OKLAHOMA
Health Care Authority

SoonerCare 1115(a) Research and Demonstration Waiver Amendment Request

Enrollment of the Expansion Adult Group and Former Foster Care Group under the SoonerCare Demonstration, Waiver of Retroactive Eligibility for the Expansion Adult Group and Implementation of SoonerSelect

Project Number: 11-W00048/6

DRAFT FOR PUBLIC COMMENT

Posted: January 4, 2021

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Section 1 Executive Summary

Demonstration Background

The Oklahoma Health Care Authority (OHCA) is the State's Single State Agency for Medicaid. The SoonerCare Demonstration has operated under Section 1115 waiver authority since 1996.

On August 31, 2018, the Centers for Medicare and Medicaid Services (CMS) approved the OHCA's request to extend Oklahoma's SoonerCare 1115(a) waiver. The State submitted a waiver request to update the Health Management Program's (HMP) description to match current practices on January 16, 2019. The State submitted a second waiver amendment on June 3, 2019 to update the standard terms and conditions related to the Health Access Networks (HAN) to remove outdated practices. The State received approval of both waiver requests on November 1, 2019. The current Demonstration is approved for the period from November 1, 2019 through December 31, 2023.

Summary of Amendment Request

The OHCA seeks modifications to the SoonerCare 1115 Demonstration's Special Terms and Conditions to authorize the following program changes:

- Enroll the Expansion Adult Group under the Demonstration
- Enroll the Former Foster Care Group under the Demonstration
- Enroll qualified individuals on a mandatory basis in SoonerSelect (the State's comprehensive managed care model).

The OHCA seeks an amendment with effective dates of July 1, 2021 through the end of the Demonstration on December 31, 2023.

Inclusion of the Expansion Adult Group under the SoonerCare Demonstration

Oklahoma's uninsured rate remains among the highest in the country. In 2019, the uninsured rate for adult Oklahomans was 14.3%, versus the national rate of 9.2%. Only Texas had a higher rate of uninsured (source: US Census Bureau).

On June 30, 2020, the Oklahoma Medicaid Expansion Initiative, State Question 802, was passed by a majority of Oklahoma voters to expand Medicaid eligibility to adults ages 19-64 whose income is at or below 138% of the Federal Poverty Level (FPL). The Medicaid expansion will go into effect on July 1, 2021.

On July 31, 2020, Oklahoma posted formal public notice for submission of three State Plan Amendments (SPAs) to CMS to expand SoonerCare to low-income adults up to 133% of the federal poverty limit, effective July 1, 2021.

The OHCA seeks to add the Expansion Adult Group under the Demonstration to authorize the following:

- *Waive Retroactive Eligibility* - The current SoonerCare Demonstration waives retroactive eligibility for most enrolled adults, with the exception of pregnant women and individuals enrolled in the Aged, Blind and Disabled (ABD) eligibility group. The OHCA seeks authority to waive of retroactive eligibility for the Expansion Adult Group, effective July 1, 2021.

- *Enroll Expansion Adults in SoonerSelect –* Oklahoma intends to enroll the Adult Expansion Group in SoonerSelect on a mandatory basis, with a targeted effective enrollment date of October 1, 2021.

Inclusion of the Former Foster Care Eligibility Group under the Demonstration

The Former Foster Care Group includes individuals Ages 19 to 26 who were enrolled in Medicaid prior to aging out of foster care. There is no income or asset test for this group. Estimated average monthly enrollment for the Former Foster Care Group in Calendar Year 2021 is equal to 542.

The State seeks authority to include the Former Foster Care Group under the Demonstration and enroll the group in SoonerSelect. Individuals in this group will have the option of enrolling with the SoonerSelect Specialty Children's Plan or a SoonerSelect Plan.

SoonerSelect Managed Care Model

The OHCA has made great strides in improving care coordination among SoonerCare Eligibles, especially those with chronic conditions through the work of its Chronic Care Unit and Health Management Program. However, Oklahoma continues to rank near the bottom on many indicators of health outcomes.

The OHCA seeks to further advance the goals of the Demonstration through implementation of SoonerSelect, a comprehensive Medicaid managed care model. The OHCA intends to contract with managed care organizations (MCOs) and prepaid ambulatory health plans (PAHPs), via a competitive procurement process, with demonstrated success in increasing access to quality care and improving health outcomes through care coordination, prioritization of preventive care and encouraging SoonerCare participants to seek care from the appropriate healthcare provider type.

The OHCA seeks approval to modify the 1115 Demonstration's Special Terms and Conditions for the current extension period that will be in effect through the end of the Demonstration (December 31, 2023). The OHCA intends to enroll qualified members into the following statewide, coordinated care models, with an effective enrollment date of October 1, 2021:

- SoonerSelect Plan
- SoonerSelect Dental Program
- SoonerSelect Specialty Children's Plan

All participating MCOs and PAHPs must demonstrate compliance with federal Medicaid managed care regulations found at 42 CFR § 438. The OHCA will assure compliance with federal and state statutes, regulations and policies through plan readiness reviews, ongoing monitoring and External Quality Review (EQR) activities.

The table on the following page summarizes the three coordinated care models.

Summary of SoonerSelect Coordinated Care Models

Model	SoonerCare Populations Served	Benefits	Contracted Entities
SoonerSelect Plan	Children, Deemed Newborns, Pregnant Women, Parent and Caretaker Relatives, and Expansion Adults	Physical health, behavioral health and pharmacy benefits	MCOs
SoonerSelect Specialty Children's Plan	Former Foster Care Children, Juvenile Justice Involved Youth, Children in Foster Care and Children Receiving Adoption Assistance and Children receiving prevention services from the Oklahoma Human Services Child Welfare Division	Physical health, behavioral health and pharmacy benefits	Single MCO
SoonerSelect Dental Plan	Populations listed above	Dental benefits	PAHPs

Additional information regarding the SoonerSelect program is detailed in the two Requests for Proposals issued by the OHCA. The RFPs and related information about the procurement is available for review at: https://okhca.org/about.aspx?id=74.

Section 2 Demonstration Amendment Goals and Description

Demonstration Amendment Goals

The OHCA seeks federal authority to enroll Expansion Adults in the Demonstration and implement a comprehensive Medicaid managed care approach. The proposed amendment will support the following goals:

- Reduce the number of uninsured Oklahomans;
- Improve health outcomes for Oklahomans;
- Transform payment and delivery system reform statewide by moving toward value-based payment and away from payment based on volume;
- Improve SoonerCare Eligibles' access to and satisfaction with necessary services;
- Contain costs through improved service coordination; and
- Increase cost predictability to the State.

Amendment Description

The OHCA seeks Demonstration authority to implement the following program changes:

- Enroll the Expansion Adult population under the Demonstration to waive retroactive eligibility and permit enrollment of the Expansion Adult Group in SoonerSelect
- Enroll the Former Foster Care Eligibility Group under the Demonstration to permit enrollment of the Former Foster Care Eligibility Group in SoonerSelect
- Enroll qualified Demonstration participants in SoonerSelect

These initiatives are described below.

Summary of Eligibility Expansion

On June 30, 2020, the Oklahoma Medicaid Expansion Initiative, State Question 802, passed by a majority vote to expand Medicaid eligibility to adults ages 19-64 whose income is at or below 138% FPL. In accordance with the ballot initiative, the effective date for the expansion is July 1, 2021.

On July 31, 2020, Oklahoma posted formal public notice for submission of three State Plan Amendments (SPAs) to CMS to expand SoonerCare to low-income adults up to 133% of the federal poverty limit. Notice included the OHCA's intent to modify the State Plan to:

- Add the New Adult Group ages 19 – 64 with incomes at or below 133% of FPL as per Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and 42 CFR 435.119 and consistent with the expanded eligibility criteria as defined in the Affordable Care Act.
- Establish an Alternative Benefit Plan (ABP) for individuals in the Expansion Adult Group.
- Establish Oklahoma's eligibility procedures for identification of the Expansion Adult Group for the purpose of securing Federal Medical Assistance Percentage (FMAP) rate for the Expansion Adult Group.

