OKLAHOMA HEALTH CARE AUTHORITY
AMENDED BOARD MEETING
November 10, 2025, at 9:30 A.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_viJCArLfQW63ICQsSwHztA
Telephone: 1-669-216-1590 Webinar ID: 160 848 6771

*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. Public Comment……..Marc Nuttle, Chair

3. Discussion and Vote on the September 30, 2025, OHCA Board Meeting Minutes……..….Marc Nuttle, Chair

4. Chief Executive Officer Report (Attachment "A")…..……..Clay Bullard, Chief Executive Officer

5. Discussion of Report from the Pharmacy……..……Jeffrey Cruzan, MD
   Advisory Committee and Possible Action Regarding Chief Pharmacy Director
   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 "B"):

Item:	Drug Name:	Used For:
i.	Zevaskyn™ (Prademagene Zamikeracel)	Recessive Dystrophic Epidermolysis Bullous (RDEB)
ii.	Zunveyl® (Denzfalantamine)	Alzheimer's Type Dementia (AD)
iii.	Blujepa (Gepotidacin) Emblaveo™ (Aztreopam/Avibactam) Likmez™ (Metronidazole Oral Suspension) Metronidazole 125mg Tablet Metronidazole 375mg Capsule	Various Infections
iv.	Proctofoam® HC (Hydrocortisone/Pramoxine 1%/1% Rectal Foam)	Inflammatory and pruritic (itching) manifestations of corticosteroid-responsive dermatoses of the anal region. 10,946 members with hemorrhoid diagnosis
v.	Ryoncil® (Remestemcel-L-rknd)	Acute Graft Versus Host Disease (aGVHD)
vi.	Datroway® (Datopotamab Deruxtecan-dlnk) Itovebi™ (Inavolisib)	Breast Cancer (BC and Non-Small Cell Lung Cancer (NSCLC) Breast Cancer
vii.	Encelto™ (Revakinagene Taroretcel-lwey)	Macular Telangiectasia (MacTel)
viii.	Fosrenol® (Lanthanum Carbonate) 750mg and	Hyperphosphatemia (DP)

	1,000mg Oral Powder Packet	
ix.	Alyftrek™ (Vanzacaftor/Tezacaftor/ Deutivicaftor)	Cystic Fibrosis (CF)
x.	Attruby™ (Acoramidis)	Cardiomyopathy of Variant Transthyretin-Mediated Amyloidosis (ATTR-CM)
xi.	Photrexa®/ Photrexa® Viscous (Riboflavin 5'-Phosphate)	Keratoconus (KC) and Corneal Ectastia (CE)

6. Discussion of Report from the Compliance Advisory Committee and Possible Action……..……..……Conner Mulvaney Deputy General Counsel II

    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 "C")

        i. EGID Member Navigation and Advocacy Services Contract Renewal (HealthChoice App)
        ii. Provision of Telemedicine Contract Renewal (Telemedicine Management)
        iii. Technology Services for Health Information Exchange Extension
        iv. Health Information Exchange

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

    a) The following EMERGENCY rules were not previously adopted and are new to the Board:

        i. APA WF # 25-16 Provider Attestation Revisions
        ii. APA WF # 25-06 Rapid Whole Genome Sequencing

8. Discussion and Possible Action Election of the OHCA 2026 Board Officers……..…Marc Nuttle, Chair

9. OHCA Board Meeting Dates and Times for Calendar Year 2026 (Attachment "E")…….……..…….…….…….…..Marc Nuttle, Chair

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

NEXT BOARD MEETING
January 21, 2026, 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
September 30, 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 September 29, 2025, at 2:00 p.m. Advance public meeting notice was provided to the Oklahoma Secretary of State. In addition to the posting of statutory public notice, the agency placed its agenda on its website on September 26, 2025, at 4:30 p.m.

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

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

BOARD MEMBER ABSENT: Member Case, Member Christ

ITEM 2 / DISCUSSION AND POSSIBLE VOTE ON THE JUNE 25, 2025, OHCA BOARD MEETING MINUTES
Chairman Nuttle, OHCA Board Chairman

MOTION: Member Jolley moved for approval of the June 25, 2025, board meeting minutes, as published. The motion was seconded by Vice-Chairman Yaffe.

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

BOARD MEMBER ABSENT: Member Case, Member Christ

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

CEO Buettner invited Jamie Van Horn, student from Teen Recovery Solutions.

CEO Buettner provided an overview of the Rural Health Transformation Program, which was established by HR1, or the Big Beautiful Bill. HR1 designated a $50 billion Rural Health Transformation Program that dedicates $10 billion annually over the course of five years. CMS has communicated that half of the funding will go directly to states, meaning each state, upon successful application, will receive at least $100 million each year over the course of the next five years. The other half is what they consider to be competitive funding and will be based on the quality of the application and the rural aspects of your state, condition of hospitals, availability of providers in rural communities, and geographic outreach. The application is submitted by each state through each state's governor's office. Applications are due by November 5th, with CMS having a quick turnaround time on them to announce those awards by the end of the calendar year. There are five strategic goals outlined by the administration: Make Rural America Healthy Again, Sustainable Access, Workforce Development, Innovations in Care, and technology Innovations.

CEO Buettner presented the options provided to states, adding that each application must reflect at least three of the permissible fund uses. The categories include, but are not limited to prevention & chronic disease, provider payments, consumer tech solutions, training & technical assistance, workforce, IT advances, appropriate care availability, behavioral health, innovative care, capital expenditures & infrastructure, and fostering collaboration. From the state side, there are multiple agencies partnering with the Governor's office and legislature, including the Oklahoma State Health Department, Health Care Authority, Oklahoma Human Services, and the Department of Mental Health and Substance Abuse Services. CMS has been generous with their time, in allowing states to ask questions and receive technical assistance as the steering committee continues to work through stakeholder engagement efforts. There has also been constant communication with CMS to understand what they're looking for and refine the application. The steering committee has engaged with various associations, including the Hospital Association, Primary Care Association, Rural Health Association, individual hospital systems, university partners, and the Office of Broadband Technology. CMS has indicated that with any grant program, they will be asking for an annual robust data report to ensure that the funding is being spent on its intended purpose and that it is connected to the outcome we're trying to accomplish. Member Jolley asked if the steering committee is making sure the applications are creating sustainable, holistic changes that are not going to continue to require the same level of fiscal influx once the grant runs out. CEO Buettner stated that element of sustainability is one of the top items that CMS is looking for in the application. Member Leland asked how many awards

will be given. CEO Buettner stated that if every state applies, each state will automatically get $100 million each year. CMS intends for the other half to be provided competitively to 25% of the states.

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

ITEM 4 / STATE AND FEDERAL UPDATE
Christina Foss, Chief of Staff

Ms. Foss provided a state-level update and grants update.

Grants: Ms. Foss highlighted OHCA’s Policy team for their work on the ReConnect Project, a three-year grant which encompasses a federal mandate requiring states to cover certain pre- and post-release services for justice-involved youth. She also highlighted the three-year School-Based Services grant that helps OHCA assist schools with billing Medicaid and training.

State-Level Update: Ms. Foss stated that there is a series of interim studies, a few that OHCA has been asked to present at. OHCA has presented an interim study about the cost of food additives. Bradley Downs, OHCA Legislative Liaison, had the opportunity to present at that study, discussing the financial impact of nutrition and diet on the Medicaid program. OHCA is also partnering with OHS to present a feasibility study. On October 21, OHCA will be presenting on its PACE program and an HR1 impact at an October 14th interim study.

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

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.	Avmapki™ Fakzynja™ Co-Pack (Avutometinib and Defactinib)	Ovarian Cancer
ii.	Bucapsol™ (Buspirone Capsule)	Anxiety Disorders
	Carbamazepine 200mg Chewable Tablet	Epilepsy
	Femlyv™ [Norethindrone Acetate/Ethinyl Estradiol Orally Disintegrating Tablet (ODT)]	Contraception
	Focinvez™ (Fosaprepitant Injection)	Nausea and Vomiting
	Imkeldi (Imatinib Oral Solution)	Multiple types of cancer
	IVRA (Melphalan 90mg/mL Injection)	Multiple myeloma
	Myhibbin™ (Mycophenolate Mofetil Oral Suspension)	Organ Rejection (OR) prevention
	Ondansetron 16mg ODT	Nausea and Vomiting
	Tezruly™ (Terazosin Oral Solution)	Benign prostatic hyperplasia (BPH) or Hypertension (HTN)
	Topiramate 50mg Sprinkle Capsule	Epilepsy or Migraine
	Veltassa® (Patiromer) 1g Powder Packet	Hyperkalemia

	Vigafyde™ (Vigabatrin Oral Solution)	Infantile spasms

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

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

BOARD MEMBER ABSENT: Member Case, Member Christ

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, Internal Audit, Expenditure of Authority Contracts, and the State Plan Amendment Rate Committee Rate.

Financials: For the period ending June 30th, 2025, the OHCA's expenditures were 0.7% under budget while revenues were 0.7% under budget. Our preliminary SFY 2026 financial statements through August show our program expenditures are 3.5% under budget.

Internal Audit: Representatives from the State Auditor and Inspector's office joined the meeting to summarize key findings in their recently released Single Audit, which this Board has already reviewed in full. No new updates or questions came from that discussion.

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. EGID Third Party Administrator for HealthChoice Plans Contract Renewal
   ii. EGID Pharmacy Benefit Manager Contract Renewal
   iii. OHCA Non-Emergency Medical Transportation Contract

MOTION: Member Jolley moved to approve item 6a.i-iii as published. The motion was seconded by Member Corbett.

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

BOARD MEMBER ABSENT: Member Case, Member Christ

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. Birthing Center Rate
   ii. Functional Family Therapy Services
   iii. Paid Family Caregiver

For more detailed information, see Attached "E" of the board packet.

MOTION: Member Jolley moved to approve item 6b.i-iii as published. The motion was seconded by Member Corbett.

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

BOARD MEMBER ABSENT: Member Case, Member Christ

ITEM 7 / DISCUSSION OF REPORT OF THE ADMINISTRATIVE RULES ADVISORY COMMITTEE AND POSSIBLE ACTION
Alex Yaffe, OHCA Board Vice-Chair

Vice-Chairman Yaffe presented the following emergency rules.

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

i. APA WF # 25-12 Clinic Services Update (Four Walls)
ii. APA WF # 25-15 340B Program Revisions
iii. APA WF # 25-16 Provider Attestation Revisions – Member Corbett asked what the process is underway to comply with the Governor's executive order on attestation. CEO Buettner stated that the first step is to promulgate the rule, as directed by the executive order. OHCA's Legal team has prepared the attestation form that will be made available to every provider with a specific due date. A core team within OHCA that will review the attestation as they get turned it. The executive order does give some discretion in reviewing the responses. At the end of the year, OHCA will compile a complete report to the Governor of any actions taken in ensuring compliance with the order. Member Corbett asked what the consequence is for those who do not turn in a signed attestation. Ms. Wheeler-Sisk stated that no response will be taken as non-compliance and could result in payment suspension, contract termination, or contract declination. Ms. Wheeler-Sisk stated that the attestation will be handled on a case-by-case basis. OHCA Legal is working on bright-line rules for responses that do have things to disclose. For those that disclose some affiliation or some referral, OHCA will review. Vice-Chairman Yaffe asked if there have been discussions at the hospital organization level. CEO Buettner stated that she has not personally had those conversations, but was contacted by the local chapter representing the College of Obstetrics and Gynecology, asking for a meeting to have a productive discussion about a smooth implementation.
iv. APA WF # 25-08 Birthing Centers and Licensed Midwives
v. APA WF # 25-01 Functional Family Therapy
vi. APA WF # 25-09 FQHC and RHC Policy Revisions – Member Jolley asked why OHCA had to add the words, "when performing medical services that are reasonable and necessary for the diagnosis and treatment of illness and injury" to Optometrist and Podiatrist. Ms. Cox stated that they can only do things that are medically necessary.
vii. APA WF # 25-14 Paid Family Caregiver

MOTION: Member Kennedy motioned to approve the declaration of compelling public interest for the promulgation of the emergency rules in item 7ai-iii. The motion was seconded by Member Jolley.

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

BOARD MEMBER ABSENT: Member Case, Member Christ

MOTION: Member Jolley moved to approve the emergency rules listed in item 7a.i-ii, iv-vii, as published. The motion was seconded by Member Leland.

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

BOARD MEMBER ABSENT: Member Case, Member Christ

MOTION: Member Jolley moved to table the emergency rule listed in item 7a.iii. The motion was seconded by Member Cruzan.

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

BOARD MEMBER ABSENT: Member Case, Member Christ

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

Chairman Nuttle provided a brief overview of the September meeting, which included discussions on the operational metrics and technology compliance. There has also been ongoing discussion on the state's efforts to become more efficient through DOGE.

ITEM 8 / ADJOURNMENT
Marc Nuttle, OHCA Board Chairman

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

Meeting adjourned at 3:57 p.m., 9/30/2025.

NEXT BOARD MEETING
December 10, 2025
Oklahoma Health Care Authority
4345 N. Lincoln Blvd
Oklahoma City, OK 73105

Martina Ordonez
Board Secretary

Minutes Approved: _____

*Initials:*_____

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CEO REPORT

Clay Bullard

November 10, 2025

INTRODUCTION

- 25 years in health care executive leadership and consulting
- Experience in long-term care, behavioral health, government and physician clinics sectors
- Expertise implementing paradigm-shifting systems and policies.

OHCA KEY PRINCIPLES

PASSION FOR PURPOSE

Our purpose is to facilitate quality health care services regardless of ability to pay and create opportunities for our members to attain healthy outcomes.

EMPOWERMENT & ACCOUNTABILITY

We follow through on commitments and take responsibility for our decisions, prioritizing member needs, fiscal stewardship and respect for others.

TRUST & TRANSPARENCY

We are committed to principles of open government by providing consistent and accurate communication to our members, stakeholders and the public.

BEST IN CLASS & OUTCOME-DRIVEN

We strive each day to find ideas and solutions that will drive positive health outcomes for Oklahoma.

SERVANT LEADERSHIP

We strive to help each member of our team achieve personal and professional success. We lead by example for our co-workers, members and stakeholders.

KEY INITIATIVES – PROGRAMS

- SoonerSelect – Modernization & Member Eligibility
- Federal Landscape – HR 1
- Food as Medicine – SNAP
- Budget & Legislation

KEY INITIATIVES – ADMINISTRATIVE

- Employee Relations
- Culture & Vision

STAKEHOLDER ENGAGEMENT

- Osteopathic Association
- Oklahoma Hospital Association
- OSU Medical Authority & Trust
- University Hospitals Authority & Trust
- Provider Engagement
- New Technology Platforms
- Other State Agency Leadership

OKLAHOMA
Health Care Authority

GET IN TOUCH

4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

oklahoma.gov/ohca
MySoonerCare.org

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

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Attachment B

Oklahoma Health Care Authority Board Meeting – Drug Summary

Drug Utilization Review Board Meetings –September 10, 2025 and October 8, 2025

Vote Item	Drug	Used for	Cost*	Notes
1	Zevaskyn™ (Prademagene Zamikeracel)	• **Recessive Dystrophic Epidermolysis Bullous (RDEB):** RDEB is one of the two main subtypes of dystrophic Epidermolysis bullosa (EB). EB is the term used to describe a number of rare genetic conditions which cause the skin to blister and shear in response to minimal friction and trauma. *12 members with the diagnosis*	• $3,100,000 per course of treatment *Budget impact estimate: $3,100,000 per year*	• Gene therapy
2	Zunveyl® (Benzgalantamine)	• **Alzheimer's type dementia (AD):** Dementia is a general term for memory loss and other cognitive abilities serious enough to interfere with daily life. AD is the most common form of dementia. *1,670 members with the diagnosis*	• $8,985 per year *Budget impact estimate: $17,970 per year*	• Other cheaper therapies required first¥
3	Blujepa (Gepotidacin)	• **Various Infections** • Uncomplicated urinary tract infection. *8,741 members with diagnosis*	• $950 per course of treatment *Budget impact estimate: $47,500 per year*	• Other cheaper therapies required first¥
	Emblaveo™ (Aztreonam/Avibactam)	• Complicated intra-abdominal infections. *1,566 members with possible diagnosis*	• $18,639 per course of treatment *Budget impact estimate: $18,639 per year*	• Other cheaper therapies required first¥

	Likmez™ (Metronidazole Oral Suspension)	• Trichomonas, amebiasis, anaerobic bacterial infections. *3,008 members with diagnoses*	• $521 per course of treatment *Budget impact estimate: $15.630 per year*	• Other cheaper therapies required first[¥]
	Metronidazole 125mg Tablet	• Trichomonas, amebiasis, anaerobic bacterial infections.	• $159 per day *Budget impact estimate: none*	• Other cheaper therapies required first[¥]
	Metronidazole 375mg Capsule	• Trichomonas, amebiasis, anaerobic bacterial infections.	• $26 per day *Budget impact estimate: none*	• Other cheaper therapies required first[¥]
4	Proctofoam® HC (Hydrocortisone/Pramoxine 1%/1% Rectal Foam)	• Inflammatory and pruritic (itching) manifestations of corticosteroid-responsive dermatoses of the anal region. *10,946 members with hemorrhoid diagnosis*	• $184 per can *Budget impact estimate: $11,040 per year*	• Other cheaper therapies required first[¥]
5	Ryoncil® (Remestemcel-L-rknd)	• **Acute Graft Versus Host Disease (aGVHD):** GVHD is a systemic disorder occurring when immune cells from transplanted tissue recognize the recipient's body as foreign and attack its cells. aGVHD presents within 100 days of transplantation and can occur in up to 50% of patients receiving hematopoetic stem cell transplants. aGVHD can cause the transplant to fail. *4 members with this diagnosis under 18 years old*	• $2,328,000 per course of treatment *Budget impact estimate: $9,312,000 per year*	• Only approved in children 2 months to 18 years old

6	Datroway® (Datopotamab Deruxtecan-dlnk)	• **Breast Cancer (BC) and Non-small Cell Lung Cancer (NSCLC):** BC can start from different parts of the breast. Breast cancer occurs almost entirely in women, but men can get breast cancer, too. *2,192 members with BC diagnosis* 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. *1,790 members with NSCLC diagnosis*	• $440,196 per year *Budget impact estimate: $1,760,784 per year*	• Not first line±
	Itovebi™ (Inavolisib)	• **Breast Cancer**	• $297,271 per year *Budget impact estimate: $297,271 per year*	• Not first line±
7	Encelto™ (Revakinagene Taroretcel-lwey)	• **Macular telangiectasia (MacTel):** MacTel is a disease affecting the macula, causing loss of central vision. *4 members with MacTel diagnosis*	• $250,000 per implant *Budget impact estimate: $1,000,000 per year*	• Only approved in MacTel type 2
8	Fosrenol® (Lanthanum Carbonate) 750mg and 1,000mg Oral Powder Packet	• **Hyperphosphatemia (HP):** HP is a condition in which you have too much phosphate in your blood often occurring in patients with end stage kidney/renal disease (ESRD). HP can cause bones to become brittle and deposit calcium in your eyes, lungs, heart and blood vessels leading to an increased risk of heart attack, stroke, and death over time. *17,164 members with diagnosis*	• $1080-$1440 per month *Budget impact estimate: $30,240 per year*	• Other cheaper therapies required first¥

9	Alyftrek™ (Vanzacaftor/Tezacaftor/ Deutivicaftor)	• **Cystic Fibrosis (CF**): CF is a hereditary condition which affects the cells that make mucus, sweat and digestive juices. In CF, the lungs are most commonly affected. The thick and sticky mucus that happens with CF clogs the tubes that carry air in and out of the lungs. *288 members with diagnosis*	• $369,256 per year *Budget impact estimate: $7,015,864 per year*	• Only approved in patients 6 years old and up
10	Attruby™ (Acoramidis)	• **Cardiomyopathy of variant Transthyretin-Mediated Amyloidosis (ATTR-CM):** ATTR-CM is a potentially fatal disease of the heart muscle. In ATTR-CM, a protein called transthyretin becomes misshapen and builds up in the heart, nerves and other organs. *2 members with diagnosis*	• $241,185 per year Budget impact estimate: $241,185 per year	• Only approved in adults
11	Photrexa®/ Photrexa® Viscous (Riboflavin 5'-Phosphate)	• **Keratoconus (KC) and Corneal Ectastia (CE):** KC is an eye condition in which the clear, dome-shaped front of the eye, called the cornea, gets thinner, steeper and bulges outward into a cone shape. CE refers to a group of conditions that cause the progressive thinning of the cornea. *496 members with diagnoses*	• $4,560 per treatment *Budget impact estimate: $45,600 per year*	• No other treatments available for progressing disease

*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 Zevaskyn™

The Drug Utilization Review Board recommends the prior authorization of Zevaskyn™ (Prademagene Zamikeracel) with the following criteria:

Zevaskyn™ (Prademagene Zamikeracel) Approval Criteria:

1. An FDA approved indication for the treatment of wounds in members with recessive dystrophic epidermolysis bullous (RDEB); and
2. Diagnosis must be confirmed by biallelic pathogenic variants in the collagen type VII alpha 1 chain (*COL7A1*) gene (results of the genetic testing must be submitted); and
3. Zevaskyn™ must be prescribed by a dermatologist at a qualified treatment center with expertise in the treatment of RDEB; and
4. Member must have the presence of partial-thickness RDEB wounds open chronically for ≥6 months; and
5. Clinical documentation (i.e., recent office notes) must be submitted with the request documenting the member's treatment plan; and
6. Prescriber must confirm that the member has been counseled and will not use other epidermolysis bullous products (e.g., Vyjuvek®, Filsuvez®) on wounds treated with Zevaskyn™; and
7. Zevaskyn™ must be administered at a Zevaskyn™ qualified treatment center, and the receiving facility must have a mechanism in place to track the patient-specific Zevaskyn™ from receipt to storage to administration; and
8. Approval will be granted for 1 year for 1 treatment cycle; and
9. A new prior authorization may be considered for any previously untreated wounds. For consideration, the prescriber must attest Zevaskyn™ will not be used on wounds previously treated by Zevaskyn™ and the member responded well to treatment with Zevaskyn™ as indicated by the presence of wound healing; and
    a. Clinical documentation (i.e., recent office notes) must be submitted with the request documenting the member's response to therapy and ongoing treatment plan.

Recommendation 2: Vote to Prior Authorize Zunveyl®

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

Zunveyl® (Benzgalantamine) Approval Criteria:

1. An FDA approved diagnosis of mild-to-moderate Alzheimer's type dementia; and
2. A patient-specific, clinically significant reason why the member cannot use galantamine immediate-release tablets, which are available

without a prior authorization, and galantamine extended-release capsules must be provided; and
3. A quantity limit of 60 tablets per 30 days will apply.

Recommendation 3: Vote to Prior Blujepa, Emblaveo™, Likmez™, and Metronidazole 125mg Tablet and 375mg Capsule

The Drug Utilization Review Board recommends the prior authorization of Blujepa (Gepotidacin), Emblaveo™ (Aztreonam/Avibactam), Likmez™ (Metronidazole Oral Suspension), and Metronidazole 125mg Tablet and 375mg Capsule with the following criteria:

Blujepa (Gepotidacin) Approval Criteria:

1. An FDA approved diagnosis of uncomplicated urinary tract infection (uUTI) caused by designated microorganisms (culture/sensitivity results must be submitted); and
2. Member must be a female 12 years of age or older and weigh ≥40kg; and
3. Member must have an estimated glomerular filtration rate (eGFR) >30mL/min/1.73m^2) and must not be on dialysis; and
4. Member must not have severe hepatic impairment (Child Pugh C); and
5. Prior to and during treatment, the potential for drug interactions should be evaluated, including:
    a. Avoid concomitant administration with strong CYP3A4 inhibitors (e.g., ketoconazole, itraconazole) or inducers (e.g., rifampin, carbamazepine, phenytoin, St. John's wort); and
    b. Avoid concomitant administration with CYP3A4 substrates with a narrow therapeutic index (e.g., quinidine, cyclosporine); and
    c. Monitor digoxin serum concentrations as clinically indicated; and
    d. Monitor for adverse effects with concomitant administration with acetylcholinesterase inhibitors, anticholinergic medications, or non-depolarizing neuromuscular blocking agents; and
6. Prescriber must verify that members with medical conditions that may be exacerbated by acetylcholinesterase inhibition will be monitored for adverse effects; and
7. If administration of Blujepa cannot be avoided in members with a history of QTc interval prolongation, taking antiarrhythmic medications, or taking other medications that may prolong the QTc interval, prescriber must verify that serum electrolyte abnormalities will be corrected and monitored and an ECG should be collected prior to administration and duration treatment, as clinically indicated; and
8. A patient-specific, clinically significant reason why the member cannot use an appropriate cost-effective, therapeutic alternative (e.g.,

nitrofurantoin, sulfamethoxazole/trimethoprim, fosfomycin) must be provided; and
9. A quantity limit of 20 tablets per 5 days will apply.

Emblaveo™ (Aztreonam/Avibactam) Approval Criteria:

1. An FDA approved diagnosis of complicated intra-abdominal infections (cIAI) caused by susceptible gram-negative microorganisms (e.g., *Escherichia coli, Klebsiella pneumoniae, Klebsiella oxytoca*, *Enterobacter cloacae* complex*, Citrobacter freundii* complex, *Serratia marcescens*) in adults who have limited or no alternative treatment options (culture/sensitivity results must be submitted); and
2. Member must 18 years of age or older; and
3. Must be used in combination with metronidazole; and
4. A patient-specific, clinically significant reason why the member cannot use an appropriate penicillin/beta lactamase inhibitor combination (e.g., piperacillin/tazobactam), a carbapenem (e.g., ertapenem, meropenem, imipenem/cilastatin), a cephalosporin (e.g., ceftriaxone, ceftazidime) in combination with metronidazole, a fluoroquinolone (e.g., ciprofloxacin or levofloxacin) in combination with metronidazole, or other cost-effective therapeutic equivalent alternative(s) must be provided; and
5. A quantity limit of 57 vials per 14 days will apply.

Likmez™ (Metronidazole 500mg/5mL Suspension) Approval Criteria:

1. A patient-specific clinically significant reason (beyond convenience) must be provided regarding why the member cannot use the 250mg and 500mg tablets, which are available without prior authorization, including but not limited to:
    a. Member is unable to swallow the oral tablet (i.e., has diagnosis characterized by difficulty or inability to swallow); or
    b. Clinically indicated dose cannot be achieved with available tablet formulations; or
    c. Treatment course was initiated inpatient; and
2. For members who require weight-based dosing, the member's recent weight (within the last 3 months) must be provided on the prior authorization request; and
3. A quantity limit of 200mL per 10 days will apply.

Oral Antibiotic Special Formulation Approval Criteria:

1. Member must have a patient-specific, clinically significant reason why the immediate-release formulation and/or other cost effective therapeutic equivalent medication(s) cannot be used.
2. The following oral antibiotics currently require prior authorization and the special formulation approval criteria will apply:

Pharmacy Agenda Items

- Metronidazole 125mg tablets
- Metronidazole 375mg capsules

Recommendation 4: Vote to Prior Authorize Proctofoam® HC

The Drug Utilization Review Board recommends the prior authorization of Proctofoam® HC (Hydrocortisone/Pramoxine 1%/1% Rectal Foam) with the following criteria:

Proctofoam® HC (Hydrocortisone/Pramoxine 1%/1% Rectal Foam) Approval Criteria:

1. A patient-specific, clinically significant reason why the member cannot use Epifoam® (hydrocortisone/pramoxine 1%/1% rectal foam) or other rectal formulations of hydrocortisone available without a prior authorization must be provided.

