



Center for Medicaid and CHIP Services

September 6, 2013

Nico Gomez
Chief Executive Officer
Oklahoma Health Care Authority
2401 N.W. 23rd Street, Suite 1A
Oklahoma City, OK 73107

Dear Mr. Gomez:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) approves your request to amend the “SoonerCare” Medicaid section 1115 demonstration (No. 11-W-00048/6) in order to not disrupt the coverage currently afforded in Oklahoma as the state continues to consider its coverage options. The Insure Oklahoma component of the SoonerCare demonstration, as amended, will continue to receive federal financial participation at the state’s regular federal medical assistance percentage (FMAP) for one year, until December 31, 2014. The larger ‘SoonerCare’ demonstration remains unchanged and in effect from the date of the approval letter through December 31, 2015, upon which date, unless reauthorized, all waivers and authorities granted to operate this demonstration will expire.

Our approval of this demonstration project is subject to the limitations specified in the enclosed lists of waiver and expenditure authorities. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been specifically waived or, with respect to expenditure authorities, listed as not applicable to expenditures for demonstration populations and other services not covered under the state plan. In addition, this amendment incorporates technical changes to the Special Terms and Conditions (STCs) that the state requested. As agreed, in light of the coverage options that will be available to residents of Oklahoma beginning on January 1, 2014, as of that date the Insure Oklahoma Individual Plan portion of the demonstration will be limited to certain adults with incomes under 100 percent of the federal poverty level, and we will continue to work with you on a transition plan to facilitate a seamless transfer of coverage to the Marketplace for those currently enrolled in the demonstration with incomes above that level.

This demonstration approval is conditional upon acceptance and compliance with the enclosed STCs defining the nature, character, and extent of anticipated federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of the STCs, waiver, and expenditure authorities within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Shanna Wiley. She is available to answer any

questions concerning your section 1115 demonstration. Ms. Wiley's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid & CHIP Services
Division of State Demonstrations and Waivers
7500 Security Boulevard, Mailstop: S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-1370
E-mail: Shanna.Wiley@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Wiley and to Mr. Bill Brooks, Associate Regional Administrator in our Dallas Regional Office. Mr. Brooks' contact information is as follows:

Centers for Medicare & Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202
Telephone: (214) 767-4461
E-mail: Bill.Brooks@cms.hhs.gov

If you have questions regarding this correspondence, please contact Mr. Eliot Fishman, Director, Children and Adults Health Programs Group, Center for Medicaid & CHIP Services, at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

/s/

Cindy Mann
Director

Enclosures

cc: Eliot Fishman, Director, Children and Adults Health Programs Group
Bill Brooks, Associate Regional Administrator, CMS Dallas Regional Office
Lynn Ward, CMS Dallas Regional Office
Shanna Wiley, CMCS

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00048/6
TITLE: SoonerCare
AWARDEE: Oklahoma Health Care Authority (OHCA)

Under the authority of section 1115(a)(1) of the Social Security Act (Act), the following waivers are granted to enable Oklahoma to operate the Oklahoma SoonerCare Medicaid section 1115 demonstration. These waivers are effective beginning September 6, 2013, the date of approval, through December 31, 2015 and are limited to the extent necessary to achieve the objectives described below. They may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in an accompanying document.

All requirements of the Medicaid program expressed in law, regulation, and policy statements, not expressly waived in this list, shall apply to the demonstration project for the period beginning September 6, 2013, through December 31, 2015.

1. Statewideness/Uniformity **Section 1902(a)(1)**

To enable the state to provide Health Access Networks (HANs) only in certain geographical areas of the State.

2. Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to restrict beneficiaries' freedom of choice of care management providers, and to use selective contracting that limits freedom of choice of certain provider groups to the extent that the selective contracting is consistent with beneficiary access to quality services. No waiver of freedom of choice is authorized for family planning providers.

3. Retroactive Eligibility **Section 1902(a)(34)**

To enable the state to waive retroactive eligibility for demonstration participants, with the exception of Tax Equity and Fiscal Responsibility Act (TEFRA) and Aged, Blind, and Disabled populations.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00048/6
TITLE: SoonerCare
AWARDEE: Oklahoma Health Care Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Oklahoma identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, beginning September 6, 2013 through December 31, 2015, be regarded as expenditures under the state's title XIX plan (except to the extent an earlier expiration date is indicated below). These expenditure authorities are granted to enable the state to operate its Oklahoma SoonerCare section 1115 demonstration and may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in an accompanying document.

All requirements of the Medicaid program expressed in law, regulation and policy statements, not expressly waived or identified as not applicable to these expenditure authorities, shall apply to the SoonerCare demonstration project for the period of this demonstration extension.

1. **Demonstration Population 5.** Expenditures for health benefits coverage for individuals who are "Non-Disabled Low Income Workers" age 19–64 years who work for a qualifying employer and have income above the Medicaid standard, but no more than 200 percent of the federal poverty level (FPL), and their spouses, and are Medicaid-eligible. This expenditure authority expires December 31, 2014.
2. **Demonstration Population 6.** Expenditures for health benefits coverage for individuals who are "Working Disabled Adults" 19-64 years of age who work for a qualifying employer who have income up to 200 percent of the FPL and are Medicaid eligible. This expenditure authority expires December 31, 2014.
3. **Demonstration Population 8.** Expenditures for health benefits coverage for no more than 3,000 individuals at any one time who are full-time college students age 19 through age 22 and have income not to exceed 200 percent of the FPL, who have no creditable health insurance coverage, work for a qualifying employer, and are Medicaid-eligible. This expenditure authority expires December 31, 2014.
4. **Demonstration population 10.** Expenditures for health benefits coverage for foster parents who work for an eligible employer, and their spouses with household incomes no greater than 200 percent of the FPL. This expenditure authority expires December 31, 2014.

5. **Demonstration Population 11.** Expenditures for health benefits coverage for individuals who are employees and spouses of not-for-profit businesses with 500 or fewer employees, work for a qualifying employer, and with household incomes no greater than 200 percent of the FPL. This expenditure authority expires December 31, 2014.
6. **Demonstration Population 12.** Effective through December 31, 2013, expenditures for health benefits coverage for individuals who are “Non-Disabled Low Income Workers” age 19–64 years whose employer elects not to participate in the Premium Assistance Employer Coverage Plan, who are self-employed, or unemployed, and have income above the Medicaid standard, but no more than 200 percent of the FPL, and their spouses, and are Medicaid-eligible. Effective January 1, 2014, expenditures for health benefits coverage for individuals who are “Non-Disabled Low Income Workers” age 19–64 years whose employer elects not to participate in the Premium Assistance Employer Coverage Plan, who are self-employed, or unemployed, and have income above the Medicaid standard, but no more than 100 percent of the FPL, and their spouses, and are Medicaid-eligible. This expenditure authority expires December 31, 2014.
7. **Demonstration Population 13.** Effective through December 31, 2013, expenditures for health benefits coverage for individuals who are “Working Disabled Adults” 19-64 years of age whose employer elects not to participate in the Premium Assistance Employer Coverage Plan, as well as those who are self-employed, or unemployed (and seeking work), who have income up to 200 percent of the FPL and are Medicaid eligible. Effective January 1, 2014, expenditures for health benefits coverage for individuals who are “Working Disabled Adults” 19-64 years of age whose employer elects not to participate in the Premium Assistance Employer Coverage Plan, as well as those who are self-employed, or unemployed (and seeking work), who have income up to 100 percent of the FPL and are Medicaid eligible. This expenditure authority expires December 31, 2014.
8. **Demonstration Population 14.** Effective through December 31, 2013, expenditures for health benefits coverage for no more than 3,000 individuals at any one time who are full-time college students age 19 through age 22 and have income not to exceed 200 percent of the FPL, who have no creditable health insurance coverage, do not have access to the Premium Assistance Employer Coverage Plan, and are Medicaid-eligible. Effective January 1, 2014, expenditures for health benefits coverage for no more than 3,000 individuals at any one time who are full-time college students age 19 through age 22 and have income not to exceed 100 percent of the FPL, who have no creditable health insurance coverage, do not have access to the Premium Assistance Employer Coverage Plan, and are Medicaid-eligible. This expenditure authority expires December 31, 2014.
9. **Demonstration Population 15.** Effective through December 31, 2013, expenditures for health benefits coverage for individuals who are working foster parents, whose employer elects not to participate in Premium Assistance Employer Coverage Plan, and their spouses with household incomes no greater than 200 percent of the FPL. Effective January 1, 2014, expenditures for health benefits coverage for individuals who are working foster parents, whose employer elects not to participate in Premium Assistance Employer Coverage Plan,

and their spouses with household incomes no greater than 100 percent of the FPL. This expenditure authority expires December 31, 2014.

10. **Demonstration Population 16.** Effective through December 31, 2013, expenditures for health benefits coverage for individuals who are employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 200 percent of the FPL, and do not have access to the Premium Assistance Employer Coverage Plan. Effective January 1, 2014, expenditures for health benefits coverage for individuals who are employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 100 percent of the FPL, and do not have access to the Premium Assistance Employer Coverage Plan. This expenditure authority expires December 31, 2014.
11. **Health Access Networks Expenditures.** Expenditures for Per Member Per Month payments made to the Health Access Networks for case management activities.
12. **Premium Assistance Beneficiary Reimbursement.** Expenditures for reimbursement of costs incurred by individuals enrolled in the Premium Assistance Employer Coverage Plan and in the Premium Assistance Individual Plan that are in excess of 5 percent of annual gross family income. This expenditure authority expires December 31, 2014.
13. **Health Management Program.** Expenditures for otherwise non-covered costs to provide health coaches and practice facilitation services through the Health Management Program.

Title XIX Requirements Not Applicable to the Demonstration Expenditure Authorities

Not Applicable to Demonstration Populations 5, 6, 8, 10, 11, 12, 13, 14, 15, and 16.

1. Comparability **Section 1902(a)(10)(B) and 1902(a)(17)**

To permit the state to provide different benefit packages to individuals in demonstration populations 5, 6, 8, 10 and 11 who are enrolled in the Premium Assistance Employer Coverage Plan that may vary by individual. This not applicable authority expires December 31, 2014.

2. Cost Sharing Requirements **Section 1902(a)(14)
insofar as it incorporates Section 1916**

To permit the state to impose premiums, deductions, cost sharing, and similar charges that exceed the statutory limitations to individuals in populations 5, 6, 8, 10 and 11 who are enrolled in the Premium Assistance Employer Coverage Plan. This not applicable authority expires December 31, 2014.

3. Freedom of Choice **Section 1902(a)(23)(A)**

To permit the state to restrict the choice of provider for beneficiaries eligible under

populations 5, 6, 8, 10 and 11 enrolled in the Premium Assistance Employer Coverage Plan. This not applicable authority expires December 31, 2014. No waiver of freedom of choice is authorized for family planning providers.

4. Retroactive Eligibility **Section 1902(a)(34)**

To enable the state to not provide retroactive eligibility for demonstration participants in populations 5, 6, 8, 10, 11, 12, 13, 14, 15, and 16. This not applicable authority expires December 31, 2014.

5. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services **Section 1902(a)(4)(B); 1902(a)(10)(A); and 1902(a)(43)**

To exempt the state from furnishing or arranging for EPSDT services for full-time college students age 19 through age 22 who are defined in populations 8 and 14. This not applicable authority expires December 31, 2014.

6. Assurance of Transportation **Sections 1902(a)(4) and 1902(a)(19)**
42 CFR 431.53

To permit the state not to provide transportation benefits to individuals in populations 12, 13, 14, 15, and 16 enrolled in the Insure Oklahoma Premium Assistance Individual Plan.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00048/6
TITLE: SoonerCare
AWARDEE: Oklahoma Health Care Authority

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Oklahoma’s “SoonerCare” section 1115(a) Medicaid demonstration extension (hereinafter “demonstration”). The parties to this agreement are the Oklahoma Health Care Authority (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter, through December 31, 2015, unless otherwise specified.

The STCs have been arranged into the following subject areas:

- I. Preface
 - II. Program Description, Objectives, Historical Context
 - III. General Program Requirements
 - IV. Eligibility
 - V. SoonerCare Benefits and Cost Sharing
 - VI. Insure Oklahoma Premium Assistance Benefits and Cost Sharing
 - VII. Delivery Systems
 - VIII. Health Management Program
 - IX. Program Monitoring
 - X. General Reporting Requirements
 - XI. General Financial Requirements under Title XIX
 - XII. General Financial Requirements under Title XXI
 - XIII. Monitoring Budget Neutrality
 - XIV. Evaluation of the Demonstration
 - XV. Schedule of State-Mandatory Deliverables for the Demonstration Extension Period
- Attachment A. Quarterly Report Content and Format

II. PROGRAM DESCRIPTION, OBJECTIVES, HISTORICAL CONTEXT

The SoonerCare Demonstration was initially approved in January 1995. The demonstration operates under a Primary Care Case Management (PCCM) model in which the Oklahoma Health Care Authority (OHCA) contracts directly with primary care providers throughout the state to provide basic health care services. The primary care providers (PCPs) receive a monthly care

coordination payment for each enrolled beneficiary, based upon the services provided at the medical home.

The demonstration provides for a modification of the service delivery system for family and child populations and some aged and disabled populations. The benefits for individuals affected by or eligible only under SoonerCare, with the exception of individuals enrolled in the Insure Oklahoma Premium Assistance Employer Coverage and the Premium Assistance Individual Plan, are state plan benefits.

Demonstration Objectives:

Major objectives of the SoonerCare waiver program are:

- To improve access to preventive and primary care services;
- To provide each member with a medical home;
- To integrate Indian Health Service (IHS) eligible beneficiaries and IHS and tribal providers into the SoonerCare delivery system;
- To expand access to affordable health insurance for low-income working adults and their spouses; and
- To optimize quality of care through effective care management.

Demonstration Hypotheses:

The state will test the demonstration hypotheses listed in Section XIV, Evaluation of the Demonstration, including:

- *Hypothesis 1: Child Health Checkup Rates.* The rate for age-appropriate well-child and adolescent visits will improve between 2013-2015.
- *Hypothesis 8: Impact of Health Access Networks on Quality of Care.* Key quality performance measures tracked for PCPs participating in the HANs will improve between 2013-2015.
- *Hypothesis 9: Impact of Health Access Networks on Effectiveness of Care.* Average per member per month expenditures will decrease for members enrolled with PCPs participating in the HANs between 2013-2015.
- *Hypothesis 10: Health Management Program (HMP).* Health outcomes for chronic diseases will improve between 2013-2015 as a result of participation in the HMP. Total expenditures for members enrolled in HMP will decrease.

Historical Context of Demonstration Extensions and Amendments:

At the program's inception in 1995, the "SoonerCare" demonstration covered Medicaid state plan populations of AFDC (TANF) and related children and adults, including pregnant women up to the minimum federal poverty level (FPL) standards as defined by state law. The original

SoonerCare populations were separated into Urban and Rural Eligibility Groups (EGs). The Urban EG included three catchment areas: Central (Oklahoma City and surrounding areas), Northeast (Tulsa and surrounding areas) and Southwest (Lawton and surrounding areas). The Rural EG included the rest of the state. The original SoonerCare demonstration also granted authority for the state to mandatorily enroll non-Medicare Aged, Blind and Disabled (ABD) beneficiaries into managed care.

In 2005, the state expanded the demonstration's state plan breast and cervical cancer group to qualifying women under age 65 and three additional eligibility groups, including: low income non-disabled workers and spouses employed by small employers; working disabled adults; and children eligible pursuant to the state option under 1902(e)(3) of the Act (TEFRA children).

On January 3, 2009, CMS approved amendments that:

- a) Changed the service delivery model from a Prepaid Ambulatory Health Plan (PAHP) to an exclusive Primary Case Management (PCCM) model;
- b) Added an expansion population to the state's Employer Sponsored Insurance program, Insure Oklahoma, for full-time college students age 19 through age 22 not to exceed 200 percent of the federal poverty level (FPL), up to a cap of 3,000 participants;
- c) Expanded the size of employers who can participate in Insure Oklahoma, from 50 employees to 250 employees;
- d) Expanded the description of qualified PCPs to permit County Health Departments to serve as medical homes for beneficiaries who choose these providers;
- e) Included an option for the voluntary enrollment of children in state or tribal custody in the SoonerCare demonstration;
- f) Implemented a new "Payments for Excellence" program to build upon the current Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and Fourth Diphtheria, Tetanus and Pertussis (DTaP) Bonus program; and,
- g) Amended cost sharing requirements for the Insure Oklahoma Program and added a \$1 co-pay for non-pregnant adults in SoonerCare.

The following programmatic changes were approved under the SoonerCare demonstration extension that was effective January 1, 2010.

- a) Approval of the Health Access Network (HAN) pilot program;
- b) Expanded eligibility under the Insure Oklahoma program to non-disabled working adults and their spouses, disabled working adults, and full-time college students, from 200 percent of the FPL up to and including 250 percent of the FPL;

- c) Added two new eligibility groups under the Insure Oklahoma program for foster parents up to and including 250 percent of the FPL and for not-for profit businesses having fewer than 500 employees, up to and including 250 percent of the FPL.

On August 1, 2011, CMS approved an amendment that eliminated the \$10 co-pay for the initial pre-natal visit under the Insure Oklahoma, Individual Plan.

The following programmatic changes were approved under the SoonerCare demonstration extension that was effective January 1, 2013.

- a) CMS has removed the waiver authority that allowed the state to exclude parental income in determining eligibility for disabled children eligible in the TEFRA category because the state has this authority under the state plan.
- b) Financial eligibility under the Insure Oklahoma program for all populations was reduced from up to and including 250 percent of FPL to up to and including 200 percent of FPL.
- c) CMS has approved a limitation on the adult outpatient behavioral health benefit in the Insure Oklahoma individual plan to limit the number of visits to 48 per year consistent with the limitation on behavioral health visits for children. This benefit is limited to individual licensed behavioral health professionals (LBHP).
- d) CMS has approved an amendment to the Health Management Program (HMP), as reflected in Section VII to rename nurse care managers as health coaches and to increase face-to-face care management by embedding health coaches within physician practices with the highest concentration of members with chronic illnesses.

The following programmatic changes are approved under the SoonerCare demonstration amendment effective as of the date of the approval letter, and the SoonerCare demonstration was extended through December 31, 2015 except as otherwise noted.

- a) The Title XXI Targeted Low-Income Child eligibility group for children ages 0-18 was added to the mandatory state plan group chart.
- b) Eligibility under the Insure Oklahoma program for populations eligible for the Individual Plan from up to and including 200 percent of the FPL has been reduced to up to and including 100 percent of FPL. Because the eligibility levels are no longer the same as those for individuals with employer-sponsored coverage, the previously authorized demonstration populations were limited to the employer-based coverage populations, and new demonstration populations were separately defined for the individual plan coverage populations. These new demonstration populations have been added to the Expenditure Authorities and Demonstration Expansion Groups in the eligibility chart. This includes: non-disabled working adults and their spouses; disabled working adults; employees of not-for profit businesses having fewer than 500 employees; foster parents and full-time college students.

- c) The authority for Insure Oklahoma populations was extended only through December 31, 2014.
- d) The following groups were added to the SoonerCare Eligibility Exclusions:
 - Individuals in the Former Foster Care group; and
 - Pregnant women with incomes between 134 percent and 185 percent FPL.
- e) Language was added to reference the fact income will be calculated using Modified Adjusted Gross Income (MAGI) for determination of SoonerCare eligibility.
- f) The charts listing the Individual Plan benefits and the Insure Oklahoma cost-sharing were deleted and language was added to reference the state changing the benefits and cost-sharing to align with federal regulations.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.
3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The

modified agreements will be effective upon the implementation of the change. The trend rates for budget neutrality agreements are not subject to change under this subparagraph.

- b) If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. State Plan Amendments. The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes to any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs.

6. Changes Subject to the Amendment Process. Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, sources of non-federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to, failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein. Amendment requests must include, but are not limited to, the following:

- a) An explanation of the public process used by the state, consistent with the requirements of STC 16, to reach a decision regarding the requested amendment;
- b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c) An up-to-date CHIP allotment neutrality worksheet, if necessary;

- d) A detailed description of the amendment, including the impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX or XXI state plan amendment, if necessary; and,
- e) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration.

- a) States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.
- b) As part of the demonstration extension request, the state must provide documentation of compliance with the transparency requirements in 42 CFR section 431.412 and the public notice requirements outlined in paragraph 16, as well as include the following supporting documentation:
 - i. **Historical Narrative Summary of the Demonstration Project:** The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
 - ii. **Special Terms and Conditions (STCs):** The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
 - iii. **Waiver and Expenditure Authorities:** The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
 - iv. **Quality:** The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) state quality assurance monitoring, and any other documentation of the quality of care provided or corrective action taken under the demonstration.
 - v. **Financial Data:** The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the

state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP allotment neutrality worksheet must be included.

- vi. Evaluation Report: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.
- vii. Documentation of Public Notice 42 CFR §431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in section 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements;

- a) Notification of Suspension or Termination: The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation State Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- b) Phase-out Plan Requirements: The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- c) Phase-out Procedures: The state must comply with all notice requirements found in

42 CFR sections 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.

- d) Federal Financial Participation (FFP): If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration transition and expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a) Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- b) Expiration Procedures: The state must comply with all notice requirements found in 42 CFR sections 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR sections 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR section 431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- c) Federal Public Notice: CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR section 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
- d) Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs

associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

- 11. CMS Right to Terminate or Suspend.** CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS shall promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.
- 12. Federal Financial Participation.** No federal matching funds for expenditures for this demonstration will be made available to the state until the effective date identified in the demonstration approval letter.
- 13. Finding of Non-Compliance.** The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.
- 14. Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.
- 15. Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
- 16. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must continue to comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

In states with federally recognized Indian tribes, Indian health programs, and / or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal,

amendment, and /or renewal of this demonstration. In the event that the state conducts additional consultation activities consistent with these requirements prior to the implementation of the demonstration, documentation of these activities must be provided to CMS .

17. Post Award Forum. Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 53, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 54.

18. Compliance with Managed Care Regulations. The state must comply with the managed care regulations at 42 CFR section 438 *et. seq.*, except as expressly waived or identified as not applicable in the expenditure authorities incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR section 438.6.

IV. ELIGIBILITY

19. Use of Modified Adjusted Gross Income (MAGI) Based Methodologies For Demonstration Groups. Mandatory and optional state plan groups described below derive their eligibility through the Medicaid State Plan, and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid State Plan, except as expressly waived in this demonstration and as described in these STCs. Any Medicaid State Plan Amendments to the eligibility standards and methodologies for these eligibility groups, including the conversion to a MAGI standard October 1, 2013, will apply to this demonstration. These state plan eligible beneficiaries are included in the demonstration for use of the managed care network and access to additional benefits not described in the state plan.

20. State Plan Populations Affected. Title XIX and title XXI populations are affected by the demonstration:

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 57)
Pregnant women and infants under age 1 1902(a)(10)(A)(i)(IV)	Up to and including 133 % FPL	Freedom of Choice, Retroactive Eligibility	Populations 1,2,3,4
Children 1-5 1902(a)(10)(A)(i)(VI)	Up to and including 133 % FPL	As Above	Populations 1,2,3,4
Children 6-18 1902(a)(10)(A)(i)(VII)	Up to and including 133% FPL	As Above	Populations 1,2,3,4
IV-E Foster Care or Adoption Assistance Children	Automatic Medicaid eligibility	As Above	Populations 1,2,3,4
1931 low-income families	73% of the AFDC standard of need.	As above	Populations 1,2,3,4
SSI recipients	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Pickle amendment	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Early widows/widowers	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Disabled Adult Children (DACs)	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
1619(b)	SSI for unearned income and earned income limit is the 1916(b) threshold amount for Disabled SSI members, as updated annually by the SSA.	Freedom of Choice	Populations 1,2,3,4
Targeted Low-Income Child	Up to and including 133% FPL	As Above	Population 9

Optional State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 57)
Infants under age 1 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	As Above	Population 9
Children 1-5 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	As Above	Population 9
Children 6-18 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	As Above	Populations 9
Non-IV-E foster care children under age 21 in State or Tribal custody	AFDC limits as of 7/16/1996	As above	Populations 1,2,3,4
Aged, Blind and Disabled	From SSI up to and including 100% FPL	Freedom of Choice	Populations 1,2,3,4
Eligible but not receiving cash assistance	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Individuals receiving only optional State supplements	100% SSI FBR + \$41 (SSP)	Freedom of Choice	Populations 1,2,3,4
Breast and Cervical Cancer Prevention and Treatment	Up to and including 185% FPL	Freedom of Choice, Counting Income and Comparability of Eligibility	Populations 1,2,3,4
TEFRA Children (under 19 years of age) with creditable health care insurance coverage	Must be disabled according to SSA definition, with gross personal income at or below 200% FPL, but less than 300% of SSI.	Freedom of Choice, Counting Income and Comparability of Eligibility	Population 7

Optional State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 57)
TEFRA Children (under 19 years of age) without creditable health care insurance coverage	Must be disabled according to SSA definition, with gross personal income at or below 200% FPL, and for whom the state is claiming title XXI funding.	Freedom of Choice, Counting Income and Comparability of Eligibility	Population 7

21. Demonstration Eligibility. The following includes individuals enrolled in the Employer Sponsored Premium Assistance Plan who receive a premium assistance benefit. Additionally, Premium Assistance Individual Plan populations are made eligible only through this demonstration, and receive premium assistance only under the demonstration through the Insure Oklahoma program.

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 57)
Non-Disabled Low Income Workers and Spouse (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who work for an eligible employer with 200 or fewer employees. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	Comparability, Cost Sharing Requirements, Freedom of Choice	Population 5
Working Disabled Adults (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who are ineligible for Medicaid due to employment earnings, and who otherwise, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits. No limit on employer size.	As Above	Population 6

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 57)
Full-time College Students (ages 19-22) (Employer Sponsored Plan)	Full time college students with FPL not to exceed 200% (limited to 3,000 participants), who have no creditable health insurance coverage, work for a qualifying employer, and are Medicaid eligible. No limit on employer size.**	As Above	Population 8
Foster Parents (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who work full-time or part-time for an eligible employer. Spouses who do not work are also eligible to enroll on their working spouse's coverage. No limit on employer size.	As Above	Population 10
Qualified Employees of Not-for-profit Businesses (ages 19-64) (Employer Sponsored Plan)	Up to and including 200% FPL, who work for an eligible employer with access to an ESI with 500 or fewer employees. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	As Above	Population 11

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 57)
Non-Disabled Low Income Workers and Spouse (ages 19-64) (Individual Plan)	Effective through 12/31/13 individuals up to and including 200% FPL, who are self-employed, or unemployed. Spouses who do not work are also eligible to enroll on their spouse's coverage. Effective 1/1/14 through 12/31/14 this population will be covered to 100% of the FPL.	Retroactive Eligibility, Assurance of Transportation	Population 12
Working Disabled Adults (ages 19-64) (Individual Plan)	Effective through 12/21/13 individuals up to and including 200% FPL, who are ineligible for Medicaid due to employment earnings, and who otherwise, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits. Effective 1/1/14 through 12/31/14 this population will be covered to 100% of the FPL.	As Above	Population 13

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 57)
Full-time College Students (ages 19-22) (Individual Plan)	Effective through 12/21/13 full time college students with FPL not to exceed 200% (limited to 3,000 participants) and who do not have access to employer sponsored insurance, do not have creditable insurance coverage, and are Medicaid eligible. Effective 1/1/14 through 12/31/14 this population will be covered to 100% of the FPL.	As Above	Population 14
Foster Parents (ages 19-64) (Individual Plan)	Effective though 12/31/13 individuals up to and including 200% FPL, who work full-time or part-time. Spouses who do not work are also eligible to enroll on their working spouse's coverage. Effective 1/1/14 through 12/31/14 this population will be covered to 100% of the FPL.	As Above	Population 15

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 57)
Qualified Employees of Not-for-profit Businesses (ages 19-64) (Individual Plan)	Effective through 12/31/13 individuals up to and including 200% FPL, who work for a not-for-profit with 500 or fewer employees. Spouses who do not work are also eligible to enroll on their working spouse's coverage. Effective 1/1/14 through 12/31/14 this population will be covered to 100% of the FPL.	As Above	Population 16

** If a dependent, household income cannot exceed 200 percent FPL.

22. Eligibility Exclusions. The following persons are excluded from the SoonerCare demonstration:

- a) Individuals dually eligible for Medicare and Medicaid;
- b) Individuals residing in an institution or nursing home;
- c) Individuals receiving home and community-based waiver services;
- d) Individuals infected with tuberculosis covered under 1902(a)(10)(A)(ii)(XII) and 1902(z)(1);
- e) Individuals covered by a Managed Care Organization other than the SoonerCare demonstration PCCM;
- f) Individuals in the Former Foster Care group; and
- g) Pregnant women with incomes between 134 percent and 185 percent FPL.

23. TEFRA Children, Population 7. The population known as “TEFRA Children” is defined as children:

- a) Under 19 years of age;
- b) Disabled according to the Social Security Administration definition;
- c) A U.S. citizen or qualified alien;
- d) With established residency in the state of Oklahoma;
- e) Who have a Social Security Number or have applied for one;
- f) Whose gross personal income is less than the current FBR income limit (300 percent of SSI maximum);
- g) Whose countable assets do not exceed \$2,000.00 (the parent's assets are not considered); and
- h) Who would be considered Medicaid eligible if they met an institutionalized level

of care.

24. TEFRA Children Retroactive Eligibility. TEFRA Children will have retroactive eligibility and will not be subject to default enrollment. SoonerCare member services staff will consult with the parents or guardians of the TEFRA-eligible children to select an appropriate Primary Care Provider/Case Manager (PCP/CM) and provide program orientation and education. Eligible TEFRA children will be able to voluntarily enroll and select a PCP/CM from the SoonerCare PCP or IHS/Tribal/Urban Indian clinic network. TEFRA Children are eligible to receive SoonerCare services and retain other health insurance. SoonerCare will be the secondary payer to other insurance plans. However, if the child is insured through a health maintenance organization, the child will be excluded from the SoonerCare demonstration and enrolled in the FFS Medicaid program in the state.

25. Eligibility Conditions for Full-Time College Students, Populations 8 and 14. The population known as “full-time college student” is described below.

- a) **Income eligibility Documentation.** Applicants must complete the Free Application for Federal Student Aid (FAFSA) as a component of their application. Parental income will not be considered in the state’s eligibility determination if the FAFSA or the university’s financial aid office verifies that the college student is financially independent. Parental income will be considered in the eligibility determination if the college student is deemed by the college or university to be a dependent. An eligible full-time college student can have no other creditable health coverage as defined by section 2701(c) of the Public Health Service Act, whether provided by their parents, their college/university, or their employer.
- b) **Enrollment Cap.** There is an enrollment cap of 3,000, at any given time, on full-time college students. The state may also impose an enrollment cap on other populations covered under Insure Oklahoma, including the non-disabled low income workers and spouses and working disabled, in order to remain within state funding limits. The state must notify CMS 60 days prior to implementing a waiting list for individuals covered under Insure Oklahoma. This notification must include a plan for how the waiting list will be implemented. When a cap is imposed, the state must institute a separate waiting list for each phase of the Insure Oklahoma program; the Premium Assistance Employer Coverage Plan and the Premium Assistance Individual Plan. To insure resources are available statewide, the state will be divided into six regions with each region eligible to receive a population density, pro-rata share of funding. Any employer or individual already approved for either the Premium Assistance Plan or the Individual Plan may continue to re-enroll not subject to the waiting list. The state will provide written notification to CMS at least 15 days before re-opening enrollment of the demonstration.

V. SOONERCARE BENEFITS and COST SHARING

26. SoonerCare Benefits. All demonstration participants except those receiving Insure Oklahoma benefits, receive SoonerCare Choice benefits. SoonerCare Choice benefits are the benefits covered under the state plan, except that there are no limits on physician visits (as determined to be medically necessary by the PCP). Under the state plan, physician services are limited to four visits per month, including specialty visits. Benefits for Insure Oklahoma Premium Assistance Employer Coverage enrollees are limited to premium assistance and cost sharing reductions, as described in section VI. Benefits for Insure Oklahoma Premium Assistance Individual Plan enrollees are limited to benefits offered by the Individual Plan Program in accordance with STC 30.

27. SoonerCare Cost Sharing. Under the SoonerCare demonstration, cost-sharing is not allowed for:

- American Indians with an I/T/U provider;
- Pregnant women;
- Children (including TEFRA children) up to and including age 18;
- Emergency room services; and,
- Family planning services.

Cost-sharing for non-pregnant adult SoonerCare beneficiaries, who would otherwise be eligible under the state plan, is the cost sharing set forth in the state plan. Cost sharing for individuals who would otherwise not be eligible under the state plan is described in Section VI, which describes Insure Oklahoma premium assistance benefits and cost sharing.

VI. INSURE OKLAHOMA PREMIUM ASSISTANCE AND COST SHARING REDUCTION BENEFITS

The STCs in this section are applicable for the renewal period of September 6, 2013 through December 31, 2014. The Insure Oklahoma program expires December 31, 2014 and the state must abide by the expiration requirements outlined in STC 10.

28. Insure OK: Premium Assistance Employer Coverage. Premium Assistance Employer Coverage provides qualifying low-income non-disabled workers and their spouses, working foster parents, disabled workers, and full-time college students ages 19-22 up to and including 200 percent of the FPL (subject to any enrollment caps), with premium assistance coverage if they are employed by a qualifying employer. In order for an employer to participate in the Premium Assistance Employer Coverage program the employer must:

- a) Have no more than 250 employees (however, working foster parents and working college students participating in the program may enroll in Premium Assistance Employer Coverage regardless of the size of their employer);
- b) Have no more than 500 employees if the business is not-for-profit;

- c) Have a business that is physically located in Oklahoma;
- d) Be currently offering or intending to offer within 90 calendar days an Insure Oklahoma qualifying plan, as outlined in paragraph 29;
- e) Offer the Insure Oklahoma qualifying plan coverage to employees in accordance with Oklahoma Small Business Statutes, Oklahoma Department of Insurance, and all other regulatory agencies; and,
- f) Contribute a minimum 25 percent of the eligible employee monthly health plan premium for non-disabled workers, disabled workers, and employed college students.

29. Insure OK: Premium Assistance Employer Coverage IO Qualifying Plans. An Insure Oklahoma qualifying plan is a health plan that meets the definition of a Qualified Health Plan as defined in Oklahoma Administrative Code 317:45-5-1 for the purposes of Insure Oklahoma. Qualifying health plans must also be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. If the health plan requires co-pays or deductibles, amounts cannot exceed the limits outlined in paragraph 33.

30. Insure OK: Premium Assistance Individual Plan (Insure Oklahoma). The Premium Assistance Individual Plan is a “safety net” option provided to working disabled adults and those non-disabled low income workers and spouses whose employer elects not to participate in the Premium Assistance Program as well as the self-employed, unemployed, and qualifying working disabled who do not have access to employer sponsored insurance (ESI). The Premium Assistance Individual Plan is also available to full-time college students, ages 19-22 up to and including 100 percent of the FPL (subject to the participant cap), who do not have access to Premium Assistance Employer Coverage. Benefits under the plan are described in paragraph 31.

- a) **Application Process.** Qualifying non-disabled low income workers and spouses, working disabled workers, and full-time college students employed by qualifying, but non-participating firms, will file an application directly with the OHCA, documenting their income, place of employment, and application for worker or worker and spouse coverage.
- b) **Premium Schedule.** Once the application is approved, the enrollee will be provided information on coverage. Enrollees will be required to make their premium payment before the first of the month to which coverage applies. The enrollment effective dates must be consistent with the policy term for the existing SoonerCare demonstration.
- c) **Delinquent Premium Payments.** If the state has billed an enrollee for a premium payment, and the enrollee does not pay the amount due within 60 days of the date on the bill, then the beneficiary’s eligibility for benefits will be terminated. The beneficiary must receive a written notice of termination prior to the date of the termination.
- d) **Repayment Process.** The beneficiary’s eligibility will not be terminated if the beneficiary, prior to the date of termination, pays all amounts which have been billed or establishes a payment plan acceptable to the state. After such a payment

plan has been established, the state will bill the beneficiary for (a) payments in accordance with the payment plan, and (b) monthly premiums due subsequent to the establishment of the payment plan. If the enrollee does not make payments in accordance with the payment plan within 30 days of the date on the bill, the beneficiary's eligibility will be terminated.

- e) **Waiver of Premiums.** If the state determines that the requirement to pay a premium results in an extreme financial hardship for an enrollee, the state may, in its sole discretion, waive payment of the premium or reduce the amount of the premiums assessed to a family or individual.
- f) **Reenrollment.** A disenrolled beneficiary may make a new application for enrollment immediately upon receiving termination notice. In the event the state has implemented a waiting list, any disenrolled beneficiary who reapplies will be placed on the waiting list and notified once the state is open to their enrollment. When the state is able to open enrollment for those on the waiting list, the beneficiaries' eligibility will be processed in the order they were placed on the waiting list.

31. Premium Assistance Individual Plan (Insure Oklahoma) Benefit. The benefits provided under the Premium Assistance Individual Plan meet the essential health benefit requirements that would be applicable to alternative benefit plans under federal regulations found in 42 CFR section 440.347. All changes to covered and non-covered services and benefits must be submitted to CMS for prior approval.

32. Insure Oklahoma Cost-Sharing. Cost-sharing for individuals covered under a Premium Assistance Employer Coverage Plan cannot exceed the amounts outlined in paragraphs 33 and 34. Under the Oklahoma Premium Assistance Individual Plan, cost-sharing is shall not exceed amounts permitted under the federal regulation 42 CFR section 447 and are set forward in a public schedule dated July 15, 2013 that is incorporated by reference in these STCs. The co-pay for emergency services is excepted from this requirement, and will remain \$30, unless the individual is admitted to the hospital. The state may lower the actual required copayment amounts at any time by notifying CMS in writing at least 30 days prior to the effective date. A family's total annual out-of-pocket cost-shares, including premiums and co-payments, cannot exceed 5 percent of the family's gross income.

33. Premium Assistance Employer Coverage Co-Payments and Deductibles. For individuals participating in Insure Oklahoma Premium Assistance Employer Coverage, co-pays will be those required by the enrollee's specific health plan, as defined in paragraph 29, subject to the following limitations:

- a) Copayments for physician office visits cannot exceed \$50 per visit;
- b) Annual pharmacy deductibles cannot exceed \$500 per individual;
- c) An annual out-of-pocket maximum cannot exceed \$3,000 per individual, excluding pharmacy deductibles; and
- d) The maximum amount of all cost sharing (co-pays, deductibles and premiums) cannot exceed five percent of a family's total income.

34. Premium Assistance Employer Coverage Plan Premiums. Individuals/families participating in Employer Coverage Programs will be responsible for up to 15 percent of the total health insurance premium not to exceed 3 percent out of the 5 percent annual gross household income cap.

- a) The state will provide reimbursement for out-of-pocket costs incurred by the household in excess of the 5 percent annual gross household income cap for individuals (or their eligible Insure Oklahoma spouse) enrolled in Premium Assistance Employer Coverage. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. The state calculates the 5 percent threshold for each enrollee and on a monthly basis applies the premiums paid by the enrollee toward the 5 percent cap. The state also records co-payments made by the enrollee based upon documentation submitted by the enrollee. Reimbursement is provided by the state once the 5 percent cap is met.
- b) For each enrollee participating in an Employer Coverage Plan, the percentage of premium paid by the state, employer, and enrollee is outlined in the following table:

Premium Assistance Employer Coverage Premium Responsibilities				
Enrollee	State/Federal Share	Employer	Enrollee	Annual Household Income Cap
Non Disabled Worker *	Minimum of 60 percent	Minimum of 25%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%
Non Disabled Worker Spouse	Minimum of 85 percent	Minimum of 0%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%
Disabled Worker	Minimum of 60 percent	Minimum of 25%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%
Full-time College Students (when employed by covering employer)	Minimum of 60 percent	Minimum of 25%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%
Full-time College Students (when dependent on parental policy)	Minimum of 85 percent	Minimum of 0%	Up to 15% of premium, (not to exceed 3% out of the 5%	5%

			household income cap)	
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* If children are covered the employer must contribute at least 40 percent of the premium cost. If coverage is for the employee only, the employer must contribute at least 25 percent of the premium cost.

35. Premium Assistance Individual Plan Premiums. Individual Plan premiums will be imposed as follows:

- a) For each state fiscal year, the state will establish age/gender premium bands for the Insure Oklahoma Individual Plan that are based on the estimated cost of the coverage. The monthly premium for an individual/family will be set at 20 percent of the age/gender band.
- b) To calculate a monthly premium for the household, the premiums for all covered members will be added together and multiplied by 20 percent. The household contribution to the premium will be capped, not to exceed 4 percent of the monthly gross household income.
- c) The state will require all individuals participating in the Premium Assistance Individual Plan to be responsible for any co-payments and premiums subject to a 5 percent annual gross household income cap.
- d) The state will provide reimbursement for incurred costs by the household in excess of the 5 percent annual gross household income cap, for individuals (or their eligible Insure Oklahoma spouse) enrolled in the Premium Assistance Individual Plan. A medical expense must be for an allowed and covered service by the health plan, to be eligible for reimbursement.

VII. SOONERCARE DELIVERY SYSTEMS (OTHER THAN INSURE OKLAHOMA)

36. Compliance with Managed Care Regulations. To the extent that benefits are delivered through managed care organizations, the state and those organizations must comply with the managed care regulations at 42 CFR section 438 *et. seq.*, except as expressly waived or identified as not applicable in the expenditure authorities incorporated into the STCs.

37. Access and Service Delivery. With the exception of individuals receiving benefits through Insure Oklahoma, all SoonerCare Choice beneficiaries select or are assigned a PCP/CM responsible for furnishing primary and preventive services and making medically necessary referrals. For purposes of determining the member’s choice of PCP, the most recent selection received by the OHCA determines the PCP with which the member is enrolled, as long as capacity is available. If capacity is not available or the member does not choose, the member is assigned to a PCP according to the assignment mechanism as defined by the OHCA. A member, who is eligible for SoonerCare Choice but is not assigned, may request enrollment with a PCP by

contacting the SoonerCare Helpline. Members may also request a change to their PCP by contacting the SoonerCare Helpline.

PCP/CMs must belong to one of the provider types listed below.

Provider	Required Qualifications
Primary Care Physician	Engaged in Family Medicine, General Internal Medicine, General Pediatrics or General Practice; may be board certified or board eligible; or meet all Federal employment requirements, be employed by the Federal Government and practice primary care in an Indian Health Services (IHS) facility.
Specialist Physician	At discretion of OHCA CEO, based on consideration of percentage of primary care services delivered in physician’s practice, the availability of primary care physicians in the geographic area, the extent to which the physician has historically served Medicaid and his/her medical education and training.
Advanced Practice Nurse	Must be licensed by the state in which s/he practices and have prescriptive authority; or meet all Federal employment requirements, be employed by the Federal Government and practice in an IHS facility.
Physician’s Assistant	Must be licensed by the state in which s/he practices; or meet all Federal employment requirements, be employed by the Federal government and practice primary care in an IHS facility.
Medical Resident	Must be at least at the Post Graduate 2 level and may serve as a PCP/CM only within his/her continuity clinic setting. Must work under the supervision of a licensed attending physician.
Health Department Clinics	Beneficiaries would be served by one of 68 county health departments or the two city-county health departments in Oklahoma City and Tulsa.

38. Care Coordination Payments.

a) *Monthly Care Coordination Payments Defined.* PCPs receive a monthly care coordination payment for each enrolled beneficiary, based upon the services provided at the medical home. In return, they are responsible for providing or otherwise assuring the provision of medically necessary primary care and case management services and for making specialty care referrals. There are three tiers of Medical Homes; Entry Level Medical Home (Tier 1), Advanced Medical Home (Tier 2), and Optimal Medical Home (Tier 3). The contracted PCP must meet certain requirements to qualify for payments in each tier. Payments are also stratified according to the PCP panel composition; children only, children and adults, or adults only. PCPs are also responsible for providing 24-hour/7-day telephone coverage for their beneficiaries.

b) *Monthly Schedule of Care Coordination Payments.* Monthly care coordination payments are paid to PCPs based on the following schedule:

Care Coordination Payments

PMPM	Tier 1	Tier 2	Tier 3
Children	\$3.46	\$6.32	\$8.41
Children and Adults	\$4.19	\$5.46	\$7.26
Adults	\$4.85	\$4.50	\$5.99

Effective January 1, 2009, the state may extend the three-tiered Medical Home care coordination reimbursement methodology to the Indian Health Service, Tribal and Urban Health Clinics for American Indians, and the Insure Oklahoma Network.

c) *Changes to Monthly Care Coordination Payments.* The state must notify CMS 60 days prior to any requested change in the amount of the monthly care coordination payments paid to PCPs and must submit a revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact of the request on budget neutrality for the remainder of the demonstration. CMS will review the state’s documentation and if approved, will provide a written confirmation to the state within 60 days of receiving the request.

d) *Monthly Care Management Payments.* In addition to the monthly care coordination payments described above, the state also makes monthly care management payments to PCPs and IHS, tribal or urban Indian clinic PCPs participating in the SoonerCare Choice and Insure Oklahoma programs. Care management payments range from \$2.00 to \$3.00 per member, per month based on the age and eligibility category of the member.

39. Other Medical Services. All other SoonerCare benefits, with the exception of emergency transportation which is paid through a capitated contract, are paid through the state’s FFS system.

40. Health Access Networks. The state may pilot up to four Health Access Networks (HANs). HANs are non-profit, administrative entities that will work with providers to coordinate and improve the quality of care for SoonerCare beneficiaries. Networks will receive a nominal Per Member per Month (PMPM) payment. This PMPM payment, initially established at \$5, will be made in addition to the care coordination payment paid to PCPs as outlined in paragraph 38. HANs are not eligible for the care coordination payment outlined in paragraph 38. The state must not make duplicative payments to the HANs for Medicaid services covered under the Medicaid state plan. The state must notify CMS 60 days prior to any requested change in the HAN PMPM payment and must submit a revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact of the request on budget neutrality for the remainder of the demonstration. CMS will review the state’s documentation and if approved, will provide a written confirmation to the state within 60 days of receiving the request.

The HAN must:

- a) Be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare beneficiaries;
- b) Ensure patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or the state;
- c) Submit a development plan to the state detailing how the network will reduce costs associated with the provision of health care services to SoonerCare enrollees, improve access to health care services, and enhance the quality and coordination of health care services to SoonerCare beneficiaries;
- d) Offer core components of electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies; and,
- e) Offer care management/care coordination to persons with complex health care needs including:
 - i. The co-management of individuals enrolled in the Health Management Program;
 - ii. Individuals with frequent Emergency Room utilization;
 - iii. Women enrolled in the Oklahoma Care Program diagnosed with breast or cervical cancer;
 - iv. Pregnant women enrolled in the High Risk OB Program; and
 - v. Individuals enrolled in the Pharmacy Lock-In Program.

41. Provider Performance. The state may provide additional incentive payments, through the state's Payments for Excellence program, to contracted providers to recognize outstanding performance. Incentive payments will be based on physician practice behavior that may include EPSDT screens, DTaP immunizations, Inpatient Admitting and Visits, Breast and Cervical Cancer Screenings, and Emergency Department Utilization. The state certifies that incentive payments will not exceed five percent of the total FFS payments for those services provided or authorized by the PCP for the period covered.

The state furnishes the Provider Performance Payments for Excellence Program to the Indian Health Service, Tribal and Urban Health Clinics for American Indians, and the Insure Oklahoma Network.

42. Services for American Indians. Eligible SoonerCare beneficiaries, with the exception of Insure Oklahoma beneficiaries, may elect to enroll with an IHS, tribal or urban Indian clinic as their PCP/Care Manager. This voluntary enrollment links American Indian members with these providers for primary care/case management services. The providers receive the care coordination payment paid to PCPs as outlined in paragraph 38. All of Oklahoma's IHS, tribal, or urban Indian clinics must have a SoonerCare American Indian PCCM contract.

43. Contracts. Procurement and the subsequent final contracts developed to implement selective contracting by the state with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers shall continue in force.

44. TEFRA Children. TEFRA Children, as defined in paragraph 23, must receive services through the SoonerCare program and its network of participating providers. The OHCA's nurse Exceptional Needs Coordinators in the Care Management Department and SoonerCare Member Services Coordinators provide extensive outreach, assessment, and enrollment assistance to TEFRA Children.

VIII. HEALTH MANAGEMENT PROGRAM

45. Health Management Program Defined. The SoonerCare Health Management Program (HMP) is offered statewide and serves SoonerCare Choice beneficiaries ages 4 through 63 with chronic illness who are at highest risk for adverse outcomes and increased health care expenditures. HMP beneficiaries are selected using HMP predictive modeling software. The state must include in the Quarterly Operational Report, described in paragraph 53, a report on HMP activities including a description of populations served and services provided.

46. Health Management Program Services. Beneficiaries covered by the HMP can be impacted by health coaches and practice facilitation.

- a) Health Coaches – Health coaches are embedded within practices that have a high number of patients with chronic disease, multiple co-morbidities, and at high risk for poor outcomes. Health coaches provide services to encourage beneficiaries to take active roles in the management of their disease processes. Health coaches provide beneficiaries with a comprehensive initial evaluation, plan of care (POC), educational materials, referrals, and self-management support. Beneficiaries will remain in the HMP until maximum benefit has been achieved, as determined by OHCA. Maximum benefit is evaluated on an individual basis for each member served in the Health Management Program. The evaluation considers the individual's diagnoses, goals and progress in ensuring that care needs are met.
- b) Practice Facilitation – Practice facilitation services are provided to selected patient-centered medical homes and offered to enhance primary care services and support chronic disease prevention. Facilitation services range from a brief period of academic detailing to a full-scope chronic disease process improvement-focused service that occurs over a lengthy period of time. Practice facilitation supports the health coaches and assists coached practices with quality improvement initiatives.

47. Changes to the HMP program. The state must notify CMS 60 days prior to any requested change in HMP services and must submit a revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact of

the request on budget neutrality for the remainder of the demonstration. CMS will review the state's documentation and, if approved, will provide a written confirmation to the state within 60 days of receiving the request.

