CENTERS FOR MEDICARE & MEDICAID SERVICES
SPECIAL TERMS AND CONDITIONS

NUMBER: **11-W-00048/6**

TITLE: **SoonerCare**

AWARDEE: **Oklahoma Health Care Authority**

I. PREFACE

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

The STCs have been arranged into the following subject areas:

II. PROGRAM DESCRIPTION, OBJECTIVES HISTORICAL CONTEXT

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

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

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

Demonstration Objectives

Major objectives of the SoonerCare waiver program are:

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

Demonstration Hypotheses:

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

- *PCP Visits.* The rate of adult members who have one or more preventive health visits with a PCP in a year will improve as a measure of access to primary care in accordance with HEDIS® guidelines between 2013-2015.

- *Child Health Checkup Rates.* The rate for age-appropriate well-child and adolescent visits will improve between 2013-2015.

- *Impact of Health Access Networks on Quality of Care.* Key quality performance measures tracked for PCPs participating in the HAN will improve between 2013-2015.

- *Impact of Health Access Networks on Effectiveness of Care.* Per member per month expenditures will decline for members enrolled with PCPs participating in the HAN between 2013-2015.

- *Integration of I/T/U Providers.* The percentage of Native American members who are enrolled with an I/T/U PCP will increase between 2013-2015.

- *Health Management Program.* Health outcomes for chronic diseases will improve between 2013-2015 as a result of participation in the HMP program. Total expenditures for patients enrolled in HMP will decline.

Historical Context of Demonstration Extensions and Amendments:

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

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

On January 3, 2009, CMS approved amendments that:

a) Changed the service delivery model from a Prepaid Ambulatory Health Plan (PAHP) to an exclusive Primary Case Management (PCCM) model;

b) Added an expansion population to the state's Employer Sponsored Insurance program, Insure Oklahoma, for full-time college students age 19 through age 22 not to exceed 200 percent of the Federal Poverty Level (FPL), up to a cap of 3,000 participants;

c) Expanded the size of employers who can participate in Insure Oklahoma, from 50 employees to 250 employees;

d) Expanded the description of qualified PCPs to permit County Health Departments to serve as medical homes for beneficiaries who choose these providers;

e) Included an option for the voluntary enrollment of children in state or tribal custody in the SoonerCare demonstration;

f) Implemented a new "Payments for Excellence" program to build upon the current Early Periodic Screening, Diagnosis, and Treatment (EPSDT) and Fourth Diphtheria, Tetanus and Pertussis (DTaP) Bonus program; and,

g) Amended cost sharing requirements for the Insure Oklahoma Program and added a $1 co-pay for non-pregnant adults in SoonerCare.

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

a) Approval of the Health Access Network (HAN) pilot program;

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

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

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

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

a) CMS has removed the waiver authority that allowed the state to exclude parental income in determining eligibility for disabled children eligible in the TEFRA category ((1902)(a)(17) because the state has this authority under the state plan.

b) CMS has reduced financial eligibility under the Insure Oklahoma program for all populations from up to and including 250 percent of FPL to up to and including 200 percent of FPL (non-disabled working adults and their spouses, disabled working adults, employees of not-for profit businesses having fewer than 500 employees, foster parents and full-time college students). This change reflects implementation levels as of the time of renewal.

c) CMS has sunset the expenditure and not applicable authorities for the Insure Oklahoma program effective December 31, 2013.

d) CMS has approved a limitation on the adult outpatient behavioral health benefit in the Insure Oklahoma individual plan to limit the number of visits to 48 per year consistent with the limitation on behavioral health visits for children. This benefit is limited to individual licensed behavioral health professionals (LBHP). However, this is a soft limit and beneficiaries may seek additional services from the LBHP with prior authorization. Additionally, beneficiaries may seek outpatient behavioral health services through a community mental health center.

e) CMS has approved an amendment to the Health Management Program (HMP), as reflected in Section VII to rename nurse care managers as health coaches and to increase face-to-face care management by embedding health coaches within physician practices with the highest concentration of members with chronic illnesses.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The state must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid and Child Health Insurance Program (CHIP) Law, Regulation, and Policy.** All requirements of the Medicaid and CHIP programs expressed in law, regulation, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the demonstration, including the protections for Indians pursuant to section 5006 of the American Recovery and Reinvestment Act of 2009.