Recommendation 5: Vote to Prior Authorize Ryoncil®

The Drug Utilization Review Board recommends the prior authorization Ryoncil® (Remestemcel-L-rknd) with the following criteria:

Ryoncil® (Remestemcel-L-rknd) Approval Criteria [Acute Graft Versus Host Disease (aGVHD) Diagnosis]:

1. Diagnosis of aGVHD; and
2. Disease is steroid refractory; and
3. Member is 2 months of age to younger than 18 years of age; and
4. Member is an allogeneic hematopoietic stem cell transplant (HSCT) recipient; and
5. Initial approvals will be for a maximum of 8 infusions; and
6. Subsequent approvals for additional infusions will require repeat authorization and clinical documentation must be submitted to support the need for additional infusions; and
    a. All requests for subsequent approvals will require review by a board-certified oncology pharmacist (BCOP) or plan-contracted oncologist or other oncology physician.

Recommendation 6: Vote to Prior Authorize Datroway® and Itovebi™

The Drug Utilization Review Board recommends the prior authorization of Datroway® (Datopotamab Deruxtecan-dlnk) and Itovebi™ (Inavolisib) with the following criteria:

Pharmacy Agenda Items

Datroway® (Datopotamab Deruxtecan-dlnk) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of unresectable or metastatic breast cancer; and
2. Disease is hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative; and
3. Member has received prior endocrine-based therapy and chemotherapy; and
4. Used as a single agent.

Datroway® (Datopotamab Deruxtecan-dlnk) Approval Criteria [Non-Small Cell Lung Cancer (NSCLC) Diagnosis]:

1. Diagnosis of locally advanced or metastatic NSCLC; and
2. Disease is epidermal growth factor receptor (EGFR)-mutated; and
3. Member has received prior EGFR-directed therapy and platinum-based chemotherapy; and
4. Used as a single agent.

Itovebi™ (Inavolisib) Approval Criteria [Breast Cancer Diagnosis]:

1. Diagnosis of locally advanced or metastatic, hormone receptor (HR)-positive, human epidermal growth factor receptor 2 (HER2)-negative breast cancer; and
2. PIK3CA-mutated; and
3. Used in combination with palbociclib and fulvestrant; and
4. Following recurrence on or after completing adjuvant endocrine therapy.

Recommendation 7: Vote to Prior Authorize Encelto™

The Drug Utilization Review Board recommends the prior authorization of Encelto™ (Revakinagene Taroretcel-lwey) with the following criteria:

Encelto™ (Revakinagene Taroretcel-lwey) Approval Criteria:

1. An FDA approved diagnosis of idiopathic macular telangiectasia (MacTel) type 2; and
2. The diagnosis must be supported by evidence of fluorescein leakage and at least 1 of the following other features typical of MacTel Type 2:
    a. Hyperpigmentation that is outside of a 500-micron radius from the center of the fovea; or
    b. Retinal opacification; or
    c. Crystalline deposits; or
    d. Right-angle vessels; or
    e. Inner/outer lamellar cavities; and
3. Member must be 18 years of age or older; and
4. Encelto™ must be prescribed and administered by a qualified ophthalmologist under aseptic conditions; and

5. Member must have a photoreceptor inner segment/outer segment (IS/OS PR) break (loss) in ellipsoid zone (EZ) between 0.16 and 2.00mm^2 measured by spectral domain-optical coherence tomography (SD-OCT); and
6. Member must have a best corrected visual acuity (BCVA) of 20/80 or better; and
7. Member must not have neovascular MacTel type 2: and
8. Member must not have ocular or periocular infections; and
9. Member must not have known hypersensitivity to Endothelial Serum Free Media (Endo-SFM); and
10. If the member is taking an antithrombotic medication (i.e., oral anticoagulants, aspirin, and nonsteroidal anti-inflammatory drugs) they have been counseled to temporarily discontinue therapy with their antithrombotic medication prior to Encelto™ implantation due to the risk of vitreous hemorrhage; and
11. Prescriber must verify the member will be monitored for vision loss, infectious endophthalmitis, retinal tear and/or detachment, vitreous hemorrhage, implant extrusion, cataract formation, suture related complications, and delayed dark adaptation after Encelto™ implantation and treated, if appropriate; and
12. A quantity limit of 1 implant per eye per lifetime will apply.

Recommendation 8: Vote to Prior Authorize Fosrenol® 750mg and 1,000mg Oral Powder Packet

The Drug Utilization Review Board recommends the prior authorization of Fosrenol® (Lanthanum Carbonate) 750mg and 1,000mg Oral Powder Packet with the following criteria:

Fosrenol® (Lanthanum Carbonate) 750mg and 1,000mg Oral Powder Packet Approval Criteria:

1. A patient specific, clinically significant reason why the member cannot use the chewable tablet formulation must be provided.

Recommendation 9: Vote to Prior Authorize Alyftrek™

The Drug Utilization Review Board recommends the prior authorization of Alyftrek™ (Vanzacaftor/Tezacaftor/Deutivicaftor) with the following criteria:

Alyftrek® (Vanzacaftor/Tezacaftor/Deutivacaftor) Approval Criteria:

1. An FDA approved diagnosis of cystic fibrosis (CF) in members who have at least 1 *F508del* mutation in the CF transmembrane conductance

regulator (*CFTR*) gene or a mutation in the *CFTR* gene that is responsive based on clinical and/or *in vitro* data; and
    a. If the member's genotype is unknown, an FDA-cleared CF mutation test should be used to detect the presence of a *CFTR* mutation followed by verification with bi-directional sequencing when recommended by the mutation test's instructions for use; and
    b. Documentation must be submitted with results of *CFTR* genetic testing; and
2. Member must be 6 years of age or older; and
3. Members using Alyftrek® must be supervised by a pulmonary specialist; and
4. If member is currently stabilized on Orkambi® (lumacaftor/ivacaftor), Symdeko® (tezacaftor/ivacaftor and ivacaftor), or Trikafta® (elexacaftor/tezacaftor/ivacaftor and ivacaftor) and experiencing adverse effects associated with Orkambi®, Symdeko®, or Trikafta® use, the prescriber must indicate that information on the prior authorization request; and
5. Prescriber must verify that member has been counseled on proper administration of Alyftrek® including taking with a fat-containing food; and
6. Prescriber must verify that liver functions tests (ALT, AST, alkaline phosphate, and bilirubin) will be assessed prior to initiating Alyftrek®, every month for the first 6 months, every 3 months for the next 12 months, and annually thereafter; and
7. Prescriber must verify that the member does not have severe hepatic impairment; and
8. Prescriber must verify that pediatric members will receive baseline and follow-up ophthalmological examinations as recommended in the package labeling; and
9. Member must not be taking strong or moderate CYP3A inducers (e.g., rifampin, carbamazepine, phenytoin, St. John's wort, phenobarbital, primidone) concomitantly with Alyftrek®; and
10. The following quantity limits will apply:
    a. Alyftrek® 4/20/50mg tablets: A quantity limit of 3 tablets per day or 84 tablets per 28 days; or
    b. Alyftrek® 10/50/125mg tablets: A quantity limit of 2 tablets per day or 56 tablets per 28 days; and
11. Approvals will be based on the recommended dosing per package labeling based on the member's age and recent weight, if applicable. For members who require weight-based dosing, the member's recent weight must be provided on the prior authorization request; and
12. Initial approval will be for the duration of 6 months. After 6 months of utilization, compliance and information regarding efficacy, such as improvement in forced expiratory volume in 1 second (FEV_1), will be

required for continued approval. Additionally, after 6 months of utilization, information regarding efficacy as previously mentioned or fewer adverse events than with a previous CFTR therapy must be provided for members who switched from Orkambi® (lumacaftor/ivacaftor), Symdeko® (tezacaftor/ivacaftor and ivacaftor), or Trikafta® (elexacaftor/tezacaftor/ivacaftor and ivacaftor); and

13. Subsequent approvals will be for the duration of 1 year.

Recommendation 10: Vote to Prior Authorize Attruby™

The Drug Utilization Review Board recommends the prior authorization of Attruby™ (Acoramidis) with the following criteria:

Attruby™ (Acoramidis) Approval Criteria:

1. An FDA approved indication for the treatment of cardiomyopathy of wild type or hereditary transthyretin-mediated amyloidosis (ATTR-CM) in adults to reduce cardiovascular (CV) mortality and CV-related hospitalization; and
2. Diagnosis confirmed by:
    a. Genetic confirmation of transthyretin (*TTR*) mutation or wild-type amyloidosis (results of genetic testing must be submitted); and
    b. Cardiac imaging (including ultrasound or MRI) confirming cardiac involvement; and
3. Presence of amyloid deposits confirmed by:
    a. Nuclear scintigraphy; or
    b. Endomyocardial biopsy; and
4. Member must be 18 years of age or older; and
5. Member must have medical history of heart failure (NYHA Class I to III); and
6. Prescriber must confirm light-chain amyloidosis (AL) has been ruled out; and
7. Attruby™ must be prescribed by or in consultation with a cardiologist or geneticist (or an advanced care practitioner with a supervising physician who is a cardiologist or geneticist); and
8. Attruby™ will not be approved for concomitant use with Amvuttra® (vutrisiran), Onpattro® (patisiran), Tegsedi® (inotersen), Vyndamax® (tafamidis), Vyndaqel® (tafamidis), or Wainua® (eplontersen); and
9. 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 approval will be for 1 year; and
10. A quantity limit of 112 tablets per 28 days will apply.

Pharmacy Agenda Items

Recommendation 11: Vote to Prior Authorize Photrexa®/ Photrexa® Viscous

The Drug Utilization Review Board recommends the prior authorization of Photrexa®/ Photrexa® Viscous (Riboflavin 5'-Phosphate) with the following criteria:

Photrexa®/Photrexa® Viscous (Riboflavin 5'-Phosphate) Approval Criteria:

1. An FDA approved diagnosis of 1 of the following:
   a. Progressive keratoconus; or
   b. Corneal ectasia following refractive surgery; and
2. Must be prescribed by and administered by an optometrist or ophthalmologist trained in the corneal cross-linking procedure; and
3. Must be used in combination with the KXL® System in the corneal cross-linking procedure; and
4. Must be administered using the epithelial-off procedure as specified in the package labeling; and
5. A quantity limit of 1 kit (6mL) per eye will apply.

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SUBMITTED TO THE C.E.O. AND BOARD ON November 10, 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	Member Navigation and Advocacy Services ("HealthChoice App") – Contract Renewal
Purpose and Scope	EGID utilizes the vendor Member Navigation and Advocacy Services through a mobile application that is utilized by HealthChoice members (the "HealthChoice App"). These services promote member engagement and provide navigation assistance to active and pre-Medicare members and dependents of the HealthChoice plans. The HealthChoice App assists individuals with application processes, explains eligibility criteria, and connects them with the appropriate healthcare providers or services, and helps resolve issues or barriers that may hinder access to care. The HealthChoice App also provides members with easier access to resources.
Mandate	N/A
Procurement Method	RFP, Request for Proposal
External Approvals	N/A
Contract Term	Contract Term January 1, 2026, through December 31, 2026. The initial Contract term, was January 1, 2025 –December 31, 2025, with four (4) one-year options to renew
BUDGET	EGID is self-funded through premiums and operates on a calendar year budget.

Amount requested for approval	$3,500,000.00 Annually
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	0% (Not applicable)

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested for the annual not-to-exceed amount of $3,500,000.00 for the procurement of the HealthChoice App for CY26, the second year of five total contract years. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 days for cause, 60 days without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $1,000,000.00 or more, the contract increase shall require additional Board approval.)
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.)
EGID Funding (The HealthChoice plans administered by EGID are self-funded, non-appropriated benefit plans with a budget derived from premiums collected. There is no federal funding or state-appropriated funding for any contracts, budget, procurement, or other purposes. Therefore, the contracts and budget for the contracts do not always follow the state fiscal year.)

SUBMITTED TO THE C.E.O. AND BOARD ON November 10, 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	Provision of Telemedicine (Telemedicine Management) – Contract Renewal
Purpose and Scope	OHCA is requesting approval to renew the first option year of the contract. Under the renewal for the Telemedicine services contract, beginning January 1, 2026, all HealthChoice members will be able to utilize telemedicine services without having to pay a consult fee, including the High Deductible Health Plan population. Telemedicine services will have an option for non-emergency healthcare needs which has the potential to generate cost savings for EGID while maintaining convenient and accessible care for members. Furthermore, in Plan Year 2026, EGID plans to pilot a Virtual Primary care program that will allow those in rural zip codes have better access to preventative care.
Mandate	N/A
Procurement Method	RFP, Request for Proposal
External Approvals	N/A
Contract Term	Contract January 1, 2026, through December 31, 2026. The Initial Contract term was January 1, 2025 – December 31, 2025, with four (4) one-year options to renew.
BUDGET	EGID is self-funded through premiums and operates on a calendar year budget.

Amount requested for approval	$1,905,000.00 Annually

Federal Match Percentage(s) within the Total Contract Not-to-Exceed	0% (Not applicable)

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested for the annual not-to-exceed amount of $1,905,000.00 to renew Telemedicine Management Services for the second year of five total contract years. OHCA staff intends to request additional Board approval for funding to cover every following renewal year of the contract.

Additional Information

Contract Term, Including all Optional Renewal Years (Oklahoma law limits State Agencies from encumbering funds for more than a single State Fiscal Year. As a result, all State of Oklahoma contracts are entered into for an initial year period with subsequent optional renewal years. Every OHCA professional services contract includes standard contract termination language, including immediate, 30 days for cause, 60 days without cause, and non-renewal terminations.)
Total Contract Not-to-Exceed Requested for Approval. (Actual not-to-exceed amounts are established by the competitive bid process. If the not-to-exceed amount exceeds the amount previously approved by $1,000,000.00 or more, the contract increase shall require additional Board approval.)
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.)
EGID Funding (The HealthChoice plans administered by EGID are self-funded, non-appropriated benefit plans with a budget derived from premiums collected. There is no federal funding or state-appropriated funding for any contracts, budget, procurement, or other purposes. Therefore, the contracts and budget for the contracts do not always follow the state fiscal year.)

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 10, 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- Extension
Purpose and Scope	The current Health Information Exchange (HIE) technology services contract ends on December 31, 2025. The requested contract extension serves to ensure the seamless continuity of HIE technology services while a new agreement for HIE services is being negotiated through a statewide contract. This extension is critical to prevent a lapse in the provision of HIE services while the Oklahoma Health Care Authority completes the negotiation process.
Mandate	63 O.S. §1-132.1; 63 O.S. §1-133.
Procurement Method	Sole Source
External Approvals	N/A
Contract Term	January 1, 2026, through June 30, 2026. This term will include month-to-month renewal options for the duration of the six months while a new 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 up to 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.)

SUBMITTED TO THE C.E.O. AND BOARD ON NOVEMBER 10, 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	Health Information Exchange – New Contract
Purpose and Scope	The Oklahoma Health Care Authority (OHCA) is seeking to contract with a qualified health information exchange (HIE) organization to operate as the State Designated Entity for Health Information Exchange (SDE) and provide HIE Technology, Capabilities, and Operations. As the Oklahoma State Health Information Network Exchange (OKSHINE) program and the Office of the State Coordinator for Health Information Exchange – as defined in 63 O.S. §§ 1-132 – 1-133, OHCA will play an active role as collaborator and coordinator in the implementation of these services. The selected vendor and HIE organization will at a minimum support, maintain, and establish connections with Oklahoma based participants and ensure the information is secure, accurate, and timely.
Mandate	63 O.S. §1-132.1; 63 O.S. §1-133.
Procurement Method	Statewide Contract
External Approvals	N/A
Contract Term	January 1, 2026, through June 30, 2026 (or from date of signature) with subsequent eight (8) one-year options to renew.

BUDGET

Amount requested for Approval	$4,500,000.00 for SFY26.
Federal Match Percentage(s) within the Total Contract Not-to-Exceed	There is no federal match for this contract

RECOMMENDATION

The Authority affirms its ability to withstand the procurement decision made by the CEO based on the budget and available funds. Board approval is requested for the not-to exceed amount of $4,500,000.00 for SFY26 for the procurement of Health Information Exchange Services for the initial contract year. OHCA staff intends to request additional Board approval for $9,000,000.00 annually to cover every following renewal year of the contract.

Additional Information

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

November 10, 2025 Board
Proposed Rule Amendment Summaries

These proposed **EMERGENCY** rules were presented at Tribal Consultation and were subject to at least a 15-day public comment period and considered by the Medical Advisory Committee.

The Governor will have 45 days to approve or disapprove these rules upon the Agency's submission for gubernatorial review.

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

APA WF# 25-16 Provider Attestation Revisions — This proposed rule was originally presented to the OHCA Board on September 30, 2025, and tabled for further refinement based on Board feedback. In response, OHCA revised the rule to improve clarity and organization by relocating language related to Executive Order 2025-16 into a new, dedicated section of rule, with cross-references to that section from existing provisions. The revisions explicitly define the definitions of “affiliated with,” “refer for,” and “abortion-related activities” to ensure consistency with the Executive Order and state law. Additionally, OHCA identified a section of rule that had not been revised in prior rulemaking and updated it to align with current practice. These updates implement Executive Order 2025-16 (issued July 31, 2025), which directs OHCA to review and revise provider credentialing standards and requires all SoonerCare providers to submit an attestation disclosing whether they or any related entities engage in abortion-related activities, including referral or affiliation.

Budget Impact: Budget neutral

Emergency Justification: The proposed emergency revisions are necessary to comply with Executive Order 2025-16, issued pursuant to 75 O.S. § 250.10, requiring OHCA to immediately review and amend provider standards in alignment with state law and policy.

The Agency is requesting an effective date of February 1, 2026 for the following item:

APA WF# 25-06 Rapid Whole Genome Sequencing — The proposed policy changes establish coverage and reimbursement for rapid whole genome sequencing (rWGS) in accordance with House Bill 1576 (2025). Coverage applies to members under age 21 who have an unknown complex or acute illness and are receiving intensive care unit hospital services. The testing may help identify genetic changes and determine the member’s condition. When medically necessary, coverage on behalf of the child will include comparator testing of one or both parents. Prior authorization will be required. Rapid whole genome sequencing will be excluded from the Per Discharge Prospective Rate for hospitals and reimbursed separately under the Ambulatory Payment Classification fee schedule. Reimbursement for testing provided in an I/T/U facility will be included in the Inpatient Hospital Per Diem Rate.

Budget Impact: The estimated total cost for SFY2026 (5 months) is $1,083,333 with $368,242 in state share. The estimated total cost for SFY2027 is $2,600,000 with $867,880 in state share.

Emergency Justification: The proposed emergency revisions are necessary to comply with state law.

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

SUBCHAPTER 3. GENERAL PROVIDER POLICIES

PART 1. GENERAL SCOPE AND ADMINISTRATION

317:30-3-2. Provider agreements

(a) In order to be eligible for payment, providers must have ~~on file with OHCA,~~ an approved Provider Agreement on file with OHCA. Through this agreement, the provider certifies all information submitted on claims is accurate and complete, assures that the State Agency's requirements are met and assures compliance with all applicable ~~Federal~~federal and ~~State~~state regulations. These agreements are renewed at least every five (5) ~~5~~ years with each provider.

(b) As a condition of the Provider Agreement, each provider further assures:

(1) **Lobbying restrictions.** ~~The provider further assures~~ ~~compliance~~Compliance with Section 1352, Title 31 of the U.S. Code and implemented at 45 CFR Part 93 which provides that if payments pursuant to services provided under Medicaid are expected to exceed $100,000.00, the provider certifies federal funds have not been used nor will they be used to influence the making or continuation of the agreement to provide services under Medicaid. Upon request, the Authority will furnish a standard form to the provider for the purpose of reporting any non-federal funds used for influencing agreements.

(2) **Debarment status.** That ~~The provider assures~~ in accordance with 31 USC 6101 and Executive Order 12549, the provider is not presently and has not within the last three (3) years been ~~that they are not presently or have not in the last three years been~~ debarred, suspended, proposed for debarment or declared ineligible by any ~~Federal~~federal department or agency.

(3) **Executive Order compliance.** The provider assures compliance with OAC 317:30-3-19.7, which implements Executive Order 2025-16, including submission and maintenance of an accurate attestation regarding abortion-related activities and affiliations as a condition of participation in the SoonerCare program.

~~(3)~~(4) **Contact Information.** For information regarding Provider Agreements or for problems related to a current agreement, contact the Oklahoma Health Care Authority, Provider Enrollment, P.O. Box 54015, Oklahoma City, Oklahoma 73154, or call 1-800-522-0114 option 5 toll free or 405-522-6205 for the Oklahoma City area, or via e-mail: providerenrollment@okhca.org.

317:30-3-19.3. Denial of application for new or renewed provider enrollment contract

(a) The following words and terms, when used in this Section, shall have the following meaning, unless the context clearly indicates otherwise:

(1) "**Affiliates**" means persons having a relationship in which any of them directly or indirectly controls or has the ability to control one or more of the others.

(2) "**Applicant**" means providers and/or persons with a five percent or more direct or indirect ownership interest therein, as well as providers' officers, directors, and managing employees.

(3) "**Conviction**" or "**convicted**" means a person has been convicted of a criminal offense pursuant to 42 U.S.C. § 1320a-7(i), or, for civil offenses, has had a judgment of conviction entered against him or her by a ~~Federal~~federal, ~~State~~state, or local court, regardless of whether an appeal from the judgment is pending.

(4) "**Person**" means any natural person, partnership, corporation, not-for-profit corporation, professional corporation, or other business entity.

(5) "**Provider**" means any person having or seeking to obtain a valid provider enrollment contract with the Oklahoma Health Care Authority (OHCA) for the purpose of providing services to eligible SoonerCare members and receiving reimbursement therefor.

(b) When deciding whether to approve an application for a new or renewed provider enrollment contract, OHCA may consider the following factors as they relate to the applicant and any of the applicant's affiliates, including, but not limited to:

(1) any false or misleading representation or omission of any material fact or information required or requested by OHCA as part of the application process;

(2) any failure to provide additional information to OHCA after receiving a written request for such additional information;

(3) any false or misleading representation or omission of any material fact in making application for any license, permit, certificate, or registration related to the applicant's profession or business in any State;

(4) any fine, termination, removal, suspension, revocation, denial, consented surrender, censure, sanction, involuntary invalidation of, or other disciplinary action taken against any license, permit, certificate, or registration related to the applicant's profession or business in any State;

(5) any previous or current involuntary surrender, removal, termination, suspension, ineligibility, exclusion, or otherwise involuntary disqualification from participation in Medicaid in any State, or from participation in any other governmental or private medical insurance program, including, but not limited to, Medicare and Workers' Compensation;

(6) any Medicaid or Medicare overpayment of which the applicant has been notified, as determined exclusively by OHCA that was received, but has not made reimbursement, unless such reimbursement is the subject of an OHCA reimbursement agreement that is not in default~~,~~;

(7) any previous failure to correct deficiencies in the applicant's business or professional operations after having received notice of the deficiencies from the OHCA or any ~~State~~state or ~~Federal~~federal licensing or auditing authority;

(8) any previous violation of any ~~State~~state or ~~Federal~~federal statute or regulation that relates to the applicant's current or past participation in Medicaid, Medicare, or any other governmental or private medical insurance program;

(9) any pending charge or prior conviction of any civil or criminal offense relating to the furnishing of, or billing for, medical care, services, or supplies, or which is considered theft, fraud, or a crime involving moral turpitude;

(10) any pending charge or prior criminal conviction for any felony or misdemeanor offense that could reasonably affect patient care, including, but not limited to, those offenses listed in OAC 317:30-3-19.4;

(11) any denial of a new or renewed provider enrollment contract within the past two (2) years that was based on the applicant's or an affiliate's prior conduct;

(12) any submission of an application that conceals the involvement in the enrolling provider's operation of a person who would otherwise be ineligible to participate in Medicaid or Medicare;

(13) any business entity that is required to register with a ~~State~~state office or agency in order to conduct its operations therein, including, but not limited to, the Oklahoma Secretary of

State, any failure to obtain and/or maintain a registration status that is valid, active, and/or in good standing~~; and~~

(14) compliance with the provisions within OAC 317:30-3-19.7; and

(15)~~(14)~~ any other factor that impacts the quality or cost of medical care, services, or supplies that the applicant furnishes to SoonerCare members, or otherwise influences the fiscal soundness, effectiveness, or efficiency of the OHCA program.

(c) OHCA shall provide any applicant who is denied a new or renewed provider enrollment contract a written notice of the denial. Any denial shall become effective on the date it is sent to the applicant.

(d) Any OHCA decision to deny a provider's contract application in accordance with this Section shall be a final agency decision that is not administratively appealable.

317:30-3-19.5. Termination of provider agreements

Pursuant to the terms of the Oklahoma Health Care Authority's (OHCA) Standard Provider Agreement, both OHCA and a provider may terminate the agreement without cause on sixty (60) days' notice, or for-cause on thirty (30) days' notice. In addition, OHCA can terminate the agreement immediately in order to protect the health and safety of members, or upon evidence of fraud (including, but not limited to, a credible allegation of fraud as defined by 42 C.F.R. ' 455.2). Conduct that may serve as a basis for a for-cause termination of a provider includes, but is not limited to, any of the following:

(1) **Noncompliance.** The provider is determined not to be in compliance with the enrollment requirements described in Oklahoma Administrative Code (OAC) 317:30-3-2 and 317:30-3-19.3, or in the enrollment application applicable for its provider type. OHCA may, but is not required to, request additional documentation from the provider to determine compliance.

(2) **Provider exclusion, debarment, or suspension.** The provider or any owner, managing employee, authorized or delegated official, medical director, supervising physician, or other health care personnel thereof is:

(A) Excluded from the Medicare, Medicaid, or any other ~~Federal~~federal health care program, as defined in 42 C.F.R ' 1001.2; or

(B) Debarred, suspended, or otherwise excluded from participating in any other ~~Federal~~federal procurement or nonprocurement program or activity.

(3) **Convictions.** Conviction of the provider or any of its affiliates for a ~~Federal~~federal or ~~State~~state offense that OHCA has determined to be detrimental to the best interests of the program and its members. Such offenses may include, but are not limited to, those offenses enumerated in OAC 317:30-3-19.3 and OAC 317:30-3-19.4.

(4) **False or misleading information.** The provider submitted or caused to be submitted misleading or false information on its enrollment application to be enrolled or to maintain enrollment in the SoonerCare program. In addition to termination of a contract, offenders may be referred for prosecution, which could result in fines or imprisonment, or both, in accordance with current law and regulations.

(5) **On-site review.** OHCA determines, upon on-site review, that the provider is no longer operational, able to furnish SoonerCare covered items, or able to safely and adequately render services; or is not meeting SoonerCare enrollment requirements under statute or regulation to supervise treatment of, or to provide SoonerCare covered items or services for SoonerCare members.

(6) **Misuse of billing number.** The provider knowingly sells to or allows another individual

or entity to use its billing number. This does not include those providers who enter into a valid reassignment of benefits as specified in 42 U.S.C. ' 1396a(a)(32) or a change of ownership as outlined in 42 C.F.R. ' 455.104(c) (within thirty-five (35) days of a change in ownership).

(7) **Abuse of billing privileges.** The provider submits a claim or claims for services that reasonably could not have been rendered, or that do not accurately reflect those services actually rendered, to a specific individual on the date of service. These instances include, but are not limited to: upcoding; unbundling of services; services that are purportedly provided to a member who has died prior to the date of service; services that are purportedly provided on a date on which the directing physician or member is not in the State or country or is otherwise physically incapable of providing or receiving the service; or the equipment necessary for testing was not present where the testing is said to have occurred, or was incapable of operating correctly at the supposed time of testing.

