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,[i] 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.**
- ✓ 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 implement a managed care structure for 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 select network of health care providers; 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	$459	$5,508
2	$620	$7,440
3	$783	$9,396
4	$945	$11,340
5	$1,107	$13,284
6	$1,269	$15,228

7	$1,431	$17,172
8	$1,593	$19,116

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.1. 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. If the application is approved:
  - **1st-14th of the month:** Coverage starts the first of the month after their application is approved
  - **15th-end of the month:** Coverage starts the first of the second following month
- Individuals **with a premium** obligation will have their coverage start based on when they pay their first premium, aligning with the health insurance marketplace. If the first premium payment occurs:
  - **1st-14th of the month:** Coverage starts the first of the following month
  - **15th-end of the month:** Coverage starts the first of the second following month

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. Individuals that have membership, enrolled or otherwise, in an American Indian/Alaska Native federally recognized tribe.

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. 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.					

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.

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 <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.

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.

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 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.

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 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

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.

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.

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.
OHCA does not anticipate any substantial enrollment decreases when projecting with the demonstration versus without the demonstration; however, the demonstration will propose the introduction of premiums and community engagement requirements. Other state experience does suggest those items will likely depress enrollment, though the extent is difficult to predict. OHCA will assume a 5% decrease in the enrollment with the demonstration for the newly eligible population. OHCA assumes a significant increase in Medicaid enrollment compared to current enrollment. If the state plan is approved and OHCA is approved to implement the demonstration, OHCA anticipates only a slight impact on enrollment of newly eligible Oklahomans from premiums and community engagement and no impact on the "woodwork" population. Expansion adults row is same as Table 3. Other rows are a distribution of woodwork effect across other eligibility groups, proportional to their current enrollment numbers. The number of uninsured Oklahomans under 133% FPL (+ 5% income disregard) who are potentially eligible under existing Medicaid eligibility categories is assumed to be 66,217 (30% of the total number of currently uninsured Oklahomans under 133% FPL (+ 5% income disregard)). Take-up rates of 75% in DY1 and 80% in subsequent years are assumed.

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. EPSDT services are also excluded.

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.
☐	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.

IMD Coverage – The state should identify below the approach it intends to take for providing IMD coverage under this proposed demonstration.	
	☒ 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."
	☐ 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 19-64 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.

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.	
☐	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.
☒	Additional Information (optional): OHCA is interested in developing an Alternative Payment Methodology in the future.

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	Primary care visits to treat injury or illness, specialty visits, and other practitioner visits are covered. Visits are limited to four visits per month. However, visits to the PCP within a medical home are unlimited. Specialty visits within a medical home are still limited to four visits a month; additional specialty visits are permitted if medical necessity is met. Outpatient facility/ambulatory surgery center, dialysis, chemotherapy, and radiation are covered. Allergy testing is covered with the limit of 60 tests for a 3-year period without prior authorization. Provider qualifications for the services listed above are the same as those delineated within the Oklahoma Medicaid State Plan. Services are only covered when provided by Medicaid enrolled providers.
Emergency Services	Services covered in an emergency department, urgent care center, and emergency transportation/ambulance are covered.
Hospitalization	Inpatient hospital, surgical and inpatient physician services are covered. Organ transplants are covered, some transplant procedures require prior authorization. Reconstructive surgery following a mastectomy is covered. Provider qualifications for the services listed above are the same as those delineated within the Oklahoma Medicaid State Plan. Services are only covered when provided by Medicaid enrolled providers.
Maternity and Newborn Care	Prenatal and postnatal care, delivery and all inpatient maternity services are covered. Provider qualifications for the services listed above are the same as those delineated within the Oklahoma Medicaid State Plan. Services are only covered when provided by Medicaid enrolled providers.

