OKLAHOMA

Health Care Authority

Oklahoma Public Health Emergency Unwinding Approach

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OKLAHOMA UNWINDING APPROACH

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

Since the continuous enrollment condition has been in effect, Oklahoma has maintained application processing standards and has not stopped conducting eligibility redeterminations. Oklahoma has real-time eligibility for MAGI and does not have any pending applications. During the continuous enrollment period, any member found to be ineligible had their end date pushed to the PHE end date.

The Oklahoma Health Care Authority implemented systemwide changes in response to the COVID-19 Public Health Emergency Provision Period. These include but are not limited to:

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

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

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

RESUMING NORMAL OPERATIONS

Oklahoma's Medicaid population obtains and renews eligibility in one of two ways: via the MySoonerCare.org website portal for MAGI, or via the Oklahoma Department of Human Services (OKDHS) OKDHSLive.org portal or via their local OKDHS office for non-

MAGI. OHCA and OKDHS have different PHE renewal/redetermination start-up processes.

MAGI

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

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

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

Since the continuous enrollment condition has been in effect, Oklahoma has maintained application processing standards and has not stopped conducting eligibility redeterminations. Oklahoma has real-time eligibility and does not have any pending applications. During the continuous enrollment period, any member found to be ineligible had their end date pushed to the PHE end date. The state will stop the process of extending coverage and will resume the normal processing of eligibility with some modifications on May 12, 2023. These modifications are created to ensure operational stability while maintaining safeguards to protect the most vulnerable members.

Member Notices

PHE-protected members will receive the following notices:

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

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

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

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

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

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

You are required to tell the Oklahoma Health Care Authority within 10 days if there are any changes in your income, the people in your home or tax household, where you live or get your mail, your health insurance, or other changes in circumstances that might affect your family's eligibility for benefits.

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

You may also call the SoonerCare helpline at 1-800-987-7767 to report any changes. Refer to the letter number and the case number listed at the top of this letter when you call.

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

Important notice to members whose services have been reduced or discontinued: If you want your services to be continued while your appeal is being decided, your LD-1 form should state you are requesting your services to be continued while your case is on appeal. If you continue receiving services, and the appeal decision is not in your favor, you may have to pay for any services you received.

Currently Eligible Cases

During the 12-month post-continuous eligibility period, application dates will be adjusted for cases with children under five. This will assist with the renewal bulge,

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

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

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

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

Ineligible Members Under PHE Protections

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

Ineligible members' coverage will be ended over the course of the 9-month period following the end of continuous enrollment for PHE-protected individuals on April 30, 2023. This plan will allow members who are at high risk to have their coverage protected for a longer period while lower risk members are phased out earlier. Additional groups will be added as they are identified.

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

Population Prioritization

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

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

Verifications

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

Ex Parte Renewals

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

Fair Hearings

When the PHE ends, the state is expected to begin to process fair hearing requests timely and take final administrative action within 90 days of the receipt of the request for non-expedited requests. The state anticipates a substantial increase in fair hearing requests based on data obtained from the fair hearing request-to-termination ratio for 2019-2021.

To mitigate risk, the state is increasing the number of staff to address pre-fair hearing work, research, and appeals. OHCA is engaging stakeholders, community partners and agency partners to communicate any process changes and address member eligibility determination questions. OHCA is increasing eligibility call center staff to address and resolve member questions regarding their eligibility determinations. In addition, Oklahoma intends to request a waiver to allow the state more time to render a fair hearing decision from 90 to 120 days.

Non-MAGI

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

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

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

Delinquent reviews will not trigger additional renewal notices and OKDHSLIVE is not available to the household after the review period expires. These updates allow the system to send a new renewal notice and gives the household the ability to submit the renewal through OKDHSLIVE. This process also balances the workload over the course of the 12 months allowed. The first two rounds of updates will be completed in February 2023.

The number of cases with expected reviews increases between July and August of 2023. We believe attrition will balance this load over time. However, we will analyze it in July 2023 and balance higher volume of reviews over the remaining months to ensure manageable workloads.

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

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

RETURNED MAIL

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

MAGI Process

OHCA will follow these steps to meet the returned mail condition.

1. For all members who have returned mail, OHCA will set a notice in their MySoonerCare.org account to alert the member they have returned mail. This will count as the first modality of outreach.
2. If returned mail has complete information:
    a. OHCA will verify the accuracy of the address on the returned mail against the information on file and any errors or incomplete information will be corrected, and the mail will be resent.
    b. If the mail is not returned, this will count as the second modality of outreach and the state will make no further outreach attempts.
    c. If the mail is returned again, the state will proceed with the returned mail process.
3. If returned mail has a forwarding address:
    a. If mail is returned with a forwarding address provided by USPS, OHCA will update the address on file with authority granted by the 1902(e)(14) waiver and forward the mail to the correct address.
    b. If the mail is not returned, this will count as the second modality of outreach, and the state will make no further outreach attempts.
    c. If the mail is returned again, the state will proceed with the returned mail process.
4. If mail is returned after updating/correcting the address as provided by USPS *or* if there is no forwarding address:
    a. OHCA will send an email to the member alerting them that they have returned mail. This will meet the second modality of outreach and the state will make no further outreach attempts.
    b. If there is no email address on file, OHCA will send a text message to the member alerting them that they have returned mail. This will meet the second modality of outreach and the state will make no further outreach attempts.
    c. If there is no cell phone on file capable of receiving a text message, an outbound call will be made to the member alerting them that they have returned mail. This will meet the second modality of outreach and the state will make no further outreach attempts.