(8) **Failure to report.** The provider did not comply with the reporting requirements specified in the SoonerCare Provider Agreement or any applicable State and/or ~~Federal~~federal statutes or regulations, including without limitation, changes in the provider's licenses, certifications, and/or accreditations provided at the time of enrollment. Providers shall report and update a change in mailing address within fourteen (14) days of such change.

(9) **Failure to document or provide OHCA access to documentation.**

(A) The provider did not comply with the documentation or OHCA access requirements specified in the SoonerCare Provider Agreement.

(B) OHCA may suspend all SoonerCare payments to a provider who refuses or fails to produce for inspection those financial and other records as are required by 42 C.F.R. ' 431.107 and the executed SoonerCare Provider Agreement, until such time as all requested records have been submitted to OHCA for review.

(10) **Adverse audit determinations.** The provider receives an adverse Program Integrity audit that demonstrates fraud, waste, abuse, and/or repeated failure or inability to comply with SoonerCare billing and provision of service requirements.

(11) Failure to comply with the provisions within OAC 317:30-3-19.7.

317:30-3-19.7. Compliance with Executive Order 2025-16

(a) This section is not intended to limit Executive Order (EO) 25-16 in any respect; rather, it is intended to give effect to Executive Order 25-16 and to operationally implement the EO. Disclosure and transparency are required by the EO. As such, for the purpose of compliance with this rule and the EO, the following words and terms shall have the following meaning, unless the context clearly indicates otherwise:

(1) "**Affiliated with**" means having staff privileges, medical staff membership, employment or contractual relationship, partnership or ownership interest, academic appointment, or other affiliation under which a medical practitioner provides the medical activity on behalf of, or in association with, the health care entity or provider that provides abortion services not permitted under state law.

(2) "**Refer for**" means the act of sending a patient to another provider for care.

(3) For purposes of this Section, abortion services "**not permitted under state law**" include, but are not limited to, services that violate 21 O.S. § 861, 63 O.S. § 1-732, 63 O.S. § 1-731, and 63 O.S. § 1-737.

(4) "**Abortion-related activities**" include but are not limited to:

(A) Performing an "abortion," "attempt[ing] to perform an abortion," or "inducing an

abortion" as defined in 63 O.S. §1-730.

(B) Assisting in the performance of an "abortion", an "attempt to perform an abortion," or the "induc[ement] of an abortion" as defined in 63 O.S. §1-730.

(C) Providing funding, material support, facilities, or other resources used to perform an "abortion," to "attempt to perform an abortion," or to "induc[e] an abortion" as defined in 63 O.S. §1-730.

(b) As a condition of participation in the SoonerCare program, each provider shall:

(1) Submit a signed attestation disclosing whether they or any related entities engage in abortion-related activities as defined in 63 O.S. §1-730, including whether they:

(A) Perform, refer for, or are affiliated with the performance of abortions not permitted under state law; or

(B) Are under common ownership or control with an entity engaged in abortion-related activities inconsistent with state law.

(C) The attestation shall be made to the best of the provider's knowledge at the time of submission. This requirement does not obligate providers to conduct additional investigations of unrelated entities.

(D) Providers shall promptly submit an updated attestation upon any change in circumstances that would render a prior attestation inaccurate or incomplete.

(2) Acknowledge that failure to comply with these requirements may result in denial, exclusion, non-renewal, or termination from the SoonerCare program.

(3) Cooperate with OHCA credentialing and contracting procedures established to implement Executive Order 2025-16 and Oklahoma's public policy objectives related to unborn life.

(c) When deciding whether to approve an application for a new or renewed provider enrollment contract, OHCA may consider the following factors as they relate to the applicant and any of the applicant's affiliates, including, but not limited to:

(1) any provider, applicant, or affiliate that performs, refers for, or is otherwise affiliated with the performance of abortions not permitted under state law;

(2) any provider, applicant, or affiliate that is under common ownership or control with an entity engaged in abortion-related activities inconsistent with state law;

(3) any failure to provide a signed attestation disclosing whether the provider or any related entity engages in abortion-related activities, as required by Executive Order 2025-16.

(d) In accordance with Executive Order 2025-16, OHCA may immediately terminate a provider agreement if the provider or any related entity is determined not to be fully aligned with Oklahoma's objectives related to the protection of unborn life. This includes, but is not limited to, the following circumstances:

(1) The provider or any related entity performs, refers for, or is affiliated with the performance of abortions not permitted under state law;

(2) The provider is under common ownership or control with an entity engaged in abortion-related activities inconsistent with state law;

(3) The provider failed to submit a timely, complete, and truthful attestation disclosing its involvement in abortion-related activities as required under OAC 317:30-3-19.7(b);

(4) OHCA determines, in its sole discretion, that the provider is not fully aligned with the requirements of Executive Order 2025-16.

317:30-5-6. Abortions

~~(a) Payment is made only for abortions in those instances where the abortion is necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, or where the pregnancy is the result of an act of rape or incest. Medicaid coverage for abortions to terminate pregnancies that are the result of rape or incest will only be provided as long as Congress considers abortions in cases of rape or incest to be medically necessary services and federal financial participation is available specifically for these services.~~

~~(1) For abortions necessary due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed, the physician must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed due to a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would place the woman in danger of death unless an abortion is performed. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician. The certification must be attached to the claim.~~

~~(2) For abortions in cases of rape or incest, there are two requirements for the payment of a claim. First, the physician must fully complete the Certification for Medicaid Funded Abortion. Second, the patient must have made a police report or counselor's report of the rape or incest. In cases where an official report of the rape or incest is not available, the physician must certify in writing and provide documentation that in his or her professional opinion, the patient was unable, for physical or psychological reasons, to comply with the requirement. The statement explains the reason the rape or incest was not reported. The patient's name and address must be included in the certification and the certification must be signed and dated by the physician and the patient. In cases where a physician provides certification and documentation of a patient's inability to file a report, the Authority will perform a prepayment review of all records to ensure there is sufficient documentation to support the physician's certification.~~

~~(b) The Oklahoma Health Care Authority performs a "look-behind" procedure for abortion claims paid from Medicaid funds. This procedure will require that this Agency obtain the complete medical records for abortions paid under Medicaid. On a post-payment basis, this Authority will obtain the complete medical records on all claims paid for abortions.~~

~~(c) Claims for spontaneous abortions, including dilation and curettage do not require certification. The following situations also do not require certification:~~

~~(1) If the physician has not induced the abortion, counseled or otherwise collaborated in inducing the abortion; and~~

~~(2) If the process has irreversibly commenced at the point of the physician's medical intervention.~~

~~(d) Claims for the diagnosis "incomplete abortion" require medical review.~~

~~(e) The appropriate diagnosis codes should be used indicating spontaneous abortion, etc., otherwise the procedure will be denied.~~

(a) Payment of abortion related services is made only in those instances where there is no detectable heartbeat of the fetus, or if, in reasonable medical judgment, the SoonerCare member has a complicating condition that necessitates termination of the pregnancy to avert death or

serious risk of substantial and irreversible physical impairment of a major bodily function, not including psychological or emotional conditions.
(b) For abortions necessary to avert death or irreversible physical impairment of a major bodily function, the physician must complete the Certification for Medicaid Funded Abortion and certify in writing that the abortion is being performed to avert death or irreversible physical impairment of a major bodily function. The patient's name and address must be included in the certification, and the certification must be signed and dated by the physician. The certification must be attached to the claim.
(c) Prior to, or post payment, OHCA may perform a review of abortion related services. These reviews will require that the Agency obtain the applicable medical records.
(d) Claims for services related to fetal demise, including dilation and curettage, do not require the Certification for Medicaid Funded Abortion.
(e) The appropriate diagnosis codes should be used; otherwise, the procedure(s) will be denied.

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

SUBCHAPTER 5. INDIVIDUAL PROVIDERS AND SPECIALTIES

PART 3. HOSPITALS

317:30-5-47. Reimbursement for inpatient hospital services

Reimbursement will be made for inpatient hospital services in the following manner:

(1) Covered inpatient services provided to eligible SoonerCare members admitted to in-state acute care and critical access hospitals will be reimbursed the lesser of the billed charges or the Diagnosis Related Group (DRG) amount. In addition to the billed charges or DRG payment, whichever is less, an outlier payment may be made to the hospital for very high-cost stays. Additional outlier payment is applicable if either the amount billed by the hospital or DRG payment, whichever applies, is less than a threshold amount of the hospital cost. Each inpatient hospital claim is tested to determine whether the claim qualified for a cost outlier payment. Payment is equal to a percentage of the cost after the threshold is met.

(2) The lesser of the billed charges or DRG amount and outlier, if applicable, represent full reimbursement for all non-physician services provided during the inpatient stay. Payment includes but is not limited to:

(A) Laboratory services;

(B) Prosthetic devices, including pacemakers, lenses, artificial joints, cochlear implants, implantable pumps;

(C) Technical component on radiology services;

(D) Transportation, including ambulance, to and from another facility to receive specialized diagnostic and therapeutic services;

(E) Pre-admission diagnostic testing performed within seventy-two (72) hours of admission; and

(F) Organ transplants.

(3) Charges for services or supplies deemed not medically necessary and/or not separately billable may be recouped upon post payment review of outlier payments.

(4) Hospitals may submit a claim for payment only upon the final discharge of the patient or upon completion of a transfer of the patient to another hospital.

(5) Covered inpatient services provided to eligible members of the SoonerCare program, when treated in out-of-state hospitals will be reimbursed in the same manner as in-state hospitals. Refer to OAC 317:30-3-90 and 317:30-3-91.

(6) Cases which indicate transfer from one (1) acute care hospital to another will be monitored under a retrospective utilization review policy to help ensure that payment is not made for inappropriate transfers.

(7) The transferring hospital will be paid the lesser of the calculated transfer fee or the DRG base payment amount for a non-transfer.

(8) If the transferring or discharge hospital or unit is exempt from the DRG, that hospital or unit will be reimbursed according to the method of payment applicable to the particular facility or units.

(9) Covered inpatient services provided in out-of-state specialty hospitals may be reimbursed at a negotiated rate not to exceed one-hundred percent (100%) of the cost to provide the service. Negotiation of rates will only be allowed when the OHCA determines that the specialty hospital or specialty unit provides a unique (non-experimental) service required by SoonerCare members and the provider will not accept the DRG payment rate. Prior authorization is required.
(10) New providers entering the SoonerCare program will be assigned a peer group and will be reimbursed at the peer group base rate for the DRG payment methodology or the statewide median rate for per diem methods.
(11) All inpatient services are reimbursed per the methodology described in this Section and/or as approved under the Oklahoma Medicaid State Plan.
(12) For high-investment drugs, refer to OAC 317:30-5-47.6.
(13) Separate reimbursement may be obtained for provision of two (2) doses of emergency opioid antagonist upon discharge as per state law.
(14) For rapid whole genome sequencing, refer to OAC 317:30-5-47.7

317:30-5-47.7 Rapid whole genome sequencing- inpatient hospitals

(a) **Coverage**. Rapid whole genome sequencing is covered for members who meet the following criteria. This service includes testing for the member and one or two biological parents. Prior authorization is required.

(1) The member is under 21 years of age;
(2) The member has a complex or acute illness of unknown etiology, that is not confirmed to be an environmental exposure, toxic ingestion, infection with normal response to therapy, or trauma; and
(3) The member is receiving inpatient hospital services in an intensive care unit or other high acuity unit.

(b) **Billing**. Rapid whole genome sequencing must be billed on an outpatient claim. All rapid whole genome sequencing, including any parental testing, must be performed on behalf of a member who meets the criteria in (a) and should be filled under that member's SoonerCare member ID number.
(c) **Reimbursement**. Rapid whole genome sequencing may be reimbursed separately from the DRG pursuant to the Oklahoma Medicaid State Plan for members receiving services at an inpatient hospital. Services will be reimbursed according to the APC fee schedule.
(d) Rapid whole genome sequencing provided to eligible members, when treated in out-of-state inpatient hospitals, may be reimbursed in the same manner as in-state hospitals. Out-of-state inpatient hospitals must meet applicable out-of-state conditions of payment set forth in OAC 317:30-3-89 through 317:30-3-92, and in the Oklahoma Medicaid State Plan.

2026 Board Meetings

Su	Mo	Tu	We	Th	Fr	Sa
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	**21**	22	23	24
25	26	27	28	29	30	31

January 21, 2026 2:00pm

Su	Mo	Tu	We	Th	Fr	Sa
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7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	**24**	25	26	27
28	29	30				

June 24, 2026 2:00pm

Su	Mo	Tu	We	Th	Fr	Sa
1	2	3	4	5	6	7
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15	16	17	18	19	20	21
22	23	24	**25**	26	27	28
29	30	31				

March 25, 2026 2:00pm

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20	21	22	23	24	25	26
27	28	29	30			

September 16, 2026 2:00pm

Su	Mo	Tu	We	Th	Fr	Sa
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17	18	19	**20**	21	22	23
24	25	26	27	28	29	30
31						

May 20, 2026 2:00pm

Su	Mo	Tu	We	Th	Fr	Sa
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6	7	8	**9**	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	31			

December 9, 2026 2:00pm

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OPERATIONAL METRICS

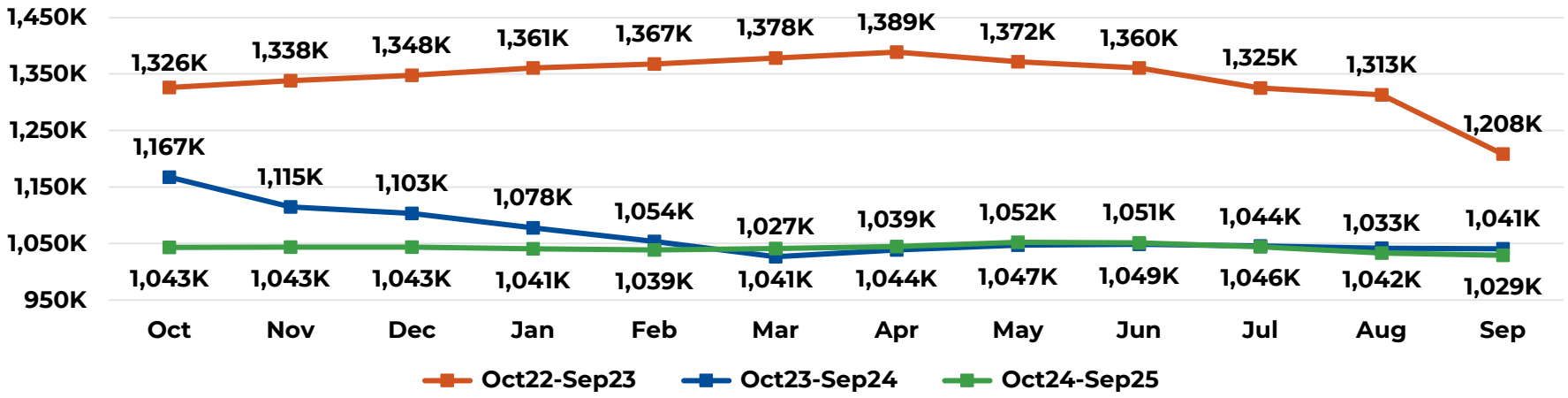
October 2025

OKLAHOMA HEALTH CARE AUTHORITY

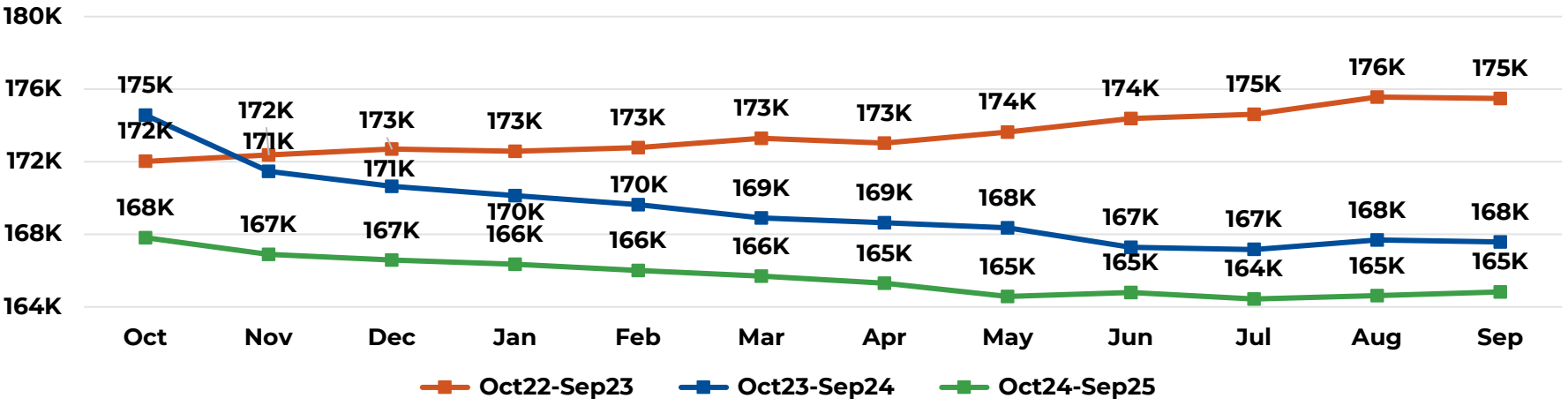
4345 N. LINCOLN BLVD. | OKHCA.ORG |

Enrollment & Utilization

Total Enrolled Members

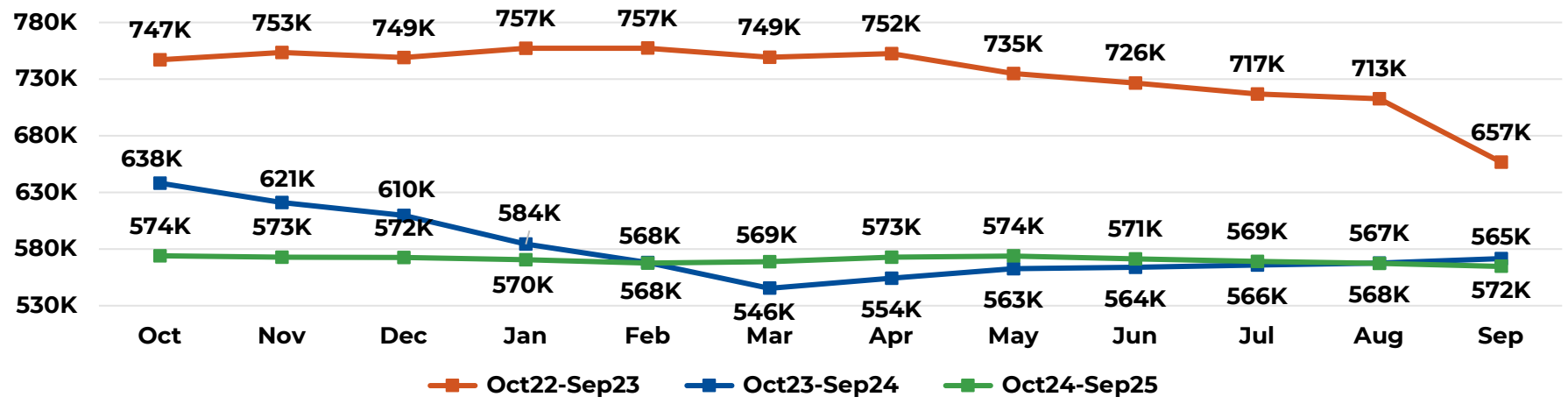


Aged/Blind/Disabled Enrolled Members

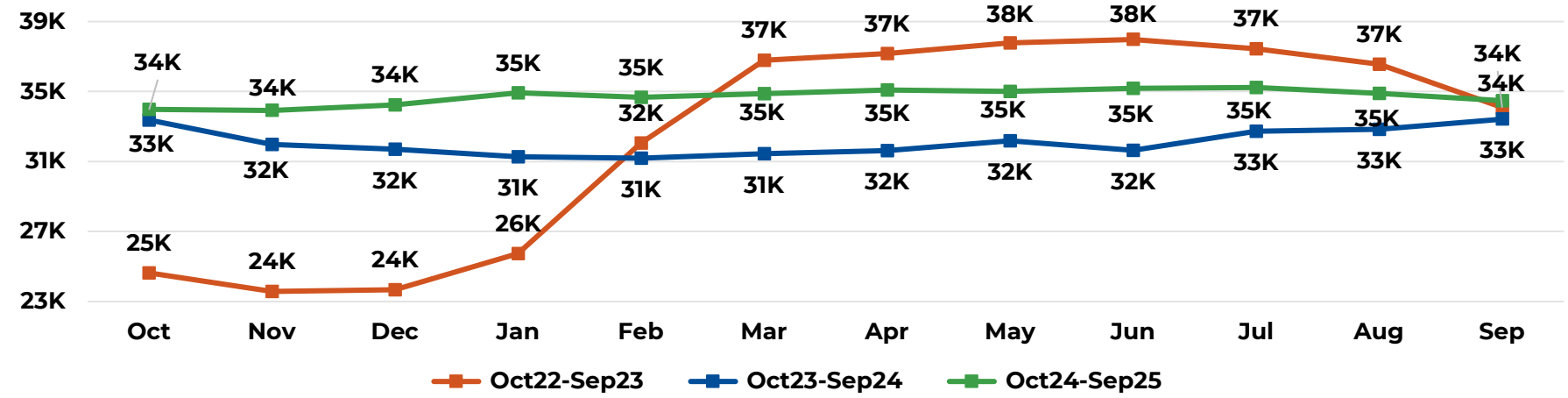


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Enrolled Members

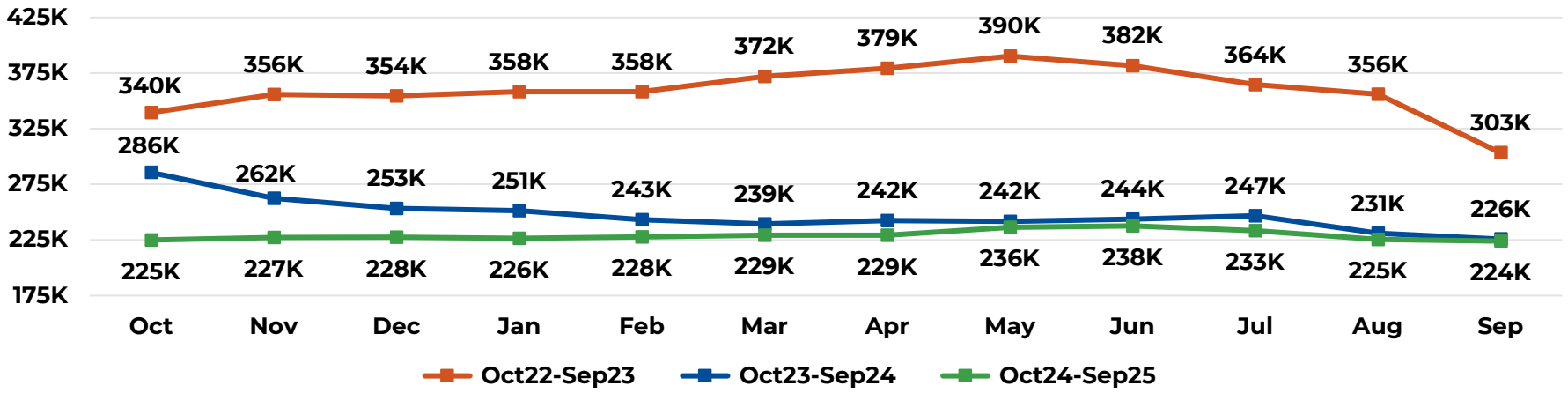


Pregnant (Full Scope) Enrolled Members

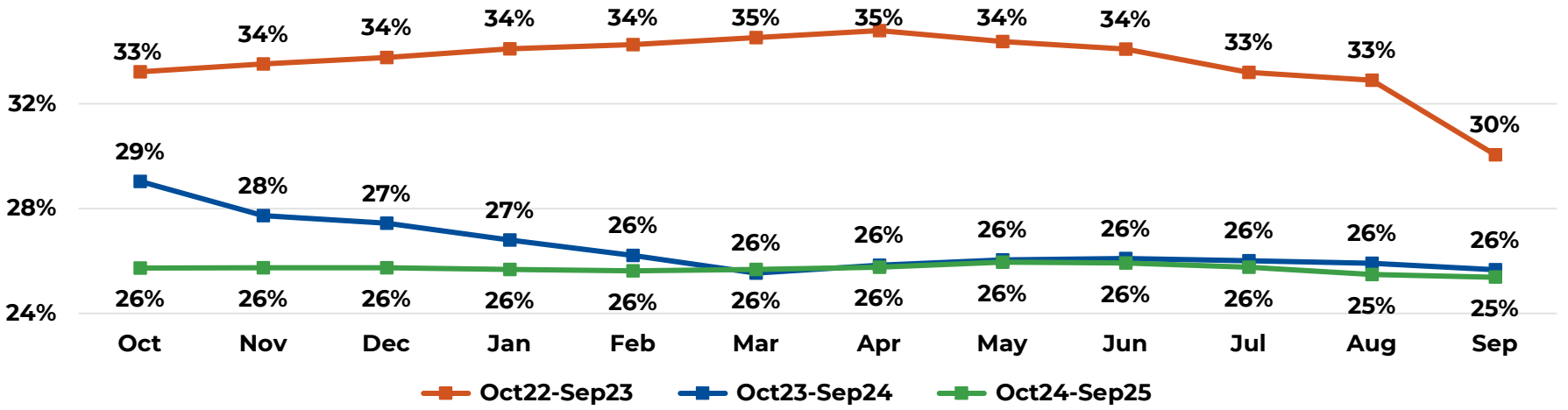


Enrollment & Utilization (Cont.)

