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

State Demonstrations Group

September 03, 2026

Melissa Miller
Medicaid Director
Oklahoma Health Care Authority
4345 N Lincoln Blvd.
Oklahoma City, OK 73105

Dear Director Miller:

The Centers for Medicare & Medicaid Services (CMS) approved Oklahoma's Evaluation Design for the COVID-19 Public Health Emergency (PHE) amendment to the section 1115 demonstration entitled, "SoonerCare" (Project No: 11-W-00048/6). We sincerely appreciate the state's commitment to efficiently meeting the requirement for an Evaluation Design as was stipulated in the approval letter for this amendment dated July 28, 2023, especially under these extraordinary circumstances.

In accordance with 42 CFR 431.424(c), the approved Evaluation Design may now be posted to the state's Medicaid website within 30 days. CMS will also post the approved Evaluation Design on Medicaid.gov.

Consistent with the approved Evaluation Design, the draft Final Report will be due to CMS no later than one year after the end of the amendment approval period.

States are responsible for following all applicable federal law and regulations when they claim and use federal Medicaid funds and must fully comply with all applicable Medicaid statutes and regulations under a section 1115 demonstration, except where specific provisions have been expressly waived or identified as not applicable for that demonstration. This obligation includes all requirements in Title XIX of the Social Security Act and implementing regulations governing provider screening and enrollment activities, pre- and post-payment review claiming, payment methodologies and rate-setting, utilization controls, and program integrity including processes to identify, investigate, and refer suspected fraud, and methods to receive complaints and identify questionable practices. States must maintain effective systems and safeguards to prevent, detect, and address any fraud, waste, or abuse (FWA) in the delivery of and payment for Medicaid services, including referrals to law enforcement when appropriate.

States should have heightened monitoring and oversight mechanisms in place featuring robust internal controls to identify and remediate all vulnerabilities (including, but not limited to, FWA and beneficiary access issues) inherent in service areas approved as part of a demonstration. At any time, CMS may request that the state provide a plan detailing the state's systems and safeguards to prevent, detect, and address any FWA relative to this demonstration. Failure to meet program integrity obligations under federal statutes and regulations or under the terms and conditions of this demonstration approval may result in compliance actions or other enforcement measures that could include requirements to develop and implement corrective action plans, withholdings, deferrals, disallowances, and termination of demonstration authority.

We sincerely appreciate the state's commitment to evaluating the COVID-19 PHE amendment under these extraordinary circumstances. We look forward to our continued partnership on the Oklahoma SoonerCare section 1115 demonstration. If you have any questions, please contact your CMS demonstration team.

Sincerely,

DANIELLE DALY -S

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Date: 2026.09.03 10:21:41 -04'00'

Danielle Daly
Director
Division of Demonstration Monitoring and Evaluation

cc: Stacey Steiner, State Monitoring Lead, CMS Medicaid and CHIP Operations Group

OKLAHOMA
Health Care Authority

SoonerCare COVID-19 Section 1115a Public Health Emergency Demonstration

Evaluation Design

SEPTEMBER 2023

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A. INTRODUCTION

Background

The COVID-19 Public Health Emergency (PHE) posed an unprecedented challenge to Oklahoma and the rest of the nation. The Medicaid population, which includes large numbers of persons with chronic health conditions, and which is lower-than-average in income, was particularly vulnerable to the effects of the pandemic.

The US Department of Health and Human Services (DHHS) declared a Public Health Emergency on January 31, 2020. Recognizing the need for state flexibility in addressing the PHE, the Centers for Medicare and Medicaid Services (CMS) on March 22, 2020 invited states to apply for COVID-19 related Section 1115 demonstration authority.

The Oklahoma Health Care Authority (OHCA), Oklahoma's Single State Agency for Medicaid, responded swiftly to the PHE through actions intended to facilitate beneficiary access to care. As part of a multi-faceted response[1], the OHCA submitted a COVID-19 amendment request to the SoonerCare Section 1115 demonstration.

The OHCA requested, and CMS approved, Medicaid waiver authority to permit the state to exempt SoonerCare members from cost-sharing for any treatment related to COVID-19 or for services/treatment of any condition that may seriously complicate the treatment of COVID-19.

