DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-25-26
Baltimore, Maryland 21244-1850

October 17, 2018

Rebecca Pasternik-Ikard
Chief Executive Officer
Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, OK 73105

Dear Ms. Pasternik-Ikard:

The Centers for Medicare & Medicaid Services (CMS) is issuing technical corrections to the Oklahoma section 1115 Medicaid demonstration, entitled "SoonerCare" (Project Number 11-W-00048/6), which was approved on August 31, 2018 under the authority of section 1115(a) of the Social Security Act (the Act). CMS has issued the following technical corrections, in accordance with Oklahoma's request:

- Updated Table of Contents numbering and titles to align with the document's contents;
- Grammatical updates in STC 2;
- Updates to STC references throughout the document;
- Updated amounts of care coordination payments based on the state's current practice;
- Added mandatory deliverable of the state's semi-annual operational report, due September 1, 2019.

To reflect upon the agreed terms between the state and CMS, CMS has incorporated the technical changes into the latest version of the STCs. Please find enclosed the updated STCs.

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

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
E-mail: Annie.Hollis@cms.hhs.gov

Sincerely,

/s/

Andrea J. Casart
Director
Division of Medicaid Expansion Demonstrations

Enclosure

cc: Bill Brooks, Associate Regional Administrator, CMS Dallas Regional Office

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-25-26
Baltimore, Maryland 21244-1850

August 31, 2018

Rebecca Pasternik-Ikard
Chief Executive Officer
Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, OK 73105

Dear Ms. Pasternik-Ikard:

I am pleased to inform you that the Centers for Medicare & Medicaid Services (CMS) has approved your request to extend Oklahoma's Medicaid demonstration, entitled "SoonerCare" (Project Number 11-W-00048/6), under authority of section 1115(a) of the Social Security Act (the Act). The state may deviate from the Medicaid state plan requirements only to the extent those requirements have been waived or specifically listed as not applicable to the expenditure authorities as described in the demonstration. The approval is effective August 31, 2018 through December 31, 2023.

In this extension package, changes were made to the special terms and conditions (STCs), waivers, and expenditure authorities to reflect the state's plans to expand Health Access Networks (HAN) statewide, to incorporate technical corrections which include corrections to numbering and grammatical changes, and to include new temporary expenditure authority in order to test whether the provision of ten months of federal financial participation in payments to certain medical education programs will help ensure the availability of residents participating in these programs to Medicaid patients, thus furthering access to services furnished to Medicaid beneficiaries by these residents. The state has indicated that it can secure funding effective July 1, 2019 for covering costs necessary to keep these programs accredited, and thus in place for purposes of availability of residents to Medicaid beneficiaries. This expenditure authority is designed to test whether the short-term expenditure authority will ensure the continuation of vital health care and provider support programs during the period of its authorization. This expenditure authority will be evaluated to determine whether this demonstration purpose has been met, and the role the funding under this demonstration played in this.

CMS also has modified the state's waiver of retroactive eligibility to remove the authority to waive retroactive eligibility for pregnant women and children under 19. Section 1902(l)(4) of the Act provides that any state providing medical assistance to its residents under a section

1115 demonstration must provide medical assistance to pregnant women (including during the 60-day post-partum period) and children under 19 years of age in the same manner as the state would be required to provide medical assistance under the state plan, which extends to the mandatory provision of retroactive eligibility. The waiver of retroactive eligibility is designed to encourage preventive care and reduce Medicaid costs. If eligible individuals wait until they are sick to enroll in Medicaid, they are less likely to obtain preventive health services during periods when they are not enrolled. By waiving retroactive eligibility for beneficiaries enrolled in SoonerCare (with exceptions for pregnant women and children under 19), the demonstration tests the efficacy of measures designed to encourage eligible individuals to enroll earlier, to maintain health insurance coverage even while healthy, and to obtain preventive health care. Similar waivers for retroactive eligibility have been included in prior demonstration projects.

The state's public comment period began on June 10, 2017, and lasted through September 30, 2017. The state held two public hearings in July and September 2017, including a tribal consultation session, to seek comment on the extension. During this notice period, the state received several comments seeking more information on the programmatic features of the demonstration. The state responded to each commenter with follow-up information.

CMS posted the extension request for public comment at the federal level on Medicaid.gov from January 11, 2018 through February 9, 2018. CMS received one comment on the extension request in support of funding for medical education. CMS also received nine comments in support of the state's January 19, 2018 demonstration amendment proposing funding for the state's request to fund graduate medical education programs between February 2, 2018 and March 4, 2018. Commenters stated strong support for the programs and cited how the clinics that provide graduate medical education serve as important points of access to medical services for SoonerCare beneficiaries.

The extension of the SoonerCare demonstration is likely to promote the objectives of the Medicaid program because the demonstration improves access to high-quality, person-centered services that produce positive health outcomes for individuals and enhances alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition.

CMS' approval of this section 1115 demonstration is conditioned upon compliance with the enclosed list of waivers, expenditure authorities and STCs defining the nature, character, and extent of anticipated federal involvement in this project. The award is subject to CMS receiving your written acknowledgement of the award and acceptance of these STCs within 30 days of the date of this letter. A copy of the revised STCs, waivers, and expenditure authorities are enclosed.

Your project officer for this demonstration is Ms. Annie Hollis. She is available to answer any questions concerning your section 1115 demonstration. Ms. Hollis's contact information is:

Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
Telephone: (410) 786-0795
E-mail: annie.hollis@cms.hhs.gov

Official communications regarding this demonstration should be sent simultaneously to Mr. Bill Brooks, Associate Regional Administrator for the Division of Medicaid and Children's Health 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 any questions regarding this approval, please contact Ms. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services at (410) 786-9686. We look forward to continuing to work with you and your staff on the operation of this demonstration.

Sincerely,

/s/

Timothy B. Hill
Acting Director

Enclosures

cc: Bill Brooks, Associate Regional Administrator, CMS Dallas Regional Office

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 August 31, 2018 through December 31, 2023 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 (STC) 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 August 31, 2018 through December 31, 2023.

1. **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.

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

   To enable the state to waive retroactive eligibility for demonstration participants, with the exception of pregnant women (and during the 60- day period beginning on the last day of the pregnancy), children described in section 1902(l)(4) of the Act, the Tax Equity and Fiscal Responsibility Act (TEFRA) and Aged, Blind, and Disabled populations. The exception to this waiver for pregnant women and children under 19 is effective January 1, 2019.

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 from August 31, 2018 through December 31, 2023, 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.

The expenditure authorities listed below promote the objectives of title XIX of the Social Security Act by providing flexibility for Oklahoma to extend coverage to certain low-income individuals, transform healthcare service delivery networks, and improve health outcomes, for a temporary period to permit Oklahoma an opportunity to review new options available to better achieve those objectives under the authority of the Medicaid statute (without the need for the same extent of demonstration authority).

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 no more than 200 percent of the federal poverty level (FPL), and their spouses.

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 and have income up to 200 percent of the FPL.

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 work for a qualifying employer.

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.

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.

6. **Demonstration Population 12.** 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 up to 100 percent of the FPL, and their spouses.

7. **Demonstration Population 13.** 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) and who have income up to 100 percent of the FPL.

8. **Demonstration Population 14.** 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, and do not have access to the Premium Assistance Employer Coverage Plan.

9. **Demonstration Population 15.** 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.

10. **Demonstration Population 16.** 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.

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 five percent of annual gross family income.

13. **Health Management Program.** Expenditures for otherwise non-covered costs to provide health coaches and practice facilitation services through the Health Management Program.