Expansion Enrolled Members

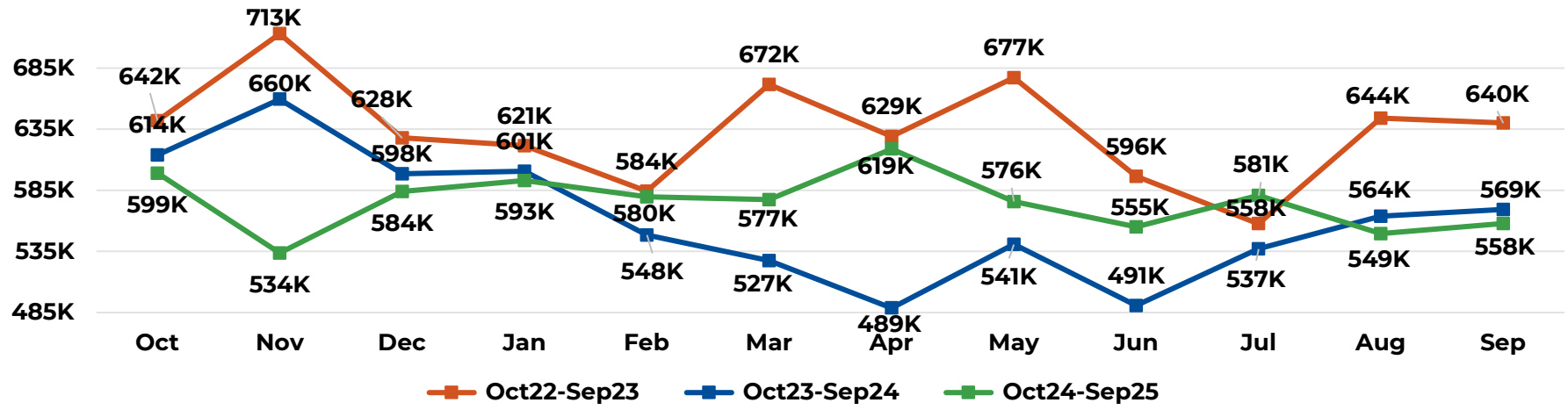


Percent of OK Population Enrolled Members

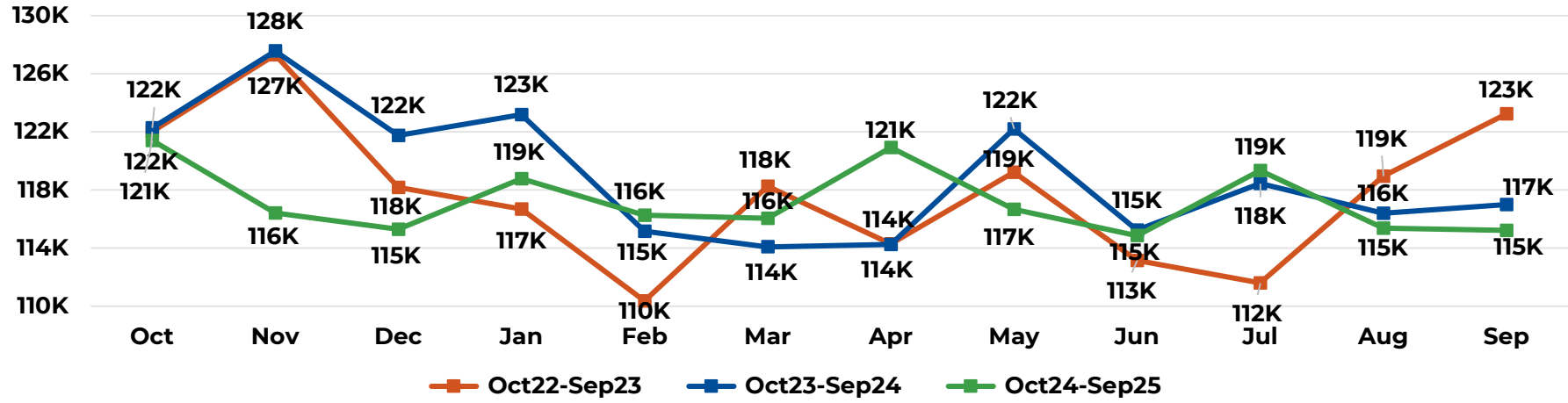


Enrollment & Utilization (Cont.)

Total Members Served

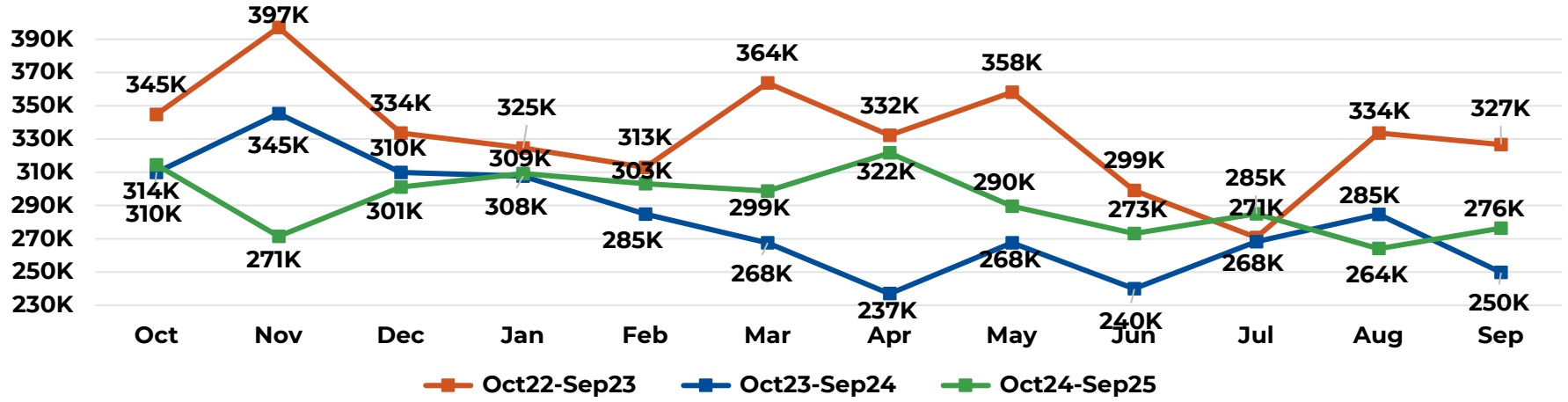


Aged/Blind/Disabled Members Served

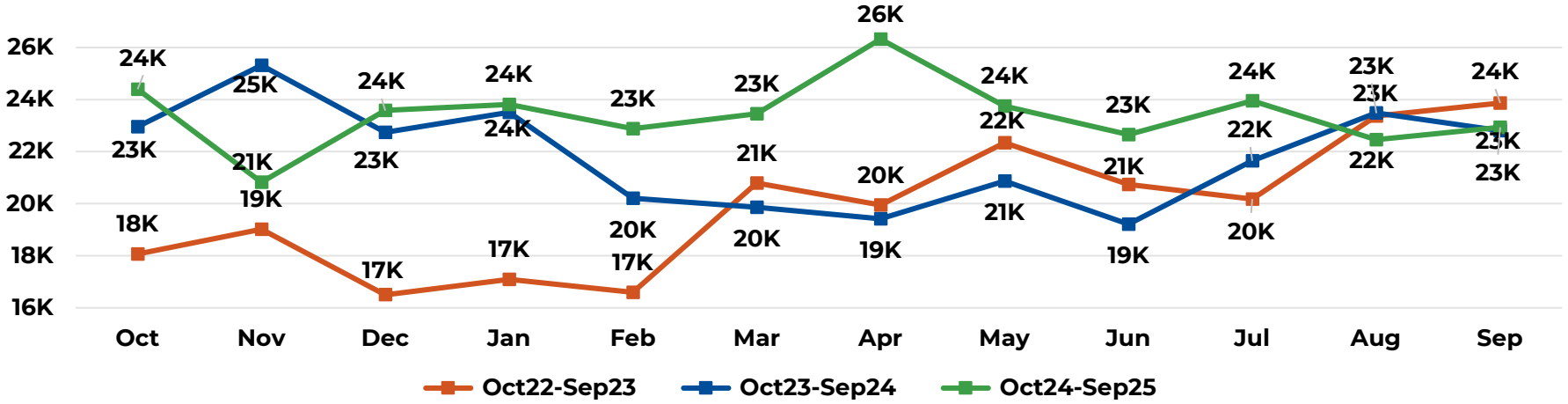


Enrollment & Utilization (Cont.)

Children & Parent/Caretaker Members Served

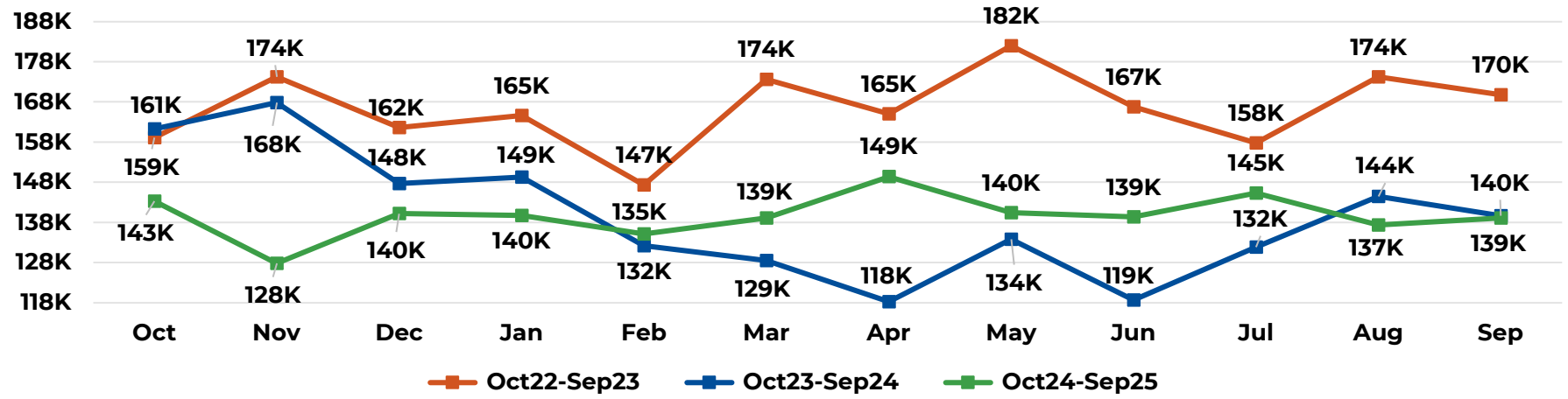


Pregnant (Full Scope) Members Served

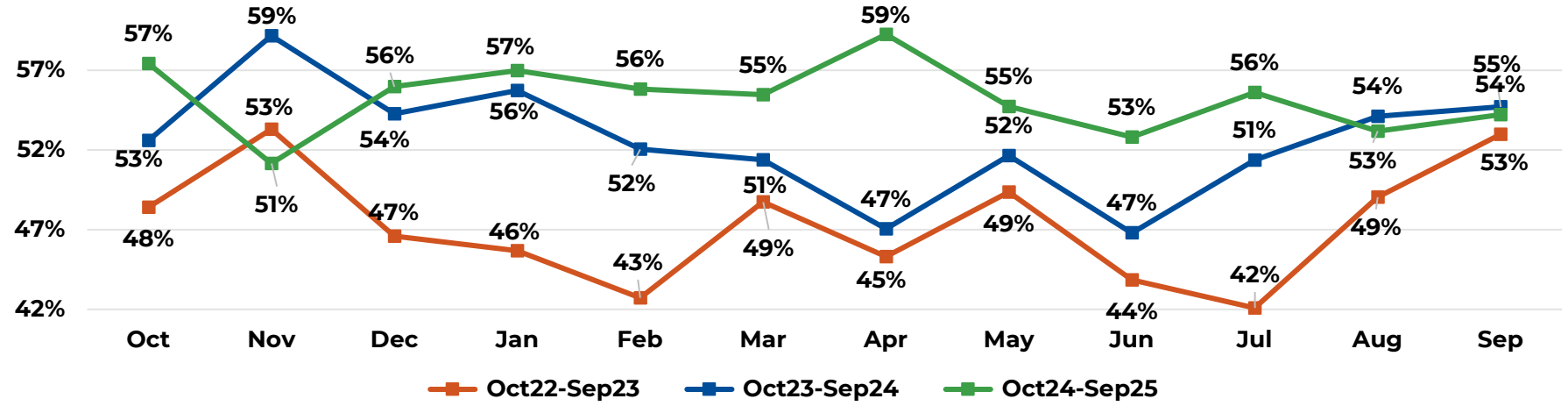


Enrollment & Utilization (Cont.)

Expansion Members Served

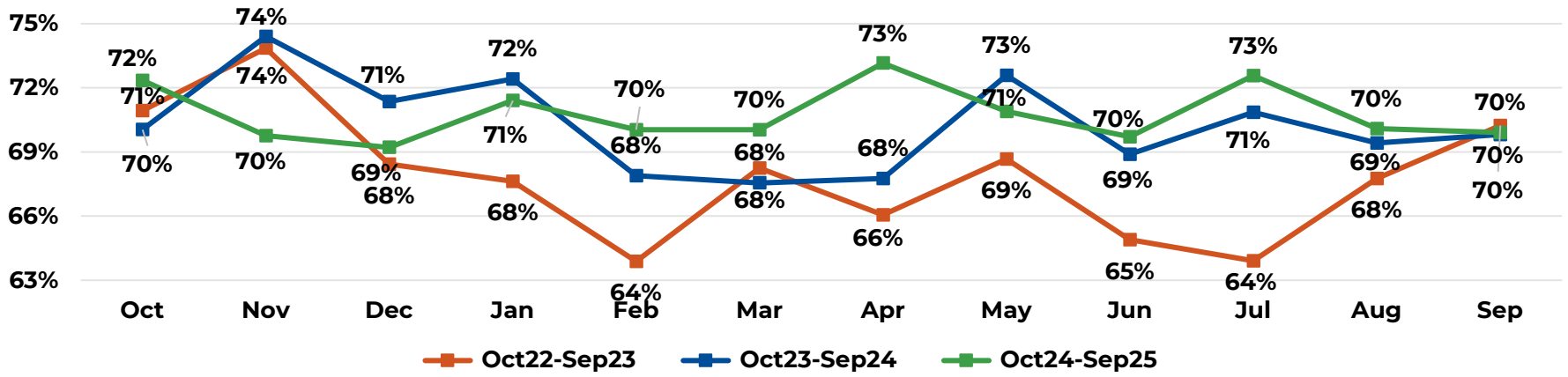


Percent of Total Enrolled Members Served

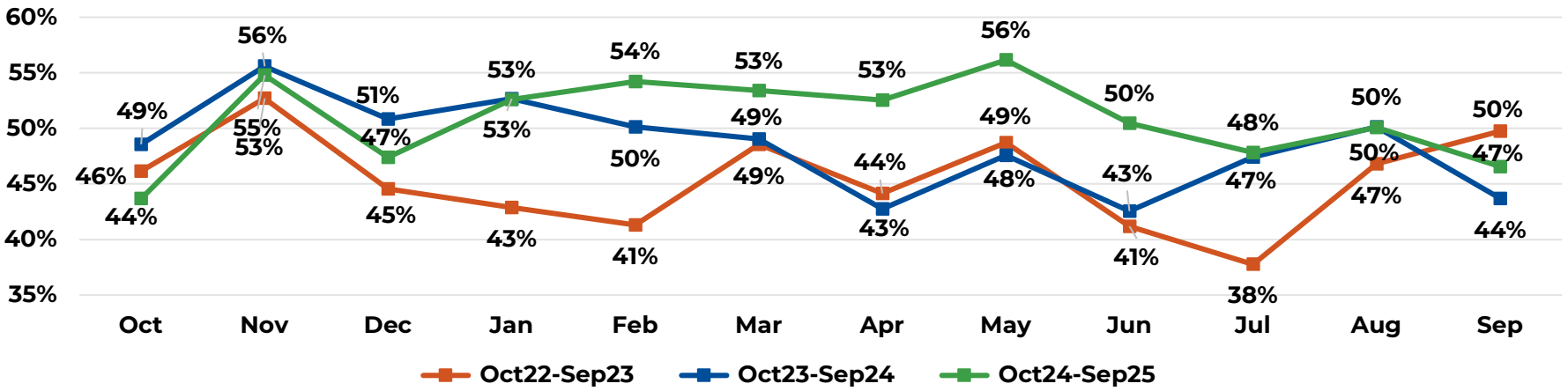


Enrollment & Utilization (Cont.)

Percent of Aged/Blind/Disabled Enrolled Members Served

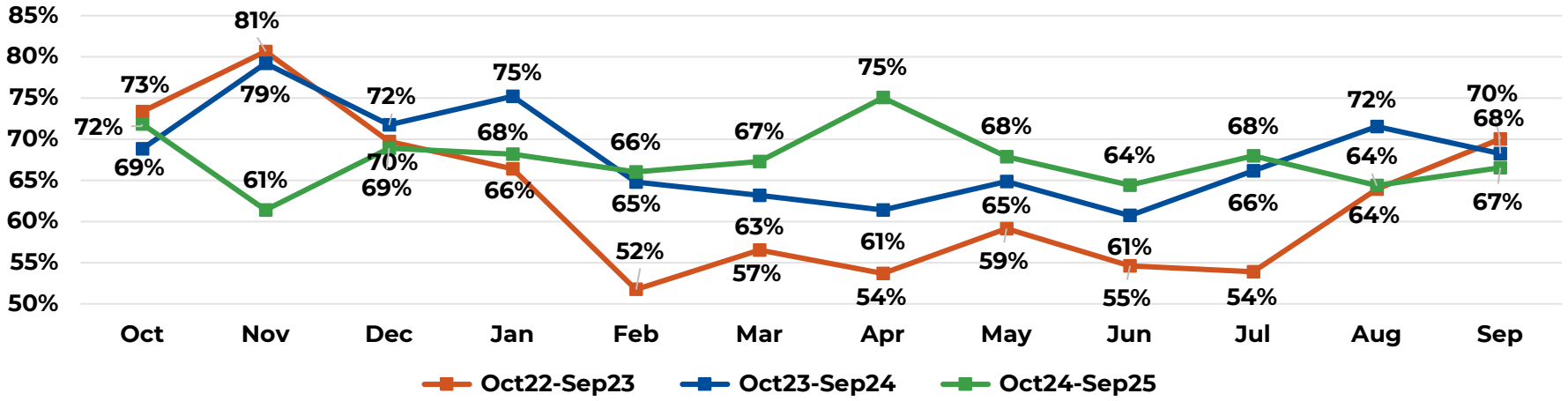


Percent of Children & Parent/Caretaker Enrolled Members Served

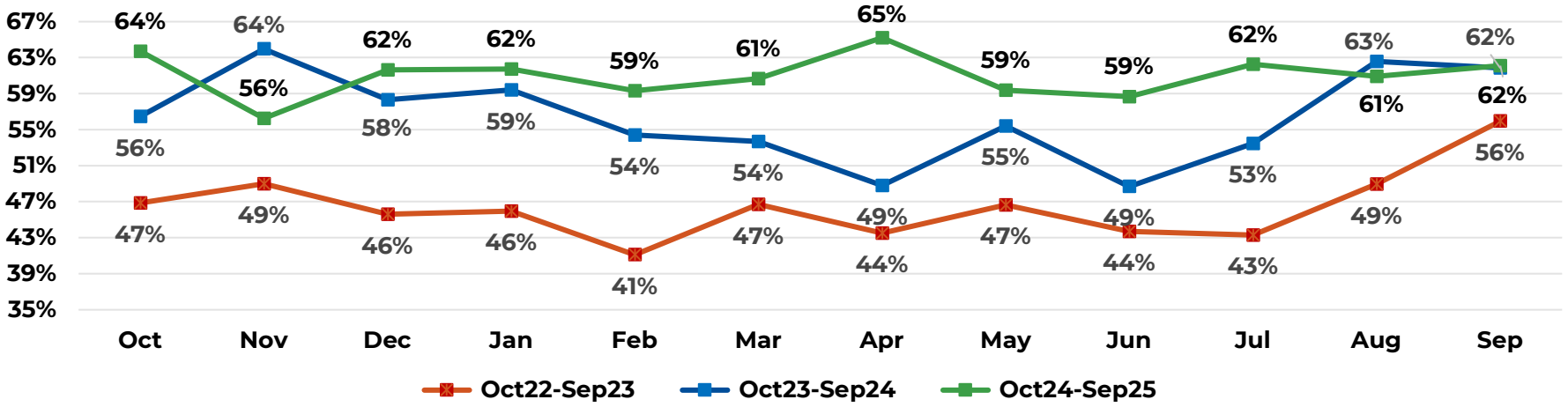


Enrollment & Utilization (Cont.)

Percent of Pregnant (Full Scope) Enrolled Members Served

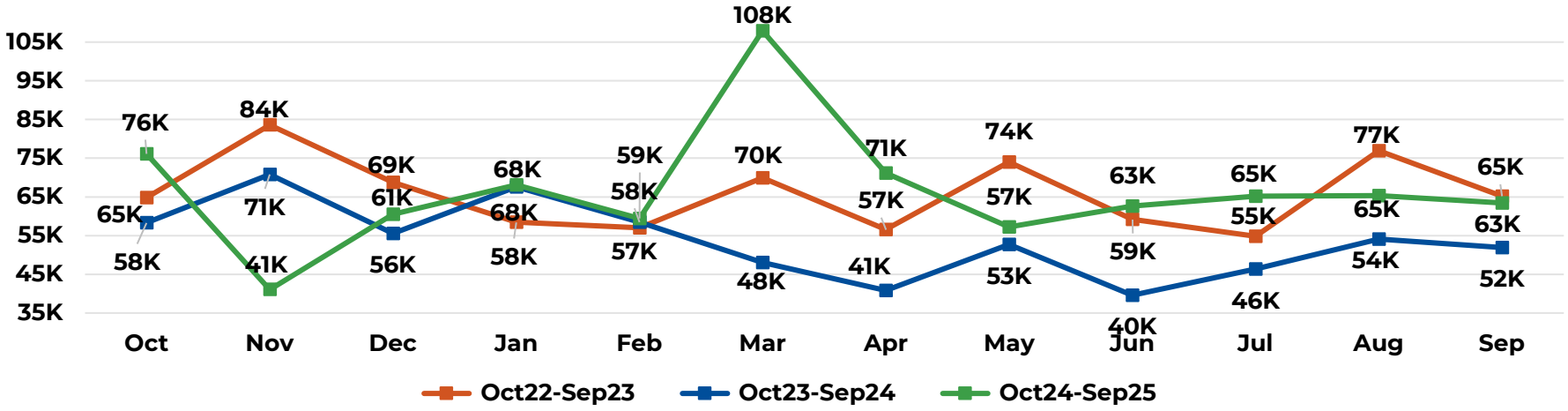


Percent of Expansion Enrolled Members Served

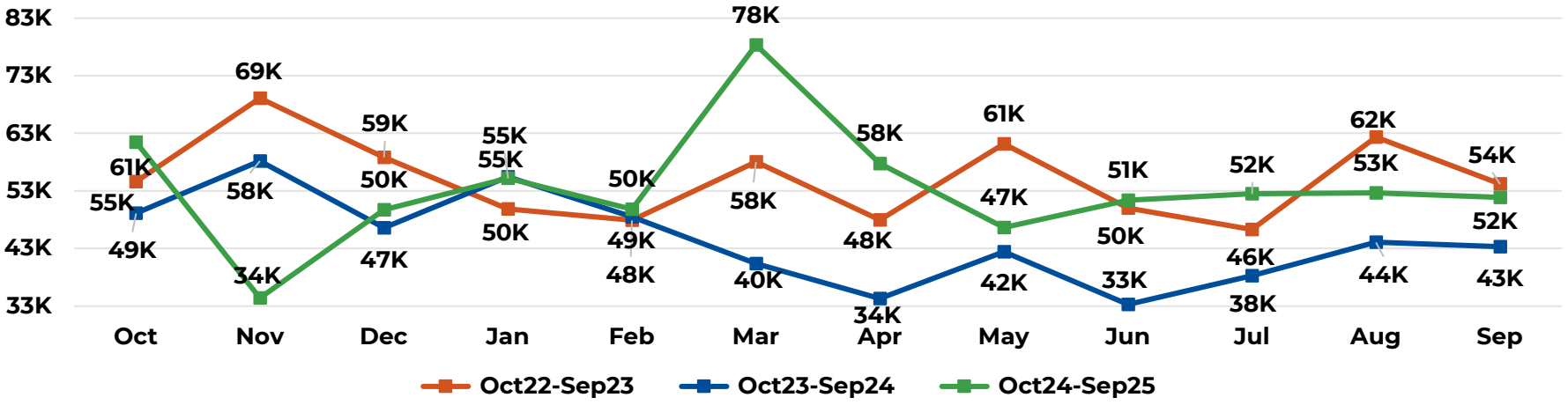


Utilization

Emergency Department - Visits (Claims)

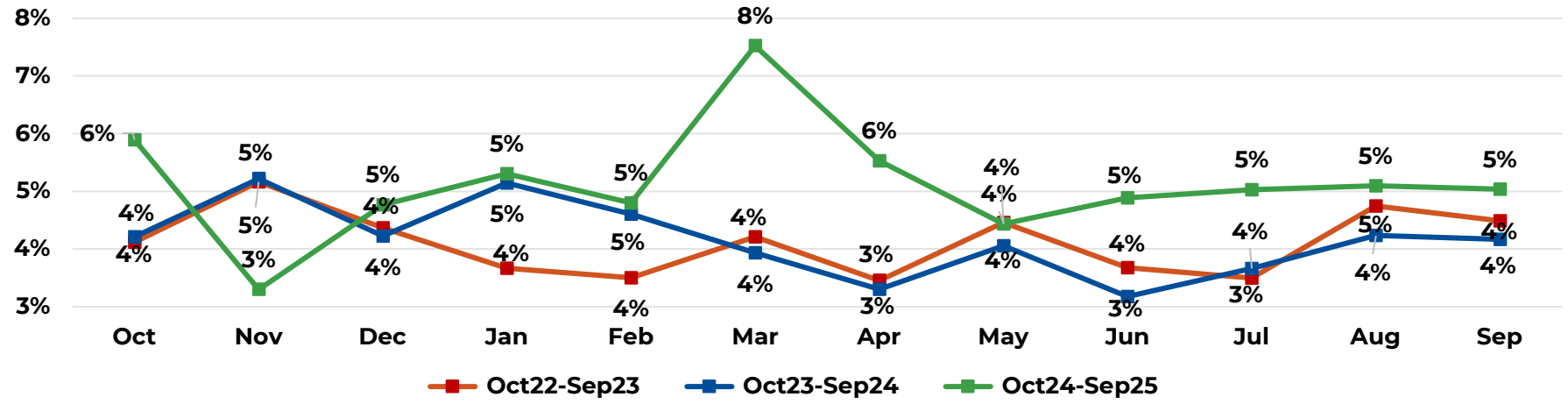


Emergency Department - Members Served



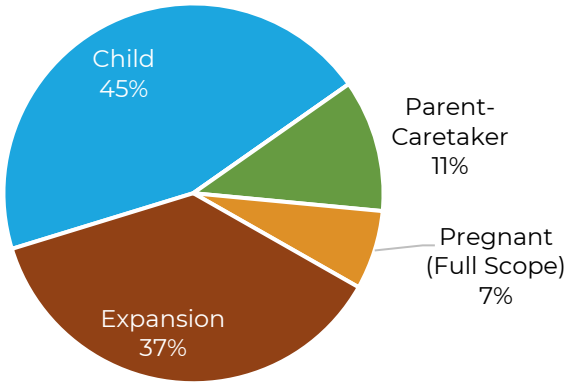
Utilization (Cont.)