In alignment with the SPA, the Expansion Adult Group will include individuals who:

- Have attained age 19 but not age 65;
- Are not pregnant;
- Are not entitled to or enrolled for Part A or B Medicare benefits; and
- Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

The OHCA will use its existing MAGI-based financial eligibility methodologies in calculating household income. The amount of the income standard for this group is 133% FPL. The OHCA estimates average monthly enrollment of 175,623 for the Expansion Adult Group in State Fiscal Year 2022 (July 1, 2021 - June 30, 2022).

Transition: Insure Oklahoma to Expansion Adult Group

The current SoonerCare Demonstration provides authority for the State to operate Insure Oklahoma, which includes two distinct programs:

- Insure Oklahoma Individual Plan (IO IP) - Offers limited coverage for uninsured Oklahomans, Ages 19 to 64 with incomes up to 100% of the Federal Poverty Level (FPL). IO IP is administered by the OHCA and program participants access care through the IO-participating providers. Individuals pay a monthly premium based on income.
- Insure Oklahoma Employer-Sponsored Insurance (IO ESI) – Offers subsidies for coverage provided through qualifying employers on behalf of individuals and their families with incomes up to 200% of the FPL.

On July 31, 2020, the OHCA issued Public Notice regarding the State's Insure Oklahoma Phase-Out Plan and demonstration amendment request. The Phase-Out Plan describes the process by which individuals currently enrolled in Insure Oklahoma will be transitioned to the Expansion Adult Group. The amendment seeks approval of the following modifications to the SoonerCare Demonstration's STCs, effective July 1, 2021:

- Phase out the IO IP program; and
- Establish a new income band for the IO ESI program at 134% - 200% of the FPL, plus any applicable income disregards.

Changes to the Insure Oklahoma program coincide with the State's requested effective date for the Adult Expansion.

Proposed changes to Insure Oklahoma are further detailed in the Insure Oklahoma Phase-Out Plan as required by the SoonerCare Demonstration's STCs. The proposed modifications will ensure continuity of care by making the transition of eligible Insure Oklahoma members to the Expansion Adult Group as seamless and effortless as possible. The reforms also will improve access to high-quality, person-centered services that produce positive health outcomes for individuals who were previously under or uninsured.

Transition: SoonerPlan Members to Adult Expansion Group

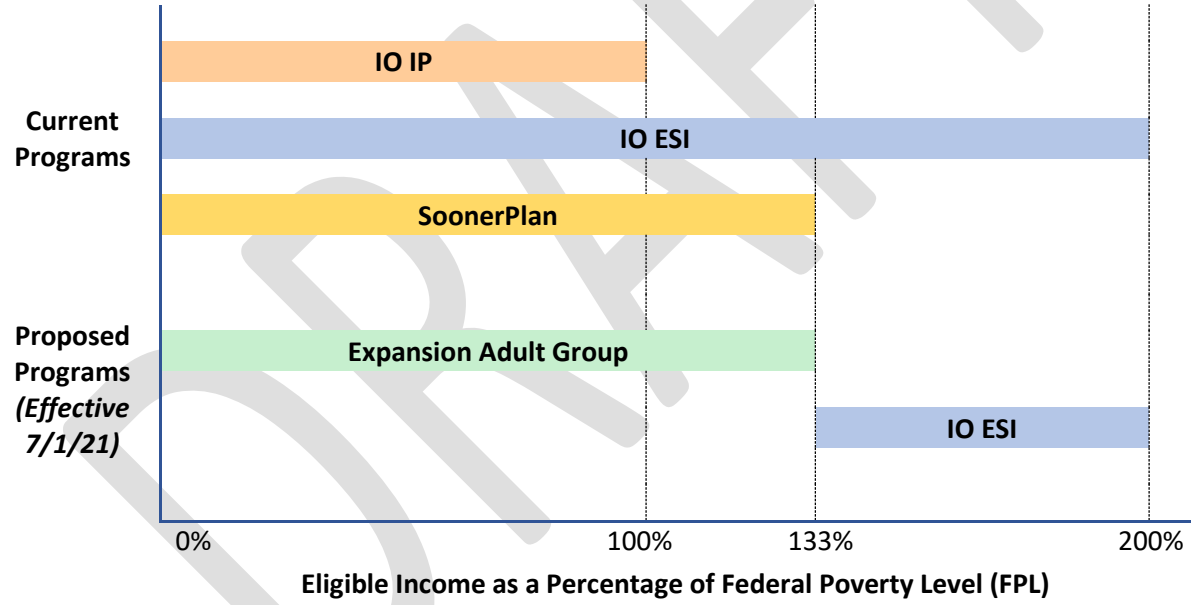
Oklahoma currently operates SoonerPlan, the State's Medicaid family planning program. SoonerPlan provides family planning benefits for non-pregnant women and men Ages 19 and above with incomes at or below 133% of the FPL. As of October of 2020, 41,037 individuals were enrolled in SoonerPlan.

Effective July 1, 2021, individuals with incomes at or below 133% of the FPL will be eligible for coverage under the Expansion Adult Group and will have access to a comprehensive array of health services, including family planning services.

The OHCA will transition current SoonerPlan members to the Adult Expansion Group. The OHCA will reprocess eligibility automatically for individuals enrolled in SoonerPlan as of June 2021 to enroll members in the Adult Expansion Group. Members will receive notification of the upcoming change to their eligibility and benefits in the spring of 2021. Members will receive follow-up case status notifications in June, 2021.

A summary of the proposed changes to eligibility is presented in the diagram below.

Summary of Program Eligibility as a Percentage of Federal Poverty Level, Current and Proposed



Waiver of Retroactive Eligibility for Expansion Adult Group

The SoonerCare Demonstration permits the State to waive retroactive eligibility for adults under the Demonstration, with the exception of pregnant women and individuals whose eligibility is based on Aged, Blind and Disabled criteria. Consistent with current program policy, the OHCA seeks to waive retroactive eligibility for the Expansion Adult Group.

Inclusion of the Former Foster Care Eligibility Group under the Demonstration

The Former Foster Care Group includes individuals Ages 19 to 26 who were enrolled in Medicaid prior to aging out of foster care. There is no income or asset test for this group. Estimated average monthly enrollment for the Former Foster Care Group in Calendar Year 2021 is equal to 542.

The State seeks authority to include the Former Foster Care Group under the Demonstration and enroll the group in SoonerSelect. Individuals in the group will have the opportunity to enroll with the SoonerSelect Specialty Children's Plan or a SoonerSelect Plan.

Summary of SoonerSelect Managed Care Model

The following coordinated care models currently operate under authority of the SoonerCare Demonstration:

- *Patient Centered Medical Home (PCMH):* A statewide enhanced Primary Care Case Management (PCCM) model in which OHCA contracts directly with primary care providers to serve as PCMHs. PCMH providers are arrayed into three levels, or tiers, depending on the number of standards they agree to meet. OHCA pays monthly care management fees (in addition to regular fee-for-service payments) that increase at the higher tiers. Providers can also earn "SoonerExcel" quality incentives for meeting or exceeding various quality-of-care targets within an area of clinical focus selected by OHCA.
- *Health Access Network (HAN):* Non-profit, administrative entities that work with affiliated providers to coordinate and improve the quality of care provided to Eligibles. The HANs employ care managers to provide telephonic and in-person care management and care coordination to members with complex health care needs who are enrolled with affiliated PCMH Providers. The HANs also work to establish new initiatives to address complex medical, social and behavioral health issues.
- *Health Management Program (HMP):* The SoonerCare HMP is an initiative developed to offer care management to members most at-risk for chronic disease and other adverse health events. The program is administered by OHCA and is managed by a vendor selected through a competitive procurement. The SoonerCare HMP serves members Ages four through 63 who are not enrolled with a HAN and have one or more chronic illnesses and are at high risk for adverse outcomes and increased health care expenditures. The program is holistic, rather than disease specific, but prominent conditions of Eligibles in the program include asthma, cardiovascular disease, chronic obstructive pulmonary disorder, diabetes, heart failure and hypertension.