Non-MAGI Process

For all members who have returned mail, OHS will use SMS messaging, emails and initiate outbound calls in a good faith effort to contact the individual.

UP-TO-DATE CONTACT INFORMATION

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

MAGI Process

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

As OHCA will not be updating the member email address, the state will implement member outreach strategies to prompt members to update their phone number, mailing address and email address themselves. OHCA outreach strategies include verifying contact information when speaking to a member, social media campaigns, member newsletters, and website messaging that specifically encourages members to update their email address, mailing address and contact information.

Non-MAGI Process

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

COMMUNICATIONS PLAN

Phase 1

Phase 1 of Oklahoma's Communications Plan began in August 2021 and will continue through January 2023. The goal of Phase 1 was to encourage potentially affected members to update their information in the member portal, educate stakeholders on the PHE and ensure there is consistent messaging regarding the PHE across all platforms. Communication was sent in English and Spanish, which are the two primary languages in Oklahoma.

Stakeholder	Communications
Core Messaging: *Make sure we know where to send your benefit information (address, email and phone number). Update your contact information at MySoonerCare.org.*	

Stakeholder	Communications
Members	• Created PHE page on Oklahoma.gov/ohca • Created PHE page on MySoonerCare.org • Targeted email campaign to PHE-protected members • Robocalls • Updated "How To" videos showing how to update information • Added messaging to hold messages • Developed FAQs • Messaging on social media • Messaging in member newsletters • Sent press releases to media
Providers	• Added red flag message to the provider portal if member has outdated information • Sent provider global alerts to inform/educate providers • Sent e-newsletters to all providers • Targeted providers seeing high numbers of PHE-protected members • Connected with provider associations • Provided flyers to display in offices • Global messages for PHE announcements from HHS
Media	• Press release to statewide media outlets • Scheduled one-on-one interviews with key media • Provided FAQs to media
Partners	• Held virtual meetings with community partners and navigators • Provided a PHE toolkit for agency partners, community partners and navigators • Ensured messaging is consistent across agency partner websites and social media • Engaged tribal partners
Employees	• Polled staff to establish employee understanding of PHE • Developed call scripts for staff • Educated staff in weekly e-newsletter

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

Phase 2

Phase 2 of Oklahoma's Communications Plan began in January 2023 after the CAA was signed. The goal of Phase 2 is to educate PHE-protected members, staff and stakeholders on the end of the continuous eligibility requirements and available resources, and to ensure consistent messaging across all platforms. Communication will be sent in English and Spanish, which are the primary two languages in Oklahoma.

Stakeholder	Communications
Core Messaging: *To educate on the end of the PHE, their specific end date and resources.*	
Members	• Send a one-time purple letter to all ineligible members • Send an email to all ineligible members • Send targeted emails to members with missing information • Send a text message to all ineligible members encouraging them to view their mail and email for important information • Update the website with end of PHE information, resources and next steps • Update social media platforms with the end of the PHE information, resources and next steps • Create a campaign based off one color as a way to bring attention to notices

Stakeholder	Communications
Providers	• Target providers who see PHE-protected members
Media	• Submit a press release with updated information on end of PHE and resources available for members
Partners	• Provide community partners, agency partners and navigators with education, training, and meetings. • Use communications toolkit to educate community partners, agency partners and navigators on consistent messaging and FAQs • PSA TV campaign with Oklahoma Department of Insurance promoting Marketplace
Employees	• Educate employees in staff newsletter • Educate employees in town hall meetings
Other Stakeholders	• Use communications toolkit to educate legislators • Hold one-on-one meetings with legislators • Provide education through electronic newsletters • Provide talking points and one-sheets to legislators and assistants

TRAINING PLAN

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

The ongoing COVID-19 outbreak and implementation of federal policies to address the PHE have disrupted routine Medicaid eligibility and enrollment operations. Medicaid enrollment in Oklahoma has grown to approximately 1.3 million individuals mostly due to the continuous enrollment condition. Oklahoma estimates approximately 300,000 Medicaid members are receiving continuous eligibility but will lose eligibility when the state begins processing renewals. It is critical to ensure the state of Oklahoma maximizes effectiveness with renewals of eligibility by solidifying an orderly process which minimizes the burden on members and promotes continuity of coverage for all members, eligible and ineligible, where possible.

Training and Development Timeline

Development

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

Training

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

Instructors

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

Training Plan Overview

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

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

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

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

Training Guide

Learning Objectives

Upon completing the training, learners are able to:

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

Delivery Method and Outline:

PowerPoint presentation via Office365 Teams covering the following topics:

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

STAFFING PLAN

Call Center Staffing

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

Timing of Tier II Staffing

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

Additional Tier 2	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sept 2023	Oct 2023	Nov 2023	Dec 2023	Jan 2023
CSRs	15	30	30	30	30	30	30	30	30	30	30
MMS Sups	1	2	2	2	2	2	2	2	2	2	2

The chart above outlines the planned timeline for the additional staff (based on continuous eligibility ending on April 30, 2023). After Month 9 (December 2023), or based on business need, Maximus would then wind down the number of additional staff in Tier 2, returning the CSRs back to the Tier 1 queues.

