DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Melody Anthony
Chief State Medicaid Director
Oklahoma Health Care Authority
4345 N. Lincoln Boulevard
Oklahoma City, OK 73105

NOV 0 1 2019

Dear Ms. Anthony:

Under section 1115 of the Social Security Act (the Act), the Secretary of Health and Human Services (HHS) may approve any experimental, pilot, or demonstration project that, in the judgment of the Secretary, is likely to assist in promoting the objectives of certain Act programs including Medicaid. Congress enacted section 1115 of the Act to ensure that federal requirements did not "stand in the way of experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients." S. Rep. No. 87-1589, at 19 (1962), *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961. As relevant here, section 1115 of the Act allows the Secretary to waive compliance with the Medicaid program requirements of section 1902 of the Act, to the extent and for the period he finds necessary to carry out the demonstration project. In addition, section 1115 of the Act allows the Secretary to provide federal financial participation for demonstration costs that would not otherwise be considered as federally matchable expenditures under section 1903 of the Act, to the extent and for the period prescribed by the Secretary.

For the reasons discussed below, the Centers for Medicare & Medicaid Services (CMS) is approving Oklahoma's request to amend its Medicaid section 1115 demonstration entitled, "SoonerCare" (Project Number 11-W00048/6). The changes to the demonstration are effective as of the date of this letter. Our approval of this demonstration amendment is subject to the enclosed Special Terms and Conditions (STC) and the limitations specified in the list of waivers, expenditure authorities, and title XIX requirements made not applicable to such expenditure authorities. The state may deviate from Medicaid state plan requirements only to the extent those requirements have been specifically listed as waived, granted expenditure authority, or as title XIX requirements not applicable. All requirements of the Medicaid program as expressed in law, regulation, and policy statement not expressly identified as waived or not applicable in this letter or the attached STCs shall apply to this demonstration.

Objectives of the Medicaid Program

As noted above, the Secretary may approve a demonstration project under section 1115 of the Act if, in his judgment, the demonstration is likely to assist in promoting the objectives of title XIX. The purposes of Medicaid include an authorization of appropriation of funds to "enabl[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care." Act § 1901. This provision makes clear that an important objective of the Medicaid program is to furnish medical assistance and other services to vulnerable populations. But there is little intrinsic value in paying for services if those services are not advancing the health and wellness of the individual receiving them, or otherwise helping the individual attain independence. Therefore, we believe an objective of the Medicaid program, in addition to furnishing services, is to advance the health and wellness needs of its beneficiaries, and that it is appropriate for the state to structure its demonstration project in a manner that prioritizes meeting those needs.

Section 1115 demonstration projects present an opportunity for states to experiment with reforms that go beyond just routine medical care and focus on interventions that drive better health outcomes and quality of life improvements, and that may increase beneficiaries' financial independence. Such policies may include those designed to address certain health determinants and those that encourage beneficiaries to engage in health-promoting behaviors and to strengthen engagement by beneficiaries in their personal health care plans. These tests will necessarily mean a change to the status quo. They may have associated administrative costs, particularly at the initial stage, and section 1115 acknowledges that demonstrations may "result in an impact on eligibility, enrollment, benefits, cost-sharing, or financing." Act § 1115(d)(1). But in the long term, they may create incentives and opportunities that help enable many beneficiaries to enjoy the numerous personal benefits that come with improved health and financial independence.

Section 1115 demonstration projects also provide an opportunity for states to test policies that ensure the fiscal sustainability of the Medicaid program, better "enabling each [s]tate, as far as practicable under the conditions in such [s]tate" to furnish medical assistance, Act § 1901, while making it more practicable for states to furnish medical assistance to a broader range of persons in need. For instance, measures designed to improve health and wellness may reduce the volume of services consumed, as healthier, more engaged beneficiaries tend to consume fewer medical services and are generally less costly to cover. Further, measures that have the effect of helping beneficiaries secure employer-sponsored or other commercial coverage or otherwise transition from Medicaid eligibility may decrease the number of beneficiaries who need financial assistance, including medical assistance, from the state. Such measures may enable states to stretch their resources further and enhance their ability to provide medical assistance to a broader range of persons in need, including by expanding the services and populations they cover.[1] By

[1] States have considerable flexibility in the design of their Medicaid programs, within federal guidelines. Certain benefits are mandatory under federal law, but many benefits may be provided at state option, such as prescription drug benefits, vision benefits, and dental benefits. Similarly, states have considerable latitude to determine whom

the same token, such measures may also preserve states' ability to continue to provide the optional services and coverage they already have in place.

