OKLAHOMA

Health Care Authority

Oklahoma Public Health Emergency Unwinding Approach

TABLE OF CONTENTS

OKLAHOMA UNWINDING APPROACH

Following guidance provided by CMS in the SHO 20-004, SHO 21-002, SHO 22-001, SHO 23-002, and the Consolidated Appropriations Act, 2023 (CAA), Oklahoma developed an unwinding plan for the public health emergency (PHE) that was intentional and compassionate, giving consideration to our most vulnerable members. The plan maintained the goals of keeping eligible members enrolled, minimized ineligible members who are enrolled, minimized member burden, achieved a sustainable renewal schedule, and met the timeline set forth by CMS by utilizing a formula that prioritized members in the middle of an episode of care, with chronic health conditions, with children under five years of age, or with higher financial need.

While the continuous enrollment condition was in effect, Oklahoma maintained application processing standards and did not stop conducting eligibility redeterminations. Oklahoma had real-time eligibility for MAGI and did 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 Oklahoma Health Care Authority implemented systemwide changes in response to the COVID-19 public health emergency provision period. These included but are not limited to:

- Safeguarding the member's eligibility.
- Eliminating premium payments.
- Notifying members of system updates being made to ensure member safety and access to care during this critical time.
- Implementing OHCA eligibility policy changes for MAGI application processing.

At the end of the public health emergency, OHCA resumed the normal processing of eligibility with some modifications. These modifications were created to ensure operational stability while maintaining safeguards to protect the most vulnerable members.

Members were 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 were reprocessed and compared with data matches to determine if they may be eligible for their current program or another program. Those not eligible for any program had their coverage end and were referred to the Federal Health Insurance Marketplace. Those found eligible had their current coverage extended or were moved to a new program the following month.

RESUMING NORMAL OPERATIONS

Oklahoma's Medicaid population obtains and renews eligibility in one of two ways: via the MySoonerCare.org website portal for MAGI, or via the Oklahoma Department of Human Services (OKDHS) through the OKDHSLive.org portal or local OKDHS office for non-MAGI. OHCA and OKDHS have different PHE renewal/redetermination start-up processes.

MAGI

States were required to initiate renewals for all individuals enrolled within 12 months of the continuous enrollment condition expiring. OHCA utilized the option allowed by CMS of initiating renewals in March 2023 before the end of the continuous eligibility requirement, ensuring no terminations occurred until after the continuous enrollment period ended.

At the end of the PHE on May 11, 2023, OHCA resumed the normal processing of eligibility with some modifications. These modifications were created to ensure operational stability while maintaining safeguards to protect the most vulnerable members. This plan breaks out how the system would be processing:

- Ineligible members currently under PHE protections.
- Restarting processes that were put on hold due to PHE.

While the continuous enrollment condition was in effect, Oklahoma had maintained application processing standards and had not stopped conducting eligibility redeterminations. Oklahoma has real-time eligibility and did 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 stopped the process of extending coverage and resumed the normal processing of eligibility with some modifications on May 12, 2023. These modifications were created to ensure operational stability while maintaining safeguards to protect the most vulnerable members.

Member Notices

PHE-protected members received the following notices:

1. On Feb. 13, 2023, a one-time letter was sent on purple paper to everyone on the PHE-protected list informing them that continuous eligibility is ending, and renewals will be resuming. This was considered the first letter.
2. On March 1, 2023, new Federal Poverty Levels (FPLs) were loaded for the April 1 effective date and all ofthe PHE-protected population were reprocessed to check eligibility under the new FPLs:
    a. Members found to be eligible under new FPLs received a 9001 Case Status letter with new certification information.
    b. All remaining PHE-protected members were assigned a renewal date based on unwind prioritization criteria, and a 9001 Case Status letter was sent to alert the member that they are approved through their assigned renewal date. This was considered the second letter.
3. Starting March 10, 2023, members with an April 30, 2023, end date were processed through the ex parte renewal process:
    a. Members who successfully renewed through ex parte received a 9001 Case Status letter with new certification information.

b. Members who do not pass ex parte renewal received the 9002 Case Renewal Notice giving them a 45-day renewal notice. Members were instructed to log into MySoonerCare.org to complete their prepopulated renewal application or to call the member services call center for assistance or to request a paper renewal form. This was considered the third notice.
c. This process was repeated on the 10th day of each month for PHE-protected members who were scheduled for renewal the end of the following month.

4. Members who took action on the 45-day renewal notice:
    a. A member who completed their renewal successfully and was approved for a new certification period received a 9001 Case Status letter with new certification information.
    b. A member who was not approved for new certification received a 9001 Case Status letter with a denial reason and assigned renewal date. This was considered the fourth notice.
5. Members who took no action on the 45-day renewal notice or were denied in earlier renewal attempts received a final termination notice on the 15th day of the last month of eligibility as the final termination of benefits notice. This was considered the fifth notice.

Below is the case level login and fair hearing information included in the case status letters:

A household member(s) eligibility is scheduled to end on _____

You will need to reapply and be approved to continue your coverage. Logon to your account at www.mysoonercare.org to reapply. You may also call the SoonerCare helpline at 1-800-987-7767 for help reapplying or to request a paper renewal form.

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.

Logon to your account at mysoonercare.org to report any changes. You will be required to register using an email address.

You may also call the SoonerCare helpline at 1-800-987-7767 to report any changes. Refer to the letter number 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 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.oklahoma.gov/ohca. Type in "Forms and Guides" to the search bar for a list of forms. 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. You must complete the "Authorized Representative Information" section on the LD-1 if you want someone else to speak for you.

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 should state you are requesting your services to be continued while your case is on appeal. If you continue receiving services, and the appeal decision is not in your favor, you may have to pay for any services you received.

Currently Eligible Cases

During the 12-month post-continuous eligibility period, application dates were

adjusted for cases with children under five. This assisted with the renewal bulge, alleviating operational burden and protecting coverage for at-risk children. This risk-based approach ensured continuity of coverage for a population that tends to have stable eligibility.

Beginning May 1, 2023, the daily data fixes that extended eligibility for the PHE-protected ineligibles were modified to ensure continuous eligibility until the final PHE unwind period.

For current Medicaid eligible members on or after May 1, 2023, changes of circumstance and data exchange processes began to have a real impact as eligibility was no longer extended for newly ineligible members. At this point, the 12- day end date was applied when appropriate.

During the 12-month post-continuous eligibility period, documentation requests for income and other verification remained at 90 days instead of returning to 30 days. This allowed members time to gather information, create accounts, and reset old account information. It also gave staff extended time to process the large influx of verification and phone calls from members.