3. **Changes in Medicaid and CHIP Law, Regulation, and Policy (e.g. CHIPRA).** The state must, within the timeframes specified in law, regulation, or policy statement, come into compliance with any changes in Federal law, regulation, or policy affecting the Medicaid or CHIP programs that occur during this demonstration approval period, unless the provision being changed is expressly waived or identified as not applicable.

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

    a) To the extent that a change in federal law, regulation, or policy requires either a reduction or an increase in federal financial participation (FFP) for expenditures made under this demonstration, the state must adopt, subject to CMS approval, a modified budget neutrality agreement as well as a modified allotment neutrality worksheet for the demonstration as necessary to comply with such change. The modified agreements will be effective upon the implementation of the change. The trend rates for budget neutrality agreements are not subject to change under this subparagraph.

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

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

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, enrollee rights, delivery systems, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements must be submitted to CMS as amendments to the demonstration. All amendment requests are subject to approval at the discretion of the Secretary in accordance with

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

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

   a) An explanation of the public process used by the state, consistent with the requirements of STC17, to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality agreement. Such analysis shall include current total computable "with waiver" and "without waiver" status on both a summary and detailed level through the current approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment, which isolates (by Eligibility Group) the impact of the amendment;

   c) An up-to-date CHIP allotment neutrality worksheet, if necessary;

   d) A detailed description of the amendment, including the impact on beneficiaries, with sufficient supporting documentation, including a conforming title XIX or XXI state plan amendment, if necessary; and,

   e) If applicable, a description of how the evaluation design will be modified to incorporate the amendment provisions.

8. **Extension of the Demonstration**.

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

   b) As part of the demonstration extension request, the state must provide documentation of compliance with the transparency requirements in 42 CFR § 431.412 and the public notice requirements outlined in paragraph 17, as well as include the following supporting documentation:

i. Historical Narrative Summary of the Demonstration Project: The state must provide a narrative summary of the demonstration project, reiterate the objectives set forth at the time the demonstration was proposed and provide evidence of how these objectives have been met as well as future goals of the program. If changes are requested, a narrative of the changes being requested along with the objective of the change and desired outcomes must be included.

ii. Special Terms and Conditions (STCs): The state must provide documentation of its compliance with each of the STCs. Where appropriate, a brief explanation may be accompanied by an attachment containing more detailed information. Where the STCs address any of the following areas, they need not be documented a second time.

iii. Waiver and Expenditure Authorities: The state must provide a list along with a programmatic description of the waivers and expenditure authorities that are being requested in the extension.

iv. Quality: The state must provide summaries of External Quality Review Organization (EQRO) reports, managed care organization (MCO) state quality assurance monitoring, and any other documentation of the quality of care provided or corrective action taken under the demonstration.

v. Financial Data: The state must provide financial data (as set forth in the current STCs) demonstrating the state's detailed and aggregate, historical and projected budget neutrality status for the requested period of the extension as well as cumulatively over the lifetime of the demonstration. CMS will work with the state to ensure that federal expenditures under the extension of this project do not exceed the federal expenditures that would otherwise have been made. In doing so, CMS will take into account the best estimate of current trend rates at the time of the extension. In addition, the state must provide up to date responses to the CMS Financial Management standard questions. If title XXI funding is used in the demonstration, a CHIP allotment neutrality worksheet must be included.

vi. Evaluation Report: The state must provide a narrative summary of the evaluation design, status (including evaluation activities and findings to date), and plans for evaluation activities during the extension period. The narrative is to include, but not be limited to, describing the hypotheses being tested and any results available.

vii. Documentation of Public Notice 42 CFR § 431.408: The state must provide documentation of the state's compliance with public notice process as specified in 42 CFR section 431.408 including the post-award public input process described in 431.420(c) with a report of the issues raised by the public during the comment period and how the state considered the comments when developing the demonstration extension application.

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

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

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

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

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

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

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

a) Expiration Requirements: The state must include, at a minimum, in its demonstration expiration plan the process by which it will notify affected beneficiaries, the content of said notices (including information on the beneficiary's appeal rights), the process by which the state will conduct administrative reviews of Medicaid eligibility for the affected beneficiaries, and ensure ongoing coverage for eligible individuals, as well as any community outreach activities.

