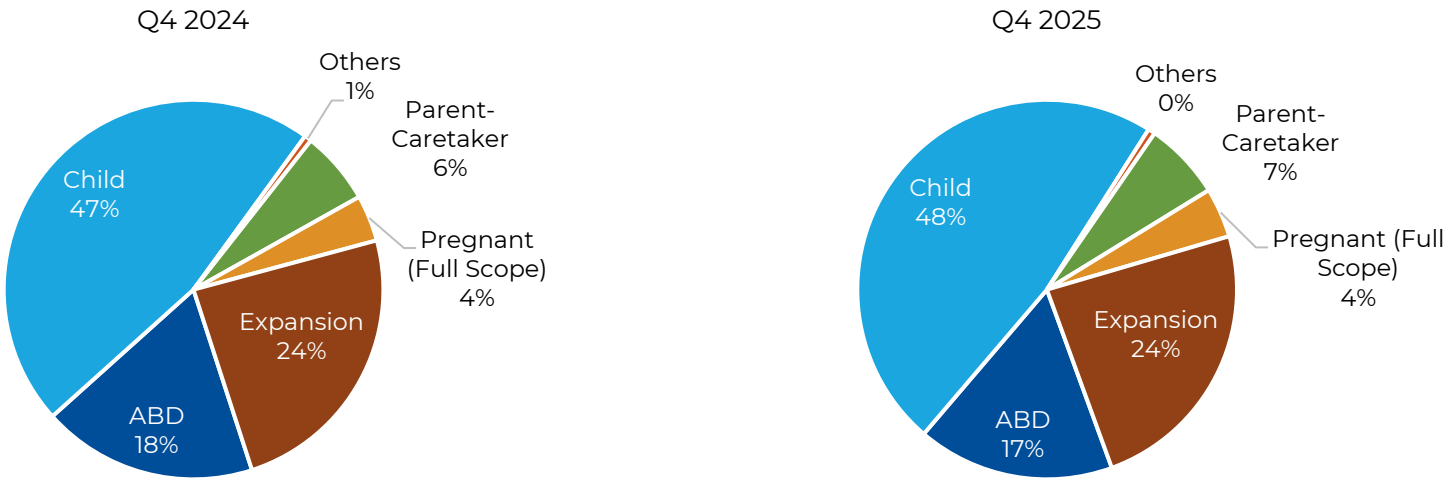
Total Agency Expenditures



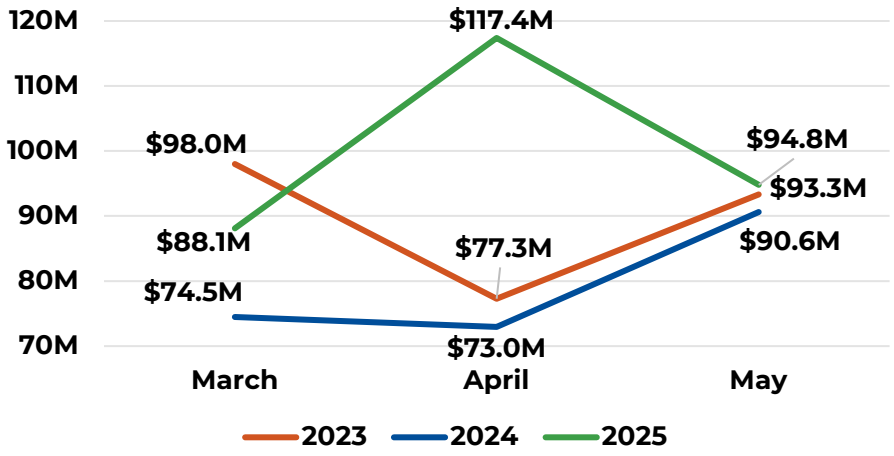


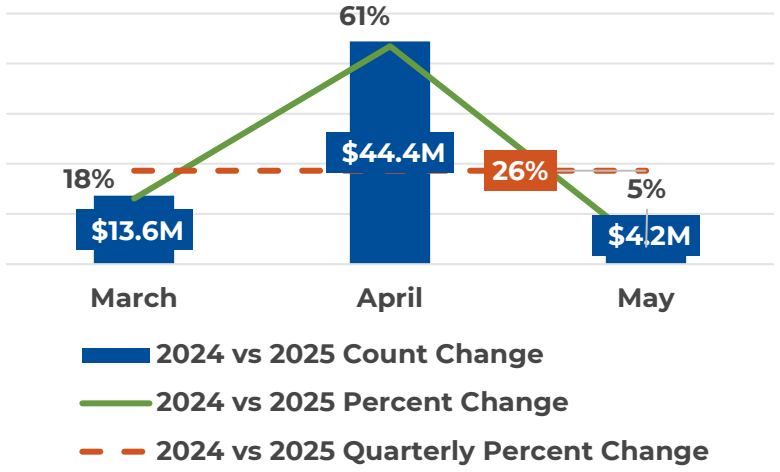
Financials (Cont.)

Total Agency Members Utilization by Qualifying Group



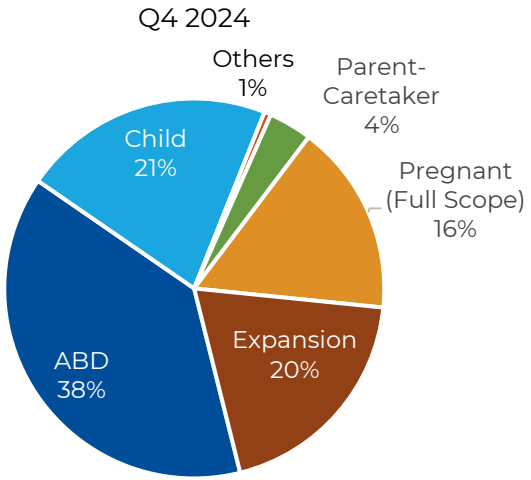
Inpatient Services Expenditures

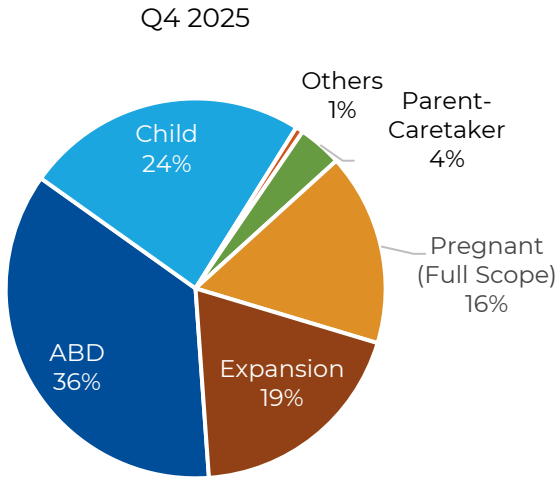




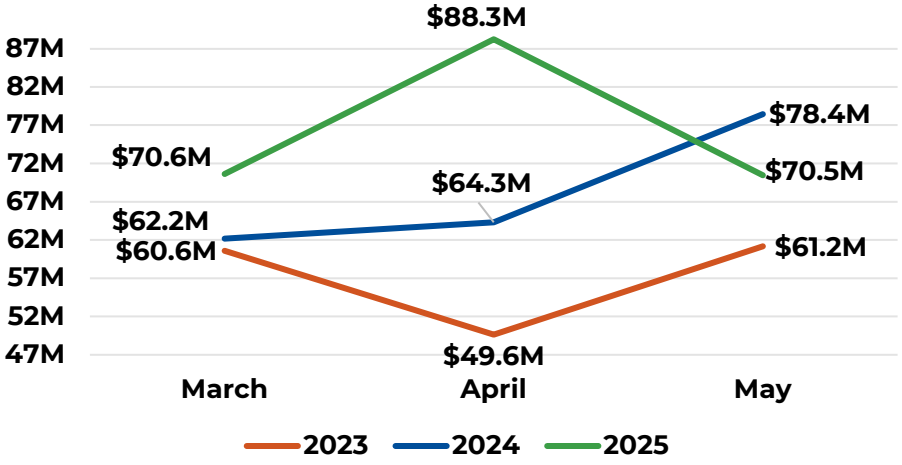
Financials (Cont.)

