

**Section 1915(b) Waiver
Oklahoma Proposal For
MCO and PAHP Programs**

Proposal for a Section 1915(b) Waiver MCO, PIHP, PAHP, and/or PCCM Program

Facesheet

Please fill in and submit this Facesheet with each waiver proposal, renewal, or amendment request.

The **State of Oklahoma** requests a waiver/amendment under the authority of section 1915(b) of the Act. The Medicaid agency will directly operate the waiver.

The name of the waiver program is **SoonerSelect Program, SoonerSelect Children's Specialty Program, and SoonerSelect Dental**. (Please list each program name if the waiver authorizes more than one program.)

Type of request. This is an:

- initial request for new waiver. All sections are filled.
- amendment request for existing waiver, which modifies Section/Part **A.I.E.1. Populations Included in Waiver, A.I.E.2. Excluded Populations, and A.IV.C.2.c Enrollment**

- Replacement pages are attached for specific Section/Part being amended (note: the State may, at its discretion, submit two versions of the replacement pages: one with changes to the old language highlighted (to assist CMS review), and one version with changes made, i.e. not highlighted, to actually go into the permanent copy of the waiver).

- Document is replaced in full, with changes highlighted

The State has evaluated internally and determined cost effectiveness will not be impacted by this change and the state will be relying on previously submitted cost effectiveness projections.

renewal request

- This is the first time the State is using this waiver format to renew an existing waiver. The full preprint (i.e. Sections A through D) is filled out.
- The State has used this waiver format for its previous waiver period. Sections C and D are filled out.

- Section A is replaced in full
- carried over from previous waiver period. The State:
 - assures there are no changes in the Program Description from the previous waiver period.
 - assures the same Program Description from the previous waiver period will be used, with the exception of changes noted in attached replacement pages.

Section B is replaced in full

- ___ carried over from previous waiver period. The State:
 - ___ assures there are no changes in the Monitoring Plan from the previous waiver period.
 - ___ assures the same Monitoring Plan from the previous waiver period will be used, with exceptions noted in attached replacement pages

Effective Dates: This waiver/renewal/**amendment** is requested for a period of 2 years; **effective March 1, 2025**, and ending **January 31, 2026**. (For beginning date for an initial or renewal request, please choose first day of a calendar quarter, if possible, or if not, the first day of a month. For an amendment, please identify the implementation date as the beginning date, and end of the waiver period as the end date)

State Contact: The State contact person for this waiver is **Traylor Rains** and can be reached by telephone at **(405) 522-9564**, or fax at **(405) 530-3416**, or e-mail at **traylor.rains@okhca.org**. (Please list for each program)

Section A: Program Description

Part I: Program Overview

Tribal consultation

For initial and renewal waiver requests, please describe the efforts the State has made to ensure Federally recognized tribes in the State are aware of and have had the opportunity to comment on this waiver proposal.

The OHCA regularly hosts tribal policy consultations to present and receive comment on proposed changes to the Medicaid program and other relevant topics that could impact Oklahoma tribes contracted with OHCA. When further consultation is warranted, tribal workgroups are convened. From July 2020 through January 2023, the OHCA met with tribal partners a total of 11 times to discuss the transition to a managed care (MCO/PAHP) service delivery system. The consultations and workgroups consisted of representatives from the Chickasaw Nation, Choctaw Nation, Cherokee Nation, Citizen Potawatomi Nation, Iowa Tribe, Oklahoma City Indian Clinic, Indian Health Service, and Wichita and Affiliated Tribes. Below is a list of the dates that the OHCA discussed its managed care proposals with tribal partners:

Meeting #1 – regularly scheduled tribal consultation: July 7, 2020

Meeting #2 – tribal policy workgroup: July 21, 2020

Meeting #3– tribal policy workgroup: July 30, 2020

Meeting #4 – regularly scheduled tribal consultation: September 1, 2020

Meeting #5– tribal policy workgroup: October 8, 2020

Meeting #6– regularly scheduled tribal consultation: November 3, 2020

Meeting #7– regularly scheduled annual tribal meeting: November 14, 2020

Meeting #8– regularly scheduled tribal consultation: January 5, 2021

Meeting #9 – regularly scheduled tribal consultation: June 8, 2022

Meeting #10 – regularly scheduled tribal consultation: November 1, 2022

Meeting #11 – regularly scheduled tribal consultation: January 3, 2023

The meeting agendas, as well as list of attendees, can be found within Attachment 1.

At the regularly scheduled tribal consultation on July 7, 2020, the initial topic of discussion was focused on the MCO/PAHP service delivery system. During the meeting, a partner asked questions about the intent of the contracting process, what populations would be included, and requested that the OHCA looked at retaining American Indian/Alaskan Native (AI/AN) populations under the Patient Centered Medical Home (PCMH) service delivery model, and if unable, the individual indicated a wish to create a separate MCO for eligible AI/AN individuals. The OHCA responded that the process was in its infancy stages, that the conversation is open around the AI/AN population, and Agency staff provided the populations that would be included within the MCO/PAHP proposal. The member noted that they looked forward to discussing more during the next tribal workgroup. A tribal partner noted concern regarding the transition process and sovereignty of tribal individuals/tribes. Another partner echoed similar concerns about the model for the future and ongoing work. The OHCA proposed further discussion at subsequent workgroup meetings.

The OHCA convened the tribal workgroup to develop recommendations for the upcoming MCO/PAHP Request for Proposal (RFP); the first workgroup meeting took place on July 21, 2020 and the workgroup met a total of three times.

In the initial workgroup meeting, the top recommendation was for the OHCA to create and administer a care coordination model specific to ITUs, in lieu of contracting directly with MCOs/PAHPs. The model proposed during the meeting was similar to the ITU Patient Centered Medical Home (PCMH) proposal that was designed after the Arizona plan. Tribal partners also provided alternative recommendations about the following topics: option for AI/AN members to opt-in to managed care instead of opt-out option, provider networks, care coordination, sovereignty, OMB rates, and switching to an MCO model.

In the following workgroup meeting on July 30, 2020, discussion centered around the opt-in/opt-out process for eligible AI/AN members and the mechanics behind it. Tribal representatives expressed the following concerns: federal funding systems, contracting and reimbursement risks to providers, verifying the Texas ITU model, implications for patient care, referrals, and timelines. The OHCA facilitated the discussion, worked recommendations into processes, and agreed to meet again with tribal partners.

At the regularly scheduled bi-monthly tribal consultation on September 1, 2020, the OHCA provided an update about the ITU MCO workgroup including that Agency staff had been working with tribal partners and will be reviewing the RFP draft in the following week.

At the third and final ITU MCO workgroup meeting on October 9, 2020, the OHCA followed up on previous concerns about OMB rate payments, the opt-out/opt-in approach, and the status of the RFP. Tribal representatives asked for more details for the three proposed MCO contracts, SoonerSelect, SoonerSelect Children's Specialty Plan, and SoonerSelect Dental. A partner asked questions about OMB rates; the OHCA verified that they would remain the same under the new

MCO/PAHP as prior to COVID-19. Another partner asked if ITUs would be required to contract with the MCOs/PAHPs; the OHCA verified that they would not be required, but encouraged, to contract with MCOs/PAHPs. A partner asked if MCOs would be required to offer contracts to all ITUs using the Medicaid managed care addendum; this question was noted for further development. A partner asked if enrolled patients would be paid on a fee-for-service basis between 7/1/21 (effective date of expansion) and 10/1/21 (effective date for the MCO/PAHP waiver amendment); the OHCA confirmed that yes, enrollees would be FFS until they were enrolled with an MCO/PAHP. A tribal partner asked if the State would add to the RFP that ITUs do not have to contract or credential with individual MCOs/PAHPs; the OHCA responded that the requirement in the RFP indicated that ITUs are essential providers with no requirement to contract. A partner asked about the opt-in process and if the dental benefit manager/services will apply to adults in the expansion population; the OHCA responded that the opt-in process was still in development and that dental benefit manager/services would apply to expansion adults.

Other topics of discussion during the October 9, 2020 tribal workgroup meeting included services offered by the MCO and the FMAP. Agency staff responded that if the AI/AN member does not opt-in to managed care, the member will remain in the PCMH model and the Agency will receive 100% FMAP; however, 100% FMAP is also available if the member elects to receive services through an MCO plan. Further comments surrounded provider credentialing, Agency eligibility portals, pharmacy formularies, member referrals, pre-authorizations, and lab processes to which the Agency responded that a one-pager would be developed to address concerns (included in Attachment 2). At the November 3, 2020 regularly scheduled bi-monthly tribal consultation, the OHCA provided updates on the developments in the ITU MCO workgroup and announced that the two full RFPs were available for review on the OHCA's website and that the OHCA was collecting questions from bidders. The Agency also announced that AI/AN members would be considered as a voluntary enrollment population into managed care and AI/AN members will be provided with an option to opt-in to managed care. Billing from tribes will go directly to the OHCA. A partner noted that they still had some continued concerns and outstanding questions; the OHCA stated they would continue with discussions and logistics with the tribal partner(s).

The OHCA hosts an annual meeting with its tribal partners in which developments are discussed from the preceding year. At the November 14, 2020 annual meeting, the OHCA discussed the MCO progress to date; a tribal representative discussed advocacy and education for potential MCO providers regarding tribal health and issues, as well as noted interest in information regarding the dental MCO and how to support the ITU system.

During the regularly scheduled bi-monthly tribal consultation on January 5, 2021, the OHCA discussed the MCO proposal at length with tribal partners. The OHCA provided updates on the developments in the RFP process for the MCOs/PAHPs.

Namely, the OHCA provided a brief overview of what has occurred so far and the next milestones in the process.

On June 1, 2021 the Oklahoma Supreme Court halted the State's delivery system transition to a managed care model due to lack of State authority.

An ad-hoc Tribal consultation was held on June 8, 2022, via teleconference; 41 stakeholders were in attendance. Sign-in sheets are enclosed with the waiver submission package.

During the ad-hoc scheduled tribal consultation on June 8, 2022, the OHCA updated tribal partners on the passage of Senate Bill 1337 and the complementary House Bill 1396, which directed the State to transform our delivery system. It was stated that the expectation is to build off a lot of the efficiencies that were created last year in the request for proposal RFP development process but changing things to accommodate new language in SB1337.

The update included the work completed since the Supreme Court decision as well as what will remain and what will change from the first transitional proposal in 2021. Tribal partners were informed that everything previously addressed to ensure protections for tribal members, namely the opt-in process and the voluntary enrollment, considering Indian Health Coverage Programs (IHCP) as essential community providers, will remain. The State explained that the legislation directs a go-live date of October 2023, pending CMS approval; this date is a targeted go live date and the State is expected to exercise good faith to achieve this date.

The main difference presented to tribal partners between the new managed care proposal and the one from 2021 is that there is now more focus on maximizing provider voice and ownership in the structure of the health plans that can bid. The legislation still allows for a managed care entity or traditional commercial plan to bid on a statewide basis; however, there is now an opportunity for provider led entities to bid on the proposal. This will allow Oklahoma provider groups an opportunity to come together, work with hospital systems, create an oversight government structure, and create an HMO-like entity. Further, the State explained that the primary difference between what OHCA would require for a commercial plan and provider-led entities is that OHCA will allow provider-led entities to also bid and be awarded if they only covered regional areas of the state as long as they worked to grow into a statewide entity within the time period noted in SB1337.

Further updates included the expected request for proposals' (RFP) release timeline for the medical and Children's Specialty RFPs and the dental RFPs. Tribal partners were alerted that the State would offer an opportunity for stakeholder input through town halls and statewide meetings prior to RFP release.

The State received three questions from partners. One partner asked if ITUs will still be allowed to bill OHCA directly for services provided at an ITU. Another partner asked if ITUs who serve non-native members that are enrolled in SoonerCare and

that are able to bill at the OMB rate and then pay back the state share (bill back process) will remain. Another tribal partner requested the State to address the questions received prior to the 2021 Supreme Court decision.

The State responded that ITUs will still be allowed to bill OHCA directly and that the State will provide the ITU roadmap that was created and provided in 2021 which included the processes for ITUs to bill the State directly, and what the billing process will look like if the patient is a non-native member or a native member that has chosen to be enrolled in a managed care plan. There was a request for subsequent meetings/workgroups to discuss the ITU bill back and other questions in further detail.

From July 2022 through October 2022, three workgroup meetings were held with tribal partners. Discussions within the workgroup meetings included how the State planned to add language to all RFPs to indicate voluntary and opt in enrollment of AI/AN members; the State sought and received feedback from tribal partners on the proposed RFP language for voluntary and opt in enrollment and the Indian Health Care Provider (IHCP) language; the process for children in tribal custody; identified agency rule changes needed; and further discussed bill back processes.

Tribal consultation was held on November 1, 2022, via teleconference; 74 stakeholders were in attendance. Sign-in sheets are enclosed with the waiver submission package.

During the November 1, 2022 regularly scheduled tribal consultation meeting, the State received three questions from tribal partners. It was asked that the State provide an update on the managed care workgroup meeting and the work that has been accomplished. Another partner asked if the medical RFP was released. The final commenter questioned how transportation is going to change with managed care.

The State responded to many of the questions that arose from the MCO tribal workgroup including: retaining the OMB rate, confirmation of AI/AN members retaining voluntary and opt in enrollment processes, and that the State will retain the bill back process already in place when OHCA partially transitions its health care delivery system to managed care. Tribal partners were informed that the dental RFP was released on 10/31/22 and the Medical and Children's Specialty RFPs would be released on 11/10/2022. The State confirmed that there were no changes to transportation under the managed care proposal but would follow-up if this is not correct.

Tribal consultation was held on January 3, 2023, via teleconference; 81 stakeholders were in attendance. Sign-in sheets are enclosed with the waiver submission package.

During the January 3, 2023 tribal consultation a discussion was held regarding the submission of the MCO/PAHP waiver to CMS. A tribal representative asked what the benefit is in moving to the 1915(b) from an 1115(a) waiver. The OHCA replied with a number of benefits including: establishing a program with quarterly reporting

and a real-time monitoring system (continuous oversight), the benefits of cost effectiveness versus budget neutrality for the State, and a shorter time period for CMS approval.

Program History

For renewal waivers, please provide a brief history of the program(s) authorized under the waiver. Include implementation date and major milestones (phase-in timeframe; new populations added; major new features of existing program; new programs added).

A. Statutory Authority

1. **Waiver Authority**. The State's waiver program is authorized under section 1915(b) of the Act, which permits the Secretary to waive provisions of section 1902 for certain purposes. Specifically, the State is relying upon authority provided in the following subsection(s) of the section 1915(b) of the Act (if more than one program authorized by this waiver, please list applicable programs below each relevant authority):

- a. **1915(b)(1)** – The State requires enrollees to obtain medical care through a primary care case management (PCCM) system or specialty physician services arrangements. This includes mandatory capitated programs.
- b. **1915(b)(2)** - A locality will act as a central broker (agent, facilitator, negotiator) in assisting eligible individuals in choosing among PCCMs or competing MCOs/PIHPs/PAHPs in order to provide enrollees with more information about the range of health care options open to them.
- c. **1915(b)(3)** - The State will share cost savings resulting from the use of more cost-effective medical care with enrollees by providing them with additional services. The savings must be expended for the benefit of the Medicaid beneficiary enrolled in the waiver. Note: this can only be requested in conjunction with section 1915(b)(1) or (b)(4) authority.
- d. **1915(b)(4)** - The State requires enrollees to obtain services only from specified providers who undertake to provide such services and meet reimbursement, quality, and utilization standards which are consistent with access, quality, and efficient and economic provision of covered care and services. The State assures it will comply with 42 CFR 431.55(f).

The 1915(b)(4) waiver applies to the following programs

- MCO
- PIHP
- PAHP
- PCCM (Note: please check this item if this waiver is for a PCCM program that limits who is eligible to be a primary care case manager. That is, a program that requires PCCMs to meet certain quality/utilization criteria beyond the minimum requirements required to be a fee-for-service Medicaid contracting provider.)
- FFS Selective Contracting program (please describe)

2. **Sections Waived.** Relying upon the authority of the above section(s), the State requests a waiver of the following sections of 1902 of the Act (if this waiver authorizes multiple programs, please list program(s) separately under each applicable statute):

- a. ___ **Section 1902(a)(1)** - Statewideness--This section of the Act requires a Medicaid State plan to be in effect in all political subdivisions of the State. This waiver program is not available throughout the State.
- b. ___ **Section 1902(a)(10)(B)** - Comparability of Services--This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope. This waiver program includes additional benefits such as case management and health education that will not be available to other Medicaid beneficiaries not enrolled in the waiver program.
- c. **X** **Section 1902(a)(23)** - Freedom of Choice--This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State. Under this program, free choice of providers is restricted. That is, beneficiaries enrolled in this program must receive certain services through an MCO, PIHP, PAHP, or PCCM.

With the exception of voluntary populations, namely AI/AN populations, enrollees will be mandatorily enrolled into an MCO for medical services and a PAHP for dental services.
- d. ___ **Section 1902(a)(4)** - To permit the State to mandate beneficiaries into a single PIHP or PAHP, and restrict disenrollment from them. (If state seeks waivers of additional managed care provisions, please list here).
- e. ___ **Other Statutes and Relevant Regulations Waived** - Please list any additional section(s) of the Act the State requests to waive, and include an explanation of the request.

B. Delivery Systems

1. Delivery Systems. The State will be using the following systems to deliver services:

- a. **MCO**: Risk-comprehensive contracts are fully-capitated and require that the contractor be an MCO or HIO. Comprehensive means that the contractor is at risk for inpatient hospital services and any other mandatory State plan service in section 1905(a), or any three or more mandatory services in that section. References in this preprint to MCOs generally apply to these risk-comprehensive entities.
- b. **PIHP**: Prepaid Inpatient Health Plan means an entity that:
provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments or other payment arrangements that do not use State Plan payment rates; (2) provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. Note: this includes MCOs paid on a non-risk basis.
- The PIHP is paid on a risk basis.
 The PIHP is paid on a non-risk basis.
- c. **PAHP**: Prepaid Ambulatory Health Plan means an entity that: (1) provides medical services to enrollees under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State Plan payment rates; (2) does not provide or arrange for, and is not otherwise responsible for the provision of any inpatient hospital or institutional services for its enrollees; and (3) does not have a comprehensive risk contract. This includes capitated PCCMs.
- The PAHP is paid on a risk basis.
 The PAHP is paid on a non-risk basis.
- d. **PCCM**: A system under which a primary care case manager contracts with the State to furnish case management services. Reimbursement is on a fee-for-service basis. Note: a capitated PCCM is a PAHP.
- e. **Fee-for-service (FFS) selective contracting**: A system under which the State contracts with specified providers who are willing to meet certain reimbursement, quality, and utilization standards. Reimbursement is:
 the same as stipulated in the state plan
 is different than stipulated in the state plan (please describe)
- f. **Other**: (Please provide a brief narrative description of the model.)

2. Procurement. The State selected the contractor in the following manner. Please complete for each type of managed care entity utilized (e.g. procurement for MCO; procurement for PIHP, etc):

- Competitive** procurement process (e.g. Request for Proposal or Invitation for Bid that is formally advertised and targets a wide audience)
- Open** cooperative procurement process (in which any qualifying contractor may participate)
- Sole source** procurement
- Other** (please describe)

C. Choice of MCOs, PIHPs, PAHPs, and PCCMs

1. Assurances.

The State assures CMS that it complies with section 1932(a)(3) of the Act and 42 CFR 438.52, which require that a State that mandates Medicaid beneficiaries to enroll in an MCO, PIHP, PAHP, or PCCM must give those beneficiaries a choice of at least two entities.

The State seeks a waiver of section 1902(a)(4) of the Act, which requires States to offer a choice of more than one PIHP or PAHP per 42 CFR 438.52. Please describe how the State will ensure this lack of choice of PIHP or PAHP is not detrimental to beneficiaries' ability to access services.

2. Details. The State will provide enrollees with the following choices (please replicate for each program in waiver):

- Two or more MCOs
- Two or more primary care providers within one PCCM system.
- A PCCM or one or more MCOs
- Two or more PIHPs.
- Two or more PAHPs.
- Other: (please describe)

3. Rural Exception.

The State seeks an exception for rural area residents under section 1932(a)(3)(B) of the Act and 42 CFR 438.52(b), and assures CMS that it will meet the requirements in that regulation, including choice of physicians or case managers, and ability to go out of network in specified circumstances. The State will use the rural exception in the **following areas** ("rural area" must be defined as any area other than an "urban area" as defined in 42 CFR 412.62(f)(1)(ii)):

4. 1915(b)(4) Selective Contracting

- Beneficiaries will be limited to a single provider in their service area (please define service area).
- Beneficiaries will be given a choice of providers in their service area.

D. Geographic Areas Served by the Waiver

1. **General.** Please indicate the area of the State where the waiver program will be implemented. (If the waiver authorizes more than one program, please list applicable programs below item(s) the State checks.

Statewide -- all counties, zip codes, or regions of the State

Less than Statewide

2. **Details.** Regardless of whether item 1 or 2 is checked above, please list in the chart below the areas (i.e., cities, counties, and/or regions) and the name and type of entity or program (MCO, PIHP, PAHP, HIO, PCCM or other entity) with which the State will contract.

City/County/Region	Type of Program (PCCM, MCO, PIHP, or PAHP)	Name of Entity (for MCO, PIHP, PAHP)
Statewide	MCO (including PLEs)	Aetna Better Health of Oklahoma Humana Healthy Horizons Oklahoma Complete Health
Regional		
Statewide	PAHP (including PLEs)	Liberty (PLE) DentaQuest

E. Populations Included in Waiver

Please note that the eligibility categories of Included Populations and Excluded Populations below may be modified as needed to fit the State's specific circumstances.

1. **Included Populations.** The following populations are included in the Waiver Program:

Section 1931 Children and Related Populations are children including those eligible under Section 1931, poverty-level related groups and optional groups of older children.

- Mandatory enrollment
- Voluntary enrollment

Section 1931 Adults and Related Populations are adults including those eligible under Section 1931, poverty-level pregnant women and optional group of caretaker relatives.

- Mandatory enrollment
- Voluntary enrollment

Medicaid Expansion Adults are Medicaid beneficiaries ages 19-64 who are eligible for Medicaid with the expanded eligibility criteria as defined by the Affordable Care Act.

- Mandatory enrollment
- Voluntary enrollment

Blind/Disabled Adults and Related Populations are beneficiaries, age 18 or older, who are eligible for Medicaid due to blindness or disability. Report Blind/Disabled Adults who are age 65 or older in this category, not in Aged.

- Mandatory enrollment
- Voluntary enrollment

Blind/Disabled Children and Related Populations are beneficiaries, generally under age 18, who are eligible for Medicaid due to blindness or disability.

- Mandatory enrollment
- Voluntary enrollment

Aged and Related Populations are those Medicaid beneficiaries who are age 65 or older and not members of the Blind/Disabled population or members of the Section 1931 Adult population.

- Mandatory enrollment
- Voluntary enrollment

X **Foster Care Children** are Medicaid beneficiaries who are receiving foster care or adoption assistance (Title IV-E), are in foster-care, or are otherwise in an out-of-home placement.

- X** Mandatory enrollment
- Voluntary enrollment

X **Former Foster Care Children** are Medicaid beneficiaries who have aged out of foster care up to age 26.

- X** Mandatory enrollment
- Voluntary enrollment

X **TITLE XXI SCHIP** is an optional group of targeted low-income children who are eligible to participate in Medicaid if the State decides to administer the State Children’s Health Insurance Program (SCHIP) through the Medicaid program.

- X** Mandatory enrollment
- Voluntary enrollment

Medicaid beneficiaries who are American Indians or Alaskan Natives (AI/ANs) and members of federally recognized tribes are a voluntary population in managed care, regardless of their Medicaid Eligibility Group (MEG) designation, and will have the option to enroll in the SoonerSelect Programs through an opt-in process in accordance with 42 C.F.R. § 438.3(d)(2).

2. Excluded Populations. Within the groups identified above, there may be certain groups of individuals who are excluded from the Waiver Program. For example, the “Aged” population may be required to enroll into the program, but “Dual Eligibles” within that population may not be allowed to participate. In addition, “Section 1931 Children” may be able to enroll voluntarily in a managed care program, but “Foster Care Children” within that population may be excluded from that program. Please indicate if any of the following populations are excluded from participating in the Waiver Program:

X **Medicare Dual Eligible**--Individuals entitled to Medicare and eligible for some category of Medicaid benefits. (Section 1902(a)(10) and Section 1902(a)(10)(E))

Poverty Level Pregnant Women -- Medicaid beneficiaries, who are eligible only while pregnant and for a short time after delivery. This population originally became eligible for Medicaid under the SOBRA legislation.

Other Insurance--Medicaid beneficiaries who have other health insurance.

Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

American Indian/Alaskan Native--Medicaid beneficiaries who are American Indians or Alaskan Natives and members of federally recognized tribes.

Special Needs Children (State Defined)--Medicaid beneficiaries who are special needs children as defined by the State. Please provide this definition.

SCHIP Title XXI Children – Medicaid beneficiaries who receive services through the SCHIP program.

Retroactive Eligibility – Medicaid beneficiaries for the period of retroactive eligibility.

Other (Please define):

Populations other than those described in the above Included Populations section that remain enrolled due to the continuous enrollment and maintenance of effort (MOE) requirement of Section 6008(b)(3) of the Families First Coronavirus Response Act (FFCRA).

Individuals enrolled in the Medicare Savings Program.

Individuals determined eligible for Medicaid on the basis of age, blindness, or disability.

Individuals determined eligible for SoonerCare on the basis of needing treatment for breast or cervical cancer under 42 C.F.R. § 435.213.

Individuals infected with tuberculosis eligible for tuberculosis-related services under 42 C.F.R. § 435.21.

Undocumented persons eligible for Emergency Services only in accordance

with 42 C.F.R. § 435.139.

Insure Oklahoma Employee Sponsored Insurance (ESI) dependent Children in accordance with the Oklahoma Title XXI Children's Health Insurance Program (CHIP) State Plan.

Individuals within the Title XIX Soon-to-be-Sooners Separate CHIP (STBS S-CHIP) program.

Individuals enrolled in the SoonerPlan program receiving family planning services only.

F. Services

List all services to be offered under the Waiver in Appendices D2.S. and D2.A of Section D, Cost-Effectiveness.

1. Assurances.

X The State assures CMS that services under the Waiver Program will comply with the following federal requirements:

- Services will be available in the same amount, duration, and scope as they are under the State Plan per 42 CFR 438.210(a)(2).
- Access to emergency services will be assured per section 1932(b)(2) of the Act and 42 CFR 438.114.
- Access to family planning services will be assured per section 1905(a)(4) of the Act and 42 CFR 431.51(b)

_____ The State seeks a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (See note below for limitations on requirements that may be waived).

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of 42 CFR 438.210(a)(2), 438.114, and 431.51 (Coverage of Services, Emergency Services, and Family Planning) as applicable. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

_____ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply. The State assures CMS that services will be available in the same amount, duration, and scope as they are under the State Plan.

X The state assures CMS that it complies with Title I of the Medicare Modernization Act of 2003, in so far as these requirements are applicable to this waiver.

Note: Section 1915(b) of the Act authorizes the Secretary to waive most requirements of section 1902 of the Act for the purposes listed in sections 1915(b)(1)-(4) of the Act. However, within section 1915(b) there are prohibitions on waiving the following subsections of section 1902 of the Act for any type of waiver program:

- Section 1902(s) -- adjustments in payment for inpatient hospital services furnished to infants under age 1, and to children under age 6 who receive inpatient hospital services at a Disproportionate Share Hospital (DSH) facility.

- Sections 1902(a)(15) and 1902(bb) – prospective payment system for FQHC/RHC
- Section 1902(a)(10)(A) as it applies to 1905(a)(2)(C) – comparability of FQHC benefits among Medicaid beneficiaries
- Section 1902(a)(4)(C) -- freedom of choice of family planning providers
- Sections 1915(b)(1) and (4) also stipulate that section 1915(b) waivers may not waive freedom of choice of emergency services providers.

2. Emergency Services. In accordance with sections 1915(b) and 1932(b) of the Act, and 42 CFR 431.55 and 438.114, enrollees in an MCO, PIHP, PAHP, or PCCM must have access to emergency services without prior authorization, even if the emergency services provider does not have a contract with the entity.

___ The PAHP, PAHP, or FFS Selective Contracting program does not cover emergency services.

3. Family Planning Services. In accordance with sections 1905(a)(4) and 1915(b) of the Act, and 42 CFR 431.51(b), prior authorization of, or requiring the use of network providers for family planning services is prohibited under the waiver program. Out-of-network family planning services are reimbursed in the following manner:

- The MCO/PIHP/PAHP will be required to reimburse out-of-network family planning services
- ___ The MCO/PIHP/PAHP will be required to pay for family planning services from network providers, and the State will pay for family planning services from out-of-network providers
- ___ The State will pay for all family planning services, whether provided by network or out-of-network providers.
- ___ Other (please explain):
- ___ Family planning services are not included under the waiver.

4. FQHC Services. In accordance with section 2088.6 of the State Medicaid Manual, access to Federally Qualified Health Center (FQHC) services will be assured in the following manner:

- ___ The program is **voluntary**, and the enrollee can disenroll at any time if he or she desires access to FQHC services. The MCO/PIHP/PAHP/PCCM is not required to provide FQHC services to the enrollee during the enrollment period.
- The program is **mandatory** and the enrollee is guaranteed a choice of at least one MCO/PIHP/PAHP/PCCM which has at least one FQHC as a participating provider. If the enrollee elects not to select a MCO/PIHP/PAHP/PCCM that gives him or her access to FQHC services, no FQHC services will be required to be furnished to the enrollee while the enrollee is enrolled with the MCO/PIHP/PAHP/PCCM he or she selected. Since reasonable access to

FQHC services will be available under the waiver program, FQHC services outside the program will not be available. Please explain how the State will guarantee all enrollees will have a choice of at least one MCO/PIHP/PAHP/PCCM with a participating FQHC: The MCO/PAHP contracts require that there be contracted FQHCs in their networks and access to FQHC services for members enrolled in MCO/PAHP plans.

___ The program is **mandatory** and the enrollee has the right to obtain FQHC services **outside** this waiver program through the regular Medicaid Program.

5. EPSDT Requirements.

X The managed care programs(s) will comply with the relevant requirements of sections 1905(a)(4)(b) (services), 1902(a)(43) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Act related to Early, Periodic Screening, Diagnosis, and Treatment (EPSDT) program.

6. 1915(b)(3) Services.

___ This waiver includes 1915(b)(3) expenditures. The services must be for medical or health-related care, or other services as described in 42 CFR Part 440, and are subject to CMS approval. Please describe below what these expenditures are for each waiver program that offers them. Include a description of the populations eligible, provider type, geographic availability, and reimbursement method.

7. Self-referrals.

X The State requires MCOs/PIHPs/PAHPs/PCCMs to allow enrollees to self-refer (i.e. access without prior authorization) under the following circumstances or to the following subset of services in the MCO/PIHP/PAHP/PCCM contract:

Enrollees shall be permitted to self-refer, at minimum, to the following services:

- **Behavioral Health Services, including SUD treatment;**
- **Vision services;**
- **Emergency Services;**
- **Family Planning Services and Supplies;**
- **Prenatal care;**
- **Department of Health Providers, including mobile clinics; and**
- **Services provided by IHCPs to AI/AN Enrollees.**

Section A: Program Description

Part II: Access

Each State must ensure that all services covered under the State plan are available and accessible to enrollees of the 1915(b) Waiver Program. Section 1915(b) of the Act prohibits restrictions on beneficiaries' access to emergency services and family planning services.

A. Timely Access Standards

1. Assurances for MCO, PIHP, or PAHP programs.

The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services; in so far as these requirements are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.206 Availability of Services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II.B. Capacity Standards.

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the activities the State uses to assure timely access to services.

a. **Availability Standards.** The State's PCCM Program includes established maximum distance and/or travel time requirements, given beneficiary's normal means of transportation, for waiver enrollees' access to the following providers. For each provider type checked, please describe the standard.

1. PCPs (please describe):

2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Hospitals (please describe):
6. ___ Mental Health (please describe):
7. ___ Pharmacies (please describe):
8. ___ Substance Abuse Treatment Providers (please describe):
9. ___ Other providers (please describe):

b. ___ **Appointment Scheduling** means the time before an enrollee can acquire an appointment with his or her provider for both urgent and routine visits. The State's PCCM Program includes established standards for appointment scheduling for waiver enrollee's access to the following providers.

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):
3. ___ Ancillary providers (please describe):
4. ___ Dental (please describe):
5. ___ Mental Health (please describe):
6. ___ Substance Abuse Treatment Providers (please describe):
7. ___ Urgent care (please describe):
8. ___ Other providers (please describe):

c. ___ **In-Office Waiting Times:** The State's PCCM Program includes established standards for in-office waiting times. For each provider type checked, please describe the standard.

1. ___ PCPs (please describe):
2. ___ Specialists (please describe):

- 3. ___ Ancillary providers (please describe):
- 4. ___ Dental (please describe):
- 5. ___ Mental Health (please describe):
- 6. ___ Substance Abuse Treatment Providers (please describe):
- 7. ___ Other providers (please describe):

d. ___ **Other Access Standards** (please describe)

3. Details for 1915(b)(4) FFS selective contracting programs: Please describe how the State assures timely access to the services covered under the selective contracting program.

B. Capacity Standards

1. Assurances for MCO, PIHP, or PAHP programs.

The State assures CMS that it complies with section 1932(b)(5) of the Act and 42 CFR 438.207 Assurances of adequate capacity and services, in so far as these requirements are applicable.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(b)(5) and 42 CFR 438.207 Assurances of adequate capacity and services. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

If the 1915(b) Waiver Program does not include a PCCM component, please continue with Part II, C. Coordination and Continuity of Care Standards.

2. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below which of the strategies the State uses assure adequate provider capacity in the PCCM program.

- a. _____ The State has set **enrollment limits** for each PCCM primary care provider. Please describe the enrollment limits and how each is determined.
- b. _____ The State ensures that there are adequate number of PCCM PCPs with **open panels**. Please describe the State’s standard.
- c. _____ The State ensures that there is an **adequate number** of PCCM PCPs under the waiver assure access to all services covered under the Waiver. Please describe the State’s standard for adequate PCP capacity.
- d. _____ The State **compares numbers of providers** before and during the Waiver. Please modify the chart below to reflect your State’s PCCM program and complete the following.

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal

Providers	# Before Waiver	# In Current Waiver	# Expected in Renewal
Pediatricians			
Family Practitioners			
Internists			
General Practitioners			
OB/GYN and GYN			
FQHCs			
RHCs			
Nurse Practitioners			
Nurse Midwives			
Indian Health Service Clinics			
Additional Types of Provider to be in PCCM			
1.			
2.			
3.			
4.			

*Please note any limitations to the data in the chart above here:

- e. ___ The State ensures adequate **geographic distribution** of PCCMs. Please describe the State's standard.

- f. ___ **PCP:Enrollee Ratio.** The State establishes standards for PCP to enrollee ratios. Please calculate and list below the expected average PCP/Enrollee ratio for each area or county of the program, and then provide a statewide average. Please note any changes that will occur due to the use of physician extenders.

<i>Area(City/County/Region)</i>	<i>PCCM-to-Enrollee Ratio</i>

<i>Statewide Average: (e.g. 1:500 and 1:1,000)</i>	

g. ____ **Other capacity standards** (please describe):

3. Details for 1915(b)(4) FFS selective contracting programs: Please describe how the State assures provider capacity has not been negatively impacted by the selective contracting program. Also, please provide a detailed capacity analysis of the number of beds (by type, per facility) – for facility programs, or vehicles (by type, per contractor) – for non-emergency transportation programs, needed per location to assure sufficient capacity under the waiver program. This analysis should consider increased enrollment and/or utilization expected under the waiver.

C. Coordination and Continuity of Care Standards

1. Assurances For MCO, PIHP, or PAHP programs.

The State assures CMS that it complies with section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care, in so far as these regulations are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(i) of the Act and 42 CFR 438.208 Coordination and Continuity of Care. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

2. Details on MCO/PIHP/PAHP enrollees with special health care needs.

The following items are required.

a. The plan is a PIHP/PAHP, and the State has determined that based on the plan's scope of services, and how the State has organized the delivery system, that the **PIHP/PAHP need not meet the requirements** for additional services for enrollees with special health care needs in 42 CFR 438.208. Please provide justification for this determination.

b. **Identification.** The State has a mechanism to identify persons with special health care needs to MCOs, PIHPs, and PAHPs, as those persons are defined by the State. Please describe.

OHCA identifies enrollees with special health care needs based on responses to health status screening questions on the initial eligibility application. The MCO/PAHPs are also required to have a health screening process.

c. **Assessment.** Each MCO/PIHP/PAHP will implement mechanisms, using appropriate health care professionals, to assess each enrollee identified by the State to identify any ongoing special conditions that require a course of treatment or regular care monitoring. Please describe.

The MCO is required to implement a risk stratification level framework that determines the intensity and frequency of care management and population health interventions received by enrollees. The MCO's risk stratification level framework determines the appropriate level of care management and

population health intervention for each enrollee based on assessed needs, as determined through the following strategies:

- 1. Initial Health Risk Screening**
- 2. Comprehensive Assessment**
- 3. Predictive modeling;**
- 4. Claims review;**
- 5. Enrollee and caregiver requests; and**
- 6. Physician referrals.**

All three medical plans and the Children’s Specialty Plan are using their own risk screenings and comprehensive assessments as permitted by our contract and in alignment with their risk stratification model.

Several additional assessments such as the PHQ series, Columbia Suicide assessment, Edinburgh depression, childhood PTSD assessment, Vanderbilt assessment, GAD-7, Adverse Childhood Event and SDOH assessments are completed as triggered by their various comprehensive assessment strategies. Once the risk stratification process results in referral for care management at a variety of risk levels, most assessments are conducted by registered nurse care managers, licensed behavioral health clinicians or licensed social workers. There are also instances where non-clinical staff conduct activities for lower risk individuals.

When the Oklahoma Universal Comprehensive Assessment Tool (UCAT) must be utilized for assessment for State Plan Personal Care, OHCA requires that initial assessment to be conducted by an RN, while the annual reassessment may also be done by an LPN or a bachelor’s degree social worker.

For PAHPs, SoonerSelect dental enrollees with special health care needs are identified through a comprehensive dental assessment which guides the course of treatment or regular care monitoring.

LIBERTY

LIBERTY proactively identifies, assesses, and implements interventions for members with complex medical or behavioral health issues, Individual Development Disabilities (IDD), high service utilization, intensive health care needs, or who consistently access services at the highest level of care utilizing the following process:

As new members are assigned to LIBERTY, member data is loaded to a staging database. Utilizing the “at- risk criteria,” LIBERTY will identify members who have one or more of the following five conditions:

- 1. Complex medical issues with dental related comorbidity**
- 2. Complex social/behavioral issues including substance abuse, opioids, and/or other substance abuse issues**
- 3. Individual Development Disabilities (“IDD”)**
- 4. High dental service utilization and/or who consistently access dental services at the highest level of care**
- 5. Reside in a nursing facility**

LIBERTY runs a proprietary algorithm against data for new member claims, prior authorizations, and pull members who meet our “at-risk” criteria. These members are flagged and placed into one of the five categories. The report further stratifies the at-risk members into the underlying reason. It is to be noted, that the State, providers, members, or their caregivers can self-refer for Case Management and Care Coordination at any time, as well as from other internal departments.

To improve outcomes, identification of members who have the highest risk needs is key. Once identified gaps in care can be assessed, care plans are developed to address individual needs. LIBERTY’s Risk Stratification is not solely conducted through claims review. Information that is self-reported by the member, such as living arrangements, social network, and health habits is critical in predicting outcome. LIBERTY derives this information from member Oral Health Risk Assessment (OHRA) form. This process is utilized to identify members who may have higher risk profiles and are at risk of poor oral health so that LIBERTY can ensure they receive proper dental care and care coordination. Key identifiers within these assessment forms that LIBERTY use to identify members who require care include but are not limited to; complex medical or behavioral health conditions, chronic health conditions, and are actively engaged in dental treatment.

The Program uses a standardized case management process for its assigned members that consists of several key areas including but not limited to:

- 1. Comprehensive Health Risk Assessment**
- 2. Nursing Care Plan- Development of an individualized care plan**
- 3. Social Determinants of Health**
- 4. Transportation Assistance**
- 5. Medical Records Request**

- 6. Dental Records Request**
- 7. Coordination of member referrals to resources such as locating appropriate dental provider, and assist with scheduling dental appointment**
- 8. Follow-up and communication with members**
- 9. Assessment of care plan effectiveness**

LIBERTY's Case Managers will provide ongoing case management for as long as a member has identified needs and expresses willingness to receive support and services from the Program. Case Management team maintains communication to address and meet varying needs including but not limited to:

- 1. support adherence to care plans to improve health**
- 2. advocacy to ensure appropriate services and resources are received**
- 3. education and promotion of self-management**
- 4. coordinated and seamless integration of complex services and/or special needs**
- 5. appropriate and timely communication with members, providers, and hospitals**
- 6. assessing, planning and implementation of case management services**
- 7. referrals to appropriate medical, behavioral, social and community resources to address member needs**

Case Managers at a minimum are Licensed Practical (Vocational) Nurse or a Registered Nurse with clinical experience. Care Coordinators at a minimum shall have an AA/AS degree or equivalent years of experience and knowledge of medical or dental terminology.

DentaQuest

DentaQuest's formal Case Management Program is responsible for coordinating medical and dental services with other SoonerCare Programs including MCOs, PAHPs, FFS, Local Oklahoma Provider Associations, community and social support Providers, state agencies and other Entities for our Enrollees. The Case Management Program will establish bi-directional relationships with MCOs, dental, and medical Providers, and

state agencies supporting Enrollees in Foster Care, with SUD, with I/DD, and with other Special Healthcare Needs in compliance with 42 C.F.R. 438.208(b)(2)(ii) - (iv). DentaQuest will also work closely with a myriad of community and social support providers such as homeless shelters, housing supports, food banks, after-school programs, WICs, and Head Starts. To optimize coordination, DentaQuest proposes a standardized tool and process for coordinating services, including:

1. Monthly calls and data sharing with each MCO and State agency to manage members with medical and dental co-occurring conditions, identify gaps in care, and identify high-risk members who are pregnant, have chronic conditions, or have visited the ED for dental care.
2. A bidirectional referral system through a single point of contact with the MCOs for effective between the care management teams to consult and collaborate in cases involving mutual members as needed. more frequent communications with our case managers to consult on individual cases, as needed.
3. Agreement on shared metrics to monitor effectiveness of our coordination processes, such as referrals opened, closed, and completed.
4. A single point of contact with each State agency, as relevant, to encourage members to participate in oral health care and enhance Members' engagement in treatment.

For ongoing identification of community and social supports, DentaQuest's Case Management team uses the findhelp.org platform, an on-line national network of verified social care providers with at least 1,200 resources in each county, to connect enrollees to social services in their own community. DentaQuest Community Dental Health Coordinators will use the platform to proactively scan for social care resources across the state and engage with these organizations to ensure successful referral of enrollees in need of their services.

The Oral Health Risk Assessment is the main tool used by the Case Management team to identify enrollees who may be experiencing significant challenges getting the dental care they need or maintaining optimal oral health. This assessment can be administered in a variety of ways:

1. imbedded in the Welcome Call script, allowing us to collect risk data within soon after enrollment;
2. included in paper form in the Enrollee Handbook with a prepaid envelope for prompt return and intake by DentaQuest; and

3. **an electronic version will be available in the Enrollee Section of our website for OK enrollees.**

The Oral Health Risk Assessment includes questions covering the following health topics:

1. **Tooth pain.**
2. **Emergency room usage for dental problems.**
3. **Last dental visit.**
4. **Brushing habits.**
5. **Special health care needs.**
6. **Presence of development, physical, or intellectual disability.**
7. **Pregnancy.**
8. **Health problems, including presence of chronic health conditions.**
9. **Specific barriers/Social Determinants of Health.**

d. **X Treatment Plans.** For enrollees with special health care needs who need a course of treatment or regular care monitoring, the State requires the MCO/PIHP/PAHP to produce a treatment plan. If so, the treatment plan meets the following requirements:

1. **X** Developed by enrollees' primary care provider with enrollee participation, and in consultation with any specialists' care for the enrollee
2. **X** Approved by the MCO/PIHP/PAHP in a timely manner (if approval required by plan)
3. **X** In accord with any applicable State quality assurance and utilization review standards.

e. **X Direct access to specialists.** If treatment plan or regular care monitoring is in place, the MCO/PIHP/PAHP has a mechanism in place to allow enrollees to directly access specialists as appropriate for enrollee's condition and identified needs.

3. Details for PCCM program. The State must assure that Waiver Program enrollees have reasonable access to services. Please note below the strategies the State uses assure coordination and continuity of care for PCCM enrollees.

- a. ___ Each enrollee selects or is assigned to a **primary care provider** appropriate to the enrollee's needs.
- b. ___ Each enrollee selects or is assigned to a **designated health care practitioner** who is primarily responsible for coordinating the enrollee's overall health care.
- c. ___ Each enrollee is receives **health education/promotion** information. Please explain.
- d. ___ Each provider maintains, for Medicaid enrollees, **health records** that meet the requirements established by the State, taking into account professional standards.
- e. ___ There is appropriate and confidential **exchange of information** among providers.
- f. ___ Enrollees receive information about specific health conditions that require **follow-up** and, if appropriate, are given training in self-care.
- g. ___ Primary care case managers address barriers that hinder enrollee compliance with prescribed treatments or regimens, including the use of traditional and/or complementary medicine.
- h. ___ **Additional case management** is provided (please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case manager's files).
- i. ___ **Referrals:** Please explain in detail the process for a patient referral. In the description, please include how the referred services and the medical forms will be coordinated among the practitioners, and documented in the primary care case managers' files.

4. Details for 1915(b)(4) only programs: If applicable, please describe how the State assures that continuity and coordination of care are not negatively impacted by the selective contracting program.

Section A: Program Description

Part III: Quality

1. Assurances for MCO or PIHP programs.

- X The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242 in so far as these regulations are applicable.
- _____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- X The CMS Regional Office has reviewed and approved the MCO, PIHP, or PAHP contracts for compliance with the provisions of section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202, 438.204, 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230, 438.236, 438.240, and 438.242. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- X Section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.202 requires that each State Medicaid agency that contracts with MCOs and PIHPs submit to CMS a written strategy for assessing and improving the quality of managed care services offered by all MCOs and PIHPs. The State assures CMS that this **quality strategy** was initially submitted to the CMS Regional Office on The State will submit its quality strategy to CMS upon the end of the required public processes and finalization to the strategy based on public comments received.
- X The State assures CMS that it complies with section 1932(c)(2) of the Act and 42 CFR 438 Subpart E, to arrange for an annual, independent, **external quality review** of the outcomes and timeliness of, and access to the services delivered under each MCO/PIHP contract. Note: EQR for PIHPs is required beginning March 2004. Please provide the information below (modify chart as necessary):

Program	Name of Organization	Activities Conducted		
		EQR study	Mandatory Activities	Optional Activities
MCO and PAHPs	KFMC Health Improvement Partners (KFMC)*	Protocol 1: Validation of Performance Improvement Projects (PIPs)	<ol style="list-style-type: none"> 1. Assess PIP methodology 2. Perform overall validation and reporting of PIP results 	
		Protocol 2: Validate Performance Measures	<ol style="list-style-type: none"> 1. Conduct pre-site visit activities 2. Conduct site visit activities 3. Conduct post-site visit activities 	
		Protocol 3: Compliance Reviews	<p>Full reviews are required every three years with follow-up in interim years; KFMC completes the full review over the three-year period by conducting approximately one-third of the review each year, along with any necessary follow-up</p>	
		Protocol 4: Network Validation	<p>KFMC will use the CMS Network Validation Protocol to validate network adequacy</p>	
		Protocol 5:		KFMC will complete validation of encounter data,

		Encounter Data Validation		<p>per CMS EQRO protocol five titled “Validating Encounter Data”. The protocol delineates 5 distinct activities:</p> <ol style="list-style-type: none"> 1. Review of the State’s requirements for encounter data collection and submission. 2. Review of the MCO’s capacity to produce accurate and complete encounter data. 3. Analysis of electronic encounter data for completeness and accuracy. 4. Review of medical records. 5. Submission of findings.
		Information Systems Capacity Assessments (ISCA)		<p>KFMC will use the ISCA processes and worksheets provided in Appendix A of the CMS EQRO Protocols, for a complete evaluation.</p>
		Quality Improvement /Compliance Support		<ol style="list-style-type: none"> 1. Assisting with the development of PIPs and survey methodology 2. Other quality improvement initiatives and activities as directed by OHCA, including, but not limited to: <ol style="list-style-type: none"> a. Monitoring of MCO Corrective Action Plan b. Organizing and holding periodic quality forums c. Assisting OHCA to implement the agency’s quality improvement

				strategy, including advising on a quality rating system for program MCOs.
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**KFMC is under contract to conduct the four mandatory EQR-related activities for MCOs and PAHPs. Potential additional optional EQR activities with KFMC is still under review.*

The good faith effort quality strategy is enclosed as Attachment 4.