14. **Medical Education Programs.** Expenditures, not to exceed $115,517,737 total computable, to phase down federal expenditures for the state's medical education programs operated at the University of Oklahoma and Oklahoma State University. The expenditure authority is effective from August 31, 2018 to June 30, 2019, with the state assuming full responsibility for funding on July 1, 2019.

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.

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 for individuals in populations 5, 6, 8, 10, and 11 who are enrolled in the Premium Assistance Employer Coverage Plan.

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. 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.

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.

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

To permit the state not to provide non-emergency 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 (STC) 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 August 31, 2018, through December 31, 2023, unless otherwise specified.

The STCs have been arranged into the following subject areas:

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.

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; and

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 VIII 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 were approved under the SoonerCare demonstration amendment that was effective September 6, 2013, and the SoonerCare demonstration was extended through December 31, 2015.

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.

On August 13, 2014, CMS approved an amendment adding individuals with other creditable healthcare coverage to the SoonerCare demonstration eligibility exclusion list. In addition, the STCs were amended to reflect the extension of the Insure Oklahoma program through December 31, 2015 that was approved on June 27, 2014.

On July 9, 2015, CMS approved a one-year extension of the SoonerCare demonstration, with no changes, through December 31, 2016.

On November 30, 2016, CMS approved a one-year extension of the SoonerCare demonstration, with no changes, through December 31, 2017.

On December 29, 2017, CMS approved a one-year extension of the SoonerCare demonstration, with technical corrections to the STCs to reflect current CMS policy around monitoring and evaluation requirements, through December 31, 2018.

On August 31, 2018, CMS approved a five-year extension of the SoonerCare demonstration, with the following changes: technical corrections to make numbering and grammatical updates; removal of the authority to waive retroactive eligibility for pregnant women and children under 19; and expenditure authority for one year of phase-down expenditures for the state's medical education program.

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 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. In addition, CMS reserves the right to amend the STCs to reflect such changes without requiring the state to submit an amendment to the demonstration under STC 7. CMS will notify the state 30 business days in advance of the expected approval date of the amended STCs to allow the state to provide comment. Changes will be considered in force upon issuance of the approval letter by CMS. The state must accept the changes in writing.

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 for the demonstration as necessary to comply with such change. The modified agreement 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 earlier date of the two following scenarios: 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. In all such cases, the Medicaid state plan governs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, 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 STC 7 below.

7. **Amendment Process.** Requests to amend the demonstration must be submitted to CMS for approval no later than 120 calendar 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 15. Such explanation shall include a summary of any public feedback received and identification of how this feedback was addressed by the state in the final amendment request submitted to CMS;

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 and/or XXI state plan amendment, if necessary; and,

e) The state must provide updates to existing demonstration reporting and quality and evaluation plans. This includes a description of how the evaluation design and annual progress reports will be modified to incorporate the amendment provisions, as well as the oversight, monitoring and measurement of the provisions.

8. **Extension of the Demonstration**. States that intend to request demonstration extensions under sections 1115(e) or 1115(f) of the Act must submit extension applications in accordance with the timelines contained in statute. Otherwise, no later than 12 months prior to the expiration date of the demonstration, the Governor or Chief Executive Officer of the state must submit to CMS either a demonstration extension request that meets the requirements of 42 Code of Federal Regulations (CFR) 431.412(c) or a phase-out plan consistent with the requirements of STC 10.

9. **Compliance with Transparency Requirements 42 CFR Section 431.412.** As part of the demonstration extension requests the state must provide documentation of compliance with the transparency requirements 42 CFR Section 431.412 and the public notice and tribal consultation requirements outlined in STC 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: 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) reports; state quality assurance monitoring; and any other documentation that validates the quality of care provided or corrective action taken under the demonstration.

e) Compliance with 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 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.

f) Evaluation Report: The state must provide an evaluation report reflecting the hypotheses being tested and any results available. For the proposed extension period, 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.

g) Documentation of Public Notice 42 CFR section 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.

10. 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 six (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) Exemption from Public Notice Procedures 42 CFR 431.416(g): CMS may expedite the federal and state public notice requirements under circumstances described in 42 CFR 431.416(g).

e) 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.

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. **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 comply with the state notice procedures as required in 42 CFR 431.408 prior to submitting an application to extend the demonstration. For applications to amend the demonstration, the state must comply with the state notice procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) prior to submitting such request. The state must also comply with the public notice procedures set forth in 42 CFR section 447.205 for changes in statewide methods and standards for setting payment rates.

    The state must also comply with tribal and Indian Health Program/Urban Indian Organization consultation requirements at section 1902(a)(73) of the Act, 42 CFR 431.408(b), State Medicaid Director Letter #01-024, and contained in the state's approved state plan, when any program changes to the demonstration, either through amendment as set out in STC 7 or extension, are proposed by the state.

16. **Federal Financial Participation.** No federal matching funds for expenditures for this demonstration will take effect until the effective date identified in the demonstration approval letter, or later date if so identified elsewhere in these STCs or in the list of waiver and expenditure authorities.

17. **Transformed Medicaid Statistical Information Systems Requirements (T-MSIS).** The state must comply with all data reporting requirements under Section 1903(r) of the Act, including but not limited to Transformed Medicaid Statistical Information Systems requirements. More information regarding T-MSIS is available in the August 23, 2013 State Medicaid Director Letter #13-004.

18. **Common Rule Exception.** The state shall ensure that the only involvement of human subjects in research activities which may be authorized and/or required by this demonstration for projects which are conducted by or subject to the approval of CMS, and which are designed to study, evaluate, or otherwise examine the Medicaid program – including public benefit or service programs; procedures for obtaining Medicaid benefits or services; possible changes in or alternatives to Medicaid programs and procedures; or possible changes in methods or levels of payments for Medicaid benefits or services. CMS has determined that this demonstration as represented in these approved STCs meets the requirements for exemption from the human subject research provisions of the Common Rule set forth in 45 CFR 46.101(b)(5).

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 as shown in the table below. Effective January 1, 2019, the waiver of retroactive eligibility does not apply to pregnant women, including in the 60-day post-partum period, or children under 19 years of age.

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 62)
Pregnant women and infants under age 1 1902(a)(10)(A)(i)(IV)	Up to and including 133 % FPL	Freedom of Choice,	Populations 1,2,3,4
Children 1-5 1902(a)(10)(A)(i)(VI)	Up to and including 133 % FPL	Freedom of Choice	Populations 1,2,3,4
Children 6-18 1902(a)(10)(A)(i)(VII)	Up to and including 133% FPL	Freedom of Choice	Populations 1,2,3,4
IV-E Foster Care or Adoption Assistance Children	Automatic Medicaid eligibility	Freedom of Choice	Populations 1,2,3,4
1931 low-income families	73% of the AFDC standard of need.	Freedom of Choice, Retroactive Eligibility (not applicable to children under 19)	Populations 1,2,3,4
SSI recipients	Up to SSI limit	Freedom of Choice	Populations 3,4, 7
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 3,4

Mandatory State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 62)
1916(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 3,4, 7
Targeted Low-Income Child	Up to and including 185% FPL	Freedom of Choice	Population 9

Optional State Plan Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 62)
Infants under age 1 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	Freedom of Choice	Population 9
Children 1-5 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	Freedom of Choice	Population 9
Children 6-18 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	Freedom of Choice	Populations 9