IX. PROGRAM MONITORING

48. Monitoring Aggregate Costs for Eligibles in the Premium Assistance Program.

- a) The state will monitor the aggregate costs for the Premium Assistance Employer Coverage Plan versus the cost of providing coverage through the Premium Assistance Individual Plan. On a quarterly basis, the state will compare the average monthly premium assistance contribution per Employer Coverage enrollee to the cost per member per month of the expansion population enrolled in the Individual Plan.
- b) On an annual basis, the state will calculate the total cost per enrollee per month for individuals receiving subsidies under the Premium Assistance Employer Coverage Plan, including any reimbursement made to enrollees whose out-of-pocket costs exceeded their income stop loss threshold (5 percent of income). The cost for this group will then be compared to the "per enrollee per month" cost for those individuals enrolled in the Premium Assistance Individual Plan.

49. Monitoring Employer Sponsored Insurance.

- a) The state will monitor the aggregate level of contributions made by participating employer's pre and post-implementation of the Premium Assistance Plan.
- b) The state must require that all participating employers report annually on their total contributions for employees covered under the Premium Assistance Plan. The state will prepare an aggregate analysis across all participating employers summarizing the total statewide employer contribution level under the demonstration.
- c) Similarly, the state will monitor changes in covered benefits and cost sharing requirements of employer-sponsored health plans and document any trends in these two areas over the life of the demonstration.

X. GENERAL REPORTING REQUIREMENTS

50. General Financial Requirements. The state must comply with all General Financial Requirements under Title XIX set forth in Section XI and all General Financial Reporting Requirements under Title XXI set forth in Section XII.

51. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for Monitoring Budget Neutrality set forth in Section XIII.

52. Monthly Calls. CMS shall schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, PCCM operations (such as contract amendments and rate certifications), health care delivery, HAN activities, enrollment, cost sharing, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

53. Quarterly Operational Reports: The state must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's data along with an analysis of the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

- a) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery including approval and contracting with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the demonstration; pertinent legislative activity; HAN activities and other operational issues;
- b) Action plans for addressing any policy and administrative issues identified;
- c) Enrollment data, member month data, and budget neutrality monitoring tables;
- d) Updates on the implementation of the Premium Assistance Employer Coverage and Premium Assistance Individual Plan products, such as summary findings from the state's monitoring and analysis as described in paragraphs 48 and 49; and
- e) Evaluation activities and interim findings.

Notwithstanding this requirement, the fourth-quarter Quarterly Report may be included as an addendum to the annual report required in paragraph 54.

54. Annual Report. The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under paragraph 53. The state must submit the draft annual report no later than 120 days after the close of each

demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

55. Title XXI Enrollment Reporting. The state will provide CMS with an enrollment report showing end of quarter actual and unduplicated ever enrolled figures. The enrollment data for the title XXI population will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

56. Quarterly Expenditure Reports. The state shall provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIII.

57. Reporting Expenditures Under the Demonstration: In order to track expenditures under this demonstration, Oklahoma must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were paid).

- a) For each demonstration year, thirteen (13) separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER must be completed, using the waiver name noted below, to report expenditures for the following demonstration populations.
 - i. **Demonstration Population 1: TANF-Urban** includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program, receiving health care services in the designated Central, Northeast, and Southwest urban areas of the state;
 - ii. **Demonstration Population 2: TANF-Rural** includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program receiving health care services in the rural areas of the state;
 - iii. **Demonstration Population 3: ABD-Urban** includes the Aged, Blind and Disabled receiving health care services in the designated Central, Northeast, and Southwest urban areas of the state;

- iv. **Demonstration Population 4: ABD-Rural** includes the Aged, Blind and Disabled receiving health care services in the rural areas of the state;
- v. **Demonstration Population 5: Non-Disabled Working Adults** includes non-disabled low income workers and their spouses with household incomes no greater than 200 percent of the FPL;
- vi. **Demonstration Population 6: Working Disabled Adults** includes low income working disabled adults with household incomes no greater than 200 percent of the FPL;
- vii. **Demonstration Population 7: TEFRA Children** includes children defined in paragraph 22;
- viii. **Demonstration Population 8: Full-Time College Students** includes full-time college students ages 19-22 up to and including 200 percent of the FPL (limited to 3,000 individuals at any given time);
- ix. **Demonstration Population 9: CHIP Medicaid Expansion Children** includes infants under age 1, children ages 1-5, and children ages 6-18, and targeted low-income children. Note: the state must report information in the Form CMS-64.9 Waiver and/or 64.9P Waiver for this population when using title XIX funds
- x. **Demonstration Population 10: Foster Parents** includes working foster parents with household incomes no greater than 200 percent of the FPL. The spouse of a working employee can be covered;
- xi. **Demonstration Population 11: Not-for-Profit Employees** includes employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 200 percent of the FPL;
- xii. **Demonstration Population 12: Non-Disabled Working Adults** effective through 12/31/13 includes non-disabled low income workers and their spouses with household incomes no greater than 200 percent of the FPL; effective 1/1/14 through 12/31/14 eligible individuals will be eligible up to 100 percent of the FPL;
- xiii. **Demonstration Population 13: Working Disabled Adults** effective through 12/31/13 includes low income working disabled adults with household incomes no greater than 200 percent of the FPL; effective 1/1/14 through 12/31/14 eligible individuals will be eligible up to 100 percent of the FPL;
- xiv. **Demonstration Population 14: Full-Time College Students** effective through 12/31/13 includes full-time college students ages 19-22 up to and including 200 percent of the FPL (limited to 3,000 individuals at any given time); effective 1/1/14 through 12/31/14 includes full-time college students ages 19-22 up to and including 100 percent of the FPL (limited to 3,000 individuals at any given time);
- xv. **Demonstration Population 15: Foster Parents** effective through 12/31/13 includes working foster parents with household incomes

no greater than 200 percent of the FPL. The spouse of a working employee can be covered. Effective 1/1/14 through 12/31/14 eligible individuals will be eligible up to 100 percent of the FPL;

- xvi. **Demonstration Population 16: Not-for-Profit Employees** effective through 12/31/13 includes employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 200 percent of the FPL; effective 1/1/14 through 12/31/14 eligible individuals will be eligible up to 100 percent of the FPL;
 - xvii. **Demonstration Expenses 1: HAN Expenditures** includes PMPM expenditures made to the HANs.
 - xviii. **Demonstration Expenses 2: HMP Expenditures** includes expenditures to provide health coaches and practice facilitation services through the Health Management Program.
- b) For each HAN, the state must collect quarterly data of expenditures made by the HAN. The state must report summary expenditure data, for each HAN, in the Narrative section of Form CMS-64.9 for demonstration Expenses 1.
 - c) For the HMP, the state must collect quarterly data of expenditures made by the HMP. The state must report summary expenditure data in the Narrative section of Form CMS-64.9 for demonstration Expenses 2.
 - d) Specific Reporting Requirements for Medicaid expansion children (including TEFRA children) who revert to title XIX only when the state has exhausted its title XXI allotment.
 - i. The state is eligible to receive title XXI funds for expenditures for these children, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or CMS-64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual.
 - ii. Title XIX funds are available under this demonstration if the state exhausts its title XXI allotment (including any reallocations or redistributions). If the state exhausts its title XXI allotment prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver. The state shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for these demonstration populations.
 - iii. The expenditures attributable to this demonstration population will count toward the budget neutrality expenditure cap calculated under Section XIII, paragraph 70, using the per member per month (PMPM)

amounts for children in the TANF Rural and TANF Urban populations described in Section XII, paragraph 57(a)(i-ii), and will be considered expenditures subject to the budget neutrality cap as defined in paragraph 57(e), so that the state is not at risk for claiming title XIX federal matching funds when title XXI funds are exhausted.

- e) The sum of the quarterly expenditures for all demonstration years will represent the expenditures subject to the budget neutrality cap as defined in paragraph 70.
- f) For purposes of this section, the term “expenditures subject to the budget neutrality cap” must include all Medicaid expenditures on behalf of individuals who are enrolled in this demonstration under paragraph 57(a). All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.
- g) Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or CMS-64.10P Waiver.
- h) All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- i) Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, both the total computable and Federal share amounts that are attributable to the demonstration must be separately reported on the CMS-64 Narrative.
- j) Mandated Increase in Physician Payment Rates in 2013 and 2014. Section 1202 of the Health Care and Education Reconciliation Act of 2010 (Pub. Law 110-152) requires state Medicaid programs to pay physicians for primary care services at rates that are no less than what Medicare pays, for services furnished in 2013 and 2014. The federal government provides a federal medical assistance percentage of 100 percent for the claimed amount by which the minimum payment exceeds the rates paid for those services as of July 1, 2009. The state may (at its option) exclude from the budget neutrality test for this demonstration the portion of the

mandated increase for which the federal government pays 100 percent. Should the state elect this, these amounts must be reported on the base forms CMS-64.9, 64.21, or 64.21U (or their “P” counterparts), and not on any waiver form.

58. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

- a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 53, the actual number of eligible member months for EGs defined in paragraph 57(a). The state must submit a statement accompanying the quarterly report which certifies the accuracy of this information. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions for an additional 180 days after the end of each quarter.
- b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.
- c) The “demonstration eligibles” that do contribute to the calculation of the budget neutrality ceiling for the SoonerCare Program include the TANF-Urban, TANF-Rural, ABD Urban and ABD Rural populations as defined in paragraph 57(a).
- d) The “demonstration eligibles” that do not contribute to the calculation of the budget neutrality ceiling for the SoonerCare Program include the non-disabled working adults, disabled working adults, parents of foster children, full-time students, individuals enrolled in the Premium Assistance Individual Plan, and the TEFRA Children as defined in paragraph 57(a).

59. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. Oklahoma must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure agreement and separately report these expenditures by quarter for each federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments and state and local administration costs. CMS shall make Federal funds available based upon the state’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

60. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at

the applicable federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section XIII:

- a) Administrative costs, including those associated with the administration of the demonstration;
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan;
- c) Net medical assistance expenditures made under section 1115 demonstration authority, with dates of service during the demonstration extension period; and
- d) Net premiums and net medical assistance expenditures for persons enrolled in the O-EPIC Program.

61. Sources of Non-Federal Share. The state certifies that the matching non-federal share of funds for the demonstration is state/local monies. Oklahoma further certifies that such funds shall not be used as the match for any other federal grant or contract, except as permitted by law. Premiums paid by enrollees and collected by the state shall not be used as a source of non-federal share for the demonstration. All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-federal share of funding are subject to CMS approval.

- a) CMS may review the sources of the non-federal share of funding for the demonstration at any time. Oklahoma agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

62. State Certification of Funding Conditions. The state must certify that the following conditions for non-Federal share of demonstration expenditures are met:

- a) Units of government, including governmentally operated health care providers,

may certify that state or local tax dollars have been expended as the non-federal share of funds under the demonstration.

- b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the state utilizes CPEs as the funding mechanism to claim federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for Federal match.
- d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

63. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

64. Quarterly Expenditure Reports. In order to track title XXI expenditures under this demonstration, the state must report quarterly demonstration expenditures through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in sections 2115 and 2500 of the State Medicaid Manual. Eligible title XXI demonstration expenditures are expenditures for services provided to title XXI children who are eligible with FPL levels within the approved CHIP state plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the state's available title XXI funding.

Title XXI expenditures must be reported on separate Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

65. Claiming Period. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64.21;

- a) The standard CHIP funding process must be used during the demonstration. Oklahoma must estimate matchable CHIP expenditures on the quarterly Form CMS-64.21B. On a separate CMS-64.21B, the state must provide updated estimates of expenditures for the demonstration population. CMS will make federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64.21U and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 with federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state; and,
- b) The state will certify that state/local monies are used as matching funds for the demonstration. The state further certifies that such funds shall not be used as matching funds for any other federal grant or contract, except as permitted by federal law. All sources of non-federal share of funding and distribution of monies involving federal match are subject to CMS approval. Upon review of the sources of the non-federal share of funding and distribution methodologies of funds under the demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-federal share of funding.

66. Limitation on Title XXI Funding. Oklahoma will be subject to a limit on the amount of federal title XXI funding that the state may receive for demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including any redistributed funds. Should the state expend its available allotment and redistribution, no further enhanced federal matching funds will be available for costs of the demonstration until the next allotment becomes available. Once all available title XXI funds are exhausted, the state will continue to provide coverage to Medicaid expansion children (demonstration Population 9) covered under the demonstration and is authorized to claim federal funding under title XIX funds until further title XXI federal funds become

available.

XIII. MONITORING BUDGET NEUTRALITY

67. Limit on Title XIX Funding. Oklahoma shall be subject to a limit on the amount of federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

68. Risk. Oklahoma shall be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, Oklahoma will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Oklahoma at risk for the per capita costs for demonstration enrollees, CMS assures that the federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no demonstration.

69. Demonstration Populations Subject to the Budget Neutrality Agreement. The following demonstration populations are subject to the budget neutrality agreement and are incorporated into the demonstration EGs used to calculate budget neutrality.

- a) **Eligibility Group 1 (Demonstration Population 1):** Temporary Assistance to Needy Families recipients in urban areas of the state;
- b) **Eligibility Group 2 (Demonstration Population 2):** Temporary Assistance to Needy Families recipients in rural areas of the state;
- c) **Eligibility Group 3 (Demonstration Population 3):** Aged, Blind and Disabled Medicaid recipients (regardless of SSI eligibility) in urban areas of the state;
- d) **Eligibility Group 4 (Demonstration Population 4):** Aged, Blind and Disabled Medicaid recipients (regardless of SSI eligibility) in rural areas of the state; and,
- e) **Eligibility Group 5 (Demonstration Population 9):** Medicaid expansion children (including TEFRA children) who revert to title XIX.

70. Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit for the demonstration:

- a) For each year of the budget neutrality agreement an annual budget neutrality

expenditure limit is calculated for each EG described in paragraph 71 as follows:

- i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under paragraph 58, for each EG, times the appropriate estimated PMPM costs from the table in subparagraph (iii) below.
- ii. The PMPM costs in subparagraph (iii) below are net of premiums paid by demonstration eligibles.
- iii. The PMPM costs for the EGs used to calculate the annual budget neutrality expenditure limit for this demonstration are specified below.

Eligibility Category	2013 PMPM	Trend Rate	2014 PMPM	Trend Rate	2015 PMPM	Trend Rate
1) TANF-Urban	\$322.03	4.4%	\$336.2	4.4%	\$350.99	4.4%
2) TANF-Rural	\$326.64	4.4%	\$341.01	4.4%	\$356.01	4.4%
3) ABD-Urban	\$1128.13	4.2%	\$1175.51	4.2%	\$1224.89	4.2%
4) ABD-Rural	\$899.03	4.2%	\$936.79	4.2%	\$976.14	4.2%

- b) The overall budget neutrality expenditure limit for the three-year demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iii) above for each of the 3 years. The federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations and expenditures described in paragraph 57(a) during the demonstration period.

71. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, if the state exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval.

Year	Cumulative Target	Percentage
Year 18	Year 18 budget neutrality cap plus	1.0 %
Year 19	Years 18 and 19 combined budget neutrality cap plus	0.5 %
Year 20	Years 18 through 20 combined budget neutrality cap plus	0.0 %

72. Exceeding Budget Neutrality. If at the end of this demonstration period the budget neutrality limit has been exceeded, the excess federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XIV. EVALUATION OF THE DEMONSTRATION

73. Submission of Draft Evaluation Design. The state should submit a draft evaluation plan to CMS no later than 120 days after the award of the demonstration. When developing the evaluation plan, the state should consider and include the following:

- a) The specific research questions and hypotheses that are being tested. The research questions should focus on the programmatic goals and objectives of the demonstration and their potential impacts, particularly as they relate to CMS' Three Part Aim of improving access to and experience of care, improving quality of health care and decreasing per capita costs.
- b) A description of any experimental study design employed (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.) including a proposed baseline and/or control comparison groups.
- c) Quantitative and qualitative process improvement and outcome measures with corresponding specifications that will be used in evaluating the impact of the demonstration, particularly as it relates to the Three Part Aim of improving access to and experience of care, improving quality of health care and decreasing per capita costs. The evaluation plan should ensure that all outcomes selected have a clear description and the numerator and denominator should be defined clearly.
- d) Data sources and collection frequency.
- e) The population being studied (consider the target population of the demonstration), including the sampling methodology for selecting the population being included in your analysis.
- f) A detailed analysis plan that describes the statistical methods that will be employed, particularly those that will allow for the effects of the demonstration to be isolated from other initiatives occurring in the state. The level of analysis might be at the beneficiary, provider, and aggregate program level, as appropriate, and may include population stratifications to the extent feasible, for further depth. Qualitative analysis methods should also be described.
- g) The timelines for evaluation related deliverables.

74. Identify the Evaluator. The evaluation plan should identify whether the state will conduct the evaluation, or whether the state will work with an outside contractor for the evaluation.

75. Demonstration Hypotheses. The state will test the demonstration hypotheses in the evaluation of the demonstration, by evaluating:

- *Hypothesis 1: Child Health Checkup Rates.* The rate for age-appropriate well-

child and adolescent visits will improve between 2013-2015.

- *Hypothesis 2: PCP Visits.* The rate of adult members who have one or more preventive health visits with a primary care provider in a year will improve as a measure of access to primary care in accordance with HEDIS® guidelines between 2013-2015.
- *Hypothesis 3: PCP Enrollments.* The number of SoonerCare Choice primary care practitioners enrolled as medical home PCPs will increase between 2013-2015.
- *Hypothesis 4: PCP Capacity Available.* There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2013-2015. For example, getting an appointment within the timeframe perceived necessary by the member, should improve between 2013-2015.
- *Hypothesis 5: Integration of I/T/U Providers.* The percentage of Native American members who are enrolled with an IHS, Tribal, or Urban Indian Clinic with a SoonerCare American Indian PCCM contract will increase between 2013-2015.
- *Hypothesis 6: Eligible Member Enrollments in Medical Homes.* The number of members eligible for SoonerCare Choice who do not have an established PCP will decrease between 2013-2015.
- *Hypothesis 7: Continuity of Care.* The number of members enrolled with one PCP during a month will increase between 2013-2015.
- *Hypothesis 8: Impact of Health Access Networks on Quality of Care.* Key quality performance measures tracked for PCPs participating in the HANs will improve between 2013-2015.
- *Hypothesis 9: Impact of Health Access Networks on Effectiveness of Care.* Average per member per month expenditures will decrease for members enrolled with PCPs participating in the HANs between 2013-2015.
- *Hypothesis 10: Health Management Program (HMP).* Health outcomes for chronic diseases will improve between 2013-2015 as a result of participation in the HMP. Total expenditures for members enrolled in HMP will decrease.
- *Hypothesis 11: Retroactive Eligibility.* The state's systems performance will ensure seamless coverage between Medicaid and the Exchange after changes outlined in the Affordable Care Act are effectuated, evaluating a need for retroactive eligibility.

76. Evaluation of Health Access Networks. The draft evaluation design required under paragraph 73 must include a discussion of the goals, objectives and specific hypotheses that are being tested through the HAN pilot program. The evaluation design must

incorporate the use of baseline data collected by the HAN and include an analyses of the HANs effectiveness in:

- a) Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HAN;
- b) Improving access to and the availability of health care services to SoonerCare beneficiaries served by the HAN;
- c) Improving the quality and coordination of health care services to SoonerCare beneficiaries served by the HAN with specific focus on the populations at greatest risk including those with multiple chronic illnesses; and,
- d) Enhancing the state's patient-centered medical home program through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance, and cost.

77. Evaluation of the Health Management Program. The draft evaluation plan required under paragraph 73 must include a discussion of the goals, objectives and specific hypotheses that are being tested through the Health Management Program. The evaluation plan must incorporate the use of baseline data collected by the HMP and include specific research questions/hypotheses, description of study design employed to address the research questions/hypotheses, any quantitative outcome measures and detailed specifications of those measures (numerator and denominator), any qualitative measures being captured, and an analysis plan that describes how the effects of the HMP program will be isolated from other initiatives. The following hypotheses must be addressed at a minimum:

- a) *Impact on Enrollment Figures:* The implementation of the HMP program, including health coaches and practice facilitation, will result in increase in enrollment as compared to baseline.
- b) *Impact on Access to Care:* Incorporating health coaches into primary care practices will result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data) as compared to baseline when care management occurred via telephonic or face-to-face contact with a nurse care manager.
- c) *Impact on Identifying Appropriate Target Population:* The implementation of the HMP program, including health coaches and practice facilitation, will result in a change in the characteristics of the beneficiary population enrolled in the HMP (as measured through population characteristics including disease burden and co-morbidity obtained through claims and algorithms.) as compared to baseline.
- d) *Impact on Nurse Care Manager Work Burden:* Incorporating health coaches and practice facilitation into primary care practices will result in reduced work burden

and improved experience of nurse care managers (as determined through surveys or focus groups).

- e) *Impact on Health Outcomes:* Use of disease registry functions by the health coach will improve the quality of care delivered to beneficiaries as measured by changes in performance on the Initial set of Health Care Quality Measures for Medicaid-Eligible adults or CHIPRA Core Set of Children's Healthcare Quality Measures.
- f) *Impact on Cost/Utilization of Care:* Beneficiaries using HMP services will have fewer ER visits as compared to beneficiaries not receiving HMP services (as measured through claims data).
- g) *Impact on Cost/Utilization of Care:* Beneficiaries using HMP services will have fewer readmissions to hospitals as compared to beneficiaries not receiving HMP services (as measured through claims data).
- h) *Impact on Satisfaction/Experience with Care:* Beneficiaries using HMP services will have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through CAHPS survey data)

78. Evaluation of Eligibility and Enrollment Systems. The interim evaluation report required in paragraph 73 must contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid, CHIP, and the Exchange. This documentation will answer one of the hypotheses that the demonstration is testing, specifically whether there is a need for retroactive eligibility after changes outlined in the Affordable Care Act are effectuated. CMS may issue further guidance to the state on the specific performance measures, however, the state, at a minimum, must include the following data in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other data that informs an assessment of whether the state's systems ensure readiness, eligibility, and enrollment.

- a) The number of eligibility determinations made broken down by type, such as application, transfer and redetermination;
- b) The number of individuals determined ineligible broken down by procedural vs. eligibility reasons;
- c) The average application processing times broken down by type, such as application, transfer and redetermination;
- d) The rate of timely eligibility determinations broken down by completed within 5 days, 10 days and 30 days;
- e) The number of individuals disenrolled broken down by procedural vs. eligibility reasons;

- f) The internal churn rate (i.e., the number of disenrolled beneficiaries reenrolling within 6 months); and
- g) The accurate transfer rate, i.e., the number of individuals transferred to Medicaid, CHIP or the Exchange, as applicable, who are determined eligible by the agency.

79. Interim Evaluation Reports. In the event the state requests to extend the demonstration beyond the current approval period under authority of section 1115(a), (e) or (f) of the Act, the state must submit an interim evaluation report as part of the state’s request for each subsequent renewal.

80. Final Evaluation Plan and Implementation. CMS shall provide comments on the draft design within 60 days of receipt, and the state must submit a final plan for the overall evaluation of the demonstration described in paragraph 73, within 60 days of receipt of CMS comments. The state must implement the evaluation design and report its progress in the quarterly reports. The state must submit to CMS a draft evaluation report 120 days after the expiration of the current demonstration. CMS shall provide comments within 60 days of receipt of the report. The state must submit the final report within 60 days after receipt of CMS comments. The content of the Final Evaluation Report should include:

- a) An Executive Summary.
- b) A description of the demonstration including programmatic goals, interventions implemented, and resulting changes to the health care system.
- c) A summary of the evaluation design employed including hypotheses, study design, population, outcomes, data sources, analysis, etc.
- d) A description of the population included in the evaluation (distribution of age, sex, etc.).
- e) Final evaluation findings.
- f) A discussion of the findings (interpretation and policy context).
- g) Implementation successes, challenges and lessons learned.

81. Cooperation with CMS Evaluators. Should CMS conduct an independent evaluation of any component of the demonstration; the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

XV. SCHEDULE OF STATE MANDATORY DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

	Deliverable	STC Reference
Annual	By May 1st - Draft Annual Report	Section X, paragraph 54
Quarterly		

	Quarterly Operational Reports	Section X, paragraph 53
	Quarterly Enrollment and Expenditure Reports	Section X, paragraphs 53 and 56
	CMS-64 Reports	Section XI, paragraph 57
	Eligible Member Months	Section XI, paragraph 58

ATTACHMENT A

Under Section X, paragraph 53 of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the Quarterly Report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT

Title Line One – SoonerCare

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 18 (1/1/2013 – 12/31/2013)

Federal Fiscal Quarter: 2/2011 (1/13 - 3/13)

Introduction

Please provide information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by “0”.

Note: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the Form CMS-64)	Current Enrollees (to date)	No. Voluntary Disenrolled in Current Quarter	No. Involuntary Disenrolled in Current Quarter
TANF-Urban			
TANF-Rural			
ABD-Urban			
ABD-Rural			
Non-Disabled Working Adults (Employer Plan)			
Disabled Working Adults (Employer Plan)			
TEFRA Children			

CHIP Medicaid Expansion Children			
Full-Time College Students (Employer Plan)			
Foster Parents (Employer Plan)			
Not-for-Profit Employees (Employer Plan)			
Non-Disabled Working Adults (Individual Plan)			
Disabled Working Adults (Individual Plan)			
Full-Time College Students (Individual Plan)			
Foster Parents (Individual Plan)			
Not-for-Profit Employees (Individual Plan)			

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and Form CMS-64 reporting for the current quarter. Identify the state's actions to address these issues.

Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
TANF-Urban				
TANF-Rural				
ABD-Urban				
ABD-Rural				

B. For Informational Purposes Only

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Non-Disabled Working Adults (Employer Plan)				
Disabled Working Adults (Employer Plan)				
TEFRA Children				
Full-Time College Students (Employer Plan)				

Foster Parents (Employer Plan)				
Not-for-Profit Employees (Employer Plan)				
CHIP Medicaid Expansion Children				
Non-Disabled Working Adults (Individual Plan)				
Disabled Working Adults (Individual Plan)				
Full-Time College Students (Individual Plan)				
Foster Parents (Individual Plan)				
Not-for-Profit Employees (Individual Plan)				

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS



December 31, 2012

Michael Fogarty
Chief Executive Officer
Oklahoma Health Care Authority
2401 N.W. 23rd Street, Suite 1A
Oklahoma City, OK 73107

Dear Mr. Fogarty:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) approves your request to renew the “SoonerCare” Medicaid section 1115 Demonstration (No. 11-W-00048/6). This renewal is effective January 1, 2013, through December 31, 2015, upon which date, unless reauthorized, all waivers and authorities granted to operate this demonstration will expire. The extension is granted under the authority of section 1115(a) of the Social Security Act.

Our approval of this demonstration project is subject to the limitations specified in the enclosed lists of waiver and expenditure authorities. The state may deviate from Medicaid State plan requirements only to the extent those requirements have been specifically waived or, with respect to expenditure authorities, listed as not applicable to expenditures for demonstration populations and other services not covered under the state plan.

The following changes have been made to the demonstration:

- a) The waiver authority that allowed the state to exclude parental income in determining eligibility for disabled children eligible in the TEFRA category ((1902)(a)(17)) has been removed because excluding parental income from the eligibility determination is inherent in the TEFRA program.
- b) Financial eligibility under the Insure Oklahoma program for all populations from up to and including 250 percent of federal poverty level (FPL) has been reduced to up to and including 200 percent of FPL. This includes: non-disabled working adults and their spouses; disabled working adults; employees of not-for profit businesses having fewer than 500 employees; foster parents and full-time college students. This reduction will occur because it is CMS policy to remove authorities for programs that have not been implemented.

- c) The expenditure and not applicable authorities for the Insure Oklahoma program will expire effective December 31, 2013.
- d) The state has been approved to limit the adult outpatient behavioral health benefit in the Insure Oklahoma individual plan to 48 visits per year. This benefit is limited to individual licensed behavioral health professionals (LBHP). However, this is a soft limit and beneficiaries may seek additional services from the LBHP with prior authorization. Additionally, beneficiaries may seek outpatient behavioral health services through a community mental health center.
- e) The Health Management Program is amended to rename nurse care managers as health coaches and to increase face-to-face care management by embedding health coaches within physician practices that have the highest concentration of members with chronic illnesses.

This demonstration approval is conditional upon acceptance and compliance with the enclosed Special Terms and Conditions (STCs) defining the nature, character, and extent of anticipated Federal involvement in the project. The award is subject to our receiving your written acknowledgement of the award and acceptance of the STCs, waiver, and expenditure authorities within 30 days of the date of this letter.

Your project officer for this demonstration is Ms. Heather Hostetler. She is available to answer any questions concerning your section 1115 demonstration renewal. Ms. Hostetler's contact information is as follows:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Division of State Demonstrations and Waivers
7500 Security Boulevard, Mailstop S2-01-16
Baltimore, MD 21244-1850
Telephone: (410) 786-4515
Facsimile: (410) 786-8534
E-mail: Heather.Hostetler@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Hostetler and to Mr. Bill Brooks, Associate Regional Administrator in our Dallas Regional Office. Mr. Brooks' contact information is as follows:

Centers for Medicare & Medicaid Services
1301 Young Street, Room 714
Dallas, Texas 75202
Telephone: (214) 767-4461
E-mail: Bill.Brooks@cms.hhs.gov

If you have questions regarding this correspondence, please contact Ms. Jennifer Ryan, Acting Director, Children and Adults Health Programs Group, Center for Medicaid and CHIP Services, at (410) 786-5647.

We look forward to continuing to work with you and your staff.

Sincerely,

//s//

Cindy Mann

Director

Enclosure

cc: Jennifer Ryan, CMCS
Mr. Bill Brooks, Associate Regional Administrator, Dallas Regional Office
Heather Hostetler, CMCS

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00048/6
TITLE: SoonerCare
AWARDEE: Oklahoma Health Care Authority (OHCA)

Under the authority of section 1115(a)(1) of the Social Security Act (Act), the following waivers are granted to enable Oklahoma to operate the Oklahoma SoonerCare Medicaid section 1115 demonstration. These waivers are effective beginning January 1, 2013 the date of approval through December 31, 2015 and are limited to the extent necessary to achieve the objectives described below. They may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in an accompanying document.

All requirements of the Medicaid program expressed in law, regulation, and policy statements, not expressly waived in this list, shall apply to the demonstration project for the period beginning January 1, 2013, through December 31, 2015.

1. Statewideness/Uniformity **Section 1902(a)(1)**

To enable the state to provide Health Access Networks (HANs) only in certain geographical areas of the State.

2. Freedom of Choice **Section 1902(a)(23)(A)**

To enable the state to restrict beneficiaries' freedom of choice of care management providers, and to use selective contracting that limits freedom of choice of certain provider groups to the extent that the selective contracting is consistent with beneficiary access to quality services. No waiver of freedom of choice is authorized for family planning providers.

3. Retroactive Eligibility **Section 1902(a)(34)**

To enable the state to waive retroactive eligibility for demonstration participants, with the exception of Tax Equity and Fiscal Responsibility Act (TEFRA) and Aged, Blind, and Disabled populations.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
EXPENDITURE AUTHORITY**

NUMBER: 11-W-00048/6
TITLE: SoonerCare
AWARDEE: Oklahoma Health Care Authority

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Oklahoma identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this demonstration extension, beginning January 1, 2013 through December 31, 2015, be regarded as expenditures under the state's title XIX plan (except to the extent an earlier expiration date is indicated below). These expenditure authorities are granted to enable the state to operate its Oklahoma SoonerCare section 1115 demonstration and may only be implemented consistent with the approved Special Terms and Conditions (STCs) set forth in an accompanying document.

All requirements of the Medicaid program expressed in law, regulation and policy statements, not expressly waived or identified as not applicable to these expenditure authorities, shall apply to the SoonerCare demonstration project for the period of this demonstration extension.

1. **Demonstration Population 5.** Expenditures for health benefits coverage for individuals who are "Non-Disabled Low Income Workers" age 19–64 years who work for a qualifying employer, are self-employed, or unemployed, and have income above the Medicaid standard, but no more than 200 percent of the Federal poverty level (FPL), and their spouses, and are Medicaid-eligible. This expenditure authority expires December 31, 2013.
2. **Demonstration Population 6.** Expenditures for health benefits coverage for individuals who are "Working Disabled Adults" 19-64 years of age who work for a qualifying employer, are self-employed, or unemployed (and seeking work), who have income up to 200 percent of the FPL and are Medicaid eligible. This expenditure authority expires December 31, 2013.
3. **Demonstration Population 8.** Expenditures for health benefits coverage for no more than 3,000 individuals at any one time who are full-time college students age 19 through age 22 and have income not to exceed 200 percent of the FPL, who have no creditable health insurance coverage, and are Medicaid-eligible. This expenditure authority expires December 31, 2013.
4. **Demonstration population 10.** Expenditures for health benefits coverage for individuals who are working foster parents and their spouses with household incomes no greater than 200 percent of the FPL. This expenditure authority expires December 31, 2013.

5. **Demonstration Population 11.** Expenditures for health benefits coverage for individuals who are employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 200% of the FPL. This expenditure authority expires December 31, 2013.
6. **Health Access Networks Expenditures.** Expenditures for Per Member Per Month payments made to the Health Access Networks for case management activities.
7. **Premium Assistance Beneficiary Reimbursement.** Expenditures for reimbursement of costs incurred by individuals enrolled in the Premium Assistance Program and in the Individual Plan that are in excess of 5 percent of annual gross family income. This expenditure authority expires December 31, 2013.
8. **Health Management Program.** Expenditures for otherwise non-covered costs to provide health coaches and practice facilitation services through the Health Management Program.

Title XIX Requirements Not Applicable to the Demonstration Expenditure Authorities

Not Applicable to Demonstration Populations 5, 6, 8, 10 and 11.

1. **Comparability** **Section 1902(a)(10)(B) and 1902(a)(17)**

To permit the state to provide different benefit packages to individuals in demonstration populations 5, 6, 8, 10 and 11 who are enrolled in the Employer Sponsored Insurance initiative that may vary by individual. This not applicable authority expires December 31, 2013.

2. **Cost Sharing Requirements** **Section 1902(a)(14)
insofar as it incorporates Section 1916**

To permit the state to impose premiums, deductions, cost sharing, and similar charges that exceed the statutory limitations to individuals in populations 5, 6, 8, 10 and 11 who are enrolled in the Employer Sponsored Insurance initiative. This not applicable authority expires December 31, 2013.

3. **Freedom of Choice** **Section 1902(a)(23)(A)**

To permit the state to restrict the choice of provider for beneficiaries eligible under populations 5, 6, 8, 10 and 11 enrolled in the Employer Sponsored Insurance initiative. This not applicable authority expires December 31, 2013. No waiver of freedom of choice is authorized for family planning providers.

4. **Retroactive Eligibility** **Section 1902(a)(34)**

To enable the state to not provide retroactive eligibility for demonstration participants in populations 5, 6, 8, 10 and 11. This not applicable authority expires December 31, 2013.

5. Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services Section 1902(a)(43)

To exempt the state from furnishing or arranging for EPSDT services for full-time college students age 19 through age 22 who have income not to exceed 200 percent of the FPL who are in population 8. This not applicable authority expires December 31, 2013. This not applicable authority expires December 31, 2013.

**6. Assurance of Transportation Sections 1902(a)(iv) and 1902(a)(19)
42 CFR 431.53**

To permit the state to limit transportation benefits to individuals in populations 5, 6, 8, 10 and 11 enrolled in the Insure Oklahoma Individual Plan. This not applicable authority expires December 31, 2013.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS**

NUMBER: 11-W-00048/6
TITLE: SoonerCare
AWARDEE: Oklahoma Health Care Authority

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Oklahoma’s “SoonerCare” section 1115(a) Medicaid demonstration extension (hereinafter “demonstration”). The parties to this agreement are the Oklahoma Health Care Authority (state) and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the demonstration and the state’s obligations to CMS during the life of the demonstration. The STCs are effective as of the date of the approval letter, through December 31, 2015, unless otherwise specified.

The STCs have been arranged into the following subject areas:

- I. Preface
- II. Program Description, Objectives, Historical Context
- III. General Program Requirements
- IV. Eligibility
- V. SoonerCare Benefits and Cost Sharing
- VI. Insure Oklahoma Premium Assistance Benefits and Cost Sharing
- VII. Delivery Systems
- VII. Health Management Program and Chronic Care Unit
- IX. Program Monitoring
- X. General Reporting Requirements
- XI. General Financial Requirements under Title XIX
- XII. General Financial Requirements under Title XXI
- XIII. Monitoring Budget Neutrality
- XIV. Evaluation of the Demonstration
- XV. Schedule of Deliverables for the Demonstration Extension.
- Attachment A. Quarterly Report Content and Format

II. PROGRAM DESCRIPTION, OBJECTIVES HISTORICAL CONTEXT

The SoonerCare Demonstration was initially approved in January 1995. The demonstration operates under a Primary Care Case Management (PCCM) model in which the Oklahoma Health Care Authority (OHCA) contracts directly with primary care providers throughout the state to provide basic health care services. The primary care providers (PCPs) receive a monthly care

coordination payment for each enrolled beneficiary, based upon the services provided at the medical home.

The demonstration provides for a modification of the service delivery system for family and child populations and some aged and disabled populations. The benefits for individuals affected by or eligible only under SoonerCare, with the exception of individuals enrolled in the Insure Oklahoma Premium Assistance Employer Coverage and the Premium Assistance Individual Plan, are state plan benefits.

Demonstration Objectives

Major objectives of the SoonerCare waiver program are:

- To improve access to preventive and primary care services;
- To provide each member with a medical home;
- To integrate Indian health Service (IHS) eligible beneficiaries and IHS and tribal providers into the SoonerCare delivery system;
- To expand access to affordable health insurance for low-income working adults and their spouses;
- To optimize quality of care through effective care management.

Demonstration Hypotheses:

The state will test the demonstration hypotheses listed in Section XIV, Evaluation of the Demonstration, including:

- *PCP Visits.* The rate of adult members who have one or more preventive health visits with a PCP in a year will improve as a measure of access to primary care in accordance with HEDIS® guidelines between 2013-2015.
- *Child Health Checkup Rates.* The rate for age-appropriate well-child and adolescent visits will improve between 2013-2015.
- *Impact of Health Access Networks on Quality of Care.* Key quality performance measures tracked for PCPs participating in the HAN will improve between 2013-2015.
- *Impact of Health Access Networks on Effectiveness of Care.* Per member per month expenditures will decline for members enrolled with PCPs participating in the HAN between 2013-2015.
- *Integration of I/T/U Providers.* The percentage of Native American members who are enrolled with an I/T/U PCP will increase between 2013-2015.
- *Health Management Program.* Health outcomes for chronic diseases will improve between 2013-2015 as a result of participation in the HMP program. Total expenditures for patients enrolled in HMP will decline.

Historical Context of Demonstration Extensions and Amendments:

At the program's inception in 1995, the "SoonerCare" demonstration covered Medicaid state plan populations of AFDC (TANF) and related children and adults, including pregnant women up to the minimum federal poverty level (FPL) standards as defined by state law. The original SoonerCare populations were separated into Urban and Rural Eligibility Groups (EGs). The Urban EG included three catchment areas: Central (Oklahoma City and surrounding areas), Northeast (Tulsa and surrounding areas) and Southwest (Lawton and surrounding areas). The Rural EG included the rest of the state. The original SoonerCare demonstration also granted authority for the state to mandatorily enroll non-Medicare Aged, Blind and Disabled (ABD) beneficiaries into managed care.

In 2005, the state expanded the demonstration's state plan breast and cervical cancer group to qualifying women under age 65 and three additional eligibility groups, including: low income non-disabled workers and spouses employed by small employers; working disabled adults; and children eligible pursuant to the state option under 1902(e)(3) of the Act (TEFRA children).

On January 3, 2009, CMS approved amendments that:

- a) Changed the service delivery model from a Prepaid Ambulatory Health Plan (PAHP) to an exclusive Primary Case Management (PCCM) model;
- b) Added an expansion population to the state's Employer Sponsored Insurance program, Insure Oklahoma, for full-time college students age 19 through age 22 not to exceed 200 percent of the Federal Poverty Level (FPL), up to a cap of 3,000 participants;
- c) Expanded the size of employers who can participate in Insure Oklahoma, from 50 employees to 250 employees;
- d) Expanded the description of qualified PCPs to permit County Health Departments to serve as medical homes for beneficiaries who choose these providers;
- e) Included an option for the voluntary enrollment of children in state or tribal custody in the SoonerCare demonstration;
- f) Implemented a new "Payments for Excellence" program to build upon the current Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and Fourth Diphtheria, Tetanus and Pertussis (DTaP) Bonus program; and,
- g) Amended cost sharing requirements for the Insure Oklahoma Program and added a \$1 co-pay for non-pregnant adults in SoonerCare.

The following programmatic changes were approved under the SoonerCare demonstration extension that was effective January 1, 2010.

- a) Approval of the Health Access Network (HAN) pilot program;
- b) Expanded eligibility under the Insure Oklahoma program to non-disabled working adults and their spouses, disabled working adults, and full-time college students, from 200 percent of the FPL up to and including 250 percent of the FPL;
- c) Added two new eligibility groups under the Insure Oklahoma program for foster parents up to and including 250 percent of the FPL and for not-for profit businesses having fewer than 500 employees, up to and including 250 percent of the FPL.

On August 1, 2011, CMS approved an amendment that eliminated the \$10 co-pay for the initial parental visit under the Insure Oklahoma, Individual Plan.

The following programmatic changes are approved under the SoonerCare demonstration extension effective January 1, 2013 through December 31, 2015.

- a) CMS has removed the waiver authority that allowed the state to exclude parental income in determining eligibility for disabled children eligible in the TEFRA category ((1902)(a)(17) because the state has this authority under the state plan.
- b) CMS has reduced financial eligibility under the Insure Oklahoma program for all populations from up to and including 250 percent of FPL to up to and including 200 percent of FPL (non-disabled working adults and their spouses, disabled working adults, employees of not-for profit businesses having fewer than 500 employees, foster parents and full-time college students). This change reflects implementation levels as of the time of renewal.
- c) CMS has sunset the expenditure and not applicable authorities for the Insure Oklahoma program effective December 31, 2013.
- d) CMS has approved a limitation on the adult outpatient behavioral health benefit in the Insure Oklahoma individual plan to limit the number of visits to 48 per year consistent with the limitation on behavioral health visits for children. This benefit is limited to individual licensed behavioral health professionals (LBHP). However, this is a soft limit and beneficiaries may seek additional services from the LBHP with prior authorization. Additionally, beneficiaries may seek outpatient behavioral health services through a community mental health center.
- e) CMS has approved an amendment to the Health Management Program (HMP), as reflected in Section VII to rename nurse care managers as health coaches and to increase face-to-face care management by embedding health coaches within physician practices with the highest concentration of members with chronic illnesses.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.
- 2. Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for budget neutrality agreements are not subject to change under this subparagraph.
 - b) If mandated changes in the federal law require state legislation, the changes must take effect on the day such state legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. State Plan Amendments.** The state will not be required to submit title XIX or title XXI state plan amendments (SPAs) for changes to any populations made eligible solely through the demonstration. If a population eligible through the Medicaid or CHIP state plan is affected by a change to the demonstration, a conforming amendment to the appropriate state plan is required, except as otherwise noted in these STCs.
- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with

section 1115 of the Act. The state must not implement changes to these elements without prior approval by CMS. Amendments to the demonstration are not retroactive and FFP will not be available for changes to the demonstration that have not been approved through the amendment process set forth in paragraph 7 below.

7. Amendment Process. Requests to amend the demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a demonstration amendment based on non-compliance with these STCs, including but not limited to, failure by the state to submit required reports and other deliverables in a timely fashion according to the deadlines specified herein.

Amendment requests must include, but are not limited to, the following:

- a) An explanation of the public process used by the state, consistent with the requirements of STC17, to reach a decision regarding the requested amendment;
- b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c) An up-to-date CHIP allotment neutrality worksheet, if necessary;
- d) A detailed description of the amendment, including the impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX or XXI state plan amendment, if necessary; and,
- e) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration.

- a) States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the chief executive officer of the state must submit to CMS either a demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.
- b) As part of the demonstration extension request, the state must provide documentation of compliance with the transparency requirements in 42 CFR § 431.412 and the public notice requirements outlined in paragraph 17, as well as include the following supporting documentation:

- i. **Historical Narrative Summary of the Demonstration Project:** The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
- ii. **Special Terms and Conditions (STCs):** The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
- iii. **Waiver and Expenditure Authorities:** The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.
- iv. **Quality:** The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) state quality assurance monitoring, and any other documentation of the quality of care provided or corrective action taken under the demonstration.
- v. **Financial Data:** The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP allotment neutrality worksheet must be included.
- vi. **Evaluation Report:** The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.
- vii. **Documentation of Public Notice 42 CFR § 431.408:** The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

9. Demonstration Phase-Out. The state may only suspend or terminate this demonstration in whole, or in part, consistent with the following requirements;

- a) **Notification of Suspension or Termination:** The state must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date and a phase-out plan. The state must submit its notification letter and a draft phase-out plan to CMS no less than 6 months before the effective date of the demonstration's suspension or termination. Prior to submitting the draft phase-out plan to CMS, the state must publish on its website the draft phase-out plan for a 30-day public comment period. In addition, the state must conduct tribal consultation in accordance with its approved tribal consultation state Plan Amendment. Once the 30-day public comment period has ended, the state must provide a summary of each public comment received, the state's response to the comment and how the state incorporated the received comment into a revised phase-out plan.

The state must obtain CMS approval of the phase-out plan prior to the implementation of the phase-out activities. Implementation of phase-out activities must be no sooner than 14 days after CMS approval of the phase-out plan.

- b) **Phase-out Plan Requirements:** The state must include, at a minimum, in its phase-out plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- c) **Phase-out Procedures:** The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- d) **Federal Financial Participation (FFP):** If the project is terminated or any relevant waivers suspended by the state, FFP shall be limited to normal closeout costs associated with terminating the demonstration including services and administrative costs of disenrolling participants.

10. Expiring Demonstration Authority. For demonstration authority that expires prior to the demonstration's expiration date, the state must submit a demonstration expiration plan to CMS no later than 6 months prior to the applicable demonstration authority's expiration date, consistent with the following requirements:

- a) **Expiration Requirements:** The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.
- b) **Expiration Procedures:** The state must comply with all notice requirements found in 42 CFR § 431.206, 431.210 and 431.213. In addition, the state must assure all appeal and hearing rights afforded to demonstration participants as outlined in 42 CFR § 431.220 and 431.221. If a demonstration participant requests a hearing before the date of action, the state must maintain benefits as required in 42 CFR §431.230. In addition, the state must conduct administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category as discussed in October 1, 2010, State Health Official Letter #10-008.
- c) **Federal Public Notice:** CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR § 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.
- d) **Federal Financial Participation (FFP):** FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

11. CMS Right to Terminate or Suspend. CMS may suspend or terminate the demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the state has materially failed to comply with the terms of the project. CMS shall promptly notify the state in writing of the determination and the reasons for the suspension or termination, together with the effective date.

12. Federal Financial Participation. No Federal matching funds for expenditures for this demonstration will be made available to the state until the effective date identified in the demonstration approval letter.

13. Finding of Non-Compliance. The state does not relinquish its rights to challenge the CMS finding that the state materially failed to comply.

14. Withdrawal of Waiver or Expenditure Authority. CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the

waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or title XXI. CMS will promptly notify the state in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the state an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

- 15. Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.
- 16. Transition Plan.** The State is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration. On June 29, 2012, the state submitted a draft transition plan describing the State's plans to implement the provisions of the ACA for individuals enrolled in the demonstration.
- 17. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must continue to comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

In states with federally recognized Indian tribes, Indian health programs, and / or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and /or renewal of this demonstration. In the event that the state conducts additional consultation activities consistent with these requirements prior to the implementation of the demonstration, documentation of these activities must be provided to CMS .

- 18. Post Award Forum.** Within six months of the demonstration's implementation, and annually thereafter, the state will afford the public with an opportunity to provide meaningful comment on the progress of the demonstration. At least 30 days prior to the date of the planned public forum, the state must publish the date, time and location of the forum in a prominent location on its website. The state can use either its Medical Care Advisory Committee, or another meeting that is open to the public and where an interested party can learn about the progress of the demonstration to meet the requirements of this STC. The state must include a summary of the comments and

issues raised by the public at the forum and include the summary in the quarterly report, as specified in paragraph 52, associated with the quarter in which the forum was held. The state must also include the summary in its annual report as required in paragraph 53.

- 19. Compliance with Managed Care Regulations.** The state must comply with the managed care regulations at 42 CFR section 438 *et. seq.*, except as expressly waived or identified as not applicable in the expenditure authorities incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR section 438.6.

V. ELIGIBILITY

- 20. State Plan Populations Affected.** Title XIX and title XXI populations are affected by the demonstration:

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 56)
Pregnant women and infants under age 1 1902(a)(10)(A)(i)(IV)	Up to 185 % FPL	Freedom of Choice, Retroactive Eligibility	Populations 1,2,3,4
Children 1-5 1902(a)(10)(A)(i)(VI)	Up to 185 % FPL	As Above	Populations 1,2,3,4
Children 6-18 1902(a)(10)(A)(i)(VII)	Up to 185% FPL	As Above	Populations 1,2,3,4
IV-E Foster Care or Adoption Assistance Children	automatic Medicaid eligibility	As Above	Populations 1,2,3,4
1931 low-income families	73% of the AFDC standard of need.	As above	Populations 1,2,3,4
SSI recipients	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Pickle amendment	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Early widows/widowers	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Disabled Adult Children (DACs)	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 56)
1619(b)	SSI for unearned income and earned income limit is the 1916(b) threshold amount for Disabled SSI members, as updated annually by the SSA.	Freedom of Choice	Populations 1,2,3,4
Pregnant women	Above 133% - 185% FPL	Freedom of Choice, Retroactive Eligibility	Population 9
Infants under age 1 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	As Above	Population 9
Children 1-5 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	As Above	Population 9
Children 6-18 through CHIP Medicaid expansion	Above 100% - 185% FPL and for whom the state is claiming title XXI funding.	As Above	Populations 9
Optional State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 51)
Non-IV-E foster care children under age 21 in State or Tribal custody	AFDC limits as of 7/16/1996	As above	Populations 1,2,3,4
Aged, Blind and Disabled	From SSI to 100% FPL	Freedom of Choice	Populations 1,2,3,4
Eligible but not receiving cash assistance	Up to SSI limit	Freedom of Choice	Populations 1,2,3,4
Individuals receiving only optional State supplements	100% SSI FBR + \$41 (SSP)	Freedom of Choice	Populations 1,2,3,4

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 56)
Breast and Cervical Cancer Prevention and Treatment	Up to 185% FPL	Freedom of Choice, Counting Income and Comparability of Eligibility	Populations 1,2,3,4
TEFRA Children (under 19 years of age) with creditable health care insurance coverage	Must be disabled according to SSA definition, with gross personal income at or below 200% FPL, but less than 300% of SSI.	Freedom of Choice, Counting Income and Comparability of Eligibility	Population 7
TEFRA Children (under 19 years of age) without creditable health care insurance coverage	Must be disabled according to SSA definition, with gross personal income at or below 200% FPL and for whom the state is claiming title XXI funding.	Freedom of Choice, Counting Income and Comparability of Eligibility	Population 7

21. Demonstration Eligibility. The following populations are made eligible only through this demonstration, and receive services under the demonstration through the Insure Oklahoma program.