Emergecy Department - Percent Total Enrolled Members Served

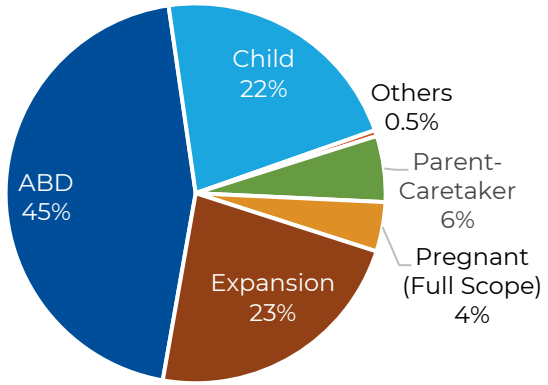


Emergency Department - Members Served By Qualifying Group (Sep2025)

MCE

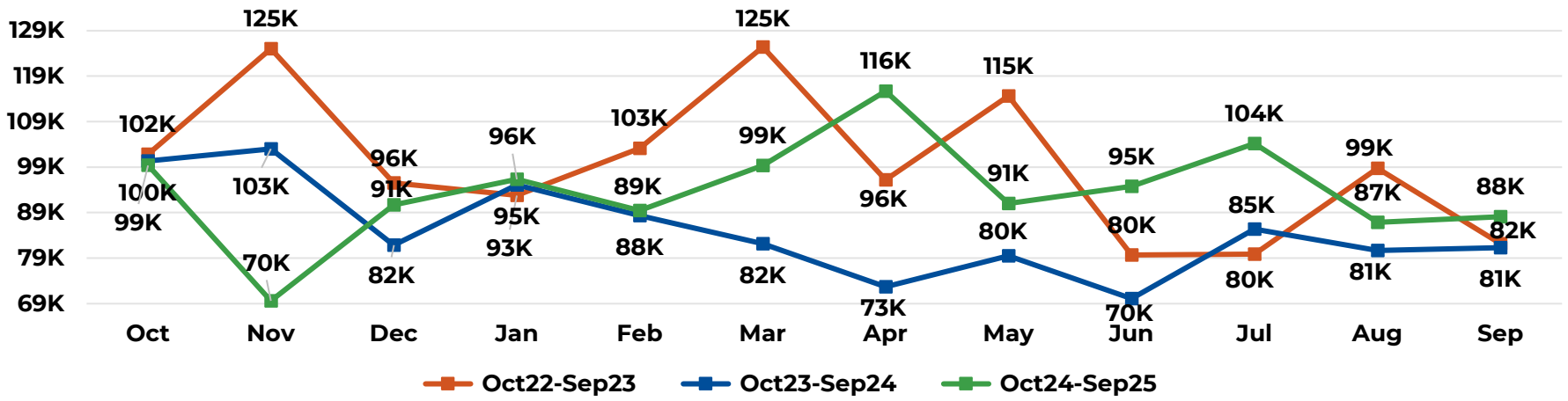


FFS

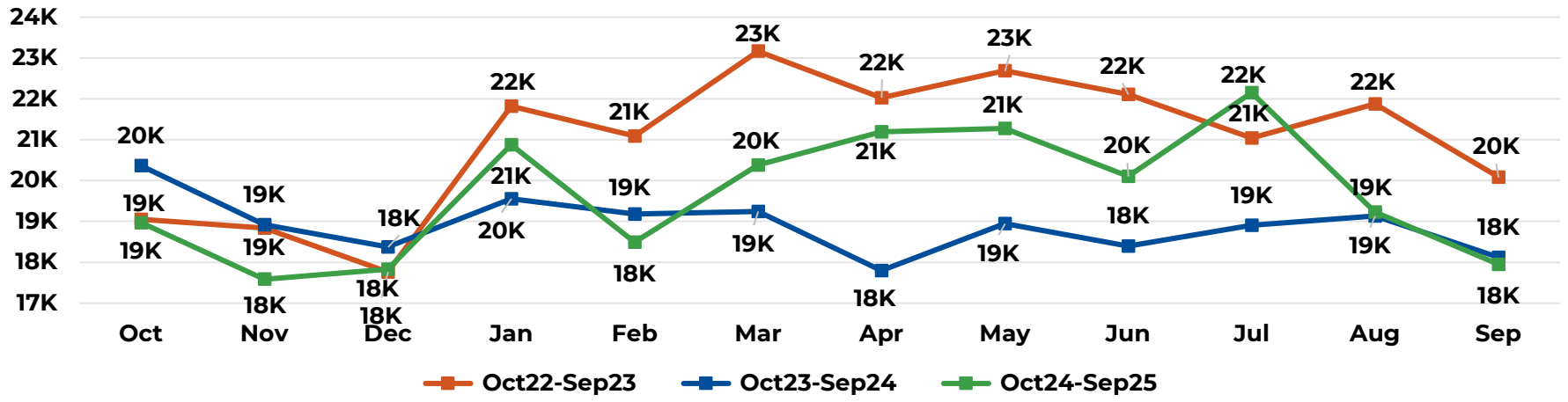


Utilization (Cont.)

Telemedicine - Total Visits (Claims)



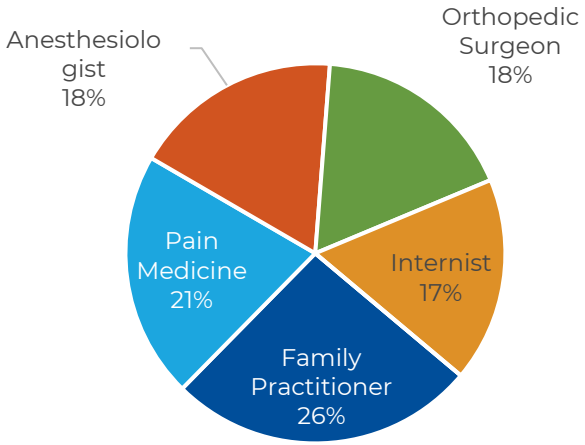
Opioid Claims - Members Served



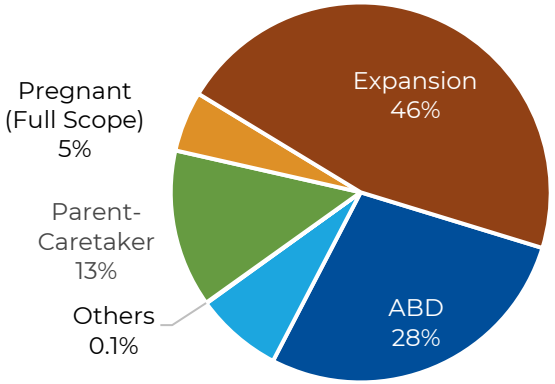
Utilization (Cont.)

Opioid Claims - Members Served By Qualifying Group & Provider Specialty (Sep2025)

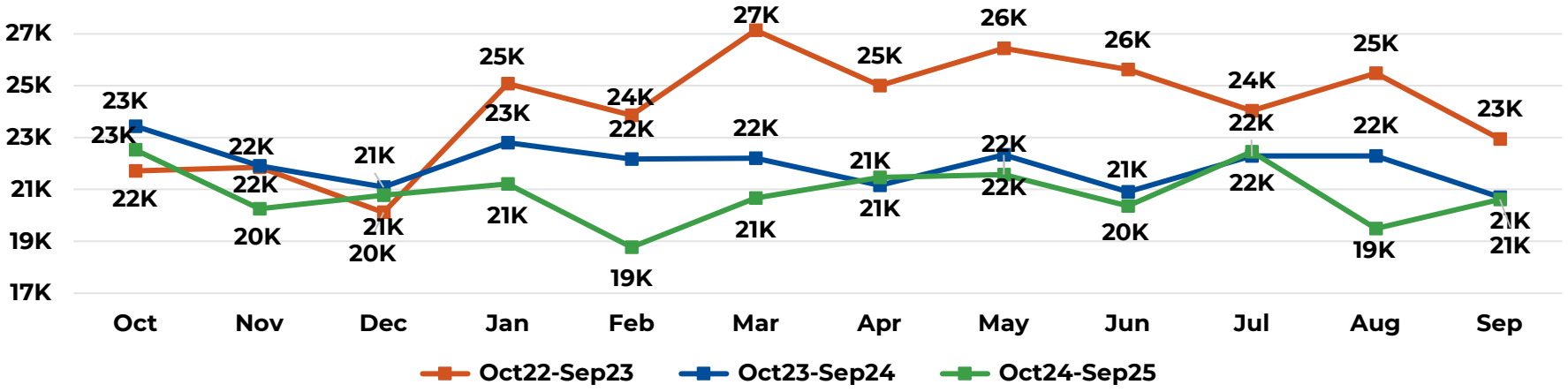
Provider Specialty (Top 5)



Qualifiying Group (All Members)

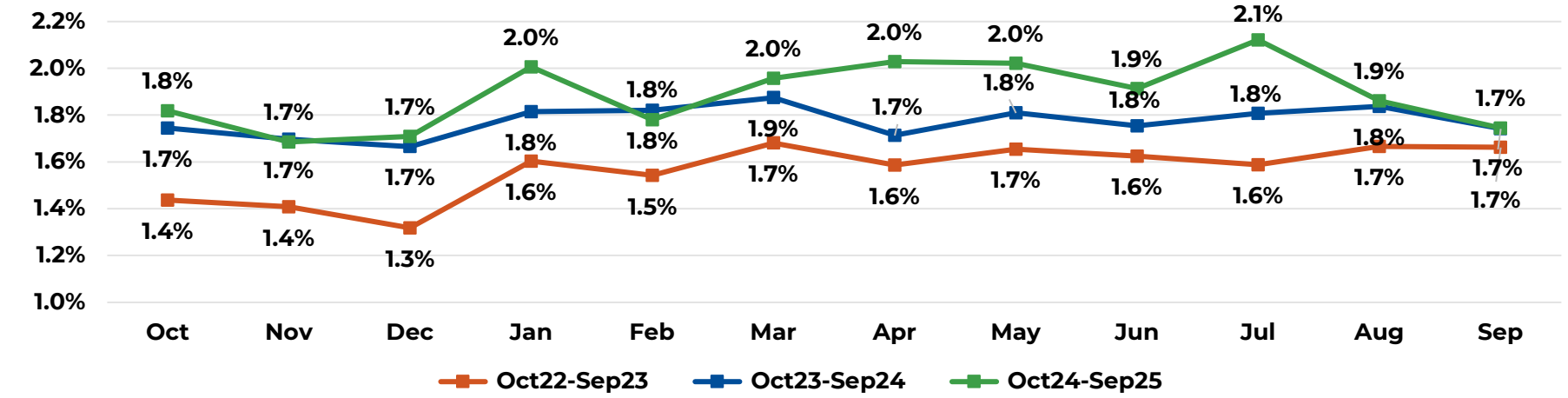


Opioid Claims - Total Claims

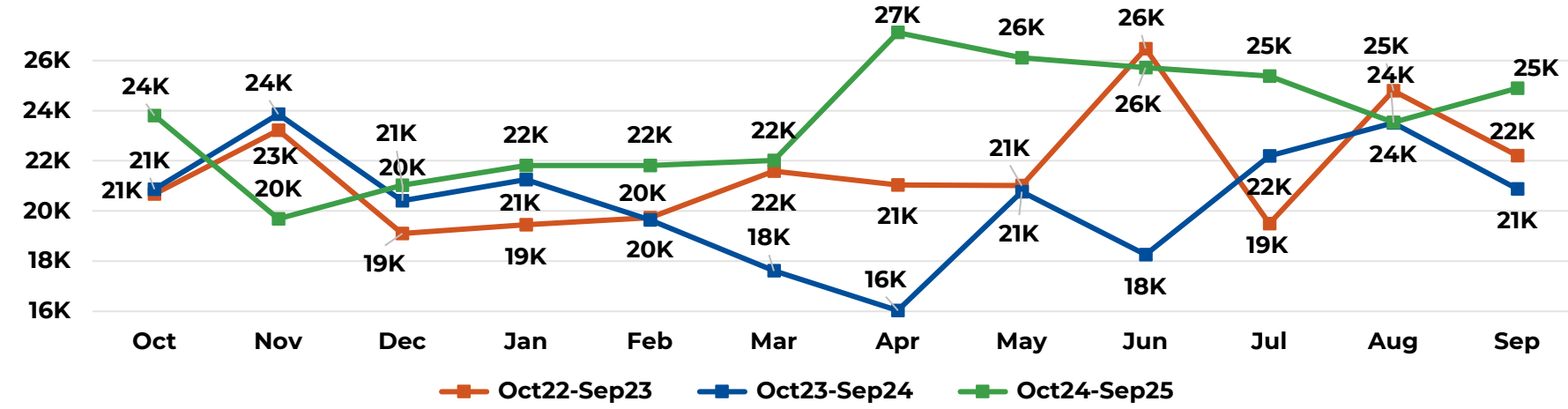


Utilization (Cont.)

Opioid Claims - Percent Total Enrolled With Opioid Claims



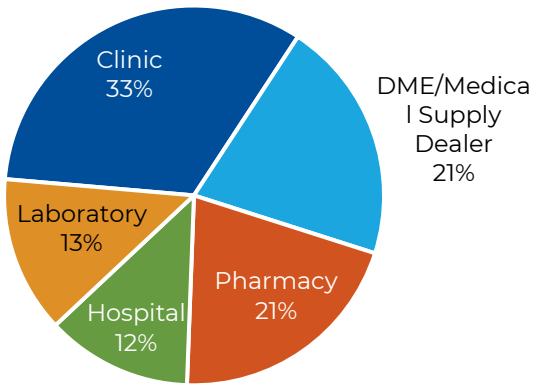
Out of State Services (Non Border County) - Total Members Served



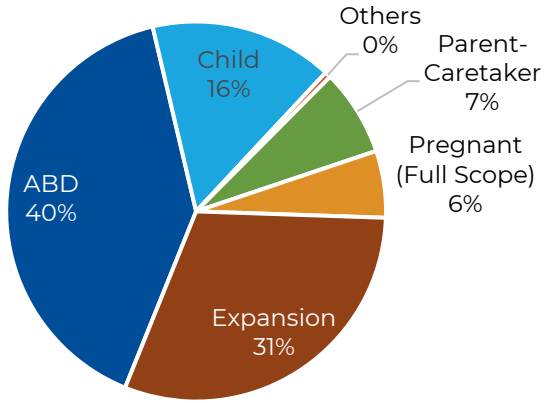
Utilization (Cont.)

Out of State Services (Non Border County) - Total Members Served By Provider Type & Qualifying Group (Sep2025)

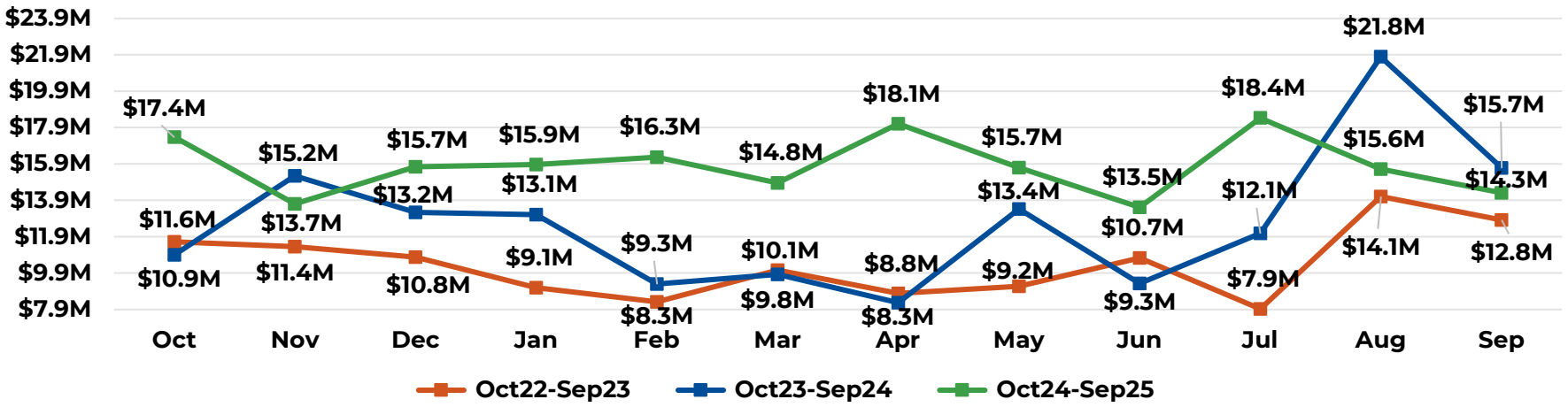
Provider Type (Top 5)



Qualifying Group (All Members)

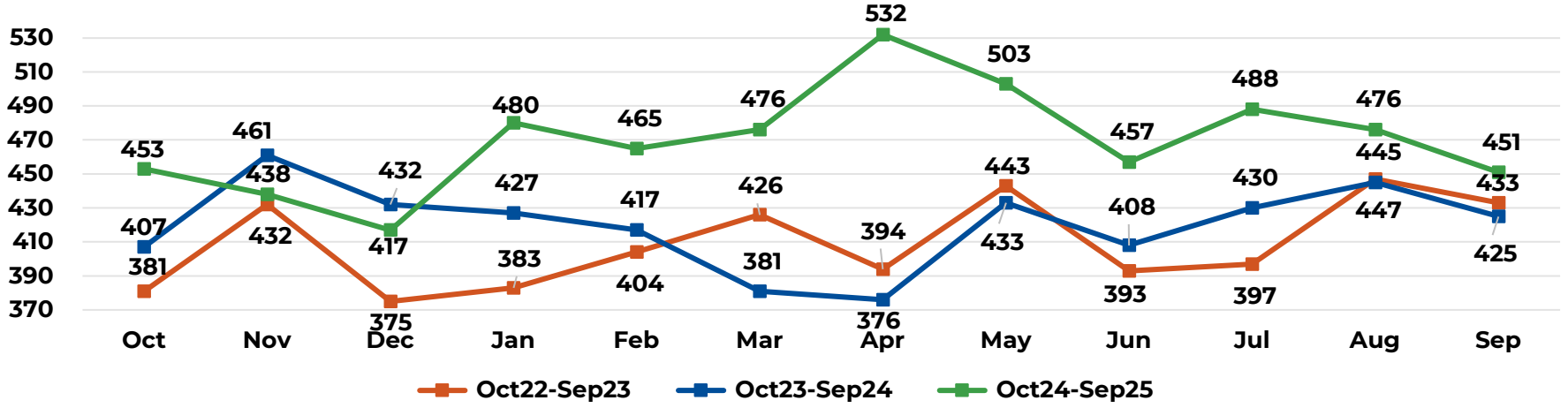


Out of State Services (Non Border County) - Total Expenditures

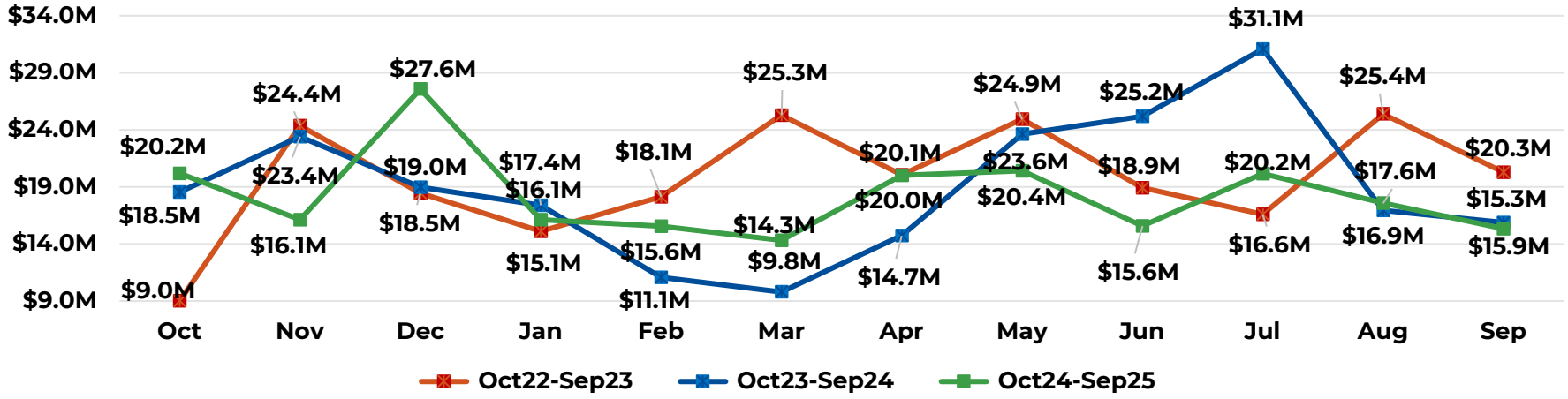


Utilization (Cont.)

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

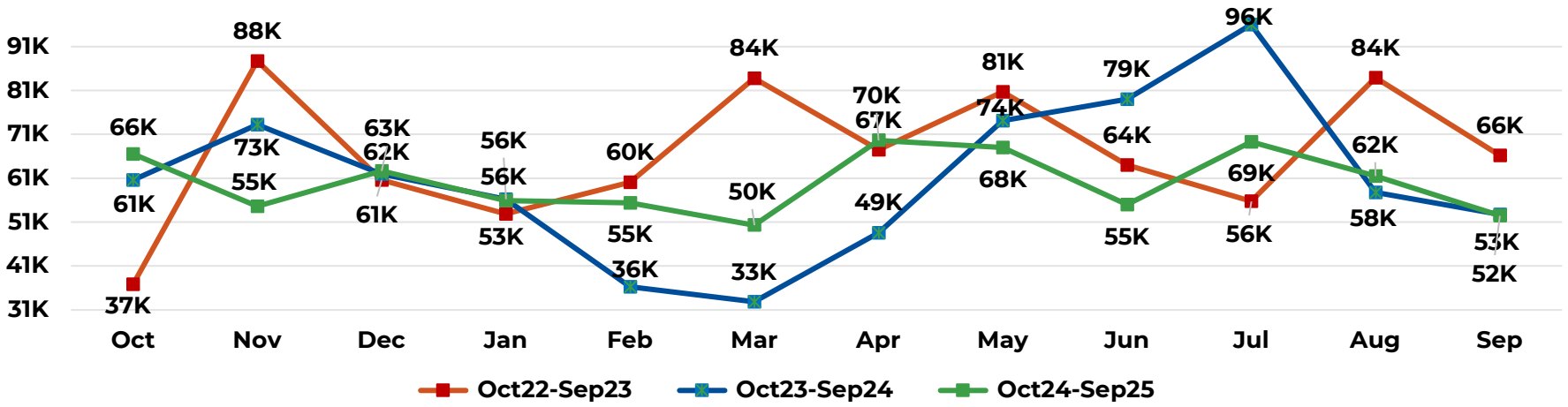


Dental Claims - Expenditures

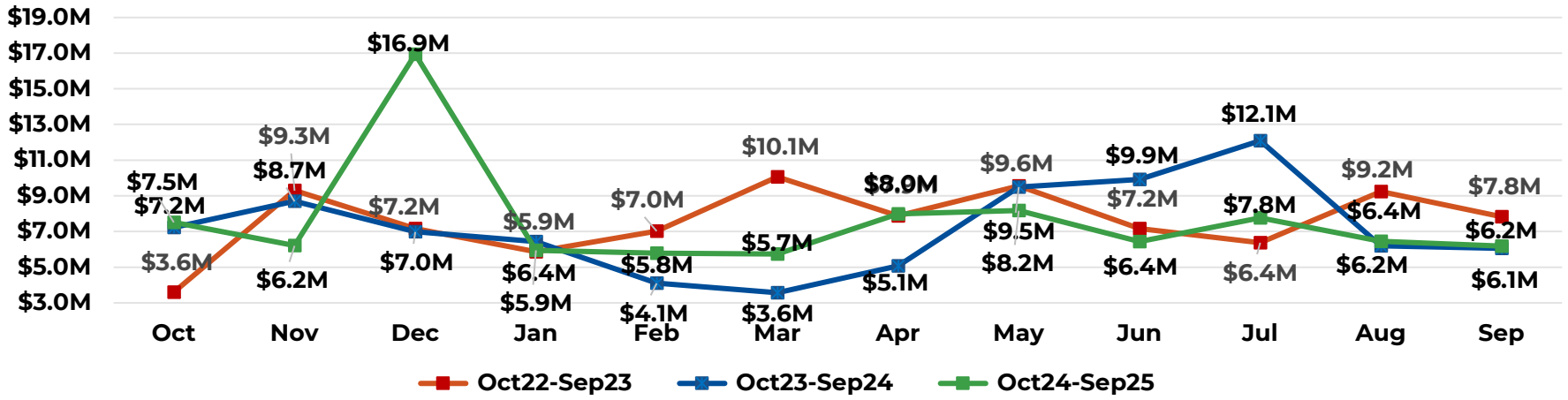


Utilization (Cont.)

Dental Claims - Members Served

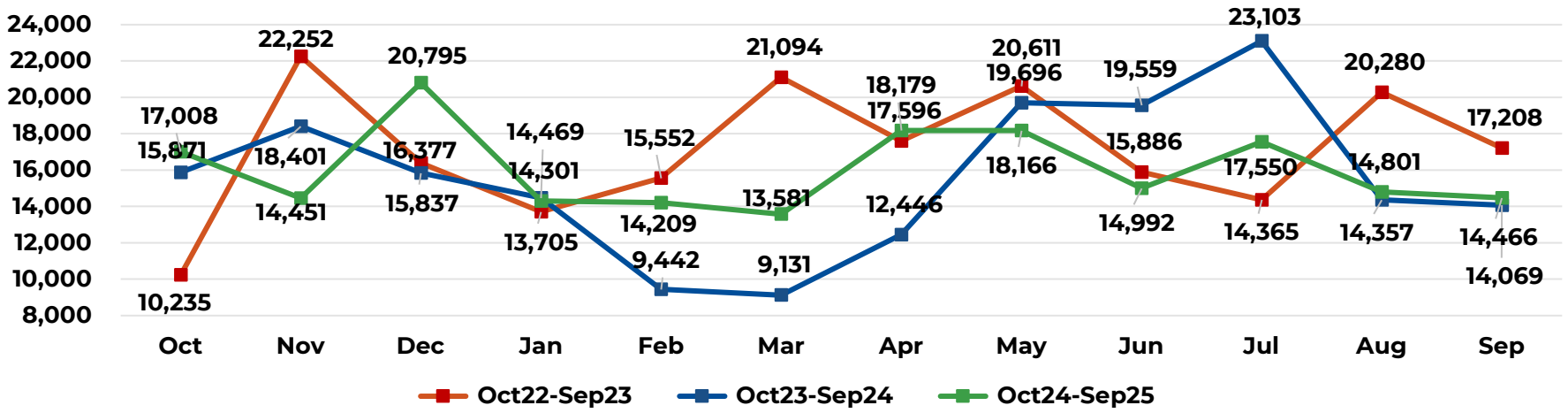


Adult Dental Claims (21 & Over) - Expenditures

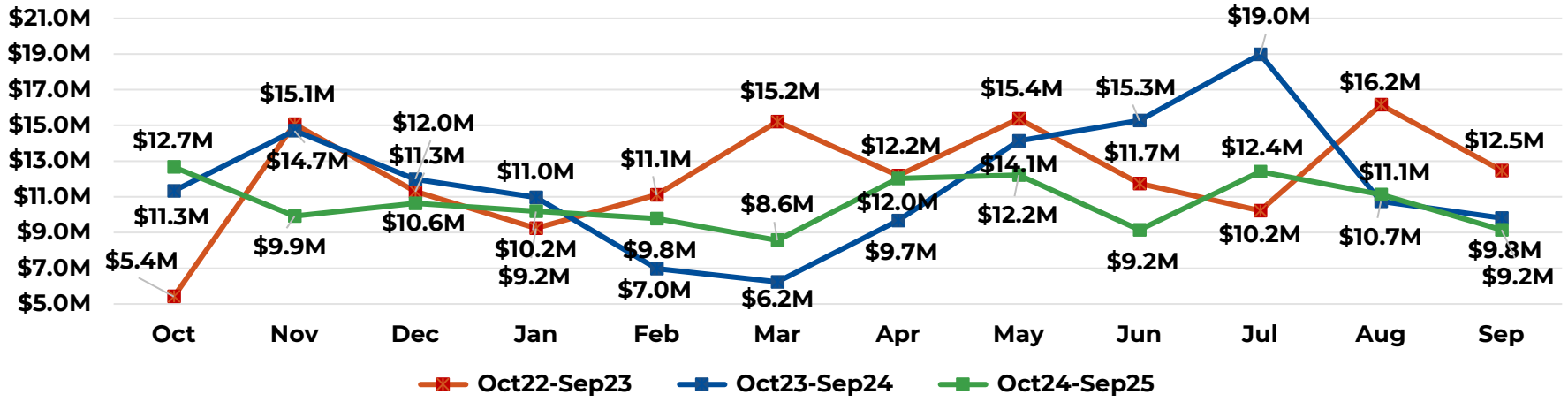


Utilization (Cont.)