Ineligible Members Under PHE Protections

All PHE-protected members had eligibility renewal dates of April 30, 2023. Beginning March 1, 2023, these members were assigned a new renewal date based on their specific situation and health conditions.

Ineligible members' coverage ended over the course of the nine-month period following the end of continuous enrollment for PHE-protected individuals on April 30, 2023. This plan allowed members who were at high risk to have their coverage protected for a longer period while lower risk members were phased out earlier. Additional groups were added as they were identified.

Members were aligned and reprocessed at a case level to minimize member burden, allowing families to receive one request for information, and align families for future years. Prior to having their coverage ended, members were reprocessed and compared with data matches to determine if they might be eligible for their current program or another program. Those that were not eligible for any program had their coverage ended and were referred to the Federal Health Insurance Marketplace. Those that were found eligible had their current coverage extended or were moved to a new program the following month.

Population Prioritization

Oklahoma developed a risk-based approach for prioritizing members through the unwind process in alignment with the goal of protecting our most vulnerable members. OHCA reviewed the circumstances of our PHE-protected population to determine if a member was higher or lower risk. To achieve the goal of aligning and reprocessing on a case level, each case was 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%)

Verifications

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

Ex Parte Renewals

The state evaluated additional data sources which might fill income verification gaps and reviewed its ex parte process to obtain a higher ex parte renewal rate.

Fair Hearings

When PHE ended, the state began to process fair hearing requests timely and take final administrative action within 90 days of the receipt of the request for non-expedited requests. The state anticipated 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 increased the number of staff to address pre-fair hearing work, research, and appeals. OHCA engaged stakeholders, community partners and agency partners to communicate any process changes and address member eligibility determination questions. OHCA increased eligibility call center staff to address and resolve member questions regarding their eligibility determinations. In addition, Oklahoma requested a waiver to allow the state more time to render a fair hearing decision from 90 to 120 days.

Non-MAGI

As of February 2023, Oklahoma Human Services began mailing customers notices to complete their annual review for an eligibility re-determination. The notices were sent in batches spread out through a 12-month period. Customers determined to be ineligible were removed from SoonerCare (Medicaid) upon the completion of their re-determination review and referred to other medical-based programs. Non-MAGI customers were also sent a letter instructing them how to apply for coverage through the Marketplace.

Per CMS guidance, the review process was done in conjunction with the USDA SNAP unwinding efforts if applicable. The steps are outlined as followed:

1) If there was open SNAP case, the renewal dates were synchronized with next SNAP renewal.
2) If there was no open SNAP case, the renewal date was updated to the same month, but the year was updated to 2022 (making it due in 2023).

Delinquent reviews did not trigger additional renewal notices and OKDHSLIVE was not available to the household after the review period expired. These updates allowed the system to send a new renewal notice and give the household the ability to submit the renewal through OKDHSLIVE. This process also balanced the workload over the course of the 12 months allowed. The first two rounds of updates were completed in February 2023.

The number of cases with expected reviews increased between July and August of 2023. We believed attrition would balance this load over time. However, we analyzed it in July 2023 and balanced higher volume of reviews over the remaining months to ensure manageable workloads.

New Review Month	Notice Issued	Work Done In	Number of Cases
April	February 2023	March 2023	18,934
May	March 2023	April 2023	19,875
June	April 2023	May 2023	20,823
July	May 2023	June 2023	21,836
August	June 2023	July 2023	21,549
September	July 2023	August 2023	23,018
October	August 2023	September 2023	24,536
November	September 2023	October 2023	23,406
December	October 2023	November 2023	27,387
January	November 2023	December 2023	12,495
February	December 2023	January 2024	6,969
March	January 2024	February 2024	7,269

These reviews could be completed via OHS' OKDHSLIVE website, Customer Services Benefits Line at 405-522-5050 and in-person at any local OHS retail hub. A refresher training for re-determining financial eligibility was developed for the OHS Family Services Specialist staff.

As of June 2023, procedural terminations were paused per CMS. A couple of redistribution runs were performed that extended the renewal date by two months. Those redistribution runs also contained any pending reviews that remained including those that fell within the SNAP e14 Strategy.

A systematic mechanism was put in place in order to prevent further procedural terminations (EXer).

RETURNED MAIL

Oklahoma made a good-faith effort to contact a member using more than one modality when return mail was received in response to a redetermination of eligibility to comply with section 6008 (f)(2)(C) of the Families First Coronavirus Response Act (FFCRA), as added by section 5131(a) of the CAA.

MAGI Process

OHCA followed these steps to meet the returned mail condition.

1. For all members who had returned mail, OHCA sent a notice in their MySoonerCare.org account to alert the member they had returned mail. This counted as the first modality of outreach.
2. If returned mail had complete information:
    a. OHCA verified the accuracy of the address on the returned mail against the information on file and any errors or incomplete information were corrected, and the mail was resent.
    b. If the mail was not returned, this counted as the second modality of outreach and the state made no further outreach attempts.
    c. If the mail was returned again, the state proceeded with the returned mail process.
3. If returned mail had a forwarding address:
    a. If mail was returned with a forwarding address provided by USPS, OHCA updated the address on file with authority granted by the 1902(e)(14) waiver and forwarded the mail to the correct address.
    b. If the mail was not returned, this counted as the second modality of outreach, and the state made no further outreach attempts.
    c. If the mail was returned again, the state proceeded with the returned mail process.
4. If mail was returned after updating/correcting the address as provided by USPS *or* if there was no forwarding address:
    a. OHCA sent an email to the member alerting them that they had returned mail. This met the second modality of outreach and the state made no further outreach attempts.
    b. If there was no email address on file, OHCA sent a text message to the member alerting them that they had returned mail. This met the second modality of outreach and the state made no further outreach attempts.
    c. If there was no cell phone on file capable of receiving a text message, an outbound call was made to the member alerting them that they had returned mail. This met the second modality of outreach and the state made no further outreach attempts.

Non-MAGI Process

For all members who had returned mail, OHS used SMS messaging, emails and initiated outbound calls in a good faith effort to contact the individual.

UP-TO-DATE CONTACT INFORMATION

As outlined under section 6008(f)(2)(B) of the FFCRA, as added by section 5131(a), Oklahoma attempted to ensure that it had up-to-date contact information, specifically mailing address, phone number and email address, for all members for whom the state

conducted a renewal.