The OHCA seeks to further advance the goals of the Demonstration through implementation of SoonerSelect, a comprehensive Medicaid managed care model. The OHCA intends to contract, via a competitive procurement process, with managed care organizations (MCOs) able to demonstrate capacity to increase access to quality care and improve health outcomes through care coordination, prioritization of preventive care and encouraging SoonerCare participants to seek care from the appropriate healthcare provider type.

The OHCA seeks approval to modify the 1115 Demonstration's STCs for the current extension period that will be in effect through the end of the Demonstration (December 31, 2023). The OHCA intends to enroll qualified members in the following statewide, coordinated care models, with an effective enrollment date of October 1, 2021:

- SoonerSelect Plan
- SoonerSelect Dental Program
- SoonerSelect Specialty Children's Plan

All participating MCOs and PAHPs must demonstrate compliance with federal Medicaid managed care regulations found at 42 CFR § 438. The OHCA will assure compliance with federal and state statutes,

regulations and policies through plan readiness reviews, ongoing monitoring and External Quality Review (EQR) activities. The OHCA's monitoring and reporting systems will comply with 42 CFR § 438.66.

A summary of SoonerSelect implementation milestones is provided in the table below.

Summary of SoonerSelect Implementation Milestones

Milestone	Date
Issue Requests for Proposals (RFPs) for SoonerSelect Managed Care Contractors	October 15, 2020
Issue RFP: External Quality Review Organization (EQRO)	December 1, 2020
Managed Care Contractor Proposals Due	December 15, 2020
Managed Care Contract Awards	February 1, 2021
EQRO Proposals Due	February 9, 2021
EQRO Contract Award (estimated)	February 26, 2021
Submit SoonerSelect Readiness Plan to CMS (including activities, timelines and deliverables)	February, 2021
Readiness Review Activities	March, 2021 to June, 2021
EQRO Start Date	April 1, 2021
Submit Final State and Managed Care Contractor Readiness Documentation	July 1, 2021
SoonerSelect Enrollment Effective Date	October 1, 2021

Beneficiary Impact

SoonerSelect Enrollment

The table below provides a summary of State Plan eligibility groups currently enrolled under the SoonerCare Demonstration that will be enrolled in SoonerSelect.

SoonerSelect Enrollment: State Plan Groups

State Plan Group	FPL and/or Other Qualifying Criteria	Demonstration Populations
Pregnant women and infants under age 1 1902(a)(10)(A)(i)(IV)	Up to and including 133 % FPL	1: TANF-Urban 2: TANF-Rural
Children 1-5 1902(a)(10)(A)(i)(VI)	Up to and including 133 % FPL	1: TANF-Urban 2: TANF-Rural
Children 6-18 1902(a)(10)(A)(i)(VII)	Up to and including 133% FPL	1: TANF-Urban 2: TANF-Rural
IV-E Foster Care or Adoption Assistance Children	Automatic Medicaid eligibility	1: TANF-Urban 2: TANF-Rural
Parents and Caretaker Relatives (1931 low income families)	Fixed monthly income limit, per approved State Plan	1: TANF-Urban 2: TANF-Rural
Pickle Amendment	Up to SSI limit	1: TANF-Urban 2: TANF-Rural
Early Widows/Widowers	Up to SSI limit	1: TANF-Urban 2: TANF-Rural
Targeted Low-Income Child	Up to and including 185% FPL	9: CHIP Medicaid Expansion Children
Infants under age 1 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	9: CHIP Medicaid Expansion Children
Children 1-5 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	9: CHIP Medicaid Expansion Children
Children 6-18 through CHIP Medicaid expansion	Above 133% - 185% FPL and for whom the state is claiming title XXI funding.	9: CHIP Medicaid Expansion Children
Non-IV-E foster care children under age 21 in State or Tribal custody	AFDC limits as of 7/16/1996	1: TANF-Urban 2: TANF-Rural

SoonerSelect Enrollment Estimates

The tables below provide a summary of estimated enrollment in SoonerSelect. The figures reflect average monthly enrollment between September 2019 and August 2020, with the exception of

Expansion Adults which reflects projected monthly enrollment. This data includes enrollment increases that were attributed to COVID-19, including requirements to maintain eligibility for otherwise ineligible individuals in accordance with Section 6008 of the Families First Coronavirus Response Act (FFCRA).

Estimated Enrollment: SoonerSelect Plan and SoonerSelect Dental Plan

Eligibility Group	Enrollment
Children (Medicaid and Children's Health Insurance Program [CHIP])	481,584
Deemed Newborns	1,959
Pregnant Women	21,015
Parent and Caretaker Relatives	62,199
Expansion Adults (projected – enrollment to begin 7/1/21)	175,623
TOTAL	**742,380**

Estimated Enrollment: SoonerSelect Specialty Children's Plan and SoonerSelect Dental Plan

Eligibility Group	Enrollment
Former Foster Children	706
Juvenile Justice Involved	558
Foster Care	9,407
Children Receiving Adoption Assistance	20,743
TOTAL	**31,414**

Enrollment: SoonerSelect Specialty Children's Plan

The following eligibility groups will be mandatorily enrolled in the SoonerSelect Specialty Children's Plan upon entering custody of the state:

- Foster Care Children (FC); and
- Certain children in the custody of OJA (JJ).

Former Foster Children, Children Receiving Adoption Assistance and children with an open prevention service case will have the option to enroll in the SoonerSelect Specialty Children's Plan. During the open enrollment period, these Eligibles (parents/guardians) may choose to enroll in the SoonerSelect Specialty Children's Plan or a SoonerSelect MCO. Eligibles who do not make a selection will be enrolled automatically with the Specialty Children's Plan.

Enrollment: American Indians and Alaska Native (AI/AN) Members

AI/AN Members who are determined eligible for a SoonerCare population will have the option to voluntarily enroll in the SoonerSelect program through an opt-in process.

Enrollment Assistance and Outreach

Qualified SoonerCare members will receive written notification regarding SoonerSelect and will be asked to choose a SoonerSelect Plan (or the Specialty Children's Plan for qualified individuals) and SoonerSelect Dental Plan.

The OHCA (or its designee) will be responsible for educating Eligibles about the SoonerSelect program and providing unbiased choice counseling with regard to enrollment options. The OHCA will provide notice to prospective Eligibles regarding the MCO selection process and the importance of making a selection in accordance with informational and timing requirements as specified in 42 C.F.R.§ 438.54.

The OHCA, at its discretion, may allow up to 60 days for Eligibles to select an MCO prior to the start of the SoonerSelect program. Subsequent to program start, SoonerCare Applicants eligible for the SoonerSelect program will have an opportunity to select an MCO on their applications. Eligibles who do not make an election within the allowed timeframe will be assigned to an MCO using an auto assignment algorithm that takes into account quality-weighted assignment factors.

Health Plan Disenrollment/Plan Changes

Health Plan Enrollees will be permitted to change MCOs, without showing cause, during their first 90 days of enrollment with the Contractor, or during the 90 days following the date the OHCA sends the Health Plan Enrollee notice of that enrollment, whichever is later. After the Health Plan Enrollee's period for Disenrollment from the Contractor has lapsed, Health Plan Enrollees will remain enrolled with the Contractor until the next annual Open Enrollment Period, unless:

- The Health Plan Enrollee is disenrolled due to loss of SoonerCare eligibility;
- The Health Plan Enrollee becomes a foster child under custody of the State;
- The Health Plan Enrollee becomes juvenile justice involved under the custody of the State;
- The Health Plan Enrollee is a Former Foster Child or Child Receiving Adoption Assistance and opts to enroll in the SoonerSelect Specialty Children's Plan;
- The Health Plan Enrollee demonstrates cause;
- A temporary loss of eligibility or enrollment has caused the Health Plan Enrollee to miss the annual Disenrollment period, then the Health Plan Enrollee may disenroll without cause upon reenrollment; or
- OHCA imposes Intermediate Sanctions on the Contractor and allows Health Plan Enrollees to disenroll without cause.