Adult Dental Claims (21 & Over) - Members Served

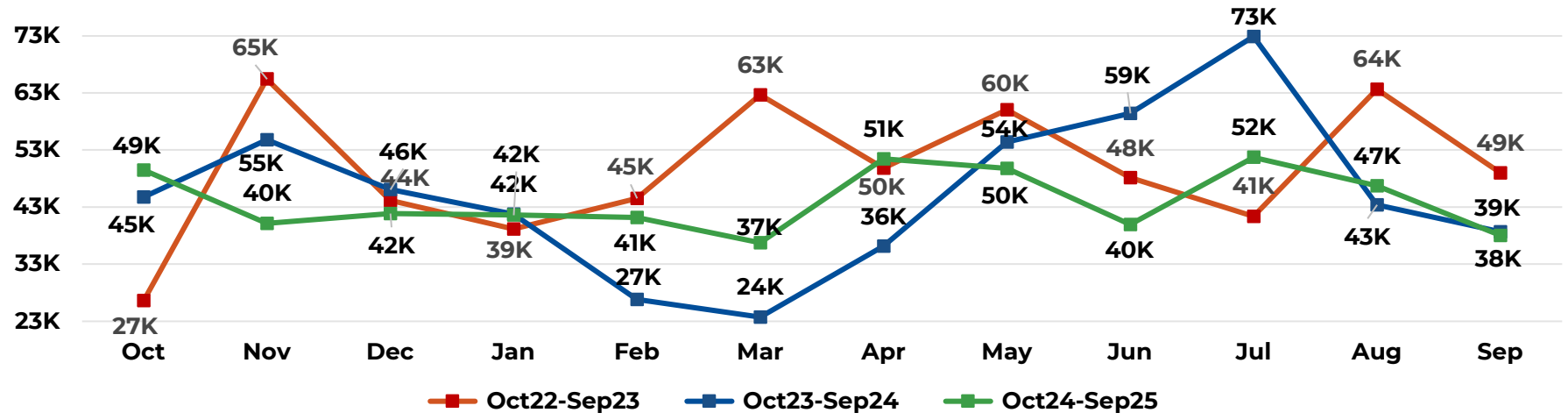


Children Dental Claims (Under 21) - Expenditures



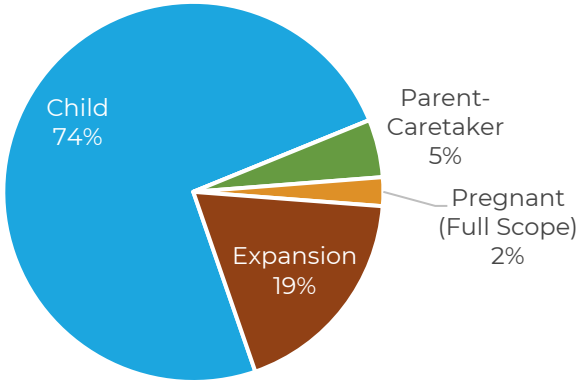
Utilization (Cont.)

Children Dental Claims (Under 21) - Members Served



Dental Claims - Members Served By Qualifying Group (Sep2025)

MCE



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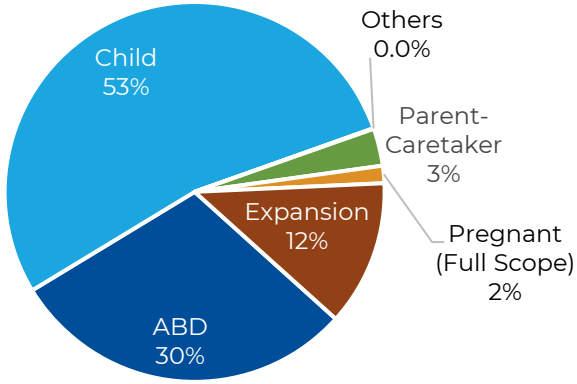
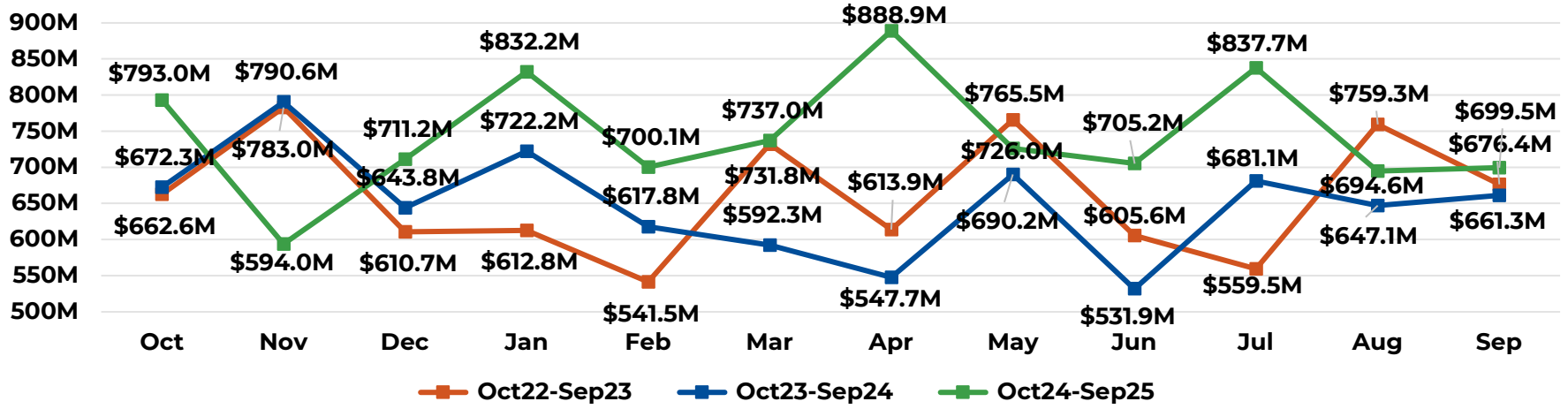


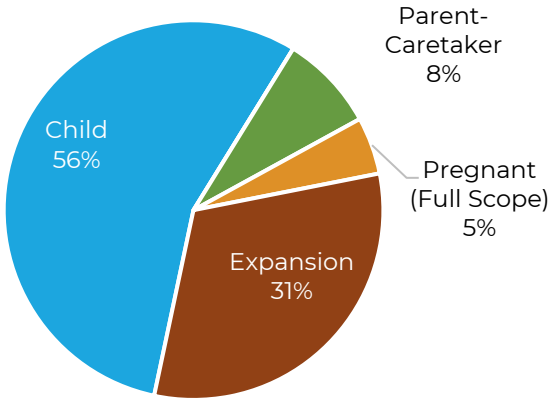
Financials

Total Agency Expenditures



Total Agency Utilization - Members Served By Qualifying Group (Sep2025)

MCE



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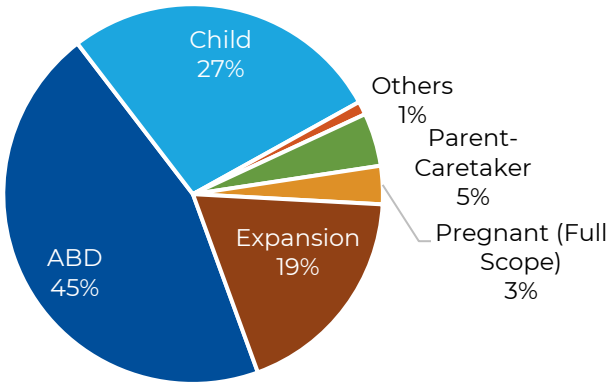
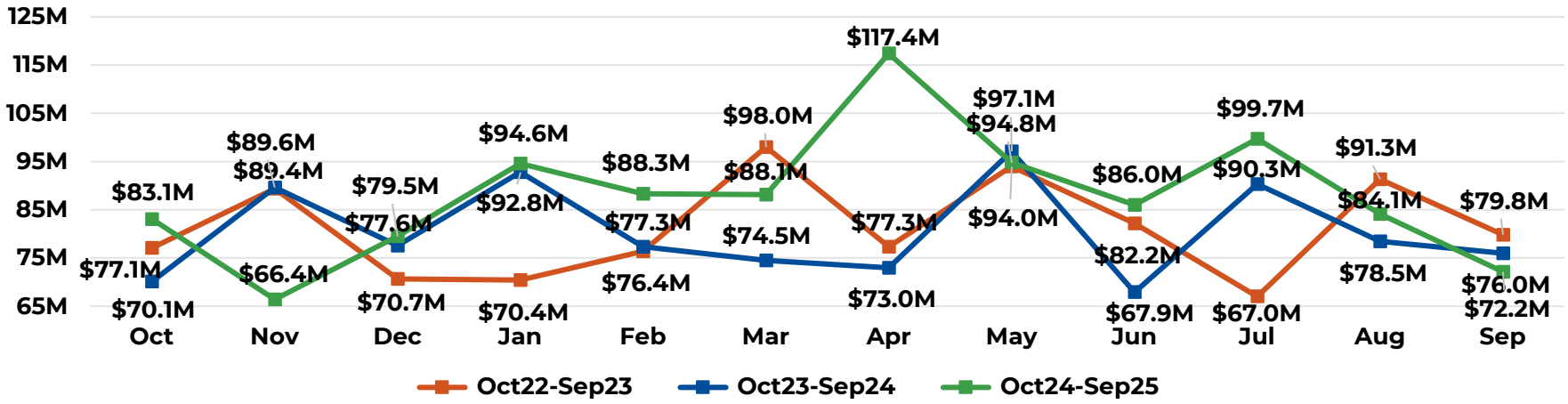


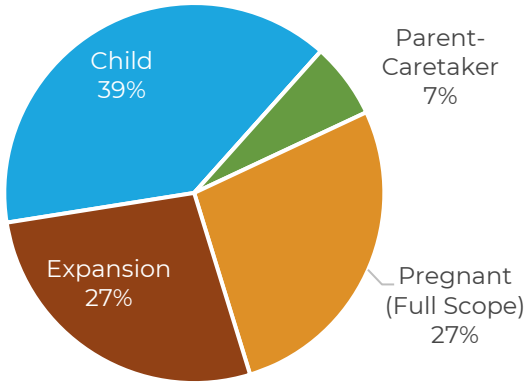
Financials (Cont.)

Inpatient Services - Expenditures



Inpatient Services - Members Served by Qualifying Group (Sep2025)

MCE



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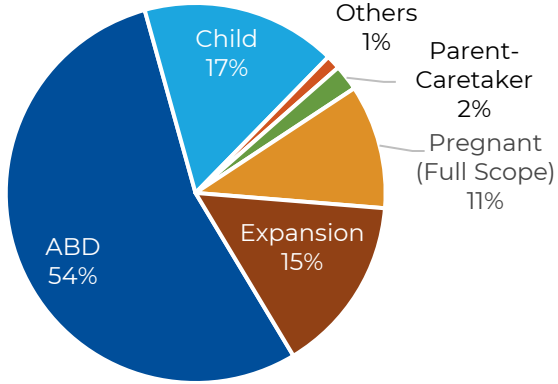
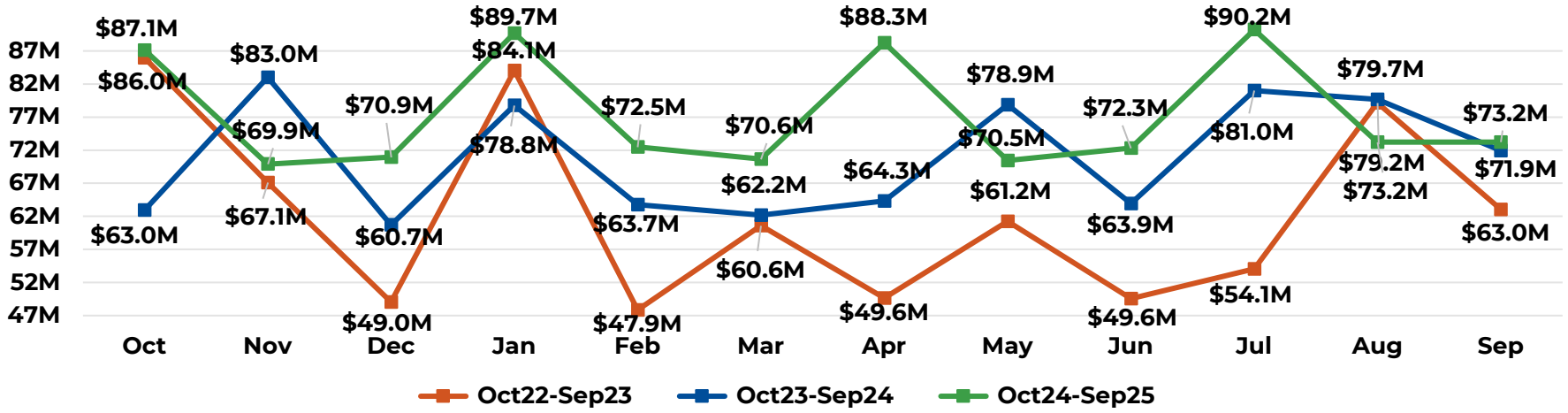
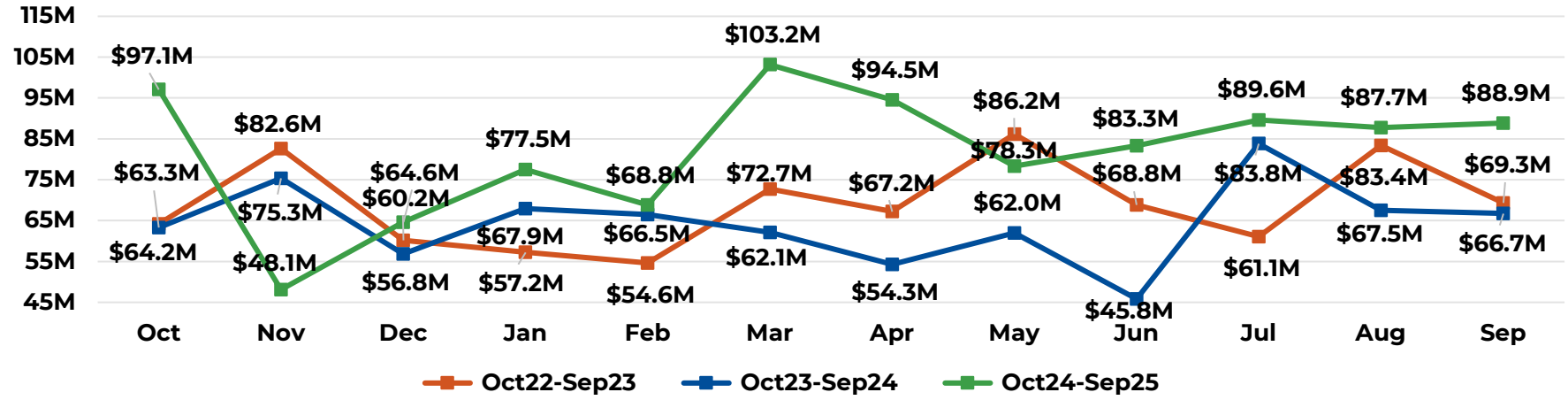


Financials (Cont.)

Nursing Facility Services - Expenditures

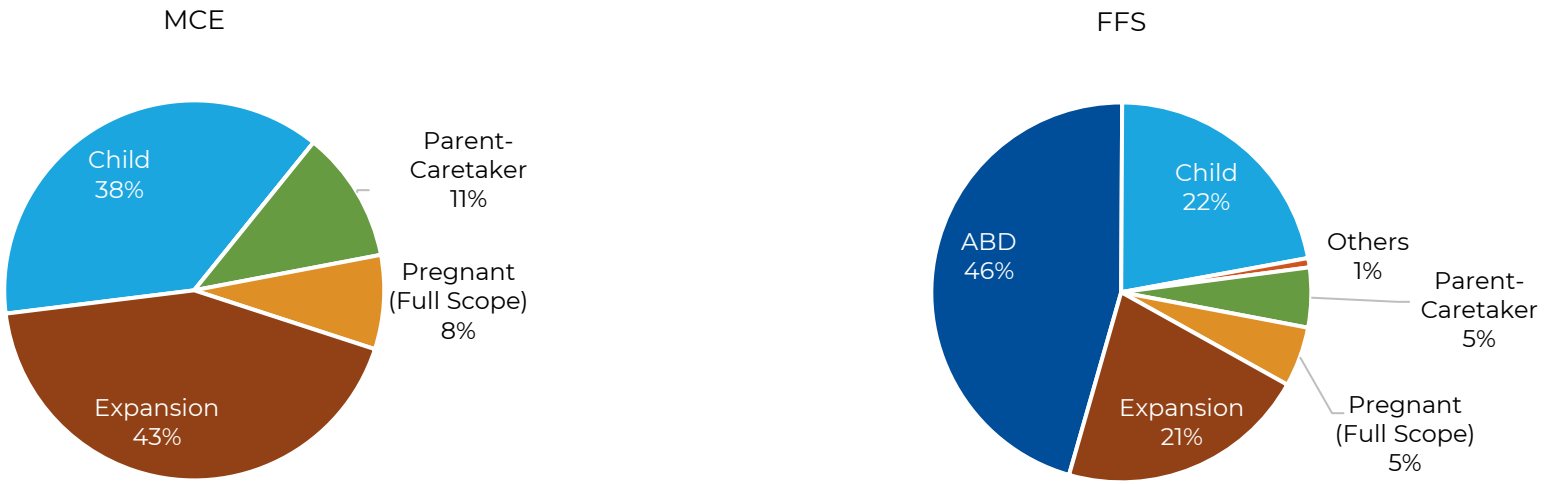


Outpatient Hospital Services - Expenditures

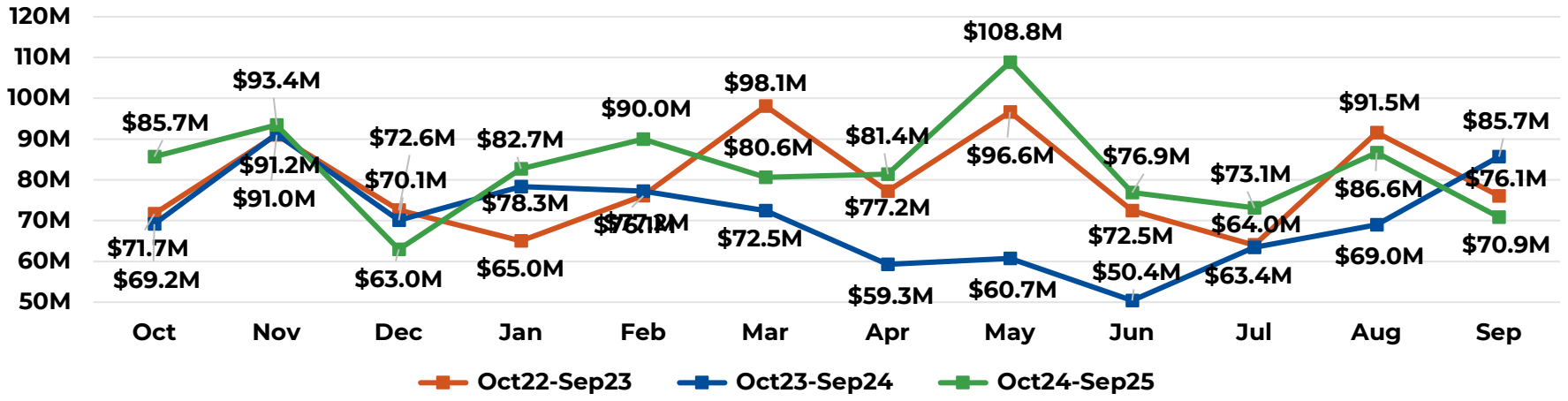


Financials (Cont.)

Outpatient Hospital Services - Members Served By Qualifying Group (Sep2025)

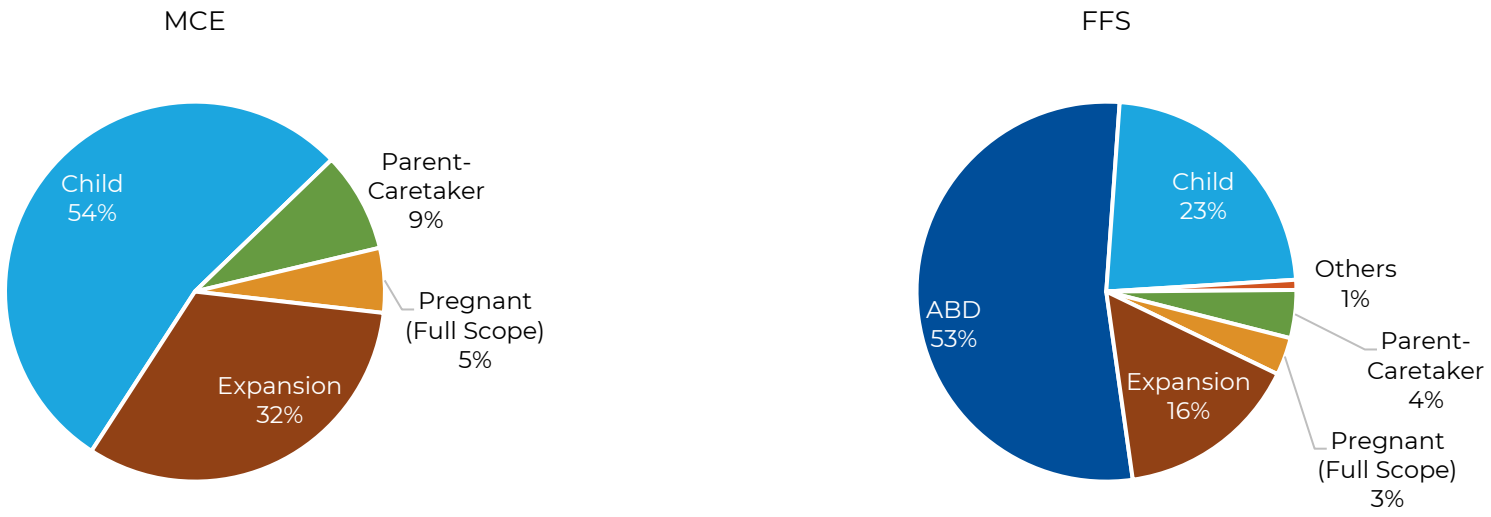


Physician Services - Expenditures

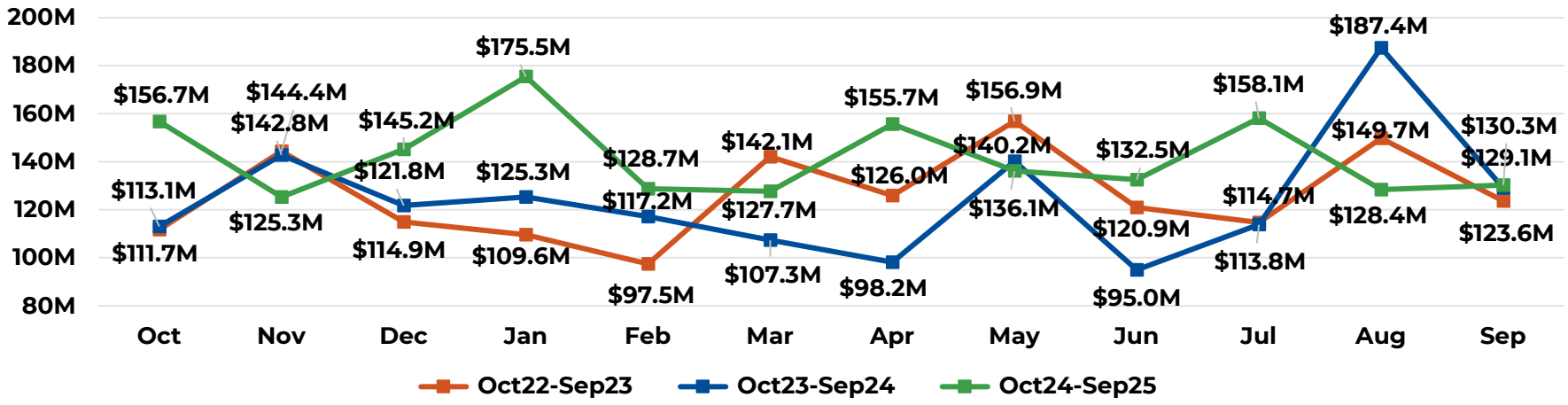


Financials (Cont.)

Physician Services - Members Served By Qualifying Group (Sep2025)



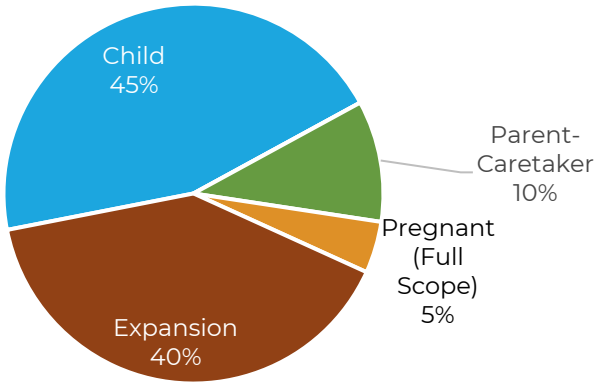
Prescribed Drugs - Expenditures



Financials (Cont.)