MAGI Process

OHCA used the state's Health Information Exchange (HIE) to verify that the state had the member's current phone number, email address and mailing address prior to initiating renewals. OHCA set up a file exchange with the HIE and updated the member's contact information with authority granted by the 1902(e)(14)(A) waiver. While the state used the information obtained from the HIE to update the member's mailing address and phone number, the state did not update the member's email address if a new one was received from the HIE. The member's email address is used as their username to log into their MySoonerCare.org account. Changing their email address without the member's knowledge could potentially lock them out of their account.

As OHCA was not updating the member's email address, the state implemented member outreach strategies to prompt members to update their phone number, mailing address and email address themselves. OHCA's outreach strategies included verifying contact information when speaking to a member, social media campaigns, member newsletter articles, and website messaging that specifically encouraged members to update their email address, mailing address and contact information.

Non-MAGI Process

OHS does not a have an automated process in place to verify current phone number or email address for initiated renewals. In the SHO-23-002, CMS states that states may look to beneficiaries themselves as a source to provide updated contact information and may use outreach efforts to obtain updated contact information. OHS used multiple modes of communication as part of their robust plan to update the member's mailing address, email address and phone number. OHS updated the member's address via the OKDHSLIVE website, benefit line and in person. OHS outreach strategies included verifying contact information when speaking to a member, social media campaigns and website messaging that specifically encouraged members to update their email address, mailing address and contact information.

COMMUNICATIONS PLAN

Phase 1

Phase 1 of Oklahoma's communications plan began in August 2021 and continued through January 2023. The goal of Phase 1 was to encourage potentially affected members to update their information in the member portal, educate stakeholders on the PHE, and ensure there was consistent messaging regarding the PHE across all platforms.

Oklahoma was committed to upholding accessibility standards across all forms of communication with members. For more information, please visit this page. Communications were 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.*

Stakeholder	Communications
Members	• Created PHE page on Oklahoma.gov/ohca • Created PHE page on MySoonerCare.org • Targeted email campaign to PHE-protected members • Initiated robocalls • Released "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 had outdated information • Sent provider global alerts to inform/educate providers • Sent e-newsletters to all providers • Targeted providers seeing high numbers of PHE-protected members • Connected with provider associations • Provided flyers to display in offices • Global messages for PHE announcements from HHS
Media	• Sent press release to statewide media outlets • Scheduled one-on-one interviews with key media • Provided FAQs to media
Partners	• Held virtual meetings with community partners and navigators • Provided a PHE toolkit for agency partners, community partners and navigators • Ensured messaging was consistent across agency partner websites and social media • Engaged tribal partners

Employees	• Polled staff to establish employee understanding of PHE • Developed call scripts for staff • Educated staff in weekly e-newsletter

Stakeholder	Communications
	• Educated employees in town hall meetings
Other Stakeholders	• Provided PHE toolkit to other stakeholders • Ensured messaging was consistent across all platforms • Provided talking points • Created flyers and one-sheets for legislators • Partnered with BCBS regarding PHE communications • Created a toolkit using CMS guidelines • Issued press releases, social media and emails for PHE announcements from HHS

Phase 2

Phase 2 of Oklahoma's communications plan began in January 2023 after the CAA was signed. The goal of Phase 2 was to educate PHE-protected members, staff and stakeholders on the end of the continuous eligibility requirements and available resources, and to ensure consistent messaging across all platforms.

Oklahoma was committed to upholding accessibility standards across all forms of communication with members. For more information, please visit this page. Communications were sent in English and Spanish, which are the two primary languages in Oklahoma.

Stakeholder	Communications
Core Messaging: *To educate on the end of the PHE, their specific end date and resources.*	

Members	• Sent a one-time purple letter to all ineligible members • Produced animated educational video around the purple letter • Sent an email to all ineligible members • Sent targeted emails to members with missing information • Sent a text message to all ineligible members encouraging them to view their mail and email for important information • Updated the website with end of PHE information, resources and next steps • Updated social media platforms with the end of the PHE information, resources and next steps • Created a campaign based off one color as a way to bring attention to notices • Sent a one-time text message to all incorrect mailing address and all with no email address on file • Sent text messages and email to parents whose children may still qualify for coverage • Shared information in monthly e-newsletter

Stakeholder	Communications
Providers	• Targeted providers who saw PHE-protected members • Flyers urged parents to verify their children's eligibility status • Shared information in monthly e-newsletter
Media	• Submitted a press release with updated information on end of PHE and resources available for members • Conducted media interviews urging parents to verify their children's eligibility, even if they recently lost coverage

Partners	• Provided community partners, agency partners and navigators with education, training and meetings • Used communications toolkit to educate community partners, agency partners and navigators on consistent messaging and FAQs • Ran a PSA TV campaign with the Oklahoma Department of Insurance promoting Marketplace • Targeted flyers with trackable QR codes urging parents to verify their children's eligibility status
Employees	• Educated employees in staff newsletter • Educated employees in town hall meetings
Other Stakeholders	• Used communications toolkit to educate legislators • Held one-on-one meetings with legislators • Provided education through electronic newsletters • Provided talking points and one-sheets to legislators and assistants

TRAINING PLAN

The following training plan supported the unwinding of the public health emergency for SoonerCare.

The COVID-19 outbreak and implementation of federal policies to address the PHE disrupted routine Medicaid eligibility and enrollment operations. Medicaid enrollment in Oklahoma had grown to approximately 1.3 million individuals mostly due to the continuous enrollment condition. Oklahoma estimated that approximately 300,000 Medicaid members who were receiving continuous eligibility would lose eligibility when the state began processing renewals. It was critical to ensure the state of Oklahoma maximized effectiveness with renewals of eligibility by solidifying an orderly process that minimized the burden on members and promoted continuity of coverage for all members, eligible and ineligible, where possible.

Training and Development Timeline

Development

- Began first draft of training materials - February 25, 2022
- First draft of training materials due - March 25, 2022
- Biweekly workgroup meetings began - March 29, 2022
- Training materials finalized - April 22, 2022

Training

- Eligibility & Coverage Services staff training - began 45-60 days before the end of the continuous enrollment requirement
- OHCA staff training - began 45 days before the end of the continuous enrollment requirement
- Contractor training - began 45-60 days before the end of the continuous enrollment requirement
- Agency partner training - began 30 days before the end of the continuous enrollment requirement

Instructors

OHCA's training academy instructors provided the training for OHCA personnel, contractors and agency partners.