Non-IV-E foster care children under age 21 in State or Tribal custody	AFDC limits as of 7/16/1996	Freedom of Choice, Retroactive Eligibility (not applicable to children under 19)	Populations 1,2,3,4
Aged, Blind and Disabled	From SSI up to and including 100% FPL	Freedom of Choice	Populations 3,4, 7
Eligible but not receiving cash assistance	Up to SSI limit	Freedom of Choice	Populations 3,4
Individuals receiving only optional State supplements	100% SSI FBR + $41 (SSP)	Freedom of Choice	Populations 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
Optional State Plan Groups	**FPL and/or Other Qualifying Criteria**	**Applicable Waivers and CNOMs (See Waiver List Summary)**	**Demonstration Population (See STC 62)**
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 STC 62)
Insure Oklahoma Employer-Sponsored Plan			
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 250 or fewer employees. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	Retroactive Eligibility, 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.	Retroactive Eligibility, Comparability, Cost Sharing Requirements, Freedom of Choice	Population 6
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.	Retroactive Eligibility, Comparability, Cost Sharing Requirements, Freedom of Choice	Population 8

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 62)
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.	Retroactive Eligibility, Comparability, Cost Sharing Requirements, Freedom of Choice	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.	Retroactive Eligibility, Comparability, Cost Sharing Requirements, Freedom of Choice	Population 11
Insure Oklahoma Individual Plan			
Non-Disabled Low Income Workers and Spouse (ages 19-64) (Individual Plan)	Individuals up to and including 100% FPL, who are self-employed, or unemployed. Spouses who do not work are also eligible to enroll on their spouse's coverage.	Retroactive Eligibility, Assurance of Transportation	Population 12

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 62)
Working Disabled Adults (ages 19-64) (Individual Plan)	Individuals up to and including 100% 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.	Retroactive Eligibility (not applicable to pregnant women), Assurance of Transportation	Population 13
Full-time College Students (ages 19-22) (Individual Plan)	Full time college students with FPL not to exceed 100% (limited to 3,000 participants) and who do not have access to employer sponsored insurance, do not have creditable insurance coverage.	Retroactive Eligibility (not applicable to pregnant women), Assurance of Transportation	Population 14
Foster Parents (ages 19-64) (Individual Plan)	Individuals up to and including 100% FPL, who work full-time or part-time. Spouses who do not work are also eligible to enroll on their working spouse's coverage.	Retroactive Eligibility (not applicable to pregnant women), Assurance of Transportation	Population 15

Demonstration Expansion Groups	FPL and/or Other Qualifying Criteria	Applicable Waivers and CNOMs (See Waiver List Summary)	Demonstration Population (See STC 62)
Qualified Employees of Not-for-profit Businesses (ages 19-64) (Individual Plan)	Individuals up to and including 100% 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.	Retroactive Eligibility (not applicable to pregnant women), Assurance of Transportation	Population 16

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;
    g. Pregnant women with incomes between 134 percent and 185 percent FPL; and
    h. Individuals with other creditable coverage.

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 PCP visits, and there are four specialty visits per month. 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 31.

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;
- Individuals enrolled in the Breast and Cervical Cancer Prevention and Treatment program; 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

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 STC 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 317:45-5-1for 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 STC 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 STC 33.

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 STCs 32 and 33. Under the Oklahoma Premium Assistance Individual Plan, cost-sharing 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 exempted 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 STC 28, 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 on a monthly basis and 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	Minimum of 60 percent	Minimum of 25%	Up to 15% of premium, (not to exceed 3% out of the 5% household income	5%

employer)			cap)	
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 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	The resident has obtained a medical license or a special license for training from the appropriate regulatory state medical board; and has the appropriate contract on file with the OHCA to render services within the scope of their licensure.
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, 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**	**$4.50**	**$5.98**
Children and Adults	**$4.18**	**$5.46**	**$7.25**
Adults	**$4.84**	**$6.31**	**$8.40**

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) *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 non-emergency transportation and PACE, which are paid through a capitated contract) are paid through the state's FFS system.

40. Health Access Networks. The state may implement Health Access Networks (HANs) statewide. 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 STC 38. HANs are not eligible for the care coordination payment outlined in STC 38. The state must not make duplicative payments to the HANs for Medicaid services covered under the Medicaid state plan.

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 as specified in the state-HAN provider agreement.

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 provider practice behavior that may include EPSDT screens, DTaP immunizations, Inpatient Admitting and Visits, Breast and Cervical Cancer Screenings, Behavioral Health Screens, 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 STC 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 STC 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 Semi-Annual Operational Report, described in STC 54, 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.

c) Effective January 1, 2016, telephonic health coaching is available as a modality for educating members.

d) Effective January 1, 2016, the SoonerCare pain management program is available to members. Practice facilitators provide evidence-based education to providers regarding pain management. Practice facilitators assist selected practices with quality improvement initiatives related to pain management.

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 semi-annual 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. Submission of Post-approval Deliverables. The state must submit all deliverables as stipulated by CMS and within the timeframes outlined within these STCs.

50. Deferral for Failure to Submit Timely Demonstration Deliverables. CMS may issue deferrals in the amount of $5,000,000 per deliverable (federal share) when items required by these STCs (e.g., required data elements, analyses, reports, design documents, presentations, and other items specified in these STCs (hereafter singly or collectively referred to as "deliverable(s)") are not submitted timely to CMS or found to not be consistent with the requirements approved by CMS. Specifically:

a. Thirty (30) calendar days after the deliverable was due, CMS will issue a written notification to the state providing advance notification of a pending deferral for late or non-compliant submissions of required deliverables.

b. For each deliverable, the state may submit a written request for an extension to submit the required deliverable. Extension requests that extend beyond the current fiscal quarter must include a Corrective Action Plan (CAP).

i. CMS may decline the extension request.
ii. Should CMS agree in writing to the state's request, a corresponding extension of the deferral process described below can be provided.
iii. If the state's request for an extension includes a CAP, CMS may agree to or further negotiate the CAP as an interim step before applying the deferral.

c. The deferral would be issued against the next quarterly expenditure report following the written deferral notification.

d. When the state submits the overdue deliverable(s) that are accepted by CMS, the deferral(s) will be released.

e. As the purpose of a section 1115 demonstration is to test new methods of operation or services, a state's failure to submit all required deliverables may preclude a state from renewing a demonstration or obtaining a new demonstration.

f. CMS will consider with the state an alternative set of operational steps for implementing the intended deferral to align the process with the state's existing deferral process, for example, what quarter the deferral applies to and how the deferral is released.

51. Compliance with Federal Systems Updates. As federal systems continue to evolve and incorporate additional 1115 demonstration reporting and analytics functions, the state will work with CMS to:

a. Revise the reporting templates and submission processes to accommodate timely compliance with the requirements of the new systems;
b. Ensure all 1115, T-MSIS, and other data elements that have been agreed to for reporting and analytics are provided by the state; and
c. Submit deliverables to the appropriate system as directed by CMS.

52. Cooperation with Federal Evaluators. As required under 42 CFR 431.420(f), the state must cooperate fully and timely with CMS and its contractors' in any federal evaluation of the demonstration or any component of the demonstration. This includes, but is not limited to, commenting on design and other federal evaluation documents and providing data and analytic files to CMS, including entering into a data use agreement that explains how the data and data files will be exchanged, and providing a technical point of contact to support specification of the data and files to be disclosed, as well as relevant data dictionaries and record layouts. The state must include in its contracts with entities who collect, produce or maintain data and files for the demonstration, that they must make such data available for the federal evaluation as is required under 42 CFR 431.420(f) to support federal evaluation. The state may claim administrative match for these activities. Failure to comply with this STC may result in a deferral being issued as outlined in STC 50.