Prescribed Drugs - Members Served By Qualifying Group (Sep2025)

MCE



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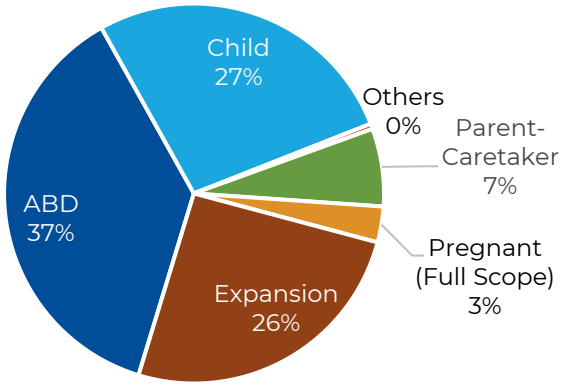
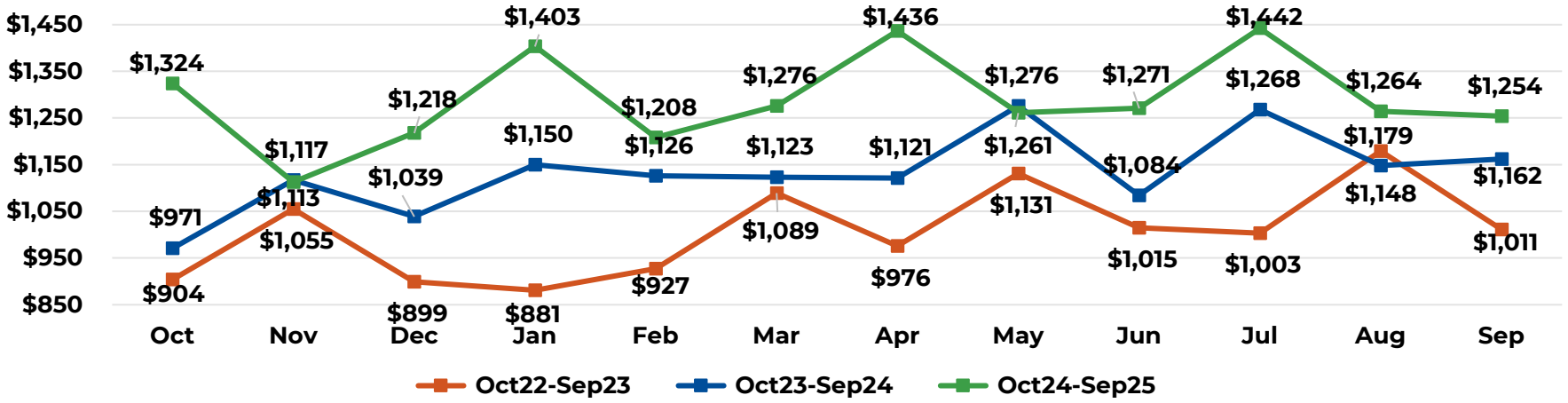
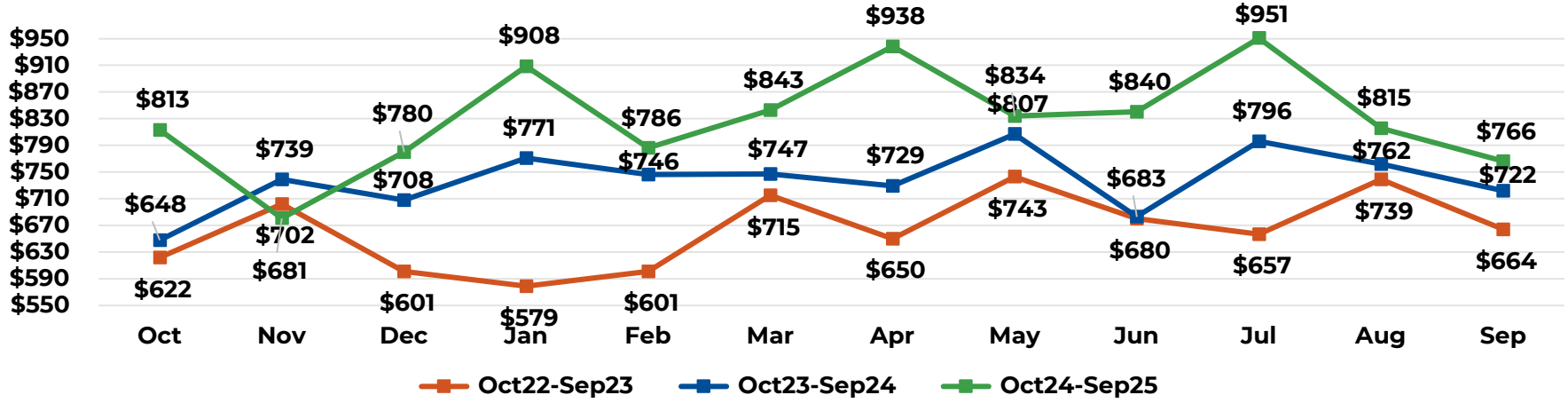


Average Expenditure Per Total Members Served

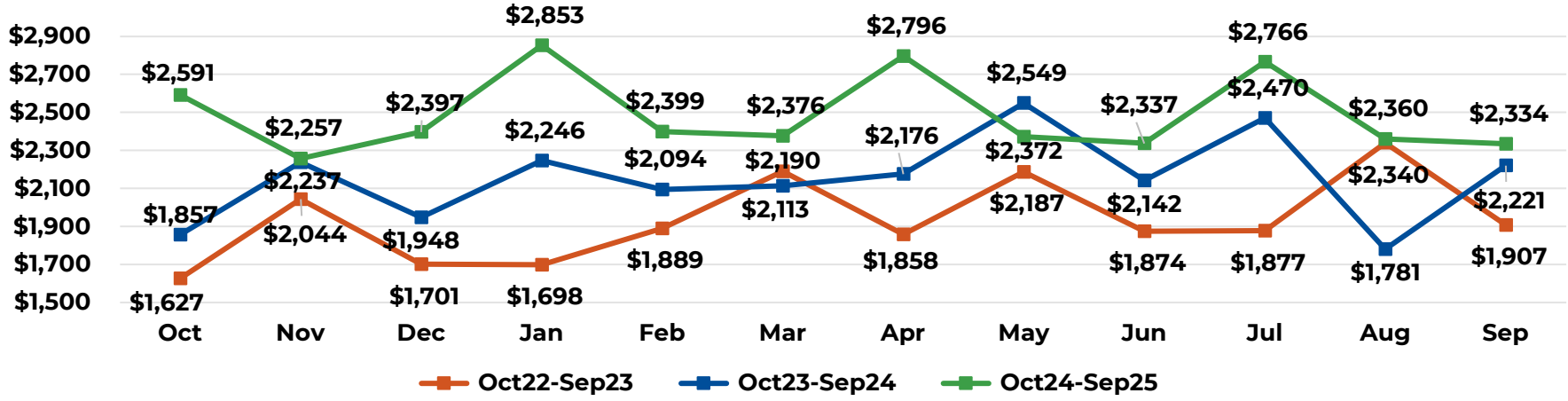


Financials (Cont.)

Average Expenditure Per Child (Under 21) Member Served

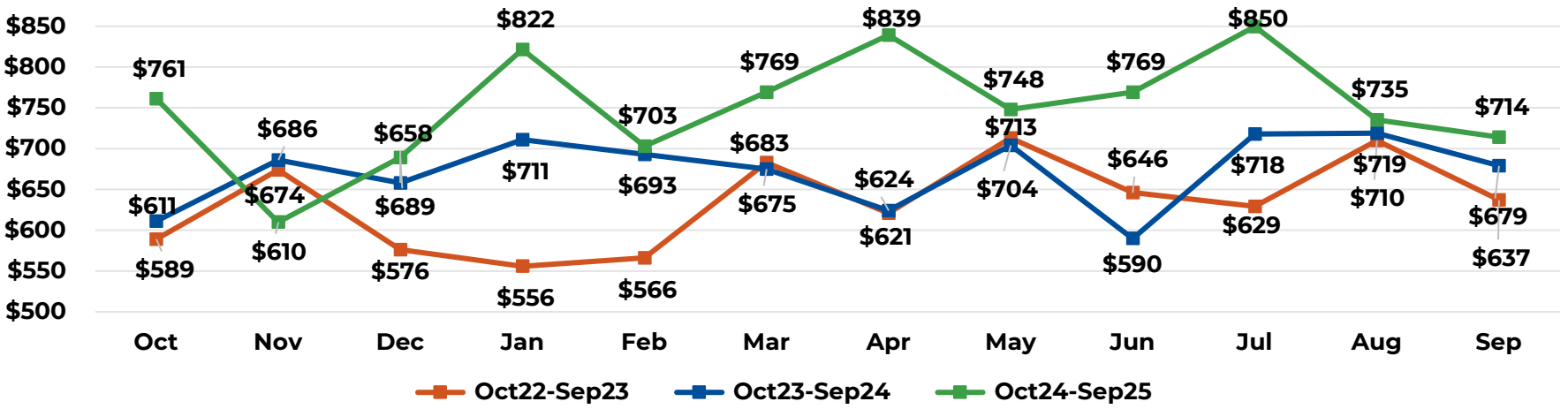


Average Expenditure Per Aged/Blind/Disabled Member Served

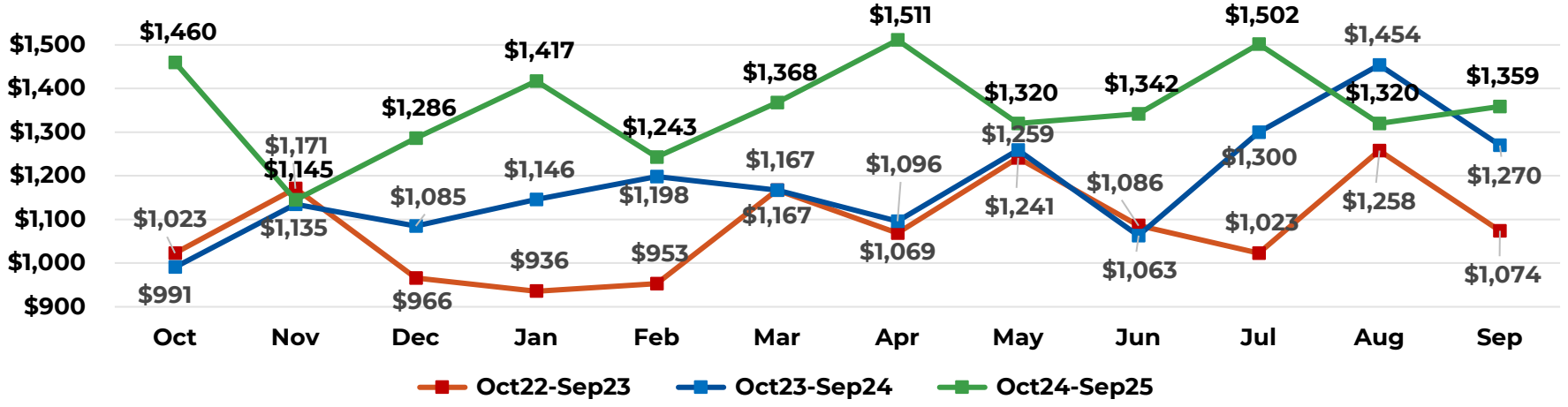


Financials (Cont.)

Average Expenditure Per Children & Parent/Caretaker Member Served

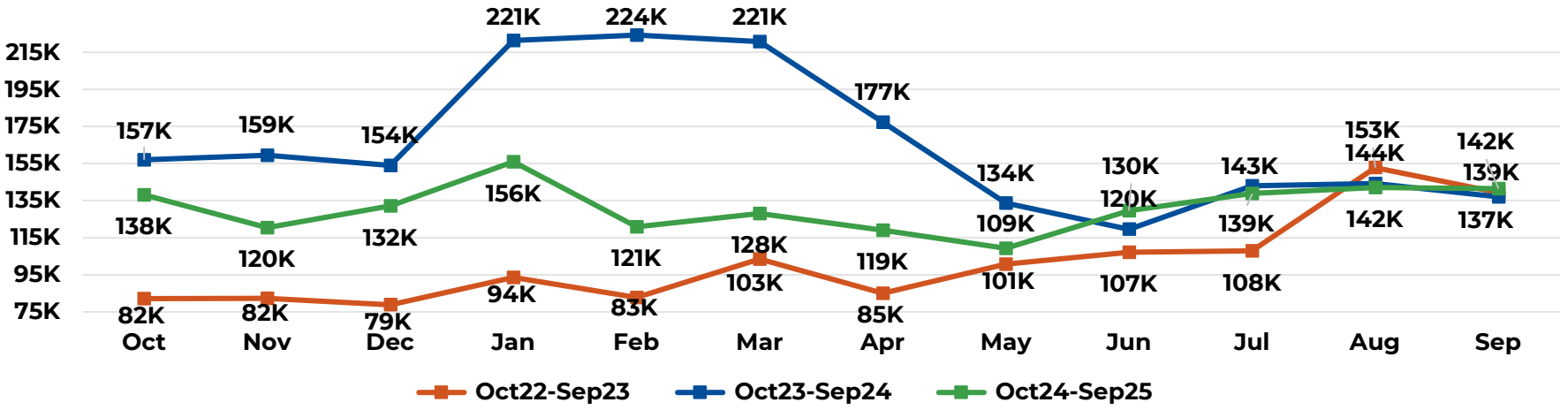


Average Expenditure Per Expansion Member Served

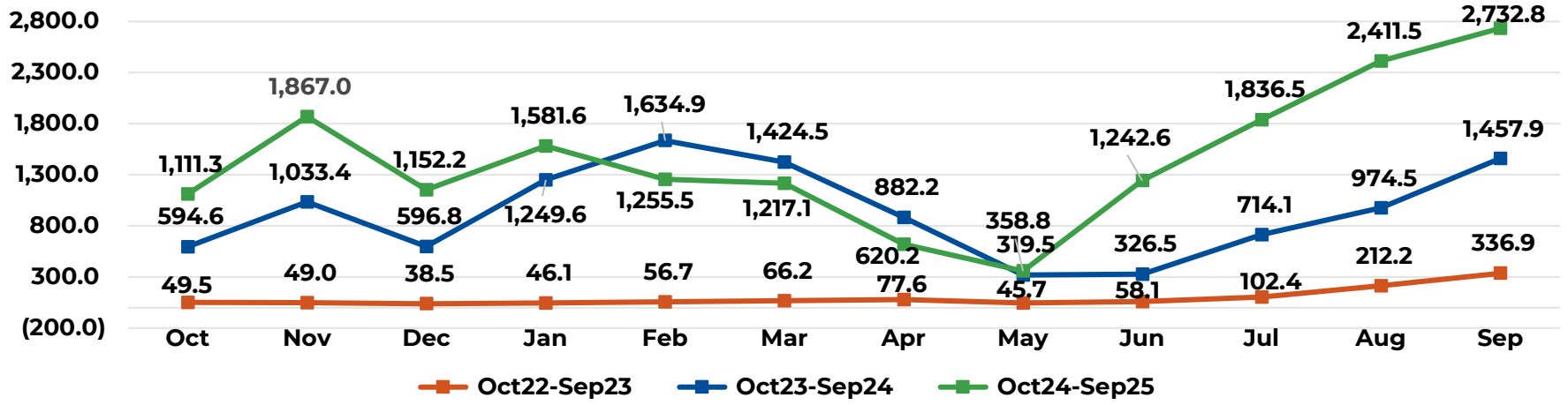


Call Center

Call Center - Member Calls Answered

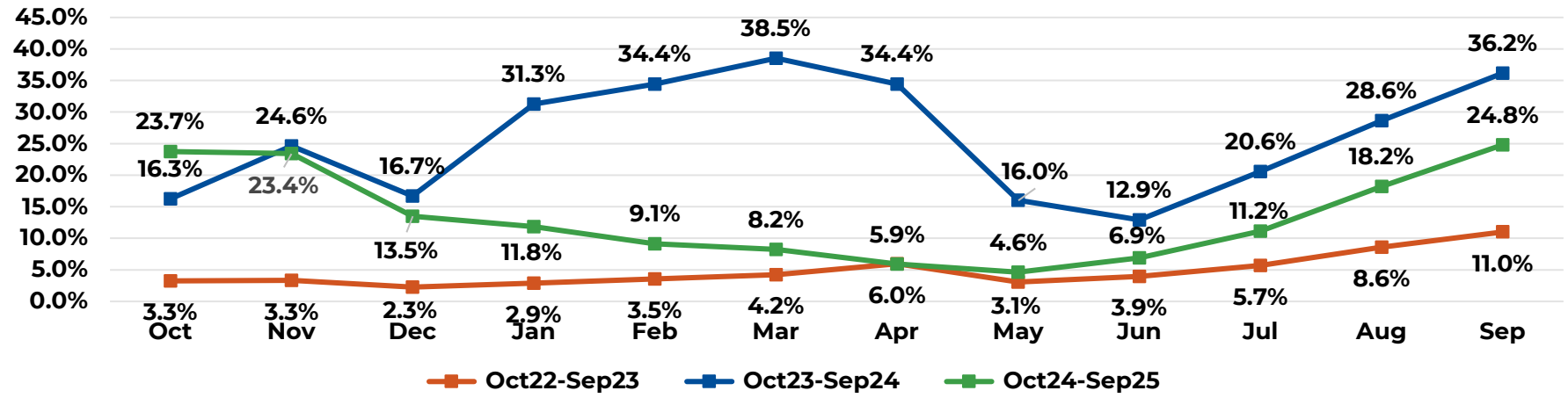


Call Center - Average Wait Time (In Seconds)



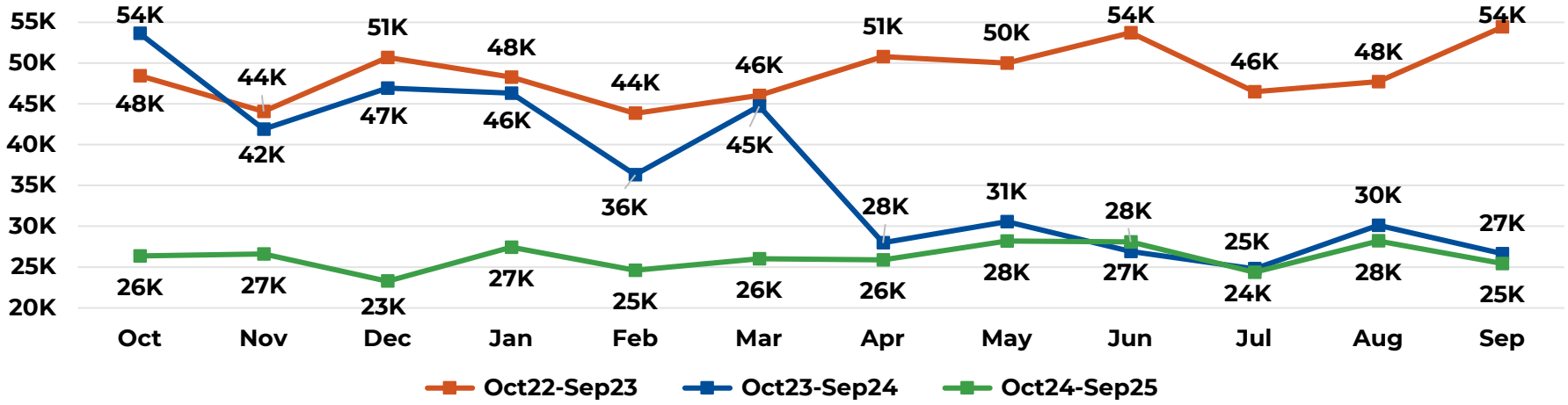
Call Center (Cont.)

Call Center - Abandoned Call Rate



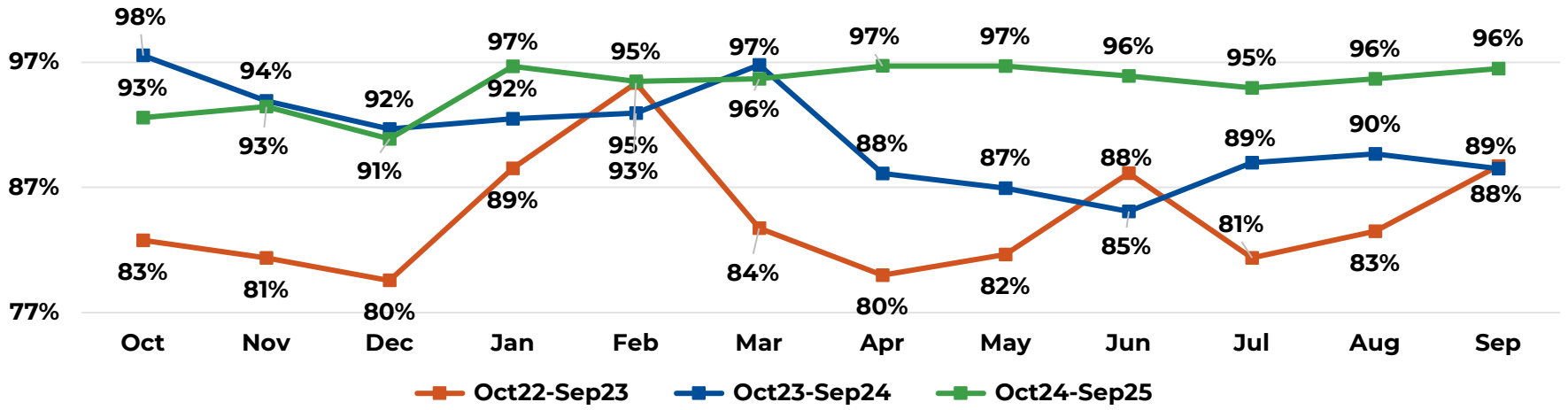
Prior Authorization

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



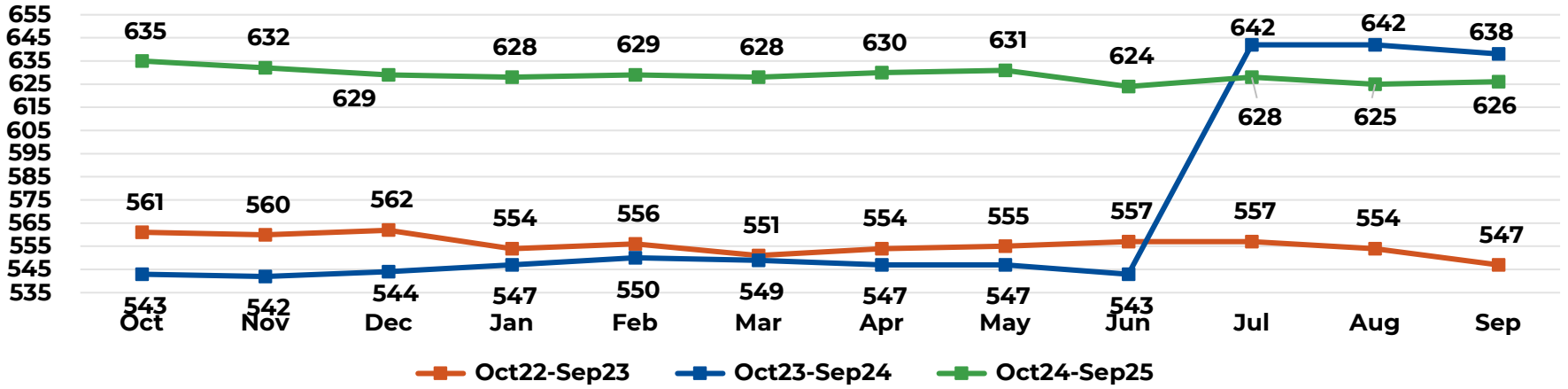
Prior Authorization (Cont.)

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



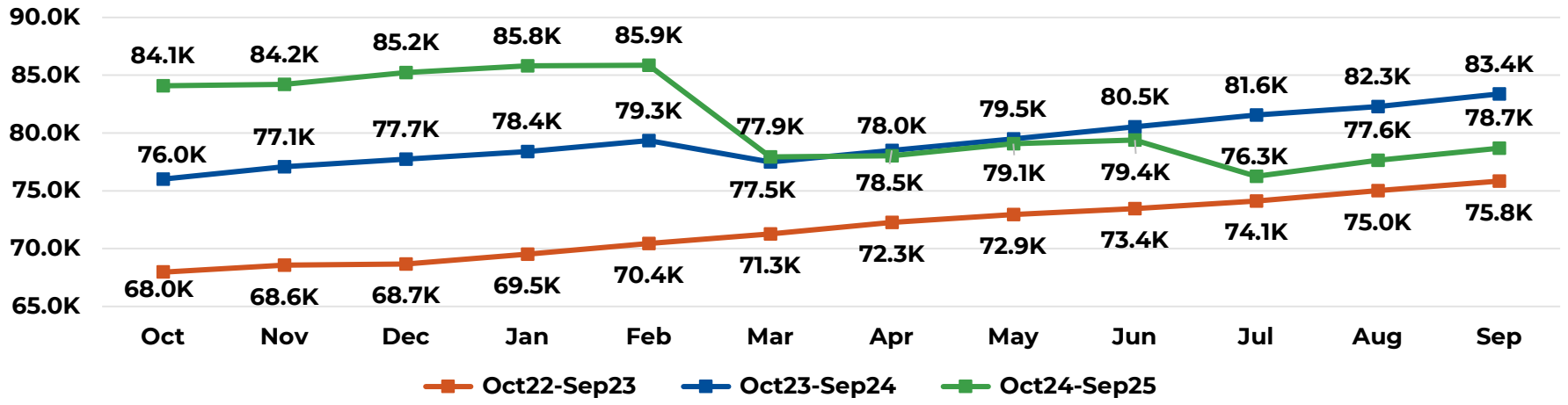
Agency Stats & Provider Network

OHCA Admin - Number of FTEs

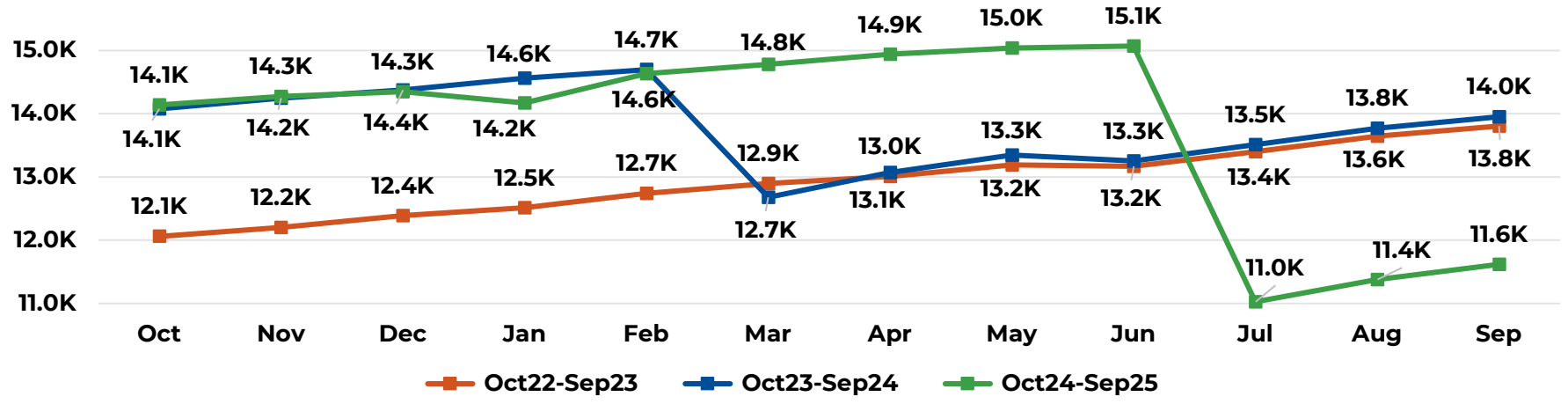


Agency Stats & Provider Network (Cont.)

Total Providers Enrolled

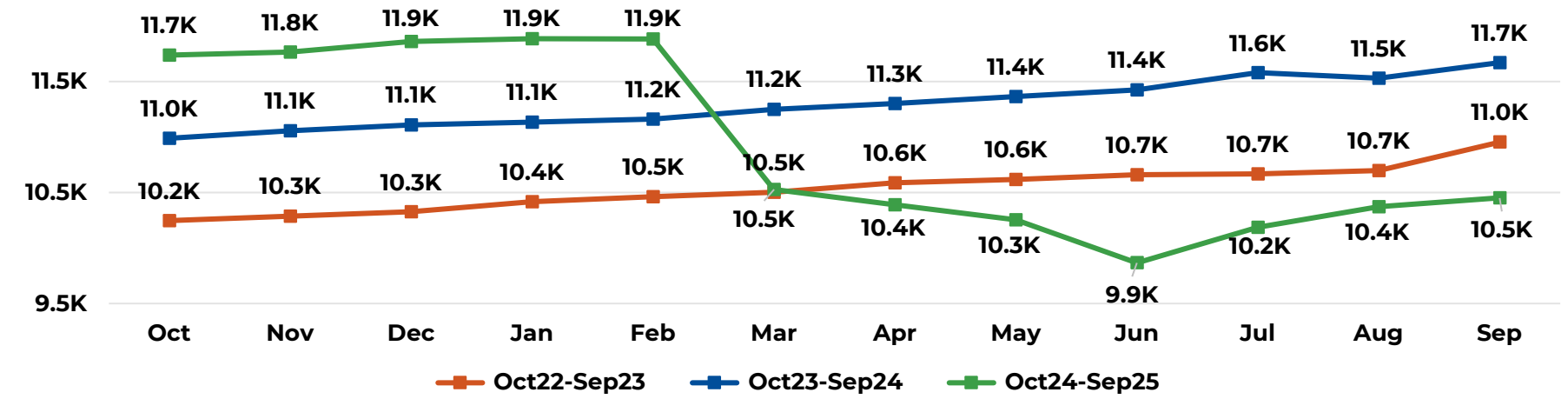


Mental Health Providers Enrolled (In-State Only)

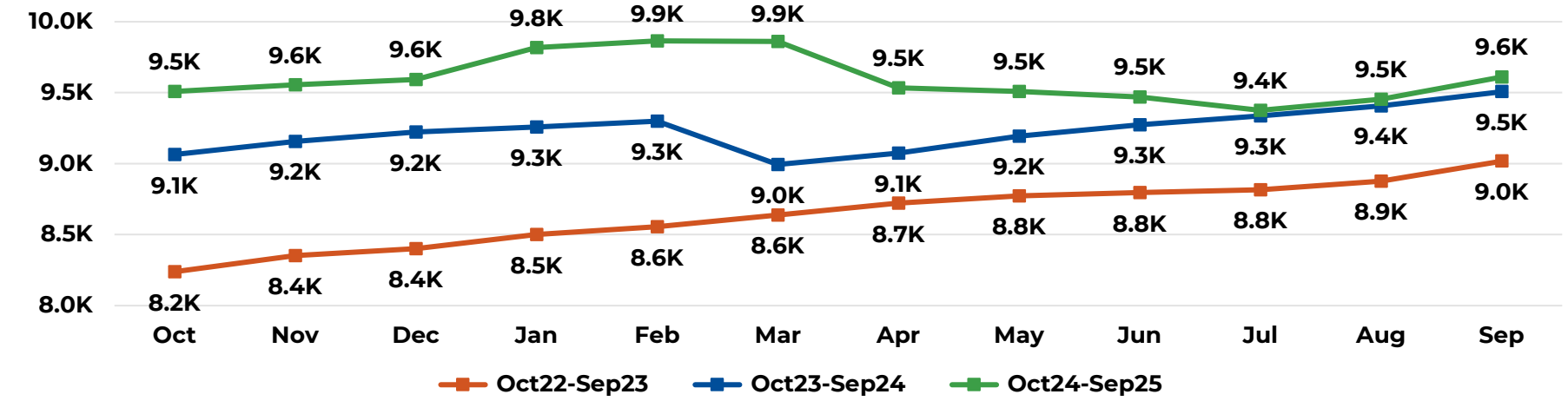


Agency Stats & Provider Network (Cont.)