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

Timing of Tier I Staffing

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

Internet Helpdesk Staffing

The OHCA Internet Helpdesk is staffed and operated by Gainwell Technologies. Most calls to the Internet Helpdesk are members requesting a password reset for their account. Portal messaging was updated to alert members they can wait 15 minutes to retry their login when they are locked out due to too many login replacing instructions that requested them to call. This will help reduce call volume. Gainwell has also increased the number of agents in the call center.

Senior Eligibility Staffing

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

FLEXIBILITIES

OHCA submitted disaster relief requests to the Centers for Medicare & Medicaid Services (CMS) for several flexibilities in response to the PHE. The requests were submitted through various 1135 waiver requests, Title XIX and Title XXI Children's Health Insurance Program (CHIP) disaster relief state plan amendments (SPAs), as well as Home and Community-Based Services (HCBS) Appendix K requests. OHCA's requests

are approved by CMS or authorized by federal legislation and CMS blanket approvals. The State's 11135 waiver requests and disaster relief SPAs expire upon the termination of the PHE declaration.

The FFCRA increased the Federal Medical Assistance Percentage (FMAP) available for qualifying expenditures incurred on or after Jan. 1, 2020, through Dec. 31, 2023. The increased FMAP rate will decrease quarterly beginning April 1, 2023. The continuous enrollment requirement in section 6008(b)(3) of the FFCRA prevents states seeking to claim the temporary FMAP increase from terminating eligibility for individuals enrolled in Medicaid as of March 18, 2020, through April 1, 2023, even if the individual no longer meets eligibility requirements, unless the person voluntarily disenrolls or is no longer a state resident. The requirements of section 6008 of the FFCRA do not apply to separate CHIPs.

The American Rescue Plan (ARP) mandates the state to provide COVID-19 related countermeasures without cost sharing to populations with full-scope Title XIX Medicaid benefits, Title XXI Children's Health Insurance Plan (CHIP) benefits and who are members of the state's separate CHIP program, Soon-to-be-Sooners (STBS), through the end of the ARP period of March 11, 2021, through Sept. 30, 2024.

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

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

Request	Status
Disaster Relief Request & American Rescue Plan Mandate: Assurance to CMS for coverage and reimbursement of COVID-related countermeasures **for full-scope Title XIX beneficiaries** without cost sharing: • Vaccine administration • COVID-19 vaccine counseling for children under the age of 21 • Testing services • Testing-related services and treatments for COVID-19 including specialized equipment and therapies (including drugs) • Treatment for conditions that may seriously complicate the treatment of COVID-19	**TEMPORARY Title XIX DR/ARP SPA pending submission** (Effective March 11, 2021, through Sept. 30, 2024)

Disaster Relief Request & American Rescue Plan Mandate: Assurance to CMS for coverage and reimbursement of COVID-related countermeasures **for all Title XXI individuals** (including S-CHIP) without cost sharing: • Vaccine administration • COVID-19 vaccine counseling for children under the age of 21 • Testing services • Testing-related services and treatments for COVID-19 including specialized equipment and therapies (including drugs) • Treatment for conditions that may seriously complicate the treatment of COVID-19	**TEMPORARY DR/ARP Title XXI SPA pending submission** (Effective March 11, 2021, through Sept. 30, 2024)
Disaster Relief Request & American Rescue Plan Mandate: Assurance to CMS for coverage of COVID-related countermeasures **for full-scope Title XIX beneficiaries** without cost sharing: • Treatments for COVID-19 including specialized equipment and therapies (including drugs) • Treatment for conditions that may seriously complicate the treatment of COVID-19	**TEMPORARY Title XIX DR/ARP 1115 waiver pending submission** (Effective March 11, 2021, through Sept. 30, 2024)
Disaster Relief Request & American Rescue Plan Mandate: Assurance to CMS for coverage and reimbursement of COVID-19 vaccine and vaccine administration for **individuals receiving family planning or tuberculosis** benefits without cost sharing	**TEMPORARY Title XIX DR/ARP SPA pending submission** (Effective March 11, 2021, through Sept. 30, 2024)
Disaster Relief Request & ARP Mandate: Provide over-the-counter at-home Covid tests.	**DR/ARP Title XIX SPA pending submission** (Effective Aug. 30, 2021 through Sept. 30, 2024)
1902(e)(14) Waiver Request: To allow the agency to deviate from the CAA required methods in which the agency must update member contact info.	**TEMPORARY Waiver pending submission** (Effective April 1, 2023, through March 31, 2024)
1902(e)(14) Waiver Request: To allow the agency to reasonably exceed the time permitted (of 90 days) for the state to take final administrative action for Medicaid and CHIP beneficiaries, excluding requests for an expedited fair hearing in accordance with 42 C.F.R. § 431.224.	**TEMPORARY Waiver pending submission** (Effective April 1, 2023, through March 31, 2024)
Disaster Relief Request: Establish a rate increase for private duty nursing (PDN) providers for PDN hours that result in overtime rate of pay for nursing staff. • Effective March 1, 2020, through December 31, 2022, the increase from $32/hour to $40/hour is to be applied only for persons with	**DRSPA requested & approved, effective March 1, 2020** **DRSPA requested & pending approval, effective Jan. 1, 2023**