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

c) Federal Public Notice: CMS will conduct a 30-day federal public comment period consistent with the process outlined in 42 CFR § 431.416 in order to solicit public input on the state's demonstration expiration plan. CMS will consider comments received during the 30-day period during its review and approval of the state's demonstration expiration plan. The state must obtain CMS approval of the demonstration expiration plan prior to the implementation of the expiration activities. Implementation of expiration activities must be no sooner than 14 days after CMS approval of the plan.

d) Federal Financial Participation (FFP): FFP shall be limited to normal closeout costs associated with the expiration of the demonstration including services and administrative costs of disenrolling participants.

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

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

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

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

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

15. **Adequacy of Infrastructure.** The state will ensure the availability of adequate resources for implementation and monitoring of the demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements; and reporting on financial and other demonstration components.

16. **Transition Plan.** The State is required to prepare, and incrementally revise, a Transition Plan consistent with the provisions of the Affordable Care Act for individuals enrolled in the Demonstration. On June 29, 2012, the state submitted a draft transition plan describing the State's plans to implement the provisions of the ACA for individuals enrolled in the demonstration.

17. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The state must continue to comply with the state Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994). The state must also comply with the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the American Recovery and Reinvestment Act of 2009, and the tribal consultation requirements contained in the state's approved state plan, when any program changes to the demonstration, including (but not limited to) those referenced in STC 6, are proposed by the state.

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

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

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

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

V. ELIGIBILITY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25. Eligibility Conditions for Demonstration Population 8.

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

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

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

V. SOONERCARE BENEFITS and COST SHARING

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

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

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

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

VI. INSURE OKLAHOMA PREMIUM ASSISTANCE BENEFITS AND COST SHARING

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

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

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

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

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

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

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

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

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

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

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

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

32. Insure Oklahoma Cost-Sharing:

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

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

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

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

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

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

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

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

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

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

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

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

a) For each state fiscal year, the state will establish age/gender premium bands for the Insure Oklahoma Individual Plan that are based on the estimated cost of the coverage. The monthly premium for an individual/family will be set at 20 percent of the age/gender band.

a) To calculate a monthly premium for the household, the premiums for all covered members will be added together and multiplied by 20 percent. The household contribution to the premium will be capped, not to exceed 4 percent of the monthly gross household income.

b) The state will require all individuals participating in the Premium Assistance Individual Plan to be responsible for any co-payments subject to the 5 percent annual gross household income cap minus any premiums paid by the enrollee.

c) The state will provide reimbursement for incurred costs by the household in excess of the 5 percent annual gross household income cap, for individuals (or their eligible Insure Oklahoma spouse) enrolled in the Premium Assistance Individual Plan. A medical expense must be for an allowed and covered service by the health plan, to be eligible for reimbursement.

VII. DELIVERY SYSTEMS

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

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

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

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

	City and Tulsa.

38. Care Coordination Payments.

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

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

Care Coordination Payments

PMPM	Tier 1	Tier 2	Tier 3
Children	**$4.32**	**$6.32**	**$8.41**
Children and Adults	**$3.66**	**$5.46**	**$7.26**
Adults	**$2.93**	**$4.50**	**$5.99**

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

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

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

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

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

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

The HAN must:

a) Be organized for the purpose of restructuring and improving the access, quality, and continuity of care to SoonerCare beneficiaries;

b) Ensure patients access to all levels of care, including primary, outpatient, specialty, certain ancillary services, and acute inpatient care, within a community or across a broad spectrum of providers across a service region or the state;

c) Submit a development plan to the state detailing how the network will reduce costs associated with the provision of health care services to SoonerCare enrollees, improve access to health care services, and enhance the quality and coordination of health care services to SoonerCare beneficiaries;

d) Offer core components of electronic medical records, improved access to specialty care, telemedicine, and expanded quality improvement strategies; and,

e) Offer care management/care coordination to persons with complex health care needs including;

    i. The co-management of individuals enrolled in the Health Management Program;
    ii. Individuals with frequent Emergency Room utilization;
    iii. Women enrolled in the Oklahoma Care Program diagnosed with breast or cervical cancer;
    iv. Pregnant women enrolled in the High Risk OB Program; and
    v. Individuals enrolled in the Pharmacy Lock-In Program.

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

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

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

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

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

VIII. HEALTH MANAGEMENT PROGRAM

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

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

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

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

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

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

IX. PROGRAM MONITORING

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

a) The state will monitor the aggregate costs for the Premium Assistance Employer Coverage Plan versus the cost of providing coverage through the Premium Assistance Individual Plan. On a quarterly basis, the state will compare the average monthly premium assistance contribution per Employer Coverage enrollee to the cost per member per month of the expansion population enrolled in the Individual Plan.

b) On an annual basis, the state will calculate the total cost per enrollee per month for individuals receiving subsidies under the Premium Assistance Employer Coverage Plan, including any reimbursement made to enrollees whose out-of-pocket costs exceeded their income stop loss threshold (5 percent of income). The cost for this group will then be compared to the "per enrollee per month" cost for those individuals enrolled in the Premium Assistance Individual Plan.