Training Plan Overview

Once the continuous enrollment end date was confirmed, all OHCA staff, contractors, agency partners and community partners were notified. Those groups were aware of the challenges the PHE created with the continuous eligibility requirement. Training was 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. That group was the front line of call center agents assisting members daily through the SoonerCare helpline. The Eligibility & Coverage Services staff routinely helped members with maintaining eligibility, completing applications, assisting with access to care and understanding their benefits. It was critically important that this primary group had an excellent foundation for understanding the needs of the individuals who were losing eligibility for Medicaid but were possibly eligible for other insurance affordability programs.

Additional call tree groups included 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 facilitated manager, director and instructor-level training and provided materials as needed for the additional call tree groups.

Additionally, to support eligibility staff in steady state operations separate from the PHE unwind training, a full review of the SoonerCare eligibility guide was completed at least 15 days prior to the first loss of coverage date.

Training Guide Learning Objectives

Upon completing the training, learners were able to:

- Discuss the public health emergency's impact on SoonerCare members.
- Understand the ending of the PHE and what SoonerCare was doing with PHE-protected members.
- Identify what a "qualifying event" was and what was needed.
- Assist with resources when no longer eligible for SoonerCare.
- Refer a member who wished to file a complaint or an appeal to the appropriate documents and process.

Delivery Method and Outline:

PowerPoint presentation via Office365 Teams covered the following topics:

- Office365 Teams Live Event
    - Training presentation on PHE unwind
    - Unwinding operational plan
    - PHE unwind one-sheet
    - Marketplace contact information
    - Navigator resources
    - Resources:
        - Housing assistance
        - Food assistance
        - Dental needs
        - Durable medical equipment
        - Parenting needs
        - Transportation

STAFFING PLAN

Call Center Staffing

The Maximus Oklahoma City (OKC) project operates a call center for the Oklahoma Health Care Authority (OHCA). OHCA informed Maximus that it wished to expand the number of staff in the Maximus Tier 2 department to address the projected increase of workflow and call volume related to the end of the continuous eligibility requirements. OHCA requested 30 additional Tier 2 CSRs and two additional Tier 2 supervisors to support the anticipated workload in Tier 2. To allow for that movement of staff to Tier 2 from Tier 1, Maximus hired additional Tier 1 staff ahead of the Tier 2 moves to ensure Tier 1 coverage was sufficient for contractual requirements.

Timing of Tier II Staffing

Staff were added to the Tier 2 team in a phased approach, adding classes of staff over a two-month period. All 30 additional CSRs and supervisors were hired to start by May 2023.

Additional Tier 2	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2023
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 timeline for the additional staff (based on continuous eligibility ending on April 30, 2023). After month nine (December 2023) or based on business need, Maximus then wound down the number of additional staff in Tier 2, returning the CSRs back to the Tier 1 queues.

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

Timing of Tier I Staffing

Maximus hired additional Tier 1 staff ahead of the Tier 2 moves to ensure queue coverage in Tier 1 before the end of the continuous enrollment requirement, and to have staff in place in Tier 1 for the projected Tier 1 call volume. This increase in Tier 1 hiring occurred with training classes between February and April 2023.

Internet Helpdesk Staffing

The 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. To help reduce call volume, portal messaging was updated to alert members they could wait 15 minutes to retry their login when they were locked out. This was intended to offset the various login instructions that requested them to call. Gainwell also increased the number of agents in the call center.

Senior Eligibility Staffing

OHCA anticipated a substantial increase in fair hearing requests. To mitigate risk and lessen the pre-hearing work, the state added an additional eligibility and coverage manager.

FLEXIBILITIES

The Oklahoma Health Care Authority submitted disaster relief requests to the Centers for Medicare & Medicaid Services (CMS) for a number of flexibilities in response to the COVID-19 public health emergency (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 were approved by CMS or authorized by federal legislation and CMS blanket approvals. The State's 1135 waiver requests and disaster-relief SPAs expired upon the termination of the public health emergency declaration.

The American Rescue Plan Act (ARPA) mandated that 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.

The Families First Coronavirus Response Act (FFCRA) increased FMAP was available for qualifying expenditures that were incurred on or after Jan. 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 prevented 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 disenrolled or was no longer a state resident**. The requirements of section 6008 of the FFCRA did not apply to separate CHIPs.

The Consolidated Appropriations Act (CAA) funding bill de-coupled the continuous enrollment requirement from the PHE and set a hard end date of March 31, 2023. Redeterminations during the unwinding period then began on April 1, 2023. Rather than eliminating the enhanced FMAP all at once on April 1, the bill gradually phased it out over the rest of calendar year 2023:

- Q1 2023: 6.2 percentage point enhancement
- Q2 2023: 5 percentage point enhancement
- Q3 2023: 2.5 percentage point enhancement
- Q4 2023: 1.5 percentage point enhancement
- Q1 2024 and onward: normal FMAP applies

Certain reporting was obligated to be made to HHS monthly from April 1, 2023 to June 20, 2024, including number of redeterminations initiated, total renewals, number of ex parte renewals, terminations, Exchange metrics and call center metrics. An FMAP penalty would apply to states not complying with these reporting requirements. During this same period, HHS had additional corrective action plan authority. If a state was deemed not in compliance with redetermination rules, a CAP could be submitted; if a state failed to submit or implement its CAP, HHS could then suspend its ability to conduct procedural terminations and could impose a penalty of $100,000 per day of noncompliance.

When the state decides affecting a beneficiary's eligibility or when ending an authority result 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 were not triggered when temporary flexibilities ended at the conclusion of the PHE, but individuals still had the right to a fair hearing if the agency's decision was made incorrectly.

Title XIX & Title XXI PHE-related Disaster Relief (DR) Requests Post-PHE Maintained Requests

Request	Status
Disaster Relief Request & American Rescue Plan Mandate: Assurance to CMS for coverage and reimbursement of COVID-related countermeasures for full-scope Title XIX beneficiaries without cost sharing: vaccine administration, COVID-19 vaccine counseling for children under the age of 21, testing services, testing-related services, treatments for COVID-19, including, specialized equipment, and therapies (including drugs), and treatment for conditions that may seriously complicate the treatment of COVID-19	TEMPORARY Title XIX DR/ARP SPA approved (Effective 3/11/2021 through 9/30/24)
Disaster Relief Request & American Rescue Plan Mandate: Assurance to CMS for coverage and reimbursement of COVID-related countermeasures for all Title XXI 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) and treatment for conditions that may seriously complicate the treatment of COVID-19	TEMPORARY DR/ARP Title XXI SPA approved (Effective 3/11/2021 through 9/30/24)
Disaster Relief Request & American Rescue Plan Mandate: Assurance to CMS for coverage of COVID-related countermeasures for full-scope Title XIX beneficiaries without cost sharing: treatments for COVID-19, including, specialized equipment, and therapies (including drugs) and treatment for conditions that may seriously complicate the treatment of COVID-19	TEMPORARY Title XIX DR/ARP 1115 waiver pending approval (Effective 3/11/2021 through 9/30/24)
Disaster Relief Request & American Rescue Plan Mandate: 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	TEMPORARY Title XIX DR/ARP SPA approved (Effective 3/11/2021 through 9/30/24)
Disaster Relief Request & ARP Mandate: Provide Over the Counter at Home Covid Tests	DR/ARP Title XIX SPA approved (Effective 8/30/21 through 9/30/24)
1902(e)(14) Waiver Request: To allow the Agency to deviate from the CAA required methods in which the Agency must update member	TEMPORARY Waiver pending approval