2. Assurances For PAHP program.

X The State assures CMS that it complies with section 1932(c)(1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236, in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the PAHP contracts for compliance with the provisions of section 1932(c) (1)(A)(iii)-(iv) of the Act and 42 CFR 438.210, 438.214, 438.218, 438.224, 438.226, 438.228, 438.230 and 438.236. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. Details for PCCM program. The State must assure that Waiver Program enrollees have access to medically necessary services of adequate quality. Please note below the strategies the State uses to assure quality of care in the PCCM program.

a. ___ The State has developed a set of overall quality **improvement guidelines** for its PCCM program. Please attach.

b. ___ **State Intervention:** If a problem is identified regarding the quality of services received, the State will intervene as indicated below. Please check which methods the State will use to address any suspected or identified problems.

1. ___ Provide education and informal mailings to beneficiaries and PCCMs;

2. ___ Initiate telephone and/or mail inquiries and follow-up;

3. ___ Request PCCM's response to identified problems;
4. ___ Refer to program staff for further investigation;
5. ___ Send warning letters to PCCMs;
6. ___ Refer to State's medical staff for investigation;
7. ___ Institute corrective action plans and follow-up;
8. ___ Change an enrollee's PCCM;
9. ___ Institute a restriction on the types of enrollees;
10. ___ Further limit the number of assignments;
11. ___ Ban new assignments;
12. ___ Transfer some or all assignments to different PCCMs;
13. ___ Suspend or terminate PCCM agreement;
14. ___ Suspend or terminate as Medicaid providers; and
15. ___ Other (explain):

___ **Selection and Retention of Providers:** This section provides the State the opportunity to describe any requirements, policies or procedures it has in place to allow for the review and documentation of qualifications and other relevant information pertaining to a provider who seeks a contract with the State or PCCM administrator as a PCCM. This section is required if the State has applied for a 1915(b)(4) waiver that will be applicable to the PCCM program.

Please check any processes or procedures listed below that the State uses in the process of selecting and retaining PCCMs. The State (please check all that apply):

1. ___ Has a documented process for selection and retention of PCCMs (please submit a copy of that documentation).
2. ___ Has an initial credentialing process for PCCMs that is based on a written application and site visits as appropriate, as well as primary source verification of licensure, disciplinary status, and eligibility for payment under Medicaid.

3. ___ Has a recredentialing process for PCCMs that is accomplished within the time frame set by the State and through a process that updates information obtained through the following (check all that apply):

___ Initial credentialing

___ Performance measures, including those obtained through the following (check all that apply):

___ The utilization management system.

___ The complaint and appeals system.

___ Enrollee surveys.

___ Other (Please describe).

4. ___ Uses formal selection and retention criteria that do not discriminate against particular providers such as those who serve high risk populations or specialize in conditions that require costly treatment.

___ Has an initial and recredentialing process for PCCMs other than individual practitioners (e.g., rural health clinics, federally qualified health centers) to ensure that they are and remain in compliance with any Federal or State requirements (e.g., licensure).

___ Notifies licensing and/or disciplinary bodies or other appropriate authorities when suspensions or terminations of PCCMs take place because of quality deficiencies.

5. ___ Other (please describe).

___ Other quality standards (**please describe**):

4. Details for 1915(b)(4) only programs: Please describe how the State assures quality in the services that are covered by the selective contracting program. Please describe the provider selection process, including the criteria used to select the providers under the waiver. These include quality and performance standards that the providers must meet. Please also describe how each criteria is weighted:

Section A: Program Description

Part IV: Program Operations

A. Marketing

Marketing includes indirect MCO/PIHP/PAHP or PCCM administrator marketing (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general) and direct MCO/PIHP/PAHP or PCCM marketing (e.g., direct mail to Medicaid beneficiaries).

1. Assurances

X The State assures CMS that it complies with section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities; in so far as these regulations are applicable.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(d)(2) of the Act and 42 CFR 438.104 Marketing activities. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

_____ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details

a. Scope of Marketing

1. _____ The State does not permit direct or indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers.

2. X The State permits indirect marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., radio and TV advertising for the MCO/PIHP/PAHP or PCCM in general). Please list types of indirect marketing permitted.

The State permits marketing by MCO/PAHPs via:

- **mass media (e.g., newspapers, magazines and other periodicals, radio, television, internet, public transportation advertising and any other media outlets);**
- **social media; and**
- **brochures and display posters at provider offices and clinics that inform patients that the provider/clinic is part of the MCO/PAHP’s network.**

3. X The State permits direct marketing by MCO/PIHP/PAHP/PCCM or selective contracting FFS providers (e.g., direct mail to Medicaid beneficiaries). Please list types of direct marketing permitted.

The State permits contracted managed care entities to respond to verbal or written requests for SoonerSelect Contractor-specific information made by a SoonerSelect Enrollee.

b. Description. Please describe the State’s procedures regarding direct and indirect marketing by answering the following questions, if applicable.

1. ___ The State prohibits or limits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers from offering gifts or other incentives to potential enrollees. Please explain any limitation or prohibition and how the State monitors this.

2. ___ The State permits MCOs/PIHPs/PAHPs/PCCMs/selective contracting FFS providers to pay their marketing representatives based on the number of new Medicaid enrollees he/she recruited into the plan. Please explain how the State monitors marketing to ensure it is not coercive or fraudulent:

3. X The State requires MCO/PIHP/PAHP/PCCM/selective contracting FFS providers to translate marketing materials into the languages listed below (If the State does not translate or require the translation of marketing materials, please explain):

All materials must be made available in English and Spanish and other prevalent non-English languages spoken by at least five percent (5%) of the general population in the Contractor’s service area or regional area based on area coverage of Contractor.

The State has chosen these languages because (check any that apply):

- i. ___ The languages comprise all prevalent languages in the service area. Please describe the methodology for determining prevalent languages.
- ii. X The languages comprise all languages in the service area spoken by approximately 5 percent or more of the population.
- iii. ___ Other (please explain):

B. Information to Potential Enrollees and Enrollees

1. Assurances.

X The State assures CMS that it complies with Federal Regulations found at section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements; in so far as these regulations are applicable.

___ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5) of the Act and 42 CFR 438.10 Information requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

___ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details.

a. **Non-English Languages**

X Potential enrollee and enrollee materials will be translated into the **prevalent non-English languages** listed below (If the State does not require written materials to be translated, please explain):

All materials must be made available in English and Spanish and other prevalent non-English languages spoken by at least five percent (5%) of the general population in the Contractor's service area or regional area based on area coverage of Contractor.

The State defines prevalent non-English languages as:
(check any that apply):

1. ___ The languages spoken by significant number of potential enrollees and enrollees. Please explain how the State defines "significant."
2. X The languages spoken by approximately 5 percent or more of the potential enrollee/ enrollee population.
3. ___ Other (please explain):

Please describe how **oral translation** services are available to all potential enrollees and enrollees, regardless of language spoken.

The MCO/PAHP ensures interpretation services are available to enrollees at no cost for all non-English languages. This includes oral interpretation and the use of auxiliary aids such as Teletypewriter (TTY)/Telecommunications Device for the Deaf (TDD) and American Sign Language (ASL). The MCO/PAHP has interpreters available both in-person, including at provider's offices, and through the telephone. For telephonic assistance, enrollees are not required to disconnect and call a different number. The MCO/PAHP provides information regarding how enrollees access interpretation services to its participating providers.

The MCO/PAHP identifies enrollees in need of interpretation services and provides them with the translation or interpretation services necessary to have their question or issue resolved in a timely manner.

The State will have a **mechanism** in place to help enrollees and potential enrollees understand the managed care program. Please describe.

Maximus will serve as the enrollment broker and provide choice counseling to potential enrollees. Choice counseling will be available at the time of initial enrollment, during the annual open enrollment period, and upon disenrollment requests. Choice counseling includes notice to prospective enrollees regarding the MCO/PAHP selection process and the importance of selecting in accordance with informational and timing requirements.

b. Potential Enrollee Information

Information is distributed to potential enrollees by:

- State
- contractor (please specify) **Maximus**

There are no potential enrollees in this program. (Check this if State automatically enrolls beneficiaries into a single PIHP or PAHP)

c. Enrollee Information

The State has designated the following as responsible for providing required information to enrollees:

- (i) the State
- (ii) State contractor (please specify): _____
- (ii) the MCO/PIHP/PAHP/PCCM/FFS selective contracting provider

C. Enrollment and Disenrollment

1. Assurances.

The State assures CMS that it complies with section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment; in so far as these regulations are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any. (Please check this item if the State has requested a waiver of the choice of plan requirements in section A.I.C)

The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(4) of the Act and 42 CFR 438.56 Disenrollment requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.

2. Details. Please describe the State's enrollment process for MCOs/PIHPs/PAHP/PCCMs and FFS selective contracting provider by checking the applicable items below.

a. **Outreach.** The State conducts outreach to inform potential enrollees, providers, and other interested parties of the managed care program. Please describe the outreach process, and specify any special efforts made to reach and provide information to special populations included in the waiver program: Please refer to Attachment - SoonerSelect Communications Plan.

b. **Administration of Enrollment Process.**

State staff conducts the enrollment process.

The State contracts with an independent contractor(s) (i.e., enrollment broker) to conduct the enrollment process and related activities.

The State assures CMS the enrollment broker contract meets the independence and freedom from conflict of interest requirements in section 1903(b) of the Act and 42 CFR 438.810.

Broker name: Maximus

Please list the functions that the contractor will perform:

- choice counseling
- enrollment
- other (please describe):

State allows MCO/PIHP/PAHP or PCCM to enroll beneficiaries. Please describe the process.

c. Enrollment. The State has indicated which populations are mandatorily enrolled and which may enroll on a voluntary basis in Section A.I.E.

This is a **new** program. Please describe the **implementation schedule** (e.g. implemented statewide all at once; phased in by area; phased in by population, etc.):

At least three statewide capitated contracts will be implemented for the coordination and delivery of Medicaid services, excluding dental services, to enrollees effective April 1, 2024.

Additionally, at least two statewide capitated contracts will be implemented for the coordination and delivery of dental Medicaid services to enrollees effective February 1, 2024.

This is an existing program that will be **expanded** during the renewal period. Please describe the **implementation schedule** (e.g. new population implemented statewide all at once; phased in by area; phased in by population, etc.):

If a potential enrollee **does not select** an MCO/PIHP/PAHP or PCCM within the given time frame, the potential enrollee will be **auto-assigned** or default assigned to a plan.

- i. Potential enrollees will have **30** days to choose a plan.
- ii. Please describe the auto-assignment process and/or algorithm. In the description please indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs.

Applicants who are eligible to choose an MCO/PAHP and fail to make an election within 30 days, will be assigned to the MCO/PAHP that is due next to receive an auto assignment. Once assigned to an initial MCO/PAHP, whether through active enrollment or auto enrollment, the enrollee shall have 90 calendar days to request a transfer to another MCO/PAHP.

Enrollees will not be auto-assigned to a MCO/PAHP if any of the following conditions exist:

- a. **The MCO/PAHP's maximum enrollment has been capped and actual enrollment has reached ninety-five percent (95%) of the cap;**
- b. **The MCO/PAHP has been excluded from receiving new enrollment due to the application of noncompliance remedies (for MCOs) or due to the imposition of administrative remedies (for PAHPs).**
- c. **The MCO/PAHP has failed to meet readiness review requirements.**

___ The State **automatically enrolls** beneficiaries
 ___ on a mandatory basis into a single MCO, PIHP, or PAHP in a rural area (please also check item A.I.C.3)
 ___ on a mandatory basis into a single PIHP or PAHP for which it has requested a waiver of the requirement of choice of plans (please also check item A.I.C.1)
 ___ on a voluntary basis into a single MCO, PIHP, or PAHP. The State must first offer the beneficiary a choice. If the beneficiary does not choose, the State may enroll the beneficiary as long as the beneficiary can opt out at any time without cause. Please specify geographic areas where this occurs: _____

___ The State provides **guaranteed eligibility** of ___ months (maximum of 6 months permitted) for MCO/PCCM enrollees under the State plan.

X The State allows otherwise mandated beneficiaries to request **exemption** from enrollment in an MCO/PIHP/PAHP/PCCM. Please describe the circumstances under which a beneficiary would be eligible for exemption from enrollment. In addition, please describe the exemption process:

AI/AN eligibles have the option to voluntarily enroll through an opt-in process. The member must actively elect to participate in managed care upon online enrollment.

X The State **automatically re-enrolls** a beneficiary with the same PCCM or MCO/PIHP/PAHP if there is a loss of Medicaid eligibility of 2 months or less.

d. Disenrollment:

X The State allows enrollees to **disenroll** from/transfer between MCOs/PIHPs/PAHPs and PCCMs. Regardless of whether plan or State makes the determination, determination must be made no later than the first day of the second month following the month in which the enrollee or plan files the request. If determination is not made within this time frame, the request is deemed approved.

- i. ___ Enrollee submits request to State.

- ii. ___ Enrollee submits request to MCO/PIHP/PAHP/PCCM. The entity may approve the request, or refer it to the State. The entity may not disapprove the request.
- iii. ___ Enrollee must seek redress through MCO/PIHP/PAHP/PCCM grievance procedure before determination will be made on disenrollment request.

___ The State **does not permit disenrollment** from a single PIHP/PAHP (authority under 1902 (a)(4) authority must be requested), or from an MCO, PIHP, or PAHP in a rural area.

X The State has a **lock-in** period (i.e. requires continuous enrollment with MCO/PIHP/PAHP/PCCM) of **12** months (up to 12 months permitted). If so, the State assures it meets the requirements of 42 CFR 438.56(c). Please describe the good cause reasons for which an enrollee may request disenrollment during the lock-in period (in addition to required good cause reasons of poor quality of care, lack of access to covered services, and lack of access to providers experienced in dealing with enrollee’s health care needs):

Enrollees will remain enrolled with the MCO until the next annual open enrollment period, unless:

- 1. The enrollee is disenrolled due to loss of SoonerCare eligibility;**
- 2. The enrollee becomes a foster child under custody of the State;**
- 3. The enrollee becomes Juvenile Justice (JJ) involved under the custody of the State;**
- 4. The enrollee is a former foster care child or child receiving adoption assistance and opts to enroll in the SoonerSelect Children’s Specialty Program;**
- 5. The enrollee demonstrates cause under the following conditions:**
 - a) The enrollee moves out of the MCO’s service area;**
 - b) The enrollee requires specialized care for a chronic condition and the enrollee or enrollee’s representative, the MCO, the State Medicaid Agency and receiving MCO agree that assignment to the receiving MCO is in the enrollee’s best interest;**
 - c) The enrollee seeks covered benefits that the MCO does not cover for moral or religious reasons;**
 - d) The enrollee needs related services (for example a cesarean section and a tubal ligation) to be performed at the same**

time; not all related services are available within the MCO's network; and the enrollee's PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

- e) The enrollee has filed and prevailed in a grievance regarding poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with the enrollee's health care needs or other matters deemed sufficient to warrant disenrollment; or**
 - f) The enrollee has been enrolled in error, as determined by the State Medicaid Agency.**
- 6. A temporary loss of eligibility or enrollment has caused the enrollee to miss the annual disenrollment period, then the enrollee may disenroll without cause upon reenrollment; or**
 - 7. The State Medicaid Agency imposes intermediate sanctions on the MCO and allows enrollees to disenroll without cause.**

Enrollees will remain enrolled with the PAHP until the next annual open enrollment period, unless:

- 1. The enrollee is disenrolled due to loss of SoonerCare eligibility;**
- 2. The enrollee demonstrates cause under the following conditions:**
 - a) The enrollee moves out of the PAHP's service area;**
 - b) The enrollee seeks covered benefits that the PAHP does not cover for moral or religious reasons;**
 - c) The enrollee needs related services to be performed at the same time; not all related services are available within the PAHP's network; and the enrollee's primary care dental provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;**
 - d) The enrollee has filed and prevailed in a grievance regarding poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with the enrollee's oral health care needs or other matters deemed sufficient to warrant disenrollment; or**
 - e) The enrollee has been enrolled in error, as determined by the State Medicaid Agency.**
- 3. A temporary loss of eligibility or enrollment has caused the enrollee to miss the annual disenrollment period, then the enrollee may disenroll without cause upon reenrollment; or**
- 4. The PAHP is terminated.**

The State **does not have a lock-in**, and enrollees in MCOs/PIHPs/PAHPs and PCCMs are allowed to terminate or change their enrollment without cause at any time. The disenrollment/transfer is effective no later than the first day of the second month following the request.

The State permits **MCOs/PIHPs/PAHPs and PCCMs to request disenrollment** of enrollees. Please check items below that apply:

MCO/PIHP/PAHP and PCCM can request reassignment of an enrollee for the following reasons:

The MCO can request to disenroll an enrollee only for the following good cause actions:

1. **Enrollee requires specialized care for a chronic condition and the enrollee or enrollee's representative, the MCO, the State Medicaid Agency and receiving MCO agree that assignment to the receiving MCO is in the enrollee's best interest;**
2. **Enrollee has been enrolled in error, as determined by State Medicaid Agency;**
3. **Enrollee has exhibited disruptive behaviors to the extent that the MCO cannot effectively manage their care, and the MCO has made all reasonable efforts to accommodate the enrollee; or**
4. **Enrollee has committed fraud, such as loaning an identification (ID) card for use by another person.**

The PAHP can request to disenroll an enrollee only for the following good cause actions:

1. **Enrollee has been enrolled in error, as determined by State Medicaid Agency;**
2. **Enrollee has exhibited disruptive behaviors to the extent that the PAHP cannot effectively manage their care, and the PAHP has made all reasonable efforts to accommodate the enrollee; or**
3. **Enrollee has committed fraud, such as loaning an ID card for use by another person.**

The State reviews and approves all MCO/PIHP/PAHP/PCCM-initiated requests for enrollee transfers or disenrollments.

If the reassignment is approved, the State notifies the enrollee in a direct and timely manner of the desire of the MCO/PIHP/PAHP/PCCM to remove the enrollee from its membership or from the PCCM's caseload.

X The enrollee remains an enrollee of the MCO/PIHP/PAHP/PCCM until another MCO/PIHP/PAHP/PCCM is chosen or assigned.

D. Enrollee rights.

1. Assurances.

- X The State assures CMS that it complies with section 1932(a)(5)(B)(ii) of the Act and 42 CFR 438 Subpart C Enrollee Rights and Protections.
- _____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.
- X The CMS Regional Office has reviewed and approved the MCO, PIHP, PAHP, or PCCM contracts for compliance with the provisions of section 1932(a)(5)(B)(ii) of the Act and 42 CFR Subpart C Enrollee Rights and Protections. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.
- _____ This is a proposal for a 1915(b)(4) FFS Selective Contracting Program only and the managed care regulations do not apply.
- X The State assures CMS it will satisfy all HIPAA Privacy standards as contained in the HIPAA rules found at 45 CFR Parts 160 and 164.

E. Grievance System

1. Assurances for All Programs. States, MCOs, PIHPs, PAHPs, and States in PCCM and FFS selective contracting programs are required to provide Medicaid enrollees with access to the State fair hearing process as required under 42 CFR 431 Subpart E, including: informing Medicaid enrollees about their fair hearing rights in a manner that assures notice at the time of an action,

ensuring that enrollees may request continuation of benefits during a course of treatment during an appeal or reinstatement of services if State takes action without the advance notice and as required in accordance with State Policy consistent with fair hearings. The State must also inform enrollees of the procedures by which benefits can be continued for reinstated, and

other requirements for fair hearings found in 42 CFR 431, Subpart E.

The State assures CMS that it complies with Federal Regulations found at 42 CFR 431 Subpart E.

2. Assurances For MCO or PIHP programs. MCOs/PIHPs are required to have an internal grievance system that allows an enrollee or a provider on behalf of an enrollee to challenge the denial of coverage of, or payment for services as required by section 1932(b)(4) of the Act and 42 CFR 438 Subpart H.

The State assures CMS that it complies with section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System, in so far as these regulations are applicable.

The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(b)(4) of the Act and 42 CFR 438 Subpart F Grievance System. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

3. Details for MCO or PIHP programs.

a. **Direct access to fair hearing.**

The State **requires** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

The State **does not require** enrollees to **exhaust** the MCO or PIHP grievance and appeal process before enrollees may request a state fair hearing.

b. **Timeframes**

The State's timeframe within which an enrollee, or provider on behalf of an enrollee, must file an **appeal** is 60 days (between 20 and 90).

The State's timeframe within which an enrollee must file a **grievance** is ___ days.

An enrollee may file a grievance, orally or in writing, at any time.

c. **Special Needs**

The State has special processes in place for persons with special needs. Please describe.

4. Optional grievance systems for PCCM and PAHP programs. States, at their option, may operate a PCCM and/or PAHP grievance procedure (distinct from the fair hearing process) administered by the State agency or the PCCM and/or PAHP that provides for prompt resolution of issues. These grievance procedures are strictly voluntary and may not interfere with a PCCM, or PAHP enrollee's freedom to make a request for a fair hearing or a PCCM or PAHP enrollee's direct access to a fair hearing in instances involving terminations, reductions, and suspensions of already authorized Medicaid covered services.

The State has a grievance procedure for its ___ PCCM and/or PAHP program characterized by the following (please check any of the following optional procedures that apply to the optional PCCM/PAHP grievance procedure):

The grievance procedures is operated by:
 the State
 the State's contractor. Please identify: _____
 the PCCM
 the PAHP.

Please describe the types of requests for review that can be made in the PCCM and/or PAHP grievance system (e.g. grievance, appeals)

The PAHP maintains a grievance and appeals systems to handle SoonerSelect dental enrollees grievance and appeals requests. A SoonerSelect dental enrollee can submit grievance or appeal (inclusive of an expedited appeal) requests for review.

Grievance - A SoonerSelect dental enrollee expression of dissatisfaction about any matter other than an adverse benefit determination. Grievances may include, but are not limited to, the quality of care or services provided, aspects of interpersonal relationships such as rudeness of a Provider, or employee, or failure to respect the SoonerSelect dental enrollee's rights regardless of whether remedial action is requested. A grievance includes a SoonerSelect dental enrollee's right to dispute an extension of time proposed by the contractor to make an authorization decision.

Appeal / Expedited appeal – A review of an adverse benefit determination by the contractor.

A state fair hearing, a process conducted and managed by the State (OHCA) as per Subpart E of 42 CFR Part 431, is also afforded to SoonerSelect dental enrollees upon exhaustion of the PAHPs grievance and appeals processes.

 X Has a committee or staff who review and resolve requests for review. Please describe if the State has any specific committee or staff composition or if this is a fiscal agent, enrollment broker, or PCCM administrator function.

The committee and/or staff who review and resolve requests for review is a PAHP function.

The PAHP shall:

- a. Ensure that any individuals making a decision on a SoonerSelect dental enrollee grievance or appeal were not involved in, nor a subordinate of any individual involved in, any previous level of review or decision-making; and
- b. Ensure that any individual making a decision on a SoonerSelect dental enrollee grievance or appeal of an adverse benefit determination are individuals with appropriate clinical expertise in treating the SoonerSelect dental enrollee's condition or disease when the decision involves the following:
 - i. An appeal of a denial that is based on lack of medical necessity;
 - ii. A grievance regarding denial of expedited resolution of an appeal; or
 - iii. A grievance or appeal that involves clinical issues.

The PAHP's decision makers on SoonerSelect dental enrollee grievance or appeal shall, in accordance with 42 C.F.R. § 438.406(b)(2)(iii), take into account all comments, documents, records, and other information submitted by the SoonerSelect dental enrollee or the SoonerSelect dental enrollee's authorized representative without regard to whether such information was submitted or considered by the PAHP in the initial adverse benefit determination, **and without regard as to its admissibility in a court of competent jurisdiction.**

 X Specifies a time frame from the date of action for the enrollee to file a request for review, which is: (please specify for each type of request for review)

Grievances

A grievance can be submitted (orally or in writing) directly to the PAHP at any time by an affected SoonerSelect dental enrollee.

Appeals

An appeal may be filed by an SoonerSelect dental enrollee, a provider, or authorized representative on behalf of the SoonerSelect dental enrollee, orally or in writing. The appeal request must be filed within sixty (60) calendar days from the date of the adverse benefit determination notice.

State Fair Hearings

A SoonerSelect dental enrollee may request a state fair hearing under Subpart E of 42 C.F.R. Part 431 only after receiving notice from the contractor upholding an adverse benefit determination and upon exhausting the PAHP's grievance and appeals process.

The SoonerSelect dental enrollee shall have one-hundred twenty (120) calendar days from the date of the adverse benefit to request a state fair hearing.

X Has time frames for resolving requests for review. Specify the time period set: _____ (please specify for each type of request for review)

Grievances

The contractor shall resolve each grievance and provide notice, as expeditiously as the SoonerSelect dental enrollee's health condition requires, which shall be within thirty (30) calendar days from the date the contractor receives the grievance.