53. Administrative Authority. When there are multiple entities involved in the administration of the demonstration, the Single State Medicaid Agency must maintain authority, accountability, and oversight of the program. The State Medicaid Agency must exercise oversight of all delegated functions to operating agencies,

MCOs and any other contracted entities. The Single State Medicaid Agency is responsible for the content and oversight of the quality strategies for the demonstration.

XI. MONITORING

54. Monitoring Reports. The state must submit one (1) Semi-Annual Report and one (1) compiled Annual Report each DY. The Semi-Annual Reports are due no later than sixty (60 calendar days) following the end of each demonstration six (6) month period. The compiled Annual Report is due no later than ninety (90 calendar days) following the end of the DY. The reports will include all required elements as per 42 CFR 431.428, and should not direct readers to links outside the report. Additional links not referenced in the document may be listed in a Reference/Bibliography section. The Monitoring Reports must follow the framework provided by CMS, which is subject to change as monitoring systems are developed/evolve, and be provided in a structured manner that supports federal tracking and analysis.

i. Operational Updates – Per 42 CFR 431.428, the Monitoring Reports must document any policy or administrative difficulties in operating the demonstration. The reports shall provide sufficient information to document key challenges, underlying causes of challenges, how challenges are being addressed, as well as key achievements and to what conditions and efforts successes can be attributed. The discussion should also include any issues or complaints identified by beneficiaries; lawsuits or legal actions; unusual or unanticipated trends; legislative updates; and descriptions of any public forums held. The Monitoring Report should also include a summary of all public comments received through post-award public forums regarding the progress of the demonstration.

ii. Performance Metrics –Per 42 CFR 431.428, the Monitoring Reports must document the impact of the demonstration in providing insurance coverage to beneficiaries and the uninsured population, measures associated with eligibility and coverage (including the waiver of retroactive eligibility) as well as outcomes of care, quality of care, and access to care. This may also include the results of beneficiary satisfaction surveys, if conducted, grievances and appeals. The required monitoring and performance metrics must be included in writing in the Monitoring Reports, and will follow the framework provided by CMS to support federal tracking and analysis.

iii. Budget Neutrality and Financial Reporting Requirements –Per 42 CFR 431.428, the Monitoring Reports must document the financial performance of the demonstration. The state must provide an updated budget neutrality workbook with every Monitoring Report that meets all the reporting requirements for monitoring budget neutrality set forth in the General Financial Requirements section of these STCs, including the submission of corrected budget neutrality data upon request. In addition, the state must report quarterly expenditures associated with the populations affected by this demonstration on the Form CMS-64.

Administrative costs should be reported separately.

iv. Evaluation Activities and Interim Findings. Per 42 CFR 431.428, the Monitoring Reports must document any results of the demonstration to date per the evaluation hypotheses. Additionally, the state shall include a summary of the progress of evaluation activities, including key milestones accomplished, as well as challenges encountered and how they were addressed.

55. Close out Operational Report. Within 120 calendar days prior to the expiration of the demonstration, the state must submit a Draft Final Operational Report to CMS for comments.

a. The draft final report must comply with the most current Guidance from CMS.
b. The state will present to and participate in a discussion with CMS on the Close-Out report.
c. The state must take into consideration CMS' comments for incorporation into the final Close-Out Report.
d. The Final Close-Out Report is due to CMS no later than 30 calendar days after receipt of CMS' comments.
e. A delay in submitting the draft or final version of the Close-Out Report may subject the state to penalties described in STC 50.

56. State Data Collection. The state must collect data and information necessary to oversee service utilization and rate setting by provider/plan, comply with the Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the Core Set of Adult Health Care Quality Measures for Medicaid (Adult Core Set), collectively referred to as the CMS Child and Adult Core Measure Sets for Medicaid and CHIP, and comply with other existing federal measure sets.

a. The state will use this information in ongoing monitoring of individual well-being, provider/plan performance, and continuous quality improvement efforts, in addition to complying with CMS reporting requirements.
b. The state must maintain data dictionary and file layouts of the data collected.
c. The raw and edited data must be made available to CMS within 30 calendar days of a written request.

57. Monitoring Calls. CMS will convene periodic conference calls with the state.

a. The purpose of these calls is to discuss ongoing demonstration operation, to include (but not limited to) any significant actual or anticipated developments affecting the demonstration. Examples include implementation activities, enrollment and access, budget neutrality, and progress on evaluation activities.
b. CMS will provide updates on any amendments or concept papers under review, as well as federal policies and issues that may affect any aspect of the demonstration.
c. The state and CMS will jointly develop the agenda for the calls.

58. Post Award Forum. Pursuant to 42 CFR 431.420(c), within six (6) months of the demonstration's implementation, and annually thereafter, the state must afford the public with an opportunity to provide meaningful comment on the progress of the

demonstration. At least thirty (30) calendar 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 must also post the most recent annual report on its website with the public forum announcement. Pursuant to 42 CFR 431.420(c), the state must include a summary of the comments in the Semi-Annual Report associated with the quarter in which the forum was held, as well as in its compiled Annual Report.

59. 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.

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

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

61. 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.

62. 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, eighteen (18) 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. **<u>Demonstration Population 1:</u> 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 STC 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 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 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 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 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 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.

xix. **Medical Education Programs**: Phase down expenditures include expenditures to University of Oklahoma and Oklahoma State University as specified in expenditure authority 14.

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, STC 75, using the per member per month (PMPM) amounts for children in the TANF Rural and TANF Urban populations described in Section XI, STC 62(a)(i-ii), and will be considered expenditures subject to the budget neutrality cap as defined in STC 61, 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 STC 75.

f) Specific Reporting Requirement for the Medical Education Programs' phase down expenditures, described in expenditure authority 14:

i. CMS must approve a plan for eligible expenditures. The plan to phase down the federal investment must be approved by CMS and will be attached to these STCs once approved. The state must comply with the plan in order to draw down FFP and must document expenditures in accordance with the plan.

ii. In order to claim FFP for phase down expenditures, the state will provide CMS a summary worksheet that identifies phase down expenditures by university each quarter.

iii. For all eligible phase down expenditures, the state will maintain and will make available to CMS upon request:

1. Certification of expenditures
2. Actual expenditure data from state financial information system or state client sub-system.

iv. The certification will describe the procedures used that ensure that FFP is not claimed for non-permissible expenditures.

v. The state will claim FFP for phase down expenditures quarterly based on actual expenditures.

vi. The state will establish standard documentation of each phase down expenditure, to be specified in the plan.

vii. The state will report all expenditures for phasedown payments to eligible medical education programs described in expenditure authority 14 on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver under the waiver name "Medical Education Phase Down." Federal funds must be claimed within two years following the calendar quarter in which the state incurs the phase down expenditures during the performance period described above in expenditure authority 14. Claims cannot be submitted for state

expenditures associated with medical education programs described in expenditure authority 14 above incurred after June 30, 2019. Sources of non-federal funding for the medical education program for the period from August 31, 2018 through June 30, 2019 must be permitted under section 1903(w) of the Act and applicable implementing regulations.

g) 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 STC 62. 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.

h) 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.

i) 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.

j) 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.

k) 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.

63. 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 STC 61, the actual number of eligible member months for EGs defined in STC 62(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 62(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 62(a).

64. 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.

65. 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 Insure Oklahoma Program.

66. 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.

67. 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.