48. Monitoring Employer Sponsored Insurance.

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

b) The state must require that all participating employers report annually on their total contributions for employees covered under the Premium Assistance Plan. The state will prepare an aggregate analysis across all participating employers summarizing the total statewide employer contribution level under the demonstration.

c) Similarly, the state will monitor changes in covered benefits and cost sharing requirements of employer-sponsored health plans and document any trends in these two areas over the life of the demonstration.

X. GENERAL REPORTING REQUIREMENTS

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

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

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

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

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

b) Action plans for addressing any policy and administrative issues identified;

c) Enrollment data, member month data, and budget neutrality monitoring tables;

d) Updates on the implementation of the Premium Assistance Employer Coverage and Premium Assistance Individual Plan products, such as summary findings from the state's monitoring and analysis as described in paragraphs 47 and 48; and

e) Evaluation activities and interim findings.

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

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

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

XI. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XIX

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

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

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

a) For each demonstration year, thirteen (13) separate Forms CMS-64.9 WAIVER and/or 64.9P WAIVER must be completed, using the waiver name noted below, to report expenditures for the following demonstration populations.

i. **Demonstration Population 1: TANF-Urban** includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program, receiving health care services in the designated Central, Northeast, and Southwest urban areas of the state;

ii. **Demonstration Population 2: TANF-Rural** includes low-income families, pregnant women and children, and women who are eligible under the Breast and Cervical Cancer Treatment Program receiving health care services in the rural areas of the state;

iii. **Demonstration Population 3: ABD-Urban** includes the Aged, Blind and Disabled receiving health care services in the designated Central, Northeast, and Southwest urban areas of the state;

iv. **Demonstration Population 4: ABD-Rural** includes the Aged, Blind and Disabled receiving health care services in the rural areas of the state;

v. **Demonstration Population 5: Non-Disabled Working Adults** includes non-disabled low income workers and their spouses with household incomes no greater than 250 percent of the FPL;

vi. **Demonstration Population 6: Working Disabled Adults** includes low income working disabled adults with household incomes no greater than 250 percent of the FPL;

vii. **Demonstration Population 7: TEFRA Children** includes children defined in paragraph 22;

viii. **Demonstration Population 8 Full-Time College Students** includes full-time college students ages 19-22 up to and including 200 percent of the FPL (limited to 3,000 individuals at any given time);

ix. **Demonstration Population 9: CHIP Medicaid Expansion Children** includes infants under age 1, children ages 1-5, and children ages 6-18.
Note: The State must report information in the Form CMS-64.9 Waiver and/or 64.9P Waiver for this population when using title XIX funds;

x. **Demonstration Population 10: Foster Parents** includes working foster parents with household incomes no greater than 200 percent of the FPL. The spouse of a working employee can be covered;

xi. **Demonstration Population 11: Not-for-Profit Employees** includes employees and spouses of not-for-profit businesses with 500 or fewer employees with household incomes no greater than 200 percent of the FPL**;** and,

xii. **Demonstration Expenses 1: HAN Expenditures** includes PMPM expenditures made to the HANs.

xiii. **Demonstration Expenses 2: HMP Expenditures** includes expenditures to provide health coaches and practice facilitation services through the Health Management Program.

b) For each HAN, the state must collect quarterly data of expenditures made by the HAN. The state must report summary expenditure data, for each HAN, in the Narrative section of Form CMS-64.9 for demonstration Expenses 1.

c) For the HMP, the state must collect quarterly data of expenditures made by the HMP. The state must report summary expenditure data in the Narrative section of Form CMS-64.9 for demonstration Expenses 2.

d) Specific Reporting Requirements for Medicaid expansion children (including TEFRA children) who revert to title XIX only when the state has exhausted its title XXI allotment.