tracheostomies or who are ventilator-dependent. Effective Jan. 1, 2023, through the remainder of the PHE, the base rate for PDN services increased from $32.68/hour to $40/hour and the overtime rate for persons with tracheostomies or who are ventilator-dependent increased from $40/hour to $48.92/hour.	PERMANENT Title XIX SPA pending submission (Effective May 12, 2023)
Disaster Relief Request: Allow adults in the Medicaid program access to services (inclusive of crisis intervention services) provided by independently contracted clinical psychologists practicing within state scope of practice.	DRSPA requested & approved, effective July 1, 2021 PERMANENT Title XIX SPA pending submission (Effective May 12, 2023)
Disaster Relief Request: The OHCA will extend the current vaccine administration reimbursement methodologies, as per the Oklahoma Medicaid State Plan, to pharmacies for all Advisory Committee on Immunization Practices (ACIP) recommended vaccines.	DRSPA requested & approved, eff. Aug. 24, 2020 PERMANENT Title XIX SPA pending submission (Effective May 12, 2023)
Disaster Relief Request & American Rescue Plan Mandate: Assurance to CMS for coverage and reimbursement of COVID-19 vaccine and vaccine administration for **individuals receiving family planning or tuberculosis** benefits without cost sharing.	TEMPORARY Title XIX DR/ARP SPA pending submission (Effective March 11, 2021, through Sept. 30, 2024)
Termination of Family Planning Eligibility Program.	PERMANENT Title XIX SPA pending submission (Effective Jan. 1, 2024)
Disaster Relief Request: Allow nurse practitioners, clinical nurse specialists or physician assistants, working in accordance with state law to order home health services as per the CARES Act.	DRSPA requested & approved, effective March 21, 2020 PERMANENT Title XIX SPA 21-0026 Approved (Effective May 12, 2023)

Maintained Telehealth Codes

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

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

Flexibilities Terminating on May 11, 2023

Additional blanket waivers approved by CMS are set forth here. *Blanket waivers apply to all applicable providers and do not require a request be sent or that notification be made to CMS.

1135 Waiver Flexibilities
Waiver of 42 CFR 431.408(a)(3) in order to conduct all public hearings required for waiver submission virtually rather than in person.
Waiving certain provider enrollment requirements, such as provider enrollment fees, criminal background checks associated with fingerprint-based criminal checks, site visits, screening levels, and in-state/territory licensure.
Temporarily suspending the revalidation of all providers who are located in Oklahoma or otherwise directly impacted by the emergency.
Waive the requirement that critical access hospitals limit the number of beds to 25 and that the length of stay be limited to 96 hours.
Suspend the three-day prior hospitalization for coverage of a skilled nursing facility stay for the duration of the emergency.
Waive Emergency Medical Treatment and Labor Act (EMTALA) sanctions for redirection of an individual to receive a focused medical screening examination related to COVID-19 in an alternative location.
Suspend minimum data set submission requirements for clients in non-skilled nursing facilities for 60 days.
Allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA-compliant teleconference or videoconference team meetings are held.
Postponing member eligibility renewals that are scheduled to occur during the emergency declaration.
Temporarily delay scheduling Medicaid fair hearings and issuing fair-hearing decisions during the emergency period to allow an additional 120 days to appeal and issue decisions.
Added flexibility to suspend or modify prior authorization requirements for accessing covered state plan and waiver benefits during the emergency period. OHCA will only utilize this option if unable to review and process PAs due to staff shortage or technology failure.
Waive state plan or waiver-imposed utilization controls on covered benefits to the extent such limits cannot be exceeded based on medical necessity in the relevant approved state plan or waiver authority.
Allowing expanded use of telehealth through the end of the declared public health emergency for most SoonerCare reimbursable services.