The grievance resolution timeframe may be extended by the contractor by up to an additional fourteen (14) calendar days if:

- a. The SoonerSelect dental enrollee or provider as authorized representative requests an extension; or
- b. The contractor shows to the satisfaction of OHCA, upon request, that there is a need for additional information and how the delay is in the SoonerSelect dental enrollee's interest.

The contractor shall provide written notice of resolution of a grievance to the impacted SoonerSelect dental enrollee within three (3) calendar days of the resolution of the grievance.

Appeals

The contractor shall resolve each appeal and provide notice, as expeditiously as the SoonerSelect dental enrollee's health condition requires, which shall be within thirty (30) calendar days from the date the contractor receives the appeal.

The appeals resolution timeframe may be extended by the contractor by up to fourteen (14) calendar days if:

- a. The SoonerSelect dental enrollee or provider as authorized representative requests an extension; or
- b. The contractor shows to the satisfaction of OHCA, upon request, that there is a need for additional information and how the delay is in the SoonerSelect dental enrollee's interest.

If the contractor extends the timeframe for resolution of an appeal, and such extension was not at the request of the SoonerSelect dental enrollee, the contractor must complete the following in accordance with 42 C.F.R. § 438.408(c)(2)(i)-(iii):

- a. Make reasonable efforts to give the SoonerSelect dental enrollee prompt oral notice of the delay;
- b. Give the SoonerSelect dental enrollee written notice of the reason for the decision to extend the timeframe within two (2) calendar days and inform the SoonerSelect dental enrollee of the right to file a grievance if the SoonerSelect dental enrollee disagrees with that decision; and
- c. Resolve the appeal as expeditiously as the SoonerSelect dental enrollee's health condition requires and no later than the date the extension expires.

X Establishes and maintains an expedited review process for the following reasons: for cases in which the PAHP determines, or when the provider as the SoonerSelect Dental enrollee's authorized representative indicates that taking the time for a standard resolution could seriously jeopardize the SoonerSelect Dental enrollee's life, physical or mental health, or ability to attain, maintain, or regain maximum function.

Specify the time frame set by the State for this process

Expedited resolution of an appeal will occur within 72 hours after the PAHP receives the appeal.

The resolution expedited appeals timeframe may be extended by the PAHP by up to fourteen (14) calendar days if:

- a. The SoonerSelect dental enrollee or provider as authorized representative requests an extension; or**
- b. The PAHP shows to the satisfaction of OHCA, upon request, a need for additional information and how the delay is in the SoonerSelect dental enrollee's interest.**

If the PAHP extends the timeframe for resolution of an expedited appeal, and such extension was not at the request of the SoonerSelect dental enrollee, the contractor must complete the following in accordance with 42 C.F.R. § 438.408(c)(2)(i)-(iii):

- a. **Make reasonable efforts to give the SoonerSelect dental enrollee prompt oral notice of the delay;**
- b. **Give the SoonerSelect dental enrollee written notice of the reason for the decision to extend the timeframe within two (2) calendar days and inform the SoonerSelect dental enrollee of the right to file a grievance if the SoonerSelect dental enrollee disagrees with that decision; and**
- c. **Resolve the appeal as expeditiously as the SoonerSelect dental enrollee's health condition requires and no later than the date the extension expires.**

If the PAHP denies a request for expedited appeal resolution, the PAHP must transfer the appeal to the standard appeal resolution timeframe.

 Permits enrollees to appear before State PCCM/ PAHP personnel responsible for resolving the request for review.

 X Notifies the enrollee in writing of the decision and any further opportunities for additional review, as well as the procedures available to challenge the decision.

A written notice informing the enrollee of an adverse benefit determination. The written notice shall include, at minimum, the following content:

1. **The adverse benefit determination the contractor has made or intends to make;**
2. **The reasons for the adverse benefit determination, including the SoonerSelect dental enrollee's right to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the SoonerSelect dental enrollee's adverse benefit determination. Such information shall include necessary criteria, processes, strategies, or evidentiary standards in setting coverage limits;**
3. **Information on how to request reasonable access to and copies of all documents, records, and other information relevant to the SoonerSelect dental enrollee's adverse benefit determination;**
4. **If an adverse benefit determination is upheld, the SoonerSelect dental enrollee must be informed of exhausting the contractor's one (1) level of appeal and the right to request a state fair hearing;**
5. **The conditions in which SoonerSelect dental enrollee may request an expedited appeal process and how the SoonerSelect dental enrollee may request it;**
6. **The SoonerSelect dental enrollee's right to continued benefits pending the resolution of the appeal, how continued benefits may be requested, consistent with OHCA's policy, and notifying the SoonerSelect dental enrollee that the SoonerSelect dental**

enrollee may be required to pay the costs of these services should the adverse benefit determination be upheld; and

- 7. The SoonerSelect dental enrollees' rights and procedures available pursuant to 42 C.F.R. § 438.404(b).**

A written notice informing the enrollee of the results of the resolution of a grievance, appeal, or expedited appeal request and date it was completed.

A written notice informing the enrollee if the contractor intends to extend the grievance, appeal, or expedited appeal resolution timeframe.

For appeals not wholly in favor of the SoonerSelect dental enrollee, the notice shall include the following:

- 1. The right to request a state fair hearing;**
- 2. How to request a state fair hearing;**
- 3. The right to request and receive continuation of benefits while the state fair hearing is pending;**
- 4. How to request the continuation of benefits while the state fair hearing is pending; and**
- 5. Notice that the SoonerSelect dental enrollee may be held liable for the cost of those benefits if the state fair hearing decision upholds the contractor's adverse benefit determination.**

___ Other (please explain):

F. Program Integrity

1. Assurances.

- X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.610 Prohibited Affiliations with Individuals Barred by Federal Agencies. The State assures that it prohibits an MCO, PCCM, PIHP, or PAHP from knowingly having a relationship listed below with:
- 1) An individual who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in nonprocurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549, or
 - 2) An individual who is an affiliate, as defined in the Federal Acquisition Regulation, of a person described above.
- The prohibited relationships are:
- 3) A director, officer, or partner of the MCO, PCCM, PIHP, or PAHP;
 - 4) A person with beneficial ownership of five percent or more of the MCO's, PCCM's, PIHP's, or PAHP's equity;
 - 5) A person with an employment, consulting or other arrangement with the MCO, PCCM, PIHP, or PAHP for the provision of items and services that are significant and material to the MCO's, PCCM's, PIHP's, or PAHP's obligations under its contract with the State.

- X The State assures that it complies with section 1902(p)(2) and 42 CFR 431.55, which require section 1915(b) waiver programs to exclude entities that:
- 1) Could be excluded under section 1128(b)(8) of the Act as being controlled by a sanctioned individual;
 - 2) Has a substantial contractual relationship (direct or indirect) with an individual convicted of certain crimes described in section 1128(b)(8)(B) of the Act;
 - 3) Employs or contracts directly or indirectly with an individual or entity that is
 - a. precluded from furnishing health care, utilization review, medical social services, or administrative services pursuant to section 1128 or 1128A of the Act, or
 - b. could be excluded under 1128(b)(8) as being controlled by a sanctioned individual.

2. Assurances For MCO or PIHP programs

- X The State assures CMS that it complies with section 1932(d)(1) of the Act and 42 CFR 438.608 Program Integrity Requirements, in so far as these regulations are applicable.
- X State payments to an MCO or PIHP are based on data submitted by the MCO or PIHP. If so, the State assures CMS that it is in compliance with 42 CFR 438.604 Data that must be Certified, and 42 CFR 438.606 Source, Content, Timing of Certification.

_____ The State seeks a waiver of a waiver of section 1902(a)(4) of the Act, to waive one or more of more of the regulatory requirements listed above for PIHP or PAHP programs. Please identify each regulatory requirement for which a waiver is requested, the managed care program(s) to which the waiver will apply, and what the State proposes as an alternative requirement, if any.

X The CMS Regional Office has reviewed and approved the MCO or PIHP contracts for compliance with the provisions of section 1932(d)(1) of the Act and 42 CFR 438.604 Data that must be Certified; 438.606 Source, Content , Timing of Certification; and 438.608 Program Integrity Requirements. If this is an initial waiver, the State assures that contracts that comply with these provisions will be submitted to the CMS Regional Office for approval prior to enrollment of beneficiaries in the MCO, PIHP, PAHP, or PCCM.

Section B: Monitoring Plan

Per section 1915(b) of the Act and 42 CFR 431.55, states must assure that 1915(b) waiver programs do not substantially impair access to services of adequate quality where medically necessary. To assure this, states must actively monitor the major components of their waiver program described in Part I of the waiver preprint:

Program Impact	(Choice, Marketing, Enrollment/Disenrollment, Program Integrity, Information to Beneficiaries, Grievance Systems)
Access	(Timely Access, PCP/Specialist Capacity, Coordination and Continuity of Care)
Quality	(Coverage and Authorization, Provider Selection, Quality of Care)

For each of the programs authorized under this waiver, this Part identifies how the state will monitor the major areas within Program Impact, Access, and Quality. It acknowledges that a given monitoring activity may yield information about more than one component of the program. For instance, consumer surveys may provide data about timely access to services as well as measure ease of understanding of required enrollee information. As a result, this Part of the waiver preprint is arranged in two sections. The first is a chart that summarizes the activities used to monitor the major areas of the waiver. The second is a detailed description of each activity.

MCO and PIHP programs. The Medicaid Managed Care Regulations in 42 CFR Part 438 put forth clear expectations on how access and quality must be assured in capitated programs. Subpart D of the regulation lays out requirements for MCOs and PIHPs, and stipulates they be included in the contract between the state and plan. However, the regulations also make clear that the State itself must actively oversee and ensure plans comply with contract and regulatory requirements (see 42 CFR 438.66, 438.202, and 438.726). The state must have a quality strategy in which certain monitoring activities are required: network adequacy assurances, performance measures, review of MCO/PIHP QAPI programs, and annual external quality review. States may also identify additional monitoring activities they deem most appropriate for their programs.

For MCO and PIHP programs, a state must check the applicable monitoring activities in Section II below, but may attach and reference sections of their quality strategy to provide details. If the quality strategy does not provide the level of detail required below, (e.g. frequency of monitoring or responsible personnel), the state may still attach the quality strategy, but must supplement it to be sure all the required detail is provided.

PAHP programs. The Medicaid Managed Care regulations in 42 CFR 438 require the state to establish certain access and quality standards for PAHP programs, including plan assurances on network adequacy. States are not required to have a written quality strategy for PAHP programs. However, states must still actively oversee and monitor PAHP programs (see 42 CFR 438.66 and 438.202(c)).

PCCM programs. The Medicaid Managed Care regulations in 42 CFR Part 438 establishes certain beneficiary protections for PCCM programs that correspond to the waiver areas under “Program Impact.” However, generally the regulations do not stipulate access or quality standards for PCCM programs. State must assure access and quality in PCCM waiver programs, but have the flexibility to determine how to do so and which monitoring activities to use.

1915(b)(4) FFS Selective Contracting Programs: The Medicaid Managed Care Regulations do not govern fee-for-service contracts with providers. States are still required to ensure that selective contracting programs do not substantially impair access to services of adequate quality where medically necessary.

I. Summary Chart of Monitoring Activities

Please use the chart on the next page to summarize the activities used to monitor major areas of the waiver program. The purpose is to provide a “big picture” of the monitoring activities, and that the State has at least one activity in place to monitor each of the areas of the waiver that must be monitored.

Please note:

- **MCO, PIHP, and PAHP** programs -- there must be at least one checkmark in each column.
- **PCCM and FFS selective contracting** programs – there must be at least one checkmark in each sub-column under “Evaluation of Program Impact.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Access.” There must be at least one check mark in one of the three sub-columns under “Evaluation of Quality.”
- **If this waiver authorizes multiple programs**, the state may use a single chart for all programs or replicate the chart and fill out a separate one for each program. If using one chart for multiple programs, the state should enter the program acronyms (MCO, PIHP, etc.) in the relevant box.

Monitoring Activity	Evaluation of Program Impact						Evaluation of Access			Evaluation of Quality		
	Choice	Marketing	Enroll/Disenroll	Program Integrity	Information to Beneficiaries	Grievance	Timely Access	PCP/Specialist Capacity	Coordination/Continuity	Coverage/Authorization	Provider Selection	Quality of Care
Accreditation for Non-duplication		MCO PAHP		MCO PAHP		MCO PAHP						MCO PAHP
Accreditation for Participation		MCO PAHP		MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP
Consumer Self-Report data					MCO PAHP		MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP		MCO PAHP
Data Analysis (non-claims)	MCO PAHP		MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP
Enrollee Hotlines				MCO PAHP					MCO			
Focused Studies												MCO PAHP
Geographic mapping	MCO PAHP						MCO PAHP	MCO PAHP			MCO PAHP	
Independent Assessment			MCO PAHP		MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP
Measure any Disparities by Racial or Ethnic Groups							MCO PAHP		MCO PAHP			MCO PAHP
Network Adequacy Assurance by Plan							MCO PAHP	MCO PAHP			MCO PAHP	

<i>Monitoring Activity</i>	<i>Evaluation of Program Impact</i>						<i>Evaluation of Access</i>			<i>Evaluation of Quality</i>		
	<i>Choice</i>	<i>Marketing</i>	<i>Enroll Disenroll</i>	<i>Program Integrity</i>	<i>Information to Beneficiaries</i>	<i>Grievance</i>	<i>Timely Access</i>	<i>PCP/Specialist Capacity</i>	<i>Coordination/Continuity</i>	<i>Coverage/Authorization</i>	<i>Provider Selection</i>	<i>Quality of Care</i>
Ombudsman												
On-Site Review	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP	MCO PAHP
Performance Improvement Projects												MCO PAHP
Performance Measures							MCO PAHP		MCO PAHP			MCO PAHP
Periodic Comparison of # of Providers	MCO PAHP							MCO PAHP			MCO PAHP	
Profile Utilization by Provider Caseload												MCO PAHP
Provider Self-Report Data						MCO PAHP			MCO PAHP	MCO PAHP		MCO PAHP
Test 24/7 PCP Availability							MCO					
Utilization Review									MCO PAHP	MCO PAHP		MCO PAHP

<i>Monitoring Activity</i>	<i>Evaluation of Program Impact</i>					<i>Evaluation of Access</i>			<i>Evaluation of Quality</i>			
	<i>Choice</i>	<i>Marketing</i>	<i>Enroll/Disenroll</i>	<i>Program Integrity</i>	<i>Information to Beneficiaries</i>	<i>Grievance</i>	<i>Timely Access</i>	<i>PCP/Specialist Capacity</i>	<i>Coordination/Continuity</i>	<i>Coverage/Authorization</i>	<i>Provider Selection</i>	<i>Quality of Care</i>
Other: Marketing Plan		MCO PAHP										
Other: Program Integrity Reports				MCO PAHP								
Other: Enrollee Service Reports			MCO PAHP				MCO PAHP		MCO PAHP	MCO PAHP		

II. Details of Monitoring Activities

Please check each of the monitoring activities below used by the State. A number of common activities are listed below, but the State may identify any others it uses. If federal regulations require a given activity, this is indicated just after the name of the activity. If the State does not use a required activity, it must explain why.

For each activity, the state must provide the following information:

- Applicable programs (if this waiver authorizes more than one type of managed care program)
- Personnel responsible (e.g., state Medicaid, other state agency, delegated to plan, EQR, other contractor)
- Detailed description of activity
- Frequency of use
- How it yields information about the area(s) being monitored

- a. Accreditation for Non-duplication (i.e., if the contractor is accredited by an organization to meet certain access, structure/operation, and/or quality improvement standards, and the state determines that the organization's standards are at least as stringent as the state-specific standards required in 42 CFR 438 Subpart D, the state deems the contractor to be in compliance with the state-specific standards)

NCQA

JCAHO

AAAHC

Other (please describe)

URAC and any future Accrediting Entity recognized by HHS in accordance with 45 CFR 156.27

Applicable Programs

MCO (SoonerSelect and SoonerSelect Children's Specialty) and PAHP (SoonerSelect Dental)

Personnel Responsible

MCOs/PAHPs and OHCA External Quality Review Organization (EQRO)

Detailed Description of Activity

Subject to meeting the non-duplication requirements in 42 CFR 438.360, the OHCA's EQRO can apply this provision to the mandatory EQR activities outlined in CMS External Quality Review Protocol 1 (Validation of Performance Improvement Projects), Protocol 2 (Validation of Performance Measures) and Protocol 3 (Review of Compliance with Medicaid and CHIP Managed Care Regulations). The OHCA's EQRO is

responsible for assessing the completeness of information from the accreditation review to evaluate the extent to which non-duplication applies.

Frequency of Use

The EQR is performed annually.

How the Activity will be Applied to the Areas being Monitored

The accrediting organization will evaluate MCO/PAHP compliance with accreditation standards and grant or deny accreditation based on findings. Specifically:

- Marketing – MCO/PAHP policies/procedures and marketing practices will be evaluated for adherence to federal standards.
- Program Integrity – MCO/PAHP policies/procedures and program integrity audits will be evaluated for sufficiency and to ensure appropriate follow-up actions are taken when findings occur.
- Grievances – MCO/PAHP policies/procedures, operations and reporting will be evaluated for adherence to federal requirements, including communication and resolution timeliness.
- Quality – MCO/PAHP quality improvement plans and related processes will be evaluated for adherence to federal and State requirements.

The OHCA will review accreditation outcomes to ensure compliance with contract standards and to identify areas that qualify for non-duplication of monitoring activities. The OHCA also will incorporate findings into its MCO/PAHP oversight, through enhanced monitoring of areas with cited deficiencies.

How it Yields Information about the Area(s) being Monitored

The three protocols subject to non-duplication provide information on MCO and PAHP quality-of-care and adherence to federal managed care regulations. The EQRO, through its assessment of the accreditation review, will verify that the MCO or PAHP meets program standards without unnecessarily expending additional state and federal resources.

- b. X Accreditation for Participation (i.e., as prerequisite to be Medicaid plan)
 X NCQA
 X JCAHO
 X AAAHC
 X Other (please describe)
URAC and any future Accrediting Entity recognized by HHS in accordance with 45 CFR 156.27

Applicable Programs

MCO (SoonerSelect and SoonerSelect Children’s Specialty) and PAHP (SoonerSelect Dental)

Personnel Responsible

MCO/PAHP must submit evidence of accreditation to the OHCA.

Detailed Description of Activity

Contractors must be accredited by an HHS-recognized Accrediting Entity within 18 months of Operations Start Date. Contractors also must earn NCQA Health Equity Accreditation within two years of Operations Start Date. (Contract Section 1.4.2 – all versions)

Frequency of Use

Evidence of accreditation must be provided within 18 months of Operations Start Date and at time of accreditation renewal.

How the Activity will be Applied to the Areas being Monitored

The accrediting organization will evaluate MCO/PAHP compliance with accreditation standards and grant or deny accreditation based on findings. Specifically:

- Marketing – MCO/PAHP policies/procedures and marketing practices will be evaluated for adherence to federal standards.
- Program Integrity – MCO/PAHP policies/procedures and program integrity audits will be evaluated for sufficiency and to ensure appropriate follow-up actions are taken when findings occur.
- Information to Beneficiaries – MCO/PAHP policies/procedures and communications will be evaluated for accuracy, reading comprehension and compliance with federal regulations.

- Grievances – MCO/PAHP policies/procedures, operations and reporting will be evaluated for adherence to federal requirements, including communication and resolution timeliness.
- Timely Access – MCO/PAHP policies/procedures, accessibility standards and internal monitoring activities will be evaluated for sufficiency and adherence to federal standards, where applicable.
- PCP/Specialist Capacity – MCO/PAHP policies/procedures, capacity standards and internal monitoring activities will be evaluated for sufficiency. (Primary Care Dentist capacity for PAHP.)
- Coordination/Continuity – MCO/PAHP policies/procedures, staffing, operations and internal monitoring activities will be evaluated for sufficiency.
- Coverage/Authorization – MCO/PAHP policies/procedures, coverage guidelines, authorization timeliness and internal monitoring activities will be evaluated for sufficiency.
- Provider Selection – MCO/PAHP policies/procedures and internal monitoring will be evaluated for sufficiency and adherence to federal standards, where applicable.
- Quality-of-Care – MCO/PAHP quality improvement plans, policies/procedures and related activities (e.g., performance improvement projects) will be evaluated to verify sufficiency and integration with plan operations.

The OHCA will review accreditation outcomes to ensure compliance with contract standards. The OHCA also will incorporate findings into its MCO/PAHP monitoring activities, through enhanced monitoring of areas with cited deficiencies.

How it Yields Information about the Area(s) being Monitored

MCOs and PAHPs must demonstrate compliance with health plan standards to an independent accrediting organization recognized by CMS for this purpose. The specific areas reviewed apply to the evaluation of Program Impact, Access and Quality. Accreditation therefore provides an important assurance that MCO/PAHP contractors have the operational infrastructure and capacity to meet state and federal program requirements.

- c. **X** Consumer Self-Report data
 X CAHPS (please identify which one(s))
 5.1H CHIP, non-CHIP Child and Adult; 5.1H Dental
 State-developed survey
 Disenrollment survey
 Consumer/beneficiary focus groups

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs through contract with an OHCA-designated CAHPS vendor.

Detailed Description of Activity

Contractors must enter into an agreement with an OHCA-selected vendor to perform annual CAHPS surveys. (There will be one vendor for the entire program.) The surveys will include the CAHPS Health Plan Survey 5.1H CHIP, non-CHIP Child and Adult surveys for MCO contractors and 5.1H dental surveys for PAHP contractors. The CHIP and non-CHIP child surveys also will include the Children with Chronic Conditions item set.

The OHCA also reserves the right under the MCO and PAHP contracts to add State-specific questions to the CAHPS survey and to require contractors to implement the CAHPS ECHO and/or additional mental health care surveys.

Frequency of Use

Surveys must be conducted annually, with findings due to the OHCA by June 15 of each year. Survey data may be included in MCO and PAHP scorecards posted by the OHCA to the agency website.

How the Activity will be Applied to the Areas being Monitored

CAHPS survey findings will be used to evaluate MCO/PAHP performance and to inform Quality Rating System findings. CAHPS data, by domain, will be applied as follows:

- Information to Beneficiaries – Will be evaluated using, at a minimum, results from “How Well Doctors Communicate” and “Customer Service” question sets.

- Timely Access – Will be evaluated, at a minimum, using results from “Getting Care Quickly” and “Getting Needed Care” question sets.
- PCP/Specialist Capacity – Will be evaluated, at a minimum, using results from “Getting Care Quickly” and “Getting Needed Care” question sets.
- Coordination/Continuity – Will be evaluated, at a minimum, using results from “Care Coordination” question and “Children with Chronic Conditions” question sets.
- Coverage/Authorization – Will be evaluated, at a minimum, using results from “Getting Needed Care” question set.
- Quality-of-Care - Will be evaluated, at a minimum, using results from “Rating of Personal Doctor”, “Rating of Specialist”, “Rating of Health Care” and “Rating of Health Plan” question sets.

How it Yields Information about the Area(s) being Monitored

The CAHPS survey provides a profile of MCO/PAHP primary and specialty care accessibility and quality, from the beneficiary’s perspective, based on his or her experience in the plan. The Children with Chronic Conditions item set further explores access and coordination/continuity of care for children with special needs, whether enrolled in the Children’s Specialty or a general SoonerSelect plan.

The OHCA will be developing and implementing a Medicaid Managed Care Quality Rating System, in accordance with 42 C.F.R. § 438.334 and Oklahoma statute 56 O.S. § 4002.11, to evaluate the annual performance of all contractors participating in the SoonerSelect Program. As part of the Quality Rating System, the OHCA will develop a scorecard that compares each contractor on an array of measures, one of which will be Enrollee satisfaction. The scorecard will be compiled quarterly and will consist of the information obtained during the prior quarter. (Survey data will be updated annually in the quarter for which it becomes available.)

- d. X Data Analysis (non-claims)
- X Denials of referral requests
 - X Disenrollment requests by enrollee
 - X From plan
 - X From PCP within plan
 - X Grievances and appeals data
 - X PCP termination rates and reasons
 - X Other (please describe)
 - Multiple reports (see detail below)

MCO and PAHP contracts define an extensive inventory of mandatory reports, logs, and related data. These reports capture the information listed within the Data Analysis (non-claims) monitoring section. More detail is presented below, by item.

DENIAL OF REFERRAL REQUESTS

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs through submission of required reports to the OHCA.

Detailed Description of Activity

Denials of referral requests are monitored through grievance and appeal reports and provider complaint reports, which break out authorization denials as a trackable item.

Frequency of Use

Contractors must submit data in accordance with SoonerSelect Reporting Manual requirements.

How the Activity will be Applied to the Areas being Monitored

Referral request denial rates will be applied, at a minimum, to the OHCA's evaluation of MCO/PAHP performance with respect to timely access, coverage/authorization and quality-of-care.