CMS approved the following waiver authority, covering the period March 1, 2020 to September 30, 2024:

> ***Comparability: Section 1902(a)(17).*** *To the extent necessary to enable the state to vary cost sharing requirements for title XIX state plan beneficiaries from cost sharing to which they otherwise would be subject under the state plan. This waiver specifically enables the state to exempt cost sharing for treatment of COVID-19, or for services/treatment of any condition that may seriously complicate the treatment of COVID-19, for individuals who are diagnosed with or presumed to have COVID-19 during the period such an individual has (or is presumed to have) COVID-19.* [2]

[1] Other elements of the response included (but were not limited to) expanded use of telehealth; waiving of certain provider enrollment requirements, such as enrollment fees; flexibility in allowing providers to receive payments for services rendered to affected members in alternative physical settings, such as mobile testing sites and temporary shelters; removal or modification of certain prior authorization requirements; and expanded availability of 90-day supplies for maintenance drugs.

[2] See: Approval letter to Traylor Rains, Chief Medicaid Director, OHCA, dated July 28, 2023, page 2.

CMS concurrently approved the following Medicaid expenditure authority for the same time period:

> ***Cost Sharing for COVID-19 Treatment.*** *Expenditures to exempt beneficiary cost-sharing for the treatment of COVID-19, or for services and/or treatment of any condition that may seriously complicate the treatment of COVID-19. This authority applies for current title XIX state plan beneficiaries and individuals in demonstration populations 1, 2, 3, 4, 12, 13, 14, 15, and 16 who are diagnosed with or presumed to have COVID-19, during the period such an individual has (or is presumed to have) COVID019.*[3]

CMS also concurrently approved the following Title XIX Requirements not Applicable to the Demonstration Expenditure Authority described above, for the same time period:

> ***Comparability: Section 1902(a)(17).*** *To the extent necessary to enable the state to vary cost sharing requirements for individuals in populations 12, 13, 14, 15, and 16 from cost sharing to which they otherwise would be subject. This non-applicable specifically enables the state to exempt cost sharing for treatment of COVID-19, or for services/treatment of any condition that may seriously complicate the treatment of COVID-19 for individuals who are diagnosed with or presumed to have COVID-19 during the period such an individual has (or is presumed to have) COVID-19.*[4]

Exhibit A-1 below identifies the demonstration populations to which the cost sharing exemption applies:

Exhibit A-1 – Demonstration Populations Subject to Exemption

MEG	Description
1	**TANF-Urban** – includes low-income families, pregnant women and children who are eligible under the Breast and Cervical Cancer Treatment Program, receiving services in the designated Central, Northeast, and Southwest urban areas of the state[5].
2	**TANF-Rural** – includes low-income families, pregnant women and children who are eligible under the Breast and Cervical Cancer Treatment Program, receiving services in the rural areas of the state.
3	**ABD-Urban** – includes the Aged, Blind, and Disabled receiving services in the designated Central, Northeast and Southwest urban areas of the state.

[3] Ibid, page 2.
[4] Ibid, page 3.
[5] Central – Oklahoma City and surrounding area; Northeast – Tulsa and surrounding area; Southwest – Lawton and surrounding area.

MEG	Description
4	**ABD-Rural** – includes the Aged, Blind, and Disabled receiving services in the rural areas of the state.
12*	**Non-Disabled Working Adults** – includes non-disabled low-income workers and their spouses, with household incomes no greater than 100 percent of Federal Poverty Level (FPL).
13*	**Working Disabled Adults** – includes low-income working disabled adults with household incomes no greater than 100 percent of the FPL.
14*	**Full-Time College Students** – includes full-time college students ages 19 – 22, up to any including 100 percent of the FPL.
15*	**Foster Parents** – includes working foster parents with household incomes no greater than 100 percent of Federal Poverty Level (FPL).
16*	**Not-for-Profit Employees** – includes employees and spouses of not-for-profit business with 500 or fewer employees with household incomes no greater than 100 percent of Federal Poverty Level (FPL).

** In July 2021, Oklahoma expanded Title XIX eligibility to adults with incomes up to 138 percent of the FPL (including income disregards). SoonerCare beneficiaries within demonstration populations 12 – 16 were, with few exceptions, transitioned to the new MEG.*

Exhibit A-2 below summarizes SoonerCare program services subject to beneficiary cost sharing. The OHCA Medicaid Management Information System (MMIS) is programmed to pay providers net of beneficiary cost share amounts when applicable.

Cost sharing applies only to non-Native American adult beneficiaries ages 21 and older. Beneficiaries under age 21 are never subject to cost sharing. Preventive services for adults also are not subject to cost sharing, even if the category (e.g., physician services) is included below.