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

XIII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

69. 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).

70. 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.

71. 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.

XIV. MONITORING BUDGET NEUTRALITY

72. 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.

73. 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.

74. 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.

75. 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 STC 75 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 STC 74, 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	2018 PMPM	Trend Rate	2019 PMPM	2020 PMPM	2021 PMPM	2022 PMPM	2023 PMPM
1) TANF-Urban	$396.34	3.8%	$411.40	$427.03	$443.26	$460.10	$477.58
2) TANF-Rural	$402.00	3.8%	$417.27	$433.13	$449.59	$466.67	$484.40
3) ABD-Urban	$1,369.89	3.6%	$1,419.21	$1,470.30	$1,523.23	$1,578.07	$1,634.88
4) ABD-Rural	$1,093.79	3.6%	$1,133.16	$1,173.95	$1,216.21	$1,259.99	$1,305.35

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 5 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 62(a) during the demonstration period.

76. Enforcement of Budget Neutrality. CMS shall enforce budget neutrality over the life of the demonstration, rather than on an annual basis. The budget neutrality test for the demonstration extension may incorporate net savings from the immediately prior demonstration period consisting of the immediately prior demonstration periods of January 1, 2013 through December 31, 2017, but not from any earlier approval period.

77. **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.

78. **Budget Neutrality Savings Phase-Down.** Beginning with the demonstration period that begins on January 1, 2018, the net variance between the without-waiver cost and actual with-waiver cost will be reduced. The reduced variance will be calculated as a percentage of the total variance, which will then be substituted for the total variance to determine overall budget neutrality for the demonstration. The formula for calculating the reduced variance is: reduced variance equals total variance times applicable percentage. The percentages are determined based on how long Medicaid populations have been subject to the demonstration. In the case of Oklahoma, the program will retain 25 percent of the total variance as future savings for the demonstration. Should the state request an extension of its demonstration beyond December 31, 2023, budget neutrality will be adjusted again to reflect revised PMPMs based on the data from the current extension.

XV. EVALUATION OF THE DEMONSTRATION

79. **Independent Evaluator.** At the beginning of the demonstration period, the state must arrange with an independent party to conduct an evaluation of the demonstration to ensure that the necessary data is collected at the level of detail needed to research the approved hypotheses. The independent party must sign an agreement to conduct the demonstration evaluation in accord with the CMS-approved, draft Evaluation Design. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. The state evaluation must follow the approved methodology, however, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

80. **Evaluation Budget.** A budget for the evaluation must be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative and other costs for all aspects of the evaluation such as any survey and measurement development, quantitative and qualitative data collection and cleaning, analyses and report generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the design or if CMS finds that the design is not sufficiently developed, or if the estimates appear to be excessive.

81. **Draft Evaluation Design.** The draft Evaluation Design must be developed in accordance with Attachments A and B of these STCs.
    a. The state must submit, for CMS comment and approval, a draft Evaluation Design with implementation timeline, no later than one hundred twenty (120) days after the effective date of these STCs. Any modifications to an existing approved

Evaluation Design will not affect previously established requirements and timelines for report submission for the demonstration, if applicable. The state may choose to use the expertise of the independent party in the development of the draft Evaluation Design.

b. The state must evaluate the impact of the waiver of retroactive eligibility. Possible areas of focus for hypotheses include the effect of the waiver on 1) enrollment and enrollment continuity (including for different types of enrollees such as prospective applicants, applicants and existing beneficiaries, and for individuals who are healthy and those with complex medical needs; 2) health outcomes; and 3) the financial impact on beneficiaries (including assessment of medical debt) and providers (such as uncompensated care costs). The state will utilize evaluation findings to inform changes to the demonstration and/or its implementation as appropriate. Consistent with subparagraph a, the state must submit a revised evaluation design 120 days after the demonstration is approved.

82. Evaluation Design Approval and Updates. The state's draft Evaluation Design may be subject to multiple revisions until a format and the content is agreed upon by CMS. The state must submit a revised draft Evaluation Design within 60 days after receipt of CMS' comments. Upon CMS approval of the draft Evaluation Design, the document will be included as an attachment to these STCs. Per 42 CFR 431.424(c), the state will publish the approved Evaluation Design within 30 calendar days of CMS approval. The state must implement the evaluation design and submit a description of its evaluation implementation progress in each of the Semi-Annual Reports and Annual Reports, including any required Rapid Cycle Assessments specified in these STCs. Once CMS approves the evaluation design, if the state wishes to make changes, the state must submit a revised evaluation design to CMS for approval.

83. Evaluation Questions and Hypotheses. Consistent with Attachments A and B of these STCs, the evaluation documents must include a discussion of the evaluation questions and hypotheses that the state intends to test. Each demonstration component should have at least one evaluation question and hypothesis. The hypothesis testing should include, where possible, assessment of both process and outcome measures. Proposed measures should be selected from nationally-recognized sources and national measures sets, where possible. Measures sets could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).

84. Evaluation of Health Access Networks. The draft evaluation design required under STC 81 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.

85. Evaluation of the Health Management Program. The draft evaluation plan required under STC 81 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 health coach.

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 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.

e) *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).

f) *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).

g) *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)

h) *Impact on Effectiveness of Care:* Total and per member per month expenditures for members enrolled in HMP will be lower than would have occurred absent their participation in nurse care management.

86. Evaluation of Eligibility and Enrollment Systems. The interim evaluation report required in STC 87 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.

87. Interim Evaluation Report. The state must submit an Interim Evaluation Report for the completed years of the demonstration, and for each subsequent renewal or extension of the demonstration, as outlined in 42 CFR 431.412(c)(2)(vi). When submitting an application for renewal, the Evaluation Report should be posted to the state's website with the application for public comment.

a. The interim evaluation report will discuss evaluation progress and present findings to date as per the approved evaluation design.
b. For demonstration authority that expires prior to the overall demonstration's expiration date, the Interim Evaluation Report must include an evaluation of the authority as approved by CMS.
c. If the state is seeking to renew or extend the demonstration, the draft Interim Evaluation Report is due when the application for renewal is submitted. If the state made changes to the demonstration in its application for renewal, the research questions and hypotheses, and how the design was adapted should be included. If the state is not requesting a renewal for a demonstration, an Interim Evaluation report is due one (1) year prior to the end of the demonstration. For demonstration phase outs prior to the expiration of the approval period, the draft Interim Evaluation Report is due to CMS on the date that will be specified in the notice of termination or suspension.
d. The state must submit the final Interim Evaluation Report 60 calendar days after receiving CMS comments on the draft Interim Evaluation Report and post the document to the state's website.
e. The Interim Evaluation Report must comply with Attachment B of these STCs.

88. Summative Evaluation Report. The draft Summative Evaluation Report must be developed in accordance with Attachment B of these STCs. The state must submit a draft Summative Evaluation Report for the demonstration's current approval period, August 31, 2018—December 31, 2023, within 18 months of the end of the approval period represented by these STCs. The Summative Evaluation Report must include the information in the approved Evaluation Design.

a. Unless otherwise agreed upon in writing by CMS, the state must submit the final Summative Evaluation Report within 60 calendar days of receiving comments from CMS on the draft.
b. The final Summative Evaluation Report must be posted to the state's Medicaid website within 30 calendar days of approval by CMS.

89. State Presentations for CMS. CMS reserves the right to request that the state present and participate in a discussion with CMS on the Evaluation Design, the interim evaluation, and/or the summative evaluation.