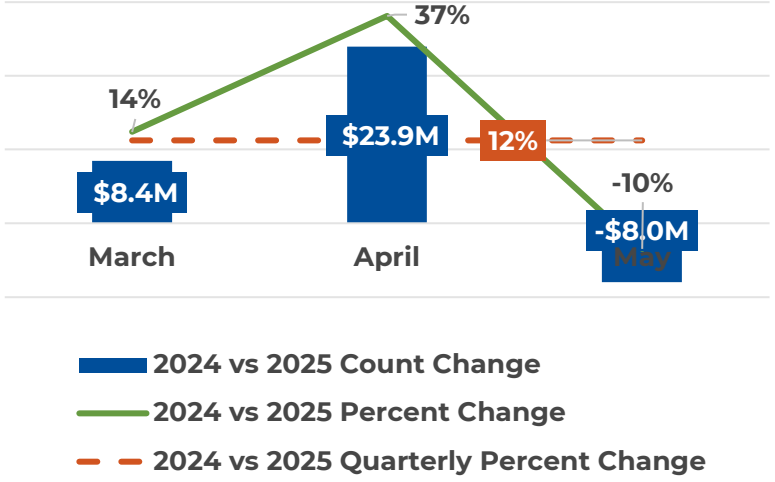
Inpatient Services Members Utilization by Qualifying Group





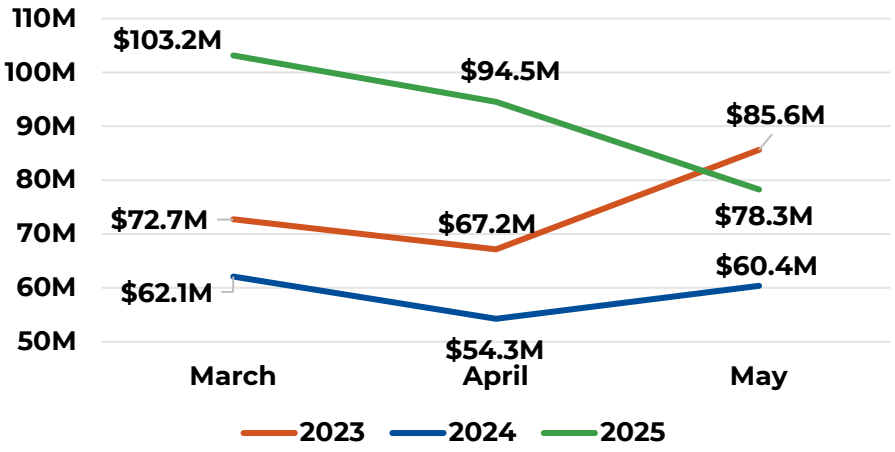
Nursing Facility Expenditures

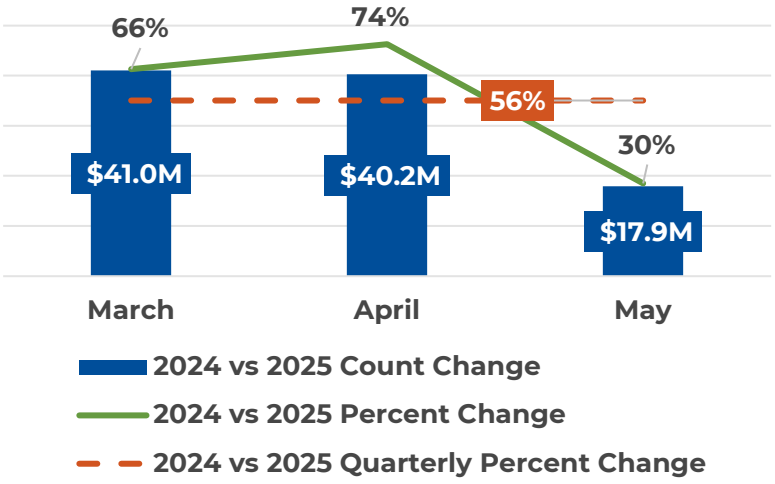




Financials (Cont.)

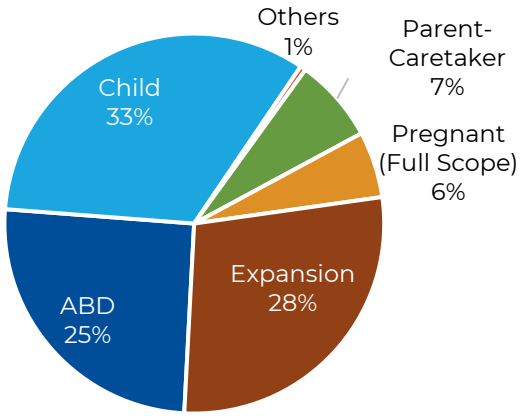
Outpatient Hospital Expenditures



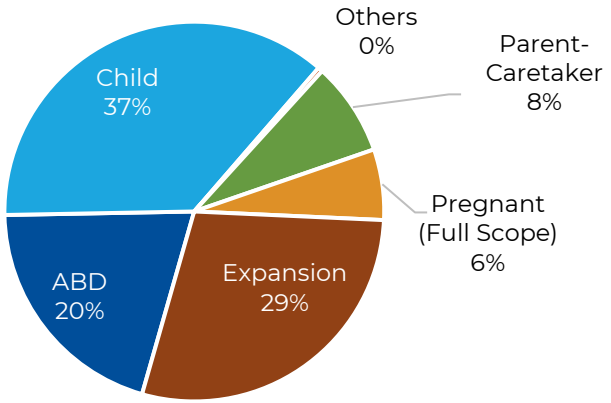


Outpatient Hospital Members Utilization by Qualifying Group

Q4 2024

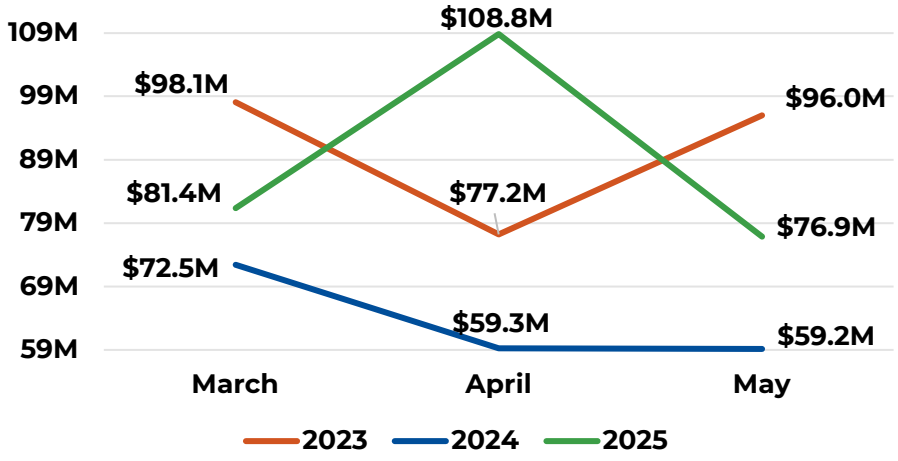


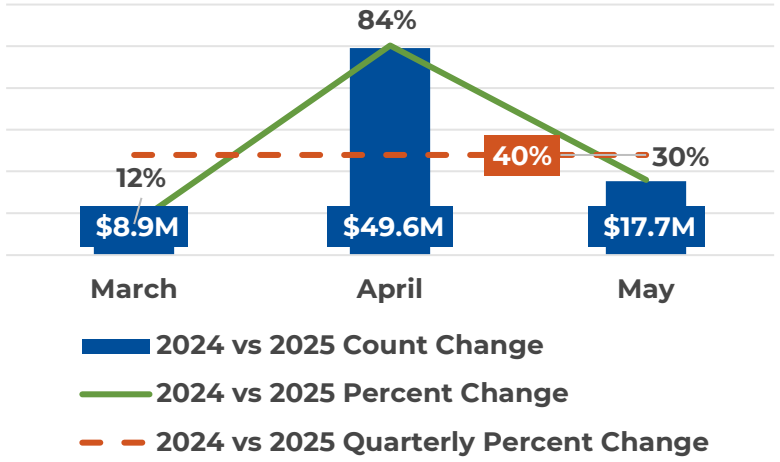
Q4 2025



Financials (Cont.)