Waive pre-admission screening and annual resident review level I and II for 30 days.
Allow durable medical equipment providers to waive replacement requirements such as the face-to-face requirement, new physician's order and a renewal medical necessity documentation.
Waiver of face-to-face encounter requirements for reimbursement in 42 CFR 405.2463(a)(B)(3) and 42 CFR 440.90(a) for FQHCs, RHCs, and Tribal 638 clinics to allow for telephonic services provided by clinic providers for new or established clinic patients. Telephonic services would be reimbursed on a fee-for-service basis and not PPS.
Waiver of requirement for Tribal 638 clinics that services be provided within the clinic's four walls except for homeless populations per 42 FR 440.90 to allow for the screening and testing away from patient areas and allow for services to homebound and others. Tribal 638 clinics would be able to bill these visits at the federally established OMB rate methodology. **CMS has extended the grace period for states and tribal facilities to come into compliance with the "four walls" requirement under 42 C.F.R. § 440.90 to nine months after the COVID-19 PHE ends**
Waiver of the requirement that clinic services must be provided within the four walls of the clinic pursuant to 42 CFR 440.90 to allow for the screening and testing away from patient areas and allow for services to homebound and others. **CMS has extended the grace period for states and tribal facilities to come into compliance with the "four walls" requirement under 42 C.F.R. § 440.90 to nine months after the COVID-19 PHE ends**
Allow payment for personal care services rendered by legally responsible individuals for the period of the public health emergency.
Flexibility allowing providers to receive payments for services provided to affected SoonerCare members in alternative physical settings, such as mobile testing sites, temporary shelters, or facilities. This would include allowing facilities such as NFs, ICF/IIDs, PRTFs and hospitals to be fully reimbursed for services rendered during an emergency evacuation to an unlicensed facility (where an evacuating facility continues to render services). The facility would be responsible for determining how to reimburse the unlicensed facility. This arrangement would only be effective for the duration of the Section 1135 waiver. However, after the initial 30 days, CMS would require that the unlicensed facility either seek licensure or the evacuating facility would need to seek new placement for the individuals.
Title XIX Disaster Relief Flexibilities
Modify the requirement to submit a SPA by March 31, 2020, to obtain an SPA effective date during the first calendar quarter of 2020.
Waive public notice requirements that would otherwise be applicable to this SPA submission.
Request to notify tribal partners of all SPA changes on or before submission to CMS, as well as offer a telephonic meeting to discuss or consult with tribes at the next regularly schedule bi-monthly consultation meeting.

Eligibility
Allow hospitals to make presumptive eligibility (PE) determinations for non-MAGI individuals including: • Individuals eligible for but not receiving cash assistance, 1902(a)((10)(A)(ii)(I). • Individuals eligible for cash except institutionalization, 1902(a)(10)(A)(ii)(IV). • Optional state supplemental beneficiaries, 1902(a)(10)(A)(ii)(XI). • Individuals in institutions eligible under a special income level, aged, blind and disabled individuals, 1902(a)(10)(A)(ii)(V) and 1905(a)(iii), (iv) and (v). • Age and disability-related poverty level, 1902(a)(10)(ii)(X) and 1902(m).
Disregard resources or built-up assets that result from any payment made by the federal, state, local, or tribal government to relieve the adverse economic impacts of the COVID-19 pandemic that would have otherwise been part of an individual's liability for his or her institutional services based on application of the post-eligibility treatment-of income (PETI) rules but which became countable resources on or after March 1, 2020, and/or retained through the end of the COVID-related public health emergency for individuals who are 65 years of age or older or are disabled individuals.
Flexibility to reasonably exceed (by 30 days) the time permitted (of 90 days) for the state to take final administrative action for Medicaid and CHIP beneficiaries (for a total of 120 days), excluding requests for an expedited fair hearing in accordance with 42 C.F.R. § 431.224, effective July 1, 2021. **(Pending CMS concurrence)**
Benefits
Establish coverage of mobile COVID-19 testing sites.
Aligning the Expansion Adult ABP with the previously approved disaster relief requests to apply newly added and/or adjusted benefits to Alternative Benefit Plans (ABP).
Change the 34-day supply prescription quantity limit to allow for a 90-day supply.
Expand prior authorization for medications by automatic renewal without clinical review, or time/quantity extensions.
Request to waive signature requirements for prescription drug counseling for the full duration of the PHE
Provider Reimbursement
Allow rural/independent Medicaid-enrolled hospitals to request an interim payment.
Establish a supplemental payment based on the cost for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) in a form of a one-time lump sum to eligible nursing facilities serving residents classified by the state as ventilator dependent.
Waive the penalties for possibly preventable readmissions that exceed 100% of the statewide average.
Increase the number of therapeutic leave days in nursing facilities (NFs) and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) from 7 days NF & 60 days ICF-IID to 10 days NF & ICF-IID 70 days.
Waive the provision that payments for therapeutic leave days could not exceed a maximum of 14 consecutive days per absence for ICF/IIDs.

Allow a temporary supplemental payment for long-term care facilities and Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID) to support increased costs due to COVID-19. The effective date for the supplemental payments will be retroactive to July 1, 2020, and will end with the PHE.
ACIP-recommended vaccine administration by state-authorized pharmacy interns and by qualified pharmacy technicians.
COVID-19 vaccine administration by qualified pharmacy technicians.
COVID-19 testing administration of by state-authorized pharmacy interns administration and by qualified pharmacy technicians.
COVID-19 treatment (select therapeutics) ordering and administering by licensed pharmacists.
1115 SoonerCare Choice Demonstration Flexibilities
Suspend premium obligations as a requirement for eligibility in the Insure Oklahoma Individual Plan during the emergency period as well as accept for purposes of eligibility. IO IP members were transitioned to Medicaid Expansion

