OKLAHOMA
Health Care Authority

SoonerCare 2.0
Healthy Adult Opportunity (HAO)
Section 1115 Demonstration Application

Healthy Adult Opportunity (HAO) Section 1115 Demonstration Application Guidance & Template

This guidance and template provides a mechanism for states to apply to the Centers for Medicare & Medicaid Services (CMS) for a Healthy Adult Opportunity (HAO) demonstration under section 1115 of the Social Security Act (the Act),[1] as further described in the January 30, 2020 release of State Medicaid Director Letter (SMDL) #20-001, entitled, "Healthy Adult Opportunity (HAO)." This application template may be used by states applying to use either an aggregate or a per capita cap financing model for certain populations, consistent with the SMDL guidance.

Submission of the information provided in this template and any attachments does not guarantee approval of a state's demonstration request, and failure to complete or agree to all elements of this template and any attachments does not guarantee disapproval of a state's demonstration request. CMS will work with states to identify any additional information necessary to consider demonstration requests. Use of this guidance and template is not required; it is a tool that states can use at their option. The guidance and template were designed to help states ensure the application contains the required elements for section 1115 demonstrations, as provided for under 42 CFR part 431 subpart G, and in particular the application procedures at 42 CFR 431.412(a), as well as to promote an efficient review process.

Submission of Application

When the state completes its application and fulfills its public transparency requirements, the state should submit its application electronically to 1115DemoRequests@cms.hhs.gov and to:

Judith Cash, Director
Centers for Medicare & Medicaid Services
State Demonstration Group
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244

Structure and Content of Application

The framework for this application guidance and template is designed to facilitate the state's application development by identifying the type of information, through a series of questions and checklists, CMS will consider for state application requests for a Healthy Adult Opportunity (HAO) demonstration. To facilitate CMS review of HAO demonstration applications, states using this application template should complete each section by providing the information requested in the text boxes as instructed in each section. The state may also provide additional information as attachments to the application template.

At the end of this application template, CMS provides in an informational appendix a list of general oversight, budget neutrality, monitoring and evaluation reporting requirements that

[1] All references to statutory sections made in this document are references to the Social Security Act, unless otherwise stated. Similarly, all references to regulations made in this document are references to regulations in title 42 of the Code of Federal Regulations (CFR), unless otherwise stated.

would apply to demonstrations approved under this HAO demonstration initiative consistent with regulations at 42 CFR 431.420 and 431.428.

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Section I -- Demonstration Overview

A. Project Description – In the box below, describe the feature(s) of the states' current Medicaid program for which it is proposing to test an alternative approach or range of approaches in the administration and design of the program. Describe the core features and components of the flexibilities the state is proposing to test under this HAO demonstration to address the challenges with the state's current program administration and design that cannot be achieved or has been difficult to achieve through regular Medicaid state plan or other federal authorities. Include planned dates for implementing the demonstration, and the anticipated impact the demonstration will have on targeted beneficiaries, providers, contractors, and other stakeholders in the state.

The Oklahoma Health Care Authority (OHCA) is the state's single state Medicaid agency. OHCA operates the SoonerCare Choice and Insure Oklahoma programs under 1115(a) demonstration authorities. Oklahoma's SoonerCare Choice program offers a managed care delivery system of enhanced primary care case management to qualified populations statewide. Insure Oklahoma provides premium assistance to small business employees and individuals. The current demonstration is approved for the period of August 31, 2018 through December 31, 2023.

Since the inception of the SoonerCare demonstration, the OHCA has implemented several programs and strategies that reflect the goals and objectives of the state to improve health outcomes for Oklahomans through the demonstration. While the SoonerCare program and the state have successfully improved some health outcomes, we

still face substantial health challenges. With a rank of 46th in the nation according to the 2019 America's Health Rankings report[2], there is still work to be done.

Based on the commitment of the state's leadership to invest in and improve upon health care and health outcomes for Oklahomans, the state continues to pursue innovative approaches. In 2017, a work group was established to assess the most effective way to engage individuals receiving public assistance in the state to develop the skills needed for long-term independence, success, better health, and well-being. The work group found that encouraging job seeking, employment, and participation in and completion of skills/training/education programs, Oklahoma could impact employment rates and improve health outcomes simultaneously.

As a result of the work group's findings, on March 5, 2018, the governor of Oklahoma signed Executive Order 2018-05, directing the OHCA to apply for waiver and state plan amendments that would allow the state to implement community engagement and work requirements in the state Medicaid program. In addition to the executive order, HB 2932 was passed by the State Legislature in the Oklahoma 56th Second Legislature Session and was signed into law on May 7, 2018. HB 2932 directed OHCA to pursue modifications to SoonerCare eligibility criteria to reflect that receipt of SoonerCare coverage for certain SoonerCare populations is conditional upon documentation of education, skills training, work, or job seeking activities. OHCA submitted its SoonerCare waiver amendment request to CMS on December 7, 2018.

Since his inauguration in 2019, Governor J. Kevin Stitt has continued to focus on improving the health and well-being of state residents. Working in close collaboration with CMS, the governor has continued to advocate for expanded flexibility to use Oklahoma-specific policies to address Oklahoma-specific challenges and preferences. The Healthy Adult Opportunity demonstration gives Oklahoma the flexibility it needs to explore strategies to engage a new group of health care consumers in a way that will align incentives and promote individual, family, and community health in a sustainable and fiscally-responsible way.

Some of the key policies Oklahoma will pursue as a part of its SoonerCare 2.0 HAO demonstration (SoonerCare 2.0) include:

- ✓ Introduce private insurance concepts like **premiums** and **commercial-like benefit packages** to prepare members to move off Medicaid and into private coverage.
- ✓ Incentivize members to access services when and where appropriate and disincentivize inappropriate use of the emergency room with an **$8 copay for non-emergency use of the ER.**
- ✓ Encourage individuals to address additional facets of their health by requiring participation in activities that are positively correlated with good health, including **work, volunteering, and educational activities.**
- ✓ Encourage individuals to obtain and maintain health coverage before they are sick by **eliminating retroactive coverage.**

[2] 2019 America's Health Rankings report

- ✓ Leverage **care coordination and managed care strategies** to improve health outcomes and member satisfaction through better coordinated services.
- ✓ Ensure appropriate coverage for eligible individuals by **eliminating hospital presumptive eligibility.**

SoonerCare 2.0 has been designed to meet some of the most pressing needs for Oklahomans, incorporating past successes and challenges, the experiences of other states, and the expertise and technical assistance of CMS. The flexibilities requested in this demonstration will improve health care access, affordability, and quality across the state as well as contain costs within the SoonerCare program. SoonerCare 2.0 will provide a responsible expansion that will reduce the number of uninsured state residents and give them the resources they need to improve and maintain aspects of their wellness—physical, emotional, social, intellectual, financial, and environmental. The demonstration policies will also encourage greater Medicaid agency and member engagement with providers, contractors, and community stakeholders.

Oklahoma is requesting approval for a five-year demonstration, effective no sooner than July 1, 2021.

B. Project Goals and Objectives – In the box below, describe the state's program goals for this demonstration and how each of the proposed demonstration flexibilities outlined in section I.A above and the anticipated program outcomes have been designed to promote the objectives of the Medicaid program. Please note that in section X of this application guidance, the state is requested to detail the specific research hypotheses that the state is proposing to evaluate for each program component being tested under the demonstration.

If the state is proposing a range of policy options or approaches that it may elect to implement over the course of the approved demonstration period, it should also describe the range of proposed policy options or approaches below. For example, a state may want to include minimum and maximum premium and other cost sharing charges that may be imposed under the demonstration, as well as the initial premiums and cost sharing to be imposed; propose several EHB-benchmark plans it may adopt at a later date; or propose optional benefits it may eliminate upon implementation or at a later date. This would enable the state to titrate the amount of premiums or cost sharing charged, or benefits covered, over the course of the demonstration period more easily. The description should include how the range of policy options or approaches align with the state's intended program goals and objectives for this demonstration.

Oklahoma has a long history of working closely with CMS to develop innovative solutions to unique health challenges. SoonerCare 2.0 furthers those efforts, requesting new flexibilities that will help improve our system of care and align incentives to promote efficient, coordinated, quality health care that drives better health outcomes for Oklahomans.

GOAL 1. Improve access to high-quality, person-centered services that produce positive health outcomes for individuals

As a part of SoonerCare 2.0, the OHCA will expand its current Patient Centered Medical Home delivery system to include SoonerCare 2.0 members. The goals of this delivery system model include:

1. Improving health outcomes by rewarding high quality care;
2. Focusing on quality improvement in specific population health goals;
3. Integrating physical and behavioral healthcare and increase care coordination;
4. Better coordinating care for Medicaid members using modern technology and methods;
5. Contracting with a network of health care providers with a strong emphasis on health outcomes and value based compensation; and
6. Containing program and incentivizing quality by leveraging new payment methodologies.

OHCA anticipates that this transition will encourage members to increase utilization of preventive, primary, urgent, and specialty care—accessing the appropriate type of care in the appropriate setting and decreasing reliance on emergency departments for services that would be better-provided in lower levels of care settings.

OHCA also anticipates that greater care coordination will mean more timely access to care and a better consumer experience.

GOAL 2. Strengthen beneficiary engagement in their personal health care plan, including incentive structures that promote responsible decision-making

One of the most effective ways to encourage preferred behaviors and discourage non-preferred behaviors is to tie those behaviors to a financial incentive. In addition to the established copayments charged in accordance with the Oklahoma state plan, SoonerCare 2.0 members will also be subject to an $8 copay for non-emergency use of the emergency department (ED).

OHCA wants EDs to be available for individuals who need them, so the Agency will test whether the $8 copay reduces inappropriate use of the ED. To further help members understand appropriate and inappropriate use of the ED, OHCA will ensure that its managed care delivery system fosters members who are more informed regarding health care, and who are empowered to make informed decisions about their care. OHCA will also encourage providers and community partners to work with members to identify and use appropriate levels of care based on their individual health needs.

GOAL 3. Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition

OHCA believes that Medicaid has an obligation to promote member health—while they are in the program and after. OHCA views Medicaid as a temporary solution for many of our residents and believe that, by preparing them for commercial coverage, the Agency is helping to not only give members coverage in their moment of need but set them up for success on private policies later.

OHCA has found that many members transitioning from public to private coverage are confused by the start dates. To help align with private coverage policies, OHCA is asking for the flexibility to eliminate the retroactive coverage period for SoonerCare 2.0 members. Instead, OHCA will have coverage start after members with a premium obligation pay that premium, aligning coverage start dates with policies for the health insurance marketplace.

We also want to help members prepare for regular premium payments by requiring non-exempt individuals with household income over the parent/caretaker income standard to pay a nominal monthly fee, which will initiate and maintain their coverage.

In addition, OHCA wants SoonerCare 2.0 members to experience a more commercial-like benefit package. The State will do that by eliminating certain optional benefits including:

- Non-emergency medical transportation benefit for most individuals. Members who have a demonstrated need for the service in accordance with their care coordination assessment and care plan will have access to the service through managed care.
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits.

GOAL 4. Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals

In addition to preparing SoonerCare 2.0 members for commercial health insurance coverage to ensure long-term access to coverage, OHCA also promotes a broader concept of individual wellness by encouraging personal and professional development with the implementation of community engagement requirements. Numerous studies have highlighted the connection between education, training, economic stability, and positive health outcomes. With the SoonerCare 2.0 flexibilities, OHCA plans to collaborate with other state agencies, providers, and stakeholders to develop opportunities for community and economic development that benefit both the individual member and the broader community.

GOAL 5. Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term

OHCA is dedicated to ensuring the integrity of the Medicaid program by verifying that only eligible individuals are receiving coverage. To date, no hospitals in Oklahoma have opted to operate a hospital presumptive eligibility program, despite the training and certification opportunities OHCA has made available. The Agency relies on partners receiving the necessary and appropriate training to ensure accurate and reliable application and processing and eligibility determinations.

Oklahoma will continue to use the Notification of Date of Service (NODOS) process for hospitals. Hospitals have the option to file a notice with OHCA within five days of an individual seeking treatment at the hospital. This notice effectively saves the eligibility date for the client. Subsequently, the hospital, client, or someone acting on behalf of the client has 15 days from the date of the NODOS form to submit a completed SoonerCare application. If the individual is determined to be eligible, the hospital is reimbursed for the stay. NODOS does not guarantee coverage and if a completed application is not submitted within 15 days, the NODOS is void.

By eliminating the hospital presumptive eligibility process, SoonerCare 2.0 can ensure the accuracy and appropriateness of our eligibility determinations and promote the integrity of the program and ensure that all covered members have been verified to meet the eligibility criteria.

C. Modification to Medicaid State Plan – In the box below, describe any other state plan program features that the demonstration would modify to permit the state to implement the demonstration flexibilities described in application section I.A. as well as any corresponding state plan amendments the state will need to effectuate these state plan program changes.

N/A

D. Modification to Existing Section 1115 Demonstration – In the box below, identify by project name and number any existing section 1115 demonstration the state proposes to transition, in whole or in part, into the proposed HAO demonstration. Describe the existing section 1115 demonstration feature(s) that the proposed HAO demonstration would modify, including identifying the individuals who would be eligible for coverage under the proposed HAO demonstration who are already eligible for coverage under the existing demonstration(s). Describe whether and how the state proposes to modify or terminate current section 1115 demonstrations should this application for a HAO demonstration be approved.

The state may also include, as an attachment to this application, its proposed transition and orderly close-out plan for current section 1115 demonstrations, if applicable. If providing an attachment, the state should identify the attachment in the box below.

N/A. Current SoonerCare (Project # 11-W-00048/6) members will transition to the state plan expansion by the end of 2020—before the anticipated effective date of this demonstration.

Section II -- Eligible Populations and Processes for Eligibility and Enrollment

This demonstration opportunity is available to all states as a mechanism to provide maximum flexibility for covering adults under age 65 who qualify for Medicaid on a basis other than disability or need for long term care services and supports and who are not covered under the Medicaid state plan, including covering all individuals described in the new adult group at section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119 (the new adult group). This demonstration opportunity can also be used to extend coverage to adult populations the state has previously covered in its Medicaid state plan or under other section 1115 demonstrations, but for whom the state has elected to end coverage.

A. Targeted Population(s) – The state should identify below the population(s) it intends to cover under this demonstration and any additional factors of eligibility it intends to apply under the proposed HAO demonstration:

☒	State will cover all adults under age 65 who qualify for Medicaid on a basis other than disability or need for long-term care services and supports and who are not covered in the state plan, including individuals described in the new adult group at section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119, and who have income at or below: ☒ 133 percent Federal Poverty Level (FPL) ☐ Other income standard: [*insert FPL level*] percent FPL

In the box below, describe in detail any additional factors of eligibility that would apply to the above population (e.g., premiums). If the state is proposing a range of options for implementing additional factors of eligibility over the course of the approved demonstration period, also describe the range of options in the box below. The description should identify the approach that the state proposes to elect at initial implementation of the HAO demonstration and then list the range of potential changes to implementation that the state may elect to impose under the demonstration later.

Oklahoma requests approval for two additional factors of eligibility intended to encourage member investment in his or her health care and long-term wellness: a monthly premium and a community engagement requirement.

1. Required contributions (premiums)

SoonerCare 2.0 is intended to be a temporary stepping-stone for many low-income adults, encouraging individuals to learn about and access local resources as they move from dependence on public assistance to independence. Therefore, as a condition of eligibility, SoonerCare members will be required to make sliding scale flat rate monthly premium payments. These premium payments are critical to member engagement, as studies have shown that making regular monthly premiums may lead to better health outcomes for members. For example, in Indiana, where Medicaid eligible adults are required to pay monthly premiums, members making contributions had higher satisfaction rates, higher primary and preventative care utilization, higher prescribed drug adherence, and lower emergency room use than those who did not. (The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016))

SoonerCare 2.0 will strive for similar results by instituting premiums that are affordable, costing members less than 2% of household income. Individuals determined eligible for SoonerCare 2.0 will be charged a premium based on their household income and the number of people in the household participating in the demonstration.

There will be three income tiers to determine household premiums:

- **Tier 1:** 0% FPL up to and including the Parent/Caretaker income standard (see Table II.A.1)
- **Tier 2:** >Parent/Caretaker income standard-100% FPL
- **Tier 3:** >100% FPL-133% FPL (+ 5% income disregard)

Table II.A.1. Parent/Caretaker income standard

Household Size	Monthly Income	Annual Income
1	$407	$4,884
2	$521	$6,252
3	$668	$8,016
4	$820	$9,840
5	$958	$11,496
6	$1,098	$13,176
7	$1,236	$14,832

8	$1,364	$16,368
9	$1,486	$17,832

Premiums will also vary based on the number of people in the household in SoonerCare 2.0, with single and family rates, reflected in Table II.A.2.

- **Single:** Only one adult in the household qualifies for and is enrolled in SoonerCare 2.0
- **Family:** Two or more adults in the household qualify for and are enrolled in SoonerCare 2.0

Table II.A.2. Monthly premium amounts, by tier and household composition

Household Size	Single	Family
Tier 1	$0	$0
Tier 2	$5	$7.50
Tier 3	$10	$15

Consistent with the goal of encouraging engagement with the community, the state will permit third parties to pay required premium payments on behalf of a member. Non-profit organizations, provider groups, and other third parties may assist members in their monthly premium responsibilities.

1.1 Paying premiums and starting coverage

Individuals with a premium obligation must pay their premium to initiate their coverage. Once applicants have been determined eligible for SoonerCare 2.0, they will have the opportunity to select their provider and pay their premium to start their coverage.

- Individuals who **do not have a premium** obligation will have their coverage begin according to the approval date of their application. The state currently conducts real-time eligibility determinations. Therefore, this policy will not delay enrollment but will encourage greater alignment with commercial insurance policies. Once the application is approved, an individual will have the opportunity to choose a primary care provider and will have immediate access to covered services.
- Individuals **with a premium** obligation will have their coverage start based on when they pay their first premium, aligning with the health insurance marketplace. Coverage will begin immediately after the first premium payment occurs. At that time, the individual will have the opportunity to choose a primary care provider and will have immediate access to covered services.

1.2 Non-payment penalties

To educate SoonerCare 2.0 members about commercial health insurance policies, OHCA has designed payment and non-payment policies to educate and prepare members for private health insurance coverage. Mirroring policies in the commercial health insurance market, individuals with a premium obligation will be required to pay that premium to initiate coverage and remain enrolled.

Upon initial enrollment, individuals with a premium obligation will have up to three months to make the initial premium. The sooner they make their first payment, the sooner their coverage will start. If they do not make the first payment by the end of the three-month period, they will be considered ineligible for coverage and their application will be denied. They will have the option to re-apply at any time after their application is denied for non-payment.

Individuals that have paid the initial premium and have effective coverage will need to continue making payments to retain their coverage. Like the health insurance marketplace, individuals who do not pay the premium will have a three-month grace period to catch up on unpaid premiums. If they do not pay the required premium(s) within that time, OHCA will process eligibility to determine if the member qualifies for any other eligibility category. If not, the individual will be notified, in alignment with federal requirements, and enrollment will be terminated.

1.3 Regaining coverage after disenrollment for non-payment

Individuals who lose their coverage for non-payment may re-apply for coverage at any time. They will not be required to re-pay their unpaid premiums as a condition of eligibility.

1.4 Premium exemptions

Some SoonerCare 2.0 members will be exempt from premium payments, regardless of their household income. Individuals diagnosed with HIV/AIDS, a substance use disorder (SUD), or serious mental illness (SMI) will be exempt from premium payments under this demonstration. They will, however, be responsible for paying copayments for their services, as described in the state plan.

Incarcerated individuals receiving inpatient hospital services, members that become pregnant, and AI/AN members will be exempt from premium payments and additional cost sharing.

When one individual in the household is exempt from premiums, the entire household will be exempt.

1.5 Modifying premiums over time

OHCA will evaluate the impact of premiums on enrollment and behaviors and requests the flexibility to adjust premiums in later years based on the results of those evaluations. OHCA requests the flexibility to adjust premiums as high as 5% of the individual's household income, consistent with federal out-of-pocket cost limitations. Individuals meeting the 5% cost sharing limitation through premium payments would not be subject to any additional cost sharing (i.e. copayments).

OHCA may also temporarily reduce or pause premium policies in response to unforeseen and acute challenges, such as natural disasters. The State requests the flexibility to apply these changes regionally or for specific population groups as necessary and appropriate to meet the challenge. The State will comply with all

public notice requirements in advance of implementing any premium policy modifications.

1.6 Other cost sharing requirements

All households will be responsible for paying copayments for their services up to the 5% out-of-pocket household maximum. This means households in Tier 1 that have no premium obligation and individuals with diagnosed HIV/AIDS, SUD, and SMI that are exempt from a premium requirement may have out-of-pocket costs at the point of service.

2. Community Engagement and work requirements

SoonerCare 2.0 is designed to support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals. One such strategy is to make community engagement (CE) a component of eligibility. To remain eligible for SoonerCare benefits:

- Non-exempt members transitioning from other Medicaid coverage or new applicants age 19 through 60 will be required to provide verification of participation in at least an average of 80 hours per month of approved CE activities.
- Non-exempt individuals will have a 90-day grace period from the time of SoonerCare 2.0 application [for newly eligible individuals] or transition [for existing Medicaid members], to verify compliance with CE requirements. Verification of compliance may be documented or provided to OHCA through various methods.
- Individuals who have recently been released from incarceration (defined as anyone who has been sentenced by a court for prison or jail time) within the last six months prior to application date will have a nine-month grace period to comply with CE reporting.

The OHCA will provide reasonable accommodations for members or applicants with disabilities protected by the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act and Section 1557 of the Patient Protection and the Affordable Care Act, who are unable to report or have difficulty reporting CE activities. Members or applicants who are classified under one of the above protections will have an opportunity to participate in and report their CE activities through the reasonable accommodations.

2.1 Qualifying Activities

In order to meet conditions of CE activity requirements for SoonerCare eligibility, non-exempt transitioning members or new applicants must comply with at least one or a combination of the following CE activities for an average of 80 hours per month, or the phased-in hours per week as detailed in Table II.A.3. The employment may be paid, in-kind, unpaid, or volunteer work. In addition to paid, in-kind, and unpaid work, members and new applicants also meet the CE requirements by participating in:

1. All state-run Workforce Innovation and Opportunity Act (WIOA) programs;

2. Complying with a work registration requirement under the Federal-State unemployment compensation system;
3. Attendance at least part-time in any school, General Education Development/Diploma (GED) education and certification class, vocational education or training program, or institution of higher education; and/or
4. Volunteer work activities (e.g., classroom volunteer, faith-based or community service programs).

2.2 Hour requirements and reporting Community Engagement activities

In general, non-exempt SoonerCare 2.0 members will be responsible for completing and reporting at least 80 hours of qualifying CE activities each month to remain eligible for SoonerCare 2.0 benefits. The OHCA recognizes that there may be challenges to comply with the CE requirements; therefore, the OHCA will employ a phased-in approach for transitioning Medicaid members and new applicants who do not meet the CE required hours per week/month. Transitioning members or new applicants may gradually meet the required hours per week/month, detailed in Table II.A.3.

Table II.A.3. Phasing in Community Engagement activities over the first year of enrollment

Hourly Requirement Phase-in of the Community Engagement Initiative	**Required Participation Hours**
0-3 months (grace period)	No verification needed
4-6 months	Verify at least 10 hours per week
7-9 months	Verify at least 15 hours per week
10-12 months	Verify at least 20 hours per week
13 months - ongoing	Verify at least 80 hours per month

OHCA recognizes that members released from city, state, or federal incarceration within six months preceding their application date may face additional challenges to complete the CE requirement, so they will have a slightly modified phase-in period, detailed in Table II.A.4.

Table II.A.4 Phasing in Community Engagement activities for those recently released from incarceration

Hourly Requirement Phase-in of the Community Engagement Initiative	**Required Participation Hours**
1-9 months	No verification needed
10-12 months	Verify at least 10 hours per week
13-15 months	Verify at least 15 hours per week
16-18 months	Verify at least 20 hours per week
19 months – ongoing	Verify at least 80 hours per month

OHCA will notify all non-exempt SoonerCare 2.0 members of the CE requirement. Notices will be compliant with state and federal requirements.

The OHCA will initially access various partner database resources to verify employment, training, or job search activities. Sources include, but are not limited to, the Oklahoma Employment Security Commission and Oklahoma Works.

1. If OHCA can verify CE activities through data resources, the member or applicant will not be required to report CE activities.
2. If the OHCA is unable to verify compliance with CE activities through data resources, the applicant or existing member will be notified of the requirements at application and via correspondence. Such notification may be provided via mail or e-mail based on their preferred notification option. Members must report their CE activities on a monthly basis unless they meet an exemption.
3. Transitioning members may report employment or CE verification activities through their MySoonerCare.org member account. If the member is unable to access MySoonerCare.org or needs assistance, they may contact the SoonerCare Helpline or mail in documentation to OHCA.
4. Volunteer hours must be documented on the OHCA form and signed by a representative of the organization where the service was provided.

The OHCA has developed CE forms that members or applicants will use to report CE activities or apply for exemptions. The forms will be available to upload directly through the member's MySoonerCare account, through a partner agency, or send by mail. Refer to Attachment A for sample exemption and activity reporting forms.

2.3 Non-compliance with the Community Engagement requirement

Members who do not meet any of the exemptions listed in Section II.A.2.5 or have a good cause exemption described in Section II.A.2.6 will have eligibility terminated in accordance with current termination and notification policies. Non-exempt SoonerCare 2.0 members who fail to comply with the CE reporting requirement will have eligibility terminated effective the first day of the month following the month in which the state determined the member was non-compliant with the number of community engagement hours required in Table II.A.3 unless an appeal is timely filed or the member requests good cause.

2.4 Re-enrolling after CE non-compliance

Individuals that lose eligibility for non-compliance with the CE requirements may re-apply for SoonerCare 2.0 benefits under the following conditions:

1. If the member complies with CE activities for at least the specified number of hours in Table II.A.3 in a 30-day period;
2. If the member participates in and complies with the requirements of a program under section 2029 of title 7 U.S.C. 2015 or a comparable program established by a state or political subdivision of a state;
3. If the member meets an exemption status in Section II.A.2.5, their eligibility will begin in the current month when the state received notification of the exemption; or
4. If the member becomes pregnant, eligibility could be retroactive to a prior month per established state policy.

2.5 Community Engagement exemptions

Members or new applicants meeting and reporting one or more of the following exemptions to OHCA will not be required to complete CE related activities during any month(s) in which the exemption applies to maintain continued eligibility.

1. Adults over 60 years of age;
2. Individuals who are pregnant;
3. Individuals who are medically certified as physically or mentally unfit for employment;
4. A parent or caretaker responsible for the care of a dependent child under the age of 6;
5. A parent or caretaker personally responsible for the care of an incapacitated person (as attested to by a Medical or Mental health provider);
6. A person currently subject to and complying with Temporary Assistance for Needy Families (TANF) or SNAP work registration requirements;
7. Individuals participating in a drug addiction or alcohol treatment and rehabilitation program;
8. Individuals diagnosed with a serious mental illness and actively receiving behavioral health treatment services;
9. Students enrolled at least part time in any recognized (to be determined in rulemaking) school, training program, or institution of higher education;
10. Persons currently subject to and complying with a work registration requirement under title IV of the Social Security Act, as amended (42 U.S.C. 602) or federal-state unemployment compensation system;
11. Persons with a disability under the definitions of the Americans with Disabilities Act and Section 504 of the Rehabilitation Act of 1973, or Section 1557 of Affordable Care Act; however, these members will have the opportunity for voluntary reporting if that is their preference
12. American Indians and Alaska Natives (AI/AN).

2.6 Community Engagement Good Cause exemptions

The State will not consider a member to be non-compliant with the community engagement requirements for a given month if the member demonstrates good cause for failing to meet the community engagement hours required for that month. The circumstances constituting good cause must have occurred during the month for which the member is seeking a good cause exception. The recognized good cause exceptions include, but are not limited to, at a minimum, the following verified circumstances:

1. The member has a disability as defined by the ADA, section 504 of the Rehabilitation Act, or section 1557 of the Patient Protection and Affordable Care Act and was unable to meet the requirement for reasons related to that disability; or has a family member in the home with a disability under federal disability rights laws and was unable to meet the requirement for reasons related to the disability of that family member; or the member or a family member who was living in the home with the member experiences a hospitalization or serious illness;
2. The member experiences the birth, or death, of a family member living with the member;

	3. The member experiences and/or was displaced by severe inclement weather (including a natural disaster) that renders him or her unable to meet the requirement; 4. The member has a family emergency or other life-changing event (e.g., divorce or domestic violence); or 5. The member is the primary caretaker of a child age 6 or older and was unable to meet the requirement due to childcare responsibilities. 2.7 Modifying Community Engagement requirements over time OHCA will evaluate the impact of community engagement on eligibility and enrollment and requests the flexibility to adjust the hour requirements or to modify the exemptions and qualifying activities in later years based on the results of those evaluations. Any future changes in community engagement requirements will not affect AI/AN members. OHCA may also temporarily reduce or pause community engagement policies in response to unforeseen and acute challenges, such as natural disasters or economic downturn. OHCA requests the flexibility to apply these changes regionally or for specific population groups as necessary and appropriate to meet the challenge and with advance public notice.
☐	State will cover targeted subgroup of adults under age 65 who qualify for Medicaid on a basis other than disability or need for long-term care services and supports and who are not covered in the state plan, including individuals described in the new adult group at section 1902(a)(10)(A)(i)(VIII) of the Act and 42 CFR 435.119, and who have income at or below [*insert FPL level*] percent FPL. Describe subgroup below:
	Below, describe in detail any additional factors of eligibility that would apply to the above population. If the state is proposing a range of options for implementing additional factors of eligibility over the course of the approved demonstration period, also describe the range of options in the box below. The description should identify the approach that the state proposes to elect at initial implementation of the HAO demonstration and then list the range of potential changes to implementation that the state may elect to impose under the demonstration at a later date.
☐	State will cover a different population, as described here:
	Below, describe in detail any additional factors of eligibility that would apply to the above population. If the state is proposing a range of options for implementing additional factors of eligibility over the course of the approved demonstration period, also describe the range of options in the box below. The description should identify the approach that the state proposes to elect at initial implementation of the HAO demonstration and then list the range of potential changes to implementation that the state may elect to impose under the demonstration at a later date.

B. Enrollment Processes – The state should identify below the approach it intends to take for processing member eligibility and enrollment under the HAO demonstration.

☒	State will follow its Medicaid state plan processes for eligibility and enrollment for this demonstration. Demonstration eligibility and enrollment processes will align with all requirements of section 1943 of the Act (as implemented in regulation at 42 CFR part 435 subpart J).
☐	State will follow requirements of section 1943 of the Act (as implemented in regulation at 42 CFR part 435 subpart J) for this demonstration EXCEPT as described below with the intended purpose of improving administrative efficiency of the state's eligibility and enrollment processes:
☐	Other: [*The state should insert here a description of any other proposed demonstration-specific eligibility and enrollment processes it seeks to implement as well as describe how these alternative eligibility and enrollment processes are necessary for the state to meet its intended program goals and objectives for this demonstration.]*

C. Enrollment Projections for Targeted Populations – For each category of member identified in application section II.A, the state should complete the below tables to provide an analysis of the expected impact of the proposed demonstration on total Medicaid enrollment; illustrating current trends in Medicaid enrollment without implementation of the proposed demonstration, projected demonstration enrollment, and an explanation and justification of the projected impacts of the HAO demonstration on total Medicaid enrollment.

All enrollment projections provided on tables 1 through 5 below should be reported in annual aggregate (i.e., total), unduplicated person counts.

C.1 – Total Medicaid Enrollment without the Proposed Demonstration

Table 1 – Historical/Current Total Enrollment Data – For each population that would be impacted by the proposed HAO demonstration, the state should report any applicable Medicaid enrollment data, or other relevant historical healthcare population data if there is insufficient historical Medicaid enrollment experience.

Targeted Population(s)	Historical Year (HY) 01 [7/1/2016-6/30/2017]	HY02 [7/1/2017-6/30/2018]	HY03 [7/1/2018-6/30/2019]	HY04 [7/1/2019-6/30/2020]	Current Year [7/1/2020-6/30/2021]
Expansion Adults 1902(a)(10)(A)(i)(VIII)	N/A	N/A	N/A	N/A	128,703

In this box, please specify the data source(s), methodology, and supporting analysis used, including an explanation of the assumptions used and any limitations on the data, as applicable, to derive the enrollment counts.

Since the expansion adult population is not a current Medicaid population in Oklahoma, OHCA is unable to provide historical enrollment data. Oklahoma has current programs that may indicate a potential portion of the new expansion adult populations but is not comprehensive and would likely only assist as an assumption of more accelerated take up rate once the program is live. One of those programs is a state fund only Mental Health and Substance Abuse program with an estimated 40,000+ Oklahomans less than 133% of FPL (+ 5% income disregard). The other program is Insure Oklahoma, a private-public partnership that assists individuals and small business access affordable health care. This program is approved in OHCAs current 1115 waiver and there are approximately 9,000 participants under 133% of FPL (+ 5% income disregard).

OHCA submitted a state plan amendment on March 6, 2020 to add adult ages 19-64 with income up to 133% of the FPL as a covered population effective July 1, 2020. According to 2017 American Community Survey (ACS) data, there are approximately 220,722 uninsured Oklahomans under 133% of FPL (+ 5% income disregard). This uninsured number is inclusive of populations other than adults ages 19-64. Other state experience also shows that there should be an expectation of a migration from the marketplace to Medicaid. If the state plan amendment is approved, OHCA will have data to support potential SoonerCare 2.0 program enrollment.

It is anticipated that enrollment under the SPA expansion will begin July 1, 2020. The current year estimate is therefore our estimate of the average projected enrollment across the year. The projection assumes 154,505 currently uninsured total potentially eligible Oklahomans, and take-up rate of 60% in the first year of the SPA expansion for this group, in addition to 36,000 Oklahomans shifting from private insurance to the Medicaid expansion.

Table 2 – Projected Total Medicaid Enrollment without the Proposed Demonstration – For each population that would be impacted by the proposed HAO demonstration, the state should report projected Medicaid enrollment assuming no HAO demonstration for each of the five years that the state expects to implement the HAO demonstration.

Targeted Population(s)	Y01 [7/1/2021-6/30/2022]	Y02 [7/1/2022-6/30/2023]	Y03 [7/1/2023-6/30/2024]	Y04 [7/1/2024-6/30/2025]	Y05 [7/1/2025-6/30/2026]
Expansion Adults 1902(a)(10)(A)(i)(VIII)	151,879	159,604	159,604	159,604	159,604

In this box, please specify the data source(s), methodology, and supporting analysis used, including an explanation of the assumptions used and any limitations on the data, as applicable, to derive the enrollment counts.

Table 2 – Projected Total Medicaid Enrollment <u>without</u> the Proposed Demonstration – For each population that would be impacted by the proposed HAO demonstration, the state should report projected Medicaid enrollment assuming no HAO demonstration for each of the five years that the state expects to implement the HAO demonstration.
The projection assumes 154,505 total currently uninsured potentially eligible Oklahomans, and take-up rate of 75% in the first year of the demonstration (the second year of expansion) and 80% in subsequent years, including 36,000 Oklahomans in each year who had previously had employer sponsored insurance. To note, this projection is based only on ACS data. Other state experience and OHCA is limited since there is no historical Oklahoma experience. This also makes no assumptions on economic outlook that could significantly impact enrollment for both the current and newly eligible populations. If the state plan is approved, OHCA will be able to use real experience to develop and refine current and future enrollment projections.

C.2 – Proposed Demonstration Program Enrollment

Table 3 – Projected Demonstration Enrollment – The state should report the projected number of individuals who are expected to be enrolled in the HAO demonstration.

This enrollment projection should reflect the total unduplicated number of individuals who would be eligible for the demonstration and reported below by each targeted population identified in section II above. This projection should not include any expected impact on member coverage from the application of any additional condition(s) of eligibility that the state has identified as a demonstration flexibility in sections II or IV.

Targeted Population(s)	**Demonstration Year (DY) 01**	**DY02**	**DY03**	**DY04**	**DY05**
Expansion Adults 1902(a)(10)(A)(i)(VIII)	144,285	151,624	151,624	151,624	151,624

In this box, please specify the data source(s), methodology, and supporting analysis used to develop these projections.

These projections are the same as the projections in Table 2, except reduced by 5% to take into account the effect of premiums and community engagement requirements.

Table 4A – Projected Number of Individuals Subject to Additional Condition(s) of Eligibility (if applicable) – If the state has identified an additional condition of eligibility as a demonstration flexibility in sections II or IV, the state should report the projected total number of unduplicated individuals, by each targeted population identified in section II above, who would be <u>subject to each identified</u> additional condition of eligibility. This projection should not include any expected impact on coverage from the application of the additional condition of eligibility.

Targeted Population(s) Subject to Additional Condition(s) of Eligibility	**DY01**	**DY02**	**DY03**	**DY04**	**DY05**
Expansion Adults 1902(a)(10)(A)(i)(VIII) – **Community Engagement**	84,524	88,823	88,823	88,823	88,823
Expansion Adults 1902(a)(10)(A)(i)(VIII) – **Premiums (Tier 1)**	0	0	0	0	0
Expansion Adults 1902(a)(10)(A)(i)(VIII) – **Premiums (Tier 2)**	48,601	51,073	51,073	51,073	51,073
Expansion Adults 1902(a)(10)(A)(i)(VIII) – **Premiums (Tier 3)**	32,806	34,475	34,475	34,475	34,475

Table 4A – Projected Number of Individuals Subject to Additional Condition(s) of Eligibility (if applicable) – If the state has identified an additional condition of eligibility as a demonstration flexibility in sections II or IV, the state should report the projected total number of unduplicated individuals, by each targeted population identified in section II above, who would be subject to each identified additional condition of eligibility. This projection should not include any expected impact on coverage from the application of the additional condition of eligibility.

Table 4B – Projected Number of Individuals Subject to an Exemption from Additional Condition(s) of Eligibility (if applicable) – If the state has completed Table 4A, also complete the below table with the projected number of individuals, by each targeted population identified in section II above, who would be exempt from each additional condition of eligibility listed in table 4A.