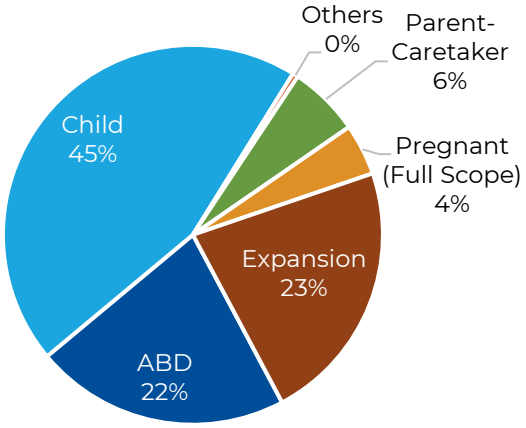
Physician Expenditures



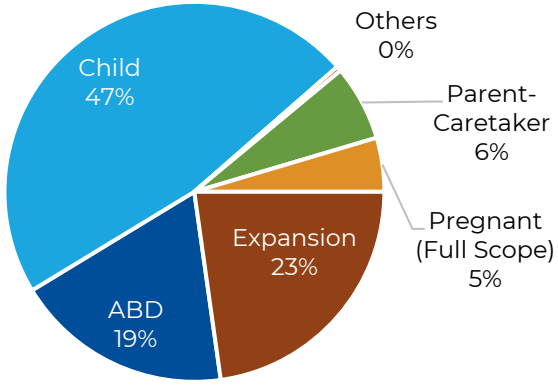


Physician Members Utilization By Qualifying Group

Q4 2024

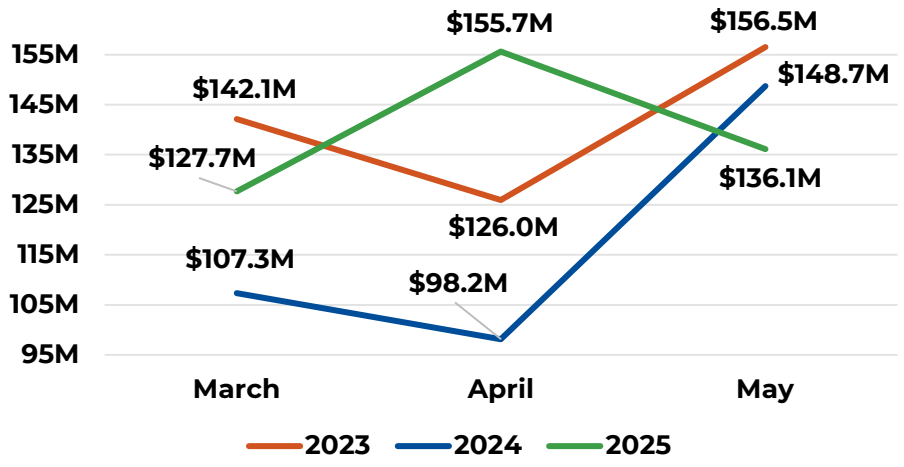


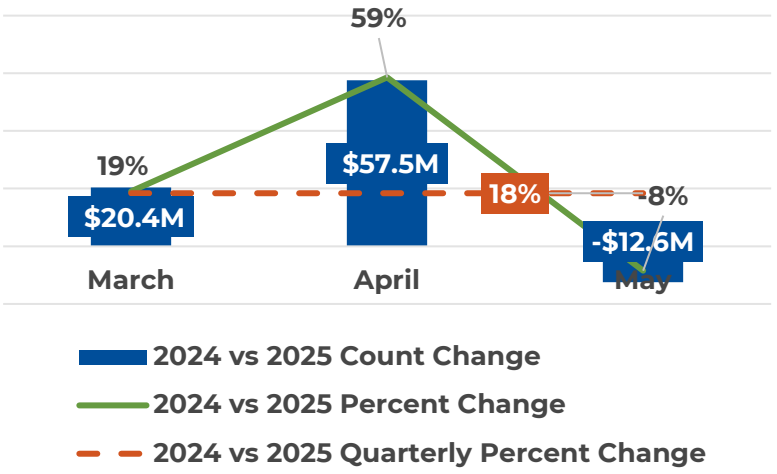
Q4 2025



Financials (Cont.)

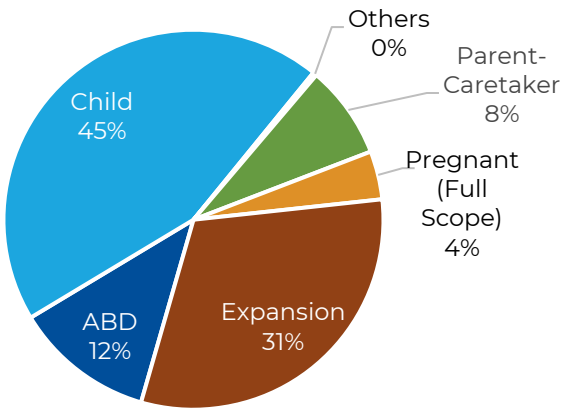
Prescribed Drugs Expenditures



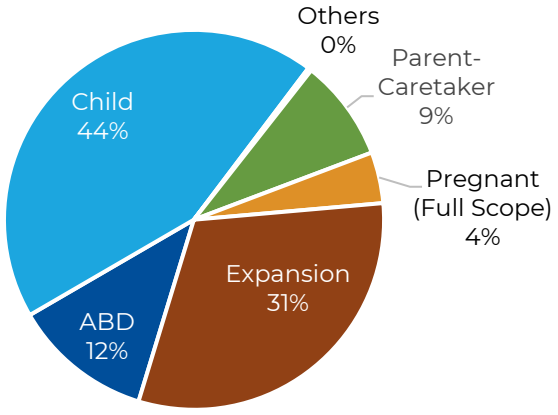


Prescribed Drugs Members Utilization By Qualifying Group

Q4 2024

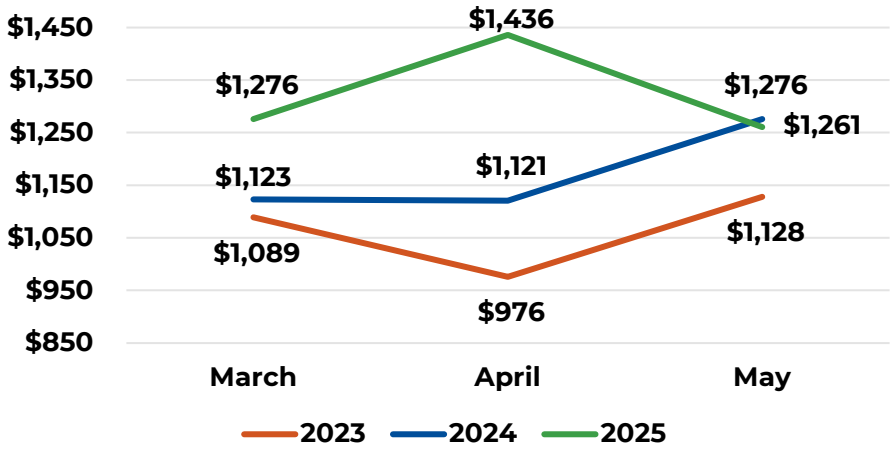


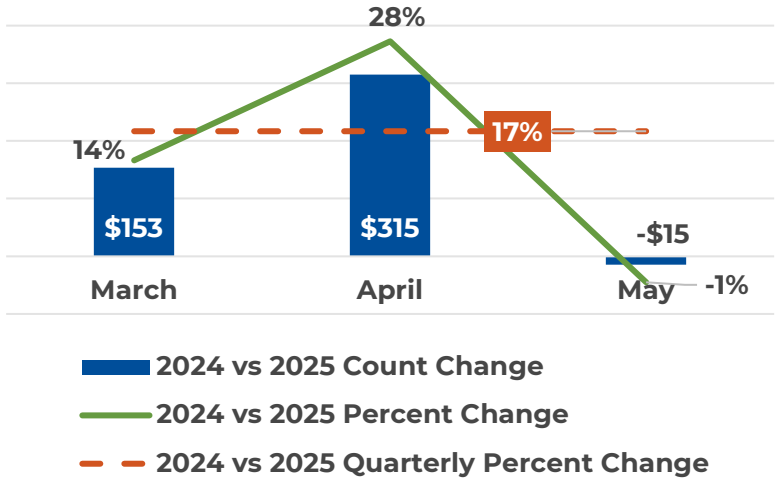
Q4 2025



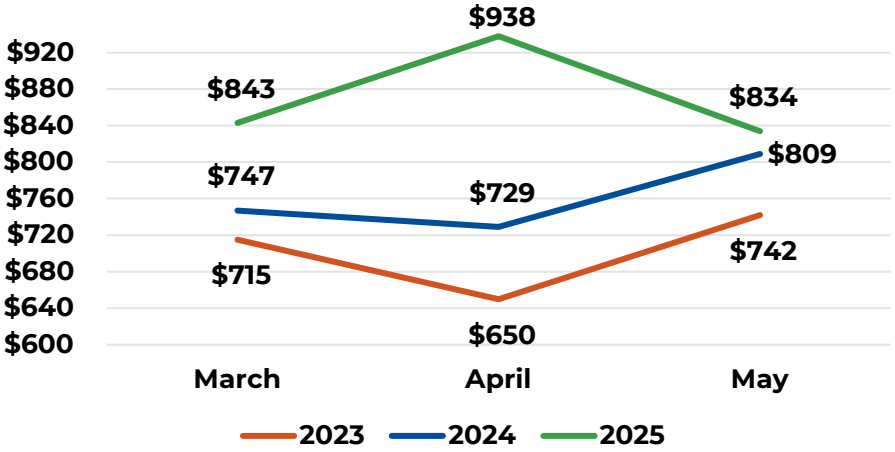
Financials (Cont.)

