OKLAHOMA
Health Care Authority

Oklahoma Public Health Emergency Unwinding Approach

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Oklahoma Unwinding Approach

Following guidance provided by CMS in the SHO 20-004, SHO 21-002 and SHO 22-001, Oklahoma has developed an unwinding plan for the Public Health Emergency that is intentional and compassionate, giving considerations to our most vulnerable members. Oklahoma has developed an unwinding plan that maintains the goals of keeping eligible members enrolled, minimizing ineligible members who are enrolled, minimizing member burden, achieving a sustainable renewal schedule, and meeting the timeline set forth by CMS by utilizing a formula that prioritizes members in the middle of an episode of care, have chronic health conditions, have children under five years of age, or have higher financial need.

Communications Plan

Phase 1

Phase 1 of Oklahoma's Communications Plan began in August 2021 and will continue until the State receives the 60-day confirmation from CMS. The goal of Phase 1 is to encourage potentially affected members to update their information in the member portal, educate stakeholders on the PHE, and to ensure there is consistent messaging regarding the PHE across all platforms. Communication will be sent in English and Spanish, which are the two primary languages in Oklahoma.

Stakeholder	Communications
Core Messaging: *Make sure we know where to send your benefit information (address, email and phone number). Update your contact information at mysoonercare.org.*	
Members	• Created PHE page on Oklahoma.gov/ohca • Created PHE page on mysoonercare.org • Targeted e-mail campaign to PHE protected members • RoboCalls • Updated "How To" videos showing how to update information • Added messaging to hold messages • Developed FAQs • Messaging on social media • Messaging in member newsletters • Sent press releases to media
Providers	• Added red flag message to the provider portal if member has outdated information • Send Provider Global Alerts to inform/educate providers

Stakeholder	Communications
	• Send e-newsletters to all providers • Target providers seeing high numbers of PHE protected members • Connect with Provider Associations • Provide flyers to display in offices
Media	• Press release to statewide media outlets • Schedule 1:1 interviews with key media • Provide FAQs tomedia
Partners	• Hold virtual meetings with Community Partners and Navigators • Provide a PHE toolkit for Agency Partners, Community Partners, and Navigators • Ensure messaging is consistent across Agency Partner websites and social media • Engage Tribal partners
Employees	• Poll staff to establish employee understanding of PHE • Develop call scripts for staff • Educate staff in weekly e-newsletter • Educate employees in town hall meetings
Other Stakeholders	• Provide PHE Toolkit to other stakeholders • Ensure messaging is consistent across websites • Provide talking points • Create flyers and one-sheets for legislators

Phase 2

Phase 2 of Oklahoma's Communications Plan will begin when the State receives the 60-day confirmation from CMS. The goal of Phase 2 is to educate PHE protected members, staff, and stakeholders on the end of the PHE and available resources, and to ensure there is consistent messaging across all platforms. Communication will be sent in English and Spanish, which are the primary two languages in Oklahoma.

Stakeholder	Communications
Core Messaging: *To educate on the end of the PHE, their specific end date, and resources.*	
Members	• Send a one-time letter to all ineligible members • Send an email to all ineligible members • Send targeted emails to members with missing information • Send a text message to all ineligible members encouraging them to view their mail and email for important information • Update the website with end of PHE information, resources, and next steps • Update social media platforms with the end of the PHE information, resources, and next steps • Create a campaign based off one color as to bring attention to notices.
Providers	• Target providers who see PHE protected members
Media	• Submit a press release with updated information on end of PHE and resources available for members
Partners	• Provide Community Partners, Agency Partners, and navigators with education, training, and meetings.

Stakeholder	Communications
	• Use Communications Toolkit to educate community partners, agency partners, and navigators on consistent messaging and FAQs • PSA TV campaign with Oklahoma Department of Insurance promoting Marketplace
Employees	• Educate employees in staff newsletter • Educate employees in Town Hall meetings
Other Stakeholders	• Use Communications Toolkit to educate legislators • Hold one on one meetings with legislators • Provide education through electronic newsletters • Provide talking points and one-sheets to legislators and assistants

Fair Hearings

When the PHE ends, the State is expected to begin to process fair hearing requests timely and take final administrative action within 90 days of the receipt of the request for non-expedited requests. OHCA anticipates a substantial increase in fair hearing requests at the end of the continuous enrollment period.

The State anticipates a substantial increase in fair hearing requests based on data obtained from the fair hearing request-to-termination ratio for 2019-2021. To mitigate risk, the State is partnering with Oklahoma Human Services and the Attorney General's office to increase the number of ALJs available to hear appeals. The State is also increasing staff to address pre-fair hearing work and research. OHCA is engaging stakeholders, community partners, and agency partners to communicate any process changes and address member eligibility determination questions. OHCA is increasing eligibility call center staff to address and resolve member questions regarding their eligibility determinations. In addition, Oklahoma intends to request a waiver to allow the State more time to render a fair hearing decision from 90 to 120 days.

Training Plan

The following training plan supports the unwinding of the Public Health Emergency for SoonerCare.