Program Benefits

The proposed amendment will preserve and enhance covered services for eligible individuals. All Medicaid-covered benefits as described in the State Plan will be provided by SoonerSelect MCOs and PAHPs. Benefits for Expansion Adults are based on the Alternative Benefit Plan. Covered benefits for the three SoonerSelect programs are described in detail in the SoonerSelect Plan and SoonerSelect Dental Program RFPs.

Contractors will also coordinate with providers of benefits outside of the SoonerSelect capitation to promote service integration and the delivery of holistic, person- and family-centered care.

Contractors may offer Value-Added Benefits and services in addition to the capitated benefit package to support the health, wellness and independence of Health Plan Enrollees and to advance the State's objectives for the SoonerSelect program. This may include, but is not limited to vision, DME, transportation, pharmacy and physician services for Health Plan Enrollees in excess of fee-for-service program limits. Value-Added Benefits and Services, if offered, shall not be included in determining the Contractor's Capitation Rates.

In accordance with 42 C.F.R. § 438.3(e), Contractors may provide services or settings that are in lieu of services or settings covered under the State Plan if:

- The Contractor has proposed any in lieu of services or settings in its response to the Solicitation and OHCA determines that the proposal is a medically appropriate and cost-effective substitute for the covered service or setting under the State Plan; and
- The Health Plan Enrollee is not required by the Contractor to use the alternative service or setting.

Examples of in lieu of services include, but are not limited to:

- Applied Behavior Analysis
- Multi Systemic Therapy

Payments for Indian Health Care Providers

All Contractor payments to Indian Health Care Providers (IHCPs) shall be made in accordance with 42 C.F.R. § 438.14. The OHCA will reimburse for services that are eligible for 100% federal reimbursement and are provided by an IHS or 638 tribal facility to AI/AN Health Plan Enrollees who are eligible to receive services through an IHS or 638 tribal facility. Encounters for SoonerCare services billed by IHS or 638 tribal facilities and eligible for 100% federal reimbursement will not be accepted by the OHCA or considered in capitation rate development.

The Contractor shall make payment to the IHCPs for covered services not eligible for 100% federal reimbursement and provided to Health Plan Enrollees who are eligible to receive services through the IHCP, regardless of whether the IHCP is a participating provider within the health plan's network, at the applicable encounter rate published annually in the Federal Register by the Indian Health Service (IHS). In the absence of a published encounter rate, the Contractor shall pay, at minimum, the amount the IHCP would receive if the services were provided under the State Plan fee-for-service methodology.

In accordance with CMS State Health Official Letter #16-002, IHS/Tribal facilities may enter into care coordination agreements with non-IHS/Tribal Providers to furnish certain services for AI/AN Eligibles and Health Plan Enrollees and such services are eligible for 100% federal funding. Contractors shall provide reporting in the timeframe and format required by OHCA to facilitate the State's collection of 100% federal funding for these services. Contractors shall also facilitate the development of care coordination agreements between IHCP and other non-IHS/Tribal Providers as necessary to support the provision of services for AI/AN Health Plan Enrollees.

The SoonerSelect Plan and SoonerSelect Dental Plan RFPs include additional detail regarding payment to IHCPs.

Cost Sharing

Health Plans and their network providers (Participating Providers) may charge Health Plan Enrollees only the amounts allowed by the OHCA. The Participating Provider shall accept payment made by the Contractor as payment in full for covered services, and the Participating Provider shall not solicit or accept any surety or guarantee of payment from the Health Plan Enrollee, OHCA or the State.

Any Cost Sharing imposed by the Contractors shall be in accordance with Medicaid FFS requirements as outlined in OHCA State Plan and 42 C.F.R. §§ 447.50 through 447.56.

Contractors shall not impose premiums on any Health Plan Enrollees. In accordance with 42 C.F.R. § 447.56, the Contractor shall not impose Cost Sharing upon any of the following:

- Health Plan Enrollees under age 21;
- Children for whom child welfare services are made available under Part B of title IV of the Act on the basis of being a child in Foster Care and individuals receiving benefits under Part E of that title, without regard to age;
- Pregnant Women for Pregnancy-Related Services during the pregnancy and through the 60-day postpartum period;
- Any Health Plan Enrollee whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs;
- Health Plan Enrollees receiving hospice care, as defined in section 1905(o) of the Act;
- An AI/AN Health Plan Enrollee who is eligible to receive or has received an item or service furnished by an IHCP or through referral under purchase and referred care is exempt from premiums. AI/AN Health Plan Enrollees who are currently receiving or have ever received an item or service furnished by an IHCP or through referral under purchase and referred care are exempt from all Cost Sharing; and
- Health Plan Enrollees receiving Medicaid due to a diagnosis of breast or cervical cancer in accordance with 42 C.F.R. § 435.213.

In accordance with 42 C.F.R. § 447.56, Contractors shall implement processes to ensure Cost Sharing is not imposed on any of the following services:

- Emergency Services;
- Family Planning Services and Supplies;
- Preventive Services, which includes, at minimum the services specified at 42 C.F.R. § 457.520 provided to children under 18 years of age regardless of family income, which reflect the well-baby and well child care and immunizations in the Bright Futures guidelines issued by the American Academy of Pediatrics;
- Pregnancy-Related Services; and
- Provider-Preventable Services.

In accordance with 42 C.F.R. § 447.56(f), a Health Plan Enrollee's total Cost Sharing shall not exceed five percent of the Health Plan Enrollee's household income applied on a monthly basis. The Contractor shall report Health Plan Enrollee Cost Sharing to the MMIS according to a process defined by OHCA. The MMIS will aggregate the Contractor's Cost Sharing data with household Cost Sharing and Health Plan Enrollee Cost Sharing incurred for any Excluded Benefits and will notify Contractors when a Health Plan Enrollee has met the five percent aggregate limit. Contractors shall ensure that Copayments are not deducted from Provider claims reimbursement through the end of the month. Contractors shall notify

the Health Plan Enrollee and Providers when the aggregate limit has been met and that Cost Sharing will not apply for the remainder of the month.

Requested Waivers

The OHCA seeks to extend currently approved waivers and requests any additional waivers necessary to waive retroactive eligibility for the Expansion Adult Group and operate SoonerSelect, including:

Comparability Section 1902(a)(10)(B) and 1902(a)(17). To permit the State to offer a different benefit package to individuals enrolled in SoonerSelect.

Freedom of Choice Section 1902(a)(23)(A): To permit the State to restrict Medicaid enrollees to receiving services through participating SoonerSelect Contractors and to permit the State to contract with a single MCO for the SoonerSelect Specialty Children's Plan.

Retroactive Eligibility Section 1902(a)(34): To permit the State to waive retroactive eligibility for Demonstration participants, with the exception of pregnant women (and during the 60-day period beginning on the last day of pregnancy), children described in section 1902(l)(4) of the Act, the Tax Equity and Fiscal Responsibility Act (TEFRA) and Aged, Blind, and Disabled populations.

Conforming State Plan Amendment

On July 31, 2020, Oklahoma posted formal public notice for submission of three State Plan Amendments (SPAs) to CMS to expand SoonerCare to low-income adults up to 133% of the federal poverty limit, effective July 1, 2020. Notice included the OHCA's intent to modify the State Plan to:

- Add the New Adult Group ages 19 – 64 with incomes at or below 133% of FPL as per Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act and 42 CFR 435.119 and consistent with the expanded eligibility criteria as defined in the Affordable Care Act.
- Establish an Alternative Benefit Plan (ABP) for individuals in the Expansion Adult Group.
- Establish Oklahoma's eligibility procedures for identification of the Expansion Adult Group for the purpose of securing Federal Medical Assistance Percentage (FMAP) rate for the Expansion Adult Group.