90. Public Access. The state shall post the final documents (e.g., Monitoring Reports, Close Out Report, approved Evaluation Design, Interim Evaluation Report, and

Summative Evaluation Report) on the state's Medicaid website within 30 days of approval by CMS.

91. Additional Publications and Presentations. For a period of twelve (12) months following CMS approval of the final reports, CMS will be notified prior to presentation of these reports or their findings, including in related publications (including, for example, journal articles), by the state, contractor, or any other third party directly connected to the demonstration. Prior to release of these reports, articles or other publications, CMS will be provided a copy including any associated press materials. CMS will be given ten (10) business days to review and comment on publications before they are released. CMS may choose to decline to comment or review some or all of these notifications and reviews. This requirement does not apply to the release or presentation of these materials to state or local government officials.

92. 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.

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

Type	Deliverable	STC Reference
Semi-Annual	By September 1, 2019 – Semi-Annual Operational Report	Section XI, STC 54
Annual	By April 1, 2020 – Draft 2019 Annual Report	Section XI, STC 54
Semi-Annual	By September 1, 2020 – Semi-Annual Operational Report	Section XI, STC 54
Annual	By April 1, 2021 – Draft 2020 Annual Report	Section XI, STC 54
Semi-Annual	By September 1, 2021 – Semi-Annual Operational Report	Section XI, STC 54
Annual	By April 1, 2022 – Draft 2021 Annual Report	Section XI, STC 54
Semi-Annual	By September 1, 2022 – Semi-Annual Operational Report	Section XI, STC 54
Annual	By April 1, 2023 – Draft 2022 Annual Report	Section XI, STC 54
Semi-Annual	By September 1, 2023 – Semi-Annual Operational Report	Section XI, STC 54
Annual	By April 1, 2024 – Draft 2023 Annual Report	Section XI, STC 54

Quarterly	Quarterly Expenditure Reports	Section XII, STC 61
Quarterly	CMS-64 Reports	Section XII, STC 62
Quarterly	Eligible Member Months	Section XII, STC 63

Attachment A
Developing the Evaluation Design

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provides important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need rigorous quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Designs

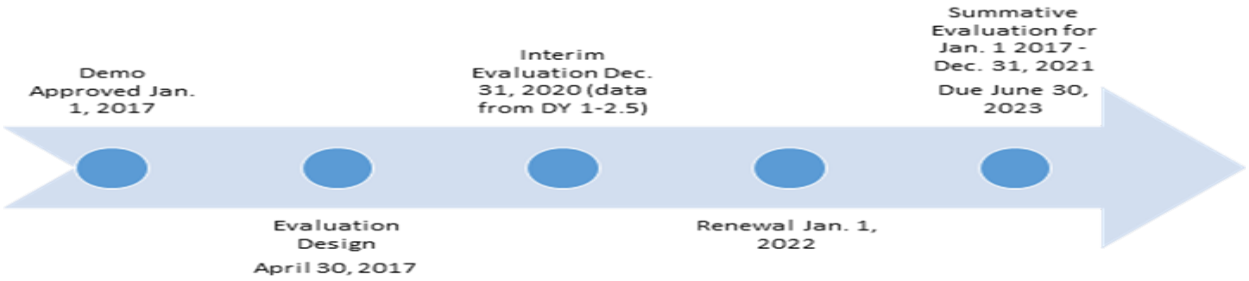
All states with Medicaid section 1115 demonstrations are required to conduct an evaluation, and the Evaluation Design is the roadmap for conducting the evaluation. The roadmap begins with the stated goals for the demonstration followed by the measurable evaluation questions and quantifiable hypotheses, all to support a determination of the extent to which the demonstration has achieved its goals. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances.

The format for the Evaluation Design is as follows:

A. General Background Information;
B. Evaluation Questions and Hypotheses;
C. Methodology;
D. Methodological Limitations;
E. Attachments.

Submission Timelines

There is a specified timeline for the state's submission of Evaluation Design and Reports. (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. The state is required to publish the Evaluation Design to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(e). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of All Evaluation Designs
The Evaluation Design sets the stage for the Interim and Summative Evaluation Reports. It is important that the Evaluation Design explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology (and limitations) for the evaluation. A copy of the state's Driver Diagram (described in more detail in paragraph B2 below) should be included with an explanation of the depicted information.

A. General Background Information – In this section, the state should include basic information about the demonstration, such as:

1) The issue/s that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, the potential magnitude of the issue/s, and why the state selected this course of action to address the issue/s (e.g., a narrative on why the state submitted an 1115 demonstration proposal).

2) The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;

3) A brief description of the demonstration and history of the implementation, and whether the draft Evaluation Design applies to an amendment, extension, renewal, or expansion of, the demonstration;

4) For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; the primary reason or reasons for the change; and how the Evaluation Design was altered or augmented to address these changes.

5) Describe the population groups impacted by the demonstration.

B. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals are translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured.

2) Include a Driver Diagram to visually aid readers in understanding the rationale behind the cause and effect of the variants behind the demonstration features and intended outcomes. A driver diagram is a particularly effective modeling tool when working to improve health and health care through specific interventions. The diagram includes information about the goal of the demonstration, and the features of the demonstration. A driver diagram depicts the relationship between the aim, the primary drivers that contribute directly to achieving the aim, and the secondary drivers that are necessary to achieve the primary drivers for the demonstration. For an example and more information on driver diagrams: https://innovation.cms.gov/files/x/hciatwoaimsdrvrs.pdf

3) Identify the state's hypotheses about the outcomes of the demonstration:
   a. Discuss how the evaluation questions align with the hypotheses and the goals of the demonstration;
   b. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and/or XXI.

C. Methodology – In this section, the state is to describe in detail the proposed research methodology. The focus is on showing that the evaluation meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable, and that where appropriate it builds upon other published research (use references).

This section provides the evidence that the demonstration evaluation will use the best available data; reports on, controls for, and makes appropriate adjustments for the limitations of the data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what will be measured and how. Specifically, this section establishes:

1) Evaluation *Design* – Provide information on how the evaluation will be designed. For example, will the evaluation utilize a pre/post comparison? A post-only assessment? Will a comparison group be included?

2) *Target and Comparison Populations* – Describe the characteristics of the target and comparison populations, to include the inclusion and exclusion criteria. Include information about the level of analysis (beneficiary, provider, or program level), and if populations will be stratified into subgroups. Additionally discuss the sampling methodology for the populations, as well as support that a statistically reliable sample size is available.

3) *Evaluation Period* – Describe the time periods for which data will be included.

4) *Evaluation Measures* – List all measures that will be calculated to evaluate the demonstration. Include the measure stewards (i.e., the organization(s) responsible for the evaluation data elements/sets by "owning", defining, validating; securing; and submitting for endorsement, etc.) Include numerator and denominator information. Additional items to ensure:

a. The measures contain assessments of both process and outcomes to evaluate the effects of the demonstration during the period of approval.
b. Qualitative analysis methods may be used, and must be described in detail.
c. Benchmarking and comparisons to national and state standards, should be used, where appropriate.
d. Proposed health measures could include CMS's Core Set of Health Care Quality Measures for Children in Medicaid and CHIP, Consumer Assessment of Health Care Providers and Systems (CAHPS), the Initial Core Set of Health Care Quality Measures for Medicaid-Eligible Adults and/or measures endorsed by National Quality Forum (NQF).
e. Proposed performance metrics can be selected from nationally recognized metrics, for example from sets developed by the Center for Medicare and Medicaid Innovation or for meaningful use under Health Information Technology (HIT).
f. Among considerations in selecting the metrics shall be opportunities identified by the state for improving quality of care and health outcomes, and controlling cost of care.