How it Yields Information about the Area(s) being Monitored

The rate of referral request denials that result in grievance/appeal activity can provide an early indication of access/network adequacy and/or quality-of-care issues. This information can be used by the OHCA to identify necessary corrective actions or performance improvement project opportunities at the individual contractor and/or program levels.

In the event that corrective action is necessary, the OHCA will require the contractor to submit a written corrective action plan (CAP) that includes a specific proposal and timeline to cure the deficiency. Once approved, the OHCA will monitor the contractor's implementation of the CAP to verify resolution of the deficiency.

DISENROLLMENT REQUESTS BY ENROLLEE – FROM PLAN

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs are responsible for notifying the OHCA through submission of required documentation when a request is made at the conclusion of a grievance process. The OHCA's Eligibility and Covered Services (ECS) Department is responsible for receiving grievance and appeal reports from the MCOs/PAHPs; the reports will document instances of Enrollee disenrollment requests during the lock-in period as the result of dissatisfaction with the MCO or PAHP. ECS will track the volume of requests originating from each MCO/PAHP and for the overall program, as well as requests processed during the first 90 days and during the open enrollment period.

Detailed Description of Activity

Enrollees are permitted to change plans, without showing cause, during the first 90 days of enrollment and at least once every 12 months during the open enrollment period. The OHCA will track these changes through the reporting function within the MMIS.

During the lock-in period, Enrollees may request disenrollment if dissatisfied with resolution of a grievance. The MCO/PAHP will send all relevant records to the OHCA for review and adjudication. The OHCA will track the volume and disposition of such requests.

MCO/PAHP contractors also must submit enrollment and disenrollment reports, which document the volume, and reason for, **such requests**. The OHCA will monitor plan- and program-level trends through these reports.

Frequency of Use

Contractors must submit data in accordance with SoonerSelect Reporting Manual requirements.

How the Activity will be Applied to the Areas being Monitored

Disenrollment request data will be applied, at a minimum, to the OHCA's evaluation of MCO/PAHP performance with respect to beneficiary choice of plans, enrollment/disenrollment, timely access, PCP/specialist capacity and quality-of-care.

How it Yields Information about the Area(s) being Monitored

The rate of disenrollment requests can provide an early indication of access/network adequacy and/or quality-of-care issues. This information can be used by the OHCA to identify necessary corrective actions or

performance improvement project opportunities at the individual contractor and/or program levels.

DISENROLLMENT REQUESTS BY ENROLLEE – FROM PCP or PRIMARY CARE DENTIST (PCD)

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs are responsible for documenting PCP and PCD disenrollment requests through submission of PCP/PCD change reports. The OHCA will track the volume of requests originating from each MCO/PAHP and for the overall program.

Detailed Description of Activity

Enrollees are permitted to change PCPs/PCDs, without showing cause. Such requests will be monitored through PCP change reports, which document the volume and reasons for PCP changes.

How the Activity will be Applied to the Areas being Monitored

PCP/PCD change request data will be applied, at a minimum, to the OHCA's evaluation of MCO/PAHP performance with respect to timely access, PCP/specialist capacity, provider selection and quality-of-care.

How it Yields Information about the Area(s) being Monitored

The rate of change requests can provide an early indication of access/network adequacy and/or quality-of-care issues, both at the individual practitioner and plan level.

GRIEVANCE AND APPEALS DATA

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs through submission of grievance and appeals summary reports. The OHCA will track the volume of grievances and appeals by MCO/PAHP.

Detailed Description of Activity

Grievance and appeals performance will be monitored through the grievance and appeal reports that document the volume, timely processing and reasons for Enrollee grievances; volume, timely processing, overturn rate and reasons for Enrollee appeals; volume of appeals escalating to State Fair Hearing; and overturn rate at the Fair Hearing stage.

Frequency of Use

Contractors must submit data in accordance with SoonerSelect Reporting Manual requirements.

How the Activity will be Applied to the Areas being Monitored

Grievance and appeals data will be applied, at a minimum, to the OHCA's evaluation of MCO/PAHP performance with respect to information to beneficiaries, timely access, PCP/specialist capacity, coordination/continuity, coverage/authorization and quality-of-care.

How it Yields Information about the Area(s) being Monitored

Grievance volume and trends can provide an early indication of unsatisfactory customer service, as well as coordination/continuity of care, access/network adequacy and/or quality-of-care issues.

Appeal volume and trends can provide an early indication of coverage/authorization, and/or quality-of-care issues. The overturn rate at the plan and Fair Hearing level also can provide an indication of inappropriate prior authorization processes.

The OHCA has established performance standards for timely resolution of grievances and appeals; 98 percent must be resolved within 30 days and 100 percent must be resolved within 60 days of receipt. Enrollees must receive written notice of resolution within three calendar days of the case being resolved. The OHCA may impose liquidated damages for failure to meet performance standards.

PCP/PCD TERMINATION RATES AND REASONS

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs through submission of network provider enrollment/disenrollment reports. The OHCA will track the volume of disenrollments by MCO/PAHP.

Detailed Description of Activity

PCP/PCD termination rates and reasons will be monitored through network provider enrollment/disenrollment reports. The reports will categorize both the volume and reasons for PCP/PCD disenrollments.

Frequency of Use

Contractors must submit data in accordance with SoonerSelect Reporting Manual requirements.

How the Activity will be Applied to the Areas being Monitored

PCP/PCD termination rate data will be applied, at a minimum, to the OHCA's evaluation of MCO/PAHP performance with respect to program integrity, PCP/specialist capacity, coordination/continuity, coverage/authorization, provider selection and quality-of-care.

How it Yields Information about the Area(s) being Monitored

PCP/PCD disenrollment trends can provide an early indication of unsatisfactory provide network management, including with respect to claims payment timeliness and accuracy, authorization processes, provider services, coordination/continuity of care and quality-of-care.

An upward trend also can be a precursor to potential network adequacy and access issues.

This information can be used by the OHCA to identify necessary corrective actions or performance improvement project opportunities at the individual contractor and/or program levels.

OTHER DATA ANALYSIS (NON-CLAIMS)

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs through submission of mandatory operational reports. The OHCA will monitor reports for early identification of potential program, access or quality issues.

Detailed Description of Activity

The OHCA will require MCO/PAHP contractors to compile and report operational data in additional categories relevant to program impact, access and quality. The categories include:

- Covered benefits reports;
- Medical management reports;
- Care management and population health reports;
- Transition of care reports;
- Quality improvement reports;
- Enrollee services reports;
- Provider network development reports;
- Provider services reports;
- Provider payment reports;
- AI/AN population and IHCP reports; and
- Program integrity reports.

More information about specific reports is presented throughout the monitoring section, as applicable.

Frequency of Use

Frequency varies by report. Contractors must submit data in accordance with SoonerSelect Reporting Manual requirements.

How the Activity will be Applied to the Areas being Monitored

Other operational reports will be applied, at a minimum, to the OHCA's evaluation of MCO/PAHP performance as follows:

- Covered benefits reports – Coverage/authorization
- Medical management reports – Timely access, continuity/coordination and coverage/authorization
- Care management and population health reports – continuity/coordination

- Transition of care reports – continuity/coordination
- Quality improvement reports – Quality-of-care
- Enrollee services reports – Enrollment/disenrollment and information to beneficiaries
- Provider network development reports – Timely access, PCP/specialist capacity and provider selection
- Provider services reports - Coverage/authorization
- Provider payment reports – Coverage/authorization
- AI/AN population and IHCP reports – Choice and information to beneficiaries
- Program integrity reports – Program integrity

How it Yields Information about the Area(s) being Monitored

The additional operational reports will support the OHCA’s broad-based monitoring activities. More specifically,

- Program impact monitoring will be supported by: covered benefits reports; enrollee services reports; AI/AN population and IHCP reports; and program integrity reports.
- Access monitoring will be supported by: medical management reports and provider network development reports.
- Quality monitoring will be supported by: care management and population health reports; transition of care reports; provider services reports; provider payment reports; and quality improvement reports.

This information can be used by the OHCA to identify necessary corrective actions or performance improvement project opportunities at the individual contractor and/or program levels.

e. **X** Enrollee Hotlines operated by State

Applicable Programs

MCO and PAHP

Personnel Responsible

Oklahoma Lifeline Vendor Network, OHCA and MCOs/PAHPs.

Detailed Description of Activity

MCO contractors must use the Oklahoma 24-hour 988 mental health lifeline vendor network for provision of telephonic behavioral health crisis services.

The OHCA maintains a toll-free compliance hotline for reporting potential fraud, waste, and abuse. Contractors must publicize the hotline to Enrollees and must also operate their own toll-free hotline for the same purpose.

Frequency of Use

The toll-free compliance hot lines are open during normal business hours.

How the Activity will be Applied to the Areas being Monitored

Data regarding calls to the mental health life line will be sent to SoonerSelect Operations, which in turn will share the information with the OHCA Behavioral Health Unit and the Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS). Both agencies will use the data to evaluate behavioral health coordination/continuity of care within the MCOs.

Compliance hotline data also will be sent to SoonerSelect Operations, for appropriate follow-up and tracking.

How it Yields Information about the Area(s) being Monitored

Data regarding calls to the mental health life line will provide information on potential behavioral health access or quality-of-care issues within MCOs.

Compliance hotline data will be used to identify potential program integrity concerns within individual MCOs/PAHPs.

- f. X Focused Studies (detailed investigations of certain aspects of clinical or non-clinical services at a point in time, to answer defined questions. Focused studies differ from performance improvement projects in that they do not require demonstrable and sustained improvement in significant aspects of clinical care and non-clinical service).

Applicable Programs

MCO and PAHP

Personnel Responsible

OHCA EQRO and MCOs/PAHPs.

Detailed Description of Activity

MCO/PAHP Contractors may be required to conduct special focused studies as determined by the OHCA, as part of a broader set of requirements to address specific quality concerns.

The OHCA, through its External Quality Review Organization (EQRO) contract, also has the ability to use the EQRO to conduct focused studies related to quality-of-care, as designated by the agency.

Frequency of Use

Focused studies will be conducted on an as-needed basis, to be determined by the OHCA.

How the Activity will be Applied to the Areas being Monitored

Focused studies will be designed and implemented in response to potential quality-of-care issues or identified opportunities for quality improvement.

How it Yields Information about the Area(s) being Monitored

Focused studies, if required, will target specific quality-of-care issues at the MCO/PAHP and/or SoonerSelect program level. Study findings will provide the OHCA with data that can be used to resolve the issues through promulgation of corrective action plans at the MCO/PAHP level and/or through changes in policy or contract standards at the program level.

- g. X Geographic mapping of provider network

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs through submission of mandatory operational reports. The OHCA will monitor reports for early identification of potential program, access or quality issues.

Detailed Description of Activity

MCO/PAHP Contractors must submit Geo-Access reports showing compliance with program travel time and distance standards.

Frequency of Use

Contractors must submit maps in accordance with SoonerSelect Reporting Manual requirements.

How the Activity will be Applied to the Areas being Monitored

Geo-Access reports will be applied to the OHCA's evaluation of individual and aggregate MCO/PAHP performance in the following areas:

- Choice – to verify adequate provider choice for beneficiaries across MCOs/PAHPs
- Timely Access – to verify contractor compliance with travel time standards
- PCP/Specialist Capacity – to verify contractor compliance with travel time standards
- Provider Selection – to verify adequate provider choice for beneficiaries within MCOs/PAHPs

How it Yields Information about the Area(s) being Monitored

MCO and PAHP contractors must demonstrate compliance with network travel time and distance standards, in accordance with 42 C.F.R. § 438.68(b)(3). The standards apply to PCP, mental health, substance use disorder, pharmacy and hospital providers.

The OHCA will review Geo-Access reports as part of network monitoring activities, to verify compliance with travel time and distance standards. MCO and PAHP contracts include provisions for addressing coverage gaps that the OHCA will enforce if such gaps are identified through the monitoring process. These may include assessment of liquidated damages, submission of a corrective action plan, more frequent reporting of network capacity and/or suspension from the new member auto-assignment process.

This information also can be used by the OHCA to identify performance improvement project opportunities (e.g., use of alternative care delivery methods/modes in rural areas lacking specialty providers) at the individual contractor and/or program levels.

- h. X Independent Assessment of program impact, access, quality, and cost-effectiveness (**Required** for first two waiver periods)

Applicable Programs

MCO and PAHP

Personnel Responsible

Independent evaluator personnel under contract to the OHCA.

Detailed Description of Activity

The OHCA has contracted with an independent organization to assess access, quality and cost-effectiveness under the existing SoonerCare Section 1115 Demonstration. The OHCA has contracted with the same organization to perform the required independent assessment of the 1915b waiver.

The OHCA's EQRO contract also includes CMS-required and optional review protocols for oversight of MCO and PAHP activities.

Contractors must cooperate fully to support the OHCA's performance of monitoring activities as set forth in 42 CFR 438.66.

Frequency of Use

Independent evaluation activities will be ongoing, with findings for the initial two-year waiver period included in the renewal application to be submitted at least 90 days prior to the waiver's expiration.

How the Activity will be Applied to the Areas being Monitored

The OHCA and its evaluator are in the process of developing a comprehensive design for the independent assessment of the 1915b waiver. Based on the approach taken for the 1115 demonstration evaluation, it is expected that the assessment will, at a minimum, be applied to the areas being monitored as follows:

- **Enroll/Disenroll** – The assessment will examine enrollment and disenrollment trends to document performance at the MCO/PAHP and program levels.
- **Information to Beneficiaries** – The assessment will examine MCO/PAHP and OHCA communications for clarity and accuracy, and will review grievance data to identify trends/issues related to communication.
- **Grievance** – The assessment will examine grievance volume and trends, by grievance type, to identify issues at the MCO/PAHP and program levels.

- Timely Access – The assessment will examine access and grievance reports and trends, as well as CAHPS data, to evaluate performance at the MCO/PAHP and program levels.
- PCP/Specialty Capacity – The assessment will examine PCP/specialist and grievance reports and trends, as well as CAHPS data, to evaluate performance at the MCO/PAHP and program levels.
- Coordination/Continuity – The assessment will examine medical management reports and trends, HEDIS/encounter, CAHPS and provider survey data, to evaluate performance at the MCO/PAHP and program levels.
- Coverage/Authorization - The assessment will examine medical management and grievance reports and trends, as well as CAHPS and provider survey data, to evaluate performance at the MCO/PAHP and program levels.
- Provider Selection – The assessment will examine PCP/specialist and grievance reports and trends, as well as CAHPS data, to evaluate performance at the MCO/PAHP and program levels.
- Quality-of-Care – The assessment will examine quality improvement reports and trends, HEDIS/encounter, CAHPS and provider survey data, to evaluate performance at the MCO/PAHP and program levels.

How it Yields Information about the Area(s) being Monitored

The independent assessment will examine program performance with respect to access, quality-of-care and cost effectiveness and will be conducted in accordance with CMS guidelines for 1915b evaluations.

Assessment findings will be presented, as appropriate, at both the contractor and program level. Contractor-specific data may be used as a component of future procurement processes while program-level data may be used to inform decision making with respect to performance improvement objectives and contractual standards.

- i. **X** Measurement of any disparities by racial or ethnic groups

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs and PAHPs. The OHCA will monitor reports for evidence of health disparities that require new strategies or corrective actions by one or more contractors.

Detailed Description of Activity

The OHCA is committed to health equity for SoonerSelect Enrollees and to the elimination of disparities based on an individual's racial or ethnic background.

MCO and PAHP contractors must participate in, and support the OHCA's efforts to reduce health disparities. Contractors must develop and submit a cultural competency and sensitivity plan to the OHCA during readiness reviews, prior to the start of operations.

The cultural competency plan must include guidelines for evaluating health equity and monitoring disparities in membership and service quality, especially with regard to minority groups. The plan must address how a contractor will identify and develop intervention strategies for high-risk health conditions found in certain cultural groups, including AI/AN Enrollees, among other activities.

Once operational, contractors must collect and use Enrollee-identified race, ethnicity, language, and Social Determinants of Health data to identify and reduce disparities in health care access, services, and outcomes. This includes, where possible, stratifying HEDIS and CAHPS, and Health Risk Assessment results by race, ethnicity, or other relevant demographics, and implementing a strategy to reduce identified disparities.

Contractors also must maintain health equity representatives who are actively involved in improvement initiatives to reduce disparities by obtaining input from Enrollees and from providers of direct services which are intended to reduce adverse health outcomes among Enrollees, determining the root cause of inequities, developing targeted interventions and measures, and collecting and analyzing data to track progress in disparity reduction efforts.

In addition, MCO and PAHP contractors must earn NCQA Health Equity Accreditation in the State of Oklahoma within two years from the Operations Start Date and maintain Health Equity Accreditation throughout the term of the contract. Contractors must provide the State with evidence of the Contractor's Health Equity Accreditation, including the results of the Contractor's most recent NCQA review.

Health Equity accreditation directly addresses disparities in care. Accredited contractors must demonstrate they have the capacity and

processes for using data to identify and address disparities in care, including unmet social needs, to support better health outcomes.

Frequency of Use

The cultural competency and sensitivity plan will be examined as part of MCO/PAHP readiness reviews. Accreditation data will be submitted annually after achievement of initial accreditation. Contractor commitment to the cultural competency plan and to identification and elimination of health disparities will be monitored through evaluation of mandatory reports that break-out data by racial and ethnic group. The frequency of use for these reports will vary by their individual submission schedules.

The OHCA will collaborate with MCO and PAHP contractors prior to the start of operations, on creation of uniform reporting standards. These standards will address the circumstances under which data should be reported by racial and ethnic group.

How the Activity will be Applied to the Areas being Monitored

MCO/PAHP data on performance by racial and ethnic group will be applied to monitoring activities in the following areas:

- Timely Access – MCO/PAHP accessibility reports and CAHPS data (if reportable by racial/ethnic category) will be reviewed to identify any disparity across racial or ethnic groups.
- Coordination/Continuity – MCO/PAHP medical management reports and CAHPS data (if reportable by racial/ethnic category) will be reviewed to identify any disparity across racial or ethnic groups.
- Quality-of-Care – MCO quality improvement reports, HEDIS and CAHPS data (if reportable by racial/ethnic category) will be reviewed to identify any disparity across racial or ethnic groups.

How it Yields Information about the Area(s) being Monitored

Operational reports and other data that stratify results by racial and ethnic group will provide the OHCA with the necessary information to monitor progress toward elimination of disparities. The OHCA, in conjunction with contractors, will identify performance improvement priorities and develop strategies for their implementation at the individual contractor or program level.

- j. X Network adequacy assurance submitted by plan [**Required** for MCO/PIHP/PAHP]

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs through submission of network adequacy plans. The OHCA EQRO through its evaluation of network adequacy, as part of annual MCO/PAHP review activities.

Detailed Description of Activity

In accordance with 42 C.F.R. § 438.207(a), contractors must provide assurances to the OHCA and furnish a Provider Network Development and Management Plan that demonstrates they have the capacity to serve the expected enrollment in their service areas in accordance with OHCA’s standards for access to care and in accordance with 42 C.F.R. §§ 438.68 and 438.206(c)(1).

The OHCA’s EQRO vendor will validate network adequacy during the preceding 12 months to comply with requirements set forth in 42 C.F.R. §§ 438.68 and 438.14(b)(1).

Frequency of Use

Contractors must submit network adequacy data in accordance with SoonerSelect Reporting Manual requirements.

The EQRO review will occur annually.

How the Activity will be Applied to the Areas being Monitored

MCO/PAHP data on network adequacy will be applied to monitoring activities in the following areas:

- Timely Access – MCO/PAHP network adequacy reports will be reviewed to identify any geographic gaps and potential barriers to timely access.
- PCP/Specialist Capacity – MCO/PAHP network adequacy reports will be reviewed to identify any potential barriers to primary or specialty care access.
- Provider Selection – MCO/PAHP network adequacy reports will be reviewed to identify any potential barriers to offering beneficiaries a choice of providers.

How it Yields Information about the Area(s) being Monitored

The approved Network Development and Management Plan will serve as a standard against which the EQRO can measure a contractor's performance. The EQRO's evaluation will provide the OHCA with findings regarding provider capacity and geographic coverage, including any gaps requiring corrective action.

- k. Ombudsman
(Not a component of the monitoring plan.)

- l. On-site review

Applicable Programs

MCO and PAHP

Personnel Responsible

OHCA and EQRO staff.

Detailed Description of Activity

In accordance with 42 C.F.R. § 438.66, the OHCA will conduct a readiness review of all MCO and PAHP contractors prior to the program operational start date. The readiness review will include both a desk review of Contractor documentation and an on-site review at the contractor's offices.

The scope of the review will include:

- Administration (e.g., staffing and resources, delegation);
- Enrollment Functions;
- Member Services;
- Provider and Provider Network;
- Coverage of Services and Benefits;
- Quality and Utilization Management;
- Care Coordination and Population Health;
- Grievance and Appeals;
- Program Integrity;
- Information Technology (e.g., claims management, encounter data, and enrollment information management);

- Finance; and
- General Terms and Conditions.

MCOs/PAHPs will be required to submit annual updates of readiness review materials to SoonerCare Operations. The OHCA’s EQRO contract permits the agency to use the EQRO for subsequent on-site reviews on an as-needed basis. MCO and PAHP contractors are obligated to cooperate with any such reviews or audits.

Frequency of Use

Readiness reviews will occur prior to a contractor’s operational start date. Future on-site reviews will occur as deemed necessary by the OHCA.

How the Activity will be Applied to the Areas being Monitored

The onsite readiness reviews will be comprehensive in scope, addressing all of the above listed MCO/PAHP areas of operation and encompassing all monitoring plan Program Impact, Access and Quality components.

OHCA staff will review policies/procedures and related materials for each area and will conduct interviews with MCO/PAHP managers responsible for MCO/PAHP implementation and operations. OHCA staff also will perform testing of systems and data transfer capacity prior to go-live.

How it Yields Information about the Area(s) being Monitored

The readiness review will serve to identify any corrective actions necessary prior to initiation of enrollment into an MCO or PAHP. Readiness review findings also will provide baseline information on each plan’s operational capacity (e.g., staffing counts), against which future performance can be evaluated.

Future on-site reviews, if deemed necessary, will be used by the OHCA to identify necessary corrective actions or performance improvement project opportunities at the individual contractor and/or program levels.

- m. Performance Improvement projects [**Required** for MCO/PIHP]
 Clinical
 Non-clinical

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs and OHCA EQRO.

Detailed Description of Activity

In accordance with 42 C.F.R. § 438.330(a)(1), each contractor must establish and implement an ongoing comprehensive Quality Assessment and Performance Improvement (QAPI) program for the services it furnishes. The contractor's QAPI program must comply with all requirements of State and federal law and regulations and use standards and guidelines from the contractor's Accrediting Entity, including standards for Quality Management, Quality Improvement, Quality Assessment, and Performance Improvement Programs (PIPs).

MCO contractors are required to conduct at least three PIPs annually. Initially, contractors must propose, for the OHCA's approval, one non-clinical and two clinical PIPs; one clinical PIP that addresses physical health and one that addresses behavioral health. PAHP contractors are required to conduct at least two PIPs annually, one clinical and one non-clinical. In subsequent years, PIP topics may be identified by CMS, the contractor, or the OHCA. All PIPs are subject to final approval by OHCA.

Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and Enrollee satisfaction, in accordance with 42 C.F.R. § 438.330(d)(2), and must include the following elements set forth at 42 C.F.R. § 438.330(d)(2)(i)-(iv):

- Measurement of performance using objective quality indicators;
- Implementation of interventions to achieve improvement in the access to and quality-of-care;
- Evaluation of the effectiveness of the intervention based on the performance measures collected as part of the PIP; and
- Planning and initiation of activities for increasing or sustaining improvement.

In accordance with 42 C.F.R. § 438.330(d)(3), the contractor must report the status and results of each PIP as requested by the OHCA, which will be no less than annually, or as needed. Improvement must be measured through comparison of a baseline measurement and an initial re-measurement following application of an intervention. Annual changes will be evaluated for statistical significance using a 95 percent confidence interval. Status reports on PIPs may be requested more frequently by the OHCA.

PIPs are subject to annual independent validation by the SoonerSelect EQRO to ensure compliance with CMS protocols and OHCA’s policy, including timeline requirements.

PIPs that have successfully achieved sustained improvement, as approved by the OHCA, will be considered complete and will no longer count toward the minimum PIP requirement, although the contractor may wish to continue to monitor the performance indicator as part of its overall QAPI program. In this event, the contractor will select a new PIP and submit it to the OHCA for approval.

Frequency of Use

Contractors must report PIP findings at least annually, or more frequently if required by the OHCA.

How the Activity will be Applied to the Areas being Monitored

MCO/PAHP PIP findings will be applied to quality-of-care monitoring activities. The specific application of the findings will be dependent on the PIP topics.