Targeted Population(s) Subject to Exemption from Additional Condition(s) of Eligibility	**DY01**	**DY02**	**DY03**	**DY04**	**DY05**
Expansion Adults 1902(a)(10)(A)(i)(VIII) – **Community Engagement**	67,355	70,781	70,781	70,781	70,781
Expansion Adults 1902(a)(10)(A)(i)(VIII) – **Premiums (Tier 1)**	50,120	52,669	52,669	52,669	52,669
Expansion Adults 1902(a)(10)(A)(i)(VIII) – **Premiums (Tier 2)**	12,150	12,768	12,768	12,768	12,768
Expansion Adults 1902(a)(10)(A)(i)(VIII) – **Premiums (Tier 3)**	8,201	8,619	8,619	8,619	8,619

In this box, please specify the data source(s), methodology, and supporting analysis used to develop the projections in tables 4A and 4B:

Projections are based on:

- Premium policy with exemptions, as described in Section II.A.
  - We assume ~33% of the enrollment will be in Tier 1 ($0 premium); 40% in Tier 2 ($5-$7.50 premium); and 27% in Tier 3 ($10-$15 premium)
- Community engagement policy with exemptions, as described in Section II.A

Projections above assume even distribution of members across age range. Therefore 70% of members will be subject to community engagement by virtue of age. The projections above further assume that 20% of the remaining members will be excluded by virtue of other exceptions (SUD/SMI, HIV, AI/AN, etc.).

Projections also assume that the projected number of individuals subject to additional conditions of eligibility (Table 4A) and exempt from additional conditions of eligibility (Table 4B) equal the "without waiver" total enrollment, as this would reflect the eligible population before the additional conditions of eligibility could impact enrollment or disenrollment. Totals may not sum due to rounding.

C.3 – Projected Total Medicaid Program Enrollment Assuming Impact of Proposed

Demonstration

Table 5 – Projected Impact of Demonstration on Total Medicaid Enrollment – The state should report overall Medicaid enrollment expected to occur over the same period that the HAO demonstration policies will be implemented. Enrollment projections should be reported in annual aggregate (i.e., total), unduplicated person counts, separately for each population whose coverage is likely to be impacted by the proposed HAO demonstration.

Targeted Population(s)	Y01	Y02	Y03	Y04	Y05
Expansion Adults 1902(a)(10)(A)(i)(VIII)	144,285	151,624	151,624	151,624	151,624
ABD	9,428	10,057	10,057	10,057	10,057
TANF	37,777	40,296	40,296	40,296	40,296
Other	2,456	2,620	2,620	2,620	2,620

In the box below, the state should specify the data source(s), methodology, and supporting analysis used to develop these projections. The state's descriptive analysis should identify how the projected overall impacts of the proposed HAO demonstration (including, but not limited to, the impact on coverage from the application of the demonstration flexibilities identified in sections II and IV) will affect total Medicaid enrollment. If the state's analysis indicates that the net effect of the proposed HAO demonstration is a decline in total Medicaid enrollment, the state should include an explanation of why the proposed demonstration would nonetheless be likely to promote the objectives of the Medicaid program.

Since the expansion adult population is not a current Medicaid population in Oklahoma, OHCA is unable to provide historical enrollment data. Oklahoma has current programs that may indicate a potential portion of the new expansion adult populations but is not comprehensive and would likely only assist as an assumption of more accelerated take up rate once the program is live. One of those programs is a state fund only Mental Health and Substance Abuse program with an estimated 40,000+ Oklahomans less than 133% of FPL (+ 5% income disregard). The other program is Insure Oklahoma, a private-public partnership that assists individuals and small business access affordable health care.

OHCA submitted a state plan amendment on March 6, 2020 to add adult ages 19-64 with income up to 133% of the FPL as a covered population effective July 1, 2020. The State used a combination of ACS data and privately insured data to estimate enrollment for Medicaid expansion beginning July 1, 2020. The 2017 ACS data indicated approximately 220,722 uninsured individuals below 133% of the FPL. Going further, it is recognized that many of these uninsured individuals are likely currently eligible but not enrolled. The State used a 70/30 distribution for newly eligible versus currently eligible. The State also estimated that there are an additional 172,000 privately insured individuals below 133% of FPL. A portion of these enrollees will transition from the current 1115 waiver program, Insure Oklahoma. Insure Oklahoma is a program assisting employees of small businesses, 19 to 64 years of age with either (1) a portion of their private health plan premiums (Employer Sponsored Insurance), or (2) the purchase of a state sponsored health plan operated under the state Medicaid program (Individual Plan). Current Insure Oklahoma program enrollees will transition either to the expansion population or the Marketplace.

It is anticipated that enrollment under the SPA expansion will begin July 1, 2020. The State recognizes that there will be a ramp up of participation; however, with the high rate of uninsured in Oklahoma, the public demand for expansion, the termination of Insure Oklahoma, and the limited benefit programs currently available, it is believed that enrollment will surge quickly. The projection assumes 154,505 currently uninsured total potentially eligible Oklahomans and a take-up rate of 60% in the SPA expansion for this group, in addition to 36,000 Oklahomans shifting from private insurance to the Medicaid expansion. The total estimated state plan expansion population enrollment in year 1 is 128,703. If continued with state plan expansion without the HAO demonstration, the State projects an additional 15% of uninsured individuals will enroll as newly eligible to increase enrollment to 151,879.

In July 2021, if approved, the state plan expansion population will transition to the HAO demonstration waiver. The demonstration proposes to introduce premiums and community engagement, which prior experience has shown to depress enrollment. Although it is difficult to predict, the State estimates an approximate 5% reduction of projected enrollment with demonstration from 151,879 to 144,285. In demonstration year 2 and beyond, an additional 5% uptake is expected. This assumed 5% reduction in participation is carried forward and the demonstration year 2 – 5 enrollment is projected to be 151,624. The State projects that after year 2 of the demonstration (year 3 of Medicaid expansion), enrollment will hold steady, assuming there is no unanticipated economic factor. There is a recognition that there may be a portion of the initial uninsured and privately insured individuals, used to arrive at these enrollment projections that will be excluded; however of the estimated enrollees, the State assumes all will be included in the HAO demonstration waiver.

Table 5 – Projected Impact of Demonstration on Total Medicaid Enrollment – The state should report overall Medicaid enrollment expected to occur over the same period that the HAO demonstration policies will be implemented. Enrollment projections should be reported in annual aggregate (i.e., total), unduplicated person counts, separately for each population whose coverage is likely to be impacted by the proposed HAO demonstration.

Expenditure projections for the HAO Expansion Adult population are based on the projected demonstration enrollment appearing in section II.C.2 (Table 3) and the projected non-demonstration PMPM for this population estimate at $580 in DY01 and $565 thereafter. This also assumes pent up demand and initial members having significant and expensive unmet needs. The State projects that the effects of managed, coordinated care will reduce the non-demonstration PMPM by 5%. The expected cost for the demonstration population tied to projected enrollment is $954.0M for DY1 and $976.6M thereafter.

Targeted Population	DY01	DY02	DY03	DY04	DY05
With waiver aggregate costs	$954,013,065	$ 976,610,854	$976,610,854	$976,610,854	$976,610,854
Without waiver aggregate costs	$1,057,078,188	$1,082,117,290	$1,082,117,290	$1,082,117,290	$1,082,117,290

The State proposes to use a per capita cap model for the HAO demonstration since the demonstration population will be inclusive of individuals in the Medicaid population beginning July 1, 2020. The State emphasizes the per capita cap model will have no impact on enrollment and that as the initial expansion implementation effective July 1, 2020 ramps up, there will be claims and demographic data to better inform these projections for the per capita cap financing model.

D. Eligibility and Enrollment Design Flexibilities – The below table lists the general standard statutory and regulatory eligibility and enrollment provisions applicable under the Medicaid state plan. As part of this demonstration opportunity, the state may elect to not apply these provisions to the demonstration population(s) identified in section II.A of this application. The state should indicate below the provision(s) that it is requesting to not apply to the demonstration in order to permit the state to implement the program flexibilities made available under the HAO demonstration initiative through the use of section 1115(a)(2) authority.

Provisions Not Being Applied by the State for Eligibility and Enrollment Flexibilities		
☒	Section 1902(a)(10)(A)(i)(VIII); 42 CFR 435.119	Flexibility to elect income standard best suited to state at, above or below 133 percent of the federal poverty level (FPL). (Income standard of at least 133 percent FPL is required for increased FMAP for adults with income at or below 133 percent FPL in accordance with sections 1905(y) and 1905(z) of the Act.)

Provisions Not Being Applied by the State for Eligibility and Enrollment Flexibilities		
☒	Section 1902(a)(1); 42 CFR 431.50 and, Section 1902(a)(10)(A)(i)(VIII); 42 CFR 435.119	Ability to limit eligibility to a defined subset of individuals described in the new adult group, based on geographic or other criteria. (Eligibility for all individuals described in the new adult group is required for increased FMAP in accordance with sections 1905(y) and 1905(z) of the Act.)
☒	Section 1903(i)(26)	Flexibility to receive FMAP for services rendered to the new adult group without having to provide such coverage through benchmark or benchmark-equivalent coverage.
☐	Section 1902(a)(8); 42 CFR 435.911(c)(1) and, Section 1902(a)(10); 42 CFR 435.119	Ability to impose additional eligibility requirements to further objectives of Medicaid program.
☒	Section 1902(a)(8); 42 CFR 435.915(c)(1)	Flexibility to establish prospective enrollment for eligible applicants.
☐	Section 1902(a)(10) and (34); 42 CFR 435.915	Flexibility to eliminate retroactive eligibility.
☐	Section 1902(a)(47)(B); 42 CFR 435.1110	Flexibility to eliminate hospital presumptive eligibility.
☒	Section 1902(e)(14)(C); 42 CFR 435.603(g) and, 42 CFR 435.916(d)	Flexibility to provide continuous eligibility up to 12 months.
☒	Section 1943; 42 CFR 435.916(a)(1)	Ability to renew eligibility of new beneficiaries prior to regular 12-month renewal in order to align Medicaid renewal cycle with Marketplace.
☒	Other: N/A	N/A

E. Additional Information. In the box below, provide any additional information the state believes is important for CMS to understand related to the proposed eligibility criteria and processes for eligibility and enrollment to be implemented under this HAO demonstration (optional).

Requested flexibilities are described in detail in Section II.A of this demonstration request.

Section III – Benefit Package

For populations covered under this HAO demonstration initiative, benefits generally will be expected to align with coverage available through the individual health insurance market, such as qualified health plans (QHPs) offered through the Exchange in the state or in another state.

States may also propose other benefit options for providing comprehensive coverage that meet larger health reform and Medicaid objectives. The state should complete the applicable sections below that correspond with the benefits package it proposes to provide under the HAO demonstration.

A. Essential Health Benefits Package

Essential Health Benefits Package Design – The state should identify the benefit design that it intends to implement upon approval of this demonstration. If the state is proposing a range of options that it may elect to use over the course of the approved demonstration period, a description of the range of options should be provided in the designated box below.	
☐	State is aligning the benefit package for this demonstration population with the EHB-benchmark plan used by the State's Department of Insurance for purposes of the individual market in the state by providing the coverage described in that EHB-benchmark plan, in a manner that complies with the EHB requirements for the individual insurance market under 45 CFR 156.100 through 156.125, including the regulation at 45 CFR 156.115(a)(3) applying the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as implemented at 45 CFR 146.136, and with the annual and lifetime dollar limit prohibition at 45 CFR 147.126. *If the state will substitute coverage of benefits for those covered by that EHB-benchmark plan, the state must also complete the benefits chart in subsection G to further describe the EHB benefits design it intends to provide under this demonstration.*
☐	State is aligning the benefit package for this demonstration population with the EHB-benchmark plan used by another State's Department of Insurance for the individual insurance market by providing the coverage described in that EHB-benchmark plan, in a manner that complies with the EHB requirements for the individual insurance market under 45 CFR 156.100 through 156.125, including the regulation at 45 CFR 156.115(a)(3) applying the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as implemented at 45 CFR 146.136, and with the annual and lifetime dollar limit prohibition at 45 CFR 147.126. Please identify the state: *If the state will substitute coverage of benefits for those covered by the EHB-benchmark plan, the state must also complete the benefits chart in subsection G to further describe the EHB benefits design it intends to provide under this demonstration.*

Essential Health Benefits Package Design – The state should identify the benefit design that it intends to implement upon approval of this demonstration.

If the state is proposing a range of options that it may elect to use over the course of the approved demonstration period, a description of the range of options should be provided in the designated box below.

☒ State is selecting one of the below options to design an EHB package that complies with the requirements for the individual insurance market under 45 CFR 156.100 through 156.125, including the regulation at 45 CFR 156.115(a)(3) applying the requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as implemented at 45 CFR 147.160 and 146.136, and with the annual and lifetime dollar limit prohibition at 45 CFR 147.126. Actuarial analysis may be required. The state intends to:

☒ Use the same EHB-benchmark plan currently operated in the state under an Alternative Benefit Plan.

☐ Replace coverage of any of the categories of EHB from their 2017 EHB-benchmark plan with coverage of the same category from another state's 2017-EHB benchmark plan.

☐ Select a set of benefits to become their new EHB-benchmark plan.

If choosing one of the above three options, the state must also complete the benefits chart in subsection G to further describe the EHB benefits design it intends to provide under this demonstration.

Range of Benefits (*if applicable*). As indicated above, describe in the box below any range of benefit options the state may elect to implement over the course of the demonstration. The description should identify the approach that the state proposes to elect at initial implementation of the HAO demonstration and then list the range of potential changes that the state may elect to impose under the demonstration later.

OHCA expects SoonerCare 2.0 benefits to be consistent with the benefits documented in section III.G. These benefits are substantially similar to the Oklahoma Medicaid state plan benefits with certain exclusions and modifications to more closely align with benefits covered in the commercial market.

There is no range of benefit options proposed to be provided under this demonstration.

B. Alternative Benefit Package – If the state is not proposing a benefits package that aligns with the Essential Health Benefits options in section III.A above, describe in the box below the overall benefits proposal the state intends to implement under this demonstration. The description should include how this alternative benefit package aligns with larger health reform and Medicaid program objectives. If the state is proposing a range of options that it may elect to use over the course of the approved demonstration period, a description of the range of options should also be provided below. The description should identify the approach that the state proposes to elect at

initial implementation of the HAO demonstration and then list the range of potential changes that the state may elect to impose under the demonstration later.

The state proposes to use the current Medicaid state plan benefits, but to exclude non-emergency transportation (NEMT) and long-term care (LTC) services to more closely align with the benefits offered via commercial coverage. OHCA may cover NEMT in limited cases based on an individualized assessment of need and in accordance with a care coordination plan. In cases where NEMT is approved through care coordination, Indian Health Service, Tribal Programs, and Urban Indian Clinics (I/T/Us) can qualify as a NEMT provider. EPSDT services are also excluded. Any future changes to benefits will not affect services provided through I/T/Us reimbursed at 100% FMAP.

C. Prescription Drug Coverage

Prescription Drug Coverage – The state should identify below the approach it intends to take for providing prescription drugs under this proposed HAO demonstration.	
☒	State will provide a prescription drug benefit in accordance with section 1927 of the Act. However, OHCA will continue to investigate the potential benefits of a limited prescription drug formulary and request the flexibility to make changes to our prescription drug benefit, following appropriate advance notice procedures. Any future changes to formulary will not affect services provided through I/T/Us at 100% FMAP.
☐	State will provide a limited prescription drug formulary in accordance with EHB requirements regarding prescription drug benefits, in addition to coverage of: (1) substantially all drugs for mental health (that is antipsychotics and antidepressants) consistent with Medicare Part D coverage; (2) substantially all antiretroviral drugs (including PrEP) consistent with Medicare Part D coverage, and (3) all forms, formulations, and delivery mechanisms for drugs approved by the FDA to treat opioid use disorders (OUDs) for which there are rebate agreements in place with the manufacturers. Section 1927(b) requirements pertaining to the obligation for a drug manufacturer with a drug rebate agreement to pay rebates will still apply pursuant to section 1115(a)(2) expenditure authority. If this option is selected, CMS will work with the state on additional information necessary for implementation.

D. Institution for Mental Disease (IMD)

IMD Coverage – The state should identify below the approach it intends to take for providing IMD coverage under this proposed demonstration.	
☒	The state will comply with the Institution for Mental Disease (IMD) Coverage Exclusion (Clause (B) following section 1905(a)(29) of the Act and 42 CFR 435.1009) as indicated below:
	☐ Exclusion applies.
	☐ State has approved state plan amendments for individuals 65 and over who are residing in an IMD consistent with 42 CFR 440.140.
	☒ State has approved state plan amendment(s) for Inpatient psychiatric services for individuals under age 21 consistent with 42 CFR 440.160.
	☐ State has an approved Substance Use Disorder demonstration authorizing services for individuals residing in an IMD or is requesting section 1115(a)(2) authority through this HAO demonstration to provide services to individuals residing in an IMD, as described in section I of this application, in accordance with CMS' November 1, 2017 State Medicaid Director Letter on "Strategies to Address the Opioid Epidemic."

IMD Coverage – The state should identify below the approach it intends to take for providing IMD coverage under this proposed demonstration.	
	☐ State has an approved Serious Mental Illness demonstration authorizing services for individuals residing in an IMD or is requesting section 1115(a)(2) authority through this HAO demonstration to provide services to individuals residing in an IMD, as described in section I of this application, in accordance with CMS' November 13, 2018 State Medicaid Director Letter on "Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance."
	☐ State has approved Medicaid state plan amendment(s) for sections of the 2018 Support for Patients and Communities Act (SUPPORT Act) that include an IMD exclusion.
☒	The state will pursue a demonstration waiver option to waive the IMD FFP exclusion for individuals aged 21-64 receiving inpatient/residential psychiatric and/or substance use disorder treatment services. The waiver request will be separate from SoonerCare 2.0 to include populations covered under traditional Title XIX (disabled individuals, pregnant women, parent caretaker relatives), as well as the expansion adult population.

E. Federally Qualified Health Centers (FQHC)

FQHC Services Coverage and Payment – The state should identify below how it intends to administer the coverage of and payment for FQHC services under this proposed HAO demonstration.	
Coverage	
☒	State is electing to cover FQHC services as defined in section 1905(a)(2)(C) of the Act.
☐	State is covering benefits otherwise covered under this HAO demonstration when provided by an FQHC, not subject to the definition of FQHC services in section 1905(a)(2)(C) of the Act, but similar to QHP coverage of services provided by FQHCs.
Payment	
☒	Payment will be made in accordance with section 1902(bb) of the Act. ☒ Prospective Payment System, or ☐ Alternative Payment Methodology.
☐	Payment will be based on a value-based payment (VBP) methodology consistent with regulations applicable to QHPs at 45 CFR 156.235(e). If VBP payment methodology is selected, please describe here or identify the attachment with the state's plan for the proposed VBP strategy including reasonable, auditable performance targets and anticipated payment rates based on those targets. Please also include information about how the VBP strategy for FQHCs relates to other VBP arrangements or delivery system reform in the state.

FQHC Services Coverage and Payment – The state should identify below how it intends to administer the coverage of and payment for FQHC services under this proposed HAO demonstration.	
☒	Additional Information (optional): OHCA is interested in developing an Alternative Payment Methodology (APM) in the future. Tribal FQHC APM already in place will apply to the demonstration. Any future APMs designed for FQHCs will not affect the Tribal FQHC APM that is already in place.

F. Optional Benefits or Provider Types

Optional Benefits or Provider Types – The state should identify below and in subsection G, if applicable, the optional services the state intends to implement under this proposed demonstration.	
☐	State is electing to cover Early and Periodic Screening, Diagnostic and Treatment services (EPSDT) according to 1905(r) of the Act.
☐	State is electing to assure Non-Emergency Medical Transportation according to 42 CFR 431.53.
☐	State is electing to cover additional benefits according to sections 1905(a), 1915(c), 1915(i), 1915(j), 1915(k), and/or 1945 of the Act that will be considered benefits in addition to EHB. Please list and describe in the "Additional Benefits" section of the table listed in subsection G below.

G. Description of Benefits – If the state selected an option above that indicated a description of benefits is needed, the state will complete the below chart to include the following information: service name, limitations on the service (if applicable), and provider qualifications. More than one service can be placed in the EHB-Benchmark Plan Services row to define EHB.

Essential Health Benefit	EHB-Benchmark Plan Service(s), Limitations, and Provider Qualifications
Ambulatory Patient Services	Refer to EHB 1, ambulatory patient services, within the Adult Expansion Alternative Benefit Plan (ABP) of the State Plan (and attachment B of this application) for EHB information related to: service name, limitations (if applicable), and provider qualifications.
Emergency Services	Refer to EHB 2, emergency services, within the Adult Expansion Alternative Benefit Plan (ABP) of the State Plan (and attachment B of this application) for EHB information related to: service name, limitations (if applicable), and provider qualifications.
Hospitalization	Refer to EHB 3, hospitalization, within the Adult Expansion Alternative Benefit Plan (ABP) of the State Plan (and attachment B of this application) for EHB information related to: service name, limitations (if applicable), and provider qualifications.
Maternity and Newborn Care	Refer to EHB 4, Maternity and newborn care, within the Adult Expansion Alternative Benefit Plan (ABP) of the State Plan (and attachment B of this application) for EHB information related to: service name, limitations (if applicable), and provider qualifications.
Mental Health and Substance Use Disorder Services, Including Behavioral Health Services	Refer to EHB 5, mental health and substance use disorder services including behavioral health treatment, within the Adult Expansion Alternative Benefit Plan (ABP) of the State Plan (and attachment B of this application) for EHB information related to: service name, limitations (if applicable), and provider qualifications.
Prescription Drugs	Refer to EHB 6, prescription drugs, within the Adult Expansion Alternative Benefit Plan (ABP) of the State Plan (and attachment B of this application) for EHB information related to: service name, limitations (if applicable), and provider qualifications.
Rehabilitative and Habilitative Services and Devices	Refer to EHB 7, rehabilitative and habilitative services and devices, within the Adult Expansion Alternative Benefit Plan (ABP) of the State Plan (and attachment B of this application) for EHB information related to: service name, limitations (if applicable), and provider qualifications.
Laboratory Services	Refer to EHB 8, laboratory services, within the Adult Expansion Alternative Benefit Plan (ABP) of the State Plan (and attachment B of this application) for EHB information related to: service name, limitations (if applicable), and provider qualifications.

Essential Health Benefit	EHB-Benchmark Plan Service(s), Limitations, and Provider Qualifications
Preventive and Wellness Services and Chronic Disease Management	Refer to EHB 9, preventive and wellness services and chronic disease management, within the Adult Expansion Alternative Benefit Plan (ABP) of the State Plan (and attachment B of this application) for EHB information related to: service name, limitations (if applicable), and provider qualifications.
Pediatric Services Including Oral and Vision Care (generally not applicable in this demonstration)	ESPDT services are not covered.

Additional Benefits	
Name of Benefit	**Service Description, Limitations, and Provider Qualifications**
Other 1937 Covered Benefits that are not Essential Health Benefits	Refer to item 14, other 1937 covered benefits that are not essential health benefits, within the Adult Expansion Alternative Benefit Plan (ABP) of the State Plan (and attachment B of this application) for additional benefit information related to: service name, limitations (if applicable), and provider qualifications. Long-term care NEMT services are not covered.

H. Additional Information – In the box below, provide any additional information the state believes is important for CMS to understand the state's intended design for the benefits component of this HAO demonstration. If the state is proposing flexibilities to vary the range or scope of the proposed benefits (as identified above) to individuals targeted under this HAO demonstration, describe those benefit flexibilities here.

The benefits as documented represent the current Medicaid state plan with the exclusion of NEMT, EPSDT, and LTC services and the addition of integrated behavioral health services provided by licensed behavioral health professionals in a primary care setting.

I. Applicable Federal Benefit Design Standards – Pursuant to the expenditure authority offered under this demonstration initiative, the expenditures under the approved HAO demonstration will be regarded as expenditures under the Medicaid state plan. The below table lists common standard requirements pertaining to the provision of benefits that we expect would be applicable under the demonstration and that states would be expected to administer in a manner analogous to the processes utilized for the administration of the Medicaid state plan. If the state is proposing to implement a *demonstration-specific process* to comply with any of the below standard requirements, the state should check the applicable provision(s) below and in the designated text box

describe how the proposed process for compliance will be administered under the demonstration *differently from the state plan*. The state's description should also include the rationale for how the targeted demonstration process is necessary for the state to meet the intended goals and objectives of the demonstration.

As each application proposal will be unique to each state, this is not intended to be a comprehensive list of benefit standards that could be applicable to this demonstration and additional benefit standards may be negotiated with the state for CMS approval in alignment with goals of this HAO demonstration. Thereby, the state should also describe in the text box below any administrative process related to providing benefits that it intends to operationalize under the approved HAO demonstration differently from the state plan.

	Standard Benefit Design Provisions Applicable to this Section 1115(a) Demonstration Opportunity
☒	The state will have a process to ensure that the demonstration operates in alignment with the Inmate Coverage Exclusion outlined in section 1905(a)(29)(A) of the Act.
☒	The state will have a process to ensure that room and board will not be eligible for reimbursement except in hospitals (section 1905(a)(1) of the Act), nursing facilities (section 1905(a)(4) of the Act), intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs)(section 1905(a)(15) of the Act) and psychiatric residential treatment facilities (PRTFs)(section 1905(a)(16) of the Act).
☒	**Changes to Benefits Post-approval** – If the state elects to suspend, eliminate, or modify benefits under the demonstration as approved by CMS, it will have a process for providing advance state public notice in accordance with 42 CFR part 431, subpart E that provides the following information: 1. The specific benefit(s) being changed (adding, removing, increasing, or decreasing the benefit) and, if applicable, whether it is an EHB; 2. If applicable, the benefits used for supplementation of EHB; 3. If applicable, an actuarial equivalence analysis if a benefit is not an EHB and is being added to the definition of EHB as a substitution for another EHB; 4. Explanation of whether the benefit change is adding, removing or modifying amount, duration or scope of the benefit; 5. The clinical justification of the benefit change in amount, duration or scope of the benefit for the population that it serves. 6. Description of how beneficiaries will access the benefit; and, 7. Description of the anticipated fiscal impact.

For the provision(s) checked above, the state is proposing the following demonstration-specific approach for compliance:

SoonerCare 2.0 processes will align with federal requirements related to:

- The Inmate Coverage Exclusion
- Restricted reimbursement for room and board
- Public and individual notices

We will continue to assess the most effective ways to conduct outreach, education, and service delivery; and request flexibility to allow and incorporate demonstration-specific processes in the future.

Section IV -- Premiums and Cost Sharing

A. Protections – States with approved demonstration programs under this demonstration opportunity may have broad flexibility to establish premiums and cost-sharing structures. We would expect states to adhere to the following overarching limitations:

- Aggregate out-of-pocket costs incurred by beneficiaries covered under the HAO demonstration would not exceed five percent of the household income, measured on a monthly or quarterly basis.

- Premiums and cost sharing charges for individuals needing treatment for substance use disorder and individuals living with HIV as well as cost sharing charges for prescription drugs needed to treat mental health conditions would not exceed amounts permitted under the statute and implementing regulations. States similarly would not be permitted to suspend enrollment for such individuals for failure to pay premiums or cost sharing, even if authorized for other individuals under the demonstration.

The state should check one of the below options to confirm whether it intends to implement cost-sharing requirements (i.e., enrollment fees, premiums, cost-sharing or similar charges) for individuals targeted by this HAO demonstration initiative.

☐	**NO**, this demonstration will not have any beneficiary requirements for premiums or cost-sharing. If the state checks this box, it should proceed to section V of this application.
☒	**YES**, this demonstration will have beneficiary requirements for premiums, deductibles, copayments, and/or similar cost-sharing charges. If the state checks this box, it should also complete subsection B and C of this application section.

B. Beneficiary Cost-Sharing Structure – The state should identify the premium and/or cost-sharing structure that it intends to implement during the approved demonstration period. If the state is anticipating using a range of premium and/or cost-sharing options over the course of the approved demonstration period, the state should identify the range of options as indicated in the designated boxes below.

Premium/Cost-Sharing Design/Flexibilities. In the boxes below, the state should describe the proposed premium and/or cost-sharing structure to be implemented under this HAO demonstration.	
☒ Premiums	To enhance alignment between Medicaid policies and the commercial health insurance market, individuals in SoonerCare 2.0 will be charged a monthly premium. The premium amount will be based on their

household income and the number of people in the household participating in the demonstration.

There will be three income tiers to determine household premiums:

- **Tier 1:** 0% FPL-Parent/Caretaker income standard (see Table IV.B.1)
- **Tier 2:** >Parent/Caretaker income standard-100% FPL
- **Tier 3:** >100% FPL-133% FPL (+ 5% income disregard)

Table IV.B.1. Parent/Caretaker income standard

Household Size	Monthly Income	Annual Income
1	$407	$4,884
2	$521	$6,252
3	$668	$8,016
4	$820	$9,840
5	$958	$11,496
6	$1,098	$13,176
7	$1,236	$14,832
8	$1,364	$16,368
9	$1,486	$17,832

The Parent/Caretaker income standard is a set dollar amount outlined in the state plan and will not change over time.

Also aligning with common commercial insurance policies and practices, premiums will vary based on the number of people in the household in SoonerCare 2.0, with single and family rates, reflected in Table IV.B.2.

- **Single:** Only one adult in the household qualifies for and is enrolled in SoonerCare 2.0
- **Family:** Two or more adults in the household qualify for and are enrolled in SoonerCare 2.0

Table IV.B.2. Monthly premium amounts, by tier and household composition

Household Size	Single	Family
Tier 1	$0	$0
Tier 2	$5	$7.50
Tier 3	$10	$15

Some members will be exempt from the monthly premium. Populations exempt from premiums include individuals diagnosed with HIV/AIDS, substance use disorder (SUD), and/or serious mental illness (SMI). Aligning with federal law, American Indians/Alaska Natives and pregnant women will be exempt from all cost sharing, including premiums. Individuals who are incarcerated and receiving inpatient

	hospital services will also be exempt from premiums. When one individual in the household is exempt from premiums, the entire household will be exempt. OHCA will evaluate the impact of premiums on enrollment and behaviors and requests the flexibility to adjust premiums in later years based on the results of those evaluations. We request the flexibility to adjust premiums as high as 5% of the individual's household income, consistent with federal out-of-pocket cost limitations. We may also temporarily adjust or pause premium policies in response to unforeseen and acute challenges, such as natural disasters.
☒ Co-payments	Individuals in SoonerCare 2.0 will be charged copays consistent with those allowable in the state plan. As we also aim to strengthen beneficiary engagement in their personal health care plan, SoonerCare 2.0 members may be subject to an additional copayment of $8 for non-emergency use of the emergency department (ED). Individuals will be charged copayments in addition to their premium obligation, up to the 5% out-of-pocket cost sharing limit. Aligning with federal guidance, American Indians/Alaska Natives and pregnant women will be exempt from all cost sharing, including copayments. OHCA will evaluate the impact of the $8 copay for non-emergency use of the ED on member behaviors and requests the flexibility to adjust the copayment in later years based on the results of those evaluations. Charging the copay with be subject to federal cost sharing limits. We will also temporarily adjust or pause the ED copay policy in response to unforeseen and acute challenges, such as natural disasters. We will also continue to assess opportunities to incentivize high-quality, high-value utilization and discourage unnecessary or avoidable utilization through new and waived copayment policies.
☐ Deductibles	N/A
☐ Other Charges	N/A

C. Beneficiary Consequences for Non-payment – In the box below, describe any consequences for beneficiary non-payment of premiums and/or cost-sharing charges.

Mirroring policies in the commercial health insurance market, individuals with a premium obligation will be required to pay that premium to remain enrolled. Like the Health Insurance Marketplace, individuals who do not pay the premium will have a

three-month grace period to catch up on unpaid premiums. If they do not pay the required premium(s) within that time, OHCA will reprocess eligibility to see if the member qualifies for any other eligibility category. If not, the individual will be notified in alignment with federal requirements and enrollment will be terminated.

Individuals who lose their coverage for non-payment may re-apply for coverage at any time. They will not be required to re-pay their unpaid premiums as a condition of eligibility, but state-approved premium collection entities may be allowed to collect that debt.

Copayments will be collected at the point of service and will not impact eligibility and enrollment in SoonerCare 2.0. The provider may not deny service based on member assertion of inability to pay the copay.

D. Calculating Beneficiary Cost-Sharing – In the box below, describe the state's process for calculating the five percent limit on a monthly or quarterly basis and ensuring that beneficiaries do not incur cost-sharing that exceeds five percent of the beneficiary' household income. Premiums and cost-sharing incurred by the beneficiary, spouse, children and other members of the beneficiary's household, as defined in 42 CFR 435.603(f), will be counted toward the five percent limit.

The Medicaid Management Information System (MMIS) tracks cost sharing expenditures incurred across household members and re-sets at the beginning of each month. Systematic tracking of cost sharing occurs in real time as claims are adjudicated in MMIS. Medicaid premiums and cost sharing incurred by all individuals in the household does not exceed an aggregate limit of 5% of income, applied on a monthly basis.

MMIS is programmed not to deduct copayments from claims for Medicaid recipients and services that are exempt from cost sharing as identified in 42 CFR 447.56(a) and 1916(a)(2) and (j) and 1916A(b) of the Social Security Act. MMIS will identify the exempt recipients by age for children under age 21, by aid category and recipient status for pregnant women and institutionalized individuals.

The state undertakes additional processes to ensure American Indian/Alaskan Native (AI/AN) are exempt from cost sharing as identified in 42 CFR 447.56(a)(1)(x). The additional processes include the following:

- An automatic, periodic claims review examines member's claims to verify if they have incurred a paid claim from an Indian Health facility. When applicable, the information is loaded into MMIS in the individual's demographic information to ensure no cost sharing.
- The AI/AN attestation questions via the application.

E. Applicable Federal Premium/Cost-sharing Design Standards – Pursuant to the expenditure authority offered under this demonstration initiative, the expenditures under the approved HAO demonstration will be regarded as expenditures under the Medicaid state plan. The below table lists common standard requirements pertaining to cost-sharing that we expect would be applicable under the demonstration and that states would be

expected to administer in a manner analogous to the processes utilized for the administration of the Medicaid state plan. If the state is proposing to implement a separate *demonstration-specific process* to comply with any of the below standard requirements, the state should check the applicable provision(s) below and in the designated text box describe how the proposed process for compliance will be administered under the demonstration *differently from the state plan*. The state's description should also include the rationale for how the targeted demonstration process is necessary for the state to meet the intended goals and objectives of the demonstration.

As each application proposal will be unique to each state, this is not intended to be a comprehensive list of cost-sharing standards that could be applicable to this demonstration and additional cost-sharing standards may be negotiated with the state for CMS approval in alignment with goals of this HAO demonstration. Thereby, the state should also describe in the text box below any administrative process related to providing benefits that it intends to operationalize under the approved HAO demonstration differently from the state plan.

	Standard Premium/Cost-sharing Design Provisions Applicable to this Section 1115(a) Demonstration Opportunity
☒	The state will have safeguards to ensure that its process as described in section IV.D above is properly calculating and ensuring adherence to the requirement that beneficiaries do not incur cost-sharing that exceeds the five percent limit on a monthly or quarterly basis.
☒	The state will have a process for providing beneficiary and public notice of premiums, cost-sharing and similar charges under the demonstration consistent with the notice requirements described in 42 CFR 447.57.

For the provision(s) checked above, the state is proposing the following demonstration-specific approach for compliance as follows:

N/A. OHCA will ensure it is appropriately calculating household cost sharing to ensure members are not responsible for more than the 5% cost sharing limit. If we choose to change the premium and copay policies, OHCA will provide appropriate advance notice to members.

Section V – Delivery System and Payment Models

A. Delivery System Type – The state should check which delivery system(s) it intends to use for this demonstration:

	Delivery System
☒	**Managed Care**
	☐ Managed Care Organization (MCO)
	☐ Prepaid Inpatient Health Plan (PIHP)

	☐ Prepaid Ambulatory Health Plan (PAHP) ☒ Primary Care Case Management (PCCM)/PCCM-Entities OHCA requests flexibility to build upon our current Patient Centered Medical Home model to deliver coordinated, timely, high-quality care to our SoonerCare 2.0 members. We will leverage new payment methodologies to include other areas of focus such as behavioral health integration and care coordination. We will continue to work closely with providers to coordinate and manage member access to appropriate levels of care and services. OHCA will also seek flexibilities through SoonerCare 2.0 to implement new value-based payment methodologies for providers throughout the SoonerCare 2.0 provider network to focus on quality services and outcomes. As we make changes to the delivery system, we will also ensure appropriate consultation with key stakeholders and will continue to comply with state and federal notice requirements.
☐	**Fee-for-Service (FFS)** ☐ Section 1902(a)(23) and implementing regulations at 42 CFR 431.51, which allows a beneficiary to obtain services from any institution, agency, community pharmacy, or person qualified to perform the services and who undertakes to provide such services. ☐ Restrict a beneficiary (except in emergency circumstances) to obtaining services from any provider or practitioner who provides services in compliance with the state's written standards for reimbursement, quality, and utilization of covered services, provided that the state's standards are consistent with accessible, high-quality delivery, and efficient and economic provision of covered services. *Please describe here the services that are subject to this approach:*
☐	**Premium Assistance**
☐	**Other:**

B. Enrollment Strategies – For a state using managed care or premium assistance delivery system(s), it should describe below how the eligibility groups will be enrolled in managed care.

Eligibility Group	Mandatory, Voluntary, Excluded	Geographic Area	Other Criteria (such as FPL range or type of premium assistance)	Notes
Expansion Adults 1902(a)(10)(A)(i)(VIII)	Mandatory Enrollment, described in Section V.A.	Statewide	N/A	

C. Exceptions to Managed Care and Premium Assistance Enrollment – The state should describe below any demonstration populations that are excluded from the enrollment strategies in subsection B.