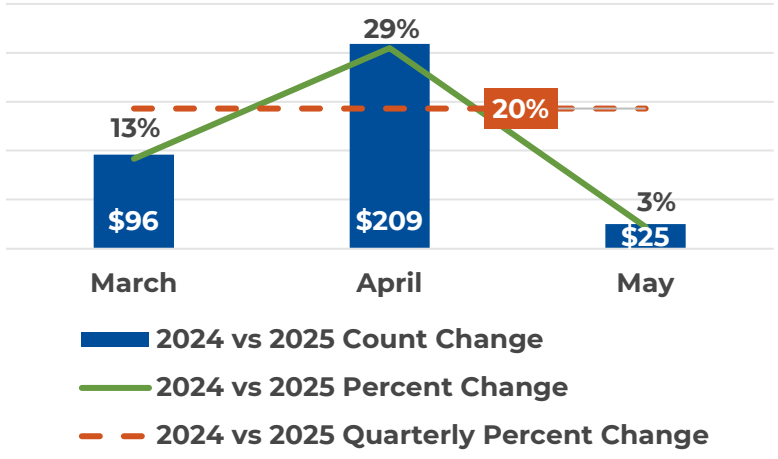
Average Per Total Member Served





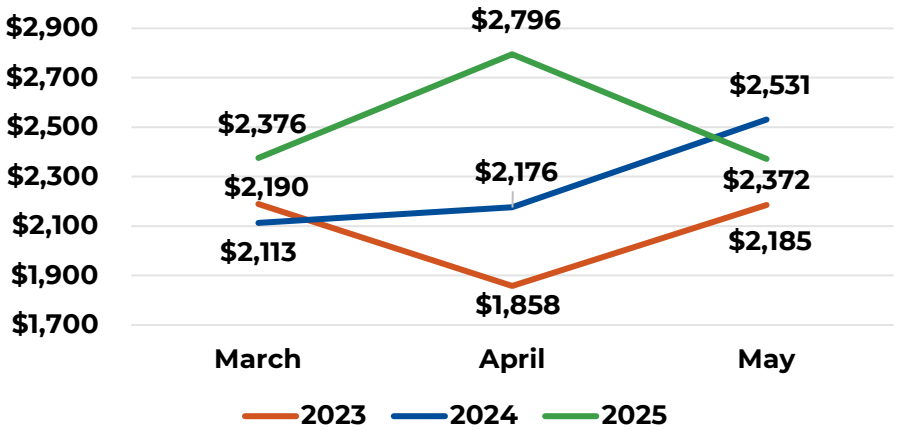
Average Per Child (Under 21) Member Served

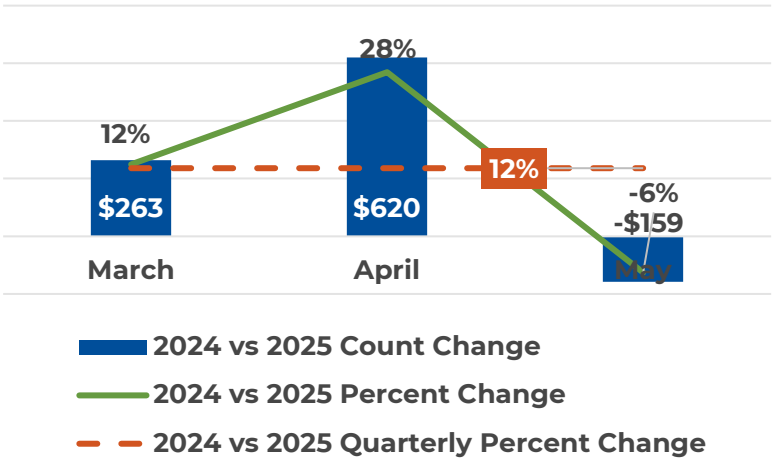




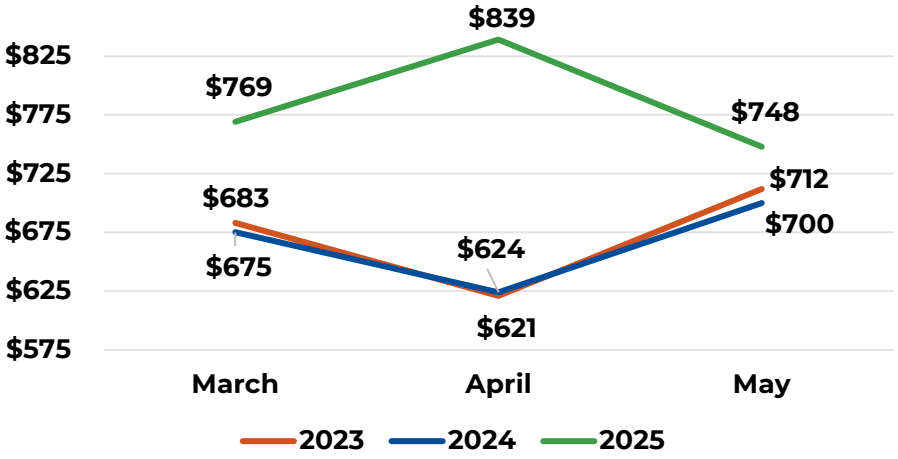
Financials (Cont.)

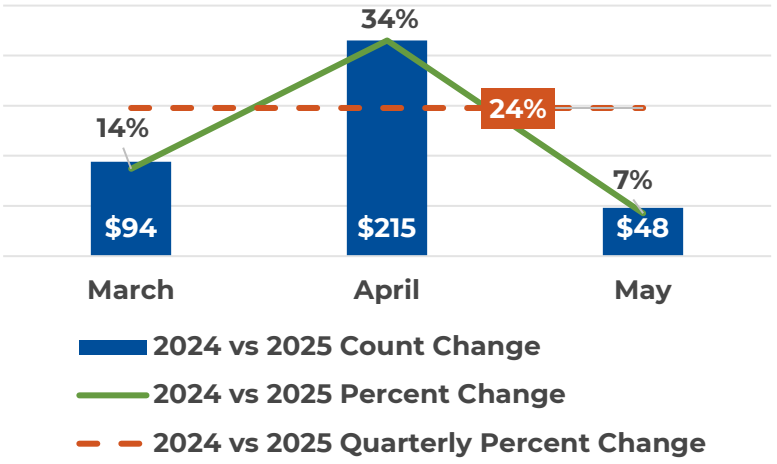
Average Per Aged/Blind/Disabled Member Served





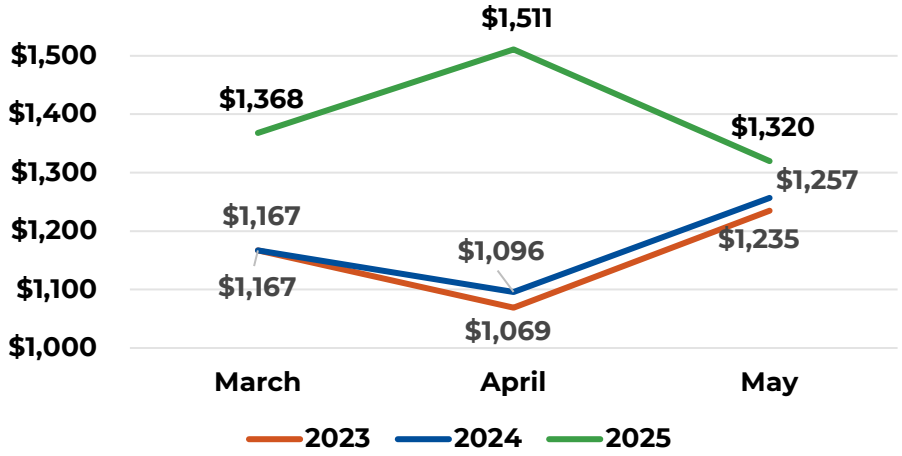
Average Per Children & Parent/Caretaker Member Served

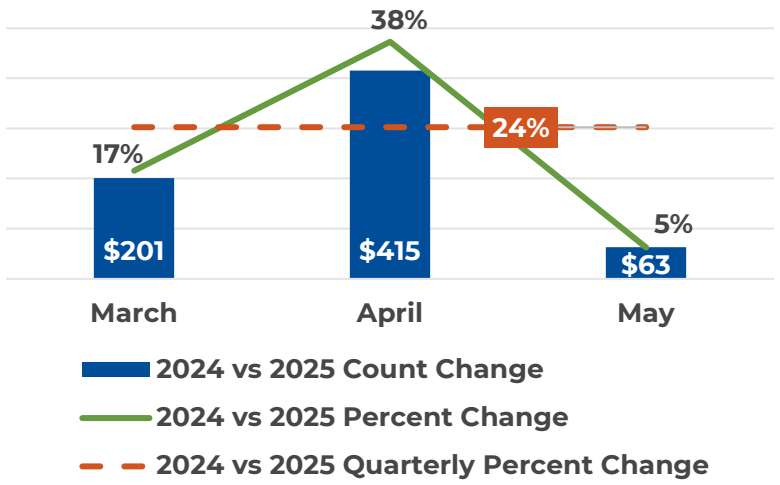




Financials (Cont.)