The OHCA seeks authority to operate SoonerSelect under its Demonstration and does not intend to submit any State Plan Amendments related to implementation of SoonerSelect.

Requested Expenditure Authority

The OHCA does not believe any additional expenditure authorities are needed to enroll the Expansion Adult Group under the Demonstration or implement SoonerSelect.

Reporting, Quality and Evaluation

The OHCA proposes to continue the currently approved monitoring and evaluation components identified in the STCs and will collaborate with CMS to modify monitoring and evaluation activities as appropriate to address the program modifications described in this amendment request.

Oversight and Monitoring: SoonerSelect

The OHCA will develop oversight and management reports to monitor access, quality and costs. Analysis of data will allow the OHCA to report key challenges, underlying causes of those challenges, and develop immediate strategies for addressing identified challenges. In accordance with 42 C.F.R. § 438.66(c), participating MCOs and PAHPs are required to submit the following:

- Enrollment and Disenrollment data;
- Health Plan Enrollee Grievance and Appeal logs;
- Provider complaint and appeal logs;
- Results of Health Plan Enrollee satisfaction surveys conducted by the Contractor;
- Results of Provider satisfaction surveys conducted by the Contractor;
- Performance on required quality measures;
- Medical management committee reports and minutes;
- Annual quality improvement plan;
- Audited financial and Encounter Data;
- MLR summary reports;
- Customer service performance data; and
- Any other data related to the provision of Long-term services and support (LTSS) not otherwise reported.

The OHCA will utilize findings from this data collection to improve the performance of the SoonerSelect program.

Quarterly and Annual Progress Reports

The OHCA will continue to prepare and submit quarterly and annual progress reports, modified to address the status of SoonerSelect implementation and ongoing performance.

Demonstration Evaluation

The approved evaluation design includes hypotheses related to evaluation of access, quality and cost effectiveness under the Demonstration. The evaluation design will be modified to specifically evaluate SoonerSelect. The evaluator also will include the Adult Group as a distinct segment within the evaluation and will stratify data, as appropriate, to produce findings specific to this population.

The approved evaluation design identifies evaluation activities specific to the Demonstration's current care coordination models, HANs and HMP. Hypotheses specific to the current care coordination models relate to improved access to care, health quality/outcomes, satisfaction, emergency room utilization and cost-effectiveness. The evaluation design will be modified to also test these hypotheses for individuals enrolled in SoonerSelect.

The approved evaluation design includes hypotheses related to waiving of retroactive eligibility for a portion of the existing SoonerCare population. The OHCA's independent evaluator again will include the

Expansion Adult Group as a distinct segment within this portion of the evaluation and will stratify all data to produce findings specific to this population.

Following approval of the amendment request, the OHCA will prepare and submit a revised Evaluation Design for CMS review and approval, in accordance with requirements and timelines specified by CMS.

Section 3 Budget Neutrality

The requested amendment does not change the budget neutrality model for current Demonstration populations. (The impact of changes to the Insure Oklahoma program on the Demonstration's Budget Neutrality model are addressed in the separately-submitted Insure Oklahoma amendment request.)

The most recently submitted Budget Neutrality report includes enrollment and expenditures through June, 2020. The summary tables from the most recent submission are included as Attachment 1. As indicated in the summary tables, the SoonerCare Demonstration currently has a budget neutrality surplus, net of savings phase-downs, equal to $1,041,923,931.

Subject to CMS guidance and approval, the OHCA proposes to add two Medicaid Eligibility Groups (MEGs): the Expansion Adult Group and the Former Foster Care Group.

Expansion Adult Group

The Expansion Adult Group represents an expansion of eligibility and the State proposes to add a new Medicaid Eligibility Group (MEG) to support reporting and budget neutrality monitoring. As a newly eligible population, historical Medicaid expenditure and enrollment data was not used to project program costs and caseload.

The OHCA developed enrollment projections for the Expansion Adult Group based on the estimated number of uninsured Oklahomans Ages 19 to 64 with household incomes under 133 percent of the FPL (+ 5 percent income disregard) and current unemployment trends in Oklahoma. The OHCA estimates annual enrollment in State Fiscal Year 2022 (July 1, 2021 – June 30, 2022) to equal 175,623. The projected average monthly enrollment during the last two quarters of Calendar Year 2021 (Demonstration Year 26) is 173,884. An annual caseload trend factor of 2 percent was applied to estimate enrollment in Calendar Years 2022 and 2023 (Demonstration Years 27 and 28).

As part of the SoonerSelect rate development process, the OHCA's actuaries calculated per member per month (pmpm) expenditure estimates for the Expansion Adult Group prior to implementation of SoonerSelect as well as draft SoonerSelect capitation rates.

The Expansion Adult Group pmpm estimate absent implementation of SoonerSelect, equal to $606.12, was used as the basis for projecting expenditures without the Demonstration. An annual inflation factor of 4.4 percent was applied to the Year 1 "Without Waiver" pmpm value to estimate the pmpm values in subsequent Demonstration Years.

The average capitation rate for the Expansion Adult Group, blended across rate cells, is equal to $581.02 (not including supplemental payments). Because Expansion Adult Group enrollment begins on July 1, 2021 and the SoonerSelect enrollment effective date is October 1, 2021, members will be enrolled in the current fee-for-service program for the third quarter and SoonerSelect for the fourth quarter of Calendar Year 2021 (Demonstration Year 26). The "with waiver" pmpm estimate for Demonstration Year 26, equal to $593.57, represents an average of the pre-SoonerSelect pmpm estimate and the draft blended capitation rate.

The capitation rate period is based on State Fiscal Year and will be adjusted on July 1, 2022, or halfway through Calendar Year 2022 (Demonstration Year 27). For purposes of estimating "with waiver" expenditures, the capitation rate is projected to increase by 3 percent in State Fiscal Year 2023, from $581.02 to $598.45. The estimated "with waiver" pmpm for Calendar Year 2022 (Demonstration Year

27) of $589.73 is equal to the average of the State Fiscal Year 2022 draft average capitation rate and the projected State Fiscal Year 2023 capitation rate ([581.02+598.45]/2=$589.73). A three percent trend rate was applied to the Calendar Year 2022 "with waiver" pmpm estimate to calculate the pmpm estimate for Calendar Year 2023 (Demonstration Year 28).

The tables below present the estimated enrollment and expenditures for the Expansion Adult Group with and without the Demonstration.

Budget Neutrality Summary: Expansion Adult Group

Projected Enrollment and Expenditures: Without Waiver

	DY26/CY21 (Second Half)	DY27/CY22	DY28/CY23
Average Enrollment	173,884	177,361	180,908
Member Months	1,043,305	2,128,332	2,170,896
Per Member Per Month (PMPM)	$ 606.12	$ 632.79	$ 660.63
Total Expenditures	$ 632,365,282	$ 1,346,779,893	$ 1,434,157,228

Projected Enrollment and Expenditures: With Waiver

	DY26/CY21 (Second Half)	DY27/CY22	DY28/CY23
Average Enrollment	173,884	177,361	180,908
Member Months	1,043,305	2,128,332	2,170,896
Per Member Per Month (PMPM)	$ 593.57	$ 589.73	$ 607.42
Total Expenditures	$ 619,271,313	$ 1,255,144,851	$ 1,318,653,576
Annual Surplus (Deficit)	***$ 13,093,970***	***$ 91,635,042***	***$ 115,503,652***
Cumulative Surplus (Deficit)	***$ -***	***$ 104,729,012***	***$ 220,232,664***

Budget Neutrality Summary: Former Foster Care Group

The Former Foster Care Group represents a new population under the Demonstration and the State proposes to add a new Medicaid Eligibility Group (MEG) to support reporting and budget neutrality monitoring.

The estimated average monthly enrollment during the last two quarters of Calendar Year 2021 (Demonstration Year 26) is 699. An annual caseload trend factor of 2 percent was applied to estimate enrollment in Calendar Years 2022 and 2023 (Demonstration Years 27 and 28).