N/A

D. Services Included in Each Delivery System – The state should list the services/benefits included in the demonstration's delivery system and note any differences by eligibility category. For services where section 1902(a)(23) of the Act does not apply and the state chooses to add providers using Essential Community Provider (ECP) rules at 45 CFR 156.235, please describe how ECPs will be incorporated into the demonstration.

Type	Population(s) Covered	Services Included
Managed care	Expansion Adults 1902(a)(10)(A)(i)(VIII)	All benefits outlined at Section III – Benefit Package
MCO	N/A	N/A
PIHP	N/A	N/A
PAHP	N/A	N/A
PCCM/ PCCM-E	N/A	N/A
FFS	N/A	N/A
Premium Assistance	N/A	N/A
Other	N/A	N/A

E. Managed Care Delivery System Flexibilities

Managed Care Flexibilities – The state should identify which of the following options the state intends to apply to the managed care delivery system to be implemented under the demonstration by checking applicable boxes below.

Access to Care - States will need to ensure, and will be expected to regularly report, that services covered under a HAO demonstration are available and accessible to beneficiaries in a timely manner.

☐	The state will document compliance with the requirements of 42 CFR 438.68, 438.206, and 438.207 to establish and monitor the adequacy and capacity of MCOs, PIHPs and PAHPs to deliver all covered services within the delivery system.
☐	The state will follow an alternative approach by providing reasonable evidence of enrollee access to care and satisfaction, including direct measures of access evidencing that the state-established standards are met. *[Describe here the alternative approach and how it will meet the statutory requirement for access described in section 1932(b)(5) of the Act to establish and monitor the adequacy and capacity of MCOs, PIHPs and PAHPs to deliver all covered services within the delivery system.]*

Managed Care Capitation Rates –The state will be expected to establish a process to assure managed care capitation rates under the demonstration are actuarially sound. The state should identify in the box below which approach it intends to implement under the demonstration.

☐	*Federal Actuarial Review* – The state will develop capitation rates consistent with the requirements of 42 CFR part 438 and CMS' Managed Care Capitation Rate Development Guide. The state will submit to CMS a final set of managed care capitation rates supported by a rate certification at least 30 days prior to the start of a rating period and make all modifications to such rates on a prospective basis.
☐	*Fiscal Integrity through Transparency, Medical Loss Ratios, and Audits* – The state will develop an alternative option as described below that exempts them from the requirements of 42 CFR 438.7(a) and eliminates the prospective federal review, but relies on the following requirements to assure capitation rates are actuarially sound: 1. *Capitation rate transparency*. Capitation rates will be developed annually consistent with the requirements of 42 CFR part 438 and an enhanced CMS Managed Care Capitation Rate Development Guide that establishes a specific outline for the rate certification and required tables to document assumptions and data used for the capitation rate development. Additionally, the rate certification will be publicly posted on the state's website 60 days in advance of the annual rating period; and changes are identified in a rate amendment certification provided to CMS and posted on the state's website 30 days prior to making the change in rates. 2. *Components of the rate development*. The state's managed care capitation rates are based only upon approved Medicaid services covered under the Medicaid state plan, a section 1115 demonstration, a section 1915 waiver, and additional services deemed by the state to be necessary to comply with the requirements of MHPAEA, as implemented in 42 CFR part 438, subpart K, 42 CFR 440.395, and 45 CFR 147.160 and 146.136, as

	applicable. Further, the state's managed care capitation rates are based only upon the expected utilization and delivery of services for the time period and the population covered under the terms of the state's contract with the managed care plans. Finally, the state's managed care capitation rates may not include any pass-through payments or supplemental provider payments. *To the extent that the state intends to make pass-through payments or supplemental payments to providers, CMS would expect that the payments would be explicitly authorized in the state's section 1115 demonstration and paid to providers outside of the managed care capitation rates. The state should also complete section VI, subsection G of this application.* 3. *Use of medical loss ratios (MLRs) with remittance*. The state's contract with each managed care plan will require remittance based on a corridor around the MLR defined in 42 CFR 438.8. The state will calculate and reconcile each managed care plan's MLR and report calculations to CMS within 12 months of the rating period. *Further, remittances will be required of plans if the MLR falls below 85 percent level, and states will be required to submit remittances to plans if the MLR is above 95 percent. Remittances required to be paid by the state in excess of the annual cap will not be eligible for FFP*. 4. *Use of audits*. The state will meet enhanced requirements by requiring plans to submit independent financial audits in order to assure that the managed care capitation rates are actuarially sound. In addition to requirements at 42 CFR 438.3(m), states and managed care plans will need to ensure that the financial audit is conducted by an independent entity in accordance with generally accepted accounting principles and auditing standards, and be of sufficient detail that the state and managed care plan can reconcile the data used for the MLR calculations to the information reported in the independent financial audit. The state will submit the audited financial reports, as well as documentation reconciling the data used for the MLR, to CMS within 12 months of the end of the rating period.
Managed Care Contracts Review - The state will submit its initial managed care contracts to CMS for review and approval. However, the state should identify flexibility in the administration of their managed care plan contract amendments.	
☐	The state will seek formal CMS approval of contract amendments in advance of the amendment taking effect. States will incorporate the potential impact of substantive contract amendments into the capitation rates paid to managed care plans.
☐	The state will not seek prior CMS approval of contract amendments but will submit amendments to CMS. States will incorporate the potential impact of substantive contract amendments into the capitation rates paid to managed care plans.

Managed Care Contracts Review - The state will submit its initial managed care contracts to CMS for review and approval. However, the state should identify flexibility in the administration of their managed care plan contract amendments. **State Directed Payments –** The state should identify how they will direct managed care plans' expenditures with regards to State Directed Payments at 42 CFR 438.6(c), if applicable.	
☐	The state will seek formal CMS approval of State Directed Payments pursuant to 42 CFR 438.6(c) in advance of the payment(s) taking effect.
☐	The state will not seek prior approval of State Directed Payments but will comply with all other requirements under 42 CFR 438.6(c). The state will maintain documentation of compliance with 42 CFR 438.6(c), including that any direction of managed care plans' expenditures is based only on delivery and utilization of services to Medicaid beneficiaries covered under the contract, or outcomes and quality of the delivered services during the rating period associated with the directed payment.
Other: List other managed care related regulatory flexibilities requested	
☒	The state will meet all other statutory requirements for managed care outside of those directly addressed in this application.
☐	The state will implement other, alternative approaches to meeting the statutory requirements for managed care beyond those specifically identified in this application, and that are not consistent with the regulations in 42 CFR part 438. The state will include the alternative approach(es) in their demonstration application, including provide reasonable evidence that the alternative approach meets the statutory requirements of 42 CFR part 438. Absent inclusion of an alternative approach in the approved STCs, the regulatory provisions in 42 CFR part 438 will apply to HAO demonstrations. Please describe here the flexibilities requested.

F. Delivery System Reform and Payment Model Integration – States may also propose an alternative approach to their delivery system that leverages the private insurance market or coverage programs designed under an applicable complementary waiver under section 1332 of the Patient Protection and Affordable Care Act. If the state is seeking such an alternative approach, please describe in the box below or as an attachment the proposed approach(es) to measuring and ensuring sufficient access to care under the demonstration. If providing an attachment, the state should identify the attachment in the box below.

N/A

G. Delivery System Reform through Choice and Competition – In the box below, the state should explain whether any of its proposed payment models or delivery system approaches described above are being initiated to support state efforts to influence state laws, regulations, guidance, and polices on choice and competition in health care workforce, provider, and insurance markets based on the 2018 *Reforming America's Healthcare System through Choice and Competition* report issued by the Departments

of Health and Human Services, Labor, and the Treasury. Also identify actions that the state will be implementing that will drive greater efficiency and improved outcomes from other providers in order to achieve increased state flexibility and improved outcomes.

OHCA requests flexibility to develop a unique managed care solution to deliver coordinated, timely, high-quality care to our members. OHCA will leverage new payment methodologies to include other areas of focus such as behavioral health integration and care coordination. OHCA will continue to work closely with providers to coordinate and manage member access to appropriate levels of care and services. OHCA will also seek flexibilities through the HAO waiver demonstration to implement new value-based payment methodologies for providers throughout the SoonerCare provider network to focus on quality services and outcomes.

OHCA will continue to modify and enhance our customized care delivery system to identify and address unique challenges as they arise. As the Agency makes changes to the delivery system, it will also ensure appropriate consultation with key stakeholders and will continue to comply with state and federal notice requirements.

The State hopes to achieve the following objectives:

- Improve health outcomes by rewarding high quality care;
- Focus on quality improvement in specific population health goals;
- Integrate physical and behavioral healthcare and increase care coordination;
- Better coordinate care for Medicaid members using modern technology and methods;
- Contract with a network of health care providers with a strong emphasis on health outcomes and value based compensation;
- Contain program costs by leveraging new payment methodologies and negotiated quality incentives; and,
- Contain program costs by utilizing payment methodologies that incentivize quality over quantity.

H. Additional Information – In the box below, provide any other information that the state believes is important for CMS to understand about the state's proposed delivery system and/or payment model for this demonstration. (optional)

N/A

Section VI – Financing and Cost Projections

A. Non-Federal Share Source(s).

Non-Federal Share Source(s). All sources of non-federal funding must be compliant with section 1903(w) of the Act and applicable regulations. The state should identify below, the source of non-federal share for each type of payment to be mad e under the demonstration, including specifying whether each source is a state general fund appropriation from the legislature to the Medicaid agency, intergovernmental transfers (IGTs), certified public expenditures (CPEs), health care-related taxes, or another mechanism. Include a full description of the financing arrangement(s) to be used.
The OHCA will utilize multiple sources of non-federal share. These include direct appropriations from the General Revenue Fund of the State Treasury, which totaled $818,977,368.00 in SFY 2020; the Special Cash Fund, which totaled $50,000,000.00 in SFY 2020; and the Health Care Enhancement Fund, which totaled $131,062,000.00 in SFY 2020. OHCA receives and will expend all or a portion of the 22.06% placed to the credit of the Health Employee and Economy Improvement Act Revolving Fund from the sale, use, gift, possession, or consumption of cigarettes, as defined in Sections 301 through 325 of Title 68 of the Oklahoma Statutes. A health care-related tax, called the supplemental hospital offset payment program (SHOPP) fee, is assessed to Oklahoma hospitals and a portion of that assessment will be used to fund the non-federal share. The assessment rate is currently capped at 4% in state statute. Funds are received in the first month of each quarter to be expended on the OHCA Medicaid program. State appropriated funds are provided from the legislature and transferred to the OHCA by inter-governmental transfer (IGT) from The University Hospital Authority / Trust (UHA / UHT), the State Regents for Higher Education, the OSU Medical Authority (OSUMA), the Oklahoma State Department of Health (OSDH), the Oklahoma Department of Mental Health and Substance Abuse (ODMHSAS) and the Oklahoma Department of Corrections (ODOC). The transferred funds are deposited into the OHCA Medicaid Program Revolving Fund. All funds described above will be used to fund the non-federal share of costs related to the demonstration. OHCA will be able to respond with certainty on the dedicated funding sources by the end of the current legislative session in May 2020.

B. Expenditure History for Relevant Population(s) and Services – In the table below, the state should identify the total computable net expenditures from the Medicaid Budget and Expenditure System (MBES), Form CMS-64 for the most recent eight consecutive quarters after December 31, 2016 for which CMS has issued a finalized grant award to the state. This should be delineated for each population covered by the demonstration. Expenditures apply to a quarter based on the date the original payment is made, consistent with 45 CFR 95.13(b). Prior period adjustments and collections/offsets should be attributed to the quarter in which the original expenditure was made. Net expenditures include current quarter expenditures, prior period adjustments, and collections and offsets. Note, expenditures for VIII group members should be separately identified.

If the state has not separately reported expenditures on the CMS-64 for the targeted demonstration population(s), please also complete subsection C of this application section for identification of the data source(s) the state used to complete the below table.

Base period expenditures provided below should exclude Medicaid Disproportionate Share Hospital payments, state administrative expenditures, expenditures for public health emergencies, and time-limited supplemental or pool payments being made under section 1115 authority such as, but not limited to: Designated State Health Program (DSHP) payments, Delivery System Reform Incentive Payments (DSRIP), and Uncompensated Care Cost (UCC) Payments.

Targeted Populations	**Expansion Adults** 1902(a)(10)(A)(i)(VIII)	**Total Sum** (across all populations)
Q01 20__	N/A	N/A
Q02 20__	N/A	N/A
Q03 20__	N/A	N/A
Q04 20__	N/A	N/A
Q01 20__	N/A	N/A
Q02 20__	N/A	N/A
Q03 20__	N/A	N/A
Q04 20__	N/A	N/A
Total Sum (by Population)	N/A	N/A

In the box below, the state should specify the source of the data provided above from the CMS-64 (by form name, line number, and quarter).

N/A. Since the expansion adult population is not a current Medicaid population in Oklahoma, OHCA is unable to provide historical expenditure data from the form CMS-64. OHCA submitted a state plan amendment on March 6, 2020 to add adult ages 19-64 with income up to 133% of FPL (+ 5% income disregard) as a covered population effective July 1, 2020. If the state plan is approved, OHCA will be able to use real experience to develop current and future expenditure projections.

C. Non-CMS 64 Based Expenditure History for Relevant Population(s) and Services – If the state has not separately reported expenditures on the CMS-64 for the targeted demonstration population(s), please indicate below the type of information the state is providing as an attachment to this application to support the expenditure information reported in subsection B of this application section:

☐	The state is providing at least two years of auditable expenditure data for the relevant population and services that ties directly to expenditures reported on the Form CMS-64. These expenditures are net of collections and include prior period adjustments as described in subsection A of this application section. This information is in attachment ___ of this application.
☐	The state is providing an audit report from an external independent auditor validating the expenditure data and demonstrating how the data ties directly to the state's expenditures reported on the CMS-64 for the base period. This information is in attachment ___ of this application.
☒	Other, including data or information for newly covered populations: Since the expansion adult population is not a current Medicaid population in Oklahoma, OHCA is unable to provide historical enrollment data. Oklahoma has current programs that may indicate a potential portion of the new expansion adult populations but is not comprehensive and would likely only assist as an assumption of more accelerated take up rate once the program is live. One of those programs is a state fund only mental health and substance abuse program with an estimated 40,000+ Oklahomans with household income below 133% of FPL (+ 5% income disregard). The other program is Insure Oklahoma, a private-public partnership that assists individuals and small businesses access affordable health care. This program is approved in OHCA's current 1115 waiver and there are approximately 9,000 participants with household income under 133% FPL (+ 5% income disregard). OHCA submitted a state plan amendment on March 6, 2020, to add adult ages 19-64 with income up to 133% of FPL (+ 5% income disregard), as a covered population effective July 1, 2020. According to 2017 American Community Survey (ACS) data, there are approximately 220,722 uninsured Oklahomans with household income under 133% of FPL (+ 5% income disregard). This uninsured number is inclusive of populations other than adults ages 19-64. Other state experience also shows that there should be an expectation of a migration from the Marketplace to Medicaid. If the state plan amendment is approved, OHCA will have data to support potential SoonerCare 2.0 enrollment. OHCA anticipates that enrollment under the SPA expansion will begin July 1, 2020. The current year estimate is therefore our estimate of the average projected enrollment across the year. The projection assumes 154,505 currently uninsured total potentially eligible Oklahomans, and take-up rate of 60% in the first year of the SPA expansion for this group, in addition to 36,000 Oklahomans shifting from private insurance to the Medicaid expansion. Expenditure projections for the Expansion Adult population are based on the projected demonstration enrollment appearing above in section II.C.2 (Table 3) and the projected non-demonstration PMPM for this population (est. $580 in DY01 and $565 thereafter), with a 5% discount to account for the effects of managed, coordinated care. This also assumes pent up demand and initial

	members having significant and expensive unmet needs. This is supported by Oklahoma current health ranking and experience in other states. The expected cost is $954.0M for DY1 and $976.6M for subsequent demonstration years, which excludes increase administrative costs and “woodwork” population costs. This makes no assumptions on economic outlook which could significantly impact enrollment for both the current and newly eligible populations. If the state plan is approved, OHCA will be able to use real experience to develop current and future enrollment projections.

D. Population Adjustments

In the box below, please indicate any proposed adjustments relating to the covered population(s) that would improve the accuracy of the base period expenditures the state reported above in subsection B of this application section. For each adjustment, please: i. Identify the amount, ii. Explain why it is necessary, and iii. Explain how the state calculated the adjustment amount.
N/A. Since the expansion adult population is not a current Medicaid population in Oklahoma and Oklahoma does not use historical expenditure data derived from the CMS-64, all assumptions and adjustments are contemplated in the estimated expenditures. The estimate includes potential adjustments such as: pent-up demand, acuity, non-MMIS transactions, co-payments, TPL, pharmacy rebate, population biased selection, FQHC/RHC cost, etc. No adjustments are proposed.

E. Adjustments for Covered Services

In the box below, please indicate any proposed adjustments relating to the covered services that would improve the accuracy of the base period expenditures the state reported above in subsection B of this application section. For each adjustment, please: i. Identify the amount, ii. Explain why it is necessary, and iii. Explain how the state calculated the adjustment amount.
N/A. Since the expansion adult population is not a current Medicaid population in Oklahoma and Oklahoma does not use historical expenditure data derived from the CMS-64, all assumptions and adjustments are contemplated in the estimated expenditures. This estimate includes the inclusion of behavioral health services. No adjustments are proposed.

F. Expenditure Projections for Targeted Demonstration Population(s) – In the table below, the state should provide its total cost projections for coverage of the targeted demonstration population(s) in annual aggregate totals for each demonstration year (DY)

of this proposed demonstration; as supported by the historical expenditure data the state reported above in subsection B of this application section.

Targeted Population	DY01	DY02	DY03	DY04	DY05
Expansion Adults 1902(a)(10)(A)(i)(VIII)	$954,013,064.67	$976,610,853.86	$976,610,854	$976,610,854	$976,610,854
Total Sum	$954,013,064.67	$976,610,853.86	$976,610,854	$976,610,854	$976,610,854

In the box below, the state should describe the analysis used to derive the above cost projections for each targeted demonstration population.

These projections are based on the projected demonstration enrollment appearing above in section II.C.2 (Table 3) and the projected non-demonstration PMPM for this population (est. $580 in DY01 and $565 thereafter), with a 5% discount to account for the effects of managed care. Calculations may not sum exactly due to rounding.

G. Supplemental and Managed Care Pass-Through Payment Adjustments

In the box below, for the applicable base period, please list all Medicaid supplemental payments and managed care pass-through payments made to providers for services and individuals covered under this HAO demonstration.

Oklahoma's Medicaid program currently does not use a managed care delivery system and thus has no managed care pass-through payments. OHCA does have supplemental payment programs. However, the 2018 proposed managed care rules as well as the proposed Medicaid Fiscal Accountability Regulation (MFAR) makes inclusion and projection of supplemental payments in any delivery system challenging.

The State intends to design a demonstration that utilizes payment methodologies (to potentially include supplemental/directed payments) that support the mission of the Oklahoma Medicaid program and enhance the quality of care received. These payments will be dependent on added value and will be allocated based on outcomes delivered.

For qualifying supplemental payments and managed care pass-through payments included in the baseline, the state must allocate supplemental payment and managed care pass-through expenditures to the HAO demonstration population based on the percentage of base Medicaid payments, on a service-specific basis, made for these populations during the corresponding base period. In the box below, for each applicable supplemental payment or managed care pass-through payment please:

i. Identify the service,
ii. Identify the total amount of the supplemental or pass-through payment,
iii. Identify the amount allocated to the HAO demonstration population,
iv. Identify the source data (e.g., MMIS for paid base claims),
v. Explain the allocation methodology, and,
vi. Indicate if the payment authority is time limited.

As OHCA modifies and enhances its customized delivery system to better manage and coordinate care, the Agency may need flexibility and allowance to adjust our projections to include supplemental payments.

Please "check" each box below to confirm the state has excluded the following supplemental payments:

☒Designated State Health Program (DSHP) payments,
☒Delivery System Reform Incentive Payments (DSRIP),
☒Uncompensated Care Cost (UCC) Payments, and,
☒Other similar pool payments made under section 1115 authority:
N/A

H. Other Adjustments (optional)

If the state proposes to make additional adjustments to improve the accuracy of base period expenditures (e.g., anticipated collections, anticipated increasing prior period adjustments, etc.), in the box below, please:

i. Identify each proposed adjustment amount,
ii. Explain why the adjustment is necessary, and,
iii. Explain how the state calculated the adjustment amount.

N/A. Since the expansion adult population is not a current Medicaid population in Oklahoma and Oklahoma does not use historical expenditure data derived from the CMS-64, all assumptions and adjustments are contemplated in the estimated expenditures. The estimates include potential adjustments such as: non-MMIS transactions, copayments, TPL, pharmacy rebate, population biased selection, FQHC/RHC cost, etc.

No adjustments are proposed.

I. FOR PER CAPITA CAP APPLICATIONS ONLY - Member Month Enrollment Data –

This subsection should only be completed by states requesting "per capita cap" financing for this demonstration. In the table below, the state should identify the total number of enrollee member months for the targeted demonstration population(s) that correspond to the base period expenditures reported by the state in subsection B of this application section.

A. Member Month Enrollment Projection for Targeted Demonstration Population(s)

In the table below, the state should provide its total enrollee member month projection for the targeted demonstration population(s) for each demonstration year (DY) of this proposed demonstration. These projections should correspond with the unduplicated person count projections provided in section II of this application.

Targeted Population	DY01	DY02	DY03	DY04	DY05
Expansion Adults	1,731,421	1,819,489	1,819,489	1,819,489	1,819,489

1902(a)(10)(A)(i)(VIII)					
Total Sum	1,731,421	1,819,489	1,819,489	1,819,489	1,819,489

B. Member Month Enrollment History for Targeted/Relevant Population(s)		
In the table below, the state should provide historical total enrollee member month data used to derive the member month projections in table A above.		
Targeted Populations	**Expansion Adults** 1902(a)(10)(A)(i)(VIII)	**Total Sum** (across all populations)
Q01 20__	0	0
Q02 20__	0	0
Q03 20__	0	0
Q04 20__	0	0
Q01 20__	0	0
Q02 20__	0	0
Q03 20__	0	0
Q04 20__	0	0
Total Sum (by Population)	**0**	**0**

In the box below, the state should specify the source of the data provided above and describe the analysis used to derive the baseline enrollee member month counts and associated enrollee member month projections for each targeted demonstration population; including how this analysis corresponds with the states' analysis described in section II above for estimating unduplicated person counts.

If the state is basing its member month data from enrollment data reported in the MBES, please also specify data by form name, line number, and quarter.

N/A. Since the expansion adult population is not a current Medicaid population in Oklahoma, OHCA is unable to provide historical enrollment data. Member month enrollment projections are based on the unique enrollment projections (detailed in Attachment B – HAO enrollment and cost projections as of 3.9.2020), multiplied by 12 (months per year).

To note, this projection is based only on ACS data, other state experience and OHCA is limited since there is no historical Oklahoma experience. This also makes no assumptions on economic outlook which could significantly impact enrollment for both the current and newly eligible populations. If the state plan is approved, OHCA will be able to use real experience to develop current and future enrollment projections.

If the state proposes to make additional adjustments to improve the accuracy of base period total enrollee member months, in the box below:

i. Identify each proposed adjustment amount,
ii. Explain why the adjustment is necessary, and,

iii. Explain how the state calculated the adjustment amount.
N/A. Since the expansion adult population is not a current Medicaid population in Oklahoma and Oklahoma does not use historical expenditure data derived from the CMS-64, all assumptions and adjustments are contemplated in the estimated expenditures. No adjustments are proposed.

Section VII – Section 1115 Authorities

The Medicaid program flexibilities requested by the state in this HAO demonstration application are designed to be provided specifically pursuant to expenditure authority under section 1115(a)(2) of the Act, without the need for section 1115(a)(1) waiver authorities. The state should describe in the box below any component of the proposed policy options or approaches to program administration and design identified in this application template that the state believes additional authorities may be necessary to authorize the HAO demonstration.
Section 1115(a)(2) expenditure authority for populations described in Section II above (populations described within 42 CFR 435.119)

Section VIII -- Fair Hearing Rights

The state should choose one of the following options for providing fair hearing rights under this proposed HAO demonstration.	
☒	The state will comply with all notice and fair hearing provisions in 42 CFR part 431 subpart E.
☐	As described below, the state is proposing the following fair hearing process, as an alternative to 42 CFR part 431 subpart E requirements, with the purpose of improving upon the fair hearing process outlined in these regulatory provisions. The state's description should include an explanation of how the state believes this alternative approach will improve upon the state's fair hearing process and will still afford to individuals applying for or receiving coverage in the HAO demonstration constitutional and statutory protections that include, but are not limited to, such basic elements as the right to advance notice of a termination or other adverse action; clearly explaining the reason for the action; a timely fair hearing before an impartial arbiter; the opportunity to be represented by counsel at the hearing and to present evidence, including the right to call witnesses; the right to know opposing evidence and cross examine witnesses; and a requirement that the tribunal hearing the case prepare a record of the evidence presented, make a decision based solely upon the evidence presented at the hearing, and produce written findings of fact and reasons for its decision). Other requirements rooted in laws other than the Medicaid statute, such as accessibility requirements for individuals living with disabilities or individuals with limited English proficiency also would apply to a HAO demonstration under section 1115(a)(2) authority.

Additional Information. In the box below, provide any additional information the state believes is important for CMS to understand its intended approach for providing fair hearing rights under this HAO demonstration.
N/A. Oklahoma will continue to use current fair hearing policies and procedures for SoonerCare 2.0 members.

Section IX – Performance Baseline Data

Baseline Data – The state should indicate below the documentation it is providing to describe its baseline performance data and any additional data the state plans to use as part of this proposed HAO demonstration. This includes baseline performance data on CMS' mandatory subset of the Medicaid Adult Core Set quality measures as well as baseline data on CMS' set of continuous performance indicators as described in the HAO demonstration SMDL guidance. The specific baseline data submission requirements will vary depending on whether the state is proposing coverage of individuals that will be newly eligible under this demonstration, individuals already eligible for coverage, or a combination.

If the state is including in this demonstration individuals **already eligible for coverage**, for whom baseline data should be available, check the box(es) below to indicate the information that the state is providing as an attachment to this application.		If the state is proposing coverage of individuals under this demonstration that will be **newly eligible**, check the box(es) below to indicate the information that the state is providing as an attachment to this application.	
☐	The state is providing as attachment ___ the baseline performance data for the mandatory subset of the Medicaid Adult Core Set quality measures described in Appendix D of the HAO demonstration SMDL guidance.	☒	The state is providing its plan and timeline for how it will collect the baseline performance data for the mandatory subset of the Medicaid Adult Core Set quality measures described in Appendix D of the HAO demonstration SMDL guidance in the "Additional Information" subsection below.
☐	The state is providing as attachment ___ the baseline performance data on the continuous performance indicators that it intends to use for timely indicators of potential issues impacting beneficiary access to coverage or care as described in Appendix H of the HAO demonstration SMDL guidance.	☒	The state is providing its plan and timeline for how it will collect the baseline performance data on the continuous performance indicators that it intends to use for timely indicators of potential issues impacting beneficiary access to coverage or care as described in Appendix H of the HAO demonstration SMDL guidance in the "Additional Information" subsection below.

Additional Information. In the box below, provide any additional information the state believes is important for CMS to understand its intended approach for performance measurement and the data it will use to establish baseline performance.

Medicaid Adult Core Set quality measures

The State currently reports 20 out of the 25 mandatory measures identified in the HAO demonstration SMDL guidance. Data will be collected via online application and claims submission channels. The 25 measures (including the five not currently reported) will be reported based on the following timeline:

Plan	Reporting Timeline
The five-year SoonerCare 2.0 HAO demonstration has an expected effective date of 7/1/2021. All 25 mandatory measures will be collected at that time. Based on this timeline, six months of data will be collected and available by the end of 2021.	**December 2022**: This will cover Calendar year 2021 data, including 6 months of data tied to SoonerCare 2.0. **December 2023**: This will cover Calendar year 2022 data, including 12 months of data tied to SoonerCare 2.0.

Table IX.1 is a list of the five measures that are not currently reported. OHCA will engage CMS to ensure OHCA captures the appropriate data elements and will build new queries. OHCA will also conduct internal quality review controls to ensure the accuracy and replicability of the data. These new data elements will be added no later than the SoonerCare 2.0 effective date.

Table IX.1. Measures to add to OHCA Medicaid Adult Core Set quality measures reporting

Measure Name	NQF #	Measure Steward	Mandatory Measure*
Controlling High Blood Pressure (CBP-AD)	0018	NCQA	Yes
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	0059	NCQA	Yes
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	1932	NCQA	Yes
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	NA***	NCQA	Yes
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)**	3400	CMS	Yes

Table IX.2. shows the complete list of the 25 mandated measures that will be reported as described in timeline. The queries for the 20 measures OHCA reports for its current Medicaid populations will also be updated to collect data about the expansion population.

Table IX.2. Comprehensive list of Medicaid Adult Core Set quality measures OHCA will report

Measure Name	NQF #	Measure Steward	Mandatory Measure*
Primary Care Access and Preventive Care			
Cervical Cancer Screening (CCS-AD)	0032	NCQA	Yes
Chlamydia Screening in Women Ages 21–24 (CHL-AD)	0033	NCQA	Yes
Flu Vaccinations for Adults Ages 18 to 64 (FVA-AD)	0039	NCQA	No
Breast Cancer Screening (BCS-AD)	2372	NCQA	Yes
Screening for Depression and Follow-Up Plan: Age 18 and Older (CDF-AD)	3148	CMS	No
Adult Body Mass Index Assessment (ABA-AD)	NA	NCQA	Yes
Maternal and Perinatal Health			
PC-01: Elective Delivery (PC01-AD)	0469/2829	TJC	No
Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	1517****	NCQA	Yes
Contraceptive Care – Postpartum: Ages 21–44 (CCP-AD)	2902	OPA	Yes
Contraceptive Care – Most and Moderately Effective Methods: Ages 21–44 (CCW-AD)	2903	OPA	Yes
Care of Acute and Chronic Conditions			
Controlling High Blood Pressure (CBP-AD)	0018	NCQA	Yes
Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	0059	NCQA	Yes
PQI 01: Diabetes Short-Term Complications Admission Rate (PQI01-AD)	0272	AHRQ	Yes
PQI 05: Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (PQI05-AD)	0275	AHRQ	Yes
PQI 08: Heart Failure Admission Rate (PQI08-AD)	0277	AHRQ	Yes
PQI 15: Asthma in Younger Adults Admission Rate (PQI15-AD)	0283	AHRQ	Yes
Plan All-Cause Readmissions (PCR-AD)	1768	NCQA	Yes
Asthma Medication Ratio: Ages 19–64 (AMR-AD)	1800	NCQA	Yes
HIV Viral Load Suppression (HVL-AD)	2082	HRSA	No
Behavioral Health Care			
Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (IET-AD)	0004	NCQA	Yes
Medical Assistance with Smoking and Tobacco Use Cessation (MSC-AD)	0027	NCQA	No
Antidepressant Medication Management (AMM-AD)	0105	NCQA	Yes
Follow-Up After Hospitalization for Mental Illness: Age 21 and Older (FUH-AD)	0576	NCQA	Yes
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD-AD)	1932	NCQA	Yes
Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence (FUA-AD)	3488*****	NCQA	Yes
Follow-Up After Emergency Department Visit for Mental Illness (FUM-AD)	3489*****	NCQA	Yes
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPCMI-AD)	2607	NCQA	No
Use of Opioids at High Dosage in Persons Without Cancer (OHD-AD)	2940	PQA	Yes
Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA-AD)	NA***	NCQA	Yes
Concurrent Use of Opioids and Benzodiazepines (COB-AD)	NA	PQA	Yes
Use of Pharmacotherapy for Opioid Use Disorder (OUD-AD)**	3400	CMS	Yes
Long Term Services and Supports			
National Core Indicators Survey (NCIDDS-AD)**	NA	NASDDDS/ HSRI	No

Continuous performance indicators

The SMDL identified the 13 metrics listed in Figure IX.1 as part of the continuous performance indicator system. The State is well positioned to begin reporting these metrics at quarterly intervals as requested by CMS, based on their applicability to the demonstration. Reporting

activities can be updated and begin the quarter following implementation. Assuming an implementation date of 7/1/2021, OHCA will capture the required reporting metrics at implementation and would report on the metrics the following quarter (i.e. 10/1/2021 – 12/31/2021).

- Key metrics will require a system change. For example, the diabetes adult measure (PQ101-AD) is already reported on an annual basis but would require some modifications to capture the newly eligible population, based on guidance from CMS.

- Some metrics may not be applicable. For example, the state currently utilizes a real-time online application system for eligibility determination, so some of the specifications for the last two metrics listed under the 'Enrollment' section might not be applicable.

Figure IX.1. Metrics for continuous performance indicator system

Appendix H: METRICS FOR CONTINUOUS PERFORMANCE INDICATOR SYSTEM	
Access to care and availability of services	
1	Provider active participation: # providers enrolled with service claims for 3 or more beneficiaries a) Primary provider b) Specialist provider
2	Managed care states: Provider availability by plan a) Number of calls to state or plan's call center indicating difficulty in finding provider or timely access to primary care services b) Number of calls to state or plan's call center indicating difficulty in finding provider or timely access to specialty care services
3	Emergency department (ED) utilization a) Total ED visits/number of member months in quarter b) Total nonemergency ED visits
4	Inpatient admissions/member months in quarter a) Total b) Avoidable
5	Diabetes Short-Term Complications Admission Rate / Adult Core Set (PQI01-AD) (NQF 0272)
Enrollment	
6	Total demonstration enrollment
7	Retention at renewal a) Total due for renewal b) Percent successfully renewed c) Percent terminated at renewal d) Pending disposition
8	Suspensions and lockouts (if applicable)
9	Total pending applications
Appeals and grievances	
10	Number of appeals requested/demonstration enrollment a) Medicaid eligibility b) Denial of benefits
11	Number of grievances, by plan (managed care)/ demonstration enrollment
Financing	
12	Claims processing (by plan if managed care) a) The percentage total claims that were clean as submitted b) Percentage of clean provider claims paid within (i) 14 days; (ii) over 45 days
13	Medical loss ratio (MLR) (managed care) a) Estimated for the quarter b) Estimated year-to-date (YTD)

Section X – Evaluation

Evaluation Design – In the table below, the state should provide research hypotheses and proposed evaluation parameters for testing the outcomes of the HAO demonstration associated with the proposed goals and objectives listed in section I.B of this application. To assist the state

in completing this section, the state may refer to CMS' published guidance on how to develop evaluations that align with CMS' expectations for rigorous evaluation by clicking the following link: https://www.medicaid.gov/medicaid/section-1115-demo/downloads/evaluation-reports/developing-the-evaluation-design.pdf.

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
GOAL 1. Improve access to high-quality, person-centered services that produce positive health outcomes for individuals	**Hypothesis 1.** Enrollment in managed care will increase the use of preventive, primary, urgent and specialty care.	**Data Sources:** Claims data; member survey **Analytic Approach:** • Descriptive quantitative analysis • Difference-in-differences regression analysis • Qualitative analysis
	Hypothesis 2. SoonerCare 2.0 members will report higher levels of satisfaction with health care access in managed care than Medicaid members that participate(d) in a fee-for-service delivery system.	**Data Sources:** Member survey **Analytic Approach:** • Descriptive quantitative analysis • Difference-in-differences regression analysis • Qualitative analysis
GOAL 2. Strengthen beneficiary engagement in their personal health care plan, including incentive structures that promote responsible decision-making	**Hypothesis 1.** Implementation of an $8 copay for non-emergency use of the ER will reduce non-emergency use of the ER.	**Data Sources:** Claims data; member survey **Analytic Approach:** • Descriptive quantitative analysis • Difference-in-differences regression analysis • Qualitative analysis
GOAL 3. Enhance alignment between Medicaid policies and commercial health insurance products to facilitate smoother beneficiary transition	**Hypothesis 1.** SoonerCare 2.0 members with a monthly premium will gain familiarity with SoonerCare 2.0 members with a common feature of commercial health insurance.	**Data Sources:** Member survey; eligibility system **Analytic Approach:** • Descriptive quantitative analysis • Qualitative analysis

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
	Hypothesis 2. SoonerCare 2.0 members will be more likely than other Medicaid members to enroll in coverage before they experience an acute health care need (retroactive coverage policy and elimination of hospital presumptive eligibility)	**Data Sources:** State administrative enrollment data; member survey; claims data **Analytic Approach:** • Difference-in-differences regression analysis
	Hypothesis 3. SoonerCare 2.0 member access to care will not be adversely impacted by the elimination of the non-emergency medical transportation benefit	**Data Sources:** Member survey **Analytic Approach:** • Qualitative analysis
GOAL 4. Support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals	**Hypothesis 1:** SoonerCare 2.0 members subject to community engagement requirements will transition out of Medicaid due to increased income at a greater rate than Medicaid members not subject to the requirements.	**Data Sources:** Member survey; state workforce or tax data; state administrative enrollment data **Analytic Approach:** • Difference-in-differences regression analysis
	Hypothesis 2: SoonerCare 2.0 members subject to community engagement requirements will have higher employment rates compared to Medicaid members not subject to the requirements.	**Data Sources:** Member survey; state workforce or tax data **Analytic Approach:** • Difference-in-differences regression analysis
	Hypothesis 3: SoonerCare 2.0 members subject to community engagement requirements will have higher household income compared to Medicaid members not subject to the requirements.	**Data Sources:** Member survey; state workforce or tax data; state administrative enrollment data **Analytic Approach:** • Difference-in-differences regression analysis
GOAL 5. Promote efficiencies that ensure Medicaid's sustainability for beneficiaries over the long term	**Hypothesis 1:** Eliminating hospital presumptive eligibility will ensure that individuals are accurately assessed as eligible for Medicaid using the real-time eligibility application.	**Data Sources:** State administrative enrollment data **Analytic Approach:** • Descriptive quantitative analysis • Difference-in-differences regression analysis • Qualitative analysis

Section XI – Adequacy of Infrastructure

A. Information Technology (IT) Infrastructure – States will be expected to ensure the availability of adequate resources for implementation and monitoring of this demonstration including education, outreach, and enrollment; maintaining eligibility systems applicable to the demonstration; compliance with any applicable cost sharing requirements; and reporting on financial and other demonstration components. In the box below or as an attachment to the application, the state should describe how it has developed, or plans to develop, the information technology (IT) systems capability needed to support this demonstration and meet the reporting requirements.