i. The state is eligible to receive title XXI funds for expenditures for these children, up to the amount of its title XXI allotment. Expenditures for these children under title XXI must be reported on separate Forms CMS-64.21U and/or CMS-64.21UP in accordance with the instructions in section 2115 of the State Medicaid Manual.
ii. Title XIX funds are available under this demonstration if the state exhausts its title XXI allotment (including any reallocations or redistributions). If the state exhausts its title XXI allotment prior to the end of a Federal fiscal year, title XIX Federal matching funds are available for these children. During the period when title XIX funds are used, expenditures related to this demonstration population must be reported as waiver expenditures on the Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver. The state shall provide CMS with 120 days prior notice before it begins to draw down title XIX matching funds for these demonstration populations.
iii. The expenditures attributable to this demonstration population will count toward the budget neutrality expenditure cap calculated under Section XIII, paragraph 69, using the per member per month (PMPM) amounts for children in the TANF Rural and TANF Urban populations described in Section XII, paragraph 56(a)(i-ii), and will be considered expenditures subject to the budget neutrality cap as defined in paragraph 56(e), so that the state is not at risk for claiming title XIX Federal matching funds when title XXI funds are exhausted.

e) The sum of the quarterly expenditures for all demonstration years will represent the expenditures subject to the budget neutrality cap as defined in paragraph 66.

f) For purposes of this section, the term "expenditures subject to the budget neutrality cap" must include all Medicaid expenditures on behalf of individuals who are enrolled in this demonstration under paragraph 56(a). All expenditures that are subject to the budget neutrality cap are considered demonstration expenditures and must be reported on Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver.

g) Administrative costs will not be included in the budget neutrality agreement, but the state must separately track and report additional administrative costs that are directly attributable to the demonstration. All administrative costs must be identified on the Forms CMS-64.10 Waiver and/or CMS-64.10P Waiver.

h) All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the state made the expenditures. All claims for services during the demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the demonstration. During the latter 2-year period, the state must continue to identify separately net expenditures related to dates of service during the operation of the demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

i) Premiums and other applicable cost sharing contributions from enrollees that are collected by the state from enrollees under the demonstration must be reported to CMS each quarter on Form CMS-64 Summary Sheet line 9.D, columns A and B. Additionally, both the total computable and Federal share amounts that are attributable to the demonstration must be separately reported on the CMS-64 Narrative.

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

a) For the purpose of calculating the budget neutrality expenditure cap and for other purposes, the state must provide to CMS, as part of the quarterly report required under paragraph 55, the actual number of eligible member months for EGs defined in paragraph 56(a). The state must submit a statement accompanying the quarterly report which certifies the accuracy of this information. To permit full recognition of "in-process" eligibility, reported counts of member months may be subject to revisions for an additional 180 days after the end of each quarter.

b) The term "eligible member months" refers to the number of months in which persons are eligible to receive services. For example, a person who is eligible for 3 months contributes 3 eligible member months to the total. Two individuals who are eligible for 2 months each contribute 2 eligible member months to the total, for a total of 4 eligible member months.

c) The "demonstration eligibles" that do contribute to the calculation of the budget neutrality ceiling for the SoonerCare Program include the TANF-Urban, TANF-Rural, ABD Urban and ABD Rural populations as defined in paragraph 55(a).

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

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

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

a) Administrative costs, including those associated with the administration of the demonstration;

b) Net expenditures and prior period adjustments of the Medicaid program that are paid in accordance with the approved Medicaid state plan;

c) Net medical assistance expenditures made under Section 1115 demonstration authority, with dates of service during the demonstration extension period; and

d) Net premiums and net medical assistance expenditures for persons enrolled in the O-EPIC Program.

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

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

a) CMS may review the sources of the non-Federal share of funding for the demonstration at any time. Oklahoma agrees that all funding sources deemed unacceptable by CMS shall be addressed within the time frames set by CMS.

b) Any amendments that impact the financial status of the program shall require the state to provide information to CMS regarding all sources of the non-Federal share of funding.

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

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

a) Units of government, including governmentally operated health care providers, may certify that state or local tax dollars have been expended as the non-Federal share of funds under the demonstration.

b) To the extent the state utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the state would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the state utilizes CPEs as the funding mechanism to claim Federal match for payments under the demonstration, governmental entities to which general revenue funds are appropriated must certify to the state the amount of such tax revenue (state or local) used to satisfy demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the state's claim for Federal match.

d) The state may use intergovernmental transfers to the extent that such funds are derived from state or local tax revenues and are transferred by units of government within the state. Any transfers from governmentally operated health care providers must be made in an amount not to exceed the non-Federal share of

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

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

XII. GENERAL FINANCIAL REQUIREMENTS UNDER TITLE XXI

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

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

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

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

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

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

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

XIII. MONITORING BUDGET NEUTRALITY FOR THE DEMONSTRATION

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

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

demonstration.