As part of the SoonerSelect rate development process, the OHCA's actuaries calculated per member per month (pmpm) expenditure estimates for the Former Foster Care Group prior to implementation of SoonerSelect as well as draft SoonerSelect capitation rates.

The Former Foster Care Group pmpm estimate absent implementation of SoonerSelect, equal to $251.27, was used as the basis for projecting expenditures without the Demonstration. An annual inflation factor of 4.4 percent was applied to the Year 1 "Without Waiver" PMPM value to estimate the PMPM values in subsequent Demonstration Years.

The average capitation rate for the Former Foster Care Group, blended across rate cells, is equal to $239.96 (not including supplemental payments). Because the SoonerSelect enrollment effective date is October 1, 2021, members will be enrolled in the current fee-for-service program for the third quarter and SoonerSelect for the fourth quarter of Calendar Year 2021 (Demonstration Year 26). The "with waiver" pmpm estimate for Demonstration Year 26, equal to $245.62, represents an average of the pre-SoonerSelect pmpm estimate and the draft average capitation rate.

The capitation rate period is based on State Fiscal Year and will adjusted on July 1, 2022, or halfway through Calendar Year 2022 (Demonstration Year 27). For purposes of estimating "with waiver" expenditures, the capitation rate is projected to increase by 3 percent in State Fiscal Year 2023, from $239.96 to $247.16. The estimated "with waiver" pmpm for Calendar Year 2022 (Demonstration Year 27) of $243.56 is equal to the average of the State Fiscal Year 2022 draft capitation rate and the projected State Fiscal Year 2023 capitation rate ([239.96+247.16]/2=$243.56). A three percent trend rate was applied to the Calendar Year 2022 "with waiver" pmpm estimate to calculate the pmpm estimate for Calendar Year 2023 (Demonstration Year 28).

The tables on the following page present the estimated enrollment and expenditures for the Former Foster Care Group with and without the Demonstration.

Budget Neutrality Summary: Former Foster Care Group

Projected Enrollment and Expenditures: Without Waiver

	DY26/CY21 (Second Half)	DY27/CY22	DY28/CY23
Average Enrollment	699	712	726
Member Months	4,194	8,544	8,712
Per Member Per Month (PMPM)	$ 251.27	$ 262.33	$ 273.87
Total Expenditures	$ 1,053,826	$ 2,241,312	$ 2,385,940

Projected Enrollment and Expenditures: With Waiver

	DY26/CY21 (Second Half)	DY27/CY22	DY28/CY23
Average Enrollment	699	712	726
Member Months	4,194	8,544	8,712
Per Member Per Month (PMPM)	$ 245.62	$ 243.56	$ 250.87
Total Expenditures	$ 1,030,109	$ 2,080,972	$ 2,185,546
Annual Surplus (Deficit)	***$ 23,717***	***$ 160,341***	***$ 200,394***
Cumulative Surplus (Deficit)	***$ -***	***$ 184,058***	***$ 384,452***

Section 4 Required Elements of Amendment Process

Public Process: Medicaid Expansion

As described previously, the proposed Oklahoma Medicaid eligibility expansion was supported Oklahoma voters as a ballot initiative. Additionally, the OHCA adhered to public notice requirements for its submission of State Plan amendments to authorize the eligibility expansion.

Public Process: SoonerSelect

The OHCA engaged stakeholders as part of its planning process for SoonerSelect. On July 16, 2020, OHCA issued a Request for Information (RFI) to solicit input and recommendations on the design of this RFP and the SoonerSelect program. Extensive feedback was received from a broad array of stakeholders including provider associations, community organizations, advocacy groups, and MCOs.

The OHCA received and reviewed written responses from 86 individuals or entities. The RFI invited respondents to offer recommendations in the following key areas:

- Managed Care Enrollees: how and when to transition SoonerCare Eligibles by population, Health Plan Enrollee engagement and education activities.
- Benefits Provided through MCOs: strategies for improving access to services, integration of services, and facilitating referrals and tracking for social services. Also, best practices in benefit design related to evidence-based care for Behavioral Health Services and Value-Added Benefits.
- Quality and Accountability: how best to incentivize MCOS to improve outcomes, and recommendations on which outcome measures to track.
- Care Management and Coordination: recommendations on the best utilization management practices and tools, network development strategies to meet Health Plan Enrollee's behavioral health needs, strategies for meeting needs of Health Plan Enrollees with chronic or complex health conditions and populations such as American Indian/Alaska Native (AI/AN) Health Plan Enrollees and justice-involved individuals.
- Member Services: how to measure MCO performance on Health Plan Enrollee services, best practices in serving Health Plan Enrollees who primarily speak a non-English language, technology-driven strategies, and strategies for Health Plan Enrollees living in Rural areas.
- Provider Payments and Services: recommendations on Provider performance measures, minimum levels of reimbursement, and claim payment timeframes.
- Network Adequacy: how best to ensure network adequacy and recommendations on supporting workforce development.
- Grievance and Appeals and Administrative Requirements: strategies for incorporating Grievance and Appeal data into program improvement and streamlining administrative processes.

OHCA has worked to incorporate into the SoonerSelect RFPs numerous recommendations that came from the RFI responses including, but not limited to:

- Encouraging MCOs to engage with community-based organizations and hire or partner with community-based extenders such as community health workers or other non-traditional health workers to assist with Health Plan Enrollee engagement and address Social Determinants of Health.
- Requiring MCOs to track and report on outcomes of Social Determinants of Health referrals.

- Requiring MCOs to develop and maintain a comprehensive behavioral health crisis response network and promoting integration of behavioral health and primary care services.
- Encouraging MCOs to offer in lieu of services and flexibility in Value Added Benefits to meet Health Plan Enrollee needs.
- Requiring Tribal Government Liaison positions in MCO staffing plans to support and collaborate with Indian Tribes and Indian Health Service, Tribal Health Providers and Urban Indian Health Centers (I/T/Us), as well as assist in informing managed care policy decisions as they relate to the AI/AN population.
- Requiring MCOs to demonstrate sufficient access to I/T/Us by considering I/T/Us essential providers, thereby requiring MCOs to offer contracts to all I/T/Us.
- Conducting annual Provider satisfaction surveys.
- Implementing standardized administrative processes to reduce Provider administrative burden.

Demonstration Amendment Public Process

The OHCA began a 30-day public notice process on January 4, 2021 and concluded the process on February 3, 2021. The public notice was posted on the OHCA's website on January 4, 2021. A copy of the public notice and instructions about the public comment process is available at www.okhca.org/PolicyBlog.

The agency conducted formal tribal consultation during the bi-monthly meetings on July 7, 2020, September 1, 2020, November 3, 2020, and January 5, 2021. The transition to MCO was further discussed at the annual tribal consultation meeting on November 12, 2020 and during tribal MCO workgroup meetings on July 21, 2020, July 30, 2020, and October 8, 2020.

Summary of Tribal Consultation

To be completed following conclusion of comment period.

Summary of Public Comment

To be completed following conclusion of comment period.

Amendment Changes Made as a Result of Tribal and Public Comment

To be completed following conclusion of comment period.

Section 5 CHIP Allotment Neutrality Worksheet

An excerpt from the State's most recently-submitted CHIP Report related to program financing is presented below.

Tell us how much you spent on your CHIP program in FFY 2020, and how much you anticipate spending in FFY 2021 and 2022.

States with a combination program should combine costs for both Medicaid Expansion CHIP and Separate CHIP programs into one budget.

Part 1: Benefit Costs

1. How much did you spend on Managed Care in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022
$237,837,784	$243,545,891	$249,878,084

2. How much did you spend on Fee for Service in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022
$23,381,767	$23,942,930	$24,565,446

3. How much did you spend on anything else related to benefit costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022

4. How much did you receive in cost sharing from beneficiaries to offset your costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022

Part 2: Administrative Costs

1. How much did you spend on personnel in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022? This includes wages, salaries, and other employee costs.