Exhibit A-2 – SoonerCare Cost Sharing Requirements (Adult Non-Preventive Care)

Service (Alphabetical Order)	Cost Share
Alternative Treatment for Pain Management	$4.00 copay per visit
Diabetic Supplies	$4.00 copay per claim
Durable Medical Equipment	$4.00 copay per claim
Habilitation Services	$4.00 copay per visit
Inpatient Hospital Services	$10.00 copay per day – first seven days $5.00 on the eighth day
Laboratory and X-Ray	$4.00 copay per visit

Service (Alphabetical Order)	Cost Share
Mental Health or Substance Use Disorder Medical Detoxification – Inpatient	$10.00 per day, up to a maximum of $75.00
Mental Health or Substance Use Disorder – Outpatient	$3.00 copay per visit (select services)
Outpatient Hospital and Surgery Services	$4.00 copay per visit
Personal Care	$4.00 copay per visit
Physician Services	$4.00 copay per visit
Primary Care Provider/Primary Care Medical Home	$4.00 copay per visit
Prescription Drugs	$4.00 copay per prescription
Prosthetics and Orthotics	$4.00 copay per prescription
Therapy Services (Physical, Speech, Occupational)	$4.00 copay per visit
Premiums (Demonstration Populations 12 – 16)	Member-specific, based on income

The OHCA implemented the cost sharing exemption on March 16, 2020. The exemption applied both to point-of-service cost sharing (copay) for all populations and monthly premiums for demonstration populations 12 – 16.

Demonstration Objective

The OHCA's objective in requesting authority to waive copayments and premiums was to remove any potential cost-related barrier to care during the PHE. This was done in concert with other actions (see footnote 1) to facilitate care for beneficiaries diagnosed with, or suspected of having, COVID-19.

In its approval letter, CMS stated that: "The demonstration amendment is likely to assist in promoting the objectives of the Medicaid statute because it is expected to help the state furnish medical assistance in a manner intended to protect, to the greatest extent possible, the health, safety, and welfare of the individuals who may be affected by COVID-19."

Independent Evaluation

As a condition of approval, states must agree to monitor and evaluate Section 1115 demonstrations in accordance with CMS guidelines. The OHCA has retained an independent evaluator, Pacific Health Policy Group (PHPG) to conduct the evaluation. PHPG serves as the independent evaluator for all Section 1115 demonstrations in the state.

In its approval letter, CMS directed the OHCA, in its evaluation, to test whether and how the approved authorities facilitated the state's response to the COVID-19 PHE, and helped promote the objectives of Medicaid. CMS further stipulated that the evaluation should include thoughtful evaluation questions that support understanding the successes and challenges in implementing the expenditure authority.

B. EVALUATION DESIGN

The COVID-19 PHE evaluation will use a mixed methods (quantitative and qualitative) analysis to document lessons learned from the state's implementation of the waiver authority and to measure the impact of the cost sharing exemption on beneficiary access to care.

Evaluation Questions

The evaluation will examine waiver implementation and the hypothesis that it facilitated access to care by exploring the following questions:

1. What are the lessons learned from the OHCA's implementation of cost sharing exemptions?
    a. How did the OHCA inform current and potential beneficiaries of the exemption?
    b. How did the OHCA inform providers of the exemption and ensure that providers did not continue to impose point-of-service cost sharing?
    c. How did the OHCA monitor provider compliance with the cost sharing exemption and ensure reconciliation of any inappropriate copay collections?
    d. What operational challenges did the OHCA encounter during implementation?
    e. How were these challenges overcome?

2. What impact did the suspension of point-of-service cost sharing have on COVID-19 related service utilization?

3. What impact did the suspension of premiums for demonstration populations 12 - 16 have on beneficiary enrollment?

Data Sources

The data sources for research question one will be qualitative. They will include interviews with OHCA managers and staff responsible for implementation of the cost sharing exemption, supplemented by policies/procedures and other internal documents related to implementation. The evaluation also will review communications to beneficiaries and providers regarding the policy change.

The data sources for research questions two and three will be quantitative. Research question two (impact on utilization) will be evaluated through a simple pre/post analysis of paid claims carrying a COVID-19 diagnosis. The data will be segregated into two time periods, based on date of service: pre-suspension of cost sharing (January 1, 2020 to March 15, 2020) and post-suspension (March 16, 2020 and later). Subject to volume, the claims data also may be stratified by category-of-service.

The OHCA's evaluator (PHPG) has been granted access to the state's MMIS, including paid claims and enrollment file subsystems. PHPG will create a paid claims extract for the analysis period.

Research question three will be evaluated through analysis of monthly new enrollment counts within demonstration populations 12 – 16. The data again will be segregated into two time periods, to facilitate a pre/post methodology. However, the post-implementation period will be truncated, ending in April, 2021. (The OHCA ceased new enrollments into the MEGs prior to the transition of these beneficiaries into the new Medicaid expansion MEG. (The expansion MEG does not have a premium requirement.)