contact info.	(Effective 4/1/2023 through 3/31/2024)
1902(e)(14) Waiver Request: To allow the Agency 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.	TEMPORARY Waiver pending approval (Effective 4/1/2023 through 9/30/2024)
Disaster Relief Request: Establish a rate increase for private duty nursing (PDN) providers for PDN hours that result in over-time rate of pay for nursing staff. Effective March 1, 2020, thru December 31, 2022, the increase from $32/hour to $40/hour is to be applied only for persons with tracheostomies or who are ventilator dependent. Effective January 1, 2023, the base rate for PDN services increased from $32.68/hour to $40/hour and the overtime rate for persons with tracheostomies or who are ventilator dependent increased from $40/hour to $48.92/hour.	DRSPA approved, eff. 3/1/20 DRSPA approved, eff. 1/1/23 PERMANENT Title XIX SPA approved (Effective 5/12/23)
Disaster Relief Request: 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.	DRSPA requested & approved, eff. 7/1/23 PERMANENT Title XIX SPA approved (Effective 5/12/23)
Disaster Relief Request: The 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 After the ARP coverage period, coverage of ACIP-recommended vaccinations without cost sharing will be mandatory for adults.	DRSPA requested & approved, eff. 8/24/20 PERMANENT Title XIX SPA approved (Effective 5/12/23)
Disaster Relief Request & American Rescue Plan Mandate: 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	TEMPORARY Title XIX DR/ARP SPA approved (Effective 3/11/2021 through 9/30/24)
1902(e)(14) Waiver Request: To enroll and/or renew non-MAGI individuals based on SNAP eligibility (Targeted SNAP Strategy).	TEMPORARY Waiver pending approval (Effective 4/11/2023 through 3/31/2024)
Disaster Relief Request: Allow nurse practitioners, clinical nurse specialists, or physician assistants, working in accordance with State	DRSPA requested & approved, eff. 3/21/20

law, to order home health services as per the CARES Act.	PERMANENT Title XIX SPA 21-0026 Approved (Effective 5/12/23)
1902(e)(14) Waiver Request: To protect beneficiaries from inappropriate terminations and to reduce state administrative burden.	TEMPORARY Waiver pending approval (Effective 8/1/2023 through 3/31/2024)

Maintained Telehealth Codes

ABA
97151 – Behavior identification assessment by qualified health professional, each 15 minutes. *176 (Board Certified Behavior Analyst)
97155 – Adaptive behavior treatment with protocol modification administered by qualified health care professional to one patient, each 15 minutes. *176 (Board Certified Behavior Analyst) and 177 (Board Certified Assistant Behavior Analyst)
97156 – Family adaptive behavior treatment guidance by qualified health care professional (with or without patient present, each 15 minutes. *176 (Board Certified Behavior Analyst) and 177 (Board Certified Assistant Behavior Analyst).

PASRR
T2011 (HCPCS Code for PASRR Level 2s) – preadmission screening and resident review level 2 evaluation, per evaluation established for state Medicaid agencies.

Medical	
90887	EXPLANATION OF PSYCHIATRIC, MEDICAL EXAMINATIONS, PROCEDURES, AND DATA TO OTHER THAN PATIENT
90951	DIALYSIS SERVICES (4 OR MORE PHYSICIAN VISITS PER MONTH), PATIENT YOUNGER THAN 2 YEARS OF AGE
90952	DIALYSIS SERVICES (2-3 PHYSICIAN VISITS PER MONTH), PATIENT YOUNGER THAN 2 YEARS OF AGE
90954	DIALYSIS SERVICES (4 OR MORE PHYSICIAN VISITS PER MONTH), PATIENT 2-11 YEARS OF AGE
90955	DIALYSIS SERVICES (2-3 PHYSICIAN VISITS PER MONTH), PATIENT 2-11 YEARS OF AGE
90957	DIALYSIS SERVICES (4 OR MORE PHYSICIAN VISITS PER MONTH), PATIENT 12-19 YEARS OF AGE
90958	DIALYSIS SERVICES (2-3 PHYSICIAN VISITS PER MONTH), PATIENT 12-19 YEARS OF AGE
90960	DIALYSIS SERVICES (4 OR MORE PHYSICIAN VISITS PER MONTH), PATIENT 20 YEARS OF AGE AND OLDER
90961	DIALYSIS SERVICES (2-3 PHYSICIAN VISITS PER MONTH), PATIENT 20 YEARS OF AGE AND OLDER
90963	HOME DIALYSIS SERVICES PER MONTH, PATIENT YOUNGER THAN 2 YEARS OF AGE