How it Yields Information about the Area(s) being Monitored

Clinical PIP findings will provide evidence of contractor physical and behavioral health quality-of-care in areas deemed to be priorities for improvement. Non-clinical PIP findings similarly will provide evidence of contractor performance in meeting Enrollee non-medical needs.

Successful outcomes may drive program-level performance improvement, through sharing of innovative approaches and adoption of these innovations by other contractors. The OHCA also will review findings to identify opportunities for strengthening the quality component of MCO and PAHP contracts by incorporating successful PIP components into future operational requirements.

- n. **X** Performance measures [**Required** for MCO/PIHP]
 - X** Process
 - X** Health status/outcomes
 - X** Access/availability of care
 - X** Use of services/utilization
 - Health plan stability/financial/cost of care
 - Health plan/provider characteristics
 - X** Beneficiary characteristics

Note: The categories denoted above with an “X” are those for which the OHCA has identified performance measures to be included as part of the formal SoonerSelect quality program and withhold payment schedule.

The OHCA also requires extensive MCO and PAHP reporting on plan stability, finances, and cost of care (through encounter data). Provider characteristics are monitored through provider network reporting described elsewhere in the monitoring plan.

Applicable Programs

MCO and PAHP

Personnel Responsible

The OHCA, for establishment of performance measures. MCOs/PAHP’s for collection and reporting of results. The OHCA EQRO for validation of performance measure results.

Detailed Description of Activity

Contractors will be expected to report the comprehensive HEDIS measure set in accordance with accreditation standards. In addition, the OHCA has established and will update annually quality performance measures in accordance with 42 C.F.R. § 438.330(c)(1)(i). The measures are specific to the SoonerSelect program and include target performance rates that will increase annually.

The performance measures have been selected to provide evidence of the overall quality-of-care and specific services provided to each SoonerSelect Program population group. The measures for the first operational year are presented below, by contract type. The measure set/source for each measure also is noted (CMS Core Set, HEDIS, OHCA, etc.). All measures are reported annually, unless otherwise noted.

SOONERSELECT MCO

Performance Measure	Measure Set/Source
1. Childhood Immunization Status (CIS-CH) Combination Three	CMS Child Core Set
2. Well-Child Visits in the First 30 Months of Life (W30-CH)	CMS Child Core Set
3. Immunizations for Adolescents (IMA-CH) Combination One	CMS Child Core Set
4. Child and Adolescent Well-Child Visits (WCV-CH)	CMS Child Core Set
5. Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	CMS Child Core Set

6. Prenatal and Postpartum Care: Postpartum Care (PPC-AD)	CMS Adult Core Set
7. Ambulatory Care: Emergency Department Visits (AMB-CH)	CMS Child Core Set
8. Emergency Department Utilization (EDU)	NCQA HEDIS
9. Follow-up after Hospitalization for Mental Illness: Ages Six to 17 (FUH-CH)	CMS Child Core Set
10. Follow-up after Emergency Department Visit for Mental Illness: Age 18 and Older (FUM-AD)	CMS Adult Core Set
11. Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Poor Control (>9.0%) (HPC-AD)	CMS Adult Core Set
12. Plan All-Cause Readmissions (PCR-AD)	CMS Adult Core Set

SOONERSELECT CHILDREN'S SPECIALTY PROGRAM

Performance Measure	Measure Set/Source
13. Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC-CH)	CMS Child Core Set
14. Chlamydia Screening in Women Ages 16 to 20 (CHL-CH)	CMS Child Core Set
15. Childhood Immunization Status (CIS-CH)	CMS Child Core Set
16. Well-Child Visits in the First 30 Months of Life (W30-CH)	CMS Child Core Set
17. Immunizations for Adolescents (IMA-CH) Combination One	CMS Child Core Set
18. Developmental Screening in the First Three Years of Life (DEV-CH)	CMS Child Core Set
19. Child and Adolescent Well-Care Visits (WCV-CH)	CMS Child Core Set
20. Live Births Weighing Less than 2,500 Grams (LBW-CH)	CMS Child Core Set
21. Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-CH)	CMS Child Core Set
22. Contraceptive Care – Postpartum Women Ages 15 to 20 (CCP-CH)	CMS Child Core Set
23. Contraceptive Care – All Women Ages 15 to 20 (CCP-CH)	CMS Child Core Set
24. Low-Risk Cesarean Delivery (LRCD-CH)	CMS Child Core Set
25. Asthma Medication Ratio: Ages Five to 18 (AMR-CH)	CMS Child Core Set
26. Ambulatory Care: Emergency Department Visits (AMB-CH)	CMS Child Core Set

Performance Measure	Measure Set/Source
27. Follow-up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-CH)	CMS Child Core Set
28. Follow-up after Hospitalization for Mental Illness: Ages Six to 17 (FUH-CH)	CMS Child Core Set
29. Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-CH)	CMS Child Core Set
30. Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP-CH)	CMS Child Core Set
31. Follow-up after Emergency Department Visit for Alcohol and other Drug Abuse and Dependence: Ages 13 to 17 (FUA-CH)	CMS Child Core Set
32. Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment	Merit-Based Incentive Payment System (MIPS)
33. Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents	NCQA/HEDIS
34. AHRQ Pediatric Quality Indicator – PDI 14 Asthma Admission Rate	AHRQ
35. AHRQ Pediatric Quality Indicator – PDI 15 Diabetes Short-Term Complications Admission Rate	AHRQ
36. First Well-Care Visit within 30 Days of Initial Entry into Foster Care (Quarterly, or as defined by the OHCA)	OHCA-defined measure
37. Appropriate Number of Well-Care Visits for their Age during Foster Care (Quarterly, or as defined by the OHCA)	OHCA-defined measure
38. Care Coordination Letters at Foster Home Changes (Quarterly, or as defined by the OHCA)	OHCA-defined measure

SOONERSELECT DENTAL

Performance Measure	Measure Set/Source
39. Oral Evaluation, Dental Services (OEV-CH)	Dental Quality Alliance (DQA) (ADA)
40. Topical Fluoride for Children (TFL-CH)	Dental Quality Alliance (DQA) (ADA)
41. Sealant Receipt on Permanent First Molars (SFM-CH)	Dental Quality Alliance (DQA) (ADA)
42. Annual Dental Visit	NCQA/HEDIS
43. Periodontal Evaluation in Adults with Periodontitis	Dental Quality Alliance (DQA) (ADA)

MCO and PAHP contractors must contract with an NCQA-certified HEDIS auditor to validate the processes of the Contractor in accordance with NCQA requirements. The OHCA EQRO will verify HEDIS data submissions and will validate non-HEDIS performance measure data.

Contractors must meet OHCA-specified performance targets for all quality performance measures. The performance targets for each of the required measures will be determined by the OHCA in collaboration with program contractors.

Although quality performance targets will be updated annually, the OHCA, at its discretion, may change these targets and/or change the timelines associated with meeting the targets.

The OHCA will post information about quality measures and performance outcomes on the agency website. This information shall be updated at least annually, or as needed.

Frequency of Use

Contractors must report performance measure results annually, or more frequently as specified by the OHCA.

How the Activity will be Applied to the Areas being Monitored

MCO/PAHP performance measure data will be applied to monitoring activities in the following areas:

- Timely Access – Will be monitored, at a minimum, through evaluation of measures 2, 4, 5, 19, 21 and 42.
- Coordination/Continuity – Will be monitored, at a minimum, through evaluation of measures 9 – 11, 25, 27 – 29, 31, 36, 38, 41 and 43.
- Quality-of-Care – Will be monitored, at a minimum, through evaluation of measures 1, 3, 6 – 8, 12 – 18, 20, 22 – 24, 26, 30, 32 – 35, 37, 39 and 40.

How it Yields Information about the Area(s) being Monitored

The quality measure sets provide critical baseline clinical and non-clinical data against which contractor performance can be measured, both longitudinally against baseline rates, and compared to other contractors.

The OHCA will be applying a quality performance withhold, starting in the second year of the program. MCO and PAHP contractors will have the

opportunity to earn back withhold amounts by meeting or exceeding performance thresholds.

If the OHCA determines that a contractor's performance relative to any of the quality performance targets is not acceptable, the OHCA may require the Contractor to submit a corrective action plan. The information also can be used by the OHCA to identify performance improvement project opportunities at the individual contractor and/or program levels.

- o. **X** Periodic comparison of number and types of Medicaid providers before and after waiver

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs and PAHPs.

Detailed Description of Activity

MCO and PAHP contractors must submit monthly listings of all participating providers, in a format specified by the OHCA. The data will be available to the OHCA for tracking the number of providers, by type, at both the plan and program level (adjusting for duplication across networks).

Frequency of Use

Contractors must submit an updated listing monthly.

How the Activity will be Applied to the Areas being Monitored

MCO/PAHP data on number and types of providers will be applied to monitoring activities in the following areas:

- Choice – MCO/PAHP provider reports will be reviewed to verify beneficiaries have an adequate choice of providers across plans. Due to their frequency (monthly), these reports will serve as an early warning indicator of potential emerging issues.
- PCP/Specialist Capacity – MCO/PAHP provider reports will be reviewed to identify any potential barriers to primary or specialty care access.

- Provider Selection – MCO/PAHP provider reports will be reviewed to identify any potential barriers to offering members a choice of providers in accordance with contract requirements.

How it Yields Information about the Area(s) being Monitored

The OHCA will use network data to track changes in capacity at the plan and program level, and for early identification of potential issues related to provider choice or timely access to services. This information can be used by the OHCA to identify necessary corrective actions or performance improvement project opportunities at the individual contractor and/or program levels.

- p. X Profile utilization by provider caseload (looking for outliers)

The OHCA will not formally be profiling utilization by provider caseload, to identify outliers. However, as part of its QAPI program, each MCO and PAHP contractor must describe a methodology for profiling providers using clinical, administrative and Enrollee satisfaction indicators of care. The contractor must establish benchmarks by provider type and geographic area, against which to evaluate individual provider performance, and must offer feedback to providers regarding their performance. It is expected this will be used as part of quality improvement activities and to identify outliers, including with respect to service utilization.

The results of the profiles will be available to the OHCA as part of the agency's broader oversight and review of each contractor's QAPI program. The agency will evaluate the profiles and follow-up with contractors to address identified issues.

- q. X Provider Self-report data
 X Survey of providers
 ___ Focus groups

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs and PAHPs in collaboration with the OHCA (survey design component).

Detailed Description of Activity

MCO and PAHP contractors must conduct an annual participating provider satisfaction survey that is inclusive of all participating providers. The OHCA will collaborate with MCO and PAHP contractors to review and approve a uniform set of provider satisfaction measures and a uniform survey instrument. The approved survey instrument will include six domains:

- Provider relations and communication;
- Clinical management processes;
- Authorization processes, including denials and Appeals;
- Timeliness of claims payment and assistance with claims processing;
- Grievance resolution process; and
- Care management support.

Each contractor will conduct the survey and compile and analyze its survey results for submission to the OHCA annually. The survey report results will include a summary of the survey methods and discrete findings for physical health and behavioral health providers, with an analysis of opportunities for improvement. The contractor will provide the survey results to the OHCA with an action plan to address findings, as appropriate.

Frequency of Use

Contractors must report survey results annually.

How the Activity will be Applied to the Areas being Monitored

MCO/PAHP provider survey results will be applied to monitoring activities in the following areas:

- Grievance – Provider responses to grievance resolution questions will be reviewed to assess MCO/PAHP performance in processing grievances timely and accurately.
- Coordination/Continuity – Provider responses to clinical management process, provider relations/communications and care management support questions will be reviewed to assess MCO/PAHP performance in coordinating and facilitating continuity of care.
- Coverage/Authorization - Provider responses to authorization process and claims timeliness questions will be reviewed to assess

MCO/PAHP performance in processing authorization requests and claims timely and appropriately.

- Quality-of-Care – Provider responses across all survey domains will be reviewed to identify potential quality-of-care issues for follow-up by the MCO/PAHP.

How it Yields Information about the Area(s) being Monitored

The uniform provider satisfaction survey will facilitate the OHCA’s monitoring activities in each of the six survey domains. The OHCA will be able to measure results both longitudinally against baseline rates, and compared to other contractors.

As described in the CAHPS section, the OHCA will be developing and implementing a Medicaid Managed Care Quality Rating System, in accordance with 42 C.F.R. § 438.334, to evaluate the annual performance of all contractors participating in the SoonerSelect Program. As part of the Quality Rating System, the OHCA will develop a scorecard that compares each contractor on an array of measures, one of which will be provider satisfaction. The scorecard will be compiled quarterly and will consist of the information obtained during the prior quarter.

- r. **X** Test 24 hours/7 days a week PCP availability

Applicable Programs

MCO

Personnel Responsible

MCOs

Detailed Description of Activity

MCO contractors must conduct a 24-Hour Availability Audit to verify participating provider compliance with requirement to be accessible to Enrollees 24 hours per day, seven days per week. Contractors must ensure corrective actions are taken when participating providers fail to meet the requirement.

MCO contractors must submit audit findings to the OHCA as part of broader network development reporting activities.

Frequency of Use

Contractors must submit results in accordance with SoonerSelect Reporting Manual requirements.

How the Activity will be Applied to the Areas being Monitored

MCO/PAHP audit results will be reviewed by the OHCA to verify MCO compliance with timely access standards.

How it Yields Information about the Area(s) being Monitored

The 24-hour audit results and related corrective action information provide information on beneficiary access to timely care at both the MCO and program levels.

- s. X Utilization review (e.g. ER, non-authorized specialist requests)

The SoonerSelect program includes utilization review monitoring through a combination of medical management reports, ER utilization reports and EPSDT compliance documentation.

MEDICAL MANAGEMENT REPORTS

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs

Detailed Description of Activity

MCO and PAHP contractors must submit utilization data as part of broader medical and dental management reporting activities. MCO contractor reports will document inpatient admissions, readmissions, non-emergent use of the ER and drug utilization. Contractors may be required to provide breakout by Enrollees in different care management levels based on the contractor's Risk Stratification Level Framework.

PAHP contractor reports will document elements such as preventive, restorative, prosthetic, orthodontic and oral surgery services.

Both contractor types also must report on approved out-of-State services, to include verification of the unavailability of the services in-State.

Frequency of Use

The submission schedule will vary by report, as delineated in the SoonerSelect Reporting Manual.

How the Activity will be Applied to the Areas being Monitored

MCO/PAHP medical management reports will be applied to monitoring activities in the following areas:

- Coordination/Continuity – The OHCA will review utilization of care data by risk stratification level (if applicable), to verify appropriate care across all risk/acuity levels.
- Quality-of-Care – The OHCA will review utilization of care data by service type and setting (in-state and out-of-state), to verify appropriate access to care across all beneficiaries.

How it Yields Information about the Area(s) being Monitored

Medical Management reports will be monitored to ensure contractor compliance with SoonerSelect standards and to identify potential issues related to access or quality-of-care. Findings will be used for development of corrective actions and/or performance improvement projects at both the individual contractor and program levels.

EMERGENCY ROOM UTILIZATION

Applicable Programs

MCO

Personnel Responsible

MCOs through submission of mandatory operational reports.

Detailed Description of Activity

MCO contractors must continuously review ER utilization data of all Enrollees with the goal of identifying unnecessary or extraneous usage. Contractors must report to the OHCA, every six months, or as otherwise required in the Reporting Manual, on ER UM activities.

For Enrollees whose utilization exceeds the threshold of ER visits defined by the OHCA, the contractor must have procedures in place to conduct the appropriate follow-up, including:

- Enrollee outreach (telephonic or mail);

- Appointment assistance with PCP or specialist;
- Enrollee education; and
- Referral to care management.

Additionally, contractors must work with hospitals to obtain data on ER utilization for behavioral health reasons and length of time in the ER. Contractors must develop remediation plans with hospitals having significant numbers of behavioral health ER stays longer than 23 hours.

Frequency of Use

Contractors must submit results every six months.

How the Activity will be Applied to the Areas being Monitored

MCO/PAHP emergency room utilization reports will be applied to monitoring activities in the following areas:

- Coordination/Continuity – The OHCA will review emergency room data to verify appropriate follow-up with frequent users of this setting.
- Quality-of-Care – The OHCA will review emergency room utilization data to identify potential access and quality-of-care issues driving utilization.

How it Yields Information about the Area(s) being Monitored

The ER utilization report will serve as an early indicator of potential issues related to timely access and care management. MCO contractors reporting negative (upward) trends and/or utilization rates in excess of OHCA thresholds will be required to take corrective action as determined by the OHCA. This information also can be used by the OHCA to identify performance improvement project opportunities at the individual contractor and/or program levels.

EPSDT COMPLIANCE

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs and OHCA EQRO

Detailed Description of Activity

SoonerSelect MCOs and PAHPs will report EPSDT data annually in accordance with specifications of the CMS-416 report.

The OHCA’s EQRO will perform an annual evaluation of each contractor’s compliance with the EPSDT requirements as set forth in the SoonerSelect contract and as required by federal regulations. The EQRO will prepare an Annual EPSDT Compliance Report that presents findings of the Contractor’s evaluation of each contractor’s processes, practices and evidence of compliance with EPSDT requirements. The evaluation will include, among other activities:

- Appropriateness and timeliness of determinations regarding medical necessity;
- Ensuring continuation of services; and
- Prior authorization and utilization review procedures.

Frequency of Use

The EQRO will submit findings annually.

How the Activity will be Applied to the Areas being Monitored

MCO/PAHP EPSDT reports will be applied to monitoring activities in the following areas:

- Coordination/Continuity – The OHCA will review EPSDT reports to verify appropriate management of EPSDT beneficiaries.
- Coverage/Authorization – The OHCA will review EPSDT reports to verify appropriate authorization of services in accordance with EPSDT requirements.
- Quality-of-Care – The OHCA will review EPSDT data to verify compliance with EPSDT screening and treatment requirements.

How it Yields Information about the Area(s) being Monitored

The OHCA will use EQRO findings to identify opportunities for corrective action and/or performance improvement projects, either at the contractor or program levels.

t. X Other: (please describe)

MARKETING PLAN

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs

Detailed Description of Activity

MCO and PAHP contractors must submit marketing plans demonstrating compliance with OHCA and federal regulations as part of readiness review activities, as well as the marketing component of employee training materials. Contractors also must submit documentation of marketing activities for OHCA review.

Frequency of Use

Contractors must submit marketing activity documentation in accordance with SoonerSelect Reporting Manual requirements, or when requested by the OHCA.

How the Activity will be Applied to the Areas being Monitored

Marketing Plan reports will be monitored to ensure contractor compliance with all state and federal regulations.

How it Yields Information about the Area(s) being Monitored

Contractor compliance with marketing regulations will at least in part be determined through marketing plan documentation. Failure to comply with these regulations may result in the imposition of corrective actions and/or liquidated damages.

PROGRAM INTEGRITY REPORTS

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs

Detailed Description of Activity

The OHCA requires contractors to report on compliance with program integrity standards, beyond submission of a compliance plan and the program integrity-related monitoring activities previously described. The reports include, but are not limited to:

- Service Delivery Verification – Report documenting the activities of the contractor to verify service delivery in accordance with contract standards, including information on the number of Evidence of Benefits (EOBs) queries distributed, Enrollee responses and resolution of Enrollee responses;
- Overpayments – Monthly report on recoveries of overpayments; and
- Investigations Opened – Documentation on program integrity investigations initiated and cases ultimately referred to the State.

Frequency of Use

The submission schedule will vary by report, as delineated in the SoonerSelect Reporting Manual.

How the Activity will be Applied to the Areas being Monitored

Program integrity reports will be monitored to ensure contractor compliance with federal and State requirements.

How it Yields Information about the Area(s) being Monitored

Contractor compliance with program integrity standards will at least in part be determined through documentation of service delivery verification and overpayment recoveries. Findings will be used for development of corrective actions or assessment of sanctions/liquidated damages, as applicable.

ENROLLEE SERVICE REPORTS

Applicable Programs

MCO and PAHP

Personnel Responsible

MCOs/PAHPs through submission of mandatory operational reports.

Detailed Description of Activity

The OHCA requires contractors to report on Enrollee services, beyond the monitoring activities previously described. The reports address both care management and service utilization. They include, but are not limited to:

- Health Risk Screening – Report documenting timely completion of Health Risk Screenings of new Enrollees;
- Health Risk Screening Unreachable Enrollees – Report documenting Enrollees the contractor was unable to reach to complete the Health Risk Screening, including name, number of outreach attempts, type(s) of attempts and Enrollee’s contact information;
- Comprehensive Assessment and Reassessment – Report documenting timely completion of comprehensive assessments in accordance with the contractor’s risk stratification level framework;
- Enrollees in Care Management – Report documenting new, closed and total cases assigned to care management;
- Care Management Activities – Report documenting assignment to a care manager, caseload, contacts and success;
- Care Plan – Report documenting the number of care plans initiated, revised, completed, reviewed and reduced;
- Social Determinants of Health - Report documenting Enrollee referrals to social services and activities surrounding contractor partnerships with community-based organizations and social service providers;
- Value-Added Benefits – Report documenting all Value-Added benefits offered by the contractor and Enrollee utilization rates for each; and
- NEMT Utilization – Report documenting the number of Enrollees who received NEMT, number of trips approved, denied, provided, no shows, waiting time and mileage reimbursement.

Frequency of Use

The submission schedule will vary by report, as delineated in the SoonerSelect Reporting Manual.

How the Activity will be Applied to the Areas being Monitored

MCO/PAHP Enrollee Service reports will be applied to monitoring activities in the following areas:

- Enroll/Disenroll – The OHCA will review health risk screening reports to verify appropriate intake of new members.
- Timely Access – The OHCA will assessment, care management/plan and NEMT reports to verify appropriate access to medically necessary services.
- Coordination/Continuity – The OHCA will review care management/plan, SDOH and value-added benefit reports to verify appropriate coordination and continuity-of-care for members with identified needs.
- Coverage/Authorization- The OHCA will review care management/plan and SDOH reports to verify appropriate coverage and authorization processes for members with identified needs.

How it Yields Information about the Area(s) being Monitored

Enrollee service and related reports will be monitored to ensure contractor compliance with SoonerSelect standards and to identify potential issues related to access or quality-of-care. Findings will be used for development of corrective actions and/or performance improvement projects at both the individual contractor and program levels.

Section C: Monitoring Results

Section 1915(b) of the Act and 42 CFR 431.55 require that the State must document and maintain data regarding the effect of the waiver on the accessibility and quality of services as well as the anticipated impact of the project on the State's Medicaid program. In Section B of this waiver preprint, the State describes how it will assure these requirements are met. For an initial waiver request, the State provides assurance in this Section C that it will report on the results of its monitoring plan when it submits its waiver renewal request. For a renewal request, the State provides evidence that waiver requirements were met for the most recent waiver period. Please use Section D to provide evidence of cost-effectiveness.

CMS uses a multi-pronged effort to monitor waiver programs, including rate and contract review, site visits, reviews of External Quality Review reports on MCOs/PIHPs, and reviews of Independent Assessments. CMS will use the results of these activities and reports along with this Section to evaluate whether the Program Impact, Access, and Quality requirements of the waiver were met.

This is an initial waiver request. The State assures that it will conduct the monitoring activities described in Section B, and will provide the results in Section C of its waiver renewal request.

This is a renewal request.

This is the first time the State is using this waiver format to renew an existing waiver. The State provides below the results of the monitoring activities conducted during the previous waiver period.

The State has used this format previously, and provides below the results of monitoring activities conducted during the previous waiver.

For each of the monitoring activities checked in Section B of the previous waiver request, the State should:

- **Confirm** it was conducted as described in Section B of the previous waiver preprint. If it was not done as described, please explain why.
- **Summarize the results** or findings of each activity. CMS may request detailed results as appropriate.
- **Identify problems** found, if any.
- **Describe plan/provider-level corrective action**, if any, that was taken. The State need not identify the provider/plan by name, but must provide the rest of the required information.
- **Describe system-level program changes**, if any, made as a result of monitoring findings.

Please replicate the template below for each activity identified in Section B:

Strategy:

Confirmation it was conducted as described:

Yes

No. Please explain:

Summary of results:
Problems identified:
Corrective action (plan/provider level)
Program change (system-wide level)

Section D – Cost-Effectiveness

Please follow the Instructions for Cost-Effectiveness (in the separate Instructions document) when filling out this section. Cost-effectiveness is one of the three elements required of a 1915(b) waiver. States must demonstrate that their waiver cost projections are reasonable and consistent with statute, regulation and guidance. The State must project waiver expenditures for the upcoming two-year waiver period, called Prospective Year 1 (P1) and Prospective Year 2 (P2). The State must then spend under that projection for the duration of the waiver. In order for CMS to renew a 1915(b) waiver, a State must demonstrate that the waiver was less than the projection during the retrospective two-year period.