5) *Data Sources* – Explain where the data will be obtained, and efforts to validate and clean the data. Discuss the quality and limitations of the data sources.

   If primary data (data collected specifically for the evaluation) – The methods by which the data will be collected, the source of the proposed question/responses, the frequency and timing of data collection, and the method of data collection. (Copies of any proposed surveys must be reviewed with CMS for approval before implementation).

6) *Analytic Methods* – This section includes the details of the selected quantitative and/or qualitative measures to adequately assess the effectiveness of the demonstration. This section should:
   a. Identify the specific statistical testing which will be undertaken for each measure (e.g., t-tests, chi-square, odds ratio, ANOVA, regression). Table A is an example of how the state might want to articulate the analytic methods for each research question and measure.
   b. Explain how the state will isolate the effects of the demonstration (from other initiatives occurring in the state at the same time) through the use of comparison groups.
   c. A discussion of how propensity score matching and difference in differences design may be used to adjust for differences in comparison populations over time (if applicable).
   d. The application of sensitivity analyses, as appropriate, should be considered.

7) *Other Additions* – The state may provide any other information pertinent to the Evaluation Design of the demonstration.

Table A. Example Design Table for the Evaluation of the Demonstration

Research Question	Outcome measures used to address the research question	Sample or population subgroups to be compared	Data Sources	Analytic Methods
Hypothesis 1				
Research question 1a	-Measure 1 -Measure 2 -Measure 3	-Sample e.g. All attributed Medicaid beneficiaries -Beneficiaries with diabetes diagnosis	-Medicaid fee-for-service and encounter claims records	-Interrupted time series
Research question 1b	-Measure 1 -Measure 2 -Measure 3 -Measure 4	-sample, e.g., PPS patients who meet survey selection requirements (used services within the last 6 months)	-Patient survey	Descriptive statistics
Hypothesis 2				
Research question 2a	-Measure 1 -Measure 2	-Sample, e.g., PPS administrators	-Key informants	Qualitative analysis of interview material

D. Methodological Limitations – This section provides detailed information on the limitations of the evaluation. This could include the design, the data sources or collection process, or analytic methods. The state should also identify any efforts to minimize the limitations. Additionally, this section should include any information about features of the demonstration that effectively present methodological constraints that the state would like CMS to take into consideration in its review.

E. Special Methodological Considerations- CMS recognizes that there may be certain instances where a state cannot meet the rigor of an evaluation as expected by CMS. In these instances, the state should document for CMS why it is not able to incorporate key components of a rigorous evaluation, including comparison groups and baseline data analyses. Examples of considerations include:

1) When the state demonstration is:
    a. Long-standing, non-complex, unchanged, or
    b. Has previously been rigorously evaluated and found to be successful, or
    c. Could now be considered standard Medicaid policy (CMS published regulations or guidance)

2) When the demonstration is also considered successful without issues or concerns that would require more regular reporting, such as:
    a. Operating smoothly without administrative changes; and
    b. No or minimal appeals and grievances; and

c. No state issues with CMS 64 reporting or budget neutrality; and
d. No Corrective Action Plans (CAP) for the demonstration.

F. Attachments

1) **Independent Evaluator.** This includes a discussion of the state's process for obtaining an independent entity to conduct the evaluation, including a description of the qualifications that the selected entity must possess, and how the state will assure no conflict of interest. Explain how the state will assure that the Independent Evaluator will conduct a fair and impartial evaluation, prepare an objective Evaluation Report, and that there would be no conflict of interest. The evaluation design should include "No Conflict of Interest" signed by the independent evaluator.

2) **Evaluation Budget.** A budget for implementing the evaluation shall be provided with the draft Evaluation Design. It will include the total estimated cost, as well as a breakdown of estimated staff, administrative, and other costs for all aspects of the evaluation. Examples include, but are not limited to: the development of all survey and measurement instruments; quantitative and qualitative data collection; data cleaning and analyses; and reports generation. A justification of the costs may be required by CMS if the estimates provided do not appear to sufficiently cover the costs of the draft Evaluation Design or if CMS finds that the draft Evaluation Design is not sufficiently developed.

3) **Timeline and Major Milestones.** Describe the timeline for conducting the various evaluation activities, including dates for evaluation-related milestones, including those related to procurement of an outside contractor, if applicable, and deliverables. The Final Evaluation Design shall incorporate an Interim and Summative Evaluation. Pursuant to 42 CFR 431.424(c)(v), this timeline should also include the date by which the Final Summative Evaluation report is due.

Attachment B: Preparing the Interim and Summative Evaluation Reports

Introduction

For states that are testing new approaches and flexibilities in their Medicaid programs through section 1115 demonstrations, evaluations are crucial to understand and disseminate what is or is not working and why. The evaluations of new initiatives seek to produce new knowledge and direction for programs and inform Medicaid policy for the future. While a narrative about what happened during a demonstration provide important information, the principal focus of the evaluation of a section 1115 demonstration should be obtaining and analyzing data on the process (e.g., whether the demonstration is being implemented as intended), outcomes (e.g., whether the demonstration is having the intended effects on the target population), and impacts of the demonstration (e.g., whether the outcomes observed in the targeted population differ from outcomes in similar populations not affected by the demonstration). Both state and federal governments need improved quantitative and qualitative evidence to inform policy decisions.

Expectations for Evaluation Reports

Medicaid section 1115 demonstrations are required to conduct an evaluation that is valid (the extent to which the evaluation measures what it is intended to measure), and reliable (the extent to which the evaluation could produce the same results when used repeatedly). To this end, the already approved Evaluation Design is a map that begins with the demonstration goals, then transitions to the evaluation questions, and to the specific hypotheses, which will be used to investigate whether the demonstration has achieved its goals. States should have a well-structured analysis plan for their evaluation. With the following kind of information, states and CMS are best poised to inform and shape Medicaid policy in order to improve the health and welfare of Medicaid beneficiaries for decades to come. When conducting analyses and developing the evaluation reports, every effort should be made to follow the approved methodology. However, the state may request, and CMS may agree to, changes in the methodology in appropriate circumstances. When submitting an application for renewal, the interim evaluation report should be posted on the state's website with the application for public comment. Additionally, the interim evaluation report must be included in its entirety with the application submitted to CMS.

Intent of this Attachment

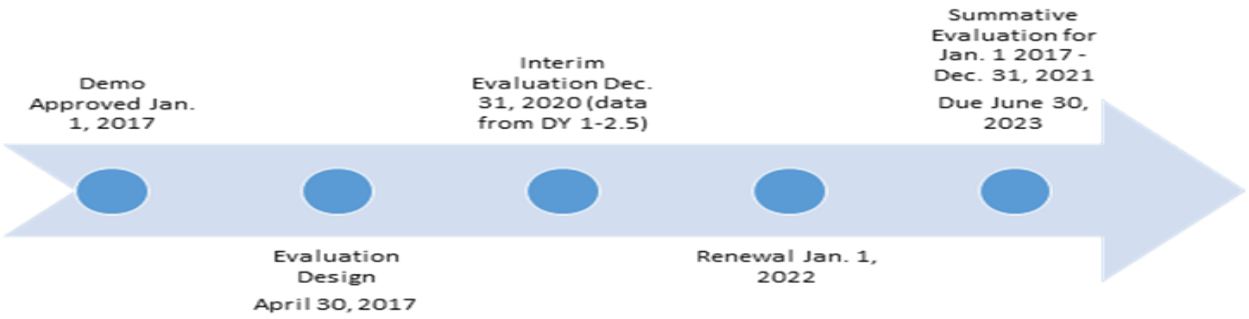
Title XIX of the Social Security Act (the Act) requires an evaluation of every section 1115 demonstration. In order to fulfill this requirement, the state's submission must provide a comprehensive written presentation of all key components of the demonstration, and include all required elements specified in the approved Evaluation Design. This Attachment is intended to assist states with organizing the required information in a standardized format and understanding the criteria that CMS will use in reviewing the submitted Interim and Summative Evaluation Reports.