Physicians Enrolled (In-State Only)

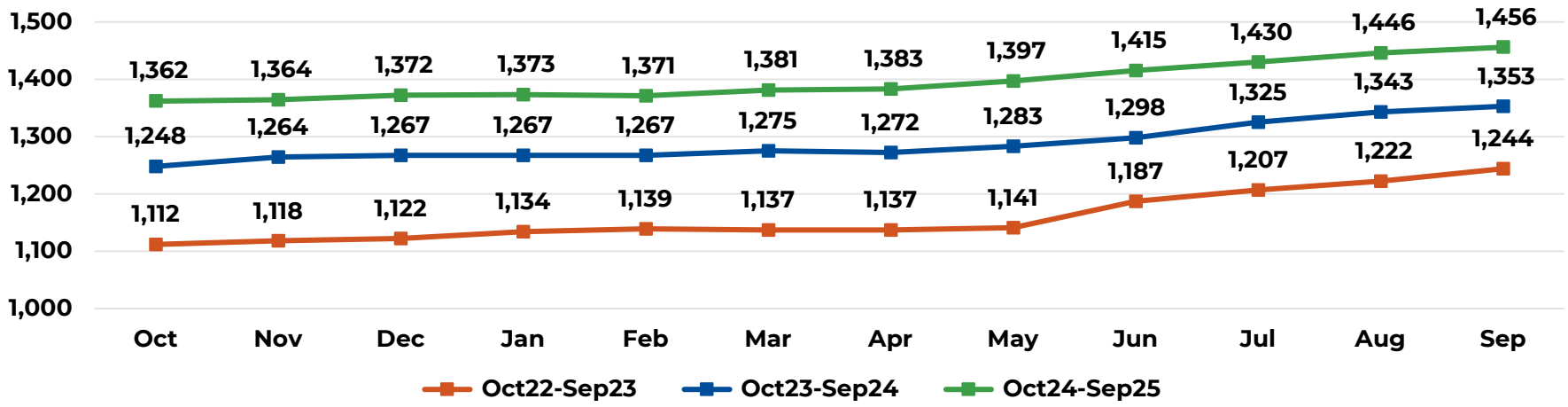


Primary Care Providers Enrolled (In-State Only)

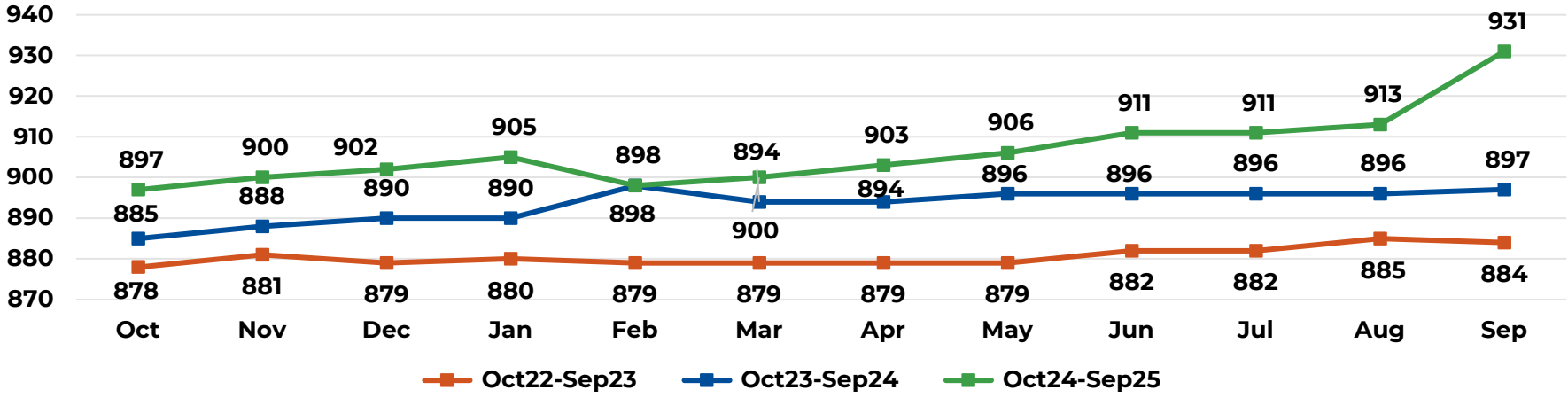


Agency Stats & Provider Network (Cont.)

Dentists Enrolled (In-State Only)

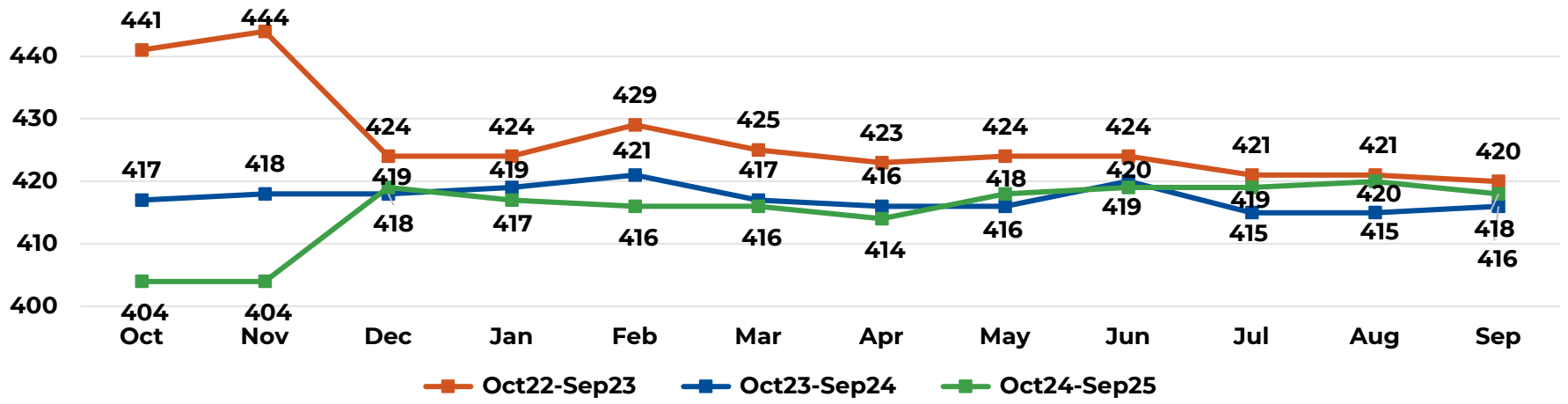


Pharmacy Enrolled (In-State Only)

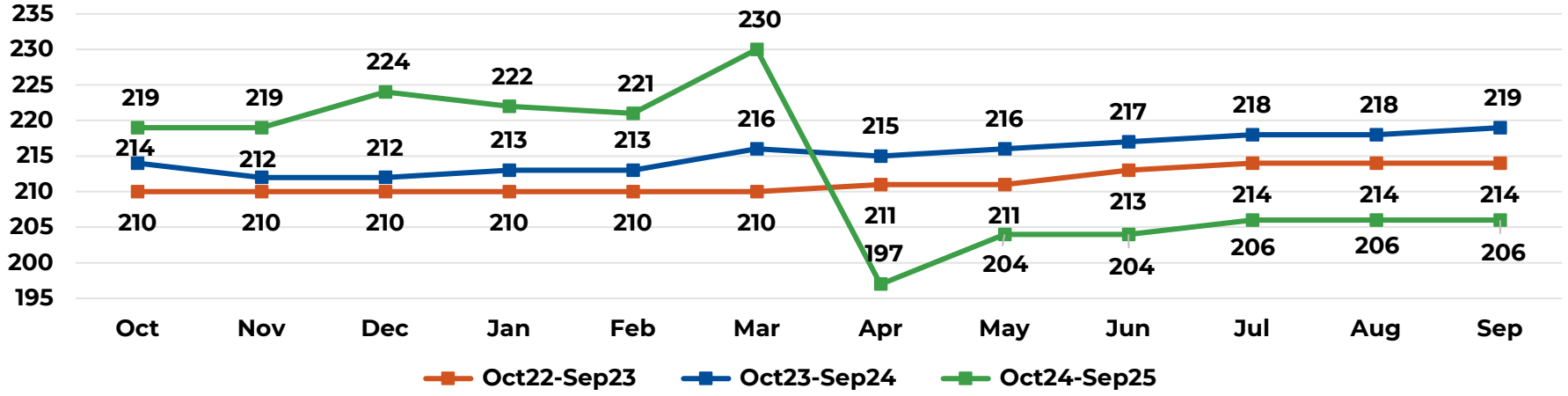


Agency Stats & Provider Network (Cont.)

Extended Care Facilities Enrolled (In-State Only)

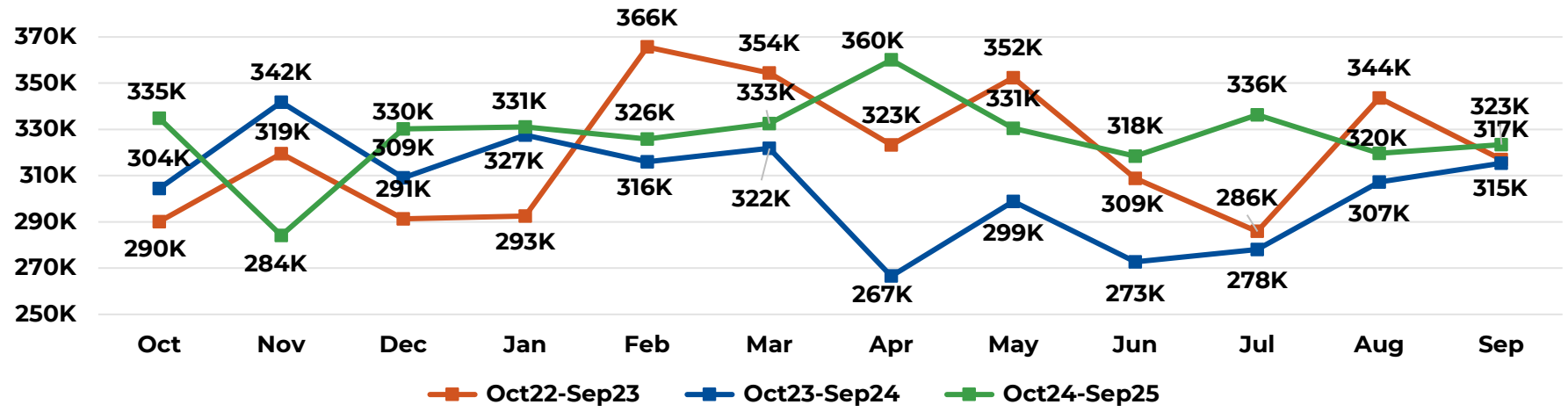


Hospitals Enrolled (In-State Only)



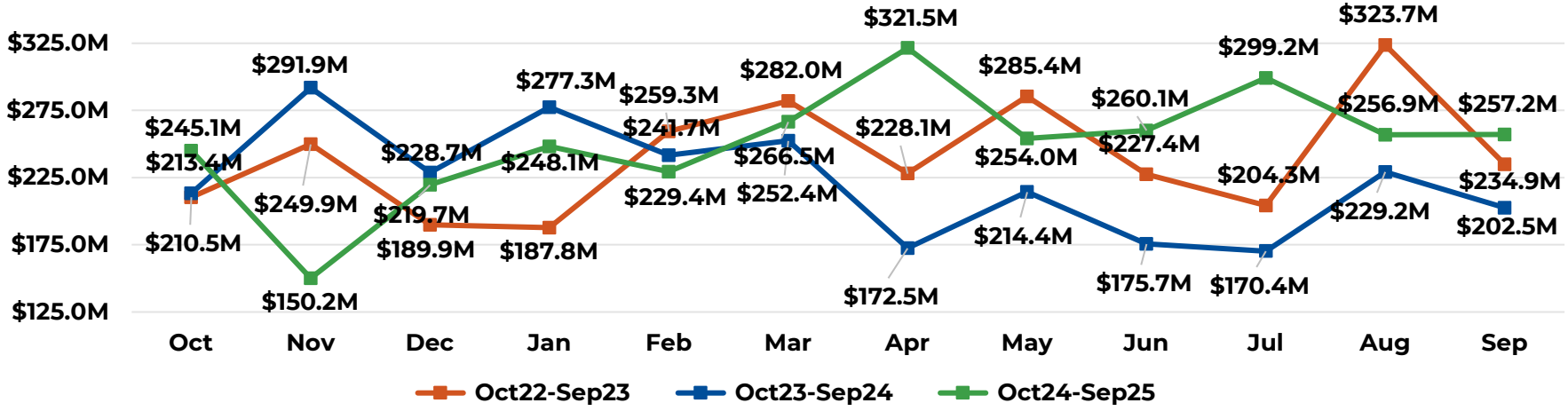
MCE Utilization

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



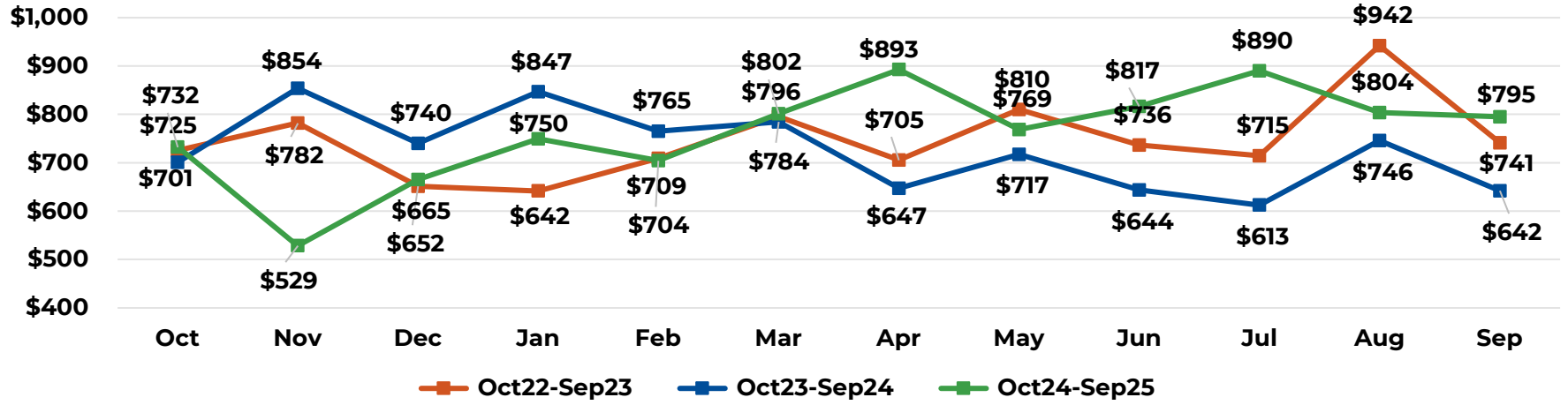
For MCE members served, expenditures and average per member, the data through June 2024 is MCE comparable group which is non ABD members eligible for MCE (Expansion, Parent/Caretaker, Non ABD Children, Full Scope Pregnant, etc.). Excludes tribal members since had low MCE opt-in. Data starting July 2024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

Total MCE Expenditures - Medical & Dental (All MCEs)

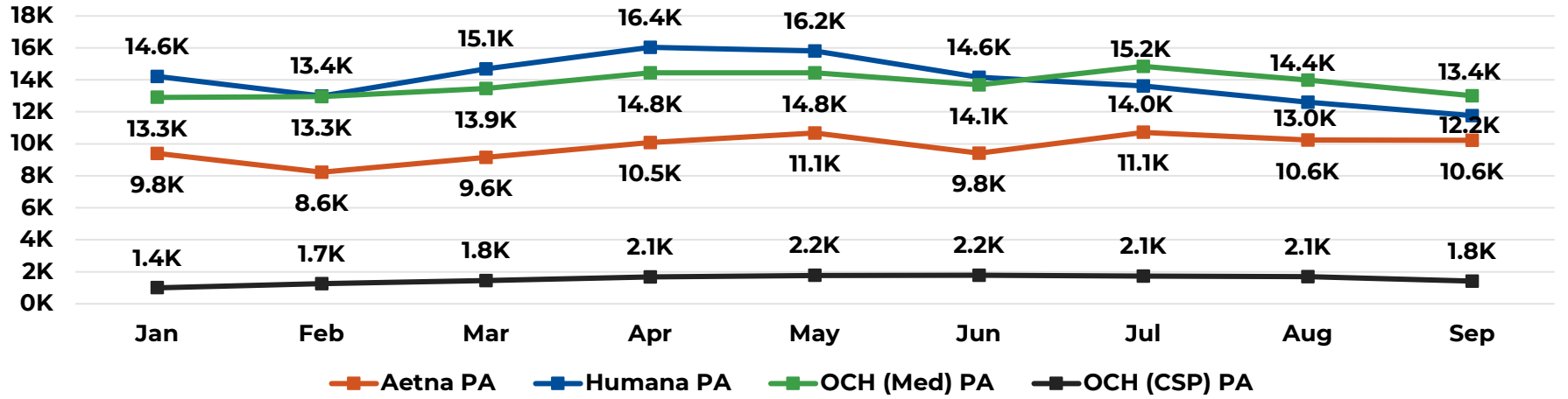


MCE Utilization (Cont.)

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

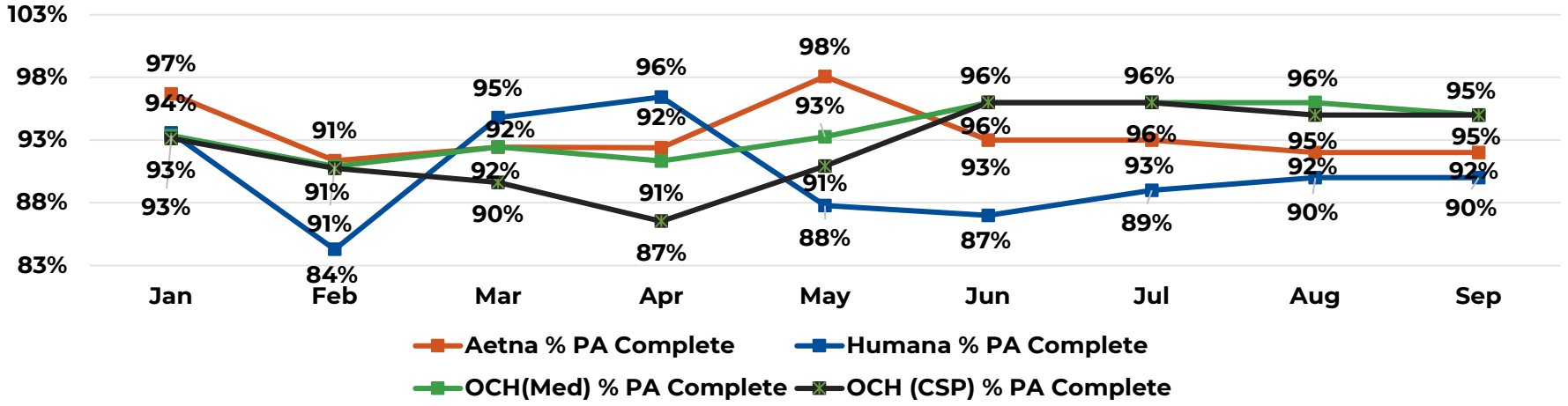


MCE Expedited & Standard Prior Authorization (Medical) - Overall PA Count

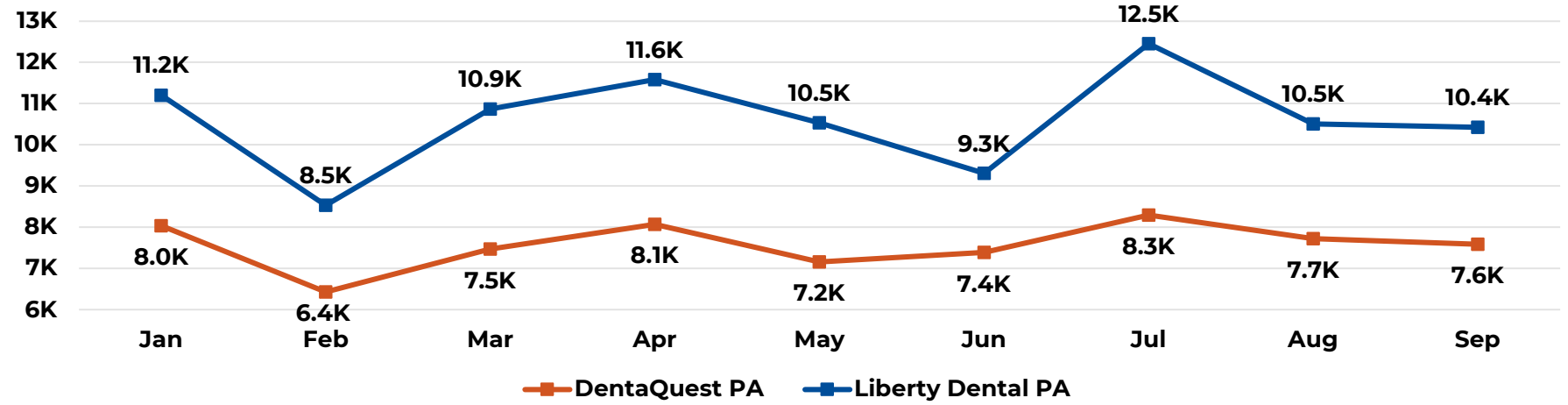


MCE Utilization (Cont.)

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

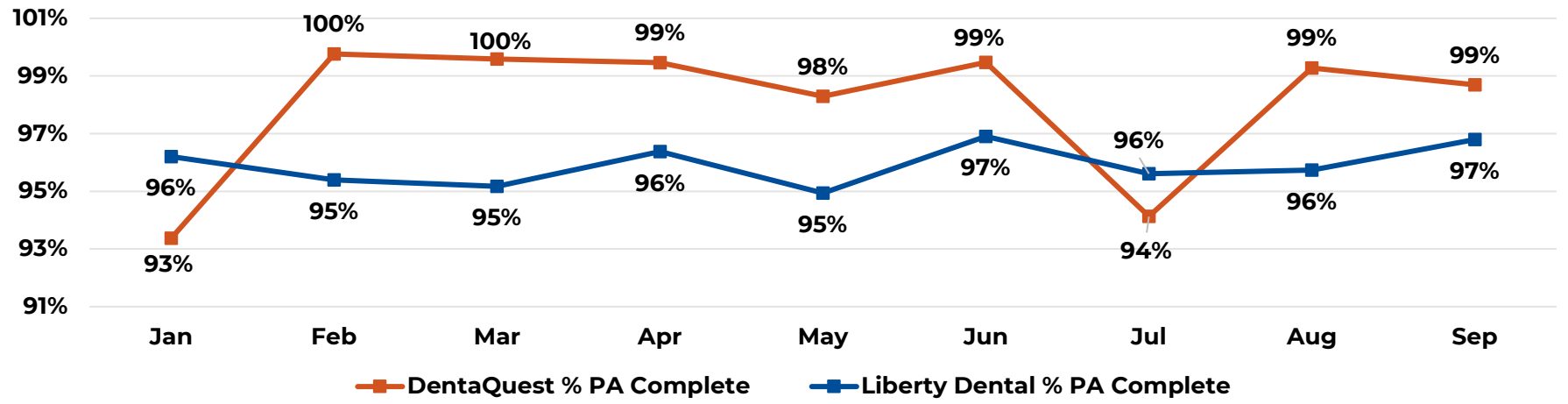


MCE Expedited & Standard Prior Authorization (Dental) - Overall PA Count



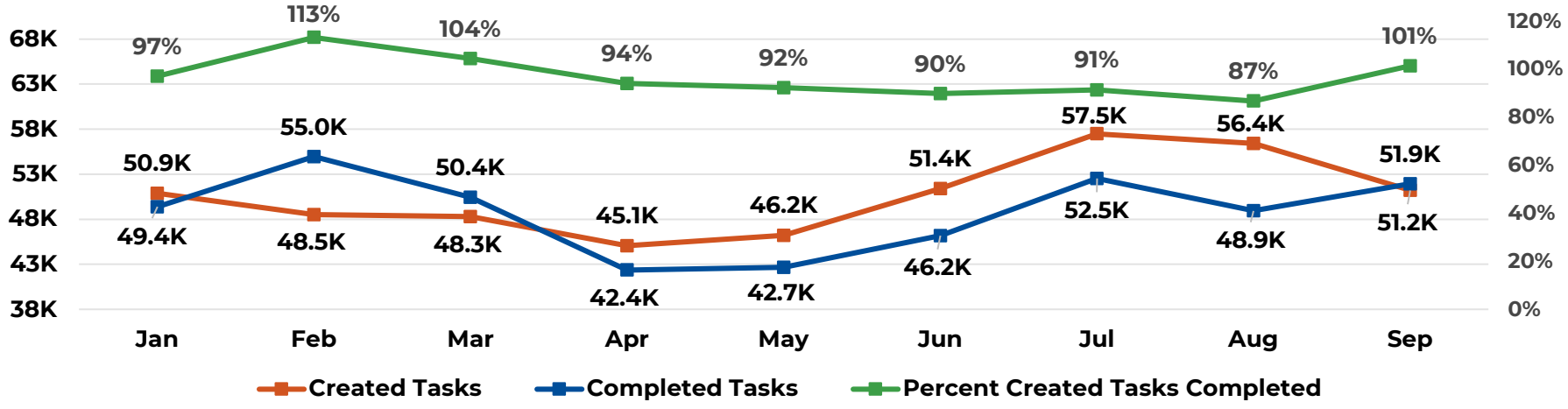
MCE Utilization (Cont.)

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



Workflow - Productivity

Created & Completed Tasks



Operational Metrics Query Notes:

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

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

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

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

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

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

Opioid data is from the Opioid dashboard MME Calculations files.

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

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

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

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

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

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

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