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 56)
Non-Disabled Low Income Workers and Spouse (ages 19-64) *	Up to 200% FPL, who work for an eligible employer with 250 or fewer employees, are self-employed, or unemployed. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	Comparability, Cost Sharing Requirements, Freedom of Choice	Population 5

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 56)
Working Disabled Adults (ages 19-64)*	Up to 200% FPL, who are ineligible for Medicaid due to employment earnings, and who otherwise, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits. No limit on employer size.	As Above	Population 6
Full-time College Students (ages 19-22)*	Not to exceed 200% FPL (limited to 3,000 participants). No limit on employer size.**	As Above	Population 8
Foster Parents (ages 19-64)*	Up to 200% FPL, who work full-time or part-time for an eligible employer. Spouses who do not work are also eligible to enroll on their working spouse's coverage. No limit on employer size.	As Above	Population 10
Qualified Employees of Not-for-profit Businesses (ages 19-64)	Up to 200% FPL, who work for an eligible employer with 500 or fewer employees. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	As Above	Population 11

* Individuals employed with a qualified employer, as defined in paragraph 28, may obtain coverage through Employer Insure Oklahoma Qualified Health Plan Coverage or if unemployed through Premium Assistance Individual Plan Coverage.

** If a dependent, household income cannot exceed 200% FPL.

22. Eligibility Exclusions. The following persons are excluded from the SoonerCare demonstration:

- a) Individuals dually eligible for Medicare and Medicaid;
- b) Individuals residing in an institution or nursing home;
- c) Individuals receiving home and community-based waiver services;
- d) Individuals infected with tuberculosis covered under 1902(a)(10)(A)(ii)(XII) and 1902(z)(1);
- e) Individuals covered by a Managed Care Organization other than the SoonerCare demonstration PCCM;

23. TEFRA Children, Population 7. The population known as “TEFRA Children” is defined as children:

- a) Under 19 years of age;
- b) Disabled according to the Social Security Administration definition;
- c) A U.S. citizen or qualified alien;
- d) With established residency in the state of Oklahoma;
- e) Who have a Social Security Number or have applied for one;
- f) Whose gross personal income is less than the current FBR income limit (300 percent of SSI maximum);
- g) Whose countable assets do not exceed \$2,000.00 (the parent’s assets are not considered); and
- h) Who would be considered Medicaid eligible if they met an institutionalized level of care.

24. TEFRA Children Retroactive Eligibility. TEFRA Children will have retroactive eligibility and will not be subject to default enrollment. SoonerCare member services staff will consult with the parents or guardians of the TEFRA-eligible children to select an appropriate Primary Care Provider/Case Manager (PCP/CM) and provide program orientation and education. Eligible TEFRA children will be able to voluntarily enroll and select a PCP/CM from the SoonerCare PCP or IHS/Tribal/Urban Indian clinic network. TEFRA Children are eligible to receive SoonerCare services and retain other health insurance. SoonerCare will be the secondary payer to other insurance plans. However, if the child is insured through a health maintenance organization, the child will be excluded from the SoonerCare demonstration and enrolled in the FFS Medicaid program in the state.

25. Eligibility Conditions for Demonstration Population 8.

- a) **Income eligibility Documentation.** Applicants must complete the Free Application for Federal Student Aid (FAFSA) as a component of their application. Parental income will not be considered in the state’s eligibility determination if the FAFSA or the university’s financial aid office verifies that the college student is financially independent. Parental income will be considered in the eligibility determination if the college student is deemed by the college or university to be a dependent. An eligible full-time college student can have no other creditable health coverage as defined by section 2701(c) of the Public

Health Service Act, whether provided by their parents, their college/university, or their employer.

- b) **Enrollment Cap.** There is an enrollment cap of 3,000, at any given time, on full-time college students. The state may also impose an enrollment cap on other populations covered under Insure Oklahoma, including the non-disabled low income workers and spouses and working disabled, in order to remain within state funding limits. The state must notify CMS 60 days prior to implementing a waiting list for individuals covered under Insure Oklahoma. This notification must include a plan for how the waiting list will be implemented. When a cap is imposed, the state must institute a separate waiting list for each phase of the Insure Oklahoma program; the Premium Assistance Employer Coverage Plan and the Premium Assistance Individual Plan. To insure resources are available statewide, the state will be divided into six regions with each region eligible to receive a population density, pro-rata share of funding. Any employer or individual already approved for either the Premium Assistance Plan or the Individual Plan may continue to re-enroll not subject to the waiting list. The state will provide written notification to CMS at least 15 days before re-opening enrollment of the demonstration.

V. SOONERCARE BENEFITS and COST SHARING

26. SoonerCare Benefits. All demonstration participants except those receiving Insure Oklahoma Premium Assistance Employer Coverage and the Premium Assistance Individual Plan Coverage, receive SoonerCare Choice benefits. SoonerCare Choice benefits are the benefits covered under the state plan, except that there are no limits on physician visits (as determined to be medically necessary by the PCP). Under the state plan, physician services are limited to four visits per month, including specialty visits.

27. SoonerCare Cost Sharing. Under the SoonerCare demonstration, cost-sharing is not allowed for:

- American Indians with an I/T/U provider;
- Pregnant women;
- Children (including TEFRA children) up to and including age 18;
- Emergency room services; and,
- Family planning services.

Cost-sharing for non-pregnant adult SoonerCare beneficiaries, who would otherwise be eligible under the state plan, is the cost sharing set forth in the state plan. Cost sharing for individuals who would otherwise not be eligible under the state plan is described in Section VI, which describes Insure Oklahoma premium assistance benefits and cost sharing.

VI. INSURE OKLAHOMA PREMIUM ASSISTANCE BENEFITS AND COST SHARING

The STCs in this section are applicable for the renewal period of January 1, 2013 through December 31, 2013. The Insure Oklahoma program expires December 31, 2013, the state must abide by the expiration requirements outlined in STC 10.

28. Insure OK: Premium Assistance Employer Coverage. Premium Assistance Employer Coverage provides qualifying low-income non-disabled workers and their spouses, working foster parents, disabled workers, and full-time college students ages 19-22 up to and including 200 percent of the FPL (subject to any enrollment caps), with premium assistance coverage if they are employed by a qualifying employer. In order for an employer to participate in the Premium Assistance Employer Coverage program the employer must:

- a) Have no more than 250 employees (however, working foster parents and working college students participating in the program may enroll in Premium Assistance Employer Coverage regardless of the size of their employer);
- b) Have no more than 500 employees if the business is not-for-profit;
- c) Have a business that is physically located in Oklahoma;
- d) Be currently offering or intending to offer within 90 calendar days an Insure Oklahoma Qualified Health Plan, as outlined in paragraph 29;
- e) Offer the Insure Oklahoma Qualified Health Plan coverage to employees in accordance with Oklahoma Small Business Statutes, Oklahoma Department of Insurance, and all other regulatory agencies; and,
- f) Contribute a minimum 25 percent of the eligible employee monthly health plan premium for non-disabled workers, disabled workers, and employed college students.

29. Insure OK: Premium Assistance Employer Coverage IO Qualified Health Plan Benefits. An Insure Oklahoma Qualified Health Plan is a health plan that meets the definition of Qualified Health Plan as defined in Oklahoma Administrative Code 317:45-5-1. A Premium Assistance Employer Coverage plan, to be approved as an Insure Oklahoma Qualified Health Plan, must offer a benefit package that at least meets the criteria for a “Secretary Approved Coverage” benefit package. Insure Oklahoma Qualified Health Plans must offer, at a minimum, benefits that include:

- a) Hospital services;
- b) Physician services;
- c) Clinical laboratory and radiology;
- d) Pharmacy; and
- e) Office visits.

Health plans must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. If the health plan requires co-pays, amounts cannot exceed the limits outlined in paragraph 33.

30. Insure OK: Premium Assistance Individual Plan (Insure Oklahoma). The Premium

Assistance Individual Plan is a “safety net” option provided to working disabled adults and those non-disabled low income workers and spouses whose employer elects not to participate in the Premium Assistance Program as well as the self-employed, unemployed, and qualifying working disabled who do not have access to employer sponsored insurance (ESI). The Premium Assistance Individual Plan is also available to full-time college students, ages 19-22 up to and including 200 percent of the FPL (subject to the participant cap), who do not have access to Premium Assistance Employer Coverage.

- a) **Application Process.** Qualifying non-disabled low income workers and spouses, working disabled workers, and full-time college students employed by qualifying, but non-participating firms, will file an application directly with the OHCA, documenting their income, place of employment, and application for worker or worker and spouse coverage.
- b) **Premium Schedule.** Once the application is approved, the enrollee will be provided information on coverage. Enrollees will be required to make their premium payment before the first of the month to which coverage applies. The enrollment effective dates must be consistent with the policy term for the existing SoonerCare demonstration.
- c) **Delinquent Premium Payments.** If the state has billed an enrollee for a premium payment, and the enrollee does not pay the amount due within 60 days of the date on the bill, then the beneficiary’s eligibility for benefits will be terminated. The beneficiary must receive a written notice of termination prior to the date of the termination.
- d) **Repayment Process.** The beneficiary’s eligibility will not be terminated if the beneficiary, prior to the date of termination, pays all amounts which have been billed or establishes a payment plan acceptable to the state. After such a payment plan has been established, the state will bill the beneficiary for (a) payments in accordance with the payment plan, and (b) monthly premiums due subsequent to the establishment of the payment plan. If the enrollee does not make payments in accordance with the payment plan within 30 days of the date on the bill, the beneficiary’s eligibility will be terminated.
- e) **Waiver of Premiums.** If the state determines that the requirement to pay a premium results in an extreme financial hardship for an enrollee, the state may, in its sole discretion, waive payment of the premium or reduce the amount of the premiums assessed to a family or individual.
- f) **Reenrollment.** A disenrolled beneficiary may make a new application for enrollment immediately upon receiving termination notice. In the event the state has implemented a waiting list, any disenrolled beneficiary who reapplies will be placed on the waiting list and notified once the state is open to their enrollment. When the state is able to open enrollment for those on the waiting list, the beneficiaries’ eligibility will be processed in the order they were placed on the waiting list.

31. Premium Assistance Individual Plan (Insure Oklahoma) Benefit Limits. The benefits provided under the Premium Assistance Individual Plan are state plan benefits

with the following limitations. All changes to covered and non-covered services and benefits must be submitted to CMS for prior approval.

Service	Insure Oklahoma Limits Premium Assistance Individual Plan (\$1 Million Lifetime)
Ambulance	Not a covered service
Behavioral health (outpatient)	48 visits per year for adults, more with prior authorization
Dental services	Not a covered service
Durable Medical Equipment and supplies	Covered medically necessary with \$15,000 annual max
EPSDT	No wraparound provided
Enhanced services for medically high risk pregnancies	Not a covered service
Family Planning services and supplies	Limited to birth control information and supplies – Pap smears – Pregnancy tests
Genetic Counseling	Not a covered service
Hearing Aids	Not a covered service
Home Health services	Not a covered service
Hospice	Not a covered service
Lactation Specialist services	Not a covered service
Maternal and Infant Health Licensed Clinical Social Worker services	Not a covered service
Nurse Midwife services	Covered as medically necessary and included in four physician visit limit per month.
Orthodontics	Not a covered service
Podiatry services	Not a covered service
Private duty nursing	Not a covered service
Prosthetic Devices	Not a covered service
Rehabilitation – inpatient and cardiac	Not a covered service
Skilled nursing facility and nursing facility services	Not a covered service
Transplants	Not a covered service
Transportation, non-emergency to obtain covered medical care	Not a covered service

32. Insure Oklahoma Cost-Sharing:

Cost-sharing for individuals covered under a Premium Assistance Employer Coverage

Plan is assessed as outlined in paragraphs 33 and 34. Under the Oklahoma Premium Assistance Individual Plan, cost-sharing is assessed according to the schedule below and as outlined in paragraph 31. This schedule reflects the maximum co-pay amounts that may be required. The state may lower the actual required copayment amounts at any time by notifying CMS in writing at least 30 days prior to the effective date. A family's total annual out-of-pocket cost-shares, including premiums and co-payments, cannot exceed 5 percent of the family's gross income.

Service	Insure Oklahoma Premium Assistance Individual Plan Co-Pays
Ambulatory Surgery Centers	\$25 per visit
Behavioral Health Inpatient	\$50 per admission
Behavioral Health Outpatient	\$10 per visit
Chemotherapy and Radiation Therapy	\$10 per visit
Clinic services including Renal Dialysis services	\$10 per office visit; no co-pay for dialysis
Diabetic supplies	\$5 per prescription
Diagnostic X-ray services	\$25 per scan (MRI, MRA, PET, and CAT scans only)
Durable Medical Equipment and supplies	\$5 per item for durable/non-durable supplies; \$25 co-pay per item for DME
Emergency services	\$30 per visit, waived if admitted
FQHC services	\$10 per visit
Immunizations	\$10 per visit
Inpatient hospital services (Acute Care only)	\$50 per admission
Laboratory	None
Outpatient hospital services	\$25 per visit
Physical Therapy, Occupational Therapy, and Speech Therapy	\$10 per visit
PCP visits	\$10 per visit; no co-pays for well child visit following recommended schedule
Perinatal dental services for pregnant women	None
Physician services, including preventive services	\$10 per visit; no co-pays for well child visit following recommended schedule
Prescription Drugs and insulin	\$5 per generic prescription, \$10 per brand name prescription
Prenatal, delivery and postpartum services	None
Rural Health Clinic services	\$10 per visit; no co-pays for well child visit following recommended schedule

Smoking Cessation products	\$5 per generic prescription, \$10 per brand name prescription
Specialty Clinic visits	\$10 per visit
Substance Abuse Treatment (Outpatient)	\$10 per visit
Tuberculosis services	\$10 per visit

33. Premium Assistance Employer Coverage Co-Payments and Deductibles. For individuals participating in Insure Oklahoma Premium Assistance Employer Coverage, co-pays will be those required by the enrollee’s specific Insure Oklahoma Qualified Health Plan, as defined in paragraph 29, with the following limitations:

- a) Physician office visits cannot require a co-pay exceeding \$50 per visit;
- b) Annual pharmacy deductibles cannot exceed \$500 per individual;
- c) An annual out-of-pocket maximum cannot exceed \$3,000 per individual, excluding pharmacy deductibles; and
- d) The maximum amount of all cost sharing (co-pays, deductibles and premiums) cannot exceed five percent of a family’s total income.

34. Premium Assistance Employer Coverage Plan Premiums. Individuals/families participating in Employer Coverage Programs will be responsible for up to 15 percent of the total health insurance premium not to exceed 3 percent out of the 5 percent annual gross household income cap.

- a) The state will provide reimbursement for out-of-pocket costs incurred by the household in excess of the 5 percent annual gross household income cap for individuals (or their eligible Insure Oklahoma spouse) enrolled in Premium Assistance Employer Coverage. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. The state calculates the 5 percent threshold for each enrollee and on a monthly basis applies the premiums paid by the enrollee toward the 5 percent cap. The state also records co-payments made by the enrollee based upon documentation submitted by the enrollee. Reimbursement is provided by the state once the 5 percent cap is met.
- b) For each enrollee participating in an Employer Coverage Plan, the percentage of premium paid by the state, employer, and enrollee is outlined in the following table:

Premium Assistance Employer Coverage Premium Responsibilities				
Enrollee	State/Federal Share	Employer	Enrollee	Annual Household Income Cap
Non Disabled Worker *	Minimum of 60 percent	Minimum of 25%	Up to 15% of premium, (not to exceed 3% out of the 5%	5%

			household income cap)	
Non Disabled Worker Spouse	Minimum of 85 percent	Minimum of 0%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%
Disabled Worker	Minimum of 60 percent	Minimum of 25%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%
Full-time College Students (when employed by covering employer)	Minimum of 60 percent	Minimum of 25%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%
Full-time College Students (when dependent on parental policy)	Minimum of 85 percent	Minimum of 0%	Up to 15% of premium, (not to exceed 3% out of the 5% household income cap)	5%

* If children are covered the employer must contribute at least 40% of premium cost. If coverage is for the employee only, the employer must contribute at least 25% of premium cost.

35. Premium Assistance Individual Plan Premiums. Individual Plan premiums will be imposed as follows:

- a) For each state fiscal year, the state will establish age/gender premium bands for the Insure Oklahoma Individual Plan that are based on the estimated cost of the coverage. The monthly premium for an individual/family will be set at 20 percent of the age/gender band.
- a) To calculate a monthly premium for the household, the premiums for all covered members will be added together and multiplied by 20 percent. The household contribution to the premium will be capped, not to exceed 4 percent of the monthly gross household income.
- b) The state will require all individuals participating in the Premium Assistance Individual Plan to be responsible for any co-payments subject to the 5 percent annual gross household income cap minus any premiums paid by the enrollee.
- c) The state will provide reimbursement for incurred costs by the household in excess of the 5 percent annual gross household income cap, for individuals (or their eligible Insure Oklahoma spouse) enrolled in the Premium Assistance Individual Plan. A medical expense must be for an allowed and covered service by the health plan, to be eligible for reimbursement.

VII. DELIVERY SYSTEMS

36. Compliance with Managed Care Regulations. The state must comply with the managed care regulations at 42 CFR section 438 *et. seq.*, except as expressly waived or identified as not applicable in the expenditure authorities incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR 438.6.

37. Access and Service Delivery. With the exception of individuals receiving benefits through Insure Oklahoma, all SoonerCare Choice beneficiaries select or are assigned a PCP/CM responsible for furnishing primary and preventive services and making medically necessary referrals. For purposes of determining the member's choice of PCP, the most recent selection received by the OHCA determines the PCP with which the member is enrolled, as long as capacity is available. If capacity is not available or the member does not choose, the member is assigned to a PCP according to the assignment mechanism as defined by the OHCA. A member, who is eligible for SoonerCare Choice but is not assigned, may request enrollment with a PCP by contacting the SoonerCare Helpline. Members may also request a change to their PCP by contacting the SoonerCare Helpline.

PCP/CMs must belong to one of the provider types listed below.

Provider	Required Qualifications
Primary Care Physician	Engaged in Family Medicine, General Internal Medicine, General Pediatrics or General Practice; may be board certified or board eligible; or meet all Federal employment requirements, be employed by the Federal Government and practice primary care in an Indian Health Services (IHS) facility.
Specialist Physician	At discretion of OHCA CEO, based on consideration of percentage of primary care services delivered in physician's practice, the availability of primary care physicians in the geographic area, the extent to which the physician has historically served Medicaid and his/her medical education and training.
Advanced Practice Nurse	Must be licensed by the state in which s/he practices and have prescriptive authority; or meet all Federal employment requirements, be employed by the Federal Government and practice in an IHS facility.
Physician's Assistant	Must be licensed by the state in which s/he practices; or meet all Federal employment requirements, be employed by the Federal government and practice primary care in an IHS facility.
Medical Resident	Must be at least at the Post Graduate 2 level and may serve as a PCP/CM only within his/her continuity clinic setting. Must work under the supervision of a licensed attending physician.
Health Department Clinics	Beneficiaries would be served by one of 68 county health departments or the two city-county health departments in Oklahoma

38. Care Coordination Payments.

a) *Monthly Care Coordination Payments Defined.* PCPs receive a monthly care coordination payment for each enrolled beneficiary, based upon the services provided at the medical home. In return, they are responsible for providing or otherwise assuring the provision of medically necessary primary care and case management services and for making specialty care referrals. There are three tiers of Medical Homes; Entry Level Medical Home (Tier 1), Advanced Medical Home (Tier 2), and Optimal Medical Home (Tier 3). The contracted PCP must meet certain requirements to qualify for payments in each tier. Payments are also stratified according to the PCP panel composition; children only, children and adults, or adults only. PCPs are also responsible for providing 24-hour/7-day telephone coverage for their beneficiaries. This phone coverage is augmented by an OHCA-contracted Patient Advice Line staffed by registered nurses utilizing nationally established protocols in assisting callers; however, the Patient Advice Line will terminate February 28, 2013.

b) *Monthly Schedule of Care Coordination Payments.* Monthly care coordination payments are paid to PCPs based on the following schedule:

Care Coordination Payments			
PMPM	Tier 1	Tier 2	Tier 3
Children	\$4.32	\$6.32	\$8.41
Children and Adults	\$3.66	\$5.46	\$7.26
Adults	\$2.93	\$4.50	\$5.99

Effective January 1, 2009, the state may extend the three-tiered Medical Home care coordination reimbursement methodology to the Indian Health Service, Tribal and Urban Health Clinics for American Indians, and the Insure Oklahoma Network.

c) *Changes to Monthly Care Coordination Payments.* The state must notify CMS 60 days prior to any requested change in the amount of the monthly care coordination payments paid to PCPs and must submit a revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact of the request on budget neutrality for the remainder of the demonstration. CMS will review the state’s documentation and if approved, will provide a written confirmation to the state within 60 days of receiving the request.

d) *Monthly Care Management Payments.* In addition to the monthly care coordination payments described above, the state also makes monthly care management payments to PCPs and IHS, tribal or urban Indian clinic PCPs participating in the SoonerCare Choice and Insure Oklahoma programs. Care management payments range from \$2.00 to \$3.00 per member, per month based on the age and eligibility category of the member.

39. Other Medical Services. All other SoonerCare benefits, with the exception of

emergency transportation which is paid through a capitated contract, are paid through the state's FFS system.

40. Health Access Networks. The state may pilot up to four Health Access Networks (HANs). HANs are non-profit, administrative entities that will work with providers to coordinate and improve the quality of care for SoonerCare beneficiaries. Networks will receive a nominal Per Member per Month (PMPM) payment. This PMPM payment, initially established at \$5, will be made in addition to the care coordination payment paid to PCPs as outlined in paragraph 38. HANs are not eligible for the care coordination payment outlined in paragraph 38. The state must not make duplicative payments to the HANs for Medicaid services covered under the Medicaid state plan. The state must notify CMS 60 days prior to any requested change in the HAN PMPM payment and must submit a revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact of the request on budget neutrality for the remainder of the demonstration. CMS will review the state's documentation and if approved, will provide a written confirmation to the state within 60 days of receiving the request.

The HAN must:

- a) Be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare beneficiaries;
- b) Ensure patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or the state;
- c) Submit a development plan to the state detailing how the network will reduce costs associated with the provision of health care services to SoonerCare enrollees, improve access to health care services, and enhance the quality and coordination of health care services to SoonerCare beneficiaries;
- d) Offer core components of electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies; and,
- e) Offer care management/care coordination to persons with complex health care needs including:
 - i. The co-management of individuals enrolled in the Health Management Program;
 - ii. Individuals with frequent Emergency Room utilization;
 - iii. Women enrolled in the Oklahoma Care Program diagnosed with breast or cervical cancer;
 - iv. Pregnant women enrolled in the High Risk OB Program; and
 - v. Individuals enrolled in the Pharmacy Lock-In Program.

41. Provider Performance. The state may provide additional incentive payments, through the state's Payments for Excellence program, to contracted providers to recognize outstanding performance. Incentive payments will be based on physician practice behavior that may include EPSDT screens, DTaP immunizations, Inpatient Admitting and Visits, Breast and Cervical Cancer Screenings, and Emergency Department Utilization. The state certifies that incentive payments will not exceed five percent of the total FFS payments for those services provided or authorized by the PCP for the period covered.

The state furnishes Provider Performance Payments for Excellence Program to the Indian Health Service, Tribal and Urban Health Clinics for American Indians, and the Insure Oklahoma Network.

42. Services for American Indians. Eligible SoonerCare beneficiaries, with the exception of Insure Oklahoma beneficiaries, may elect to enroll with an IHS, tribal or urban Indian clinic as their PCP/Care Manager. This voluntary enrollment links American Indian members with these providers for primary care/case management services. The providers receive the care coordination payment paid to PCPs as outlined in paragraph 38. All of Oklahoma's IHS, tribal, or urban Indian clinics must have a SoonerCare American Indian PCCM contract.

43. Contracts. Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers shall continue in force.

44. TEFRA Children. TEFRA Children, as defined in paragraph 23, must receive services through the SoonerCare program and its network of participating providers. The OHCA's nurse Exceptional Needs Coordinators in the Care Management Department and SoonerCare Member Services Coordinators provide extensive outreach, assessment, and enrollment assistance to TEFRA Children.

VIII. HEALTH MANAGEMENT PROGRAM

45. Health Management Program Defined. The SoonerCare Health Management Program (HMP) is offered statewide and serves SoonerCare Choice beneficiaries ages 4 through 63 with chronic illness who are at highest risk for adverse outcomes and increased health care expenditures. HMP beneficiaries are selected using HMP predictive modeling software. The state must include in the Quarterly Operational Report, described in paragraph 52, a report on HMP activities including a description of populations served and services provided.

46. Health Management Program Services. Beneficiaries covered by the HMP can be impacted by health coaches and practice facilitation.

a) Health Coaches – Health coaches are embedded within practices that have a high

number of patients with chronic disease, multiple co-morbidities, and at high risk for poor outcomes. Health coaches provide services to encourage beneficiaries to take active roles in the management of their disease processes. Health coaches provide beneficiaries with a comprehensive initial evaluation, plan of care (POC), educational materials, referrals, and self-management support. Beneficiaries will remain in the HMP until maximum benefit has been achieved, as determined by OHCA. Maximum benefit is evaluated on an individual basis for each member served in the Health Management Program. The evaluation considers the individual's diagnoses, goals and progress in ensuring that care needs are met.

- b) Practice Facilitation – Practice facilitation services are provided to selected patient-centered medical homes and offered to enhance primary care services and support chronic disease prevention. Facilitation services range from a brief period of academic detailing to a full-scope chronic disease process improvement-focused service that occurs over a lengthy period of time. Practice facilitation supports the health coaches and assists coached practices with quality improvement initiatives.

Changes to the HMP program. The state must notify CMS 60 days prior to any requested change in HMP services and must submit a revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact of the request on budget neutrality for the remainder of the demonstration. CMS will review the state's documentation and, if approved, will provide a written confirmation to the state within 60 days of receiving the request.

IX. PROGRAM MONITORING

47. Monitoring Aggregate Costs for Eligibles in the Premium Assistance Program.

- a) The state will monitor the aggregate costs for the Premium Assistance Employer Coverage Plan versus the cost of providing coverage through the Premium Assistance Individual Plan. On a quarterly basis, the state will compare the average monthly premium assistance contribution per Employer Coverage enrollee to the cost per member per month of the expansion population enrolled in the Individual Plan.
- b) On an annual basis, the state will calculate the total cost per enrollee per month for individuals receiving subsidies under the Premium Assistance Employer Coverage Plan, including any reimbursement made to enrollees whose out-of-pocket costs exceeded their income stop loss threshold (5 percent of income). The cost for this group will then be compared to the "per enrollee per month" cost for those individuals enrolled in the Premium Assistance Individual Plan.

48. Monitoring Employer Sponsored Insurance.

- a) The state will monitor the aggregate level of contributions made by participating employer's pre and post-implementation of the Premium Assistance Plan.

- b) The state must require that all participating employers report annually on their total contributions for employees covered under the Premium Assistance Plan. The state will prepare an aggregate analysis across all participating employers summarizing the total statewide employer contribution level under the demonstration.
- c) Similarly, the state will monitor changes in covered benefits and cost sharing requirements of employer-sponsored health plans and document any trends in these two areas over the life of the demonstration.

X. GENERAL REPORTING REQUIREMENTS

49. General Financial Requirements. The state must comply with all General Financial Requirements under Title XIX set forth in Section X and all General Financial Reporting Requirements under Title XXI set forth in Section XI.

50. Reporting Requirements Related to Budget Neutrality. The state must comply with all reporting requirements for Monitoring Budget Neutrality set forth in Section XII.

51. Monthly Calls. CMS shall schedule monthly conference calls with the state. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the demonstration. Areas to be addressed include, but are not limited to, PCCM operations (such as contract amendments and rate certifications), health care delivery, HAN activities, enrollment, cost sharing, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the demonstration, progress on evaluations, state legislative developments, and any demonstration amendments, concept papers, or state plan amendments the state is considering submitting. The state and CMS shall discuss quarterly expenditure reports submitted by the state for purposes of monitoring budget neutrality. CMS shall update the state on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the demonstration. The state and CMS shall jointly develop the agenda for the calls.

52. Quarterly Operational Reports: The state must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the state's data along with an analysis of the status of the various operational areas under the demonstration. These quarterly reports must include, but are not limited to:

- a) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery including approval and contracting with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the demonstration; pertinent legislative activity; HAN activities and other operational issues;

- b) Action plans for addressing any policy and administrative issues identified;
- c) Enrollment data, member month data, and budget neutrality monitoring tables;
- d) Updates on the implementation of the Premium Assistance Employer Coverage and Premium Assistance Individual Plan products, such as summary findings from the state's monitoring and analysis as described in paragraphs 47 and 48; and
- e) Evaluation activities and interim findings.

Notwithstanding this requirement, the fourth-quarter Quarterly Report may be included as an addendum to the annual report required in paragraph 53.

53. Annual Report. The state must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under paragraph 52. The state must submit the draft annual report no later than 120 days after the close of each demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

54. Title XXI Enrollment Reporting. The state will provide CMS with an enrollment report showing end of quarter actual and unduplicated ever enrolled figures. The enrollment data for the title XXI population will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

55. Quarterly Expenditure Reports. The state shall provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the demonstration period. CMS shall provide FFP for allowable demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XIII.

56. Reporting Expenditures Under the demonstration: In order to track expenditures under this demonstration, Oklahoma must report demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the state Medicaid Manual. All demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the demonstration project number assigned by CMS (including the project number extension, which indicates the

demonstration year in which services were rendered or for which capitation payments were paid).

- a) For each demonstration year, thirteen (13) separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER must be completed, using the waiver name noted below, to report expenditures for the following demonstration populations.
- i. **Demonstration Population 1: TANF-Urban** includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program, receiving health care services in the designated Central, Northeast, and Southwest urban areas of the state;
 - ii. **Demonstration Population 2: TANF-Rural** includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program receiving health care services in the rural areas of the state;
 - iii. **Demonstration Population 3: ABD-Urban** includes the Aged, Blind and Disabled receiving health care services in the designated Central, Northeast, and Southwest urban areas of the state;
 - iv. **Demonstration Population 4: ABD-Rural** includes the Aged, Blind and Disabled receiving health care services in the rural areas of the state;
 - v. **Demonstration Population 5: Non-Disabled Working Adults** includes non-disabled low income workers and their spouses with household incomes no greater than 250 percent of the FPL;
 - vi. **Demonstration Population 6: Working Disabled Adults** includes low income working disabled adults with household incomes no greater than 250 percent of the FPL;
 - vii. **Demonstration Population 7: TEFRA Children** includes children defined in paragraph 22;
 - viii. **Demonstration Population 8 Full-Time College Students** includes full-time college students ages 19-22 up to and including 200 percent of the FPL (limited to 3,000 individuals at any given time);
 - ix. **Demonstration Population 9: CHIP Medicaid Expansion Children** includes infants under age 1, children ages 1-5, and children ages 6-18.
Note: The State must report information in the Form CMS-64.9 Waiver and/or 64.9P Waiver for this population when using title XIX funds;
 - x. **Demonstration Population 10: Foster Parents** includes working foster parents with household incomes no greater than 200 percent of the FPL. The spouse of a working employee can be covered;
 - xi. **Demonstration Population 11: Not-for-Profit Employees** includes employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 200 percent of the FPL; and,

- xii. **Demonstration Expenses 1: HAN Expenditures** includes PMPM expenditures made to the HANs.
 - xiii. **Demonstration Expenses 2: HMP Expenditures** includes expenditures to provide health coaches and practice facilitation services through the Health Management Program.
- b) For each HAN, the state must collect quarterly data of expenditures made by the HAN. The state must report summary expenditure data, for each HAN, in the Narrative section of Form CMS-64.9 for demonstration Expenses 1.
 - c) For the HMP, the state must collect quarterly data of expenditures made by the HMP. The state must report summary expenditure data in the Narrative section of Form CMS-64.9 for demonstration Expenses 2.
 - d) Specific Reporting Requirements for Medicaid expansion children (including TEFRA children) who revert to title XIX only when the state has exhausted its title XXI allotment.
 - i. The state is eligible to receive title XXI funds for expenditures for these children, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or CMS-64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual.
 - ii. Title XIX funds are available under this demonstration if the state exhausts its title XXI allotment (including any reallocations or redistributions). If the state exhausts its title XXI allotment prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver. The state shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for these demonstration populations.
 - iii. The expenditures attributable to this demonstration population will count toward the budget neutrality expenditure cap calculated under Section XIII, paragraph 69, using the per member per month (PMPM) amounts for children in the TANF Rural and TANF Urban populations described in Section XII, paragraph 56(a)(i-ii), and will be considered expenditures subject to the budget neutrality cap as defined in paragraph 56(e), so that the state is not at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.
 - e) The sum of the quarterly expenditures for all demonstration years will represent the expenditures subject to the budget neutrality cap as defined in paragraph 66.

- f) For purposes of this section, the term “expenditures subject to the budget neutrality cap” must include all Medicaid expenditures on behalf of individuals who are enrolled in this demonstration under paragraph 56(a). All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.
- g) Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or CMS-64.10P Waiver.
- h) All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- i) Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, both the total computable and Federal share amounts that are attributable to the demonstration must be separately reported on the CMS-64 Narrative.

57. Reporting Member Months. The following describes the reporting of member months for demonstration populations:

- a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 55, the actual number of eligible member months for EGs defined in paragraph 56(a). The state must submit a statement accompanying the quarterly report which certifies the accuracy of this information. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions for an additional 180 days after the end of each quarter.
- b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

- c) The “demonstration eligibles” that do contribute to the calculation of the budget neutrality ceiling for the SoonerCare Program include the TANF-Urban, TANF-Rural, ABD Urban and ABD Rural populations as defined in paragraph 55(a).
- d) The “demonstration eligibles” that do not contribute to the calculation of the budget neutrality ceiling for the SoonerCare Program include the non-disabled working adults, disabled working adults, parents of foster children, full-time students, individuals enrolled in the Premium Assistance Individual Plan, and the TEFRA Children as defined in paragraph 56(a).

58. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the demonstration. Oklahoma must estimate matchable demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure agreement and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments and state and Local Administration Costs. CMS shall make Federal funds available based upon the state’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the state, and include the reconciling adjustment in the finalization of the grant award to the state.

59. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the demonstration as a whole as outlined below, subject to the limits described in Section XIII:

- a) Administrative costs, including those associated with the administration of the demonstration;
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan;
- c) Net medical assistance expenditures made under Section 1115 demonstration authority, with dates of service during the demonstration extension period; and
- d) Net premiums and net medical assistance expenditures for persons enrolled in the O-EPIC Program.

60. Sources of Non-Federal Share. The state certifies that the matching non-Federal share of funds for the demonstration is state/local monies. Oklahoma further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by law. Premiums paid by enrollees and collected by the state shall not be used as a source of non-Federal share for the demonstration. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations.

In addition, all sources of the non-Federal share of funding are subject to CMS approval.

- a) CMS may review the sources of the non-Federal share of funding for the demonstration at any time. Oklahoma agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the state as demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the state government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

61. State Certification of Funding Conditions. The state must certify that the following conditions for non-Federal share of demonstration expenditures are met:

- a) Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-Federal share of funds under the demonstration.
- b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for Federal match.
- d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of

title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and state and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

62. Monitoring the Demonstration. The state will provide CMS with information to effectively monitor the demonstration, upon request, in a reasonable time frame.

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

63. Quarterly Expenditure Reports. In order to track title XXI expenditures under this demonstration, the state must report quarterly demonstration expenditures through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in sections 2115 and 2500 of the State Medicaid Manual. Eligible title XXI demonstration expenditures are expenditures for services provided to title XXI children who are eligible with FPL levels within the approved CHIP state plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the state's available title XXI funding.

Title XXI expenditures must be reported on separate Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the demonstration project number assigned by CMS (including project number extension, which indicates the demonstration year in which services were rendered or for which capitation payments were made).

64. Claiming Period. All claims for expenditures related to the demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. Furthermore, all claims for services during the demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 demonstration on the Form CMS-64.21;

- a) The standard CHIP funding process must be used during the demonstration. Oklahoma must estimate matchable CHIP expenditures on the quarterly Form CMS-64.21B. On a separate CMS-64.21B, the state must provide updated estimates of expenditures for the demonstration population. CMS will make Federal funds available based upon the state's estimate, as approved by CMS. Within 30 days after the end of each quarter, the state must submit the Form CMS-64.21U and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 with Federal funding previously made available

to the state, and include the reconciling adjustment in the finalization of the grant award to the state; and,

- b) The state will certify that state/local monies are used as matching funds for the demonstration. The state further certifies that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law. All sources of non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding.

65. Limitation on Title XXI Funding. Oklahoma will be subject to a limit on the amount of Federal title XXI funding that the state may receive for demonstration expenditures during the demonstration period. Federal title XXI funding available for demonstration expenditures is limited to the state's available allotment, including any redistributed funds. Should the state expend its available allotment and redistribution, no further enhanced Federal matching funds will be available for costs of the demonstration until the next allotment becomes available. Once all available title XXI funds are exhausted, the state will continue to provide coverage to Medicaid expansion children (demonstration Population 9) covered under the demonstration and is authorized to claim Federal funding under title XIX funds until further title XXI Federal funds become available.

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

66. Limit on Title XIX Funding. Oklahoma shall be subject to a limit on the amount of Federal title XIX funding that the state may receive on selected Medicaid expenditures during the period of approval of the demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire demonstration. The data supplied by the state to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the state's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

67. Risk. Oklahoma shall be at risk for the per capita cost for demonstration enrollees under this budget neutrality agreement, but not for the number of demonstration enrollees in each of the groups. By providing FFP for all demonstration enrollees, Oklahoma will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Oklahoma at risk for the per capita costs for demonstration enrollees, CMS assures that the Federal demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no

demonstration.

68. Demonstration Populations Subject to the Budget Neutrality Agreement. The following demonstration populations are subject to the budget neutrality agreement and are incorporated into the demonstration EGs used to calculate budget neutrality.

- a) **Eligibility Group 1 (Demonstration Population 1):** Temporary Assistance to Needy Families recipients in urban areas of the state;
- b) **Eligibility Group 2 (Demonstration Population 2):** Temporary Assistance to Needy Families recipients in rural areas of the state;
- c) **Eligibility Group 3 (Demonstration Population 3):** Aged, Blind and Disabled Medicaid recipients (regardless of SSI eligibility) in urban areas of the state;
- d) **Eligibility Group 4 (Demonstration Population 4):** Aged, Blind and Disabled Medicaid recipients (regardless of SSI eligibility) in rural areas of the state; and,
- e) **Eligibility Group 5 (Demonstration Population 9):** Medicaid expansion children (including TEFRA children) who revert to title XIX.

69. Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit for the demonstration:

- a) For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described in paragraph 68 as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under paragraph 57, for each EG, times the appropriate estimated PMPM costs from the table in subparagraph (iii) below.
 - ii. The PMPM costs in subparagraph (iii) below are net of premiums paid by demonstration eligibles.
 - iii. The PMPM costs for the EGs used to calculate the annual budget neutrality expenditure limit for this demonstration are specified below.

Eligibility Category	2013 PMPM	Trend Rate	2014 PMPM	Trend Rate	2015 PMPM	Trend Rate
1) TANF-Urban	\$322.03	4.4%	\$336.2	4.4%	\$350.99	4.4%
2) TANF-Rural	\$326.64	4.4%	\$341.01	4.4%	\$356.01	4.4%
3) ABD-Urban	\$1128.13	4.2%	\$1175.51	4.2%	\$1224.89	4.2%
4) ABD-Rural	\$899.03	4.2%	\$936.79	4.2%	\$976.14	4.2%

- b) The overall budget neutrality expenditure limit for the three-year demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iii) above for each of the 3 years. The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the state may receive for expenditures on behalf of demonstration populations and expenditures described in paragraph 56(a) during the demonstration period.

70. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. However, if the state exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the demonstration years, the state must submit a corrective action plan to CMS for approval.

Year	Cumulative Target	Percentage
Year 18	Year 18 budget neutrality cap plus	1.0 %
Year 19	Years 18 and 19 combined budget neutrality cap plus	0.5 %
Year 20	Years 18 through 20 combined budget neutrality cap plus	0.0 %

71. Exceeding Budget Neutrality. If at the end of this demonstration period the budget neutrality limit has been exceeded, the excess Federal funds must be returned to CMS. If the demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XIV. EVALUATION OF THE DEMONSTRATION

72. Submission of Draft Evaluation Design. The State should submit a draft evaluation plan to CMS no later than 120 days after the award of the demonstration. When developing the evaluation plan, the state should consider and include the following:

- a) The specific research questions and hypotheses that are being tested. The research questions should focus on the programmatic goals and objectives of the demonstration and their potential impacts, particularly as they relate to CMS' Three Part Aim of improving access to and experience of care, improving quality of health care and decreasing per capita costs.
- b) A description of any experimental study design employed (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.) including a proposed baseline and/or control comparison groups.
- c) Quantitative and qualitative process improvement and outcome measures with corresponding specifications that will be used in evaluating the impact of the Demonstration, particularly as it relates to the Three Part Aim of improving access to and experience of care, improving quality of health care and decreasing per capita costs. The evaluation plan should ensure that all outcomes selected

have a clear description and the numerator and denominator should be defined clearly.

- d) Data sources and collection frequency.
- e) The population being studied (consider the target population of the demonstration), including the sampling methodology for selecting the population being included in your analysis.
- f) A detailed analysis plan that describes the statistical methods that will be employed, particularly those that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the State. The level of analysis might be at the beneficiary, provider, and aggregate program level, as appropriate, and may include population stratifications to the extent feasible, for further depth. Qualitative analysis methods should also be described.
- g) The timelines for evaluation related deliverables.

73. Identify the Evaluator. The evaluation plan should identify whether the State will conduct the evaluation, or whether the State will work with an outside contractor for the evaluation.

74. Demonstration Hypotheses. The state will test the demonstration hypotheses in the evaluation of the demonstration, by evaluating:

- a) *Hypothesis 1: Child Health Checkup Rates.* The rate for age-appropriate well-child and adolescent visits will improve between 2013-2015.
- b) *Hypothesis 2: PCP Visits.* The rate of adult members who have one or more preventive health visits with a primary care provider in a year will improve as a measure of access to primary care in accordance with HEDIS® guidelines between 2013-2015.
- c) *Hypothesis 3: PCP Enrollments.* The number of SoonerCare Choice primary care practitioners enrolled as medical home PCPs will increase between 2013-2015.
- d) *Hypothesis 4: PCP Capacity Available.* There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2013-2015. For example, getting an appointment within the timeframe perceived necessary by the member, should improve between 2013-2015.
- e) *Hypothesis 5: Integration of I/T/U Providers.* The percentage of Native American members who are enrolled with an IHS, Tribal, or Urban Indian Clinic with a SoonerCare American Indian PCCM contract will increase between 2013-2015.

- f) *Hypothesis 6: Eligible Member Enrollments in Medical Homes.* The number of members eligible for SoonerCare Choice who do not have an established PCP will decrease between 2013-2015.
- g) *Hypothesis 7: Continuity of Care.* The number of members enrolled with one PCP during a month will increase between 2013-2015.
- h) *Hypothesis 8: Impact of Health Access Networks on Quality of Care.* Key quality performance measures tracked for PCPs participating in the HANs will improve between 2013-2015.
- i) *Hypothesis 9: Impact of Health Access Networks on Effectiveness of Care.* Average per member per month expenditures will decrease for members enrolled with PCPs participating in the HANs between 2013-2015.
- j) *Hypothesis 10: Health Management Program (HMP).* Health outcomes for chronic diseases will improve between 2013-2015 as a result of participation in the HMP. Total expenditures for members enrolled in HMP will decrease.
- k) *Hypothesis 11: Retroactive Eligibility.* The state's systems performance will ensure seamless coverage between Medicaid and the Exchange after changes outlined in the Affordable Care Act are effectuated, evaluating a need for retroactive eligibility.

75. Evaluation of Health Access Networks. The draft evaluation design required under paragraph 72 must include a discussion of the goals, objectives and specific hypotheses that are being tested through the HAN pilot program. The evaluation design must incorporate the use of baseline data collected by the HAN and include an analyses of the HANs effectiveness in:

- a) Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HAN;
- b) Improving access to and the availability of health care services to SoonerCare beneficiaries served by the HAN;
- c) Improving the quality and coordination of health care services to SoonerCare beneficiaries served by the HAN with specific focus on the populations at greatest risk including those with multiple chronic illnesses; and,
- d) Enhancing the state's patient-centered medical home program through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance, and cost.

76. Evaluation of the Health Management Program. The draft evaluation plan required under paragraph 72 must include a discussion of the goals, objectives and specific hypotheses that are being tested through the Health Management Program. The

evaluation plan must incorporate the use of baseline data collected by the HMP and include specific research questions/hypotheses, description of study design employed to address the research questions/hypotheses, any quantitative outcome measures and detailed specifications of those measures (numerator and denominator), any qualitative measures being captured, and an analysis plan that describes how the effects of the HMP program will be isolated from other initiatives. The following hypotheses must be addressed at a minimum:

- a) *Impact on Enrollment Figures:* The implementation of the HMP program, including health coaches and practice facilitation, will result in increase in enrollment as compared to baseline.
- b) *Impact on Access to Care:* Incorporating health coaches into primary care practices will result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data) as compared to baseline when care management occurred via telephonic or face-to-face contact with a nurse care manager.
- c) *Impact on Identifying Appropriate Target Population:* The implementation of the HMP program, including health coaches and practice facilitation, will result in a change in the characteristics of the beneficiary population enrolled in the HMP (as measured through population characteristics including disease burden and co-morbidity obtained through claims and algorithms.) as compared to baseline.
- d) *Impact on Nurse Care Manager Work Burden:* Incorporating health coaches and practice facilitation into primary care practices will result in reduced work burden and improved experience of nurse care managers (as determined through surveys or focus groups).
- e) *Impact on Health Outcomes:* Use of disease registry functions by the health coach will improve the quality of care delivered to beneficiaries as measured by changes in performance on the Initial set of Health Care Quality Measures for Medicaid-Eligible adults or CHIPRA Core Set of Children's Healthcare Quality Measures.
- f) *Impact on Cost/Utilization of Care:* Beneficiaries using HMP services will have fewer ER visits as compared to beneficiaries not receiving HMP services (as measured through claims data).
- g) *Impact on Cost/Utilization of Care:* Beneficiaries using HMP services will have fewer readmissions to hospitals as compared to beneficiaries not receiving HMP services (as measured through claims data).
- h) *Impact on Satisfaction/Experience with Care:* Beneficiaries using HMP services will have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through CAHPS survey data)

77. Evaluation of Eligibility and Enrollment Systems. The interim evaluation report required in paragraph 8 must contain documentation demonstrating the state's systems performance to ensure seamless coverage between Medicaid, CHIP, and the Exchange. This documentation will answer one of the hypotheses that the demonstration is testing, specifically whether there is a need for retroactive eligibility after changes outlined in the Affordable Care Act are effectuated. CMS may issue further guidance to the state on the specific performance measures, however, the state, at a minimum, must include the following data in its interim evaluation report. This is not an exhaustive list, and the state is free to include any other data that informs an assessment of whether the state's systems ensure readiness, eligibility, and enrollment.

- a) The number of eligibility determinations made broken down by type, such as application, transfer and redetermination;
- b) The number of individuals determined ineligible broken down by procedural vs. eligibility reasons;
- c) The average application processing times broken down by type, such as application, transfer and redetermination;
- d) The rate of timely eligibility determinations broken down by completed within 5 days, 10 days and 30 days;
- e) The number of individuals disenrolled broken down by procedural vs. eligibility reasons;
- f) The internal churn rate (i.e., the number of disenrolled beneficiaries reenrolling within 6 months); and
- g) The accurate transfer rate, i.e., the number of individuals transferred to Medicaid, CHIP or the Exchange, as applicable, who are determined eligible by the agency.

78. Interim Evaluation Reports. In the event the state requests to extend the demonstration beyond the current approval period under authority of section 1115(a), (e) or (f) of the Act, the state must submit an interim evaluation report as part of the state's request for each subsequent renewal.

79. Final Evaluation Plan and Implementation. CMS shall provide comments on the draft design within 60 days of receipt, and the state must submit a final plan for the overall evaluation of the demonstration described in paragraph 66, within 60 days of receipt of CMS comments. The state must implement the evaluation design and report its progress in the quarterly reports. The state must submit to CMS a draft evaluation report 120 days after the expiration of the current demonstration. CMS shall provide comments within 60 days of receipt of the report. The state must submit the final report within 60 days after receipt of CMS comments. The content of the Final Evaluation Report should include:

- a) An Executive Summary.
- b) A description of the Demonstration including programmatic goals, interventions implemented, and resulting changes to the health care system.
- c) A summary of the evaluation design employed including hypotheses, study design, population, outcomes, data sources, analysis, etc.
- d) A description of the population included in the evaluation (distribution of age, sex, etc.).
- e) Final evaluation findings.
- f) A discussion of the findings (interpretation and policy context).
- g) Implementation successes, challenges and lessons learned.

80. Cooperation with CMS Evaluators. Should CMS conduct an independent evaluation of any component of the demonstration; the state will cooperate fully with CMS or the independent evaluator selected by CMS. The state will submit the required data to the contractor or CMS.