The ongoing COVID-19 outbreak and implementation of federal policies to address the PHE have disrupted routine Medicaid eligibility and enrollment operations. Medicaid enrollment in Oklahoma has grown to nearly 1.2 million individuals mostly due to the continuous enrollment condition. Oklahoma estimates approximately 225,000 Medicaid members are receiving continuous eligibility but are truly ineligible and will lose coverage when the PHE ends. It is critical to ensure when the PHE ends the state of Oklahoma maximizes effectiveness with renewals of eligibility by solidifying an orderly process minimizing the burden on members and promotes continuity of coverage for all members, eligible and ineligible, where possible.

Training and Development Timeline

Development

- Begin first draft of training materials- February 25th, 2022
- First draft of training materials due- March 25th, 2022
- Biweekly workgroup meetings to begin- March 29th, 2022
- Training materials to be finalized- April 22nd, 2022

Training

- Eligibility & Coverage Services staff training - To begin 60 days before the end of the PHE
- Contractor training - To begin 60 days before the end of the PHE
- Agency Partner training - To begin 45 days before the end of the PHE
- Community Partner training - To begin 30 days before the end of the PHE

Instructors

OHCA's Training Academy Instructors will provide the training for OHCA personnel, contractors, and Agency Partners.

Training Plan Overview

Once the PHE end date has been confirmed, all OHCA staff, contractors, Agency Partners, and Community Partners will be notified. These groups are currently aware of the challenges the PHE has created with the continuous eligibility requirement. Training will be focused on all departments that interact with members and providers, including external Agency Partners, with a special emphasis on the Eligibility & Coverage Services (ECS) Department. This group is the front line of call center agents assisting members daily through the SoonerCare Helpline. The Eligibility & Coverage Services staff routinely help members with maintaining eligibility, completing applications, access to care and understanding their benefits. It will be critically important this primary group has an excellent foundation for understanding the needs of the individuals losing eligibility for Medicaid but possibly eligible for other insurance affordability programs.

Additional call tree groups include: Adjustments, Behavioral Health, Dental Authorizations, Electronic Data Interchange (EDI) Helpdesk, Insure Oklahoma Call Center, Provider Secure Site Internet Help Desk, Medical Authorizations, Online Enrollment Agency Partners Helpdesk, Apply by Phone, Online Enrollment Helpdesk and Internet Helpdesk, Pharmacy Helpdesk, Provider Enrollment, Provider Services, and Third Party Liability.

The ECS Training Academy Instructors will facilitate a manager, director, and instructor level training and provide materials as needed for the additional call tree groups.

Training Guide

Learner Objectives

Learners will be able to do the following by the end of the training:

1. Assist individuals ineligible for Medicaid with other affordable coverage options
2. Provide an extensive list of community resources to ineligible individuals

Delivery Method and Outline:

PowerPoint presentation via Office365 Teams covering the following topics:

- PHE Unwind Timeline
- Communications Plan
- Fair Hearing and Appeals Rights
- Marketplace
- Resources for members

Staffing Plan

Call Center Staffing

The Maximus Oklahoma City (OKC) project operates a call center for OHCA. OHCA has informed Maximus of the intent to expand the number of staff in the Maximus Tier II department to address the projected increase of workflow and call volume related to the end of the PHE. OHCA requested an additional thirty (30) Tier II customer service representatives (CSRs) and an additional two (2) Tier II supervisors.

Timing of Tier II Staffing

Staff will be added to the Tier II team in a phased approach, adding classes of staff over a two-month period. All 30 additional CSRs and supervisors will be hired and starting by month one. Month one is defined as the month the PHE ends.

Additional Tier2	-60 Days	-30 Days	Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7	Month 8	Month 9
CSRs	15	30	30	30	30	30	30	30	30	30	30
MMS Sups	1	2	2	2	2	2	2	2	2	2	2

The chart above outlines the planned timeline for the additional staff (based on when Maximus and OHCA are notified that the PHE will end). After Month 9, or based on business need, Maximus would then wind down the number of additional staff in Tier 2, returning the CSRs back to the Tier 1 queues.

Maximus will maintain this level of supervisors and CSRs through this period, backfilling any losses to maintain this staffing level.

Internet Helpdesk Staffing

OHCA Internet Helpdesk is staffed and operated by Gainwell Technologies. Most calls to the Internet Helpdesk are members requesting a password reset for their account. Portal messaging has been updated to alert members they can wait 15 minutes to retry their login when they get locked out due to too many login attempts instead of instructing them to call. This will help reduce call volume.

Gainwell will increase staffing by up to ten additional agents once the State receives the 60-day notice from CMS. This will allow time for the hiring process and enough time for training before the end of the PHE.

Senior Eligibility Staffing

OHCA anticipates a substantial increase in fair hearing requests. To mitigate risk and lessen the pre-hearing work, the State is hiring an additional Eligibility and Coverage Manager.

Resuming Normal Operations

States will be required to initiate renewals for all individuals enrolled within 12 months of the ending of the continuous enrollment condition. Oklahoma will utilize the option allowed by CMS of initiating renewals two months before the end of the month in which the PHE ends, ensuring no terminations occur until after the continuous enrollment period ends.

Since the continuous enrollment condition has been in effect, Oklahoma has maintained application processing standards and has not stopped conducting eligibility redeterminations. Oklahoma has real time eligibility and does not have any pending applications. During the continuous enrollment period, any member found to be ineligible had their end date pushed to the PHE end date. The State will stop the process of extending coverage and will resume the normal processing of eligibility with some modifications following the end of the PHE. These modifications are created to ensure operational stability while maintaining safeguards to protect the most vulnerable members.