Essential Health Benefit	EHB-Benchmark Plan Service(s), Limitations, and Provider Qualifications
Mental Health and Substance Use Disorder Services, Including Behavioral Health Services	Additionally, mental and substance use disorder outpatient services are covered when provided in an outpatient behavioral health agency setting and are limited to 35 hours per rendering provider per week. Services not included in this limitation are: (1) Assessments; (2) Testing; (3) Service Plan Development; and (4) Crisis Intervention Services. Mental and behavioral inpatient services are covered for adults when provided in general/medical surgical hospital. Primary and preventive integrated behavioral health care is covered for adults in a primary care setting when provided by an independently contracted Licensed Behavioral Health Professional or Psychologist. Substance use disorder inpatient detoxification services are available for individuals age 21-64 when not provided in an IMD. Additional SUD inpatient/residential is not covered. • Services provided in an IMD will be addressed in a separate waiver request. Provider qualifications for the services listed above are the same as those delineated within the Oklahoma Medicaid State Plan. Services are only covered when provided by Medicaid enrolled providers.
Prescription Drugs	As per the State Plan, generic, preferred, non-preferred, and specialty drugs are covered. Combined monthly prescription limit of six per month with two brand names allowed. Prenatal vitamins and smoking cessation products do not count towards prescription limits. Products that are considered Medication-Assisted Treatment (MAT) drugs used to address opioid disorders do not count towards prescription limits. Provider qualifications for the services listed above are the same as those delineated within the Oklahoma Medicaid State Plan. Services are only covered when provided by Medicaid-enrolled providers.

Essential Health Benefit	EHB-Benchmark Plan Service(s), Limitations, and Provider Qualifications
Rehabilitative and Habilitative Services and Devices	Outpatient rehabilitation services/skilled nursing facilities are covered at 90 days per year. PT/ST/OT covered for rehabilitative and habilitative services limited to 1 evaluation/re-evaluation visit per year and 15 visits per calendar year. Home health and durable medical equipment, supplies and appliances are covered. Prosthetic devices are covered, coverage includes home dialysis equipment and supplies, nerve stimulators, external breast prosthesis and support accessories, and implantable devices inserted during the course of surgical procedures. Provider qualifications for the services listed above are the same as those delineated within the Oklahoma Medicaid State Plan. Services are only covered when provided by Medicaid-enrolled providers.
Laboratory Services	Imaging including CT/PET and MRIs are covered. Laboratory outpatient and professional services are covered. X-rays and diagnostic services are covered. Provider qualifications for the services listed above are the same as those delineated within the Oklahoma Medicaid State Plan. Services are only covered when provided by Medicaid-enrolled providers.

Essential Health Benefit	EHB-Benchmark Plan Service(s), Limitations, and Provider Qualifications
Preventive and Wellness Services and Chronic Disease Management	Preventive care and screening, including: • Mammography screening and follow-ups; • Family planning services including over the counter contraceptives; • Screening and follow-up Pap smears; • Smoking and tobacco cessation counseling; • Immunizations as per ACIP guidelines; • Genetic testing and molecular pathology services when medically necessary; • Nutritional counseling limited to six hours per year for diagnosis treating and preventing or minimizing the effects of illness; and • Diabetic self-management training is covered at one hour of individual and nine hours of group instruction in the first 12-month period and two hours of individual instruction after the first 12-month period. Provider qualifications for the services listed above are the same as those delineated within the Oklahoma Medicaid State Plan. Services are only covered when provided by Medicaid-enrolled providers.
Pediatric Services Including Oral and Vision Care (generally not applicable in this demonstration)	ESPDT services are not covered. See Section III.F.
Additional Benefits	
Name of Benefit	**Service Description, Limitations, and Provider Qualifications**
Dental- Emergency Extractions	Adult dental coverage is limited to medically necessary extractions.

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	$459	$5,508
2	$620	$7,440
3	$783	$9,396
4	$945	$11,340
5	$1,107	$13,284
6	$1,269	$15,228
7	$1,431	$17,172
8	$1,593	$19,116

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 guidance, American

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.	
	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 develop a unique managed care solution to deliver coordinated, timely, high-quality care to our 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.
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.

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 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 select network of health care providers;
- 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 1902(a)(10)(A)(i)(VIII)	1,731,421	1,819,489	1,819,489	1,819,489	1,819,489
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.
No additional authorities under 1115(a)(1) are expected to be required to authorize this HAO demonstration.

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
	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

Objective/Goal	Hypothesis	Evaluation Parameters/Methodology
	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, including capitated encounters, 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. OHCA will process all encounter claims via our Claims Processing function with edits and audits in place as required.
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

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 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 [Placeholder for other posting methods]. A copy of the full public notice, abbreviated public notice, and instructions about the public comment process is available at www.okhca.org/PolicyBlog.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.

The agency's initial priorities were to educate the public on the requirements under SoonerCare 2.0, the populations impacted, and the populations exempted.