XV. SCHEDULE OF STATE MANDATORY DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

	Deliverable	STC Reference
Annual	By May 1st - Draft Annual Report	Section X, paragraph 53
Quarterly		
	Quarterly Operational Reports	Section X, paragraph 52
	Quarterly Enrollment and Expenditure Reports	Section X, paragraphs 52 and 55
	CMS-64 Reports	Section XI, paragraph 56
	Eligible Member Months	Section XI, paragraph 57

ATTACHMENT A

Under Section X, paragraph 52 of these STCs, the state is required to submit quarterly progress reports to CMS. The purpose of the Quarterly Report is to inform CMS of significant demonstration activity from the time of approval through completion of the demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the state. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT

Title Line One – SoonerCare

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 18 (1/1/2013 – 12/31/2013)

Federal Fiscal Quarter: 2/2011 (1/13 - 3/13)

Introduction

Please provide information describing the goal of the demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the demonstration. The state should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the state should indicate that by “0”.

Note: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the Form CMS-64)	Current Enrollees (to date)	No. Voluntary Disenrolled in Current Quarter	No. Involuntary Disenrolled in Current Quarter
TANF-Urban			
TANF-Rural			
ABD-Urban			
ABD-Rural			
Non-Disabled Working Adults			
Disabled Working Adults			
TEFRA Children			

CHIP Medicaid Expansion Children			
Full-Time College Students			
Foster Parents			
Not-for-Profit Employees			

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and Form CMS-64 reporting for the current quarter. Identify the state's actions to address these issues.

Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
TANF-Urban				
TANF-Rural				
ABD-Urban				
ABD-Rural				

B. For Informational Purposes Only

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Non-Disabled Working Adults				
Disabled Working Adults				
TEFRA Children				
Full-Time College Students				
Foster Parents				
Not-for-Profit Employees				
CHIP Medicaid Expansion Children				

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

Oklahoma Health Care Authority



§1115(a) SoonerCare Research and Demonstration Waiver Amendment Request

Project Number: 11-W-00048/6

**Submitted
July 19, 2013**

I. OVERVIEW

The recent health reform legislation, the Patient Protection and Affordable Care Act (PPACA), passed in March 2010 by Congress, requires new mandates and modifications to the current Medicaid program. The State proposes to amend the Oklahoma Medicaid program, known as SoonerCare, in order to comply with federal law.

Oklahoma's single-state Medicaid agency, the Oklahoma Health Care Authority (OHCA), operates Medicaid, known as the §1115(a) SoonerCare Choice Research and Demonstration Waiver, which was initially approved in 1995. The SoonerCare demonstration utilizes an enhanced Primary Care Case Management (PCCM) delivery system that furnishes a medical home for qualified members. OHCA contracts directly with medical home primary care providers throughout the State to provide accessible, quality health care services.

As Oklahoma moves forward with health reform and the mandated compliance with the PPACA, the OHCA continues its mission to provide quality health care to Oklahoma's most vulnerable populations, as well as to ensure seamless coverage and accessibility to care. During this health reform transition, the OHCA's objectives are to:

- Comply with eligibility and enrollment provisions;
- Preserve SoonerCare services to current members who are MAGI-exempt or would benefit from maintenance-of-effort provisions; and
- Enable the smooth transition of Oklahomans between insurance affordability programs.

The State submitted the SoonerCare Choice Renewal Application to the Centers for Medicare & Medicaid Services (CMS) on December 31, 2011, requesting an extension of the program for the period January 1, 2013 to December 31, 2015. OHCA received CMS approval for the SoonerCare Choice Renewal Application on December 31, 2012.

The State seeks an amendment approval from CMS by September 15, 2013, in order to initiate certain federal health reform requirements, as well as to ensure seamless operational transitions, by October 1, 2013. Certain components of the proposed amendment, however, have an effective date of January 1, 2014, in order to accommodate other federal timeframes for health reform implementation. *To review a history of SoonerCare amendments throughout the demonstration, see Appendix A.*

II. EXECUTIVE SUMMARY

The OHCA seeks to amend the current §1115(a) SoonerCare Choice Research and Demonstration Waiver to comply with the mandated requirements of the PPACA. The proposed amendment changes incorporate some of the demonstration's main program elements, as outlined in CMS' Special Terms and Conditions (STCs) for Oklahoma.

OHCA proposes the following amendment provisions:

- To amend eligibility guidelines by adding the mandated PPACA Targeted Low-Income Child¹ eligibility group to the SoonerCare Choice demonstration beginning January 1, 2014;
- To amend eligibility guidelines by covering pregnant women at the federally-required Medicaid minimum of 133 percent FPL after January 1, 2014, as Maintenance of Effort provisions specify that existing coverage for adults expires on January 1, 2014.
- To amend the Enrollment section of the STCs specifying that all SoonerCare applicants, unless exempt, adhere to the new 2014 Modified Adjusted Gross Income (MAGI) requirements for income verification, effective January 1, 2014;
- To amend SoonerCare Choice budget neutrality modifying the eligibility groups.

OHCA submits the 2014 SoonerCare Choice amendment to comply with the mandated requirements of the PPACA. As OHCA works toward implementation and the federal requirement timeframes, OHCA will work with CMS on the details and execution of the proposed changes in order to effectively serve members.

¹ In accordance with 42 CFR 457.310.

III. PROPOSED CHANGES TO SOONERCARE CHOICE DEMONSTRATION

The following section modifies the existing Eligibility portion of the SoonerCare Choice STCs.

1. Eligibility

OHCA proposes the following eligibility criteria for the SoonerCare Choice demonstration to take effect January 1, 2014:

a) The State adds the mandatory Targeted Low-Income Child eligibility group for children ages 0-18, under Title XXI. This group includes children who are enrolled in SoonerCare on December 31, 2013, and are ineligible for Medicaid as a result of the elimination of income disregard.

MAGI methodology is not applied to determine eligibility for children who are enrolled in SoonerCare on December 31, 2013, until March 31, 2014 or the child's next regularly scheduled renewal, whichever is later. Since the application of MAGI eliminates income disregards, if the elimination of those income disregards makes the child financially ineligible, the child is related to the Targeted Low-Income Child eligibility group. OHCA estimates that approximately zero children will be eligible for this group.

Eligibility for children in this group expires on the date of the child's next regularly scheduled recertification after the recertification for which the MAGI methodology was first used. This eligibility group terminates for all children December 31, 2015.

b) In accordance with State Medicaid Director's Letter 11-001, the Maintenance of Effort (MOE) provision for existing adult coverage will expire January 1, 2014, or until the Department of Health and Human Services Secretary determines that a Federally-Facilitated health insurance marketplace is fully operational within the State. Pursuant to the expiration of the MOE for adults, the OHCA exercises its option and authority to cover pregnant women at the federally-required Medicaid minimum of 133 percent FPL, effective January 1, 2014, as mandated under Section 2001 of the PPACA.

OHCA Information Systems staff is currently in the process of making these systems changes.

As a condition of Maintenance of Effort indicated in Section 2001 of the PPACA, if the Federally-Facilitated health insurance marketplace is not fully operational by January 1, 2014, the State will maintain existing eligibility standards and benefits for pregnant women approved by the Secretary under Title XIX until the Federally-Facilitated health insurance marketplace is fully operational.

c) All other existing SoonerCare Choice eligibility groups remain consistent with the January 1, 2013 to December 31, 2015, SoonerCare Choice Renewal Application.

OHCA proposes to collaborate with CMS to incorporate the above changes into the following SoonerCare Choice Eligibility chart.

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria ²
Pregnant women (1902(a)(10)(A)(i)(IV))	Up to 133 percent FPL
Children under age 1 (42 CFR 435.118)	Up to 133 percent FPL
Children ages 1-5 (this includes the CHIP Medicaid expansion) (1902)(a)(10)(A)(i)(VI))	Up to 133 percent FPL
Children ages 6-18 (this includes the CHIP Medicaid expansion) (1902)(a)(10)(A)(i)(VII))	Up to 100 percent FPL
IV-E Foster Care or Adoption Assistance Children	Automatic Medicaid eligibility
Low-Income Families with Children (1931)	73 percent of AFDC need standard
SSI Recipients	Up to SSI limit.
Pickle Amendment	Up to SSI limit.
Early Widows/Widowers	Up to SSI limit.
Disabled Adult Children	Up to SSI limit.
1619(b)	SSI for unearned income and earned income limit is the 1916(b) threshold amount for Disabled SSI members, as updated annually by the SSA.
Targeted Low-Income Child	Up to 185 percent FPL

Optional State Plan Groups	FPL and/or Other Qualifying Criteria ²
Children under age 1 (42 CR 435.118)	Above 133 – 185 percent FPL
Children ages 1-5 (this includes the CHIP Medicaid expansion) (1902)(a)(10)(A)(i)(VI))	Above 133 – 185 percent FPL
Children ages 6-18 (this includes the CHIP Medicaid expansion) (1902)(a)(10)(A)(i)(VII))	Above 100 – 185 percent FPL
Non-IV-E foster care children under age 21 in State or Tribal custody	AFDC limits as of 7/16/1996
Aged, Blind and Disabled	From SSI to 100 percent FPL
Eligibly but not receive cash assistance	Up to SSI limit
Individuals receiving only optional state supplements	100 percent SSI FBR + \$41 (SSP)
Breast and Cervical Cancer Prevention and	Up to 185 percent FPL (250 percent FPL for

² It should be noted that the State receives Title XIX matching dollars for income up to 133 percent FPL and the enhanced Title XXI matching dollars for income between 134 percent and 185 percent FPL.

Optional State Plan Groups	FPL and/or Other Qualifying Criteria ²
Treatment	tribes)
TEFRA children (under 19 years of age) with creditable health care insurance coverage	Must be disabled according to SSA definition, with gross personal income at or below 200 percent FPL, but less than 300 percent of SSI.
TEFRA children (under 19 years of age) without creditable health care insurance	Must be disabled according to SSA definition, with gross personal income at or below 200 percent FPL, but less than 300 percent of SSI and for whom the State is claiming Title XXI.

Eligibility Exclusions

OHCA would like to add the following persons to the Eligibility Exclusions section of the STCs:

- Individuals receiving minimum essential coverage from the Federally-Facilitated health insurance marketplace.
- Individuals in the Former Foster Care group.
- Pregnant women with incomes between 134 percent and 185 percent FPL.

2. Enrollment

All persons who apply for SoonerCare Choice beginning January 1, 2014, will have their information processed through the OHCA online enrollment and eligibility system. This includes processing applicants' income information through Modified Adjusted Gross Income (MAGI) for determination of SoonerCare eligibility.

MAGI methodologies will not be applied for current SoonerCare beneficiaries (adults and children) until March 31, 2014, or the next scheduled redetermination date, whichever is later. Eligibility groups exempt from MAGI who will continue to use current income verification rules include Aged, Blind, and Disabled, TEFRA, and BCC members.

3. Budget Neutrality

See attached budget neutrality.

IV. PROGRAM INTEGRITY AND QUALITY ASSURANCE

OHCA continues to provide program integrity through monitoring of the SoonerCare Choice demonstration. OHCA's Program Integrity and Accountability unit performs a financial audit of the Waiver's service providers as part of a more comprehensive provider audit process. Staff makes available to providers a report of financial audits that include findings and recommendations/requirements for plan correction/improvement of provider business processes, if any.

OHCA also participates in the Payment Error Rate Measurement (PERM), as a response to the Improper Payments Information Act of 2002. This initiative measures Medicaid and CHIP error payment rates for each program. Oklahoma received a 1.2 percent error rate on 2011 Medicaid program payments.

In addition, OHCA contracts with APS Healthcare to perform an External Quality Review for the SoonerCare Choice program.

V. MODIFICATION OF EVALUATION DESIGN

At this time, OHCA will not be adding an additional hypothesis for the 2013-2015 demonstration extension period since the mandated eligibility group – the Targeted Low-Income Child – is expected to have zero enrollment.

VI. PUBLIC NOTICE

In accordance with the STCs regarding *Public Notice, Tribal Consultation, and Consultation with Interested Parties*, Oklahoma has provided meaningful public notice to the American Indian Tribes, as well as to the general public, for the proposed program changes outlined in the aforementioned sections.

Public Notice:

- OHCA Board Retreat – OHCA Medicaid Director presented PPACA options for the 2014 SoonerCare Demonstration during Session 4 of the August 23, 2012, annual OHCA Board Retreat, held in Tulsa, Oklahoma. The meeting times and locations are published beforehand in accordance with Oklahoma’s Open Meeting Act.
- OHCA Medical Advisory Committee (MAC) – OHCA staff presented the SoonerCare proposed changes at the MAC meeting in Oklahoma City, Oklahoma on September 20, 2012. The meeting’s times and locations are published beforehand in accordance with Oklahoma’s Open Meeting Act.
- Member Advisory Task Force (MATF) – OHCA staff presented the SoonerCare proposed changes to members of the MATF on October 6, 2012. The MATF was held at the OHCA in Oklahoma City, Oklahoma.
- Perinatal Advisory Task Force (PATF) – OHCA staff presented the SoonerCare proposed changes at the PATF meeting on October 16, 2012, at the Oklahoma City OU Health Science Center Campus, which included teleconferencing with the OU Tulsa Schusterman Campus. The meeting’s times and locations are published beforehand in accordance with Oklahoma’s Open Meeting Act.
- Tribal Consultation – OHCA sent notice of the SoonerCare proposed changes to the tribes on August 21, 2012. Staff presented and discussed the proposed amendment changes with tribal partners at the September 4, 2012, Tribal Consultation meeting held at OHCA.

Comments Received³:

Comment: How are 2014 SoonerCare changes going to be made available and communicated?

Response: OHCA is providing sufficient public notification through public hearings held at different locations and the Tribal Consultation process, which includes representatives from each of the Oklahoma tribes.

Comment: If the State lowers the income level for pregnant women to 133 percent of FPL, will pregnant women with income between 134 percent and 185 percent FPL receive pregnancy-related benefits through SoonerCare and be eligible for benefits on the Federally-Facilitated health insurance marketplace?

Response: Since the Maintenance of Effort provision for existing adult coverage will expire on January 1, 2014, the State will lower the income level for pregnant women to the federally-required Medicaid minimum of 133 percent of the FPL. Pregnant women with income levels between 134 percent and 185 percent of the FPL will be able to receive limited pregnancy-related benefits as it relates to the unborn child under Title XXI, in accordance with Maintenance of Effort, or receive tax subsidies for the Federally-Facilitated health insurance marketplace. In accordance with Oklahoma Administrative Code (OAC) 317:35-22-1 and Title XXI, pregnant women with incomes 134-185 percent FPL cannot receive dual coverage.

VII. STATE PLAN AMENDMENT(S)

OHCA plans to submit corresponding state plan amendments for the federal mandated provisions, as it relates to the SoonerCare Choice demonstration. The state plan amendment(s) will:

- Add the mandated Targeted Low-Income Child eligibility group, effective January 1, 2014;
- Amend eligibility guidelines by covering pregnant women at the federally-required Medicaid minimum of 133 percent FPL beginning January 1, 2014; and
- Amend eligibility guidelines to require SoonerCare applicants, unless exempt, to adhere to the Modified Adjusted Gross Income requirements for income verification, effective January 1, 2014.

³ Comments received also included topics outside the scope of this amendment. Those comments have not been included.

APPENDIX A

Timeline of SoonerCare Choice Amendments

- August 1995 Oklahoma received approval from the Health Care Financing Administration to operate SoonerCare under Section 1915(b). The program was subsumed under a Section 1115(a) demonstration waiver, effective January 1, 1996.
- September 30, 2005 Health Insurance Flexibility and Accountability (HIFA) amendment approved to provide insurance coverage to adults employed by small employers and working disabled adults.
- September 30, 2005 A Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) amendment approved to expand coverage to eligible disabled children.
- January 3, 2009 Amendment approved to change the service delivery model from a prepaid Ambulatory Health Plan to an exclusive Primary Care Case Management model.
- January 3, 2009 Amendment approved to add an expansion population to the State's Employer-Sponsored Insurance program, Insure Oklahoma, for full-time college students age 19 through age 22 not to exceed 200 percent of the Federal Poverty Level, up to a cap of 3,000 participants.
- January 3, 2009 Amendment approved to expand the size of employers who can participate in Insure Oklahoma from 50 employees to 250 employees.
- January 3, 2009 Amendment approved to expand the description of qualified primary care physicians to permit County Health Departments to serve as medical homes for members who choose these providers.
- January 3, 2009 Amendment approved to include an option for the voluntary enrollment of children in State or Tribal custody in the SoonerCare demonstration.
- January 3, 2009 Amendment approved to implement a new "Payments for Excellence" incentive payments program to build upon the current Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and Fourth Diphtheria, Tetanus and Pertussis (DTaP) Bonus program.
- January 3, 2009 Amendment approved to amend cost sharing requirements for the Insure Oklahoma program and add a \$1 copay for non-pregnant adults in SoonerCare.
- January 1, 2010 Amendment approved to implement the Health Access Network pilot program.
- January 1, 2010 Amendment approved for the expansion of eligibility under the Insure Oklahoma program for non-disabled working adults and their spouses,

disabled working adults and full-time college students from 200 percent of the FPL up to and including 250 percent of the FPL.

- January 1, 2010 Amendment approved to add a new eligibility group under the Insure Oklahoma program for foster parents up to and including 250 percent of the FPL.
- January 1, 2010 Amendment approved to add a new eligibility group under the Insure Oklahoma program for employees of not-for-profit businesses having fewer than 500 employees, up to and including 250 percent of the FPL.
- November 2, 2010 Amendment approved to update cost sharing for non-pregnant adults to be consistent with cost sharing assessed under the State Plan.
- April 25, 2011 Amendment approved to implement a waiting list for the Insure Oklahoma program when enrollment reaches 35,000.
- August 1, 2011 Amendment approved to eliminate the \$10 copay for the initial prenatal visit under Insure Oklahoma Individual Plan.
- January 2012 OHCA submits to CMS a SoonerCare Choice amendment to comply with the Patient Protection and Affordable Care Act.
- December 31, 2012 CMS approved the State's 2013-2015 Renewal Application, which included the State's amendment requests to limit the Insure Oklahoma Individual Plan adult outpatient behavioral health benefit to 48 visits per year, and to modify the Health Management Program.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-01-16
Baltimore, Maryland 21244-1850



Center for Medicaid and CHIP Services
Children and Adults Health Programs Group

Mr. Michael Fogarty
Chief Executive Officer
Oklahoma Health Care Authority
4545 Lincoln Boulevard, Suite 124
Oklahoma City, OK 73105

Dear Mr. Fogarty:

The State recently brought to our attention that the Special Terms and Conditions (STCs) document issued by the Centers for Medicare & Medicaid Services (CMS) with the July 15, 2011, SoonerCare Medicaid section 1115 Demonstration (No. 11-W-00048/6) award letter, cited an approval period date that was not accurate. We have made the corrections to the STC document which now reflects an approval period of January 1, 2010, through December 31, 2012. The document had previously indicated an approval period of December 1, 2010, through December 31, 2012.

Your project officer is Mark Pahl. He can be reached at (410) 786-1584 or by email at Mark.Pahl@cms.hhs.gov if you have any questions about this communication.

Sincerely,

Richard Jensen
Director, Division of State Demonstrations and
Waivers

Enclosure

cc: Bill Brooks, ARA, Dallas Regional Office

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER LIST**

NUMBER: 11-W-00048/6
TITLE: SoonerCare
AWARDEE: Oklahoma Health Care Authority (OHCA)

All requirements of the Medicaid program expressed in law, regulation, and policy statements, not expressly waived in this list, shall apply to the Demonstration project beginning January 1, 2010, through December 31, 2012.

The following waivers shall enable Oklahoma to implement the approved Special Terms and Conditions (STCs) for the Oklahoma SoonerCare Medicaid Section 1115 Demonstration. The waivers shall apply to all SoonerCare populations with the exception of expansion populations and populations specifically referenced below.

1. **Statewideness/Uniformity** **Section 1902(a)(1)**

To enable the State to provide Health Access Networks (HANs) only in certain geographical areas of the State.

2. **Freedom of Choice** **Section 1902(a)(23)**

To enable the State to restrict beneficiaries freedom of choice of providers.

3. **Retroactive Eligibility** **Section 1902(a)(34)**

To enable the State to waive retroactive eligibility for Demonstration participants, with the exception of Tax Equity and Fiscal Responsibility Act (TEFRA) and Aged, Blind, and Disabled populations.

4. **Counting Income and Comparability of Eligibility** **Section 1902(a)(17)**

To permit the State to exclude parental income in determining eligibility for disabled children eligible in the TEFRA category.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
WAIVER & EXPENDITURE AUTHORITY**

NUMBER: 11-W-00048/6

TITLE: SoonerCare

AWARDEE: Oklahoma Health Care Authority

All requirements of the Medicaid program expressed in law, regulation and policy statements, not identified as not applicable in this list, shall apply to the Demonstration project beginning January 1, 2010, through December 31, 2012.

Under the authority of section 1115(a)(2) of the Social Security Act (the Act), expenditures made by Oklahoma for the items identified below, which are not otherwise included as expenditures under section 1903 of the Act shall, for the period of this Demonstration extension, be regarded as expenditures under the State's title XIX plan.

1. **Demonstration Population 5.** Expenditures for expanded coverage for individuals who are "Non-Disabled Low Income Workers" age 19–64 years who work for a qualifying employer, are self-employed, or unemployed, and have income above the Medicaid standard, but no more than 250 percent of the Federal poverty level (FPL), and their spouses, and are Medicaid-eligible. This includes foster parents and employees of not-for-profit organizations.
2. **Demonstration Population 6.** Expenditures for expanded coverage for individuals who are "Working Disabled Adults" 19-64 years of age who work for a qualifying employer, are self-employed, or unemployed (and seeking work), who have income up to 250 percent of the FPL and are Medicaid eligible. This includes foster parents and employees of not-for-profit organizations.
3. **Demonstration Population 8.** Expenditures for expanded coverage for no more than 3,000 individuals at any one time who are full-time college students age 19 through age 22 and have income not to exceed 250 percent of the FPL, who have no creditable health insurance coverage, and are Medicaid-eligible.
4. **Demonstration Expenses 1.** Expenditures for Per Member Per Month payments made to the Health Access Networks.
5. Expenditures for reimbursing out-of-pocket costs in excess of 5 percent of annual gross income for individuals enrolled in the Premium Assistance Program and in the Individual Plan, in a manner and to the extent defined by the State and approved by the Centers for Medicare & Medicaid Services (CMS).

6. Expenditures for otherwise non-covered costs related to the Health Management Program.

Medicaid Requirements Not Applicable

Non-Medicaid-eligible groups receiving Demonstration services by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid laws or regulations except as specified below.

Not Applicable to Demonstration Populations 5, 6 and 8.

1. **Comparability** **Section 1902(a)(10)(B) and 1902(a)(17)**

To permit the State to provide different benefit packages to different populations in the Employer Sponsored Insurance initiative. Benefits (i.e., amount, duration, and scope) may vary by individual based on eligibility category.

2. **Cost Sharing Requirements** **Section 1902(a)(14)
insofar as it incorporates Section 1916**

To permit the State to impose premiums, deductions, cost sharing, and similar charges that exceed the statutory limitations to populations in the Employer Sponsored Insurance initiative.

3. **Freedom of Choice** **Section 1902(a)(23)**

To permit the State to restrict the choice of provider for beneficiaries eligible under the Employer Sponsored Insurance initiative.

4. **Retroactive Eligibility** **Section 1902(a)(34)**

To enable the State to waive retroactive eligibility for Demonstration participants.

Not Applicable to Demonstration Population 8.

5. **Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services** **Section 1902(a)(43)**

To exempt the State from furnishing or arranging for EPSDT services for full-time college students age 19 through age 22 and have income not to exceed 250 percent of the FPL.

**CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS
REVISED AUGUST 1, 2011**

NUMBER: 11-W-00048/6
TITLE: SoonerCare
AWARDEE: Oklahoma Health Care Authority

I. PREFACE

The following are Special Terms and Conditions (STCs) for Oklahoma's "SoonerCare" section 1115(a) Medicaid Demonstration extension (hereinafter "Demonstration"). The parties to this agreement are the Oklahoma Health Care Authority (State) and the Centers for Medicare & Medicaid Services (CMS). The STCs are applicable to services provided and individuals applying for benefits under the Demonstration on or after January 1, 2010 unless otherwise specified. All previously approved STCs, waivers, and expenditure authorities are superseded by the STCs set forth below. This Demonstration is approved through December 31, 2012.

The STCs have been arranged into the following subject areas: Program Description and Objectives; General Program Requirements; Eligibility, Benefits, and Enrollment; Cost Sharing; Delivery Systems; Health Management Program; Program Monitoring; General Reporting Requirements; General Financial Requirements Under Title XIX; General Financial Requirements Under Title XXI; Monitoring Budget Neutrality; Evaluation of the Demonstration; and Schedule of Deliverables for the Demonstration Extension.

II. PROGRAM DESCRIPTION AND OBJECTIVES

The SoonerCare Demonstration was initially approved in January 1995. The Demonstration operates under a Primary Care Case Management (PCCM) model in which the Oklahoma Health Care Authority (OHCA) contracts directly with primary care providers throughout the State to provide basic health care services. The primary care providers (PCPs) receive a monthly care coordination fee for each enrolled beneficiary, based upon the services provided at the medical home.

The Demonstration provides services to Temporary Assistance for Needy Families (TANF) related populations and the aged and disabled with some exceptions. SoonerCare benefits, with the exception of the Insure Oklahoma Premium Assistance Employer Coverage and the Premium Assistance Individual Plan, are State plan benefits.

On September 30, 2005, the following two amendments were approved expanding the Demonstration.

- a) A Health Insurance Flexibility and Accountability (HIFA) amendment to provide insurance coverage to adults employed by small employers and working disabled adults; and,

- b) A Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) amendment to expand coverage to eligible disabled children.

On January 3, 2009, amendments were approved to:

- a) Change the service delivery model from a partially capitated payment to an exclusive Primary Case Management (PCCM) model;
- b) Add an expansion population to the State's Employer Sponsored Insurance program, Insure Oklahoma, for full-time college students age 19 through age 22 not to exceed 200 percent of the Federal Poverty Level (FPL), up to a cap of 3,000 participants;
- c) Expand the size of employers who can participate in Insure Oklahoma, from 50 employees to 250 employees;
- d) Expand the description of qualified PCPs to permit County Health Departments to serve as medical homes for beneficiaries who choose these providers;
- e) Include an option for the voluntary enrollment of children in State or Tribal custody in the SoonerCare Demonstration;
- f) Implement a new "Payments for Excellence" program to build upon the current Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and Fourth Diphtheria, Tetanus and Pertussis (DTaP) Bonus program; and,
- g) Amend cost sharing requirements for the Insure Oklahoma Program and added a \$1 co-pay for non-pregnant adults in SoonerCare.

The following programmatic changes were approved under the SoonerCare Demonstration renewal that is effective January 1, 2010.

- a) Approval of the Health Access Network (HAN) pilot program;
- b) Expansion of eligibility under the Insure Oklahoma program for non-disabled working adults and their spouses, disabled working adults, and full-time college students, from 200 percent of the FPL up to and including 250 percent of the FPL;
- c) Adding a new eligibility group under the Insure Oklahoma program for foster parents up to and including 250 percent of the FPL; and
- d) Adding a new eligibility group under the Insure Oklahoma program employees of not-for profit businesses having fewer than 500 employees, up to and including 250 percent of the FPL.

III. GENERAL PROGRAM REQUIREMENTS

- 1. Compliance with Federal Non-Discrimination Statutes.** The State must comply with all

applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

- 2. Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.
- 3. Changes in Medicaid and CHIP Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this Demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.
- 4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy.**
 - a) To the extent that a change in Federal law, regulation, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, modified budget neutrality and allotment neutrality agreements for the Demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for budget neutrality agreements are not subject to change under this subparagraph.
 - b) If mandated changes in the Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.
- 5. State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes to any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid or CHIP State plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State plan is required, except as otherwise noted in these STCs.
- 6. Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below.
- 7. Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and

may not be implemented until approved. Amendment requests must be reviewed by the Federal Review Team and must include, but are not limited to, the following:

- a) An explanation of the public process used by the State, consistent with the requirements of paragraph 15, to reach a decision regarding the requested amendment;
- b) A data analysis which identifies the specific “with waiver” impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable “with waiver” and “without waiver” status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the “with waiver” expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;
- c) An up-to-date CHIP allotment neutrality worksheet, if necessary;
- d) A detailed description of the amendment, including the impact on beneficiaries, with sufficient supporting documentation; and,
- e) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. Extension of the Demonstration. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) are advised to observe the timelines contained in those statutes. Otherwise, no later than 12 months prior to the expiration date of the Demonstration, the chief executive officer of the State must submit to CMS either a Demonstration extension request or a phase-out plan consistent with the requirements of paragraph 9.

As part of the Demonstration extension request, the state must provide documentation of compliance with the public notice requirements outlined in paragraph 15, as well as include the following supporting documentation:

- a) **Demonstration Summary and Objectives:** The State must provide a narrative summary of the Demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.
- b) **Special Terms and Conditions (STCs):** The State must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.
- c) **Waiver and Expenditure Authorities:** The State must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

- d) **Quality:** The State must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) and State quality assurance monitoring, and any other documentation of the quality of care provided under the demonstration.
- e) **Compliance with the Budget Neutrality Cap:** The State must provide financial data (as set forth in the current STCs) demonstrating the State's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the State to insure that Federal expenditures under the extension of this project do not exceed the Federal expenditures that would otherwise have been made. In addition, the State must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP Allotment Neutrality worksheet must be included.
- f) **Draft report with Evaluation Status and Findings:** The State must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

9. Demonstration Phase-Out. The State may suspend or terminate this Demonstration in whole, or in part, at any time prior to the date of expiration. The State must promptly notify CMS in writing of the reason(s) for the suspension or termination, together with the effective date. In the event the State elects to phase out the Demonstration, the State must submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. Consistent with the enrollment limitation requirement in paragraph 11, a phase-out plan shall not be shorter than six months unless such action is necessitated by emergent circumstances. The phase-out plan is subject to CMS approval. If the project is terminated or any relevant waivers suspended by the State, FFP shall be limited to normal closeout costs associated with terminating the Demonstration, including services and administrative costs of disenrolling participants.

10. CMS Right to Terminate or Suspend. CMS may suspend or terminate the Demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS shall promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

11. Enrollment Limitation during Demonstration Phase-Out. If the State elects to suspend, terminate, or not renew this Demonstration as described in paragraph 9, during the last 6 months of the Demonstration, individuals who would not be eligible for Medicaid under the current Medicaid State plan must not be enrolled unless the Demonstration is extended by CMS. Enrollment must be suspended if CMS notifies the State in writing that the Demonstration will not be renewed.

12. Finding of Non-Compliance. The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

- 13. Withdrawal of Waiver or Expenditure Authority.** CMS reserves the right to withdraw waiver or expenditure authorities at any time it determines that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX and/or title XXI. CMS will promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.
- 14. Adequacy of Infrastructure.** The State will ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.
- 15. Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, when any program changes to the Demonstration, including (but not limited to) those referenced in STC 6, are proposed by the State. In States with Federally recognized Indian tribes, Indian health programs, and / or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any waiver proposal, amendment, and /or renewal of this Demonstration. In the event that the State conducts additional consultation activities consistent with these requirements prior to the implementation of the demonstration, documentation of these activities must be provided to CMS .
- 16. Compliance with Managed Care Regulations.** The State must comply with the managed care regulations at 42 CFR section 438 *et. seq.*, except as expressly waived or identified as not applicable in the expenditure authorities incorporated into the STCs. Capitation rates must be developed and certified as actuarially sound in accordance with 42 CFR section 438.6.
- 17. Federal Funds Participation.** No Federal matching funds for expenditures for this Demonstration will be made available to the State until the effective date identified in the Demonstration approval letter.

IV. ELIGIBILITY, BENEFITS, AND ENROLLMENT

At the program's inception in 1995, the "SoonerCare" Demonstration covered AFDC (TANF) and related children and adults, including pregnant women up to the minimum FPL standards as defined by State law. The original SoonerCare populations were separated into Urban and Rural Eligibility Groups (EGs). The Urban EG included three catchment areas: Central (Oklahoma City and surrounding areas), Northeast (Tulsa and surrounding areas) and Southwest (Lawton and surrounding areas). The Rural EG included the rest of the State. The original SoonerCare Demonstration also granted authority to the State to mandatorily enroll non-Medicare Aged, Blind and Disabled (ABD)

beneficiaries into managed care.

In 2005, the State added Breast and Cervical Cancer Prevention and Treatment coverage for qualifying women under age 65 and three additional eligibility groups: Low Income Non-Disabled Workers and Spouses, Working Disabled, and TEFRA Children. In January 2009, the State added Foster Children eligible for Medicaid under the State plan as a population that could elect to enroll voluntarily in the Demonstration.

In January 2009, the Demonstration was amended to add full time college students age 19 through age 22 up to and including 200 percent of the FPL as an expansion population (with a ceiling of 3,000 participants) in Insure Oklahoma.

For the current renewal period January 1, 2010 through December 31, 2012, eligibility under Insure Oklahoma coverage was expanded to include:

- a) Non-disabled low income workers and their spouses, and working disabled adults, from 200 percent up to and including 250 percent of the FPL;
- b) Foster parents up to and including 250 percent of the FPL; and,
- c) Employees of not-for-profit businesses having fewer than 500 employees up to and including 250 percent of the FPL.

SoonerCare Demonstration populations receive Medicaid State plan benefits with the exception of beneficiaries enrolled in the Insure Oklahoma Program. The Insure Oklahoma Program was previously known as the Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) Program. Beneficiaries enrolled in the Insure Oklahoma Program receive benefits through either Premium Assistance Employer Coverage or the Premium Assistance Individual Plan as defined in these STCs. The Insure Oklahoma Program offers health care benefits to non-disabled low income workers (and their spouses) and the working disabled through the Premium Assistance Employer Coverage and Premium Assistance Individual Plan programs. The benefits for full-time college students, ages 19–22 up to and including 250 percent of the FPL, are delivered through the Insure Oklahoma Program.

18. Eligibility. Mandatory and optional State plan groups described below are subject to all applicable Medicaid laws and regulations, except as expressly waived for this Demonstration. Those groups described below who are made eligible for the Demonstration by virtue of the expenditure authorities expressly granted in this Demonstration are subject to Medicaid laws or regulations only as specified in the expenditure authorities for this Demonstration.

For applicants that are full-time college students, the students must complete the Free Application for Federal Student Aid (FAFSA) as a component of their application. Parental income will not be considered in the State's eligibility determination if the FAFSA or the university's financial aid office verifies that the college student is financially independent. Parental income will be considered in the eligibility determination if the college student is deemed by the college or university to be a dependent. An eligible full-time college student can have no other creditable health coverage as defined by section 2701(c) of the Public

Health Service Act, whether provided by their parents, their college/university, or their employer.

Title XIX and title XXI populations are included as follows:

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 51)
Pregnant women and infants under age 1	Up to 133 % FPL	Freedom of Choice, Retroactive Eligibility	Populations 1,2,3,4
Children 1-5	Up to 133 % FPL	As Above	Populations 1,2,3,4
Children 6-18	Up to 100% FPL	As Above	Populations 1,2,3,4
Children in State or Tribal Custody	State AFDC Level	As Above	Populations 1,2,3,4
Adults with children (ages 19-64) TANF	Up to 37% FPL	As Above	Populations 1,2,3,4
Aged, Blind and Disabled	Up to 100% FPL	Freedom of Choice	Populations 1,2,3,4
Optional State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See Paragraph 51)
Pregnant women	Above 133% - 185% FPL	Freedom of Choice, Retroactive Eligibility	Population 9
Infants under age 1 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the State is claiming title XXI funding.	As Above	Population 9
Children 1-5 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the State is claiming title XXI funding.	As Above	Population 9
Children 6-18 through CHIP Medicaid expansion	Above 100% - 185% FPL and for whom the State is claiming title XXI funding.	As Above	Populations 9
TEFRA Children (under 19 years of age) with creditable health care insurance coverage	Must be disabled according to SSA definition, with gross personal income at or below 200% FPL, but less than 300% of SSI.	Freedom of Choice, Counting Income and Comparability of Eligibility	Population 7
TEFRA Children (under 19 years of age) without creditable health care insurance	Must be disabled according to SSA definition, with gross personal income at or	Freedom of Choice, Counting Income and Comparability of Eligibility	Population 7

coverage	below 200% FPL and for whom the State is claiming title XXI funding.		
Breast and Cervical Cancer Prevention and Treatment	Women under 65 per CDC Guidelines.	Freedom of Choice, Retroactive Eligibility,	Populations 1,2,3,4
Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	
Non-Disabled Low Income Workers and Spouse (ages 19-64) *	Up to 250% FPL, who work for an eligible employer with 250 or fewer employees, are self-employed, or unemployed. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	Comparability, Cost Sharing Requirements, Freedom of Choice	Population 5
Working Disabled Adults (ages 19-64)*	Up to 250% FPL, who are ineligible for Medicaid due to employment earnings, and who otherwise, except for earned income, would be eligible to receive Supplemental Security Income (SSI) benefits. No limit on employer size.	As Above	Population 6
Foster Parents (ages 19-64)*	Up to 250% FPL, who work full-time or part-time for an eligible employer. Spouses who do not work are also eligible to enroll on their working spouse's coverage. No limit on employer size.	As Above	Population 10
Qualified Employees of Not-for-profit Businesses (ages 19-64)	Up to 250% FPL, who work for an eligible employer with 500 or fewer employees. Spouses who do not	As Above	Population 11

	work are also eligible to enroll on their working spouse's coverage.		
Full-time College Students (ages 19-22)*	Not to exceed 250% FPL (limited to 3,000 participants). No limit on employer size.**	As Above	Population 8

* Individuals employed with a qualified employer, as defined in paragraph 24, may obtain coverage through Employer Qualified Health Plan Coverage or if unemployed through Premium Assistance Individual Plan Coverage.

** If a dependent, household income cannot exceed 250% FPL.

19. Eligibility Exclusions. The following persons are excluded from the SoonerCare Demonstration:

- a) Individuals dually eligible for Medicare and Medicaid;
- b) Individuals residing in an institution or nursing home;
- c) Individuals receiving home and community-based waiver services;
- d) Individuals covered by a Managed Care Organization; and

20. TEFRA Children. The population known as “TEFRA Children” is defined as children:

- a) Under 19 years of age;
- b) Disabled according to the Social Security Administration definition;
- c) A U.S. citizen or qualified alien;
- d) With established residency in the State of Oklahoma;
- e) Who have a Social Security Number or have applied for one;
- f) Whose gross personal income is less than the current FBR income limit (300 percent of SSI maximum);
- g) Whose countable assets do not exceed \$2,000.00 (the parent's assets are not considered); and
- h) Who would be considered Medicaid eligible if they met an institutionalized level of care.

21. TEFRA Children Retroactive Eligibility. TEFRA Children will have retroactive eligibility and will not be subject to default enrollment. SoonerCare member services staff will consult with the parents or guardians of the TEFRA-eligible children to select an appropriate Primary Care Provider/Case Manager (PCP/CM) and provide program orientation and education. Eligible TEFRA children will be able to voluntarily enroll and select a PCP/CM from the SoonerCare IHS/Tribal/Urban Indian clinic network. TEFRA Children are eligible to receive SoonerCare services and retain other health insurance. SoonerCare will be the secondary payer to other insurance plans. However, if the child is insured through a fully-capitated health maintenance organization, the child will be excluded from the SoonerCare demonstration and enrolled in the FFS Medicaid program in the State.

22. Enrollment Cap. There is an enrollment cap of 3,000, at any given time, on full-time college

students. The State may also impose an enrollment cap on other populations covered under Insure Oklahoma, including the non-disabled low income workers and spouses and working disabled, in order to remain within State funding limits. The State must notify CMS 60 days prior to implementing a waiting list for individuals covered under Insure Oklahoma. This notification must include a plan for how the waiting list will be implemented. When a cap is imposed, the State must institute a separate waiting list for each phase of the Insure Oklahoma program; the Premium Assistance Employer Coverage Plan and the Premium Assistance Individual Plan. To insure resources are available statewide, the State will be divided into six regions with each region eligible to receive a population density, pro-rata share of funding. Any employer or individual already approved for either the Premium Assistance Plan or the Individual Plan may continue to re-enroll not subject to the waiting list. The State will provide written notification to CMS at least 15 days before re-opening enrollment of the Demonstration.

23. SoonerCare Benefits. SoonerCare benefits, with the exception of the Insure Oklahoma Premium Assistance Employer Coverage and the Premium Assistance Individual Plan, are State plan benefits. The SoonerCare benefits plan does provide the enhanced benefit of unlimited physician visits (as medically necessary with the PCP) as compared to the State plan, which limits physician services to four visits per month, including specialty visits.

24. Insure OK: Premium Assistance Employer Coverage. Premium Assistance Employer Coverage provides qualifying low-income non-disabled workers and their spouses, working foster parents, disabled workers, and full-time college students ages 19-22 up to and including 250 percent of the FPL (subject to any enrollment caps), with premium assistance coverage if they are employed by a qualifying employer. In order for an employer to participate in the Premium Assistance Employer Coverage program the employer must:

- a) Have no more than 250 employees (however, working foster parents and working college students participating in the program may enroll in Premium Assistance Employer Coverage regardless of the size of their employer);
- b) Have no more than 500 employees if the business is not-for-profit;
- c) Have a business that is physically located in Oklahoma;
- d) Be currently offering or intending to offer within 90 calendar days an Insure Oklahoma Qualified Health Plan, as outlined in paragraph 25;
- e) Offer the Qualified Health Plan coverage to employees in accordance with Oklahoma Small Business Statutes, Oklahoma Department of Insurance, and all other regulatory agencies; and,
- f) Contribute a minimum 25 percent of the eligible employee monthly health plan premium for non-disabled workers, disabled workers, and employed college students.

25. Insure OK: Premium Assistance Employer Coverage Qualified Health Plan Benefits. A Premium Assistance Employer Coverage plan, to be approved as a Qualified Health Plan, must offer a benefit package that at least meets the criteria for a “Secretary Approved Coverage” benefit package. Qualified Health Plans must offer, at a minimum, benefits that include:

- a) Hospital services;

- b) Physician services;
- c) Clinical laboratory and radiology;
- d) Pharmacy; and
- e) Office visits.

Health plans must be approved by the Oklahoma Insurance Department for participation in the Oklahoma market. If the health plan requires co-pays, amounts cannot exceed the limits outlined in paragraph 29.

26. Insure OK: Premium Assistance Individual Plan (Insure Oklahoma). The Premium Assistance Individual Plan is a “safety net” option provided to working disabled adults and those non-disabled low income workers and spouses whose employer elects not to participate in the Premium Assistance Program as well as the self-employed, unemployed, and qualifying working disabled who do not have access to ESI. The Premium Assistance Individual Plan is also available to full-time college students, ages 19-22 up to and including 250 percent of the FPL (subject to the participant cap), who do not have access to Premium Assistance Employer Coverage.

- a) **Application Process.** Qualifying non-disabled low income workers and spouses, working disabled workers, and full-time college students employed by qualifying, but non-participating firms, will file an application directly with the OHCA, documenting their income, place of employment, and application for worker or worker and spouse coverage.
- b) **Premium Schedule.** Once the application is approved, the enrollee will be provided information on coverage. Enrollees will be required to make their premium payment before the first of the month to which coverage applies. The enrollment effective dates must be consistent with the policy term for the existing SoonerCare Demonstration.
- c) **Delinquent Premium Payments.** If the State has billed an enrollee for a premium payment, and the enrollee does not pay the amount due within 60 days of the date on the bill, then the beneficiary’s eligibility for benefits will be terminated. The beneficiary must receive a written notice of termination prior to the date of the termination.
- d) **Repayment Process.** The beneficiary’s eligibility will not be terminated if the beneficiary, prior to the date of termination, pays all amounts which have been billed or establishes a payment plan acceptable to the State. After such a payment plan has been established, the State will bill the beneficiary for (a) payments in accordance with the payment plan, and (b) monthly premiums due subsequent to the establishment of the payment plan. If the enrollee does not make payments in accordance with the payment plan within 30 days of the date on the bill, the beneficiary’s eligibility will be terminated.
- e) **Waiver of Premiums.** If the State determines that the requirement to pay a premium results in an extreme financial hardship for an enrollee, the State may, in its sole discretion, waive payment of the premium or reduce the amount of the premiums assessed to a family or individual.
- f) **Reenrollment.** A disenrolled beneficiary may make a new application for enrollment immediately upon receiving termination notice. In the event the State has implemented a waiting list, any disenrolled beneficiary who reapplies will be placed on the waiting list and notified once the State is open to their enrollment. When the State is able to

open enrollment for those on the waiting list, the beneficiaries' eligibility will be processed in the order they were placed on the waiting list.

27. Premium Assistance Individual Plan (Insure Oklahoma) Benefits. The benefits provided under the Premium Assistance Individual Plan are State plan benefits with the following limitations. (All non-covered services may not be listed.)

Service	Insure Oklahoma Limits Premium Assistance Individual Plan (\$1 Million Lifetime)
Ambulance	Not a covered service
Dental services	Not a covered service
Durable Medical Equipment and supplies	Covered medically necessary with \$15,000 annual max
EPSDT	No wraparound provided
Enhanced services for medically high risk pregnancies	Not a covered service
Family Planning services and supplies	Birth control information and supplies – Pap smears – Pregnancy tests
Genetic Counseling	Not a covered service
Hearing Aids	Not a covered service
Home Health services	Not a covered service
Hospice	Not a covered service
Lactation Specialist services	Not a covered service
Maternal and Infant Health Licensed Clinical Social Worker services	Not a covered service
Nurse Midwife services	Covered as medically necessary and included in four physician visit limit per month.
Orthodontics	Not a covered service
Podiatry services	Not a covered service
Private duty nursing	Not a covered service
Prosthetic Devices	Not a covered service
Rehabilitation – inpatient and cardiac	Not a covered service
Skilled nursing facility services	Not a covered service
Transplants	Not a covered service
Transportation, non-emergency to obtain covered medical care	Not a covered service

V. COST SHARING

28. SoonerCare and Insure Oklahoma Cost-Sharing: Under the SoonerCare Demonstration, cost-sharing is not allowed for:

- Pregnant women;
- Children (including TEFRA children) up to and including age 18;
- Emergency room services; and,
- Family planning services.

Cost-sharing for non-pregnant adult SoonerCare beneficiaries, who would otherwise be eligible under the State plan, is consistent with cost sharing assessed under the State plan.

Cost-sharing for individuals covered under a Premium Assistance Employer Coverage Plan is assessed as outlined in paragraphs 29 and 30. Under the Oklahoma Premium Assistance Individual Plan, cost-sharing is assessed according to the schedule below and as outlined in paragraph 31. This schedule reflects the maximum co-pay amounts that may be required. The State may lower the actual required copayment amounts at any time by notifying CMS in writing at least 30 days prior to the effective date. A family's total annual out-of-pocket cost-shares, including premiums and co-payments, cannot exceed 5 percent of the family's gross income.

Service	Insure Oklahoma Premium Assistance Individual Plan Co-Pays
Ambulatory Surgery Centers	\$25 per visit
Behavioral Health Inpatient	\$50 per admission
Behavioral Health Outpatient	\$10 per visit
Chemotherapy and Radiation Therapy	\$10 per visit
Clinic services including Renal Dialysis services	\$10 per office visit; no co-pay for dialysis
Dental services	Not a covered service
Diabetic supplies	\$5 per prescription
Diagnostic X-ray services	\$25 per scan (MRI, MRA, PET, and CAT scans only)
Durable Medical Equipment and supplies	\$5 per item for durable/non-durable supplies; \$25 co- pay per item for DME
Emergency services	\$30 per visit, waived if admitted
FQHC services	\$10 per visit
Home Health services	Not a covered service

Immunizations	\$10 per visit
Inpatient hospital services (Acute Care only)	\$50 per admission
Laboratory	None
Outpatient hospital services	\$25 per visit
Physical Therapy, Occupational Therapy, and Speech Therapy	\$10 per visit
PCP visits	\$10 per visit; no co-pays for well child visit following recommended schedule
Perinatal dental services for pregnant women	None
Physician services, including preventive services	\$10 per visit; no co-pays for well child visit following recommended schedule
Podiatry services	Not a covered service
Prescription Drugs and insulin	\$5 per generic prescription, \$10 per brand name prescription
Prenatal, delivery and postpartum services	None
Rural Health Clinic services	\$10 per visit; no co-pays for well child visit following recommended schedule
Smoking Cessation products	\$5 per generic prescription, \$10 per brand name prescription
Specialty Clinic visits	\$10 per visit
Substance Abuse Treatment (Outpatient)	\$10 per visit
Transplants (requires prior authorization)	Not a covered service
Tuberculosis services	\$10 per visit

29. Premium Assistance Employer Coverage Co-Payments and Deductibles. For individuals participating in Insure Oklahoma Premium Assistance Employer Coverage, co-pays will be consistent with the enrollee's specific Qualified Health Plan, as defined in paragraph 25, with the following limitations:

- a) Office visits cannot require a co-pay exceeding \$50 per visit;
- b) Annual pharmacy deductibles cannot exceed \$500 per individual;
- c) An annual out-of-pocket maximum cannot exceed \$3,000 per individual, excluding pharmacy deductibles; and
- d) The maximum amount of all cost sharing (co-pays, deductibles and premiums) cannot exceed five percent of a family's total income.

30. Premium Assistance Employer Coverage Plan Premiums. Individuals/families participating in Employer Coverage Programs will be responsible for up to 15 percent of the health insurance premium not to exceed 3 percent out of the 5 percent annual gross household income cap.

- a) The State will provide reimbursement for out-of-pocket costs in excess of the 5 percent annual gross household income cap for individuals (or their eligible Insure Oklahoma

spouse) enrolled in Premium Assistance Employer Coverage. A medical expense must be for an allowed and covered service by the health plan to be eligible for reimbursement. The State calculates the 5 percent threshold for each enrollee and on a monthly basis applies the premiums paid by the enrollee toward the 5 percent cap. The State also records co-payments made by the enrollee based upon documentation submitted by the enrollee. Reimbursement is provided by the State once the 5 percent cap is met.