Currently Eligible Cases

During the 12-month post-PHE period, application dates will be adjusted for cases with children under 5. This will assist with the renewal bulge, alleviate operational

burden, and protect coverage for at-risk children. This risk-based approach ensures continuity of coverage for a population that tends to have stable eligibility.

Ineligible Members Under PHE Protections

Upon receiving the 60-day notice from CMS, members who are currently protected by the continuous eligibility requirements will have their eligibility pushed out to a "final" PHE end date based on their specific situation and health conditions to protect our most vulnerable members. This plan will allow high risk members to have their coverage protected for a longer period while lower risk members are phased out earlier. Additional groups will be added as they are identified.

Ineligible MAGI members will lose their eligibility over the course of a nine-month period following the end of the PHE and ineligible Non-MAGI members will lose their eligibility over the course of the twelve-month period following the end of the PHE.

Members will be aligned and reprocessed at a case level to minimize member burden, allow families to receive one request for information, and align families for future years. Prior to having their coverage ended, members will be run through reprocessing and data matches to determine if they may be eligible for their current program or another program. Those not eligible for any program will have their coverage end and will be referred to the Federal Marketplace. Those found eligible will have their current coverage extended or will be moved to a new program the following month.

Population Prioritization

Oklahoma has developed a risk-based approach for prioritizing members through the unwind process in alignment with the goal of protecting our most vulnerable members. OHCA will be reviewing the circumstances of our PHE protected population to determine if a member is higher or lower risk. To achieve the goal of aligning and reprocessing on a case level, each case will be prioritized and processed according to the most at risk member on the case.

Lower Risk Considerations	Higher Risk Considerations
• Cases with no children under 5 • Current insurance coverage other than SoonerCare • No recent claims • Lower financial need (FPL of 228% or higher)	• Cases with children Under 5 • Members with chronic health conditions • Members in the middle of an episode of care • No current insurance coverage other than SoonerCare • Recent claims • Higher financial need (FPL under 228%)

Processes That Impact All Members

Verifications

Documentation requests for income and other verification will remain at 90 days instead of returning to 30 days during the 12-month post PHE period. This will allow members time to gather information, create accounts, and reset old account information. It will give OHCA staff extended time to process the large influx of verification and phone calls from members.

Returned Mail

Cases with returned mail will continue to be flagged so physical mail stops and alerts are set in Home View, Agency View, and the Provider Portal; however, eligibility will not be ended for "unable to locate."

Ex-parte Renewals

The State is evaluating additional data sources which may fill income verification gaps and is reviewing its ex-parte process to obtain a higher ex-parte renewal rate.

Notices

All members receive a DET-9001-D Case Status letter anytime their eligibility changes. The letter provides member specific information such as their eligibility period, denial reason, removal reason, and outstanding documentation requests and due dates. Below is the case level login and fair hearing information included in all DET letters:

You are required to tell the Oklahoma Health Care Authority within 10 days if there are any changes in your income, the people in your home or tax household, where you live or get your mail, your health insurance, or other changes in circumstances that might affect your family's eligibility for benefits. To report any changes login to your SoonerCare account at www.mySoonerCare.org and click Manage My Account. If you don't have a login, use the PIN provided at the top of this letter to create a User ID and Password to access your account. You will be required to register using an email address. You may also call Member Services.

SoonerCare Helpline: 1-800-987-7767
Insure Oklahoma Helpline: 1-888-365-3742
TDD/Oklahoma Relay 711

Refer to letter DET-9001-D and the case number listed at the top of this letter when you call.

You have the right to appeal any denied or reduced services. To appeal, send in an LD-1 form to the OHCA Docket Clerk in the OHCA Office of Hearings and Appeals. LD-1 Forms are available on OHCA's website at www.okhca.org. You may also call 405-522-7217 or email docketclerk@okhca.org to have one sent to you. A completed LD-1 form must be received by the Docket Clerk within 30 days of the date on this notice. Include a copy of this notice and any other information you want to be considered at the hearing. You may represent yourself at the hearing or you may have someone else speak for you. If you want someone else to speak for you, you must complete the "Authorized Representative Information" section on the LD-1.

Important notice to members whose services have been reduced or discontinued: If you want your services to be continued while your appeal is being decided, your LD-1 form must be received by the Docket Clerk within 10 days of the date on this notice. If you want to continue receiving services, and the appeal decision is not in your favor, you may have to pay for any services you received.

Flexibilities

OHCA submitted disaster-relief requests to the Centers for Medicare & Medicaid Services (CMS) for several flexibilities in response to the PHE. The requests were submitted through various 1135 waiver requests, Title XIX and Title XXI Children's Health Insurance Program (CHIP) disaster-relief state plan amendments (SPAs), as well as Home and Community-Based Services (HCBS) Appendix K requests. OHCA's requests are approved by CMS or authorized by federal legislation and CMS blanket approvals. The State's 11135 waiver requests and disaster-relief SPAs expire upon the termination of the PHE declaration.

The Families First Coronavirus Response Act (FFCRA) increased FMAP is available for qualifying expenditures incurred on or after January 1, 2020, and through the end of the quarter in which the PHE ends. The continuous enrollment requirement in section 6008(b)(3) of the FFCRA prevents states seeking to claim the temporary FMAP increase from terminating eligibility for individuals enrolled in Medicaid as of or after March 18, 2020, through the end of the month in which the PHE ends, even if the individual no longer meets eligibility requirements, unless the person voluntarily disenrolls or is no longer a state resident. The requirements of section 6008 of the FFCRA do not apply to separate CHIPs.