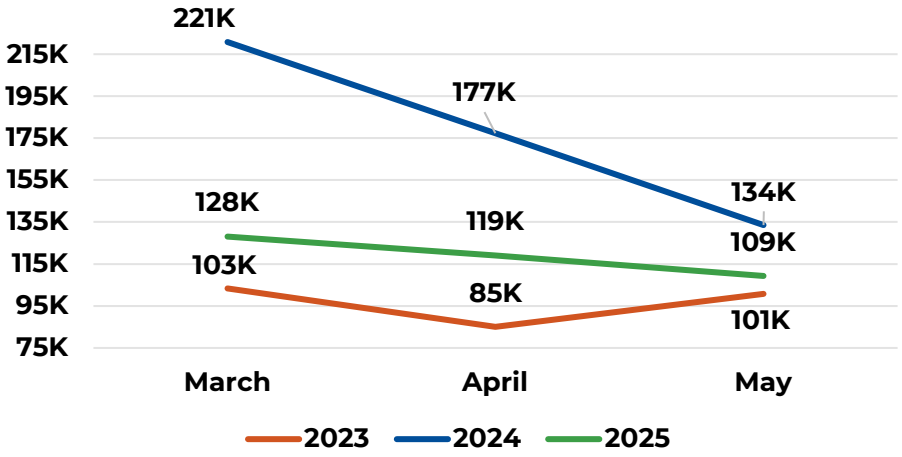
Average Per Expansion Member Served (Effective July 2021)

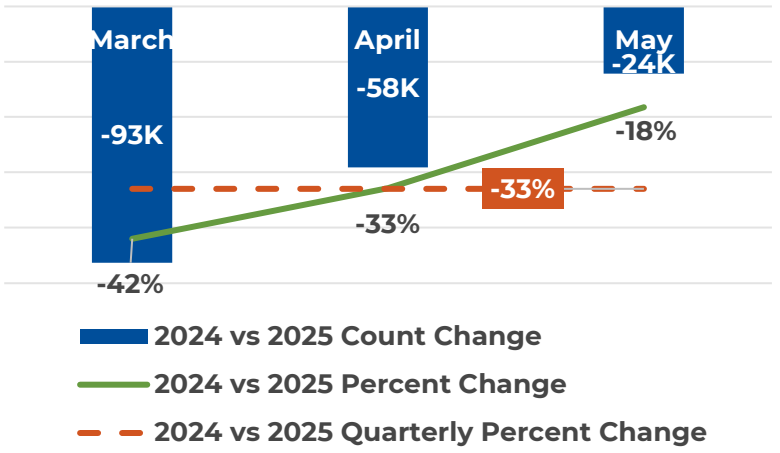




Call Center

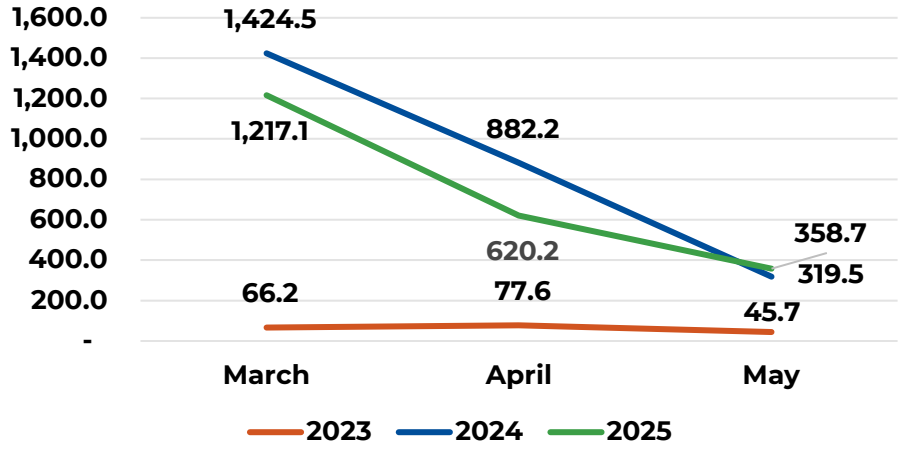
Call Center - Member Calls Answered

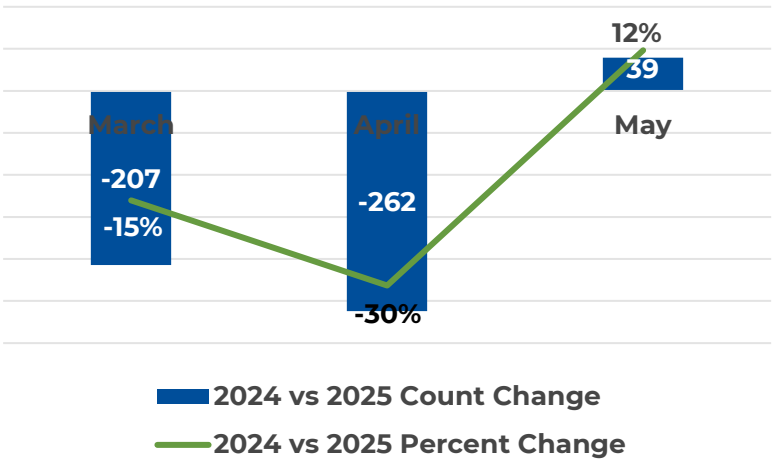




Call Center (Cont.)

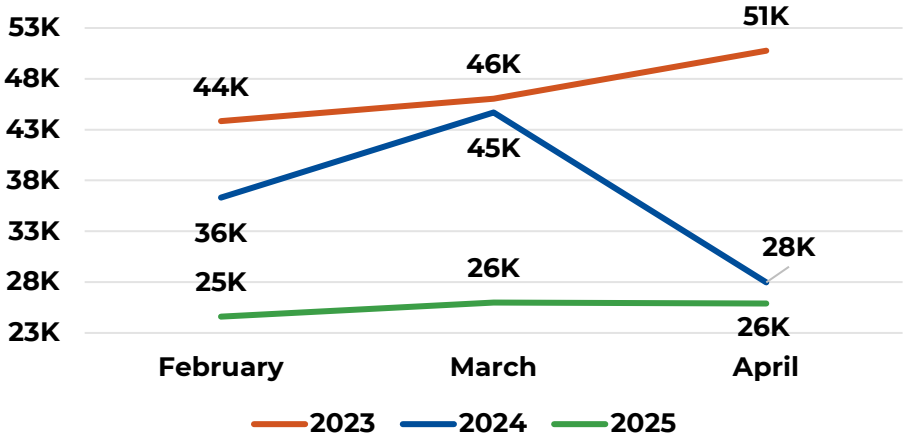
Call Center - Average Wait Time (In Seconds)

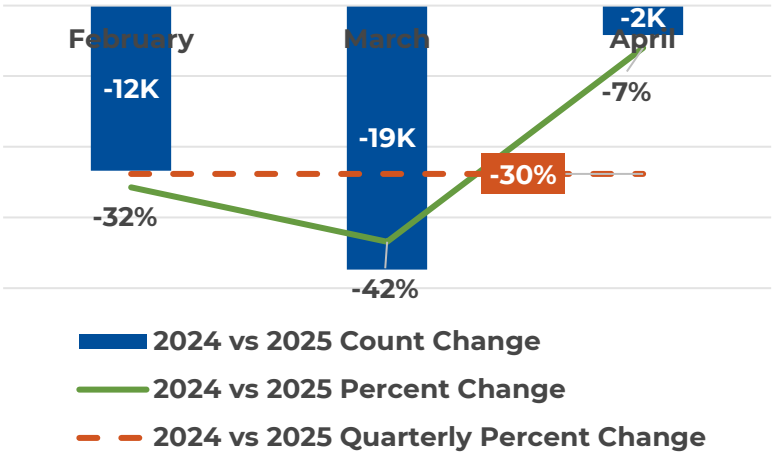




Prior Authorization

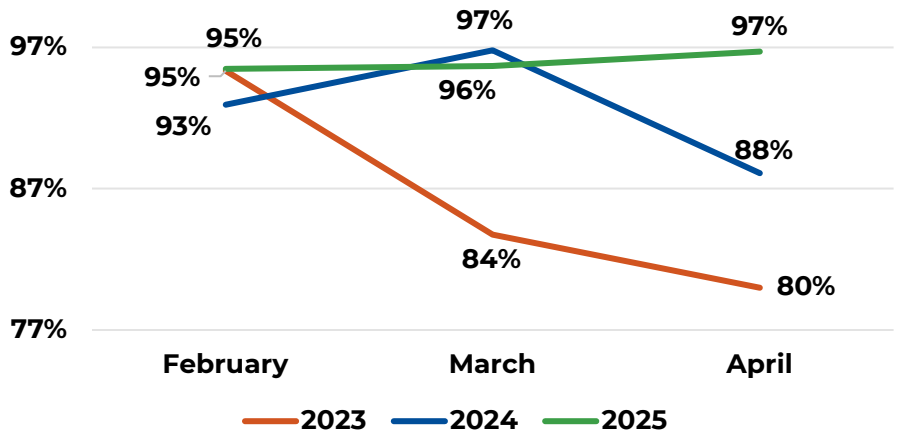
Prior Authorization - Total Combined - Total Completed PA Volume