- b) For each enrollee participating in an Employer Coverage Plan, the percentage of premium paid by the State, employer, and enrollee is outlined in the following table:

Premium Assistance Employer Coverage Premiums				
Enrollee	State/Federal Share	Employer	Enrollee Premiums	Annual Household Income Cap
Non Disabled Worker *	Minimum of 60 percent	25%	Up to 15% of premiums, (not to exceed 3% out of the 5% household income cap)	5%
Non Disabled Worker Spouse	Minimum of 85 percent	0%	Up to 15% of premiums, (not to exceed 3% out of the 5% household income cap)	5%
Disabled Worker	Minimum of 60 percent	25%	Up to 15% of premiums, (not to exceed 3% out of the 5% household income cap)	5%
Full-time College Students (when employed by covering employer)	Minimum of 60 percent	25%	Up to 15% of premiums, (not to exceed 3% out of the 5% household income cap)	5%
Full-time College Students (when dependent on parental policy)	Minimum of 85 percent	0%	Up to 15% of premiums, (not to exceed 3% out of the 5% household income cap)	5%

* If children are covered the employer must contribute 40% of premium cost. If coverage is for the employee only, the employer must contribute 25% of premium cost.

31. Premium Assistance Individual Plan Premiums. Individual Plan premiums will be imposed as follows:

- a) For each State fiscal year, the State will establish age/gender premium bands for the Insure Oklahoma Individual Plan. The monthly premium for an individual/family will be set at 20 percent of the age/gender band.

- b) To calculate a monthly premium for the household, the premiums for all covered members will be added together and multiplied by 20 percent. The household contribution to the premium will be capped, not to exceed 4 percent of the monthly gross household income.
- c) The State will require all individuals participating in the Premium Assistance Individual Plan to be responsible for any co-payments subject to the 5 percent annual gross household income cap minus any premiums paid by the enrollee.
- d) The State will provide reimbursement for out-of-pocket costs in excess of the 5 percent annual gross household income cap, for individuals (or their eligible Insure Oklahoma spouse) enrolled in the Premium Assistance Individual Plan. A medical expense must be for an allowed and covered service by the health plan, to be eligible for reimbursement.

VI. DELIVERY SYSTEMS

32. Access and Service Delivery. With the exception of Insure Oklahoma members enrolled in Qualified Health Plans, all SoonerCare beneficiaries select or are aligned with a PCP/CM responsible for furnishing primary and preventive services and making medically necessary referrals. PCP/CMs must belong to one of the provider types listed below.

Provider	Required Qualifications
Primary Care Physician	Engaged in Family Medicine, General Internal Medicine, General Pediatrics or General Practice; may be board certified or board eligible; or meet all Federal employment requirements, be employed by the Federal Government and practice primary care in an Indian Health Services (IHS) facility.
Specialist Physician	At discretion of OHCA CEO, based on consideration of percentage of primary care services delivered in physician's practice, the availability of primary care physicians in the geographic area, the extent to which the physician has historically served Medicaid and his/her medical education and training.
Advanced Practice Nurse	Must be licensed by the State in which s/he practices and have prescriptive authority; or meet all Federal employment requirements, be employed by the Federal Government and practice in an IHS facility.
Physician's Assistant	Must be licensed by the State in which s/he practices; or meet all Federal employment requirements, be employed by the Federal government and practice primary care in an IHS facility.
Medical Resident	Must be at least at the Post Graduate 2 level and may serve as a PCP/CM only within his/her continuity clinic setting. Must work under the supervision of a licensed attending physician.
Health Department Clinics	Beneficiaries would be served by one of 68 county health departments or the two city-county health departments in Oklahoma City and Tulsa.

33. Care Coordination Fees. PCPs receive a monthly care coordination fee for each enrolled beneficiary, based upon the services provided at the medical home. In return, they are responsible for providing or otherwise assuring the provision of medically necessary primary care and case management services and for making specialty care referrals. There are three tiers of Medical Homes; Entry Level Medical Home, Advanced Medical Home, and Optimal Medical Home. The contracted PCP must meet certain requirements to qualify for payments in each tier. Payments are also stratified according to the PCP panel composition; children only, children and adults, or adults only. PCPs are also responsible for providing 24-hour/7-day telephone coverage for their beneficiaries. This phone coverage is augmented by an OHCA-contracted Patient Advice Line staffed by registered nurses utilizing nationally established protocols in assisting callers. Monthly care coordination fees are paid to PCPs based on the following schedule:

Care Coordination Fees

PMPM	Tier 1	Tier 2	Tier 3
Children	\$3.03	\$4.65	\$6.19
Children and Adults	\$3.78	\$5.64	\$7.50
Adults	\$4.47	\$6.53	\$8.69

Effective January 1, 2009, the State may extend the three-tiered Medical Home care coordination reimbursement methodology to the Indian Health Service, Tribal and Urban Health Clinics for American Indians, and the Insure Oklahoma Network.

The State must notify CMS 60 days prior to any requested change in the amount of the monthly care coordination fees paid to PCPs and must submit a revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact of the request on budget neutrality for the remainder of the Demonstration. CMS will review the State’s documentation and if approved, will provide a written confirmation to the State within 60 days of receiving the request.

34. Other Medical Services. All other medical services in the Demonstration, with the exception of emergency transportation, which is paid through a capitated contract, are paid through the State’s FFS system.

35. Health Access Networks. The State may pilot up to four Health Access Networks (HANs). HANs are non-profit, administrative entities that will work with providers to coordinate and improve the quality of care for SoonerCare beneficiaries. Networks will receive a nominal Per Member Per Month (PMPM) payment. This PMPM payment, initially established at \$5, will be made in addition to the care coordination fee paid to PCPs as outlined in paragraph 33 which is reimbursement for the cost to the provider. HANs are not eligible for the care coordination fee outlined in paragraph 33. The State must not make duplicative payments to the HANs for Medicaid services covered under the Medicaid State plan. The State must notify CMS 60 days prior to any requested change in the HAN PMPM payment and must submit a revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact of the request on budget neutrality for the remainder of the Demonstration. CMS will review the State’s documentation and if approved, will provide a written

confirmation to the State within 60 days of receiving the request.

The HAN must:

- a) Be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare beneficiaries;
- b) Offer patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or the State;
- c) Submit a development plan to the State detailing how the network will reduce costs associated with the provision of health care services to SoonerCare enrollees, improve access to health care services, and enhance the quality and coordination of health care services to SoonerCare beneficiaries;
- d) Offer core components of electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies; and,
- e) Offer care management/care coordination to persons with complex health care needs including:
 - i. The co-management of individuals enrolled in the Health Management Program;
 - ii. Individuals with frequent Emergency Room utilization;
 - iii. Women enrolled in the Oklahoma Care Program diagnosed with breast or cervical cancer;
 - iv. Pregnant women enrolled in the High Risk OB Program; and
 - v. Individuals enrolled in the Pharmacy Lock-In Program.

36. Provider Performance. The State may provide additional incentive payments, through the State's Payments for Excellence program, to contracted providers to recognize outstanding performance. Incentive payments will be based on physician practice behavior that may include EPSDT screens, DTaP immunizations, Inpatient Admitting and Visits, Breast and Cervical Cancer Screenings, and Emergency Department Utilization. The State certifies that incentive payments will not exceed five percent of the total FFS payments for those services provided or authorized by the PCP for the period covered.

Effective January 1, 2009, the State may Provider Performance Payments for Excellence Program to the Indian Health Service, Tribal and Urban Health Clinics for American Indians, and the Insure Oklahoma Network.

37. Services for American Indians. Eligible SoonerCare beneficiaries, with the exception of Insure Oklahoma beneficiaries, may elect to enroll with an IHS, tribal or urban Indian clinic as their PCP/Care Manager. This voluntary enrollment links American Indian members with these providers for primary care/case management services. The providers receive the care coordination fee paid to PCPs as outlined in paragraph 33. All of Oklahoma's IHS, tribal, or urban Indian clinics must have a SoonerCare American Indian PCCM contract.

38. Contracts. Procurement and the subsequent final contracts developed to implement selective contracting by the State with any provider group shall be subject to CMS approval prior to implementation. Existing contracts with Federally Qualified Health Centers shall continue in force.

39. TEFRA Children. TEFRA Children, as defined in paragraph 20, must receive services through the SoonerCare program and its network of participating providers. The OHCA's nurse Exceptional Needs Coordinators in the Care Management Department and SoonerCare Member Services Coordinators provide extensive outreach, assessment, and enrollment assistance to TEFRA Children.

VII. HEALTH MANAGEMENT PROGRAM

40. Health Management Program Defined. The SoonerCare Health Management Program (SHMP) is offered to SoonerCare Choice beneficiaries statewide, who are at highest risk for adverse outcomes and increased health care expenditures. The program serves beneficiaries ages 4 through 63 with a chronic illness, and are selected by the SHMP using predictive modeling software. The State must include in the Quarterly Report, described in paragraph 47, a report on SHMP activities including a description of populations served and services provided.

41. Health Management Program Services. Beneficiaries covered by the SHMP can be impacted by nurse care management and practice facilitation.

- a) Nurse Case Management (NCM) – All participating beneficiaries receive NCM. These services are designed to encourage beneficiaries to take active roles in the management of their disease processes. Beneficiaries receive a comprehensive initial evaluation, care plan, educational materials, and appropriate referrals. Follow up calls, visits, and mailings are provided in addition to a toll-free call center number for health related inquiries. Beneficiaries will receive an initial call and introductory letter, and be provided a toll free call center number for health related inquiries. Beneficiaries remain in the SHMP until maximum benefit has been achieved, as determined by OHCA.
 - i. Beneficiaries that are determined to be high risk are designated as Tier 2 and receive the above services telephonically by licensed practical nurses or registered nurses on a monthly basis. Tier 2 services can be provided to approximately 4,000 beneficiaries.
 - ii. Beneficiaries that are determined to be at the “highest risk” are designated as Tier 1 and receive face to face NCM services. These beneficiaries receive an intensive care management plan with a registered nurse including an individualized plan of care. Tier 1 services can be provided to approximately 1,000 beneficiaries.
- b) Practice Facilitation – Practice facilitation services are offered to enhance primary care services and support chronic disease prevention. Beneficiaries also receive health care management through individual primary care providers in the community. Training is provided to selective provides which includes quality improvement, performance

monitoring and practice re-design principles designed to lead to improvement in evidence-based quality measures, beneficiary education and beneficiary compliance.

The State must notify CMS 60 days prior to any requested change in SHMP services and must submit a revised budget neutrality assessment that indicates the current budget neutrality status and the projected impact of the request on budget neutrality for the remainder of the Demonstration. CMS will review the State's documentation and if approved, will provide a written confirmation to the State within 60 days of receiving the request.

VIII. PROGRAM MONITORING

42. Monitoring Aggregate Costs for Eligibles in the Premium Assistance Program.

- a) The State will monitor the aggregate costs for the Premium Assistance Employer Coverage Plan versus the cost of providing coverage through the Premium Assistance Individual Plan. On a quarterly basis, the State will compare the average monthly premium assistance contribution per Employer Coverage enrollee to the cost per member per month of the expansion population enrolled in the Individual Plan.
- b) On an annual basis, the State will calculate the total cost per enrollee per month for individuals receiving subsidies under the Premium Assistance Employer Coverage Plan, including any reimbursement made to enrollees whose out-of-pocket costs exceeded their income stop loss threshold (5 percent of income). The cost for this group will then be compared to the "per enrollee per month" cost for those individuals enrolled in the Premium Assistance Individual Plan.

43. Monitoring Employer Sponsored Insurance.

- a) The State will monitor the aggregate level of contributions made by participating employer's pre and post-implementation of the Premium Assistance Plan.
- b) The State must require that all participating employers report annually on their total contributions for employees covered under the Premium Assistance Plan. The State will prepare an aggregate analysis across all participating employers summarizing the total statewide employer contribution level under the Demonstration.
- c) Similarly, the State will monitor changes in covered benefits and cost sharing requirements of employer-sponsored health plans and document any trends in these two areas over the life of the demonstration.

IX. GENERAL REPORTING REQUIREMENTS

44. General Financial Requirements. The State must comply with all General Financial Requirements Under Title XIX set forth in Section X and all General Financial Reporting Requirements Under Title XXI set forth in Section XI.

45. Reporting Requirements Related to Budget Neutrality. The State must comply with all reporting requirements for Monitoring Budget Neutrality set forth in Section XII.

46. Monthly Calls. CMS shall schedule monthly conference calls with the State. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, PCCM operations (such as contract amendments and rate certifications), health care delivery, HAN activities, enrollment, cost sharing, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, health plan financial performance that is relevant to the Demonstration, progress on evaluations, State legislative developments, and any Demonstration amendments, concept papers, or State plan amendments the State is considering submitting. The State and CMS shall discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS shall update the State on any amendments or concept papers under review, as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS shall jointly develop the agenda for the calls.

47. Quarterly Operational Reports: The State must submit progress reports in the format specified in Attachment A no later than 60 days following the end of each quarter. The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the Demonstration. These quarterly reports must include, but are not limited to:

- a) Events occurring during the quarter or anticipated to occur in the near future that affect health care delivery including approval and contracting with new plans; benefits; enrollment; grievances; quality of care; access; health plan financial performance that is relevant to the Demonstration; pertinent legislative activity; HAN activities and other operational issues;
- b) Action plans for addressing any policy and administrative issues identified;
- c) Enrollment data, member month data, and budget neutrality monitoring tables;
- d) Updates on the implementation of the Premium Assistance Employer Coverage and Premium Assistance Individual Plan products, such as summary findings from the State's monitoring and analysis as described in paragraphs 42 and 43; and
- e) Evaluation activities and interim findings.

Notwithstanding this requirement, the fourth-quarter Quarterly Report may be included as an addendum to the annual report required in paragraph 48.

48. Annual Report. The State must submit a draft annual report documenting accomplishments, project status, quantitative and case study findings, interim evaluation findings, utilization data, and policy and administrative difficulties in the operation of the Demonstration. This report must also contain a discussion of the items that must be included in the quarterly operational reports required under paragraph 47. The State must submit the draft annual report no later than 120 days after the close of each Demonstration year. Within 30 days of receipt of comments from CMS, a final annual report must be submitted.

49. Title XXI Enrollment Reporting. The State will provide CMS with an enrollment report showing end of quarter actual and unduplicated ever enrolled figures. The enrollment data for the title XXI population will be entered into the Statistical Enrollment Data System within 30 days after the end of each quarter.

X. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

50. Quarterly Expenditure Reports. The State shall provide quarterly expenditure reports using the Form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS shall provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section XII.

51. Reporting Expenditures Under the Demonstration: In order to track expenditures under this Demonstration, Oklahoma must report Demonstration expenditures through the Medicaid and Children's Health Insurance Program Budget and Expenditure System (MBES/CBES), following routine CMS-64 reporting instructions outlined in Section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act must be reported each quarter on separate Forms CMS-64.9 Waiver and/or 64.9P Waiver, identified by the Demonstration project number assigned by CMS (including the project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were paid).

a) For each Demonstration year, twelve (12) separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER must be completed, using the waiver name noted below, to report expenditures for the following Demonstration populations.

- i. **Demonstration Population 1: TANF-Urban** includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program, receiving health care services in the designated Central, Northeast, and Southwest urban areas of the State;
- ii. **Demonstration Population 2: TANF-Rural** includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program receiving health care services in the rural areas of the State;
- iii. **Demonstration Population 3: ABD-Urban** includes the Aged, Blind and Disabled receiving health care services in the designated Central, Northeast, and Southwest urban areas of the State;
- iv. **Demonstration Population 4: ABD-Rural** includes the Aged, Blind and Disabled receiving health care services in the rural areas of the State;
- v. **Demonstration Population 5: Non-Disabled Working Adults** includes non-disabled low income workers and their spouses with household incomes no greater than 250 percent of the FPL;

- vi. **Demonstration Population 6: Working Disabled Adults** includes low income working disabled adults with household incomes no greater than 250 percent of the FPL;
 - vii. **Demonstration Population 7: TEFRA Children*** includes children defined in paragraph 20;
 - viii. **Demonstration Population 8 Full-Time College Students** includes full-time college students ages 19-22 up to and including 250 percent of the FPL (limited to 3,000 individuals at any given time);
 - ix. **Demonstration Population 9: CHIP Medicaid Expansion Children** includes infants under age 1, children ages 1-5, and children ages 6-18. Note: The State must report information in the Form CMS-64.9 Waiver and/or 64.9P Waiver for this population when using title XIX funds;
 - x. **Demonstration Population 10: Foster Parents** includes working foster parents with household incomes no greater than 250 percent of the FPL. The spouse of a working employee can be covered;
 - xi. **Demonstration Population 11: Not-for-Profit Employees** includes employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 250 percent of the FPL; and,
 - xii. **Demonstration Expenses 1: HAN Expenditures** includes PMPM expenditures mad to the HANs.
- b) For each HAN, the State must collect quarterly data of expenditures made by the HAN. The State must report summary expenditure data, for each HAN, in the Narrative section of Form CMS-64.9 for Demonstration Population 12.
- c) Specific Reporting Requirements for Medicaid expansion children (including TEFRA children) who revert to title XIX only when the State has exhausted its title XXI allotment.
- i. The State is eligible to receive title XXI funds for expenditures for these children, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or CMS-64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual.
 - ii. Title XIX funds are available under this demonstration if the State exhausts its title XXI allotment (including any reallocations or redistributions). If the State exhausts its title XXI allotment prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this Demonstration population must be reported as waiver expenditures on the Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver. The State shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for these Demonstration populations.
 - iii. The expenditures attributable to this Demonstration population will count toward the budget neutrality expenditure cap calculated under Section XII, paragraph 63, using the per member per month (PMPM) amounts for

children in the TANF Rural and TANF Urban populations described in Section XII, paragraph 64(a)(iii), and will be considered expenditures subject to the budget neutrality cap as defined in paragraph 51(e), so that the State is not at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

- d) The sum of the quarterly expenditures for all Demonstration years will represent the expenditures subject to the budget neutrality cap as defined in paragraph 64.
- e) For purposes of this section, the term “expenditures subject to the budget neutrality cap” must include all Medicaid expenditures on behalf of individuals who are enrolled in this Demonstration under paragraph 51(a). All expenditures that are subject to the budget neutrality cap are considered Demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.
- f) Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or CMS-64.10P Waiver.
- g) All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.
- h) Premiums and other applicable cost sharing contributions from enrollees that are collected by the State from enrollees under the Demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, both the total computable and Federal share amounts that are attributable to the Demonstration must be separately reported on the CMS-64 Narrative.

52. Reporting Member Months. The following describes the reporting of member months for Demonstration populations:

- a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the State must provide to CMS, as part of the quarterly report required under paragraph 47, the actual number of eligible member months for EGs defined in paragraph 51(a). The State must submit a statement accompanying the quarterly report which certifies the accuracy of this information. To permit full recognition of “in-process” eligibility, reported counts of member months may be subject to revisions for an additional 180 days after the end of each quarter.
- b) The term "eligible member months" refers to the number of months in which persons

are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

- c) The “Demonstration eligibles” that do contribute to the calculation of the budget neutrality ceiling for the SoonerCare Program include the TANF-Urban, TANF-Rural, ABD Urban and ABD Rural populations as defined in paragraph 51(a).
- d) The “Demonstration eligibles” that do not contribute to the calculation of the budget neutrality ceiling for the SoonerCare Program include the non-disabled working adults, disabled working adults, parents of foster children, full-time students, individuals enrolled in the Premium Assistance Individual Plan, and the TEFRA Children as defined in paragraph 51(a).

53. Standard Medicaid Funding Process. The standard Medicaid funding process must be used during the Demonstration. Oklahoma must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure agreement and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments and State and Local Administration Costs. CMS shall make Federal funds available based upon the State’s estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

54. Extent of Federal Financial Participation for the Demonstration. Subject to CMS approval of the source(s) of the non-Federal share of funding, CMS shall provide FFP at the applicable Federal matching rates for the Demonstration as a whole as outlined below, subject to the limits described in Section XII:

- a) Administrative costs, including those associated with the administration of the Demonstration;
- b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid State plan;
- c) Net medical assistance expenditures made under Section 1115 Demonstration authority, with dates of service during the Demonstration extension period; and
- d) Net premiums and net medical assistance expenditures for persons enrolled in the O-EPIC Program.

55. Sources of Non-Federal Share. The State certifies that the matching non-Federal share of funds for the Demonstration is State/local monies. Oklahoma further certifies that such funds shall not be used as the match for any other Federal grant or contract, except as permitted by

law. Premiums paid by enrollees and collected by the State shall not be used as a source of non-Federal share for the Demonstration. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

- a) CMS may review the sources of the non-Federal share of funding for the Demonstration at any time. Oklahoma agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.
- b) Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

Under all circumstances, health care providers must retain 100 percent of the reimbursement amounts claimed by the State as Demonstration expenditures. Moreover, no pre-arranged agreements (contractual or otherwise) may exist between the health care providers and the State government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business (such as payments related to taxes (including health care provider-related taxes), fees, and business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments) are not considered returning and/or redirecting a Medicaid payment.

56. State Certification of Funding Conditions. The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

- a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.
- b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.
- c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.
- d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed

expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

57. Monitoring the Demonstration. The State will provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

58. Quarterly Expenditure Reports. In order to track title XXI expenditures under this Demonstration, the State must report quarterly Demonstration expenditures through the MBES/CBES, following routine CMS-64.21 reporting instructions as outlined in sections 2115 and 2500 of the State Medicaid Manual. Eligible title XXI Demonstration expenditures are expenditures for services provided to title XXI children who are eligible with FPL levels within the approved SCHIP State plan. CMS will provide enhanced FFP only for allowable expenditures that do not exceed the State's available title XXI funding.

Title XXI expenditures must be reported on separate Forms CMS-64.21U Waiver and/or CMS-64.21UP Waiver, identified by the Demonstration project number assigned by CMS (including project number extension, which indicates the Demonstration year in which services were rendered or for which capitation payments were made).

59. Claiming Period. All claims for expenditures related to the Demonstration (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. Furthermore, all claims for services during the Demonstration period (including cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the section 1115 Demonstration on the Form CMS-64.21;

- a) The standard CHIP funding process must be used during the Demonstration. Oklahoma must estimate matchable CHIP expenditures on the quarterly Form CMS-64.21B. On a separate CMS-64.21B, the State must provide updated estimates of expenditures for the Demonstration population. CMS will make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64.21U and/or CMS-64.21UP Waiver. CMS will reconcile expenditures reported on the Form CMS-64.21 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State; and,
- b) The State will certify that State/local monies are used as matching funds for the Demonstration. The State further certifies that such funds shall not be used as matching funds for any other Federal grant or contract, except as permitted by Federal law. All

sources of non-Federal share of funding and distribution of monies involving Federal match are subject to CMS approval. Upon review of the sources of the non-Federal share of funding and distribution methodologies of funds under the Demonstration, all funding sources and distribution methodologies deemed unacceptable by CMS shall be addressed within the timeframes set by CMS. Any amendments that impact the financial status of the program shall require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

60. Limitation on Title XXI Funding. Oklahoma will be subject to a limit on the amount of Federal title XXI funding that the State may receive for Demonstration expenditures during the Demonstration period. Federal title XXI funding available for Demonstration expenditures is limited to the State's available allotment, including any redistributed funds. Should the State expend its available allotment and redistribution, no further enhanced Federal matching funds will be available for costs of the Demonstration until the next allotment becomes available. Once all available title XXI funds are exhausted, the State will continue to provide coverage to Medicaid expansion children (Demonstration Population 9) covered under the Demonstration and is authorized to claim Federal funding under title XIX funds until further title XXI Federal funds become available.

XII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

61. Limit on Title XIX Funding. Oklahoma shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The limit is determined by using a per capita cost method. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. The data supplied by the State to CMS to set the annual limits is subject to review and audit, and if found to be inaccurate, will result in a modified budget neutrality expenditure limit. CMS' assessment of the State's compliance with these annual limits will be done using the Schedule C report from the Form CMS-64.

62. Risk. Oklahoma shall be at risk for the per capita cost for Demonstration enrollees under this budget neutrality agreement, but not for the number of Demonstration enrollees in each of the groups. By providing FFP for all Demonstration enrollees, Oklahoma will not be at risk for changing economic conditions which impact enrollment levels. However, by placing Oklahoma at risk for the per capita costs for Demonstration enrollees, CMS assures that the Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration.

63. Demonstration Populations Subject to the Budget Neutrality Agreement. The following Demonstration populations are subject to the budget neutrality agreement and are incorporated into the Demonstration EGs used to calculate budget neutrality.

- a) **Eligibility Group 1 (Demonstration Population 1):** Temporary Assistance to Needy Families recipients in urban areas of the State;
- b) **Eligibility Group 2 (Demonstration Population 2):** Temporary Assistance to Needy Families recipients in rural areas of the State;

- c) **Eligibility Group 3 (Demonstration Population 3):** Aged, Blind and Disabled Medicaid recipients (regardless of SSI eligibility) in urban areas of the State;
- d) **Eligibility Group 4 (Demonstration Population 4):** Aged, Blind and Disabled Medicaid recipients (regardless of SSI eligibility) in rural areas of the State; and,
- e) **Eligibility Group 5 (Demonstration Population 9):** Medicaid expansion children (including TEFRA children) who revert to title XIX.

64. Budget Neutrality Expenditure Limit. The following describes the method for calculating the budget neutrality expenditure limit for the Demonstration:

- a) For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described in paragraph 63 as follows:
 - i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the State under paragraph 52, for each EG, times the appropriate estimated PMPM costs from the table in subparagraph (iii) below.
 - ii. The PMPM costs in subparagraph (iii) below are net of premiums paid by Demonstration eligibles.
 - iii. The PMPM costs for the EGs used to calculate the annual budget neutrality expenditure limit for this Demonstration are specified below.

Eligibility Category	2010 PMPM	Trend Rate	2011 PMPM	Trend Rate	2012 PMPM	Trend Rate
1) TANF-Urban	\$279.09	5.13%	\$293.42	5.13%	\$308.46	5.13%
2) TANF-Rural	\$283.08	5.13%	\$297.61	5.13%	\$312.87	5.13%
3) ABD-Urban	\$978.28	5.20%	\$1,029.15	5.20%	\$1,082.66	5.20%
4) ABD-Rural	\$779.61	5.20%	\$820.15	5.20%	\$862.79	5.20%

- b) The overall budget neutrality expenditure limit for the three-year demonstration period is the sum of the annual budget neutrality expenditure limits calculated in subparagraph (a)(iii) above for each of the 3 years. The Federal share of the overall budget neutrality expenditure limit represents the maximum amount of FFP that the State may receive for expenditures on behalf of Demonstration populations and expenditures described in paragraph 51(a) during the Demonstration period.

65. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the Demonstration, rather than on an annual basis. However, if the State exceeds the calculated cumulative budget neutrality expenditure limit by the percentage identified below for any of the Demonstration years, the State must submit a corrective action plan to CMS for approval.

Year	Cumulative Target	Percentage
Year 15	Year 12 budget neutrality cap plus	1%
Year 16	Years 12 and 13 combined budget neutrality cap plus	.05%

Year 17 Years 12 through 14 combined budget neutrality cap plus 0%

66. Exceeding Budget Neutrality. If at the end of this Demonstration period the budget neutrality limit has been exceeded, the excess Federal funds must be returned to CMS. If the Demonstration is terminated prior to the end of the budget neutrality agreement, an evaluation of this provision shall be based on the time elapsed through the termination date.

XIII. EVALUATION OF THE DEMONSTRATION

67. Submission of Draft Evaluation Design. The State must submit to CMS for approval within 120 days from the award of the Demonstration a draft evaluation design. At a minimum, the draft design must include a discussion of the goals, objectives, and specific hypotheses that are being tested, including those that focus specifically on the target population for the Demonstration. The draft design must discuss the outcome measures that will be used in evaluating the impact of the Demonstration during the period of approval, particularly among the target population. It must discuss the data sources and sampling methodology for assessing these outcomes. The draft evaluation design must include a detailed analysis plan that describes how the effects of the Demonstration shall be isolated from other initiatives occurring in the State. The draft design must identify whether the State will conduct the evaluation, or select an outside contractor for the evaluation.

68. Evaluation of Health Access Networks. The draft evaluation design required under paragraph 67 must include a discussion of the goals, objectives and specific hypotheses that are being tested through the HAN pilot program. The evaluation design must incorporate the use of baseline data collected by the HAN and include an analyses of the HANs effectiveness in:

- a) Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HAN;
- b) Improving access to and the availability of health care services to SoonerCare beneficiaries served by the HAN;
- c) Improving the quality and coordination of health care services to SoonerCare beneficiaries served by the HAN with specific focus on the populations at greatest risk including those with multiple chronic illnesses; and,
- d) Enhancing the State's patient-centered medical home program through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance, and cost.

69. Interim Evaluation Reports. In the event the state requests to extend the Demonstration beyond the current approval period under authority of section 1115(a), (e) or (f) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

70. Final Evaluation Plan and Implementation. CMS shall provide comments on the draft design within 60 days of receipt, and the State must submit a final plan for the overall evaluation of the Demonstration described in paragraph 66, within 60 days of receipt of CMS comments. The State must implement the evaluation design and report its progress in the quarterly reports. The State must submit to CMS a draft evaluation report 120 days after the expiration of the current Demonstration. CMS shall provide comments within 60 days of receipt of the report. The State must submit the final report prior to the expiration date of the Demonstration.

71. Cooperation with CMS Evaluators. Should CMS conduct an independent evaluation of any component of the Demonstration, the State will cooperate fully with CMS or the independent evaluator selected by CMS. The State will submit the required data to the contractor or CMS.

XIV. SCHEDULE OF STATE MANDATORY DELIVERABLES FOR THE DEMONSTRATION EXTENSION PERIOD

	Deliverable	STC Reference
Annual	By May 1st - Draft Annual Report	Section IX, paragraph 48
Quarterly		
	Quarterly Operational Reports	Section IX, paragraph 47
	Quarterly Enrollment Reports	Section IX, paragraph 49
	CMS-64 Reports	Section X, paragraph 51
	Eligible Member Months	Section X, paragraph 52

ATTACHMENT A

Under Section IX, paragraph 47 of these STCs, the State is required to submit quarterly progress reports to CMS. The purpose of the Quarterly Report is to inform CMS of significant Demonstration activity from the time of approval through completion of the Demonstration. The reports are due to CMS 60 days after the end of each quarter.

The following report guidelines are intended as a framework and can be modified when agreed upon by CMS and the State. A complete quarterly progress report must include an updated budget neutrality monitoring workbook.

NARRATIVE REPORT FORMAT

Title Line One – SoonerCare

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:

Demonstration Year: 14 (1/1/2009 – 12/31/2009)

Federal Fiscal Quarter: 2/2007 (1/09 - 3/09)

Introduction

Please provide information describing the goal of the Demonstration, what it does, and key dates of approval/operation. (This should be the same for each report.)

Enrollment Information

Please complete the following table that outlines all enrollment activity under the Demonstration. The State should indicate “N/A” where appropriate. If there was no activity under a particular enrollment category, the State should indicate that by “0”.

Note: Enrollment counts should be person counts, not member months

Demonstration Populations (as hard coded in the Form CMS-64)	Current Enrollees (to date)	No. Voluntary Disenrolled in Current Quarter	No. Involuntary Disenrolled in Current Quarter
TANF-Urban			
TANF-Rural			
ABD-Urban			
ABD-Rural			
Non-Disabled Working Adults			
Disabled Working Adults			
TEFRA Children			
SCHIP Medicaid Expansion Children			
Full-Time College Students			

Foster Parents			
Not-for-Profit Employees			

Outreach/Innovative Activities

Summarize outreach activities and/or promising practices for the current quarter.

Operational/Policy Developments/Issues

Identify all significant program developments/issues/problems that have occurred in the current quarter, including but not limited to approval and contracting with new plans, benefit changes, and legislative activity.

Financial/Budget Neutrality Development/Issues

Identify all significant developments/issues/problems with financial accounting, budget neutrality, and Form CMS-64 reporting for the current quarter. Identify the State’s actions to address these issues.

Member Month Reporting

Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
TANF-Urban				
TANF-Rural				
ABD-Urban				
ABD-Rural				

B. For Informational Purposes Only

Eligibility Group	Month 1	Month 2	Month 3	Total for Quarter Ending XX/XX
Non-Disabled Working Adults				
Disabled Working Adults				
TEFRA Children				
Full-Time College Students				
Foster Parents				
Not-for-Profit Employees				
SCHIP Medicaid Expansion Children				

Consumer Issues

A summary of the types of complaints or problems consumers identified about the program in the current quarter. Include any trends discovered, the resolution of complaints, and any actions taken or to be taken to prevent other occurrences.

Quality Assurance/Monitoring Activity

Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation

Discuss progress of evaluation design and planning.

Enclosures/Attachments

Identify by title any attachments along with a brief description of what information the document contains.

State Contact(s)

Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS

Oklahoma Health Care Authority



SoonerCare Choice and Insure Oklahoma §1115(a) Demonstration 11-W-0048/6

Application for Extension of the Demonstration, 2013 – 2015

Submitted to the Centers for Medicare and Medicaid Services

December 30, 2011

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Request for Extension and Amendment of the Demonstration

The SoonerCare 1115(a) Research and Demonstration Waiver is currently approved through December 31, 2012. Oklahoma requests an extension of the program for the period January 1, 2013 to December 31, 2015. Oklahoma is aware that the SoonerCare / Insure Oklahoma waiver will need to be amended in order to bring the program into compliance with provisions of the Patient Protection and Affordable Care Act (PPACA) that take effect in 2014. At this time, the State is requesting renewal of this waiver in its present form, pending instructions from State leadership on the direction Oklahoma intends to take with regard to health reform. The Oklahoma Health Care Authority (OHCA) plans to request appropriate amendments to the waiver after receiving proper guidance. OHCA is also requesting that approval of the Health Access Network (HAN) program be maintained as a pilot from 2013 to 2015. The State is not at present requesting authorization to implement the HANs statewide.

The State requests that one amendment be made to the waiver for the extension period; it is specific to the Insure Oklahoma (IO) Individual Plan (IP) program. The State requests that the adult outpatient behavioral health benefit for IO IP be limited to 48 visits per year. This change will match the adult benefit with the children's benefit, which is already limited to 48 outpatient behavioral health visits per year.¹

¹ See Appendix A for documentation related to the amendment request.
Oklahoma SoonerCare 11-W-00048/6 §1115(a) Demonstration; Application for Extension 2013-2015

Program Objectives

Narrative Summary of the Demonstration Project

The Oklahoma SoonerCare Demonstration program manages care for enrollees statewide and offers coverage to expansion populations who would otherwise be ineligible for medical assistance.

Care is managed through a Primary Care Case Management (PCCM) system that provides each member with a medical home of his or her choice. Enrolled primary care providers (PCPs) are paid monthly care coordination fees for each member on their panels in amounts that vary depending on the level of medical home services provided and the mix of adults and children the provider accepts. Providers are also eligible for performance incentive payments when they meet certain quality improvement goals defined by the State.

Outside of care coordination, all other services provided in the medical home as well as by specialists, hospitals or other providers are reimbursed on a fee-for-service basis. Members are required to get referrals from their PCPs for most services provided outside of the medical home, but may receive primary care services from any provider enrolled as a Choice PCP, without a referral, limited to a maximum of 4 visits per month. Visits to the medical home PCP are unlimited. Members also actively choose their medical homes: they are no longer automatically enrolled with a PCP, they can change PCPs with no delay in the enrollment effective date, and there is no limit on the number of times a member can change PCPs. These features of the medical home delivery system give members greater access to primary care and incentivize PCPs to proactively care for the members assigned to their panels.

Members of the Temporary Assistance for Needy Families (TANF)-related populations and the Aged, Blind and Disabled (ABD) populations are eligible for SoonerCare Choice with some exceptions. SoonerCare benefits are Title XIX State Plan benefits, with the exception of the Insure Oklahoma Employer Sponsored Insurance (ESI) and the Insure Oklahoma Individual Plan (IP).

Coverage is authorized to be expanded to disabled children through TEFRA and to working and unemployed adults, their children, college students and foster parents through Insure Oklahoma, a public/private partnership for subsidizing health insurance premiums. Members receiving coverage through Insure Oklahoma are otherwise ineligible for Medicaid. Eligible adults are receiving unemployment benefits, are disabled and working, or are working for a small employer with fewer than 250 employees.

Major objectives of the SoonerCare Waiver program are:

- To improve access to preventive and primary care services,
- To provide each member with a medical home,
- To integrate IHS beneficiaries and providers into the SoonerCare delivery system,
- To expand access to affordable health insurance for low-income working adults and their spouses,
- To effectively and efficiently purchase appropriate care for members, and
- To optimize quality of care through effective care management.

Objectives at the Time the Demonstration was Proposed

The SoonerCare Demonstration was first implemented in 1995 under a 1915(b) waiver. Since then, the program has changed from Managed Care Organizations (MCOs) in urban areas to a statewide partially capitated PCCM model, to the current patient-centered medical home model of service delivery.² The objectives that apply to the current model were outlined in the State's renewal request for the 2010-2012 extension period as follows:

² See Appendix B for a detailed history of the Demonstration and its amendments.
Oklahoma SoonerCare 11-W-00048/6 §1115(a) Demonstration; Application for Extension 2013-2015

- Improve access to preventive and primary care services;
- Increase the number of participating primary care providers, and overall primary care capacity, in both urban and rural areas;
- Provide active, comprehensive care management to beneficiaries with complex and/or exceptional health care needs;
- Integrate IHS beneficiaries and providers into the SoonerCare delivery system; and
- Expand access to affordable health insurance for low income adults in the work force and their spouses.

Access to Care

Under the Demonstration program, Healthcare Effectiveness Data and Information Set (HEDIS®) results for the access to PCP / ambulatory health care measure have improved in every age range from 2008 to 2009.³

Provider Enrollments

The number of PCPs enrolled as medical homes has increased from a baseline of 1,409 in December 2008 to 1,576 PCPs as of September 2011. Overall capacity declined from the baseline in December 2008 (1,373,058) in 2009, but has since increased by 2.05% from 1,039,583 in January 2010 to 1,060,883 as of September 2011.

Care Management

In January 2010, the Demonstration provided care management through OHCA nurse care managers to 3,018 members, at a rate of 6.82 per 1,000 SoonerCare members. As of September 2011, 2,239 members are receiving care management through OHCA, at a rate of 5.02 per 1,000 SoonerCare members. Another 118 members are receiving care management through the OU Sooner HAN, raising the total to 2,447, at a rate of 5.48 per 1,000 members.

Integration of IHS Beneficiaries and Providers

In December 2009, 62,826 IHS members were enrolled in SoonerCare Choice, of whom 12,866 or 20.48% were enrolled with an I/T/U PCP. I/T/U capacity at that time was 116,150. As of September 2011, IHS membership has expanded to 70,586 people, of whom 13,718 or 19.43% are enrolled with an I/T/U PCP. I/T/U capacity is now lower, at 113,150 as of September 2011, but is still significantly higher than the number of IHS members.

Expansion of Access to Affordable Health Insurance

Access to health insurance for adults and children ineligible for SoonerCare is provided through the Insure Oklahoma program. Insure Oklahoma enrollments (combined for Employer Sponsored Insurance, ESI, and Individual Plan, IP) were 28,958 in December 2009. Enrollments increased by 11.05% to 32,159 in September 2011.

³ HEDIS data are not yet available for 2010.

Special Terms and Conditions

1. Compliance with Federal Non-Discrimination Statutes

The State complies with all applicable State and Federal statutes related to non-discrimination, including but not limited to the Americans with Disabilities Act of 1990, Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975.

2. Compliance with Medicaid and CHIP Law, Regulation, and Policy including protections for Indians pursuant to section 5006 of ARRA (2009)

The State complies with all Medicaid and CHIP program requirements in law, regulation and policy statement that are not expressly waived or identified as not applicable in the waiver and expenditure authority documents received from the Centers for Medicare and Medicaid Services (CMS), including protections for Indians pursuant to Section 5006 of the American Recovery and Reinvestment Act of 2009.

3. Compliance with Changes in Medicaid and CHIP Law, Regulation, and Policy

Within the timeframes specified by law, regulation or policy statement, the State brings the Demonstration into compliance with changes in Federal and State law, regulation or policy that affect the Medicaid or CHIP programs, unless the provision changed is expressly waived or identified as not applicable to the Demonstration.

4. Impact on Demonstration of Changes in Federal Law, Regulation, and Policy

If a change in Federal law, regulation or policy results in a change in Federal financial participation (FFP) for expenditures made under the SoonerCare Demonstration, the State submits modified budget neutrality and allotment neutrality agreements for CMS approval. The State recognizes that the modified agreements referred to in this paragraph do not involve changes to trend rates for the budget neutrality agreement, and that modified agreements take effect on the date the relevant change is implemented. Changes that require state legislation take effect the day the state law becomes effective or the last effective day required by the Federal law.

5. State Plan Amendments

State Plan Amendments are submitted if changes to the Demonstration affect populations eligible through the Medicaid or CHIP State Plans.

6. Changes Subject to the Amendment Process

The State does not implement changes related to eligibility, enrollment, benefits, cost sharing, sources of non-Federal share of funding, budget neutrality or other comparable program elements without submission of amendment requests and receipt of prior approval by CMS. Amendments are not retroactive, and the State recognizes that FFP is not available for changes to the Demonstration that have not been approved through the proper amendment process.

7. Amendment Process

Amendment requests are submitted to CMS no later than 120 days prior to the planned implementation date, and are not implemented until approved. Amendment requests include all required elements for Federal review.

8. Extension of the Demonstration

The State is submitting its extension request no later than 12 months prior to the expiration date of the Demonstration, December 31, 2012, including all required supporting documentation.

9. Demonstration Phase-Out

In the event that the State elects to suspend or terminate the Demonstration in whole or in part, the State will promptly notify CMS in writing and will submit a phase-out plan to CMS at least six months prior to initiating phase-out activities. Such a plan will not be shorter than six months unless quicker action is

necessitated by emergent circumstances. The State understands that FFP upon suspension or termination will be limited to normal closeout costs, including services and administrative costs of disenrolling participants.

10. CMS Right to Terminate or Suspend

The State understands that CMS may suspend or terminate the Demonstration in whole or in part whenever it determines, after a hearing, that the State has materially failed to comply with the terms of the Demonstration.

11. Enrollment Limitation during Demonstration Phase-Out

In the event that the State elects to suspend, terminate or not renew the Demonstration, the State will not enroll individuals who would not be eligible for Medicaid under the current State Plan in the final six months, unless CMS extends the Demonstration. If CMS notifies the State in writing that the Demonstration will not be renewed, enrollment will be suspended.

12. Finding of Non-Compliance

The State understands its rights to challenge a CMS finding that the State materially failed to comply with the terms of the Demonstration.

13. Withdrawal of Waiver or Expenditure Authority

The State understands that CMS reserves the right to withdraw waiver or expenditure authorities and that the State may request a hearing prior to the effective date to challenge CMS' determination that continuing the waiver or expenditure authorities would no longer be in the public interest or promote the objectives of Title XIX and/or Title XXI.

14. Adequacy of Infrastructure

The State ensures the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach and enrollment; maintenance of eligibility systems; compliance with cost sharing requirements; and reporting on financial and other Demonstration components.

15. Public Notice, Tribal Consultation, and Consultation with Interested Parties

Documentation of compliance with these requirements is provided in the section titled "Public Notice".

16. Compliance with Managed Care Regulations

The State complies with all managed care regulations at 42 CFR section 438 et seq. that are applicable to the Demonstration.

17. Federal Funds Participation

The State understands that Federal matching funds for expenditures under this Demonstration will not be made available to the State until the effective date identified in the Demonstration approval letter.

18. Eligibility

The State maintains the eligibility rules outlined in the Special Terms and Conditions (STC) and is not requesting any changes to the populations eligible to participate in the Demonstration.

19. Eligibility Exclusions

The State maintains the eligibility exclusion rules outlined in the STC and is not requesting any changes to the populations not eligible to participate in the Demonstration.

20. TEFRA Children

The State maintains the rules for eligibility in the TEFRA category and is not requesting any changes in the definition of the population or their eligibility for the Demonstration.

21. TEFRA Children Retroactive Eligibility

The waiver of retroactive eligibility does not apply to TEFRA children. Their parents or guardians choose an appropriate PCP/Case Manager. The State is not requesting any changes to these rules.

22. Enrollment Cap

The State maintains an enrollment cap of 3,000 on full-time college students enrolled in Insure Oklahoma. As of September 2011, 114 college students are enrolled in ESI and 353 are enrolled in IP, for a total of 467. The State received authorization for a waiting list for IO from CMS and understands that the State must notify CMS a minimum of 60 days prior to implementing a waiting list. A waiting list is not in place at present.

23. SoonerCare Benefits

This paragraph does not apply to IO ESI or IP. SoonerCare Choice benefits are Title XIX State Plan benefits, with one difference. The State Plan limits physician visits (including specialty visits) to four per month, whereas the waiver package allows unlimited physician visits with the member's PCP as medically necessary. The State is not requesting any changes to SoonerCare benefits.

24. Insure OK: Premium Assistance Employer Coverage

The State maintains the definitions and eligibility rules given in this paragraph of the STC, and is not requesting any changes.

25. Insure OK: Premium Assistance Employer Coverage Qualified Health Plan Benefits

The State maintains the required criteria for qualified health plans as defined in this section of the STC. All IO ESI health plans are approved by the Oklahoma Insurance Department for the Oklahoma market. The State is not requesting any changes to the maximum allowed copay amounts defined in paragraph 29 of the STC.

26. Insure OK: Premium Assistance Individual Plan (Insure Oklahoma)

The State maintains the rules outlined in the STC with regard to eligibility criteria, the application process, the premium schedule, delinquent premium payments, the repayment process, waiver of premiums in cases of hardship and reenrollment. The State is not requesting changes to these elements of the program.

27. Premium Assistance Individual Plan (Insure Oklahoma) Benefits

The State currently maintains the benefit package with the limitations listed in the STC. The State is requesting addition of a limitation: regarding the Service Outpatient Behavioral Health visits, the State requests a limit of 48 visits per year.

28. SoonerCare and Insure Oklahoma Cost Sharing

Under the SoonerCare program, pregnant women, children (including TEFRA children) 18 years or younger, emergency room services and family planning services are not subject to cost sharing. Cost sharing for non-pregnant adults enrolled in SoonerCare is the same as the cost sharing assessed under the Title XIX State plan.

The State currently maintains co-pays assessed under the Insure Oklahoma Individual Plan program at the maximum levels listed in the STC. The State understands that the State may lower the co-pays at any time by notifying CMS in writing at least 30 days prior to the effective date. Annual out-of-pocket cost sharing does not exceed five percent of a family's gross income.

29. Premium Assistance Employer Coverage Co-Payments and Deductibles

The State continues to require the limitations on cost sharing for Qualified Health Plans offered through IO ESI and is not requesting any changes in the limitations.

30. Premium Assistance Employer Coverage Plan Premiums

The State maintains all rules regarding premiums charged, reimbursements for out-of-pocket costs in excess of five percent of annual gross household income, and the schedule of premium assistance outlined in this section of the STC. The State is not requesting any changes to these elements of the program.

31. Premium Assistance Individual Plan Premiums

The State maintains all rules established in this paragraph with regard to IP premiums and is not requesting any changes.

32. Access and Service Delivery

The State maintains all requirements and definitions for PCP/CMs available to members and is not requesting any changes to this paragraph.

33. Care Coordination Fees

The State maintains the schedule of monthly care coordination fees dependent upon medical home tier and the composition of the PCP's panel outlined in this section of the STC. The State is not requesting any changes to the care coordination fees. The State understands the requirement to notify CMS at least 60 days prior to changing the fees paid to PCPs and to include a revised budget neutrality assessment with such a notification.

34. Other Medical Services

It continues to be the case that other than monthly care coordination fees and non-emergency transportation (which is paid through a capitated contract), all other medical services are provided through the State's Fee-For-Service system. The State is not requesting any changes to this arrangement.

35. Health Access Networks

The State is currently piloting three Health Access Networks (HANs). The State is not requesting authorization to expand the HAN element of the Demonstration beyond the current maximum of four pilots. The State maintains all other definitions, rules and requirements for the HANs outlined in this paragraph and is not requesting any changes in this area. The State understands that duplicative payments for services offered under the State Plan are not to be made to HANs. The State also recognizes the requirement to notify CMS 60 days prior to any change to the HAN PMPM payment and to include a revised budget neutrality assessment with the notification.

36. Provider Performance

The State maintains the incentive payment for performance program outlined in this paragraph and is not requesting that any changes be made to it.

37. Services for American Indians

Eligible American Indian SoonerCare members continue to enroll with I/T/U clinics as their PCP/CMs. This enrollment is voluntary. The I/T/U providers enrolled as SoonerCare PCPs receive the care coordination fees established in paragraph 33 and are eligible for the incentive payments established in paragraph 36. The State is not requesting any changes to this paragraph.

38. Contracts

The State maintains existing contracts with Federally Qualified Health Centers and understands that procurement and resulting final contracts that implement selective contracting by the State with any provider group must be approved by CMS prior to implementation.

39. TEFRA Children

The State maintains the arrangements for service delivery for TEFRA children outlined in this paragraph and is not requesting that any changes be made.

40. Health Management Program Defined

The State is not requesting any changes to the definition of the Health Management Program (HMP) or the reporting requirements outlined in this paragraph of the STC. The State reports on the HMP in the Quarterly Report, which is submitted no later than 60 days after the last day of each calendar quarter.

41. Health Management Program Services

The State maintains the services provided through the HMP as defined in this paragraph and is not requesting that any changes be made. The State understands the requirement to notify CMS 60 days prior to any change in these services and recognizes that a revised budget neutrality assessment must accompany such a notification.

42. Monitoring Aggregate Costs for Eligibles in the Premium Assistance Program

The State monitors and publishes the aggregate costs for ESI as compared with IP, the average monthly premium assistance contributions in both plans, the annual total cost PMPM for ESI members and the total PMPM costs for IP members.⁴

43. Monitoring Employer Sponsored Insurance

The State monitors the aggregate level of contributions made by participating employers, requires that participating employers report annually their total contributions for employees, summarizes the total statewide employer contribution level and monitors changes in covered benefits and cost-sharing requirements of employer-sponsored plans, documenting any trends noted.⁵

44. General Financial Requirements

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

45. Reporting Requirements Related to Budget Neutrality

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

46. Monthly Calls

The State participates in the monthly calls with CMS outlined in this paragraph of the STC.

47. Quarterly Operational Reports

The State submits operational reports on the Demonstration to CMS in the format specified in Attachment A of the STC every quarter, no later than 60 days following the end of the quarter. The reports include all elements listed in this section of the STC.

48. Annual Report

The State submits the annual report specified in this paragraph in a format that combines the report with the quarterly report referred to in paragraph 47. The State submits the report within 60 days following the last quarter of the calendar year, and no later than 120 days after the close of the year.