Subsequently, the agency conducted at least three public and targeted forums statewide to garner public and stakeholder input into the development of the SoonerCare 2.0 HAO demonstration, as listed below:

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

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

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

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

5. Oklahoma Health Care Authority Board Meeting
   March 18, 2020 at 3:00pm
   4345 N. Lincoln Blvd.
   Oklahoma City, OK 73105

6. OSU Center for Health Sciences
   March 24, 2020 at 1:30 pm
   AR and Marylouise Tandy Medical Academic Building
   1111W. 17th St.
   Tulsa, Oklahoma 74107

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.

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:

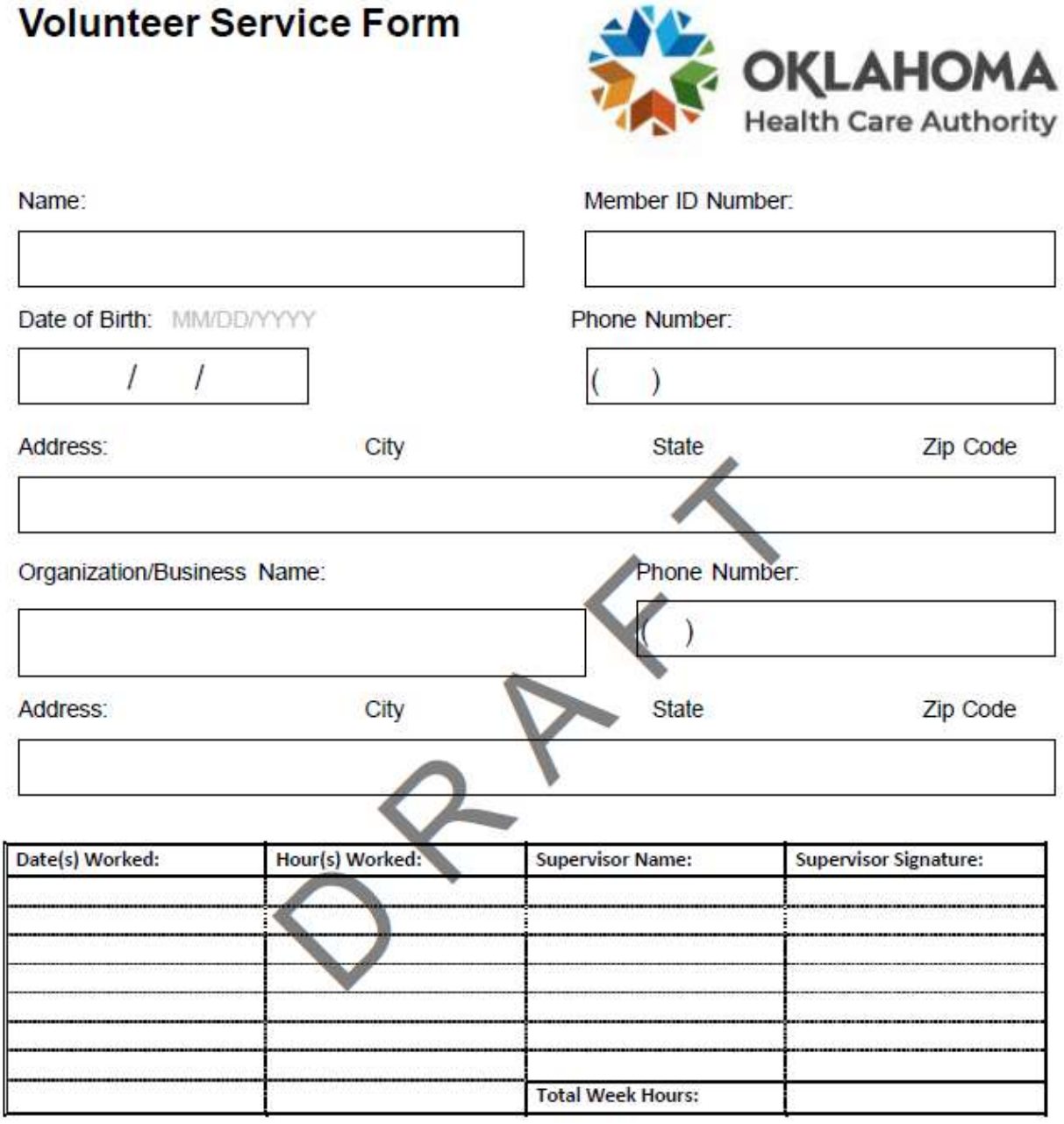
DRAFT

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

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:

DRAFT

[i] 2019 America's Health Rankings report