90964	HOME DIALYSIS SERVICES PER MONTH, PATIENT 2-11 YEARS OF AGE
90965	HOME DIALYSIS SERVICES PER MONTH, PATIENT 12-19 YEARS OF AGE
90966	HOME DIALYSIS SERVICES PER MONTH, PATIENT 20 YEARS OF AGE OR OLDER
90967	DIALYSIS SERVICES, PER DAY (LESS THAN FULL MONTH SERVICE), PATIENT YOUNGER THAN 2 YEARS OF AGE
90968	DIALYSIS SERVICES, PER DAY (LESS THAN FULL MONTH SERVICE), PATIENT 2-11 YEARS OF AGE
90969	DIALYSIS SERVICES, PER DAY (LESS THAN FULL MONTH SERVICE), PATIENT 12-19 YEARS OF AGE
90970	DIALYSIS SERVICES, PER DAY (LESS THAN FULL MONTH SERVICE), PATIENT 20 YEARS OF AGE OR OLDER
92227	REMOTE IMAGING FOR DETECTION OF RETINAL DISEASE (EG, RETINOPATHY IN A PATIENT WITH DIABETES) WITH ANALYSIS AND REPORT UNDER PHYSICIAN SUPERVISION, UNILATERAL OR BILATERAL
92228	REMOTE IMAGING FOR MONITORING AND MANAGEMENT OF ACTIVE RETINAL DISEASE (EG, DIABETIC RETINOPATHY) WITH PHYSICIAN REVIEW, INTERPRETATION AND REPORT, UNILATERAL OR BILATERAL
92507	TREATMENT OF SPEECH, LANGUAGE, VOICE, COMMUNICATION, AND/OR HEARING PROCESSING DISORDER
92521	EVALUATION OF SPEECH FLUENCY
92522	EVALUATION OF SPEECH SOUND PRODUCTION
92523	EVALUATION OF SPEECH SOUND PRODUCTION WITH EVALUATION OF LANGUAGE COMPREHENSION AND EXPRESSION
92524	BEHAVIORAL AND QUALITATIVE ANALYSIS OF VOICE AND RESONANCE
95251	AMBULATORY CONTINUOUS GLUCOSE (SUGAR) INCLUDING INTERPRETATION AND REPORT FOR A MINIMUM OF 72 HOURS
96040	MEDICAL GENETICS AND GENETIC COUNSELING SERVICES, EACH 30 MINUTES FACE-TO-FACE WITH PATIENT/FAMILY
96127	BRIEF EMOTIONAL OR BEHAVIORAL ASSESSMENT
96156	HEALTH BEHAVIOR ASSESSMENT OR REASSESMENT
96158	HEALTH BEHAVIOR INTERVENTION, INDIVIDUAL, FACE-TO-FACE, INITIAL 30 MINUTES
96159	HEALTH BEHAVIOR INTERVENTION, INDIVIDUAL, FACE-TO-FACE, EACH ADDITIONAL 15 MINUTES
96160	ADMINISTRATION AND INTERPRETATION OF PATIENT-FOCUSED HEALTH RISK ASSESSMENT

96161	ADMINISTRATION AND INTERPRETATION OF CAREGIVER-FOCUSED HEALTH RISK ASSESSMENT
96167	HEALTH BEHAVIOR INTERVENTION, FAMILY (WITH THE PATIENT PRESENT), FACE-TO-FACE, INITIAL 30 MINUTES
96168	HEALTH BEHAVIOR INTERVENTION, FAMILY (WITH THE PATIENT PRESENT), FACE-TO-FACE, EACH ADDITIONAL 15 MINUTES
96170	HEALTH BEHAVIOR INTERVENTION, FAMILY (WITHOUT THE PATIENT PRESENT), FACE-TO-FACE, INITIAL 30 MINUTES
96171	HEALTH BEHAVIOR INTERVENTION, FAMILY (WITHOUT THE PATIENT PRESENT), FACE-TO-FACE, EACH ADDITIONAL 15 MINUTES
97802	MEDICAL NUTRITION THERAPY, ASSESSMENT AND INTERVENTION, EACH 15 MINUTES
97803	MEDICAL NUTRITION THERAPY RE-ASSESSMENT AND INTERVENTION, EACH 15 MINUTES
99202	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 20 MINUTES
99203	NEW PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 30 MINUTES
99211	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 5 MINUTES
99212	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 10 MINUTES
99213	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT VISIT, TYPICALLY 15 MINUTES
99214	ESTABLISHED PATIENT OFFICE OR OTHER OUTPATIENT, VISIT TYPICALLY 25 MINUTES
99224	SUBSEQUENT OBSERVATION CARE, TYPICALLY 15 MINUTES PER DAY
99225	SUBSEQUENT OBSERVATION CARE, TYPICALLY 25 MINUTES PER DAY
99226	SUBSEQUENT OBSERVATION CARE, TYPICALLY 35 MINUTES PER DAY
99231	SUBSEQUENT HOSPITAL INPATIENT CARE, TYPICALLY 15 MINUTES PER DAY
99232	SUBSEQUENT HOSPITAL INPATIENT CARE, TYPICALLY 25 MINUTES PER DAY
99233	SUBSEQUENT HOSPITAL INPATIENT CARE, TYPICALLY 35 MINUTES PER DAY
99307	SUBSEQUENT NURSING FACILITY VISIT, TYPICALLY 10 MINUTES PER DAY
99308	SUBSEQUENT NURSING FACILITY VISIT, TYPICALLY 15 MINUTES PER DAY
99309	SUBSEQUENT NURSING FACILITY VISIT, TYPICALLY 25 MINUTES PER DAY
99310	SUBSEQUENT NURSING FACILITY VISIT, TYPICALLY 35 MINUTES PER DAY

99315	NURSING FACILITY DISCHARGE DAY MANAGEMENT, 30 MINUTES OR LESS
99316	NURSING FACILITY DISCHARGE MANAGEMENT, MORE THAN 30 MINUTES
99334	ESTABLISHED PATIENT ASSISTED LIVING VISIT, TYPICALLY 15 MINUTES
99335	ESTABLISHED PATIENT ASSISTED LIVING VISIT, TYPICALLY 25 MINUTES
99336	ESTABLISHED PATIENT ASSISTED LIVING VISIT, TYPICALLY 40 MINUTES
99337	ESTABLISHED PATIENT ASSISTED LIVING VISIT, TYPICALLY 60 MINUTES
99347	ESTABLISHED PATIENT HOME VISIT, TYPICALLY 15 MINUTES
99348	ESTABLISHED PATIENT HOME VISIT, TYPICALLY 25 MINUTES
99349	ESTABLISHED PATIENT HOME VISIT, TYPICALLY 40 MINUTES
99350	ESTABLISHED PATIENT HOME VISIT, TYPICALLY 60 MINUTES
99406	SMOKING AND TOBACCO USE INTERMEDIATE COUNSELING, GREATER THAN 3 MINUTES UP TO 10 MINUTES
99407	SMOKING AND TOBACCO USE INTENSIVE COUNSELING, GREATER THAN 10 MINUTES
99408	ALCOHOL AND/OR SUBSTANCE ABUSE SCREENING AND INTERVENTION, 15-30 MINUTES
99477	INITIAL INTENSIVE CARE OF NEWBORN, 28 DAYS OF AGE OR YOUNGER, PER DAY
99478	SUBSEQUENT INTENSIVE CARE OF RECOVERING LOW BIRTH WEIGHT INFANT, PER DAY
99479	SUBSEQUENT INTENSIVE CARE OF RECOVERING LOW BIRTH WEIGHT INFANT, PER DAY
99480	SUBSEQUENT INTENSIVE CARE OF RECOVERING LOW BIRTH WEIGHT INFANT, PER DAY
G0108	DIABETES OUTPATIENT SELF-MANAGEMENT TRAINING SERVICES, INDIVIDUAL, PER 30 MINUTES
G0296	COUNSELING VISIT TO DISCUSS NEED FOR LUNG CANCER SCREENING (LDCT) USING LOW DOSE CT SCAN (SERVICE IS FOR ELIGIBILITY DETERMINATION AND SHARED DECISION MAKING)
G0396	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE STRUCTURED ASSESSMENT (E.G., AUDIT, DAST), AND BRIEF INTERVENTION 15 TO 30 MINUTES
G0397	ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE STRUCTURED ASSESSMENT (E.G., AUDIT, DAST), AND INTERVENTION, GREATER THAN 30 MINUTES
H1001	PRENATAL CARE, AT-RISK ENHANCED SERVICE; ANTEPARTUM MANAGEMENT
T1015	CLINIC VISIT/ENCOUNTER, ALL-INCLUSIVE