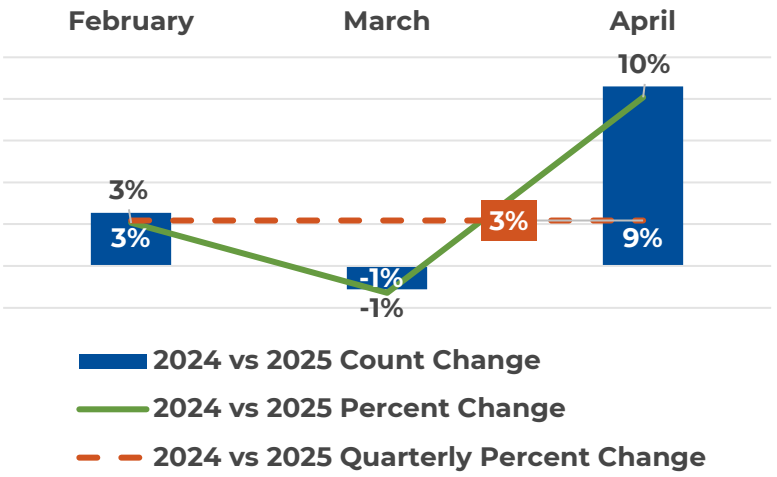




Prior Authorization (Cont.)

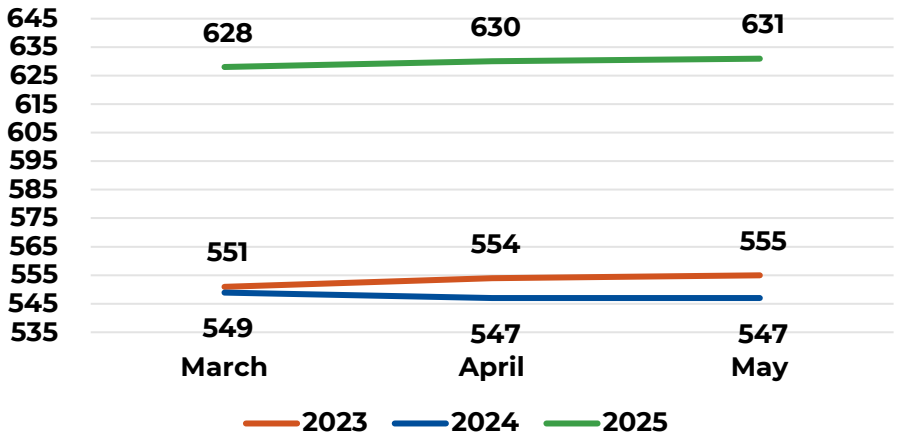
Prior Authorization - Total Combined - Total Percent Completed 0-6 Days

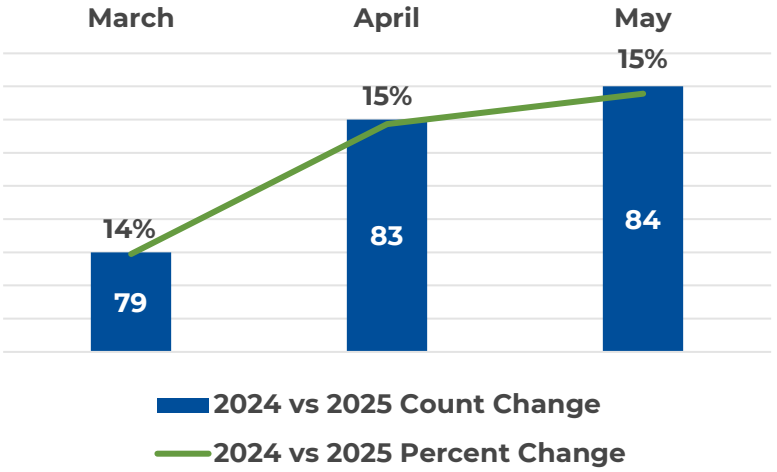




Agency Stats & Provider Network

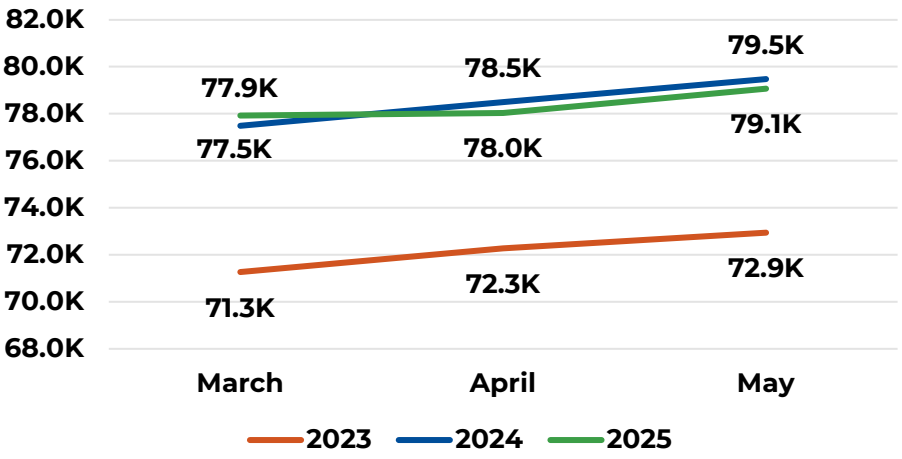
OHCA Admin - Number of FTEs

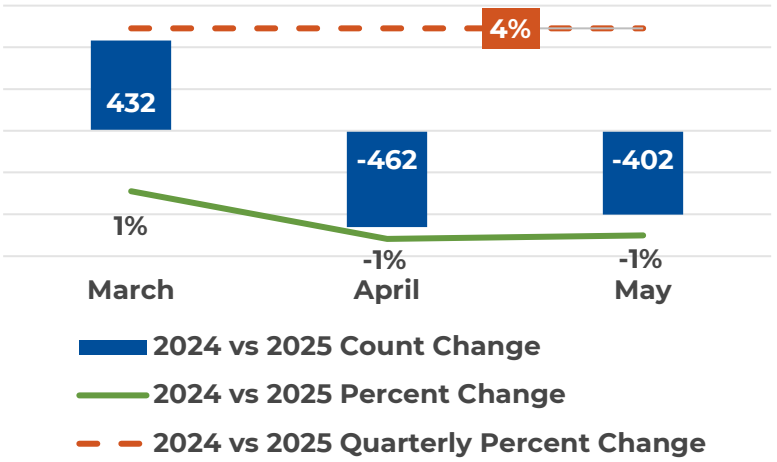




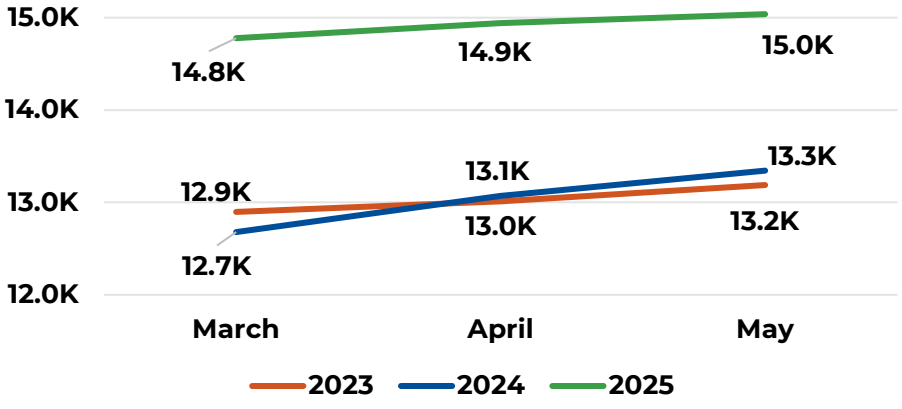
Agency Stats & Provider Network (Cont.)