Analysis Methods

Stakeholder interviews will be conducted using a structured format. The interviews will be summarized and reviewed for accuracy with participants.

The interviews will be used to document the implementation process and its challenges, and to explore how these challenges were overcome. Lessons learned and recommendations for responding effectively to future public health emergencies also will be documented.

Agency internal documents and communications with beneficiaries and providers will be examined prior to the interviews. The materials will used to inform the content of the interview guides and the interviews themselves.

The quantitative analysis will be performed using a simple pre/post methodology, with March 16, 2020 (cost sharing exemption effective date) serving as the inflection point. For research question 2, per beneficiary utilization will be trended in aggregate on a monthly and quarterly basis, as well as by category-of-service (subject to claims volume). Subject to volume, utilization also will be stratified by age cohort and gender, to identify differences, if any, between younger and older adults, and between male and female beneficiaries.

For research question 3, new enrollments will be trended on a monthly and quarterly basis. The analysis will be stratified by demonstration population, to identify differences, if any, between the various MEGs.

T-tests will be used to identify statistically significant differences in pre/post utilization. The traditionally accepted significance level ($p \leq 0.05$) will be used for all comparisons.

The adult cost sharing exemption was implemented statewide, which rules out the opportunity to conduct a population-based comparison group analysis. However, services lacking a COVID-19 diagnosis were not exempted from cost sharing. Exempt and non-exempt utilization will be trended and compared as a point of reference.

Beneficiaries under age 21 have never been subject to a cost sharing requirement. While not a true comparison group, their service utilization (COVID-19 diagnosis related) also will be trended and compared to their adult counterparts as another point of reference.

Exhibit B-1 below summarizes the evaluation design, including research questions, measures, data sources and analysis methods.

Exhibit B-1 – Evaluation Design Summary

Research Question	Measure	Data Source	Analysis Method
What are the lessons learned from implementation of the cost share exemption?	Stakeholder experience	OHCA stakeholders and related documents	Structured interviews and document review
What impact did the suspension of point-of-service cost sharing have on COVID-19 related service utilization?	Monthly utilization per beneficiary by category-of-service	OHCA MMIS paid claims data	Comparison of pre/post implementation periods, stratified by age and gender T-test
What impact did the suspension of premiums for demonstration populations 12 - 16 have on beneficiary enrollment?	Monthly new enrollments	OHCA enrollment file	Comparison of pre/post implementation periods, stratified by MEG T-test

Methodological Limitations

The response to the COVID-19 PHE encompassed multiple, concurrent policy changes at the federal and state levels. These changes, which were intended to facilitate access to services, included suspension of certain prior authorization requirements and expanded use of telehealth, among others. It will not be possible to control for the effects of these policy changes when quantifying the impact of the cost sharing exemption.

During the height of the pandemic, PHPG surveyed SoonerCare beneficiaries with chronic/complex health conditions enrolled in one of the OHCA's care management programs. The surveys inquired about whether beneficiaries were experiencing disruptions to their routine care. Approximately 25 percent of respondents reported experiencing delayed or missed primary or specialty care visits. This was due to a combination of provider-initiated cancellations and beneficiary cancellations over fear of exposure to the virus. It will not be possible to control for the effect of this care disruption when evaluating service utilization trends pre/post suspension of cost sharing.

The cost sharing exemption applied to all adults statewide, making it infeasible to evaluate the impact of the exemption against a true comparison group. The evaluation lacks a true comparison group, which limits the potential for quantifying the impact of the cost sharing exemption. The analysis will examine adult services subject to cost sharing and child/adolescent services (COVID-19 related), but only to serve as reference points in the pre/post evaluation. (Child/adolescent cases also may be limited due to the virus' prevalence among older adults.)

Both the pre and post implementation time periods for the evaluation are relatively short, particularly the pre-implementation period, which limits the available data for the analysis. This is an unavoidable artifact of the speed with which the pandemic emerged and the rapidity with which both the state and federal governments responded.

C. REPORTING OF FINDINGS

The COVID-19 PHE demonstration amendment authority runs from March 1, 2020 to September 30, 2024. In accordance with demonstration approval special terms and conditions, the OHCA will submit a draft final evaluation report no later than one year after the end of the amendment approval period.

The final report will consolidate the monitoring and evaluation reporting requirements for the demonstration. The evaluation will describe the methodology, methodological limitations, findings and implications for states responding to future public health emergencies.