The ARP mandates the State provide COVID-19 related countermeasures without cost sharing to populations with the State's separate CHIP program, Soon-to-be-Sooners (STBS), through the end of the ARP period.

When the State makes a decision affecting a beneficiary's eligibility or when ending an authority results in a member's termination, reduction or change in benefits or services, the State must generally provide at least 10-days advance notice of the change and the beneficiary's right to a Medicaid fair hearing or a CHIP review. Fair hearing rights are not triggered when temporary flexibilities end at the conclusion of the PHE, but individuals still have the right to a fair hearing if the Agency's decision was made incorrectly.

Temporary or Permanent State-requested Disaster-relief Flexibilities Post-PHE

Title XIX Disaster-Relief Flexibilities

Title XIX Disaster-Relief Flexibilities	Status Post-PHE
Allow nurse practitioners, clinical nurse specialists, or physician assistants, working in accordance with State law, to order home health services as per the CARES Act.	**Approved Permanent Change Effectuated within Title XIX SPA 21-0026** (effective indefinitely)
Allow adults in the Medicaid program access to services (inclusive of crisis intervention services) provided by independently contracted clinical psychologists practicing within state scope of practice.	**ODMHSAS is pursuing a permanent Title XIX SPA** (effective indefinitely)

Title XIX Disaster-Relief Flexibilities	Status Post-PHE
OHCA will extend the current vaccine administration reimbursement methodologies, as per the Oklahoma Medicaid State Plan, to pharmacies for all Advisory Committee on Immunization Practices (ACIP) recommended vaccines • Coverage of ACIP-recommended vaccinations without cost sharing will be mandatory for adults enrolled in an ABP after the ARP coverage period.	OHCA is pursuing a permanent Title XIX SPA (effective indefinitely)
Establish a rate increase for private duty nursing (PDN) providers for PDN hours that result in over-time rate of pay for nursing staff. • The increase from $32/hour to $40/hour is to be applied only for persons with tracheostomies or who are ventilator dependent.	OHCA is pursuing a permanent Title XIX SPA (effective indefinitely)
Flexibility to reasonably exceed the time permitted (of 90 days) for the State to take final administrative action for Medicaid and CHIP beneficiaries, excluding requests for an expedited fair hearing in accordance with 42 C.F.R. § 431.224.	OHCA is pursuing a temporary waiver (effective for 12 months during the unwinding period)

1915(c) Disaster-Relief Flexibilities

1915(c) Disaster-Relief Flexibilities	Status Post-PHE
Community Waiver	
Temporarily allow HTS services to be participant directed.	Added to waiver effective 9/1/2020
Temporarily allow DHS/DDS case management to conduct required monitoring using Health Insurance Portability and Accountability Act (HIPAA) compliant phone and/or video conferencing.	Added to waiver effective 7/1/2021
Temporarily allow for payment of HTS services to assist with communication and stabilization when a member with COVID-19 or COVID-19 like symptoms is in a short-term care facility or hospital, not to exceed 30 consecutive days.	Added to waiver effective 7/1/2021
Temporarily allow professional providers to utilize HIPAA compliant telehealth.	Added to waiver effective 7/1/2021

1915(c) Disaster-Relief Flexibilities	Status Post-PHE
Temporarily allow the use of monitoring via HIPAA compliant phone or video conferencing in the Daily Living Support service setting.	Added to waiver effective 7/1/2021
Temporarily allow providers to monitor an employment site via HIPAA compliant phone or video conferencing.	Added to waiver effective 7/1/2021
Temporarily increase the combined additional cost limit for Prevocational services and Supported Employment services.	Added to waiver effective 7/1/2021
Temporarily allow the provision via HIPAA compliant phone or video conferencing in the Prevocational service setting.	Added to waiver effective 7/1/2021 (Can only supplement required face to face visits)
Temporarily allow provision of Habilitation Training Specialist service to adult members using HIPAA compliant phone or video conferencing in non-residential service settings.	Added to waiver effective 7/1/2021
Temporarily allow the completion of required signatures for consent forms to be obtained via mail or electronically.	Added to waiver effective 7/1/2021
Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA compliant teleconference or video conference team meetings are held. Verbal consent, including the date the individual planning meeting was held, should be documented on the service plan.	Added to waiver effective 7/1/2021 (Sign agreement to implement service plan electronically when plan is held virtually)
Temporarily allow the SD-HTS to be someone who lives in the same household for the IHSWs and Community Waiver	Adding to waiver effective 7/1/2022
Temporarily allow DHS/DDS case management to conduct team meetings, including individual planning meetings, via HIPAA compliant teleconference or videoconference.	Will be added to waiver effective 7/1/2022