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

a) **Eligibility Group 1 (Demonstration Population 1):** Temporary Assistance to Needy Families recipients in urban areas of the state;

b) **Eligibility Group 2 (Demonstration Population 2):** Temporary Assistance to Needy Families recipients in rural areas of the state;

c) **Eligibility Group 3 (Demonstration Population 3):** Aged, Blind and Disabled Medicaid recipients (regardless of SSI eligibility) in urban areas of the state;

d) **Eligibility Group 4 (Demonstration Population 4):** Aged, Blind and Disabled Medicaid recipients (regardless of SSI eligibility) in rural areas of the state; and,

e) **Eligibility Group 5 (Demonstration Population 9):** Medicaid expansion children (including TEFRA children) who revert to title XIX.

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

a) For each year of the budget neutrality agreement an annual budget neutrality expenditure limit is calculated for each EG described in paragraph 68 as follows:

i. An annual EG estimate must be calculated as a product of the number of eligible member months reported by the state under paragraph 57, for each EG, times the appropriate estimated PMPM costs from the table in subparagraph (iii) below.

ii. The PMPM costs in subparagraph (iii) below are net of premiums paid by demonstration eligibles.

iii. The PMPM costs for the EGs used to calculate the annual budget neutrality expenditure limit for this demonstration are specified below.

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

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

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

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

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

XIV. EVALUATION OF THE DEMONSTRATION

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

a) The specific research questions and hypotheses that are being tested. The research questions should focus on the programmatic goals and objectives of the demonstration and their potential impacts, particularly as they relate to CMS' Three Part Aim of improving access to and experience of care, improving quality of health care and decreasing per capita costs.

b) A description of any experimental study design employed (e.g., cohort, controlled before-and-after studies, interrupted time series, case-control, etc.) including a proposed baseline and/or control comparison groups.

c) Quantitative and qualitative process improvement and outcome measures with corresponding specifications that will be used in evaluating the impact of the Demonstration, particularly as it relates to the Three Part Aim of improving access to and experience of care, improving quality of health care and decreasing per capita costs. The evaluation plan should ensure that all outcomes selected

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

d) Data sources and collection frequency.

e) The population being studied (consider the target population of the demonstration), including the sampling methodology for selecting the population being included in your analysis.

f) A detailed analysis plan that describes the statistical methods that will be employed, particularly those that will allow for the effects of the Demonstration to be isolated from other initiatives occurring in the State. The level of analysis might be at the beneficiary, provider, and aggregate program level, as appropriate, and may include population stratifications to the extent feasible, for further depth. Qualitative analysis methods should also be described.

g) The timelines for evaluation related deliverables.

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

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

a) *Hypothesis 1: Child Health Checkup Rates.* The rate for age-appropriate well-child and adolescent visits will improve between 2013-2015.

b) *Hypothesis 2: PCP Visits.* The rate of adult members who have one or more preventive health visits with a primary care provider in a year will improve as a measure of access to primary care in accordance with HEDIS® guidelines between 2013-2015.

c) *Hypothesis 3: PCP Enrollments.* The number of SoonerCare Choice primary care practitioners enrolled as medical home PCPs will increase between 2013-2015.

d) *Hypothesis 4: PCP Capacity Available*. There will be adequate PCP capacity to meet the health care needs of the SoonerCare members between 2013-2015. For example, getting an appointment within the timeframe perceived necessary by the member, should improve between 2013-2015.

e) *Hypothesis 5: Integration of I/T/U Providers.* The percentage of Native American members who are enrolled with an IHS, Tribal, or Urban Indian Clinic with a SoonerCare American Indian PCCM contract will increase between 2013-2015.

f) *Hypothesis 6: Eligible Member Enrollments in Medical Homes.* The number of members eligible for SoonerCare Choice who do not have an established PCP will decrease between 2013-2015.

g) *Hypothesis 7: Continuity of Care.* The number of members enrolled with one PCP during a month will increase between 2013-2015.

h) *Hypothesis 8: Impact of Health Access Networks on Quality of Care.* Key quality performance measures tracked for PCPs participating in the HANs will improve between 2013-2015.

i) *Hypothesis 9: Impact of Health Access Networks on Effectiveness of Care.* Average per member per month expenditures will decrease for members enrolled with PCPs participating in the HANs between 2013-2015.

j) *Hypothesis 10: Health Management Program (HMP).* Health outcomes for chronic diseases will improve between 2013-2015 as a result of participation in the HMP. Total expenditures for members enrolled in HMP will decrease.

k) *Hypothesis 11: Retroactive Eligibility.* The state's systems performance will ensure seamless coverage between Medicaid and the Exchange after changes outlined in the Affordable Care Act are effectuated, evaluating a need for retroactive eligibility.