A complete application includes the State completing the seven Appendices and the Section D. State Completion Section of the Preprint:

- Appendix D1. Member Months
- Appendix D2.S Services in the Actual Waiver Cost
- Appendix D2.A Administration in the Actual Waiver Cost
- Appendix D3. Actual Waiver Cost
- Appendix D4. Adjustments in Projection
- Appendix D5. Waiver Cost Projection
- Appendix D6. RO Targets
- Appendix D7. Summary Sheet

States should complete the Appendices first and then describe the Appendices in the State Completion Section of the Preprint. Each State should modify the spreadsheets to reflect their own program structure. Technical assistance is available through each State’s CMS Regional Office.

Part I: State Completion Section

The State has completed the cost effectiveness section of the waiver application using CMS-64 expenditure data for the base period of calendar year 2022. To align with the CMS-64 report, the data is presented for three Medicaid Eligibility Groups – TANF and related MEG; CHIP MEG; and Adult Expansion MEG.

The cost effectiveness projections assume a waiver implementation date of February 1, 2024 for all populations and services (medical and dental). Dental services under the waiver will be transitioned to PAHP contractors effective February 1, 2024. Medical services under the waiver will be reimbursed on a fee-for-service basis in February and March, and will be transitioned to MCO contractors effective April 1, 2024.

The State intends to file a separate application under Section 438.6(c) to modify its schedule of provider payment initiatives to support the 1915b managed care program. This application includes estimated amounts for each of the payment initiatives under the proposed methodologies.

A. Assurances

- a. [Required] Through the submission of this waiver, the State assures CMS:
 - The fiscal staff in the Medicaid agency has reviewed these calculations for accuracy and attests to their correctness.
 - The State assures CMS that the actual waiver costs will be less than or equal to or the State’s waiver cost projection.
 - Capitated rates will be set following the requirements of 42 CFR 438.6(c) and will be submitted to the CMS Regional Office for approval.
 - Capitated 1915(b)(3) services will be set in an actuarially sound manner based only on approved 1915(b)(3) services and their administration subject to CMS RO prior approval.
 - The State will monitor, on a regular basis, the cost-effectiveness of the waiver (for example, the State may compare the PMPM Actual Waiver Cost from the CMS 64 to the approved Waiver Cost Projections). If changes are needed, the State will submit a prospective amendment modifying the Waiver Cost Projections.
 - The State will submit quarterly actual member month enrollment statistics by MEG in conjunction with the State’s submitted CMS-64 forms.
- b. Name of Medicaid Financial Officer making these assurances: **Aaron Morris**.
- c. Telephone Number: **(405) 522-7533**
- d. E-mail: **Aaron.Morris@okhca.org**
- e. **e.** The State is choosing to report waiver expenditures based on
 X date of payment.
 ___ date of service within date of payment. The State understands the additional reporting requirements in the CMS-64 and has used the cost effectiveness spreadsheets designed specifically for reporting by date of service within day of payment. The State will submit an initial test upon the first renewal and then an initial and final test (for the preceding 4 years) upon the second renewal and thereafter.

B. For Renewal Waivers only (not conversion)- Expedited or Comprehensive Test—

To provide information on the waiver program to determine whether the waiver will be subject to the Expedited or Comprehensive cost effectiveness test. *Note: All waivers, even those eligible for the Expedited test, are subject to further review at the discretion of CMS and OMB.*

- a. ___ The State provides additional services under 1915(b)(3) authority.
- b. ___ The State makes enhanced payments to contractors or providers.
- c. ___ The State uses a sole-source procurement process to procure State Plan services under this waiver.

- d. Enrollees in this waiver receive services under another 1915(b) waiver program that includes additional waiver services under 1915(b)(3) authority; enhanced payments to contractors or providers; or sole-source procurement processes to procure State Plan services. Note: do not mark this box if this is a waiver for transportation services and dental pre-paid ambulatory health plans (PAHPs) that has overlapping populations with another waiver meeting one of these three criteria. For transportation and dental waivers alone, States do not need to consider an overlapping population with another waiver containing additional services, enhanced payments, or sole source procurement as a trigger for the comprehensive waiver test. However, if the transportation services or dental PAHP waiver meets the criteria in a, b, or c for additional services, enhanced payments, or sole source procurement then the State should mark the appropriate box and process the waiver using the Comprehensive Test.

If you marked any of the above, you must complete the entire preprint and your renewal waiver is subject to the Comprehensive Test. If you did not mark any of the above, your renewal waiver (not conversion or initial waiver) is subject to the Expedited Test:

- Do not complete **Appendix D3**
- Attach the most recent waiver Schedule D, and the corresponding completed quarters of CMS-64.9 waiver and CMS-64.21U Waiver and CMS 64.10 Waiver forms, and
- Your waiver will not be reviewed by OMB *at the discretion of CMS and OMB*.

The following questions are to be completed in conjunction with the Worksheet Appendices. All narrative explanations should be included in the preprint. Where further clarification was needed, we have included additional information in the preprint.

C. Capitated portion of the waiver only: Type of Capitated Contract

The response to this question should be the same as in **A.I.b**.

- a. MCO
b. PIHP
c. PAHP
d. Other (please explain):

D. PCCM portion of the waiver only: Reimbursement of PCCM Providers

Under this waiver, providers are reimbursed on a fee-for-service basis. PCCMs are reimbursed for patient management in the following manner (please check and describe):

- a. Management fees are expected to be paid under this waiver. The management fees were calculated as follows.
1. First Year: \$_____ per member per month fee
 2. Second Year: \$_____ per member per month fee
 3. Third Year: \$_____ per member per month fee

4. ___ Fourth Year: \$___ per member per month fee
- b. ___ Enhanced fee for primary care services. Please explain which services will be affected by enhanced fees and how the amount of the enhancement was determined.
- c. ___ Bonus payments from savings generated under the program are paid to case managers who control beneficiary utilization. Under **D.I.H.d.**, please describe the criteria the State will use for awarding the incentive payments, the method for calculating incentives/bonuses, and the monitoring the State will have in place to ensure that total payments to the providers do not exceed the Waiver Cost Projections (Appendix D5). Bonus payments and incentives for reducing utilization are limited to savings of State Plan service costs under the waiver. Please also describe how the State will ensure that utilization is not adversely affected due to incentives inherent in the bonus payments. The costs associated with any bonus arrangements must be accounted for in Appendix D3. Actual Waiver Cost. d. ___ Other reimbursement method/amount. \$___ Please explain the State's rationale for determining this method or amount.

E. Appendix D1 – Member Months

Please mark all that apply.

For Initial Waivers only:

- a. Population in the base year data
- Base year data is from the same population as to be included in the waiver.
- ___ Base year data is from a comparable population to the individuals to be included in the waiver. (Include a statement from an actuary or other explanation, which supports the conclusion that the populations are comparable.)
- b. ___ For an initial waiver, if the State estimates that not all eligible individuals will be enrolled in managed care (i.e., a percentage of individuals will not be enrolled because of changes in eligibility status and the length of the enrollment process) please note the adjustment here.
- c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
- Projected year one enrollment has been adjusted to account for the end of the Public Health Emergency and reinstatement of eligibility determinations. This is anticipated to result in a reduction in membership as compared to the base year.**

- d. [Required] Explain any other variance in eligible member months from BY to P2: **The state has applied a 0.5% enrollment trend rate from PY1 to PY2.**
- e. [Required] List the year(s) being used by the State as a base year: CY 2022. If multiple years are being used, please explain:
CMS-64 Calendar Year 2022 data was used as the base year for all expenditures.
- f. [Required] Specify whether the base year is a State fiscal year (SFY), Federal fiscal year (FFY), or other period:
Other period: **Calendar Year 2022.**
- g. [Required] Explain if any base year data is not derived directly from the State's MMIS fee-for-service claims data: **N/A**

Member Month Summary

MEG	Base Year (CY22) Member Months	Projected P1 Member Months	Projected P2 Member Months
TANF and Related: Child and Adult	7,344,085	5,654,844	5,683,116
CHIP	1,493,649	1,140,960	1,146,664
Expansion	3,697,122	3,069,964	3,085,312
Total	12,534,856	9,865,768	9,915,092

For Conversion or Renewal Waivers:

- a. [Required] Population in the base year and R1 and R2 data is the population under the waiver.
- b. For a renewal waiver, because of the timing of the waiver renewal submittal, the State did not have a complete R2 to submit. Please ensure that the formulas correctly calculated the annualized trend rates. *Note: it is no longer acceptable to estimate enrollment or cost data for R2 of the previous waiver period.*
- c. [Required] Explain the reason for any increase or decrease in member months projections from the base year or over time:
-

- d. ____ [Required] Explain any other variance in eligible member months from BY/R1 to P2: ____
- e. ____ [Required] Specify whether the BY/R1/R2 is a State fiscal year (SFY), Federal fiscal year (FFY), or other period: _____.

F. Appendix D2.S - Services in Actual Waiver Cost

For Initial Waivers:

- f. X [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account.

All waiver services are included in the cost-effectiveness analysis. One expenditure line item (Employer Sponsored Insurance premiums) was removed from the base year expenditure data for the CHIP MEG; this line item equaled \$948,906.

For Conversion or Renewal Waivers:

- a. ____ [Required] Explain if different services are included in the Actual Waiver Cost from the previous period in **Appendix D3** than for the upcoming waiver period in **Appendix D5**. Explain the differences here and how the adjustments were made _____ on **Appendix D5**:
- b. ____ [Required] Explain the exclusion of any services from the cost-effectiveness analysis. For States with multiple waivers serving a single beneficiary, please document how all costs for waiver covered individuals taken into account: _____

The table below provides a summary of the CMS-64 base year (CY22) expenditures that are included in the cost effectiveness analysis.

MEG	Total Computable	Fee For Service	Indian Health Services	Family Planning
TANF and Related: Child and Adult	\$2,109,823,248	\$1,814,049,379	\$ 282,493,980	\$ 13,279,889
CHIP	\$ 386,436,418	\$ 334,354,919	\$ 49,905,218	\$ 2,176,280
Expansion	\$2,422,983,078	\$2,037,112,122	\$ 375,109,435	\$ 10,761,521
Total	\$4,919,242,744	\$4,185,516,420	\$ 707,508,633	\$ 26,217,691

G. Appendix D2.A - Administration in Actual Waiver Cost

[Required] The State allocated administrative costs between the Fee-for-service and managed care program depending upon the program structure. *Note: initial programs will enter only FFS costs in the BY. Renewal and Conversion waivers will enter all waiver and FFS administrative costs in the R1 and R2 or BY.*

The table below provides a summary of base year FFS administrative costs, base year pmpm administrative costs and projected pmpm administrative costs by MEG. The allocation percentage and line-item distribution of administrative expenses as presented in Appendix D2 are derived from actual reported administrative costs and program costs for the SoonerCare Choice TANF-Urban and TANF-Rural MEGs. FFS administrative costs represent 3.55 percent of base year program costs.

	TANF and Related: Child and Adult	CHIP	Expansion
Base Year FFS Costs	\$ 2,109,823,248	\$ 386,436,418	\$ 2,422,983,078
FFS Administrative Allocation	3.55%	3.55%	3.55%
Base Year FFS Administration Costs	\$ 74,898,725	\$ 13,718,493	\$ 86,015,899
Base Year Member Months	7,344,085	1,493,649	3,697,122
Base Year Administration PMPM	\$ 10.20	\$ 9.18	\$ 23.27
Annual Trend (President's Budget)	4.80%	4.80%	4.80%
Trend Factor: Base Year to P1 (25 Months)	10.26%	10.26%	10.26%
P1 Administration PMPM	\$ 11.24	\$ 10.13	\$ 25.65
Trend Factor: P1 to P2	4.80%	4.80%	4.80%
P2 Administration PMPM	\$ 11.78	\$ 10.61	\$ 26.88

For Initial Waivers:

- g. For an initial waiver, please document the amount of savings that will be accrued in the State Plan services. Savings under the waiver must be great enough to pay for the waiver administration costs in addition to those costs in FFS. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. **Appendix D5** should reflect any savings to be accrued as well as any additional administration expected. The savings should at least offset the administration.

The table below presents a summary of waiver administrative costs in addition to the base year FFS administrative costs. The State's actuaries are in the process of developing capitation rates and State Plan service cost savings are expected to offset the additional administrative costs presented in the table below. Because program savings are expected to offset the additional waiver administrative costs, projected administrative expenses included in Appendix D5 are derived from base year FFS administrative costs and have not been adjusted to include additional waiver administrative costs.

Additional Administration Expense	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: Actuary, Independent Assessment, EQRO, Enrollment Broker- See attached documentation for justification of savings.)</i>	<i>\$54,264 savings or .03 PMPM</i>	<i>9.97% or \$5,411</i>	<i>\$59,675 or .03 PMPM P1</i> <i>\$62,488 or .03 PMPM P2</i>
OHCA projected administrative expenses are presented in the table below. The expenses equal \$2.6 million in program year 1 and \$1.8 million in program year	The state's Actuaries are in the process of establishing capitation rates. The state anticipates the final rates will yield savings in excess of additional administration expenses.		
Total	<i>Appendix D5 should reflect this.</i>		<i>Appendix D5 should reflect this.</i>

Administrative Activity	Program Year 1	Program Year 2	All Years
Actuarial Consulting	\$250,000	\$250,000	\$500,000
Enrollment Broker (OHCA Staff)	\$1,000,000	\$1,000,000	\$2,000,000
MMIS Modifications	\$1,000,000	---	\$1,000,000
EQRO	\$200,000	\$300,000	\$500,000
Independent Evaluation	\$150,000	\$250,000	\$400,000
TOTAL	\$2,600,000	\$1,800,000	\$4,400,000

The allocation method for either initial or renewal waivers is explained below:

- a. ____ The State allocates the administrative costs to the managed care program based upon the number of waiver enrollees as a percentage of total Medicaid enrollees. *Note: this is appropriate for MCO/PCCM programs.*

- b. X The State allocates administrative costs based upon the program cost as a percentage of the total Medicaid budget. It would not be appropriate to allocate the administrative cost of a mental health program based upon the percentage of enrollees enrolled. *Note: this is appropriate for statewide PIHP/PAHP programs.*
- c. ___ Other (Please explain).

H. Appendix D3 – Actual Waiver Cost

- a. ___ The State is requesting a 1915(b)(3) waiver in **Section A.I.A.1.c** and will be providing non-state plan medical services. The State will be spending a portion of its waiver savings for additional services under the waiver.

For an initial waiver, in the chart below, please document the amount of savings that will be accrued in the State Plan services. The amount of savings that will be spent on 1915(b)(3) services must be reflected on **Column T of Appendix D5** in the initial spreadsheet Appendices. Please include a justification of the amount of savings expected and the cost of the 1915(b)(3) services. Please state the aggregate budgeted amount projected to be spent on each additional service in the upcoming waiver period in the chart below. This amount should be reflected in the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Initial Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Savings projected in State Plan Services	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$54,264 savings or .03 PMPM</i>	<i>9.97% or \$5,411</i>	<i>\$59,675 or .03 PMPM P1 \$62,488 or .03 PMPM P2</i>
Total	<i>(PMPM in Appendix D5 Column T x projected member months should correspond)</i>		(PMPM in Appendix D5 Column W x projected member months should correspond)

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For a renewal or conversion waiver, in the chart below, please state the actual amount spent on each 1915(b)(3) service in the retrospective waiver period. This amount must be built into the State’s Actual Waiver Cost for R1 and R2 (BY for Conversion) on **Column H in Appendix D3**. Please state the aggregate amount of 1915(b)(3) savings budgeted for each additional service in the upcoming waiver period in the chart below. This amount must be built into the State’s Waiver Cost Projection for P1 and P2 on **Column W in Appendix D5**.

Chart: Renewal/Conversion Waiver State Specific 1915(b)(3) Service Expenses and Projections

1915(b)(3) Service	Amount Spent in Retrospective Period	Inflation projected	Amount projected to be spent in Prospective Period
<i>(Service Example: 1915(b)(3) step-down nursing care services financed from savings from inpatient hospital care. See attached documentation for justification of savings.)</i>	<i>\$1,751,500 or \$1.97 PMPM R1</i> <i>\$1,959,150 or \$1.04 PMPM R2 or BY in Conversion</i>	<i>8.6% or \$169,245</i>	<i>\$2,128,395 or 1.07 PMPM in P1</i> <i>\$2,291,216 or 1.10 PMPM in P2</i>
Total	(PMPM in Appendix D3 Column H x member months should correspond)		(PMPM in Appendix D5 Column W x projected member months should correspond)

b. X The State is including voluntary populations in the waiver. Describe below how the issue of selection bias has been addressed in the Actual Waiver Cost calculations:

The voluntary population is limited to American Indian/Alaska Native beneficiaries. The State’s actuaries will evaluate the need for an adjustment as part of the rate setting process.

- c. X Capitated portion of the waiver only -- Reinsurance or Stop/Loss Coverage: Please note how the State will be providing or requiring reinsurance or stop/loss coverage as required under the regulation. States may require MCOs/PIHPs/PAHPs to purchase reinsurance. Similarly, States may provide stop-loss coverage to MCOs/PIHPs/PAHPs when MCOs/PIHPs/PAHPs exceed certain payment thresholds for individual enrollees. Stop loss provisions usually set limits on maximum days of coverage or number of services for which the MCO/PIHP/PAHP will be responsible. If the State plans to provide stop/loss coverage, a description is required. The State must document the probability of incurring costs in excess of the stop/loss level and the frequency of such occurrence based on FFS experience. The expenses per capita (also known as the stoploss premium amount) should be deducted from the capitation year projected costs. In the initial application, the effect should be neutral. In the renewal report, the actual reinsurance cost and claims cost should be reported in Actual Waiver Cost.

Basis and Method:

1. ___ The State does not provide stop/loss protection for MCOs/PIHPs/PAHPs, but requires MCOs/PIHPs/PAHPs to purchase reinsurance coverage privately. No adjustment was necessary.
2. X The State provides stop/loss protection (please describe):

The State has established a Medical Loss Ratio (MLR) risk corridor to ensure MCOs maintain at least an 85% Medical Loss Ratio, but also to offer stop/loss protection. As illustrated in the table below, the State will share 50% of MLR costs greater than 92% and less than 95%. The State will assume 100% of the costs above 95% MLR.

MLR Corridor	MCO Share of Gain/Loss	State Share of Gain/Loss
MLR less than 85%	0%	100%
MLR greater than 85% and less than 88%	50%	50%
MLR greater than 88% and less than 92%	100%	0%

MLR Corridor	MCO Share of Gain/Loss	State Share of Gain/Loss
MLR greater than 92% and less than 95%	50%	50%
MLR greater than 95%	0%	100%

d. ____ Incentive/bonus/enhanced Payments for both Capitated and fee-for-service Programs:

1. ____ [For the capitated portion of the waiver] the total payments under a capitated contract include any incentives the State provides in addition to capitated payments under the waiver program. The costs associated with any bonus arrangements must be accounted for in the capitated costs (**Column D of Appendix D3 Actual Waiver Cost**). Regular State Plan service capitated adjustments would apply.

Document the criteria for awarding the incentive payments.
Document the method for calculating incentives/bonuses, and

Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs do not exceed the Waiver Cost Projection.

2. ____ For the fee-for-service portion of the waiver, all fee-for-service must be accounted for in the fee-for-service incentive costs (**Column G of Appendix D3 Actual Waiver Cost**). For PCCM providers, the amount listed should match information provided in **D.I.D Reimbursement of Providers**. Any adjustments applied would need to meet the special criteria for fee-for-service incentives if the State elects to provide incentive payments in addition to management fees under the waiver program (**See D.I.I.e and D.I.J.e**)

- i. Document the criteria for awarding the incentive payments.
- ii. Document the method for calculating incentives/bonuses, and
- iii. Document the monitoring the State will have in place to ensure that total payments to the MCOs/PIHPs/PAHPs/PCCMs do not exceed the Waiver Cost Projection.

Current Initial Waiver Adjustments in the preprint

I. Appendix D4 – Initial Waiver – Adjustments in the Projection OR Conversion Waiver for DOS within DOP

Initial Waiver Cost Projection & Adjustments (If this is a Conversion or Renewal waiver for DOP, skip to J. Conversion or Renewal Waiver Cost Projection and Adjustments): States may need to make certain adjustments to the Base Year in order to accurately reflect the waiver program in P1 and P2. If the State has made an adjustment to its Base Year, the State should note the adjustment and its location in Appendix D4, and include information on the basis and method used in this section of the preprint. Where noted, certain adjustments should be mathematically accounted for in Appendix D5.

The following adjustments are appropriate for initial waivers. Any adjustments that are required are indicated as such.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The BY data already includes the actual Medicaid cost changes to date for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from BY to the end of the waiver (P2). Trend adjustments may be service-specific. The adjustments may be expressed as percentage factors. Some states calculate utilization and cost increases separately, while other states calculate a single trend rate encompassing both utilization and cost increases. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. **This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.**
 1. [Required, if the State’s BY is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: _____. Please document how that trend was calculated:
 2. [Required, to trend BY to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
 - i. State historical cost increases. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

- ii. X National or regional factors that are predictive of this waiver's future costs. Please indicate the services and indicators used:

The State has selected the President's Budget annual trend rate of 4.8 percent as the basis for trending base year expenditures.

Please indicate how this factor was determined to be predictive of this waiver's future costs. Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.

The President's Budget trend factor was selected as a reasonable, independently established benchmark for future cost growth.

The calculations do not include factors other than price, as reported on a PMPM basis.

3. ____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects the changes in utilization between the BY and the beginning of the P1 and between years P1 and P2.
- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
 - ii. Please document how the utilization did not duplicate separate cost increase trends.

b. X State Plan Services Programmatic/Policy/Pricing Change Adjustment: This adjustment should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. Adjustments to the BY data are typically for changes that occur after the BY (or after the collection of the BY data) and/or during P1 and P2 that affect the overall Medicaid program. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend. If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.*

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)

- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in cost increases or pricing (+/-)

1. The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.
2. X An adjustment was necessary. The adjustment(s) is(are) listed and described below:

Waiver cost projections include a series of program adjustments. The impact to base year PMPM expenditures is presented in the table below, as well as the percentage adjustment factor applied in Appendix D5.

Adjustment	Base PMPM Adjustment		
	TANF	CHIP	Expansion
Member Mix - Adjustment was made to account for discontinuation of the PHE and anticipated higher PMPM costs among non-PHE beneficiaries. The adjustment includes a six percent (6%) increase among adults and a one percent (1%) increase among children, for a blended increase of 2.2%.	\$ 6.50	\$ 2.34	\$ 28.06
EPSDT - Adjustment for change in policy to permit reimbursement for EPSDT and preventive or sick visits on the same day. Program change represents the cost of an additional office visit and applies to children 18 and under.	\$ -	\$.01	\$ -
Behavioral Health Rate Increase - Partial year adjustment for rate increases taking effect on July 1, 2022. Applies to individual and family therapy, individual assertive community treatment, individual and group community recovery support, group psychosocial rehabilitation/illness management and recovery and screening and referral. The amount of increase varies from 7.5% to 100.0%, depending on the service. Also, a new rate of \$75.00 for complex screening and referral.	\$ 0.70	\$ 0.63	\$ 0.61
Adult Dental - Adjustment for increased utilization of expanded adult dental services.	\$ 0.32	\$ -	\$ 2.18
Dental Copays - Downward adjustment for increased adult dental copay amounts.	\$ (0.02)	\$ -	\$ (0.14)
Leap Year (Dental) - Adjustment for 2024 leap day. Applies to dental services only (February 1 implementation date).	\$ 0.04	\$ 0.05	\$ 0.03
Partial Hospitalization Program - Adjustment for new benefit with effective date of September 1, 2022.	\$ 0.19	\$ -	\$ 0.96
Applied Behavioral Analysis (ABA) Therapy - Adjustment for expected increased utilization of service for members with autism spectrum disorder.	\$ 1.12	\$ 1.24	\$ -
Specialized Program Costs: Children in Custody - Adjustment to reflect enhanced service costs for serving children in custody not included in base year expenditures	\$ 12.11	\$ -	\$ -

Private Duty Nursing - Adjustment for rate increase scheduled to take effect on July 1, 2023.	\$ 0.23	\$ 0.15	\$ 0.01
Pharmacy Rebate - Downward adjustment for collection of rebate dollars.	\$ (26.01)	\$ (27.37)	\$ (72.73)
State Directed Payments - Adjustment for inclusion of State Directed Payments	\$ 122.53	\$ 72.17	\$ 138.25
Total PMPM Adjustment	\$ 117.71	\$ 49.21	\$ 97.23
Base Year PMPM State Plan Service Costs	\$ 287.28	\$ 258.71	\$ 655.37
Program Adjustment Percentage (D5, Column L)	40.97%	19.02%	14.83%

- i. The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B. ___ The size of the adjustment was based on pending SPA. _____Approximate PMPM size of adjustment _____
C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D. ___ *Determine adjustment for Medicare Part D dual eligibles.*
E. Other (please describe): **See above table.**
- ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
- iii. ___ Changes brought about by legal action (please describe):
For each change, please report the following:
A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
D. ___ Other (please describe):
- iv. ___ Changes in legislation (please describe):
For each change, please report the following:
A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

- D. ___ Other (please describe):
- v. ___ Other (please describe):
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):

c. **X** **Administrative Cost Adjustment***: The administrative expense factor in the initial waiver is based on the administrative costs for the eligible population participating in the waiver for fee-for-service. Examples of these costs include per claim claims processing costs, per record PRO review costs, and Surveillance and Utilization Review System (SURS) costs. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the fee-for-service program then the State needs to estimate the impact of that adjustment.