Oklahoma intends to leverage its MMIS Fiscal Agent contract for the implementation of SoonerCare 2.0. The MMIS was developed by DXC Technology to serve the needs of the federally mandated program for all states. It is CMS-certified and has current operational agreement through CY2024. The system will be based on the Medicaid Information Technology Architecture (MITA) Maturity Model principles and Service Oriented Architecture (SOA) Integration Framework. MMIS is a highly sophisticated, feature-rich system centered on a strong, Medicaid-specific relational data model. It divides the application into components (subsystems) which has the supporting architecture to deliver enhanced flexibility, scalability, and reliability for HAO needs.

Some of the utilized subsystems and system assurances include:

1. The managed care function is designed to assure enrollment and access using standard transactions such as the 834/820/835, 270/271, etc. Member notifications regarding plan selection, enrollment and all other eligibility needs will be transmitted via our MMIS' COLD/Letter Generator applications.
2. The MAR function uses key information from other MMIS functions to generate standard reports. The major inputs to MAR are data from all the claims processing functions and the Reference Data Maintenance, Recipient Data Access, and Provider Data Maintenance functions. The major process is the generation of reports and program data, and the major outputs are the financial, statistical, and summary reports and data required by federal regulations, and other reports and data that assist the state in the management and administration of the Oklahoma Medical Assistance Programs. MAR also is responsible for submitting T-MSIS data and will provide enrollment data and related encounter claims data in the appropriate set of T-MSIS extracts.
3. The Claims Processing function for SoonerCare 2.0 that remain fee-for-service includes Edit/Audit Processing function ensures that claim records are processed in accordance with state policy, adjustment processes of any previously adjudicated claim, and claims resolution.
4. A certified Eligibility and Enrollment web application for benefits that accepts on-line applications for SoonerCare, SoonerPlan, Presumptive Eligibility, Alien, and DMH Behavioral Health programs over the OHCA secure web site. Eligibility is determined in real-time, so that clients applying know immediately if they are eligible, what they are eligible for, and what if any documentation they need to provide.
5. The Recipient Data function is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals eligible for medical assistance in Oklahoma and to support analysis of the data contained within the recipient data maintenance system. The maintenance of recipient data is required to

support claim processing in both batch and online mode, reporting functions, and eligibility verification.

6. The Interchange (iCE) web application used by OHCA employees was created as a multithreaded architecture that provides the flexibility, scalability, and reliability that OHCA needs to ensure the long-term success of adding new populations and programs like SoonerCare 2.0.
7. The Decision Support System/Data Warehouse (DSS) function provides for access to the Oklahoma MMIS data and various external data sources such as immunizations and vital records. The data is stored in an Oracle relational database and is accessed through the BusinessObjects application.
8. Data exchange systems for purposes of determining third-party information concerning the application for Medicaid. This is enabled via an Enterprise Services Bus (ESB) to expand the use of web service and to link the multiple application in a Service Oriented Architecture (SOA) environment. This includes but not limited to earned and unearned income, employment status, incarceration status, death records and enrollment in public assistance outside of the state.
9. Education and outreach can be captured via Interchange and computer-telephony integration software.
10. Compliance with any applicable cost sharing requirements will fall within current procedures under the state plan for covered beneficiaries.

B. Transition Planning – States will be expected to have a plan for transition and orderly close-out if the HAO demonstration, in whole or in part, is being suspended or terminated prior to the date of expiration, or not being extended beyond the date of expiration. In the box below or as an attachment to the application, the state should describe how it has developed, or plans to develop, a transition plan that aligns with each of the listed minimum requirements:

Transition Plan Requirement	**State Process**
Description of how the state will comply with all notice requirements found in 42 CFR 431.206, 431.210 and 431.213.	N/A
Description of how the state will notify affected beneficiaries, including leveraging community outreach activities or community resources that are available. Including providing notice that enrollment of new individuals into the demonstration will be suspended during the last six months of the demonstration.	N/A
Description of the proposed content of beneficiary notices or sample notices that will be sent to affected beneficiaries.	N/A
Description of how the state will assure all appeal and hearing rights are afforded to demonstration participants as outlined in 42 CFR 431.220 and 431.221; including maintaining benefits as required by 42 CFR 431.230 if a demonstration participant requests a hearing before the date of action.	N/A
Description of the state's process for conducting renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category (42 CFR 435.916).	N/A

Transition Plan Requirement	State Process
If suspension or early termination is being initiated by the state, description of how the state will notify CMS in writing of the effective date and reason(s) for any suspension or early termination initiated by the state at least 120 days before the effective date of the demonstration's suspension or termination.	N/A
Description of how the state will track and ensure that demonstration expenditures claimed for FFP are limited to normal closeout costs associated with suspension or terminating the demonstration such as administrative costs of disenrolling participants.	N/A
If the state is requesting exemption from public notice procedures pursuant to 42 CFR 431.416(g), description of the qualifying circumstances for which the state is requesting CMS to expedite or waive federal and/or state public notice requirements.	N/A

Section XII – Programmatic Changes

Program Options Not Subject to Prior CMS Approval:

States may maximize its ability to make administrative and programmatic changes after the HAO demonstration is approved, without need for additional CMS approval, by describing in the box below a range of policy options or approaches to the design or operation of the demonstration that it may consider implementing over the course of the demonstration approval period. CMS will incorporate in the Special Terms and Conditions (STCs) the range of changes to the policy, design or operation of the HAO demonstration that is being authorized as part of the demonstration approval. States would be expected to provide notice to CMS, an opportunity for public notice and comment, and tribal consultation (if applicable) at least 60 days in advance of implementing a planned change. If the state intends to revise its planned programmatic change, within approved STC parameters, in response to public comments received, states are expected to provide CMS with written notification at least 30 days prior to implementation of such revised change(s).

States do not need to repeat here any range of policy options it has already outlined in any of the above application sections.

N/A

Please note that any programmatic options not approved in the demonstration STCs will require a demonstration amendment, subject to the federal transparency requirements set forth in 42 CFR part 431 subpart G, and (if applicable) tribal consultation requirements as outlined in the state's approved Medicaid state plan or CMS' July 17, 2001 State Medicaid Director Letter (#01-024).

Section XIII – Documentation of State Public Notice and Transparency Efforts

States are expected to comply with the federal transparency requirements set forth at 42 CFR part 431 subpart G prior to submission of this demonstration application to CMS. Consistent with 42 CFR 431.408(b) and the CMS Tribal Consultation Policy, states developing HAO demonstration applications will be expected to hold meaningful consultation on a government-to-government basis with federally recognized tribes located in their state, in order to develop the details of how a HAO demonstration would be implemented and apply to tribal beneficiaries. In particular, under 42 CFR 431.408(b), states with federally recognized Indian tribes, Indian health programs, and/or urban Indian health organizations must consult with tribes and solicit advice from Indian health programs and urban Indian health organizations in the state, prior to submitting a demonstration application to CMS, if the demonstration would have a direct effect on Indians, tribes, Indian health programs, or urban Indian health organizations.

In the box below or as an attachment to this application, the state should describe how it complied with these requirements prior to submission to CMS. The description should include the following: 1) a description of all mechanisms used by the state to publish its public notice and the structured formats used to solicit input from interested parties; 2) documentation of the state's full public notice, abbreviated public notice, and tribal consultation notice (if applicable); 3) the active link(s) to the state's website where the public notice documents and public input procedures were made available to the public; and 4) a report of the issues raised during the state public comment period that includes the number of comments received, types of commenters (individual, professional organizations, etc.), common themes or trends of comments received, and the correlation to how these comments were addressed via changes to the state's proposed application or implementation of the demonstration.

The State drafted its abbreviated public notice and sent to CMS for review of content on February 28, 2020 and received feedback on content from CMS on February 28, 2020; refer to email attachment 1. The notice was finalized and sent to the Agency's contracted entity to publish in areas newspapers on February 28, 2020; the notice was to be published in area newspapers on March 16, 2020; refer to email attachment 2. The Agency revised its abbreviated public notice to make a change in venue for the first hearing from the Medical Advisory Committee (MAC) on March 12, 2020 to the OHCA Board meeting on March 18, 2020 at the Children's Center Rehabilitation Hospital in Bethany, OK; staff sent a revised copy of the public notice to the publisher on March 6, 2020 to reflect change in venue; refer to email attachment 3. On March 10, 2020, the Agency notified the public notice publisher of yet another change in venue for the first public hearing due to cancellation by the Children's Rehabilitation Hospital's administrator who cited COVID-19 concerns; the Agency changed the venue to the Oklahoma Health Care Authority Boardroom, but kept the date and time of the meeting the same (March 18, 3PM); refer to email attachment 4 & 5.

While the public health emergency (PHE) was declared by Secretary Azar on January 31, 2020, there were no standards/changes to business processes at the Oklahoma level during the scheduling of the HAO hearings, drafting of public notice, and publishing of such notice in late February/early March 2020. The HAO waiver application and public notice were posted on the OHCA's policy blog and SoonerCare 2.0 dedicated webpage on March 16, 2020. On March 16, 2020 the State engaged CMS on whether it could conduct hearings virtually due to the growing concern of COVID-19 and received a response from CMS on March 18, 2020 alerting the State that newly published FAQs addressed social distancing and deviation from usual public hearing processes. The FAQs noted that States could be exempted from typical public notice procedures by invoking 42 CFR 431.416(g); refer to email attachment 14. On March 17, 2020,

the OHCA's legislative liaison made Agency staff aware of a proposed bill (HB3888) which amended state public meeting procedures [virtual meetings]; it was approved by the Governor on March 17, 2020; refer to email attachment 6. Additionally, the Governor of Oklahoma, J. Kevin Stitt, proclaimed a public health emergency in the State on March 17, 2020 via Executive Order (EO) 2020-07 and provided social distancing guidelines that mirrored the President's Coronavirus guidelines through Executive Order 2020-08. EO 2020-08 informed Oklahomans to avoid social gatherings of more than 10 people. On March 17, 2020, the Agency began receiving cancellation notices for the sites that it had secured to conduct public hearings; refer to email attachments 7, 8, 9, 10, and 11. On March 17, 2020, the Agency sent out a social media posting and a press release to alert the public of its HAO application posting on the website and the request for public comment. The OHCA Board meeting was rescheduled to March 30 and to be held virtually only. The Agency had already published a notice with a hearing for HAO on March 18 at 3PM; therefore, to reduce confusion and yet continue to engage the public, the Agency decided to keep its HAO hearing scheduled for March 18 at 3PM and hold it virtually (refer to email attachment 16). The Agency sent out social media announcements as soon as the Agency's decision was made to keep the public hearing even though the date of the Board moved on March 18, 2020 via Facebook and Twitter (refer to email attachment 13), and through a press release, refer to attachment 19. OHCA press releases are sent to state media outlets and those outlets publish their own releases, refer to email attachment 18, press releases dated 3/18/2020 as examples. Legislators were also provided with information regarding the first public hearing being held virtually, refer to attachment 20.

Because there was little time between the venue cancellations, executive orders, rescheduling of the Board meeting, turning the 03.18.2020 hearing into a virtual hearing, and applicable federal and state social distancing guidelines, the OHCA made the decision to evoke federal authority at 42 CFR 431.416(g)(ii) and move all HAO-related face-to-face hearings to virtual moving forward from March 18, 2020. Therefore, the Agency published various social media posts informing the public of this change and of the various upcoming hearings (refer to attachment 15 and below):
https://www.facebook.com/172132388269/posts/10158178334763270/?d=n
https://www.facebook.com/172132388269/posts/10158185657218270/?d=n
https://www.facebook.com/172132388269/posts/10158190813403270/?d=n
https://www.facebook.com/172132388269/posts/10158201535228270/?d=n
https://www.facebook.com/172132388269/posts/10158205706738270/?d=n
https://www.facebook.com/172132388269/posts/10158274385938270/?d=n
https://www.facebook.com/events/163067818382482/
https://www.facebook.com/172132388269/posts/10158297916418270/?d=n&substory_index=0
https://twitter.com/ok_hca/status/1240308990300639233?s=21
https://twitter.com/ok_hca/status/1240339697634852865?s=21
https://twitter.com/ok_hca/status/1241035395120410624?s=21
https://twitter.com/ok_hca/status/1241452275249360897?s=21
https://twitter.com/ok_hca/status/1242503701723521029?s=21
https://twitter.com/ok_hca/status/1242884962929565696?s=21

On March 19, 2020, the Agency published a revised full public notice for the HAO application on its policy changes webpage noting the move to virtual public hearings and also published a press release to inform the public that hearings for the HAO application would be expanded (to include more than the federally required hearings), provide future hearing dates, and links to sign up for the virtual hearings.

The State facilitates notification of changes to policy through webalerts on its various webpages, inclusive of the OHCA policy changes webpage, OHCA tribal policy changes webpage, its dedicated SoonerCare 2.0 webpage, and its press release notifications venue. When a press release is posted on the OHCA website, it is sent to a listserv, GovDelivery, which sends emails to media outlets on file and provides them with the press release. In total, the agency has approximately 3,742 email addresses on file that receive alerts through webalert mechanisms.

In light of the public health emergency, COVID-19, the CDC's social distancing guidelines, Oklahoma executive orders, and the federal authority provided to States at 42 CFR 431.416(g)(ii), Oklahoma engaged in a rigorous virtual public comment process rather than the traditional process for seeking the public's input on new 1115 waiver demonstration applications. The State sent out web alerts to email addresses on file of the posting of the full waiver to garner public input, leveraged its social media platforms (Facebook and Twitter), created a targeted webpage for the purposes of the HAO proposal (the webpage included another venue for individuals to provide their email addresses to receive updates on the HAO application), facilitated workgroups with tribal partners/stakeholders, published media releases during the public comment period, and conducted more than the required number of public hearings/meetings – one in particular on April 20,2020 to inform the public of what information was ultimately included in the final waiver submission to CMS; refer to email attachment 17 for a recording of the additional meeting.

After conducting the first public hearing, the State received feedback on how to enhance the virtual platform; therefore, the public virtual hearings were set up to allow individuals to see questions as they were submitted from other stakeholders in the meeting to the panelist, closed captioning was enabled, screen sharing was applied, and anonymous comments were disabled to increase engagement and participation. Additionally, public hearing participants were able to call in to the public hearing via phone and were not limited to using internet audio. Virtual public hearing agendas were also published prior to each virtual public hearing. Comments received during the hearings and responses provided to inquirers were then compiled and provided to the public on the dedicated SoonerCare 2.0 webpage for public consumption.

The agency began its public notice process March 16, 2020 and concluded online comments April 15, 2020. The public notice was posted on the OHCA's website and within six Oklahoma-based newspapers. A copy of the full public notice, the draft HAO application, and instructions about the public comment process is available at www.okhca.org/PolicyBlog; Attachment C contains the proof of public notice. The agency also offered an in-person tribal notice meeting on February 13, 2020, notifying the tribes of the in-person consultation which took place on March 3, 2020; 64 stakeholders were in attendance. The agenda and sign-in sheets from the consultation are enclosed as Attachment D.

During the face-to-face tribal consultation, five participants sought clarification regarding the proposed HAO changes. The participants' questions focused on the FMAP rate for ITU providers, impact on AI/AN members as well as other agency programs, timelines, and the delivery system, including opposition to operating under a managed care organization.

Additional tribal workgroups were formed to facilitate communication with tribal partners, answer questions, and seek input regarding the content in the HAO application; the state has

reflected changes in the official waiver application based on the feedback received within the tribal consultation public comment process.

The agency conducted a total of 11 public and targeted forums statewide, through virtual technology, to garner public and stakeholder input into the development of the SoonerCare 2.0 HAO demonstration, as listed below. Each meeting contains a link to the list of questions and answers received during that public meeting and attachment E contains the list of attendees from all of the virtual public hearings (888 total participants). The State received a total of 2,420 comments from the public hearings and as well as the policy change blog. Attachment F contains a summary of the public comments received and the Agency's response as part of the application's public review period on the Agency's website (policy change blog).

1. Oklahoma Behavioral Health Association Meeting
   March 3, 2020 at 12:00pm
   Kamps 1910 Boardroom
   10 NE 10th ST
   Oklahoma City, Oklahoma 73104

2. Behavioral Health Advisory Council
   March 11, 2020 at 9:30am

3. Oklahoma Department of Mental Health and Substance Abuse Services
   2000 N. Classen Blvd.
   Oklahoma City, OK 73106

4. Oklahoma Primary Care Association Meeting
   March 11, 2020 at 12:00pm
   OKPCA Boardroom
   6501 N. Broadway Ext., Suite 200
   Oklahoma City, OK 73116

5. Oklahoma Psychiatric Hospital Association
   March 11, 2020 at 1:30pm
   4000 N. Lincoln Blvd.
   Oklahoma City, OK 73105

6. VIRTUAL PUBLIC MEETING
   March 18, 2020 at 3:00 p.m.
   Meeting Questions & Answers:
   http://okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=24602&libID=23585

7. VIRTUAL PUBLIC MEETING
   March 20, 2020 at 3:00 p.m.
   Meeting Questions & Answers:
   https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=24656&libID=23639

8. VIRTUAL PUBLIC MEETING
   March 24, 2020 at 1:30 p.m.

Meeting Questions & Answers:
http://okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=24697&libID=23680

9. VIRTUAL PUBLIC MEETING
   March 26, 2020 at 5:30 p.m.
   Meeting Questions & Answers:
   http://okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=24700&libID=23683

10. OHCA Member Advisory Taskforce
    April 4, 2020 at 10:00am
    Zoom virtual meeting

11. VIRTUAL PUBLIC MEETING
    April 20, 2020 at 11:00am
    Zoom virtual meeting

Based on comments received during the public comment process, the State made the following revisions to the waiver application:

- Based on public comment received through the virtual hearings, the initiation of coverage date was changed. Original timeframes were built around the 15th of the month and could result in an individual not having coverage until 45 days after application and premium payment. In response, OHCA revised the application in order to reflect the coverage noted in Section II (A), subsection 1.1 "Paying Premiums and Starting Coverage"
- Based on feedback received during tribal workgroups focused on the HAO application, OHCA made an assurance within Section II (A) subsection 2.7 "Modifying Community Engagement Requirements Over Time" that any future changes in community engagement requirements will not affect AI/AN members.
- Based on feedback received during tribal workgroups focused on the HAO application, OHCA made an assurance within Section III (B) "Alternative Benefit Package" that any future changes to benefits will not affect services provided through I/T/Us reimbursed at 100% FMAP.
- Based on feedback received during tribal workgroups focused on the HAO application, the OHCA made an assurance within Section III (E) "Federally Qualified Health Centers" that the Tribal FQHC APM already in place will apply to the demonstration. Any future APMs designed for FQHCs will not affect the Tribal FQHC APM that is already in place.
- Based on feedback from stakeholders during the public comment process regarding the HAO delivery system, OHCA requested flexibility to build upon its current Patient Centered Medical Home (PCMH) model to deliver coordinated, timely, high-quality care to our SoonerCare 2.0 members; refer to Section V "Delivery Systems and Payment Methods".

Section XIV – State Contact Information

In the box below, the state should identify the state representative(s) that CMS can contact with any questions regarding this application submission.

Melody Anthony
Chief Operating Officer
State Medicaid Director
Melody.Anthony@okhca.org

Attachment A – Sample Community Engagement Exemption and Reporting Forms

Figures A.1 and A.2 are examples of the exemption request and activity reporting forms for individuals subject to the community engagement requirement.

Attachment B – Adult Expansion Alternative Benefit Plan (ABP)

Attachment C – Proof of Public Notice

Attachment D – Tribal Consultation Documents

- 2020-02 I/T/U Notice (inclusive of the 3/3/20 tribal consultation agenda)
- 3/3/20 Tribal Consultation List of Attendees
- 3/3/20 Tribal Consultation Sign-in Sheets

Attachment E – Virtual Public Hearing Attendee Lists

Attachment F – Public Comments received from the Public Posting

Figure A.1. Exemption request form

Exemption Request Form

OKLAHOMA
Health Care Authority

Name:

Member ID Number:

Date of Birth: MM/DD/YYYY

Phone Number:

/ /

( )

Address: City State Zip Code

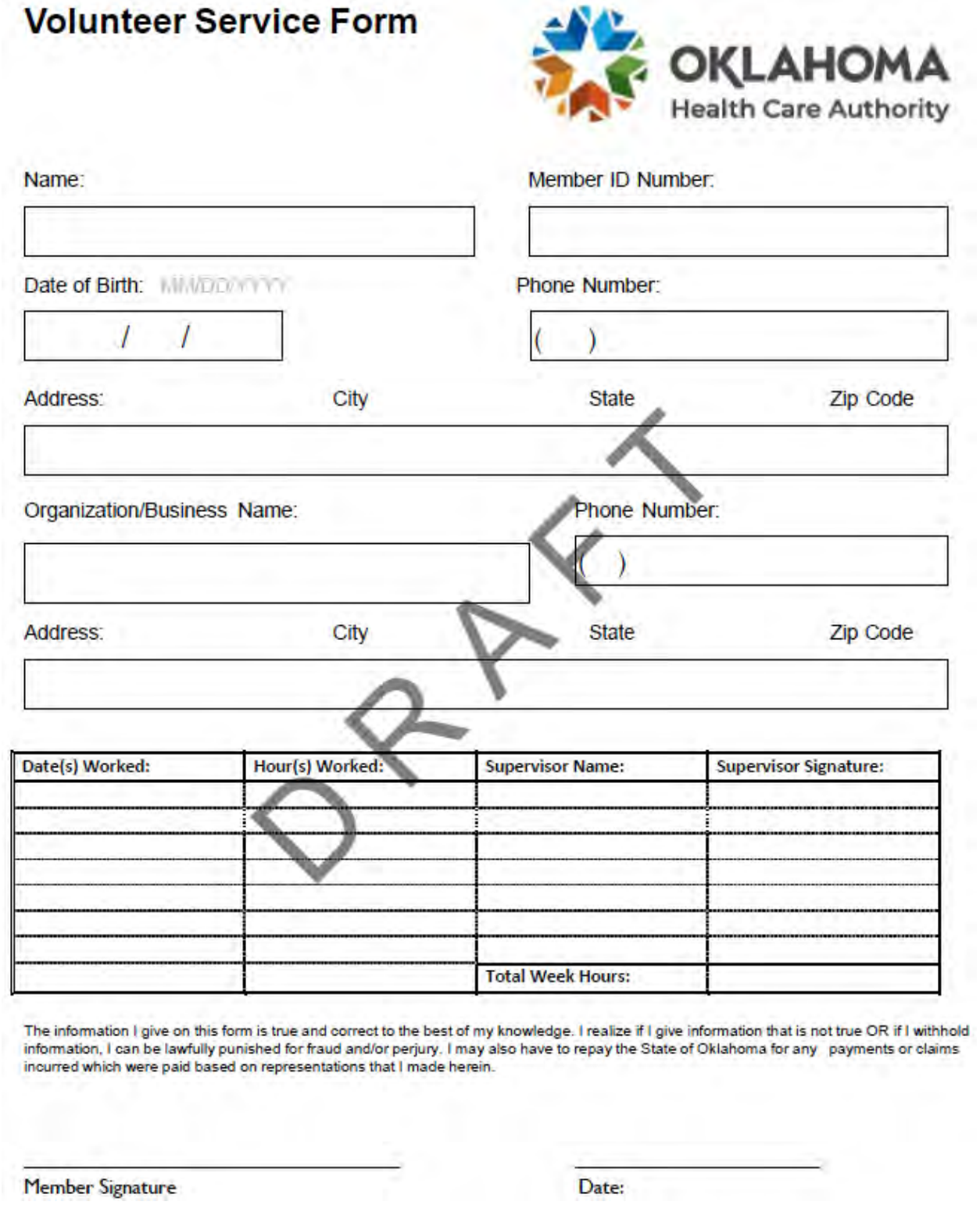
Brief explanation for exemption:

The information I give in this form is true and correct to the best of my knowledge. I realize if I give information that is not true OR if I withhold information, I can be lawfully punished for fraud and/or perjury. I may also have to repay the State of Oklahoma for any payments or claims incurred which were paid based on representation that I made herein.

Member Signature

Date:

Figure A.2. Community Engagement activity reporting form



Volunteer Service Form

OKLAHOMA Health Care Authority

Name:

Member ID Number:

Date of Birth: MM/DD/YYYY

/ /

Phone Number:

( )

Address: City State Zip Code

Organization/Business Name:

Phone Number:

( )

Address: City State Zip Code

DRAFT

Date(s) Worked:	Hour(s) Worked:	Supervisor Name:	Supervisor Signature:
		Total Week Hours:	

The information I give on this form is true and correct to the best of my knowledge. I realize if I give information that is not true OR if I withhold information, I can be lawfully punished for fraud and/or perjury. I may also have to repay the State of Oklahoma for any payments or claims incurred which were paid based on representations that I made herein.

Member Signature

Date:

Attachment B – Adult Expansion Alternative Benefit Package (ABP)

Alternative Benefit Plan

State Name: Oklahoma Attachment 3.1-L- [ ] OMB Control Number: 0938-1148

Transmittal Number: OK - 20 - 0023

Benefits Description	ABP5

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

Blue Cross Blue Shield of Oklahoma/Blue Options Gold 002 plan

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-approved

Alternative Benefit Plan

1. Essential Health Benefit: Ambulatory patient services — Collapse All

Benefit Provided: Primary Care Visits to Treat Injury or Illness
Source: State Plan 1905(a)
Remove
Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan
Amount Limit: 4 visits/month
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 5.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Specialty Visits
Source: State Plan 1905(a)
Remove
Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan
Amount Limit: 4 visits/month
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 5.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Other Practitioner Office Visits
Source: State Plan 1905(a)
Remove
Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan
Amount Limit: 4 visits/month for PA and APRN visits
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Outpatient Facility (ambulatory surgery ctr)

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Remove

Benefit Provided: Dialysis

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Remove

Benefit Provided: Allergy Testing

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 60 tests/3 years

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 5
Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Chemotherapy

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided: Radiation

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided: Outpatient Surgery Physician/Surgical Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.

Add

Alternative Benefit Plan

☑ 2. Essential Health Benefit: Emergency services Collapse All ☐

Benefit Provided: Emergency Room Services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.

Benefit Provided: Emergency Transportation/Ambulance
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-D.

Benefit Provided: Urgent Care Center
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 9.

Add

Alternative Benefit Plan

☑ 3. Essential Health Benefit: Hospitalization Collapse All ☐

Benefit Provided: Inpatient Hospital Services (Inpatient Stay)
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 1.

Benefit Provided: Inpatient Physician & Surgical Services
Source: State Plan 1905(a)
Remove

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit:
Inpatient physician services: 24 days per individual per State Fiscal Year (SFY); one visit per day per physician.
Inpatient surgical services: no limit.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 1.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Organ Transplants
Source: State Plan 1905(a)
Remove

Authorization: Other
Provider Qualifications: Medicaid State Plan

Amount Limit: None
Duration Limit: None

Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-E.

Benefit Provided:

Reconstructive Surgery

Source:

State Plan 1905(a)

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

Non-cosmetic; breast reconstruction/implantation/removal is covered only when it is a direct result of a mastectomy which is medically necessary.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.

Add

Alternative Benefit Plan

☑ 4. Essential Health Benefit: Maternity and newborn care Collapse All ☐

Benefit Provided: Prenatal & Postnatal care

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 3.
Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 6.d.
Reference approved State Plan, Attachment 3.1-A, section 17.
Reference approved State Plan, Attachment 3.1-A, section 20 and section 21.

Benefit Provided: Delivery & Inpatient Services for Maternity Care

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.
Reference approved State Plan, Attachment 3.1-A, section 3.
Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 6.d.
Reference approved State Plan, Attachment 3.1-A, section 17.
Reference approved State Plan, Attachment 3.1-A, section 20.

Add

Alternative Benefit Plan

Collapse All ☐

■ 5. Essential Health Benefit: Mental health and substance use disorder services including behavioral health treatment

☑ The state/territory assures that it does not apply any financial requirement or treatment limitation to mental health or substance use disorder benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification.

Remove

Benefit Provided: Mental/Behavioral Health Outpatient Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 13.d.1.
Amount limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Mental/Behavioral Health Inpatient Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.
Amount limits can be exceeded based on medical necessity.

Remove

Benefit Provided: Substance Abuse Disorder Outpatient Services

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 13.d.1.
Amount limits can be exceeded based on medical necessity.

Add

Alternative Benefit Plan

■ 6. Essential Health Benefit: Prescription drugs

☑ The state/territory assures that the ABP prescription drug benefit plan is the same as under the approved Medicaid State Plan for prescribed drugs.

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):

- ☒ Limit on days supply
- ☒ Limit on number of prescriptions
- ☒ Limit on brand drugs
- ☐ Other coverage limits
- ☒ Preferred drug list

Authorization: No

Provider Qualifications: State licensed

Coverage that exceeds the minimum requirements or other:

The state's ABP prescription drug benefit is the same as the approved Medicaid state plan for prescribed drugs.

Alternative Benefit Plan

■ 7. Essential Health Benefit: Rehabilitative and habilitative services and devices — Collapse All ☐

☑ The state/territory assures that it is not imposing limits on habilitative services and devices that are more stringent than limits on rehabilitative services (45 CFR 156.115(a)(5)(ii)). Further, the state/territory understands that separate coverage limits must also be established for rehabilitative and habilitative services and devices. Combined rehabilitative and habilitative limits are allowed, if these limits can be exceeded based on medical necessity.

Benefit Provided: Outpatient Rehabilitation Services
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: 15 visits/year for each OT, PT, & ST
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.
The benefit amount limits exceed the quantity limits within the base benchmark.

Benefit Provided: Home Health
Source: State Plan 1905(a)
Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: 36 visits/year
Duration Limit: None
Scope Limit: Provided by Home Health agencies
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 7.
The benefit amount limits exceed the quantity limits within the base benchmark.

Benefit Provided: Durable Medical Equipment
Source: State Plan 1905(a)
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 12.c.
Reference approved State Plan, Attachment 3.1-A, section 7 on or after 07.01.2020

Benefit Provided: Prosthetic Devices

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 12.c.

Benefit Provided: Habilitation Services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: 15 visits/year for each OT, PT, & ST

Duration Limit: None

Scope Limit:

Provided only in outpatient hospitals

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.
The benefit amount limits exceed the quantity limits within the base benchmark.

Benefit Provided: Skilled Nursing Facility/Inpatient Rehab Hospital

Source: State Plan 1905(a)

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Alternative Benefit Plan

Amount Limit:

24 days per individual per State Fiscal Year (SFY)

Duration Limit:

None

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 1.
Amount limits can be exceeded based on medical necessity; maximum of 30 days/year.

Add

Alternative Benefit Plan

☑ 8. Essential Health Benefit: Laboratory services Collapse All ☐

Benefit Provided: Imaging (CT/PET scans, MRIs)
Source: State Plan 1905(a)
Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.
Reference approved State Plan, Attachment 3.1-A, section 3.

Benefit Provided: Laboratory Outpatient & Professional Services
Source: State Plan 1905(a)
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Reference approved State Plan, Attachment 3.1-A, section 2.a.
Reference approved State Plan, Attachment 3.1-A, section 3.

Benefit Provided: X-rays & Diagnostic Imaging
Source: State Plan 1905(a)
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 2.a.
Reference approved State Plan, Attachment 3.1-A, section 3.

Add

Alternative Benefit Plan

☑ 9. Essential Health Benefit: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided: Diabetes Education

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 10 hours/first year; 2 hours/subsequent year

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Benefit Provided: Preventive Care/Screening/Immunization

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 5.
Reference approved State Plan, Attachment 3.1-A, section 6.d.

Benefit Provided: Nutritional Services

Source: State Plan 1905(a)

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: 6 hours/year

Duration Limit: None

Alternative Benefit Plan

Scope Limit:

None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 6.d.
Amount limits can be exceeded based on medical necessity.

Add

Alternative Benefit Plan

☑ 10. Essential Health Benefit: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided: Medicaid State Plan EPSDT Benefits

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: None

Duration Limit: None

Scope Limit: None

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Reference approved State Plan, Attachment 3.1-A, section 4.b.

Add

☐ 11. Other Covered Benefits from Base Benchmark Collapse All ☐

Alternative Benefit Plan

☒ 12. Base Benchmark Benefits Not Covered due to Substitution or Duplication Collapse All ☐

Base Benchmark Benefit that was Substituted: Hospice - Substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hospice services are a base benchmark benefit substituted with 1945 health home services covered under the State Plan, Attachment 3.1-H and are within 14, other 1937 covered benefits that are not essential health benefits.

Base Benchmark Benefit that was Substituted: Private Duty Nursing (PDN) - Substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

PDN services are a base benchmark benefit substituted with skilled nursing under the home health services benefit covered under the State Plan, Attachment 3.1-A, section 7 and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Chiropractic Services - Substitution
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Chiropractic services are a base benchmark benefit substituted with rehabilitation occupational therapy, physical therapy, and speech therapy services in the outpatient hospital setting covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Substance Abuse Disorder Outpatient Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance abuse disorder outpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 13.d.1. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Substance Abuse Disorder Inpatient Services - Sub
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substance Abuse Disorder Inpatient Services are a base benchmark benefit substituted with the Mental/ Behavioral outpatient services array; particularly Intensive Outpatient BH services covered under the State Plan, Attachment 3.1-A, section 13.d.1. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Accidental Dental - substitution

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Accidental Dental is a base benchmark benefit substituted with emergency extractions covered under the State Plan, Attachment 3.1-A, section 10 and are within 14, other 1937 covered benefits that are not essential health benefits.

Base Benchmark Benefit that was Substituted: Primary Care Visit to Treat Injury/Illness - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Primary care visits to treat injury or illness are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Specialist Visits - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Specialty visits are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Other Practitioner Office Visits - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Other practitioner office visits are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Outpatient Facility (Ambulatory Surgery Ctr) - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient facility fee (e.g., ambulatory surgery center) services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Outpatient Surgery Physician/Surgical - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient surgery physician/surgical services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, Section 2.a. and are within EHB 1, ambulatory patient services.

Base Benchmark Benefit that was Substituted: Urgent Care Centers or Facilities - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Urgent care centers or facilities services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 9 and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted: Home Health Care Services - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Home health care services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 7 and are within EHB 7, rehabilitation and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Emergency Room Services - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency room services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted: Emergency Transportation/Ambulance - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Emergency transportation/ambulance services are a base benchmark benefit covered under the State Plan, Attachment 3.1-D and are within EHB 2, emergency services.

Base Benchmark Benefit that was Substituted: Inpatient Hospital Services - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient hospital services (inpatient stay) are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Inpatient Physician & Surgical Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Inpatient physician & surgical services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 & section 5 and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility/Inpatient Rehab - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Skilled nursing facility services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Prenatal and postnatal care is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 3, section 5, section 6.d., section 17, section 20, & section 21 and is within EHB 4, maternity and newborn care.

Base Benchmark Benefit that was Substituted: Delivery & Inpatient Services for Maternity - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Delivery & all inpatient services for maternity care is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1, section 3, section 5, section 6.d., section 17, & section 20 and is within EHB 4, maternity and newborn care.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Outpatient Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental/behavioral health outpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 13.d.1. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Inpatient Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Mental/behavioral health inpatient services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1. and are within EHB 5, mental health and substance use disorder services including behavioral health treatment.

Base Benchmark Benefit that was Substituted:	Source:	
Habilitation Services - Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Habilitation services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:	Source:	
Durable Medical Equipment - Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Durable medical equipment is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 12.c. & section 7 (on or after 07.01.20) and is within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:	Source:	
Hearing Aids for Children - Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Hearing aids for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted:	Source:	
Imaging (CT/PET Scans, MRIs) - Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Imaging (CT/PET Scans, MRIs) services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted:	Source:	
Preventive Care/Screening/Immunization - Dup	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Preventive care/screening/immunization services are a base benchmark benefit covered under the State

Plan, Attachment 3.1-A, section 5 & section 6.d. and are within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted: Routine Eye Exam for Children - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Routine eye exams for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Eye Glasses for Children - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Eye glasses for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Dental Check-Up for Children - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Dental check-up for children are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Well Baby Visits and Care - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Well baby visits and care are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Lab Outpatient & Professional Services - Dup
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Laboratory outpatient & professional services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted: X-rays and Diagnostic Imaging - Duplication
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

X-rays and diagnostic imaging services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. & section 3 and are within EHB 8, laboratory services.

Base Benchmark Benefit that was Substituted: Basic Dental Care – Child - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and are within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Orthodontia – Child - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Basic dental care for children is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and is within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Major Dental Care – Child - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Major dental care for children is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 4.b. and is within EHB 10, pediatric services including oral and vision care.

Base Benchmark Benefit that was Substituted: Transplant - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Transplant services are a base benchmark benefit covered under the State Plan, Attachment 3.1-E and are within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Dialysis - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Dialysis is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:	Source:	
Allergy Testing - Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Allergy testing is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 5 & section 6.d. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted:	Source:	
Chemotherapy - Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Chemotherapy is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted:	Source:	
Radiation - Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Radiation is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and is within EHB 1, ambulatory services.

Base Benchmark Benefit that was Substituted:	Source:	
Diabetes Education - Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Diabetes education is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and is within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted:	Source:	
Prosthetic Devices - Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Prosthetic devices is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 12.c. and is within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted:	Source:	
Nutritional Counseling - Duplication	Base Benchmark	Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Nutritional counseling is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 6.d. and is within EHB 9, preventive and wellness services and chronic disease management.

Base Benchmark Benefit that was Substituted: Reconstructive Surgery - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Reconstructive surgery is a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 1 and is within EHB 3, hospitalization.