1915(c) Disaster-Relief Flexibilities	Status Post-PHE
Temporarily allow addition of examination for eyeglasses and corrective lenses	Will be added to waiver effective 7/1/2022
Temporarily allow increase for dental services for adults to $3500 per year - does not apply to class members	Will be added to waiver effective 7/1/2022
Temporarily remove amount of public transportation services to be accessed within plan year	Will be added to waiver effective 7/1/2022
Temporarily allow limit for each family training service (individual and group) to increase from $5500 to $6500 per plan year	Will be added to waiver effective 7/1/2022
Homeward Bound Waiver	
Temporarily allow DHS/DDS case management to conduct required monitoring using HIPAA compliant phone and/or video conferencing.	Added to waiver effective 7/1/2021
Temporarily allow for payment of HTS services to assist with communication and stabilization when a member with COVID-19 or COVID-19 like symptoms is in a short-term care facility or hospital, not to exceed 30 consecutive days.	Added to waiver effective 7/1/2021
Temporarily allow professional providers to utilize HIPAA compliant telehealth.	Added to waiver effective 7/1/2021
Temporarily allow the use of monitoring via HIPAA compliant phone or video conferencing in the Daily Living Support service setting.	Added to waiver effective 7/1/2021
Temporarily allow providers to monitor an employment site via HIPAA compliant phone or video conferencing.	Added to waiver effective 7/1/2021
Temporarily increase the combined additional cost limit for Prevocational services and Supported Employment services.	Added to waiver effective 7/1/2021

1915(c) Disaster-Relief Flexibilities	Status Post-PHE
Temporarily allow the provision via HIPAA compliant phone or video conferencing in the Prevocational service setting.	Added to waiver effective 7/1/2021 (Can only supplement required face to face visits)
Temporarily allow provision of Habilitation Training Specialist service to adult members using HIPAA compliant phone or video conferencing in non-residential service settings.	Added to waiver effective 7/1/2021
Temporarily allow the completion of required signatures for consent forms to be obtained via mail or electronically.	Added to waiver effective 7/1/2021
Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA compliant teleconference or video conference team meetings are held. Verbal consent, including the date the individual planning meeting was held, should be documented on the service plan.	Added to waiver effective 7/1/2021 (sign agreement to implement service plan electronically when plan is held virtually)
Temporarily allow DHS/DDS case management to conduct team meetings, including individual planning meetings, via HIPAA compliant teleconference or videoconference.	Will be added to waiver effective 7/1/2022
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Temporarily allow increase for dental services for adults to $3500 per year - does not apply to class members	Will be added to waiver effective 7/1/2022
Temporarily remove amount of public transportation services to be accessed within plan year	Will be added to waiver effective 7/1/2022
Temporarily allow limit for each family training service (individual and group) to increase from $5500 to $6500 per plan year	Will be added to waiver effective 7/1/2022
In Home Supports Waiver for Adults	

1915(c) Disaster-Relief Flexibilities	Status Post-PHE
Temporarily allow DHS/DDS case management to conduct required monitoring using HIPAA compliant phone and/or video conferencing.	Added to waiver effective 7/1/2021
Temporarily allow for payment of HTS services to assist with communication and stabilization when a member with COVID-19 or COVID-19 like symptoms is in a short-term care facility or hospital, not to exceed 30 consecutive days.	Added to waiver effective 7/1/2021
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Temporarily allow provision of Habilitation Training Specialist service to adult members using HIPAA compliant phone or video conferencing in non-residential service settings.	Added to waiver effective 7/1/2021
Temporarily allow the completion of required signatures for consent forms to be obtained via mail or electronically.	Added to waiver effective 7/1/2021
Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA compliant teleconference or video conference team meetings are held. Verbal consent, including the date the	Added to waiver effective 7/1/2021 (sign agreement to implement service plan electronically when plan is held virtually)

1915(c) Disaster-Relief Flexibilities	Status Post-PHE
individual planning meeting was held, should be documented on the service plan.	
Temporarily allow the SD-HTS to be someone who lives in the same household for the IHSWs and Community Waiver	Adding to waiver effective 7/1/2022
Temporarily allow DHS/DDS case management to conduct team meetings, including individual planning meetings, via HIPAA compliant teleconference or videoconference.	Will be added to waiver effective 7/1/2022
Temporarily allow addition of examination for eyeglasses and corrective lenses	Will be added to waiver effective 7/1/2022
Temporarily allow increase for dental services for adults to $3500 per year - does not apply to class members	Will be added to waiver effective 7/1/2022
Temporarily remove amount of public transportation services to be accessed within plan year	Will be added to waiver effective 7/1/2022
Temporarily allow limit for each family training service (individual and group) to increase from $5500 to $6500 per plan year	Will be added to waiver effective 7/1/2022
In Home Supports Waiver for Children	
Temporarily allow professional providers to utilize HIPAA compliant telehealth.	Added to waiver effective 7/1/2021
Temporarily allow the use of monitoring via HIPAA compliant phone or video conferencing in the Daily Living Support service setting.	Added to waiver effective 7/1/2021
Temporarily allow providers to monitor an employment site via HIPAA compliant phone or video conferencing.	Added to waiver effective 7/1/2021
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Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA compliant teleconference or video conference team meetings are held. Verbal consent, including the date the individual planning meeting was held, should be documented on the service plan.	Added to waiver effective 7/1/2021 (sign agreement to implement service plan electronically when plan is held virtually)
Temporarily allow the SD-HTS to be someone who lives in the same household for the IHSWs and Community Waiver	Adding to waiver effective 7/1/2022
Temporarily allow increase for dental services for adults to $3500 per year - does not apply to class members	Will be added to waiver effective 7/1/2022
Temporarily remove amount of public transportation services that can be accessed within plan year	Will be added to waiver effective 7/1/2022
Temporarily allow limit for each family training service (individual and group) to increase from $5500 to $6500 per plan year	Will be added to waiver effective 7/1/2022
Medically Fragile Waiver	
Allow certified case management and skilled nursing to conduct required service planning and monitoring activities using Tele-Health; phone and/or video conferencing.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)