The format for the Interim and Summative Evaluation reports are as follows:

A. Executive Summary;
B. General Background Information;
C. Evaluation Questions and Hypotheses;
D. Methodology;

E. Methodological Limitations;
F. Results;
G. Conclusions;
H. Interpretations, and Policy Implications and Interactions with Other State Initiatives;
I. Lessons Learned and Recommendations; and
J. Attachment(s).

Submission Timelines
There is a specified timeline for the state's submission of Evaluation Designs and Evaluation Reports. These dates are specified in the demonstration Special Terms and Conditions (STCs). (The graphic below depicts an example of this timeline). In addition, the state should be aware that section 1115 evaluation documents are public records. In order to assure the dissemination of the evaluation findings, lessons learned, and recommendations, the state is required to publish the evaluation design and reports to the state's website within 30 days of CMS approval, as per 42 CFR 431.424(d). CMS will also publish a copy to the Medicaid.gov website.



Required Core Components of Interim and Summative Evaluation Reports

The section 1115 Evaluation Report presents the research about the section 1115 Demonstration. It is important that the report incorporate a discussion about the structure of the Evaluation Design to explain the goals and objectives of the demonstration, the hypotheses related to the demonstration, and the methodology for the evaluation. A copy of the state's Driver Diagram (described in the Evaluation Design Attachment) must be included with an explanation of the depicted information. The Evaluation Report should present the relevant data and an interpretation of the findings; assess the outcomes (what worked and what did not work); explain the limitations of the design, data, and analyses; offer recommendations regarding what (in hindsight) the state would further advance, or do differently, and why; and discuss the implications on future Medicaid policy. Therefore, the state's submission must include:

a. **Executive Summary** – A summary of the demonstration, the principal results, interpretations, and recommendations of the evaluation.

B. General Background Information about the Demonstration – In this section, the state should include basic information about the demonstration, such as:

i. The issues that the state is trying to address with its section 1115 demonstration and/or expenditure authorities, how the state became aware of the issue, the potential magnitude of the issue, and why the state selected this course of action to address the issues.
ii. The name of the demonstration, approval date of the demonstration, and period of time covered by the evaluation;
iii. A brief description of the demonstration and history of the implementation, and if the evaluation is for an amendment, extension, renewal, or expansion of, the demonstration;
iv. For renewals, amendments, and major operational changes: A description of any changes to the demonstration during the approval period; whether the motivation for change was due to political, economic, and fiscal factors at the state and/or federal level; whether the programmatic changes were implemented to improve beneficiary health, provider/health plan performance, or administrative efficiency; and how the Evaluation Design was altered or augmented to address these changes.
v. Describe the population groups impacted by the demonstration.

C. Evaluation Questions and Hypotheses – In this section, the state should:

1) Describe how the state's demonstration goals were translated into quantifiable targets for improvement, so that the performance of the demonstration in achieving these targets could be measured. The inclusion of a Driver Diagram in the Evaluation Report is highly encouraged, as the visual can aid readers in understanding the rationale behind the demonstration features and intended outcomes.
2) Identify the state's hypotheses about the outcomes of the demonstration;
   a. Discuss how the goals of the demonstration align with the evaluation questions and hypotheses;
   b. Explain how this Evaluation Report builds upon and expands earlier demonstration evaluation findings (if applicable); and
   c. Address how the research questions / hypotheses of this demonstration promote the objectives of Titles XIX and XXI.

D. Methodology – In this section, the state is to provide an overview of the research that was conducted to evaluate the section 1115 demonstration consistent with the approved Evaluation Design. The evaluation Design should also be included as an attachment to the report. The focus is on showing that the evaluation builds upon other published research (use references), and meets the prevailing standards of scientific and academic rigor, and the results are statistically valid and reliable.

An interim report should provide any available data to date, including both quantitative and qualitative assessments. The Evaluation Design should assure there is appropriate data development and collection in a timely manner to support developing an interim evaluation.

This section provides the evidence that the demonstration evaluation used the best available data and describes why potential alternative data sources were not used; reported on, controlled for, and made appropriate adjustments for the limitations of the

data and their effects on results; and discusses the generalizability of results. This section should provide enough transparency to explain what was measured and how. Specifically, this section establishes that the approved Evaluation Design was followed by describing:

1) *Evaluation Design*—Will the evaluation be an assessment of: pre/post, post-only, with or without comparison groups, etc?
2) *Target and Comparison Populations*—Describe the target and comparison populations; include inclusion and exclusion criteria.
3) *Evaluation Period*—Describe the time periods for which data will be collected
4) *Evaluation Measures*—What measures are used to evaluate the demonstration, and who are the measure stewards?
5) *Data Sources*—Explain where the data will be obtained, and efforts to validate and clean the data.
6) *Analytic methods*—Identify specific statistical testing which will be undertaken for each measure (t-tests, chi-square, odds ratio, ANOVA, regression, etc.).
7) *Other Additions* – The state may provide any other information pertinent to the evaluation of the demonstration.

E. Methodological Limitations

This section provides sufficient information for discerning the strengths and weaknesses of the study design, data sources/collection, and analyses.

F. Results – In this section, the state presents and uses the quantitative and qualitative data to show to whether and to what degree the evaluation questions and hypotheses of the demonstration were achieved. The findings should visually depict the demonstration results (tables, charts, graphs). This section should include information on the statistical tests conducted.

G. Conclusions – In this section, the state will present the conclusions about the evaluation results.

1) In general, did the results show that the demonstration was/was not effective in achieving the goals and objectives established at the beginning of the demonstration?

2) Based on the findings, discuss the outcomes and impacts of the demonstration and identify the opportunities for improvements. Specifically:
   a. If the state did not fully achieve its intended goals, why not? What could be done in the future that would better enable such an effort to more fully achieve those purposes, aims, objectives, and goals?

H. Interpretations, Policy Implications and Interactions with Other State Initiatives – In this section, the state will discuss the section 1115 demonstration within an overall Medicaid context and long range planning. This should include interrelations of the demonstration with other aspects of the state's Medicaid program, interactions with other Medicaid demonstrations, and other federal awards affecting service delivery, health outcomes and the cost of care under Medicaid. This section provides the state with an opportunity to provide interpretation of the data using evaluative reasoning to make

judgments about the demonstration. This section should also include a discussion of the implications of the findings at both the state and national levels.

I. Lessons Learned and Recommendations – This section of the Evaluation Report involves the transfer of knowledge. Specifically, the "opportunities" for future or revised demonstrations to inform Medicaid policymakers, advocates, and stakeholders is just as significant as identifying current successful strategies. Based on the evaluation results:

1) What lessons were learned as a result of the demonstration?
2) What would you recommend to other states which may be interested in implementing a similar approach?

J. Attachment

1) Evaluation Design: Provide the CMS-approved Evaluation Design

Attachment C: Phase-Down Expenditures Plan (Reserved)