Base Benchmark Benefit that was Substituted: Rehabilitation Speech Therapy - Duplication

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Rehabilitation speech therapy services are a base benchmark benefit duplicated with outpatient rehabilitation services covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Rehab Occupational & Physical Therapy - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Rehabilitation occupational and physical therapy services are a base benchmark benefit duplicated with outpatient rehabilitation services covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services - Dup

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Outpatient rehabilitation services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Base Benchmark Benefit that was Substituted: Habilitation Services - Duplicated

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Habilitation services are a base benchmark benefit covered under the State Plan, Attachment 3.1-A, section 2.a. and are within EHB 7, rehabilitative and habilitative services and devices.

Alternative Benefit Plan

Add

Alternative Benefit Plan

☒ 13. Other Base Benchmark Benefits Not Covered Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source:	
Basic Dental - Adult	Base Benchmark	Remove

Explain why the state/territory chose not to include this benefit:
It is not a mandatory benefit

Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source:	
Orthodontia - Adult	Base Benchmark	Remove

Explain why the state/territory chose not to include this benefit:
It is not a mandatory benefit

Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source:	
Major Dental Care - Adult	Base Benchmark	Remove

Explain why the state/territory chose not to include this benefit:
It is not a mandatory benefit

Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source:	
Infusion Therapy	Base Benchmark	Remove

Explain why the state/territory chose not to include this benefit:
It is not a mandatory benefit

Base Benchmark Benefit not Included in the Alternative Benefit Plan:	Source:	
Routine Dental - adult	Base Benchmark	Remove

Explain why the state/territory chose not to include this benefit:
It is not a mandatory benefit

Add

Alternative Benefit Plan

☒ 14. Other 1937 Covered Benefits that are not Essential Health Benefits Collapse All ☐

Other 1937 Benefit Provided: LTC/Nursing home
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other: Reference approved State Plan Section 3.1-A, section 15.

Other 1937 Benefit Provided: Emergency Extractions - Adult
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: None
Duration Limit: None
Scope Limit: None
Other: Reference approved State Plan, Attachment 3.1-A, section 10.

Other 1937 Benefit Provided: Family planning
Source: Section 1937 Coverage Option Benchmark Benefit Package
Remove
Authorization: Other
Provider Qualifications: Medicaid State Plan
Amount Limit: See below
Duration Limit: None
Scope Limit: None
Other: Reference approved State Plan, Attachment 3.1-A, section 4.c.

Alternative Benefit Plan

Other 1937 Benefit Provided:
Bariatric Surgery

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Bariatric surgery is not covered for the treatment of obesity alone.

Other:
Reference approved State Plan, Attachment 3.1-A, section 1.
Reference approved State Plan, Attachment 3.1-A, section 5.

Other 1937 Benefit Provided:
Non-emergency transportation

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
Covers expenses for transportation (and meals and lodging) that are determined necessary to secure medical or behavioral health services.

Other:
Reference approved State Plan, Attachment 3.1-D.

Other 1937 Benefit Provided:
1945 Health Homes

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
None

Duration Limit:
None

Scope Limit:
None

Alternative Benefit Plan

Other:

Reference approved State Plan, Attachment 3.1-H.

Other 1937 Benefit Provided:

Podiatric services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

None

Duration Limit:

None

Scope Limit:

None

Other:

Reference approved State Plan, Attachment 3.1-A, section 6.a.

Add

Alternative Benefit Plan

☐ 15. Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.)

Collapse All ☐

PRA Disclosure Statement

Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) for the purpose of standardizing data. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20190808

Attachment C – Proof of Public Notice

The Black Chronicle
CLASSIFIED

Advertising – 1

ADVERTISE STATEWIDE Put your message where it matters most – in Oklahoma newspapers. We can place your ad in 158 newspapers. For more information or to place an ad, contact Landon Cobb at (405) 499-0022 or toll-free in OK at 1-888-815-2672.

Want to Buy—32

OLD GUITARS WANTED! Larry bring$ ca$h for vintage USA guitars, tube amps, banjos, mandolins, etc. Fender, Gibson, Martin, Gretsch, others. Call or text 918-288-2222. www.stringswest.com

Religion –96

SIGNATORIES B3P372B2017P73 Ryan. Nonuples? Hosea 1:2. . .Go, take unto thee a wife of whoredoms and children of whoredoms. . .? Mat. 19:10-12-11 . .SAVE THEY to whom it is given. Luke 20:34-36. . .for they are equal unto the angels . . .11-05-1952 3:12rev Delbert, Madden, advertised gavings, lates three's Luke 13:16x Sale's Jobs Duties? None Sundays 10358170-02? Educables's whopping God's Earth's 56-2571153! 405-902-6398

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INVITATION TO BID

Community Action Agency is accepting bids for install of eleven (11) central heat units in residential homes. Bid packages are available at 319 S.W. 25th OKC room LL030. For more information contact R.A. Roberson at 232-0199. **EOE**

INVITATION TO BID

Community Action Agency is accepting bids for roof replacement on ten (10) residential roofs. Bid packages are available at 319 S.W. 25th OKC room LL030. For more information contact R.A. Roberson at 232-0199. **EOE**

OKLAHOMA HOUSING FINANCE AGENCY 5-YEAR PHA PLAN AND ANNUAL PLAN

Oklahoma Housing Finance Agency's (OHFA) draft 5-Year PHA Plan for 2020-2025 and the draft Annual Plan for 2020-2021, along with supporting documentation, may be viewed Monday thru Friday from 8:00 AM to 4:00 PM at OHFA's main office, located at 100 N.W. 63rd Street, Suite 200 in Oklahoma City. The Plans provide details about OHFA's Housing Choice Voucher program, operations and services and OHFA's strategy for handling operational concerns and participants' concerns and needs. A public hearing on the Plans will be held at 11:00 AM on May 19, 2020, in the Will Rogers Conference Room at OHFA. For more information, please call (405) 419-8141.

JOB ANNOUNCEMENT
Senior Research Epidemiologist

Sr. Research Epidemiologist located in Oklahoma City. Collaborates with other researchers in the study design and evaluation of public health programs. Develops research instruments, collects, manages and analyzes data, interprets results, prepares reports, and publishes findings. MS or US equivalent in Epidemiology or related plus 4 years of experience in a public health or biomedical science. No travel. Send resume to Dr. Barish Edil, 800 Stanton L. Young Blvd., Suite 9000, OKC, OK 73104. EEOC

ABBREVIATED PUBLIC NOTICE

Pursuant to Section 431.408 of Title 42 of the Code of Federal Regulations, the Oklahoma Health Care Authority (OHCA) is required to provide public notice of its intent to submit a request to the Centers for Medicare & Medicaid Services (CMS) for a five-year approval of SoonerCare 2.0 under the Healthy Adult Opportunity Demonstration provided under §1115(a)(2) waiver authority.

Beginning no sooner than July 1, 2021, and contingent upon CMS approval, SoonerCare 2.0 will provide the coverage avenue for individuals made newly eligible for Medicaid as of the state's July 1, 2020, expansion. This includes individuals with income up to 133% of the federal poverty level and applicable income disregards who are not otherwise eligible for Medicaid services provided by OHCA. SoonerCare 2.0 will implement policies to align with commercial market coverage and will:

- Provide health coverage consisting of a comprehensive package of essential health benefits;
- Require nominal cost sharing including premiums and copays;
- Encourage individuals to address additional facets of their health by requiring participation in activities that are positively correlated with good health, including work, volunteering and educational activities;
- Encourage individuals to obtain and maintain health coverage before becoming sick by eliminating retroactive coverage and aligning coverage start date with the commercial market; and
- Leverage care coordination strategies to improve health outcomes and member satisfaction.

OHCA will be holding public hearings on this proposal as follows:

1. Oklahoma Health Care Authority Board Meeting
   March 18, 2020, at 3 p.m.
   Oklahoma Health Care Authority
   4345 N. Lincoln Blvd.
   Oklahoma City, OK 73105

2. OSU Center for Health Sciences
   March 24, 2020, at 1:30 p.m.
   A.R. and Marylouise Tandy Medical Academic Building
   1111W. 17th St.
   Tulsa, Oklahoma 74107

   Additional sites holding the March 24, 2020, hearing include:
   The Oklahoma Health Care Authority
   Charles Ed McFall Board Room
   4345 N. Lincoln Blvd.
   Oklahoma City, Oklahoma 73105

   Guymon Public Library
   Safe Room
   1718 N. Oklahoma St.
   Guymon, Oklahoma 73942

   Northwestern Oklahoma State University – Enid Campus
   2929 E. Randolph Ave.
   Room 131
   Enid, Oklahoma 73701
   Additionally, interested parties can join the March 24, 2020, hearing through a Zoom webinar by registering through the link below:
   https://okhca.zoom.us/webinar/register/WN_0bexX6YgQ_CDXAnTY4WDEA

Interested persons may visit www.okhca.org/SoonerCare2 to view a copy of the proposed waiver, full and abbreviated public notices, location and times of public hearings, a link to provide public comments on the proposal, supplemental information, and updates. Persons wishing to present their views in writing or obtain copies of the proposed waiver may do so at the following address: Oklahoma Health Care Authority, Federal Authorities Unit, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, or by email at federalauthorities@okhca.org. Written and/or oral comments or requests for copies of the proposed waiver will be accepted during regular business hours by contacting OHCA as indicated. Comments submitted will be available for review by the public Monday-Friday, 9 a.m.–4:30 p.m. at OHCA located at the above address, or viewed online at www.okhca.org/PolicyBlog. Comments will be accepted beginning March 16, 2020, through April 15, 2020.

Classified Deadline Is Tuesdays At 1 p.m.!

OKLAHOMA ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION

NOTICE OF INTENTION TO APPLY FOR AN ALCOHOLIC BEVERAGE LICENSE

In accordance with Title 37, Section 522 and Title 37A, Section 2-141 Trinity Breaktime, INC dba Oak Tree Fuel & Food 6 West Memorial Road Oklahoma City, OK, a/an corporation hereby publishes notice of their intention to apply within sixty days from this date to the Oklahoma Alcoholic Beverage Laws Enforcement Commission for a Retail Beer and Retail Wine license under authority of and in compliance with the said Act. That they intend(s) if granted such license to operate as a Retail Beer and Retail Wine establishment with business premises located at 6 West Memorial Road in Oklahoma City, Oklahoma under the business name of Oak Tree Fuel and Food.

Dated this 19th day of February, 2020

Signature of applicant (s): If partnership, all partners must sign. If corporation an officer of the corporation must sign. If limited liability company a manager must sign.
Babu Peringol

County of Oklahoma, State of Oklahoma

Before me, the undersigned notary public, personally appeared:

Babu Peringol

To me known to be the person (s) described in and who executed the foregoing application and acknowledged that he executed the same as his free act and deed.

Augustina L. Gainey	7/18/2020
(Notary Public)	(My commission expires)

OKLAHOMA ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION

NOTICE OF INTENTION TO APPLY FOR AN ALCOHOLIC BEVERAGE LICENSE

In accordance with Title 37, Section 522 and Title 37A, Section 2-141 Rafes Turn LLC 500 East Locust Street, Suite 500, Des Moines, IA 50309, a/an limited liability company, hereby publishes notice of its intention to apply within sixty days from this date to the Oklahoma Alcoholic Beverage Laws Enforcement Commission for a Caterer/Mixed Beverage license under authority of and in compliance with the said Act. That it intend(s) if granted such license to operate as a Caterer/Mixed Beverage establishment with business premises located at 1629 Northwest 16th Street in Oklahoma City, Oklahoma, Oklahoma under the business name of Up Down.

Dated this 9th day of March, 2020

Signature of applicant (s): If partnership, all partners must sign. If corporation an officer of the corporation must sign. If limited liability company a manager must sign.

Joshua Ivey

County of Polk, State of Iowa
Before me, the undersigned notary public, personally appeared:

Joshua Ivey, member/manager of Rafes Turn, LLC

To me known to be the person (s) described in and who executed the foregoing application and acknowledged that he executed the same as his free act and deed.

Loyd W. Ogle	10/12/2020
(Notary Public)	(My commission expires)

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28-34 Words	$16.00
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An additional 40 cents per word is charged for ads over 41 words.

OKLAHOMA ALCOHOLIC BEVERAGE LAWS ENFORCEMENT COMMISSION

NOTICE OF INTENTION TO APPLY FOR AN ALCOHOLIC BEVERAGE LICENSE

In accordance with Title 37, Section 522 and Title 37A, Section 2-141 Ahtisham Masood – Masood LLC Express Discount Grocery at 700 W. Britton Road Oklahoma City, OK 73114 a/an LLC, hereby publishes notice of their intention to apply within sixty days from this date to the Oklahoma Alcoholic Beverage Laws Enforcement Commission for a Retail Beer license under authority of and in compliance with the said Act. That it intend(s) if granted such license to operate as a Retail Beer establishment with business premises located at 700 W. Britton Road in Oklahoma City, Oklahoma, Oklahoma under the business name of Masood LLC DBA Express Discount Grocery.

Dated this 12th day of March, 2020

Signature of applicant (s): If partnership, all partners must sign. If corporation an officer of the corporation must sign. If limited liability company a manager must sign.

Ahtisham Masood

County of Oklahoma, State of Oklahoma
Before me, the undersigned notary public, personally appeared:

Ahtisham Masood

To me known to be the person (s) described in and who executed the foregoing application and acknowledged that he executed the same as his free act and deed.

Debbie Schwab	08/09/2023
(Notary Public)	(My commission expires)

Alcoholic Beverage License Deadline Is Tuesday at 1 p.m.!

La Semana
March 18, 2020

ABBREVIATED PUBLIC NOTICE

Pursuant to Section 431.408 of Title 42 of the Code of Federal Regulations, the Oklahoma Health Care Authority (OHCA) is required to provide public notice of its intent to submit a request to the Centers for Medicare & Medicaid Services (CMS) for a five-year approval of SoonerCare 2.0 under the Healthy Adult Opportunity Demonstration provided under §1115(a)(2) waiver authority.

Beginning no sooner than July 1, 2021, and contingent upon CMS approval, SoonerCare 2.0 will provide the coverage avenue for individuals made newly eligible for Medicaid as of the state's July 1, 2020, expansion. This includes individuals with income up to 133% of the federal poverty level and applicable income disregards who are not otherwise eligible for Medicaid services provided by OHCA. SoonerCare 2.0 will implement policies to align with commercial market coverage and will:

- Provide health coverage consisting of a comprehensive package of essential health benefits;
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- Encourage individuals to address additional facets of their health by requiring participation in activities that are positively correlated with good health, including work, volunteering and educational activities;
- Encourage individuals to obtain and maintain health coverage before becoming sick by eli minating retroactive coverage and aligning coverage start date with the commercial market; and
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OHCA will be holding public hearings on this proposal as follows:

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   4345 N. Lincoln Blvd. | Oklahoma City, Oklahoma 73105

   Guymon Public Library
   Safe Room
   1718 N. Oklahoma St. | Guymon, Oklahoma 73942

   Northwestern Oklahoma State University – Enid Campus
   2929 E. Randolph Ave.
   Room 131
   Enid, Oklahoma 73701

   Additionally, interested parties can join the March 24, 2020, hearing through a Zoom webinar by registering through the link below:
   https://okhca.zoom.us/webinar/register/WN_0bzxX6VgQ_CDXAnTY4WDEA.

Interested persons may visit www.okhca.org/SoonerCare2 to view a copy of the proposed waiver, full and abbreviated public notices, location and times of public hearings, a link to provide public comments on the proposal, supplemental information, and updates. Persons wishing to present their views in writing or obtain copies of the proposed waiver may do so at the following address: Oklahoma Health Care Authority, Federal Authorities Unit, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, or by email at federal.authorities@okhca.org. Written and/or oral comments or requests for copies of the proposed waiver will be accepted during regular business hours by contacting OHCA as indicated. Comments submitted will be available for review by the public Monday-Friday, 9 a.m.-4:30 p.m. at OHCA located at the above address, or viewed online at www.okhca.org/PolicyBlog. Comments will be accepted beginning March 16, 2020, through April 15, 2020.

Enid, Oklahoma 73701
Additionally, interested parties can join the March 24, 2020, hearing through a Zoom webinar by registering through the link below:
https://okhca.zoom.us/webinar/register/WN_ObzoX6VgQ_CDXAnTY4WDEA.
Interested persons may visit www.okhca.org/SoonerCare2 to view a copy of the proposed waiver, full and abbreviated public notices, location and times of public hearings, a link to provide public comments on the proposal, supplemental information, and updates. Persons wishing to present their views in writing or obtain copies of the proposed waiver may do so at the following address: Oklahoma Health Care Authority, Federal Authorities Unit, 4345 N. Lincoln Blvd., Oklahoma City, Oklahoma 73105, or by email at federal.authorities@okhca.org. Written and/or oral comments or requests for copies of the proposed waiver will be accepted during regular business hours by contacting OHCA as indicated. Comments submitted will be available for review by the public Monday-Friday, 9 a.m.-4:30 p.m. at OHCA located at the above address, or viewed online at www.okhca.org/PolicyBlog. Comments will be accepted beginning March 16, 2020, through April 15, 2020.

Attachment D – Tribal Consultation Documents

KEVIN S. CORBETT
CHIEF EXECUTIVE OFFICER

J. KEVIN STITT
GOVERNOR

STATE OF OKLAHOMA
OKLAHOMA HEALTH CARE AUTHORITY

I/T/U Public Notice 2020-02

Feb. 13, 2020

RE: Oklahoma Health Care Authority (OHCA) Proposed Rule, State Plan, and Waiver Amendments

Dear Tribal Representative:

The purpose of this letter is to give you notice of proposed changes that will be reviewed at the tribal consultation meeting on March 3, 2020 at 11 a.m. in the Oklahoma Health Care Authority's (OHCA) Charles Ed McFall Boardroom located at 4345 N Lincoln, Oklahoma City, OK., 73105. The OHCA invites you to attend this meeting, and we welcome any comments regarding the proposed changes. The Agency is committed to active communication with tribal governments during the decision-making and priority-setting process to keep you apprised of all proposed changes.

Enclosed are summaries of the current proposed rules, state plan, and waiver amendments for your review; the summaries describe the purpose of each change.

Please note that these are only proposed changes and have not yet taken effect. Before implementation, proposed changes must obtain budget authorization and approval by the OHCA Board, and when applicable, federal approval and Governor approval must be obtained.

Additionally, the OHCA posts all proposed changes on the Agency's Policy Change Blog and the Native American Consultation Page. These public website pages are designed to give all constituents and stakeholders an opportunity to review and make comments regarding upcoming policy changes. To ensure that you stay informed of proposed policy changes, you may sign up for web alerts to be automatically notified when any new proposed policy changes are posted for comment.

The OHCA values consultation with tribal governments and will provide your representatives a reasonable amount of time to respond to this notification. If you have any questions or comments about the proposed policy changes, please use the online comment system found on the Policy Change Blog and/or the Native American Consultation Page.

Sincerely,

S\

Dana Miller
Director, Tribal Government Relations

Proposed Rule, State Plan, and Waiver Amendments

Oklahoma Department of Human Services (OKDHS) Recommended Changes to Policy and Waiver Amendments – Durable Medical Equipment and Supplies (DME) — The OHCA will submit amendments to five 1915(c) waivers to align with the proposed DME, supplies and appliances State Plan Amendment (SPA). The waivers being amended are operated by the OKDHS and include the ADvantage, Community, Homeward Bound, In-Home Supports for Children, and In-Home Supports for Adults waivers. The proposed amendments will clarify the coverage description in Appendix C, Specialized Medical Equipment and Supplies, as well as, the reimbursement methodology in Appendix I-2:a, Rate Setting Methodology. Furthermore, revisions will also be made to the waiver programs' policy to reflect these changes.

Therapy Assistants — The proposed policy changes will add physical therapy assistants, occupational therapy assistants, speech language pathology assistants (SLPAs), and speech language pathology clinical fellows as eligible providers that can render services to SoonerCare members. Additionally, the proposed revisions will outline provider qualifications and other requirements for provision of these therapy services. Finally, revisions will be made to clarify that these providers will be reimbursed at a percentage of the rate paid to fully licensed therapists.

Healthy Adult Opportunity (HAO) Waiver — The OHCA will be seeking 1115(a)(2) waiver authority, through the HAO waiver application, to create new health care coverage approaches and options for adults defined as the "new adult group" per Section 435.119 of Title 42 of the Code of Federal Regulations. The waiver application will include, but not be limited to, the following topics: a description of eligible populations; processes for eligibility under the demonstration; the benefit package for the applicable population(s); applicable premiums and cost sharing; delivery system and payment methods; financing; state specific elements/requirements; implementation of a fair hearing process; and information regarding evaluations. **(30-day expedited consultation, comments are due to OHCA by April 2, 2020).**

Continuation of Services Pending Appeals — The proposed new rule will describe under what conditions Medicaid benefits will continue or be reinstated pending an appeal to comply with Section 431.230 of Title 42 of the Code of Federal Regulations. Additionally, the proposed new rule will describe the application, obligations, and implications for the appellant when Medicaid benefits are continued or reinstated pending an appeal.

Attachment F – Public Comments received from the Public Posting

OKLAHOMA Health Care Authority | Serving Oklahomans through SoonerCare

OHCA RESPONSES TO PUBLIC COMMENTS ON SOONERCARE 2.0

On March 16, 2020, the Oklahoma Health Care Authority asked the public to weigh in on its draft application to the Centers for Medicare & Medicaid Services for the Healthy Adult Opportunity demonstration waiver. The draft application was posted to the OHCA website and outlined the agency's plans for implementing SoonerCare 2.0, Gov. J. Kevin Stitt's health plan proposal to extend health coverage to qualifying adults. The application was posted for 30 days and comments were made through OHCA's online policy blog, the federal authorities' mailbox and through four public hearings. Six hundred forty individuals attended at least one of the public hearings, and OHCA received over 2,000 comments through the blog and mailbox, in addition to the comments received through the public hearing process. OHCA responded in writing to all comments and questions received through the public hearing process. Those responses can be found at www.okhca.org/SoonerCare2. Comments received through the other avenues all had common themes that are addressed herein.

OHCA also sent public notice and held a face-to-face tribal consultation on March 3, 2020, with tribal partners. After the formal consultation, tribal/state workgroups were formed to facilitate communication with tribal partners, answer questions and seek input regarding the content in the HAO application.

Premium requirements as a condition of eligibility for the Healthy Adult Opportunity and other cost sharing

Comments received: Many commenters expressed concern over the implementation of cost sharing requirements for the HAO population, including premiums as a condition of SoonerCare 2.0 eligibility. Concerns center around increase in churn for the HAO population as individuals may come on and off the program because of non-compliance with the nominal premium

ADDRESS
4345 N. Lincoln Blvd.
Oklahoma City, OK 73105

WEBSITES
okhca.org
mysoonercare.org

PHONE
Admin: 405-522-7300
Helpline: 800-987-7767

requirements. Commenters also disagreed with OHCA's request to require $8 co-pays for non-emergency services received in an emergency department.

OHCA response: The premiums requested under the HAO application range from $0 to $15 per month and are tiered based on a household's income with the understanding that those with lower incomes should have lower premiums. Co-pays for individual services will be the same as they are currently for non-exempt populations in Title XIX Medicaid. Most encounter-based co-payments are $4 per visit. Behavioral health visits are $3 per visit. Inpatient stays are $10 per day with a max of $75. All cost sharing will be limited to 5% of the household's monthly income, as it is today in Title XIX Medicaid. Premiums will be collected by OHCA through internal processes currently utilized for the Insure Oklahoma Individual Plan program administered by OHCA. Individuals who have not paid their premiums for three months will be unenrolled but will be eligible to reapply the following month. OHCA will not pursue collections of unpaid premiums and will not require that the unpaid premiums be paid in order to re-enroll in the program.

Premiums are not intended to be a revenue source but are being required with the understanding that investment in one's own health care is critical to member engagement. Studies have shown that making regular monthly premiums may lead to better health outcomes for members. For example, in Indiana, where Medicaid eligible adults are required to pay monthly premiums, members making contributions had higher satisfaction rates, higher primary and preventive care utilization, higher prescribed drug adherence, and lower emergency room use than those who did not. (The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016)).

OHCA plans to utilize the 12-month period that members are in state plan expansion (effective July 2, 2020) to do member outreach to prepare members for the premium requirements that will occur July 1, 2021.

Currently, the individuals who will have access to health care coverage through HAO either have coverage through the federally facilitated marketplace with premiums higher than those proposed in HAO, coverage through Insure Oklahoma IP where premiums average $32 a month, or have no coverage and pay 100% out-of-pocket for health care services at safety net providers such as FQHCs and CMHCs who often charge sliding scale fees on a per service basis. Likewise, ER and hospital services are paid for 100% by the uninsured individual in cases of emergencies that require hospitalization and those providers pursue collection from the uninsured individual. Applying for coverage through SoonerCare is a personal choice that involves considerations such as the cost of

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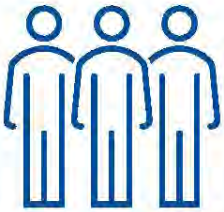
nominal premiums ranging from $0-$15 per month versus paying out-of-pocket 100% for health care services.

In order to encourage more utilization of primary and preventive care, OHCA is requesting through the HAO application to implement $8 co-pays for individuals who seek non-emergency care in an emergency department. Services received through an emergency department are costly to state Medicaid programs and should be avoided by members when appropriate and when there are less costly alternatives to provide the care such as after-hours primary care and urgent care. However, as with other co-pays in SoonerCare, a member cannot be denied services based on the member's assertion that they are unable to pay the co-pay.



Community engagement requirements as a condition of eligibility for the Healthy Adult Opportunity

Comments received: Many commenters expressed concern over the community engagement requirements proposed through the HAO waiver as a condition of eligibility for SoonerCare 2.0, saying that reporting requirements will result in limiting access to care. Commenters highlighted specific situations such as debilitating conditions and other diagnoses that would prohibit an individual from meeting the requirements and could cause disruptions in their health care when they need it most.

OHCA response: SoonerCare 2.0 is designed to support coordinated strategies to address certain health determinants that promote upward mobility, greater independence, and improved quality of life among individuals. One such strategy is to make community engagement (CE) a component of eligibility. To remain eligible for SoonerCare benefits:

- Non-exempt members transitioning from other Medicaid coverage or new applicants age 19 through 60 will be required to provide verification of participation in at least an average of 80 hours per month of approved CE activities.

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- Non-exempt individuals will have a 90-day grace period from the time of SoonerCare 2.0 application (for newly eligible individuals) or transition (for existing Medicaid members), to verify compliance with CE requirements. Verification of compliance may be documented or provided to OHCA through various methods.

A large body of research has shown that employed individuals are healthier than those who are not employed. Enhancing employment opportunities for working-age people can improve health status and decrease the overall cost of providing health care. Employment can improve health by increasing social capital, enhancing psychological well-being, providing income and reducing the negative health impacts of economic hardship. Incentivizing employment, pursuit of educational and vocational activities, and volunteerism promotes all of these objectives.

For individuals experiencing circumstances that would preclude them from satisfying the CE requirements, OHCA is proposing a list of blanket exemptions from reporting requirements and will allow for "good cause" exemptions on a case-by-case basis.

OHCA is working to create efficient data collection systems, including data matching with other state agencies, to make the reporting process as simple and efficient as possible for members. The agency will provide outreach on the different requirements and reporting mechanisms over the next year to ensure members are prepared for the CE reporting requirements.

Refer to Section (II)(A)(2) of the HAO application for details on qualifying activities, exempted populations and guidelines for good cause exemptions.

Per-capita spending caps for Healthy Adult Opportunity expenditures

Comments received: Numerous commenters expressed concern with the proposed federal funding structure for the HAO population. Specifically, comments mentioned worry about OHCA's ability to respond quickly to an economic downturn, public health emergency or unexpected enrollment growth, if federal funds were not endlessly available to the state's Medicaid program.

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OHCA response: OHCA is proposing to accept federal funds to subsidize the cost of care provided to the SoonerCare 2.0 population by using a methodology based on a per capita spending cap (see page 50 of the application found at www.okhca.org/soonercare2). The HAO demonstration employs a financing model geared at incentivizing OHCA and providers to improve the overall health of SoonerCare 2.0 members through care coordination, health promotion and increased use of primary care. Caps on spending advance the triple aim of improving patient experience of care, improving the health of the population and reducing the per capita cost of health care. After the initial years of the demonstration, OHCA will be able to share in the savings achieved through these measures with CMS up to 50/50. These dollars can in turn be used to re-invest into Oklahoma's health care system and economy.

The per capita spending cap will be trended forward based on factors including medical inflation, as well as increases in program enrollment. Excluded from the HAO cap would be expenditures for public health emergencies, such as COVID-19, so that OHCA can respond quickly to emergency needs of the state's SoonerCare population.

Despite federal funding being open-ended for traditional Title XIX Medicaid programs, OHCA is accustomed to managing the SoonerCare program within a capped funding model since OHCA is required to manage the program with the dollars appropriated to the agency by the Oklahoma Legislature. In the event of economic downturn, OHCA will employ the processes currently used to make the tough decisions that result from cuts to the agency's appropriated dollars. Additionally, the governor and Oklahoma Legislature has implemented measures across the state, including investing in the state's Rainy Day fund at unprecedented levels and creation of the Medicaid Rate Stabilization fund, to prepare for state economic downturns and state revenue failures.

Waiver of retroactive eligibility and hospital presumptive eligibility for the HAO population

Comments received: Many commenters expressed concerns over OHCA waiving the requirement to provide retroactive eligibility and presumptive eligibility for the SoonerCare 2.0 population. Comments noted that individuals may not know they are eligible for Medicaid until they

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experience a health emergency and require services through an ER or hospital. Those individuals would not be able to afford the care and would risk being turned away.

OHCA response: Through the HAO waiver opportunity, OHCA is placing a strong emphasis on primary and preventive care for the SoonerCare 2.0 population and encouraging individuals to obtain and maintain coverage prior to getting sick or experiencing a health emergency. Therefore, OHCA is eliminating presumptive eligibility for this population.

Retroactive eligibility is a process whereby once an individual is found eligible for Medicaid, the agency must do a look back to determine if at any point during the previous three months, the individual received a service that would be reimbursable by SoonerCare. If they did, OHCA would be responsible for the payment. OHCA currently waives the retroactive eligibility requirement for certain existing populations through its 1115 Patient Centered Medical Home. Additionally, retroactive eligibility is a fairly recent concept for SoonerCare and is in the early implementation phase for mandatory populations. Oklahoma health care providers and SoonerCare members are not expected to experience a significant impact from its waiver in the SoonerCare 2.0 population.

Additionally, OHCA is requesting to waive the requirement of hospital presumptive eligibility for the SoonerCare 2.0 population. Presumptive eligibility is a process of finding an individual preliminarily eligible for Medicaid based on limited information. If the individual is later found to not be eligible, Medicaid is still responsible for paying for the individual's care provided when the individual was presumptively eligible. Oklahoma currently allows for hospital presumptive eligibility, but to date no hospitals in Oklahoma have implemented presumptive eligibility processes. However, Oklahoma will continue to use the notification of date of service (NODOS) process, which allows a hospital to submit basic identifying information to OHCA to save the date for eligibility when an individual admits to the hospital for services. If the individual is later found to be eligible for SoonerCare, OHCA reimburses the hospital for individual's hospital stay. Through the NODOS process, OHCA is ensuring the state and federal dollars entrusted to OHCA to manage the SoonerCare program are used on qualified SoonerCare members.

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SoonerCare 2.0 benefit design

Comments received: OHCA received several comments regarding the various benefits included and waived within the HAO application including: (1) Exclusion of non-emergency transportation; (2) exclusion of Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit for individuals 19-20; and (3) the prescription formulary.

OHCA response: Through the flexibilities offered through the HAO demonstration, OHCA is seeking to create health coverage benefit design similar to those offered through the private insurance market for healthy working adults. While OHCA understands transportation can sometimes be a barrier, especially in rural areas of the state, OHCA has been a leader in reimbursing for a wide range of telehealth services that allows for SoonerCare members to receive services wherever they are. OHCA also understands there are some conditions that require ongoing in person care, which is why OHCA is seeking flexibility to cover non-emergency transportation in limited cases based on an individualized assessment of need and in accordance with a care coordination plan.

The benefit plan OHCA is proposing for the SoonerCare 2.0 population is comprehensive and covers essential health care services similar to plans offered in the private insurance market for adults and comparable to the benefits currently covered for adults in Title XIX SoonerCare.

With regard to prescriptions, OHCA plans to use the formulary and pharmacy benefit design used under Title XIX State Plan. In demonstration applications, however, the state reserves the right with CMS to be flexible without submitting an additional waiver amendment. OCHA will engage the public through an open process if changes are made to benefit design later on after HAO implementation.

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Concerns with moving forward during a national public health emergency and the public comment process

Comments received: Many commenters expressed concern with the state continuing to move forward with the HAO application process in light of the COVID-19 public health emergency. Specific comments addressed concern over the state's transition to virtual hearings in accordance with CDC social distancing guidelines, that attendees without broadband couldn't access the hearing, attendees couldn't tell who else was in the meeting, and that the ability to comment was limited.

OHCA response: Per federal requirements OHCA is required to present an 1115 demonstration application in two separate forums in order to elicit public comment on the application. Prior to the national emergency declaration, OHCA had plans for two public meetings, which included the regularly scheduled OHCA board meeting and a special meeting on March 24 at OSU Health Sciences Center in Tulsa. After the emergency declaration, CMS issued guidance to the states that waived the in-person requirement of these meetings and allowed states to conduct hearings virtually. Instead of the required two hearings, OHCA held four virtual public meetings, one of which was outside of traditional working hours, during which attendees had the option to ask an unlimited number of questions through the Zoom Q&A function, many of which were responded to live by the OHCA representative during the hearing. Questions that were not answered live were responded to in writing and posted on the agency's public website. Six hundred forty unique individuals attended at least one of the four hearings, many of which submitted comments and questions in written form. OHCA feels providing meetings in this manner allowed for more individuals to attend and provide comment, as opposed to in person meetings when barriers such as transportation would have prevented individuals, especially in rural areas of the state, from attending.

In addition to the public hearings, OHCA also posted the HAO application to its SoonerCare 2.0 website and Policy Blog for 30 days and accepted comments through the blog, as well as the OHCA Federal Authorities mailbox. Through the blog and mailbox alone, OHCA received over 2,000 comments.

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options, said agency spokeswoman Katelynn Burns.

Amber England, campaign manager for Yes on 802, said Stitt's timing couldn't be worse. State Question 802 seeks to add straight Medicaid expansion, with no work requirements or premiums to Oklahoma's constitution

"Right now, we all need to focus on the health and well-being of our friends, family members, and neighbors," England said. "That's the focus of our campaign and it should be the focus of our elected leaders as well. It's unfortunate that the governor has chosen this moment to promote a plan that would actually provide Oklahomans less care and cost our state more money."

Stitt has not yet set an election date for SQ 802. The Yes on 802 campaign has suspended some campaign activities through March due to COVID-19.

The Healthy Adult Opportunity waiver seeks to phase in community-engagement requirements that largely call for participants to work, volunteer or go to school a certain number of hours per month. Some states' attempts to impose work requirements on Medicaid beneficiaries have been challenged in court.

By the second year of SoonerCare 2.0, most people within the expansion population would ill be required to work, volunteer or go to school for at least 80 hours per month. Those who are not exempt, but do not follow the requirements would stop receiving Medicaid benefits.

Among the exceptions are pregnant women, enrolled members of tribes, those with a disability, serious mental illness, and those who are undergoing drug or alcohol rehabilitation.

At a recent event, Stitt said the premiums give Medicaid beneficiaries some "skin in the game."

“I believe you should have to pay some premiums to appreciate the service that you get,” he said. “It’s not huge premiums.”

The waiver also seeks to impose monthly premiums of $10 a month for individuals or $15 a month per family. There are some exemptions.

Beneficiaries also would be responsible for co-payments for health care services up to the 5% out-of-pocket household maximum. SoonerCare 2.0 participants also would be charged an $8 copay for non-emergency visits to the emergency room.

The expansion would allow Oklahomans ages 19 through 64 whose annual income is below

133% of the federal poverty level, which is $16,970 annually for an individual and $34,846 for a family of four, to receive Medicaid benefits.

The Health Care Authority plans to study the impact of the premiums on Medicaid enrollment and reserves the right to raise them at a later point.

The authority estimates Oklahoma would have 5% fewer enrollees receiving Medicaid benefits under the waiver proposal as opposed to traditional Medicaid expansion. That would be between 7,000 and 8,000 fewer Oklahomans receiving Medicaid coverage, depending on the implementation year.

With the waiver, an estimated 144,285 Oklahomans would receive health coverage in the first year, compared with 151,879 people receive benefits under a traditional expansion.

The waiver also seeks to implement a managed-care system which aims to cut Medicaid costs while improving outcomes. Critics of managed care say the incentives to reduce costs are at odds with delivering quality health care.

"I'm focusing on the delivery mechanism," Stitt said. "How do we improve health outcomes in Oklahoma? That's going to be by changing from a fee-for-service model to more of an outcome-based, incentive-based health care plan.

The Health Care Authority anticipates submitting the waiver application in April and receiving approval by November

Those interested can find the waiver application and public hearing dates at okhca.org/SoonerCare2. A virtual public hearing is set for 3 p.m. Friday.

Oklahoma Policy Institute Executive Director Ahniwake Rose on Wednesday criticized the agency's decision to go ahead with the waiver process despite the global outbreak derailing an in-person public hearing set for this week. The nonpartisan, left-leaning think tank has endorsed SQ 802.

"The Oklahoma Health Care Authority is making a mockery of the public hearing process and appears oblivious to the fact that there is a national health emergency occurring," Rose said. "Instead, OHCA is moving ahead with a 'virtual public hearing' on a health care proposal that would put needless barriers on health care coverage for up to 200,000 Oklahomans."

The Health Care Authority was taking steps toward SoonerCare 2.0 prior to the outbreak.

Amid Epidemic, New Details on Stitt's Health Plan Are Released for Public Comment

3/18/20 -- Oklahoma Watch – By Trevor Brown

Oklahoma has quietly released details of Gov. Kevin Stitt's Medicaid expansion plan, with the state's own report saying the plan "will likely depress enrollment" by thousands of Oklahomans compared to a traditional Medical expansion plan.