1915(c) Disaster-Relief Flexibilities	Status Post-PHE
Temporarily modify person-centered service plan development to allow increased service delivery after documentation of changes on the plan but prior to authorization of the service.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Temporarily allow professional providers to utilize telehealth and will be utilized in accordance with HIPPA requirements.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Temporarily allow legal guardians and authorized representative to provide Personal Care and Advanced Supportive/Restorative services under the self-direction model in the absence of the regular paid caregiver. (With language revisions)	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Temporarily suspend Eligible Provider Exception requirements to allow family members/legal guardians to provide personal care services for Medically Fragile waiver members including personal care, advanced supportive/restorative and self-directed services.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Allow legal guardian, power of attorney, spouse or authorized representative to provide personal care services as needed. (With language revisions)	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Allow online training of personal care attendants (for all PCS types) to be done electronically.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Allow increases in PCA to be provided once added to the plan of care and without awaiting prior authorization.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Allow for the increased provision of home delivered meals up to two times per day, seven days per week, for a total of 14 meals per week.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Temporarily allow for respite services to be provided in a nursing facility contracted with OHCA when members needing nursing facility respite are in an area with no Medically Fragile waiver contracted providers. (With language revisions)	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Allow signatures for service plan development to be obtained via e-signature or US postal mail from the case manager.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Reassessment for ongoing Medically Fragile waiver eligibility will continue as per the waiver. When questions regarding ongoing eligibility exist, the nurse will contact the case manager and/or Medically Fragile	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)

1915(c) Disaster-Relief Flexibilities	Status Post-PHE
waiver member for additional information to validate ongoing eligibility.	
Provider trainings for Case Management and Home Health providers will be modified to an on-line training format.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Required case management assessment, reassessment, and monitoring visits will be conducted by phone or video conferencing unless an extreme situation warrants an in-person visit. Video conferencing will be utilized in accordance with HIPPA requirements.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Required skilled nursing visits for monitoring/supervision of personal care services may be completed via phone or videoconferencing. Nursing visits for direct care should be completed in person when feasible. Phone consultation for direct care supervision should occur only when member access to teleconferencing technology is unavailable.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
State will allow the use of Tele-health through options such as mobile video conferencing, Zoom, etc. and will be done in accordance with the HIPPA requirements. Signatures to verify time and date of meeting(s) will be obtained through an e-signature process or through U.S. Postal mail with the meeting date and time. Service plans authorized pending member signature will have case management services conditionally authorized for up to 45 days to ensure receipt.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Providers of Speech Therapy, Physical Therapy and Occupational Therapy, may utilize video conferencing/telehealth during times of emergency declaration and will be utilized in accordance with HIPPA requirements.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)

Temporary ARP-Mandated Disaster-Relief Flexibilities

ARP-Mandated Requests	Status Post PHE
Assurance to CMS for coverage and reimbursement of COVID-19 vaccine and vaccine administration for individuals receiving Family Planning or Tuberculosis benefits without cost sharing	OHCA is pursuing a TEMPORARY Title XIX ARP SPA (effective 3/11/2021 through the day the PHE ends)

ARP-Mandated Requests	Status Post PHE
Assurance to CMS for coverage and reimbursement of COVID-related countermeasures for TXIX individuals receiving full Medicaid benefits without cost sharing: • Vaccine administration • COVID-19 vaccine counseling for children under the age of 21 • Testing services • Testing-related services, and treatments for COVID-19, including, specialized equipment, and therapies (including drugs) • Treatment for conditions that may seriously complicate the treatment of COVID	OHCA is pursuing a TEMPORARY Title XIX ARP SPA (effective 3/11/2021 through 15 months post-PHE)
Assurance to CMS for coverage and reimbursement of COVID-related countermeasures for all TXXI individuals (including S-CHIP) without cost sharing: • Vaccine administration • COVID-19 vaccine counseling for children under the age of 21 • Testing services • Testing-related services, and treatments for COVID-19, including, specialized equipment, and therapies (including drugs) • Treatment for conditions that may seriously complicate the treatment of COVID	OHCA is pursuing a TEMPORARY Title XXI ARP SPA (effective 3/11/2021 through 15 months post-PHE)
Assurance to CMS for coverage of COVID-related countermeasures for all other TXIX individuals without cost sharing: • Treatments for COVID-19, including, specialized equipment, and therapies (including drugs) • Treatment for conditions that may seriously complicate the treatment of COVID	OHCA is pursuing a TEMPORARY 1115 Demonstration ARP Waiver (effective 3/11/2021 through 15 months post-PHE)

Disaster-Relief Requests Pending Post-PHE Status

1915(c) HCBS Waiver Flexibilities

1915c HCBS Waiver Flexibilities	Status Post-PHE
Advantage Waiver	
Temporarily modify service scope and coverage, exceeding certain service limitations, adding services, expanding service settings, suspending exception requirements, modifying provider qualifications, modifying licensure requirements, modifying level of care evaluation processes, modifying person-centered	Pending LTCSS & OHS Expires 6 Months after the PHE Ends