Behavioral Health Services Reimbursable Via Telemedicine

Physician	
90792	Psychiatric diagnostic evaluation with medical services
99201*	E/M new patient level I
99202*	E/M new patient level II
99203*	E/M new patient level III
99204*	E/M new patient level IV
99205*	E/M new patient level V
99211*	E/M established patient Level I
99212*	E/M established patient level II
99213*	E/M established patient level III
99214*	E/M established patient level IV
99215*	E/M established patient level V
99231***	Subsequent hospital care
99232***	Subsequent hospital care
99233***	Subsequent hospital care
90833*	Psychotherapy, 30 minutes when performed with E/M service
90836*	Psychotherapy, 45 minutes when performed with E/M service
90838*	Psychotherapy, 60 minutes when performed with E/M service
Individual Practitioner	
90785	Interactive Complexity add-on
90791	Psychiatric diagnostic evaluation
90832	Psychotherapy, 30 minutes
90834	Psychotherapy, 45 minutes
90837	Psychotherapy, 60 minutes
Outpatient Behavioral Health Agency	
H0004 HE/HF/HH	Psychotherapy (Individual Only)
H0031	BH Assessment (non-MD)
H0032	BH Service Plan Development
H0035	Partial Hospitalization (PHP)
H0036	PACT (Health Home Client)
H0039	PACT
H2011	Crisis Intervention per 15 minutes
H2015	Individual Community Recovery Support
T1027	Family Training and Support
H2017	Individual Psychosocial rehabilitation
S9485	Crisis Assessment (Urgent Recovery Clinic Encounter)
90839**	Psychotherapy for Crisis, first 60 minutes
90840**	Psychotherapy for Crisis, each additional 30 minutes

*Only reimbursable via telemedicine when provided by a licensed Psychiatrist
**Only reimbursable when provided by a certified mobile crisis team
***Only reimbursable in an inpatient psychiatric facility

Flexibilities Terminating on May 11, 2023

1135 Waiver Flexibilities Additional blanket waivers approved by CMS were set forth here. *Blanket waivers applied to all applicable providers and did not require a request be sent or notification be made to CMS.
Waiver of 42 CFR 431.408(a)(3) in order 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 who are located in Oklahoma or otherwise directly impacted by the emergency.
Waive the requirement that critical access hospitals limit the number of beds to 25 and that 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.
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 that are 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 public health emergency, 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 COVID-19 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 COVID-19 PHE ends**

Allow payment for personal care services rendered by legally responsible individuals for the period of the public health emergency.

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 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 that the unlicensed facility either seek licensure or the evacuating facility would need to seek new placement for the individuals.

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); and
- 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 COVID-related public health emergency 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.
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.
Request to waive signature requirements for prescription drug counseling for the full duration of the PHE
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.
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.
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 with the PHE.
ACIP-recommended vaccine administration by state-authorized pharmacy interns and by qualified pharmacy technicians
COVID-19 Vaccine administration by qualified pharmacy technicians
COVID-19 testing administration of by state-authorized pharmacy interns administration and by qualified pharmacy technicians
COVID-19 treatment (select therapeutics) ordering and administering by licensed pharmacists

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

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

PHE-related 1915c Requests PENDING Post-PHE Status

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 service plans, modifying incident reporting requirements, allowing payments for hospitalized services, including retainer payments, and allowing for video conferencing/telehealth opportunities.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends
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 Jan. 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 public health emergency 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 Oct. 1, 2020, through Dec. 31, 2020.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends

Maintained PHE-related 1915c Requests

1915(c) Disaster-Relief Flexibilities	Status Post-PHE
Community Waiver	
Temporarily allow HTS services to be participant directed.	Added to waiver effective Sept. 1, 2020

Temporarily allow DHS/DDS case management to conduct required monitoring using Health Insurance Portability and Accountability Act (HIPAA)-compliant phone and/or videoconferencing.	Added to waiver effective July 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 July 1, 2021
Temporarily allow professional providers to utilize HIPAA-compliant telehealth.	Added to waiver effective July 1, 2021
Temporarily allow the use of monitoring via HIPAA-compliant phone or videoconferencing in the Daily Living Support service setting.	Added to waiver effective July 1, 2021
Temporarily allow providers to monitor an employment site via HIPAA-compliant phone or videoconferencing.	Added to waiver effective July 1, 2021
Temporarily increase the combined additional cost limit for Prevocational services and Supported Employment Services.	Added to waiver effective July 1, 2021
Temporarily allow the provision via HIPAA-compliant phone or videoconferencing in the Prevocational service setting.	Added to waiver effective July 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 videoconferencing in non-residential service settings.	Added to waiver effective July 1, 2021
Temporarily allow the completion of required signatures for consent forms to be obtained via mail or electronically.	Added to waiver effective July 1, 2021
Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA-compliant teleconference or videoconference 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 July 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.	Added to waiver effective July 1, 2022