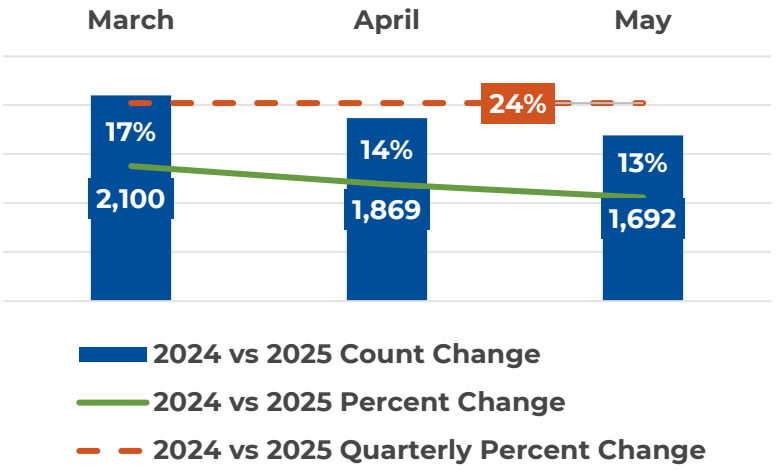
Total Providers





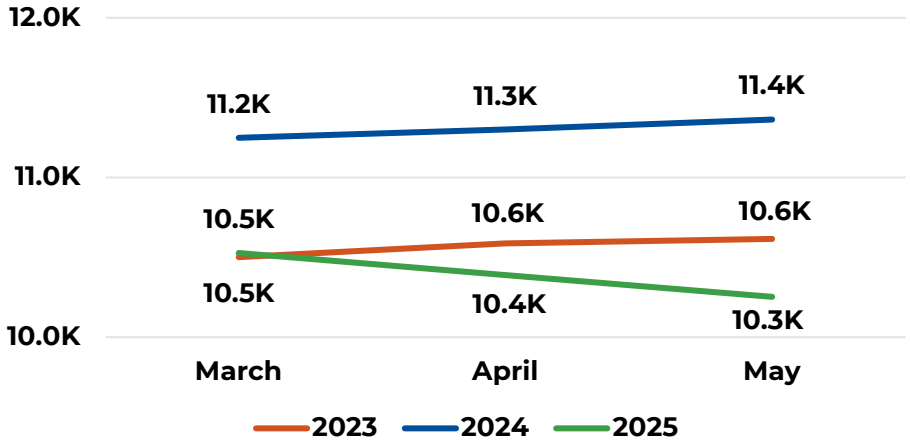
Mental Health Providers (In-State Only)

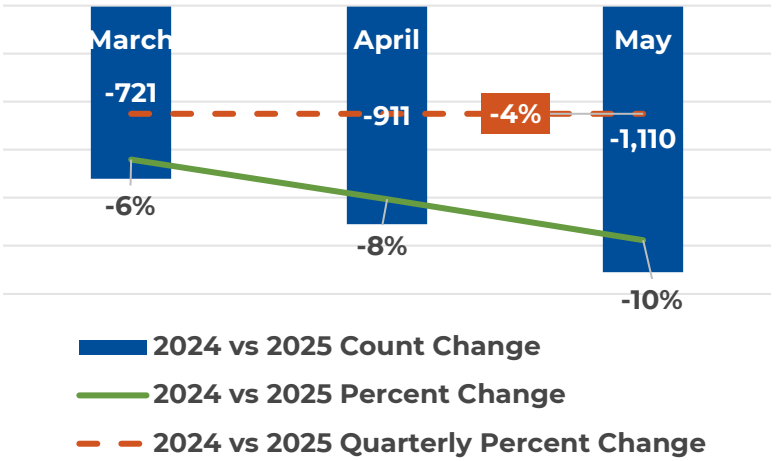




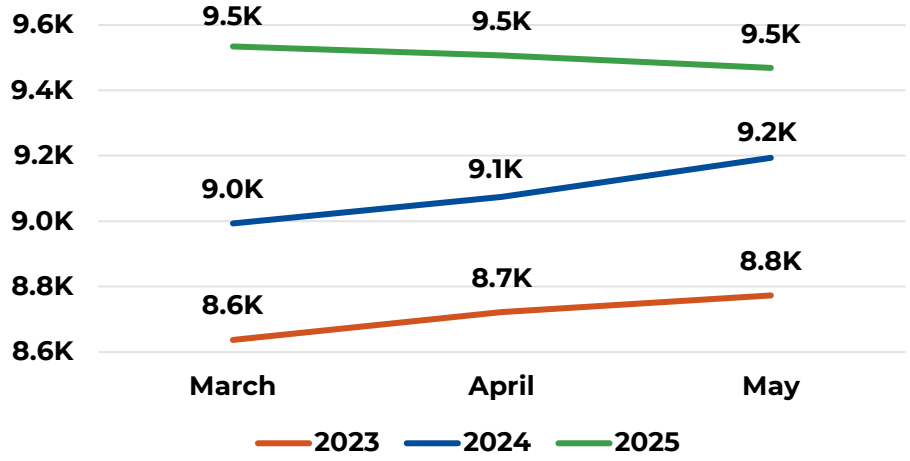
Agency Stats & Provider Network (Cont.)

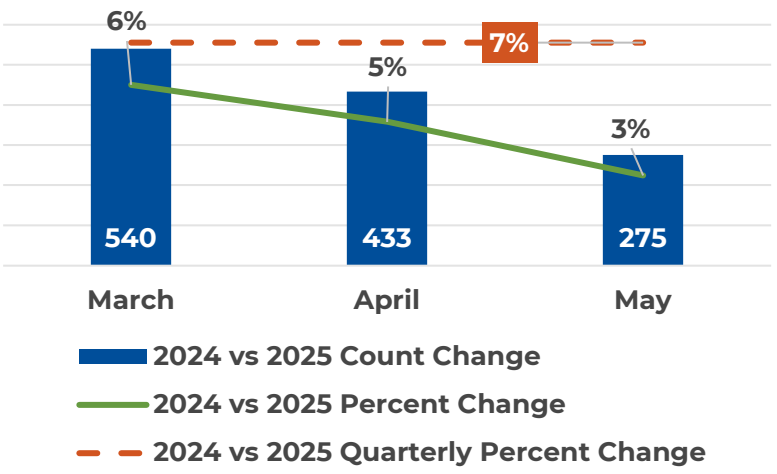
Physicians (In-State Only)





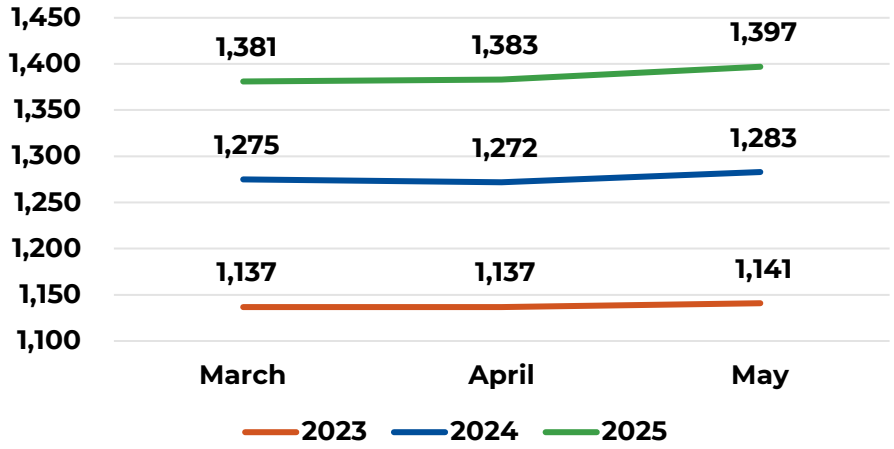
Primary Care Providers (In-State Only)