1915c HCBS Waiver Flexibilities	Status Post-PHE
service plans, modifying incident reporting requirements, allowing payments for hospitalized services, including retainer payments, and allowing for video conferencing/telehealth opportunities.	
Allow an extension of three months to respond to the Draft Quality Review Report for the Advantage Waiver.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends
Update the end date to 1/26/2021	Pending LTCSS & OHS Expires 6 Months after the PHE Ends
Temporarily increase payment rates for home care services, adult day health services, assisted living services, hospice services, and nursing facility respite services.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends
Update the end date to six months after the PHE expiration.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends
Temporarily include a retroactive COVID-19 add on payment not to exceed 20% of the provider's current rate during the period beginning October 1, 2020 through December 31, 2020.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends

Terminating Disaster-Relief Flexibilities Post-PHE

1135 Waiver Flexibilities

1135 Waiver Flexibilities
Waiver of 42 CFR 431.408(a)(3) to conduct all public hearings required for waiver submission virtually rather than in person.
Waiving certain provider enrollment requirements, such as provider enrollment fees, criminal background checks associated with fingerprint-based criminal checks, site visits, screening levels, and in-state/territory licensure.
Temporarily suspending the revalidation of all providers located in Oklahoma or otherwise directly impacted by the PHE.
Waive the requirement that critical access hospitals limit the number of beds to 25 and the length of stay be limited to 96 hours.
Suspend the three-day prior hospitalization for coverage of a skilled nursing facility stay for the duration of the emergency.
Waive Emergency Medical Treatment and Labor Act (EMTALA) sanctions for redirection of an individual to receive a focused medical screening examination related to COVID-19 in an alternative location.

1135 Waiver Flexibilities
Suspend minimum data set submission requirements for clients in non-skilled nursing facilities for 60 days.
Allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA compliant teleconference or video conference team meetings are held.
Postponing member-eligibility renewals scheduled to occur during the emergency declaration.
Temporarily delay scheduling Medicaid fair hearings and issuing fair-hearing decisions during the emergency period to allow an additional 120 days to appeal and issue decisions.
Added flexibility to suspend or modify prior authorization requirements for accessing covered state plan and waiver benefits during the emergency period. OHCA will only utilize this option if unable to review and process PAs due to staff shortage or technology failure.
Waive state plan or waiver-imposed utilization controls on covered benefits to the extent such limits cannot be exceeded based on medical necessity in the relevant approved state plan or waiver authority.
Allowing expanded use of telehealth through the end of the declared PHE for most SoonerCare reimbursable services.
Waive pre-admission screening and annual resident review level I and II for 30 days.
Allow durable medical equipment providers to waive replacement requirements, such as the face-to-face requirement, new physician's order, and a renewal medical necessity documentation.
Waiver of face-to-face encounter requirements for reimbursement in 42 CFR 405.2463(a)(B)(3) and 42 CFR 440.90(a) for FQHCs, RHCs, and Tribal 638 Clinics to allow for telephonic services provided by clinic providers for new or established clinic patients. Telephonic services would be reimbursed on a fee-for-service basis and not PPS.
Waiver of requirement for Tribal 638 clinics that services be provided within the clinic four walls except for homeless populations per 42 FR 440.90 to allow for the screening and testing away from patient areas and allow for services to homebound and others. Tribal 638 clinics would be able to bill these visits at the federally established OMB rate methodology. **CMS has extended the grace period for states and Tribal facilities to come into compliance with the "Four Walls" requirement under 42 C.F.R. § 440.90 to nine months after the PHE ends**
Waiver of the requirement that clinic services must be provided within the four walls of the clinic pursuant to 42 CFR 440.90 to allow for the screening and testing away from patient areas and allow for services to homebound and others. **CMS has extended the grace period for states and Tribal facilities to come into compliance with the "Four Walls" requirement under 42 C.F.R. § 440.90 to nine months after the PHE ends**
Allow payment for personal care services rendered by legally responsible individuals for the period of the PHE.
Flexibility allowing providers to receive payments for services provided to affected SoonerCare members in alternative physical settings, such as mobile testing sites, temporary shelters, or facilities. This would include allowing facilities such as NFs, ICF/IIDs, PRTFs and

1135 Waiver Flexibilities
hospitals to be fully reimbursed for services rendered during an emergency evacuation to an unlicensed facility (where an evacuating facility continues to render services). The facility would be responsible for determining how to reimburse the unlicensed facility. This arrangement would only be effective for the duration of the Section 1135 Waiver. However, after the initial 30 days, CMS would require the unlicensed facility either seek licensure or the evacuating facility would need to seek new placement for the individuals.