FFY 2020	FFY 2021	FFY 2022
$2,439,743	$2,498,297	$2,563,253

2. How much did you spend on general administration in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022
$3,503,644	$3,587,731	$3,681,012

3. How much did you spend on contractors and brokers, such as enrollment contractors in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022

4. How much did you spend on claims processing in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022

5. How much did you spend on outreach and marketing in FFY 2020?

How much do you anticipate spending in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022

6. How much did you spend on your Health Services Initiatives (HSI) if you had any in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022
$1,494,623	$2,556,857	$2,556,857

7. How much did you spend on anything else related to administrative costs in FFY 2020? How much do you anticipate spending in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022
$ 3,587,557	$3,673,658	$3,769,173

Federal and State Shares

CHIP is funded by federal and state budgets. The federal share of funding is calculated by multiplying your state's enhanced Federal Medical Assistance Percentage (eFMAP) by your total program costs (the sum of your benefit and administrative costs). The remaining amount of your total program costs is covered by your state share of funding.

CMS will enter the eFMAP rates for each year and auto-calculate the total program costs, as well as the federal and state shares.

FMAP Table	FFY 2020	FFY 2021	FFY 2022
Total program costs	$ 272,245,118	$279,805,364	$287,013,825
eFMAP	92.05%	81.93%	77.82%
Federal share	$ 250,601,631	$229,244,535	$223,354,159
State share	$ 21,643,487	$50,560,829	$63,659,666

1. What were your state funding sources in FFY 2020?
   Select all that apply.
   X State appropriations
   ☐ County/local funds
   ☐ Employer contributions
   ☐ Foundation grants
   X Private donations
   X Tobacco settlement
   ☐ Other

   a. If you answered "other," what other type of funding did you receive?
2. Did you experience a short fall in federal CHIP funds this year?
   ☐ Yes
   X No

   a. If you answered "yes," briefly explain why your state didn't have enough federal funding to cover your CHIP program costs.

Part 3: Managed Care Costs

Complete this section only if you have a Managed Care delivery system.

1. How many children were eligible for Managed Care in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022
144,355	146,753	149,191

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022? Round to the nearest whole number.

FFY 2020	FFY 2021	FFY 2022
$172	$174	$175

Part 4: Fee for Service Costs

Complete this section only if you have a Fee for Service delivery system.

1. How many children were eligible for Fee for Service in FFY 2020? How many do you anticipate will be eligible in FFY 2021 and 2022?

FFY 2020	FFY 2021	FFY 2022
12,591	12,800	13,013

2. What was your per member per month (PMPM) cost based on the number of children eligible for Managed Care in FFY 2020? What is your projected PMPM cost for FFY 2021 and 2022? Round to the nearest whole number.

FFY 2020	FFY 2021	FFY 2022
$206	$208	$210

Part 5

1. Is there anything else you'd like to add about your program finances that wasn't already covered?
2. Optional: Attach any additional documents here.

Section 6 Non-Federal Share

This amendment request will enroll the Expansion Adult Group and Former Foster Care Group under the SoonerCare Demonstration and transition all qualified individuals to SoonerSelect.

The OHCA will utilize multiple sources of non-federal share to fund the SoonerSelect and the Adult Group expansion. These include but are not limited to direct appropriations from the: General Revenue Fund of the State Treasury, which totaled $698,679,598 in SFY 2021; the Special Cash Fund, which totaled $112,000,000 in SFY 2021; the Health Care Enhancement Fund, which totaled $144,863,600 in SFY 2021; the Tobacco Settlement fund, which totaled $11,718,750; the Opioid Lawsuit Settlement Fund, which totaled $7,977,420; and the Health Employee and Economy Improvement Act (HEEIA) Fund, which totaled $24,800,000.

The OHCA receives and may 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 may 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. Subject to CMS guidance and approval, the OHCA intends to transition the current supplemental payments for physicians and hospitals, such as the Supplemental Hospital Offset Payment Program (SHOPP), to directed payments to be made through MCOs to Participating Providers. Supplemental payments for other providers, including emergency ground medical transport and community-based mental health centers, likewise may be converted into directed payments.

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 may be used to fund the non-federal share of costs related to the Demonstration.

Attachments

1. Current Budget Neutrality Summary Tables
2. Tribal Consultation Documentation
3. Public Notice Documentation

Attachment 1 - Current Budget Neutrality Summary Tables

(As submitted to CMS, through June 30, 2020)

Without-Waiver Total Expenditures

			23	24	25	26	27	28	Total
Medicaid Per Capita									
TANF-Urban	1	**Total**	$ 1,637,520,722	$ 1,699,328,429	$ 2,742,277,340	$ 1,946,519,109	$ 2,076,234,837	$ 2,214,595,770	
		PMPM	$ 396.34	$ 411.40	$ 427.03	$ 443.26	$ 460.10	$ 477.58	
		Mem-Mon	4,131,606	4,130,599	6,421,744	4,391,371	4,512,573	4,637,120	
TANF-Rural	2	**Total**	$ 1,092,371,484	$ 1,113,767,487	$ 1,780,068,578	$ 1,245,383,632	$ 1,315,059,727	$ 1,388,637,230	
		PMPM	$ 402.00	$ 417.27	$ 433.13	$ 449.59	$ 466.67	$ 484.40	
		Mem-Mon	2,717,342	2,669,177	4,109,779	2,770,043	2,817,965	2,866,716	
ABD-Urban	3	**Total**	$ 518,962,278	$ 531,427,442	$ 817,702,934	$ 557,808,349	$ 574,076,617	$ 590,817,839	
		PMPM	$ 1,369.89	$ 1,419.21	$ 1,470.30	$ 1,523.23	$ 1,578.07	$ 1,634.88	
		Mem-Mon	378,835	374,453	556,147	366,201	363,784	361,383	
ABD-Rural	4	**Total**	$ 316,981,436	$ 315,574,862	$ 488,171,846	$ 335,881,932	$ 345,675,737	$ 355,756,173	
		PMPM	$ 1,093.79	$ 1,133.16	$ 1,173.95	$ 1,216.21	$ 1,259.99	$ 1,305.35	
		Mem-Mon	289,801	278,491	415,837	276,171	274,348	272,537	
CHIP Medicaid Expansion Children Urban	5	**Total**	$ -	$ -	$ -	$ -	$ -	$ -	
		PMPM	$ 396.34	$ 411.40	$ 427.03	$ 443.26	$ 460.10	$ 477.58	
		Mem-Mon							
CHIP Medicaid Expansion Children Rural	6	**Total**	$ -	$ -	$ -	$ -	$ -	$ -	
		PMPM	$ 402.00	$ 417.27	$ 433.13	$ 449.59	$ 466.67	$ 484.40	
		Mem-Mon							
TOTAL			**$ 3,565,835,920**	**$ 3,660,098,219**	**$ 5,828,220,699**	**$ 4,085,593,023**	**$ 4,311,046,917**	**$ 4,549,807,012**	**$ 26,000,601,790**