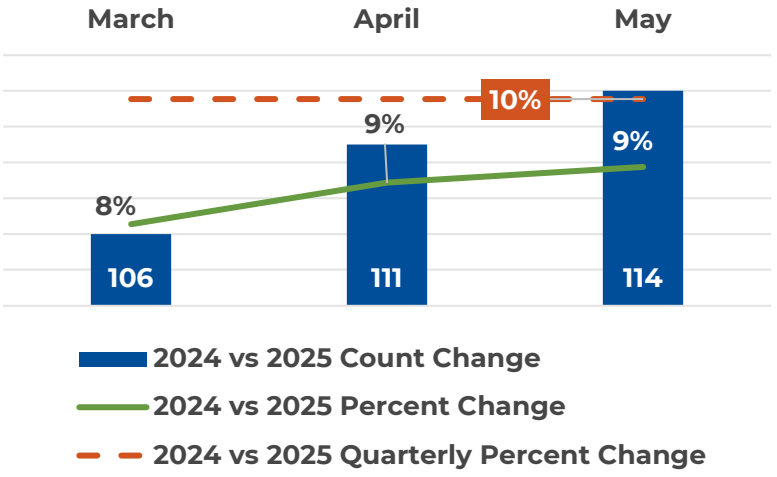




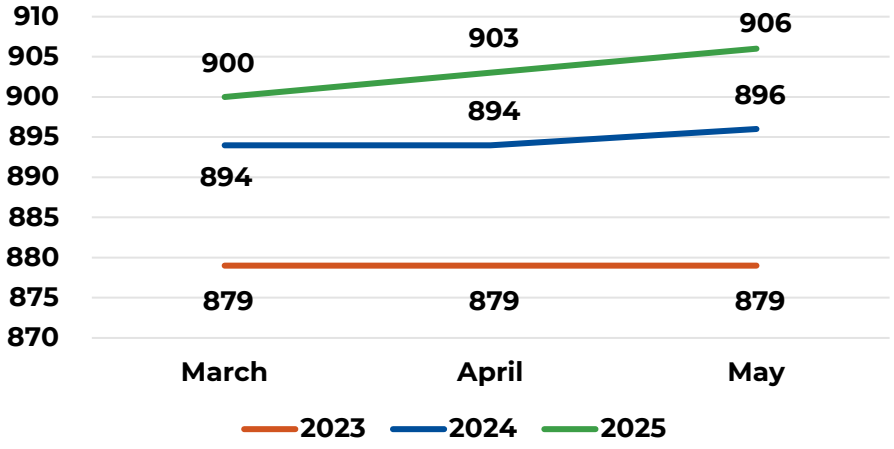
Agency Stats & Provider Network (Cont.)

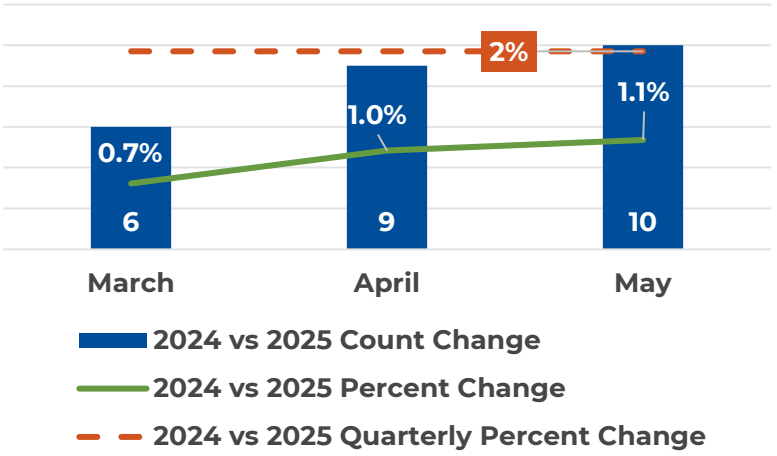
Dentists (In-State Only)





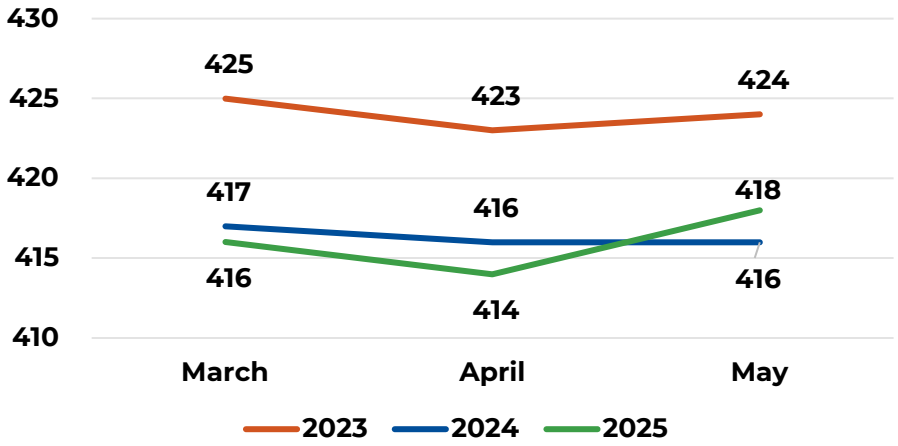
Pharmacy (In-State Only)

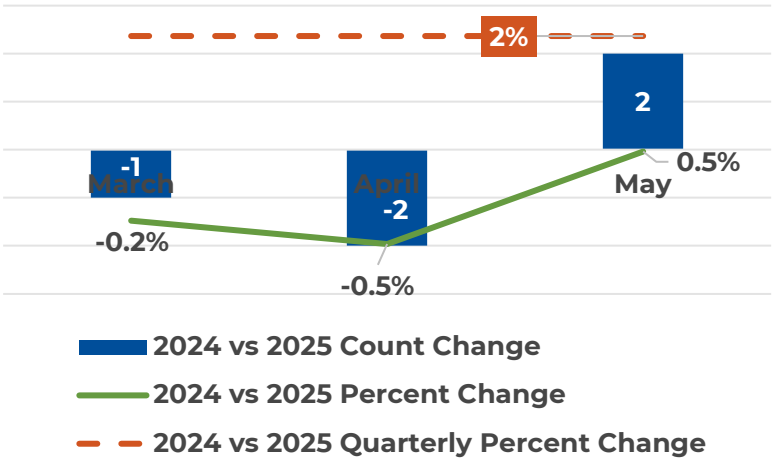




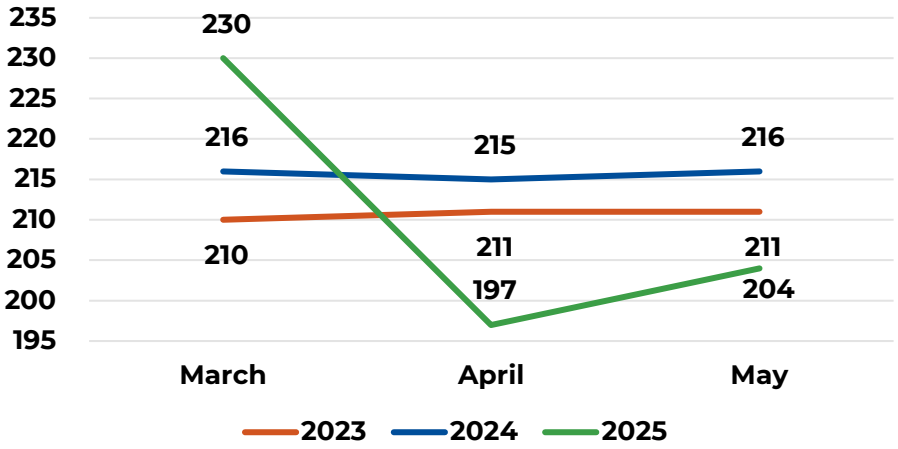
Agency Stats & Provider Network (Cont.)

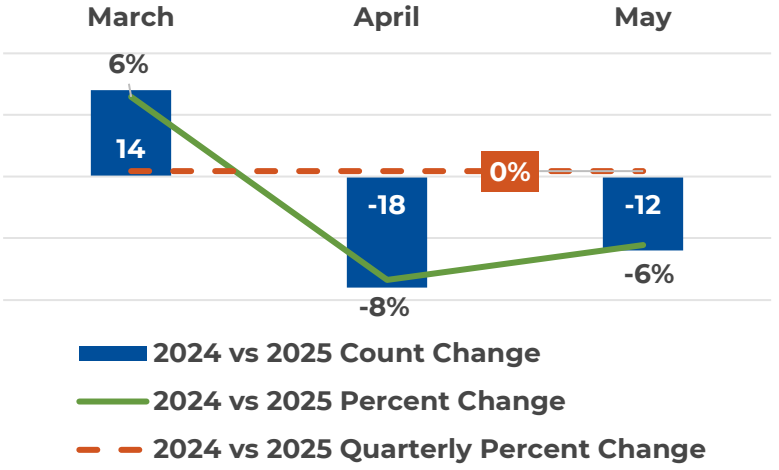
Extended Care Facilities (In-State Only)





Hospitals (In-State Only)





Operational Metrics Query Notes:

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

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

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

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

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

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

Opioid data is from the Opioid dashboard MME Calculations files.

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

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

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

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

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