Title XIX Disaster Relief Flexibilities

Title XIX Disaster Relief Flexibilities
Modify the requirement to submit a SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020.
Waive public notice requirements that would otherwise be applicable to this SPA submission.
Request to notify tribal partners of all SPA changes on or before submission to CMS as well as offer a telephonic meeting to discuss or consult with Tribes at the next regularly schedule bi-monthly consultation meeting.
Eligibility
Allow hospitals to make presumptive eligibility (PE) determinations for non-MAGI individuals, including: • Individuals Eligible for But Not Receiving Cash Assistance, 1902(a)((10)(A)(ii)(I) • Individuals Eligible for Cash Except Institutionalization, 1902(a)(10)(A)(ii)(IV) • Optional State Supplemental Beneficiaries, 1902(a)(10)(A)(ii)(XI) • Individuals in Institutions Eligible under a Special Income Level, aged, blind, and disabled individuals, 1902(a)(10)(A)(ii)(V) and 1905(a)(iii), (iv) and (v) • Age and Disability-Related Poverty Level, 1902(a)(10)(ii)(X) and 1902(m)
Disregard resources or built-up assets that result from any payment made by the federal, state, local, or tribal government to relieve the adverse economic impacts of the COVID-19 pandemic that would have otherwise been part of an individual's liability for his or her institutional services based on application of the post-eligibility treatment-of income (PETI) rules but which became countable resources on or after March 1, 2020 and/or retained through the end of the PHE for individuals who are 65 years of age or older or are disabled individuals.
Flexibility to reasonably exceed (by 30 days) the time permitted (of 90 days) for the State to take final administrative action for Medicaid and CHIP beneficiaries (for a total of 120 days), excluding requests for an expedited fair hearing in accordance with 42 C.F.R. § 431.224, effective July 1, 2021. **(Pending CMS concurrence)**
Benefits
Establish coverage of mobile COVID-19 testing sites.

Title XIX Disaster Relief Flexibilities
Aligning the Expansion Adult ABP with the previously approved disaster-relief requests to apply newly added and/or adjusted benefits to Alternative Benefit Plans (ABP).
Change the 34-day supply prescription quantity limit to allow for a 90-day supply.
Expand prior authorization for medications by automatic renewal without clinical review, or time/quantity extensions.
Provider Reimbursement
Allow rural/independent Medicaid-enrolled hospitals to request an interim payment.
Establish a supplemental payment based on the cost for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), in a form of a one-time lump sum to eligible nursing facilities serving residents classified by the State as ventilator dependent.
Allow a temporary supplemental payment for long-term care facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to support increased costs due to COVID-19. The effective date for the supplemental payments will be retroactive to July 1, 2020 and will end on June 30, 2021. If the PHE is extended past June 30, 2021 supplemental payments will continue to be made to eligible facilities.
Waive the penalties for possibly preventable readmissions that exceed 100% of the statewide average.
Increase the number of therapeutic leave days in nursing facilities (NFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) from 7 days NF & 60 days ICF-IID to 10 days NF & ICF-IID 70 days.
Waive the provision that payments for therapeutic leave days could not exceed a maximum of 14 consecutive days per absence for ICF/IIDs.

1115 SoonerCare Choice Demonstration Flexibilities

1115 SoonerCare Choice Demonstration Flexibilities
Suspend premium obligations as a requirement for eligibility in the Insure Oklahoma Individual Plan during the emergency period as well as accept, for purposes of eligibility. IO IP members were transitioned to Medicaid Expansion.

1915(c) HCBS Disaster-Relief Flexibilities

1915(c) HCBS Disaster-relief Flexibilities	
Community Waiver	
20% retroactive rate add-ons (4/1/20-9/30/20, 10/1/20-12/31/20)	The retroactive provider rates will end Sept 2022
Homeward Bound Waiver	
20% retroactive rate add-ons (4/1/20-9/30/20, 10/1/20-12/31/20)	The retroactive provider rates will end Sept 2022

In Home Supports Waiver for Adults	
20% retroactive rate add-ons (4/1/20-9/30/20, 10/1/20-12/31/20)	The retroactive provider rates will end Sept 2022
In Home Supports Waiver for Children	
20% retroactive rate add-ons (4/1/20-9/30/20, 10/1/20-12/31/20)	The retroactive provider rates will end Sept 2022
Medically Fragile Waiver	
Temporarily allow for payment of personal care assistance services when a member is in a short-term care facility or hospital for a duration and not to exceed 30 days consecutively.	Expires 6 Months after the PHE Ends
Remove requirement of in-home training for Advanced Supportive/Restorative Assistants and waiver requirement for annual in-service training.	Expires 6 Months after the PHE Ends
Allow PCA to be provided in an acute care setting when needed to assist members with communication, intensive personal care, behavioral stabilization, or other supports the hospital is unable to provide, not to exceed 30 consecutive days.	Expires 6 Months after the PHE Ends
Temporarily allow for the provision of nursing facility respite services up to a period of 30 days.	Expires 6 Months after the PHE Ends
Allow all case management activities to be completed electronically, including service plan development and service monitoring.	Expires 6 Months after the PHE Ends
Initial medical eligibility assessment will be completed by a OHCA care management nurse using the UCAT. Video conferencing should include face time with the member and staff when possible and will be utilized in accordance with HIPPA requirements.	Expires 6 Months after the PHE Ends
Temporarily modify annual provider qualifications by extending current verification from annually to up to every other year.	Expires 6 Months after the PHE Ends
Service plan modifications, increases of personal care services may be implemented once documented on the member's plan and prior to authorization. This does not apply to service decreases, which will continue to require service authorization	Expires 6 Months after the PHE Ends
Suspend the requirements for community activities including efforts to pursue community integrated efforts, as well as the requirements for allowing visitors (providers may prohibit/restrict visitation in-line with CMS recommendations).	Expires 6 Months after the PHE Ends