- 1. **X** No adjustment was necessary and no change is anticipated.
- 2. ___ An administrative adjustment was made.
- i. ___ FFS administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ___ Other (please describe):
- ii. ___ FFS cost increases were accounted for.
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ___ Other (please describe):
- iii. ___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs

trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.

- A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years_____ In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.
- B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.

* For Combination Capitated and PCCM Waivers: If the capitated rates are adjusted by the amount of administration payments, then the PCCM Actual Waiver Cost must be calculated less the administration amount. For additional information, please see Special Note at end of this section.

d. 1915(b)(3) Adjustment: The State must document the amount of State Plan Savings that will be used to provide additional 1915(b)(3) services in Section D.I.H.a above. The Base Year already includes the actual trend for the State Plan services in the program. This adjustment reflects the expected trend in the 1915(b)(3) services between the Base Year and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and expressed as percentage factors.

1. _____ [Required, if the State's BY is more than 3 months prior to the beginning of P1 to trend BY to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.

2. _____ [Required, when the State's BY is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the State's trend for State Plan Services.

e. State Plan Service trend

- A. Please indicate the State Plan Service trend rate from **Section D.I.I.a.** above _____.

e. Incentives (not in capitated payment) Trend Adjustment: If the State marked Section D.I.H.d , then this adjustment reports trend for that factor. Trend is limited to the rate for State Plan services.

- 1. List the State Plan trend rate by MEG from **Section D.I.I.a.**_____
- 2. List the Incentive trend rate by MEG if different from **Section D.I.I.a** _____

3. Explain any differences:

f. Graduate Medical Education (GME) Adjustment: 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments for managed care participant utilization in the capitation rates. However, GME payments on behalf of managed care waiver participants must be included in cost-effectiveness calculations.

1. ___ We assure CMS that GME payments are included from base year data.
2. ___ We assure CMS that GME payments are included from the base year data using an adjustment. (Please describe adjustment.)
3. Other (please describe): **The GME payment methodology will be modified for managed care participants and the estimated amount of the revised payments is included in the cost effectiveness analysis.**

If GME rates or the GME payment method has changed since the Base Year data was completed, the Base Year data should be adjusted to reflect this change and the State needs to estimate the impact of that adjustment and account for it in **Appendix D5**.

1. GME adjustment was made.
 - i. GME rates or payment method changed in the period between the end of the BY and the beginning of P1 (please describe). **The State has submitted an application for modification of the existing payment methodology. Cost effectiveness appendices include an estimated amount under the proposed methodology.**
 - ii. ___ GME rates or payment method is projected to change in the period between the beginning of P1 and the end of P2 (please describe).
2. ___ No adjustment was necessary and no change is anticipated.

Method:

1. ___ Determine GME adjustment based upon a newly approved State Plan Amendment (SPA).
2. ___ Determine GME adjustment based on a pending SPA.
3. Determine GME adjustment based on currently approved GME SPA.
4. ___ Other (please describe):

g. Payments / Recoupments not Processed through MMIS Adjustment: Any payments or recoupments for covered Medicaid State Plan services included in the waiver but processed outside of the MMIS system should be included in the Waiver Cost Projection. Any adjustments that would appear on the CMS-64.9 Waiver form should be reported and adjusted here. Any adjustments that would appear on the CMS summary form (line 9) would not be put into the waiver cost-effectiveness (e.g., TPL, probate, fraud and abuse). Any payments or recoupments made should be accounted for in Appendix D5.

1. ___ Payments outside of the MMIS were made. Those payments include (please describe):

2. ___ Recoupments outside of the MMIS were made. Those recoupments include (please describe):

3. X The State had no recoupments/payments outside of the MMIS.

- h. Copayments Adjustment:** This adjustment accounts for any copayments that are collected under the FFS program but will not be collected in the waiver program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program.

Basis and Method:

1. ___ Claims data used for Waiver Cost Projection development already included copayments and no adjustment was necessary.
2. ___ State added estimated amounts of copayments for these services in FFS that were not in the capitated program. Please account for this adjustment in Appendix D5.
3. ___ The State has not to made an adjustment because the same copayments are collected in managed care and FFS.
4. X Other (please describe):

A downward adjustment was made to the cost projections to reflect the adult dental copayment requirement.

If the State's FFS copayment structure has changed in the period between the end of the BY and the beginning of P1, the State needs to estimate the impact of this change adjustment.

1. X No adjustment was necessary and no change is anticipated.
2. ___ The copayment structure changed in the period between the end of the BY and the beginning of P1. Please account for this adjustment in Appendix D5.

Method:

1. ___ Determine copayment adjustment based upon a newly approved State Plan Amendment (SPA).
2. ___ Determine copayment adjustment based on pending SPA.
3. ___ Determine copayment adjustment based on currently approved copayment SPA.
4. ___ Other (please describe):

- i. Third Party Liability (TPL) Adjustment:** This adjustment should be used only if the State is converting from fee-for-service to capitated managed care, and will delegate the collection and retention of TPL payments for post-pay recoveries to the MCO/PIHP/PAHP. If the MCO/PIHP/PAHP will collect and keep TPL, then the Base Year costs should be reduced by the amount to be collected.

Basis and method:

1. X No adjustment was necessary
2. ___ Base Year costs were cut with post-pay recoveries already deducted from the database.
3. ___ State collects TPL on behalf of MCO/PIHP/PAHP enrollees

4. The State made this adjustment:*
 - i. Post-pay recoveries were estimated and the base year costs were reduced by the amount of TPL to be collected by MCOs/PIHPs/PAHPs. Please account for this adjustment in **Appendix D5**.
 - ii. Other (please describe):

- j. Pharmacy Rebate Factor Adjustment:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the fee-for-service or capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.
2. The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor's providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
3. Other (please describe):

- k. Disproportionate Share Hospital (DSH) Adjustment:** Section 4721 of the BBA specifies that DSH payments must be made solely to hospitals and not to MCOs/PIHPs/PAHPs. Section 4721(c) permits an exemption to the direct DSH payment for a limited number of States. If this exemption applies to the State, please identify and describe under "Other" including the supporting documentation. Unless the exemption in Section 4721(c) applies or the State has a FFS-only waiver (e.g., selective contracting waiver for hospital services where DSH is specifically included), DSH payments are not to be included in cost-effectiveness calculations.

1. We assure CMS that DSH payments are excluded from base year data.
2. We assure CMS that DSH payments are excluded from the base year data using an adjustment.
3. Other (please describe):

- l. Population Biased Selection Adjustment (Required for programs with Voluntary Enrollment):** Cost-effectiveness calculations for waiver programs with voluntary populations must include an analysis of the population that can be expected to enroll in the waiver. If the State finds that the population most likely to enroll in the waiver differs significantly from the population that will voluntarily remain in FFS, the Base Year costs must be adjusted to reflect this.

1. This adjustment is not necessary as there are no voluntary populations in the waiver program.

2. This adjustment was made:
 - a. Potential Selection bias was measured in the following manner:
 - b. The base year costs were adjusted in the following manner:

The voluntary population is limited to American Indian/Alaska Native beneficiaries. The State's actuaries will evaluate the need for an adjustment as part of the rate setting process.

- m. **FQHC and RHC Cost-Settlement Adjustment:** Base Year costs should not include cost-settlement or supplemental payments made to FQHCs/RHCs. The Base Year costs should reflect fee-for-service payments for services provided at these sites, which will be built into the capitated rates.
 1. We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the Base Year costs. Payments for services provided at FQHCs/RHCs are reflected in the following manner:
 2. We assure CMS that FQHC/RHC cost-settlement and supplemental payments are excluded from the base year data using an adjustment.
 3. *We assure CMS that Medicare Part D coverage has been accounted for in the FQHC/RHC adjustment.*
 4. Other (please describe):

Special Note section:

Waiver Cost Projection Reporting: Special note for new capitated programs:

The State is implementing the first year of a new capitated program (converting from fee-for-service reimbursement). The first year that the State implements a capitated program, the State will be making capitated payments for future services while it is reimbursing FFS claims from retrospective periods. This will cause State expenditures in the initial period to be much higher than usual. In order to adjust for this double payment, the State should not use the first quarter of costs (immediately following implementation) from the CMS-64 to calculate future Waiver Cost Projections, unless the State can distinguish and exclude dates of services prior to the implementation of the capitated program.

- a. The State has excluded the first quarter of costs of the CMS-64 from the cost-effectiveness calculations and is basing the cost-effectiveness projections on the remaining quarters of data.
- b. The State has included the first quarter of costs in the CMS-64 and excluded claims for dates of services prior to the implementation of the capitated program.

The state has checked box a., as this approach will be used for renewal cost effectiveness calculations.

Special Note for initial combined waivers (Capitated and PCCM) only:

Adjustments Unique to the Combined Capitated and PCCM Cost-effectiveness Calculations -- Some adjustments to the Waiver Cost Projection are applicable only to the capitated program. When these adjustments are taken, there will need to be an offsetting

adjustment to the PCCM Base year Costs in order to make the PCCM costs comparable to the Waiver Cost Projection. **In other words, because we are creating a single combined Waiver Cost Projection applicable to the PCCM and capitated waiver portions of the waiver, offsetting adjustments (positive and/or negative) need to be made to the PCCM Actual Waiver Cost for certain *capitated-only* adjustments.** When an offsetting adjustment is made, please note and include an explanation and your calculations. The most common offsetting adjustment is noted in the chart below and indicated with an asterisk (*) in the preprint.

Adjustment	Capitated Program	PCCM Program
Administrative Adjustment	The Capitated Waiver Cost Projection includes an administrative cost adjustment. That adjustment is added into the combined Waiver Cost Projection adjustment. (This in effect adds an amount for administration to the Waiver Cost Projection for both the PCCM and Capitated program. You must now remove the impermissible costs from the PCCM With Waiver Calculations -- See the next column)	The PCCM Actual Waiver Cost must include an exact offsetting addition of the amount of the PMPM Waiver Cost Projection adjustment. (While this may seem counter-intuitive, adding the exact amount to the PCCM PMPM Actual Waiver Cost will subtract out of the equation: PMPM Waiver Cost Projection – PMPM Actual Waiver Cost = PMPM Cost-effectiveness).

n. **Incomplete Data Adjustment (DOS within DOP only)** – The State must adjust base period data to account for incomplete data. When fee-for-service data is summarized by date of service (DOS), data for a particular period of time is usually incomplete until a year or more after the end of the period. In order to use recent DOS data, the State must calculate an estimate of the services ultimate value after all claims have been reported . Such incomplete data adjustments are referred to in different ways, including “lag factors,” “incurred but not reported (IBNR) factors,” or incurring factors. If date of payment (DOP) data is used, completion factors are not needed, but projections are complicated by the fact that payments are related to services performed in various former periods. *Documentation of assumptions and estimates is required for this adjustment.*

1. ___ Using the special DOS spreadsheets, the State is estimating DOS within DOP. Incomplete data adjustments are reflected in the following manner on **Appendix D5** for services to be complete and on **Appendix D7** to create a 12-month DOS within DOP projection:
2. X The State is using Date of Payment only for cost-effectiveness – no adjustment is necessary.
3. ___ Other (please describe):

- o. **PCCM Case Management Fees (Initial PCCM waivers only)** – The State must add the case management fees that will be claimed by the State under new PCCM waivers. There should be sufficient savings under the waiver to offset these fees.
 - 1. ___ The new PCCM case management fees will be accounted for with an adjustment on Appendix D5.
 - 2. ___ This adjustment is not necessary as this is not an initial PCCM waiver in the waiver program.
 - 3. ___ This adjustment was made in the following manner:

- p. **Other adjustments:** Federal law, regulation, or policy change: If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.
 - Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
 - 1. X No adjustment was made.
 - 2. ___ This adjustment was made (Please describe) This adjustment must be mathematically accounted for in **Appendix D5**.

J. Appendix D4 -- Conversion or Renewal Waiver Cost Projection and Adjustments.

If this is an Initial waiver submission, skip this section: States may need to make certain adjustments to the Waiver Cost Projection in order to accurately reflect the waiver program. If the State has made an adjustment to its Waiver Cost Projection, the State should note the adjustment and its location in **Appendix D4**, and include information on the basis and method, and mathematically account for the adjustment in **Appendix D5**.

CMS should examine the Actual Waiver Costs to ensure that if the State did not implement a programmatic adjustment built into the previous Waiver Cost Projection, that the State did not expend funds associated with the adjustment that was not implemented.

If the State implements a one-time only provision in its managed care program (typically administrative costs), the State should not reflect the adjustment in a permanent manner. CMS should examine future Waiver Cost Projections to ensure one-time-only adjustments are not permanently incorporated into the projections.

- a. **State Plan Services Trend Adjustment** – the State must trend the data forward to reflect cost and utilization increases. The R1 and R2 (BY for conversion) data already include the actual Medicaid cost changes for the population enrolled in the program. This adjustment reflects the expected cost and utilization increases in the managed care program from R2 (BY for conversion) to the end of the waiver (P2). Trend adjustments may be service-specific and expressed as percentage factors. Some states calculate utilization and cost separately, while other states calculate a single trend rate. The State must document the method used and how utilization and cost increases are not duplicative if they are calculated separately. This adjustment must be mutually exclusive of programmatic/policy/pricing changes and CANNOT be taken twice. The State must document how it ensures there is no duplication with programmatic/policy/pricing changes.
1. ____ [Required, if the State’s BY or R2 is more than 3 months prior to the beginning of P1] The State is using actual State cost increases to trend past data to the current time period (*i.e., trending from 1999 to present*) The actual trend rate used is: _____. Please document how that trend was calculated:
 2. ____ [Required, to trend BY/R2 to P1 and P2 in the future] When cost increases are unknown and in the future, the State is using a predictive trend of either State historical cost increases or national or regional factors that are predictive of future costs (same requirement as capitated ratesetting regulations) (*i.e., trending from present into the future*).
 - i. ____ State historical cost increases. Please indicate the years on which the rates are based: base years_____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 - ii. ____ National or regional factors that are predictive of this waiver’s future costs. Please indicate the services and indicators used _____. In addition, please indicate how this factor was determined to be predictive of this waiver’s future costs. Finally, please note and explain if the State’s cost increase calculation includes more factors than a price increase such as changes in technology, practice patterns, and/or units of service PMPM.
 3. ____ The State estimated the PMPM cost changes in units of service, technology and/or practice patterns that would occur in the waiver separate from cost increase. Utilization adjustments made were service-specific and expressed as percentage factors. The State has documented how utilization and cost increases were not duplicated. This adjustment reflects

the changes in utilization between R2 and P1 and between years P1 and P2.

- i. Please indicate the years on which the utilization rate was based (if calculated separately only).
- ii. Please document how the utilization did not duplicate separate cost increase trends.

b. _____ State Plan Services Programmatic/Policy/Pricing Change Adjustment: These adjustments should account for any programmatic changes that are not cost neutral and that affect the Waiver Cost Projection. For example, changes in rates, changes brought about by legal action, or changes brought about by legislation. For example, Federal mandates, changes in hospital payment from per diem rates to Diagnostic Related Group (DRG) rates or changes in the benefit coverage of the FFS program. This adjustment must be mutually exclusive of trend and CANNOT be taken twice. The State must document how it ensures there is no duplication with trend. If the State is changing one of the aspects noted above in the FFS State Plan then the State needs to estimate the impact of that adjustment. *Note: FFP on rates cannot be claimed until CMS approves the SPA per the 1/2/01 SMD letter. Prior approval of capitation rates is contingent upon approval of the SPA.* The R2 data was adjusted for changes that will occur after the R2 (BY for conversion) and during P1 and P2 that affect the overall Medicaid program.

Others:

- Additional State Plan Services (+)
- Reductions in State Plan Services (-)
- Legislative or Court Mandated Changes to the Program Structure or fee schedule not accounted for in Cost increase or pricing (+/-)
- Graduate Medical Education (GME) Changes - This adjustment accounts for changes in any GME payments in the program. 42 CFR 438.6(c)(5) specifies that States can include or exclude GME payments from the capitation rates. However, GME payments must be included in cost-effectiveness calculations.
- Copayment Changes - This adjustment accounts for changes from R2 to P1 in any copayments that are collected under the FFS program, but not collected in the MCO/PIHP/PAHP capitated program. States must ensure that these copayments are included in the Waiver Cost Projection if not to be collected in the capitated program. If the State is changing the copayments in the FFS program then the State needs to estimate the impact of that adjustment.

1. _____ The State has chosen not to make an adjustment because there were no programmatic or policy changes in the FFS program after the MMIS claims tape was created. In addition, the State anticipates no programmatic or policy changes during the waiver period.

2. ___ An adjustment was necessary and is listed and described below:
- i. ___ The State projects an externally driven State Medicaid managed care rate increases/decreases between the base and rate periods.
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ *Determine adjustment for Medicare Part D dual eligibles.*
 - E. ___ Other (please describe):
 - ii. ___ The State has projected no externally driven managed care rate increases/decreases in the managed care rates.
 - iii. ___ The adjustment is a one-time only adjustment that should be deducted out of subsequent waiver renewal projections (i.e., start-up costs). Please explain:
 - iv. ___ Changes brought about by legal action (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
 - v. ___ Changes in legislation (please describe):
For each change, please report the following:
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____
 - D. ___ Other (please describe):
 - vi. ___ Other (please describe):
 - A. ___ The size of the adjustment was based upon a newly approved State Plan Amendment (SPA). PMPM size of adjustment _____
 - B. ___ The size of the adjustment was based on pending SPA. Approximate PMPM size of adjustment _____
 - C. ___ Determine adjustment based on currently approved SPA. PMPM size of adjustment _____

D. ___ Other (please describe):

- c. **Administrative Cost Adjustment:** This adjustment accounts for changes in the managed care program. The administrative expense factor in the renewal is based on the administrative costs for the eligible population participating in the waiver for managed care. Examples of these costs include per claim claims processing costs, additional per record PRO review costs, and additional Surveillance and Utilization Review System (SURS) costs; as well as actuarial contracts, consulting, encounter data processing, independent assessments, EQRO reviews, etc. *Note: one-time administration costs should not be built into the cost-effectiveness test on a long-term basis. States should use all relevant Medicaid administration claiming rules for administration costs they attribute to the managed care program.* If the State is changing the administration in the managed care program then the State needs to estimate the impact of that adjustment.

1. ___ No adjustment was necessary and no change is anticipated.
2. ___ An administrative adjustment was made.
 - i. ___ Administrative functions will change in the period between the beginning of P1 and the end of P2. Please describe:
 - ii. ___ Cost increases were accounted for.
 - A. ___ Determine administration adjustment based upon an approved contract or cost allocation plan amendment (CAP).
 - B. ___ Determine administration adjustment based on pending contract or cost allocation plan amendment (CAP).
 - C. ___ State Historical State Administrative Inflation. The actual trend rate used is: _____. Please document how that trend was calculated:
 - D. ___ Other (please describe):
 - iii. ___ [Required, when State Plan services were purchased through a sole source procurement with a governmental entity. No other State administrative adjustment is allowed.] If cost increase trends are unknown and in the future, the State must use the lower of: Actual State administration costs trended forward at the State historical administration trend rate or Actual State administration costs trended forward at the State Plan services trend rate. Please document both trend rates and indicate which trend rate was used.
 - A. Actual State Administration costs trended forward at the State historical administration trend rate. Please indicate the years on which the rates are based: base years _____. In addition, please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.). Finally, please note and explain if the State's cost increase calculation includes more factors than a price increase.

B. Actual State Administration costs trended forward at the State Plan Service Trend rate. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.

d. 1915(b)(3) Trend Adjustment: The State must document the amount of 1915(b)(3) services in the R1/R2/BY Section D.I.H.a above. The R1/R2/BY already includes the actual trend for the 1915(b)(3) services in the program. This adjustment reflects the **expected** trend in the 1915(b)(3) services between the R2/BY and P1 of the waiver and the trend between the beginning of the program (P1) and the end of the program (P2). Trend adjustments may be service-specific and **expressed** as percentage factors.

1. ____ [Required, if the State's BY or R2 is more than 3 months prior to the beginning of P1 to trend BY or R2 to P1] The State is using the actual State historical trend to project past data to the current time period (*i.e., trending from 1999 to present*). The actual documented trend is: _____. Please provide documentation.

2. ____ [Required, when the State's BY or R2 is trended to P2. No other 1915(b)(3) adjustment is allowed] If trends are unknown and in the future (*i.e., trending from present into the future*), the State must use the lower of State historical 1915(b)(3) trend or the State's trend for State Plan Services. Please document both trend rates and indicate which trend rate was used.

i. State historical 1915(b)(3) trend rates

1. Please indicate the years on which the rates are based: base years _____

2. Please indicate the mathematical method used (multiple regression, linear regression, chi-square, least squares, exponential smoothing, etc.):

ii. State Plan Service Trend

1. Please indicate the State Plan Service trend rate from **Section D.I.J.a.** above _____.

e. Incentives (not in capitated payment) Trend Adjustment: Trend is limited to the rate for State Plan services.

1. List the State Plan trend rate by MEG from Section D.I.J.a _____

2. List the Incentive trend rate by MEG if different from Section D.I.J.a. _____

3. Explain any differences:

f. Other Adjustments including but not limited to federal government changes. (Please describe):

- If the federal government changes policy affecting Medicaid reimbursement, the State must adjust P1 and P2 to reflect all changes.

- Once the State’s FFS institutional excess UPL is phased out, CMS will no longer match excess institutional UPL payments.
 - ◆ Excess payments addressed through transition periods should not be included in the 1915(b) cost-effectiveness process. Any State with excess payments should exclude the excess amount and only include the supplemental amount under 100% of the institutional UPL in the cost effectiveness process.
 - ◆ For all other payments made under the UPL, including supplemental payments, the costs should be included in the cost effectiveness calculations. This would apply to PCCM enrollees and to PAHP, PIHP or MCO enrollees if the institutional services were provided as FFS wrap-around. The recipient of the supplemental payment does not matter for the purposes of this analysis.
- **Pharmacy Rebate Factor Adjustment (Conversion Waivers Only)*:** Rebates that States receive from drug manufacturers should be deducted from Base Year costs if pharmacy services are included in the capitated base. If the base year costs are not reduced by the rebate factor, an inflated BY would result. Pharmacy rebates should also be deducted from FFS costs if pharmacy services are impacted by the waiver but not capitated.

Basis and Method:

1. ___ Determine the percentage of Medicaid pharmacy costs that the rebates represent and adjust the base year costs by this percentage. States may want to make separate adjustments for prescription versus over the counter drugs and for different rebate percentages by population. States may assume that the rebates for the targeted population occur in the same proportion as the rebates for the total Medicaid population *which includes accounting for Part D dual eligibles*. Please account for this adjustment in **Appendix D5**.
2. ___ The State has not made this adjustment because pharmacy is not an included capitation service and the capitated contractor’s providers do not prescribe drugs that are paid for by the State in FFS *or Part D for the dual eligibles*.
3. ___ Other (please describe):
4. ___ No adjustment was made.
5. ___ This adjustment was made (Please describe). This adjustment must be mathematically accounted for in **Appendix D5**.

K. Appendix D5 – Waiver Cost Projection

The State should complete these appendices and include explanations of all adjustments in **Section D.I.I and D.I.J** above.

L. Appendix D6 – RO Targets

The State should complete these appendices and include explanations of all trends in enrollment in **Section D.I.E.** above.

M. Appendix D7 - Summary

a. Please explain any variance in the overall percentage change in spending from BY/R1 to P2.

1. Please explain caseload changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in **Section D.I.E.c & d**:

Please see response in referenced section.

2. Please explain unit cost changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of cost increase given in **Section D.I.I and D.I.J**:

Please see response in referenced section.

3. Please explain utilization changes contributing to the overall annualized rate of change in **Appendix D7 Column I**. This response should be consistent with or the same as the answer given by the State in the State's explanation of utilization given in **Section D.I.I and D.I.J**:

Please see response in referenced section.

Please note any other principal factors contributing to the overall annualized rate of change in **Appendix D7 Column I**.

Part II: Appendices D.1-7

Please see attached OK 1915b Waiver Cost Effectiveness Excel spreadsheets.