An ongoing series on efforts in Oklahoma to extend health coverage to thousands of uninsured people through Medicaid expansion or other approaches.

As state and federal leaders focused their attention on the coronavirus pandemic, the Oklahoma Health Care Authority posted on its website Monday the state's waiver application and a notice of the start of a 30-day public comment period. The application is part of the federal Healthy Adult Opportunity program, which allows states to seek multi-year waivers to traditional expansion.

The 66-page application lays out new details on the second phase of Stitt's SoonerCare 2.0 health plan. Those include how the state would charge some premiums and co-pays and place work requirements on the new Medicaid expansion population.

Stitt's first phase is already underway. The state has submitted a state plan amendment to allow Oklahoma to expand Medicaid through the traditional model that dozens of other states have followed.

According to state projections, about 220,000 low-income Oklahomans – adults under age 65 earning up to 138% of the federal poverty level – would be newly eligible for subsidized health coverage through Medicaid starting July 1 if lawmakers find $150 million for the state's share of the costs.

Once that's in place, Stitt wants to use a federal waiver to would allow Oklahoma to add cost-sharing provisions, work requirements and other provisions, including moving to a block grant model for the expansion group. The waiver application seeks to launch these changes by July 1, 2021.

Stitt first unveiled the plan's framework in late January in Washington, D.C., alongside Trump administration officials.

He billed it as a more flexible and tailored alternative to State Question 802, a proposed

constitutional amendment that would accept the expansion without conditions.

Stitt, who opposes the ballot initiative, has yet to set a date for the state question. But it's expected to be on the June primary or November general-election ballot.

What's in the Plan?

For the first time, the federal waiver application spells out many details of how Stitt's plan would differ from traditional expansion.

A big difference is how many people will be covered.

The application states that although it is difficult to estimate, "based on other state experiences," Oklahoma could see 5% fewer enrollees than if the state enacted a traditional expansion model without the cost-sharing or work requirements.

That would mean nearly 7,600 fewer Oklahomans covered during the first year of its implementation, according to state projections.

Another big change would make more than half of projected new enrollees in the expansion group pay monthly premiums – a feature not included in most other states' expansion plans.

Depending on their salary and household size, enrollees in SoonerCare 2.0 could pay up to $10 a month if they are the only enrolled adult in a household or $15 a month if two or more adults in a home are enrolled.

The application also states that all households will be responsible for paying copayments for their services up to the 5% out-of-pocket household maximum. In addition, there will be an $8 copay for "non-emergency" use of emergency room visits.

The state's proposal also calls for members of the expansion group to work, volunteer or attend classes unless they are exempt. They would have to work an average of 80 hours a month to keep their enrollment following a phased-in grace period. Recently released incarcerated Oklahomans would get an extended grace period.

Other details include eliminating retroactive eligibility that would have covered unpaid medical bills up to three months before a beneficiary applies for Medicaid and moving to a managed care system for the expansion group.

The application is largely silent on how the state would transform Medicaid into a block-grant program for low-income adults in the expansion group and set caps on Medicaid spending.

Opponents Blast Timing, Plan Details

Release of the application and starting the 30-day comment period comes only days after Stitt, and governors nationwide, announced a state of emergency because of the coronavirus epidemic.

Carly Putnam, a health policy analyst with the left-leaning Oklahoma Policy Institute, called the decision to proceed with the waiver application during the crisis "shameful."

"We know what works with Medicaid expansion, and that is putting as few barriers between people and their care as possible," she said. "And under the guise of doing something innovative, the state is suggesting failed policies like charging premiums and work requirements."

Putnam said concerns that thousands will lose their jobs or be forced into unpaid leave for weeks or months because of the coronavirus is another reason why Stitt's plan will further strain the financial resources of low-income Oklahomans and make getting care more difficult.

"Saying we'll cut off coverage if people don't pay a symbolic premium when all of the bars are closing and all the restaurants are eliminating their wait staff right now, is just incredibly tone deaf," she said.

Minority Leader Rep. Emily Virgin, D-Norman, said the state's focus right now should be on combating the COVID-19 pandemic, adding there will be time in the future to talk about "how unnecessary" Democrats believe the work requirements are.

The governor's office did not respond with comments Tuesday. But the state's application addresses many of the criticisms directed at the plan.

The document, for instance, notes that Medicaid "is intended to be a temporary stepping-stone for many low-income adults" and cited a 2016 study out of Indiana that showed that having Medicaid enrollees there pay premiums resulted in better health outcomes.

It also said the work requirements would "promote upward mobility, greater independence, and improved quality of life among individuals."

What's Next

Oklahoma is still far from getting the application approved and implemented.

Residents can voice their thoughts on the plan during the comment period through April 15 by visiting the Health Care Authority's SoonerCare 2.0 page. The authority originally scheduled two in-person public hearings.

But concerns of the spread of the coronavirus prompted state officials to move the first meeting (scheduled for 3 p.m. Wednesday) to an online meeting and add another online hearing for 3 p.m. Friday. Another hearing, planned for March 24 in Tulsa, was still tentatively scheduled to go on as of Wednesday afternoon. That meeting will also be broadcast online.

The state hopes the waiver will be approved by November, allowing the state to implement the changes by July 1, 2021. But many factors could complicate the timetable.

The National Health Law Program sent a letter Tuesday to Centers for Medicare and Medicaid Services Administrator Seema Verma, urging her to immediately postpone the public hearings and extend the public comment period until the coronavirus crisis has ended. The legal group, which calls itself progressive, noted the cautions against public gatherings and said many Oklahomans may not be able to attend by person or video.

Democrats and health advocates have vowed to challenge state waivers in court that include the block grant or work requirements. It's also likely that if Democrats retake the White House this November, the new president would reverse Trump's guidance encouraging states to apply for the waiver.

Oklahoma voters could also stop Stitt's plan. If SQ 802 were to pass, it would supersede any changes that Stitt or the Legislature want to make.

This story was updated at 1:30 p.m. Wednesday to include changes the state made to the scheduled public comment meetings.

View the interactive charts here: https://oklahomawatch.org/2020/03/17/new-details-on-stitts-health-plan-spell-out-work-rules-premiums-projections/?_gl=1*qaru7*_ga*YW1wLVkzRnVrT3ZCX2N2WFRCbm1mWUEzNnc.

GOP-led states diverge on easing Medicaid access during COVID-19

3/18/20 -- Modern Healthcare – By Harris Meyer

At least two Republican-led states want to temporarily ease their Medicaid waiver requirements and make it easier for residents to get and keep coverage under Medicaid and the Children's Health Insurance Program during the coronavirus pandemic.

On Tuesday, Arizona and Iowa sent requests to the CMS so they can make temporary changes to their Medicaid programs, including eliminating premiums and pausing disenrollments.

Meanwhile, two other Republican-led states, Oklahoma and Utah, are pushing ahead with Medicaid waiver changes intended to tighten eligibility for expanded coverage to low-income adults under the Affordable Care Act, including work requirements.

The sharply different directions these states are taking illustrate the pull between pragmatic and ideological pressures in the midst of the COVID-19 outbreak, which experts say requires making testing and treatment as accessible and affordable as possible to limit the spread of the epidemic.

Congress is considering allowing states to broaden Medicaid to cover uninsured people for COVID-19 testing, treatment, and recovery.

"Work requirements and premiums are precisely the kinds of policies that are dangerous now and divert energy for state government staff, who are under enormous stress," said Joan Alker, executive director of the Center for Children and Families at Georgetown University. "They need to focus on facilitating as many people's access to care as they can."

The Arizona Health Care Cost Containment System's request would help them mitigate any disruption in care for their members during the emergency declaration, the agency said in a March 17 letter to CMS Administrator Seema Verma.

Arizona also wants to use Medicaid money to provide temporary housing for beneficiaries who are homeless or at risk of homelessness and have tested positive for COVID-19.

Iowa asked to temporarily waive premiums and copays and permit continuous eligibility for adults and children. That runs counter to the Trump administration's effort to test beneficiaries for eligibility more often to ensure program integrity, which has led to hundreds of thousands of people being disenrolled.

Going in the other direction, the Oklahoma Health Care Authority on Monday published its Medicaid Section 1115 waiver application and announced the start of a 30-day public comment period. The waiver would include a work requirement, premiums and co-pays.

Oklahoma wants to expand Medicaid coverage by July 1, but the state also wants to impose

conservative-friendly features on the expansion under the Trump administration's Healthy Adult Opportunity demonstration program.

"At this time, we don't anticipate changing our timeline for the submission of the Healthy Adult Opportunity demonstration waiver," an Oklahoma Health Care Authority spokesman said. "However, we are in communication with CMS discussing flexibility with the public comment period and evaluating all options available."

Utah is proceeding with its plan to require Medicaid expansion enrollees report at least 48 job searches in the first 90 days of eligibility, as well as to complete an online job readiness survey.

"At a time when the job market is collapsing, the absurdity of that requirement is even more apparent," Alker said. "I hope good-faith leaders in Utah will drop that requirement, which is a threat to public health."

A spokeswoman for Utah's Republican Gov. Gary Herbert could not immediately respond to requests for comment because the administration is focused on the major earthquake that hit the Salt Lake City area Wednesday.

Indiana, another Republican-led state that established premiums and other restrictive conditions on coverage through a Section 1115 waiver, did not respond to requests for comment on its plans in light of the pandemic.

A handful of states have limited Medicaid's traditional 90-day retroactive eligibility when people seek care. Experts warn that may put a heavy financial burden on hospitals serving lots of uninsured, low-income coronavirus patients.

Arizona and Iowa, which want to ease coverage requirements, have restricted retroactive eligibility under 1115 waivers. That's also true for Florida, which received an emergency Section 1135 waiver this week to loosen provider payment and certification rules.

Some experts want the CMS and the states to do what they've done in past emergencies and implement fast-tracked waivers temporarily extending Medicaid coverage to those affected, as happened following Hurricane Katrina and other catastrophes.

"Our state has moved toward the proper response to this pandemic, bringing more people into coverage," said Siman Qaasim, CEO of the Children's Action Alliance in Arizona. "This is really promising. It will be interesting to see if CMS approves it."

OHCA holds virtual public meeting on SoonerCare 2.0 waiver

3/18/20 -- eCapitol – By Tyler Talley

eCap) The Oklahoma Health Care Authority (OHCA) hosted a virtual public meeting Wednesday afternoon to field questions regarding Gov. Kevin Stitt's Medicaid proposal.

The process began earlier this month as the agency formally submitted a state plan amendment (SPA) to the federal government, seeking to expand Medicaid as soon as this summer.

The state plan amendment represents the first step for Oklahoma in seeking federal approval for Medicaid expansion as the Centers for Medicare and Medicaid Services (CMS) will have to now review the amendment for potential approval. If approved, SoonerCare 2.0 would extend health coverage to qualifying adults through CMS' Healthy Adult Opportunity demonstration waiver.

The plan, as submitted to CMS, would add a new adult group ages 19-64 with incomes at or below 133 percent of the federal poverty level, which is $34,846 for a family of four. The request will increase the number of adult Oklahomans who qualify for Medicaid benefits.

The second phase of Stitt's plan began Monday as OHCA posted on its website Monday the state's waiver application and a notice of the start of a 30-day public comment period, as required by law. The application is part of the federal Healthy Adult Opportunity program, which allows states to seek multi-year waivers to traditional expansion.

The agency's 66-page application lays out new details on the second phase of Stitt's SoonerCare 2.0 health plan, including how the state would charge some premiums and co-pays and eventually place work requirements on the new Medicaid expansion population.

According to the waiver application, Oklahoma could see 5 percent fewer enrollees than if the state enacted a traditional expansion model without the cost-sharing or work requirements although it concedes it is difficult to estimate based on other states' experiences.

The proposal would make more than half of projected new enrollees in the expansion group pay monthly premiums with SoonerCare 2.0 enrollees, depending on their household size, potentially paying up to $10 a month if they are the only enrolled adult in a household or $15 a month if two or more adults in a home are enrolled.

It also calls for members of the new expansion group to work, volunteer or attend classes

unless they are otherwise exempted, requiring them to work an average of 80 hours a month to keep their enrollment following a phased-in grace period.

Due the ongoing novel cornavirus pandemic, OHCA canceled the two originally scheduled in-person public hearings opting instead to host online meetings, the first of which took place Wednesday.

OHCA's Deputy State Medicaid Director Traylor Rains hosted Wednesday's virtual meeting, providing information and answering questions for approximately an hour.

A recurring question was why the agency was moving forward with the waiver proposal amid the COVID-19 pandemic.

"The governor made it clear in his State of the State (address)] earlier this year that we would pursue this option and the Health Care Authority has been diligently on-track to make sure that we are keeping up with all the timelines that we previously committed to," Rains said, reiterating the virtual meeting was held to make up for the cancellation of the in-person hearing.

"We are not implementing the Health Adult Opportunity (program) currently or even this year," he continued. "We would plan to implement these provisions July 1 of 2021."

Rains was also asked about potential litigation regarding work and community engagement requirements seen in other states. He noted OHCA was working "shoulder-to-shoulder" with their partners at CMS to create a plan "best for Oklahomans" while remaining within federal regulations.

Rains clarified the waiver application was not yet in its final form as the agency continues to take comments and concerns from the public and converse with its stakeholders.

"We look forward to the public's full input so we can incorporate them as we're able," he said.

There were critics of Wednesday's meeting and Stitt's waiver proposal in general with OK Policy Director Ahniwake Rose arguing OHCA was making a "mockery of the public hearing process" and "oblivious to the fact that there is a national health emergency occurring."

"Instead, OHCA is moving ahead with a 'virtual public hearing' on a health care proposal that would put needless barriers on health care coverage for up to 200,000 Oklahomans," she wrote.

OHCA will host its next public online hearing at 3 p.m. Friday.

Stitt's SoonerCare 2.0 Plan Released for Public Comment

3/18/20 -- Tulsa Public Radio – By Matt Trotter

Oklahoma Gov. Kevin Stitt is moving ahead with his SoonerCare 2.0 proposal as the state deals with the COVID-19 pandemic.

On Monday, the Oklahoma Health Care Authority released Stitt's Medicaid proposal for public comment. It's the first public look at the full plan, which aims for full expansion for low-income, able-bodied adults July 1 followed by a transition to a capped federal funding system and implementation of restrictions July 1, 2021

Those restrictions include a community engagement requirement that increases from zero to 80 hours a week of work, schooling or volunteering over the course of a year. Oklahoma Policy Institute Police Director Carly Putnam said the state will need a system to track compliance and account for exemptions.

"But in order to set that up, we know, can be extraordinarily costly, but the state the state has absolutely no mention of what it expects those costs to be or how they will be paid for," Putnam said.

Stitt's proposal would kick people off SoonerCare 2.0 once they don't meet those requirements. There are some exemptions, including for adults over 60, pregnant women, parents and caretakers, and people in addiction treatment.

Other features Stitt wants to implement in 2021 are tiered monthly premiums and copays. The plan estimates enrollment under the work requirements and other restrictions would be 5% lower than traditional Medicaid expansion.

A state question would put traditional expansion on the ballot, but Stitt has not scheduled it for an election yet.

Putnam said those restrictions will mean fewer people actually getting on SoonerCare, and the current situation with the coronavirus shows health coverage is a public safety issue.

"For the state to have moved forward with this at all was poor planning. For the state to have

moved forward with this at this moment is, frankly, baffling," Putnam said.

Comments on Stitt's plan are due by April 15 and can be submitted through coverok.org. More information about the proposal and a schedule of public meetings on it is available from the Oklahoma Health Care Authority.

Senate Passes COVID-19 Bill, Ensuring Free Tests, Upping Medicaid Match

3/18/20 -- Inside Health Policy – By Chelsea Cirruzzo

The Senate passed a second legislative package to tackle the coronavirus pandemic on Wednesday (March 18) that includes provisions to ensure all individuals, including those with private plans, Medicare or Medicare Advantage and Medicaid can access COVID-19 tests at no cost and allow states to cover the uninsured under Medicaid for COVID-19 testing and related medical visits. The president is expected to sign it into law.

The package includes a 6.2% increase to the Medicaid federal match which the left-leaning Center on Budget and Policy Priorities estimated would cost the federal government $45 billion and would stop states from having to cut back on benefits and eligibility. The bill also gives states the option to use their Medicaid programs to provide uninsured individuals with COVID-19 testing and related medical services with a 100% federal match.

Additionally, the package contains funding for food assistance for low-income pregnant women and mothers, as well as seniors. There is also unemployment aid and a paid sick leave provision. The bill now goes to the president's desk and he has already signaled support for it.

House Ways & Means Ranking Republican Kevin Brady (TX) said the bill gives the president all the resources he needs to ensure COVID-19 tests for all Americans.

House Energy & Commerce Chair Frank Pallone (D-NJ) praised its passage and said Congress is working on a third package to "help protect against the economic consequences of the coronavirus."

The package is the second coronavirus bill to pass Congress after one earlier this month put $8.3 billion towards vaccination research and emergency response by providers and waived some Medicare telehealth regulations. The Senate is already working on a third package that providers are asking to include more surge funding to tackle supply and workforce shortages,

as well as further expand telehealth flexibility.

In a letter to his colleagues on Tuesday, Senate Minority Leader Chuck Schumer (D-NY) called for the surge in funding for hospitals in the third package.

The American Hospital Association said it was pleased Congress passed the package, but again called for a “comprehensive funding strategy to ensure that hospitals, health systems, and our frontline caregivers are directly supported for preparedness and response.” The group said its needs are time-sensitive in order to replenish supplies as well as diagnose and treat patients.

EXPANSION/HAO WAIVER	
COMMENT/QUESTION	RESPONSE
Aren't we in the 30 day window for public comments on our plan? That's the question about timelne, isn't it? Not whether we put this change in place a year from now.	Yes. The HAO application and public notice was posted on Monday, March 16. This began the 30 day comment period.
What's the approval process for this? Is the July 1st the current approval date because it's already been approved?	CMS does not have a specified timeframe in which to approve waiver applications. However, we are expecting an April 20 submission date to CMS with CMS approval some time in October 2020. We plan to use the time between 10/10/20 to 7/1/2021 to work on implementation.
How would this differ from the full Medicaid Expansion? What does full expansion look like in terms of the details you discussed for HAO?	HAO is full Medicaid expansion in the fact that all adults are eligible for SoonerCare if they make at or below 133% of the Federal Poverty Level. HAO differs from state plan medicaid expansion in that there are additional requirements tied to eligibility such as Community Engagement requirements and nominal premiums.
You note all of these new requirements for eligibility. how many more jobs are going to be required to do this work? who is going to pay that expense?	If the question is referring to jobs at OHCA, the current anticipated additional employees that would be needed are staff within the Population Care Management team that would provide the in-house managed care component of HAO rather than contract with a third party managed care organization. At this time, OHCA is plannign for an additional 100 employees (mostly nurses, behavioral health professionals, case managers, etc.)
So can you explain how that would work? We would expand Medicaid for this year, but then it would all go away in July?	OHCA has submitted a state plan amendment to do full medicaid (adults over 133%) expansion that would be effective July 1, 2020. Then on July 1, 2021, we would transition this population into the HAO waiver program which is very similar to the state plan option except that there are nominal premiums, community engagement requirements and funding mechanisms that allow for shared savings that can be further invested into the program.
How much does the HAO waiver cost the state compared to a "traditional" expansion?	Please refer to the HAO application for projected enrollment / cost data for traditional expansion and demonstration expansion. Overall, OHCA anticipates a 5% reduction of cost in the demonstration in year 1 as opposed to traditional state plan expansion.
Will the State be ready to handle the significant increase of applications beginning July 1st?	Yes. Oklahoma utilizes an online enrollment system that utilizes a rules engine capable of making real time eligibility determinations. We are confident in OE's ability to handle the increase in applications beginning July 1, 2020
Is there going to be Medicaid buy in option with the expansion?	Indiviuals who make over 133% (with the applicable 5% disregard) will not have the option to buy into the HAO demonstration program. Indivdiuals who make over 133% of the FPL are eligible to seek coverage through the federally facilitated marketplace.
If you don't have the money for college, university, or vo-tech books & tuition, what's the state's plan to fully cover those costs especially if you're disabled or unemployed?	Individuals who have been determined disabled by the Social Security Administration with incomes under 100% of the FPL are eligible for traditional Title XIX Medicaid. If the question is referring to work requirements, there are options to achieve the 80 hour a month requirement that do not require a monetary investment by the member.
So full Medicaid expansion as of July 1 will not have all these restrictions and requirements?	Correct. July 1, 2020 state plan expansion will not have nominal premiums nor community engagement requirements.
The application is very vague and doesn't really describe the model of delivery other than checking the box on MCO. At the last meeting we were told that it is still a little unclear what model of care will be used. Is that the reason for a lack of description? If so, do you know anymore now on the topic?	The state is pursuing a managed care option that would build off of OHCA's current Patient Centered Medical Home which is a Primary Care Case Management model. This would be administered through OHCA in-house staff.
Why have you not put a plan together to implement Medicaid expansion until the citizens of Oklahoma demanded it through a petition drive?	OHCA is pursuing flexibilities offered through the Healthy Adult Opportunity demontration that were first made available January 30, 2020
Also doesn't the HAO system impairment a block grant system and how does the OHCA think block grants will fair in the future with changes in the economy?	The HAO demonstration employs a financing model geared at incentivizing OHCA and providers to improve the overall health of SoonerCare 2.0 members through care coordination, health promotion and increased use of primary care. Caps on spending advance the triple aim of improving patient experience of care, improving the health of the population and reducing the per capita cost of healthcare. OHCA will b able to share in the savings associated acheived through these masures with CMS up to 50/50. These dollars can in turn be used to re-invest into Oklahoma's healthcare system and economy. The Governor has implemented measures across the state, including investing in the state's Rainy Day fund at unprecedented levels in order to prepare for state economic downturns.
Given the sudden downturns of Oklahoma economy----which system allows for quicker adjustment of federal dollars for Medicaid.....the full expansion unlimited-90%-match or the SC 2.0 pre-determined shoebox "block" of funds?	See above
The Healthy Adult Opportunity has some characteristics of a block grant in limiting federal participation, so the state is volunteering to take additional financial risk. How is this a good strategy for the state?	See above
Also doesn't the HAO system impliment a block grant system and how does the OHCA think block grants will fair in the future with changes in the economy?	See above

Is the HAO a block grant and how do you all think it will effect eligibility in light of recent economic troubles?	See above
Are you saying that we will have full Medcaid Expansion until July 2021 and then convert to the new plan?	OHCA has submitted a state plan amendment to do full medicaid (adults over 133%) expansion that would be effective July 1, 2020. Then on July 1, 2021, we would transition this population into the HAO waiver program which is very similar to the state plan option except that there are nominal premiums, community engagement requirements and funding mechanisms that allow for shared savings that can be further invested into the program.
So after almost 10 years of our elected officials not providing Medicaid expansion to our citizens and continuing to have one of the worst levels of healthcare outcomes, our state has suddenly had a change of heart?	Governor Stitt has made healthcare a priority since taking office. He has asked OHCA to take advantage of the flexibilities granted through the HAO Demonstration Waiver that has just recently been made available to states.
How was July 1st decided. Does that mean July 1st 2020 or 2021?	The HAO demonstration (SoonerCare 2.0) would begin July 1, 2021. This coincides with the beginning of the new state fiscal year.
Explain when HAO would become effective for an applicant. The first of the month the application is submitted?	Similar to commerical insurance plans, an applicants coverage start date would depend on when the applicant applies and pays their initial premium. If the applicant applies on or before the 15th of the month and pays their premium, coverage would begin the 1st of the following month. If done after the 15th of the month, coverage would begin the first of the month thereafter. For example, if I apply August 17, my coverage would begin October 1.
Since we have expanded through a SPA and we expect the HAO program to be tied up in lawsuits for an extended period of time, do we expect to be providing traditional Medicaid expansion care for an extended period of time?	OHCA is prepared to navigate any unexpected change in circumstances in order to ensure Oklahomans have access to quality health care services regardless of their ability to pay
My understanding of "block grant" is that a certain amount is available, once that amount is reached, that is it. how is this different.	The HAO demonstration employs a financing model geared at incentivizing OHCA and providers to improve the overall health of SoonerCare 2.0 members through care coordination, health promotion and increased use of primary care. Caps on spending advance the triple aim of improving patient experience of care, improving the health of the population and reducing the per capita cost of healthcare. OHCA will b able to share in the savings associated acheived through these masures with CMS up to 50/50. These dollars can in turn be used to re-invest into Oklahoma's healthcare system and economy. The Governor has implemented measures across the state, including investing in the state's Rainy Day fund at unprecedented levels in order to prepare for state economic downturns. If a time comes when OHCA reaches the extent of federal funding in a given time period, the state will leverage state dollars to ensure Oklahomans continue to have access to care.
Is there a diffrence in the number of people who would be covered under the two different plans?	There is an assumption that there will on average 5% less individuals in the HAO Demonstration as compared to traditional state plan expansion, given the premium and community engagement requirements.
Can we make it sooner than July 1, 2020?	Due to public notice timeframes, it would be difficult to meet all federal and state pubic notice requirements in order to meet state plan expansion effective date prior to July 1, 2020.
Will the July 2021 rollout be possible under the current CMS rules or will Congress need to make changes before then?	The HAO can be implemented under current CMS authorities.
Will we reassess the feasibility of proceeding with implementing the Waiver as we become closer to the implementation date due to the increasing economic situation in Oklahoma?	State leadership, as well as OHCA staff are continually assessing all variables regarding implementation of new programs.
In my understanding of your response to Block grant funds being expended and then the State pay the rest. where is this contingency in the state budget? I predict the projected block amount will be exceeded. where does the money come from to cover this cost?	State leadership has taken several steps over the last few years to prepare for downturns in the economy as well as additional, unexpected costs to the state's healthcare sysytem. Steps taken include additional funding to the state's rainy day fund as well as investing in the Medicaid rate stabilization fund.
What does the “good-cause” waiver application look like? How is that process administered?	The good cause exception to community engagement requirements give the state flexibilities in considering cases on an individual basis. OHCA welcomes all suggestions from the public on criteria for what would constitute a good cause exception
You make accepting Medicaid Expansion now is smart, will offset costs the state already covers with state appropriations, and would "undoubtedly help rural hospitals." Can you explain why these benefits of expansion are just now being recognized by OHCA?	OHCA has always understood the importance of Oklahomans having access to quality heatlhcare. OHCA is grateful for Governor Stitt's leadership in pursuing an Oklahoma based solution to expanding Medicaid that has an emphasis on healthcare outcomes while also working to control the spending of Oklahomans’ tax dollars.
Other states have found that accepting straight Medicaid Expansion without work requirements and without premiums and co-pays has caused more people to be covered and has cost the state less. Are you open to straight expansion for the long term if you find that it works well for Oklahomans?	The benefits to an 1115 demonstration project is that the state has the opportunity to implement novel ideas that work best for Oklahoma. OHCA will continually evaluate and monitor the demonstration throughout implementation to ensure that we are acheiving the desired outcome.
What states have tried Block Grants for Medicaid and for what populations have they done so?	Through various 1115 waiver authorities, Vermont has a Medicaid program with a fixed federal dollar limit

So how're we supposed to make an educated and informed decision if you won't help us understand the differences comparatively?	OHCA will continue to do our best through public forums, public postings and responses to comments to inform interested individuals about any initiatives under consideration.
Does this program totally replace the SoonerCare program?	No. Sooner Care as it exists today for children, pregnant women and the aged, blind and disabled population will remain the same.
Many people who will be impacted may have difficulty posting their concerns and questions to the website. Were people in the community who would be impacted by the plan, included in the planning process?	If anyone has difficulty submitting comments through the onling portal, we would be happy to have phones conversations around the details of the HAO waiver.
So what do you say to people who may see this as more restrictive than other options?	OHCA respects the opinions of all individuals and believes that public input, especially input that questions decisions being made, is vital to policy making process. Public engagement in the process is what makes the end result truly successful.
Can this HAO waiver be submitted without a clear funding plan from the legislature?	SoonerCare 2.0 will be implemented in July 2021 (state fiscal year 2022). The Application can be submitted concurrent to a funding plan being developed by State leadership
If you want to do a waiver, why not recruit volunteers to go under your waiver plan and then compare their status with those who were not subjected to the changes?	Federal Medicaid regulations do not allow for such a demonstration project.
How is SoonerCare 2.0 better than regular Medicaid Expansion? What is the benefit of SoonerCare2	See previous responses.
Can the IMD waiver be submitted without being linked to the HAO waiver?	Yes.
Can you go over the requirements for the IMD waiver again in more detail?	The waiver of the IMD exception would allow SoonerCare to reimburse for inpatient and residential psychiatric and substance use disorder treatment services for indiviuals between the ages of 19-64. Without the waiver, federal funds are not available for these services.
Will this help the 8 rural hospitals that have shuttered their doors reopen?	Bringing more federal dollars into the state would help all heatlhcare provdiers in the state by reducing the amount of uncompensated care.
Why would managed care by a third party be considered? If managed care is necessary why would it not be a state run program?	OHCA is exploring a state run, in-house managed care program which would be an expansion of the current patient centered medical home program currently administered by OHCA.
After Arkansas selected to go to their own version of Medicaid, their number of insureds dropped. Why should Oklahoma expect a different result? Why should Oklahomans have different standards of eligibility than other citizens from the 37 states that accepted Medicaid? The block grant scheme seems to be an answer to the persistent rejection of the Affordable Care Act. Ideological rather than practical or efficient.	Governor Stitt and OHCA are utilizing new flexibilities and opportunities afforded through the Healthy Adult Opportunity that were not in place prior to January 30, 2020.
Which states currently have block grants for expansion and for Title 19?	Through various 1115 waiver authorities, Vermont has a Medicaid program with a fixed federal dollar limit.
Why does the governor want to make it more difficult to get Sooner Care and at the same time the state of Oklahoma takes on more risk since the block grant takes less federal dollars and Oklahoma takes on more . That does not compute with me. Thanks for taking my question.	The HAO demonstration employs a financing model geared at incentivizing OHCA and providers to improve the overall health of SoonerCare 2.0 members through care coordination, health promotion and increased use of primary care. Caps on spending advance the triple aim of improving patient experience of care, improving the health of the population and reducing the per capita cost of health care. OHCA will be able to share in the savings associated acheived through these masures with CMS up to 50/50. These dollars can in turn be used to re-invest into Oklahoma's health care system and economy. The Governor has implemented measures across the state, including investing in the state's Rainy Day fund at unprecedented levels in order to prepare for state economic downturns.
Should the waiver be implemented and it turns out to be a poor choice for the state (if there's another pandemic, for instance), can the state extricate itself?	The state always has an option to sunset a waiver program. There are waiver sunset timelines and public notice requirements from CMS that the state would have to follow.
STATE QUESTION	
When do you foresee this being on a ballot?	OHCA has no control over when state questions added to election ballots.

How would this affect the Medicaid Expansion state question?	HAO affords the state much more flexibility in providing healthcare to Oklahomans as compared to a constitutional amendment.
Can this be approved without a vote?	Yes.
How does the state plan differ from/compare to the actual expansion? Will the actual expansion get voted on? When?	State plan expansion is actual expansion. It expands Medicaid coverage to all adults with incomes at or below 133% of FPL.
Will this proposal effect the state question that the people want? Is this different than block granting Medicaid?	State Question 802 will be voted on this year regardless of any of the initiatives currently being pursued by OHCA.
When will Gov. Stitt setup a election date for State Question 802 for this year?	OHCA has no control over when state questions added to election ballots.
Why has the governor not set a date for SQ 802	OHCA has no control over when state questions added to election ballots.
Why not pursue this plan without a State Block Grant from CMS ? In otherwords, why not pursue this plan in conformance with the potential passage of SQ 802? This would also seem to be more prudent given the current Covid-19 crisis.	OHCA is currently pursuing full Medicaid expansion through a state plan amendment submitted to CMS. If approved, it will be effective July 1, 2020
Why have we not had a public vote on the petition that has been certified?	OHCA has no control over when state questions added to election ballots.
When do you foresee this being on a ballot?	OHCA has no control over when state questions added to election ballots.
You mentioned there would be no additional benefit for the passing of 802 vs this proposed state plan, however a constitutional amendment proposed in state question 802 would protect the government from finding ways to widdle away benefits. How would this state plan be protected if not a constitutional amendment?	802 would tie the eligibility for able bodied adults to those of pregnant women and children. In times of economic downturns when hard decisions must be made, the State would be forced to reduce eligibility and benefits for ALL populations instead of being able to prioritize the healthcare needs of children, aged, blind, disabled and pregnant women.
Why are you doing this now rather than let SQ802 be voted on by the citizens of OK?	Oklahomans need healthcare coverage now, which is why OHCA has submitted necessary authorities to implement full expansion effective July 1, 2020
How can it go into affect in 2020 if we haven't voted on SQ 802?	States have had the option to provide medicaid expansion since the Affordable Care Act became the law in 2010.
Are you intentionally not taking questions in regard to SA802?	No. My apologies. While we appreciate the advantages and broad access that a virtual forum provides, it is difficult to respond to multiple questions coming through in the matter of minutes. We appreciate your patience. All submitted questions are addressed in writing.
What's the 3 possible 2020 election dates for state question 802?	June 30, August 25 and November 3
Are we voting on Soonercare 2.0 or has it already been approved?	SoonerCare 2.0 does not require a vote.
So at these meetings, will they be able to answer 802 Q's?	We will always do our best to answer all questions.
How would state question 802's passing effect this HAO waiver?	802 would tie the eligibility for able bodied adults to those of pregnant women and children. In times of economic downturns when hard decisions must be made, the State would be forced to reduce benefits for ALL populations instead of being able to prioritize the healthcare needs of children, aged, blind, disabled and pregnant women.

What is the difference in the benefits of this and what SQ802 would offer?	HAO and SQ802 would offer the same covered services.
When will the citizens of Oklahoma be able to vote on Medicaid expansion as requested in the recent petition signed to allow us to choose to expand Medicaid. I want to be able to vote on this issue.	OHCA does not have any control on when state questions are presented for a vote. Please contact the governor's office.
When will Gov. Stitt comply with the state law and schedule the vote for SQ 802?	OHCA does not have any control on when state questions are presented for a vote. Please contact the governor's office.
Why can't the state vote on SQ 802 before we look at a plan that doesn't cover as many people?	Full Medicaid expansion under the state plan is happening and will be effective July 1, 2020.
Can you explain again what happens to SoonerCare 2.0 if the people of Oklahoma vote for traditional expansion when given the opportunity?	802 would tie the eligibility for able-bodied adults to those of pregnant women and children. In times of economic downturns when hard decisions must be made, the state would be forced to reduce benefits for ALL populations instead of being able to prioritize the health care needs of children, aged, blind, disabled and pregnant women. If 802 passes, the state would explore managed care opportunities for the expansion population outside of am HAO environment.
ELIGIBILITY/COVERAGE	
Looking at page 9 of Application----Is it correct that SC 2.0 will have NO presumptive coverage....NO retroactive coverage....and NEW delay of up-to 6-weeks before coverage is effective? The info about delay based on 1st/16th is NOT consistent with Marketplace Exchange when a member had previous coverage. For example, someone losing job March 18 with job coverage ending March 31 could apply to Marketplace and choose plan before March 31 to get coverage starting April 1 (no gap in coverage). Will people losing their current coverage have a gap in transition to SC 2.0? Or does the gap only apply to those coming to SC 2.0 with no previous coverage? Will the "gap" apply to members transitioning from Full Expansion Medicaid to SC 2.0 on July 1, 2021? Thanks.	It is true that HAO does not have presumptive eligibility. Presumptive eligibility is a process of finding an individual preliminarily eligible for Medicaid based on limited information. If the individual is later found to not be eligible, Medicaid is still responsible for paying for the individual's care. Oklahoma currently allows for hospital presumptive eligibility, but to date no individuals have utilized this. OHCA will continue to explore options around coverage begin dates.
How will OHCA continue to provide EPSDT benefits to 19 and 20 year olds who are part of the HAO population?	EPSDT benefits are a requirement for individuals under the age of 21 in traditional Title XIX Medicaid. It is not a requirement of the adult expansion population through the HAO Waiver demonstration.
Given that the draft plan projects flat enrollment for all five years of the demonstration, how many Oklahomans do you expect will remain uninsured?	The information we have is based on current uninsured data in the State. Unfortunately, not all counties report their uninsured data based on FPL limits. We expect the number of uninsured individuals across Oklahoma to decrease initially by around 200,000 lives.
You are only suggesting coverage up to 133% FPL.	Yes. This is the income limit allowed for the adult expansion population in the Affordable Care Act
In dollars what is 133% of poverty level?	$16,970 for an individual and $34,846 for a family of four
What is OHCA's estimate of the percentage of the uninsured adult population who will sign up for this program, once implemented? Is it possible there will be caps on treatment, since the federal funds would come through a block grant?	OHCA expects a year 1 enrollment target of ~160,000 individuals. In SoonerCare today, there are service limits for individual treatment services. Similar limits will exist in HAO.
What kind of identification and registration will be required to access these benefits?	Please refer to OHCA Rules 317:35-5 Part 3
So will there be a gap in coverage? if people are rolled into this category?	OHCA will do everything we can to ensure individuals experience the least amount of disruption in coverage as possible. This will include transitioning individuals in the state plan adult expansion seamlessly into SoonerCare 2.0 without a gap in coverage. This transitioning will being on July 1, 2020.
Is there any reason that there's no change in enrollment, given that medical inflation and economic fluctuations would suggest otherwise?	Enrollment and cost projections are based on assumptions based on historical data and research gained from experiences in other states.
Will people be able to still enroll in the ACA?	The medicaid expansion for adults up to and including 133% of FPL that will be effective July 1, 2020 is authorized by the ACA
Will you offer a a state Medicaid public option for self employed individuals?	Self employed indivduals with incomes under 133% of FPL will be eligible for SoonerCare 2.0

is there are diffrence in the number of people who would be covered under the two different plans?	Enrollment in SoonerCare 2.0 is expected to be 5% less than a state plan expansion benefit.
How many people do you anticipate will qualify for expansion? How was that number extrapolated?	Based on state date on the uninsured, we expect around 200,000 people to be eligible. See OHCA's Uninsured Fast Facts.
So if these 9000 cannot afford Market Place they will fall into the uninsured gap?	OHCA will work with the individuals in the Insure Oklahoma ESI plan over 133% (roughly 9000 individuals) to transition to affordable health insurance option after the planned phase out of Insure Oklahoma on 12/31/2020.
Does this plan allow for indigent care?	Indigent care is a term used for individuals who cannot otherwise afford healthcare due to low income. Adults who are not otherwise eligible for traditional Medicaid may be eligible for coverage in both the July 1, 2020 state plan expansion as well as the July 1 2021 HAO demonstration.
If a family of four makes above the 133% FPL will they still be able to purchase coverage through the ACA marketplace?	Yes.
Can we pull enrollment forward?	Federal public notice and comment requirement timelines would make it difficult to implement state plan expansion prior to the planned effective date of July 1, 2020
Do other states that have Medicaid Expansion over coverage for individuals or families above the 133% FPL?	The ACA only allows for the adult expansion population to go up to 133% of FPL.
Can a 60 year old healthy female, who meets the poverty requirement, currently get Medicaid insurance in Oklahoma?	Not traditional Title XIX Medicaid. She may qualify for Insure Oklahoma Inidividual Plan or Employer Sponsored Insurance if she meets eligiblity requirements.
What about children who are currently on Sooner are, but parents may go slightly over on income. Are you increasing the income range	Chidlren on SoonerCare will continue to have coverage up to 185% of their household's income, regardless of the parent's coverage.
About the NEW delay of up-to-6-weeks before coverage is effective.... The info about delay based on enrollment dates of 1st/16th is NOT consistent with Marketplace Exchange when a member had previous coverage. For example, someone losing job March 18 with job coverage ending March 31 could apply to Marketplace and choose plan before March 31 to get coverage starting April 1 (no gap in coverage). Will people losing their current coverage have a gap in transition to SC 2.0? Or does the gap only apply to those coming to SC 2.0 with no previous coverage? Will the "gap" apply to members transitioning from Full Expansion Medicaid to SC 2.0 on July 1, 2021? Thanks.	OHCA will continue to explore all options related to this question in order to ensure that individuals have the least amount of coverage disruption possible.
Other states DO go over the 133% poverty line with CHIP programs to cover "gap" children. Why does Oklahoma no longer do that, and will they expand coverage for those kids who fall through the cracks by being slightly over income?	Oklahoma does currently cover children through CHIP up to 185% of FPL and will continue to do so as long as CHIP is reauthorized. Nothing in the HAO demonstration plan applies to coverage of children.
Why does soonercare end at age 19? Shouldn't college students be covered?	Federal regulations set eligiblity requirements for traditional Medicaid. There are options for individuals attending college such as the Insure Oklahoma Individual Plan.
Why not increase the income range, to cover more children? Last year Oklahoma kicked more kids off of Medicaid than almost any other state. Shouldn't we be including all children?	Title XIX Coverage for Children is and will continue to be 185% of FPL. Children are not affected by SoonerCare 2.0
Just for clarification, with the expansion it will cover 19 - 64?	Yes.
Why would you not allow retro eligibility for hospitals that is currently allowed by Medicaid? You are looking to fund part of the costs on increased SHOPP fees and yet this plan harms the hospital - specifically struggling rural hospitals -- by not covering these costs.	Despite being currently available, hospitals have not taken advantage of the Hospital presumptive eligibility option. Oklahoma currently uses and will continue to use the notification of date of service (NODOS) process which allows a hospital to submit basic identifying information to OHCA to "save the date" for eligibility when an individual admits to the hospital. If the individual is later found to be eligible for SoonerCare, OHCA reimburses the hospital for individual's hospital stay.
Does this plan cover older teens?	HAO covers individuals aged 19-64. Teens younger than 19 with household incomes under 185% will continue to have coverage through traditional Title XIX Medicaid.