Our demonstration authority under section 1115 of the Act allows us to offer states more flexibility to experiment with different ways of improving health outcomes and strengthening the financial independence of beneficiaries. Demonstration projects that seek to improve beneficiary health and financial independence improve the well-being of Medicaid beneficiaries and, at the same time, allow states to maintain the long-term fiscal sustainability of their Medicaid programs and to provide more medical services to more Medicaid beneficiaries. Accordingly, such demonstration projects advance the objectives of the Medicaid program.

Extent and Scope of Demonstration

Through this amendment to the SoonerCare demonstration, CMS is approving a number of modifications to the demonstration related to the SoonerCare Choice delivery system.

Health Management Program (HMP) Amendment

Oklahoma developed the HMP in 2008 in order to improve the quality of care and reduce the cost of care for SoonerCare beneficiaries with chronic conditions. The SoonerCare demonstration authorizes expenditures for the HMP, which works to offer voluntary, additional support services to beneficiaries served under SoonerCare Choice who have or are at risk for developing a chronic disease, at risk for adverse outcomes, or who have an increased likelihood of experiencing a health care crisis. The HMP offers in-person and telephonic health coaching, educational materials and support, behavioral health screening and access to behavioral health resources, and assistance with referrals community resources.

The amendment revises the existing definition of its HMP to expand the data analytics base used to identify beneficiaries to receive HMP services beyond the current HMP predictive modeling software to include additional data sources including Medicaid Management Information System (MMIS) claims, health information exchange information, provider referrals, and other sources. The demonstration's previously approved STCs included health coaching and practice facilitation as services available under the HMP. This amendment also modifies the "services" language authorized under the HMP to further define health coaching and practice facilitation,

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their Medicaid programs will cover. Certain eligibility groups must be covered under a state's program, but many states opt to cover additional eligibility groups that are optional under the Medicaid statute. The optional groups include a new, non-elderly adult population (ACA expansion population) that was added to the Act at section 1902(a)(10)(A)(i)(VIII) by the Patient Protection and Affordable Care Act (ACA). Coverage of the ACA expansion population became optional as a result of the Supreme Court's decision in *NFIB v. Sebelius*, 567 U.S. 519 (2012). Accordingly, several months after the *NFIB* decision was issued, CMS informed the states that they "have flexibility to start or stop the expansion." CMS, *Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid* at 11 (Dec. 10, 2012). In addition to expanding Medicaid coverage by covering optional eligibility groups and benefits beyond what the Medicaid statute requires, many states also choose to cover benefits beyond what is authorized by statute by using expenditure authority under section 1115(a)(2) of the Act. For example, recently, many states have been relying on this authority to expand the scope of services they offer to address substance use disorders, beyond what the statute explicitly authorizes.

and newly incorporates emerging interventions such as health navigation, performance improvement projects, and assistance with transitions of care.

During CMS review of the amendment, it was determined that the HMP vendor meets the regulatory definition of a primary care case management entity (PCCM-E) under 42 CFR 438.2. Therefore, the demonstration now incorporates language clarifying that the HMP vendor qualifies as a PCCM-E, and that all PCCM-E contracts must be submitted to CMS for review and approval. The state will need to make modifications to its existing HMP vendor contracts to come into compliance with the managed care rules, and CMS is working with the state to provide technical assistance on necessary contract modifications.

Health Access Networks (HAN) Amendment

Oklahoma developed its Health Access Networks (HAN) in 2010 to support implementation of its patient-centered medical home (PCMH) delivery system. The HANs are non-profit, administrative entities that work with providers to coordinate and improve the quality of care for SoonerCare members. The demonstration contains expenditure authority for the HANs to receive nominal per member per month (PMPM) payments, initially established at $5. The HAN provide a care management system that includes analytics, secure communications, care management, assistance with PCMH tier advancement, and quality improvement programs. HAN payments are made in addition to care coordination payment paid to primary care providers (PCPs), but HANs cannot receive care coordination payments intended for payment to PCPs.

CMS has amended language in the STCs that describes the HAN's duties. The previous language, originally written in 2010, relates to ensuring patient access to all levels of care, submitting a development plan to the state detailing how the network will reduce costs and improve access and quality, and offering core components of electronic health records (EHR). This language change reflects that the HAN program is no longer a pilot program, and has been evaluated by the state with results showing that the HAN program does reduce costs and improve access and quality for beneficiaries. In the last renewal of SoonerCare, CMS granted authority to the state to expand the HAN program statewide, and this change reflects that the HAN program is no longer a pilot program. As such, the language requiring the HANs to submit development plans to the state, and to offer core components of EHR, is being removed. The remaining language will continue to describe the HANs as organized for improving access, quality, and continuity of care for SoonerCare members, and offering care management and coordination to persons with complex health care needs. The evaluation design language in the STCs is similarly being modified to reflect these changes.