49. Title XXI Enrollment Reporting

The State complies with Title XXI enrollment reporting requirements.

50. Quarterly Expenditure Reports

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

51. Reporting Expenditures Under the Demonstration

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

⁴ See Appendix C.

⁵ See Appendix C.

52. Reporting Member Months

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

53. Standard Medicaid Funding Process

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

54. Extent of Federal Financial Participation for the Demonstration

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

55. Sources of Non-Federal Share

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

56. State Certification of Funding Conditions

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

57. Monitoring the Demonstration

The State provides CMS with information requested in order to allow CMS to effectively monitor the Demonstration.

58. Quarterly Expenditure Reports

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

59. Claiming Period

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

60. Limitation on Title XXI Funding

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

61. Limit on Title XIX Funding

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

62. Risk

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

63. Demonstration Populations Subject to the Budget Neutrality Agreement

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

64. Budget Neutrality Expenditure Limit

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap. The State submits certifications of financial matters quarterly through the CMS-64.

65. Enforcement of Budget Neutrality

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

66. Exceeding Budget Neutrality

See Section 6 of this Renewal Application, Compliance with the Budget Neutrality Cap.

67. Submission of Draft Evaluation Design

See Section 7 of this Renewal Application, Draft of Evaluation Status and Findings.

68. Evaluation of Health Access Networks

See Section 7 of this Renewal Application, Draft of Evaluation Status and Findings.

69. Interim Evaluation Reports

See Section 7 of this Renewal Application, Draft of Evaluation Status and Findings.

70. Final Evaluation Plan and Implementation

See Section 7 of this Renewal Application, Draft of Evaluation Status and Findings.

71. Cooperation with CMS Evaluators

The State will fully cooperate with any CMS evaluation of the Demonstration.

Waiver and Expenditure Authorities

The State requests the following waiver and expenditure authorities for the 2013-2015 extension period.

Waiver Authorities Applicable to SoonerCare Populations

Stewardship/Uniformity; Section 1902(a)(1)

To enable the State to provide Health Access Networks (HANs) only in certain geographical areas of the State.

Freedom of Choice; Section 1902(a)(23)

To enable the State to restrict beneficiaries' freedom of choice of providers.

Retroactive Eligibility; Section 1902(a)(34)

To enable the State to waive retroactive eligibility for Demonstration participants, with the exception of Tax Equity and Fiscal Responsibility Act (TEFRA) and Aged, Blind and Disabled populations.

Counting Income and Comparability of Eligibility; Section 1902(a)(17)

To permit the State to exclude parental income in determining eligibility for disabled children eligible in the TEFRA category.

Waiver Authorities Applicable to Expansion Demonstration Populations 5, 6, and 8⁶

Comparability; Section 1902(a)(10)(B) and 1902(a)(17)

To permit the State to provide different benefit packages to different populations in the Insure Oklahoma program. Benefits (i.e., amount, duration, and scope) may vary by individual based on eligibility category.

Cost-Sharing Requirements; Section 1902(a)(14) insofar as it incorporates Section 1916

To permit the State to impose premiums, deductibles, cost sharing, and similar charges that exceed the statutory limitations to populations in the Insure Oklahoma program.

Freedom of Choice; Section 1902(a)(23)

To permit the State to restrict the choice of provider for beneficiaries eligible under the Insure Oklahoma program.

Retroactive Eligibility; Section 1902(a)(34)

To enable the State to waive retroactive eligibility for Demonstration participants.

Waiver Authorities Applicable to Expansion Demonstration Population 8

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services; Section 1902(a)(43)

To exempt the State from furnishing or arranging for EPSDT services for full-time college students ages 19 to 22 who have income not to exceed 250 percent of the FPL.

Expenditure Authorities

Demonstration Population 5

Expenditures for expanded coverage for individuals who are "Non-Disabled Low Income Workers" 19-64 years of age who work for a qualifying employer, are self-employed, or unemployed, and have income above the Medicaid standard, but no more than 250 percent of the Federal poverty level (FPL), and their spouses, and who are not Medicaid eligible. This includes foster parents and employees of not-for-profit organizations.

⁶ See Appendix B for definitions of Demonstration populations.
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Demonstration Population 6

Expenditures for expanded coverage for individuals who are “Working Disabled Adults” 19-64 years of age who work for a qualifying employer, are self-employed, or unemployed (and seeking work), who have income up to 250 percent of the FPL and are not Medicaid eligible. This includes foster parents and employees of not-for-profit organizations.

Demonstration Population 8

Expenditures for expanded coverage for no more than 3,000 individuals at any one time who are full-time college students ages 19 to 22 who have income not to exceed 250 percent of the FPL, who have no creditable health insurance coverage, and are not Medicaid eligible.

Demonstration Expenses 1

Expenditures for Per Member Per Month payments made to the Health Access Networks.

Demonstration Expenses 2

Expenditures for reimbursing out-of-pocket costs in excess of five percent of annual gross income for individuals enrolled in the Premium Assistance Program and in the Individual Plan, in a manner and to the extent defined by the State and approved by CMS.

Demonstration Expenses 3

Expenditures for otherwise non-covered costs related to the Health Management Program.

Evidence of Beneficiary Satisfaction

Oklahoma hires contractors to conduct and analyze member satisfaction surveys: the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) and the ECHO® Behavioral Health Survey, both of which are conducted separately for adults and children in alternating years. The most recent ECHO® surveys are the 2010 report for children, which reviews data collected in 2009, and the 2009 report for adults, which reviews data collected in 2008. The most recent CAHPS® surveys are the 2010 report for adults, which reviews data collected in 2009, and the 2011 report for children, which reviews data gathered from January through May of 2011. The 2011 CAHPS® for children is the only study that covers data gathered during the 2010-2012 extension period.⁷

CAHPS®

Both adult and child ratings on all measures have generally improved over the course of the Demonstration, other than slight declines on the child survey in 2011 for care coordination; the percent reporting that it is usually or always easy to get the care, tests, and treatment they think they need; and the percent ranking the health plan 8-10 on a scale of 1 to 10. The percent reporting that they have a personal doctor on the child survey increased from 84.65% in 2009 to 87.10% in 2011. The most substantial increase was in the percent reporting that it is usually or always easy to get appointments with specialists; it rose from 70.95% in 2009 to 81.10% in 2011 on the child survey.

ECHO®

The ECHO® Behavioral Health Survey gives results for two global measures in addition to the individual questions. SoonerCare's scores on those two measures are displayed in Appendix D. Analysts of the survey data found that none of the differences in either the adult or child survey were statistically significant.

Analysts of the Children's ECHO® 2010 Survey found overall that

Comparing the SFY 2008 survey and the SFY 2010 survey, results indicated relatively high levels of satisfaction holding steady across an array of 21 quality measures. Although the majority of the differences were not statistically significant, many of the quality measures showed slight improvements. These results continue to reflect a positive upward trend occurring in regards to member satisfaction with the behavioral health services for children.

Analysts of the Adult's ECHO® 2009 Survey found overall that

Comparing the SFY 2007 survey and the SFY 2009 survey, results indicate relatively high levels of satisfaction holding steady across an array of 11 quality measures. One measure showed statistically significant differences between SFY 2007 and SFY 2009. The composite measure "Information about Treatment Options" had a significant increase of members from SFY 2007 to SFY 2009 who indicated they were informed of alternative treatment options.

Insure Oklahoma ESI and IP Member Satisfaction Surveys

The Primary Care Health Policy Division of the University of Oklahoma Department of Family and Preventive Medicine prepared a report on member experience in the Insure Oklahoma ESI and IP programs in 2011.

The OU researchers' primary findings for both ESI and IP were that member satisfaction overall is high for both programs. Their recommendations for ESI include, "costs were the most challenging issue for ESI members"; "employers said they would like more materials available explaining the IO program for employees"; and "[d]ental and vision benefits were requested by ESI members." Primary recommendations for the IP program are that "IP members reported they were least satisfied with the application and renewal process ... [s]tremlining the process, especially with regard to renewal, might be investigated"; "[l]ike ESI members, IP members requested access to dental and vision benefits"; and "[s]ome IP members had challenges finding PCPs who accepted their insurance within a reasonable distance from their homes ...

⁷ See Appendix D for detailed survey results over time.

[o]utreach efforts aimed at attracting physicians to participate as providers for the IP plan could benefit both IP members and the physicians.”

PCMH Provider Survey

The Primary Care Health Policy Division of the OU Health Sciences Center also completed a survey and report titled “The Patient-Centered Medical Home Model of Care: A Survey of SoonerCare-Contracted Primary Care Providers” in March 2010. Researchers mailed the survey to all 755 practice locations of providers enrolled as SoonerCare Choice PCPs; the response rate was 20.6%. A detailed summary of survey results is provided in Appendix D.

The Discussion portion of the report notes that

Visits by the QA Review Teams were very useful. Respondents who were called on and assisted by OHCA QA Review Teams were more likely to feel that OHCA had been helpful and supportive during the transition from the previous reimbursement system to the PCMH tiered system. ... Although many of the PCPs responding to this survey agreed that the Patient-Centered Medical Home was the best model of care for their patients, there is still a great deal of work to be done to increase the tier status of SoonerCare PCPs, which in turn increases access, continuity, and coordination of care for patients. Support – financial, technical and personal – will be essential as the PCMH model grows in Oklahoma.

Quality

Quality Initiatives

OHCA recently issued the SFY 2010 report “Minding Our P’s and Q’s: The OHCA Performance and Quality Report”. The report documents quality initiatives, reviews, programs and performance trends. Its findings are summarized here, and the report is available for download from the OHCA website.

Pregnancy Outreach Program

- Outreach letters sent: 16,463
- Return calls generated by letters: 7,194
- Response rate: 43.70%
- Members referred to Care Management for high-risk pregnancy evaluation: 624

Health Management Program

- Number of Tier 1 members who received face-to-face case management: 889
- Number of Tier 2 members who received telephonic case management: 3,824
- Providers who received practice facilitation: 63
- Members served by providers who received facilitation: 85,000
- Savings credited to the program through SFY 2010: \$5.2 million

Reducing Disparities at the Practice Site

- Number of practices participating: 10
- Focus population of the program: racially and ethnically diverse members with diabetes
- Provider improvement in performance rates on diabetic measures: aggregate improvement of up to 13%

Provider Profiles

- Child health checkups performed: 1,850 profiles sent to providers
- Cervical cancer screenings received: 749 profiles sent to providers
- Mammograms received: 292 profiles sent to providers
- Ratio of ER visits to office visits: 477 profiles sent to providers

SoonerQuit: Prenatal Tobacco Cessation Initiative

- Number of OB providers who received practice facilitation focused on tobacco cessation: 6

SoonerEnroll Outreach and Enrollment Initiative

- Number of community partners engaged in outreach, enrollment and retention of children: more than 500

Patient Centered Medical Home Provider Reviews

- Visits made to providers to educate on PCMH medical home requirements: 557
- On-site provider reviews performed: 137

PCP Compliance with 24-Hour Access Requirement

- Number of provider contacts made after hours to ensure member access to appropriate services: 1,914
- Percentage of PCPs providing after-hours access: 81%

Dental Audits

- Practices audited: 93
- Total audits performed: 124

Medical Record Review

- Inpatient hospital admission cases randomly selected for retrospective review: 10,429
- Outpatient observation cases randomly selected for retrospective review: 353

Quality Studies and Reports

HEDIS® Measures

Quality Assurance staff are currently reviewing procedures for collection and analysis of HEDIS® measures; as a result, 2010 data are not yet available in a form that can be compared with that of previous years. The table of results from 2001 to 2009 shows that there was no significant decrease on any quality measure, and that the program’s performance on 18 measures increased significantly in 2009.

<i>HEDIS Measures⁸</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>
<i>Annual Dental Visit (Combined rate <21 years) (ADV)</i>	41.6%	46.6% ↑	51.2% ↑	53.6% ↑	56.6% ↑	56.3%	57.2% ↑	59.7% ↑	62.1% ↑
<i>Breast Cancer Screening (BCS)</i>	N/A	N/A	29.8%	29.2%	31.9%	33.8%	35.1%	38.3% ↑	43.0% ↑
<i>Cervical Cancer Screening (CCS)</i>	N/A	N/A	32.6%	34.5% ↑	43.5% ↑	42.0% ↓	43.7% ↑	44.4%	46.6% ↑
<i>Child Health Checkups in first 15 months (1 or more visits) (W15)</i>	87.6%	91.4% ↑	92.6%	91.6%	95.2% ↑	96.5% ↑	96.8%	97.3%*** ↑	97.4% ↑
<i>Child Health Checkups 3-6 yrs (1 or more visits) (W34)</i>	35.3%	40.1% ↑	47.3% ↑	48.6%	54.7% ↑	56.7% ↑	57.1%	60.0%*** ↑	64.9% ↑
<i>Child Health Checkups adolescent (1 or more visits) (AWC)</i>	N/A	N/A	23.7%	23.8%	25.9% ↑	26.4%	28.6% ↑	32.1%*** ↑	40.1% ↑
<i>Children’s Access to PCP (CAP) (at least one PCP visit): 12-24 months</i>	88.1%	89.5% ↑	90.8% ↑	91.4%	91.6%	94.3% ↑	94.1%	94.1%	96.2% ↑
<i>Children’s Access to PCP (CAP) (at least one PCP visit): 25 months - 6 yrs</i>	74.1%	77.0% ↑	79.3% ↑	78.2% ↓	78.7%	81.2% ↑	81.4%	83.1% ↑	86.9% ↑
<i>Children’s Access to PCP (CAP) (at least one PCP visit): 7-11 yrs</i>	76.7%	79.0% ↑	79.2%	77.3%	81.5% ↑	80.4% ↓	80.8%	82.7% ↑	87.6% ↑
<i>Children’s Access to PCP (CAP) (at least one PCP visit): 12-19 yrs</i>	N/A	N/A	77.4%	77.0%	81.7% ↑	79.8% ↓	80.1%	81.4% ↑	85.8% ↑
<i>Adult Access to Preventive/Amb Health Services (AAP): 20-44 yrs</i>	68.4%	68.8%	69.8%	71.6% ↑	72.0%	74.9% ↑	75.6%	78.4% ↑	83.3% ↑
<i>Adult Access to Preventive/Amb Health Services (AAP): 45-64 yrs</i>	80.3%	81.5%	81.3%	81.8%	82.8%	84.2% ↑	85.2% ↑	86.8% ↑	89.7% ↑
<i>Comprehensive Diabetes Care (CDC): HbA1C Screening</i>	N/A	N/A	44.4%	49.2% ↑	64.1% ↑	62.0%	63.3%	66.5% ↑	71.3% ↑

⁸ * May not be trendable to previous year because of extensive changes in prescription lists used in the measures.

** No valid statistical comparison to previous year because of changes in the measure’s technical specifications.

*** Includes data from Indian Health Service.

ASM measure age groupings changed.

Note: SoonerCare Choice 2001-2003; SoonerCare 2004-2005; SoonerCare Choice 2006-2009

Last update: January 24, 2011

Oklahoma SoonerCare 11-W-00048/6 §1115(a) Demonstration; Application for Extension 2013-2015

<i>HEDIS Measures⁸</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>
<i>CDC: LDL-C Screening</i>	N/A	N/A	34.7%	39.4% ↑	43.9% ↑	55.8%**	55.2%	60.4% ↑	65.7% ↑
<i>CDC: Eye Exam Screening for diabetic retinopathy</i>	N/A	N/A	14.1%	20.7%	27.7% ↑	↓ 25.4%	26.3%	26.9%	30.2% ↑
<i>CDC: Nephropathy Screening (or evidence of nephropathy)</i>	N/A	N/A	40.9%	45.3% ↑	49.9% ↑	79.5%**	78.1%	79.1%	80.3%
<i>Appropriate Medications for Asthma (ASM): 5-9 yrs (5-11 yrs CY2009)</i>	N/A	N/A	72.1%	73.9%	89.8%**	↓ 86.2%	89.7% ↑	90.3%	87.8%****
<i>Appropriate Medications for Asthma (ASM): 10-17 yrs (12-50 yrs CY2009)</i>	N/A	N/A	65.7%	64.2%	82.7%**	83.3%	86.1% ↑	86.7%	76.2%****
<i>Appropriate Medications for Asthma (ASM): 18-56 yrs</i>	N/A	N/A	44.7%	48.6%	63.1%**	59.7%	65.4% ↑	63.5%	NA
<i>Appropriate Treatment for Children with URI (URI)</i>	N/A	N/A	N/A	N/A	N/A	64.3%	66.0% ↑	65.3%	67.2% ↑
<i>Appropriate Testing for Children with Pharyngitis (CWP)</i>	N/A	N/A	N/A	N/A	N/A	N/A	20.9%	20.8%	24.7% ↑
<i>Lead Screening in Children (LSC)</i>	N/A	N/A	N/A	N/A	N/A	N/A	34.4%	38.7% ↑	41.8% ↑
<i>Cholesterol Management for Patients with Cardiovascular Conditions (CMC) (LDL-C screening)</i>	N/A	N/A	N/A	N/A	N/A	35.6%	34.1%	33.7%	40.8% ↑

↑: Significant increase from previous year
 ↓: Significant decrease from previous year

SoonerCare External Quality Review Organization Report, 2010

SoonerCare’s External Quality Review Organization (EQRO) issued the following findings in the major areas of assessment for State Fiscal Year 2010:

<i>Domain</i>	<i>Finding</i>
Quality Assessment and Performance Improvement (QAPI) Program	Full Compliance
Enrollee Rights	Full Compliance
Health Services Delivery	Full Compliance
Delegation	Full Compliance

Under domain 1, QAPI program, the EQRO found that

Findings of Quality studies impacted agency policy and procedure decisions.

The agency makes QAPI studies available to the public via its website.

Agency QA/QI staff completed 277 on-site provider reviews in SFY 2009, the dental unit reviewed 118 practices, and the EQRO reviewed thousands of inpatient hospital admissions.

Administrative data is sound, reliable and valid.

SoonerCare meets requirements for a policy-making body that oversees the QA program and for communication and collaboration between the policy-making body and other areas of the organization.

Under domain 2, enrollee rights, the EQRO found that

The agency ensures compliance with laws on enrollees rights with regard to discrimination, confidentiality, right to privacy and accessibility.

SoonerCare ensures that each member has the option to select a PCP who is accepting new members, and monitors member access to their assigned PCPs.

The agency makes information needed to file complaints or grievances or request an appeal or fair hearing readily available to members.

The agency received and investigated 4,289 member complaints in SFY 2009 (representing less than 1% of enrollees).

Under domain 3, health services delivery, the EQRO found that

The agency monitors access to a selection of PCPs; availability of appointment times with specialists; geographic accessibility of PCPs; and availability of PCPs based on hours of operation, timely appointments and after-hours access.

The Patient Advice Line ensures that members have access to medical advice 24 hours a day, seven days a week.

SoonerCare provides each member with a medical home, ensuring enrollment with a PCP whose contract lists responsibilities for coordinating care.

The agency communicates frequently with providers through a variety of media, keeping them updated on member benefits and program procedures.

The agency has processes in place for provider termination; the procedures and appeal process are included in provider contracts.

Under domain 4, delegation, the EQRO found that

The agency only delegates operational functions, not services, to other organizations.

Delegated operations are monitored through reports and audits.

Overall, the EQRO found that the SoonerCare program met standards on all 122 quality measures.

SoonerCare HMP Evaluation, 2010

This evaluation of the SoonerCare Health Management Program (HMP) assessed both OHCA administration of the program and the performance of the HMP vendor, the Iowa Foundation for Medical Care (IFMC). Evaluators concluded that

The SoonerCare HMP completed its second full year of operations with a well-defined structure and processes for conducting nurse care management and practice facilitation/provider education. Participants, both members and providers, are very satisfied with the program and their decision to enroll. Quality-of-care measures and cost indicators are moving in a positive direction. The program demonstrated net savings of \$5.2 million across its two components and, if current trend lines continue, should achieve even greater savings in the next year.

Emergency Room Utilization QAPI Study, 2010

The ER utilization study was completed in 2010, reviewing data from State Fiscal Year (SFY) 2009. It focused on provider characteristics to determine whether they contributed to the likelihood that providers were in the top or bottom 15% for high or low ER utilization by members on their panels. The study found that

Pediatricians were less likely to have high risk-adjusted ER utilization than family physicians.

Rural health centers (RHCs), either free-standing or hospital-based, were more likely to have high ER utilization, compared to family physicians.

Providers with higher percentages of Native American members were more likely to have high ER utilization than providers with lower percentages of Native American patients on their panels.

Providers with higher percentages of African American members were more likely to have high ER utilization than providers with lower percentages of African American patients on their panels.

Comprehensive Diabetes Care QAPI Study, 2010

The most recent diabetes quality study was completed in 2010, reviewing data from calendar year 2008. The study analyzes 10 HEDIS® measures of diabetes care services. The study found that comparing results for 2007 and 2008, the nine measures that are comparable showed improvement; of those, three of the changes were statistically significant. It also found that “although the number of Hispanic members was small, Hispanics had the highest compliance rates for six of the 10 measures.”

Behavioral Health QAPI Study, 2010

This study analyzes behavioral health data for SFY 2009 to determine frequencies of follow-up care and recidivism/readmission for members under 21 who received inpatient behavioral health services during the study period. The study found that the proportion of members receiving follow-up care within 30 days increased with age. However, after discharge from a Residential Treatment Center (RTC), members aged 18-20 were significantly less likely than all other age groups to receive follow-up services. A higher proportion of members living in urban areas received follow-up care than members living in rural areas (62.7% versus 56.6%).

The results also indicated that “members in the 18 to 20 years age group were significantly more likely to return to inpatient acute care within 30 days of discharge and composed almost half (49.4%) of inpatient acute recidivism... Females (47.1%) were significantly more likely to access follow-up care after a discharge from an acute inpatient behavioral health setting than males (41%).” Members enrolled in Sooner Care Choice were less likely to have an acute readmission within 30 days than members enrolled in fee-for-service Title XIX coverage.

Breast and Cervical Cancer QAPI Study, SFY 2009

The most recent QAPI study of the Breast and Cervical Cancer program (Oklahoma Cares) was completed in 2009, reviewing data from the period July 1, 2007 to June 30, 2008. The study examines paid claims, and finds that “BCC members are receiving the types of treatment for cancer listed by the CDC.”

Early Preterm Birth Outcomes QAPI Study, 2009

The most recent QAPI study of early preterm birth outcomes was completed in 2009, reviewing data for CY 2007. Findings are based on delivery records for 33 infants born to 29 mothers in 4 hospitals; because of the low response rate to the 140 requests for records, the results are not generalizable. Case studies indicated that “appropriate prophylactic and reactive procedures were used for these babies.”

Child Health Checkups QAPI Study, 2009

Other than regular annual reports of HEDIS® results for Choice members, the most recent study of utilization of child health checkups was completed in 2009, reviewing data for CY 2007. The study covered well-child visits, or Early and Periodic Screening, Diagnosis and Treatment (EPSDT) visits, for four age groups: 0 to 15 months, 3 to 6 years, 7 to 11 years and 12 to 21 years. The expectation incorporated in the study is that children 0 to 15 months should have six visits in the study period, and members aged 3 to 21 should have one visit in the period.

The study found that SoonerCare child health checkup rates were lower than the national Medicaid means for all age groups for the same time period, and that the difference was statistically significant. It also found that SoonerCare rates for members aged 0 to 15 months having at least 1, 2 or 3 visits were consistent with the national Medicaid mean, whereas those having 4, 5 or 6 visits were lower than the national Medicaid mean by a statistically significant margin.

Compliance with the Budget Neutrality Cap

As of June 2011, the State has \$2.2 billion in savings over the life of the Demonstration. Actuarial analysis of the Demonstration, including the amendment requested with this extension, projects that the State will maintain compliance with the budget neutrality cap through 2015. It is projected that the State will have \$3.2 billion in savings by the end of 2015.

This section contains updated enrollment and expenditure projections for the SoonerCare program through the upcoming 2013 - 2015 extension period. The exhibits⁹ incorporate full-year enrollment and expenditure data through calendar year 2010 (demonstration year 15). Data for 2011 is annualized based on actual enrollment and expenditures for the first nine months of the year.

Projections for 2012 – 2015 are based on Medicaid Eligibility Group (MEG) specific assumptions, as described in detail throughout the section. These include adjustments for the expected impact of the 2014 Medicaid expansion on the TANF, Insure Oklahoma and College Student MEGs.

Budget Neutrality Data for Individual MEGs

The SoonerCare program includes four traditional MEGs that, in combination, provide the “without waiver” expenditure estimates for calculation of the budget neutrality cap. They are TANF-Urban, TANF-Rural, ABD-Urban and ABD-Rural.

The “with waiver” expenditure estimates include three expansion populations: Insure Oklahoma Low Income Workers and Spouses (“Insure Oklahoma”), TEFRA Children and College Students. State and Federal expenditures for these MEGs are funded with waiver savings.

Traditional MEGs

Budget neutrality exhibits for the four traditional MEGs are presented in the Appendix. Each exhibit includes enrollment, expenditure and budget neutrality data. Expenditures consist of both paid claims and non-claim medical expenses.

The exhibits include actual enrollment and expenditure data through calendar year 2010. Calendar year 2011 enrollment and expenditures are estimated by annualizing actual data for the first nine months of the year.

Calendar year 2012 – 2015 member months for each MEG are projected based on the historical member month growth trend, as shown in exhibit 1 in Appendix E, with a one-time adjustment to the TANF-Urban and TANF-Rural MEGs to account for the expected impact of the Affordable Care Act (ACA) Medicaid expansion.

The State is not at present requesting that persons newly eligible for Medicaid under ACA be added to the waiver, so that adult population is not included in the budget neutrality analysis. However, the OHCA estimates that approximately 50,000 persons eligible but not enrolled under current rules will enroll in 2014 as the result of ACA-related outreach. The 2014 TANF-Urban and TANF-Rural member months have been adjusted to include these new member months (prorated between the two MEGs based on 2011 enrollment).

Calendar year 2012 – 2015 per member per month (PMPM) expenditures are trended forward using the currently approved waiver trend factors of 5.13 percent for the TANF MEGs and 5.20 percent for the ABD MEGs, as shown in exhibit 2 in the Appendix.

⁹ See Appendix E for the budget neutrality exhibits, including historical and projected data.

Budget neutrality data for the traditional MEGs is presented in exhibits 3 – 6. Exhibit 3 (TANF-Urban MEG) includes data for the nominal \$5.00 PMPM Health Access Network (HAN) payments within the Actual/Projected expenditure amounts¹⁰.

Expansion MEGs

Budget neutrality data for the three expansion populations is presented in exhibits 7 – 9. Member month and expenditure data has been prepared using the same methodology as for the traditional MEGs, subject to the adjustments described below.

The Insure Oklahoma and College Student MEGs have been adjusted to account for the expected impact of the ACA Medicaid expansion in 2014. The average FPL of Insure Oklahoma members is approximately 135 percent, or nearly equal to the ACA eligibility threshold. The Insure Oklahoma and College Student MEGs have been reduced by 50 percent in 2014 on the assumption that this portion of the membership will become eligible for Medicaid.

The Insure Oklahoma MEG has also been adjusted to account for a proposed benefit change. The OHCA is proposing to set Insure Oklahoma adult Individual Plan benefits for behavioral health outpatient visits at a maximum of 48 per year, to align with the benefit for children enrolled in the program. The estimated impact of the change in 2012, based on annualized and trended 2011 data, is (\$99,692). Projected expenditures in 2012 and beyond have been adjusted to account for the proposed change.

All MEGs

Exhibit 10 provides updated aggregate budget neutrality projections through calendar year 2015. As the exhibit illustrates, the SoonerCare demonstration is projected to continue generating savings throughout the remainder of the current waiver period and during the three-year extension.

Standard CMS Financial Management Questions

Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by States for services under the approved State Plan.

1. Do providers receive and retain the total Medicaid expenditures claimed by the State (includes normal per diem, DRG, DSH, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other), including the Federal and non-Federal share (NFS)?

Answer: Yes, SoonerCare providers retain 100% of the payments.

- a. Do any providers (including managed care organizations [MCOs], prepaid inpatient health plans [PIHPs] and prepaid ambulatory health plans [PAHPs]) participate in such activities as intergovernmental transfers (IGTs) or certified public expenditure (CPE) payments, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization?

Answer: Yes, some providers participate in IGTs. Nothing is returned to the state.

- b. If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description of the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned, and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

Answer: N/A

¹⁰ HAN \$5.00 PMPM payments in 2010 totaled \$745,520. HAN \$5.00 PMPM payments in 2011 are estimated to be \$1,823,225, based on nine months of actual data. HAN PMPM payments in 2012 - 2015 are included in the total projected expenditure amounts and trended at the same annual rate as other TANF-Urban expenditures.

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in the lowering of the amount, duration, scope, or quality of care and services available under the plan.

a. Please describe how the NFS of each type of Medicaid payment (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, capitation payments, other) is funded.

Answer: The NFS of the medical home care coordination payments and HAN payments are funded from appropriations from the legislature to the Medicaid agency. The NFS for Insure OK is funded by tobacco tax. The NSF payments to Academic medical centers are funded through IGTs from appropriations from the legislature.

b. Please describe whether the NFS comes from appropriations from the legislature to the Medicaid agency, through IGT agreements, CPEs, provider taxes, or any other mechanism used by the State to provide NFS. Note that, if the appropriation is not to the Medicaid agency, the source of the state share would necessarily be derived through either an IGT or CPE. In this case, please identify the agency to which the funds are appropriated.

Answer: Appropriations from the legislature to the Medicaid agency and through IGTs from: OU and OSU Medical Schools and the Physician Manpower Training Commission for the GME Payments.

c. Please provide an estimate of total expenditures and NFS amounts for each type of Medicaid payment.

<i>Type</i>	<i>Total</i>	<i>NFS</i>
Care Coordination fees & SoonerExcel Payments*	\$28,887,142	\$10,357,485
HAN Payments*	\$3,300,000	\$1,183,215
GME Payments*	\$62,729,093	\$22,491,516

*The above are annual estimates based on the SFY 2012 Budget.

d. If any of the NFS is being provided using IGTs or CPEs, please fully describe the matching arrangement, including when the state agency receives the transferred amounts from the local government entity transferring the funds.

Answer: The state receives the transferred amounts prior to making the payments.

e. If CPEs are used, please describe the methodology used by the State to verify that the total expenditures being certified are eligible for Federal matching funds is in accordance with 42 CFR 433.51(b).

Answer: N/A

f. For any payment funded by CPEs or IGTs, please provide the following: a complete list of the names of entities transferring or certifying funds; the operational nature of the entity (state, county, city, other); the total amounts transferred or certified by each entity; clarify whether the certifying or transferring entity has general taxing authority; and whether the certifying or transferring entity received appropriations (identify level of appropriations).

- OU and OSU Medical schools and the Physician Manpower Training Commission
- State Medical schools and State Commission
- \$22,491,516
- No general taxing authority
- Yes, they receive appropriations

3. Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State Plan. If supplemental or enhanced payments

are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type.

Answer: Supplemental payments include "SoonerExcel" bonus payments to Medical homes. Total amount = \$4,500,000 (Budgeted Amount, Annual Average payment for last two years of \$3.6 million)

- a. Please provide a detailed description of the methodology used by the State to estimate the upper payment limit for each class of providers (State owned or operated, non-state government owned or operated, and privately owned or operated).

Answer: These hospital classes are not applicable for this amendment.

- b. Does any governmental provider or contractor receive payments (normal per diem, DRG, fee schedule, global payments, supplemental payments, enhanced payments, other) that, in the aggregate, exceed its reasonable costs of providing services?

Answer: No

- c. In the case of MCOs, PIHPs, PAHPs, are there any actual or potential payments which supplement or otherwise exceed the amount certified as actuarially sound as required under 42 CFR 438.6(c)? (These payments could be for such things as incentive arrangements with contractors, risk sharing mechanisms such as stop-loss limits or risk corridors, or direct payments to providers such as DSH hospitals, academic medical centers, or FQHCs.)

Answer: No

- d. If so, how do these arrangements comply with the limits on payments in §438.6(c)(5) and §438.60 of the regulations?

Answer: N/A

- e. If payments exceed the cost of services (as defined above), does the State recoup the excess and return the Federal share of the excess to CMS on the quarterly expenditure report?

Answer: N/A

Draft of Evaluation Status and Findings

Summary of Evaluation Results to Date

Table 0.1: Hypotheses and Current Findings

<i>Hypothesis</i>	<i>Do current outcomes of the Demonstration confirm the hypothesis?</i>
1. Access to primary care: rates will be maintained and/or improved for well-child and adolescent visits	Unknown; data is not yet available
2. Access to primary care providers: percentage of children and adults with at least one visit to a PCP will increase by 4 percentage points from 2010 to 2012	Unknown; data is not yet available
3. Access to dental care: the percentage of members aged 3 to 21 with at least one visit to a dentist will increase	Unknown; data is not yet available
4.A.1 The number of Choice PCPs will be maintained or will increase	Yes
4.A.2 The capacity of Choice PCPs will be maintained or will increase	No
4.B.1 The proportion of IHS members whose PCP is an I/T/U provider will increase	No
4.B.2 I/T/U provider capacity will be maintained	No
4.C Members will continue to have access to age-appropriate PCPs within 45 miles/minutes	Yes
5. Implementation of HANs will allow the OHCA Care Management Unit to identify an additional population to enroll in agency care management	Yes
6. At least 500 children will be enrolled in the Title XXI State Plan for stand-alone CHIP children	Yes
7.A The HAN will improve member access to all levels of care	Unknown; data is not yet available
7.B The HAN will enhance the quality and coordination of services	Unknown; data is not yet available
7.C The HAN will reduce inappropriate utilization and costs	Unknown; data is not yet available
7.D The HAN will increase the number of participating PCPs using electronic medical record systems	No, because all PCPs who joined already had EMRs

Hypothesis One

This hypothesis posits that the number of members who have regular visits with their primary care providers is a measure of how much access members have to primary care. One of the objectives of the medical home model of primary care delivery is improvement of access to regular primary care. The

measure predicts that as a result of the waiver, rates will be maintained and/or improved for well-child and adolescent visits over the duration of the waiver extension period (2010-2012).

The data used is administrative, derived from paid claims and encounters, following HEDIS® measure guidelines. The members included in the measurement group are divided by age cohorts (0 to 15 months, 3 to 6 years, and adolescents) and are limited to those who were enrolled in SoonerCare for 11 or 12 months of the measurement year, allowing for a maximum gap in enrollment of 45 days.

HEDIS® data are not yet available for 2010. The medical home model was implemented in January 2009, however, so initial effects of the waiver’s primary care model can be seen in 2009 data.

Table 1. 1: Percentage of Child and Adolescent Members with at least One Checkup Per Year

<i>Age cohort</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>
<i>0-15 months</i>	87.6%	91.4%	92.6%	91.6%	95.2%	96.5%	96.8%	97.3%	97.4%
<i>3-6 years</i>	35.3%	40.1%	47.3%	48.6%	54.7%	56.7%	57.1%	60.0%	64.9%
<i>12-19 years</i>	N/A	N/A	23.7%	23.8%	25.9%	26.4%	28.6%	32.1%	40.1%

This hypothesis specifies that checkup rates for children aged 0 to 15 months will be maintained at or above 95%. The rate reached 95% in 2005, and has increased yearly since then. The slight increase in 2009 is not statistically significant.

The checkup rate for children aged 3 to 6 years is to increase by 4 percentage points over the extension period, 2010-2012, which would be an average of 1.33 percentage points per year. Data for the extension period is not yet available. The rate increased by at least 4 percentage points in 2002, 2003, 2005, and 2009. The increase in the rate was statistically significant in 2002, 2003, 2005, 2006, 2008 and 2009. The average yearly increase from 2002 to 2009 is 3.7%. If the average from 2002 to 2009 is maintained over the extension period, the total increase from 2010 to 2012 would be 11.1%, well over the hypothesized amount.

The evaluation measures hypothesize that the checkup rate for adolescents will also increase by 4 percentage points over the period from 2010 to 2012, which is an average of 1.33 percentage points per year. Data for the adolescent rate is only available from 2003 to 2009. Increases were statistically significant in 2005, 2007, 2008 and 2009. The rate only increased by more than 4 percentage points in 2009, when it increased by 8 percentage points. The average yearly increase before the implementation of medical homes in 2009 was 1.68 per year, which would be 5.04 over a 3-year period. The average including 2009 is 2.73, which would be 8.2 points over a 3-year period.

The total number of children and adolescents whose visit rates are included in this analysis (the number who had maximum one break in eligibility of no more than 45 days during the year) for 2009 is 193,269; for 2008, it is 172,199. Compare those totals with the total unduplicated number of children enrolled for the state fiscal year, given in the OHCA Annual Report (although this total includes infants): 519,880 for SFY 2008, 531,410 for SFY 2009, and 561,974 for SFY 2010.

Although data for the extension period 2010-2012 is not yet available, analysis of the data from 2001 to 2009 shows that, in the absence of a significant negative effect on access to primary care, child and adolescent checkup rates should meet the terms specified in the hypothesis.

Hypothesis Two

This hypothesis postulates that children’s and adolescents’ rate of access to primary care providers will increase by 4 percentage points over the life of the extension, and that adults’ rate of access to preventive/ambulatory health care services will increase by 4 percentage points over the life of the

extension, 2010-2012. Access is determined in accordance with HEDIS® guidelines: a member with at least one paid claim or encounter with a primary care provider in a 12-month period is determined to have access to primary care. Only members who were enrolled for 11 or 12 months of the data year who did not have gaps in enrollment of more than 45 days during the year are included in the population for whom the access rate is determined. The adult rate excludes claims for inpatient procedures, hospitalizations, emergency room visits and visits primarily related to mental health and/or chemical dependency.

Table 2.1: Percentage of Children and Adults with at least One Primary Care Visit

<i>Age cohort</i>	<i>2001</i>	<i>2002</i>	<i>2003</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007</i>	<i>2008</i>	<i>2009</i>
<i>12-24 months</i>	88.1%	89.5%	90.8%	91.4%	91.6%	94.3%	94.1%	94.1%	96.2%
<i>25 months-6 years</i>	74.1%	77.0%	79.3%	78.2%	78.7%	81.2%	81.4%	83.1%	86.9%
<i>7-11 years</i>	76.7%	79.0%	79.2%	77.3%	81.5%	80.4%	80.8%	82.7%	87.6%
<i>12-19 years</i>	N/A	N/A	77.4%	77.0%	81.7%	79.8%	80.1%	81.4%	85.8%
<i>20-44 years</i>	68.4%	68.8%	69.8%	71.6%	72.0%	74.9%	75.6%	78.4%	83.3%
<i>45-64 years</i>	80.3%	81.5%	81.3%	81.8%	82.8%	84.2%	85.2%	86.8%	89.7%

All increases in access rates for all age cohorts in 2009 were statistically significant.

Table 2.2 Average yearly percentage point increase by age cohort

	<i>12-24 months</i>	<i>25 months-6 years</i>	<i>7-11 years</i>	<i>12-19 years</i>	<i>20-44 years</i>	<i>45-64 years</i>
<i>Avg yearly percentage increase 2002-2008</i>	0.86%	1.29%	0.86%	0.80%	1.43%	0.93%
<i>Avg yearly percentage increase 2002-2009</i>	1.01%	1.60%	1.36%	1.40%	1.86%	1.18%

The average yearly increase from 2010 to 2012 called for in the evaluation hypothesis is 1.33%. Only the age cohort of 20-44 years met that average increase for the period from 2002-2008. When the increases in access rates in 2009 are included in the average, children 7-11 years old, adolescents 12-19 years old and adults 20-44 years old all met the average increase in access rates. If those averages, weighted toward the 2009 increases, continue in the 2010 to 2012 extension period, the second hypothesis criteria will be met.

Hypothesis Three

This hypothesis postulates that the dental visit rate of members ages 3 to 21 will continue to improve over the extension period 2010-2012. The member population included is those members who were enrolled in SoonerCare Choice for 11 out of 12 months of the year with no more than one gap in enrollment of up to 45 days. Whether the member had at least one dental visit during the year is determined according to HEDIS® guidelines using paid claims and encounters. The baseline comparison is the 2009 dental visit rate. Given that none of the HEDIS® measures are available for 2010, it is not yet possible to report on the first year of the Demonstration extension.

Table 3.1: Percentage of Members Ages 3-21 with at least One Dental Visit

	2001	2002	2003	2004	2005	2006	2007	2008	2009
Percentage	41.6%	46.6%	51.2%	53.6%	56.6%	56.3%	57.2%	59.7%	62.1%

Dental visit rates increased every year from 2001 to 2009 except for 2006, when a 0.3% decrease was recorded. The increase was statistically significant in 2002, 2003, 2004, 2005, 2007, 2008 and 2009. Provided that program or external factors for years 2010-2012 do not adversely affect members' access to dental care, this pattern is likely to continue, meeting the criteria of the hypothesis.

Hypothesis Four

This hypothesis postulates that the number of primary care providers enrolled as SoonerCare Choice PCPs and their available capacity will equal or exceed the number and capacity of Choice PCPs recorded when the medical home model was implemented in January 2009 over the duration of the extension period from 2010 to 2012. It also specifies that the proportion of SoonerCare IHS members whose PCP is an Indian Health Service/Tribal/Urban Indian Clinic (I/T/U) will increase, and I/T/U provider capacity will be maintained over the life of the waiver extension period. It further postulates that members will continue to have access to age-appropriate PCPs within the waiver-mandated travel time/distance radius of 45 miles or 45 minutes during the 2010-2012 extension period.

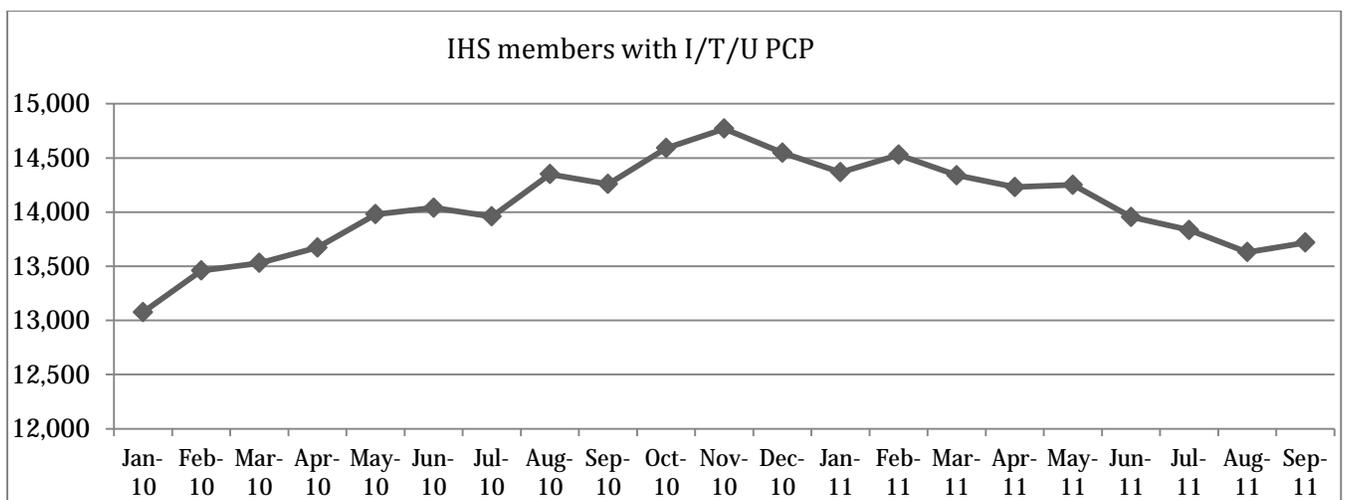
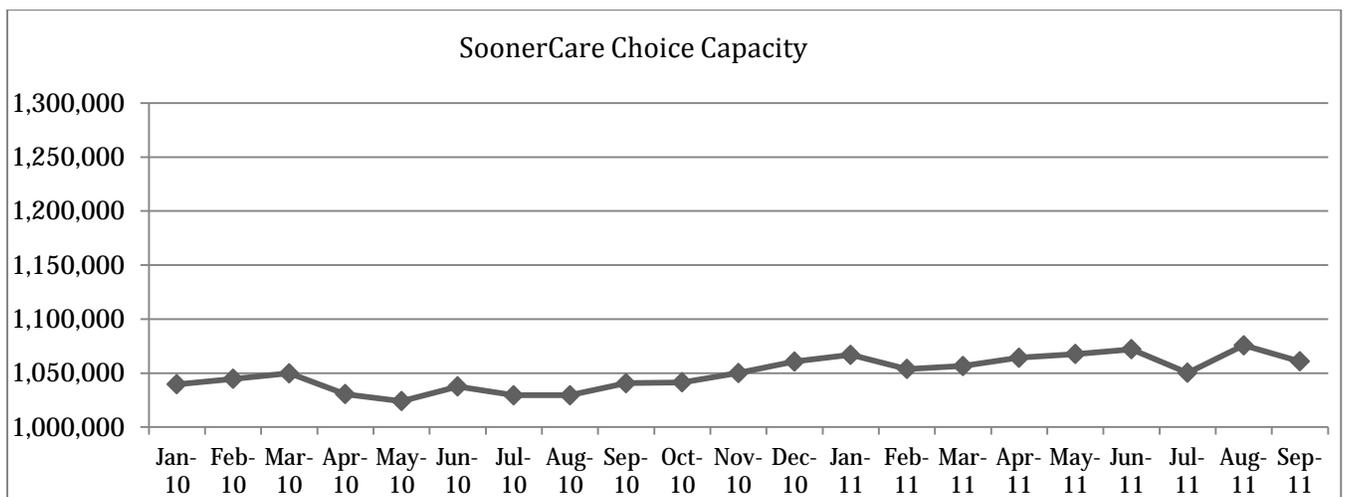
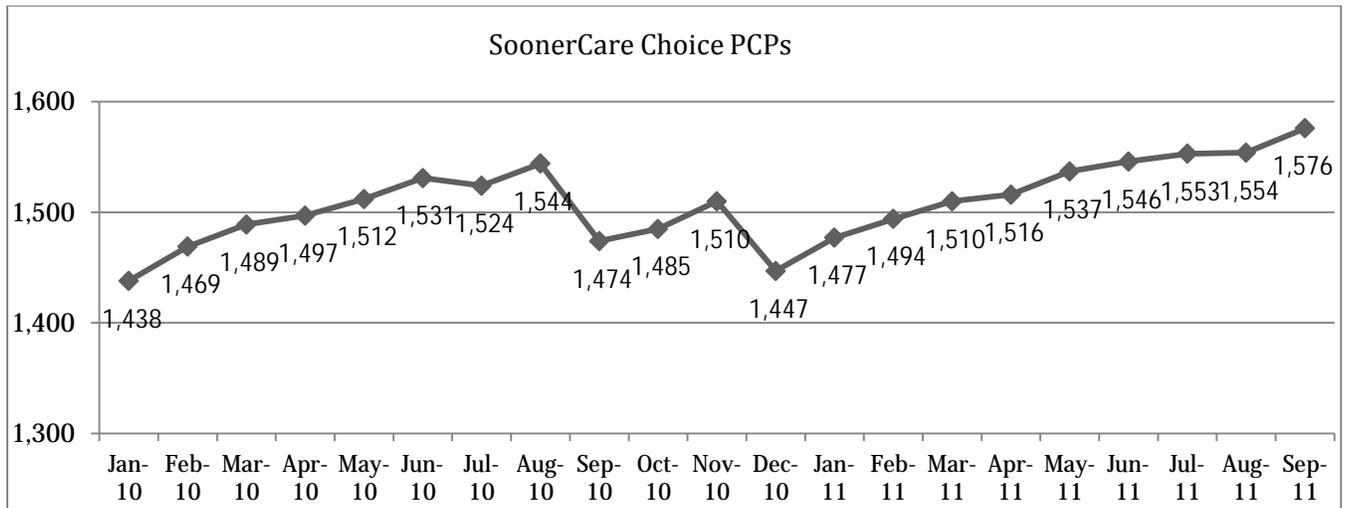
Table 4.1 Comparison of Baseline and Current PCP Capacities

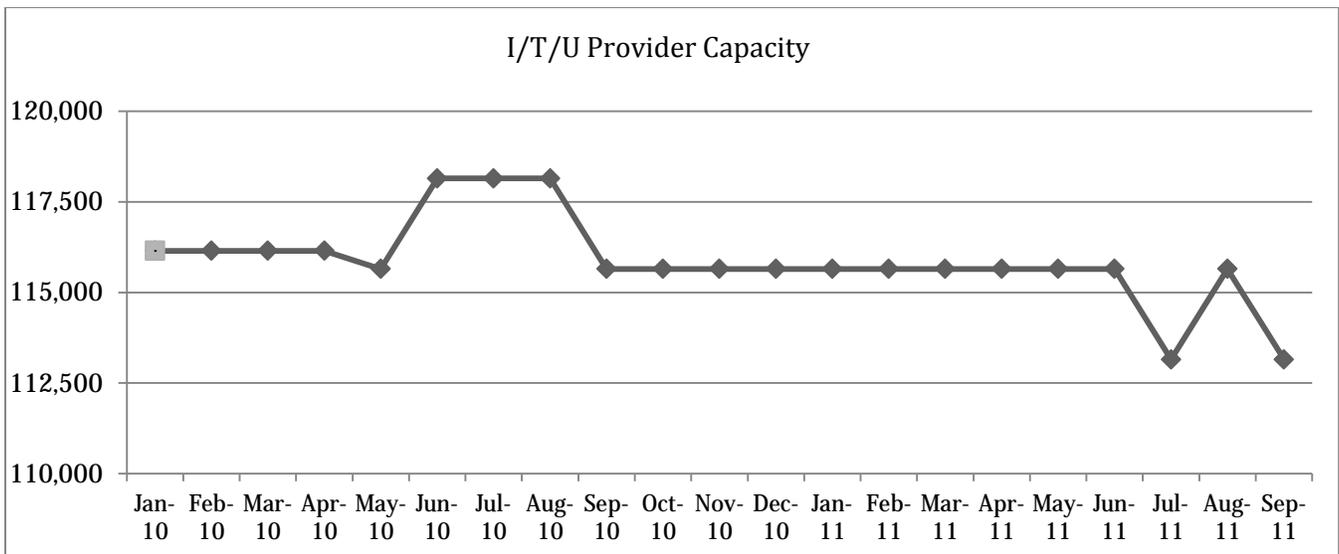
Hypothesis Measure	Baseline data	September 2011 data
Number of Choice PCPs enrolled	1,409	1,576
Capacity of Choice PCPs	1,373,058	1,060,883
Average number of members per PCP	289.15	283.18
Proportion of IHS members with I/T/U PCP	20.48%	19.43%
I/T/U Provider Capacity	116,150	113,150
Percentage of Members with a PCP within 45 miles/minutes	100%	100%

The number of Choice PCPs enrolled has increased by 167 providers. The PCP capacity, however, decreased by a quarter of a million lives the month the medical home model was implemented, to 1,113,577 in January 2009, and has not recovered. Capacity after implementation decreased further to 1,039,583 at the beginning of the extension period, January 2010, and has since increased slightly over the last year and a half, although it has yet to recover to January 2009 levels. PCP declared capacity is currently 312,175 lives under the capacity recorded in December 2008. Although capacity has decreased, the percentage of capacity used is only 40.45% in September 2011. Additionally, the average number of members per PCP has decreased by 2% from the December 2008 baseline.