With-Waiver Total Expenditures

			23	24	25	26	27	28	TOTAL
Medicaid Per Capita									
TANF-Urban	1		$ 807,177,426	$ 892,743,565	$ 1,427,059,145	$ 1,051,171,233	$ 1,121,351,475	$ 1,196,217,455	$ 13,841,203,210
TANF-Rural	2		$ 620,389,523	$ 642,381,366	$ 1,025,383,620	$ 742,270,691	$ 783,881,785	$ 827,825,745	$ 9,296,013,872
ABD-Urban	3		$ 439,698,547	$ 473,031,006	$ 727,222,811	$ 493,744,634	$ 508,154,556	$ 522,985,051	$ 5,861,786,644
ABD-Rural	4		$ 337,361,416	$ 362,590,612	$ 546,558,203	$ 384,680,066	$ 396,065,691	$ 407,788,306	$ 4,653,827,621
CHIP Medicaid Expansion Children Urban	5		$ -	$ -	$ -	$ -	$ -	$ -	
CHIP Medicaid Expansion Children Rural	6		$ -	$ -	$ -	$ -	$ -	$ -	
Medicaid Aggregate - WW only									
Non-Disabled Working Adults ESI	1		$ 58,392,924	$ 55,060,585	$ 89,792,140	$ 65,789,186	$ 69,980,698	$ 74,439,257	$ 375,995,578
Working Disabled Adults ESI	2		$ -	$ -	$ -	$ -	$ -	$ -	
TEFRA Children	3		$ 7,123,897	$ 9,059,365	$ 15,034,003	$ 11,414,642	$ 12,728,688	$ 14,194,006	$ 84,599,994
Full-Time College Students ESI	4		$ 450,306	$ 460,889	$ 733,733	$ 516,218	$ 547,488	$ 580,653	$ 2,951,834
Foster Parents ESI	5		$ -	$ -	$ -	$ -	$ -	$ -	
Not-for-Profit Employees ESI	6		$ -	$ -	$ -	$ -	$ -	$ -	
Non-Disabled Working Adults IP	7		$ 37,146,874	$ 41,345,641	$ 68,830,677	$ 51,959,648	$ 56,876,221	$ 62,258,014	$ 250,882,772
Working Disabled Adults IP	8		$ -	$ -	$ -	$ -	$ -	$ -	$ 64,686
Full-Time College Students IP	9		$ 643,932	$ 444,908	$ 671,226	$ 428,088	$ 442,676	$ 457,760	$ 3,248,121
Foster Parents IP	10		$ -	$ -	$ -	$ -	$ -	$ -	
Not-for-Profit Employees IP	11		$ -	$ -	$ -	$ -	$ -	$ -	
HAN Expenditures	12		$ 9,868,155	$ 10,671,780	$ 16,813,154	$ 11,405,439	$ 11,720,229	$ 12,043,707	$ 76,258,189
HMP Expenditures	13		$ 10,651,907	$ 10,176,586	$ 16,830,295	$ 12,679,813	$ 13,440,501	$ 14,248,007	$ 81,818,299
Medical Education Programs	14		$ -	$ 107,687,388	$ -	$ -	$ -	$ -	$ 107,687,388
TOTAL			**$ 2,328,904,907**	**$ 2,605,653,691**	**$ 3,934,929,006**	**$ 2,826,059,658**	**$ 2,975,190,008**	**$ 3,133,037,961**	**$ 17,803,775,231**

Savings Phase-Down

Medicaid Per Capita			23	24	25	26	27	28	TOTAL
		Savings Phase-Down							
TANF-Urban	1	**Without Waiver**	$ 1,637,520,722	$ 1,699,328,429	$ 2,742,277,340	$ 1,946,519,109	$ 2,076,234,837	$ 2,214,595,770	
		With Waiver	$ 807,177,426	$ 892,743,565	$ 1,427,059,145	$ 1,051,171,233	$ 1,121,351,475	$ 1,196,217,455	
Difference			$ 830,343,296	$ 806,584,864	$ 1,315,218,196	$ 895,347,876	$ 954,883,362	$ 1,018,378,314	
Phase-Down Percentage			25%	25%	25%	25%	25%	25%	
Savings Reduction			$ 622,757,472	$ 604,938,648	$ 986,413,647	$ 671,510,907	$ 716,162,522	$ 763,783,736	
		Savings Phase-Down							
TANF-Rural	2	**Without Waiver**	$ 1,092,371,484	$ 1,113,767,487	$ 1,780,068,578	$ 1,245,383,632	$ 1,315,059,727	$ 1,388,637,230	
		With Waiver	$ 620,389,523	$ 642,381,366	$ 1,025,383,620	$ 742,270,691	$ 783,881,785	$ 827,825,745	
Difference			$ 471,981,961	$ 471,386,121	$ 754,684,959	$ 503,112,941	$ 531,177,942	$ 560,811,485	
Phase-Down Percentage			25%	25%	25%	25%	25%	25%	
Savings Reduction			$ 353,986,471	$ 353,539,591	$ 566,013,719	$ 377,334,706	$ 398,383,456	$ 420,608,614	
		Savings Phase-Down							
ABD-Urban	3	**Without Waiver**	$ 518,962,278	$ 531,427,442	$ 817,702,934	$ 557,808,349	$ 574,076,617	$ 590,817,839	
		With Waiver	$ 439,698,547	$ 473,031,006	$ 727,222,811	$ 493,744,634	$ 508,154,556	$ 522,985,051	
Difference			$ 79,263,731	$ 58,396,436	$ 90,480,123	$ 64,063,715	$ 65,922,061	$ 67,832,788	
Phase-Down Percentage			25%	25%	25%	25%	25%	25%	
Savings Reduction			$ 59,447,798	$ 43,797,327	$ 67,860,092	$ 48,047,786	$ 49,441,546	$ 50,874,591	
		Savings Phase-Down							
ABD-Rural	4	**Without Waiver**	$ 16,981,436	$ 315,574,862	$ 488,171,846	$ 335,881,932	$ 345,675,737	$ 355,756,173	
		With Waiver	$ 337,361,416	$ 362,590,612	$ 546,558,203	$ 384,680,066	$ 396,065,691	$ 407,788,306	
Difference			$ (20,379,980)	$ (47,015,750)	$ (58,386,356)	$ (48,798,134)	$ (50,389,954)	$ (52,032,133)	
Phase-Down Percentage			25%	25%	25%	25%	25%	25%	
Savings Reduction			$ -	$ -	$ -	$ -	$ -	$ -	
		Savings Phase-Down							
CHIP Medicaid Expansion Children Urban	5	**Without Waiver**	$ -	$ -	$ -	$ -	$ -	$ -	
		With Waiver	$ -	$ -	$ -	$ -	$ -	$ -	
Difference			$ -	$ -	$ -	$ -	$ -	$ -	
Phase-Down Percentage			25%	25%	25%	25%	25%	25%	
Savings Reduction			$ -	$ -	$ -	$ -	$ -	$ -	
		Savings Phase-Down							
CHIP Medicaid Expansion Children Rural	6	**Without Waiver**	$ -	$ -	$ -	$ -	$ -	$ -	
		With Waiver	$ -	$ -	$ -	$ -	$ -	$ -	
Difference			$ -	$ -	$ -	$ -	$ -	$ -	
Phase-Down Percentage			25%	25%	25%	25%	25%	25%	
Savings Reduction			$ -	$ -	$ -	$ -	$ -	$ -	
Total Reduction			**$ 1,036,191,741**	**$ 1,002,275,565**	**$ 1,620,287,458**	**$ 1,096,893,400**	**$ 1,163,987,524**	**$ 1,235,266,941**	**$ 7,154,902,629**

BASE VARIANCE			**$ 200,739,272**	**$ 52,168,963**	**$ 273,004,235**	**$ 162,639,965**	**$ 171,869,386**	**$ 181,502,110**	**$ 1,041,923,931**
Excess Spending from Hypotheticals									$ -
1115A Dual Demonstration Savings (state preliminary estimate)									$ -
1115A Dual Demonstration Savings (OACT certified)									$ -
Carry-Forward Savings From Prior Period									
NET VARIANCE									**$ 1,041,923,931**

Cumulative Target Limit

			23	24	25	26	27	28
Cumulative Target Percentage (CTP)								
Cumulative Budget Neutrality Limit (CBNL)			$ 2,529,644,179	$ 5,187,466,833	$ 9,395,400,073	$ 12,384,099,696	$ 15,531,159,090	$ 18,845,699,161
Allowed Cumulative Variance (= CTP X CBNL)			$ -	$ -	$ -	$ -	$ -	$ -
Actual Cumulative Variance (Positive = Overspending)			$ (200,739,272)	$ (252,908,235)	$ (525,912,470)	$ (688,552,435)	$ (860,421,820)	$ (1,041,923,931)
Is a Corrective Action Plan needed?								

Attachment 2 - Tribal Consultation Documentation

To be completed following conclusion of comment period.

Attachment 3 - Public Notice Documentation

To be completed following conclusion of comment period.