Temporarily allow DHS/DDS case management to conduct team meetings, including individual planning meetings, via HIPAA-compliant teleconference or videoconference.	Added to waiver effective July 1, 2022
Temporarily allow addition of examination for eyeglasses and corrective lenses.	Added to waiver effective July 1, 2022
Temporarily allow increase for dental services for adults to $3,500 per year — does not apply to class members.	Added to waiver effective July 1, 2022
Temporarily remove amount of public transportation services that can be accessed within plan year.	Added to waiver effective July 1, 2022
Temporarily allow limit for each family training service (individual and group) to increase from $5,500 to $6,500 per plan year.	Added to waiver effective July 1, 2022
Homeward Bound Waiver	
Temporarily allow DHS/DDS case management to conduct required monitoring using Health Insurance Portability and Accountability Act (HIPAA)-compliant phone and/or videoconferencing.	Added to waiver effective July 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 July 1, 2021
Temporarily allow professional providers to utilize HIPAA-compliant telehealth.	Added to waiver effective July 1, 2021
Temporarily allow the use of monitoring via HIPAA-compliant phone or videoconferencing in the Daily Living Support service setting.	Added to waiver effective July 1, 2021
Temporarily allow providers to monitor an employment site via HIPAA-compliant phone or videoconferencing.	Added to waiver effective July 1, 2021
Temporarily increase the combined additional cost limit for Prevocational services and Supported Employment services.	Added to waiver effective July 1, 2021

Temporarily allow the provision via HIPAA-compliant phone or videoconferencing in the Prevocational service setting.	Added to waiver effective July 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 videoconferencing in non-residential service settings.	Added to waiver effective July 1, 2021
Temporarily allow the completion of required signatures for consent forms to be obtained via mail or electronically.	Added to waiver effective July 1, 2021
Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA-compliant teleconference or videoconference 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 July 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.	Added to waiver effective July 1, 2022
Temporarily allow addition of examination for eyeglasses and corrective lenses	Added to waiver effective July 1, 2022
Temporarily allow increase for dental services for adults to $3,500 per year — does not apply to class members	Added to waiver effective July 1, 2022
Temporarily remove amount of public transportation services that can be accessed within plan year	Added to waiver effective July 1, 2022
Temporarily allow limit for each family training service (individual and group) to increase from $5,500 to $6,500 per plan year.	Added to waiver effective July 1, 2022
In Home Supports Waiver for Adults	
Temporarily allow DHS/DDS case management to conduct required monitoring using Health Insurance Portability and Accountability Act (HIPAA)-compliant phone and/or videoconferencing.	Added to waiver effective July 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 July 1, 2021
Temporarily allow professional providers to utilize HIPAA-compliant telehealth.	Added to waiver effective July 1, 2021
Temporarily allow the use of monitoring via HIPAA-compliant phone or videoconferencing in the Daily Living Support service setting.	Added to waiver effective July 1, 2021
Temporarily allow providers to monitor an employment site via HIPAA-compliant phone or videoconferencing.	Added to waiver effective July 1, 2021
Temporarily increase the combined additional cost limit for Prevocational services and Supported Employment services.	Added to waiver effective July 1, 2021
Temporarily allow the provision via HIPAA-compliant phone or videoconferencing in the Prevocational service setting.	Added to waiver effective July 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 videoconferencing in non-residential service settings.	Added to waiver effective July 1, 2021
Temporarily allow the completion of required signatures for consent forms to be obtained via mail or electronically.	Added to waiver effective July 1, 2021
Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA-compliant teleconference or videoconference 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 July 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	Added to waiver effective July 1, 2022
Temporarily allow DHS/DDS case management to conduct team meetings, including individual planning meetings, via HIPAA-compliant teleconference or videoconference.	Added to waiver effective July 1, 2022

Temporarily allow addition of examination for eyeglasses and corrective lenses.	Added to waiver effective July 1, 2022
Temporarily allow increase for dental services for adults to $3,500 per year — does not apply to class members.	Added to waiver effective July 1, 2022
Temporarily remove amount of public transportation services that can be accessed within plan year.	Added to waiver effective July 1, 2022
Temporarily allow limit for each family training service (individual and group) to increase from $5,500 to $6,500 per plan year	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 July 1, 2021
Temporarily allow the use of monitoring via HIPAA-compliant phone or videoconferencing in the Daily Living Support service setting.	Added to waiver effective July 1, 2021
Temporarily allow providers to monitor an employment site via HIPAA-compliant phone or videoconferencing.	Added to waiver effective July 1, 2021
Temporarily increase the combined additional cost limit for Prevocational services and Supported Employment services.	Added to waiver effective July 1, 2021
Temporarily allow the provision via HIPAA-compliant phone or videoconferencing in the Prevocational service setting.	Added to waiver effective July 1, 2021 (can only supplement required face-to-face visits)
Temporarily allow the completion of required signatures for consent forms to be obtained via mail or electronically.	Added to waiver effective July 1, 2021
Temporarily allow DHS/DDS case management to conduct team meetings, including individual planning meetings, via HIPAA-compliant teleconference or videoconference.	Added to waiver effective July 1, 2021

Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA-compliant teleconference or videoconference 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 July 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.	Added to waiver effective July 1, 2022
Temporarily allow increase for dental services for adults to $3,500 per year — does not apply to class members.	Added to waiver effective July 1, 2022
Temporarily remove amount of public transportation services that can be accessed within plan year.	Added to waiver effective July 1, 2022
Temporarily allow limit for each family training service (individual and group) to increase from $5,500 to $6,500 per plan year.	Added to waiver effective July 1, 2022
Medically Fragile Waiver	
Allow certified case management and skilled nursing to conduct required service planning and monitoring activities using telehealth, phone and/or videoconferencing.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
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 HIPAA 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 U.S 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 waiver member for additional information to validate ongoing eligibility.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Provider trainings for Case Management and Home Health providers will be modified to an online 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 videoconferencing unless an extreme situation warrants an in-person visit. Videoconferencing will be utilized in accordance with HIPAA 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 telehealth through options such as mobile videoconferencing, Zoom, etc., and will be done in accordance with the HIPAA 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 videoconferencing/telehealth during times of emergency declaration and will be utilized in accordance with HIPAA requirements.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)

TERMINATING Disaster Relief Flexibilities Post-PHE

1915(c) HCBS Disaster-relief Flexibilities	
Community Waiver	
20% retroactive rate add-ons (April 1-Sept. 30, 2020, Oct. 1-Dec. 31, 2020)	The retroactive provider rates ended September 2022
Homeward Bound Waiver	
20% retroactive rate add-ons (April 1-Sept. 30, 2020, Oct. 1-Dec. 31, 2020)	The retroactive provider rates ended September 2022
In-Home Supports Waiver for Adults	
20% retroactive rate add-ons (April 1-Sept. 30, 2020, Oct. 1-Dec. 31, 2020)	The retroactive provider rates ended September 2022
In-Home Supports Waiver for Children	
20% retroactive rate add-ons (April 1-Sept. 30, 2020, Oct. 1-Dec. 31, 2020)	The retroactive provider rates ended September 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. Videoconferencing should include Facetime with the member and staff when possible and will be utilized in accordance with HIPAA 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 and 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