Although SoonerCare Choice continues to attract primary care providers, the PCPs enrolled are accepting fewer SoonerCare patients on their panels than they were before the implementation of the patient-centered medical home model of service delivery. Overall, the available capacity of primary care providers has declined since 2008, so the outcomes of the Demonstration do not meet expectations for this hypothesis. It is worth noting, however, that the nominal decrease in capacity does not appear to have negatively impacted member access to primary or preventive care. Program staff have reason to believe that prior to implementation of the medical home model in January 2009, PCPs were declaring a larger capacity than they could reasonably serve. For that reason, the agency does not consider the results of this hypothesis, when weighed against other program performance measures, to be reason for concern.

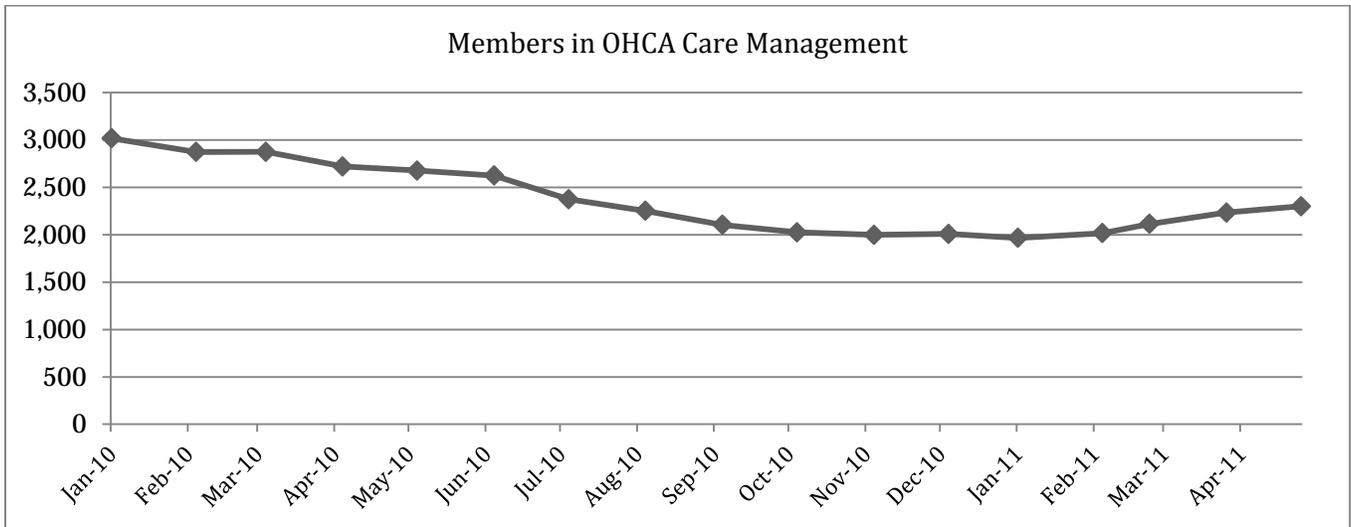
The proportion of IHS members with an I/T/U PCP has decreased slightly, by 1.05 percentage points. I/T/U provider capacity has decreased by 3,000 lives over the first 21 months of the Demonstration extension period.





Hypothesis Five

This hypothesis predicts that as members transition to the Health Access Network(s) (HAN) for care management, the OHCA Care Management Unit will be able to identify new populations to receive care management services through the agency. At present, only one HAN, the OU Sooner HAN out of Tulsa, has been operating for long enough to collect meaningful data. The hypothesis does not specify numbers or proportions of members, but notes that the agency will track the number of Choice members under active care management, the rate per 1,000 of Choice members under active care management, the number of members transitioned to HAN care management, and the identification and introduction of a new population to be enrolled in OHCA care management.



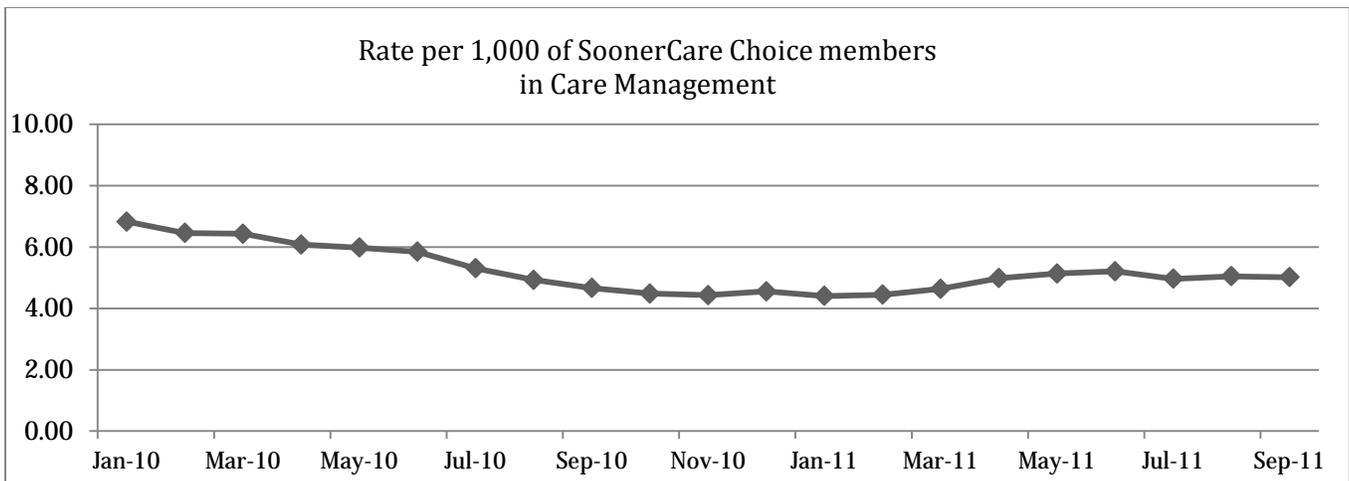


Table 5.3 Populations Transitioned to OU Sooner HAN Care Management

Populations Transitioned	Oct-Dec 2010	Jan-Mar 2011	Apr-June 2011	July-Sept 2011	Total Transitioned
High Risk OB	23	25	28	38	114
Hemophilia	7	1	0	0	8
ER Utilization ¹¹	222	170	251	318	961
Pharmacy Lock-in ¹²	39	15	19	8	81
OK Cares (BCC)	19	12	10	15	56
Total	310	223	308	379	1,220

Two new populations have been identified to be enrolled in OHCA Care Management: infants receiving Synagis therapy and pregnant women who live in the ten rural counties with the highest fetal infant mortality rates (FIMR).

Hypothesis Six

This hypothesis predicts that at least 500 children will be enrolled in the Title XXI CHIP Stand-Alone (186-200% FPL) eligibility group over the duration of the extension period, 2010-2012. As of September 2011, that goal has been exceeded with 565 children enrolled.

Hypothesis Seven

This hypothesis postulates that the HAN pilot program will improve access to care for members, quality and coordination of health care and use of electronic medical record systems (EMR) for participating providers. The Partnership for a Healthy Canadian County and Oklahoma State University (OSU) HANs began enrolling members in July and September, 2011, respectively; data is not yet available to measure their performance. The measures used as indicators of success in these areas include the number and type of specialty providers participating, the number of PCPs participating by tier, the time that elapses between a PCP referral and a specialty transaction within the network, clinical measures for quality improvement and coordination (from MEDai profiles), costs for each HAN given by MEDai profiles and MMIS paid warrants, and the number of HAN PCPs adding EMR capabilities. At present, sufficient data for most measures are only available for the OU Sooner HAN. Data for assessment of quality of care and cost avoidance measures are not yet available.

¹¹ This is the number of outreach letters the HAN has sent; not all of the members respond or are engaged in active care management. These members are also co-managed by OHCA.

¹² These members are currently care managed by their PCPs in place of the HAN.

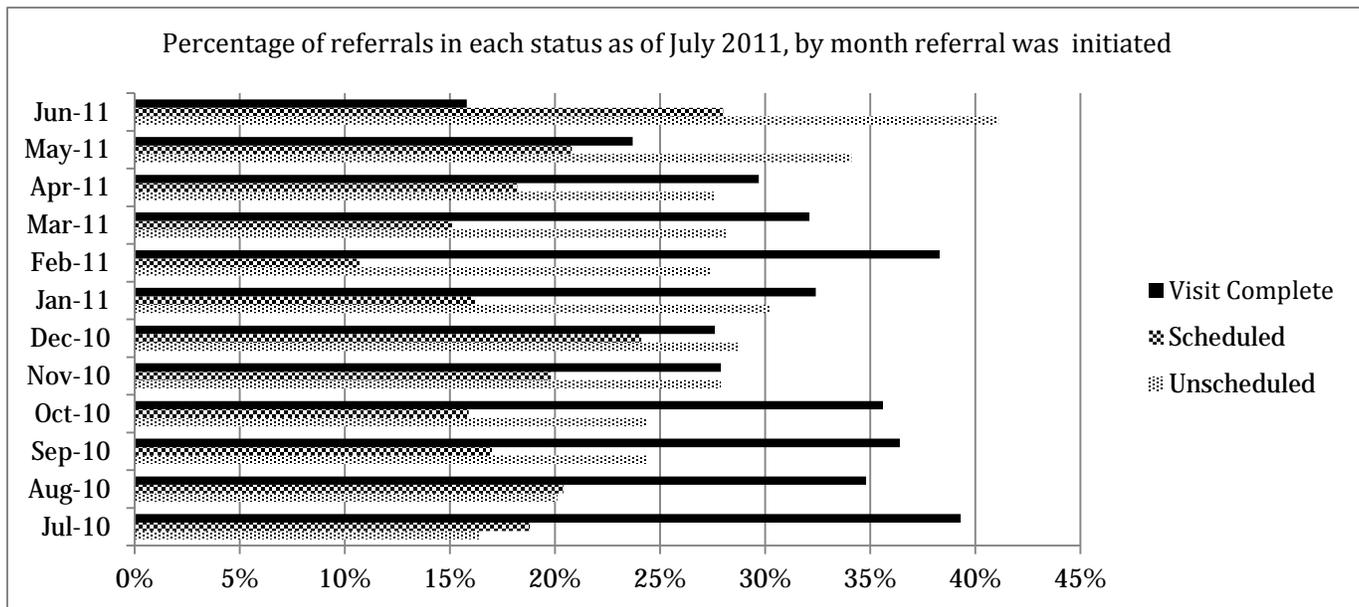
Provider Participation

<i>OU Sooner HAN</i>	<i>As of July, 2010</i>	<i>As of Feb, 2011</i>	<i>As of Aug, 2011</i>
<i>PCPs</i>	4	9	12
<i>Members Enrolled</i>	24,967	28,085	31,365
<i>Specialists</i>	N/A	N/A	689

Medical Home / PCP Participation by Tier (as of August 2011; no PCPs have changed tiers since they began participating in the HAN)

<i>Tier 1</i>	3
<i>Tier 2</i>	2
<i>Tier 3</i>	4
<i>FQHC (no other tier)</i>	3

Care Coordination: Referrals to Specialists



These data begin with the month the OU Sooner HAN was initiated; as a result, there is no baseline for the participating PCPs to use to establish a difference in time-to-visit-completion as a result of enrollment in the HAN. The more detailed status for referrals initiated in July 2010 after one year can be compared with the status of referrals initiated in December 2010 after 6 months:

<i>Referral Status</i>	<i>1 year status (initiated July 2010): number</i>	<i>1 year status: percentage</i>	<i>6 month status (initiated Dec 2010): number</i>	<i>6 month status: percentage</i>
<i>Pending appointment</i>	322	16.4%	449	28.7%
<i>Scheduled</i>	369	18.8%	377	24.1%
<i>Consult in Progress</i>	6	0.3%	4	0.3%
<i>Visit Occurred: Report Pending</i>	47	2.4%	68	4.3%

<i>Referral Status</i>	<i>1 year status (initiated July 2010): number</i>	<i>1 year status: percentage</i>	<i>6 month status (initiated Dec 2010): number</i>	<i>6 month status: percentage</i>
<i>Visit Occurred: Complete</i>	770	39.3%	432	27.6%
<i>Cancelled</i>	446	22.8%	236	15.1%
<i>Total</i>	1,960	100%	1,566	100%

EMR Capabilities

All PCPs participating in the OU Sooner HAN had already implemented Electronic Medical Records at the time of their enrollment in the HAN.

Quality of Care and Cost Avoidance

Data is not yet available for this performance measure.

Plans for Evaluation Activities 2013 – 2015

The State plans to continue its focus on access to and quality of care provided under the Demonstration in its selection of program evaluation measures and hypotheses for the extension period. Agency staff housed in the Waiver Development and Reporting unit are responsible for evaluating the Demonstration program through analysis of administrative data provided by various units within the agency. In the interest of conserving state resources, the agency does not at present plan to undertake an evaluation that would involve scientific methods or surveys, other than consideration of such studies conducted by the agency for other purposes. In developing these evaluation measures, the State is mindful of recommendations listed in recent Proposed Rules issued by CMS on waiver transparency and access measures in relation to changes in provider rates. Where possible, the State will aim to streamline data collection and analysis activities to meet various reporting and evaluation requirements. The evaluation measures listed below may change, therefore, depending on the final rules.

Hypothesis 1: Child Health Checkup Rates

Providing access to primary and preventive care is one of the primary functions of the Demonstration program. If the administrative structure, medical home incentives and outreach initiatives function as expected, rates for well-child and adolescent visits should be maintained or improved over the extension period 2013-2015.

Hypothesis 2: PCP Visits

In addition to tracking well-child visits in the first hypothesis, the agency tracks the rate of members who have one or more visits with a primary care provider in a year as a measure of access to primary care in accordance with HEDIS® guidelines. The rates are grouped by age cohort: 12 to 24 months, 25 months to 6 years, 7 to 11 years, 12 to 19 years, 20 to 44 years and 45 to 64 years.

Hypothesis 3: Dental Visits

Dental visit rates should also improve for members aged 3 to 21.

Hypothesis 4: PCP Enrollments

SoonerCare Choice is designed to provide incentives to primary care practitioners that encourage them to enroll as medical home PCPs; if the program functions as designed, the number of PCPs enrolled should increase.

Hypothesis 5: PCP Capacity Available

In order for members to have adequate access to PCPs, the primary care providers enrolled as Choice medical homes must be willing to accept adequate numbers of SoonerCare members. If the Demonstration performs well in this area, the percentage of PCPs' declared SoonerCare capacity that remains available to members should not decrease significantly.

Hypothesis 6: Integration of I/T/U Providers

As I/T/U providers continue to be better integrated into the medical home model, it is reasonable to expect that the percentage of Native American members who are enrolled with an I/T/U PCP will increase.

Hypothesis 7: Eligible Member Enrollments in Medical Homes

A *sine qua non* of the program is that members need to be enrolled with a PCP in order to access services through the medical home delivery model. If the Demonstration performs as designed, the number of members eligible for enrollment in Choice who are not enrolled with a PCP should decrease.

Hypothesis 8: Access to Care Call Volumes

This hypothesis looks at two types of call volumes. One is calls to OHCA's Patient Advice Line, which is staffed by nurses and offers medical advice after hours. The other is calls to the SoonerCare Helpline that indicate that a member is having difficulty getting access to primary or specialty care and has called OHCA for assistance.

Given that Choice PCPs are required to offer 24/7 access to care, it is reasonable to expect that the number of calls to the Patient Advice Line, controlling for differences in enrollment numbers, should decrease with time, provided that PCPs are offering access to care that effectively replaces that offered by the Patient Advice Line.

As the medical home model develops in primary care offices across the state, provided the SoonerCare network of PCPs and specialists remains strong, member calls for assistance with matters like getting an appointment within the timeframe perceived necessary by the member should decrease.

Hypothesis 9: Continuity of Care

While it is important that members be able to move between providers to find the most suitable medical home, the medical home model also presumes that continuity of care can best be achieved with continuity of the relationship with one's PCP. Long-term stability of enrollment on a doctor's panel also suggests that the member is satisfied with care received in the medical home. As the medical home model develops and matures, the number of members enrolled with more than one PCP during a month should decrease.

Hypothesis 10: Impact of Health Access Networks on Quality of Care

As the HANs in operation continue to develop, their impact on the quality of care received by members enrolled with participating PCPs should increase. Provider profiles that capture key quality performance measures can be tracked for PCPs participating in the HAN, and should indicate improvement over the Demonstration extension period. The number of HAN-affiliated PCPs using Electronic Medical Records in their practices should also increase.

Hypothesis 11: Impact of Health Access Networks on Effectiveness of Care

A key assumption underlying the HAN model is that better networks and better coordination and management of care lead to reduced medical expenses. As the HANs continue their operations, expenditures per member per month for members enrolled with PCPs participating in the HAN should decrease.

Documentation of Compliance with Public Notice Requirements

In compliance with public notice requirements, OHCA has provided meaningful notice of the state's intent to renew the SoonerCare Demonstration to the Native American Tribes and to the general public. The notice included explanation of the amendment the State is requesting be made to the Demonstration.

OHCA made use of the methods listed below to inform the public of the state's intent to renew the Demonstration and to solicit feedback from the public.

- OHCA published an announcement in the five major newspapers in the state (*The Daily Oklahoman* on Nov 23, 2011; the *Tulsa World* on Nov 23, 2011; the *Norman Transcript* on Nov 23, 2011; the *Lawton Constitution* on Nov 23, 2011; and the *Broken Arrow Ledger* on Nov 25, 2011), directing interested parties to consult the application online or to request it from OHCA.
- OHCA posted the draft of the renewal application on the agency's public website, www.okhca.org. A prominent scrolling banner at the top of the home page provided a link to the page where visitors can download the application document and submit comments to the agency electronically.
- OHCA sent notice of the renewal to the tribes on October 15, 2011, and discussed the renewal application with the tribes at the Tribal Consultation Meeting held at OHCA on November 1, 2011.
- OHCA discussed the renewal at two public hearings: at a meeting of the Medical Advisory Committee on November 16, 2011 and at a meeting of the Board of the OHCA on December 8, 2011. Both meetings' times and locations are published beforehand in accordance with Oklahoma's Open Meeting Act.

Comments Received

At the Tribal Consultation Meeting on November 1, 2011, a representative of the Chickasaw Nation commented that she would appreciate more information on the medical home model. A representative of the Kickapoo Nation concurred that more educational material would be helpful. The representative of the Chickasaw Nation also noted, regarding Demonstration evaluation results, that the percentage of Native American members enrolled with an I/T/U PCP (about 20%) sounded low to her; she said that the agency might want to work on improving outreach to Native American members. Dana Miller, OHCA Director of Indian Health, will address both comments.

At the Medical Advisory Committee meeting on November 16, 2011, a committee member inquired regarding the amendment limiting adult outpatient behavioral health visits to 48; the member asked who would pay for visits beyond 48 in a year. The OHCA representative responded that visits over 48 in a calendar year would not be covered services. A committee member representing the Oklahoma Department of Mental Health and Substance Abuse Services commented that 48 is a reasonable number of visits.

At the OHCA Board Meeting on December 8, 2011, State Representative Mark McCullough referred to page twenty-seven of this renewal application and inquired whether there is a conflict between the data showing that Choice PCP capacity had decreased while enrollments had increased. The State Medicaid Director explained that the capacity data do not represent the number of members enrolled with PCPs; rather, they represent the maximum number of SoonerCare members participating PCPs declare that they can serve. Representative McCullough also inquired about when the State received authorization to provide coverage for unemployed adults and college students, and about the legal authorities behind changes in Native American cost-sharing. The Waiver Coordinator explained the Federal mandate behind changes in Native American cost-sharing requirements and gave information on State legislation and Federal approvals for the Insure Oklahoma program.

Only two comments were received through the online form; neither were relevant to the renewal, and both appear to have been generated by other websites without the involvement of a person. OHCA did not receive any other comments apart from those summarized above.

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- The Myers Group. "CAHPS 2011 Medicaid Child Survey: Final Report." Duluth, GA, 2011.

Appendix A: Amendment Request Documentation

Amendment Request

The State requests that benefit limitations in the Insure Oklahoma Individual Plan be revised to limit coverage of outpatient behavioral health visits to 48 per year. At present, children’s outpatient behavioral health visits are limited to 48 per year, while adults’ visits are unlimited. This amendment will revise the adult benefit to match the children’s benefit.

Public Process

The State included this amendment request in all public notice materials and processes documented for the renewal of the waiver. See the section of the renewal application titled “Documentation of Compliance with Public Notice Requirements”.

Impact on Budget Neutrality

The amendment is projected to produce nominal additional savings. See the section of the renewal application titled “Compliance with the Budget Neutrality Cap” and Appendix E.

CHIP Allotment Neutrality Worksheet

This requirement is not applicable to the amendment requested.

Impact on Beneficiaries

Utilization of Adult Outpatient Behavioral Health Visits, IO IP, by Calendar Year

<i>Year</i>	<i>Member Count</i>	<i>Total Cost of All Visits</i>	<i>Average Cost / Recipient</i>
<i>2007</i>	<i>32</i>	<i>\$9,136.79</i>	<i>\$285.52</i>
<i>2008</i>	<i>269</i>	<i>\$45,478.31</i>	<i>\$169.06</i>
<i>2009</i>	<i>719</i>	<i>\$178,319.84</i>	<i>\$248.01</i>
<i>2010</i>	<i>1,287</i>	<i>\$458,168.56</i>	<i>\$356.00</i>
<i>2011 (through Sept)</i>	<i>1,076</i>	<i>\$421,688.93</i>	<i>\$391.90</i>

Utilization of Outpatient Behavioral Health Visits by Members Who had More than 48 Visits per Calendar Year

<i>Year</i>	<i>Member Count</i>	<i>Total Cost of All Visits</i>	<i>Average Cost/Recipient</i>
<i>2009</i>	<i>2</i>	<i>\$12,085.14</i>	<i>\$6,042.57</i>
<i>2010</i>	<i>15</i>	<i>\$84,980.52</i>	<i>\$5,665.37</i>
<i>2011 (through Sept)</i>	<i>14</i>	<i>\$71,099.04</i>	<i>\$5,078.50</i>

Cost of Outpatient Behavioral Health Visits Received over 48 per Calendar Year

<i>Year</i>	<i>Member Count</i>	<i>Total Cost of Visits Exceeding 48</i>	<i>Average Cost/Recipient of Visits Exceeding 48</i>
<i>2009</i>	<i>2</i>	<i>\$6,125.00</i>	<i>\$3,062.50</i>
<i>2010</i>	<i>15</i>	<i>\$34,253.60</i>	<i>\$2,283.57</i>
<i>2011 (through Sept)</i>	<i>14</i>	<i>\$28,875.25</i>	<i>\$2,062.52</i>

Using 2010 as the most recent year for which complete data is available, it can be expected that about 1.2% of all members who utilize the outpatient behavioral health visit benefit will be affected by the amendment if it is approved. The total savings can be expected to be about \$99,692 in 2012. Please see the budget

neutrality exhibits in Appendix E for projections of the effect of the amendment on budget neutrality for the waiver.

Evaluation Design

This Amendment does not require any modification of the Demonstration evaluation design, and will not have an impact on Demonstration evaluation results.

Appendix B: The History of the Waiver

January 1995	SoonerCare Demonstration approved.
August 1995	The State implements a fully capitated managed care organization (MCO) model in urban areas.
October 12, 1995	Authority granted to waive retroactive eligibility.
July 1996	The State implements a primary care case management (PCCM) partial capitation model in rural areas.
December 31, 2003	The State terminates the MCO program and transitions managed care enrollees to the PCCM model statewide.
January 1, 2004	Renewal approved effective January 1, 2004 through December 31, 2006.
September 30, 2005	HIFA amendment approved to provide insurance coverage to adults employed by small employers and working disabled adults.
September 30, 2005	TEFRA amendment approved to expand coverage to eligible disabled children.
January 1, 2007	Renewal approved effective January 1, 2007 through December 31, 2009.
January 3, 2009	Amendment approved to change the service delivery model from a partially capitated payment to an exclusive Primary Care Case Management (PCCM) model. Medical home implemented.
January 3, 2009	Amendment approved to add an expansion population to Insure Oklahoma for full-time college students aged 19 to 22 not to exceed 200% FPL, capped at 3,000 members.
January 3, 2009	Amendment approved to expand the size of employers eligible to participate in Insure Oklahoma from 50 employees to 250 employees.
January 3, 2009	Amendment approved to expand the description of qualified PCPs to permit County Health Departments to serve as medical homes for members who choose these providers.
January 3, 2009	Amendment approved to include an option for voluntary enrollment of children in State or Tribal custody in the Demonstration.
January 3, 2009	Amendment approved to implement SoonerExcel incentive payments for PCPs to build upon the EPSDT and Fourth DTaP Bonus program.
January 3, 2009	Amendment approved to amend cost sharing requirements for the Insure Oklahoma Program and to add a \$1 co-pay for non-pregnant adults in SoonerCare.
January 1, 2010	Renewal approved effective January 1, 2010 to December 31, 2012.
January 1, 2010	Amendment approved to implement Health Access Network (HAN) pilot program.
January 1, 2010	Amendment approved to expand eligibility under Insure Oklahoma for non-disabled working adults and their spouses, disabled working adults, and full-time college students, from 200% FPL up to and including 250% FPL.
January 1, 2010	Amendment approved to add a new eligibility group under Insure Oklahoma for foster parents up to and including 250% FPL.
January 1, 2010	Amendment approved to add a new eligibility group under Insure Oklahoma for employees of not-for-profit businesses having fewer than 500 employees, up to and including 250% FPL.

August 1, 2011

Amendment approved to eliminate the \$10 co-pay for the initial prenatal visit under Insure Oklahoma, Individual Plan.

Demonstration Eligibility Groups

1 *TANF-Urban*

Includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program, receiving health care services in the designated Central, Northeast, and Southwest urban areas of the State.

2 *TANF-Rural*

Includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program, receiving health care services in the rural areas of the State.

3 *ABD-Urban*

Includes the Aged, Blind and Disabled receiving health care services in the designated Central, Northeast, and Southwest urban areas of the State.

4 *ABD-Rural*

Includes the Aged, Blind and Disabled receiving health care services in the rural areas of the State.

5 *Non-Disabled Working Adults*

Includes non-disabled low income workers and their spouses with household incomes no greater than 250 percent of the FPL.

6 *Working Disabled Adults*

Includes low income working disabled adults with household incomes no greater than 250 percent of the FPL.

7 *TEFRA Children*

Includes children defined in paragraph 20 of the Special Terms and Conditions.

8 *Full-Time College Students*

Includes full-time college students ages 19-22 up to and including 250 percent of the FPL (limited to 3,000 individuals at any given time).

9 *CHIP Medicaid Expansion Children*

Includes infants under age 1, children ages 1-5, and children ages 6-18.

10 *Foster Parents*

Includes working foster parents with household incomes no greater than 250 percent of the FPL. The spouse of a working employee can be covered.

11 *Not-for-Profit Employees*

Includes employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 250 percent of the FPL.

12 *HAN Expenditures*

Includes PMPM expenditures made to the HANs.

Appendix C: Insure Oklahoma Monitoring

Average Monthly Premium Assistance Contribution per ESI member and Cost PMPM for IP Member

<i>Quarter</i>	<i>ESI Average Premium Contribution</i>	<i>IP Average Cost PMPM</i>
<i>July – Sept 2007</i>	\$231.22	\$175.39
<i>Oct – Dec 2007</i>	\$227.94	\$214.55
<i>Jan – Mar 2008</i>	\$230.70	\$288.31
<i>Apr – June 2008</i>	\$227.96	\$267.36
<i>July – Sept 2008</i>	\$236.10	\$286.77
<i>Oct – Dec 2008</i>	\$238.16	\$328.33
<i>Jan – Mar 2009</i>	\$242.83	\$279.51
<i>Apr – June 2009</i>	\$244.93	\$311.93
<i>July – Sept 2009</i>	\$246.79	\$321.44
<i>Oct – Dec 2009</i>	\$251.13	\$337.94
<i>Jan – Mar 2010</i>	\$256.00	\$315.60
<i>Apr – June 2010</i>	\$259.27	\$310.78
<i>July – Sept 2010</i>	\$265.43	\$324.83
<i>Oct – Dec 2010</i>	\$270.31	\$313.10
<i>Jan – Mar 2011</i>	\$274.79	\$317.70
<i>Apr – June 2011</i>	\$278.31	\$336.43
<i>July – Sept 2011</i>	\$281.30	\$339.03

ESI Mean Premium Contribution PMPM: \$250.77

IP Mean Cost PMPM: \$298.18

Total Costs PMPM for ESI and IP Members, Including Reimbursements of Out-of-Pocket Expenses over 5% of Gross Income

<i>Year</i>	<i>Total Cost PMPM, ESI</i>	<i>Total Cost PMPM, IP</i>
<i>2007</i>	\$230.55	\$199.60
<i>2008</i>	\$234.82	\$298.70
<i>2009</i>	\$248.40	\$317.40
<i>2010</i>	\$265.57	\$316.28
<i>2011 (through Sept)</i>	\$285.30	\$331.50

ESI Mean PMPM Total Cost 2007 – 2011: \$252.93

IP Mean PMPM Total Cost 2007 – 2011: \$292.69

Contributions by Employers Pre- and Post-Participation in ESI

Total annual employer premiums pre-implementation: \$155,431,255

Total annual employer premiums post-implementation: \$167,442,237

Total annual amount paid by employers toward subsidized employees' premiums: \$51,020,236

Total Statewide Employer Contributions Per Year

<i>Year</i>	<i>Total Employer Contribution</i>
<i>2007</i>	\$1,110,129.95
<i>2008</i>	\$6,371,915.40
<i>2009</i>	\$11,303,340.57
<i>2010</i>	\$15,092,287.60
<i>2011 (through Sept)</i>	\$11,836,870.73

ESI Health Plan Monitoring

Insure Oklahoma program staff monitor ESI qualified health plans as they are submitted for each year and ensure that the benefits covered and cost-sharing requirements meet OHCA rules and standards. Staff have not noted any trends in health plan changes.

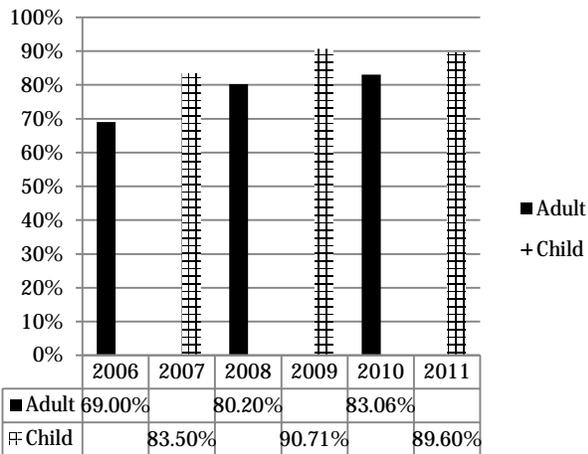
Appendix D: Beneficiary Satisfaction Survey Results

CAHPS®

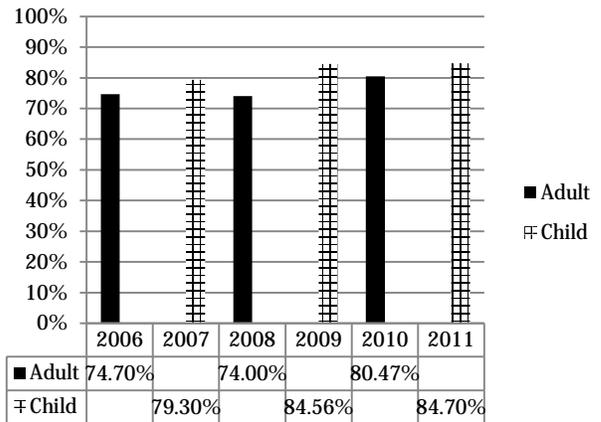
The following table summarizes the major findings of the 2011 survey by health plan evaluation area.

<i>Evaluation Area</i>	<i>2011 Score</i>	<i>Significantly different from 2010 NCBD benchmark?</i>	<i>Significantly different from 2009 score?</i>	<i>Percentile Ranking of 2011 Score</i>
Rating of Health Plan	78.4% rate Choice 8, 9, or 10 on scale of 1-10	No	No (82.3%)	16 th
Getting Needed Care	80%	No	No (76.8%)	28 th
Customer Service	80.1%	No	No (75.3%)	31 st
Rating of Health Care	78.1% rate health care received 8, 9, or 10	No	No (74.5%)	< 10 th
Getting Care Quickly	87.1%	No	No (87.6%)	25 th
How Well Doctors Communicate	91.6% “always” or “usually” satisfied	No	No (88.8%)	24 th
Shared Decision Making	68.3% feel doctors discussed options and asked their opinion	No	No (66.4%)	47 th
Health Promotion and Education	64.1% feel doctors discussed specific ways to prevent illness	No	No (61.2%)	52 nd
Coordination of Care	71.9% feel doctor was “always” or “usually” informed and up-to-date about their care	No	No (79.1%)	10 th
Rating of Personal Doctor	82.2%	No	No (80.3%)	< 10 th
Rating of Specialist	84.7%	No	No (75.0%)	80 th

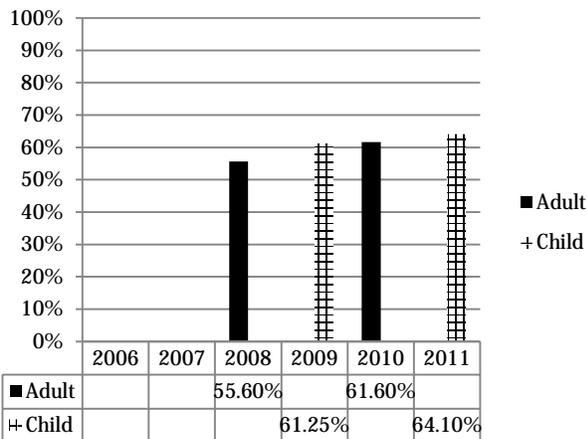
Percent reporting that it is usually or always easy to get urgently needed care right away



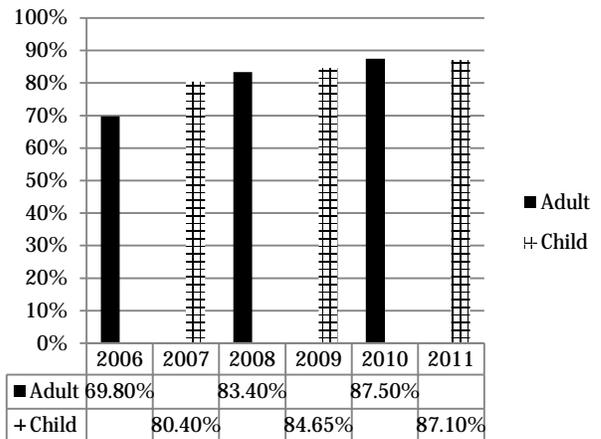
Percent reporting that it is usually or always easy to get non-urgent care when it is needed



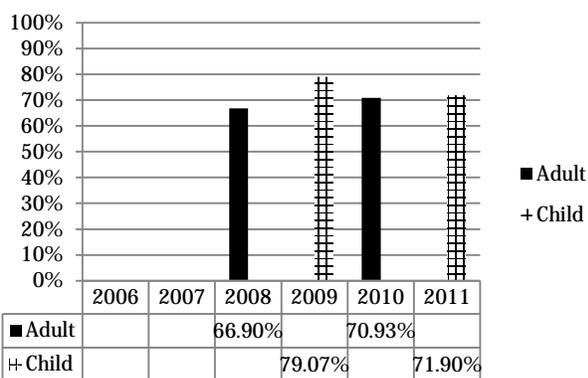
Percent reporting that their doctors usually or always discuss ways to prevent illness



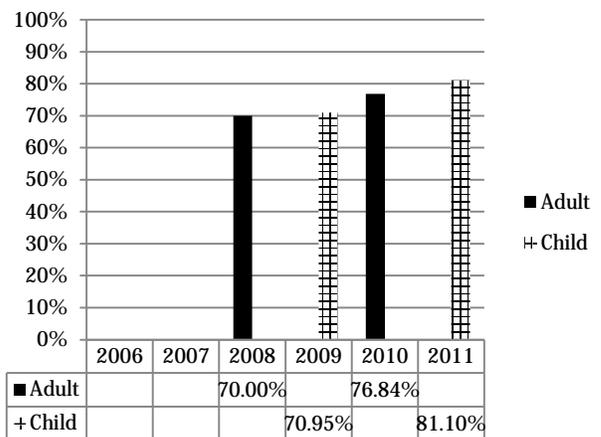
Percent reporting that they have a personal doctor



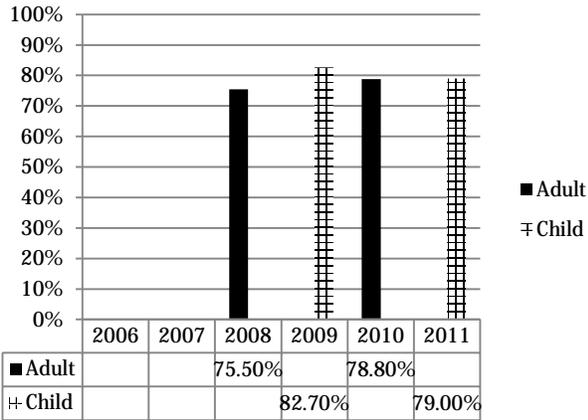
Percent reporting that their personal doctor usually or always seemed informed about visits to other providers (general care coordination)



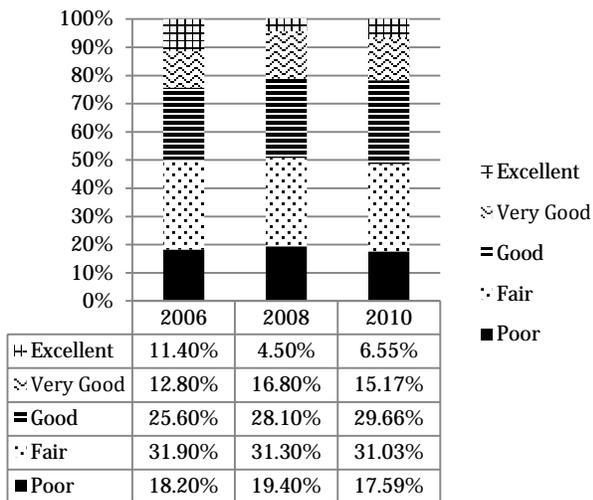
Percent reporting that it is usually or always easy to get appointments with specialists



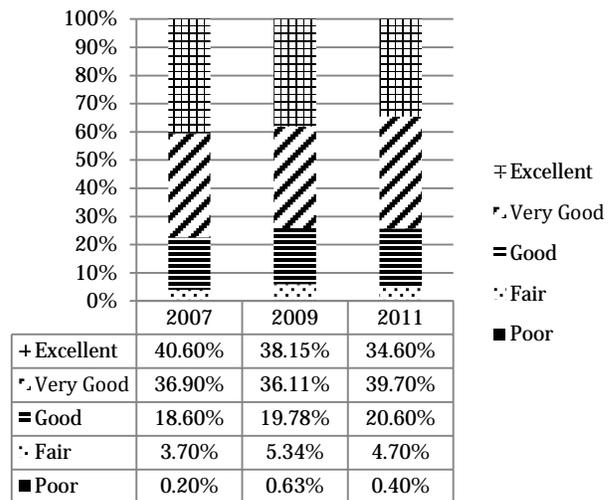
Percent reporting that it is usually or always easy to get care, tests, treatment they thought they needed



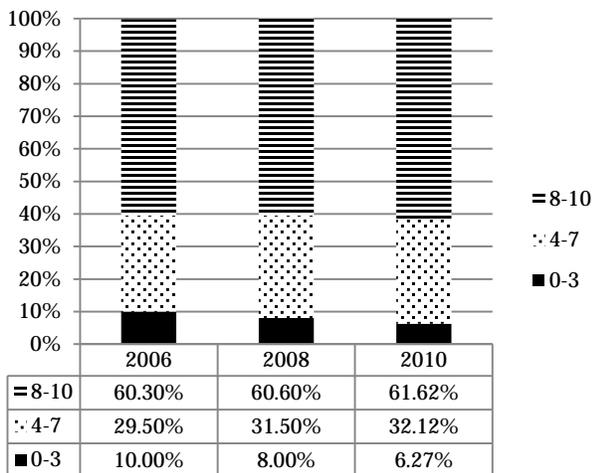
General Rating of Overall Health: Adults



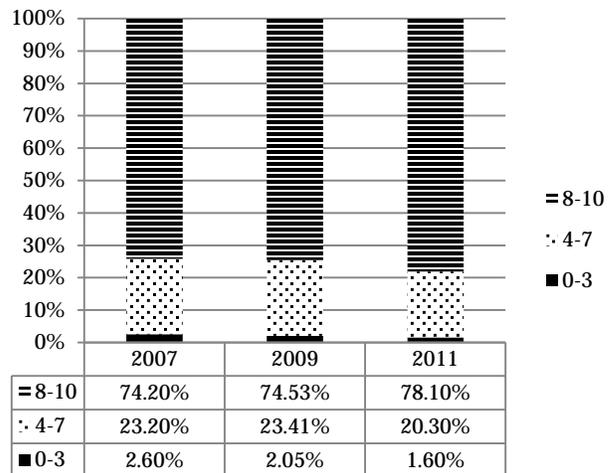
General Rating of Overall Health: Children



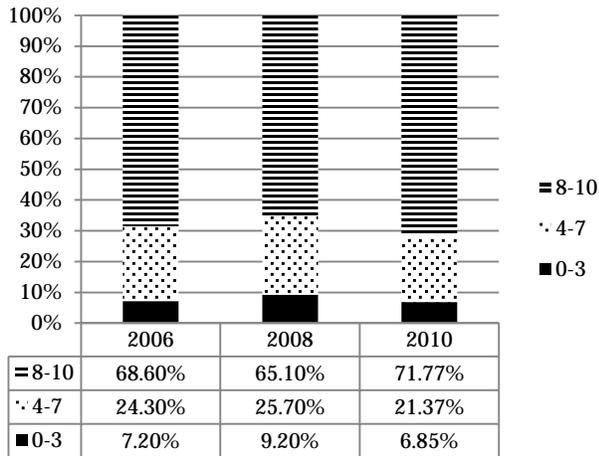
Rankings of all health care received from 1 to 10, where 10 is best: Adults



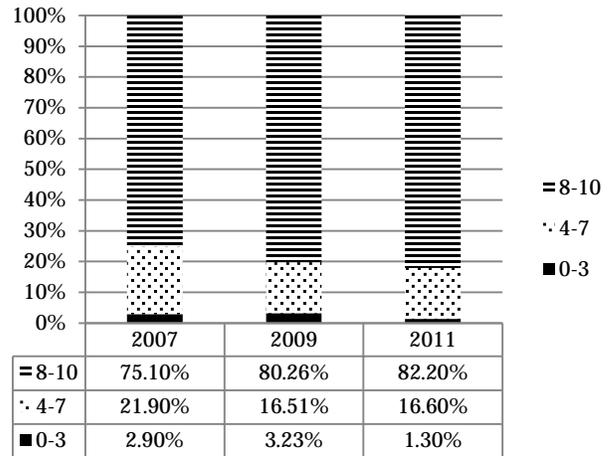
Rankings of all health care received from 1 to 10, where 10 is best: Children



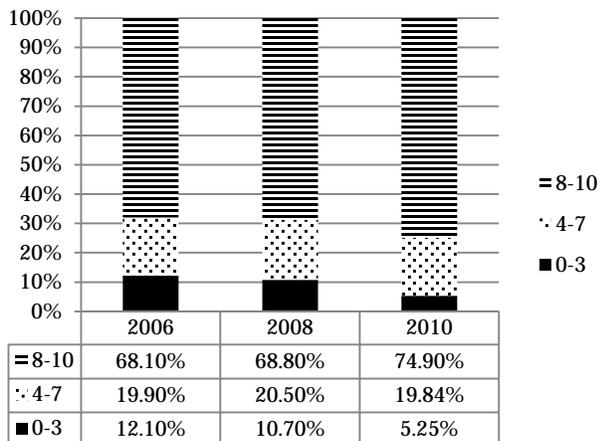
Rankings of personal doctors from 1 to 10, where 10 is best: Adults



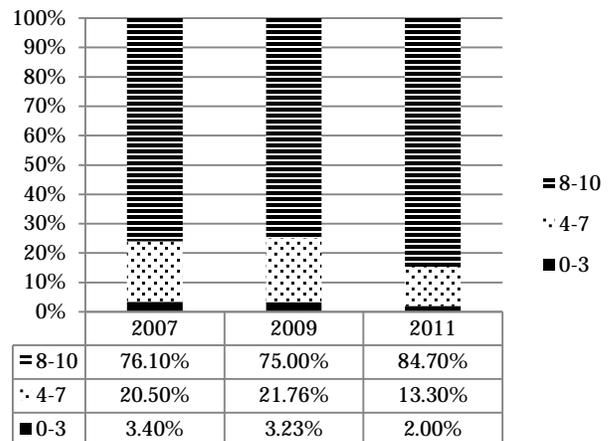
Rankings of personal doctors from 1 to 10, where 10 is best: Children



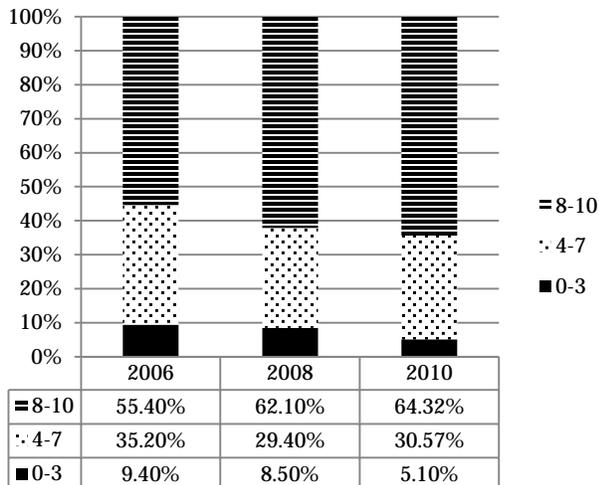
Rankings of specialists from 1 to 10, where 10 is best: Adults



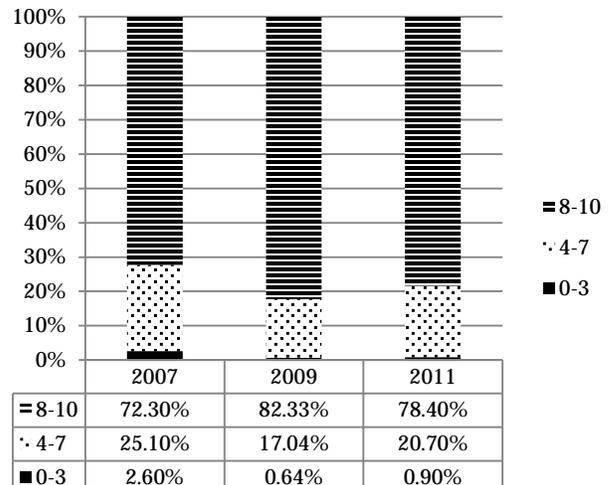
Rankings of specialists from 1 to 10, where 10 is best: Children



Rankings of the health plan from 1 to 10, where 10 is best: Adults



Rankings of the health plan from 1 to 10, where 10 is best: Children



ECHO®

Children

<i>Measure</i>	<i>2008</i>	<i>2010</i>
Overall rating of treatment received in the last 12 months on a scale of 1 to 10	7.83	7.84
Overall rating of health plan for counseling or treatment on a scale of 1 to 10	8.19	8.20

Adults

<i>Measure</i>	<i>2007</i>	<i>2009</i>
Overall rating of treatment received in the last 12 months on a scale of 1 to 10; responses were recoded with 0-6=1; 7-8=2 & 9-10=3	2.10	2.11 [7.40 on 1-10 scale]
Overall rating of health plan for counseling or treatment on a scale of 1 to 10; responses were recoded with 0-6=1; 7-8=2 & 9-10=3	No comparable data available	2.19 [7.72 on 1-10 scale]

Insure Oklahoma ESI and IP Member Satisfaction Surveys

<i>Measure</i>	<i>ESI</i>	<i>IP</i>
Uninsured before beginning coverage through IO	44%	74%
“Very Satisfied” or “Okay” with current health plan	93%	94%
Have used health care services under the plan	88%	92%
“Very Satisfied” or “Okay” with application and renewal process	89%	86%
“Very Satisfied” or “Okay” with costs and out-of-pocket expenses	84%	97%
“Very Satisfied” or “Okay” with benefits and coverage	91%	96%
“Very Satisfied” or “Okay” with customer service	89%	93%
“Very Satisfied” or “Okay” with ability to locate a PCP	94%	93%
“Very Satisfied” or “Okay” with referral process	68%	81%
“Very Satisfied” or “Okay” with pharmacy/prescription drug benefits	87%	93%

PCMH Provider Survey

PCMH Tiers of responding providers

<i>Tier</i>	<i>Self-Reported Tier</i>	<i>Actual Tier</i>	<i>Choice PCP Tier proportions at time of survey (Oct 2009)</i>
1	49%	56%	65%
2	43%	38%	30%
3	8%	6%	5%

As these data indicate, providers tended to self-report a higher tier than their actual tier; tier 2 and tier 3 providers were also slightly over-represented among PCPs responding to the survey.¹³

Responses to key measures related to quality and the relationship between PCPs and members

<i>Survey Question</i>	<i>Result</i>	<i>Interpretation/Notes</i>
Rate your familiarity with the PCMH model	Not familiar: 6% Somewhat familiar: 24% Familiar: 28% Knowledgeable: 30% Very knowledgeable: 12%	Responses fell mostly in the mid-range between somewhat familiar and knowledgeable. (mean = 3.18 out of 5; SEM = .09)
What would incentivize PCP to advance tier status	Higher pay: 33% No interest: 13% Less red tape: 12% Don't know: 12% More PCPs: 10% OHCA help: 9% Patient effort: 7% EHR: 4%	25% of respondents had either no interest in advancing their tier or didn't know what to do. 33% asked for higher pay.
What might incentivize patients to take more responsibility for their health.	Regulatory changes: 37% ¹⁴ Pt education/responsibility: 24% Rewards: 17% Don't know: 13% Good PCP/pt relationship: 9%	Two categories that emerged were unique and interesting: good PCP/pt relationship and rewards for meeting health milestones or responsibility. Most were frustrated, however, with 'no shows' and the inability to penalize for inappropriate use of health care services (e.g., ER); they didn't know of anything that would help.
Willingness to communicate, provide certain medical services via e-mail.	Not willing: 39% Willing: 43% Very willing: 18%	Some respondents reported being hesitant about providing medical services via e-mail.
If willing to provide e-mail services, what should the reimbursement be?	Mean: \$36.56 Range: \$5-\$100 Mode: \$25 Median: \$30	Comments indicated that many felt both e-mail and phone services should be coded and billed like an office visit.