Can you clarify how the agency will accommodate people with disabilities who did not qualify for Medicaid on the basis of that disability?	We would encourage individuals with disabilities to apply through the Social Security Administration for a disability determination.
How does this plan specifically address the needs of the many Oklahomans with disabilities? How will it help shorten the 11 year long waiting list for services? How does this plan benefit rural communities that have lost their hospitals?	HAO covers non-diabled adults. Adults who have been determined disabled by the Social Security Adminisrtation would be eligible under traditional medicaid and other home and community based waiver services.
Would Medicaid expansion affect choices on the exchange for people above the poverty level who have to purchase their own insurance? Choices are currently very limited and expensive.	No.
What advantages does private coverage have over Medicaid that would lead the agency to work to transition people to private coverage?	Private coverage provides essential health benefits, like Medicaid, in order to ensure indivdiuals have appropriate health care coverage. Transitioning individuals who can afford private insurance to the private market helps keep state costs down in providing coverage to those individuals who can not otherwise afford healthcare coverage.
Is transitioning people off Medicaid to private coverage one of the stated goals of the Oklahoma Health Care Authority?	Please refer to the goals identified in the HAO waiver.
WORK REQUIREMENTS	
How does the OHCA view the challenges to work requirements in other states and their overall legality?	OHCA continues to monitor the status of litigation in other states. However, OHCA is working with our federal partners, CMS to implement a plan that utilizes the flexibilities given to states through the Healthy Adult Opportunity which allows for the use of community engagement requirements.
Can you explain the point of work requirements?	A large body of research has shown that employed individuals are healthier than those who are not employed. Enhancing employment opportunities for working-age people can improve health status and decrease the overall costof providing healthcare. Employment can improve health by increasing social capital, enhancing psychological well-being, providing income, and reducing the negative health impacts of economic hardship. Incentivizing employment, pursuit of educational / vocational activities and volunteerism promotes all of these objectives.
To confirm - young people with foster care experience will be exempt for work requirements?	Former foster care youth up to age 26 is an eligibility group in traditional Title XIX Medicaid. This group will continue to have state plan coverage. After attaining the age of 27, these individuals can transition to the adult expansion group.
What steps are the Healthcare Authority taking in their design of SoonerCare 2.0 to reduce the burden of work requirements on eligible working Oklahomans?	Working oklahomans meeting the 80 hour a month engagement requirements will have no difficulty in maintaining their coverage. OHCA will work to create efficient data collection systems to make the report process as simple and efficient as possible.
Why are we targeting the work requirements? Expansion is for the "working poor" who work at businesses who do not offer health insurance or the health insurance is so costly, they can't afford to purchase it.	Individuals who are working will meet the community engagement requirements.
How much will it cost to monitor compliance with the work and education requirements, especially for those without internet access?	OHCA intends to utilize existing human resources and leverage technology to keep compliance costs low.
How will you address the large rural population with barriers to the work reqments?	OHCA would be happy to discuss any perceived barriers and work with individuals to overcome them. There are qualifying activies other than employment that qualify as community engagement activities.
Would any type of volunteer work be considered community engagement?	Yes.
Is there a workforce development development plan that will work in combination with your HOA plan to increase the technical skills to find higher paying jobs in order to move off the state's Medicaid program?	visit www.oklahomaworks.gov
Why not pursue this plan without a State Block Grant from CMS ? In otherwords, why not pursue this plan in conformance with the potential passage of SQ 802? This would also seem to be more prudent given the current Covid-19 crisis.	See responses related to HAO funding opportunities and flexibilities.
Will premium exemptions apply to the same population as work requirements? Or specifically will young people with foster care experience also be required to pay premiums?	Individuals exmpt from premiums are individuals with HIV/AIDS, Serious Mental Illness and Substancve Use Disorders.

How will work be reported?	OHCA is working on reporting processes that will be part of the design phase of implementation.
Work incentives add a bureaucratic layer and have proven uneffective in increasing labor rates in other states. Why prevent people from getting the care that keeps them out of the hospital for this?	See previous response regarding health benefits of employment and incentivizing employment.
When Arkansas implemented their work requirement program the added reporting burden led to a large disenrollment of eligible adults. What measures is the Healthcare Authority taking to reduce these burdens and ensure eligible adults maintain their coverage?	In HAO, community engagement requirements are a condition of eligiblity. If they are not met, the individual is not eligible.
In the work requirements.....how to handle single parents who work while children are in school....but do not work during summer and school holidays? (since child day care not available or cost-effective).	Individual cases can be reviwed on a case by case basis for a "good cause exception"
Thank you for helping us navigate these concerns. :-) Are gig-economy or entertainers/artists included in the work requirement?	Yes. And these activities qualify as community egagement activities. Also, income from these activities are counted toward an individual's household income for purposes of financial eligility for SoonerCare.
How does “incentivizing” people to work make people more healthy?	See previous response regarding health benefits of employment.
Can you address seasonal workers - construction, farm, etc. regarding work requirments?	Seasonal employment counts toward community engagement requirements.
Will OHCA consider evaluating work requirements on a quarterly or 6-month basis in light of the fact that many low-income adults work seasonally or on an irregular basis?	OHCA will explore this option to account for seasonal employment. Thank you for your response.
What is considered good cause? Would that apply to parents who have individuals on DDSD or other types of children with disabilities?	OHCA will evaluate these on a case by case basis. We welcome suggestions as to what should be inluded in the good cause exemption criteria.
Is OHCA confident this premium and work reqs coverage will not harm program integrity by decreasing participation by eligible people?	Premiums and community engagement are conditions of eligibility. If an individual is not exempt from the requirements failure to comply will render the individual uneligible.
What happens if people fail to meet the community engagement requirement?	Please refer to page 13 of the HAO waiver application.
Can you confirm how OHCA intends to confirm in-kind work?	These processes are in design phase. We will let you know when we have more detail.
Can you confirm where OHCA generated the 5% reduction in enrollment from? It's substantially lower than other states have experienced with work requirements and below researchers' projections?	These assumptions are based on historical data and information gained from experience in other states.
Can the state explain why it's still saying that work requirements lead to better health when the author of the study you cited said you misinterpreted it? As a reminder: “I think to cite this brief as an unqualified statement that work is good for your health is misquoting it. It’s a gross distortion of what the brief is about,” https://stateimpact.npr.org/oklahoma/2018/12/20/oklahomas-medicaid-work-requirement-targets-poor-caregivers/	There have been numerous studies on how gainful employment leads to better health outcomes and overall well being. Incentivizing work through CE helps to get individuals employed.
Are there going to be hiring requirements for employers to hire people to fulfill this there work requirement?	OHCA can not compel an employer to hire someone.
How much will it cost to implement a work requirement?	These figures are not readily available, but OHCA will utilize current staff and processes to track reporting and leverage technology to improve efficiencies.
Other states who have instituted work requirements have seen thousands of citizens lose eligibility. How will those in rural areas report work time without internet access?	OHCA will work to create reporting processes that are efficient and easy to use for the member.

FINANCIALS (CO-PAYS, PREMIUMS, SAVINGS, COSTS)	
How much do you expect to collect on $5/adult premiums? How much do you expect to spend to build and implement systems to collect those premiums?	OHCA already has systems and processes in place to collect premiums. We will utilize our current infrastructure used in the Insure Oklahoma IP program.
A $40 monthly premium puts a new annual cost on a struggling family of almost $500 a year. How will this disincentive for coverage save us money, when our state is near the top for uncompensated care? This drives up premiums on all Oklahoma businesses, employees in group plans, and individuals paying full premiums for individual plans under the ACA.	$40 premiums are those that are currently assessed to Insure Oklahoma IP members. The premiums under the HAO demonstration are much lower and range from $0 per month to $15.00 per month.
Why are the suggested pay guidelines so below the suggested FPL currently being used to determine co-payments on a sliding scale for FQHC's?	FQHCs have different flexibilities offered to them through the Health Resources and Services Administration, who funds FQHCs through a block grant system in addition to Medicaid reimbursement.
How will premiums be collected, and what happens if people don't pay their premiums?	Premiums will be collected through an OHCA process. Individuals who have not paid their premiums for 3 months will be unenrolled, but will be eligible to reapply the following month.
Is the income going to be based on the taxable household as in SoonerCare, as some will not be filing taxes with no income.	Eligibility will be based on the household's modified adjusted gross income (MAGI)
To what extent have Oklahoma policymakers looked at market-based reforms that look not only at lowering the costs of insurance, but the overall costs of care? For example, Michael Porter's value-based health care framework or ideas from the market-based model in Singapore?	Thank you for this suggestion. We will research Mr. Porter's ideas and suggestions.
On co-pays, are they tiered to encourage the use of primary care and discourage the use of emergency rooms?	Premiums are tiered based on the family's income with the understanding that those with lower incomes should have lower premiums. We are disincentivizing improper use of Ers through charging an $8 copay for ER visits for non emergency diagnoses.
Where can we find the premium tiered list?	Page 9 of the HAO Application
What is the cost that will have to appropriated every year by the OK Legislature?	Projections estimate $150M annually
Have other states implemented premiums when expanding Medicaid? Can you explain the rationale behind premiums?	Premium's are an individual's investment into their own healthcare and instill a sense of ownership in the SoonerCare product.
You say the infrastructure already exists to collect premiums, but will there be any public costs to reconfigure or modify that collection infrastructure to implement this program? If so, what are estimates for those costs?	OHCA is evaluating any and all costs associated with design and implementation of SoonerCare 2.0. We do not anticipate costs much over current spending levels for this element.
Will you limit increased SHOPP fees for already stressed hospitals outside the urban centers?	The proposed SHOPP assessment fee is 4%. Hospitals have benefited from the SHOPP program by receiving supplemental payments funded through federal dollars matched with the SHOPP assessments and redistributed throughout the hospital network.
It sounds like there will be a need for new staff and new systems to track th costs associated with the exemptions and new requirements. How much will that cost?	See previous response ragarding costs.
Who will pay the hospital? many of the rural hospitals are now closing because of this situation. you do not seem to correct it.	Hospitals have faced hard times in Oklahoma due to the amount of uncompensated care throughout the state because of our high uninsured rate. Through this demonstration, the overall amount of uncompensated care will go down due to more individuals being covered by SoonerCare.
NOT ALL hospitals pay into SHOPP. How will that work?	Correct. The SHOPP assessment collection methodology will not change, just the assessment amount on those hospitals that do pay into SHOPP.
Will this plan pay a higher reimbursement rate to physicians?	OHCA anticipates that reimbursement levels will mirror those in traditional Title XIX Medicaid.

133% FPL for family of 4 is $34,846. Is there catastrophic care or gap insurance available for people making more than this but not enough to afford insurance on the regular marketplace?	Not through SoonerCare.
Could you please again give the website that has the application details including premium levels?	http://www.okhca.org/SoonerCare2/
If taking federal funds would help rural hospitals stay open, why wasn't a Medicaid Expansion plan put together before now?	We are thankful for Governor Stitt's leadership and willingness to pursue this option for more Oklahomans to have access to quality healthcare.
What is the Governors current the anticpated increase in the SHOPP assessment for the hospitals participating?	Requested SHOPP assessment is 4%.
Does the governor have the authority to expand the SHOPP assessment or is that something the legislature would have to do? If it depends on the legislature, can this application be submitted before they vote to expand SHOPP (or pay for the waiver some other way)?	It requires legislative action.
The marketplace enrollment dates you refrerence in this announcement regarding effective dates related to premiums are not consistent with what we encounter utilzing the marketplace. If you enroll someone in the marketplace by the 15th of the month, their plan will become effective on the 1st of the following month as long as a premium is paid by the 1st of the month. Premiums are not required to be paid by the 15th.	OHCA will continue to develop this process and will work to create a process that prevents coverage gaps to the extent possible.
How much do you expect to collect on $5 premiums though? We've seen in other states that even with low premiums, people often fall behind due to the extra step and the state collects only a token amount of revenue.	Premiums are not intended to be a revenue sourvce. Premium payments are critical to member engagement, as studies have shown that making regular monthly premiums may lead to better health outcomes for members. For example, in Indiana, where Medicaid eligible adults are required to pay monthly premiums, members making contributions had higher satisfaction rates, higher primary and preventative care utilization, higher prescribed drug adherence, and lower emergency room use than those who did not. (The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016))
Is income going to be declared or taxable?	SoonerCare 2.0 financial eligibility is based off of the modified adjusted gross income methodology.
CAN OUR RURAL HOSPITALS MANAGE THE INCREASE IN THEIR PAYMENT REQUIREMENT FOR THIS?	Rural hospitals will benefit through a decrease in uncompensated care due to a significant decrease in the state's uninsured rate.
OHCA used a managed care model in the past without success. Since Oklahoma is a rural state, please provide option for rural providers to remain in fee for service	OHCA is planning to leverage knowledge gained from our past experiences in order to create a successful in house managed care model building off of the success of our patient centered medical home model.
Why now, when we are facing a State of Emergency, would the governor pursue HIS plan that would decrease the number of enrollees in Medicaid by as much as 5%, and ask Medicaid Enrollees to be responsible for paying copayments for their services up to the 5% out-of-pocket maximum, and an $8 copay for "non-emergeny" use of non-emergency room visits? Is this not the time that we need to keep ALL Oklahomans as healthy as possible and providing medical services to ALL Oklahomans to better ensure the coronavirus does not spread?	The HAO plan would not go into effect until July 1, 2021. OHCA is currently working on a full state plan Medicaid expansion for the adult population that will go into effect July 1, 2020, which we expect will assist those individuals financially impacted by the COVID-10 national emergency.
Can you clarify on the anticipated copayment costs for for people who do not have to pay a premium. The waiver draft suggested they could still be subject to up to 5% cost-sharing.	The 5% cost sharing is a cap. If someone is specificallly exempted from premiums and co-pays, they are not obligated to pay. For individuals who are obligated, their max out-of-pocket cost sharing is capped at 5% of their household income for any given month.
What's the ROI on the premium collection OHCA already does?	Currently for the Insure Oklahoma IP program, OHCA averages premium collections of roughly $160,000 per month.
Is the state still pursuing TSET money to pay for some or all of the state expenses?	Refer to page 45 of the HAO application for state funding.
Has OHCA forecasted to what extent the Rainy Day Fund would need to be tapped in the event of a downturn and the other competing demands on that money?	No.

Can you clarify your comments on state funding? You stated that we couldn't expand before July 2020 without state funding. If that's the only holdup and with a pandemic on the horizon, has OHCA investigated this?	We are in continuous dialogue with our state leaders regarding funding.
Can you tell us how running out of federal dollars and needing to cover with state-only dollars won't lead to people or services being cut?	OHCA is accustomed to working with our stakeholders to make tough decisions in times of economic downturn and increases in utilization above our state appropriated dollars. If this occurs, we will use our same processes to make these tough decisions.
Has OHCA calculated how much federal money won't come into the state due to this project? Commonwealth put it at $2billion and the waiver is silent on the topic.	Currently $0 federal dollars are coming into the state for the adult expansion population. Anything federal funding the state brings in subsequent to HAO implementation is more than $0.
I don't understand why you're saying that the exemptions for premiums and work requirements are very similar. It sounds like there's strikingly little overlap! Can you clarify?	Please refer to the HAO application for a detailed list of premium / cost sharing exemptions and community engagement exemptions.
What are the estimated costs of ending retroactive eligibility?	Retroactive eligibility is a fairly new concept and there is not enough data, historical or otherwise, to creat cost projections.
Can you speak to concerns that in order for states to realize savings per the HAO waiver, they would have to cut their program outside the waiver per Manatt etc?	OHCA does not believe this will be the case. We expect to realize savings through better management / coordination of care for members while emphasising health promotion and employment stability.
Will the 'nominal' fees be suspended during the pandemic?	We expect that the panedmic will have concluded prior to July 1, 2021. However, CMS allows for states to apply for 1135 emergency waivers in order to suspend, temporarily, cost sharing requirements for SoonerCare members. We are currently pursuing this option for Insure Oklahoma members and have eliminated any cost sharing requirements for COVID-19 testing and treatment.
BENEFITS, SERVICES	
Does this plan support expansion of substance abuse treatment and mental health care?	Yes, through this plan, roughly 200,000 more adults would have access to behavioral heatlhcare.
Will this expansion allow more people to be eligible for mental health care?	Yes, through this plan, roughly 200,000 more adults would have access to behavioral heatlhcare.
Does this plan cover birth control? Does this plan include a robust pharmacy benefit?	Yes, and yes the pharmacy benefit wil mirror that of the current state plan.
Does the plan address wellness benefits for those with metabolic disorders like diabetes?	The plan will include services currently covered under Title XIX with few exceptions. Managed Care includes care coordinationand health promotional services that are not traditionally covered under traditional Title XIX Medicaid.
Can you talk about why you are excluding NEMT? This is a service that participants need a lot in able to get to provider appointments. Seems if we want folks to comply with going to provider office visits, we would leave this benefit.	Non emergency transportation is a Title XIX benefit for low income individuals covered by traditional Medicaid. The HAO demonstration allows states flexibilities in creating a benefit package geared toward working adults. This adult expansion population, overall, is less reliant upon Medicaid covered NEMT. However, OHCA will allow for limited coverage of NEMT for individuals on a case by case basis.
Can you explain the PCCM under the HAO and how it compares to existing operation, and how PCMH will be utilized? Thanks	The PCCM plan for HAO will look very similar to the patient centered medical home currently utilized by OHCA in providing care management/ care coorindation for the SoonerCare Choice population. Please see the Patient Centered Medical Home page of the OHCA website for more information.
How will this impact the portion of the Medicaid program that funds home and community-based services for people with intellectual and developmental disabilities?	HAO does not impact individuals been served through 1915(c) waivers.
Does this apply at all to outpatient mental health?	Yes, the HAO plan will have the same robust outpatient behavioral health services available as are currently covered under the Title XIX state plan.
What do you mean when you say "we will follow 1927 but will "investigate potential benefits of a limited formulary and request flexibility to make changed to the drug benefit using advance notice. Question: In what circumstances would the state choose to forgo 1927 in the future and seek that flexibility? Thanks!	Currently the state plans to use the formulary and pharmacy benefit design used under Title XIX State Plan. In demonstration applications, however, the state reserves the right with CMS to be flexible without submitting an additional waiver amendment. We will engage the public through an open process if changes are made to benefit design later on after HAO implementation.

Will the inclusion of more behavioral services in a possible PCCM option require additional waivers or SPAs?	No. Everything we need to accomplish can be done so through the HAO waiver application, except for the IMD waiver which will be an additional waiver amendment.
How will this impact the portion of the Medicaid program that funds home and community-based services for people with intellectual and developmental disabilities?	It won't.
HAO allows for drug formulary restrictions.....does SC 2.0 use this "flexibility" to add restrictions to formulary?	There are currently no plans to restrict the pharmacy formulary in HAO.
Will clients receive more benefits than they are currently receiving through DMH?	The behavioral health benefit will be the same as is offered under current Title XIX authorities with the exception of adding integrated behavioral health into primary care settings through HAO
What does primary care have to do with mental health care/substance abuse care? Those issues are handled by psychiatrists, not primary care doctors.	HAO will allow licensed behavioral health professionals to provide services alongside primary care physicians in the PCP practice. This way if a PCP identifies that a client needs additional services from a LBHP, that can hand them off to a LBHP within their practice who can now be reimbursed for services rather than setting up a referral.
Will the state use the potential of access to the increase pool of Medicaid customers as leverage against pharmaceutical companies to significantly lower all prescription drugs costs?	OHCA already has access to tools that reduce the overall costs of prescription drugs purchased by OHCA including the drug rebate program.
Is there a limit of 6 scripts on this plan per month?	The pharmacy benefit in HAO will mirror that of Title XIX which currently has a prescription limit of 6 per months for adults.
So only adults would be eligible for birth control?	Birth control will continue to be covered in Title XIX as well as HAO.
How would the proposed plan impact recipients of current Medicaid Waiver programs for the elderly and people with developmental disabilities on waiting lists. Will service options under these programs be changed?	It won't.
Is there a dental benefit associated with this plan?	Medically necessary extractions.
Will TEFRA go away?	No.
What's the definition of "serious mental disease"? Where to find it?	Please see 317:30-5-240.1
Will this plan support care (counseling or confirmation processes) for trans or non traditional gendered individuals?	
Can you go into more detail about pharmacy/drug coverage?	Pharmacy coverage will be the same as it is under the SoonerCare plan now. Please refer to 317:30-5 Part 5
Pardon me if I am suspicious. As our state politically identifies with pro-life agendas, we have withheld healthcare from thousands for almost a decade. What can you tell me to address this suspicion of the state's intention?	I'm sorry, I don't understand the question.
Are there any particular delivery system reforms you're considering implementing specifically for the expansion population, such as expanded telehealth services, social determinants of health integration, etc.?	OHCA continues to develop plans to incorporate the use of more technology in all services that we cover. We will also provide more opportunities for behavioral health care coordination and integration with medicla services through HAO.
This seems to put a lot more on Primary Care Doctors. What is your feedback on that?	The patient centered medical home model that is currently used and will be built upon through HAO does focus on the primary care provider as the patient's medical home. This has proven to improve health outcomes through greater care coordination and monitoring of the patient's health. OHCA provies a robust network to support the PCP through activities such as nurse care management and health access networks.
Would women be able to select their obgyn as their pcp?	

Is all hospitals, insurance companies, pharmaceutical companies, and medical professionals required to accept Medicaid customers under this plan?	The HAO will build upon the current SoonerCare provider network, but enrollment is not and has not been mandatory for providers in Oklahoma.
Will telemedicine be covered?	Yes.
What are provisions and procedures to required to provided ongoing Occupational Therapy services through Telehealth at this time?	We believe this question is related to COVID-19 flexibilities. Please call OHCA Provider Services at 800-522-0114.
How will the proposed plan impact recipients of current Medicaid Waiver programs and future individuals who are waiting to be served? Will the service options currently provide under approved waivers be changed?	HAO will not affect individuals receiving services through a 1915 (c) waiver program.
COVID-19 IMPACT	
Why are we doing this in the middle of a pandemic?	Governor Stitt and the OHCA began plans for state plan expansion and HAO immediately after CMS announced the HAO opportunity in January. It is essential to cover as many lives as we can as quickly as possible, so we are holding true to our timeframes in order to enroll expansion population adults beginning July 1, 2020.
This should be deferred until we are past this crisis. Instead, we should immediately except Medicaid expansion to allow all OK access to medicare in the face of this pandemic.	
This should be deferred until we are past this crisis. Instead, we should immediately accept Medicaid expansion to allow all Oklahomans access to medical care in the face of this pandemic.	
How does the state plan on overcoming an argument that this hearing does not conform with appropriate public notice resulting in an arbitrary and capricious decision as public participation is so limited due to the current pandemic?	Virtual meetings conform with CMS public notice requirements for wiaver submissions during the COVID-19 national emergency. See https://www.medicaid.gov/state-resource-center/downloads/covid-19-faqs.pdf
With all the businesses being affected by Coronavirus and the drop in oil prices, is there a temporary coverage for individuals who may lose their jobs or are drawing unemployment?	We are doing everything we can to ensure that we have full state plan Medicaid expansion effective July 1, 2020 which would provide coverage for these individuals.
Can enrollment be pulled up in time to April or May to help those who become ill during the pandemic?	See previous resopnses about timelines for state plan medicaid expansion implementation and effective dates.
Can enrollement in medicaid expansion be pulled up in time to help those sickened by COVID-19?	See earlier response
Why are we not supporting medicare for all during this pandemic? How will we make sure 100% of Oklahomans are covered even as many are being laid off?	Medicare for all is not currently authorized under any federal authority. OHCA is pursuing state plan and 1115 authorities currently available to us by CMS.
Can enrollment in medicaid expansion be pulled forward during the pandemic?	See previous responses about timelines for state plan medicaid expansion implementation and effective dates.
How prepared is the OHCA to start the SPA July 1st if the COVID is still happening? We are hearing the surge won Can all your employees work remotely? How redundant are your systems?	OHCA will continue to provide eservices throughout the emergency period and beyond.
Will your plan cover the full cost of testing and treatment of COVID19?	SoonerCare currently covers COVID-19 testing and treatment for SoonerCare members with $0 cost sharing obligations.
Provided that there are no public hearings per COVID-19: Can you stream future meetings via Youtube, Facebook or other free digital services that would allow the public to better engage?	OHCA will explore all options for virtual public meetings. However, other than being able to see the speaker, we are unsure how other virtual forums would allow for more public engagement. Typically OHCA requires individuals requesting to make comment to sign up 24 hours in advance and only allows 2 minutes for comment and for board and MAC meetings, limits commenting parties to 20. This forum allowed for over 300 individuals to be present, with over 200 comments submitted, with some individuals submitting over 30 comments. We are delighted to see this level of public engagement in this process and feel that the current virtual forum has been successful.

Would the Governor and state leadership be willing to meet with Wes Bledsoe to discuss the problems with the current plan and an effective plan that can blunt the virus' spread from staff, to their homes, and into the community?	This question is not related to the HAO application and is better directed to the governor's office.
Why is Oklahoma not purchasing the Covid19 test kits directly from sources outside of the US. I have identified 1 with a proven 99% reliability and that Scotland has an existing and reliable source.	This question is not related to the HAO application.
INSURE OKLAHOMA	
Will this program take the place of Insure Oklahoma Individual Plan?	Yes. Currently the Insure Oklahoma individual plan covers some adults up to 100% of the FPL and has premium obligations which average $32 a month. Once these individuals transition to full state plan expansion, they will have $0 premiums. When they transition to 2.0, their premiums will range from $0 to $15 a month depending on their income.
What happens to Insure Oklahoma? Both IP and ESI?	See previous response ragarding IO IP. ESI members under 133% will be eligible for HAO coverage. Those over 133% (9000 individuals) will be eligible for coverage on the federal marketplace.
What happens to the tobacco tax funds that currently are used for Insure Oklahoma, will they be used to pay for this expansion?	
How will sooner care 2.0 differ from insure ok? Now the state pays 60% Employer 25% and Employees 15% for real insurance that all employees would have. SC2.0 might stigmatize those participating a in the work place. Is SC2.0 going to be enrolled like Insure Ok?	SoonerCare and SoonerCare 2.0 is real healthcare coverage with premiums ranging from $0-$15 a month.
What happens to the people on Insure Oklahoma that income in more than 133%?	See above.
Insure Ok enrollees ARE working... save the program!	
Insure OKlahoma has been a highly successful program that requires enrollees to be working. These are the people that normally enroll, communicate benefits and how to use them and help in the claims process. Let's increase insure OKLAHOMA not destroy it.	
Insure Oklahoma covers a substantially smaller population than this waiver would. Why doesn't OHCA think they would need to staff up or develop new tech to implement?	
COMMUNICATION/OUTREACH	
At some point in today's call, I'd like to know who is in attendance at this virtual meeting, as it's something I could reasonably learn at an in-person meeting. Thanks.	This information will be posted on the 2.0 website.
If my questions are not answered in this session I would request the courtesy of replies sent to cindydvm@hotmail.com	All responses will be posted to the 2.0 website.
Is this webinar being recorded and will it be posted to the OHCA website so people can listen to it later, given the extremely late notice.	Notice of this meeting was posted on Monday, March 16. All Q&A will be posted to the 2.0 website for public review.
Will Governor Stitt ask AC Hunter to no longer be a state plaintiff against the ACA?	This is a question for the governor's office.
What is the best way to comment on this, for the public to use, during this comment period?	Please visit www.okhca.org/SoonerCare2

Can OHCA teach other state Medicaid agencies how to run public hearings like this and have strong, clear answers like the ones Traylor is providing? Please, and thank you. Great job on this, Team OHCA.	Yes, we are always happy to share our expertise with other states.
Will Q&A be sent out to participants vis email? Could recording also be sent to participants via email ?	Q&A will be posted to the SoonerCare 2.0 website.
So we'll get responses after you guys decide how you're going to spin it?	OHCA respectfully disagrees. The agency has worked dilligently to provide factual and concise answers to all the public's questions and comments.
When will the next virtual public hearing occur on Facebook? Do you plan to have in-person public hearings smaller cities such as Lawton, Oklahoma in the next 3 months?	Due to CDC recommendations on social distancing, we will not have any in person meetings, however we will increase the number of virtual publi hearings in order to give everyone a chance to participate.
There doesn't seem to be a Web Alert signup link on the SoonerCare 2.0 page. These work great usually.	This has been fixed. Please visit www.okhca.org/soonercare2 and sign up for web alerts.
Will a recording of this meeting be available so we can re-listen?	The meeting did not have an audio recording.
What is OKHCA doing to evaluate the adequacy of virtual meetings vs. in-person meetings for people with limited internet access?	OHCA feels like the virtual forum has a broader reach than in person meetings, especially for those in rural areas that may not have otherwsie been able to drive to Oklahoma City for a public hearing. If you know individuals who cannot participate virtually, please have them contact Traylor Rains at OHCA who be happy to speak with them personally.
I don't understand your response about not being able to provide a recording of this webinar due to file size. It's 2020 and Youtube is free. Is there another reason why you are electing not to post this webinar?	This meeting did not have a recording.
If we can't have in-person meetings due to a national healthcare emergency, then why are we not postponing this process so that people can be adequately informed and have the chance to comment/engage around this process?	OHCA will explore all options for virtual public meetings. However, other than being able to see the speaker, we are unsure how other virtual forums would allow for more public engagement. Typically OHCA requires individuals requesting to make comment to sign up 24 hours in advance and only allows 2 minutes for comment and for board and MAC meetings, limits commenting parties to 20. This forum allowed for over 300 individuals to be present, with over 200 comments submitted, with some individuals submitting over 30 comments. We are delighted to see this level of public engagement in this process and feel that the current virtual forum has been successful.
Please hold the hearing at another time because most of us in Oklahoma are pre-occupied with the coronavirus Disease 2019 (COVID-19) pandemic. In addition, consider that Gov. Stitt's proposal is inadequate when increasing access to Medicaid and the benefits of the Affordable Care Act.	Thank you for your suggestion. Please visit www.okhca.org/soonercare2 for a list of upcoming virtual public hearings. We hope you can attend!
CMS	
After the state's previous issues with CMS backing out of a verbal promise and Utah's experience with their legislative expansion post-state question, why does OHCA feel confident that CMS will be a faithful partner in this effort?	OHCA has noticed unprecedented levels of cooperation with our federal partners (CMS) during not only the HAO demonstration application processes, but also the state plan expansion.
MARKETPLACE	
Can you elaborate on how the state's marketplace is anticipated to operate? It sounds like a much more robust operation than the IO platform.	OHCA does not operate the federally facilitated markeplace.

EXPANSION/HAO WAIVER	
COMMENT/QUESTION	RESPONSE
Why is it that the Healthy Adult Opportunity Block Grant waiver, estimated by Leavitt Partners, $50 Million more expensive and delivers less services than straight Medicaid expansion for the working adult population?	Please clarify which Leavitt report are you referring to? Information about the covered benefits and enrollment estimates are available in the HAO application at https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=24572&libID=23555.
Why should we trust the Sooner Care2.0 to be an improvement after Oklahoma has so terribly taken care of the health of its working class citizens. Let's have a true Medicaid Expansion. Stop micromanaging people's lives. No work requirement.	HAO is full Medicaid expansion in the fact that all adults are eligible for SoonerCare if they make at or below 133% of the federal poverty level. The HAO demonstration employs a financing model geared at incentivizing OHCA and providers to improve the overall health of SoonerCare 2.0 members through care coordination, health promotion and increased use of primary care. Caps on spending advance the triple aim of improving patient experience of care, improving the health of the population and reducing the per capita cost of health care. Additionally, a large body of research has shown that employed individuals are healthier than those who are not employed. Enhancing employment opportunities for working-age people can improve health status and decrease the overall cost of providing health care. Employment can improve health by increasing social capital, enhancing psychological well-being, providing income, and reducing the negative health impacts of economic hardship. Incentivizing employment, pursuit of educational and vocational activities, and volunteerism promotes all of these objectives.
What will OHCA do with SoonerCare expansion if HAO is taken off the table by a future federal administration or ruled invalid in court?	OHCA is accustomed to navigating changes in laws governing the Medicaid system at both the state and federal level. If those changes occur OHCA will evaluate all options available to the state to best ensure health care coverage for the state's most vulnerable.

Why should Oklahoma try to pioneer anything when we have a very poor rating healthcare? Let us have Medicaid like most of the rest of the country.	Oklahoma has a state Medicaid program referred to as SoonerCare and administered by the Oklahoma Health Care Authority. Through SoonerCare 2.0, the state will implement an expansion of Medicaid coverage to adults who are not otherwise covered by Medicaid and have incomes at or below 133% of the FPL.
If state opts to block grant at end of year 2, would this just apply to the expansion population or does the application allow the state to include the entire Medicaid program?	The HAO demonstration only applies to the new adult expansion population, not traditional SoonerCare populations.
Why apply for the waiver now?	Gov. Stitt and the OHCA began plans for state plan expansion and HAO immediately after CMS announced the HAO opportunity in January. It is essential to cover as many lives as we can as quickly as possible, so we are holding true to our time frames in order to enroll expansion population adults beginning July 1, 2020.
If the state fears that the federal government will pull funding for Medicaid Expansion (which has never happened) then why accept a block grant that we know can be tenuous?	OHCA is working shoulder-to-shoulder with our federal partners at CMS to implement the HAO opportunity. OHCA does not fear the federal government pulling funding for Medicaid expansion.

Funding the SoonerCare 2.0 implementation continues to be a priority for the state legislature and governor.	Oklahoma will continue to draw a 90% match from the federal government after implementation of the HAO demonstration. OHCA has always worked under a capped system of state funding since Oklahoma executive agencies are subject to a balanced budget requirement and must administer the SoonerCare program within the amount appropriated to OHCA from the Oklahoma Legislature.
What are the prospects for the legislative funding needed to support the waiver version of expansion?	Funding the SoonerCare 2.0 implementation continues to be a priority for the Oklahoma Legislature and governor.
What happens if CMS does not approve the 1115 Waiver?	OHCA has noticed unprecedented levels of cooperation with our federal partners (CMS) during, not only the HAO demonstration application processes, but also the state plan expansion.
Have you filed the IMD Waiver yet and if not what is the proposed timing for the filing of that waiver?	OHCA and ODMHSAS plan to submit the IMD waiver in June with a planned effective date of Oct. 1, 2020.