Care Coordination Payments

Finally, this amendment makes changes to the amount authorized for care coordination payments made to PCPs because the state's provider rates have increased. The increases in monthly care coordination payments are nominal, and CMS is processing these changes as a technical correction to the demonstration.

Determination that the demonstration project is likely to assist in promoting Medicaid's objectives

Demonstration projects under section 1115 of the Act offer a way to give states more freedom to test and evaluate innovative solutions to improve quality, accessibility, and health outcomes in a budget-neutral manner, provided that, in the judgment of the Secretary, the demonstration is likely to assist with promoting the objectives of Medicaid. This amendment makes clarifications to two important, beneficiary-centered programs in SoonerCare that ensure the demonstration continues to improve access to high-quality, person-centered services that produce positive health outcomes for beneficiaries and that support the advancement innovative delivery system and payment models to strengthen provider network capacity and drive greater value for Medicaid. Therefore, the Secretary has determined that this amendment to the SoonerCare section 1115 demonstration is likely to assist in promoting the objectives of the Medicaid program.

Consideration of Public Comments

Consistent with federal transparency requirements, CMS considers all public comments received during both the state and federal public comment periods when evaluating whether the demonstration amendment will likely assist in promoting the objectives of Medicaid.

Oklahoma received one comment on the HMP amendment inquiring as to whether the amendment affected Indian Health Care Providers; the state confirmed to the commenter that the amendment does not affect Indian Health Care Providers. The federal comment period on the HMP amendment began on March 12, 2019 and ended April 11, 2019. CMS received one public comment on this amendment which stated that the respondent did not live in Oklahoma and did not offer any comment on the amendment itself.

Oklahoma received one comment on the HAN program amendment requesting further information on provider costs related to working with the HANs. The state clarified that SoonerCare Choice providers join a HAN at no cost to them. The federal comment period on the HAN program amendment began on June 13, 2019 and ended July 13, 2019. CMS received one public comment on this amendment, which was of a personal nature and was unrelated to the amendment.

CMS's approval of this amendment is conditioned on continued compliance with the enclosed set of waivers, expenditure authorities, title XIX requirements not applicable, and STCs that define the nature, character, and extent of anticipated federal involvement in the project. All requirements of the Medicaid program as expressed in law, regulations, and policy statement not expressly identified as waived or not applicable in this letter or the attached STCs shall apply to this demonstration. The award is subject to your written acknowledgement of the award and acceptance of the STCs within 30 days of this letter.

Your project officer for this demonstration is Ms. Kelsey Smyth. She is available to answer any questions concerning your section 1115 demonstration. Ms. Smyth's contact information is as follows:

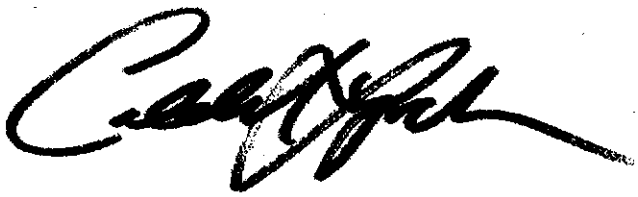
Centers for Medicare & Medicaid Services
Center for Medicaid and CHIP Services
Mail Stop: S2-25-26
7500 Security Boulevard
Baltimore, MD 21244-1850
E-mail: Kelsey.Smyth@cms.hhs.gov

Official communications regarding program matters should be sent simultaneously to Ms. Smyth and to Mr. Bill Brooks, Director, Division of Medicaid Field Operations South. His contact information is as follows:

Bill Brooks, Director
Division of Medicaid Field Operations South
Center for Medicaid and CHIP Services
1301 Young St. Suite 714
Dallas, TX 75202
E-mail: Bill.Brooks@cms.hhs.gov

If you have questions regarding this approval, please contact Mrs. Judith Cash, Director, State Demonstrations Group, Center for Medicaid and CHIP Services, at (410) 786-9686.

Sincerely,



Calder Lynch
Acting Deputy Administrator and Director

Enclosures

cc: Bill Brooks, Director, Division of Medicaid Field Operations South