¹³ The report notes that some respondents indicated that they did not know what a tier was and 15 did not answer the question.

¹⁴ "37% of PCPs felt that only regulatory changes to allow them to dismiss patients or charge co-pays would incentivize SoonerCare patients to become more accountable for their health."

<i>Survey Question</i>	<i>Result</i>	<i>Interpretation/Notes</i>
EHR in your practice? If no, do you plan to implement?	Yes: 48% No: 52% By 2011: 38% By 2015: 32% No plans: 30%	48% of respondents had an EHR in place. Approximately 1/3 had no plans to implement. Some reasons given were: loss of productivity, cost, too close to retirement.
If no plans to implement an EHR, would financial assistance change your mind?	Unlikely: 19% Somewhat likely: 36% Very likely: 45%	Financial aid would impact respondents' decision regarding an EHR to a great degree.
Additional comments.	E-mail: 29% Provider issues: 26% Patient issues: 18% Positive remarks: 13% EHR: 7% Support/education: 7%	Most remarks had to do with provider issues related to advancing tier status (e.g. 24/7 coverage) and providing services using e-mail.

Appendix E: Budget Neutrality Exhibits

Exhibit 1: Enrollment Trends for Traditional MEGs

MEG	2007	2008	2009	2010	2011 (Annualized)	Annual Trend	Trending Years
TANF - Urban	2,808,278	2,772,622	3,029,870	3,333,170	3,320,081	4.27%	2007 - 2011
TANF - Rural	2,130,548	2,078,460	2,246,021	2,429,264	2,414,579	3.18%	2007 - 2011
ABD - Urban	268,332	283,834	301,034	327,267	344,304	6.43%	2007 - 2011
ABD - Rural	244,220	251,088	262,857	278,093	285,347	3.97%	2007 - 2011
Insure OK	38,417	139,822	172,704	392,155	388,776	-0.86%	2010 - 2011
TEFRA	1,813	2,515	3,299	4,018	4,443	10.57%	2010 - 2011
College Students	-	-	873	3,972	5,348	34.64%	2010 - 2011

Exhibit 2: PMPM Expenditure Trends by MEG

MEG	Factor
TANF-U	1.0513
TANF-R	1.0513
ABD-U	1.0520
ABD-R	1.0520
INSURE OK	1.0513
TEFRA	1.0520
College Students	1.0513

Exhibit 3: Budget Neutrality for TANF-Urban MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996	1,248,591	\$121.60	\$151,828,666	\$109.06	\$136,166,854	\$15,661,812	\$15,661,812
2	1997	1,201,538	\$129.52	\$155,618,588	\$121.58	\$146,088,131	\$9,530,457	\$25,192,268
3	1998	1,299,675	\$137.95	\$179,287,128	\$118.62	\$154,165,878	\$25,121,250	\$50,313,518
4	1999	1,489,962	\$146.93	\$218,917,218	\$120.93	\$180,176,146	\$38,741,072	\$89,054,590
5	2000	1,575,250	\$156.49	\$246,515,710	\$142.38	\$224,278,709	\$22,237,001	\$111,291,592
6	2001	1,988,010	\$166.68	\$331,363,038	\$156.92	\$311,964,540	\$19,398,498	\$130,690,090
7	2002	2,159,002	\$177.53	\$383,291,270	\$156.45	\$337,784,795	\$45,506,475	\$176,196,565
8	2003	2,319,441	\$189.09	\$438,580,782	\$163.84	\$380,021,639	\$58,559,143	\$234,755,708
9	2004	2,426,341	\$201.40	\$488,661,911	\$136.62	\$331,495,295	\$157,166,616	\$391,922,324
10	2005	2,528,654	\$214.51	\$542,420,938	\$141.17	\$356,967,558	\$185,453,380	\$577,375,704
11	2006	2,643,157	\$228.47	\$603,893,538	\$213.25	\$563,645,768	\$40,247,770	\$617,623,474
12	2007	2,808,278	\$240.19	\$674,520,293	\$204.58	\$574,528,973	\$99,991,320	\$717,614,794

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
13	2008	2,772,622	\$252.51	\$700,119,625	\$237.41	\$658,239,328	\$41,880,297	\$759,495,092
14	2009	3,029,870	\$265.47	\$804,339,589	\$249.71	\$756,593,334	\$47,746,255	\$807,241,346
15	2010	3,333,170	\$279.09	\$930,249,786	\$235.05	\$783,461,815	\$146,787,971	\$954,029,317
16	2011 (est)	3,320,081	\$293.42	\$974,178,265	\$259.23	\$860,668,761	\$113,509,504	\$1,067,538,821
17	2012 (proj)	3,461,991	\$308.46	\$1,067,885,608	\$272.53	\$943,495,560	\$124,390,048	\$1,191,928,868
18	2013 (proj)	3,609,965	\$324.28	\$1,170,654,002	\$286.51	\$1,034,293,229	\$136,360,773	\$1,328,289,641
19	2014 (proj)	4,111,635	\$340.92	\$1,401,737,650	\$301.21	\$1,238,459,663	\$163,277,988	\$1,491,567,629
20	2015 (proj)	4,287,377	\$358.41	\$1,536,634,428	\$316.66	\$1,357,643,318	\$178,991,110	\$1,670,558,739

Exhibit 4: Budget Neutrality for TANF-Rural MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996	1,088,941	\$123.34	\$134,309,983	\$103.62	\$112,839,567	\$21,470,416	\$21,470,416
2	1997	1,081,206	\$131.37	\$142,037,420	\$125.66	\$135,865,141	\$6,172,279	\$27,642,695
3	1998	1,250,830	\$139.92	\$175,018,115	\$119.50	\$149,478,153	\$25,539,962	\$53,182,657
4	1999	1,510,946	\$149.03	\$225,177,007	\$110.12	\$166,390,827	\$58,786,180	\$111,968,837
5	2000	1,522,229	\$158.73	\$241,627,007	\$129.42	\$197,013,558	\$44,613,449	\$156,582,286
6	2001	1,915,864	\$169.07	\$323,907,157	\$130.46	\$249,934,052	\$73,973,105	\$230,555,391
7	2002	2,014,674	\$180.07	\$362,786,430	\$134.34	\$270,655,613	\$92,130,817	\$322,686,208
8	2003	1,941,227	\$191.79	\$372,317,080	\$141.26	\$274,223,683	\$98,093,397	\$420,779,605
9	2004	1,984,722	\$204.28	\$405,440,105	\$148.84	\$295,405,508	\$110,034,597	\$530,814,202
10	2005	2,015,932	\$217.58	\$438,624,903	\$159.74	\$322,029,698	\$116,595,205	\$647,409,407
11	2006	2,036,491	\$231.74	\$471,943,801	\$190.64	\$388,233,608	\$83,710,193	\$731,119,599
12	2007	2,130,548	\$243.63	\$519,065,409	\$195.93	\$417,441,217	\$101,624,192	\$832,743,791
13	2008	2,078,460	\$256.13	\$532,352,258	\$208.78	\$433,930,837	\$98,421,421	\$931,165,212
14	2009	2,246,021	\$269.27	\$604,780,677	\$220.17	\$494,500,234	\$110,280,443	\$1,041,445,655
15	2010	2,429,264	\$283.08	\$687,678,542	\$213.62	\$518,943,390	\$168,735,152	\$1,210,180,807
16	2011 (est)	2,414,579	\$297.61	\$718,602,757	\$223.69	\$540,119,553	\$178,483,204	\$1,388,664,010
17	2012 (proj)	2,491,316	\$312.87	\$779,458,129	\$235.17	\$585,873,795	\$193,584,334	\$1,582,248,344
18	2013 (proj)	2,570,493	\$328.92	\$845,487,057	\$247.23	\$635,503,939	\$209,983,119	\$1,792,231,463

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
19	2014 (proj)	2,904,815	\$345.79	\$1,004,467,284	\$259.91	\$755,000,222	\$249,467,063	\$2,041,698,525
20	2015 (proj)	2,997,133	\$363.53	\$1,089,557,037	\$273.25	\$818,957,289	\$270,599,748	\$2,312,298,273

Exhibit 5: Budget Neutrality for ABD-Urban MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996							
2	1997							
3	1998							
4	1999	96,785	\$536.14	\$51,889,826	\$408.54	\$39,540,909	\$12,348,917	\$12,348,917
5	2000	190,315	\$567.55	\$108,013,756	\$441.30	\$83,985,855	\$24,027,901	\$36,376,818
6	2001	279,689	\$600.81	\$168,040,252	\$363.42	\$101,645,621	\$66,394,631	\$102,771,450
7	2002	306,526	\$636.02	\$194,956,243	\$402.14	\$123,267,004	\$71,689,239	\$174,460,688
8	2003	233,742	\$673.29	\$157,375,990	\$578.12	\$135,130,199	\$22,245,791	\$196,706,479
9	2004	244,590	\$712.74	\$174,330,070	\$488.80	\$119,555,202	\$54,774,868	\$251,481,347
10	2005	255,066	\$754.51	\$192,450,068	\$668.41	\$170,487,473	\$21,962,595	\$273,443,942
11	2006	259,473	\$798.73	\$207,247,624	\$854.61	\$221,748,359	(\$14,500,734)	\$258,943,208
12	2007	268,332	\$840.26	\$225,468,646	\$887.41	\$238,121,801	(\$12,653,155)	\$246,290,053
13	2008	283,834	\$883.96	\$250,898,901	\$954.33	\$270,870,487	(\$19,971,585)	\$226,318,468
14	2009	301,034	\$929.92	\$279,937,423	\$1,003.30	\$302,026,585	(\$22,089,162)	\$204,229,306
15	2010	327,267	\$978.28	\$320,157,269	\$960.49	\$314,336,505	\$5,820,764	\$210,050,070
16	2011 (est)	344,304	\$1,029.15	\$354,339,003	\$926.94	\$319,148,246	\$35,190,758	\$245,240,828
17	2012 (proj)	366,446	\$1,082.66	\$396,736,447	\$975.14	\$357,335,037	\$39,401,410	\$284,642,238
18	2013 (proj)	390,011	\$1,138.96	\$444,206,838	\$1,025.85	\$400,090,963	\$44,115,875	\$328,758,113
19	2014 (proj)	415,092	\$1,198.19	\$497,357,166	\$1,079.19	\$447,962,729	\$49,394,437	\$378,152,550
20	2015 (proj)	441,786	\$1,260.49	\$556,867,047	\$1,135.31	\$501,562,457	\$55,304,590	\$433,457,140

Exhibit 6: Budget Neutrality for ABD-Rural MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996							

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
2	1997							
3	1998							
4	1999	103,533	\$427.26	\$44,235,510	\$387.69	\$40,139,140	\$4,096,370	\$4,096,370
5	2000	209,188	\$452.30	\$94,615,196	\$416.00	\$87,022,957	\$7,592,239	\$11,688,609
6	2001	329,747	\$478.80	\$157,883,545	\$332.70	\$109,707,133	\$48,176,412	\$59,865,020
7	2002	343,627	\$506.86	\$174,170,735	\$350.27	\$120,361,978	\$53,808,757	\$113,673,778
8	2003	222,348	\$536.56	\$119,303,455	\$516.96	\$114,944,808	\$4,358,647	\$118,032,425
9	2004	231,151	\$568.00	\$131,294,780	\$598.48	\$138,339,043	(\$7,044,263)	\$110,988,163
10	2005	238,426	\$601.29	\$143,363,035	\$637.30	\$151,950,033	(\$8,586,998)	\$102,401,165
11	2006	241,661	\$636.52	\$153,823,267	\$793.03	\$191,644,245	(\$37,820,978)	\$64,580,187
12	2007	244,220	\$669.62	\$163,534,596	\$834.57	\$203,819,591	(\$40,284,995)	\$24,295,192
13	2008	251,088	\$704.44	\$176,876,491	\$871.89	\$218,920,190	(\$42,043,699)	(\$17,748,507)
14	2009	262,857	\$741.07	\$194,795,734	\$930.09	\$244,480,177	(\$49,684,443)	(\$67,432,950)
15	2010	278,093	\$779.61	\$216,803,202	\$943.46	\$262,368,307	(\$45,565,105)	(\$112,998,055)
16	2011 (est)	285,347	\$820.15	\$234,026,037	\$962.04	\$274,514,325	(\$40,488,288)	(\$153,486,343)
17	2012 (proj)	296,668	\$862.79	\$255,963,366	\$1,012.06	\$300,246,979	(\$44,283,613)	(\$197,769,956)
18	2013 (proj)	308,439	\$907.66	\$279,957,074	\$1,064.69	\$328,391,782	(\$48,434,707)	(\$246,204,663)
19	2014 (proj)	320,676	\$954.86	\$306,199,925	\$1,120.06	\$359,174,846	(\$52,974,921)	(\$299,179,584)
20	2015 (proj)	333,399	\$1,004.51	\$334,902,751	\$1,178.30	\$392,843,479	(\$57,940,728)	(\$357,120,312)

Exhibit 7: Budget Neutrality for Insure Oklahoma MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996							
2	1997							
3	1998							
4	1999							
5	2000							
6	2001							
7	2002							
8	2003							
9	2004							

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
10	2005							
11	2006	9,744			\$198.81	\$1,937,239	(\$1,937,239)	(\$1,937,239)
12	2007	38,417			\$204.54	\$7,857,841	(\$7,857,841)	(\$9,795,080)
13	2008	139,822			\$239.62	\$33,504,032	(\$33,504,032)	(\$43,299,112)
14	2009	172,704			\$437.93	\$75,632,880	(\$75,632,880)	(\$118,931,992)
15	2010	392,155			\$285.37	\$111,910,574	(\$111,910,574)	(\$230,842,565)
16	2011 (est)	388,776			\$313.25	\$121,785,792	(\$121,785,792)	(\$352,628,357)
17	2012 (proj)	385,426			\$329.07	\$126,830,512	(\$126,830,512)	(\$479,458,869)
18	2013 (proj)	382,105			\$345.95	\$132,188,021	(\$132,188,021)	(\$611,646,890)
19	2014 (proj)	189,406			\$363.69	\$68,885,920	(\$68,885,920)	(\$680,532,810)
20	2015 (proj)	187,774			\$382.35	\$71,795,763	(\$71,795,763)	(\$752,328,573)

Exhibit 8: Budget Neutrality for TEFRA Children MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996							
2	1997							
3	1998							
4	1999							
5	2000							
6	2001							
7	2002							
8	2003							
9	2004							
10	2005							
11	2006	931			\$943.85	\$878,723	(\$878,723)	(\$878,723)
12	2007	1,813			\$1,055.94	\$1,914,416	(\$1,914,416)	(\$2,793,139)
13	2008	2,515			\$914.81	\$2,300,739	(\$2,300,739)	(\$5,093,878)
14	2009	3,299			\$1,393.11	\$4,595,878	(\$4,595,878)	(\$9,689,756)
15	2010	4,018			\$1,127.92	\$4,532,001	(\$4,532,001)	(\$14,221,757)
16	2011 (est)	4,443			\$933.61	\$4,147,729	(\$4,147,729)	(\$18,369,486)

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
17	2012 (proj)	4,912			\$982.16	\$4,824,584	(\$4,824,584)	(\$23,194,070)
18	2013 (proj)	5,431			\$1,033.23	\$5,611,893	(\$5,611,893)	(\$28,805,963)
19	2014 (proj)	6,005			\$1,086.96	\$6,527,681	(\$6,527,681)	(\$35,333,644)
20	2015 (proj)	6,640			\$1,143.48	\$7,592,914	(\$7,592,914)	(\$42,926,558)

Exhibit 9: Budget Neutrality for College Student MEG

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996							
2	1997							
3	1998							
4	1999							
5	2000							
6	2001							
7	2002							
8	2003							
9	2004							
10	2005							
11	2006							
12	2007							
13	2008							
14	2009	873			\$65.14	\$56,867	(\$56,867)	(\$56,867)
15	2010	3,972			\$150.85	\$599,168	(\$599,168)	(\$656,035)
16	2011 (est)	5,348			\$147.77	\$790,285	(\$790,285)	(\$1,446,320)
17	2012 (proj)	7,201			\$155.35	\$1,118,646	(\$1,118,646)	(\$2,564,966)
18	2013 (proj)	9,695			\$163.32	\$1,583,439	(\$1,583,439)	(\$4,148,405)
19	2014 (proj)	6,527			\$171.70	\$1,120,677	(\$1,120,677)	(\$5,269,082)
20	2015 (proj)	8,788			\$180.51	\$1,586,314	(\$1,586,314)	(\$6,855,396)

Exhibit 10: Revised Budget Neutrality

DY	CY	Member Months	Budget Neutrality Limit PMPM	Budget Neutrality Limit Aggregate	Actual/Projected Expenditures PMPM	Actual/Projected Expenditures Aggregate	Savings/ (Deficit)	Cumulative Savings/ (Deficit)
1	1996	2,337,532	\$122.41	\$286,138,649	\$106.53	\$249,006,421	\$37,132,228	\$37,132,228
2	1997	2,282,744	\$130.39	\$297,656,008	\$123.52	\$281,953,272	\$15,702,736	\$52,834,964
3	1998	2,550,505	\$138.92	\$354,305,243	\$119.05	\$303,644,031	\$50,661,212	\$103,496,175
4	1999	3,201,226	\$168.75	\$540,219,561	\$133.15	\$426,247,022	\$113,972,539	\$217,468,714
5	2000	3,496,982	\$197.53	\$690,771,669	\$169.37	\$592,301,079	\$98,470,590	\$315,939,304
6	2001	4,513,310	\$217.40	\$981,193,992	\$171.33	\$773,251,346	\$207,942,646	\$523,881,951
7	2002	4,823,829	\$231.19	\$1,115,204,678	\$176.64	\$852,069,390	\$263,135,288	\$787,017,239
8	2003	4,716,758	\$230.58	\$1,087,577,307	\$191.72	\$904,320,329	\$183,256,978	\$970,274,217
9	2004	4,886,804	\$245.50	\$1,199,726,867	\$181.06	\$884,795,048	\$314,931,819	\$1,285,206,036
10	2005	5,038,078	\$261.38	\$1,316,858,944	\$198.77	\$1,001,434,762	\$315,424,182	\$1,600,630,217
11	2006	5,180,782	\$277.35	\$1,436,908,230	\$264.07	\$1,368,087,941	\$68,820,289	\$1,669,450,506
12	2007	5,451,378	\$290.31	\$1,582,588,944	\$264.83	\$1,443,683,838	\$138,905,106	\$1,808,355,612
13	2008	5,386,004	\$308.25	\$1,660,247,275	\$300.36	\$1,617,765,613	\$42,481,662	\$1,850,837,275
14	2009	5,839,782	\$322.59	\$1,883,853,423	\$321.57	\$1,877,885,955	\$5,967,468	\$1,856,804,742
15	2010	6,367,794	\$338.40	\$2,154,888,798	\$313.48	\$1,996,151,759	\$158,737,039	\$2,015,541,782
16	2011 (est)	6,364,311	\$358.43	\$2,281,146,062	\$333.29	\$2,121,174,691	\$159,971,372	\$2,175,513,153
17	2012 (proj)	6,616,420	\$377.85	\$2,500,043,549	\$350.60	\$2,319,725,113	\$180,318,436	\$2,355,831,589
18	2013 (proj)	6,878,908	\$398.36	\$2,740,304,972	\$368.90	\$2,537,663,266	\$202,641,706	\$2,558,473,295
19	2014 (proj)	7,752,218	\$414.04	\$3,209,762,026	\$371.14	\$2,877,131,736	\$332,630,289	\$2,891,103,584
20	2015 (proj)	8,059,695	\$436.49	\$3,517,961,262	\$391.08	\$3,151,981,534	\$365,979,728	\$3,257,083,313



STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

December 30, 2011

Mark Pahl, Project Officer
Centers for Medicare and Medicaid Services
Division of State Demonstrations and Waivers
7500 Security Blvd., Mail Stop S2-01-16
Baltimore, MD 21244-1850

RE: Request to Renew SoonerCare Demonstration, 2013-2015
Waiver No. 11-W-00048/6

Dear Mr. Pahl:

Oklahoma requests approval to renew the SoonerCare §1115(a) Research and Demonstration Waiver from January 1, 2013 to December 31, 2015. The current extension is approved through December 31, 2012.

The State requests renewal of the Demonstration with one amendment to limit outpatient behavioral health visits for adult members of the Insure Oklahoma Individual Plan program to 48 per calendar year. The State requests that the Health Access Network (HAN) approval be extended as a pilot; the State is not at present requesting that HANs be implemented statewide.

The State recognizes that further amendments to the Demonstration will be necessary in order to bring the program into compliance with provisions of the Patient Protection and Affordable Care Act that go into effect in 2014. The State requests renewal of the Demonstration in its present form with the understanding that amendment requests will be submitted to the Centers for Medicare and Medicaid Services when a consensus has been reached regarding the shape health care reform will take in Oklahoma.

The State's application for renewal of the waiver, including all supporting documentation, is enclosed.

If you have any questions, please contact Rebecca Pasternik-Ikard, Deputy State Medicaid Director, at (405) 522-7208, or Tywanda Cox, Health Policy Director, at (405) 522-7153.

Regards,

A handwritten signature in black ink, appearing to read "Mike Fogarty".

Mike Fogarty
CEO, Oklahoma Health Care Authority

Enclosure: Application for Extension of the Demonstration, 2013-2015

SOONERCARE 1115 BUDGET NEUTRALITY TREND FACTORS

Traditional MEG Enrollment Trend Calculation

MEG	2007	2008	2009	2010	2011 (Annualized)	Annual Trend	Trending Years
TANF - Urban	2,808,278	2,772,622	3,029,870	3,333,170	3,320,081	4.27%	2007 - 2011
TANF - Rural	2,130,548	2,078,460	2,246,021	2,429,264	2,414,579	3.18%	2007 - 2011
ABD - Urban	268,332	283,834	301,034	327,267	344,304	6.43%	2007 - 2011
ABD - Rural	244,220	251,088	262,857	278,093	285,347	3.97%	2007 - 2011
Insure OK	38,417	139,822	172,704	392,155	388,776	-0.86%	2010 - 2011
TEFRA	1,813	2,515	3,299	4,018	4,443	10.57%	2010 - 2011
College Students	-	-	873	3,972	5,348	34.64%	2010 - 2011

PMPM Trend Factors

MEG	Factor
TANF-U	1.0513
TANF-R	1.0513
ABD-U	1.0520
ABD-R	1.0520
INSURE OK	1.0513
TEFRA	1.0520
College Students	1.0513

**SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - BY MEG**

TANF URBAN MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Previous Waiver Periods	1	1996	1,248,591	\$ 121.60	\$ 151,828,666	\$ 109.06	\$ 136,166,854	\$ 15,661,812	\$ 15,661,812
	2	1997	1,201,538	\$ 129.52	\$ 155,618,588	\$ 121.58	\$ 146,088,131	\$ 9,530,457	\$ 25,192,268
	3	1998	1,299,675	\$ 137.95	\$ 179,287,128	\$ 118.62	\$ 154,165,878	\$ 25,121,250	\$ 50,313,518
	4	1999	1,489,962	\$ 146.93	\$ 218,917,218	\$ 120.93	\$ 180,176,146	\$ 38,741,072	\$ 89,054,590
	5	2000	1,575,250	\$ 156.49	\$ 246,515,710	\$ 142.38	\$ 224,278,709	\$ 22,237,001	\$ 111,291,592
	6	2001	1,988,010	\$ 166.68	\$ 331,363,038	\$ 156.92	\$ 311,964,540	\$ 19,398,498	\$ 130,690,090
	7	2002	2,159,002	\$ 177.53	\$ 383,291,270	\$ 156.45	\$ 337,784,795	\$ 45,506,475	\$ 176,196,565
	8	2003	2,319,441	\$ 189.09	\$ 438,580,782	\$ 163.84	\$ 380,021,639	\$ 58,559,143	\$ 234,755,708
	9	2004	2,426,341	\$ 201.40	\$ 488,661,911	\$ 136.62	\$ 331,495,295	\$ 157,166,616	\$ 391,922,324
	10	2005	2,528,654	\$ 214.51	\$ 542,420,938	\$ 141.17	\$ 356,967,558	\$ 185,453,380	\$ 577,375,704
	11	2006	2,643,157	\$ 228.47	\$ 603,893,538	\$ 213.25	\$ 563,645,768	\$ 40,247,770	\$ 617,623,474
	12	2007	2,808,278	\$ 240.19	\$ 674,520,293	\$ 204.58	\$ 574,528,973	\$ 99,991,320	\$ 717,614,794
	13	2008	2,772,622	\$ 252.51	\$ 700,119,625	\$ 237.41	\$ 658,239,328	\$ 41,880,297	\$ 759,495,092
	14	2009	3,029,870	\$ 265.47	\$ 804,339,589	\$ 249.71	\$ 756,593,334	\$ 47,746,255	\$ 807,241,346
Current Waiver Period	15	2010	3,333,170	\$ 279.09	\$ 930,249,786	\$ 235.05	\$ 783,461,815	\$ 146,787,971	\$ 954,029,317
	16	2011 (est)	3,320,081	\$ 293.42	\$ 974,178,265	\$ 259.23	\$ 860,668,761	\$ 113,509,504	\$ 1,067,538,821
	17	2012 (proj)	3,461,991	\$ 308.46	\$ 1,067,885,608	\$ 272.53	\$ 943,495,560	\$ 124,390,048	\$ 1,191,928,868
Extension	18	2013 (proj)	3,609,965	\$ 324.28	\$ 1,170,654,002	\$ 286.51	\$ 1,034,293,229	\$ 136,360,773	\$ 1,328,289,641
	19	2014 (proj)	4,111,635	\$ 340.92	\$ 1,401,737,650	\$ 301.21	\$ 1,238,459,663	\$ 163,277,988	\$ 1,491,567,629
	20	2015 (proj)	4,287,377	\$ 358.41	\$ 1,536,634,428	\$ 316.66	\$ 1,357,643,318	\$ 178,991,110	\$ 1,670,558,739

**SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - BY MEG**

TANF RURAL MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Previous Waiver Periods	1	1996	1,088,941	\$ 123.34	\$ 134,309,983	\$ 103.62	\$ 112,839,567	\$ 21,470,416	\$ 21,470,416
	2	1997	1,081,206	\$ 131.37	\$ 142,037,420	\$ 125.66	\$ 135,865,141	\$ 6,172,279	\$ 27,642,695
	3	1998	1,250,830	\$ 139.92	\$ 175,018,115	\$ 119.50	\$ 149,478,153	\$ 25,539,962	\$ 53,182,657
	4	1999	1,510,946	\$ 149.03	\$ 225,177,007	\$ 110.12	\$ 166,390,827	\$ 58,786,180	\$ 111,968,837
	5	2000	1,522,229	\$ 158.73	\$ 241,627,007	\$ 129.42	\$ 197,013,558	\$ 44,613,449	\$ 156,582,286
	6	2001	1,915,864	\$ 169.07	\$ 323,907,157	\$ 130.46	\$ 249,934,052	\$ 73,973,105	\$ 230,555,391
	7	2002	2,014,674	\$ 180.07	\$ 362,786,430	\$ 134.34	\$ 270,655,613	\$ 92,130,817	\$ 322,686,208
	8	2003	1,941,227	\$ 191.79	\$ 372,317,080	\$ 141.26	\$ 274,223,683	\$ 98,093,397	\$ 420,779,605
	9	2004	1,984,722	\$ 204.28	\$ 405,440,105	\$ 148.84	\$ 295,405,508	\$ 110,034,597	\$ 530,814,202
	10	2005	2,015,932	\$ 217.58	\$ 438,624,903	\$ 159.74	\$ 322,029,698	\$ 116,595,205	\$ 647,409,407
	11	2006	2,036,491	\$ 231.74	\$ 471,943,801	\$ 190.64	\$ 388,233,608	\$ 83,710,193	\$ 731,119,599
	12	2007	2,130,548	\$ 243.63	\$ 519,065,409	\$ 195.93	\$ 417,441,217	\$ 101,624,192	\$ 832,743,791
	13	2008	2,078,460	\$ 256.13	\$ 532,352,258	\$ 208.78	\$ 433,930,837	\$ 98,421,421	\$ 931,165,212
	14	2009	2,246,021	\$ 269.27	\$ 604,780,677	\$ 220.17	\$ 494,500,234	\$ 110,280,443	\$ 1,041,445,655
Current Waiver Period	15	2010	2,429,264	\$ 283.08	\$ 687,678,542	\$ 213.62	\$ 518,943,390	\$ 168,735,152	\$ 1,210,180,807
	16	2011 (est)	2,414,579	\$ 297.61	\$ 718,602,757	\$ 223.69	\$ 540,119,553	\$ 178,483,204	\$ 1,388,664,010
	17	2012 (proj)	2,491,316	\$ 312.87	\$ 779,458,129	\$ 235.17	\$ 585,873,795	\$ 193,584,334	\$ 1,582,248,344
Extension	18	2013 (proj)	2,570,493	\$ 328.92	\$ 845,487,057	\$ 247.23	\$ 635,503,939	\$ 209,983,119	\$ 1,792,231,463
	19	2014 (proj)	2,904,815	\$ 345.79	\$ 1,004,467,284	\$ 259.91	\$ 755,000,222	\$ 249,467,063	\$ 2,041,698,525
	20	2015 (proj)	2,997,133	\$ 363.53	\$ 1,089,557,037	\$ 273.25	\$ 818,957,289	\$ 270,599,748	\$ 2,312,298,273

**SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - BY MEG**

ABD URBAN MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Previous Waiver Periods	1	1996							
	2	1997							
	3	1998							
	4	1999	96,785	\$ 536.14	\$ 51,889,826	\$ 408.54	\$ 39,540,909	\$ 12,348,917	\$ 12,348,917
	5	2000	190,315	\$ 567.55	\$ 108,013,756	\$ 441.30	\$ 83,985,855	\$ 24,027,901	\$ 36,376,818
	6	2001	279,689	\$ 600.81	\$ 168,040,252	\$ 363.42	\$ 101,645,621	\$ 66,394,631	\$ 102,771,450
	7	2002	306,526	\$ 636.02	\$ 194,956,243	\$ 402.14	\$ 123,267,004	\$ 71,689,239	\$ 174,460,688
	8	2003	233,742	\$ 673.29	\$ 157,375,990	\$ 578.12	\$ 135,130,199	\$ 22,245,791	\$ 196,706,479
	9	2004	244,590	\$ 712.74	\$ 174,330,070	\$ 488.80	\$ 119,555,202	\$ 54,774,868	\$ 251,481,347
	10	2005	255,066	\$ 754.51	\$ 192,450,068	\$ 668.41	\$ 170,487,473	\$ 21,962,595	\$ 273,443,942
	11	2006	259,473	\$ 798.73	\$ 207,247,624	\$ 854.61	\$ 221,748,359	\$ (14,500,734)	\$ 258,943,208
	12	2007	268,332	\$ 840.26	\$ 225,468,646	\$ 887.41	\$ 238,121,801	\$ (12,653,155)	\$ 246,290,053
	13	2008	283,834	\$ 883.96	\$ 250,898,901	\$ 954.33	\$ 270,870,487	\$ (19,971,585)	\$ 226,318,468
	14	2009	301,034	\$ 929.92	\$ 279,937,423	\$ 1,003.30	\$ 302,026,585	\$ (22,089,162)	\$ 204,229,306
Current Waiver Period	15	2010	327,267	\$ 978.28	\$ 320,157,269	\$ 960.49	\$ 314,336,505	\$ 5,820,764	\$ 210,050,070
	16	2011 (est)	344,304	\$ 1,029.15	\$ 354,339,003	\$ 926.94	\$ 319,148,246	\$ 35,190,758	\$ 245,240,828
	17	2012 (proj)	366,446	\$ 1,082.66	\$ 396,736,447	\$ 975.14	\$ 357,335,037	\$ 39,401,410	\$ 284,642,238
Extension	18	2013 (proj)	390,011	\$ 1,138.96	\$ 444,206,838	\$ 1,025.85	\$ 400,090,963	\$ 44,115,875	\$ 328,758,113
	19	2014 (proj)	\$ 415,092	\$ 1,198.19	\$ 497,357,166	\$ 1,079.19	\$ 447,962,729	\$ 49,394,437	\$ 378,152,550
	20	2015 (proj)	\$ 441,786	\$ 1,260.49	\$ 556,867,047	\$ 1,135.31	\$ 501,562,457	\$ 55,304,590	\$ 433,457,140

**SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - BY MEG**

ABD RURAL MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Previous Waiver Periods	1	1996							
	2	1997							
	3	1998							
	4	1999	103,533	\$ 427.26	\$ 44,235,510	\$ 387.69	\$ 40,139,140	\$ 4,096,370	\$ 4,096,370
	5	2000	209,188	\$ 452.30	\$ 94,615,196	\$ 416.00	\$ 87,022,957	\$ 7,592,239	\$ 11,688,609
	6	2001	329,747	\$ 478.80	\$ 157,883,545	\$ 332.70	\$ 109,707,133	\$ 48,176,412	\$ 59,865,020
	7	2002	343,627	\$ 506.86	\$ 174,170,735	\$ 350.27	\$ 120,361,978	\$ 53,808,757	\$ 113,673,778
	8	2003	222,348	\$ 536.56	\$ 119,303,455	\$ 516.96	\$ 114,944,808	\$ 4,358,647	\$ 118,032,425
	9	2004	231,151	\$ 568.00	\$ 131,294,780	\$ 598.48	\$ 138,339,043	\$ (7,044,263)	\$ 110,988,163
	10	2005	238,426	\$ 601.29	\$ 143,363,035	\$ 637.30	\$ 151,950,033	\$ (8,586,998)	\$ 102,401,165
	11	2006	241,661	\$ 636.52	\$ 153,823,267	\$ 793.03	\$ 191,644,245	\$ (37,820,978)	\$ 64,580,187
	12	2007	244,220	\$ 669.62	\$ 163,534,596	\$ 834.57	\$ 203,819,591	\$ (40,284,995)	\$ 24,295,192
	13	2008	251,088	\$ 704.44	\$ 176,876,491	\$ 871.89	\$ 218,920,190	\$ (42,043,699)	\$ (17,748,507)
	14	2009	262,857	\$ 741.07	\$ 194,795,734	\$ 930.09	\$ 244,480,177	\$ (49,684,443)	\$ (67,432,950)
Current Waiver Period	15	2010	278,093	\$ 779.61	\$ 216,803,202	\$ 943.46	\$ 262,368,307	\$ (45,565,105)	\$ (112,998,055)
	16	2011 (est)	285,347	\$ 820.15	\$ 234,026,037	\$ 962.04	\$ 274,514,325	\$ (40,488,288)	\$ (153,486,343)
	17	2012 (proj)	296,668	\$ 862.79	\$ 255,963,366	\$ 1,012.06	\$ 300,246,979	\$ (44,283,613)	\$ (197,769,956)
Extension	18	2013 (proj)	308,439	\$ 907.66	\$ 279,957,074	\$ 1,064.69	\$ 328,391,782	\$ (48,434,707)	\$ (246,204,663)
	19	2014 (proj)	320,676	\$ 954.86	\$ 306,199,925	\$ 1,120.06	\$ 359,174,846	\$ (52,974,921)	\$ (299,179,584)
	20	2015 (proj)	333,399	\$ 1,004.51	\$ 334,902,751	\$ 1,178.30	\$ 392,843,479	\$ (57,940,728)	\$ (357,120,312)

**SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - BY MEG**

INSURE OKLAHOMA MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Previous Waiver Periods	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006	9,744			\$ 198.81	\$ 1,937,239	\$ (1,937,239)	\$ (1,937,239)
	12	2007	38,417			\$ 204.54	\$ 7,857,841	\$ (7,857,841)	\$ (9,795,080)
	13	2008	139,822			\$ 239.62	\$ 33,504,032	\$ (33,504,032)	\$ (43,299,112)
	14	2009	172,704			\$ 437.93	\$ 75,632,880	\$ (75,632,880)	\$ (118,931,992)
Current Waiver Period	15	2010	392,155			\$ 285.37	\$ 111,910,574	\$ (111,910,574)	\$ (230,842,565)
	16	2011 (est)	388,776			\$ 313.25	\$ 121,785,792	\$ (121,785,792)	\$ (352,628,357)
	17	2012 (proj)	385,426			\$ 329.07	\$ 126,830,512	\$ (126,830,512)	\$ (479,458,869)
Extension	18	2013 (proj)	382,105			\$ 345.95	\$ 132,188,021	\$ (132,188,021)	\$ (611,646,890)
	19	2014 (proj)	189,406			\$ 363.69	\$ 68,885,920	\$ (68,885,920)	\$ (680,532,810)
	20	2015 (proj)	187,774			\$ 382.35	\$ 71,795,763	\$ (71,795,763)	\$ (752,328,573)

**SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - BY MEG**

TEFRA CHILDREN MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Previous Waiver Periods	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006	931			\$ 943.85	\$ 878,723	\$ (878,723)	\$ (878,723)
	12	2007	1,813			\$ 1,055.94	\$ 1,914,416	\$ (1,914,416)	\$ (2,793,139)
	13	2008	2,515			\$ 914.81	\$ 2,300,739	\$ (2,300,739)	\$ (5,093,878)
	14	2009	3,299			\$ 1,393.11	\$ 4,595,878	\$ (4,595,878)	\$ (9,689,756)
Current Waiver Period	15	2010	4,018			\$ 1,127.92	\$ 4,532,001	\$ (4,532,001)	\$ (14,221,757)
	16	2011 (est)	4,443			\$ 933.61	\$ 4,147,729	\$ (4,147,729)	\$ (18,369,486)
	17	2012 (proj)	4,912			\$ 982.16	\$ 4,824,584	\$ (4,824,584)	\$ (23,194,070)
Extension	18	2013 (proj)	5,431			\$ 1,033.23	\$ 5,611,893	\$ (5,611,893)	\$ (28,805,963)
	19	2014 (proj)	6,005			\$ 1,086.96	\$ 6,527,681	\$ (6,527,681)	\$ (35,333,644)
	20	2015 (proj)	6,640			\$ 1,143.48	\$ 7,592,914	\$ (7,592,914)	\$ (42,926,558)

**SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - BY MEG**

COLLEGE STUDENT MEG

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Previous Waiver Periods	1	1996							
	2	1997							
	3	1998							
	4	1999							
	5	2000							
	6	2001							
	7	2002							
	8	2003							
	9	2004							
	10	2005							
	11	2006							
	12	2007							
	13	2008							
	14	2009	873			\$ 65.14	\$ 56,867	\$ (56,867)	\$ (56,867)
Current Waiver Period	15	2010	3,972			\$ 150.85	\$ 599,168	\$ (599,168)	\$ (656,035)
	16	2011 (est)	5,348			\$ 147.77	\$ 790,285	\$ (790,285)	\$ (1,446,320)
	17	2012 (proj)	7,201			\$ 155.35	\$ 1,118,646	\$ (1,118,646)	\$ (2,564,966)
Extension	18	2013 (proj)	9,695			\$ 163.32	\$ 1,583,439	\$ (1,583,439)	\$ (4,148,405)
	19	2014 (proj)	6,527			\$ 171.70	\$ 1,120,677	\$ (1,120,677)	\$ (5,269,082)
	20	2015 (proj)	8,788			\$ 180.51	\$ 1,586,314	\$ (1,586,314)	\$ (6,855,396)

**SOONERCARE BUDGET NEUTRALITY
HISTORICAL AND PROJECTED MEMBER MONTHS AND EXPENDITURES - BY MEG**

ALL MEGs

	DY	CY	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures		Savings/ (Deficit)	Cumulative Savings/ (Deficit)
				PMPM	Aggregate	PMPM	Aggregate		
Previous Waiver Periods	1	1996	2,337,532	\$ 122.41	\$ 286,138,649	\$ 106.53	\$ 249,006,421	\$ 37,132,228	\$ 37,132,228
	2	1997	2,282,744	\$ 130.39	\$ 297,656,008	\$ 123.52	\$ 281,953,272	\$ 15,702,736	\$ 52,834,964
	3	1998	2,550,505	\$ 138.92	\$ 354,305,243	\$ 119.05	\$ 303,644,031	\$ 50,661,212	\$ 103,496,175
	4	1999	3,201,226	\$ 168.75	\$ 540,219,561	\$ 133.15	\$ 426,247,022	\$ 113,972,539	\$ 217,468,714
	5	2000	3,496,982	\$ 197.53	\$ 690,771,669	\$ 169.37	\$ 592,301,079	\$ 98,470,590	\$ 315,939,304
	6	2001	4,513,310	\$ 217.40	\$ 981,193,992	\$ 171.33	\$ 773,251,346	\$ 207,942,646	\$ 523,881,951
	7	2002	4,823,829	\$ 231.19	\$ 1,115,204,678	\$ 176.64	\$ 852,069,390	\$ 263,135,288	\$ 787,017,239
	8	2003	4,716,758	\$ 230.58	\$ 1,087,577,307	\$ 191.72	\$ 904,320,329	\$ 183,256,978	\$ 970,274,217
	9	2004	4,886,804	\$ 245.50	\$ 1,199,726,867	\$ 181.06	\$ 884,795,048	\$ 314,931,819	\$ 1,285,206,036
	10	2005	5,038,078	\$ 261.38	\$ 1,316,858,944	\$ 198.77	\$ 1,001,434,762	\$ 315,424,182	\$ 1,600,630,217
	11	2006	5,180,782	\$ 277.35	\$ 1,436,908,230	\$ 264.07	\$ 1,368,087,941	\$ 68,820,289	\$ 1,669,450,506
	12	2007	5,451,378	\$ 290.31	\$ 1,582,588,944	\$ 264.83	\$ 1,443,683,838	\$ 138,905,106	\$ 1,808,355,612
	13	2008	5,386,004	\$ 308.25	\$ 1,660,247,275	\$ 300.36	\$ 1,617,765,613	\$ 42,481,662	\$ 1,850,837,275
	14	2009	5,839,782	\$ 322.59	\$ 1,883,853,423	\$ 321.57	\$ 1,877,885,955	\$ 5,967,468	\$ 1,856,804,742
Current Waiver Period	15	2010	6,367,794	\$ 338.40	\$ 2,154,888,798	\$ 313.48	\$ 1,996,151,759	\$ 158,737,039	\$ 2,015,541,782
	16	2011 (est)	6,364,311	\$ 358.43	\$ 2,281,146,062	\$ 333.29	\$ 2,121,174,691	\$ 159,971,372	\$ 2,175,513,153
	17	2012 (proj)	6,616,420	\$ 377.85	\$ 2,500,043,549	\$ 350.60	\$ 2,319,725,113	\$ 180,318,436	\$ 2,355,831,589
Extension	18	2013 (proj)	6,878,908	\$ 398.36	\$ 2,740,304,972	\$ 368.90	\$ 2,537,663,266	\$ 202,641,706	\$ 2,558,473,295
	19	2014 (proj)	7,752,218	\$ 414.04	\$ 3,209,762,026	\$ 371.14	\$ 2,877,131,736	\$ 332,630,289	\$ 2,891,103,584
	20	2015 (proj)	8,059,695	\$ 436.49	\$ 3,517,961,262	\$ 391.08	\$ 3,151,981,534	\$ 365,979,728	\$ 3,257,083,313

**SOONERCARE BUDGET NEUTRALITY
ANNUALIZED 2011 MEMBER MONTHS AND EXPENDITURES BY MEG**

TANF URBAN MEG

DY	Quarter	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures	
			PMPM	Aggregate	PMPM	Aggregate
16	2011 / 1st qtr	820,792	\$ 293.41	\$ 240,826,379	\$ 277.15	\$ 227,479,437
	2011 / 2nd qtr	830,816	\$ 293.41	\$ 243,767,493	\$ 242.20	\$ 201,222,066
	2011 / 3rd qtr	838,453	\$ 293.41	\$ 246,008,245	\$ 256.94	\$ 215,432,650
	TOTAL	2,490,061	\$ 293.41	\$ 730,602,117	\$ 258.68	\$ 644,134,152
	Annualized	3,320,081			\$ 258.68	\$ 858,845,536

TANF RURAL MEG

DY	Quarter	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures	
			PMPM	Aggregate	PMPM	Aggregate
16	2011 / 1st qtr	600,975	\$ 297.60	\$ 178,851,364	\$ 238.50	\$ 143,333,732
	2011 / 2nd qtr	603,398	\$ 297.60	\$ 179,572,454	\$ 211.47	\$ 127,602,687
	2011 / 3rd qtr	606,561	\$ 297.60	\$ 180,513,769	\$ 221.17	\$ 134,153,246
	TOTAL	1,810,934	\$ 297.60	\$ 538,937,588	\$ 223.69	\$ 405,089,665
		2,414,579			\$ 223.69	\$ 540,119,553

ABD URBAN MEG

TEFRA Children displayed separately below

DY	Quarter	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures	
			PMPM	Aggregate	PMPM	Aggregate
16	2011 / 1st qtr	85,713	\$ 1,029.15	\$ 88,211,582	\$ 903.85	\$ 77,471,700
	2011 / 2nd qtr	85,969	\$ 1,029.15	\$ 88,475,044	\$ 940.28	\$ 80,835,004
	2011 / 3rd qtr	86,546	\$ 1,029.15	\$ 89,068,864	\$ 936.55	\$ 81,054,480
	TOTAL	258,228	\$ 1,029.15	\$ 265,755,491	\$ 926.94	\$ 239,361,184
		344,304			\$ 926.94	\$ 319,148,246

**SOONERCARE BUDGET NEUTRALITY
ANNUALIZED 2011 MEMBER MONTHS AND EXPENDITURES BY MEG**

ABD RURAL MEG

DY	Quarter	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures	
			PMPM	Aggregate	PMPM	Aggregate
16	2011 / 1st qtr	71,107	\$ 820.15	\$ 58,318,386	\$ 961.83	\$ 68,393,009
	2011 / 2nd qtr	71,382	\$ 820.15	\$ 58,543,927	\$ 973.63	\$ 69,499,517
	2011 / 3rd qtr	71,521	\$ 820.15	\$ 58,657,928	\$ 950.67	\$ 67,993,218
	TOTAL	214,010	\$ 820.15	\$ 175,520,242	\$ 962.04	\$ 205,885,744
		285,347			\$ 962.04	\$ 274,514,325

INSURE OKLAHOMA MEG

College Students removed from totals and displayed separately below

DY	Quarter	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures	
			PMPM	Aggregate	PMPM	Aggregate
16	2011 / 1st qtr	100,836			\$ 292.60	\$ 29,504,436
	2011 / 2nd qtr	95,320			\$ 303.61	\$ 28,939,683
	2011 / 3rd qtr	95,426			\$ 344.72	\$ 32,895,224
	TOTAL	291,582			\$ 313.25	\$ 91,339,344
		388,776			\$ 313.25	\$ 121,785,792

TEFRA CHILDREN MEG

DY	Quarter	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures	
			PMPM	Aggregate	PMPM	Aggregate
16	2011 / 1st qtr	1,084			\$ 720.24	\$ 780,735
	2011 / 2nd qtr	1,120			\$ 918.17	\$ 1,028,354
	2011 / 3rd qtr	1,128			\$ 1,154.00	\$ 1,301,708
	TOTAL	3,332			\$ 933.61	\$ 3,110,797
		4,443			\$ 933.61	\$ 4,147,729

**SOONERCARE BUDGET NEUTRALITY
ANNUALIZED 2011 MEMBER MONTHS AND EXPENDITURES BY MEG**

COLLEGE STUDENT MEG

DY	Quarter	Member Months	Budget Neutrality Limit		Actual/Projected Expenditures	
			PMPM	Aggregate	PMPM	Aggregate
16	2011 / 1st qtr	1,245			\$ 145.47	\$ 181,107
	2011 / 2nd qtr	1,371			\$ 142.38	\$ 195,198
	2011 / 3rd qtr	1,395			\$ 155.13	\$ 216,409
	TOTAL	4,011			\$ 147.77	\$ 592,714
		5,348			\$ 147.77	\$ 790,285

**SOONERCARE BUDGET NEUTRALITY
ESTIMATED IMPACT OF ACA ON TANF ENROLLMENT IN 2014 (PERSONS)**

MEG	Persons	MM	Distribution
TANF-U	28,947	347,370	57.9%
TANF-R	21,053	252,630	42.1%
Total	50,000	600,000	100.0%

NS CURRENTLY ELIGIBLE)

**SOONERCARE BUDGET NEUTRALITY
HAN PMPM PAYMENTS - 2010 and 2011 (Annualized)**

Monthly Totals	July-10	August-10	September-10	October-10	November-10
HAN Client Count	24,967	25,416	25,145	25,018	24,507
HAN Payment Monthly	\$124,835	\$127,080	\$125,725	\$125,090	\$122,535

Annual Totals

CY 2010 **\$745,520**

CY 2011 (Annualized) **\$ 1,823,225**

December-10	January-11	February-11	March-11	April-11	May-11
24,051	24,141	28,085	28,096	27,386	27,096
\$120,255	\$120,705	\$140,425	\$140,480	\$136,930	\$135,480

June-11	July-11	August-11	September-11
26,411	29,182	34,122	48,965
\$132,055	\$145,910	\$170,610	\$244,825