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

PHE-related 1915c Requests PENDING Post-PHE Status

1915c HCBS Waiver Flexibilities	Status Post-PHE
Advantage Waiver	
Temporarily modify service scope and coverage, exceeding certain service limitations, adding services, expanding service settings, suspending exception requirements, modifying provider qualifications, modifying licensure requirements, modifying level of care evaluation processes, modifying person-centered service plans, modifying incident reporting requirements, allowing payments for hospitalized services, including retainer payments, and allowing for video conferencing/telehealth opportunities.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends
Allow an extension of three months to respond to the Draft Quality Review Report for the Advantage Waiver.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends
Update the end date to Jan. 26, 2021.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends
Temporarily increase payment rates for home care services, adult day health services, assisted living services, hospice services, and nursing facility respite services.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends

Update the end date to six months after the public health emergency expiration.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends
Temporarily include a retroactive COVID-19 add-on payment not to exceed 20% of the provider's current rate during the period beginning Oct. 1, 2020, through Dec. 31, 2020.	Pending LTCSS & OHS Expires 6 Months after the PHE Ends

Maintained PHE-related 1915c Requests

1915(c) Disaster-Relief Flexibilities	Status Post-PHE
Community Waiver	
Temporarily allow HTS services to be participant directed.	Added to waiver effective Sept. 1, 2020
Temporarily allow DHS/DDS case management to conduct required monitoring using Health Insurance Portability and Accountability Act (HIPAA)-compliant phone and/or videoconferencing.	Added to waiver effective July 1, 2021
Temporarily allow for payment of HTS services to assist with communication and stabilization when a member with COVID-19 or COVID-19-like symptoms is in a short-term care facility or hospital, not to exceed 30 consecutive days.	Added to waiver effective July 1, 2021
Temporarily allow professional providers to utilize HIPAA-compliant telehealth.	Added to waiver effective July 1, 2021
Temporarily allow the use of monitoring via HIPAA-compliant phone or videoconferencing in the Daily Living Support service setting.	Added to waiver effective July 1, 2021
Temporarily allow providers to monitor an employment site via HIPAA-compliant phone or videoconferencing.	Added to waiver effective July 1, 2021
Temporarily increase the combined additional cost limit for Prevocational services and Supported Employment Services.	Added to waiver effective July 1, 2021
Temporarily allow the provision via HIPAA-compliant phone or videoconferencing in the Prevocational service setting.	Added to waiver effective July 1, 2021 (can only supplement required face to face visits)

Temporarily allow provision of Habilitation Training Specialist service to adult members using HIPAA-compliant phone or videoconferencing in non-residential service settings.	Added to waiver effective July 1, 2021
Temporarily allow the completion of required signatures for consent forms to be obtained via mail or electronically.	Added to waiver effective July 1, 2021
Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA-compliant teleconference or videoconference team meetings are held. Verbal consent, including the date the individual planning meeting was held, should be documented on the service plan.	Added to waiver effective July 1, 2021 (sign agreement to implement service plan electronically when plan is held virtually)
Temporarily allow the SD-HTS to be someone who lives in the same household for the IHSWs and Community Waiver.	Added to waiver effective July 1, 2022
Temporarily allow DHS/DDS case management to conduct team meetings, including individual planning meetings, via HIPAA-compliant teleconference or videoconference.	Added to waiver effective July 1, 2022
Temporarily allow addition of examination for eyeglasses and corrective lenses.	Added to waiver effective July 1, 2022
Temporarily allow increase for dental services for adults to $3,500 per year — does not apply to class members.	Added to waiver effective July 1, 2022
Temporarily remove amount of public transportation services that can be accessed within plan year.	Added to waiver effective July 1, 2022
Temporarily allow limit for each family training service (individual and group) to increase from $5,500 to $6,500 per plan year.	Added to waiver effective July 1, 2022
Homeward Bound Waiver	
Temporarily allow DHS/DDS case management to conduct required monitoring using Health Insurance Portability and Accountability Act (HIPAA)-compliant phone and/or videoconferencing.	Added to waiver effective July 1, 2021

Temporarily allow for payment of HTS services to assist with communication and stabilization when a member with COVID-19 or COVID-19-like symptoms is in a short-term care facility or hospital, not to exceed 30 consecutive days.	Added to waiver effective July 1, 2021
Temporarily allow professional providers to utilize HIPAA-compliant telehealth.	Added to waiver effective July 1, 2021
Temporarily allow the use of monitoring via HIPAA-compliant phone or videoconferencing in the Daily Living Support service setting.	Added to waiver effective July 1, 2021
Temporarily allow providers to monitor an employment site via HIPAA-compliant phone or videoconferencing.	Added to waiver effective July 1, 2021
Temporarily increase the combined additional cost limit for Prevocational services and Supported Employment services.	Added to waiver effective July 1, 2021
Temporarily allow the provision via HIPAA-compliant phone or videoconferencing in the Prevocational service setting.	Added to waiver effective July 1, 2021 (can only supplement required face-to-face visits)
Temporarily allow provision of Habilitation Training Specialist service to adult members using HIPAA-compliant phone or videoconferencing in non-residential service settings.	Added to waiver effective July 1, 2021
Temporarily allow the completion of required signatures for consent forms to be obtained via mail or electronically.	Added to waiver effective July 1, 2021
Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA-compliant teleconference or videoconference team meetings are held. Verbal consent, including the date the individual planning meeting was held, should be documented on the service plan.	Added to waiver effective July 1, 2021 (sign agreement to implement service plan electronically when plan is held virtually)
Temporarily allow DHS/DDS case management to conduct team meetings, including individual	Added to waiver effective July 1, 2022