What does the OHCA expect to accomplish due to the block grant in the waiver?	The HAO demonstration employs a financing model geared at incentivizing OHCA and providers to improve the overall health of SoonerCare 2.0 members through care coordination, health promotion and increased use of primary care. Caps on spending advance the triple aim of improving patient experience of care, improving the health of the population and reducing the per capita cost of health care. OHCA will be able to share in the savings achieved through these measures with CMS up to 50/50. These dollars can in turn be used to re-invest into Oklahoma's health care system and economy.
Can you clarify what elements make the HAO waiver unique? Work requirements and premiums are not new concepts. What is the state testing with the block grant?	Please review the HAO waiver Evaluation section beginning at page 56 of the waiver application. www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=24572&libID=23555
STATE QUESTION	
Why is the governor determined to push through his plan rather than allowing the people of the state to express their wishes a over 300,000 people expresed on the Medicaid Expansion petition in October?	The governor sets the date for state question elections. You may reach out to the governor’s office if you have questions about the timing of the state question vote.
If expansion is put on a ballot and it passes how would that change what is currently being pursued?	State Question 802 would tie the eligibility for able-bodied adults to those of pregnant women and children. In times of economic downturns when hard decisions must be made, the state would be forced to reduce benefits for ALL populations instead of being able to prioritize the health care needs of children, aged, blind, disabled and pregnant women. If 802 passes, the state would explore managed care opportunities for the expansion population outside of an HAO environment.
ELIGIBILITY/COVERAGE/APPLICATION	

Is it correct that all SC 2.0 applications for the new-adult group (VIII) will have coverage-start dates delayed by 2 to 6 weeks? With an average delay of 4 weeks, there are certainly savings by covering members one fewer month in their first year. But, with many Medicaid applications coming at a time of urgent need, how much will this new delay in coverage affect outcomes? Does the HAO evaluation look for "avoidable ER visits" during the new waiting period delay (when under historic SoonerCare, the member may have gone to a primary care provider).	OHCA is exploring system modifications that would allow coverage to begin more quickly after application and payment of premiums.
"Otherwise covered" would this exclude those who currently are covered as a caregiver of a dependent child who is elligibale for SoonerCare? Would this mean they will still qualify for SoonerCare under the traditional means and not the SoonerCare 2.0	Populations currently covered through Title XIX SoonerCare would maintain their current coverage under the state plan and would not transition to the HAO demonstration. Parent/Caretaker relatives of children on SoonerCare with incomes at or below approximately 46% FPL would maintain Title XIX benefits.
Do you plan to use the same formulary for full Medicaid?	Currently the state plans to use the formulary and pharmacy benefit design used under Title XIX State Plan. In demonstration applications, however, the state reserves the right with CMS to be flexible without submitting an additional waiver amendment. If changes to benefit design are considered after HAO implementation, OHCA will engage the public through an open process.

Will this affect people that are currently covered by an ACA plan but are under the 133% FPL but over the 100%? And if so how will this work for them?	Members under 133% FPL will be eligible for HAO coverage.
Many Oklahomans have internet access only on their phone screens, especially those in rural areas at low income. However, the SoonerCare application is not formatted to be readable or do-able on a phone screen……same with the premium payment website. Why make it so difficult for the people that SC 2.0 is meant to help to actually apply?	OHCA understands the importance of making it easy for individuals to access SoonerCare coverage and was a trailblazer in creating an eligibility application capable of making real-time coverage determinations. MySoonerCare.org is accessible through smartphone browsers. Further, OHCA continues to explore enhancements to improve our members' experience and are also engaging more community partners to help potential members who need assistance with enrollment.
FOR AGENCY PARTNERS, WILL WE UTILIZE AGENCY VIEW FOR THESE NEW APPLICATIONS?	Yes.

Under the ACA, insurance plans may not charge copayments and deductibles against preventive care, yet a managed care plan could if a SoonerCare 2.0 member accesses preventive care outside the managed care network, which they may have to do in rural parts to the state where managed care plans have had difficulty building a network. This was the experience in 2004 and 2005 when the state decided to end Medicaid managed care. How will the state avoid this outcome in the future?	OHCA plans to utilize a PCCM managed care option administered directly by OHCA. This will build upon our current SoonerCare Choice (Patient Centered Medical Home) model. Primary care will continue to be available in HAO with no co-pays.
Premium payments can currently be made only by bank account or debit/credit card. But since premiums are required from folks living at just one-half of poverty level, so are likely "un-banked" more options may be needed. It is good that third-parties can make premium payments for members, so someone in poverty does not have to spend $5 on debit card fees to make a $7.50 premium payment.	Thank you.
Would you review the retrospective or presumptive eligibility provisions applicable to the waiver application proposal?	The HAO does not have presumptive eligibility. Presumptive eligibility is a process of finding an individual preliminarily eligible for Medicaid based on limited information. If the individual is later found to not be eligible, Medicaid is still responsible for paying for the individual's care. Oklahoma currently allows for hospital presumptive eligibility, but to date no individuals have utilized this. OHCA will continue to explore options around coverage begin dates.

There has been mention of hospital "alternative" presumptive coverage.....will all this go away when the 2-to-6 week delay starts with HAO?	HAO will not include hospital presumptive eligibility.
Could you describe the difference between presumptive and retroactive eligibility?	Presumptive eligibility is a process of finding an individual preliminarily eligible for Medicaid based on limited information. If the individual is later found to not be eligible, Medicaid is still responsible for paying for the individual's care provided when the individual was presumptively eligible. Oklahoma currently allows for hospital presumptive eligibility, but to date no individuals have utilized this. OHCA will continue to explore options around coverage begin dates. Retroactive eligibility is a process in which OHCA looks back over a 3-month period and determines if at any point during that time that the individual met Medicaid eligibility requirements .If they did, OHCA would find them "retroactively eligible" and reimburse for SoonerCare covered services rendered to that individual.
How will NODOS work in the expansion population if premiums are required for coverage?	Oklahoma will continue to use the notification of date of service (NODOS) process that allows a hospital to submit basic identifying information to OHCA to save the date for eligibility when an individual admits to the hospital. If the individual is later found to be eligible for SoonerCare, OHCA reimburses the hospital for individual's hospital stay. We are exploring how this process will fit within a premium-based eligibility system.
With new delay in coverage....apply on July 16, 2020 and start coverage same day. Under HAO, apply on July 16, 2020 and coverage starts Sept 1? Right?	Yes, current system configuration requires that an applicant's coverage start date would depend on when the applicant applies and pays their initial premium. If the applicant applies on or before the 15th of the month and pays their premium, coverage would begin the 1st of the following month. If done after the 15th of the month, coverage would begin the first of the month thereafter. For example, if I apply August 17, my coverage would begin October 1. However, OHCA is exploring what system modifications would be required in order to prevent delays or disruptions in coverage.

Presumptive eligibility plays an important role in emergencies, including 9/11 and Hurricane Katerina. Can you explain what is gained by removing the option of presumptive eligibility and putting uninsured people at risk?	Presumptive eligibility is a process of finding an individual preliminarily eligible for Medicaid based on limited information. If the individual is later found to not be eligible, Medicaid is still responsible for paying for the individual's care. Oklahoma currently allows for hospital presumptive eligibility, but to date no individuals have utilized this. OHCA will continue to explore options around coverage begin dates. During periods of national health emergencies, state Medicaid programs are granted flexibilities in order to quickly respond to the emergency. Nothing in HAO prevents OHCA from requesting flexibilities in the future in order to respond to a national or state emergency.
What protections is OHCA building in for people with disabilities who didn't qualify for Medicaid on the basis of that disability?	We would encourage individuals with disabilities to apply through the Social Security Administration for a disability determination. Individuals in HAO with a disability who are not covered through Title XIX Medicaid, are exempt from Community Engagement requirements.
WORK REQUIREMENTS	
Has OHCA developed estimates of what it will cost to implement the work requirement and premiums?	These figures are not readily available, but OHCA will utilize current staff and processes to track reporting and leverage technology to improve efficiencies.
FINANCIALS (CO-PAYS, PREMIUMS, SAVINGS, COSTS)	
When will co-pay amounts be announced? Will they be on 3 tiers also? Knowing co-pays will help evaluation of the practicality of SC 2.0.	Premiums are tiered based on the family's income with the understanding that those with lower incomes should have lower premiums. Co-pays will be the same as they are for non-exempt populations in Title XIX Medicaid. Most encounter based co-payments are $4 per visit. Behavioral health visits are $3 per visit. Inpatient stays are $10 per day with a max of $75.

Are there copays associated with your plans? if so what are they? and are they different between plans?	Premiums are tiered based on the family's income with the understanding that those with lower incomes should have lower premiums. Premiums can be found on page 9 of the HAO application. Co-pays are explained above. https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=24572&libID=23555
Have other states implemented premiums when expanding Medicaid? Can you clarify the rationale behind implementing premiums on low-income Oklahomans?	Through various 1115 waiver authorities, Vermont has a Medicaid program with a fixed federal dollar limit. Premiums are tiered based on the family's income with the understanding that those with lower incomes should have lower premiums. Premiums can be found on page 9 of the HAO application.
Is the state proposing a per member cap on expenditures? If so, how is this calculated?	See page 50 of the HAO demonstration application. https://www.okhca.org/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=24572&libID=23555
Do you realize how high the Oklahoma marketplace plan premiums are for the population from insure ok thAG7:AL8at you are considering moving to the marketplace. Affordability standard for declining health insurance through the individual or spouse employer is based on employee cost only -- not spouse or family. That prevents a premium tax credit being available.	Thank you for your comment. OHCA is exploring the feasibility in keeping the IO ESI program for individuals above 133% and below 200% FPL.

Individuals at or below 133% FPL will be eligible for SoonerCare+AG8 2.0, including the HAO demonstration.	Individuals at or below 133% FPL will be eligible for SoonerCare 2.0, including the HAO demonstration.
WILL THE INDIVIDUAL DECLARE THEIR INCOME OR WILL INCOME VERIFICATION BE NEEDED AT APPLICATION?	The process will continue to be a self-declared income at the time of application, which will be verified through data matches between OHCA and other entities such as the Oklahoma Tax Commission, IRS, and Oklahoma Employment and Securities Commission.
When OHCA is able to administer at 5 % or less overhead with Oklahoma employees why does the governor want to pay a New York or Connecticut company 15 to 20 % overhead and send the money out of state?	The governor has asked OHCA to move forward with a managed care model that is administered and managed-in house at OHCA. We are not pursuing a third party managed care model at this time.
Can you describe which organizations OHCA thinks might pay premiums on behalf of enrollees?	Anyone who does not have a vested interest in the coverage such as health care providers.

Can we get clarification on the nonemergent copay charges vs. inability to pay?	OHCA is utilizing flexibilities through the HAO demonstration to charge an $8 co-pay for non-emergent use of the ER. The copay will be required at the time of service, but an ER can't deny a service based on an individual's assertion that they are unable to pay.
BENEFITS, SERVICES	
Since "service cannot be denied if co-payment cannot be made"---will HealthCare Authority require a sign saying this at provider sites....or print it on the member ID card so services are not denied?	No. All SoonerCare contracted providers are fully aware of their contractual requirement that prevents them from denying a service based on an individual's inability to pay.
What if they need more than 6 prescritions a month?	The pharmacy benefit in HAO will mirror that of Title XIX, which currently has a prescription limit of six per month for adults. There are current means by which OHCA assists individuals with obtaining prescriptions at little to no cost outside of Medicaid, such as the prescription drug card, nominal co-pay plans at pharmacies, etc.
What protections are you putting in place to support our hospitals -- specifically rural hospitals?	Rural hospitals will benefit through a decrease in uncompensated care due to a significant decrease in the state's uninsured rate.

FOR OUR ADULT TITLE 19 INDIVIDUALS THERE IS A LIFE-TIME INPATIENT FOR MENTAL HEALTH, IS THERE A CAP FOR 2.0	The behavioral health benefit will be the same as is offered under current Title XIX authorities with the exception of adding integrated behavioral health into primary care settings through HAO.
Can you discuss any drug coverage?	There are currently no plans to restrict the pharmacy formulary in HAO. The pharmacy benefit in HAO will mirror that of Title XIX.
The word "flexibility" is used a lot to describe new restrictions, delays, downgrades....please list 10 new HAO "flexibilities" that increase services.	OHCA is not adding services for an adult population that are not available for our more vulnerable populations (i.e. children, pregnant women, aged, blind and disabled) under Title XIX SoonerCare. What we will do, however, is reinvest savings achieved through value-based payment methodologies and improvement in coordinated care into services not traditionally covered by Medicaid for this population.
Given that both are eliminated under the HAO waiver, has OKHCA anaylzed the impact on community mental health centers?	Community Mental Health Centers should expect to see an influx of Medicaid dollars into their programs, being that a majority of their current indigent adult population will meet eligibility requirements for SoonerCare 2.0.

How many IO participants will not be eligible for Soonercare 2.0, and what is the plan for "phasing out" -- will they have coverage?	ESI members under 133% FPL will be eligible for HAO coverage. Those over 133% FPL (9,000 individuals) will be eligible for coverage on the federal marketplace. OHCA continues to explore options for maintaining ESI coverage for these individuals.
COMMUNICATION/OUTREACH	
Are these meetings beeing closed captioned to allow for Deaf Oklahomans to participate?	Yes, and information from the meeting will be posted on the 2.0 website.
Thank you for explaining the timeline. What is the rationale for holding the public comment period right now? Will you consider extending the public comment period?	The HAO application and public notice was posted on Monday, March 16. This began the 30-day comment period. The OHCA plans to submit the waiver application to CMS by April 20. Gov. Stitt and the OHCA began plans for state plan expansion and HAO immediately after CMS announced the HAO opportunity in January. It is essential to cover as many lives as we can as quickly as possible, so we are holding true to our time frames in order to enroll expansion population adults beginning July 1, 2020.
This process has greatly limited the ablility of the public at large to participate in this process, especially those with diasablities and low income individuls without internet access.	OHCA feels the virtual forum has a broader reach than in-person meetings, especially for those in rural areas who may not have otherwise been able to drive to Oklahoma City for a public hearing. If you know individuals who cannot participate virtually, please have them contact Traylor.Rains@okhca.org who be happy to speak with them personally.

Will all the questions that you answered be posted in addition to ones you didn't get to?	Yes. Q&As will be posted to the SoonerCare 2.0 website.

EXPANSION/HAO WAIVER	
COMMENT/QUESTION	RESPONSE
The HAO financing plan seems too risky for a state which has unexpected downturns in its economy (beyond COVID-19), which lead to a surge of new SoonerCare members. The OHCA spokesperson has said that when the pre-set dollar amount in the HAO grant is used-up early, then the state pays 100% of SoonerCare costs, likely from the Rainy Day Fund. Under HAO, if $10million more is needed, the state pays the full $10million; but if Standard Expansion is continued, then the state pays only $1million (the 10% share). It seems the HAO “flexibility” to charge a $5 premium puts millions of dollars at risk, draining the Rainy Day Fund. If HAO financing proves more costly, can the state return to standard Expansion matching funds quickly, or must the state stay with HAO limited funding for the full 5 years of the demonstration?	The per capita spending cap will be trended forward based on factors including medical inflation and increases in program enrollment. Excluded from the HAO cap would be expenditures for public health emergencies, such as COVID-19 so that OHCA can respond quickly to emergency needs of the state's SoonerCare population.
The word "flexibility" is used a lot to describe new restrictions, fees, delays, downgrades. Please list 10 new HAO "flexibilities" that increase services and remove barriers to coverage (beyond the Standard Expansion).	OHCA is not adding services for an adult population that are not available for our more vulnerable populations (i.e. children, pregnant women, aged, blind and disabled) under Title XIX SoonerCare. What we will do, however, is reinvest savings achieved through value-based payment methodologies and improvement in coordinated care into services not traditionally covered by Medicaid for this population.
How many new state employees will need to be hired and what will the total cost be for “in-house managed care“?	The current anticipated additional employees that would be needed are staff within the Population Care Management team that would provide the in-house managed care component of HAO rather than contract with a third-party managed care organization. At this time, OHCA is planning for an additional 100 employees (mostly nurses, behavioral health professionals, case managers, etc.).

Please clarify the coverage of incarcerated persons. The HAO application document notes that "Individuals who are incarcerated and receiving inpatient hospital services will also be exempt from premiums." What coverages will incarcerated persons have under SC 2.0? Full coverage or just inpatient hospital coverage? How will they enroll while incarcerated? Will there be an up-to-6-week waiting period for coverage, during which the state pays 100% of these medical costs, rather than 10% cost-share? Individuals leaving incarceration are another example how the unnecessary waiting period of up to 6 weeks harms health and personal outcomes. It's cost-effective to have immediate access to medications and care during a time of transition back to family and a job search. What are plans for close coordination between Dept of Corrections and OHCA to ensure timely enrollment of individuals who are incarcerated?	Incarcerated individuals will be covered as they are under SoonerCare today. When an inmate leaves the DOC facility and is admitted into a hospital for an inpatient service, OHCA "turns on" their eligibility so the hospital service is covered by SoonerCare if the individual is eligible for SoonerCare. OHCA will follow this same process post-expansion.
So much of HAO seems to be about inducing behavior changes---where are the positive reinforcements? How about after two on-time refill pickups, the next refill has no co-pay? Or after completing an on-time A1c diabetes re-check, the next provider visit has no copay?	Thank you for your suggestion.
Does the application indicate how block grant funding would work? Is it per capita based on enrollment at that time or can it be adjusted by enrollment at end of OHCA calendar year?	OHCA is requesting a per capita cap through the HAO demonstration (see page 50 of the application found at www.okhca.org/soonercare2). The HAO demonstration employs a financing model geared at incentivizing OHCA and providers to improve the overall health of SoonerCare 2.0 members through care coordination, health promotion and increased use of primary care. Caps on spending advance the triple aim of improving patient experience of care, improving the health of the population and reducing the per capita cost of health care. OHCA will be able to share in the savings associated achieved through these measures with CMS up to 50/50. These dollars can in turn be used to re-invest into Oklahoma's health care system and economy. The governor has implemented measures across the state, including investing in the state's Rainy Day fund at unprecedented levels in order to prepare for state economic downturns.

Are you modeling your program on any other state's program? What is the average caseload you are projecting for each new state employee case worker?	For our delivery system, we are building upon our current Patient-Centered Medical Home system by adding more staff to accommodate the needs of the new population. On average, current nurse care managers at OHCA maintain an average caseload of 125 members.
ELIGIBILITY/COVERAGE/APPLICATION	
Has OKHCA examined the impact of the elimination of retroactive eligibility on community mental health centers?	Community Mental Health Centers should expect to see an influx of Medicaid dollars into their programs, being that a majority of their current indigent adult population will meet eligibility requirements for SoonerCare 2.0.
Is it true that even members in 2.0 who do not have a premium are also subject to delays in coverage start date? Is this example correct?--Someone at 25% FPL completes application and enrolls on July 1, 2021...the enrollment is complete at $0 premium....but actual coverage starts Aug 1? This is different than current practice of enrollment and coverage start on the same day--no delay.	After receiving comments during the public hearing process, OHCA has been able to identify changes to our claims payment system that would allow for real-time access to covered service once the applicant is determined eligible and pays their premium. There will not be a delay in coverage based on which day of the month the member applies and pays the premium.
The delay in coverage for up to 6 weeks will be a sad surprise to many. Oklahomans traditionally come to SoonerCare in time of acute need, and will now endure an unnecessary delay. The HAO rules do not require a waiting period---correct? While a delay in coverage seems to initially save Medicaid money, it's not cost-effective to treat disease later, rather than sooner. This won't be captured in OHCA evaluations, because it looks at only the time someone is on SoonerCare, not what happens during the waiting period. Many "avoidable ER visits" will happen during the waiting period because a patient could not refill an inhaler, or their condition severely worsens 5 weeks into a 6-week waiting period. It may be rural hospitals who are most impacted by uncompensated "avoidable ER visits" during the new "waiting period". How will OHCA evaluate the cost-efficacy of the "waiting period"?	After receiving comments during the public hearing process, OHCA has been able to identify changes to our claims payment system that would allow for real-time access to covered service once the applicant is determined eligible and pays their premium. There will not be a delay in coverage based on which day of the month the member applies and pays the premium.

In the event of natural disaster or emergencies, the "waiting period" of up to 6 weeks will be a roadblock to serving Oklahomans in need. Language should be added to give authority to "pause" or "waive" the waiting period. This would be similar to existing language allowing a "pause" in premium and community engagement policies for emergencies (see Sec 1.5 and 2.7). Or, is there some reason in HAO that "waiting periods" cannot be "paused" in emergencies?	After receiving comments during the public hearing process, OHCA has been able to identify changes to our claims payment system that would allow for real-time access to covered services once the applicant is determined eligible and pays their premium. There will not be a delay in coverage based on which day of the month the member applies and pays the premium.
Even after Expansion, many single parents still will not receive SoonerCare, although they qualify based on income. The current SoonerCare application requires a single parent to disclose the name and contact info for the other parent of the child (or else the applying parent is locked-out of coverage). Given the high rate of domestic violence in Oklahoma, is there flexibility in HAO to modify this outdated rule? This may also affect grandparents-raising-grandchildren, when the grandparents are low income and should be eligible for adult SoonerCare. With the goal of healthy families, how can this system be improved? The current SoonerCare application requires an on-paper "Good Cause" form, which creates complexity and delay for Oklahoma single parents. An improvement may be from the Marketplace application. For sensitive topics, the application presents check-boxes for a few choices of the most common situations, for later follow-up if needed. This allows the consumer to begin coverage.	Federal law still requires cooperation with the state child welfare enforcement division when applying for SoonerCare and the minor child is also covered on SoonerCare. Thank you for your feedback regarding improved application processes around this topic. We will explore what options may be available to us.
What about Tefra? Will this effect that population?	No, TEFRA will not go away or be affected.
When speaking of exceptions, will parents caring for dependaant children recieve exemption as well? Will the parent qualify for services?	The parent will qualify for SoonerCare if their household income is at or below 133% of the FPL. With regard to Community Engagement requirements, included in exempted populations are parent or caretaker responsible for the care of a dependent child under the age of 6 and a parent or caretaker personally responsible for the care of an incapacitated person (as attested to by a medical or mental health provider).

As OHCA is embracing "flexibility" and "innovative opportunities"--- If a member is receiving unemployment benefits, let's have an option to have premiums deducted from unemployment? Or an option to say "withdraw my premium from whatever account my unemployment benefits go to"? This would align with employer practices of paycheck deductions. On the OESC website for unemployment benefits, there should be strong cross-promotion for SoonerCare, such as "enroll now so you might wait less than 6 weeks for coverage to start". This is a good example of the administration's goal of inter-departmental coordination.	This is indeed an innovative idea. OHCA will explore this opportunity to collaborate with our sister agency.
Marshall Islanders are specifically excluded from Medicaid benefits and are classified as permanent non immigrants by USCIS; Oklahoma has one of the largest populations in the US. Will they be included in expansion and 2.0?	Mandatory and optional state plan groups within the Section 1115 demonstration wavier derive their eligibility through the Medicaid state plan and are subject to all applicable Medicaid laws and regulations in accordance with the Medicaid state plan, except as expressly waived in this demonstration and as described in the STCs. Marshall Islanders and individuals from the Republic of Palau and the Federated States of Micronesia are classified as permanent non-immigrants by USCIS.
Page 7 of application states – "Current SoonerCare (Project # 11-W-00048/6) members will transition to the state plan expansion by the end of 2020—before the anticipated effective date of this demonstration." What does that mean?	This is referring to the Insure Oklahoma program. OHCA intends to transition Insure Oklahoma Individual Plan members to the expansion state plan population on July 1, 2020, and also allow for the Employer Sponsored Insurance Plan population begin applying for state plan benefits at the same time. OHCA will then sunset both IO programs effective December 31, 2020.
EPSDT is excluded. Does that mean for 19 and 20 year olds?	EPSDT benefits are a requirement for individuals under the age of 21 who qualify for traditional Title XIX Medicaid. It is not a requirement of the adult expansion population through the HAO waiver demonstration.

Please clarify the waiving of presumptive hospital eligibility.	The HAO will not have presumptive eligibility. Presumptive eligibility is a process of finding an individual preliminarily eligible for Medicaid based on limited information. If the individual is later found to not be eligible, Medicaid is still responsible for paying for the individual's care. Oklahoma currently allows for hospital presumptive eligibility, but to date no individuals have utilized this. Oklahoma will continue to use the notification of date of service (NODOS) process that allows a hospital to submit basic identifying information to OHCA to save the date for eligibility when an individual admits to the hospital. If the individual is later found to be eligible for SoonerCare, OHCA reimburses the hospital for individual's hospital stay. We are exploring how this process will fit within a premium-based eligibility system.
WORK REQUIREMENTS	
What measures will the Health Care Authority be taking to clarify the programs requirements and reporting mechanisms to working oklahomans?	OHCA will work to create efficient data collection systems to make the report process as simple and efficient as possible. The agency will provide outreach on the different requirements and reporting mechanisms.
Who will oversee the work requirements/community engagement requirements? Will they be self reported?	OHCA will oversee this process and will work to create efficient data collection systems to make the report process as simple and efficient as possible.
Has the state seen any negative impacts from work requirements being applied to SNAP benefits that may carry over to CE requirements for Medicaid coverage? Any take-aways from this experience that may inform possible exemptions, etc.?	A large body of research has shown that employed individuals are healthier than those who are not employed. Enhancing employment opportunities for working-age people can improve health status and decrease the overall cost of providing health care. Employment can improve health by increasing social capital, enhancing psychological well-being, providing income, and reducing the negative health impacts of economic hardship. Incentivizing employment, pursuit of educational and vocational activities and volunteerism promotes all of these objectives.

About Community Engagement.....The situation of a single parent who can put in time when school is in session, but not when school is out....this is a common-enough situation...would it be a good idea to specifically list in in exclusions (and avoid excess paperwork on this common situation)?	Individual cases can be reviewed on a case-by-case basis for a "good-cause exception."
FINANCIALS (CO-PAYS, PREMIUMS, SAVINGS, COSTS)	
Under the FFM you are also not allowed to re-enroll in a plan if you cancel for non payment of premium?	Premiums will be collected through an OHCA process. Individuals who have not paid their premiums for three months will be unenrolled, but will be eligible to reapply the following month.
What are plans for the 100-133%FPL group who are currently on Marketplace? Do they lose their tax credits and move to SC 2.0?	These individuals will have the option to apply for and receive SoonerCare benefits as a secondary payor.
So right now if you do not file your taxes you can not enroll for the next year. Are you going to have special treament under the FFM?	Filing previous year's taxes is not a condition for any SoonerCare MAGI determination. Should we require proof of income or earnings, OHCA offers opportunities for tax non-filers. This could be a statement, or for self-employed could be profit/loss statement or projections for current tax year. If they are employed we'd check our data exchanges before requesting documentation if they didn't show up in the database.
If a consumer is under 133%FPL but employer offers coverage, can they be on SC 2.0?	Yes. SoonerCare would be the secondary payor.
Do you think that employers will drop group coverage and send everyone to the new plan which will leave some employees over the 133% without coverage?	OHCA cannot speculate to this.
Regarding late payment of premium, will providers be paid for service during the 90 day "grace" until the Member is unenrolled? Or will the claim be dependent on the status of the paid premium?	Yes, the member will retain coverage and providers will be reimbursed.

The HAO application notes that premiums may be adjusted upwards in the future. Even seemingly small premiums may subtract from health. Someone trying to live on just one-half of poverty level will pay a $5 monthly premium to SoonerCare. Is it useful to put a $5 premium in context with SNAP per-meal per-person benefits? At the SNAP $1.40 per-meal allotment, a $5 premium cost equates to 3.5 meals. What evaluation processes will OHCA have to determine if premiums, co-pays etc. are too high? (In an artificially funds-restricted HAO finance system, there will always be evidence that premiums are too low.)	If OHCA determines that premiums should be adjusted, we will go through a public process to make the change and engage our members and stakeholders in determining reasonable cost sharing requirements.
Enrollment and eligibility for SPA start July 1 2020 when would payments to providers begin?	July 1, 2020.
What will happen to adults in the HAO who do not pay their premiums? Will they lose coverage? Will the state have the ability to send overdue premiums to collections, place a lien on property, or garnish wages? According to healthinsurance.org, the state of Arkansas does not have these abilities through the Arkansas Works plan.	Premiums will be collected through an OHCA process. Individuals who have not paid their premiums for three months will be unenrolled, but will be eligible to reapply the following month. OHCA will not pursue collections of unpaid premiums and will not require that the unpaid premiums be paid in order to re-enroll in the program.
BENEFITS, SERVICES	
What about those individuals who have in excess of six prescriptions per month?	The pharmacy benefit in HAO will mirror that of Title XIX, which currently has a prescription limit of six per month for adults. Our current process is to refer an individual who needs additional prescriptions to our population care management division for assistance in identifying resources to assist with additional prescriptions.
INSURE OKLAHOMA	
Are you still planning to transition IO ESI population not moving into HAO to FFM.	OHCA plans to sunset both Insure Oklahoma plans effective December 31, 2020. All of the IP members will transition to the state plan expansion on July 1, 2020. ESI members under 133% FPL will have the option to enroll in the expansion July 1, 2020. Those above 133% FPL can apply for coverage through the federally facilitated marketplace.

With Insure OK adults moving to HAO, will anything change for the children who have Insure OK as part of CHIP?	Oklahoma does currently cover children through CHIP up to 185% of FPL and will continue to do so as long as CHIP is reauthorized. Nothing in the HAO demonstration plan applies to coverage of children.
So what happens to the fund for Insure Oklahoma that is in place now. Will the fund be divided? Including the ESI side?	It will be utilized to assist in funding Oklahoma's Medicaid expansion.
So would IO IP go away? What about ESI?	OHCA plans to sunset both Insure Oklahoma plans effective December 31, 2020. All of the IP members will transition to the state plan expansion on July 1, 2020. ESI members under 133% FPL will have the option to enroll in the expansion July 1, 2020. Those above 133% FPL can apply for coverage through the federally facilitated marketplace.
Are you going to leave the Insure Oklahoma Group side in place?	OHCA plans to sunset both Insure Oklahoma plans effective December 31, 2020. All of the IP members will transition to the state plan expansion on July 1, 2020. ESI members under 133% FPL will have the option to enroll in the expansion July 1, 2020. Those above 133% FPL can apply for coverage through the federally facilitated marketplace.
COMMUNICATION/OUTREACH	
The questions from these virtual meetings have not appeared on the official comments page. Should we re-post our questions on the comments page so they are recorded as part of an official record?	It is on the SoonerCare 2.0 page at http://www.okhca.org/soonercare2. All comments received through public hearings will be included in our official documents submitted to CMS.
For full transparency, how can you provide this information?	All information is available on the SoonerCare 2.0 page at http://www.okhca.org/soonercare2.
Will you be posting they questions and answers from the 3/20 public meetings?	Yes. They will be available on on the SoonerCare 2.0 page http://www.okhca.org/soonercare2.
Will audio of these virtual meetings be uploaded on OKHCAs website?	No.
CMS	
Do you Know if Oklahoma intends to file a 1135 waiver?	Yes, the agency has filed one, and it has been approved by CMS.
On the state plan amendment, when does OHCA anticipate approval?	The agency hopes to have the expansion in place and approved by July 1, 2020. The agency continues to work with CMS to get the SPA approved.

EXPANSION/HAO WAIVER	
COMMENT/QUESTION	RESPONSE
Oklahoma has the 2nd highest rate of uninsured in the nation. Why is the governor touting the fact that this plan will insure 5% less than traditional Medicaid expansion?	Gov. Stitt has made health care a priority since taking office. He has asked OHCA to implement full Medicaid expansion effective July 1, 2020, and to then take advantage of the flexibilities granted through the HAO demonstration waiver that has recently been made available to states. These flexibilities encourage personal responsibility through nominal premiums and co-pays and encourage work and volunteerism among members.
Can you explain block grants for this program?	The HAO demonstration employs a financing model geared at incentivizing OHCA and providers to improve the overall health of SoonerCare 2.0 members through care coordination, health promotion and increased use of primary care. OHCA is requesting a per capita cap through the HAO demonstration (see page 50 of the application found at www.okhca.org/soonercare2). The per capita spending cap will be trended forward based on factors including medical inflation as well as increases in program enrollment. Excluded from the HAO cap would be expenditures for public health emergencies, such as COVID-19, so OHCA can respond quickly to emergency needs of the state's SoonerCare population. Caps on spending advance the triple aim of improving patient experience of care, improving the health of the population and reducing the per capita cost of health care. OHCA will be able to share in the savings achieved through these measures with CMS up to 50/50. These dollars can in turn be used to re-invest into Oklahoma's health care system and economy.
Is the outside consultatnt report still due soon?	OHCA is utilizing Health Management Associates to assist with the development of the SoonerCare 2.0 application and implementation. Once implemented, OHCA will employ a consultant to do a program evaluation, as we currently do with other 1115 waivers.
ELIGIBILITY/COVERAGE/APPLICATION	

Can you explain the waiting period after a person signs up?	After receiving comments during the public hearing process, OHCA has been able to identify changes to our claims payment system that would allow for real-time access to covered services once the applicant is determined eligible and pays their premium. There will not be a delay in coverage based on which day of the month the member applies and pays the premium.
Are there any exemptions for the "waiting period"?	There is no waiting period. See response above.
How do you plan to increase Primary care in rural areas?	OHCA has evaluated the capacity of our current provider network and determined we have adequate primary care capacity to serve the expansion population. However, OHCA will continue to focus on recruitment for, not only primary care, but also specialty care, in both urban and rural areas.
FINANCIALS (CO-PAYS, PREMIUMS, SAVINGS, COSTS)	
While the premium requirements are an exhorbatant amount for people who qualify, it doesn't bring in enough money for the state to set up an infrastructure to manage and enforce this. Why in the world is the governor doing this?	Premiums are not intended to be a revenue source. Premium payments are critical to member engagement, as studies have shown that making regular monthly premiums may lead to better health outcomes for members. For example, in Indiana, where Medicaid eligible adults are required to pay monthly premiums, members making contributions had higher satisfaction rates, higher primary and preventative care utilization, higher prescribed drug adherence, and lower emergency room use than those who did not. (The Lewin Group, Indiana Healthy Indiana Plan 2.0 Interim Evaluation Report (2016)).
Are there estimates of the cost to OHCA of administering the premium and co-pay provisions? What share does the federal government pay of those costs?	OHCA is evaluating any and all costs associated with design and implementation of SoonerCare 2.0. We do not anticipate costs much over current spending levels for this element. OHCA administrative costs are matched by CMS at 50%. The cost of services provided to the new adult population is matched by CMS at 90%.

5200 moving from paying $32/month to lower premiums VS 133,000+ that are currently uninsured but will now have premiums + copays to be able to receive medical care. How is this better for them?	Currently, these individuals have no access to health coverage and pay 100% out of pocket for medical and behavioral health services at safety net providers such as FQHCs and CMHCs who often charge sliding scale fees on a per service basis. ER and hospital services are paid for 100% by the uninsured individual in cases of emergencies that require hospitalization and those providers pursue collection from the uninsured individual. Applying for coverage through SoonerCare is a personal choice. One that involves considerations such as the cost of nominal premiums ranging from $0-$15 per month versus paying out-of-pocket 100% for health care services.
What happens if it costs more than expected?	State leadership has taken several steps over the last few years to prepare for downturns in the economy, as well as additional, unexpected costs to the state's health care system. Steps taken include additional funding to the state's rainy day fund, as well as investing in the Medicaid rate stabilization fund. OHCA is requesting a per capita cap through the HAO demonstration (see page 50 of the application found at www.okhca.org/soonercare2). The per capita spending cap will be trended forward based on factors including medical inflation, as well as increases in program enrollment. Excluded from the HAO cap would be expenditures for public health emergencies, such as COVID-19, so OHCA can respond quickly to emergency needs of the state's SoonerCare population.
BENEFITS, SERVICES	
What about SoonerRide?	Non-emergency transportation services will not be available to the new adult population. OHCA may cover NEMT in limited cases based on an individualized assessment of need and in accordance with a care coordination plan.

Summary of New Adult Enrollment Projections
SoonerCare PCMH Amendment and Healthy Adult Opportunity (HAO) Proposal

Enrollment projections for both the PCMH Amendment and HAO Proposal were derived from the same "Average Quarterly Enrollment" projections. The "Without Waiver" and "With Waiver" enrollment projections for the PCMH Amendment are identical. The "Without Waiver" and "With Waiver" enrollment projections for the HAO Amendment are different due to the impact of the HAO's proposed policy initiatives that require Members to participate in Community Engagement and pay monthly premiums.

The table below presents the average quarterly enrollment estimates as well as the average annual enrollment for each of the two proposals, by Demonstration Year. As depicted in the table, the slight variances in projected enrollment are due to the differences in reporting periods (SoonerCare Demonstration Years align with Calendar Years and HAO Demonstration Years align with State Fiscal Years).

Quarter	Average Quarterly Enrollment	SoonerCare PCMH Amendment (Without and With waiver)			HAO Proposal (Without Waiver)		
		Calendar Year	Demonstration Year	Average Enrollment	State Fiscal Year	Demonstration Year	Average Enrollment
July-Sept '20	118,703	2020	DY25 (Second Half)	121,203			
Oct-Dec '20	123,703						
Jan-Mar '21	133,703	2021	DY26	140,291			
Apr-June '21	138,703						
July-Sept '21	141,879				2022	DY1	151,879
Oct-Dec '21	146,879						
Jan-Mar '22	156,879	2022	DY27	159,492			
Apr-June '22	161,879						
July-Sept '22	159,604				2023	DY2	159,604
Oct-Dec '22	159,604						
Jan-Mar '23	159,604	2023	DY28	159,604			
Apr-June '23	159,604						
July-Sept '23	159,604				2024	DY3	159,604
Oct-Dec '23	159,604						
Jan-Mar '24	159,604						
Apr-June '24	159,604						
July-Sept '24	159,604				2025	DY4	159,604
Oct-Dec '24	159,604						
Jan-Mar '25	159,604						
Apr-June '25	159,604						
July-Sept '25	159,604				2026	DY5	159,604
Oct-Dec '25	159,604						
Jan-Mar '26	159,604						
Apr-June '26	159,604						