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

a) Reducing costs associated with the provision of health care services to SoonerCare beneficiaries served by the HAN;

b) Improving access to and the availability of health care services to SoonerCare beneficiaries served by the HAN;

c) Improving the quality and coordination of health care services to SoonerCare beneficiaries served by the HAN with specific focus on the populations at greatest risk including those with multiple chronic illnesses; and,

d) Enhancing the state's patient-centered medical home program through an evaluation of PCP profiles that incorporates a review of utilization, disease guideline compliance, and cost.

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

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

a) *Impact on Enrollment Figures:* The implementation of the HMP program, including health coaches and practice facilitation, will result in increase in enrollment as compared to baseline.

b) *Impact on Access to Care:* Incorporating health coaches into primary care practices will result in increased contact with HMP beneficiaries by the PCP (measured through claims encounter data) as compared to baseline when care management occurred via telephonic or face-to-face contact with a nurse care manager.

c) *Impact on Identifying Appropriate Target Population:* The implementation of the HMP program, including health coaches and practice facilitation, will result in a change in the characteristics of the beneficiary population enrolled in the HMP (as measured through population characteristics including disease burden and co-morbidity obtained through claims and algorithms.) as compared to baseline.

d) *Impact on Nurse Care Manager Work Burden:* Incorporating health coaches and practice facilitation into primary care practices will result in reduced work burden and improved experience of nurse care managers (as determined through surveys or focus groups).

e) *Impact on Health Outcomes:* Use of disease registry functions by the health coach will improve the quality of care delivered to beneficiaries as measured by changes in performance on the Initial set of Health Care Quality Measures for Medicaid-Eligible adults or CHIPRA Core Set of Children's Healthcare Quality Measures.

f) *Impact on Cost/Utilization of Care:* Beneficiaries using HMP services will have fewer ER visits as compared to beneficiaries not receiving HMP services (as measured through claims data).

g) *Impact on Cost/Utilization of Care:* Beneficiaries using HMP services will have fewer readmissions to hospitals as compared to beneficiaries not receiving HMP services (as measured through claims data).

h) *Impact on Satisfaction/Experience with Care:* Beneficiaries using HMP services will have higher satisfaction compared to beneficiaries not receiving HMP services (as measured through CAHPS survey data)

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

a) The number of eligibility determinations made broken down by type, such as application, transfer and redetermination;

b) The number of individuals determined ineligible broken down by procedural vs. eligibility reasons;

c) The average application processing times broken down by type, such as application, transfer and redetermination;

d) The rate of timely eligibility determinations broken down by completed within 5 days, 10 days and 30 days;

e) The number of individuals disenrolled broken down by procedural vs. eligibility reasons;

f) The internal churn rate (i.e., the number of disenrolled beneficiaries reenrolling within 6 months); and

g) The accurate transfer rate, i.e., the number of individuals transferred to Medicaid, CHIP or the Exchange, as applicable, who are determined eligible by the agency.

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

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

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

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

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

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

ATTACHMENT A

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

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

NARRATIVE REPORT FORMAT

Title Line One – SoonerCare

Title Line Two - Section 1115 Quarterly Report

Demonstration/Quarter Reporting Period:

Example:
Demonstration Year: 18 (1/1/2013 – 12/31/2013)
Federal Fiscal Quarter: 2/2011 (1/13 - 3/13)

Introduction

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

Enrollment Information

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

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

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

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

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

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

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

Member Month Reporting
Enter the member months for each of the EGs for the quarter.

A. For Use in Budget Neutrality Calculations

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

B. For Informational Purposes Only

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

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

Quality Assurance/Monitoring Activity
Identify any quality assurance/monitoring activity in current quarter.

Demonstration Evaluation
Discuss progress of evaluation design and planning.

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

State Contact(s)
Identify individuals by name, title, phone, fax, and address that CMS may contact should any questions arise.

Date Submitted to CMS