planning meetings, via HIPAA-compliant teleconference or videoconference.	
Temporarily allow addition of examination for eyeglasses and corrective lenses	Added to waiver effective July 1, 2022
Temporarily allow increase for dental services for adults to $3,500 per year — does not apply to class members	Added to waiver effective July 1, 2022
Temporarily remove amount of public transportation services that can be accessed within plan year	Added to waiver effective July 1, 2022
Temporarily allow limit for each family training service (individual and group) to increase from $5,500 to $6,500 per plan year.	Added to waiver effective July 1, 2022
In Home Supports Waiver for Adults	
Temporarily allow DHS/DDS case management to conduct required monitoring using Health Insurance Portability and Accountability Act (HIPAA)-compliant phone and/or videoconferencing.	Added to waiver effective July 1, 2021
Temporarily allow for payment of HTS services to assist with communication and stabilization when a member with COVID-19 or COVID-19-like symptoms is in a short-term care facility or hospital, not to exceed 30 consecutive days.	Added to waiver effective July 1, 2021
Temporarily allow professional providers to utilize HIPAA-compliant telehealth.	Added to waiver effective July 1, 2021
Temporarily allow the use of monitoring via HIPAA-compliant phone or videoconferencing in the Daily Living Support service setting.	Added to waiver effective July 1, 2021
Temporarily allow providers to monitor an employment site via HIPAA-compliant phone or videoconferencing.	Added to waiver effective July 1, 2021
Temporarily increase the combined additional cost limit for Prevocational services and Supported Employment services.	Added to waiver effective July 1, 2021

Temporarily allow the provision via HIPAA-compliant phone or videoconferencing in the Prevocational service setting.	Added to waiver effective July 1, 2021 (can only supplement required face-to-face visits)
Temporarily allow provision of Habilitation Training Specialist service to adult members using HIPAA-compliant phone or videoconferencing in non-residential service settings.	Added to waiver effective July 1, 2021
Temporarily allow the completion of required signatures for consent forms to be obtained via mail or electronically.	Added to waiver effective July 1, 2021
Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA-compliant teleconference or videoconference team meetings are held. Verbal consent, including the date the individual planning meeting was held, should be documented on the service plan.	Added to waiver effective July 1, 2021 (sign agreement to implement service plan electronically when plan is held virtually)
Temporarily allow the SD-HTS to be someone who lives in the same household for the IHSWs and Community Waiver	Addedto waiver effective July 1, 2022
Temporarily allow DHS/DDS case management to conduct team meetings, including individual planning meetings, via HIPAA-compliant teleconference or videoconference.	Added to waiver effective July 1, 2022
Temporarily allow addition of examination for eyeglasses and corrective lenses.	Added to waiver effective July 1, 2022
Temporarily allow increase for dental services for adults to $3,500 per year — does not apply to class members.	Added to waiver effective July 1, 2022
Temporarily remove amount of public transportation services that can be accessed within plan year.	Added to waiver effective July 1, 2022
Temporarily allow limit for each family training service (individual and group) to increase from $5,500 to $6,500 per plan year	Added to waiver effective 7/1/2022

In Home Supports Waiver for Children	
Temporarily allow professional providers to utilize HIPAA-compliant telehealth.	Added to waiver effective July 1, 2021
Temporarily allow the use of monitoring via HIPAA-compliant phone or videoconferencing in the Daily Living Support service setting.	Added to waiver effective July 1, 2021
Temporarily allow providers to monitor an employment site via HIPAA-compliant phone or videoconferencing.	Added to waiver effective July 1, 2021
Temporarily increase the combined additional cost limit for Prevocational services and Supported Employment services.	Added to waiver effective July 1, 2021
Temporarily allow the provision via HIPAA-compliant phone or videoconferencing in the Prevocational service setting.	Added to waiver effective July 1, 2021 (can only supplement required face-to-face visits)
Temporarily allow the completion of required signatures for consent forms to be obtained via mail or electronically.	Added to waiver effective July 1, 2021
Temporarily allow DHS/DDS case management to conduct team meetings, including individual planning meetings, via HIPAA-compliant teleconference or videoconference.	Added to waiver effective July 1, 2021
Temporarily allow verbal consent from beneficiaries and all providers responsible for service plan implementation when HIPAA-compliant teleconference or videoconference team meetings are held. Verbal consent, including the date the individual planning meeting was held, should be documented on the service plan.	Added to waiver effective July 1, 2021 (sign agreement to implement service plan electronically when plan is held virtually)
Temporarily allow the SD-HTS to be someone who lives in the same household for the IHSWs and Community Waiver.	Added to waiver effective July 1, 2022
Temporarily allow increase for dental services for adults to $3,500 per year — does not apply to class members.	Added to waiver effective July 1, 2022

Temporarily remove amount of public transportation services that can be accessed within plan year.	Added to waiver effective July 1, 2022
Temporarily allow limit for each family training service (individual and group) to increase from $5,500 to $6,500 per plan year.	Added to waiver effective July 1, 2022
Medically Fragile Waiver	
Allow certified case management and skilled nursing to conduct required service planning and monitoring activities using telehealth, phone and/or videoconferencing.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Temporarily modify person-centered service plan development to allow increased service delivery after documentation of changes on the plan but prior to authorization of the service.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Temporarily allow professional providers to utilize telehealth and will be utilized in accordance with HIPAA requirements.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Temporarily allow legal guardians and authorized representative to provide Personal Care and Advanced Supportive/Restorative services under the self-direction model in the absence of the regular paid caregiver. (With language revisions)	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Temporarily suspend Eligible Provider Exception requirements to allow family members/legal guardians to provide personal care services for Medically Fragile waiver members including personal care, advanced supportive/restorative and self-directed services.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Allow legal guardian, power of attorney, spouse or authorized representative to provide personal care services as needed. (With language revisions)	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Allow online training of personal care attendants (for all PCS types) to be done electronically.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Allow increases in PCA to be provided once added to the plan of care and without awaiting prior authorization.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Allow for the increased provision of home delivered meals up to two times per day, seven days per week, for a total of 14 meals per week.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Temporarily allow for respite services to be provided in a nursing facility contracted with OHCA when members needing nursing facility respite are in an	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)

area with no Medically Fragile waiver contracted providers. (With language revisions)	
Allow signatures for service plan development to be obtained via e-signature or U.S postal mail from the case manager.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Reassessment for ongoing Medically Fragile waiver eligibility will continue as per the waiver. When questions regarding ongoing eligibility exist, the nurse will contact the case manager and/or Medically Fragile waiver member for additional information to validate ongoing eligibility.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Provider trainings for Case Management and Home Health providers will be modified to an online training format.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Required case management assessment, reassessment and monitoring visits will be conducted by phone or videoconferencing unless an extreme situation warrants an in-person visit. Videoconferencing will be utilized in accordance with HIPAA requirements.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Required skilled nursing visits for monitoring/supervision of personal care services may be completed via phone or videoconferencing. Nursing visits for direct care should be completed in person when feasible. Phone consultation for direct care supervision should occur only when member access to teleconferencing technology is unavailable.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
State will allow the use of telehealth through options such as mobile videoconferencing, Zoom, etc., and will be done in accordance with the HIPAA requirements. Signatures to verify time and date of meeting(s) will be obtained through an e-signature process or through U.S. postal mail with the meeting date and time. Service plans authorized pending member signature will have case management services conditionally authorized for up to 45 days to ensure receipt.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)
Providers of speech therapy, physical therapy and occupational therapy may utilize videoconferencing/telehealth during times of emergency declaration and will be utilized in accordance with HIPAA requirements.	To Be Incorporated into Renewal of Medically Fragile Waiver (July 1, 2023)

TERMINATING Disaster Relief Flexibilities Post-PHE

1915(c) HCBS Disaster-relief Flexibilities	
Community Waiver	
20% retroactive rate add-ons (April 1-Sept. 30, 2020, Oct. 1-Dec. 31, 2020)	The retroactive provider rates ended September 2022
Homeward Bound Waiver	
20% retroactive rate add-ons (April 1-Sept. 30, 2020, Oct. 1-Dec. 31, 2020)	The retroactive provider rates ended September 2022
In-Home Supports Waiver for Adults	
20% retroactive rate add-ons (April 1-Sept. 30, 2020, Oct. 1-Dec. 31, 2020)	The retroactive provider rates ended September 2022
In-Home Supports Waiver for Children	
20% retroactive rate add-ons (April 1-Sept. 30, 2020, Oct. 1-Dec. 31, 2020)	The retroactive provider rates ended September 2022
Medically Fragile Waiver	
Temporarily allow for payment of personal care assistance services when a member is in a short-term care facility or hospital for a duration and not to exceed 30 days consecutively.	Expires 6 months after the PHE ends
Remove requirement of in-home training for Advanced Supportive/Restorative Assistants and waiver requirement for annual in-service training.	Expires 6 months after the PHE ends
Allow PCA to be provided in an acute care setting when needed to assist members with communication, intensive personal care, behavioral stabilization, or other supports the hospital is unable to provide, not to exceed 30 consecutive days.	Expires 6 months after the PHE ends
Temporarily allow for the provision of nursing facility respite services up to a period of 30 days.	Expires 6 months after the PHE ends
Allow all case management activities to be completed electronically, including service plan development and service monitoring.	Expires 6 months after the PHE ends
Initial medical eligibility assessment will be completed by a OHCA care management nurse using the UCAT. Videoconferencing should include Facetime with the member and staff when possible and will be utilized in accordance with HIPAA requirements.	Expires 6 months after the PHE ends
Temporarily modify annual provider qualifications by extending current verification from annually to up to every other year.	Expires 6 months after the PHE ends

Service plan modifications and increases of personal care services may be implemented once documented on the member's plan and prior to authorization. This does not apply to service decreases, which will continue to require service authorization	Expires 6 months after the PHE ends
Suspend the requirements for community activities including efforts to pursue community integrated efforts, as well as the requirements for allowing visitors (providers may prohibit/restrict visitation in-line with CMS recommendations).	Expires 6 months after the PHE ends